Greer, Leslie

From: Martone, Kim
Sent: Thursday, July 16, 2015 11:04 AM
To: Brancifort, Janet; Hansted, Kevin; Lazarus, Steven
Cc: Greer, Leslie; Riggott, Kaila
Subject: FW: Determination Request - ECHN/Prospect Medical
Attachments: ECHN-Prospect Medical Determination Request to AGO and OHCA - FILED 7-16-15.PDF

From: Matthews, Rebecca [mailto:RMatthews@wiggin.com]
Sent: Thursday, July 16, 2015 11:01 AM
To: Martone, Kim
Cc: Dennis P. McConville (dmcconville@echn.org); Gina Kline (gkline@echn.org); Joyce Tichy; Agsten, Melinda A.
Subject: Determination Request - ECHN/Prospect Medical

Dear Kim:

Attached is a pdf of the filing that is being hand-delivered to your office this afternoon. Please let us know if you have any questions or need additional copies.

Thank you.

-Rebecca

Rebecca A. Matthews
Wiggin and Dana LLP
265 Church Street, P.O. Box 1832
New Haven, Connecticut 06508-1832
Direct: 203.498.4502 | rmatthews@wiggin.com

50 S. 16th Street, Suite 2925
Philadelphia, Pennsylvania 19102
Phone: 215.988.8310

WIGGIN AND DANA
New Haven | Stamford | New York | Hartford | Philadelphia | Greenwich | www.wiggin.com

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Disclosure under U.S. IRS Circular 230: **Wiggin and Dana LLP** informs you that any tax advice contained in this communication (including any attachments) was not intended or written to be used, and cannot be used, for the purpose of avoiding federal tax related penalties or promoting, marketing or recommending to another party any transaction or matter addressed herein.

WIGGIN AND DANA

Counsellors at Law

Wiggin and Dana LLP
One Century Tower
P.O. Box 1832
New Haven, Connecticut
06508-1832
www.wiggin.com

Rebecca A. Matthews
Melinda A. Agsten
203.498.4400
203.782.2889 fax
rmatthews@wiggin.com
magsten@wiggin.com

July 16, 2015

VIA HAND DELIVERY

The Honorable George C. Jepsen
Attorney General
Office of the Attorney General
55 Elm Street
Hartford, CT 06106

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

Re: Eastern Connecticut Health Network, Inc.

Dear Attorney General Jepsen and Commissioner Mullen:

Please be advised that Wiggin and Dana LLP represents Eastern Connecticut Health Network, Inc. and its affiliated entities (collectively "***ECHN***") in connection with the proposed transfer of certain assets of ECHN to Prospect Medical Holdings, Inc. ("***PMH***"). Please accept the enclosed Determination Letter submitted by ECHN and PMH to begin the review process for the proposed transaction as required by Connecticut General Statutes §§19a-486 et seq. and 19a-630 et seq.

ECHN's proposal to transfer certain of its assets to PMH follows an extensive review and due diligence process. The proposed transfer will provide a number of benefits for the community currently served by ECHN including, but not limited to:

- Continued operation of Manchester Memorial and Rockville General Hospitals;
- Capital investments to improve facilities and equipment; and
- Development of a high-quality, accessible and cost-effective health care network.

We kindly request that the appearance of Wiggin and Dana LLP be entered on behalf of ECHN for matters conducted both at the Office of Attorney General and the Department of Public Health, Office of Health Care Access. We look forward to working with your offices to ensure continued access to high quality health care services for the communities served by ECHN.

Thank you for your time and attention. Please forward all subsequent materials to our attention.

Sincerely,

Wiggin and Dana LLP

By_____
Rebecca A. Matthews
Its Partner

By_____
Melinda A. Agsten
Its Partner

cc: Dennis P. McConville, Senior Vice President and Chief Strategy Officer, Eastern Connecticut Health Network, Inc.
Thomas M. Reardon, President, Prospect Medical Holdings-East, Inc.
Frank Saidara, Vice President, Corporate Development, Prospect Medical Holdings, Inc.
Joyce Tichy, Senior Vice President and General Counsel
Michele M. Volpe, Esq., Bershtein, Volpe & McKeon, P.C.

88888888/810/3314984.1

State of Connecticut
Office of Health Care Access
CON Determination Form
Form 2020

All persons who are requesting a determination from OHCA as to whether a CON is required for their proposed project must complete this Form 2020. The completed form should be submitted to the Director of the Office of Health Care Access, 410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

SECTION I. PETITIONER INFORMATION

If this proposal has more than two Petitioners, please attach a separate sheet, supplying the same information for each Petitioner in the format presented in the following table.

	Petitioner	Petitioner
Full Legal Name	Eastern Connecticut Health Network, Inc.	Prospect Medical Holdings, Inc.
Doing Business As		
Name of Parent Corporation		
Petitioner's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail	71 Haynes Street Manchester, CT 06040	10780 Santa Monica Blvd., Suite 400 Los Angeles, CA 90025
What is the Petitioner's Status: P for profit and NP for Nonprofit	NP	P
Contact Person at Facility, including Title/Position: This Individual at the facility will be the Petitioner's Designee to receive all correspondence in this matter.	Dennis McConville, Senior Vice President & Chief Strategy Officer	Jonathan Spees Senior Vice President, Corporate Development

	Petitioner	Petitioner
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail	71 Haynes Street Manchester, CT 06040	10780 Santa Monica Blvd., Suite 400 Los Angeles, CA 90025
Contact Person's Telephone Number	(860) 533-3429	(310) 696-4738
Contact Person's Fax Number	(860) 647-6860	(714) 560-7320
Contact Person's e-mail Address	dmcconville@echn.org	Jonathan.spees@prospectmedical.com

SECTION II. GENERAL PROPOSAL INFORMATION

a. **Proposal/Project Title:** Proposed Transfer of Assets of Eastern Connecticut Health Network, Inc. and Affiliates to Prospect Medical Holdings, Inc.

b. **Estimated Total Project Cost:** $105,000,000 (subject to certain adjustments, including substantial reductions for items such as outstanding indebtedness, liabilities relating to pension, retiree health, captive insurer, capital leases and asbestos abatement, and any joint venture interests that do not transfer).

c. **Location of proposal, identifying Street Address, Town and Zip Code:** 71 Haynes Street, Manchester, CT 06040; 31 Union Street, Vernon, CT 06066; and locations served by joint ventures to be transferred as described below.

d. **List each town this project is intended to serve:**
Andover, Ashford, Bolton, Columbia, Coventry, East Hartford, East Windsor, Ellington, Glastonbury, Hebron, Manchester, Mansfield, Somers, South Windsor, Stafford, Tolland, Vernon, Willington, Union

e. **Estimated starting date for the project:** Following regulatory approval and satisfaction of other closing conditions, including approval of the transaction by ECHN's Corporators

SECTION IV. PROPOSAL DESCRIPTION

Please provide a description of the proposed project, highlighting each of its important aspects, on at least one, but not more than two separate 8.5" X 11" sheets of paper. At a minimum each of the following elements need to be addressed, if applicable:

1. If applicable, identify the types of services currently provided and provide a copy of each Department of Public Health license held by the Petitioner.

2. Identify the types of services that are being proposed and what DPH licensure categories will be sought, if applicable.

3. Identify the current population served and the target population to be served.

Please see attached pages for proposal description.

PROPOSAL DESCRIPTION:

Eastern Connecticut Health Network, Inc., including its affiliates (collectively, "ECHN") is seeking approval from the Office of Health Care Access ("OHCA") and the Office of the Attorney General for the proposed transfer of certain of the assets of ECHN, including certain assets of ECHN's two hospitals, Manchester Memorial Hospital and Rockville General Hospital, and ECHN's ownership interests in affiliated entities, to one or more affiliates of Prospect Medical Holdings, Inc. ("PMH").

Prospect Medical Holdings, Inc. ("PMH") is a Delaware corporation with its principal place of business located in Los Angeles, California. PMH is a healthcare services company that owns and operates hospitals, including, but not limited to, Roger Williams Medical Center and Our Lady of Fatima Hospital in Rhode Island. PMH is the parent entity to thirteen (13) acute care and behavioral hospitals located in Rhode Island, Texas and California. PMH also owns a network of specialty and primary care clinics in each of its regions. Through PMH's medical group segment, PMH manages the provision of physician services to approximately 300,000 patients in southern California, South Central Texas and Rhode Island through a network of over 9,000 physicians. Through PMH's Coordinated-Regional-Care model, PMH works closely with hospitals and affiliated medical groups for the benefit of every person who comes to them for care. Building comprehensive networks of quality healthcare services that are designed to offer patients highly coordinated, personalized care and help them live healthier lives. Through collaboration, PMH strives to provide every patient with the quality, affordable healthcare they need and deserve.

The estimated total project cost is $105,000,000, which is subject to certain adjustments, including substantial reductions for items such as outstanding indebtedness, liabilities relating to pension, retiree health, captive insurer, capital leases and asbestos abatement, and any joint venture interests that do not transfer.

The transfer will include the operating and other assets of ECHN (other than restricted charitable funds), including the properties, assets and businesses of, or ownership interests of ECHN and its affiliates, in the following entities:

- Manchester Memorial Hospital, a licensed general hospital;
- Rockville General Hospital, a licensed general hospital;
- ECHN Eldercare Services, Inc. (d/b/a Woodlake at Tolland Rehabilitation & Nursing Center), a licensed chronic and convalescent nursing home;
- Visiting Nurse and Health Services of Connecticut, Inc., a licensed home health care agency, and its direct subsidiary, A Caring Hand, LLC, a licensed homemaker-companion agency;
- Clinically Integrated Network of Eastern Connecticut, LLC;
- Connecticut Healthcare Insurance Company, Inc.;
- ECHN Corporate Services, Inc. and its direct subsidiary, Medical Practice Partners, LLC;
- ECHN Enterprises, Inc.;
- Haynes Street Property Management, LLC; and
- Eastern Connecticut Medical Professionals Foundation, Inc.

Copies of licenses issued by the Department of Public Health to each of the above licensed entities are attached as Exhibit A.

The transfer is proposed to also include the purchase of ECHN's (or an affiliate's) ownership interests in the following joint ventures, subject to approval by other members of the joint ventures as may be required by law or by the applicable joint venture governing documents:

- Aetna Ambulance Service, Inc., a licensed EMS organization
- Metro Wheelchair Service, Inc., a licensed EMS organization
- Ambulance Service of Manchester, LLC, a licensed EMS organization
- Evergreen Endoscopy Center, LLC, a licensed ambulatory surgical center

- WBC Connecticut East, LLC, a licensed mental health day treatment provider and psychiatric outpatient clinic
- Northeast Regional Radiation Oncology Network, Inc., a licensed outpatient clinic
- Connecticut Occupational Medicine Partners, LLC
- Eastern Connecticut Physician Hospital Organization, Inc.
- Tolland Imaging Center, LLC
- Haynes Street Medical Associates, LLC
- Haynes Street Medical Associates II, LLC
- Evergreen Medical Associates, LLC
- Evergreen Medical Associates II, LLC

To the extent required by OHCA, ECHN will submit separate CON applications relating to the transfers of ownership of the joint venture interests listed above.

Finally, the parties will work to restructure ECHN's medical foundation, Eastern Connecticut Medical Professionals Foundation, Inc. (the "ECHN Medical Foundation"). Consistent with Connecticut law, this restructuring will take the form of either (i) a member substitution, pursuant to which PMH or an affiliate of PMH will become the sole member of ECHN Medical Foundation; or (ii) a transfer of the assets and liabilities of ECHN Medical Foundation to a new medical foundation or another entity permissible under Connecticut law, the sole member of which will be PMH or an affiliate of PMH.

There are a number of features of the proposed transaction that will benefit the current employees and communities served by ECHN. Although not an exhaustive list, these features will include:

- Maintenance of ownership interest in ECHN's continuum of care network.
- A commitment to maintain and adhere to ECHN's current policies regarding charity care, indigent care, community volunteer services and community outreach services or to adopt other policies that are at least as favorable to the indigent and uninsured as ECHN's current policies.
- Offers of employment to substantially all ECHN employees with comparable salaries and benefits packages consistent with benefits packages offered to similarly situated employees at other hospitals operated by PMH in similar markets. Existing bargaining agreements will be assumed and honored for existing terms.
- Establishment of a local advisory board of trustees ("local board") that will serve as a resource on topics such as capital investment , maintenance and implementation of the strategic business plans, medical staff credentialing, and quality assurance oversight. Approximately half of the governing board members will be physicians who provide the input for clinical quality and clinical programmatic planning. The balance of the local board will be comprised of individuals drawn from the local community, ensuring a mechanism for input regarding community needs and expectations.
- Continued participation in graduate medical education programs and the University of New England health professions teaching programs.
- A commitment to invest $75 million, beyond the estimated project cost, in routine and non-routine facility improvements, general upgrades and renovations, deferred maintenance items, and initiatives to develop, expand or acquire new programs or services, and to support the recruitment of medical staff.

In addition to approval from OHCA and the Office of the Attorney General, the proposed transfer of the assets described herein is subject to approval of the Corporators of ECHN, the parties entering into a definitive purchase agreement and the satisfaction of closing conditions that will be set forth therein.

No service changes are currently anticipated in connection with the proposed transaction. PMH will continue to provide care to the residents in the service area towns that have historically been served by ECHN including, Andover, Ashford, Bolton, Columbia, Coventry, East Hartford, East Windsor, Ellington, Glastonbury, Hebron, Manchester, Mansfield, Somers, South Windsor, Stafford, Tolland, Vernon, Willington, and Union.

SECTION V. AFFIDAVIT

(Each Petitioner must submit a completed Affidavit.)

Petitioner: Eastern Connecticut Health Network, Inc.

Project Title: Proposed Transfer of Assets of Eastern Connecticut Health Network, Inc. and Affiliates to Prospect Medical Holdings, Inc.

I, Peter J. Karl (Name) President and Chief Executive Officer (Position – CEO or CFO)

of Eastern Connecticut Health Network, Inc. being duly sworn, depose and state that the (Organization Name)

information provided in this CON Determination form is true and accurate to the best of my knowledge.

Peter J Karl
Signature

7/15/15
Date

Subscribed and sworn to before me on July 15, 2015

Yvonne Johnson
Notary Public/Commissioner of Superior Court

Yvonne Johnson, Notary Public
My Commission Expires Jan. 31, 2017

My commission expires: _____

SECTION V. AFFIDAVIT

(Each Petitioner must submit a completed Affidavit.)

Petitioner: Prospect Medical Holdings, Inc.

Project Title: Proposed Transfer of Assets of Eastern Connecticut Health Network, Inc. and Affiliates to Prospect Medical Holdings, Inc.

I, Thomas M. Reardon (Name) President (Position – CEO or CFO)

of Prospect Medical Holdings-East Inc. (Organization Name) being duly sworn, depose and state that the information provided in this CON Determination form is true and accurate to the best of my knowledge.

Signature 7/15/2015 Date

Subscribed and sworn to before me on July 15, 2015

Yvonne Johnson
Notary Public/Commissioner of Superior Court

Yvonne Johnson, Notary Public
My Commission Expires Jan. 31, 2017

My commission expires: _____

EXHIBIT A

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0048

General Hospital

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

The Manchester Memorial Hospital of Manchester, CT d/b/a Manchester Memorial Hospital is hereby licensed to maintain and operate a General Hospital.

Manchester Memorial Hospital is located at 71 Haynes Street, Manchester, CT 06040.

The maximum number of beds shall not exceed at any time:

34 Bassinets
249 General Hospital Beds

This license expires **December 31, 2015** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, January 1, 2014. RENEWAL.

Satellites:
Adult Ambulatory Behavioral Health Services, 150 North Main Street, Manchester, CT

Jewel Mullen, MD, MPH, MPA
Commissioner

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0036

General Hospital

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

Rockville General Hospital of Vernon, CT d/b/a Rockville General Hospital is hereby licensed to maintain and operate a General Hospital.

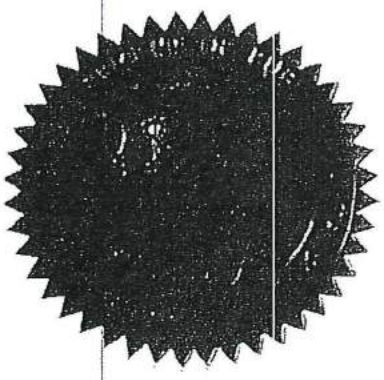
Rockville General Hospital is located at 31 Union Street, Vernon, CT 06066.

The maximum number of beds shall not exceed at any time:

16 Bassinets
102 General Hospital Beds

This license expires **December 31, 2015** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, January 1, 2014. RENEWAL.



Jewel Mullen, MD, MPH, MPA
Commissioner

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 2099-C

Chronic & Convalescent Nursing Home

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

ECHN Eldercare Services, Inc. of Tolland, CT d/b/a Woodlake at Tolland Rehabilitation and Nursing Center is hereby licensed to maintain and operate a Chronic & Convalescent Nursing Home.

Woodlake at Tolland Rehabilitation and Nursing Center is located at 26 Shenipsit Lake Road, Tolland, CT 06084 with:

*Faria Mahmood, MD as Medical Director
Katherine E. Mon as Administrator
Margaret A. Candito, RN as Director of Nurses

The maximum number of beds shall not exceed at any time:

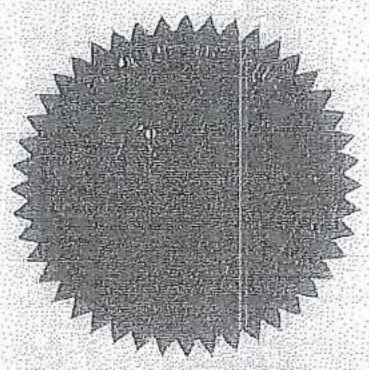
130 Chronic and Convalescent Nursing Home Beds

This license expires **December 31, 2016** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, January 1, 2015. RENEWAL.

Waiver Sec. 19-13-D8t(v)(7)(iii) Exp. N/A
Waiver Sec. 19-13-D8t(v)(7)(C) Exp. N/A
Waiver Sec. 19-13-D8u(a)(1) Exp. N/A
Waiver Sec. 19-13-D8t(n)(8)(B)(ii) Exp. N/A
Waiver Sec. 19-13-D8t(v)(8)(C) Exp. N/A

Revised to include:
*Change of Medical Director effective 5/26/14



Jewel Mullen, MD, MPH, MPA
Commissioner

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. C81791

Home Health Care Agency

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:
PERMISSION IS GRANTED TO:

Visiting Nurse & Health Services of Connecticut, Inc.
d/b/a Visiting Nurse & Health Services of Connecticut, Inc.

located at 8 Keynote Drive, Vernon, CT 06066

Additional Patient Services Offices:

155 Hazard Avenue, Suites 5 & 6, Enfield, CT

To provide the following Home Health Care Services:

Home-Maker Home Health Aide
Hospice
Medical Social Work
Nursing
Occupational Therapy
Physical Therapy
Speech Therapy

in the patient's home or a substantially equivalent environment in the towns named in the agency's application for licensure.

This license expires **December 31, 2015** and may be revoked for cause at any time.
Dated at Hartford, Connecticut, January 1, 2014. RENEWAL.

Jewel Mullen, MD, MPH, MPA
Commissioner

STATE OF CONNECTICUT ✦ DEPARTMENT OF CONSUMER PROTECTION

Be it known that

A CARING HAND LLC

27 HARTFORD TPKE STE 201

VERNON, CT 06066-5245

is certified by the Department of Consumer Protection as a registered

HOMEMAKER COMPANION AGENCY

REGISTRATION #HCA.0000138

Effective: 11/01/2014

Expiration: 10/31/2015

William M. Rubenstein, Commissioner

BERSHTEIN, VOLPE & McKEON P.C.
ATTORNEYS AT LAW
105 COURT STREET, THIRD FLOOR
NEW HAVEN, CONNECTICUT 06511
203-777-5800
Fax: 203-777-5806

July 17, 2015

VIA OVERNIGHT MAIL

The Honorable George C. Jepsen
Attorney General
Office of the Attorney General
55 Elm Street
Hartford, CT 06106

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

RE: Eastern Connecticut Health Network Inc.'s proposal to transfer certain assets to Prospect Medical Holdings, Inc. or its affiliate

Dear Attorney General Jepsen and Commissioner Mullen:

We respectfully request that you enter the appearance of Bershtein, Volpe & McKeon PC, on behalf of Prospect Medical Holdings, Inc. for all matters coming before both the Office of the Attorney General and the Department of Public Health, including its Division of Office of Health Care Access.

Sincerely,

Bershtein, Volpe & McKeon PC

By _____
Michele M. Volpe



WIGGIN AND DANA

Counsellors at Law

Wiggin and Dana LLP
One Century Tower
P.O. Box 1832
New Haven, Connecticut
06508-1832
www.wiggin.com

Rebecca A. Matthews
Melinda A. Agsten
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July 16, 2015



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Thank you for your time and attention. Please forward all subsequent materials to our attention.

Sincerely,

Wiggin and Dana LLP

By _____
Rebecca A. Matthews
Its Partner

By _____
Melinda A. Agsten
Its Partner

cc: Dennis P. McConville, Senior Vice President and Chief Strategy Officer, Eastern Connecticut Health Network, Inc.
Thomas M. Reardon, President, Prospect Medical Holdings-East, Inc.
Frank Saidara, Vice President, Corporate Development, Prospect Medical Holdings, Inc.
Joyce Tichy, Senior Vice President and General Counsel
Michele M. Volpe, Esq., Bershtein, Volpe & McKeon, P.C.

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	Petitioner	Petitioner
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Contact Person's Telephone Number	(860) 533-3429	(310) 696-4738
Contact Person's Fax Number	(860) 647-6860	(714) 560-7320
Contact Person's e-mail Address	dmcconville@echn.org	Jonathan.spees@prospectmedical.com

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b. **Estimated Total Project Cost:** $105,000,000 (subject to certain adjustments, including substantial reductions for items such as outstanding indebtedness, liabilities relating to pension, retiree health, captive insurer, capital leases and asbestos abatement, and any joint venture interests that do not transfer).

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The transfer is proposed to also include the purchase of ECHN's (or an affiliate's) ownership interests in the following joint ventures, subject to approval by other members of the joint ventures as may be required by law or by the applicable joint venture governing documents:

- Aetna Ambulance Service, Inc., a licensed EMS organization
- Metro Wheelchair Service, Inc., a licensed EMS organization
- Ambulance Service of Manchester, LLC, a licensed EMS organization
- Evergreen Endoscopy Center, LLC, a licensed ambulatory surgical center

- WBC Connecticut East, LLC, a licensed mental health day treatment provider and psychiatric outpatient clinic
- Northeast Regional Radiation Oncology Network, Inc., a licensed outpatient clinic
- Connecticut Occupational Medicine Partners, LLC
- Eastern Connecticut Physician Hospital Organization, Inc.
- Tolland Imaging Center, LLC
- Haynes Street Medical Associates, LLC
- Haynes Street Medical Associates II, LLC
- Evergreen Medical Associates, LLC
- Evergreen Medical Associates II, LLC

To the extent required by OHCA, ECHN will submit separate CON applications relating to the transfers of ownership of the joint venture interests listed above.

Finally, the parties will work to restructure ECHN's medical foundation, Eastern Connecticut Medical Professionals Foundation, Inc. (the "ECHN Medical Foundation"). Consistent with Connecticut law, this restructuring will take the form of either (i) a member substitution, pursuant to which PMH or an affiliate of PMH will become the sole member of ECHN Medical Foundation; or (ii) a transfer of the assets and liabilities of ECHN Medical Foundation to a new medical foundation or another entity permissible under Connecticut law, the sole member of which will be PMH or an affiliate of PMH.

There are a number of features of the proposed transaction that will benefit the current employees and communities served by ECHN. Although not an exhaustive list, these features will include:

- Maintenance of ownership interest in ECHN's continuum of care network.
- A commitment to maintain and adhere to ECHN's current policies regarding charity care, indigent care, community volunteer services and community outreach services or to adopt other policies that are at least as favorable to the indigent and uninsured as ECHN's current policies.
- Offers of employment to substantially all ECHN employees with comparable salaries and benefits packages consistent with benefits packages offered to similarly situated employees at other hospitals operated by PMH in similar markets. Existing bargaining agreements will be assumed and honored for existing terms.
- Establishment of a local advisory board of trustees ("local board") that will serve as a resource on topics such as capital investment , maintenance and implementation of the strategic business plans, medical staff credentialing, and quality assurance oversight. Approximately half of the governing board members will be physicians who provide the input for clinical quality and clinical programmatic planning. The balance of the local board will be comprised of individuals drawn from the local community, ensuring a mechanism for input regarding community needs and expectations.
- Continued participation in graduate medical education programs and the University of New England health professions teaching programs.
- A commitment to invest $75 million, beyond the estimated project cost, in routine and non-routine facility improvements, general upgrades and renovations, deferred maintenance items, and initiatives to develop, expand or acquire new programs or services, and to support the recruitment of medical staff.

In addition to approval from OHCA and the Office of the Attorney General, the proposed transfer of the assets described herein is subject to approval of the Corporators of ECHN, the parties entering into a definitive purchase agreement and the satisfaction of closing conditions that will be set forth therein.

No service changes are currently anticipated in connection with the proposed transaction. PMH will continue to provide care to the residents in the service area towns that have historically been served by ECHN including, Andover, Ashford, Bolton, Columbia, Coventry, East Hartford, East Windsor, Ellington, Glastonbury, Hebron, Manchester, Mansfield, Somers, South Windsor, Stafford, Tolland, Vernon, Willington, and Union.

SECTION V. AFFIDAVIT

(Each Petitioner must submit a completed Affidavit.)

Petitioner: Eastern Connecticut Health Network, Inc.

Project Title: Proposed Transfer of Assets of Eastern Connecticut Health Network, Inc. and Affiliates to Prospect Medical Holdings, Inc.

I, Peter J. Karl (Name) President and Chief Executive Officer (Position – CEO or CFO)

of Eastern Connecticut Health Network, Inc. (Organization Name) being duly sworn, depose and state that the information provided in this CON Determination form is true and accurate to the best of my knowledge.

Peter J. Karl
Signature

7/15/15
Date

Subscribed and sworn to before me on July 15, 2015

Yvonne Johnson
Notary Public/Commissioner of Superior Court

Yvonne Johnson, Notary Public
My Commission Expires Jan. 31, 2017

My commission expires:

SECTION V. AFFIDAVIT

(Each Petitioner must submit a completed Affidavit.)

Petitioner: Prospect Medical Holdings, Inc.

Project Title: Proposed Transfer of Assets of Eastern Connecticut Health Network, Inc. and Affiliates to Prospect Medical Holdings, Inc.

I, Thomas M. Reardon (Name) President (Position – CEO or CFO)

of Prospect Medical Holdings-East Inc. (Organization Name) being duly sworn, depose and state that the information provided in this CON Determination form is true and accurate to the best of my knowledge.

Signature 7/15/2015 Date

Subscribed and sworn to before me on July 15, 2015

Yvonne Johnson
Notary Public/Commissioner of Superior Court

My commission expires: Yvonne Johnson, Notary Public My Commission Expires Jan. 31, 2017

EXHIBIT A

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0048

General Hospital

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

The Manchester Memorial Hospital of Manchester, CT d/b/a Manchester Memorial Hospital is hereby licensed to maintain and operate a General Hospital.

Manchester Memorial Hospital is located at 71 Haynes Street, Manchester, CT 06040.

The maximum number of beds shall not exceed at any time:

34 Bassinets
249 General Hospital Beds

This license expires **December 31, 2015** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, January 1, 2014. RENEWAL.

Satellites:
Adult Ambulatory Behavioral Health Services, 150 North Main Street, Manchester, CT

Jewel Mullen, MD, MPH, MPA
Commissioner

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0036

General Hospital

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

Rockville General Hospital of Vernon, CT d/b/a Rockville General Hospital is hereby licensed to maintain and operate a General Hospital.

Rockville General Hospital is located at 31 Union Street, Vernon, CT 06066.

The maximum number of beds shall not exceed at any time:

16 Bassinets
102 General Hospital Beds

This license expires **December 31, 2015** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, January 1, 2014. RENEWAL.

Jewel Mullen, MD, MPH, MPA
Commissioner

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 2099-C

Chronic & Convalescent Nursing Home

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

ECHN Eldercare Services, Inc. of Tolland, CT d/b/a Woodlake at Tolland Rehabilitation and Nursing Center is hereby licensed to maintain and operate a Chronic & Convalescent Nursing Home.

Woodlake at Tolland Rehabilitation and Nursing Center is located at 26 Shenipsit Lake Road, Tolland, CT 06084 with:

*Faria Mahmood, MD as Medical Director
Katherine E. Mon as Administrator
Margaret A. Candito, RN as Director of Nurses

The maximum number of beds shall not exceed at any time:

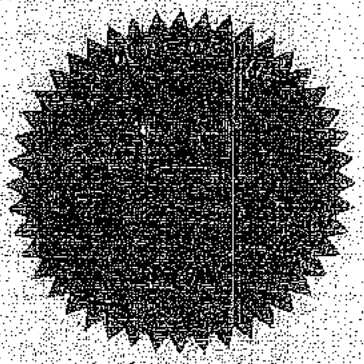
130 Chronic and Convalescent Nursing Home Beds

This license expires **December 31, 2016** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, January 1, 2015. RENEWAL.

Waiver Sec. 19-13-D8t(v)(7)(iii) Exp. N/A
Waiver Sec. 19-13-D8t(v)(7)(C) Exp. N/A
Waiver Sec. 19-13-D8u(a)(1) Exp. N/A
Waiver Sec. 19-13-D8t(n)(8)(B)(ii) Exp. N/A
Waiver Sec. 19-13-D8t(v)(8)(C) Exp. N/A

Revised to include:
*Change of Medical Director effective 5/26/14



Jewel Mullen, MD, MPH, MPA
Commissioner

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. C81791

Home Health Care Agency

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:
PERMISSION IS GRANTED TO:

Visiting Nurse & Health Services of Connecticut, Inc.
d/b/a Visiting Nurse & Health Services of Connecticut, Inc.

located at 8 Keynote Drive, Vernon, CT 06066

Additional Patient Services Offices:

155 Hazard Avenue, Suites 5 & 6, Enfield, CT

To provide the following Home Health Care Services:

Home-Maker Home Health Aide
Hospice
Medical Social Work
Nursing
Occupational Therapy
Physical Therapy
Speech Therapy

in the patient's home or a substantially equivalent environment in the towns named in the agency's application for licensure.

This license expires **December 31, 2015** and may be revoked for cause at any time.
Dated at Hartford, Connecticut, January 1, 2014. RENEWAL.

Jewel Mullen, MD, MPH, MPA
Commissioner

STATE OF CONNECTICUT ✦ DEPARTMENT OF CONSUMER PROTECTION

Be it known that

A CARING HAND LLC

27 HARTFORD TPKE STE 201

VERNON, CT 06066-5245

is certified by the Department of Consumer Protection as a registered

HOMEMAKER COMPANION AGENCY

REGISTRATION #HCA.0000138

Effective: 11/01/2014

Expiration: 10/31/2015

William M. Rubenstein, Commissioner

BERSHTEIN, VOLPE & McKEON P.C.
ATTORNEYS AT LAW
105 COURT STREET, THIRD FLOOR
NEW HAVEN, CONNECTICUT 06511
203-777-5800
Fax: 203-777-5806

July 17, 2015

VIA OVERNIGHT MAIL

The Honorable George C. Jepsen
Attorney General
Office of the Attorney General
55 Elm Street
Hartford, CT 06106

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

RE: Eastern Connecticut Health Network Inc.'s proposal to transfer certain assets to Prospect Medical Holdings, Inc. or its affiliate

Dear Attorney General Jepsen and Commissioner Mullen:

We respectfully request that you enter the appearance of Bershtein, Volpe & McKeon PC, on behalf of Prospect Medical Holdings, Inc. for all matters coming before both the Office of the Attorney General and the Department of Public Health, including its Division of Office of Health Care Access.

Sincerely,

Bershtein, Volpe & McKeon PC

By _____
Michele M. Volpe



Greer, Leslie

From: Greer, Leslie
Sent: Thursday, August 06, 2015 3:11 PM
To: Dennis McConville; 'jonathan.spees@prospectmedical.com'; 'rmatthews@wiggin.com'
Cc: michelemvolpe@aol.com; Lazarus, Steven; Riggott, Kaila; Hansted, Kevin; Martone, Kim; Cotto, Carmen; Hawes, Gary W.
Subject: DN: 15-32016-486 and DN: 15-486-01
Attachments: 15-32016-486 and 15-486-01_201508061354.pdf

Tracking:

Recipient	Delivery
Dennis McConville	
'jonathan.spees@prospectmedical.com'	
'rmatthews@wiggin.com'	
michelemvolpe@aol.com	
Lazarus, Steven	Delivered: 8/6/2015 3:12 PM
Riggott, Kaila	Delivered: 8/6/2015 3:12 PM
Hansted, Kevin	Delivered: 8/6/2015 3:12 PM
Martone, Kim	Delivered: 8/6/2015 3:12 PM
Cotto, Carmen	Delivered: 8/6/2015 3:12 PM
Hawes, Gary W.	Delivered: 8/6/2015 3:12 PM

Please see the attached application for hospital conversion process for Eastern Connecticut Health Network, Inc. and Prospect Medical Holdings, Inc. (DN: 15-32016-486 & AG's DN: 15-486-01.) Any questions, please contact Steven W. Lazarus @ (860) 418-7012 or Gary Hawes @ (860) 808-5020.

Thank you,

Leslie M. Greer
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134
Phone: (860) 418-7013 Fax: (860) 418-7053
Website: www.ct.gov/ohca

GEORGE JEPSEN
ATTORNEY GENERAL

55 Elm Street
P.O. Box 120
Hartford, CT 06141-0120

Office of the Attorney General
State of Connecticut

August 6, 2015

VIA ELECTRONIC MAIL AND FACSIMILE
Dennis McConville, Senior Vice President &
Chief Strategy Officer
Eastern Connecticut Health Network, Inc.
71 Haynes Street
Manchester, Connecticut 06040

Jonathan Spees, Senior Vice President
Prospect Medical Holdings, Inc.
10780 Santa Monica Blvd., Suite 400
Los Angeles, California 90025

Re: Eastern Connecticut Health Network, Inc. – Proposed Asset Purchase by Prospect Medical Holdings, Inc. - OHCA Docket No. 15-31216-486 and Attorney General Docket No. 15-486-01

Dear Mr. McConville and Mr. Spees:

After our review of the certificate of need determination letter submitted by you, dated July 16, 2015, we have determined that the proposed transfer of certain assets of the Eastern Connecticut Health Network, Inc. ("ECHN") to Prospect Medical Holdings, Inc. ("PMH") requires approval pursuant to Conn. Gen. Stat. § 19a-486 et seq.

Accordingly, the parties to the proposed asset purchase (the "Asset Purchase") shall submit to the Commissioner of Public Health (the "Commissioner") and to the Attorney General, within sixty (60) days of the date of the mailing of this application form, an application for approval of the Asset Purchase. Please mail two (2) complete hard copies and two (2) complete electronic copies of the application for approval to the following address:

Office of the Attorney General
55 Elm Street, P.O. Box 120
Hartford, Connecticut 06141-0120
Attn: Gary W. Hawes, AAG

Please mail seven (7) complete hard copies and three (3) complete electronic copies of the application for approval to the following address:

Commissioner of Public Health
410 Capitol Avenue
Hartford, Connecticut 06134
Attn: Kevin Hansted, Staff Attorney

We request that your application for approval include the following information (Conn. Gen. Stat. § 19a-486a(c)), address the following issues (Conn. Gen. Stat. §§ 19a-486c and 19a-486d), and be presented in substantially the following format:

1. Identify the contact information for ECHN and PMH, including the individual(s) to whom the Attorney General and the Department of Public Health shall submit bills for contracts with experts or consultants.

2. Provide an executive summary of the application for approval.

3. Describe the terms of the proposed Asset Purchase. This section should include, but is not limited to:

   a. descriptions of ECHN, PMH, the assets to be transferred pursuant to the Asset Purchase, any assets excluded from transaction, the assumed and excluded liabilities of the Asset Purchase, the commitment to spend $75 million dollars on capital items, and any plan to expand or acquire new programs or services;

   b. a financial analysis of the proposed transaction that identifies the source of funding for PMH's initial purchase price, the uses of the proceeds of the transaction, and the valuations of included and excluded assets; and

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

4. Provide copies of all contracts, agreements, memoranda of understanding, and pro forma financial statements relating to the proposed Asset Purchase.

5. Describe the due diligence undertaken by ECHN in deciding to enter into the Asset Purchase. This section should include, but is not limited to, considerations regarding the current financial condition of ECHN and any projected financial condition of ECHN, any professional assessments of or reports regarding ECHN or PMH, any and all alternatives explored by ECHN or other offers received by ECHN, the reasons for rejecting such alternatives and offers, ECHN's selection of PMH, and the specific terms of the Asset Purchase. In addition, the parties should discuss the due diligence in obtaining the fairness evaluation required by Conn. Gen. Stat. § 19a-486a(c)(5), including providing a copy of said independent expert's resume or other

documentation of his or her qualifications and describing the process undertaken to identify and retain this person as an independent expert.

6. Describe any and all potential conflicts of interest between, among, or pertaining to, at a minimum, any and all board members, officers, key employees, and experts of ECHN, PMH, any other party to the transaction, and any person or entity that performed assessments requested in this application. In addition, describe the due diligence taken to determine the existence of any conflicts of interest, including how ECHN and PMH defined "conflict of interest" for purposes of the response to this question.

7. Provide an assessment of the fair market value of the transaction, including, but not limited to, a discussion regarding whether the fair market value of ECHN's assets has been manipulated. Describe how the assessment was performed (including any method to verify results of the assessment), the persons that performed the assessment, and their qualifications to perform the assessment. Provide copies of all documents and statements, financial and otherwise, in support of this assessment.

8. Provide an assessment of whether the transaction will place ECHN's assets, including but not limited to Manchester Memorial Hospital ("MMH") and Rockville General Hospital ("RGH"), at unreasonable risk. Provide copies of all documents and statements, financial and otherwise, in support of this assessment. Describe how the assessment was performed (including any method to verify results of the assessment), the persons that performed the assessment, and their qualifications to perform the assessment.

9. Provide an assessment of whether any managerial contracts to be entered into are for reasonable fair value. Provide copies of the managerial contracts and of all documents and statements, financial and otherwise, in support of the fair value assessment. Describe how the assessment was performed (including any method to verify results of the assessment), the persons that performed the assessment, and their qualifications to perform the assessment.

10. Describe the entity to which the fair market value of ECHN's assets will be transferred, including the funding of the entity, its corporate structure, governance and membership, and the charitable purpose of the entity. Provide copies of documents related to the creation, structure, and purpose of the entity.

11. Identify any and all assets of ECHN that are subject to a charitable use restrictions imposed by a donor and the intended handling of those assets as a result of the proposed Asset Purchase. Please provide a listing of these assets in Microsoft Excel format. Also, please provide copies of the original gift instruments for each gift identified. Only one hard copy of the gift instruments needs to be produced to the Attorney General.

12. Provide copies of all correspondence, memoranda, and any other documents that include the terms of any other offers to transfer assets or operations or change control of operations received by ECHN.

13. Provide a copy of a fairness evaluation by an independent person who is an expert in such Asset Purchases that includes the expert's evaluation of each of the criteria set forth in Conn. Gen. Stat. § 19a-486c(a). Also provide copies of the information and documents relied upon by the expert in the preparation and issuance of the fairness evaluation.

14. Please provide a copy of the transcript for the informal hearing required by Conn. Gen. Stat. § 19a-486a(c).

15. Explain how ECHN determined the need for the Asset Purchase and discuss the benefits of this Asset Purchase for MMH and RGH (collectively, the "ECHN Hospitals"), respectively (provide discussion on history and time-line).

16. For each of the ECHN Hospitals, provide a listing of the hospital's current service lines and service locations and describe any planned changes to either the service lines or service locations as a result of the Asset Purchase. Provide an explanation for each change and detail how hospital's affiliation with PMH will aid in service line development.

17. Describe the existing populations served by the ECHN Hospitals and how the Asset Purchase will affect these populations. Include demographic information.

18. How will the for-profit nature of PMH affect the provision of health care in the community?

19. Provide a transition plan for the Asset Purchase and describe how ECHN and PMH (collectively, the "Applicants") will ensure continuity of care and hospital services through this plan.

20. Understanding that the proposal is for PMH to exercise common ownership over MMH and RGH, how will care be coordinated between the two hospitals? Please explain in detail how care coordination efforts will be aided by the proposed Asset Purchase (i.e., how they will be different from ECHN's present efforts). Provide any written plans documenting this coordinated approach to care for the patient population served.

21. Provide a description of the relationship between the proposal and the Statewide Health Care Facilities and Services Plan.

22. Please explain how the post transaction ECHN will address the needs of service area residents with respect to prevention and treatment of diseases and conditions in relation to ECHN's most recent Community Health Needs Assessment ("CHNA") and the priority of needs listed therein. Please provide a copy of the most recent CHNA.

23. Provide a description of plans that the Applicants will implement to control cost, such as discharge care coordination, implementation of electronic medical records and emergency department triaging to the appropriate level of care. In responding to this question, report any anticipated savings from the following expense categories for the ECHN Hospitals: salaries and wages, fringe benefits, contractual labor fees, medical supplies and pharmaceutical costs, depreciation and amortization, bad debts, interest expense, malpractice expense, utilities, business expense and other operating expenses.

24. Provide a description of the Applicants' plans to continue to provide services to the uninsured and underinsured. In responding to this question, please describe any changes to the ECHN Hospitals' current charity care, uncompensated care and financial assistance policies and procedures, and hospital bed funds that will result from the Asset Purchase. Describe any plans Applicants have to work with other providers in the community, such as federally qualified health centers or community health centers, to provide specialty care to patients, or low cost programs that the Applicants will provide in the area that are tailored toward the uninsured or underinsured.

25. Submit a list of all key professional, administrative and clinical department heads related to this proposal. Additionally, provide a copy of the Curriculum Vitae of each individual listed.

26. Provide evidence as to how the Asset Purchase will improve quality, accessibility and cost effectiveness of health care delivery in the region, including but not limited to, provision of or any change in the access to services for Medicaid recipients and indigent persons.

27. Provide the corporate organizational chart prior to and after the proposed Asset Purchase, including all affiliates. For the organizational chart that depicts the post-Asset Purchase structure, working upward on the chain of ownership from the ECHN Hospitals, please: (i) describe the nature of the ownership and control that each entity has in the entity directly below it; (ii) describe the major business activities/functions of each entity; (iii) provide the principal place of business address for each entity; and (iv) provide the name and business address of each individual currently serving as a member of the governing body of each entity.

28. Please provide the date on which both MMH, RGH, and ECHN filed audited financial statements with OHCA. Applicants may reference these statements in responding to questions. In addition, provide a copy of PMH's most recent audited financial statements.

29. List all funding or financing sources for the $105,000,000 in projects costs (the "Project Costs") estimated for this acquisition by PMH, including PMH's commitment to invest $75,000,000 in-routine and non-routine facility improvements, general upgrades and renovations, deferred maintenance items, and initiatives to develop, expand or acquire

new programs or services, and to support the recruitment of medical staff (the "Capital Commitment"). Provide applicable details such as interest rate; term; monthly payment; pledges and funds received to date; letter of interest or approval from a lending institution.

30. In reference to the Capital Commitment, provide the following:

    a. A copy of any related capital expenditure plan;

    b. Define the terms "routine" and "non-routine" facility improvements and "deferred maintenance items". Provide specific examples, of each.

31. Please explain in detail the reasons why, and with respect to each item, the extent to which, the Project Costs related to this proposal may be adjusted for each of the following:

    a. outstanding indebtedness;
    b. pension liabilities;
    c. retiree health benefits;
    d. captive insurers;
    e. capital leases;
    f. asbestos abatement; and
    g. joint venture interests that may not transfer.

32. How, if at all, will non-approval by any of the joint venture interests referred to in Question 31(g) above affect the Asset Purchase?

33. Please explain in detail the terms of the Capital Commitment and in particular:

    a. how it will be allocated between MMH and RGH, including the annual amounts projected to be available to each hospital;

    b. the capital projects that are deemed top priorities by the Applicants for both of the hospitals;

    c. the service improvements for both of the hospitals that are deemed top priorities by the Applicants;

    d. a list of capital projects and service improvements that are expected to be carried out within the first three years following the closing date; and

    e. discuss the ability of ECHN to address items listed in 33(b) and 33(c) for each of the hospitals without the approval of this proposal.

34. Describe in detail how this proposal will affect the financial strength of the State's health care system and will be financially feasible.

35. Please provide the current payer mix for both of MMH and RGH and the projected payer mix for both respective hospital after the Asset Purchase (based on the number of patients, not based on revenue) in the following reporting format:

Table 1: Patient Population/Payer Mix

Payer	Current FY 20__**		Projected					
			FY 20__**		FY 20__**		FY 20__**	
	Discharges	%	Discharges	%	Discharges	%	Discharges	%
Medicare*								
Medicaid*								
CHAMPUS & TriCare								
Total Government								
Commercial Insurers								
Uninsured								
Workers Compensation								
Total Non-Government								
Total Payer Mix								

* Includes managed care activity.

** Fill in years. Ensure the period covered by this table corresponds to the period covered in the projections provided. New programs may leave the "current" column blank.

36. Provide the assumptions used to project the patient population/payer mix after the proposed Asset Purchase.

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

    a. Financial Worksheet (C) – for ECHN, MMH, RGH (for MMH and RGH, hospital only data, no affiliates) and PMH without the CON project (columns 1, 2 5, 8 & 11) and with the CON project and incremental to the CON project (remainder columns); and

b. Submit Financial Worksheet (C) using the same page and print layouts (size, font, page orientation, margins, etc.) as provided by OHCA.

Note that the actual results for the fiscal year reported in the first column must agree with ECHN's, MMH's and RGH's audited financial statements. The projections must include the first three full fiscal years of the project.

38. Provide the assumptions utilized in developing Financial Worksheet (C) (e.g., full-time equivalents, volume statistics, other expenses, revenue and expense percentage increases, project commencement of operation date, etc.).

39. Explain any projected incremental losses from operations contained in the financial projections that result from approval of the Asset Purchase and operation of MMH, RGH, ECHN and PMH.

40. Please describe any anticipated change to existing reimbursement contracts with payers (e.g., Medicare, Medicaid, commercial) as a result of the Asset Purchase. Is it assumed in the financial projections that Applicants will willingly negotiate with the payers that ECHN currently has contracts with?

41. Please explain in detail how the proposed Asset Purchase will be able to assure satisfaction of ECHN's and/or both of MMH's and RGH's debt and pension obligations.

42. For each the ECHN Hospitals, please address the following regarding staffing at the hospital by completing "Staffing Attachments I&II."

a. Provide the levels of staffing for fiscal year ("FY") 2015 broken out as follows:

i. Average patient to nursing staff ratios per shift (a.m., p.m. and overnight) for both department and/or unit of the hospital;

ii. The same information as provided in subsection (a)(i) above showing the RN to patient ratio only; and

iii. The average nursing hours per patient day (NHpPD) for both department and/or unit of the hospital (all nursing staff should be included in the calculation of nursing hours).

b. Provide the projected levels of staffing by department and/or unit for the hospital for the first three (3) full FYs following approval of the Asset Purchase broken out as follows:

i. Average patient to nursing staff ratios per shift (a.m., p.m. and overnight) for both department and/or unit of the Hospital; and

ii. The same information as provided in subsection (b)(i) above showing the projected RN to patient ratio only.

43. For each of the ECHN Hospitals, provide a detailed explanation by department and/or unit as completed by the Applicants in Staffing Attachment I, to reconcile any differences between FY 2015 nursing staff levels and those projected for the first three (3) full FYs following approval of the Asset Purchase.

44. For each of the ECHN Hospitals, describe any other hospital-employed or hospital-contracted staff besides nursing staff (e.g., hospitalists, mid-level providers, therapists, etc.) that were engaged to provide direct patient care at the hospital (collectively, "Ancillary Caregivers") for FY 2015 broken out as follows:

    a. The type of Ancillary Caregivers and the department and/or unit to which such staff was assigned;

    b. The average number of hours per week that such Ancillary Caregivers provided patient care for the department and/or unit; and

    c. For the first three (3) full FYs following approval of the Asset Purchase, the average number of hours per week that such Ancillary Caregivers are projected to provide patient care for both department and/or unit of the hospital described in subsection (a) above.

45. For each of the ECHN Hospitals, provide a detailed explanation by department and/or unit to reconcile any differences between the average number of hours per week that the Ancillary Caregivers described in Question 44 above provided patient care in FY 2015 with those projected for the first three (3) full FYs following approval of the Asset Purchase.

46. For each of the ECHN Hospitals, provide evidence that the proposed staffing for nursing staff and Ancillary Caregivers for the first three (3) full FYs following approval of the Asset Purchase meet all Connecticut Department of Public Health ("DPH") staffing requirements and assure continued access to high quality and affordable health care. Be sure to cite the appropriate DPH regulations and/or other industry benchmarks as applicable.

47. Applicants are required to provide copies of the most recent CMS statements of deficiencies and plans of correction (CMS Form 2567) for all hospitals owned by PMH. Provide these documents in an electronic format only. PDF file on a CD to accompany the responses. No paper copies required.

48. Provide a copy of, and describe any changes to, any of the following policies and procedures that will be in place at MMH and RGH if the Asset Purchase is approved:

    a. hospital collection policies (including charity care and bad debt);

    b. annual or periodic review and/or revision to the hospital's pricing structure (the chargemaster or pricemaster); and

c. the annual or periodic market rate assessment for the hospital.

49. MMH and RGH have provided OHCA with their annual FY 2015 combined pricemasters, which was most recently updated for the month of June 2015. With respect to this submission please answer the following:

a. Will the pricemaster change as a result of the Asset Purchase?

b. If so, please identify any anticipated increases or decreases to the pricemaster as a result of the Asset Purchase.

c. Please quantify the overall percentage increase or decrease in the pricemaster that is anticipated in subsection (b) above and explain the rationale for such change.

50. Please provide monthly financial statistics reports for the months of April, May and June for FY 2015, current month and year-to-date, and comparable period for FY 2014 to OHCA, for MMH and RGH, ECHN and PMH, with the Application and thereafter on a monthly basis for both month (formatted side by side), until a public hearing in this matter is held. The following financial measurements/indicators should be addressed in the reports:

Monthly Financial Measurement/Indicators

A. Operating Performance
Operating Margin
Non-Operating Margin
Total Margin
Bad Debt as % Gross Revenue
B. Liquidity
Current Ratio
Days Cash on Hand
Days in Net Accounts Receivables
Average Payment Period
C. Leverage and Capital Structure
Long-term Debt to Equity
Long-term Debt to Capitalization
Unrestricted Cash to Debt
Times Interest Earned Ratio
Debt Service Coverage Ratio
Equity Financing Ratio
D. Additional Statistics
Income from Operations
Revenue Over/(Under) Expense
EBITDA
Cash from Operations

Cash and Cash Equivalents
Net working Capital
Unrestricted Assets
Credit Ratings (S&P, FITCH and Moody's)

51. For each of the ECHN Hospitals, provide a copy of the hospital's IRS Form 990 for tax year ending September 30, 2014 and with respect to the amounts listed on both line item within Part 1, Section 7 of Schedule H ("Financial Assistance and Certain Other Community Benefits at Cost"), provide a projected amount for both line item for the first three (3) tax years following the Asset Purchase. Please note that it is understood that MMH and RGH will not file an IRS Form 990 following the Asset Purchase. This question is directed at determining the amount of programmatic and financial support that the hospitals will continue to provide in these community benefit categories. In providing this information, please elaborate on the specific activities included and how the projections demonstrate PMH's commitment to maintain and adhere to ECHN's current policies regarding charity care, indigent care, community volunteer services and community outreach services or to adopt other policies that are at least as favorable to the community as ECHN's current policies.

52. For each of the ECHN Hospitals, with respect to the amounts listed on both line item within Part II of Schedule H of the Hospital's IRS Form 990 for tax year ending September 30, 2014 ("Community Building Activities"), provide a projected amount for both line item for the first three (3) tax years following the Asset Purchase. Please note that it is understood that MMH and RGH will not file an IRS Form 990 following the Asset Purchase. This question is directed at determining the amount of programmatic and financial support that the hospitals will continue to provide in these community building activity categories. In providing this information, please elaborate on the specific activities included and how the projections demonstrate PMH's commitment to maintain and adhere to ECHN's current policies regarding charity care, indigent care, community volunteer services and community outreach services or to adopt other policies that are at least as favorable to the community as ECHN's current policies.

53. Please discuss whether the Asset Purchase is expected to achieve an improved negotiating position with vendors and/or payers and, if such an improved negotiating position is anticipated, how it will translate into tangible savings for the consumer of health care services. Provide a response that both describes any anticipated improvements in detail and quantifies the expected results for the consumer.

54. Provide details of plans to be put in place to ensure the proposed health care services provided by the Applicants adhere to the National Standards on Culturally and Linguistically Appropriate Services (CLAS) to advance health equity, improve quality and help eliminate health care disparities in the projected service area. (For more details on CLAS standards see http://minorityhealth.hhs.gov/Default.aspx#sthash.U320zUXq.dpuf.)

55. What criteria will PMH use to offer current employees employment post transaction or in any new entities that may be formed as a result of this proposal? For those employees that will be employed post transaction by the Applicants, what is the projected difference in salary for current employees and similarly situated employees at other hospitals operated by PMH in similar markets?

56. Please provide information regarding whether any health care providers or insurers have an ownership interest in PMH.

57. Please provide information on the relationship, if any, PMH's existing medical group segment will have to this proposal.

58. Please identify PMH's five (5) most recent acute care hospital acquisitions and, for each acquisition, describe in detail how:

    (a) the acquisition improved access to care for the hospital's service area;

    (b) the acquisition improved the quality of health care for the hospital's service area;

    (c) the acquisition lowered the cost of health care for the hospital's service area; and

    (d) with respect to subsections (a) through (c) above, please demonstrate these improvements/cost reductions through benchmarks and other data that are commonly used in the hospital industry.

After receipt of your application for approval, the Commissioner and the Attorney General shall review the submission to determine whether the application for approval is complete. If not, the Commissioner and the Attorney General shall provide written notice of any deficiencies within twenty (20) days of receipt of the application for approval.

Should you have any questions regarding this application form, your application for approval, or any other issues relating to the Commissioner's and Attorney General's review, please do not hesitate to contact either Steven Lazarus at the Department of Public Health (860-418-7012; Steven.Lazarus@ct.gov) or Assistant Attorney General Gary W. Hawes at the Office of the Attorney General (860-808-5020; gary.hawes@ct.gov).

Very truly yours,

Perry Zinn Rowthorn
Deputy Attorney General

Janet M. Brancifort, MPH
Deputy Commissioner, DPH

Attachments

cc: Steven W. Lazarus, Associate Health Care Analyst, OHCA
Gary W. Hawes, Assistant Attorney General, OAG

Staffing Attachment I

Current Staffing Levels

Name of Hospital Unit or Department	Average Nurse to Patient Ratio			Average RN to Patient Ratio			Average Nursing Hours per Patient Day
	Shift #1 AM	Shift #2 PM	Shift #3 overnight	Shift #1 AM	Shift #2 PM	Shift #3 overnight	
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Staffing Attachment II

	Projected Staffing Levels FY 201x						Projected Staffing Levels FY 201x						Projected Staffing Levels FY 201x					
	Average Nurse to Patient Ratio			Average RN to Patient Ratio			Average Nurse to Patient Ratio			Average RN to Patient Ratio			Average Nurse to Patient Ratio			Average RN to Patient Ratio		
Name of Hospital Unit or Department	Shift #1 AM	Shift #2 PM	Shift #3 overnight	Shift #1 AM	Shift #2 PM	Shift #3 overnight	Shift #1 AM	Shift #2 PM	Shift #3 overnight	Shift #1 AM	Shift #2 PM	Shift #3 overnight	Shift #1 AM	Shift #2 PM	Shift #3 overnight	Shift #1 AM	Shift #2 PM	Shift #3 overnight
Department or Unit Name	1:xxx	1:xxx	1:xxx	1:xxx	1:xxx	1:xxx	1:xxx	1:xxx	1:xxx	1:xxx	1:xxx	1:xxx	1:xxx	1:xxx	1:xxx	1:xxx	1:xxx	1:xxx
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August 14, 2015

VIA HAND-DELIVERY



The Honorable George C. Jepsen
Attorney General
Office of the Attorney General
55 Elm Street
Hartford, CT 06106

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

Re: Eastern Connecticut Health Network, Inc. ("ECHN")
Proposed Asset Purchase by Prospect Medical Holdings, Inc.
OHCA Docket Number: 15-31216-486
Attorney General Docket Number: 15-486-01

Dear Attorney General Jepsen and Commissioner Mullen:

In accordance with Section 19a-486a(c) of the Connecticut General Statutes we are enclosing copies of the transcripts and recordings from the two public hearings held on ECHN's Certificate of Need Determination Letter, which was filed with your offices on July 16, 2015.

The first hearing was held at the Vernon Senior Center on August 3, 2015. A second hearing was held at Manchester Memorial Hospital on August 4, 2015. Both hearings were recorded, and digital copies of the recordings were transcribed by Del Vecchio Reporting Services, LLC. The digital recordings are enclosed on DVD.

Also enclosed are copies of the following, in paper form and on a disk (in .pdf format), for each of the hearings:

1. Transcripts for each hearing prepared by Del Vecchio Reporting Services, LLC.
2. Slides presented at the hearings.
3. Written statements submitted at or in connection with the hearing.

Please let us know if you have any questions about the digital recordings or transcribed reports for the two hearings. Thank you for your time and attention.

Sincerely,

Wiggin and Dana LLP

By _____
Rebecca A. Matthews
Its Partner

By _____
Melinda A. Agsten
Its Partner

cc: Dennis P. McConville, Senior Vice President and Chief Strategy Officer, Eastern Connecticut Health Network, Inc.
Thomas M. Reardon, President, Prospect Medical Holdings-East, Inc.
Frank Saidara, Vice President, Corporate Development, Prospect Medical Holdings, Inc.
Jonathan Spees, Senior Vice President, Corporate Development, Prospect Medical Holdings, Inc.
Joyce Tichy, Senior Vice President and General Counsel
Michele M. Volpe, Esq., Bershtein, Volpe & McKeon, P.C.

PROPOSED TRANSFER OF ASSETS OF

EASTERN CONNECTICUT HEALTH NETWORK, INC. AND AFFILIATES

TO

PROSPECT MEDICAL HOLDINGS, INC.

OHCA Docket Number: 15-31216-486 and Attorney General Docket Number: 15-486-01

Public Hearing Held Pursuant to
Section 19a-486a of the Connecticut General Statutes

Location: **Vernon Senior Center, Vernon, CT**

Date: **August 3, 2015**

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PUBLIC MEETING

THE PROPOSED TRANSFER OF ASSETS OF EASTERN CONNECTICUT HEALTH NETWORK, INC. AND AFFILIATES TO PROSPECT MEDICAL HOLDINGS, INC.

Meeting taken at the offices of the Vernon Senior Center, 26 Park Place, Vernon, Connecticut, before Clifford Edwards, LSR, Connecticut License No. SHR.407, a Professional Shorthand Reporter and Notary Public, in and for the State of Connecticut on August 3, 2015, at 6:00 p.m.

DEL VECCHIO REPORTING SERVICES, LLC
PROFESSIONAL SHORTHAND REPORTERS
117 RANDI DRIVE
MADISON, CT 06443

HARTFORD NEW HAVEN STAMFORD

A P P E A R A N C E S:

JOY DORIN

PETER J. KARL

MICHAEL VEILLETTE

JOYCE TICHY

DENNIS P. McCONVILLE

DR. MITCHELL LEW

THOMAS M. REARDON

NINA KRUSE

ALSO PRESENT:

DAVID GONCI

DAN CHAMPAGNE

TONI ROYAL

CHET MORGAN

BECKY JANENDA

ERIC KLOTER

THEA CARDAMONE

ERIC KLOTER

TERI ROGERS

AND MEMBERS OF THE PUBLIC

JOY DORIN: Welcome everybody. Welcome and thank you for joining us this evening. My name is Joy Dorin and I'm the vice chair of ECHN network and chair of the ECHN board's transaction committee.

ECHN is valuable asset to the eastern Connecticut community. And after nearly three and a half years review, consideration, due diligence and determination to strengthen ECHN's future, a selection has been made to preserve ECHN through an acquisition by Prospect Medical Holdings. Previously, a decision was made to pursue the acquisition ECHN by a joint venture between Tenet Healthcare Corporation and Yale-New Haven Health Systems. For reasons that were beyond our control, we were not able to proceed with that transaction.

Over the course of the past five months, the transaction committee of the board worked diligently to secure proposals from interested parties and

thoroughly evaluated those proposals to make its decision and recommendation to the board of trustees. This decision was made through the engagement of a community government structure of trustees and corporators associated with ECHN which includes representatives of our medical staff.

The board of trustees voted unanimously to pursue an acquisition by Prospect. This decision was also supported by the ECHN corporators with a 98 percent favorable vote to pursue the proposed transaction. These votes allow ECHN to move into our next phase which includes the regulatory process as governed and outlined by the state and federal governments. You will hear more about this phase throughout the evening.

And now to review tonight's agenda and statutory requirements, I'm going to hand it over to Dennis McConville, the chief strategy officer at ECHN.

Dennis.

DENNIS McCONVILLE: Thank you, Joy.

ECHN is hosting two public hearings for our letter of determination, one tonight, August 3, 2015, here in Vernon Connecticut, and another tomorrow evening, August 4, 2015, at Manchester Memorial Hospital in Manchester, Connecticut.

These hearings are to provide the information in the letter of determination that was filed with the State of Connecticut on July 16, 2015. Our agenda for this evening is as follows: I will take a few moments to present the purpose for the hearing, the statutory requirements that we believe apply to our proposed transaction, and let you know how the format for your participation will go.

Peter Karl, ECHN's president and CEO, will present information about the healthcare landscape for ECHN, the rationale for pursuing our transaction with Prospect Medical Holdings and the process that ECHN followed.

Joyce Tichy, who is ECHN's senior

vice president and general legal counsel, will present the letter of determination, and then we'll have a comment, question and answer period for you with our panel. Our panel will include Peter Karl, Joyce Tichy, Mike Veillette, the chief financial officer of ECHN, as well as Dr. Mitchell Lew, who is president of Prospect Medical Holdings, Incorporated, and Thomas Reardon who is president of Prospect East Holdings, Incorporated.

For the public comment and Q&A portion of our hearing, we want to conduct this evening's hearing in as precise a manner as possible, it's structured to present you with information about our proposed transaction before we open the floor to comments or questions to address that letter of determination and related matters. I anticipate this part of the hearing will take 45 to 50 minute.

This hearing is a legal requirement for the State regulatory approval process. Additional hearings will be

held by the Attorney General and the office of healthcare access later in the process after our application for approval of the transaction is deemed complete.

Tonight's presentation and question and answer period will be recorded, transcribed, and submitted to the State of Connecticut, Department of Public Health, Office of Health Care Access and the Office of the Attorney General. You must sign in if you wish to comment or ask a question of the panel regarding the letter of determination.

If you've not signed in and wish to speak, please see Nina Kruse at the back of the room to do so. If you've signed up to comment or to ask a question, I will call your name to come up to the podium to make your statement or to ask your question.

Before you begin your statement, please state your name and your town of residence. In order to give everyone who wishes to speak an opportunity and in the

interest of time, we request that each speaker limit his or her participation to one appearance at the microphone and also try to limit comments to three minute or less.

Your statements or comments should be directed to the contents of the letter of determination. Copies of the letter of determination are available this evening for your review. We expect that the letter of determination and other filings for this regulatory approval process will be available both on the website of the Attorney General's Office and the Office of Health Care Access as the process advances.

Our focus this evening is the letter of determination which described the proposal for transfer of the assets of Eastern Connecticut Health Network and its affiliates to Prospect Medical Holdings, Incorporated. The first step in this process is the filing of that letter of determination.

Within 30 days of the filing of the

letter of determination, the nonprofit hospital and the proposed purchaser must hold a public hearing on the contents of the letter of determination. Again, this hearing is being recorded and transcribed as required and it will be filed with the OHCA and the Office of the Attorney General. The transcript will be made available to members of the public upon request.

The Commissioner and the Attorney General will review the letter of determination. The Attorney General determines whether the transaction requires approval under the so-called conversion statute as a conversion of a nonprofit hospital to for-profit status. A joint review process is then undertaken by the Commissioner of Public Health and the Attorney General.

The certificate of need process for hospital conversions is governed by Connecticut law. The law contains standards that the Attorney General and the Commissioner of Public Health must

apply in rendering a decision for each application. The law allows for each agency to engage experts to assist in the certificate of need process.

The statute states that the Attorney General shall deny an application as not in the public interest if the transaction is prohibited by Connecticut statutory or common law governing nonprofit entities trusts or charities. The Attorney General shall deny an application if the applicant fails to exercise due diligence in deciding to transfer, selecting the purchaser, obtaining the fairness evaluation or negotiating the terms or condition of the transfer.

An application will be denied if the nonprofit hospital failed to disclose any conflict of interest or if the nonprofit hospital will not receive the fair market value for its assets. By statute, the Commissioner of Public Health must also apply standards in reviewing and ruling on an application.

The Commissioner of Public Health

must deny an application unless a commitment has been made to provide care to the uninsured and underinsured. The proposal is also reviewed under standard certificate of need guidelines, including whether there is public need for the proposal, the impact on the financial strength of the healthcare system in the state and whether the proposal will improve on the quality, accessibility, and cost effectiveness of the healthcare delivery in the region.

Now I'm going -- okay. A bit of a technical -- okay. Thank you for your patience.

Now I'm going to walk you through the estimated timeline for the certificate of need approval process. Some of these intervals are mandated by statute and others are estimates so they may change. The process begins with the filing of the letter of determination which we did on July 16th. Within 30 days, we are required to hold public hearings on the content of the letter of

determination.

We expect that the Attorney General will rule that our proposed transaction is subject to the conversion statute. We hope to receive an application from the Attorney General within 14 days which brings us to mid August.

Once we receive an application, we have 60 days to file the completed application. We plan to file our application within 45 days, which gets us to early October. The Attorney General's office and OHCA have 20 days to determine if the application is complete. If they identify deficiencies in the application, we will receive what are known as completeness questions, and we estimate it will take seven more days to respond to those and then 20 more days for the agencies to respond.

We could see one to two cycles of completeness questions. The target for our application would be deemed -- deeming our application complete is early December. Once deemed complete, the

Attorney General and the Commissioner of Public Health have 120 days to decide on the application. They will hold their public hearings during that time. We estimate that the process will take between nine and 12 months with a decision coming between March and April of next year.

Joyce Tichy will provide more detailed information regarding the transaction in a few minutes but here is a summary of the proposed transaction.

We are proposing that Prospect Medical Holdings buy ECHN. There would be the continued operation of Manchester Memorial and Rockville General Hospitals and our post acute care network, including Woodlake at Tolland and Visiting Nurse and Health Services of Connecticut, the continued involvement of a community advisory board, capital investments to fund new programs, investment technology and improved facilities and equipment.

The acquisition of ECHN by a leading

organization will bring decades of experience with managing the health of populations and is focused on value based care. The establishment of a community foundation to oversee certain charitable funds and continuation of ECHN brand and mission including the continued commitment to charity care and indigent care.

Now to review our process and the background for the application is ECHN's president and CEO, Peter Karl.

PETER KARL: Good evening. I apologize in advance because this hearing is official I need to read my testimony for the record instead of speaking informally about the slides. Please bear with me.

Thank you for joining us this evening. We are here to discuss the proposed transfer of assets of the Eastern Connecticut Health Network and affiliates to Prospect Medical Holdings.

ECHN is proud to serve eastern Connecticut by improving the well being

of the community by offering quality, compassionate healthcare. That is our mission and our organization has pursued this mission for nearly a hundred years. Our commitment to the mission is what we want to continue on behalf of the patients and their families, our physicians and our employees.

We want to see the ECHN name and brand continue. ECHN has made an obligation to training our next generation of physicians. We have developed a strong relationship with our medical staff. We support the education medical students and have established a new graduate medical education residency program at ECHN.

Manchester Memorial and Rockville General Hospitals, Woodlake at Tolland, Visiting Nurse and Health Services as well as dozens of affiliates and joint venture companies are anchors in the region we serve. ECHN is a significant economic engine providing the salaries for over 3,000 skilled jobs and

purchasing over $90 million in services and supplies each year.

The Patient Protection and Affordable Care Act is designed to provide insurance of 32 million Americans who are uninsured. Hospitals as an industry agree that they would accept lower payments as more of their patients would now have some form of insurance.

In Connecticut, unlike other parts of the country, residents are relatively well insured so there's not the benefit of more revenue for our hospitals. We estimate that we need to reduce expenses by 15 to 20 percent, which would mean cutting services and staff.

In addition, the government and the commercial insurers are pushing for payment reforms that shift the risk for getting paid to providers including our hospitals and our physicians. The resulting new payment systems reward those who deliver care at lower costs with improved quality and outcomes. This means that we need to reform and refocus

our delivery of care to keep patients well in the lowest cost settings, generally at home or in an outpatient setting, preventing patients from needing expensive hospital stays.

The focus on our patients needs to be ongoing and proactive not just on episodes of illness and hospital stays. The information about our patients needs to be accessible to providers across the network. Care management programs need to be expanded through the community. The investments needed to succeed with population health are major and difficult for organizations that are operating on extremely thin margins.

As you can see here in this slide, in 2001 ECHN lost more than $10 million and continued to operate in the red for many years. During this time the level of debt continued to rise. I took office 11 years ago and ECHN began to make course corrections but it took six years to catch up and we were forced to defer capital investments.

You can see that with the Connecticut Hospital Tax, implemented in 2011, we have not been able to generate the operating results needed to reinvest in the organization. You can also see by the lower graph that our pension liability grew dramatically, the result of pension funding reforms that came at a time when the market crashed in 2008.

Debt service and pension contributions consume a large portion of ECHN's annual cash flow and making capital investments difficult. The pension liability will grow again by an estimated $14 million next year resulting from new actuarial tables reflecting the longevity of retirees.

Hospital systems are extremely capital intensive. The cost for new medical and information technology are significant. The building codes for our facilities to make improvements are expensive. I mentioned population health and the need to share technology across the system. A new electronic medical

record system will cost at least $20 million.

There are programs that we'd like to develop to address health needs that require capital investments. Private accommodations for our patients are not only about comfort and privacy but they offer a safer environment for our patients. Again, hospitals are expensive to build or renovate.

Eastern Connecticut Health Network and all Connecticut hospitals are struggling with financial challenges associated with the reduction of government payments for services provided to our patients. Payments for services to Medicaid and Medicare beneficiaries make up 55 percent of our revenues.

Since we started our journey to evaluate a partnership, more has happened that worsens our financial position. As mentioned, the State imposed a tax on hospitals that remains a significant burden for ECHN. For a $330 million

system, we have struggled to achieve a 1 to 2 percent margin, which is three to $6 million. You can see that tax represents the margin that we need to produce to remain viable.

ECHN, along with other hospitals, also had to shoulder the financial impact of federal sequestration. Medicare provider payments have been cut by 2 percent since April of 2013. The act requires federal spending cuts to be achieved over the course of nine years so the sequestration is expected to remain in place through 2022.

The sequestration equates to a loss of more than 2.2 million each year for ECHN. This year the State has implemented a new system for Medicaid patients for inpatient care. While we were told that the change would be revenue neutral, we have determined that this is not the case. We will see 1.6 million less in revenue for those admissions this coming year.

As a result of this year's state budget,

the pool of dollars for low cost hospitals was eliminated. While a couple of hospitals were successful in restoring that funding during the special session in a new small hospital pool, Rockville was not so fortunate and we will see 300,000 less this year.

Finally, the formula used by the federal government to calculate our Medicare payments is subject to a wage index. The current projections for payments resulting from the way that that index is applied will lead to even further reductions.

As you can see here, the negative forces associated with the reduction in payment for services coupled with the increased salary and non-salary costs equates to an inability to reinvest in ECHN and an unsustainable financial path.

In order to prepare for the future of ECHN, a work group of trustees, corporators, medical staff and administrators was formed in 2011 to

study ECHN's needs and the benefits that would come from partnering with another healthcare institution. After studying the national, regional, and Connecticut landscapes, along with ECHN's current and potential future position, it was decided that a partnership was in the best interest of ECHN.

The partnering work group developed criteria in which to evaluate potential partners including cultural and strategic fit, financial strength and long term viability, and the partner's interest to invest in our organization. The work group made their findings and recommendations to a committee of the ECHN board of trustees, the transaction committee.

When the deal with Tenet and Yale-New Haven Health System did not work out, the board reaffirmed the need for a partner. In January, the transaction committee employed the same process to select and then recommend to the board a transaction with Prospect Medical

Holdings.

The reasons to join another system are clear. We want to improve our access to capital and afford investments. We have to improve finances and reduce or eliminate our debt. Together, with our physicians, we have to be prepared to participate in the new systems ensuring that we protect, preserve, and grow the local access to healthcare services.

Request for proposals were sent to six healthcare systems. Three proposals were received from Hartford Healthcare, from St. Francis Care and Trinity Health and one from Prospect Medical Holdings. After careful due diligence, which included rounds of questions and answers, site visits and meetings with the parties, the board selected the proposal from Prospect Medical Holdings as the best one that best meets ECHN needs.

The combination with Prospect Medical Holdings will secure the future

of ECHN and local access to healthcare for the communities we serve east of the river. There's a strong alignment of mission, vision, and values with Prospect. Prospect is a strong partner for physicians, both independent physicians and those employed by hospitals.

They have decades of experience with managed care and the value-based risk-based contracts that are emerging as a result of healthcare reform. Risk based contracts place the economic risk, the risk for payments based on performance, on the healthcare providers including hospitals.

Prospect is successful in these risk arrangements because of the programs and resources that they employ to promote health in managing the healthcare needs of the population of patients in the lowest cost settings, at home or in ambulatory settings, while producing the best outcomes for their patients. Prospect has a history of success in

markets where there is significant competition from much larger hospital systems. They have already begun educating our physicians about their model, which is important to building a sustainable, thriving network of value-based care for our communities.

ECHN firmly believes that this partnership will allow us to continue to serve our mission, it will protect accessibility and the affordability of care for our patients while continuing our focus on the quality and safety of patient care. This will support our efforts to continuously improve patient satisfaction and it will enable us to reinvest in programs, technology, and facilities for the benefit of our patients.

Now I'd like to ask Joyce Tichy to walk you through some of the finer details associated with the letter of determination.

Joyce.

JOYCE TICHY: Okay. All right. We have to -- there. Okay. Five and six and then the slide that starts, I think it's 20.

Okay. So I just wanted to start -- my part is to give you a little bit of a summary of the transaction and the manner in which we think it complies with the requirements of the legislature and our regulators to show that our board engaged in a diligent negotiation of the terms and conditions of the transfer.

But I wanted to go back to slide five, which Dennis presented, and slide six, just to give you the framework for within which our board operated. There's been an enormous amount of focus and attention on the subject of hospital transfers in our state and in Hartford. And I would say that based on the amount of legislative change, our legislators have done their absolute very best to try to preserve these assets as best as they know how on behalf of the

communities like you for which these assets were created and have been maintained.

So the way our board looked at it was, you know, they are fiduciaries, they are representing the community and they heard loud and clear that this is what their goal was, so they followed with a great deal of energy and focus the legislative mandate that was presented to them.

So this first slide that Dennis presented gives to you what it is that the Attorney General is supposed the look at. And mostly, what the Attorney General's office is going to check for, is to make sure that there's not been any wasting of the assets, that they have been preserved as best as possible under the circumstances in honor of those who have contributed and maintained these assets over the many years that they were maintained.

So you can see that these are the things that the -- that the board was

supposed to pay attention to, making sure that the purchaser was a good purchaser, making sure that there was fairness in the amount of money being agreed to, making sure that there's a fair market value evaluation by a third party that has nothing to do with any of us in order to establish the fairness of the deal, that's what the Attorney General is going to do.

So now if you turn to slide six, OHCA, the Office of healthcare Access, looks at the transaction from a different perspective. Their goal is to make sure that once the deal is completed, the commitment to the uninsured and the underinsured remains, that the financial strength of the entity, that is Rockville here and Manchester Hospital and the rest of ECHN, is maintained and that there's quality, accessibility, and cost effectiveness going forward. That's the frame within which the board worked and that's the framework of the transaction as it -- as it ultimately was

developed.

So next I'm going to talk about -- if you now can turn to page 20 -- the part that's sort of the meat of the deal; right? And it's going to take a little bit to get through but I'm going to try to be as high level as I possibly can. And that's in order to show you, and to show our regulators, that there was a diligent negotiation of the terms and conditions.

So the way the letter of determination is set out, it has these various categories of subject matters in them, and so I'll just give you a little bit of summary of each of those. And this is going to sound very familiar to those who were here last year because, effectively, the transaction ended up being very, very similar to the Tenet deal, and in some ways I'll get into, an improvement over it.

So the form of the transaction is an action asset purchase, and that's very common in these kinds of transactions

where a for-profit purchaser is buying a not for profit entity. And what means is that Prospect is effectively buying substantially all of the assets of ECHN.

The key assets to be acquired, which are listed in the letter of determination are, obviously, the two acute care hospitals, Manchester Memorial and Rockville General Hospital, Woodlake at Tolland, our subacute rehab and long term care entity, our visiting nurse service, Visiting Nurse and Healthcare Service of Connecticut, our insurance captive, which is the entity that we have that handles our medical malpractice claims, our billing physician office administration entity, which is named Medical Practice Partners, and all of the other entities that bear the ECHN name.

And those of you who are in the community and, you know, drive around and we proudly put our name on all of our physician offices and physician office buildings, and those are going with this

transaction. Some of those buildings we only own shares in, and to the extent we own a share in those buildings, those are transferring as well.

Another thing that's transferring over is ECHN's interest in a variety of our joint ventures including an endoscopy center, the Dequattro Cancer Center, which provides cancer services on the other side of the street of Manchester Hospital, two ambulance companies, a wheelchair transport company, an occupational medicine provider and others.

So this list is not exclusive and one thing to know is that some of the joint ventures will require permission from the other parties, and that's also going to be part of the process that we engage in. Along with the entities, then all of the material, equipment, property leases, accounts receivable, networking capital, and all the physical and tangible evidence of ECHN will transfer as well.

Then you get to, and this was very, very important to our board, along with the assets they insured, they are insuring, that the liabilities that ECHN has incurred over the many years of its existence are also being resolved and handled appropriately. So those are -- again, these are the already existing obligations of ECHN. And just like any hospital system, over time those gather, and as Peter mentioned, for example, the pension liabilities which have grown very large over time, our post-retiree health benefits plan, the captive insurer liabilities, as I mentioned, and our Workers' Compensation claim -- liabilities.

The board was very interested in making sure that we deliver ECHN with a clean slate, all of our creditors paid off, and we can basically be proud to move it forward into its next phase without those liabilities hanging around.

On the other hand, there are some

assets and liabilities that will be excluded, again, as common in transactions of this kind. So the first one to know about is our donor restricted charitable contributions. So those were contributions that were made to ECHN or Manchester Hospital or Rockville or our foundation with an instruction by the donor that, for example, the principal was not to be used but only the interest or income. Those funds, when they have that kind of designation, are placed separate from the rest. They cannot go to any purchaser and they will be set aside.

Also, not included in the transaction, are the results of lawsuits, cost or court settlements, and that being that Medicare pays awfully slow so you just don't wait around and the transaction will close while cost or court settlements remain to be completed. Tax settlements and other things -- other liabilities relating to ECHN's pre-closing activities but they show up

after the closing.

Also, not transferring as part of the transaction but staying aside are ECHN's cash and investments, which will be used to payoff debt at closing, I'll get to that in a minute, and our long term debt. And these will be -- these are set aside and either will flow differently as part of the deal or will be handled by a residual ECHN corporation that will basically be set up just in order to close down activities.

We have a medical foundation, and that's basically the employed physicians, they work in a separate subsidiary. There was quite a lot of legislation about medical foundations of very recent vintage, actually. And we will work with our regulators to ensure that the legislative intent is followed in the manner in which the medical foundation will be transferred.

So as part of the transaction, our board felt, and it heard the community in

this, that there would be a strong interest in maintaining a local voice with respect to the governance of Manchester Hospital, Rockville Hospital -- Rockville and the rest of ECHN. So as a result of that, each hospital will have an advisory board, which is sometimes also called in these papers, a local board.

That board will be appointed by ECHN before the closing, and initially is to be made up of five ECHN trustees along with five others to be identified by ECHN. And the members are going to include community representatives, physicians on the medical staff, and the hospital CEO. That's, namely, Peter, who just spoke.

The role of the advisory board is actually going to be substantial. It's going to be an adviser to Prospect on how to best spend the capital commitment that it is making of $75 million. This is after the transaction closes Prospect is promising to invest $75 million in ECHN

and this advisory board will be -- will assist in the determination of how that is best to be spent.

It will also assist in the development of ECHN's strategic business plan. It will be responsible for medical staff credentialing, it will oversee quality assurance -- a very key aspect of ECHN services is quality -- and it will oversee and manage the hospital's accreditation.

The CON requires that we show and that Prospect shows that there's a continued commitment to maintain community support, charity care and the continuum of care. And so to that end, we have ensured that Prospect has agreed it will maintain ECHN's policies on charity care, indigent care, community volunteer services and community outreach services.

Also, we have and are very proud of the fact that we have a graduate medical education program, which we started a few years back. It's starting to show really

great results. We're graduating physicians, some of whom are staying in the community, and we're really thrilled about that. It's with University of New England College of Medicine, and Prospect has agreed to continue that relationship.

It's also agreed to maintain for three years our two acute care hospitals, along with their emergency departments and to maintain an ownership interest in VNHSC and Woodlake at Tolland, our long-term care facility.

With respect to employment, Prospect has agreed to offer employment to substantially all of ECHN's employees, a comparable benefit package to what people had pre-closing, and it's also agreed to assume our collective bargaining agreements.

When ECHN went into the process of seeking out a buyer, it decided that in order to protect the employees well, it would negotiate a -- a -- collective bargaining agreements with fairly long

termination provisions. And so at this point in time, even though we're actually going, I'm sorry to say, through our second buyer, we still -- we still have a ways to go with them.

The RNs at Manchester Hospital, their collective bargaining agreement goes until June 2018. Our Manchester service and skilled maintenance employees' contract goes to May 2017. Our technical and LPN employees at Manchester go to June 2017.

And our RNs at Rockville go to December 2018. So we have a fairly long period of time yet. And that, again, was ECHN's attempt to best protect employees as we were moving into discussions with purchasers.

And I also now want to talk about the capital commitment. So as I mentioned, Prospect has agreed to spend $75 million within five years, that's in addition to the purchase price, to pay for upgrades to ECHN facilities and projects to improve services. Given our

financial condition, we have been unable to invest in capital improvements, and an entity can go only so long before that becomes an untenable situation. So that 75 million was a very important piece of the transaction to ECHN.

This money will be used to renovate ECHN facilities. It'll be used for recruitment costs, for needed medical staff, for expansion of our clinical departments, purchase of essential medical equipment or -- and/or electronic medical records, without which a hospital system can no longer continue today. And all of those will be toward the improvement of ECHN post closing.

There is a caveat, and that is if a -- a law or rule is passed or applied in Connecticut that discriminates against for-profit systems, that obligation can be deferred beyond five years, but if that happens, Prospect will have to have a conversation with us and probably with you. So I think that that will be a -- a fruitful conversation if

needed.

With respect to the services or towns served, there are no changes. No changes to the services or towns served, which is something that we have to establish or explain in the CON.

I did want to spend just a minute or two describing to you the fact that the Prospect transaction -- the proposed Prospect deal is actually better than what we had with Tenet. First of all, it's reduced the indemnity reserve, which is the amount that you need to put aside to cover potential liabilities after the transaction, from 7.5 million to $4.5 million.

It's also agreed to cap the value of the joint ventures, which means if we have a joint venture, remember, we are part owner of that entity, if there's a reason that it can't transfer or for one reason or another because we'll need the other party's consent, Prospect has agreed to cap the total amount that's a deduct from the purchase price if that

eventuality happens. And it also has agreed to loan us the money that would count towards those joint ventures if they are in process, but not quite completed at the time of the transaction. Lastly, it's allowed to -- allowed us to access that capital commitment of $75 million earlier than otherwise, if need be, to close the transaction.

So all of these factors were evidence to us that Prospect was in good faith and it -- and it is really, really diligently interested in having us close the transaction for the benefit of ECHN.

So the next slide -- I know this is a lot for, you know, a couple of slides. What I'm going to describe to you on this slide is what transaction lawyers call the waterfall, which is kind of how the money comes in and then in a very brief way how it goes out.

Some of this is repetitive of what I and -- and Dennis said already, but a lot

of people have the question sort of, Where's the money? Where's it going? What's this? So this is kind of how it works.

So, first of all, you start by saying we are excluding a number of things. Those donor-restricted funds, they stay on the side. They go directly where the Attorney General tells us to send them. We're not touching them.

Then we have cash investments. Those are not going as part of the deal. Again, they sit on the side, and they -- and they effectively wait.

Also, our cost report settlements, we don't know what they are, but they're not part of the deal right now. So they're also sitting on the side. Putting those on the side.

Then you start with the hundred and five million purchase price. That amount could be a hundred and fifteen million if we get a loan, but if there's a loan -- and a -- a loan that's transferable to Prospect, if that's true, then the debt

we -- that we are responsible to pay goes up by 10 million.

So it's just a wash. You might as well just assume it's a hundred and five million. Just -- it'll be an add and subtract from the two sides of the balance sheet.

Okay. So here we are with the hundred and five million. First thing we do is we true up to make sure we have enough networking capital. So that's the money that you basically work with all day long. Sort of like your checkbook, you know, you've got to always have enough money in your checkbook to pay the bills when they come in before you get your paycheck. So that's the amount there.

There's an amount there in -- in the -- in the deal. It's $24 million. And if we have more than that, we true up down to 24. If we have less than that, we true up to 24. Okay. So that's the first step.

The second step is you start taking

reductions because Prospect is taking on liabilities. Of course, these are things it's not its problem. So, you know, we have to pay to have those liabilities taken away from ECHN, and those include our indebtedness, which is effectively our capital leases, our unfunded pension liability and our post-retirement health, very important for us to make sure are handled, our employment-related liabilities, if any, our captive and Workers' Comp liabilities.

Remember, I just described these to you before. This is how they come off of the transaction. You pay them off. The -- the value of those joint venture interests that we can't transfer for one reason or another and a miscellaneous, like our asbestos liabilities, which are going to be somewhere in the range of, I think, a -- a million dollars or so.

Okay. Then there's an amount of money that's left. That amount gets combined with the cash and investments

that remember I said we put on the side, and those -- those combined monies are used to pay off our long-term debt, which are the monies we owe to bondholders and lenders that have been accumulating over time that Peter mentioned on another slide.

Okay. Then after that, we take that $4.5 million, and we put it in a bank account just in case something comes up after the transaction that was our fault and our liability. And that money stays there for three years. If nothing happens and -- and nobody sues us for things that happened before the transaction, no new liabilities happen, that money becomes available for the charitable foundation that will be set up. That money, along with whatever is left after all this -- this waterfall deduct, all goes effectively to where the Attorney General tells us to put it, and that will be basically the amount of money that represents the charitable asset that's left.

After closing, again, we still have that 75 million-dollar capital commitment that Prospect is -- has agreed to pay to -- for the upkeep of ECHN.

So there are a couple of caveats here as there are always in a complicated transaction. The deal is contingent on there being no material change to our business assets, liabilities, financial condition or results of operations. That's a phrase you always put in these and -- but it can be significant. We have to make sure that our medical foundation is successfully transferred as the regulators require it. And there are additional other closing conditions involved.

One thing that -- and I just want to close with this piece that I -- that I want to emphasize is: There will be numerous independent verifications of the appropriateness and thoughtfulness of the board's decisions here. And I sat through them, and I know they were very deep and thoughtful, but you want to

make sure that somebody else is checking.

The fairness of the purchase price by law will have to be confirmed by a third-party fairness opinion, which we did in the Tenet case and we will do again, a new fairness opinion. We'll have the outside audit of our financial statements. We'll have actuarial reports for our pension and retiree health to make sure that we calculated those liabilities correctly.

We'll have the Attorney General and OHCA review with yet another hearing or series of hearings, and they will hire their own independent experts to test and document the representations that we're making to you and to them, and those will be paid by the parties.

So that's all I have. And so I guess I'm turning it back over to you, Dennis.

DENNIS McCONVILLE: Yes. Thank you, Joyce.

Okay. We've reached the -- the part

of the hearing where you, the public, may participate. Again, for this portion of the hearing, you must sign in if you wish to comment or ask a question of the panel regarding the letter of determination. If you've not signed in and wish to speak, please see Nina Kruse at the back of the room to do so. If you've signed up to speak, I will call your name to come up to the podium and make your statement or ask your question.

Before you begin your comment or comments or a question, please state your name and the town -- your town of residence. In order to give everyone an opportunity to speak who wishes to do so and in the interest of time, again, we request that you limit your participation to one appearance at the microphone, and you try to limit your comments to three minutes or less.

Your statements or comments should be directed to the contents of the letter of determination. If you have signed up to speak, but have changed your mind,

when I call your name, just state no comment. If you prepared written legible comments, you may leave your comments with Nina Kruse as well.

And I would like to point out that this hearing is being videotaped for those that plan to participate.

And with that, I would like to introduce our panel. I'd like to reintroduce Peter Karl, our president and CEO; Joyce Tichy, senior vice president and general legal counsel for ECHN; mike Veillette, who is senior vice president and chief financial officer for ECHN; Dr. Mitchell Lew, who is president of Prospect Medical Holdings, and Thomas Reardon, who is president of Prospect East Holdings, to take your questions.

First, I'd like to call to the microphone Dave Gonci on behalf of Dr. Saud Anwar of South Windsor.

DAVID GONCI: My name is David Gonci. I'm a resident of Glastonbury, and I'm reading this letter which was presented by Dr. Saud Anwar. It's

addressed to the commissioner of the Office of Health Care Access and the State of Connecticut Attorney General, Mr. Jepsen.

The letter reads as follows: My name is Suad Anwar, and I'm a pulmonary and critical care physician affiliated with Eastern Connecticut Health Network for over 17 years. I support the proposed partnership of Eastern Connecticut Health Network and Prospect Medical Holdings.

I am an independent physician who has the opportunity to interact not only with the patients in the community, but also the staff essentially in most parts of our hospital, and I also have an opportunity to cooperate with the community physicians providing primary care to our community.

As a medical director of the clinically integrated network of Eastern Connecticut and also with Eastern Connecticut Physicians Hospital Organization and medical adviser to the

care management department of the hospital, I have had the opportunity to closely observe the sustainability challenges our healthcare system has. We're struggling to continue to provide best quality to all the patients with ongoing challenges, with increasing social challenges in insurance and reimbursement and bureaucracy.

I have also had the opportunity to learn firsthand from the representatives of Prospect Medical Holdings and their existing hospitals and their track record of providing quality care to patients with all capabilities of payments.

It is quite clear to the physicians that integrated network and -- and coordination of care in a healthcare system with strong primary care delivery, along with collaborative specialty care with appropriate transitions according to the patients' needs is the best and the most effective way of maintaining and managing population health.

Prospect Medical Holdings has many

years of experience and success in managing risks with their delivery models. The size of our healthcare system and the opportunity to collaborate with an experienced partner who believes in collaboration between the independent physician in the community and the hospital will truly strengthen health care within our network.

Our hospital continues to employ members of the community and serves as a backbone of the economic engine within our towns. In my other role as mayor of the Town of South Windsor, I know that over 250 people in my community are employed by ECHN. A stronger, efficient and sustainable healthcare system allows industry to identify and choose communities to invest in. With growth of population health management, we truly can have an impact at all levels according to the needs of the people.

I strongly feel that the track record in the current system needs to move to for-profit model, and this

partnership will not compromise the quality of care, but actually enhance the quality of care and would be able to provide care to the patients irrespective of their insurance status and abilities to pay.

I thank you for your consideration. If you have any questions, please do not -- do not hesitate to contact me. Sincerely, signed M. Saud Anwar, M.D., Chairman of Department of Medicine, Eastern Connecticut Health Network.

DENNIS McCONVILLE: Thank you, Dave.

Next I'd like to call on Mayor Dan Champagne of Vernon.

DAN CHAMPAGNE: Well, I thought I was further down the list, but, okay.

You know, we were in this position about a year ago.

Sorry to turn my back to you guys.

JOYCE TICHY: That's okay.

DAN CHAMPAGNE: And a year ago with Tenet, it was a -- I think it was a different deal. My concern is the same as last time, you know. The three years,

I wish it was a lot longer, but given the condition, you know, that Hartford has put us in and -- Hartford and Washington, you know, I don't think the -- I don't think ECHN has enough money left to even last three years if they don't combine with somebody. And that's -- that makes me nervous.

Truly, Rockville Hospital is our hospital. Back in 1921, when they -- when the hospital started on Prospect Street, it was done through community donations, and then we moved to the current location of 31 Union Street. And -- and every time the hospital is in trouble, we turned around and -- and we pulled them out, you know, the donations that this community has made, the jobs provided.

Rockville Hospital is the second biggest employer in town, and the Visiting Nurses is the third biggest employer. So that makes us very concerned about this three-year deadline, and I wish we -- I wish we had a lot

longer than that. I said that last year as well.

If you look at the new partnership, you know, I -- they're not in the business of closing hospitals. They're in the business of -- of making a profit, yes, but they're not in the business of closing hospitals. And I think that's important to keep in mind.

In Connecticut's environment right now, you know, we keep taxing. They saw that hospitals were having a profit, a profit in quotes, and they decided to -- to tax that profit. That profit wasn't a profit.

What it was is it was money left over so they could reinvest into the community, into those hospitals in -- in -- in many different forms. And once the -- the -- the budget -- the biggest tax increase was done a couple years ago. Hospitals took a hit, and they took a hit this time as well. And -- and it's -- it's a sad state we live in and, you know, we have to live with that.

The medical services that Rockville Hospital provides to all of our citizens, you know, we have a lot of in- -- individuals in our town that are in low-cost housing. And the services are offered to them right here in our neighborhood. We don't have to drive. We can make our way there.

If Rockville Hospital leaves, we're going to Hartford or -- I don't think a lot of people are going to stop in Manchester. They're just going to bypass and go all the way out. So I think it's important that we do something to save our hospitals because in the condition that -- you know, under what we're currently doing, it's not working because the taxes continue to go up and -- and the repayments nationally are going down.

I'm going to continue to do everything in my power to make sure Rockville Hospital remains a vital part of this community. We need it, both medically and for the jobs it provides.

And it's our history.

Again, I want to end with it's our hospital. We started it. Thank you. Thank you, guys.

DENNIS McCONVILLE: Thank you, Mayor.

Next I'd like to call on Toni Royal.

TONI ROYAL: Hi. My name is Toni Royal, and I'm from the Town of Vernon.

I'd like to say that it's been great having a community hospital here. I've had good service from them for years, both when I arrived at the hospital with a medical condition and to be there with someone who was seriously ill. And you can go home and come back and go several times a day when the time is there, and that has happened to me.

I have a question, though. I'm just curious to know or have you comment on the contrast between a for-profit entity and not-for-profit and how it impacts taxes and your -- your volunteers. I've heard that for-profits are not permitted to have volunteers. And can you comment

on the number of volunteers and the amount of service that that represents?

Thank you.

DENNIS McCONVILLE: Who'd like to take that question? Peter?

PETER KARL: Sure. I'll take that question.

Volunteers can volunteer whether -- whether it's for-profit or not-for-profit. That can continue, so -- and we hope that, of course, the volunteers will continue. We work very closely with them at ECHN. And you won't see any difference as it relates to volunteers.

As it relates for-profit or not-for-profit, Tom, you want to take that or -- or Mitch?

THOMAS REARDON: I need a -- I need a 12-year-old to turn this on for me.

Yes, I'd -- I'd -- I'd be delighted to, Peter.

You know, in the old days there was a -- some -- they -- there was an allegation there; was a difference

between for-profits and non-profits. The for-profits were more concerned about efficiency and producing a profit and less concerned about quality. And that line has blurred.

For-profits like Prospect are all about quality at this point. That is our essential message. Our value-based population management capabilities, that's what we go after, and so there's been a blurring of lines. So when you think about a for-profit versus non-profit, there's not much difference anymore, except for-profits pay taxes, Mr. Mayor. And so we -- we have the same charity care policy. We have the same commitment to the community.

I don't think you're going to see any difference whatsoever in terms of the services that are provided to this community. There's not much difference anymore.

DENNIS McCONVILLE: Thank you.

Chet Morier (phonetic).

CHET MORGAN: Morgan.

DENNIS McCONVILLE: Morgan.

CHET MORGAN: I guess we're addressing you.

My name is Chet Morgan. I live here in Vernon, moved here in 1961. But before that, I had an interest in Manchester Hospital 'cause I was born there in 1937. So everything's changed since then, but I just want to give you a little history before my question.

As a member of the legislature in the late '70s, I was in the public health and safety committee. And the executive director on the Commission on Hospital and Health Care came to me and said, I'm going to close your hospital.

Well, we can't stand this hospital to close, and we keep going through this. But I asked him why. And the maternity and pediatrics board were in the old Maxwell building. So I dealt with the president at the time. And I forget his name. And I got some serious state dollars, and we revamped Rockville Hospital, and we put in a new emergency

room, which is now changed. And now the maternity ward is growing, too.

But anyhow, that's where it was. They were going close -- the Commission on Hospital were going to close Rockville General because of that fire hazard, and I wouldn't let that happen, you know. I was very thankful for all the support from the town and community and everybody here. So that's my background.

And I -- I fought -- and I just had to say up front that I do agree that it has come to this that we have to be in a takeover. I agree with that. However, I was here tonight, and Ms. Tichy answered most of my questions in the letter of determination on eight was employment matters. And you told me how many long-term contracts you had with the various unions.

But I have a question for Dr. Lee. Can Prospect, once they take over, eliminate those contracts or renegotiate those contracts?

DR. MITCHELL LEW: What contracts

are you referring to?

THOMAS REARDON: Labor contracts?

CHET MORGAN: The labor contracts.

THOMAS REARDON: We have a very good working relationship with labor -- labor unions. We're going to assume those contracts, and we're -- we're going to work with those labor unions. We see them as partners. We're very good at partnering.

CHET MORGAN: Thank you, sir. I'll hold you to that.

And thank you for your being here tonight. And like I said --

JOYCE TICHY: Can I add something?

So when you're -- when you're speaking legally, what Prospect is agreeing is to step in ECHN's shoes and become the employer. And once an employer ends up doing that, it really basically is --

CHET MORGAN: Okay.

JOYCE TICHY: It can't just cancel a union contract.

CHET MORGAN: Okay. 'Cause --

JOYCE TICHY: They don't. That's just --

CHET MORGAN: -- from what you told me, the length of -- of the many contracts -- the labor contracts go out a couple years. So if there is a problem, there's enough that we can negotiate as --

JOYCE TICHY: Right.

CHET MORGAN: -- a -- as a community and -- and -- and work with people 'cause it's obvious you people are willing to listen, and I thank you for that, but hopefully --

JOYCE TICHY: Right. So at that point there will be a negotiation of terms like wages, et cetera.

CHET MORGAN: Yeah, yeah.

JOYCE TICHY: But it can't just be thrown away.

CHET MORGAN: Thank you. Thank you. Thank you.

DENNIS McCONVILLE: Thank you, Mr. Morgan.

Next is Becky Janenda on behalf of

Dr. Ronald Burt of Farmington. Will you come up?

BECKY JANENDA: This letter was written by Ronald E. Burt, M.D. And I'm just reading it on his behalf. These are his opinions, not that I'm disagreeing, but these are his -- this is his word -- these are his words.

To whom it may concern: I am writing in strong support of the proposed acquisition of Eastern Connecticut Health Network, ECHN, by Prospect Medical Holdings, Inc., a national healthcare services company headquartered in Los Angeles, California.

My support of this transaction is based on over 30 years' experience in all aspects of clinical healthcare delivery in settings as diverse as large tertiary care, Anchor, private teaching hospitals, numerous community hospitals and university-based delivery systems. Moreover, I have had a close association with the ECHN organization and the community that it serves for a number of

years and am well aware of and sensitive to the needs and challenges that both face in the current climate of unprecedented changes in the healthcare services industry.

ECHN is an organization that has been a community pillar both in medical services it provides to all who enter its doors as well as a key employer within the eastern Connecticut geographic area. The preservation of enhancement to the services it delivers and opportunities it provides is critical. And it is my opinion, after having substantial exposure to and involvement with the acquisition and merger dy- -- dynamics occurring at all levels of health care, that Prospect Medical's acquisition of -- of ECHN presents the best opportunity for ECHN's legacy of service and opportunity to be carried into the next generation of healthcare delivery, which is indeed upon us.

ECHN's leadership has und- -- undertaken an extraordinary --

extraordinarily lengthy and diligent process of research and deliberation over several years in arriving at the choice of Prospect Medical Holdings, one that's solidly supported by both details of the transaction and well-paired blend of corporate and institutional cultures that will be the result of the transaction.

Prospect's approach to coordinated regional healthcare delivery and population-based disease management expertise are essential to ECHN delivering the most efficient and highest quality healthcare delivery in the new environment of the industry. And Prospect has well demonstrated success in achieving the needed results through a variety of competencies.

At least some of these are: A keen focus on providing to each patient the right care and the right setting by the right provider with the most appropriate application of resources. B, the ability to integrate effectively with the

physician and other clinical provider community that patients know and trust and follow to ECHN's facilities. C, a track record of robust -- robust investment in -- excuse me -- robust investment and reinvestment of resources into the systems it manages, maintaining the expanding healthcare services as well as preserving and creating employment opportunities within the local communities served. D, the ability to work constructively and effectively with healthcare employee unions. And, E, the ability to do all of the foregoing in a state environment characterized by a high degree of regulation of healthcare services.

Any person who has -- has even a nodding acquaintance with the sea of change that all hospitals in Connecticut are now facing will know that ECHN is not at all alone in the challenges and even peril that it faces, and every hospital must make responsible, effective and timely decisions in setting their future

course in this storm of healthcare industry change.

Such I believe are the characteristics of the decision that ECHN is endeavoring to gain approval for and to effectuate. It is my hope that ECHN's -- excuse me, I lost my eyesight -- ECHN's served community and the governmental entities impacting on this process will understand that they have the opportunity to either allow ECHN to pull into the undertow of this tidal wave of change and be lost or to facilitate its ascent to the crest of the new wave of services, which will ultimately land the organization and its patients -- the patients it serves safely ashore for another generation of extraordinarily skilled healthcare delivery.

Submitted by Ronald E. Burt, M.D.

DENNIS McCONVILLE: Thank you.

Next I'd like to call on Linna Rack.

Linna Rack, am I pronouncing that, or is it Rock, perhaps?

No?

Okay. Gene Merz?

Gene Merz?

He left?

Okay. Thea Cardamone -- Cardamone.

THEA CARDAMONE: Thanks very much for coming and addressing us and telling us about the plans.

Joyce, I think you led us pretty well through the determination, but I have a question. I hope it's a short one for you. And I have another question for the gentleman from Prospect. So I think more important is probably the one from Prospect.

I'd like to know a little bit about the hospitals that you -- that you already have and what their level of quality is. And if you're going to be trying to -- if this works, this deal works, would you be trying to institute similar procedures, like is it the local advisory board that does the accreditation for those hospitals? So I think that would really be useful for all

of us to know.

And, Joyce, my only question for you was "this letter of determination and agreement, does that bind Prospect to whatever actuarial valuations you have done on the patient and retiree health?

Because if you get two actuaries together who don't work for the same firm and you ask them to do a valuation, you get two different valuations pretty easily. So I guess my question is really: Is it going to be acceptable that whatever ECHN has done for the valuation?

Thank you.

DENNIS McCONVILLE: Can you just -- excuse me, Thea, just for the record --

THEA CARDAMONE: Oh, I'm from Vernon. Sorry.

DENNIS McCONVILLE: Okay.

MIKE VEILLETTE: Gene --

DENNIS McCONVILLE: It's Thea.

MIKE VEILLETTE: Thea. My -- my apologies.

JOYCE TICHY: I can answer the --

MIKE VEILLETTE: I'll answer the question about the actuarial --

THEA CARDAMONE: Okay.

MIKE VEILLETTE: -- valuation. In the -- in the agreement, we are looking to agree to the 9/30/15 valuation based on the actuary that we have used historically.

THEA CARDAMONE: Okay. So they're not controversial?

MIKE VEILLETTE: We don't believe that it will be.

THEA CARDAMONE: Good.

DR. MITCHELL LEW: Thea, thank you for that question.

Prospect, as you know, is a hospital company, and we own 13 hospitals that are all located in communities, and they -- they serve local communities with local physicians.

We also have a physician group unit within our company in which we integrate and organize physicians from the local community into what we call independent

practice associations and -- and -- and basically those are networks of doctors that work together and coordinate care. And some -- these doctors can be independent or they can be employed.

So our -- our model is one which integrates our hospitals and physicians. We work very closely with the local health plans and in some cases the government to coordinate and integrate care and deliver the quality that health plans require.

Really our goals are quality, access and affordability. You know, our -- our model of care, yes, we would love to bring here to Manchester and Rockville. We would love to engage the local physicians as we have -- have already started doing. And we would love to talk to the health plans about keeping care local and not taking care to more expensive hospitals outside of the service area. That -- that has been a focus. And, yes, we would -- we would bring that model of care here.

THEA CARDAMONE: Okay.

DENNIS McCONVILLE: All set?

THEA CARDAMONE: Yeah. I -- your hospitals meet the joint accreditation standards? You're not in trouble anywhere?

DR. MITCHELL LEW: No. We're -- we're --

THEA CARDAMONE: That's really what I wanted to hear.

DR. MITCHELL LEW: No. We're -- we're not in trouble. As I said, quality and safety in the hospitals is of absolute importance. And then on the physician group side, certain quality with outcomes, the patient care experience, but doing this in a very affordable way.

THEA CARDAMONE: All right.

DENNIS McCONVILLE: Thank you.

THOMAS REARDON: May I just make -- make a comment to -- first of all, I -- I should have said this in a prefatory comment. We very much appreciate you coming here tonight. I'm from the Boston

area. Mitchell's from Los Angeles.

You know this community better than we'll ever know this community. And so not only is the advisory board important to us, but your input and your thoughts are -- are very, very much appreciated, and I mean that sincerely.

Coming back to your quality comment, we just went through a very rigorous regulatory process in Rhode Island where we've acquired two hospitals. And, no, we don't close hospitals. We've never closed a hospital. And we're a growth company, not a contraction company.

But one of the things that the Department of Health there did was they hired a -- a very, very prominent physician by the name of Dr. Mary Reich Cooper, who actually is the chief quality officer of the Connecticut Hospital Association coin- -- coincidentally.

And one of the things they did was they asked her to take a look at two things. One was: What are our quality

metrics? Do -- do we measure up. And, number two, do we have any bad record? Have we ever been in trouble for fraud abuse or any of that kind of stuff?

And she came back with a glowing report. Yes, we have quality. No, we've never been in trouble with any of those fraud abuse type things.

THEA CARDAMONE: Stay out of --

THOMAS REARDON: It's all in the public record.

THEA CARDAMONE: Don't go to Florida.

THOMAS REARDON: Okay.

DENNIS McCONVILLE: Thank you.

Next I'd like to call on Eric Kloter on behalf of Kye Cohen.

ERIC KLOTER: This is a rather --

DENNIS McCONVILLE: Name and town, please --

ERIC KLOTER: Thank you.

DENNIS McCONVILLE: -- for the record.

ERIC KLOTER: My name is Eric Kloter. I live in Tolland.

This letter is written over the signature of Kye Cohen, who is the owner of ShopRite of Manchester and East Hartford.

As the incorporator of ECHN, I've always been extremely impressed with the vision, intellect and communication skills of Peter Karl and Dr. Dennis O'Neill. I am comfortable with their decisions regarding the ECHN acquisition by Prospect Medical Holdings, and it is my hope that the company becomes more viable and successful as a result.

As a business owner, I am keenly aware of the need for economies of scale and the benefits that are derived from collaborating with an experienced partner. My organization's ability to work with a larger entity allows us to stay in business, pass immense savings on to our customers and be phil- -- philanthropic to the greater Manchester community.

The common thread that exists between ECHN and my business is that we

both face a highly competitive marketplace. I truly understand the need for ECHN to adapt to a rapidly changing healthcare environment and fully support the merger so that we may be -- that we may go forward and keep quality health care in greater Manchester.

And, again, re- -- respectfully submitted over the signature of Kyle -- Kye Cohen, owner of ShopRite of Manchester and East Hartford.

DENNIS McCONVILLE: Thank you.

Next I'd like to call on Teri Rogers.

TERI ROGERS: Good evening. I'd just like to ask --

DENNIS McCONVILLE: Would you please state your name and the town for the record?

TERI ROGERS: Teri Rogers of Rockville, Connecticut.

I just have one simple question. What would be some of your long-term plans for Rockville General Hospital?

DENNIS McCONVILLE: I guess I'll

answer that.

TERI ROGERS: Okay.

DENNIS McCONVILLE: With our -- the board's decision to select Prospect as our acquirer, we'll be working on a strategic plan for ECHN as a healthcare system, and certainly we'll be focused on Rockville General Hospital and the panel of services that we will offer to Rockville General Hospital.

I know that there's been concern expressed time and time again over the years about, you know, what happens to Rockville General Hospital. I think the evidence is clear that Rockville is a very important services provider to the community around Vernon -- in Vernon and around Vernon. Our emergency department sees close to 26,000 visits per year. We also know that there are many patients who rely on Rockville General Hospital for their inpatient services as well.

So as we go forward and assess what the community needs are for healthcare services, we'll be working to establish

some new programs at Rockville General Hospital as need dictates, and we'll be doing our very best to attract more business to Rockville General Hospital. And we think that the Prospect model in engaging our physicians, in particular our primary care physicians who help patients make many decisions for where they receive their care will align the physicians, their patients and ECHN to actually improve the demand for services at Rockville General Hospital so more of the services can be offered locally, and we can all benefit from the results that will allow us to make more investments in the community.

Anything else to add?

No.

Did that answer your question okay?

TERI ROGERS: Thank you.

DENNIS McCONVILLE: Thank you.

I think I have one more on the list. Eric Kloter, did you have something you want to say?

You can state your name and town.

ERIC KLOTER: Eric -- excuse me. Eric Kloter, and I live in Tolland.

I'm going to turn my back to these folks because they know who I am, and I know them, too.

I live in Tolland now. I grew up in Rockville. I went to Sykes at junior high. I ran up Mckinley Hill when we practiced soccer and baseball. The coaches wouldn't let us ride a car or walk.

We had to run up -- up to Henry Park. I walked to Rockville High School and back from Orchard Street where I lived. My four kids were born at Rockville Hospital on the third floor in the old maternity floor.

So I care about Rockville like everybody else does that's here. I also was a owner of a family business that operated in Vernon since 1913, and we still operate here. So our roots in Rockville go pretty deep. I care about Rockville.

Why am I saying this? Well, I also

sit on the ECHN board, and I'm a member of the transaction committee that Joy talked about earlier. I've seen a lot of printed materials. I've read most of it. A lot of it's pretty technical.

I know the gentlemen that sit behind me and Joyce. ECHN has a fine leadership team. I respect them. The trust is deep. I know that what they are saying is what they believe. So that's my point No. 1.

I don't really -- I just can't believe that they would close Rockville Hospital. I'm also involved with Visiting Nurse. I don't believe they're going to close Visiting Nurse either.

My second point is just basic common sense. When a company pays a hundred and five million dollars to acquire an entity and then is willing to contribute another $75 million to operations. Are they going to close it? I don't think so. They're going to make it work.

And having listened to the Prospect presentation, having visited their

offices, they're strong strategic players. They're agile, and they're going to make it happen. Just hang on tight because change is going to happen, but we'll all benefit by it.

Thank you.

DENNIS McCONVILLE: Thank you, Eric.

Is there anybody else that wishes to speak or is signed in with Nina?

No?

Okay. I want to thank our panel and turn it back over to Joy Dorin.

JOY DORIN: Thank you all for coming and for your comments and questions.

ECHN has been privileged to care for this community for nearly 100 years. The proposed transaction reviewed tonight will continue to fulfill the mission of ECHN, and that mission is to provide high-quality, compassionate care to the communities we serve.

Thank you again for joining us. Please drive safely. Please enjoy the rest of your evening, and please enjoy the rest of your summer.

Thank you.

(THEREUPON, THE MEETING WAS CONCLUDED AT 7:27 P.M.)

C E R T I F I C A T E

I hereby certify that I am a Notary Public, in and for the State of Connecticut, duly commissioned and qualified to administer oaths.

I further certify that said meeting was taken by me stenographically and reduced to typewriting under my direction, and the foregoing is a true and accurate transcript of the proceedings.

I further certify that I am neither of counsel nor attorney to any of the parties to said matter, nor am I an employee of any party to said matter, nor am I interested in the outcome of said matter.

Witness my hand and seal as Notary Public this 6th day of August, 2015.



Clifford Edwards

Notary Public

My commission expires: 9/30/2016

Preparing for the Future of ECHN

Letter of Determination Public Hearing

Manchester Memorial Hospital

Manchester, CT 06040

August 4, 2015

ECHN℠

Eastern Connecticut Health Network

AGENDA

Welcome & Introductions	Dennis G. O'Neill, MD, Chair of the Board, ECHN
Hearing Purpose, Statutory Requirements & Format	Dennis McConville, SVP, ECHN
Healthcare Landscape, Transaction Rationale & Process	Peter J. Karl, President & CEO, ECHN
Certificate of Need Letter of Determination	Joyce A. Tichy, SVP, Legal Counsel, ECHN
Questions & Answers	Panel

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The Proposed Transfer of Assets of Eastern Connecticut Health Network, Inc. and Affiliates to Prospect Medical Holdings, Inc.

ECHN℠
Eastern Connecticut Health Network

State Regulatory Process

Review by Office of Health Care Access (OHCA) and Office of the Attorney General (1)

* First step in process is the filing of a Letter of Determination
* Within thirty (30) days of filing of the Letter of Determination, the nonprofit hospital and the proposed purchaser hold a public hearing on the contents of the Letter of Determination.
* The hearing is to be transcribed, with the recording or transcription made available to the Commissioner of OHCA, the Attorney General, and members of the public upon request.
* The Commissioner and the Attorney General review the Letter of Determination. The Attorney General determines whether the transaction requires approval under the so-called "Conversion Statute" as a conversion of a non-profit to a for-profit.
* A joint review process is then undertaken by the Commissioner and the Attorney General.

(1) Section 19a-486a of the Connecticut general statutes

State Regulatory Process

Statutory Standards – Review by the Attorney General (1)

* The Attorney General shall deny an application as not in the public interest if:
  * The transaction is prohibited by Connecticut statutory or common law governing nonprofit entities, trusts or charities.
  * The applicant fails to exercise due diligence in:
    * Deciding to transfer
    * Selecting the purchaser
    * Obtaining a fairness evaluation
    * Negotiating the terms and conditions of the transfer
  * The nonprofit hospital failed to disclose any conflict of interest.
  * The nonprofit hospital will not receive fair market value for its assets.

(1) Section 19a-486c of the Connecticut general statutes

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State Regulatory Process

Statutory Standards – Review by OHCA (1)

* The Commissioner of Public Health must deny an application unless a commitment has been made to provide care to uninsured and underinsured.
* The proposal is also reviewed under standard certificate of need guidelines, including public need, impact on financial strength of health care system in the state, whether proposal will improve quality, accessibility and cost-effectiveness of health care delivery in the region, etc.

(1) Section 19a-639 of the Connecticut general statutes

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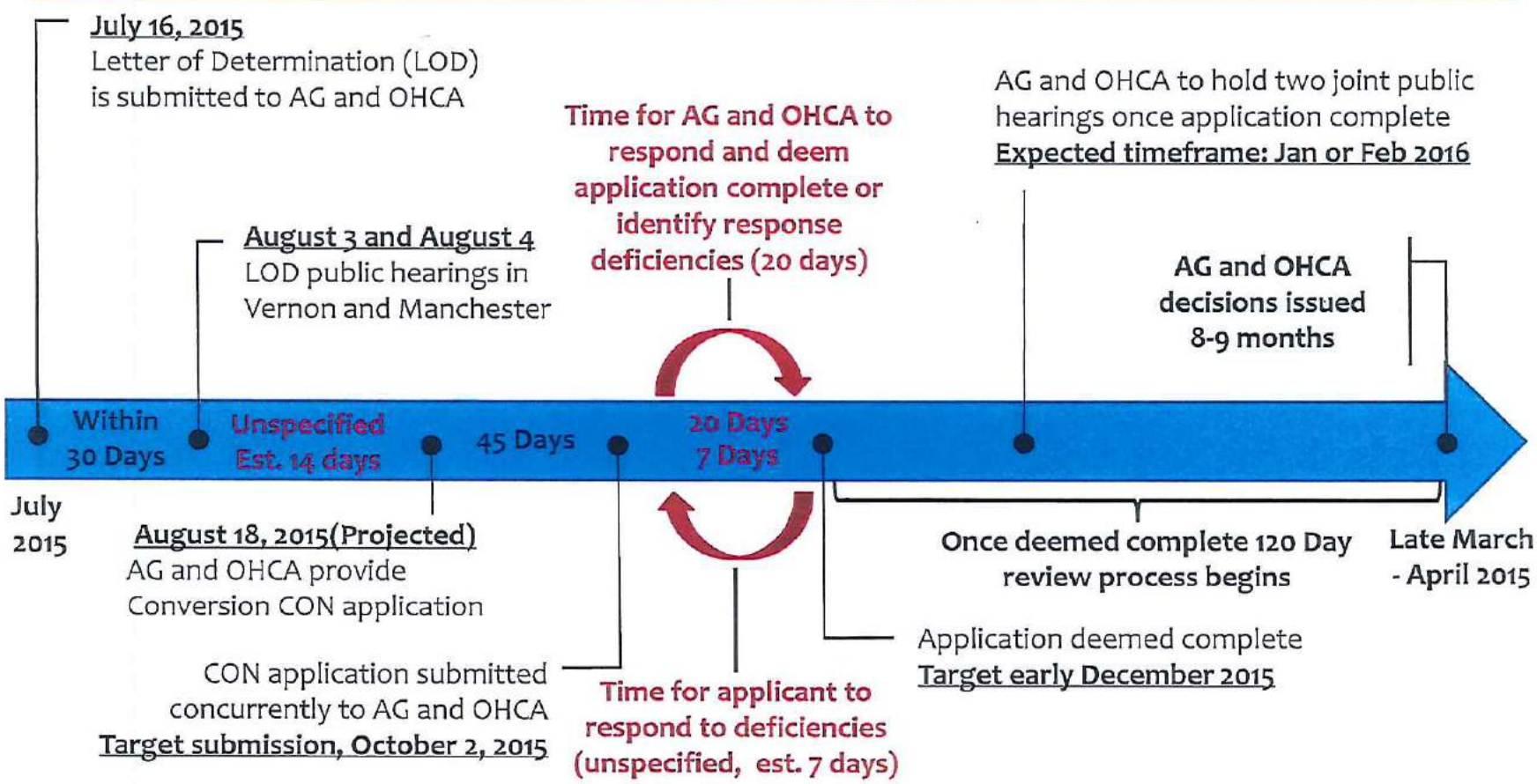
Conversion/CON Process Timeline



Note: Timeline shows estimated dates only and may change

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The Proposed Transaction

Prospect Medical Holdings to buy ECHN

* Continued operation of Manchester Memorial and Rockville General Hospitals, Woodlake at Tolland and VNHSC;
* Continued involvement of an advisory board that includes community representatives;
* Capital to fund new programs and invest in technology, facilities and equipment;
* Partnership with a leading organization that will bring decades of experience with population health management and value-based care;
* Establishment of a community foundation to oversee certain charitable funds; and
* Continuation of the ECHN brand and mission, including a continued commitment to charity care and indigent care.

Preparing for the Future at ECHN

Our Mission : Our Community

* Caring for & serving the community, continuing our mission & vision
  * Improving your wellbeing with quality, compassionate health care
  * Preserving ECHN: its name, pride and institutions
  * Developing the next generation of physicians to serve you
* Preserving jobs
* Economic engine for eastern CT with over $165 million in salaries and $90 million purchased supplies & services annually

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Preparing for the Future at ECHN

Impact of Healthcare Reform (PPACA)

* More than insuring 32M more people
* Declining government payments to hospitals
* Focus on value, lowest cost and best results
* New payment systems with providers at risk
* New delivery models, community focused
* Major investments required

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ECHN's Financial Challenges

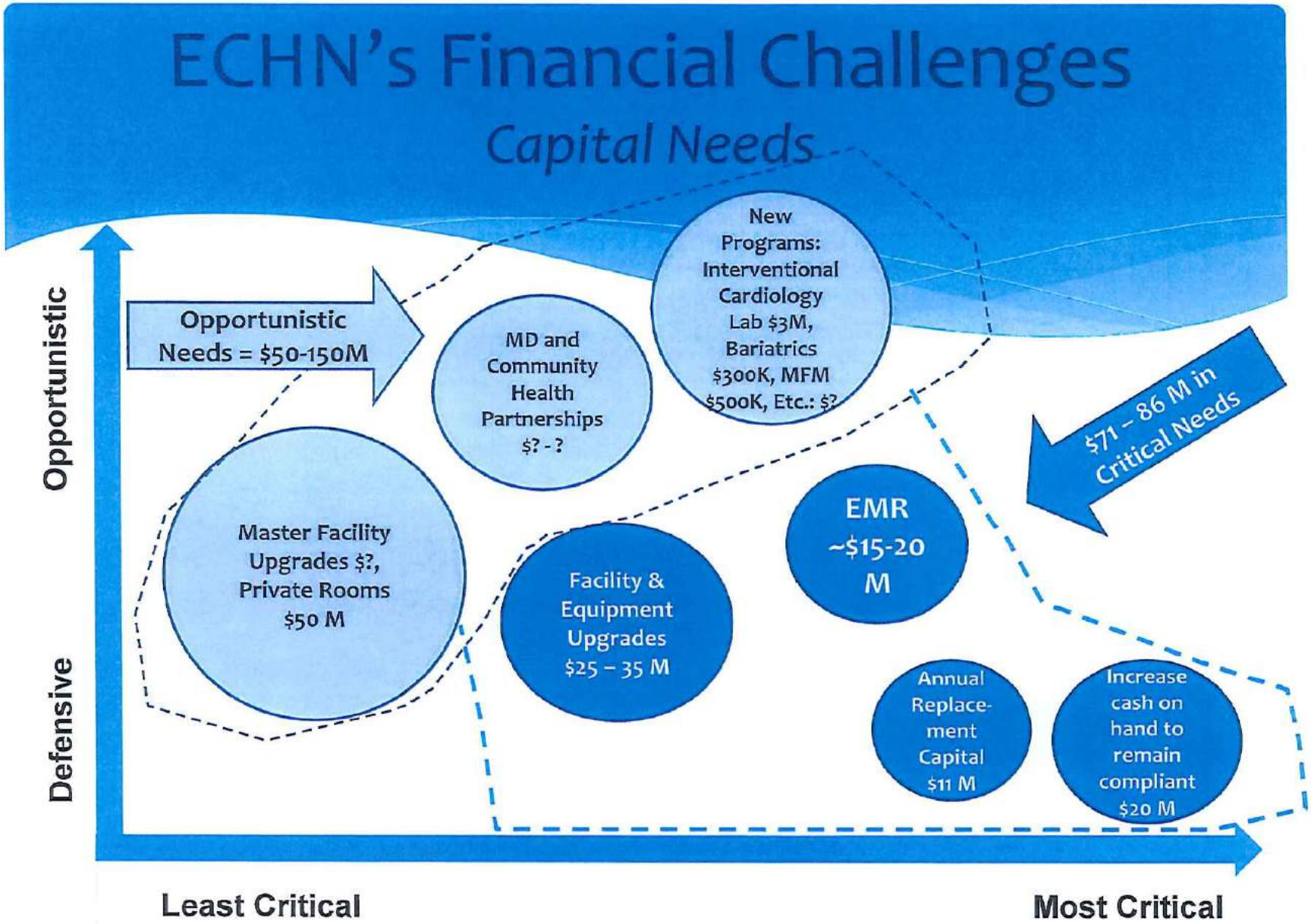
Low margins and growth in debt have forced ECHN to defer capital investments; our historical financial performance has left the organization with a large debt structure that cannot be mitigated through margin alone

1. Operations contributed only $9.3M total over the last 14 years: Operational deficits in 2001-2004 of $23.1 million required 6 years to be overcome



2. Long term debt and pension liabilities have grown 102% ($65M) in the last 14 years– annual debt service and pension contributions now take up the lions share of annual cash flows




ECHN's Financial Challenges
Capital Needs
Opportunistic
Defensive
Opportunistic Needs = $50-150M
New Programs: Interventional Cardiology Lab $3M, Bariatrics $300K, MFM $500K, Etc.: $?
MD and Community Health Partnerships $? - ?
$71 – 86 M in Critical Needs
Master Facility Upgrades $?, Private Rooms $50 M
Facility & Equipment Upgrades $25 – 35 M
EMR ~$15-20 M
Annual Replace-ment Capital $11 M
Increase cash on hand to remain compliant $20 M
Least Critical
Most Critical

12

Continuing Financial Challenges

Taxes and Reduced Government Payments

	FY 2014	FY 2015	FY 2016
CT State User Tax	(3,914,000)	(7,960,000)	(7,141,852)
CMS Sequestration	(1,104,000)	(2,208,000)	(2,208,000)
Medicaid Inpatient Modernization Program		(1,200,000)	(1,600,000)
Low Cost Hospital Pool Eliminated			(300,000)
Medicare Wage Index		(4,825,000)	(6,525,000)
	($5,018,000)	($16,193,000)	($17,774,852)

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Negative Forces into the Future



-Continued payment erosion from federal government

-Declining levels of payment from state government

-Payment reforms with more financial risk

-Continued pension obligations

-Rising costs

= *Unsustainable results with an inability to REINVEST in ECHN*

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Preparing for the Future at ECHN

Process, Questions Answered

1 Should We Affiliate?

- Stand-alone scenario; how viable?
- Benefits of and Vision for, the Affiliation

2 If so,

- Which Partner Organizations are attractive?
- What Criteria will we use to evaluate them?
- How might each partner help us achieve our Vision ?

3 What can each potential partner organization offer ECHN?

- Enhance services; Attract top Clinicians
- Position us to be "Provider of Choice" east of the CT River
- Improve Finances and Access to Capital

4 How Attractive are the Prospective Partnership Proposals?

- Is there a compelling Business Case for each partnership?
- What is the proposed Deal Structure? Is it attractive?

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Preparing for the Future at ECHN

Why join another health care system?

Rationale

* Improve access to capital and afford investments
* Improve finances, reduce/eliminate debt
* Participate in the new payment systems
* Protect, preserve and grow local access to services

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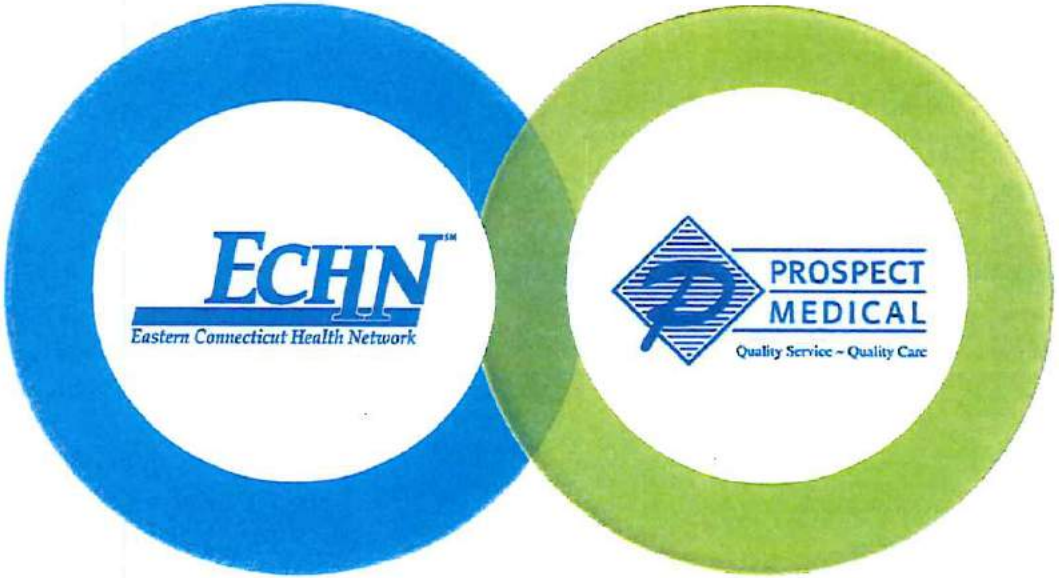
The Request for Proposal Process:

* RFPs were sent to 6 potential partners, both for-profit and non-profit.
* Responses were received from:

1. Hartford HealthCare
2. Saint Francis – Trinity Health
3. Prospect Medical Holdings

The combination of ECHN with Prospect Medical Holdings will secure the future of care and access for residents



* Aligned mission, vision & values
* Strong medical staff partner
* Extensive risk management experience
* Long history of population health management
* Track record of success in markets having large for profit and nonprofit hospital systems

Together with our Medical Staff, building a sustainable, thriving network of value-based care for our communities.

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What will be achieved?

* Continue our Mission, Vision & Values
* Protect Accessibility and Affordability of Care
* Continued Focus on Quality & Safety of Patient Care
* Continuously Improve Patient Satisfaction
* Ability to invest allowing resources for our medical staff, employees, and for patients' care and benefit

Letter of Determination

1. Form of Transaction
2. Key Assets and Liabilities to be Acquired by Buyer
3. Key Assets and Liabilities Excluded from the Transaction
4. Medical Foundation
5. Local Advisory Board
6. Commitment to Maintain Community Support – Charity Care
7. Commitment to Maintain Hospitals and Continuum of Care Network
8. Employment Matters
9. Capital Commitment
10. No changes requested to services or changes to towns served

Project Cost
Overview of Financial Provisions

Excluded Assets:	Donor restricted funds, cash & investments, cost report settlements
Purchase Price:	$105 Million, or $115 Million if refinancing obtained
minus/plus:	Net working capital
Minus:	Indebtedness
	Unfunded pension plan liability
	Post retiree health plan liabilities
	Special employee benefit liabilities (accrued vacation, etc.)
	Captive insurance liabilities
	Worker's compensation liabilities
	Joint venture interests not conveyed
	Asbestos liabilities
Capital Commitment:	$75 Million, reduced by amount of refinancing spent

** Risk of interim operations, stock market performance, etc. remain on ECHN prior to closing

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Public Comments & Questions

Panel:

* Peter Karl, President & CEO, ECHN
* Joyce Tichy, SVP, General Counsel, ECHN
* Michael Veillette, SVP, Chief Financial Officer, ECHN
* Mitchell Lew, MD, President, Prospect Medical Holdings
* Thomas Reardon, President, Prospect East Holdings

Moderator:

* Dennis McConville, SVP, Chief Strategy Officer, ECHN

Eastern Connecticut Health Network, Inc.

Proposed Asset Purchase by Prospect Medical Holdings, Inc.

OHCA Docket Number: 15-31216-486 and Attorney General Docket Number: 15-486-01

Written Statements Submitted at Public Hearing –
Vernon Senior Center, August 3, 2015

As a Corporator of ECHN, I have always been extremely impressed with the vision, intellect and communication skills of Peter Karl and Dr. Dennis O'Neill. I am comfortable with their decisions regarding the ECHN acquisition by Prospect Medical Holdings and it's my hope that the company becomes more viable and successful as a result.

As a business owner, I am keenly aware of the need for economies of scale and the benefits that are derived from collaborating with an experienced partner. My organization's ability to work with a larger entity allows us to stay in business, pass immense savings onto our customers and be philanthropic to the greater Manchester community.

The common thread that exists between ECHN, and my business is that we both face a highly competitive marketplace.

I truly understand the need for ECHN to adapt to a rapidly changing healthcare environment and fully support the merger so that we may go forward and keep quality healthcare in greater Manchester.

Respectfully submitted,
Kye Cohen
Owner, ShopRite of Manchester and East Hartford

Ronald E. Burt, M.D.
Clinical Instructor in Anesthesiology
University of Connecticut School of Medicine
Past President, Medical and Dental Staff, St. Francis Hospital and Medical Center
Past Chairman, Department of Anesthesiology, St. Francis Hospital and Medical Center
Past Chairman, Department of Anesthesiology, Eastern Connecticut Health Network
Past Director of Cardiac Anesthesia, Heart Center of Greater Waterbury

July 27, 2015

To Whom It May Concern:

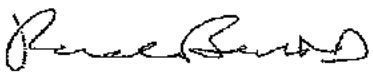
I am writing in strong support of the proposed acquisition of Eastern Connecticut Health Network (ECHN) by Prospect Medical Holdings, Inc., a national healthcare services company headquartered in Los Angeles, California. My support of this transaction is based on over thirty years experience in all aspects of clinical healthcare delivery in settings as diverse as large tertiary care anchor private teaching hospitals, numerous community hospitals and University based delivery systems. Moreover, I have had a close association with the ECHN organization and the community that it serves for a number of years, and am well aware of and sensitive to the needs and challenges that both face in the current climate of unprecedented changes in the health care services industry.

ECHN is an organization that has been a community pillar both in the medical services it provides to all who enter its doors, as well as a key employer within the eastern Connecticut geographic area. The preservation of and enhancement to the services it delivers and the opportunities it provides is critical, and it is my opinion after having substantial exposure to and involvement with the acquisition and merger dynamics occurring at all levels of health care, that Prospect Medical's acquisition of ECHN presents the best opportunity for ECHN's legacy of service and opportunity to be carried into the next generation of health care delivery, which is indeed upon us.

ECHN's leadership has undertaken an extraordinarily lengthy and diligent process of research and deliberation over several years in arriving at the choice of Prospect Medical Holdings, one that solidly supported by both the details of the transaction and the well-paired blend of corporate and institutional cultures that will be the result of the transaction. Prospect's approach to coordinated regional health care delivery and population-based disease management expertise are essential to ECHN delivering the most efficient and highest quality health care delivery in the new environment of the industry, and Prospect has well-demonstrated success in achieving the needed results through a variety of competencies. At least some of these are: a) a keen focus on providing to each patient the right care in the right setting by the right provider with the most appropriate application of resources; b) the ability to integrate effectively with the physician and other clinical provider community that patients know and trust, and follow to ECHN facilities; c) a track record of robust investment and re-investment of resources into the systems it manages, maintaining and expanding health care services as well as preserving and creating employment opportunities within the local communities served; d) the ability to work constructively and effectively with health care employee unions; and e) the ability to do all of the foregoing in a state environment characterized by a high degree of regulation of health care services.

Any person who has even a nodding acquaintance with the sea of change that *all* hospitals in Connecticut are now facing will know that ECHN is not at all alone in the challenges, and even peril, that it faces, and every hospital must make responsible, effective and timely decisions in setting their future course in this storm of health care industry change. Such, I believe, are the characteristics of the decision that ECHN is endeavoring to gain approval for and to effectuate. It is my hope that ECHN's served community and the governmental entities impacting on this process will understand that they have the opportunity to either allow ECHN to pulled into the undertow of this tidal wave of change and be lost, or to facilitate its ascent to the crest of a new wave of services which will ultimately land the organization and the patients it serves safely ashore for another generation of extraordinarily skilled health care delivery.

Very Respectfully Submitted,



Ronald E. Burt, M.D.

Northeastern Pulmonary Associates, LLC

DAVID A. WASSERSTEIN, M.D., F.C.C.P.
M. SAUD ANWAR, M.D., M.P.H., F.C.C.P.
FAUSTINUS C. ONYIRIMBA, M.D., F.C.C.P., M.R.C.P.
KAREN HALASAN, M.D.
SAIMA ANSARI, M.D.
STEFANIE C. WESTCOTT, APRN

Letter of support for the partnership between Eastern Connecticut Health Network and Prospect Medical Holdings Inc.

To: Office of Healthcare Access and the State Attorney General

From: M. Saud Anwar MD, MPH, FCCP
Partner Northeastern Pulmonary Associates, LLC,
Chairman of Department of Medicine, Eastern Connecticut Healthcare Network.

RE: Certificate of Need, Application for Hospital Conversion to "For Profit" Status.

Dear Commissioner of the Office of Healthcare Access and State of Connecticut Attorney General Mr. Jepsen,

My name is Saud Anwar, I am a Pulmonary and Critical Care physician affiliated with Eastern Connecticut Health Network for over 17 years. I support the proposed partnership of Eastern Connecticut Health Network and Prospect Medical Holdings. I am an independent physician who has the opportunity to interact not only with the patients in the community, but also the staff essentially in most parts of our hospital and I also have an opportunity to cooperate with the community physicians providing primary care to our community. As a medical director of the Clinically Integrated Network of Eastern Connecticut and also with the Eastern Connecticut Physician Hospital Organization and medical advisor to the care management department of the hospital, I have had the opportunity to closely observe the sustainability challenges our healthcare system has who are struggling to continue to provide best quality to all the patients with ongoing challenges with increasing social challenges and insurance reimbursement and bureaucracy.

I have also had the opportunity to learn first hand from the representatives of the Prospect Medical Holdings and their existing hospitals and their track record of providing quality care to patients with all capabilities of payments. It is quite clear to the physicians that integrated network and coordination of care in a healthcare system with strong primary care delivery along with collaborative specialty care with appropriate transitions according to the patients' needs is the best and the most effective way of maintaining and managing population health. Prospect Medical Holdings has many years of experience and success in managing risks with their delivery models. The size of our healthcare system and the opportunity to collaborate with an experienced partner who believes in collaboration between the independent physician in the community and the hospital will truly strengthen healthcare within our network.

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KAREN HALASAN, M.D.
STEFANIE C. WESTCOTT, APRN

Our hospital continues to employ members in the community and serves as a backbone of the economic engine within our towns. In my other role as a Mayor of the Town of South Windsor, I know that over 250 people in my community are employed by ECHN. Stronger, efficient and sustainable healthcare system allows industry to identify and choose communities to invest in. With the growth of population health management, we truly can have an impact at all levels according to the needs of the people.

I strongly feel that the track record and the current system needs to move to "for-profit" model and this partnership will not compromise the quality of care, but actually enhance the quality of care and would be able to provide care to the patients irrespective of their insurance status and abilities to pay.

I thank you for your consideration. Should you have any questions, please do not hesitate to contact me.

Sincerely,

M. Saud Anwar, M.D.
Chairman of Department of Medicine,
Eastern Connecticut Health Network
860-875-2444

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PROPOSED TRANSFER OF ASSETS OF

EASTERN CONNECTICUT HEALTH NETWORK, INC. AND AFFILIATES

TO

PROSPECT MEDICAL HOLDINGS, INC.

OHCA Docket Number: 15-31216-486 and Attorney General Docket Number: 15-486-01

Public Hearing Held Pursuant to
Section 19a-486a of the Connecticut General Statutes

Location: **Manchester Memorial Hospital, Manchester, CT**

Date: **August 4, 2015**

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PUBLIC MEETING

THE PROPOSED TRANSFER OF ASSETS OF EASTERN

CONNECTICUT HEALTH NETWORK, INC. AND AFFILIATES TO

PROSPECT MEDICAL HOLDINGS, INC.

Meeting taken at the offices of Manchester Memorial Hospital, Louise Ruddell Auditorium, 72 Haynes Street, Manchester, Connecticut, before Clifford Edwards, LSR, Connecticut License No. SHR.407, a Professional Shorthand Reporter and Notary Public, in and for the State of Connecticut on August 4, 2015, at 6:00 p.m.

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MADISON, CT 06443

HARTFORD NEW HAVEN STAMFORD

A P P E A R A N C E S:

DENNIS O'NEILL

PETER J. KARL

MICHAEL VEILLETTE

JOYCE TICHY

DENNIS P. McCONVILLE

DR. MITCHELL LEW

THOMAS M. REARDON

NINA KRUSE

ALSO PRESENT:

DR. BOB CARROLL

AVA HILL

ERIC KLOTER

RAY RUETE

RUDY LUGINBUHL

JOE TYLER

DR. JOEL REICH

AND MEMBERS OF THE PUBLIC

DENNIS O'NEILL: Good evening, everyone. And thank you for joining us this evening. My name is Dennis O'Neill, and I'm the chairman of the Eastern Connecticut Health Network board of trustees.

ECHN is a valuable asset to the eastern Connecticut community, and after nearly three-and-a-half years of review, consideration, due diligence and determination to strengthen ECHN's future, a selection has been made to preserve ECHN through an acquisition by Prospect Medical Holdings.

Previously, a decision was made to pursue the acquisition of ECHN by a joint venture between Tenet Healthcare Corporation and Yale-New Haven Health Systems. For reasons that were beyond our control, we were not able to proceed with that transaction.

Over the course of the past five months, the transaction committee of the board of trustees worked diligently to secure proposals from interested parties

and thoroughly evaluated those proposals to make its decision and recommendation to the board of trustees. This decision was made through the engagement of the community governing structure of trustees and corporators associated with ECHN, which includes representatives of our medical staff. The board of trustees voted unanimously to pursue an acquisition of ECHN by Prospect, and this decision was also supported by the EC -- ECHN corporators with a 98 percent favorable vote to move forward in pursuance of the proposed transaction.

This allows ECHN to move into our next phase, which includes the regulatory process as governed and -- and outlined by the state and federal governments. You'll hear more about this phase throughout this evening.

Now, to review some of this evening's agenda and statutory requirements affecting the acquisition, I'll hand it over to Dennis McConville, the chief strategy officer of ECHN.

Dennis.

DENNIS McCONVILLE: Good evening.

ECHN is hosting two public hearings for letter of determination. We hosted one last evening, August 3rd, 2015, at the Vernon Senior Center in Rockville and another this evening here at Manchester Memorial Hospital. These hearings are to provide the information in the letter of determination that was filed with the State of Connecticut on July 16th of 2015.

Our agenda for this evening is as follows: I'll take a few minute -- minutes or moments to present the purpose for the hearing, the statutory requirements that we believe apply to our proposed transaction, and let you know the format for our -- your participation in the hearing.

Peter Karl, ECHN's president and CEO, will present information about the healthcare landscape for ECHN, the rationale for pursuing our trans- -- transaction with Prospect Medical

Holdings and the process that ECHN followed.

Joyce Tichy, who is ECHN's senior vice president and general legal counsel, will present the letter of determination. And then we'll have a comment question and answer period for you with our panel.

Our panel will include Peter Karl, Joyce Tichy, Mike Veillette, who is chief financial officer for Eastern Connecticut Health Network, as well as Dr. Mitchell Lew, who is president of Prospect Medical Holdings, Incorporated, and Thomas Reardon, president of Prospect East Holdings, Incorporated.

We want -- for the public comment or Q&A portion of the hearing, we want to conduct this evening's hearing in as a precise a manner as possible. It's structured to present you with information about our proposed transaction before we open the floor to comments and questions to address the letter of determination. I anticipate

that this will take about 45 to 50 minutes.

This hearing is a legal requirement for the state regulatory approval process. Additional hearings will be held by the Attorney General and the Office of Health Care Access later in the process after our application for approval of the transaction has been deemed complete. Tonight's presentation and question and answer period will be recorded, transcribed and then submitted to the State Department of Public Health Office of Health Care Access and the Office of the Attorney General.

You must sign in if you wish to comment or ask a question of the panel regarding the letter of determination. If you've not signed in and wish to speak, please see Nina Kruse in the back of the room to do so.

If you've signed up to comment or ask a question, I will call your name to come up to one of the podiums to make your statement or ask your question.

Before you begin your statement, please state your name and your town of residence.

In order to give everyone who wishes an opportunity to speak and in the interest of time, we request that each speaker limit his or her participation to one appearance at the microphone and try to limit your comments to three minutes or less. Your statements or comments should be directed to the contents of the letter of determination.

Copies of the letter of determination are available this evening for your review. We expect that the letter of determination and other filings for our regulatory approval process will be available on both the website of the Attorney General's Office as well as the Office of Health Care Access as the process advances.

Our focus for this evening is the letter of determination, which describes a proposal for the transfer of assets of Eastern Connecticut Health Network and

its affiliates to Prospect Medical Holdings.

The first step -- okay. The first step in the process is the filing of the letter of determination. Within 30 days of filing the letter of determination, the nonprofit hospital and the proposed purchaser hold a public hearing on the contents of that letter of determination. Again, this evening's hearing is being recorded and transcribed as required. It will be filed with OHCA and the Attorney General's Office. The transcript will be made available to you upon request as well.

The Commissioner and the Attorney General will review our letter of determination. The Attorney General will determine whether the transaction requires approval under the so-called conversion statute as a conversion of a nonprofit hospital to for-profit status. A joint review process is then undertaken by the Commissioner and the Attorney General.

A certificate of need approval process for hospital conversions is governed by Connecticut law. The law contains standards that the Attorney General and the Commissioner of Public Health must apply in rendering a decision for each application. The law also allows for each agency to engage experts to assist in the certificate of need process.

The statute states that the Attorney General shall deny an application as not being in the public interest if the transaction is prohibited by Connecticut statutory or common law governing nonprofit entities, trusts or charities. The Attorney General shall deny an application if the applicant fails to exercise due diligence in deciding to transfer selection of a purchaser obtaining a fairness evaluation or in negotiating the terms and conditions for the transfer. An application will be denied if the nonprofit hospital failed to disclose any conflict of interest or

if the nonprofit hospital will not receive fair market value for its assets.

By statute, the Commissioner of Public Health must also apply standards in reviewing and ruling on an application. The Commissioner of Public Health must deny an application unless a commitment has been made to provide care to the uninsured and to the underinsured.

The proposal is also reviewed under standard certificate of need guidelines including whether there's clear public need, the impact on the financial strength of the healthcare system in the state, where there's a proposal, the proposal will improve quality, accessibility and cost effectiveness of healthcare delivery in the region.

Now I'm going to walk you through an estimated timeline for our certifi- -- certificate of need approval process. Some of these intervals are mandated by statute and others are estimates, so they

may change. The process begins with the filing of our letter of determination, which we did on July 16. Within 30 days we're required to hold public hearings on the contents of the determin- -- the letter of determination.

We expect that the Attorney General will rule that our proposed transaction is subject to the conversion statute. We hope that we receive an application from the Attorney General and OHCA within 14 days, bringing us to mid-August. Once we receive an application, we have 60 days to file a completed application. We plan to file our application within 45 days, which gets us to early October.

The Attorney General -- General's Office and OHCA have 20 days to determine if our application is complete. If they identify deficiencies in the application, we will receive what are known as completeness questions. And we estimate that it will take seven more days to respond to those and then 20 more days for the agencies to respond as to whether

an application is complete.

We could see one to two cycles of completeness questions. The target for when our application would be deemed complete is early December. Once the application has been deemed complete, the Attorney General and the Commissioner of Public Health have a hundred and twenty days to decide our application. They will hold public hearings during that time. We estimate that the process will take between eight and nine months, with a decision coming between March and April of next year.

Joyce Tichy will provide a more -- a more detailed description of our transaction in a few minutes, but here's a summary of the proposed transaction: We're proposing that Prospect Medical Holdings buy ECHN. They would be the continued operation of Manchester Memorial and Rockville General Hospital and our post-acute care network including Woodlake at Tolland and Visiting Nurse and Health Services of Connecticut.

There would be the continued involvement of an advisory board that includes community representatives.

There will be capital investments to fund new programs, invest in technology, improve facilities and equipment, the acquisition of ECHN by a leading organization that will bring decades of experience with managing the health of populations and is focused on value-based care, the establishment of a community foundation to oversee certain charitable funds and the contin- -- continuation of the ECHN-branded mission, including a continued commitment to charity care and indigent care.

Now to review our process and background for the acquisition is ECHN's president and CEO, Peter Karl.

PETER KARL: Okay. I apologize in advance. Because this hearing is official and being transcribed, I need to read my testimony for the record instead of speaking informally about these slides. Please bear with me.

Thank you for coming this evening. We're here to discuss the proposed transfer of assets of Eastern Connecticut Health Network and affiliates to Prospect Medical Holdings.

ECHN is proud to serve eastern Connecticut by improving the well-being of the community by offering quality, compassionate health care. That is our mission, and our organization has pursued this mission for nearly a hundred years. Our commitment to the mission is what -- is what we want to continue on behalf of the patients and their families, our physicians and our employees.

We want to see the ECHN name and brand continue. ECHN has made an obligation to training our next generation of physicians. We have developed a strong relationship with our medical staff. We support the education of medical students have -- and have established a new graduate medical education residency program at ECHN.

Manchester Memorial and Rockville

General Hospitals, Woodlake at Tolland, Visiting Nurse and Health Services, as well as dozens of affiliates and joint venture companies, are anchors in the region we serve. ECHN is a significant economic engine providing the salaries for over 3,000 skilled jobs and pur- -- purchasing over $90 million in services and supplies each year.

The Patient Protection and Affordable Care Act is designed to provide insurance of 32 million Americans who are uninsured. Hospitals as an industry agree that they would accept lower payments as more of their patients would now have some form of insurance.

In Connecticut, unlike other parts of the country, residents are relatively well insured, so there is -- there is not the benefit of more revenue for our hospitals. We estimate that we need to reduce expenses by 15 to 20 percent which would mean cutting services and staff.

In addition, the government and the commercial insurers are pushing for payment reforms that shift the risk for getting paid to providers, including our hospitals and our physicians. The -- the resulting new payment systems reward -- reward those who deliver care at lower costs with improved quality and outcomes. This means that we need to reform and refocus our delivery of care to keep patients well in the lowest cost settings, generally at home or in an outpatient setting, preventing patients from needing expensive hospital stays.

The focus on our patients needs to be ongoing and proactive, not just on episodes of illness and hospital stays. The information about our patients needs to be accessible to providers across the network. Care management programs need to be expanded through the community. The investments needed to succeed with population health are major and difficult for organizations that are extremely --

organizations that are operating on extremely thin margins.

As you can see here in this slide, in 2001 ECHN lost more than $10 million and continued to operate in the red for many years. During this time, the lev-- level of debt continued to rise. I took office 11 years ago, and ECHN began to make course corrections, but it took six years to catch up, and we were forced to defer capital investments.

You can see that with the Connecticut Hospital Tax implemented in 2011, we have not been able to generate the operating results needed to reinvest in the organization. You can also see by the lower graph that our pension liability grew dramatically, the result of pension funding reforms that came at a time when the market crashed in 2008.

Debt service and pension contributions consume a large portion of ECHN's annual cash flow and making capital investments -- making capital investments difficult. The pension

liability will grow again by an estimated $14 million next year resulting from new actuarial tables reflecting the longevity of retirees.

Hospital systems are extremely capital intensive. The cost for new medical and information technology are significant. The building codes for our facilities make -- for our facilities to make improvements are expensive. I mentioned population health and the need to share technology across the system. A new electronic medical record system will cost at least $20 million.

There are programs that we'd like to develop to address health needs that require capital investments. Private accommodations for our patients are not only about comfort and privacy, but they offer a safer environment for our patients. Again, hospitals are expensive to build or renovate.

Eastern Connecticut Health Network and all Connecticut hospitals are struggling with financial challenges

associated with the reduction of government payments for services provided to our patients. Payments for services to Medicaid and Medicare beneficiaries make up 55 percent of our revenues.

Since we started our journey to evaluate a partnership, more has happened that worsens our financial position. As mentioned, the State imposed a -- a tax on hospitals that remains a significant burden for ECHN. For a 330 million-dollar system, we have struggled to achieve a 1 to 2 percent margin, which is three to $6 million. You can see that tax represents the margin that we need to produce to remain viable.

ECHN, along with other -- other hospitals, also had to shoulder the finan- -- financial impact of federal sequestration. Medicare provider payments have been cut by 2 percent since April of 2013. The act requires federal spending cuts to be achieved over the course of nine years. So the

sequestration is expected to remain in place through 2022.

The sequestration equates to a loss of more than 2.2 million each year for ECHN. This year the State has implemented a new system for Medicaid payments for inpatient care. While we were told that the change would be revenue neutral, we have determined that this is not the case. We will see 1.6 million less in revenue for those admissions this coming year.

As a result of this year's budget, the pool of dollars for low-cost hospitals was eliminated. While a couple of hospitals were successful in restoring that funding during the special session in a new small hospital pool, Rockville was not so fortunate, and we will see 300 less this year -- 300,000 less.

Finally, the formu- -- formula used by the federal government to calculate our Medicare payments is subject to a wage index. The current projections for payments resulting from the way that that

index is applied will lead to even further reductions.

As you can see here, the negative forces associated with the reduction in payment for services coupled with the increased salary and non-salary costs equates to an ina- -- inability to reinvest in ECHN and an unsustainable financial path.

In order to prepare for the future of ECHN, a work group of trustees, corporators, medical staff, administrators -- and administrators was formed in 2011 to study ECHN's needs and the benefits that would come from partnering with another healthcare institution. After studying the national, regional, and Connecticut landscapes, along with ECHN's current and potential future position, it was decided that a partnership was in the best interest of ECHN.

The partnering work group developed criterion in which to evaluate potential partners, including cultural and

strategic fit, financial strength and long-term viability, and the partner's interest to invest in our organization. The work group made their findings and recommendations to a committee of the ECHN board of trustees, the transaction committee.

When the deal with Tenet and Yale-New Haven Health System did not work out, the board reaffirmed the need for a partner. In January, the transaction committee employed the same process to select and then recommend to the board a transaction with Prospect Medical Holdings.

The reasons to join another system are clear. We want to improve our access to capital and afford investments. We have to improve finances and reduce and eliminate our debt. Together, we -- with our physicians, we have prepared to participate in the new payment system to ensure that -- that we protect, preserve, and grow the local access to healthcare services.

Request for proposals were sent to six healthcare systems. Three proposals were received from Hartford Healthcare, from St. Francis Care and Trinity Health, and one from Prospect Medical Holdings. After careful due diligence, which included rounds of questions and answers, site visits and meetings with the parties, the board selected the proposal from Prospect Medical Holdings as the best one that best meets -- meets ECHN needs.

The combination with Prospect Medical Holdings will secure the future of ECHN and local access to health care for the communities we serve east of the river. There's a strong alignment of mission, vision, and values with Prospect. Prospect is a strong partner for physicians, both independent physicians and those employed by hospitals.

They have decades of experience with managed care and the value-based, risk-based contracts that are emerging as

a result of healthcare reform. Risk-based contracts place the economic risk, the risk for payments based on performance, on the healthcare providers, including hospitals.

Prospect is successful in these risk arrange- -- arrangements because of the programs and resources that they have -- they employ to promote health in managing the healthcare needs of the population of patients in the lowest cost settings, at home or in ambulatory settings, while produce the best outcomes for their patients. Prospect has a history of success in markets where there is significant competition from much larger hospital systems. They have already begun working and educating our physicians about the model, which is important to building a sustainable, thriving network of value-based care for our communities.

ECHN firmly believes that this partnership will allow us to continue to serve our mission. It will protect

accessibility and the affordability of care for our patients while continuing our focus on the quality and safety of patient care. This will support our efforts to continuously improve patient satisfaction, and it will enable us to reinvest in programs, technology, and facilities for the benefit of our patients.

Now, I'd like to ask Joyce Tichy to walk you through some of the finer details associated with the letter of determination.

Joyce.

JOYCE TICHY: Okay. This is a little high. Okay.

So to start here, I'm going to take you back to one of the slides -- two of the slides that Dennis presented just a few minutes ago. I'm -- and I'm doing that because I want to frame the conversation here around what the statutory requirements are that have been set by the State of Connecticut, which have basically directed everything that

the ECHN board has done in this process. And that's by way of saying the legislature of Connecticut has really tried very hard to represent the interests of you, the communities in Connecticut, including this one. As the -- as the market has changed under everyone's feet, they've tried and -- and really developed quite a number of legislative initiatives in order to support the process to make sure that a transfer of a hospital from a not-for-profit to a for-profit status is fair and appropriate.

And our board, knowing this, has attempted to follow each of the directives set by the legislature in the very best way they know how. They've attempted to be faithful to the goals that were set in the creation of ECHN and ECHN's charitable assets and in the transfer of them now to -- to Prospect.

So this slide describes the role of the Attorney General. We have really two of the most significant regulators who

are reviewing the -- this transaction, one of which is the Attorney General. And the Attorney General's role in -- in this process is to make sure that we, like all other charities, follow the process that is -- that makes sure that the charitable asset that was developed and contributed to and supported over time by the community is appropriately honored and the amount of value that was placed in it goes back to the community, less the liabilities that it -- that have been created over time as a fairness matter.

So this is -- the list that you see on the screen really reflects what the Attorney General requires us to show in order to get through that regulatory process.

The next slide describes a little different process or a different focus, and that's the Office of Health Care Access. And their role is a little different, and that is to make sure that whatever the process is and the

transaction is, that the impact on the health of the community is -- is such that the availability of -- of health care is preserved and not reduced. So you can see that these -- what this slide shows of the standards that the ECHN board had to meet.

So those are the things within which our board framed its conversations and discussions and research. And I just want you to know that because the guide for how the Attorney General and the Office of Health Care Access will review this transaction is through these lenses.

So the part that I'm going to talk about now is the -- an additional piece of the set of tests that we have to meet, and that is we have to show that in engaging in this transaction and completing it, our board conducted a diligent negotiation of the terms and conditions of the transfer. Aside from just ultimately making sure that there was fair value, we have to show that we

actually diligently -- the board has to show that it diligently went through the process and make sure it could get -- it got the best deal it could for this community.

So this slide -- I'm going to be on the next two slides for a while, and so excuse me for that. But what I'm going to try to do is describe to you the 30,000-feet description of the transaction.

So the form of the transaction, which is very common in a transfer of a-- of an entity from a not-for-profit to a for-profit company is an asset purchase, and that is by which to -- to say Prospect will be buying substantially all of the assets of ECHN.

The key assets to be acquired by Prospect, which are listed in the proposal -- the -- the letter of determination proposal that we submitted are the -- the two acute care hospitals, Manchester Memorial and Rockville General, Woodlake and Tolland, our rehab

and long term-care facility, Visiting Nurse Service of Connecticut, which is our visiting nurse and home care company.

We have an insurance captive, which handles our medical malpractice liabilities. That's transferring as well. Our medical billing and physician office administration company, which is named Medical Practice Partners, is transferring, and all of the other entities that bear the ECHN name in your community, such as our physician offices in the area, along with our shares in the office buildings in which those physician offices are present.

We also have interests in a variety of -- of joint ventures, which is, again, very common for hospitals -- in hospital systems. Those include an endoscopy center, an entity that provides oncology services across the street from Manchester. It's called -- in our Dequattro Cancer Center. We have two ambulance companies, a wheelchair -- a

wheelchair transfer company, an occupational medicine provider and others. So we will be transferring, to the extent that the rules of those joint ventures allow, our interests also in those entities to Prospect.

So the list that I've just given you is not exclusive, and some of the joint ventures that we are intending to transfer may not transfer for one or another reasons, including our need to get permissions from other third parties, and the effort to transfer those will be part of this process as well.

Along with all of those entities, all the equipment, property leases, the chairs you're sitting in, the screens here, all of those things will become property owned by Prospect.

So as part of the -- a transaction like this, while you list the assets that are to be transferred, you also list the liabilities that are going to be taken on by the acquirer. Those liabilities will

be accompanied by a reduction in the purchase price that ref- -- reflects the value of those liabilities. So these are already existing obligations of ECHN which a hospital system typically acquires over time just as it operates its business.

Those include very significantly, what Peter mentioned earlier, our unfunded pension liabilities and obligations under our post-retiree health plan. Those are two items that our board was very interested in to make sure it got transferred so that our -- our commitments to our retirees would remain and be honored.

In addition, we're transferring over to Prospect our captive insurer liabilities, which cover our med- -- our medical malpractice claims and our Workers' Compensation liabilities. On -- on the other hand, there are also some assets that will -- are not included in the transaction. Those include our donor-restricted charitable

contributions, and that being when a donor contributes money to Manchester Hospital or has contributed to Manchester Hospital or Rockville or our -- our charitable foundation, if they placed a restriction on it, for example, you may not spend the principal, you can only spend the income on the charitable works, that money now needs to be set aside.

It can't be delivered to a third party, and it will be placed in a -- in a separate account. And the Attorney General will define as part of his job to define where that is to go next. We don't really have any control over that, and we're just identifying it and putting on the side for instructions.

Also, that -- what will not be transferred are the results of our lawsuits that occurred before the -- the closing of the transaction. So they're basically incurred by ECHN, not the responsibility of Prospect. So that remains our liability and something that

ECHN will continue to be responsible to pay for.

Cost report settlements with -- with Medicare and tax settlements are similar. These are pre-closing liabilities that we have that will not transfer.

Also not going with the transaction, are ECHN's cash investments. And as I'll explain in a minute, those will be used to pay off the debt that we -- these debts that we have at closing, and ECHN's long-term debt, again, to be settled at closing.

After all the puts and takes, which I'll go through in a second, whatever -- you know, these liabilities to the extent that they're not resolved and cleaned up and cleared out will be managed and handled by a residual ECHN corporation, which basically will be a shell entity just there in order to close out operations.

An additional piece of the transaction is our medical foundation, and that's the name that we use in

Connecticut for the entity that ECHN as an -- as a healthcare entity owns and it is where our physicians are employed. So there's been a fair number of changes in the law regarding medical foundations. Our legislature has been actively involved in making sure that those are appropriately managed in Connecticut. The law recently changed, and we will make sure that when we transfer the medical foundation, we do it in accordance with the way our regulators direct us to do. It's a little bit unclear at the moment, but there is going to be certainly a process for doing that.

As part of the transaction, our board was very interested in, and Prospect agreed, to set up a local advisory board. There will be one for each of the hospitals, Rockville and Manchester. The members of that board will be appointed by ECHN before the closing, and they are initially to be made up of five ECHN trustees and five

others identified by ECHN. The members will include community representatives, physicians on our medical staff, and our hospital CEO, which is -- which is Peter.

The role of the advisory board will actually be significant. It's going to be an adviser for how to spend the 75 million-dollar capital commitment that's part of the transaction that Prospect has agreed to. It will assist with the development of our strategic business plan, that is, Prospect strategic business plan in furtherance of the community -- community's interests. It'll be responsible for medical staff credentialing. It'll oversee quality assurance, a very key part of our operations. And it will oversee and manage the hospital's accreditation.

One of the things that the Office of Health Care Access is going to ensure that we have as part of the deal and that we ask Prospect to commit to, and they

willingly did, is a commitment to maintain community support, charity care and the continuum of care. Those are CON requirements, and Prospect has agreed to maintain ECHN's policies on charity care, indigent care, community volunteer services, community -- and community outreach services.

In addition, we have a graduate medical education program, which was referred to earlier, in partnership with the University of New England College of Medicine. It's been a -- a very good program for the community and for ECHN. It's already begun graduating young doctors into our community, some of whom have decided to stay, much to our happy -- I wouldn't say surprise, but much to our happiness. And Prospect has agreed to maintain that program in -- at ECHN.

Prospect has also agreed to maintain for three years our two acute care hospitals and their emergency part -- departments, and it's agreed to maintain

an ownership interest in our visiting nurse service, VNHSC, our -- and our subacute and long-term care facility, Woodlake at Tolland.

With respect to employment, Prospect has agreed to offer employment to substantially all of our ECHN employees and to give them comparable benefits to the packages that they had pre-closing.

As ECHN began the journey to partner with an entity, it knew that it -- it had collective bargaining agreements with our unions. And as part of the effort to protect their interests, ECHN negotiated the last round of collective bargaining agreements to have a fairly long end date. And so what that means -- and Prospect has agreed to take on our collective bargaining agreements that have a fairly long expiration date from now, that being June 2018 for the RNs at Manchester Hospital, May 2017 for the service and skilled maintenance em- -- employees at Manchester, June 2017 for

our technical and LPN employees at Manchester, and December 2018 for the RNs at Rock- -- Rockville.

As -- as I also mentioned, Prospect has agreed to spend $75 million within five years. This is after the closing. So Prospect will already be the owner of ECHN. And it's agreed to invest $75 million in our facilities to pay for upgrades to the facilities and projects that we have in order to improve services.

Examples of how that money may be used are renovations to our facilities, which as Peter earlier noted, we haven't had sufficient capital in order to invest in our facilities for a period of time. So they are in great need of renovation, and that money will be used toward that purpose. They'll also be used for recruitment costs as appropriate to bring in needed medical staff, expansion of our clinical departments and the purchase of medical equipment or the electronic medical records earlier mentioned.

If a law or rule is passed, though, that discriminates against for-profit systems, our agreement with Prospect provides that they can defer that obligation beyond the five years, but in -- if they are to do that, they need to confer with the local board that I mentioned earlier.

With respect to changes to the service or towns served, which is another provision that the CON requires us to respond to, there are to be no changes in this transaction requested to the services or towns that are served, no changes.

If anyone heard me speak on this subject last year, you'll probably think that this arrangement is pretty similar to the one that we had with Tenet and, in fact, it is in many ways similar. We were pleased with that result because Prospect agreed effectively to take on Tenet's commitments, even though our financial condition is not as good as it was a year earlier. And in addition, it

agreed to some improvements over the Tenet transaction.

So, for example, Prospect agreed to reduce the indemnity reserve, which I'll describe in a minute, from 75 million -- excuse me -- from 7.5 million to $4.5 million, and it agreed to cap the value of our joint ventures if we are unable to transfer them to Prospect in case we need to deduct from the purchase price because we can't transfer them over. And in addition, if we can't transfer the joint ventures over to Prospect, they've agreed to give us a loan to carry us over to the closing despite the inability to transfer those joint ventures.

So those agreements indicated to us a strong willingness on -- on Prospect's part to partner with us and to make the arrangements work. They're also going to allow us to use and access the capital commitment earlier in furtherance of the closing if need be.

Okay. So that was pretty long on

this slide, and the next slide is going to be kind of long, too. And I do apologize for that.

So what this next slide describes for you is what transaction lawyers call the waterfall. And people ask, Okay, where's the money -- you know, sort of, How's the money coming in? Where is it going? Sort of how -- you know, who gets -- you know, how -- what are the steps involved? So that's what this slide is really intended to describe for you.

So I -- the purchase price as mentioned is a hundred and five million dollars, but before we get to that, there is a line on the top which indicates what I described to you earlier, the excluded assets. So as you kind of view how this process works, think about sort of buckets. So I mentioned the donor-restricted funds, the ones that we can't access because the donor has said, Don't spend them; they're for -- you know, if you can't -- don't -- don't

access them, only access the -- the principal. So in that instance, you take that money and you put it aside in a bucket, and you keep it over there and don't do anything with it.

Then you take another bucket, and you put our cash and investments into that bucket. And then the cost report settlements, if there are any at that point in time, you put it in a third bucket. You just keep those buckets there.

Then you get a hundred and five million dollars from Prospect. Immediately at that moment, you do a true-up to make sure that you have enough networking capital, which is the money that you need basically to run the business on a day-to-day basis. You think of it as your checkbook. You have to have enough money in there even before your paycheck gets in to pay all -- all of your bills. That amount needs to be, as we've predetermined it, $24 million. So if there's more in our net working

capital accounts, we true it down, and if there's less, we true it up.

After that, we then take reductions from the hundred and five million, and those will be used to pay the liabilities already -- that ECHN already owes to others. One of those is our indebtedness for things such as capital leases. Another is those unfunded pension liabilities that I mentioned and Peter mentioned earlier, and our post-retiree health liabilities.

The next is our employment-related liabilities. The next is our captive and Workers' Compensation liabilities, the values of our joint venture interests not conveyed, and our asbestos liabilities. So remember, Prospect is taking those liabilities. So we have to give them the money to cover the liabilities that they're taking so that they in turn can pay the others to whom those monies are owed.

If there's anything left, that amount that's left will be combined with

the cash investments that remember I told you put in the buckets over -- one of the buckets over here, and that money will be used to pay off our long-term debt to bondholders and lenders, which is, again, a -- a typical liability that an entity like a hospital system has over time.

Whatever is left from that is then used to fund the indemnity reserve of $4.5 million, and that amount is -- sits basically in a bank account to cover our liabilities for things like lawsuits or liabilities that we're just not aware of as yet that occurred, that -- that came to be before we closed the transaction, but really belonged to ECHN.

If -- if at the end of three years, that money hasn't needed to be used for that purpose, it gets combined with the amounts that we have already set aside in the donor-restricted fund and any other monies that are left from after you take all the -- all the deductions that I described earlier.

Again, after the closing there will still be another $75 million in a capital commitment that Prospect promises to spend in order to enhance and improve ECHN's facilities.

So that's basically how the transaction is going to work. Caveats to this are that the agreement between us and Prospect says that there will be no material changes to the business assets, liabilities, financial condition or results of operation of ECHN, that the medical foundation that I described earlier needs to be successfully set up and transferred to Prospect. And there are many other closing conditions which are -- again, there are many of them, but they are typical in a transaction of this kind. So those would be conditions that would allow Prospect to -- to not close the transaction, and we hope none of them comes to be.

The last thing I want to point out is that there will be a number of levels of independent verification to the

fairness of the decisions made by the board of directors -- the board of trustees of ECHN in order to protect the interests of the community. The fairness of the purchase price will be confirmed by a third-party fairness opinion. There will be an outside audit of our financial statements.

There will be actuarial reports for our pension and retiree health to make sure that those amounts have been accurately identified so that the liabilities can be covered. There will be the independent Attorney General and OHCA review that I described earlier. And each of them will hire and use independent experts to test and document the representations and -- and those experts will be paid for by the parties.

DENNIS McCONVILLE: Okay. Fifty minutes.

Now we've reached the part of our hearing where you, the public, may participate. Again, for this portion of

the hearing you must sign in if you wish to comment or ask a question of our panel regarding the letter of determination. If you've not signed in and wish to speak, please see Nina Kruse in the back of the room to do so.

If you've signed up to speak, I'll call your name to come up to the one of the podiums to make your statement or to ask your question. Before you begin your comments or questions, please state your name and your town of residence. In order to give everyone who wishes to speak an opportunity to do so and in the interest of time, we request that each speaker limit your participation to one appearance at the microphone, and that you try and limit your comments to three minutes or less.

Your statements or comments should be directed towards the contents of the letter of determination. If you've signed up to speak, but you've changed your mind, just state no comment when I read your name. If you've prepared

written legible comments, you may leave those comments with Nina Kruse, and we will enter them into the record.

At this time, I'd like to introduce our panel.

Can you turn that off, please? Great.

Joyce Tichy, senior vice president and general legal counsel for ECHN, and Peter Karl, president and CEO for ECHN, and Michael Veillette, senior vice president and chief financial officer for ECHN, for Prospect Medical Holdings, Dr. Mitchell Lew, who is president of Prospect Medical Holdings, and Thomas Reardon, who is president of Prospect East Holdings, to take your questions.

Okay. I'd like to call to one of the microphones Dr. Bob Carroll.

BOB CARROLL: Hi. My name is Bob Carroll. I'm a physician on staff here. My town of residence is Farmington, Connecticut. I've been at ECHN for 15 years.

Dear Attorney General Jepsen,

Commissioner Mullen, and citizens of the towns and cities served by Eastern Connecticut Health Network. I would like to express my opinion on the acquisition publicly. As the chair and senior medical director of the Department of Emergency Medicine and the service line director for emergency services at ECHN, I would like to express my excitement about the future acquisition of ECHN by Prospect Medical Holdings, subsequently referred to as PMH.

For the past several years, we have been facing one financial challenge after the next in the form of hospital taxes, sequestration, Medicare reimbursement cuts, pension reform and unfunded quality reporting mandates.

The only way we have been able to meet these challenges has been to do more with less. My view on health care is that we are facing the same struggles now that the smaller department stores and hardware stores faced a decade or more ago with the emergence of Wal-Mart and

Home Depot. Their ability to produce goods in such large quantities made it impossible to compete with their prices, and many of the mom-and-pop stores eventually went out of business. This is the path that I believe ECHN would be on if we didn't proceed with the acquisition.

I, as a healthcare provider, and ECHN, as a healthcare system, have an obligation to the patients we serve. Our obligation is to be there for them in their time of need and to provide the expertise, staff and equipment necessary to diagnose and treat them at any hour of the day or night.

The acquisition of ECHN by a larger system is the only option that would allow us to continue our mission of improving your well-being by providing high-quality, compassionate health care. Without the ability to join a larger system, our costs will be higher than our competitors, our ability to recruit skilled physicians and nurses will become

more difficult, and we will eventually find ourselves out of business.

I have been asked many times, Why partner with PMH rather than one of the other larger systems closer to Manchester and Rockville? My desire for PMH is based on my belief that they would the best option for both the patients we serve and the staff we employ.

In order to succeed, PMH has to help grow our system to allow us to directly compete with our local competitors. I feel that if we had chosen to partner with a nearby competitor, we would become victim to consolidations of services and locations. This would directly impact access to health care for our patients in our communities.

In my 15 years at ECHN, I watched our competitors advertise their cutting-edge therapies during the prime-time news and open healthcare centers in our neighborhoods. I've read about their latest minimally invasive cardiac procedures and have heard on the

radio about their world-class stroke therapies. It would be really nice to have the access to capital funding that would allow us to advertise the cutting-edge programs we have here at ECHN. However, the ability to grow and advertise these types of services is becoming virtually impossible under the financial constraints we are facing.

With the implementation of the Affordable Care Act, the increase in Medicaid volume and the State's tax on hospitals remaining independent is futile and no longer an option. A partnership with PMH will afford us access to the clinical expertise our patients need as well as access to the desperately needed capital funding so that we can resume investing in our technology, staff and infrastructure.

This position -- this partnership will position ECH competitively for the foreseeable future of health care. Sincerely, Robert Carroll, M.D.

DENNIS McCONVILLE: Thank you,

Doctor.

I'd like to call Ava Hill to the microphone, please.

AVA HILL: Let's see.

DENNIS McCONVILLE: Please state your name and your town of residence, please.

AVA HILL: Ava Hill, Manchester, Connecticut.

I've been with ECHN for about ten years now. I work Monday, Wednesdays and Fridays, and I've been a float for many years, along with working at Rockville Hospital, the off-sites, and at the cancer center currently, and I teach at Goodwin College. I've been there for about nine years as well teaching phlebotomy.

And so I'm here because I had a question, but I decided to retract that question. And I know that -- I'm sure that everyone here this evening, along with countless devoted employees who are not present, do understand the extreme need for some type of transaction -- this

type of transaction to take place in order for this institution to continue the amazing work that they do to serve the community.

My main concern now, however, is that ECHN employees ultimately must know how this affects their future beyond 2017, 'cause you spoke about 2017. So it's important to know for everyone how -- you know, how it will ultimately affect their future. And if I'm repeating -- if I'm asking questions that you've already answered, I -- I do apologize.

Will the employees need to reapply for their positions?

That's my first question.

They will?

PETER KARL: No. I was --

AVA HILL: Okay.

PETER KARL: I was waiting for all your --

AVA HILL: Okay.

PETER KARL: They won't have to.

AVA HILL: I'm wondering if there's

a difference between the union and nonunion workers?

PETER KARL: No, there are not.

AVA HILL: Okay. How many employees are at risk of losing jobs based on -- what I've -- I've heard some -- some people speaking about it -- for instance, with -- in the phlebotomy department and in the lab department, I heard that there was a possibility that one may lose their job if they're not currently certified.

I don't have that issue because I teach a program, and I've been with -- with ECHN for many, many years. However, my coworkers are asking me, Do I need to go and get recertified in order to be rehired or in order to be able to sustain or, you know, keep my job at this point?

And that's an important question because they -- it affects so many people that are not certified.

PETER KARL: Any more questions? And then I'll just --

AVA HILL: Okay. All right.

Are there any number of employees that are at risk of losing jobs? That's an important question.

And I'm -- I'm speaking specifically on behalf of the laboratory. I'm wondering because I -- again, I have -- I've been around for many years. I've been in many places. And I want to know -- that I want to report back to them who is at risk and will the employees be required to have any additional -- well, okay, I'm repeating -- certifications or licenses. I'm sorry to repeat myself.

PETER KARL: Okay. So I'll -- I'll respond to --

AVA HILL: -- okay.

PETER KARL: -- some your questions, and then I'll -- I'll pass it over --

AVA HILL: Okay.

PETER KARL: -- to Tom or Mitchell.

The employees will not have to reapply for their jobs.

AVA HILL: Okay.

PETER KARL: Okay?

The reason why the term "substantially all employees" is used instead of saying all employees are used --

AVA HILL: Uh-huh.

PETER KARL: -- is because if there are poor performers that are --

AVA HILL: We don't want them.

PETER KARL: -- suspended and are on their last final warning, and so on or so forth, you know, that -- that may be 1 percent or a half a percent, they may not come along.

AVA HILL: Okay.

PETER KARL: But substantially all means the benefits, the union contracts, the nonunion employees, so on and so forth, they will all come along.

AVA HILL: And -- and even if they're in the upper -- in terms of compensation?

PETER KARL: Absolutely.

AVA HILL: That's another question that has come.

PETER KARL: Absolutely.

AVA HILL: And -- and I said, Well, I will try to --

PETER KARL: Absolutely.

AVA HILL: -- find the answer.

PETER KARL: Whether they're currently certified or not, as long as they meet State requirements to perform their duties.

AVA HILL: Okay. And so currently in State of Connecticut, there are not certifications required. I -- I know -- I do know that many institutions are requiring that at this point. So I'm wondering if once the takeover happens, if these people will be at risk of losing their jobs if they don't hold a current certification?

PETER KARL: That has not been -- that has not been discussed.

AVA HILL: Okay. But that might happen? We don't know?

PETER KARL: We don't know that.

AVA HILL: Okay.

PETER KARL: That's very far in the weeds, but I understand --

AVA HILL: Okay.

PETER KARL: -- the importance of that question.

AVA HILL: Right. Absolutely.

PETER KARL: But if there isn't a certification in Connecticut at this point in time, those employees would come across.

AVA HILL: Okay.

PETER KARL: Okay?

THOMAS REARDON: Hi.

AVA HILL: Hi.

THOMAS REARDON: First of all, I just wanted to say to everybody, thank you for coming tonight. We very much appreciate it.

I'm from Boston. Mitchell's from LA. But you know this community better than we'll ever know it, and so we really, really appreciate your input, and I mean that sincerely. We are excited to be here as potential partners for ECHN.

As an employee, nobody likes change. And the first thing any employee, myself included, asks -- says, What happens to

me?

AVA HILL: Uh-huh.

THOMAS REARDON: We are a growth company. We are not a contraction company.

AVA HILL: Okay.

THOMAS REARDON: You will not have to reapply for your jobs. As I said, we are a growth company. We work very well with the unions and nonunions.

AVA HILL: Uh-huh.

THOMAS REARDON: And -- and -- and I'll leave it at that.

AVA HILL: I'll be able to report back wonderful news. I'm happy about that.

DENNIS McCONVILLE: Thank you. Okay. All set?

AVA HILL: Okay. I'm good.

DENNIS McCONVILLE: Thank you, very much.

AVA HILL: Thank you.

DENNIS McCONVILLE: I'd like to call up Eric Kloter on behalf of Senators Cassano, Guglielmo, and Larson, and State

Representative Mark Tweedie.

ERIC KLOTER: My name is Eric Kloter. I live in Tolland.

This letter is over the letterhead of the State of Connecticut General Assembly, and it is signed by the gentlemen that Dennis referred to, and it's addressed to the Honorable George C. Jepsen, who is Attorney General, and the Honorable Jewel Mullen, who is the Commissioner of Public Health and the Office of Public -- the Office of Health Care Access.

Dear Attorney General Jepsen and Commissioner Mullen. We are pleased to endorse the proposed transaction, including a formal public hearing process with public input, for Eastern Connecticut Health Network to be acquired by Prospect Medical -- Medical Holdings. They will pre- -- preserve and enhance our residents' access to the community-based care that they have relied on for generations for themselves and their families.

Prospect has a strong track record of collaborating with physicians, community providers, payors and other key stakeholders to provide high-quality, cost-effective services to the communities it serves.

We have an obligation to support the efforts of our community hospitals which are striving to continuously improve quality while reducing cost, but struggling with lower payments for services and continued cuts in state and federal reimbursements for care. It is important for state public servants to ensure that our constituents have local access to quality health care that is affordable.

Prospect has decades of experience and success with provider payment risk arrangements now emerging in the state. With their experience and resources, the result will be better care for individuals, better health for the residents of Eastern and lower costs for health care. Access to capital will

allow ECHN to reform and strengthen its care delivery network to offer even more community-based services and to keep its two hospitals, Manchester Memorial and Rockville General, viable to meet patient needs and expectations.

Therefore, we encourage OHCA and the Office of the Attorney General to look favorably upon the proposed transfer of assets as described in the certificate of need determination letter recently filed by ECHN.

Sincerely, Senator Steve Cassano, Senator Tony Guglielmo, Senator Tim Larson, and Representative Mark Tweedie.

DENNIS McCONVILLE: Thank you.

Next I'd like to call on Ray Ruete. Am I pronouncing that correctly? I hope.

RAY RUETE: Close enough.

DENNIS McCONVILLE: Thank you, sir.

RAY RUETE: Ray Ruete, Ellington Connecticut. I'm not an employee of ECHN. I'm just a consumer of services.

Through the presentation, Mr. Karl

brought up a lot of significant drags on the finances of ECHN, most of which or many of which are being levied by our state politicians and federal government, and so forth. It doesn't seem to me like that's going to change whatsoever and perhaps only get worse, barring a collective heart transplant of our politicians.

Why would you think taking over this company, that you can then make it better with that kind of a situation in the environment of Medicare payments, and so forth, that the government handles?

MITCHELL LEW: Thank you, Mr. Ruete. A very good question.

First of all, on the hospital side we have a lot of experience with community hospitals. We run very efficient, lean hospitals. And due to our size now, 13 hospitals, we can achieve some economies in terms of ordering supplies and medications and such.

But really our model is one which we

work with our hospitals, and we also own physician groups. And what we do is we -- we coordinate care, we integrate our hospitals and our physician groups together, and we approach health plans with the idea that we will take financial risk and manage a population. That's what we've been doing in all of our various regions where we have hospitals and physician groups, Southern California, Texas, and Rhode Island.

And what this allows us to do is manage the care of a population under a budget, but with the goal of achieving highest quality, access, but do it at -- at an affordable price.

And so where there are a lot of waste in the system, perhaps some fraud and abuse, a lot of redundancies, we've learned to really do a very efficient job of delivering the right care at the right time in the most appropriate setting. So in some cases, it may not be in a hospital. It may be in a member or a patient's home or in a skilled nursing

facility or wherever the patient may be, we've -- we've learned how to do it in a -- really in a -- in the most appropriate way, but not necessarily in a more expensive setting such as a hospital.

So that -- that really is our model, is to -- to take more of a financial risk in health care and -- and manage it in a way that the patient gets the care that they need at the right time, as I said, but really not necessarily -- not necessarily do it in the most expensive setting such as a hospital, but perhaps send a team of physicians and nurses and pharmacists out to a patient's home or maybe in a physician's office to help support the physician.

So it -- it's really a -- a community local physician approach that really manages across what we call the entire continuum of care. So that means no matter where a patient is, we will take care of the patient. And -- and we've learned that what that does is it

reduces the risk of a patient being readmitted to a hospital. We can allocate resources that are, you know, less costly. But, again, the end result is it -- it does it for a lot less than the more traditional fragmented approach where volume is more important to -- to certain systems and -- you know, and the ECHN system, I think, is a much lower cost system than some of the more expensive competitors.

And so our ability to -- to then go out and recruit physicians and work with plans to -- to take care of more patients will drive business into the system. And -- and it's -- it's a growth model. It's very sustainable and -- and we have no plans to -- to contract.

RAY RUETE: If you're looking for suggestions on improvements or possible cost savings, I have some on the billing system that ECHN uses to send out bills to patients.

MITCHELL LEW: Well, we'll -- we would look forward to that, but the local

leadership will certainly --

RAY RUETE: Not so far.

DENNIS McCONVILLE: Thank you, Mr. Ruete.

I'd like to call on Rudy Luginbuhl, please.

RUDY LUGINBUHL: Good evening. Rudy Luginbuhl, 29 Middle Butcher Road in Ellington.

It's -- it's highly -- I can't hardly think of the time that's gone by here since -- I'm going back a little bit now -- in -- in the beginning of all of this because I was the chairman of Rockville Hospital when we merged with Manchester, and we did it in the late '80s, into the '90s. So we're talking 20, 30 years where the progressing of the type of care that we needed and all was improved through that move. We -- we know that -- that it was a good move because it grew to Eastern Connecticut Health that we have today.

But when you -- when you think about why did we do it then, it's no different

than why you're doing it now. The economy of scale is the first thing you have to think about. If you can do something together that you were doing separate, and you can go out and get a bid that's a better bid for what you're doing, then you're going to be able to do it at a less cost. So that's kind of where we were led to the, you know, combining laundries, the -- the food service, whatever came into being.

And so when I think about that, that's what's going on now, only a larger scale, but it's still the same motivating force that says you must -- the -- the idea of saying, well, you know, there's an option. The option is to do nothing. We know that. If you do nothing, then slowly but surely you're going to probably not be here for long. So you've got to do something.

So you -- we have a group here that's studied all this in -- in detail and -- and we believe and I believe that -- that they are telling us that we

need to go forward. And I certainly strongly support what's going on here and -- and hope that the community does realize that no one wants change. We -- like you mentioned before, but it's inevitable when it comes to this type of operation where the funding is changing and you -- you need to have a -- a beg -- a bigger buy so you can buy better and all that.

So I just want to say that, you know, it's -- it's almost 20-something years now and -- a d here we are at a position where we've got to move another step forward. And I do support it completely. Thank you.

DENNIS McCONVILLE: Thank you, Mr. Luginbuhl.

I'd like to call on Joe Tyler.

JOE TYLER: Hi. I've got a couple questions here.

DENNIS McCONVILLE: Would you please state your name and your town of residence, sir.

JOE TYLER: Joe Tyler, Manchester,

Connecticut.

First of all, what percentage of the current employees of ECHN are contract employees versus full-time employees who get benefits and everything like that?

MICHAEL VEILLETTE: When you say -- Joe, when you say "contract," you mean outsourced?

JOE TYLER: Yeah.

MICHAEL VEILLETTE: And I would say that it's a very low percentage. I don't have the exact percentage, but I'd say it's less than 5 percent. Most of our employees are internal employees.

JOE TYLER: Okay.

MICHAEL VEILLETTE: With the exception, I think, of our hospitalists, they are contract employees, and valet services, as Peter is reminding me. But other than that, no other service comes to mind.

JOE TYLER: Under your model, what percentage of the employees will be contract employees versus full-time

employees, either unionized or nonunionized?

THOMAS REARDON: Basically, we have -- I mentioned earlier that -- that my friend Mitchell here lives in Los Angeles, and I live in Boston. We determined long ago that we -- all health care is local. We don't try to run things from Los Angeles or Boston.

So the current management team will continue to be the management team. There'll be a strategic planning process that is led by the local folks, and they will decide what the -- what the ratios are. We will have very little to say about that frankly.

JOE TYLER: The reason I asked that is that's been one of the problems from my studies of for-profit operations in things like this, is they wind up contracting more out than keeping employees, either nonunion or other. So I think that's one of the concerns we have.

The other question I have is for

Mr. Karl. You -- it was indicated during the presentation that you folks set out only six invitations to bid; is that true?

PETER KARL: That's correct.

JOE TYLER: Why only six?

PETER KARL: How many should we have sent out in your opinion?

JOE TYLER: Well, to be honest with you, I -- I think there's a lot more than six. Like, for instance, I contacted Mayo Clinic, and they never heard from you, you know. There's a lot of places around the country and that these operations, nonprofits, are trying to grow, too. And I just am astounded that only six invitations to bid were sent out.

PETER KARL: You --

JOE TYLER: That would be extremely low given the dynamics.

PETER KARL: Joe, you brought this up last time that we had Yale-New Haven and Tenet here and --

JOE TYLER: Well, I would have

thought you would have learned something.

PETER KARL: And we answered the question the same way. Health care is local. We use an outside consulting firm that goes nationally -- that works nationally. We use a national attorney firm and valuation firm. And they look at the landscape. They come around and they say, Okay, this -- these are the organizations that are growing in the local areas.

The Mayo Clinic, for instance, in Minnesota are looking more nationally, internationally, and they are growing in their areas. Hospitals that are growing in Connecticut are Yale-New Haven Health System, Hartford HealthCare, and Trinity has come into play, which is a national system. They were asked to bid, as was Western Connecticut and a couple other organizations.

What we do is we do an analysis on each of the players, and then we look at what would be best for the community that

we serve currently. What -- what is -- what is this firm going to do for the community to make sure that the mission is continued to be carried out, to make sure that the jobs are preserved in the community?

And what we have found through all of the analysis, when we narrowed it all down, we came down to Prospect Medical, who's going to invest, not only eliminate our debt, make sure pensions are paid, and invest $75 million over five years to rebuild health care the way it should be rebuilt, and also to provide the care at a lower cost to bring in the right specialists. And that's the type of research that we do in detail, and that's what our consultants do for us, also.

JOE TYLER: In all honesty, you should have gotten different consultants.

To give you an example, Mayo Clinic operates in Arizona. They also operate, I think, in Georgia. I would have -- you

know, they might like to grow in the Northeast somewhere.

So I just think that -- that your consultant -- and -- and there's no disrespect for these people. I mean, I -- I hope they do what they say they're going to do and everything else. So I hope it works out. But I just find it absolutely astounding that you only had six -- you only had sent out six proposals to bid.

The other question I've got is: There was some story that they might cut acute care at the hospitals in Manchester and Rockville. Could you describe what you mean or what was meant by that?

MITCHELL LEW: I don't know what was meant by cutting care -- acute care.

JOE TYLER: Acute care, yeah.

MITCHELL LEW: Don't know who made that statement, can't -- can't really comment.

I mean, I can say that as -- as I described to Mr. Ruete, that, you know,

our model embraces acute care. It embraces care in the community outside of the hospital and all facilities where patients were going to be at. And, you know, we -- we fully intend to invest in the hospital and grow and provide a better product and -- and obviously better health for the whole population.

JOE TYLER: Thank you very much.

MITCHELL LEW: Sure.

DENNIS McCONVILLE: Thank you.

Now I'd like to call on Dr. Joel Reich.

JOEL REICH: Hi. I am Dr. Joel Reich. I live in Glastonbury, Connecticut. And I'm just going to read this so I get into the record properly.

Attorney General Jepsen, Commissioner Mullen, and community members. I'm here to express my total support for Prospect Medical Holdings' acquisition of ECHN. I've lived in this community and I've been with ECHN for most of my professional career as a practicing emergency Physician, chief of

emergency care, medical director of the areas EMS system and currently as chief medical officer.

These roles have enabled me to attain a deep understanding of our community's needs and how our health system can best continue to provide excellent care and improve the health of residents in towns we serve. Clinical advances, maturation of health information technology, increasing economic pressures, policy and legislative initiatives, including the Affordable Care Act, and our state taxes have driven unprecedented change in the health care system during the past five years. What worked before no longer works today and won't work in the future.

ECHN has completed a carefully planned due diligence process to determine what best meets our future needs. I was part of the team that visited Prospect Medical Holdings in Los Angeles and Providence, Rhode Island.

While each of the health systems is addressing its local needs, we found three things in common: Substantial investment in the hospitals, significant growth of clinical services, and highly satisfied community physicians. It's rare to see any one of these, and almost unheard of to see all three of these in any one place.

Prospect has applied its extensive experience in health system leadership and management, care coordination, independent physician alignment and value-based contracting to advance high-quality patient care while thoughtfully managing costs.

Prospect is by far the best option for ECHN for the following reasons: It's the best cultural fit for us. It has extensive experience with community hospitals serving communities very much like our own. Its leadership is focused on innovation and growth, and its strategy execution is agile. It will bring much needed capital to ECHN to

ensure financial stability and future growth.

Prospect is much more than a hospital company. It's a healthcare services company. While it very successfully operates 13 hospitals, it's also fully integrated over ninety thousand independent physicians and other community caregivers into its model, which is fully compatible with the Affordable Care Act, Obamacare.

Through its care management programs, health coaching structure and sophisticated health information exchange and analytic capabilities, it's helped families and -- on -- patients and families navigate the complexities of the healthcare system while reducing expenses for nonvalue-added services.

In short, Prospect Medical has already mastered what other health systems are talking about doing in the future. I believe that Prospect Medical Holdings is the best partner for ECHN and hope this will be supported through the

regulatory process.

I thank you for this opportunity to comment.

DENNIS McCONVILLE: Thank you, Dr. Reich.

I'd like to now call -- call on Dr. Dennis O'Neill on behalf of Dr. Barbara Phillips.

DENNIS O'NEILL: Dennis O'Neill. This is a letter from Dr. Barbara Phillips to the Office of Health Care Access and the State Attorney General, from Barbara Phillips, M.D., Family Medicine, LLC, regarding the certificate of need application for hospital conversion.

Dear colleagues and community members. My name is Dr. Barbara Phillips, and I support the proposed partnership of ECHN and Prospect Medical Holdings. I speak as a community physician on behalf of myself and my patients and also as the chair representing three organizations, the Eastern Connecticut Individual Provider

Group, which has 309 member physicians and advanced practice clinicians, the Eastern Connecticut Physician Hospital Organization, and now the Clinically Integrated Network of Eastern Connecticut.

I am a family physician practicing in Manchester since 2004. I chose to join the practice of Dr. Martin Keibel, a physician here for now 30 years. I also selected this location because of the presence of a strong community hospital network. Our practice, like many, advocates for a population with deep roots in this community. We have a number of three- and four-generation extended families, and our patients range from newborns to those over 100 years old.

We live here, and we raise our families here. We are dedicated to the future of quality care for every segment of our population, and increasingly we feel the pressures all small practices have adapting to the rapid pace of change

in health care.

As primary care physicians in this community, we are fortunate to have both high-quality physicians and a high-quality hospital system to help us care for our patients. Good patient care thrives with access to quality community hospitals which are well equipped to take care of 95 percent of the healthcare needs provided by tertiary hospitals at substantially less cost.

Strong community hospitals stay closely allied with the needs of their individual communities and can -- and can be flexible to adapt to changes in those needs. At the same time, community hospitals all face the challenging forces in health care and many are looking to partner in varying ways to maintain viability and patient access to quality health care. The choice of partner is a profound decision for a health system. We have witnessed the varying face of some of our sister hospitals who have joined larger health systems and have

seen what seems like inevitable consolidation and centralization of health care, often without clear benefit in cost or care.

Concerns about the potential movement of for-profit medical systems into the state have raised valid concerns about preserving access to patient-centered medical care. Through my work over the past years with the IPG, the PHO, and now our Clinically Integrated Network, I've participated in the development of an increasingly cooperative, creative and effective network of individuals and entities dedicated to improving regional patient care.

A partnership between ECHN and Prospect Medical Holdings, with their many years of innovation and success in managing risk and with their coordinated regional care delivery model, offers the citizens of this region the most viable option for maintaining access to a thriving, forward-thinking, local medical

community dedicated to their well-being.

The partnership will stabilize a key employer and -- and corporate member of the region. The primacy of quality metrics and patient-centered care aligns the interests of this for-profit partner with the historical stewardship of the not-for-profit health system, greatly lessening concerns regarding for-profit medicine.

PMH offers the best option for this medical community to preserve its strong base and enhance its capabilities.

Thank you for your attention. I'm happy to be available for any questions regarding these concerns. Signed Barbara Phillips, M.D.

DENNIS McCONVILLE: And that concludes any comments or questions unless there are others who have signed in, Nina?

No? Yes?

AVA HILL: I just have a quick question. I -- I thought I --

DENNIS McCONVILLE: Did you want to

come up to the microphone?

AVA HILL: Just a quick question. Yeah, I promise.

DENNIS McCONVILLE: State your name and your town of residence, please.

AVA HILL: Ava Hill, Manchester, Connecticut. Just a quick question.

What I thought I understood was that Prospect is moving more towards doing more ambulatory than - than hospital care.

So with that wonderful letter from Barbara Phillips, I'm just curious and -- you know, how that will affect the hospital organization, you know, the hospital and the people that -- will -- will you be looking more like at -- at -- looking at people and saying, You probably should go to an ambulatory center rather than the hospital?

MITCHELL LEW: If -- only if it's appropriate.

AVA HILL: Okay.

MITCHELL LEW: We -- we definitely focus on the, you know, best possible and

highest quality care within a hospital.

AVA HILL: Okay.

MITCHELL LEW: But we focus a lot on taking care of a patient across the entire. Continuum. So when a patient is discharged, we want to make sure they're continuing to get that care, whether they go to a skilled nursing facility or go home so that they don't get readmitted.

AVA HILL: And so are we looking at the possibility of -- of building more ambulatory care centers?

MITCHELL LEW: Well, we -- we want to make sure that there's going to be a lot of good access for patients --

AVA HILL: Uh-huh.

MITCHELL LEW: -- whether --

AVA HILL: Other than going to Manchester and Rockville Hospital?

MITCHELL LEW: I'm sorry?

AVA HILL: Other than going to Manchester or Rockville Hospital. And I understand the financial need for that completely.

MITCHELL LEW: Yeah. We want access whether it be in a physician's office or --

AVA HILL: Okay.

MITCHELL LEW: -- or urgent care or community clinics. That -- that's our goal.

AVA HILL: Thank you.

MITCHELL LEW: Sure.

JOE TYLER: Can I just ask one more question?

THOMAS REARDON: Could I just follow up on Ms. Hill's --

JOE TYLER: Yeah.

THOMAS REARDON: -- question?

JOE TYLER: Ava?

AVA HILL: Oh, I'm sorry. What's that?

THOMAS REARDON: Ms. Hill, I wanted to just follow up on your question.

AVA HILL: Sorry.

THOMAS REARDON: When we talk about coordinate regional care, we talk about partnership with all kinds of different providers, ambulatory centers,

nursing homes, hospitals, et cetera, et cetera.

And the whole idea is to coordinate care so, as -- as Dr. Lew said, getting patients to the right place at the right time and at the right cost and -- and what we have found over time as you -- as you do this and as you get into risk contracts with managed care plans and -- and frankly Connecticut is ripe for that 'cause there's not much managed care penetration here at this point. What we find is that, strangely enough, you may think, the volumes at the hospitals increase.

AVA HILL: Oh, absolutely. I understand that completely.

THOMAS REARDON: It's across --

AVA HILL: I understand the need financially.

THOMAS REARDON: It's across the board.

AVA HILL: It's just a question, again, so I can report back, but I do understand completely.

I -- I don't advocate people going in with sore throats and fevers and whatever and utilizing the -- the tremendous expense and the time and waste.

DENNIS McCONVILLE: Thank you. Thank you for your question.

AVA HILL: Thank you.

DENNIS McCONVILLE: Dr. O'Neill?

DENNIS O'NEILL: Thanks, Dennis.

Well, ECHN has enjoyed caring for our communities for nearly 100 years. And the proposed transaction you've reviewed tonight will continue to fulfill the mission of ECHN and provide high-quality, compassionate care to the communities we serve.

I'd like to thank our panel members for their presence and responses this evening. And I'd like to also thank all of you again for coming and participating. And please enjoy the rest of your evening.

Thanks again.

(THEREUPON, THE MEETING WAS CONCLUDED

AT 7:30 P.M.)

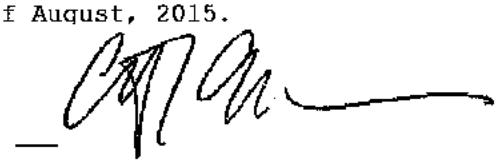
C E R T I F I C A T E

I hereby certify that I am a Notary Public, in and for the State of Connecticut, duly commissioned and qualified to administer oaths.

I further certify that said meeting was taken by me stenographically and reduced to typewriting under my direction, and the foregoing is a true and accurate transcript of the proceedings.

I further certify that I am neither of counsel nor attorney to any of the parties to said matter, nor am I an employee of any party to said matter, nor am I interested in the outcome of said matter.

Witness my hand and seal as Notary Public this 6th day of August, 2015.



Clifford Edwards

Notary Public

My commission expires: 9/30/2016

Preparing for the Future of ECHN

Letter of Determination Public Hearing

Manchester Memorial Hospital

Manchester, CT 06040

August 4, 2015

ECHN℠

Eastern Connecticut Health Network

AGENDA

Welcome & Introductions	Dennis G. O'Neill, MD, Chair of the Board, ECHN
Hearing Purpose, Statutory Requirements & Format	Dennis McConville, SVP, ECHN
Healthcare Landscape, Transaction Rationale & Process	Peter J. Karl, President & CEO, ECHN
Certificate of Need Letter of Determination	Joyce A. Tichy, SVP, Legal Counsel, ECHN
Questions & Answers	Panel

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The Proposed Transfer of Assets of Eastern Connecticut Health Network, Inc. and Affiliates to Prospect Medical Holdings, Inc.

ECHN℠
Eastern Connecticut Health Network

State Regulatory Process

Review by Office of Health Care Access (OHCA) and Office of the Attorney General (1)

* First step in process is the filing of a Letter of Determination
* Within thirty (30) days of filing of the Letter of Determination, the nonprofit hospital and the proposed purchaser hold a public hearing on the contents of the Letter of Determination.
* The hearing is to be transcribed, with the recording or transcription made available to the Commissioner of OHCA, the Attorney General, and members of the public upon request.
* The Commissioner and the Attorney General review the Letter of Determination. The Attorney General determines whether the transaction requires approval under the so-called "Conversion Statute" as a conversion of a non-profit to a for-profit.
* A joint review process is then undertaken by the Commissioner and the Attorney General.

(1) Section 19a-486a of the Connecticut general statutes

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State Regulatory Process

Statutory Standards – Review by the Attorney General (1)

* The Attorney General shall deny an application as not in the public interest if:
  * The transaction is prohibited by Connecticut statutory or common law governing nonprofit entities, trusts or charities.
  * The applicant fails to exercise due diligence in:
    * Deciding to transfer
    * Selecting the purchaser
    * Obtaining a fairness evaluation
    * Negotiating the terms and conditions of the transfer
  * The nonprofit hospital failed to disclose any conflict of interest.
  * The nonprofit hospital will not receive fair market value for its assets.

(1) Section 19a-486c of the Connecticut general statutes

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State Regulatory Process

Statutory Standards – Review by OHCA (1)

* The Commissioner of Public Health must deny an application unless a commitment has been made to provide care to uninsured and underinsured.
* The proposal is also reviewed under standard certificate of need guidelines, including public need, impact on financial strength of health care system in the state, whether proposal will improve quality, accessibility and cost-effectiveness of health care delivery in the region, etc.

(1) Section 19a-639 of the Connecticut general statutes

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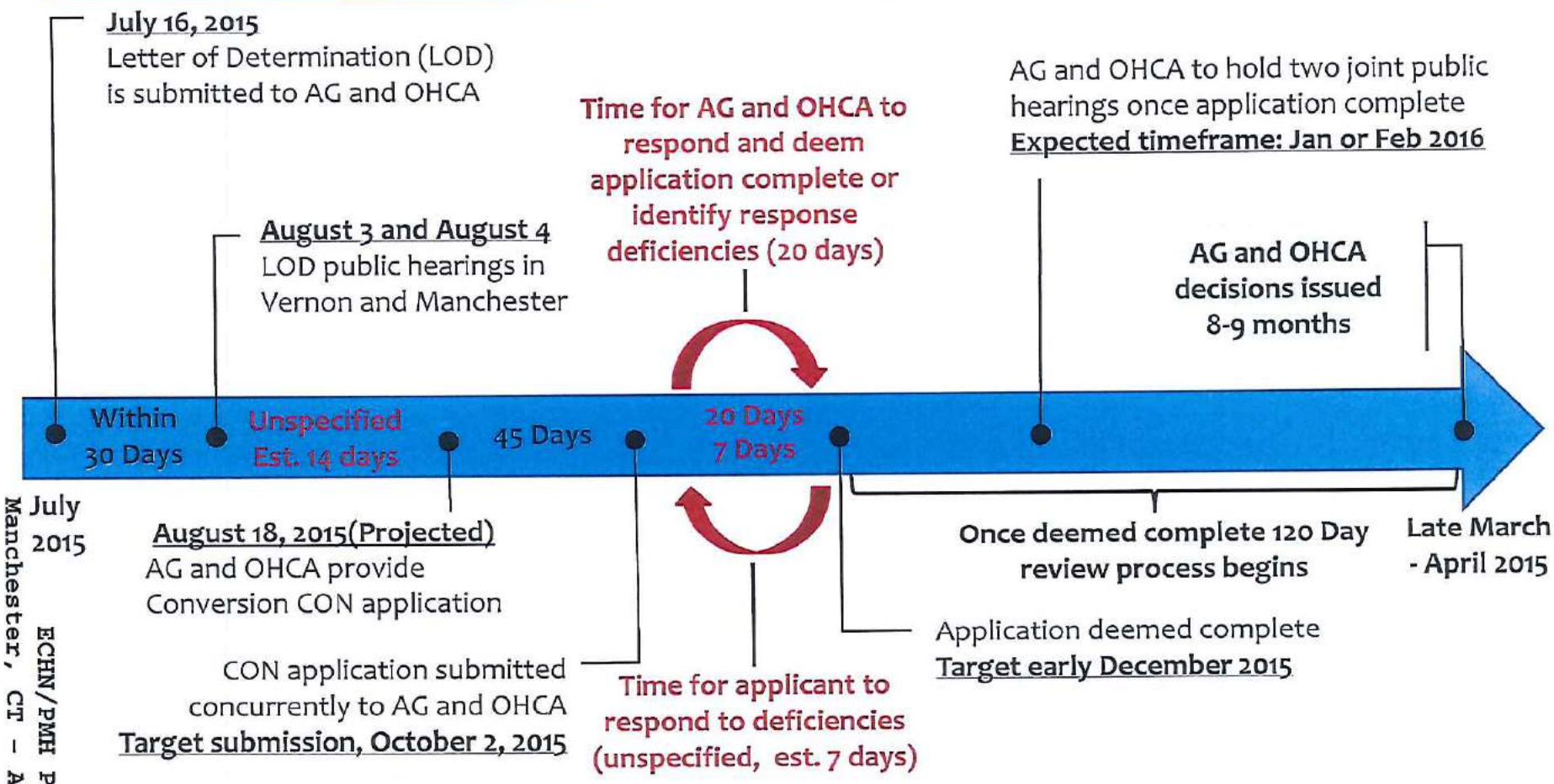
Conversion/CON Process Timeline



Note: Timeline shows estimated dates only and may change

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The Proposed Transaction

Prospect Medical Holdings to buy ECHN

* Continued operation of Manchester Memorial and Rockville General Hospitals, Woodlake at Tolland and VNHSC;
* Continued involvement of an advisory board that includes community representatives;
* Capital to fund new programs and invest in technology, facilities and equipment;
* Partnership with a leading organization that will bring decades of experience with population health management and value-based care;
* Establishment of a community foundation to oversee certain charitable funds; and
* Continuation of the ECHN brand and mission, including a continued commitment to charity care and indigent care.

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Preparing for the Future at ECHN

Our Mission : Our Community

* Caring for & serving the community, continuing our mission & vision
  * Improving your wellbeing with quality, compassionate health care
  * Preserving ECHN: its name, pride and institutions
  * Developing the next generation of physicians to serve you
* Preserving jobs
* Economic engine for eastern CT with over $165 million in salaries and $90 million purchased supplies & services annually

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Preparing for the Future at ECHN

Impact of Healthcare Reform (PPACA)

* More than insuring 32M more people
* Declining government payments to hospitals
* Focus on value, lowest cost and best results
* New payment systems with providers at risk
* New delivery models, community focused
* Major investments required

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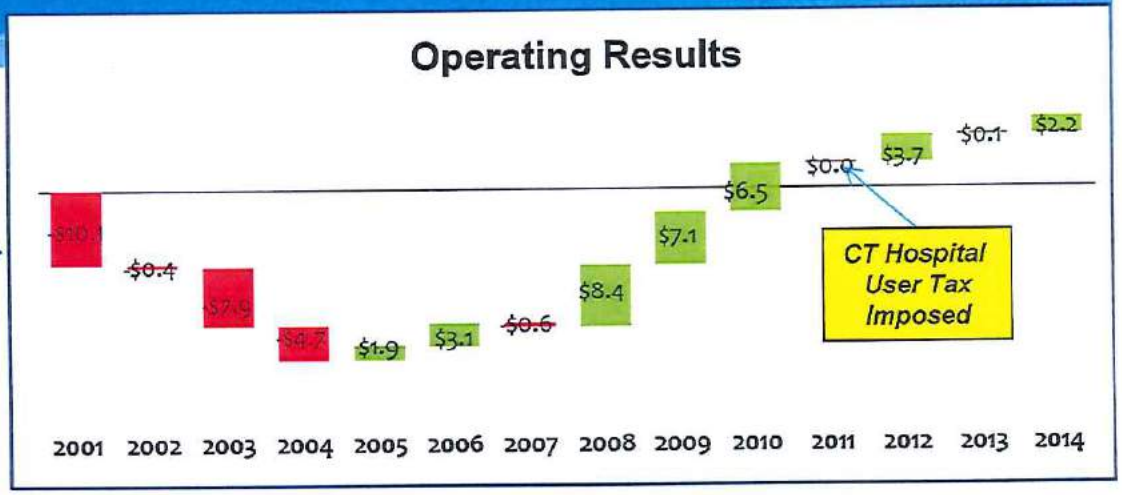
ECHN's Financial Challenges

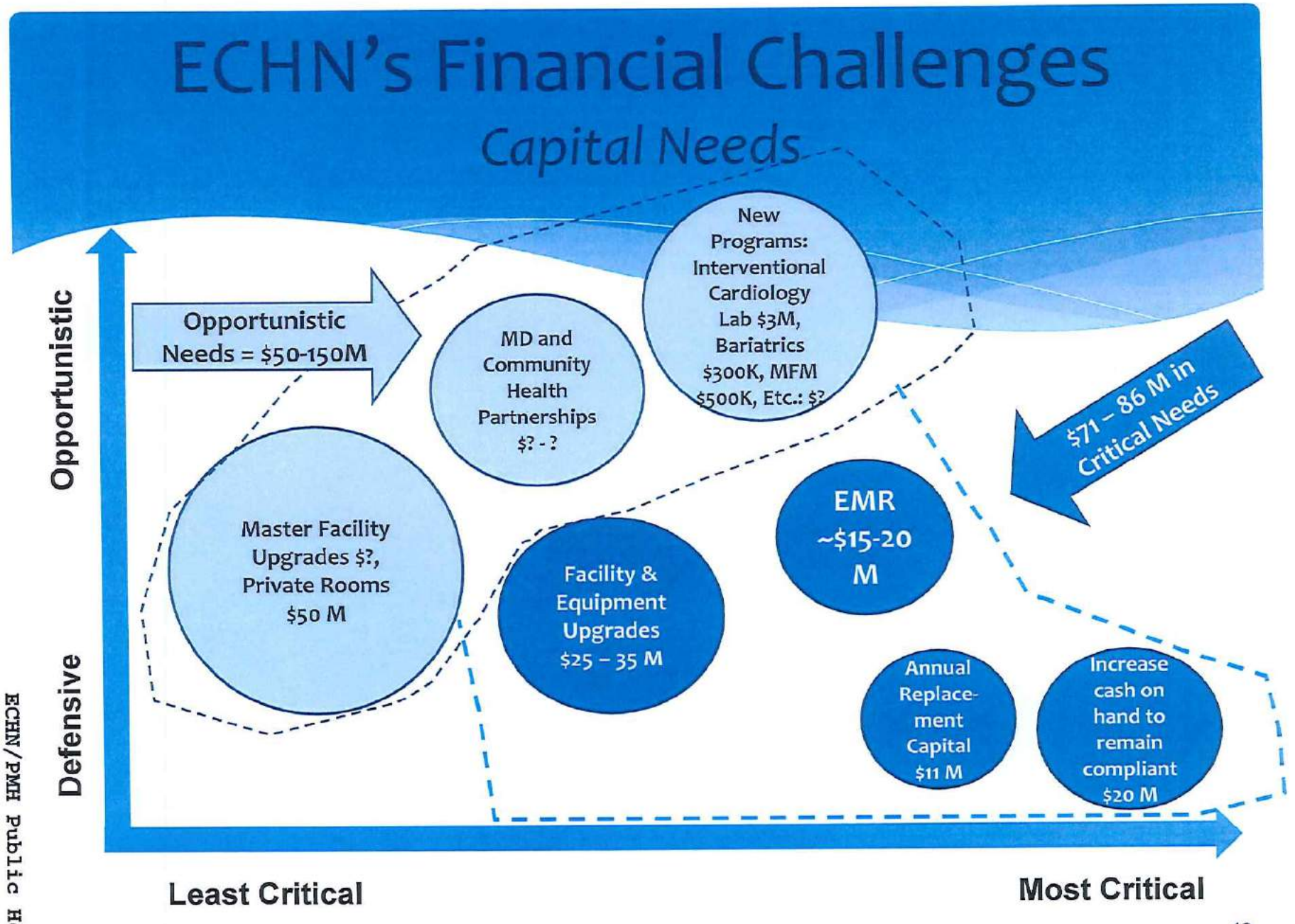
Low margins and growth in debt have forced ECHN to defer capital investments; our historical financial performance has left the organization with a large debt structure that cannot be mitigated through margin alone

1. Operations contributed only $9.3M total over the last 14 years: Operational deficits in 2001-2004 of $23.1 million required 6 years to be overcome



2. Long term debt and pension liabilities have grown 102% ($65M) in the last 14 years– annual debt service and pension contributions now take up the lions share of annual cash flows




ECHN's Financial Challenges
Capital Needs
Opportunistic
Defensive
Opportunistic Needs = $50-150M
New Programs: Interventional Cardiology Lab $3M, Bariatrics $300K, MFM $500K, Etc.: $?
MD and Community Health Partnerships $? - ?
$71 – 86 M in Critical Needs
Master Facility Upgrades $?, Private Rooms $50 M
EMR ~$15-20 M
Facility & Equipment Upgrades $25 – 35 M
Annual Replace-ment Capital $11 M
Increase cash on hand to remain compliant $20 M
Least Critical
Most Critical

12

Continuing Financial Challenges

Taxes and Reduced Government Payments

	FY 2014	FY 2015	FY 2016
CT State User Tax	(3,914,000)	(7,960,000)	(7,141,852)
CMS Sequestration	(1,104,000)	(2,208,000)	(2,208,000)
Medicaid Inpatient Modernization Program		(1,200,000)	(1,600,000)
Low Cost Hospital Pool Eliminated			(300,000)
Medicare Wage Index		(4,825,000)	(6,525,000)
	($5,018,000)	($16,193,000)	($17,774,852)

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Negative Forces into the Future

-Continued payment erosion from federal government

-Declining levels of payment from state government

-Payment reforms with more financial risk

-Continued pension obligations

-Rising costs

= ***Unsustainable results with an inability to REINVEST in ECHN***

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Preparing for the Future at ECHN

Process, Questions Answered

1 Should We Affiliate?

- Stand-alone scenario; how viable?
- Benefits of and Vision for, the Affiliation

2 If so,

- Which Partner Organizations are attractive?
- What Criteria will we use to evaluate them?
- How might each partner help us achieve our Vision ?

3 What can each potential partner organization offer ECHN?

- Enhance services; Attract top Clinicians
- Position us to be "Provider of Choice" east of the CT River
- Improve Finances and Access to Capital

4 How Attractive are the Prospective Partnership Proposals?

- Is there a compelling Business Case for each partnership?
- What is the proposed Deal Structure? Is it attractive?

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Preparing for the Future at ECHN

Why join another health care system?

Rationale

* Improve access to capital and afford investments
* Improve finances, reduce/eliminate debt
* Participate in the new payment systems
* Protect, preserve and grow local access to services

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The Request for Proposal Process:

* **RFPs were sent to 6 potential partners, both for-profit and non-profit.**
* **Responses were received from:**

1. **Hartford HealthCare**
2. **Saint Francis – Trinity Health**
3. **Prospect Medical Holdings**

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The combination of ECHN with Prospect Medical Holdings will secure the future of care and access for residents



* Aligned mission, vision & values
* Strong medical staff partner
* Extensive risk management experience
* Long history of population health management
* Track record of success in markets having large for profit and nonprofit hospital systems

Together with our Medical Staff, building a sustainable, thriving network of value-based care for our communities.

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What will be achieved?

* Continue our Mission, Vision & Values
* Protect Accessibility and Affordability of Care
* Continued Focus on Quality & Safety of Patient Care
* Continuously Improve Patient Satisfaction
* Ability to invest allowing resources for our medical staff, employees, and for patients' care and benefit

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Letter of Determination

1. Form of Transaction
2. Key Assets and Liabilities to be Acquired by Buyer
3. Key Assets and Liabilities Excluded from the Transaction
4. Medical Foundation
5. Local Advisory Board
6. Commitment to Maintain Community Support – Charity Care
7. Commitment to Maintain Hospitals and Continuum of Care Network
8. Employment Matters
9. Capital Commitment
10. No changes requested to services or changes to towns served

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Project Cost
Overview of Financial Provisions

Excluded Assets:	Donor restricted funds, cash & investments, cost report settlements
Purchase Price:	$105 Million, or $115 Million if refinancing obtained
minus/plus:	Net working capital
Minus:	Indebtedness
	Unfunded pension plan liability
	Post retiree health plan liabilities
	Special employee benefit liabilities (accrued vacation, etc.)
	Captive insurance liabilities
	Worker's compensation liabilities
	Joint venture interests not conveyed
	Asbestos liabilities
Capital Commitment:	$75 Million, reduced by amount of refinancing spent

** Risk of interim operations, stock market performance, etc. remain on ECHN prior to closing

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Public Comments & Questions

Panel:

* Peter Karl, President & CEO, ECHN
* Joyce Tichy, SVP, General Counsel, ECHN
* Michael Veillette, SVP, Chief Financial Officer, ECHN
* Mitchell Lew, MD, President, Prospect Medical Holdings
* Thomas Reardon, President, Prospect East Holdings

Moderator:

* Dennis McConville, SVP, Chief Strategy Officer, ECHN

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Eastern Connecticut Health Network, Inc.

Proposed Asset Purchase by Prospect Medical Holdings, Inc.

OHCA Docket Number: 15-31216-486 and Attorney General Docket Number: 15-486-01

Written Statements Submitted at Public Hearing –
Manchester Memorial Hospital, August 4, 2015

Letter of Recommendation for the Partnership between
Eastern Connecticut Health Network and Prospect Medical Holdings

To: Office of Health Care Access and the State Attorney General
From: Barbara L. Phillips, MD, Family Medicine Center, LLC
Re: Certificate of Need application for hospital conversion

Dear Colleagues and Community Members:

My name is Dr. Barbara Phillips, and I support the proposed partnership of ECHN and Prospect Medical Holdings. I speak as a community physician on behalf of myself and my patients, and also as the chair representing three organizations: the Eastern Connecticut Individual Provider Group which has 309 member physicians and advanced practice clinicians, the Eastern Connecticut Physician Hospital Organization and now the Clinically Integrated Network of Eastern Connecticut.

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Thank you for your attention. I am happy to be available for any questions regarding these concerns.
Barbara L. Phillips, MD

ECHN™
Eastern Connecticut Health Network

Eastern Connecticut Health Network
71 Haynes Street
Manchester, CT 06040
860.533.3414
www.echn.org

July 27, 2015

The Honorable George C. Jepsen
Attorney General
Office of the Attorney General
55 Elm Street
Hartford, CT 06106

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

Dear Attorney General Jepsen and Commissioner Mullen,

I apologize for not being able to attend this forum in person, but would like to express my opinion on the acquisition publically. As the Chair and Senior Medical Director of the Department of Emergency Medicine and the Service Line Director for Emergency Services at ECHN, I would like to express my excitement about the future acquisition of ECHN by Prospect Medical Holdings (PMH). For the past several years we have been facing one financial challenge after the next in the form of hospital taxes, sequestration, Medicare reimbursement cuts, pension reform, or unfunded quality reporting mandates. The only way we have been able to meet these challenges has been to "do more with less".

My view on Healthcare is that we are facing the same struggles now that the smaller department stores and hardware stores faced a decade or more ago with the emergence of Walmart and Home Depot. Their ability to purchase goods in such large quantities made it impossible to compete with their prices, and many of the mom and pop stores eventually went out of business. This is the path that I believe ECHN would be on if we didn't proceed with this acquisition.

I, as a healthcare provider, and ECHN as a healthcare system, have an obligation to the patients we serve. Our obligation is to be there for them in their time of need and to provide the expertise, staff, and equipment necessary to diagnose and treat them at any hour of the day or night. The acquisition of ECHN by a larger system is the only option that would allow us to continue our mission of "improving your well-being by providing high-quality, compassionate healthcare." Without the ability to join a larger system, our costs will be higher than our competitors, our ability to recruit skilled physicians and nurses will become more difficult, and we would eventually find ourselves out of business.

I have been asked many times, "Why partner with PMH, rather than with one of the other large systems closer to Manchester and Rockville?" My desire for PMH is based on my belief that they would be the best option for both the patients we serve and for the staff we employ. In order to succeed, PMH has to help grow our system to allow us to directly compete with our local competitors. I feel that if we had chosen to partner with a nearby competitor, we would become victim to consolidations of services and locations. This would directly impact access to healthcare for our patients in our communities.

In my 15 years at ECHN, I have watched our competitors advertise their cutting edge therapies during the prime time news and open healthcare centers in our own neighborhood. I've read about their latest minimally invasive cardiac procedures and have heard on the radio about their world-class stroke therapies. It would be really nice to have the access to capital funding that would allow us to advertise the cutting-edge programs we have here at ECHN. However, the ability to grow and advertise these types of services is becoming virtually impossible under the financial constraints we are facing. With the implementation of the Affordable Care Act, the increase in Medicaid volume, and the State's tax on hospitals, remaining independent is futile and no longer an option. A partnership with PMH will afford us access to the clinical expertise our patients need, as well as access to the desperately needed capital funding so that we can resume investing in our technology, staff, and infrastructure. This partnership will position ECHN competitively for the foreseeable future of healthcare.

Sincerely,

R. Carroll MD

Robert Carroll, MD, FACEP, MBA
Chair and Senior Medical Director
Department of Emergency Medicine, ECHN

ECHN/PMH Public Hearing
Manchester, CT - August 4, 2015
OHCA Docket Number: 15-31216-486
Attorney General Docket Number: 15-486-01

ECHN
Eastern Connecticut Health Network, Inc.
Department of Medical Affairs
860-647-6866

July 27, 2015

The Honorable George C. Jepsen
Attorney General
Office of the Attorney General
55 Elm Street
Hartford, CT 06101

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

Dear Attorney General Jepsen and Commissioner Mullen:

I am writing this letter to express my total support for Prospect Medical Holdings acquisition of Eastern Connecticut Health Network. I have lived in this community and have been with ECHN for 31 years as a practicing emergency physician, Chair of Emergency & Ambulatory Care, Medical Director of EMS, and currently as Chief Medical Officer. These roles have enabled me to attain a deep understanding of our community's needs and how our health system can best continue to provide excellent care and improve the health of the residents of the towns we serve.

Clinical advances, maturation of health information technology, increasing economic pressures, and policy and legislative initiatives including the Affordable Care Act have driven unprecedented change in the healthcare system during the past 5 years. What worked before, no longer works today, and won't work in the future.

ECHN has completed a carefully planned due diligence process to determine what best meets our future needs. I was part of the team that visited Prospect Medical Holdings' health systems in Los Angeles, CA and Providence, RI. While each of the health systems is addressing its local needs, we found three things in common: (1) substantial capital investment, (2) significant growth of clinical services, and (3) highly satisfied community physicians. It is rare to see *any one* of these, and almost unheard of to see all three in one place. Prospect Medical Holdings has applied its extensive experience in health system leadership

& management, care coordination, independent physician association alignment, and value-based purchasing contracting to advance high quality patient care, while thoughtfully managing cost.

Prospect Medical Holdings is by far the best option for ECHN for the following reasons:

- It is the best "cultural fit". It has extensive experience with community hospitals serving communities very much like our own. Its leadership is focused on innovation and growth and its strategy execution is agile.
- It will bring much-needed capital investment to ECHN to ensure financial stability and future growth.
- Prospect Medical Holdings is much more than a "hospital company". It is healthcare services company. While it very successfully operates its 13 current hospitals, it has fully integrated 9,000 independent physicians and other community care givers into its system model which is fully compatible with the Affordable Care Act. Through its care management programs, health coaching structure, and sophisticated health information exchange and analytics capabilities, it helps patients and families navigate the complexities of the healthcare system, while reducing expenditures for non-value-added services. In short, Prospect Medical Holdings has already mastered what most other health systems are *talking about* doing in the future.

I believe that Prospect Medical Holdings is the best partner for ECHN and hope that you will be able to support this choice through the regulatory process. Thank you for your consideration of this request.

Sincerely,

Joel J. Reich, MD, FACEP
Chief Medical Officer/Senior Vice President for Medical Affairs

State of Connecticut

GENERAL ASSEMBLY

August 3, 2015

The Honorable George C. Jepsen, Attorney General
Office of the Attorney General
55 Elm Street, Hartford, CT 06106

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

Dear Attorney General Jepsen and Commissioner Mullen,

We are pleased to endorse the proposed transaction including a formal public hearing process with public input for Eastern Connecticut Health Network to be acquired by Prospect Medical Holdings. It will preserve and enhance our residents' access to the community-based care that they have relied on for generations, for themselves and their families. Prospect has a strong track record of collaborating with physicians, community providers, payers and other key stakeholders to provide high-quality, cost-effective services to the communities it serves.

We have an obligation to support the efforts of our community hospitals, which are striving to continuously improve quality while reducing cost but struggling with lower payments for services and continued cuts in state and federal reimbursements for care. It is important for state public servants to ensure that our constituents have local access to quality health care that is affordable. Prospect has decades of experience and success with provider payment risk arrangements now emerging in the state. With their experience and resources, the result will be better care for individuals, better health for the residents of eastern and lower costs for health care. Access to capital will allow ECHN to reform and strengthen its care delivery network to offer even more community-based services and keep its two hospitals, Manchester Memorial and Rockville General, viable to meet patient needs and expectations.

Therefore, we encourage OHCA and the Office of the Attorney General to look favorably upon the proposed transfer of assets as described in the Certificate of Need Determination Letter recently filed by ECHN.

Sincerely,

Steve Cassano
State Senator
Fourth District

Tony Guglielmo
State Senator
Thirty-Fifth District

Tim Larson
State Senator
Third District

Mark Tweedie
State Representative
Thirteenth District

GEORGE JEPSEN
ATTORNEY GENERAL

55 Elm Street
P.O. Box 120
Hartford, CT 06141-0120

Office of the Attorney General
State of Connecticut

August 6, 2015

VIA ELECTRONIC MAIL AND FACSIMILE
Dennis McConville, Senior Vice President &
Chief Strategy Officer
Eastern Connecticut Health Network, Inc.
71 Haynes Street
Manchester, Connecticut 06040

Jonathan Spees, Senior Vice President
Prospect Medical Holdings, Inc.
10780 Santa Monica Blvd., Suite 400
Los Angeles, California 90025

Re: Eastern Connecticut Health Network, Inc. – Proposed Asset Purchase by Prospect Medical Holdings, Inc. - OHCA Docket No. 15-31216-486 and Attorney General Docket No. 15-486-01

Dear Mr. McConville and Mr. Spees:

After our review of the certificate of need determination letter submitted by you, dated July 16, 2015, we have determined that the proposed transfer of certain assets of the Eastern Connecticut Health Network, Inc. ("ECHN") to Prospect Medical Holdings, Inc. ("PMH") requires approval pursuant to Conn. Gen. Stat. § 19a-486 et seq.

Accordingly, the parties to the proposed asset purchase (the "Asset Purchase") shall submit to the Commissioner of Public Health (the "Commissioner") and to the Attorney General, within sixty (60) days of the date of the mailing of this application form, an application for approval of the Asset Purchase. Please mail two (2) complete hard copies and two (2) complete electronic copies of the application for approval to the following address:

Office of the Attorney General
55 Elm Street, P.O. Box 120
Hartford, Connecticut 06141-0120
Attn: Gary W. Hawes, AAG

Please mail seven (7) complete hard copies and three (3) complete electronic copies of the application for approval to the following address:

Commissioner of Public Health
410 Capitol Avenue
Hartford, Connecticut 06134
Attn: Kevin Hansted, Staff Attorney

We request that your application for approval include the following information (Conn. Gen. Stat. § 19a-486a(c)), address the following issues (Conn. Gen. Stat. §§ 19a-486c and 19a-486d), and be presented in substantially the following format:

1. Identify the contact information for ECHN and PMH, including the individual(s) to whom the Attorney General and the Department of Public Health shall submit bills for contracts with experts or consultants.

2. Provide an executive summary of the application for approval.

3. Describe the terms of the proposed Asset Purchase. This section should include, but is not limited to:

   a. descriptions of ECHN, PMH, the assets to be transferred pursuant to the Asset Purchase, any assets excluded from transaction, the assumed and excluded liabilities of the Asset Purchase, the commitment to spend $75 million dollars on capital items, and any plan to expand or acquire new programs or services;

   b. a financial analysis of the proposed transaction that identifies the source of funding for PMH's initial purchase price, the uses of the proceeds of the transaction, and the valuations of included and excluded assets; and

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

4. Provide copies of all contracts, agreements, memoranda of understanding, and pro forma financial statements relating to the proposed Asset Purchase.

5. Describe the due diligence undertaken by ECHN in deciding to enter into the Asset Purchase. This section should include, but is not limited to, considerations regarding the current financial condition of ECHN and any projected financial condition of ECHN, any professional assessments of or reports regarding ECHN or PMH, any and all alternatives explored by ECHN or other offers received by ECHN, the reasons for rejecting such alternatives and offers, ECHN's selection of PMH, and the specific terms of the Asset Purchase. In addition, the parties should discuss the due diligence in obtaining the fairness evaluation required by Conn. Gen. Stat. § 19a-486a(c)(5), including providing a copy of said independent expert's resume or other

documentation of his or her qualifications and describing the process undertaken to identify and retain this person as an independent expert.

6. Describe any and all potential conflicts of interest between, among, or pertaining to, at a minimum, any and all board members, officers, key employees, and experts of ECHN, PMH, any other party to the transaction, and any person or entity that performed assessments requested in this application. In addition, describe the due diligence taken to determine the existence of any conflicts of interest, including how ECHN and PMH defined "conflict of interest" for purposes of the response to this question.

7. Provide an assessment of the fair market value of the transaction, including, but not limited to, a discussion regarding whether the fair market value of ECHN's assets has been manipulated. Describe how the assessment was performed (including any method to verify results of the assessment), the persons that performed the assessment, and their qualifications to perform the assessment. Provide copies of all documents and statements, financial and otherwise, in support of this assessment.

8. Provide an assessment of whether the transaction will place ECHN's assets, including but not limited to Manchester Memorial Hospital ("MMH") and Rockville General Hospital ("RGH"), at unreasonable risk. Provide copies of all documents and statements, financial and otherwise, in support of this assessment. Describe how the assessment was performed (including any method to verify results of the assessment), the persons that performed the assessment, and their qualifications to perform the assessment.

9. Provide an assessment of whether any managerial contracts to be entered into are for reasonable fair value. Provide copies of the managerial contracts and of all documents and statements, financial and otherwise, in support of the fair value assessment. Describe how the assessment was performed (including any method to verify results of the assessment), the persons that performed the assessment, and their qualifications to perform the assessment.

10. Describe the entity to which the fair market value of ECHN's assets will be transferred, including the funding of the entity, its corporate structure, governance and membership, and the charitable purpose of the entity. Provide copies of documents related to the creation, structure, and purpose of the entity.

11. Identify any and all assets of ECHN that are subject to a charitable use restrictions imposed by a donor and the intended handling of those assets as a result of the proposed Asset Purchase. Please provide a listing of these assets in Microsoft Excel format. Also, please provide copies of the original gift instruments for each gift identified. Only one hard copy of the gift instruments needs to be produced to the Attorney General.

12. Provide copies of all correspondence, memoranda, and any other documents that include the terms of any other offers to transfer assets or operations or change control of operations received by ECHN.

13. Provide a copy of a fairness evaluation by an independent person who is an expert in such Asset Purchases that includes the expert's evaluation of each of the criteria set forth in Conn. Gen. Stat. § 19a-486c(a). Also provide copies of the information and documents relied upon by the expert in the preparation and issuance of the fairness evaluation.

14. Please provide a copy of the transcript for the informal hearing required by Conn. Gen. Stat. § 19a-486a(c).

15. Explain how ECHN determined the need for the Asset Purchase and discuss the benefits of this Asset Purchase for MMH and RGH (collectively, the "ECHN Hospitals"), respectively (provide discussion on history and time-line).

16. For each of the ECHN Hospitals, provide a listing of the hospital's current service lines and service locations and describe any planned changes to either the service lines or service locations as a result of the Asset Purchase. Provide an explanation for each change and detail how hospital's affiliation with PMH will aid in service line development.

17. Describe the existing populations served by the ECHN Hospitals and how the Asset Purchase will affect these populations. Include demographic information.

18. How will the for-profit nature of PMH affect the provision of health care in the community?

19. Provide a transition plan for the Asset Purchase and describe how ECHN and PMH (collectively, the "Applicants") will ensure continuity of care and hospital services through this plan.

20. Understanding that the proposal is for PMH to exercise common ownership over MMH and RGH, how will care be coordinated between the two hospitals? Please explain in detail how care coordination efforts will be aided by the proposed Asset Purchase (i.e., how they will be different from ECHN's present efforts). Provide any written plans documenting this coordinated approach to care for the patient population served.

21. Provide a description of the relationship between the proposal and the Statewide Health Care Facilities and Services Plan.

22. Please explain how the post transaction ECHN will address the needs of service area residents with respect to prevention and treatment of diseases and conditions in relation to ECHN's most recent Community Health Needs Assessment ("CHNA") and the priority of needs listed therein. Please provide a copy of the most recent CHNA.

23. Provide a description of plans that the Applicants will implement to control cost, such as discharge care coordination, implementation of electronic medical records and emergency department triaging to the appropriate level of care. In responding to this question, report any anticipated savings from the following expense categories for the ECHN Hospitals: salaries and wages, fringe benefits, contractual labor fees, medical supplies and pharmaceutical costs, depreciation and amortization, bad debts, interest expense, malpractice expense, utilities, business expense and other operating expenses.

24. Provide a description of the Applicants' plans to continue to provide services to the uninsured and underinsured. In responding to this question, please describe any changes to the ECHN Hospitals' current charity care, uncompensated care and financial assistance policies and procedures, and hospital bed funds that will result from the Asset Purchase. Describe any plans Applicants have to work with other providers in the community, such as federally qualified health centers or community health centers, to provide specialty care to patients, or low cost programs that the Applicants will provide in the area that are tailored toward the uninsured or underinsured.

25. Submit a list of all key professional, administrative and clinical department heads related to this proposal. Additionally, provide a copy of the Curriculum Vitae of each individual listed.

26. Provide evidence as to how the Asset Purchase will improve quality, accessibility and cost effectiveness of health care delivery in the region, including but not limited to, provision of or any change in the access to services for Medicaid recipients and indigent persons.

27. Provide the corporate organizational chart prior to and after the proposed Asset Purchase, including all affiliates. For the organizational chart that depicts the post-Asset Purchase structure, working upward on the chain of ownership from the ECHN Hospitals, please: (i) describe the nature of the ownership and control that each entity has in the entity directly below it; (ii) describe the major business activities/functions of each entity; (iii) provide the principal place of business address for each entity; and (iv) provide the name and business address of each individual currently serving as a member of the governing body of each entity.

28. Please provide the date on which both MMH, RGH, and ECHN filed audited financial statements with OHCA. Applicants may reference these statements in responding to questions. In addition, provide a copy of PMH's most recent audited financial statements.

29. List all funding or financing sources for the $105,000,000 in projects costs (the "Project Costs") estimated for this acquisition by PMH, including PMH's commitment to invest $75,000,000 in-routine and non-routine facility improvements, general upgrades and renovations, deferred maintenance items, and initiatives to develop, expand or acquire

new programs or services, and to support the recruitment of medical staff (the "Capital Commitment"). Provide applicable details such as interest rate; term; monthly payment; pledges and funds received to date; letter of interest or approval from a lending institution.

30. In reference to the Capital Commitment, provide the following:

    a. A copy of any related capital expenditure plan;

    b. Define the terms "routine" and "non-routine" facility improvements and "deferred maintenance items". Provide specific examples, of each.

31. Please explain in detail the reasons why, and with respect to each item, the extent to which, the Project Costs related to this proposal may be adjusted for each of the following:

    a. outstanding indebtedness;
    b. pension liabilities;
    c. retiree health benefits;
    d. captive insurers;
    e. capital leases;
    f. asbestos abatement; and
    g. joint venture interests that may not transfer.

32. How, if at all, will non-approval by any of the joint venture interests referred to in Question 31(g) above affect the Asset Purchase?

33. Please explain in detail the terms of the Capital Commitment and in particular:

    a. how it will be allocated between MMH and RGH, including the annual amounts projected to be available to each hospital;

    b. the capital projects that are deemed top priorities by the Applicants for both of the hospitals;

    c. the service improvements for both of the hospitals that are deemed top priorities by the Applicants;

    d. a list of capital projects and service improvements that are expected to be carried out within the first three years following the closing date; and

    e. discuss the ability of ECHN to address items listed in 33(b) and 33(c) for each of the hospitals without the approval of this proposal.

34. Describe in detail how this proposal will affect the financial strength of the State's health care system and will be financially feasible.

35. Please provide the current payer mix for both of MMH and RGH and the projected payer mix for both respective hospital after the Asset Purchase (based on the number of patients, not based on revenue) in the following reporting format:

Table 1: Patient Population/Payer Mix

Payer	Current FY 20__**		Projected					
			FY 20__**		FY 20__**		FY 20__**	
	Discharges	%	Discharges	%	Discharges	%	Discharges	%
Medicare*								
Medicaid*								
CHAMPUS & TriCare								
Total Government								
Commercial Insurers								
Uninsured								
Workers Compensation								
Total Non-Government								
Total Payer Mix								

* Includes managed care activity.

** Fill in years. Ensure the period covered by this table corresponds to the period covered in the projections provided. New programs may leave the "current" column blank.

36. Provide the assumptions used to project the patient population/payer mix after the proposed Asset Purchase.

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

    a. Financial Worksheet (C) – for ECHN, MMH, RGH (for MMH and RGH, hospital only data, no affiliates) and PMH without the CON project (columns 1, 2 5, 8 & 11) and with the CON project and incremental to the CON project (remainder columns); and

b. Submit Financial Worksheet (C) using the same page and print layouts (size, font, page orientation, margins, etc.) as provided by OHCA.

Note that the actual results for the fiscal year reported in the first column must agree with ECHN's, MMH's and RGH's audited financial statements. The projections must include the first three full fiscal years of the project.

38. Provide the assumptions utilized in developing Financial Worksheet (C) (e.g., full-time equivalents, volume statistics, other expenses, revenue and expense percentage increases, project commencement of operation date, etc.).

39. Explain any projected incremental losses from operations contained in the financial projections that result from approval of the Asset Purchase and operation of MMH, RGH, ECHN and PMH.

40. Please describe any anticipated change to existing reimbursement contracts with payers (e.g., Medicare, Medicaid, commercial) as a result of the Asset Purchase. Is it assumed in the financial projections that Applicants will willingly negotiate with the payers that ECHN currently has contracts with?

41. Please explain in detail how the proposed Asset Purchase will be able to assure satisfaction of ECHN's and/or both of MMH's and RGH's debt and pension obligations.

42. For each the ECHN Hospitals, please address the following regarding staffing at the hospital by completing "Staffing Attachments I&II."

a. Provide the levels of staffing for fiscal year ("FY") 2015 broken out as follows:

i. Average patient to nursing staff ratios per shift (a.m., p.m. and overnight) for both department and/or unit of the hospital;

ii. The same information as provided in subsection (a)(i) above showing the RN to patient ratio only; and

iii. The average nursing hours per patient day (NHpPD) for both department and/or unit of the hospital (all nursing staff should be included in the calculation of nursing hours).

b. Provide the projected levels of staffing by department and/or unit for the hospital for the first three (3) full FYs following approval of the Asset Purchase broken out as follows:

i. Average patient to nursing staff ratios per shift (a.m., p.m. and overnight) for both department and/or unit of the Hospital; and

ii. The same information as provided in subsection (b)(i) above showing the projected RN to patient ratio only.

43. For each of the ECHN Hospitals, provide a detailed explanation by department and/or unit as completed by the Applicants in Staffing Attachment I, to reconcile any differences between FY 2015 nursing staff levels and those projected for the first three (3) full FYs following approval of the Asset Purchase.

44. For each of the ECHN Hospitals, describe any other hospital-employed or hospital-contracted staff besides nursing staff (e.g., hospitalists, mid-level providers, therapists, etc.) that were engaged to provide direct patient care at the hospital (collectively, "Ancillary Caregivers") for FY 2015 broken out as follows:

    a. The type of Ancillary Caregivers and the department and/or unit to which such staff was assigned;

    b. The average number of hours per week that such Ancillary Caregivers provided patient care for the department and/or unit; and

    c. For the first three (3) full FYs following approval of the Asset Purchase, the average number of hours per week that such Ancillary Caregivers are projected to provide patient care for both department and/or unit of the hospital described in subsection (a) above.

45. For each of the ECHN Hospitals, provide a detailed explanation by department and/or unit to reconcile any differences between the average number of hours per week that the Ancillary Caregivers described in Question 44 above provided patient care in FY 2015 with those projected for the first three (3) full FYs following approval of the Asset Purchase.

46. For each of the ECHN Hospitals, provide evidence that the proposed staffing for nursing staff and Ancillary Caregivers for the first three (3) full FYs following approval of the Asset Purchase meet all Connecticut Department of Public Health ("DPH") staffing requirements and assure continued access to high quality and affordable health care. Be sure to cite the appropriate DPH regulations and/or other industry benchmarks as applicable.

47. Applicants are required to provide copies of the most recent CMS statements of deficiencies and plans of correction (CMS Form 2567) for all hospitals owned by PMH. Provide these documents in an electronic format only. PDF file on a CD to accompany the responses. No paper copies required.

48. Provide a copy of, and describe any changes to, any of the following policies and procedures that will be in place at MMH and RGH if the Asset Purchase is approved:

    a. hospital collection policies (including charity care and bad debt);

    b. annual or periodic review and/or revision to the hospital's pricing structure (the chargemaster or pricemaster); and

c. the annual or periodic market rate assessment for the hospital.

49. MMH and RGH have provided OHCA with their annual FY 2015 combined pricemasters, which was most recently updated for the month of June 2015. With respect to this submission please answer the following:

a. Will the pricemaster change as a result of the Asset Purchase?

b. If so, please identify any anticipated increases or decreases to the pricemaster as a result of the Asset Purchase.

c. Please quantify the overall percentage increase or decrease in the pricemaster that is anticipated in subsection (b) above and explain the rationale for such change.

50. Please provide monthly financial statistics reports for the months of April, May and June for FY 2015, current month and year-to-date, and comparable period for FY 2014 to OHCA, for MMH and RGH, ECHN and PMH, with the Application and thereafter on a monthly basis for both month (formatted side by side), until a public hearing in this matter is held. The following financial measurements/indicators should be addressed in the reports:

Monthly Financial Measurement/Indicators

A. Operating Performance
Operating Margin
Non-Operating Margin
Total Margin
Bad Debt as % Gross Revenue
B. Liquidity
Current Ratio
Days Cash on Hand
Days in Net Accounts Receivables
Average Payment Period
C. Leverage and Capital Structure
Long-term Debt to Equity
Long-term Debt to Capitalization
Unrestricted Cash to Debt
Times Interest Earned Ratio
Debt Service Coverage Ratio
Equity Financing Ratio
D. Additional Statistics
Income from Operations
Revenue Over/(Under) Expense
EBITDA
Cash from Operations

Cash and Cash Equivalents
Net working Capital
Unrestricted Assets
Credit Ratings (S&P, FITCH and Moody's)

51. For each of the ECHN Hospitals, provide a copy of the hospital's IRS Form 990 for tax year ending September 30, 2014 and with respect to the amounts listed on both line item within Part 1, Section 7 of Schedule H ("Financial Assistance and Certain Other Community Benefits at Cost"), provide a projected amount for both line item for the first three (3) tax years following the Asset Purchase. Please note that it is understood that MMH and RGH will not file an IRS Form 990 following the Asset Purchase. This question is directed at determining the amount of programmatic and financial support that the hospitals will continue to provide in these community benefit categories. In providing this information, please elaborate on the specific activities included and how the projections demonstrate PMH's commitment to maintain and adhere to ECHN's current policies regarding charity care, indigent care, community volunteer services and community outreach services or to adopt other policies that are at least as favorable to the community as ECHN's current policies.

52. For each of the ECHN Hospitals, with respect to the amounts listed on both line item within Part II of Schedule H of the Hospital's IRS Form 990 for tax year ending September 30, 2014 ("Community Building Activities"), provide a projected amount for both line item for the first three (3) tax years following the Asset Purchase. Please note that it is understood that MMH and RGH will not file an IRS Form 990 following the Asset Purchase. This question is directed at determining the amount of programmatic and financial support that the hospitals will continue to provide in these community building activity categories. In providing this information, please elaborate on the specific activities included and how the projections demonstrate PMH's commitment to maintain and adhere to ECHN's current policies regarding charity care, indigent care, community volunteer services and community outreach services or to adopt other policies that are at least as favorable to the community as ECHN's current policies.

53. Please discuss whether the Asset Purchase is expected to achieve an improved negotiating position with vendors and/or payers and, if such an improved negotiating position is anticipated, how it will translate into tangible savings for the consumer of health care services. Provide a response that both describes any anticipated improvements in detail and quantifies the expected results for the consumer.

54. Provide details of plans to be put in place to ensure the proposed health care services provided by the Applicants adhere to the National Standards on Culturally and Linguistically Appropriate Services (CLAS) to advance health equity, improve quality and help eliminate health care disparities in the projected service area. (For more details on CLAS standards see http://minorityhealth.hhs.gov/Default.aspx#sthash.U320zUXq.dpuf.)

55. What criteria will PMH use to offer current employees employment post transaction or in any new entities that may be formed as a result of this proposal? For those employees that will be employed post transaction by the Applicants, what is the projected difference in salary for current employees and similarly situated employees at other hospitals operated by PMH in similar markets?

56. Please provide information regarding whether any health care providers or insurers have an ownership interest in PMH.

57. Please provide information on the relationship, if any, PMH's existing medical group segment will have to this proposal.

58. Please identify PMH's five (5) most recent acute care hospital acquisitions and, for each acquisition, describe in detail how:

    (a) the acquisition improved access to care for the hospital's service area;

    (b) the acquisition improved the quality of health care for the hospital's service area;

    (c) the acquisition lowered the cost of health care for the hospital's service area; and

    (d) with respect to subsections (a) through (c) above, please demonstrate these improvements/cost reductions through benchmarks and other data that are commonly used in the hospital industry.

After receipt of your application for approval, the Commissioner and the Attorney General shall review the submission to determine whether the application for approval is complete. If not, the Commissioner and the Attorney General shall provide written notice of any deficiencies within twenty (20) days of receipt of the application for approval.

Should you have any questions regarding this application form, your application for approval, or any other issues relating to the Commissioner's and Attorney General's review, please do not hesitate to contact either Steven Lazarus at the Department of Public Health (860-418-7012; Steven.Lazarus@ct.gov) or Assistant Attorney General Gary W. Hawes at the Office of the Attorney General (860-808-5020; gary.hawes@ct.gov).

Very truly yours,

Perry Zinn Rowthorn
Deputy Attorney General

Janet M. Brancifort, MPH
Deputy Commissioner, DPH

Attachments

cc: Steven W. Lazarus, Associate Health Care Analyst, OHCA
Gary W. Hawes, Assistant Attorney General, OAG

Staffing Attachment I

Current Staffing Levels

Name of Hospital Unit or Department	Average Nurse to Patient Ratio			Average RN to Patient Ratio			Average Nursing Hours per Patient Day
	Shift #1 AM	Shift #2 PM	Shift #3 overnight	Shift #1 AM	Shift #2 PM	Shift #3 overnight	
Department or Unit Name	1:xxx	1:xxx	1:xxx	1:xxx	1:xxx	1:xxx	0.00
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Staffing Attachment II

	Projected Staffing Levels FY 201x						Projected Staffing Levels FY 201x						Projected Staffing Levels FY 201x					
	Average Nurse to Patient Ratio			Average RN to Patient Ratio			Average Nurse to Patient Ratio			Average RN to Patient Ratio			Average Nurse to Patient Ratio			Average RN to Patient Ratio		
Name of Hospital Unit or Department	Shift #1 AM	Shift #2 PM	Shift #3 overnight	Shift #1 AM	Shift #2 PM	Shift #3 overnight	Shift #1 AM	Shift #2 PM	Shift #3 overnight	Shift #1 AM	Shift #2 PM	Shift #3 overnight	Shift #1 AM	Shift #2 PM	Shift #3 overnight	Shift #1 AM	Shift #2 PM	Shift #3 overnight
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August 14, 2015

VIA HAND-DELIVERY



The Honorable George C. Jepsen
Attorney General
Office of the Attorney General
55 Elm Street
Hartford, CT 06106

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

Re: Eastern Connecticut Health Network, Inc. ("ECHN")
Proposed Asset Purchase by Prospect Medical Holdings, Inc.
OHCA Docket Number: 15-31216-486
Attorney General Docket Number: 15-486-01

Dear Attorney General Jepsen and Commissioner Mullen:

In accordance with Section 19a-486a(c) of the Connecticut General Statutes we are enclosing copies of the transcripts and recordings from the two public hearings held on ECHN's Certificate of Need Determination Letter, which was filed with your offices on July 16, 2015.

The first hearing was held at the Vernon Senior Center on August 3, 2015. A second hearing was held at Manchester Memorial Hospital on August 4, 2015. Both hearings were recorded, and digital copies of the recordings were transcribed by Del Vecchio Reporting Services, LLC. The digital recordings are enclosed on DVD.

Also enclosed are copies of the following, in paper form and on a disk (in .pdf format), for each of the hearings:

1. Transcripts for each hearing prepared by Del Vecchio Reporting Services, LLC.
2. Slides presented at the hearings.
3. Written statements submitted at or in connection with the hearing.

Please let us know if you have any questions about the digital recordings or transcribed reports for the two hearings. Thank you for your time and attention.

Sincerely,

Wiggin and Dana LLP

By _____
Rebecca A. Matthews
Its Partner

By _____
Melinda A. Agsten
Its Partner

cc: Dennis P. McConville, Senior Vice President and Chief Strategy Officer, Eastern Connecticut Health Network, Inc.
Thomas M. Reardon, President, Prospect Medical Holdings-East, Inc.
Frank Saidara, Vice President, Corporate Development, Prospect Medical Holdings, Inc.
Jonathan Spees, Senior Vice President, Corporate Development, Prospect Medical Holdings, Inc.
Joyce Tichy, Senior Vice President and General Counsel
Michele M. Volpe, Esq., Bershtein, Volpe & McKeon, P.C.

PROPOSED TRANSFER OF ASSETS OF

EASTERN CONNECTICUT HEALTH NETWORK, INC. AND AFFILIATES

TO

PROSPECT MEDICAL HOLDINGS, INC.

OHCA Docket Number: 15-31216-486 and Attorney General Docket Number: 15-486-01

Public Hearing Held Pursuant to
Section 19a-486a of the Connecticut General Statutes

Location: **Vernon Senior Center, Vernon, CT**

Date: **August 3, 2015**

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PUBLIC MEETING

THE PROPOSED TRANSFER OF ASSETS OF EASTERN CONNECTICUT HEALTH NETWORK, INC. AND AFFILIATES TO PROSPECT MEDICAL HOLDINGS, INC.

Meeting taken at the offices of the Vernon Senior Center, 26 Park Place, Vernon, Connecticut, before Clifford Edwards, LSR, Connecticut License No. SHR.407, a Professional Shorthand Reporter and Notary Public, in and for the State of Connecticut on August 3, 2015, at 6:00 p.m.

DEL VECCHIO REPORTING SERVICES, LLC
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117 RANDI DRIVE
MADISON, CT 06443

HARTFORD NEW HAVEN STAMFORD

A P P E A R A N C E S:

JOY DORIN

PETER J. KARL

MICHAEL VEILLETTE

JOYCE TICHY

DENNIS P. McCONVILLE

DR. MITCHELL LEW

THOMAS M. REARDON

NINA KRUSE

ALSO PRESENT:

DAVID GONCI

DAN CHAMPAGNE

TONI ROYAL

CHET MORGAN

BECKY JANENDA

ERIC KLOTER

THEA CARDAMONE

ERIC KLOTER

TERI ROGERS

AND MEMBERS OF THE PUBLIC

JOY DORIN: Welcome everybody. Welcome and thank you for joining us this evening. My name is Joy Dorin and I'm the vice chair of ECHN network and chair of the ECHN board's transaction committee.

ECHN is valuable asset to the eastern Connecticut community. And after nearly three and a half years review, consideration, due diligence and determination to strengthen ECHN's future, a selection has been made to preserve ECHN through an acquisition by Prospect Medical Holdings. Previously, a decision was made to pursue the acquisition ECHN by a joint venture between Tenet Healthcare Corporation and Yale-New Haven Health Systems. For reasons that were beyond our control, we were not able to proceed with that transaction.

Over the course of the past five months, the transaction committee of the board worked diligently to secure proposals from interested parties and

thoroughly evaluated those proposals to make its decision and recommendation to the board of trustees. This decision was made through the engagement of a community government structure of trustees and corporators associated with ECHN which includes representatives of our medical staff.

The board of trustees voted unanimously to pursue an acquisition by Prospect. This decision was also supported by the ECHN corporators with a 98 percent favorable vote to pursue the proposed transaction. These votes allow ECHN to move into our next phase which includes the regulatory process as governed and outlined by the state and federal governments. You will hear more about this phase throughout the evening.

And now to review tonight's agenda and statutory requirements, I'm going to hand it over to Dennis McConville, the chief strategy officer at ECHN.

Dennis.

DENNIS McCONVILLE: Thank you, Joy.

ECHN is hosting two public hearings for our letter of determination, one tonight, August 3, 2015, here in Vernon Connecticut, and another tomorrow evening, August 4, 2015, at Manchester Memorial Hospital in Manchester, Connecticut.

These hearings are to provide the information in the letter of determination that was filed with the State of Connecticut on July 16, 2015. Our agenda for this evening is as follows: I will take a few moments to present the purpose for the hearing, the statutory requirements that we believe apply to our proposed transaction, and let you know how the format for your participation will go.

Peter Karl, ECHN's president and CEO, will present information about the healthcare landscape for ECHN, the rationale for pursuing our transaction with Prospect Medical Holdings and the process that ECHN followed.

Joyce Tichy, who is ECHN's senior

vice president and general legal counsel, will present the letter of determination, and then we'll have a comment, question and answer period for you with our panel. Our panel will include Peter Karl, Joyce Tichy, Mike Veillette, the chief financial officer of ECHN, as well as Dr. Mitchell Lew, who is president of Prospect Medical Holdings, Incorporated, and Thomas Reardon who is president of Prospect East Holdings, Incorporated.

For the public comment and Q&A portion of our hearing, we want to conduct this evening's hearing in as precise a manner as possible, it's structured to present you with information about our proposed transaction before we open the floor to comments or questions to address that letter of determination and related matters. I anticipate this part of the hearing will take 45 to 50 minute.

This hearing is a legal requirement for the State regulatory approval process. Additional hearings will be

held by the Attorney General and the office of healthcare access later in the process after our application for approval of the transaction is deemed complete.

Tonight's presentation and question and answer period will be recorded, transcribed, and submitted to the State of Connecticut, Department of Public Health, Office of Health Care Access and the Office of the Attorney General. You must sign in if you wish to comment or ask a question of the panel regarding the letter of determination.

If you've not signed in and wish to speak, please see Nina Kruse at the back of the room to do so. If you've signed up to comment or to ask a question, I will call your name to come up to the podium to make your statement or to ask your question.

Before you begin your statement, please state your name and your town of residence. In order to give everyone who wishes to speak an opportunity and in the

interest of time, we request that each speaker limit his or her participation to one appearance at the microphone and also try to limit comments to three minute or less.

Your statements or comments should be directed to the contents of the letter of determination. Copies of the letter of determination are available this evening for your review. We expect that the letter of determination and other filings for this regulatory approval process will be available both on the website of the Attorney General's Office and the Office of Health Care Access as the process advances.

Our focus this evening is the letter of determination which described the proposal for transfer of the assets of Eastern Connecticut Health Network and its affiliates to Prospect Medical Holdings, Incorporated. The first step in this process is the filing of that letter of determination.

Within 30 days of the filing of the

letter of determination, the nonprofit hospital and the proposed purchaser must hold a public hearing on the contents of the letter of determination. Again, this hearing is being recorded and transcribed as required and it will be filed with the OHCA and the Office of the Attorney General. The transcript will be made available to members of the public upon request.

The Commissioner and the Attorney General will review the letter of determination. The Attorney General determines whether the transaction requires approval under the so-called conversion statute as a conversion of a nonprofit hospital to for-profit status. A joint review process is then undertaken by the Commissioner of Public Health and the Attorney General.

The certificate of need process for hospital conversions is governed by Connecticut law. The law contains standards that the Attorney General and the Commissioner of Public Health must

apply in rendering a decision for each application. The law allows for each agency to engage experts to assist in the certificate of need process.

The statute states that the Attorney General shall deny an application as not in the public interest if the transaction is prohibited by Connecticut statutory or common law governing nonprofit entities trusts or charities. The Attorney General shall deny an application if the applicant fails to exercise due diligence in deciding to transfer, selecting the purchaser, obtaining the fairness evaluation or negotiating the terms or condition of the transfer.

An application will be denied if the nonprofit hospital failed to disclose any conflict of interest or if the nonprofit hospital will not receive the fair market value for its assets. By statute, the Commissioner of Public Health must also apply standards in reviewing and ruling on an application.

The Commissioner of Public Health

must deny an application unless a commitment has been made to provide care to the uninsured and underinsured. The proposal is also reviewed under standard certificate of need guidelines, including whether there is public need for the proposal, the impact on the financial strength of the healthcare system in the state and whether the proposal will improve on the quality, accessibility, and cost effectiveness of the healthcare delivery in the region.

Now I'm going -- okay. A bit of a technical -- okay. Thank you for your patience.

Now I'm going to walk you through the estimated timeline for the certificate of need approval process. Some of these intervals are mandated by statute and others are estimates so they may change. The process begins with the filing of the letter of determination which we did on July 16th. Within 30 days, we are required to hold public hearings on the content of the letter of

determination.

We expect that the Attorney General will rule that our proposed transaction is subject to the conversion statute. We hope to receive an application from the Attorney General within 14 days which brings us to mid August.

Once we receive an application, we have 60 days to file the completed application. We plan to file our application within 45 days, which gets us to early October. The Attorney General's office and OHCA have 20 days to determine if the application is complete. If they identify deficiencies in the application, we will receive what are known as completeness questions, and we estimate it will take seven more days to respond to those and then 20 more days for the agencies to respond.

We could see one to two cycles of completeness questions. The target for our application would be deemed -- deeming our application complete is early December. Once deemed complete, the

Attorney General and the Commissioner of Public Health have 120 days to decide on the application. They will hold their public hearings during that time. We estimate that the process will take between nine and 12 months with a decision coming between March and April of next year.

Joyce Tichy will provide more detailed information regarding the transaction in a few minutes but here is a summary of the proposed transaction.

We are proposing that Prospect Medical Holdings buy ECHN. There would be the continued operation of Manchester Memorial and Rockville General Hospitals and our post acute care network, including Woodlake at Tolland and Visiting Nurse and Health Services of Connecticut, the continued involvement of a community advisory board, capital investments to fund new programs, investment technology and improved facilities and equipment.

The acquisition of ECHN by a leading

organization will bring decades of experience with managing the health of populations and is focused on value based care. The establishment of a community foundation to oversee certain charitable funds and continuation of ECHN brand and mission including the continued commitment to charity care and indigent care.

Now to review our process and the background for the application is ECHN's president and CEO, Peter Karl.

PETER KARL: Good evening. I apologize in advance because this hearing is official I need to read my testimony for the record instead of speaking informally about the slides. Please bear with me.

Thank you for joining us this evening. We are here to discuss the proposed transfer of assets of the Eastern Connecticut Health Network and affiliates to Prospect Medical Holdings.

ECHN is proud to serve eastern Connecticut by improving the well being

of the community by offering quality, compassionate healthcare. That is our mission and our organization has pursued this mission for nearly a hundred years. Our commitment to the mission is what we want to continue on behalf of the patients and their families, our physicians and our employees.

We want to see the ECHN name and brand continue. ECHN has made an obligation to training our next generation of physicians. We have developed a strong relationship with our medical staff. We support the education medical students and have established a new graduate medical education residency program at ECHN.

Manchester Memorial and Rockville General Hospitals, Woodlake at Tolland, Visiting Nurse and Health Services as well as dozens of affiliates and joint venture companies are anchors in the region we serve. ECHN is a significant economic engine providing the salaries for over 3,000 skilled jobs and

purchasing over $90 million in services and supplies each year.

The Patient Protection and Affordable Care Act is designed to provide insurance of 32 million Americans who are uninsured. Hospitals as an industry agree that they would accept lower payments as more of their patients would now have some form of insurance.

In Connecticut, unlike other parts of the country, residents are relatively well insured so there's not the benefit of more revenue for our hospitals. We estimate that we need to reduce expenses by 15 to 20 percent, which would mean cutting services and staff.

In addition, the government and the commercial insurers are pushing for payment reforms that shift the risk for getting paid to providers including our hospitals and our physicians. The resulting new payment systems reward those who deliver care at lower costs with improved quality and outcomes. This means that we need to reform and refocus

our delivery of care to keep patients well in the lowest cost settings, generally at home or in an outpatient setting, preventing patients from needing expensive hospital stays.

The focus on our patients needs to be ongoing and proactive not just on episodes of illness and hospital stays. The information about our patients needs to be accessible to providers across the network. Care management programs need to be expanded through the community. The investments needed to succeed with population health are major and difficult for organizations that are operating on extremely thin margins.

As you can see here in this slide, in 2001 ECHN lost more than $10 million and continued to operate in the red for many years. During this time the level of debt continued to rise. I took office 11 years ago and ECHN began to make course corrections but it took six years to catch up and we were forced to defer capital investments.

You can see that with the Connecticut Hospital Tax, implemented in 2011, we have not been able to generate the operating results needed to reinvest in the organization. You can also see by the lower graph that our pension liability grew dramatically, the result of pension funding reforms that came at a time when the market crashed in 2008.

Debt service and pension contributions consume a large portion of ECHN's annual cash flow and making capital investments difficult. The pension liability will grow again by an estimated $14 million next year resulting from new actuarial tables reflecting the longevity of retirees.

Hospital systems are extremely capital intensive. The cost for new medical and information technology are significant. The building codes for our facilities to make improvements are expensive. I mentioned population health and the need to share technology across the system. A new electronic medical

record system will cost at least $20 million.

There are programs that we'd like to develop to address health needs that require capital investments. Private accommodations for our patients are not only about comfort and privacy but they offer a safer environment for our patients. Again, hospitals are expensive to build or renovate.

Eastern Connecticut Health Network and all Connecticut hospitals are struggling with financial challenges associated with the reduction of government payments for services provided to our patients. Payments for services to Medicaid and Medicare beneficiaries make up 55 percent of our revenues.

Since we started our journey to evaluate a partnership, more has happened that worsens our financial position. As mentioned, the State imposed a tax on hospitals that remains a significant burden for ECHN. For a $330 million

system, we have struggled to achieve a 1 to 2 percent margin, which is three to $6 million. You can see that tax represents the margin that we need to produce to remain viable.

ECHN, along with other hospitals, also had to shoulder the financial impact of federal sequestration. Medicare provider payments have been cut by 2 percent since April of 2013. The act requires federal spending cuts to be achieved over the course of nine years so the sequestration is expected to remain in place through 2022.

The sequestration equates to a loss of more than 2.2 million each year for ECHN. This year the State has implemented a new system for Medicaid patients for inpatient care. While we were told that the change would be revenue neutral, we have determined that this is not the case. We will see 1.6 million less in revenue for those admissions this coming year.

As a result of this year's state budget,

the pool of dollars for low cost hospitals was eliminated. While a couple of hospitals were successful in restoring that funding during the special session in a new small hospital pool, Rockville was not so fortunate and we will see 300,000 less this year.

Finally, the formula used by the federal government to calculate our Medicare payments is subject to a wage index. The current projections for payments resulting from the way that that index is applied will lead to even further reductions.

As you can see here, the negative forces associated with the reduction in payment for services coupled with the increased salary and non-salary costs equates to an inability to reinvest in ECHN and an unsustainable financial path.

In order to prepare for the future of ECHN, a work group of trustees, corporators, medical staff and administrators was formed in 2011 to

study ECHN's needs and the benefits that would come from partnering with another healthcare institution. After studying the national, regional, and Connecticut landscapes, along with ECHN's current and potential future position, it was decided that a partnership was in the best interest of ECHN.

The partnering work group developed criteria in which to evaluate potential partners including cultural and strategic fit, financial strength and long term viability, and the partner's interest to invest in our organization. The work group made their findings and recommendations to a committee of the ECHN board of trustees, the transaction committee.

When the deal with Tenet and Yale-New Haven Health System did not work out, the board reaffirmed the need for a partner. In January, the transaction committee employed the same process to select and then recommend to the board a transaction with Prospect Medical

Holdings.

The reasons to join another system are clear. We want to improve our access to capital and afford investments. We have to improve finances and reduce or eliminate our debt. Together, with our physicians, we have to be prepared to participate in the new systems ensuring that we protect, preserve, and grow the local access to healthcare services.

Request for proposals were sent to six healthcare systems. Three proposals were received from Hartford Healthcare, from St. Francis Care and Trinity Health and one from Prospect Medical Holdings. After careful due diligence, which included rounds of questions and answers, site visits and meetings with the parties, the board selected the proposal from Prospect Medical Holdings as the best one that best meets ECHN needs.

The combination with Prospect Medical Holdings will secure the future

of ECHN and local access to healthcare for the communities we serve east of the river. There's a strong alignment of mission, vision, and values with Prospect. Prospect is a strong partner for physicians, both independent physicians and those employed by hospitals.

They have decades of experience with managed care and the value-based risk-based contracts that are emerging as a result of healthcare reform. Risk based contracts place the economic risk, the risk for payments based on performance, on the healthcare providers including hospitals.

Prospect is successful in these risk arrangements because of the programs and resources that they employ to promote health in managing the healthcare needs of the population of patients in the lowest cost settings, at home or in ambulatory settings, while producing the best outcomes for their patients. Prospect has a history of success in

markets where there is significant competition from much larger hospital systems. They have already begun educating our physicians about their model, which is important to building a sustainable, thriving network of value-based care for our communities.

ECHN firmly believes that this partnership will allow us to continue to serve our mission, it will protect accessibility and the affordability of care for our patients while continuing our focus on the quality and safety of patient care. This will support our efforts to continuously improve patient satisfaction and it will enable us to reinvest in programs, technology, and facilities for the benefit of our patients.

Now I'd like to ask Joyce Tichy to walk you through some of the finer details associated with the letter of determination.

Joyce.

JOYCE TICHY: Okay. All right. We have to -- there. Okay. Five and six and then the slide that starts, I think it's 20.

Okay. So I just wanted to start -- my part is to give you a little bit of a summary of the transaction and the manner in which we think it complies with the requirements of the legislature and our regulators to show that our board engaged in a diligent negotiation of the terms and conditions of the transfer.

But I wanted to go back to slide five, which Dennis presented, and slide six, just to give you the framework for within which our board operated. There's been an enormous amount of focus and attention on the subject of hospital transfers in our state and in Hartford. And I would say that based on the amount of legislative change, our legislators have done their absolute very best to try to preserve these assets as best as they know how on behalf of the

communities like you for which these assets were created and have been maintained.

So the way our board looked at it was, you know, they are fiduciaries, they are representing the community and they heard loud and clear that this is what their goal was, so they followed with a great deal of energy and focus the legislative mandate that was presented to them.

So this first slide that Dennis presented gives to you what it is that the Attorney General is supposed the look at. And mostly, what the Attorney General's office is going to check for, is to make sure that there's not been any wasting of the assets, that they have been preserved as best as possible under the circumstances in honor of those who have contributed and maintained these assets over the many years that they were maintained.

So you can see that these are the things that the -- that the board was

supposed to pay attention to, making sure that the purchaser was a good purchaser, making sure that there was fairness in the amount of money being agreed to, making sure that there's a fair market value evaluation by a third party that has nothing to do with any of us in order to establish the fairness of the deal, that's what the Attorney General is going to do.

So now if you turn to slide six, OHCA, the Office of healthcare Access, looks at the transaction from a different perspective. Their goal is to make sure that once the deal is completed, the commitment to the uninsured and the underinsured remains, that the financial strength of the entity, that is Rockville here and Manchester Hospital and the rest of ECHN, is maintained and that there's quality, accessibility, and cost effectiveness going forward. That's the frame within which the board worked and that's the framework of the transaction as it -- as it ultimately was

developed.

So next I'm going to talk about -- if you now can turn to page 20 -- the part that's sort of the meat of the deal; right? And it's going to take a little bit to get through but I'm going to try to be as high level as I possibly can. And that's in order to show you, and to show our regulators, that there was a diligent negotiation of the terms and conditions.

So the way the letter of determination is set out, it has these various categories of subject matters in them, and so I'll just give you a little bit of summary of each of those. And this is going to sound very familiar to those who were here last year because, effectively, the transaction ended up being very, very similar to the Tenet deal, and in some ways I'll get into, an improvement over it.

So the form of the transaction is an action asset purchase, and that's very common in these kinds of transactions

where a for-profit purchaser is buying a not for profit entity. And what means is that Prospect is effectively buying substantially all of the assets of ECHN.

The key assets to be acquired, which are listed in the letter of determination are, obviously, the two acute care hospitals, Manchester Memorial and Rockville General Hospital, Woodlake at Tolland, our subacute rehab and long term care entity, our visiting nurse service, Visiting Nurse and Healthcare Service of Connecticut, our insurance captive, which is the entity that we have that handles our medical malpractice claims, our billing physician office administration entity, which is named Medical Practice Partners, and all of the other entities that bear the ECHN name.

And those of you who are in the community and, you know, drive around and we proudly put our name on all of our physician offices and physician office buildings, and those are going with this

transaction. Some of those buildings we only own shares in, and to the extent we own a share in those buildings, those are transferring as well.

Another thing that's transferring over is ECHN's interest in a variety of our joint ventures including an endoscopy center, the Dequattro Cancer Center, which provides cancer services on the other side of the street of Manchester Hospital, two ambulance companies, a wheelchair transport company, an occupational medicine provider and others.

So this list is not exclusive and one thing to know is that some of the joint ventures will require permission from the other parties, and that's also going to be part of the process that we engage in. Along with the entities, then all of the material, equipment, property leases, accounts receivable, networking capital, and all the physical and tangible evidence of ECHN will transfer as well.

Then you get to, and this was very, very important to our board, along with the assets they insured, they are insuring, that the liabilities that ECHN has incurred over the many years of its existence are also being resolved and handled appropriately. So those are -- again, these are the already existing obligations of ECHN. And just like any hospital system, over time those gather, and as Peter mentioned, for example, the pension liabilities which have grown very large over time, our post-retiree health benefits plan, the captive insurer liabilities, as I mentioned, and our Workers' Compensation claim -- liabilities.

The board was very interested in making sure that we deliver ECHN with a clean slate, all of our creditors paid off, and we can basically be proud to move it forward into its next phase without those liabilities hanging around.

On the other hand, there are some

assets and liabilities that will be excluded, again, as common in transactions of this kind. So the first one to know about is our donor restricted charitable contributions. So those were contributions that were made to ECHN or Manchester Hospital or Rockville or our foundation with an instruction by the donor that, for example, the principal was not to be used but only the interest or income. Those funds, when they have that kind of designation, are placed separate from the rest. They cannot go to any purchaser and they will be set aside.

Also, not included in the transaction, are the results of lawsuits, cost or court settlements, and that being that Medicare pays awfully slow so you just don't wait around and the transaction will close while cost or court settlements remain to be completed. Tax settlements and other things -- other liabilities relating to ECHN's pre-closing activities but they show up

after the closing.

Also, not transferring as part of the transaction but staying aside are ECHN's cash and investments, which will be used to payoff debt at closing, I'll get to that in a minute, and our long term debt. And these will be -- these are set aside and either will flow differently as part of the deal or will be handled by a residual ECHN corporation that will basically be set up just in order to close down activities.

We have a medical foundation, and that's basically the employed physicians, they work in a separate subsidiary. There was quite a lot of legislation about medical foundations of very recent vintage, actually. And we will work with our regulators to ensure that the legislative intent is followed in the manner in which the medical foundation will be transferred.

So as part of the transaction, our board felt, and it heard the community in

this, that there would be a strong interest in maintaining a local voice with respect to the governance of Manchester Hospital, Rockville Hospital -- Rockville and the rest of ECHN. So as a result of that, each hospital will have an advisory board, which is sometimes also called in these papers, a local board.

That board will be appointed by ECHN before the closing, and initially is to be made up of five ECHN trustees along with five others to be identified by ECHN. And the members are going to include community representatives, physicians on the medical staff, and the hospital CEO. That's, namely, Peter, who just spoke.

The role of the advisory board is actually going to be substantial. It's going to be an adviser to Prospect on how to best spend the capital commitment that it is making of $75 million. This is after the transaction closes Prospect is promising to invest $75 million in ECHN

and this advisory board will be -- will assist in the determination of how that is best to be spent.

It will also assist in the development of ECHN's strategic business plan. It will be responsible for medical staff credentialing, it will oversee quality assurance -- a very key aspect of ECHN services is quality -- and it will oversee and manage the hospital's accreditation.

The CON requires that we show and that Prospect shows that there's a continued commitment to maintain community support, charity care and the continuum of care. And so to that end, we have ensured that Prospect has agreed it will maintain ECHN's policies on charity care, indigent care, community volunteer services and community outreach services.

Also, we have and are very proud of the fact that we have a graduate medical education program, which we started a few years back. It's starting to show really

great results. We're graduating physicians, some of whom are staying in the community, and we're really thrilled about that. It's with University of New England College of Medicine, and Prospect has agreed to continue that relationship.

It's also agreed to maintain for three years our two acute care hospitals, along with their emergency departments and to maintain an ownership interest in VNHSC and Woodlake at Tolland, our long-term care facility.

With respect to employment, Prospect has agreed to offer employment to substantially all of ECHN's employees, a comparable benefit package to what people had pre-closing, and it's also agreed to assume our collective bargaining agreements.

When ECHN went into the process of seeking out a buyer, it decided that in order to protect the employees well, it would negotiate a -- a -- collective bargaining agreements with fairly long

termination provisions. And so at this point in time, even though we're actually going, I'm sorry to say, through our second buyer, we still -- we still have a ways to go with them.

The RNs at Manchester Hospital, their collective bargaining agreement goes until June 2018. Our Manchester service and skilled maintenance employees' contract goes to May 2017. Our technical and LPN employees at Manchester go to June 2017.

And our RNs at Rockville go to December 2018. So we have a fairly long period of time yet. And that, again, was ECHN's attempt to best protect employees as we were moving into discussions with purchasers.

And I also now want to talk about the capital commitment. So as I mentioned, Prospect has agreed to spend $75 million within five years, that's in addition to the purchase price, to pay for upgrades to ECHN facilities and projects to improve services. Given our

financial condition, we have been unable to invest in capital improvements, and an entity can go only so long before that becomes an untenable situation. So that 75 million was a very important piece of the transaction to ECHN.

This money will be used to renovate ECHN facilities. It'll be used for recruitment costs, for needed medical staff, for expansion of our clinical departments, purchase of essential medical equipment or -- and/or electronic medical records, without which a hospital system can no longer continue today. And all of those will be toward the improvement of ECHN post closing.

There is a caveat, and that is if a -- a law or rule is passed or applied in Connecticut that discriminates against for-profit systems, that obligation can be deferred beyond five years, but if that happens, Prospect will have to have a conversation with us and probably with you. So I think that that will be a -- a fruitful conversation if

needed.

With respect to the services or towns served, there are no changes. No changes to the services or towns served, which is something that we have to establish or explain in the CON.

I did want to spend just a minute or two describing to you the fact that the Prospect transaction -- the proposed Prospect deal is actually better than what we had with Tenet. First of all, it's reduced the indemnity reserve, which is the amount that you need to put aside to cover potential liabilities after the transaction, from 7.5 million to $4.5 million.

It's also agreed to cap the value of the joint ventures, which means if we have a joint venture, remember, we are part owner of that entity, if there's a reason that it can't transfer or for one reason or another because we'll need the other party's consent, Prospect has agreed to cap the total amount that's a deduct from the purchase price if that

eventuality happens. And it also has agreed to loan us the money that would count towards those joint ventures if they are in process, but not quite completed at the time of the transaction. Lastly, it's allowed to -- allowed us to access that capital commitment of $75 million earlier than otherwise, if need be, to close the transaction.

So all of these factors were evidence to us that Prospect was in good faith and it -- and it is really, really diligently interested in having us close the transaction for the benefit of ECHN.

So the next slide -- I know this is a lot for, you know, a couple of slides. What I'm going to describe to you on this slide is what transaction lawyers call the waterfall, which is kind of how the money comes in and then in a very brief way how it goes out.

Some of this is repetitive of what I and -- and Dennis said already, but a lot

of people have the question sort of, Where's the money? Where's it going? What's this? So this is kind of how it works.

So, first of all, you start by saying we are excluding a number of things. Those donor-restricted funds, they stay on the side. They go directly where the Attorney General tells us to send them. We're not touching them.

Then we have cash investments. Those are not going as part of the deal. Again, they sit on the side, and they -- and they effectively wait.

Also, our cost report settlements, we don't know what they are, but they're not part of the deal right now. So they're also sitting on the side. Putting those on the side.

Then you start with the hundred and five million purchase price. That amount could be a hundred and fifteen million if we get a loan, but if there's a loan -- and a -- a loan that's transferable to Prospect, if that's true, then the debt

we -- that we are responsible to pay goes up by 10 million.

So it's just a wash. You might as well just assume it's a hundred and five million. Just -- it'll be an add and subtract from the two sides of the balance sheet.

Okay. So here we are with the hundred and five million. First thing we do is we true up to make sure we have enough networking capital. So that's the money that you basically work with all day long. Sort of like your checkbook, you know, you've got to always have enough money in your checkbook to pay the bills when they come in before you get your paycheck. So that's the amount there.

There's an amount there in -- in the -- in the deal. It's $24 million. And if we have more than that, we true up down to 24. If we have less than that, we true up to 24. Okay. So that's the first step.

The second step is you start taking

reductions because Prospect is taking on liabilities. Of course, these are things it's not its problem. So, you know, we have to pay to have those liabilities taken away from ECHN, and those include our indebtedness, which is effectively our capital leases, our unfunded pension liability and our post-retirement health, very important for us to make sure are handled, our employment-related liabilities, if any, our captive and Workers' Comp liabilities.

Remember, I just described these to you before. This is how they come off of the transaction. You pay them off. The -- the value of those joint venture interests that we can't transfer for one reason or another and a miscellaneous, like our asbestos liabilities, which are going to be somewhere in the range of, I think, a -- a million dollars or so.

Okay. Then there's an amount of money that's left. That amount gets combined with the cash and investments

that remember I said we put on the side, and those -- those combined monies are used to pay off our long-term debt, which are the monies we owe to bondholders and lenders that have been accumulating over time that Peter mentioned on another slide.

Okay. Then after that, we take that $4.5 million, and we put it in a bank account just in case something comes up after the transaction that was our fault and our liability. And that money stays there for three years. If nothing happens and -- and nobody sues us for things that happened before the transaction, no new liabilities happen, that money becomes available for the charitable foundation that will be set up. That money, along with whatever is left after all this -- this waterfall deduct, all goes effectively to where the Attorney General tells us to put it, and that will be basically the amount of money that represents the charitable asset that's left.

After closing, again, we still have that 75 million-dollar capital commitment that Prospect is -- has agreed to pay to -- for the upkeep of ECHN.

So there are a couple of caveats here as there are always in a complicated transaction. The deal is contingent on there being no material change to our business assets, liabilities, financial condition or results of operations. That's a phrase you always put in these and -- but it can be significant. We have to make sure that our medical foundation is successfully transferred as the regulators require it. And there are additional other closing conditions involved.

One thing that -- and I just want to close with this piece that I -- that I want to emphasize is: There will be numerous independent verifications of the appropriateness and thoughtfulness of the board's decisions here. And I sat through them, and I know they were very deep and thoughtful, but you want to

make sure that somebody else is checking.

The fairness of the purchase price by law will have to be confirmed by a third-party fairness opinion, which we did in the Tenet case and we will do again, a new fairness opinion. We'll have the outside audit of our financial statements. We'll have actuarial reports for our pension and retiree health to make sure that we calculated those liabilities correctly.

We'll have the Attorney General and OHCA review with yet another hearing or series of hearings, and they will hire their own independent experts to test and document the representations that we're making to you and to them, and those will be paid by the parties.

So that's all I have. And so I guess I'm turning it back over to you, Dennis.

DENNIS McCONVILLE: Yes. Thank you, Joyce.

Okay. We've reached the -- the part

of the hearing where you, the public, may participate. Again, for this portion of the hearing, you must sign in if you wish to comment or ask a question of the panel regarding the letter of determination. If you've not signed in and wish to speak, please see Nina Kruse at the back of the room to do so. If you've signed up to speak, I will call your name to come up to the podium and make your statement or ask your question.

Before you begin your comment or comments or a question, please state your name and the town -- your town of residence. In order to give everyone an opportunity to speak who wishes to do so and in the interest of time, again, we request that you limit your participation to one appearance at the microphone, and you try to limit your comments to three minutes or less.

Your statements or comments should be directed to the contents of the letter of determination. If you have signed up to speak, but have changed your mind,

when I call your name, just state no comment. If you prepared written legible comments, you may leave your comments with Nina Kruse as well.

And I would like to point out that this hearing is being videotaped for those that plan to participate.

And with that, I would like to introduce our panel. I'd like to reintroduce Peter Karl, our president and CEO; Joyce Tichy, senior vice president and general legal counsel for ECHN; mike Veillette, who is senior vice president and chief financial officer for ECHN; Dr. Mitchell Lew, who is president of Prospect Medical Holdings, and Thomas Reardon, who is president of Prospect East Holdings, to take your questions.

First, I'd like to call to the microphone Dave Gonci on behalf of Dr. Saud Anwar of South Windsor.

DAVID GONCI: My name is David Gonci. I'm a resident of Glastonbury, and I'm reading this letter which was presented by Dr. Saud Anwar. It's

addressed to the commissioner of the Office of Health Care Access and the State of Connecticut Attorney General, Mr. Jepsen.

The letter reads as follows: My name is Suad Anwar, and I'm a pulmonary and critical care physician affiliated with Eastern Connecticut Health Network for over 17 years. I support the proposed partnership of Eastern Connecticut Health Network and Prospect Medical Holdings.

I am an independent physician who has the opportunity to interact not only with the patients in the community, but also the staff essentially in most parts of our hospital, and I also have an opportunity to cooperate with the community physicians providing primary care to our community.

As a medical director of the clinically integrated network of Eastern Connecticut and also with Eastern Connecticut Physicians Hospital Organization and medical adviser to the

care management department of the hospital, I have had the opportunity to closely observe the sustainability challenges our healthcare system has. We're struggling to continue to provide best quality to all the patients with ongoing challenges, with increasing social challenges in insurance and reimbursement and bureaucracy.

I have also had the opportunity to learn firsthand from the representatives of Prospect Medical Holdings and their existing hospitals and their track record of providing quality care to patients with all capabilities of payments.

It is quite clear to the physicians that integrated network and -- and coordination of care in a healthcare system with strong primary care delivery, along with collaborative specialty care with appropriate transitions according to the patients' needs is the best and the most effective way of maintaining and managing population health.

Prospect Medical Holdings has many

years of experience and success in managing risks with their delivery models. The size of our healthcare system and the opportunity to collaborate with an experienced partner who believes in collaboration between the independent physician in the community and the hospital will truly strengthen health care within our network.

Our hospital continues to employ members of the community and serves as a backbone of the economic engine within our towns. In my other role as mayor of the Town of South Windsor, I know that over 250 people in my community are employed by ECHN. A stronger, efficient and sustainable healthcare system allows industry to identify and choose communities to invest in. With growth of population health management, we truly can have an impact at all levels according to the needs of the people.

I strongly feel that the track record in the current system needs to move to for-profit model, and this

partnership will not compromise the quality of care, but actually enhance the quality of care and would be able to provide care to the patients irrespective of their insurance status and abilities to pay.

I thank you for your consideration. If you have any questions, please do not -- do not hesitate to contact me. Sincerely, signed M. Saud Anwar, M.D., Chairman of Department of Medicine, Eastern Connecticut Health Network.

DENNIS McCONVILLE: Thank you, Dave.

Next I'd like to call on Mayor Dan Champagne of Vernon.

DAN CHAMPAGNE: Well, I thought I was further down the list, but, okay.

You know, we were in this position about a year ago.

Sorry to turn my back to you guys.

JOYCE TICHY: That's okay.

DAN CHAMPAGNE: And a year ago with Tenet, it was a -- I think it was a different deal. My concern is the same as last time, you know. The three years,

I wish it was a lot longer, but given the condition, you know, that Hartford has put us in and -- Hartford and Washington, you know, I don't think the -- I don't think ECHN has enough money left to even last three years if they don't combine with somebody. And that's -- that makes me nervous.

Truly, Rockville Hospital is our hospital. Back in 1921, when they -- when the hospital started on Prospect Street, it was done through community donations, and then we moved to the current location of 31 Union Street. And -- and every time the hospital is in trouble, we turned around and -- and we pulled them out, you know, the donations that this community has made, the jobs provided.

Rockville Hospital is the second biggest employer in town, and the Visiting Nurses is the third biggest employer. So that makes us very concerned about this three-year deadline, and I wish we -- I wish we had a lot

longer than that. I said that last year as well.

If you look at the new partnership, you know, I -- they're not in the business of closing hospitals. They're in the business of -- of making a profit, yes, but they're not in the business of closing hospitals. And I think that's important to keep in mind.

In Connecticut's environment right now, you know, we keep taxing. They saw that hospitals were having a profit, a profit in quotes, and they decided to -- to tax that profit. That profit wasn't a profit.

What it was is it was money left over so they could reinvest into the community, into those hospitals in -- in -- in many different forms. And once the -- the -- the budget -- the biggest tax increase was done a couple years ago. Hospitals took a hit, and they took a hit this time as well. And -- and it's -- it's a sad state we live in and, you know, we have to live with that.

The medical services that Rockville Hospital provides to all of our citizens, you know, we have a lot of in- -- individuals in our town that are in low-cost housing. And the services are offered to them right here in our neighborhood. We don't have to drive. We can make our way there.

If Rockville Hospital leaves, we're going to Hartford or -- I don't think a lot of people are going to stop in Manchester. They're just going to bypass and go all the way out. So I think it's important that we do something to save our hospitals because in the condition that -- you know, under what we're currently doing, it's not working because the taxes continue to go up and -- and the repayments nationally are going down.

I'm going to continue to do everything in my power to make sure Rockville Hospital remains a vital part of this community. We need it, both medically and for the jobs it provides.

And it's our history.

Again, I want to end with it's our hospital. We started it. Thank you. Thank you, guys.

DENNIS McCONVILLE: Thank you, Mayor.

Next I'd like to call on Toni Royal.

TONI ROYAL: Hi. My name is Toni Royal, and I'm from the Town of Vernon.

I'd like to say that it's been great having a community hospital here. I've had good service from them for years, both when I arrived at the hospital with a medical condition and to be there with someone who was seriously ill. And you can go home and come back and go several times a day when the time is there, and that has happened to me.

I have a question, though. I'm just curious to know or have you comment on the contrast between a for-profit entity and not-for-profit and how it impacts taxes and your -- your volunteers. I've heard that for-profits are not permitted to have volunteers. And can you comment

on the number of volunteers and the amount of service that that represents?

Thank you.

DENNIS McCONVILLE: Who'd like to take that question? Peter?

PETER KARL: Sure. I'll take that question.

Volunteers can volunteer whether -- whether it's for-profit or not-for-profit. That can continue, so -- and we hope that, of course, the volunteers will continue. We work very closely with them at ECHN. And you won't see any difference as it relates to volunteers.

As it relates for-profit or not-for-profit, Tom, you want to take that or -- or Mitch?

THOMAS REARDON: I need a -- I need a 12-year-old to turn this on for me.

Yes, I'd -- I'd -- I'd be delighted to, Peter.

You know, in the old days there was a -- some -- they -- there was an allegation there; was a difference

between for-profits and non-profits. The for-profits were more concerned about efficiency and producing a profit and less concerned about quality. And that line has blurred.

For-profits like Prospect are all about quality at this point. That is our essential message. Our value-based population management capabilities, that's what we go after, and so there's been a blurring of lines. So when you think about a for-profit versus non-profit, there's not much difference anymore, except for-profits pay taxes, Mr. Mayor. And so we -- we have the same charity care policy. We have the same commitment to the community.

I don't think you're going to see any difference whatsoever in terms of the services that are provided to this community. There's not much difference anymore.

DENNIS McCONVILLE: Thank you.

Chet Morier (phonetic).

CHET MORGAN: Morgan.

DENNIS McCONVILLE: Morgan.

CHET MORGAN: I guess we're addressing you.

My name is Chet Morgan. I live here in Vernon, moved here in 1961. But before that, I had an interest in Manchester Hospital 'cause I was born there in 1937. So everything's changed since then, but I just want to give you a little history before my question.

As a member of the legislature in the late '70s, I was in the public health and safety committee. And the executive director on the Commission on Hospital and Health Care came to me and said, I'm going to close your hospital.

Well, we can't stand this hospital to close, and we keep going through this. But I asked him why. And the maternity and pediatrics board were in the old Maxwell building. So I dealt with the president at the time. And I forget his name. And I got some serious state dollars, and we revamped Rockville Hospital, and we put in a new emergency

room, which is now changed. And now the maternity ward is growing, too.

But anyhow, that's where it was. They were going close -- the Commission on Hospital were going to close Rockville General because of that fire hazard, and I wouldn't let that happen, you know. I was very thankful for all the support from the town and community and everybody here. So that's my background.

And I -- I fought -- and I just had to say up front that I do agree that it has come to this that we have to be in a takeover. I agree with that. However, I was here tonight, and Ms. Tichy answered most of my questions in the letter of determination on eight was employment matters. And you told me how many long-term contracts you had with the various unions.

But I have a question for Dr. Lee. Can Prospect, once they take over, eliminate those contracts or renegotiate those contracts?

DR. MITCHELL LEW: What contracts

are you referring to?

THOMAS REARDON: Labor contracts?

CHET MORGAN: The labor contracts.

THOMAS REARDON: We have a very good working relationship with labor -- labor unions. We're going to assume those contracts, and we're -- we're going to work with those labor unions. We see them as partners. We're very good at partnering.

CHET MORGAN: Thank you, sir. I'll hold you to that.

And thank you for your being here tonight. And like I said --

JOYCE TICHY: Can I add something?

So when you're -- when you're speaking legally, what Prospect is agreeing is to step in ECHN's shoes and become the employer. And once an employer ends up doing that, it really basically is --

CHET MORGAN: Okay.

JOYCE TICHY: It can't just cancel a union contract.

CHET MORGAN: Okay. 'Cause --

JOYCE TICHY: They don't. That's just --

CHET MORGAN: -- from what you told me, the length of -- of the many contracts -- the labor contracts go out a couple years. So if there is a problem, there's enough that we can negotiate as --

JOYCE TICHY: Right.

CHET MORGAN: -- a -- as a community and -- and -- and work with people 'cause it's obvious you people are willing to listen, and I thank you for that, but hopefully --

JOYCE TICHY: Right. So at that point there will be a negotiation of terms like wages, et cetera.

CHET MORGAN: Yeah, yeah.

JOYCE TICHY: But it can't just be thrown away.

CHET MORGAN: Thank you. Thank you. Thank you.

DENNIS McCONVILLE: Thank you, Mr. Morgan.

Next is Becky Janenda on behalf of

Dr. Ronald Burt of Farmington. Will you come up?

BECKY JANENDA: This letter was written by Ronald E. Burt, M.D. And I'm just reading it on his behalf. These are his opinions, not that I'm disagreeing, but these are his -- this is his word -- these are his words.

To whom it may concern: I am writing in strong support of the proposed acquisition of Eastern Connecticut Health Network, ECHN, by Prospect Medical Holdings, Inc., a national healthcare services company headquartered in Los Angeles, California.

My support of this transaction is based on over 30 years' experience in all aspects of clinical healthcare delivery in settings as diverse as large tertiary care, Anchor, private teaching hospitals, numerous community hospitals and university-based delivery systems. Moreover, I have had a close association with the ECHN organization and the community that it serves for a number of

years and am well aware of and sensitive to the needs and challenges that both face in the current climate of unprecedented changes in the healthcare services industry.

ECHN is an organization that has been a community pillar both in medical services it provides to all who enter its doors as well as a key employer within the eastern Connecticut geographic area. The preservation of enhancement to the services it delivers and opportunities it provides is critical. And it is my opinion, after having substantial exposure to and involvement with the acquisition and merger dy- -- dynamics occurring at all levels of health care, that Prospect Medical's acquisition of -- of ECHN presents the best opportunity for ECHN's legacy of service and opportunity to be carried into the next generation of healthcare delivery, which is indeed upon us.

ECHN's leadership has und- -- undertaken an extraordinary --

extraordinarily lengthy and diligent process of research and deliberation over several years in arriving at the choice of Prospect Medical Holdings, one that's solidly supported by both details of the transaction and well-paired blend of corporate and institutional cultures that will be the result of the transaction.

Prospect's approach to coordinated regional healthcare delivery and population-based disease management expertise are essential to ECHN delivering the most efficient and highest quality healthcare delivery in the new environment of the industry. And Prospect has well demonstrated success in achieving the needed results through a variety of competencies.

At least some of these are: A keen focus on providing to each patient the right care and the right setting by the right provider with the most appropriate application of resources. B, the ability to integrate effectively with the

physician and other clinical provider community that patients know and trust and follow to ECHN's facilities. C, a track record of robust -- robust investment in -- excuse me -- robust investment and reinvestment of resources into the systems it manages, maintaining the expanding healthcare services as well as preserving and creating employment opportunities within the local communities served. D, the ability to work constructively and effectively with healthcare employee unions. And, E, the ability to do all of the foregoing in a state environment characterized by a high degree of regulation of healthcare services.

Any person who has -- has even a nodding acquaintance with the sea of change that all hospitals in Connecticut are now facing will know that ECHN is not at all alone in the challenges and even peril that it faces, and every hospital must make responsible, effective and timely decisions in setting their future

course in this storm of healthcare industry change.

Such I believe are the characteristics of the decision that ECHN is endeavoring to gain approval for and to effectuate. It is my hope that ECHN's -- excuse me, I lost my eyesight -- ECHN's served community and the governmental entities impacting on this process will understand that they have the opportunity to either allow ECHN to pull into the undertow of this tidal wave of change and be lost or to facilitate its ascent to the crest of the new wave of services, which will ultimately land the organization and its patients -- the patients it serves safely ashore for another generation of extraordinarily skilled healthcare delivery.

Submitted by Ronald E. Burt, M.D.

DENNIS McCONVILLE: Thank you.

Next I'd like to call on Linna Rack.

Linna Rack, am I pronouncing that, or is it Rock, perhaps?

No?

Okay. Gene Merz?

Gene Merz?

He left?

Okay. Thea Cardamone -- Cardamone.

THEA CARDAMONE: Thanks very much for coming and addressing us and telling us about the plans.

Joyce, I think you led us pretty well through the determination, but I have a question. I hope it's a short one for you. And I have another question for the gentleman from Prospect. So I think more important is probably the one from Prospect.

I'd like to know a little bit about the hospitals that you -- that you already have and what their level of quality is. And if you're going to be trying to -- if this works, this deal works, would you be trying to institute similar procedures, like is it the local advisory board that does the accreditation for those hospitals? So I think that would really be useful for all

of us to know.

And, Joyce, my only question for you was "this letter of determination and agreement, does that bind Prospect to whatever actuarial valuations you have done on the patient and retiree health?

Because if you get two actuaries together who don't work for the same firm and you ask them to do a valuation, you get two different valuations pretty easily. So I guess my question is really: Is it going to be acceptable that whatever ECHN has done for the valuation?

Thank you.

DENNIS McCONVILLE: Can you just -- excuse me, Thea, just for the record --

THEA CARDAMONE: Oh, I'm from Vernon. Sorry.

DENNIS McCONVILLE: Okay.

MIKE VEILLETTE: Gene --

DENNIS McCONVILLE: It's Thea.

MIKE VEILLETTE: Thea. My -- my apologies.

JOYCE TICHY: I can answer the --

MIKE VEILLETTE: I'll answer the question about the actuarial --

THEA CARDAMONE: Okay.

MIKE VEILLETTE: -- valuation. In the -- in the agreement, we are looking to agree to the 9/30/15 valuation based on the actuary that we have used historically.

THEA CARDAMONE: Okay. So they're not controversial?

MIKE VEILLETTE: We don't believe that it will be.

THEA CARDAMONE: Good.

DR. MITCHELL LEW: Thea, thank you for that question.

Prospect, as you know, is a hospital company, and we own 13 hospitals that are all located in communities, and they -- they serve local communities with local physicians.

We also have a physician group unit within our company in which we integrate and organize physicians from the local community into what we call independent

practice associations and -- and -- and basically those are networks of doctors that work together and coordinate care. And some -- these doctors can be independent or they can be employed.

So our -- our model is one which integrates our hospitals and physicians. We work very closely with the local health plans and in some cases the government to coordinate and integrate care and deliver the quality that health plans require.

Really our goals are quality, access and affordability. You know, our -- our model of care, yes, we would love to bring here to Manchester and Rockville. We would love to engage the local physicians as we have -- have already started doing. And we would love to talk to the health plans about keeping care local and not taking care to more expensive hospitals outside of the service area. That -- that has been a focus. And, yes, we would -- we would bring that model of care here.

THEA CARDAMONE: Okay.

DENNIS McCONVILLE: All set?

THEA CARDAMONE: Yeah. I -- your hospitals meet the joint accreditation standards? You're not in trouble anywhere?

DR. MITCHELL LEW: No. We're -- we're --

THEA CARDAMONE: That's really what I wanted to hear.

DR. MITCHELL LEW: No. We're -- we're not in trouble. As I said, quality and safety in the hospitals is of absolute importance. And then on the physician group side, certain quality with outcomes, the patient care experience, but doing this in a very affordable way.

THEA CARDAMONE: All right.

DENNIS McCONVILLE: Thank you.

THOMAS REARDON: May I just make -- make a comment to -- first of all, I -- I should have said this in a prefatory comment. We very much appreciate you coming here tonight. I'm from the Boston

area. Mitchell's from Los Angeles.

You know this community better than we'll ever know this community. And so not only is the advisory board important to us, but your input and your thoughts are -- are very, very much appreciated, and I mean that sincerely.

Coming back to your quality comment, we just went through a very rigorous regulatory process in Rhode Island where we've acquired two hospitals. And, no, we don't close hospitals. We've never closed a hospital. And we're a growth company, not a contraction company.

But one of the things that the Department of Health there did was they hired a -- a very, very prominent physician by the name of Dr. Mary Reich Cooper, who actually is the chief quality officer of the Connecticut Hospital Association coin- -- coincidentally.

And one of the things they did was they asked her to take a look at two things. One was: What are our quality

metrics? Do -- do we measure up. And, number two, do we have any bad record? Have we ever been in trouble for fraud abuse or any of that kind of stuff?

And she came back with a glowing report. Yes, we have quality. No, we've never been in trouble with any of those fraud abuse type things.

THEA CARDAMONE: Stay out of --

THOMAS REARDON: It's all in the public record.

THEA CARDAMONE: Don't go to Florida.

THOMAS REARDON: Okay.

DENNIS McCONVILLE: Thank you.

Next I'd like to call on Eric Kloter on behalf of Kye Cohen.

ERIC KLOTER: This is a rather --

DENNIS McCONVILLE: Name and town, please --

ERIC KLOTER: Thank you.

DENNIS McCONVILLE: -- for the record.

ERIC KLOTER: My name is Eric Kloter. I live in Tolland.

This letter is written over the signature of Kye Cohen, who is the owner of ShopRite of Manchester and East Hartford.

As the incorporator of ECHN, I've always been extremely impressed with the vision, intellect and communication skills of Peter Karl and Dr. Dennis O'Neill. I am comfortable with their decisions regarding the ECHN acquisition by Prospect Medical Holdings, and it is my hope that the company becomes more viable and successful as a result.

As a business owner, I am keenly aware of the need for economies of scale and the benefits that are derived from collaborating with an experienced partner. My organization's ability to work with a larger entity allows us to stay in business, pass immense savings on to our customers and be phil- -- philanthropic to the greater Manchester community.

The common thread that exists between ECHN and my business is that we

both face a highly competitive marketplace. I truly understand the need for ECHN to adapt to a rapidly changing healthcare environment and fully support the merger so that we may be -- that we may go forward and keep quality health care in greater Manchester.

And, again, re- -- respectfully submitted over the signature of Kyle -- Kye Cohen, owner of ShopRite of Manchester and East Hartford.

DENNIS McCONVILLE: Thank you.

Next I'd like to call on Teri Rogers.

TERI ROGERS: Good evening. I'd just like to ask --

DENNIS McCONVILLE: Would you please state your name and the town for the record?

TERI ROGERS: Teri Rogers of Rockville, Connecticut.

I just have one simple question. What would be some of your long-term plans for Rockville General Hospital?

DENNIS McCONVILLE: I guess I'll

answer that.

TERI ROGERS: Okay.

DENNIS McCONVILLE: With our -- the board's decision to select Prospect as our acquirer, we'll be working on a strategic plan for ECHN as a healthcare system, and certainly we'll be focused on Rockville General Hospital and the panel of services that we will offer to Rockville General Hospital.

I know that there's been concern expressed time and time again over the years about, you know, what happens to Rockville General Hospital. I think the evidence is clear that Rockville is a very important services provider to the community around Vernon -- in Vernon and around Vernon. Our emergency department sees close to 26,000 visits per year. We also know that there are many patients who rely on Rockville General Hospital for their inpatient services as well.

So as we go forward and assess what the community needs are for healthcare services, we'll be working to establish

some new programs at Rockville General Hospital as need dictates, and we'll be doing our very best to attract more business to Rockville General Hospital. And we think that the Prospect model in engaging our physicians, in particular our primary care physicians who help patients make many decisions for where they receive their care will align the physicians, their patients and ECHN to actually improve the demand for services at Rockville General Hospital so more of the services can be offered locally, and we can all benefit from the results that will allow us to make more investments in the community.

Anything else to add?

No.

Did that answer your question okay?

TERI ROGERS: Thank you.

DENNIS McCONVILLE: Thank you.

I think I have one more on the list. Eric Kloter, did you have something you want to say?

You can state your name and town.

ERIC KLOTER: Eric -- excuse me. Eric Kloter, and I live in Tolland.

I'm going to turn my back to these folks because they know who I am, and I know them, too.

I live in Tolland now. I grew up in Rockville. I went to Sykes at junior high. I ran up Mckinley Hill when we practiced soccer and baseball. The coaches wouldn't let us ride a car or walk.

We had to run up -- up to Henry Park. I walked to Rockville High School and back from Orchard Street where I lived. My four kids were born at Rockville Hospital on the third floor in the old maternity floor.

So I care about Rockville like everybody else does that's here. I also was a owner of a family business that operated in Vernon since 1913, and we still operate here. So our roots in Rockville go pretty deep. I care about Rockville.

Why am I saying this? Well, I also

sit on the ECHN board, and I'm a member of the transaction committee that Joy talked about earlier. I've seen a lot of printed materials. I've read most of it. A lot of it's pretty technical.

I know the gentlemen that sit behind me and Joyce. ECHN has a fine leadership team. I respect them. The trust is deep. I know that what they are saying is what they believe. So that's my point No. 1.

I don't really -- I just can't believe that they would close Rockville Hospital. I'm also involved with Visiting Nurse. I don't believe they're going to close Visiting Nurse either.

My second point is just basic common sense. When a company pays a hundred and five million dollars to acquire an entity and then is willing to contribute another $75 million to operations. Are they going to close it? I don't think so. They're going to make it work.

And having listened to the Prospect presentation, having visited their

offices, they're strong strategic players. They're agile, and they're going to make it happen. Just hang on tight because change is going to happen, but we'll all benefit by it.

Thank you.

DENNIS McCONVILLE: Thank you, Eric.

Is there anybody else that wishes to speak or is signed in with Nina?

No?

Okay. I want to thank our panel and turn it back over to Joy Dorin.

JOY DORIN: Thank you all for coming and for your comments and questions.

ECHN has been privileged to care for this community for nearly 100 years. The proposed transaction reviewed tonight will continue to fulfill the mission of ECHN, and that mission is to provide high-quality, compassionate care to the communities we serve.

Thank you again for joining us. Please drive safely. Please enjoy the rest of your evening, and please enjoy the rest of your summer.

Thank you.

(THEREUPON, THE MEETING WAS CONCLUDED AT 7:27 P.M.)

C E R T I F I C A T E

I hereby certify that I am a Notary Public, in and for the State of Connecticut, duly commissioned and qualified to administer oaths.

I further certify that said meeting was taken by me stenographically and reduced to typewriting under my direction, and the foregoing is a true and accurate transcript of the proceedings.

I further certify that I am neither of counsel nor attorney to any of the parties to said matter, nor am I an employee of any party to said matter, nor am I interested in the outcome of said matter.

Witness my hand and seal as Notary Public this 6th day of August, 2015.



Clifford Edwards

Notary Public

My commission expires: 9/30/2016

Preparing for the Future of ECHN

Letter of Determination Public Hearing

Manchester Memorial Hospital

Manchester, CT 06040

August 4, 2015

ECHN℠

Eastern Connecticut Health Network

AGENDA

Welcome & Introductions	Dennis G. O'Neill, MD, Chair of the Board, ECHN
Hearing Purpose, Statutory Requirements & Format	Dennis McConville, SVP, ECHN
Healthcare Landscape, Transaction Rationale & Process	Peter J. Karl, President & CEO, ECHN
Certificate of Need Letter of Determination	Joyce A. Tichy, SVP, Legal Counsel, ECHN
Questions & Answers	Panel

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The Proposed Transfer of Assets of Eastern Connecticut Health Network, Inc. and Affiliates to Prospect Medical Holdings, Inc.

ECHN℠
Eastern Connecticut Health Network

State Regulatory Process

Review by Office of Health Care Access (OHCA) and Office of the Attorney General (1)

* First step in process is the filing of a Letter of Determination
* Within thirty (30) days of filing of the Letter of Determination, the nonprofit hospital and the proposed purchaser hold a public hearing on the contents of the Letter of Determination.
* The hearing is to be transcribed, with the recording or transcription made available to the Commissioner of OHCA, the Attorney General, and members of the public upon request.
* The Commissioner and the Attorney General review the Letter of Determination. The Attorney General determines whether the transaction requires approval under the so-called "Conversion Statute" as a conversion of a non-profit to a for-profit.
* A joint review process is then undertaken by the Commissioner and the Attorney General.

(1) Section 19a-486a of the Connecticut general statutes

State Regulatory Process

Statutory Standards – Review by the Attorney General (1)

* The Attorney General shall deny an application as not in the public interest if:
  * The transaction is prohibited by Connecticut statutory or common law governing nonprofit entities, trusts or charities.
  * The applicant fails to exercise due diligence in:
    * Deciding to transfer
    * Selecting the purchaser
    * Obtaining a fairness evaluation
    * Negotiating the terms and conditions of the transfer
  * The nonprofit hospital failed to disclose any conflict of interest.
  * The nonprofit hospital will not receive fair market value for its assets.

(1) Section 19a-486c of the Connecticut general statutes

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State Regulatory Process

Statutory Standards – Review by OHCA (1)

* The Commissioner of Public Health must deny an application unless a commitment has been made to provide care to uninsured and underinsured.
* The proposal is also reviewed under standard certificate of need guidelines, including public need, impact on financial strength of health care system in the state, whether proposal will improve quality, accessibility and cost-effectiveness of health care delivery in the region, etc.

(1) Section 19a-639 of the Connecticut general statutes

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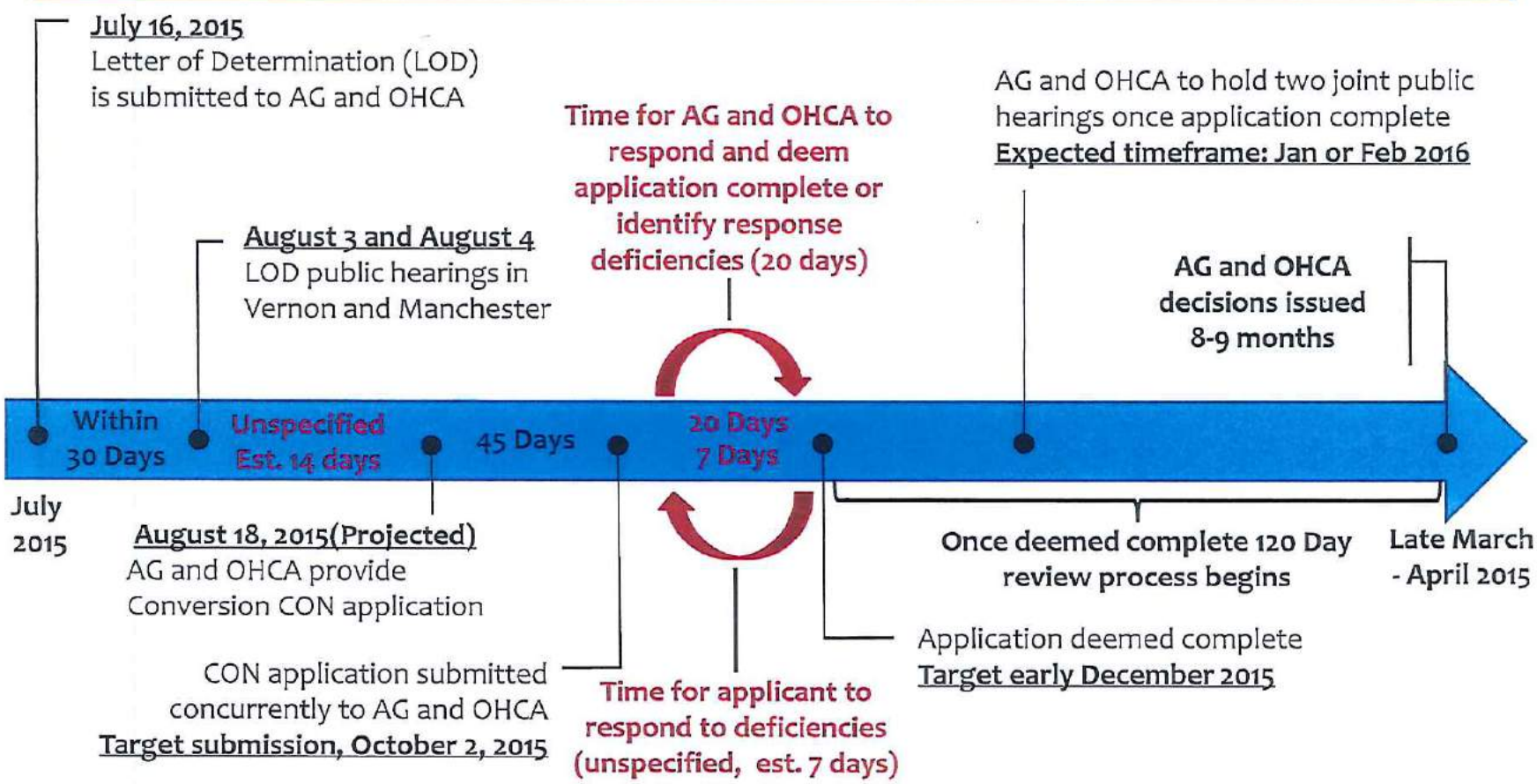
Conversion/CON Process Timeline



Note: Timeline shows estimated dates only and may change

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The Proposed Transaction

Prospect Medical Holdings to buy ECHN

* Continued operation of Manchester Memorial and Rockville General Hospitals, Woodlake at Tolland and VNHSC;
* Continued involvement of an advisory board that includes community representatives;
* Capital to fund new programs and invest in technology, facilities and equipment;
* Partnership with a leading organization that will bring decades of experience with population health management and value-based care;
* Establishment of a community foundation to oversee certain charitable funds; and
* Continuation of the ECHN brand and mission, including a continued commitment to charity care and indigent care.

Preparing for the Future at ECHN

Our Mission : Our Community

* Caring for & serving the community, continuing our mission & vision
  * Improving your wellbeing with quality, compassionate health care
  * Preserving ECHN: its name, pride and institutions
  * Developing the next generation of physicians to serve you
* Preserving jobs
* Economic engine for eastern CT with over $165 million in salaries and $90 million purchased supplies & services annually

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Preparing for the Future at ECHN

Impact of Healthcare Reform (PPACA)

* More than insuring 32M more people
* Declining government payments to hospitals
* Focus on value, lowest cost and best results
* New payment systems with providers at risk
* New delivery models, community focused
* Major investments required

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ECHN's Financial Challenges

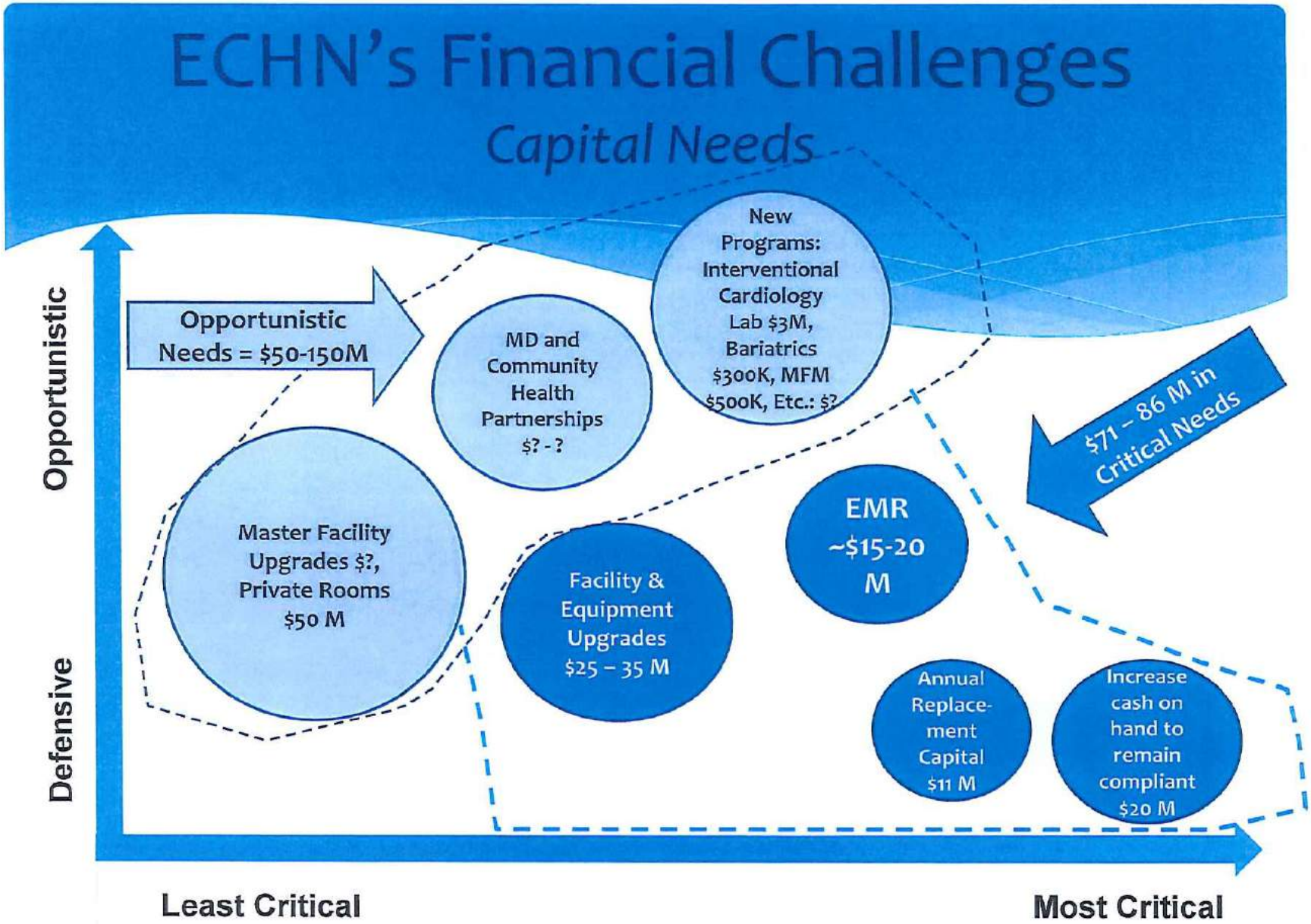
Low margins and growth in debt have forced ECHN to defer capital investments; our historical financial performance has left the organization with a large debt structure that cannot be mitigated through margin alone

1. Operations contributed only $9.3M total over the last 14 years: Operational deficits in 2001-2004 of $23.1 million required 6 years to be overcome



2. Long term debt and pension liabilities have grown 102% ($65M) in the last 14 years– annual debt service and pension contributions now take up the lions share of annual cash flows




ECHN's Financial Challenges
Capital Needs
Opportunistic
Defensive
Opportunistic Needs = $50-150M
New Programs: Interventional Cardiology Lab $3M, Bariatrics $300K, MFM $500K, Etc.: $?
MD and Community Health Partnerships $? - ?
$71 – 86 M in Critical Needs
Master Facility Upgrades $?, Private Rooms $50 M
Facility & Equipment Upgrades $25 – 35 M
EMR ~$15-20 M
Annual Replace-ment Capital $11 M
Increase cash on hand to remain compliant $20 M
Least Critical
Most Critical

12

Continuing Financial Challenges

Taxes and Reduced Government Payments

	FY 2014	FY 2015	FY 2016
CT State User Tax	(3,914,000)	(7,960,000)	(7,141,852)
CMS Sequestration	(1,104,000)	(2,208,000)	(2,208,000)
Medicaid Inpatient Modernization Program		(1,200,000)	(1,600,000)
Low Cost Hospital Pool Eliminated			(300,000)
Medicare Wage Index		(4,825,000)	(6,525,000)
	($5,018,000)	($16,193,000)	($17,774,852)

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Negative Forces into the Future



-Continued payment erosion from federal government

-Declining levels of payment from state government

-Payment reforms with more financial risk

-Continued pension obligations

-Rising costs

= *Unsustainable results with an inability to REINVEST in ECHN*

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Preparing for the Future at ECHN

Process, Questions Answered

1 Should We Affiliate?

- Stand-alone scenario; how viable?
- Benefits of and Vision for, the Affiliation

2 If so,

- Which Partner Organizations are attractive?
- What Criteria will we use to evaluate them?
- How might each partner help us achieve our Vision ?

3 What can each potential partner organization offer ECHN?

- Enhance services; Attract top Clinicians
- Position us to be "Provider of Choice" east of the CT River
- Improve Finances and Access to Capital

4 How Attractive are the Prospective Partnership Proposals?

- Is there a compelling Business Case for each partnership?
- What is the proposed Deal Structure? Is it attractive?

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Preparing for the Future at ECHN

Why join another health care system?

Rationale

* Improve access to capital and afford investments
* Improve finances, reduce/eliminate debt
* Participate in the new payment systems
* Protect, preserve and grow local access to services

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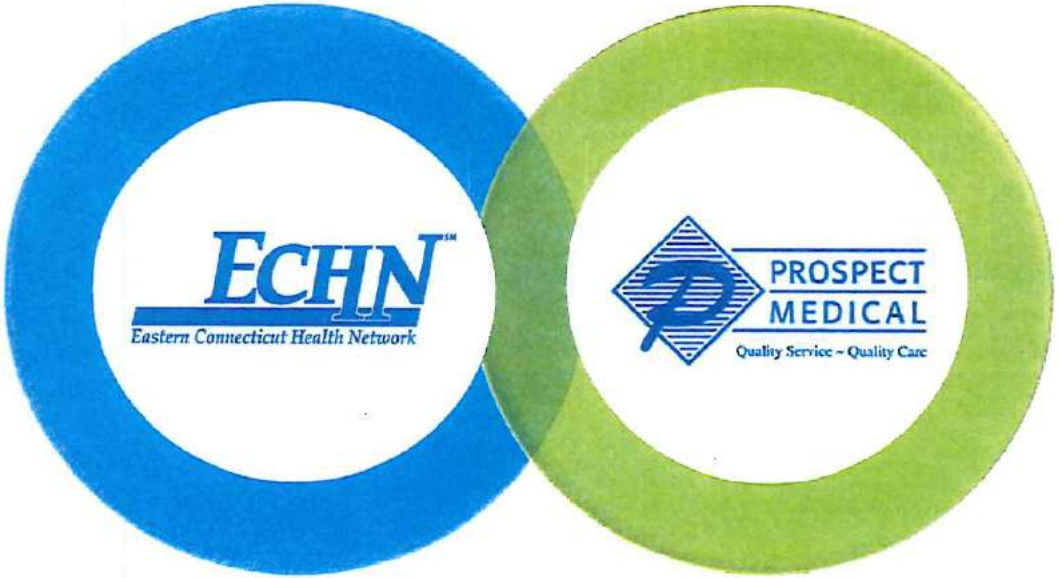
The Request for Proposal Process:

* RFPs were sent to 6 potential partners, both for-profit and non-profit.
* Responses were received from:

1. Hartford HealthCare
2. Saint Francis – Trinity Health
3. Prospect Medical Holdings

The combination of ECHN with Prospect Medical Holdings will secure the future of care and access for residents



* Aligned mission, vision & values
* Strong medical staff partner
* Extensive risk management experience
* Long history of population health management
* Track record of success in markets having large for profit and nonprofit hospital systems

Together with our Medical Staff, building a sustainable, thriving network of value-based care for our communities.

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What will be achieved?

* Continue our Mission, Vision & Values
* Protect Accessibility and Affordability of Care
* Continued Focus on Quality & Safety of Patient Care
* Continuously Improve Patient Satisfaction
* Ability to invest allowing resources for our medical staff, employees, and for patients' care and benefit

Letter of Determination

1. Form of Transaction
2. Key Assets and Liabilities to be Acquired by Buyer
3. Key Assets and Liabilities Excluded from the Transaction
4. Medical Foundation
5. Local Advisory Board
6. Commitment to Maintain Community Support – Charity Care
7. Commitment to Maintain Hospitals and Continuum of Care Network
8. Employment Matters
9. Capital Commitment
10. No changes requested to services or changes to towns served

Project Cost
Overview of Financial Provisions

Excluded Assets:	Donor restricted funds, cash & investments, cost report settlements
Purchase Price:	$105 Million, or $115 Million if refinancing obtained
minus/plus:	Net working capital
Minus:	Indebtedness
	Unfunded pension plan liability
	Post retiree health plan liabilities
	Special employee benefit liabilities (accrued vacation, etc.)
	Captive insurance liabilities
	Worker's compensation liabilities
	Joint venture interests not conveyed
	Asbestos liabilities
Capital Commitment:	$75 Million, reduced by amount of refinancing spent

** Risk of interim operations, stock market performance, etc. remain on ECHN prior to closing

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Public Comments & Questions

Panel:

* Peter Karl, President & CEO, ECHN
* Joyce Tichy, SVP, General Counsel, ECHN
* Michael Veillette, SVP, Chief Financial Officer, ECHN
* Mitchell Lew, MD, President, Prospect Medical Holdings
* Thomas Reardon, President, Prospect East Holdings

Moderator:

* Dennis McConville, SVP, Chief Strategy Officer, ECHN

Eastern Connecticut Health Network, Inc.

Proposed Asset Purchase by Prospect Medical Holdings, Inc.

OHCA Docket Number: 15-31216-486 and Attorney General Docket Number: 15-486-01

Written Statements Submitted at Public Hearing –
Vernon Senior Center, August 3, 2015

As a Corporator of ECHN, I have always been extremely impressed with the vision, intellect and communication skills of Peter Karl and Dr. Dennis O'Neill. I am comfortable with their decisions regarding the ECHN acquisition by Prospect Medical Holdings and it's my hope that the company becomes more viable and successful as a result.

As a business owner, I am keenly aware of the need for economies of scale and the benefits that are derived from collaborating with an experienced partner. My organization's ability to work with a larger entity allows us to stay in business, pass immense savings onto our customers and be philanthropic to the greater Manchester community.

The common thread that exists between ECHN, and my business is that we both face a highly competitive marketplace.

I truly understand the need for ECHN to adapt to a rapidly changing healthcare environment and fully support the merger so that we may go forward and keep quality healthcare in greater Manchester.

Respectfully submitted,
Kye Cohen
Owner, ShopRite of Manchester and East Hartford

Ronald E. Burt, M.D.
Clinical Instructor in Anesthesiology
University of Connecticut School of Medicine
Past President, Medical and Dental Staff, St. Francis Hospital and Medical Center
Past Chairman, Department of Anesthesiology, St. Francis Hospital and Medical Center
Past Chairman, Department of Anesthesiology, Eastern Connecticut Health Network
Past Director of Cardiac Anesthesia, Heart Center of Greater Waterbury

July 27, 2015

To Whom It May Concern:

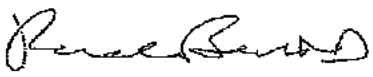
I am writing in strong support of the proposed acquisition of Eastern Connecticut Health Network (ECHN) by Prospect Medical Holdings, Inc., a national healthcare services company headquartered in Los Angeles, California. My support of this transaction is based on over thirty years experience in all aspects of clinical healthcare delivery in settings as diverse as large tertiary care anchor private teaching hospitals, numerous community hospitals and University based delivery systems. Moreover, I have had a close association with the ECHN organization and the community that it serves for a number of years, and am well aware of and sensitive to the needs and challenges that both face in the current climate of unprecedented changes in the health care services industry.

ECHN is an organization that has been a community pillar both in the medical services it provides to all who enter its doors, as well as a key employer within the eastern Connecticut geographic area. The preservation of and enhancement to the services it delivers and the opportunities it provides is critical, and it is my opinion after having substantial exposure to and involvement with the acquisition and merger dynamics occurring at all levels of health care, that Prospect Medical's acquisition of ECHN presents the best opportunity for ECHN's legacy of service and opportunity to be carried into the next generation of health care delivery, which is indeed upon us.

ECHN's leadership has undertaken an extraordinarily lengthy and diligent process of research and deliberation over several years in arriving at the choice of Prospect Medical Holdings, one that solidly supported by both the details of the transaction and the well-paired blend of corporate and institutional cultures that will be the result of the transaction. Prospect's approach to coordinated regional health care delivery and population-based disease management expertise are essential to ECHN delivering the most efficient and highest quality health care delivery in the new environment of the industry, and Prospect has well-demonstrated success in achieving the needed results through a variety of competencies. At least some of these are: a) a keen focus on providing to each patient the right care in the right setting by the right provider with the most appropriate application of resources; b) the ability to integrate effectively with the physician and other clinical provider community that patients know and trust, and follow to ECHN facilities; c) a track record of robust investment and re-investment of resources into the systems it manages, maintaining and expanding health care services as well as preserving and creating employment opportunities within the local communities served; d) the ability to work constructively and effectively with health care employee unions; and e) the ability to do all of the foregoing in a state environment characterized by a high degree of regulation of health care services.

Any person who has even a nodding acquaintance with the sea of change that *all* hospitals in Connecticut are now facing will know that ECHN is not at all alone in the challenges, and even peril, that it faces, and every hospital must make responsible, effective and timely decisions in setting their future course in this storm of health care industry change. Such, I believe, are the characteristics of the decision that ECHN is endeavoring to gain approval for and to effectuate. It is my hope that ECHN's served community and the governmental entities impacting on this process will understand that they have the opportunity to either allow ECHN to pulled into the undertow of this tidal wave of change and be lost, or to facilitate its ascent to the crest of a new wave of services which will ultimately land the organization and the patients it serves safely ashore for another generation of extraordinarily skilled health care delivery.

Very Respectfully Submitted,



Ronald E. Burt, M.D.

Northeastern Pulmonary Associates, LLC

DAVID A. WASSERSTEIN, M.D., F.C.C.P.
M. SAUD ANWAR, M.D., M.P.H., F.C.C.P.
FAUSTINUS C. ONYIRIMBA, M.D., F.C.C.P., M.R.C.P.
KAREN HALASAN, M.D.
SAIMA ANSARI, M.D.
STEFANIE C. WESTCOTT, APRN

Letter of support for the partnership between Eastern Connecticut Health Network and Prospect Medical Holdings Inc.

To: Office of Healthcare Access and the State Attorney General

From: M. Saud Anwar MD, MPH, FCCP
Partner Northeastern Pulmonary Associates, LLC,
Chairman of Department of Medicine, Eastern Connecticut Healthcare Network.

RE: Certificate of Need, Application for Hospital Conversion to "For Profit" Status.

Dear Commissioner of the Office of Healthcare Access and State of Connecticut Attorney General Mr. Jepsen,

My name is Saud Anwar, I am a Pulmonary and Critical Care physician affiliated with Eastern Connecticut Health Network for over 17 years. I support the proposed partnership of Eastern Connecticut Health Network and Prospect Medical Holdings. I am an independent physician who has the opportunity to interact not only with the patients in the community, but also the staff essentially in most parts of our hospital and I also have an opportunity to cooperate with the community physicians providing primary care to our community. As a medical director of the Clinically Integrated Network of Eastern Connecticut and also with the Eastern Connecticut Physician Hospital Organization and medical advisor to the care management department of the hospital, I have had the opportunity to closely observe the sustainability challenges our healthcare system has who are struggling to continue to provide best quality to all the patients with ongoing challenges with increasing social challenges and insurance reimbursement and bureaucracy.

I have also had the opportunity to learn first hand from the representatives of the Prospect Medical Holdings and their existing hospitals and their track record of providing quality care to patients with all capabilities of payments. It is quite clear to the physicians that integrated network and coordination of care in a healthcare system with strong primary care delivery along with collaborative specialty care with appropriate transitions according to the patients' needs is the best and the most effective way of maintaining and managing population health. Prospect Medical Holdings has many years of experience and success in managing risks with their delivery models. The size of our healthcare system and the opportunity to collaborate with an experienced partner who believes in collaboration between the independent physician in the community and the hospital will truly strengthen healthcare within our network.

27 Nash Road, Suite 2, Vernon, CT 06066
94 Union Street, Rockville, CT 06066
Telephone: (860) 875-2444 • Fax (860) 872-2936

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Northeastern Pulmonary Associates, LLC

DAVID A. WASSERSTEIN, M.D., F.C.C.P.
FAUSTINUS C. ONYIRIMBA, M.D., F.C.C.P., M.R.C.P.
SAIMA ANSARI, M.D.
M. SAUD ANWAR, M.D., M.P.H., F.C.C.P.
KAREN HALASAN, M.D.
STEFANIE C. WESTCOTT, APRN

Our hospital continues to employ members in the community and serves as a backbone of the economic engine within our towns. In my other role as a Mayor of the Town of South Windsor, I know that over 250 people in my community are employed by ECHN. Stronger, efficient and sustainable healthcare system allows industry to identify and choose communities to invest in. With the growth of population health management, we truly can have an impact at all levels according to the needs of the people.

I strongly feel that the track record and the current system needs to move to "for-profit" model and this partnership will not compromise the quality of care, but actually enhance the quality of care and would be able to provide care to the patients irrespective of their insurance status and abilities to pay.

I thank you for your consideration. Should you have any questions, please do not hesitate to contact me.

Sincerely,

M. Saud Anwar, M.D.
Chairman of Department of Medicine,
Eastern Connecticut Health Network
860-875-2444

27 Naek Road, Suite 2, Vernon, CT 06066
94 Union Street, Rockville, CT 06066
Telephone: (860) 875-2444 • Fax (860) 872-2936

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PROPOSED TRANSFER OF ASSETS OF

EASTERN CONNECTICUT HEALTH NETWORK, INC. AND AFFILIATES

TO

PROSPECT MEDICAL HOLDINGS, INC.

OHCA Docket Number: 15-31216-486 and Attorney General Docket Number: 15-486-01

Public Hearing Held Pursuant to
Section 19a-486a of the Connecticut General Statutes

Location: **Manchester Memorial Hospital, Manchester, CT**

Date: **August 4, 2015**

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Statement of Robert Carroll, M.D.	
Statement of Joel Reich, M.D.	
Statement of State Representatives	

PUBLIC MEETING

THE PROPOSED TRANSFER OF ASSETS OF EASTERN

CONNECTICUT HEALTH NETWORK, INC. AND AFFILIATES TO

PROSPECT MEDICAL HOLDINGS, INC.

Meeting taken at the offices of Manchester Memorial Hospital, Louise Ruddell Auditorium, 72 Haynes Street, Manchester, Connecticut, before Clifford Edwards, LSR, Connecticut License No. SHR.407, a Professional Shorthand Reporter and Notary Public, in and for the State of Connecticut on August 4, 2015, at 6:00 p.m.

DEL VECCHIO REPORTING SERVICES, LLC
PROFESSIONAL SHORTHAND REPORTERS
117 RANDI DRIVE
MADISON, CT 06443

HARTFORD NEW HAVEN STAMFORD

A P P E A R A N C E S:

DENNIS O'NEILL

PETER J. KARL

MICHAEL VEILLETTE

JOYCE TICHY

DENNIS P. McCONVILLE

DR. MITCHELL LEW

THOMAS M. REARDON

NINA KRUSE

ALSO PRESENT:

DR. BOB CARROLL

AVA HILL

ERIC KLOTER

RAY RUETE

RUDY LUGINBUHL

JOE TYLER

DR. JOEL REICH

AND MEMBERS OF THE PUBLIC

DENNIS O'NEILL: Good evening, everyone. And thank you for joining us this evening. My name is Dennis O'Neill, and I'm the chairman of the Eastern Connecticut Health Network board of trustees.

ECHN is a valuable asset to the eastern Connecticut community, and after nearly three-and-a-half years of review, consideration, due diligence and determination to strengthen ECHN's future, a selection has been made to preserve ECHN through an acquisition by Prospect Medical Holdings.

Previously, a decision was made to pursue the acquisition of ECHN by a joint venture between Tenet Healthcare Corporation and Yale-New Haven Health Systems. For reasons that were beyond our control, we were not able to proceed with that transaction.

Over the course of the past five months, the transaction committee of the board of trustees worked diligently to secure proposals from interested parties

and thoroughly evaluated those proposals to make its decision and recommendation to the board of trustees. This decision was made through the engagement of the community governing structure of trustees and corporators associated with ECHN, which includes representatives of our medical staff. The board of trustees voted unanimously to pursue an acquisition of ECHN by Prospect, and this decision was also supported by the EC -- ECHN corporators with a 98 percent favorable vote to move forward in pursuance of the proposed transaction.

This allows ECHN to move into our next phase, which includes the regulatory process as governed and -- and outlined by the state and federal governments. You'll hear more about this phase throughout this evening.

Now, to review some of this evening's agenda and statutory requirements affecting the acquisition, I'll hand it over to Dennis McConville, the chief strategy officer of ECHN.

Dennis.

DENNIS McCONVILLE: Good evening.

ECHN is hosting two public hearings for letter of determination. We hosted one last evening, August 3rd, 2015, at the Vernon Senior Center in Rockville and another this evening here at Manchester Memorial Hospital. These hearings are to provide the information in the letter of determination that was filed with the State of Connecticut on July 16th of 2015.

Our agenda for this evening is as follows: I'll take a few minute -- minutes or moments to present the purpose for the hearing, the statutory requirements that we believe apply to our proposed transaction, and let you know the format for our -- your participation in the hearing.

Peter Karl, ECHN's president and CEO, will present information about the healthcare landscape for ECHN, the rationale for pursuing our trans- -- transaction with Prospect Medical

Holdings and the process that ECHN followed.

Joyce Tichy, who is ECHN's senior vice president and general legal counsel, will present the letter of determination. And then we'll have a comment question and answer period for you with our panel.

Our panel will include Peter Karl, Joyce Tichy, Mike Veillette, who is chief financial officer for Eastern Connecticut Health Network, as well as Dr. Mitchell Lew, who is president of Prospect Medical Holdings, Incorporated, and Thomas Reardon, president of Prospect East Holdings, Incorporated.

We want -- for the public comment or Q&A portion of the hearing, we want to conduct this evening's hearing in as a precise a manner as possible. It's structured to present you with information about our proposed transaction before we open the floor to comments and questions to address the letter of determination. I anticipate

that this will take about 45 to 50 minutes.

This hearing is a legal requirement for the state regulatory approval process. Additional hearings will be held by the Attorney General and the Office of Health Care Access later in the process after our application for approval of the transaction has been deemed complete. Tonight's presentation and question and answer period will be recorded, transcribed and then submitted to the State Department of Public Health Office of Health Care Access and the Office of the Attorney General.

You must sign in if you wish to comment or ask a question of the panel regarding the letter of determination. If you've not signed in and wish to speak, please see Nina Kruse in the back of the room to do so.

If you've signed up to comment or ask a question, I will call your name to come up to one of the podiums to make your statement or ask your question.

Before you begin your statement, please state your name and your town of residence.

In order to give everyone who wishes an opportunity to speak and in the interest of time, we request that each speaker limit his or her participation to one appearance at the microphone and try to limit your comments to three minutes or less. Your statements or comments should be directed to the contents of the letter of determination.

Copies of the letter of determination are available this evening for your review. We expect that the letter of determination and other filings for our regulatory approval process will be available on both the website of the Attorney General's Office as well as the Office of Health Care Access as the process advances.

Our focus for this evening is the letter of determination, which describes a proposal for the transfer of assets of Eastern Connecticut Health Network and

its affiliates to Prospect Medical Holdings.

The first step -- okay. The first step in the process is the filing of the letter of determination. Within 30 days of filing the letter of determination, the nonprofit hospital and the proposed purchaser hold a public hearing on the contents of that letter of determination. Again, this evening's hearing is being recorded and transcribed as required. It will be filed with OHCA and the Attorney General's Office. The transcript will be made available to you upon request as well.

The Commissioner and the Attorney General will review our letter of determination. The Attorney General will determine whether the transaction requires approval under the so-called conversion statute as a conversion of a nonprofit hospital to for-profit status. A joint review process is then undertaken by the Commissioner and the Attorney General.

A certificate of need approval process for hospital conversions is governed by Connecticut law. The law contains standards that the Attorney General and the Commissioner of Public Health must apply in rendering a decision for each application. The law also allows for each agency to engage experts to assist in the certificate of need process.

The statute states that the Attorney General shall deny an application as not being in the public interest if the transaction is prohibited by Connecticut statutory or common law governing nonprofit entities, trusts or charities. The Attorney General shall deny an application if the applicant fails to exercise due diligence in deciding to transfer selection of a purchaser obtaining a fairness evaluation or in negotiating the terms and conditions for the transfer. An application will be denied if the nonprofit hospital failed to disclose any conflict of interest or

if the nonprofit hospital will not receive fair market value for its assets.

By statute, the Commissioner of Public Health must also apply standards in reviewing and ruling on an application. The Commissioner of Public Health must deny an application unless a commitment has been made to provide care to the uninsured and to the underinsured.

The proposal is also reviewed under standard certificate of need guidelines including whether there's clear public need, the impact on the financial strength of the healthcare system in the state, where there's a proposal, the proposal will improve quality, accessibility and cost effectiveness of healthcare delivery in the region.

Now I'm going to walk you through an estimated timeline for our certifi- -- certificate of need approval process. Some of these intervals are mandated by statute and others are estimates, so they

may change. The process begins with the filing of our letter of determination, which we did on July 16. Within 30 days we're required to hold public hearings on the contents of the determin- -- the letter of determination.

We expect that the Attorney General will rule that our proposed transaction is subject to the conversion statute. We hope that we receive an application from the Attorney General and OHCA within 14 days, bringing us to mid-August. Once we receive an application, we have 60 days to file a completed application. We plan to file our application within 45 days, which gets us to early October.

The Attorney General -- General's Office and OHCA have 20 days to determine if our application is complete. If they identify deficiencies in the application, we will receive what are known as completeness questions. And we estimate that it will take seven more days to respond to those and then 20 more days for the agencies to respond as to whether

an application is complete.

We could see one to two cycles of completeness questions. The target for when our application would be deemed complete is early December. Once the application has been deemed complete, the Attorney General and the Commissioner of Public Health have a hundred and twenty days to decide our application. They will hold public hearings during that time. We estimate that the process will take between eight and nine months, with a decision coming between March and April of next year.

Joyce Tichy will provide a more -- a more detailed description of our transaction in a few minutes, but here's a summary of the proposed transaction: We're proposing that Prospect Medical Holdings buy ECHN. They would be the continued operation of Manchester Memorial and Rockville General Hospital and our post-acute care network including Woodlake at Tolland and Visiting Nurse and Health Services of Connecticut.

There would be the continued involvement of an advisory board that includes community representatives.

There will be capital investments to fund new programs, invest in technology, improve facilities and equipment, the acquisition of ECHN by a leading organization that will bring decades of experience with managing the health of populations and is focused on value-based care, the establishment of a community foundation to oversee certain charitable funds and the contin- -- continuation of the ECHN-branded mission, including a continued commitment to charity care and indigent care.

Now to review our process and background for the acquisition is ECHN's president and CEO, Peter Karl.

PETER KARL: Okay. I apologize in advance. Because this hearing is official and being transcribed, I need to read my testimony for the record instead of speaking informally about these slides. Please bear with me.

Thank you for coming this evening. We're here to discuss the proposed transfer of assets of Eastern Connecticut Health Network and affiliates to Prospect Medical Holdings.

ECHN is proud to serve eastern Connecticut by improving the well-being of the community by offering quality, compassionate health care. That is our mission, and our organization has pursued this mission for nearly a hundred years. Our commitment to the mission is what -- is what we want to continue on behalf of the patients and their families, our physicians and our employees.

We want to see the ECHN name and brand continue. ECHN has made an obligation to training our next generation of physicians. We have developed a strong relationship with our medical staff. We support the education of medical students have -- and have established a new graduate medical education residency program at ECHN.

Manchester Memorial and Rockville

General Hospitals, Woodlake at Tolland, Visiting Nurse and Health Services, as well as dozens of affiliates and joint venture companies, are anchors in the region we serve. ECHN is a significant economic engine providing the salaries for over 3,000 skilled jobs and pur- -- purchasing over $90 million in services and supplies each year.

The Patient Protection and Affordable Care Act is designed to provide insurance of 32 million Americans who are uninsured. Hospitals as an industry agree that they would accept lower payments as more of their patients would now have some form of insurance.

In Connecticut, unlike other parts of the country, residents are relatively well insured, so there is -- there is not the benefit of more revenue for our hospitals. We estimate that we need to reduce expenses by 15 to 20 percent which would mean cutting services and staff.

In addition, the government and the commercial insurers are pushing for payment reforms that shift the risk for getting paid to providers, including our hospitals and our physicians. The -- the resulting new payment systems reward -- reward those who deliver care at lower costs with improved quality and outcomes. This means that we need to reform and refocus our delivery of care to keep patients well in the lowest cost settings, generally at home or in an outpatient setting, preventing patients from needing expensive hospital stays.

The focus on our patients needs to be ongoing and proactive, not just on episodes of illness and hospital stays. The information about our patients needs to be accessible to providers across the network. Care management programs need to be expanded through the community. The investments needed to succeed with population health are major and difficult for organizations that are extremely --

organizations that are operating on extremely thin margins.

As you can see here in this slide, in 2001 ECHN lost more than $10 million and continued to operate in the red for many years. During this time, the lev-- level of debt continued to rise. I took office 11 years ago, and ECHN began to make course corrections, but it took six years to catch up, and we were forced to defer capital investments.

You can see that with the Connecticut Hospital Tax implemented in 2011, we have not been able to generate the operating results needed to reinvest in the organization. You can also see by the lower graph that our pension liability grew dramatically, the result of pension funding reforms that came at a time when the market crashed in 2008.

Debt service and pension contributions consume a large portion of ECHN's annual cash flow and making capital investments -- making capital investments difficult. The pension

liability will grow again by an estimated $14 million next year resulting from new actuarial tables reflecting the longevity of retirees.

Hospital systems are extremely capital intensive. The cost for new medical and information technology are significant. The building codes for our facilities make -- for our facilities to make improvements are expensive. I mentioned population health and the need to share technology across the system. A new electronic medical record system will cost at least $20 million.

There are programs that we'd like to develop to address health needs that require capital investments. Private accommodations for our patients are not only about comfort and privacy, but they offer a safer environment for our patients. Again, hospitals are expensive to build or renovate.

Eastern Connecticut Health Network and all Connecticut hospitals are struggling with financial challenges

associated with the reduction of government payments for services provided to our patients. Payments for services to Medicaid and Medicare beneficiaries make up 55 percent of our revenues.

Since we started our journey to evaluate a partnership, more has happened that worsens our financial position. As mentioned, the State imposed a -- a tax on hospitals that remains a significant burden for ECHN. For a 330 million-dollar system, we have struggled to achieve a 1 to 2 percent margin, which is three to $6 million. You can see that tax represents the margin that we need to produce to remain viable.

ECHN, along with other -- other hospitals, also had to shoulder the finan- -- financial impact of federal sequestration. Medicare provider payments have been cut by 2 percent since April of 2013. The act requires federal spending cuts to be achieved over the course of nine years. So the

sequestration is expected to remain in place through 2022.

The sequestration equates to a loss of more than 2.2 million each year for ECHN. This year the State has implemented a new system for Medicaid payments for inpatient care. While we were told that the change would be revenue neutral, we have determined that this is not the case. We will see 1.6 million less in revenue for those admissions this coming year.

As a result of this year's budget, the pool of dollars for low-cost hospitals was eliminated. While a couple of hospitals were successful in restoring that funding during the special session in a new small hospital pool, Rockville was not so fortunate, and we will see 300 less this year -- 300,000 less.

Finally, the formu- -- formula used by the federal government to calculate our Medicare payments is subject to a wage index. The current projections for payments resulting from the way that that

index is applied will lead to even further reductions.

As you can see here, the negative forces associated with the reduction in payment for services coupled with the increased salary and non-salary costs equates to an ina- -- inability to reinvest in ECHN and an unsustainable financial path.

In order to prepare for the future of ECHN, a work group of trustees, corporators, medical staff, administrators -- and administrators was formed in 2011 to study ECHN's needs and the benefits that would come from partnering with another healthcare institution. After studying the national, regional, and Connecticut landscapes, along with ECHN's current and potential future position, it was decided that a partnership was in the best interest of ECHN.

The partnering work group developed criterion in which to evaluate potential partners, including cultural and

strategic fit, financial strength and long-term viability, and the partner's interest to invest in our organization. The work group made their findings and recommendations to a committee of the ECHN board of trustees, the transaction committee.

When the deal with Tenet and Yale-New Haven Health System did not work out, the board reaffirmed the need for a partner. In January, the transaction committee employed the same process to select and then recommend to the board a transaction with Prospect Medical Holdings.

The reasons to join another system are clear. We want to improve our access to capital and afford investments. We have to improve finances and reduce and eliminate our debt. Together, we -- with our physicians, we have prepared to participate in the new payment system to ensure that -- that we protect, preserve, and grow the local access to healthcare services.

Request for proposals were sent to six healthcare systems. Three proposals were received from Hartford Healthcare, from St. Francis Care and Trinity Health, and one from Prospect Medical Holdings. After careful due diligence, which included rounds of questions and answers, site visits and meetings with the parties, the board selected the proposal from Prospect Medical Holdings as the best one that best meets -- meets ECHN needs.

The combination with Prospect Medical Holdings will secure the future of ECHN and local access to health care for the communities we serve east of the river. There's a strong alignment of mission, vision, and values with Prospect. Prospect is a strong partner for physicians, both independent physicians and those employed by hospitals.

They have decades of experience with managed care and the value-based, risk-based contracts that are emerging as

a result of healthcare reform. Risk-based contracts place the economic risk, the risk for payments based on performance, on the healthcare providers, including hospitals.

Prospect is successful in these risk arrange- -- arrangements because of the programs and resources that they have -- they employ to promote health in managing the healthcare needs of the population of patients in the lowest cost settings, at home or in ambulatory settings, while produce the best outcomes for their patients. Prospect has a history of success in markets where there is significant competition from much larger hospital systems. They have already begun working and educating our physicians about the model, which is important to building a sustainable, thriving network of value-based care for our communities.

ECHN firmly believes that this partnership will allow us to continue to serve our mission. It will protect

accessibility and the affordability of care for our patients while continuing our focus on the quality and safety of patient care. This will support our efforts to continuously improve patient satisfaction, and it will enable us to reinvest in programs, technology, and facilities for the benefit of our patients.

Now, I'd like to ask Joyce Tichy to walk you through some of the finer details associated with the letter of determination.

Joyce.

JOYCE TICHY: Okay. This is a little high. Okay.

So to start here, I'm going to take you back to one of the slides -- two of the slides that Dennis presented just a few minutes ago. I'm -- and I'm doing that because I want to frame the conversation here around what the statutory requirements are that have been set by the State of Connecticut, which have basically directed everything that

the ECHN board has done in this process. And that's by way of saying the legislature of Connecticut has really tried very hard to represent the interests of you, the communities in Connecticut, including this one. As the -- as the market has changed under everyone's feet, they've tried and -- and really developed quite a number of legislative initiatives in order to support the process to make sure that a transfer of a hospital from a not-for-profit to a for-profit status is fair and appropriate.

And our board, knowing this, has attempted to follow each of the directives set by the legislature in the very best way they know how. They've attempted to be faithful to the goals that were set in the creation of ECHN and ECHN's charitable assets and in the transfer of them now to -- to Prospect.

So this slide describes the role of the Attorney General. We have really two of the most significant regulators who

are reviewing the -- this transaction, one of which is the Attorney General. And the Attorney General's role in -- in this process is to make sure that we, like all other charities, follow the process that is -- that makes sure that the charitable asset that was developed and contributed to and supported over time by the community is appropriately honored and the amount of value that was placed in it goes back to the community, less the liabilities that it -- that have been created over time as a fairness matter.

So this is -- the list that you see on the screen really reflects what the Attorney General requires us to show in order to get through that regulatory process.

The next slide describes a little different process or a different focus, and that's the Office of Health Care Access. And their role is a little different, and that is to make sure that whatever the process is and the

transaction is, that the impact on the health of the community is -- is such that the availability of -- of health care is preserved and not reduced. So you can see that these -- what this slide shows of the standards that the ECHN board had to meet.

So those are the things within which our board framed its conversations and discussions and research. And I just want you to know that because the guide for how the Attorney General and the Office of Health Care Access will review this transaction is through these lenses.

So the part that I'm going to talk about now is the -- an additional piece of the set of tests that we have to meet, and that is we have to show that in engaging in this transaction and completing it, our board conducted a diligent negotiation of the terms and conditions of the transfer. Aside from just ultimately making sure that there was fair value, we have to show that we

actually diligently -- the board has to show that it diligently went through the process and make sure it could get -- it got the best deal it could for this community.

So this slide -- I'm going to be on the next two slides for a while, and so excuse me for that. But what I'm going to try to do is describe to you the 30,000-feet description of the transaction.

So the form of the transaction, which is very common in a transfer of a-- of an entity from a not-for-profit to a for-profit company is an asset purchase, and that is by which to -- to say Prospect will be buying substantially all of the assets of ECHN.

The key assets to be acquired by Prospect, which are listed in the proposal -- the -- the letter of determination proposal that we submitted are the -- the two acute care hospitals, Manchester Memorial and Rockville General, Woodlake and Tolland, our rehab

and long term-care facility, Visiting Nurse Service of Connecticut, which is our visiting nurse and home care company.

We have an insurance captive, which handles our medical malpractice liabilities. That's transferring as well. Our medical billing and physician office administration company, which is named Medical Practice Partners, is transferring, and all of the other entities that bear the ECHN name in your community, such as our physician offices in the area, along with our shares in the office buildings in which those physician offices are present.

We also have interests in a variety of -- of joint ventures, which is, again, very common for hospitals -- in hospital systems. Those include an endoscopy center, an entity that provides oncology services across the street from Manchester. It's called -- in our Dequattro Cancer Center. We have two ambulance companies, a wheelchair -- a

wheelchair transfer company, an occupational medicine provider and others. So we will be transferring, to the extent that the rules of those joint ventures allow, our interests also in those entities to Prospect.

So the list that I've just given you is not exclusive, and some of the joint ventures that we are intending to transfer may not transfer for one or another reasons, including our need to get permissions from other third parties, and the effort to transfer those will be part of this process as well.

Along with all of those entities, all the equipment, property leases, the chairs you're sitting in, the screens here, all of those things will become property owned by Prospect.

So as part of the -- a transaction like this, while you list the assets that are to be transferred, you also list the liabilities that are going to be taken on by the acquirer. Those liabilities will

be accompanied by a reduction in the purchase price that ref- -- reflects the value of those liabilities. So these are already existing obligations of ECHN which a hospital system typically acquires over time just as it operates its business.

Those include very significantly, what Peter mentioned earlier, our unfunded pension liabilities and obligations under our post-retiree health plan. Those are two items that our board was very interested in to make sure it got transferred so that our -- our commitments to our retirees would remain and be honored.

In addition, we're transferring over to Prospect our captive insurer liabilities, which cover our med- -- our medical malpractice claims and our Workers' Compensation liabilities. On -- on the other hand, there are also some assets that will -- are not included in the transaction. Those include our donor-restricted charitable

contributions, and that being when a donor contributes money to Manchester Hospital or has contributed to Manchester Hospital or Rockville or our -- our charitable foundation, if they placed a restriction on it, for example, you may not spend the principal, you can only spend the income on the charitable works, that money now needs to be set aside.

It can't be delivered to a third party, and it will be placed in a -- in a separate account. And the Attorney General will define as part of his job to define where that is to go next. We don't really have any control over that, and we're just identifying it and putting on the side for instructions.

Also, that -- what will not be transferred are the results of our lawsuits that occurred before the -- the closing of the transaction. So they're basically incurred by ECHN, not the responsibility of Prospect. So that remains our liability and something that

ECHN will continue to be responsible to pay for.

Cost report settlements with -- with Medicare and tax settlements are similar. These are pre-closing liabilities that we have that will not transfer.

Also not going with the transaction, are ECHN's cash investments. And as I'll explain in a minute, those will be used to pay off the debt that we -- these debts that we have at closing, and ECHN's long-term debt, again, to be settled at closing.

After all the puts and takes, which I'll go through in a second, whatever -- you know, these liabilities to the extent that they're not resolved and cleaned up and cleared out will be managed and handled by a residual ECHN corporation, which basically will be a shell entity just there in order to close out operations.

An additional piece of the transaction is our medical foundation, and that's the name that we use in

Connecticut for the entity that ECHN as an -- as a healthcare entity owns and it is where our physicians are employed. So there's been a fair number of changes in the law regarding medical foundations. Our legislature has been actively involved in making sure that those are appropriately managed in Connecticut. The law recently changed, and we will make sure that when we transfer the medical foundation, we do it in accordance with the way our regulators direct us to do. It's a little bit unclear at the moment, but there is going to be certainly a process for doing that.

As part of the transaction, our board was very interested in, and Prospect agreed, to set up a local advisory board. There will be one for each of the hospitals, Rockville and Manchester. The members of that board will be appointed by ECHN before the closing, and they are initially to be made up of five ECHN trustees and five

others identified by ECHN. The members will include community representatives, physicians on our medical staff, and our hospital CEO, which is -- which is Peter.

The role of the advisory board will actually be significant. It's going to be an adviser for how to spend the 75 million-dollar capital commitment that's part of the transaction that Prospect has agreed to. It will assist with the development of our strategic business plan, that is, Prospect strategic business plan in furtherance of the community -- community's interests. It'll be responsible for medical staff credentialing. It'll oversee quality assurance, a very key part of our operations. And it will oversee and manage the hospital's accreditation.

One of the things that the Office of Health Care Access is going to ensure that we have as part of the deal and that we ask Prospect to commit to, and they

willingly did, is a commitment to maintain community support, charity care and the continuum of care. Those are CON requirements, and Prospect has agreed to maintain ECHN's policies on charity care, indigent care, community volunteer services, community -- and community outreach services.

In addition, we have a graduate medical education program, which was referred to earlier, in partnership with the University of New England College of Medicine. It's been a -- a very good program for the community and for ECHN. It's already begun graduating young doctors into our community, some of whom have decided to stay, much to our happy -- I wouldn't say surprise, but much to our happiness. And Prospect has agreed to maintain that program in -- at ECHN.

Prospect has also agreed to maintain for three years our two acute care hospitals and their emergency part -- departments, and it's agreed to maintain

an ownership interest in our visiting nurse service, VNHSC, our -- and our subacute and long-term care facility, Woodlake at Tolland.

With respect to employment, Prospect has agreed to offer employment to substantially all of our ECHN employees and to give them comparable benefits to the packages that they had pre-closing.

As ECHN began the journey to partner with an entity, it knew that it -- it had collective bargaining agreements with our unions. And as part of the effort to protect their interests, ECHN negotiated the last round of collective bargaining agreements to have a fairly long end date. And so what that means -- and Prospect has agreed to take on our collective bargaining agreements that have a fairly long expiration date from now, that being June 2018 for the RNs at Manchester Hospital, May 2017 for the service and skilled maintenance em- -- employees at Manchester, June 2017 for

our technical and LPN employees at Manchester, and December 2018 for the RNs at Rock- -- Rockville.

As -- as I also mentioned, Prospect has agreed to spend $75 million within five years. This is after the closing. So Prospect will already be the owner of ECHN. And it's agreed to invest $75 million in our facilities to pay for upgrades to the facilities and projects that we have in order to improve services.

Examples of how that money may be used are renovations to our facilities, which as Peter earlier noted, we haven't had sufficient capital in order to invest in our facilities for a period of time. So they are in great need of renovation, and that money will be used toward that purpose. They'll also be used for recruitment costs as appropriate to bring in needed medical staff, expansion of our clinical departments and the purchase of medical equipment or the electronic medical records earlier mentioned.

If a law or rule is passed, though, that discriminates against for-profit systems, our agreement with Prospect provides that they can defer that obligation beyond the five years, but in -- if they are to do that, they need to confer with the local board that I mentioned earlier.

With respect to changes to the service or towns served, which is another provision that the CON requires us to respond to, there are to be no changes in this transaction requested to the services or towns that are served, no changes.

If anyone heard me speak on this subject last year, you'll probably think that this arrangement is pretty similar to the one that we had with Tenet and, in fact, it is in many ways similar. We were pleased with that result because Prospect agreed effectively to take on Tenet's commitments, even though our financial condition is not as good as it was a year earlier. And in addition, it

agreed to some improvements over the Tenet transaction.

So, for example, Prospect agreed to reduce the indemnity reserve, which I'll describe in a minute, from 75 million -- excuse me -- from 7.5 million to $4.5 million, and it agreed to cap the value of our joint ventures if we are unable to transfer them to Prospect in case we need to deduct from the purchase price because we can't transfer them over. And in addition, if we can't transfer the joint ventures over to Prospect, they've agreed to give us a loan to carry us over to the closing despite the inability to transfer those joint ventures.

So those agreements indicated to us a strong willingness on -- on Prospect's part to partner with us and to make the arrangements work. They're also going to allow us to use and access the capital commitment earlier in furtherance of the closing if need be.

Okay. So that was pretty long on

this slide, and the next slide is going to be kind of long, too. And I do apologize for that.

So what this next slide describes for you is what transaction lawyers call the waterfall. And people ask, Okay, where's the money -- you know, sort of, How's the money coming in? Where is it going? Sort of how -- you know, who gets -- you know, how -- what are the steps involved? So that's what this slide is really intended to describe for you.

So I -- the purchase price as mentioned is a hundred and five million dollars, but before we get to that, there is a line on the top which indicates what I described to you earlier, the excluded assets. So as you kind of view how this process works, think about sort of buckets. So I mentioned the donor-restricted funds, the ones that we can't access because the donor has said, Don't spend them; they're for -- you know, if you can't -- don't -- don't

access them, only access the -- the principal. So in that instance, you take that money and you put it aside in a bucket, and you keep it over there and don't do anything with it.

Then you take another bucket, and you put our cash and investments into that bucket. And then the cost report settlements, if there are any at that point in time, you put it in a third bucket. You just keep those buckets there.

Then you get a hundred and five million dollars from Prospect. Immediately at that moment, you do a true-up to make sure that you have enough networking capital, which is the money that you need basically to run the business on a day-to-day basis. You think of it as your checkbook. You have to have enough money in there even before your paycheck gets in to pay all -- all of your bills. That amount needs to be, as we've predetermined it, $24 million. So if there's more in our net working

capital accounts, we true it down, and if there's less, we true it up.

After that, we then take reductions from the hundred and five million, and those will be used to pay the liabilities already -- that ECHN already owes to others. One of those is our indebtedness for things such as capital leases. Another is those unfunded pension liabilities that I mentioned and Peter mentioned earlier, and our post-retiree health liabilities.

The next is our employment-related liabilities. The next is our captive and Workers' Compensation liabilities, the values of our joint venture interests not conveyed, and our asbestos liabilities. So remember, Prospect is taking those liabilities. So we have to give them the money to cover the liabilities that they're taking so that they in turn can pay the others to whom those monies are owed.

If there's anything left, that amount that's left will be combined with

the cash investments that remember I told you put in the buckets over -- one of the buckets over here, and that money will be used to pay off our long-term debt to bondholders and lenders, which is, again, a -- a typical liability that an entity like a hospital system has over time.

Whatever is left from that is then used to fund the indemnity reserve of $4.5 million, and that amount is -- sits basically in a bank account to cover our liabilities for things like lawsuits or liabilities that we're just not aware of as yet that occurred, that -- that came to be before we closed the transaction, but really belonged to ECHN.

If -- if at the end of three years, that money hasn't needed to be used for that purpose, it gets combined with the amounts that we have already set aside in the donor-restricted fund and any other monies that are left from after you take all the -- all the deductions that I described earlier.

Again, after the closing there will still be another $75 million in a capital commitment that Prospect promises to spend in order to enhance and improve ECHN's facilities.

So that's basically how the transaction is going to work. Caveats to this are that the agreement between us and Prospect says that there will be no material changes to the business assets, liabilities, financial condition or results of operation of ECHN, that the medical foundation that I described earlier needs to be successfully set up and transferred to Prospect. And there are many other closing conditions which are -- again, there are many of them, but they are typical in a transaction of this kind. So those would be conditions that would allow Prospect to -- to not close the transaction, and we hope none of them comes to be.

The last thing I want to point out is that there will be a number of levels of independent verification to the

fairness of the decisions made by the board of directors -- the board of trustees of ECHN in order to protect the interests of the community. The fairness of the purchase price will be confirmed by a third-party fairness opinion. There will be an outside audit of our financial statements.

There will be actuarial reports for our pension and retiree health to make sure that those amounts have been accurately identified so that the liabilities can be covered. There will be the independent Attorney General and OHCA review that I described earlier. And each of them will hire and use independent experts to test and document the representations and -- and those experts will be paid for by the parties.

DENNIS McCONVILLE: Okay. Fifty minutes.

Now we've reached the part of our hearing where you, the public, may participate. Again, for this portion of

the hearing you must sign in if you wish to comment or ask a question of our panel regarding the letter of determination. If you've not signed in and wish to speak, please see Nina Kruse in the back of the room to do so.

If you've signed up to speak, I'll call your name to come up to the one of the podiums to make your statement or to ask your question. Before you begin your comments or questions, please state your name and your town of residence. In order to give everyone who wishes to speak an opportunity to do so and in the interest of time, we request that each speaker limit your participation to one appearance at the microphone, and that you try and limit your comments to three minutes or less.

Your statements or comments should be directed towards the contents of the letter of determination. If you've signed up to speak, but you've changed your mind, just state no comment when I read your name. If you've prepared

written legible comments, you may leave those comments with Nina Kruse, and we will enter them into the record.

At this time, I'd like to introduce our panel.

Can you turn that off, please? Great.

Joyce Tichy, senior vice president and general legal counsel for ECHN, and Peter Karl, president and CEO for ECHN, and Michael Veillette, senior vice president and chief financial officer for ECHN, for Prospect Medical Holdings, Dr. Mitchell Lew, who is president of Prospect Medical Holdings, and Thomas Reardon, who is president of Prospect East Holdings, to take your questions.

Okay. I'd like to call to one of the microphones Dr. Bob Carroll.

BOB CARROLL: Hi. My name is Bob Carroll. I'm a physician on staff here. My town of residence is Farmington, Connecticut. I've been at ECHN for 15 years.

Dear Attorney General Jepsen,

Commissioner Mullen, and citizens of the towns and cities served by Eastern Connecticut Health Network. I would like to express my opinion on the acquisition publicly. As the chair and senior medical director of the Department of Emergency Medicine and the service line director for emergency services at ECHN, I would like to express my excitement about the future acquisition of ECHN by Prospect Medical Holdings, subsequently referred to as PMH.

For the past several years, we have been facing one financial challenge after the next in the form of hospital taxes, sequestration, Medicare reimbursement cuts, pension reform and unfunded quality reporting mandates.

The only way we have been able to meet these challenges has been to do more with less. My view on health care is that we are facing the same struggles now that the smaller department stores and hardware stores faced a decade or more ago with the emergence of Wal-Mart and

Home Depot. Their ability to produce goods in such large quantities made it impossible to compete with their prices, and many of the mom-and-pop stores eventually went out of business. This is the path that I believe ECHN would be on if we didn't proceed with the acquisition.

I, as a healthcare provider, and ECHN, as a healthcare system, have an obligation to the patients we serve. Our obligation is to be there for them in their time of need and to provide the expertise, staff and equipment necessary to diagnose and treat them at any hour of the day or night.

The acquisition of ECHN by a larger system is the only option that would allow us to continue our mission of improving your well-being by providing high-quality, compassionate health care. Without the ability to join a larger system, our costs will be higher than our competitors, our ability to recruit skilled physicians and nurses will become

more difficult, and we will eventually find ourselves out of business.

I have been asked many times, Why partner with PMH rather than one of the other larger systems closer to Manchester and Rockville? My desire for PMH is based on my belief that they would the best option for both the patients we serve and the staff we employ.

In order to succeed, PMH has to help grow our system to allow us to directly compete with our local competitors. I feel that if we had chosen to partner with a nearby competitor, we would become victim to consolidations of services and locations. This would directly impact access to health care for our patients in our communities.

In my 15 years at ECHN, I watched our competitors advertise their cutting-edge therapies during the prime-time news and open healthcare centers in our neighborhoods. I've read about their latest minimally invasive cardiac procedures and have heard on the

radio about their world-class stroke therapies. It would be really nice to have the access to capital funding that would allow us to advertise the cutting-edge programs we have here at ECHN. However, the ability to grow and advertise these types of services is becoming virtually impossible under the financial constraints we are facing.

With the implementation of the Affordable Care Act, the increase in Medicaid volume and the State's tax on hospitals remaining independent is futile and no longer an option. A partnership with PMH will afford us access to the clinical expertise our patients need as well as access to the desperately needed capital funding so that we can resume investing in our technology, staff and infrastructure.

This position -- this partnership will position ECH competitively for the foreseeable future of health care. Sincerely, Robert Carroll, M.D.

DENNIS McCONVILLE: Thank you,

Doctor.

I'd like to call Ava Hill to the microphone, please.

AVA HILL: Let's see.

DENNIS McCONVILLE: Please state your name and your town of residence, please.

AVA HILL: Ava Hill, Manchester, Connecticut.

I've been with ECHN for about ten years now. I work Monday, Wednesdays and Fridays, and I've been a float for many years, along with working at Rockville Hospital, the off-sites, and at the cancer center currently, and I teach at Goodwin College. I've been there for about nine years as well teaching phlebotomy.

And so I'm here because I had a question, but I decided to retract that question. And I know that -- I'm sure that everyone here this evening, along with countless devoted employees who are not present, do understand the extreme need for some type of transaction -- this

type of transaction to take place in order for this institution to continue the amazing work that they do to serve the community.

My main concern now, however, is that ECHN employees ultimately must know how this affects their future beyond 2017, 'cause you spoke about 2017. So it's important to know for everyone how -- you know, how it will ultimately affect their future. And if I'm repeating -- if I'm asking questions that you've already answered, I -- I do apologize.

Will the employees need to reapply for their positions?

That's my first question.

They will?

PETER KARL: No. I was --

AVA HILL: Okay.

PETER KARL: I was waiting for all your --

AVA HILL: Okay.

PETER KARL: They won't have to.

AVA HILL: I'm wondering if there's

a difference between the union and nonunion workers?

PETER KARL: No, there are not.

AVA HILL: Okay. How many employees are at risk of losing jobs based on -- what I've -- I've heard some -- some people speaking about it -- for instance, with -- in the phlebotomy department and in the lab department, I heard that there was a possibility that one may lose their job if they're not currently certified.

I don't have that issue because I teach a program, and I've been with -- with ECHN for many, many years. However, my coworkers are asking me, Do I need to go and get recertified in order to be rehired or in order to be able to sustain or, you know, keep my job at this point?

And that's an important question because they -- it affects so many people that are not certified.

PETER KARL: Any more questions? And then I'll just --

AVA HILL: Okay. All right.

Are there any number of employees that are at risk of losing jobs? That's an important question.

And I'm -- I'm speaking specifically on behalf of the laboratory. I'm wondering because I -- again, I have -- I've been around for many years. I've been in many places. And I want to know -- that I want to report back to them who is at risk and will the employees be required to have any additional -- well, okay, I'm repeating -- certifications or licenses. I'm sorry to repeat myself.

PETER KARL: Okay. So I'll -- I'll respond to --

AVA HILL: -- okay.

PETER KARL: -- some your questions, and then I'll -- I'll pass it over --

AVA HILL: Okay.

PETER KARL: -- to Tom or Mitchell.

The employees will not have to reapply for their jobs.

AVA HILL: Okay.

PETER KARL: Okay?

The reason why the term "substantially all employees" is used instead of saying all employees are used --

AVA HILL: Uh-huh.

PETER KARL: -- is because if there are poor performers that are --

AVA HILL: We don't want them.

PETER KARL: -- suspended and are on their last final warning, and so on or so forth, you know, that -- that may be 1 percent or a half a percent, they may not come along.

AVA HILL: Okay.

PETER KARL: But substantially all means the benefits, the union contracts, the nonunion employees, so on and so forth, they will all come along.

AVA HILL: And -- and even if they're in the upper -- in terms of compensation?

PETER KARL: Absolutely.

AVA HILL: That's another question that has come.

PETER KARL: Absolutely.

AVA HILL: And -- and I said, Well, I will try to --

PETER KARL: Absolutely.

AVA HILL: -- find the answer.

PETER KARL: Whether they're currently certified or not, as long as they meet State requirements to perform their duties.

AVA HILL: Okay. And so currently in State of Connecticut, there are not certifications required. I -- I know -- I do know that many institutions are requiring that at this point. So I'm wondering if once the takeover happens, if these people will be at risk of losing their jobs if they don't hold a current certification?

PETER KARL: That has not been -- that has not been discussed.

AVA HILL: Okay. But that might happen? We don't know?

PETER KARL: We don't know that.

AVA HILL: Okay.

PETER KARL: That's very far in the weeds, but I understand --

AVA HILL: Okay.

PETER KARL: -- the importance of that question.

AVA HILL: Right. Absolutely.

PETER KARL: But if there isn't a certification in Connecticut at this point in time, those employees would come across.

AVA HILL: Okay.

PETER KARL: Okay?

THOMAS REARDON: Hi.

AVA HILL: Hi.

THOMAS REARDON: First of all, I just wanted to say to everybody, thank you for coming tonight. We very much appreciate it.

I'm from Boston. Mitchell's from LA. But you know this community better than we'll ever know it, and so we really, really appreciate your input, and I mean that sincerely. We are excited to be here as potential partners for ECHN.

As an employee, nobody likes change. And the first thing any employee, myself included, asks -- says, What happens to

me?

AVA HILL: Uh-huh.

THOMAS REARDON: We are a growth company. We are not a contraction company.

AVA HILL: Okay.

THOMAS REARDON: You will not have to reapply for your jobs. As I said, we are a growth company. We work very well with the unions and nonunions.

AVA HILL: Uh-huh.

THOMAS REARDON: And -- and -- and I'll leave it at that.

AVA HILL: I'll be able to report back wonderful news. I'm happy about that.

DENNIS McCONVILLE: Thank you. Okay. All set?

AVA HILL: Okay. I'm good.

DENNIS McCONVILLE: Thank you, very much.

AVA HILL: Thank you.

DENNIS McCONVILLE: I'd like to call up Eric Kloter on behalf of Senators Cassano, Guglielmo, and Larson, and State

Representative Mark Tweedie.

ERIC KLOTER: My name is Eric Kloter. I live in Tolland.

This letter is over the letterhead of the State of Connecticut General Assembly, and it is signed by the gentlemen that Dennis referred to, and it's addressed to the Honorable George C. Jepsen, who is Attorney General, and the Honorable Jewel Mullen, who is the Commissioner of Public Health and the Office of Public -- the Office of Health Care Access.

Dear Attorney General Jepsen and Commissioner Mullen. We are pleased to endorse the proposed transaction, including a formal public hearing process with public input, for Eastern Connecticut Health Network to be acquired by Prospect Medical -- Medical Holdings. They will pre- -- preserve and enhance our residents' access to the community-based care that they have relied on for generations for themselves and their families.

Prospect has a strong track record of collaborating with physicians, community providers, payors and other key stakeholders to provide high-quality, cost-effective services to the communities it serves.

We have an obligation to support the efforts of our community hospitals which are striving to continuously improve quality while reducing cost, but struggling with lower payments for services and continued cuts in state and federal reimbursements for care. It is important for state public servants to ensure that our constituents have local access to quality health care that is affordable.

Prospect has decades of experience and success with provider payment risk arrangements now emerging in the state. With their experience and resources, the result will be better care for individuals, better health for the residents of Eastern and lower costs for health care. Access to capital will

allow ECHN to reform and strengthen its care delivery network to offer even more community-based services and to keep its two hospitals, Manchester Memorial and Rockville General, viable to meet patient needs and expectations.

Therefore, we encourage OHCA and the Office of the Attorney General to look favorably upon the proposed transfer of assets as described in the certificate of need determination letter recently filed by ECHN.

Sincerely, Senator Steve Cassano, Senator Tony Guglielmo, Senator Tim Larson, and Representative Mark Tweedie.

DENNIS McCONVILLE: Thank you.

Next I'd like to call on Ray Ruete. Am I pronouncing that correctly? I hope.

RAY RUETE: Close enough.

DENNIS McCONVILLE: Thank you, sir.

RAY RUETE: Ray Ruete, Ellington Connecticut. I'm not an employee of ECHN. I'm just a consumer of services.

Through the presentation, Mr. Karl

brought up a lot of significant drags on the finances of ECHN, most of which or many of which are being levied by our state politicians and federal government, and so forth. It doesn't seem to me like that's going to change whatsoever and perhaps only get worse, barring a collective heart transplant of our politicians.

Why would you think taking over this company, that you can then make it better with that kind of a situation in the environment of Medicare payments, and so forth, that the government handles?

MITCHELL LEW: Thank you, Mr. Ruete. A very good question.

First of all, on the hospital side we have a lot of experience with community hospitals. We run very efficient, lean hospitals. And due to our size now, 13 hospitals, we can achieve some economies in terms of ordering supplies and medications and such.

But really our model is one which we

work with our hospitals, and we also own physician groups. And what we do is we -- we coordinate care, we integrate our hospitals and our physician groups together, and we approach health plans with the idea that we will take financial risk and manage a population. That's what we've been doing in all of our various regions where we have hospitals and physician groups, Southern California, Texas, and Rhode Island.

And what this allows us to do is manage the care of a population under a budget, but with the goal of achieving highest quality, access, but do it at -- at an affordable price.

And so where there are a lot of waste in the system, perhaps some fraud and abuse, a lot of redundancies, we've learned to really do a very efficient job of delivering the right care at the right time in the most appropriate setting. So in some cases, it may not be in a hospital. It may be in a member or a patient's home or in a skilled nursing

facility or wherever the patient may be, we've -- we've learned how to do it in a -- really in a -- in the most appropriate way, but not necessarily in a more expensive setting such as a hospital.

So that -- that really is our model, is to -- to take more of a financial risk in health care and -- and manage it in a way that the patient gets the care that they need at the right time, as I said, but really not necessarily -- not necessarily do it in the most expensive setting such as a hospital, but perhaps send a team of physicians and nurses and pharmacists out to a patient's home or maybe in a physician's office to help support the physician.

So it -- it's really a -- a community local physician approach that really manages across what we call the entire continuum of care. So that means no matter where a patient is, we will take care of the patient. And -- and we've learned that what that does is it

reduces the risk of a patient being readmitted to a hospital. We can allocate resources that are, you know, less costly. But, again, the end result is it -- it does it for a lot less than the more traditional fragmented approach where volume is more important to -- to certain systems and -- you know, and the ECHN system, I think, is a much lower cost system than some of the more expensive competitors.

And so our ability to -- to then go out and recruit physicians and work with plans to -- to take care of more patients will drive business into the system. And -- and it's -- it's a growth model. It's very sustainable and -- and we have no plans to -- to contract.

RAY RUETE: If you're looking for suggestions on improvements or possible cost savings, I have some on the billing system that ECHN uses to send out bills to patients.

MITCHELL LEW: Well, we'll -- we would look forward to that, but the local

leadership will certainly --

RAY RUETE: Not so far.

DENNIS McCONVILLE: Thank you, Mr. Ruete.

I'd like to call on Rudy Luginbuhl, please.

RUDY LUGINBUHL: Good evening. Rudy Luginbuhl, 29 Middle Butcher Road in Ellington.

It's -- it's highly -- I can't hardly think of the time that's gone by here since -- I'm going back a little bit now -- in -- in the beginning of all of this because I was the chairman of Rockville Hospital when we merged with Manchester, and we did it in the late '80s, into the '90s. So we're talking 20, 30 years where the progressing of the type of care that we needed and all was improved through that move. We -- we know that -- that it was a good move because it grew to Eastern Connecticut Health that we have today.

But when you -- when you think about why did we do it then, it's no different

than why you're doing it now. The economy of scale is the first thing you have to think about. If you can do something together that you were doing separate, and you can go out and get a bid that's a better bid for what you're doing, then you're going to be able to do it at a less cost. So that's kind of where we were led to the, you know, combining laundries, the -- the food service, whatever came into being.

And so when I think about that, that's what's going on now, only a larger scale, but it's still the same motivating force that says you must -- the -- the idea of saying, well, you know, there's an option. The option is to do nothing. We know that. If you do nothing, then slowly but surely you're going to probably not be here for long. So you've got to do something.

So you -- we have a group here that's studied all this in -- in detail and -- and we believe and I believe that -- that they are telling us that we

need to go forward. And I certainly strongly support what's going on here and -- and hope that the community does realize that no one wants change. We -- like you mentioned before, but it's inevitable when it comes to this type of operation where the funding is changing and you -- you need to have a -- a beg -- a bigger buy so you can buy better and all that.

So I just want to say that, you know, it's -- it's almost 20-something years now and -- a d here we are at a position where we've got to move another step forward. And I do support it completely. Thank you.

DENNIS McCONVILLE: Thank you, Mr. Luginbuhl.

I'd like to call on Joe Tyler.

JOE TYLER: Hi. I've got a couple questions here.

DENNIS McCONVILLE: Would you please state your name and your town of residence, sir.

JOE TYLER: Joe Tyler, Manchester,

Connecticut.

First of all, what percentage of the current employees of ECHN are contract employees versus full-time employees who get benefits and everything like that?

MICHAEL VEILLETTE: When you say -- Joe, when you say "contract," you mean outsourced?

JOE TYLER: Yeah.

MICHAEL VEILLETTE: And I would say that it's a very low percentage. I don't have the exact percentage, but I'd say it's less than 5 percent. Most of our employees are internal employees.

JOE TYLER: Okay.

MICHAEL VEILLETTE: With the exception, I think, of our hospitalists, they are contract employees, and valet services, as Peter is reminding me. But other than that, no other service comes to mind.

JOE TYLER: Under your model, what percentage of the employees will be contract employees versus full-time

employees, either unionized or nonunionized?

THOMAS REARDON: Basically, we have -- I mentioned earlier that -- that my friend Mitchell here lives in Los Angeles, and I live in Boston. We determined long ago that we -- all health care is local. We don't try to run things from Los Angeles or Boston.

So the current management team will continue to be the management team. There'll be a strategic planning process that is led by the local folks, and they will decide what the -- what the ratios are. We will have very little to say about that frankly.

JOE TYLER: The reason I asked that is that's been one of the problems from my studies of for-profit operations in things like this, is they wind up contracting more out than keeping employees, either nonunion or other. So I think that's one of the concerns we have.

The other question I have is for

Mr. Karl. You -- it was indicated during the presentation that you folks set out only six invitations to bid; is that true?

PETER KARL: That's correct.

JOE TYLER: Why only six?

PETER KARL: How many should we have sent out in your opinion?

JOE TYLER: Well, to be honest with you, I -- I think there's a lot more than six. Like, for instance, I contacted Mayo Clinic, and they never heard from you, you know. There's a lot of places around the country and that these operations, nonprofits, are trying to grow, too. And I just am astounded that only six invitations to bid were sent out.

PETER KARL: You --

JOE TYLER: That would be extremely low given the dynamics.

PETER KARL: Joe, you brought this up last time that we had Yale-New Haven and Tenet here and --

JOE TYLER: Well, I would have

thought you would have learned something.

PETER KARL: And we answered the question the same way. Health care is local. We use an outside consulting firm that goes nationally -- that works nationally. We use a national attorney firm and valuation firm. And they look at the landscape. They come around and they say, Okay, this -- these are the organizations that are growing in the local areas.

The Mayo Clinic, for instance, in Minnesota are looking more nationally, internationally, and they are growing in their areas. Hospitals that are growing in Connecticut are Yale-New Haven Health System, Hartford HealthCare, and Trinity has come into play, which is a national system. They were asked to bid, as was Western Connecticut and a couple other organizations.

What we do is we do an analysis on each of the players, and then we look at what would be best for the community that

we serve currently. What -- what is -- what is this firm going to do for the community to make sure that the mission is continued to be carried out, to make sure that the jobs are preserved in the community?

And what we have found through all of the analysis, when we narrowed it all down, we came down to Prospect Medical, who's going to invest, not only eliminate our debt, make sure pensions are paid, and invest $75 million over five years to rebuild health care the way it should be rebuilt, and also to provide the care at a lower cost to bring in the right specialists. And that's the type of research that we do in detail, and that's what our consultants do for us, also.

JOE TYLER: In all honesty, you should have gotten different consultants.

To give you an example, Mayo Clinic operates in Arizona. They also operate, I think, in Georgia. I would have -- you

know, they might like to grow in the Northeast somewhere.

So I just think that -- that your consultant -- and -- and there's no disrespect for these people. I mean, I -- I hope they do what they say they're going to do and everything else. So I hope it works out. But I just find it absolutely astounding that you only had six -- you only had sent out six proposals to bid.

The other question I've got is: There was some story that they might cut acute care at the hospitals in Manchester and Rockville. Could you describe what you mean or what was meant by that?

MITCHELL LEW: I don't know what was meant by cutting care -- acute care.

JOE TYLER: Acute care, yeah.

MITCHELL LEW: Don't know who made that statement, can't -- can't really comment.

I mean, I can say that as -- as I described to Mr. Ruete, that, you know,

our model embraces acute care. It embraces care in the community outside of the hospital and all facilities where patients were going to be at. And, you know, we -- we fully intend to invest in the hospital and grow and provide a better product and -- and obviously better health for the whole population.

JOE TYLER: Thank you very much.

MITCHELL LEW: Sure.

DENNIS McCONVILLE: Thank you.

Now I'd like to call on Dr. Joel Reich.

JOEL REICH: Hi. I am Dr. Joel Reich. I live in Glastonbury, Connecticut. And I'm just going to read this so I get into the record properly.

Attorney General Jepsen, Commissioner Mullen, and community members. I'm here to express my total support for Prospect Medical Holdings' acquisition of ECHN. I've lived in this community and I've been with ECHN for most of my professional career as a practicing emergency Physician, chief of

emergency care, medical director of the areas EMS system and currently as chief medical officer.

These roles have enabled me to attain a deep understanding of our community's needs and how our health system can best continue to provide excellent care and improve the health of residents in towns we serve. Clinical advances, maturation of health information technology, increasing economic pressures, policy and legislative initiatives, including the Affordable Care Act, and our state taxes have driven unprecedented change in the health care system during the past five years. What worked before no longer works today and won't work in the future.

ECHN has completed a carefully planned due diligence process to determine what best meets our future needs. I was part of the team that visited Prospect Medical Holdings in Los Angeles and Providence, Rhode Island.

While each of the health systems is addressing its local needs, we found three things in common: Substantial investment in the hospitals, significant growth of clinical services, and highly satisfied community physicians. It's rare to see any one of these, and almost unheard of to see all three of these in any one place.

Prospect has applied its extensive experience in health system leadership and management, care coordination, independent physician alignment and value-based contracting to advance high-quality patient care while thoughtfully managing costs.

Prospect is by far the best option for ECHN for the following reasons: It's the best cultural fit for us. It has extensive experience with community hospitals serving communities very much like our own. Its leadership is focused on innovation and growth, and its strategy execution is agile. It will bring much needed capital to ECHN to

ensure financial stability and future growth.

Prospect is much more than a hospital company. It's a healthcare services company. While it very successfully operates 13 hospitals, it's also fully integrated over ninety thousand independent physicians and other community caregivers into its model, which is fully compatible with the Affordable Care Act, Obamacare.

Through its care management programs, health coaching structure and sophisticated health information exchange and analytic capabilities, it's helped families and -- on -- patients and families navigate the complexities of the healthcare system while reducing expenses for nonvalue-added services.

In short, Prospect Medical has already mastered what other health systems are talking about doing in the future. I believe that Prospect Medical Holdings is the best partner for ECHN and hope this will be supported through the

regulatory process.

I thank you for this opportunity to comment.

DENNIS McCONVILLE: Thank you, Dr. Reich.

I'd like to now call -- call on Dr. Dennis O'Neill on behalf of Dr. Barbara Phillips.

DENNIS O'NEILL: Dennis O'Neill. This is a letter from Dr. Barbara Phillips to the Office of Health Care Access and the State Attorney General, from Barbara Phillips, M.D., Family Medicine, LLC, regarding the certificate of need application for hospital conversion.

Dear colleagues and community members. My name is Dr. Barbara Phillips, and I support the proposed partnership of ECHN and Prospect Medical Holdings. I speak as a community physician on behalf of myself and my patients and also as the chair representing three organizations, the Eastern Connecticut Individual Provider

Group, which has 309 member physicians and advanced practice clinicians, the Eastern Connecticut Physician Hospital Organization, and now the Clinically Integrated Network of Eastern Connecticut.

I am a family physician practicing in Manchester since 2004. I chose to join the practice of Dr. Martin Keibel, a physician here for now 30 years. I also selected this location because of the presence of a strong community hospital network. Our practice, like many, advocates for a population with deep roots in this community. We have a number of three- and four-generation extended families, and our patients range from newborns to those over 100 years old.

We live here, and we raise our families here. We are dedicated to the future of quality care for every segment of our population, and increasingly we feel the pressures all small practices have adapting to the rapid pace of change

in health care.

As primary care physicians in this community, we are fortunate to have both high-quality physicians and a high-quality hospital system to help us care for our patients. Good patient care thrives with access to quality community hospitals which are well equipped to take care of 95 percent of the healthcare needs provided by tertiary hospitals at substantially less cost.

Strong community hospitals stay closely allied with the needs of their individual communities and can -- and can be flexible to adapt to changes in those needs. At the same time, community hospitals all face the challenging forces in health care and many are looking to partner in varying ways to maintain viability and patient access to quality health care. The choice of partner is a profound decision for a health system. We have witnessed the varying face of some of our sister hospitals who have joined larger health systems and have

seen what seems like inevitable consolidation and centralization of health care, often without clear benefit in cost or care.

Concerns about the potential movement of for-profit medical systems into the state have raised valid concerns about preserving access to patient-centered medical care. Through my work over the past years with the IPG, the PHO, and now our Clinically Integrated Network, I've participated in the development of an increasingly cooperative, creative and effective network of individuals and entities dedicated to improving regional patient care.

A partnership between ECHN and Prospect Medical Holdings, with their many years of innovation and success in managing risk and with their coordinated regional care delivery model, offers the citizens of this region the most viable option for maintaining access to a thriving, forward-thinking, local medical

community dedicated to their well-being.

The partnership will stabilize a key employer and -- and corporate member of the region. The primacy of quality metrics and patient-centered care aligns the interests of this for-profit partner with the historical stewardship of the not-for-profit health system, greatly lessening concerns regarding for-profit medicine.

PMH offers the best option for this medical community to preserve its strong base and enhance its capabilities.

Thank you for your attention. I'm happy to be available for any questions regarding these concerns. Signed Barbara Phillips, M.D.

DENNIS McCONVILLE: And that concludes any comments or questions unless there are others who have signed in, Nina?

No? Yes?

AVA HILL: I just have a quick question. I -- I thought I --

DENNIS McCONVILLE: Did you want to

come up to the microphone?

AVA HILL: Just a quick question. Yeah, I promise.

DENNIS McCONVILLE: State your name and your town of residence, please.

AVA HILL: Ava Hill, Manchester, Connecticut. Just a quick question.

What I thought I understood was that Prospect is moving more towards doing more ambulatory than - than hospital care.

So with that wonderful letter from Barbara Phillips, I'm just curious and -- you know, how that will affect the hospital organization, you know, the hospital and the people that -- will -- will you be looking more like at -- at -- looking at people and saying, You probably should go to an ambulatory center rather than the hospital?

MITCHELL LEW: If -- only if it's appropriate.

AVA HILL: Okay.

MITCHELL LEW: We -- we definitely focus on the, you know, best possible and

highest quality care within a hospital.

AVA HILL: Okay.

MITCHELL LEW: But we focus a lot on taking care of a patient across the entire. Continuum. So when a patient is discharged, we want to make sure they're continuing to get that care, whether they go to a skilled nursing facility or go home so that they don't get readmitted.

AVA HILL: And so are we looking at the possibility of -- of building more ambulatory care centers?

MITCHELL LEW: Well, we -- we want to make sure that there's going to be a lot of good access for patients --

AVA HILL: Uh-huh.

MITCHELL LEW: -- whether --

AVA HILL: Other than going to Manchester and Rockville Hospital?

MITCHELL LEW: I'm sorry?

AVA HILL: Other than going to Manchester or Rockville Hospital. And I understand the financial need for that completely.

MITCHELL LEW: Yeah. We want access whether it be in a physician's office or --

AVA HILL: Okay.

MITCHELL LEW: -- or urgent care or community clinics. That -- that's our goal.

AVA HILL: Thank you.

MITCHELL LEW: Sure.

JOE TYLER: Can I just ask one more question?

THOMAS REARDON: Could I just follow up on Ms. Hill's --

JOE TYLER: Yeah.

THOMAS REARDON: -- question?

JOE TYLER: Ava?

AVA HILL: Oh, I'm sorry. What's that?

THOMAS REARDON: Ms. Hill, I wanted to just follow up on your question.

AVA HILL: Sorry.

THOMAS REARDON: When we talk about coordinate regional care, we talk about partnership with all kinds of different providers, ambulatory centers,

nursing homes, hospitals, et cetera, et cetera.

And the whole idea is to coordinate care so, as -- as Dr. Lew said, getting patients to the right place at the right time and at the right cost and -- and what we have found over time as you -- as you do this and as you get into risk contracts with managed care plans and -- and frankly Connecticut is ripe for that 'cause there's not much managed care penetration here at this point. What we find is that, strangely enough, you may think, the volumes at the hospitals increase.

AVA HILL: Oh, absolutely. I understand that completely.

THOMAS REARDON: It's across --

AVA HILL: I understand the need financially.

THOMAS REARDON: It's across the board.

AVA HILL: It's just a question, again, so I can report back, but I do understand completely.

I -- I don't advocate people going in with sore throats and fevers and whatever and utilizing the -- the tremendous expense and the time and waste.

DENNIS McCONVILLE: Thank you. Thank you for your question.

AVA HILL: Thank you.

DENNIS McCONVILLE: Dr. O'Neill?

DENNIS O'NEILL: Thanks, Dennis.

Well, ECHN has enjoyed caring for our communities for nearly 100 years. And the proposed transaction you've reviewed tonight will continue to fulfill the mission of ECHN and provide high-quality, compassionate care to the communities we serve.

I'd like to thank our panel members for their presence and responses this evening. And I'd like to also thank all of you again for coming and participating. And please enjoy the rest of your evening.

Thanks again.

(THEREUPON, THE MEETING WAS CONCLUDED

AT 7:30 P.M.)

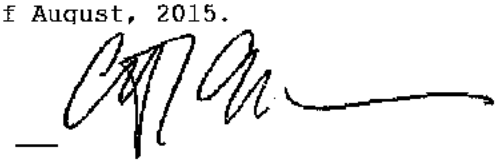
C E R T I F I C A T E

I hereby certify that I am a Notary Public, in and for the State of Connecticut, duly commissioned and qualified to administer oaths.

I further certify that said meeting was taken by me stenographically and reduced to typewriting under my direction, and the foregoing is a true and accurate transcript of the proceedings.

I further certify that I am neither of counsel nor attorney to any of the parties to said matter, nor am I an employee of any party to said matter, nor am I interested in the outcome of said matter.

Witness my hand and seal as Notary Public this 6th day of August, 2015.



Clifford Edwards

Notary Public

My commission expires: 9/30/2016

Preparing for the Future of ECHN

Letter of Determination Public Hearing

Manchester Memorial Hospital

Manchester, CT 06040

August 4, 2015

ECHN℠

Eastern Connecticut Health Network

AGENDA

Welcome & Introductions	Dennis G. O'Neill, MD, Chair of the Board, ECHN
Hearing Purpose, Statutory Requirements & Format	Dennis McConville, SVP, ECHN
Healthcare Landscape, Transaction Rationale & Process	Peter J. Karl, President & CEO, ECHN
Certificate of Need Letter of Determination	Joyce A. Tichy, SVP, Legal Counsel, ECHN
Questions & Answers	Panel

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The Proposed Transfer of Assets of Eastern Connecticut Health Network, Inc. and Affiliates to Prospect Medical Holdings, Inc.

ECHN℠
Eastern Connecticut Health Network

State Regulatory Process

Review by Office of Health Care Access (OHCA) and Office of the Attorney General (1)

* First step in process is the filing of a Letter of Determination
* Within thirty (30) days of filing of the Letter of Determination, the nonprofit hospital and the proposed purchaser hold a public hearing on the contents of the Letter of Determination.
* The hearing is to be transcribed, with the recording or transcription made available to the Commissioner of OHCA, the Attorney General, and members of the public upon request.
* The Commissioner and the Attorney General review the Letter of Determination. The Attorney General determines whether the transaction requires approval under the so-called "Conversion Statute" as a conversion of a non-profit to a for-profit.
* A joint review process is then undertaken by the Commissioner and the Attorney General.

(1) Section 19a-486a of the Connecticut general statutes

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State Regulatory Process

Statutory Standards – Review by the Attorney General (1)

* The Attorney General shall deny an application as not in the public interest if:
  * The transaction is prohibited by Connecticut statutory or common law governing nonprofit entities, trusts or charities.
  * The applicant fails to exercise due diligence in:
    * Deciding to transfer
    * Selecting the purchaser
    * Obtaining a fairness evaluation
    * Negotiating the terms and conditions of the transfer
  * The nonprofit hospital failed to disclose any conflict of interest.
  * The nonprofit hospital will not receive fair market value for its assets.

(1) Section 19a-486c of the Connecticut general statutes

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State Regulatory Process

Statutory Standards – Review by OHCA (1)

* The Commissioner of Public Health must deny an application unless a commitment has been made to provide care to uninsured and underinsured.
* The proposal is also reviewed under standard certificate of need guidelines, including public need, impact on financial strength of health care system in the state, whether proposal will improve quality, accessibility and cost-effectiveness of health care delivery in the region, etc.

(1) Section 19a-639 of the Connecticut general statutes

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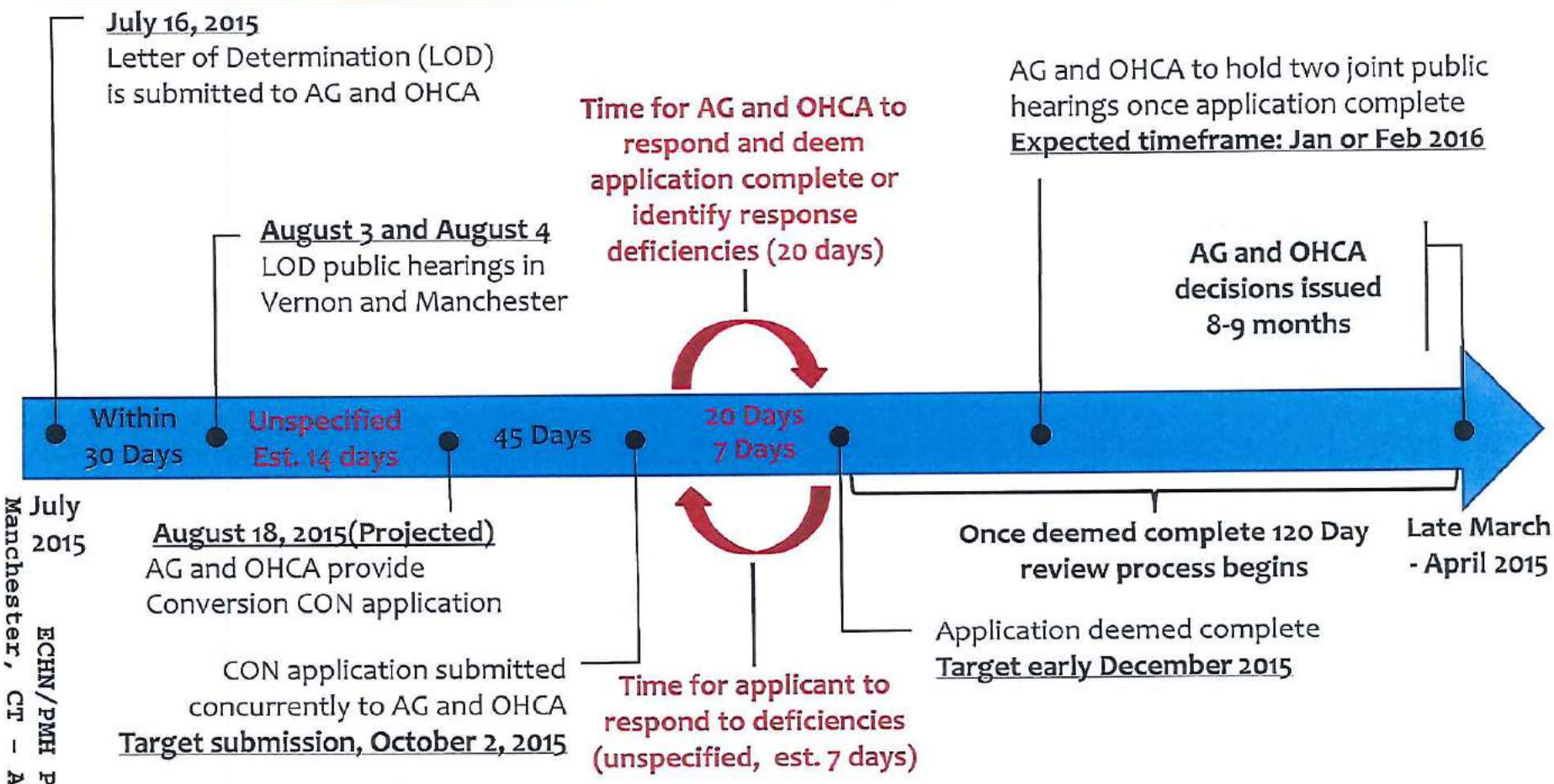
Conversion/CON Process Timeline



Note: Timeline shows estimated dates only and may change

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The Proposed Transaction

Prospect Medical Holdings to buy ECHN

* Continued operation of Manchester Memorial and Rockville General Hospitals, Woodlake at Tolland and VNHSC;
* Continued involvement of an advisory board that includes community representatives;
* Capital to fund new programs and invest in technology, facilities and equipment;
* Partnership with a leading organization that will bring decades of experience with population health management and value-based care;
* Establishment of a community foundation to oversee certain charitable funds; and
* Continuation of the ECHN brand and mission, including a continued commitment to charity care and indigent care.

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Preparing for the Future at ECHN

Our Mission : Our Community

* Caring for & serving the community, continuing our mission & vision
  * Improving your wellbeing with quality, compassionate health care
  * Preserving ECHN: its name, pride and institutions
  * Developing the next generation of physicians to serve you
* Preserving jobs
* Economic engine for eastern CT with over $165 million in salaries and $90 million purchased supplies & services annually

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Preparing for the Future at ECHN

Impact of Healthcare Reform (PPACA)

* More than insuring 32M more people
* Declining government payments to hospitals
* Focus on value, lowest cost and best results
* New payment systems with providers at risk
* New delivery models, community focused
* Major investments required

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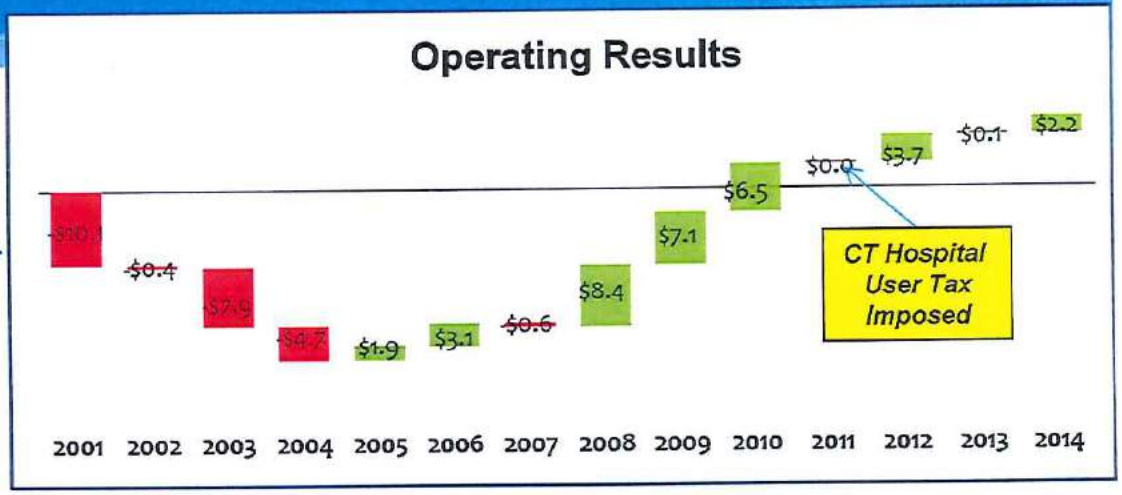
ECHN's Financial Challenges

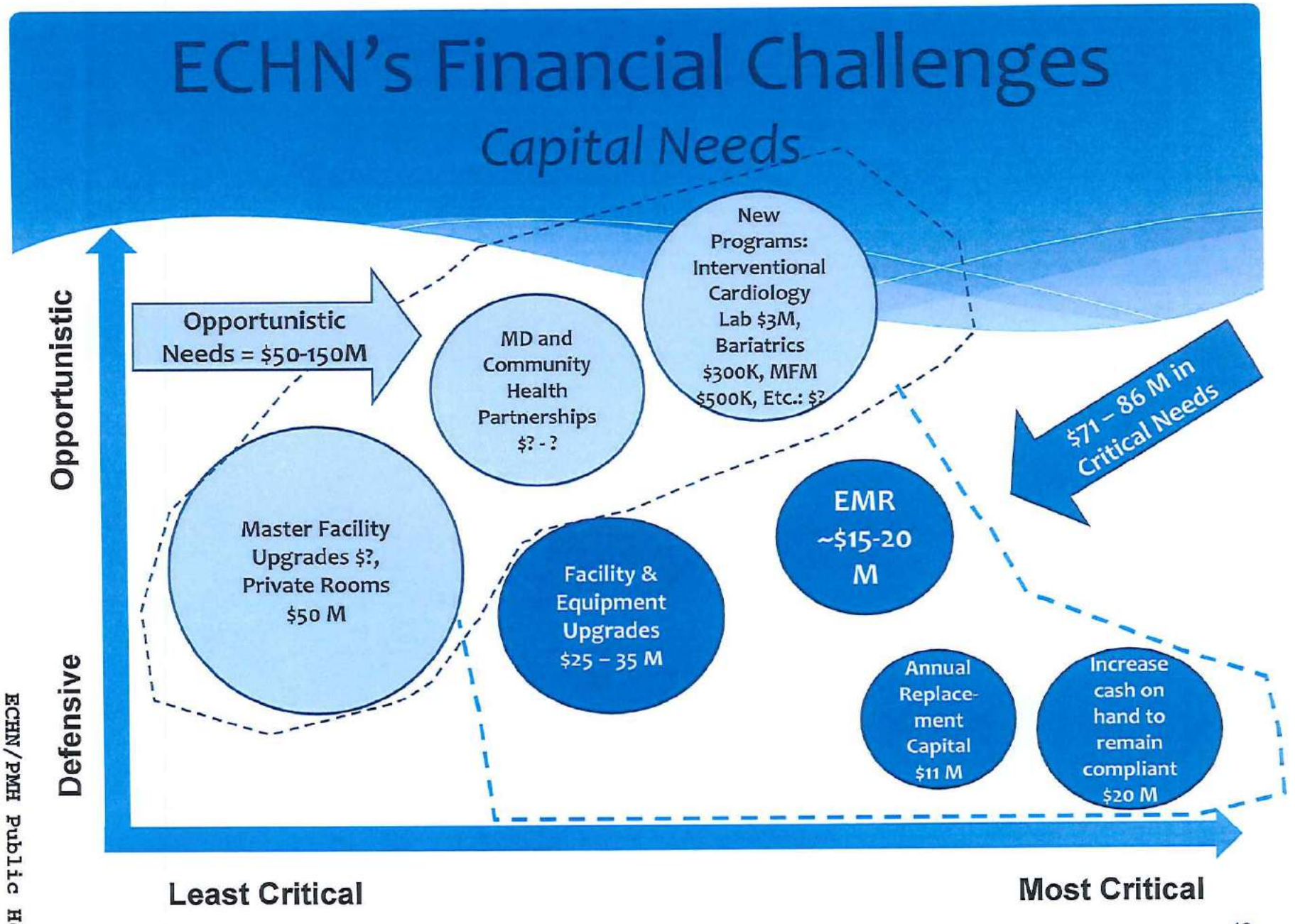
Low margins and growth in debt have forced ECHN to defer capital investments; our historical financial performance has left the organization with a large debt structure that cannot be mitigated through margin alone

1. Operations contributed only $9.3M total over the last 14 years: Operational deficits in 2001-2004 of $23.1 million required 6 years to be overcome



2. Long term debt and pension liabilities have grown 102% ($65M) in the last 14 years– annual debt service and pension contributions now take up the lions share of annual cash flows




ECHN's Financial Challenges
Capital Needs
Opportunistic
Defensive
Opportunistic Needs = $50-150M
New Programs: Interventional Cardiology Lab $3M, Bariatrics $300K, MFM $500K, Etc.: $?
MD and Community Health Partnerships $? - ?
$71 – 86 M in Critical Needs
Master Facility Upgrades $?, Private Rooms $50 M
EMR ~$15-20 M
Facility & Equipment Upgrades $25 – 35 M
Annual Replace-ment Capital $11 M
Increase cash on hand to remain compliant $20 M
Least Critical
Most Critical

12

Continuing Financial Challenges

Taxes and Reduced Government Payments

	FY 2014	FY 2015	FY 2016
CT State User Tax	(3,914,000)	(7,960,000)	(7,141,852)
CMS Sequestration	(1,104,000)	(2,208,000)	(2,208,000)
Medicaid Inpatient Modernization Program		(1,200,000)	(1,600,000)
Low Cost Hospital Pool Eliminated			(300,000)
Medicare Wage Index		(4,825,000)	(6,525,000)
	($5,018,000)	($16,193,000)	($17,774,852)

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Negative Forces into the Future

-Continued payment erosion from federal government

-Declining levels of payment from state government

-Payment reforms with more financial risk

-Continued pension obligations

-Rising costs

= ***Unsustainable results with an inability to REINVEST in ECHN***

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Preparing for the Future at ECHN

Process, Questions Answered

1 Should We Affiliate?

- Stand-alone scenario; how viable?
- Benefits of and Vision for, the Affiliation

2 If so,

- Which Partner Organizations are attractive?
- What Criteria will we use to evaluate them?
- How might each partner help us achieve our Vision ?

3 What can each potential partner organization offer ECHN?

- Enhance services; Attract top Clinicians
- Position us to be "Provider of Choice" east of the CT River
- Improve Finances and Access to Capital

4 How Attractive are the Prospective Partnership Proposals?

- Is there a compelling Business Case for each partnership?
- What is the proposed Deal Structure? Is it attractive?

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Preparing for the Future at ECHN

Why join another health care system?

Rationale

* Improve access to capital and afford investments
* Improve finances, reduce/eliminate debt
* Participate in the new payment systems
* Protect, preserve and grow local access to services

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The Request for Proposal Process:

* **RFPs were sent to 6 potential partners, both for-profit and non-profit.**
* **Responses were received from:**

1. **Hartford HealthCare**
2. **Saint Francis – Trinity Health**
3. **Prospect Medical Holdings**

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The combination of ECHN with Prospect Medical Holdings will secure the future of care and access for residents



* Aligned mission, vision & values
* Strong medical staff partner
* Extensive risk management experience
* Long history of population health management
* Track record of success in markets having large for profit and nonprofit hospital systems

Together with our Medical Staff, building a sustainable, thriving network of value-based care for our communities.

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What will be achieved?

* Continue our Mission, Vision & Values
* Protect Accessibility and Affordability of Care
* Continued Focus on Quality & Safety of Patient Care
* Continuously Improve Patient Satisfaction
* Ability to invest allowing resources for our medical staff, employees, and for patients' care and benefit

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Letter of Determination

1. Form of Transaction
2. Key Assets and Liabilities to be Acquired by Buyer
3. Key Assets and Liabilities Excluded from the Transaction
4. Medical Foundation
5. Local Advisory Board
6. Commitment to Maintain Community Support – Charity Care
7. Commitment to Maintain Hospitals and Continuum of Care Network
8. Employment Matters
9. Capital Commitment
10. No changes requested to services or changes to towns served

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Project Cost
Overview of Financial Provisions

Excluded Assets:	Donor restricted funds, cash & investments, cost report settlements
Purchase Price:	$105 Million, or $115 Million if refinancing obtained
minus/plus:	Net working capital
Minus:	Indebtedness
	Unfunded pension plan liability
	Post retiree health plan liabilities
	Special employee benefit liabilities (accrued vacation, etc.)
	Captive insurance liabilities
	Worker's compensation liabilities
	Joint venture interests not conveyed
	Asbestos liabilities
Capital Commitment:	$75 Million, reduced by amount of refinancing spent

** Risk of interim operations, stock market performance, etc. remain on ECHN prior to closing

ECHN/PMH Public Hearing
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Public Comments & Questions

Panel:

* Peter Karl, President & CEO, ECHN
* Joyce Tichy, SVP, General Counsel, ECHN
* Michael Veillette, SVP, Chief Financial Officer, ECHN
* Mitchell Lew, MD, President, Prospect Medical Holdings
* Thomas Reardon, President, Prospect East Holdings

Moderator:

* Dennis McConville, SVP, Chief Strategy Officer, ECHN

ECHN/PMH Public Hearing
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Eastern Connecticut Health Network, Inc.

Proposed Asset Purchase by Prospect Medical Holdings, Inc.

OHCA Docket Number: 15-31216-486 and Attorney General Docket Number: 15-486-01

Written Statements Submitted at Public Hearing –
Manchester Memorial Hospital, August 4, 2015

Letter of Recommendation for the Partnership between
Eastern Connecticut Health Network and Prospect Medical Holdings

To: Office of Health Care Access and the State Attorney General
From: Barbara L. Phillips, MD, Family Medicine Center, LLC
Re: Certificate of Need application for hospital conversion

Dear Colleagues and Community Members:

My name is Dr. Barbara Phillips, and I support the proposed partnership of ECHN and Prospect Medical Holdings. I speak as a community physician on behalf of myself and my patients, and also as the chair representing three organizations: the Eastern Connecticut Individual Provider Group which has 309 member physicians and advanced practice clinicians, the Eastern Connecticut Physician Hospital Organization and now the Clinically Integrated Network of Eastern Connecticut.

I am a family physician practicing in Manchester since 2004. I chose to join the practice of Dr. Martin Keibel, a physician here for now 30 years. I also selected this location because of the presence of a strong community hospital network. Our practice, like many, advocates for a population with deep roots in this community. We have a number of three- and four-generation extended families, and our patients range from newborns to those over one hundred. We live here and raise our families here. We are dedicated to the future of quality care for every segment of our population. And increasingly, we feel the pressures all small practices have adapting to the rapid pace of change in health care.

As primary care physicians in this community we are fortunate to have both high-quality physicians and a high-quality hospital system to help us care for our patients. Good patient care thrives with access to quality community hospitals, which are well-equipped to take care of 95% of the healthcare needs provided by tertiary hospitals, at substantially less cost. Strong community hospitals stay closely allied with the needs of their individual communities, and can be flexible to adapt to changes in those needs. At the same time, community hospitals all face the challenging forces in health care, and many are looking to partner in varying ways to maintain viability and patient access to quality healthcare.

The choice of partner is a profound decision for a health system. We have witnessed the varying fates of some of our sister hospitals who have joined larger health systems, and seen what seems like inevitable consolidation and centralization of health care, often without clear benefit in cost or care. Concerns about the potential movement of for-profit medical systems into the state have raised valid concerns about preserving access to patient-centered medical care.

Through my work over the past years with the IPG, PIIO and now our Clinically Integrated Network, I have participated in the development of an increasingly cooperative, creative, and effective network of individuals and entities dedicated to improving regional patient care. A partnership between ECHN and Prospect Medical Holdings, with their many years of innovation and success in managing risk and with their coordinated regional care delivery model, offers the citizens of this region the most viable option for maintaining access to a thriving, forward-thinking local medical community dedicated to their well-being. The partnership will stabilize a key employer and corporate member of the region. The primacy of quality metrics and patient-centered care aligns the interests of this for-profit partner with the historical stewardship of the not-for-profit health system, greatly lessening concerns regarding for-profit medicine. PMH offers the best option for this medical community to preserve its strong base and enhance its capabilities.

Thank you for your attention. I am happy to be available for any questions regarding these concerns.
Barbara L. Phillips, MD

ECHN™
Eastern Connecticut Health Network

Eastern Connecticut Health Network
71 Haynes Street
Manchester, CT 06040
860.533.3414
www.echn.org

July 27, 2015

The Honorable George C. Jepsen
Attorney General
Office of the Attorney General
55 Elm Street
Hartford, CT 06106

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

Dear Attorney General Jepsen and Commissioner Mullen,

I apologize for not being able to attend this forum in person, but would like to express my opinion on the acquisition publically. As the Chair and Senior Medical Director of the Department of Emergency Medicine and the Service Line Director for Emergency Services at ECHN, I would like to express my excitement about the future acquisition of ECHN by Prospect Medical Holdings (PMH). For the past several years we have been facing one financial challenge after the next in the form of hospital taxes, sequestration, Medicare reimbursement cuts, pension reform, or unfunded quality reporting mandates. The only way we have been able to meet these challenges has been to "do more with less".

My view on Healthcare is that we are facing the same struggles now that the smaller department stores and hardware stores faced a decade or more ago with the emergence of Walmart and Home Depot. Their ability to purchase goods in such large quantities made it impossible to compete with their prices, and many of the mom and pop stores eventually went out of business. This is the path that I believe ECHN would be on if we didn't proceed with this acquisition.

I, as a healthcare provider, and ECHN as a healthcare system, have an obligation to the patients we serve. Our obligation is to be there for them in their time of need and to provide the expertise, staff, and equipment necessary to diagnose and treat them at any hour of the day or night. The acquisition of ECHN by a larger system is the only option that would allow us to continue our mission of "improving your well-being by providing high-quality, compassionate healthcare." Without the ability to join a larger system, our costs will be higher than our competitors, our ability to recruit skilled physicians and nurses will become more difficult, and we would eventually find ourselves out of business.

I have been asked many times, "Why partner with PMH, rather than with one of the other large systems closer to Manchester and Rockville?" My desire for PMH is based on my belief that they would be the best option for both the patients we serve and for the staff we employ. In order to succeed, PMH has to help grow our system to allow us to directly compete with our local competitors. I feel that if we had chosen to partner with a nearby competitor, we would become victim to consolidations of services and locations. This would directly impact access to healthcare for our patients in our communities.

In my 15 years at ECHN, I have watched our competitors advertise their cutting edge therapies during the prime time news and open healthcare centers in our own neighborhood. I've read about their latest minimally invasive cardiac procedures and have heard on the radio about their world-class stroke therapies. It would be really nice to have the access to capital funding that would allow us to advertise the cutting-edge programs we have here at ECHN. However, the ability to grow and advertise these types of services is becoming virtually impossible under the financial constraints we are facing. With the implementation of the Affordable Care Act, the increase in Medicaid volume, and the State's tax on hospitals, remaining independent is futile and no longer an option. A partnership with PMH will afford us access to the clinical expertise our patients need, as well as access to the desperately needed capital funding so that we can resume investing in our technology, staff, and infrastructure. This partnership will position ECHN competitively for the foreseeable future of healthcare.

Sincerely,

R. Carroll MD

Robert Carroll, MD, FACEP, MBA
Chair and Senior Medical Director
Department of Emergency Medicine, ECHN

ECHN/PMH Public Hearing
Manchester, CT - August 4, 2015
OHCA Docket Number: 15-31216-486
Attorney General Docket Number: 15-486-01

ECHN
Eastern Connecticut Health Network, Inc.
Department of Medical Affairs
860-647-6866

July 27, 2015

The Honorable George C. Jepsen
Attorney General
Office of the Attorney General
55 Elm Street
Hartford, CT 06101

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

Dear Attorney General Jepsen and Commissioner Mullen:

I am writing this letter to express my total support for Prospect Medical Holdings acquisition of Eastern Connecticut Health Network. I have lived in this community and have been with ECHN for 31 years as a practicing emergency physician, Chair of Emergency & Ambulatory Care, Medical Director of EMS, and currently as Chief Medical Officer. These roles have enabled me to attain a deep understanding of our community's needs and how our health system can best continue to provide excellent care and improve the health of the residents of the towns we serve.

Clinical advances, maturation of health information technology, increasing economic pressures, and policy and legislative initiatives including the Affordable Care Act have driven unprecedented change in the healthcare system during the past 5 years. What worked before, no longer works today, and won't work in the future.

ECHN has completed a carefully planned due diligence process to determine what best meets our future needs. I was part of the team that visited Prospect Medical Holdings' health systems in Los Angeles, CA and Providence, RI. While each of the health systems is addressing its local needs, we found three things in common: (1) substantial capital investment, (2) significant growth of clinical services, and (3) highly satisfied community physicians. It is rare to see *any one* of these, and almost unheard of to see all three in one place. Prospect Medical Holdings has applied its extensive experience in health system leadership

& management, care coordination, independent physician association alignment, and value-based purchasing contracting to advance high quality patient care, while thoughtfully managing cost.

Prospect Medical Holdings is by far the best option for ECHN for the following reasons:

- It is the best "cultural fit". It has extensive experience with community hospitals serving communities very much like our own. Its leadership is focused on innovation and growth and its strategy execution is agile.
- It will bring much-needed capital investment to ECHN to ensure financial stability and future growth.
- Prospect Medical Holdings is much more than a "hospital company". It is healthcare services company. While it very successfully operates its 13 current hospitals, it has fully integrated 9,000 independent physicians and other community care givers into its system model which is fully compatible with the Affordable Care Act. Through its care management programs, health coaching structure, and sophisticated health information exchange and analytics capabilities, it helps patients and families navigate the complexities of the healthcare system, while reducing expenditures for non-value-added services. In short, Prospect Medical Holdings has already mastered what most other health systems are *talking about* doing in the future.

I believe that Prospect Medical Holdings is the best partner for ECHN and hope that you will be able to support this choice through the regulatory process. Thank you for your consideration of this request.

Sincerely,

Joel J. Reich, MD, FACEP
Chief Medical Officer/Senior Vice President for Medical Affairs

State of Connecticut

GENERAL ASSEMBLY

August 3, 2015

The Honorable George C. Jepsen, Attorney General
Office of the Attorney General
55 Elm Street, Hartford, CT 06106

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

Dear Attorney General Jepsen and Commissioner Mullen,

We are pleased to endorse the proposed transaction including a formal public hearing process with public input for Eastern Connecticut Health Network to be acquired by Prospect Medical Holdings. It will preserve and enhance our residents' access to the community-based care that they have relied on for generations, for themselves and their families. Prospect has a strong track record of collaborating with physicians, community providers, payers and other key stakeholders to provide high-quality, cost-effective services to the communities it serves.

We have an obligation to support the efforts of our community hospitals, which are striving to continuously improve quality while reducing cost but struggling with lower payments for services and continued cuts in state and federal reimbursements for care. It is important for state public servants to ensure that our constituents have local access to quality health care that is affordable. Prospect has decades of experience and success with provider payment risk arrangements now emerging in the state. With their experience and resources, the result will be better care for individuals, better health for the residents of eastern and lower costs for health care. Access to capital will allow ECHN to reform and strengthen its care delivery network to offer even more community-based services and keep its two hospitals, Manchester Memorial and Rockville General, viable to meet patient needs and expectations.

Therefore, we encourage OHCA and the Office of the Attorney General to look favorably upon the proposed transfer of assets as described in the Certificate of Need Determination Letter recently filed by ECHN.

Sincerely,

Steve Cassano
State Senator
Fourth District

Tony Guglielmo
State Senator
Thirty-Fifth District

Tim Larson
State Senator
Third District

Mark Tweedie
State Representative
Thirteenth District

BERSHTEIN, VOLPE & McKEON, P.C.
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105 COURT STREET—THIRD FLOOR
NEW HAVEN, CONNECTICUT 06511
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Michele M. Volpe
203-777-6995

October 1, 2015

VIA FEDEX AND EMAIL (kevin.hansted@ct.gov; gary.hawes@ct.gov)

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

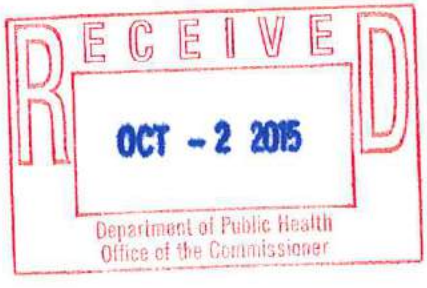
Commissioner Jewel Mullen, MD, MPH, MPA
Department of Public Health
410 Capitol Avenue
Hartford, Connecticut 06134

Re: Eastern Connecticut Health Network, Inc. – Proposed Asset Purchase by Prospect Medical Holdings, Inc. – OHCA Docket No. 15-31216-486 and Attorney General Docket No. 15-486-01

Dear Mr. Jepsen and Dr. Mullen:

On behalf of Prospect Medical Holdings, Inc. in connection with the above referenced matters, we hereby submit a request for an extension to the sixty (60) day time period set forth in Conn. Gen. Stat. §19a-486a(e) to the above referenced matters in the application for approval of the proposed asset purchase.

The parties require additional time to evaluate certain terms of the transaction. Accordingly, we are hereby requesting a thirty (30) day extension to this application submission deadline to fully complete and assemble the information required. Eastern Connecticut Health Network, Inc. joins in on this request and will be simultaneously submitting the same extension request.



If you have any questions or require anything further, please contact me at 203-777-6995. Thank you for your assistance in this matter.

Very truly yours,

Michele M. Volpe,
Bershtein, Volpe & McKeon, P.C.

Cc: Kimberly Martone, Director of Operations, Department of Public Health Division of Office of Health Care Access
Steven Lazarus, Associate Health Care Analyst, Department of Public Health Division of Office of Health Care Access
Kevin Hansted, Staff Attorney, Department of Public Health Division of Office of Health Care Access
Perry Zinn Rowthorn, Deputy Attorney General, Office of the Attorney General
Gary Hawes, Associate Attorney General, Office of the Attorney General
Rebecca Matthews, Wiggin and Dana LLP
Melinda Agsten, Wiggin and Dana LLP
Jonathan Spees, Prospect Medical Holdings, Inc.

WIGGIN AND DANA

Counsellors at Law

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Melinda A. Agsten
203.498.4362
magsten@wiggin.com

Rebecca A. Matthews
203.498.4502
rmatthews@wiggin.com



October 1, 2015

VIA FEDEX AND EMAIL (kevin.hansted@ct.gov; gary.hawes@ct.gov)

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

Commissioner Jewel Mullen, MD, MPH, MPA
Department of Public Health
410 Capitol Avenue
Hartford, Connecticut 06134

Re: Eastern Connecticut Health Network, Inc. – Proposed Asset Purchase by Prospect Medical Holdings, Inc. – OHCA Docket No. 15-31216-486 and Attorney General Docket No. 15-486-01

Dear Mr. Jepsen and Dr. Mullen:

On behalf of Eastern Connecticut Health Network, Inc., in connection with the above referenced matters, we hereby submit a request for an extension to the sixty (60) day time period set forth in Conn. Gen. Stat. §19a-486a(e) for filing the application for approval of the proposed asset purchase.

The parties require additional time to evaluate certain terms of the transaction. Accordingly, we are hereby requesting a thirty (30) day extension of the application submission deadline to assemble the information required. Prospect Medical Holdings, Inc. joins in this request and will be simultaneously submitting the same extension request.

If you have any questions or require anything further, please contact Rebecca Matthews at (203) 498-4502 or Melinda Agsten at (203) 498-4326. Thank you for your assistance in this matter.

Sincerely,

Wiggin and Dana LLP

By _____
Rebecca A. Matthews
Its Partner

By _____
Melinda A. Agsten
Its Partner

Cc: Kimberly Martone, Director of Operations, Department of Public Health Division of Office of Health Care Access
Steven Lazarus, Associate Health Care Analyst, Department of Public Health Division of Office of Health Care Access
Kevin Hansted, Staff Attorney, Department of Public Health Division of Office of Health Care Access
Perry Zinn Rowthorn, Deputy Attorney General, Office of the Attorney General
Gary Hawes, Associate Attorney General, Office of the Attorney General
Michele M. Volpe, Bershstein, Volpe & McKeon, P.C.
Dennis P. McConville, Senior Vice President and Chief Strategy Officer, Eastern Connecticut Health Network, Inc.
Joyce Tichy, Senior Vice President and General Counsel, Eastern Connecticut Health Network, Inc.

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OFFICE OF THE ATTORNEY GENERAL

GEORGE JEPSEN
ATTORNEY GENERAL

DR. JEWEL MULLEN
COMMISSIONER

October 2, 2015

Melinda A. Agsten, Esq.
Wiggin and Dana LLP
One Century Tower, P.O. Box 1832
New Haven, Connecticut 06508-1832

Michele M. Volpe, Esq.
Bershtein, Volpe & McKeon, P.C.
105 Court Street, Third Floor
New Haven, Connecticut 06511

Re: Eastern Connecticut Health Network, Inc. – Proposed Asset Purchase by Prospect Medical Holdings, Inc. – OHCA Docket No. 15-31216-486 and AG Docket No. 15-486-01

Dear Attorney Agsten and Attorney Volpe:

Thank you for your letter dated October 1, 2015, pursuant to which you have requested a 30-day extension of the 60-day time period set forth in Conn. Gen. Stat. § 19a-486a(e) for the filing the Application for approval of the proposed asset purchase by Prospect Medical Holdings, Inc., of Eastern Connecticut Health Network, Inc.

Our Offices agree to extend the Application time period as you have requested and as set forth above. The 60-day time period was due to expire on October 5, 2015. With the 30-day extension, the due date for the Application will now be November 4, 2015.

Should you have any questions regarding this extension, your Application for approval, or any other issues relating to the Commissioner's and the Attorney General's review, please do not hesitate to contact either Steven Lazarus at the

Department of Public Health (860-418-7012; Steven.Lazarus@ct.gov) or Assistant Attorney General Gary W. Hawes at the Office of the Attorney General (860-808-5020; gary.hawes@ct.gov).

Very truly yours,

Gary W. Hawes
Assistant Attorney General
Office of the Attorney General

Very truly yours,

Kimberly Martone
Director of Operations
Office of Health Care Access
Department of Public Health





CERTIFICATE OF NEED APPLICATION

Eastern Connecticut Health Network, Inc.
Proposed Asset Purchase by
Prospect Medical Holdings, Inc.

OHCA Docket Number: 15-31216-486
Attorney General Docket Number: 15-486-01

October 13, 2015

WIGGIN AND DANA

Counsellors at Law

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Melinda A. Agsten
203.498.4362
magsten@wiggin.com

Rebecca A. Matthews
203.498.4502
rmatthews@wiggin.com

RECEIVED
OCT 13 2015
Office of
HEALTHCARE ACCESS

October 13, 2015

VIA HAND-DELIVERY

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

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

Re: Eastern Connecticut Health Network, Inc.
Proposed Asset Purchase by Prospect Medical Holdings, Inc.
OHCA Docket Number: 15-31216-486
Attorney General Docket Number: 15-486-01

Dear Attorney General Jepsen and Commissioner Mullen:

Eastern Connecticut Health Network, Inc. ("***ECHN***") and Prospect Medical Holdings, Inc. ("***PMH***") (together, the "***Applicants***") hereby submit a Certificate of Need application (the "***Application***") for the proposed purchase of the assets of ECHN and its affiliates by one or more affiliates of PMH. At your request, two (2) hard copies and two (2) electronic copies have been provided to the Office of the Attorney General and one (1) copy and one (1) electronic copy have been provided to the Office of Health Care Access.

Please note that, per the instructions to Question 11 of the Application, only one hard copy of the gift instruments referenced in the response to that question (identified as Exhibit Q11-2) has been filed with the Office of the Attorney General. In addition, Exhibit Q47-1 has been provided only in electronic form as instructed by Application Question 47.

The Applicants look forward to working with you and your staff through the approval process. If you have any questions or need anything further, please feel free to contact Rebecca Matthews at (203) 498-4502 or Melinda Agsten at (203) 498-4326. Thank you for your assistance in this matter.

Sincerely,

Wiggin and Dana LLP

By_____
Rebecca A. Matthews
Its Partner

By_____
Melinda A. Agsten
Its Partner

cc: Kevin Hansted, Staff Attorney, Department of Public Health Division of Office of Health Care Access
Perry Zinn Rowthorn, Deputy Attorney General, Office of the Attorney General
Gary Hawes, Associate Attorney General, Office of the Attorney General
Dennis P. McConville, Senior Vice President and Chief Strategy Officer, Eastern Connecticut Health Network, Inc.
Thomas M. Reardon, President, Prospect Medical Holdings-East, Inc.
Frank Saidara, Vice President, Corporate Development, Prospect Medical Holdings, Inc.
Jonathan Spees, Senior Vice President, Corporate Development, Prospect Medical Holdings, Inc.
Joyce Tichy, Senior Vice President and General Counsel, Eastern Connecticut Health Network, Inc.
Michele M. Volpe, Esq., Bershtein, Volpe & McKeon, P.C

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Checklist

Instructions:

1. Please check each box below, as appropriate; and
2. The completed checklist *must* be submitted as the first page of the CON application.

☒ Attached is a paginated hard copy of the CON application including a completed affidavit, signed and notarized by the appropriate individuals.

☒ *(*New*).* A completed supplemental application specific to the proposal type, available on OHCA's website under "OHCA Forms."

☒ Attached is the CON application filing fee in the form of a certified, cashier or business check made out to the "Treasurer State of Connecticut" in the amount of $500.

☒ Attached is evidence demonstrating that public notice has been published in a suitable newspaper that relates to the location of the proposal, 3 days in a row, at least 20 days prior to the submission of the CON application to OHCA. (*OHCA requests that the Applicant fax a courtesy copy to OHCA (860) 418-7053, at the time of the publication)*

☒ Attached is a completed Financial Attachment

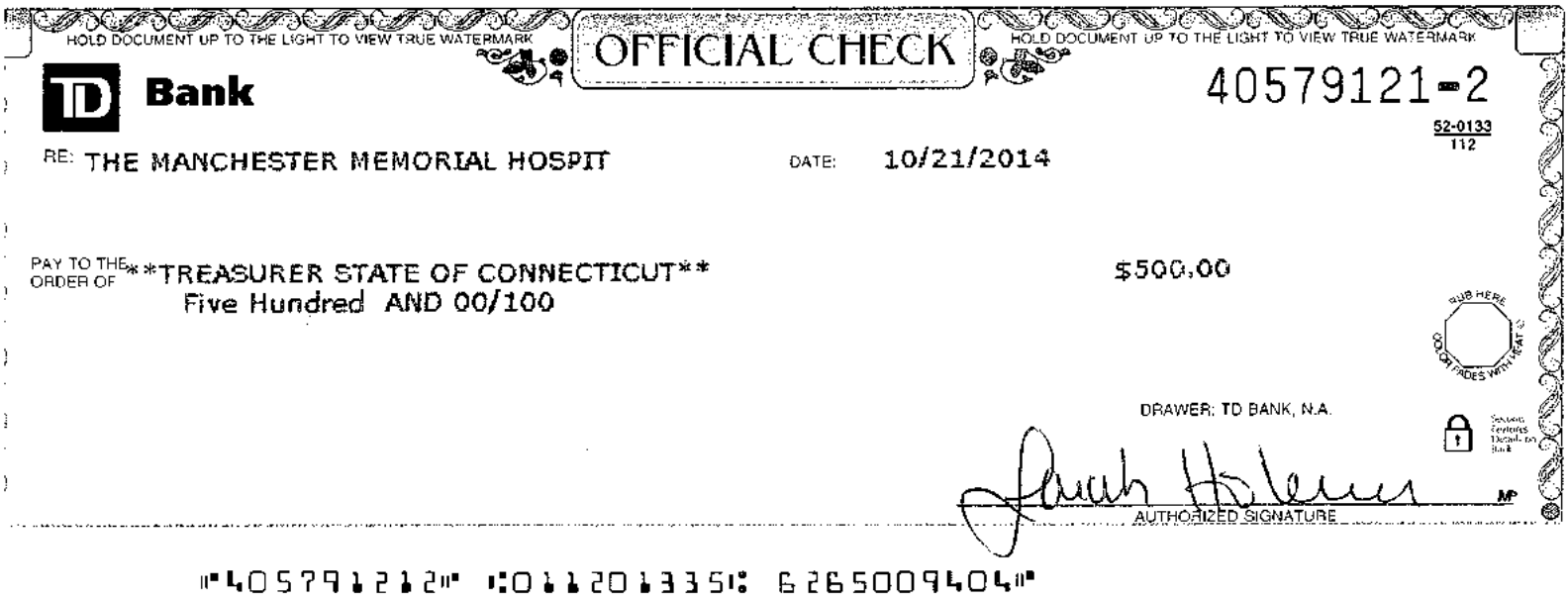
☒ Submission includes one (1) original hard copy placed in a 3-ring binder.

☒ The following have been submitted on a USB flash drive:

1. A scanned copy of each submission in its entirety, including all attachments in Adobe (.pdf) format.
2. An electronic copy of the applicant's responses in MS Word (the applications) and MS Excel (the financial attachment).

For OHCA Use Only:

Docket No.: 15-32016-CON **Check No.:** 40579121-2
OHCA Verified by: SO **Date:** 10/13/15



HOLD DOCUMENT UP TO THE LIGHT TO VIEW TRUE WATERMARK

OFFICIAL CHECK

HOLD DOCUMENT UP TO THE LIGHT TO VIEW TRUE WATERMARK

TD Bank

40579121-2

52-0133
112

RE: THE MANCHESTER MEMORIAL HOSPIT

DATE: 10/21/2014

PAY TO THE ORDER OF **TREASURER STATE OF CONNECTICUT**

Five Hundred AND 00/100

$500.00

DRAWER: TD BANK, N.A.

AUTHORIZED SIGNATURE

⑈40579121 2⑈ ⑆011201335⑆ 6265009404⑈

AFFIDAVIT

(Each Petitioner must submit a completed Affidavit.)

Petitioner: Eastern Connecticut Health Network, Inc.

Project Title: Proposed Assets Purchase of Eastern Connecticut Health Network, Inc. by Prospect Medical Holdings, Inc.

I, Peter J. Karl (Name) President & Chief Executive Officer (Position – CEO or CFO)

of Eastern Connecticut Health Network, Inc. being duly sworn, depose and state that the (Organization Name)

information provided in this CON Determination form is true and accurate to the best of my

knowledge.

Peter J. Karl
Signature

10/9/15
Date

Subscribed and sworn to before me on October 9, 2015

Yvonne Johnson
Notary Public/Commissioner of Superior Court

Yvonne Johnson, Notary Public
My Commission Expires Jan. 31, 2017

My commission expires:

AFFIDAVIT

(Each Petitioner must submit a completed Affidavit.)

Petitioner: Prospect Medical Holdings, Inc.

Project Title: Proposed Assets Purchase of Eastern Connecticut Health Network, Inc. by Prospect Medical Holdings, Inc.

I, Samuel S. Lee (Name) Chief Executive Officer (Position – CEO or CFO)

of Prospect Medical Holdings, Inc. (Organization Name) being duly sworn, depose and state that the information provided in this CON Determination form is true and accurate to the best of my knowledge.

Signature 10/9/2015 Date

Subscribed and sworn to before me on _____

Notary Public/Commissioner of Superior Court

My commission expires: _____

Pls. see attached certificate.

JURAT

A notary public or other officer completing this Certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California
County of Los Angeles

Subscribed and sworn to (or affirmed) before me on
this 9th day of October, 2015,

by Sang Bum Lee -

proved to me on the basis of satisfactory evidence to
be the person(s) who appeared before me.

ELAINE M. LUCAS
Commission # 2064193
Notary Public - California
Los Angeles County
My Comm. Expires May 9, 2018

Signature E. Lucas (Seal)

PUBLIC

PUBLIC NOTICE

LEGAL NOTICE

Pursuant to Section 19a-486 of the Connecticut General Statutes ("C.G.S"), a nonprofit hospital seeking to transfer a material amount of its assets or operations or change in control of operations to a person that is organized or operated for profit will be required to hold a hearing for the public on the contents of the certificate of need determination letter submitted to the Attorney General and the Office of Health Care Access ("OHCA") not later than thirty days after receipt of the letter.

Applicants
Eastern Connecticut Health Network, Inc.
Prospect Medical Holdings, Inc.

Town
Vernon, Connecticut

Proposal
Proposed Transfer of Assets of Eastern Connecticut Health Network, Inc.
and Affiliates to Prospect Medical Holdings, Inc.

Date
Monday, August 3, 2015

Time
6:00 p.m.

Place
Vernon Senior Center
26 Park Place, Vernon, Connecticut 06066

PLEASE NOTE:
An additional public hearing will be held on **Tuesday, August 4, 2015** beginning at **6:00 p.m.** at the Manchester Memorial Hospital H. Louise Ruddell Auditorium located at **71 Haynes Street, Manchester, Connecticut 06040**. Formal notice for this hearing has been published simultaneously in the Hartford Courant.

PROPOSAL DESCRIPTION
Eastern Connecticut Health Network, Inc., including its affiliates (collectively, "ECHN") is seeking approval from the Office of Health Care Access ("OHCA") and the Office of the Attorney General for the proposed transfer of certain of the assets of ECHN, including certain assets of ECHN's two hospitals, Manchester Memorial Hospital and Rockville General Hospital, and ECHN's ownership interests in affiliated entities, to one or more affiliates of Prospect Medical Holdings, Inc. ("PMH").

The estimated total project cost is $105,000,000, which is subject to certain adjustments, including substantial reductions for items such as outstanding indebtedness, liabilities relating to pension, retiree health, captive insurer, capital leases and asbestos abatement, and any joint venture interests that do not transfer.

The transfer will include the operating and other assets of ECHN (other than restricted charitable funds), including the properties, assets and businesses of, or ownership interests of ECHN and its affiliates, in the following entities:

- Manchester Memorial Hospital, a licensed general hospital;
- Rockville General Hospital, a licensed general hospital;
- ECHN Eldercare Services, Inc. (d/b/a Woodlake at Tolland Rehabilitation & Nursing Center), a licensed chronic and convalescent nursing home;
- Visiting Nurse and Health Services of Connecticut, Inc., a licensed home health care agency, and its direct subsidiary, A Caring Hand, LLC, a licensed homemaker-companion agency;
- Clinically Integrated Network of Eastern Connecticut, LLC;
- Connecticut Healthcare Insurance Company, Inc.;
- ECHN Corporate Services, Inc. and its direct subsidiary, Medical Practice Partners, LLC;
- ECHN Enterprises, Inc.;
- Haynes Street Property Management, LLC; and
- Eastern Connecticut Medical Professionals Foundation, Inc.

(continued)

ESTIMATES • Yard Work Improvements, LLC Roofing

NOTICE

(continued)

The transfer is proposed to also include the purchase of ECHN's (or an affiliate's) ownership interests in the following joint ventures, subject to approval by other members of the joint ventures as may be required by law or by the applicable joint venture governing documents:

- Aetna Ambulance Service, Inc., a licensed EMS organization
- Metro Wheelchair Service, Inc., a licensed EMS organization
- Ambulance Service of Manchester, LLC, a licensed EMS organization
- Evergreen Endoscopy Center, LLC, a licensed ambulatory surgical center
- WBC Connecticut East, LLC, a licensed mental health day treatment provider and psychiatric outpatient clinic
- Northeast Regional Radiation Oncology Network, Inc., a licensed outpatient clinic
- Connecticut Occupational Medicine Partners, LLC
- Eastern Connecticut Physician Hospital Organization, Inc.
- Tolland Imaging Center, LLC
- Haynes Street Medical Associates, LLC
- Haynes Street Medical Associates II, LLC
- Evergreen Medical Associates, LLC
- Evergreen Medical Associates II, LLC

Finally, the parties will work to restructure ECHN's medical foundation, Eastern Connecticut Medical Professionals Foundation, Inc. (the "ECHN Medical Foundation"). Consistent with Connecticut law, this restructuring will take the form of either (i) a member substitution, pursuant to which PMH or an affiliate of PMH will become the sole member of ECHN Medical Foundation; or (ii) a transfer of the assets and liabilities of ECHN Medical Foundation to a new medical foundation or another entity permissible under Connecticut law, the sole member of which will be PMH or an affiliate of PMH.

There are a number of features of the proposed transaction that will benefit the current employees and communities served by ECHN. Although not an exhaustive list, these features will include:

- Maintenance of ownership interest in ECHN's continuum of care network.
- A commitment to maintain and adhere to ECHN's current policies regarding charity care, indigent care, community volunteer services and community outreach services or to adopt other policies that are at least as favorable to the indigent and uninsured as ECHN's current policies.
- Offers of employment to substantially all ECHN employees with comparable salaries and benefits packages consistent with benefits packages offered to similarly situated employees at other hospitals operated by PMH in similar markets. Existing bargaining agreements will be assumed and honored for existing terms.
- Establishment of a local advisory board of trustees ("local board") that will serve as a resource on topics such as capital investment , maintenance and implementation of the strategic business plans, medical staff credentialing, and quality assurance oversight. Approximately half of the governing board members will be physicians who provide the input for clinical quality and clinical programmatic planning. The balance of the local board will be comprised of individuals drawn from the local community, ensuring a mechanism for input regarding community needs and expectations.
- Continued participation in graduate medical education programs and the University of New England health professions teaching programs.
- A commitment to invest $75 million, beyond the estimated project cost, in routine and non-routine facility improvements, general upgrades and renovations, deferred maintenance items, and initiatives to develop, expand or acquire new programs or services, and to support the recruitment of medical staff.

No service changes are currently anticipated in connection with the proposed transaction. PMH will continue to provide care to the residents in the service area towns that have historically been served by ECHN including, Andover, Ashford, Bolton, Columbia, Coventry, East Hartford, East Windsor, Ellington, Glastonbury, Hebron, Manchester, Mansfield, Somers, South Windsor, Stafford, Tolland, Vernon, Willington, and Union.

ADDITIONAL INFORMATION

A copy of the certificate of need determination letter submitted to the Attorney General and OHCA as well as additional information on the scheduled public hearings can be found on the ECHN website at the following location. www.echn.org/caringneverchanges

Journal Inquirer
July 16, 2015
July 17, 2015
July 18, 2015

PUBLIC NOTICE

LEGAL NOTICE

Pursuant to Section 19a-486 of the Connecticut General Statutes ("C.G.S"), a nonprofit hospital seeking to transfer a material amount of its assets or operations or change in control of operations to a person that is organized or operated for profit will be required to hold a hearing for the public on the contents of the certificate of need determination letter submitted to the Attorney General and the Office of Health Care Access ("OHCA") not later than thirty days after receipt of the letter

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Prospect Medical Holdings, Inc.

Town
Vernon, Connecticut

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- Clinically Integrated Network of Eastern Connecticut, LLC;
- Connecticut Healthcare Insurance Company, Inc.;
- ECHN Corporate Services, Inc. and its direct subsidiary, Medical Practice Partners, LLC;
- ECHN Enterprises, Inc.;
- Haynes Street Property Management, LLC; and
- Eastern Connecticut Medical Professionals Foundation, Inc.

(continued)

ESTIMATES • Dump Runs • Odd Jobs Tom Casey Home Improvements, LLC

NOTICE

(continued)

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- Continued participation in graduate medical education programs and the University of New England health professions teaching programs.
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ADDITIONAL INFORMATION

A copy of the certificate of need determination letter submitted to the Attorney General and OHCA as well as additional information on the scheduled public hearings can be found on the ECHN website at the following location: www.echn.org/caringneverchanges

Journal Inquirer
July 16, 2015
July 17, 2015
July 18, 2015

PUBLIC

PUBLIC NOTICE

LEGAL NOTICE

Pursuant to Section 19a-486 of the Connecticut General Statutes ("C.G.S"), a nonprofit hospital seeking to transfer a material amount of its assets or operations or change in control of operations to a person that is organized or operated for profit will be required to hold a hearing for the public on the contents of the certificate of need determination letter submitted to the Attorney General and the Office of Health Care Access ("OHCA") not later than thirty days after receipt of the letter.

Applicants
Eastern Connecticut Health Network, Inc.
Prospect Medical Holdings, Inc.

Town
Vernon, Connecticut

Proposal
Proposed Transfer of Assets of Eastern Connecticut Health Network, Inc.
and Affiliates to Prospect Medical Holdings, Inc.

Date
Monday, August 3, 2015

Time
6:00 p.m.

Place
Vernon Senior Center
26 Park Place, Vernon, Connecticut 06066

PLEASE NOTE:
An additional public hearing will be held on **Tuesday, August 4, 2015** beginning at **6:00 p.m.** at the Manchester Memorial Hospital H. Louise Ruddell Auditorium located at **71 Haynes Street, Manchester, Connecticut 06040**. Formal notice for this hearing has been published simultaneously in the Hartford Courant.

PROPOSAL DESCRIPTION
Eastern Connecticut Health Network, Inc., including its affiliates (collectively, "ECHN") is seeking approval from the Office of Health Care Access ("OHCA") and the Office of the Attorney General for the proposed transfer of certain of the assets of ECHN, including certain assets of ECHN's two hospitals, Manchester Memorial Hospital and Rockville General Hospital, and ECHN's ownership interests in affiliated entities, to one or more affiliates of Prospect Medical Holdings, Inc. ("PMH").

The estimated total project cost is $105,000,000, which is subject to certain adjustments, including substantial reductions for items such as outstanding indebtedness, liabilities relating to pension, retiree health, captive insurer, capital leases and asbestos abatement, and any joint venture interests that do not transfer.

The transfer will include the operating and other assets of ECHN (other than restricted charitable funds), including the properties, assets and businesses of, or ownership interests of ECHN and its affiliates, in the following entities:

- Manchester Memorial Hospital, a licensed general hospital;
- Rockville General Hospital, a licensed general hospital;
- ECHN Eldercare Services, Inc. (d/b/a Woodlake at Tolland Rehabilitation & Nursing Center), a licensed chronic and convalescent nursing home;
- Visiting Nurse and Health Services of Connecticut, Inc., a licensed home health care agency, and its direct subsidiary, A Caring Hand, LLC, a licensed homemaker-companion agency;
- Clinically Integrated Network of Eastern Connecticut, LLC;
- Connecticut Healthcare Insurance Company, Inc.;
- ECHN Corporate Services, Inc. and its direct subsidiary, Medical Practice Partners, LLC;
- ECHN Enterprises, Inc.;
- Haynes Street Property Management, LLC; and
- Eastern Connecticut Medical Professionals Foundation, Inc.

(continued)

NOTICE

(continued)

The transfer is proposed to also include the purchase of ECHN's (or an affiliate's) ownership interests in the following joint ventures, subject to approval by other members of the joint ventures as may be required by law or by the applicable joint venture governing documents:

- Aetna Ambulance Service, Inc., a licensed EMS organization
- Metro Wheelchair Service, Inc., a licensed EMS organization
- Ambulance Service of Manchester, LLC, a licensed EMS organization
- Evergreen Endoscopy Center, LLC, a licensed ambulatory surgical center
- WBC Connecticut East, LLC, a licensed mental health day treatment provider and psychiatric outpatient clinic
- Northeast Regional Radiation Oncology Network, Inc., a licensed outpatient clinic
- Connecticut Occupational Medicine Partners, LLC
- Eastern Connecticut Physician Hospital Organization, Inc.
- Tolland Imaging Center, LLC
- Haynes Street Medical Associates, LLC
- Haynes Street Medical Associates II, LLC
- Evergreen Medical Associates, LLC
- Evergreen Medical Associates II, LLC

Finally, the parties will work to restructure ECHN's medical foundation, Eastern Connecticut Medical Professionals Foundation, Inc. (the "ECHN Medical Foundation"). Consistent with Connecticut law, this restructuring will take the form of either (i) a member substitution, pursuant to which PMH or an affiliate of PMH will become the sole member of ECHN Medical Foundation; or (ii) a transfer of the assets and liabilities of ECHN Medical Foundation to a new medical foundation or another entity permissible under Connecticut law, the sole member of which will be PMH or an affiliate of PMH.

There are a number of features of the proposed transaction that will benefit the current employees and communities served by ECHN. Although not an exhaustive list, these features will include:

- Maintenance of ownership interest in ECHN's continuum of care network.
- A commitment to maintain and adhere to ECHN's current policies regarding charity care, indigent care, community volunteer services and community outreach services or to adopt other policies that are at least as favorable to the indigent and uninsured as ECHN's current policies
- Offers of employment to substantially all ECHN employees with comparable salaries and benefits packages consistent with benefits packages offered to similarly situated employees at other hospitals operated by PMH in similar markets. Existing bargaining agreements will be assumed and honored for existing terms.
- Establishment of a local advisory board of trustees ("local board") that will serve as a resource on topics such as capital investment , maintenance and implementation of the strategic business plans, medical staff credentialing, and quality assurance oversight. Approximately half of the governing board members will be physicians who provide the input for clinical quality and clinical programmatic planning. The balance of the local board will be comprised of individuals drawn from the local community, ensuring a mechanism for input regarding community needs and expectations.
- Continued participation in graduate medical education programs and the University of New England health professions teaching programs.
- A commitment to invest $75 million, beyond the estimated project cost, in routine and non-routine facility improvements, general upgrades and renovations, deferred maintenance items, and initiatives to develop, expand or acquire new programs or services, and to support the recruitment of medical staff.

No service changes are currently anticipated in connection with the proposed transaction. PMH will continue to provide care to the residents in the service area towns that have historically been served by ECHN including, Andover, Ashford, Bolton, Columbia, Coventry, East Hartford, East Windsor, Ellington, Glastonbury, Hebron, Manchester, Mansfield, Somers, South Windsor, Stafford, Tolland, Vernon, Willington, and Union.

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Applicants
Eastern Connecticut Health Network, Inc
Prospect Medical Holdings, Inc
Town
Manchester, Connecticut
Proposal
Proposed Transfer of Assets of Eastern Connecticut Health Network, Inc. and Affiliates to Prospect Medical Holdings, Inc
Date
Tuesday, August 4, 2015
Time
6:00 p.m.
Place
H. Louise Ruddell Auditorium
Manchester Memorial Hospital
71 Haynes Street, Manchester, Connecticut 06040

PLEASE NOTE:
An additional public hearing will be held on Monday, August 3, 2015 beginning at 6:00 p.m. at the Vernon Senior Center located at 26 Park Place in Vernon, Connecticut 06066. Formal notice for this hearing has been published simultaneously in the Journal Inquirer
PROPOSAL DESCRIPTION
Eastern Connecticut Health Network, Inc., including its affiliates (collectively, "ECHN") is seeking approval from the Office of Health Care Access ("OHCA") and the Office of the Attorney General for the proposed transfer of certain of the assets of ECHN, including certain assets of ECHN's two hospitals, Manchester Memorial Hospital and Rockville General Hospital, and ECHN's ownership interests in affiliated entities, to one or more affiliates of Prospect Medical Holdings, Inc ("PMH")
The estimated total project cost is $105,000,000, which is subject to certain adjustments, including substantial reductions for items such as outstanding indebtedness, liabilities relating to pension, retiree health, captive insurer, capital leases and asbestos abatement, and any joint venture interests that do not transfer.
The transfer will include the operating and other assets of ECHN (other than restricted charitable funds), including the properties, assets and businesses of, or ownership interests of ECHN and its affiliates, in the following entities:
- Manchester Memorial Hospital, a licensed general hospital;
- Rockville General Hospital, a licensed general hospital;
- ECHN Eldercare Services, Inc. (d/b/a Woodlake at Tolland Rehabilitation & Nursing Center), a licensed chronic and convalescent nursing home;
- Visiting Nurse and Health Services of Connecticut, Inc., a licensed home health care agency, and its direct subsidiary, A Caring Hand, LLC, a licensed homemaker-companion agency;
- Clinically Integrated Network of Eastern Connecticut, LLC;
- Connecticut Healthcare Insurance Company, Inc.;
- ECHN Corporate Services, Inc. and its direct subsidiary, Medical Practice Partners, LLC;
- ECHN Enterprises, Inc.;
- Haynes Street Property Management, LLC; and
- Eastern Connecticut Medical Professionals Foundation, Inc.

The transfer is proposed to also include the purchase of ECHN's (or an affiliate's) ownership interests in the following joint ventures, subject to approval by other members of the joint ventures as may be required by law or by the applicable joint venture governing documents:
- Aetna Ambulance Service, Inc., a licensed EMS organization
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- Establishment of a local advisory board of trustees ("local board") that will serve as a resource on topics such as capital investment, maintenance and implementation of the strategic business plans, medical staff credentialing, and quality assurance oversight. Approximately half of the governing board members will be physicians who provide the input for clinical quality and clinical programmatic planning. The balance of the local board will be comprised of individuals drawn from the local community, ensuring a mechanism for input regarding community needs and expectations.
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ADDITIONAL INFORMATION
A copy of the ECHN Proposed Asset Purchase by PMH Attorney General and OHCA as well as additional information on the scheduled public hearings can be found

Connecticut

LEGAL NOTICE

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Prospect Medical Holdings, Inc.
Town
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Date
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Applicants
Eastern Connecticut Health Network, Inc.
Prospect Medical Holdings, Inc.
Town
Manchester, Connecticut
Proposal
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Date
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Time
6:00 p.m.
Place
H. Louise Ruddell Auditorium
Manchester Memorial Hospital
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- A commitment to maintain and adhere to ECHN's current policies regarding charity care, no-gen care, community volunteer services and community outreach services or to adopt other policies that are at least as favorable to the indigent and uninsured as ECHN's current policies.
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APPLICATION FOR APPROVAL OF THE PROPOSED ASSET PURCHASE

Eastern Connecticut Health Network, Inc. ("ECHN") and Prospect Medical Holdings, Inc. ("PMH") hereby respectfully submit to the Attorney General and the Commissioner of the Department of Public Health the following application for approval of the proposed asset purchase per Conn. Gen. Stat § 19a-486 et seq. and Conn. Gen. Stat. § 19a-630 et seq. (the "Application").

1. **Identify the contact information for ECHN and PMH, including the individual(s) to whom the Attorney General and the Department of Public Health shall submit bills for contracts with experts or consultants.**

   Response:

   Prospect Medical Holdings:
   Jonathan Spees, Senior Vice President, Mergers and Acquisitions
   10780 Santa Monica Blvd.
   Suite 400
   Los Angeles, CA 90025
   Phone: (310) 696-4738
   Fax: (714) 560-7320

   Email: jonathan.spees@prospectmedical.com

   Bills for contracts with experts and consultants should be sent to PMH as indicated above.

   Eastern Connecticut Health Network:
   Dennis P. McConville, Senior Vice President and Chief Strategy Officer
   71 Haynes Street
   Manchester, CT 06040
   Phone: (860) 533-3429
   Fax: (860) 647-6860

   Email: dmcconville@echn.org

2. Provide an executive summary of the application for approval.

Response:

This Application is submitted by ECHN and PMH for approval of the sale of substantially all of the assets of ECHN and its controlled affiliates to PMH or one or more affiliates of PMH.

Pursuant to the terms of the proposed Asset Purchase Agreement ("APA"), PMH will pay either $105,000,000 or $115,000,000[1] for the assets of ECHN, subject to certain adjustments, including a Net Working Capital[2] reconciliation and reductions for the value of certain ECHN liabilities assumed by PMH and for the value of any joint venture interest that ECHN is unable to assign or transfer provided, however, that the parties have agreed that no adjustment related to joint ventures shall be greater than $22,000,000. In addition, PMH will commit to spend not less than $75,000,000 on capital items, over five years.

The proceeds from the asset sale will first be used to settle all of ECHN's bond liabilities and other indebtedness and then to fund an indemnity reserve for payment of ECHN liabilities to PMH that may arise post-closing. Any remaining proceeds will be used to settle post-closing liabilities and wind down the operations of ECHN. Following wind down, any remaining funds will be transferred as directed by the Office of the Attorney General of the State of Connecticut with the expectation that such funds will be transferred to a community foundation and used to support charitable health related efforts in the ECHN community.

ECHN conducted a thorough and extensive process to determine the proposed course of action. Trustees and senior management worked extensively and concluded that affiliation with a larger health system will better position ECHN to continue to meet the health care needs of its communities. An effort to sell ECHN's assets to a new joint venture company to be formed by Tenet Healthcare and Yale-New Haven Health Services Corporation was initially pursued, but subsequently withdrawn by Tenet Healthcare in December 2014. A second diligent request for proposal and proposal review process was performed by ECHN and led to the decision to sell ECHN's assets to PMH. Extensive due diligence and a fairness evaluation were completed.

[1] As stated in Section 2.05(b) of the APA, If ECHN obtains, prior to the date of closing, an assumable loan in the amount not to exceed $45,000,000 to refinance certain of its outstanding bond liabilities, the agreed upon purchase price of $105,000,000 that appears in Section 2.05(a)(i) shall be deemed deleted and replaced with $115,000,000.

[2] For purposes of this transaction, Net Working Capital is defined in the APA as "the amount by which (i) the value of all non-cash current assets of the Hospital Businesses acquired by Buyer, including inventory and supplies, Accounts Receivable, other receivables, prepaid expenses, and deposits (including security deposits made by Seller pursuant to Assumed Contracts), that Seller and Buyer agree will be usable after Closing, exceeds (ii) the value of all current liabilities assumed by Buyer, including trade accounts payable, accrued expenses (including payroll), advance payments on patient accounts and employee benefit accruals (as such terms are used in the Financial Statements) (for the purpose of clarity, employee benefit accruals include paid time off accruals for vacation and sick time but exclude Extended Illness Bank Obligations)." "Hospital Businesses" are defined below in the response to Question 3.a.

This proposal enables ECHN to move from a small health care system to a fully integrated health care system that offers resources, systems, and efficiencies which are essential for long term success in the evolving health care marketplace. PMH will bring the strength of its Coordinated Regional Care model (described in more detail further below) to the service area of ECHN and provide innovation that ECHN could not possibly do independently. PMH offers both financial strength and health care experience in the development of multi-level regional networks of healthcare providers.

For at least three years, PMH will continue to operate both Manchester Memorial Hospital ("MMH") and Rockville General Hospital ("RGH") as acute care hospitals. PMH or a designated affiliate or subsidiary will offer employment to substantially all employees of ECHN and its affiliates. Existing union contracts, medical education relationships and ownership in post-acute providers will also be maintained. MMH and RGH will each maintain an advisory board (the "Local Board") made up of community representatives, physicians on the respective hospitals' medical staffs, and the Chief Executive Officer of the respective hospital. PMH will establish a medical foundation that will offer employment to all licensed providers employed by ECHN or its affiliates.

Further description of each of the parties is provided below.

The Parties

ECHN

ECHN is a not-for-profit health care system that serves 19 towns in eastern Connecticut including Andover, Bolton, Coventry, Ellington, Manchester, South Windsor, Tolland, Vernon, Willington, Ashford, Columbia, East Hartford, East Windsor, Glastonbury, Hebron, Mansfield, Somers, Stafford, and Union (the "Service Area"). ECHN was formed in 1995 when MMH and RGH joined as partners. By bringing together the experience and resources of all ECHN health care facilities, ECHN has provided more convenient access to a wider range of health care services, in order to exceed the expectations of the patients and communities it serves.

ECHN's care network consists of a number of wholly owned entities including:

- MMH
- RGH
- ECHN ElderCare Services, Inc.
- Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC")
- A Caring Hand, LLC
- Clinically Integrated Network of Eastern Connecticut, LLC
- Connecticut Healthcare Insurance Company
- ECHN Corporate Services, Inc.
- Medical Practice Partners, LLC
- ECHN Enterprises, Inc.
- Haynes Street Property Management, LLC

- Eastern Connecticut Medical Professionals Foundation, Inc.
- ECHN Community HealthCare Foundation, Inc.

ECHN has ownership interests in number of community based services including the following joint ventures:

- Evergreen Endoscopy Center, LLC
- WBC Connecticut East, LLC
- Aetna Ambulance Service, Inc.
- Metro Wheelchair Service, Inc.
- Ambulance Service of Manchester, LLC
- Connecticut Occupational Medicine Partners, LLC
- Eastern Connecticut Physician Hospital Organization, Inc.
- Northeast Regional Radiation Oncology Network, Inc.
- Tolland Imaging Center, LLC
- Haynes Street Medical Associates, LLC
- Haynes Street Medical Associates II, LLC
- Evergreen Medical Associates, LLC
- Evergreen Medical Associates II, LLC

ECHN's mission has been impeded over the last decade by various factors, including reduced reimbursement from government payors, limited access to the capital required to improve infrastructure and to recruit and maintain needed physicians, and mounting pension liabilities. ECHN's financial condition since 2001 has been strained, and the reinstitution of Connecticut's hospital tax in 2011 created an additional financial burden. The combination of these factors led to the Board's decision to consider other options in order to ensure continued operations of healthcare services in the Service Area. ECHN's community will be best served with the proposed sale of its assets to PMH, whereby existing facilities and services will be continued, enhanced and integrated into an evolving health care system of the future.

Prospect Medical Holdings

PMH is a Delaware corporation with its principal place of business located in Los Angeles, California. PMH is a healthcare services company that owns and operates thirteen acute care and behavioral hospitals located in Rhode Island, Texas and California. PMH also owns a network of specialty and primary care clinics in each of its regions. Through PMH's medical group segment, PMH manages the provision of physician services to approximately 260,000 patients in Southern California, South Central Texas and Rhode Island through a network of approximately 8,900 physicians.

PMH currently owns the following hospitals:

- Los Angeles Community Hospital;
- Los Angeles Community Hospital at Bellflower;
- Los Angeles Community Hospital at Norwalk;

- Southern California Hospital at Hollywood;
- Southern California Hospital at Van Nuys;
- Southern California Hospital at Culver City;
- Foothill Regional Medical Center;
- Nix Health (four campuses);
- Roger Williams Medical Center (RI); and
- Our Lady of Fatima Hospital (RI)

PMH aligns its hospitals and physicians under a model referred to as Coordinated Regional Care ("CRC"). CRC provides for clinical integration among hospitals, physicians and other medical, social and community providers working closely with strategic partner health plans and other payers under a value-based, global risk reimbursement payment system to achieve the triple aim of improved patient care and experience, better patient health, and lower costs. This model has been highly successful in aligning physicians with PMH hospitals and improving quality, efficiency and financial performance in California, and local versions of the model have been implemented in Texas and Rhode Island with similar success. Through PMH's CRC model, PMH works closely with hospitals and affiliated medical groups for the benefit of every person who comes to them for care, building comprehensive networks of quality healthcare services that are designed to offer patients highly coordinated, personalized care and help them live healthier lives. Through collaboration, PMH strives to provide every patient with the quality, affordable healthcare they need and deserve.

The proposed sale of ECHN's assets represents an innovative solution to long-standing challenges and offers ECHN's Service Area patients continued access to ECHN's services and facilities. Many of these services and facilities will be enhanced through capital investments and operating efficiencies. The proposal is financially feasible, ensures and enhances access, and improves the financial health of Connecticut's health care system. Also see response to Question 21, below, regarding the relationship between the proposal and the Statewide Health Care Facilities and Services Plan.

3. Describe the terms of the proposed Asset Purchase.

This section should include, but is not limited to:

a. descriptions of ECHN, PMH, the assets to be transferred pursuant to the Asset Purchase and any assets excluded from transaction, the assumed and excluded liabilities of the Asset Purchase, and the commitment to spend $75 million dollars on capital items and any plan to expand or acquire new programs or services;

b. a financial analysis of the proposed transaction that identifies the source of funding for PMH's initial purchase price, the uses of the proceeds of the transaction and the valuations of included and excluded assets; and

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

Response:

The draft APA commits ECHN and its affiliates, subject to satisfaction of various conditions, to the sale of substantially all of their assets to one or more subsidiaries of PMH. The transaction reflected in the draft APA, which is subject to any changes that might be required to conform to the Letter of Intent or as the result of PMH's Due Diligence, follows largely from the Letter of Intent signed on June 25, 2015 by ECHN and PMH, as amended (a copy of which is attached hereto as Exhibit Q3-1). All capitalized terms not defined herein are defined in the draft APA, a copy of which is attached as Exhibit Q3-2. Additionally, a balance sheet of the proposed transaction that lists the assets and liabilities of the ECHN Hospitals as of June 30, 2015 and the projected balance sheets of the surviving nonprofit entity and the for-profit purchaser that reflect the agreement of the parties has been included as Exhibit Q3-3.

1. Description of ECHN

A. ECHN is a not-for-profit health care system that serves 19 towns in eastern Connecticut. It includes both MMH and RGH (MMH and RGH are sometimes referred to herein as the "Hospitals"), as well as a post-acute care continuum of care network, a physician network, and other health care services.

2. Description of PMH

A. PMH is a for-profit, privately-owned Delaware corporation that owns and operates thirteen acute care and behavioral hospitals, and a network of 32 specialty and primary care clinics, in Southern California, Texas and Rhode Island.

3. Form of Transaction

A. PMH or a PMH designated subsidiary will purchase substantially all of the assets of ECHN, including the properties, assets and businesses of, or ownership interests of ECHN affiliates in, the following entities (referred to collectively as the "Hospital Businesses"):

- MMH
- RGH
- ECHN ElderCare Services, Inc.
- Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC")
- A Caring Hand, LLC
- Clinically Integrated Network of Eastern Connecticut, LLC

- Connecticut Healthcare Insurance Company
- ECHN Corporate Services, Inc.
- Medical Practice Partners, LLC
- ECHN Enterprises, Inc.
- Haynes Street Property Management, LLC
- Eastern Connecticut Medical Professionals Foundation, Inc.

B. PMH or a PMH designated subsidiary will also purchase ECHN's interests in the following joint ventures (each an "ECHN Joint Venture," and collectively the "ECHN Joint Ventures"), subject to approval by other members of the ECHN Joint Ventures as may be required by law or the applicable joint venture agreements:

- Evergreen Endoscopy Center, LLC
- WBC Connecticut East, LLC
- Aetna Ambulance Service, Inc.
- Metro Wheelchair Service, Inc.
- Ambulance Service of Manchester, LLC
- Connecticut Occupational Medicine Partners, LLC
- Eastern Connecticut Physician Hospital Organization, Inc.

C. In addition, PMH or a PMH designated subsidiary will purchase ECHN's affiliates' interests in the following joint ventures (each an "ECHN Affiliate Joint Venture," and collectively the "ECHN Affiliate Joint Ventures"), subject to approval by other members of the joint ventures as may be required by law or the applicable joint venture agreements:

- Northeast Regional Radiation Oncology Network, Inc.
- Tolland Imaging Center, LLC
- Haynes Street Medical Associates, LLC
- Haynes Street Medical Associates II, LLC
- Evergreen Medical Associates, LLC
- Evergreen Medical Associates II, LLC

4. <u>Key Assets and Liabilities To Be Acquired by PMH or a PMH designated subsidiary</u>

A. PMH or a PMH designated subsidiary will acquire real property, leased property, equipment, accounts receivable, and net working capital (*i.e.*, non-cash current assets less the value of all current liabilities) of ECHN and the ECHN affiliates. (*See* Exhibit Q3-2, Section 2.01)

B. Key liabilities PMH or a PMH designated subsidiary will assume include ECHN's unfunded pension liabilities, ECHN's health benefit plan for retirees, ECHN's captive insurer liabilities (*i.e.*, Connecticut Healthcare Insurance Company) and ECHN's workers' compensation obligations. (*See* Exhibit Q3-2, Sections 1.01(7), 2.03)

C. If the ECHN liabilities to be acquired by PMH exceed $77,000,000 (or $122,000,000 if ECHN obtains an assumable $45,000,000 loan to refinance certain of its bond liabilities), PMH will assume such liabilities provided that ECHN reimburses PMH, dollar for dollar, first from its available cash and then from unspent amounts in the indemnity reserve described below, and thereafter in an amount up to $10,000,000 which shall be reflected in a reduction in the capital commitment described below. (*See* Exhibit Q3-2, Section 2.05(d)). PMH can, in its sole discretion, assume liabilities in excess of $10 million, which amount shall also be reflected as a reduction in the capital commitment.

D. ECHN obtained a "fairness evaluation" from Duff & Phelps Corporation valuing the above-listed assets and liabilities. The detail regarding this valuation may be found in response to Question 7 below.

5. <u>Key Assets and Liabilities Excluded from the Transaction</u>

A. PMH or a PMH designated subsidiary will exclude some current ECHN liabilities that will then remain the responsibility of ECHN's residual corporation following the transaction. (*See* Exhibit Q3-2, Section 2.04)

- For example, PMH will not assume liabilities that could arise from lawsuits or tax settlements based on pre-closing activities.

B. ECHN will exclude certain of its assets, defined as Excluded Assets in the APA, including certain cash and cash equivalents of ECHN or the Hospital Businesses; all short-term and long-term investments, but excluding ECHN's investment interests in the joint ventures; board- designated, restricted and trustee-held or escrowed funds (such as funded depreciation, debt service reserves, self-insurance trusts, working capital trust assets, and assets and investments restricted to use), beneficial interests in charitable trusts, and accrued earnings on all of the foregoing; and those other assets listed in Section 2.02 of the APA. (*See* Exhibit Q3-2, Section 2.02)

6. <u>Purchase Price and Use of Proceeds</u>

A. PMH will pay $105,000,000 (or $115,000,000 if ECHN obtains an assumable $45,000,000 refinancing of its bond liabilities) subject to Net Working Capital reconciliation (as defined in footnote 2), ***<u>minus</u>*** the amount of certain ECHN liabilities assumed by PMH (*e.g.* ECHN's unfunded pension obligations, captive insurer liability, capital leases, and the workers' compensation liability), ***<u>minus</u>*** asbestos abatement liability of up to $1,000,000, and ***<u>minus</u>***, in the event that ECHN is unable to assign and transfer to PMH or a PMH designated subsidiary ECHN's interest in an ECHN Joint Venture or an ECHN Affiliate Joint Venture, a dollar amount to be fixed in advance for each ECHN Joint Venture or ECHN Affiliate Joint Venture. (Refer to the response to Question 32 for additional information. (*See* Exhibit Q3-2, Section 2.05(a))

B. The proceeds from the asset sale will first be used to settle all of ECHN's bond liabilities and all of ECHN's other indebtedness not otherwise assumed by PMH.

C. Remaining proceeds will next be used to fund an indemnity reserve (the "Reserve") for a period of at least three years (the "Reserve Period") following the closing of the transaction for payment of ECHN liabilities to PMH or a PMH designated subsidiary that may arise post-closing. Any proceeds that remain after settling bond liabilities, settling other indebtedness, and funding the Reserve will be held by the residual ECHN corporation to be used for post-closing liabilities and wind down of operations. (*See* Exhibit Q3-2, Section 9.08)

D. After expiration of the Reserve Period (which may be extended until the fifth anniversary of the closing date in the event of claims arising during the Reserve Period), any funds remaining in the Reserve and not used to pay claims will be transferred as directed by the Office of the Attorney General of the State of Connecticut with the expectation that such funds will be transferred to a community foundation and used to support charitable health related efforts in the ECHN Service Area.

7. Local Governance

A. Following the closing, MMH and RGH will each maintain an advisory board made up of community representatives, physicians on the respective Hospital's medical staff, and the Chief Executive Officer of the respective Hospital (the "Local Board"). (*See* Exhibit Q3-2, Sections 1.01(61), 5.18, 5.21, 5.26, 5.27). The members of each advisory board will be selected in the same way.

- The initial members of the Local Board shall include at least five members of ECHN's Board of Trustees immediately prior to the closing and five other individuals identified by ECHN prior to the closing.

- Among other things, the Local Board will serve as a resource for PMH with respect to PMH's investment of the capital commitment described below, assist with maintenance and implementation of a strategic business plan for the Hospitals, make recommendations for medical staff credentialing at the Hospitals, review and make recommendations regarding the quality assurance program at the Hospitals and assist in issues relating to accreditation for the Hospitals.

- PMH will consult with the medical staff of the Hospitals on clinical quality matters to share best practices and establish clinical quality goals and measure progress.

8. Capital Commitment

A. After closing, PMH, in consultation with ECHN will develop a strategic capital plan with respect to the Hospital Businesses. (*See* Exhibit Q3-2, Section 5.18)

B. In accordance with the provisions of the APA, PMH will commit to spend within five years of the closing not less than $75,000,000 (the "Commitment Amount") for the benefit of the Hospital Businesses and for the benefit of the Service Area of MMH and RGH. These expenditures may include: (i) capital projects, including routine and non-routine capital expenditures for the improvement of ECHN's facilities; (ii) development, expansion, or acquisition of a department, program, service or facility; (iii) upgrades or renovations generally; (iv) deferred maintenance items; and (v) capital expended in support of the recruitment of the Hospitals' medical staff located in the Hospitals' Service Area. For the purpose of determining whether the Commitment Amount has been satisfied, operating leases for (i) buildings or the fit-out or build-out of space used in the provision or support of medical services or (ii) medical equipment with a useful life of more than one year, shall be included.

- PMH has the right to defer this commitment beyond a five-year period if the state or Federal authorities enact requirements after closing that discriminate against for-profit hospitals and cause the Hospital Businesses to suffer a decline in EBITDA of more than ten percent in any year on a consolidated basis. To the extent PMH defers this commitment, it shall make available to the public reasonably detailed information to support PMH's position and shall consult with the Local Board to determine an alternate mutually agreeable timeframe to complete the capital commitment.

9. ECHN Community HealthCare Foundation, Inc.

A. The assets of ECHN Community HealthCare Foundation, Inc. (the "Foundation") will not be included in the assets purchased by PMH. It is anticipated that the funds remaining in the Foundation at closing will be transferred to a community foundation designated by the Office of the Attorney General of the State of Connecticut. See responses to Questions 10 and 11 below for additional information.

10. Employment Matters

A. PMH or an affiliate will offer employment as of the closing to substantially all employees of ECHN and its affiliates who work at the Hospital Businesses, including employees on approved leaves of absence as of the closing. (*See* Exhibit Q3-2, Section 5.03(a))

B. PMH or an affiliate will offer the hired employees salaries that are equal to their salaries as of the closing date and benefits packages that are comparable to those offered to similarly-situated employees at other hospitals operated by PMH. (*See* Exhibit Q3-2, Section 5.03(a))

C. PMH or an affiliate will assume and honor ECHN's (and its affiliates') collective bargaining agreements. (*See* Exhibit Q3-2, Section 5.03(e))

11. <u>Commitment to Maintain Key Clinical Operations and Community Support</u>

A. *Operation of Hospitals*: For at least three years after the closing of the transaction, PMH will continue operating the Hospitals in their current locations as acute care hospitals with emergency departments. (*See* Exhibit Q3-2, Section 5.15)

B. *Post-Acute Care*: Also, for at least three years after the closing of the transaction, PMH will maintain an ownership interest in ECHN's current post-acute care continuum of care network (*e.g.*, the service lines currently operated by VNHSC and ECHN ElderCare Services, Inc.) and require any wholly owned entity involved with such post-acute care continuum of care network to maintain appropriate service lines during such three-year period. (*See* Exhibit Q3-2, Section 5.15)

C. *Medical Education*: PMH will maintain and support financially ECHN's University of New England medical student and other health professions teaching programs, as well as ECHN's graduate medical education programs, while operating at a level not to exceed the Indirect Medical Education and Direct Graduate Medical Education caps that may be established by the Centers for Medicare and Medicaid Services. (*See* Exhibit Q3-2, Section 5.17)

D. *Community Benefits*: PMH will also ensure that each Hospital maintains and adheres to ECHN's current policies regarding charity care, indigent care, community volunteer services and community benefits (or adopts other policies that are at least as favorable to the community as ECHN's current policies). (*See* Exhibit Q3-2, Section 5.16)

12. <u>Physician Alignment</u>

A. PMH will maintain a medical foundation (the "Medical Foundation"). The Medical Foundation will offer employment to all licensed providers employed by ECHN or its affiliates immediately prior to closing. (See Exhibit Q3-2, Section 7.11)

13. <u>Regulatory Approvals</u>

A. Prior to the closing of the transaction, ECHN and PMH will apply for all necessary regulatory approvals needed to consummate the transactions contemplated in the APA.

   - Among the regulatory approvals required are: (i) approval of the Connecticut Attorney General for conversion of the Hospital Businesses from non-profit to for-profit status; (ii) certificate of need approval from the Department of Public Health, Office of Health Care Access; and (iii) antitrust clearance from the Federal Trade Commission.

14. Key Closing Conditions

A. The closing of the transactions contemplated by the APA are conditioned upon a number of items, including there being no material adverse change to the business, assets, liabilities, financial condition or results of operations of ECHN and ECHN having sufficient funds to fund all of its liabilities that are not assumed by PMH.

B. In addition, the closing is conditioned on the receipt of all consents, approvals licenses and other authorizations necessary to consummate the transactions and operate the business(See Exhibit Q3-2, Section 7.04(c)), which include owning a medical foundation and maintaining the employment of licensed providers employed by ECHN or its affiliates immediately prior to closing.

15. Covenant Not to Compete

A. ECHN covenants that for a period five years after the closing date, it shall not, directly or indirectly, own, lease, manage, operate, control, be employed by, maintain or continue any interest whatsoever or participate in any manner with the ownership, leasing, management, operation, or control of any business or enterprise that offers services in competition with the Hospital Businesses within a 30 mile radius of each hospital. (*See* Exhibit Q3-2, Section 5.10)

B. ECHN will not be precluded from participating in activities that promote health care services for residents of the Service Area. (*See* Exhibit Q3-2, Section 5.10)

16. Termination Fee

A. PMH will reimburse ECHN up to $1,000,000 for out of pocket legal, valuation and consulting expenses related to the transaction, which may, subject to certain exceptions, be retained by ECHN if the transaction does not close. If the transaction closes, the reimbursement paid to ECHN will be subtracted from the purchase price. (*See* Exhibit Q3-2, Section 8.04(b))

17. Termination Prior to Closing

A. The APA may be terminated at any time on or prior to the closing date: (i) by mutual consent of the parties; (ii) by PMH if any event occurs or condition exists which causes ECHN to be unable to satisfy one or more conditions to the obligations of PMH to consummate the transaction; (iii) by ECHN if any event occurs or condition exists which causes PMH to be unable to satisfy one or more conditions to the obligations of ECHN to consummate the transaction; and (iv) by either party if the closing date shall not have taken place on or before December 31, 2016 (though such date may be extended by mutual agreement of ECHN and PMH). (*See* Exhibit Q3-2, Section 8.04(a))

18. Indemnification

A. Subject to certain limitations set forth in the APA, ECHN shall indemnify PMH against: (i) any inaccuracy in or breach of any representation or warranty of ECHN set forth in the APA or in any Closing Document to which ECHN is a party; (ii) any claim against PMH or its Affiliates that, if meritorious, would give rise to a breach of any of ECHN's representations and warranties as the direct cause of such claim; (iii) the nonfulfillment or breach of any covenant of ECHN set forth in the APA or in any other closing document to which ECHN is a party; (iv) excluded liabilities; (v) any actual damages resulting from claims by a creditor of ECHN relating to a claim in existence as of the closing date that the transfer of any of the Assets constitutes a fraudulent conveyance or transfer, or is avoidable under applicable law; and (vi) any liabilities, costs or expenses incurred by PMH or its Affiliates in connection with the Connecticut Transfer Act. (*See* Exhibit Q3-2, Section 9.01)

B. Subject to certain limitations set forth in the APA, PMH shall indemnify ECHN against: (i) any inaccuracy in or breach of any representation or warranty of PMH set forth in the APA or in any closing document to which PMH is a party; (ii) the nonfulfillment or breach of any covenant of PMH in the APA or in any Closing Document to which PMH is a party; (iii) the assumed liabilities; and (iv) ownership by PMH of the Assets or the operation by PMH of the Hospital Businesses after the Closing Date. (*See* Exhibit Q3-2, Section 9.03)

19. <u>Indemnity Reserve</u>

ECHN agrees to maintain an indemnity reserve in the amount of $4,500,000 for a period of three years after the closing date so that PMH will have meaningful recourse against ECHN for any potential indemnification claims. If certain claims arise during this three year period, the indemnification reserve may be extended, but not beyond the fifth anniversary of the closing date. (*See* Exhibit Q3-2, Section 9.08) The indemnification obligations of PMH's subsidiary buyer to ECHN are guaranteed by PMH. (*See* Exhibit Q3-2, Section 10.23)

4. Provide copies of all contracts, agreements, memoranda of understanding, and pro forma financial statements relating to the proposed Asset Purchase.

<u>Response</u>

Please see Exhibit Q3-1 for the Letter of Intent signed by the Applicants on June 25, 2015 and Exhibit Q3-2 for a copy of the unsigned APA.

A copy of the Confidentiality and Non-Disclosure Agreement between ECHN and PMH has been included as Exhibit Q4-1.

5. Describe the due diligence undertaken by ECHN in deciding to enter into the Asset Purchase.

This section should include, but is not limited to, considerations regarding the current financial condition of ECHN and any projected financial condition of ECHN, any professional assessments of or reports regarding ECHN or PMH, any and all alternatives explored by ECHN or other offers received by ECHN, the reasons for rejecting such alternatives and offers, ECHNs selection of PMH, and the specific terms of the Asset Purchase.

In addition, the parties should discuss the due diligence in obtaining the fairness evaluation required by Conn. Gen. Stat.§ 19a-486a(c)(5), including providing a copy of said independent expert's resume or other documentation of his or her qualifications and describing the process undertaken to identify and retain this person as an independent expert.

Response:

ECHN's decision to enter into the APA was the result of a lengthy and thorough process, as described in more detail below.

BACKGROUND

ECHN has a long history of providing care in the community, including to a large number of Medicare, Medicaid and uninsured patients. Like many nonprofit community hospitals, ECHN has seen its mission impeded over the last decade or so by various factors, including reduced reimbursement from government payors, limited access to the capital required to improve infrastructure and to recruit and maintain needed physicians, and mounting pension liabilities.

In 2001, ECHN lost more than $10 million and continued to operate in the red over the next several years. ECHN's management took various actions to mitigate losses during this time and was able to improve ECHN's financial condition significantly. However, capital investments had to be deferred and long-term debt and pension liabilities continued to grow.

Pension funding reforms and the market crash in 2008 exacerbated ECHN's already fragile financial condition. Hiring freezes, wage freezes, reductions in force, a permanently reduced workweek of 37.5 hours, LEAN program initiatives and group purchasing initiatives were all instituted to respond to ECHN's financial challenges. Despite these measures, a large portion of ECHN's annual cash flow was required to fund debt service and pension obligations, making capital investments difficult. As a result, infrastructure improvements continued to be deferred, as were plans to expand and introduce new programs to help recruit physicians to replace those who were relocating or retiring.

The adoption of the Patient Protection and Affordable Care Act ("PPACA") in 2010 further changed the landscape for health care providers, including ECHN, with significant planned reductions in government payments for services and requirements to participate in new payment models with a focus on collaboration and coordinated care. Then, in 2011, Connecticut reinstituted the hospital tax, putting an even further strain on ECHN's finances. The combination of these factors led to the Board's decision to consider affiliation options.

ECHN ended fiscal year 2011 breakeven from operations with an overall bottom line loss of $1,299,000. This was the first fiscal year impacted by the new State of Connecticut hospital tax. The net revenue reduction to ECHN was over $580,000 for the 4th quarter and the following fiscal year (2012) was impacted by a $2,323,000 revenue reduction. In fiscal year 2012, ECHN also experienced a decline in inpatient and outpatient volumes. In the first half of fiscal year 2012, with the implementation of health insurance exchanges pending, ECHN began to model pro forma projections for the next five years. The projections included anticipated payer mix shifts to the exchanges and Medicaid. For fiscal years 2014 and 2015, the first two years affected by the exchanges, ECHN projected that net revenues would decline by $11,000,000 per year and that ECHN would realize operating losses close to $6,000,000 per year. These significant financial challenges led ECHN management to conclude that future financial viability would require partnering. As ECHN considered partnering options over the next two years, the increases to the state hospital tax, Medicare sequestration, and the continued evolution of the health spending accounts/new consumerism added merit to the position to partner.

ESTABLISHMENT OF PARTNERING WORKGROUP AND DECISION TO PURSUE A TRANSACTION

In September, 2011 the ECHN Board authorized the establishment of a workgroup to study the impact of PPACA on ECHN and to evaluate whether benefits would be realized by affiliating with another health care system, or whether ECHN would better serve the community by remaining an independent system.

The workgroup (the "Partnering Workgroup" or the "Affiliation Subcommittee") was assembled in November, 2011 and included Trustees, Corporators, Medical Staff members and key executives. To assist the Partnering Workgroup in its evaluation, ECHN engaged The Chartis Group, LLC ("Chartis"), a national healthcare consulting firm. Background regarding Chartis and the Chartis team is included in Exhibit Q5-1. With the help of Chartis, the Partnering Workgroup tasked itself with considering the issues set forth below:

Table 1: Affiliation Subcommittee Composition and Role	
AFFILATION SUBCOMMITTEE	ROLE OF THE SUB-COMMITTEE
• Dr. Dennis O'Neill – Board Chair • Dr. Angelee Carta • Dr. Anthony DiStefano • Ms. Joy Dorin • Mr. Jeffrey Heidtman • Mr. Joseph Jeamel, Jr. • Mr. Peter Karl • Dr. Pamela Lewis • Mr. Dennis McConville • Ms. Robin Murdoch-Meggers • Dr. Claudio Milite • Dr. Saqib Naseer • Ms. Rosemary Papa • Dr. Joel Reich	• Guide affiliation planning process • Determine if some form of affiliation would be helpful • Develop Vision and Goals for such an affiliation • Assess benefits & risks of potential affiliation options / partners • Define recommended partnership structure and terms • Ensure appropriate communication and engagement with key constituencies • Seek concurrence of full Board at appropriate intervals

The Partnering Workgroup began its study in earnest in December, 2011 and met numerous times over the next several months. In addition to evaluating local and national data, the Partnering Workgroup met with key constituents (community and Board members, physicians, management and staff) and with prospective partner organizations to obtain their perspectives on ECHN, its current state and its future.

In September of 2012, the Partnering Workgroup presented its initial findings to the ECHN Board. The Partnering Workgroup concluded that affiliation with a larger health system would better position ECHN to achieve the following goals: (i) attract patients and providers based on quality, service, accessibility and affordability; (ii) enhance physician retention and recruitment; (iii) improve ECHN's financial position in order to invest in new equipment and technologies; and (iv) coordinate care to manage risk and participate in new payment vehicles.

In light of this conclusion, the Partnering Workgroup identified several potential partners, including nonprofit and for-profit health systems, and developed a set of key criteria to be considered when evaluating partners. Criteria included: (i) cultural compatibility with that of ECHN; (ii) strategic and financial fit; (iii) organizational strength and capabilities; and (iv) risks of implementation.

Following the presentation of the Partnering Workgroup, the Board voted to pursue an affiliation and tasked the Partnering Workgroup with further evaluating how potential partners could further ECHN's goals and developing key affiliation terms.

REQUEST FOR AND EVALUATION OF PROPOSALS BY AFFILIATION SUBCOMMITTEE

From November 2012 through April 2013, the Partnering Workgroup worked with Chartis to develop and conduct a request for proposal (RFP) process for potential partners. RFPs were mailed to three nonprofit health systems and three for-profit health systems. The Workgroup received and considered four Indications of Interest against the selection criteria approved by the Board. One Indication of Interest was from a nonprofit health system that proposed a management relationship with ECHN; the remaining three Indications of Interest were from joint ventures between nonprofit and for-profit health systems proposing to acquire all or substantially all of the assets of ECHN, including the proposed joint venture between Yale New Haven Health System ("YNHHS") and Vanguard Health Systems, Inc. ("Vanguard"). Members of the Partnering Workgroup then met with each respondent for further detail on the proposals submitted, followed up with formal requests for clarification/additional information, conducted site visits to facilities operated by those healthcare systems and performed due diligence for each of the respondents.

ESTABLISHMENT OF BOARD TRANSACTION COMMITTEE

The findings of the Partnering Workgroup were summarized by Chartis and a formal presentation was made to the Board in April of 2013. The Board was asked to consider both (i) whether the proposals made would meet ECHN's needs; and (ii) whether other options should be considered. The Board determined that other alternatives were unlikely and that further evaluation should be undertaken regarding the proposals presented to date. Accordingly, at the April 27, 2013 Board meeting, the Board authorized the creation of a formal Board Transaction Committee to further evaluate the work of the Partnering Workgroup and conduct additional diligence regarding the proposals submitted.

The Transaction Committee carefully considered all of the proposals and evaluated their benefits and risks. The Transaction Committee also reviewed "reverse due diligence" information prepared by Chartis on the proposed acquirers, including information regarding financial condition, leadership, strategic focus, quality indicator trends, and clinical programs. Ultimately, the Transaction Committee made a preliminary finding that the joint Vanguard-YNHHS proposal was superior to the other proposals.

SELECTION OF INITIAL AFFILIATION PARTNER

In June of 2013, the Transaction Committee reviewed final information from the respondents and made its recommendation and report to the Board. The recommendation of the Transaction Committee was to proceed with negotiating a term sheet and draft letter of intent with YNHHS and Vanguard. The Board considered and approved the recommendation of the Transaction Committee.

On June 24, 2013, ECHN was informed by Vanguard that it was to be acquired by Tenet, but that Tenet intended to proceed with negotiating a letter of intent for the acquisition with ECHN. In July of 2013, the ECHN Board of Trustees considered the diligence review of Tenet conducted by the Transaction Committee and a proposed Letter of Intent. As a result of that review, the Board approved the Letter of Intent and it authorized management, in consultation with the Transaction Committee, to proceed to negotiation of a definitive APA.

The Letter of Intent among ECHN, YNHHS and Vanguard was executed on August 8, 2013. Following its execution, the parties conducted confirmatory due diligence and negotiated an APA. That agreement was presented to and approved by the Board on April 9, 2014. The APA was then submitted to and approved by ECHN's Corporators.

ECHN, Tenet and YNHHS initiated the regulatory approval process in June of 2014 holding Letter of Determination Hearings in Vernon and Manchester. A certificate of need application for the acquisition of ECHN's assets by a joint venture to be formed by Tenet Healthcare and YNHHS was filed with the Office of the Attorney General and with the Office of Health Care Access on October 24, 2014. Responses to completeness questions received on November 13, 2014 were filed with the agencies on November 25, 2014.

TENET HEALTHCARE WITHDRAWAL

On December 11, 2014, Tenet informed ECHN that it was withdrawing its certificate of need application for the acquisition of ECHN citing the proposed regulatory conditions that had been placed on its application to partner with Waterbury Hospital. Following the announcement, ECHN made efforts to revive its Tenet-YNHHS deal. On February 4, 2015, following some discussions between representatives of Tenet and the Malloy Administration, Governor Malloy and Tenet issued a joint statement announcing that they had decided to end their discussions.

2015 ECHN AFFILIATION EFFORT

While waiting to see if Tenet would return to Connecticut to pursue its acquisition of ECHN, the Board discussed ECHN's continued financial challenges and capital needs, as well as the goals that it had set for joining another healthcare system. As a result, the Board reaffirmed the need for ECHN to partner. To that end, on January 6, 2015, letters requesting expressions of interest to partner with ECHN were sent to five health systems, four located in Connecticut and one out-of-state nonprofit system. Letters expressing interest were received from the four Connecticut-based systems.

REQUEST FOR PROPOSALS BY TRANSACTION COMMITTEE

Relying on its deal experience with Tenet and YNHHS, and with guidance of The Chartis Group, the Transaction Committee conducted a second RFP process. On February 6, 2015, RFPs were sent to the four systems that had expressed interest in partnering and to two additional out-of-state systems that had approached ECHN with interest in an affiliation. A

copy of the RFP delivered to PMH is attached as Exhibit Q5-2 (the RFPs delivered to the other potential partners were in substantially the same form as the RFP delivered to PMH).

ECHN provided limited confidential due diligence information to potential parties and asked them to address specific elements in a proposal. ECHN also included template affiliation and asset purchase agreements that reflected ECHN's contract requirements and asked the potential partners to include with their proposals any required or requested revisions to the templates. The parties were asked to submit proposals by mid-March, including the following:

1. How the affiliation would help ECHN to achieve its vision and goals, with a focus on access to care, medical staff integration, clinical quality, safety, service and patient satisfaction.

2. Proposed form or structure of affiliation (e.g., merger, acquisition of assets, member substitution or joint venture).

3. Financial terms of affiliation, including proposed treatment of ECHN's existing debt, consideration, and future capital commitments.

4. Proposed governance and management structure.

5. Plans for retention of employees.

6. Commitments to continuing and expanding services.

7. Proposed timing, required regulatory approvals, and material contingencies.

8. If the organization was subject to any religious or ethical restrictions that would apply to ECHN post-closing and, if so, how ECHN would continue to meet the needs of its community in the event the restrictions applied.

EVALUATION OF PROPOSALS BY THE TRANSACTION COMMITTEE

By March 16, 2015, three proposals were received. One was from a nonprofit system that proposed making a minority investment in ECHN, purchasing its home care agency and providing a management agreement for ECHN. A second was from a national nonprofit organization that was merging with a Connecticut nonprofit system and that proposed a member substitution pursuant to which it would become ECHN's corporate parent. The third proposal was from PMH to acquire all or substantially all of the assets of ECHN.

The proposals were evaluated by the Transaction Committee against the selection criteria approved by the Board. In its analysis and consideration of the proposals, the Transaction Committee evaluated each with respect to ECHN's financial needs and its obligations to creditors, antitrust considerations and state regulatory acceptance for a hospital conversion.

The Transaction Committee then met with each respondent for further detail on the proposals submitted and followed up with formal requests for clarification/additional information on April 10, 2014.

Following receipt of responses to the requests for clarification/additional information, the Transaction Committee conducted its reverse due diligence for the respondents. The Committee reviewed financial, quality and corporate compliance data for each of the respondents. In addition, members of the Transaction Committee and ECHN's executive team made site visits to affiliated hospitals that had recently been merged with or acquired by the respondents. During those visits, Committee members and members of the executive team met with leadership, members of the medical staffs and employees of each organization.

The Transaction Committee evaluated each of the proposals and responses received by considering the following questions:

1. a. How would an ECHN partnership with this organization help improve the convenience, quality, accessibility and affordability of care in the community?
   b. What are the risks inherent in achieving the above?

2. a. How would an ECHN partnership with this organization help ECHN achieve its strategic objectives (be the provider of choice east of the Connecticut River; provide a full spectrum of services; improve finances; increase capabilities to manage population health and risk/incentives)?
   b. What are the risks inherent in achieving the above?

3. How closely aligned is the potential partner with ECHN for structural and cultural fit?

4. How would you rate their strategy to succeed in the future?

5. How would you assess their organizational strength?

6. What is their willingness to invest locally?

7. What do you think are greatest advantages of entering into some form of affiliation with this organization/partnership?

8. What do you see as the greatest risks or concerns in entering into some form of affiliation with this organization or partnership?

9. What other information will you want to see and what issues would you like to see addressed before making a final recommendation?

10. Which affiliation option is likely to be the most successful in the market in your opinion – and why?

On May 7 and on May 14, 2015, two teams of Transaction Committee members and ECHN executives made visits to Los Angeles to tour Prospect Medical Systems, Inc., PMH's management services organization that supports its independent physician practice associations (IPAs) and hospitals for risk-based contracting and population health management. Information for PMH's Southern California operations may be found in Exhibit Q5-3. The groups also toured Prospect's Southern California Hospital in Culver City and met with and interviewed representatives in the areas of governance, medical staff leadership and administration from Prospect's Los Angeles Coordinated Regional Care Market.

On June 8, 2015, members of the Transaction Committee and ECHN executives visited CharterCARE Health Partners' Roger Williams Medical Center in Providence, RI. CharterCARE Health Partners is PMH's coordinated regional care network comprised of Roger Williams Medical Center, Our Lady of Fatima Hospital, a skilled nursing facility, a regional cancer center, a rehabilitation center, a community primary care center, a home health services company, an IPA, and a physician group practice based in Providence. Information for Prospect Rhode Island may be found in Exhibit Q5-4. The organization was the result of a merger of the two hospital parent organizations in 2010. In 2014, CharterCARE and PMH formed a joint venture to own and operate the health system. During the visit, there was discussion regarding PMH's transaction experience, the PMH organizational culture and PMH's implementation of PMH's CRC Model with the CharterCARE Chair of the Board, physician leadership of its Independent Practice Association ("IPA") and with the executive team. Within a year of closing its transaction with CharterCARE, PMH had successfully engaged independent medical staff to form its IPA, successfully partnered with Blue Cross and Blue Shield of Rhode Island to secure a risk-based contract for 6,500 covered lives, and achieved positive financial results for the hospitals.

In its analysis and consideration of the proposals made to ECHN, the Transaction Committee evaluated each proposal with respect to satisfying ECHN's financial needs and liabilities, any antitrust considerations and state regulatory requirements for a hospital conversion.

SELECTION OF AFFILIATION PARTNER

On June 1, requests were made to each of the respondents for best and final offers. At its meeting on June 16, 2015, the Transaction Committee reviewed final information from the respondents and it was agreed that ECHN would negotiate solely with PMH to address open items in their proposed APA..

On June 22, 2015, the Transaction Committee reviewed and discussed the Letter of Intent and APA negotiated with PMH. The Transaction Committee made the unanimous decision to recommend to the Board acceptance of PMH's proposal to acquire ECHN.

The Board held a retreat on June 25, 2015 at which it reviewed and discussed the Transaction Committee's recommendations along with the financial environment, the partner selection criteria, the uncertainty and risks involved with each potential partner, and the results of due diligence performed on the potential affiliation partners. The Letter

of Intent and draft APA for the acquisition of ECHN by PMH were presented to the Board for approval. Following discussion of the proposed transaction and further consideration of alternative proposals presented to ECHN, the Board unanimously approved the Letter of Intent and APA in substantially the form presented.

The draft APA was then submitted to ECHN's Corporators for consideration. The ECHN Corporators approved the draft APA on July 29, 2015. A total of 169 Corporators voted in person or by proxy, with 165 voting in favor of the transaction and 4 against, a 98% favorable vote (Exhibit Q5-5).

On September 8, 2015, the Transaction Committee met to review a fairness valuation presented by Duff & Phelps. Please see Applicants' response to Question 7 for a description of the due diligence undertaken to identify the expert giving the fairness valuation.

6. Describe any and all potential conflicts of interest between, among, or pertaining to, at a minimum, any and all board members, officers, key employees, and experts of ECHN, PMH, any other party to the transaction, and any person or entity that performed assessments requested in this application.

In addition, describe the due diligence taken to determine the existence of any conflicts of interest, including how ECHN and PMH defined "conflict of interest" for purposes of the response to this question.

Response:

Conflict of Interest/Financial Disclosure forms (the "Disclosure") were prepared and disseminated to (i) those individuals who were members of the Board of Trustees of ECHN, MMH, RGH, ECHN Eldercare Services, Inc., and Visiting Nurse and Health Services of Connecticut, Inc. at any time during the period from the date that the transaction with PMH was first contemplated through the date of filing of this application; (ii) experts consulted with respect to the transaction; and (iii) the senior executives of ECHN and PMH who have direct involvement in the transaction. The Disclosure required respondents to disclose any financial interest, beneficial interest and/or employment interest in the proposed transaction and/or in any entity associated with the principals involved in the transaction. The Disclosure also required statements regarding Related Persons, defined as:

> *"A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent."*

The completed Disclosures for ECHN are attached as Exhibit Q6-1.

ECHN's Board of Trustees has performed thorough due diligence, including periodic in-depth reviews of Trustee relationships, for transaction-related conflicts of interest. This process began in March 2013 when, in contemplation of the earlier transaction with Vanguard, later Tenet Healthcare, the Chairman of the Board of Trustees of ECHN created an ad hoc Conflict of Interest Task Force (the "Conflict of Interest Task Force") to which he appointed three independent Trustees. The Conflict of Interest Task Force met actively throughout the spring and summer of 2013 to review applicable statutory, regulatory and organizational conflict of interest requirements and evaluate the status of each Trustee with respect to those requirements, with particular focus on the financial relationships, if any, that each Trustee had with ECHN and any potential bidders and conflicts that might be raised by the Board's consideration of a potential partnering transaction. This process included a review of all contracts, employment relationships and family member relationships that any Trustee had with ECHN or any bidder under consideration, along with reviews of prior completed annual conflicts disclosure forms and a specific disclosure form developed in anticipation of the transaction. As a result of this work, the Conflict of Interest Task Force recommended, and on May 29, 2013 the Board adopted, a two-step process for voting on transaction related resolutions so as minimize the potential that any personal interest would impact the ultimate vote on these matters. In the first step, those Trustees having a conflict of interest would be recused, and the remaining Trustees (both independent and non-independent under the IRS Form 990 "independence" test) would confer and vote on transaction related resolutions. In the second step the non-independent Trustees would be recused and the independent Trustees would separately confer and hold a second vote on the transaction related resolutions. The Trustees used this two-step voting process when they voted to negotiate a letter of intent with ECHN's prior potential acquirer Vanguard in 2013, and a second time when the Trustees voted to approve the terms of that proposed acquisition in 2014 with Vanguard's new parent, Tenet Healthcare. The Trustees also used this process when they voted on the proposed PMH transaction as detailed further below.

Before voting on the PMH transaction, all Trustees completed a transaction related questionnaire designed to disclose potential conflicts of interests with new bidders. The Conflict of Interest Task Force reviewed the questionnaires along with any additional relevant information about Trustee relationships with ECHN and/or bidders, at which time it concluded that no Board member had any conflict of interest that that would trigger recusal during the first vote. Accordingly, when the Board voted to approve the Letter of Intent and APA with PMH at a meeting on June 25, 2015, all thirteen Trustees present voted during the first vote. During the second vote, six of the thirteen Board members present voluntarily recused themselves from voting under the independence test due to employment with ECHN (the CEO) or due to physician contractual relationships with ECHN. In all instances, including the votes by the independent Trustees, the votes were unanimous in favor of proceeding with the transaction.

In order to further ensure independence from conflicts in the selection process, on April 27, 2013 the Board ratified the appointment of a Transaction Committee with independent Trustees as its majority to evaluate the potential transaction from a disinterested perspective throughout the negotiation process. The Transaction Committee met

numerous times throughout the process of selecting Vanguard/Tenet, and then when selecting PMH, in order to evaluate the fairness of the transaction terms for ECHN from an independent perspective, and as to each transaction had the role of evaluating and recommending the terms to the full Board for approval before its vote. (See response to Question 5, above, for additional information on the process of review undertaken by the Transaction Committee.)

For purposes of their conflict of interest determinations during this period of time, the ECHN Conflict of Interest Task Force and the Board of Trustees utilized the "conflict of interest" standards set forth in the Connecticut Revised Nonstock Corporation Act, as required by the ECHN Bylaws and the ECHN Conflict of Interest Policy, and specifically Connecticut General Statutes Chapter 602, Nonstock Corporations, § 33-1127(f), "Directors' Conflicting Interest Transactions", and § 33-1003a, "Qualified Director", including but not limited to the following definitions:

> "**Director's conflicting interest transaction"** means a transaction effected or proposed to be effected by the corporation, or by an entity controlled by the corporation, (A) to which, at the relevant time, the director is a party, (B) respecting which, at the relevant time, the director had knowledge and a material financial interest known to the director, or (C) respecting which, at the relevant time, the director knew that a related person was a party or had a material financial interest.
>
> "**Material financial interest"** means a financial interest in a transaction that would reasonably be expected to impair the objectivity of the director when participating in action on the authorization of the transaction.

Furthermore, the ECHN Board of Trustees evaluated the relationship between each Trustee and ECHN utilizing the definition of "independence" set forth in the 2012 instructions to IRS Form 990, as follows:

> **Independent voting member of governing body:** "A member of the governing body is considered "independent" only if all four of the following circumstances applied at all times during the organization's tax year".
>
> 1. The member was not compensated as an officer or other employee of the organization or of a related organization (see the instructions for Schedule R, Related Organizations and Unrelated Partnerships), except as provided in the religious exception discussed in the Instructions for Form 990, Part VI.
>
> 2. The member did not receive total compensation or other payments exceeding $10,000 during the organization's tax year from the organization or from related organizations as an independent contractor, other than reasonable compensation for services provided in the capacity as a member of the governing body. For example, a person who receives reasonable expense reimbursements and reasonable compensation as a director of the organization

does not cease to be independent merely because he or she also receives payments of $7,500 from the organization for other arrangements.

3. Neither the member, nor any family member of the member, was involved in a transaction with the organization (whether directly or indirectly through affiliation with another organization) that is required to be reported on Schedule L (Form 990 or 990-EZ) for the organization's tax year.

4. Neither the member, nor any family member of the member, was involved in a transaction with the organization (whether directly or indirectly through affiliation with another organization) required to be reported on Schedule L (Form 990 or 990-EZ) Transactions with Interested Persons, for the organization's tax year.

A member of the governing body is not considered to lack independence merely because of the following circumstances.

1. The member is a donor to the organization, regardless of the amount of the contribution.

2. The member has taken a *bona fide* vow of poverty and either (a) receives compensation as an agent of a religious order or a section 501(d) religious or apostolic organization, but only under circumstances in which the member does not receive taxable income (see Rev. Rul. 77-290, 1977-2 C.B. 26; Rev. Rul. 80-332, 1980-2 C.B. 34) or (b) belongs to a religious order that receives sponsorship or payments from the organization that do not constitute taxable income to the member.

3. The member receives financial benefits from the organization solely in the capacity of being a member of the charitable or other class served by the organization in the exercise of its exempt function, such as being a member of a section 501(c)(6) organization, so long as the financial benefits comply with the organization's terms of membership.

Finally, the Trustees relied on the provisions of the ECHN Bylaws and the ECHN Conflict of Interest Policy, which are consistent with the above standards.

PMH has no conflict of interest with the proposed transfer of certain assets of ECHN to PMH between, among or pertaining to its board members, officers, key employees and experts. The due diligence undertaken by PMH to determine that there is no existence of a conflict of interest included the collection of conflict of interest/disclosure forms from the relevant individuals. PMH disclosure forms were disseminated in August 2015 to those individuals who are PMH board members, experts and consultants retained by PMH and senior executives at PMH who have direct involvement with the transaction. The Disclosure required respondents to disclose any financial interest, beneficial interest and/or employment interest in the proposed transaction and/or in any entity associated with the

principals involved in the transaction. All of the PMH Disclosure forms are attached (Exhibit Q6-2), along with PMH's Code of Business Conduct (Exhibit Q6-3).

7. Provide an assessment of the fair market value of the transaction, including, but not limited to, a discussion regarding whether the fair market value of ECHN's assets has been manipulated.

Describe how the assessment was performed (including any method to verify results of the assessment), the persons that performed the assessment, and their qualifications to perform the assessment.

Provide copies of all documents and statements, financial and otherwise, in support of this assessment.

Response:

ECHN engaged Duff & Phelps to opine as to the fairness, from a financial perspective, of the consideration to be received regarding the sale of ECHN's assets and assumption of certain liabilities. Duff & Phelps is a national and global provider of fairness opinions, with a dedicated healthcare practice. Duff & Phelps' qualifications and conflict disclosures are provided in Exhibit Q7-1, and the scope of engagement is provided in Exhibit Q7-2. The extent of Duff & Phelps' role in the transaction was limited to the performance of the analysis/evaluation of the transaction in rendering the fairness opinion and payment for services was a fixed fee. In conducting the engagement, Duff & Phelps evaluated the proposed terms of the sale and what ECHN would receive in consideration. They considered the historical financial performance and probable future financial performance to determine a fairness range for the gross and net purchase price. The proposed transaction was compared to both gross (estimated enterprise value) and net (enterprise value less assumed liabilities) fairness ranges. The Duff & Phelps Fairness Analysis and Fairness Opinion Letter are included as Exhibit Q7-3 and Exhibit Q7-4.

With regard to whether or not ECHN's assets were "manipulated" in providing the assessment of the fair market value of the transaction, Duff & Phelps adhered to their model in evaluating ECHN's acquisition price and net proceeds based on market multiples and discounted cash flows. Both ranges of fairness relating to these two approaches were nearly aligned and they were weighted 50/50 in determining the final fairness range for the acquisition of ECHN.

As part of the first acquisition bid with Tenet Healthcare, ECHN consulted with Ropes & Gray, its transaction counsel, to obtain recommendations for pursuit of a fairness evaluation. Additional recommendations were provided by the Chartis Group. In total, five firms were solicited for bids to provide a fairness evaluation/opinion including: Goldman Sachs, DGA Partners, Cain Brothers, Duff & Phelps, and Principle Valuation. Duff & Phelps was selected based on their solid reputation in the healthcare fairness marketplace and a strong recommendation from ECHN's transaction counsel. ECHN had also received documentation from Duff & Phelps regarding their experience in independent service

rankings. Based on the due diligence in vetting out Duff & Phelps for the original fairness opinion engagement, ECHN re-engaged Duff & Phelps to perform the current assessment.

8. Provide an assessment of whether the transaction will place ECHN's assets, including but not limited to, Manchester Memorial Hospital ("MMH") and Rockville General Hospital ("RGH"), at unreasonable risk.

Provide copies of all documents and statements, financial and otherwise, in support of this assessment.

Describe how the assessment was performed (including any method to verify results of the assessment), the persons that performed the assessment, and their qualifications to perform the assessment.

Response:

ECHN's assets will not be placed at unreasonable risk. Rather, ECHN's assets will be strengthened by the proposed acquisition. PMH is a $1.3 billion revenue healthcare organization and has the financial capacity to provide the capital necessary for this transaction. Please see Exhibit Q8-1 for PMH's 2014 audited financial statements and Exhibit Q8-2 for PMH's 2015 2nd quarter unaudited financial statement, which demonstrate PMH's strong financial position.

Please also see the response to Question 7 for additional discussion on the issue of the fairness evaluation. The fairness opinion states that the transaction does not have a financing contingency (Refer to Exhibit Q7-4, previously referenced).

9. Provide an assessment of whether any managerial contracts to be entered into are for reasonable fair value.

Provide copies of the managerial contracts and of all documents and statements, financial and otherwise, in support of the fair value assessment.

Describe how the assessment was performed (including any method to verify results of the assessment), the persons that performed the assessment, and their qualifications to perform the assessment.

Response:

It is not currently anticipated that there will be a management contract between PMH and ECHN as of the closing. Any future management contract would be at reasonable fair value.

10. Describe the entity to which the fair market value of ECHN's assets will be transferred including the funding of the entity, its corporate structure, governance and membership, and the charitable purpose of the entity.

Provide copies of any documents related to the creation, structure, and purpose of the entity.

Response:

At present, ECHN is planning to establish a new charitable entity ("New Foundation") to receive the net proceeds and other assets remaining in ECHN after payment of its liabilities.

Structure, Governance, and Membership. The contemplated structure, governance, and membership, which are in the process of development, are as follows:

- The New Foundation will be a nonstock corporation exempt under section 501(c)(3) of the Internal Revenue Code (the "Code").

- It will be governed by a Board of Trustees of approximately 8 to 15 Directors who reside or work in the communities previously served by ECHN. The Board is expected to include individuals knowledgeable about, among other things, health care services and community needs, investment, and grant making. Directors will serve staggered terms of 3 years and may serve two terms, after which they may not be reelected to the Board until one year has passed.

- The New Foundation will be structured to meet the Code requirements to be a "public charity" (and not a private foundation) as a Type 1 supporting organization under section 509(a)(3) of the Code. At least a majority of the Board of Directors of the New Foundation will be appointed by local organizations that are themselves section 501(c)(3) public charities or other organizations, such as municipalities, that are treated as public charities for this purpose. At this time, the specific organizations or municipalities that will each have the right to appoint one Director have not yet been determined. To achieve a well-rounded board, it is possible that some Directors will be elected by the New Foundation Board of Directors as a self-perpetuating component of the Board.

- Independence. To insure that all Directors are independent of ECHN and the purchaser, the following individuals will not be eligible to serve on the initial Board or subsequent Boards of the New Foundation:

    - Members of the governing boards of ECHN, MMH, RGH, and any ECHN affiliate until at least two years after the later of (1) the date of the closing and (2) the date their service on the board(s) in question has ended;

- Employees of ECHN, MMH, RGH, and any ECHN affiliate until at least two years after their employment has ended;

- Individuals who are on one of the two local (or advisory) boards for the post-closing hospitals, for at least two years after their service on the board(s) in question has ended; and

- Individuals who are on the governing board of or employed by PMH or an affiliate of PMH for at least two years after their service on the board in question or employment, as the case may be, has ended.

Individuals who have served as Corporators of MMH and RGH will be eligible to serve on the Board of the New Foundation as long as they were not on one of the governing boards mentioned above or employed by one of the entities mentioned above within the past two years.

An individual who is on the Board of the New Foundation will be deemed to have resigned from the Board if the individual (1) ceases to reside or work in the communities served by ECHN, (2) becomes a member of a Local (or advisory) board for a post-closing hospital, or (3) becomes a member of the governing board or an employee of PMH or an affiliate of PMH.

The organizations that appoint Directors will not be members of the New Foundation and will not have the right to vote on amendments to the Certificate of Incorporation or bylaws.

Purpose. The charitable purpose of the New Foundation will be to promote the health-related and health education-related purposes of the appointing charities and the health of the residents of the 19 communities served by ECHN. The New Foundation's purposes will include engaging in activities to assess community needs and providing grants and resources to organizations, projects, or activities that promote health, including the health of underserved populations and care to populations that are unable to pay. At present it is not contemplated that the New Foundation will engage in operating activities, but it is possible that it might do so in the future.

Assets. The New Foundation will receive the proceeds remaining in ECHN after the Asset Purchase and after payment of the liabilities that are being retained by ECHN. In addition, ECHN contemplates that the New Foundation will receive all, or substantially all, the restricted charitable funds remaining in MMH, RGH, and any other ECHN affiliated entities. Transfer of these charitable funds determined to be restricted will, in most cases, be accomplished through an equitable deviation or cy pres proceeding authorizing the transfer to the New Foundation and modifying, to the extent necessary, donor imposed restrictions.

The New Foundation might also be the beneficiary of income from one or more trusts held by outside trustees that were established for the benefit of MMH or RGH; this will depend on the terms of the individual trust documents as well as judicial review and authorization.

Finally the New Foundation will also receive any funds that remain in the indemnity reserve as of the third anniversary of the closing if there are no claims pending against the reserve, or, alternatively, after the resolution of pending bona fide claims.

The estimated value of the funds that will be transferred to the New Foundation, including restricted funds, is still being determined.

Other Issues. At present, ECHN is consulting with community leaders and organizations to identify those organizations that will have the right to appoint a Director of the New Foundation. The Certificate of Incorporation and Bylaws of the New Foundation are not yet final; ECHN expects that the final structure and corporate documents will be in place by Fall 2016, at which time the New Foundation will prepare and submit Form 1023, Application for Recognition of Exemption, to the Internal Revenue Service ("IRS"). ECHN intends to transfer assets or restricted funds to the New Foundation after approval of the Application and issuance of the section 501(c)(3) determination letter by the IRS.

The Boards of ECHN, MMH and RGH have begun reviewing the contemplated structure but have not yet considered it in detail, and they will do so in the future.

Copies of Documents Drafts of the Certificate of Incorporation and Bylaws of the New Foundation are attached as Exhibits Q10-1 and Q10-2, respectively.

11. Identify any and all assets of ECHN that are subject to a charitable use restriction imposed by a donor and the intended handling of those assets as a result of the proposed Asset Purchase.

Please provide a listing of these assets in Microsoft Excel format.

Also, please provide copies of the original gift instruments for each gift identified. Only one hardcopy of the gift instruments needs to be produced to the Attorney General.

Response:

Assets subject to a charitable use restriction are held by four corporations: Manchester Memorial Hospital ("MMH"), Rockville General Hospital ("RGH"), ECHN Community HealthCare Foundation ("Foundation"), and ECHN ElderCare Services ("Woodlake at Tolland").

CLASSES OF FUNDS

The classes of charitable assets they hold are described below.

ENDOWMENT FUNDS

Unrestricted Endowment Funds

The unrestricted endowment funds are those funds subject to a donor restriction that income only may be spent for the general purposes of the charitable entity in question. They are "not wholly expendable by the institution on a current basis under the terms of a gift instrument" and are therefore endowment funds as defined by the Connecticut Uniform Prudent Management of Institutional Funds Act ("CUPMIFA").

Restricted Endowment Funds

The restricted endowment funds are those funds subject to a donor restriction that income only may be spent and that such income may only be spent for the specific purpose designated by the donor. These funds also are "not wholly expendable by the institution on a current basis under the terms of a gift instrument" and are therefore endowment funds as defined by CUPMIFA.

Free Bed Funds. MMH and RGH hold a special category of endowment funds known as "free bed funds." These funds, which were typically established by donors many years ago to provide care to individuals who could not afford to pay for care, continue to be held with their income restricted to provide free care. These funds are also governed by Section 19a-509b of the General Statutes.

Preservation of Endowment Funds

As stated on their audited financial statements, MMH, RGH, and the Foundation interpret CUPMIFA as requiring the preservation of the fair market value of the original gift or bequest as of the date of the gift absent explicit donor stipulations to the contrary. They therefore classify as permanently restricted net assets (a) the original value of the gift donated to an endowment fund, (b) the original value of subsequent gifts to the endowment fund, and (c) accumulations to the endowment fund made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added. The remaining portion of an endowment fund that is not classified as permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure by the governing board of the institution consistent with the standard of prudence prescribed by CUPMIFA.

FUNDS SUBJECT TO USE RESTRICTION (SPECIAL PURPOSE FUNDS)

These are fully expendable funds held subject to a "use restriction" imposed by the donor. MMH, RGH, the Foundation, and Woodlake at Tolland believe there are some special purpose funds that they will not be able to use for the designated purposes prior to the

closing. In some cases, that may be because the funds are subject to obsolete, wasteful or impracticable restrictions.

UNRESTRICTED FUNDS

These are fully expendable funds held by the institution that (1) its governing board has determined will be held as endowment for its use or (2) are generally unrestricted by donors or the board. The board designated and unrestricted funds are not subject to any donor restriction on use (other than use for the institution's general charitable purposes) and, in the discretion of the governing board, can be spent for general charitable purposes.

MISCELLANEOUS ITEMS

MMH is the beneficiary of an unrestricted bequest from an estate currently pending in the probate court; at this point, one preliminary distribution has been received, but the remaining value of MMH's interest is unknown. MMH also owns and is the beneficiary of one life insurance policy.

RGH and the Foundation have three charitable gift annuity arrangements. RGH's two charitable gift annuities at this point no longer have a residuary value and in fact constitute liabilities; the ECHN charitable gift annuity has a possible contingent residuary value.

TRUSTS HELD BY OUTSIDE TRUSTEES

Both MMH and RGH are the income beneficiaries of various trusts held by third party trustees and receive periodic distributions from those trusts. In most cases the trust instrument does not include an alternative disposition in the event the Hospital in question ceases to exist. The outside Trustee(s) will have primary responsibility for actions and decisions on the distribution of trust income/assets after ECHN ceases operations and will be responsible for requesting any necessary judicial cy pres relief. ECHN will support, to the extent possible and to the extent consistent with the terms of a given trust, the payment of trust income to the new Foundation to be used to promote the health of the ECHN communities.

DETAIL ON SPECIFIC FUNDS

Detailed information about individual funds held by or for the benefit of ECHN is provided on the attached Excel spreadsheet labelled Exhibit Q11-1. The funds are organized and presented as follows:

Endowment and Other Charitable Funds are listed as Funds 11-1.1 through 11-1.84. These funds include all the charitable funds except for some Special Purpose Funds and Trusts Held by Outside Trustees. MMH's funds are listed first, followed by those of RGH and then those of the Foundation. Notably, most funds recorded on the books of the Foundation were in fact left by the donors to MMH and RGH but were transferred to the Foundation to be held for the benefit of the Hospital in question. These funds are reported here as Foundation funds, but it is contemplated that they will be transferred back to MMH and RGH prior to the Asset Purchase. Fund balances are reported as of 6/30/15.

Table 2: Summary of Endowment & Other Charitable Funds
(Fair Market Values as of 06/30/2015)

Manchester Memorial Hospital		
Endowment: Unrestricted Income	$	8,853,630
Endowment: Free Bed Funds	$	580,783
Endowment: Restricted for Other Purposes	$	71,052
Miscellaneous: Cash Value Life Insurance*	$	55,639
Total	$	9,561,103

Rockville General Hospital		
Endowment: Unrestricted Income	$	8,988,179
Endowment: Free Bed Funds	$	337,839
Endowment: Restricted for Other Purposes	$	384,059
Unrestricted Funds	$	2,817,785
Miscellaneous*	$	0
Total	$	12,527,862

ECHN Community HealthCare Foundation, Inc.		
Endowment f/b/o MMH: Unrestricted Income	$	1,285,023
Endowment f/b/o RGH: Restricted Income	$	282,289
Miscellaneous*	$	0
Total	$	1,567,312
Total - Funds 11-1.1 through 11-1.84	$	23,656,277

* Notes re Miscellaneous Lines. The $55,639 reported in Miscellaneous is the current cash value of one life insurance policy donated to Manchester Memorial Hospital. No current asset values are reported for charitable gift annuities or an interest in a new estate.

Special Purpose Funds are listed as Funds 11-1.85 through 11-1.96. These funds include those Special Purpose Funds that ECHN believes may not be able to be spent or applied prior to the closing. This chart consolidates the information for all four corporations and reports fund balances as of 6/30/15. This Exhibit does not include information about the special purpose funds that ECHN believes will be spent before closing. The market value of these funds on 6/30/15 is $19,060.

Trusts Held by Outside Trustees are listed as Funds 11-1.97 through 11-1.06. These funds include all the Trusts Held by Outside Trustees for the benefit of MMH or RGH; they are organized by entity, with trusts f/b/o MMH listed first, followed by those f/b/o RGH. The market value of these outside trusts on 6/30/15 is $11,708,758.

As noted, Funds 11-1.1 through 11-1.96 report fund values as of 6/30/15; they do not reflect the assets expected to be available for continued charitable use after closing and after ECHN dissolves. ECHN contemplates that it will use fully expendable funds and appropriate net appreciation on endowment in connection with the transaction.

The underlying documentation for all the funds listed in Exhibit Q11-1 is provided in Exhibit Q11-2.

Exhibit Q11-3 is a balance sheet for the ECHN Foundation as of June 30, 2015.

12. Provide copies of all correspondence, memoranda, and any other documents that include the terms of any other offers to transfer assets or operations or change control of operations received by ECHN.

Response:

Please refer to Exhibit Q5-5, previously referenced, for a summary of the proposals submitted. Certain proprietary information has been redacted per executed confidentiality agreements. The Applicants have not provided materials protected as attorney-client work product or materials that the Applicants are not permitted to disclose under the terms of the executed confidentiality agreements.

13. Provide a copy of a fairness evaluation by an independent person who is an expert in such Asset Purchases that includes the expert's evaluation of each of the criteria set forth in Conn. Gen. Stat.§ 19a-486c(a).

Also provide copies of the information and documents relied upon by the expert in the preparation and issuance of the fairness evaluation.

Response:

A copy of the fairness evaluation performed by Duff & Phelps has already been referenced in response to Question 7.

Information provided to Duff & Phelps and relied upon in the preparation and issuance of the fairness evaluation included ECHN's audited financial statements from 2010–2014 along with projected financials for 2015-2019. The audited financial statements are already on file with the Office of Health Care Access "OHCA". The projected financials which were prepared and provided to Duff & Phelps are included as Exhibit Q13-1. In addition, Exhibit Q13-2 contains a financial summary from 2010-2014 of ECHN's joint venture businesses which were included in the fairness evaluation.

14. Please provide a copy of the transcript for the informal hearing required by Conn. Gen. Stat.§ 19a-486a(c).

Response:

Copies of the transcripts for the informal hearings were filed with OHCA and the Attorney General's office on August 14, 2015 as required by Public Act 14-168.

15. Explain how ECHN determined the need for the Asset Purchase and discuss the benefits of this Asset Purchase for MMH and RGH (collectively, the "ECHN Hospitals"), respectively (provide discussion on history and time-line).

Response:

Please see Applicants' response to Question 5 for the time-line and discussion of how ECHN determined the need for the Asset Purchase.

The Asset Purchase will benefit MMH and RGH in numerous ways. Significantly, the transaction will provide the Hospitals and ECHN's other provider organizations access to capital and resources necessary to sustain and grow high quality medical services in eastern Connecticut. In addition, the transaction will allow ECHN the ability to adjust to a rapidly changing healthcare delivery environment and reinvest in itself to continuously improve care coordination, address continued improvement in quality and safety, expand and add needed services, recruit and retain physicians, and improve access to services across its service area.

The benefits of this transaction will inure to ECHN's entire network, including the Hospitals and ECHN's other affiliates. ECHN's mission to improve the well-being of its patients by providing high quality, compassionate care involves healthcare provided in settings across the network continuum including care delivered at physician offices, ambulatory centers, the Hospitals, its sub-acute and skilled nursing facility, Woodlake at Tolland, and in the home by Visiting Nurse and Health Services of CT. To effectively participate in the evolving risk-based payment environment, health systems must manage across a complete continuum of care in order to deliver services in the right place at the right time. This transaction will allow ECHN the ability to rebuild and retool itself for the new world of accountable health care delivery. ECHN will be able to take advantage of PMH's experience in its CRC model which will enable ECHN to be successful with new risk-based payment systems and new care delivery models that reward value-based care, achieving the best outcomes for patients at lower costs. With the resources and the intensive care management programs of PMH and the commitment to implementing its CRC model in the local service area, not only will ECHN's hospitals see reinvestments, but ECHN will be positioned to continue to integrate and expand its network of providers and program offerings. Development of ambulatory services, coupled with ECHN's position and clinical integration in partnership with its medical staff, will bring the numbers of covered lives

needed to be successful in developing and executing programs to manage population health.

PMH has access to the capital markets that will make capital available to ECHN for replacements and upgrades to systems and the infrastructures of ECHN's facilities; investments to improve the sharing of electronic medical records in order to improve the collection and documentation of information and, most importantly, to enhance the availability of information for critical treatment decisions for our patients; upgrades to the medical equipment and technology to provide our patients access to state-of-the-art technology for their diagnosis, care and treatment; and program development to attract and retain physicians to the communities served.

The transaction will bring the clinical strength and leadership to augment clinical programs. The intent of this transaction is to develop local access to services where it is clinically appropriate.

Affiliation with PMH will offer ECHN economies of scale and purchasing power to reduce the cost of operations which will improve finances and help ensure the sustainability of ECHN. This benefits ECHN's communities as well. The financial health of ECHN allows it to offer continued levels of employment that are critical to the health of our local economy. As important for our communities, the asset purchase will mean that ECHN will continue to adhere to the same policies with respect to charity care following the closing.

16. For each of the ECHN Hospitals, provide a listing of the hospitals' current service lines and service locations and describe any planned changes to either the service lines or service locations as a result of the Asset Purchase.

Provide an explanation for each change and detail how the hospitals' affiliation with PMH will aid in service line development.

Response:

Services are provided on the Hospitals' main campuses as well as in outpatient locations throughout ECHN's service area, including but not limited to a hospital-based imaging center in South Windsor. Please see Exhibit Q16-1 for the list of service lines, key services and service locations currently offered by MMH and RGH.[3] Also, please see Exhibit Q16-2 for the Supplemental CON Application forms for the Acquisition of Equipment related to the MRI, PET/CTCT scanners utilized by MMH, RGH and ECHN's Evergreen Imaging Center which operates as a department of RGH.

ECHN and PMH are committed to ensuring the long-term future and viability of MMH and RGH. No service line or service location changes with respect to MMH and RGH are currently planned in connection with the proposed transaction, although it is expected that

[3] A listing of the Eastern Connecticut Medical Professionals Foundation, Inc. (ECMPF) primary care and specialty care locations will be submitted in the Change of Ownership CON application for ECMPF.

the ECHN ambulatory network will be expanded and services configured to promote the most efficient delivery of coordinated care following the closing. PMH will continue to provide care to the residents in the communities that are currently served by ECHN.

Using the ECHN Community Health Needs Assessment (see response to Question 22) and other planning information available to ECHN, PMH will work with management to identify programs and services that best augment those currently provided in the community. In addition, PMH may have the ability to attract and retain certain types of specialty physicians to a community hospital setting that ECHN may not be able to attract on its own.

Please note that while the Applicants expect PMH to expand and enhance services, there are no definitive plans at this time to add service locations for either MMH or RGH. PMH will conduct a planning effort with the Local Board post-closing to determine where there are opportunities to improve access, enhance services and introduce programs that address identified health needs.

17. Describe the existing populations served by the ECHN Hospitals and how the Asset Purchase will affect these populations. Include demographic information.

Response:

MMH, located in the town of Manchester, and RGH, located in the Rockville section of Vernon, serve patients in various towns, including Andover, Bolton, Coventry, Ellington, Manchester, South Windsor, Tolland, Vernon, Willington, Ashford, Columbia, East Hartford, East Windsor, Glastonbury, Hebron, Mansfield, Somers, Stafford, and Union.

The ECHN primary and secondary service areas are identified in the following map. The primary service area contains nine towns and is shaded in orange. The ten town secondary service area is shaded in yellow.

Figure 1: Eastern Connecticut Health Network Service Area



Service Area Demographics

The following table summarizes the service area population projected forward to 2020. The area population is experiencing growth in both the primary and secondary service areas. The city of Manchester is the largest municipality in the ECHN service area while Union is smallest.

Table 3: Service Area Population

Total Population by Town 2000 - 2020

Town	2000	2012	2020
Andover	3,036	3,185	3,378
Bolton	5,017	4,990	4,882
Coventry	11,504	12,445	13,026
Ellington	12,921	15,549	18,020
Manchester	54,740	58,078	63,453
South Windsor	24,412	25,684	26,171
Tolland	13,146	14,980	16,191
Vernon	28,063	29,188	30,658
Willington	5,959	6,042	6,544
Primary Service Area Subtotal	**158,798**	**170,141**	**182,323**
Ashford	4,098	4,306	4,483
Columbia	4,971	5,464	5,787
East Hartford	49,575	51,171	53,384
East Windsor	9,818	11,196	12,543
Glastonbury	31,876	34,401	35,918
Hebron	8,610	9,649	10,188
Mansfield	20,720	26,182	27,481
Somers	10,417	11,451	10,400
Stafford	11,307	12,058	12,581
Union	693	954	958
Secondary Service Area Subtotal	**152,085**	**166,832**	**173,723**
Total Service Area	**310,883**	**336,973**	**356,046**

Source: Connecticut Economics Resource Center Town Profile October, 2014

Table 4 below displays population by service area town by age cohort. Table 5 compares age distribution by service area town to the State age distribution. The ECHN service area age distribution is consistent with that of the State of Connecticut.

Table 4 : Age Distribution

Age Distribution by Service Area Town 2012

Town	0 - 4	5 - 17	18 - 24	25 - 49	50 - 64	65+	Total
Andover	156	619	286	983	765	376	3,185
Bolton	131	896	426	1,419	1,375	743	4,990
Coventry	393	2,270	1,040	4,268	3,027	1,447	12,445
Ellington	979	2,927	1,126	5,733	3,082	1,702	15,549
Manchester	3,990	8,179	5,180	21,985	11,249	7,495	58,078
South Windsor	1,306	4,908	1,923	8,306	5,298	3,943	25,684
Tolland	710	3,204	1045	4,753	3,413	1,855	14,980
Vernon	1,609	3,595	2,595	10,807	5,752	4,830	29,188
Willington	216	712	1,585	1,696	1,251	582	6,042
Primary Service Area Subtotal	**9,490**	**27,310**	**15,206**	**59,950**	**35,212**	**22,973**	**170,141**
Ashford	254	670	421	1,474	1,069	418	4,306
Columbia	191	964	371	1,534	1,569	835	5,464
East Hartford	3,012	8,590	4,416	17,640	10,609	6,904	51,171
East Windsor	650	1,799	697	3,892	2,577	1,581	11,196
Glastonbury	2,023	6,869	2,038	10,853	7,704	4,914	34,401
Hebron	546	2,109	659	3,145	2,229	961	9,649
Mansfield	719	2,567	13,409	4,393	2,937	2,157	26,182
Somers	380	1,779	1,094	4,248	2,446	1,504	11,451
Stafford	747	1,868	1,291	4,174	2,586	1,392	12,058
Union	34	161	63	369	169	158	954
Secondary Service Area Subtotal	**8,556**	**27,376**	**24,459**	**51,722**	**33,895**	**20,824**	**166,832**
Total Service Area	**18,046**	**54,686**	**39,665**	**111,672**	**69,107**	**43,797**	**336,973**

Source: Connecticut Economics Resource Center Town Profile October, 2014

Table 5: Percent Age Distribution

Percent Age Distribution by Service Area Town 2012

Town	0 - 4	5 - 17	18 - 24	25 - 49	50 - 64	65+
Andover	5%	19%	9%	30%	24%	11%
Bolton	3%	18%	9%	28%	28%	15%
Coventry	4%	19%	8%	34%	24%	11%
Ellington	6%	18%	7%	37%	20%	11%
Manchester	7%	15%	9%	38%	19%	12%
South Windsor	5%	19%	7%	32%	20%	15%
Tolland	5%	22%	7%	32%	23%	13%
Vernon	6%	13%	9%	37%	20%	17%
Willington	4%	12%	26%	28%	21%	10%
Primary Service Area Subtotal	**6%**	**16%**	**9%**	**35%**	**21%**	**14%**
Ashford	6%	16%	10%	35%	25%	10%
Columbia	4%	17%	7%	28%	29%	15%
East Hartford	6%	16%	9%	34%	21%	14%
East Windsor	6%	16%	6%	35%	23%	14%
Glastonbury	6%	20%	5%	32%	22%	14%
Hebron	6%	22%	7%	32%	23%	10%
Mansfield	2%	9%	52%	17%	11%	8%
Somers	4%	15%	9%	37%	21%	13%
Stafford	6%	16%	10%	35%	21%	12%
Union	3%	17%	7%	39%	18%	17%
Secondary Service Area Subtotal	**5%**	**16%**	**15%**	**31%**	**20%**	**12%**
Total Service Area	**5%**	**16%**	**12%**	**33%**	**21%**	**13%**
State Total	**6%**	**17%**	**9%**	**33%**	**20%**	**14%**

Source: Connecticut Economics Resource Center Town Profile October, 2014

Table 6 below provides data regarding the socioeconomic condition of the ECHN service area towns in comparison to the State of Connecticut as a whole. With the exception of Willington (18.1%), East Hartford (15.3%), and Mansfield (17.9%), the poverty rates of towns within the ECHN service area are below the State rate of 10.0%. Median household incomes range from $48,438 in East Hartford to $114,286 in Hebron. Five of the nineteen service area town's median household incomes are below that of the State. Two service area towns, East Hartford and Stafford, had unemployment rates above that of the State.

Table 6: Socioeconomic Status of the Service Area

Socioeconomic Data

	Town	Poverty Rate[(1)]	Median Household Income[(1)]	Unemployment Rate[(2)]	Median Age[(1)]
PSA	Andover	4.9%	$97,762	6.4%	43
	Bolton	2.1%	$87,885	6.0%	47
	Coventry	3.5%	$92,308	7.1%	43
	Ellington	2.7%	$84,934	6.0%	40
	Manchester	8.9%	$63,656	7.4%	37
	South Windsor	4.3%	$91,519	5.9%	42
	Tolland	3.7%	$103,358	5.5%	41
	Vernon	9.2%	$61,848	7.5%	41
	Willington	18.1%	$70,013	5.5%	35
SSA	Ashford	4.2%	$75,242	7.2%	38
	Columbia	3.8%	$92,973	6.4%	47
	East Hartford	15.3%	$48,438	9.8%	39
	East Windsor	5.0%	$71,310	7.4%	42
	Glastonbury	2.6%	$106,872	5.3%	43
	Hebron	0.9%	$114,286	5.4%	42
	Mansfield	17.9%	$67,615	7.2%	21
	Somers	4.8%	$100,100	7.2%	42
	Stafford	6.7%	$63,672	8.1%	40
	Union	1.1%	$83,500	5.5%	42
	State	10.0%	$69,519	7.8%	40

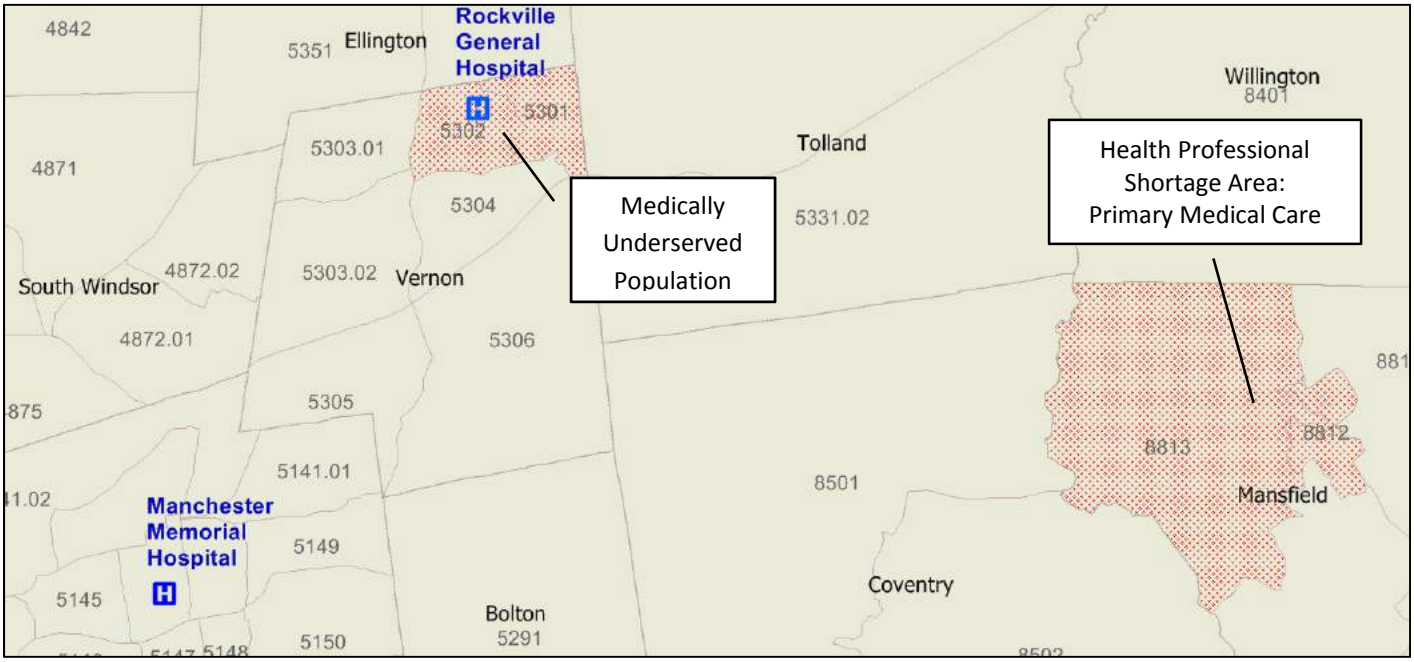
[(1)]2012

[(2)]2013

Source: Connecticut Economics Resource Center Town Profile October, 2014

The Rockville section of Vernon, where RGH is located, has been designated by the Health Resources and Services Administration as a Medically Underserved Population and the northwestern part of Mansfield has been designated as a Health Professional Shortage Area for Primary Medical Care. RGH, MMH and their System affiliates provide safety net services to this region of the State. This proposal will support the availability of health care services to the vulnerable populations in the ECHN service area. The proposal will ensure a more secure financial future so that MMH and RGH are better able to provide essential health services to the community.

Figure 2: Shortage Designation in ECHN Service Area[4]



As discussed previously in the response to Question 16, ECHN and PMH are committed to ensuring the long-term future and viability of ECHN and its hospitals. No service line or service location changes are currently planned in connection with the proposed transaction, although it is expected that the ECHN ambulatory network will be expanded and services configured to promote the most efficient delivery of coordinated care following the closing. The Applicants will continue to provide care to residents in the communities that are currently served by ECHN. Given this, the Applicants do not anticipate any changes to the populations to be served by the hospitals.

Using the ECHN Community Health Needs Assessment (see response to Question 22) and other planning information available to ECHN, PMH will work with management to identify programs and services that best augment those currently provided in the community. In addition, PMH may have the ability to attract and retain certain types of specialty physicians to a community hospital setting that ECHN may not be able to attract on its own. For example, PMH may utilize one or more physician alignment strategies, such as physician participation in an IPA or physician-hospital organization, hospital-based clinics staffed by an independent contractor physician and pay-for-performance compensation arrangements which incentivize quality, patient satisfaction and patient outcomes. Please note that while the Applicants expect PMH to expand and enhance services, there are no definitive plans at

[4] **Source:** U.S. Department of Health and Human Services, Health Resources and Services Administration Shortage Designation: Health Professional Shortage Areas and Medically Underserved Areas/Populations (designation as of August 2014) http://www.hrsa.gov/shortage/

this time to add service locations for either MMH or RGH. PMH will conduct a planning effort with input and recommendations from the Local Board post-closing to determine where there are opportunities to improve access, enhance services and introduce programs that address identified health needs.

18. How will the for-profit nature of PMH affect the provision of health care in the community?

Response:

There is no correlation between tax status and the quality of care, charity care and other benefits provided to the community served. Therefore, PMH's tax status will have no negative bearing on the provision of health care in the community. The opportunity represented by this application affords the greatest opportunity for ECHN to enhance financial stability, make needed capital investments and increase the quality and access to care for the entire community.

PMH's financial resources, access to capital and expertise in operating thirteen hospitals in California, Texas and Rhode Island will positively affect the provision of healthcare in the community. PMH's capital and access to capital will mean that ECHN will have the financial resources to purchase new technology, upgrade its facilities, attract skilled providers, and upgrade electronic health records. In addition, PMH will introduce practices that will reduce costs and improve care by sharing its best practices. Access to health care will be improved through implementation of CRC. (Also see response to Question 19, below, regarding a transition plan for the Asset Purchase, and the discussion of CRC in response to Question 26.) Moreover, the post-closing for-profit entity will no longer have to raise funds from the community but will pay property taxes to the applicable municipalities, which will benefit the community (note that PMH and ECHN will seek abatement of property taxes for a transition period after closing of the proposed transaction). The conversion will also result in the establishment of the New Foundation, an independent charitable entity.

In summary, PMH's tax status will have no negative bearing on the provision of health care in the community. PMH's financial resources and operational expertise will, however, have a positive impact. In fact, and as evidenced in California, Texas and Rhode Island, where PMH has acquired hospitals, the access and quality of care improved, significant capital investments were and are continuing to be made, and job growth has occurred.

19. Provide a transition plan for the Asset Purchase and describe how ECHN and PMH (collectively, the "Applicants") will ensure continuity of care and hospital services through this plan.

Response:

The approach to the transition is segregated into four phases of implementation: (1) execution of immediate cost efficiencies; (2) development of clinical efficiencies; (3) deployment of a strategic capital plan; and (4) implementation of CRC. The four phases will be implemented concurrently and in a coordinated fashion.

PMH has already begun implementation efforts with respect to its CRC model, including formation of an IPA and Board, review of regulatory requirements, discussions with payers and evaluation of the care delivery network.

A meaningful long-term integration plan requires the collaboration of the medical staff and the community. Clinical efficiencies will be captured as PMH has the opportunity to fully engage with the medical staff of each hospital and the Hospital's respective communities to jointly develop a clinical strategy to best serve the populations described in response to Question 17.

The strategic capital plan is formulated to complement the clinical strategy. After closing, PMH will seek the input of the Local Boards to prioritize capital projects and service improvements based on hospital and community needs. (Please also see the response to Question 33 regarding capital projects.)

20. Understanding that the proposal is for PMH to exercise common ownership over MMH and RGH, how will care be coordinated between the two hospitals?

Please explain in detail how care coordination efforts will be aided by the proposed Asset Purchase (i.e., how they will be different from ECHN's present efforts) and provide any written plans documenting this coordinated approach to care for the patient population served.

Response:

The care coordination efforts will be aided and greatly enhanced through implementation of PMH's CRC model. The proposed common ownership structure will provide both Hospitals access to capital and funding necessary to provide even greater access to high quality medical services for the Manchester/Rockville region. It will provide the Hospitals assurance that they will be able to execute a long range strategic plan that addresses continued improvement in quality and safety, expansion of services, new services, physician and service integration, and improvements to access to services.

The ECHN administrative team responsible for operations of MMH and RGH has responsibilities for both hospitals. Likewise, the physician providers in the Emergency Departments of MMH and RGH and the hospitalist service share the same physician staff at both hospitals. This provides for operations conducted under the same policies, procedures and practice standards. Furthermore, it facilitates the coordination of care between the two hospitals.

The more important goal for ECHN and PMH is not just the coordination of care across its hospitals but across all providers in its network: owned, affiliated and contracted. The PMH CRC Model is predicated on building and managing a tightly integrated, coordinated care system with providers across the continuum. PMH's thirty years of operating and supporting IPAs under risk-based arrangements with payers in California allows PMH to bring its process knowledge and experience to build and operate such a system here. PMH will engage the insurers and seek partnerships with them that will result in a full range of risk contracts for ECHN. Risk management unifies the incentives for providers across the network. It will be essential to identify patients with significant co-morbidities and then design comprehensive medical and psychosocial high intensity care management services for their care. This is some of the process knowledge and experience that PMH will bring to the region for the benefit of our patients. Importantly, the CRC model is designed to demonstrate and improve performance with a focus not only on the hospital value-based purchasing measures, but the programs and measures looked to by the government for the health plan operators that address all providers contributing to a patient's care and the management of the health of a population of individuals.

21. Provide a description of the relationship between the proposal and the Statewide Health Care Facilities and Services Plan.

Response:

The APA is consistent with the Statewide Health Care Facilities and Services Plan (the "Plan") published by OHCA in October of 2012 and supplemented in 2014. The Plan can be found on OHCA's website. The transaction contemplated by the APA is clearly aligned with the premise of the Plan. The applicants believe that this proposal supports the goals stated in the Plan and addresses all of the guiding principles set forth in it. Section 1.4 of the Guiding Principles of the Plan states:

> "The goal of OHCA's planning and regulation activities is to improve the health of Connecticut's residents; increase the accessibility, continuity and quality of health services; prevent unnecessary duplication of health resources; and provide financial stability and cost containment of health care services.
>
> The guiding principles of the Plan are intended to:

- Promote and support the long term viability of the state's health care delivery system;

- Ensure that any regulated service will maintain overall access to quality health care;

- Promote equitable access to health care services (e.g., reducing financial barriers, increasing availability of physicians) and facilitate access to preventive and medically necessary health care;

- Encourage collaboration among health care providers to develop health care delivery networks;

- Support the need for a sufficient health care workforce that facilitates access to the appropriate level of care in a timely manner (e.g., optimal number of primary and specialty care providers);

- Maintain and improve the quality of health care services offered to the state's residents;

- Promote planning that helps to contain the cost of delivering health care services to its residents;

- Encourage regional and local participation in discussions/collaboration on health care delivery, financing and provider supply;

- Promote public policy development through measuring and monitoring unmet need; and

- Promote planning or other mechanisms that will achieve appropriate allocation of health care resources in the state." (Plan at p. 2).

As the Plan makes clear, OHCA has long acknowledged that mergers, affiliations and acquisitions were part of a transformation that had begun as the State's health care system responded to major changes in the way health care is delivered and financed. (Plan at pp. 7-8, Sec. 1.8.5). Becoming part of a health care system such as PMH will aid ECHN and its provider affiliates to benefit from economies of scale when purchasing supplies and services, sharing of best practices, and will also improve access to capital. This will allow ECHN to make capital investments and reinvestments in its facilities, equipment, and in medical and information technology to support needed programs and services for patients. These investments will in turn allow ECHN to attract and retain physicians and providers needed to serve its communities.

As OHCA has recognized in the Plan, the strategic financial and quality of care advantages associated with the affiliation or mergers of hospitals and health care providers is a key driver in today's health care environment. Connecticut hospitals are pursing affiliation

arrangements and mergers as a means of offsetting financial pressures due to the provision of uncompensated care, treating the uninsured in crowded emergency departments, caring for Medicaid patients and reduced reimbursement by the government payers and health insurers. Hospitals are struggling to make needed facility improvements and acquire needed technology. (Plan at pp. 7-8, Sec. 1.8.5 and pp. 11-12, Sec. 2.1.1). This proposal serves as an example of this trend. The implementation of the proposal will allow ECHN and its provider affiliates to better meet their financial obligations, make needed capital improvements, acquire new technology and continue to provide continued access to services currently available in the surrounding communities.

By entering into the proposed APA, ECHN and its provider affiliates will be able to fulfill ECHN's obligations, including retiring its debt, and funding its pension plan. As a result, ECHN will be better positioned to expand cost control initiatives in community-based settings, and remain a lower-cost, high-quality provider for the patients in its service area.

More important to residents served by ECHN, the transaction with PMH will result in stronger integration between ECHN and its provider affiliates to coordinate care, improve the overall population health and enhance the standard of care for its patients. The PMH approach to care coordination with the pursuit of delegated risk-based provider contracts aligns the incentives for providers across a system. Shared risk requires that a system achieve a more formal degree of integration among providers than the traditional fee-for-service system. It unifies the incentives for providers. Risk drives an imperative to manage care proactively for a defined population by understanding the health of that population, by identifying those who require more intensive care management and, importantly, by addressing unmet healthcare needs and gaps in care. (Plan at pp. 81-83, Sec. 7.1, 7.2). Opportunities to further integrate care delivery among ECHN providers and regionalize the health care delivery system in the ECHN service area will be enhanced, to more effectively identify patients at risk and build upon existing initiatives such as ECHN's telemedicine program which monitors patients with chronic conditions such as with congestive heart failure in their homes. PMH has developed and implemented high intensity care management programs that integrate behavioral and physical health capabilities to effectively manage the care of patients with significant co-morbidities. It will bring those capabilities to ECHN along with other resources to meet the health care reform requirements of the PPACA.

The Patient Protection and Affordable Care Act of 2010 requires hospitals to improve quality of care delivered to patients through a variety of means such as improving reducing preventable readmissions for certain conditions. (Plan at pp. 12-13, Sec. 2.1.2, 2.1.3, 2.1.4., 2.1.4.2 and 2.1.4.3). PMH is committed to succeed in new value-based performance delivery models and has the ability to share best practices among its member hospitals to reduce readmissions. This proposal promotes Population Health Management which is a system that seeks a very high level of integrated care among providers to work collaboratively along the health care continuum, emphasize health promotion and the delivery of preventive and medically necessary care. Population Health Management promotes collaboration among providers and the development of a continuum of care where providers are more closely aligned and work in a cohesive environment. The

collaboration with PMH, utilizing its CRC model, will provide an environment that aligns ECHN's physicians and other providers across the continuum of care, provide access to evidence-based practices to improve quality and patient safety, enhance efficiency through uniform productivity and financial management, and develop integrated information systems.

22. Please explain how the post transaction ECHN will address the needs of service area residents with respect to prevention and treatment of diseases and conditions in relation to ECHN's most recent Community Health Needs Assessment ("CHNA") and the priority of needs listed therein. Please provide a copy of the most recent CHNA.

Response:

In 2013, MMH and RGH collaborated to conduct a comprehensive Community Health Needs Assessment (CHNA).

The goals of the assessment were to identify the current and future healthcare needs of the community and to improve and strengthen the programs and services available to address them.

The CHNA process was led by an Oversight Committee that included individuals from ECHN with established relationships with community groups and agencies. Data was collected from community, civic and social service agencies, as well as residents and community leaders to describe the demographics, morbidity and mortality statistics and health indicators. Once assembled, the data was analyzed and reviewed by the Oversight Committee, who then identified and prioritized the service area's key health needs.

Four priority health needs were identified by the Oversight Committee related to heart disease incidence, cancer incidence, diabetes incidence and arthritis incidence. An implementation plan to respond to the identified health needs was developed with the overall goals to (1) reduce preventable risk factors that contribute to incidence of the respective health issue and (2) promote quality of life for those diagnosed. The implementation plan identified specific strategies and tactics to be employed in order to attain these goals.

The CHNA and the implementation plan were reviewed and approved by the ECHN Strategic Planning Committee on August 21, 2013. The ECHN Board of Trustees reviewed and approved the CHNA and implementation plan on September 25, 2013. Please see Exhibit Q22-1 and Q22-2 for a copy of the Community Health Needs Assessment Implementation Plans for MMH and RGH.

ECHN and PMH are committed to improving the overall health of the communities served by MMH and RGH. PMH and its affiliates will continue to support the CHNA

implementation plans as they are rolled out through 2016. The current implementation strategy initiatives identified in the plan include:

Strategies to Address Heart Disease Incidence:

- Educate the public about managing lifestyle behaviors that impact diet, blood pressure, cholesterol, weight, physical activity, and stress.

    - Offer free community health educational lecture and seminar programs presented by hospital medical and clinical staff.
    - Include educational information in each issue of Better Being, ECHN's free community magazine distributed to approximately 155,000 households in service area.
    - Participate in community health fairs throughout service area where free blood pressure, cholesterol, body fat composition analysis and educational resources will be shared.
    - Launch the "Freedom from Smoking" smoking cessation program.
    - Provide nutrition counseling services.
    - Offer integrative medicine programs for stress reduction.
    - Provide information and services to individuals diagnosed with heart disease to help them best manage their symptoms.
    - Offer free "Heart Talk" community program for people living with heart failure.

- Promote cardiac rehabilitation services to restore people who have had a heart condition or heart surgery to the highest possible physiological, emotional, social, and vocational level.

Strategies to Address Cancer Incidence:

- Monitor reports of newly- diagnosed cancer cases in the service area using the National Cancer Center Data Base (NCDB) to identify significant changes, trends or abnormal activity.

- Educate the public about managing lifestyle behaviors that impact cancer risks

    - Cancer Community Outreach will coordinate free community health educational lecture and seminar programs.
    - Include educational information in each issue of Better Being, ECHN's free community magazine distributed to approximately 155,000 households in service area.
    - Participate in community health fairs throughout service area.
    - Launch the "Freedom from Smoking" smoking cessation program.

- Provide free screenings in the community and access to follow-up care.

- Offer comprehensive support programs for cancer survivors and caregivers.

    - Oncology Nurse Navigator and Survivorship Navigator services
    - Annual Cancer Survivors Day event
    - Regular support group meetings
    - Cancer Caregiver Workshops

Strategies to Address Diabetes Incidence:

- Raise awareness of diabetes preventable risk factors and educate the public on ways to manage lifestyle behaviors that affect them including diet, weight and physical activity.

    - Offer free community health educational lecture and seminar programs presented by hospital medical and clinical staff.
    - Include educational information in each issue of Better Being, ECHN's free community magazine distributed to approximately 155,000 households in service area.
    - Participate in community health fairs throughout service area where free glucose tests are conducted and educational resources are shared.

- Offer Diabetes Self-Management Program and Nutrition Counseling for individuals already diagnosed with diabetes.

Strategies to Address Arthritis Incidence:

- Educate the public about ways to help prevent or slow the progression of arthritis and manage the symptoms of joint pain.

    - Offer free community health educational lecture and seminar programs presented by hospital medical and clinical staff.
    - Include educational information in each issue of Better Being, ECHN's free community magazine distributed to approximately 155,000 households in service area.
    - Participate in community health fairs throughout service area.

- Offer free program to help individuals with arthritis prepare for hip or knee replacement surgery and achieve the best outcome.

- Develop a comprehensive surgical spine program to support individuals experiencing chronic neck and back pain including symptom management and perioperative care.

Section 5.16(b) of the proposed APA states that the "Buyer [PMH] will strive to provide care through community-based health programs, including by cooperating with local organizations that sponsor health care initiatives to address community needs and to

improve the health status of the elderly, poor, and at-risk populations in the community."

PMH will continue to focus efforts on improving population health, including reducing the incidence of heart disease, cancer, diabetes and arthritis in the surrounding communities. PMH will utilize its experience and knowledge in population health management to enhance the efforts previously identified by MMH and RGH in their original plan, and incorporate best-practice recommendations for disease prevention, early detection screenings, and treatment options within each of the priority areas.

Support from PMH in implementing strategies to address priority needs:

PMH will support the priority needs identified by the CHNA with a variety of physician alignment and population health management strategies, enhanced through PMH's implementation of CRC, which focuses on the health of vulnerable populations.

23. Provide a description of plans that the Applicants will implement to control cost, such as discharge care coordination, implementation of electronic medical records and emergency department triaging to the appropriate level of care.

In responding to this question, report any anticipated savings from the following expense categories for the ECHN hospitals: salaries and wages, fringe benefits, contractual labor fees, medical supplies and pharmaceutical costs, depreciation and amortization, bad debts, interest expense, malpractice expense, utilities, business expense and other operating expenses.

Response:

The specific anticipated savings are presented by expense category in response to Question 37 and described in response to Question 38.

PMH manages costs by eliminating inefficiency and reducing unwarranted variation in the delivery of patient care services. The CRC model promotes the efficient operation of hospitals by aligning physician interests with the efficient and effective delivery of healthcare. PMH's delivery model rewards physicians for quality and outcomes, not outputs, through shared savings and pay-for-performance standards and benchmarks. Its delivery model of integrating physicians, hospital and health plans to population and performance management is proven in three markets in Southern California, Texas and Rhode Island. PMH has demonstrated improved clinical outcomes, higher quality scores, higher patient satisfaction, lower re-admission rates, lower average lengths of stay, and lower medical-cost ratios. With leadership and input from the Local Board, PMH will use its delivery model to engage physicians and strengthen their alignment with the ECHN hospitals.

24. Provide a description of the Applicants plans to continue to provide services to the uninsured and underinsured.

In responding to this question, please describe any changes to the ECHN Hospitals' current charity care, uncompensated care and financial assistance policies and procedures, and hospital bed funds that will result from the Asset Purchase.

Describe any plans the Applicants have to work with other providers in the community, such as federally qualified health centers or community health centers, to provide specialty care to patients, or low cost programs that the Applicants will provide in the area that are tailored towards the uninsured or underinsured.

Response:

PMH will continue to provide high quality care to the uninsured and underinsured. PMH will ensure that MMH and RGH each maintains and adheres to ECHN's current policies regarding charity care, indigent care, community volunteer services and community benefits or adopts other policies that are at least as favorable to the indigent and uninsured as ECHN's current policies.

PMH will actively work with other providers in the community such as federally qualified health centers or community health centers to meet the needs of uninsured and underinsured individuals in the Service Area, including Medicaid recipients. PMH will continue to operate low cost hospitals and provide high-value services to those in need. Also see response to Question 26 regarding how the transaction will improve quality, accessibility and cost effectiveness of health care delivery.

25. Submit a list of all key professional, administrative and clinical department heads related to this proposal. Additionally, provide a copy of the Curriculum Vitae of each individual listed.

Response:

Eastern Connecticut Health Network

ECHN's Administrative and Clinical Department Heads include the following. Curriculum Vitae for each are included as Exhibit Q25-1.

Peter Karl, President and Chief Executive Officer
Dennis McConville, Sr. VP and Chief Strategy Officer
Mary Powers, Sr. VP Patient Care Services
Joel Reich, MD, Sr. VP of Medical Affairs and Chief Medical Officer

Joyce Tichy, Sr. VP and General Counsel
Michael Veillette, Sr. VP of Finance and Chief Financial Officer
Gregory Williams, Sr. VP Network Services
Pamela Lewis, MD, President, ECHN Medical Staff
Maher Suede, MD, Vice President, ECHN Medical Staff

Prospect Medical Holdings

PMH Administrative and Department Heads are listed below. Biographical summaries for each are included as Exhibit Q25-2.

Samuel S. Lee, Chief Executive Officer
David Topper, President of Alta Hospitals System, LLC
Mitchell Lew, MD, President
Stephen O'Dell Sr. VP, Coordinated Regional Care
Steve Aleman, Chief Financial Officer
Ellen J. Shin, General Counsel and Secretary
Cindra Syverson, Chief Human Resources Officer
Von Crocket, Sr. VP, Corporate Development
Thomas Reardon, President of Prospect East Hospital Advisory Services, Inc.
Hoyt Sze, Chief Compliance & Privacy Officer
Jonathan J. Spees, Senior Vice President, Mergers and Acquisitions

26. Provide evidence as to how the Asset Purchase will improve quality, accessibility and cost effectiveness of health care delivery in the region, including but not limited to provision of or any change in the access to services for Medicaid recipients and indigent persons.

Response:

a. Medicaid recipients and indigent persons will have the same, if not better, access to high quality services than that to which they currently have access. PMH and ECHN representatives have already met with leadership for Connecticut's Medicaid Program and expressed their desire to work under a risk-based arrangement to provide care to Medicaid recipients. PMH is currently working with officials in Rhode Island to pilot a Medicaid risk-based program in that state. With regard to access to services for indigent individuals, PMH will ensure that each Hospital maintains and adheres to ECHN's current policies regarding charity care, indigent care, community volunteer services and community benefits, or adopts other policies that are at least as favorable to the community as ECHN's current policies. (See APA Section 5.16).

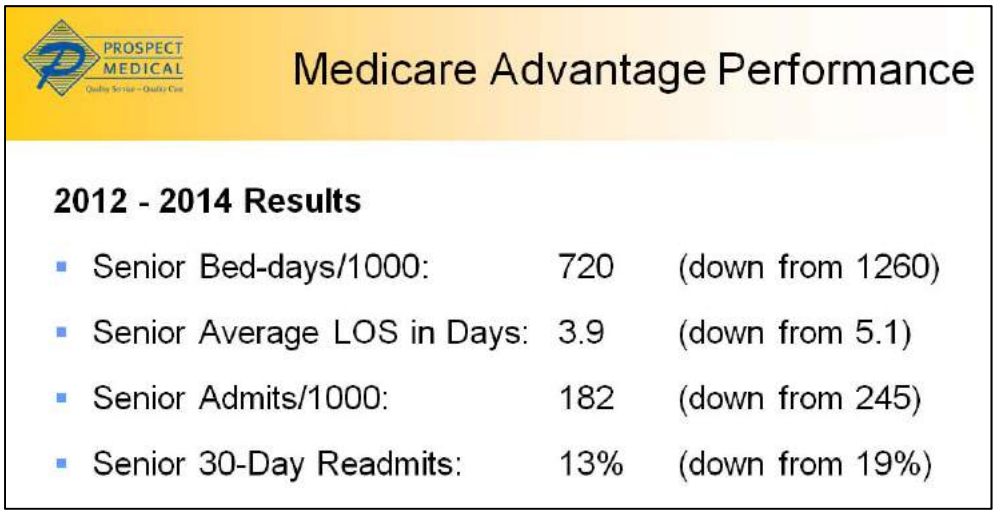
b. PMH's vision for Connecticut is to have strong and quality-driven hospitals with a robust network of aligned physicians operating from its CRC platform. PMH will develop its CRC model for the communities served by ECHN by working with payers and physicians. Its experience with CRC in all of its other markets has allowed PMH to attract more primary care providers and improve access to care. Prospect builds regional networks

with its hospitals and medical groups that contribute to the entire continuum of care. In its development of the Eastern Connecticut Health Network, it will partner with the medical staff to address gaps in care and services to ensure the effective management of all patients across the network.

c. PMH has a proven track record of effectively managing risk, capitation and bundled payments for its hospitals and medical groups, while at the same time delivering cost-effective, quality care. PMH manages the provision of healthcare services to approximately 260,000 members through its network of over 8,900 primary care physicians and specialists. Its hospitals manage the care of 30,000 capitated Medicaid beneficiaries.

The CRC model allows PMH to respond to the rapid changes in reimbursement and care delivery by operating its hospitals efficiently, aligning physician interests with the efficient and effective delivery of healthcare, and offering a full continuum of non-acute services in the hospitals' service areas. The goal is to ensure that patients receive the right care, at the right time, in the right setting, while avoiding unnecessary, inefficient and duplicative services and reducing medical errors. PMH is proud of its results. For example, from 2012 to 2014 in California and Texas where PMH participates in HMO contracts for seniors, PMH has reduced hospital beds days per thousand from 1,260 to 720. Length of hospital stay for this population has been reduced from 5.1 days to 3.9 days, admissions per thousand have dropped from 245 per thousand to 182 per thousand and hospital readmissions within thirty days has dropped from 19% to 13%. (See Figure 3, below.) PMH recognizes that the delivery of care varies from region to region, and while the same results may not be achieved here, PMH is confident that improvements in these areas can be achieved to contribute to the cost effectiveness of care for the patients it serves.

Figure 3: Medicare Advantage Performance following CRC Implementation



27. Provide the corporate organizational chart prior to and after the proposed Asset Purchase, including all affiliates.

For the organizational chart that depicts the post-Asset Purchase structure, working upward on the chain of ownership from the ECHN Hospitals, please:

(i) **Describe the nature of the ownership and control that each entity has in the entity directly below it;**

(ii) **Describe the major business activities/functions of each entity;**

(iii) **Provide the principal place of business address for each entity; and**

(iv) **Provide the name and business address of each individual currently serving as a member of the governing body of each entity.**

Response:

(i) Please see Exhibit Q27-1 for ECHN's organizational chart prior to the Asset Purchase.

Please see Exhibit Q27-2 for PMH's organizational chart after the Asset Purchase.

(ii) The major business activities and functions of the post-closing entities will mirror those of the corresponding pre-closing entities.

(iii) The principal place of business address for each entity will not be known until the entities have been formed.

(iv) The name and business address of each individual currently serving as a member of the governing body of each entity will not be known until the entities have been formed.

Other Related Entities

PMH will maintain a medical foundation that will employ physicians and other healthcare care providers from each of the health systems acquired in Connecticut.

28. Please provide the date on which both of MMH, RGH and ECHN filed audited financial statements with OHCA. Applicants may reference these statements in responding to questions. In addition, provide a copy of PMH's most recent audited financial statements.

Response:

MMH, RGH and ECHN filed FY 2014 audited financial statements with OHCA on February 26, 2015. Please refer to Exhibit Q8-1 for a copy of PMH's audited financial statements for the fiscal year ending September 30, 2014.

29. List all funding or financing sources for the $105,000,000 in Projects Costs (the "Project Cost") estimated for this acquisition by PMH, including PMH's commitment to invest $75,000,000 in routine and non-routine facility improvements, general upgrades and renovations, deferred maintenance items, and initiatives to develop, expand or acquire new programs or services, and to support the recruitment of medical staff (the "Capital Commitment"). Provide applicable details such as interest rate; term; monthly payment; pledges and funds received to date; letter of interest or approval from a lending institution.

Response:

PMH has access to an existing corporate level credit facility in addition to its cash on hand. There is no financing contingency with respect to this transaction. The Applicants anticipate that PMH would fund this acquisition (after giving effect for the assumption of liabilities), by using its existing cash.

With respect to the future capital commitments, the Applicants anticipate that such commitments would be funded through the operations of ECHN (if ECHN generates sufficient cash flow at the time of expenditures), PMH's existing cash at the time of expenditure or, if necessary, PMH's corporate level credit facility. Details such as interest rate, term, and monthly payment amounts do not apply to this Asset Purchase.

30. In reference to the Capital Commitment, provide the following:

a. A copy of any related capital expenditure plan;

b. Define the terms "routine" and "non-routine" facility improvements and "deferred maintenance items". Provide specific examples of each.

Response:

a. There is not a capital plan related to the proposed transaction at this time. Post-Closing, PMH and the Local Board will develop a strategic capital plan with respect to the Hospital Businesses, which include the hospitals, affiliates and joint ventures.

b. Routine capital expenditures for facility improvements extend the useful life of the plant. Examples would include replacement of infrastructure/engineering system components such as boilers, electrical switchgear, elevator upgrades, or heating-air conditioning-ventilation units.

Non-routine capital expenditures would result in new technology or improvements to a facility that allow for new or expanded uses. Examples of non-routine facility

improvements would include the addition or expansion of a clinical unit that would provide for a new service to be offered such as those made to house a wound care program with hyperbaric chambers, or adding additional birthing rooms to accommodate a growth in demand for obstetrical services.

Deferred maintenance items involve maintenance activities, system upgrades, or repairs that are deferred to a future budget cycle or postponed until funding becomes available. Deferred maintenance most often involves routine capital expenditures as described above. Other examples of items that may be deferred or postponed could include replacements of equipment such as a computer server or installation of new finishes to an area within the facility.

31. Please explain in detail the reasons why, and with respect to each item, the extent to which, the Project Costs related to this proposal may be adjusted for each of the following:

a. outstanding indebtedness;

b. pension liabilities;

c. retiree health benefits;

d. captive insurers;

e. capital leases;

f. asbestos abatement; and

g. joint venture interests that may not transfer

Response:

Outstanding indebtedness. Other than long term indebtedness, ECHN's debt largely consists of capital leases. For a description of the manner in which capital leases will be handled, see "Capital Leases" below.

To address ECHN's outstanding long-term indebtedness, the APA provides for two different scenarios. Under the first scenario, ECHN will use the net proceeds of the transaction to defease its outstanding bond and other long-term indebtedness. Under this scenario, there will be no adjustment applied to the purchase price relating to outstanding indebtedness as PMH will not be assuming this debt. Under the second scenario, ECHN will prior to closing refinance some of its outstanding long-term indebtedness and will additionally finance up to $10,000,000 of new debt. Under this scenario, PMH will assume this refinanced and new debt at closing, with all other long-term debt not refinanced to be paid off with net proceeds and existing ECHN cash and investments. The purchase price would be increased by PMH by the amount of new debt up to $10,000,000.

Pension and retiree health benefits. In order to ensure that ECHN's pension obligations will be satisfied, ECHN negotiated to have PMH assume these liabilities. The purchase price will be reduced by the actuarial funding shortfall of both plans at the time of closing. As of the last actuarial review, conducted on September 30, 2014, the Purchase Price would be reduced by $45,990,000. It is anticipated that the actuarial review that will occur for September 30, 2015 will increase the funding shortfall by an estimated $18,000,000 due to the new mortality tables that must be adhered to in estimating the projected liability. Therefore the projected purchase price adjustment for these liabilities will be an estimated $64,000,000. The September 30, 2015 review will be the actuarial review of record as updated as of the closing date.

Captive insurers and Worker's Compensation. ECHN negotiated to have PMH assume Connecticut Healthcare Insurance Company's liability due to limited options and the prohibitive cost associated with pursuing a loss portfolio transfer in the insurance market. The other potential option, not deemed acceptable due to unforeseeable risk, was having Connecticut Healthcare Insurance Company retain post-closing responsibility to wind-down the captive. As a result of negotiations between the Parties, there is no anticipated adjustment to be made to the purchase price at the closing, except to the extent that the liability of the captive (including the tail liability of the captive) exceeds the assets of the captive as of the closing. PMH will be receiving the assets of the captive. In addition, the Worker's Compensation liability also will be assumed by PMH. As a result of negotiations between the Parties, there is also no adjustment to be made to the purchase price at the closing for the Worker's Compensation liability, except to the extent that the Worker's Compensation liability exceeds the investments held by the Worker's Compensation Trust as of the closing. PMH will be receiving the assets reserved for the Worker's Compensation trust. ECHN, however, reserves the right to retain either or both of these liabilities and pursue tail insurance and/or a loss portfolio transfer if this were deemed a preferable transaction option.

Capital leases. PMH will assume ECHN's capital lease obligations, which are primarily for equipment purchased by ECHN with a lease term of five years or less. The purchase price adjustment based upon outstanding capital lease principal as of September 30, 2014, would be $9,984,000. It is estimated that the outstanding lease principal on September 30, 2015 will be $8,543,000. The purchase price adjustment will be based on the amount of the outstanding principal is as of the closing date.

Asbestos abatement. PMH will assume the asbestos abatement liability, which relates to an accounting matter, whereby the Financial Accounting Standards Board (FASB) issued Financial Interpretation Number 47 in 2005, requiring an entity to recognize the future cost of removing asbestos to the best of its ability. ECHN recognized this liability in fiscal year ending September 30, 2006, as that was the first year affected by the new FASB ruling. The purchase price adjustment for asbestos abatement will be $412,000.

Joint venture interests. It is the expectation per the APA to transfer all ECHN joint ventures interests to PMH, and the value of those joint venture interests is therefore included in the total purchase price. To address the possibility that a joint venture interest cannot be transferred at the time of closing, however, ECHN and PMH have identified an adjustment

that will be taken as a deduction from the purchase price for any joint venture interest not transferred. If any joint venture interests are not transferred to PMH, it is ECHN's intent to sell its interests in such joint venture to a third party. The maximum possible purchase price deduction is $22,000,000 which was based on a six times multiple of EBITDA as of 9/30/14. Each joint venture was individually valued using the same methodology should they not be conveyed to PMH at closing.

The amounts indicated above are intended to illustrate the anticipated plan for payment of debt and pension obligations as well as payment of other liabilities but are subject to adjustment at closing.

32. How, if at all, will non-approval by any of the joint venture interests referred to in Question 31(g) above affect the Asset Purchase?

Response:

If ECHN is unable to transfer some or all of the joint venture interests prior to the closing because of its inability to obtain the required consents from its joint venture partners, the purchase price will be reduced to reflect the value allocable to the joint venture interests not transferred at closing; provided however, that the maximum deduction from the purchase price for failure of joint venture interests to transfer will be $22 million. In addition, if ECHN is not able to transfer some or all of ECHN's interests in the joint ventures prior to the closing, Prospect will lend to ECHN pursuant to a promissory note bearing interest at 3% per annum payable from and secured by future distributions from the joint ventures and ECHN's interests in the joint ventures (to the extent the grant of such security interest is permissible under Connecticut law and the joint venture agreements) an amount equal to the deduction made from the purchase price due to the fact that such joint venture interests are not transferred at closing. As joint venture interests are transferred to Prospect following the closing, the principal amount of the promissory note will be reduced by the portion of the note that was allocable to the transferred joint venture interests.

33. Please explain in detail the terms of the Capital Commitment and in particular:

a. How it will be allocated as between MMH and RGH, including the annual amounts projected to be available to each hospital;

b. The capital projects for each of the hospitals that are deemed top priorities by the Applicants; and

c. The service improvements for each of the hospitals that are deemed top priorities by the Applicants.

d. A list of capital projects and service improvements that are expected to be carried out within the first three years following the closing date; and

e. Discuss the ability of ECHN to address items listed in 33(b) and 33(c) for each of the hospitals without approval of this proposal.

Response:

a. The $75 million has been committed to ECHN, but has not been specifically apportioned to each Hospital or its affiliates. To effectively manage in a risk based payment system, a complete continuum of care to deliver services at the right place at the right time must be supported with capital investments in information technology and alternative ambulatory sites of care. By nature, capital projects can have multiple phases and span across several years. As such, the capital spent will most likely not be spread equally over the five years. PMH will seek the input of the Local Board and medical staff in making those determinations.

b. The following are the priority capital projects for the hospitals that have been identified by ECHN management. Aside from renovations to the MMH emergency department necessary for the benefit of our behavioral health patients, they are not budgeted for fiscal year 2015 or 2016. Funding for the remaining projects is dependent on the closing of the transaction with PMH. The projects will require the approval of PMH with input of the Local Boards.

    1. Upgrades to emergency department for behavioral health patients (MMH)
    2. Electronic medical record system replacement (MMH & RGH)
    3. Upgrades to nursing units (RGH)
    4. Upgrades to nursing units (MMH)
    5. Vessel sealing systems (MMH & RGH)
    6. MRI replacement (MMH)
    7. SPECT scanner replacement (MMH)

c. The service improvements that are deemed capital expenditure priorities are the upgrades to nursing units included in the list of capital projects above. The upgrades would allow for the construction of more single patient rooms which offer privacy, quiet and isolation from potential infection. The upgrades to the Emergency Department at MMH involve the construction of a discrete sub-unit within the department to treat patients presenting with acute behavioral health conditions. The design of the sub-unit includes features to promote the safety of patients, caregivers and the public which incorporate the finishes, hardware and security equipment recommended by the Department of Public Health.

d. As stated above in response to question 30a, there is not a capital plan related to the proposed transaction at this time. Post-closing, PMH and the Local Board will develop a strategic capital plan with respect to the Hospital Businesses which include the hospitals, affiliates and joint ventures.

e. ECHN is not in the financial position to pursue most, if any, of the above capital priorities without this proposal due to the continued weakening of its balance sheet from annual governmental reimbursement cuts, pension funding obligations and current annual debt service. The challenge over the past four to five years has been balancing investments in projects that ECHN can afford while adjusting to the continued declines in payments for services year over year. The priority focus each year has been on meeting bond covenants such as minimum days cash on hand and keeping the debt service coverage ratio just above the minimum acceptable rate of 1.25 times annual debt. For the most recent years, ECHN has spent very little on capital other than required expenditures to repair or replace plant and equipment. More recently, creditors have been reluctant to work with ECHN on large projects that would require financing. They are waiting for ECHN to be acquired.

34. Describe in detail how this proposal will affect the financial strength of the State's health care system and will be financially feasible.

Response:

The financial strength of the State of Connecticut's health care system will be improved with this proposal as it will lead to a stronger and more financially secure ECHN. Connecticut's hospitals and their affiliated hospital networks are an important part of the State's health care system. The financial strength of Connecticut's hospitals significantly contributes to the financial strength of the State's entire health care system. Financially strong hospital systems can provide access to new and innovative services and improve access to necessary services. Increased access to needed heath care services reduces the burden on State resources and improves the health status of the community.

The proposal enables ECHN to more fully integrate its health care system utilizing PMH's CRC model which offers resources, systems, and efficiencies which are essential for long term success in the evolving health care marketplace. PMH will bring the strength of its CRC model to the service area of ECHN and provide innovation and a level of integration that ECHN could not possibly do independently. In order to offer high value health care and participate in the emerging value-based payment models, an essential focus of health care reform, providers across the continuum must establish new relationships, infrastructure and capabilities to provide cost efficient care. Significant investments are necessary for health systems to develop new competencies, process skills and knowledge. Examples include, but are not limited to: development and management of an advanced, comprehensive care continuum delivery network; population health management with the identification of those patients requiring high intensity care and sophisticated care management programs; actuarial and health economics data analytics; and integrated information technology, which few small hospital systems can afford. This proposal will allow ECHN to benefit from the process skills and knowledge that allow clinical integration and coordination of care. The CRC model promotes efficiency that PMH has developed over

decades of participating in hospital operations by aligning physician interests with the efficient and effective delivery of healthcare, and offering a full continuum of non-acute services in the hospitals' service areas. The goal of the CRC model is to ensure that patients receive appropriate care, at the appropriate time, in the appropriate setting, while avoiding unnecessary, inefficient and duplicative services and reducing medical errors.

Hospital capital needs are significant and necessary in order to offer the latest technology and competitive facilities. Physical plant renovations are constantly required just to keep hospitals in good working order. For many hospitals like those affiliated with ECHN, the capital needs are large and cannot be met with current avenues for funding.

Over the past five years (FY 2011-FY 2015), ECHN has absorbed over $17.0 million in governmental reimbursement reductions. A significant portion of these reductions occurred just within the current fiscal year (FY 2015). It is expected that another $2.5 million will be added on to government reimbursement cuts for FY 2016. With costs going up, and reimbursement going down, remaining a small hospital system will result in a further drain on its financial resources.

PMH offers both financial strength and health care experience. PMH is prepared to make the necessary investments, and has the financial resources to pay for this investment. These investments will strengthen ECHN, an integral part of Connecticut's health care system. The proposal is financially feasible, and will add to the strength of the State's health care system.

35. Please provide the current payer mix for both MMH and RGH and the projected payer mix for both respective hospitals after the Asset Purchase (based on the number of patients, not based on revenue) in the following reporting format:

Table 7: Patient Population / Payer Mix

Manchester Memorial	Current FY 2015	Projected FY 2016	Year 1 FY 2017	Year 2 FY 2018	Year 3 FY 2019
Medicare [1]	41.39%	41.39%	41.39%	41.39%	41.39%
Medicaid [2]	17.24%	17.24%	17.24%	17.24%	17.24%
CHAMPUS or TriCare	0.43%	0.43%	0.43%	0.43%	0.43%
Total Government Payers	**59.06%**	**59.06%**	**59.06%**	**59.06%**	**59.06%**
Commercial Insurers [1]	38.05%	38.05%	38.05%	38.05%	38.05%
Uninsured	2.37%	2.37%	2.37%	2.37%	2.37%
Workers Compensation	0.52%	0.52%	0.52%	0.52%	0.52%
Total Non-Government Payers	**40.94%**	**40.94%**	**40.94%**	**40.94%**	**40.94%**
Total Payer Mix	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**

Rockville General	Current FY 2015	Projected FY 2016	Year 1 FY 2017	Year 2 FY 2018	Year 3 FY 2019
Medicare [1]	31.00%	31.00%	31.00%	31.00%	31.00%
Medicaid [2]	17.66%	17.66%	17.66%	17.66%	17.66%
CHAMPUS or TriCare	0.56%	0.56%	0.56%	0.56%	0.56%
Total Government Payers	**49.22%**	**49.22%**	**49.22%**	**49.22%**	**49.22%**
Commercial Insurers [1]	46.38%	46.38%	46.38%	46.38%	46.38%
Uninsured	3.50%	3.50%	3.50%	3.50%	3.50%
Workers Compensation	0.90%	0.90%	0.90%	0.90%	0.90%
Total Non-Government Payers	**50.78%**	**50.78%**	**50.78%**	**50.78%**	**50.78%**
Total Payer Mix	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**

(1) Includes managed care activity

(2) Includes managed care activity and other medical assistance

36. Provide the assumptions used to project the patient population/payer mix after the proposed Asset Purchase.

Response:

The current payer mix is based on fiscal year 2015 (October 1, 2014 – June 30, 2015). The patient population mix is not expected to change as a result of the APA. Therefore, we would assume the same patient population mix for the first three years after the acquisition.

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

a. Financial Worksheet (C) for ECHN, MMH, RGH (for MMH and RGH, hospital only data, no affiliates) and PMH without the CON project (columns 1, 2 5, 8 & 11) and with the CON project and incremental to the CON project (remainder columns); and

b. Submit Financial Attachment (C) using the same page and print layouts (size, font, page orientation, margins, etc.) as provided by OHCA.

Note that the actual results for the fiscal year reported in the first column must agree with ECHN's audited financial statements. The projections must include the first three full fiscal years of the project.

Response:

Financial Worksheet (C) for ECHN without the CON project and for PMH ECHN with the CON project and incremental to the CON project has been included in Exhibit Q37-1. Financial Worksheet (C) has been provided using the same page and print layouts as provided by OHCA.

38. Provide the assumptions utilized in developing Financial Worksheet (C) (e.g., full-time equivalents, volume statistics, other expenses, revenue and expense percentage increases, project commencement of operation date, etc.).

Response:

The assumptions utilized in developing Financial Worksheet (C) are included as Exhibit Q38-1.

39. Explain any projected incremental losses from operations contained in the financial projections that result from approval of the Asset Purchase and operation of MMH, RGH, ECHN and PMH.

Response:

There are no projected incremental losses from operations contained in the financial projections that result from approval of the Asset Purchase and operation of PMH.

40. Please describe any anticipated change to existing reimbursement contracts with payers (e.g., Medicare, Medicaid, commercial) as a result of the Asset Purchase. Is it assumed in the financial projections that the Applicants will willingly negotiate with the payers that ECHN currently has contracts with?

Response:

PMH will accept all existing contracts with payers and will complete a Change of Ownership process with commercial payers, as well as Medicare and the Connecticut Medical Assistance Program (Medicaid).

41. Please explain in detail how the proposed Asset Purchase will be able to assure satisfaction of ECHN's and/or both of MMH's and RGH's debt and pension obligations.

Response:

The Asset Purchase will satisfy ECHN's debt and satisfy the funding obligations of the pension plan. At the time of the close, the purchase price paid by PMH less all adjustments will be combined with ECHN's cash, investments, and debt service reserve funds (but excluding restricted charitable funds not available to satisfy ECHN liabilities), to fully satisfy all debt. Pertaining to the pension plan, PMH will assume full responsibility for satisfying all funding obligations post-closing. The funding gap of the pension plan will be deducted from the purchase price of $105 million in consideration for assuming this liability. The current underfunded status of the plan as of the last measurement date of September 30, 2014 was $43.1 million. It is estimated that this underfunded status will increase as of September 30, 2015 by $18.0 million. This is due to the development of new mortality tables per the Society of Actuaries, who generally provide changes every 10 years or so. There is the potential for some other changes to the funding gap due to the performance of interest rates but the change in funding status will not be known until September 30, 2015. With respect to debt obligations, the possibility exists that some new financing may be added to ECHN's liabilities between now and the closing date. In the event this does happen, PMH is prepared to increase their purchase price up to $10.0 million to offset the assumption of any new debt dollar for dollar. This new debt or any debt that were to be refinanced would be assumed by PMH at closing and not paid off with net proceeds, but would be deducted from the purchase price.

Table 8 below summarizes the net proceeds and flow of funds. Although the amounts below are subject to adjustment to the closing date, the table below shows the anticipated plan for payment of debt and pension obligations as well as payment of other liabilities. A portion of the post-closing surplus will be used to fund necessary wind-down operations and legal obligations of the ECHN legacy entity (e.g., tax filings). The surplus amount shown below is not assured.

Table 8: Net Proceeds Analysis
Assumes transaction will close on 09/30/2015

			Scenario B 9/30/2015	Scenario A 9/30/2015
ACQUISITION PRICE (EV)	A		$115,000,000	$105,000,000
ASSUMED LIABILITIES:				
Pension & Retiree Medical			($64,000,000)	($64,000,000)
Captive & Workers Comp.			($2,411,000)	($2,411,000)
Net Working Capital True-up			($6,177,000)	($6,177,000)
"Taxable" Long Term Debt			($43,660,500)	
Capital Leases, Misc (FIN47)			($8,955,000)	($8,955,000)
TOTAL ACQ LIABILITIES	B		($125,203,500)	($81,543,000)
NET PROCEEDS (CASH to ECHN)	C	A-B	($10,203,500)	$23,457,000
CASH & INVESTMENTS (ECHN)	D		$57,551,000	$56,551,000
TOTAL CASH for DEBT PAYOFF	E	C+D	$47,347,500	$80,008,000
LONG TERM DEBT (Net AWUIL)	F		($43,052,500)	($76,713,000)
SURPLUS after DEBT DEFEASANCE	G	E-F	$4,295,000	$3,295,000
INDEMNITY RESERVE	H		($3,295,000)	($2,295,000)
SURPLUS for COMM. FOUNDATION	I	G-H	$1,000,000	$1,000,000

Risk Areas:
- **OPERATIONS (Next 12 Mos.)**
- **CAPTIVE & TAIL**
- **WORKERS COMP**
- **PENSION**

42. For each of the ECHN Hospitals, please address the following regarding staffing at the hospital by completing "Staffing Attachments I&II."

a. Provide the levels of staffing for fiscal year ("FY") 2015 broken out as follows:

(i) **Average patient to nursing staff ratios per shift (a.m., p.m. and overnight) for each department and/or unit of the hospital;**

(ii) **The same information as provided in subsection (a)(i) above showing the RN to patient ratio only; and**

(iii) **The average nursing hours per patient day (NHPPD) for each department and/or unit of the hospital (all nursing staff should be included in the calculation of nursing hours).**

b. Provide the projected levels of staffing by department and/or unit for the hospital for the first three (3) full FYs following approval of the Asset Purchase broken out as follows:

(i) **Average patient to nursing staff ratios per shift (a.m., p.m. and overnight) for each department and/or unit of the Hospital; and**

(ii) **The same information as provided in subsection (b)(i) above showing the projected RN to patient ratio only.**

Response:

Please see Exhibit Q42-1 for Staffing Attachment I which responds to Section a and Exhibit Q42-2 for Staffing Attachment II which responds to Section b of this question.

43. For each of the ECHN Hospitals, provide a detailed explanation by department and/or unit as completed by the Applicants in Staffing Attachment I, to reconcile any differences between FY 2015 nursing staff levels and those projected for the first three (3) full FYs following approval of the Asset Purchase.

Response:

The nursing staff levels projected for the first three full fiscal years following the Asset Purchase are projected to remain at FY 2015 staffing levels. Such staffing ratios are estimates based on current circumstances and may be updated as appropriate to reflect PMH and industry best practices, and which reflect changes in technology, implementation of the CRC model of coordinated care, and other factors related to the delivery of high quality, cost-effective care. PMH is committed to staffing levels that comply with ratios

mandated by Connecticut state law and which take into account patient safety and acuity, employee safety and facility census.

PMH expects very close to 100% of all employees, including patient care staff, to accept employment with a PMH affiliate.

44. For each of the ECHN Hospitals, describe any other hospital-employed or hospital-contracted staff besides nursing staff (e.g., hospitalists, mid-level providers, therapists, etc.) that were engaged to provide direct patient care at the hospital (collectively, "Ancillary Caregivers") for FY 2015 broken out as follows:

a. The type of Ancillary Caregivers and the department and/or unit to which such staff was assigned;

b. The average number of hours per week that such Ancillary Caregivers provided patient care for the department and/or unit; and

c. For the first three (3) full FYs following approval of the Asset Purchase, the average number of hours per week that such Ancillary Caregivers are projected to provide patient care for each department and/or unit of the hospital described in subsection (a) above.

Response:

Please see Exhibit Q44-1 for the completed Ancillary Caregivers Staffing Attachment.

The Ancillary Caregivers Staffing Attachment has been completed for FY 2015 based on the actual worked hours experienced from October 1, 2014 through June 30, 2015.

Regarding the average number of hours per week that Ancillary Caregivers are projected to provide patient care for each hospital department and/or unit during the first three full FYs following approval of the Asset Purchase, please see response to Question 46, below, regarding satisfaction of DPH staffing requirements following approval of the Asset Purchase.

The staffing estimates provided on Exhibit Q44-1 are based on current circumstances and volume and may be updated as appropriate to reflect PMH and industry best practices, and which reflect changes in technology, implementation of the CRC model of coordinated care, and other factors related to the delivery of high quality, cost-effective care. Staffing of Ancillary Caregivers may eventually shift with the implementation of the CRC model, which is expected eventually to result in changes in patient acuity and relative volume of inpatient and outpatient services.

45. For each of the ECHN Hospitals, provide a detailed explanation by department and/or unit to reconcile any differences between the average number of hours per week that the Ancillary Caregivers described in Question 44 above provided patient care in FY 2015 with those projected for the first three (3) full FYs following approval of the Asset Purchase.

Response:

Ancillary Caregiver staffing levels will be based upon volume demands (which would impact unit configuration and size), patient acuity, staff experience levels, technology and best practice industry benchmarking. Over time, PMH's implementation of clinical integration strategies would be expected to improve efficiency and effectiveness in the allocation of staff.

46. For each of the ECHN Hospitals, provide evidence that the proposed staffing for nursing staff and Ancillary Caregivers for the first three (3) full FYs following approval of the Asset Purchase meet all Connecticut Department of Public Health ("DPH") staffing requirements and assure continued access to high quality and affordable health care. Be sure to cite the appropriate DPH regulations and/or other industry benchmarks as applicable.

Response:

Proposed staffing levels for nursing staff and Ancillary Caregivers following approval of the Asset Purchase will comply with DPH staffing requirements as outlined in Connecticut Statute § 19-13-D3(c)-(h).[5] MMH and RGH will maintain compliance with this statute and have consistently demonstrated compliance to DPH surveyors as requested.

The specific regulation pertaining to nursing staff ratios is as follows:

Department of Public Health § 19-13-D3(e) Nursing service.

(1) There shall be a competent nurse, licensed in Connecticut, as director of nursing service or an equivalent position, who shall be responsible to the administrator for nursing service in the hospital.

(2) The ratio of patients to registered nurses on duty throughout the hospital shall at no time exceed twenty-five patients or fraction thereof to one registered nurse.

(3) The ratio of patients to all nursing staff, registered nurses, licensed practical nurses and other nursing attendants on duty in the hospital shall not exceed seven patients, or fraction thereof, to one from 7 a.m. to 7 p.m., and fifteen patients, or fraction thereof, to one from 7 p.m. to 7 a.m.

(4) If there is an in-patient obstetrical department, the following shall apply:

(A) The ratio of all nursing staff to patients for obstetrical services shall be no less than one nurse to each ten patients, or fraction thereof, on the 7am to 3pm shift; no less than one nurse to each fifteen patients, or fraction thereof,

[5] http://www.sots.ct.gov/sots/lib/sots/regulations/title_19/013d.pdf

on the 3pm to 11pm shift; and no less than one nurse to each twenty patients, or fraction thereof, on the 11pm to 7 am shift;

(B) there shall be at least one registered nurse on duty at all times. For obstetrical services with a census of twenty or more patients, there shall also be a registered nurse on duty for overall supervision of the unit;

(C) these ratios shall be calculated without inclusion of newborns or pediatric patients.

With respect to the three full FYs following approval of the Asset Purchase, at a minimum, PMH will continue to meet DPH staffing requirements for nursing and ancillary caregivers. Staffing levels may also change over time as population health management strategies and techniques are implemented. In the absence of DPH rules or other applicable regulations, PMH will utilize its own or industry best practices to determine appropriate staffing levels, taking into account the health and safety of patients and employees, patient acuity and overall facility volume.

47. Applicants are required to provide copies of the most recent CMS statements of deficiencies and plans of correction (CMS Form 2567) for all hospitals owned by PMH. Provide these documents in an electronic format only. PDF file on a CD to accompany the responses. No paper copies required.

Response:

PMH has provided the most recent CMS statements of deficiency and plans of correction for the Rhode Island hospitals owned by PMH, as these represent the hospitals most recently acquired by PMH. A summary of each statement and copies of the related documents have been provided in electronic format only, as requested, in Exhibit Q47-1.

PMH is committed to providing the highest quality care at all of its facilities and networks, as evidenced by the following quality care awards (see Figure 4):

Figure 4: PMH Quality Care Awards



48. Provide a copy of, and describe any changes to, any of the following policies and procedures that will be in place at MMH and RGH if the Asset Purchase is approved:

a. Hospital collection policies (including charity care and bad debt);

b. Annual or periodic review and/or revision to the hospital's pricing structure (the chargemaster or pricemaster); and

c. The annual or periodic market rate assessment for the hospital.

Response:

a. Hospital collection policies are included in Exhibit Q48-1. There are no planned changes to these policies, except as may be required to comply with new legal or regulatory requirements such as Internal Revenue Code Section 501(r).

b. The chargemaster is provided to OHCA on a monthly basis. The structure will remain unchanged if the Asset Purchase is approved. The chargemaster is generally adjusted annually for inflation and/or market adjustments.

c. Not applicable.

49. MMH and RGH have provided OHCA with their annual FY 2015 combined pricemasters, which were most recently updated for the months of June 2015. With respect to this submissions, please answer the following:

a. Will the pricemaster change as a result of the Asset Purchase?

b. If so, please identify any anticipated increases or decreases to the pricemaster as a result of the Asset Purchase.

c. Please quantify the overall percentage increase or decrease in the pricemaster that is anticipated in subsection (b) above and explain the rationale for such change.

Response:

a. No. The pricemaster will not change as a result of the Asset Purchase, but PMH will conduct periodic reviews of the pricemaster.

b. Not applicable.

c. Not applicable.

50. **Please provide monthly financial statistics reports for the months of April, May and June for FY 2015, current month and year to date, and comparable period for FY 2014 to OHCA, for MMH and RGH, ECHN, and PMH with the Application and thereafter on a monthly basis for both month (formatted side by side), until a public hearing in this matter is held. The following financial measurements/indicators should be addressed in the reports:**

Monthly Financial Measurements/Indicators

A. Operating Performance
- **Operating Margin**
- **Non-Operating Margin**
- **Total Margin**
- **Bad Debt as % Gross Revenue**

B. Liquidity
- **Current Ratio**
- **Days Cash on Hand**
- **Days in Net Accounts Receivables**
- **Average Payment Period**

C. Leverage and Capital Structure
- **a. Long-term Debt to Equity**
- **Long-term Debt to Capitalization**
- **Unrestricted Cash to Debt**
- **Times Interest Earned Ratio**

Debt Service Coverage Ratio
Equity Financing Ratio

D. Additional Statistics
Income from Operations
Revenue Over/(Under) Expense
EBITDA
Cash from Operations
Cash and Cash Equivalents
Net Working Capital
Unrestricted Assets
Credit Ratings (S&P, FITCH, and Moody's)

Response:

Exhibit Q50-1 contains the monthly OHCA financial statistics reports for April, May and June of FY 2015 showing the current month and year- to- date, and the comparable period for FY 2014, for MMH, RGH, and ECHN. FY 2014 financial statistics for the entity which will acquire ECHN (Prospect ECHN, Inc.) are not available as the entity does not currently exist and will not be formed unless the proposed asset purchase is approved.

51. For each of each of the ECHN Hospitals, provide a copy of the hospital's IRS Form 990 for tax year ending September 30, 2014 and with respect to the amounts listed on both line item within Part 1, Section 7 of Schedule H ("Financial Assistance and Certain Other Community Benefits at Cost"), provide a projected amount for both line item for the first three (3) tax years following the Asset Purchase.

Please note that it is understood that MMH and RGH will not file an IRS Form 990 following the Asset Purchase. This question is directed at determining the amount of programmatic and financial support that the hospitals will continue to provide in these community benefit categories.

In providing this information, please elaborate on the specific activities included and how the projections demonstrate PMH's commitment to maintain and adhere to ECHN's current policies regarding charity care, indigent care, community volunteer services and community outreach services or to adopt other policies that are at least as favorable to the community as ECNH's current policies.

Response:

The IRS Tax Form 990 filed by MMH and RGH for tax year 2014 is included as Exhibit Q51-1 and Exhibit Q51-2. The proposed transaction will result in the transfer of substantial assets to the New Foundation, investment income from which has historically been used, in part, to provide community benefits to the Manchester/Rockville area. As described in the answer to Question 10, the New Foundation will assess community needs and provide grants and resources to organizations, projects, or activities that promote health, including the health of underserved populations and care to populations that are unable to pay. In addition, PMH will continue to provide financial assistance and community benefits to the Manchester/Rockville area. As noted in response to Question 26, PMH will ensure that MMH and RGH each maintains and adheres to ECHN's current policies regarding charity care, indigent care, community volunteer services, and community benefits or adopts other policies that are at least as favorable to the community as ECHN's policies.

See Tables 9 and 10 below for the projected amount for each line item for the first three tax years following the Asset Purchase. The amounts are projected to increase 1% each year and assume no changes in the Medicaid population served or the complement of community benefit programs offered by the hospitals.

Table 9. Schedule H, Part I, Section 7 – Financial Assistance
Manchester Memorial Hospital

		Actual	Projected				
		FY 2014	**FY 2015**	**FY 2016**	**FY 2017** ***Year 1***	**FY 2018** ***Year 2***	**FY 2019** ***Year 3***
a	Financial Assistance at cost	577,404	583,178	589,010	594,900	600,849	606,857
b	Medicaid	8,167,609	8,249,285	8,331,778	8,415,096	8,499,247	8,584,239
c	Costs – other means-tested government programs	-	-	-	-	-	-
d	**Total Financial Assistance**	8,745,013	8,832,463	8,920,788	9,009,996	9,100,096	9,191,097
Other Benefits							
e	Community health improvement services and community benefit operations[(1)]	1,100,122	1,111,123	1,122,234	1,133,457	1,144,791	1,156,239
f	Health professions education	2,328,005	2,351,285	2,374,798	2,398,546	2,422,531	2,446,757
g	Subsidized health services	2,730,647	2,757,953	2,785,533	2,813,388	2,841,522	2,869,937
h	Research	275,691	278,448	281,232	284,045	286,885	289,754
i	Cash and in-kind contributions for community benefit[(1)]	200,698	202,705	204,732	206,779	208,847	210,936
j	**Total Other Benefits**	**6,635,163**	**6,701,515**	**6,768,530**	**6,836,215**	**6,904,577**	**6,973,623**
k	**Total**	**15,380,176**	**15,533,978**	**15,689,318**	**15,846,211**	**16,004,673**	**16,164,720**

(1) Includes estimated amounts for PMH and the New Foundation

Table 10. Schedule H, Part I, Section 7 – Financial Assistance
Rockville General Hospital

		Actual	Projected				
		FY 2014	**FY 2015**	**FY 2016**	**FY 2017** ***Year 1***	**FY 2018** ***Year 2***	**FY 2019** ***Year 3***
a	Financial Assistance at cost	333,537	336,872	340,241	343,644	347,080	350,551
b	Medicaid	4,675,911	4,722,670	4,769,897	4,817,596	4,865,772	4,914,429
c	Costs – other means-tested government programs	-	-	-	-	-	-
d	**Total Financial Assistance**	**5,009,448**	**5,059,542**	**5,110,138**	**5,161,239**	**5,212,852**	**5,264,980**
Other Benefits							
e	Community health improvement services and community benefit operations[(1)]	195,777	197,735	199,712	201,709	203,726	205,764
f	Health professions education	340,895	344,304	347,747	351,224	354,737	358,284
g	Subsidized health services	840,690	849,097	857,588	866,164	874,825	883,574
h	Research	13,668	13,805	13,943	14,082	14,223	14,365
i	Cash and in-kind contributions for community benefit[(1)]	23,874	24,113	24,354	24,597	24,843	25,092
j	**Total Other Benefits**	**1,414,904**	**1,429,053**	**1,443,344**	**1,457,777**	**1,472,355**	**1,487,078**
k	**Total**	**6,424,352**	**6,488,596**	**6,553,481**	**6,619,016**	**6,685,206**	**6,752,059**

(1) Includes estimated amounts for PMH and the New Foundation

In addition to the above, PMH will pay sales and property taxes which will benefit the State and the local communities (note, however, that PMH and ECHN will seek abatement from sales and property taxes for a transition period after closing and such abatement is deemed critical to the overall success of the proposed transaction) . The description below identifies each category noted above and how the 2014 figures were calculated.

Manchester Memorial Hospital

- Financial Assistance - $577,404 – This relates to cost of charges written off as a result of the Hospital's Charity Care policies. A cost to charge ratio was applied to the gross charges written off to determine the cost of the charity care.
- Medicaid - $8,167,609 – This relates to the Medicaid Shortfall when comparing Medicaid payments to costs. The Hospital multiplied Medicaid gross charges by a cost to charge ratio to determine cost, then compared to related payments received. We also factored in the Hospital Tax and supplemental DSH payments when calculating the Medicaid Shortfall (the above Schedule H does not include the effect of recently announced increases in the Hospital Tax).
- Community Health Improvement Services and Community Benefit Operations - $1,100,122 – These benefits relate to Community Health Education ($472,215), Community Based Clinical Services ($27,678), Health Care Support Services ($412,862), Community Benefit Operations ($187,367) including dedicated staff, and community health needs assessment costs. The related actual costs of these services, including

staff time, supplies, purchased services and other direct expenses, were compiled to determine the amount of benefit.

- Health Professions Education - $2,328,005 – These benefits relate to Physicians/Medical Students, including the Residency Program ($1,571,670), Nursing/Nursing Student Education ($683,014), and Other Health Professional Education ($73,321). The expenses were calculated using actual expenses for the related education.
- Subsidized Health Services - $2,730,647 – These benefits relate to Neonatal Intensive Care ($1,590,000), Diabetes Self-Management ($189,000), Dialysis ($86,000), Lifeline ($52,647), and the Behavioral Health Clinic ($813,000). The expenses were determined by our cost accounting related to the service line. Medicaid Shortfall was excluded so as not to double count the community benefit.
- Research - $275,691 – This benefit relates to expenditures related to the Cancer Registry ($244,839) and Institutional Review Committee ($30,852). The amounts were calculated using actual expenses, including staff time, supplies, purchased services and other direct expenses.
- Cash and In-Kind Contributions - $200,698 – These benefits relate to the donations of cash ($23,351), Grants ($58,448) and In-Kind Donations ($118,899). The amounts were calculated using actual donations and calculations of people's time associated with the related community benefit.

Rockville General Hospital

- Financial Assistance - $333,537 – This relates to cost of charges written off as a result of the Hospital's Charity Care policies. A cost to charge ratio was applied to the gross charges written off to determine the cost of the charity care.
- Medicaid - $4,675,911 – This relates to the Medicaid Shortfall when comparing Medicaid payments to costs. The Hospital multiplied Medicaid gross charges by a cost to charge ratio to determine cost, then compared to related payments received. We also factored in the Hospital Tax and supplemental DSH payments when calculating the Medicaid Shortfall (the above Schedule H does not include the effect of recently announced increases in the Hospital Tax).
- Community Health Improvement Services and Community Benefit Operations - $195,777 – These benefits relate to Community Health Education ($86,637), Community Based Clinical Services ($287), Health Care Support Services ($47,369), Community Benefit Operations ($61,484) including dedicated staff, and community health needs assessment costs. The related actual costs of these services, including staff time, supplies, purchased services and other direct expenses, were compiled to determine the amount of benefit.
- Health Professions Education - $340,895 – These benefits relate to Physicians/Medical Students, including the Residency Program ($21,632), Nursing/Nursing Student Education ($244,847), and Other Health Professional Education ($74,416). The expenses were calculated using actual expenses for the related education.
- Subsidized Health Services - $840,690 – These benefits relate to Women and Children's Services ($618,825), Dialysis ($33,008), Lifeline ($16,819), HIV Care ($39,388) and Behavioral Health ($132,650). The expenses were determined by our cost accounting

related to the service line. Medicaid Shortfall was excluded so as not to double count the community benefit.

- Research - $13,668 – This benefit relates to expenditures related to the Institutional Review Committee. The amounts were calculated using actual expenses, including staff time, supplies, purchased services and other direct expenses.
- Cash and In-Kind Contributions - $23,874 – These benefits relate to the donations of cash ($9,346) and In-Kind Donations ($14,528). The amounts were calculated using actual donations and calculations of people's time associated with the related community benefit.

52. For each of the ECHN Hospitals, with respect to the amounts listed on each line item within Part II of Schedule H of the Hospital's IRS Form 990 for tax year ending September 30, 2014 ("Community Building Activities"), provide a projected amount for each line item for the first three (3) tax years following the Asset Purchase.

Please note that it is understood that MMH and RGH will not file an IRS Form 990 following the Asset Purchase. This question is directed at determining the amount of programmatic and financial support that the hospitals will continue to provide in these community building activity categories.

In providing this information, please elaborate on the specific activities included and how the projections demonstrate PMH's commitment to maintain and adhere to ECHN's current policies regarding charity care, indigent care, community volunteer services and community outreach services or to adopt other policies that are at least as favorable to the community as ECHN's current policies.

Response:

PMH will continue to provide financial support for community building activities in the Manchester/Rockville area. As noted in response to Question 26, PMH will ensure that MMH and RGH each maintains and adheres to ECHN's current policies regarding charity care and indigent care, or adopts other policies that are at least as favorable to the community as ECHN's current policies.

See Tables 11 and 12 below for the projected amount for each line item for the first three tax years following the Asset Purchase. Similar to the amounts projected in the response to Question 51, the spending for Community Building Activities is projected to increase 1% each year and assumes no change in the Medicaid population served or the complement of community benefit programs offered by the hospitals.

Table 11. Schedule H, Part II – Community Building Activities
Manchester Memorial Hospital

		Actual	Projected				
		FY 2014	FY 2015	FY 2016	FY 2017 *Year 1*	FY 2018 *Year 2*	FY 2019 *Year 3*
1	Physical Improvements/Housing	-	-	-	-	-	-
2	Economic Development	1,543	1,558	1,574	1,590	1,606	1,622
3	Community Support	140,797	142,205	143,627	145,063	146,514	147,979
4	Environmental Improvements	-	-	-	-	-	-
5	Leadership Dev/Training for Community Members	-	-	-	-	-	-
6	Coalition Building	20,884	21,093	21,304	21,517	21,732	21,949
7	Community Health Improvement Advocacy	5,472	5,527	5,582	5,638	5,694	5,751
8	Workforce Development	124,710	125,957	127,217	128,489	129,774	131,071
9	Other	-	-	-	-	-	-
10	**Total**	**293,406**	**296,340**	**299,303**	**302,296**	**305,319**	**308,373**

Table 12. Schedule H, Part II – Community Building Activities
Rockville General Hospital

		Actual	Projected				
		FY 2014	FY 2015	FY 2016	FY 2017 *Year 1*	FY 2018 *Year 2*	FY 2019 *Year 3*
1	Physical Improvements/Housing	-	-	-	-	-	-
2	Economic Development	706	713	720	727	735	742
3	Community Support	11,438	11,552	11,668	11,785	11,902	12,021
4	Environmental Improvements	-	-	-	-	-	-
5	Leadership Dev/Training for Community Members	-	-	-	-	-	-
6	Coalition Building	4,070	4,111	4,152	4,193	4,235	4,278
7	Community Health Improvement Advocacy	2,376	2,400	2,424	2,448	2,472	2,497
8	Workforce Development	480	485	490	495	499	504
9	Other	-	-	-	-	-	-
10	**Total**	19,070	19,261	19,453	19,648	19,844	20,043

With respect to Schedule H, Part II, the specific activities and the amount of spending allocated to each activity for both MMH and RGH, as reported on the 2013 Form 990 (for FY 2014 which began on October 1, 2013) has been included as Exhibit Q52-1.

ECHN's community benefit activities are established and coordinated at a system level, but must be reported separately for each hospital on Schedule H. Salary expense and other expenditures associated with the identified Community Building Activities are allocated to either MMH or RGH based on the internal cost center where the expense was incurred. For example, the Family Development Center and behavioral health services are MMH cost

centers, so all of the community benefit activity associated with these two areas can only be allocated to MMH. Spending tied to an ECHN cost center, such as those associated with senior leadership or corporate departments (i.e. Marketing and Communications) are allocated to both hospitals, with 70% of the spending credited to MMH and the remaining 30% allocated to RGH.

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

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

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

The projected spending for the Community Building Activities assumes that the same types of activities and services that were provided in FY 2014 will continue to be offered by PMH through FY 2019 and beyond if the proposed Asset Purchase is approved.

53. Please discuss whether the Asset Purchase is expected to achieve an improved negotiating position with vendors and/or payers and, if such an improved negotiating position is anticipated, how it will translate into tangible savings for the consumer of health care services. Provide a response that both describes any anticipated improvements in detail and quantifies the expected results for the consumer.

Response:

As noted in Applicants' response to Question 26, a primary objective of the transaction is to allow for a coordinated approach to care. When care is coordinated among the hospitals in Manchester and Rockville and community physicians and other providers, the patient population will benefit not only from the perspective of better care and better outcomes, but also from a cost perspective.

PMH expects its approach to population management services to harness the efficiencies of facilities to enhance care at lower costs. It is anticipated that these cost savings will be

passed on to consumers. Moreover, PMH expects that the transactions will allow ECHN to offer plans in which ECHN assumes financial risk which, with the support of PMH, ECHN will be in an improved position to assume.

The Applicants expect that for all of the reasons noted above and in response to Question 20, the transaction will benefit consumers from a financial standpoint, as ECHN will have a lower cost structure and superior, cost-competitive products than it otherwise would be in a position to offer.

54. Provide details of plans to be put in place to ensure the proposed health care services provided by the Applicants adhere to the National Standards on Culturally and Linguistically Appropriate Services (CLAS) to advance health equity, improve quality and help eliminate health care disparities in the projected service area. (For more details on CLAS standards see http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53

Response:

ECHN offers a number of programs addressing the National Standards on Culturally and Linguistically Appropriate Services (CLAS) and ensuring compliance. These programs will be maintained by PMH. Specifically, ECHN offers language assistive services which can be accessed by any hospital employee when needed for interacting with a patient or family. PMH's will maintain ECHN's AT&T Language Line which provides quick access to a large variety of languages over the telephone. In addition, PMH will maintain the existing resources for accessing in-person interpreters for hearing impaired patients or family members. One such resource is Family Services of Woodfield who will provide an interpreter within 15 minutes of a request. ECHN offers Assistive Listening Devices and TTY/TDD equipment, which PMH will continue to provide. In addition there are Deaf and Hearing Impaired liaisons located at both hospital campuses.

iTi is a local company in Manchester that provides document translation services. This resource, which is utilized as needed to prepare patient information and education materials as well as translate medical records that may be written in a foreign language, will be maintained by PMH.

ECHN's commitment to enhancing cultural awareness and embracing diversity is evident through several employee education initiatives including:

- Diversity training during new employee orientation – General information about culture, belief systems, and cultural responsiveness is provided along with a case study for discussion.

- Annual staff education is provided to review services and equipment available for Deaf and Hearing Impaired patients and families.

These services will continue to be provided by PMH and adjusted as patient need necessitates.

55. **What criteria will PMH use to offer current employees employment post transaction or in any new entities that may be formed as a result of this proposal? For those employees that will be employed post transaction by the Applicants, what is the projected difference in salary for current employees and similarly situated employees at other hospitals operated by PMH in similar markets?**

Response:

PMH or an affiliate will offer employment to substantially all active employees in good standing as of the closing date, subject to the satisfactory completion of PMH's usual and customary hiring practices, in positions and at salaries at least equal to those then being provided by ECHN and with employee benefits substantially similar to employee benefit plans that are comparable to those offered to similarly situated employees at other hospitals operated by PMH in similar markets.

56. Please provide information regarding whether any health care providers or insurers have an ownership interest in PMH.

Response:

PMH shareholders include Jeereddi Prasad, M.D., and Sudathi Jeereddi, M.D., each of whom is a California-licensed physician.

57. Please provide information on the relationship, if any, PMH's existing medical group segment will have to this proposal.

Response:

PMH's existing medical group affiliates do not have operations in Connecticut and will not participate in post-closing arrangements related to the proposed Asset Purchase. Post-closing, however, it is anticipated that Provider Group CT – ECHN, LLC and Prospect Medical Systems, Inc., PMH's CRC subsidiary, will play a significant role in the development, implementation and management of physician-hospital alignment strategies, e.g., through CRC, and will share leadership, best practices, experience and knowledge.

58. Please identify PMH's five (5) most recent acute care hospital acquisitions and, for each acquisition, describe in detail how:

a. the acquisition improved access to care for the hospital's service area;

b. the acquisition improved the quality of health care for the hospital's service area;

c. the acquisition lowered the cost of health care for the hospital's service area; and

d. with respect to subsections (a) through (c) above, please demonstrate these improvements/cost reductions through benchmarks and other data that are commonly used in the hospital industry.

Response:

Please refer to Exhibit Q58-1, which presents detailed information regarding the 2014 acquisitions by PMH of Bellflower Medical Center in Bellflower, California (now known as Los Angeles Community Hospital at Bellflower), Newport Specialty Hospital in Tustin, California (now known as Foothill Regional Medical Center), Roger Williams Medical Center in Providence, Rhode Island, and Our Lady of Fatima Hospital in North Providence, Rhode Island, as well as the 2012 acquisition by PMH of four hospital facilities from Nix Health Care System.

Exhibits

EXHIBIT Q3-1 - LETTER OF INTENT



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

June 25, 2015

VIA EMAIL

Mr. Peter J. Karl, President & CEO
Eastern Connecticut Health Network
71 Haynes Street
Manchester, CT 06040

Re: Eastern Connecticut Health Network

Dear Mr. Karl:

Please accept this Letter of Intent related to a transaction in which Prospect Medical Holdings, Inc. ("Prospect") or a designated subsidiary, would acquire substantially all of the assets of Eastern Connecticut Health Network and its controlled affiliates (collectively "ECHN").

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

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

1. **Assets to be Acquired**. We propose to form one or more new entities to purchase substantially all of the assets of ECHN including all tangible and intangible assets (other than cash) owned or used by ECHN and its affiliates. We contemplate that the assets

would be conveyed and assigned free and clear of all liens, claims, charges or encumbrances, except as related to the assumable loan described in Section 2. Other than as set forth in Section 5 of this Letter of Intent, Prospect will not assume any liabilities except those liabilities specifically agreed to as part of definitive agreements for the transaction.

2. **Purchase Price.** ECHN has an ownership interest in a number of joint ventures (together referred to as "JVs") as reflected on ECHN's corporate organizational chart attached hereto as Exhibit A. Assuming that ECHN is able to transfer all of its ownership interests in the JVs to ECHN upon closing, then the Purchase Price shall be either $105 million or $115 million depending on whether ECHN is successful in obtaining a $45 million assumable loan to refinance approximately $35 million of bonds prior to the closing of the transaction. It is the understanding of the parties that the additional $10 million will be used prior to the closing by ECHN on capital projects. If ECHN is successful in its refinancing efforts, the purchase price shall be $115 million. If ECHN is not successful in refinancing efforts, then the purchase price shall be $105 million.

3. **Assumable Loan.** ECHN shall not obtain the assumable loan described in paragraph 2 without first obtaining the consent of Prospect to the terms of such loan, provided that Prospect will not withhold approval of any loan that is on commercially reasonable terms given ECHN's credit profile with an interest rate that is no greater than the current rate and with no assumption fee.

4. **Joint Ventures.** In the event that ECHN is not able to transfer some or all of ECHN's interests in the JVs prior to the closing because of its inability to obtain all required consents from its joint venture partners, then the purchase price shall be reduced by an amount equal to the EBITDA for fiscal year 9/30/2014 allocable to the JV interests not transferred at closing multiplied by six (as reflected in a schedule previously exchanged by the parties); provided however, that the assigned value for ECHN's interest in the "Metro Wheelchair Service, Inc." joint venture shall be $175,000. The parties agree that the maximum deduction from the purchase price for failure of JV interests to transfer is $22 million. Furthermore, in the event that ECHN is not able to transfer some or all of ECHN's interests in the JVs prior to the closing, Prospect shall lend ECHN, pursuant to a promissory note bearing interest at 3% per annum payable from and secured by future distributions from the JVs and further secured by ECHN's interests in such JVs (to the extent the grant of such security interest is permissible under Connecticut law and the JV agreements), in an amount equal to the deduction made from the purchase price due to the fact that such JV interest(s) are not transferred at closing. ECHN shall not sell its JV interests to any third party without Prospect's written consent (except as required under a JV agreement and necessary to meet a closing condition of this transaction that has not been waived by Prospect). As JV interests are transferred to Prospect following the closing, the principal amount of the promissory note shall be reduced by the portion of the note that was allocable to the transferred JV interest(s). For avoidance of doubt, the provisions of this paragraph shall not be construed as an offer to separately purchase ECHN's JV interests.

5. **Assumption of Liabilities.** Prospect is expected to assume either (i) up to $122 million of ECHN's liabilities if the purchase price is $115 million (*i.e.*, the refinancing has occurred ("Plan A")), or (ii) up to $77 million if the purchase price is $105 million (*i.e.*, the refinancing has not occurred ("Plan B")). The liabilities to be assumed by Prospect (the "Threshold Liabilities") are expected to be in the following categories: (i) accrued pension and other post-retirement benefits, (ii) net liabilities associated with ECHN's captive insurance company and workers' compensation program, including all tail liability associated with ECHN's captive insurance company regardless of when any claims arose; (iii) capital lease obligations; (iv) assumable taxable debt arising out of ECHN's efforts to re-finance $35 million of its tax exempt bonds after the execution of this letter of intent; (v) such other liabilities as agreed upon in the transaction documents. The assumption of liabilities shall reduce the cash purchase price on a dollar-for-dollar basis. If at time of the closing of the transaction, ECHN has more than $122 million (Plan A) or $77 million of liabilities other than long-term debt (Plan B), as the case may be, then Prospect shall assume such excess liabilities; provided however, that ECHN shall reimburse Prospect dollar for dollar for the assumption of such liabilities from its "Available Cash" to the extent that ECHN's Available Cash is greater than $1 million. For the purposes of the LOI, "Available Cash" means all unrestricted cash of ECHN on a consolidated basis after the payment of third party liabilities and any adjustments specified in the Asset Purchase Agreement referenced in paragraph 14, less the amount of the indemnity reserves. Once ECHN's Available Cash balance has been reduced to $1 million under the foregoing calculation and there are still additional liabilities to be assumed, then Prospect shall be entitled to retain the corresponding amount of the indemnity reserve that would have been refunded to ECHN if such reserve were not fully expended, on a dollar-to-dollar basis up to $4.5 million. If the indemnity reserve has been exhausted and there are still additional liabilities to assume, then Prospect shall assume up to $10 million of such liabilities without any further reimbursement; provided however, that the capital commitment set forth in paragraph 7 shall be reduced by an amount equal to the assumption of such liabilities. Prospect shall not be required (although it might choose to) assume liabilities in excess of $10 million without reimbursement ("Assumed Excess Liabilities"); provided however, that in the event that Prospect assumes such liabilities without reimbursement, then Prospect's capital commitments pursuant to paragraph 8 of this letter of intent shall be reduced by an amount equal to the amount of the Assumed Excess Liabilities.

6. **Taxable Bank Refinancing.** Prospect acknowledges that ECHN is pursuing a taxable bank financing to refinance approximately $35 million of existing debt and provide approximately $10 million of new capital to fund improvements in its OB and Behavioral Health facilities. To the extent that the additional funds from the refinancing are spent on the capital projects described above prior to the closing, Prospect's future capital commitment, pursuant to paragraph 8, shall be reduced by the same amount - ten million dollars ($10,000,000). If less than $10 million is spent on capital projects as described above prior to the closing, then Prospect shall receive cash in an amount equal to $10 million less the amount spent on the capital projects at the time of the close and Prospect's future capital commitment pursuant to paragraph 8 shall be reduced by the amount actually spent on capital projects prior to the closing.

7. **Indemnity Reserve.** The indemnity reserve holdback under the definitive transaction documents shall be $4.5 million.

8. **Capital Commitment**. Prospect commits to spend at least $75 million over 5 years on capital projects including routine and non-routine capital expenditures for the benefit of the facilities and operations of ECHN. The amount of the capital commitment may be reduced as described in paragraphs 5 and 6 of this letter of intent.

9. **Consulting Agreement**. Subject to compliance with applicable laws, immediately after the execution of this letter of intent, the parties shall negotiate a consulting agreement pursuant to which Prospect would provide operational support to ECHN's leadership. The agreement shall not be executed or take effect until 30 days after the parties make any required filing pursuant to the Hart-Scott-Rodino Act with respect to the transaction contemplated hereunder. The consulting fee payable to Prospect shall be equal to 2% of Net Patient Revenue per month. ECHN agrees to reasonably consent to make recommended operational changes. The consulting fees payable to Prospect would be deferred and would only be payable to Prospect if the transaction fails to close as a result of a breach of the transaction documents where such breach is willful and intentional by ECHN and based on factors within ECHN's control.

10. **Implementation of CRC Strategy.** Subject to the approval of the board of directors of Eastern Connecticut Physician Hospital Organization, ("ECPHO"), ECPHO and Clinically Integrated Network of Eastern Connecticut ("CINECT") will enter into a 5-year management agreement with Coordinated Regional Care Group, Inc. (a subsidiary of Prospect) to manage the affairs of CINECT and ECPHO and to implement Prospect's CRC strategy.

11. **Commitment to Maintain Hospitals and Post-Acute Care Service Lines.** Prospect agrees that for at least three years following the closing of the transaction contemplated herein, it will (i) continuing operating The Manchester Memorial Hospital and The Rockville General Hospital, Incorporated (the "Hospitals") in their current locations as acute care hospitals with emergency departments, and (ii) maintain an ownership interest in Seller's current post-acute care continuum of care network (e.g., VNA/home care, sub-acute and long-term lines of service) and require any joint venture involving such post-acute care continuum of care network to maintain the applicable service line for such three-year period. During such periods that Prospect operates the Hospitals, Prospect agrees to maintain ECHN's commitment to quality, safety, and patient satisfaction, including maintaining appropriate enrollment, certifications, and accreditations necessary to receive reimbursement under Government Payment Programs.

12. **Timing of Regulatory Approval Filings.** Prospect agrees that it shall make the necessary filings for regulatory approval in connection with the transaction contemplated hereunder before making regulatory filings for any other transaction that Prospect is currently negotiating with any another health care organization in the State of Connecticut.

13. **Commitment to Local Advisory Board.** Prospect agrees that a local advisory board led by local community leaders and physicians will be formed with oversight responsibility over quality in the facilities located in ECHN's service area.

14. **Asset Purchase Agreement.** The parties agree to use the Asset Purchase Agreement ("APA") dated as of June 23, 2015 attached hereto as Exhibit B as a basis to negotiate the final terms of the transactions contemplated by this letter of intent. The parties acknowledge and understand that the attached APA must be modified to reflect the terms and conditions described in this letter of intent and to address issues that may arise during the confirmatory due diligence process.

15. **Break-up Fee.** This provision does not take effect unless and until the Certificate of Need ("CON") has been filed. Upon the filing of the CON application with the State of Connecticut, ECHN shall present its invoices for out-of-pocket legal, valuation and consulting expenses incurred by ECHN after the execution of this Letter of Intent up to the time of the filing of the CON application ("CON Preparation Period"). Within 10 days of receipt of such invoices, Prospect shall reimburse ECHN for such out-of-pocket legal, valuation and consulting expenses up to $1 million. If, however, the out-of-pocket legal expenses incurred by ECHN during the CON Preparation Period total less than $1 million, then ECHN may present Prospect with additional invoices for out-of-pocket legal, valuation and consulting expenses incurred by ECHN after the filing of the CON but prior to the closing of the transaction; provided, however, that the total amount of the out-of-pocket legal invoices during the CON Preparation Period and thereafter shall not in the aggregate exceed $1 million. In the event that the transaction closes, the total amount paid by Prospect pursuant to this paragraph 15 shall be credited against the cash purchase price. In the event that the transaction does not close because of (i) a breach by Prospect or (ii) Prospect does not accept the conditions finally issued by the Connecticut Attorney General or by the Connecticut Office of Health Care Access, then ECHN shall be entitled to retain the amount received pursuant to this paragraph 15. In the event that the transaction does not close as a result of (i) a breach by ECHN of the provisions of section 5.23 of the attached APA (as if that document were in effect) where such breach is willful and intentional by ECHN; or (ii) the failure of any material regulatory approval to issue despite the good faith efforts of the parties to cooperate with each other and regulators as part of the regulatory process, then ECHN shall refund to Prospect all amounts paid to ECHN under this paragraph 15.

16. **Conditions to Transaction.** The transaction documents (other than the APA, which has already been negotiated subject to paragraph 14), would include customary legal and business provisions mutually agreed upon by the parties. In addition to any other requirement set forth in this Letter of Intent, the consummation of the proposed transaction shall be subject to and contingent upon each of the following being satisfied at closing:

    a. The negotiation and delivery of mutually satisfactory transaction documents;

b. Completion and satisfaction of the results of due diligence by Prospect, in its sole and absolute discretion;
c. The approval of the transaction by Prospect's board of directors, in its sole and absolute discretion; and
d. Receipt of any necessary governmental consents or approvals that are acceptable to Prospect.

17. **Exclusive Negotiations**. ECHN and Prospect shall enter into exclusive negotiations regarding the proposed transaction. During the Exclusivity Period (as defined below), neither, ECHN nor any of its respective representatives, directly or indirectly, shall: (i) offer any of the assets described in this Letter of Intent for sale, lease or other disposition to any person or entity other than Prospect; (ii) merge, or conduct a business combination of any sort involving ECHN or any of its affiliates with any other person or entity except that any ECHN affiliate may merge with any other affiliate or transfer all or substantially all of its assets to another ECHN affiliate in connection with the proposed transaction; (iii) transfer the membership, control, or any ownership interest in ECHN or any of its affiliates (including the JV interests) to any other person or entity except as required under a JV agreement and necessary to meet a closing condition of this transaction that has not been waived by Prospect; (iv) enter into a partnership or any other joint venture involving ECHN or any of its affiliates; (v) enter into any agreement with any person or entity other than Prospect with respect to any of the matters set forth in *(i)* through *(iv)* above; (vi) solicit, encourage (by way of furnishing non-public information or otherwise), negotiate, hold discussions regarding, entertain, accept, or take any other actions to facilitate, any offers regarding any of the matters or actions set forth in *(i)* through *(v)* above. The "Exclusivity Period" shall be the period beginning on the date that this Letter of Intent is signed by ECHN (the "Execution Date") and ending at 5:00 P.M. Eastern Time ninety (90) days after the Execution Date (the "Expiration Date").

18. **Announcement of Selection of Bidder**. The parties shall work together to determine a method to announce publicly the transaction contemplated herein.

19. **Change in Control.** If Prospect undergoes a Change in Control prior to the closing of the transaction identified herein, Prospect shall (i) provide 30 days' advance notice to ECHN of such Change in Control, and (ii) ECHN shall have the right to terminate this Letter of Intent and the APA without penalty, including that ECHN shall not be required to pay the consulting fee identified in paragraph 9 above. For purposes of this paragraph 19, the term "Change in Control" means (i) a sale of all or substantially all the assets of Prospect, (ii) any merger, consolidation or acquisition of Prospect by or into another corporation, entity or person, or (iii) any change in the direct or indirect ownership of more than fifty percent (50%) of the voting capital stock of Prospect in one or more related transactions. Notwithstanding the forgoing, a Change in Control shall not include a transfer of 50% or more of the shares of Prospect in connection with one or more public offerings of its shares. A transfer of 50% or more of the shares of Prospect in connection with one or more transactions involving the sale of Prospect shares to one or more private equity firms shall require the consent of ECHN, which consent shall not unreasonably be withheld.

20. **Expenses**. Subject to paragraph 15, above, the parties acknowledge and agree that each party shall be responsible for its own expenses in connection with its individual assessment as to whether to proceed with the proposed transaction. Accordingly, each party shall pay for its own fees and expenses and those of its respective agents, representatives and advisors, including but not limited to all attorneys and accountants with respect to the negotiations of this Letter of Intent, the negotiation of the transaction documents, and if the transaction documents are executed, the closing the transaction and any other transactions contemplated by the transaction documents.

21. **Entire Agreement; Future Modifications**. Except for the Mutual Nondisclosure Agreement dated as of February 19, 2015 (the "Confidentiality Agreement"), this Letter of Intent constitutes the full and complete agreement and understanding between the parties hereto concerning the subject matter hereof and supersedes any prior written and oral agreements with regard to such subject matter. This Letter of Intent may be modified or waived only by a separate written agreement signed by the parties hereto.

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

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

24. **Paragraph Headings**. The headings of the paragraphs in this Letter of Intent are provided for convenience only and shall not affect its construction or interpretation.

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

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

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

If to ECHN:

Mr. Peter J. Karl, President & CEO
Eastern Connecticut Health Network
71 Haynes Street
Manchester, CT 06040

With a simultaneous copy to:

Ms. Joyce Tichy, Senior Vice President & General Counsel
Eastern Connecticut Health Network
71 Haynes Street
Manchester, CT 06040

If to Prospect:

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

With a simultaneous copy to counsel for Prospect:

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

28. **Due Diligence, Access to Information, Access to Facilities.** Prospect has conducted an initial review and examination of certain data and information with respect to ECHN and its affiliates. The parties agree and acknowledge that Prospect requires further due diligence review and requires access to additional information and ECHN's facilities

above and beyond that which has been provided to Prospect prior to the execution of this Letter of Intent. During the Exclusivity Period, ECHN and its affiliates will provide Prospect with reasonable access to (i) information and materials related to ECHN, its affiliates and their respective related assets as requested by Prospect from time to time, and (ii) all real property, facilities and equipment that are part of the proposed transaction.

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

30. **Ordinary Course**. Until the earlier of the closing of the proposed transaction or termination of this Letter of Intent, ECHN and its affiliates shall conduct business in the ordinary course of business and shall not sell or dispose of any asset other than in ordinary course except as permitted under paragraph 17.

31. **Term**. The term of this Letter of Intent shall commence as of the Execution Date and shall continue in effect during the Exclusivity Period unless extended by mutual agreement of the parties.

32. **Binding Provisions**. The obligations of ECHN and Prospect under paragraphs 14 through 33 (collectively, the "Binding Provisions"), shall be binding on both parties to this Letter of Intent. All other provisions shall be non-binding on the parties.

33. **Non-Binding With Respect to Consummation of Proposed Transaction**. This Letter of Intent represents an expression of intent only with respect to the consummation of the proposed transaction. Accordingly, unless and until the transaction documents are executed and all other conditions to closing have been satisfied or waived, no party shall be obligated to consummate the proposed transaction. As a result, in the absence of the transaction documents or any other definitive agreements between the parties with respect to the proposed transaction, and subject to the Binding Provisions, none of the expiration or earlier termination of the Exclusivity Period, the failure by either party to agree to extend the Exclusivity Period or the failure by either party to agree to the transaction documents shall, in and of itself, give rise to any legally enforceable right or claim for damages or injunctive relief or any other form of judicially recognized award or right with respect to the proposed transaction or the consummation thereof. No past or future action, course of conduct, or failure to act relating to the proposed transaction, or relating to the negotiations of the terms of the transaction documents, will give rise to or serve as a basis for any obligation or other liability on the part of any party. The parties acknowledge and agree that this Letter of Intent is an expression made in good faith by Prospect regarding Prospect's intentions. The omission of certain terms from this Letter of Intent shall not be construed so as to diminish the importance or the materiality of such term, and the parties acknowledge that, in addition to the proposed terms contained in this Letter of Intent, additional terms may remain to be resolved in further negotiations. It shall remain in the sole and absolute discretion of each party whether or not to enter into any definitive agreements or transactions with the other party, or parties, and no party

shall have any liability or obligation for failing to do so except as expressly provided in this Letter of Intent.

If this Letter of Intent is acceptable to ECHN, we ask that ECHN please sign and date this Letter of Intent where indicated below. Please return an originally signed and completed copy of this Letter of Intent to me. This Letter of Intent shall be effective as of the date set forth next to your signature but shall have no force or effect if not executed and returned to Prospect prior to 5:00 p.m. Eastern Standard Time on June 26, 2015.

We look forward to working with you.

Very truly yours,
PROSPECT MEDICAL HOLDINGS, INC.

Samuel S. Lee
Chief Executive Officer

Accepted and Agreed.

Eastern Connecticut Health Network

By: Peter J. Karl

Name: Peter J. Karl

Title: President & CEO

Dated: 6/25/2015

[EXECUTION COPY]

AMENDMENT NO. 1 TO LETTER OF INTENT

This AMENDMENT NO. 1 TO LETTER OF INTENT (this "Amendment") is made as of the 13th day of October, 2015 by and between Prospect Medical Holdings, Inc., a Delaware corporation ("Prospect"), and Eastern Connecticut Health Network, Inc., a Connecticut non-stock corporation ("ECHN").

WHEREAS, Prospect and ECHN are parties to that certain Letter of Intent dated June 25, 2015 (the "LOI"); and

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

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

1. Paragraph 17 of the LOI is hereby amended such that the Exclusivity Period shall expire at 5:00 p.m. (Eastern Time), on the earlier of (w) the execution by both parties of a definitive purchase agreement with respect to the matters set forth in the LOI, (x) thirty (30) days following the receipt by the parties of the proposed conditions or proposed settlement for certificate of need approval for the Hospitals by the Office of Healthcare Access of the Connecticut Department of Public Health ("OHCA"), (y) either the application for approval of the certificate of need by OHCA or the application for approval of the conversion of the Hospitals to a for-profit entity by the Attorney General of the State of Connecticut is withdrawn, and (z) June 30, 2016 (the "Expiration Date"). Notwithstanding the foregoing, Prospect shall have the right (an "Extension Right"), exercisable upon prior written notice to ECHN and with the consent of ECHN, such consent to not be unreasonably withheld, to extend the Expiration Date by up to an additional thirty (30) days, if the foregoing regulatory approvals have not been received on or prior to thirty (30) days prior to the Expiration Date, in a form that Prospect has determined in good faith is on terms reasonably satisfactory to Prospect, and such failure to receive such approvals in satisfactory form is for reasons beyond the reasonable control of Prospect and without any fault on the part of Prospect. Prospect will have the right to exercise up to an aggregate of three (3) Extension Rights if the foregoing conditions to such exercise (including such consent of ECHN) are satisfied. The ECHN Board of Trustees shall be entitled to deny (i.e. withhold the required consent of ECHN) an Extension Right if it makes a good faith determination that the transaction is unlikely to close in the 90-Day period following June 30, 2016.

2. Paragraph 32 of the LOI shall be deleted in its entirety and replaced with the following:

"32. **Binding Provisions**. The obligations of ECHN and Prospect under Paragraph 14 through Paragraph 34 (collectively, the "Binding Provisions"), shall be binding on both parties to this Letter of Intent. All other provisions shall be non-binding on the parties."

3. The first sentence of Paragraph 33 of the LOI shall be deleted in its entirety and replaced with the following:

"33. **Non-Binding With Respect to Consummation of Proposed Transaction.** Except as otherwise set forth in this Letter of Intent, and subject to the Binding Provisions, this Letter of Intent represents an expression of intent only with respect to the consummation of the proposed transaction."

The remainder of Paragraph 33 shall remain in full force and effect.

4. A new Paragraph 34 of the LOI is hereby added immediately following Paragraph 33 of the LOI, as follows:

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

5. A new Paragraph 35 of the LOI is hereby added immediately following Paragraph 34 of the LOI, as follows:

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

6. Thirty (30) days following the filing for approval of governmental authorities under the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended, the parties hereto shall enter into an Interim Consulting Agreement.

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

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

[signature page follows]

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

PROSPECT MEDICAL HOLDINGS, INC.

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

EASTERN CONNECTICUT HEALTH NETWORK, INC.

By: _____
Name:
Title: Peter J. Karl
President & CEO

[Signature Page to Amendment No. 1 to Letter of Intent]

EXHIBIT Q3-2 - ASSET PURCHASE AGREEMENT

ASSET PURCHASE AGREEMENT

by and between

EASTERN CONNECTICUT HEALTH NETWORK, INC.

SELLER

and

[●]

BUYER

Dated as of [●], 2015

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ASSET PURCHASE AGREEMENT

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

RECITALS:

WHEREAS, Seller desires to sell substantially all of its assets, real, personal and mixed, tangible and intangible, and operations to Buyer, including the properties, assets, and businesses of The Manchester Memorial Hospital and The Rockville General Hospital, Incorporated (collectively, the "**Hospitals**"), ECHN Eldercare Services, Inc., Visiting Nurse and Health Services of Connecticut, Inc. including its wholly owned subsidiary A Caring Hand, LLC, Clinically Integrated Network of Eastern Connecticut, LLC, Connecticut Healthcare Insurance Company, Inc., ECHN Corporate Services, Inc. including its wholly owned subsidiary Medical Practice Partners, LLC, and ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Eastern Connecticut Medical Professionals Foundation, Inc. (the entities and businesses operated by the foregoing entities, including the Hospitals, are collectively referred to as the "**Hospital Businesses**"), together with Seller's joint venture interests in Northeast Regional Radiation Oncology Network, Inc., Evergreen Endoscopy Center, LLC, WBC Connecticut East, LLC, Aetna Ambulance Service, Inc., Metro Wheelchair Service, Inc., Ambulance Service of Manchester, LLC, Connecticut Occupational Medicine Partners, LLC, and Eastern Connecticut Physician Hospital Organization, Inc. and Seller's Affiliates' joint venture interests in Tolland Imaging Center, LLC, Pathology Laboratory Services, LLC, Haynes Street Medical Associates, LLC, Haynes Street Medical Associates II, LLC, Evergreen Medical Associates, LLC and Evergreen Medical Associates II LLC (the foregoing entities are collectively referred to herein as the "**Joint Ventures**");

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

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

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

AGREEMENT:

1. DEFINITIONS AND REFERENCES

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

(1) **Accounts Receivable** means all accounts receivable of the Hospital Businesses, accrued and unaccrued, including Government Payment Program receivables and accounts that have been written off, but excluding all Cost Report settlement amounts;

(2) **Accumulated Benefit Obligation** means the accumulated benefit obligation of Seller's defined benefit pension plan, determined for purposes of Seller's audited financial statements as of September 30, 2015 using GAAP (i) reflecting the assumptions used for purposes of Note 10 of such financial statements (as updated for the MRP-2007 mortality tables as developed by Mercer, which are derived from the Society of Actuaries mortality study) and (ii) assuming continuation of the Seller's defined benefit pension plan and no change in its provisions after September 30, 2015 (other than the freeze of such plan to new participation);

(3) **Additional Liabilities** is defined in Section 2.05(d);

(4) **Affiliate** means any Person that, directly or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with another Person where "control" means the power to direct or cause the direction of the management and policies of a Person, whether through the ownership of securities, election or appointment of directors, by contract or otherwise. For purposes of this Agreement, any reference to Affiliates of Seller shall only mean those persons listed on Schedule 1.01(3) attached hereto;

(5) **Affiliated Group** means any affiliated group within the meaning of section 1504 of the Code or any similar group defined under a similar provision of state, local or foreign law;

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

(7) **Assets** means all assets, real property, personal and mixed property of every kind, character or description, known or unknown, tangible or intangible, owned or leased by Seller wherever located and whether or not reflected in the Financial Statements or referenced or scheduled herein, (i) including those assets owned by a Subsidiary of Seller and held or used in connection with the operation of the Hospital Businesses, but (ii) excluding the Excluded Assets;

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

(9) **Assumed Excess Liabilities** is defined in Section 2.05(d);

(10) **Assumed Liabilities** means (i) the current liabilities included in Net Working Capital, but only to the extent accrued on the Closing Balance Sheets, (ii) all obligations of Seller and its Affiliates arising under the Assumed Contracts with respect to periods (or portions thereof) following the Closing Date, (iii) all participating provider agreements and provider numbers with third party payors, including contracts and provider numbers of Government Payment Programs, to the extent the same are assignable to Buyer, (iv) the Special Employee Liabilities, (v) the Extended Illness Bank

Obligations, (vi) Permitted Encumbrances, (vii) the Unfunded Pension Liabilities, (viii) the Post-Retiree Health Plan Liability and other retirement obligations described on Schedule 2.03, (ix) the Captive Insurer Liability and (x) the other liabilities and obligations agreed to be assumed by Buyer, if any, described on Schedule 2.03;

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

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

(13) **Available Cash** means all unrestricted cash available to Seller as of the Closing after payment of Third Party Debt, other than the Refinancing Loan or capital leases to be assumed by Buyer, and any adjustments specified in Section 2.05 of this Agreement or any cash resulting from the application of Section 2.07, less the amount of the Indemnity Reserve described in Section 9.08.

(14) **Bond Liabilities** means those certain long-term bond liabilities and tax-exempt leases of Seller to be defeased at Closing;

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

(16) **Buyer Deductible** is defined in Section 9.04;

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

(18) **Buyer's Plan** means a retirement plan □ualified under section 401(a) of the Code that is sponsored by Buyer or one of its controlled group or affiliated service group members, as defined in section 414 of the Code;

(19) **Captive Insurer Liability** means all liabilities relating to Seller□s captive insurer, the Connecticut Health Insurance Company, Inc., regardless of when incurred and including all tail liability. The book value of the Captive Insurer Liability shall be based on the Financial Statements as of September 30, 2015.

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

(21) **Closing** is defined in Section 8.01(a);

(22) **Closing Balance Sheets** means the unaudited individual and/or combined balance sheets of Seller and its Subsidiaries as of the close of business on the Closing Date, as finally determined in accordance with Section 2.05 following the resolution of all disputes with respect thereto;

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

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

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

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

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

(28) **Controlled Group** means with respect to a party, a group consisting of each trade or business (whether or not incorporated) that, together with such party, would be deemed a "*single employer*" within the meaning of section 4001(a) of ERISA;

(29) **Cost Reports** means all cost and other reports filed pursuant to the requirements of the Government Payment Programs for payment or reimbursement of amounts due from them;

(30) **Current Seller Plan** is defined in Section 3.22(a);

(31) **Disability Obligations** mean liabilities for long-term or short-term disability benefits to employees of the Hospital Businesses. The Disability Obligations include liabilities of the Hospital Businesses for long-term or short-term disability benefits that may have commenced being paid prior to Closing and that remain ongoing after the Closing.

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

(33) **Employee Benefit Plan** means, with respect to any Person, (i) each plan, fund, program, agreement, arrangement or scheme, in each case, that is at any time sponsored or maintained, or required to be sponsored or maintained, by such Person or to which such Person makes or has made, or has or has had an obligation to make, contributions providing for employee benefits or for the remuneration, direct or indirect, of the employees, former employees, directors, officers, managers, consultants, independent contractors, contingent workers or leased employees of such Person or the dependents of any of them (whether written or oral), including each deferred compensation, bonus, incentive compensation, pension, retirement, stock purchase, stock option and other equity compensation plan, or "*welfare*" plan (within the meaning of section 3(1) of ERISA, determined without regard to whether such plan is subject to ERISA), (ii) each "*pension*" plan (within the meaning of section 3(2) of ERISA, determined without regard to whether such plan is subject to ERISA), including each Multiemployer Plan, (iii) each severance, retention or change in control plan or agreement, each plan or agreement providing health, vacation or paid time off, summer hours, supplemental unemployment benefit, hospitalization insurance, medical, dental, or legal benefit and (iv) each other employee benefit plan, fund, program, agreement or arrangement, including any of the foregoing that provides cash or non-cash benefits or perquisites to current or former employees of such Person;

(34) **Employee Pension Benefit Plan** is defined in section 3(2) of ERISA;

(35) **Employee Welfare Benefit Plan** is defined in section 3(1) of ERISA;

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

(37) **Environmental Claim** means any written notice (or oral notice reduced to writing by Seller) by a Person alleging potential liability (including potential liability for investigatory costs, cleanup costs, Governmental Authority response costs, natural resource damages, property damages, personal injuries, or penalties) of Seller or any Subsidiary of Seller arising out of, based on or resulting from (i) the presence, or release into the environment, of any Materials of Environmental Concern at any location, whether or not owned by Seller, or (ii) circumstances forming the basis of any violation, or alleged violation, of any Environmental Laws;

(38) **Environmental Laws** means any and all Legal Requirements relating to pollution or protection of human health or the environment (including ground water, land surface or subsurface strata), including Legal Requirements relating to emissions, discharges, releases or threatened releases of Materials of Environmental Concern, or otherwise relating to the manufacture, processing, distribution, use, treatment, storage, disposal, transport, recycling, reporting or handling of Materials of Environmental Concern, including the Comprehensive Environmental Response, Compensation and Liability Act of 1980, as amended, 42 U.S.C. §9601, *et seq.*, the Resource Conservation

and Recovery Act, as amended, 42 U.S.C. §6901, *et seq.*, the Clean Air Act, 42 U.S.C. §7401, *et seq.*, the Federal Water Pollution Control Act, 33 U.S.C. §1251 *et seq.*, the Occupational Safety and Health Act, 29 U.S.C. §600, *et seq.*, and any similar state or local Legal Requirements;

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

(40) **ERISA Fiduciary** is defined in section 3(21) of ERISA;

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

(42) **Excluded Liabilities** means any and all liabilities of Seller other than the Assumed Liabilities, whether known or unknown, fixed or contingent, recorded or unrecorded, and whether arising before or after Closing, including any line of credit to which Seller is a party, the Bond Liabilities, tax-exempt leases, and any other indebtedness of Seller, any interest accrued on indebtedness of Seller, any settlements due as of Closing to third party payors;

(43) **Extended Illness Bank Obligations** means the Hired Employees' accrued or allocated paid time off that is in the form of an "*extended illness bank*" (i.e., paid time off that may be used by a Hired Employee during the term of employment, but the value of the unused portion of which is not paid in cash to the Hired Employee upon termination of employment);

(44) **Financial Statements** means the Audited Financial Statements and the Unaudited Financial Statements;

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

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

(47) **Government Payment Programs** means federal and state Medicare, Medicaid and TRICARE programs, and similar or successor programs with or for the benefit of Governmental Authorities;

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

(49) **Hired Employees** means those employees of Seller or its Affiliates who accept Buyer's offer of employment as of the Closing Date, including those employees who are employed pursuant to an Assumed Contract;

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

(51) **Immaterial Contract** means any Contract to which Seller or any of its Subsidiaries is a party that re□uires either the payment by Seller or its Subsidiaries of □50,000 or less or the provision of goods or the performance of services by Seller or any of its Subsidiaries having an annual value of □50,000 or less, in either case during the period from the date of this Agreement until (i) if the Contract is terminable at any time by Seller or the respective Subsidiary without cause upon notice of 90 days or less, the date on which the Contract would terminate if Seller or the respective Subsidiary was to give notice of termination on the date of this Agreement, or (ii) if the Contract is not terminable at any time by Seller or the respective Subsidiary without cause upon notice of 90 days or less, the expiration of the term of the Contract, *provided* that an Immaterial Contract does not include any Contract described in Sections 3.18(a) through 3.18(m);

(52) **Immediate Family Member** means any individual described in the definition of □*Immediate Family Member*□ found at 42 C.F.R. □411.351;

(53) **Indemnifying Party** means any Person obligated to indemnify another Person under Article 9;

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

(55) **Indemnity Notice** means written notification of a claim for indemnity under Article 9, other than a Third Party Claim, made by an Indemnitee to an Indemnifying Party pursuant to Section 9.05(b);

(56) **Indenture** is defined in Section 6.04;

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

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

hereafter become due or payable with respect to any of the foregoing rights, including damages for past, present or future infringement, misappropriation or unauthorized use thereof;

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

(60) **Investments** means shares of capital stock of any corporation, equity interests in partnerships or limited liability companies, or other equity or debt instruments in any other Person, and proceeds from the sale thereof;

(61) **Local Board** means the advisory board of trustees of each Hospital composed of community representatives, physicians on the respective Hospital's medical staff, and the Chief Executive Officer of each respective Hospital (for avoidance of doubt, each Hospital shall have its own Local Board). The initial members of the Local Board shall include at least five members of the Seller's Board of Trustees immediately prior to Closing and five other individuals identified by the Seller prior to Closing;

(62) **Leased Real Property** means the real property described on Schedule 2.01(b), together with all buildings, improvements and fixtures thereon, leased by Seller or any Subsidiary of Seller;

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

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

(65) **Lower Threshold Liability** is defined in Section 2.05(c);

(66) **Material Adverse Change** means a material adverse change, individually or in the aggregate, of the business, assets, liabilities, financial condition or results of operations of Seller and the Hospital Businesses, which taken as a whole (i) has or could reasonably be expected to have a material adverse effect upon the validity or enforceability of this Agreement or (ii) is or could reasonably be expected to be material and adverse to the Hospital Businesses or the Assets, but excluding the effect of (x) matters described in the Schedules, (y) changes in the economy of the United States in general, and (z) changes in Legal Requirements generally applicable to owners and operators of general acute care hospitals in the United States or in Connecticut if such change does not disproportionately affect Seller or the Hospital Businesses; provided, however, that a change resulting from the downward adjustment to the Medicare wage index or the failure of the Seller to meet its debt service coverage ratio, if waived by applicable lender(s), shall not constitute a Material Adverse Change;

(67) **Materials of Environmental Concern** means chemicals, pollutants, contaminants, wastes (including Medical Waste), toxic substances, petroleum and petroleum products listed or regulated under Environmental Laws, including hazardous wastes under the Resource Conservation and Recovery Act, as amended, 42 U.S.C. §6901, *et seq*., hazardous substances under the Comprehensive Environmental Response, Compensation and Liability Act of 1980, as amended, 42 U.S.C. §9601, *et seq*., asbestos, polychlorinated biphenyls and urea formaldehyde, and low-level nuclear materials, special nuclear materials or nuclear-byproduct materials, all within the meaning of the Atomic Energy Act of 1954, as amended, and any rules, regulations or policies promulgated thereunder;

(68) **Medical Waste** means any substance, pollutant, material or contaminant listed or regulated under any Medical Waste Law that is generated in the diagnosis, treatment or immunization of human beings, in research pertaining thereto, or in the production or testing of biologicals, including (i) pathological waste, (ii) blood, (iii) sharps, (iv) wastes from surgery or autopsy, (v) dialysis waste, including contaminated disposable equipment and supplies, (vi) cultures and stocks of infectious agents and associated biological agents, (vii) isolation wastes, (viii) contaminated equipment, (ix) laboratory waste, and (x) various other biological waste and discarded materials contaminated with or exposed to blood, excretion, or secretions from human beings;

(69) **Medical Waste Law** means the Medical Waste Tracking Act of 1988, 42 U.S.C. §6992, *et seq.*, the U.S. Public Vessel Medical Waste Anti-Dumping Act of 1988, 33 U.S.C. §2501, *et seq.*, the Marine Protection, Research, and Sanctuaries Act of 1972, 33 U.S.C. §1401, *et seq.*, The Occupational Safety and Health Act, 29 U.S.C. §651, *et seq.*, the United States Department of Health and Human Services, National Institute for Occupational Self-Safety and Health Infectious Waste Disposal Guidelines, Publication No. 88-119, and any other federal, state, regional, county, municipal or other Legal Requirements insofar as they purport to regulate Medical Waste, or impose requirements relating to Medical Waste;

(70) **Multiemployer Plan** is defined in section 3(37) of ERISA or section 4001(a)(3) of ERISA;

(71) **Multiple Employer Plan** means an Employee Pension Benefit Plan that is not a Multiemployer Plan and for which a Person who is not a member of a Controlled Group that includes Seller or any Subsidiary is or has been a contributing sponsor;

(72) **Net Working Capital** means the amount by which (i) the value of all non-cash current assets of the Hospital Businesses acquired by Buyer, including inventory and supplies, Accounts Receivable, other receivables, prepaid expenses, and deposits (including security deposits made by Seller pursuant to Assumed Contracts), that Seller and Buyer agree will be usable after Closing, exceeds (ii) the value of all current liabilities assumed by Buyer, including trade accounts payable, accrued expenses (including payroll), advance payments on patient accounts and employee benefit accruals (as such terms are used in the Financial Statements) (for the purpose of clarity, employee benefit accruals include paid time off accruals for vacation and sick time but exclude

Extended Illness Bank Obligations), and Net Working Capital shall be calculated in accordance with the methodology set forth on Annex A;

(73) **Notice Period** is defined in Section 9.05(a)(i);

(74) **Owned Real Property** means real property owned (legally or beneficially) by Seller or any Subsidiary of Seller, including the real property described on Schedule 2.01(a), together with all buildings, improvements and fixtures thereon owned by Seller or any Subsidiary of Seller and all appurtenances and rights thereto;

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

(76) **Permit** means each license, permit, right, franchise, concession, certificate, authorization, consent, certificate of need or other approval of a Governmental Authority owned or held by Seller or relating to the ownership or operations of the Hospital Businesses and the Assets, including applications for, and pending, Permits;

(77) **Permitted Encumbrances** means the Permitted Personal Property Encumbrances and the Permitted Real Property Encumbrances;

(78) **Permitted Personal Property Encumbrances** means those Encumbrances described on Schedule 3.11 as being Permitted Personal Property Encumbrances;

(79) **Permitted Real Property Encumbrances** means those Encumbrances identified on Schedule 3.12(a) as being Permitted Real Property Encumbrances;

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

(81) **Post-Retiree Health Plan Liability** means the book value of the liability relating to Seller's post-retiree health benefit plan, determined for purposes of Seller's audited financial statements as of September 30, 2015 using GAAP (i) reflecting the assumptions used for purposes of Note 10 of such financial statements (as updated for the MRP-2007 mortality tables as developed by Mercer, which are derived from the Society of Actuaries mortality study) and (ii) assuming continuation of the Seller's post-retiree health benefit plan and no change in its provisions after September 30, 2015 (other than the freeze of such plan to new participation);

(82) **Prior Seller Plan** is defined in Section 3.22(b);

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

(84) **Prohibited Transaction** is defined in Section 5.09;

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

(86) **Purchase Price Adjustment** is defined in Section 2.05(i);

(87) **Reportable Event** is defined in section 4043 of ERISA;

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

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

(90) **Seller Deductible** is defined in Section 9.02;

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

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

(93) **Strategic Business Plan** means the strategic plan developed prior to Closing by Buyer, in consultation with Seller, and, with respect to clinical service lines, in consultation with Seller-Affiliated physicians, as the same may be amended from time to time, *provided, however*, that the Strategic Business Plan does not include the strategic capital plan referenced in Section 5.18 herein;

(94) **Subsidiary** means, with respect to any Person, (i) any corporation more than 50% of whose stock of any class or classes having by the terms thereof ordinary voting power to elect a majority of the directors of such corporation (irrespective of whether or not at the time stock of any class or classes of such corporation shall have or might have voting power by reason of the happening of any contingency) is at the time owned by such Person and/or one or more Subsidiaries of such Person, (ii) any partnership, limited liability company, association, joint venture or other entity in which such Person and/or one or more Subsidiaries of such Person has more than a 50% equity interest at the time and the management of which is controlled, directly or indirectly, by such Person or through one or more Subsidiaries of such Person and (iii) any entity that is organized as a not-for-profit business organization and (A) whose accounts are required in accordance with GAAP to be consolidated with the accounts of such Person or (B) whose sole member is such Person;

(95) **Target Net Working Capital** means $24,000,000;

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

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

(98) **Tenant Leases** is defined in Section 3.12(i);

(99) **Third Party Claim** is defined in Section 9.05(a)(i);

(100) **Third Party Debt** means indebtedness of Seller for borrowed money other than the Refinancing Loan and any assumed capital leases. For the avoidance of doubt Third Party Debt shall not include any Assumed Liabilities;

(101) **Transfer Act** means the Connecticut Transfer Act, 22 Conn. Gen. Stat. □134 *et seq.*;

(102) **Transitional Services Agreement** means the agreement between Buyer and Seller whereby Buyer will lease Hired Employees to Seller at cost for the orderly wind down of the benefits and administration of Seller□s other post-Closing obligations (*e.g.*, finali□ing Cost Reports), in substantially the form of Exhibit A attached hereto;

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

(104) **Unfunded Pension Liabilities** means the unfunded pension liabilities of Seller□s defined benefit pension plan, calculated as the Accumulated Benefit Obligation reduced by the fair market value of the assets of Seller□s defined benefit pension plan, all as measured by an actuary chosen by Seller, as of September 30, 2015;

(105) **Upper Threshold Liability** is defined in Section 2.05(c);

(106) **WARN Act** means the Worker Adjustment and Retraining Notification Act, 29 U.S.C. □2101, *et seq*; and

(107) **Workers' Compensation Liability** means all workers compensation liabilities of Seller and its Affiliates, regardless of when incurred and including all tail liability. The book value of the Workers Compensation Liability shall be based on the Financial Statements as of September 30, 2015.

1.02. Certain References. As used in this Agreement:

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

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

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

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

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

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

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

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

(i) references to *Seller's knowledge* mean the actual knowledge of each of the Persons whose names or titles are set forth on Schedule 1.02, after due in uiry by Seller of such Persons;

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

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

2. SALE OF ASSETS AND RELATED MATTERS

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

(a) the Owned Real Property described on Schedule 2.01(a);

(b) the Leased Real Property described on Schedule 2.01(b);

(c) all equipment (including medical and computer equipment located at the Hospital Businesses), vehicles, furniture and furnishings and other tangible personal properties owned or leased by Seller or used in the conduct of the Hospital Businesses; *provided* that any such leased personal property shall be described on Schedule 2.01(c);

(d) all current assets included in Net Working Capital;

(e) all financial, patient, medical staff, personnel and other records of the Hospital Businesses (including equipment records, medical administrative libraries, medical records, documents, catalogs, books, records, files and operating manuals);

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

(g) all Permits of Seller, to the extent legally assignable, relating to the ownership of the Assets and the conduct of the Hospital Businesses, including those described on Schedule 2.01(g);

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

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

(j) the Investment interests in the Joint Ventures, including all transferable rights relating thereto, but only to the extent that the governing instruments of the Joint Ventures permit such transfer;

(k) subject to Section 5.13, all insurance proceeds with respect to the Assets or the Assumed Liabilities (including insurance proceeds received by Seller or payable to Seller and all deductibles, copayments and self-insurance requirements payable by Seller) arising in connection with damage to the Assets occurring on or prior to the Closing Date, to the extent not expended for the repair or restoration of the Assets;

(l) claims of Seller against third parties relating to the Assets or the Assumed Liabilities, choate or inchoate, known or unknown, contingent or otherwise, except for those claims described on Schedule 2.02(p) and any claims relating to Excluded Assets or the Excluded Liabilities;

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

(n) all cash and investments held by Connecticut Health Insurance Company, Inc. or held in the workers compensation trust;

(o) Seller s provider agreements with Government Payment Programs;

(p) all proceeds of the foregoing and, except for the Excluded Assets, all other property of every kind, character or description, tangible and intangible, known or unknown, owned or leased by Seller, wherever located and whether or not reflected in the Financial Statements or similar to the properties described above; and

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

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

(a) any financial, patient, medical staff, personnel and other records of the Hospital Businesses that Seller cannot transfer to Buyer due to applicable Legal Re uirements by which Seller is bound;

(b) all cash, bank accounts (except for those that receive deposits from Government Payment Programs), certificates of deposit, treasury bills, treasury notes, marketable securities and other cash e uivalents (including the Purchase Price payable to Seller) of Seller or the Hospital Businesses, except for those listed in Section 2.01(n);

(c) all short-term and long-term Investments, but excluding the Investment interests in the Joint Ventures;

(d) board-designated, restricted, and trustee-held or escrowed funds (such as funded depreciation, debt service reserves, self-insurance trusts, working capital trust assets, and assets and Investments restricted as to use), beneficial interests in charitable trusts, and accrued earnings on all of the foregoing;

(e) inventory and supplies disposed of or exhausted after the date of this Agreement and on or before the Closing Date in the ordinary course of the Hospital Businesses, and Assets transferred or disposed of in accordance with Section 5.02(e);

(f) Cost Report settlement receivables for periods ended on or prior to the Closing Date and all appeals and appeal rights relating thereto;

(g) all funds held by trustees pursuant to bond indentures of Seller (including the Indenture) related to the Bond Liabilities;

(h) all deductions, benefits, claims, refunds, receivables and other rights of Seller or any Affiliate of Seller relating to Taxes in respect of periods ending on or before the Closing Date (or portions thereof) or resulting from the consummation of the transactions contemplated by this Agreement;

(i) all other current financial assets not included in Net Working Capital and all deferred expenses;

(j) all Contracts that are listed or described on Schedule 2.02(j) and all other Contracts that are not Assumed Contracts (including this Agreement and the Closing Documents);

(k) all Permits to the extent not legally assignable to Buyer or not relating to the ownership of the Assets and the conduct of the Hospital Businesses;

(l) the corporate or trade names set forth on Schedule 2.02(l) and all Intellectual Property rights relating thereto;

(m) all physician loans and receivables other than repayment obligations under Assumed Contracts;

(n) all right, title and interest of ECHN Community Healthcare Foundation in and to its assets and properties (whether owned, leased or otherwise) described on Schedule 2.02(n);

(o) all insurance proceeds received by Seller or payable to Seller (i) with respect to other Excluded Assets or the Excluded Liabilities or (ii) arising in connection with the operation of the Assets for periods prior to Closing to the extent that all material damage to any such Asset has been repaired and to the extent consistent with Section 5.13 herein;

(p) the claims of Seller against third parties described on Schedule 2.02(p), appeals and other risk settlements of the Hospital Businesses which arose during or relate to a pre-Closing period, and all rights, remedies, claims and defenses against third parties thereunder or otherwise relating solely to the Excluded Assets or to the Excluded Liabilities, whether choate or inchoate, known or unknown, contingent or otherwise;

(□) any other assets identified on Schedule 2.02(□) or excluded after the execution of this Agreement by mutual written agreement of the parties;

(r) any Investment interest in a Joint Venture that did not transfer at Closing because the governing instruments of such Joint Venture did not permit such transfer at Closing and all re□uired consents to such transfer were not obtained from the owners or other participants in the Joint Venture; and

(s) all proceeds of the foregoing.

2.03. Assumed Liabilities. As of the Closing Date, Buyer shall assume from Seller and its Affiliates the Assumed Liabilities, including the Assumed Liabilities described on Schedule 2.03, and agrees to pay and satisfy all such Assumed Liabilities.

2.04. Excluded Liabilities. Notwithstanding anything to the contrary set forth in this Agreement, under no circumstance will Buyer assume or be obligated to pay, and from and after the Closing, none of the Assets will be or become liable for or subject to, any of the Excluded Liabilities, which Excluded Liabilities are and will remain liabilities of Seller, including the following:

(a) all liabilities accrued on the Closing Balance Sheets, other than those included in Net Working Capital constituting Assumed Contracts;

(b) liabilities or obligations for Taxes of the Hospital Businesses in respect of periods ending on or before the Closing Date or resulting from the consummation of the transactions contemplated by this Agreement;

(c) liabilities or obligations for federal or state income Taxes of Seller or any Affiliate of Seller, including any amounts accrued or incurred by the Hospital Businesses as a result of being a member of a consolidated, affiliated, combined, unitary or similar group that includes such other Persons;

(d) liabilities or obligations relating to the Excluded Assets;

(e) liabilities or obligations associated with indebtedness for borrowed money (other than capital lease obligations under any Assumed Contract and the Refinancing Loan) ;

(f) (i) obligations required to be performed by Seller on or before the Closing Date under the Assumed Contracts, (ii) liabilities or obligations resulting from a breach or default on or before the Closing Date of any Assumed Contracts and (iii) liabilities arising under any Contracts that are not Assumed Contracts;

(g) liabilities or obligations arising out of or in connection with the Proceedings described on Schedule 3.23, and Proceedings and claims (whether instituted before or after Closing) relating to acts or omissions that occurred on or before the Closing Date, including those relating to peer review activities;

(h) liabilities or obligations under the Hill-Burton Act or other restricted grant or loan programs;

(i) liabilities and obligations to Seller's employees, Seller's Employee Benefit Plans, the Internal Revenue Service, PBGC or any other Governmental Authority arising from or relating to periods on or before the Closing Date (whether or not triggered by the transactions contemplated by this Agreement), including liabilities or obligations arising on or before the Closing Date under any Seller Employee Benefit Plan, United States Equal Employment Opportunity Commission claim, unfair labor practice, and wage and hour practice, and liabilities or obligations arising under the WARN Act,

provided that this subsection (i) shall not apply to (i) liabilities or obligations under the Employee Benefit Plans assumed by Buyer under Section 5.03(d), including but not limited to the Unfunded Pension Liabilities and the Post-Retiree Health Plan Liability, (ii) Special Employee Liabilities, (iii) Extended Illness Bank Obligations, (iv) obligations under Assumed Contracts or (v) the Worker□s Compensation Liability;

(j) Cost Report settlement payables relating to all Cost Report periods ending on or before the Closing Date;

(k) liabilities or obligations of Seller, including arising out of the operation of the Hospital Businesses or ownership of the Assets, with respect to periods ending on or before the Closing Date, or resulting from the consummation of the transactions contemplated by this Agreement, including pursuant to third-party payor programs and Government Payment Programs, including recoupment rights of the Centers for Medicare & Medicaid Services (□**CMS**□) or the Connecticut Department of Social Services and recapture of previously reimbursed charges or expenses; and

(l) penalties, fines, settlements, interest, costs and expenses arising out of or incurred as a result of any actual or alleged violation by Seller of any Legal Re□uirement prior to the Closing Date.

2.05. Purchase Price; Purchase Price Adjustment.

(a) Subject to the terms and conditions of this Agreement, in reliance upon the representations and covenants of Seller in this Agreement, and as consideration for the sale of the Assets, Buyer shall assume the Assumed Liabilities from Seller and tender the Purchase Price, determined as follows, subject to the limitations and adjustments described in Sections 2.05(b)-(i):

(i) □105,000,000 (One Hundred Five Million Dollars), *plus*

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

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

(iv) the book value (including the current portion) as of the Closing of any indebtedness (including capitali□ed leases) assumed by Buyer and *minus*

(v) The Special Employee Liabilities, the Unfunded Pension Liabilities and the Post-Retiree Health Plan Liability, and *minus*

(vi) the amount, if any, by which the sum of the Workers□ Compensation Liability and the Captive Insurer Liability exceeds the investments held by the Connecticut Health Insurance Company, Inc. and the workers□ compensation trust with respect to such liabilities, and *minus*

(vii) Asbestos abatement liability as determined within five business days of closing by an independent third party mutually agreed upon by Seller and Buyer; provided, however, that the total asbestos abatement liability shall not exceed $1,000,000 (One Million Dollars), and *minus*

(viii) In the event Seller is unable to assign and transfer to Buyer or Buyer's designee all of Seller's Investment in one or more Joint Ventures due to the inability to satisfy the requirements of the governing instruments of such Joint Ventures with respect to such transfer at Closing, an amount equal to the value listed next to the name of such Joint Venture on Schedule 2.05(a), provided, however, that the provisions of this Agreement shall not be construed as an offer to separately purchase Seller's Investment in one or more Joint Ventures, and *minus*

(ix) Any amounts paid to Seller by Buyer to reimburse Seller's out-of-pocket legal, valuation, or consulting expenses pursuant to Section 8.04(b).

(b) Notwithstanding the foregoing Section 2.05(a), if Seller obtains, prior to the Closing Date, an assumable loan in an amount not to exceed $45,000,000 (Forty Five Million Dollars) to refinance certain of Seller's outstanding Bond Liabilities (the "**Refinancing Loan**"), the figure in Section 2.05(a)(i) shall be deemed deleted and replaced with the following: "$115,000,000 (One Hundred Fifteen Million Dollars)." In addition, if Seller obtains the Refinancing Loan and spends less than $10,000,000 (Ten Million Dollars) on capital projects of the kind that could be counted toward the Commitment Amount under Section 5.18, in addition to the deductions described in Section 2.05(a)(i)-2.05(a)(ix) above, the Purchase Price shall be further reduced by the difference between $10,000,000 (Ten Million Dollars) and the amount spent on such capital projects.

(c) If Seller does not obtain the Refinancing Loan, the sum of the liabilities subtracted from the Purchase Price pursuant to Sections 2.05(a)(iii)-(a)(vii) above shall not exceed $77,000,000 (Seventy Seven Million Dollars) (the "**Lower Threshold Liability**"). If Seller obtains the Refinancing Loan, the sum of the liabilities subtracted from the Purchase Price pursuant to Sections 2.05(a)(iii)-(a)(vii) above shall not exceed $122,000,000 (One Hundred Twenty Two Million Dollars) (the "**Upper Threshold Liability**"), and Seller shall pay to Buyer the difference between the sum of Sections 2.05(a)(iii)-(a)(vii) (capped at the Upper Threshold Liability) and $115,000,000 (One Hundred Fifteen Million Dollars) to the extent possible from Available Cash and the Indemnity Reserve established pursuant to Section 9.08.

(d) If (i) Seller obtains the Refinancing Loan and, as of the Closing Date, has liabilities, excluding Third Party Debt, that exceed the Upper Threshold Liability, or (ii) Seller does not obtain the Refinancing Loan, and as of the Closing Date, has liabilities, excluding Third Party Debt, that exceed the Lower Threshold Liability, Buyer shall assume such excess liabilities; provided, however, that Seller shall reimburse Buyer on a dollar-for-dollar basis for the liabilities assumed in excess of the Upper Threshold

Liability (if Seller obtains the Refinancing Loan) or the Lower Threshold Liability (if Seller does not obtain the Refinancing Loan), from the following sources:

(i) First, from Seller's Available Cash, if any in excess of $1,000,000 (One Million Dollars); and

(ii) Second, from the Indemnity Reserve established pursuant to Section 9.08.

If additional liabilities remain following the reimbursement described in Section 2.05(d)(i)-(ii) above ("**Additional Liabilities**"), Buyer shall assume up to an additional $10,000,000 (Ten Million Dollars) of such liabilities, and Seller shall have no obligation to reimburse Buyer for such assumption of liabilities, provided, however, that the Commitment Amount shall be reduced by an amount equal to the assumption of such liabilities. For these purposes Additional Liabilities shall include any increase from September 30, 2015 to the Closing Date in the following liabilities: Unfunded Pension Liabilities, the Post-Retiree Health Plan Liability and other retirement obligations described on Schedule 2.03, the Workers' Compensation Liability, the Captive Insurer Liability, and any other Assumed Liabilities measured as of September 30, 2015. Buyer may, in its sole discretion, assume liabilities in excess of this additional $10,000,000, and such liabilities shall be referred to as the "**Assumed Excess Liabilities**" and shall be deducted from the Commitment Amount as set forth in Section 5.18(a). For the avoidance of doubt, examples of how the provisions of this Section 2.05 will be implemented are included in Schedule 2.05. Seller and Buyer shall equally share the cost of obtaining updated actuarial valuations of the Unfunded Pension Liabilities and the Post-Retiree Health Plan Liability as of the Closing.

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

(f) As further described in Sections 2.05(g) and 2.05(h) below, the Purchase Price, including an estimate of the Net Working Capital at Closing, will be calculated by Buyer and Seller at Closing from the physical count of inventory and supplies conducted pursuant to Section 2.05(g), if available, the relevant entries in the Interim Closing Balance Sheets (other than inventory and supplies if the physical inventory is available) and the parties' mutual good faith estimate as of the Closing Date of the amount of the prorations to be made pursuant to Section 2.06. At Closing, Buyer shall pay such Purchase Price by wire transfer of immediately available funds to an account designated by the Seller to Buyer prior to the Closing Date, and Seller shall immediately use whatever portion of the Purchase Price is necessary to defease the Bond Liabilities and to pay off all other indebtedness of Seller (other than capitalized leases assumed by Buyer).

(g) The portion of Net Working Capital constituting the value of inventory and supplies will be determined based on a physical count conducted by Seller on a date not more than five business days before the Closing Date. Seller shall give Buyer at least five business days prior notice of the date of the count and permit Buyer to monitor the

count. Seller shall count the usable items of inventory and supplies that are not damaged or obsolete, and that are of a type, □uality and □uantity that may be used in the ordinary course of the Hospital Businesses (having due regard for the services offered by the Hospital Businesses). Seller will conduct the count in the same manner that Seller conducted the count of, and will count the same classes and categories of items that Seller counted to determine the value of, inventory and supplies in the most recent Audited Financial Statements. Upon completion of the count, Seller shall determine the value of the inventory and supplies (determined by the lower of cost or market on a first in, first out basis). If the results of the count and the resulting value of inventory and supplies are available by Closing, then the portion of Net Working Capital attributable to inventory and supplies will be the value determined pursuant to the count (updated for actual usage and purchases between the date of the count and the Closing Date). If the results of the count or the resulting value of inventory and supplies are not available by Closing, then for purposes of the Closing, the value of the inventory and supplies will be the amount set forth in the Interim Closing Balance Sheets and the value of the inventory and supplies determined pursuant to the count (updated for actual usage and purchases between the date of the count and the Closing Date) will be set forth in the Closing Balance Sheets.

(h) The portion of Net Working Capital constituting the value of prepaid expenses and deposits will be determined based on mutual agreement of Seller and Buyer. No more than five business days before the Closing Date, Buyer and Seller will agree on the value as of Closing of the prepaid expenses and deposits that Buyer reasonably determines will be usable after Closing.

(i) Within 90 days after the Closing Date, Buyer will deliver to Seller the Closing Balance Sheets together with any proposed revisions in the amount of the prorations to be made pursuant to Section 2.06 (based on paid invoices delivered by Buyer to Seller after the Closing). Except as otherwise provided herein, the Closing Balance Sheets shall be prepared using the same principles and methodologies, including the determination of Accounts Receivable and doubtful accounts, as used in preparing the Interim Closing Balance Sheets. The Purchase Price will be recalculated (based on clauses (i) and (ii) below) (the "**Purchase Price Adjustment**") to reflect (i) any such revisions in the amount of the prorations to be made pursuant to Section 2.06, and (ii) the difference between the Net Working Capital (excluding differences in prepaid expenses and deposits calculated in accordance with Section 2.05(h) and, if a physical inventory was used to calculate the Purchase Price, in inventory and supplies) on the Interim Closing Balance Sheets and on the Closing Balance Sheets. Following the resolution of any disputes pursuant to Section 2.05(j), Seller shall pay Buyer (if the Purchase Price is adjusted downward by the Purchase Price Adjustment), or Buyer shall pay the Seller (if the Purchase Price is adjusted upward by the Purchase Price Adjustment), as the case may be, the amount by which the Purchase Price is adjusted, by wire transfer of immediately available funds to one or more accounts designated by the recipient, within five business days after its determination.

(j) Should Seller disagree with the Closing Balance Sheets prepared by Buyer, it shall notify Buyer within 30 days after Buyer□s delivery of the Closing Balance Sheets; if no notice shall be delivered by Seller to Buyer within such 30 day period,

Seller will be deemed to have agreed with the Closing Balance Sheets prepared by Buyer. If Seller disputes any entry in the Closing Balance Sheets relevant to the calculation of the Purchase Price Adjustment or disputes the value of the inventory and supplies, then Buyer and Seller shall, for 15 days after Seller notifies Buyer of its dispute, attempt to resolve such dispute among themselves and to their mutual satisfaction. If Buyer and Seller are unable to resolve such dispute within such 15 day period, then either Seller or Buyer may submit the dispute to PricewaterhouseCoopers LLP or to such other independent, certified public accounting firm as Seller and Buyer may then agree in writing, in either case acting as experts and not as arbitrators to resolve the computation or verification of the disputed Closing Balance Sheets entries in accordance with this Agreement and otherwise where applicable in accordance with GAAP consistently applied.

(k) Seller and Buyer will each pay their own respective fees and expenses (including any fees and expenses of their accountants and other representatives) in connection with the resolution of disputes pursuant to this Section 2.05. Notwithstanding the foregoing, the fees and expenses of any accounting firm incurred in connection with the resolution of such disputes will be paid by Seller and Buyer in proportion to the difference between the Purchase Price Adjustment determined by the accounting firm and the respective amounts of the Purchase Price Adjustment asserted by each such party at the time of the initial referral of the dispute to the accounting firm.

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

2.07. Promissory Note. To the extent Seller is unable to transfer to Buyer on the Closing Date Seller's Investment in one or more Joint Ventures as a result of the failure to obtain a consent or to otherwise comply with the governing instruments of such Joint Venture , Buyer shall lend to Seller an amount equal to the value of such Joint Venture(s) as such value is listed on Schedule 2.05(a). The loan described in the previous sentence shall be made pursuant to a a promissory note bearing interest at 3% per annum payable solely from, and secured by, future distributions from the Joint Ventures, and further secured by the Joint Venture Investments themselves, to the extent the granting of such a security interest is permissible under the laws of the State of Connecticut and the Joint Venture agreements (the "**Joint Venture Promissory Note**"). If, after the Closing Date, one or more of Seller's Joint Venture Investments whose value is included in the Joint Venture Promissory Note is transferred to Buyer, the principal amount of the Joint Venture Promissory Note shall be reduced by an amount equal to the value set forth next to the name of such Joint Venture on Schedule 2.05(a).

3. REPRESENTATIONS OF SELLER

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

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

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

(a) are within Seller's powers, are not in contravention of its articles of incorporation, bylaws and other governing documents, and have been duly authorized by all appropriate corporate action;

(b) do not conflict with, result in any breach or contravention of, or permit the acceleration of the maturity of any liabilities of Seller (other than Excluded Liabilities to be satisfied as of the Closing Date), and do not create or permit the creation of any Encumbrance on or affecting any of the Assets;

(c) do not violate any Legal Requirement to which Seller, the Assets, or the Hospital Businesses may be subject other than with respect to the Excluded Liabilities to be satisfied as of the Closing Date; and

(d) assuming the receipt of all consents set forth in Schedule 3.02, do not conflict with or result in a breach or violation of any material Contract to which Seller is a party or by which it is bound and will not be terminated as of the Closing Date.

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

3.04. Subsidiaries and Third Party Rights. Seller holds no Investment interest in any Person involved in the ownership or operation of the Hospital Businesses or the Assets, other than those Persons identified on Schedule 3.04. Schedule 3.04 indicates for each Person identified thereon whether it is currently active or inactive and whether it, together with its consolidated Subsidiaries, has total assets of 10,000 or more. Schedule 3.04 also indicates, for each Joint Venture, the percentage of equity interests owned by Seller or its Affiliate in such Joint Venture and the name of, and percentage of equity interests owned by, third parties in such

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

3.05. Legal and Regulatory Compliance. Except as otherwise provided in this Agreement and other than as set forth on Schedule 3.05, Seller and all of its officers, directors, agents, or employees comply in all material respects with, and have complied in all material respects with, all Legal Requirements, and Seller has timely filed all material reports, data and other information required to be filed with Governmental Authorities. Seller has not received notice of any currently pending or threatened Proceeding against it alleging or based upon an alleged violation of any Legal Requirements. Neither Seller nor any Affiliate of Seller is party to or otherwise bound by (i) a corporate integrity agreement with the Office of Inspector General of the United States Department of Health and Human Services or written agreement with such Governmental Authority to establish or maintain a corporate integrity program applicable to any of the Hospital Businesses or (ii) a settlement or other agreement with any other Governmental Authority, other than participation agreements with Medicare and Medicaid, that imposes continuing obligations on any of the Hospital Businesses or contains obligations that have not been fully discharged.

3.06. Financial Statements. Attached as Schedule 3.06 are copies of the Audited Financial Statements and the Unaudited Financial Statements. The Financial Statements fairly present the financial condition and results of operations of Seller and the Hospital Businesses as of the respective dates thereof and for the periods therein referred to, all in accordance with GAAP, subject, in the case of the Unaudited Financial Statements, to normal recurring year-end adjustments (the effect of which will not, individually or in the aggregate, have a Material Adverse Change) and the absence of notes (which, if presented, would not differ materially from those included in the Audited Financial Statements), and the Financial Statements reflect the consistent application of such accounting principles throughout the periods involved.

3.07. Undisclosed Liabilities. Except and to the extent accrued or disclosed in the Financial Statements, Seller does not have any liabilities or obligations of any nature whatsoever with respect to the Hospital Businesses or the Assets, due or to become due, accrued, absolute, contingent or otherwise, that are required by GAAP to be accrued or disclosed in audited financial statements, except for liabilities and obligations incurred in the ordinary course of business and consistent with past practice since the date of the Unaudited Financial Statements, which are not, individually or in the aggregate, expected to result in a Material Adverse Change.

3.08. Recent Activities. Since September 30, 2014 and except as set forth on Schedule 3.08:

(a) no material damage, destruction or loss (whether or not covered by insurance) has occurred affecting the Assets;

(b) except in the ordinary course of the Hospital Businesses or as set forth on Schedule 3.08(b), consistent with past practice and existing personnel policies of Seller, Seller has not (i) increased or agreed to increase the compensation payable to any employees who work in the Hospital Businesses, (ii) agreed to make any bonus or severance payment to any of the employees who work in the Hospital Businesses or (iii) employed any additional management personnel in respect of the Hospital Businesses;

(c) no labor dispute, enactment or promulgation of a state or local Legal Re□uirement, or other event or condition, has occurred that has materially adversely affected any of the Hospital Businesses or reasonably could be expected to have such an effect on the Hospital Businesses;

(d) other than as set forth on Schedule 3.08(d), Seller has not sold or factored, or agreed to sell or factor, any Accounts Receivable, and Seller has not sold, distributed or otherwise disposed of any other Assets except in the ordinary course of the Hospital Businesses and, for e□uipment having an original cost in excess of □25,000, with a comparable replacement thereof;

(e) to Seller□s knowledge, no Encumbrance has been imposed on any of the Assets;

(f) Seller has not canceled or waived any material rights in respect of the Assets, except in the ordinary course of the Hospital Businesses;

(g) other than in connection with the free□e of Seller□s defined benefit pension plan and post-retiree health plan, there has been no change in any accounting method, policy or practice of Seller with respect to the Hospital Businesses;

(h) other than compensation paid in the ordinary course of employment or ordinary course professional services agreements disclosed to Buyer, Seller has not paid any amount to, sold any Assets to, or entered into any Contract with any officer, director, or trustee of Seller or its Affiliates, or with any Affiliate of any such Person;

(i) Seller has not paid or agreed to pay to any Person any damages, fines, penalties or other amounts in respect of an actual or alleged violation of any Legal Re□uirement excluding routine workers□compensation claims in amounts no greater than □100,000;

(j) Other than ordinary course plan benefit design changes, Seller has not instituted any new, or terminated or amended any existing, Employee Benefit Plan, except for amendments re□uired to comply with applicable Legal Re□uirements and the free□e of Seller□s defined benefit pension plan and post-retiree health plan;

(k) Seller has not entered into or agreed to enter into any transaction outside the ordinary course of the Hospital Businesses (other than the transactions contemplated by this Agreement); and

(l) no Material Adverse Change has occurred and no event or circumstance has occurred that could reasonably be expected to result, individually or in the aggregate, in a Material Adverse Change.

3.09. Accounts Receivable; Inventory.

(a) The Accounts Receivable, to the extent uncollected, are valid and existing and represent monies due for goods sold and delivered and services performed in bona fide commercial transactions, have been billed or are billable, and are not subject to any Encumbrances. Except as reflected or reserved for in the Financial Statements, no refunds, discounts or setoffs are payable or assessable with respect to the Accounts Receivable.

(b) All Assets consisting of inventory and supplies are carried at the lower of cost or market on a first-in, first-out basis and are properly stated in the Audited Financial Statements as of the dates thereof. All items of inventory and supplies are of a quality usable or saleable in the ordinary course of business, except for those items that are obsolete, below standard quality or in the process of repair and for which adequate reserves have been provided in the Financial Statements. The quantities of inventory and supplies, taken as a whole, are reasonable and justified under the normal operations of the Hospital Businesses.

3.10. Equipment. Schedule 3.10 includes a depreciation schedule as of a recent date that lists all items of equipment associated with, or constituting any part of, the Assets. To Seller's knowledge, and excluding information technology equipment and systems, all major items of Seller's equipment (e.g., heating systems, magnetic resonance imaging units, ultrasound units, robotic surgery and similar equipment) are usable for their intended purposes in the ordinary course of the Hospital Business and are in working condition, subject to reasonable wear and tear.

3.11. Title. Except as provided in Schedule 3.11 and subject to Section 10.03, Seller owns and holds good and valid title to all of the Assets, free and clear of any Encumbrances other than the Encumbrances described on Schedule 3.11. At Closing, Seller will convey to Buyer good and valid title to all Assets, free and clear of any Encumbrances other than the Permitted Encumbrances.

3.12. Real Property.

(a) Seller owns fee simple title to the Owned Real Property, free and clear of any Encumbrances other than the Encumbrances described on Schedule 3.12(a). The Owned Real Property described on Schedule 2.01(a) comprises all of the real property owned by Seller or any Subsidiary of Seller that is associated with or utilized in the operation of the Hospital Businesses. At Closing, Seller will convey to Buyer good and marketable fee simple title to all Owned Real Property, free and clear of any Encumbrances other than the Permitted Real Property Encumbrances.

(b) Seller has not received notice of condemnation or similar Proceedings relating to the Owned Real Property or any part thereof.

(c) Except as set forth on Schedule 3.12(c), to Seller's knowledge, the buildings standing on the Owned Real Property are structurally sound and in need of no material maintenance or repairs, except for ordinary, routine maintenance. All essential utilities (including water, sewer, gas, electricity and telephone service) are available to the Owned Real Property, and, to Seller's knowledge, no conditions exist that are reasonably likely to result in the termination or reduction of the current access from the Owned Real Property to existing roadways. To Seller's knowledge, no part of the Owned Real Property contains, is located within or abuts any flood plain, navigable water or other body of water, tideland, wetland, marshland or other area that is subject to special state, federal or municipal regulation, control or protection (other than Legal Requirements pertaining to zoning or other land use restrictions customarily applicable to all real estate within the applicable jurisdiction).

(d) Except for tenants in possession of the Owned Real Property under Contracts described on Schedule 3.18, no Person other than Seller possesses, or claims possession of, adverse or not, any Owned Real Property, whether as lessee, tenant at sufferance, trespasser or otherwise.

(e) No tenant is entitled to any rebate, concession, or free rent, other than as reflected in the Contract with such tenant; no commitments have been made to any tenant for repairs or improvements other than for normal repairs and maintenance in the future or improvements required by the tenant Contract; and no rents due under any of the Contracts with tenants have been assigned or hypothecated to, or encumbered by, any Person other than in connection with financing. All material obligations of Seller as landlord required to be performed under each of the tenant Contracts have been performed.

(f) All Owned Real Property and, to Seller's knowledge, Leased Real Property currently in use for the operation of the Hospital Businesses is in compliance in all material respects with all applicable Legal Requirements, and all material Permits and requisite certificates of the local board of fire underwriters (or other material body exercising a similar function) have been issued for the Owned Real Property and Leased Real Property.

(g) (i) Seller has provided to Buyer accurate and complete copies of those leases of which Seller or one of its Subsidiaries is landlord (collectively, the "**Space Leases**"), and (ii) attached as Schedule 3.12(g) is a "rent roll" that sets forth the following information, if any, for each of the Space Leases: (A) the names of the current tenants; (B) the rental payments for the then current month under each of the Space Leases; (C) a list of all then delinquent rental payments; (D) a list of all outstanding concessions granted to tenants; (E) a list of all tenant deposits and a description of any application thereof; (F) the dates that each of the Space Leases commenced and will expire; (G) the square footage of any such space leased pursuant to the Space Leases; (H) any renewal options available to tenants under the Space Leases; and (I) a list of all uncured material defaults under the Space Leases known to Seller.

(h) There are no tenants or other Persons occupying any space in the Owned Real Property, other than pursuant to the Space Leases.

(i) Seller has (A) a valid leasehold estate in all of the Leased Real Property, free and clear of any Encumbrances other than the Encumbrances described on Schedule 3.12(i) pursuant to the leases described on Schedule 2.01(b) (the **"Tenant Leases"**), and (B) provided accurate and complete copies of each of the Tenant Leases to Buyer. The Leased Real Property comprises all of the real property leased by Seller or any Subsidiary of Seller that is associated with or utilized in the operation of the Hospital Businesses.

3.13. Environmental Matters and Medical Waste.

(a) Seller has all material Permits required under applicable Environmental Laws for the operation of the Hospital Businesses, and all such Permits are listed on Schedule 2.01(g). Other than as listed on Schedule 3.13(a), no Environmental Claim is pending, or to Seller's knowledge, threatened by any Person against Seller or, to Seller's knowledge, any other Person the liability for which Seller has retained or assumed, either contractually or by operation of law. To Seller's knowledge, no activities, circumstances, conditions, events or incidents, including the release, emission, discharge or disposal of any Materials of Environmental Concern, have occurred that could reasonably be expected to form the basis of any Environmental Claim by any Person against Seller or any other Person the liability for which Seller has retained or assumed, either contractually or by operation of law.

(b) Without in any way limiting the generality of the foregoing, (i) all on-site and off-site locations where Seller stores, disposes or arranges for the disposal of material quantities or volumes of Materials of Environmental Concern for the Hospital Businesses are identified on Schedule 3.13(b), (ii) all Contracts dealing with the removal, storage, disposal and handling of Materials of Environmental Concern of the Hospital Businesses are with vendors who are, to Seller's knowledge, properly licensed, (iii) all underground storage tanks, and the capacity and contents of such tanks, located on Owned Real Property are identified on Schedule 3.13(b) and (iv) to Seller's knowledge, no polychlorinated biphenyls are used or stored at any Owned Real Property.

(c) Seller and the Hospital Businesses have complied in all material respects with all Medical Waste Laws.

3.14. Intellectual Properties and Information Systems. Seller owns or is licensed to use, free and clear of royalty and other payment obligations, claims of infringement or other Encumbrances, each of the Intellectual Properties and the Information Systems. Seller is not, in any material respect, in conflict with or in violation or infringement of, and has not received any notice alleging any conflict with or violation or infringement of, any rights of any other Person with respect to any such Intellectual Properties or Information Systems. To Seller's knowledge, no other Person is in conflict with or in violation or infringement of Seller's rights in such Intellectual Properties or Information Systems. Schedule 3.14 identifies those Intellectual Properties and Information Systems used in the conduct of the Hospital Businesses that are owned by or licensed directly to Seller (other than the Intellectual Properties and Information

Systems owned by Seller, for which no copyright registration or application has been made and none of which is, individually or in the aggregate, material to the Hospital Businesses) and those Intellectual Properties and Information Systems that are owned by or licensed to third parties who provide information technology services to Seller pursuant to Contracts described in Section 3.18(c).

3.15. Insurance. Schedule 3.15 describes all insurance arrangements, including self-insurance, in place for the benefit of the Assets and the conduct of the Hospital Businesses (other than Current Seller Plans described in Schedule 3.22). Seller has provided to Buyer a true and complete copy of all such policies and endorsements thereto. With respect to third party insurance, Schedule 3.15 sets forth the name of each insurer, whether such insurer is an Affiliate of Seller, and the number, coverage, limits, term and premium for each policy of insurance purchased or held by Seller covering the ownership and operation of the Assets and the Hospital Businesses. Except as set forth on Schedule 3.15, all of such policies are now, and until Closing will remain, valid, outstanding, in full force and effect, and enforceable with no premium arrearages. Since September 30, 2011, Seller has not been denied, or reduced, or requested a reduction in the scope or amount of, any insurance or indemnity bond coverage. No insurance carrier has canceled or reduced, or given written notice of its intention to cancel or reduce, any insurance coverage and, to Seller's knowledge, there exist no reasonable grounds to cancel or void any such policies or the coverage provided thereby. Except as set forth on Schedule 3.15, since September 30, 2011, Seller has not made any claims against any excess insurance coverage set forth on Schedule 3.15 or any predecessor excess insurance policies applicable during such time period.

3.16. Permits. Schedule 2.01(g) describes all material Permits relating to the ownership of the Assets and the conduct of the Hospital Businesses, all of which are in good standing and not subject to meritorious challenge. Seller has not received any written notice from any Governmental Authority relating to the threatened, pending or possible revocation, termination, suspension or limitation of any of such material Permits. Each Hospital is duly licensed as an acute care hospital by the appropriate Governmental Authorities, and all departments or other business units, including the other Hospital Businesses, that are required to be separately licensed are duly licensed by the appropriate Governmental Authorities. The Hospitals and all departments or business units, including the Hospital Businesses, comply in all material respects with the applicable licensing requirements. Each Hospital has complied in all material respects with the requirements and conditions of all certificates of need (including applications therefor, non-review letters and implemented and unimplemented certificates of need if not lapsed and unexpired).

3.17. Government Payment Programs; Accreditation. Each Hospital has a current and valid provider Contract with the Government Payment Programs and/or their fiscal intermediaries, administrative contractors or paying agents and complies in all material respects with the conditions of participation therein. Each Hospital is entitled to receive and is receiving payment under the Government Payment Programs for services rendered to qualified beneficiaries and, to Seller's knowledge, except as reflected in the Audited Financial Statements, is not subject to any withholds or offsets in respect thereof. Seller has timely filed all Cost Reports due for Cost Report periods through September 30, 2014, and Cost Reports have been audited and notices of program reimbursement have been issued for all Cost Report periods

through September 30, 2010. All amounts shown as due from Seller in the Cost Reports were remitted with such reports and all amounts shown in the notices of program reimbursement as due have been paid. Except to the extent liabilities and contractual adjustments of each Hospital under the Government Payment Programs have been properly reflected and adequately reserved in the Financial Statements in the ordinary course of business, neither Hospital has to its knowledge received nor submitted any claim for payment in excess of the amount provided by Legal Requirements or applicable Contract, and Seller has not received notice of any dispute or claim by any Governmental Authority, fiscal intermediary or other Person regarding the Government Payment Programs or each Hospital's participation therein that remains outstanding or unresolved. All Medicare and Medicaid incentive payments for meaningful use of certified electronic health record technology received by Seller under The American Recovery and Reinvestment Act of 2009 were awarded based on truthful attestations made by Seller or its Affiliates, and no such incentive payments were remitted due to any knowingly fraudulent, negligent or unlawful act or omission of Seller or its Affiliates. Seller has registered with the QNet Exchange ("**QNet**") as required by CMS under its Hospital Quality Initiative Program (the "**HQI Program**"). Seller has submitted all quality data required under the HQI Program to CMS or its agent, and all quality data required under the ORYX Core Measure Performance Measurement System ("**ORYX**") to The Joint Commission, for all calendar quarters concluded prior to the date of this Agreement, except for any quarter for which the respective reporting deadlines have not yet expired. All such submissions of quality data have been made materially in the form and manner required by CMS and The Joint Commission, respectively. Seller has not received notice of any reduction in reimbursement under the Medicare program resulting from its failure to report quality data to CMS or its agent as required under the HQI Program. Seller has provided Buyer with the HQI Program validation results for all calendar quarters concluded prior to the date of this Agreement, except for any quarter for which the respective reporting deadlines have not yet expired. Each Hospital is duly accredited, with no contingencies except as disclosed on Schedule 3.17, by the Joint Commission and Seller's certification for participation in the Medicare program is based on such Joint Commission accreditation. A copy of the most recent accreditation letter from the Joint Commission pertaining to each Hospital has been made available to Buyer. Seller has delivered to Buyer copies of all accreditation survey reports, deficiency lists, statements of deficiency, and plans of correction since September 30, 2011. Seller has taken or is taking all reasonable steps to correct all material deficiencies noted therein. Schedule 3.17 includes a list and description of all unexpected occurrences involving death or serious physical or psychological injury since September 30, 2011.

3.18. Agreements and Commitments. Schedule 3.18 identifies the Contracts related to the Hospital Businesses in the categories below:

(a) Contracts that relate to the ownership or use of, title to or interest in Owned Real Property or Leased Real Property;

(b) Contracts with (i) a physician or physician group, (ii) an Immediate Family Member of a physician on the medical staff of the Hospitals or (iii) any Person that provides marketing services for Seller or its Subsidiaries;

(c) Contracts relating to Intellectual Properties and Information Systems;

(d) collective bargaining agreements or other Contracts with labor unions or other employee representatives or groups;

(e) Contracts with directors, trustees, officers, employees, or other agents of Seller or its Subsidiaries;

(f) re□uirements or exclusive Contracts and Contracts that prohibit or limit competition or the conduct by Seller or any Subsidiary of any lawful business;

(g) Contracts with any health plan, health provider, independent practice association or similar Person providing for capitation or risk-sharing arrangements;

(h) Contracts relating to the administration, operation or funding of any Employee Benefit Plan;

(i) Contracts between Seller and any of the Joint Ventures;

(j) Contracts with Governmental Authorities;

(k) Contracts providing for payments based in any manner on the revenue or profits of Seller or any Subsidiary thereof, the Hospital Businesses or the Assets;

(l) loan agreements, indentures, bonds, mortgages, liens, or other security agreements (excluding those that will be terminated at Closing);

(m) e□uipment leases and other leases that are capital leases; and

(n) all other Contracts which re□uire payment by Seller of amounts in excess of □50,000 annually after the date of this Agreement, unless Seller may terminate the Contract, without cause, within ninety (90) days and all payments due by Seller under the Contract through such termination e□ual, in the aggregate, less than □50,000 (including any penalty or termination fee).

3.19. The Assumed Contracts. With respect to the Assumed Contracts listed on Schedule 2.01(f):

(a) the Assumed Contracts constitute lawful, valid and legally binding obligations of Seller and, to Seller□s knowledge, each other party thereto and are enforceable against Seller and, to Seller□s knowledge, against each other party thereto, in accordance with their terms;

(b) each Assumed Contract (together with all amendments and supplements thereto listed on Schedule 2.01(f)) is in full force and effect and constitutes the entire agreement between the parties thereto;

(c) all material obligations re□uired to be performed under the Assumed Contracts by Seller, and, to Seller□s knowledge, each other party thereto, have been performed, and no event has occurred or failed to occur that constitutes, or with the

giving of notice, the lapse of time or both would constitute, a material default by Seller under the Assumed Contracts that has or would reasonably be expected to have a material impact on the Hospital Businesses;

(d) except as set forth on Schedule 3.19(d), no Assumed Contract contains a prohibition on competition by Seller or any Affiliate or otherwise restricts the ability of Seller or any Affiliate to engage in any lawful business after Closing; and

(e) except as set forth on Schedule 3.19(e), the assignment of any Assumed Contract to, and assumption of such Assumed Contract by, Buyer will not give a third party the right to terminate such Assumed Contract, or result in the payment of any penalty or premium to, or change in the rights, remedies, benefits or obligations of, any party thereunder.

3.20. Transactions with Affiliates. Except as disclosed in the Financial Statements of the Seller, since September 30, 2013, Seller has not purchased, acquired or leased any property or services from, or sold, transferred or leased any property or services to, or lent or advanced any money to, or borrowed any money from, or acquired any capital stock, obligations or securities of, or made any management consulting or similar fee agreement with, any officer, director or trustee of Seller or of any Affiliate of Seller except upon terms that would have been paid or received by Seller in similar transactions with independent parties negotiated at arm's length.

3.21. Employees and Employee Relations.

(a) Seller has delivered to Buyer (i) a list (as of the most recent practicable date) of names, positions, current annual salaries or wage rates, target or actual bonuses, other compensation arrangements, and paid time off or extended illness bank credits of all full-time and part-time non-physician employees of Seller and its Affiliates (indicating in the list whether each employee is classified as exempt or nonexempt by Seller), and (ii) a separate list (as of the most recent practicable date) of names, positions, current annual salaries or wage rates, target or actual bonuses, other compensation arrangements, and paid time off or extended illness bank credits of all full-time and part-time physician employees of Seller and its Affiliates (indicating in both lists whether each employee is part-time or full-time, whether such employee is employed under written Contract, the immigration status of any such employee who is eligible for employment based solely on a temporary work permit and, if such employee is not actively at work, the reason therefor).

(b) To Seller's knowledge, all employees, former employees and independent contractors of Seller and its Subsidiaries are properly classified as such for all purposes under the Code and ERISA and have been properly classified as exempt or nonexempt under the Fair Labor Standards Act and any applicable state Legal Requirement.

(c) Except as set forth in Schedule 3.21(c), Seller is in compliance in all material respects with all Legal Requirements relating to employment, employment practices, terms and conditions of employment, equal employment opportunity,

nondiscrimination, immigration, wages, hours, benefits, payment of employment, social security, and similar taxes, occupational safety and health, and plant closing; Seller is not liable for the payment of any material compensation, damages, taxes, fines, penalties, interest, or other amounts, however designated, for failure to comply with any of the foregoing Legal Requirements; there are no pending or, to the knowledge of Seller, threatened claims before the Equal Employment Opportunity Commission (or any comparable state civil or human rights commission or other Governmental Authority), complaints before the Occupational Safety and Health Administration (or any comparable state safety or health administration or other Governmental Authority), wage and hour claims, unemployment compensation claims, workers compensation claims, or the like.

(d) Schedule 3.21(d) states the number of employees terminated by Seller and its Affiliates within 90 days prior to the Closing Date, laid off by Seller within the six months prior to the Closing Date, or whose hours of work have been reduced by more than 50% by Seller in the six months prior to the Closing Date, and contains a complete and accurate list of the following information for such employees: (i) the date of termination, layoff, or reduction in work hours and (ii) the location to which the employee was assigned. In relation to the foregoing, except as set forth in Schedule 3.21(d), Seller has not violated the WARN Act or any similar state or local Legal Requirements.

(e) To the knowledge of Seller, no officer, director, agent, employee, consultant, or independent contractor of Seller is bound by any contract that purports to limit the ability of such officer, director, agent, employee, consultant, or independent contractor (i) to engage in or continue or perform any conduct, activity, duties, or practice relating to the business of Seller in respect of the Hospital Businesses or the Assets; or (ii) to assign to Seller any rights to any invention, improvement, or discovery. Except as set forth on Schedule 3.21(e), to the knowledge of Seller, no former or current employee of Seller is a party to, or is otherwise bound by, any contract that in any way adversely affected, affects, or will affect the ability of Buyer following Closing to conduct the Hospital Businesses as Seller did prior to Closing.

(f) Except as set forth on Schedule 3.21(f), (i) no employee strike, work stoppage or slowdown, labor dispute, grievance or unfair labor practice at the Hospital Businesses is pending or, to Seller's knowledge, threatened, (ii) no employees of Seller are represented by, or have made demand for recognition of, a labor union or employee organization, and, to Seller's knowledge, no other union organizing or collective bargaining activities by or with respect to any employees of Seller are taking place and (iii) no complaint, charge or claim is pending, or, to Seller's knowledge, threatened to be brought or filed, with any Governmental Authority or arbitrator relating to the employment or termination of employment of any individual by Seller or the Hospital Businesses.

(g) All necessary visa or work authorization petitions have been timely and properly filed on behalf of any employees of Seller requiring a visa stamp, I-94 status document, employment authorization document or other immigration document to legally work in the United States, and all paperwork retention requirements with respect to such

applications and petitions have been met. To the knowledge of Seller, no employee of Seller who is a foreign national has ever worked for Seller without employment authorization from the Department of Homeland Security or any other Government Authority that must authorize such employment, and Seller has complied in all material respects with all applicable immigration laws and other Legal Requirements with respect to the employment of foreign nationals. To the knowledge of Seller, Seller has timely and properly completed I-9 forms for all employees hired since the effective date of the Immigration Reform and Control Act of 1986 and has lawfully retained and re-verified all such I-9 forms. There are no Proceedings pending or, to Seller's knowledge, threatened against Seller relating to Seller's compliance with Legal Requirements relating to immigration, except as set forth on Schedule 3.21(g). Seller has not received any letters or other correspondence from the Social Security Administration regarding the failure of an employee's social security number to match his or her name in the Social Security Administration database, and Seller has not received any letters or other correspondence from the Department of Homeland Security or other Governmental Authorities regarding the employment authorization of any employees of Seller. Seller does not participate in the Department of Homeland Security's e-Verify electronic employment verification system.

3.22. Employee Benefit Plans.

(a) Schedule 3.22 lists each Employee Benefit Plan that Seller or any member of the Controlled Group that includes Seller maintains or to which it contributes (including employee elective deferrals) (each, a "**Current Seller Plan**").

(b) Each Current Seller Plan (and related trust, insurance contract or fund) complies in form and in operation in all material respects with applicable Legal Requirements, and has been administered and operated in all material respects in accordance with the terms of the Current Seller Plan and applicable Legal Requirements. All required reports and descriptions (including form 5500 annual reports, summary annual reports and summary plan descriptions) have been filed or distributed appropriately with respect to each Current Seller Plan. Seller has delivered to Buyer copies of the plan documents and summary plan descriptions, most recent determination letters received from the Internal Revenue Service, most recent form 5500 annual report, and all related trust, insurance and funding Contracts that implement each Current Seller Plan. No Governmental Authority has audited any Current Seller Plan or any other Employee Benefit Plan that Seller or any member of the Controlled Group that includes Seller has maintained, or to which it has contributed or been required to contribute (each, a "**Prior Seller Plan**"), during the five (5) years preceding the date of this Agreement, and Seller has not received any notice that such an audit will or may be conducted.

(c) Each Current Seller Plan that is an Employee Pension Benefit Plan intended to be qualified under section 401(a) of the Code has a current favorable determination letter or opinion or approval letter from the Internal Revenue Service that the plan is so qualified and its trust is exempt from federal income taxation under section 501(a) of the Code, or the remedial amendment period for such Employee Pension Benefit Plan to be submitted to the Internal Revenue Service for such a

determination letter or opinion or approval letter has not yet expired. All contributions (including employer contributions and employee salary reduction contributions) to each such Employee Pension Benefit Plan that are due to be paid have been paid, and all Seller contributions to any Employee Pension Benefit Plan that is a defined contribution plan in respect of periods ending on the Closing Date will be accrued on the Closing Balance Sheets. To Seller's knowledge, nothing has occurred that could reasonably be expected to cause the revocation of such determination letter from the Internal Revenue Service or the unavailability of reliance on such opinion or approval letter from the Internal Revenue Service, as applicable. To Seller's knowledge, nothing has occurred with respect to any Current Seller Plan that has subjected or could reasonably be expected to subject Seller, or, with respect to any period on or after the Closing Date, Buyer or any of its Affiliates, to a penalty under Section 502 of ERISA or to an excise tax under the Code. To Seller's knowledge, with respect to any Current Seller Plan, no event has occurred or is reasonably expected to occur that has resulted in or would subject the Seller or, with respect to any period on or after the Closing Date, Buyer or any of its Affiliates, to a tax under Section 4971 of the Code or the assets of any of the foregoing persons to a lien under Section 430(k) of the Code.

(d) The requirements of part 6 of subtitle B of Title I of ERISA and of section 4980B of the Code have been met in all material respects with respect to each Current Seller Plan that is an Employee Welfare Benefit Plan, and all premiums or other payments that are due have been paid with respect to each such Employee Welfare Benefit Plan.

(e) There have been no "*prohibited transactions*," as defined in section 406 of ERISA and section 4975 of the Code, with respect to any Current Seller Plan that would subject Seller or any member of the Controlled Group that includes Seller to any material liability. No ERISA Fiduciary has any material liability for breach of fiduciary duty or any other failure to act or comply in connection with the administration or investment of the assets of any Current Seller Plan. No Proceeding with respect to the administration or the investment of the assets of any Current Seller Plan (other than routine claims for benefits) is pending or, to Seller's knowledge, threatened and, to Seller's knowledge, there exists no basis for any such Proceeding. To Seller's knowledge, no "*party in interest*" (as defined in section 3(14) of ERISA) and no "*disqualified person*" (as defined in the Code) has any interest in any assets of any Current Seller Plan that is an Employee Benefit Pension Plan other than as a beneficiary by virtue of such Person's participation in the plan.

(f) Except as provided on Schedule 3.22(f), no Current Seller Plan that is an Employee Pension Benefit Plan has been completely or partially terminated or the subject of a Reportable Event, and no Proceeding by the PBGC to terminate any such Employee Pension Benefit Plan has been instituted or, to Seller's knowledge, threatened. Seller has not incurred, and, to Seller's knowledge, Seller will not incur, any material liability to the PBGC (other than PBGC premium payments) or otherwise under Title IV of ERISA (including any withdrawal liability) or under the Code with respect to any Current Seller Plan or Prior Seller Plan that is or was an Employee Pension Benefit Plan.

(g) Neither Seller nor any member of a Controlled Group that includes Seller contributes to, has contributed to, or has been required to contribute to any Multiple Employer Plan or any Multiemployer Plan or has any liability (including withdrawal liability) under any Multiple Employer Plan or any Multiemployer Plan. Except as provided on Schedule 3.22(g), neither Seller nor any member of a Controlled Group that includes Seller maintains or contributes, has maintained or contributed, or has been required to maintain or contribute to any Employee Welfare Benefit Plan providing medical, health or life insurance or other welfare-type benefits for current or future retired or terminated employees, their spouses or their dependents (other than in accordance with section 4980B of the Code).

3.23. Proceedings and Legal Claims. Schedule 3.23 contains a list and summary description of each Proceeding and legal claim (including *qui tam* Proceedings and legal claims) pending or, to Seller's knowledge, threatened against or otherwise affecting the Assets, the Hospital Businesses, Seller or any Affiliate of Seller (together with the reserve amount, if any, included in the Financial Statements for each uninsured Proceeding or legal claim). All such Proceedings and legal claims are or will be fully insured (except for applicable deductibles or self-insurance retentions) and no carrier has issued a "*reservation of rights*" letter or otherwise denied its obligation to insure and defend Seller against covered Losses arising therefrom. None of the Proceedings or legal claims described on Schedule 3.23, if determined adverse to Seller, could reasonably be expected to result, individually or in the aggregate, in a Material Adverse Change.

3.24. Taxes.

(a) Seller has filed all Tax Returns required to be filed by or on behalf of Seller on or prior to the date of this Agreement (taking into account applicable extensions), all such Tax Returns are accurate in all material respects and Seller has duly paid or made provision in the Financial Statements for the payment of all Taxes shown as due and payable on such Tax Returns.

(b) Seller has withheld proper amounts from its employees' compensation in compliance with all applicable withholding and similar provisions of the Code and any and all other applicable Legal Requirements, and has withheld and paid, or caused to be withheld and paid, all Taxes on monies paid by it to independent contractors, creditors and other Persons for which withholding or payment is required by Legal Requirements.

(c) No deficiencies for any Taxes relating to the Assets or the Hospital Businesses have been asserted or, to the knowledge of Seller, threatened, and no audit on any Tax Returns is currently under way or, to the knowledge of Seller, threatened. There are no outstanding agreements by Seller for the extension of time for the assessment of any Taxes (other than ordinary course extensions of time within which to file Tax Returns).

(d) To Seller's knowledge, no Governmental Authority intends to assess any additional Taxes on Seller for any period for which Tax Returns have been filed. No Governmental Authority has disputed in writing any Tax liability of Seller. No claim has

ever been made in writing by a Governmental Authority in a jurisdiction where Seller does not file Tax Returns that Seller is or may be subject to Tax in that jurisdiction, and no Encumbrances exist against Seller or the Assets in connection with any failure (or alleged failure) of Seller to pay any Tax that is due and payable.

(e) No waiver of a statute of limitations in respect of Taxes or agreement to extend the time with respect to a Tax assessment or deficiency is currently in effect, in each case with respect to Seller (other than ordinary course extensions of time within which to file Tax Returns).

(f) Seller is not a party to any Tax allocation or sharing Contract. Seller is not and has not been a member of an Affiliated Group filing a consolidated federal income Tax Return.

(g) Each of Seller and its Subsidiaries that is a corporation exempt from federal and state income Tax has received a favorable letter of determination from the Internal Revenue Service and the State of Connecticut regarding such Tax status and, to Seller's knowledge, nothing has occurred, whether by action or failure to act, that could reasonably be expected to cause the loss of such exemption (except with respect to the transactions contemplated by this Agreement).

(h) To Seller's knowledge, Seller has no liability for the Taxes of any other Person (other than a Subsidiary under Internal Revenue Service regulation 1.1502-6), as a transferee or successor, by Contract or otherwise.

3.25. Medical Staff; Physician Relations.

(a) Seller has delivered to Buyer a copy of the bylaws, policies, rules and regulations of the medical staff and medical executive committees of each Hospital. As set forth on Schedule 3.25(a), Seller has also delivered to Buyer a list, current as of the date of this Agreement, that sets forth (i) the name and age of each member of the medical staff of each Hospital (active, associate, consulting, courtesy or other), (ii) the degree (M.D., D.O., etc.), title, specialty and board certification, if any, of each such medical staff member, (iii) the names of the medical staff members (current and former) of each Hospital in respect of whom Seller has made a report to the National Practitioners Data Bank during the last three years, and (iv) the number of current medical staff members of each Hospital in respect of whom any committee of the medical staff of such Hospital has recommended adverse action with respect to any member of the medical staff of such Hospital that is not yet final.

(b) Except as set forth on Schedule 3.25(b), no material disputes between Seller and any medical staff member of either Hospital are pending or, to Seller's knowledge, threatened and all appeal periods in respect of any medical staff member against whom an adverse action has been taken by Seller have expired. To the knowledge of Seller, no current member of the medical staff of either Hospital has been excluded from participation in any Government Payment Program.

3.26. Restricted Assets. Except as set forth on Schedule 3.26, none of the Assets is subject to any restriction or limitation concerning the purchase, improvement or use of such Assets or the conduct of the Hospital Businesses, including restricted or conditioned grants or donations and monies received under the Hill-Burton Act.

3.27. Brokers and Finders. Neither Seller nor any Affiliate, officer, trustee, director, employee or agent acting on behalf thereof has engaged any finder or broker in connection with the transactions contemplated hereunder.

3.28. Payments. None of the Hospital Businesses has, to Seller's knowledge, made any request for payment from a Government Payment Program in respect of health care services furnished by or directed or prescribed by any physician or other Person who at such time was excluded from participation in such Government Payment Program. Seller has not, directly or indirectly, paid or delivered, or agreed to pay or deliver, any money or item of property, however characterized, to any Person in violation of any Legal Requirement. Neither Seller nor, to Seller's knowledge, any officer, director or trustee of Seller has received, or will receive as a result of the consummation of the transaction contemplated by this Agreement, any rebate, kickback or other improper or illegal payment from any Person with whom Seller conducts or has conducted any of the Hospital Businesses.

3.29. Solvency. As of immediately after Closing, Seller will not, as a result of the transactions contemplated by this Agreement, be rendered insolvent or otherwise unable to pay its debts as they become due. Seller has no intention of filing a petition in bankruptcy or insolvency or for reorganization or for the appointment of a receiver or trustee of all or any portion of Seller's property and, to Seller's knowledge, no other Person has filed or threatened to file such a petition against Seller.

3.30. Hospital Businesses and Joint Ventures.

(a) Each of Seller's Subsidiaries is a corporation duly organized under the laws of the State of Connecticut with full corporate power to carry on its business as it is now being conducted with the exception of Connecticut Health Insurance Company, which is organized with full corporate power to carry on its business as it is now being conducted under the laws of the Cayman Islands. Each of Seller's Subsidiaries is duly licensed, qualified or admitted to do business and is in good standing in the State of Connecticut, which is the only jurisdiction in which the ownership, use or leasing of their respective assets or properties, or the conduct or nature of their respective businesses, makes such licensing, qualification or admission necessary. All of the issued and outstanding shares of capital stock of Seller's Subsidiaries that are stock corporations are owned as specified on Schedule 3.30(a). All of the issued and outstanding shares of capital stock of Seller's Subsidiaries that are stock corporations have been duly and validly authorized, were validly issued and are fully paid and non-assessable. There are no outstanding rights (including preemptive rights), options, warrants or agreements for the transfer by Seller of any shares of capital stock of Seller's Subsidiaries that are stock corporations and no authorization for any such rights, options, warrants or agreements has been given. Seller has delivered to Buyer a copy of the articles of incorporation and bylaws and other agreements, instruments and documents relating to the creation,

ownership and governance of Seller's Subsidiaries and has provided to Buyer a copy of, or access to, the minute books of Seller's Subsidiaries.

(b) To Seller's knowledge, for each Joint Venture that is a for-profit or nonprofit corporation, it (i) is a corporation duly organized under the laws of the state of its incorporation, (ii) has full corporate power to carry on its business as it is now being conducted, and (iii) is duly licensed, qualified or admitted to do business and is in good standing in the state of its incorporation, which is the only jurisdiction in which the ownership, use or leasing of their respective assets or properties, or the conduct or nature of their respective businesses, makes such licensing, qualification or admission necessary. To Seller's knowledge, all of the issued and outstanding shares of capital stock of the corporate Joint Ventures that are stock corporations are owned as specified on Schedule 3.30(b). To Seller's knowledge, all of the issued and outstanding shares of capital stock of the corporate Joint Ventures that are stock corporations have been duly and validly authorized, were validly issued and are fully paid and non-assessable. To Seller's knowledge, there are no outstanding rights (including preemptive rights), options, warrants or agreements for the transfer by Seller of any shares of capital stock of the corporate Joint Ventures and no authorization for any such rights, options, warrants or agreements has been given. Seller has delivered to Buyer a copy of the articles of incorporation and bylaws and other agreements, instruments and documents relating to the creation, ownership and governance of the corporate Joint Ventures in Seller's possession.

(c) To Seller's knowledge, for each Joint Venture that is a limited liability company, it (i) is organized under the laws of the state of its incorporation, (ii) has full limited liability company power to carry on its respective business as it is now being conducted, and (iii) is duly licensed, qualified or admitted to do business and is in good standing in the state of its incorporation, which is the only jurisdiction in which the ownership, use or leasing of its respective assets or properties, or the conduct or nature of its respective businesses, makes such licensing, qualification or admission necessary. To Seller's knowledge, all of the issued and outstanding membership interests of the limited liability company Joint Ventures are owned as specified on Schedule 3.30(c), have been duly and validly authorized, were validly issued and are fully paid and non-assessable. To Seller's knowledge, except as set forth in the operating agreements of the limited liability company Joint Ventures, the transfers to Buyer of the membership interests in the limited liability company Joint Ventures are not subject to any preemptive rights or third party approvals. Seller has delivered to Buyer a copy of the articles of organization and operating agreements and other agreements, instruments and documents relating to the creation, ownership and governance of the limited liability company Joint Ventures in Seller's possession.

3.31. Operation of the Hospital Businesses. The Assets, together with the Excluded Assets, constitute all assets, properties, goodwill and businesses necessary to operate the Hospital Businesses in the manner in which they have been operated since September 30, 2014, except for property, plant and equipment sold or disposed of since such date in the ordinary course of business. Schedule 3.31 sets forth a list of the ten largest non-governmental payors of the Hospital Businesses, determined on the basis of net patient revenues from services provided

during the year ended September 30, 2014. Since September 30, 2013, no payor listed on Schedule 3.31 has terminated its contract with or materially reduced reimbursement rates to, or has notified Seller in writing of its determination to terminate its contract with or to materially reduce reimbursement rates to, the Hospital Businesses.

4. REPRESENTATIONS OF BUYER

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

4.01. Organization. Buyer is a corporation duly organized and validly existing and in good standing under the laws of Connecticut. Buyer is, or by Closing will be, qualified to do business in the State of Connecticut. Buyer has full power and authority to own, lease and operate its properties and to conduct its business as presently conducted and as proposed to be conducted immediately following the Closing. Buyer has neither conducted any business prior to the date of this Agreement nor will conduct any business, other than in contemplation of the consummation of the transactions contemplated by this Agreement, prior to the Closing. Buyer has made available to Seller a true and complete copy of its organizational documents.

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

4.03. Consents; Absence of Conflicts, Etc. The execution, delivery and performance by Buyer of this Agreement and the Closing Documents to which it is or becomes a party at the Closing, and the consummation of the transactions contemplated by this Agreement:

(a) are within its corporate powers, are not in contravention of its certificate of formation and operating agreement and have been approved by all required limited liability company and member action;

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

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

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

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

4.06. Availability of Funds. Buyer has the ability to obtain funds in cash in amounts e□ual to the Purchase Price and necessary to perform its obligations hereunder that are to be performed as of Closing by means of credit facilities or otherwise and will at Closing have immediately available funds in cash which will be sufficient to pay the Purchase Price and to perform its obligations hereunder that are re□uired to be performed as of Closing under this Agreement.

4.07. Solvency. Buyer has no intention of filing a petition in bankruptcy or insolvency or for reorgani□ation or for the appointment of a receiver or trustee of all or any portion of Buyer□s property and, to the knowledge of Buyer, no other Person has filed or threatened to file such a petition against Buyer.

4.08. Brokers and Finders. Neither Buyer nor any Affiliate of Buyer, nor any officer, director, employee or agent thereof, has engaged or is liable for the payment of any fee to any finder or broker in connection with the transactions contemplated hereunder.

4.09. Full Disclosure. The representations of Buyer in this Agreement do not contain any untrue statement of a material fact or omit to state any material fact necessary to make the statements made therein, in the light of the circumstances under which they were made, not misleading.

5. COVENANTS OF THE PARTIES

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

(a) conduct the Hospital Businesses in substantially the same manner as it has heretofore and not make any material change in personnel, operations, finances, accounting policies, or real or personal property of the Hospital Businesses except as set forth on Schedule 5.01;

(b) except as set forth on Schedule 5.01(b), maintain the Assets in working condition in the ordinary course of business, ordinary wear and tear excepted, and make all normal, planned and budgeted capital expenditures related to the Assets and□or the Hospital Businesses, *provided* that Seller may (i) make, in its discretion, necessary expenditures in the ordinary course from its designated capital needs fund and provide advance notice to Buyer of any individual expenditure greater than □250,000 and (ii) consult with and solicit Buyer□s input on individual capital expenditures (or a series of related capital expenditures) not paid from its designated capital needs fund that exceed □250,000;

(c) comply in all material respects with all Legal Requirements and perform, when due, in all material respects all obligations under Contracts;

(d) deliver to Buyer title to the Assets free and clear of all Encumbrances (except for the Permitted Encumbrances) and to obtain appropriate releases, consents, estoppels, certificates, opinions and other instruments as Buyer may reasonably request;

(e) keep in full force and effect present insurance policies or other comparable insurance benefiting the Assets and the conduct of the Hospital Businesses and maintain sufficient liquid reserves reasonably estimated to be sufficient to meet all deductible, self-insurance and copayment requirements of such policies; and

(f) maintain and preserve its business organizations and operations intact, retain the present employees at the Hospital Businesses (subject to the right of Seller to discharge any employee in the ordinary course of the Hospital Businesses), and maintain in the ordinary course its relationships with physicians, suppliers, patients and other Persons doing business with Seller at the Hospital Businesses.

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

(a) excluding capital expenditures, amend or terminate any Assumed Contract, or enter into any Contract, except in the ordinary course of the Hospital Businesses consistent with past practices, *provided* that Seller shall obtain Buyer's consent on any new Contract (or a series of related Contracts) that has required payments by Seller that exceed $1,000,000 annually, unless such Contract may be terminated without cause upon no more than 90 days written notice and such termination will not result in any penalty or fee (and excluding any waivers or amendments relating to Bond Liabilities that will be defeased or repaid at Closing);

(b) enter into any tertiary or quaternary affiliation with a third-party healthcare provider other than an agreement for hospitalist services;

(c) other than as set forth on Schedule 5.02(c), increase compensation payable or to become payable to, make a bonus or severance payment to, or otherwise enter into one or more bonus or severance Contracts with any employee, contractor or agent of any of the Hospital Businesses except in the ordinary course of the Hospital Businesses consistent with past practices in accordance with existing personnel policies or pursuant to Contract requirements in force on the date of this Agreement;

(d) create, assume or voluntarily consent to any new Encumbrance upon any of the Assets other than pursuant to the Refinancing Loan;

(e) sell or otherwise transfer or dispose of any item of property, plant, equipment or other Asset including any interest in a Joint Venture, except in the ordinary course of the Hospital Businesses consistent with past practices with comparable replacement thereof, and with respect to a an interest in a Joint Venture, except as may be

required under the governing instruments of the Joint Venture and necessary to satisfy a closing condition in Section 7 that has not been waived by Buyer;

(f) take any action other than execution of this Agreement, which would trigger any right of first refusal, or any similar right to purchase, with respect to any Investment interest in a Joint Venture except as necessary to satisfy a closing condition in Section 7 that has not been waived by Buyer;

(g) distribute any assets, other than Excluded Assets, to any Affiliate of Seller other than its Subsidiaries that are transferring Assets pursuant to this Agreement;

(h) make necessary expenditures in the ordinary course from its designated capital needs fund of more than $100,000 per expenditure without providing advanced notice to Buyer of such expenditure and will not make individual capital expenditures (or a series of related capital expenditures) that are outside the ordinary course in excess of $100,000 individually or $500,000 in the aggregate if such capital expenditures are not included in Seller's annual operating or capital budgets that have been provided to Buyer;

(i) add, modify, or discontinue the provision of any material clinical service by the Hospital Businesses other than entering into an agreement with a third party for the provision of hospitalist services, open a new location for the provision of any material clinical service, or close the location at which any such material clinical service is currently provided without consent of Buyer, which will not be unreasonably withheld or delayed;

(j) create, incur, assume, guarantee or otherwise become liable for any liability or obligation except in the ordinary course of the Hospital Businesses consistent with past practices in excess of $250,000, other than Seller's customary annual line of credit renewal with TD Bank in the currently issued amount, or agree to do any of the foregoing including, enter into and consummate the Refinancing Loan, provided however, that Buyer shall not withhold its consent for the Refinancing Loan so long as the Refinancing Loan is on commercially reasonable terms given Seller's credit profile with an interest rate that is no greater than the current rate payable on the Bond Liabilities and with no assumption fee;

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

(l) amend, change or modify the title or duties of the chief executive officer of Seller;

(m) sell or factor any Accounts Receivable;

(n) change any accounting method, policy or practice or reduce any reserves in the Financial Statements except (i) reductions in reserves pertaining to Government Payment Programs or third party payors made in the ordinary course of business

consistent with past practices, and (ii) changes required by GAAP or applicable Legal Requirements;

(o) except with respect to the previously planned freeze of Seller's defined benefit pension plan and post-retiree health plan, terminate, amend or otherwise modify in any material respect any Employee Benefit Plan, except for normal course annual changes and amendments required to comply with this Agreement or applicable Legal Requirements; or

(p) amend or agree to amend the articles of incorporation or the bylaws or articles of formation or operating agreement (or comparable organizational documents) of Seller or any Subsidiary thereof or otherwise take any action relating to any liquidation or dissolution of Seller or any Subsidiary thereof, except as expressly contemplated by this Agreement, provided that Seller may merge any one or more of the Subsidiaries into each other or into the Seller in connection with the proposed transaction;

(q) amend or agree to amend the governing documents of any Joint Venture, except immaterial amendments or amendments required to comply with applicable Legal Requirements or reasonably necessary to assign and transfer to Buyer or Buyer's designee Seller's Investment in, or for Buyer to become a partner, member or shareholder of, such Joint Venture or to restructure such joint Venture to permit Buyer to participate in such Joint Venture; or

(r) take any action outside the ordinary course of the Hospital Businesses other than modifying its bond documents as needed.

5.03. Employee Matters.

(a) Subject to the exclusions set forth in this Section and in reliance upon the representations of Seller in Sections 3.21 and 3.22, Buyer will offer, or cause its Affiliates to offer, to employ as of the Closing Date substantially all employees of Seller and its Affiliates who work at the Hospital Businesses, including but not limited to employees on approved leaves of absence as of the Closing Date for any reason including without limitation by reason of a military leave, family or medical leave, illness, injury, disability or similar situation (provided employment shall not commence until such employees return from such approved leave), on the same terms and conditions with respect to job duties, titles and responsibilities that are applicable to such employees on the date of such offer. Buyer will offer the Hired Employees salaries equal to their salaries as of the Closing Date and Employee Benefit Plans that are consistent with Employee Benefit Plans offered to similarly-situated employees at other hospitals operated by Buyer in similar markets. Notwithstanding the foregoing, Buyer will, and will cause its Affiliates to, in all events provide each Hired Employee terms and conditions of employment, including compensation and employee benefits, sufficient to avoid Seller or its Affiliates from incurring any liability under the WARN Act or any comparable Legal Requirement due to actions or omissions of Buyer and its Affiliates related to the Hired Employees at any time on or after the Closing Date.

(b) Seller acknowledges that all employment offers are for "at will" employment only and are subject to the satisfactory completion of Buyer's usual and customary hiring practices, including employee background checks and pre-employment screenings. Nothing in this Section or elsewhere in this Agreement may be deemed to limit or otherwise affect in any manner the right of Buyer or any Affiliate of Buyer to terminate at will the employment of any Hired Employee or, subject to Buyer's covenants in Section 5.03(a) and (c), to change individual features or plans in the employment compensation and benefits package of the Hired Employees, provided that Buyer will assume and honor all written severance agreements between Seller and Seller's employees existing as of Closing that are provided to Buyer prior to the date hereof, as set forth on Schedule 5.03(b).

(c) Following the Closing Date, each Employee Benefit Plan sponsored by Buyer or any Affiliate of Buyer in which the Hired Employees are eligible to participate shall credit the Hired Employees with their periods of employment with Seller or any Affiliate of Seller for all purposes (other than benefit accrual under any defined benefit pension plan), including, but not limited to, application of any preexisting condition limitation or eligibility period otherwise applicable to the Hired Employees and their eligible dependents. In addition, if prior to the Closing Date a Hired Employee or his or her covered dependents paid any amounts towards a deductible or out-of-pocket maximum in Seller's medical and health plan's current fiscal year, such amounts shall be applied toward satisfaction of the deductible or out-of-pocket maximum in the current fiscal year of Buyer's medical and health plan that covers Hired Employees on and after the Closing Date. Buyer will give all Hired Employees credit for their vacation, holiday, personal time and sick pay (whether in such form or in the forms of so-called "paid time off" or an "extended illness bank") to the extent the same constitute Assumed Liabilities. With respect to the Hired Employees, Buyer will assume the Workers' Compensation Liability that exists as of Closing and any such claims filed on or after Closing with respect to periods prior to Closing. Except as provided in subsection (b) above, this subsection (c), subsection (e) below, or Schedule 2.03, or as otherwise required by Legal Requirements, Buyer will not assume or otherwise become liable for, and Seller will remain solely responsible for, (i) Seller's Employee Welfare Benefit Plans and (ii) any other obligations to former or currently retired employees or their dependents. Buyer will make available group health plan continuation coverage required under COBRA to employees and former employees of Seller who are eligible for COBRA, provided that, with respect to COBRA beneficiaries whose qualifying events occurred on or prior to the Closing Date, Seller will reimburse Buyer for all claims of such COBRA beneficiaries paid by Buyer and its Affiliates in excess of the sum of (A) COBRA premiums collected from the COBRA beneficiaries; and (B) amounts reimbursed from stop loss insurance, determined in the aggregate with respect to all such individuals on the first anniversary of the Closing Date and again at the end of the COBRA period for all such COBRA beneficiaries. Buyer agrees to accept rollovers of eligible rollover distributions (within the meaning of Code section 402(c)(4)), including to the extent applicable rollovers of any outstanding loans made as part of a direct rollover, made by Hired Employees from Seller's Employee Pension Benefit Plans to Buyer's Plans.

(d) Seller has frozen its defined benefit pension plan known as the Eastern Connecticut Health Network, Inc. Pension Plan amended and restated as of December 31, 2013 to new participation and future accruals and has frozen the post-retiree health plan to new participation. With respect to the post-retiree health plan, Buyer agrees to maintain post-retiree health coverage for the group of employees and former employees eligible for such coverage as of the Closing. With respect to the post-retiree health plan, Buyer agrees to maintain post-retiree health coverage for the group of employees and former employees eligible for such coverage as of the Closing and shall not amend or terminate the post-retiree health plan unless the members of such group are provided another retiree medical benefit or cash payment of equivalent value (as calculated using reasonable assumptions determined in consultation with an actuary at the time of the determination).

(e) As of the Closing, Buyer agrees to assume, administer, and become the sponsor of Seller's defined benefit pension plan known as the Eastern Connecticut Health Network, Inc. Pension Plan amended and restated as of December 31, 2013 and Seller's post-retiree health plan and assume all collective bargaining agreements of Seller that pertain to the Hospital Businesses.

(f) Between the date of this Agreement and Closing, Buyer may run newspaper advertisements, in the name of any of the Hospital Businesses or in the name of Buyer, to recruit employees for the Hospital Businesses to commence on or after the Closing Date.

(g) At Closing, Seller shall deliver to Buyer a list setting forth the names of all employees of the Hospital Businesses whose employment was terminated between the date of this Agreement and the Closing Date.

(h) This Section 5.03 shall not apply to employees employed by Seller under Assumed Contracts, including but not limited to the collective bargaining agreements described in subsection (d) above. Buyer shall offer employment to all such employees, subject to the satisfactory completion of Buyer's usual and customary hiring practices, including employee background checks and pre-employment screenings, and employment of such employees will be governed by the terms and conditions of the Assumed Contracts, if any, relating to the employment of such employees.

(i) On or prior to the Closing Date, Seller will be responsible for compliance with the WARN Act and all similar state and local Legal Requirements with respect to the employees of the Hospital Businesses, and for all obligations or liabilities arising thereunder as a result of any action (or failure to act) of Seller on or prior to the Closing Date, and after the Closing Date, Buyer will be responsible for compliance with the WARN Act and all similar state and local Legal Requirements with respect to the Hired Employees, and for all obligations or liabilities arising thereunder as a result of any action (or failure to act) of Buyer after the Closing Date.

5.04. Access to and Provision of Additional Information.

(a) Except to the extent prohibited by applicable Legal Requirements (including antitrust laws), until the Closing Date, Seller shall (i) give Buyer reasonable access to and the right to inspect, during normal business hours and upon reasonable prior notice, Seller's Assets and books and records relating to the Hospital Businesses, (ii) give Buyer reasonable access to Seller's employees and medical staff members providing services at or for the Hospital Businesses and (iii) give Buyer such additional financial, operating and other data and information (including auditors' workpapers) regarding the Hospital Businesses as Buyer may reasonably request and that is reasonably available to Seller. Buyer shall exercise its rights under this Section 5.04(a) in such a manner as to cause the least possible interference with the normal operations of the Hospital Businesses.

(b) Seller will deliver to Buyer:

(i) within 25 days after the end of each calendar month before the Closing Date, copies of the unaudited balance sheet and the related unaudited statements of income and cash flows of the Hospital Businesses for each such month then ended and for the fiscal year-to-date then ended, in consolidating and consolidated format;

(ii) within 35 days after the end of each fiscal quarter ending on or before the Closing Date, copies of the unaudited balance sheet and the related unaudited statements of income and cash flows of the Hospital Businesses for the fiscal quarter then ended and for the fiscal year-to-date then ended; and

(iii) promptly after prepared, copies of any other financial or operating statements, reports or analyses prepared by or for management relating to the Hospital Businesses.

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

(d) With respect to any individually identifiable health information disclosed by Seller to Buyer pursuant to this Section, Buyer and Seller shall comply with the Health Insurance Portability and Accountability Act of 1996, as codified at 42 U.S.C. Section 1320d, *et seq.*, as amended by the Health Information Technology for Economic and Clinical Health Act, and any current and future Legal Requirements promulgated thereunder, and with any other federal or state Legal Requirements that govern or pertain

to the confidentiality, privacy, security of, and electronic transactions involving, health care information.

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

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

(a) After Closing, each party may need access to books, records, documents or other information in the control or possession of the other party for purposes of concluding the transactions contemplated by this Agreement, preparing Tax Returns or conducting Tax audits, obtaining insurance, complying with Government Payment Programs and other Legal Re□uirements, and prosecuting or defending third party claims. Accordingly, each party shall keep and maintain in the ordinary course of business all books, records (including patient medical records), documents and other information in the possession or control of such party for a period of at least five years after the Closing and otherwise in accordance with all applicable Legal Re□uirements and record retention policies maintained by such party. In addition, to facilitate the foregoing purposes, each party shall also make such books, records, documents and other information available for inspection and copying upon the reasonable re□uest and at the expense (for out-of-pocket costs) of the other party.

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

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

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

(e) To the extent Seller remains in existence and maintains sufficient operational control over relevant functions and pursuant to the Transitional Services Agreement, for seven years after the Closing Date, Seller will give Buyer, within 30 days

after request, an updated claims history, including losses paid and open reserves, for all claims relating to the conduct of the Hospital Businesses on or before the Closing Date.

5.06. Governmental Authority Approvals; Consents to Assignment.

(a) Until the Closing Date, Seller and Buyer shall (i) promptly apply for, and use commercially reasonable efforts to obtain before Closing, all consents, approvals, authorizations and clearances of Governmental Authorities required to consummate the transactions contemplated by this Agreement, including approvals of the applications to the Attorney General and the Office of Health Care Access of the Connecticut Department of Public Health, (ii) provide such information and communications to Governmental Authorities as the other party or such Governmental Authorities may reasonably request, and (iii) assist and cooperate with the other party to obtain all Permits, including approvals of the applications to the Attorney General and the Office of Health Care Access of the Connecticut Department of Public Health, that the other party deems necessary or appropriate, and to prepare any document or other information reasonably required of it by any such Governmental Authority to consummate the transactions contemplated by this Agreement, *provided* that no party may be required without the party's consent (x) to pay any sum to Governmental Authorities other than filing fees or past due amounts, or (y) to agree to divest assets or limit the conduct of the business.

(b) Until the Closing Date, each party shall file, if and to the extent required by applicable Legal Requirements, all reports and other documents required or requested by Governmental Authorities under the HSR Act concerning the transactions contemplated by this Agreement, and shall promptly comply with any requests by the Governmental Authorities for additional information concerning such transactions, so that the waiting period specified in the HSR Act will expire as soon as reasonably possible. Each party shall furnish to the other party such information as the other party reasonably requires to comply with its obligations under the HSR Act and shall exchange drafts of the relevant portions of each other's report forms before filing. The parties shall also share equally the costs of any fees due in respect of filings required by the HSR Act.

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

(d) To obtain one or more of the consents and approvals described in this Section, Buyer may be required by applicable Legal Requirement or practical necessity to enter into a contract that supersedes or replaces an existing Contract between Seller and a third party. Such new contract may require Buyer to assume, for the benefit of such third party, certain obligations and liabilities of Seller that are Excluded Liabilities. Alternatively, Buyer may be required by Legal Requirements to assume, or may be deemed as a matter of law to have assumed, obligations and liabilities of Seller that are Excluded Liabilities. If Buyer enters into a replacement contract or assumes such Excluded Liabilities, then as between Seller and Buyer such contract or assumption of

Excluded Liabilities will not affect the contractual rights and remedies provided in this Agreement in respect of such contract or Excluded Liabilities, including Buyer's rights to indemnification from Seller (subject to the limitations set forth in Article 9), or otherwise diminish Seller's obligations to Buyer or enlarge Seller's liabilities to Buyer (or diminish Seller's defenses or limitations on liability) under this Agreement and will under no circumstances be claimed by Seller as a defense (whether of waiver, estoppel, consent, operation of law, or otherwise) against Buyer's assertion of any claim under this Agreement against Seller, and the rights and obligations of the parties to each other under this Agreement will be determined as if such replacement contract did not exist or such assumption of Excluded Liabilities was not required.

5.07. Use of Controlled Substance Permits. To the extent permitted by applicable Legal Requirements, Buyer shall have the right, for a period not to exceed 120 days following the Closing Date, to operate the Hospital Businesses under the licenses and registrations of Seller relating to controlled substances and the operations of pharmacies and laboratories, until Buyer is able to obtain such licenses and registrations for the Hospital Businesses. In furtherance thereof, Seller shall execute and deliver to Buyer at or prior to the Closing limited powers of attorney substantially in the form of Exhibit B hereto. Buyer or its Affiliates shall apply for all such licenses and registrations as soon as reasonably practicable before and after the Closing Date and shall diligently pursue such applications. Buyer shall indemnify and hold harmless Seller and its Affiliates, and their officers, trustees and employees for all claims, liabilities and costs arising from or relating to use of such licenses and registration after the Closing Date.

5.08. Connecticut Transfer Act. Certain components of the Real Property (including the Hospitals) may constitute, in whole or in part, "Establishments" as the term is defined in the Transfer Act (collectively, the "**Establishment Real Properties**"). Accordingly, Seller and Buyer shall prepare an appropriate Transfer Act Form and accompanying ECAF for each Establishment Real Property to satisfy the requirements of the Transfer Act in connection with the transaction contemplated herein. Seller shall execute as transferor and Buyer shall execute as transferee and Certifying Party (as all such terms are defined in the Transfer Act). Within ten (10) days after the Closing Date, Buyer shall (i) file the fully executed Form and ECAF with the Connecticut Department of Energy and Environmental Protection ("**CTDEEP**"); (ii) pay the initial filing fee and any and all subsequent Transfer Act fees (which shall be reimbursed by Seller); and (iii) provide written confirmation to Seller that the Transfer Act filing has been completed (with a copy of such filing). In order to evaluate the potential scope and cost of Transfer Act obligations that may be required, prior to the Closing, Buyer shall have the right to perform limited Phase II Assessments subject to and in accordance with the provisions of Section 7.09 hereof. Buyer or its designee shall conduct and complete, at Buyer's sole expense, any actions required (as determined by Buyer in its reasonable discretion) as a result of the filing of the Form and the ECAF, to comply with the Transfer Act, and, if appropriate, to obtain written approval from CTDEEP or a "verification" from a "Licensed Environmental Professional" that the Facilities have been remediated in full compliance with the Connecticut Remediation Standard Regulations (collectively "**Transfer Act Activities**"). Buyer shall complete all Transfer Act Activities as soon as practicable, but in any event within any deadline defined by or pursuant to the Transfer Act (as the same may be extended). Notwithstanding the foregoing, Seller shall pay Buyer for all costs and expenses that Buyer incurs in connection with Transfer Act Activities. Seller and Buyer agree to execute and deliver all documents reasonably requested by

the other to comply with the Transfer Act. All undefined terms in this Section 5.08 shall have the meanings set forth in the Transfer Act. Notwithstanding anything to the contrary in this Agreement, the parties agree that any and all fees, expenses and other costs to be paid by Seller under this Section 5.08 shall be paid first from funds held as part of the Indemnity Reserve established pursuant to Section 9.08.

5.09. No-Shop Clause. Until termination of this Agreement, Seller shall not, and shall not permit any Affiliate of Seller or any other Person acting for or on behalf of Seller or any Affiliate of Seller to, without the prior written consent of Buyer: (a) offer for sale, lease or other disposition all or substantially all of the Assets or any material portion thereof, or any ownership interest in any entity owning any of the Assets, whether by virtue of an asset sale transaction, a lease transaction, affiliation transaction, or a change of control, change of membership, merger, consolidation or other combination transaction with respect to Seller or any entity owning any of the Assets (collectively, a "**Prohibited Transaction**"), or negotiate in respect of an unsolicited offer therefor; (b) solicit offers to acquire all or substantially all of the Assets, or any material portion thereof, or offers to acquire any ownership interest in an entity owning any of the Assets, in a Prohibited Transaction; (c) enter into any Contract with any Person with respect to the disposition of all or substantially all of the Assets, or any material portion thereof, or the sale of any ownership interest in an entity owning any of the Assets, in a Prohibited Transaction; or (d) furnish or permit or cause to be furnished any information to any Person that Seller knows or has reason to believe is in the process of considering a Prohibited Transaction. If Seller, any Affiliate of Seller, or any Person acting for or on behalf of any of the foregoing receives from any Person (other than Buyer or its representatives) any offer, inquiry or informational request referred to above, Seller will promptly advise such Person, by written notice, of this Section.

5.10. Noncompetition. For a period of five years after the Closing Date, Seller shall not, directly or indirectly, and Seller shall cause its Affiliates not to, in any capacity: (i) own, lease, manage, operate, control, be employed by, maintain or continue any interest whatsoever or participate in any manner with the ownership, leasing, management, operation, or control of any business or enterprise that offers services in competition with the Hospital Businesses, including any acute care hospital, specialty hospital, rehabilitation facility, diagnostic imaging center, inpatient or outpatient psychiatric or substance abuse facility, ambulatory or other type of surgery center, wellness center, urgent care center, ambulatory service, nursing home, skilled nursing facility, home health or hospice agency, or physician clinic or physician medical practice, within a 30 mile radius of either Hospital (the "**Restricted Area**"); (ii) employ or solicit the employment of any Hired Employee, other than no more than five (5) individuals employed solely for winding down operations, unless (x) such employee resigns voluntarily (without any solicitation from Seller or any of its Affiliates), (y) Buyer consents in writing to such employment or solicitation, or (z) such employee is terminated by Buyer or its Affiliate after the Closing Date; (iii) induce, cause or attempt to induce or cause any Person (including any physician employee or medical staff member) to replace or terminate any contract for the provision or arrangement of health care services from the Hospital Businesses with products or services of any other Person after the Closing Date; or (iv) request, induce or cause any physician employee or medical staff member to terminate any contract with or change practice patterns at the Hospital Businesses. Notwithstanding the foregoing, however, (i) Seller and its Affiliates will not be precluded from participating in the following activities that promote health care services for residents of the communities historically served by Seller and its Affiliates

through the Hospitals: development, ownership, and operation of indigent or charity care clinics and services; preventative care programs and services and educational programs; health screening services; child care services; and other similar services or programs intended to better serve the health care needs of the community's indigent population in the Restricted Area that are not directly competitive with services to be provided by Buyer or its Affiliates. In the event of a breach of this Section, Seller recognizes that monetary damages shall be inadequate to compensate Buyer, and Buyer shall be entitled, without the posting of a bond or similar security, to an injunction restraining such breach, with the costs (including attorneys' fees) of securing such injunction to be borne by Seller. Nothing contained herein shall be construed as prohibiting Buyer from pursuing any other remedy available to it for such breach or threatened breach. All parties hereto hereby acknowledge the necessity of protection against the competition of Buyer and its Affiliates and that the nature and scope of such protection has been carefully considered by the parties. Seller further acknowledges and agrees that the covenants and provisions of this Section form part of the consideration under this Agreement and are among the inducements for Buyer entering into and consummating the transactions contemplated herein. The period provided and the area covered are expressly represented and agreed to be fair, reasonable, and necessary. The consideration provided for herein is deemed to be sufficient and adequate to compensate for agreeing to the restrictions contained in this Section. If, however, any court determines that the foregoing restrictions are not reasonable, such restrictions shall be modified, rewritten, or interpreted to include as much of their nature and scope as will render them enforceable.

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

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

purposes and intent of this Agreement. If any interest in a Joint Venture has not been transferred at Closing as a result of the failure to obtain a consent or to otherwise comply with the governing instruments of such Joint Venture, then Seller shall use commercially reasonable efforts following the Closing to obtain such consent or otherwise comply with the governing instruments of the Joint Venture to permit the transfer of such interest to Buyer as soon as practical following the Closing. Seller shall also furnish Buyer with such information and documents in its possession or under its control, or which Seller can execute or cause to be executed, as will enable Buyer to prosecute any and all petitions, applications, claims and demands relating to or constituting a part of the Assets and Hospital Businesses. After the Closing, upon request of Seller, Buyer shall do, execute, acknowledge and deliver, or cause to be done, executed, acknowledged and delivered, such further acts, deeds, assignments, transfers, conveyances, powers of attorney, confirmations and assurances as Seller may reasonably request to more effectively convey, assign and transfer to Buyer each of the Assumed Liabilities, to confirm Buyer's capacities and abilities to perform its post-Closing covenants under this Agreement and the Closing Documents, and to generally carry out the purposes and intent of this Agreement.

5.13. Casualty. If, on or before the Closing Date, any of the Hospital Businesses are destroyed or materially damaged by fire, theft, vandalism or other cause or casualty and as a result thereof any material part of such Hospital Business is rendered unsuitable for its primary intended use and the cost of repair would exceed $1,000,000, Buyer may elect, by giving written notice to Seller within 15 business days after having actual notice of the occurrence of such destruction or damage and the extent of the loss, to: (i) terminate this Agreement in accordance with Section 8.04(a), (ii) consummate the transaction in spite of such destruction or damage but reduce the Purchase Price by the fair market value of the Assets destroyed or damaged (determined as of the date immediately before the destruction or damage) or, if greater, the estimated cost to restore, repair or replace such Assets, in which event Seller will retain all right, title and interest in and to insurance proceeds payable on account of such destruction or damage, or (iii) consummate the transaction in spite of such destruction or damage without any reduction in the Purchase Price, in which event Seller shall pay, transfer and assign to Buyer at Closing the insurance proceeds less any reasonable out-of-pocket costs incurred in collecting the proceeds or in securing or repairing the property (or the right to receive the insurance proceeds) payable on account of such destruction or damage, and Buyer shall receive a credit for any deductibles or copayments required under the applicable insurance policy in respect of such claim. Notwithstanding the foregoing, Buyer and Seller acknowledge and agree that the Purchase Price shall not be reduced by an amount that would preclude Seller from paying, or providing for payment of, all of its liabilities in full.

5.14. Seller's Cost Reports. Pursuant to the Transitional Services Agreement, Seller will prepare and timely file all Cost Reports required to be filed after Closing for periods ending on or before the Closing Date, including terminating Cost Reports required as a result of the consummation of the transactions described in this Agreement. Buyer will provide information to Seller and reasonably assist Seller in the preparation and filing of the terminating Cost Reports and the Purchase Price will be allocated in the terminating Cost Reports in a manner consistent with the allocation for Tax purposes described in Section 5.11. Buyer will forward to Seller any and all correspondence, remittances and demands relating to Seller's Cost Reports within ten business days after receipt by Buyer. Seller retains all rights to its Cost Reports, including any

payables resulting from or reserves relating to the Cost Reports and the right to appeal any Medicare determinations relating to the Cost Reports.

5.15. Continuation of Hospitals and Post-Care Continuum. For at least 3 (three) years after Closing, Buyer will (i) continue operating the Hospitals in their current locations as acute care hospitals with emergency departments, and (ii) maintain an ownership interest in Seller's current post-acute care continuum of care network (e.g., VNA home care, sub-acute and long-term lines of service) and require any joint venture involving such post-acute care continuum of care network to maintain the applicable service line for such three-year period. During such periods that Buyer operates the Hospitals, Buyer agrees to maintain Seller's commitment to quality, safety, and patient satisfaction, including maintaining appropriate enrollment, certifications, and accreditations necessary to receive reimbursement under Government Payment Programs.

5.16. Charity Care and Community Obligations.

(a) Seller has historically provided significant levels of care for indigent and low-income patients and has also provided support for community volunteer services and care through a variety of community-based health programs. Subject to changes in Legal Requirements or governmental guidelines or policies, Buyer will ensure that each Hospital maintains and adheres to Seller's current policies on charity care, indigent care, community volunteer services and community benefits attached as Schedule 5.16 or adopt other policies and procedures that are at least as favorable to the indigent and uninsured in the aggregate as Seller's existing policies.

(b) During all times that Buyer owns and operates the Hospitals, Buyer will strive to provide care through community-based health programs, including by cooperating with local organizations that sponsor health care initiatives to address community needs and improve the health status of the elderly, poor, and at-risk populations in the community.

5.17. Educational Support. Buyer agrees to maintain and support financially the University of New England medical student and other health professions teaching programs established by Seller, in addition to Seller's graduate medical education programs, while operating at a level to not exceed the Indirect Medical Education and Direct Graduate Medical Education caps that may be established by CMS.

5.18. Capital Commitment.

(a) Post-Closing, Buyer, in consultation with Seller, the Local Board and potentially an outside consultant, will develop a strategic capital plan with respect to the Hospital Businesses (which for purposes of this Section 5.18 includes the Joint Ventures). In accordance with such strategic capital plan, Buyer agrees to spend within five years of Closing or commit in a binding contract to spend (or cause or permit its Affiliates or third parties to spend or commit in a binding contract to spend) within five years of Closing not less than $75,000,000 (the "**Commitment Amount**") at Seller facilities on (i) capital projects, including routine and non-routine capital expenditures for the improvement of

Seller's facilities and/or the acquisition, development, expansion and improvement of hospital, ambulatory or other health care services (such as implementation of a comprehensive and system-wide electronic medical record such as the Epic system), (ii) de novo development, expansion, or acquisition of a department, program, service or facility (whether for inpatient or outpatient services), (iii) upgrades or renovations generally, (iv) deferred maintenance items, and (v) capital expended in support of the recruitment of the Hospitals' medical staff located in the Hospitals' service area, limited to physician practice acquisitions, loan security agreements and real estate acquisition or development (including any associated medical equipment) in support of physician practice acquisitions. Buyer shall provide a written report to Seller on an annual basis that verifies its compliance with the capital commitment, which Seller may share publically. For the purposes of determining whether the Commitment Amount has been expended or committed to be expended, (x) only operating leases for (i) buildings or the fit-out or build-out of space used in the provision or support of medical services or (ii) medical equipment with a useful life of more than one year, shall count towards the Commitment Amount, (y) capital leases, and those operating leases that are permitted to be counted toward the Commitment Amount under Sections 5.18(a)(x)(i)-(ii), shall be valued at the net present value of any lease commitments, and (z) solely with respect to expenditures for equipment not currently owned or leased by the Hospital Businesses or space that is renovated, acquired or newly leased (with respect to incremental Buyer improvements) or obtained after Closing consistent with Section 5.18, it shall not be a prerequisite that the applicable expenditure be classified as a capital expenditure for accounting purposes. Notwithstanding the foregoing, (i) if Seller obtains the Refinancing Loan, the Commitment Amount shall be reduced by the portion of such loan spent on capital projects, and (ii) regardless of whether Seller obtains the Refinancing Loan, if Buyer assumes any Assumed Excess Liabilities, the Commitment Amount shall be further reduced by the amount of such Assumed Excess Liabilities and as otherwise described in Section 2.05(d).

(b) Notwithstanding the above capital commitment, in the event that any Legal Requirement is enacted or imposed by the State of Connecticut after Closing that discriminates against, or adversely affects a disproportionate number of for-profit hospitals and causes the Hospital Businesses to suffer a decline in EBITDA of more than ten (10) percent in any year, on a consolidated basis, then, Buyer may defer in its discretion the above capital commitment beyond the five-year period provided in Section 5.18(a) but only to the extent of the decline in EBITDA resulting from the discriminatory Legal Requirement. To the extent Buyer desires to defer the capital commitment as a result of a discriminatory Legal Requirement, (i) Buyer shall make available to the public reasonably detailed information to support Buyer's position (provided that in no event shall Buyer be required to disclose any information that is subject to a confidentiality or other similar arrangement) and (ii) Buyer shall consult with the Local Board to determine an alternate mutually agreeable timeframe to complete the capital commitment that is reasonable and appropriate in light of the changed circumstances caused by the new Legal Requirement.

5.19. Connecticut Transactions. If at any time prior to Closing, Buyer or any of its Affiliates enter into an agreement with another Connecticut hospital that seeks to consummate

transactions similar to the transactions described herein, then Buyer shall promptly inform Seller of such fact, subject to such hospital's approval of waiving any nondisclosure obligation in a confidentiality agreement between such hospital and Buyer, or an Affiliate of Buyer.

5.20. Fees and Expenses.

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

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

(c) Buyer shall pay the following: (i) all third party fees and expenses reasonably incurred by Buyer for Buyer's land title surveys and environmental, engineering and other inspections, studies, tests, reviews and analyses undertaken by or on behalf of Buyer for the benefit of Buyer, (ii) all transfer Taxes, sales and use and similar Taxes arising out of the transfer of the Assets (whether or not originally arising with or assessed to Seller or its applicable Subsidiary) and (iii) the premium for Buyer's title insurance policies described in Section 7.06.

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

5.21. Clinical Quality and Integration. For at least three (3) years after Closing, Buyer shall (i) collaborate with the Local Board and remaining former hospital staff of Seller on clinical quality matters of the Hospital Businesses to share best practices, establish clinical quality goals and measure progress, and (ii) to the extent consistent with antitrust Legal Requirements, consult with physicians on the medical staff of each Hospital, including at least

some independent (*i.e.*, non-employed) physicians, in managed care contracting and clinical integration with respect to the Hospital Businesses.

5.22. Insurance Ratings. Seller will take all commercially reasonable actions requested by Buyer to enable Buyer, at Buyer's expense, to succeed to the workers' compensation and unemployment insurance ratings of Seller and the Hospital Businesses for insurance purposes. Buyer shall not be obligated to succeed to any such rating, except as it may elect to do so or as is otherwise required to do so by Legal Requirements.

5.23. Fulfillment of Conditions. If all of the conditions to a party's obligation to consummate the transactions contemplated by this Agreement at the Closing are satisfied (or waived by that party in its sole discretion), such party will execute and deliver at Closing each Closing Document that such party is required by this Agreement to execute and deliver at Closing. Each party will use all commercially reasonable efforts to satisfy each condition to the obligations of the other party to consummate the transactions contemplated by this Agreement, to the extent that satisfaction of any such condition is within the control of such party.

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

5.25. Insurance Transition Provisions.

(a) With respect to the Disability Obligations, Buyer and Seller acknowledge and agree that no tail insurance shall be required in connection with the Disability Obligations because Seller is fully insured with respect to the Disability Obligations.

(b) Other than with respect to the Accumulated Benefit Obligation, the Post-Retiree Health Plan Liability, the Captive Insurer Liability and the Workers' Compensation Liability, on or before the Closing Date, Seller will purchase and obtain an unlimited extended claims reporting provision for all primary and excess insurance policies, including but not limited to coverage for directors, trustees and officers of Seller and its Affiliates, in force as of the date of this Agreement that cover Seller, its Affiliates and each physician employee of Seller or its Affiliates (or for which Seller otherwise has an obligation to provide such insurance), and that are written on a claims-made insuring agreement. Such extended claim endorsements must name Buyer (and other Affiliates of Buyer designated by Buyer prior to the Closing) as named insureds thereunder.

(c) Notwithstanding anything in this Agreement to the contrary and to the extent in the best interests of Seller, Seller may choose in its sole discretion to retain the Captive Insurer Liability, the Workers' Compensation Liability or both and, at or prior to Closing, purchase its own tail insurance policy or policies with respect to the Captive Insurer Liability, the Workers' Compensation Liability or both. To the extent Seller elects to retain the Captive Insurer Liability, the Workers' Compensation Liability or both, Seller shall provide written notice to Buyer of such election, and Buyer will be relieved of its obligations set forth in this Agreement with respect to any liability or liabilities that Seller elects to retain as set forth in such written notice, and there shall be

no reduction in the Purchase Price pursuant to Section 2.05(a)(vi) for any liabilities so retained.

5.26. Strategic Business Plan. After Closing, Buyer will use commercially reasonable efforts to execute and implement the Strategic Business Plan in accordance with its terms, as the Strategic Business Plan may be modified by Buyer, in consultation with the Local Board, from time to time.

5.27. Local Board. The Local Board shall, among other things, serve as a resource for Buyer with respect to Buyer's investment of the Capital Commitment (see Section 5.18 herein), maintenance and implementation of the Strategic Business Plan, be responsible for medical staff credentialing at the Hospitals, maintain and oversee the quality assurance program at the Hospitals and oversee and manage the accreditation process for the Hospitals.

5.28. Compliance Program. The Buyer and its Affiliates have established and implemented corporate compliance and ethics programs to ensure that high ethical and conduct standards are met in the conduct of their business. Buyer shall extend after Closing its corporate compliance and ethics programs to the Hospital Businesses.

6. CONDITIONS PRECEDENT TO OBLIGATIONS OF SELLER

The obligations of Seller to consummate the transactions contemplated by this Agreement, including by taking the actions specified in Section 8.02, are subject to the satisfaction on or before Closing of the following conditions, unless waived by Seller:

6.01. Representations; Covenants.

(a) Each of the representations and warranties of Buyer in this Agreement that is qualified as to materiality was true and correct on and as of the date of this Agreement, each of the other representations and warranties of Buyer was true and correct in all material respects on and as of the date of this Agreement, each of the representations and warranties of Buyer in this Agreement that is qualified as to materiality is true and correct on and as of the Closing Date, and each of the other representations and warranties of Buyer in this Agreement is true and correct in all material respects on and as of the Closing Date.

(b) Each of the covenants to be complied with or performed by Buyer on or before Closing (other than actions to be taken at the Closing, including the delivery of the Closing Documents described in Section 8.03) has been complied with and performed in all material respects.

6.02. Adverse Proceeding. No Proceeding by any Governmental Authority (including the Attorney General) has been instituted or threatened to restrain or prohibit the transactions contemplated by this Agreement, no Governmental Authority (including the Attorney General) has taken any other action or made any request of Seller or Buyer as a result of which Seller reasonably and in good faith deems it inadvisable to proceed with the transactions contemplated by this Agreement, and no order is in effect restraining, enjoining or otherwise preventing consummation of the transactions contemplated by this Agreement.

6.03. Pre-Closing Confirmations. Seller has received all consents, approvals, licenses and other authori□ations of Governmental Authorities, on terms reasonably satisfactory to Seller, including (i) the certificate of need approval by the Office of Health Care Access of the Connecticut Department of Public Health, (ii) confirmation that the Bond Liabilities have been satisfied, and (iii) approval for the conversion of the Hospitals to a for-profit entity by the Attorney General (including receipt of a fairness evaluation or fairness opinion satisfactory to the Seller and the Attorney General) and approval of the transfer or disposition of all donor restricted funds of the Hospitals and all Subsidiaries in a manner acceptable to the Attorney General, re□uired for Seller to consummate the transactions contemplated by this Agreement and that all applicable waiting periods under the HSR Act shall have expired or been terminated.

6.04. Redemption of the Bonds□Satisfaction of the Indenture. All actions re□uired to be taken and all conditions re□uired to be satisfied in connection with the defeasance or redemption of all outstanding tax-exempt debt issued by or on behalf of Seller, including the Bond Liabilities, and the satisfaction, discharge, release, and termination of all trust indentures, tax-exempt e□uipment loans and related documents (collectively, the "**Indenture**") associated with such tax-exempt debt, and all Encumbrances created by or in connection with the Indenture, have been, or at Closing will be, taken and satisfied. The Indenture and all Encumbrances created by or in connection with the Indenture shall have been satisfied, discharged and terminated, and Seller shall have received an opinion from counsel to the Connecticut Health and Education Facilities Authority to the effect that all Bond Liabilities have been defeased or prepaid, together with evidence satisfactory to Buyer of the discharge of all Encumbrances on the Assets under the Indenture.

6.05. Extraordinary Events. Buyer (a) is not in receivership or dissolution, (b) has not made any assignment for the benefit of creditors, (c) has not admitted in writing its inability to pay its debts as they mature, (d) has not been adjudicated a bankrupt, (e) has not filed a petition in voluntary bankruptcy, a petition or answer seeking reorgani□ation, or an arrangement with creditors under the federal bankruptcy law or any other similar Legal Re□uirement of the United States or any state (and no such petition has been filed against Buyer), or (f) has not entered into any contract to do any of the foregoing on or after the Closing Date.

7. CONDITIONS PRECEDENT TO OBLIGATIONS OF BUYER

The obligations of Buyer to consummate the transactions contemplated by this Agreement, including by taking the actions specified in Section 8.03, are subject to the satisfaction on or before Closing of the following conditions, unless waived by Buyer:

7.01. Representations; Covenants; Schedules.

(a) Each of the representations and warranties of Seller in this Agreement that is □ualified as to materiality was true and correct on and as of the date of this Agreement, each of the other representations and warranties of Seller in this Agreement was true and correct in all material respects on and as of the date of this Agreement, each of the representations and warranties of Seller in this Agreement that is □ualified as to materiality is true and correct on and as of the Closing Date, and each of the other representations and warranties of Seller in this Agreement is true and correct in all

material respects on and as of the Closing Date (other than the representation in Section 3.08(l) which shall be true and correct in all respects).

(b) Each of the covenants to be complied with or performed by Seller on or before Closing (other than actions to be taken at the Closing, including the delivery of the Closing Documents described in Section 8.02) has been complied with and performed in all material respects.

(c) Each of Seller's Schedules, Exhibits and other instruments required under this Agreement has been updated or delivered by Seller, and approved by Buyer, all in accordance with Section 10.01.

7.02. Adverse Action or Proceeding. No Proceeding by any Governmental Authority (including the Attorney General) has been instituted or threatened to restrain or prohibit the transactions contemplated by this Agreement, no Governmental Authority (including the Attorney General) has taken any other action or made any request of Seller or Buyer as a result of which Buyer reasonably and in good faith deems it inadvisable to proceed with the transactions contemplated by this Agreement, and no order is in effect restraining, enjoining or otherwise preventing consummation of the transactions contemplated by this Agreement.

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

7.04. Pre-Closing Confirmations and Contractual Consents. Buyer has obtained documentation or other evidence reasonably satisfactory to Buyer that:

(a) All Permits required to operate the Hospital Businesses will be transferred to or issued in the name of Buyer as of the Closing Date, without the imposition of any condition that is materially burdensome to the operation of the Hospital Businesses after Closing;

(b) The applicable Hospital Businesses that participate in the Government Payment Programs as of the date of this Agreement will be qualified effective as of Closing to participate in the Government Payment Programs in which they participate as of the date of this Agreement and will be entitled to receive payment under such Government Payment Programs for services rendered to qualified beneficiaries of such Government Payment Programs immediately after the Closing Date with respect to the Hospitals, and within a reasonable period of time after the Closing Date with respect to the other applicable Hospital Businesses;

(c) All other consents, approvals, licenses and other authorizations of Governmental Authorities, including the certificate of need approval by the Office of Health Care Access of the Connecticut Department of Public Health and approval for the conversion of the Hospitals to a for-profit entity by the Attorney General, required for Buyer to consummate the transactions contemplated by this Agreement and all other material consents, approvals, licenses and other authorizations of Governmental

Authorities required for Buyer to operate the Hospital Businesses after Closing shall have been received on terms reasonably satisfactory to Buyer;

(d) Seller has delivered to Buyer copies of consents to assignment of the Assumed Contracts, and certain other consents, waivers and estoppels, that are listed on Schedule 7.04(d);

(e) Seller has obtained approvals from its Board of Trustees, corporators and, to the extent required, the governing boards of its Subsidiaries; and

(f) All applicable waiting periods under the HSR Act have expired or been terminated.

7.05. Extraordinary Events. Seller (a) is not in receivership or dissolution, (b) has not made any assignment for the benefit of creditors, (c) has not admitted in writing its inability to pay its debts as they mature, (d) has not been adjudicated a bankrupt, (e) has not filed a petition in voluntary bankruptcy, a petition or answer seeking reorganization, or an arrangement with creditors under the federal bankruptcy law or any other similar Legal Requirement of the United States or any state (and no such petition has been filed against it), and (f) has not entered into any Contract to do any of the foregoing on or after the Closing Date.

7.06. Title Insurance Policies and Surveys. Buyer has received:

(a) One or more commitments from a recognized national title insurance company chosen by Buyer to issue as of the Closing Date ALTA extended coverage owner's title insurance policies for the Owned Real Property, in amounts reasonably acceptable to Buyer, in form reasonably acceptable to Buyer and with such endorsements as Buyer may reasonably require, at Buyer's sole cost and expense; and

(b) ALTA land title surveys of the Owned Real Property, in form reasonably satisfactory to Buyer and the title insurance company, from a firm designated by Buyer and certified to Buyer and the title insurance company, at Buyer's sole cost and expense.

7.07. Opinion of Seller's Counsel. Buyer has received an opinion from counsel to Seller, dated as of the Closing Date and addressed to Buyer, in a form reasonably satisfactory to Buyer.

7.08. The Indenture. The Indenture and all Encumbrances created by or in connection with the Indenture, specifically the Bond Liabilities and other tax-exempt debt, shall have been satisfied, discharged and terminated, and Buyer shall be entitled to rely on the opinion of Seller's bond counsel described in Section 6.04.

7.09. Environmental Assessments. Buyer shall, at its election, have received a Phase I environmental site assessment in a form reasonably satisfactory to Buyer, on each parcel of Owned Real Property and, at Buyer's option, any portion of the premises forming a part of the Leased Real Property (each, a "**Phase I Assessment**," collectively, the "**Phase I Assessments**"). Buyer shall not be permitted to conduct any Phase II environmental site assessments, or other intrusive or destructive testing on or relating to the Owned Real Property or Leased Real

Property (each, a "**Phase II Assessment**," collectively, the "**Phase II Assessments**") unless pursuant to information contained in the applicable Phase I Assessment and subject to the prior approval of Seller (including any conditions which Seller may impose on such investigations, and, if Seller so requires, memorialized in an environmental access agreement between Buyer and Seller), in Seller's sole discretion. Notwithstanding the foregoing, if, after review of any Phase I Assessment, the parties reasonably determine that the subject real property is an Establishment Real Property (as defined in Section 5.08 hereof) and reasonably identifies any "areas of concern" ("**AOCs**") warranting additional investigation pursuant to the Transfer Act, then, in order to obtain a preliminary (but not definitive) understanding of the nature and extent of any contamination potentially associated with such AOC, Buyer shall have the right to perform a limited Phase II Assessment of each such AOC pursuant to a scope of work approved by Seller in advance, which approval (including any conditions which Seller may reasonably impose on such investigation) shall not be unreasonably withheld, conditioned or delayed. Buyer shall pay the full costs of any Phase I Assessment(s) and any Phase II Assessment(s) that may occur pursuant to this Section 7.09. Notwithstanding any other provision hereof to the contrary, Buyer shall not provide Seller with copies of any Phase II Assessment(s) (or any of the data contained therein) unless requested by Seller. To the extent any Phase II Assessments are performed in accordance with this provision, Buyer shall be reasonably satisfied with same.

7.10. Hill-Burton Facilities. No Encumbrance affects any of the Assets or Hospital Businesses relating to or arising under the Hill-Burton Act.

7.11. [Physician Organization. Simultaneous with the Closing, Eastern Connecticut Medical Professionals Foundation, Inc. shall amend its Bylaws and Certificate of Incorporation, as necessary, to specify that Buyer (or its designee) is its sole corporate member. Eastern Connecticut Medical Professionals Foundation, Inc. shall continue to employ on the Closing Date those physicians and other licensed "Providers," as defined in Section 33-182aa of the Connecticut General Statutes, that it employs immediately prior to the Closing Date.]

7.12. Additional Liabilities. Seller shall not have Additional Liabilities as described in Section 2.05(d) in excess of $10,000,000 (Ten Million Dollars), unless Buyer in its sole discretion agrees to assume such liabilities in accordance with Section 2.05(d).

8. CLOSING; TERMINATION OF AGREEMENT

8.01. Closing.

(a) Consummation of the sale and purchase of the Assets and the other transactions contemplated by this Agreement (the "**Closing**") will take place at [_____] at 10:00 a.m., or at such other place and time as the parties may mutually agree, on _____, 2015, or if at such time any conditions to Closing set forth in Articles 6 and 7 have not been satisfied (or waived by the parties entitled to the benefit thereof), on the third business day following satisfaction or waiver of such conditions, or at such time or place as the parties may mutually agree. The Closing shall be effective for all purposes as of 12:01 a.m. on the day immediately following the Closing Date.

(b) At the Closing, Seller shall deliver, or cause to be delivered, to Buyer, each of the Closing Documents and other items set forth in Section 8.02, all in forms reasonably acceptable to Buyer and its counsel, and such Closing Documents, as appropriate, shall be duly executed by, and acknowledged on behalf of, Seller. At the Closing, Buyer shall deliver, or cause to be delivered, to Seller, each of the Closing Documents and the consideration set forth in Section 8.03, all in forms reasonably acceptable to Seller and its counsel, and such Closing Documents, as appropriate, shall be duly executed by, and acknowledged on behalf of, Buyer and, where applicable, PMH.

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

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

(a) special warranty deeds, duly executed by Seller in recordable form, conveying to Buyer fee simple title to the Owned Real Property, free and clear of Encumbrances other than the Permitted Real Property Encumbrances;

(b) assignment and assumption agreements duly executed by Seller conveying to Buyer all of Seller's right, title and leasehold interest in and to the Leased Real Property;

(c) bills of sale and assignment duly executed by Seller conveying to Buyer good and valid title to all personal property Assets, free and clear of Encumbrances other than the Permitted Personal Property Encumbrances;

(d) assignments duly executed by Seller conveying to Buyer Seller's interests in the Assumed Contracts;

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

(f) an original or certified copy of the tail insurance policies required by Section 5.25 and receipts evidencing payment of the premiums therefor;

(g) a copy of resolutions duly adopted by the board of directors of Seller authorizing and approving the execution and delivery of this Agreement and the Closing Documents and the consummation of the transactions contemplated herein and therein, certified as in full force and effect as of the Closing Date by an appropriate officer of Seller;

(h) a certificate of a duly authori□ed officer of Seller certifying that (i) each of the representations and warranties of Seller in this Agreement that is □ualified as to materiality was true and correct on and as of the date of this Agreement, (ii) each of the other representations and warranties of Seller in this Agreement was true and correct in all material respects on and as of the date of this Agreement, (iii) each of the representations and warranties of Seller in this Agreement that is □ualified as to materiality is true and correct on and as the Closing Date, (iv) each of the other representations and warranties of Seller in this Agreement was true and correct in all material respects on and as of the Closing Date and (v) each of the covenants to be complied with or performed by Seller on or before Closing (other than actions to be taken at the Closing, including the delivery of the Closing Documents described in this Section 8.02) has been complied with and performed in all material respects;

(i) a certificate of incumbency for the officers of Seller executing this Agreement and the Closing Documents;

(j) a certificate of existence and good standing for Seller and each of its Subsidiaries from the State of Connecticut, dated no earlier than 15 days prior to the Closing Date;

(k) stock certificates and certificates or other appropriate instruments of transfer of the ownership interests in the Joint Ventures, duly endorsed for transfer to Buyer, and, to the extent obtained prior to Closing, any amendment to the operating agreement, bylaws or other governing documents of each Joint Venture that Buyer determines, in its reasonable discretion, is necessary to fully effectuate the transfer of the ownership interest in the Joint Ventures to Buyer;

(l) a statement pursuant to section 1.1445-2(b)(2)(iv) of the Treasury Regulations under the Code, executed on behalf of Seller or any Affiliate conveying an interest in Owned Real Property to Buyer or its Affiliates, certifying that such entity is not a foreign corporation and is not otherwise a foreign Person;

(m) all certificates of title and other documents evidencing an ownership interest conveyed as part of the Assets, including for all motor vehicles;

(n) all necessary state and local real estate conveyance tax forms duly executed by Seller;

(o) final execution copy of the Transfer Act Form III and ECAF with a □3,000 filing fee, as more fully described in Section 5.08;

(p) UCC termination statements or other releases for all Encumbrances on the Assets not constituting Permitted Encumbrances, which termination statements and releases will be effective as of Closing;

(□) the opinion of counsel to Seller as provided in Section 7.07;

(r) owner's affidavits, certificates, rent rolls and other documentation that may be reasonably necessary to consummate the transactions contemplated by this Agreement and obtain the title policies required to be issued hereunder;

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

(t) such other Closing Documents as Buyer deems reasonably necessary to consummate the transactions contemplated by this Agreement.

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

(a) The Purchase Price due to Seller, as adjusted in accordance with Section 2.05;

(b) an assumption agreement duly executed by Buyer pursuant to which Buyer assumes the Assumed Liabilities, as well as any documents Seller may reasonably require to effectuate Buyer's assumption of certain of Seller's Employee Benefit Plans pursuant to Section 5.03(e);

(c) a copy of resolutions duly adopted by the boards of directors, members or managers of PMH and Buyer, as appropriate, authorizing and approving the execution and delivery of this Agreement and the Closing Documents and the consummation of the transactions contemplated herein and therein, certified as in full force and effect as of the Closing Date by an appropriate officer of PMH and Buyer;

(d) a certificate of a duly authorized officer of Buyer certifying that each of the representations and warranties of Buyer in this Agreement that is qualified as to materiality was true and correct on and as of the date of this Agreement, that each of the other representations and warranties of Buyer in this Agreement was true and correct in all material respects on and as of the date of this Agreement, that each of the representations and warranties of Buyer in this Agreement that is qualified as to materiality is true and correct on and as of the Closing Date, that each of the other representations and warranties of Buyer in this Agreement is true and correct in all material respects on and as of the Closing Date, and that each of the covenants to be complied with or performed by Buyer on or before Closing (other than actions to be taken at the Closing, including the delivery of the Closing Documents described in this Section) has been complied with and performed in all material respects;

(e) a certificate of incumbency for the officers of [Buyer's ultimate parent] and Buyer executing this Agreement and the Closing Documents;

(f) a certificate of existence and good standing of Buyer from the State of [], dated no earlier than 15 days prior to the Closing Date;

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

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

8.04. Termination Prior to Closing; Termination Fee.

(a) Notwithstanding anything herein to the contrary, this Agreement may be terminated at any time: (i) by mutual consent of Seller and Buyer; (ii) by Buyer, by written notice to Seller if any event occurs or condition exists that causes Seller to be unable to satisfy one or more conditions to the obligations of Buyer to consummate the trasnactions contemplated by this Agreement as set forth in Article 7; (iii) by Seller, by written notice to Buyer if any event occurs or condition exists that causes Buyer to be unable to satisfy one or more conditions to the obligations of Seller to consummate the trasnactions contemplated by this Agreement as set forth in Article 6; (iv) by Seller or Buyer, if the Closing Date shall not have taken place on or before December 31, 2016 (as such date may be extended by mutual agreement of Seller and Buyer); *provided*, however, that no party may terminate this Agreement if the failure of Closing to occur by such date resulted from a material breach of this Agreement by such party; (v) by Buyer, pursuant to Section 5.13 hereof, or (vi) by Seller pursuant to Section 10.11(b).

(b) For the avoidance of doubt, this Section 8.04(b) shall not be effective unless and until the Certificate of Need (“**CON**”) application has been filed with the State of Connecticut. Upon the filing of the CON application with the State of Connecticut, Seller shall present its invoices for reasonable out-of-pocket legal, valuation and consulting expenses incurred by Seller after the execution of that Letter of Intent between Buyer and Seller dated June 25, 2015 up to the time of the filing of the CON application (the “**CON Preparation Period**”). Within 10 days of receipt of such invoices, Buyer shall reimburse Seller for such reasonable out-of-pocket legal, valuation and consulting expenses up to $1,000,000 (One Million Dollars). If, however, the out-of-pocket legal, valuation and consulting expenses incurred by Seller during the CON Preparation Period total less than $1,000,000 (One Million Dollars), then Seller may present Buyer with additional invoices for out-of-pocket legal, valuation and consulting expenses incurred by Seller after the filing of the CON but prior to the closing of the transaction, and Buyer shall reimburse Seller for such additional out-of-pocket legal, valuation, and consulting expenses within 10 days of receipt of such invoices; provided, however, that the total amount of the invoices reimbursed by Buyer for out-of-pocket legal, valuation and consulting expenses paid by Seller during the CON Preparation Period and thereafter shall not in the aggregate exceed $1,000,000 (One Million Dollars). In the event that the transaction closes, the total amount paid by Buyer to Seller pursuant to this Section 8.04(b) shall be credited against the Purchase Price as shown in Section 2.05(a)(ix). In the event that the transaction does not close because Buyer breaches its obligations under this Agreement or refuses to accept regulatory conditions placed on the transaction by the Attorney General and the Office of Health Care Access of the Connecticut Department of Public Health, Seller shall be entitled to retain all amounts it receives pursuant to this Section 8.04(b). In the event that the transaction does not close as a result of (i) a breach by Seller of the provisions of Section 5.23 where such breach is willful and intentional by Seller or (ii) the failure of any material regulatory approval to issue despite the good faith efforts of the parties to cooperate with each other and regulators as part of the regulatory process, then Seller shall refund to Buyer all amounts paid to Seller under this Section 8.04(b).

(c) If this Agreement is validly terminated pursuant to Section 8.04(a), this Agreement will be null and void, and there will be no liability on the part of any party pursuant to this Agreement, except that (i) upon termination of this Agreement pursuant to Section 8.04(a), subject to Section 8.04(b), Seller will remain liable to Buyer and Buyer will remain liable to Seller for any breach of their respective obligations existing at the time of such termination, and each party may seek such remedies or damages against the other with respect to any such breach as are provided in this Agreement or as are otherwise available at law or in equity and (ii) the expense allocation provisions of Section 5.20 and the confidentiality provisions of Section 10.22 shall remain in full force and effect and survive any termination of this Agreement.

(d) Upon termination of this Agreement, each party's existing rights of access to the books and records of the other party shall terminate, and each party shall promptly return every document furnished it by the other party (or any Affiliate of such other party) in connection with the transactions contemplated hereby, whether obtained before or after execution of this Agreement, and all copies thereof, and will destroy all copies of any analyses, studies, compilations or other documents prepared by it or its representatives to the extent they contain any information with respect to the business of the other parties hereto or their Affiliates, and will cause its representatives to whom such documents were furnished to comply with the foregoing. This Section 8.04 shall survive any termination of this Agreement.

9. INDEMNIFICATION

9.01. Indemnification by Seller. Subject to the conditions and limitations, and solely to the extent provided in this Article 9, Seller shall indemnify, defend and hold harmless Buyer's Indemnified Persons, and each of them, from and against any Losses incurred or suffered by Buyer's Indemnified Persons, directly or indirectly, as a result of or arising from:

(a) any inaccuracy in or breach of any representation or warranty of Seller set forth in this Agreement or in any Closing Document to which Seller is a party, whether or not Buyer's Indemnified Persons relied thereon or had knowledge thereof, *provided* that, in determining whether there has been any such inaccuracy or breach, any qualification as to materiality included in any representation or warranty shall not be taken into account;

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

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

(d) the Excluded Liabilities;

(e) any actual damages (including reasonable attorneys' fees) resulting from claims by any creditor of Seller relating to a claim in existence as of the Closing Date that the transfer of any of the Assets constitutes a fraudulent conveyance or transfer, or is

avoidable under applicable state or federal insolvency, bankruptcy, bulk sales, fraudulent conveyance or creditors rights Legal Re uirements; and

(f) any liabilities, costs or expenses incurred by Buyer or its Affiliates in connection with the Transfer Act Activities contemplated by Section 5.08.

9.02. Seller s Limitations. Seller will have no liability under Section 9.01(a) and no claim will accrue against Seller under Section 9.01(a) unless and until the total amount of Losses that would otherwise be indemnifiable by Seller in respect of claims arising under Section 9.01(a) exceeds 675,000 (the **Seller Deductible**) in the aggregate, at which time Buyer s Indemnified Persons shall be entitled to indemnification for all Losses under Section 9.01(a) in excess of the Seller Deductible, *provided* that there shall be no minimum Loss re uirement, and liability of Seller shall arise for all Losses, in respect of Losses resulting from Seller s intentional misrepresentation or fraud.

9.03. Indemnification by Buyer. Subject to the conditions and limitations, and solely to the extent, provided in this Article 9, Buyer shall indemnify, defend and hold harmless Seller s Indemnified Persons, and each of them, from and against any Losses incurred or suffered by Seller s Indemnified Persons, directly or indirectly, as a result of or arising from:

(a) the inaccuracy in or breach of any representation or warranty of Buyer set forth in this Agreement or in any Closing Document to which Buyer is a party, whether or not Seller s Indemnified Persons relied thereon or had knowledge thereof, *provided* that, in determining whether there has been any such inaccuracy or breach, any ualification as to materiality included in any representation or warranty shall not be taken into account;

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

(c) the Assumed Liabilities; and

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

9.04. Buyer s Limitations. Buyer will have no liability under Section 9.03(a) and no claim will accrue against Buyer under Section 9.03(a) unless and until the total amount of Losses that would otherwise be indemnifiable by Buyer in respect of claims arising under Section 9.03(a) exceeds 675,000 (the **Buyer Deductible**) in the aggregate, at which time Seller s Indemnified Persons shall be entitled to indemnification for all Losses under Section 9.03(a) in excess of the Buyer Deductible, *provided* that there shall be no minimum Loss re uirement, and liability of Buyer shall arise for all Losses, in respect of Losses resulting from any intentional misrepresentation or fraud by Buyer.

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

(a) Third Party Claims.

(i) If the basis for any claim for indemnification against an Indemnifying Party pursuant to this Article 9 is a claim or demand made against an Indemnitee by a Person other than Buyer's Indemnified Person or Seller's Indemnified Person (a "**Third Party Claim**"), the Indemnitee shall deliver a Claim Notice with reasonable promptness to the Indemnifying Party (with copies of all relevant written documentation, including papers served, if any, and a reasonable summary of any relevant oral discussions with such third party) specifying the nature of and alleged basis for the Third Party Claim and, to the extent then feasible and known, the alleged amount or the estimated amount of the Third Party Claim. If the Indemnitee fails to deliver the Claim Notice (and related materials) to the Indemnifying Party within 60 days after the Indemnitee receives notice of such Third Party Claim, the Indemnifying Party will not be obligated to indemnify the Indemnitee with respect to such Third Party Claim if and only to the extent that the Indemnifying Party's ability to defend the Third Party Claim or otherwise minimize the Losses for which the Indemnifying Party must indemnify the Indemnitee has been prejudiced by such failure. The Indemnifying Party will notify the Indemnitee within 15 days after receipt of the Claim Notice by the Indemnifying Party (the "**Notice Period**") whether the Indemnifying Party elects, at the sole cost and expense of the Indemnifying Party, to assume the defense of the Indemnitee against the Third Party Claim.

(ii) If the Indemnifying Party notifies the Indemnitee within the Notice Period that the Indemnifying Party elects to assume the defense of the Indemnitee against the Third Party Claim, then the Indemnifying Party will defend, at its sole cost and expense, the Third Party Claim by all appropriate proceedings, which proceedings will be diligently prosecuted by the Indemnifying Party to a final conclusion or settled, at the discretion of the Indemnifying Party (with the consent of the Indemnitee, which consent shall not be unreasonably withheld with respect to any settlement that does not include any non-monetary relief). The Indemnifying Party will have full control of such defense and proceedings, including any compromise or settlement thereof; *provided* that, prior to the Indemnitee's receipt of the Indemnifying Party's notice that it elects to assume such defense, the Indemnitee may file, at the sole cost and expense of the Indemnitee, any motion, answer or other pleading that the Indemnitee reasonably deems necessary to protect its interests and that is not prejudicial to the Indemnifying Party (it being understood that, except as provided in this Section 9.05(a)(ii), if an Indemnitee takes any such action that is prejudicial to the Indemnifying Party, the Indemnifying Party will be relieved of its obligations hereunder with respect to that portion of the Third Party Claim (or the Losses attributable thereto) prejudiced by the Indemnitee's action); and *provided further* that, if requested by the Indemnifying Party, the Indemnitee shall reasonably cooperate, at the sole cost and expense of the Indemnifying Party, with the Indemnifying Party and its counsel in contesting any Third Party Claim that the Indemnifying Party elects to contest or, if related to the Third Party Claim, in making any counterclaim or cross-claim against any Person (other than the

Indemnitee or its Affiliates). The Indemnitee may participate in, but not control, any defense or settlement of any Third Party Claim assumed by the Indemnifying Party pursuant to this Section 9.05(a)(ii) and, except in respect of cooperation requested by the Indemnifying Party as provided in the preceding sentence, the Indemnitee will bear its own costs and expenses with respect to such participation. Notwithstanding the foregoing, the Indemnifying Party may not assume the defense of the Third Party Claim on behalf of the Indemnitee if (1) the Persons against whom the Third Party Claim is made, or any impleaded Persons, include both one or more of Buyer's Indemnified Persons and one or more of Seller's Indemnified Persons, and (2) representation of all of such Persons by the same counsel creates an actual or potential conflict of interest that, after giving effect to any waivers made by such Persons, would breach or violate the ethical rules applicable to such counsel, in which case the Indemnitee shall have the right to defend the Third Party Claim on its own behalf and to employ counsel at the expense of the Indemnifying Party.

(iii) If the Indemnifying Party fails to notify the Indemnitee within the Notice Period that the Indemnifying Party intends to defend the Indemnitee against the Third Party Claim, or if the Indemnifying Party gives such notice but fails to diligently prosecute or settle the Third Party Claim, or if the Indemnifying Party is precluded by the last sentence of Section 9.05(a)(ii) from assuming the defense of such Third Party Claim, then (A) the Indemnitee will defend the Third Party Claim by all appropriate proceedings, which proceedings will be diligently prosecuted by the Indemnitee to a final conclusion or settled at the discretion of the Indemnitee (*provided*, however, that no Indemnifying Party shall be liable to any Indemnitee for any Losses arising from any settlement that is made or entered into without an Indemnifying Party's prior, written consent, such consent not to be unreasonably withheld or delayed) and (B) the out-of-pocket costs and expenses reasonably incurred in good faith by the Indemnitee in the defense of such Third Party Claim will be paid by the Indemnifying Party. The Indemnitee will have full control of such defense and proceedings, including any compromise or settlement thereof (subject to the proviso in the first sentence of this clause (iii)), *provided* that, if requested by the Indemnitee, the Indemnifying Party shall reasonably cooperate, at the sole cost and expense of the Indemnifying Party, with the Indemnitee and its counsel in contesting the Third Party Claim which the Indemnitee is contesting or, if related to the Third Party Claim in question, in making any counterclaim or cross-claim against any Person (other than the Indemnifying Party or its Affiliates).

(b) First Party Claims.

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

Indemnifying Party disputes its obligation to indemnify the Indemnitee hereunder, the claim will be presumed to be a liability of the Indemnifying Party hereunder.

(ii) Upon receipt of any Indemnity Notice, the Indemnifying Party will be entitled to request in writing and receive from the Indemnitee a reasonable extension of the 60-day period in which to respond pursuant to Section 9.05(b)(i) for the purpose of investigating the claims made therein or the proper amount thereof. The Indemnitee, to the extent requested by the Indemnifying Party, shall reasonably cooperate, at the sole cost and expense of the Indemnifying Party, with the Indemnifying Party's investigation of such claims or the proper amount thereof.

(c) Resolution of Disputes. If the Indemnifying Party timely disputes, or is deemed to have disputed, its liability with respect to a claim described in a Claim Notice or an Indemnity Notice, the Indemnifying Party and the Indemnitee shall proceed promptly and in good faith to negotiate a resolution of such dispute within 60 days following receipt by the Indemnifying Party of the Claim Notice or Indemnity Notice and, if such dispute is not resolved through negotiations during such 60-day period, it shall be resolved pursuant to Section 10.04 and, if not resolved thereby, by other appropriate legal process.

(d) Payment of Indemnifiable Losses. Subject to the terms of any final order entered by a court of competent jurisdiction, the Indemnifying Party shall pay the amount of any indemnifiable Losses to the Indemnitee within ten days following the later to occur of (i) the date on which such indemnifiable Losses are incurred or sustained by the Indemnitee or (ii) the date on which the Indemnifying Party has acknowledged its liability for such indemnifiable Losses. Indemnifiable Losses not paid when so due shall accrue interest from (and including) the date on which such indemnifiable Losses were incurred or sustained by the Indemnitee until (but excluding) the date on which such amount is paid, at the interest rate provided in Section 10.20.

(e) Certain Disclaimers. Any estimated amount of a claim submitted in a Claim Notice or an Indemnity Notice shall not be conclusive of the final amount of such claim, and the giving of a Claim Notice when an Indemnity Notice is properly due, or the giving of an Indemnity Notice when a Claim Notice is properly due, shall not impair such Indemnitee's rights hereunder. Notice of any claim comprised in part of Third Party Claims and claims that are not Third Party Claims shall be appropriately bifurcated and given pursuant to each of Section 9.05(a)(i) and Section 9.05(b)(i), as applicable.

9.06. Survival of Representations and Warranties; Indemnity Periods. Notwithstanding any right of Buyer to investigate Seller and the Hospital Businesses or any right of any party to investigate the accuracy of the representations and warranties of the other party in this Agreement, or any actual investigation by or knowledge of a party, Seller has, on the one hand, and Buyer has, on the other hand, the right to rely fully upon the representations and warranties of the other in this Agreement. The representations, warranties and covenants of Seller and Buyer in this Agreement respectively will survive the Closing (a) indefinitely with respect to matters covered by Sections 2.04, 3.01, 3.02, 3.03, 3.11, 4.01, 4.02, 4.04, 8.04(b), 8.04(c),

8.04(d), 9.01(b)-(e), 9.03(b)-(d), 10.15, 10.20, 10.22 and 10.23, (b) until the expiration of all applicable statutes of limitations (including all periods of extension) with respect to matters covered by Sections 3.05, 3.07, 3.11, 3.12(a), 3.13, 3.17, 3.22, 3.24 and 3.28, and (c) until the second anniversary of the Closing Date in the case of all other representations and warranties, except that:

(i) the right to indemnification with respect to any claim relating to a breach or default of any representation and warranty whose survival expires in accordance with clause (b) or (c) above will continue to survive if a Claim Notice or an Indemnity Notice with respect to such claim has been given on or before the expiration of such representation or warranty until the claim for indemnification has been satisfied or otherwise resolved as provided in this Article;

(ii) in the event of intentional misrepresentation or fraud in the making of any representation and warranty, all representations and warranties that are the subject of the intentional misrepresentation, fraud or intentional nonfulfillment or breach shall survive until the expiration of all applicable statutes of limitations (including all periods of extension) with respect to claims made for such intentional misrepresentation, fraud or intentional nonfulfillment or breach; and

(iii) covenants to be performed or complied with after the Closing Date will survive the Closing until 60 days after the end of the term specified in each covenant, or, if no term is specified, indefinitely.

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

9.08. Indemnity Reserve. Subject to any adjustment as described in Section 2.05(d), Seller agrees to maintain an indemnity reserve in the amount of $4,500,000 (Four Million Five Hundred Thousand Dollars) for a period of three years after the Closing so that Buyer will have

meaningful financial recourse against Seller for indemnification claims; provided, however, that (a) if, as of the third anniversary of the Closing Date, Buyer has pending indemnification claims, then Seller shall maintain an indemnity reserve in the amount of Buyer□s Indemnified Person□s bona fide claims until final resolution of such matters, and (b) if Buyers has not yet received written approval from CTDEEP or a □verification□from a □Licensed Environmental Professional□as contemplated by Section 5.08 that the Establishment Real Properties have been remediated in full compliance with the Connecticut Remediation Standard Regulations, then the indemnification reserve shall be extended for an additional period until such written approval has been received by Buyer. Notwithstanding the foregoing, in no circumstance shall the indemnification reserve established by this Section 9.08 be extended beyond the fifth anniversary of the closing date.

10. GENERAL

10.01. Exhibits; Schedules.

(a) Each Schedule and Exhibit to this Agreement shall be considered a part hereof as if set forth herein in full. From the date hereof until Closing, Seller shall update its Schedules such that all of its representations and warranties are true and accurate as of the Closing Date. Any other provision herein to the contrary notwithstanding, all Schedules, Exhibits, or other instruments provided for herein and not delivered at the time of execution of this Agreement or that are incomplete at the time of execution of this Agreement shall be delivered or completed within ten (10) days after the date hereof or ten (10) days prior to the Closing, whichever is sooner. It shall be deemed a condition precedent to the obligations of Buyer that each of the Schedules, Exhibits and related documents, instruments, books and records shall meet with the approval of Buyer. If Buyer, in its reasonable discretion, determines that it should not consummate the transactions contemplated by this Agreement because of any information contained in a Schedule, Exhibit, or other instrument that is delivered to Buyer after the execution of this Agreement, then Buyer may terminate this Agreement on or before the Closing by giving written notice thereof to Seller.

(b) Nothing in the Schedules shall be deemed ade□uate to disclose an exception to a representation or warranty made in this Agreement unless the Schedule identifies the exception with reasonable particularity and, without limiting the generality of the foregoing, the mere listing of a document as an exception to any representation and warranty shall not be deemed to disclose the contents of such document as an exception to any representation or warranty (but shall be ade□uate to disclose the existence of the document itself).

10.02. E□uitable Remedies. Subject to Section 8.04(b), each party acknowledges and agrees that its breach of this Agreement, or its failure to perform its obligations pursuant to this Agreement in accordance with its specific terms, would cause the other party to suffer irreparable damage or injury that would not be fully compensable by money damages, or the exact amount of which may be impossible to determine, and, therefore, such other party would not have an ade□uate remedy available at law. Accordingly, each party agrees that the other party shall be entitled to seek specific performance, injunctive and□or other e□uitable relief from

any court of competent jurisdiction (without the necessity of posting bond) as may be necessary or appropriate to enforce specifically this Agreement and the terms and provisions hereof and to prevent or curtail any breach (or threatened breach) of the provisions of this Agreement. Such equitable remedies shall not be the exclusive remedy of any party for any such breach or failure to perform by another party, but shall be in addition to all other remedies available to such party at law or in equity (the availability of which remedies shall be, after the Closing, subject to the applicable limitations set forth in Article 9).

10.03. Other Owners of Assets. Buyer, Seller and its undersigned Subsidiaries acknowledge that certain Assets may be owned by Subsidiaries of Seller and not Seller. Notwithstanding the foregoing, and for purposes of all representations, warranties, covenants, and agreements contained herein, Seller agrees, and, as evidenced by their acknowledgement to this Agreement, its undersigned Subsidiaries agree and acknowledge, that (i) its obligations with respect to any Assets shall be joint and several with any Subsidiary of Seller that owns or controls such Assets, (ii) the representations and warranties herein, to the extent applicable, shall be deemed to have been made by, on behalf of and with respect to such Subsidiaries of Seller in their ownership capacity, and (iii) it has the legal capacity to cause, and it shall cause, any of its Subsidiaries that owns or controls any Assets to meet all of Seller's obligations under this Agreement with respect to such Assets. Seller hereby waives any defense to a claim made by Buyer or its Affiliates under this Agreement based on the failure of any Person who owns or controls the Assets to be a party to this Agreement. Notwithstanding the foregoing, the parties acknowledge and agree that Seller shall not make pursuant to this Agreement, and this Section 10.03 shall not otherwise suggest, any representation, warranty or other commitment as to the Subsidiaries of Seller listed on Schedule 10.03.

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

(a) In the event of a controversy or claim arising under this Agreement, either party may give the other party notice of such dispute pursuant to Section 10.14 hereof, and promptly thereafter the parties will each select two or more senior executives to negotiate in good faith in an effort to resolve the controversy or claim. The senior executives shall meet at such location as from time to time may be mutually agreed by the parties and such meetings shall be in person to the extent practicable.

(b) If the parties are unable to resolve the controversy or claim as provided in Section 10.04(a) within 30 days of the notice of the controversy or claim, then either party may notify the other party that it wants to pursue non-binding mediation in an attempt to resolve the controversy or claim. The parties shall jointly appoint a mutually acceptable mediator to mediate the dispute or, if the parties are unable to agree on a mutually acceptable mediator within 15 days after receipt of notice requesting mediation, then the parties shall request assistance from the American Arbitration Association in finding a mutually acceptable mediator. Each party shall bear its own costs incurred in the mediation and shall bear one-half the costs and expenses of the mediator and any similar parties that may assist in the mediation. The parties agree to participate in good

faith in the mediation and negotiations related thereto for a period of 30 days, unless a longer period is otherwise agreed.

10.05. Tax and Government Payment Program Effect. None of the parties (nor such parties' counsel or accountants) has made or is making in this Agreement any representation to any other party (or such party's counsel or accountants) concerning any of the Tax or Government Payment Program effects or consequences on the other party of the transactions provided for in this Agreement. Each party represents that it has obtained, or may obtain, independent Tax and Government Payment Program advice with respect thereto and upon which it, if so obtained, has solely relied.

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

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

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

10.09. Consents, Approvals and Discretion. Except as expressly provided to the contrary in this Agreement, whenever this Agreement requires any consent or approval to be given by any

party or any party must or may exercise discretion, such consent or approval shall not be unreasonably withheld or delayed and such discretion shall be reasonably exercised.

10.10. Choice of Law. This Agreement and all matters arising out of or relating to this Agreement shall be governed by and construed in accordance with the laws of the State of Connecticut without regard to any conflicts of laws rules (whether of the State of Connecticut or any other jurisdiction). Any litigation or proceedings among the parties arising out of or relating to this Agreement shall be commenced in a court of the State of Connecticut or the federal district court of Connecticut.

10.11. Benefit and Assignment; Change in Control of PMH.

(a) Subject to the provisions herein to the contrary, this Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective legal representatives, successors and assigns; *provided* however that no party may assign this Agreement without the prior written consent of the other party. Notwithstanding the foregoing, (i) Buyer may designate one or more Affiliates to purchase any or all of the Assets including the Hospital Businesses, provided that PMH hall unconditionally guarantee any and all obligations of such Affiliates pursuant to Section 10.23, and (ii) Buyer and PMH shall be permitted to grant a security interest in and collaterally assign and transfer all their rights, interests and benefits, but not their obligations under this Agreement to any entity providing financing to Buyer and□or Buyer□s Affiliates at any time and from time to time without obtaining the written consent of Seller.

(b) If PMH undergoes a □Change in Control□prior to the Closing PMH shall (i) provide 30 days□advance notice to Seller of such Change in Control, and (ii) Seller shall have the right to terminate this Agreement without penalty, including that Seller shall not be re□uired to pay any consulting fees to PMH or Buyer pursuant to any consulting agreement entered into by Seller and PMH or Buyer. For purposes of this Section 10.11(b), the term □Change in Control□means (i) a sale of all or substantially all the assets of PMH, (ii) any merger, consolidation or ac□uisition of PMH by or into another corporation, entity or person, or (iii) any change in the direct or indirect ownership of more than fifty percent (50□) of the voting capital stock of PMH in one or more related transactions. Notwithstanding the forgoing, a Change in Control shall not include a transfer of 50□ or more of the shares of PMH in connection with one or more public offerings of its shares. A transfer of 50□ or more of the shares of PMH in connection with one or more transactions involving the sale of PMH shares to one or more private e□uity firms shall re□uire the prior written consent of Seller, which consent shall not unreasonably be withheld.

10.12. Third Party Beneficiary. This Agreement (including provisions regarding employee and employee benefit matters) and the Closing Documents are intended solely for the benefit of the parties to this Agreement (and their respective successors and permitted assigns) and (solely in their capacities as Indemnified Persons) Buyer□s Indemnified Persons and Seller□s Indemnified Persons, and are not intended to confer third-party beneficiary rights upon any other Person (or, in the case of Buyer□s Indemnified Persons and Seller□s Indemnified Persons, to such Persons in any other capacity). Any reference in this Agreement to one or more Employee

Benefit Plans of Buyer includes provisions, if any, in such plans permitting their termination or amendment and any covenant in this Agreement to provide any Employee Benefit Plan shall not be deemed or construed to limit Buyer's right to terminate or amend such plan of Buyer in accordance with its terms (except as otherwise provided in Section 5.03(d)).

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

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

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

If to Seller: Eastern Connecticut Health Network, Inc.
General Counsel
Eastern Connecticut Health Network
71 Haynes Street
Manchester, Connecticut 06040
Attn: Joyce Tichy
Fax:
Email: jtichy@echn.org

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

Ropes & Gray LLP
Prudential Tower

800 Boylston Street
Boston, MA 02199-3600
Attn: Anne Ogilby
Fax: 617-235-0234
Email: anne.ogilby@ropesgray.com

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

10.15. Misdirected Payments; Physician Loans. After Closing, (a) Seller shall remit to Buyer with reasonable promptness any monies received by Seller (or its Affiliates) constituting or in respect of the Assets and Assumed Liabilities, and (b) Buyer shall remit to Seller with reasonable promptness any monies received by Buyer (or its Affiliates) constituting or in respect of the Excluded Assets and Excluded Liabilities. If any funds previously paid or credited to Seller or the Hospital Businesses in respect of services rendered on or before the Closing Date have resulted in an overpayment or must be repaid, Seller shall be responsible for the repayment of said monies (and the defense of such actions), except to the extent that such credit or repayment obligation was included in the calculation of Net Working Capital as shown on the Closing Balance Sheets in which case Seller shall not be liable for any such repayment. If Buyer suffers any deduction to or offset or withhold against amounts due Buyer of funds previously paid or credited to Seller or the Hospital Businesses in respect of services rendered on or before the Closing Date (other than in respect of overpayments addressed by the preceding sentence), Seller shall pay to Buyer the amounts so deducted, offset or withheld within five business days after demand therefor, except to the extent that the amount of such deduction, offset or withholding was included in the calculation of Net Working Capital as shown on the Closing Balance Sheets. Any amounts payable pursuant to this Agreement that are due Buyer by Seller or one of its Affiliates, or due Seller by Buyer or one of its Affiliates, may be offset against monies or other funds owed by the party entitled to receive payment to the party re□uired to make payment (other than such owed amounts that are being disputed in good faith). Seller shall use, and cause its Affiliates to use, good faith efforts to collect any and all loans and other amounts due from physicians and their Affiliates that constitute Excluded Assets.

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

10.17. CON Disclaimer. This Agreement shall not be deemed to be an ac□uisition or obligation of a capital expenditure or of funds within the meaning of the certificate of need statute of any state, until the appropriate governmental agencies shall have granted a certificate

of need or the appropriate approval or ruled that no certificate of need or other approval is required.

10.18. Entire Agreement; Amendment. This Agreement supersedes all previous contracts, agreements and understandings and constitutes the entire agreement of whatsoever kind or nature existing between or among the parties respecting the within subject matter and no party shall be entitled to benefits with respect to the Assets or the Hospital Businesses other than those specified in this Agreement. As between or among the parties, any oral or written representation, warranty, covenant, agreement or statement not expressly incorporated in this Agreement, whether given before or on the date of this Agreement, shall be of no force and effect unless and until made in writing and signed by the parties on or after the date of this Agreement. The representations, warranties and covenants set forth in this Agreement shall survive the Closing and remain in full force and effect as provided in Section 9.06, and shall survive the execution and delivery of, and shall not be merged with or into, the Closing Documents and all other agreements, instruments or other documents described, referenced in or contemplated by this Agreement. Each representation, warranty and covenant in this Agreement has independent legal significance and if any party has breached any representation, warranty or covenant in any respect, whether there exists another representation, warranty or covenant relating to the same subject matter (regardless of the relative level of specificity) that such party has not breached shall not detract from or mitigate the party's breach of the first representation, warranty or covenant. This Agreement may not be amended or supplemented except in a written instrument executed by each of the parties.

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

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

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

10.22. Confidentiality; Public Announcements.

(a) Except as required by Legal Requirements or in order to coordinate the defeasance of tax-exempt debt, Seller and Buyer (and their respective Affiliates) shall

keep this Agreement and the Closing Documents and their contents confidential and not disclose the same to any Person (except the parties' attorneys, accountants or other professional advisors who need to know such contents for the purpose of advising such party in connection with the transactions contemplated hereby, and except to the applicable Governmental Authorities in connection with any required notification or application for approval or a license or exemption therefrom) without the prior written consent of the other party.

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

10.23. Guarantee of Buyer's Obligations. PMH, as principal obligor and not merely as a surety, hereby unconditionally guarantees full, punctual and complete performance by Buyer of all of Buyer's obligations under this Agreement and each of the Closing Documents subject to the terms hereof and thereof and so undertakes to Seller that, if and whenever Buyer is in default, PMH will on demand duly and promptly perform or procure the performance of Buyer's obligations. The foregoing guarantee is a continuing guarantee and will remain in full force and effect indefinitely (in light of the fact that, as provided in Section 9.06, certain representations, warranties, covenants and indemnification obligations of Buyer survive the Closing indefinitely) and will be reinstated with respect to any sum paid to Seller that must be restored by Seller upon the bankruptcy, liquidation or reorganization of Buyer. PMH's obligations under this Section 10.23 shall not be affected or discharged in any way by any Proceeding with respect to Buyer under any federal or state bankruptcy, insolvency or debtor relief laws (or any order, judgment, ruling, writ, injunction or decree entered or made in connection therewith) or any other fact, development, occurrence or circumstance affecting the legal capacity of Buyer or the enforceability of this Agreement or any of the Closing Documents against Buyer in accordance with their respective terms.

[*Signature Page Follows*]

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

EASTERN CONNECTICUT HEALTH NETWORK, INC.

By: _____

Title: _____

[BUYER]

By: _____

Title: _____

[*Acknowledgement Page Follows*]

Each of the undersigned Subsidiaries of Seller hereby joins this Agreement to acknowledge that Seller has executed this Agreement on its behalf and that, with respect to the Assets or Hospital Businesses owned or operated by it, it is subject to and bound by the same obligations, representations, and warranties as Seller as provided under Section 10.03.

ACKNOWLEDGED BY:

THE MANCHESTER MEMORIAL HOSPITAL

By: _____

Title: _____

THE ROCKVILLE GENERAL HOSPITAL, INCORPORATED

By: _____

Title: _____

ECHN ELDERCARE SERVICES, INC.

By: _____

Title: _____

VISITING NURSE AND HEALTH SERVICES OF CONNECTICUT, INC.

By: _____

Title: _____

A CARING HAND, LLC

By: _____

Title: _____

ECHN ENTERPRISES, INC.

By: _____

Title: _____

HAYNES STREET PROPERTY MANAGEMENT, LLC

By: _____

Title: _____

ECHN CORPORATE SERVICES, INC.

By: _____

Title: _____

MEDICAL PRACTICE PARTNERS, LLC

By: _____

Title: _____

CLINICALLY INTEGRATED NETWORK OF EASTERN CONNECTICUT, LLC

By: _____

Title: _____

CONNECTICUT HEALTHCARE INSURANCE COMPANY, INC.

By: _____

Title: _____

EASTERN CONNECTICUT MEDICAL PROFESSIONALS FOUNDATION, INC.

By: _____

Title: _____

Exhibit A

Form of Transitional Services Agreement

See attached.

Exhibit B

Form of Limited Power of Attorney

See attached.

Schedule 1.02

Persons with "Seller's Knowledge"

Peter □arl	President and Chief Executive Officer
Dennis McConville	Senior Vice President and Chief Strategy Officer
Michael Veillette	Senior Vice President and Chief Financial Officer
Joel J. Reich, M.D.	Senior Vice President, Medical Affairs and Chief Medical Officer

EXHIBIT Q3-3 - BALANCE SHEET OF PROPOSED TRANSACTION

ECHN Completeness Questions
Exhibit 3
Balance Sheet Allocation
($000's)

	Actual Jul 2015 Pre Close	Total Excluded Entities	Retained by Seller	ECHN Adjusted Jul-15	Purchase Adjustments	Opening PMH BS
ASSETS						
Cash	$ 9,545	$ -	$ 9,241	$ 304	$ 5,000 (1)	$ 5,304
Current portion of assets whose use is limited	386	-	386	-		-
Accounts Receivable (NWC)	44,879	-	-	44,879		44,879
Inventory (NWC)	5,441	-	-	5,441		5,441
Estimated settlements from 3rd party payers	1,514	-	1,514	-		-
GME & Meaningful Use (NWC)	692	-	-	692		692
Other Current Assets (NWC)	5,487	-	122	5,365		5,365
Total Current Assets	67,944	-	11,263	56,681	5,000	61,681
Marketable Securities	7,121	-	7,121	-	-	-
Assets Whose Use is Limited						
By Donor and Held in Trust	5,652	2,177	3,475	-		-
By Board of Trustees	36,762	3,623	33,139	-		-
For Estimated Self Insurance Liability	5,387	-	-	5,387		5,387
By Bond Indenture	5,558	-	5,558	-		-
Outside Trusts	11,709	11,709	-	-		-
(less) current portion	(386)	-	(386)	-		-
Total Assets Whose Use is Limited	64,682	17,509	41,786	5,387	-	5,387
Property, Plant, and Equipment	88,463	-	-	88,463	(30,291) (2)	58,172
Investment in Joint Ventures	15,411	-	-	15,411		15,411
Deferred Financing Costs	2,223	-	2,223	-		-
Excess Recoverable - W/C & PL/GL	2,642	-	-	2,642		2,642
Other Noncurrent Assets	7,764	-	347	7,417		7,417
Total Other Assets	28,040	-	2,570	25,470	-	25,470
Total Assets	$ 256,250	$ 17,509	$ 62,740	$ 176,001	$ (25,291)	$ 150,710
LIABILITIES AND NET ASSETS						
Current Portion of Long Term Debt	$ 6,885	-	$ 6,885	$ -		$ -
Line of Credit	4,100	-	4,100	-		-
1 Accounts Payable (NWC)	26,925	-	-	26,925		26,925
Accrued Payroll Expenses (NWC)	4,168	-	-	4,168		4,168
Due to Third Parties	101	-	101	-		-
Intercompany					5,000 (1)	5,000
C/P Pension & PR	1,314	-		1,314		1,314
Self Insurance Liabilities	3,758	-		3,758		3,758
2 Accrued Other Expenses (NWC)	2,633	-	-	2,633		2,633
Total Current Liabilities	49,884	-	11,086	38,798	5,000	43,798
Long Term Obligations	79,159	-	71,776	7,383		7,383
Estimated Self Insurance Liability	8,354	-	-	8,354		8,354
Unfunded Pension Liability	46,869	-	-	46,869	15,817 (3)	62,686
Other Long Term Liabilities	441	-	26	415		415
Total Long Term Liabilities	134,823	-	71,802	63,021	15,817	78,838
Unrestricted	54,034	-	(20,148)	74,182	(46,108) (4)	28,074
Temporarily Restricted	1,556	1,556	-	-		-
Permanently Restricted	15,953	15,953	-	-		-
Total Net Assets	71,543	17,509	(20,148)	74,182	(46,108)	28,074
Total Liabilities and Fund Balance	$ 256,250	$ 17,509	$ 62,740	$ 176,001	$ (25,291)	$ 150,710

Footnotes
1 Initial cash contribution from PMH
2 Adjustments to fixed assets to reflect purchase price
3 Estimated increase in unfunded pension liability due to mortality table update
4 To reflect cash purchase price

EXHIBIT Q4-1 - CONFIDENTIALITY AND NON-DISCLOSURE AGREEMENT

CONFIDENTIALITY AND NON-DISCLOSURE AGREEMENT

This Confidentiality and Non-Disclosure Agreement (this "Agreement") is made and entered into this 19th day of February, 2015, by and between Eastern Connecticut Health Network, Inc. a Connecticut non-stock corporation ("ECHN"), and Prospect Medical Holdings, Inc. ("Company"). ECHN and Company may be referred to herein individually as a "Party" and collectively as the "Parties."

WITNESSETH:

WHEREAS, the Parties are interested in evaluating a possible sale of substantially all of the assets of ECHN to Company (the "Proposed Transaction"); and

WHEREAS, in connection with such Proposed Transaction, each Party may receive certain proprietary and confidential information, disclosure of which could cause competitive harm to the other Party; and

WHEREAS, the Parties desire to set forth in writing their mutual agreement to protect all such information from unauthorized use and disclosure, and to establish general policies and procedures in order to maintain the confidentiality of such information.

NOW, THEREFORE, in consideration of the foregoing and the mutual covenants contained herein, the Parties hereby agree as follows:

1. This Agreement shall apply to all proprietary or confidential information relating to either Party, irrespective of the form in which such information is created, stored, maintained, or reproduced, including but not limited to information related to the business, assets, liabilities, financial condition, budgets, operations programs, service lines, strategies, plans, policies, patients, market or demographic data, personnel, facilities, or equipment of any Party (the "Confidential Information"). The term "Confidential Information" shall also be deemed to include all notes, analyses, studies, compilations, interpretations, calculations, summaries, tables, or other documents which contain, reflect, or are based upon such proprietary or confidential information, in whole or in part.

2. All Confidential Information furnished or disclosed by either Party, before, on, or after the date of this Agreement, shall be held in strict confidence by the receiving Party and shall be used solely for the purposes of evaluating whether or not the Party wants to enter into the Proposed Transaction. The receiving Party shall make no other use or disclosure of the Confidential Information of any nature whatsoever, at any time during or after the term of the Proposed Transaction. The receiving Party shall make all such Confidential Information available only to its own attorneys, accountants, financial advisors, employees or agents having a "need to know" in order to carry out their proper functions, provided, however, that prior to disclosure thereof to any such employees or agents, the receiving Party shall have informed them of the confidential nature of the Confidential Information. The receiving Party shall ensure that all of its officers, employees, or agents abide by the terms of this Agreement.

3. With the exception of any Protected Health Information as defined by the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Regulation")

under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), which shall be maintained in accordance with HIPAA and its implementing regulations, as the same may be amended from time to time, Confidential Information shall not be afforded the protection of this Agreement if such Confidential Information is (a) publicly available other than through the fault or negligence of the receiving Party; (b) properly obtained without restriction from a third Party properly in possession thereof; (c) independently developed without any use of or reference to such Confidential Information; or (d) disclosed pursuant to the provisions of a court order, provided that if disclosure of Confidential Information is required pursuant to a court order, the receiving Party shall promptly notify the disclosing Party, and shall exercise reasonable efforts to cooperate with the disclosing Party in obtaining an order or other reliable assurance that confidential treatment will be accorded to such Confidential Information.

4. All Confidential Information shall remain the property of the disclosing Party. All materials provided to the receiving Party must be returned or, after consultation between the Parties, destroyed, together with all copies thereof, immediately upon request by the disclosing Party or upon termination or completion of the Proposed Transaction. Subsequent to a request for return of Confidential Information or termination of the Proposed Transaction, any Confidential Information shall continue to be kept confidential, and the provisions of this Agreement shall continue with respect to all Confidential Information after the termination of this Agreement.

5. No license of any nature is granted or conveyed by the transmission of the Confidential Information to any Party, nor shall such transmission constitute any representation, warranty, assurance, guaranty or inducement by any Party with respect to infringement of any rights of third Parties, the quality of the Confidential Information, or any other matter of any nature whatsoever, although the disclosing Party will use good faith efforts to provide accurate information, with respect to information prepared by it, to the receiving Party.

6. Neither Party shall, without the prior written consent of the other Party, make any public announcement or issue any press release with respect to the purpose, scope, or other terms of the Proposed Transaction or the Confidential Information evaluated in connection therewith. In addition, each Party agrees that it will not disclose to any other person or Party the fact that the Confidential Information has been made available or any of the terms, conditions or other facts with respect to the Proposed Transaction. No Party shall use the name(s) or trademark(s) of the other Party without prior written consent.

7. Both Parties acknowledge and agree that the other Party reserves the right, in its sole and absolute discretion, to terminate discussions in connection with the Proposed Transaction and to withdraw from this Agreement at any time upon notice to the other Party.

8. This Agreement shall be governed by and construed in accordance with the internal laws of the State of Connecticut without regard to conflicts of laws provisions. Each Party hereby acknowledges that access to and use of confidential health information is subject to state and federal laws (collectively, the "Privacy Laws"), including HIPAA and the regulations promulgated thereunder, each as amended from time to time. Such Privacy Laws may require that a business associate agreement be executed and/or that a statement of information practices be made available upon request. The Parties agree to work cooperatively to ensure compliance

with the Privacy Laws, and to protect the confidentiality of individually identifiable patient health information.

9. Any waiver of a breach of any provision of this Agreement shall not operate or be construed as a waiver of any subsequent breach of such provision or any other provision hereof. Each provision herein shall be treated as a separate and independent clause, and the unenforceability of any one clause shall in no way impair the enforceability of any of the other clauses herein. Moreover, if one or more of the provisions contained in this Agreement shall for any reason be held to be excessively broad as to scope, activity or otherwise so as to be unenforceable at law, such provision or provisions shall be construed by the appropriate judicial body by eliminating, limiting or reducing it or them, so as to allow this Agreement to be enforceable to the maximum extent consistent with the applicable law then in effect.

10. This Agreement constitutes the entire agreement between the Parties concerning the subject matter hereof and supersedes any prior or contemporaneous agreements and understandings in connection therewith. This Agreement may be amended, waived, or revoked only by a written instrument executed by both Parties.

11. Both Parties acknowledge and agree that any breach of this Agreement could cause irreparable damage to the other Party, and in the event of such breach the non-breaching Party shall have, in addition to any and all remedies available at law, the right to an injunction, specific performance, or any other equitable relief to prevent the violation of any obligations hereunder.

12. This Agreement shall expire two (2) years from the date hereof.

13. This Agreement may be executed on one or more separate signature pages and by facsimile signatures, each of which shall be considered an original document, and all of which together shall constitute a single agreement.

[Signatures on following page]

IN WITNESS WHEREOF, the Parties hereto have executed this Agreement under seal in counterpart originals as of the date first written above.

EASTERN CONNECTICUT HEALTH NETWORK, INC.

By: Peter Karl

Title: President & CEO

PROSPECT MEDICAL HOLDINGS, INC.

By: _____

Title: VP Contracts Development

EXHIBIT Q5-1 - CHARTIS BACKGROUND

The Chartis Group

ECHN Affiliation Strategy Engagement
Biographies for Chartis Group Project Team

R. Christopher Regan, Managing Director

Mr. Regan is a founding partner and Managing Director of The Chartis Group. He has a wide range of experience in the healthcare consulting field having directed a variety of strategic, operational and organizational engagements for healthcare clients across the country over a twenty eight year career. Mr. Regan previously served as President of H-Works, the consulting division of The Advisory Board Company. He is a frequent speaker at industry conferences, forums and Board Retreats.

Prior to co-founding The Chartis Group and serving as President of H*Works, Mr. Regan spent fourteen years at CSC Healthcare and its predecessor APM Incorporated where he played an integral role in building the firm from 30 to over 300 staff. While at CSC/APM, Mr. Regan was as one of twelve senior partners leading the firm's healthcare consulting practice. He also served as the National Director of the firm's Clinical Effectiveness practice.

Mr. Regan's recent client work has focused in particular on competitive strategy, mergers and acquisitions and physician joint venture development. He has completed several prior engagements for ECHN in recent years.

Mr. Regan is a Trustee of Ascension Health Ventures, Seacor Holdings, Inc. and Hamilton College. He holds an M.B.A. in Finance and Accounting from New York University's Graduate School of Business Administration and a B.A. in English Literature from Hamilton College.

Keith Dickey, Principal

Mr. Dickey, a Principal with The Chartis Group, has more than 18 years of experience providing strategic and financial advisory services to the healthcare industry. He has advised a broad range of healthcare providers, including integrated delivery systems, academic medical centers, children's hospitals, provider-sponsored managed care organizations, senior care facilities, clinical laboratories and medical equipment companies. Mr. Dickey's areas of focus include enterprise and service line strategies; strategic capital planning; valuations; mergers, acquisitions and joint ventures, and financial advisory services in connection with public and private capital markets transactions (debt and equity).

Prior to joining The Chartis Group, Mr. Dickey worked as a healthcare investment banker, first at Shattuck Hammond Partners from 1996 until 2006, where he served as Chief Knowledge Officer and later Principal, and subsequently as a senior healthcare investment banker at the successor firms of Morgan Keegan & Company and then Raymond James and Associates following Morgan Keegan's acquisition of Shattuck Hammond Partners in 2007 and its merger with Raymond James in 2012. From 2006 to 2010, Mr. Dickey also owned and operated Butter's Fine Food and Wine, a retail gourmet food and wine business in Concord, NH. From 1992 to 1996, Mr. Dickey was a consultant at APM, Inc., a healthcare management consulting firm, where he focused on health system strategy and hospital operations re-engineering projects.

Mr. Dickey holds a Ph.D. and M.A. in Classical Archaeology from Bryn Mawr College and an A.B., magna cum laude, from Dartmouth College. He was a Fulbright scholar to Greece in 1987.

EXHIBIT Q5-2 - REQUEST FOR PROPOSAL TO PMH

Eastern Connecticut Health Network
71 Haynes Street
Manchester, CT 06040
860.533.3414
www.echn.org

February 19, 2015

Thomas M. Reardon
President
Prospect Medical Holdings-East
10780 Santa Monica Blvd., Suite 400
Los Angeles, CA 90025

Dear Tom,

Thank you for the interest in Eastern Connecticut Health Network, Inc. (ECHN). As we discussed yesterday, ECHN is looking for an affiliation partner. The ECHN leadership is issuing this Request for Proposal (RFP) to a limited number of organizations like yours. We believe that ECHN and Prospect Medical Holdings share a common commitment to improve the well-being of our communities by offering high-quality, compassionate, safe and efficient healthcare services.

The enclosed materials contain additional information regarding our organization and the type of transaction we are seeking. The materials included are as follows:

I. **Description of ECHN, Requested Proposal Elements:** This document provides information regarding ECHN and the goals that have been established for an affiliation. The document also includes some questions for areas for the affiliation covering vision, governance, operations, capital investments, operational efficiencies and cost avoidance, service enhancements and management structure.

II. **Template Affiliation Agreement/Asset Purchase Agreement**: Two years ago, after careful consideration, the Board and Executive leadership of ECHN determined that a strategic affiliation was in the best interest of the organization. A thorough request for proposal and review process led ECHN'S Board of Directors to accept an offer by VHS Eastern Connecticut, LLC, a joint venture of Tenet Healthcare Corporation and Yale New Haven Health Services Corporation, to acquire substantially all of ECHN's assets. For reasons beyond ECHN's control, that anticipated transaction did not proceed. Because the terms of that transaction were the product of extensive study of the market opportunities, due diligence and negotiations among the parties, and because they met ECHN's then-

minimum contracting requirements as well as those of our anticipated acquirer, we request that you use those terms as the starting point for any negotiated contract terms.

In anticipation of the fact that bidding organizations may have different preferences for the structure of their proposed transaction based on their own organizational structures, we enclose a template Affiliation Agreement (member substitution) and a template Asset Purchase Agreement, either of which is acceptable to ECHN. As part of your response, please revise the appropriate template with any changes that you deem necessary rather than submitting your own form of agreement. If your organization is a for-profit entity that is subject to C.G.S. § 19a-486c, we also enclose a side letter that ECHN will request that you complete as part of the transaction.

III. **Due Diligence:** We understand that you will want to perform some preliminary due diligence regarding ECHN before deciding to proceed further with a transaction. Toward that end, we are providing you access to a data room that contains relevant diligence materials. The data room is organized topically and includes a wide variety of information regarding ECHN's organizational structure, licensure, finances and clinical operations. You may access the data room by contacting Dennis McConville whose contact information is included below. If your organization is selected as a potential affiliation partner, ECHN will need to perform diligence on your organization, and we will work with your organization to determine a mutually agreeable mechanism through which to complete such diligence.

Your revised draft of the template Affiliation Agreement or Asset Purchase Agreement is due no later than **Friday, March 6, 2015**. We will review carefully each revised template agreement that we receive, and we anticipate continuing discussions with potential partners through early May 2015. Our goal is to make a selection and have a definitive agreement in place by late May 2015.

The materials included with this letter and all materials available in the data room are subject to the confidentiality and non-disclosure agreement in place between ECHN and your organization. ECHN expressly reserves the right to evaluate the terms and conditions of any revised draft agreement that we receive and to accept or reject any or all such drafts in whole or in part and to terminate discussions or negotiations with any or all parties at any time without assigning any reasons therefor. ECHN further reserves the right to amend or modify the process outlined in this letter at any time in its sole and absolute discretion with or without sending notice of any changes.

Please submit your response and direct any questions concerning this RFP to:

Mr. Dennis P. McConville
Senior Vice President and Chief Strategy Officer
Eastern Connecticut Health Network, Inc.
Via email at dmcconville@echn.org.
Via phone at (860) 533-3429.

The ECHN Board believes that by combining all or substantially all of ECHN's assets and/or ownership interests with another system, it would present the best opportunity to meet the challenges ahead and ensure continued local access to quality healthcare. It is our hope that your organization will agree and is prepared to offer resources, systems, and efficiencies which are essential for our combined long term success. We believe that the right agreement has the potential to offer mutual, enduring benefits to our organizations and those we serve.

Thank you again for your interest in ECHN. We look forward to receiving your response.

Sincerely,



Peter J. Karl
President and Chief Executive Officer
Eastern Connecticut Health Network, Inc.

Enclosures (3)

cc: Dennis G. O'Neill, M.D, Chairman

Eastern Connecticut Health Network, Inc.
Description and Requested Proposal Elements

Description of Eastern Connecticut Health Network, Inc. ("ECHN")

ECHN is a well-regarded community-based health system committed to enhancing care delivery for patients in its core markets east of the Connecticut River. Aided by the commitment and support of the communities it serves and a loyal, high quality medical staff, ECHN has built a continuum of healthcare programs and affiliated companies that position it to thrive in the healthcare care delivery system of the future.

ECHN owns and operates thirteen companies and has membership interests in fourteen joint venture arrangements that, in combination, provide patient care services or support services across the continuum of care. ECHN has $330MM in revenues and revenues exceeding $350MM with its joint venture interests. The system includes two acute care inpatient facilities, Manchester Memorial Hospital (249 licensed beds) and Rockville General Hospital (102 adult licensed beds), a skilled nursing and rehabilitation center, Woodlake at Tolland Rehabilitation and Nursing Center (130 licensed beds), Visiting Nurse and Health Services of Connecticut, multiple imaging and ambulatory centers, and various other allied health services. In addition, ECHN has a medical foundation, Eastern Connecticut Medical Professionals Foundation, which includes 39 community-based physicians and 16 allied health professionals. ECHN has 488 physicians and 87 allied health professionals on its medical staff.

ECHN's History

ECHN was formed in 1995 when Manchester Memorial Hospital and Rockville General Hospital joined as partners. Similar to the challenges that we face today, the merger was in response to a push for health care reform that promised a shift of economic risk to hospitals and other health care providers. Combining the assets of Rockville General Hospital and Manchester Memorial Hospital was an innovative concept at that time in that it created a networked, community-based continuum of care with economic scale. Over the years, ECHN has evolved into a much more complex system, while simultaneously lowering costs and improving the quality of the care provided.

Initially anchored by Rockville General Hospital, Manchester Memorial Hospital and Woodlake at Tolland Rehabilitation and Nursing Center, ECHN has grown over the years to include many more companies, providers, sites of service, service offerings and joint venture affiliates resulting in a robust continuum of care sites and access centers. Its Eastern Connecticut Medical Providers Foundation (ECMPF) continues to grow as more primary care and specialty physicians seek employment in health system-sponsored organizations. Medical access centers have been developed in key eastern Connecticut communities to support ECMPF, outpatient service offerings and joint venture companies. In 2012, ECHN partnered with University of New England College of Osteopathic Medicine (UNECOM) to provide medical education and clinical opportunities at ECHN for 16 of UNECOM's third year medical students. In 2013, in response to

the growing need for primary care providers, ECHN launched a graduate medical education program that includes a family medicine residency program (with 24 residents) and a rotating internship program (with 8 interns). In January 2014, ECHN formed its newest company, Clinically Integrated Network of Eastern Connecticut, LLC (CINECT) with the support of the ECHN medical staff, to pursue system-wide clinical integration and position the network for risk-based payments.

In September 2012, after careful consideration, the Board and executive leadership of ECHN determined that a strategic affiliation with a larger health system was in the best interest of the organization and would better position ECHN to continue to meet the health care needs of its communities. A diligent request for proposal and proposal review process led to the decision to sell ECHN's assets to VHS Eastern Connecticut Health System, LLC, a proposed joint venture of Tenet Healthcare, Inc. and Yale New Haven Health Services Corporation. For reasons beyond ECHN's control, the anticipated transaction with that new joint venture company did not proceed.

ECHN's Future Vision

ECHN believes that it has a significant opportunity to serve a broader patient base with improved clinical capabilities that are more conveniently accessible. We are committed to offering high-quality, cost-effective services. There are four principal components to ECHN's future vision that have remained constant throughout the affiliation effort:

1. **Be the 'Provider of Choice' east of the river**: Ensure that ECHN attracts patients and providers based on its quality, service, accessibility and affordability.
2. **Provide a broader and full spectrum of services**: Expand ECHN's patient base across the markets it serves in primary and specialty care services, deepen its footprint of services, enhance physician retention and recruitment, and grow patient volumes.
3. **Improve finances (margins, cash flow and capital access) to ensure continued investment in the organization's capabilities**: Invest in state-of-the-art equipment and technologies, upgrade facilities, and bolster financial performance through revenue and cost improvements while strengthening the organization's balance sheet.
4. **Build population health management and accountable care capabilities**: Strengthen capabilities to manage care across the continuum in an accountable care environment. Participate in new value-based contracting vehicles.

Requested Proposal Elements

In addition to providing a markup of either the template Affiliation Agreement or the template Asset Purchase Agreement included with this package, please address the items below in your proposal. You need not be limited to these items, and may include other items you believe should be considered.

Vision and Operations

1. How will affiliation with your organization help ECHN achieve its vision and goals as outlined above?

2. Based on your vision of the market, how can you help us improve the range of healthcare services available within the communities ECHN serves and access to those services?
3. If you have facilities in ECHN's primary and secondary services areas or within the city of Hartford, how do you envision ECHN working with these facilities? What services, if any, would you anticipate growing, adding or eliminating at the local community level?
4. What governance or other changes would you propose to make to our medical staffs?
5. What governance or other changes would you make to the medical foundation? What level of local governance or influence would ECHN-based providers or ECHN management have in the medical foundation?
6. How would a strategic transaction with your organization enhance ECHN's ability to attract and retain high quality physicians to the medical staff in ECHN's service area? Please discuss:
    - Your organization's processes and capabilities regarding physician recruitment and retention,
    - Your organization's strategy for fostering clinical integration and alignment with employed and independent medical staff.
7. How would the proposed affiliation enhance clinical quality, safety, service and patient satisfaction? Please describe the ways in which you measure quality and safety. Discuss how your hospitals perform in terms of CMS quality indicators and patient satisfaction.
8. Please describe your anticipated operational approach to ECHN, including anticipated operating efficiencies and cost avoidance, if any, resulting from the proposed transaction and any savings associated with such efficiencies/avoidance.

Governance and Management

9. Please discuss the governance structure and continuing role of ECHN and/or the ECHN Board in the governance of the Health System, and if applicable, at your health system corporate level. Please describe your willingness to commit to the following roles as part of an affiliation agreement. Examples of comparable transactions where you have employed the proposed structure would be helpful.

    - ***Affiliation and Board Structure***
        i. Describe the anticipated role of the local board with respect to the following activities:
            - Fundraising
            - Overseeing medical staff credentialing
            - Participating in the selection of the system CEO and other senior management
            - Reviewing and approving local quality and service goals
            - Reviewing and approving annual operating and capital budgets
            - Monitoring local quality, service, and financial performance
        ii. Describe the anticipated role of the local board, if any, at the system level, e.g., in strategic planning, capital investments, etc.

iii. If the transaction is accomplished through a member substitution rather than an asset purchase, describe any "reserved powers" that would be given to the system board, *i.e.*, powers that the local board could exercise only after obtaining the approval of the system board. For example, approval of the following:
   - Annual operating and capital budgets
   - Capital expenditures beyond the approved capital budget
   - Borrowing or incurring of debt
   - Appointment of the independent auditor

iv. If the transaction is accomplished through a member substitution rather than an asset purchase, describe any "initiatory powers" that would be given to the system board, *i.e.*, powers that the system board could take on its own initiative without the recommendation of, or approval by, the local board. For example:
   - Single signature contracting

v. Describe the conditions, if any, under which ECHN would be able to "unwind" the affiliation within the first three to five years should the affiliation prove unsuccessful from ECHN's point of view.

10. Please indicate the senior management positions you would anticipate having at ECHN, as well as the roles and positions these individuals would have in the organization post-affiliation.
11. Please describe your willingness, if requested, to commit to the following service enhancements and capital investments as part of an affiliation agreement. To the extent that some of these commitments are in the future and subject to changes in the market/context, please describe the requirements these initiatives have to meet in order to be implemented (e.g., an ROI within a period of time requirement, system Board approval, etc.). Additionally, to the extent there are capital investments required, please describe the structure of the capital pool(s) that these programs would be accessing and the mechanism for accessing them (e.g., would you segregate a certain capital pool for these programs over a period of time, would these programs be competing for capital with other facilities in your system, etc.).

- ***Service Enhancements***

i. In addition to maintaining the services outlined in its template Agreement, ECHN anticipates developing, expanding or enhancing service in the following clinical areas. Please comment on how affiliation with your organization would support and enable clinical program development and/or expansion, how you approach medical staffing, and/or facility and equipment enhancements for the following services:
   1. Enhancing and expanding Primary Care capabilities, in existing and new markets

2. Cardiovascular Services, including diagnostic and interventional catheterization, electrophysiology and pacemaker programs
3. Cancer Care, including medical oncology and specialty oncologic surgery
4. Bariatric Surgery
5. Orthopedics, with an emphasis on spine surgery and joint replacement surgery
6. Pain Management Service/Program

ii. Maintaining joint ventures such as Tolland Imaging Center, Evergreen Endoscopy Center, Community Cancer Care and others.

- ***Capital Investments***
  i. Electronic Medical Record system replacement and implementation
  ii. New care management capabilities and systems
  iii. Building an ambulatory surgery center
  iv. Transitioning capacity to private rooms
  v. Upgrading and expanding OB and neonatal nursery
  vi. Upgrading and expanding the inpatient operating rooms
  vii. Renovating and expanding the radiology suite
  viii. Investing in medical equipment

Additional Information / Due Diligence Required

12. Please provide a detailed list of additional information required if selected to proceed with further due diligence.
13. Please indicate the names of the financial, legal or other advisors who will be engaged in connection with the transaction.

Timing, Required Corporate Approvals and Contingencies

14. Upon the selection of a preferred acquirer/partner, ECHN intends to promptly negotiate a Definitive Agreement and consummate the transaction. Please discuss any corporate approvals required to complete the transaction, the time required for those approvals and any potential risks that could increase the time required or stop the process.
15. Please indicate any financing or other contingencies or material conditions to the consummation of the transaction, including any key assumptions in your valuation of ECHN that, if revised, could have a significant impact on the financial terms.

Additional Questions for Religious Organizations

If your organization is subject to any religious or ethical restrictions that would apply to ECHN post-closing, please respond to the following:

16. Describe the religious or ethical restrictions in detail.

17. Explain how ECHN would continue to meet the needs of its community in the event the restrictions apply.

* * * * *

ECHN reserves the unilateral right to alter or terminate the transaction process at any time and for any reason. In addition, ECHN reserves the right to terminate discussions with any or all prospective purchasers, to reject any or all proposals, or to negotiate with any party regarding the transaction, and without obligation to disclose any reasons therefor. This letter and any materials supplied in connection therewith shall be Confidential Information as defined by the Confidentiality Agreement previously signed by your organization.

AFFILIATION AGREEMENT

by and between

EASTERN CONNECTICUT HEALTH NETWORK, INC.

and

[●]

Dated as of [●], 2015

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AFFILIATION AGREEMENT

This Affiliation Agreement, dated _____, 2015, is by and between Eastern Connecticut Health Network, Inc., a Connecticut non-stock corporation ("**ECHN**"), on its behalf and on behalf of its Subsidiaries, and [●] a [ ] corporation ("**System**"), a [] nonprofit corporation.

RECITALS:

WHEREAS, ECHN is a Connecticut non-stock corporation that controls, either directly or indirectly, certain affiliates, including, without limitation, The Manchester Memorial Hospital and The Rockville General Hospital, Incorporated (collectively, the "**Hospitals**"), ECHN Eldercare Services, Inc., Visiting Nurse and Health Services of Connecticut, Inc. including its wholly owned subsidiary A Caring Hand, LLC, Clinically Integrated Network of Eastern Connecticut, LLC, Connecticut Healthcare Insurance Company, Inc., ECHN Corporate Services, Inc. including its wholly owned subsidiary Medical Practice Partners, LLC, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Eastern Connecticut Medical Professionals Foundation, Inc. (the entities and businesses operated by the foregoing entities, including the Hospitals, are collectively referred to as the "**Hospital Businesses**"); and

WHEREAS, ECHN owns joint venture interests in Northeast Regional Radiation Oncology Network, Inc., Evergreen Endoscopy Center, LLC, WBC Connecticut East, LLC, Aetna Ambulance Service, Inc., Metro Wheelchair Service, Inc., Ambulance Service of Manchester, LLC, Connecticut Occupational Medicine Partners, LLC, and Eastern Connecticut Physician Hospital Organization, Inc. and ECHN's Affiliates' joint venture interests in Tolland Imaging Center, LLC, Pathology Laboratory Services, LLC, Haynes Street Medical Associates, LLC, Haynes Street Medical Associates II, LLC, Evergreen Medical Associates, LLC and Evergreen Medical Associates II LLC (the foregoing entities are collectively referred to herein as the "**Joint Ventures**"); and

WHEREAS, System is a [ ] non-profit corporation that owns and operates health facilities throughout the [] region; and

WHEREAS, the parties believe that the transaction contemplated herein (the "**Affiliation**") will allow the parties to further their common charitable mission of promoting the health of the communities they serve and will enhance the Hospitals' ability to maintain their status as clinically superior, financially secure community hospitals allowing them to continue to meet and better respond to the health care needs of patients and the community in their service areas.

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

AGREEMENT:

1. DEFINITIONS AND REFERENCES

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

(1) **Accounts Receivable** means all accounts receivable of the Hospital Businesses, accrued and unaccrued, including Government Payment Program receivables and accounts that have been written off, but excluding all Cost Report settlement amounts;

(2) **Affiliate** means any Person that, directly or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with another Person where "control" means the power to direct or cause the direction of the management and policies of a Person, whether through the ownership of securities, election or appointment of directors, by contract or otherwise. For purposes of this Agreement, any reference to Affiliates of ECHN shall only mean those persons listed on Schedule 1.01(2) attached hereto;

(3) **Affiliated Group** means any affiliated group within the meaning of section 1504 of the Code or any similar group defined under a similar provision of state, local or foreign law;

(4) **Assets** means all assets, real property, personal and mixed property of every kind, character or description, known or unknown, tangible or intangible, owned or leased by ECHN wherever located and whether or not reflected in the Financial Statements or referenced or scheduled herein, including those assets owned by a Subsidiary of ECHN and held or used in connection with the operation of the Hospital Businesses;

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

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

(7) **Bond Liabilities** means those certain long-term bond liabilities and tax-exempt leases of ECHN;

(8) **Closing** is defined in Section 8.01(a);

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

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

(11) **CMS** means the Centers for Medicare and Medicaid Services;

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

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

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

(15) **Controlled Group** means with respect to ECHN, a group consisting of each trade or business (whether or not incorporated) that, together with such ECHN, would be deemed a "*single employer*" within the meaning of section 4001(a) of ERISA;

(16) **Cost Reports** means all cost and other reports filed pursuant to the requirements of the Government Payment Programs for payment or reimbursement of amounts due from them;

(17) **Current ECHN Plan** is defined in Section 3.17(a);

(18) **ECHN Board** means the Board of Trustees of ECHN;

(19) **Employee Benefit Plan** means, with respect to any Person, (i) each plan, fund, program, agreement, arrangement or scheme, in each case, that is at any time sponsored or maintained, or required to be sponsored or maintained, by such Person or to which such Person makes or has made, or has or has had an obligation to make, contributions providing for employee benefits or for the remuneration, direct or indirect, of the employees, former employees, directors, officers, managers, consultants, independent contractors, contingent workers or leased employees of such Person or the dependents of any of them (whether written or oral), including each deferred compensation, bonus, incentive compensation, pension, retirement, stock purchase, stock option and other equity compensation plan, or "*welfare*" plan (within the meaning of section 3(1) of ERISA, determined without regard to whether such plan is subject to ERISA), (ii) each "*pension*" plan (within the meaning of section 3(2) of ERISA, determined without regard to whether such plan is subject to ERISA), including each

Multiemployer Plan, (iii) each severance, retention or change in control plan or agreement, each plan or agreement providing health, vacation or paid time off, summer hours, supplemental unemployment benefit, hospitalization insurance, medical, dental, or legal benefit and (iv) each other employee benefit plan, fund, program, agreement or arrangement, including any of the foregoing that provides cash or non-cash benefits or perquisites to current or former employees of such Person;

(20) **Employee Pension Benefit Plan** is defined in section 3(2) of ERISA;

(21) **Employee Welfare Benefit Plan** is defined in section 3(1) of ERISA;

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

(23) **Environmental Claim** means any written notice (or oral notice reduced to writing by ECHN) by a Person alleging potential liability (including potential liability for investigatory costs, cleanup costs, Governmental Authority response costs, natural resource damages, property damages, personal injuries, or penalties) of ECHN or any Subsidiary of ECHN arising out of, based on or resulting from (i) the presence, or release into the environment, of any Materials of Environmental Concern at any location, whether or not owned by ECHN, or (ii) circumstances forming the basis of any violation, or alleged violation, of any Environmental Laws;

(24) **Environmental Laws** means any and all Legal Requirements relating to pollution or protection of human health or the environment (including ground water, land surface or subsurface strata), including Legal Requirements relating to emissions, discharges, releases or threatened releases of Materials of Environmental Concern, or otherwise relating to the manufacture, processing, distribution, use, treatment, storage, disposal, transport, recycling, reporting or handling of Materials of Environmental Concern, including the Comprehensive Environmental Response, Compensation and Liability Act of 1980, as amended, 42 U.S.C. §9601, *et seq.*, the Resource Conservation and Recovery Act, as amended, 42 U.S.C. §6901, *et seq.*, the Clean Air Act, 42 U.S.C. §7401, *et seq.*, the Federal Water Pollution Control Act, 33 U.S.C. §1251 *et seq.*, the Occupational Safety and Health Act, 29 U.S.C. §600, *et seq.*, and any similar state or local Legal Requirements;

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

(26) **ERISA Fiduciary** is defined in section 3(21) of ERISA;

(27) **Financial Statements** means the Audited Financial Statements and the Unaudited Financial Statements;

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

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

(30) **Government Payment Programs** means federal and state Medicare, Medicaid and TRICARE programs, and similar or successor programs with or for the benefit of Governmental Authorities;

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

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

(33) **Immediate Family Member** means any individual described in the definition of "*Immediate Family Member*" found at 42 C.F.R. §411.351;

(34) **Indemnified Party** means any Person entitled to indemnification under Section 9.02;

(35) **Indemnifying Party** means any Person obligated to indemnify another Person under Section 9.02;

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

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

(1) **Leased Real Property** means the real property described on Schedule 1.01(1), together with all buildings, improvements and fixtures thereon, leased by ECHN or any Subsidiary of ECHN;

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

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

(4) **Material Adverse Change** means a material adverse change, individually or in the aggregate, of the business, assets, liabilities, financial condition or results of operations of ECHN and the Hospital Businesses, which taken as a whole (i) has or could reasonably be expected to have a material adverse effect upon the validity or enforceability of this Agreement or (ii) is or could reasonably be expected to be material and adverse to the Hospital Businesses or the Assets, but excluding the effect of (x) matters described in the Schedules, (y) changes in the economy of the United States in general, and (z) changes in Legal Requirements generally applicable to owners and operators of general acute care hospitals in the United States or in Connecticut if such change does not disproportionately affect ECHN or the Hospital Businesses; provided, however, that a change resulting from the downward adjustment to the Medicare wage index or the failure of the ECHN to meet its debt service coverage ratio, if waived by applicable lender(s), shall not constitute a Material Adverse Change;

(5) **Materials of Environmental Concern** means chemicals, pollutants, contaminants, wastes (including Medical Waste), toxic substances, petroleum and petroleum products listed or regulated under Environmental Laws, including hazardous wastes under the Resource Conservation and Recovery Act, as amended, 42 U.S.C. §6901, *et seq*., hazardous substances under the Comprehensive Environmental Response, Compensation and Liability Act of 1980, as amended, 42 U.S.C. §9601, *et seq*., asbestos, polychlorinated biphenyls and urea formaldehyde, and low-level nuclear materials, special nuclear materials or nuclear-byproduct materials, all within the meaning of the Atomic Energy Act of 1954, as amended, and any rules, regulations or policies promulgated thereunder;

(6) **Medical Waste** means any substance, pollutant, material or contaminant listed or regulated under any Medical Waste Law that is generated in the diagnosis, treatment or immunization of human beings, in research pertaining thereto, or in the production or testing of biologicals, including (i) pathological waste, (ii) blood, (iii) sharps, (iv) wastes from surgery or autopsy, (v) dialysis waste, including contaminated disposable equipment and supplies, (vi) cultures and stocks of infectious agents and associated biological agents, (vii) isolation wastes, (viii) contaminated equipment, (ix)

laboratory waste, and (x) various other biological waste and discarded materials contaminated with or exposed to blood, excretion, or secretions from human beings;

(7) **Medical Waste Law** means the Medical Waste Tracking Act of 1988, 42 U.S.C. §6992, *et seq.*, the U.S. Public Vessel Medical Waste Anti-Dumping Act of 1988, 33 U.S.C. §2501, *et seq.*, the Marine Protection, Research, and Sanctuaries Act of 1972, 33 U.S.C. §1401, *et seq.*, The Occupational Safety and Health Act, 29 U.S.C. §651, *et seq.*, the United States Department of Health and Human Services, National Institute for Occupational Self-Safety and Health Infectious Waste Disposal Guidelines, Publication No. 88-119, and any other federal, state, regional, county, municipal or other Legal Requirements insofar as they purport to regulate Medical Waste, or impose requirements relating to Medical Waste;

(8) **Multiemployer Plan** is defined in section 3(37) of ERISA or section 4001(a)(3) of ERISA;

(9) **Multiple Employer Plan** means an Employee Pension Benefit Plan that is not a Multiemployer Plan and for which a Person who is not a member of a Controlled Group that includes ECHN or any Subsidiary is or has been a contributing sponsor;

(10) **Owned Real Property** means real property owned (legally or beneficially) by ECHN or any Subsidiary of ECHN, including the real property described on Schedule 1.01(10), together with all buildings, improvements and fixtures thereon owned by ECHN or any Subsidiary of ECHN and all appurtenances and rights thereto;

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

(12) **Permit** means each license, permit, right, franchise, concession, certificate, authorization, consent, certificate of need or other approval of a Governmental Authority owned or held by ECHN or relating to the ownership or operations of the Hospital Businesses and the Assets, including applications for, and pending, Permits;

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

(14) **Prior ECHN Plan** is defined in Section 3.17(b);

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

(16) **Prohibited Transaction** is defined in Section 5.06;

(17) **Reportable Event** is defined in section 4043 of ERISA;

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

(19) **Subsidiary** means, with respect to any Person, (i) any corporation more than 50% of whose stock of any class or classes having by the terms thereof ordinary voting power to elect a majority of the directors of such corporation (irrespective of whether or not at the time stock of any class or classes of such corporation shall have or might have voting power by reason of the happening of any contingency) is at the time owned by such Person and/or one or more Subsidiaries of such Person, (ii) any partnership, limited liability company, association, joint venture or other entity in which such Person and/or one or more Subsidiaries of such Person has more than a 50% equity interest at the time and the management of which is controlled, directly or indirectly, by such Person or through one or more Subsidiaries of such Person and (iii) any entity that is organized as a not-for-profit business organization and (A) whose accounts are required in accordance with GAAP to be consolidated with the accounts of such Person or (B) whose sole member is such Person;

(20) **System** is defined in the preamble;

(21) **System Audited Financial Statements** means the audited consolidated balance sheets of System for the three most recently ended fiscal years, and the related consolidated statements of operations, of changes in net assets, and of cash flows for the fiscal years then ended, and the notes thereto and the report thereon of [_____], independent certified public accountants;

(22) **System Board** means the Board of Trustees of System;

(23) **System Financial Statements** means the System Audited Financial Statements and the System Unaudited Financial Statements;

(24) **System Unaudited Financial Statements** means the unaudited consolidated balance sheets of System as of [_____], 2015, and the unaudited consolidated statements of operations and changes in net assets and the unaudited consolidated statements of cash flows for the [_____]-month period then ended, and the financial statements described in clauses (i) and (ii) of Section 5.04(c);

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

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

(27) **Tenant Leases** is defined in Section 3.09(g);

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

(29) **WARN Act** means the Worker Adjustment and Retraining Notification Act, 29 U.S.C. §2101, *et seq*.

1.02. Certain References. As used in this Agreement:

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

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

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

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

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

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

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

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

(i) references to "*ECHN's knowledge*" mean the actual knowledge of each of the Persons whose names or titles are set forth on Schedule 1.02, after due inquiry by ECHN of such Persons;

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

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

2. EFFECTUATION OF AFFILIATION

2.01. Form of Affiliation. The Affiliation will be effected by (i) ECHN adopting an amended and restated certificate of incorporation and amended and restated bylaws stating that System is the sole corporate member of ECHN and that System reserves certain powers with respect to ECHN as described in Sections 7.02-7.03, and (ii) System adopting amended and restated bylaws as described in Section 6.02.

2.02. Operations and Assets and Liabilities after the Closing. On and after the Closing, each of ECHN and System will retain ownership of its assets and remain responsible for its operations and liabilities except as otherwise stated in this Agreement. The parties specifically agree that ECHN will continue to retain any locally raised charitable funds that are donated to ECHN.

3. REPRESENTATIONS OF ECHN

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

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

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

(a) are within ECHN's powers, are not in contravention of its certificate of incorporation, bylaws and other governing documents, and have been duly authorized by all appropriate corporate action;

(b) do not violate any Legal Requirement to which ECHN, the Assets, or the Hospital Businesses may be subject; and

(c) assuming the receipt of all consents set forth in Schedule 3.02 do not conflict with or result in a breach or violation of any material Contract to which ECHN is a party or by which it is bound and will not be terminated as of the Closing Date.

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

3.04. Legal and Regulatory Compliance. Except as otherwise provided in this Agreement and other than as set forth on Schedule 3.04, ECHN and all of its officers, directors, agents, or employees comply in all material respects with, and have complied in all material respects with, all Legal Requirements, and ECHN has timely filed all material reports, data and other information required to be filed with Governmental Authorities. ECHN has not received notice of any currently pending or threatened Proceeding against it alleging or based upon an alleged violation of any Legal Requirements. Neither ECHN nor any Affiliate of ECHN is party to or otherwise bound by (i) a corporate integrity agreement with the Office of Inspector General of the United States Department of Health and Human Services or written agreement with such Governmental Authority to establish or maintain a corporate integrity program applicable to any of the Hospital Businesses or (ii) a settlement or other agreement with any other Governmental Authority, other than participation agreements with Medicare and Medicaid, that imposes continuing obligations on any of the Hospital Businesses or contains obligations that have not been fully discharged.

3.05. Financial Statements. Attached as Schedule 3.05 are copies of the Audited Financial Statements and the Unaudited Financial Statements. The Financial Statements fairly present the financial condition and results of operations of ECHN and the Hospital Businesses as of the respective dates thereof and for the periods therein referred to, all in accordance with GAAP, subject, in the case of the Unaudited Financial Statements, to normal recurring year-end adjustments (the effect of which will not, individually or in the aggregate, have a Material Adverse Change) and the absence of notes (which, if presented, would not differ materially from those included in the Audited Financial Statements), and the Financial Statements reflect the consistent application of such accounting principles throughout the periods involved.

3.06. Undisclosed Liabilities. Except and to the extent accrued or disclosed in the Financial Statements, ECHN does not have any liabilities or obligations of any nature whatsoever with respect to the Hospital Businesses or the Assets, due or to become due, accrued, absolute, contingent or otherwise, that are required by GAAP to be accrued or disclosed in audited financial statements, except for liabilities and obligations incurred in the ordinary course of business and consistent with past practice since the date of the Unaudited Financial Statements, which are not, individually or in the aggregate, expected to result in a Material Adverse Change.

3.07. Recent Activities. Since September 30, 2013 and except as set forth on Schedule 3.07:

(a) no material damage, destruction or loss (whether or not covered by insurance) has occurred affecting the Assets;

(b) except in the ordinary course of the Hospital Businesses or as set forth on Schedule 3.07(b), consistent with past practice and existing personnel policies of ECHN,

ECHN has not (i) increased or agreed to increase the compensation payable to any employees who work in the Hospital Businesses, (ii) agreed to make any bonus or severance payment to any of the employees who work in the Hospital Businesses or (iii) employed any additional management personnel in respect of the Hospital Businesses;

(c) no labor dispute, enactment or promulgation of a state or local Legal Requirement, or other event or condition, has occurred that has materially adversely affected any of the Hospital Businesses or reasonably could be expected to have such an effect on the Hospital Businesses;

(d) other than as set forth on Schedule 3.07(d), ECHN has not sold or factored, or agreed to sell or factor, any Accounts Receivable, and ECHN has not sold, distributed or otherwise disposed of any other Assets except in the ordinary course of the Hospital Businesses and, for equipment having an original cost in excess of $25,000, with a comparable replacement thereof;

(e) to ECHN's knowledge, no Encumbrance has been imposed on any of the Assets;

(f) ECHN has not canceled or waived any material rights in respect of the Assets, except in the ordinary course of the Hospital Businesses;

(g) other than in connection with the freeze of ECHN's defined benefit pension plan and post-retiree health plan, there has been no change in any accounting method, policy or practice of ECHN with respect to the Hospital Businesses;

(h) other than compensation paid in the ordinary course of employment or ordinary course professional services agreements disclosed to System, ECHN has not paid any amount to, sold any Assets to, or entered into any Contract with any officer, director, or trustee of ECHN or its Affiliates, or with any Affiliate of any such Person;

(i) ECHN has not paid or agreed to pay to any Person any damages, fines, penalties or other amounts in respect of an actual or alleged violation of any Legal Requirement excluding routine workers' compensation claims in amounts no greater than $100,000;

(j) Other than ordinary course plan benefit design changes, ECHN has not instituted any new, or terminated or amended any existing, Employee Benefit Plan, except for amendments required to comply with applicable Legal Requirements and the freeze of ECHN's defined benefit pension plan and post-retiree health plan;

(k) ECHN has not entered into or agreed to enter into any transaction outside the ordinary course of the Hospital Businesses (other than the transactions contemplated by this Agreement); and

(l) no Material Adverse Change has occurred and no event or circumstance has occurred that could reasonably be expected to result, individually or in the aggregate, in a Material Adverse Change.

3.08. Title. Except as provided in Schedule 3.08 and subject to Section 9.04, ECHN owns and holds good and valid title to all of the Assets, free and clear of any Encumbrances other than the Encumbrances described on Schedules 3.08 (Permitted Personal Property Encumbrances) and Schedule 3.09(a) (Permitted Real Property Encumbrances).

3.09. Real Property.

(a) ECHN owns fee simple title to the Owned Real Property described on Schedule 1.01(10), free and clear of any Encumbrances other than the Encumbrances described on Schedule 3.09(a). The Owned Real Property described on Schedule 2.01(a) comprises all of the real property owned by ECHN or any Subsidiary of ECHN that is associated with or utilized in the operation of the Hospital Businesses.

(b) ECHN has not received notice of condemnation or similar Proceedings relating to the Owned Real Property or any part thereof.

(c) Except as set forth on Schedule 3.09(c), to ECHN's knowledge, the buildings standing on the Owned Real Property are structurally sound and in need of no material maintenance or repairs, except for ordinary, routine maintenance. All essential utilities (including water, sewer, gas, electricity and telephone service) are available to the Owned Real Property, and, to ECHN's knowledge, no conditions exist that are reasonably likely to result in the termination or reduction of the current access from the Owned Real Property to existing roadways. To ECHN's knowledge, no part of the Owned Real Property contains, is located within or abuts any flood plain, navigable water or other body of water, tideland, wetland, marshland or other area that is subject to special state, federal or municipal regulation, control or protection (other than Legal Requirements pertaining to zoning or other land use restrictions customarily applicable to all real estate within the applicable jurisdiction).

(d) Except for tenants in possession of the Owned Real Property under Contracts described on Schedule 3.14, no Person other than ECHN possesses, or claims possession of, adverse or not, any Owned Real Property, whether as lessee, tenant at sufferance, trespasser or otherwise.

(e) No tenant is entitled to any rebate, concession, or free rent, other than as reflected in the Contract with such tenant; no commitments have been made to any Tenant for repairs or improvements other than for normal repairs and maintenance in the future or improvements required by the tenant Contract; and no rents due under any of the Contracts with tenants have been assigned or hypothecated to, or encumbered by, any Person other than in connection with financing. All material obligations of ECHN as landlord required to be performed under each of the tenant Contracts have been performed.

(f) All Owned Real Property and, to ECHN's knowledge, Leased Real Property currently in use for the operation of the Hospital Businesses is in compliance in all material respects with all applicable Legal Requirements, and all material Permits and requisite certificates of the local board of fire underwriters (or other material body exercising a similar function) have been issued for the Owned Real Property and Leased Real Property.

(g) ECHN has (A) a valid leasehold estate in all of the Leased Real Property, free and clear of any Encumbrances other than the Encumbrances described on Schedule 3.09(g) pursuant to the leases described on Schedule 2.01(b) (the **"Tenant Leases"**), and (B) provided accurate and complete copies of each of the Tenant Leases to System. The Leased Real Property comprises all of the real property leased by ECHN or any Subsidiary of ECHN that is associated with or utilized in the operation of the Hospital Businesses.

3.10. Environmental Matters and Medical Waste.

(a) ECHN has all material Permits required under applicable Environmental Laws for the operation of the Hospital Businesses, and all such Permits are listed on Schedule 3.12. Other than as listed on Schedule 3.10(a), no Environmental Claim is pending, or to ECHN's knowledge, threatened by any Person against ECHN or, to ECHN's knowledge, any other Person the liability for which ECHN has retained or assumed, either contractually or by operation of law. To ECHN's knowledge, no activities, circumstances, conditions, events or incidents, including the release, emission, discharge or disposal of any Materials of Environmental Concern, have occurred that could reasonably be expected to form the basis of any Environmental Claim by any Person against ECHN or any other Person the liability for which ECHN has retained or assumed, either contractually or by operation of law.

(b) Without in any way limiting the generality of the foregoing, (i) all on-site and off-site locations where ECHN stores, disposes or arranges for the disposal of material quantities or volumes of Materials of Environmental Concern for the Hospital Businesses are identified on Schedule 3.10(b), (ii) all Contracts dealing with the removal, storage, disposal and handling of Materials of Environmental Concern of the Hospital Businesses are with vendors who are, to ECHN's knowledge, properly licensed, (iii) all underground storage tanks, and the capacity and contents of such tanks, located on Owned Real Property are identified on Schedule 3.10(b) and (iv) to ECHN's knowledge, no polychlorinated biphenyls are used or stored at any Owned Real Property.

(c) ECHN and the Hospital Businesses have complied in all material respects with all Medical Waste Laws.

3.11. Insurance. Schedule 3.11 describes all insurance arrangements, including self-insurance, in place for the benefit of the Assets and the conduct of the Hospital Businesses (other than Current ECHN Plans described in Schedule 3.17). ECHN has provided to System a true and complete copy of all such policies and endorsements thereto. With respect to third party insurance, Schedule 3.11 sets forth the name of each insurer, whether such insurer is an Affiliate

of ECHN, and the number, coverage, limits, term and premium for each policy of insurance purchased or held by ECHN covering the ownership and operation of the Assets and the Hospital Businesses. Except as set forth on Schedule 3.11 , all of such policies are now, and until Closing will remain, valid, outstanding, in full force and effect, and enforceable with no premium arrearages. Since September 30, 2010, ECHN has not been denied, or reduced, or requested a reduction in the scope or amount of, any insurance or indemnity bond coverage. No insurance carrier has canceled or reduced, or given written notice of its intention to cancel or reduce, any insurance coverage and, to ECHN's knowledge, there exist no reasonable grounds to cancel or void any such policies or the coverage provided thereby. Except as set forth on Schedule 3.11, since September 30, 2010, ECHN has not made any claims against any excess insurance coverage set forth on Schedule 3.11 or any predecessor excess insurance policies applicable during such time period.

3.12. Permits. Schedule 3.12 describes all material Permits relating to the ownership of the Assets and the conduct of the Hospital Businesses, all of which are in good standing and not subject to meritorious challenge. ECHN has not received any written notice from any Governmental Authority relating to the threatened, pending or possible revocation, termination, suspension or limitation of any of such material Permits. Each Hospital is duly licensed as an acute care hospital by the appropriate Governmental Authorities, and all departments or other business units, including the other Hospital Businesses, that are required to be separately licensed are duly licensed by the appropriate Governmental Authorities. The Hospitals and all departments or business units, including the Hospital Businesses, comply in all material respects with the applicable licensing requirements. Each Hospital has complied in all material respects with the requirements and conditions of all certificates of need (including applications therefor, non-review letters and implemented and unimplemented certificates of need if not lapsed and unexpired).

3.13. Government Payment Programs; Accreditation. Each Hospital has a current and valid provider Contract with the Government Payment Programs and/or their fiscal intermediaries, administrative contractors or paying agents and complies in all material respects with the conditions of participation therein. Each Hospital is entitled to receive and is receiving payment under the Government Payment Programs for services rendered to qualified beneficiaries and, to ECHN's knowledge, except as reflected in the Audited Financial Statements, is not subject to any withholds or offsets in respect thereof. ECHN has timely filed all Cost Reports due for Cost Report periods through September 30, 2012, and Cost Reports have been audited and notices of program reimbursement have been issued for all Cost Report periods through September 30, 2010. All amounts shown as due from ECHN in the Cost Reports were remitted with such reports and all amounts shown in the notices of program reimbursement as due have been paid. Except to the extent liabilities and contractual adjustments of each Hospital under the Government Payment Programs have been properly reflected and adequately reserved in the Financial Statements in the ordinary course of business, neither Hospital has to its knowledge received nor submitted any claim for payment in excess of the amount provided by Legal Requirements or applicable Contract, and ECHN has not received notice of any dispute or claim by any Governmental Authority, fiscal intermediary or other Person regarding the Government Payment Programs or each Hospital's participation therein that remains outstanding or unresolved. All Medicare and Medicaid incentive payments for meaningful use of certified electronic health record technology received by ECHN under The American Recovery and

Reinvestment Act of 2009 were awarded based on truthful attestations made by ECHN or its Affiliates, and no such incentive payments were remitted due to any knowingly fraudulent, negligent or unlawful act or omission of ECHN or its Affiliates. ECHN has registered with the QNet Exchange ("**QNet**") as required by CMS under its Hospital Quality Initiative Program (the "**HQI Program**"). ECHN has submitted all quality data required under the HQI Program to CMS or its agent, and all quality data required under the ORYX Core Measure Performance Measurement System ("**ORYX**") to The Joint Commission, for all calendar quarters concluded prior to the date of this Agreement, except for any quarter for which the respective reporting deadlines have not yet expired. All such submissions of quality data have been made materially in the form and manner required by CMS and The Joint Commission, respectively. ECHN has not received notice of any reduction in reimbursement under the Medicare program resulting from its failure to report quality data to CMS or its agent as required under the HQI Program. ECHN has provided System with the HQI Program "validation results" for all calendar quarters concluded prior to the date of this Agreement, except for any quarter for which the respective reporting deadlines have not yet expired. Each Hospital is duly accredited, with no contingencies except as disclosed on Schedule 3.13, by the Joint Commission and ECHN's certification for participation in the Medicare program is based on such Joint Commission accreditation. A copy of the most recent accreditation letter from the Joint Commission pertaining to each Hospital has been made available to System. ECHN has delivered to System copies of all accreditation survey reports, deficiency lists, statements of deficiency, and plans of correction since September 30, 2010. ECHN has taken or is taking all reasonable steps to correct all material deficiencies noted therein. Schedule 3.13 includes a list and description of all unexpected occurrences involving death or serious physical or psychological injury since September 30, 2010.

3.14. Agreements and Commitments. Schedule 3.14 identifies the Contracts related to the Hospital Businesses in the categories below:

(a) Contracts that relate to the ownership or use of, title to or interest in Owned Real Property or Leased Real Property;

(b) Contracts with (i) a physician or physician group, (ii) an Immediate Family Member of a physician on the medical staff of the Hospitals or (iii) any Person that provides marketing services for ECHN or its Subsidiaries;

(c) Contracts relating to Intellectual Properties and Information Systems;

(d) collective bargaining agreements or other Contracts with labor unions or other employee representatives or groups;

(e) Contracts with directors, trustees, officers, employees, or other agents of ECHN or its Subsidiaries;

(f) requirements or exclusive Contracts and Contracts that prohibit or limit competition or the conduct by ECHN or any Subsidiary of any lawful business;

(g) Contracts with any health plan, health provider, independent practice association or similar Person providing for capitation or risk-sharing arrangements;

(h) Contracts relating to the administration, operation or funding of any Employee Benefit Plan;

(i) Contracts between ECHN and any of the Joint Ventures;

(j) Contracts with Governmental Authorities;

(k) Contracts providing for payments based in any manner on the revenue or profits of ECHN or any Subsidiary thereof, the Hospital Businesses or the Assets;

(l) loan agreements, indentures, bonds, mortgages, liens, or other security agreements (excluding those that will be terminated at Closing);

(m) equipment leases and other leases that are capital leases; and

(n) all other Contracts which require payment by ECHN of amounts in excess of $50,000 annually after the date of this Agreement, unless ECHN may terminate the Contract, without cause, within ninety (90) days and all payments due by ECHN under the Contract through such termination equal, in the aggregate, less than $50,000 (including any penalty or termination fee).

3.15. Transactions with Affiliates. Except as disclosed in the Financial Statements of the ECHN, since September 30, 2012, ECHN has not purchased, acquired or leased any property or services from, or sold, transferred or leased any property or services to, or lent or advanced any money to, or borrowed any money from, or acquired any capital stock, obligations or securities of, or made any management consulting or similar fee agreement with, any officer, director or trustee of ECHN or of any Affiliate of ECHN except upon terms that would have been paid or received by ECHN in similar transactions with independent parties negotiated at arm's length.

3.16. Employees and Employee Relations.

(a) ECHN has delivered to System (i) a list (as of the most recent practicable date) of names, positions, current annual salaries or wage rates, target or actual bonuses, other compensation arrangements, and paid time off or extended illness bank credits of all full-time and part-time non-physician employees of ECHN and its Affiliates (indicating in the list whether each employee is classified as exempt or nonexempt by ECHN), and (ii) a separate list (as of the most recent practicable date) of names, positions, current annual salaries or wage rates, target or actual bonuses, other compensation arrangements, and paid time off or extended illness bank credits of all full-time and part-time physician employees of ECHN and its Affiliates (indicating in both lists whether each employee is part-time or full-time, whether such employee is employed under written Contract, the immigration status of any such employee who is eligible for employment based solely on a temporary work permit and, if such employee is not actively at work, the reason therefor).

(b) To ECHN's knowledge, all employees, former employees and independent contractors of ECHN and its Subsidiaries are properly classified as such for

all purposes under the Code and ERISA and have been properly classified as exempt or nonexempt under the Fair Labor Standards Act and any applicable state Legal Requirement.

(c) Except as set forth in Schedule 3.16(c), ECHN is in compliance in all material respects with all Legal Requirements relating to employment, employment practices, terms and conditions of employment, equal employment opportunity, nondiscrimination, immigration, wages, hours, benefits, payment of employment, social security, and similar taxes, occupational safety and health, and plant closing; ECHN is not liable for the payment of any material compensation, damages, taxes, fines, penalties, interest, or other amounts, however designated, for failure to comply with any of the foregoing Legal Requirements; there are no pending or, to the knowledge of ECHN, threatened claims before the Equal Employment Opportunity Commission (or any comparable state civil or human rights commission or other Governmental Authority), complaints before the Occupational Safety and Health Administration (or any comparable state safety or health administration or other Governmental Authority), wage and hour claims, unemployment compensation claims, workers' compensation claims, or the like.

(d) Schedule 3.16(d) states the number of employees terminated by ECHN and its Affiliates within 90 days prior to the Closing Date, laid off by ECHN within the six months prior to the Closing Date, or whose hours of work have been reduced by more than 50% by ECHN in the six months prior to the Closing Date, and contains a complete and accurate list of the following information for such employees: (i) the date of termination, layoff, or reduction in work hours and (ii) the location to which the employee was assigned. In relation to the foregoing, except as set forth in Schedule 3.16(d), ECHN has not violated the WARN Act or any similar state or local Legal Requirements.

(e) To the knowledge of ECHN, no officer, director, agent, employee, consultant, or independent contractor of ECHN is bound by any contract that purports to limit the ability of such officer, director, agent, employee, consultant, or independent contractor (i) to engage in or continue or perform any conduct, activity, duties, or practice relating to the business of ECHN in respect of the Hospital Businesses or the Assets; or (ii) to assign to ECHN any rights to any invention, improvement, or discovery.

(f) Except as set forth on Schedule 3.16(f), (i) no employee strike, work stoppage or slowdown, labor dispute, grievance or unfair labor practice at the Hospital Businesses is pending or, to ECHN's knowledge, threatened, (ii) no employees of ECHN are represented by, or have made demand for recognition of, a labor union or employee organization, and, to ECHN's knowledge, no other union organizing or collective bargaining activities by or with respect to any employees of ECHN are taking place and (iii) no complaint, charge or claim is pending, or, to ECHN's knowledge, threatened to be brought or filed, with any Governmental Authority or arbitrator relating to the employment or termination of employment of any individual by ECHN or the Hospital Businesses.

(g) All necessary visa or work authorization petitions have been timely and properly filed on behalf of any employees of ECHN requiring a visa stamp, I-94 status document, employment authorization document or other immigration document to legally work in the United States, and all paperwork retention requirements with respect to such applications and petitions have been met. To the knowledge of ECHN, no employee of ECHN who is a foreign national has ever worked for ECHN without employment authorization from the Department of Homeland Security or any other Government Authority that must authorize such employment, and ECHN has complied in all material respects with all applicable immigration laws and other Legal Requirements with respect to the employment of foreign nationals. To the knowledge of ECHN, ECHN has timely and properly completed I-9 forms for all employees hired since the effective date of the Immigration Reform and Control Act of 1986 and has lawfully retained and re-verified all such I-9 forms. There are no Proceedings pending or, to ECHN's knowledge, threatened against ECHN relating to ECHN's compliance with Legal Requirements relating to immigration, except as set forth on Schedule 3.16(g). ECHN has not received any letters or other correspondence from the Social Security Administration regarding the failure of an employee's social security number to match his or her name in the Social Security Administration database, and ECHN has not received any letters or other correspondence from the Department of Homeland Security or other Governmental Authorities regarding the employment authorization of any employees of ECHN. ECHN does not participate in the Department of Homeland Security's e-Verify electronic employment verification system.

3.17. Employee Benefit Plans.

(a) Schedule 3.17 lists each Employee Benefit Plan that ECHN or any member of the Controlled Group that includes ECHN maintains or to which it contributes (including employee elective deferrals) (each, a "**Current ECHN Plan**").

(b) Each Current ECHN Plan (and related trust, insurance contract or fund) complies in form and in operation in all material respects with applicable Legal Requirements, and has been administered and operated in all material respects in accordance with the terms of the Current ECHN Plan and applicable Legal Requirements. All required reports and descriptions (including form 5500 annual reports, summary annual reports and summary plan descriptions) have been filed or distributed appropriately with respect to each Current ECHN Plan. ECHN has delivered to System copies of the plan documents and summary plan descriptions, most recent determination letters received from the Internal Revenue Service, most recent form 5500 annual report, and all related trust, insurance and funding Contracts that implement each Current ECHN Plan. No Governmental Authority has audited any Current ECHN Plan or any other Employee Benefit Plan that ECHN or any member of the Controlled Group that includes ECHN has maintained, or to which it has contributed or been required to contribute (each, a "**Prior ECHN Plan**"), during the five (5) years preceding the date of this Agreement, and ECHN has not received any notice that such an audit will or may be conducted.

(c) Each Current ECHN Plan that is an Employee Pension Benefit Plan intended to be qualified under section 401(a) of the Code has a current favorable determination letter or opinion or approval letter from the Internal Revenue Service that the plan is so qualified and its trust is exempt from federal income taxation under section 501(a) of the Code, or the remedial amendment period for such Employee Pension Benefit Plan to be submitted to the Internal Revenue Service for such a determination letter or opinion or approval letter has not yet expired. All contributions (including employer contributions and employee salary reduction contributions) to each such Employee Pension Benefit Plan that are due to be paid have been paid. To ECHN's knowledge, nothing has occurred that could reasonably be expected to cause the revocation of such determination letter from the Internal Revenue Service or the unavailability of reliance on such opinion or approval letter from the Internal Revenue Service, as applicable. To ECHN's knowledge, nothing has occurred with respect to any Current ECHN Plan that has subjected or could reasonably be expected to subject ECHN to a penalty under Section 502 of ERISA or to an excise tax under the Code. To ECHN's knowledge, with respect to any Current ECHN Plan, no event has occurred or is reasonably expected to occur that has resulted in or would subject ECHN or to a tax under Section 4971 of the Code or the assets of any of the foregoing persons to a lien under Section 430(k) of the Code.

(d) The requirements of part 6 of subtitle B of Title I of ERISA and of section 4980B of the Code have been met in all material respects with respect to each Current ECHN Plan that is an Employee Welfare Benefit Plan, and all premiums or other payments that are due have been paid with respect to each such Employee Welfare Benefit Plan.

(e) There have been no "*prohibited transactions*," as defined in section 406 of ERISA and section 4975 of the Code, with respect to any Current ECHN Plan that would subject ECHN or any member of the Controlled Group that includes ECHN to any material liability. No ERISA Fiduciary has any material liability for breach of fiduciary duty or any other failure to act or comply in connection with the administration or investment of the assets of any Current ECHN Plan. No Proceeding with respect to the administration or the investment of the assets of any Current ECHN Plan (other than routine claims for benefits) is pending or, to ECHN's knowledge, threatened and, to ECHN's knowledge, there exists no basis for any such Proceeding. To ECHN's knowledge, no "*party in interest*" (as defined in section 3(14) of ERISA) and no "*disqualified person*" (as defined in the Code) has any interest in any assets of any Current ECHN Plan that is an Employee Pension Benefit Plan other than as a beneficiary by virtue of such Person's participation in the plan.

(f) Except as provided on Schedule 3.17(f), no Current ECHN Plan that is an Employee Pension Benefit Plan has been completely or partially terminated or the subject of a Reportable Event, and no Proceeding by the PBGC to terminate any such Employee Pension Benefit Plan has been instituted or, to ECHN's knowledge, threatened. ECHN has not incurred, and, to ECHN's knowledge, ECHN will not incur, any material liability to the PBGC (other than PBGC premium payments) or otherwise under Title IV of

ERISA (including any withdrawal liability) or under the Code with respect to any Current ECHN Plan or Prior ECHN Plan that is or was an Employee Pension Benefit Plan.

(g) Neither ECHN nor any member of a Controlled Group that includes ECHN contributes to, has contributed to, or has been required to contribute to any Multiple Employer Plan or any Multiemployer Plan or has any liability (including withdrawal liability) under any Multiple Employer Plan or any Multiemployer Plan. Except as provided on Schedule 3.17(g), neither ECHN nor any member of a Controlled Group that includes ECHN maintains or contributes, has maintained or contributed, or has been required to maintain or contribute to any Employee Welfare Benefit Plan providing medical, health or life insurance or other welfare-type benefits for current or future retired or terminated employees, their spouses or their dependents (other than in accordance with section 4980B of the Code).

3.18. Proceedings and Legal Claims. Schedule 3.18 contains a list and summary description of each Proceeding and legal claim (including *qui tam* Proceedings and legal claims) pending or, to ECHN's knowledge, threatened against or otherwise affecting the Assets, the Hospital Businesses, ECHN or any Affiliate of ECHN (together with the reserve amount, if any, included in the Financial Statements for each uninsured Proceeding or legal claim). All such Proceedings and legal claims are or will be fully insured (except for applicable deductibles or self-insurance retentions) and no carrier has issued a "*reservation of rights*" letter or otherwise denied its obligation to insure and defend ECHN against covered Losses arising therefrom. None of the Proceedings or legal claims described on Schedule 3.18, if determined adverse to ECHN, could reasonably be expected to result, individually or in the aggregate, in a Material Adverse Change.

3.19. Taxes.

(a) ECHN has filed all Tax Returns required to be filed by or on behalf of ECHN on or prior to the date of this Agreement (taking into account applicable extensions), all such Tax Returns are accurate in all material respects and ECHN has duly paid or made provision in the Financial Statements for the payment of all Taxes shown as due and payable on such Tax Returns.

(b) ECHN has withheld proper amounts from its employees' compensation in compliance with all applicable withholding and similar provisions of the Code and any and all other applicable Legal Requirements, and has withheld and paid, or caused to be withheld and paid, all Taxes on monies paid by it to independent contractors, creditors and other Persons for which withholding or payment is required by Legal Requirements.

(c) No deficiencies for any Taxes relating to the Assets or the Hospital Businesses have been asserted or, to the knowledge of ECHN, threatened, and no audit on any Tax Returns is currently under way or, to the knowledge of ECHN, threatened. There are no outstanding agreements by ECHN for the extension of time for the assessment of any Taxes (other than ordinary course extensions of time within which to file Tax Returns).

(d) To ECHN's knowledge, no Governmental Authority intends to assess any additional Taxes on ECHN for any period for which Tax Returns have been filed. No Governmental Authority has disputed in writing any Tax liability of ECHN. No claim has ever been made in writing by a Governmental Authority in a jurisdiction where ECHN does not file Tax Returns that ECHN is or may be subject to Tax in that jurisdiction, and no Encumbrances exist against ECHN or the Assets in connection with any failure (or alleged failure) of ECHN to pay any Tax that is due and payable.

(e) No waiver of a statute of limitations in respect of Taxes or agreement to extend the time with respect to a Tax assessment or deficiency is currently in effect, in each case with respect to ECHN (other than ordinary course extensions of time within which to file Tax Returns).

(f) ECHN is not a party to any Tax allocation or sharing Contract. ECHN is not and has not been a member of an Affiliated Group filing a consolidated federal income Tax Return.

(g) Each of ECHN and its Subsidiaries that is a corporation exempt from federal and state income Tax has received a favorable letter of determination from the Internal Revenue Service and the State of Connecticut regarding such Tax status and, to ECHN's knowledge, nothing has occurred, whether by action or failure to act, that could reasonably be expected to cause the loss of such exemption (except with respect to the transactions contemplated by this Agreement).

(h) To ECHN's knowledge, ECHN has no liability for the Taxes of any other Person (other than a Subsidiary under Internal Revenue Service regulation 1.1502-6), as a transferee or successor, by Contract or otherwise.

3.20. Medical Staff; Physician Relations.

(a) ECHN has delivered to System a copy of the bylaws, policies, rules and regulations of the medical staff and medical executive committees of each Hospital. As set forth on Schedule 3.20(a), ECHN has also delivered to System a list, current as of the date of this Agreement, that sets forth (i) the name and age of each member of the medical staff of each Hospital (active, associate, consulting, courtesy or other), (ii) the degree (M.D., D.O., etc.), title, specialty and board certification, if any, of each such medical staff member, (iii) the names of the medical staff members (current and former) of each Hospital in respect of whom ECHN has made a report to the National Practitioners Data Bank during the last three years, and (iv) the number of current medical staff members of each Hospital in respect of whom any committee of the medical staff of such Hospital has recommended adverse action with respect to any member of the medical staff of such Hospital that is not yet final.

(b) Except as set forth on Schedule 3.20(b), no material disputes between ECHN and any medical staff member of either Hospital are pending or, to ECHN's knowledge, threatened and all appeal periods in respect of any medical staff member against whom an adverse action has been taken by ECHN have expired. To the

knowledge of ECHN, no current member of the medical staff of either Hospital has been excluded from participation in any Government Payment Program.

3.21. Restricted Assets. Except as set forth on Schedule 3.26, none of the Assets is subject to any restriction or limitation concerning the purchase, improvement or use of such Assets or the conduct of the Hospital Businesses, including restricted or conditioned grants or donations and monies received under the Hill-Burton Act.

3.22. Brokers and Finders. Neither ECHN nor any Affiliate, officer, trustee, director, employee or agent acting on behalf thereof has engaged any finder or broker in connection with the transactions contemplated hereunder.

3.23. Payments. None of the Hospital Businesses has, to ECHN's knowledge, made any request for payment from a Government Payment Program in respect of health care services furnished by or directed or prescribed by any physician or other Person who at such time was excluded from participation in such Government Payment Program. ECHN has not, directly or indirectly, paid or delivered, or agreed to pay or deliver, any money or item of property, however characterized, to any Person in violation of any Legal Requirement. Neither ECHN nor, to ECHN's knowledge, any officer, director or trustee of ECHN has received, or will receive as a result of the consummation of the transaction contemplated by this Agreement, any rebate, kickback or other improper or illegal payment from any Person with whom ECHN conducts or has conducted any of the Hospital Businesses.

3.24. Solvency. As of immediately after Closing, ECHN will not, as a result of the transactions contemplated by this Agreement, be rendered insolvent or otherwise unable to pay its debts as they become due. ECHN has no intention of filing a petition in bankruptcy or insolvency or for reorganization or for the appointment of a receiver or trustee of all or any portion of ECHN's property and, to ECHN's knowledge, no other Person has filed or threatened to file such a petition against ECHN.

3.25. Hospital Businesses and Joint Ventures.

(a) Each of ECHN's Subsidiaries is duly organized under the laws of the State of Connecticut with full corporate power to carry on its business as it is now being conducted with the exception of Connecticut Health Insurance Company, which is organized with full corporate power to carry on its business as it is now being conducted under the laws of the Cayman Islands. Each of ECHN's Subsidiaries is duly licensed, qualified or admitted to do business and is in good standing in the State of Connecticut, which is the only jurisdiction in which the ownership, use or leasing of their respective assets or properties, or the conduct or nature of their respective businesses, makes such licensing, qualification or admission necessary. All of the issued and outstanding shares of capital stock of ECHN's Subsidiaries that are stock corporations are owned as specified on Schedule 3.25(a). All of the issued and outstanding shares of capital stock of ECHN's Subsidiaries that are stock corporations have been duly and validly authorized, were validly issued and are fully paid and non-assessable. There are no outstanding rights (including preemptive rights), options, warrants or agreements for the transfer by ECHN of any shares of capital stock of ECHN's Subsidiaries that are stock

corporations and no authorization for any such rights, options, warrants or agreements has been given. ECHN has delivered to System a copy of the articles of incorporation and bylaws and other agreements, instruments and documents relating to the creation, ownership and governance of ECHN's Subsidiaries and has provided to System a copy of, or access to, the minute books of ECHN's Subsidiaries.

(b) To ECHN's knowledge, for each Joint Venture that is a for-profit or nonprofit corporation, it (i) is a corporation duly organized under the laws of the state of its incorporation, (ii) has full corporate power to carry on its business as it is now being conducted, and (iii) is duly licensed, qualified or admitted to do business and is in good standing in the state of its incorporation, which is the only jurisdiction in which the ownership, use or leasing of their respective assets or properties, or the conduct or nature of their respective businesses, makes such licensing, qualification or admission necessary. To ECHN's knowledge, all of the issued and outstanding shares of capital stock of the corporate Joint Ventures that are stock corporations are owned as specified on Schedule 3.25(b). To ECHN's knowledge, all of the issued and outstanding shares of capital stock of the corporate Joint Ventures that are stock corporations have been duly and validly authorized, were validly issued and are fully paid and non-assessable. To ECHN's knowledge, there are no outstanding rights (including preemptive rights), options, warrants or agreements for the transfer by ECHN of any shares of capital stock of the corporate Joint Ventures and no authorization for any such rights, options, warrants or agreements has been given. ECHN has delivered to System a copy of the articles of incorporation and bylaws and other agreements, instruments and documents relating to the creation, ownership and governance of the corporate Joint Ventures in ECHN's possession.

(c) To ECHN's knowledge, for each Joint Venture that is a limited liability company, it (i) is organized under the laws of the state of its incorporation, (ii) has full limited liability company power to carry on its respective business as it is now being conducted, and (iii) is duly licensed, qualified or admitted to do business and is in good standing in the state of its incorporation, which is the only jurisdiction in which the ownership, use or leasing of its respective assets or properties, or the conduct or nature of its respective businesses, makes such licensing, qualification or admission necessary. To ECHN's knowledge, all of the issued and outstanding membership interests of the limited liability company Joint Ventures are owned as specified on Schedule 3.25(c), have been duly and validly authorized, were validly issued and are fully paid and non-assessable. Except as set forth on Schedule 3.25(c), the transfers to System of indirect ownership interests in the limited liability company Joint Ventures are not subject to any preemptive rights or third party approvals with respect to the Joint Venture. ECHN has delivered to System a copy of the articles of organization and operating agreements and other agreements, instruments and documents relating to the creation, ownership and governance of the limited liability company Joint Ventures in ECHN's possession.

3.26. Operation of the Hospital Businesses. Schedule 3.26 sets forth a list of the ten largest non-governmental payors of the Hospital Businesses, determined on the basis of net patient revenues from services provided during the year ended September 30, 2013. Since September 30, 2012, no payor listed on Schedule 3.26 has terminated its contract with or

materially reduced reimbursement rates to, or has notified ECHN in writing of its determination to terminate its contract with or to materially reduce reimbursement rates to, the Hospital Businesses.

4. REPRESENTATIONS OF SYSTEM

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

4.01. Organization. System is a [ ] duly organized and validly existing and in good standing under the laws of [ ]. System is, or by Closing will be, qualified to do business in the State of Connecticut. System has full power and authority to own, lease and operate its properties and to conduct its business as presently conducted and as proposed to be conducted immediately following the Closing. System has neither conducted any business prior to the date of this Agreement nor will conduct any business, other than in contemplation of the consummation of the transactions contemplated by this Agreement, prior to the Closing. System has made available to ECHN a true and complete copy of its organizational documents.

4.02. Power and Authority; Due Authorization. System has full power and authority to (a) execute and deliver this Agreement and the Closing Documents to which it is or becomes a party, (b) perform its obligations under this Agreement and such Closing Documents and (c) consummate the transactions contemplated by this Agreement. The execution and delivery by System of this Agreement and the Closing Documents to which it is or becomes a party, the performance by System of its obligations under this Agreement and such Closing Documents, and the consummation by System of the transactions contemplated by this Agreement have been duly authorized on behalf of System by all necessary [] action.

4.03. Consents; Absence of Conflicts, Etc. The execution, delivery and performance by System of this Agreement and the Closing Documents to which it is or becomes a party at the Closing, and the consummation of the transactions contemplated by this Agreement:

(a) are within its [] powers, are not in contravention of its certificate of formation and operating agreement and have been approved by all required limited liability company and member action;

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

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

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

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

4.06. System Financial Statements. Attached as Schedule 4.06 are copies of the System Audited Financial Statements and the System Unaudited Financial Statements. The System Financial Statements fairly present the financial condition and results of operations of System as of the respective dates thereof and for the periods therein referred to, in all in accordance with GAAP, subject, in the case of the System Unaudited Financial Statements, to normal recurring year-end adjustments (the effect of which will not, individually or in the aggregate, have a Material Adverse Change) and the absence of notes (which, if presented, would not differ materially from those included in the System Audited Financial Statements), and the System Financial Statements reflect the consistent application of such accounting principles throughout the periods involved.

4.07. Undisclosed Liabilities. Except and to the extent accrued or disclosed in the System Financial Statements, System does not have any liabilities or obligations of any nature whatsoever, due or to become due, accrued, absolute, contingent or otherwise, that are required by GAAP to be accrued or disclosed in audited financial statements, except for liabilities and obligations incurred in the ordinary course of business and consistent with past practice since the date of the System Unaudited Financial Statements, which are not, individually or in the aggregate, expected to result in a Material Adverse Change.

4.08. Solvency. System has no intention of filing a petition in bankruptcy or insolvency or for reorganization or for the appointment of a receiver or trustee of all or any portion of System's property and, to the knowledge of System, no other Person has filed or threatened to file such a petition against System.

4.09. Brokers and Finders. Neither System nor any Affiliate of System, nor any officer, director, employee or agent thereof, has engaged or is liable for the payment of any fee to any finder or broker in connection with the transactions contemplated hereunder.

4.10. Full Disclosure. The representations of System in this Agreement do not contain any untrue statement of a material fact or omit to state any material fact necessary to make the statements made therein, in the light of the circumstances under which they were made, not misleading.

4.11. Tax-Exempt Status. System is an organization described in Section 501(c)(3) of the Code, or corresponding provisions of prior law, as set forth in a determination letter issued by the Internal Revenue Service and no such letter has been modified, limited, or revoked. System is in material compliance with the terms, conditions, and limitations in such letter, and the facts and circumstances that form the basis of such letter as represented to the Internal Revenue Service continue substantially to exist, and (i) no proceedings are pending with respect to which

System has been served and threatened in any way contesting or adversely affecting such entity's status as an organization described in Section 501(c)(3) of the Code, and (ii) System has no knowledge of any challenge, investigation or inquiry that the Internal Revenue Service has made regarding its status as an organization described in Section 501(c)(3) of the Code. System has provided ECHN a complete and accurate set of all reports, filings, correspondence, and other documents to or from the Internal Revenue Service, the Attorney General, or the Connecticut Department of Revenue Services on any tax, compliance, or other issue related to System.

5. COVENANTS OF THE PARTIES

5.01. Operations. Until the Closing Date and except as otherwise expressly provided in this Agreement or agreed to in writing by System, ECHN will, and will require its Affiliates to:

(a) conduct the Hospital Businesses in substantially the same manner as it has heretofore and not make any material change in personnel, operations, finances, accounting policies, or real or personal property of the Hospital Businesses except as set forth on Schedule 5.01;

(b) except as set forth on Schedule 5.01(b), maintain the Assets in working condition in the ordinary course of business, ordinary wear and tear excepted, and make all normal, planned and budgeted capital expenditures related to the Assets and/or the Hospital Businesses, *provided* that ECHN may (i) make, in its discretion, necessary expenditures in the ordinary course from its designated capital needs fund and provide advance notice to System of any individual expenditure greater than $1,000,000 and (ii) consult with and solicit System's input on individual capital expenditures (or a series of related capital expenditures) not paid from its designated capital needs fund that exceed $1,000,000;

(c) comply in all material respects with all Legal Requirements and perform, when due, in all material respects all obligations under Contracts;

(d) keep in full force and effect present insurance policies or other comparable insurance benefiting the Assets and the conduct of the Hospital Businesses and maintain sufficient liquid reserves reasonably estimated to be sufficient to meet all deductible, self-insurance and copayment requirements of such policies; and

(e) maintain and preserve its business organizations and operations intact, retain the present employees at the Hospital Businesses (subject to the right of ECHN to discharge any employee in the ordinary course of the Hospital Businesses), and maintain in the ordinary course its relationships with physicians, suppliers, patients and other Persons doing business with ECHN at the Hospital Businesses.

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

(a) excluding capital expenditures, enter into any Contract, except in the ordinary course of the Hospital Businesses consistent with past practices, *provided* that

ECHN shall obtain System's consent on any new Contract (or a series of related Contracts) that has required payments by ECHN that exceed $1,000,000 annually, unless such Contract may be terminated without cause upon no more than 90 days written notice and such termination will not result in any penalty or fee;

(b) enter into any tertiary or quaternary affiliation with a third-party healthcare provider other than an agreement for hospitalist services;

(c) other than as set forth on Schedule 5.02(c), increase compensation payable or to become payable to, make a bonus or severance payment to, or otherwise enter into one or more bonus or severance Contracts with any employee, contractor or agent of any of the Hospital Businesses except in the ordinary course of the Hospital Businesses consistent with past practices in accordance with existing personnel policies or pursuant to Contract requirements in force on the date of this Agreement;

(d) create, assume or voluntarily consent to any new Encumbrance upon any of the Assets;

(e) sell or otherwise transfer or dispose of any item of property, plant, equipment or other Asset except in the ordinary course of the Hospital Businesses consistent with past practices with comparable replacement thereof;

(f) make necessary expenditures in the ordinary course from its designated capital needs fund of more than $1,000,000 per expenditure without providing advanced notice to System of such expenditure and will not make individual capital expenditures (or a series of related capital expenditures) that are outside the ordinary course in excess of $1,000,000 individually or $5,000,000 in the aggregate if such capital expenditures are not included in ECHN's annual operating or capital budgets that have been provided to System;

(g) add, modify, or discontinue the provision of any material clinical service by the Hospital Businesses other than entering into an agreement with a third party for the provision of hospitalist services, open a new location for the provision of any material clinical service, or close the location at which any such material clinical service is currently provided without consent of System, which will not be unreasonably withheld or delayed;

(h) create, incur, assume, guarantee or otherwise become liable for any liability or obligation except in the ordinary course of the Hospital Businesses consistent with past practices in excess of $1,00,000, other than ECHN's customary annual line of credit renewal with TD Bank in the currently issued amount, or agree to do any of the foregoing;

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

(j) amend, change or modify the title or duties of the chief executive officer of ECHN;

(k) except with respect to the previously planned freeze of ECHN's defined benefit pension plan and post-retiree health plan, terminate, amend or otherwise modify in any material respect any Employee Benefit Plan, except for normal course annual changes and amendments required to comply with this Agreement or applicable Legal Requirements; or

(l) amend or agree to amend the articles of incorporation or the bylaws or articles of formation or operating agreement (or comparable organizational documents) of ECHN or otherwise take any action relating to any liquidation or dissolution of ECHN or any Subsidiary thereof, except as expressly contemplated by this Agreement, provided that ECHN may merge any one or more of the Subsidiaries into each other or into the ECHN in connection with the proposed transaction.

5.03. Employee Matters. ECHN will continue to employ, as of the Closing Date, substantially all employees of ECHN and its Affiliates who work at the Hospital Businesses, including but not limited to employees on approved leaves of absence as of the Closing Date for any reasons including without limitation by reason of a military leave, family or medical leave, illness, injury, disability or similar situation, on the same terms and conditions with respect to job duties, titles, responsibilities, compensation and employee benefits that are applicable to such employees immediately prior to the Closing Date.

5.04. Access to and Provision of Additional Information.

(a) Except to the extent prohibited by applicable Legal Requirements (including antitrust laws), until the Closing Date, ECHN shall (i) give System reasonable access to and the right to inspect, during normal business hours and upon reasonable prior notice, ECHN's Assets and books and records relating to the Hospital Businesses, (ii) give System reasonable access to ECHN's employees and medical staff members providing services at or for the Hospital Businesses and (iii) give System such additional financial, operating and other data and information (including auditors' workpapers) regarding the Hospital Businesses as System may reasonably request and that is reasonably available to ECHN. System shall exercise its rights under this Section 5.03(a) in such a manner as to cause the least possible interference with the normal operations of the Hospital Businesses.

(b) ECHN will deliver to System:

(i) within 25 days after the end of each calendar month before the Closing Date, copies of the unaudited balance sheet and the related unaudited statements of income and cash flows of the Hospital Businesses for each such month then ended and for the fiscal year-to-date then ended, in consolidating and consolidated format;

(ii) within 35 days after the end of each fiscal quarter ending on or before the Closing Date, copies of the unaudited balance sheet and the related

unaudited statements of income and cash flows of the Hospital Businesses for the fiscal quarter then ended and for the fiscal year-to-date then ended; and

(iii) promptly after prepared, copies of any other financial or operating statements, reports or analyses prepared by or for management relating to the Hospital Businesses.

(c) System will deliver to ECHN:

(i) within 25 days after the end of each calendar month before the Closing Date, copies of the unaudited balance sheet and the related unaudited statements of income and cash flows of System for each such month then ended and for the fiscal year-to-date then ended, in consolidating and consolidated format; and

(ii) within 35 days after the end of each fiscal quarter ending on or before the Closing Date, copies of the unaudited balance sheet and the related unaudited statements of income and cash flows of System for the fiscal quarter then ended and for the fiscal year-to-date then ended.

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

(e) With respect to any individually identifiable health information disclosed by ECHN to System pursuant to this Section 5.03, System and ECHN shall comply with the Health Insurance Portability and Accountability Act of 1996, as codified at 42 U.S.C. Section 1320d, *et seq.*, as amended by the Health Information Technology for Economic and Clinical Health Act, and any current and future Legal Requirements promulgated thereunder, and with any other federal or state Legal Requirements that govern or pertain to the confidentiality, privacy, security of, and electronic transactions involving, health care information.

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

5.05. Governmental Authority Approvals; Approvals Under Existing Agreements.

(a) Until the Closing Date, ECHN and System shall (i) promptly apply for, and use commercially reasonable efforts to obtain before Closing, all consents, approvals, authorizations and clearances of Governmental Authorities required to consummate the transactions contemplated by this Agreement, including approvals of the applications to

the Office of Health Care Access of the Connecticut Department of Public Health, (ii) provide such information and communications to Governmental Authorities as the other party or such Governmental Authorities may reasonably request, and (iii) assist and cooperate with the other party to obtain all Permits, including approvals of the applications to the Office of Health Care Access of the Connecticut Department of Public Health, that the other party deems necessary or appropriate, and to prepare any document or other information reasonably required of it by any such Governmental Authority to consummate the transactions contemplated by this Agreement.

(b) Until the Closing Date, each party shall file, if and to the extent required by applicable Legal Requirements, all reports and other documents required or requested by Governmental Authorities under the HSR Act concerning the transactions contemplated by this Agreement, and shall promptly comply with any requests by the Governmental Authorities for additional information concerning such transactions, so that the waiting period specified in the HSR Act will expire as soon as reasonably possible. Each party shall furnish to the other party such information as the other party reasonably requires to comply with its obligations under the HSR Act and shall exchange drafts of the relevant portions of each other's report forms before filing. The parties shall also share equally the costs of any fees due in respect of filings required by the HSR Act.

(c) Each of ECHN and System shall obtain all approvals that may be required under existing agreements to which it or its respective Subsidiaries may be a party, including all agreements relating to long-term debt, all as set forth on Schedule 5.05(c). Any conditions imposed in connection with any such approval shall be acceptable to both parties in each of their sole discretion.

5.06. No-Shop Clause. Until termination of this Agreement, ECHN shall not, and shall not permit any Affiliate of ECHN or any other Person acting for or on behalf of ECHN or any Affiliate of ECHN to, without the prior written consent of System: (a) offer for sale, lease or other disposition all or substantially all of the Assets or any material portion thereof, or any ownership interest in any entity owning any of the Assets, whether by virtue of an asset sale transaction, a lease transaction, affiliation transaction, or a change of control, change of membership, merger, consolidation or other combination transaction with respect to ECHN or any entity owning any of the Assets (collectively, a "**Prohibited Transaction**"), or negotiate in respect of an unsolicited offer therefor; (b) solicit offers to acquire all or substantially all of the Assets, or any material portion thereof, or offers to acquire any ownership interest in an entity owning any of the Assets, in a Prohibited Transaction; (c) enter into any Contract with any Person with respect to the disposition of all or substantially all of the Assets, or any material portion thereof, or the sale of any ownership interest in an entity owning any of the Assets, in a Prohibited Transaction; or (d) furnish or permit or cause to be furnished any information to any Person that ECHN knows or has reason to believe is in the process of considering a Prohibited Transaction. If ECHN, any Affiliate of ECHN, or any Person acting for or on behalf of any of the foregoing receives from any Person (other than System or its representatives) any offer, inquiry or informational request referred to above, ECHN will promptly advise such Person, by written notice, of this Section 5.06.

5.07. Casualty. If, on or before the Closing Date, any of the Hospital Businesses are destroyed or materially damaged by fire, theft, vandalism or other cause or casualty and as a result thereof any material part of such Hospital Business is rendered unsuitable for its primary intended use and the cost of repair would exceed $1,000,000, System may elect, by giving written notice to ECHN within 15 business days after having actual notice of the occurrence of such destruction or damage and the extent of the loss, to terminate this Agreement in accordance with Section 8.04(a).

5.08. Continuation of Hospitals and Post-Care Continuum. For at least [X] ([X]) years after Closing, System will (i) ensure that the Hospitals continue to operate in their current locations as acute care hospitals with emergency departments, and (ii) ensure that ECHN, or any successor entity, maintains an ownership interest in ECHN's current post-acute care continuum of care network (e.g., VNA/home care, sub-acute and long-term lines of service) and require any joint venture involving such post-acute care continuum of care network to maintain the applicable service line for such three-year period.

5.09. Charity Care and Community Obligations.

(a) ECHN has historically provided significant levels of care for indigent and low-income patients and has also provided support for community volunteer services and care through a variety of community-based health programs. Subject to changes in Legal Requirements or governmental guidelines or policies, System will ensure that each Hospital maintains and adheres to ECHN's current policies on charity care, indigent care, community volunteer services and community benefits attached as Schedule 5.09 or adopt other policies and procedures that are at least as favorable to the indigent and uninsured in the aggregate as ECHN's existing policies.

(b) During all times that System remains the sole corporate member of ECHN, System will ensure that ECHN strives to provide care through community-based health programs, including by cooperating with local organizations that sponsor health care initiatives to address community needs and improve the health status of the elderly, poor, and at-risk populations in the community.

5.10. Educational Support. System agrees to maintain and support financially the University of New England medical student and other health professions teaching programs established by ECHN, in addition to ECHN's graduate medical education programs, while operating at a level to not exceed the Indirect Medical Education and Direct Graduate Medical Education caps that may be established by CMS.

5.11. Equity Transfer. Post-Closing, the System Board, in consultation with the ECHN Board and potentially an outside consultant, will develop a strategic capital plan with respect to the Hospital Businesses (which for purposes of this Section 5.11 includes the Joint Ventures). In accordance with such strategic capital plan, System agrees to spend not less than $[X] within [X] years of the Closing Date (the "**Commitment Amount**") for the following purposes at ECHN facilities: (i) capital projects, including routine and non-routine capital expenditures for the improvement of ECHN's facilities and/or the acquisition, development, expansion and improvement of hospital, ambulatory or other health care services (such as implementation of a

comprehensive and system-wide electronic medical record such as the Epic system), (ii) de novo development, expansion, or acquisition of a department, program, service or facility (whether for inpatient or outpatient services), (iii) upgrades or renovations generally, (iv) deferred maintenance items, and (v) capital expended in support of the recruitment of the Hospitals' medical staff located in the Hospitals' service area, limited to physician practice acquisitions, loan security agreements and real estate acquisition or development (including any associated medical equipment) in support of physician practice acquisitions. System shall provide a written report to ECHN on an annual basis that verifies its compliance with this Section 5.11. For the avoidance of doubt, the Commitment Amount shall be deemed to be an equity transfer and shall not be repayable by ECHN.

5.12. Connecticut Transactions. If at any time prior to Closing, System or any of its Affiliates enter into an agreement with another Connecticut hospital that seeks to consummate transactions similar to the transactions described herein, then System shall promptly inform ECHN of such fact, subject to such hospital's approval of waiving any nondisclosure obligation in a confidentiality agreement between such hospital and System, or an Affiliate of System.

5.13. Bond Liabilities. System agrees that effective on and after the Closing Date it will either (i) repay or defease all of the Bond Liabilities, or (ii) guarantee full and timely payment of amounts due in connection with the Bond Liabilities (which may occur by means of adding ECHN to the System's obligated group).

5.14. Defined Benefit Pension. System agrees that effective on and after the Closing Date it will guarantee the full and timely payment of amounts necessary to satisfy all applicable minimum funding requirements under Section 412 of the Code with respect to ECHN's defined benefit pension plan, known as the "Eastern Connecticut Health Network, Inc. Pension Plan (Plan Number 001)."

5.15. Post-Retiree Health Plan. System agrees that effective on and after the Closing Date it will guarantee the full and timely payment of amounts due under ECHN's post-retiree health plan.

5.16. Fees and Expenses.

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

(b) System shall pay the following: all third party fees and expenses reasonably incurred by System for System's land title surveys and environmental, engineering and other inspections, studies, tests, reviews and analyses undertaken by or on behalf of System for the benefit of System.

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

5.17. Fulfillment of Conditions. If all of the conditions to a party's obligation to consummate the transactions contemplated by this Agreement at the Closing are satisfied (or waived by that party in its sole discretion), such party will execute and deliver at Closing each Closing Document that such party is required by this Agreement to execute and deliver at Closing. Each party will use all commercially reasonable efforts to satisfy each condition to the obligations of the other party to consummate the transactions contemplated by this Agreement, to the extent that satisfaction of any such condition is within the control of such party.

6. CONDITIONS PRECEDENT TO OBLIGATIONS OF ECHN

The obligations of ECHN to consummate the transactions contemplated by this Agreement, including by taking the actions specified in Section 8.02, are subject to the satisfaction on or before Closing of the following conditions, unless waived by ECHN:

6.01. Representations; Covenants.

(a) Each of the representations and warranties of System in this Agreement that is qualified as to materiality was true and correct on and as of the date of this Agreement, each of the other representations and warranties of System was true and correct in all material respects on and as of the date of this Agreement, each of the representations and warranties of System in this Agreement that is qualified as to materiality is true and correct on and as of the Closing Date, and each of the other representations and warranties of System in this Agreement is true and correct in all material respects on and as of the Closing Date.

(b) Each of the covenants to be complied with or performed by System on or before Closing (other than actions to be taken at the Closing, including the delivery of the Closing Documents described in Section 8.03) has been complied with and performed in all material respects.

6.02. System Approvals and Filings. The System Board shall have taken all actions necessary to approve and adopt, conditional on and effective as of the Closing Date, amended and restated bylaws providing that for at least [_] years following the Closing Date, at least [_] member(s) of the System Board will be current or former members of the ECHN Board or persons who reside in ECHN's service area as such service area existed on the Closing Date.

System shall file the Amended and Restated Bylaws adopted in accordance with this Section 6.02 with any governmental agency as may be required by law.

6.03. Adverse Proceeding. No Proceeding by any Governmental Authority (including the Attorney General) has been instituted or threatened to restrain or prohibit the transactions contemplated by this Agreement, no Governmental Authority (including the Attorney General) has taken any other action or made any request of ECHN or System as a result of which ECHN reasonably and in good faith deems it inadvisable to proceed with the transactions contemplated by this Agreement, and no order is in effect restraining, enjoining or otherwise preventing consummation of the transactions contemplated by this Agreement.

6.04. Pre-Closing Confirmations. ECHN has received all consents, approvals, licenses and other authorizations of Governmental Authorities, including the certificate of need approval by the Office of Health Care Access of the Connecticut Department of Public Health, on terms reasonably satisfactory to ECHN.

6.05. Bond Liabilities. ECHN shall have received evidence satisfactory to it that the Bond Liabilities have been paid or defeased or that a guarantee meeting the requirements of Section 5.13 has been delivered.

6.06. Defined Benefit Pension. ECHN shall have received evidence satisfactory to it that a guarantee meeting the requirements of Section 5.14 has been delivered.

6.07. Post-Retiree Health Plan. ECHN shall have received evidence satisfactory to it that a guarantee meeting the requirements of Section 5.15 has been delivered.

6.08. Extraordinary Events. System (a) is not in receivership or dissolution, (b) has not made any assignment for the benefit of creditors, (c) has not admitted in writing its inability to pay its debts as they mature, (d) has not been adjudicated a bankrupt, (e) has not filed a petition in voluntary bankruptcy, a petition or answer seeking reorganization, or an arrangement with creditors under the federal bankruptcy law or any other similar Legal Requirement of the United States or any state (and no such petition has been filed against System), or (f) has not entered into any contract to do any of the foregoing on or after the Closing Date.

6.09. Due Diligence. ECHN shall have completed its due diligence investigation of System, and the resulting information from such investigation shall have been acceptable to ECHN in its sole discretion; *provided, however*, that the parties agree to have each completed their due diligence investigation of the other by [X], 2015.

7. CONDITIONS PRECEDENT TO OBLIGATIONS OF SYSTEM

The obligations of System to consummate the transactions contemplated by this Agreement, including by taking the actions specified in Section 8.03, are subject to the satisfaction on or before Closing of the following conditions, unless waived by System:

7.01. Representations; Covenants; Schedules.

(a) Each of the representations and warranties of ECHN in this Agreement that is qualified as to materiality was true and correct on and as of the date of this Agreement, each of the other representations and warranties of System in this Agreement was true and correct in all material respects on and as of the date of this Agreement, each of the representations and warranties of ECHN in this Agreement that is qualified as to materiality is true and correct on and as of the Closing Date, and each of the other representations and warranties of ECHN in this Agreement is true and correct in all material respects on and as of the Closing Date (other than the representation in Section 3.07(l) which shall be true and correct in all respects).

(b) Each of the covenants to be complied with or performed by ECHN on or before Closing (other than actions to be taken at the Closing, including the delivery of the Closing Documents described in Section 8.02) has been complied with and performed in all material respects.

(c) Each of ECHN's Schedules, Exhibits and other instruments required under this Agreement has been updated or delivered by ECHN, and approved by System, all in accordance with Section 9.01.

7.02. ECHN Approvals and Filings. The ECHN Board shall have taken all actions necessary to approve and adopt conditional on and effective as of the Closing Date, an amended and restated certificate of incorporation and amended and restated bylaws naming System as the sole corporate member of ECHN and affording System the Reserved Powers and Approval Powers listed in sections 7.03-7.04 below. System acknowledges that it will be charged with, and act in accordance with, its fiduciary duty to ECHN as the sole member of ECHN.

7.03. System's Reserved Powers in ECHN. The amended and restated bylaws of ECHN adopted pursuant to Section 7.02 shall state that the following are reserved powers of System (the "**Reserved Powers**"): [INSERT PROPOSED RESERVED POWERS]

7.04. System's Approval Powers. The amended and restated bylaws of ECHN adopted pursuant to Section 7.02 shall state that the exercise by the ECHN Board of Trustees of the following matters are subject to the prior approval of System Board (the "**Approval Powers**"): [INSERT PROPOSED APPROVAL POWERS]

7.05. Adverse Action or Proceeding. No Proceeding by any Governmental Authority (including the Attorney General) has been instituted or threatened to restrain or prohibit the transactions contemplated by this Agreement, no Governmental Authority (including the Attorney General) has taken any other action or made any request of ECHN or System as a result of which System reasonably and in good faith deems it inadvisable to proceed with the transactions contemplated by this Agreement, and no order is in effect restraining, enjoining or otherwise preventing consummation of the transactions contemplated by this Agreement.

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

7.07. Pre-Closing Confirmations and Contractual Consents. System has obtained documentation or other evidence reasonably satisfactory to System that:

(a) The applicable Hospital Businesses that participate in the Government Payment Programs as of the date of this Agreement will be qualified effective as of Closing to participate in the Government Payment Programs in which they participate as of the date of this Agreement and will be entitled to receive payment under such Government Payment Programs for services rendered to qualified beneficiaries of such Government Payment Programs immediately after the Closing Date with respect to the Hospitals, and within a reasonable period of time after the Closing Date with respect to the other applicable Hospital Businesses;

(b) All other consents, approvals, licenses and other authorizations of Governmental Authorities, including the certificate of need approval by the Office of Health Care Access of the Connecticut Department of Public Health required for the consummation of the transactions contemplated by this Agreement and for the continued operation of the Hospital Businesses following the Closing shall have been received on terms reasonably satisfactory to System;

(c) ECHN has obtained approvals for the transactions contemplated herein from its Board of Trustees, corporators and, to the extent required, the governing boards of its Subsidiaries;

(d) Each party has delivered to the other copies of approvals that are listed on Schedule 5.05(c); and

(e) All applicable waiting periods under the HSR Act have expired or been terminated.

7.08. Extraordinary Events. ECHN (a) is not in receivership or dissolution, (b) has not made any assignment for the benefit of creditors, (c) has not admitted in writing its inability to pay its debts as they mature, (d) has not been adjudicated a bankrupt, (e) has not filed a petition in voluntary bankruptcy, a petition or answer seeking reorganization, or an arrangement with creditors under the federal bankruptcy law or any other similar Legal Requirement of the United States or any state (and no such petition has been filed against it), and (f) has not entered into any Contract to do any of the foregoing on or after the Closing Date.

7.09. Opinion of ECHN's Counsel. System has received an opinion from counsel to ECHN, dated as of the Closing Date and addressed to System, in a form reasonably satisfactory to System.

7.10. Environmental Assessments. System, at its election, shall have received a Phase I environmental site assessment in a form reasonably satisfactory to System, on each parcel of Owned Real Property and, at System's option, any portion of the premises forming a part of the Leased Real Property (each, a "Phase I Assessment," collectively, the "Phase I Assessments"). System shall not be permitted to conduct any Phase II environmental site assessments, or other intrusive or destructive testing on or relating to the Owned Real Property or Leased Real Property (each, a "Phase II Assessment," collectively, the "Phase II Assessments") unless

pursuant to information contained in the applicable Phase I Assessment and subject to the prior approval of ECHN (including any conditions which ECHN may impose on such investigations, and, if ECHN so requires, memorialized in an environmental access agreement between System and ECHN), in ECHN's sole discretion. System shall pay all costs associated with any Phase I Assessment(s) and any Phase II Assessment(s).

7.11. Hill-Burton Facilities. No Encumbrance affects any of the Assets or Hospital Businesses relating to or arising under the Hill-Burton Act.

7.12. Due Diligence. System shall have completed its due diligence investigation of ECHN, and the resulting information from such investigation shall have been acceptable to System in its sole discretion; *provided, however*, that the parties agree to have each completed their due diligence investigation of the other by [X], 2015.

8. CLOSING; TERMINATION OF AGREEMENT

8.01. Closing.

(a) Consummation of the transactions contemplated by this Agreement (the "**Closing**") will take place at [_____] at 10:00 a.m., or at such other place and time as the parties may mutually agree, on _____, 2015, or if at such time any conditions to Closing set forth in Articles 6 and 7 have not been satisfied (or waived by the parties entitled to the benefit thereof), on the third business day following satisfaction or waiver of such conditions, or at such time or place as the parties may mutually agree. The Closing shall be effective for all purposes as of 12:01 a.m. on the day immediately following the Closing Date.

(b) At the Closing, ECHN shall deliver, or cause to be delivered, to System, each of the Closing Documents and other items set forth in Section 8.02, all in forms reasonably acceptable to System and its counsel, and such Closing Documents, as appropriate, shall be duly executed by, and acknowledged on behalf of, ECHN. At the Closing, System shall deliver, or cause to be delivered, to ECHN, each of the Closing Documents and the consideration set forth in Section 8.03, all in forms reasonably acceptable to ECHN and its counsel, and such Closing Documents, as appropriate, shall be duly executed by, and acknowledged on behalf of, System and, where applicable, [System's ultimate parent].

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

8.02. Action of ECHN at Closing. At the Closing, ECHN shall deliver to System:

(a) a copy of resolutions duly adopted by the board of directors of ECHN authorizing and approving the execution and delivery of this Agreement and the Closing

Documents and the consummation of the transactions contemplated herein and therein, certified as in full force and effect as of the Closing Date by an appropriate officer of ECHN;

(b) a certificate of a duly authorized officer of ECHN certifying that (i) each of the representations and warranties of ECHN in this Agreement that is qualified as to materiality was true and correct on and as of the date of this Agreement, (ii) each of the other representations and warranties of ECHN in this Agreement was true and correct in all material respects on and as of the date of this Agreement, (iii) each of the representations and warranties of ECHN in this Agreement that is qualified as to materiality is true and correct on and as the Closing Date, (iv) each of the other representations and warranties of ECHN in this Agreement was true and correct in all material respects on and as of the Closing Date and (v) each of the covenants to be complied with or performed by ECHN on or before Closing (other than actions to be taken at the Closing, including the delivery of the Closing Documents described in this Section 8.02) has been complied with and performed in all material respects;

(c) a certificate of incumbency for the officers of ECHN executing this Agreement and the Closing Documents;

(d) a certificate of existence and good standing for ECHN and each of its Subsidiaries from the State of Connecticut, dated no earlier than 15 days prior to the Closing Date;

(e) the opinion of counsel to ECHN as provided in Section 7.09; and

(f) such other Closing Documents as System deems reasonably necessary to consummate the transactions contemplated by this Agreement.

8.03. Action of System at Closing. At the Closing, System shall deliver to ECHN:

(a) a copy of resolutions duly adopted by the boards of trustees, directors, members or managers of System, as appropriate, authorizing and approving the execution and delivery of this Agreement and the Closing Documents and the consummation of the transactions contemplated herein and therein, certified as in full force and effect as of the Closing Date by an appropriate officer of System;

(b) a certificate of a duly authorized officer of System certifying that each of the representations and warranties of System in this Agreement that is qualified as to materiality was true and correct on and as of the date of this Agreement, that each of the other representations and warranties of System in this Agreement was true and correct in all material respects on and as of the date of this Agreement, that each of the representations and warranties of System in this Agreement that is qualified as to materiality is true and correct on and as of the Closing Date, that each of the other representations and warranties of System in this Agreement is true and correct in all material respects on and as of the Closing Date, and that each of the covenants to be complied with or performed by System on or before Closing (other than actions to be

taken at the Closing, including the delivery of the Closing Documents described in this Section) has been complied with and performed in all material respects;

(c) a certificate of incumbency for the officers of System executing this Agreement and the Closing Documents;

(d) a certificate of existence and good standing of System from the State of [], dated no earlier than 15 days prior to the Closing Date; and

(e) such other Closing Documents as ECHN deems reasonably necessary to consummate the transactions contemplated by this Agreement.

8.04. Termination Prior to Closing; Termination Fee.

(a) Notwithstanding anything herein to the contrary, this Agreement may be terminated at any time: (i) by mutual consent of ECHN and System; (ii) by ECHN or System, if the Closing Date shall not have taken place on or before December 31, 2015 (as such date may be extended by mutual agreement of ECHN and System); *provided*, however, that no party may terminate this Agreement if the failure of Closing to occur by such date resulted from a material breach of this Agreement by such party; or (iii) by System, pursuant to Section 5.07 hereof.

(b) In the event that this Agreement is terminated by System or ECHN (the "**Terminating Party**") because the other party (the "**Breaching Party**") refuses to close the transactions contemplated by this Agreement, other than as expressly permitted hereunder, when the Terminating Party is in compliance in all material respects with the terms of this Agreement, then the Breaching Party shall, within five business days after receipt of written notice of such termination, pay to the Terminating Party by wire transfer of immediately available funds to an account designated by the Terminating Party a fee equal to $4,500,000 (the "**Termination Fee**"). The parties acknowledge and agree that the agreements contained in this Section 8.04(b) are an integral part of the transactions contemplated by this Agreement and constitute liquidated damages and not a penalty. If the Breaching Party fails to pay the Termination Fee in accordance with the terms of this Section 8.04(b), then the Breaching Party shall pay the costs and expenses (including legal fees and expenses) of the Terminating Party in connection with any action, including the filing of any lawsuit or other legal action, taken to collect payment, together with interest as provided in Section 9.19 from the date such Termination Fee was required to be paid. Notwithstanding anything to the contrary in this Agreement, the Terminating Party's right to receive payment of the Termination Fee pursuant to this Section 8.04(b), and the right to receive the payment of its costs and expenses as provided in this Section 8.04(b), shall be the sole and exclusive remedy of the Terminating Party against the Breaching Party and its Affiliates for any and all Losses that may be suffered based upon, resulting from or arising out of the circumstances giving rise to such termination, and upon payment of the Termination Fee in accordance with this Section 8.04(b), neither the Breaching Party nor any of its Affiliates or their respective stockholders, partners or members shall have any further liability or obligation

relating to or arising out of this Agreement or the transactions contemplated by this Agreement.

(c) If this Agreement is validly terminated pursuant to Section 8.04(a), this Agreement will be null and void, and there will be no liability on the part of any party pursuant to this Agreement, except that (i) upon termination of this Agreement pursuant to Section 8.04(a), subject to Section 8.04(b), ECHN will remain liable to System and System will remain liable to ECHN for any breach of their respective obligations existing at the time of such termination, and each party may seek such remedies or damages against the other with respect to any such breach as are provided in this Agreement or as are otherwise available at law or in equity and (ii) the expense allocation provisions of Section 5.16 and the confidentiality provisions of Section 9.21 shall remain in full force and effect and survive any termination of this Agreement.

(d) Upon termination of this Agreement, each party's existing rights of access to the books and records of the other party shall terminate, and each party shall promptly return every document furnished it by the other party (or any Affiliate of such other party) in connection with the transactions contemplated hereby, whether obtained before or after execution of this Agreement, and all copies thereof, and will destroy all copies of any analyses, studies, compilations or other documents prepared by it or its representatives to the extent they contain any information with respect to the business of the other parties hereto or their Affiliates, and will cause its representatives to whom such documents were furnished to comply with the foregoing. This Section 8.04 shall survive any termination of this Agreement.

8.05. Survival of Representations and Warranties; Indemnity Periods. Notwithstanding any right of System to investigate ECHN and the Hospital Businesses or any right of any party to investigate the accuracy of the representations and warranties of the other party in this Agreement, or any actual investigation by or knowledge of a party, ECHN has, on the one hand, and System has, on the other hand, the right to rely fully upon the representations and warranties of the other in this Agreement. The representations and warranties of ECHN and System in this Agreement respectively will survive the Closing (a) indefinitely with respect to matters covered by Sections 3.01, 3.02, 3.03, 3.08, 4.01, 4.02, 4.04, 8.04(b), 8.04(c), 8.04(d), 9.19, 9.21 and, (b) until the expiration of all applicable statutes of limitations (including all periods of extension) with respect to matters covered by Sections 3.04, 3.06, 3.08, 3.09(a), 3.10, 3.13, 3.17, 3.19 and 3.23, and (c) until the second anniversary of the Closing Date in the case of all other representations and warranties, except that:

(i) the right to indemnification with respect to any claim relating to a breach or default of any representation and warranty whose survival expires in accordance with clause (b) or (c) above will continue to survive if a notice of claim with respect to such claim has been given on or before the expiration of such representation or warranty until the claim for indemnification has been satisfied or otherwise resolved; and

(ii) in the event of intentional misrepresentation or fraud in the making of any representation and warranty, all representations and warranties that are the

subject of the intentional misrepresentation, fraud or intentional nonfulfillment or breach shall survive until the expiration of all applicable statutes of limitations (including all periods of extension) with respect to claims made for such intentional misrepresentation, fraud or intentional nonfulfillment or breach.

8.06. Similar Affiliation Agreement. From the execution date of this Agreement until the Closing Date, in the event System enters into a similar affiliation arrangement with another community acute care hospital or health system in Connecticut, System shall provide a copy to ECHN of the agreements relating to such arrangement within fifteen (15) days of System entering into a binding agreement with such entity. If ECHN determines in good faith that the terms of such arrangement are more favorable to such entity than the terms applicable to ECHN hereunder, ECHN shall provide written notice to System within fifteen (15) days of receipt of the binding agreements. Within forty-five (45) days of ECHN's delivery of such notice, System and ECHN agree to amend the terms of this Agreement, as applicable, to incorporate for the benefit of ECHN such more favorable terms.

9. GENERAL

9.01. Exhibits; Schedules.

(a) Each Schedule and Exhibit to this Agreement shall be considered a part hereof as if set forth herein in full. From the date hereof until Closing, each of ECHN and System shall update its Schedules such that all of its representations and warranties are true and accurate as of the Closing Date. Any other provision herein to the contrary notwithstanding, all Schedules, Exhibits, or other instruments provided for herein and not delivered at the time of execution of this Agreement or that are incomplete at the time of execution of this Agreement shall be delivered or completed within ten (10) days after the date hereof or ten (10) days prior to the Closing, whichever is sooner.

(b) Nothing in the Schedules shall be deemed adequate to disclose an exception to a representation or warranty made in this Agreement unless the Schedule identifies the exception with reasonable particularity and, without limiting the generality of the foregoing, the mere listing of a document as an exception to any representation and warranty shall not be deemed to disclose the contents of such document as an exception to any representation or warranty (but shall be adequate to disclose the existence of the document itself).

9.02. Indemnification. Each party (the "**Indemnifying Party**") shall defend, indemnify, and hold the other party and its officers, trustees, employees, agents and affiliates (collectively, the "**Indemnified Party**") harmless from all loss, cost, damage, expense or other liability, including reasonable costs and attorney fees, incurred in connection with any and all third party claims, suits, investigations or enforcement actions which may be asserted against, imposed upon or incurred by the Indemnified Party arising out of or in connection with any breach of representation, warranty or covenant contained in this Agreement by the Indemnifying Party.

9.03. Equitable Remedies. Subject to Section 8.04(b), each party acknowledges and agrees that its breach of this Agreement, or its failure to perform its obligations pursuant to this Agreement in accordance with its specific terms, would cause the other party to suffer irreparable damage or injury that would not be fully compensable by money damages, or the exact amount of which may be impossible to determine, and, therefore, such other party would not have an adequate remedy available at law. Accordingly, each party agrees that the other party shall be entitled to seek specific performance, injunctive and/or other equitable relief from any court of competent jurisdiction (without the necessity of posting bond) as may be necessary or appropriate to enforce specifically this Agreement and the terms and provisions hereof and to prevent or curtail any breach (or threatened breach) of the provisions of this Agreement. Such equitable remedies shall not be the exclusive remedy of any party for any such breach or failure to perform by another party, but shall be in addition to all other remedies available to such party at law or in equity.

9.04. Other Owners of Assets. System, ECHN and its undersigned Subsidiaries acknowledge that certain Assets may be owned by Subsidiaries of ECHN and not ECHN. Notwithstanding the foregoing, and for purposes of all representations, warranties, covenants, and agreements contained herein, ECHN agrees, and, as evidenced by their acknowledgement to this Agreement, its undersigned Subsidiaries agree and acknowledge, that (i) its obligations with respect to any Assets shall be joint and several with any Subsidiary of ECHN that owns or controls such Assets, (ii) the representations and warranties herein, to the extent applicable, shall be deemed to have been made by, on behalf of and with respect to such Subsidiaries of ECHN in their ownership capacity, and (iii) it has the legal capacity to cause, and it shall cause, any of its Subsidiaries that owns or controls any Assets to meet all of ECHN's obligations under this Agreement with respect to such Assets. ECHN hereby waives any defense to a claim made by System or its Affiliates under this Agreement based on the failure of any Person who owns or controls the Assets to be a party to this Agreement. Notwithstanding the foregoing, the parties acknowledge and agree that ECHN shall not make pursuant to this Agreement, and this Section 9.04 shall not otherwise suggest, any representation, warranty or other commitment as to the Subsidiaries of ECHN listed on Schedule 9.04.

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

(a) In the event of a controversy or claim arising under this Agreement, either party may give the other party notice of such dispute pursuant to Section 9.15 hereof, and promptly thereafter the parties will each select two or more senior executives to negotiate in good faith in an effort to resolve the controversy or claim. The senior executives shall meet at such location as from time to time may be mutually agreed by the parties and such meetings shall be in person to the extent practicable.

(b) If the parties are unable to resolve the controversy or claim as provided in Section 9.05(a) within 30 days of the notice of the controversy or claim, then either party may notify the other party that it wants to pursue non-binding mediation in an attempt to resolve the controversy or claim. The parties shall jointly appoint a mutually acceptable mediator to mediate the dispute or, if the parties are unable to agree on a mutually

acceptable mediator within 15 days after receipt of notice requesting mediation, then the parties shall request assistance from the American Arbitration Association in finding a mutually acceptable mediator. Each party shall bear its own costs incurred in the mediation and shall bear one-half the costs and expenses of the mediator and any similar parties that may assist in the mediation. The parties agree to participate in good faith in the mediation and negotiations related thereto for a period of 30 days, unless a longer period is otherwise agreed.

9.06. Tax and Government Payment Program Effect. None of the parties (nor such parties' counsel or accountants) has made or is making in this Agreement any representation to any other party (or such party's counsel or accountants) concerning any of the Tax or Government Payment Program effects or consequences on the other party of the transactions provided for in this Agreement. Each party represents that it has obtained, or may obtain, independent Tax and Government Payment Program advice with respect thereto and upon which it, if so obtained, has solely relied.

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

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

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

practicable and pursue all necessary regulatory approvals required in connection with this Agreement.

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

9.11. Choice of Law. This Agreement and all matters arising out of or relating to this Agreement shall be governed by and construed in accordance with the laws of the State of Connecticut without regard to any conflicts of laws rules (whether of the State of Connecticut or any other jurisdiction). Any litigation or proceedings among the parties arising out of or relating to this Agreement shall be commenced in a court of the State of Connecticut or the federal district court of Connecticut.

9.12. Benefit and Assignment. Subject to the provisions herein to the contrary, this Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective legal representatives, successors and assigns; *provided* however that no party may assign this Agreement without the prior written consent of the other party.

9.13. Third Party Beneficiary. This Agreement (including provisions regarding employee and employee benefit matters) and the Closing Documents are intended solely for the benefit of the parties to this Agreement (and their respective successors and permitted assigns) and are not intended to confer third-party beneficiary rights upon any other Person.

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

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

If to System: [SYSTEM]

_____

_____

_____
Attn:
Fax:
Email:

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

[INSERT NAME AND ADDRESS]

If to ECHN: Eastern Connecticut Health Network, Inc.
General Counsel
Eastern Connecticut Health Network
71 Haynes Street
Manchester, Connecticut 06040
Attn: Joyce Tichy
Fax:
Email: jtichy@echn.org

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

Ropes & Gray LLP
Prudential Tower
800 Boylston Street
Boston, MA 02199-3600
Attn: Anne Ogilby
Fax: 617-235-0234
Email: anne.ogilby@ropesgray.com

or to such other address or fax number, and to the attention of such other Person, as any party may designate in writing in conformity with this Section 9.15.

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

9.17. Entire Agreement; Amendment. This Agreement supersedes all previous contracts, agreements and understandings and constitutes the entire agreement of whatsoever kind or nature existing between or among the parties respecting the within subject matter and no

party shall be entitled to benefits with respect to the Assets or the Hospital Businesses other than those specified in this Agreement. As between or among the parties, any oral or written representation, warranty, covenant, agreement or statement not expressly incorporated in this Agreement, whether given before or on the date of this Agreement, shall be of no force and effect unless and until made in writing and signed by the parties on or after the date of this Agreement. The representations, warranties and covenants set forth in this Agreement shall survive the Closing and remain in full force and effect as provided in Section 8.05, and shall survive the execution and delivery of, and shall not be merged with or into, the Closing Documents and all other agreements, instruments or other documents described, referenced in or contemplated by this Agreement. Each representation, warranty and covenant in this Agreement has independent legal significance and if any party has breached any representation, warranty or covenant in any respect, whether there exists another representation, warranty or covenant relating to the same subject matter (regardless of the relative level of specificity) that such party has not breached shall not detract from or mitigate the party's breach of the first representation, warranty or covenant. This Agreement may not be amended or supplemented except in a written instrument executed by each of the parties.

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

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

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

9.21. Confidentiality; Public Announcements.

(a) Except as required by Legal Requirements, ECHN and System (and their respective Affiliates) shall keep this Agreement and the Closing Documents and their contents confidential and not disclose the same to any Person (except the parties' attorneys, accountants or other professional advisors who need to know such contents for the purpose of advising such party in connection with the transactions contemplated hereby, and except to the applicable Governmental Authorities in connection with any required notification or application for approval or a license or exemption therefrom) without the prior written consent of the other party.

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

[*Signature Page Follows*]

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

EASTERN CONNECTICUT HEALTH NETWORK, INC.

By: _____

Title: _____

[SYSTEM]

By: _____

Title: _____

[*Acknowledgement Page Follows*]

Each of the undersigned Subsidiaries of ECHN hereby joins this Agreement to acknowledge that ECHN has executed this Agreement on its behalf and that, with respect to the Assets or Hospital Businesses owned or operated by it, it is subject to and bound by the same obligations, representations, and warranties as ECHN as provided under Section 9.04.

ACKNOWLEDGED BY:

THE MANCHESTER MEMORIAL HOSPITAL

By: _____

Title: _____

THE ROCKVILLE GENERAL HOSPITAL, INCORPORATED

By: _____

Title: _____

ECHN ELDERCARE SERVICES, INC.

By: _____

Title: _____

VISITING NURSE AND HEALTH SERVICES OF CONNECTICUT, INC.

By: _____

Title: _____

A CARING HAND, LLC

By: _____

Title: _____

ECHN ENTERPRISES, INC.

By: _____

Title: _____

HAYNES STREET PROPERTY MANAGEMENT, LLC

By: _____

Title: _____

ECHN CORPORATE SERVICES, INC.

By: _____

Title: _____

MEDICAL PRACTICE PARTNERS, LLC

By: _____

Title: _____

CLINICALLY INTEGRATED NETWORK OF EASTERN CONNECTICUT, LLC

By: _____

Title: _____

CONNECTICUT HEALTHCARE INSURANCE COMPANY, INC.

By: _____

Title: _____

EASTERN CONNECTICUT MEDICAL PROFESSIONALS FOUNDATION, INC.

By: _____

Title: _____

Schedule 1.02

Persons with "ECHN's Knowledge"

Peter Karl	President and Chief Executive Officer
Dennis McConville	Senior Vice President and Chief Strategy Officer
Michael Veillette	Senior Vice President and Chief Financial Officer
Joel J. Reich, M.D.	Senior Vice President, Medical Affairs and Chief Medical Officer

ASSET PURCHASE AGREEMENT

by and between

EASTERN CONNECTICUT HEALTH NETWORK, INC.

SELLER

and

[●]

BUYER

Dated as of [●], 2015

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ASSET PURCHASE AGREEMENT

This Asset Purchase Agreement, dated _____, 2014, is by and between Eastern Connecticut Health Network, Inc., a Connecticut non-stock corporation ("**Seller**"), on its behalf and on behalf of its Subsidiaries, and [●] a [●] corporation ("**Buyer**"), with [Buyer's ultimate parent], a [●] corporation and the [indirect] owner of Buyer, joining for the limited purposes described herein.

RECITALS:

WHEREAS, Seller desires to sell substantially all of its assets, real, personal and mixed, tangible and intangible, and operations to Buyer, including the properties, assets, and businesses of The Manchester Memorial Hospital and The Rockville General Hospital, Incorporated (collectively, the "**Hospitals**"), ECHN Eldercare Services, Inc., Visiting Nurse and Health Services of Connecticut, Inc. including its wholly owned subsidiary A Caring Hand, LLC, Clinically Integrated Network of Eastern Connecticut, LLC, Connecticut Healthcare Insurance Company, Inc., ECHN Corporate Services, Inc. including its wholly owned subsidiary Medical Practice Partners, LLC, and ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Eastern Connecticut Medical Professionals Foundation, Inc. (the entities and businesses operated by the foregoing entities, including the Hospitals, are collectively referred to as the "**Hospital Businesses**"), together with Seller's joint venture interests in Northeast Regional Radiation Oncology Network, Inc., Evergreen Endoscopy Center, LLC, WBC Connecticut East, LLC, Aetna Ambulance Service, Inc., Metro Wheelchair Service, Inc., Ambulance Service of Manchester, LLC, Connecticut Occupational Medicine Partners, LLC, and Eastern Connecticut Physician Hospital Organization, Inc. and Seller's Affiliates' joint venture interests in Tolland Imaging Center, LLC, Pathology Laboratory Services, LLC, Haynes Street Medical Associates, LLC, Haynes Street Medical Associates II, LLC, Evergreen Medical Associates, LLC and Evergreen Medical Associates II LLC (the foregoing entities are collectively referred to herein as the "**Joint Ventures**");

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

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

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

AGREEMENT:

1. DEFINITIONS AND REFERENCES

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

(1) **Accounts Receivable** means all accounts receivable of the Hospital Businesses, accrued and unaccrued, including Government Payment Program receivables and accounts that have been written off, but excluding all Cost Report settlement amounts;

(2) **Accumulated Benefit Obligation** means the accumulated benefit obligation of Seller's defined benefit pension plan, determined for purposes of Seller's audited financial statements as of September 30 of the most recently ended fiscal year of Seller, and projected to Closing by Seller's actuaries using GAAP (i) reflecting the assumptions used for purposes of Note 9 of such financial statements and (ii) assuming continuation of the Seller's defined benefit pension plan and no change in its provisions after the date of Seller's most recent audited financial statements (other than the freeze of such plan to new participation and future accruals). Notwithstanding the foregoing, if Closing does not occur on or prior to December 31, 2015, then Seller shall obtain an actuarial valuation of Seller's defined benefit pension plan, and the Accumulated Benefit Obligation shall be derived from such actuarial valuation. The parties will share equally the cost of any such actuarial valuation;

(3) **Affiliate** means any Person that, directly or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with another Person where "control" means the power to direct or cause the direction of the management and policies of a Person, whether through the ownership of securities, election or appointment of directors, by contract or otherwise. For purposes of this Agreement, any reference to Affiliates of Seller shall only mean those persons listed on Schedule 1.01(3) attached hereto.

(4) **Affiliated Group** means any affiliated group within the meaning of section 1504 of the Code or any similar group defined under a similar provision of state, local or foreign law;

(5) **Assets** means all assets, real property, personal and mixed property of every kind, character or description, known or unknown, tangible or intangible, owned or leased by Seller wherever located and whether or not reflected in the Financial Statements or referenced or scheduled herein, (i) including those assets owned by a Subsidiary of Seller and held or used in connection with the operation of the Hospital Businesses, but (ii) excluding the Excluded Assets;

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

(7) **Assumed Liabilities** means (i) the current liabilities included in Net Working Capital, but only to the extent accrued on the Closing Balance Sheets, (ii) all obligations of Seller and its Affiliates arising under the Assumed Contracts with respect to periods (or portions thereof) following the Closing Date, (iii) all participating provider agreements and provider numbers with third party payors, including contracts and provider numbers of Government Payment Programs, to the extent the same are assignable to Buyer, (iv) the Special Employee Liabilities, (v) the Extended Illness Bank Obligations, (vi) Permitted Encumbrances, (vii) the Unfunded Pension Liabilities, (viii)

the Post-Retiree Health Plan Liability and other retirement obligations described on Schedule 2.03, (ix) the Captive Insurer Liability and (x) the other liabilities and obligations agreed to be assumed by Buyer, if any, described on Schedule 2.03;

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

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

(10) **Bond Liabilities** means those certain long-term bond liabilities and tax-exempt leases of Seller to be defeased at Closing;

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

(12) **Buyer Deductible** is defined in Section 9.04;

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

(14) **Buyer's Plan** means a retirement plan qualified under section 401(a) of the Code that is sponsored by Buyer or one of its controlled group or affiliated service group members, as defined in section 414 of the Code;

(15) **Captive Insurer Liability** means all liabilities relating to Seller's captive insurer, the Connecticut Health Insurance Company, Inc. The book value of the Captive Insurer Liability shall be based on the Financial Statements as of September 30 of the most recently ended fiscal year of Seller.

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

(17) **Closing** is defined in Section 8.01(a);

(18) **Closing Balance Sheets** means the unaudited individual and/or combined balance sheets of Seller and its Subsidiaries as of the close of business on the Closing Date, as finally determined in accordance with Section 2.05 following the resolution of all disputes with respect thereto;

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

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

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

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

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

(24) **Controlled Group** means with respect to a party, a group consisting of each trade or business (whether or not incorporated) that, together with such party, would be deemed a "*single employer*" within the meaning of section 4001(a) of ERISA;

(25) **Cost Reports** means all cost and other reports filed pursuant to the requirements of the Government Payment Programs for payment or reimbursement of amounts due from them;

(26) **Current Seller Plan** is defined in Section 3.17(a);

(27) **Disability Obligations** mean liabilities for long-term or short-term disability benefits to employees of the Hospital Businesses. The Disability Obligations include liabilities of the Hospital Businesses for long-term or short-term disability benefits that may have commenced being paid prior to Closing and that remain ongoing after the Closing.

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

(29) **Employee Benefit Plan** means, with respect to any Person, (i) each plan, fund, program, agreement, arrangement or scheme, in each case, that is at any time sponsored or maintained, or required to be sponsored or maintained, by such Person or to which such Person makes or has made, or has or has had an obligation to make, contributions providing for employee benefits or for the remuneration, direct or indirect, of the employees, former employees, directors, officers, managers, consultants, independent contractors, contingent workers or leased employees of such Person or the dependents of any of them (whether written or oral), including each deferred

compensation, bonus, incentive compensation, pension, retirement, stock purchase, stock option and other equity compensation plan, or "*welfare*" plan (within the meaning of section 3(1) of ERISA, determined without regard to whether such plan is subject to ERISA), (ii) each "*pension*" plan (within the meaning of section 3(2) of ERISA, determined without regard to whether such plan is subject to ERISA), including each Multiemployer Plan, (iii) each severance, retention or change in control plan or agreement, each plan or agreement providing health, vacation or paid time off, summer hours, supplemental unemployment benefit, hospitalization insurance, medical, dental, or legal benefit and (iv) each other employee benefit plan, fund, program, agreement or arrangement, including any of the foregoing that provides cash or non-cash benefits or perquisites to current or former employees of such Person;

(30) **Employee Pension Benefit Plan** is defined in section 3(2) of ERISA;

(31) **Employee Welfare Benefit Plan** is defined in section 3(1) of ERISA;

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

(33) **Environmental Claim** means any written notice (or oral notice reduced to writing by Seller) by a Person alleging potential liability (including potential liability for investigatory costs, cleanup costs, Governmental Authority response costs, natural resource damages, property damages, personal injuries, or penalties) of Seller or any Subsidiary of Seller arising out of, based on or resulting from (i) the presence, or release into the environment, of any Materials of Environmental Concern at any location, whether or not owned by Seller, or (ii) circumstances forming the basis of any violation, or alleged violation, of any Environmental Laws;

(34) **Environmental Laws** means any and all Legal Requirements relating to pollution or protection of human health or the environment (including ground water, land surface or subsurface strata), including Legal Requirements relating to emissions, discharges, releases or threatened releases of Materials of Environmental Concern, or otherwise relating to the manufacture, processing, distribution, use, treatment, storage, disposal, transport, recycling, reporting or handling of Materials of Environmental Concern, including the Comprehensive Environmental Response, Compensation and Liability Act of 1980, as amended, 42 U.S.C. §9601, *et seq.*, the Resource Conservation and Recovery Act, as amended, 42 U.S.C. §6901, *et seq.*, the Clean Air Act, 42 U.S.C. §7401, *et seq.*, the Federal Water Pollution Control Act, 33 U.S.C. §1251 *et seq.*, the Occupational Safety and Health Act, 29 U.S.C. §600, *et seq.*, and any similar state or local Legal Requirements;

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

(36) **ERISA Fiduciary** is defined in section 3(21) of ERISA;

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

(38) **Excluded Liabilities** means any and all liabilities of Seller other than the Assumed Liabilities, whether known or unknown, fixed or contingent, recorded or unrecorded, and whether arising before or after Closing, including any line of credit to which Seller is a party, the Bond Liabilities, tax-exempt leases, and any other indebtedness of Seller, any interest accrued on indebtedness of Seller, any settlements due as of Closing to third party payors, and all medical malpractice or general liability claims that relate to any pre-Closing period except to the extent reflected in the Financial Statements;

(39) **Extended Illness Bank Obligations** means the Hired Employees' accrued or allocated paid time off that is in the form of an "*extended illness bank*" (i.e., paid time off that may be used by a Hired Employee during the term of employment, but the value of the unused portion of which is not paid in cash to the Hired Employee upon termination of employment);

(40) **Financial Statements** means the Audited Financial Statements and the Unaudited Financial Statements;

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

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

(43) **Government Payment Programs** means federal and state Medicare, Medicaid and TRICARE programs, and similar or successor programs with or for the benefit of Governmental Authorities;

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

(45) **Hired Employees** means those employees of Seller or its Affiliates who accept Buyer's offer of employment as of the Closing Date, including those employees who are employed pursuant to an Assumed Contract;

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

(47) **Immaterial Contract** means any Contract to which Seller or any of its Subsidiaries is a party that requires either the payment by Seller or its Subsidiaries of $50,000 or less or the provision of goods or the performance of services by Seller or any of its Subsidiaries having an annual value of $50,000 or less, in either case during the period from the date of this Agreement until (i) if the Contract is terminable at any time

by Seller or the respective Subsidiary without cause upon notice of 90 days or less, the date on which the Contract would terminate if Seller or the respective Subsidiary was to give notice of termination on the date of this Agreement, or (ii) if the Contract is not terminable at any time by Seller or the respective Subsidiary without cause upon notice of 90 days or less, the expiration of the term of the Contract, *provided* that an Immaterial Contract does not include any Contract described in Sections 3.14(a) through 3.14(m);

(48) **Immediate Family Member** means any individual described in the definition of "*Immediate Family Member*" found at 42 C.F.R. §411.351;

(49) **Indemnifying Party** means any Person obligated to indemnify another Person under Article 9;

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

(51) **Indemnity Notice** means written notification of a claim for indemnity under Article 9, other than a Third Party Claim, made by an Indemnitee to an Indemnifying Party pursuant to Section 9.05(b);

(52) **Indenture** is defined in Section 6.04;

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

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

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

(56) **Investments** means shares of capital stock of any corporation, equity interests in partnerships or limited liability companies, or other equity or debt instruments in any other Person, and proceeds from the sale thereof;

(57) **Local Board** means the advisory board of trustees of each Hospital composed of community representatives, physicians on the respective Hospital's medical staff, and the Chief Executive Officer of each respective Hospital (for avoidance of doubt, each Hospital shall have its own Local Board). The initial members of the Local Board shall include at least five members of the Seller's Board of Trustees immediately prior to Closing and five other individuals identified by the Seller prior to Closing;

(58) **Leased Real Property** means the real property described on Schedule 2.01(b), together with all buildings, improvements and fixtures thereon, leased by Seller or any Subsidiary of Seller;

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

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

(61) **Material Adverse Change** means a material adverse change, individually or in the aggregate, of the business, assets, liabilities, financial condition or results of operations of Seller and the Hospital Businesses, which taken as a whole (i) has or could reasonably be expected to have a material adverse effect upon the validity or enforceability of this Agreement or (ii) is or could reasonably be expected to be material and adverse to the Hospital Businesses or the Assets, but excluding the effect of (x) matters described in the Schedules, (y) changes in the economy of the United States in general, and (z) changes in Legal Requirements generally applicable to owners and operators of general acute care hospitals in the United States or in Connecticut if such change does not disproportionately affect Seller or the Hospital Businesses; provided, however, that a change resulting from the downward adjustment to the Medicare wage index or the failure of the Seller to meet its debt service coverage ratio, if waived by applicable lender(s), shall not constitute a Material Adverse Change;

(62) **Materials of Environmental Concern** means chemicals, pollutants, contaminants, wastes (including Medical Waste), toxic substances, petroleum and petroleum products listed or regulated under Environmental Laws, including hazardous wastes under the Resource Conservation and Recovery Act, as amended, 42 U.S.C.

§6901, *et seq*., hazardous substances under the Comprehensive Environmental Response, Compensation and Liability Act of 1980, as amended, 42 U.S.C. §9601, *et seq*., asbestos, polychlorinated biphenyls and urea formaldehyde, and low-level nuclear materials, special nuclear materials or nuclear-byproduct materials, all within the meaning of the Atomic Energy Act of 1954, as amended, and any rules, regulations or policies promulgated thereunder;

(63) **Medical Waste** means any substance, pollutant, material or contaminant listed or regulated under any Medical Waste Law that is generated in the diagnosis, treatment or immunization of human beings, in research pertaining thereto, or in the production or testing of biologicals, including (i) pathological waste, (ii) blood, (iii) sharps, (iv) wastes from surgery or autopsy, (v) dialysis waste, including contaminated disposable equipment and supplies, (vi) cultures and stocks of infectious agents and associated biological agents, (vii) isolation wastes, (viii) contaminated equipment, (ix) laboratory waste, and (x) various other biological waste and discarded materials contaminated with or exposed to blood, excretion, or secretions from human beings;

(64) **Medical Waste Law** means the Medical Waste Tracking Act of 1988, 42 U.S.C. §6992, *et seq.*, the U.S. Public Vessel Medical Waste Anti-Dumping Act of 1988, 33 U.S.C. §2501, *et seq.*, the Marine Protection, Research, and Sanctuaries Act of 1972, 33 U.S.C. §1401, *et seq.*, The Occupational Safety and Health Act, 29 U.S.C. §651, *et seq*., the United States Department of Health and Human Services, National Institute for Occupational Self-Safety and Health Infectious Waste Disposal Guidelines, Publication No. 88-119, and any other federal, state, regional, county, municipal or other Legal Requirements insofar as they purport to regulate Medical Waste, or impose requirements relating to Medical Waste;

(65) **Multiemployer Plan** is defined in section 3(37) of ERISA or section 4001(a)(3) of ERISA;

(66) **Multiple Employer Plan** means an Employee Pension Benefit Plan that is not a Multiemployer Plan and for which a Person who is not a member of a Controlled Group that includes Seller or any Subsidiary is or has been a contributing sponsor;

(67) **Net Working Capital** means the amount by which (i) the value of all non-cash current assets of the Hospital Businesses acquired by Buyer, including inventory and supplies, Accounts Receivable, other receivables, prepaid expenses, and deposits (including security deposits made by Seller pursuant to Assumed Contracts), that Seller and Buyer agree will be usable after Closing, exceeds (ii) the value of all current liabilities assumed by Buyer, including trade accounts payable, accrued expenses (including payroll), advance payments on patient accounts and employee benefit accruals (as such terms are used in the Financial Statements) (for the purpose of clarity, employee benefit accruals include paid time off accruals for vacation and sick time but exclude Extended Illness Bank Obligations);

(68) **Notice Period** is defined in Section 9.05(a)(i);

(69) **Owned Real Property** means real property owned (legally or beneficially) by Seller or any Subsidiary of Seller, including the real property described on Schedule 2.01(a), together with all buildings, improvements and fixtures thereon owned by Seller or any Subsidiary of Seller and all appurtenances and rights thereto;

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

(71) **Permit** means each license, permit, right, franchise, concession, certificate, authorization, consent, certificate of need or other approval of a Governmental Authority owned or held by Seller or relating to the ownership or operations of the Hospital Businesses and the Assets, including applications for, and pending, Permits;

(72) **Permitted Encumbrances** means the Permitted Personal Property Encumbrances and the Permitted Real Property Encumbrances;

(73) **Permitted Personal Property Encumbrances** means those Encumbrances described on Schedule 3.11 as being Permitted Personal Property Encumbrances;

(74) **Permitted Real Property Encumbrances** means those Encumbrances identified on Schedule 3.12(a) as being Permitted Real Property Encumbrances;

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

(76) **Post-Retiree Health Plan Liability** means the book value of the liability relating to Seller's post-retiree health benefit plan, determined for purposes of Seller's audited financial statements as of September 30 of the most recently ended fiscal year of Seller, and projected to Closing by Seller's actuaries using GAAP (i) reflecting the assumptions used for purposes of Note 9 of such financial statements and (ii) assuming continuation of the Seller's post-retiree health benefit plan and no change in its provisions after the date of Seller's most recent audited financial statements (other than the freeze of such plan to new participation).

(77) **Prior Seller Plan** is defined in Section 3.17(b);

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

(79) **Prohibited Transaction** is defined in Section 5.06;

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

(81) **Purchase Price Adjustment** is defined in Section 2.05(f);

(82) **Reportable Event** is defined in section 4043 of ERISA;

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

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

(85) **Seller Deductible** is defined in Section 9.02;

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

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

(88) **Strategic Business Plan** means the strategic plan developed prior to Closing by Buyer, in consultation with Seller, and, with respect to clinical service lines, in consultation with Seller-Affiliated physicians, as the same may be amended from time to time, *provided, however*, that the Strategic Business Plan does not include the strategic capital plan referenced in Section 5.11 herein;

(89) **Subsidiary** means, with respect to any Person, (i) any corporation more than 50% of whose stock of any class or classes having by the terms thereof ordinary voting power to elect a majority of the directors of such corporation (irrespective of whether or not at the time stock of any class or classes of such corporation shall have or might have voting power by reason of the happening of any contingency) is at the time owned by such Person and/or one or more Subsidiaries of such Person, (ii) any partnership, limited liability company, association, joint venture or other entity in which such Person and/or one or more Subsidiaries of such Person has more than a 50% equity interest at the time and the management of which is controlled, directly or indirectly, by such Person or through one or more Subsidiaries of such Person and (iii) any entity that is organized as a not-for-profit business organization and (A) whose accounts are required in accordance with GAAP to be consolidated with the accounts of such Person or (B) whose sole member is such Person;

(90) **Target Net Working Capital** means $[●];

(91) **Tax** means any income, unrelated business income, gross receipts, license, payroll, employment, excise, severance, occupation, privilege, premium, net worth, windfall profits, environmental (including taxes under section 59A of the Code), customs duties, capital stock, franchise, profits, withholding, social security, unemployment, disability, real property, personal property, recording, stamp, sales, use, services, service

use, transfer, registration, escheat, unclaimed property, value added, alternative or add-on minimum, estimated or other tax, assessment, charge, levy or fee of any kind whatsoever, including payments or services in lieu of Taxes, interest or penalties on and additions to all of the foregoing, that are due or alleged to be due to any Governmental Authority, whether disputed or not;

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

(93) **Tenant Leases** is defined in Section 3.09(g);

(94) **Third Party Claim** is defined in Section 9.05(a)(i);

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

(96) **Transitional Services Agreement** means the agreement between Buyer and Seller whereby Buyer will lease Hired Employees to Seller at cost for the orderly wind down of the benefits and administration of Seller's other post-Closing obligations (*e.g.*, finalizing Cost Reports), in substantially the form of Exhibit A attached hereto;

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

(98) **Unfunded Pension Liabilities** means the unfunded pension liabilities of Seller's defined benefit pension plan, calculated as the Accumulated Benefit Obligation reduced by the fair market value of the assets of Seller's defined benefit pension plan as of Closing; and

(99) **WARN Act** means the Worker Adjustment and Retraining Notification Act, 29 U.S.C. §2101, *et seq*.

(100) **Workers' Compensation Liability** means all workers' compensation liabilities of Seller and its Affiliates. The book value of the Workers' Compensation Liability shall be based on the Financial Statements as of September 30 of the most recently ended fiscal year of Seller.

1.02. Certain References. As used in this Agreement:

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

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

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

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

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

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

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

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

(i) references to "*Seller's knowledge*" mean the actual knowledge of each of the Persons whose names or titles are set forth on Schedule 1.02, after due inquiry by Seller of such Persons;

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

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

2. SALE OF ASSETS AND RELATED MATTERS

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

(a) the Owned Real Property described on Schedule 2.01(a);

(b) the Leased Real Property described on Schedule 2.01(b);

(c) all equipment (including medical and computer equipment located at the Hospital Businesses), vehicles, furniture and furnishings and other tangible personal properties owned or leased by Seller or used in the conduct of the Hospital Businesses; *provided* that any such leased personal property shall be described on Schedule 2.01(c);

(d) all current assets included in Net Working Capital;

(e) all financial, patient, medical staff, personnel and other records of the Hospital Businesses (including equipment records, medical/administrative libraries, medical records, documents, catalogs, books, records, files and operating manuals);

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

(g) all Permits of Seller, to the extent legally assignable, relating to the ownership of the Assets and the conduct of the Hospital Businesses, including those described on Schedule 2.01(g);

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

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

(j) the Investment interests in the Joint Ventures, including all transferable rights relating thereto;

(k) subject to Section 5.13, all insurance proceeds with respect to the Assets or the Assumed Liabilities (including insurance proceeds received by Seller or payable to Seller and all deductibles, copayments and self-insurance requirements payable by Seller) arising in connection with damage to the Assets occurring on or prior to the Closing Date, to the extent not expended for the repair or restoration of the Assets;

(l) claims of Seller against third parties relating to the Assets or the Assumed Liabilities, choate or inchoate, known or unknown, contingent or otherwise, except for those claims described on Schedule 2.02(p) and any claims relating to Excluded Assets or the Excluded Liabilities;

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

(n) cash and investments in the amount of $7,600,000 (Six Million Three Hundred Thousand Dollars), being the agreed upon amount of assets maintained by Seller and its Affiliates with respect to the Captive Insurer Liability and the Workers' Compensation Liability;

(o) Seller's provider agreements with Government Payment Programs; and

(p) all proceeds of the foregoing and, except for the Excluded Assets, all other property of every kind, character or description, tangible and intangible, known or unknown, owned or leased by Seller, wherever located and whether or not reflected in the Financial Statements or similar to the properties described above.

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

(a) any financial, patient, medical staff, personnel and other records of the Hospital Businesses that Seller cannot transfer to Buyer due to applicable Legal Requirements by which Seller is bound;

(b) all cash, bank accounts, certificates of deposit, treasury bills, treasury notes, marketable securities and other cash equivalents (including the Purchase Price payable to Seller) of Seller or the Hospital Businesses except for those listed in Section 2.01(n);

(c) all short-term and long-term Investments, but excluding the Investment interests in the Joint Ventures;

(d) board-designated, restricted, and trustee-held or escrowed funds (such as funded depreciation, debt service reserves, self-insurance trusts, working capital trust assets, and assets and Investments restricted as to use), beneficial interests in charitable trusts, and accrued earnings on all of the foregoing;

(e) inventory and supplies disposed of or exhausted after the date of this Agreement and on or before the Closing Date in the ordinary course of the Hospital Businesses, and Assets transferred or disposed of in accordance with Section 5.02(e);

(f) Cost Report settlement receivables for periods ended on or prior to the Closing Date and all appeals and appeal rights relating thereto;

(g) all funds held by trustees pursuant to bond indentures of Seller (including the Indenture) related to the Bond Liabilities;

(h) all deductions, benefits, claims, refunds, receivables and other rights of Seller or any Affiliate of Seller relating to Taxes in respect of periods ending on or before the Closing Date (or portions thereof) or resulting from the consummation of the transactions contemplated by this Agreement;

(i) all other current financial assets not included in Net Working Capital and all deferred expenses;

(j) all Contracts that are listed or described on Schedule 2.02(j) and all other Contracts that are not Assumed Contracts (including this Agreement and the Closing Documents);

(k) all Permits to the extent not legally assignable to Buyer or not relating to the ownership of the Assets and the conduct of the Hospital Businesses;

(l) the corporate or trade names set forth on Schedule 2.02(l) and all Intellectual Property rights relating thereto;

(m) all physician loans and receivables other than repayment obligations under Assumed Contracts;

(n) all right, title and interest of ECHN Community Healthcare Foundation in and to its assets and properties (whether owned, leased or otherwise) described on Schedule 2.02(n);

(o) all insurance proceeds received by Seller or payable to Seller (i) with respect to other Excluded Assets or the Excluded Liabilities or (ii) arising in connection with the operation of the Assets for periods prior to Closing to the extent that all material damage to any such Asset has been repaired and to the extent consistent with Section 5.13 herein;

(p) the claims of Seller against third parties described on Schedule 2.02(p), appeals and other risk settlements of the Hospital Businesses which arose during or relate to a pre-Closing period, and all rights, remedies, claims and defenses against third parties thereunder or otherwise relating solely to the Excluded Assets or to the Excluded Liabilities, whether choate or inchoate, known or unknown, contingent or otherwise;

(q) any other assets identified on Schedule 2.02(q) or excluded after the execution of this Agreement by mutual written agreement of the parties; and

(r) all proceeds of the foregoing.

2.03. Assumed Liabilities. As of the Closing Date, Buyer shall assume from Seller and its Affiliates the Assumed Liabilities, including the Assumed Liabilities described on Schedule 2.03, and agrees to pay and satisfy all such Assumed Liabilities.

2.04. Excluded Liabilities. Notwithstanding anything to the contrary set forth in this Agreement, under no circumstance will Buyer assume or be obligated to pay, and from and after the Closing, none of the Assets will be or become liable for or subject to, any of the Excluded Liabilities, which Excluded Liabilities are and will remain liabilities of Seller, including the following:

(a) all liabilities accrued on the Closing Balance Sheets, other than those included in Net Working Capital constituting Assumed Contracts;

(b) liabilities or obligations for Taxes of the Hospital Businesses in respect of periods ending on or before the Closing Date or resulting from the consummation of the transactions contemplated by this Agreement;

(c) liabilities or obligations for federal or state income Taxes of Seller or any Affiliate of Seller, including any amounts accrued or incurred by the Hospital Businesses as a result of being a member of a consolidated, affiliated, combined, unitary or similar group that includes such other Persons;

(d) liabilities or obligations relating to the Excluded Assets;

(e) liabilities or obligations associated with indebtedness for borrowed money (other than capital lease obligations under any Assumed Contract);

(f) (i) obligations required to be performed by Seller on or before the Closing Date under the Assumed Contracts, (ii) liabilities or obligations resulting from a breach or default on or before the Closing Date of any Assumed Contracts and (iii) liabilities arising under any Contracts that are not Assumed Contracts;

(g) liabilities or obligations arising out of or in connection with the Proceedings described on Schedule 3.23, and Proceedings and claims (whether instituted before or after Closing) relating to acts or omissions that occurred on or before the Closing Date, including those relating to peer review activities;

(h) liabilities or obligations under the Hill-Burton Act or other restricted grant or loan programs;

(i) liabilities and obligations to Seller's employees, Seller's Employee Benefit Plans, the Internal Revenue Service, PBGC or any other Governmental Authority arising from or relating to periods on or before the Closing Date (whether or not triggered by the transactions contemplated by this Agreement), including liabilities or obligations arising on or before the Closing Date under any Seller Employee Benefit Plan, United States Equal Employment Opportunity Commission claim, unfair labor practice, and wage and hour practice, and liabilities or obligations arising under the WARN Act, provided that this subsection (i) shall not apply to (i) liabilities or obligations under the Employee Benefit Plans assumed by Buyer under Section 5.03(d), including but not limited to the Unfunded Pension Liabilities and the Post-Retiree Health Plan Liability, (ii) Special Employee Liabilities, (iii) Extended Illness Bank Obligations, (iv) obligations under Assumed Contracts or (v) the Worker's Compensation Liability;

(j) Cost Report settlement payables relating to all Cost Report periods ending on or before the Closing Date;

(k) liabilities or obligations of Seller, including arising out of the operation of the Hospital Businesses or ownership of the Assets, with respect to periods ending on or before the Closing Date, or resulting from the consummation of the transactions contemplated by this Agreement, including pursuant to third-party payor programs and Government Payment Programs, including recoupment rights of the Centers for Medicare & Medicaid Services ("**CMS**") or the Connecticut Department of Social Services and recapture of previously reimbursed charges or expenses; and

(l) penalties, fines, settlements, interest, costs and expenses arising out of or incurred as a result of any actual or alleged violation by Seller of any Legal Requirement prior to the Closing Date.

2.05. Purchase Price; Purchase Price Adjustment.

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

(i) $105,000,000, *plus*

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

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

(iv) the book value (including the current portion) of any indebtedness (including capitalized leases) assumed by Buyer, and *minus*

(v) The Special Employee Liabilities, the Unfunded Pension Liabilities and the Post-Retiree Health Plan Liability, and *minus*

(vi) In the event Seller is unable to assign and transfer to Buyer or Buyer's designee all of Seller's Investment in one or more Joint Ventures because another party to such Joint Venture(s) has exercised a right of first refusal or similar right to purchase such Investment(s) from Seller, an amount equal to the consideration received by Seller from such party(ies), in a bona fide, arms-length sale of such Investment(s) (the parties shall agree in a separate writing as to an appropriate reduction for any of Seller's Investment in a Joint Venture that remains the property of Seller after Closing due to the refusal of another party to such Joint Venture to permit the transfer).

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

(c) As further described in Sections 2.05(d) and 2.05(e) below, the Purchase Price will be calculated by Buyer and Seller at Closing from the physical count of inventory and supplies conducted pursuant to Section 2.05(d), if available, the relevant entries in the Interim Closing Balance Sheets (other than inventory and supplies if the physical inventory is available) and the parties' mutual good faith estimate as of the Closing Date of the amount of the prorations to be made pursuant to Section 2.06. At Closing, Buyer shall pay such Purchase Price by wire transfer of immediately available funds to an account designated by the Seller to Buyer prior to the Closing Date, and Seller shall immediately use whatever portion of the Purchase Price is necessary to defease the Bond Liabilities and to pay off all other indebtedness of Seller (other than capitalized leases assumed by Buyer).

(d) The portion of Net Working Capital constituting the value of inventory and supplies will be determined based on a physical count conducted by Seller on a date not more than five business days before the Closing Date. Seller shall give Buyer at least five business days prior notice of the date of the count and permit Buyer to monitor the count. Seller shall count the usable items of inventory and supplies that are not damaged or obsolete, and that are of a type, quality and quantity that may be used in the ordinary course of the Hospital Businesses (having due regard for the services offered by the Hospital Businesses). Seller will conduct the count in the same manner that Seller conducted the count of, and will count the same classes and categories of items that Seller counted to determine the value of, inventory and supplies in the most recent Audited Financial Statements. Upon completion of the count, Seller shall determine the value of the inventory and supplies (determined by the lower of cost or market on a first in, first out basis). If the results of the count and the resulting value of inventory and supplies are available by Closing, then the portion of Net Working Capital attributable to inventory and supplies will be the value determined pursuant to the count (updated for actual usage and purchases between the date of the count and the Closing Date). If the results of the count or the resulting value of inventory and supplies are not available by Closing, then for purposes of the Closing, the value of the inventory and supplies will be the amount set forth in the Interim Closing Balance Sheets and the value of the inventory and supplies determined pursuant to the count (updated for actual usage and purchases between the date of the count and the Closing Date) will be set forth in the Closing Balance Sheets.

(e) The portion of Net Working Capital constituting the value of prepaid expenses and deposits will be determined based on mutual agreement of Seller and Buyer. No more than five business days before the Closing Date, Buyer and Seller will agree on the value as of Closing of the prepaid expenses and deposits that Buyer reasonably determines will be usable after Closing.

(f) Within 90 days after the Closing Date, Buyer will deliver to Seller the Closing Balance Sheets together with any proposed revisions in the amount of the prorations to be made pursuant to Section 2.06 (based on paid invoices delivered by Buyer to Seller after the Closing). Except as otherwise provided herein, the Closing Balance Sheets shall be prepared using the same principles and methodologies, including the determination of Accounts Receivable and doubtful accounts, as used in preparing the Interim Closing Balance Sheets. The Purchase Price will be recalculated (based on clauses (i) and (ii) below) (the "**Purchase Price Adjustment**") to reflect (i) any such revisions in the amount of the prorations to be made pursuant to Section 2.06, and (ii) the difference between the Net Working Capital (excluding differences in prepaid expenses and deposits calculated in accordance with Section 2.05(e) and, if a physical inventory was used to calculate the Purchase Price, in inventory and supplies) on the Interim Closing Balance Sheets and on the Closing Balance Sheets. Following the resolution of any disputes pursuant to Section 2.05(g), Seller shall pay Buyer (if the Purchase Price is adjusted downward by the Purchase Price Adjustment), or Buyer shall pay the Seller (if the Purchase Price is adjusted upward by the Purchase Price Adjustment), as the case may be, the amount by which the Purchase Price is adjusted, by wire transfer of immediately available funds to one or more accounts designated by the recipient, within five business days after its determination.

(g) Should Seller disagree with the Closing Balance Sheets prepared by Buyer, it shall notify Buyer within 30 days after Buyer's delivery of the Closing Balance Sheets; if no notice shall be delivered by Seller to Buyer within such 30 day period, Seller will be deemed to have agreed with the Closing Balance Sheets prepared by Buyer. If Seller disputes any entry in the Closing Balance Sheets relevant to the calculation of the Purchase Price Adjustment or disputes the value of the inventory and supplies, then Buyer and Seller shall, for 15 days after Seller notifies Buyer of its dispute, attempt to resolve such dispute among themselves and to their mutual satisfaction. If Buyer and Seller are unable to resolve such dispute within such 15 day period, then either Seller or Buyer may submit the dispute to PricewaterhouseCoopers LLP or to such other independent, certified public accounting firm as Seller and Buyer may then agree in writing, in either case acting as experts and not as arbitrators to resolve the computation or verification of the disputed Closing Balance Sheets entries in accordance with this Agreement and otherwise where applicable in accordance with GAAP consistently applied.

(h) Seller and Buyer will each pay their own respective fees and expenses (including any fees and expenses of their accountants and other representatives) in connection with the resolution of disputes pursuant to this Section 2.05. Notwithstanding the foregoing, the fees and expenses of any accounting firm incurred in connection with the resolution of such disputes will be paid by Seller and Buyer in proportion to the difference between the Purchase Price Adjustment determined by the accounting firm and the respective amounts of the Purchase Price Adjustment asserted by each such party at the time of the initial referral of the dispute to the accounting firm.

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

3. REPRESENTATIONS OF SELLER

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

3.01. Organization and Qualification. Seller is a non-stock corporation duly organized and validly existing in good standing under the laws of the State of Connecticut. Seller is not licensed, qualified or admitted to do business in any jurisdiction other than in the State of Connecticut and there is no other jurisdiction in which the ownership, use or leasing of Seller's

assets or properties, or the conduct or nature of its business, makes such licensing, qualification or admission necessary.

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

(a) are within Seller's powers, are not in contravention of its articles of incorporation, bylaws and other governing documents, and have been duly authorized by all appropriate corporate action;

(b) do not conflict with, result in any breach or contravention of, or permit the acceleration of the maturity of any liabilities of Seller (other than Excluded Liabilities to be satisfied as of the Closing Date), and do not create or permit the creation of any Encumbrance on or affecting any of the Assets;

(c) do not violate any Legal Requirement to which Seller, the Assets, or the Hospital Businesses may be subject other than with respect to the Excluded Liabilities to be satisfied as of the Closing Date; and

(d) assuming the receipt of all consents set forth in Schedule 3.02, do not conflict with or result in a breach or violation of any material Contract to which Seller is a party or by which it is bound and will not be terminated as of the Closing Date.

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

3.04. Subsidiaries and Third Party Rights. Seller holds no Investment interest in any Person involved in the ownership or operation of the Hospital Businesses or the Assets, other than those Persons identified on Schedule 3.04. Schedule 3.04 indicates for each Person identified thereon whether it is currently active or inactive and whether it, together with its consolidated Subsidiaries, has total assets of $10,000 or more. Schedule 3.04 also indicates, for each Joint Venture, the percentage of equity interests owned by Seller or its Affiliate in such Joint Venture and the name of, and percentage of equity interests owned by, third parties in such Joint Venture. Other than Seller and those Persons set forth on Schedule 3.04, there are no other Persons that own any interest in any of the Hospital Businesses. There are no Contracts with, or rights of, any Person to acquire, directly or indirectly, any material assets, or any interest therein, of Seller, including any of the Assets, other than Contracts entered into in the ordinary course of the Hospital Businesses or Contracts entered into with Buyer with respect to the transactions contemplated by this Agreement.

3.05. Legal and Regulatory Compliance. Except as otherwise provided in this Agreement and other than as set forth on Schedule 3.05, Seller and all of its officers, directors, agents, or employees comply in all material respects with, and have complied in all material

respects with, all Legal Requirements, and Seller has timely filed all material reports, data and other information required to be filed with Governmental Authorities. Seller has not received notice of any currently pending or threatened Proceeding against it alleging or based upon an alleged violation of any Legal Requirements. Neither Seller nor any Affiliate of Seller is party to or otherwise bound by (i) a corporate integrity agreement with the Office of Inspector General of the United States Department of Health and Human Services or written agreement with such Governmental Authority to establish or maintain a corporate integrity program applicable to any of the Hospital Businesses or (ii) a settlement or other agreement with any other Governmental Authority, other than participation agreements with Medicare and Medicaid, that imposes continuing obligations on any of the Hospital Businesses or contains obligations that have not been fully discharged.

3.06. Financial Statements. Attached as Schedule 3.06 are copies of the Audited Financial Statements and the Unaudited Financial Statements. The Financial Statements fairly present the financial condition and results of operations of Seller and the Hospital Businesses as of the respective dates thereof and for the periods therein referred to, all in accordance with GAAP, subject, in the case of the Unaudited Financial Statements, to normal recurring year-end adjustments (the effect of which will not, individually or in the aggregate, have a Material Adverse Change) and the absence of notes (which, if presented, would not differ materially from those included in the Audited Financial Statements), and the Financial Statements reflect the consistent application of such accounting principles throughout the periods involved.

3.07. Undisclosed Liabilities. Except and to the extent accrued or disclosed in the Financial Statements, Seller does not have any liabilities or obligations of any nature whatsoever with respect to the Hospital Businesses or the Assets, due or to become due, accrued, absolute, contingent or otherwise, that are required by GAAP to be accrued or disclosed in audited financial statements, except for liabilities and obligations incurred in the ordinary course of business and consistent with past practice since the date of the Unaudited Financial Statements, which are not, individually or in the aggregate, expected to result in a Material Adverse Change.

3.08. Recent Activities. Since September 30, 2013 and except as set forth on Schedule 3.08:

(a) no material damage, destruction or loss (whether or not covered by insurance) has occurred affecting the Assets;

(b) except in the ordinary course of the Hospital Businesses or as set forth on Schedule 3.08(b), consistent with past practice and existing personnel policies of Seller, Seller has not (i) increased or agreed to increase the compensation payable to any employees who work in the Hospital Businesses, (ii) agreed to make any bonus or severance payment to any of the employees who work in the Hospital Businesses or (iii) employed any additional management personnel in respect of the Hospital Businesses;

(c) no labor dispute, enactment or promulgation of a state or local Legal Requirement, or other event or condition, has occurred that has materially adversely

affected any of the Hospital Businesses or reasonably could be expected to have such an effect on the Hospital Businesses;

(d) other than as set forth on Schedule 3.08(d), Seller has not sold or factored, or agreed to sell or factor, any Accounts Receivable, and Seller has not sold, distributed or otherwise disposed of any other Assets except in the ordinary course of the Hospital Businesses and, for equipment having an original cost in excess of $25,000, with a comparable replacement thereof;

(e) to Seller's knowledge, no Encumbrance has been imposed on any of the Assets;

(f) Seller has not canceled or waived any material rights in respect of the Assets, except in the ordinary course of the Hospital Businesses;

(g) other than in connection with the freeze of Seller's defined benefit pension plan and post-retiree health plan, there has been no change in any accounting method, policy or practice of Seller with respect to the Hospital Businesses;

(h) other than compensation paid in the ordinary course of employment or ordinary course professional services agreements disclosed to Buyer, Seller has not paid any amount to, sold any Assets to, or entered into any Contract with any officer, director, or trustee of Seller or its Affiliates, or with any Affiliate of any such Person;

(i) Seller has not paid or agreed to pay to any Person any damages, fines, penalties or other amounts in respect of an actual or alleged violation of any Legal Requirement excluding routine workers' compensation claims in amounts no greater than $100,000;

(j) Other than ordinary course plan benefit design changes, Seller has not instituted any new, or terminated or amended any existing, Employee Benefit Plan, except for amendments required to comply with applicable Legal Requirements and the freeze of Seller's defined benefit pension plan and post-retiree health plan;

(k) Seller has not entered into or agreed to enter into any transaction outside the ordinary course of the Hospital Businesses (other than the transactions contemplated by this Agreement); and

(l) no Material Adverse Change has occurred and no event or circumstance has occurred that could reasonably be expected to result, individually or in the aggregate, in a Material Adverse Change.

3.09. Accounts Receivable; Inventory.

(a) The Accounts Receivable, to the extent uncollected, are valid and existing and represent monies due for goods sold and delivered and services performed in bona fide commercial transactions, have been billed or are billable, and are not subject to any Encumbrances. Except as reflected or reserved for in the Financial Statements, no

refunds, discounts or setoffs are payable or assessable with respect to the Accounts Receivable.

(b) All Assets consisting of inventory and supplies are carried at the lower of cost or market on a first-in, first-out basis and are properly stated in the Audited Financial Statements as of the dates thereof. All items of inventory and supplies are of a quality usable or saleable in the ordinary course of business, except for those items that are obsolete, below standard quality or in the process of repair and for which adequate reserves have been provided in the Financial Statements. The quantities of inventory and supplies, taken as a whole, are reasonable and justified under the normal operations of the Hospital Businesses.

3.10. Equipment. Schedule 3.10 includes a depreciation schedule as of a recent date that lists all items of equipment associated with, or constituting any part of, the Assets. To Seller's knowledge, and excluding information technology equipment and systems, all major items of Seller's equipment (e.g., heating systems, magnetic resonance imaging units, ultrasound units, robotic surgery and similar equipment) are usable for their intended purposes in the ordinary course of the Hospital Business and are in working condition, subject to reasonable wear and tear.

3.11. Title. Except as provided in Schedule 3.11 and subject to Section 9.04, Seller owns and holds good and valid title to all of the Assets, free and clear of any Encumbrances other than the Encumbrances described on Schedule 3.11. At Closing, Seller will convey to Buyer good and valid title to all Assets, free and clear of any Encumbrances other than the Permitted Encumbrances.

3.12. Real Property.

(a) Seller owns fee simple title to the Owned Real Property, free and clear of any Encumbrances other than the Encumbrances described on Schedule 3.12(a). The Owned Real Property described on Schedule 2.01(a) comprises all of the real property owned by Seller or any Subsidiary of Seller that is associated with or utilized in the operation of the Hospital Businesses. At Closing, Seller will convey to Buyer good and marketable fee simple title to all Owned Real Property, free and clear of any Encumbrances other than the Permitted Real Property Encumbrances.

(b) Seller has not received notice of condemnation or similar Proceedings relating to the Owned Real Property or any part thereof.

(c) Except as set forth on Schedule 3.12(c), to Seller's knowledge, the buildings standing on the Owned Real Property are structurally sound and in need of no material maintenance or repairs, except for ordinary, routine maintenance. All essential utilities (including water, sewer, gas, electricity and telephone service) are available to the Owned Real Property, and, to Seller's knowledge, no conditions exist that are reasonably likely to result in the termination or reduction of the current access from the Owned Real Property to existing roadways. To Seller's knowledge, no part of the Owned Real Property contains, is located within or abuts any flood plain, navigable water or

other body of water, tideland, wetland, marshland or other area that is subject to special state, federal or municipal regulation, control or protection (other than Legal Requirements pertaining to zoning or other land use restrictions customarily applicable to all real estate within the applicable jurisdiction).

(d) Except for tenants in possession of the Owned Real Property under Contracts described on Schedule 3.18, no Person other than Seller possesses, or claims possession of, adverse or not, any Owned Real Property, whether as lessee, tenant at sufferance, trespasser or otherwise.

(e) No tenant is entitled to any rebate, concession, or free rent, other than as reflected in the Contract with such tenant; no commitments have been made to any Tenant for repairs or improvements other than for normal repairs and maintenance in the future or improvements required by the tenant Contract; and no rents due under any of the Contracts with tenants have been assigned or hypothecated to, or encumbered by, any Person other than in connection with financing. All material obligations of Seller as landlord required to be performed under each of the tenant Contracts have been performed.

(f) All Owned Real Property and, to Seller's knowledge, Leased Real Property currently in use for the operation of the Hospital Businesses is in compliance in all material respects with all applicable Legal Requirements, and all material Permits and requisite certificates of the local board of fire underwriters (or other material body exercising a similar function) have been issued for the Owned Real Property and Leased Real Property.

(g) (i) Seller has provided to Buyer accurate and complete copies of those leases of which Seller or one of its Subsidiaries is landlord (collectively, the "**Space Leases**"), and (ii) attached as Schedule 3.12(g) is a "rent roll" that sets forth the following information, if any, for each of the Space Leases: (A) the names of the current tenants; (B) the rental payments for the then current month under each of the Space Leases; (C) a list of all then delinquent rental payments; (D) a list of all outstanding concessions granted to tenants; (E) a list of all tenant deposits and a description of any application thereof; (F) the dates that each of the Space Leases commenced and will expire; (G) the square footage of any such space leased pursuant to the Space Leases; (H) any renewal options available to tenants under the Space Leases; and (I) a list of all uncured material defaults under the Space Leases known to Seller.

(h) There are no tenants or other Persons occupying any space in the Owned Real Property, other than pursuant to the Space Leases.

(i) Seller has (A) a valid leasehold estate in all of the Leased Real Property, free and clear of any Encumbrances other than the Encumbrances described on Schedule 3.12(i) pursuant to the leases described on Schedule 2.01(b) (the **"Tenant Leases"**), and (B) provided accurate and complete copies of each of the Tenant Leases to Buyer. The Leased Real Property comprises all of the real property leased by Seller or any Subsidiary of Seller that is associated with or utilized in the operation of the Hospital Businesses.

3.13. Environmental Matters and Medical Waste.

(a) Seller has all material Permits required under applicable Environmental Laws for the operation of the Hospital Businesses, and all such Permits are listed on Schedule 2.01(g). Other than as listed on Schedule 3.13(a), no Environmental Claim is pending, or to Seller's knowledge, threatened by any Person against Seller or, to Seller's knowledge, any other Person the liability for which Seller has retained or assumed, either contractually or by operation of law. To Seller's knowledge, no activities, circumstances, conditions, events or incidents, including the release, emission, discharge or disposal of any Materials of Environmental Concern, have occurred that could reasonably be expected to form the basis of any Environmental Claim by any Person against Seller or any other Person the liability for which Seller has retained or assumed, either contractually or by operation of law.

(b) Without in any way limiting the generality of the foregoing, (i) all on-site and off-site locations where Seller stores, disposes or arranges for the disposal of material quantities or volumes of Materials of Environmental Concern for the Hospital Businesses are identified on Schedule 3.13(b), (ii) all Contracts dealing with the removal, storage, disposal and handling of Materials of Environmental Concern of the Hospital Businesses are with vendors who are, to Seller's knowledge, properly licensed, (iii) all underground storage tanks, and the capacity and contents of such tanks, located on Owned Real Property are identified on Schedule 3.13(b) and (iv) to Seller's knowledge, no polychlorinated biphenyls are used or stored at any Owned Real Property.

(c) Seller and the Hospital Businesses have complied in all material respects with all Medical Waste Laws.

3.14. Intellectual Properties and Information Systems. Seller owns or is licensed to use, free and clear of royalty and other payment obligations, claims of infringement or other Encumbrances, each of the Intellectual Properties and the Information Systems. Seller is not, in any material respect, in conflict with or in violation or infringement of, and has not received any notice alleging any conflict with or violation or infringement of, any rights of any other Person with respect to any such Intellectual Properties or Information Systems. To Seller's knowledge, no other Person is in conflict with or in violation or infringement of Seller's rights in such Intellectual Properties or Information Systems. Schedule 3.14 identifies those Intellectual Properties and Information Systems used in the conduct of the Hospital Businesses that are owned by or licensed directly to Seller (other than the Intellectual Properties and Information Systems owned by Seller, for which no copyright registration or application has been made and none of which is, individually or in the aggregate, material to the Hospital Businesses) and those Intellectual Properties and Information Systems that are owned by or licensed to third parties who provide information technology services to Seller pursuant to Contracts described in Section (c).

3.15. Insurance. Schedule 3.15 describes all insurance arrangements, including self-insurance, in place for the benefit of the Assets and the conduct of the Hospital Businesses (other than Current Seller Plans described in Schedule 3.22). Seller has provided to Buyer a true and complete copy of all such policies and endorsements thereto. With respect to third party

insurance, Schedule 3.15 sets forth the name of each insurer, whether such insurer is an Affiliate of Seller, and the number, coverage, limits, term and premium for each policy of insurance purchased or held by Seller covering the ownership and operation of the Assets and the Hospital Businesses. Except as set forth on Schedule 3.15, all of such policies are now, and until Closing will remain, valid, outstanding, in full force and effect, and enforceable with no premium arrearages. Since September 30, 2010, Seller has not been denied, or reduced, or requested a reduction in the scope or amount of, any insurance or indemnity bond coverage. No insurance carrier has canceled or reduced, or given written notice of its intention to cancel or reduce, any insurance coverage and, to Seller's knowledge, there exist no reasonable grounds to cancel or void any such policies or the coverage provided thereby. Except as set forth on Schedule 3.15, since September 30, 2010, Seller has not made any claims against any excess insurance coverage set forth on Schedule 3.15 or any predecessor excess insurance policies applicable during such time period.

3.16. Permits. Schedule 2.01(g) describes all material Permits relating to the ownership of the Assets and the conduct of the Hospital Businesses, all of which are in good standing and not subject to meritorious challenge. Seller has not received any written notice from any Governmental Authority relating to the threatened, pending or possible revocation, termination, suspension or limitation of any of such material Permits. Each Hospital is duly licensed as an acute care hospital by the appropriate Governmental Authorities, and all departments or other business units, including the other Hospital Businesses, that are required to be separately licensed are duly licensed by the appropriate Governmental Authorities. The Hospitals and all departments or business units, including the Hospital Businesses, comply in all material respects with the applicable licensing requirements. Each Hospital has complied in all material respects with the requirements and conditions of all certificates of need (including applications therefor, non-review letters and implemented and unimplemented certificates of need if not lapsed and unexpired).

3.17. Government Payment Programs; Accreditation. Each Hospital has a current and valid provider Contract with the Government Payment Programs and/or their fiscal intermediaries, administrative contractors or paying agents and complies in all material respects with the conditions of participation therein. Each Hospital is entitled to receive and is receiving payment under the Government Payment Programs for services rendered to qualified beneficiaries and, to Seller's knowledge, except as reflected in the Audited Financial Statements, is not subject to any withholds or offsets in respect thereof. Seller has timely filed all Cost Reports due for Cost Report periods through September 30, 2012, and Cost Reports have been audited and notices of program reimbursement have been issued for all Cost Report periods through September 30, 2010. All amounts shown as due from Seller in the Cost Reports were remitted with such reports and all amounts shown in the notices of program reimbursement as due have been paid. Except to the extent liabilities and contractual adjustments of each Hospital under the Government Payment Programs have been properly reflected and adequately reserved in the Financial Statements in the ordinary course of business, neither Hospital has to its knowledge received nor submitted any claim for payment in excess of the amount provided by Legal Requirements or applicable Contract, and Seller has not received notice of any dispute or claim by any Governmental Authority, fiscal intermediary or other Person regarding the Government Payment Programs or each Hospital's participation therein that remains outstanding or unresolved. All Medicare and Medicaid incentive payments for meaningful use of certified

electronic health record technology received by Seller under The American Recovery and Reinvestment Act of 2009 were awarded based on truthful attestations made by Seller or its Affiliates, and no such incentive payments were remitted due to any knowingly fraudulent, negligent or unlawful act or omission of Seller or its Affiliates. Seller has registered with the QNet Exchange ("**QNet**") as required by CMS under its Hospital Quality Initiative Program (the "**HQI Program**"). Seller has submitted all quality data required under the HQI Program to CMS or its agent, and all quality data required under the ORYX Core Measure Performance Measurement System ("**ORYX**") to The Joint Commission, for all calendar quarters concluded prior to the date of this Agreement, except for any quarter for which the respective reporting deadlines have not yet expired. All such submissions of quality data have been made materially in the form and manner required by CMS and The Joint Commission, respectively. Seller has not received notice of any reduction in reimbursement under the Medicare program resulting from its failure to report quality data to CMS or its agent as required under the HQI Program. Seller has provided Buyer with the HQI Program "validation results" for all calendar quarters concluded prior to the date of this Agreement, except for any quarter for which the respective reporting deadlines have not yet expired. Each Hospital is duly accredited, with no contingencies except as disclosed on Schedule 3.17, by the Joint Commission and Seller's certification for participation in the Medicare program is based on such Joint Commission accreditation. A copy of the most recent accreditation letter from the Joint Commission pertaining to each Hospital has been made available to Buyer. Seller has delivered to Buyer copies of all accreditation survey reports, deficiency lists, statements of deficiency, and plans of correction since September 30, 2010. Seller has taken or is taking all reasonable steps to correct all material deficiencies noted therein. Schedule 3.17 includes a list and description of all unexpected occurrences involving death or serious physical or psychological injury since September 30, 2010.

3.18. Agreements and Commitments. Schedule 3.18 identifies the Contracts related to the Hospital Businesses in the categories below:

(a) Contracts that relate to the ownership or use of, title to or interest in Owned Real Property or Leased Real Property;

(b) Contracts with (i) a physician or physician group, (ii) an Immediate Family Member of a physician on the medical staff of the Hospitals or (iii) any Person that provides marketing services for Seller or its Subsidiaries;

(c) Contracts relating to Intellectual Properties and Information Systems;

(d) collective bargaining agreements or other Contracts with labor unions or other employee representatives or groups;

(e) Contracts with directors, trustees, officers, employees, or other agents of Seller or its Subsidiaries;

(f) requirements or exclusive Contracts and Contracts that prohibit or limit competition or the conduct by Seller or any Subsidiary of any lawful business;

(g) Contracts with any health plan, health provider, independent practice association or similar Person providing for capitation or risk-sharing arrangements;

(h) Contracts relating to the administration, operation or funding of any Employee Benefit Plan;

(i) Contracts between Seller and any of the Joint Ventures;

(j) Contracts with Governmental Authorities;

(k) Contracts providing for payments based in any manner on the revenue or profits of Seller or any Subsidiary thereof, the Hospital Businesses or the Assets;

(l) loan agreements, indentures, bonds, mortgages, liens, or other security agreements (excluding those that will be terminated at Closing);

(m) equipment leases and other leases that are capital leases; and

(n) all other Contracts which require payment by Seller of amounts in excess of $50,000 annually after the date of this Agreement, unless Seller may terminate the Contract, without cause, within ninety (90) days and all payments due by Seller under the Contract through such termination equal, in the aggregate, less than $50,000 (including any penalty or termination fee).

3.19. The Assumed Contracts. With respect to the Assumed Contracts listed on Schedule 2.01(f):

(a) the Assumed Contracts constitute lawful, valid and legally binding obligations of Seller and, to Seller's knowledge, each other party thereto and are enforceable against Seller and, to Seller's knowledge, against each other party thereto, in accordance with their terms;

(b) each Assumed Contract (together with all amendments and supplements thereto listed on Schedule 2.01(f)) is in full force and effect and constitutes the entire agreement between the parties thereto;

(c) all material obligations required to be performed under the Assumed Contracts by Seller, and, to Seller's knowledge, each other party thereto, have been performed, and no event has occurred or failed to occur that constitutes, or with the giving of notice, the lapse of time or both would constitute, a material default by Seller under the Assumed Contracts that has or would reasonably be expected to have a material impact on the Hospital Businesses;

(d) except as set forth on Schedule 3.19(d), no Assumed Contract contains a prohibition on competition by Seller or any Affiliate or otherwise restricts the ability of Seller or any Affiliate to engage in any lawful business after Closing; and

(e) except as set forth on Schedule 3.19(e), the assignment of any Assumed Contract to, and assumption of such Assumed Contract by, Buyer will not give a third party the right to terminate such Assumed Contract, or result in the payment of any penalty or premium to, or change in the rights, remedies, benefits or obligations of, any party thereunder.

3.20. Transactions with Affiliates. Except as disclosed in the Financial Statements of the Seller, since September 30, 2012, Seller has not purchased, acquired or leased any property or services from, or sold, transferred or leased any property or services to, or lent or advanced any money to, or borrowed any money from, or acquired any capital stock, obligations or securities of, or made any management consulting or similar fee agreement with, any officer, director or trustee of Seller or of any Affiliate of Seller except upon terms that would have been paid or received by Seller in similar transactions with independent parties negotiated at arm's length.

3.21. Employees and Employee Relations.

(a) Seller has delivered to Buyer (i) a list (as of the most recent practicable date) of names, positions, current annual salaries or wage rates, target or actual bonuses, other compensation arrangements, and paid time off or extended illness bank credits of all full-time and part-time non-physician employees of Seller and its Affiliates (indicating in the list whether each employee is classified as exempt or nonexempt by Seller), and (ii) a separate list (as of the most recent practicable date) of names, positions, current annual salaries or wage rates, target or actual bonuses, other compensation arrangements, and paid time off or extended illness bank credits of all full-time and part-time physician employees of Seller and its Affiliates (indicating in both lists whether each employee is part-time or full-time, whether such employee is employed under written Contract, the immigration status of any such employee who is eligible for employment based solely on a temporary work permit and, if such employee is not actively at work, the reason therefor).

(b) To Seller's knowledge, all employees, former employees and independent contractors of Seller and its Subsidiaries are properly classified as such for all purposes under the Code and ERISA and have been properly classified as exempt or nonexempt under the Fair Labor Standards Act and any applicable state Legal Requirement.

(c) Except as set forth in Schedule 3.21(c), Seller is in compliance in all material respects with all Legal Requirements relating to employment, employment practices, terms and conditions of employment, equal employment opportunity, nondiscrimination, immigration, wages, hours, benefits, payment of employment, social security, and similar taxes, occupational safety and health, and plant closing; Seller is not liable for the payment of any material compensation, damages, taxes, fines, penalties, interest, or other amounts, however designated, for failure to comply with any of the foregoing Legal Requirements; there are no pending or, to the knowledge of Seller, threatened claims before the Equal Employment Opportunity Commission (or any comparable state civil or human rights commission or other Governmental Authority), complaints before the Occupational Safety and Health Administration (or any comparable

state safety or health administration or other Governmental Authority), wage and hour claims, unemployment compensation claims, workers' compensation claims, or the like.

(d) Schedule 3.21(d) states the number of employees terminated by Seller and its Affiliates within 90 days prior to the Closing Date, laid off by Seller within the six months prior to the Closing Date, or whose hours of work have been reduced by more than 50% by Seller in the six months prior to the Closing Date, and contains a complete and accurate list of the following information for such employees: (i) the date of termination, layoff, or reduction in work hours and (ii) the location to which the employee was assigned. In relation to the foregoing, except as set forth in Schedule 3.21(d), Seller has not violated the WARN Act or any similar state or local Legal Requirements.

(e) To the knowledge of Seller, no officer, director, agent, employee, consultant, or independent contractor of Seller is bound by any contract that purports to limit the ability of such officer, director, agent, employee, consultant, or independent contractor (i) to engage in or continue or perform any conduct, activity, duties, or practice relating to the business of Seller in respect of the Hospital Businesses or the Assets; or (ii) to assign to Seller any rights to any invention, improvement, or discovery. Except as set forth on Schedule 3.21(e), to the knowledge of Seller, no former or current employee of Seller is a party to, or is otherwise bound by, any contract that in any way adversely affected, affects, or will affect the ability of Buyer following Closing to conduct the Hospital Businesses as Seller did prior to Closing.

(f) Except as set forth on Schedule 3.21(f), (i) no employee strike, work stoppage or slowdown, labor dispute, grievance or unfair labor practice at the Hospital Businesses is pending or, to Seller's knowledge, threatened, (ii) no employees of Seller are represented by, or have made demand for recognition of, a labor union or employee organization, and, to Seller's knowledge, no other union organizing or collective bargaining activities by or with respect to any employees of Seller are taking place and (iii) no complaint, charge or claim is pending, or, to Seller's knowledge, threatened to be brought or filed, with any Governmental Authority or arbitrator relating to the employment or termination of employment of any individual by Seller or the Hospital Businesses.

(g) All necessary visa or work authorization petitions have been timely and properly filed on behalf of any employees of Seller requiring a visa stamp, I-94 status document, employment authorization document or other immigration document to legally work in the United States, and all paperwork retention requirements with respect to such applications and petitions have been met. To the knowledge of Seller, no employee of Seller who is a foreign national has ever worked for Seller without employment authorization from the Department of Homeland Security or any other Government Authority that must authorize such employment, and Seller has complied in all material respects with all applicable immigration laws and other Legal Requirements with respect to the employment of foreign nationals. To the knowledge of Seller, Seller has timely and properly completed I-9 forms for all employees hired since the effective date of the Immigration Reform and Control Act of 1986 and has lawfully retained and re-verified

all such I-9 forms. There are no Proceedings pending or, to Seller's knowledge, threatened against Seller relating to Seller's compliance with Legal Requirements relating to immigration, except as set forth on Schedule 3.21(g). Seller has not received any letters or other correspondence from the Social Security Administration regarding the failure of an employee's social security number to match his or her name in the Social Security Administration database, and Seller has not received any letters or other correspondence from the Department of Homeland Security or other Governmental Authorities regarding the employment authorization of any employees of Seller. Seller does not participate in the Department of Homeland Security's e-Verify electronic employment verification system.

3.22. Employee Benefit Plans.

(a) Schedule 3.22 lists each Employee Benefit Plan that Seller or any member of the Controlled Group that includes Seller maintains or to which it contributes (including employee elective deferrals) (each, a "**Current Seller Plan**").

(b) Each Current Seller Plan (and related trust, insurance contract or fund) complies in form and in operation in all material respects with applicable Legal Requirements, and has been administered and operated in all material respects in accordance with the terms of the Current Seller Plan and applicable Legal Requirements. All required reports and descriptions (including form 5500 annual reports, summary annual reports and summary plan descriptions) have been filed or distributed appropriately with respect to each Current Seller Plan. Seller has delivered to Buyer copies of the plan documents and summary plan descriptions, most recent determination letters received from the Internal Revenue Service, most recent form 5500 annual report, and all related trust, insurance and funding Contracts that implement each Current Seller Plan. No Governmental Authority has audited any Current Seller Plan or any other Employee Benefit Plan that Seller or any member of the Controlled Group that includes Seller has maintained, or to which it has contributed or been required to contribute (each, a "**Prior Seller Plan**"), during the five (5) years preceding the date of this Agreement, and Seller has not received any notice that such an audit will or may be conducted.

(c) Each Current Seller Plan that is an Employee Pension Benefit Plan intended to be qualified under section 401(a) of the Code has a current favorable determination letter or opinion or approval letter from the Internal Revenue Service that the plan is so qualified and its trust is exempt from federal income taxation under section 501(a) of the Code, or the remedial amendment period for such Employee Pension Benefit Plan to be submitted to the Internal Revenue Service for such a determination letter or opinion or approval letter has not yet expired. All contributions (including employer contributions and employee salary reduction contributions) to each such Employee Pension Benefit Plan that are due to be paid have been paid, and all Seller contributions to any Employee Pension Benefit Plan that is a defined contribution plan in respect of periods ending on the Closing Date will be accrued on the Closing Balance Sheets. To Seller's knowledge, nothing has occurred that could reasonably be expected to cause the revocation of such determination letter from the Internal Revenue Service or the unavailability of reliance on such opinion or approval letter from the Internal

Revenue Service, as applicable. To Seller's knowledge, nothing has occurred with respect to any Current Seller Plan that has subjected or could reasonably be expected to subject Seller, or, with respect to any period on or after the Closing Date, Buyer or any of its Affiliates, to a penalty under Section 502 of ERISA or to an excise tax under the Code. To Seller's knowledge, with respect to any Current Seller Plan, no event has occurred or is reasonably expected to occur that has resulted in or would subject the Seller or, with respect to any period on or after the Closing Date, Buyer or any of its Affiliates, to a tax under Section 4971 of the Code or the assets of any of the foregoing persons to a lien under Section 430(k) of the Code.

(d) The requirements of part 6 of subtitle B of Title I of ERISA and of section 4980B of the Code have been met in all material respects with respect to each Current Seller Plan that is an Employee Welfare Benefit Plan, and all premiums or other payments that are due have been paid with respect to each such Employee Welfare Benefit Plan.

(e) There have been no "*prohibited transactions*," as defined in section 406 of ERISA and section 4975 of the Code, with respect to any Current Seller Plan that would subject Seller or any member of the Controlled Group that includes Seller to any material liability. No ERISA Fiduciary has any material liability for breach of fiduciary duty or any other failure to act or comply in connection with the administration or investment of the assets of any Current Seller Plan. No Proceeding with respect to the administration or the investment of the assets of any Current Seller Plan (other than routine claims for benefits) is pending or, to Seller's knowledge, threatened and, to Seller's knowledge, there exists no basis for any such Proceeding. To Seller's knowledge, no "*party in interest*" (as defined in section 3(14) of ERISA) and no "*disqualified person*" (as defined in the Code) has any interest in any assets of any Current Seller Plan that is an Employee Benefit Pension Plan other than as a beneficiary by virtue of such Person's participation in the plan.

(f) Except as provided on Schedule 3.22(f), no Current Seller Plan that is an Employee Pension Benefit Plan has been completely or partially terminated or the subject of a Reportable Event, and no Proceeding by the PBGC to terminate any such Employee Pension Benefit Plan has been instituted or, to Seller's knowledge, threatened. Seller has not incurred, and, to Seller's knowledge, Seller will not incur, any material liability to the PBGC (other than PBGC premium payments) or otherwise under Title IV of ERISA (including any withdrawal liability) or under the Code with respect to any Current Seller Plan or Prior Seller Plan that is or was an Employee Pension Benefit Plan.

(g) Neither Seller nor any member of a Controlled Group that includes Seller contributes to, has contributed to, or has been required to contribute to any Multiple Employer Plan or any Multiemployer Plan or has any liability (including withdrawal liability) under any Multiple Employer Plan or any Multiemployer Plan. Except as provided on Schedule 3.22(g), neither Seller nor any member of a Controlled Group that includes Seller maintains or contributes, has maintained or contributed, or has been required to maintain or contribute to any Employee Welfare Benefit Plan providing medical, health or life insurance or other welfare-type benefits for current or future

retired or terminated employees, their spouses or their dependents (other than in accordance with section 4980B of the Code).

3.23. Proceedings and Legal Claims. Schedule 3.23 contains a list and summary description of each Proceeding and legal claim (including *qui tam* Proceedings and legal claims) pending or, to Seller's knowledge, threatened against or otherwise affecting the Assets, the Hospital Businesses, Seller or any Affiliate of Seller (together with the reserve amount, if any, included in the Financial Statements for each uninsured Proceeding or legal claim). All such Proceedings and legal claims are or will be fully insured (except for applicable deductibles or self-insurance retentions) and no carrier has issued a "*reservation of rights*" letter or otherwise denied its obligation to insure and defend Seller against covered Losses arising therefrom. None of the Proceedings or legal claims described on Schedule 3.23, if determined adverse to Seller, could reasonably be expected to result, individually or in the aggregate, in a Material Adverse Change.

3.24. Taxes.

(a) Seller has filed all Tax Returns required to be filed by or on behalf of Seller on or prior to the date of this Agreement (taking into account applicable extensions), all such Tax Returns are accurate in all material respects and Seller has duly paid or made provision in the Financial Statements for the payment of all Taxes shown as due and payable on such Tax Returns.

(b) Seller has withheld proper amounts from its employees' compensation in compliance with all applicable withholding and similar provisions of the Code and any and all other applicable Legal Requirements, and has withheld and paid, or caused to be withheld and paid, all Taxes on monies paid by it to independent contractors, creditors and other Persons for which withholding or payment is required by Legal Requirements.

(c) No deficiencies for any Taxes relating to the Assets or the Hospital Businesses have been asserted or, to the knowledge of Seller, threatened, and no audit on any Tax Returns is currently under way or, to the knowledge of Seller, threatened. There are no outstanding agreements by Seller for the extension of time for the assessment of any Taxes (other than ordinary course extensions of time within which to file Tax Returns).

(d) To Seller's knowledge, no Governmental Authority intends to assess any additional Taxes on Seller for any period for which Tax Returns have been filed. No Governmental Authority has disputed in writing any Tax liability of Seller. No claim has ever been made in writing by a Governmental Authority in a jurisdiction where Seller does not file Tax Returns that Seller is or may be subject to Tax in that jurisdiction, and no Encumbrances exist against Seller or the Assets in connection with any failure (or alleged failure) of Seller to pay any Tax that is due and payable.

(e) No waiver of a statute of limitations in respect of Taxes or agreement to extend the time with respect to a Tax assessment or deficiency is currently in effect, in

each case with respect to Seller (other than ordinary course extensions of time within which to file Tax Returns).

(f) Seller is not a party to any Tax allocation or sharing Contract. Seller is not and has not been a member of an Affiliated Group filing a consolidated federal income Tax Return.

(g) Each of Seller and its Subsidiaries that is a corporation exempt from federal and state income Tax has received a favorable letter of determination from the Internal Revenue Service and the State of Connecticut regarding such Tax status and, to Seller's knowledge, nothing has occurred, whether by action or failure to act, that could reasonably be expected to cause the loss of such exemption (except with respect to the transactions contemplated by this Agreement).

(h) To Seller's knowledge, Seller has no liability for the Taxes of any other Person (other than a Subsidiary under Internal Revenue Service regulation 1.1502-6), as a transferee or successor, by Contract or otherwise.

3.25. Medical Staff; Physician Relations.

(a) Seller has delivered to Buyer a copy of the bylaws, policies, rules and regulations of the medical staff and medical executive committees of each Hospital. As set forth on Schedule 3.25(a), Seller has also delivered to Buyer a list, current as of the date of this Agreement, that sets forth (i) the name and age of each member of the medical staff of each Hospital (active, associate, consulting, courtesy or other), (ii) the degree (M.D., D.O., etc.), title, specialty and board certification, if any, of each such medical staff member, (iii) the names of the medical staff members (current and former) of each Hospital in respect of whom Seller has made a report to the National Practitioners Data Bank during the last three years, and (iv) the number of current medical staff members of each Hospital in respect of whom any committee of the medical staff of such Hospital has recommended adverse action with respect to any member of the medical staff of such Hospital that is not yet final.

(b) Except as set forth on Schedule 3.25(b), no material disputes between Seller and any medical staff member of either Hospital are pending or, to Seller's knowledge, threatened and all appeal periods in respect of any medical staff member against whom an adverse action has been taken by Seller have expired. To the knowledge of Seller, no current member of the medical staff of either Hospital has been excluded from participation in any Government Payment Program.

3.26. Restricted Assets. Except as set forth on Schedule 3.26, none of the Assets is subject to any restriction or limitation concerning the purchase, improvement or use of such Assets or the conduct of the Hospital Businesses, including restricted or conditioned grants or donations and monies received under the Hill-Burton Act.

3.27. Brokers and Finders. Neither Seller nor any Affiliate, officer, trustee, director, employee or agent acting on behalf thereof has engaged any finder or broker in connection with the transactions contemplated hereunder.

3.28. Payments. None of the Hospital Businesses has, to Seller's knowledge, made any request for payment from a Government Payment Program in respect of health care services furnished by or directed or prescribed by any physician or other Person who at such time was excluded from participation in such Government Payment Program. Seller has not, directly or indirectly, paid or delivered, or agreed to pay or deliver, any money or item of property, however characterized, to any Person in violation of any Legal Requirement. Neither Seller nor, to Seller's knowledge, any officer, director or trustee of Seller has received, or will receive as a result of the consummation of the transaction contemplated by this Agreement, any rebate, kickback or other improper or illegal payment from any Person with whom Seller conducts or has conducted any of the Hospital Businesses.

3.29. Solvency. As of immediately after Closing, Seller will not, as a result of the transactions contemplated by this Agreement, be rendered insolvent or otherwise unable to pay its debts as they become due. Seller has no intention of filing a petition in bankruptcy or insolvency or for reorganization or for the appointment of a receiver or trustee of all or any portion of Seller's property and, to Seller's knowledge, no other Person has filed or threatened to file such a petition against Seller.

3.30. Hospital Businesses and Joint Ventures.

(a) Each of Seller's Subsidiaries is a corporation duly organized under the laws of the State of Connecticut with full corporate power to carry on its business as it is now being conducted with the exception of Connecticut Health Insurance Company, which is organized with full corporate power to carry on its business as it is now being conducted under the laws of the Cayman Islands. Each of Seller's Subsidiaries is duly licensed, qualified or admitted to do business and is in good standing in the State of Connecticut, which is the only jurisdiction in which the ownership, use or leasing of their respective assets or properties, or the conduct or nature of their respective businesses, makes such licensing, qualification or admission necessary. All of the issued and outstanding shares of capital stock of Seller's Subsidiaries that are stock corporations are owned as specified on Schedule 3.30(a). All of the issued and outstanding shares of capital stock of Seller's Subsidiaries that are stock corporations have been duly and validly authorized, were validly issued and are fully paid and non-assessable. There are no outstanding rights (including preemptive rights), options, warrants or agreements for the transfer by Seller of any shares of capital stock of Seller's Subsidiaries that are stock corporations and no authorization for any such rights, options, warrants or agreements has been given. Seller has delivered to Buyer a copy of the articles of incorporation and bylaws and other agreements, instruments and documents relating to the creation, ownership and governance of Seller's Subsidiaries and has provided to Buyer a copy of, or access to, the minute books of Seller's Subsidiaries.

(b) To Seller's knowledge, for each Joint Venture that is a for-profit or nonprofit corporation, it (i) is a corporation duly organized under the laws of the state of its incorporation, (ii) has full corporate power to carry on its business as it is now being conducted, and (iii) is duly licensed, qualified or admitted to do business and is in good standing in the state of its incorporation, which is the only jurisdiction in which the ownership, use or leasing of their respective assets or properties, or the conduct or nature

of their respective businesses, makes such licensing, qualification or admission necessary. To Seller's knowledge, all of the issued and outstanding shares of capital stock of the corporate Joint Ventures that are stock corporations are owned as specified on Schedule 3.30(b). To Seller's knowledge, all of the issued and outstanding shares of capital stock of the corporate Joint Ventures that are stock corporations have been duly and validly authorized, were validly issued and are fully paid and non-assessable. To Seller's knowledge, there are no outstanding rights (including preemptive rights), options, warrants or agreements for the transfer by Seller of any shares of capital stock of the corporate Joint Ventures and no authorization for any such rights, options, warrants or agreements has been given. Seller has delivered to Buyer a copy of the articles of incorporation and bylaws and other agreements, instruments and documents relating to the creation, ownership and governance of the corporate Joint Ventures in Seller's possession.

(c) To Seller's knowledge, for each Joint Venture that is a limited liability company, it (i) is organized under the laws of the state of its incorporation, (ii) has full limited liability company power to carry on its respective business as it is now being conducted, and (iii) is duly licensed, qualified or admitted to do business and is in good standing in the state of its incorporation, which is the only jurisdiction in which the ownership, use or leasing of its respective assets or properties, or the conduct or nature of its respective businesses, makes such licensing, qualification or admission necessary. To Seller's knowledge, all of the issued and outstanding membership interests of the limited liability company Joint Ventures are owned as specified on Schedule 3.30(c), have been duly and validly authorized, were validly issued and are fully paid and non-assessable. To Seller's knowledge, except as set forth in the operating agreements of the limited liability company Joint Ventures, the transfers to Buyer of the membership interests in the limited liability company Joint Ventures are not subject to any preemptive rights or third party approvals. Seller has delivered to Buyer a copy of the articles of organization and operating agreements and other agreements, instruments and documents relating to the creation, ownership and governance of the limited liability company Joint Ventures in Seller's possession.

3.31. Operation of the Hospital Businesses. The Assets, together with the Excluded Assets, constitute all assets, properties, goodwill and businesses necessary to operate the Hospital Businesses in the manner in which they have been operated since September 30, 2013, except for property, plant and equipment sold or disposed of since such date in the ordinary course of business. Schedule 3.31 sets forth a list of the ten largest non-governmental payors of the Hospital Businesses, determined on the basis of net patient revenues from services provided during the year ended September 30, 2013. Since September 30, 2012, no payor listed on Schedule 3.31 has terminated its contract with or materially reduced reimbursement rates to, or has notified Seller in writing of its determination to terminate its contract with or to materially reduce reimbursement rates to, the Hospital Businesses.

4. REPRESENTATIONS OF BUYER

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

4.01. Organization. Buyer is a [] duly organized and validly existing and in good standing under the laws of [ ]. Buyer is, or by Closing will be, qualified to do business in the State of Connecticut. Buyer has full power and authority to own, lease and operate its properties and to conduct its business as presently conducted and as proposed to be conducted immediately following the Closing. Buyer has neither conducted any business prior to the date of this Agreement nor will conduct any business, other than in contemplation of the consummation of the transactions contemplated by this Agreement, prior to the Closing. Buyer has made available to Seller a true and complete copy of its organizational documents.

4.02. Power and Authority; Due Authorization. Buyer has full power and authority to (a) execute and deliver this Agreement and the Closing Documents to which it is or becomes a party, (b) perform its obligations under this Agreement and such Closing Documents and (c) consummate the transactions contemplated by this Agreement. The execution and delivery by Buyer of this Agreement and the Closing Documents to which it is or becomes a party, the performance by Buyer of its obligations under this Agreement and such Closing Documents, and the consummation by Buyer of the transactions contemplated by this Agreement have been duly authorized on behalf of Buyer by all necessary [] action.

4.03. Consents; Absence of Conflicts, Etc. The execution, delivery and performance by Buyer of this Agreement and the Closing Documents to which it is or becomes a party at the Closing, and the consummation of the transactions contemplated by this Agreement:

(a) are within its [] powers, are not in contravention of its certificate of formation and operating agreement and have been approved by all required limited liability company and member action;

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

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

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

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

4.06. Availability of Funds. Buyer has the ability to obtain funds in cash in amounts equal to the Purchase Price and necessary to perform its obligations hereunder that are to be performed as of Closing by means of credit facilities or otherwise and will at Closing have immediately available funds in cash which will be sufficient to pay the Purchase Price and to perform its obligations hereunder that are required to be performed as of Closing under this Agreement.

4.07. Solvency. Buyer has no intention of filing a petition in bankruptcy or insolvency or for reorganization or for the appointment of a receiver or trustee of all or any portion of Buyer's property and, to the knowledge of Buyer, no other Person has filed or threatened to file such a petition against Buyer.

4.08. Brokers and Finders. Neither Buyer nor any Affiliate of Buyer, nor any officer, director, employee or agent thereof, has engaged or is liable for the payment of any fee to any finder or broker in connection with the transactions contemplated hereunder.

4.09. Full Disclosure. The representations of Buyer in this Agreement do not contain any untrue statement of a material fact or omit to state any material fact necessary to make the statements made therein, in the light of the circumstances under which they were made, not misleading.

5. COVENANTS OF THE PARTIES

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

(a) conduct the Hospital Businesses in substantially the same manner as it has heretofore and not make any material change in personnel, operations, finances, accounting policies, or real or personal property of the Hospital Businesses except as set forth on Schedule 5.01;

(b) except as set forth on Schedule 5.01(b), maintain the Assets in working condition in the ordinary course of business, ordinary wear and tear excepted, and make all normal, planned and budgeted capital expenditures related to the Assets and/or the Hospital Businesses, *provided* that Seller may (i) make, in its discretion, necessary expenditures in the ordinary course from its designated capital needs fund and provide advance notice to Buyer of any individual expenditure greater than $1,000,000 and (ii) consult with and solicit Buyer's input on individual capital expenditures (or a series of related capital expenditures) not paid from its designated capital needs fund that exceed $1,000,000;

(c) comply in all material respects with all Legal Requirements and perform, when due, in all material respects all obligations under Contracts;

(d) deliver to Buyer title to the Assets free and clear of all Encumbrances (except for the Permitted Encumbrances) and to obtain appropriate releases, consents, estoppels, certificates, opinions and other instruments as Buyer may reasonably request;

(e) keep in full force and effect present insurance policies or other comparable insurance benefiting the Assets and the conduct of the Hospital Businesses and maintain sufficient liquid reserves reasonably estimated to be sufficient to meet all deductible, self-insurance and copayment requirements of such policies; and

(f) maintain and preserve its business organizations and operations intact, retain the present employees at the Hospital Businesses (subject to the right of Seller to discharge any employee in the ordinary course of the Hospital Businesses), and maintain in the ordinary course its relationships with physicians, suppliers, patients and other Persons doing business with Seller at the Hospital Businesses.

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

(a) excluding capital expenditures, amend or terminate any Assumed Contract, or enter into any Contract, except in the ordinary course of the Hospital Businesses consistent with past practices, *provided* that Seller shall obtain Buyer's consent on any new Contract (or a series of related Contracts) that has required payments by Seller that exceed $1,000,000 annually, unless such Contract may be terminated without cause upon no more than 90 days written notice and such termination will not result in any penalty or fee (and excluding any waivers or amendments relating to Bond Liabilities that will be defeased or repaid at Closing);

(b) enter into any tertiary or quaternary affiliation with a third-party healthcare provider other than an agreement for hospitalist services;

(c) other than as set forth on Schedule 5.02(c), increase compensation payable or to become payable to, make a bonus or severance payment to, or otherwise enter into one or more bonus or severance Contracts with any employee, contractor or agent of any of the Hospital Businesses except in the ordinary course of the Hospital Businesses consistent with past practices in accordance with existing personnel policies or pursuant to Contract requirements in force on the date of this Agreement;

(d) create, assume or voluntarily consent to any new Encumbrance upon any of the Assets;

(e) sell or otherwise transfer or dispose of any item of property, plant, equipment or other Asset except in the ordinary course of the Hospital Businesses consistent with past practices with comparable replacement thereof;

(f) distribute any assets, other than Excluded Assets, to any Affiliate of Seller other than its Subsidiaries that are transferring Assets pursuant to this Agreement;

(g) make necessary expenditures in the ordinary course from its designated capital needs fund of more than $1,000,000 per expenditure without providing advanced notice to Buyer of such expenditure and will not make individual capital expenditures (or a series of related capital expenditures) that are outside the ordinary course in excess of

$1,000,000 individually or $5,000,000 in the aggregate if such capital expenditures are not included in Seller's annual operating or capital budgets that have been provided to Buyer;

(h) add, modify, or discontinue the provision of any material clinical service by the Hospital Businesses other than entering into an agreement with a third party for the provision of hospitalist services, open a new location for the provision of any material clinical service, or close the location at which any such material clinical service is currently provided without consent of Buyer, which will not be unreasonably withheld or delayed;

(i) create, incur, assume, guarantee or otherwise become liable for any liability or obligation except in the ordinary course of the Hospital Businesses consistent with past practices in excess of $1,000,000, other than Seller's customary annual line of credit renewal with TD Bank in the currently issued amount, or agree to do any of the foregoing;

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

(k) amend, change or modify the title or duties of the chief executive officer of Seller;

(l) except with respect to the previously planned freeze of Seller's defined benefit pension plan and post-retiree health plan, terminate, amend or otherwise modify in any material respect any Employee Benefit Plan, except for normal course annual changes and amendments required to comply with this Agreement or applicable Legal Requirements; or

(m) amend or agree to amend the articles of incorporation or the bylaws or articles of formation or operating agreement (or comparable organizational documents) of Seller or any Subsidiary thereof or otherwise take any action relating to any liquidation or dissolution of Seller or any Subsidiary thereof, except as expressly contemplated by this Agreement, provided that Seller may merge any one or more of the Subsidiaries into each other or into the Seller in connection with the proposed transaction.

5.03. Employee Matters.

(a) Subject to the exclusions set forth in this Section and in reliance upon the representations of Seller in Sections 3.16 and 3.17, Buyer will offer, or cause its Affiliates to offer, to employ as of the Closing Date substantially all employees of Seller and its Affiliates who work at the Hospital Businesses, including but not limited to employees on approved leaves of absence as of the Closing Date for any reason including without limitation by reason of a military leave, family or medical leave, illness, injury, disability or similar situation (provided employment shall not commence until such employees return from such approved leave), on the same terms and conditions with

respect to job duties, titles and responsibilities that are applicable to such employees on the date of such offer. Buyer will offer the Hired Employees salaries equal to their salaries as of the Closing Date and Employee Benefit Plans that are consistent with Employee Benefit Plans offered to similarly-situated employees at other hospitals operated by Buyer in similar markets. Notwithstanding the foregoing, Buyer will, and will cause its Affiliates to, in all events provide each Hired Employee terms and conditions of employment, including compensation and employee benefits, sufficient to avoid Seller or its Affiliates from incurring any liability under the WARN Act or any comparable Legal Requirement due to actions or omissions of Buyer and its Affiliates related to the Hired Employees at any time on or after the Closing Date.

(b) Seller acknowledges that all employment offers are for "at will" employment only and are subject to the satisfactory completion of Buyer's usual and customary hiring practices, including employee background checks and pre-employment screenings. Nothing in this Section or elsewhere in this Agreement may be deemed to limit or otherwise affect in any manner the right of Buyer or any Affiliate of Buyer to terminate at will the employment of any Hired Employee or, subject to Buyer's covenants in Section 5.03(a) and (c), to change individual features or plans in the employment compensation and benefits package of the Hired Employees, provided that Buyer will assume and honor all written severance agreements between Seller and Seller's employees existing as of Closing that are provided to Buyer prior to the date hereof, as set forth on Schedule 5.03(b).

(c) Following the Closing Date, each Employee Benefit Plan sponsored by Buyer or any Affiliate of Buyer in which the Hired Employees are eligible to participate shall credit the Hired Employees with their periods of employment with Seller or any Affiliate of Seller for all purposes (other than benefit accrual under any defined benefit pension plan), including, but not limited to, application of any preexisting condition limitation or eligibility period otherwise applicable to the Hired Employees and their eligible dependents. In addition, if prior to the Closing Date a Hired Employee or his or her covered dependents paid any amounts towards a deductible or out-of-pocket maximum in Seller's medical and health plan**'**s current fiscal year, such amounts shall be applied toward satisfaction of the deductible or out-of-pocket maximum in the current fiscal year of Buyer**'**s medical and health plan that covers Hired Employees on and after the Closing Date. Buyer will give all Hired Employees credit for their vacation, holiday, personal time and sick pay (whether in such form or in the forms of so-called "paid time off" or an "extended illness bank") to the extent the same constitute Assumed Liabilities. With respect to the Hired Employees, Buyer will assume the Workers' Compensation Liability that exists as of Closing and any such claims filed on or after Closing with respect to periods prior to Closing. Except as provided in subsection (b) above, this subsection (c), subsection (e) below, or Schedule 2.03, or as otherwise required by Legal Requirements, Buyer will not assume or otherwise become liable for, and Seller will remain solely responsible for, (i) Seller's Employee Welfare Benefit Plans and (ii) any other obligations to former or currently retired employees or their dependents. Buyer will make available group health plan continuation coverage required under COBRA to employees and former employees of Seller who are eligible for COBRA, provided that, with respect to COBRA beneficiaries whose qualifying events occurred on or prior to the

Closing Date, Seller will reimburse Buyer for all claims of such COBRA beneficiaries paid by Buyer and its Affiliates in excess of the sum of (A) COBRA premiums collected from the COBRA beneficiaries; and (B) amounts reimbursed from stop loss insurance, determined in the aggregate with respect to all such individuals on the first anniversary of the Closing Date and again at the end of the COBRA period for all such COBRA beneficiaries. Buyer agrees to accept rollovers of eligible rollover distributions (within the meaning of Code section 402(c)(4)), including to the extent applicable rollovers of any outstanding loans made as part of a direct rollover, made by Hired Employees from Seller's Employee Pension Benefit Plans to Buyer's Plans.

(d) Prior to Closing, Seller shall freeze its defined benefit pension plan known as the "Eastern Connecticut Health Network, Inc. Pension Plan amended and restated as of December 31, 2013" to new participation and future accruals and shall freeze the post-retiree health plan to new participation. With respect to the post-retiree health plan, Buyer agrees to maintain post-retiree health coverage for the group of employees and former employees eligible for such coverage as of the Closing. With respect to the post-retiree health plan, Buyer agrees to maintain post-retiree health coverage for the group of employees and former employees eligible for such coverage as of the Closing and shall not amend or terminate the post-retiree health plan unless the members of such group are provided another retiree medical benefit or cash payment of equivalent value (as calculated using reasonable assumptions determined in consultation with an actuary at the time of the determination).

(e) As of the Closing, Buyer agrees to assume, administer, and become the sponsor of Seller's defined benefit pension plan known as the "Eastern Connecticut Health Network, Inc. Pension Plan amended and restated as of December 31, 2013" and Seller's post-retiree health plan and assume all collective bargaining agreements of Seller that pertain to the Hospital Businesses.

(f) Between the date of this Agreement and Closing, Buyer may run newspaper advertisements, in the name of any of the Hospital Businesses or in the name of Buyer, to recruit employees for the Hospital Businesses to commence on or after the Closing Date.

(g) At Closing, Seller shall deliver to Buyer a list setting forth the names of all employees of the Hospital Businesses whose employment was terminated between the date of this Agreement and the Closing Date.

(h) This Section 5.03 shall not apply to employees employed by Seller under Assumed Contracts, including but not limited to the collective bargaining agreements described in subsection (d) above. Buyer shall offer employment to all such employees, subject to the satisfactory completion of Buyer's usual and customary hiring practices, including employee background checks and pre-employment screenings, and employment of such employees will be governed by the terms and conditions of the Assumed Contracts, if any, relating to the employment of such employees.

(i) On or prior to the Closing Date, Seller will be responsible for compliance with the WARN Act and all similar state and local Legal Requirements with respect to the employees of the Hospital Businesses, and for all obligations or liabilities arising thereunder as a result of any action (or failure to act) of Seller on or prior to the Closing Date, and after the Closing Date, Buyer will be responsible for compliance with the WARN Act and all similar state and local Legal Requirements with respect to the Hired Employees, and for all obligations or liabilities arising thereunder as a result of any action (or failure to act) of Buyer after the Closing Date.

5.04. Access to and Provision of Additional Information.

(a) Except to the extent prohibited by applicable Legal Requirements (including antitrust laws), until the Closing Date, Seller shall (i) give Buyer reasonable access to and the right to inspect, during normal business hours and upon reasonable prior notice, Seller's Assets and books and records relating to the Hospital Businesses, (ii) give Buyer reasonable access to Seller's employees and medical staff members providing services at or for the Hospital Businesses and (iii) give Buyer such additional financial, operating and other data and information (including auditors' workpapers) regarding the Hospital Businesses as Buyer may reasonably request and that is reasonably available to Seller. Buyer shall exercise its rights under this Section 5.03(a) in such a manner as to cause the least possible interference with the normal operations of the Hospital Businesses.

(b) Seller will deliver to Buyer:

(i) within 25 days after the end of each calendar month before the Closing Date, copies of the unaudited balance sheet and the related unaudited statements of income and cash flows of the Hospital Businesses for each such month then ended and for the fiscal year-to-date then ended, in consolidating and consolidated format;

(ii) within 35 days after the end of each fiscal quarter ending on or before the Closing Date, copies of the unaudited balance sheet and the related unaudited statements of income and cash flows of the Hospital Businesses for the fiscal quarter then ended and for the fiscal year-to-date then ended; and

(iii) promptly after prepared, copies of any other financial or operating statements, reports or analyses prepared by or for management relating to the Hospital Businesses.

(c) Until the Closing Date, Seller shall confer regularly with Buyer, as reasonably requested by Buyer, and answer Buyer's reasonable questions regarding matters relating to the conduct of the Hospital Businesses and the status of transactions contemplated by this Agreement. Seller shall notify Buyer of any material changes in the operations, financial condition or prospects of the Hospital Businesses and of any material complaints, investigations, hearings or adjudicatory proceedings (or

communications indicating that the same may be contemplated) concerning the Hospital Businesses and shall keep Buyer reasonably informed of the status of such matters.

(d) With respect to any individually identifiable health information disclosed by Seller to Buyer pursuant to this Section, Buyer and Seller shall comply with the Health Insurance Portability and Accountability Act of 1996, as codified at 42 U.S.C. Section 1320d, *et seq.*, as amended by the Health Information Technology for Economic and Clinical Health Act, and any current and future Legal Requirements promulgated thereunder, and with any other federal or state Legal Requirements that govern or pertain to the confidentiality, privacy, security of, and electronic transactions involving, health care information.

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

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

(a) After Closing, each party may need access to books, records, documents or other information in the control or possession of the other party for purposes of concluding the transactions contemplated by this Agreement, preparing Tax Returns or conducting Tax audits, obtaining insurance, complying with Government Payment Programs and other Legal Requirements, and prosecuting or defending third party claims. Accordingly, each party shall keep and maintain in the ordinary course of business all books, records (including patient medical records), documents and other information in the possession or control of such party for a period of at least five years after the Closing and otherwise in accordance with all applicable Legal Requirements and record retention policies maintained by such party. In addition, to facilitate the foregoing purposes, each party shall also make such books, records, documents and other information available for inspection and copying upon the reasonable request and at the expense (for out-of-pocket costs) of the other party.

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

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

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

(e) To the extent Seller remains in existence and maintains sufficient operational control over relevant functions and pursuant to the Transitional Services Agreement, for seven years after the Closing Date, Seller will give Buyer, within 30 days after request, an updated claims history, including losses paid and open reserves, for all claims relating to the conduct of the Hospital Businesses on or before the Closing Date.

5.06. Governmental Authority Approvals; Consents to Assignment.

(a) Until the Closing Date, Seller and Buyer shall (i) promptly apply for, and use commercially reasonable efforts to obtain before Closing, all consents, approvals, authorizations and clearances of Governmental Authorities required to consummate the transactions contemplated by this Agreement, including approvals of the applications to the Attorney General and the Office of Health Care Access of the Connecticut Department of Public Health, (ii) provide such information and communications to Governmental Authorities as the other party or such Governmental Authorities may reasonably request, and (iii) assist and cooperate with the other party to obtain all Permits, including approvals of the applications to the Attorney General and the Office of Health Care Access of the Connecticut Department of Public Health, that the other party deems necessary or appropriate, and to prepare any document or other information reasonably required of it by any such Governmental Authority to consummate the transactions contemplated by this Agreement.

(b) Until the Closing Date, each party shall file, if and to the extent required by applicable Legal Requirements, all reports and other documents required or requested by Governmental Authorities under the HSR Act concerning the transactions contemplated by this Agreement, and shall promptly comply with any requests by the Governmental Authorities for additional information concerning such transactions, so that the waiting period specified in the HSR Act will expire as soon as reasonably possible. Each party shall furnish to the other party such information as the other party reasonably requires to comply with its obligations under the HSR Act and shall exchange drafts of the relevant portions of each other's report forms before filing. The parties shall also share equally the costs of any fees due in respect of filings required by the HSR Act.

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

(d) To obtain one or more of the consents and approvals described in this Section, Buyer may be required by applicable Legal Requirement or practical necessity to enter into a contract that supersedes or replaces an existing Contract between Seller and a

third party. Such new contract may require Buyer to assume, for the benefit of such third party, certain obligations and liabilities of Seller that are Excluded Liabilities. Alternatively, Buyer may be required by Legal Requirements to assume, or may be deemed as a matter of law to have assumed, obligations and liabilities of Seller that are Excluded Liabilities. If Buyer enters into a replacement contract or assumes such Excluded Liabilities, then – as between Seller and Buyer – such contract or assumption of Excluded Liabilities will not affect the contractual rights and remedies provided in this Agreement in respect of such contract or Excluded Liabilities, including Buyer's rights to indemnification from Seller (subject to the limitations set forth in Article 9), or otherwise diminish Seller's obligations to Buyer or enlarge Seller's liabilities to Buyer (or diminish Seller's defenses or limitations on liability) under this Agreement and will under no circumstances be claimed by Seller as a defense (whether of waiver, estoppel, consent, operation of law, or otherwise) against Buyer's assertion of any claim under this Agreement against Seller, and the rights and obligations of the parties to each other under this Agreement will be determined as if such replacement contract did not exist or such assumption of Excluded Liabilities was not required.

5.07. Use of Controlled Substance Permits. To the extent permitted by applicable Legal Requirements, Buyer shall have the right, for a period not to exceed 120 days following the Closing Date, to operate the Hospital Businesses under the licenses and registrations of Seller relating to controlled substances and the operations of pharmacies and laboratories, until Buyer is able to obtain such licenses and registrations for the Hospital Businesses. In furtherance thereof, Seller shall execute and deliver to Buyer at or prior to the Closing limited powers of attorney substantially in the form of Exhibit B hereto. Buyer or its Affiliates shall apply for all such licenses and registrations as soon as reasonably practicable before and after the Closing Date and shall diligently pursue such applications. Buyer shall indemnify and hold harmless Seller and its Affiliates, and their officers, trustees and employees for all claims, liabilities and costs arising from or relating to use of such licenses and registration after the Closing Date.

5.08. Connecticut Transfer Act. Certain components of the Real Property (including the Hospitals) may constitute, in whole or in part, "Establishments" as the term is defined in the Transfer Act (collectively, the "**Establishment Real Properties**"). Accordingly, Seller and Buyer shall prepare an appropriate Transfer Act Form and accompanying ECAF for each Establishment Real Property to satisfy the requirements of the Transfer Act in connection with the transaction contemplated herein. Seller shall execute as transferor and Buyer shall execute as transferee and Certifying Party (as all such terms are defined in the Transfer Act). Within ten (10) days after the Closing Date, Buyer shall (i) file the fully executed Form and ECAF with the Connecticut Department of Energy and Environmental Protection ("**CTDEEP**"); (ii) pay the initial filing fee and any and all subsequent Transfer Act fees; and (iii) provide written confirmation to Seller that the Transfer Act filing has been completed (with a copy of such filing). In order to evaluate the potential scope and cost of Transfer Act obligations that may be required, prior to the Closing, Buyer shall have the right to perform limited Phase II Assessments subject to and in accordance with the provisions of Section 7.09 hereof. Buyer or its designee shall conduct and complete, at Buyer's sole expense, any actions required (as determined by Buyer in its reasonable discretion) as a result of the filing of the Form and the ECAF, to comply with the Transfer Act, and, if appropriate, to obtain written approval from CTDEEP or a "verification" from a "Licensed Environmental Professional" that the Facilities have been

remediated in full compliance with the Connecticut Remediation Standard Regulations (collectively "**Transfer Act Activities**"). Buyer shall complete all Transfer Act Activities as soon as practicable, but in any event within any deadline defined by or pursuant to the Transfer Act (as the same may be extended). Seller and Buyer agree to execute and deliver all documents reasonably requested by the other to comply with the Transfer Act. All undefined terms in this Section 5.08 shall have the meanings set forth in the Transfer Act.

5.09. No-Shop Clause. Until termination of this Agreement, Seller shall not, and shall not permit any Affiliate of Seller or any other Person acting for or on behalf of Seller or any Affiliate of Seller to, without the prior written consent of Buyer: (a) offer for sale, lease or other disposition all or substantially all of the Assets or any material portion thereof, or any ownership interest in any entity owning any of the Assets, whether by virtue of an asset sale transaction, a lease transaction, affiliation transaction, or a change of control, change of membership, merger, consolidation or other combination transaction with respect to Seller or any entity owning any of the Assets (collectively, a "**Prohibited Transaction**"), or negotiate in respect of an unsolicited offer therefor; (b) solicit offers to acquire all or substantially all of the Assets, or any material portion thereof, or offers to acquire any ownership interest in an entity owning any of the Assets, in a Prohibited Transaction; (c) enter into any Contract with any Person with respect to the disposition of all or substantially all of the Assets, or any material portion thereof, or the sale of any ownership interest in an entity owning any of the Assets, in a Prohibited Transaction; or (d) furnish or permit or cause to be furnished any information to any Person that Seller knows or has reason to believe is in the process of considering a Prohibited Transaction. If Seller, any Affiliate of Seller, or any Person acting for or on behalf of any of the foregoing receives from any Person (other than Buyer or its representatives) any offer, inquiry or informational request referred to above, Seller will promptly advise such Person, by written notice, of this Section.

5.10. Noncompetition. For a period of five years after the Closing Date, Seller shall not, directly or indirectly, and Seller shall cause its Affiliates not to, in any capacity: (i) own, lease, manage, operate, control, be employed by, maintain or continue any interest whatsoever or participate in any manner with the ownership, leasing, management, operation, or control of any business or enterprise that offers services in competition with the Hospital Businesses, including any acute care hospital, specialty hospital, rehabilitation facility, diagnostic imaging center, inpatient or outpatient psychiatric or substance abuse facility, ambulatory or other type of surgery center, wellness center, urgent care center, ambulatory service, nursing home, skilled nursing facility, home health or hospice agency, or physician clinic or physician medical practice, within a 30 mile radius of either Hospital (the "**Restricted Area**"); (ii) employ or solicit the employment of any Hired Employee, other than no more than five (5) individuals employed solely for winding down operations, unless (x) such employee resigns voluntarily (without any solicitation from Seller or any of its Affiliates), (y) Buyer consents in writing to such employment or solicitation, or (z) such employee is terminated by Buyer or its Affiliate after the Closing Date; (iii) induce, cause or attempt to induce or cause any Person (including any physician employee or medical staff member) to replace or terminate any contract for the provision or arrangement of health care services from the Hospital Businesses with products or services of any other Person after the Closing Date; or (iv) request, induce or cause any physician employee or medical staff member to terminate any contract with or change practice patterns at the Hospital Businesses. Notwithstanding the foregoing, however, (i) Seller and its Affiliates will not be precluded from participating in the following activities that promote health

care services for residents of the communities historically served by Seller and its Affiliates through the Hospitals: development, ownership, and operation of indigent or charity care clinics and services; preventative care programs and services and educational programs; health screening services; child care services; and other similar services or programs intended to better serve the health care needs of the community's indigent population in the Restricted Area that are not directly competitive with services to be provided by Buyer or its Affiliates. In the event of a breach of this Section, Seller recognizes that monetary damages shall be inadequate to compensate Buyer, and Buyer shall be entitled, without the posting of a bond or similar security, to an injunction restraining such breach, with the costs (including attorneys' fees) of securing such injunction to be borne by Seller. Nothing contained herein shall be construed as prohibiting Buyer from pursuing any other remedy available to it for such breach or threatened breach. All parties hereto hereby acknowledge the necessity of protection against the competition of Buyer and its Affiliates and that the nature and scope of such protection has been carefully considered by the parties. Seller further acknowledges and agrees that the covenants and provisions of this Section form part of the consideration under this Agreement and are among the inducements for Buyer entering into and consummating the transactions contemplated herein. The period provided and the area covered are expressly represented and agreed to be fair, reasonable, and necessary. The consideration provided for herein is deemed to be sufficient and adequate to compensate for agreeing to the restrictions contained in this Section. If, however, any court determines that the foregoing restrictions are not reasonable, such restrictions shall be modified, rewritten, or interpreted to include as much of their nature and scope as will render them enforceable.

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

5.12. Further Assurances. After the Closing, upon request of Buyer, Seller shall do, execute, acknowledge and deliver, or cause to be done, executed, acknowledged and delivered, such further acts, deeds, assignments, transfers, conveyances, powers of attorney, confirmations and assurances as Buyer may reasonably request to more effectively convey, assign and transfer to and vest in Buyer full legal right, title and interest in and actual possession of the Assets and the Hospital Businesses, to confirm Seller's capacities and abilities to perform its post-Closing

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

5.13. Casualty. If, on or before the Closing Date, any of the Hospital Businesses are destroyed or materially damaged by fire, theft, vandalism or other cause or casualty and as a result thereof any material part of such Hospital Business is rendered unsuitable for its primary intended use and the cost of repair would exceed $1,000,000, Buyer may elect, by giving written notice to Seller within 15 business days after having actual notice of the occurrence of such destruction or damage and the extent of the loss, to: (i) terminate this Agreement in accordance with Section 8.04(a), (ii) consummate the transaction in spite of such destruction or damage but reduce the Purchase Price by the fair market value of the Assets destroyed or damaged (determined as of the date immediately before the destruction or damage) or, if greater, the estimated cost to restore, repair or replace such Assets, in which event Seller will retain all right, title and interest in and to insurance proceeds payable on account of such destruction or damage, or (iii) consummate the transaction in spite of such destruction or damage without any reduction in the Purchase Price, in which event Seller shall pay, transfer and assign to Buyer at Closing the insurance proceeds less any reasonable out-of-pocket costs incurred in collecting the proceeds or in securing or repairing the property (or the right to receive the insurance proceeds) payable on account of such destruction or damage, and Buyer shall receive a credit for any deductibles or copayments required under the applicable insurance policy in respect of such claim. Notwithstanding the foregoing, Buyer and Seller acknowledge and agree that the Purchase Price shall not be reduced by an amount that would preclude Seller from paying, or providing for payment of, all of its liabilities in full.

5.14. Seller's Cost Reports. Pursuant to the Transitional Services Agreement, Seller will prepare and timely file all Cost Reports required to be filed after Closing for periods ending on or before the Closing Date, including terminating Cost Reports required as a result of the consummation of the transactions described in this Agreement. Buyer will provide information to Seller and reasonably assist Seller in the preparation and filing of the terminating Cost Reports and the Purchase Price will be allocated in the terminating Cost Reports in a manner consistent with the allocation for Tax purposes described in Section 5.11. Buyer will forward to Seller any and all correspondence, remittances and demands relating to Seller's Cost Reports within ten business days after receipt by Buyer. Seller retains all rights to its Cost Reports, including any payables resulting from or reserves relating to the Cost Reports and the right to appeal any Medicare determinations relating to the Cost Reports.

5.15. Continuation of Hospitals and Post-Care Continuum. For at least [X] ([X]) years after Closing, Buyer will (i) continue operating the Hospitals in their current locations as acute care hospitals with emergency departments, and (ii) maintain an ownership interest in Seller's current post-acute care continuum of care network (e.g., VNA/home care, sub-acute and long-term lines of service) and require any joint venture involving such post-acute care continuum of care network to maintain the applicable service line for such three-year period. During such periods that Buyer operates the Hospitals, Buyer agrees to maintain Seller's commitment to quality, safety, and patient satisfaction, including maintaining appropriate enrollment, certifications, and accreditations necessary to receive reimbursement under Government Payment Programs.

5.16. Charity Care and Community Obligations.

(a) Seller has historically provided significant levels of care for indigent and low-income patients and has also provided support for community volunteer services and care through a variety of community-based health programs. Subject to changes in Legal Requirements or governmental guidelines or policies, Buyer will ensure that each Hospital maintains and adheres to Seller's current policies on charity care, indigent care, community volunteer services and community benefits attached as Schedule 5.16 or adopt other policies and procedures that are at least as favorable to the indigent and uninsured in the aggregate as Seller's existing policies.

(b) During all times that Buyer owns and operates the Hospitals, Buyer will strive to provide care through community-based health programs, including by cooperating with local organizations that sponsor health care initiatives to address community needs and improve the health status of the elderly, poor, and at-risk populations in the community.

5.17. Educational Support. Buyer agrees to maintain and support financially the University of New England medical student and other health professions teaching programs established by Seller, in addition to Seller's graduate medical education programs, while operating at a level to not exceed the Indirect Medical Education and Direct Graduate Medical Education caps that may be established by CMS.

5.18. Capital Commitment.

(a) Post-Closing, Buyer, in consultation with Seller, the Local Board and potentially an outside consultant, will develop a strategic capital plan with respect to the Hospital Businesses (which for purposes of this Section 5.18 includes the Joint Ventures). In accordance with such strategic capital plan, Buyer agrees to spend within five years of Closing or commit in a binding contract to spend (or cause or permit its Affiliates or third parties to spend or commit in a binding contract to spend) within five years of Closing not less than $[X] (the "**Commitment Amount**") at Seller facilities on (i) capital projects, including routine and non-routine capital expenditures for the improvement of Seller's facilities and/or the acquisition, development, expansion and improvement of hospital, ambulatory or other health care services (such as implementation of a comprehensive and system-wide electronic medical record such as the Epic system), (ii)

de novo development, expansion, or acquisition of a department, program, service or facility (whether for inpatient or outpatient services), (iii) upgrades or renovations generally, (iv) deferred maintenance items, and (v) capital expended in support of the recruitment of the Hospitals' medical staff located in the Hospitals' service area, limited to physician practice acquisitions, loan security agreements and real estate acquisition or development (including any associated medical equipment) in support of physician practice acquisitions. Buyer shall provide a written report to Seller on an annual basis that verifies its compliance with the capital commitment, which Seller may share publically.

(b) Notwithstanding the above capital commitment, in the event that any Legal Requirement is enacted or imposed by the State of Connecticut after Closing that discriminates against, or adversely affects a disproportionate number of for-profit hospitals and causes the Hospital Businesses to suffer a decline in EBITDA of more than ten (10) percent in any year, on a consolidated basis, then, Buyer may defer in its discretion the above capital commitment beyond the five-year period provided in Section 5.11 but only to the extent of the decline in EBITDA resulting from the discriminatory Legal Requirement. To the extent Buyer desires to defer the capital commitment as a result of a discriminatory Legal Requirement, (i) Buyer shall make available to the public reasonably detailed information to support Buyer's position (provided that in no event shall Buyer be required to disclose any information that is subject to a confidentiality or other similar arrangement) and (ii) Buyer shall consult with the Local Board to determine an alternate mutually agreeable timeframe to complete the capital commitment that is reasonable and appropriate in light of the changed circumstances caused by the new Legal Requirement.

5.19. Connecticut Transactions. If at any time prior to Closing, Buyer or any of its Affiliates enter into an agreement with another Connecticut hospital that seeks to consummate transactions similar to the transactions described herein, then Buyer shall promptly inform Seller of such fact, subject to such hospital's approval of waiving any nondisclosure obligation in a confidentiality agreement between such hospital and Buyer, or an Affiliate of Buyer.

5.20. Fees and Expenses.

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

(b) Seller shall pay all costs reasonably necessary for Seller to remove all Encumbrances on the Assets that are not Permitted Encumbrances and all expenses

incurred by Seller in obtaining any third party consents or approvals necessary to assign to Buyer any Assumed Contracts (it being understood that Seller shall have no obligation to make any monetary payment to a third party beyond any nominal review fee of not more than $1,000 or accept any material concession in the terms of any Contract in order to obtain any such consents or approvals).

(c) Buyer shall pay the following: (i) all third party fees and expenses reasonably incurred by Buyer for Buyer's land title surveys and environmental, engineering and other inspections, studies, tests, reviews and analyses undertaken by or on behalf of Buyer for the benefit of Buyer, (ii) all transfer Taxes, sales and use and similar Taxes arising out of the transfer of the Assets (whether or not originally arising with or assessed to Seller or its applicable Subsidiary) and (iii) the premium for Buyer's title insurance policies described in Section 7.06.

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

5.21. Clinical Quality and Integration. For at least three (3) years after Closing, Buyer shall (i) collaborate with the Local Board and remaining former hospital staff of Seller on clinical quality matters of the Hospital Businesses to share best practices, establish clinical quality goals and measure progress, and (ii) to the extent consistent with antitrust Legal Requirements, consult with physicians on the medical staff of each Hospital, including at least some independent (*i.e.*, non-employed) physicians, in managed care contracting and clinical integration with respect to the Hospital Businesses.

5.22. Insurance Ratings. Seller will take all commercially reasonable actions requested by Buyer to enable Buyer, at Buyer's expense, to succeed to the workers' compensation and unemployment insurance ratings of Seller and the Hospital Businesses for insurance purposes. Buyer shall not be obligated to succeed to any such rating, except as it may elect to do so or as is otherwise required to do so by Legal Requirements.

5.23. Fulfillment of Conditions. If all of the conditions to a party's obligation to consummate the transactions contemplated by this Agreement at the Closing are satisfied (or waived by that party in its sole discretion), such party will execute and deliver at Closing each Closing Document that such party is required by this Agreement to execute and deliver at Closing. Each party will use all commercially reasonable efforts to satisfy each condition to the obligations of the other party to consummate the transactions contemplated by this Agreement, to the extent that satisfaction of any such condition is within the control of such party.

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

5.25. Insurance Transition Provisions.

(a) With respect to the Disability Obligations, Buyer and Seller acknowledge and agree that no tail insurance shall be required in connection with the Disability Obligations because Seller is fully insured with respect to the Disability Obligations.

(b) Other than with respect to the Accumulated Benefit Obligation, the Post-Retiree Health Plan Liability, the Captive Insurer Liability and the Workers' Compensation Liability, on or before the Closing Date, Seller will purchase and obtain an unlimited extended claims reporting provision for all primary and excess insurance policies, including but not limited to coverage for directors, trustees and officers of Seller and its Affiliates, in force as of the date of this Agreement that cover Seller, its Affiliates and each physician employee of Seller or its Affiliates (or for which Seller otherwise has an obligation to provide such insurance), and that are written on a claims-made insuring agreement. Such extended claim endorsements must name Buyer (and other Affiliates of Buyer designated by Buyer prior to the Closing) as named insureds thereunder.

(c) Notwithstanding anything in this Agreement to the contrary and to the extent in the best interests of Seller, Seller may choose in its sole discretion to retain the Captive Insurer Liability, the Workers' Compensation Liability or both and, at or prior to Closing, purchase its own tail insurance policy or policies with respect to the Captive Insurer Liability, the Workers' Compensation Liability or both. To the extent Seller elects to retain the Captive Insurer Liability, the Workers' Compensation Liability or both, Seller shall provide written notice to Buyer of such election, and Buyer will be relieved of its obligations set forth in this Agreement with respect to any liability or liabilities that Seller elects to retain as set forth in such written notice, and there shall be no reduction in the Purchase Price pursuant to Section **Error! Reference source not ound.-Error! Reference source not found.**for any liabilities so retained.

5.26. Strategic Business Plan. After Closing, Buyer will use commercially reasonable efforts to execute and implement the Strategic Business Plan in accordance with its terms, as the Strategic Business Plan may be modified by Buyer, in consultation with the Local Board, from time to time.

5.27. Local Board. The Local Board shall, among other things, serve as a resource for Buyer with respect to Buyer's investment of the Capital Commitment (see Section 5.11 herein), maintenance and implementation of the Strategic Business Plan, be responsible for medical staff credentialing at the Hospitals, maintain and oversee the quality assurance program at the Hospitals and oversee and manage the accreditation process for the Hospitals.

5.28. Compliance Program. The Buyer and its Affiliates have established and implemented corporate compliance and ethics programs to ensure that high ethical and conduct standards are met in the conduct of their business. Buyer shall extend after Closing its corporate compliance and ethics programs to the Hospital Businesses.

6. CONDITIONS PRECEDENT TO OBLIGATIONS OF SELLER

The obligations of Seller to consummate the transactions contemplated by this Agreement, including by taking the actions specified in Section 8.02, are subject to the satisfaction on or before Closing of the following conditions, unless waived by Seller:

6.01. Representations; Covenants.

(a) Each of the representations and warranties of Buyer in this Agreement that is qualified as to materiality was true and correct on and as of the date of this Agreement, each of the other representations and warranties of Buyer was true and correct in all material respects on and as of the date of this Agreement, each of the representations and warranties of Buyer in this Agreement that is qualified as to materiality is true and correct on and as of the Closing Date, and each of the other representations and warranties of Buyer in this Agreement is true and correct in all material respects on and as of the Closing Date.

(b) Each of the covenants to be complied with or performed by Buyer on or before Closing (other than actions to be taken at the Closing, including the delivery of the Closing Documents described in Section 8.03) has been complied with and performed in all material respects.

6.02. Adverse Proceeding. No Proceeding by any Governmental Authority (including the Attorney General) has been instituted or threatened to restrain or prohibit the transactions contemplated by this Agreement, no Governmental Authority (including the Attorney General) has taken any other action or made any request of Seller or Buyer as a result of which Seller reasonably and in good faith deems it inadvisable to proceed with the transactions contemplated by this Agreement, and no order is in effect restraining, enjoining or otherwise preventing consummation of the transactions contemplated by this Agreement.

6.03. Pre-Closing Confirmations. Seller has received all consents, approvals, licenses and other authorizations of Governmental Authorities, on terms reasonably satisfactory to Seller, including (i) the certificate of need approval by the Office of Health Care Access of the Connecticut Department of Public Health, (ii) confirmation that the Bond Liabilities have been satisfied, and (iii) approval for the conversion of the Hospitals to a for-profit entity by the Attorney General (including receipt of a fairness evaluation or fairness opinion satisfactory to the Seller and the Attorney General) and approval of the transfer or disposition of all donor restricted funds of the Hospitals and all Subsidiaries in a manner acceptable to the Attorney General, required for Seller to consummate the transactions contemplated by this Agreement and that all applicable waiting periods under the HSR Act shall have expired or been terminated.

6.04. Redemption of the Bonds/Satisfaction of the Indenture. All actions required to be taken and all conditions required to be satisfied in connection with the defeasance or redemption of all outstanding tax-exempt debt issued by or on behalf of Seller, including the Bond Liabilities, and the satisfaction, discharge, release, and termination of all trust indentures, tax-exempt equipment loans and related documents (collectively, the "**Indenture**") associated with such tax-exempt debt, and all Encumbrances created by or in connection with the Indenture, have

been, or at Closing will be, taken and satisfied. The Indenture and all Encumbrances created by or in connection with the Indenture shall have been satisfied, discharged and terminated, and Seller shall have received an opinion from counsel to the Connecticut Health and Education Facilities Authority to the effect that all Bond Liabilities have been defeased or prepaid, together with evidence satisfactory to Buyer of the discharge of all Encumbrances on the Assets under the Indenture.

6.05. Extraordinary Events. Buyer (a) is not in receivership or dissolution, (b) has not made any assignment for the benefit of creditors, (c) has not admitted in writing its inability to pay its debts as they mature, (d) has not been adjudicated a bankrupt, (e) has not filed a petition in voluntary bankruptcy, a petition or answer seeking reorganization, or an arrangement with creditors under the federal bankruptcy law or any other similar Legal Requirement of the United States or any state (and no such petition has been filed against Buyer), or (f) has not entered into any contract to do any of the foregoing on or after the Closing Date.

7. CONDITIONS PRECEDENT TO OBLIGATIONS OF BUYER

The obligations of Buyer to consummate the transactions contemplated by this Agreement, including by taking the actions specified in Section 8.03, are subject to the satisfaction on or before Closing of the following conditions, unless waived by Buyer:

7.01. Representations; Covenants; Schedules.

(a) Each of the representations and warranties of Seller in this Agreement that is qualified as to materiality was true and correct on and as of the date of this Agreement, each of the other representations and warranties of Seller in this Agreement was true and correct in all material respects on and as of the date of this Agreement, each of the representations and warranties of Seller in this Agreement that is qualified as to materiality is true and correct on and as of the Closing Date, and each of the other representations and warranties of Seller in this Agreement is true and correct in all material respects on and as of the Closing Date (other than the representation in Section 3.07(l) which shall be true and correct in all respects).

(b) Each of the covenants to be complied with or performed by Seller on or before Closing (other than actions to be taken at the Closing, including the delivery of the Closing Documents described in Section 8.02) has been complied with and performed in all material respects.

(c) Each of Seller's Schedules, Exhibits and other instruments required under this Agreement has been updated or delivered by Seller, and approved by Buyer, all in accordance with Section 9.01.

7.02. Adverse Action or Proceeding. No Proceeding by any Governmental Authority (including the Attorney General) has been instituted or threatened to restrain or prohibit the transactions contemplated by this Agreement, no Governmental Authority (including the Attorney General) has taken any other action or made any request of Seller or Buyer as a result of which Buyer reasonably and in good faith deems it inadvisable to proceed with the

transactions contemplated by this Agreement, and no order is in effect restraining, enjoining or otherwise preventing consummation of the transactions contemplated by this Agreement.

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

7.04. Pre-Closing Confirmations and Contractual Consents. Buyer has obtained documentation or other evidence reasonably satisfactory to Buyer that:

(a) All Permits required to operate the Hospital Businesses will be transferred to or issued in the name of Buyer as of the Closing Date, without the imposition of any condition that is materially burdensome to the operation of the Hospital Businesses after Closing;

(b) The applicable Hospital Businesses that participate in the Government Payment Programs as of the date of this Agreement will be qualified effective as of Closing to participate in the Government Payment Programs in which they participate as of the date of this Agreement and will be entitled to receive payment under such Government Payment Programs for services rendered to qualified beneficiaries of such Government Payment Programs immediately after the Closing Date with respect to the Hospitals, and within a reasonable period of time after the Closing Date with respect to the other applicable Hospital Businesses;

(c) All other consents, approvals, licenses and other authorizations of Governmental Authorities, including the certificate of need approval by the Office of Health Care Access of the Connecticut Department of Public Health and approval for the conversion of the Hospitals to a for-profit entity by the Attorney General, required for Buyer to consummate the transactions contemplated by this Agreement and all other material consents, approvals, licenses and other authorizations of Governmental Authorities required for Buyer to operate the Hospital Businesses after Closing shall have been received on terms reasonably satisfactory to Buyer;

(d) Seller has delivered to Buyer copies of consents to assignment of the Assumed Contracts, and certain other consents, waivers and estoppels, that are listed on Schedule 7.04(d);

(e) Seller has obtained approvals from its Board of Trustees, corporators and, to the extent required, the governing boards of its Subsidiaries; and

(f) All applicable waiting periods under the HSR Act have expired or been terminated.

7.05. Extraordinary Events. Seller (a) is not in receivership or dissolution, (b) has not made any assignment for the benefit of creditors, (c) has not admitted in writing its inability to pay its debts as they mature, (d) has not been adjudicated a bankrupt, (e) has not filed a petition in voluntary bankruptcy, a petition or answer seeking reorganization, or an arrangement with creditors under the federal bankruptcy law or any other similar Legal Requirement of the United

States or any state (and no such petition has been filed against it), and (f) has not entered into any Contract to do any of the foregoing on or after the Closing Date.

7.06. Title Insurance Policies and Surveys. Buyer has received:

(a) One or more commitments from a recognized national title insurance company chosen by Buyer to issue as of the Closing Date ALTA extended coverage owner's title insurance policies for the Owned Real Property, in amounts reasonably acceptable to Buyer, in form reasonably acceptable to Buyer and with such endorsements as Buyer may reasonably require, at Buyer's sole cost and expense; and

(b) ALTA land title surveys of the Owned Real Property, in form reasonably satisfactory to Buyer and the title insurance company, from a firm designated by Buyer and certified to Buyer and the title insurance company, at Buyer's sole cost and expense.

7.07. Opinion of Seller's Counsel. Buyer has received an opinion from counsel to Seller, dated as of the Closing Date and addressed to Buyer, in a form reasonably satisfactory to Buyer.

7.08. The Indenture. The Indenture and all Encumbrances created by or in connection with the Indenture, specifically the Bond Liabilities and other tax-exempt debt, shall have been satisfied, discharged and terminated, and Buyer shall be entitled to rely on the opinion of Seller's bond counsel described in Section 6.04.

7.09. Environmental Assessments. Buyer shall, at its election, have received a Phase I environmental site assessment in a form reasonably satisfactory to Buyer, on each parcel of Owned Real Property and, at Buyer's option, any portion of the premises forming a part of the Leased Real Property (each, a "**Phase I Assessment**," collectively, the "**Phase I Assessments**"). Buyer shall not be permitted to conduct any Phase II environmental site assessments, or other intrusive or destructive testing on or relating to the Owned Real Property or Leased Real Property (each, a "**Phase II Assessment**," collectively, the "**Phase II Assessments**") unless pursuant to information contained in the applicable Phase I Assessment and subject to the prior approval of Seller (including any conditions which Seller may impose on such investigations, and, if Seller so requires, memorialized in an environmental access agreement between Buyer and Seller), in Seller's sole discretion. Notwithstanding the foregoing, if, after review of any Phase I Assessment, the parties reasonably determine that the subject real property is an Establishment Real Property (as defined in Section 5.08 hereof) and reasonably identifies any "areas of concern" ("**AOCs**") warranting additional investigation pursuant to the Transfer Act, then, in order to obtain a preliminary (but not definitive) understanding of the nature and extent of any contamination potentially associated with such AOC, Buyer shall have the right to perform a limited Phase II Assessment of each such AOC pursuant to a scope of work approved by Seller in advance, which approval (including any conditions which Seller may reasonably impose on such investigation) shall not be unreasonably withheld, conditioned or delayed. Buyer shall pay the full costs of any Phase I Assessment(s) and any Phase II Assessment(s) that may occur pursuant to this Section 7.09. Notwithstanding any other provision hereof to the contrary, Buyer shall not provide Seller with copies of any Phase II Assessment(s) (or any of the

data contained therein) unless requested by Seller. To the extent any Phase II Assessments are performed in accordance with this provision, Buyer shall be reasonably satisfied with same.

7.10. Hill-Burton Facilities. No Encumbrance affects any of the Assets or Hospital Businesses relating to or arising under the Hill-Burton Act.

7.11. [Physician Organization. Simultaneous with the Closing, Eastern Connecticut Medical Professionals Foundation, Inc. shall amend its Bylaws and Certificate of Incorporation, as necessary, to specify that Buyer (or its designee) is its sole corporate member. Eastern Connecticut Medical Professionals Foundation, Inc. shall continue to employ on the Closing Date those physicians and other licensed "Providers," as defined in Section 33-182aa of the Connecticut General Statutes, that it employs immediately prior to the Closing Date.]

8. CLOSING; TERMINATION OF AGREEMENT

8.01. Closing.

(a) Consummation of the sale and purchase of the Assets and the other transactions contemplated by this Agreement (the "**Closing**") will take place at [_____] at 10:00 a.m., or at such other place and time as the parties may mutually agree, on _____, 2015, or if at such time any conditions to Closing set forth in Articles 6 and 7 have not been satisfied (or waived by the parties entitled to the benefit thereof), on the third business day following satisfaction or waiver of such conditions, or at such time or place as the parties may mutually agree. The Closing shall be effective for all purposes as of 12:01 a.m. on the day immediately following the Closing Date.

(b) At the Closing, Seller shall deliver, or cause to be delivered, to Buyer, each of the Closing Documents and other items set forth in Section 8.02, all in forms reasonably acceptable to Buyer and its counsel, and such Closing Documents, as appropriate, shall be duly executed by, and acknowledged on behalf of, Seller. At the Closing, Buyer shall deliver, or cause to be delivered, to Seller, each of the Closing Documents and the consideration set forth in Section 8.03, all in forms reasonably acceptable to Seller and its counsel, and such Closing Documents, as appropriate, shall be duly executed by, and acknowledged on behalf of, Buyer and, where applicable, [Buyer's ultimate parent].

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

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

(a) special warranty deeds, duly executed by Seller in recordable form, conveying to Buyer fee simple title to the Owned Real Property, free and clear of Encumbrances other than the Permitted Real Property Encumbrances;

(b) assignment and assumption agreements duly executed by Seller conveying to Buyer all of Seller's right, title and leasehold interest in and to the Leased Real Property;

(c) bills of sale and assignment duly executed by Seller conveying to Buyer good and valid title to all personal property Assets, free and clear of Encumbrances other than the Permitted Personal Property Encumbrances;

(d) assignments duly executed by Seller conveying to Buyer Seller's interests in the Assumed Contracts;

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

(f) an original or certified copy of the tail insurance policies required by Section 5.25 and receipts evidencing payment of the premiums therefor;

(g) a copy of resolutions duly adopted by the board of directors of Seller authorizing and approving the execution and delivery of this Agreement and the Closing Documents and the consummation of the transactions contemplated herein and therein, certified as in full force and effect as of the Closing Date by an appropriate officer of Seller;

(h) a certificate of a duly authorized officer of Seller certifying that (i) each of the representations and warranties of Seller in this Agreement that is qualified as to materiality was true and correct on and as of the date of this Agreement, (ii) each of the other representations and warranties of Seller in this Agreement was true and correct in all material respects on and as of the date of this Agreement, (iii) each of the representations and warranties of Seller in this Agreement that is qualified as to materiality is true and correct on and as the Closing Date, (iv) each of the other representations and warranties of Seller in this Agreement was true and correct in all material respects on and as of the Closing Date and (v) each of the covenants to be complied with or performed by Seller on or before Closing (other than actions to be taken at the Closing, including the delivery of the Closing Documents described in this Section 8.02) has been complied with and performed in all material respects;

(i) a certificate of incumbency for the officers of Seller executing this Agreement and the Closing Documents;

(j) a certificate of existence and good standing for Seller and each of its Subsidiaries from the State of Connecticut, dated no earlier than 15 days prior to the Closing Date;

(k) stock certificates and certificates or other appropriate instruments of transfer of the ownership interests in the Joint Ventures, duly endorsed for transfer to Buyer, and, to the extent obtained prior to Closing, any amendment to the operating agreement, bylaws or other governing documents of each Joint Venture that Buyer determines, in its reasonable discretion, is necessary to fully effectuate the transfer of the ownership interest in the Joint Ventures to Buyer;

(l) a statement pursuant to section 1.1445-2(b)(2)(iv) of the Treasury Regulations under the Code, executed on behalf of Seller or any Affiliate conveying an interest in Owned Real Property to Buyer or its Affiliates, certifying that such entity is not a foreign corporation and is not otherwise a foreign Person;

(m) all certificates of title and other documents evidencing an ownership interest conveyed as part of the Assets, including for all motor vehicles;

(n) all necessary state and local real estate conveyance tax forms duly executed by Seller;

(o) final execution copy of the Transfer Act Form III and ECAF with a $3,000 filing fee, as more fully described in Section 5.08;

(p) UCC termination statements or other releases for all Encumbrances on the Assets not constituting Permitted Encumbrances, which termination statements and releases will be effective as of Closing;

(q) the opinion of counsel to Seller as provided in Section 7.09;

(r) owner's affidavits, certificates, rent rolls and other documentation that may be reasonably necessary to consummate the transactions contemplated by this Agreement and obtain the title policies required to be issued hereunder;

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

(t) such other Closing Documents as Buyer deems reasonably necessary to consummate the transactions contemplated by this Agreement.

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

(a) The Purchase Price due to Seller, as adjusted in accordance with Section 2.05;

(b) an assumption agreement duly executed by Buyer pursuant to which Buyer assumes the Assumed Liabilities, as well as any documents Seller may reasonably

require to effectuate Buyer's assumption of certain of Seller's Employee Benefit Plans pursuant to Section 5.03(e);

(c) a copy of resolutions duly adopted by the boards of directors, members or managers of [Buyer's ultimate parent] and Buyer, as appropriate, authorizing and approving the execution and delivery of this Agreement and the Closing Documents and the consummation of the transactions contemplated herein and therein, certified as in full force and effect as of the Closing Date by an appropriate officer of [Buyer's ultimate parent] and Buyer;

(d) a certificate of a duly authorized officer of Buyer certifying that each of the representations and warranties of Buyer in this Agreement that is qualified as to materiality was true and correct on and as of the date of this Agreement, that each of the other representations and warranties of Buyer in this Agreement was true and correct in all material respects on and as of the date of this Agreement, that each of the representations and warranties of Buyer in this Agreement that is qualified as to materiality is true and correct on and as of the Closing Date, that each of the other representations and warranties of Buyer in this Agreement is true and correct in all material respects on and as of the Closing Date, and that each of the covenants to be complied with or performed by Buyer on or before Closing (other than actions to be taken at the Closing, including the delivery of the Closing Documents described in this Section) has been complied with and performed in all material respects;

(e) a certificate of incumbency for the officers of [Buyer's ultimate parent] and Buyer executing this Agreement and the Closing Documents;

(f) a certificate of existence and good standing of Buyer from the State of [], dated no earlier than 15 days prior to the Closing Date;

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

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

8.04. Termination Prior to Closing; Termination Fee.

(a) Notwithstanding anything herein to the contrary, this Agreement may be terminated at any time: (i) by mutual consent of Seller and Buyer; (ii) by Seller or Buyer, if the Closing Date shall not have taken place on or before December 31, 2015 (as such date may be extended by mutual agreement of Seller and Buyer); *provided*, however, that no party may terminate this Agreement if the failure of Closing to occur by such date resulted from a material breach of this Agreement by such party; or (iii) by Buyer, pursuant to Section 5.13 hereof.

(b) In the event that this Agreement is terminated by Buyer or Seller (the "**Terminating Party**") because the other party (the "**Breaching Party**") refuses to close the transactions contemplated by this Agreement, other than as expressly permitted hereunder, when the Terminating Party is in compliance in all material respects with the

terms of this Agreement, then the Breaching Party shall, within five business days after receipt of written notice of such termination, pay to the Terminating Party by wire transfer of immediately available funds to an account designated by the Terminating Party a fee equal to $4,500,000 (the "**Termination Fee**"). The parties acknowledge and agree that the agreements contained in this Section are an integral part of the transactions contemplated by this Agreement and constitute liquidated damages and not a penalty. If the Breaching Party fails to pay the Termination Fee in accordance with the terms of this Section 8.04(b), then the Breaching Party shall pay the costs and expenses (including legal fees and expenses) of the Terminating Party in connection with any action, including the filing of any lawsuit or other legal action, taken to collect payment, together with interest as provided in Section 9.19 from the date such Termination Fee was required to be paid. Notwithstanding anything to the contrary in this Agreement, the Terminating Party's right to receive payment of the Termination Fee pursuant to this Section 8.04(b), and the right to receive the payment of its costs and expenses as provided in this Section 8.04(b), shall be the sole and exclusive remedy of the Terminating Party against the Breaching Party and its Affiliates for any and all Losses that may be suffered based upon, resulting from or arising out of the circumstances giving rise to such termination, and upon payment of the Termination Fee in accordance with this Section 8.04(b), neither the Breaching Party nor any of its Affiliates or their respective stockholders, partners or members shall have any further liability or obligation relating to or arising out of this Agreement or the transactions contemplated by this Agreement.

(c) If this Agreement is validly terminated pursuant to Section 8.04(a), this Agreement will be null and void, and there will be no liability on the part of any party pursuant to this Agreement, except that (i) upon termination of this Agreement pursuant to Section 8.04(a), subject to Section 8.04(b), Seller will remain liable to Buyer and Buyer will remain liable to Seller for any breach of their respective obligations existing at the time of such termination, and each party may seek such remedies or damages against the other with respect to any such breach as are provided in this Agreement or as are otherwise available at law or in equity and (ii) the expense allocation provisions of Section 5.16 and the confidentiality provisions of Section 9.21 shall remain in full force and effect and survive any termination of this Agreement.

(d) Upon termination of this Agreement, each party's existing rights of access to the books and records of the other party shall terminate, and each party shall promptly return every document furnished it by the other party (or any Affiliate of such other party) in connection with the transactions contemplated hereby, whether obtained before or after execution of this Agreement, and all copies thereof, and will destroy all copies of any analyses, studies, compilations or other documents prepared by it or its representatives to the extent they contain any information with respect to the business of the other parties hereto or their Affiliates, and will cause its representatives to whom such documents were furnished to comply with the foregoing. This Section 8.04 shall survive any termination of this Agreement.

9. INDEMNIFICATION

9.01. Indemnification by Seller. Subject to the conditions and limitations, and solely to the extent provided in this Article 9, Seller shall indemnify, defend and hold harmless Buyer's Indemnified Persons, and each of them, from and against any Losses incurred or suffered by Buyer's Indemnified Persons, directly or indirectly, as a result of or arising from:

(a) any inaccuracy in or breach of any representation or warranty of Seller set forth in this Agreement or in any Closing Document to which Seller is a party, whether or not Buyer's Indemnified Persons relied thereon or had knowledge thereof, *provided* that, in determining whether there has been any such inaccuracy or breach, any qualification as to materiality included in any representation or warranty shall not be taken into account;

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

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

(d) the Excluded Liabilities;

(e) any actual damages (including reasonable attorneys' fees) resulting from claims by any creditor of Seller relating to a claim in existence as of the Closing Date that the transfer of any of the Assets constitutes a fraudulent conveyance or transfer, or is avoidable under applicable state or federal insolvency, bankruptcy, bulk sales, fraudulent conveyance or creditors' rights Legal Requirements; and

(f) any liabilities, costs or expenses incurred by Buyer or its Affiliates in connection with the Transfer Act Activities contemplated by Section 5.08.

9.02. Seller's Limitations. Seller will have no liability under Section 9.01(a) and no claim will accrue against Seller under Section 9.01(a) unless and until the total amount of Losses that would otherwise be indemnifiable by Seller in respect of claims arising under Section 9.01(a) exceeds $675,000 (the "**Seller Deductible**") in the aggregate, at which time Buyer's Indemnified Persons shall be entitled to indemnification for all Losses under Section 9.01(a) in excess of the Seller Deductible, *provided* that there shall be no minimum Loss requirement, and liability of Seller shall arise for all Losses, in respect of Losses resulting from Seller's intentional misrepresentation or fraud.

9.03. Indemnification by Buyer. Subject to the conditions and limitations, and solely to the extent, provided in this Article 9, Buyer shall indemnify, defend and hold harmless Seller's Indemnified Persons, and each of them, from and against any Losses incurred or suffered by Seller's Indemnified Persons, directly or indirectly, as a result of or arising from:

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

that, in determining whether there has been any such inaccuracy or breach, any qualification as to materiality included in any representation or warranty shall not be taken into account;

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

(c) the Assumed Liabilities; and

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

9.04. Buyer's Limitations. Buyer will have no liability under Section 9.03(a) and no claim will accrue against Buyer under Section 9.03(a) unless and until the total amount of Losses that would otherwise be indemnifiable by Buyer in respect of claims arising under Section 9.03(a) exceeds $675,000 (the "**Buyer Deductible**") in the aggregate, at which time Seller's Indemnified Persons shall be entitled to indemnification for all Losses under Section 9.03(a) in excess of the Buyer Deductible, *provided* that there shall be no minimum Loss requirement, and liability of Buyer shall arise for all Losses, in respect of Losses resulting from any intentional misrepresentation or fraud by Buyer.

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

(a) Third Party Claims.

(i) If the basis for any claim for indemnification against an Indemnifying Party pursuant to this Article 9 is a claim or demand made against an Indemnitee by a Person other than Buyer's Indemnified Person or Seller's Indemnified Person (a "**Third Party Claim**"), the Indemnitee shall deliver a Claim Notice with reasonable promptness to the Indemnifying Party (with copies of all relevant written documentation, including papers served, if any, and a reasonable summary of any relevant oral discussions with such third party) specifying the nature of and alleged basis for the Third Party Claim and, to the extent then feasible and known, the alleged amount or the estimated amount of the Third Party Claim. If the Indemnitee fails to deliver the Claim Notice (and related materials) to the Indemnifying Party within 60 days after the Indemnitee receives notice of such Third Party Claim, the Indemnifying Party will not be obligated to indemnify the Indemnitee with respect to such Third Party Claim if and only to the extent that the Indemnifying Party's ability to defend the Third Party Claim or otherwise minimize the Losses for which the Indemnifying Party must indemnify the Indemnitee has been prejudiced by such failure. The Indemnifying Party will notify the Indemnitee within 15 days after receipt of the Claim Notice by the Indemnifying Party (the "**Notice Period**") whether the Indemnifying Party elects, at the sole cost and expense of the Indemnifying Party, to assume the defense of the Indemnitee against the Third Party Claim.

(ii) If the Indemnifying Party notifies the Indemnitee within the Notice Period that the Indemnifying Party elects to assume the defense of the Indemnitee against the Third Party Claim, then the Indemnifying Party will defend, at its sole cost and expense, the Third Party Claim by all appropriate proceedings, which proceedings will be diligently prosecuted by the Indemnifying Party to a final conclusion or settled, at the discretion of the Indemnifying Party (with the consent of the Indemnitee, which consent shall not be unreasonably withheld with respect to any settlement that does not include any non-monetary relief). The Indemnifying Party will have full control of such defense and proceedings, including any compromise or settlement thereof; *provided* that, prior to the Indemnitee's receipt of the Indemnifying Party's notice that it elects to assume such defense, the Indemnitee may file, at the sole cost and expense of the Indemnitee, any motion, answer or other pleading that the Indemnitee reasonably deems necessary to protect its interests and that is not prejudicial to the Indemnifying Party (it being understood that, except as provided in this Section 9.05(a)(ii), if an Indemnitee takes any such action that is prejudicial to the Indemnifying Party, the Indemnifying Party will be relieved of its obligations hereunder with respect to that portion of the Third Party Claim (or the Losses attributable thereto) prejudiced by the Indemnitee's action); and *provided further* that, if requested by the Indemnifying Party, the Indemnitee shall reasonably cooperate, at the sole cost and expense of the Indemnifying Party, with the Indemnifying Party and its counsel in contesting any Third Party Claim that the Indemnifying Party elects to contest or, if related to the Third Party Claim, in making any counterclaim or cross-claim against any Person (other than the Indemnitee or its Affiliates). The Indemnitee may participate in, but not control, any defense or settlement of any Third Party Claim assumed by the Indemnifying Party pursuant to this Section 9.05(a)(ii) and, except in respect of cooperation requested by the Indemnifying Party as provided in the preceding sentence, the Indemnitee will bear its own costs and expenses with respect to such participation. Notwithstanding the foregoing, the Indemnifying Party may not assume the defense of the Third Party Claim on behalf of the Indemnitee if (1) the Persons against whom the Third Party Claim is made, or any impleaded Persons, include both one or more of Buyer's Indemnified Persons and one or more of Seller's Indemnified Persons, and (2) representation of all of such Persons by the same counsel creates an actual or potential conflict of interest that, after giving effect to any waivers made by such Persons, would breach or violate the ethical rules applicable to such counsel, in which case the Indemnitee shall have the right to defend the Third Party Claim on its own behalf and to employ counsel at the expense of the Indemnifying Party.

(iii) If the Indemnifying Party fails to notify the Indemnitee within the Notice Period that the Indemnifying Party intends to defend the Indemnitee against the Third Party Claim, or if the Indemnifying Party gives such notice but fails to diligently prosecute or settle the Third Party Claim, or if the Indemnifying Party is precluded by the last sentence of Section 9.05(a)(ii) from assuming the defense of such Third Party Claim, then (A) the Indemnitee will defend the Third Party Claim by all appropriate proceedings, which proceedings will be diligently

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

(b) First Party Claims.

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

(ii) Upon receipt of any Indemnity Notice, the Indemnifying Party will be entitled to request in writing and receive from the Indemnitee a reasonable extension of the 60-day period in which to respond pursuant to Section 9.05(b)(i) for the purpose of investigating the claims made therein or the proper amount thereof. The Indemnitee, to the extent requested by the Indemnifying Party, shall reasonably cooperate, at the sole cost and expense of the Indemnifying Party, with the Indemnifying Party's investigation of such claims or the proper amount thereof.

(c) Resolution of Disputes. If the Indemnifying Party timely disputes, or is deemed to have disputed, its liability with respect to a claim described in a Claim Notice or an Indemnity Notice, the Indemnifying Party and the Indemnitee shall proceed promptly and in good faith to negotiate a resolution of such dispute within 60 days following receipt by the Indemnifying Party of the Claim Notice or Indemnity Notice and, if such dispute is not resolved through negotiations during such 60-day period, it shall be resolved pursuant to Section 9.05 and, if not resolved thereby, by other appropriate legal process.

(d) Payment of Indemnifiable Losses. Subject to the terms of any final order entered by a court of competent jurisdiction, the Indemnifying Party shall pay the amount

of any indemnifiable Losses to the Indemnitee within ten days following the later to occur of (i) the date on which such indemnifiable Losses are incurred or sustained by the Indemnitee or (ii) the date on which the Indemnifying Party has acknowledged its liability for such indemnifiable Losses. Indemnifiable Losses not paid when so due shall accrue interest from (and including) the date on which such indemnifiable Losses were incurred or sustained by the Indemnitee until (but excluding) the date on which such amount is paid, at the interest rate provided in Section 9.19.

(e) Certain Disclaimers. Any estimated amount of a claim submitted in a Claim Notice or an Indemnity Notice shall not be conclusive of the final amount of such claim, and the giving of a Claim Notice when an Indemnity Notice is properly due, or the giving of an Indemnity Notice when a Claim Notice is properly due, shall not impair such Indemnitee's rights hereunder. Notice of any claim comprised in part of Third Party Claims and claims that are not Third Party Claims shall be appropriately bifurcated and given pursuant to each of Section 9.05(a)(i) and Section 9.05(b)(i), as applicable.

9.06. Survival of Representations and Warranties; Indemnity Periods. Notwithstanding any right of Buyer to investigate Seller and the Hospital Businesses or any right of any party to investigate the accuracy of the representations and warranties of the other party in this Agreement, or any actual investigation by or knowledge of a party, Seller has, on the one hand, and Buyer has, on the other hand, the right to rely fully upon the representations and warranties of the other in this Agreement. The representations and warranties of Seller and Buyer in this Agreement respectively will survive the Closing (a) indefinitely with respect to matters covered by Sections 2.04, 3.01, 3.02, 3.03, 3.08, 4.01, 4.02, 4.04, 8.04(b), 8.04(c), 8.04(d), 9.01(b)-(e), 9.03(b)-(d), 10.15, 9.19, 9.21 and 10.23, (b) until the expiration of all applicable statutes of limitations (including all periods of extension) with respect to matters covered by Sections 3.04, 3.06, 3.08, 3.09(a), 3.10, 3.13, 3.17, 3.19 and 3.23, and (c) until the second anniversary of the Closing Date in the case of all other representations and warranties, except that:

(i) the right to indemnification with respect to any claim relating to a breach or default of any representation and warranty whose survival expires in accordance with clause (b) or (c) above will continue to survive if a Claim Notice or an Indemnity Notice with respect to such claim has been given on or before the expiration of such representation or warranty until the claim for indemnification has been satisfied or otherwise resolved as provided in this Article; and

(ii) in the event of intentional misrepresentation or fraud in the making of any representation and warranty, all representations and warranties that are the subject of the intentional misrepresentation, fraud or intentional nonfulfillment or breach shall survive until the expiration of all applicable statutes of limitations (including all periods of extension) with respect to claims made for such intentional misrepresentation, fraud or intentional nonfulfillment or breach.

9.07. Mitigation. Each Indemnitee shall take all commercially reasonable steps to mitigate its Losses upon and after becoming aware of any event or condition that has given rise to any Losses for which it may be indemnified pursuant to this Agreement. The amount of Losses for which an Indemnitee may make an indemnification claim pursuant to this Agreement

shall be reduced by any amounts actually recovered by the Indemnitee under insurance policies or other collateral sources (such as contractual indemnities of any Person that are contained outside of this Agreement or the Closing Documents) with respect to such Losses. Each Indemnitee must use commercially reasonable efforts to obtain recovery under such insurance policies or other collateral sources. To the extent that any payment received by an Indemnitee under any insurance policy or other collateral source was not previously taken into account to reduce the amount of indemnifiable Losses paid to such Indemnitee, such Indemnitee shall promptly pay over to the Indemnifying Party the amount so recovered or realized (after deducting therefrom the full amount of the expenses incurred by the Indemnitee in procuring such recovery or realization), but such amount paid over to the Indemnifying Party shall not exceed the sum of (a) the amount previously paid by the Indemnifying Party to the Indemnitee in respect of such matter plus (b) the amount expended by the Indemnifying Party in pursuing or defending any third party claim arising out of such matter. Notwithstanding the foregoing, no Indemnitee shall be required to seek recovery under any insurance policy issued by, or other collateral source that is, an Affiliate of the Indemnitee.

9.08. Indemnity Reserve. Seller agrees to maintain an indemnity reserve in the amount of $3,000,000 (Three Million Dollars) for a period of three years after the Closing so that Buyer will have meaningful financial recourse against Seller for indemnification claims.

10. GENERAL

10.01. Exhibits; Schedules.

(a) Each Schedule and Exhibit to this Agreement shall be considered a part hereof as if set forth herein in full. From the date hereof until Closing, Seller shall update its Schedules such that all of its representations and warranties are true and accurate as of the Closing Date. Any other provision herein to the contrary notwithstanding, all Schedules, Exhibits, or other instruments provided for herein and not delivered at the time of execution of this Agreement or that are incomplete at the time of execution of this Agreement shall be delivered or completed within ten (10) days after the date hereof or ten (10) days prior to the Closing, whichever is sooner.

(b) Nothing in the Schedules shall be deemed adequate to disclose an exception to a representation or warranty made in this Agreement unless the Schedule identifies the exception with reasonable particularity and, without limiting the generality of the foregoing, the mere listing of a document as an exception to any representation and warranty shall not be deemed to disclose the contents of such document as an exception to any representation or warranty (but shall be adequate to disclose the existence of the document itself).

10.02. Equitable Remedies. Subject to Section 8.04(b), each party acknowledges and agrees that its breach of this Agreement, or its failure to perform its obligations pursuant to this Agreement in accordance with its specific terms, would cause the other party to suffer irreparable damage or injury that would not be fully compensable by money damages, or the exact amount of which may be impossible to determine, and, therefore, such other party would not have an adequate remedy available at law. Accordingly, each party agrees that the other

party shall be entitled to seek specific performance, injunctive and/or other equitable relief from any court of competent jurisdiction (without the necessity of posting bond) as may be necessary or appropriate to enforce specifically this Agreement and the terms and provisions hereof and to prevent or curtail any breach (or threatened breach) of the provisions of this Agreement. Such equitable remedies shall not be the exclusive remedy of any party for any such breach or failure to perform by another party, but shall be in addition to all other remedies available to such party at law or in equity (the availability of which remedies shall be, after the Closing, subject to the applicable limitations set forth in Article 9).

10.03. Other Owners of Assets. Buyer, Seller and its undersigned Subsidiaries acknowledge that certain Assets may be owned by Subsidiaries of Seller and not Seller. Notwithstanding the foregoing, and for purposes of all representations, warranties, covenants, and agreements contained herein, Seller agrees, and, as evidenced by their acknowledgement to this Agreement, its undersigned Subsidiaries agree and acknowledge, that (i) its obligations with respect to any Assets shall be joint and several with any Subsidiary of Seller that owns or controls such Assets, (ii) the representations and warranties herein, to the extent applicable, shall be deemed to have been made by, on behalf of and with respect to such Subsidiaries of Seller in their ownership capacity, and (iii) it has the legal capacity to cause, and it shall cause, any of its Subsidiaries that owns or controls any Assets to meet all of Seller's obligations under this Agreement with respect to such Assets. Seller hereby waives any defense to a claim made by Buyer or its Affiliates under this Agreement based on the failure of any Person who owns or controls the Assets to be a party to this Agreement. Notwithstanding the foregoing, the parties acknowledge and agree that Seller shall not make pursuant to this Agreement, and this Section 9.04 shall not otherwise suggest, any representation, warranty or other commitment as to the Subsidiaries of Seller listed on Schedule 10.03.

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

(a) In the event of a controversy or claim arising under this Agreement, either party may give the other party notice of such dispute pursuant to Section 9.15 hereof, and promptly thereafter the parties will each select two or more senior executives to negotiate in good faith in an effort to resolve the controversy or claim. The senior executives shall meet at such location as from time to time may be mutually agreed by the parties and such meetings shall be in person to the extent practicable.

(b) If the parties are unable to resolve the controversy or claim as provided in Section 9.059.05(a) within 30 days of the notice of the controversy or claim, then either party may notify the other party that it wants to pursue non-binding mediation in an attempt to resolve the controversy or claim. The parties shall jointly appoint a mutually acceptable mediator to mediate the dispute or, if the parties are unable to agree on a mutually acceptable mediator within 15 days after receipt of notice requesting mediation, then the parties shall request assistance from the American Arbitration Association in finding a mutually acceptable mediator. Each party shall bear its own costs incurred in the mediation and shall bear one-half the costs and expenses of the mediator and any similar parties that may assist in the mediation. The parties agree to participate in good

faith in the mediation and negotiations related thereto for a period of 30 days, unless a longer period is otherwise agreed.

10.05. Tax and Government Payment Program Effect. None of the parties (nor such parties' counsel or accountants) has made or is making in this Agreement any representation to any other party (or such party's counsel or accountants) concerning any of the Tax or Government Payment Program effects or consequences on the other party of the transactions provided for in this Agreement. Each party represents that it has obtained, or may obtain, independent Tax and Government Payment Program advice with respect thereto and upon which it, if so obtained, has solely relied.

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

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

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

10.09. Consents, Approvals and Discretion. Except as expressly provided to the contrary in this Agreement, whenever this Agreement requires any consent or approval to be given by any

party or any party must or may exercise discretion, such consent or approval shall not be unreasonably withheld or delayed and such discretion shall be reasonably exercised.

10.10. Choice of Law. This Agreement and all matters arising out of or relating to this Agreement shall be governed by and construed in accordance with the laws of the State of Connecticut without regard to any conflicts of laws rules (whether of the State of Connecticut or any other jurisdiction). Any litigation or proceedings among the parties arising out of or relating to this Agreement shall be commenced in a court of the State of Connecticut or the federal district court of Connecticut.

10.11. Benefit and Assignment. Subject to the provisions herein to the contrary, this Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective legal representatives, successors and assigns; *provided* however that no party may assign this Agreement without the prior written consent of the other party.

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

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

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

If to Buyer: [BUYER]

_____
_____
_____
Attn:
Fax:
Email:

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

[INSERT NAME AND ADDRESS]

If to Seller: Eastern Connecticut Health Network, Inc.
General Counsel
Eastern Connecticut Health Network
71 Haynes Street
Manchester, Connecticut 06040
Attn: Joyce Tichy
Fax:
Email: jtichy@echn.org

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

Ropes & Gray LLP
Prudential Tower
800 Boylston Street
Boston, MA 02199-3600
Attn: Anne Ogilby
Fax: 617-235-0234
Email: anne.ogilby@ropesgray.com

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

10.15. Misdirected Payments; Physician Loans. After Closing, (a) Seller shall remit to Buyer with reasonable promptness any monies received by Seller (or its Affiliates) constituting or in respect of the Assets and Assumed Liabilities, and (b) Buyer shall remit to Seller with reasonable promptness any monies received by Buyer (or its Affiliates) constituting or in respect of the Excluded Assets and Excluded Liabilities. If any funds previously paid or credited to Seller or the Hospital Businesses in respect of services rendered on or before the Closing Date have resulted in an overpayment or must be repaid, Seller shall be responsible for the repayment of said monies (and the defense of such actions), except to the extent that such credit or repayment obligation was included in the calculation of Net Working Capital as shown on the Closing Balance Sheets in which case Seller shall not be liable for any such repayment. If Buyer suffers any deduction to or offset or withhold against amounts due Buyer of funds previously paid or credited to Seller or the Hospital Businesses in respect of services rendered on or before the Closing Date (other than in respect of overpayments addressed by the preceding sentence),

Seller shall pay to Buyer the amounts so deducted, offset or withheld within five business days after demand therefor, except to the extent that the amount of such deduction, offset or withholding was included in the calculation of Net Working Capital as shown on the Closing Balance Sheets. Any amounts payable pursuant to this Agreement that are due Buyer by Seller or one of its Affiliates, or due Seller by Buyer or one of its Affiliates, may be offset against monies or other funds owed by the party entitled to receive payment to the party required to make payment (other than such owed amounts that are being disputed in good faith). Seller shall use, and cause its Affiliates to use, good faith efforts to collect any and all loans and other amounts due from physicians and their Affiliates that constitute Excluded Assets.

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

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

10.18. Entire Agreement; Amendment. This Agreement supersedes all previous contracts, agreements and understandings and constitutes the entire agreement of whatsoever kind or nature existing between or among the parties respecting the within subject matter and no party shall be entitled to benefits with respect to the Assets or the Hospital Businesses other than those specified in this Agreement. As between or among the parties, any oral or written representation, warranty, covenant, agreement or statement not expressly incorporated in this Agreement, whether given before or on the date of this Agreement, shall be of no force and effect unless and until made in writing and signed by the parties on or after the date of this Agreement. The representations, warranties and covenants set forth in this Agreement shall survive the Closing and remain in full force and effect as provided in Section 8.05, and shall survive the execution and delivery of, and shall not be merged with or into, the Closing Documents and all other agreements, instruments or other documents described, referenced in or contemplated by this Agreement. Each representation, warranty and covenant in this Agreement has independent legal significance and if any party has breached any representation, warranty or covenant in any respect, whether there exists another representation, warranty or covenant relating to the same subject matter (regardless of the relative level of specificity) that such party has not breached shall not detract from or mitigate the party's breach of the first representation, warranty or covenant. This Agreement may not be amended or supplemented except in a written instrument executed by each of the parties.

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

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

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

10.22. Confidentiality; Public Announcements.

(a) Except as required by Legal Requirements or in order to coordinate the defeasance of tax-exempt debt, Seller and Buyer (and their respective Affiliates) shall keep this Agreement and the Closing Documents and their contents confidential and not disclose the same to any Person (except the parties' attorneys, accountants or other professional advisors who need to know such contents for the purpose of advising such party in connection with the transactions contemplated hereby, and except to the applicable Governmental Authorities in connection with any required notification or application for approval or a license or exemption therefrom) without the prior written consent of the other party.

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

10.23. Guarantee of Buyer's Obligations. [Buyer's ultimate parent], as principal obligor and not merely as a surety, hereby unconditionally guarantees full, punctual and complete performance by Buyer of all of Buyer's obligations under this Agreement and each of the

Closing Documents subject to the terms hereof and thereof and so undertakes to Seller that, if and whenever Buyer is in default, [Buyer's ultimate parent] will on demand duly and promptly perform or procure the performance of Buyer's obligations. The foregoing guarantee is a continuing guarantee and will remain in full force and effect indefinitely (in light of the fact that, as provided in Section 8.05, certain representations, warranties, covenants and indemnification obligations of Buyer survive the Closing indefinitely) and will be reinstated with respect to any sum paid to Seller that must be restored by Seller upon the bankruptcy, liquidation or reorganization of Buyer. [Buyer's ultimate parent's] obligations under this Section 10.23 shall not be affected or discharged in any way by any Proceeding with respect to Buyer under any federal or state bankruptcy, insolvency or debtor relief laws (or any order, judgment, ruling, writ, injunction or decree entered or made in connection therewith) or any other fact, development, occurrence or circumstance affecting the legal capacity of Buyer or the enforceability of this Agreement or any of the Closing Documents against Buyer in accordance with their respective terms.

[*Signature Page Follows*]

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

EASTERN CONNECTICUT HEALTH NETWORK, INC.

By: _____

Title: _____

[BUYER]

By: _____

Title: _____

[*Acknowledgement Page Follows*]

Each of the undersigned Subsidiaries of Seller hereby joins this Agreement to acknowledge that Seller has executed this Agreement on its behalf and that, with respect to the Assets or Hospital Businesses owned or operated by it, it is subject to and bound by the same obligations, representations, and warranties as Seller as provided under Section 9.04.

ACKNOWLEDGED BY:

THE MANCHESTER MEMORIAL HOSPITAL

By: _____

Title: _____

THE ROCKVILLE GENERAL HOSPITAL, INCORPORATED

By: _____

Title: _____

ECHN ELDERCARE SERVICES, INC.

By: _____

Title: _____

VISITING NURSE AND HEALTH SERVICES OF CONNECTICUT, INC.

By: _____

Title: _____

A CARING HAND, LLC

By: _____

Title: _____

ECHN ENTERPRISES, INC.

By: _____

Title: _____

HAYNES STREET PROPERTY MANAGEMENT, LLC

By: _____

Title: _____

ECHN CORPORATE SERVICES, INC.

By: _____

Title: _____

MEDICAL PRACTICE PARTNERS, LLC

By: _____

Title: _____

CLINICALLY INTEGRATED NETWORK OF EASTERN CONNECTICUT, LLC

By: _____

Title: _____

CONNECTICUT HEALTHCARE INSURANCE COMPANY, INC.

By: _____

Title: _____

EASTERN CONNECTICUT MEDICAL PROFESSIONALS FOUNDATION, INC.

By: _____

Title: _____

Exhibit A

Form of Transitional Services Agreement

See attached.

Exhibit B

Form of Limited Power of Attorney

See attached.

Schedule 1.02

Persons with "Seller's Knowledge"

Peter Karl	President and Chief Executive Officer
Dennis McConville	Senior Vice President and Chief Strategy Officer
Michael Veillette	Senior Vice President and Chief Financial Officer
Joel J. Reich, M.D.	Senior Vice President, Medical Affairs and Chief Medical Officer

[__], 2015

[INSERT ADDRESS]

Re: Termination Fee for Asset Purchase Agreement

Dear [ ]:

Reference is made to that certain Asset Purchase Agreement, attached hereto as Exhibit A (the "Asset Purchase Agreement"), by and among Eastern Connecticut Health Network, Inc. ("Seller") and its affiliates, including The Manchester Memorial Hospital, Visiting Nurse and Health Services of Connecticut, Inc., including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, ECHN ElderCare Services, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, Clinically Integrated Network of Eastern Connecticut, LLC, and Eastern Connecticut Medical Professionals Foundation, Inc. and [ ] ("Buyer") and [ ] ("Buyer's Ultimate Parent"), which is agreeing to be jointly and severally liable with Buyer hereunder, providing for the sale of substantially all the assets of Seller and its Subsidiaries to Buyer (the "Transaction"). Each of the Buyer and Seller is referred herein as a "Party" and collectively as the "Parties." Capitalized terms used but not otherwise defined in this side letter (this "Side Letter") shall have the meanings given to such terms in the Asset Purchase Agreement.

For good and valuable consideration, including the agreement by each Party to undertake the expense and effort of obtaining regulatory approvals needed to carry out the Transaction, the Parties hereto hereby agree as follows:

1. If the Parties fail to complete the Transaction as contemplated in the Asset Purchase Agreement other than for a reason that would be permitted under Section 5.23 of such agreement (draft of January __, 2015, a copy of which is attached hereto as Exhibit A) if such agreement had been duly executed, then the Party that refuses to complete the Transaction contemplated by the Asset Purchase Agreement (the "Breaching Party") shall, within five days of receipt of written notice from the other party (the "Non-Breaching Party"), pay to the Non-Breaching Party by wire transfer of immediately available funds to an account designated by the Non-Breaching Party a fee equal to $4,500,000 (Four Million and Five Hundred Thousand) (the "Termination Fee"). If the Breaching Party fails to pay the Termination Fee in accordance with the terms of this Side Letter, then the Breaching Party shall pay the costs and expenses (including legal fees and expenses) of the Non-Breaching Party in connection with any action, including the filing of any lawsuit or other legal action, taken to collect payment, together with interest as provided in Section 10.20 of the Asset Purchase Agreement from the date such Termination Fee was required to be

paid. Notwithstanding anything to the contrary in the Asset Purchase Agreement, the Terminating Party's right to receive payment of the Termination Fee pursuant to this Side Letter, and the right to receive the payment of its costs and expenses as provided in this Side Letter, shall be the sole and exclusive remedy of the Non-Breaching Party against the Breaching Party and its Affiliates for any and all Losses that may be suffered based upon, resulting from or arising out of the circumstances giving rise to the failure to complete the Transaction, and upon payment of the Termination Fee in accordance with this Side Letter, neither the Breaching Party nor any of its Affiliates or their respective stockholders, partners or members shall have any further liability or obligation relating to or arising out of the Asset Purchase Agreement or the Transaction contemplated thereunder.

2. From the execution date of this Side Letter until the Closing Date, in the event Buyer or Buyer's Ultimate Parent enters into a similar affiliation arrangement with another community acute care hospital or health system located in the State of Connecticut, Buyer or Buyer's Ultimate Parent shall provide a copy to ECHN of the agreements relating to such arrangement within fifteen (15) days of Buyer or Buyer's Ultimate Parent entering into a binding agreement with such entity. If ECHN determines in good faith that the terms of such arrangement are more favorable to such entity than the terms applicable to ECHN under the Asset Purchase Agreement, ECHN shall provide written notice to Buyer and Buyer's Ultimate Parent within fifteen (15) days of receipt of the binding agreements. Within forty-five (45) days of ECHN's delivery of such notice, Buyer, Buyer's Ultimate Parent and ECHN agree to amend the terms of the Asset Purchase Agreement to incorporate for the benefit of ECHN such more favorable terms.

3. Buyer agrees that if the Office of Health Care Access of the Connecticut Department of Public Health ("OHCA") and/or the Connecticut Attorney General ("AG") imposes conditions on Buyer as part of the certificate of need and/or hospital conversion approval process equivalent to those imposed in OHCA's December 1, 2014 proposed decision in the matter of *Greater Waterbury Health Network, Inc. and Vanguard Health Systems, Inc.* (Docket No. 13-31838-486), a copy of which is attached as Exhibit B, and/or the AG's December 1, 2014 proposed decision *In re Application for Joint Venture Between Greater Waterbury Health Network, Inc. and Vanguard Health Systems, Inc.* (Docket No. OAG 13-486-01), a copy of which is attached as Exhibit C, Buyer shall consider such conditions to be "reasonably satisfactory" for purposes of Section 7.04 of the Asset Purchase Agreement and will not refuse to consummate the transactions contemplated in the Asset Purchase Agreement as a result of such conditions.

4. This Side Letter shall be governed by the interpretation and enforcement provisions of Article 10 of the Asset Purchase Agreement as if such provisions were incorporated herein.

[Remainder of page left intentionally blank]

Very truly yours,

SELLER:

EASTERN CONNECTICUT HEALTH NETWORK, INC.

By: _____
Name: Peter J. Karl
Title: President and CEO

Acknowledged and agreed to by the undersigned, acting jointly and severally, as of the date first set forth above.

BUYER:

[INSERT NAME OF BUYER]

By: _____
Name:
Title:

[INSERT NAME OF BUYER'S ULTIMATE PARENT]

By: _____
Name:
Title:

EXHIBIT Q5-3 - PROSPECT SOUTHERN CALIFORNIA FACT SHEET



The Prospect Medical Family
Southern California

Southern California Network

Prospect provides quality, coordinated healthcare and physician services in three Southern California counties where it owns and operates seven acute care hospitals. Prospect hospitals maintain contracts with all the major health plans. Through its management services companies and its network of over 8,900 specialty and primary care physicians, Prospect also manages the provision of physician services to approximately 257,000 Southern California members.

Prospect Operations

- Southern California Hospital at Culver City
- Southern California Hospital at Hollywood
- Southern California Hospital at Van Nuys
- Los Angeles Community Hospital at Los Angeles
- Los Angeles Community Hospital at Bellflower
- Los Angeles Community Hospital at Norwalk
- Foothill Regional Medical Center
- Prospect Medical Group
- ProMed Health Services

Key Facts

Total beds	1,080
ER visits	41,671
Patients admitted	26,681
Inpatient surgeries	3,604
Outpatient surgeries	2,990

SOUTHERN CALIFORNIA HEALTHCARE SYSTEM, INC.



Southern California Hospital at Culver City.



ProMed Health Care Administrators.

Prospect's Southern California Model: Coordinated-Regional-Care

Several years prior to the introduction of the Affordable Care Act, Prospect was among the first healthcare providers to adopt an operating model that prefigures the objectives of the legislation. In Southern California, Prospect has successfully implemented a quality, cost-effective healthcare solution through its unified network of hospitals and medical groups that is designed to provide Coordinated-Regional-Care.

Development of Prospect's C-R-C model in Southern California began in 2007 when the company acquired a group of four community-based hospitals in Los Angeles County. Prospect also expanded its Prospect Medical Group services into San Bernardino County with the acquisition of ProMed Health Services Company and its affiliates. In 2009, Prospect acquired an additional Los Angeles County hospital, Southern California Hospital at Culver City (formerly known as Brotman Medical Center), a 420-bed general acute care hospital in Culver City. And in 2014, Prospect's Southern California operations further expanded with the acquisition of Bellflower Medical Center (since renamed Los Angeles Community Hospital at Bellflower) and Newport Specialty Hospital in Tustin (now known as Foothill Regional Medical Center).

While developing this unified network, Prospect has been able to respond to the rapid changes in reimbursement and care delivery by operating its hospitals efficiently, aligning physician interests with the efficient and effective delivery of health care, and offering a full continuum of non-acute services in the hospitals' service areas. The goal of C-R-C is to ensure that patients receive the right care, at the right time, in the right setting, while avoiding unnecessary, inefficient and duplicative services and reducing medical errors. Prospect is committed to providing a Coordinated-Regional-Care solution in the communities that it serves.

Prospect's Commitment to the Community
Southern California

Prospect has a strong track record of supporting the communities served by its hospitals and other health care-related businesses. This includes offering discounted or charity care to uninsured and underinsured patients, as well as financial and other support to community charitable organizations. We provide award-winning care designed to meet the specific needs of the diverse populations we serve. And we take pride in the extensive positive impact – both financial and cultural – that our hospitals have on their communities.

Charity Care

In 2014, Prospect's Southern California hospitals provided $626,000 in charity care and $25 million in uncompensated care for patients who were unable to pay for the medical care they received. We also supported a wide variety of nonprofit community, education and service organizations, including:

- American Red Cross
- National Health Foundation
- Partners in Care
- Arthritis Foundation
- Starlight Foundation
- Wounded Warriors
- Culver City's *Fiesta La Ballona*
- Academy of Persian Physicians
- Culver Palms YMCA
- Feeding America

Economic Impact

Prospect's hospitals and businesses had a significant economic impact in 2014 on the Southern California communities in which we operate.

• Total number of employees	3,107
• Salaries, wages and benefits	$164,447,107
• Capital investment	$17,450,842
• Property taxes paid	$1,306,226
• Sales taxes paid	$1,923,667

Awards & Distinctions

Prospect's hospitals and other businesses continue to receive recognition for the quality of care they provide. Recent awards and distinctions earned by some of our Southern California facilities include:

- Top 10% Nationwide for Stroke Care by CareChex
- Top 10% Nationwide for Women's Health by CareChex
- Top 15% Nationwide for Gastrointestinal Health by CareChex
- California Association of Physician Groups — Standards of Excellence Program — Elite Status (Prospect Medical Group)
- California Association of Physician Groups — Standards of Excellence Program — Elite Status (ProMed Health Services)

Medical Services

Clinical programs and services at Prospect hospitals in Southern California are designed to meet the needs of the diverse communities they serve and are provided to patients and their families in a warm, caring environment. Our services include:

- 24-Hour Emergency Care
- Bariatric & Surgical Weight Reduction
- Behavioral Health
- Bloodless Medicine & Surgery
- Cardiology
- Detox/Recovery Program
- Diabetes Program
- Endocrinology
- Family Medicine
- Gastroenterology
- Imaging
- Internal Medicine
- Nephrology
- Obstetrics and Gynecology
- Orthopedics
- Outpatient Services
- Pediatric Subacute
- Pediatrics
- Podiatry
- Pulmonology
- Rehabilitation
- Rheumatology
- Skilled Nursing
- Spine and Neurosurgery
- Surgical Services
- Urgent Care

About Prospect Medical Prospect Medical Holdings, Inc. is an innovative healthcare services company that owns 13 hospitals, with a total of 2,258 licensed beds, as well as 40 clinics and outpatient centers. Prospect also manages the provision of healthcare services for approximately 257,000 members enrolled in its networks of over 8,900 primary care physicians and specialists. Prospect's hospitals are located in diverse, high-density population areas within five markets in California, Texas, and Rhode Island.

PROSPECT MEDICAL HOLDINGS, INC.
10780 SANTA MONICA BLVD., SUITE 400, LOS ANGELES, CA 90025 www.pmh.com / 310.943.4500

EXHIBIT Q5-4 - PROSPECT RHODE ISLAND FACT SHEET



The Prospect Medical Family
Rhode Island

Rhode Island Network

CharterCARE Health Partners is a joint venture with Prospect Medical Holdings and CharterCARE Community Board that is developing an innovative regional coordinated health care network, anchored by 220-bed Roger Williams Medical Center and 278-bed Our Lady of Fatima Hospital.

Our network includes Elmhurst Extended Care, one of Rhode Island's largest long-term care facilities and the only one affiliated with a hospital system; St. Joseph Health Center, a network of primary care programs and specialty services for underserved children and families; the Roger Williams Cancer Center, the area's leader in cancer treatment and research programs; Southern New England Rehabilitation Center, the premier rehabilitation provider; the state's most comprehensive behavioral health program, and one of the state's busiest home health services. The joint venture also operates Prospect Provider Group of Rhode Island, an independent physician association with several hundred primary care and specialty physicians, and CharterCARE Medical Associates, a multi-group physician practice.

Key Facts

Total beds	579
ER visits	50,572
Patients admitted	12,847
Inpatient surgeries	3,139
Outpatient surgeries	8,240

CharterCARE HEALTH PARTNERS

Prospect Operations

- Roger Williams Medical Center
- Our Lady of Fatima Hospital
- St. Joseph Health Center
- Elmhurst Extended Care
- CharterCARE Home Health Services
- Prospect Provider Group of Rhode Island
- CharterCARE Medical Associates



Roger Williams Medical Center

Prospect's Track Record in Rhode Island

In June 2014, Prospect entered into a unique and innovative partnership in Rhode Island to help ensure the future of CharterCARE Health Partners' two hospitals – Roger Williams Medical Center and Our Lady of Fatima Hospital. Through a joint venture agreement, Prospect became the majority owner of CharterCARE but maintains a shared governance structure with local representation, including two hospital advisory boards.

Following Prospect's operating model of building Coordinated-Regional-Care networks of hospitals and medical groups that offer the entire continuum of care, Prospect and CharterCARE are developing Rhode Island's first fully clinically integrated, multi-level network of providers designed specifically for the challenges and opportunities of the healthcare reform era. This network of hospitals, physician groups and specialty service providers coordinates with one another to provide patients with quality healthcare, in a timely manner and in the right care setting.

Several years prior to the introduction of the Affordable Care Act, Prospect was among the first healthcare providers to adopt an operating model that prefigures the objectives of the legislation. Prospect is committed to providing a C-R-C solution in all of the communities that it serves.



Our Lady of Fatima Hospital

Prospect's Commitment to the Community
Rhode Island

Prospect has a strong track record of supporting the communities served by its hospitals and other health care-related businesses. This includes offering discounted or charity care to uninsured and underinsured patients, as well as financial and other support to community charitable organizations. We provide award-winning care designed to meet the specific needs of the diverse populations we serve. And we take pride in the extensive positive impact – both financial and cultural – that our hospitals have on their communities.

Charity Care

In 2014, CharterCARE provided nearly $3 million in charity care and $18.7 million in uncompensated care for patients who were unable to pay for the medical care they received. We also supported a wide variety of nonprofit community, education and service organizations, including:

- American Heart Association
- Crossroads Rhode Island
- The Tomorrow Fund
- Clinica Esperanza
- Federal Hill House
- Alzheimer's Association
- Arthritis Association
- RI Assisted Living Association
- Elmwood Neighborhood Association
- Brain Injury Association of RI
- Family Services of RI
- RI KIDS Count

Economic Impact

The CharterCARE hospitals and businesses had a significant economic impact in 2014 on the Rhode Island communities in which we operate.

• Total number of employees	2,874
• Salaries, wages and benefits	$194,870,564
• Capital investment*	$2,694,306
• Property taxes (paid/accrued)**	$312,951
• Sales taxes paid**	$618,570

*October 2013 to Sept 2014
** June to September 2014

Awards & Distinctions

Prospect's hospitals and other businesses continue to receive recognition for the quality of care they provide. Recent awards and distinctions earned by our Rhode Island facilities include:

Roger Williams Medical Center

- Joint Commission Certified as Advanced Primary Stroke Center, 2 years
- American Heart/Stroke Association's Silver Award for Advanced Primary Stroke Center's composite performance
- Highlighted in *Stroke* and *US News and World Report*, "Best Hospitals" issue, 2013
- Joint Commission's Gold Seal of Approval for total hip and knee replacement programs

Our Lady of Fatima Hospital

- Joint Commission Certified as Advanced Primary Stroke Center, 2 years
- Joint Commission Certified as Advanced Diabetes Center, 2 years
- Joint Commission Certified for Joint Replacement-Hip and Knee, 2 years
- Designated a NICHE hospital, Nursing Improving the Care of Hospitalized Elders
- Designated a Pathway to Excellence hospital by the American Nurses Association

Medical Services

Clinical programs and services at CharterCARE hospitals in Rhode Island are designed to meet the needs of the diverse communities they serve and are provided to patients and their families in a warm, caring environment. Our services include:

- 24-Hour Emergency Care
- Bariatric Surgery
- Addiction medicine
- Bariatric Surgery/ Weight Reduction
- Behavioral Health
- Breast Care Center
- Cancer Center
- Cardiology
- Diabetes Care
- Diagnostic Imaging
- Digestive Diseases
- Elder Care
- Endocrinology
- Gastroenterology
- Geriatric Psychiatry
- Home Health Services
- Infectious Diseases
- Nephrology
- Neurology
- Occupational Medicine
- Oncology
- Orthopedics
- Outpatient Services
- Palliative Care
- Pain Management
- Partial Hospitalization
- Podiatry
- Psychiatry
- Pulmonology
- Rehabilitation
- Rheumatology
- Stroke Center
- Surgical Services
- Urology
- Women's Health
- Wound Care

About Prospect Medical Prospect Medical Holdings, Inc. is an innovative healthcare services company that owns 13 hospitals, with a total of 2,258 licensed beds, as well as 40 clinics and outpatient centers. Prospect also manages the provision of healthcare services for approximately 257,000 members enrolled in its networks of over 8,900 primary care physicians and specialists. Prospect's hospitals are located in diverse, high-density population areas within five markets in California, Texas, and Rhode Island.

PROSPECT MEDICAL HOLDINGS, INC.
10780 SANTA MONICA BLVD., SUITE 400, LOS ANGELES, CA 90025 www.pmh.com / 310.943.4500

EXHIBIT Q5-5 ECHN CORPORATOR VOTE

Memo

To: ECHN Corporators

From: Dennis O'Neill, MD, Chairman of the ECHN Board of Trustees; Peter J. Karl, President & CEO

Date: June 26, 2015

RE: Sale of ECHN: ECHN Corporator Vote

During a special retreat of the Eastern Connecticut Health Network, Inc. (ECHN) Board of Trustees on June 25, the members of ECHN's Transaction Committee made a recommendation to ECHN's Board of Trustees to authorize a sale of substantially all the assets of ECHN to Prospect Medical Holdings, Inc. (PMH) (the Proposed Transaction). After considering the options available to ECHN, the trustees cast a unanimous vote in favor of the Proposed Transaction, and authorized ECHN to move forward with the signing of a Letter of Intent and finalization of an Asset Purchase Agreement with PMH.

PMH is a company that owns and operates 13 hospitals, with a total of 2,258 licensed beds, manages over 8,900 providers in 19 independent physician associations, and operates 40 clinics and outpatient centers in diverse population areas within five markets in California, Texas and Rhode Island.

The selection of PMH comes after an extensive study by ECHN of the health care market, and review of the strategic, financial and cultural objectives for seeking a partner that aligns with ECHN's mission and vision.

Earlier this year, ECHN issued a request for proposal seeking an affiliation partner. In response to this request, ECHN received bids from three organizations, including a bid for an asset sale from PMH, a bid for a member substitution transaction from Saint Francis *Care*, Inc. in collaboration with Trinity Health Corporation, and a bid for purchase of a minority interest in ECHN from Hartford HealthCare Corporation. ECHN and its advisers conducted due diligence on, and engaged in further negotiation with, each of these bidders. ECHN considered the three bids thoroughly and determined that in view of the likelihood of continuing changes in the health care market and ongoing financial pressures, the alternative that will best enable continued availability of high-quality health care for ECHN's community is the bid submitted by PMH.

ECHN agreed to the terms of PMH's bid in the Asset Purchase Agreement to include a sale of substantially all of the assets of ECHN and its affiliates, including:

- The Manchester Memorial Hospital
- The Rockville General Hospital, Incorporated,

- Visiting Nurse and Health Services of Connecticut, Inc.
- A Caring Hand, LLC,
- ECHN ElderCare Services, Inc.,
- ECHN Corporate Services, Inc.,
- Medical Practice Partners, LLC,
- Connecticut Healthcare Insurance Company,
- ECHN Enterprises, Inc.,
- Haynes Street Property Management, LLC,
- Clinically Integrated Network of Eastern Connecticut, LLC,
- and Eastern Connecticut Medical Professional Foundation, Inc.

With the Board of Trustees' approval, the Asset Purchase Agreement is now presented to the 232 ECHN Corporators for their review.

Enclosed with this correspondence you will find important information that we hope will help guide you through the vote process including:

- ECHN's Position Statement
- A summary of the Asset Purchase Agreement
- An explanation of the ECHN Corporator voting process and instructions
- A Resolution of the Corporators
- A vote card and stamped reply envelope

The terms of the APA are confidential in nature and we trust this information will not be shared with any parties except fellow ECHN Corporators.

During the next 30 days, we ask that you review this information and ask any questions or speak to us about any concerns by contacting ECHN at 860-646-1222 ext. 3645. On July 29 at 5:30 p.m., a special **Corporator only** vote meeting will be held at the Manchester Memorial Hospital Auditorium. You are encouraged to ask any questions leading up to and during the July 29 meeting prior to the vote. Also, a special **Corporator only** educational session will be held on July 7, 2015 from 5-6:30 p.m. where you may ask questions and speak with Peter Karl, ECHN President & CEO, members of the Board of Trustees, and expert legal counsel.

A copy of the full Asset Purchase Agreement is available for review at the ECHN Administration Office at 71 Haynes Street, Manchester, CT. Please contact Chantal Perigo, office of the President at 860-646-1222 ext. 3645 to make arrangements to view this document. Your vote as a Corporator is crucial to the future of ECHN. We hope you will review these materials in detail and provide your support of this transaction.

ECHN's Position Statement

ECHN is a health system made up of two hospitals and a variety of affiliates that, after careful due diligence and analyses, seeks to enter into an asset purchase agreement with Prospect Medical Holdings (PMH). The ECHN system would become controlled by a for-profit company. The asset purchase agreement makes clear that PMH would continue ECHN's longstanding commitments to providing charity care and healthcare benefits to the wider ECHN community. ECHN, if it were to remain an independent not-for-profit system, might not have the financial resources to keep these commitments in the future. Through this transaction, we believe that the ECHN system can continue its mission to improve your well-being by providing high-quality, compassionate healthcare to our community.

In this era of unprecedented health care reform, declining payments for health care services resulting from recent federal and state legislation, increasing hospital taxes and prolonged regulatory uncertainty leave ECHN challenged to reduce expenses at a time when we desperately need capital to invest in maintaining and improving our care delivery systems. The collaboration we hope to enter now with your approval will bring PMH's considerable financial resources, scale and access to capital, together with their strong national reputation for partnering with physicians to prepare for value-based care delivery systems. This will ensure a strong future for healthcare in eastern Connecticut. Given ECHN's current economic position, we believe this transaction represents the best opportunity we have to continue to deliver high-quality care at the lowest possible cost and also preserve jobs throughout eastern Connecticut.

*PMH is a p*rivately-held for-profit corporation that issues stock or other interests in the company to private investors. Any sale of stock is exempt from Securities and Exchange Commission (SEC) regulations. Unlike a publicly-held for-profit corporation, the interests or stock are not available to the public to buy on a stock market.

We have been careful and deliberate with our affiliation process. We have worked hard to consider the interests and engage all of our constituents in this process, including our patients, employees, medical staff, corporators, the communities we serve and legislative and union leadership. We ask for your support and approval of the transaction contemplated by the Asset Purchase Agreement between ECHN and PMH, as presented here.

ECHN Corporator Voting Instructions

As explained below, if you are unable or prefer not to attend the scheduled meeting of the Corporators described here, you may designate a proxy who will cast your vote by mailing the completed proxy card enclosed here to the designated address in advance of the scheduled meeting of the Corporators and as explained on the attached proxy card.

It is important that your vote is represented, whether or not you attend the Corporator only vote meeting in person. **To ensure your voice is heard, we urge you to vote promptly by completing and mailing the enclosed proxy card, in accordance with the instructions on your proxy card.** Alternatively, you may attend the July 29, 2015 Corporator only vote meeting and cast your vote in person. Please send in your proxy even if you intend to attend the meeting, as presence in person will revoke your proxy.

Votes will be tallied and the result reported during the meeting of the Corporators on July 29, 2015.

Each ECHN Corporator is entitled to one vote.

EASTERN CONNECTICUT HEALTH NETWORK, INC.
CORPORATOR MEETING
PRO□Y CARD

I, the undersigned Corporator of Eastern Connecticut Health Network, Inc. (the □Corporation□) do hereby appoint Dennis O□Neill, M.D. and Peter Karl, or either of them, with full power of substitution, my duly authorized attorneys-in-fact and proxies for purposes of voting at the meeting of the Corporators of the Corporation to be held on July 29, 2015, and any continuation thereof, with respect to the proposed sale of all or substantially all of the assets of the Corporation to Prospect Medical Holdings, Inc. and in connection therewith to vote with respect to approval of a proposed Asset Purchase Agreement and to act upon such other matters as may come before the meeting. I instruct my duly authorized attorneys-in-fact and proxies to cast my vote as follows (check one):

□□□ In favor of the attached resolutions approving the sale of substantially all the assets of the Corporation.

□□□ Against the attached resolutions.

IN WITNESS WHEREOF, I have hereunto set my hand as of the date set forth below.

□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□ Dated: □□□□□□□□□□□□□□□□□□□□□, 2015
Print Name

□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□
Signature

YOUR PRO□Y MUST BE RECEIVED BY THE OFFICE OF THE PRESIDENT OF EASTERN CONNECTICUT HEALTH NETWORK C/O CHANTAL PERIGO BY 12:00 NOON EASTERN TIME ON JULY 29, 2015 IN THE POSTAGE PAID ENVELOPE PROVIDED.

EASTERN CONNECTICUT HEALTH NETWORK, INC.

MEETING OF THE CORPORATORS

July 29, 2015

WHEREAS, the Board of Trustees of Eastern Connecticut Health Network, Inc. (the "Corporation") has engaged in an extensive study of the health care market and future prospects and alternatives facing the Corporation; and

WHEREAS, after conducting such extensive study and considering the likelihood of continuing changes in the health care market and ongoing financial pressures, the Board of Trustees of the Corporation has negotiated that certain Asset Purchase Agreement by and among the Corporation and its affiliates pursuant to which substantially all of the assets of the Corporation and its affiliates will be sold to a corporation that is owned by Prospect Medical Holdings, Inc. ("PMH"); and

WHEREAS, the Board of Trustees of the Corporation voted at its meeting of June 25, 2015 to approve the Asset Purchase Agreement as being in the best interest of the Corporation and its affiliates and to authorize the execution of the Asset Purchase Agreement by certain officers of the Corporation.

NOW, THEREFORE, be it resolved as follows:

Asset Purchase

RESOLVED: That the sale of substantially all the assets of the Corporation pursuant to the Asset Purchase Agreement is approved.

General Authorization

RESOLVED: That the President and CEO, Treasurer and Secretary of the Corporation be and they hereby are, and each of them acting singly is, hereby authorized from time to time, on behalf of the Corporation to take such other action as is necessary or desirable in connection with the transactions contemplated by the Asset Purchase Agreement.

EXHIBIT Q6-1 - CONFLICT OF INTEREST/FINANCIAL DISCLOSURES – ECHN

ECHN CONFLICT OF INTEREST DISCLOSURES

Name	Affiliation
Gordon Brodie, MD	ECHN Trustee
Thomasina Clemons	ECHN Trustee
Michele Conlon, MD	ECHN Trustee
Joy Dorin	ECHN Trustee
Louise C. England	ECHN Trustee
Donald S. Genovesi	ECHN Trustee
David H Gonci	ECHN Trustee
Rebecca D Janenda	ECHN Trustee
Peter Karl	ECHN Trustee/Senior Management Team
Eric Kloter	ECHN Trustee
Pamela Lewis, MD	ECHN Trustee
Kathleen O'Neill	ECHN Trustee
Dennis O'Neill	ECHN Trustee
Keith J. Wolff	ECHN Trustee
Natalie Cook	ECHN Senior Management Team
Nina Kruse	ECHN Senior Management Team
Linda Lemire	ECHN Senior Management Team
Dennis McConville	ECHN Senior Management Team
Linda Quirici	ECHN Senior Management Team
Joel Reich, MD	ECHN Senior Management Team
Edward Roberts	ECHN Senior Management Team
Todd Rose	ECHN Senior Management Team
Joyce Tichy	ECHN Senior Management Team
Michael Veillette	ECHN Senior Management Team
Gregory Williams	ECHN Senior Management Team
Susan Breslau	ElderCare Services Board
Richard Bundy	ElderCare Services Board
David Engleson	ElderCare Services Board
Joanne Renee Irvin	ElderCare Services Board
Marianne Lassman-Fisher	ElderCare Services Board
Rev. Donald Miller	ElderCare Services Board
Irene Quong-Conlon	ElderCare Services Board
Americo Rodrigues	ElderCare Services Board
Kathleen Stavens	ElderCare Services Board
Krystal Anderson	ElderCare Senior Management Team
Margaret Candito	ElderCare Senior Management Team
Catherine Collette	ElderCare Senior Management Team
Janet Gallugi	ElderCare Senior Management Team
Paul Golino	ElderCare Senior Management Team
Rosemary Harding	ElderCare Senior Management Team
Christine McGuire	ElderCare Senior Management Team
Katherine Mon	ElderCare Senior Management Team

Name	Affiliation
Melinda Agsten	Advisor
Jonathan Barry	Advisor
Aaron Bayer	Advisor
David Blackwell	Advisor
Cody Braithwaite	Advisor
Leslie DesMarteau	Advisor
Keith Dickey	Advisor
Adam Eckart	Advisor
Merton Gollaher	Advisor
Patrick Griffin	Advisor
Thomas Hurley	Advisor
Thomas Kaltman	Advisor
Rebecca Matthews	Advisor
Michael McDonough	Advisor
Anne Ogilby	Advisor
David Peloquin	Advisor
Lisa Pelta	Advisor
R. Christopher Regan	Advisor
Joseph Simpson	Advisor
Louis Spadaccini	Advisor
Nicolas Tarditti	Advisor
Lori Stone	Advisor
Jane Willis	Advisor
Mark Wilson	Advisor

Exhibit A referenced in 2(b) of the Conflict of Interest Financial Disclosure Form

Legal Name	Jurisdiction of Organization/Type of Organization
Ivy Holdings Inc.	Delaware Corporation
Ivy Intermediate Holding Inc.	Delaware Corporation
Prospect Medical Holdings, Inc.	Delaware Corporation
Alta Hospitals System, LLC	California LLC
Alta Los Angeles Hospitals, Inc.	California Corporation
Alta Newport Hospital, Inc.	California Corporation
Southern California Healthcare System, Inc.	California Corporation
Prospect Medical Systems, Inc.	Delaware Corporation
ProMed Health Care Administrators	California Corporation
Prospect Medical Group, Inc.	Delaware Corporation
Prospect Health Source Medical Group, Inc.	California Corporation
Prospect Professional Care Medical Group, Inc.	California Corporation
Prospect NWOC Medical Group, Inc.	California Corporation
StarCare Medical Group, Inc.	California Corporation
Genesis Healthcare of Southern California, Inc., a Medical Group	California Corporation
Pomona Valley Medical Group, Inc.	California Corporation
Upland Medical Group, a Professional Medical Corporation	California Corporation
Nuestra Familia Medical Group, Inc.	California Corporation
AMVI Prospect Medical Group	California Joint Venture
Prospect Provider Groups, Inc.	Delaware Corporation
Prospect Provider Group RI, LLC	Delaware LLC
Prospect Provider Group NJ, LLC	Delaware LLC
Prospect NJ, Inc.	Delaware Corporation
Prospect EOGH, Inc.	New Jersey Corporation
Prospect ACO Holdings, LLC	Delaware LLC
Prospect ACO CA, LLC	Delaware LLC
Prospect ACO TX, LLC	Delaware LLC
Prospect ACO RI, LLC	Delaware LLC
PHP Holdings, Inc.	Delaware LLC
Prospect Health Plan, Inc.	Delaware Corporation
Prospect Health Services, Inc.	Texas 501(a) non-profit corporation
Prospect Health Services RI, Inc.	Delaware Corporation
Prospect Health Services NJ, Inc.	Delaware Corporation

Legal Name	Jurisdiction of Organization/Type of Organization
Prospect Hospital Holdings, LLC	Texas LLC
Nix Hospitals System, LLC	Texas LLC
Nix Services, LLC	Texas LLC
Nix SPE, LLC	Texas LLC
Nix Community General Hospital, LLC	Texas LLC
Chaparral Medical Group, Inc.	California Corporation
New Genesis Medical Associates, Inc.	California Corporation
New University Medical Group, LLC	Rhode Island LLC
Prospect CharterCARE, LLC	Rhode Island LLC
Prospect CharterCARE RWMC, LLC	Rhode Island LLC
Prospect CharterCARE SJHSRI, LLC	Rhode Island LLC
Prospect CharterCARE Elmhurst, LLC	Rhode Island LLC
Prospect CharterCARE Physicians, LLC	Rhode Island LLC
Prospect CharterCARE Ancillary Services, LLC	Rhode Island LLC
Prospect East Hospital Advisory Services, LLC	Delaware LLC
Prospect East Holdings, Inc.	Delaware Corporation
Prospect Provider Group CT Waterbury, LLC	Delaware LLC
Prospect Provider Group CT ECHN, LLC	Delaware LLC
Prospect Health Services CT, Inc.	Delaware Corporation
Prospect Integrated Behavioral Health, Inc.	Delaware Corporation
Coordinated Regional Care Group, Inc.	Delaware Corporation
Prospect Hospital Advisory Services, Inc.	Delaware Corporation
Alta Metro Hospital, Inc.	California Corporation
Prospect Raritan, Inc.	New Jersey Corporation
APAC Medical Group, Inc.	California Corporation
Santa Ana Tustin Physicians Group, Inc.	California Corporation

Conflict of Interest / Financial Disclosure Form

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All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. Instructions:

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Gordon Brodie, MD

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

XX Eastern Connecticut Health Network, Inc. The Manchester Memorial Hospital The Rockville General Hospital, Incorporated

Position(s): Trustee

_____ ECHN ElderCare Services, Inc. Visiting Nurse & Health Services of Connecticut, Inc.

Position(s):_____

(b) Please complete and return this Disclosure Form no later than **August 24, 2015** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such event or information as soon as possible.

2. Definitions:

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. Financial Interests:

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)□

__xx__ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity□

__xx__ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction□

__xx__ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity□

__xx__ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction□

__xx__ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction□

__xx__ NO _____YES. If YES, please provide details. _____

_____

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a Prospect Medical Holdings, Inc. Entity□

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

XX NO _____YES. If YES, please provide details. _____

_____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity□

XX NO _____YES. If YES, please provide details. _____

_____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity□

XX NO _____YES. If YES, please provide details. _____

_____

(iv) Furnished or ac□uired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity□

XX NO _____YES. If YES, please provide details. _____

_____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Gordon Brodie, MD Digitally signed by Gordon Brodie, MD DN: cn=Gordon Brodie, MD, o=ECHN, ou=BOT, email=olderndrt@cox.net, c=US Date: 2015.08.15 07:07:21 -04'00'

Signature

August 15, 2015

Date

Gordon Brodie, MD

Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. ("ECHN") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., Eastern Connecticut Medical Professionals Foundation, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. Instructions:

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: THOMASINA CLEMONS

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

X Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): TRUSTEE

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s):_____

(b) Please complete and return this Disclosure Form no later than **August 24, 2015** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such event or information as soon as possible.

2. **Definitions:**

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)?

x NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity?

x NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity?

x NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a Prospect Medical Holdings, Inc. Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Thomasina Clemons Digitally signed by Thomasina Clemons Date: 2015.08.25 11:04:54 -04'00'

Signature

AUGUST 25, 2015

Date

THOMASINA CLEMONS

Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. ("ECHN") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., Eastern Connecticut Medical Professionals Foundation, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: MICHELE CONLON

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

X Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): TRUSTEE, SECRETARY

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s):_____

(b) Please complete and return this Disclosure Form no later than **August 24, 2015** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such event or information as soon as possible.

2. **Definitions:**

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)?

✓ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity?

✓ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

✓ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity?

✓ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction?

✓ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction?

✓ NO _____YES. If YES, please provide details. _____

_____

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a Prospect Medical Holdings, Inc. Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

✓ NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity?

✓ NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity?

✓ NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity?

✓ NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Michele B Conlon — 8-17-15

Signature **Date**

MICHELE B CONLON

Printed Name

Conflict of Interest / Financial Disclosure Form

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1. **Instructions:**

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Please provide the following information:

Print Name: Joy W Dorin

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

X Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): Board member, officer, committee member

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s):_____

(b) Please complete and return this Disclosure Form no later than **August 24, 2015** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such event or information as soon as possible.

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(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)?

__X__ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity?

__X__ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity?

__X__ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction?

__X__ NO _____YES. If YES, please provide details. Not officially offered, but my name, however, is on a list of potential members identified to serve on the local board

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a Prospect Medical Holdings, Inc. Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Joy W Dorin
Signature

August 19, 2014
Date

JOY W DORIN
Printed Name

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Please provide the following information:

Print Name: Louise C. England

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

x Eastern Connecticut Health Network, Inc. The Manchester Memorial Hospital The Rockville General Hospital, Incorporated

Position(s): Trustee

x ECHN ElderCare Services, Inc. Visiting Nurse & Health Services of Connecticut, Inc.

Position(s): Trustee

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3. Financial Interests:

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)□

x_____ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity□

x_____ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____
_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction□

x_____ NO _____YES. If YES, please provide details. _____
_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity□

x_____ NO _____YES. If YES, please provide details. _____
_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction□

x_____ NO _____YES. If YES, please provide details. _____
_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction□

x_____ NO _____YES. If YES, please provide details. _____
_____

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a Prospect Medical Holdings, Inc. Entity□

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____YES. If YES, please provide details. _____

_____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity□

X NO _____YES. If YES, please provide details. _____

_____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity□

X NO _____YES. If YES, please provide details. _____

_____

(iv) Furnished or ac□uired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity□

X NO _____YES. If YES, please provide details. _____

_____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Louise C. England Digitally signed by Louise C. England DN: cn=Louise C. England, o, ou, email=lcengland@sbcglobal.net, c=US Date: 2015.08.17 08:25:03 -04'00'

Signature

08-17-15

Date

Louise C. England

Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. (ECHN) application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. (VNHSC), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., Eastern Connecticut Medical Professionals Foundation, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. Instructions:

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Donald S. Genovesi

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

☐ _____ Eastern Connecticut Health Network, Inc. The Manchester Memorial Hospital The Rockville General Hospital, Incorporated

Position(s): Trustee

_____ ECHN ElderCare Services, Inc. Visiting Nurse & Health Services of Connecticut, Inc.

Position(s):_____

(b) Please complete and return this Disclosure Form no later than **August 24, 2015** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such event or information as soon as possible.

2. Definitions:

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. Financial Interests:

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)□

□_____ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity□

□_____ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____
_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction□

□_____ NO _____YES. If YES, please provide details. _____
_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity□

□_____ NO _____YES. If YES, please provide details. _____
_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction□

□_____ NO _____YES. If YES, please provide details. _____
_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction□

□_____ NO _____YES. If YES, please provide details. _____
_____

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a Prospect Medical Holdings, Inc. Entity□

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

□ NO _____YES. If YES, please provide details. _____
_____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity□

□ NO _____YES. If YES, please provide details. _____
_____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity□

□ NO _____YES. If YES, please provide details. _____
_____

(iv) Furnished or ac□uired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity□

□ NO _____YES. If YES, please provide details. _____
_____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Donald S. Genovesi Digitally signed by Donald S. Genovesi Date: 2015.08.17 07:58:58 -04'00'
Signature

August 17, 2015
Date

Donald S. Genovesi
Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. (ECHN) application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. (VNHSC), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., Eastern Connecticut Medical Professionals Foundation, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. Instructions:

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: David H. Gonci

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

☐ _____ Eastern Connecticut Health Network, Inc. The Manchester Memorial Hospital The Rockville General Hospital, Incorporated

Position(s): Board Member

_____ ECHN ElderCare Services, Inc. Visiting Nurse & Health Services of Connecticut, Inc.

Position(s):_____

(b) Please complete and return this Disclosure Form no later than **August 24, 2015** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such event or information as soon as possible.

2. Definitions:

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. Financial Interests:

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)□

□_____ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity□

□_____ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____
_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction□

□_____ NO _____YES. If YES, please provide details. _____
_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity□

□_____ NO _____YES. If YES, please provide details. _____
_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction□

□_____ NO _____YES. If YES, please provide details. _____
_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction□

□_____ NO _____YES. If YES, please provide details. _____
_____

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a Prospect Medical Holdings, Inc. Entity□

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

□ _____ NO _____YES. If YES, please provide details. _____
_____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity□

□ _____ NO _____YES. If YES, please provide details. _____
_____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity□

□ _____ NO _____YES. If YES, please provide details. _____
_____

(iv) Furnished or ac□uired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity□

□ _____ NO _____YES. If YES, please provide details. _____
_____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

David Gonci Digitally signed by David Gonci
DN: cn=David Gonci, o=Berkshire Hills Bancorp, ou=Finance, email=dgonci@berkshirebank.com, c=US
Date: 2015.08.27 06:53:24 -04'00'

Signature

August 26, 2015

Date

David Gonci

Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. (ECHN) application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. (VNHSC), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., Eastern Connecticut Medical Professionals Foundation, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. Instructions:

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Rebecca D. Janenda

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

NA Expert or Consultant with:

Company Name: _____

Title: _____

☐ Eastern Connecticut Health Network, Inc. The Manchester Memorial Hospital The Rockville General Hospital, Incorporated

Position(s): Trustee of ECHN Inc

NA ECHN ElderCare Services, Inc. Visiting Nurse & Health Services of Connecticut, Inc.

Position(s): _____

(b) Please complete and return this Disclosure Form no later than **August 24, 2015** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such event or information as soon as possible.

2. Definitions:

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. Financial Interests:

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)□

□_____ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity□

□_____ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____
_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction□

□_____ NO _____YES. If YES, please provide details. _____
_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity□

□_____ NO _____YES. If YES, please provide details. _____
_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction□

□_____ NO _____YES. If YES, please provide details. _____
_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction□

□_____ NO _____YES. If YES, please provide details. _____
_____

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a Prospect Medical Holdings, Inc. Entity□

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

_____ NO _____YES. If YES, please provide details. _____
_____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity□

_____ NO _____YES. If YES, please provide details. _____
_____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity□

_____ NO _____YES. If YES, please provide details. _____
_____

(iv) Furnished or ac□uired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity□

_____ NO _____YES. If YES, please provide details. _____
_____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Rebecca D. Janenda Digitally signed by Rebecca D. Janenda Date: 2015.08.18 16:55:40 -04'00'
Signature

August 18, 2015
Date

Rebecca D. Janenda
Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. ("ECHN") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., Eastern Connecticut Medical Professionals Foundation, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Peter J Karl

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

✓ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): CEO

✓ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s): Board Member

(b) Please complete and return this Disclosure Form no later than **August 24, 2015** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such event or information as soon as possible.

2. **Definitions:**

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)?

✓ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity?

✓ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

✓ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity?

✓ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction?

_____ NO ✓ YES. If YES, please provide details. Board Member

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction?

_____ NO ✓ YES. If YES, please provide details. CEO of Local Hospital Entity

_____

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a Prospect Medical Holdings, Inc. Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

✓ NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity?

✓ NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity?

✓ NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity?

✓ NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Ruth J Karl
Signature

8-18-15
Date

Peter J Karl
Printed Name

Conflict of Interest / Financial Disclosure Form

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1. Instructions:

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Eric L. Kloter

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name: _____

Title: _____

X Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): Compensation Committee, Chair - Non-Corparate Investment, Board of Trustees

X ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s): Board of Trustees, Chair

(b) Please complete and return this Disclosure Form no later than August 24, 2015 to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such event or information as soon as possible.

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(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)?

x NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity?

x NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity?

x NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a Prospect Medical Holdings, Inc. Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

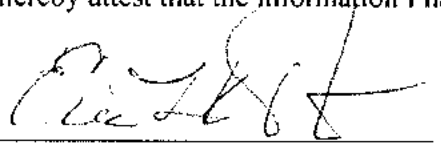
(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.



Signature

August 17, 2015

Date

Eric L. Kloter

Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. ("ECHN") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., Eastern Connecticut Medical Professionals Foundation, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. Instructions:

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Pamela Lewis

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

X Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): President of medical Staff

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s):_____

(b) Please complete and return this Disclosure Form no later than **August 24, 2015** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such event or information as soon as possible.

2. **Definitions:**

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)?

__X__ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity?

__X__ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity?

__X__ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a Prospect Medical Holdings, Inc. Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

__X__ NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity?

__X__ NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity?

__X__ NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity?

__X__ NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Pamela L Lewis
Signature

8/19/15
Date

Pamela Lewis
Printed Name

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Please provide the following information:

Print Name: Kathleen A. O'Neill

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

__X__ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): Trustee / Corporator

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s):_____

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(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such event or information as soon as possible.

2. **Definitions:**

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(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)?

__X__ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity?

__X__ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity?

__X__ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a Prospect Medical Holdings, Inc. Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

__X__ NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity?

__X__ NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity?

__X__ NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity?

__X__ NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Kathleen A. O'Neill
Signature

8/26/15
Date

Kathleen A. O'Neill
Printed Name

Conflict of Interest / Financial Disclosure Form

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Please provide the following information:

Print Name: DENNIS G O'NEIL MD

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

/ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): CHAIR OF BOARD

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s):_____

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(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)?

_✓_ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity?

_✓_ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

_✓_ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity?

_✓_ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction?

_✓_ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction?

_✓_ NO _____YES. If YES, please provide details. _____

_____

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a Prospect Medical Holdings, Inc. Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

__✓__ NO _____ YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity?

__✓__ NO _____ YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity?

__✓__ NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity?

__✓__ NO _____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature _____ Date 8 14 15

Printed Name

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Please provide the following information:

Print Name: Keith Wolff

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

☐ _____ Eastern Connecticut Health Network, Inc. The Manchester Memorial Hospital The Rockville General Hospital, Incorporated

Position(s): Trustee

_____ ECHN ElderCare Services, Inc. Visiting Nurse & Health Services of Connecticut, Inc.

Position(s):_____

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2. Definitions:

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(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. Financial Interests:

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)□

□_____ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity□

□_____ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____
_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction□

□_____ NO _____YES. If YES, please provide details. _____
_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity□

□_____ NO _____YES. If YES, please provide details. _____
_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction□

□_____ NO _____YES. If YES, please provide details. _____
_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction□

□_____ NO _____YES. If YES, please provide details. _____
_____

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a Prospect Medical Holdings, Inc. Entity□

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

□ _____ NO _____YES. If YES, please provide details. _____
_____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity□

□ _____ NO _____YES. If YES, please provide details. _____
_____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity□

□ _____ NO _____YES. If YES, please provide details. _____
_____

(iv) Furnished or ac□uired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity□

□ _____ NO _____YES. If YES, please provide details. _____
_____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Keith Wolff Digitally signed by Keith Wolff
DN: cn=Keith Wolff, o=Wolff Financial Group, LLC, ou, email=kwolff@wolff-financialgroup.com, c=US
Date: 2015.08.24 08:45:22 -04'00'

Signature

8/24/15
Date

Keith Wolff
Printed Name

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Please provide the following information:

Print Name: Natalie Cook

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

X Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): senior executive

X ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s): senior executive

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(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)?

x NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity?

x NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity?

x NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction?

_____ NO x YES. If YES, please provide details. Under the terms of the proposed Asset Purchase Agreement, Prospect has agreed to offer at-will employment to "substantially all employees" of ECHN. With the exception of this generally applicable provision, I have received no offer of employment.

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a Prospect Medical Holdings, Inc. Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Natalie Cook Digitally signed by Natalie Cook Date: 2015.08.14 15:07:38 -04'00'

Signature

8/14/15

Date

Natalie Cook

Printed Name

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Please provide the following information:

Print Name: Nina Kruse

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

X Expert or Consultant with:
Company Name: ECHN Community Healthcare Foundation, Inc.
Title: Vice President of Corporate Communication and Public Affairs

X Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated
Position(s): Vice President of Corporate Communication and Public Affairs

X ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.
Position(s): Vice President of Corporate Communication and Public Affairs

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2. **Definitions:**

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)?

x NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity?

x NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity?

x NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction?

_____ NO x YES. If YES, please provide details. Under the terms of the proposed Asset Purchase Agreement, Prospect has agreed to offer at-will employment to "substantially all employees" of ECHD. With the exception of this generally applicable provision, I have received no offer of employment.

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a Prospect Medical Holdings, Inc. Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Nina Kruse
Signature

8-24-15
Date

Nina Kruse
Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. ("ECHN") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., Eastern Connecticut Medical Professionals Foundation, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Linda C. Lemire

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

X Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): Vice President, Patient Care Services

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s):_____

(b) Please complete and return this Disclosure Form no later than **August 24, 2015** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such event or information as soon as possible.

2. **Definitions:**

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)?

x NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity?

x NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity?

x NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction?

_____ NO x YES. If YES, please provide details. Under the terms of the proposed Asset Purchase Agreement, Prospect has agreed to offer at-will employment to "substantially all employees" of ECHN. With the exception of this generally applicable provision, I have received no offer of employment.

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X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Linda C. Lemire Digitally signed by Linda C. Lemire DN: cn=Linda C. Lemire, o=Eastern Connecticut Health Network, inc, email=llemire@eachn.org, c=US Date: 2015.08.17 08:26:08 -04'00'

Signature

August 17, 2015

Date

Linda C. Lemire

Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. ("ECHN") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., Eastern Connecticut Medical Professionals Foundation, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Dennis P. McConville

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

X Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): Senior Vice President

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s):_____

(b) Please complete and return this Disclosure Form no later than August 24, 2015 to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such event or information as soon as possible.

2. Definitions:

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)?

x NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity?

x NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity?

x NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction?

_____ NO x YES. If YES, please provide details. Under the terms of the proposed Asset Purchase Agreement, Prospect has agreed to offer at-will employment to "substantially all employees" of ECHN. With the exception of this generally applicable provision, I have received no offer of employment.

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X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

8/19/15
Date

Dennis P. McGuire
Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. ("ECHN") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., Eastern Connecticut Medical Professionals Foundation, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

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1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Linda Quirici

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

X Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): Vice President of Quality and Safety

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s):_____

(b) Please complete and return this Disclosure Form no later than **August 24, 2015** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

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2. **Definitions:**

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)?

x NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity?

x NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity?

x NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction?

_____ NO x YES. If YES, please provide details. Under the terms of the proposed Asset Purchase Agreement, Prospect has agreed to offer at-will employment to "substantially all employees" of ECHN. With the exception of this generally applicable provision, I have received no offer of employment.

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(i) Sold or transferred assets to or purchased assets from or exchanged assets.

__X__ NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity?

__X__ NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity?

__X__ NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity?

__X__ NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Linda Quirici Digitally signed by Linda Quirici DN: cn=Linda Quirici, o=Eastern Connecticut Health Network, ou=Quality and Safety, email=lquirici@eche.org, c=US Date: 2015.08.14 15:02:17 -04'00'

Signature

8-14-15

Date

Linda Quirici

Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. ("ECHN") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., Eastern Connecticut Medical Professionals Foundation, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

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1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Joel J. Reich

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

X Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): VPMA/CMO of ECHN; Board member of CHIC and ECMPF

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s):_____

(b) Please complete and return this Disclosure Form no later than **August 24, 2015** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

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(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)?

x NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity?

x NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity?

x NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

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_____ NO x YES. If YES, please provide details. Under the terms of the proposed Asset Purchase Agreement, Prospect has agreed to offer at-will employment to "substantially all employees" of ECHN. With the exception of this generally applicable provision, I have received no offer of employment.

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X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Joel J. Reich Digitally signed by Joel J. Reich Date: 2015.08.15 12:57:28 -04'00'

Signature

8/15/15

Date

Joel J. Reich

Printed Name

Conflict of Interest / Financial Disclosure Form

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Please provide the following information:

Print Name: Edward J. Roberts

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

X Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): Executive Director, CINECT; ECPHO

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s):_____

(b) Please complete and return this Disclosure Form no later than **August 24, 2015** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

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(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)?

x NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

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x NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity?

x NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction?

_____ NO x YES. If YES, please provide details. Under the terms of the proposed Asset Purchase Agreement, Prospect has agreed to offer at-will employment to "substantially all employees" of ECHN. With the exception of this generally applicable provision, I have received no offer of employment.

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a Prospect Medical Holdings, Inc. Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

__X__ NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity?

__X__ NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity?

__X__ NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity?

__X__ NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Edward J. Roberts Digitally signed by Edward J. Roberts DN: cn=Edward J. Roberts, o=ECHN, ou=CHNECT, email=ejroberts@echn.org, c=US Date: 2015.08.14 16:37:26 -04'00'

Signature

August 14, 2015

Date

Edward J. Roberts

Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. ("ECHN") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., Eastern Connecticut Medical Professionals Foundation, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Todd Rose

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

X Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): V.P. of Post Acute Care Services

X ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s): President & CEO Visiting Nurse & Health Service of CT, Inc.

(b) Please complete and return this Disclosure Form no later than **August 24, 2015** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such event or information as soon as possible.

2. **Definitions:**

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)?

x NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity?

x NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity?

x NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction?

_____ NO x YES. If YES, please provide details. Under the terms of the proposed Asset Purchase Agreement, Prospect has agreed to offer at-will employment to "substantially all employees" of ECHN. With the exception of this generally applicable provision, I have received no offer of employment.

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a Prospect Medical Holdings, Inc. Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Todd D Rose Digitally signed by Todd D Rose DN: cn=Todd D Rose, o=Eastern Connecticut Health Network, ou=ECHN Post Acute Care, email=trose@echnet.org, c=US Date: 2015.08.17 09:27:35 -04'00'

Signature

August 17, 2015

Date

Todd D. Rose

Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. ("ECHN") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., Eastern Connecticut Medical Professionals Foundation, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Joyce Tichy

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

X Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): Senior Vice President and General Counsel

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s):_____

(b) Please complete and return this Disclosure Form no later than **August 24, 2015** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such event or information as soon as possible.

2. **Definitions**:

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)?

x NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity?

x NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity?

x NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction?

_____ NO x YES. If YES, please provide details. Under the terms of the proposed Asset Purchase Agreement, Prospect has agreed to offer at-will employment to "substantially all employees" of ECHN. With the exception of this generally applicable provision, I have received no offer of employment.

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a Prospect Medical Holdings, Inc. Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

__X__ NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity?

__X__ NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity?

__X__ NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity?

__X__ NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Joyce Tichy Digitally signed by Joyce Tichy DN: cn=Joyce Tichy, o=ECHN, ou=Administration, email=jtichy@echn.org, c=US Date: 2015.08.18 17:12:50 -04'00'

Signature

August 18, 2015

Date

Joyce Tichy

Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. ("ECHN") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., Eastern Connecticut Medical Professionals Foundation, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Michael D. Veillette

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

X Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): Chief Financial Officer

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s):_____

(b) Please complete and return this Disclosure Form no later than **August 24, 2015** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such event or information as soon as possible.

2. **Definitions:**

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)?

x NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity?

x NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity?

x NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction?

_____ NO x YES. If YES, please provide details. Under the terms of the proposed Asset Purchase Agreement, Prospect has agreed to offer at-will employment to "substantially all employees" of ECHN. With the exception of this generally applicable provision, I have received no offer of employment.

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a Prospect Medical Holdings, Inc. Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Michael D. Veillette Digitally signed by Michael D. Veillette DN: cn=Michael D. Veillette, o=ECHN, Inc., ou=Chief Financial Officer, email=veillette@echn.org, c=US Date: 2015.08.17 14:17:01 -04'00'

Signature

August 17, 2015

Date

Michael D. Veillette

Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. ("ECHN") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., Eastern Connecticut Medical Professionals Foundation, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Gregory M. Williams

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

✓ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): Senior Vice President Ambulatory Network Services

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s):_____

(b) Please complete and return this Disclosure Form no later than **August 24, 2015** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such event or information as soon as possible.

2. **Definitions:**

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)?

__✓__ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity?

__✓__ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

__✓__ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity?

__✓__ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction?

__✓__ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction?

__✓__ NO _____YES. If YES, please provide details. _____

_____

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a Prospect Medical Holdings, Inc. Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

__✓__ NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity?

__✓__ NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity?

__✓__ NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity?

__✓__ NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature _____ Date 8-21-15

Gregory M. Witham
Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. (ECHN) application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. (VNHSC), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., Eastern Connecticut Medical Professionals Foundation, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

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1. Instructions:

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Susan R. Breslau

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

_____ Eastern Connecticut Health Network, Inc. The Manchester Memorial Hospital The Rockville General Hospital, Incorporated

Position(s): _____

XX ECHN ElderCare Services, Inc. Visiting Nurse & Health Services of Connecticut, Inc.

Position(s): Trustee

(b) Please complete and return this Disclosure Form no later than **August 24, 2015** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such event or information as soon as possible.

2. Definitions:

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. Financial Interests:

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)□

xx NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity□

xx NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction□

xx NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity□

xx NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction□

xx NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction□

xx NO _____YES. If YES, please provide details. _____

_____

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a Prospect Medical Holdings, Inc. Entity□

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

XX NO _____YES. If YES, please provide details. _____

_____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity□

XX NO _____YES. If YES, please provide details. _____

_____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity□

XX NO _____YES. If YES, please provide details. _____

_____

(iv) Furnished or ac□uired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity□

XX NO _____YES. If YES, please provide details. _____

_____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Susan R. Breslau Digitally signed by Susan R. Breslau DN: cn=Susan R. Breslau, o, ou, email=srbreslau@comcast.net, c=US Date: 2015.08.27 12:01:29 -04'00'

Signature

08/27/15

Date

Susan R. Breslau

Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. ("ECHN") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., Eastern Connecticut Medical Professionals Foundation, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Richard G. Bundy SR

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:
Company Name:_____
Title: _____

_____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated
Position(s): _____

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.
Position(s): Board of Directors

(b) Please complete and return this Disclosure Form no later than **August 24, 2015** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such event or information as soon as possible.

2. Definitions:

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. Financial Interests:

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)?

__X__ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity?

__X__ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

__X__ NO _____YES. If YES, please provide details. _____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity?

__X__ NO _____YES. If YES, please provide details. _____

4. Beneficial and/or Employment Interests

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction?

__X__ NO _____YES. If YES, please provide details. _____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction?

__X__ NO _____YES. If YES, please provide details. _____

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a Prospect Medical Holdings, Inc. Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

__X__ NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity?

__X__ NO _____YES. If YES, please provide details.

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity?

__X__ NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity?

__X__ NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Richard G Bundy Jr 8/24/2015

Signature Date

Richard G. Bundy Jr.

Printed Name

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Please provide the following information:

Print Name: David A. Engelson

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

_____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): _____

✓ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s): Vice Chair

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2. **Definitions:**

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(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)?

__✓__ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity?

__✓__ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

__✓__ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity?

__✓__ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction?

__✓__ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction?

__✓__ NO _____YES. If YES, please provide details. _____

_____

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✓ NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity?

✓ NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity?

✓ NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity?

✓ NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

David A. Engelson
Signature

8/24/15
Date

David A. Engelson
Printed Name

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Please provide the following information:

Print Name: Joanne Renee Irvin

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

_____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): _____

X ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s): Board Member

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(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)?

x NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity?

x NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity?

x NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a Prospect Medical Holdings, Inc. Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

8/17/15
Date

JOANNE RENEE IRVIN
Printed Name

Conflict of Interest / Financial Disclosure Form

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Please provide the following information:

Print Name: Marianne Lassman Fisher

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

_____ Eastern Connecticut Health Network, Inc. The Manchester Memorial Hospital The Rockville General Hospital, Incorporated

Position(s): _____

_____ ECHN ElderCare Services, Inc. Visiting Nurse & Health Services of Connecticut, Inc.

Position(s): Board member Eldercare Services, Inc./VNHSC, Chairman, Community Health Services

(b) Please complete and return this Disclosure Form no later than **August 24, 2015** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

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2. Definitions:

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. Financial Interests:

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)□

□□_____ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity□

□□_____ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____
_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction□

□□_____ NO _____YES. If YES, please provide details. _____
_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity□

□□_____ NO _____YES. If YES, please provide details. _____
_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction□

□□_____ NO _____YES. If YES, please provide details. _____
_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction□

□□_____ NO _____YES. If YES, please provide details. _____
_____

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a Prospect Medical Holdings, Inc. Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

XX NO _____YES. If YES, please provide details. _____

_____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity?

XX NO _____YES. If YES, please provide details. _____

_____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity?

XX NO _____YES. If YES, please provide details. _____

_____

(iv) Furnished or acquired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity?

XX NO _____YES. If YES, please provide details. _____

_____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Marianne Lassman Fisher August 19, 2015

Signature Date

Marianne Lassman Fisher

Printed Name

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Please provide the following information:

Print Name: DONALD G. MILLER

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name: _____

Title: _____

✓ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): Corporator

✓ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s): Secretary

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_____

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__✓__ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

__✓__ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity?

__✓__ NO _____YES. If YES, please provide details. _____

_____

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_____

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__✓__ NO _____YES. If YES, please provide details. _____

_____

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__✓__ NO _____ YES. If YES, please provide details. _____

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__✓__ NO _____ YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity?

__✓__ NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity?

__✓__ NO _____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Donald G. Miller
Signature

aug. 27, 2015
Date

DONALD G. MILLER
Printed Name

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Please provide the following information:

Print Name: Irene Query Conlon

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

_____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): _____

✓ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s): Trustee

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3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)?

__✓__ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity?

__✓__ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

__✓__ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity?

__✓__ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction?

__✓__ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction?

__✓__ NO _____YES. If YES, please provide details. _____

_____

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a Prospect Medical Holdings, Inc. Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

__✓__ NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity?

__✓__ NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity?

__✓__ NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity?

__✓__ NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature _____ Date 9/1/2015

Irene Quang Conlon
Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. (ECHN) application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. (VNHSC), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., Eastern Connecticut Medical Professionals Foundation, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. Instructions:

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Americo Rodrigues

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

_____ Eastern Connecticut Health Network, Inc. The Manchester Memorial Hospital The Rockville General Hospital, Incorporated

Position(s): _____

_____ ECHN ElderCare Services, Inc. Visiting Nurse & Health Services of Connecticut, Inc.

Position(s): Board Member

(b) Please complete and return this Disclosure Form no later than **August 24, 2015** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such event or information as soon as possible.

2. Definitions:

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. Financial Interests:

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)□

□_____ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity□

□_____ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____
_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction□

□_____ NO _____YES. If YES, please provide details. _____
_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity□

□_____ NO _____YES. If YES, please provide details. _____
_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction□

□_____ NO _____YES. If YES, please provide details. _____
_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction□

□_____ NO _____YES. If YES, please provide details. _____
_____

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a Prospect Medical Holdings, Inc. Entity□

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

□ _____ NO _____YES. If YES, please provide details. _____
_____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity□

□ _____ NO _____YES. If YES, please provide details. _____
_____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity□

□ _____ NO _____YES. If YES, please provide details. _____
_____

(iv) Furnished or ac□uired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity□

□ _____ NO _____YES. If YES, please provide details. _____
_____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Americo Rodrigues Digitally signed by Americo Rodrigues Date: 2015.08.17 09:29:40 -04'00'
Signature

8/17/15
Date

Americo Rodrigues
Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. ("ECHN") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., Eastern Connecticut Medical Professionals Foundation, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. Instructions:

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: KATHLEEN A. STAVENS

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

✓ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): CORPORATOR

✓ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s): Board Member/Treasurer

(b) Please complete and return this Disclosure Form no later than August 24, 2015 to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such event or information as soon as possible.

2. **Definitions:**

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)?

__X__ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity?

__X__ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity?

__X__ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a Prospect Medical Holdings, Inc. Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature _____ Date 8/27/15

Kathleen A. Stavens
Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. (ECHN) application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. (VNHSC), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., Eastern Connecticut Medical Professionals Foundation, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. Instructions:

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Krystal Anderson

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

_____ Eastern Connecticut Health Network, Inc. The Manchester Memorial Hospital The Rockville General Hospital, Incorporated

Position(s): _____

_____ ECHN ElderCare Services, Inc. Visiting Nurse & Health Services of Connecticut, Inc.

Position(s): Human Resource Manager

(b) Please complete and return this Disclosure Form no later than **August 24, 2015** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such event or information as soon as possible.

2. Definitions:

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. Financial Interests:

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)□

□_____ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity□

□_____ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction□

□_____ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity□

□_____ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction□

□_____ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction□

_____ NO □_____YES. If YES, please provide details. Under the terms of the proposed Asset Purchase Agreement, Prospect has agreed to offer at-will employment to "substantially all employees" of ECHN. With the exception of this generally applicable provision, I have received no offer of employment.

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a Prospect Medical Holdings, Inc. Entity□

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____YES. If YES, please provide details. _____

_____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity□

X NO _____YES. If YES, please provide details. _____

_____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity□

X NO _____YES. If YES, please provide details. _____

_____

(iv) Furnished or ac□uired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity□

X NO _____YES. If YES, please provide details. _____

_____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Krystal Anderson Digitally signed by Krystal Anderson DN: cn=Krystal Anderson, o=Visiting Nurse & Health Services of CT., Inc., ou=VNHSC, email=Kanderson@vnhsc.org, c=US Date: 2015.08.24 09:22:46 -04'00'

Signature

08/24/2015

Date

Krystal Anderson

Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. (ECHN) application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. (VNHSC), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., Eastern Connecticut Medical Professionals Foundation, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. Instructions:

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Margaret Candito

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

_____ Eastern Connecticut Health Network, Inc. The Manchester Memorial Hospital The Rockville General Hospital, Incorporated

Position(s): _____

_____ ECHN ElderCare Services, Inc. Visiting Nurse & Health Services of Connecticut, Inc.

Position(s): Director of Nursing

(b) Please complete and return this Disclosure Form no later than **August 24, 2015** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such event or information as soon as possible.

2. Definitions:

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. Financial Interests:

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)□

□_____ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity□

□_____ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____
_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction□

x_____ NO _____YES. If YES, please provide details. _____
_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity□

□_____ NO _____YES. If YES, please provide details. _____
_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction□

□_____ NO _____YES. If YES, please provide details. _____
_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction□

□_____ NO _____YES. If YES, please provide details. _____
_____

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a Prospect Medical Holdings, Inc. Entity□

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

□ _____ NO _____YES. If YES, please provide details. _____
_____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity□

□ _____ NO _____YES. If YES, please provide details. _____
_____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity□

□ _____ NO _____YES. If YES, please provide details. _____
_____

(iv) Furnished or ac□uired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity□

□ _____ NO _____YES. If YES, please provide details. _____
_____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Margaret Candito Digitally signed by Margaret Candito
DN: cn=Margaret Candito, o=Woodlake at Tolland, ou=Director of Nursing, email=mcandito@echn.org, c=US
Date: 2015.08.19 12:03:24 -04'00'

Signature

8/19/15

Date

Margaret Candito

Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. (ECHN) application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. (VNHSC), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., Eastern Connecticut Medical Professionals Foundation, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

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1. Instructions:

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Catherine P Collette

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

_____ Eastern Connecticut Health Network, Inc. The Manchester Memorial Hospital The Rockville General Hospital, Incorporated

Position(s): _____

_____ ECHN ElderCare Services, Inc. Visiting Nurse & Health Services of Connecticut, Inc.

Position(s): Vice President Quality Assurance

(b) Please complete and return this Disclosure Form no later than **August 24, 2015** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such event or information as soon as possible.

2. Definitions:

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. Financial Interests:

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)□

□_____ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity□

□_____ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction□

□_____ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity□

□_____ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction□

□_____ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction□

_____ NO □_____YES. If YES, please provide details. Under terms of the Asset Purchase agreement, Prospect has agreed to offer at-will employment to "substantially all employees" of ECHN. With the exception of this generally applicable provision, I have received no offer of employment

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a Prospect Medical Holdings, Inc. Entity□

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____YES. If YES, please provide details. _____

_____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity□

X NO _____YES. If YES, please provide details. _____

_____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity□

X NO _____YES. If YES, please provide details. _____

_____

(iv) Furnished or ac□uired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity□

X NO _____YES. If YES, please provide details. _____

_____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Catherine P. Collette RN MSN

Digitally signed by Catherine P. Collette RN MSN
DN: cn=Catherine P. Collette RN MSN, o=Visiting Nurse and Health Services of CT, ou, email=kcollette@vnhsc.org, c=US
Date: 2015.08.27 10:47:23 -04'00'

Signature

08/27/2015

Date

Catherine P Collette

Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. ("ECHN") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., Eastern Connecticut Medical Professionals Foundation, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Janet Gallugi

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name: _____

Title: _____

_____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): _____

✓ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s): VP Business Development

(b) Please complete and return this Disclosure Form no later than **August 24, 2015** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such event or information as soon as possible.

2. **Definitions:**

(a) **Related Person:** A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)?

✓ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity?

✓ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

✓ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity?

✓ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction?

✓ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction?

✓ NO _____YES. If YES, please provide details. _____

_____

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a Prospect Medical Holdings, Inc. Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

✓ NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity?

✓ NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity?

✓ NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity?

✓ NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Janet M. Galiey
Signature

August 24, 2015
Date

Janet M. Galiey
Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. (ECHN) application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. (VNHSC), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., Eastern Connecticut Medical Professionals Foundation, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. Instructions:

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Paul Golino

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

x Eastern Connecticut Health Network, Inc. The Manchester Memorial Hospital The Rockville General Hospital, Incorporated

Position(s): AVP Finance,Senior Executive - Finance Committee, Audit Committee, & ECPHO Board

x ECHN ElderCare Services, Inc. Visiting Nurse & Health Services of Connecticut, Inc.

Position(s): Senior Executive - Board

(b) Please complete and return this Disclosure Form no later than **August 24, 2015** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such event or information as soon as possible.

2. Definitions:

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. Financial Interests:

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)□

x_____ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity□

x_____ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction□

x_____ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity□

x_____ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction□

x_____ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction□

_____ NO x_____YES. If YES, please provide details. Under the terms of the proposed Asset Purchase Agreement, Prospect has agreed to offer at-will employment to "substantially all employees" of ECHN . With the exception of this generally applicable provision, I have received no offer of employment.

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a Prospect Medical Holdings, Inc. Entity□

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____YES. If YES, please provide details. _____

_____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity□

X NO _____YES. If YES, please provide details. _____

_____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity□

X NO _____YES. If YES, please provide details. _____

_____

(iv) Furnished or ac□uired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity□

X NO _____YES. If YES, please provide details. _____

_____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Paul Golino Digitally signed by Paul Golino Date: 2015.09.14 09:55:48 -04'00'

Signature

9/14/2015

Date

Paul Golino

Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. ("ECHN") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., Eastern Connecticut Medical Professionals Foundation, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

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1. Instructions:

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Rosemary Harding

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name: _____

Title: _____

_____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): _____

X ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s): Vice President Clinical Services

(b) Please complete and return this Disclosure Form no later than **August 24, 2015** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such event or information as soon as possible.

2. **Definitions:**

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)?

_x____ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity?

_x____ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

_x____ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity?

_x____ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction?

_x____ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction?

_x____ NO _____YES. If YES, please provide details. _____

_____

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a Prospect Medical Holdings, Inc. Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Rosemary Harding
Signature

8/19/2015
Date

Rosemary Harding
Printed Name

Conflict of Interest / Financial Disclosure Form

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Please provide the following information:

Print Name: Christine McGuire

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name:_____

Title: _____

_____ Eastern Connecticut Health Network, Inc. The Manchester Memorial Hospital The Rockville General Hospital, Incorporated

Position(s): _____

X_____ ECHN ElderCare Services, Inc. Visiting Nurse & Health Services of Connecticut, Inc.

Position(s): Chief Financial Officer, VNHSC

(b) Please complete and return this Disclosure Form no later than **August 24, 2015** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such event or information as soon as possible.

2. Definitions:

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. Financial Interests:

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)□

x_____ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity□

x_____ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____
_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction□

x_____ NO _____YES. If YES, please provide details. _____
_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity□

x_____ NO _____YES. If YES, please provide details. _____
_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction□

x_____ NO _____YES. If YES, please provide details. _____
_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction□

x_____ NO _____YES. If YES, please provide details. _____
_____

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a Prospect Medical Holdings, Inc. Entity□

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____YES. If YES, please provide details. _____

_____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity□

X NO _____YES. If YES, please provide details. _____

_____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity□

X NO _____YES. If YES, please provide details. _____

_____

(iv) Furnished or ac□uired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity□

X NO _____YES. If YES, please provide details. _____

_____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Christine McGuire Digitally signed by Christine McGuire DN: cn=Christine McGuire, o=VNHSC, ou, email=cmcguire@vnhsc.org, c=US Date: 2015.08.27 10:11:22 -04'00'

Signature

8/27/15

Date

Christine McGuire

Printed Name

Conflict of Interest / Financial Disclosure Form

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1. **Instructions:**

   (a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Katherine E. Mon

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:

Company Name: _____

Title: _____

_____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): _____

X ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s): Executive Director for Woodlake at Tolland

(b) **Please complete and return this Disclosure Form no later than August 24, 2015 to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.**

(c) **When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such event or information as soon as possible.**

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(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)?

x NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity?

x NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity?

x NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction?

_____ NO x YES. If YES, please provide details. Under the terms of the proposed Asset Purchase Agreement, Prospect has agreed to offer at-will employment to "substantially all employees" of ECHN. With the exception of this generally applicable provision, I have received no offer of employment.

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a Prospect Medical Holdings, Inc. Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Katherine E Mon
Signature

August 17, 2015
Date

Katherine E. Mon
Printed Name

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Please provide the following information:

Print Name: Melinda A. Agsten

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

X Expert or Consultant with:
Company Name: Wiggin and Dana LLP
Title: Partner

____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated
Position(s): _____

____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.
Position(s): _____

(b) Please complete and return this Disclosure Form no later than **August 24, 2015** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such event or information as soon as possible.

2. **Definitions**:

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)?

x NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity?

x NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity?

x NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a Prospect Medical Holdings, Inc. Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

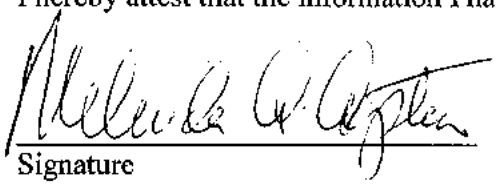
(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.



Signature

August 17, 2015
Date

Melinda A. Agsten
Printed Name

Conflict of Interest / Financial Disclosure Form

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All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Jonathan Barry

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

X Expert or Consultant with:
Company Name: Mercer
Title: Partner

____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated
Position(s): _____

____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.
Position(s): _____

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(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)?

x NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

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(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity?

x NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

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(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

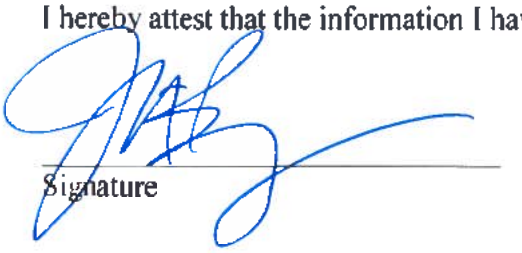
(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.



Signature

August 19, 2015
Date

Jonathan Barry
Printed Name

Conflict of Interest / Financial Disclosure Form

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All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. Instructions:

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Aaron Bayer

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

X Expert or Consultant with:
Company Name: Wiggin and Dana LLP
Title: Partner

____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated
Position(s): _____

____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.
Position(s): _____

(b) Please complete and return this Disclosure Form no later than **August 24, 2015** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such event or information as soon as possible.

2. Definitions:

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)?

X NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction?

X NO _____YES. If YES, please provide details. _____

_____

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X NO _____YES. If YES, please provide details. _____

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X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

8/17/15
Date

Aaron Bayer
Printed Name

Conflict of Interest / Financial Disclosure Form

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(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: David H. Blackwell

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

X Expert or Consultant with:

Company Name: Blackwell & Goodacre, LLC

Title: Attorney

____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): _____

____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s): _____

(b) Please complete and return this Disclosure Form no later than **August 24, 2015** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

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(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)?

__X__ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity?

__X__ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity?

__X__ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

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__X__ NO _____YES. If YES, please provide details. _____

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__X__ NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

8/27/15
Date

David H. Blackwell
Printed Name

Conflict of Interest / Financial Disclosure Form

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Please provide the following information:

Print Name: Cody Braithwaite

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

x Expert or Consultant with:
Company Name: Harter Secrest & Emery LLP
Title: Counsel

_____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated
Position(s): _____

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.
Position(s): _____

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(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

x NO _____YES. If YES, please provide details. _____

_____

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x NO _____YES. If YES, please provide details. _____

_____

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x NO _____YES. If YES, please provide details. _____

_____

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X NO _____YES. If YES, please provide details. _____

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X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

08/21/2015
Date

Cody Braithwaite
Printed Name

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Please provide the following information:

Print Name: Leslie Desmarais

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

X Expert or Consultant with:

Company Name: Hinckley Allen & Snyder LLP

Title: POSA counsel

_____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): _____

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s): _____

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✓ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

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(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

✓ NO _____YES. If YES, please provide details. _____

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(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity?

✓ NO _____YES. If YES, please provide details. _____

_____

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(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction?

✓ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction?

✓ NO _____YES. If YES, please provide details. _____

_____

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a Prospect Medical Holdings, Inc. Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

__✓__ NO _____ YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity?

__✓__ NO _____ YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity?

__✓__ NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity?

__✓__ NO _____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

[signature] 8/18/2015

Signature Date

Leslie DesMarteau

Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. (ECHN) application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. (VNHSC), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., Eastern Connecticut Medical Professionals Foundation, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. Instructions:

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Keith Dickey

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

x Expert or Consultant with:
Company Name: The Chartis Group
Title: Principal

_____ Eastern Connecticut Health Network, Inc. The Manchester Memorial Hospital The Rockville General Hospital, Incorporated
Position(s): _____

_____ ECHN ElderCare Services, Inc. Visiting Nurse & Health Services of Connecticut, Inc.
Position(s): _____

(b) Please complete and return this Disclosure Form no later than **August 24, 2015** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such event or information as soon as possible.

2. Definitions:

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. Financial Interests:

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)□

□□□_____ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity□

□□□_____ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____
_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction□

□□□_____ NO _____YES. If YES, please provide details. _____
_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity□

□□□_____ NO _____YES. If YES, please provide details. _____
_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction□

□□□_____ NO _____YES. If YES, please provide details. _____
_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction□

□□□_____ NO _____YES. If YES, please provide details. _____
_____

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a Prospect Medical Holdings, Inc. Entity□

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

□□□ NO _____YES. If YES, please provide details. _____
_____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity□

□□□ NO _____YES. If YES, please provide details. _____
_____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity□

□□□ NO _____YES. If YES, please provide details. _____
_____

(iv) Furnished or ac□uired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity□

□□□ NO _____YES. If YES, please provide details. _____
_____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Keith Dickey Digitally signed by Keith Dickey DN: cn=Keith Dickey, o=The Chartis Group, ou, email=kdickey@chartis.com, c=US Date: 2015.08.17 07:44:46 -04'00'

Signature

08-17-2015

Date

Keith Dickey

Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. (ECHN) application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. (VNHSC), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., Eastern Connecticut Medical Professionals Foundation, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. Instructions:

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Adam N. Eckart

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:
Company Name: Ropes & Gray LLP
Title: Associate

_____ Eastern Connecticut Health Network, Inc. The Manchester Memorial Hospital The Rockville General Hospital, Incorporated
Position(s): _____

_____ ECHN ElderCare Services, Inc. Visiting Nurse & Health Services of Connecticut, Inc.
Position(s): _____

(b) Please complete and return this Disclosure Form no later than **August 24, 2015** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such event or information as soon as possible.

2. Definitions:

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. Financial Interests:

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)□

□_____ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity□

□_____ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____
_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction□

□_____ NO _____YES. If YES, please provide details. _____
_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity□

□_____ NO _____YES. If YES, please provide details. _____
_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction□

□_____ NO _____YES. If YES, please provide details. _____
_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction□

□_____ NO _____YES. If YES, please provide details. _____
_____

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a Prospect Medical Holdings, Inc. Entity□

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

□ _____ NO _____YES. If YES, please provide details. _____
_____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity□

□ _____ NO _____YES. If YES, please provide details. _____
_____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity□

□ _____ NO _____YES. If YES, please provide details. _____
_____

(iv) Furnished or ac□uired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity□

□ _____ NO _____YES. If YES, please provide details. _____
_____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

aeckart@ropesgray.firm Digitally signed by aeckart@ropesgray.firm DN: cn=aeckart@ropesgray.firm Date: 2015.08.14 15:12:17 -04'00'
Signature

8/14/2015
Date

Adam N. Eckart
Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. ("ECHN") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., Eastern Connecticut Medical Professionals Foundation, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. Instructions:

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Merton G. Gollaher

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

X Expert or Consultant with:
Company Name: Wiggin and Dana LLP
Title: Partner

____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated
Position(s): _____

____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.
Position(s): _____

(b) Please complete and return this Disclosure Form no later than **August 24, 2015** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such event or information as soon as possible.

2. **Definitions:**

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)?

X NO _____ YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity?

X NO _____ YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

_____ NO X YES. If YES, please provide details. I am a partner in Wiggin and Dana LLP, a law firm advising ECHN in connection with the Transaction. Wiggin and Dana LLP will be paid compensation for such services.

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity?

X NO _____ YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction?

X NO _____ YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction?

X NO _____ YES. If YES, please provide details. _____

_____

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a Prospect Medical Holdings, Inc. Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____ YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity?

X NO _____ YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity?

X NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity?

X NO _____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Merton G. Gollaher
Signature

August 28, 2015
Date

Merton G. Gollaher
Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. ("ECHN") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., Eastern Connecticut Medical Professionals Foundation, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. Instructions:

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Patrick W. Griffin

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

X Expert or Consultant with:
Company Name: Purple Strategies
Title: Managing Partner

X Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated
Position(s): _____

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.
Position(s): _____

(b) Please complete and return this Disclosure Form no later than **August 24, 2015** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such event or information as soon as possible.

2. Definitions:

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)?

X NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a Prospect Medical Holdings, Inc. Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X
_____ NO _____YES. If YES, please provide details. _____
_____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity?

X
_____ NO _____YES. If YES, please provide details. _____
_____

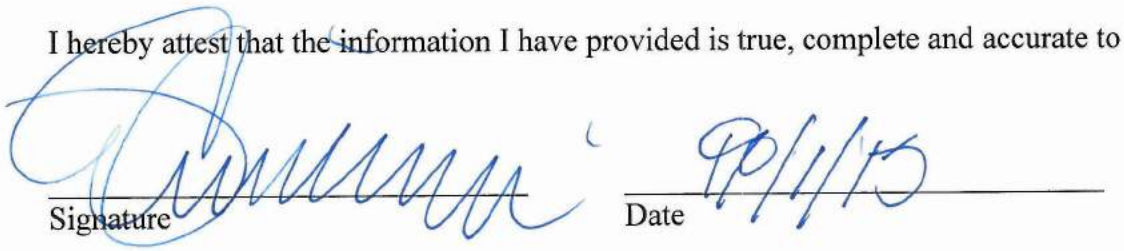
(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity?

X
_____ NO _____YES. If YES, please provide details. _____
_____

(iv) Furnished or acquired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity?

X
_____ NO _____YES. If YES, please provide details. _____
_____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.



_____ _____
Signature Date

Patrick W. Griffin
_____
Printed Name

Conflict of Interest / Financial Disclosure Form

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1. Instructions:

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Thomas J. Hurley

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

x Expert or Consultant with:
Company Name: Harter Secrest & Emery LLP
Title: Partner

_____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated
Position(s): _____

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.
Position(s): _____

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(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such event or information as soon as possible.

2. Definitions:

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)?

x NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity?

x NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity?

x NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

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(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

08-19-15
Date

Thomas J. Hurley
Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. (ECHN) application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. (VNHSC), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., Eastern Connecticut Medical Professionals Foundation, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. Instructions:

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Todd A. Kaltman

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:
Company Name: Duff & Phelps, LLC
Title: Managing Director

_____ Eastern Connecticut Health Network, Inc. The Manchester Memorial Hospital The Rockville General Hospital, Incorporated
Position(s): _____

_____ ECHN ElderCare Services, Inc. Visiting Nurse & Health Services of Connecticut, Inc.
Position(s): _____

(b) Please complete and return this Disclosure Form no later than **August 24, 2015** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such event or information as soon as possible.

2. Definitions:

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. Financial Interests:

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)□

□ _____ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity□

□ _____ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction□

_____ NO □ _____YES. If YES, please provide details. My employer, Duff & Phelps, LLC, will receive compensation for professional services rendered. No such compensation is contingent upon the completion of the proposed transaction.

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity□

□ _____ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction□

□ _____ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction□

□ _____ NO _____YES. If YES, please provide details. _____

_____

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a Prospect Medical Holdings, Inc. Entity□

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

□ _____ NO _____YES. If YES, please provide details. _____
_____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity□

□ _____ NO _____YES. If YES, please provide details. _____
_____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity□

□ _____ NO _____YES. If YES, please provide details. _____
_____

(iv) Furnished or ac□uired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity□

□ _____ NO _____YES. If YES, please provide details. _____
_____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Digitally signed by: Todd A. Kaltman
DN: CN = Todd A. Kaltman C = AD
Date: 2015.08.17 09:57:53 -07'00'

Signature

August 17, 2015
Date

Todd A. Kaltman
Printed Name

Conflict of Interest / Financial Disclosure Form

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1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Rebecca A. Matthews

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

X Expert or Consultant with:
Company Name: Wiggin and Dana LLP
Title: Partner

____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated
Position(s): _____

____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.
Position(s): _____

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(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such event or information as soon as possible.

2. **Definitions:**

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)?

X NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a Prospect Medical Holdings, Inc. Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____ YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity?

X NO _____ YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity?

X NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity?

X NO _____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

August 15, 2015
Date

Rebecca A. Matthews
Printed Name

Conflict of Interest / Financial Disclosure Form

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1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Michael McDonough

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

✓ Expert or Consultant with:
Company Name: Murtha Cullina LLP
Title: Partner

_____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated
Position(s): I am a corporator, but not a board member of ECHN

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.
Position(s): _____

(b) Please complete and return this Disclosure Form no later than **August 24, 2015** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such event or information as soon as possible.

2. **Definitions:**

(a) **Related Person:** A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)?

__✓__ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity?

__✓__ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

_____ NO __✓__ YES. If YES, please provide details. as counsel to ECHN
We will be paid by ECHN to represent it in aspects of the transaction

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity?

__✓__ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction?

__✓__ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction?

__✓__ NO _____ YES. If YES, please provide details. _____

_____

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a Prospect Medical Holdings, Inc. Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

__✓__ NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity?

__✓__ NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity?

__✓__ NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity?

__✓__ NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature _____ Date 8/28/15

Michael McDonough
Printed Name

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Please provide the following information:

Print Name: Anne Ogilby

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

X Expert or Consultant with:
Company Name: Ropes & Gray LLP
Title: Partner

____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated
Position(s): _____

____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.
Position(s): _____

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(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such event or information as soon as possible.

2. **Definitions:**

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(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)?

X NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity?

_____ NO X YES. If you answered YES, please note the name of the entity and income generated from the entity. As noted in the waiver consent provided to ECHN, Ropes & Gray does represent Prospect Medical Holdings, Inc. in unrelated matters. Ropes & Gray's relationship with all clients is subject to applicable legal ethics requirements, and the firm maintains a robust conflict management system.

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction?

_____ NO X YES. If YES, please provide details. As noted in the waiver consent provided to ECHN, Ropes & Gray does represent Prospect Medical Holdings, Inc. in unrelated matters. Ropes & Gray's relationship with all clients is subject to applicable legal ethics requirements, and the firm maintains a robust conflict management system.

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(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity?

_____ NO X YES. If YES, please provide details. As noted in the waiver consent provided to ECHN, Ropes & Gray does represent Prospect Medical Holdings, Inc. in unrelated matters. Ropes & Gray's relationship with all clients is subject to applicable legal ethics requirements, and the firm maintains a robust conflict management system.

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

8/20/15
Date

A.P. OGILBY
Printed Name

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Please provide the following information:

Print Name: David Peloquin

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

X Expert or Consultant with:
Company Name: Ropes & Gray LLP
Title: Associate

_____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated
Position(s): _____

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.
Position(s): _____

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(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)?

_x____ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity?

_____ NO _x____YES. If you answered YES, please note the name of the entity and income generated from the entity. As noted in the waiver consent provided to ECHN, Ropes & Gray does represent Prospect Medical Holdings, Inc. in unrelated matters. Ropes & Gray's relationship with all clients is subject to all applicable legal ethics requirements, and the firm maintains a robust conflict management system.

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

_x____ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity?

_x____ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction?

_x____ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction?

_____ NO _x____YES. If YES, please provide details. As noted in the waiver consent provided to ECHN, Ropes & Gray does represent Prospect Medical Holdings, Inc. in unrelated matters. Ropes & Gray's relationship with all clients is subject to applicable legal ethics requirements, and the firm maintains a robust conflict management system.

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X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity?

_____NO X YES. If YES, please provide details. As noted in the waiver consent provided to ECHN, Ropes & Gray does represent Prospect Medical Holdings, Inc. in unrelated matters. Ropes & Gray's relationship with all clients is subject to applicable legal ethics requirements, and the firm maintains a robust conflict management system.

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

David Pelogrin
Signature

9/24/15
Date

David Pelogrin
Printed Name

Conflict of Interest / Financial Disclosure Form

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Please provide the following information:

Print Name: Lisa G. Pelta

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

X Expert or Consultant with:
Company Name: Harter Secrest & Emery LLP
Title: Counsel

_____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated
Position(s): _____

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.
Position(s): _____

(b) Please complete and return this Disclosure Form no later than August 24, 2015 to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such event or information as soon as possible.

2. **Definitions:**

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)?

x NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity?

x NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity?

x NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a Prospect Medical Holdings, Inc. Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Lisa G. Pelta
Signature

8/17/15
Date

Lisa G. Pelta
Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. ("ECHN") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., Eastern Connecticut Medical Professionals Foundation, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: R. Christopher Regan

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

✓ Expert or Consultant with:
Company Name: The Chartis Group
Title: Managing Director

_____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated
Position(s): _____

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.
Position(s): _____

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(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such event or information as soon as possible.

2. Definitions:

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(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)?

✓ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity?

✓ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

✓ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity?

✓ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction?

✓ NO _____YES. If YES, please provide details. _____

_____

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_____

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__✓__ NO _____ YES. If YES, please provide details. _____

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__✓__ NO _____ YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity?

__✓__ NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity?

__✓__ NO _____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

8/15/15
Date

R. Chris Regan
Printed Name

Conflict of Interest / Financial Disclosure Form

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Please provide the following information:

Print Name: Joseph Simpson

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

X Expert or Consultant with:
Company Name: Harter Secrest & Emery LLP
Title: Counsel

____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated
Position(s): _____

____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.
Position(s): _____

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(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)?

x NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

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x NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity?

x NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction?

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_____

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(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.



Signature

08/24/2015

Date

Joseph Simpson

Printed Name

Conflict of Interest / Financial Disclosure Form

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1. Instructions:

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: LOUIS A. SPADACCINI

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

X Expert or Consultant with:
Company Name: BLACKWELL & SPADACCINI, LLC
Title: ATTORNEY

____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated
Position(s): _____

____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.
Position(s): _____

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(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)?

__X__ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity?

__X__ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity?

__X__ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a Prospect Medical Holdings, Inc. Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

8/27/15
Date

LOUIS A. SPADACCINI
Printed Name

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Please provide the following information:

Print Name: Nicolas Tarditti

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:
Company Name: Duff & Phelps, LLC
Title: _____

_____ Eastern Connecticut Health Network, Inc. The Manchester Memorial Hospital The Rockville General Hospital, Incorporated
Position(s): _____

_____ ECHN ElderCare Services, Inc. Visiting Nurse & Health Services of Connecticut, Inc.
Position(s): _____

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(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. Financial Interests:

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)□

□ _____ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity□

□ _____ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction□

_____ NO □ _____YES. If YES, please provide details. My employer, Duff & Phelps, LLC, will receive compensation for professional services rendered. No such compensation is contingent upon the completion of the proposed transaction.

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity□

□ _____ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction□

□ _____ NO _____YES. If YES, please provide details. _____

_____

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□ _____ NO _____YES. If YES, please provide details. _____

_____

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(i) Sold or transferred assets to or purchased assets from or exchanged assets.

□ _____ NO _____YES. If YES, please provide details. _____
_____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity□

□ _____ NO _____YES. If YES, please provide details. _____
_____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity□

□ _____ NO _____YES. If YES, please provide details. _____
_____

(iv) Furnished or ac□uired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity□

□ _____ NO _____YES. If YES, please provide details. _____
_____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

nick.tarditti@duffandphelps.com

Digitally signed by: nick.tarditti@duffandphelps.com
DN: CN = nick.tarditti@duffandphelps.com
Date: 2015.08.31 09:25:35 -07'00'

Signature

8/31/2015
Date

Nicolas Tarditti
Printed Name

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Please provide the following information:

Print Name: Lori Stone

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

__X__ Expert or Consultant with:

Company Name: Harter Secrest & Emery LLP

Title: Counsel

_____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated

Position(s): _____

_____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.

Position(s): _____

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(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)?

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x NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

x NO _____YES. If YES, please provide details. _____

_____

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x NO _____YES. If YES, please provide details. _____

_____

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(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

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x NO _____YES. If YES, please provide details. _____

_____

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a Prospect Medical Holdings, Inc. Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

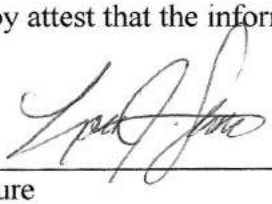
(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.



Signature

August 18, 2015
Date

Lori J. Stone
Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. ("ECHN") application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., Eastern Connecticut Medical Professionals Foundation, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Jane Willis

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

X Expert or Consultant with:
Company Name: Ropes & Gray LLP
Title: Partner

____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated
Position(s): _____

____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.
Position(s): _____

(b) Please complete and return this Disclosure Form no later than **August 24, 2015** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such event or information as soon as possible.

2. **Definitions:**

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)?

X NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity?

_____ NO X YES. If you answered YES, please note the name of the entity and income generated from the entity. As noted in the waiver consent provided to ECHN, Ropes & Gray does represent Prospect Medical Holdings, Inc. in unrelated matters. Ropes & Gray's relationship with all clients is subject to applicable legal ethics requirements, and the firm maintains a robust conflict management system.

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction?

_____ NO X YES. If YES, please provide details. As noted in the waiver consent provided to ECHN, Ropes & Gray does represent Prospect Medical Holdings, Inc. in unrelated matters. Ropes & Gray's relationship with all clients is subject to applicable legal ethics requirements, and the firm maintains a robust conflict management system.

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(i) Sold or transferred assets to or purchased assets from or exchanged assets.

X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity?

_____NO X YES. If YES, please provide details. As noted in the waiver consent provided to ECHN, Ropes & Gray does represent Prospect Medical Holdings, Inc. in unrelated matters. Ropes Gray's relationship with all clients is subject to applicable legal ethics requirements, and the firm maintains a robust conflict management system.

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Pame Willis/djp
Signature

8/27/2015
Date

Jane Willis
Printed Name

Conflict of Interest / Financial Disclosure Form

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All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. **Instructions:**

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Mark Wilson

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

X Expert or Consultant with:
Company Name: Harter Secrest & Emery LLP
Title: Partner

____ Eastern Connecticut Health Network, Inc./The Manchester Memorial Hospital/The Rockville General Hospital, Incorporated
Position(s): _____

____ ECHN ElderCare Services, Inc./Visiting Nurse & Health Services of Connecticut, Inc.
Position(s): _____

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2. Definitions:

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Prospect Entity**: includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)?

x NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity?

x NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity?

x NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction?

x NO _____YES. If YES, please provide details. _____

_____

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X NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

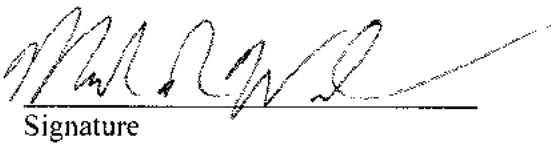
(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.



Signature

8/20/15

Date

Mark R Wilson

Printed Name

EXHIBIT Q6-2 - CONFLICT OF INTEREST/FINANCIAL DISCLOSURES – PMH

PMH CONFLICT OF INTEREST DISCLOSURES

Name	**Affiliation**
Alyse Wagner	Director, BOD
John Baumer	Director, BOD
Michael Solomon	Director, BOD
Sam Lee	Chairman, BOD; CEO, PMH
Dr. Jeereddi Prasad	Director, BOD, President, ProMed
Dr. Mitchell Lew	President, PMH
Steve Aleman	CFO, PMH
Ellen Shin	General Counsel & Secretary, PMH
David Topper	President, Alta
Jonathan Spees	SVP, M&A, PMH
Von Crockett	SVP, Corporate Development, PMH
Steve O'Dell	SVP, CRC, PMH
Thomas Reardon	President, Prospect East
Gary Herschman	PMH Advisor, Epstein, Becker
Michele Volpe	PMH Advisor, Bernstein, Volpe
Jay Krupin	PMH Advisor, Baker Hostetler
Elizabeth Dold	PMH Advisor, Groom Law Group
Alan Weiss	PMH Advisor, Lockton
Jim Tinyo	PMH Advisor, Keenan
Arthur Rains-McNally	PMH Advisor, Milliman
Chris Kujawa	PMH Advisor, Ernst & Young LLP
Rosemary Free	PMH Advisor, Ernst & Young LLP

Conflict of Interest / Financial Disclosure Form

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1. Instructions:

(a) This Disclosure Form is to be completed by (i) Prospect Medical Holdings, Inc. board members and officers; (ii) experts and consultants retained by Prospect Medical Holdings, Inc. in connection with the Transaction; and (iii) senior executives at Prospect Medical Holdings, Inc. who have direct involvement in the Transaction.

Please provide the following information:

Print Name: ALYSE WAGNER

(b) Please complete and return the Disclosure Form by **August 24, 2015** to Ellen Shin, ellen.shin@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Ellen Shin at 310-943-4520.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Ellen Shin, ellen.shin@prospectmedical.com, of any such event or information as soon as possible.

2. Definitions:

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

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3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any ECHN Entity (see definitions above)?

__X__ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any ECHN Entity?

__X__ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any ECHN Entity?

__X__ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of an ECHN Entity or the Local Hospital Board to be formed as part of the Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with an ECHN Entity or the Local Hospital Board to be formed as a part of the Transaction?

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_____

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with an ECHN Entity?

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__X__ NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from an ECHN Entity?

__X__ NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to an ECHN Entity?

__X__ NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to an ECHN Entity?

__X__ NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Alyse Wagner
Signature

8-24-15
Date

ALYSE WAGNER
Printed Name

Conflict of Interest / Financial Disclosure Form

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1. Instructions:

(a) This Disclosure Form is to be completed by (i) Prospect Medical Holdings, Inc. board members and officers; (ii) experts and consultants retained by Prospect Medical Holdings, Inc. in connection with the Transaction; and (iii) senior executives at Prospect Medical Holdings, Inc. who have direct involvement in the Transaction.

Please provide the following information:

Print Name: JOHN BAUMER

(b) Please complete and return the Disclosure Form by **August 24, 2015** to Ellen Shin, ellen.shin@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Ellen Shin at 310-943-4520.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Ellen Shin, ellen.shin@prospectmedical.com, of any such event or information as soon as possible.

2. Definitions:

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **ECHN Entity:** includes Eastern Connecticut Health Network, Inc. ("ECHN"), Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., Eastern Connecticut Medical Professionals Foundation, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any ECHN Entity (see definitions above)?

__X__ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any ECHN Entity?

__X__ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any ECHN Entity?

__X__ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of an ECHN Entity or the Local Hospital Board to be formed as part of the Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

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_____

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X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to an ECHN Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to an ECHN Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature _____ Date 8-24-15

JOHN BAUMER
Printed Name

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Please provide the following information:

Print Name: Michael S. Solomon

(b) Please complete and return the Disclosure Form by **August 24, 2015** to Ellen Shin, ellen.shin@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Ellen Shin at 310-943-4520.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Ellen Shin, ellen.shin@prospectmedical.com, of any such event or information as soon as possible.

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_____

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✓ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

✓ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any ECHN Entity?

✓ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

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✓ NO _____YES. If YES, please provide details. _____

_____

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_____

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✓ NO _____ YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to an ECHN Entity?

✓ NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to an ECHN Entity?

✓ NO _____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

[signature] 8/24/15

Signature Date

Michael Solomon

Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the application of Prospect Medical Holdings, Inc. to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer certain assets of Eastern Connecticut Health Network, Inc. ("ECHN") and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., Eastern Connecticut Medical Professionals Foundation, Inc., ECHN **Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut** Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC, to a for profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

1. Instructions:

(a) This Disclosure Form is to be completed by (i) Prospect Medical Holdings, Inc. board members and officers; (ii) experts and consultants retained by Prospect Medical Holdings, Inc. in connection with the Transaction; and (iii) senior executives at Prospect Medical Holdings, Inc. who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Sam Lee

(b) Please complete and return the Disclosure Form by **August 24, 2015** to Ellen Shin, ellen.shin@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Ellen Shin at 310-943-4520.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Ellen Shin, ellen.shin@prospectmedical.com, of any such event or information as soon as possible.

2. Definitions:

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **ECHN Entity:** includes Eastern Connecticut Health Network, Inc. ("ECHN"), Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., Eastern Connecticut Medical Professionals Foundation, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any ECHN Entity (see definitions above)?

X NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any ECHN Entity?

X NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

X NO _____YES. If YES, please provide details. _____

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(d) Do you or any Related Person own stock or options to purchase stock in any ECHN Entity?

X NO _____YES. If YES, please provide details. _____

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4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of an ECHN Entity or the Local Hospital Board to be formed as part of the Transaction?

X NO _____YES. If YES, please provide details. _____

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(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with an ECHN Entity or the Local Hospital Board to be formed as a part of the Transaction?

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X NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to an ECHN Entity?

X NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to an ECHN Entity?

X NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

_____ 8/20/15

Signature Date

Sam Lee

Printed Name

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Please provide the following information:

Print Name: PRASAD A JEEREDDI

(b) Please complete and return the Disclosure Form by **August 24, 2015** to Ellen Shin, ellen.shin@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Ellen Shin at 310-943-4520.

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I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Jeeredi Aprasad
Signature

8/23/2015
Date

PRASAD A JEEREDDI
Printed Name

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Please provide the following information:

Print Name: Mitchell Lew

(b) Please complete and return the Disclosure Form by **August 24, 2015** to Ellen Shin, ellen.shin@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Ellen Shin at 310-943-4520.

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Mitchell Law
Signature

8/20/15
Date

Mitchell Law
Printed Name

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Please provide the following information:

Print Name: STEVE ALEMAN

(b) Please complete and return the Disclosure Form by **August 24, 2015** to Ellen Shin, ellen.shin@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Ellen Shin at 310-943-4520.

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(iv) Furnished or acquired goods, services or facilities to an ECHN Entity?

__X__ NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

8-25-15
Date

STEVE ALEMAN
Printed Name

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Please provide the following information:

Print Name: Ellen Shin

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[signature] 8/20/15

Signature Date

Ellen Shin

Printed Name

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Please provide the following information:

Print Name: DAVID TOPPER

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I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature _____ Date 8/20/15

DAVID TOPPER
Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the application of Prospect Medical Holdings, Inc. to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer certain assets of Eastern Connecticut Health Network, Inc. ("ECHN") and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., Eastern Connecticut Medical Professionals Foundation, Inc., ECHN **Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut** Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC, to a for profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

1. Instructions:

(a) This Disclosure Form is to be completed by (i) Prospect Medical Holdings, Inc. board members and officers; (ii) experts and consultants retained by Prospect Medical Holdings, Inc. in connection with the Transaction; and (iii) senior executives at Prospect Medical Holdings, Inc. who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Jonathan Rees

(b) Please complete and return the Disclosure Form by **August 24, 2015** to Ellen Shin, ellen.shin@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Ellen Shin at 310-943-4520.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Ellen Shin, ellen.shin@prospectmedical.com, of any such event or information as soon as possible.

2. Definitions:

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **ECHN Entity:** includes Eastern Connecticut Health Network, Inc. ("ECHN"), Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., Eastern Connecticut Medical Professionals Foundation, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any ECHN Entity (see definitions above)?

✓ NO _____ YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any ECHN Entity?

✓ NO _____ YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

✓ NO _____ YES. If YES, please provide details. NOTE: TRANSACTIONS ARE MY PRINCIPAL JOB RESPONSIBILITY AND THE PROPOSED TRANSACTION WILL BE CONSIDERED IN MY OVERALL PERFORMANCE EVALUATION AND BONUS CALCULATION

(d) Do you or any Related Person own stock or options to purchase stock in any ECHN Entity?

✓ NO _____ YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of an ECHN Entity or the Local Hospital Board to be formed as part of the Transaction?

✓ NO _____ YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with an ECHN Entity or the Local Hospital Board to be formed as a part of the Transaction?

✓ NO _____ YES. If YES, please provide details. _____

_____

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with an ECHN Entity?

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✓ NO _____ YES. If YES, please provide details. _____

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(iii) Been indebted to or loaned money to an ECHN Entity?

✓ NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to an ECHN Entity?

✓ NO _____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

8/20/15
Date

JONATHAN SIEGS
Printed Name

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(a) This Disclosure Form is to be completed by (i) Prospect Medical Holdings, Inc. board members and officers; (ii) experts and consultants retained by Prospect Medical Holdings, Inc. in connection with the Transaction; and (iii) senior executives at Prospect Medical Holdings, Inc. who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Von Crockett

(b) Please complete and return the Disclosure Form by **August 24, 2015** to Ellen Shin, ellen.shin@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Ellen Shin at 310-943-4520.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Ellen Shin, ellen.shin@prospectmedical.com, of any such event or information as soon as possible.

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_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

X NO _____YES. If YES, please provide details. _____

_____

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_____

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(iv) Furnished or acquired goods, services or facilities to an ECHN Entity?

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I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

8/24/15
Date

Vori Crockett
Printed Name

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Please provide the following information:

Print Name: STEPHEN T. O'DELL

(b) Please complete and return the Disclosure Form by **August 24, 2015** to Ellen Shin, christine.cohn@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Ellen Shin at 310-943-4520.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Ellen Shin, ellen.shin@prospectmedical.com, of any such event or information as soon as possible.

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(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

X NO _____YES. If YES, please provide details. _____

_____

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_____

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X NO _____YES. If YES, please provide details. _____

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Signature

8/20/15
Date

STEPHEN T. O'DELL
Printed Name

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Please provide the following information:

Print Name: Thomas M. Rennoon

(b) Please complete and return the Disclosure Form by **August 24, 2015** to Ellen Shin, christine.cohn@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Ellen Shin at 310-943-4520.

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(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

X NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any ECHN Entity?

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_____

4. Beneficial and/or Employment Interests

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X NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with an ECHN Entity or the Local Hospital Board to be formed as a part of the Transaction?

X NO _____YES. If YES, please provide details. _____

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TRANSACTIONS ARE A SUBSTANTIAL PART OF MY JOB RESPONSIBILITIES AND THE PROPOSED TRANSACTION WILL BE CONSIDERED IN MY OVERALL PERFORMANCE AND BONUS CALCULATION.

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(iv) Furnished or acquired goods, services or facilities to an ECHN Entity?

X NO _____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

[signature] 8/24/15

Signature Date

Thomas M. Reardon

Printed Name

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Please provide the following information:

Print Name: Gary W. Herschman, Esq.

(b) Please complete and return the Disclosure Form by **August 24, 2015** to Ellen Shin, ellen.shin@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Ellen Shin at 310-943-4520.

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Gary W. Herschman
Signature

9/27/2015
Date

Gary W. Herschman
Printed Name

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Please provide the following information:

Print Name: Michele Volpe

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✓ NO _____YES. If YES, please provide details. _____

_____

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with an ECHN Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

✓ NO _____ YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from an ECHN Entity?

✓ NO _____ YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to an ECHN Entity?

✓ NO _____ YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to an ECHN Entity?

✓ NO _____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature _____ Date 8/24/15

Michael Volpe
Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the application of Prospect Medical Holdings, Inc. to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer certain assets of Eastern Connecticut Health Network, Inc. ("ECHN") and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., Eastern Connecticut Medical Professionals Foundation, Inc., ECHN **Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut** Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC, to a for profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

1. Instructions:

(a) This Disclosure Form is to be completed by (i) Prospect Medical Holdings, Inc. board members and officers; (ii) experts and consultants retained by Prospect Medical Holdings, Inc. in connection with the Transaction; and (iii) senior executives at Prospect Medical Holdings, Inc. who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Jay P. Krupin, Attorney, Baker & Hostetler LLP

(b) Please complete and return the Disclosure Form by **August 24, 2015** to Ellen Shin, ellen.shin@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Ellen Shin at 310-943-4520.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Ellen Shin, ellen.shin@prospectmedical.com, of any such event or information as soon as possible.

2. Definitions:

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **ECHN Entity:** includes Eastern Connecticut Health Network, Inc. ("ECHN"), Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., Eastern Connecticut Medical Professionals Foundation, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any ECHN Entity (see definitions above)?

__X__ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any ECHN Entity?

__X__ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any ECHN Entity?

__X__ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of an ECHN Entity or the Local Hospital Board to be formed as part of the Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with an ECHN Entity or the Local Hospital Board to be formed as a part of the Transaction?

__X__ NO _____YES. If YES, please provide details. _____

_____

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with an ECHN Entity?

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(ii) Leased assets to or leased assets from an ECHN Entity?

__X__ NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to an ECHN Entity?

__X__ NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to an ECHN Entity?

__X__ NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature (Attorney) Date: Aug 21, 2015

JAY P. KRUPIN
Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the application of Prospect Medical Holdings, Inc. to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer certain assets of Eastern Connecticut Health Network, Inc. ("ECHN") and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., Eastern Connecticut Medical Professionals Foundation, Inc., ECHN **Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut** Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC, to a for profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

1. Instructions:

(a) This Disclosure Form is to be completed by (i) Prospect Medical Holdings, Inc. board members and officers; (ii) experts and consultants retained by Prospect Medical Holdings, Inc. in connection with the Transaction; and (iii) senior executives at Prospect Medical Holdings, Inc. who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Elizabeth Thomas Dold

(b) Please complete and return the Disclosure Form by **August 24, 2015** to Ellen Shin, ellen.shin@prospectmedical.com. If you have a ny questions reg arding thc Disclosure Form, please contact Ellen Shin at 310-943-4520.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Ellen Shin, ellen.shin@prospectmedical.com, of any such event or information as soon as possible.

2. Definitions:

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3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any ECHN Entity (see definitions above)?

✓ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any ECHN Entity?

✓ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

✓ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any ECHN Entity?

✓ NO _____YES. If YES, please provide details. _____

_____

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✓ NO _____YES. If YES, please provide details. _____

_____

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_____

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(iv) Furnished or acquired goods, services or facilities to an ECHN Entity?

✓ NO _____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Elizabeth T. Dodd
Signature

8/20/15
Date

Elizabeth T. Dodd
Printed Name

Conflict of Interest / Financial Disclosure Form

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1. Instructions:

(a) This Disclosure Form is to be completed by (i) Prospect Medical Holdings, Inc. board members and officers; (ii) experts and consultants retained by Prospect Medical Holdings, Inc. in connection with the Transaction; and (iii) senior executives at Prospect Medical Holdings, Inc. who have direct involvement in the Transaction.

Please provide the following information:

Print Name: ALAN M. WEISS

(b) Please complete and return the Disclosure Form by **August 24, 2015** to Ellen Shin, ellen.shin@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Ellen Shin at 310-943-4520.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Ellen Shin, ellen.shin@prospectmedical.com, of any such event or information as soon as possible.

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3. **Financial Interests:**

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_____

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_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

✓ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any ECHN Entity?

✓ NO _____YES. If YES, please provide details. _____

_____

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✓ NO _____YES. If YES, please provide details. _____

_____

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(iv) Furnished or acquired goods, services or facilities to an ECHN Entity?

✓ NO _____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

[signature] 8/25/2015

Signature Date

ALAN M WEISS

Printed Name

Conflict of Interest / Financial Disclosure Form

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Please provide the following information:

Print Name: James D. Tinyo

(b) Please complete and return the Disclosure Form by **August 24, 2015** to Ellen Shin, ellen.shin@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Ellen Shin at 310-943-4520.

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__X__ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any ECHN Entity?

__X__ NO _____YES. If YES, please provide details. _____

_____

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(iv) Furnished or acquired goods, services or facilities to an ECHN Entity?

__X__ NO _____ YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

James D Tinyo
Signature

8-24-15
Date

James D. Tinyo
Printed Name

Conflict of Interest / Financial Disclosure Form

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Please provide the following information:

Print Name: Arthur Rains - McNally

(b) Please complete and return the Disclosure Form by **August 24, 2015** to Ellen Shin, ellen.shin@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Ellen Shin at 310-943-4520.

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_____

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_____

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✓ NO _____YES. If YES, please provide details. _____

_____

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I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Signature

8/26/15
Date

Arthur Rains-McNally
Printed Name

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Please provide the following information:

Print Name: Rosemary Free of EY, LLP

(b) Please complete and return the Disclosure Form by **August 24, 2015** to Ellen Shin, ellen.shin@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Ellen Shin at 310-943-4520.

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_____

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_✓_ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any ECHN Entity?

_✓_ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of an ECHN Entity or the Local Hospital Board to be formed as part of the Transaction?

_✓_ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with an ECHN Entity or the Local Hospital Board to be formed as a part of the Transaction?

_✓_ NO _____YES. If YES, please provide details. _____

_____

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with an ECHN Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

✓ NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from an ECHN Entity?

✓ NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to an ECHN Entity?

✓ NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to an ECHN Entity?

✓ NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Rosemary P Free
Signature

8/25/15
Date

Rosemary P FREE
Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest / Financial Disclosure Form is being completed as part of the application of Prospect Medical Holdings, Inc. to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer certain assets of Eastern Connecticut Health Network, Inc. ("ECHN") and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., Eastern Connecticut Medical Professionals Foundation, Inc., ECHN **Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut** Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC, to a for profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

1. Instructions:

(a) This Disclosure Form is to be completed by (i) Prospect Medical Holdings, Inc. board members and officers; (ii) experts and consultants retained by Prospect Medical Holdings, Inc. in connection with the Transaction; and (iii) senior executives at Prospect Medical Holdings, Inc. who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Rosemary Free of EY, LLP

(b) Please complete and return the Disclosure Form by **August 24, 2015** to Ellen Shin, ellen.shin@prospectmedical.com. If you have any questions regarding the Disclosure Form, please contact Ellen Shin at 310-943-4520.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Ellen Shin, ellen.shin@prospectmedical.com, of any such event or information as soon as possible.

2. Definitions:

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **ECHN Entity:** includes Eastern Connecticut Health Network, Inc. ("ECHN"), Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., Eastern Connecticut Medical Professionals Foundation, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC.

3. **Financial Interests:**

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any ECHN Entity (see definitions above)?

_✓_ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any ECHN Entity?

_✓_ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction?

_✓_ NO _____YES. If YES, please provide details. _____

_____

(d) Do you or any Related Person own stock or options to purchase stock in any ECHN Entity?

_✓_ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of an ECHN Entity or the Local Hospital Board to be formed as part of the Transaction?

_✓_ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with an ECHN Entity or the Local Hospital Board to be formed as a part of the Transaction?

_✓_ NO _____YES. If YES, please provide details. _____

_____

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with an ECHN Entity?

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

✓ NO _____YES. If YES, please provide details. _____

(ii) Leased assets to or leased assets from an ECHN Entity?

✓ NO _____YES. If YES, please provide details. _____

(iii) Been indebted to or loaned money to an ECHN Entity?

✓ NO _____YES. If YES, please provide details. _____

(iv) Furnished or acquired goods, services or facilities to an ECHN Entity?

✓ NO _____YES. If YES, please provide details. _____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

Rosemary P Free
Signature

8/25/15
Date

Rosemary P FREE
Printed Name

EXHIBIT Q6-3 PMH CODE OF BUSINESS CONDUCT



Code of Business Conduct
Ethical Business Practice

As approved by the Board of Directors on September 10, 2013

A Message to Directors and Employees:

As Directors and employees of Prospect Medical Holdings, Inc and its subsidiaries (referred to in the following pages as "Company"), we are responsible for conducting the business affairs of the Company in accordance with applicable laws, in an honest manner, and with the highest professional and ethical standards.

To make certain that we understand what is expected of us, the Company and its Board of Directors have adopted the following policies.

This Code of Business Conduct / Ethical Business Practice and the incorporated corporate policies (collectively, "Code") contain commonsense rules of conduct. We ask that you read the Code carefully and completely, because it is essential that you fully comply with these policies in the future. If you have any questions, talk them over with your manager or another member of management. Alternatively, feel free to contact the Human Resources or Legal Departments.

Please sign the acknowledgment page confirming that you have received the Code, understand it represents mandatory policies of the Company and agree to abide by it. Return the signed copy to the Human Resources Department where it will be placed in your personnel file and keep the Code for future reference.

Thank you for your attention to this important matter.

Sincerely,



Samuel S. Lee
Chairman and Chief Executive Officer

Code of Business Conduct / Ethical Business Practice

Directors and employees of the Company, its subsidiaries and affiliated companies, are to conduct their business affairs in accordance with the highest ethical standards. Policies are to be applied in good faith with reasonable business judgment to enable the Company to achieve its operating and financial goals within the framework of the law. Directors and employees shall not conduct themselves in a manner that is directly or indirectly detrimental to the best interests of the Company or in a manner which would bring financial or any other gain to any Director or employee at the expense of the Company. Ethical as well as legal obligations will be fulfilled openly, promptly, and in a manner that will reflect positively on the Company's name.

Agreements, whether written or verbal, will be honored. No bribes, bonuses, kickbacks, lavish entertainment, or gifts will be exchanged for special position, price, or privilege. It is Company policy that contracts are reviewed by legal counsel. By contract, we mean each agreement, memorandum of understanding, or other document or arrangement that could reasonably be expected to impose an obligation. Please bear in mind that your conduct and/or your conversations may have, under certain circumstances, the unintended effect of creating an obligation which the Company cannot meet.

The Company requires Directors and employees to observe high standards of business and personal ethics in the conduct of their duties and responsibilities. Directors and employees must practice honesty and integrity in every aspect of dealing with other Directors and employees, the public, the business community, stockholders, customers, members and government authorities.

Directors and employees will maintain the confidentiality of the Company's sensitive or proprietary information and will not use such information for their personal benefit or the benefit of another person or entity. Directors and employees shall refrain, both during and after their employment, from publishing any oral or written statements about the Company or any of its Directors or employees that are slanderous, libelous or defamatory. Statements disclosing private or confidential information about their business affairs or constituting an intrusion into their private lives should be avoided.

Directors and employees will comply with the stock ownership requirements set forth by the Board of Directors, which may relate to the ownership of stock in the Company's parent company or other affiliates.

The Company prohibits unlawful discrimination against Directors and employees, stockholders, members, customers or suppliers on account of race, color, religion, sex, sexual orientation, gender identity or expression, pregnancy, marital status, national origin, citizenship, veteran status, ancestry, age, physical or mental disability, medical condition, genetic predisposition, or any other consideration made unlawful by applicable laws. All persons shall be treated with dignity and respect and they shall not be interfered with in the conduct of their duties and responsibilities.

Directors and employees should not be misguided by any sense of loyalty to the Company or a desire for profitability that might cause them to disobey any applicable law or Company policy. Illegal behavior on the part of any Director or employee in the performance of Company duties will not be condoned or tolerated.

The Company is committed to evaluating the effectiveness of the Code through various efforts on an ongoing basis. Adherence to and support of the Code is a condition of employment. Violation may result in disciplinary action, which may include termination.

The Code will be distributed to new Directors and employees and be distributed again to all Directors and employees on an annual basis. Directors and employees are required to sign the acknowledgment confirming they have received the Code, read it and understand it represents mandatory policies of the Company and agree to abide by it. The Company welcomes any suggestions to help improve its business conduct.

Directors and employees can report violations of the law or the Code by calling the Ethics and Compliance Hotline at (877) 814-9252. The Hotline is open 24 hours a day, 7 days a week, and is operated by an independent company. Directors and employees may remain anonymous and translators are available.

Antitrust & Competition

No Director or employee of the Company shall enter into any understanding, agreement, plan or scheme, express or implied, formal or informal, with any competitor to fix prices, contract terms, territories or customers. Authorized senior management of the Company must authorize any discussion with competitors in connection with a project in which the competitor is an alliance partner, joint venturer or subcontractor.

Directors and employees responsible for the conduct or practices of the Company which could in any way involve antitrust or anti-competitive activities should consult with their manager or another appropriate member of management about such matters.

There shall be no exception to this Policy, nor shall it be compromised or qualified by anyone acting for or on behalf of the Company.

Bribery

The Company prohibits payment to suppliers or customers in the form of bribes, kickbacks or payoffs. Directors and employees are also prohibited from receiving, directly or indirectly from a third party, anything of a significant value (other than salary or other ordinary compensation paid by the Company) in connection with a transaction entered into by the Company.

The Company also prohibits Directors and employees from paying any bribe, kickback or other similar unlawful payment to, or otherwise entering into a sensitive transaction with, any public official, political party, candidate for public office or other individual, to secure any contract,

concession or other favorable treatment for the Company or for personal gain. Any extraordinary payments, including extravagant entertainment or gifts of significant value (in general this means the cost will exceed £100), for the express purpose of obtaining or retaining business or unduly influencing some matter in favor of the Company is prohibited. Directors and employees who make such agreements are subject to appropriate action by the Company, as well as the legal consequences of applicable law.

Bribes, kickbacks and payoffs include, but are not limited to: gifts other than nominal value (in general this means the cost will not exceed £100); the uncompensated use of Company services, facilities or property; loans, or loan guarantees or other extensions of credit.

This Policy does not prohibit reasonable expenditures for meals and entertainment of suppliers and customers, which are an ordinary and customary business expense. These expenditures should be included on expense reports and approved under standard Company procedures.

Confidential Information

In carrying out the Company's business, Directors and employees often learn confidential or proprietary information about the Company, its customers, suppliers or members. An unauthorized disclosure could be harmful to the Company or helpful to a competitor.

Therefore, no Director or employee entrusted with or otherwise knowledgeable about information of a confidential or proprietary nature shall disclose or use that information outside the Company or for personal gain, either during or after employment without the valid and proper written authorization from the Company.

The Company also works with proprietary data of suppliers, members and customers. The protection of such data is of the highest importance and must be discharged with the greatest care for the Company to merit the continued confidence of such persons. No Director or employee shall disclose or use confidential or proprietary information owned by someone other than the Company to non-employees without Company authorization, or disclose the information to others unless a need-to-know basis is established.

In general when describing or talking about the Company, it is safe to mention what we do and not how we do it or how much it costs.

Conflicts of Interest

Directors and employees have a duty to the Company to advance the Company's legitimate interests when the opportunity to do so arises. Timely and proper disclosure of possible conflicts of interest that Directors and employees may have in connection with job duties and responsibilities is necessary to protect the best interests of the Company. Possible conflict of interest situations should be promptly and fully disclosed to the Company's senior management.

A conflict of interest may occur if outside activities, personal financial interests, or other interests influence one's ability to make objective decisions in the course of their responsibilities as a Director or employee. A conflict of interest may also exist if the demands of any outside activities hinder or distract Directors or employees from the performance of their responsibilities or cause the individual to use Company resources for other than Company business.

The Company has always been concerned with outside business interests of its Directors and employees that might possibly conflict with the interests of the Company. The Company expects and requires Directors and employees to be honest and ethical in the handling of actual or apparent conflicts of interest between personal and business relationships.

A precise definition of what constitutes a conflict of interest is difficult. There are certain situations which the Company will always consider to be a conflict of interest. These occur if any person having a close personal relationship with the Director or employee, such as, spouse, parents, children, siblings, in-laws, any person living in the same home with the Director or employee or any business associate of the Director or employee:

1. Obtains a significant financial or other beneficial interest in one of the Company's suppliers, customers or competitors without first notifying the Company and obtaining written approval from authorized senior management of the Company;
2. Engages in a significant personal business transaction involving the Company for profit or gain, without first notifying the Company and obtaining written approval from authorized senior management of the Company;
3. Accepts money, gifts, hospitality, loans, guarantees of obligations or other special treatment from any supplier, customer or competitor of the Company;
4. Participates in any sale, loan or gift of Company property without first notifying the Company and obtaining written approval from authorized senior management of the Company;
5. Learns of a business opportunity through association with the Company and discloses it to a third party or invests in or takes the opportunity personally without first notifying the Company;
6. Uses corporate property, information, or position for personal gain; or
7. Competes with the Company.

Equal Opportunity Employer

The Company is an equal opportunity employer and makes employment decisions on the basis of merit. The Company wants to have the best available people in every job. Therefore, the Company does not discriminate, and does not permit its employees to discriminate against other employees or applicants because of race, color, religion, gender, sex, sexual orientation, gender identity or expression, pregnancy, marital status, national origin, citizenship, veteran status, ancestry, age, physical or mental disability, medical condition, genetic predisposition, or any other basis protected by applicable federal, state, or local law. Equal employment opportunity

will be extended to all persons in all aspects of the employer-employee relationship, including recruitment, hiring, upgrading, training, promotion, transfer, compensation, benefits, discipline, layoff, recall and termination.

An employee who believes he or she has been or is being subjected to discrimination should bring this matter to the attention of his or her immediate supervisor, department head or Human Resources. If management receives a complaint of discrimination, they shall report the complaint immediately to Human Resources. Nothing in this policy requires any employee complaining of discrimination to present the matter to the person who is the subject of the complaint. All complaints of discrimination will be promptly investigated. The privacy of the persons involved will be protected, except to the extent necessary to conduct a proper investigation. If the investigation substantiates the complaint, immediate action will be taken to end the discrimination, prevent its recurrence and remedy the situation.

An employee who reports discrimination or participates in an investigation related to a complaint of discrimination shall not be retaliated against or adversely treated on the basis thereof.

Fraud & Similar Irregularities

Directors and employees are obligated to protect Company assets and ensure their efficient use. Theft, carelessness and waste of Company assets by Directors and employees may result in their termination and other corrective actions by the Company. Company assets shall be used only for the legitimate business purposes of the Company.

Fraud includes, but is not limited to, dishonest or fraudulent acts; embezzlement; misappropriation of assets; forgery or alteration of negotiable instruments such as Company checks and drafts; taking or using Company supplies or any other Company asset for a purpose other than Company business; unauthorized handling or reporting of Company transactions; and falsification of Company records or financial statements for personal reasons or any other reason.

Directors and employees are obligated to report any fraud, whether material or not to the Company. Reports will be investigated promptly and discreetly. Directors and employees will not suffer adverse consequences as a result of making such a report. However, failure to report a fraud will have a direct negative effect on that person's relations with the Company.

Policy Against Harassment

The Company is committed to providing a work environment that is free of unlawful discrimination and/or harassment. In keeping with this commitment, the Company maintains a strict policy prohibiting unlawful harassment in the workplace, including sexual harassment, by any employee and by any third parties such as patients, doctors, vendors or visitors. In addition, any harassment of an employee on the basis of race, color, religion, gender, sex, sexual orientation, gender identity or expression, pregnancy, marital status, national origin, citizenship, veteran status, ancestry, age, physical or mental disability, medical condition, genetic predisposition or any other protected classification is also strictly prohibited.

The Company considers harassment a serious act of misconduct for which an employee will be disciplined, up to and including immediate discharge. Management who fail to report violations of the Company's Policy Against Harassment will be disciplined , up to and including suspension and termination of employment. The term "harassment" includes sexual, racial, ethnic, and other forms of harassment, including harassment based upon disability.

Some examples of what may be considered harassment, depending on facts and circumstances, include the following:

Sexual Harassment. Unwelcome sexual advances, requests for sexual favors, widespread sexual favoritism, and other verbal, physical or visual conduct of a sexual nature constitute unlawful sexual harassment if (i) submission to such conduct is made an explicit or implicit term or condition of employment; (ii) submission to or rejection of such conduct is used as the basis for employment decisions affecting an individual; or (iii) such conduct has the purpose or effect of either (a) unreasonably interfering with an individual's work performance or (b) creating an intimidating, hostile, or offensive working environment. Sexual harassment includes gender harassment and harassment on the basis of pregnancy, childbirth or related medical conditions, and also includes sexual harassment of an employee of the same gender as the harasser.

Examples of conduct which may violate this Policy include, but are not limited to: offensive or unwelcome sexual flirtations, advances or propositions; threats and demands to submit to sexual requests; offering employment benefits in exchange for sexual favors; making or threatening reprisals after a negative response to sexual advances; widespread sexual favoritism; verbal abuse of a sexual nature; graphic verbal commentaries about an individual's body; sexually degrading words used to describe an individual; sexually-oriented jokes, e-mails, or written materials; visual conduct, including leering, making sexual gestures, displaying of sexually suggestive objects or pictures, cartoons or posters; accessing sexually explicit, pornographic and/or socially offensive websites, chat rooms or other material on the internet or other computer systems; and the unwelcome physical touching of others.

Other Harassment. The Company also will not tolerate any harassment of an employee on the basis of race, gender, religion, color, national origin, sex, sexual orientation, sexual identity, transgender identity, age, ancestry, marital status, disability, medical condition, pregnancy, veteran's status, genetic predisposition or any other protected classification. Examples of such conduct which may violate this policy include, but are not limited to, verbal abuse of a racially derogatory nature; the use of racial or ethnic slurs; racially or ethnically disparaging words used to describe an individual; and racial, ethnic or other derogatory jokes, e-mail, written materials, drawings or cartoons which are racially or otherwise offensive.

Manager Training

As part of the Company's commitment to provide a harassment free workplace, the Company provides and requires training for all managers and supervisors on sexual harassment and other forms of prohibited harassment.

Complaint Procedure

If you believe that you have been discriminated against or you have been harassed by a co-worker, supervisor, patient, or vendor; have witnessed possible discrimination and/or harassment; or if you believe that the Company or another employee has violated any applicable law in the conduct of the Company's business, you have a duty to immediately bring the incident(s) to the attention of Human Resources, or to your supervisor or manager. Any supervisory or managerial employee who receives such a complaint must promptly report it to Human Resources. The description of the incident(s) can be given verbally or in writing.

The matter will be thoroughly investigated, with confidentiality maintained to the extent possible. The Company will promptly investigate the complaint and take appropriate remedial action. It is the obligation of all employees to cooperate fully in the investigation process.

The Company will take action to deter any future discrimination and/or harassment. The Company considers any discrimination and/or harassment to be a serious offense which can result in disciplinary action for the offender, up to and including termination. In addition, disciplinary action will be taken against any employee who attempts to discourage or prevent another employee from bringing discrimination, harassment and/or a violation of law to the attention of management.

Policy Against Retaliation

The Company strictly prohibits retaliation, coercion or intimidation against any person who has, in good faith, opposed harassment or discrimination, filed a complaint of harassment or discrimination, or participated in any proceeding involving a complaint of harassment or discrimination. Any employee who is found to have committed such retaliation will be subject to discipline, up to and including termination. Any employee who experiences or witnesses any conduct believed to be retaliatory should immediately follow the reporting procedures stated above.

Health & Safety

Health and safety is a primary goal of the Company. The Company will comply with all applicable laws to protect the health and safety of its employees in the workplace. Management shall take such actions as are reasonable and necessary to protect Directors, employees and the Company.

To maintain a safe workplace, employees must be safety conscious at all times. Employees must advise their Supervisor or Human Resources if they are aware of any condition presenting a danger so that corrective action may be taken to remove the danger.

Employees should report personal injury, however minor, to the Human Resources Department immediately. First aid kits are readily available in all work areas. In case of emergency, the first person in contact with the injured or ill worker will be responsible for seeking help. The Human Resources Department will assist in obtaining treatment for the injured worker.

Political Activities & Contributions

The Company encourages participation in the political process by its Directors and employees. The federal government and some states have, however, enacted laws regulating campaign contributions in order to limit the political influence of certain types of contributors, such as corporations, to political candidates and participation in political campaigns.

The Company will comply with applicable laws regulating political influence and campaign contributions. The Company believes strongly in the democratic political process and that its Directors and employees should take an active interest in fostering principles of good government in the communities in which they live. Directors and employees may spend their own time and funds supporting political candidates and issues but the Company will not reimburse them for time or funds used for political contributions.

No Director or employee shall apply pressure, direct or implied, that infringes upon an individual s right to decide whether, to whom and in what amount a personal political contribution is to be made. Directors and employees who represent the Company in political and governmental matters must comply with all laws that regulate corporate participation in public affairs.

When permitted by law and authori ed by authori ed senior management of the Company, Company funds and facilities may be used to inform or influence the voting public on an issue of importance to the business of the Company and its stockholders.

If a Director or employee is asked to make a political contribution and he or she has uestions regarding this policy or applicable law, they should consult with authori ed senior management of the Company.

Code of Business Conduct and Ethical Business Practice

Acknowledgment of Receipt

I certify that I have received the Prospect Medical Holdings, Inc. Code of Business Conduct and Ethical Business Practice, understand it represents mandatory policies of the Company and agree to abide by it.

Name (please print): _____

Signature: _____

Date: _____

EXHIBIT Q7-1 - DUFF & PHELPS' QUALIFICATIONS AND CONFLICT DISCLOSURE



ECHN

Fairness Opinion and Healthcare Experience and Qualifications

October 2013

DUFF & PHELPS

Table of Contents

Sections

1. Healthcare Practice Overview
2. Overview of Duff & Phelps
3. Professional Biographies

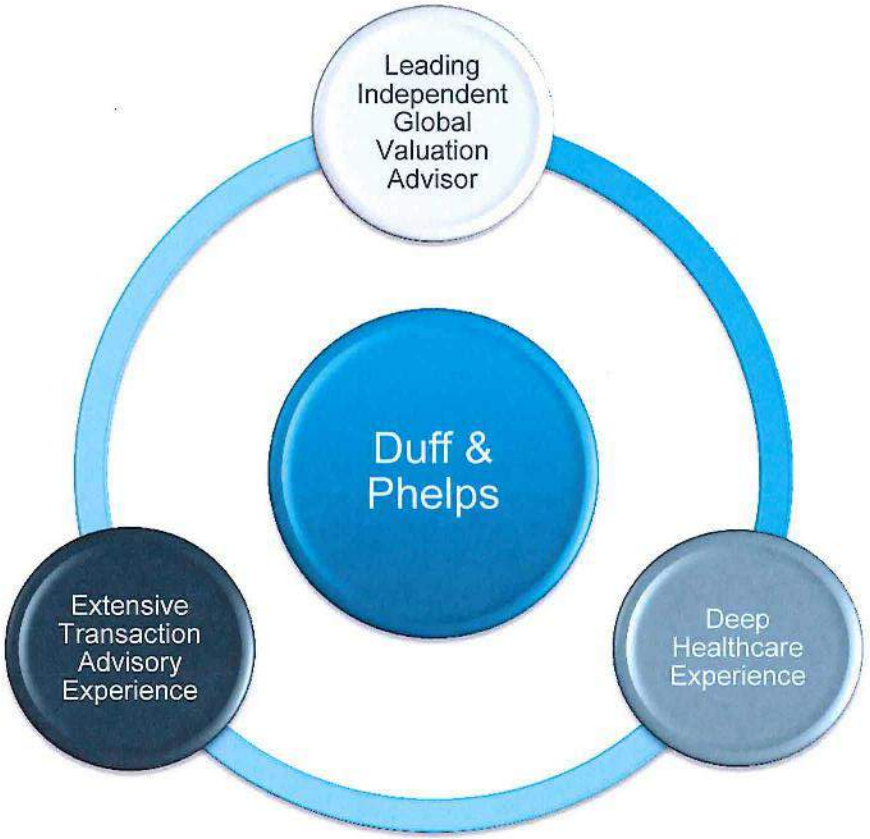
Section 1

Healthcare Practice Overview

Summary of Qualifications

The blend of broad services and deep expertise that we offer make us uniquely qualified to provide the valuation and fairness opinion services requested by the board.

- **Leading Independent Global Valuation Advisor**
  - We provide a broad array of financial advisory and investment banking services, and valuation is the cornerstone of all that we do.
- **Deep Healthcare Industry Experience**
  - We have advised some of the most prominent healthcare companies in the United States and the world regarding valuation and other financial advisory matters.
- **Extensive Transaction Advisory Experience**
  - Our valuation work is not just theoretical. Through our investment banking practice, we provide merger & acquisition advisory services and transaction opinions on a wide range of corporate transactions.



Healthcare Practice Overview



Duff & Phelps distinguishes itself with the depth of experience of our Healthcare Industry Group. Because we place so much importance on the industry expertise of our service team leaders, we bring a wealth of experience to each healthcare engagement. We believe that our healthcare clients are best served by those who have experience with the industry specific issues that are often unique to this sector.

Our experience in the healthcare is substantial:

- Our firm has performed numerous valuations in connection with various aspects of mergers & acquisitions, divestitures, partnerships, corporate restructuring, capital raising, and related-party transactions
- Our firm has substantial experience with the valuation of healthcare service providers, healthcare facilities, managed care plans, and companies engaged in medical technology, pharmaceuticals and biotechnology
- Our team will provide an educated analysis and meaningful conclusions formulated from our understanding of each client's issues and valuation drivers, as well as the best practices and trends that shape the future development of each company



Representative Healthcare Clients

HEALTHSOUTH. ManorCare RUSH UNIVERSITY MEDICAL CENTER Children's Memorial Hospital

Catholic Healthcare West MERITER USC UNIVERSITY OF SOUTHERN CALIFORNIA TORRANCE MEMORIAL MEDICAL CENTER UNIVERSITY OF PENNSYLVANIA HEALTH SYSTEM

ECHN Proposed Asset Purchase by PMH
Submitted October 19, 2015

Representative Healthcare Clients



Selected Healthcare Experience

Fairness Opinion

Clear One Health Plans, Inc. has merged with PacificSource Health Plans, Inc.

ClearOne Health Plans

Financial advisor to the board of directors of Clear One Health Plans, Inc.

Debt Opinion

Tallahassee Memorial HealthCare, Inc. has entered into a tax-exempt financing with related parties

Tallahassee Memorial HealthCare

Financial advisor to the board of directors of Tallahassee Memorial HealthCare, Inc. and its tax and bond counsel.

Fairness Opinion

University of Southern California has acquired USC University Hospital and Norris Cancer Center from Tenet Healthcare Corp.

USC University of Southern California

Financial advisor to the board of trustees of the University of Southern California.

Debt Opinion

Yuma Regional Medical Center has entered into a tax-exempt financing with related parties

Yuma Regional Medical Center
Caring for the growing needs of our communities

Financial advisor to the board of directors of Yuma Regional Medical Center and its tax and bond counsel.

Fairness Opinion

Symbion Healthcare has acquired equity interests in certain entities operating under the Specialty Surgical Center name.

Specialty Surgical Center

Financial advisor to the board of directors of the target entities.

Debt Opinion

Sisters of St. Francis Health Services, Inc. has entered into a tax-exempt financing with related parties.

St. Elizabeth Regional Health
Sisters of St. Francis Health Services

Financial advisor to the board of directors of Sisters of St. Francis Health Services, Inc. and its tax and bond counsel

M&A Sell-Side Advisor

HealthNet, Inc. has sold its wholly owned subsidiaries, collectively known as VitalCare, to RehabCare Group.

Health Net

Financial advisor to HealthNet, Inc.

Solvency Opinion

Myriad Genetics, Inc. has completed the spin-off of Myriad Pharmaceuticals, Inc.

MYRIAD

Financial advisor to the board of directors of Myriad Genetics, Inc.

Selected Healthcare Experience

Sell-Side Advisor and Fairness Opinion

Clear One Health Plans, Inc. has merged with PacificSource Health Plans, Inc.

ClearOne Health Plans

Financial advisor to Clear One Health Plans, Inc. and its the board of directors.

Sell-Side Advisor

Care Ambulance Service, Inc. was acquired by Falck A/S.

CARE AMBULANCE SERVICE

Financial advisor to Care Ambulance Service, Inc.

Fairness Opinion

University of Southern California has acquired USC University Hospital and Norris Cancer Center from Tenet Healthcare Corp.

USC UNIVERSITY OF SOUTHERN CALIFORNIA

Financial advisor to the board of trustees of the University of Southern California.

Buy-Side Advisor

Meriter Health System, Inc. has acquired a controlling interest in Physicians Plus Insurance Corporation.

MERITER

Financial advisor to Meriter Health System, Inc.

Fairness Opinion

Children's Memorial Medical Center sold its interest in Focused Health Solutions, Inc. to Linden.

Children's Memorial Hospital

Financial advisor to the special committee of the board of directors of Children's Memorial Medical Center.

Solvency Opinion

United Surgical Partners International, a portfolio company of Welsh Carson, has completed a dividend recapitalization transaction in conjunction with the spin-off of its U.K. subsidiary to existing shareholders.

United Surgical Partners INTERNATIONAL

Financial advisor to the board of directors of United Surgical Partners International.

Buy-Side Advisor

Clear Choice Health Plans, Inc. has acquired Trusteed Plan Service Corporation.

CLEAR CHOICE HEALTH PLANS

Financial advisor to Clear Choice Health Plans, Inc.

Fairness Opinion

KKR Private Equity Investors, L.P. has sold a portion of its co-investment in HCA, Inc. to an affiliate of Kohlberg Kravis Roberts & Co.

HCA Hospital Corporation of America

Financial advisor to the independent directors of the general partner of KKR Private Equity Investors, L.P.

Selected Healthcare Experience

Private Financing

First Choice ER, LLC was financed by Sterling Partners.

FIRST CHOICE EMERGENCY ROOM

Financial advisor to First Choice, LLC

Solvency Opinion

Allscripts has completed a recapitalization transaction.

Allscripts

Financial advisor to the board of directors of Allscripts.

Buy-Side Advisor

The Conjoin Group has acquired PHNS.

THE CONJOIN GROUP
TRANSFORM • FINANCE • GROW

Financial advisor to the Conjoin Group.

Solvency Opinion

Aveta, Inc. has completed a leveraged dividend recapitalization transaction.

Aveta

Financial advisor to the board of directors of Aveta, Inc.

Solvency Opinion

Universal American Corp. sold its Medicare Prescription Drug Business to CVS Caremark Corporation.

UNIVERSAL AMERICAN
A Healthy Collaboration℠

Financial advisor to the board of directors of Universal American Corp.

Fairness Opinion

Symbion Healthcare has acquired equity interests in certain entities operating under the Specialty Surgical Center name.

SPECIALTY SURGICAL CENTER

Financial advisor to the board of directors of the target entities.

Solvency Opinion

Cardinal Health, Inc. spun off CareFusion into a separate publicly traded company.

CardinalHealth

Financial advisor to the board of directors of Cardinal Health, Inc.

Sell-Side Advisor

Healthcare Laundry Systems has been acquired by Crothall Services Group.

HLS
Healthcare Laundry Systems

Financial advisor to Healthcare Laundry Systems.

Selected Healthcare Experience

Solvency Opinion

Center for Diagnostic Imaging has completed a recapitalization transaction.

CDI
CENTER FOR DIAGNOSTIC IMAGING

Financial advisor to the board of directors of Diagnostic Imaging Holdings, Inc. and Center for Diagnostic Imaging, Inc.

Fairness Opinion

Children's Mercy Hospital has completed the sale of its 100%-owned subsidiary, Children's Mercy's Family Health Partners, Inc. to Coventry Health Care, Inc.

Children's Mercy HOSPITALS & CLINICS

Financial advisor to the boards of directors of Children's Mercy Hospital and Children's Mercy's Family Health Partners, Inc.

Solvency Opinion

Trident USA Health Services, LLC has completed a recapitalization transaction.

TridentUSA℠
HEALTH SERVICES

Financial advisor to the board of directors of Trident USA Health Services, LLC.

Sell-Side Advisor

Pacific Ambulance, Inc. has been acquired by Rural/Metro Corporation, a portfolio company of Warburg Pincus LLC.

PACIFIC AMBULANCE

Financial advisor to Pacific Ambulance, Inc. and its shareholders.

Solvency Opinion

Myriad Genetics, Inc. has completed the spin-off of Myriad Pharmaceuticals, Inc.

MYRIAD®

Financial advisor to the board of directors of Myriad Genetics, Inc.

Sell-Side Advisor

Rush Behavioral Health Network has been acquired by Resurrection Health Care.

RUSH UNIVERSITY MEDICAL CENTER

Financial advisor to Rush University Medical Center.

Sell-Side Advisor

Bowers Companies, Inc. has been acquired by Rural/Metro Corporation, a portfolio company of Warburg Pincus LLC.

BOWERS AMBULANCE

Financial advisor to Bowers Companies, Inc. and its shareholders.

Solvency Opinion

Medical Card System has completed a recapitalization transaction.

MCS

Financial advisor to the board of directors of Medical Card System, Inc.

Additional Healthcare Industry Experience

Senior professionals were involved in the following valuation engagements prior to their employment with Duff & Phelps. These services were provided for a wide variety of purposes, including compliance with fraud and abuse regulations, tax and financial reporting, fulfillment of fiduciary duties, expert witness testimony and general transaction advisory.

Select Advisory Engagements

- Valuation of surgical center in connection with the sale of equity interests to affiliated physicians
- Valuation of IPA enrollment base in southern California in connection with a purchase by a local hospital
- Valuation of the technical component of a women's health screening business in connection with a purchase by the associated hospital
- Valuation of a large multi-specialty medical group in Arkansas in connection the purchase by the affiliated hospital
- Valuation of a large southern California physician practice management company for potential purchase by an associated hospital
- Valuation of medical group, management company, health insurance agency, and managed care portion of hospital business in connection with the potential formation of an integrated delivery system
- Valuation of an acute care hospital in Riverside County in connection with an application for loan insurance from Cal Mortgage
- Valuation of an acute care hospital in Dallas, Texas in connection with financing and buyer's application for not-for-profit status
- Valuation of an acute care hospital in northern California, and allocation of intangible value, in connection with potential eminent domain proceedings by local governmental body
- Valuation of an acute care hospital in Northern California in connection with a long-term lease negotiation
- Valuation of hospital-based pharmacy business in connection with an acquisition
- Valuation of a multiple location, multi-modality diagnostic imaging business in Riverside county for internal planning purposes
- Valuation of a Riverside county physician practice management company for donation to a not-for-profit entity

Additional Healthcare Industry Experience

Select Advisory Engagements (continued)

- Valuation of a southern California physical therapy practice in connection with a minority shareholder buyout
- Valuation of a Nevada outpatient surgery center in connection with a purchase transaction
- Valuation of the technical component of a brain mapping and epilepsy treatment program in connection with mediation between the physician owners
- Valuation of a northern California home health agency in connection with a potential purchase of a minority interest
- Valuation of a multi-modality diagnostic imaging business in northern California in connection with a potential sale
- Valuation of a Medi-Cal HMO and related staff-model primary care practices for estate tax purposes
- Valuation of two southern California outpatient surgery centers in connection with potential buyout of minority partners
- Valuation of multiple home health agencies and related entities in connection with the formation of a new joint venture and the relative contributions thereto
- Valuation of two northern California ASC's in connection with the redemption of equity interests from certain affiliated physicians
- Valuation of a San Bernardino county physician practice management company in connection with the formation of an Employee Stock Ownership Plan
- Valuation of a southern California physician practice management company and related OB/GYN practice for litigation support purposes
- Valuation of a Los Angeles county IPA management company in connection with a potential buyout of the minority shareholder
- Valuation of 15 outpatient diagnostic imaging centers in connection with a tender offer to purchase outstanding limited partnership units

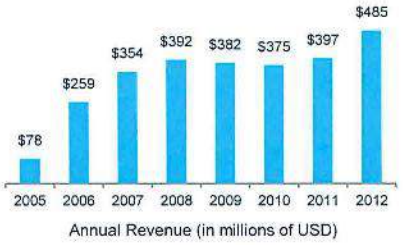
Section 2

Overview of Duff & Phelps

Duff & Phelps Overview

Delivering Value Since 1932

- Duff & Phelps Corporation is a leading provider of **investment banking** and independent **financial advisory services**, supporting client needs principally in the areas of M&A transactions, valuation, fairness opinions, financial restructurings and disputes
- We perform approximately 6,600 engagements annually for over 2,800 clients, including over one-third of the S&P 500
- We have advised clients for more than 80 years and have a proven track record in delivering value to clients



Leading Financial Advisory Firm

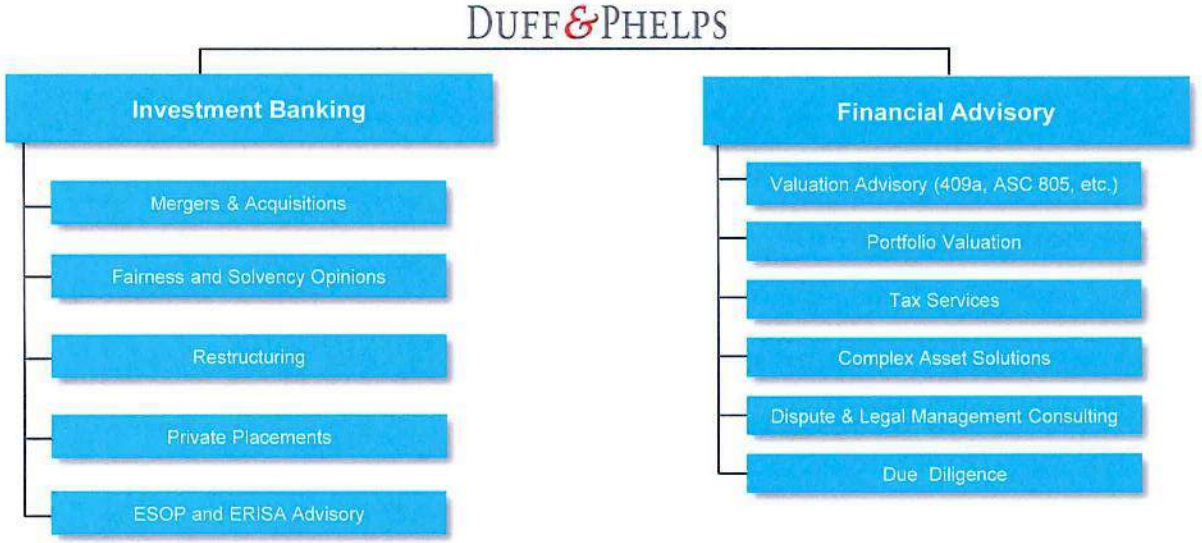
1,400+ Employees

Serving clients globally through

29 Offices

In North America, Europe and Asia

Diversified Advisory Capabilities



1932-1994

Duff & Phelps is founded and evolves into a diversified financial services firm providing investment banking and investment management services to companies across industries.

1994

The credit ratings business of Duff & Phelps is spun-off as a separate public company.

2005

Duff & Phelps acquires the Corporate Value Consulting ("CVC") business of Standard & Poor's. The constituent parts of CVC had been formed in the 1970s as part of PwC's valuation practice.

2007

Duff & Phelps lists on the New York Stock Exchange.

DUF
LISTED
NYSE

2009

Engaged by the U.S. Trustee for the Southern District of New York as the financial advisor to the examiner in the Lehman Brothers bankruptcy case.

Engaged by the Congressional Oversight Panel on the Troubled Asset Relief Program ("TARP") to analyze the government's investments in TARP.

2010

Established platform in Canada with acquisition of Cole & Partners, a Toronto-based independent financial advisory firm.

2011

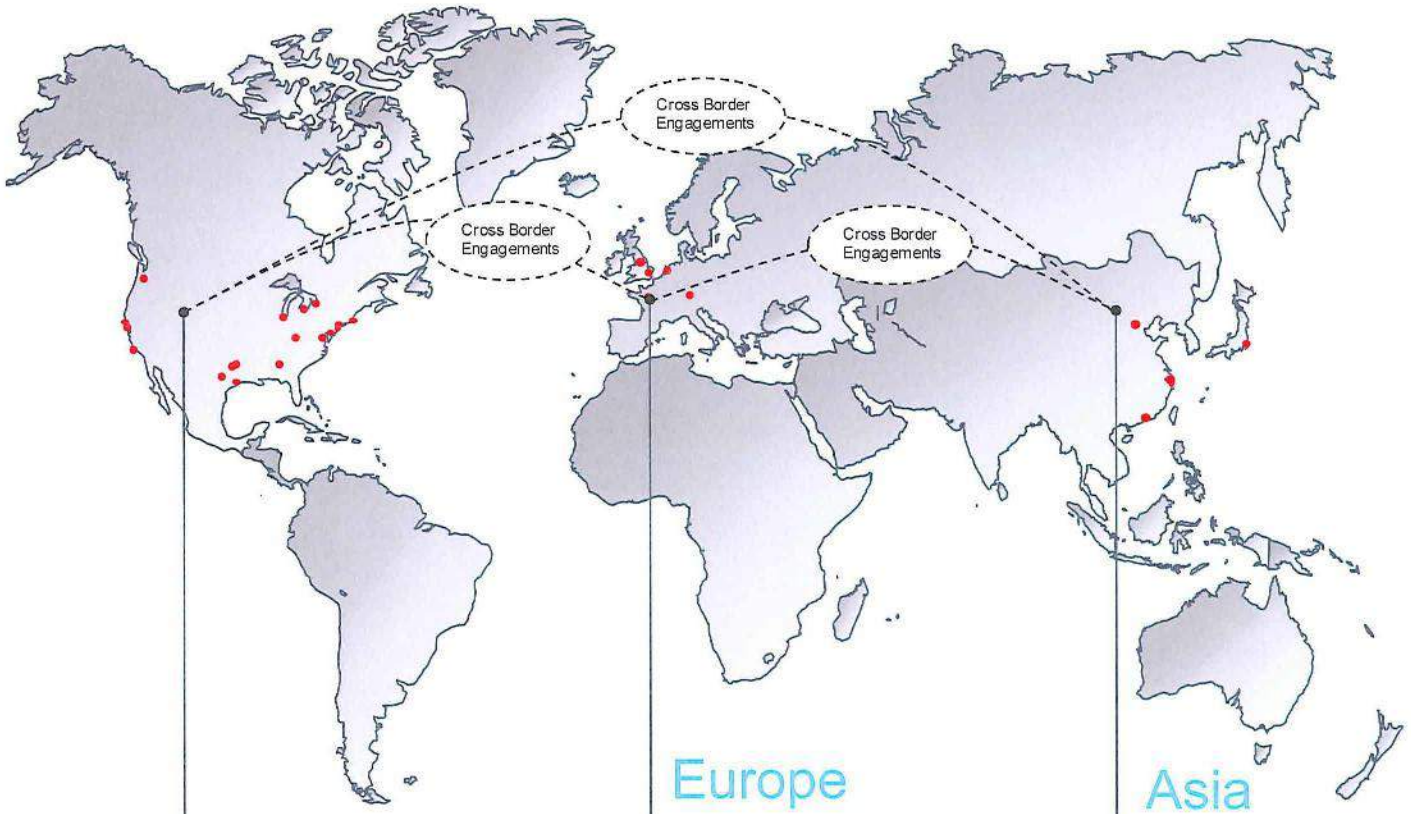
Expanded Investment Banking platform with the acquisitions of MCR and RSM Richter's Financial Restructuring Practice in Toronto, Pagemill Partners, a technology-focused investment banking and valuation services firm and Growth Capital Partners, a Houston-based leading energy-focused middle-market merchant bank.

2013

Taken private by a consortium of leading financial sponsors, led by The Carlyle Group.

Strong Global Presence and Expertise

- Cross border transaction teams work seamlessly, combining specific industry and technical expertise
- Senior staffing commitment and involvement throughout the transaction process



North America

Atlanta, Austin, Boston, Chicago, Dallas (2), Denver, Detroit, Houston (2), Los Angeles, Morristown, New York, Philadelphia, San Francisco, Seattle, Silicon Valley, Toronto, Washington D.C.

Europe

London (2), Birmingham, Manchester, Amsterdam, Munich, Paris

Asia

Beijing, Hong Kong, Shanghai, Tokyo

One Corporation. One Team.

Sell Side Advisor

Southern Heat Exchanger Corp., a portfolio company of Harbour Group, has been acquired by NDA

Sell Side Advisor

Channel Technologies, Inc. has sold its wholly-owned subsidiary Harris Acoustic Products to Ultra Electronics

Sell Side Advisor

Hydril Co. (NasdaqNM: HYDL) has been acquired by Tenaris SA (NYSE: TS)

Sell Side Advisor

SEMCO Incorporated has been acquired by Flakt Woods Group, a portfolio company of Segard Private Equity Partners, et al.

Fairness Opinion

Master Tek International, Inc., a wholly owned subsidiary of SouthWest Water Co., has been acquired by Mirat USA

Sell Side Advisor

Talley Defense Systems, Inc., a 100% ESOP-owned company, has been acquired by Nammo AS

Sell Side Advisor

Command Tooling Systems, LLC, a portfolio company of Norwest Equity Partners, has been acquired by EWS Tool Technologies

Sell Side Advisor

H.C. Duke and Sons, Inc., d/b/a Electro Freeze, has been acquired by All Group Spa

2012 Accomplishments



The Deal

Ranked #1 investment bank by The Deal Pipeline – number of global bankruptcy cases from Q4 2011 through Q4 2012

ACQ GLOBAL AWARDS 2012

Named **"UK Corporate Restructuring Advisor of the Year"** (2012 ACQ Financial Magazine Global Awards)

THOMSON REUTERS

Ranked #1 Thomson Financial Securities Data – number of global fairness opinions in 2012

THOMSON REUTERS

Ranked #3 Thomson Financial Securities Data – number of U.S. middle-market M&A transactions in 2012 (deals < $250M)

2012 ACG New York CHAMPION'S AWARDS WINNER

Named **"Services and Valuation Firm of the Year"** (2012 ACG New York Champion's Awards)

TURNAROUND ATLAS AWARDS

Named **"Mid Markets Restructuring Financial Advisor of the Year"** (2012 Turnaround Atlas Awards)

Board Advisory and Transaction Opinions

- Duff & Phelps serves as an independent advisor to boards of directors, special committees and other fiduciaries and is a leading global provider of fairness, solvency and debt opinions in corporate transactions.

Key Services

- Fairness Opinions and Special Committee Advisory
- Solvency Opinions
- Commercially Reasonable Debt Opinions

Differentiators

- **Core Practice**: Ranked # 1 for fairness opinions in 2012 and the leading financial advisor for solvency opinions (over 311 solvency opinions and $1.3 trillion in deal value since 2005)
- **Independence**: Vast majority of our opinions involve transactions in which Duff & Phelps is not the investment banker
- **Analytical Rigor**: Comfortable providing opinions in transactions involving minority interests, debt securities and those transactions absent a market-clearing mechanism

2012 Global Fairness Opinion Rankings

Fairness Opinion Provider	No. of Deals	Rank
Duff & Phelps	**57**	**1**
JP Morgan	48	2
Stout Risius Ross Inc.	41	3
Houlihan Lokey	36	4
UBS	29	5
Morgan Stanley	28	6
Barclays	27	7
Deutsche Bank AG	27	7

Source: Thomson Financial Securities Data

Selected Transactions

Solvency Opinion & Fairness Opinion
United Rentals, Inc. has acquired RSC Holdings Inc.
United Rentals
Financial advisor to the board of directors of the Company

Solvency Opinion
Marriott International, Inc. has completed the spin-off of Marriott Vacations Worldwide Corp.
Marriott
Financial advisor to the board of directors of the Company

Fairness Opinion
On2 Technologies , Inc. has been acquired by Google Inc.
on2 technologies
Financial advisor to the board of directors of the Company

Fairness Opinion
CommScope, Inc. has acquired Andrew Corporation
CommScope
Financial advisor to the board of directors of the Company

Solvency Opinion
Clear Channel Outdoor Holdings, Inc., has completed a leveraged dividend recapitalization
Clear Channel Outdoor
Financial advisor to the board of directors of the Company

Solvency Opinion
T-Mobile USA, Inc., an indirect subsidiary of Deutsche Telekom AG, has issued cross-border debt to a related party as part of a leveraged recapitalization transaction
T-Mobile
Financial advisor to the board of directors of the Company

Section 3

Professional Credentials

Christopher L. Janssen

Managing Director, Head of Transaction Opinions



Duff & Phelps Securities, LLC
311 S. Wacker Drive
Suite 4200
Chicago, IL 60606
+1 312 697 4643
Chris.Janssen@duffandphelps.com

Chris Janssen is a managing director in the Chicago office and head of the global Transaction Opinions group within the Investment Banking segment. He is also a member of the firm's Fairness and Solvency Opinion Senior Review Committee. Chris specializes in board and special committee advisory, fairness opinions, and solvency opinions. He has advised public and private companies and their boards of directors on numerous corporate transactions, including mergers and acquisitions, leveraged buy-outs, going-private transactions, spinoffs, split-ups and recapitalizations. Chris' experience includes:

- Advising the boards of directors of portfolio companies of ABRY Partners, Stone Point Capital, Hellman & Friedman, JLL Partners, Bain Capital, and The Blackstone Group on leveraged dividend transactions;
- Advising the boards of directors of Rockwood Holdings, Choice Hotels International, Delphi Automotive, Unisys, and Realogy on dividend and stock repurchase transactions;
- Advising the special committee of the board of directors of Andatee China Marine Fuel Services Company, National Investment Managers, and Eagle Point Software on going-private transactions;
- Advising the boards of directors of CommScope, Boulder Specialty Brands, and Patriot Coal on acquisitions; and
- Advising the boards of directors of Murphy Oil Corporation, Sears Holdings, Cardinal Health, American Standard, Bentley Pharmaceuticals, Cendant, and Tyco on spin-off transactions.

Chris has also been a guest lecturer on business valuations at the J.L. Kellogg Graduate School of Management. Prior to joining Duff & Phelps, he was a commercial lender with The Northern Trust Company in Chicago.

Chris received his M.B.A. in finance and marketing and *Beta Gamma Sigma* from Northwestern University's J.L. Kellogg Graduate School of Management and his B.A. in economics with highest distinction and *Phi Beta Kappa* from Northwestern University. He is also a Financial Industry Regulatory Authority registered representative and holds the Series 7 and 63 licenses. Chris is a member of the American Bar Association, the National Association of Corporate Directors and the Business Valuation Association of Chicago. He has been a host committee chair of the Greater Chicago Food Depository's Bag Hunger event.

Todd Kaltman

Managing Director, Transaction Opinions



Duff & Phelps Securities, LLC
Los Angeles
+1 424 249 1693
todd.kaltman@duffandphelps.com

Todd Kaltman is a managing director in Duff & Phelps' Investment Banking unit, with a specialization in transaction opinions, which includes fairness and solvency opinions as well as valuations in the context of a corporate transaction. Todd is also a member of the firm's Senior Review Committee, which approves all fairness and solvency opinions issued by Duff & Phelps. He has been with Duff & Phelps for more than 12 years and has more than 20 years of experience providing corporate and securities valuation and financial advisory services.

Over the course of his career, Todd has provided financial opinions and advice to public and private companies in relation to mergers and acquisitions, recapitalization transactions, spin-offs, debt and equity securities issuance, joint venture formation and employee stock ownership plans. Todd has also provided valuations related to tax and financial reporting, shareholder buy/sell agreements, and marital and partnership dissolution.

He has experience across a wide range of industries, including financial services, food and agribusiness, manufacturing, professional services, technology and communications. In addition to this broader experience, Todd has substantial expertise in the healthcare services segment. Prior work has touched on nearly every aspect of this sector, including medical groups and IPAs, imaging and surgery centers, managed care plans, acute care and long-term care hospitals, skilled nursing and assisted living centers, and large integrated health systems.

Some of Todd's noteworthy engagements include: serving as investment banker to Health Net, Inc. in the sale of its VitalCare business to Rehabcare Group, Inc.; providing a fairness opinion to the board of trustees of the University of Southern California in connection with its acquisition of two hospital facilities from Tenet Healthcare; providing a fairness opinion to the board of directors of ClearOne Health Plans in connection with its merger with PacificSource Health Plans, Inc.; and serving as financial advisor to Sisters of St. Francis Health Services, Inc. in connection with an offering of tax-exempt debt securities to its affiliated physicians.

Todd received his B.S. in business administration, magna cum laude, from California State University, Northridge. He is a chartered financial analyst (CFA) charterholder and he holds the Financial Industry Regulatory Authority Series 7 and 63 licenses. He is also a member of the American Society of Appraisers, the CFA Institute, the CFA Society of Los Angeles, the National Association of Corporate Directors and the Association for Corporate Growth.

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. (ECHN) application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. (VNHSC), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., Eastern Connecticut Medical Professionals Foundation, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. Instructions:

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Todd A. Kaltman

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:
Company Name: Duff & Phelps, LLC
Title: Managing Director

_____ Eastern Connecticut Health Network, Inc. The Manchester Memorial Hospital The Rockville General Hospital, Incorporated
Position(s): _____

_____ ECHN ElderCare Services, Inc. Visiting Nurse & Health Services of Connecticut, Inc.
Position(s): _____

(b) Please complete and return this Disclosure Form no later than **August 24, 2015** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such event or information as soon as possible.

2. Definitions:

(a) **Related Person**: A person related to you by blood, law or marriage as a spouse, child, stepchild, parent, sibling, grandparent, grandchild or domestic partner (individual not related by blood or marriage, but currently in a committed relationship and residing in a common household sharing joint responsibility for the household), or any entity directly or indirectly controlled by you or any such person or in which you or any such person has a direct or indirect ownership interest of greater than thirty percent.

(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. Financial Interests:

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)□

□_____ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity□

□_____ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction□

_____ NO □_____YES. If YES, please provide details. My employer, Duff & Phelps, LLC, will receive compensation for professional services rendered. No such compensation is contingent upon the completion of the proposed transaction.

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity□

□_____ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction□

□_____ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction□

□_____ NO _____YES. If YES, please provide details. _____

_____

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a Prospect Medical Holdings, Inc. Entity□

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

□ _____ NO _____YES. If YES, please provide details. _____
_____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity□

□ _____ NO _____YES. If YES, please provide details. _____
_____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity□

□ _____ NO _____YES. If YES, please provide details. _____
_____

(iv) Furnished or ac□uired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity□

□ _____ NO _____YES. If YES, please provide details. _____
_____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.



Signature

August 17, 2015
Date

Todd A. Kaltman
Printed Name

Conflict of Interest / Financial Disclosure Form

This Conflict of Interest Financial Disclosure Form is being completed as part of the Eastern Connecticut Health Network, Inc. (ECHN) application to the Connecticut Attorney General and Connecticut Department of Public Health for approval to transfer the assets of ECHN and its affiliates, including Visiting Nurse and Health Services of Connecticut, Inc. (VNHSC), including its wholly owned subsidiary, A Caring Hand, LLC, The Rockville General Hospital, Incorporated, The Manchester Memorial Hospital, ECHN ElderCare Services, Inc., Eastern Connecticut Medical Professionals Foundation, Inc., ECHN Corporate Services, Inc., including its wholly owned subsidiary Medical Practice Partners, LLC, Connecticut Healthcare Insurance Company, ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Clinically Integrated Network of Eastern Connecticut, LLC to a for profit company to be named prior to or at the time of the closing that is directly or indirectly owned by Prospect Medical Holdings, Inc.

All Members and officers of the Board of Trustees of ECHN, key employees, and experts and consultants retained by ECHN must complete this Disclosure Form to disclose any actual or potential conflicts of interest for themselves and any Related Person.

1. Instructions:

(a) This Disclosure Form is to be completed by (i) ECHN board members and officers; (ii) experts and consultants retained by ECHN in connection with the Transaction; and (iii) senior executives at ECHN with management responsibility who have direct involvement in the Transaction.

Please provide the following information:

Print Name: Nicolas Tarditti

Please identify below all positions and/or the entities on which you serve as a board member, officer or senior executive:

_____ Expert or Consultant with:
Company Name: Duff & Phelps, LLC
Title: _____

_____ Eastern Connecticut Health Network, Inc. The Manchester Memorial Hospital The Rockville General Hospital, Incorporated
Position(s): _____

_____ ECHN ElderCare Services, Inc. Visiting Nurse & Health Services of Connecticut, Inc.
Position(s): _____

(b) Please complete and return this Disclosure Form no later than **August 24, 2015** to Chantal Perigo, Executive Secretary, Office of the President, 71 Haynes Street, Manchester, CT 06040. If you have any questions regarding the Disclosure Form, please contact Joyce Tichy, General Counsel, at 860-533-3430.

(c) When answering the questions, if you are uncertain whether you or a Related Person may have a conflict of interest, please err on the side of caution and disclose the information. If the space provided is insufficient, please attach additional sheets as needed. Retain a completed copy of this Disclosure Form for your files. If, following your return of the Disclosure Form, any events occur or information comes to your attention that would affect the accuracy of any of your answers in this Disclosure Form, please notify Chantal Perigo of any such event or information as soon as possible.

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(b) **Prospect Entity:** includes Prospect Medical Holdings, Inc. and the subsidiaries and affiliates listed on Exhibit A attached to this form.

3. Financial Interests:

(a) Do you or any Related Person (see definition above) have a direct or indirect ownership interest in any Prospect Medical Holdings, Inc. Entities (see definitions above)□

□_____ NO _____YES. If YES, please note the name of the entity, ownership percentage and any income generated from the ownership or investment interest.

_____

(b) Since December 12, 2014, did you or any Related Person have a compensation arrangement, including without limitation, as an employee, consultant or contractor with any Prospect Medical Holdings, Inc. Entity□

□_____ NO _____YES. If you answered YES, please note the name of the entity and income generated from the entity. _____

_____

(c) Did or will you or any Related Person receive any payment or other financial benefit as a result of the proposed Transaction□

_____ NO □_____YES. If YES, please provide details. My employer, Duff & Phelps, LLC, will receive compensation for professional services rendered. No such compensation is contingent upon the completion of the proposed transaction.

(d) Do you or any Related Person own stock or options to purchase stock in any Prospect Medical Holdings, Inc. Entity□

□_____ NO _____YES. If YES, please provide details. _____

_____

4. **Beneficial and/or Employment Interests**

(a) Since December 12, 2014, were you or any Related Person offered a position as a director or trustee of a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as part of the Transaction□

□_____ NO _____YES. If YES, please provide details. _____

_____

(b) Since December 12, 2014, were you or any Related Person offered a consulting position or employment with a Prospect Medical Holdings, Inc. Entity or the Local Hospital Board to be formed as a part of the Transaction□

□_____ NO _____YES. If YES, please provide details. _____

_____

(c) Since December 12, 2014, have you or any Related Person engaged in any of the following transactions with a Prospect Medical Holdings, Inc. Entity□

(i) Sold or transferred assets to or purchased assets from or exchanged assets.

□ _____ NO _____YES. If YES, please provide details. _____
_____

(ii) Leased assets to or leased assets from a Prospect Medical Holdings, Inc. Entity□

□ _____ NO _____YES. If YES, please provide details. _____
_____

(iii) Been indebted to or loaned money to a Prospect Medical Holdings, Inc. Entity□

□ _____ NO _____YES. If YES, please provide details. _____
_____

(iv) Furnished or ac□uired goods, services or facilities to a Prospect Medical Holdings, Inc. Entity□

□ _____ NO _____YES. If YES, please provide details. _____
_____

I hereby attest that the information I have provided is true, complete and accurate to the best of my knowledge.

nick.tarditti@duffandphelps.com

Digitally signed by: nick.tarditti@duffandphelps.com
DN: CN = nick.tarditti@duffandphelps.com
Date: 2015.08.31 09:25:35 -07'00'

Signature

8/31/2015
Date

Nicolas Tarditti
Printed Name

EXHIBIT Q7-2 - DUFF & PHELPS' SCOPE OF ENGAGEMENT

DUFF & PHELPS

Confidential

August 14, 2015

Eastern Connecticut Health Network, Inc.
71 Haynes Street
Manchester, CT 06040

Ladies and Gentlemen:

This letter sets forth the terms of an agreement between Duff & Phelps, LLC ("Duff & Phelps") and Eastern Connecticut Health Network, Inc. and its wholly owned subsidiaries (collectively, the "Company") under which Duff & Phelps will serve as an independent financial advisor to the Company and its boards of trustees (collectively, the "Board of Trustees") (solely in their capacity as members of the Board of Trustees) (the Company and Board of Trustees collectively, the "Client") to provide an opinion (the "Fairness Opinion" as defined below) in connection with a proposed transaction (the "Proposed Transaction" as described below). Please review this letter agreement, including the attached Terms of Retention (collectively, the "Agreement"), as it will govern the engagement of Duff & Phelps (the "Engagement").

Description of the Proposed Transaction. It is Duff & Phelps' understanding that the Proposed Transaction involves the sale of substantially all of the assets of the Company and substantially all of the assets of the Company's subsidiaries to a third-party buyer for cash consideration and certain post-closing covenants.

Fairness Opinion. Duff & Phelps will opine as to the fairness, from a financial point of view, to the Company of the consideration to be received by the Company in the Proposed Transaction. Duff & Phelps hereby acknowledges and agrees that it is an independent third party with respect to the Proposed Transaction, and is an expert in providing opinions like the Fairness Opinion.

Nature and Scope of Engagement. The scope of this Engagement will include such inquiries, analyses, and other procedures as Duff & Phelps deems necessary to enable Duff & Phelps to render the Fairness Opinion, which Fairness Opinion shall take into account the criteria set forth in Connecticut General Statute §19a-486c(a), including but not limited to an analysis of the fair market value to be paid in connection with the Proposed Transaction. The Company shall make available to Duff & Phelps all documents and information concerning the Company's business and operations which Duff & Phelps reasonably requests, including, without limitation: current and historical financial information; financial projections or forecasts prepared by management; third-party appraisals or valuations previously performed, if any; and any other relevant information relating to the Company or the Proposed Transaction prepared by the Company or any of its other advisors. The Company will provide documentation relating to the Proposed Transaction as

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Los Angeles, CA 90067

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it becomes available. The Company will also provide Duff & Phelps with reasonable access to the Company's officers, directors, and legal, financial and accounting advisors as appropriate. In addition to reviewing documents and information provided by the Company, Duff & Phelps will also review industry and selected public company financial data it deems relevant, to the extent available, obtained from public and other available sources. Duff & Phelps will use generally accepted valuation and analytical techniques as the basis for its analysis and Fairness Opinion.

The scope of Duff & Phelps' analysis and Fairness Opinion will exclude any opinion as to the fairness of compensation arrangements arising from the Proposed Transaction which benefit any officer, director, or employee of the Company, or any class of such persons.

Prior to the issuance of the Fairness Opinion, Duff & Phelps will confirm certain facts and representations with the Company's management. Duff & Phelps may do this by providing the Company's management with drafts of the Fairness Opinion or presentation materials under the condition that in no circumstances are such drafts to be copied or given to other persons. Duff & Phelps may also require a letter from management confirming representations management has made and upon which Duff & Phelps has relied.

Upon concluding Duff & Phelps' analysis, and after the review of the findings, analysis, and conclusions by Duff & Phelps' Opinion Review Committee, Duff & Phelps would be available to make a presentation to the Client summarizing Duff & Phelps' analysis and conclusions at no additional cost other than reasonable out-of-pocket expenses. Assuming timely availability of management and receipt of the information requested, Duff & Phelps will provide the Fairness Opinion by September 4, 2015. The Fairness Opinion will be set out in a written opinion letter, which will be in a form and substance Duff & Phelps deems appropriate and will set forth the scope of its assignment, the principal materials reviewed and assumptions and qualifications upon which it has relied.

The Company acknowledges that it is contracting with Duff & Phelps on an arm's length basis to provide the services described herein, and that it is not the intent of the parties to create a fiduciary relationship.

Fees. Duff & Phelps' professional fees for the Engagement will be $100,000, with a nonrefundable retainer of $50,000 payable upon execution of this Agreement and $50,000 payable upon Duff & Phelps informing the Company that it is prepared to deliver the Fairness Opinion. No portion of these fees is refundable or contingent upon the consummation of a transaction or the conclusion reached in the Fairness Opinion. Furthermore, the Company agrees to pay additional fees at Duff & Phelps' standard hourly rates for any time incurred should Duff & Phelps be called upon to support its findings subsequent to the delivery of the Fairness Opinion (e.g., discuss its findings and analysis with a regulatory agency or deposition preparation and testimony as a fact witness) and/or to assist in the preparation or review of relevant sections of documents associated with the Proposed Transaction. In addition to professional fees, the Company agrees to promptly reimburse Duff & Phelps, from time to time upon request, for its reasonable out-of-pocket expenses (including travel, meals, lodging, telephone, document

reproduction, telecopying, computer charges, and database access fees), and for reasonable fees and expenses of outside counsel retained by Duff & Phelps, incurred in connection with the Engagement. In the event that: (1) the terms of the Engagement are modified after substantial completion of the analysis by Duff & Phelps in preparation of its Fairness Opinion and such modification requires substantial additional analysis or other services by Duff & Phelps, or (2) the Fairness Opinion is delivered subsequent to November 30, 2015, the Company agrees to negotiate in good faith the terms of additional compensation to Duff & Phelps.

Term. Either the Company or Duff & Phelps may terminate the Engagement at any time by written notice. After termination, Duff & Phelps will no longer be obligated to render any additional services, and the Company will only be liable for paying Duff & Phelps for its professional time in excess of the retainer and reimbursing Duff & Phelps for expenses incurred through the date of termination. The other terms of this Agreement will remain in effect, including the indemnification provisions set forth in the Terms of Retention.

Please indicate the Company's acceptance of, and agreement to, all of the terms and provisions of this Agreement by executing and returning it to Duff & Phelps along with the retainer.

Duff & Phelps, LLC

By: _____
Todd A. Kaltman
Managing Director

AGREED AND ACCEPTED BY:

Eastern Connecticut Health Network, Inc. for itself and on behalf of its wholly controlled subsidiaries

By: _____
Name: Michael D. Villette
Title: CFO

Duff & Phelps, LLC
Terms of Retention

The following terms set out the agreements under which Duff & Phelps is being engaged by the Company on behalf of the Client. Capitalized terms used in these Terms of Retention but not defined herein have the meanings ascribed thereto in the letter agreement to which these Terms of Retention are attached.

Information. The Company agrees to promptly notify Duff & Phelps if the Company believes that any such information has become materially misleading. The Company further warrants and represents that any projections provided by it to Duff & Phelps will have been prepared in good faith and will be based upon assumptions which, in light of the circumstances under which they are made are reasonable. In rendering its services hereunder, Duff & Phelps assumes no responsibility for, and will not independently verify, the accuracy or completeness of any information provided by or on behalf of the Company, any other information provided or otherwise made available to Duff & Phelps regarding the Company or the Proposed Transaction, or any other information, data, advice, opinions or representations, whether obtained from public or private sources. Duff & Phelps' Fairness Opinion will state that it has not independently verified the accuracy or completeness of any such information.

Certain Limitations. Duff & Phelps will not evaluate the Company's solvency or independently appraise or physically inspect any of the Company's specific assets or liabilities (contingent or otherwise). Duff & Phelps further will not independently investigate any legal matters involving the Company. The Fairness Opinion will not address any related transaction, will not address the market price or value of any of the Company's securities following the announcement or consummation of the Proposed Transaction, and will not constitute a recommendation as to how the Client or any stockholder should vote or act with respect to any matters relating to the Proposed Transaction or any related transactions. The Fairness Opinion will be based upon Duff & Phelps' assessment of general economic, financial, and market conditions as they exist and can be evaluated by Duff & Phelps as of the date of the Fairness Opinion. The Fairness Opinion is inherently subjective; reasonable professionals or individuals reviewing the same information could reach different conclusions. The ultimate decision must be made by the Client and will need to take into account factors unrelated to the specific financial analysis provided by Duff & Phelps. The Fairness Opinion will specifically set forth these and other reasonable limitations and will state that, to the extent that any of these assumptions or any of the facts on which the Fairness Opinion is based proves to be untrue in any material respect, the Fairness Opinion could not and should not be relied upon. Duff & Phelps will provide the services described herein but will not act as an agent or broker to any person. Duff & Phelps will not solicit the purchase or sale of securities.

Coordination; Legal Matters. For Duff & Phelps to be effective, it will need the cooperation of the Company and its other advisors. The Company acknowledges that it will need to retain counsel for review of legal matters. Duff & Phelps may rely upon the fact that the Company has been advised by counsel as to all legal matters and may further rely on any advice given the

Company by such counsel. Duff & Phelps will not make, and assumes no responsibility to make, any representation, or render any opinion, as to any legal matter.

Confidentiality. Duff & Phelps will use any non-public or proprietary information provided by the Company ("Confidential Information") solely in the course of this Engagement and in a manner which Duff & Phelps believes in good faith is consistent with the Company's interests or is required by law. To allow Duff & Phelps to comply with this obligation, all Confidential Information whose sensitivity and confidentiality is not obvious must be marked "confidential."

Use of Advice. It is understood that the advice rendered by Duff & Phelps is solely for the information of the Client (including its corporators) in connection with its evaluation of the Proposed Transaction and may not be used for any other purpose without Duff & Phelps' prior written consent. Notwithstanding the prior sentence, Duff & Phelps' Fairness Opinion may be included in its entirety by Client in response to any request by or filing with a regulatory agency or court made by the Client in connection with the Proposed Transaction. The Client may also summarize or otherwise reference the existence of the Fairness Opinion in response to any press or other inquiry provided that any such summary or reference language shall be subject to the prior approval of Duff & Phelps. Except as set forth above, the Client agrees to obtain Duff & Phelps' written consent (not to be unreasonably withheld) before disclosing any of Duff & Phelps' advice or analysis to anyone, or otherwise making reference to its role, whether orally or in writing.

Potential Conflicts. Duff & Phelps has undertaken a limited review of its records to determine Duff & Phelps' professional relationship with the Client, and other parties of interest, and has identified no current relationships that would preclude it from accepting this Engagement. However, Duff & Phelps may represent (in unrelated matters), parties interested in the Company or the Proposed Transaction, or persons who are the Company's competitors or creditors, or whose interests otherwise conflict with those of the Company. Duff & Phelps will not have any obligation to disclose any unrelated representation or any information it learns in the course of any unrelated representation to the Company, or to use that information in connection with the Engagement.

Relationships and Compensation. It is understood and agreed that any Fairness Opinion rendered by Duff & Phelps with respect to the Proposed Transaction may disclose: (1) Duff & Phelps' role with respect to the Proposed Transaction, (2) the compensation therefor and any other payment or compensation that Duff & Phelps will receive which is contingent upon the successful completion of the Proposed Transaction, for rendering the Fairness Opinion, and/or for serving as an advisor, and (3) any material relationship that existed during the two years preceding the date of such Fairness Opinion or that, as of such date, is mutually understood to be contemplated and any compensation received or to be received as a result of the relationship between Duff & Phelps, the Company, and/or any party involved in the Proposed Transaction. In order to facilitate such disclosures, the Company will (and will exercise commercially reasonable efforts to cause any other parties to the Proposed Transaction to) cooperate with Duff & Phelps to identify and describe any material relationships between the Company or any other transaction

party and Duff & Phelps that existed during the two years preceding the date of the Fairness Opinion or that is mutually understood to be contemplated as of the date of the Fairness Opinion, and any compensation received or to be received by Duff & Phelps as a result of such relationship between Duff & Phelps and the Company or any other transaction party.

Corporate Obligation. The obligations of Duff & Phelps are solely corporate obligations. None of its directors, officers, employees, agents, stockholders, or controlling persons will individually be subject to any liability to the Company or anyone else, and the Company will not assert any such claim.

Disputes. Client and Duff & Phelps do not anticipate any disputes between them, but it is always prudent to provide a rational process to resolve any that may occur. Client and Duff & Phelps agree that any legal action or proceeding with respect to this Agreement may be brought in the courts of the State of New York or of any United States District Court located in the State of New York, and each consents to the non-exclusive jurisdiction of those courts. Client and Duff & Phelps hereto also irrevocably waive any objection, including any objection to the laying of venue or based on the grounds of forum non conveniens, which it may now or hereafter have to the bringing of any action or proceeding in such jurisdiction in respect of this Agreement. Client and Duff & Phelps waive personal service of any summons, complaint, or other process, which may be made by any other means permitted by the law of such state. Each of Duff & Phelps and the Client waives its constitutional right to a jury trial. Solely for purposes of enforcing the indemnification provisions herein, the Company hereby consents to personal jurisdiction, service of process, and venue in any court in which any Claim which is subject to the terms provided for herein is brought against Duff & Phelps or any other Indemnified Person. Client and Duff & Phelps agree that any legal proceeding arising from or in connection with this Engagement (or any variation or addition thereto) must be commenced within one year from the date when such party becomes aware of or ought reasonably to have become aware of the facts which give rise to the alleged liability and in any event not later than two years after any alleged breach of contract or act of gross negligence or commission of any other tort.

Indemnification and Contribution. The Company agrees to promptly, upon demand, indemnify and hold harmless Duff & Phelps and its affiliates, and its and their respective directors, officers, attorneys and other agents, stockholders, employees, and controlling persons (each an "Indemnified Person"), from and against any losses, claims, damages, judgments, assessments, and liabilities (joint or several) to the Company or third parties, (collectively, "Losses"), and will reimburse each Indemnified Person for all costs (including, without limitation, expenses, fees and disbursements, and time charges related to giving testimony or furnishing documents in response to a subpoena or otherwise) and fees and expenses (including, without limitation, reasonable fees and disbursements of counsel and accountants and the costs of any investigation and preparation) as and when they are incurred (collectively, "Expenses"), resulting directly or indirectly from any threatened or pending investigation, lawsuit, action, claim, proceeding, or dispute, including securityholder actions (whether or not Duff & Phelps or any other Indemnified Person is a potential or actual named party or witness) (collectively, a "Claim"), which: (1) are related to or arise out of any untrue statement or alleged untrue statement of a material fact

contained in any oral or written information provided to Duff & Phelps or any other person by the Company or used by the Company in connection with the transaction contemplated by this Agreement or any omission or alleged omission by the Company to state therein a material fact necessary to make the statements therein, in light of the circumstances under which they were made, not misleading, or (2) are otherwise related to or arise out of Duff & Phelps' Engagement, role, activities, or the performance or non-performance of professional services on the Company's behalf. The Company will not be responsible, however, for any Losses or Expenses pursuant to clause (2) of the preceding sentence which are judicially determined to have resulted primarily from the fraud, willful misconduct or gross negligence of the Indemnified Person; but pending any such judicial determination, the indemnification and reimbursement obligations of the Company hereunder shall continue to apply. Upon any such determination any Losses or Expenses previously funded by the Company shall be refunded by such Indemnified Person. However, the Company will not be responsible for any Losses which: (1) result from any settlement not approved by the Company in its reasonable judgment, or (2) are determined by a final judgment of a court of competent jurisdiction to have resulted primarily and directly from the fraud, willful misconduct or gross negligence of an Indemnified Person. The Company also agrees that no Indemnified Person will be liable to the Company for or in connection with this Engagement, except for Losses incurred by the Company which are determined by a final judgment of a court of competent jurisdiction to have resulted primarily and directly from the fraud, willful misconduct or gross negligence of that Indemnified Person.

Duff & Phelps will notify the Company if it learns that any Claim has been instituted based, directly or indirectly, on the transactions which were the subject of Duff & Phelps' Engagement under the Agreement, although failure to do so will not relieve the Company from any obligation or liability it has hereunder or otherwise, except to the extent such failure causes the Company to forfeit substantial rights and defenses. Should any Claim be formally instituted against Duff & Phelps or any other Indemnified Person based, directly or indirectly, on Duff & Phelps' Engagement under the Agreement, the Company will be entitled to participate therein with counsel chosen by it and, to the extent that it may wish or as requested by Duff & Phelps, to assume the defense of the Claim, with counsel reasonably satisfactory to Duff & Phelps, so long as the Company continues to pay all costs and expenses of the defense and preparation for such Claim. Even if the Company assumes the defense of a Claim, each Indemnified Person will have the right to participate in such Claim and to retain its own counsel. The Company will be required to pay all reasonable fees and expenses of such counsel as they are incurred only if: (1) such Indemnified Person has been advised by such counsel that there may be legal defenses available to it which are in conflict with or are materially different from or additional to defenses available to the Company (in which case the Company shall not have the right to assume the defense of the Claim on behalf of such Indemnified Person), (2) the Company shall not have assumed the defense of the Claim and employed counsel reasonably satisfactory to such Indemnified Person in a timely manner, or (3) the Company shall have authorized the employment of such counsel in connection with the defense of the Claim.

If any indemnification sought by an Indemnified Person pursuant to the terms hereof is held by a court of competent jurisdiction to be unavailable for any reason or insufficient to hold such

Indemnified Person harmless (other than as a result of the fraud, willful misconduct or gross negligence of any such Indemnified Person), then the Company and Duff & Phelps will contribute to the Losses and Expenses for which such indemnification is held unavailable or insufficient in such proportion as is appropriate to reflect the relative benefits of the Company and the Indemnified Person, or if such allocation is not permitted by applicable law, then in such proportion as is appropriate to reflect not only the relative benefits received by the Company and the Indemnified Person, but also the relative fault of the Company, its directors, officers, employees, affiliates, agents and advisors, on the one hand, and the Indemnified Person, on the other hand, as well as any other relevant equitable considerations, subject to the limitation that the contribution by Duff & Phelps and the other Indemnified Persons will not exceed the amount of fees actually received by Duff & Phelps pursuant to Duff & Phelps' Engagement. The Company agrees that for the purposes hereof the relative benefits received, or sought to be received, by the Company and its securityholders and creditors and ourselves shall be deemed to be in the same proportion as (i) the total value paid or proposed to be paid or received by the Company and its securityholders and creditors, as the case may be, pursuant to the Proposed Transaction (whether or not consummated) for which Duff & Phelps has been engaged to perform the services described in this Agreement bears to (ii) the fees paid or proposed to be paid to Duff & Phelps in connection with the Engagement. No person found liable for fraudulent misrepresentation shall be entitled to contribution from any person who is not also found liable for such fraudulent misrepresentation.

These indemnification and contribution provisions shall: (1) remain operative and in full force and effect regardless of any termination or completion of the Engagement; (2) inure to the benefit of the successors, assigns, heirs, or personal representative of any Indemnified Person; (3) be in addition to any other rights that any Indemnified Person may have at common law or otherwise; and (4) apply to activities prior to this date and after any amendment, modification, or future addition to the Agreement.

Settlement of Claims. The Company will not, without the prior written consent of Duff & Phelps (which consent shall not be unreasonably withheld), settle, compromise, or consent to the entry of any judgment in or otherwise seek to terminate any pending or threatened Claim in respect of which indemnification or contribution could be sought hereunder (whether or not Duff & Phelps or any other Indemnified Person is a potential or actual named party to such Claim) unless such settlement, compromise, consent, or termination includes provisions holding harmless and unconditionally releasing Duff & Phelps and each other Indemnified Person hereunder from all liability related to or arising out of such Claim, including claims for contribution.

Miscellaneous. Notice given pursuant to any of the provisions of this Agreement shall be in writing and shall be mailed or delivered: (a) if to the Company, at its offices at 71 Haynes Street, Manchester, CT 06040; and (b) if to Duff & Phelps, at its offices at 55 East 52nd Street, 31st Floor, New York NY 10055, Attention: General Counsel with a copy to Todd A. Kaltman, 10100 Santa Monica Boulevard, Suite 1100, Los Angeles, CA 90067.

This Agreement has been and is made solely for the benefit of the Client, Duff & Phelps and the Indemnified Persons and their respective successors and assigns. No other person shall acquire or have any right under or by virtue of this Agreement.

This Agreement: (1) contains all of the understandings between the parties hereto with respect to the subject matter hereof, and no party can rely upon or be bound by any understanding or statement, oral or otherwise, not specifically in this Agreement; (2) cannot be modified or changed except by a written instrument signed by each party hereto; (3) shall be governed by the law of the State of New York, without regard to any conflicts of law provisions; (4) may be executed in counterparts; and (5) shall inure to the benefit of, and shall be binding upon, the respective successors and assigns of the parties hereto and the Indemnified Persons. If any term, provision, covenant, or restriction contained in this Agreement is unenforceable, the remainder of this Agreement shall remain in full force and effect and shall not be affected, impaired, or invalidated in any way.

Duff & Phelps, LLC

By: _____
Todd A. Kaltman
Managing Director

AGREED AND ACCEPTED BY:

Eastern Connecticut Health Network, Inc. for itself and on behalf of its wholly controlled subsidiaries

By: _____

Name: Michael D. Veillette

Title: CFO

EXHIBIT Q7-3 - DUFF & PHELPS' FAIRNESS ANALYSIS

DUFF & PHELPS

ECHN
Eastern Connecticut Health Network

Eastern Connecticut Health Network, Inc.

September 9, 2015

Fairness Analysis

The information contained herein is of a confidential nature and is intended for the exclusive use of the persons or firm to whom it is furnished by us.
Reproduction, publication, or dissemination of portions hereof may not be made without prior approval of Duff & Phelps, LLC.

Duff & Phelps Disclaimer

- The following pages contain material that is being provided by Duff & Phelps, LLC ("Duff & Phelps") to the board of trustees (the "Board of Trustees") of Eastern Connecticut Health Network, Inc. and its wholly owned subsidiaries (the "Company" or "ECHN") in connection with the Proposed Transaction (as defined herein).
- The accompanying material was compiled and prepared on a confidential basis for the use of the Board of Trustees and not with a view toward public disclosure and, except as expressly provided for in the engagement letter between Duff & Phelps and the Company dated August 14, 2015 (the "Engagement Letter"), may not be disclosed, summarized, reproduced, disseminated or quoted from or otherwise referred to, in whole or in part, without the prior written consent of Duff & Phelps.
- Without limiting the statement made in the prior bullet, because this material was prepared for use in the context of a presentation to the Board of Trustees, which is familiar with the business, assets, liabilities, prospects and affairs of the Company, neither the Company nor Duff & Phelps, nor any of their respective legal or financial advisors or accountants take any responsibility for the accuracy or completeness of any of the material if used by persons other than the Board of Trustees.
- These materials are not intended to represent an opinion but rather to serve as discussion materials for the Board of Trustees to review and as a summary of the basis upon which Duff & Phelps may render an opinion.
- The information utilized in preparing this presentation was obtained from the Company and public sources. Duff & Phelps relied without independent verification upon the accuracy, completeness, and fair presentation in all material respects of all information reviewed; and relied without independent verification on the accuracy of data and representations that Duff & Phelps obtained from public sources, private sources, and Company management ("Management").
- Duff & Phelps has relied on the Company's representation that any estimates and projections contained herein have been prepared in good faith by the Management of the Company. Such estimates and projections involve numerous and significant subjective assumptions and determinations, which may or may not prove to be correct. Projections necessarily involve risks and uncertainties. No representation or warranty, expressed or implied, is made as to the accuracy or completeness of such information, or the achievability of any such estimates or projections, and nothing contained herein is, or shall be relied upon as, a representation, whether as to the past, present, or the future. Duff & Phelps did not independently verify such information and expressly disclaims any and all liability relating to or resulting from the use of this material.
- Duff & Phelps did not independently appraise or physically inspect any of the Company's assets or liabilities (contingent or otherwise).
- No selected public company used in our analysis is directly comparable to the Company.
- These materials should not be construed as a valuation opinion, credit rating, solvency opinion, an analysis of the Company's credit worthiness, or as tax advice, or as accounting advice. Any opinion rendered by Duff & Phelps would be provided in a separate written opinion letter. Duff & Phelps has not made, and assumes no responsibility to make, any representations, or render any opinion, as to any legal or regulatory matters.
- Duff & Phelps is not addressing the merits of the underlying business decision to enter into the Proposed Transaction nor addressing any related transaction. Duff & Phelps makes no recommendation as to how the Board of Trustees or any other party should vote or act with respect to any matter relating to the Proposed Transaction or any related transactions.

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I. Introduction and Scope of Analysis

Introduction and Scope of Analysis

Background of Engagement

Engagement

- Duff & Phelps has been engaged by the Company to serve as an independent financial advisor to the Board of Trustees (solely in its capacity as such) to provide an opinion (the "Opinion" as defined below) in connection with a proposed transaction (the "Proposed Transaction" as described below).

- Specifically, Duff & Phelps has been asked to opine as to the fairness, from a financial point of view, to the Company of the consideration to be received by the Company in the Proposed Transaction.

Proposed Transaction

- It is Duff & Phelps' understanding that the Proposed Transaction involves the sale of substantially all of the assets of the Company and substantially all of the assets of the Company's subsidiaries, other than cash and investments, to an indirect, wholly-owned subsidiary of Prospect Medical Holdings, Inc. ("Prospect" or such subsidiary, the "Buyer") for cash consideration in the amount of $105 million, subject to certain adjustments as described in the Asset Purchase Agreement (as defined below).

- It is our further understanding that the buyer will make certain post-closing covenants with respect to the continued provision of medical services as well as a minimum level of future capital investment.

Introduction and Scope of Analysis

Scope of Analysis

In connection with this Opinion, Duff & Phelps has made such reviews, analyses and inquiries as it has deemed necessary and appropriate under the circumstances. Duff & Phelps also took into account its assessment of general economic, market and financial conditions, as well as its experience in securities and business valuation, in general, and with respect to similar transactions, in particular. Duff & Phelps' procedures, investigations, and financial analysis with respect to the preparation of its Opinion included, but were not limited to, the items summarized below:

- Reviewed the following documents:
  - The Company's consolidated audited financial statements for the fiscal years ("FY") ended September 30, 2010 through 2014 and the Company's unaudited interim financial statements for the nine-month periods ended June 30, 2014 and 2015;
  - Various audited and unaudited financial statements related to the joint venture investments held by ECHN (the "JV Investments");
  - Other internal documents relating to the history, current operations, and probable future outlook of the Company, including financial projections for FY 2015 through FY 2019, provided to us by Management (the "Management Projections"); and
  - Documents related to the Proposed Transaction, including the draft Asset Purchase Agreement, dated July 9, 2015, by and between the Company and the Buyer (the "Asset Purchase Agreement");
- Discussed the information referred to above and the background and other elements of the Proposed Transaction with the Management;
- Performed certain valuation and comparative analyses using generally accepted valuation and analytical techniques including a discounted cash flow analysis, an analysis of selected public companies that Duff & Phelps deemed relevant, and an analysis of selected transactions that Duff & Phelps deemed relevant; and
- Conducted such other analyses and considered such other factors as Duff & Phelps deemed appropriate.

II. Executive Summary

Executive Summary

Transaction Background

- According to management, ECHN determined during 2011 that a stand-alone strategy was no longer a viable option. This determination was based in part on:
  - Weak financial performance – low growth and low margin
  - Coupled with a high debt burden and growing pension liability
  - Leading to an inability to make necessary capital investment in equipment, facilities and technology
  - Leading to difficulties in attracting and retaining both patients and physicians
  - Resulting in further deteriorating financial performance and potential violation of bond covenants

- As a result, in 2012 the Company circulated a request for proposal to six parties with hospital operations in Connecticut, soliciting a range of transaction alternatives. In late 2013, the Company came to an agreement with Vanguard Health Systems ("Vanguard") (subsequently acquired by Tenet Healthcare Corporation) and Yale New Haven Health System ("YNHHS") under which Vanguard and YNHHS would acquire substantially all of the assets and assume certain liabilities of ECHN for a purchase price of $105 million. In December 2014, Vanguard and YNHHS terminated the acquisition in response to the conditions placed upon them by Connecticut's Office of Health Care Access.

- After discussions with several parties, in June 2015 the Company came to agreement with Prospect under which Prospect would acquire substantially all of the assets and assume certain liabilities of ECHN for a purchase price of $105 million subject to certain adjustments as described in the Asset Purchase Agreement. Since the original transaction with Vanguard and YNHHS in fiscal 2013, the Company's financial performance has further deteriorated and its estimated pension liability has significantly increased due to changes in actuarial assumptions.

- In addition to the cash consideration to be paid in the Proposed Transaction, the Buyer will agree to:
  - The continuation, for a minimum of three years, of providing certain healthcare services that ECHN currently provides;
  - The formation of a local advisory board led by community leaders and physicians with oversight responsibility over quality of care;
  - The continuation of ECHN's current policies of providing charity care, indigent care and other community services;
  - The maintenance and financial support for certain health professions teaching programs established by ECHN; and
  - The expenditure of not less than $75 million on capital projects within five years of closing (subject to potential adjustments as described in the Asset Purchase Agreement.)

Executive Summary

Valuation Conclusions

- The following table summarizes our valuation of ECHN relative to the Proposed Transaction.

Conclusion Summary

($ in thousands)

	Estimated Range of Values			Proposed Transaction
	Low	Mid	High	
Enterprise Value				
Discounted Cash Flow Analysis	$57,800	$58,700	$59,700	
Market Approach	52,400	55,500	58,600	
Estimated / Implied Enterprise Value (excluding JV Investments)	55,100	57,100	59,200	**$83,000**
Plus: Estimated Value of JV Investments	12,400	13,100	13,800	22,000 (1)
Value of Assets Transferred / Gross Purchase Price	**$67,500**	**$70,200**	**$73,000**	**$105,000**
Assumed Liabilities:				
Unfunded Pension / Post-Retiree Health Plan Liability (2)	(60,000)	(60,000)	(60,000)	(60,000)
Excess Captive Insurer / Workers' Compensation Liability (2)	(2,411)	(2,411)	(2,411)	(2,411)
Net Working Capital Adjustment (3)	NA	NA	NA	(6,177)
Capital Lease Obligations (2)	(8,543)	(8,543)	(8,543)	(8,543)
Asset Value Less Assumed Liabilities / Net Purchase Price	**NM**	**NM**	**$2,046**	**$27,869**
Implied Enterprise Value Multiples (excluding JV Investments):				
LTM Adjusted Revenue	$306,230	0.18x	0.19x	0.19x	0.27x
LTM Adjusted EBITDAP	5,887	9.4x	9.7x	10.1x	14.1x
Proj. 2015 Adjusted EBITDAP	4,487	12.3x	12.7x	13.2x	18.5x
Proj. 2016 Adjusted EBITDAP	12,967	4.2x	4.4x	4.6x	6.4x

(1) Represents the aggregate agreed upon value of JV Investments, for purpose of purchase price adjustment, for any interests not transferred to the Buyer at closing.
(2) Per management, estimated balance as of September 30, 2015.
(3) Based on management's estimate. Represents working capital deficiency compared to the closing working capital target of approximately $24 million.

EBITDAP = Earnings before interest, taxes, depreciation, amortization and pension/post-retirement healthcare expense

III. Methodology

Valuation Analysis

Methodologies

Valuation of the Company

- Discounted Cash Flow Analysis
  - The Discounted Cash Flow ("DCF") analysis is based on the theory that the current value of an investment is based on the expected receipt of future economic benefits. The DCF value includes the present value of interim cash flows plus the present value of the terminal value. The terminal value of the Company was estimated by applying a multiple to FY 2019 Adjusted EBITDAP.

- Selected Public Companies Analysis / M&A Transaction Analysis
  - Analyzed financial performance and trading multiples of selected public companies in the industry in which the Company operates.
  - Compared the Company's financial performance and other operating characteristics with those of the selected public companies.
  - Identified transactions involving the sale of a controlling interest in companies we deemed similar to the Company.
  - Analyzed the implied valuation multiples paid (Enterprise Value as a multiple of revenue, EBITDAP and beds in service).
  - Applied valuation multiples to the Company's financial performance to derive indications of total enterprise value.

Valuation of the JV Investments

- Selected Public Company Analysis – JV Investments
  - Applied valuation multiples to the estimated after-tax net income of the JV Investments to derive indications of value.
  - Analyzed the implied distribution yield from the distributions of the JV Investments relative to the indications of value.

- Gordon Growth Approach
  - Applied the Gordon Growth Model to the after-tax pro form distributions of the JV Investments.

IV. Financial Performance

Financial Performance

ECHN Historical and Projected Financial Performance Summary – Unadjusted

Financial Performance Summary

($ in thousands)

	Audited Financial Statements					YTD June 30,		LTM	Management Projections				
FYE September 30:	2010	2011	2012	2013	2014	2014 (Internal)	2015 (Internal)	6/30/15	2015	2016	2017	2018	2019
Net Patient Revenue (1)	$251,337	$250,242	$265,758	$298,980	$299,755	$228,683	$226,677	$297,749	$302,868	$300,594	$304,865	$310,068	$316,152
Other Operating Revenue	17,827	19,641	28,839	28,988	29,000	26,632	19,662	22,030	25,716	24,839	24,886	24,933	24,981
Total Revenue	269,163	269,884	294,597	327,968	328,755	255,315	246,339	319,779	328,584	325,433	329,750	335,001	341,133
% Growth			*9.16%*	*11.33%*	*0.24%*	*NA*	*-3.52%*	*NA*	*-0.05%*	*-0.96%*	*1.33%*	*1.59%*	*1.83%*
Salaries and Wages	131,183	134,218	139,916	163,729	162,727	122,050	118,336	159,014	156,292	150,022	150,778	153,794	156,870
Fringe Benefits	32,963	35,697	40,920	47,592	43,859	34,178	35,373	45,055	47,763	50,610	49,260	49,710	50,160
Supplies and Other (2)	81,433	83,803	93,818	100,335	104,034	87,297	83,589	100,327	97,400	98,400	99,384	100,377	101,381
Physician Fees (2)	NA	NA	NA	NA	NA	NA	NA	NA	14,606	14,606	15,044	15,495	15,960
Total Operating Expenses	245,579	253,718	274,654	311,657	310,621	243,524	237,299	304,396	316,060	313,637	314,466	319,376	324,371
EBITDA	23,584	16,166	19,943	16,311	18,134	11,791	9,040	15,383	12,524	11,796	15,284	15,624	16,762
% Margin	*8.8%*	*6.0%*	*6.8%*	*5.0%*	*5.5%*	*4.6%*	*3.7%*	*4.8%*	*3.8%*	*3.6%*	*4.6%*	*4.7%*	*4.9%*
Depreciation and Amortization	(12,556)	(11,899)	(11,812)	(12,291)	(12,197)	(9,390)	(9,063)	(11,870)	(11,959)	(11,959)	(11,959)	(11,959)	(11,959)
EBIT	11,028	4,267	8,131	4,020	5,937	2,401	(23)	3,513	565	(163)	3,325	3,665	4,803
Capital Expenditures	$7,394	$10,620	$7,498	$12,105	$10,074	$7,555	$5,625	$8,143	$7,500	$7,500	$9,000	$8,500	$9,000
as % of Total Adjusted Revenue	*2.6%*	*3.7%*	*2.5%*	*3.9%*	*3.2%*	*3.1%*	*2.4%*	*2.7%*	*2.4%*	*2.4%*	*2.8%*	*2.6%*	*2.7%*
Net Working Capital	$17,706	$19,307	$17,101	$16,221	$13,927	$21,220	$17,418	$17,418	$16,833	$16,713	$17,404	$17,758	$18,265
as % of Total Adjusted Revenue	*6.2%*	*6.8%*	*5.7%*	*5.2%*	*4.4%*	*NA*	*NA*	*5.7%*	*5.3%*	*5.2%*	*5.4%*	*5.4%*	*5.5%*
Total Debt & Capital Leases	$93,728	$100,560	$100,946	$97,748	$94,685	*NA*	*NA*	$93,288	*NA*	*NA*	*NA*	*NA*	*NA*
Debt to EBITDA	*4.0x*	*6.2x*	*5.1x*	*6.0x*	*5.2x*	*NA*	*NA*	*6.1x*	*NA*	*NA*	*NA*	*NA*	*NA*
Salaries and Wages % of Net Patient Revenue	*52.2%*	*53.6%*	*52.6%*	*54.8%*	*54.3%*	*53.4%*	*52.2%*	*53.4%*	*51.6%*	*49.9%*	*49.5%*	*49.6%*	*49.6%*
Salaries, Wages and Benefits % of Net Patient Rev.	*65.3%*	*67.9%*	*68.0%*	*70.7%*	*68.9%*	*68.3%*	*67.8%*	*68.5%*	*67.4%*	*66.7%*	*65.6%*	*65.6%*	*65.5%*
Fringe Benefits % of Salaries and Wages	*25.1%*	*26.6%*	*29.2%*	*29.1%*	*27.0%*	*28.0%*	*29.9%*	*28.3%*	*30.6%*	*33.7%*	*32.7%*	*32.3%*	*32.0%*

(1) Net of bad debt expense
(2) Supplies and Other and Physician Fees are combined in the historical periods

Financial Performance

ECHN Adjusted Revenue and EBITDAP

Revenue and EBITDAP Adjustments

($ in thousands)

	Audited Financial Statements					YTD June 30,		LTM	Management Projections				
FYE September 30:	2010	2011	2012	2013	2014	2014 (Internal)	2015 (Internal)	6/30/15	2015	2016	2017	2018	2019
Revenue													
Total Revenue as Reported	$269,163	$269,884	$294,597	$327,968	$328,755	$255,315	$246,339	$319,779	$328,584	$325,433	$329,750	$335,001	$341,133
Less: Contributions	(1,748)	(732)	(2,243)	(1,614)	(1,164)	(845)	(1,000)	(1,319)	(1,266)	(1,266)	(1,266)	(1,266)	(1,266)
Less: JV Income	(2,250)	(1,806)	(2,796)	(2,161)	(2,479)	(1,946)	(1,700)	(2,232)	(2,311)	(2,311)	(2,358)	(2,405)	(2,453)
Less: Contribution of VNHSC	NA	NA	(4,592)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Excess Reserves / (Use of Reserves)	NA	NA	NA	NA	4,800	0	(2,824)	1,976	(4,800)	NA	NA	NA	NA
Plus: Full Year Revenue for VNHSC (1)	22,901	23,000	23,484	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Less: Net Assets Released	(539)	(801)	(638)	(1,871)	(834)	(765)	(606)	(676)	(913)	(913)	(913)	(913)	(913)
Less: Grant Income	(2,249)	(3,075)	(2,600)	(2,102)	(2,268)	(1,655)	(1,343)	(1,956)	(1,840)	(1,840)	(1,840)	(1,840)	(1,840)
Less: Energy Rebate	NA	NA	NA	(1,218)	NA	NA	NA	NA	NA	NA	NA	NA	NA
Less: Interest/Dividend Income and Realized Gains	(801)	(1,357)	(1,327)	(7,115)	(9,140)	(2,192)	(186)	(7,134)	(230)	(230)	(230)	(230)	(230)
Less: EHR Incentive Income	NA	(975)	(3,833)	(2,631)	(1,786)	(1,368)	(651)	(1,070)	(877)	0	0	0	0
Less: Rural Floor Adjustment	NA	NA	(1,621)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
DSH Adjustment	0	0	0	0	1,519	1,139	(1,519)	(1,139)	(1,519)	0	0	0	0
Adjusted Total Revenue	**$284,478**	**$284,138**	**$298,430**	**$309,255**	**$317,405**	**$247,685**	**$236,510**	**$306,230**	**$314,827**	**$318,873**	**$323,143**	**$328,347**	**$334,431**
% Growth		*-0.1%*	*5.0%*	*3.6%*	*2.6%*	*NA*	*-4.5%*	*NA*	*-0.8%*	*1.3%*	*1.3%*	*1.6%*	*1.9%*
EBITDAP													
EBITDA as Reported	$23,584	$16,166	$19,943	$16,311	$18,134	$11,791	$9,040	$15,383	$12,524	$11,796	$15,284	$15,624	$16,762
Plus (Less): Revenue Adjustments Above	15,314	14,254	3,833	(18,713)	(11,350)	(7,630)	(9,829)	(13,549)	(13,757)	(6,560)	(6,607)	(6,654)	(6,702)
Less: Full Year Expenses for VNHSC (1)	(21,444)	(22,059)	(22,203)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Plus: Certain Costs Related to Net Assets Released	270	401	319	936	417	382	303	338	457	457	457	457	457
Plus: Certain Costs Related to Grant Income	1,124	1,537	1,300	1,051	1,134	827	671	978	920	920	920	920	920
Plus: Est. Expenses related to Interest/Dividend Income	100	100	100	100	100	42	42	100	100	100	100	100	100
Plus: Estimated EHR Administrative Expenses	NA	250	250	250	250	104	104	250	250	250	0	0	0
Plus: Excess Captive Losses	NA	NA	2,584	4,443	0	0	0	0	NA	NA	NA	NA	NA
Plus: Pension and PRMB Expense	1,295	2,266	5,119	3,491	341	273	2,845	2,913	3,994	6,005	3,924	3,636	3,347
Less: Non-Recurring Income (2)	0	0	0	0	(535)	0	0	(535)	0	0	0	0	0
Plus: Net Intercompany Eliminations	NA	NA	NA	0	0	(192)	(183)	9	NA	NA	NA	NA	NA
Adjusted EBITDAP	**$20,244**	**$12,915**	**$11,244**	**$7,869**	**$8,490**	**$5,597**	**$2,994**	**$5,887**	**$4,487**	**$12,967**	**$14,079**	**$14,083**	**$14,884**
% Margin	*7.1%*	*4.5%*	*3.8%*	*2.5%*	*2.7%*	*2.3%*	*1.3%*	*1.9%*	*1.4%*	*4.1%*	*4.4%*	*4.3%*	*4.5%*
% Growth		*-36.2%*	*-12.9%*	*-30.0%*	*7.9%*	*NA*	*-46.5%*	*NA*	*-47.1%*	*189.0%*	*8.6%*	*0.0%*	*5.7%*

(1) Based on financial statements as of fiscal year end June 30.
(2) Includes nonrecurring software license settlements and adjustments to inventory.

Financial Performance

JV Investments Income and Distributions

JV Income and Distributions Summary

($ in thousands)

FYE September 30:	% Owned	Actual 2010	2011	2012	2013	2014	YTD June 30, 2014	2015	LTM 6/30/15
JV Investment Income (Not-for-Profit or Passthrough Entities):									
Tolland Imaging Center	70%	($11)	($50)	$66	$28	$180	$121	$180	$239
Northeast Regional Radiation Oncology Network, Inc. ("NRRON")(1)	50%	643	(12)	472	362	382	435	160	107
Walden Behavioral Health	16%	-	-	-	(2)	(1)	(6)	-	4
Ambulance Service of Manchester, LLC (2)	50%	1,324	1,120	1,217	1,247	1,026	838	1,018	1,207
Haynes Street Medical Associates	23%	3	42	(31)	24	20	25	15	11
Haynes Street Medical Associates II	15%	(0)	(49)	56	33	65	50	39	55
Evergreen Medical Associates, LLC	20%	16	24	17	87	109	67	79	121
Evergreen Medical Associates II, LLC	20%	(35)	28	(51)	(0)	71	38	36	69
Evergreen Endoscopy Center, LLC	50%	380	327	366	346	492	280	190	402
Pre-Tax Income (Not-for-Profit/Passthrough Entities)		$2,319	$1,430	$2,110	$2,124	$2,344	$1,846	$1,718	$2,215
Estimated After-Tax Income (Not-for-Profit/Passthrough Entities)		$1,394	$860	$1,269	$1,277	$1,409	$1,110	$1,033	$1,332
JV Investment Income (Taxable Entities):									
Metro Wheelchair Service Inc.	50%	NA	NA	(42)	(30)	(54)	(41)	25	11
Aetna Ambulance Service Inc.	50%	NA	NA	177	210	189	141	(43)	5
After-Tax Income (Taxable Entities)		NA	NA	135	180	135	100	(18)	16
Total JV Investment Income After-Tax		**$1,394**	**$860**	**$1,404**	**$1,457**	**$1,544**	**$1,210**	**$1,015**	**$1,348**
JV Investment Distributions:									
Ambulance Service of Manchester	50%	$900	$1,300	$1,050	$1,150	$1,000	$600	$800	$1,200
Haynes Street Medical Associates	23%	12	13	19	20	21	15	15	20
Haynes Street Medical Associates II	15%	-	23	45	49	52	39	39	52
Evergreen Medical Associates, LLC	20%	27	33	60	88	103	76	79	105
Evergreen Medical Associates II, LLC	20%	5	18	36	46	47	35	36	48
Evergreen Endoscopy Center, LLC	50%	200	525	350	450	425	325	-	100
NRRON Estimated Free Cash Flow (3)	50%	NA	NA	206	533	322	NA	NA	322
Total Distributions		**$1,144**	**$1,912**	**$1,765**	**$2,336**	**$1,970**	**$1,091**	**$969**	**$1,848**

(1) Fiscal 2013 income reflects 50% of the change in net assets as reported on NRRON's audited financial statements.
(2) Includes income from Metro Wheelchair Service Inc. and Aetna Ambulance Service Inc. in fiscal 2010 and 2011.
(3) Based on NRRON audited financial statements; represents cash generated by operating activies minus capital expenditures.

V. Valuation Analysis

Valuation Analysis

Discounted Cash Flow Analysis

- In performing the DCF analysis, we relied on the Management Projections from FY 2015 through 2019.
  - Adjusted Revenue was estimated to grow at a compounded annual growth rate of 1.1% from FY 2014 through 2019.
  - Adjusted EBITDAP margins were estimated to increase from 2.7% in FY 2014 to 4.5% in FY 2019.
  - Capital expenditures are estimated to be between 5.3% and 5.5% of adjusted revenues from FY 2015 through 2019.
- Our DCF utilized a weighted average cost of capital ("WACC") range of 10.75% to 11.75% to discount the unlevered free cash flows of ECHN.
- As a not-for-profit entity, the Company does not pay taxes; however, standard valuation practices dictate that we determine the value of the Company as if it were a taxable corporation. Therefore a tax rate of 39.9% is applied in our analysis based on currently prevailing federal and the state of Connecticut's corporate income tax rates.

Valuation Analysis

Discounted Cash Flow Analysis

Discounted Cash Flow Analysis
($ in thousands)

	Management Projections					5-Year
	2015	2016	2017	2018	2019	CAGR
Adjusted Revenue	$316,347	$318,873	$323,143	$328,347	$334,431	1.1%
Growth	*(0.3%)*	*0.8%*	*1.3%*	*1.6%*	*1.9%*	
Adjusted EBITDAP	4,487	12,967	14,079	14,083	14,884	11.9%
EBITDAP Margin	*1.4%*	*4.1%*	*4.4%*	*4.3%*	*4.5%*	
EBITDAP Growth	*(47.1%)*	*189.0%*	*8.6%*	*0.0%*	*5.7%*	
	Partial Period (1)					
Earnings Before Interest and Taxes (2)	($1,323)	$1,885	$2,120	$2,124	$2,925	
Pro Forma Taxes @ 39.9%	0	(402)	(845)	(847)	(1,166)	
Net Operating Profit After Tax	(1,323)	1,483	1,275	1,277	1,759	
Depreciation	2,896	11,959	11,959	11,959	11,959	
Capital Expenditures	(1,875)	(7,500)	(9,000)	(8,500)	(9,000)	
(Increase) Decrease in Working Capital	584	120	(690)	(354)	(507)	
Free Cash Flow	$283	$6,062	$3,543	$4,382	$4,210	
Terminal EBITDAP Multiple	4.5x	4.5x	4.5x			
Weighted Average Cost of Capital	11.75%	11.25%	10.75%			
Concluded Enterprise Value Range (Rounded) (3)	**$57,800**	**$58,700**	**$59,700**			

Implied Enterprise Value Multiples

LTM Adjusted Revenue	$306,230	0.19x	0.19x	0.19x
Est. 2015 Adjusted EBITDAP	$4,487	12.9x	13.1x	13.3x
Proj. 2016 Adjusted EBITDAP	$12,967	4.5x	4.5x	4.6x

(1) Represents the period from July 1st through September 30th.
(2) Adjusted to include projected income from reimbursment related to the EHR conversion, net of expenses.
(3) Includes the present value of net operating loss carryforwards generated in fiscal 2015.

Valuation Analysis

M&A Transactions Analysis Summary

Nonprofit Hospital Transactions - Summary Tables

	EBITDA Margin			Number of Beds			Committed Capital	
	< 5%	5% - 10%	> 10%	< 200	200 - 400	> 400	No	Yes
Implied EV / EBITDA Multiples								
Average	12.3x	9.5x	4.6x	8.8x	10.2x	4.6x	11.0x	5.9x
Median	9.8x	7.2x	3.4x	7.2x	10.8x	4.3x	9.2x	4.8x
1st Quartile	8.9x	6.4x	2.3x	5.1x	4.5x	2.6x	6.7x	2.2x
3rd Quartile	16.3x	11.9x	4.8x	9.8x	15.4x	4.8x	14.5x	9.1x
Observations	10	14	12	16	14	6	19	17
Implied EV / Revenue Multiples								
Average	0.44x	0.74x	0.55x	0.54x	0.58x	0.65x	0.67x	0.46x
Median	0.34x	0.58x	0.40x	0.42x	0.57x	0.75x	0.59x	0.35x
1st Quartile	0.25x	0.46x	0.30x	0.26x	0.24x	0.36x	0.30x	0.22x
3rd Quartile	0.60x	0.77x	0.60x	0.60x	0.78x	0.89x	0.88x	0.60x
Observations	26	14	12	31	24	13	39	28
Implied Price / Beds								
Average	$309	$526	$412	$395	$327	$571	$419	$385
Median	$234	$479	$339	$288	$308	$456	$396	$308
1st Quartile	$89	$382	$222	$122	$114	$313	$179	$130
3rd Quartile	$404	$683	$635	$549	$479	$738	$610	$479
Observations	27	13	12	33	25	13	43	27

Source: Irving Levin Associates and Standard & Poor's Capital IQ (see Appendix for details)

Valuation Analysis

Selected Public Companies – Financial Performance

Selected Public Company Analysis

COMPANY INFORMATION	REVENUE GROWTH					EBITDAP GROWTH					EBITDAP MARGIN				
Company Name	3-YR CAGR	LTM	2015	2016	2017	3-YR CAGR	LTM	2015	2016	2017	3-YR AVG	LTM	2015	2016	2017
Community Health Systems, Inc.	16.1%	27.3%	6.6%	4.3%	4.8%	14.1%	33.6%	12.0%	4.6%	5.0%	15.5%	15.5%	16.0%	16.1%	16.1%
HCA Holdings, Inc.	7.5	8.7	7.5	5.3	5.3	8.1	10.1	5.9	5.0	6.2	21.0	21.3	20.9	20.9	21.1
HEALTHSOUTH Corp.	5.8	16.3	28.5	6.7	7.1	8.4	7.6	15.0	8.5	9.4	24.8	23.7	22.5	22.9	23.4
Kindred Healthcare Inc.	6.1	23.6	43.3	5.7	4.3	11.6	56.0	84.0	12.8	4.4	6.8	7.4	8.8	9.4	9.4
LifePoint Health, Inc.	14.0	27.0	16.1	8.8	5.2	4.1	25.8	22.1	6.5	4.8	14.4	13.1	14.1	13.8	13.8
Select Medical Holdings Corporation	3.1	6.8	22.8	14.1	2.5	-2.4	2.8	17.8	17.4	5.5	12.9	11.9	11.5	11.8	12.2
Tenet Healthcare Corp.	24.3	23.2	10.4	5.1	4.9	20.7	40.8	16.9	10.4	6.1	12.9	13.0	13.1	13.8	13.9
Universal Health Services Inc.	6.1	12.7	11.3	6.2	6.6	7.5	13.9	14.2	6.0	7.7	18.9	18.9	19.2	19.2	19.4
Mean	**10.4%**	**18.2%**	**18.3%**	**7.0%**	**5.1%**	**9.0%**	**23.8%**	**23.5%**	**8.9%**	**6.1%**	**15.9%**	**15.6%**	**15.8%**	**16.0%**	**16.2%**
Median	**6.8%**	**19.8%**	**13.7%**	**5.9%**	**5.0%**	**8.2%**	**19.9%**	**16.0%**	**7.5%**	**5.8%**	**14.9%**	**14.3%**	**15.1%**	**15.0%**	**15.0%**
Eastern Connecticut Health (1)	**3.8%**	**NA**	**-0.8%**	**1.3%**	**1.3%**	**-13.1%**	**NA**	**-47.1%**	**189.0%**	**8.6%**	**3.0%**	**1.9%**	**1.4%**	**4.1%**	**4.4%**

(1) Calculated using adjusted revenue and EBITDAP amounts
LTM = Latest Twelve Months
CAGR = Compounded Annual Growth Rate
EBITDAP = Earnings Before Interest, Taxes, Depreciation, Amortization and Pension Expense
Source: Bloomberg, Capital IQ, SEC filings

Valuation Analysis

Selected Public Companies – Valuation Metrics

Selected Public Company Analysis

($ in millions, except per share and per licensed bed)

COMPANY INFORMATION	MARKET DATA			ENTERPRISE VALUE AS MULTIPLE OF						STOCK PRICE AS A MULTIPLE OF		
Company Name	Stock Price on 9/02/15	% of 52-Wk High	Enterprise Value	LTM EBITDAP	2015 EBITDAP	2016 EBITDAP	LTM Revenue	2015 Revenue	Licensed Beds ($000s)	LTM EPS	2015 EPS	2016 EPS
Community Health Systems, Inc.	$53.70	83.9%	$23,565	7.8x	7.4x	7.1x	1.21x	1.19x	$782	12.9x	13.3x	10.5x
HCA Holdings, Inc.	86.62	91.4	67,873	8.3	8.2	7.8	1.77	1.71	1,565	16.6	16.4	14.9
HEALTHSOUTH Corp.	42.70	89.1	6,283	9.9	9.2	8.4	2.35	2.06	886	21.3	19.0	16.5
Kindred Healthcare Inc.	20.08	82.2	4,913	11.0	7.8	6.9	0.82	0.68	255	NMF	14.9	12.0
LifePoint Health, Inc.	78.13	89.0	5,497	8.4	7.5	7.0	1.11	1.06	666	20.4	19.9	18.3
Select Medical Holdings Corporation	12.90	76.1	4,455	11.8	10.4	8.9	1.41	1.20	836	13.3	13.9	12.4
Tenet Healthcare Corp.	49.23	77.8	21,212	9.3	8.8	8.0	1.21	1.16	1,019	17.3	22.7	18.4
Universal Health Services Inc.	137.14	93.8	16,884	10.4	9.8	9.2	1.97	1.88	628	21.8	19.6	18.3
Mean	**60.06**	**85.4%**	**18,835**	**9.6x**	**8.6x**	**7.9x**	**1.48x**	**1.37x**	**$830**	**17.7x**	**17.4x**	**15.2x**
Median	**51.47**	**86.4%**	**11,583**	**9.6x**	**8.5x**	**7.9x**	**1.31x**	**1.19x**	**$809**	**17.3x**	**17.7x**	**15.7x**

LTM = Latest Twelve Months
Enterprise Value = (Market Capitalization) + (Debt + Preferred Stock + Non-Controlling Interest) - (Cash & Equivalents)
EBITDAP = Earnings Before Interest, Taxes, Depreciation, Amortization and Pension Expense
EPS - Earnings per Share
Source: Bloomberg, Capital IQ, SEC filings

Valuation Analysis

Market Approach

Market Approach

($ in thousands)

Enterprise Valuation Multiples				Valuation Summary			
Metric	Public Company Range	Public Company Median	M&A Transactions Median (1)	Selected Multiple Range	Company Performance	Enterprise Value Range	
LTM Adjusted EBITDAP	7.7x - 11.6x	9.4x	7.2x	**9.0x - 10.0x**	$5,887	$52,984	- $58,872
Proj. 2016 Adjusted EBITDAP	7.3x - 10.2x	8.3x	7.2x	**4.0x - 4.5x**	$12,967	$51,869	- $58,353
				Concluded Value Range (Rounded)		**$52,400**	- **$58,600**
				Implied Enterprise Value Multiples			
				Price Per Bed ($000s) (2)	327	$160	- $179
				LTM Adjusted Revenue	$306,230	0.17x	- 0.19x
				Est. 2015 Adjusted EBITDAP	$4,487	11.7x	- 13.1x

(1) LTM EBITDA multiple
(2) Includes staffed, psychiatric, and skilled nursing beds

Valuation Analysis

JV Investments

JV Investments Valuation
($ in thousands)

Market Approach			
LTM JV Income After Tax (1)	$1,348	$1,348	$1,348
Selected Multiple Range	9.5x	10.0x	10.5x
Estimated Range of Value (Rounded)	**$12,800**	**$13,500**	**$14,200**
Gordon Growth Approach			
After-Tax Estimated LTM Distributions (2)	$1,111	$1,111	$1,111
Estimated Range of Discount Rate	12.50%	12.00%	11.50%
Estimated Perpetuity Growth Rate	3.0%	3.0%	3.0%
Estimated Range of Value (Rounded)	**$12,045**	**$12,714**	**$13,462**
Estimated Value of JV Investments	**$12,400**	**$13,100**	**$13,800**

(1) LTM as of June 30, 2015
(2) JV Investments income and distributions burdened with taxes at an estimated rate of 39.9% and includes an adjustment for estimated free cash flow from NRRON

Appendix

M&A Transaction Detail

M&A Transaction Detail

Nonprofit Hospital Transactions

Date	Target	State	Acquirer	Purchase Price ($MM)	Committed Capital ($MM)	Revenues ($MM)	EBITDA ($MM)	EBITDA Margin	Beds	Price / Revenue	Price / EBITDA	Price / Bed ($000)
6/8/2015	Lodi Health	California	Adventist Health	100.0	0.0	168.1	4.0	2.4%	182	0.59x	24.7x	549
6/5/2015	Ty Cobb Regional Medical Center	Georgia	St. Mary's Health Care System	12.9	0.0	27.9	(6.7)	-24.1%	56	0.46x	NM	230
5/15/2015	Watertown Regional Medical Center	Wisconsin	LifePoint Health	0.0	100.0	97.4	11.3	11.6%	95	NA	NA	NA
4/15/2015	Pennock Health Services	Michigan	Spectrum Health	0.0	56.0	61.4	8.8	14.3%	88	NA	NA	NA
12/23/2014	Bert Fish Medical Center	Florida	Florida Hospital Tampa	40.0	0.0	95.5	5.6	5.9%	112	0.42x	7.2x	357
12/16/2014	Runnells Specialized Hospital	New Jersey	Center Management Groupe, LLC	26.0	0.0	24.8	0.0	NA	44	1.05x	NA	591
11/20/2014	Saint Joseph Mercy Port Huron	Michigan	Prime Healthcare Services	20.0	0.0	81.0	8.3	10.2%	164	0.25x	2.4x	122
11/6/2014	SwedishAmerican Health System	Illinois	UW Health	255.0	0.0	460.3	40.2	8.7%	357	0.55x	6.3x	714
10/31/2014	Citrus Memorial Hospital	Florida	HCA	0.0	195.0	179.6	5.7	3.2%	198	NA	NA	NA
9/22/2014	Our Lady of the Resurrection Medical	Illinois	Community First Healthcare of Illinois, Inc.	10.0	0.0	270.5	7.2	2.7%	272	1.38x	1.4x	37
9/9/2014	Community Medical Center	Montana	RCHP / Billings Clinic joint venture	74.8	0.0	161.5	14.4	8.9%	151	0.46x	5.2x	495
8/21/2014	Conemaugh Health System	Pennsylvania	Duke LifePoint Healthcare	500.0	425.0	516.0	0.0	NA	600	0.97x	NA	833
8/1/2014	MedWest Haywood	North Carolina	Duke LifePoint Healthcare	36.0	36.0	105.5	4.0	3.7%	138	0.34x	9.1x	261
7/11/2014	Natchez Regional Medical Center	Mississippi	Community Health Systems, Inc.	10.0	0.0	60.1	3.8	6.3%	179	0.17x	2.6x	56
6/26/2014	UA Health Network	Arizona	Banner Health	446.0	0.0	1,613.6	97.2	6.0%	1,339	0.28x	4.6x	333
5/29/2014	East Orange General Hospital	New Jersey	Prospect Medical Holdings, Inc.	84.0	0.0	0.0	0.0	NM	212	NA	NA	396
5/12/2014	Long Beach Medical Center	New York	South Nassau Communities Hospital	11.8	0.0	0.0	0.0	NM	162	NA	NA	73
4/30/2014	Restora Healthcare Hospitals	Arizona	Acuity and Tutera Senior Living partnership	5.0	0.0	20.1	0.0	0.2%	240	0.25x	NM	21
4/10/2014	Community Memorial Healthcenter	Virginia	VCU Health System	0.0	75.0	90.3	2.8	3.1%	274	NA	NA	NA
4/1/2014	Fairmont General Hospital	West Virginia	Alecto Healthcare Services LLC	15.3	0.0	81.5	(0.4)	-0.5%	207	0.19x	NM	74
4/1/2014	Bedford Memorial Hospital and rehab center	Virginia	Centra Health	11.0	0.0	32.9	1.2	3.8%	161	0.33x	8.9x	68

M&A Transaction Detail

Nonprofit Hospital Transactions

	Date	Target	State	Acquirer	Purchase Price ($MM)	Committed Capital ($MM)	Revenues ($MM)	EBITDA ($MM)	EBITDA Margin	Beds	Price / Revenue	Price / EBITDA	Price / Bed ($000)
	2/28/2014	Mercy Regional Health Center	Kansas	Via Christi Health	7.0	15.5	92.3	12.9	13.9%	111	0.08x	0.5x	63
	2/24/2014	Saint Francis Hospital and Health Centers	New York	Westchester Medical Center	45.0	0.0	145.3	(7.6)	-5.2%	185	0.31x	NM	243
	2/17/2014	Chindex International, Inc.	Maryland	Buyer Consortium	461.0	0.0	170.0	15.8	9.3%	-	2.71x	23.4x	NA
	2/6/2014	Garden City Hospital	Michigan	Prime Healthcare Services	80.0	0.0	134.4	10.2	7.6%	203	0.60x	7.9x	394
	1/29/2014	Hackettstown Regional Medical Center	New Jersey	Atlantic Health System	54.0	0.0	89.7	7.5	8.3%	103	0.60x	7.2x	524
	1/8/2014	Wilson Medical Center	North Carolina	Duke LifePoint Healthcare, LLC	96.0	120.0	141.4	25.1	17.8%	274	0.68x	3.8x	350
	12/30/2013	Casa Grande Community Hospital	Arizona	Banner Health	87.0	0.0	138.6	NA	NA	174	0.63x	NA	500
	10/31/2013	WestCare	North Carolina	Duke LifePoint Healthcare, LLC	26.3	36.0	96.0	(4.3)	-4.5%	110	0.27x	NM	239
	10/25/2013	Oak Park Hospital	Illinois	Rush University Medical Center	21.1	0.0	107.5	2.3	2.1%	237	0.20x	9.2x	89
(1)	8/6/2013	Portage Health	Michigan	LifePoint Hospitals, Inc.	50.0	60.0	87.4	10.4	11.9%	96	0.57x	4.8x	521
	7/11/2013	Stanly Health Services	North Carolina	Carolinas HealthCare System	0.0	70.0	134.7	14.1	10.5%	119	NA	NA	NA
	6/23/2013	Altoona Regional Health System	Pennsylvania	UPMC Health System	131.8	250.0	372.7	61.0	16.4%	402	0.35x	2.2x	328
	4/19/2013	St. Luke's Episcopal Health System	Texas	Catholic Health Initiatives	1,000.0	1,000.0	1,275.7	26.5	2.1%	1,098	0.78x	NM	911
	3/28/2013	Two Kansas Hospital	Kansas	Prime Healthcare Services	54.3	0.0	184.8	(8.8)	-4.8%	232	0.29x	NM	234
	3/8/2013	Cleveland County HealthCare System	North Carolina	Carolinas HealthCare System	101.0	0.0	222.3	24.8	11.1%	504	0.45x	4.1x	200
	1/2/2013	Knapp Medical Center	Texas	Prime Healthcare Foundation	100.0	10.0	128.6	8.2	6.4%	209	0.78x	12.2x	478
	12/13/2012	New York Westchester Square Medical	New York	Montefiore Medical Center	14.0	0.0	75.7	(2.4)	-3.1%	140	0.18x	NM	100
	12/10/2012	Medical Center of Newark	Ohio	Licking Memorial Health Systems	26.0	0.0	18.2	(0.2)	-0.9%	20	1.43x	NM	1,300
	11/29/2012	St. Mary's Hospital	New Jersey	Prime Healthcare Services	25.0	44.0	166.4	1.3	0.8%	279	0.15x	19.2x	90
	11/14/2012	University of Louisville Hospital	Kentucky	KentuckyOne Health	0.0	1,394.0	450.6	10.9	2.4%	345	NA	NA	NA
	11/5/2012	North Texas Community Hospital	Texas	Wise Regional Health System	20.0	0.0	NA	NA	NA	21	NA	NA	952

M&A Transaction Detail

Nonprofit Hospital Transactions

	Date	Target	State	Acquirer	Purchase Price ($MM)	Committed Capital ($MM)	Revenues ($MM)	EBITDA ($MM)	EBITDA Margin	Beds	Price / Revenue	Price / EBITDA	Price / Bed ($000)
	10/19/2012	St. Vincent's Health System	Pennsylvania	HighMark, Inc.	20.0	45.0	327.4	15.3	4.7%	400	0.06x	1.3x	50
	10/10/2012	Chilton Hospital	New Jersey	Atlantic Health System	43.0	0.0	166.9	(2.9)	-1.7%	260	0.26x	NM	165
	8/27/2012	Hawaii Medical Center - West Campus	Hawaii	Queen's Health Systems	70.0	0.0	NA	NA	NA	102	NA	NA	686
	7/1/2012	Fox Chase Cancer Center	Pennsylvania	Temple University Health System	83.8	30.9	236.6	36.5	15.4%	100	0.35x	2.3x	838
	6/12/2012	Jefferson Regional Medical Center	Pennsylvania	HighMark, Inc.	275.0	0.0	204.7	22.6	11.0%	376	1.34x	12.2x	731
	6/1/2012	Westerly Hospital	Rhode Island	Lawrence & Memorial Hospital	69.0	0.0	90.6	5.8	6.4%	101	0.76x	12.0x	683
	5/3/2012	Cheboygan Memorial Hospital	Michigan	McLaren Health Care	5.0	0.0	45.9	(7.4)	-16.1%	91	0.11x	NM	55
	4/3/2012	Bay Medical Center	Florida	Sacred Heart Health System, Inc.	154.0	0.0	258.4	9.5	3.7%	323	0.60x	16.2x	477
	3/27/2012	Christ Hospital	New Jersey	Hudson Hospital Holdco, Inc.	43.5	0.0	125.1	1.4	1.1%	227	0.35x	NM	192
	3/6/2012	Marquette General Health System	Michigan	Duke LifePoint Healthcare, LLC	147.0	328.0	244.2	15.6	6.4%	307	0.60x	9.4x	479
	3/1/2012	Satilla Health Services	Georgia	Mayo Clinic Health System	0.0	51.0	152.8	4.2	2.7%	231	NA	NA	NA
(1)	2/3/2012	Integris Health joint venture	Oklahoma	Health Management Associates, Inc.	75.0	0.0	96.5	1.8	1.8%	226	0.78x	NM	332
	1/24/2012	Memorial Health Systems	Pennsylvania	Community Health Systems, Inc.	47.6	75.0	97.0	7.1	7.3%	100	0.49x	6.7x	476
	12/15/2011	Alamance Regional Medical Center	North Carolina	Cone Health	50.0	150.0	213.9	23.6	11.0%	218	0.23x	2.1x	229
	12/7/2011	Virginia Regional Medical Center	Minnesota	Essentia Health	10.0	17.0	50.7	NA	NA	164	0.20x	NA	61
	11/1/2011	Leake Memorial Hospital	Mississippi	Baptist Health System	2.8	0.0	11.7	NA	NA	25	0.24x	NA	110
(1)	10/27/2011	Twin County Regional Hospital	Virginia	Duke LifePoint Healthcare, LLC	12.5	20.0	55.0	NA	NA	86	0.23x	NA	145
	9/29/2011	Bay Medical Center	Florida	LHP Hospital Group, Inc.	155.0	0.0	258.4	9.5	3.7%	323	0.60x	16.3x	480
	9/6/2011	Mercy Hospital & Medical Center	Illinois	Trinity Health	26.0	150.0	251.4	15.3	6.1%	449	0.10x	1.7x	58
	9/1/2011	Logan Medical Center	Oklahoma	Mercy	7.2	0.0	22.3	1.0	4.5%	25	0.32x	7.2x	288
	7/28/2011	Tomball Regional Medical Center	Texas	Community Health Systems, Inc.	225.4	0.0	151.0	17.6	11.7%	358	1.49x	12.8x	630

M&A Transaction Detail

Nonprofit Hospital Transactions

	Date	Target	State	Acquirer	Purchase Price ($MM)	Committed Capital ($MM)	Revenues ($MM)	EBITDA ($MM)	EBITDA Margin	Beds	Price / Revenue	Price / EBITDA	Price / Bed ($000)
	7/19/2011	Moses Taylor Health Care System	Pennsylvania	Community Health Systems, Inc.	172.4	0.0	148.8	9.5	6.4%	242	1.16x	18.1x	712
	7/1/2011	Mercy Health Partners	Tennessee	Health Management Associates, Inc.	532.4	0.0	600.0	22.8	3.8%	833	0.89x	NM	639
	6/28/2011	Quincy Medical Center	Massachusetts	Steward Health Care System	35.0	44.0	78.1	1.5	1.9%	196	0.45x	NM	179
	6/25/2011	West Penn Allegheny Health System	Pennsylvania	HighMark, Inc.	1,475.0	0.0	1,600.0	33.3	2.1%	2,000	0.92x	NM	738
	6/7/2011	Landmark Medical Center	Rhode Island	Steward Health Care System	23.1	53.5	122.3	NA	NA	203	0.19x	NA	114
	5/25/2011	Civista Health System	Maryland	University of Maryland Medical System	4.0	12.5	103.8	NA	NA	130	0.04x	NA	31
	5/10/2011	Twin City Hospital	Ohio	Franciscan Services Corp.	4.9	0.0	15.5	NA	NA	25	0.32x	NA	196
	4/27/2011	Alexian Brothers Health System	Illinois	Ascension Health	490.0	155.0	952.6	101.9	10.7%	752	0.51x	4.8x	652
	4/25/2011	Hoboken University Medical System	New Jersey	HUMC Holdco, LLC	70.8	20.9	115.3	NA	NA	230	0.61x	NA	308
	4/18/2011	Sierra Kings District Hospital	California	Adventist Health	24.8	0.0	22.1	NA	NA	44	1.12x	NA	564
	3/31/2011	Morton Hospital and Medical Center	Massachusetts	Steward Health Care System	58.5	120.0	127.3	8.6	6.8%	153	0.46x	6.8x	382
	3/25/2011	Hospital of Saint Raphael	Connecticut	Yale-New Haven Hospital	160.0	135.0	450.3	15.4	3.4%	511	0.36x	10.4x	313
	3/22/2011	St. Mary's Hospital	Connecticut	LHP Hospital Group, Inc.	200.0	0.0	201.4	17.1	8.5%	175	0.99x	11.7x	1,143
(1)	3/18/2011	St. Joseph Medical Center	Texas	Iasis Healthcare, LLC	198.2	0.0	245.0	NA	NA	792	0.81x	NA	250
	3/7/2011	Loyola University Health System	Illinois	Trinity Health	1,405.0	375.0	1,100.0	NA	NA	820	1.28x	NA	1,713
(1)	2/16/2011	Valley Baptist Health System	Texas	Vanguard Health Systems, Inc.	394.9	0.0	527.0	NA	NA	866	0.75x	NA	456
	2/10/2011	Mercy Health Partners	Pennsylvania	Community Health Systems, Inc.	161.0	0.0	183.9	NA	NA	313	0.88x	NA	514
	2/1/2011	Hamot Medical Center	Pennsylvania	UPMC Health System	100.0	200.0	315.2	33.0	10.5%	351	0.32x	3.0x	285
				Median	**$54.0**	**$0.0**	**$134.7**	**$8.2**	**5.3%**	**203**	**0.46x**	**7.2x**	**342**

(1) Purchase price was grossed up to reflect an acquisition of 100% of the implied enterprise value
Source: Irving Levin Associates and Standard & Poor's Capital IQ

EXHIBIT Q7-4 - DUFF & PHELPS' FAIRNESS OPINION LETTER

DUFF & PHELPS

Confidential September 9, 2015

Eastern Connecticut Health Network, Inc.
71 Haynes Street
Manchester, CT 06040

Ladies and Gentlemen:

Eastern Connecticut Health Network, Inc. and its wholly owned subsidiaries (collectively, the "Company") has engaged Duff & Phelps, LLC ("Duff & Phelps") to serve as an independent financial advisor to the board of trustees (collectively the "Board of Trustees") of the Company and to provide an opinion (the "Opinion") as of the date hereof as to the fairness, from a financial point of view, to the Company of the consideration to be received by the Company in the contemplated transaction described below (the "Proposed Transaction").

Description of the Proposed Transaction

It is Duff & Phelps' understanding that the Proposed Transaction involves the sale of substantially all of the assets of the Company and substantially all of the assets of the Company's subsidiaries, other than cash and investments, to an indirect, wholly-owned subsidiary of Prospect Medical Holdings, Inc. (such subsidiary, the "Buyer") for cash consideration in the amount of $105 million, subject to certain adjustments as described in the Asset Purchase Agreement (as defined below). It is our further understanding that the buyer will make certain post-closing covenants with respect to the continued provision of medical services as well as a minimum level of future capital investment.

Scope of Analysis

In connection with this Opinion, Duff & Phelps has made such reviews, analyses and inquiries as it has deemed necessary and appropriate under the circumstances. Duff & Phelps also took into account its assessment of general economic, market and financial conditions, as well as its experience in securities and business valuation, in general, and with respect to similar transactions, in particular. Duff & Phelps' procedures, investigations, and financial analysis with respect to the preparation of its Opinion included, but were not limited to, the items summarized below:

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1. Reviewed the following documents:

    a. The Company's consolidated audited financial statements for the years ended September 30, 2010 through 2014 and the Company's unaudited interim financial statements for the nine-month periods ended June 30, 2014 and 2015;

    b. Various audited and unaudited financial statements related to joint venture investments held by ECHN;

    c. Other internal documents relating to the history, current operations, and probable future outlook of the Company, including financial projections, provided to us by management of the Company; and

    d. Documents related to the Proposed Transaction, including the draft Asset Purchase Agreement, dated July 9, 2015, by and between the Company and the Buyer (the "Asset Purchase Agreement");

2. Discussed the information referred to above and the background and other elements of the Proposed Transaction with the management of the Company;

3. Performed certain valuation and comparative analyses using generally accepted valuation and analytical techniques including a discounted cash flow analysis, an analysis of selected public companies that Duff & Phelps deemed relevant, and an analysis of selected transactions that Duff & Phelps deemed relevant; and

4. Conducted such other analyses and considered such other factors as Duff & Phelps deemed appropriate.

Assumptions, Qualifications and Limiting Conditions

In performing its analyses and rendering this Opinion with respect to the Proposed Transaction, Duff & Phelps, with the Company's consent:

1. Relied upon the accuracy, completeness, and fair presentation of all information, data, advice, opinions and representations obtained from public sources or provided to it from private sources, including Company management, and did not independently verify such information;

2. Relied upon the fact that the Board of Trustees and the Company have been advised by counsel as to all legal matters with respect to the Proposed Transaction, including whether all procedures required by law to be taken in connection with the Proposed Transaction have been duly, validly and timely taken;

3. Assumed that any estimates, evaluations, forecasts and projections furnished to Duff & Phelps were reasonably prepared and based upon the best currently available information and good faith judgment of the person furnishing the same;

4. Assumed that information supplied and representations made by Company management are substantially accurate regarding the Company and the Proposed Transaction

5. Assumed that the representations and warranties made in Asset Purchase Agreement are substantially accurate;

6. Assumed that the final versions of all documents reviewed by Duff & Phelps in draft form conform in all material respects to the drafts reviewed;

7. Assumed that there has been no material change in the assets, financial condition, business, or prospects of the Company since the date of the most recent financial statements and other information made available to Duff & Phelps;

8. Assumed that all of the conditions required to implement the Proposed Transaction will be satisfied and that the Proposed Transaction will be completed in accordance with the Agreement without any amendments thereto or any waivers of any terms or conditions thereof; and

9. Assumed that all governmental, regulatory or other consents and approvals necessary for the consummation of the Proposed Transaction will be obtained without any adverse effect on the Company.

To the extent that any of the foregoing assumptions or any of the facts on which this Opinion is based prove to be untrue in any material respect, this Opinion cannot and should not be relied upon. Furthermore, in Duff & Phelps' analysis and in connection with the preparation of this Opinion, Duff & Phelps has made numerous assumptions with respect to industry performance, general business, market and economic conditions and other matters, many of which are beyond the control of any party involved in the Proposed Transaction.

Duff & Phelps has prepared this Opinion effective as of the date hereof. This Opinion is necessarily based upon market, economic, financial and other conditions as they exist and can be evaluated as of the date hereof, and Duff & Phelps disclaims any undertaking or obligation to advise any person of any change in any fact or matter affecting this Opinion which may come or be brought to the attention of Duff & Phelps after the date hereof.

Duff & Phelps did not evaluate the Company's solvency or conduct an independent appraisal or physical inspection of any specific assets or liabilities (contingent or otherwise). Duff & Phelps has not been requested to, and did not: (i) initiate any discussions with, or solicit any indications of interest from, third parties with respect to the Proposed Transaction, the assets, businesses or operations of the Company, or any alternatives to the Proposed Transaction, (ii) negotiate the

terms of the Proposed Transaction, and therefore, Duff & Phelps has assumed that such terms are the most beneficial terms, from the Company's perspective, that could, under the circumstances, be negotiated among the parties to the Asset Purchase Agreement and the Transaction, or (iii) advise the Board of Directors or any other party with respect to alternatives to the Proposed Transaction. Duff & Phelps was not requested to and did not determine the Company's value under any liquidation scenario, including the potential proceeds that might be obtained therefrom.

This Opinion should not be construed as a valuation opinion, credit rating, solvency opinion, an analysis of the Company's credit worthiness, as tax advice, or as accounting advice. Duff & Phelps has not made, and assumes no responsibility to make, any representation, or render any opinion, as to any legal matter.

In rendering this Opinion, Duff & Phelps is not expressing any opinion with respect to the amount or nature of any compensation to any of the Company's officers, directors, or employees, or any class of such persons, relative to the consideration to be received by the Company in the Proposed Transaction, or with respect to the fairness of any such compensation.

This Opinion is furnished solely for the use and benefit of the Company, its corporators and the Board of Trustees in connection with its consideration of the Proposed Transaction and is not intended to, and does not, confer any rights or remedies upon any other person, and is not intended to be used, and may not be used, by any other person or for any other purpose, without Duff & Phelps' express consent. This Opinion: (i) does not address the merits of the underlying business decision to enter into the Proposed Transaction versus any alternative strategy or transaction; (ii) does not address any transaction related to the Proposed Transaction; (iii) is not a recommendation as to how the Board of Trustees, any corporator or any other party should vote or act with respect to any matters relating to the Proposed Transaction, or whether to proceed with the Proposed Transaction or any related transaction, and (iv) does not indicate that the consideration received is the best possibly attainable under any circumstances; instead, it merely states whether the consideration in the Proposed Transaction is within a range suggested by certain financial analyses. The decision as to whether to proceed with the Proposed Transaction or any related transaction may depend on an assessment of factors unrelated to the financial analysis on which this Opinion is based. This letter should not be construed as creating any fiduciary duty on the part of Duff & Phelps to any party.

This Opinion is solely that of Duff & Phelps, and Duff & Phelps' liability in connection with this letter shall be limited in accordance with the terms set forth in the engagement letter between Duff & Phelps and the Company dated August 14, 2015 (the "Engagement Letter"). This letter is confidential, and its use and disclosure is strictly limited in accordance with the terms set forth in the Engagement Letter.

Disclosure of Prior Relationships

Duff & Phelps has acted as financial advisor to the Board of Directors and will receive a fee for its services. No portion of Duff & Phelps' fee is contingent upon either the conclusion expressed in this Opinion or whether or not the Proposed Transaction is successfully consummated. Pursuant to the terms of the Engagement Letter, a portion of Duff & Phelps' fee is payable upon Duff & Phelps' informing the Company that it is prepared to deliver its Opinion. Duff & Phelps has provided a similar financial opinion to the Board Directors in connection with a prior agreement to sell substantially all assets of the Company; however, such transaction was ultimately terminated prior to closing. Other than the prior engagement noted above, during the two years preceding the date of this Opinion, Duff & Phelps has not had any material relationship with any party to the Proposed Transaction for which compensation has been received or is intended to be received, nor is any such material relationship or related compensation mutually understood to be contemplated.

Conclusion

Based upon and subject to the foregoing, Duff & Phelps is of the opinion that as of the date hereof the consideration to be received by the Company in the Proposed Transaction is fair from a financial point of view to the Company.

This Opinion has been approved by the Opinion Review Committee of Duff & Phelps.

Respectfully submitted,



Duff & Phelps, LLC

EXHIBIT Q8-1 - PMH'S FISCAL YEAR 2014 AUDITED FINANCIAL STATEMENTS

Prospect Medical Holdings, Inc.

Consolidated Financial Statements

For the Years Ended
September 30, 2014 and 2013

The report accompanying these financial statements was issued by BDO USA, LLP, a Delaware limited liability partnership and the U.S. member of BDO International Limited, a UK company limited by guarantee.

BDO

Prospect Medical Holdings, Inc.

Consolidated Financial Statements
For the Years Ended September 30, 2014 and 2013

Prospect Medical Holdings, Inc.

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Independent Auditor's Report

Board of Directors
Prospect Medical Holdings, Inc.
Los Angeles, California

We have audited the accompanying consolidated financial statements of Prospect Medical Holdings, Inc. (the "Company"), which comprise the consolidated balance sheets as of September 30, 2014 and 2013, and the related consolidated statements of income, statements of stockholder's deficit, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Prospect Medical Holdings, Inc. and its subsidiaries as of September 30, 2014 and 2013, and the results of their operations and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

BDO USA, LLP

December 17, 2014

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BDO is the brand name for the BDO network and for each of the BDO Member Firms.

Consolidated Financial Statements

Prospect Medical Holdings, Inc.

Consolidated Balance Sheets
(in thousands except par value and share amounts)

September 30,	2014	2013
Assets		
Current assets:		
Cash and cash equivalents	$ 39,072	$ 86,315
Restricted cash	4,976	563
Investments, primarily restricted money market funds	642	637
Patient accounts receivable, net of allowance for doubtful accounts of $49,727 and $28,050	123,733	75,606
Due from government payers	42,518	27,408
Other receivables	15,947	8,034
Income taxes receivable, net	57	2,365
Deferred income taxes, net	68,304	8,254
Inventories	10,448	4,679
Hospital fee program receivable	-	18,895
Prepaid expenses and other current assets	14,317	8,967
Total current assets	320,014	241,723
Property, improvements and equipment, net	229,474	126,532
Deferred financing costs, net	9,457	11,625
Deferred income taxes, net	-	6,361
Goodwill	158,864	158,864
Intangible assets, net	35,274	31,325
Other assets	8,234	2,516
Total assets	$ 761,317	$ 578,946

See accompanying notes to the consolidated financial statements.

Prospect Medical Holdings, Inc.

Consolidated Balance Sheets
(in thousands except par value and share amounts)

September 30,	2014	2013
Liabilities and Stockholder's Deficit		
Current liabilities:		
Accrued medical claims and other healthcare costs payable	$ 39,314	$ 30,352
Accounts payable and other accrued liabilities	88,218	52,151
Accrued salaries, wages and benefits	53,808	30,057
Hospital fee program liability and deferred revenue	2,806	8,609
Due to government payers	26,584	19,634
Income taxes payable, net	5,879	1,288
Revolving line of credit	20,000	-
Current portion of capital leases	4,691	5,429
Current portion of long-term debt	133	178
Other current liabilities	1,659	485
Total current liabilities	243,092	148,183
Long-term debt, net of current portion	421,755	420,889
Deferred income taxes, net	70,447	24,869
Malpractice reserves	4,590	4,660
Capital leases, net of current portion	10,463	11,816
Asset retirement obligations	4,310	-
Other long-term liabilities	7,866	570
Total liabilities	762,523	610,987
Commitments, contingencies and subsequent events		
Stockholder's deficit:		
Common stock, $0.01 par value; 100 shares authorized, issued and outstanding at September 30, 2014 and 2013	1	1
Additional paid-in capital	18,457	15,334
Accumulated deficit	(28,481)	(47,496)
Total stockholder's deficit attributable to Prospect Medical Holdings, Inc.	(10,023)	(32,161)
Non-controlling interests	8,817	120
Total stockholder's deficit	(1,206)	(32,041)
Total liabilities and stockholder's deficit	$ 761,317	$ 578,946

See accompanying notes to the consolidated financial statements.

Prospect Medical Holdings, Inc.

Consolidated Statements of Income
(in thousands)

For the Years Ended September 30,	2014	2013
Revenues:		
Net Hospital Services revenues	$ 618,956	$ 518,206
Provision for bad debts	(32,945)	(34,067)
Net Hospital Services revenues less provision for bad debts	586,011	484,139
Medical Group revenues	253,980	221,743
Other revenues	14,525	7,700
Total net revenues	854,516	713,582
Operating Expenses:		
Hospital operating expenses	449,742	348,961
Medical Group cost of revenues	185,342	164,457
General and administrative	133,056	99,935
Depreciation and amortization	23,580	16,814
Impairment of intangible assets	-	3,476
Total operating expenses	791,720	633,643
Operating income from unconsolidated joint venture	3,356	2,217
Operating income	66,152	82,156
Other (income) expense:		
Interest expense and amortization of deferred financing costs, net	41,437	38,860
Gain on bargain purchase	(4,817)	-
Other expense	419	244
Total other (income) expense, net	37,039	39,104
Income before income taxes	29,113	43,052
Income tax provision	10,561	9,810
Net income	18,552	33,242
Net income attributable to non-controlling interests	(463)	7
Net income attributable to Prospect Medical Holdings, Inc.	$ 19,015	$ 33,235

See accompanying notes to the consolidated financial statements.

ECHN Proposed Asset Purchase by PMH
Submitted October 13, 2015

Prospect Medical Holdings, Inc.

Consolidated Statements of Stockholder's Deficit
(in thousands except share amounts)

	Number of Common Shares	Common Stock	Additional Paid-in Capital	Retained Earnings (Accumulated Deficit)	Prospect Medical Holdings, Inc. Stockholder's Deficit	Non-controlling Interests	Total Stockholder's Deficit
Balance at September 30, 2012	100	$ 1	$ 11,634	$ 19,269	$ 30,904	$ 113	$ 31,017
Options exercised	-	-	105	-	105	-	105
Stock-based compensation	-	-	3,595	-	3,595	-	3,595
Distribution to Ivy Holdings Inc. (Parent)	-	-	-	(100,000)	(100,000)	-	(100,000)
Net income	-	-	-	33,235	33,235	7	33,242
Balance at September 30, 2013	100	1	15,334	(47,496)	(32,161)	120	(32,041)
Stock-based compensation	-	-	2,673	-	2,673	-	2,673
Investment in Chaparral Medical Group (see Note 1)	-	-	450	-	450	-	450
Non-controlling interest attributed to PCC Seller (see Note 4)	-	-	-	-	-	9,160	9,160
Net income	-	-	-	19,015	19,015	(463)	18,552
Balance at September 30, 2014	100	$ 1	$ 18,457	$ (28,481)	$ (10,023)	$ 8,817	$ (1,206)

See accompanying notes to the consolidated financial statements.

Prospect Medical Holdings, Inc.

Consolidated Statements of Cash Flows
(in thousands)

For the Years Ended September 30,	2014	2013
Operating activities		
Net income	$ 18,552	$ 33,242
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	23,580	16,814
Amortization of deferred financing costs, net	2,218	2,071
Amortization of original issue discount and premium, net	992	1,002
Provision for bad debts	32,945	34,067
Deferred income taxes, net	(8,111)	(340)
Stock-based compensation	2,673	3,595
Income from equity method investments	(178)	-
Impairment of intangible assets	-	3,476
Loss on disposal of assets	-	28
Gain on bargain purchase	(4,817)	-
Changes in operating assets and liabilities, net of business combinations:		
Patient accounts receivable and other receivables	(50,596)	(47,956)
Due to/from government payers, net	(8,827)	(14,962)
Prepaid expenses and other current assets	(1,682)	560
Hospital fee program receivable	18,895	14,578
Inventories	(814)	(12)
Hospital fee program liability and deferred revenue	(5,803)	(11,168)
Income taxes payable/receivable, net	6,899	(10,286)
Deposits and other assets	1,338	(960)
Accrued medical claims and other healthcare costs payable	8,962	3,367
Accounts payable and other accrued liabilities	16,177	11,831
Net cash provided by operating activities	52,403	38,947
Investing activities		
Purchases of property, improvements and equipment	(50,107)	(14,283)
Cash paid for acquisitions, net of cash received and working capital adjustments	(58,300)	(3,085)
Cash paid for investment in Chaparral Medical Group, Inc. (see Note 1)	(1,100)	-
Change in note receivable (net)	66	63
Increase in restricted investments	(5)	(3)
Net cash used in investing activities	(109,446)	(17,308)
Financing activities		
Borrowings of 2019 Notes	-	102,000
Borrowings on line of credit, net	20,000	-
Repayments of long-term debt	(176)	(211)
Repayments on SCH Culver City Creditors Trust Note	-	(500)
Repayments of capital leases	(5,435)	(4,370)
Cash paid for deferred financing costs, net	(50)	(3,948)

Prospect Medical Holdings, Inc.

Consolidated Statements of Cash Flows (Continued)
(in thousands)

For the Years Ended September 30,	2014	2013
Change in restricted cash	(2,676)	(300)
Cash paid for lender consent fees - 2019 Notes	-	(8,914)
Distribution to Ivy Holdings Inc. (Parent)	-	(100,000)
Proceeds from exercises of stock options and warrants	-	105
Repayments of insurance premium financing	(1,863)	(1,613)
Net cash provided by (used in) financing activities	9,800	(17,751)
(Decrease) Increase in cash and cash equivalents	(47,243)	3,888
Cash and cash equivalents, beginning of year	86,315	82,427
Cash and cash equivalents, end of year	$ 39,072	$ 86,315
Supplemental disclosure of cash flow information		
Interest paid	$ 37,608	$ 32,435
Income taxes paid, net	$ 12,004	$ 20,438
Schedule of non-cash investing and financing activities		
Equipment acquired under capital leases	$ 2,028	$ 4,274
Building lease capitalized	$ -	$ 5,675
Tenant improvement allowance	$ -	$ 1,227
Conversion of note payables to capital leases	$ -	$ 804
Insurance premium financed	$ 1,842	$ 1,635
Long-term liability assumed from acquisition of PCC (see Note 4)	$ 6,440	$ -

See accompanying notes to the consolidated financial statements.

1. Organization

Prospect Medical Holdings, Inc. ("Prospect" or the "Company" or the "Parent Entity") is a Delaware corporation and a wholly owned indirect subsidiary of Ivy Holdings Inc. ("Ivy Holdings").

During the year ended September 30, 2013, the Company incorporated Prospect Health Plan, Inc. ("PHP"), a Delaware corporation and a wholly owned indirect subsidiary of Prospect. On November 4, 2014, the California Department of Managed Health Care ("DMHC") approved PHP's application and issued its license to operate as a Knox-Keene Health Care Service Plan for the purpose of managing "plan-to-plan" contracts with fully licensed Medicare Advantage ("MA") health plans. As part of the strategic effort to expand the Company's plan-to-plan global capitation structure into other geographic markets, Prospect Health Services, Inc. ("PHS") and Prospect Health Services RI, Inc. ("PHSRI") were incorporated during the year ended September 30, 2014, in Texas and Rhode Island, respectively. Collectively, PHP, PHS, and PHSRI will become a new segment in Prospect's operations. For the year ended September 30, 2014, PHP, PHS, and PHSRI did not have any operations.

The Company's operations are currently organized into three primary reportable segments: Hospital Services, Medical Group and Corporate, as discussed below.

Hospital Services Segment

The Company owns 13 acute care and behavioral hospitals and extended care facilities in Southern California, the Greater San Antonio, Texas region, and Rhode Island with a total of 2,258 licensed beds, and a network of specialty and primary care clinics, through its subsidiaries, Southern California Healthcare System, Inc. ("SCHS"), Alta Los Angeles Hospitals, Inc. ("Alta Los Angeles Hospitals"), Alta Newport Hospital, Inc., Prospect Hospital Holdings, LLC ("Nix Health"), and Prospect CharterCARE, LLC ("PCC") (collectively, the "Hospital Services segment"). The Hospital Services segment subsidiaries are wholly owned by Prospect, except for PCC, in which Prospect has an 85% interest (see Note 4).

Effective January 1, 2013, the Company merged its Brotman Medical Center subsidiary into its Alta Hollywood Hospitals, Inc. subsidiary. The surviving entity was renamed Southern California Healthcare System, Inc. on June 26, 2013. In connection with the merger, the Company changed the names of the hospitals owned by SCHS to Southern California Hospital at Hollywood ("SCH Hollywood") fka Hollywood Community Hospital, Southern California Hospital at Van Nuys ("SCH Van Nuys") fka Van Nuys Community Hospital, and Southern California Hospital at Culver City ("SCH Culver City") fka Brotman Medical Center.

Effective April 16, 2013, Nix Health acquired Community General Hospital of Dilley, Texas, Inc., through its newly created subsidiary, Nix Community General Hospital, LLC ("Nix CGH"). Nix CGH operates a hospital with 18 licensed beds in the city of Dilley, Texas.

Effective May 6, 2014, Prospect acquired substantially all of the assets and associated real estate of Newport Specialty Hospital ("NSH") through Prospect's newly created subsidiary, Alta Newport Hospital, Inc., and Bellflower Medical Center (subsequently renamed Los Angeles Community Hospital at Bellflower or "LACH Bellflower") through Prospect's subsidiary Alta Los Angeles Hospitals, Inc. NSH, located in Tustin, California, was substantially closed in 2013 except for its pediatric sub-acute unit. LACH Bellflower, located in Bellflower, California, was closed in 2013 and has been non-operational since that time. Prospect intends to fully reopen both facilities, including maintaining the NSH pediatric sub-acute unit.

Effective June 20, 2014, Prospect acquired, through its subsidiary, PCC, substantially all of the assets of CharterCARE Health Partners and its subsidiaries. PCC's operating subsidiaries include Prospect CharterCARE RWMC, LLC ("Roger Williams Medical Center"), Prospect CharterCARE SJHSRI, LLC ("St. Joseph Health Services of Rhode Island"), and Prospect CharterCARE Elmhurst, LLC ("Elmhurst Extended Care"), which include hospitals, medical centers and assisted living facilities located in Rhode Island with 785 licensed beds (collectively, "CharterCARE"). PCC is 85% owned by Prospect and 15% by CharterCARE Community Board (formerly known as CharterCARE Health Partners).

The Company's three community hospitals in Hollywood, Los Angeles and Norwalk offer a comprehensive range of medical and surgical services, including general acute care hospital services, pediatrics, obstetrics and gynecology, pediatric sub-acute care, general surgery, medical-surgical services, orthopedic surgery, and diagnostic, outpatient, skilled nursing and urgent care services. The Company's psychiatric hospital in Van Nuys provides acute inpatient and outpatient psychiatric services on a voluntary basis. SCH Culver City offers a comprehensive range of inpatient and outpatient services, including general surgery, orthopedic, spine, cardiology, diagnostic outpatient, rehabilitation, psychiatric and detox services. In addition, SCH Culver City has an active emergency room that plays an integral part in providing emergency services to the West Los Angeles area.

Nix Health provides comprehensive service offerings at various locations throughout the greater San Antonio, Texas region. These locations include Nix Medical Center, which provides inpatient acute care, geriatric psychiatry services, and emergency room services, Nix Specialty Health Center, which provides a full range of behavioral health and rehabilitation services for children, adolescents, and adults, and a range of health clinics and provider based clinics throughout San Antonio, Texas, and Nix CGH, which operates an inpatient acute hospital in Dilley, Texas and a medical clinic in Pearsall, Texas. Nix Health also opened a 73-bed behavioral health center during the year ended September 30, 2014, which provides psychiatric emergency services and crisis intervention unit.

CharterCARE provides a comprehensive range of services at both Roger Williams Medical Center and St. Joseph's Health Services Rhode Island as well as multiple levels of elder care at Elmhurst Extended Care.

Admitting physicians are primarily practitioners in the local area. The hospitals have payment arrangements with Medicare, Medicaid (Medi-Cal in California) and other third party payers, including commercial insurance carriers, health maintenance organizations ("HMOs") and preferred provider organizations ("PPOs").

Medical Group Segment

The Medical Group segment is a healthcare management services organization that provides management services to affiliated physician organizations that operate as independent physician associations ("Medical Groups" or "IPAs"). The affiliated physician organizations enter into agreements with HMOs to provide HMO enrollees with a full range of medical services in exchange for fixed, prepaid monthly fees known as "capitation" payments. The Medical Groups contract with physicians (primary care and specialist) and other healthcare providers to provide enrollees with all medical services. Prospect currently manages the provision of prepaid healthcare services for its affiliated physician organizations in Southern California. The network consists of the following physician organizations as of September 30, 2014 (stand alone or individually referred to as, an "Affiliate"):

Prospect Medical Group, Inc. ("PMG")
Prospect Health Source Medical Group, Inc. ("PHS")

Prospect Medical Holdings, Inc.

Notes to Consolidated Financial Statements

Prospect Professional Care Medical Group, Inc. ("PPCM")
Genesis HealthCare of Southern California, Inc. ("Genesis")
Prospect NWOC Medical Group, Inc. ("PNW")
StarCare Medical Group, Inc. ("PSC")
AMVI/Prospect Medical Group ("AMVI/Prospect")
Nuestra Familia Medical Group, Inc. ("Nuestra")
Upland Medical Group, a Professional Medical Group ("UMG")*
Pomona Valley Medical Group, Inc. ("PVMG")*

* PVMG and UMG are collectively referred to as the "ProMed Entities."

These Affiliates are managed by the following two medical management company subsidiaries that are wholly-owned by Prospect:

Prospect Medical Systems, Inc. ("PMS")
ProMed Healthcare Administrators ("PHCA")

All of the Affiliates are wholly-owned by PMG, with the exception of Nuestra, which was 66.95% owned by PMG as of September 30, 2014, and AMVI/Prospect which is a 50/50 Joint Venture between AMVI Care Health Network, Inc. ("AMVI") and PMG. The operations of all of these entities, with the exception of AMVI/Prospect, are consolidated in the accompanying consolidated financial statements. PMG is owned by a nominee physician shareholder pursuant to an assignable option agreement described below.

PMG's ownership in Nuestra increased from 62% as of September 30, 2013 to 66.95% as of September 30, 2014. On October 7, 2013, Nuestra repurchased 109 shares from a physician shareholder that left Nuestra's group medical practice for a de minimis purchase price in accordance with Nuestra's Agreement Concerning Shares of the Company dated September 19, 1995. The repurchase increased the share percentage holdings of all remaining shareholders and Prospect's percentage rose to 66.95% as of October 7, 2013.

The AMVI Joint Venture was formed for the sole purpose of combining enrollment in order to meet minimum enrollment levels required for participation in the CalOptima Medicaid (Medi-Cal in California) program in Orange County, California. The joint venture ownership is set at 50/50 to prevent either party from exerting control over the other; however, AMVI's and PMG's businesses are operated autonomously, and enrollees, financial results and cash flows are each separately tracked and recorded. In accordance with the joint venture partnership agreement, profits and losses are not split in accordance with the partnership ownership interest, but rather, are directly tied to the results generated by each separate portion of the business. Separate from any earnings the Company generates from PMG's portion of business within the joint venture, the Company also earns fees for management services PMS provides to PMG's partner in the joint venture. The Company accounts for PMG's interest in the joint venture partnership using the equity method of accounting. The Company includes in the consolidated financial statements only the net results attributable to those enrollees specifically identified as assigned to the Company, together with the management fee that PMS charges for managing those enrollees specifically assigned to the other joint venture partner.

PMS has entered into an assignable option agreement with PMG and the nominee physician shareholder of PMG. Under the assignable option agreement, Prospect has an assignable option, obtained for a nominal amount from PMG and the nominee shareholder to designate the purchaser (successor physician) for all or part of PMG's issued and outstanding stock held by the nominee physician shareholder (the "Stock Option") in its sole discretion. The Company may also assign the assignable option agreement to any person. The assignable option agreement has an initial term of 30 years and is

automatically extended for additional terms of 10 years each, as long as the term of the related management services agreement described below (the "Management Agreement") is automatically extended. Upon termination of the Management Agreement with PMG, the related Stock Option would be automatically and immediately exercised. The Stock Option may be exercised for a purchase price of $1,000. Under these nominee shareholder agreements, Prospect has the unilateral right to establish or effect a change of the nominee, at will, and without the consent of the nominee, on an unlimited basis and at nominal cost throughout the term of the Management Agreement. In addition to the Management Agreement with PMG, Prospect, through one of its management company subsidiaries, has a management agreement with each Affiliate. The term of the Management Agreements is generally 30 years. PMG is the sole shareholder of PHS, PPCM, Genesis, PNW, PSC, UMG, and PVMG.

The Company's Affiliates have entered into Management Agreements with PMS or PHCA, as applicable (each of which is a wholly-owned subsidiary of Prospect). Each Affiliate has agreed to pay a management fee to PMS or PHCA, as applicable. The fee is based in part on the costs to the management company and on a percentage of revenues the Affiliate receives (i) for the performance of medical services by the Affiliate's employees and independent contractor physicians and physician extenders, and (ii) for all other services performed by the Affiliates. The revenue from which this fee is determined includes medical capitation, all sums earned from participation in any risk pools and all fee-for-service revenue earned. The management fee also includes a fixed amount for marketing and public relations services. Except in the case of Nuestra and AMVI/Prospect, the Management Agreements had initial terms of 30 years, renewable for successive 10-year periods thereafter, unless terminated by either party for cause. Effective September 1, 2013, the Managements Agreements for the ProMed Entities were consolidated under one new Management Agreement with PHCA. Effective October, 1, 2013, the Management Agreements for the rest of the Affiliates, other than Nuestra and AMVI/Prospect, were consolidated under one new Management Agreement with PMS. Those two new Management Agreements with PHCA and PMS include initial five year terms and are renewable for successive five year periods thereafter. In the case of Nuestra, its Management Agreement had an initial 10 year term renewable for successive one year terms, subsequently amended in January 15, 2009 to an initial 20 year term renewable for two 10 year periods. In the case of AMVI/Prospect, the Management Agreement has a one year term with successive one year renewal terms. In return for payment of the management fee, Prospect (through PMS and PHCA) has agreed to provide financial management, information systems, marketing, advertising, public relations, risk management, and administrative support, including for utilization review and quality of care. At its cost, Prospect has assumed the obligations for all facilities, medical and non-medical supplies, and employment of non-physician personnel of its affiliated medical clinics.

The management fee earned by Prospect fluctuates based on the profitability of each wholly-owned Affiliate. Prospect is allocated a 50% residual interest in any profits after the first 8% of the profits. The remaining balance is retained by the Affiliates.

The Management Agreements are not terminable by the Affiliates except in the case of gross negligence, fraud or other illegal acts of Prospect, or bankruptcy of the Company.

Further, Prospect's rights under the Management Agreements are unilaterally saleable or transferable. Based on the provisions of the Management Agreements and the assignable option agreement with PMG, Prospect has determined that it has a controlling financial interest in the Affiliates, with the exception of AMVI/Prospect. Consequently, under applicable accounting principles, Prospect consolidates the revenues and expenses of all the Affiliates except AMVI/Prospect from the respective dates of execution of the Management Agreements. All significant inter-entity balances have been eliminated in consolidation. In the case of AMVI/Prospect, only that portion of the results which are contractually

identified as Prospect's are recognized in the consolidated financial statements, together with the management fee that the Company charges AMVI for managing AMVI's share of the joint venture operations.

Prospect has also entered into management agreements with unaffiliated third parties to manage services to their HMO enrollees. These management agreements do not have characteristics that give rise to the consolidation of the entities under current accounting literature.

The affiliated physician organizations provided medical services to a combined total of approximately 264,600 and 186,100 HMO enrollees as of September 30, 2014 and 2013, respectively. The enrollees include approximately 87,000 and 34,400 enrollees that the Company manages for the economic benefit of six independent third parties, and for which the Company earns management fee income as of September 30, 2014 and 2013, respectively. The total paid member months including managed enrollees, for the fiscal years ended September 30, 2014 and 2013 was 2,785,000 and 2,193,000, respectively.

Effective October 1, 2012, the Company, through its newly created affiliate, New Genesis Medical Associates, Inc. ("NGMA"), dba Genesis Medical Clinic, acquired substantially all of the assets of a physician medical practice located in Orange County, California. NGMA is controlled through a nominee shareholder arrangement like the Stock Option structure utilized for PMG and discussed above.

On December 19, 2013, the Company, through its subsidiary NGMA, purchased stock of Chaparral Medical Group, Inc. ("CMG"), a California medical corporation. Consideration was composed of $1,100,000 in cash at the closing, $700,000 in future cash consideration to be used for the acquired company's general corporate purposes, and 3,750 shares of Ivy Holdings common stock issued at closing to the selling shareholders. After payment of the entire consideration, including the future cash consideration, Prospect will own 17.29% of the stock of CMG. Pursuant to the terms of the stock purchase agreement, Prospect will have the right and option to make additional stock investments at the same share valuations and prices and upon the same applicable terms and conditions as the initially acquired shares, to bring its aggregate ownership up to 50%. CMG is a 60 physician multi-specialty group serving communities primarily in the Los Angeles and San Bernardino counties. The Company accounts for NGMA's interest in CMG using the equity method as the Company has the ability to exercise significant influence over the operating and financial policies of CMG.

Corporate Segment

The Corporate segment reflects certain expenses incurred at the Parent Entity not specifically allocable to the Hospital Services or Medical Group segments. These include, but are not limited to: salaries, benefits and other compensation for corporate employees; financing expenses; insurance expenses; rent; legal fees; and accounting fees. The Company does not allocate interest expense related to acquisition debt or income taxes to the other reporting segments.

2. Significant Accounting Policies

Basis of Presentation

The consolidated financial statements have been prepared in accordance with accounting principles generally accepted in the United States of America ("GAAP") and include the accounts of all controlled subsidiaries, which control is effectuated through ownership of voting common stock or by other means, but do not include the accounts of the parent companies, Ivy Holdings and Ivy Intermediate Holding Inc.

The Medical Group entities (subsidiaries) have been determined to be variable interest entities due to the existence of a call option under which the Company has the ability to require the holders of all of the voting common stock of the underlying subsidiaries to sell their shares at a fixed nominal price ($1,000) to another designated physician chosen by the Company. This call option agreement represents rights provided through a variable interest other than the equity interest itself that caps the returns that could be earned by the equity holders. In addition, the Company has a management agreement with the subsidiaries and the holders of the voting common stock of the subsidiaries which allows the Company to direct all of the activities of the subsidiaries, retain all of the economic benefits and assume all of the risks associated with ownership of the subsidiaries. In this manner, the Company has all of the economic benefits and risks associated with the subsidiaries but has disproportionately few voting rights (based on the terms of the equity). As the Company retains all of the economic benefits and assumes all of the risks associated with ownership of the subsidiaries, the Company is considered to be the primary beneficiary of the activities of the subsidiaries and therefore must consolidate the underlying subsidiaries.

Operating results for NGMA, Nix CGH, CMG, NSH and LACH Bellflower, and PCC are consolidated with the Company's financial statements from their acquisition dates or inception date in the case of LACH Bellflower (October 1, 2012, April 16, 2013, December 19, 2013, May 6, 2014, and June 20, 2014 respectively) (see Note 4). All significant intercompany balances and transactions have been eliminated in consolidation.

Reclassifications

Certain reclassifications were made to the 2013 consolidated financial statements in order to conform to the 2014 presentation.

Revenues

Revenues by reportable segment are comprised of the following amounts (in thousands):

For the Years Ended September 30,	2014 *(a)*	2013 *(b)*
Net Hospital Services		
Inpatient	$ 440,961	$ 403,183
Outpatient	96,802	63,382
Capitation	70,077	44,923
Other	11,116	6,718
Total Hospital Services revenues	618,956	518,206
Less: Provision for bad debts	(32,945)	(34,067)
Total net Hospital Services revenues less provision for bad debts	586,011	484,139
Medical Group		
Capitation	244,573	215,971
Management fees	6,586	2,352
Other	2,821	3,420
Total Medical Group revenues	253,980	221,743
Other revenues	14,525	7,700
Total net revenues	$ 854,516	$ 713,582

(a) CMG, NSH, and PCC revenues have been included in the accompanying consolidated financial statements for the period from acquisition, December 19, 2013, May 6, 2014, and June 20, 2014, respectively, through September 30, 2014.

(b) NGMA and Nix CGH revenues have been included in the accompanying consolidated financial statements for the period from acquisition, October 1, 2012 and April 16, 2013, respectively, through September 30, 2013.

Hospital Services Segment

Net Patient Service Revenues

Operating revenue of the Hospital Services segment consists primarily of net patient service revenue. The Company reports net patient service revenue at the estimated net realizable amounts from patients and third-party payers and others in the period in which services are rendered. The Company has agreements with third-party payers, including Medicare, Medicaid (Medi-Cal in California), managed care and other insurance programs that are paid at negotiated rates. These payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges and per diem payments, as further described below. Estimates of contractual allowances are based upon the payment terms specified in the related contractual agreements. The Company accrues for amounts that it believes may ultimately be due to or from the third-party payers. Normal estimation differences between final settlements and amounts accrued in previous years are reported as changes in estimates in the current year. Outstanding receivables, net of allowances for contractual discounts and bad debts, are included in patient accounts receivable in the accompanying consolidated balance sheets.

The following is a summary of sources of patient service revenues (net of contractual allowances and discounts) before provision for bad debts:

September 30,	2014	2013
Medicare	$ 224,984	$ 211,482
Medicaid	189,668	158,048
Managed Care	95,853	77,390
Self Pay/Other	27,258	19,645
Capitation	70,077	44,923
Other	11,116	6,718
Total	$ 618,956	$ 518,206

A summary of the payment arrangements with major third-party payers follows:

Medicare: Medicare is a federal program that provides certain hospital and medical insurance benefits to persons aged 65 and over, some disabled persons with end-stage renal disease and certain other beneficiary categories. Inpatient services rendered to Medicare program beneficiaries are paid at prospectively determined rates per discharge, according to a patient classification system based on clinical, diagnostic, and other factors. Outpatient services are paid based on a blend of prospectively determined rates and cost-reimbursed methodologies. The Company is also reimbursed for various disproportionate share and Medicare bad debt components at tentative rates, with final settlement determined after submission of the annual Medicare cost report and audit thereof by the Medicare fiscal intermediary. Normal estimation differences between filed settlements and amounts accrued are reflected in net patient service revenue.

Cost report settlement estimates are recorded based upon as-filed cost reports and are usually not adjusted until a final Notice of Program Reimbursement ("NPR") is issued. The latest updated SSI ratios for 2012 were issued on June 12, 2014. To date, the Company has received final NPRs for Brotman Medical Center, Inc. through 2011 for cost report years prior to its merger into the Alta Hollywood Hospitals, Inc. subsidiary, SCH Hollywood through 2010, Alta Los Angeles Hospitals through 2010, and Nix Health through 2011. Additionally, the Company joined a second round of litigation relating to Medicare's recent settlement with providers relating to the manner in which the Centers for Medicare and Medicaid Services ("CMS") handled the budget neutrality adjustment associated with the rural floor wage index in setting the Medicare inpatient prospective system rates ("Rural Floor"). The Company entered into a settlement agreement with CMS and, as a result, Alta Los Angeles Hospitals, SCH Culver City, and CharterCARE recognized a net benefit of $2,495,000, $1,230,000, and $1,672,000, respectively, during the year ended September 30, 2014 related to the Rural Floor litigation.

Medicaid: Medicaid is a joint federal-state funded healthcare benefit program that is administered by states to provide benefits to qualifying individuals who are unable to afford care. The Company receives reimbursements under the Medicaid program at prospectively determined rates for both inpatient and outpatient services. Medi-Cal is the version of the federal Medicaid program that is applicable to California residents. Inpatient services rendered to Medi-Cal fee-for-service program beneficiaries in California are in the process of a three-year transition to payment at prospectively determined rates based on diagnosis related groups from a contracted per diem rate. Outpatient services are paid based on prospectively determined rates per procedure provided. Inpatient and outpatient services rendered to Medi-Cal managed care beneficiaries in California are paid at either contracted rates or at the Medi-Cal fee-for-service rates. The SCHS and Alta Los Angeles Hospitals are eligible to participate in the State of California Medi-Cal Disproportionate Share ("DSH") programs, under which medical facilities that serve a disproportionate number of low-income patients receive additional reimbursements. Eligibility is determined annually based on prescribed guidelines. Prior to the merger of SCH Culver City with the SCH Hollywood and SCH Van Nuys Hospitals, SCH Culver City did not participate in the program. The Company accrues revenue based on the expected total annual DSH awards. Differences between the estimated and the actual awards are recorded in the period they become known. DSH amounts are subject to retrospective revision prior to finalization and such revisions could lead to material retractions. The Company records retrospective retractions when they are estimable and probable. Retrospective additional DSH revenues are recorded when the amounts are received. The Medi-Cal DSH receivable as of September 30, 2014 and 2013 totaled approximately $9,094,000 and $5,437,000, respectively, and were included in due from government program payers in the accompanying consolidated balance sheets. For fiscal years ended September 30, 2014 and 2013, total Medi-Cal DSH payments received by the SCHS and Alta Los Angeles Hospitals were approximately $16,325,000 and $11,618,000, respectively, and total Medi-Cal DSH revenues recorded were approximately $20,475,000 and $11,218,000, respectively. Additionally, pursuant to an audit of Medi-Cal cost reports and notification sent to the Company, the Company accrued a cost report liability payable to Medi-Cal of $1,803,000 and $1,316,000 as of September 30, 2014 and 2013, respectively.

During the fourth quarter of fiscal 2011, the Company's SCHS and Alta Los Angeles Hospitals received notification that the DSH amounts received related to the State fiscal year 2009-2010 were being re-examined and that the DSH amounts to be received for State fiscal years 2010-2011 would be significantly reduced. The notification was the result of legislation that extended payments under Senate Bill 90 ("SB 90"). During the year ended September 30, 2013, the Company recorded a reduction of $2,146,000 in Medi-Cal DSH revenue related to this matter. The matter had no impact on Medi-Cal DSH revenue during the year ended September 30, 2014.

Certain of the Company's California hospitals also participate in *the California Hospital Fee Program* (see Note 10).

In Texas, the Medicaid program reimburses under prospectively determined rates for both inpatient and outpatient services. Medicaid reimbursement may be subject to periodic adjustment, as well as to changes in existing payment levels and rates, based on the amount of funding available to the Medicaid program. Nix Health has also been receiving payments from the Texas Health and Human Services Commission under the Section 1115 Waiver ("the waiver") that was recently granted to the state of Texas by CMS. Under the first year of the waiver ending September 30, 2012, a transition payment was paid to Nix Health based upon prior levels of payment under the "Upper Payment Limit" ("UPL") program, which the waiver replaced. Payments for years two through five under the waiver are based upon two pools. One pool is for payments for uncompensated care ("UCC") which includes the shortfall in Medicaid reimbursement as compared to cost and the cost of providing services to uninsured patients. The other pool is the Delivery System Reform Initiative Payments ("DSRIP"), where approved programs and services are undertaken to improve access and services provided. Programs are established by regions and approved by the Texas Health and Human Services Commission and CMS. These programs are assigned a value and milestones are established to measure success and the timing and level of payment from the DSRIP funds. Nix Health recorded revenue related to the UCC pool of $12,366,000 and $12,804,000 for the years ended September 30, 2014 and 2013, respectively. Revenue recorded related to the DSRIP pool was $9,801,000 and $7,078,000 for the years ended September 30, 2014 and 2013, respectively. At September 30, 2014 and 2013, amounts receivable under the Section 1115 Waiver totaled $23,145,000 and $14,781,000, respectively.

Nix Health also recorded $5,746,000 and $9,477,000 during the years ended September 30, 2014 and 2013, respectively, in costs for rural community provision of services. At September 30, 2014 and 2013, amounts payable related to such costs amounted to $0 and $4,754,000, respectively.

The CharterCARE hospitals are participants in the State of Rhode Island's DSH program, which was established in 1995 to assist hospitals that provide a disproportionate amount of uncompensated care. Under the program, Rhode Island hospitals, including the CharterCARE hospitals, receive federal and state Medicaid funds as additional reimbursement for treating a disproportionate share of low income patients. Total DSH payments received and revenues recorded by the CharterCARE hospitals were $3,524,000 from June 20, 2014 (acquisition date) through September 30, 2014. The State of Rhode Island also assesses a license fee to all hospitals in Rhode Island based on each hospital's net patient revenue. The CharterCARE hospitals recorded $4,036,000 of expense from June 20, 2014 through September 30, 2014 as a result of the license fee.

Managed Care: The Company has also entered into payment agreements with certain commercial insurance carriers, HMOs, and PPOs. The basis for payment under these agreements is in accordance with negotiated contracted rates or at the Company's standard charges for services provided. Some of these payments are capitated, meaning that the Company receives an agreed amount per patient for providing an agreed range of services.

Self-Pay: Self-pay patients represent those patients who do not have health insurance and are not covered by some other form of third party arrangement. Such patients are evaluated, at the time of services or shortly thereafter, for their ability to pay based upon federal and state poverty guidelines, qualifications for Medicaid, as well as the Company's local hospital's indigent and charity care policy.

See "Concentrations of Credit Risks" below for discussion of revenues received from the Medicare and Medicaid programs.

The Company accrued $895,000 of liabilities as of September 30, 2013 for ongoing Recovery Audit Contractor ("RAC") audits and other similar programs. Effective August 29, 2014, CMS provided a simplified process and timely partial payment to settle certain previously denied claims with dates of service prior to October 1, 2013 whereby such claims under appeal that had been retracted by CMS were settled with the provider receiving 68% of the face value. As a result, the Company recorded $3,887,000 in revenue during the year ended September 30, 2014 related to claims which were previously subject to ongoing RAC audits and other similar programs.

SCH Culver City Outlier Liability

Following the acquisition of a majority stake in SCH Culver City, effective April 14, 2009, the Company consolidated SCH Culver City's estimated liability to CMS arising out of outlier payments received for services provided by the hospital to Medicare eligible inpatients, primarily for the last four months of calendar year 2005 and all of calendar year 2006.

While SCH Culver City reports financial statements on a fiscal year ending September 30, Medicare cost reports are filed on a calendar year basis. Acute care hospitals receive Medicare reimbursement payments pursuant to a prospective payment methodology primarily based on the diagnosis of the patient, but are entitled to receive additional payments, referred to as "outliers" for patients whose treatment is very costly. When Brotman Medical Center, Inc. acquired the hospital in 2005, CMS provided a ratio of cost to charges (the "RCC") based on the statewide average. Payments received by SCH Culver City on this basis were an interim estimate, subject to final determination upon auditing of SCH Culver City's cost reports. SCH Culver City filed its Medicare cost reports, but determined that its outlier reimbursement for services provided in fiscal years 2005, 2006 and part of 2007 might be subject to adjustment based on certain outlier reconciliation rules. On October 12, 2012, SCH Culver City received from its Medicare fiscal intermediary a proposed outlier adjustment for Medicare fiscal year 2006 in the amount of $12,785,000. SCH Culver City had previously been notified of an adjustment of $2,149,000 for 2005. As of September 30, 2014 and 2013, the Company has accrued $13,834,000 of the estimated $14,934,000 liability to CMS included in the accompanying consolidated balance sheets. The difference between the $14,934,000 asserted by CMS and the $13,834,000 accrued by the Company relates to accrued interest of approximately $1,100,000. The Company does not agree, however, with the outlier reconciliation liability. Accordingly, in accordance with relevant literature related to accounting for contingencies, the Company has recorded to the lower end of the range. In March 2013, the Company received a notice of program reimbursement for the 2006 cost report year which approximated the October 2012 adjustment. The Medicare fiscal intermediary has placed the recoupment on hold while the Company is currently in discussions with CMS to resolve this issue. The ultimate resolution of this item is unknown at this stage. The Company has also filed an appeal of the outlier issue with the Provider Reimbursement Review Board for the 2006 cost reporting period since it received a notice of program reimbursement for the 2006 cost report. The ultimate resolution of this appeal is unknown at this stage.

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Prospect Medical Holdings, Inc.

Notes to Consolidated Financial Statements

The following is a summary of due from and due to governmental payers at September 30 (in thousands):

September 30,	2014	2013
Due from government payers:		
Medi-Cal Disproportionate Share (DSH)	$ 9,094	$ 5,437
Medicare cost report settlements	10,279	7,191
Medicaid Section 1115 receivable	23,145	14,780
	$ 42,518	$ 27,408
Due to government payers:		
Outlier liability	$ 13,834	$ 13,834
Medicare cost report settlements	10,947	4,484
Medi-Cal cost report settlements	1,803	1,316
	$ 26,584	$ 19,634

The Company is not aware of any material claims, disputes, or unsettled matters with any payers that would affect revenues that have not been adequately provided for and disclosed in the accompanying consolidated financial statements.

Charity Care

The Company provides charity care to patients whose income level is below 300% of the Federal Poverty Level. Patients with income levels between 300% and 350% of the Federal Poverty Level qualify to pay a discounted rate under the requirements of California State Assembly Bill 774 (AB 774) based on various government program reimbursement levels. Patients without insurance are offered assistance in applying for Medicaid and other programs they may be eligible for, such as state disability. Patient advocates from the Company's Medical Eligibility Program ("MEP") screen patients in the Hospital and determine potential linkage to financial assistance programs. They also expedite the process of applying for these government programs. The approximate cost of providing charity care was $2,029,000 and $1,003,000 for the years ended September 30, 2014 and 2013, respectively. The Company has estimated the cost of charity care based on a ratio of the cost to charges of operating expenses, excluding depreciation, interest and management fees.

Provisions for Contractual Allowances and Bad Debts

Collection of receivables from third-party payers and patients is the Company's primary source of cash and is critical to its operating performance. The Company closely monitors its historical collection rates, as well as changes in applicable laws, rules and regulations and contract terms, to assure that provisions for contractual allowances are made using the most accurate information available. However, due to the complexities involved in these estimations, actual payments from payers may be materially different from the amounts management estimates and records. The Company's primary collection risks relate to uninsured patients and the portion of the bill which is the patient's responsibility, primarily co-payments and deductibles. Payments for services may also be denied due to issues over patient eligibility for medical coverage, the Company's ability to demonstrate medical necessity for services rendered and payer authorization of hospitalization.

Accounts receivable are reduced by an allowance for doubtful accounts. Valuation of the collectability of accounts receivable and provision for bad debts is based on historical collection experience, payer mix and the age of the receivables. Management routinely reviews accounts receivable balances in conjunction with these factors and other economic conditions which might ultimately affect the collectability of the patient accounts, and makes adjustments to the Company's allowances as warranted. For receivables associated with services provided to patients who have third-party coverage, management analyzes contractually due amounts and subsequently calculates an allowance for doubtful accounts and provision for bad debts once the age of the accounts reaches a specific age category based on historical experience. For receivables associated with self-pay patients, management records a significant provision for bad debts beginning in the period services were provided based on past experience that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The allowance for doubtful accounts as a percent of gross accounts receivable increased from 27% at September 30, 2013 to 29% at September 30, 2014. The allowance for doubtful accounts was $49,727,000 and $28,050,000 for the years ended September 30, 2014 and 2013, respectively. The increase in the allowance for doubtful accounts as a percent of gross accounts receivable and in the allowance for doubtful accounts was due primarily to CharterCARE, which was acquired during the year ended September 30, 2014 and had an allowance for doubtful accounts of $16,839,000 at September 30, 2014.

Legislation

All of the Company's hospital facilities are subject to the Emergency Medical Treatment and Active Labor Act ("EMTALA"). This federal law requires any hospital that participates in the Medicare program to conduct an appropriate medical screening examination of every person who presents to the hospital's emergency department for treatment and, if the patient is suffering from an emergency medical condition, to either stabilize that condition or make an appropriate transfer of the patient to a facility that can handle the condition. The obligation to screen and stabilize emergency medical conditions exists regardless of a patient's ability to pay for treatment. There are severe penalties under EMTALA if a hospital fails to screen or appropriately stabilize or transfer a patient or if the hospital delays appropriate treatment in order to first inquire about the patient's ability to pay. Penalties for violations of EMTALA include civil monetary penalties and exclusion from participation in the Medicare program. In addition, an injured patient, the patient's family or a medical facility that suffers a financial loss as a direct result of another hospital's violation of the law can bring a civil suit against that other hospital. The Company believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing that would have a material effect on the Company's financial statements.

See Note 10 regarding the *Affordable Care Act*.

Other Revenues

Other revenues consist primarily of the CMS Rural Floor settlement, meaningful use incentive payments and rental revenue from operating leases, and totaled $14,525,000 and $7,700,000 for the years ended September 30, 2014 and 2013, respectively.

A summary of other revenues recorded during the years follows:

Rural Floor settlement: The Company entered into a settlement agreement with CMS and recognized $6,091,000 of revenue during the year ended September 30, 2014 related to the Rural Floor litigation.

Meaningful Use incentives: The American Recovery and Reinvestment Act of 2009 ("ARRA") established incentive payments under the Medicare and Medicaid programs for certain professionals and hospitals that meaningfully use certified electronic health record ("EHR") technology or adopt or implement such technology. The Medicare incentive payments will be paid out to qualifying hospitals over four consecutive years on a transitional schedule. To qualify for Medicare incentives, hospitals and physicians must meet EHR "meaningful use" criteria that become more stringent over three stages.

Medicaid programs and payment schedules vary from state to state. The Medicaid programs require hospitals to register for the program prior to 2016, to engage in efforts to adopt, implement or upgrade certified EHR technology in order to qualify for the initial year of participation, and to demonstrate meaningful use of certified EHR technology in order to qualify for payment for up to three additional years.

For the years ended September 30, 2014 and 2013, the Company recorded revenues of $5,389,000 and $5,872,000, respectively, related to the Medicare and Medicaid programs in the consolidated statements of income. These incentives have been recognized following the grant accounting model, recognizing income ratably over the applicable reporting period as management becomes reasonably assured of meeting the required criteria. Subsequent changes to these estimates will be recognized in the consolidated statement of operations in the period in which additional information is available. Such estimates are subject to audit by the federal government, the state, or its designee.

Rental Revenue: Rental revenue from operating leases is recorded based on the fixed, minimum required rents (base rents) per the lease agreements. Rental revenue from base rents is recorded on the straight-line method over the terms of the related lease agreements. During the years ended September 30, 2014 and 2013, the Company recorded rental revenues of $2,220,000 and $1,600,000, respectively.

Medical Group Segment

Medical Group Revenues

Operating revenue of the Medical Group segment consists primarily of payments for medical services procured by the Affiliates under capitated contracts with various managed care providers including HMOs. Capitation revenue under HMO contracts is prepaid monthly to the Affiliates based on the number of enrollees electing any one of the Affiliates as their health care provider. See "Concentrations of Credit Risks" below for revenues received from the five largest contracted HMOs.

Capitation revenue (net of capitation withheld to fund risk share deficits discussed below) is recognized in the month in which the Affiliates are obligated to provide services. Minor ongoing adjustments to prior months' capitation, primarily arising from contracted HMOs' finalizing of monthly patient eligibility data for additions or subtractions of enrollees, are recognized in the month they are communicated to the Company. Additionally, Medicare pays capitation using a "Risk Adjustment model," which compensates managed care organizations and providers based on the health status (acuity) of each individual enrollee. Health plans and providers with higher acuity enrollees will receive more and those with healthier enrollees will receive less. Under Risk Adjustment, capitation is determined based on health severity, measured using patient encounter data. Capitation is paid on an interim basis based on data submitted for the enrollee for the preceding year and is adjusted in subsequent periods (generally in the Company's fourth quarter) after the final data is compiled. Positive or negative capitation adjustments are made for Medicare enrollees with conditions requiring more or less healthcare services than assumed in the interim payments. Since the Company cannot reliably predict these adjustments,

periodic changes in capitation amounts earned as a result of Risk Adjustment are recognized generally in the fourth quarter when those changes are communicated by the health plans to the Company. The Company received and recorded as additional revenue, approximately $8,889,000 and $6,145,000, respectively, in positive capitation risk adjustments during the years ended September 30, 2014 and 2013, respectively.

HMO contracts also include provisions to share in the risk for hospitalization, whereby the Affiliate can earn additional incentive revenue or incur penalties based upon the utilization of hospital services. Typically, any shared risk deficits are not payable until and unless the Company generates future risk sharing surpluses, or if the HMO withholds a portion of the capitation revenue to fund any risk share deficits. At the termination of the HMO contract, any accumulated risk share deficit is typically extinguished. Due to the lack of access to information necessary to estimate the related costs, shared-risk amounts receivable from the HMOs are only recorded when such amounts are known. Risk pools for the prior contract years are generally final settled in the third or fourth quarter of the following fiscal year. For the years ended September 30, 2014 and 2013, Medical Group revenues included approximately $2,406,000 and $2,880,000, respectively, of additional revenues due to favorable settlements on prior year risk-sharing arrangements. At September 30, 2014 and 2013, contingent liabilities for carry-forward risk-pool deficits expected to be forgiven, or offset against future surpluses were approximately $5,547,000 and $6,365,000, respectively, based on the available information from the health plans.

The Company also receives incentives under "pay-for-performance" programs for quality medical care based on various criteria. These incentives, which are included in other revenues within Medical Group revenues, are generally recorded in the third and fourth quarters of the fiscal year when such amounts are known. Pay-for-performance revenues recorded during the years ended September 30, 2014 and 2013, were $1,886,000 and $2,375,000, respectively.

Management fee revenue is earned in the month the services are rendered. Management fee arrangements with unaffiliated entities provide for compensation ranging from 6.5% to 12.5% of revenues. Management fee revenues recorded during the years ended September 30, 2014 and 2013, were $6,586,000 and $2,352,000, respectively.

Medical Group Cost of Revenues

The cost of health care services consists primarily of capitation and claims payments, pharmacy costs and incentive payments to contracted providers. These costs are recognized in the period incurred, or when the services are provided. Claims costs also include an estimate of the cost of services which have been incurred but not yet reported to the Company. The estimate for accrued medical costs is based on projections of costs using historical studies of claims paid and adjusted for seasonality, utilization and cost trends. These estimates are subject to trends in loss severity and frequency. Although considerable variability is inherent in such estimates, management records its best estimate of the amount of medical claims incurred at each reporting period. Estimates are continually monitored and reviewed and, as settlements are made or estimates adjusted, differences are reflected in current operations. See Note 12 for changes in claims estimates during the years ended September 30, 2014 and 2013.

In addition to contractual reimbursements to providers, the Company also makes discretionary incentive payments to physicians, which are in large part based on the pay-for-performance and shared risk revenues and favorable senior capitation risk adjustment payments received by the Company. Since the Company records these revenues generally in the third or fourth quarter of each fiscal year when the incentives and capitation adjustments due from the health plans are known, the Company also finalizes

the discretionary physician bonuses in the same periods. During the years ended September 30, 2014 and 2013, the Company recorded discretionary physician incentives expense totaling approximately $5,067,000 and $3,993,000, respectively. As of September 30, 2014 and 2013, physician bonus accruals of approximately $4,339,000 and $2,623,000, respectively, were included in accounts payable and other accrued liabilities.

The Company also periodically evaluates the need to establish premium deficiency reserves for the probability that anticipated future health care costs could exceed future capitation payments from HMOs under capitated contracts and, where appropriate, records a premium deficiency reserve.

The Company, for certain matters, maintains stop loss coverage for health care costs that are in excess of set thresholds.

Property, Improvements and Equipment

Property, improvements and equipment are stated on the basis of cost or, in the case of acquisitions, at their acquisition date fair values. Depreciation is provided using the straight-line method over the estimated useful lives of the assets, and amortization of leasehold improvements is provided using the straight-line basis over the shorter of the remaining lease period or the estimated useful lives of the leasehold improvements. Leasehold improvements are generally depreciated over five to ten years, buildings are depreciated over five to 28 years, equipment is depreciated over two to five years and furniture and fixtures are depreciated over two to seven years. Equipment capitalized under capital lease obligations are amortized over the lesser of the life of the lease or the useful life of the asset.

As more fully described in Note 10, the Company is required to comply with certain seismic standards as required by the state of California by January 1, 2020. The useful life of buildings subject to seismic retrofit requirements may be limited if the Company does not make the necessary upgrades by the required compliance date.

Goodwill and Other Intangible Assets

Goodwill totaled approximately $158,864,000 at both September 30, 2014 and 2013 and arose as a result of the ProMed, Alta, SCH Culver City, and Nix Health (including Nix CGH) acquisitions. Goodwill represents the excess of the consideration paid and liabilities assumed over the fair value of the net assets acquired, including identifiable intangible assets.

Goodwill is not amortized; rather it is reviewed annually for impairment for each reporting unit, or more frequently if impairment indicators arise. Impairment is the condition that exists when the carrying amount of goodwill exceeds its implied fair value. A two-step impairment test is used to identify potential goodwill impairment and to measure the amount of goodwill impairment loss to be recognized, if any. The Company has four reporting units with goodwill, consisting of the Alta Hospitals (which include SCH Hollywood, SCH Van Nuys, Los Angeles Community Hospital, and Norwalk Community Hospital), SCH Culver City, Nix Health, and ProMed (which includes other affiliated physician organizations).

The Company tests for goodwill impairment as of September 30 each year. In evaluating whether indicators of impairment exist, the Company considers adverse changes in market value, laws and regulations, profitability, cash flows, ability to maintain enrollment and renew payer contracts at favorable terms, among other factors. The goodwill impairment test is a two-step process. The first step consists of estimating the fair value of the reporting unit based on a weighted combination of (i) the

guideline company method that utilizes revenue or earnings multiples for comparable publicly-traded companies, and (ii) a discounted cash flow model that utilizes expected future cash flows, the timing of those cash flows, and a discount rate (or weighted average cost of capital, which considers the cost of equity and cost of debt financing expected by a typical market participant) representing the time value of money and the inherent risk and uncertainty of the future cash flows. If the estimated fair value of the reporting unit is less than its carrying value, a second step is performed to compute the amount of the impairment by determining the "implied fair value" of the goodwill, which is compared to its corresponding carrying value. The Company's impairment test related to goodwill at September 30, 2014 resulted in no impairment charge.

Long-Lived Assets and Amortizable Intangibles

Amortizable intangible assets totaled approximately $35,274,000 and $31,325,000, net of accumulated amortization at September 30, 2014 and 2013, respectively, and arose as a result of the ProMed, Alta, SCH Culver City, Nix Health, NGMA, and PCC acquisitions. Intangible assets include customer relationships, trade names, favorable leasehold, and physician guarantees. The Company reviews long-lived assets for impairment whenever events or changes in circumstances indicate that the carrying value of such assets may not be recoverable. The Company considers assets to be impaired and writes them down to fair value if estimated undiscounted cash flows associated with those assets are less than their carrying amounts. Fair value is based upon the present value of the associated cash flows. Changes in circumstances (for example, changes in laws or regulations, technological advances or changes in strategies) may also reduce the useful lives from initial estimates. Changes in planned use of intangibles may result from changes in customer base, contractual agreements, or regulatory requirements. In such circumstances, management will revise the useful life of the long-lived asset and amortize the remaining net book value over the adjusted remaining useful life. There were no impairments recorded during the year ended September 30, 2014. During the year ended September 30, 2013, the Company changed the original names of the SCHS Hospitals and expects to transition into the new names over the next three years. As a result of the change, the Company recorded an impairment charge of $3,476,000 at September 30, 2013 related to the trade names (see Note 5).

Medical Malpractice Liability Insurance

The individual physicians who contract with the Affiliates carry their own medical malpractice insurance. In the Hospital Services segment, the Company's hospitals carry professional and general liability insurance to cover medical malpractice claims under claims-made policies. Under the policies, insurance premiums cover only those claims actually reported during the policy term. Should the claims-made policy not be renewed or replaced with equivalent insurance, claims related to occurrences during the policy term but reported subsequent to the policy's termination may be uninsured. During the year ended September 30, 2013, the SCHS Hospitals and Alta Los Angeles Hospitals were covered under one professional and general liability insurance policy, and Nix Health was covered under a separate policy. Effective October 1, 2013, the hospitals renewed the professional and general liability insurance under one consolidated policy with separate retentions for each entity that runs through September 30, 2014. LACH Bellflower, NSH, and CharterCARE were included under the consolidated policy from their respective dates of acquisition or inception (LACH Bellflower).

Accounting principles generally accepted in the United States of America require that a health care organization record and disclose the estimated costs of medical malpractice claims in the period of the incident of malpractice, if it is reasonably possible that liabilities may be incurred and losses can be reasonably estimated. The Company has recognized an estimated liability for incurred but not reported claims and the self-insured risks (including deductibles and potential claims in excess of policy limits)

based upon an actuarial valuation of the Company's historical claims experience of the Company's hospitals. At September 30, 2014 and 2013, the total gross claims liability was approximately $4,590,000 and $4,660,000 and insurance receivables were $618,000 and $1,487,000, respectively, and were estimated using a discount factor of 4%.

The claims reserve is based on the best data available to the Company. The estimate, however, is subject to a significant degree of inherent variability. The estimate is continually monitored and reviewed, and as the reserve is adjusted, the difference is reflected in current operations. While the ultimate amount of medical malpractice liability is dependent on future developments, management is of the opinion that the associated liabilities recognized in the accompanying consolidated financial statements are adequate to cover such claims. Management is not aware of any potential medical malpractice claims whose settlement, if any, would have a material adverse effect on the Company's consolidated financial position, results of operations or cash flows.

Workers' Compensation Insurance

The workers' compensation coverage provides the statutory benefits required by law and that the employer's liability limits are $1,000,000 (excluding Nix Health and CharterCARE). Nix Health has opted out of the Texas Workers' Compensation system as a non-subscriber, and provides its employees with benefits for occupational injury or disease through an ERISA plan. Nix Health has an Employer's Excess Indemnity policy with a $25,000 deductible policy with limits of $10,000,000 per occurrence and $25,000,000 aggregate. CharterCARE was fully insured for workers' compensation claims with no deductible from June 20, 2014 through September 30, 2014. From October 1, 2012 to September 30, 2014, the Company's (excluding Nix Health and CharterCARE) workers' compensation coverage was written on a $250,000 incurred loss retro program without an aggregate loss limitation. At September 30, 2014 and 2013, included in accrued salaries, wages and benefits are accruals for uninsured claims and claims incurred but not reported of approximately $7,210,000 and $4,409,000, respectively. The amounts are estimated based upon an actuarial valuation of their claims experience, using a discount factor of 4%.

The claims reserve is based on the best data available to the Company. The estimate, however, is subject to a significant degree of inherent variability. The estimate is monitored and reviewed, and as the reserve is adjusted, the difference is reflected in current operations. While the ultimate amount of the claims liability is dependent on future developments, management is of the opinion that the associated liabilities recognized in the accompanying consolidated financial statements are adequate to cover such claims. Management is not aware of any potential claims whose settlement, if any, would have a material adverse effect on the Company's consolidated financial position, results of operations or cash flows.

Asset Retirement Obligations

The Company recognizes the fair value of a liability for legal obligations associated with asset retirements in the period in which it is incurred, if a reasonable estimate of the fair value of the obligation can be made. Over time, the liability is accreted to its present value each period. Upon settlement of the obligation, any difference between the cost to settle the asset retirement obligation and the liability recorded is recognized as a gain or loss in the statement of operations. The Company has accrued $4,310,000 in other long-term liabilities related to asset retirement obligations for the CharterCARE hospitals as of September 30, 2014. There were no asset retirement obligations as of September 30, 2013.

Stock Options

On December 15, 2010, the Board of Directors (the "Ivy Board") of Ivy Holdings adopted the 2010 Stock Option Plan of Ivy Holdings Inc. (the "Ivy Plan") and, on December 16, 2010, the stockholders of Ivy Holdings adopted the Ivy Plan. The Ivy Plan provides that it shall be administered by the Compensation Committee of the Ivy Board. The Ivy Plan includes an Incentive Stock Option Agreement and a Non-Qualified Stock Option Agreement to be used in connection with the grant of options under the Ivy Plan. These options granted under the Ivy Plan are exercisable into Ivy Holdings stock and vest based on a number of criteria, including time, performance and CEO discretion.

Compensation costs for option awards are measured and recognized in the consolidated financial statements based on their grant date fair value, net of estimated forfeitures over the awards' service period. Options subject to variable accounting treatment are subject to revaluation at the end of each reporting period. The Company uses the Black-Scholes option pricing model and a single option award approach to estimate the fair value of stock options granted. The fair value of restricted stock grants are determined on the date of grant, based on the number of shares granted and the quoted price or estimated fair market value of the Company's common stock. Equity-based compensation is classified within the same line items as cash compensation paid to employees.

Cash and Cash Equivalents

The Company considers all highly liquid debt instruments with initial maturities of 90 days or less to be cash equivalents. Cash and cash equivalents are primarily comprised of deposits with banks. The Company maintains its cash at banks with high credit-quality ratings.

Restricted Cash

At September 30, 2014 and 2013, $233,000 was held in a restricted account in connection with workers compensation arrangements, and $30,000 was restricted related to a capitation agreement. At September 30, 2014, a further $420,000 was restricted on behalf of Prospect CharterCARE SJHSRI, LLC for its School of Nursing as required by the U.S. Department of Education, $1,993,000 was restricted for research at CharterCARE hospitals, and $2,300,000 was restricted to meet certain regulatory requirements for PHP. At September 30, 2013, $300,000 was restricted in connection with a statutory deposit required by the Department of Managed Health Care for Knox-Keene licensing related to PHP.

Restricted Investments

The Company is required to keep restricted deposits by certain HMOs for the payment of claims. Such restricted deposits are classified as a current asset in the accompanying consolidated balance sheets, as they are restricted for payment of current liabilities. Investments also include certificates of deposit with maturity dates of more than 90 days when purchased.

Inventories

Inventories of supplies are valued at the lower of amounts that approximate the weighted average cost or market. Inventories consist primarily of medical and surgical supplies and pharmaceuticals.

Deferred Financing Costs

Deferred financing costs are amortized over the period in which the related debt is outstanding using the effective interest method. On November 16, 2012, the Company issued $100 million of 8.375% senior secured notes (see note 8) and capitalized deferred financing costs of $3,948,000 associated with the

offering during the year ended September 30, 2013, which are reflected in deferred financing costs in the accompanying consolidated balance sheets.

Deferred financing costs at September 30, 2014 and 2013 are as follows (in thousands):

September 30,	2014			2013		
	Gross Book Value	Accumulated Amortization	Net Book Value	Gross Book Value	Accumulated Amortization	Net Book Value
Deferred financing costs	$14,398	$4,941	$9,457	$14,345	$2,720	$11,625

Income Taxes

Deferred income tax assets and liabilities are recognized for differences between financial and income tax reporting bases of assets and liabilities based on enacted tax rates and laws. To the extent a deferred tax asset cannot be recognized under the preceding criteria, allowances must be established. The impact on deferred taxes of changes in tax rates and laws, if any, are applied to the years during which temporary differences are expected to be settled and reflected in the financial statements in the period of enactment. The Company recognizes interest and penalties associated with income tax matters and unrecognized tax benefits in the income tax expense line item of the statements of operations. For the years ended September 30, 2014 and 2013, no interest and/or penalties related to incomes taxes were accrued and/or expensed.

An entity is required to evaluate its tax positions using a two-step process. First, the entity should evaluate the position for recognition. An entity should recognize the financial statement benefit of a tax position if it determines that it is more likely than not that the position will be sustained on examination. Next, the entity should measure the amount of benefit that should be recognized for those tax positions that meet the more-likely-than-not test.

Consolidated and separate income tax returns are filed with the U.S. Federal jurisdiction and in the State of California, Texas, and Rhode Island. The Company's filed tax returns are generally subject to examination by the IRS and state tax boards for 3 to 4 years.

The net deferred tax liabilities are primarily comprised of temporary differences between book and tax bases for intangible and capital assets acquired and net operating loss carryforwards.

Fair Value of Financial Instruments

Financial instruments consist primarily of cash and cash equivalents, restricted cash investments, patient and other accounts receivables, accrued salaries and benefits, accounts payable and accrued expenses, medical claims and related liabilities, amounts due to government agencies, notes receivable and payable, capital lease obligations, debt, and other liabilities. The carrying amounts of current assets and liabilities approximate their fair value due to the relatively short period of time between the origination of the instruments and their expected realization.

Fair Value Measurement

Relevant accounting guidance establishes a framework for measuring fair value and clarifies that fair value is an exit price, representing the amount that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants.

The guidance requires disclosure about how fair value is determined for assets and liabilities and establishes a hierarchy for which these assets and liabilities must be grouped, based on significant levels of inputs as follows: Level 1 quoted prices in active markets for identical assets or liabilities; Level 2 quoted prices in active markets for similar assets and liabilities and inputs that are observable for the asset or liability; or Level 3 unobservable inputs for the asset or liability, such as discounted cash flow models or valuations. The determination of where assets and liabilities fall within this hierarchy is based upon the lowest level of input that is significant to the fair value measurement.

The Company's Level 1 assets include cash and cash equivalents and investments (certificates of deposit and money market mutual funds). The inputs for fair value of goodwill and intangible assets (including long lived assets and intangible assets subject to amortization) would be based on Level 3 inputs as data used for such fair value calculations would be based on discounted cash flows that are not observable from the market, directly or indirectly.

Financial Items Measured at Fair Value on a Recurring Basis

The following table sets forth the Company's financial assets and liabilities measured at fair value on a recurring basis and where they are classified within the hierarchy (in thousands):

	Total	Level 1	Level 2	Level 3
As of September 30, 2014				
Certificates of deposit and money market mutual funds	$ 642	$ 642	$ -	$ -
As of September 30, 2013				
Certificates of deposit and money market mutual funds	$ 637	$ 637	$ -	$ -

The Company's investments are classified within Level 1 of the fair value hierarchy because they are valued using quoted market prices.

Nonfinancial Items Measured at Fair Value on a Nonrecurring Basis

Nonfinancial assets such as goodwill and identifiable intangible assets are measured at fair value when there is an indicator of impairment and recorded at fair value only when impairment is recognized. The Company performs an annual impairment test on the goodwill, and performs an impairment test on the intangibles when there are indications of impairment.

Prospect Medical Holdings, Inc.

Notes to Consolidated Financial Statements

The following table presents the fair value of intangible assets subject to amortization measured at fair value during the year ended September 30, 2013 and included in the Company's consolidated balance sheet as of September 30, 2013 (in thousands):

	Total	Fair Value Measurement Using Level 1	Level 2	Level 3	Total impairment
Trade names	$ 1,940	$ -	$ -	$ 1,940	$ (3,476)

During the year ended September 30, 2013, the Company recorded $3,476,000 of impairment relating to intangible assets subject to amortization, which is reflected in the accompanying consolidated statements of income. No impairment was recorded during the year ended September 30, 2014.

The Company uses the discounted cash flow approach to estimate the fair value of the Company's trade names. The following table provides quantitative information related to the significant unobservable inputs to determine fair value and impairment as of September 30, 2013:

Fair value of trade names	Valuation Technique	Unobservable Input	Rates
$ 1,940	Discounted cash flow	Weighted average cost of capital	13.0% - 13.5%
		Revenue growth rate	2% - 3%
		Reduction of revenue attributable to trade names	(30%) - (70%)
		Royalty rate	1.0%

Significant increases or decreases in the Company's weighted average cost of capital may result in a significantly lower or higher fair value measurement, respectively. Significant increases or decreases in the revenue growth rate and royalty rates in isolation may result in a significantly higher or lower fair value measurement, respectively. The fair values of the Company's current financial liabilities approximate their reported carrying amounts. The carrying values and the fair values of non-current financial liabilities that qualify as financial instruments under the guidance are as follows (in thousands).

	2014		2013	
September 30,	Carrying Amount	Fair Value	Carrying Amount	Fair Value
Liabilities:				
Long-term debt	$ 421,888	$ 457,620	$ 421,067	$ 449,339

The fair value of the Company's long-term debt was determined based on market prices.

Concentrations of Credit Risk

Cash and cash equivalents are maintained at financial institutions and, at times, balances may exceed federally insured limits of $250,000 per depositor of each financial institution. The Company has not experienced any losses to date related to these balances.

Financial instruments that potentially subject the Company to concentrations of credit risk consist of receivables due from Medicare, Medicaid (Medi-Cal in California), patients, health plans including shared-risk arrangements, and notes receivable.

The Company invests excess cash in liquid securities at institutions with strong credit ratings, following established guidelines relative to diversification and maturities to maintain safety and liquidity. These guidelines are periodically reviewed and modified to take into consideration trends in yields and interest rates and principal risk. Management attempts to schedule the maturities of the Company's investments to coincide with the Company's expected cash requirements. Credit risk with respect to receivables is limited since amounts are generally due from large HMOs within the Medical Group Management segment and from the Medicare and Medicaid (Medi-Cal in California) programs within the Hospital Services segment. Notes receivable are fully secured by collateral of equal or greater value. Management reviews the financial condition of these institutions on a periodic basis and does not believe the concentration of cash or receivables results in a high level of risk.

For the years ended September 30, 2014 and 2013, the Hospital Services segment received a total of 67% and 71%, respectively, of its net patient revenues from Medicare and Medicaid programs, and the Medical Group segment received a total of 63% and 69%, respectively, of their capitation revenues from its five largest HMOs, as follows (in thousands):

Years Ended September 30,	2014	% of Total Revenue	2013	% of Total Revenue
Hospital Services:				
Government Payers:				
Medicare	$ 224,984	36%	$ 211,482	41%
Medicaid	189,668	31%	158,048	30%
Total	$ 414,652	67%	$ 369,530	71%
Medical Group:				
HMO A	$ 33,784	14%	$ 36,194	17%
HMO B	31,632	13%	28,346	13%
HMO C	31,481	13%	31,735	15%
HMO D	31,283	13%	28,754	13%
HMO E	25,133	10%	23,159	11%
Totals	$ 153,313	63%	$ 148,188	69%

Use of Estimates

The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets, liabilities, revenues and expenses, and the disclosure of contingent assets and liabilities at the dates, and for the periods, that the consolidated financial statements are prepared. Actual results could materially differ from those estimates. Principal areas requiring the use of estimates include third party settlements, settlements under risk sharing programs, allowances for contractual discounts and doubtful accounts, accruals for medical claims, impairment of goodwill, long-lived assets and intangible assets, share-based payments, professional and general

liability claims and workers' compensation claims, reserves for outcome of legislation and valuation allowances against deferred tax assets.

New Accounting Pronouncements

In June 2011, the FASB issued an accounting standards update that specifies that the liability for the annual fee imposed on certain health insurers under the recently enacted Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act, should be estimated and recorded in full once the entity provides qualifying health insurance in the applicable calendar year in which the fee is payable with a corresponding deferred cost that is amortized to expense using a straight-line method of allocation unless another method better allocates the fee over the calendar year that it is payable. This update is effective for calendar years beginning after December 31, 2013, when the fee initially becomes effective. The Company is currently evaluating the effect of this guidance on its consolidated results of operations and consolidated financial position.

In July 2013, the FASB issued an accounting standards update that requires an unrecognized tax benefit or portion of an unrecognized tax benefit to be presented as a reduction to a deferred tax asset for a net operating loss carryforward, a similar tax loss, or a tax credit carryforward except when certain conditions exist. The amendment is effective for the Company for fiscal years beginning after December 15, 2014, including interim periods in 2014. The Company is currently evaluating the effect of this guidance on its consolidated results of operations and consolidated financial position.

In May 2014, the FASB issued ASU No. 2014-09, Revenue from Contracts with Customers (ASU 2014-09). The core principle of ASU 2014-09 is built on the contract between a vendor and a customer for the provision of goods and services, and attempts to depict the exchange of rights and obligations between the parties in the pattern of revenue recognition based on the consideration to which the vendor is entitled. To accomplish this objective, the standard requires five basic steps: (i) identify the contract with the customer, (ii) identify the performance obligations in the contract, (iii) determine the transaction price, (iv) allocate the transaction price to the performance obligations in the contract, (v) recognize revenue when (or as) the entity satisfies a performance obligation. Nonpublic entities will apply the new standard for annual periods beginning after December 15, 2017, including interim periods therein. Three basic transition methods are available – full retrospective, retrospective with certain practical expedients, and a cumulative effect approach. Under the third alternative, an entity would apply the new revenue standard only to contracts that are incomplete under legacy U.S. GAAP at the date of initial application (e.g. October 1, 2018) and recognize the cumulative effect of the new standard as an adjustment to the opening balance of retained earnings. That is, prior years would not be restated and additional disclosures would be required to enable users of the financial statements to understand the impact of adopting the new standard in the current year compared to prior years that are presented under legacy U.S. GAAP. Early adoption is prohibited. The Company is currently evaluating the effect of this guidance on its consolidated results of operations and consolidated financial position.

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3. Property, Improvements and Equipment

Property, improvements and equipment, consisted of the following (in thousands):

September 30,	2014	2013
Property, improvements and equipment:		
Land and land improvements	$ 53,381	$ 34,985
Buildings and improvements	119,163	59,270
Leasehold improvements	22,967	4,007
Equipment	87,249	64,842
Furniture and fixtures	7,187	5,759
	289,947	168,863
Less: accumulated depreciation	(60,473)	(42,331)
Property, improvements and equipment, net	$ 229,474	$ 126,532

Effective May 6, 2014, Prospect acquired the property, improvements, and equipment of Bellflower Medical Center, located in Bellflower, California, for cash consideration of $20 million. The assets, including land and building, were named Los Angeles Community Hospital at Bellflower. Bellflower Medical Center was closed in 2013 by its previous owner and was not operational since that time. The Company accounted for this transaction as an acquisition of assets. The primary factors influencing the determination that the acquisition should be accounted for in this manner included the complete closure of the hospital, the fact that there were no inputs and/or processes acquired, the requirement for significant additional capital expenditures and development efforts to reopen the hospital, and the lack of acquired workforce. Accordingly, the Company determined that this transaction lacked the key characteristics for business combination accounting. In addition to the $20 million purchase price, Prospect capitalized $546,000 of transaction costs directly related to the purchase of these assets. The purchase price and transaction costs were allocated to the assets acquired based on the relative fair value of the acquired assets.

On July 18, 2013, Nix Health entered into a lease agreement to rent land and building located in the city of San Antonio, Texas, which was used for a 73-bed behavioral health center which was opened during the year ended September 30, 2014. The Company determined that the lease qualified as a capital lease and recorded fixed assets of $5,675,000 and a capital lease liability of $6,902,000 as of September 30, 2013. The difference of $1,227,000 relates to a tenant improvement allowance from the landlord, which was used for construction costs during the year ended September 30, 2014.

During the years ended September 30, 2014 and 2013, the Company made investments of approximately $7,633,000 and $6,200,000, respectively, in equipment related to implementation of EHR technology and new hospital systems at the Company's hospitals.

At September 30, 2014 and 2013, the Company had assets under capitalized leases of approximately $19,294,000 and $17,288,000, respectively, and related accumulated depreciation of $11,465,000 and $7,350,000, respectively.

Depreciation expense was approximately $18,386,000 and $12,443,000 for the years ended September 30, 2014 and 2013, respectively.

4. Acquisitions

Newport Specialty Hospital

Effective May 6, 2014, Prospect acquired substantially all of the assets of Newport Specialty Hospital ("NSH") for cash consideration of $15 million. NSH, located in Tustin, California was substantially closed prior to acquisition, operating only its pediatric subacute unit as of the acquisition date.

The acquisition of NSH was accounted for as a business combination using purchase accounting. Under the purchase accounting method, assets acquired and liabilities assumed are recorded based on their estimated fair values. This transaction resulted in a bargain gain of approximately $523,000, which is included in other income in the accompanying consolidated statements of income. The Company incurred $556,000 and $37,000 of transaction costs during the years ended September 30, 2014 and 2013, respectively, which are included in General and Administrative expenses in the accompanying consolidated statements of income.

The following table summarizes the assets acquired and liabilities assumed in connection with the NSH acquisition, as of May 6, 2014 (in thousands):

	Purchase Price Allocation (Preliminary)
Property, improvements and equipment	$ 15,523
Bargain purchase gain	(523)
Net cash consideration	$ 15,000

CharterCARE

Effective June 20, 2014, Prospect, through its newly formed subsidiary, PCC, acquired substantially all of the assets of CharterCARE Health Partners and its subsidiaries in exchange for a 15% interest in PCC, $43.3 million in cash and a commitment to invest at least $50 million in PCC and its subsidiaries for strategic business development and capital improvements over the next four years. As a result of the acquisition, PCC is owned 85% by Prospect and 15% by CharterCARE Health Partners (which was subsequently renamed CharterCARE Community Board).

PCC, through its subsidiaries, operates Roger Williams Medical Center, St. Joseph Health Services of Rhode Island, and Elmhurst Extended Care Facilities, Inc., which operate hospitals, medical centers and assisted living facilities located in Rhode Island with approximately 785 licensed beds.

The acquisition was accounted for as a business combination using purchase accounting. Under the purchase accounting method, assets acquired and liabilities assumed are recorded based on their estimated fair values. This transaction resulted in a bargain gain of approximately $4,294,000, which is included in other income in the accompanying consolidated statements of income. Subsequent to September 30, 2014, the Company received $2,125,000 for a working capital adjustment, which resulted in a reduction in total consideration and an increase in the bargain gain recognized during the year ended September 30, 2014.

Prospect Medical Holdings, Inc.

Notes to Consolidated Financial Statements

The following table summarizes the assets acquired and liabilities assumed in connection with the PCC acquisition, as of June 20, 2014 (in thousands):

	Purchase Price Allocation (Preliminary)
Restricted cash	$ 1,739
Patient accounts receivable and other receivables	34,264
Prepaid expenses and other current assets	8,777
Property, improvements and equipment	53,642
Intangible assets	8,590
Other long-term assets	4,698
Accounts payable and other liabilities	(44,656)
Capital leases	(1,315)
Long-term debt	(25)
Other long-term liabilities	(4,645)
Net assets acquired	61,069
Less: amount attributable to non-controlling interest	(9,160)
Net assets acquired by Prospect	51,909
Total purchase consideration	47,615
Bargain purchase gain	$ 4,294

The total purchase consideration of $47,615,000 includes net cash consideration of $41,175,000 after the working capital adjustment plus a long-term liability of $6,440,000, which represents the discounted fair value of the non-controlling interest's 15% interest in the $50 million future commitment of the Company to PCC as part of the Purchase Agreement. The Company's long-term liability increased from $6,440,000 as of June 20, 2014 to $6,506,000 as of September 30, 2014 due to accretion of the liability.

The Company incurred $2,145,000 and $976,000 of transaction costs during the years ended September 30, 2014 and 2013, respectively, which are included in General and Administrative expenses in the accompanying consolidated statements of income.

New Genesis Medical Associates

On October 1, 2012, the Company, through its newly created affiliate, New Genesis Medical Associates, Inc. dba Genesis Medical Clinic, a California professional medical corporation, acquired substantially all of the assets of a physician medical practice located in Orange County, California. The consideration for the NGMA acquisition consisted of approximately $400,000 in cash. The acquisition of NGMA is accounted for as a business combination using purchase accounting. Under the purchase accounting method, assets acquired and liabilities assumed are recorded based on their estimated fair values.

The following table summarizes the assets acquired in connection with the NGMA acquisition, as of October 1, 2012 (in thousands):

	Purchase Price Allocation
Property, improvements and equipment	$ 50
Intangible assets	350
Net cash consideration	$ 400

Nix Community General Hospital

On April 16, 2013, the Company acquired substantially all of the assets and assumed certain liabilities of Community General Hospital of Dilley, Texas Inc. dba Community General Hospital, a hospital with 18 licensed beds, which offers Dilley, Texas and the surrounding communities an array of medical services including primary care. Upon close of the transaction, the hospital was renamed to Nix Community General Hospital. The consideration for the Community General Hospital acquisition included approximately $2,705,000 in cash, contingent cash consideration of $250,000 and assumption of approximately $795,000 in liabilities, for total consideration of approximately $3,750,000. The acquisition of Community General Hospital is accounted for as a business combination using purchase accounting. Under the purchase accounting method, assets acquired and liabilities assumed are recorded based on their estimated fair values. The Company incurred $255,000 of transaction costs during the years ended September 30, 2013, which are included in General and Administrative expenses in the accompanying consolidated statements of income.

The following table summarizes the assets acquired and liabilities assumed in connection with the Community General Hospital acquisition, as of April 16, 2013 (in thousands):

	Purchase Price Allocation
Current assets	$ 7
Property, improvements and equipment	1,267
Goodwill	2,476
Contingent cash consideration	(250)
Accounts payable and other liabilities	(795)
Net cash consideration	$ 2,705

As an asset purchase, the goodwill and the intangible assets acquired in the PCC, NGMA and Nix CGH acquisitions are deductible for tax purposes.

5. Goodwill and Intangible Assets

As of September 30, 2014 and 2013, goodwill and intangible assets relate to the ProMed, Alta, SCH Culver City, Nix Health, NGMA, Nix CGH, and PCC acquisitions. The Company performed its annual goodwill impairment analysis for each reporting unit that constitutes a business for which 1) discrete financial information is produced and reviewed by management, and 2) services that are distinct from the other reporting units.

Prospect Medical Holdings, Inc.

Notes to Consolidated Financial Statements

For the Medical Group segment, the Company has determined that PHCA and the ProMed Entities (collectively referred to as "ProMed"), as well as PMS and the other affiliated physician organizations as a group (collectively referred to as "Prospect IPAs") each constitutes a separate reporting unit. NGMA is consolidated within the Prospect reporting unit.

For the Hospital Services segment, the reporting unit for the annual goodwill impairment analysis is determined to be at the business unit level. A separate analysis was prepared for Alta Hospitals, SCH Culver City, and Nix Health. Nix CGH is consolidated within the Nix Health business unit.

During the year ended September 30, 2013, the Company recorded additional goodwill of $2,476,000 related to the Nix CGH acquisition. In addition, the Company recorded a working capital adjustment of $157,000 against the goodwill balance related to the Nix Health acquisition.

The carrying value of goodwill for Alta Hospitals, SCH Culver City, Nix Health (including Nix CGH), and ProMed at September 30, 2014 and 2013 was $106,539,000, $24,373,000, $5,613,000, and $22,339,000, respectively.

The following is a rollforward of goodwill from October 1, 2012 to September 30, 2014 (in thousands):

	Amount
Balance, October 1, 2012	$ 156,545
Acquisition of Nix CGH (see Note 4)	2,476
Working capital adjustments - Nix Health (see Note 4)	(157)
Balance, September 30, 2013	158,864
Balance, September 30, 2014	$ 158,864

Identifiable intangible assets are comprised of the following (in thousands):

	September 30, 2014						
	Alta	SCH Culver City	Nix Health	Charter CARE	Prospect	Promed	Total
HMO membership	$ -	$ -	$ -	$ -	$ -	$ 25,200	$ 25,200
Trade names, net of impairment	10,310	1,320	2,740	8,590	-	9,450	32,410
Favorable leasehold	-	-	20	-	-	-	20
Physician guarantees	-	-	1,596	-	-	-	1,596
Customer relationships	-	-	-	-	350	-	350
Gross carrying value	10,310	1,320	4,356	8,590	350	34,650	59,576
Accumulated amortization	(3,670)	(440)	(2,171)	(482)	(100)	(17,439)	(24,302)
Intangible assets, net	$ 6,640	$ 880	$ 2,185	$ 8,108	$ 250	$ 17,211	$ 35,274

Prospect Medical Holdings, Inc.

Notes to Consolidated Financial Statements

	September 30, 2013					
	Alta	SCH Culver City	Nix Health	Prospect	Promed	Total
HMO membership	$ -	$ -	$ -	$ -	$ 25,200	$ 25,200
Trade names, net of impairment	10,310	1,320	2,740	-	9,450	23,820
Favorable leasehold	-	-	20	-	-	20
Physician guarantees	-	-	1,537	-	-	1,537
Customer relationships	-	-	-	350	-	350
Gross carrying value	10,310	1,320	4,297	350	34,650	50,927
Accumulated amortization	(2,978)	-	(1,513)	(50)	(15,061)	(19,602)
Intangible assets, net	$ 7,332	$ 1,320	$ 2,784	300	$ 19,589	$ 31,325

During the year ended September 30, 2013, the Company changed the names of the hospitals owned by SCHS to SCH Hollywood, SCH Van Nuys, and SCH Culver City. The fair value of the original trade names at September 30, 2013 was estimated using the relief-from-royalty method and their remaining useful lives were reduced to three years based on the Company's planned use of the trade names. As a result of the valuation, the trade names were valued at $1,940,000 and the Company recorded an impairment charge of $3,476,000 for the year ended September 30, 2013, which is presented as part of operating expenses in the accompanying consolidated statements of income. The Company adjusted the cost basis of the trade names to the new fair value, which resulted in writing off $5,510,000 of gross intangibles and accumulated amortization of $2,034,000. There were no impairments recorded for the year ended September 30, 2014.

During the year ended September 30, 2014 and 2013, intangibles related to physician guarantees, covenants not-to-compete and provider networks of $487,000 and $3,300,000, respectively, were fully amortized and removed from intangible assets.

Amortization is recognized on a straight-line basis (management's best estimate of the period of economic benefit) over the respective useful lives and expense for the years ended September 30, 2014 and 2013 was approximately $5,194,000 and $4,371,000, respectively.

Estimated amortization expense for each future fiscal year is as follows (in thousands):

Years ended September 30,	
2015	$ 6,345
2016	6,146
2017	4,869
2018	4,632
2019	4,149
Thereafter	9,133
Total	$ 35,274

The following table shows the estimated useful lives for each of the intangible assets:

	Estimated useful lives
HMO membership	14 years
Trade names	3 - 20 years
Favorable leasehold	6 years
Physician guarantees	2 to 3 years
Customer relationships	7 years

The weighted-average remaining useful life for the intangible assets was 7.13 years as of September 30, 2014.

6. Related Party Transactions

Jeereddi Prasad, M.D., a shareholder of Ivy Holdings, a director of Ivy Holdings and the Company, and an officer of the ProMed Entities, has ownership interests in physician medical groups that provide medical services to ProMed members, including CMG. For the years ended September 30, 2014 and 2013, the ProMed Entities paid these groups approximately $12,677,000 and $16,742,000, respectively.

Pursuant to a Management Services Agreement, dated December 15, 2010 and amended on May 3, 2012 (the "LGP Management Agreement"), between the Company and Leonard Green & Partners, L.P. ("LGP"), a private equity fund with affiliated funds that collectively constitute the majority shareholder of Ivy Holdings, LGP provides to the Company, (a) certain investment banking services, (b) management, consulting and financial planning services and (c) financial advisory and investment banking services in connection with major financial transactions from time to time. In consideration for the services provided by LGP under the LGP Management Agreement, the Company pays LGP an annual fee of $1,000,000, payable in monthly installments, and reimburses LGP for its related expenses up to $50,000 annually. If approved by the unanimous consent of the Board of Directors of the Company, additional customary fees may be due to LGP pursuant to the terms of the LGP Management Agreement for services rendered in connection with major transactions from time to time.

The Company is a wholly-owned indirect subsidiary of Ivy Holdings. Therefore, Ivy Holdings is the parent of an affiliated group of corporations within the meaning of Section 1504(a) of the Internal Revenue Code of 1986. On December 15, 2010, Ivy Holdings, Ivy Intermediate and the Company entered into a Tax Sharing Agreement. The Tax Sharing Agreement allows the Company to make payments to Ivy Holdings as necessary to fund their payment of any required taxes incurred due to such parent status. During the years ended September 30, 2014 and 2013, the Company made payments under this arrangement of $5,703,000 and $17,477,000, respectively.

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7. Income Taxes

The components of the income tax provision are as follows (in thousands):

For the years ended September 30,	2014	2013
Current:		
Federal	$ 14,430	$ 8,000
State	4,242	2,184
	18,672	10,184
Deferred:		
Federal	(4,529)	(318)
State	(3,582)	(56)
	(8,111)	(374)
Total:		
Federal	9,901	7,682
State	660	2,128
	$ 10,561	$ 9,810

Temporary differences and carry forward items that result in deferred income tax balances as of September 30 are as follows (in thousands):

September 30,	2014	2013
Deferred tax assets:		
State tax benefit	$ 2,593	$ 2,103
Allowances for bad debts	5,119	4,304
Vacation accrual and other	5,440	4,434
Workers compensation	2,656	1,889
Accrued bonuses	3,898	4,847
Malpractice reserves	1,952	1,204
Deferred rent	107	105
Enterprise zone tax credit	2,433	-
Other	359	379
Net operating losses	8,789	8,798
Capital loss carryforward	2,274	2,255
Deferred tax assets	35,620	30,318
Valuation allowance	(10,737)	(10,742)
Net deferred tax assets	24,883	19,576
Deferred tax liabilities:		
Intangible assets	(7,247)	(8,211)
Fixed assets	(17,664)	(21,038)
Deferred compensation	(112)	-
Partnership outside basis difference	(1,982)	-
Prepaid expenses	(21)	(581)
Deferred tax liabilities	(27,026)	(29,830)
Net deferred tax liabilities	$ (2,143)	$ (10,254)

Prospect Medical Holdings, Inc.

Notes to Consolidated Financial Statements

Deferred tax assets and liabilities reflect the effect of temporary differences between the assets and liabilities recognized for financial reporting purposes and the amounts recognized for income tax purposes.

For the year ended September 30, 2013, the Company released $8,000,000 of deferred tax valuation allowance in connection with net operating losses that became available for use due to the Brotman Medical Center and Alta Hollywood Hospitals merger. The Company maintains approximately $10,737,000 and $10,742,000 as of September 30, 2014 and 2013, respectively, of valuation allowance against its deferred tax assets for capital loss and certain net operation loss carry forwards subject to limitations under tax law. At September 30, 2014, the Company had federal and state net operating loss carryovers of approximately $17,935,000 and $34,039,000 which, if not utilized, will expire beginning 2034 and 2024, respectively. A substantial portion of these net operating loss carry forwards are subject to limitations under Internal Revenue Code Section 382, and their use may be severely limited in the future.

During the year ended September 30, 2013, the Internal Revenue Service ("IRS") concluded its audit of SCH Culver City for the years ended September 30, 2008 through 2010 and its audit of PMG for the year ended September 30, 2010. During the year ended September 30, 2014, the IRS completed its audit of PMH for the year ended September 30, 2010 and the period from October 1, 2010 to December 15, 2010 with no adjustments. The Company's tax years 2010 and after are generally open for federal and state tax examination. At September 30, 2013, the Company has approximately $970,000 of unrealized excess tax benefits related to employee stock options. This amount is not included in the table of deferred tax assets above and the benefit will be recorded as an increase to additional paid in capital if and when realized.

The Company does not have any material unrecognized benefit as of September 30, 2014 and does not anticipate that any material change will occur within the next 12 months.

The differences between the income tax provision at the federal statutory rate and that reflected in the accompanying consolidated statements of operations are summarized as follows:

For the years ended September 30,	**2014**	2013
Tax provision at statutory rate	35%	35%
State taxes, net of federal benefit	6%	6%
Permanent and other items	0%	3%
Enterprize zone tax credits	(7)%	0%
Change in valuation allowances	0%	(19)%
Other	2%	(2)%
	36%	**23%**

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Prospect Medical Holdings, Inc.

Notes to Consolidated Financial Statements

8. Long-Term Debt

Long-term debt consists of the following (in thousands):

September 30,	2014	2013
Prospect's debt:		
Senior secured notes		
2019 Notes	$ 325,000	$ 325,000
Less: discount, net	(6,339)	(7,641)
	318,661	317,359
Additional 2019 Notes	100,000	100,000
Plus: premium, net	1,419	1,729
	101,419	101,729
Other	-	21
	420,080	419,109
Nix Health's debt:		
Mortgage debt	1,801	1,919
Note payable	-	39
	1,801	1,958
Other debt:	7	-
Total Debt:	421,888	421,067
Less: current maturities	(133)	(178)
Long-term debt, net of current maturities	$ 421,755	$ 420,889

Prospect's Debt:

Senior Secured Notes

On May 3, 2012, the Company closed the offering of $325 million in 8.375% senior secured notes due May 1, 2019 ("PMH 2019 Notes"). Interest is payable semi-annually in arrears on May 1 and November 1, commencing on November 1, 2012. The offering was executed in accordance with Rule 144A and Regulation S under the Securities Act of 1933. The terms of the PMH 2019 Notes are governed by an indenture among the Company, certain of its subsidiaries and affiliates (as "Guarantors"), and U.S. Bank National Association (as trustee) (the "Indenture"). The Indenture contains certain covenants that, among other things, limit the Company's ability, and the ability of its restricted subsidiaries (as such term is defined in the Indenture) to: retire and pay dividends or distributions on capital stock or equity interests, prepay subordinated indebtedness or make other restricted payments; incur additional debt; make investments; create liens on assets; enter into transactions with affiliates; engage in other businesses; sell or issue capital stock of restricted subsidiaries; merge or consolidate with another company; transfer and sell assets; create dividend and other payment restrictions affecting subsidiaries; and designate unrestricted subsidiaries. The Credit Agreement (defined below), executed in connection

with the PMH Senior Secured Credit Facility (discussed below), contains a number of customary covenants as well as covenants requiring the Company to maintain a maximum consolidated secured leverage ratio and limiting the amount of capital expenditures.

Concurrent with the issuance of the PMH 2019 Notes, the Company entered into a five year $50 million revolving senior secured credit facility (the "PMH Senior Secured Credit Facility") which replaced the existing senior secured credit facility. The PMH Senior Secured Credit Facility provides, among other things, for borrowings up to the amount of the facility with sublimits of up to (i) $20 million to be available for the issuance of letters of credit and (ii) $10 million to be available for swingline loans. The commitment under the facility may be increased by up to $10 million upon the Company's request at the discretion of the lenders and subject to certain customary requirements. The interest rate per annum applicable to loans under the PMH Senior Secured Credit Facility will be, at the Company's option, either a rate per annum equal to (i) LIBOR plus 3.50% or (ii) an alternate base rate, which will be the higher of the administrative agent's prime rate, the federal funds rate plus 0.50%, and the 1-month LIBOR rate plus 1.00%, plus in each case, 2.50%. In August 2013, the PMH Senior Secured Credit Facility limit was increased to $60 million. As of September 30, 2014, the Company had $20 million outstanding debt related to the PMH Senior Secured Credit Facility.

The PMH 2019 Notes and the PMH Senior Secured Credit Facility are jointly and severally guaranteed on a senior secured basis by all of the Company's subsidiaries (as such term is defined in the Indenture) other than AMVI/Prospect Medical Group, Nuestra and certain immaterial subsidiaries. The PMH 2019 Notes are secured pari passu with the PMH Senior Secured Credit Facility by first-priority Liens and security interests on substantially all of the tangible and intangible assets of the Guarantors, including, but not limited to, the accounts receivable, inventories, other personal property, real property, fixtures and equipment, in each case now owned or hereafter acquired by the Company and the Subsidiary Guarantors, with certain exceptions. The PMH 2019 Notes are effectively senior to all of the Guarantors' existing and future Indebtedness.

The terms of the PMH Senior Secured Credit Facility are governed by the Credit Agreement, dated as of May 3, 2012, (as amended in connection with the Company's November 2012 offering of additional PMH 2019 Notes - see below) among the Company, Morgan Stanley Senior Funding, Inc. (as administrative agent), Royal Bank of Canada and Credit Suisse AG, Cayman Islands Branch (as co-syndication agents) and the lenders party thereto (the "Credit Agreement").

The Company, at its option, may redeem all or part of the notes at a redemption price equal to 106.281%, 104.188%, 102.094% and 100.0% on or after May 1, 2015, 2016, 2017 and 2018, respectively. Prior to May 1, 2015, the Company, at its option, may (i) redeem up to 35% of the original principal amount of the notes with the proceeds of certain equity offerings at a redemption price of 108.375% (ii) redeem up to 10% of the original principal amount of the PMH 2019 Notes during each 12-month period, commencing on May 1 in each of 2012, 2013 and 2014, at a redemption price of 103.0% of the principal amount thereof (this redemption option was terminated in connection with the Company's November 2012 offering of additional PMH 2019 Notes) or (iii) redeem the PMH 2019 Notes, in whole, but not in part, at a redemption price of 100.0% of the aggregate principal plus a make-whole premium. There are no required principal payments on the PMH 2019 Notes until maturity.

On November 16, 2012, the Company closed the offering of $100 million in aggregate principal amount of 8.375% senior secured notes due 2019 (the "Additional 2019 Notes") at a price equal to 102% of the principal amount of the Additional 2019 Notes. The Additional 2019 Notes were issued in a private placement to qualified institutional buyers and form a part of the same series as the PMH 2019 Notes issued on May 3, 2012.

The Additional 2019 Notes were issued under the Indenture, dated May 3, 2012 and described above, as supplemented by two supplemental indentures entered into in connection with the issuance of the Additional 2019 Notes (the "Supplemental Indentures"). The Additional 2019 Notes are treated as a single series with the previously issued PMH 2019 Notes for all purposes under the Indenture, including, without limitation, restrictive covenants, waivers, amendments, redemptions and offers to purchase. Prior to closing the issuance of the Additional 2019 Notes, the Company was required to obtain the consent of the majority in interest of its PMH 2019 Notes issued on May 3, 2012 to certain amendments to the Indenture contained in the first Supplemental Indenture. The Company obtained such consent from the holders of approximately $324 million in aggregate principal amount of outstanding PMH 2019 Notes and paid an aggregate consent fee of approximately $8.9 million. The Company determined that the transaction represents a debt modification under the applicable accounting guidance and capitalized the consent fee and recorded it as a debt discount during the year ended September 30, 2013, which is being amortized over the term of the Additional 2019 Notes using the effective interest method. As of September 30, 2013, the aggregate outstanding principal balance of the PMH 2019 Notes was $425,000,000, net of unamortized original issue discount of $7,641,000 and plus unamortized original issue premium of $1,729,000.

The proceeds from the offering, together with approximately $10.9 million of the Company's available cash, were utilized to pay a dividend to the stockholders of the Company's indirect parent, Ivy Holdings, in an aggregate amount equal to $100 million, to pay the aforementioned $8.9 million consent fee and to pay approximately $2.5 million for other fees and expenses related to the offering.

In connection with the issuance of the Additional 2019 Notes, the Company entered into an amendment of its Credit Agreement governing the PMH Senior Secured Credit Facility that waived and amended certain provisions of the Credit Agreement, including certain restrictive covenants.

As of September 30, 2014 and 2013, the Company was in compliance with the financial covenants of the Indenture and Credit Agreement.

Demand Notes

During the year ended September 30, 2012, the Company obtained a commitment from a bank for a $9.3 million equipment leasing facility to finance various equipment at the Company's hospital facilities. During January 2014, the commitment was increased to $22.3 million. As of September 30, 2014 and 2013, $10.7 million and $8.4 million, respectively, were drawn under the facility and are classified as capital lease arrangements. Draws represent demand notes until conversion to capital leases, and interest accrues on such draws at the bank prime rate plus 1.5% with a floor of 4.5% and payable monthly.

Nix Health's Debt:

Mortgage Debt

In connection with the Nix Health acquisition, Nix SPE, LLC ("Nix SPE") executed a Loan Assumption Agreement, effective as of February 29, 2012, pursuant to which Nix SPE assumed the obligations of the sellers of Nix Health under a mortgage loan facility provided by The Ohio National Life Insurance Company on December 27, 1999. Nix SPE assumed the obligation to pay the outstanding principal amount of the mortgage loan and interest accruing thereafter. The outstanding balance of the mortgage loan as of September 30, 2014 and 2013 was $1,801,000 and $1,919,000, respectively.

Prospect Hospital Holdings, LLC, the parent company of Nix SPE, has provided a guaranty of the obligations of Nix SPE under the loan. The obligations under the loan facility are secured by a deed of trust on a neighborhood medical center known as Nix Alamo Heights. The loan is subject to a 7.0% interest rate and requires monthly installment payments of $20,674, with a balloon payment on the maturity date of November 1, 2019. Prepayment is subject to a fee and the loan contains customary covenants.

Note Payable

Nix Health entered into a note payable due in March of 2014. Interest accrued on this note at 8.96% and was payable monthly. The outstanding balance of this note as of September 30, 2013 was $39,000, and the note payable was repaid during the year ended September 30, 2014.

Scheduled payments under the Company's current and long-term debt as of September 30, 2014 are as follows (in thousands):

Years ending September 30,	
2015	$ 133
2016	135
2017	145
2018	155
2019	420,247
Thereafter	1,073
	$ 421,888

9. Stockholder's Deficit

Equity Based Compensation Plans

Effective December 15, 2010, the Board of Directors of Ivy Holdings adopted the Ivy Plan that authorized the issuance of options exercisable for up to 155,110 shares of the common stock of Ivy Holdings to employees, certain consultants and independent members of the boards of directors, of Ivy Holdings and its subsidiaries (including the Company and its subsidiaries). During the years ended September 30, 2014 and 2013, the Compensation Committee of the Board of Directors of Ivy Holdings ("Compensation Committee") granted 4,113 and 18,462 options to certain members of the Company's management and employees. These options are exercisable into Ivy Holdings stock and vest based on a number of criteria, including time, Company and Business Unit performance based on EBITDA targets and CEO and Compensation Committee discretion. Since the Ivy Holdings stock options were granted to Company employees for their services related to the Company, the related compensation cost has been recorded in the Company's consolidated financial statements.

Under the terms of the Ivy Plan, the exercise price of an incentive stock option ("ISO") may not be less than 100% of the fair market value of the Company's common stock on the date of grant and, if granted to a shareholder owning more than 10% of the Company's common stock, then not less than 110%. Stock options granted under the Ivy Plan have a maximum term of 10 years from the grant date, and are exercisable at such time and upon such terms and conditions as determined by the Compensation Committee. Stock options granted to employees generally vest over four years, subject to continued service, performance, and other criteria. In the case of an ISO, the amount of the aggregate fair market

value of common stock with respect to which the ISO grant is exercisable, for the first time by an employee during any calendar year, may not exceed $100,000.

Stock Options Activity

The following table summarizes information about Ivy Holdings stock options outstanding as of September 30, 2014 and 2013 and activity during the years then ended:

	Shares Subject to Options	Weighted Average Exercise Price	Weighted Average Aggregate Intrinsic Value	Weighted Average Remaining Contractual Term (Months)
Outstanding as of September 30, 2012	112,583	$ 100.00	$ 20.00	104.2
Granted	18,462	120.00	—	—
Exercised	(3,513)	30.00	—	—
Canceled/Forfeited	(9,255)	61.68	—	—
Outstanding as of September 30, 2013 *(1)*	118,277	43.44	76.56	95.8
Granted	4,113	120.00	—	—
Exercised	—	—	—	—
Canceled/Forfeited	(5,957)	58.71	—	—
Outstanding as of September 30, 2014	116,433	$ 45.37	$ 74.63	84.10

(1) The number of options at September 30, 2013 includes 100,611 options modified in connection with the Repricing (see below).

The aggregate intrinsic value is calculated as the difference between the exercise price of the underlying awards and the estimated fair value of the Company's common stock for those awards that have an exercise price currently below the estimated fair value. As of September 30, 2014, the aggregate intrinsic value of outstanding shares was approximately $8,700,000. As of September 30, 2014, there were 102,931 options that are exercisable at a weighted average exercise price of $38.01.

A summary of Ivy Holdings non-vested options and the changes during the fiscal years ended September 30, 2014 and 2013 is presented as follows:

	Shares	Weighted Average Grant Date Fair Value
Ivy Holdings Stock Options:		
Nonvested at September 30, 2012	62,657	$ 50.73
Granted	18,462	62.83
Vested	(29,492)	92.53
Canceled/Forfeited	(8,435)	79.53
Nonvested at September 30, 2013 *(2)*	43,192	86.99
Granted	4,113	63.81
Vested	(29,890)	92.00
Canceled/Forfeited	(3,913)	82.72
Nonvested at September 30, 2014	13,502	$ 70.20

(2) The number of non-vested options at September 30, 2013 includes 29,930 options modified in connection with the repricing (see below).

On April 5, 2013, the Compensation Committee approved the repricing of the exercise price of all outstanding stock options as of that date. Pursuant to such resolution of the Ivy Holdings Compensation Committee, as of the effective date, all of the previously granted options were exchanged for new options with a lower exercise price granted on a one-for-one basis. As a result of this repricing, the Company repriced 49,380 vested options and 59,748 unvested options from an original exercise price of $100.00 per share to a new exercise price of $30.00 per share. Other than the exercise price, all other terms of the repriced options, such as vesting and contractual life, remained the same. The Company has accounted for the repricing as a modification and recorded any net incremental fair value related to vested awards as compensation expense on the date of modification. In addition, the Company is recording the incremental fair value related to the unvested awards, together with unamortized stock-based compensation expense associated with the unvested awards, over the remaining requisite service period of the option holders. In connection with the repriced options, the Company recorded stock compensation expense of $1,454,000 on the date of the modification. Incremental compensation cost resulting from the modification was $1,097,000 and $548,000 during the year ended September 30, 2014 and from the modification date through September 30, 2013, respectively.

The original fair value of the options granted ranges from $50.73 to $63.81 per option. In connection with the repricing, the stock compensation expense related to the stock options granted prior to April 5, 2013 is calculated based on a fair value of $97.75. The fair value was determined using the Black-Scholes option pricing model.

Fair value of the repriced options was estimated with the following assumptions for Ivy Holdings:

For the year ended September 30,	2013
Weighted average fair value of repriced options	$97.75
Estimated fair market value of the Company's common stock on the date of grant	$120.00
Weighted average expected life of the options	8.2 years
Risk-free interest rate	1.7%
Weighted average expected volatility	45.9%
Dividend yield	0.00%

Stock-Based Compensation Expense

Stock-based compensation expense for all share-based payments in exchange for employee services (including stock options and restricted stock) is measured at fair value on the date of grant, estimated using an option pricing model and is recognized in the consolidated financial statements, net of estimated forfeitures over the awards requisite service period.

The Company uses the Black-Scholes option pricing model and a single option award approach to estimate the fair value of options granted. Estimated forfeitures will be revised in future periods if actual forfeitures differ from the estimates and will impact compensation cost in the period in which the change in estimate occurs. The determination of fair value using the Black-Scholes option-pricing model is affected by the Company's estimated stock price as well as assumptions regarding a number of complex and subjective variables, including expected stock price volatility, risk-free interest rate, expected dividends and projected employee stock option exercise behaviors.

Prospect Medical Holdings, Inc.

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Fair value for options granted during the years ended September 30, 2014 and 2013 was estimated with the following assumptions for Ivy Holdings:

For the years ended September 30,	2014	2013
Weighted average fair value of option grants	$ 63.81	$ 62.83
Estimated fair market value of the Company's common stock on the date of grant	$ 120.00	$ 120.00
Weighted average expected life of the options	8.0 years	8.2 years
Risk-free interest rate	2.7%	1.7%
Weighted average expected volatility	45.0%	45.9%
Dividend yield	0.00%	0.00%

Expected Term - The expected term of options granted represents the period of time that they are estimated to be outstanding.

Risk-Free Interest Rate - The Company bases the risk-free interest rate on the implied yield in effect at the time of option grant on U.S. Treasury zero-coupon issues with equivalent remaining terms.

Expected Volatility—The Company estimates the volatility of the common stock at the date of grant based on the average of the historical volatilities of a group of peer companies. The Company has identified a group of comparable companies to calculate historical volatility from publicly available data for sequential periods approximately equal to the expected terms of the option grants. In selecting comparable companies, Management considered several factors including industry, stage of development, size and market capitalization.

Forfeitures—Share-based compensation is recognized only for those awards that are ultimately expected to vest. Compensation expense is recorded net of estimated forfeitures. Those estimates are revised in subsequent periods if actual forfeitures differ from those estimates. The Company used data since May 2005 to estimate pre-vesting option forfeitures.

Stock-based compensation expense for the Ivy Holdings stock options recognized during the years ended September 30, 2014 and 2013 was approximately $2,673,000 and $3,595,000 (including the impact of the option repricing noted above), respectively. At September 30, 2014, there were 13,502 unvested options which could potentially vest over the next three fiscal years, subject to meeting various vesting requirements which include time, discretion, and various performance targets as defined. The remaining maximum estimated stock compensation expense to be amortized to expense in future periods is approximately $960,000. The stock-based compensation expense is based on a number of criteria, including time, achievement of Company and Business Unit EBITDA targets and CEO and Compensation Committee discretion. Options which are expected to vest based on CEO and Compensation Committee discretion, are treated as variable stock options and are subject to revaluation at each reporting period. Management determined the fair value of the discretionary vested options using a Black Scholes calculation but determined that the change in compensation expense was not material to the consolidated financial statements for the years ended September 30, 2013 and 2014.

Dividends

The Company distributed $100 million in connection with the issuance of the Additional 2019 Notes, during the year ended September 30, 2013, which was recorded against retained earnings, and was ultimately paid to the common stockholders of Ivy Holdings.

10. Commitments and Contingencies

Leases

The Company leases various office facilities and equipment from third parties under non-cancelable operating and capital lease arrangements expiring at various dates through 2026. Certain operating leases contain rent escalation clauses and renewal options, which have been factored into determining rent expense on a straight-line basis over the lease terms. Capital leases bear interest at rates ranging from 2% to 11% per annum.

The future minimum annual lease payments (net of anticipated sublease income) required under leases in effect at September 30, 2014, are as follows (in thousands):

For the Years ending September 30,	Capital Leases	Operating Leases
2015	$ 5,776	$ 5,772
2016	3,215	4,746
2017	2,046	3,821
2018	1,438	3,098
2019	1,217	2,142
Thereafter	7,433	2,503
Total minimum lease payments	21,125	$ 22,082
Less: amounts representing interest	(5,971)	
	15,154	
Less: current portion	(4,691)	
	$ 10,463	

Rent expense for the years ended September 30, 2014 and 2013 was approximately $9,615,000 and $7,365,000, respectively. Sublease rental income of approximately $271,000 and $209,000, for the years ended September 30, 2014 and 2013, respectively, was recorded as a reduction to rental expense.

Litigation

The Company is subject to a variety of claims and suits that arise from time to time in the ordinary course of its business, acquisitions, or other transactions. While the Company's management currently believes that resolving all of these matters, individually or in the aggregate, will not have a material adverse impact on the Company's consolidated financial position or results of operations, the litigation and other claims that the Company faces are subject to inherent uncertainties and management's view of these matters may change in the future. Should an unfavorable final outcome occur, there exists the possibility of a material adverse impact on the Company's consolidated financial position, results of operations and cash flows for the period in which the effect becomes probable and reasonably estimable.

Following the acquisition of the Company in August 2010, two putative class action complaints were filed against the Company, each of the Company's special committee members, Ivy Holdings, LGP, and certain other parties. These complaints, which were consolidated into a single action, allege generally

that defendants breached their fiduciary duties, or aided and abetted others' breaches of their fiduciary duties, in connection with the transaction with the Company by, among other things, authorizing the transaction for what plaintiffs claim to be inadequate consideration and pursuant to what plaintiffs claim to be an inadequate process and with inadequate disclosures. An amended complaint was filed in July 2011 alleging the same general facts.

On December 30, 2010, another lawsuit was filed in Delaware Chancery Court by Terrier Partners and five related entities against the same defendants identified above. The complaint alleges generally that the consideration offered to shareholders in connection with the transaction with the Company was inadequate in light of the revenue received under AB 1383 (see California Hospital Fee Program below), and that defendants breached their fiduciary duties, or aided and abetted others' breaches of their fiduciary duties by not obtaining a higher price in light of this additional revenue.

In May 2012, the Court of Chancery granted motions to consolidate the Terrier Partners case and the class action cases, and for class certification, certifying the class as a non-opt out class. The Court also entered a schedule permitting the plaintiffs to file a new amended complaint, and on June 11, 2012, plaintiffs filed their Verified Consolidated Third Amended Class Action Complaint. On July 26, 2012, the director defendants answered the Third Amended Complaint. That same day, Prospect moved to dismiss itself as a party to the Third Amended Complaint. The Court granted the motion to dismiss the Company as a defendant, leaving only the individuals as defendants in the case.

The parties subsequently engaged in discovery, and agreed to stay the matter in order to explore the possibility of mediation, which was unsuccessful. The defendants have vigorously defended the matter, and will continue to do so. No trial date is currently set.

Many of the Company's payer and provider contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of medical services. Such differing interpretations may not come to light until a substantial period of time has passed following contract implementation. Liabilities for claims disputes are recorded when the loss is probable and can be estimated. Any adjustments to reserves are reflected in current operations.

Seismic Standards

Our SCHS Hospitals and Alta Los Angeles Hospitals are required to comply with California's Alfred E. Alquist Hospital Facilities Seismic Safety Act (the "Alquist Act"), which regulates the seismic performance of all aspects of hospital facilities in California. The Alquist Act imposes near-term and long-term compliance deadlines for seismic safety assessment, submission of corrective plans, and the retrofitting or replacement of medical facilities to comply with current seismic standards. The Alquist Act also requires that the California Building Standards Commission adopt earthquake performance categories, seismic evaluation procedures, standards and timeframes for upgrading certain facilities, and seismic retrofit building standards. These regulations require hospitals to meet seismic performance standards to ensure that they are capable of providing medical services to the public after an earthquake or other disaster. The Building Standards Commission completed its adoption of evaluation criteria and retrofit standards in 1998.

The Alquist Act requires that within three years after the Building Standards Commission had adopted evaluation criteria and retrofit standards:

- Hospitals in California must conduct seismic evaluation and submit these evaluations to the Office of Statewide Health Planning and Development ("OSHPD"), Facilities Development Division for its review and approval;

- Hospitals in California must identify the most critical nonstructural systems that represent the greatest risk of failure during an earthquake and submit timetables for upgrading these systems to the OSHPD, Facilities Development Division for its review and approval; and

- Hospitals in California must prepare a plan and compliance schedule for each regulated building demonstrating the steps a hospital will take to bring the hospital buildings into substantial compliance with the regulations and standards.

The Company was required to conduct engineering studies at its hospitals to determine whether and to what extent modifications to the hospital facilities will be required. Management believes that SCH Culver City meets all current requirements; however, it may be required to make significant capital expenditures in the future to comply with the seismic standards, which could impact its earnings. The cost at September 30, 2014, is unknown at this time but could be material. In addition, such modifications to the hospital facilities could potentially result in environmental remediation liabilities which may be material to the Company.

The OSHPD has a voluntary program to re-evaluate the seismic risk of hospital buildings classified as Structural Performance Category ("SPC") 1. These buildings are considered hazardous and at risk of collapse in the event of an earthquake and they were required to be retrofitted, replaced or removed from providing acute care services by 2013, unless granted an extension. OSHPD is using HAZARDS U.S. ("HAZUS"), a state-of-the-art methodology, to reassess the seismic risk of SPC-1 buildings and those that are determined to pose a low seismic risk may be reclassified to SPC-2. The SPC-2 buildings would have until 2030 to comply with the structural seismic safety standards. Participation in the HAZUS program is optional for hospital owners wishing to have their SPC-1 building(s) re-evaluated. Applications for a HAZUS re-evaluation of the seismic risk were submitted for SCH Hollywood, SCH Culver City and Los Angeles Community Hospital, but there is no assurance they will result in extensions.

In addition, in 2011, the California Legislature enacted Senate Bill 90, which permitted some hospitals to apply for up to an additional seven year extension to the seismic retrofit deadlines, not to extend beyond January 1, 2020. SB 90 also permits OSHPD to extend until January 1, 2018 the date by which the hospitals must obtain a building permit and commence the required retrofit project.

SCH Culver City and Los Angeles Community Hospitals both applied for the SB 90 extension from OSHPD. Two of the buildings owned by SCH Culver City were granted SB 90 extensions until January 2019 and July 2019, respectively. Also, the facility operated by Los Angeles Community Hospital received an SB 90 extension until January 2019. All three extensions are contingent upon the delivery of certain additional plans and reports prior to January 2015 that have either been delivered or are in process at the time of this report. OSHPD is still reviewing the SB 90 extension request filed for a third building owned by SCH Culver City, which is also still subject to our application to be reclassified as a SPC-2 building.

OSHPD has discretion to approve or disapprove SB 90 extension requests, and to determine the length of the extension (up to the maximum seven years), based on eligibility factors including seismic risks associated with the affected buildings (which can be impacted by the updated HAZUS findings), community access to essential hospital services in the area and financial hardships facing the applicant.

Effective May 6, 2014, Prospect acquired the hospital facilities NSH and LACH Bellflower (see Note 4). For the newly acquired facilities, the Company is in the process of pursuing Non-Structural Performance Category ("NPC") 2 classification and the extension of the compliance deadlines that would result.

These requirements can result in significant operational changes and capital outlays. Management is continuing to assess its options and the methods of financing the required retrofits. Based on management's evaluation, the costs of renovation needed to comply with the California seismic safety standards for its acute-care facilities, including asbestos abatement, are not estimable at this time.

Legislation and HIPAA

The healthcare industry is subject to numerous laws and regulations of federal, state and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government healthcare program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Government activity has continued with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed.

The Company believes that it is in compliance with fraud and abuse regulations as well as other applicable government laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time.

The Health Insurance Portability and Accountability Act ("HIPAA") assures health insurance portability, reduces healthcare fraud and abuse, guarantees security and privacy of health information, and enforces standards for health information. The Health Information Technology for Economic and Clinical Health Act ("HITECH Act") expanded upon HIPAA in a number of ways, including establishing notification requirements for certain breaches of protected health information. In addition to these federal rules, California has also developed strict standards for the privacy and security of health information as well as for reporting certain violations and breaches. The Company may be subject to significant fines and penalties if found not to be compliant with these state or federal provisions.

Affordable Care Act

The Patient Protection and Affordable Care Act ("PPACA") will substantially reform the United States health care system. The legislation impacts multiple aspects of the health care system, including many provisions that change payments from Medicare, Medicaid and insurance companies. Starting in 2014, the legislation requires the establishment of health insurance exchanges, which will provide individuals without employer-provided health care coverage the opportunity to purchase insurance. It is anticipated that some employers currently offering insurance to employees will opt to have employees seek insurance coverage through the insurance exchanges. It is possible that the reimbursement rates paid by insurers participating in the insurance exchanges may be substantially different than rates paid under current health insurance products. Another significant component of the PPACA is the expansion of the Medicaid program to a wide range of newly eligible individuals. In anticipation of this expansion, payments under certain existing programs, such as Medicare disproportionate share, will be substantially decreased. Each state's participation in an expanded Medicaid program is optional.

California Hospital Fee Program

The State of California enacted Assembly Bill 1383 ("AB 1383") effective January 1, 2010, as amended by Assembly Bill 1653 (collectively, the "Program"), to provide supplemental payments to certain hospitals such as the hospitals owned and operated by the Company's subsidiaries. The Program requires participating hospitals to pay fee assessments into a pool of funds to which the federal government contributes matching funds. Most of these funds, including the federal matching funds, are then distributed to qualifying hospitals. In addition, on April 13, 2011 SB 90 was signed into law and provided for a six-month extension of the Hospital Fee Program for dates of service from January 1, 2011 through June 30, 2011. CMS granted final approval of SB 90 on December 29, 2011, at which point the revenue and expense was recognized for the retroactive period. In September 2011, the State of California enacted Senate Bill 335 ("SB 335") which provides a 30-month hospital fee program for dates of service from July 1, 2011 through December 31, 2013. The elements of SB 335 related to the fee for service payments were approved by CMS on June 22, 2012. The payments due under the managed care component are scheduled to be made in three cycles. The first two cycles were previously approved by CMS, and the third cycle was approved by CMS subsequent to September 30, 2014. Certain technical changes to the legislation required by CMS are included in Senate Bill 920.

Governor Brown signed Senate Bill 239 ("SB 239") in October 2013, which enacted a hospital fee program for the period January 1, 2014 through December 31, 2016. This program was approved by CMS on December 5, 2014. SB 239 provides that the hospital fee program will continue through December 31, 2022 in three year cycles and will require authorization of each cycle by the California legislature. The Company has not recognized any amounts related to SB 239 as of and for the years ended September 30, 2014 and 2013.

For the years ended September 30, 2012 and 2011, SCH Culver City received invoices for fee assessments under AB 1383 and SB 90 of approximately $6,310,000 and $19,000,000, respectively, following payment of which, SCH Culver City was scheduled to receive approximately $5,236,000 and $15,000,000, respectively. Management of SCH Culver City estimated that SCH Culver City would be a "net" payer under the Program, since the fee assessments on SCH Culver City exceeded the supplemental payments by approximately $1,074,000 and $4,000,000, respectively. Accordingly, on October 6, 2010, the Company notified the California Department of Healthcare Services ("DHCS") that SCH Culver City was opting out of the Program.

SCH Culver City did not pay the required fee assessments under the Program. Beginning February 14, 2011, the DHCS began withholding against amounts otherwise due SCH Culver City, in the amount of $65,000 per week indicating that withholdings would continue for 108 weeks and would total approximately $7,000,000. Through September 30, 2012, a total of approximately $2,986,000 had been withheld against SCH Culver City's Medi-Cal fee-for-service payments. As of September 30, 2012, SCH Culver City recorded a liability of approximately $5,494,000, representing the accrued loss above, as well as deferred recognition of payments received from managed care plans. On November 15, 2012 the Company entered into a settlement agreement with DHCS with regards to SCH Culver City's liability under AB 1383, SB 90 and SB 335, as discussed above. Under the terms of the agreement, the DHCS agreed to forgive approximately $2,000,000 of the fees due under AB 1383, which was recorded by the Company during the year ended September 30, 2013. The remaining liability due to DHCS of $4,605,000 will be repaid by the Company monthly over a 10-year period without interest or penalties. The Company recorded a net liability of $3,233,000 as of the settlement date, which represents the net present value of the liability due to DHCS discounted at an effective interest rate of 7.5%. As of September 30, 2014 and 2013, the unamortized balance of the liability amounted to $2,806,000 and $3,046,000, respectively. The DHCS will no longer withhold against any other amounts due to SCH Culver City unless the Company is delinquent on payments owed under the agreement.

As of September 30, 2013, the Company had a receivable related to the California Hospital Fee Program of $18,895,000 in the accompanying consolidated balance sheets. The Company did not have a receivable related to the California Hospital Fee Program as of September 30, 2014. As of September 30, 2014 and 2013, the Company had a liability related to the California Hospital Fee Program of $2,806,000 and $8,609,000, respectively, in the accompanying consolidated balance sheets.

Total California Hospital Fee program revenues and expenses recognized during the years ended September 30, 2014 and 2013 were as follows (in thousands):

Year Ended September 30,	2014	2013
Hospital services revenues	$ 11,884	$ 63,371
Hospital operating expenses	5,863	37,925
Net pre-tax impact	$ 6,021	$ 25,446

Collective Bargaining Agreements

A small group of employees at SCH Hollywood, which is one of the hospitals under the consolidated group of Alta Hospitals System, LLC, and Service Employees International Union, United Healthcare Workers-West ("SEIU") are currently parties to a collective bargaining agreement with a termination date of April 27, 2017. In addition, approximately 77% of the employees of SCH Culver City are part of a collective bargaining agreement with the SEIU or the California Nurses Association ("CNA"). SCH Culver City and CNA are currently parties to a collective bargaining agreement that expires on December 21, 2015. SEIU and SCH Culver City are currently parties to a three-year term agreement that expires on April 27, 2017.

As of September 30, 2014, approximately 25% of the employees at CharterCARE St. Joseph's are subject to a collective bargaining agreement with United Nurses and Allied Professionals ("UNAP"), which expires July 31, 2016. An additional 1% are subject to a collective bargaining agreement with the Federation of Nurses and Health Professionals ("FNHP"), which expires April 30, 2016.

Tangible Net Equity ("TNE") requirement

The Company's affiliated physician organizations must comply with a minimum working capital requirement, Tangible Net Equity ("TNE") requirement, cash-to-claims ratio and claims payment requirements prescribed by the California Department of Managed Health Care. TNE is defined as net assets, less intangibles and amounts due from affiliates, plus subordinated obligations. At September 30, 2014 and 2013, the Company and the affiliated physician organizations were in compliance with these regulatory requirements.

Employee Health Plans

From October 1, 2012 through December 31, 2012, the Company (except for SCH Culver City and Nix Health) was fully insured for its HMO and PPO plans to employees. For the fully insured groups, health benefits were administered by a commercial insurance carrier, based on plan coverage and eligibility guidelines determined by the Company. The insurance policies had guaranteed cost and the Medical Group and Corporate segment incurred no claim liability if terminated. SCH Culver City and Nix were self-insured for their EPO/HMO and PPO plans.

Effective January 1, 2013 the Company offered self-insured EPO/HMO and PPO plans to all eligible employees. The CharterCARE hospitals were not included under such plans from the date of acquisition through September 30, 2014 and have a separate low-deductible plan. Employee health benefits are administered by a third party claims administrator, based on plan coverage and eligibility guidelines determined by the Company, as well as by collective bargaining agreements (as reflected above). A commercial insurance policy covers losses in excess of $250,000 per occurrence for the Hospital Segment and $175,000 for the Medical Group and Corporate segments. An actuarially estimated liability of approximately $1,828,000 and $1,788,000 for incurred but not reported claims has been included in accrued salaries, wages, and benefits as of September 30, 2014 and 2013, respectively.

Provider Contracts

Many of the Company's payer and provider contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of medical services. Such differing interpretations may not come to light until a substantial period of time has passed following contract implementation. Liabilities for claims disputes are recorded when the loss is probable and can be estimated. Any adjustments to reserves are reflected in current operations.

11. Defined Contribution Plan

The Company sponsors a defined contribution plan covering substantially all employees who meet certain eligibility requirements. Under this plan, employees can contribute up to 100% of their compensation up to the IRS deferred annual maximum. There is currently no company match offered under the plan, except at Nix Health and PCC, for which the expense for the employer match was $576,000 and $463,000 for the years ended September 30, 2014 and 2013, respectively. Total expenses under the plan were approximately $197,000 and $87,000 during the years ended September 30, 2014 and 2013, respectively.

12. Accrued Medical Claims and Other Healthcare Costs Payable

The following table presents the roll-forward of incurred but not reported ("IBNR"), claims reserves (Medical Group and full risk contracts) as of and for each of the fiscal years ended September 30, 2014 and 2013 (in thousands):

September 30,	2014	2013
IBNR as of beginning of year	$ 30,352	$ 26,985
Claim expenses incurred during the year:		
Related to current year	161,088	128,747
Related to prior year	(3,571)	(3,646)
Total incurred	157,517	125,101
Claims paid during the year:		
Related to current year	(124,393)	(100,301)
Related to prior year	(24,162)	(21,433)
Total paid	(148,555)	(121,734)
IBNR as of end of year	$ 39,314	$ 30,352

Following is a table showing the details of the medical group cost of revenues per the consolidated statements of operations (in thousands):

Years Ended September 30,	2014	2013
Capitation expense	$ 85,754	$ 76,918
Fee-for-service claims expense	94,749	82,846
Other physician compensation	5,066	3,993
Other cost of revenues	(227)	700
Total cost of revenues	$ 185,342	$ 164,457

13. Joint Venture

The Company (through Prospect Medical Group, Inc.) and an unrelated third party, AMVI Care Health Network, Inc. ("AMVI") are partners in a joint venture initially formed to service Medi-Cal members under the CalOptima program in Orange County, California. Healthy Families and OneCare members were subsequently added to the joint venture arrangement. Effective January 1, 2013, all Healthy Family participants were transferred to the Company's Medi-Cal line of business and therefore no longer part of the joint venture. The Company does not consolidate the joint venture. The Company includes in its consolidated financial statements only the net results attributable to those enrollees specifically identified as assigned to it, together with the management fee that it charges the joint venture partner for managing those enrollees specifically assigned to AMVI. Costs incurred by the Company in managing the joint venture are included in general and administrative expenses in the accompanying consolidated financial statements. As of September 30, 2014 and 2013, the net liability balances of the Company investment in the joint venture under the equity method were approximately $1,594,000 and $2,000,000, respectively, and were included in accounts payable and other accrued liabilities in the accompanying consolidated financial statements.

Summarized unaudited financial information for the unconsolidated joint venture as of and for each of the years ended September 30, 2014 and 2013 is as follows (in thousands):

September 30,	2014	2013
Cash	$ 1,753	$ 742
Receivables	2,232	2,037
Total assets	$ 3,985	$ 2,779
Accrued medical claims	$ 1,658	$ 1,556
Other payables	1,470	34
Other partner's capital	856	1,188
Prospect's capital	1	1
Total liabilities and partner's capital	$ 3,985	$ 2,779

Years Ended September 30,	2014	2013
Revenues	$ 19,289	$ 16,307
Income before income taxes	$ 2,915	$ 2,206
Prospect's equity income	$ 3,295	$ 2,150
Management fees earned by Prospect	$ 1,141	$ 1,016

14. Segment Information

The Company's operations are organized into three reporting segments: (i) Hospital Services – which is comprised of the Alta Hospitals, SCH Culver City, Nix Health, and PCC reporting units, owns 13 hospitals or extended care facilities – Los Angeles Community Hospital, Norwalk Community Hospital, Los Angeles Community Hospital at Bellflower, Newport Specialty Hospital, SCH Hollywood, SCH Van Nuys, SCH Culver City, Nix Medical Center, Nix Specialty Health Center, Nix CGH, Roger Williams Medical Center, Saint Joseph's Health Services of Rhode Island, and Elmhurst Extended Care; (ii) Medical Group – which is comprised of the Prospect and ProMed reporting units, provides management services to affiliated physician organizations that operate as independent physician associations or medical practice groups and certain unaffiliated independent physician associations; and (iii) Corporate, which represents expenses incurred in Prospect Medical Holdings, Inc., that were not allocated to the other reporting segments.

The accounting policies of the reporting segments are the same as those described in the summary of significant accounting policies (see Note 2). The Company evaluates financial performance and allocates resources primarily based on earnings from operations before interest expense, interest income, income taxes, depreciation and amortization, as well as income or loss from operations before income taxes, excluding infrequent or unusual items.

The reporting segments are strategic business units that offer different services within the healthcare industry. Business in each reporting segment is conducted by one or more direct or indirect wholly-owned subsidiaries of the Company and certain affiliated physician organizations controlled through assignable option agreements and management services agreements. The Company voluntarily discloses the following table which summarizes certain information for each of the reporting segments regularly provided to and reviewed by the chief operating decision maker (in thousands):

	As of and for the Year Ended September 30, 2014				
	Hospital Services *(3)*	Medical Group *(2)*	Corporate *(1)*	Intersegment Eliminations	Consolidated
Revenues from external customers	$ 600,536	$ 253,980	$ -	$ -	$ 854,516
Intersegment revenues	-	1,039	-	(1,039)	-
Total revenues	600,536	255,019	-	(1,039)	854,516
Depreciation and amortization	20,694	2,846	40	-	23,580
Operating income (loss)	57,748	29,080	(20,676)	-	66,152
Other (income) expense	(3,037)	(26)	38,480	1,622	37,039
Income (loss) before income taxes	60,785	29,106	(59,156)	(1,622)	29,113
Provision for income tax	-	-	10,561	-	10,561
Net income (loss)	$ 60,785	$ 29,106	$ (69,717)	$ (1,622)	$ 18,552
Identifiable segment assets	$ 599,516	$ 75,612	$ 86,189	$ -	$ 761,317
Segment capital expenditures, net of dispositions	$ 49,181	$ 924	$ 2	$ -	$ 50,107
Segment goodwill	$ 136,525	$ 22,339	$ -	$ -	$ 158,864

Prospect Medical Holdings, Inc.

Notes to Consolidated Financial Statements

	As of and for the Year Ended September 30, 2013				
	Hospital Services *(3)*	Medical Group *(2)*	Corporate *(1)*	Intersegment Eliminations	Consolidated
Revenues from external customers	$ 491,839	$ 221,743	$ -	$ -	$ 713,582
Intersegment revenues	-	727	-	(727)	-
Total revenues	491,839	222,470	-	(727)	713,582
Depreciation and amortization	14,062	2,715	37	-	16,814
Operating income (loss)	75,199	24,399	(17,442)	-	82,156
Other (income) expense	1,314	(49)	37,839	-	39,104
Income (loss) before income taxes	73,885	24,448	(55,281)	-	43,052
Provision for income tax	-	-	9,810	-	9,810
Net income (loss)	$ 73,885	$ 24,448	$ (65,091)	$ -	$ 33,242
Identifiable segment assets	$ 453,232	$ 117,556	$ 8,158	$ -	$ 578,946
Segment capital expenditures, net of dispositions	$ 13,583	$ 650	$ 50	$ -	$ 14,283
Segment goodwill	$ 136,526	$ 22,338	$ -	$ -	$ 158,864

(1) Prospect files consolidated tax returns and allocates costs for shared services and corporate overhead to each of the reporting segments. With the exception of Nix Health and PCC, all debt, including debt related to the Medical Group and Hospital Services segment, is recorded at the Parent Entity level. The Company does not allocate interest expense related to acquisition debt to the operating segments.

(2) Prospect Medical Group, Inc. (which serves as a holding company for the other affiliated physician organizations) files consolidated tax returns. The Medical Group segment includes the results for NGMA from October 1, 2012 (acquisition date) through September 30, 2014.

(3) The Hospital Services segment includes the results for Nix CGH, Los Angeles Community Hospital at Bellflower and Newport Specialty Hospital, and CharterCARE from the acquisition dates of April 16, 2013, May 6, 2014, and June 20, 2014, respectively, through September 30, 2014. Included in revenues from external customers are $14,525,000 and $7,700,000 of other revenues related primarily to the CMS Rural Floor settlement, meaningful use incentive payments and rental revenue from operating leases for the years ended September 30, 2014 and 2013, respectively.

15. Subsequent Events (Unaudited)

The Company has evaluated subsequent events through December 17, 2014, the date the Company's consolidated financial statements were available for issuance.

Acquisitions

Effective October 21, 2014, the Company, through its subsidiary, Prospect CharterCARE Physicians, LLC ("PCCP"), entered into two separate asset purchase agreements pursuant to which PCCP will acquire substantially all of the assets of physician medical practices located in Rhode Island.

Pursuant to the first purchase agreement, PCCP will acquire substantially all of the assets of Physicians of Rhode Island Medical Enterprises, Inc., a primary care practice group with one physician and five nurse practitioners located in Cumberland, Rhode Island, and PMA, LLC, a primary care practice group with one physician and one nurse practitioner located in Pawtucket, Rhode Island. Pursuant to the same purchase agreement, on October 21, 2014, PCCP acquired 49% of the issued and outstanding membership interests in Partners in Clinical Research, LLC, a clinical research business located in Cumberland, Rhode Island. The Company paid $2,410,000 as consideration under the asset purchase agreement.

Pursuant to the second purchase agreement, PCCP will acquire substantially all of the assets of Physicians of East Side Primary Care, LLC, a primary care practice group with one physician, two physician assistants and one nurse practitioner located in Providence, Rhode Island. The Company paid $860,000 as consideration under this asset purchase agreement. Additionally, on each of the first four (4) anniversaries of the October 21st closing date, the Company will pay to the seller an EBITDA bonus based on the performance of the acquired practice.

The majority of the assets of the groups were acquired on October 21, 2014. However, the acquisition of certain professional licenses and related assets, and the employment of certain professional staff, will occur at a later date after all necessary licensing and credentialing by PCCP has occurred. PCCP and the sellers of the groups have entered into Interim Administrative Services Agreements that will provide for the administration of the seller entities during the period prior to such second acquisition dates. PCCP and the two physicians that are the principal owners of the seller entities have entered into employment agreements and non-compete restrictions. Additionally, PCCP entered into three (3) separate office leases with five (5) year terms that provide for the lease of the spaces currently occupied by the practices. The lessors under each office lease are the employed physicians that are the former principal owners of the groups.

California Hospital Fee Program

Governor Brown signed SB 239 in October 2013, which enacted a hospital fee program for the period January 1, 2014 through December 31, 2016. The fee for service component of the program was approved by CMS on December 5, 2014, and the managed care component has not yet been approved. The Company has not recognized any amounts related to SB 239 as of and for the year ended September 30, 2014. The Company anticipates a net benefit from the program for service periods from January 1, 2014 to December 31, 2016.

EXHIBIT Q8-2 - PMH'S FISCAL YEAR 2015 2ND QUARTER UNAUDITED FINANCIAL STATEMENTS

Prospect Medical Holdings, Inc.
August 14, 2015

PROSPECT MEDICAL HOLDINGS, INC.
CONDENSED CONSOLIDATED BALANCE SHEETS
(In thousands, except par value and share amounts)

	June 30, 2015 (unaudited)	September 30, 2014
ASSETS		
Current assets:		
Cash and cash equivalents	$ 34,708	$ 39,072
Restricted cash	4,298	4,976
Investments, primarily restricted money market funds	1,266	642
Patient accounts receivable, net of allowance for doubtful accounts of $53,724 and $49,727	143,810	123,733
Due from government payors	55,100	42,518
Other receivables	24,425	15,947
Income taxes receivable, net	3,685	57
Deferred income taxes, net	68,304	68,304
Inventories	12,373	10,448
Hospital fee program receivable	24,011	-
Prepaid expenses and other current assets	20,674	14,317
Total current assets	392,654	320,014
Property, improvements and equipment, net	237,923	229,474
Deferred financing costs, net	7,789	9,457
Goodwill	161,461	158,864
Intangible assets, net	31,454	35,274
Other assets	9,341	8,234
Total assets	$ 840,622	$ 761,317
LIABILITIES AND STOCKHOLDER'S EQUITY (DEFICIT)		
Current liabilities:		
Accrued medical claims and other healthcare costs payable	$ 50,633	$ 39,314
Accounts payable and other accrued liabilities	94,467	88,218
Accrued salaries, wages and benefits	59,424	53,808
Hospital fee program liability	13,623	2,806
Due to government payors	36,428	26,584
Income taxes payable, net	6,120	5,879
Revolving line of credit	20,000	20,000
Current portion of capital leases	3,285	4,691
Current portion of long-term debt	568	133
Other current liabilities	1,481	1,659
Total current liabilities	286,029	243,092
Long-term debt, net of current portion	422,464	421,755
Deferred income taxes, net	70,447	70,447
Malpractice reserves	6,619	4,590
Capital leases, net of current portion	9,096	10,463
Asset retirement obligations	4,514	4,310
Other long-term liabilities	6,632	7,866
Total liabilities	805,801	762,523
Commitments, Contingencies and Subsequent Events		
Stockholder's equity (deficit):		
Common stock, $0.01 par value; 100 shares authorized, issued and outstanding at June 30, 2015 and September 30, 2014	1	1
Additional paid-in capital	20,647	18,457
Retained earnings (Accumulated deficit)	3,565	(28,481)
Total Prospect Medical Holdings, Inc.'s stockholder's equity (deficit)	24,213	(10,023)
Noncontrolling interest	10,608	8,817
Total stockholder's equity (deficit)	34,821	(1,206)
Total liabilities and stockholder's equity (deficit)	$ 840,622	$ 761,317

Prospect Medical Holdings, Inc.
August 14, 2015

PROSPECT MEDICAL HOLDINGS, INC.
CONDENSED CONSOLIDATED STATEMENTS OF OPERATIONS
(Unaudited, in thousands)

	Three Months Ended June 30,		Nine Months Ended June 30,	
	2015	2014	2015	2014
Revenues:				
Net Hospital Services revenues	$ 238,378	$ 131,472	$ 760,537	$ 383,183
Medical Group revenues	91,018	69,575	235,945	181,795
Net Global Risk Management revenues	813	-	1,389	-
Other revenues	690	1,485	5,465	2,603
Total net revenues	330,899	202,532	1,003,336	567,581
Operating expenses:				
Hospital operating expenses	185,976	102,517	594,046	291,154
Medical Group cost of revenues	52,613	47,121	161,679	134,385
Global Risk Management operating expenses	710	-	1,152	-
General and administrative	49,172	32,864	143,064	86,095
Depreciation and amortization	8,676	5,488	25,212	15,481
Total operating expenses	297,147	187,990	925,153	527,115
Operating income from unconsolidated joint ventures	3,119	1,001	4,133	1,604
Operating income	36,871	15,543	82,316	42,070
Other (income) expense:				
Interest expense and amortization of deferred financing costs, net	10,491	10,282	31,535	30,946
Gain on bargain purchase adjustment	-	(4,068)	318	(4,068)
Other (income) expense	(25)	(50)	(71)	61
Total other expense, net	10,466	6,164	31,782	26,939
Income before income taxes	26,405	9,379	50,534	15,131
Income tax provision	9,579	3,403	18,464	5,934
Net income	16,826	5,976	32,070	9,197
Net income attributable to noncontrolling interest	268	1,489	26	1,503
Net income attributable to Prospect Medical Holdings, Inc.	$ 16,558	$ 4,487	$ 32,044	$ 7,694

Prospect Medical Holdings, Inc.
August 14, 2015

PROSPECT MEDICAL HOLDINGS, INC.
CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS
(Unaudited, in thousands)

	Nine Months Ended June 30,	
	2015	2014 (1)
Operating activities		
Net income	$ 32,070	$ 9,197
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	25,212	15,481
Amortization of deferred financing costs, net	1,668	1,662
Amortization of original issue (premium) discount	810	810
Provision for bad debts	34,634	25,258
Stock-based compensation	2,018	2,018
Undistributed earnings from equity method investments	(172)	-
Gain on sale of assets	(25)	-
Gain on bargain purchase adjustment	318	(4,068)
Gain on sale of equity method investment	(296)	-
Change in operating assets and liabilities, net of business combinations:		
Patient accounts receivable and other receivables	(65,322)	(39,655)
Due to/from government payors, net	(2,737)	(2,876)
Prepaid expenses and other current assets	(1,885)	(2,503)
Hospital fee program receivable	(24,011)	18,895
Hospital fee program liability	10,817	(5,733)
Inventories	(1,927)	17
Income taxes receivable/payable, net	(3,387)	(10)
Deposits and other assets	(33)	298
Accrued medical claims and other healthcare costs payable	11,319	6,852
Accounts payable and other accrued liabilities	13,243	3,937
Net cash provided by operating activities	32,314	29,579
Investing activities		
Purchases of property, improvements and equipment	(28,517)	(41,141)
Proceeds from sale of property and improvements	987	-
Cash paid for acquisitions, net of cash received and working capital adjustment	(895)	(58,300)
Cash paid for equity method investment	(1,880)	(1,100)
Proceeds for partial disposition of equity method investment	1,233	-
Collections from note receivable	52	674
Increase in restricted investments	(624)	(5)
Issuance of note receivable	-	(625)
Net cash (used in) investing activities	(29,644)	(100,497)
Financing activities		
Repayments of long-term debt	(100)	(127)
Borrowings on line of credit, net	-	40,000
Repayments of capital leases	(3,685)	(3,945)
Cash paid for deferred financing costs, net	-	(50)
Change in restricted cash	678	(2,423)
Proceeds from exercises of stock options and warrants	172	-
Repayments of insurance premiums financing	(4,099)	(1,628)
Other, net	-	(17)
Net cash (used in) provided by financing activities	(7,034)	31,811
(Decrease) in cash and cash equivalents	(4,364)	(39,108)
Cash and cash equivalents at beginning of period	39,072	86,315
Cash and cash equivalents at end of period	$ 34,708	$ 47,207

Continued at next page

PROSPECT MEDICAL HOLDINGS, INC.
CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS
(Unaudited, in thousands)
(continued)

	Nine Months Ended June 30,	
	2015	2014
Supplemental disclosure of cash flow information:		
Interest paid	$ 37,545	$ 36,927
Income taxes paid, net	$ 21,777	$ 6,179
Schedule of non-cash investing and financing activities:		
Equipment acquired under capital leases	$ 905	$ 1,892
Insurance premium financed	$ 4,472	$ 2,122
Long-term liability assumed from acquisition of CharterCARE	$ -	$ 6,440

(1) Certain reclassifications were made to the fiscal 2014 presentation in order to conform to the fiscal 2015 presentation.

EXHIBIT Q10-1 - NEW FOUNDATION CERTIFICATE OF INCORPORATION (DRAFT)

Exhibit Q10-1

CERTIFICATE OF INCORPORATION

[NAME TO BE DETERMINED]

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

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

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

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

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

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

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

(g) To work cooperatively with Prospect Medical Holdings, Inc. ("PMH") to ensure and augment a network of affordable and accessible health and medical care in the region; provided, however, that the Corporation will not support programs operated by or for the direct benefit of PMH while it operates as a for profit entity; and

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

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

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

4. The Corporation shall have no members.

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

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

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

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

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

(d) A member of the governing board or an employee of PMH or one of its affiliates for two years after their service on the board in question or employment ends, as the case may be.

6. No part of the net earnings of the Corporation shall inure to the benefit of or be distributable to the Corporation's Directors, officers or other private persons, except that the Corporation shall be authorized and empowered to pay reasonable compensation for services rendered and to make payments and distributions in furtherance of the purposes set forth in Paragraph 2 hereof. No substantial part of the activities of the Corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation, and the Corporation shall not participate in, or intervene in (including the publishing or distribution of statements), any political campaign on behalf of (or in opposition to) any candidate for public office. Notwithstanding any other provision of this Certificate of Incorporation, the

Corporation shall not carry on any other activities not permitted to be carried on by a corporation exempt from federal income taxation under section 501(c)(3) of the Code or by a corporation contributions to which are deductible under section 170(c)(2) of the Code.

7. If in any taxable year the Corporation is a private foundation as defined by section 509 of the Code, the Corporation will distribute its income for each such tax year at a time and in a manner as not to become subject to the tax on undistributed income imposed by section 4942 of the Code. Further, in any such year the Corporation will not (1) engage in any act of self-dealing as defined in section 4941(d) of the Code, (2) retain any excess business holdings as defined in section 4943(c) of the Code, (3) make any investments in a manner as to subject it to tax under section 4944 of the Code, or (4) make any taxable expenditures as defined in section 4945(d) of the Code.

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

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

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

11. The Corporation's initial registered office is _____ Connecticut _____. The Corporation's initial registered agent at that office is _____, with a business address of _____, Connecticut _____, and a residence address of _____, Connecticut _____.

Acceptance of Appointment

_____

12. The incorporator of the Corporation is _____, with an address of _____, Connecticut.

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

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

Dated at _____, Connecticut, this_____ day of _____, 201_.

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

_____

Incorporator

765/2611/3333909.2

EXHIBIT Q10-2 - NEW FOUNDATION BYLAWS (DRAFT)

Exhibit Q10-2

CORPORATE BYLAWS

[NAME TO BE DETERMINED]

ARTICLE I

NAME AND OFFICES

Section 1.1. Name

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

Section 1.2. Offices

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

ARTICLE II

PURPOSES

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

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

ARTICLE III

BOARD OF DIRECTORS

Section 3.1. Powers and Duties

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

Section 3.2. Number and Composition

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

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

Section 3.3. Eligibility

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

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

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

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

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

(d) A member of the governing board or an employee of PMH or one of its affiliates for two years after their service on the board in question or employment ends, as the case may be.

Section 3.4. Appointment, Election, and Term

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

Section 3.4.1. Terms

The Incorporator shall assign the initial Directors to initial terms that will establish a Board of Directors with staggered three (3) year terms, with approximately one-third appointed to a one (1) year term, approximately one-third appointed to a two (2) year term, and approximately one-third appointed to a three (3) year term. Directors shall thereafter be appointed or elected, as the case may be, to three (3) years terms except for those Directors who are appointed or elected to fill an unexpired term, and further provided, that the Board of Directors may assign newly-elected Elected Directors to such shorter terms as may be necessary to maintain a balanced staggered Board.

Section 3.4.2. Directors Appointed by Supported Organizations

Each Supported Organization shall appoint one (1) Director. If the Supported Organization is a municipality, it shall effect its appointment through a written communication from its chief elected officer, whether denoted Mayor, First Selectperson, or by another term, directed to the President of the Board of Directors. If the Supported Organization is an organization exempt under section 501(c)(3) of the Code, it shall effect its appointment through a written communication from its chief executive officer (or, if no such position is then held, by the President of its Board of Directors) directed to the President of the Board of Directors. An Appointed Director does not represent or advocate for the specific interests of the Supported Organization that appointed such Director but acts in the best interests of the Corporation generally.

Section 3.4.3 . Elected Directors

The Board of Directors may elect one (1) or more Elected Directors, provided that the number of Elected Directors must be less than half of the Directors. Elected Directors shall possess experience, knowledge, or perspectives that will augment the strength and competence of the Board as a whole. Directors shall generally be elected to three (3) year terms subject to the ability of the Board of Directors under Section 3.4.1 to assign shorter terms as may be necessary to maintain a balanced staggered Board.

Section 3.5. Resignation

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

A Director who ceases to reside or work in the Communities shall automatically be deemed to have resigned from the Board of Directors. A Director who becomes (1) a member of the local (or advisory) board of the two hospitals owned by PMH or (2) a member of the governing board or an employee of PMH or one of its affiliates shall automatically be deemed to have resigned from the Board of Directors.

Section 3.6. Removal

Section 3.6.1. Appointed Directors

An Appointed Director may be removed with or without cause by the Supported Organization that appointed the Director. If the Supported Organization is a municipality, it shall effect the removal through a written communication from its chief elected officer, whether denoted Mayor, First Selectperson, or by another term, directed to the President of the Board of Directors. If the Supported Organization is an organization exempt under section 501(c)(3) of the Code, it shall effect the removal through a written communication from its chief executive officer (or, if no such position is then held, by the President of its Board of Directors) directed to the President of the Board of Directors. The effective date of removal shall be the date of receipt of the communication or such later date as is specified in the written communication. A Director removed in accordance with this section shall be notified in writing of said removal.

Section 3.6.2. Elected Directors

An Elected Director may be removed with or without cause by the Board of Directors upon the affirmative vote of a majority of the Directors present and voting at a meeting, a quorum being present, provided that each Director shall have been given written notice prior to the meeting that a purpose of the meeting is to consider the removal of the Director in question. The effective date of removal shall be the date of the meeting at which the vote of the Board of Directors regarding the Director in question occurred, unless otherwise provided by the Board of Directors. A Director removed in accordance with this section shall be notified in writing of said removal.

Section 3.7. Vacancies

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

Section 3.8. Compensation

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

Section 3.9. Regular Meetings of the Board of Directors

The Board of Directors shall have regular meetings at least four (4) times each year at such times and places as the Board may determine. Reasonable notice of the date, time, and place of each such meeting shall be given to each Director by mail, telephone, telefax, other electronic means, or personally a minimum of two (2) days prior to the meeting, provided that no notice need be given of any meeting held in accordance with a schedule of regular meetings distributed to Directors.

Section 3.10. Special Meetings of the Board of Directors

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

Section 3.11. Annual Meeting of the Board of Directors

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

Section 3.12. Waiver of Notice

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

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

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

Section 3.14. Quorum

A majority of the number of Directors in office immediately before a meeting of the Board begins shall constitute a quorum for the transaction of business at that meeting. If a quorum is not

present at any meeting of the Board of Directors, a majority of the Directors present may adjourn the meeting, from time to time, without notice other than announcement at the meeting, until a quorum is present.

Section 3.15. Voting

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

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

Section 3.16. Director Participation in Meeting by Telephone or Other Communications Equipment

A Director or a member of a committee of the Board of Directors may participate in a meeting of the Board of Directors or of such committee by means of conference telephone or similar communications equipment enabling all Directors participating in the meeting to hear one another, and participation in a meeting pursuant to this subsection shall constitute presence in person at such meeting.

Section 3.17. Indemnification

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

ARTICLE IV

OFFICERS

Section 4.1. Designation of Officers

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

Section 4.2. Election, Term of Office, and Qualification

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

Section 4.3. President

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

Section 4.4. Secretary

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

Section 4.5. Treasurer

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

Section 4.6. Resignation and Removal

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

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

Section 4.7. Vacancies.

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

ARTICLE V

COMMITTEES OF THE BOARD

The Board of Directors may from time to time appoint committees of two or more Directors, each to serve at the pleasure of the Board of Directors, which committees shall have and may exercise such authority and powers of the Board of Directors as shall be specified in the resolution of appointment. Any committee that has the power to exercise the Board's power shall be comprised only of Directors and shall comply with the notice, quorum and voting requirements applicable to the Board of Directors. Any committee with responsibility for the Corporation's independent audit or executive compensation shall be comprised only of Directors who are independent of the Corporation as defined in Article X of these Bylaws.

ARTICLE VI

ADVISORY BOARDS AND COMMITTEES

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

ARTICLE VII

CONFLICTS OF INTEREST AND CONFIDENTIALITY POLICY

Section 7.1. Conflicts of Interest and Confidentiality Policy

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

Section 7.2. Conflicting Interest Transactions

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

ARTICLE VIII

FINANCE AND PROPERTY

Section 8.1. Fiscal Year

The fiscal year of the Corporation shall be January 1 through December 31.

Section 8.2. Approved Signatures

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

Section 8.3. Contracts and Debts

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

Section 8.4. Deposits

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

ARTICLE IX

GIFTS, GRANTS AND DISTRIBUTIONS

Section 9.1. Gift Policies and Procedures

The Board of Directors may from time to time adopt policies and procedures governing the acceptance, management and investment of gifts, grants, and other charitable funds for the Corporation's charitable and educational purposes. All such policies and procedures will be consistent with the requirements of applicable Federal tax law. Further, any such policy or procedure shall be recognize the right of the Board of Directors in its discretion to refuse any conditional or restricted gift, grant, bequest, or contribution and/or to return to the donor any such gift

Section 9.2. Distributions

All grants, gifts, contributions, or other distributions by the Corporation for the advancement of its charitable and educational purposes shall be authorized or ratified by the Board of Directors. The Board of Directors will at all times maintain control and discretion over the distribution of funds received by the Corporation, provided that such control and discretion shall be exercised consistent with any applicable donor restrictions. The Board of Directors may solicit or receive gifts, grants, bequests, or contributions for a specific project that it has reviewed and approved as in furtherance of the purposes of the Corporation as stated in the Certificate of Incorporation.

The Board of Directors may from time to time adopt policies and procedures governing the approval and distribution of grants, gifts, contributions, or other distributions by the Corporation. All such policies and procedures will be consistent with the requirements of applicable Federal tax law.

Section 9.3. Evaluation and Site Visits

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

Section 9.4. Recognition of Donors

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

ARTICLE X

DIRECTOR INDEPENDENCE

Section 10.1. Generally

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

Section 10.2. Independent Director

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

Section 10.3. Annual Disclosure

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

Section 10.4. Conflicts of Interest and Confidentiality Policy

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

ARTICLE XI

AMENDMENTS

These Bylaws may be amended at any meeting of the Board of Directors at which a quorum is present by a majority vote of those Directors present and voting, provided that notice of the general nature of such amendments has been sent to the Directors by mail, telefax, other electronic means, or personally at least ten (10) days preceding the meeting at which they are to be acted upon.

Adopted:_____, 201_

765/2611/3333910.2

EXHIBIT Q11-1 - LISTING OF SPECIFIC FUNDS

EXHIBIT Q 11-1
ECHN ENDOWMENT AND OTHER CHARITABLE FUNDS - FUNDS 11-1.1 - 11-1.84

Explanatory Notes:

1. ECHN has provided a copy of each available gift instrument. In some cases, although it conducted a thorough review of its records as well as the records of local probate courts, it was unable to locate the original gift instrument.
In those cases, it has provided other available documentation of the gifts, including copies of minutes of Board meetings and/or copies of old audited financials.
2. References to the 1990 Report of the Attorney General are to the June, 1990 Report of the Office of the Attorney General on Hospital Bed Fund Trusts.
3. Proposed requests for cy pres relief will apply to the balances of the funds remaining at the time and not appropriated or used by ECNH for proper purposes.

Fund Number	Fund Name	Value of Original Gift	Total Market Value 6/30/15	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
MANCHESTER MEMORIAL HOSPITAL								
	Endowment: Unrestricted Income Funds							
11-1.1	Dwight W. Blish Fund	$19,920	$492,052	Devise under Article Fourth of the Last Will and Testament of Dwight W. Blish dated September 6, 1923, with Codicil dated July 3, 1933	Upon the deaths of Mr. Blish's wife and son, the testamentary trust he had established for their benefit terminated, and the property then remaining was given outright "to The Manchester Memorial Hospital to be held by the trustees of said hospital as a trust fund to be known as the Dwight W. Blish fund, the income therefrom to be used for such purposes in connection with said hospital as the trustees shall decide." Income unrestricted	The Last Will and Testament of Dwight W. Blish dated September 6, 1923; and Codicil dated July 3, 1933		Request cy pres relief and transfer to the new Foundation
11-1.2	John & Eliza Carpenter	$2,555	$110,461	Unknown	There is no specific documentation for the terms of this gift, but it has been consistently booked on MMH's books for a number of years as endowment with unrestricted income. Income unrestricted	Excerpt from the Hospital's audited financial statements as of 9/30/1996 and 1995; and supporting reconciliation of funds as of 9/30/1995		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 6/30/15	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.3	Helen G. Chapman	$5,000	$81,551	Bequest under Article FOURTH of the Last Will and Testament of Helen G. Chapman dated July 1, 1938	Bequest of $5,000 "to the Manchester Memorial Hospital, of Manchester, Connecticut, to be held by it in perpetuity, with power of investment, sale and reinvestment, and to apply the income only for the support of the Hospital maintained by it in the town of Manchester." Income unrestricted	The Last Will and Testament of Helen G. Chapman dated July 1, 1938		Request cy pres relief and transfer to the new Foundation
11-1.4	William H. Coates (Costes)	$500	$5,545	Bequest under the Last Will and Testament of William H. Coates (date unknown)	This bequest is documented in the minutes of the August 12, 1925 meeting of the Board of Trustees of the Hospital, which state that "A report was given by the Manchester Trust Company, Executor of the will of William H. Coates, of a gift of $500.00, the interest only to be used for hospital purposes." This bequest is also referenced in a document titled "Exhibit A - Report of the Finance Committee" apparently excerpted from Board minutes. That Exhibit also classifies this fund as an endowment fund and states [the income is to be used] "...as the trustees of said hospital may deem best..." Income unrestricted	Minutes of the August 12, 1925 meeting of the Board of Trustees; and "Exhibit A - Report of the Finance Committee" from other Board minutes.	Note: This fund has sometimes (incorrectly) been identifed as a gift from William H. Costes rather than William H. Coates.	Request cy pres relief and transfer to the new Foundation
11-1.5	Grace K. Dart	$4,007	$123,195	Devise under ARTICLE VI. of the Last Will and Testament of Grace Kingsbury Dart dated December 7, 1931.	Devise of half the residuary estate. Article VI. provides as follows: All the rest, residue and remainder of my property, both real and personal, wherever it may be situated and of whatsoever it may consist I direct be divided into two (2) equal parts. The first of said equal parts, I give, devise and bequeath to The Manchester Memorial Hospital, a Connecticut Corporation, located in said Manchester, to take, hold, manage, invest and reinvest and to use the income therefrom for the general running expenses of said Hospital. Income unrestricted	The Last Will and Testament of Grace Kingsbury Dart dated December 7, 1931		Request cy pres relief and transfer to the new Foundation
11.1-6	The Grace L. House Fund	$2,500	$30,057	Bequest under Article VI. of the Last Will and Testament of Charles E. House dated May 4, 1933	Bequest to the Hospital of $2500 "to be held by said Hospital as a permanent fund, and to be know[n] as "The Grace L. House Fund". The income therefrom is to be used for the running expenses of said Hospital." Income unrestricted	The Last Will and Testament of Charles E. House dated May 4, 1933		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 6/30/15	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.7	The John Porter & Caroline E. Porter Fund	$7,464	$172,634	Devise under Paragraph EIGHTH (c) of the Last Will and Testament of John Porter dated November 4, 1936, with Codicil dated November 4 1937. Devise under Article SIXTH (f) of the Last Will and Testament of Caroline E. Porter, dated July 3, 1956.	Devise of a share in the residue of a testamentary trust established by the Will of John Porter as follows: "Twenty per cent. (20%) [of this trust], ..., I give in equal shares to the following fourteen charitable institutions, in each instance to be known as "The John Porter and Caroline E. Porter Fund", to be held in perpetuity, with power of investment and reinvestment, the income only to be used for the support of the institutions hereinafter named, viz.: ...13. The Manchester Memorial Hospital, of Manchester,..." Subsequent devise by Caroline E. Porter of a portion of another testamentary trust established under the Will of John Porter through her exercise of a power of appointment over one-half of the trust as follows:: "SIXTH: ... Accordingly,..., I nominate and appoint [the following] to receive out of said one-half of said residuary estate of my late husband, John Porter, the following gifts, to wit: ... (f) The balance ...shall be distributed by said trustees in equal shares to the following fourteen charitable institutions, ..., in each instance to be known as "The John Porter and Caroline E. Porter Fund", to be held in perpetuity, with power of investment and reinvestment, the income only to be used for the support of the institutions hereinafter named, viz: ...13. The Manchester Memorial Hospital, of Manchester, Connecticut;..." Income unrestricted	The Last Will and Testament of John Porter dated November 4, 1936, with Codicil dated November 4 1937; the Last Will and Testament of Caroline E. Porter, dated July 3, 1956; and May 23, 1958, letter from Hartford National Bank and Trust Company to Robert Hathaway of the Manchester Trust Company.		Request cy pres relief and transfer to the new Foundation
11-1.8	William & Mary Rice Fund	$122,361	$986,865	Devise under Article FOURTH of the Last Will and Testament of Richard W. Rice dated April 11, 1924	Upon the deaths of the last named life beneficiary, the testamentary trust Mr. Rice had established terminated, "... and the principal thereof, and all accumulations thereto, I give, devise and bequeath to the Manchester Memorial Hospital, of Manchester, Connecticut, in trust, to be known as the William and Mary Rice Fund, the income therefrom to be used for the purposes of uses of said Hospital." Income unrestricted	The Last Will and Testament of Richard W. Rice dated April 11, 1924		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 6/30/15	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.9	Robert N. and Florella Stanley Trust Fund	$3,000	$33,895	Bequest under ARTICLE V. of the Last Will and Testament of Flora May Stanley dated December 2, 1940	Bequest of $3000 to The Manchester Memorial Hospital, a Connecticut corporation, "... to be known as the Robert N. and Florella Stanley Trust Fund, to be added to the Endowment Fund of said hospital, and the income to be used for such purposes as the Trustees may deem best." Income unrestricted	The Last Will and Testament of Flora May Stanley dated December 2, 1940		Request cy pres relief and transfer to the new Foundation
11-1.10	George W. Strant and Rose B. Strant Memorial Fund	$128,043	$691,585	Two bequests and a share in the residuary estate as follows: (1) Bequest under Article THIRD 1. of the Last Will and Testament of Rose B. Strant dated December 22, 1954; (2) Bequest under Article THIRD 6. of said Will; and (3) Devise of a share in the residuary estate under Article FOURTH a. of said Will	Rose Strant left three testamentary gifts to Manchester Memorial Hospital, all of which were to the Hospital's endowment,"the income only from which is to be used for the general purposes of said hospital." The Bequest (in Article THIRD 1(b) and (c)) was the remainder interest in a $2000 trust or, if the life beneficary predeceased her, $2000: "b. Upon the death of [my cousin] "... said trust shall thereupon terminate and ...the principal of said trust, together with any unpaid income, [shall] be paid to the MANCHESTER MEMORIAL HOSPITAL, of Manchester, Connecticut, to be added to its endowment fund and the income only from which is to be used for the general purposes of said hospital. c. If my said cousin... shall predecease me, then in that event, I give and bequeath said Two Thousand (($2,000.00) Dollars to the Manchester Memorial Hospital, to be used as set forth above. Article THIRD 6. bequeathed "the sum of Five Thousand ($5,000.00) Dollars to the Manchester Memorial Hospital, to be added to its endowment fund and to be known as the George W. Strant and Rose B. Strant Memorial Fund, the income only from which is to be used for the general purposes of said hospital." Article FOURTH A. left two of three three equal parts "to the MANCHESTER MEMORIAL HOSPITAL, of Manchester, Connecticut, to be added to its endowment fund and to be known as the Geroge W. Strant and Rose B. Strant Memorial Fund, the income only from which is to be used for the general purposes of said hospital." Income unrestricted	The Last Will and Testament of Rose B. Strant dated December 22, 1954		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 6/30/15	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.11	Minnie R. Strickland	$2,511	$108,545	Devise under ARTICLE IX of the Last Will and Testament of Minnie R. Strickland dated June 29, 1942	Devise of one-third of the residuary estate pursuant to Article IX, which provides as follows: "I direct that all the rest and residue of my property of whatever kind and wherever situated shall be divided into three (3) equal parts: I give one of said equal parts to the Manchester Memorial Hospital; of Manchester, Conn., to be added to the Endowment Fund of said Hospital;..." Income unrestricted	The Last Will and Testament of Minnie R. Strickland dated June 29, 1942		Request cy pres relief and transfer to the new Foundation
11-1.12	Arthur B. and Carrie E. Ellis Trust Fund	$5,000	$55,536	Bequest under ARTICLE IV. of the Last Will and Testament of Carrie E. Ellis dated February 9, 1940, with Codicil dated October 8, 1942	Bequest to The Manchester Memorial Hospital of "the sum of Five Thousand ($5,000.00) Dollars, to be added to the Endowment Fund of said hospital and to be known as "The Arthur B. and Carrie E. Ellis Trust Fund", the income therefrom to be used for such hospital purposes as its Trustees may desire." Income unrestricted	The Last Will and Testament of Carrie E. Ellis dated February 9, 1940; Codicil dated October 8, 1942		Request cy pres relief and transfer to the new Foundation
11-1.13	Ralph and Lula Pinney Fund	$31,031	$312,141	Devise under Article 7th.of the Last Will and Testament of Lula M. Pinney dated May 13, 1924	Upon the deaths of the respective life beneficiaries,two testamentary trusts Mrs. Pinney had established terminated, and she gave " ... One-half (1/2) [of the principal] to the Manchester Memorial Hospital as a permanent fund to be known as the Ralph and Lula Pinney Fund, the income of which Fund to be used and applied for the general purposes of said hospital, but as I am now maintaining a room in said hospital in memory of Sanford Keeney, I direct that so much of said income as may be required shall be used and applied towards the maintenance of said room..." Income unrestricted as to this part of the gift; see also Fund 11-1.27.	The Last Will and Testament of Lula M. Pinney dated May 13, 1924	Note: There is no record that Mrs. Pinney endowed a room in memory of Sanford Keeney; rather, it appears that she supported a room for free care through annual gifts. The Hospital historically treated her entire gift as endowment for the general purposes of the Hospital, but it has now allocated one-fourth of the fund to the Sanford Keeney Free Bed Fund, which is included here as Fund 11-1.27.	Request cy pres relief and transfer to the new Foundation
11-1.14	Emil L. G. Hohenthal	$750	$7,729	Unknown	This fund is documented in the June 16, 1953 minutes of a meeting of the Board of Trustees of the Hospital. The minutes do not quote or refer to gift language, but state that the "original amount" of the gift was $750, and the context suggests that this is an endowment. This fund has been consistently booked on MMH's books for a number of years as endowment with unrestricted income. Income unrestricted	The minutes of the June 16, 1953 meeting of the Board of Trustees of the Hospital; the financial records of the Hospital.	Note: The Hospital located the Last Will and Testament of Mr. Hohenthal's wife Hazel, but it did not include this gift.	Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 6/30/15	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.15	George Wells Cheney and Harriet Richmond Cheney Memorial Fund	$75,000	$573,293	Devise under Article SEVENTH C. of the Last Will and Testament of Louis R. Cheney dated February 22, 1944	Devise of a share in the residuary estate as follows: "Seventh: I direct my Executors to divide all the rest, residue and remainder of my property both real and personal, and wheresoever situated including any property over which I may have power of disposal or appointment, into one Hundred Fifty-five (155) equal parts, and I give, bequeath and devise said parts as follows: ... C. Ten (10) of said parts to the Manchester Memorial Hospital as a memorial to my father and mother, George Wells Cheney and Harriet Richmond Cheney, to be held as a separate fund and the income only used for the general purposes of said Hospital." Income unrestricted	The Last Will and Testament of Louis R. Cheney dated February 22, 1944		Request cy pres relief and transfer to the new Foundation
11-1.16	Helen Campbell Cheney Fund	$543,562	$4,653,518	Devise under Article Sixth (b) of the Last Will and Testament of Helen Campbell Cheney dated June 29, 1960	Devise of a share in the residuary estate as follows: "Sixth: All the rest, residue and remainder of my estate, both real and personal and wherever situated, I direct my Executor to divide into three (3) equal parts and to transfer and pay over said three (3) equal parts and I so give, devise and bequeath the same as follows: ... (b) One (1) of said equal parts to Manchester Memorial Hospital, a hospital corporation organized and existing under the laws of the State of Connecticut and located in said Manchester, to be held as a permanent fund in memory of my husband, Philip Cheney, with power of investment and reinvestment, the income only to be used and applied for the benefit of said Hospital in such manner as the Trustees of said Hospital may in their discretion determine." Income unrestricted	The Last Will and Testament of Helen Campbell Cheney dated June 29, 1960		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 6/30/15	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.17	Albert (Herbert) Dewey	$1,498	$64,778	Unknown	There is no original or specific documentation of the terms of this gift, but it has been consistently booked on MMH's books for a number of years as endowment with unrestricted income. Income unrestricted	Excerpt from the Hospital's audited financial statements as of 9/30/1996 and 1995; and supporting reconciliation of funds as of 9/30/1995	Note: The Hospital located the Will of Albert Dewey at the Manchester probate court, but the Will does not include this gift; the Will indicates that Mr. Dewey had an inter vivos trust, but no copy of the trust was in the probate court records. Note: There is some confusion whether this fund is named for Albert or Herbert Dewey; the Hospital believes it is the Albert Dewey Fund. Note: The June 30, 1981, minutes of the Development Committee reference an $8,000 bequest from Albert T. Dewey that will be memorialized with a plaque in the Vestibule on the Second Floor East Building (244) as the "Gift of Albert T. and Jane N. Dewey". This does not appear to be the same gift.	Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 6/30/15	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.18	Jane (June) Dewey	$936	$40,485	Unknown	There is no specific documentation for the terms of this gift, but it has been consistently booked on MMH's books for a number of years as endowment with unrestricted income. Income unrestricted	Excerpt from the Hospital's audited financial statements as of 9/30/1996 and 1995; and supporting reconciliation of funds as of 9/30/1995	Note: The Hospital located the Will of Jane Dewey at the Manchester probate court, but it does not include this gift; the Will indicates that Jane Dewey had an inter vivos trust, but no copy of the trust was in the probate court records. Note: There is some confusion whether this fund is named for Jane or June; the Hospital believes it is the Jane Dewey Fund. Note: The June 30, 1981, minutes of the Development Committee note a $5,000 bequest from Jane N. Dewey that will be memorialized with a plaque in the Nurses' Lounge in the Surgical Suite "In memory of Hilma N. Dillon and Emily D. Coburn". This does not appear to be the same gift.	Request cy pres relief and transfer to the new Foundation
11-1.19	The Loren Gardner Fund	$25,000	$71,582	Bequest under Article FIFTH of the Last Will and Testament of Ella C. Livermore dated October 12, 1929	Bequest of "twenty five thousand dollars ($25,000) to the Manchester Memorial Hospital, a corporation specially chartered by the State of Connecticut, located at South Manchester in said State, in memory of my father, Loren Gardner, to be held by said Hospital as a fund to be known as The Loren Gardner Fund, the income therefrom to be used for the proper uses of the Hospital. I request, but do not make it a condition, that the income, or so much as may be necessary, be applied to the maintenance of a free bed in said Hospital for poor patients." Income unrestricted with a request that it be used for free care	The Last Will and Testament of Ella C. Livermore dated October 12, 1929	Note: The Hospital has historically classified and reported this fund as restricted for free care, and it reported this as a free bed fund to the Office of the Attorney General for inclusion in the 1990 Report of the Attorney General. The donor did not, however, impose that as a binding condition. This income from this endowment fund is thus unrestricted, and the fund has been reclassified.	Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 6/30/15	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.20	Donald G. Piper and Hazel B. Piper Memorial	$75,000	$119,090	Preliminary distribution of Devise under Article FOURTH of the Last Will and Testament of Hazel B. Piper dated November 30,1990	Preliminary distribution on 6/28/06 of portion of devise of the residuary estate as follows: "FOURTH: All the rest, residue and remainder of my property, both real and personal, and of whatsoever nature, wherever the same may be located or found, which I may own or have the right to dispose of at my death (intending hereby to exercise any power of disposition or appointment that I may have at my death, I give, devise and bequeath unto MANCHESTER MEMORIAL HOSPITAL of Manchester, Connecticut, in memory of DONALD G. PIPER and HAZEL B. PIPER, to be held in the Consolidated Investment Fund, the income only from which is to be used at the discretion of the Board of Trustees of the hospital for its general uses and purposes." Income unrestricted	The Last Will and Testament of Hazel B. Piper dated Novermber 30,1990	Note: The Hospital received two preliminary distributions of $75,000 each from the Estate (reported herein as Funds 11-1.20 and 11-1.21). The remainder of this devise is reported under the ECHN Community Healthcare Foundation as Fund 11-1.81.	Request cy pres relief and transfer to the new Foundation
11-1.21	Donald G. Piper and Hazel B. Piper Memorial	$75,000	$119,090	Preliminary distribution of Devise under Article FOURTH of the Last Will and Testament of Hazel B. Piper dated November 30,1990	Preliminary distribution on 7/26/06 of portion of devise of the residuary estate as follows: "FOURTH: All the rest, residue and remainder of my property, both real and personal, and of whatsoever nature, wherever the same may be located or found, which I may own or have the right to dispose of at my death (intending hereby to exercise any power of disposition or appointment that I may have at my death, I give, devise and bequeath unto MANCHESTER MEMORIAL HOSPITAL of Manchester, Connecticut, in memory of DONALD G. PIPER and HAZEL B. PIPER, to be held in the Consolidated Investment Fund, the income only from which is to be used at the discretion of the Board of Trustees of the hospital for its general uses and purposes." Income unrestricted	The Last Will and Testament of Hazel B. Piper dated Novermber 30,1990	Note: The Hospital received two preliminary distributions of $75,000 each from the Estate (reported herein as Funds 11-1.20 and 11-1.21). The remainder of this devise is reported under the ECHN Community Healthcare Foundation as Fund 11-1.81.	Request cy pres relief and transfer to the new Foundation
Subtotal: Endowment: Unrestricted Income Funds		$1,130,638	$8,853,630					

Fund Number	Fund Name	Value of Original Gift	Total Market Value 6/30/15	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
	Free Bed Funds (Endowment Restricted for Free Care)							
11-1.22	Drake Fund	$90,500	$174,004	Devise under Article EIGHTH (c)(2) of the Last Will and Testament of Edith Drake Quimby dated September 7, 1949 with Codicil dated October 4, 1950	Upon the deaths of the life beneficiaries and the payment of specific bequests, Article EIGHTH (c) directs that the Trustees divide the balance of the funds: "into ten(10) equal parts and I give, devise and bequeath said parts as follows:... " (2) Two (2) of said parts to the Manchester Public Hospital, of Manchester, Connecticut, in memory of my father and mother, Levi Drake and Julia Pease Drake, the income therefrom to be used to support a bed in said hospital. It is my wish that said fund shall be known as the "Drake Bed Fund" and I request that the nomination to this bed be vested in the governing body of the Congregational Church in North Manchester, Connecticut, of which my parents were members for many years." Income restricted for free care	The Last Will and Testament of Edith Drake Quimby dated September 7, 1949; and Codicil dated October 4, 1950	Note: MMH has an active contact at the Congregational Church, which is the nominator for this fund.	Request cy pres relief and transfer to the new Foundation
11-1.23	The Mattie Hills Preston Free Bed Endowment	$8,000	$9,114	Bequest under Article FIFTH (a) of the Last Will and Testament of Janes M. Preston dated April 3, 1924	Bequest of "Eight Thousand ($8,000) Dollars, the same to be held by said Hospital in trust and the income thereof applied for the maintenance of a free bed, such endowment to be known as "The Mattie Hills Preston Free Bed Endowment." Income restricted for free care	The Last Will and Testament of Janes M. Preston dated April 3, 1924	Note: As stated in the Will and in the 1990 Report of the Attorney General, Article FIFTH (d) of the Will creates a second $8,000 bed fund in the name of Janes Preston if there is sufficient money. The Hospital's records do not reflect that this second bed fund was established or what happened to the second bequest.	Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 6/30/15	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.24	F. O. Boynton	$923	$1,067	Devise under Last Will and Testament of F.O. Boynton (date and location unknown)	Devise of the residuary estate as follows: "I give and bequeath to the Manchester Memorial Hospital of Manchester, Connecticut,...all the rest, residue and remainder of my estate, to be held as a separate and permanent fund and the income therefrom to be used for the general purposes of the hospital with special reference to the furnishing of hospital facilities to persons then not able to pay for the service so rendered." Income restricted for free care	Excerpt from the Hospital's audited financial statements as of 9/30/1996 and 1995 with supporting reconciliation of funds as of 9/30/1995; excerpt from the 1990 Report of the Attorney General; and undated Exhibit A to Report to Finance Committee		Request cy pres relief and transfer to the new Foundation
11-1.25	Erna W. Loomis	$196,394	$218,036	(1) Bequest under ARTICLE V, paragraph L. of the Last Will and Testament of Erna W. Loomis dated July 20, 1992; and (2) Devise of a share in the residuary estate under ARTICLE V, paragraph R.4. of said Will	Erna W. Loomis left two testamentary gifts to Manchester Memorial Hospital, both of which were endowment restricted for the same purpose: Bequest under ARTICLE V, paragraph L.of "TWENTY-FIVE THOUSAND ($25,000) DOLLARS to MANCHESTER MEMORIAL HOSPITAL of Manchester, Connecticut, to be held in trust, the income only to be included in any program providing for the payment of anyone's expenses who cannot otherwise afford the same." Devise under ARTICLE V, paragraph R.: "All of my property thereafter remaining is to be divided into the following four (4) equal parts: ... 4. The fourth of said parts is to be added to my bequest to MANCHESTER MEMORIAL HOSPITAL, under Article V, Paragraph L of this Will and held and administered in accordance with its terms." Income restricted for free care	The Last Will and Testament of Erna W. Loomis dated July 20, 1992		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 6/30/15	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.26	Elsie Cheney Disher (Sophie H. Cheney)	$151,579	$168,198	Gift of an interest in the remainder of a trust created by Elsie C. Disher upon termination of the trust (date of trust unknown.)	The Trust provided as follows: "The remainder in equal shares to the Manchester Memorial Hospital of Manchester, Connecticut, and to _____. The gift to the Manchester Memorial Hospital is to be held as a permanent fund, in memory of my mother, the income thereof to be used so far as is necessary for the support of a private room in said Hospital, to be known as the "Sophie H. Cheney Room", said room in the discretion of the Hospital authorities to be used for the benefit of worthy cases of special need. Any balance of the income not necessary for the foregoing purpose shall be used by the Hospital authorities for the general purposes of the Hospital. I request that said authorities use a portion of the income for the erection of a suitable table in said room to be inscribed with an appropriate reference to my said mother and to her general benefactions to the community." Income restricted for free care	Excerpt from Trust Agreement of Elsie C. Disher.	Note: The Hospital has only a copy of an excerpt from the Trust agreement, which was an inter vivos trust. The Hospital has a copy of Mrs. Disher's Last Will and Testament dated May 11, 1923; that included a contingent unrestricted gift to the Hospital but did not include this trust provision. Mrs. Disher died in 1923.	Request cy pres relief only for funds, if any, not used by the Hospital
11-1.27	Sanford Keeney	$10,344	$10,364	Devise under Article 7th of the Last Will and Testament of Lula M. Pinney dated May 13, 1924	Upon the deaths of the respective life beneficiaries,two testamentary trusts Mrs. Pinney had established terminated, and she gave " ... One-half (1/2) [of the principal] to the Manchester Memorial Hospital as a permanent fund to be known as the Ralph and Lula Pinney Fund, the income of which Fund to be used and applied for the general purposes of said hospital, but as I am now maintaining a room in said hospital in memory of Sanford Keeney, I direct that so much of said income as may be required shall be used and applied towards the maintenance of said room..." Income restricted for free care as to this part of the gift; see also Fund 11-1.13	The Last Will and Testament of Lula M. Pinney dated May 13, 1924	Note: There is no record that during her lifetime Mrs. Pinney endowed a room in memory of Sanford Keeney; rather, it appears that she supported a room for free care through annual gifts. The Hospital historically treated her entire gift as endowment for the general purposes of the Hospital, but it has now allocated one-fourth of the fund to the Sanford Keeney Free Bed Fund, which is included here as Fund 11-1.27. The balance of her testamentary gift is reported at Fund 11-1.13.	Request cy pres relief and transfer to the new Foundation
Subtotal: Free Bed Funds		$457,740	$580,783					

Fund Number	Fund Name	Value of Original Gift	Total Market Value 6/30/15	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
	Endowment Restricted to Purposes Other Than Free Care							
11-1.28	Thomas D. Trotter Memorial Fund	$500	$5,476	Bequest under ITEM VII of the Last Will and Testament of Thomas D. Trotter dated January 20, 1951	Bequest to Manchester Memorial Hospital of "the sum of Five Hundred (500) Dollars to be known as the Thomas D. Trotter Memorial Fund, and I direct that only the income from this fund is to be used, in the absolute and uncontrolled discretion of the supervisor of said hospital, in some way for the benefit of the children patients." Income restricted to benefit pediatric patients	The Last Will and Testament of Thomas D. Trotter dated January 20, 1951		Request cy pres relief and transfer to the new Foundation
11-1.29	William and Rebecca J. Wright Fund	$6,124	$65,575	Devise under ARTICLE IV of the Last Will and Testament of Rebecca J. Wright dated May 26, 1948	Devise of a share in the residuary estate as follows: "ARTICLE IV: ....In the event my said brother should die before me, I direct my Executor, without the requirement of setting up the Trust, to distribute the funds designated for the Trust directly to the remainder men thereof as hereinafter set forth. I direct my Trustee to divide all funds in its hands into three (3) equal shares and I direct my Trustee to pay over one (1) of said shares to The Manchester Memorial Hospital of Manchester, Connecticut, and that said share shall be kept intact as an endowment fund and that the income therefrom shall be used in the fight again Cancer, and that said share or fund shall be known as the William and Rebecca J. Wright Fund." Income restricted for cancer	The Last Will and Testament of Rebecca J. Wright dated May 26, 1948		Request cy pres relief and transfer to the new Foundation
Subtotal: Endowment Restricted to Purposes Other Than Free Care		$6,624	$71,052					

Fund Number	Fund Name	Value of Original Gift	Total Market Value 6/30/15	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
Miscellaneous Funds								
11-1.30	Interests in the Estate of Raymond F. Damato	Unknown at this time	Unknown at this time	(1) Devise under Article SEVENTH D. of the Last Will and Testament of Raymond F. Damato dated July 7, 2009, with Codicils dated April 10, 2010, and February 11, 2011; and (2) bequests of trust termination shares under Article SIXTH of the Will.	Devise of 20% of the residuary estate "to Manchester Memorial Hospital, of Manchester, Connecticut.....Except as set forth in the individual bequests above, the bequests subject to this Paragraph shall be unrestrcied in purpose and left to the discretion of the governing board of each of the respective charitable organizations. Article SIXTH provides that, upon the termination of each of the eleven trusts created under that Article, "...the Trustee shal distribute the then remaining Trust of said deceased beneficiary,... absolutely and free of trust, to those beneficiaries and in the respective percentages set forth in Article Seventh of this my last Will and Testament. Unrestricted	The Last Will and Testament of Raymond F. Damato dated July 7, 2009,Codicil dated April 10, 2010; and Codicil dated February 11, 2011;	Note: Mr. Damato died April 25, 2014, and his Will and Codicils were admitted to probate May 6, 2014. It is premature to estimate the values of the Hospital's interests, but the estate is known to be substantial.	Use by the Hospital in the discretion of its Board
11-1.31	Life Insurance Policy (Name of Insured withheld)	NA	$55,639	Life Insurance Policy with face value of $50,000 issued by National Life Insurance Company	Policy owned by the Hospital with a current cash value of $55,639 Unrestricted	Face sheet of the Policy, with the name of the insured redacted		Request cy pres relief and transfer to the new Foundation if the insured is then living
Subtotal: Miscellaneous		$0	$55,639					
Grand Total: Manchester Memorial Hospital		$1,595,002	$9,561,103					

Fund Number	Fund Name	Value of Original Gift	Total Market Value 6/30/15	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
	ROCKVILLE GENERAL HOSPITAL							
Endowment: Unrestricted Income Funds								
11-1.32	Alice Farmer Bissell Fund	$25,000	$3,717,033	Bequest under Article Fourth of the Last Will and Testament of Arthur T. Bissell dated September 1, 1932	Bequest to the Rockville City Hospital of "the sum of Twenty-five Thousand Dollars ($25,000) to be kept as a permanent fund in memory of my wife, Alice Farmer Bissell, and to be known as the Alice Farmer Bissell Fund. The net income from said fund shall be used and applied for the general purposes of said Hospital." Income unrestricted	The Last Will and Testament of Arthur T. Bissell dated September 1, 1932		Request cy pres relief and transfer to the new Foundation
11-1.33	Frances Taylor Maxwell Memorial Fund	$50,000	$83,253	Devise under Article FOURTEENTH (b) of the Last Will and Testament of Florence Parsons Maxwell dated February 24, 1956, with Codicil dated April 9, 1959	Devise of a share of the residue of a trust upon the death of the life beneficiary as follows: "FOURTENTH: All the rest, residue and remainder of my estate of every name and nature, real and personal,..., I direct my executors hereinafter named to divide into six (6) equal shares: ...(b) I give, devise and bequeath one (1) of said shares to said Hartford National Bank and Trust Company, absolutely and in fee simple, but in trust, nevertheless, ... to pay over, apply or expend for the benefit of my granddaughter VIRGINIA BELDING ..the net income thereof ...Upon the death of said VIRGINIA BELDING, I direct my said Trustee to divide the principal of said trust fund into two equal portions. One (1) such portion shall be paid over to ROCKVILLE CITY HOSPITAL, an eleemosynary corporation of Connecticut located in Rockville, the principal to be kept safely invested and known as the FRANCIS TAYLOR MAXWELL MEMORIAL FUND, and the net income only used for its general uses and purposes." Income unrestricted	The Last Will and Testament of Florence Parsons Maxwell dated February 24, 1956; and Codicil dated April 9, 1959		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 6/30/15	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.34	Stephen Goodale and Emeret Scott Risley Fund	$89,689	$918,398	(1) Bequest under Paragraph NINTH of the Last Will and Testament of May Risley Adams dated February 26, 1944; and (2) Devise under Paragraph TWENTY-FIRST of said Will	May R. Adams left two testamentary gifts to Rockville City Hospital, both of which were endowment restricted for the same purpose as follows: Bequest under Paragraph NINTH to "THE ROCKVILLE CITY HOSPITAL, INC. of said Rockville, the sum of Ten Thousand Dollars, in memory of my father and mother, Stephen Goodale Risley, M.D. and Emeret Scott Risley, for the establishment of a fund to be known as the Stephen Goodale Risley and Emeret Scott Risley Fund, the income thereof to be used for the general uses and purposes of said Hospital; together with the diploma of my late father, Stephen Goodale Risley, M.D. and my John Hamilton clock, made in Glasgow, Scotland, before 1720." Devise of the residue of the estate under Paragraph TWENTY-FIRST: "All the rest, residue and remainder of all my property, of every description, both real and personal, of whatsoever the same may consist or wheresoever it may be situated, I give, devise and bequeath unto said THE ROCKVILLE CITY HOSPITAL, INC., in order that the same may be added to and become a part of the Stephen Goodale Risley and Emeret Scott Risley Fund, which is estabished in paragraph Ninth of this my last will and testament. Income unrestricted	The Last Will and Testament of May Risley Adams dated February 26, 1944		Request cy pres relief and transfer to the new Foundation
11-1.35	United German Society Fund	$10,724	$25,684	Gift from United German Society	Excerpt from "Source and Terms of Fund Held": "Gift from United German Society - considered permanent endowment - income is used for general expenses of the Hospital." Income unrestricted	Document titled "Source and Terms of Funds Held" originally compiled November 24, 1952, and later supplemented through 1957 (at Page 6)		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 6/30/15	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.36	William H. Prescott	$50,000	$660,815	Bequest under Article 13. of the Last Will and Testament of William H. Prescott dated January 17, 1908 Bequests under Paragraphs 5, 9, and 15 of the Last Will and Testament of Celia E. Prescott dated June 13, 1917	Bequest as follows: "13. I give and bequeath to Francis T. Maxwell, Arthur T. Bissell, J. Alice Maxwell, A. N. Belding and Thomas W. Sykes, all of Rockville, Connecticut, the sum of fifty thousand dollars ($50,000) in perpetual trust to them and their successors in office, for the purpose of establishing and maintaining at said city of Rockville, a general hospital for the sick ....." Bequests under the Will of Celia E. Prescott of the remainders of three $5,000 trusts upon the deaths of the respective life beneficiaries, the remainder of each given "... to the trustees of the Rockville City Hospital, in trust, for the benefit of said hospital, that the same may be added to the endowment fund provided for in the will of my late husband, William H. Prescott, for the purpose of establishing and maintaining said proposed hospital." Income unrestricted	The Last Will and Testament of William H. Prescott dated January 17, 1908; and The Last Will and Testament of Celia E. Prescott dated June 13, 1917		Request cy pres relief and transfer to the new Foundation
11-1.37	William Maxwell Fund	$171,719	$437,207	Devise under Article FOURTEENTH of the Last Will and Testament of William Maxwell dated December 3, 1938, with Codicils dated December 3, 1938 and January 3, 1939; inter vivos gifts, and life insurance proceeds	Devise of share of residue of estate as follows: "FOURTEENTH: To ROCKVILLE CITY HOSPITAL in Rockville, Connecticut, I give, devise, and bequeath four of said equal [one hundred] parts of my said residuary estate in trust to use the income thereof for the general purposes of said Hospital." Income unrestricted	The Last Will and Testament of William Maxwell dated December 3, 1938; Codicil dated December 3, 1938; Codicl dated January 3, 1939; document titled "Source and Terms of Funds Held" dated in 1952 and updated in 1957 (at Page 3); and minutes of January 20, 1953 meeting of the Board of Trustees of the Hospital.		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 6/30/15	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.38	Cora Lloyd Smith Fund	$7,658	$19,126	Devise under Article SIXTH (b) of the Last Will and Testament of Cora Lloyd Smith dated May 10, 1940	Devise of a share of the residue of a trust upon the death of the life beneficiary as follows: "...Upon the death of my said husband CLARENCE SMITH, I direct that said trust shall cease and terminate, and I give, devise and bequeath said trust fund remaining at said time, as follows, to wit: ... (b) The remaining one-half thereof unto The ROCKVILLE CITY HOSPITAL, INC. of said town of Vernon, to be known as the Cora Lloyd Smith Fund. I direct the trustees of said Hospital to lawfully invest said legacy and to use the income therefrom for the general uses and purposes of said Hospital." Income unrestricted	The Last Will and Testament of Cora Lloyd Smith dated May 10, 1940		Request cy pres relief and transfer to the new Foundation
11-1.39	Bruno E. and Maud J. Doss	$8,000	$15,179	Bequest under Article THIRD d. of the Last Will and Testament of Bruno E. Doss dated May 4, 1956, as amended by Codicil dated June 17, 1957, with additional Codicils dated October 14, 1958 and January 22, 1959	Bequest under the Codicil of "...Eight Thousand (8,000) Dollars in cash to ROCKVILLE CITY HOSPITAL, INC., in trust for the following purpose: To set up a fund to be known as BRUNO E. DOSS and MAUD J. DOSS fund; to invest and reinvest the same in its discretion and to pay over only the income therefrom, at least annually, to the ROCKVILL CITY HOSPITAL GENERAL OPERATING EXPENSE ACCOUNT." Income unrestricted (for use for operations)	The Last Will and Testament of Bruno E. Doss dated May 4, 1956; Codicil dated June 17, 1957; Second Codicil dated October 14, 1958; and Third Codicil dated January 22, 1959		Request cy pres relief and transfer to the new Foundation
11-1.40	Eva Noble Wood Fund	$1,000	$13,398	Bequest under Article FIFTH of the Last Will and Testament of Eva Noble Wood dated June 18, 1964	Bequest to "...the ROCKVILLE CITY HOSPITAL, INC., of said Town of Vernon, the sum of One Thousand (1,000) Dollars to be held by said Hospital and the income from said sum to be used for its general uses and purposes and said sum is to be known as the Eva Noble Wood Fund." Income unrestricted	The Last Will and Testament of Eva Noble Wood dated June 18, 1964		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 6/30/15	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.41	Maud Henry	$50,000	$167,475	Bequest under Article Ninth of the Last Will and Testament of Edward Stevens Henry dated April 22, 1914, with Codicil dated March 3, 1920	Bequest "...to the Hospital to be established in Rockville under the provisions of the will of the late William H. Prescott to be known as the "Rockville City Hospital" This bequest is to constitute a special endowment fund of Fifty thousand dollars $50,000. to be set apart and known as the Maud Henry fund in memory of my deceased daughter Maud....The income of [this fund] is to be used for the maintenance of said Hospital..." Income unrestricted	The Last Will and Testament of Edward Stevens Henry dated April 22, 1914; and Codicil dated March 3, 1920	Note: Mr. Henry left two $50,000 bequests, one for each of his deceased daughters, Maud and Lenore.	Request cy pres relief and transfer to the new Foundation
11-1.42	Lenore Henry	$50,000	$148,101	Bequest under Article Ninth of the Last Will and Testament of Edward Stevens Henry dated April 22, 1914, with Codicil dated March 3, 1920	Bequest of "...Fifty thousand dollars $50,000. to said [Rockville City] Hospital also to be set apart as a separate endowment fund and known as the "Lenore Henry" fund in memory of my deceased daughter Lenore. Income of [this fund] is to be used for the maintenance of said Hospital...." Income unrestricted	The Last Will and Testament of Edward Stevens Henry dated April 22, 1914; and Codicil dated March 3, 1920	Note: Mr. Henry left two $50,000 bequests, one for each of his deceased daughters, Maud and Lenore.	Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 6/30/15	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.43	George Palmer Charter Fund	$10,000	$14,396	Bequest under Article SECOND of the Last Will and Testament of George Palmer Charter (date unknown)	Bequest "...to the Rockville City Hospital, located in the city of Rockville, State of Connecticut, the sum of Ten Thousand (10,000) dollars, in trust, however, for the following uses and purposes, namely: The governing body of said hospital shall invest said sum of $10,000 and the annual income of said sum shall be used for the general maintenance of said Hospital." In addition, the Hospital's records indicate it was entitled to a share of the residue as follows: "SEVENTEENTH: All the rest, residue and remainder of my estate, of whatsoever nature and wheresoever situated which I may own or have the right to dispose of at the time of my decease, I give, devise and bequeath in equal proportions, share and share alike to the Rockville City Hospital located in the city of Rockville, State of Connecticut, and to the Cyril and Julia C. Johnson Memorial Hospital, Inc. located at Stafford Springs, State of Connecticut, in trust each of said hospitals shall invest the sums derived under this Article of my last Will and Testament and the annual income of said sums shall be used for the general maintenance of each of said hospitals." Income unrestricted	Document titled "Source and Terms of Funds Held" originally compiled November 24, 1952, and later supplemented through 1957 (at Pages 3-4)	Note: This fund holds the bequest of $10,000. Whether the Hospital received any distribution under Article SEVENTEENTH is unknown.	Request cy pres relief and transfer to the new Foundation
11-1.44	Anna & Albert Bilson Fund	$10,372	$14,932	Devise under Article NINTH of the Last Will and Testament of Anna M. Bilson dated October 3, 1952	Devise of a share in the residue of the estate as follows: "NINTH: All the rest, residue and remainder of my estate, both real and personal of whatsoever nature and wheresoever situated is to be sold and one-half of the proceeds are to be given to the Union Congregational Church of Christ, Inc. .... The remaining one-half thereof I give and devise unto the Rockville City Hospital, Inc., of the Town of Vernon to be known as the Anna & Albert Bilson Fund. I direct the trustees of said Hospital to lawfully invest said legacy, and to use the income therefrom for the general uses and purposes of said Hospital." Income unrestricted	The Last Will and Testament of Anna M. Bilson dated October 3, 1952		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 6/30/15	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.45	Alvah N. Belding Fund	$3,000	$5,759	Bequest under Paragraph 4. of the Last Will and Testament of Alvah N. Belding dated October 4, 1916	Bequest "...to the trustees of the Rockville City Hospital of Rockville, Connecticut, the sum of Three Thousand (3,000.) Dollars to be used and expended by them for the purposes indicated in the will of the late William H. Prescott regarding the establishment of a City Hospital, as they may deem most advisable." Income unrestricted	The Last Will and Testament of Alvah N. Belding dated October 4, 1916	Note: The Will of William H. Prescott created an endowment with income to be used to establish the Hospital. See Fund 11-1.36	Request cy pres relief and transfer to the new Foundation
11-1.46	Frederick W. Bradley	$2,000	$2,879	Bequest under Article FOURTEENTH of the Last Will and Testament of Frederick W. Bradley dated June 22, 1948	Bequest to "...THE ROCKVILLE CITY HOSPITAL, INC. of said Town of Vernon, the sum of Two Thousand Dollars, in memory of the donor and I direct that said sum be added to the endowment fund of said Hospital, the income thereof to be used for its general uses and purposes." Income unrestricted	The Last Will and Testament of Frederick W. Bradley dated June 22, 1948		Request cy pres relief and transfer to the new Foundation
11-1.47	Ruth T. Britton Fund	$5,000	$7,198	Bequest under Article SIXTEENTH of the Last Will and Testament of Ruth Talcott Britton dated March 12, 1924, with Codicil dated January 26, 1929	Bequest "...to the Rockville Hospital, of Rockville, in the Town of Vernon, Connecticut, the sum of Five Thousand (5,000) Dollars, IN TRUST, NEVERTHELESS, to keep said sum safely invested, and to use and apply the income for the general purposes of said Hospital at the discretion of its trustees." Income unrestricted	The Last Will and Testament of Ruth Talcott Britton dated March 12, 1924; and Codicil dated January 26, 1929		Request cy pres relief and transfer to the new Foundation
11-1.48	William B. and Lizzie Lathrop Sprague Fund	$5,000	$7,198	Bequest under the Will of Lizzie L. Sprague dated February 5, 1921	Bequest of the residue of a testatmentary trust following the death of the life beneficiary as follows: "...at her decease said principal sum of five thousand dollars shall go to The Rockville City Hospital of Rockville, Conn, the same to be known as The Wm. B. and Lizzie Lathrop Sprague Fund." This fund is treated as endowment with income unrestricted.	The Last Will and Testament of Lizzie L. Sprague dated February 5, 1921; and minutes of February 18, 1924 meeting of the Board of Trustees of the Hospital.	Note: The Hospital has treated this as an endowment fund but the language is not clearly so restricted.	Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 6/30/15	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.49	George S. Doane	$5,000	$7,198	Unknown	The document prepared in 1952 and titled "Source and Terms of Funds Held" states as follows: "No record found of source of this fund. Principal is considered permanent endowment - all income is used for expenses of the Hospital." Income unrestricted	Document titled "Source and Terms of Funds Held" dated in 1952 and updated in 1957 (at Page 1); and minutes of January 20, 1953 meeting of the Board of Trustees of the Hospital.	Note: The Hospital located the Will of a George W. Doane in Springfield, but it did not include a bequest to the Hospital.	Request cy pres relief and transfer to the new Foundation
11-1.50	Edgar Keney (Keeney)	$500	$720	Unknown	The document prepared in 1952 and titled "Source and Terms of Funds Held" states as follows: "No record found of source of this fund. It is believed to have been left for a special purpose. In accordance with the instructions of the Board of Trustees of the Hospital, income accumulates and is transferred to principal for reinvestment." Income unrestricted	Document titled "Source and Terms of Funds Held" dated in 1952 and updated in 1957 (at Page 2); and minutes of January 20, 1953 meeting of the Board of Trustees of the Hospital.	Note: The Hospital located the Will of Edgar Keeney and that of Clara, his wife, but neither included a bequest to the Hospital.	Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 6/30/15	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.51	Rockville Chapter American Red Cross Fund	$4,000	$5,759	Gift from Rockville Chapter	The minutes of the 1920 meeting of the Board at which the gift was reported do not document any restriction on use. The document prepared in 1952 and titled "Source and Terms of Funds Held" states as follows: "Gift from Rockville Chapter of American Red Cross - considered permanent endowment - income is used for general expenses of the Hospital". Income unrestricted	Minutes of the January 29, 1920 meeting of the Board of Trustees; and document titled "Source and Terms of Funds Held" dated in 1952 and updated in 1957;	Note: The Hospital has treated this as an endowment fund but the 1920 minutes do not document that restriction.	Request cy pres relief and transfer to the new Foundation
11-1.52	Fred Talcott Fund	$5,000	$7,198	Bequest under Article SIXTEENTH of the Last Will and Testament of Fred Talcott dated January 16, 1917	Bequest as follows: "SIXTEENTH: Whereas one William H. Prescott of said Rockville, now deceased, in and by his will bequeathed a large sum of money towards the support and maintenance of a hospital to be thereafterwards established in said Rockville, and it is my desire to make a contribution towards the erection and establishment of such hospital. I give and bequeath to the persons who at the time of my decease may be the custodians of the said fund, bequeathed as aforesaid by said Prescott, the sum of five thousand dollars to be used by them or their successors in such trust towards the erection and establishment of such hospital." Income unrestricted	The Last Will and Testament of Fred Talcott dated January 16, 1917	Note: See Fund 11-1.36 for the William Prescott Fund and its terms.	Request cy pres relief and transfer to the new Foundation
11-1.53	J. Alice Maxwell Fund	$6,095	$8,774	Devise under Article NINTH of the Last Will and Testament of J. Alice Maxwell dated March 28, 1941; with Codicil dated April 17, 1942	Devise to the Hospital as follows: "NINTH: To ROCKVILLE CITY HOSPITAL, in Rockville, Connecticut, I give, devise and bequeath four of said equal parts of my said residuary estate in trust to use the income thereof for the general purposes of the said Hospital." Income unrestricted	The Last Will and Testament of J. Alice Maxwell dated March 28, 1941; and Codicil dated April 17, 1942		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 6/30/15	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.54	William A. and Caroline E. Metcalf Fund	$7,231	$10,410	Devise under Article NINTH of the Last Will and Testament of Caroline E. Steele Metcalf dated February 13, 1941	Devise of all the rest, residue and remainder of the estate "...to the Trustees of the Rockville City Hospital, Inc., a charitable corporation organized and existing under the laws of the State of Connecticut, ...in trust, nevertheless, to hold, invest and reinvest the same and to use the income thereof for the general uses and purposes of said Hospital as said Trustees shall see fit. Said Trust shall be known as the William A. and Caroline E. Metcalf Fund." Income unrestricted	The Last Will and Testament of Caroline E. Steele Metcalf dated February 13, 1941		Request cy pres relief and transfer to the new Foundation
11-1.55	E. Stevens Henry	$1,742,007	$2,690,090	Article Fourteenth of the Last Will and Testament of Edward Stevens Henry dated April 22, 1914; and Codicil dated March 3, 1920	Devise of the residue of a testamentary trust following the death of the last surviving life beneficiary as follows: "Fourteenth: I give and bequeath One hundred thousand dollars - $100000- to constitute a Trust Fund to be set apart and in custody of the "Security Trust Company" of Hartford or in some other Connecticut Trust Company to be determined by Executors. The net income of said trust fund shall if my wife survives me be paid to my said wife Lucina E. Henry ... If my said wife does not survive me then upon my death, and if she does survive me then upon her death, this trust fund shall thereupon accumulate, if my grand daughter Lucina Ackerly, is then living until she attains the age of twenty five years and then and thereafter the original fund and its accumulations up to the time she attains the age of twenty five years shall be deemed to be the principal of said trust fund, the net income of said principal after said Lucina Ackerly attains the age of twenty five years, as aforesaid shall be paid to my said grandaughter Lucina Ackerly ... Upon the death of said Lucina Ackerly the entire principal fund then remaining I give, devise and bequeath to the Rockville City Hospital hereinbefore referred to, and the same shall thereupon become part of the endowment fund of that institution, absolutely and forever, it being my intention and will that said Rockville City Hospital shall have and possess all the rest residue and remainder of the said trust fund and the principal aforesaid to it absolutely and forever. Income unrestricted	The Last Will and Testament of Edward Stevens Henry dated April 22, 1914; and Codicil dated March 3, 1920	Note: The Hospital received differing advice about the nature of this fund from outside counsels; one advised the Hospital that this fund is totally unrestricted, and another advised that it is endowment with income only to be spent. The fund has been classified as endowment.	Request cy pres relief only for funds, if any, not used by the Hospital

Fund Number	Fund Name	Value of Original Gift	Total Market Value 6/30/15	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
Subtotal: Endowment: Unrestricted Income Funds		$2,318,995	$8,988,179					

Fund Number	Fund Name	Value of Original Gift	Total Market Value 6/30/15	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
Free Bed Funds (Endowment Restricted for Free Care)								
11-1.56	Trumbull Chapter DAR	$157,268	$219,528	Gift of a free bed fund from the Sabra Trumbull Chapter of the Daughters of the American Revolution	Gift from the Sabra Trumbull Chapter of the D.A.R. Althugh the early history of the fund is cloudy, it appears that the fund was started at a bank in 1919, and by 1921 it had reached $5,000. In December 1954, the Advisory Board of the Chapter adopted resolutions governing the use of the bed fund summarized as follows: Income from the fund was to be used for free care with preference given to Chapter members, and, if on January 1 of a year, any income from the prior year remained on hand, it could be used for "deserving and needy people," with any unused income added to principal. The Advisory Board of the Chapter had to right to designate use of the fund. The Chapter subsequently dissolved, and by letter to the Hospital's Board of Trustees dated May 29,1962, Mrs. Donald Fisk of the Chapter advised the Hospital of the dissolution of the Chapter. The letter stated that the bank would continue to maintain the fund "with the discretion in you, as trustees, to choose beneficiaries. The former members of the Sabra Trumbull Chapter will appreciate any preference which you may choose to give to them or to other D.A.R. members as beneficiaries of this fund." Income restricted to free care, with a request to consider use for former members of the Chapter or other members of the D.A.R.	Resolution of the Board of Advisors of the Sabra Trumbull Chapter of the Daughters of the American Revolution dated December 4, 1954; letter dated May 29, 1962 from Mrs. Donald C. Fisk to the Board of Trustees, Rockville City Hospital		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 6/30/15	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.57	Celia E. Prescott Fund holding (two bed funds): 1. Francis and Eliza Porter Keeney Bed Fund (originally $10,000); and 2. Francis Keeney Prescott Bed Fund (originally $5,000)	$15,000	$28,399	Bequests under Paragraph 34 of the Last Will and Testament of Celia E. Prescott dated June 13, 1917	Two bequests to establish free bed funds as follows: 34. I give to the trustees of the said Rockville City Hospital for the benefit of the same, the sum of Ten Thusand (10,000.) Dollars, for the establishment of a free bed in honor of my late father and mother, Francis and Eliza Porter Keeney, and I request that in the use of the same preference be given, if occasion arises, to any of the descendants of the Keeney family....I also give to the trustees of the said hospital, for the benefit of the same, the sum of Five Thousand (5,000.) Dollars, for the establishment of a free bed in loving memory of my late son, Francis Keeney Prescott. Income restricted to free care, with preference for descendants of the Keeney family members for the Francis and Eliza Porter Keeney Bed Fund	The Last Will and Testament of Celia E. Prescott dated June 13, 1917		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 6/30/15	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.58	Charles Phelps Free Bed Fund	$10,000	$15,382	Inter Vivos Gift from Elsie S. Phelps	Inter vivos gift from Elsie S. Phelps to establish a free bed fund in honor of her husband to be known as the Charles Phelps Free Bed Fund. Per the records of the Hospital, the terms are as follows: "Gift of $10,000 from Mrs. Elsie S. Phelps - Permanent endowment - Income for special purposes. Any amount of this fund in excess of $10,000 represents accumulated income and is considered available if necessary. Terms of Gift: 1. For the benefit of any members of my household staff or their families who may be in need of the services which the fund can provide. 2. For the general use and benefit of the residents of the City of Rockville. The fund, aside from the small conditions which I wish to impose for the benefit of my household staff, which will fall within the income limitations of the fund, will be managed by the Board of Trustees and Finance Committee of The Rockville City Hospital with full powers or sale, investment and reinvestment." Income restricted to free care, first for members of Elsie Phelps's household staff and their families and then for residents of Rockville	Document titled "Source and Terms of Funds Held" originally compiled November 24, 1952, and later supplemented through 1957 (at Page 3)		Request cy pres relief and transfer to the new Foundation
11-1.59	Winchell-Foster	$15,000	$22,083	Bequest under ARTICLE THIRD (j) of the Last Will and Testament of Minnie Foster Riley	Bequest of "The sum of Fifteen Thousand ($15000) Dollars to the Rockville City Hospital of Rockville, Connecticut, as a permanent fund to be known as the "Winchell-Foster Free Bed Fund" in memory of my grandparents, Cyrus and Hester Winchell, and my parents, Wilbur and Mary Edna Foster, and which sum shall be held and invested and reinvested as the governing body of said Hospital shall, in its sole discretion deem best, and the income from which shall be used for the maintenance of a free bed in said Hospital." Income restricted for free care	Letter of unclear date (July 31, 19??) from The First National Bank of Denver to the Hospital with the extract from the Will.		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 6/30/15	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.60	Betsey C. Tucker	$2,000	$3,345	Bequest under Article SECOND of the Last Will and Testament of Betsey C. Tucker dated June 21, 1949	Bequest "to the Rockville City Hospital, of Rockville, Connecticut, Two Thousand (2000) Dollars to be its absolutely and forever. This bequest is to be used by said Hospital as an endowment for the partial maintenance of a free bed in said Hospital." Income restricted for free care	The Last Will and Testament of Betsey C. Tucker dated June 21, 1949		Request cy pres relief and transfer to the new Foundation
11-1.61	Anna Shelton Whitlock	$20,120	$27,768	Devise under Article 2. of the Last Will and Testament of Florence R. Whitlock dated August 28, 1929	Upon the death of the life beneficiary of the residuary trust, the remainder of the residue was ro be divided into ten (10) equal parts, to be "disposed of as follows:... The remaining Four-tenths (4/10th) of said residue, I give, devise and bequeath to the Rockville City Hospital for the purpose of establishing a free bed or beds in said Hospital in memory of my mother, Anna Shelton Whitlock." Income restricted for free care	The Last Will and Testament of Florence R. Whitlock dated August 28, 1929		Request cy pres relief and transfer to the new Foundation
11-1.62	Elsie Sykes Phelps Free Bed Fund	$5,975	$18,684	Bequest under Article IV (c) of the Last Will and Testament of Elsie Sykes Phelps dated September 28, 1955	Bequest "To the ROCKVILLE CITY HOSPITAL, of said Rockville, founded by the late William H. Prescott of said Rockville, fifty (50) shares of the capital stock of The Travelers Insurance Company, and I direct that the Trustees of said Hospital add the same to the permanent endowment of a free bed for said Rockville City Hospital, such gift to be called the "Elsie Sykes Phelps Free Bed Fund". Income restricted for free care	The Last Will and Testament of Elsie Sykes Phelps dated September 28, 1955		Request cy pres relief and transfer to the new Foundation
11-1.63	John and Martha Kress Fund	$500	$2,650	Bequest under Article Fourth of the Last Will and Testament of Martha M. Kress dated April 3, 1918	Bequest of "...the sum of Five Hundred Dollars to the Rockville City Hospital to be used for the purpose of equipping, furnishing and maintaining a room in [the] Hospital to be known and called the "John and Martha Kress room." Income restricted for free care	The Last Will and Testament of Martha M. Kress dated April 3, 1918	Note: The Hospital has historically classified this as a free bed fund, but the language of the bequest is not clear on this point.	Request cy pres relief and transfer to the new Foundation
Subtotal: Free Bed Funds		$225,863	$337,839					
Endowment Restricted to Purpose Other Than Free Care								

Fund Number	Fund Name	Value of Original Gift	Total Market Value 6/30/15	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.64	Julia and Percy Baker Family Memorial Fund	$145,770	$206,703	Devise under ARTICLE III (a) of the Last Will and Testament of Percy W. Baker dated June 22, 1990, with Codicils dated April 26, 1995 and May 16, 1997	Devise of a share in the residuary estate as follows: "Residue. All the rest, residue and remainder of my property, real and personal, of whatever nature and wherever situated, I give, devise and bequest as follows: (a) twenty (20) per cent to be held in trust to establish a fund known as the Julia and Percy Baker Family Memorial Fund. Said fund is to be used for the upkeep and physical maintenance of the Rockville General Hospital, Rockville, Connecticut. The physical maintenance of the Hospital by said fund is defined to include items such as painting, roof repairs, furnace repairs or replacement carpet repairs or replacement, or any other repairs or replacement of existing fixtures so as to keep the Hospital in good physical condition. The intent is that the principal of the fund so established and known as the Julia and Percy Baker Family Memorial Fund not be invaded. Only interest or other income generated by the Fund shall be used for purposes of physical maintenance, and the corpus of said fund is not to be invaded by the Trustee." Income for the upkeep and physical maintenance of the Hospital	The Last Will and Testament of Percy W. Baker dated June 22, 1990; First Codicil dated April 26, 1995; and Second Codicil dated May 16, 1997		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 6/30/15	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.65	Faith S. Schortmann Fund	$132,820	$177,356	(1) Bequest under ARTICLE VI of the Last Will and Testament of Faith S. Schortmann dated November 21, 1990; and (2) Devise of a share in the residuary estate under ARTICLE VIII A of said Will.	Bequest to ROCKVILLE GENERAL HOSPITAL of "the proceeds of all my investments with the IDS Financial Services, Inc., and its related companies, to be held as a separate fund known as the FAITH S. SCHORTMANN FUND. Said Fund shall be restricted, and the Board of Trustees or other governing body of said ROCKVILLE GENERAL HOSPITAL, INC., shall invest and reinvest such Fund in any manner it deems appropriate, but shall use or expend only the income therefrom (without invasion of the principal of said Fund) for such purposes directly related to the operation and/or improvement of the maternity and nursery facilities of said ROCKVILLE GENERAL HOSPITAL, INC., in whatever manner it deems appropriate." Devise of "FORTY-FIVE PERCENT (45%) of my said residuary estate to ROCKVILLE GENERAL HOSPITAL, INC., of Vernon, Connecticut, to be added to and become a part of the FAITH S. SCHORTMANN FUND, to be used and expended in accordance with the terms of Article VI of this, my Last Will and Testament." Income for the operation or improvement of the maternity and nursery facilities of the Hospital.	The Last Will and Testament of Faith S. Schortmann dated November 21, 1990		Request cy pres relief and transfer to the new Foundation
Subtotal: Endowment Restricted to Purpose Other Than Free Care		$278,590	$384,059					

Fund Number	Fund Name	Value of Original Gift	Total Market Value 6/30/15	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
Unrestricted Funds								
11-1.66	Swindells Fund	$74,473	$107,214	Gifts from the F.W. Swindells Charitable Foundation, which was established under Article Sixth of the Last Will and Testament of Frederick W. Swindells dated October 15, 1930	The income from the Foundation (Trust) established under the Will, is to be paid "... to charitable corporations or societies incorporated for the relief of sick and suffering poor children and/or for the sick, suffering and indigent, aged men and women, and/or for the support of public and charitable hospitals....The ultimate beneficiaries of this charity shall be poor and suffering individuals." Available documentation supports that this fund is fully expendable.	The Last Will and Testament of Frederick W. Swindells dated October 15, 1930; Letters dated October 24, 1933, from The Hartford National Bank and Trust Company and The Travelers Bank and Trust Company, Trustees, transmitting two $500 checks (unrestricted); Minutes of January 27, 1936 meeting of the Board of Trustees documenting receipt of $500; Minutes of January 21, 1941 meeting of the Board of Trustees documenting receipt of $500; and document titled "Source and Terms of Funds Held" dated in 1952 and updated in 1957 (at Page 5)	Note: In an effort to obtain additional information, the Hospital spoke with Kate Kirkheart of the Swindells Charitable Foundation at the Bank of America; although the Bank has some old correspondence related to donations, it declined to release copies of the correspondence or a statement of gifts.	Request cy pres relief only for funds, if any, not used by the Hospital
11-1.67	Harriet K. Maxwell Fund	$5,000	$15,325	Bequest under Article Third of the Will of Harriet K. Maxwell	Bequest "...unto the Rockville City Hospital of Rockville, Connecticut, the sum of Five Thousand Dollars ($5,000)". Unrestricted	Minutes of the January 20, 1953 meeting of the Board of Trustees; and document titled "Source and Terms of Funds Held" originally compiled November 24, 1952, and later supplemented through 1957 (at Page 2)	Note: A Harriet K. Maxwell died in 1996 in Arizona, but her Will does not include this gift, which is believed either to have come from the Will of a different member of the family or have been incorrectly designated in the old Board records as a bequest. A May 11, 1998 letter from William W. Graulty concerning gifts from the Harriet K. Maxwell Foundation also does not include any information about this fund.	

Fund Number	Fund Name	Value of Original Gift	Total Market Value 6/30/15	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.68	Robert Maxwell Fund	$100,000	$143,964	Bequest under Article First of the Last Will and Testament of Robert Maxwell dated November 21, 1919	Bequest to "...my Executors hereinafter named, or the survivors or survivor of them, the sum of One hundred thousand dollars ($100,000.), to be devoted by them to the establishment and maintenance of a suitable building or buildings, grounds and equipment in the City of Rockville, State of Connecticut, where the residents of the City of Rockville and vicinity may, without charge and without regard to race or religion, obtain healthful exercise, recreation, amusement and instruction, or, in the discretion of my Executors, the said principal sum or the income thereof, or both, to be devoted by them in such other manner as they deem suitable for the benefit of the said residents of Rockville and vicinity." Unrestricted	The Last Will and Testament of Robert Maxwell dated November 21, 1919		Request cy pres relief only for funds, if any, not used by the Hospital
11-1.69	F. Maxwell Memorial	$283,919	$1,171,938	Bequest under Article FIRST of the Codicil dated Novermber 19, 1941; and Devise under Article THIRTEENTH of the Last Will and Testament of Francis T. Maxwell dated May 15, 1940	Bequest to Rockville City Hospital of "the sum of One hundred thousand dollars ($100,000)." Devise of a share of trust assets upon termination of various testamentary trusts if no issue of the Testator is living at the time of termination as follows: "THIRTEENTH: All the rest, residue and remainder of my property, real and person, of every kind, nature and description and wheresoever situated, ... I give, devise, bequeath and appoint to my TRUSTEES.... ..(e) In the event that, upon the termination of any of said trusts, there should be no issue of mine then living, then, and in such event, I direct that the capital of such trust shall be divided into two equal parts, one of which parts I give, devise and bequeath to ROCKVILLE CITY HOSPITAL and the other to HARTFORD HOSPITAL." Unrestricted	The Last Will and Testament of Francis T. Maxwell dated May 15, 1940; and Codicil dated November 13, 1940		Request cy pres relief only for funds, if any, not used by the Hospital

Fund Number	Fund Name	Value of Original Gift	Total Market Value 6/30/15	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.70	Memorial Funds	$328,454	$1,284,252	Unknown	This fund holds on a consolidated basis many gifts contributed to the Hospital over the years from many sources. It has been reported as unrestricted endowment for many years. The creation of this fund is referenced in the January 20,1953 Minutes of the Board of Trustees of the Hospital. This fund is believed to be totally unrestricted as to income and principal.	Minutes of January 20, 1953 meeting of the Board of Trustees of the Hospital; and January 24, 1968 letter from Attorney Donald B. Caldwell to Robert C. Hector of CHEFA		Request cy pres relief only for funds, if any, not used by the Hospital
11-1.71	Mary E. Snyder	$1,621	$2,121	Devise under Paragraph SIXTH(hh) of the Last Will and Testament of Mary E. Snyder dated My 20, 1955	Devise of a share in the residuary estate as follows: "SIXTH: All the rest, residue and remainder of all my property, both real and person, of whatsoever the same may consist or wheresoever it may be situated, I direct be divided into thirty-five equal shares and distributed as follows, to wit:... (hh) one equal share to the ROCKVILLE CITY HOSPITAL, INC. of said Rockville, in memory of my late sister Flora C. Snyder and in my memory, for its general uses and purposes." Unrestricted	The Last Will and Testament of Mary E. Snyder dated May 20, 1955		Request cy pres relief only for funds, if any, not used by the Hospital
11-1.72	Charles F. Batz	$4,000	$5,957	Inter Vivos Gift from Emma Batz for her brother, Charles F. Batz	Inter vivos gift of $4,000 Unrestricted	Correspondence between the Hospital and Emma Batz in 1993 and 1994; and the Last Will and Testament of Charles F. Batz dated November 2, 1992.	Note: ARTICLE FIVE of Charles Batz's Last Will and Testament dated November 2, 1992, left the residue of his estate outright to his sister, Emma, and, if she did not survive him, one-fourth of the residue to the Hospital outright. Emma did survive, so the Hospital was not entitled to a portion of the Estate, but Emma Batz made a $4,000 gift to the Hospital in his memory. The correspondence documenting the gift incorrectly says or suggests that this gift was a bequest from the Estate.	Request cy pres relief only for funds, if any, not used by the Hospital

Fund Number	Fund Name	Value of Original Gift	Total Market Value 6/30/15	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.73	Francis J. Gregory	$122,965	$34,238	Devise under Article FOURTH of the Last Will and Testament of Francis J. Gregory dated March 16, 1979	Devise of a share of the residuary estate as follows: "FOURTH: All the rest, residue and remainder of my estate, wherever it may be found, shall be distributed equally among the following [six organizations]: ...Rockville General Hospital, Rockville, Connecticut,..." Unrestricted	The Last Will and Testament of Francis J. Gregory dated March 16, 1979		Request cy pres relief only for funds, if any, not used by the Hospital
11-1.74	John A. Duell	$5,000	$7,445	Bequest under Article THIRD of the Last Will and Testament of John A. Duell dated September 14, 1988	Bequest to "ROCKVILLE GENERAL HOSPITAL of Rockville, Connecticut, the sum of FIVE THOUSAND ($5,000) DOLLARS, for its general use and purpose." Unrestricted	The Last Will and Testament of John A. Duell dated September 14, 1988		Request cy pres relief only for funds, if any, not used by the Hospital
11-1.75	Edna O. Rider	$10,000	$14,892	Bequest under Article THIRD A. of the Last Will and Testament of Edna O. Rider dated April 1, 1982	Bequest as follows: "THIRD: I give, devise and bequeath all the rest, residue and remainder of the property which I may own at the time of my death, real, personal and mixed, of whatsoever nature and wheresoever situated, as follows: A. The sum of Ten Thousand ($10,000.00) Dollars to the ROCKVILLE GENERAL HOSPITAL of Rockville, Connectiuct to be used and expended for the benefit of such hospital in any manner it deems appropriate." Unrestricted	The Last Will and Testament of Edna O. Rider dated April 1, 1982		Request cy pres relief only for funds, if any, not used by the Hospital
11-1.76	Barbara J. Sadrozinski	$20,739	$30,438	Devise under Article THIRD B. of the Last Willl and Testament of Barbara J. Sadrozinski dated January 22, 1993.	Devise of a share of the residuary estate as follows: "THIRD I give, devise and bequeath all the rest, residue and remainder of my proprty, both real and personal, of which I shall die seized and possessed, wherever situated, as follows:...B. Twenty (20%) percent thereof to ROCKVILLE GENERAL HOSPITAL, INC., of Vernon, Connecticut, to be its absolutely and forever." Unrestricted	The Last Willl and Testament of Barbara J. Sadrozinski dated January 22, 1993.		Request cy pres relief only for funds, if any, not used by the Hospital
Subtotal: Unrestricted Funds		$956,171	$2,817,785					

Fund Number	Fund Name	Value of Original Gift	Total Market Value 6/30/15	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
Addiitonal Information								
11-1.77	$9,603.46 Two-Life Survivor Charitable Gift Annuity (Names of Annuitants withheld)	NA	NA	Gift of remainder interest in annuity	$9,603.46 Two-Life Survivor Charitable Gift Annuity; remainder to Hospital on the death of the second to die Unrestricted	Two-Life Survivor Charitable Gift Annuity Agreement dated December 20, 1993 (with names redacted)	One of the two joint annuitants has now lived beyond his/her life expectancy determined as of the time of the gift. This annuity therefore now is a contractual liability of the Hospital rather than a charitable asset.	RGH will explore options with the annuitant to terminate this arrangement at fair value.
11-1.78	$10,000 Two-Life Survivor Charitable Gift Annuity (Names of Annuitants withheld)	NA	NA	Gift of remainder interest in annuity	$10,000 Two-Life Survivor Charitable Gift Annuity; remainder to Hospital on the death of the second to die Unrestricted	Two-Life Survivor Charitable Gift Annuity Agreement dated November 3, 1994 (with names redacted)	One of the two joint annuitants has now lived beyond his/her life expectancy determined as of the time of the gift. This annuity therefore now is a contractual liability of the Hospital rather than a charitable asset.	RGH will explore options with the annuitant to erminate this arrangement at fair value.
Subtotal: Additional Information		$0	$0					
Grand Total: Rockville General Hospital		$3,779,619	$12,527,862					

Fund Number	Fund Name	Value of Original Gift	Total Market Value 6/30/15	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
	ECHN COMMUNITY HEALTHCARE FOUNDATION, INC.							
	Endowment for Benefit of MMH: Unrestricted Income							
11-1.79	Hazel Burgess	$113,624	$113,624	Devise under Article THIRD of the Last Will and Testament of Hazel S. Burgess dated July 20, 1959	Devise of half the residue of a testamentary trust following the death of the last surviving life beneficiary as follows: "THIRD: All the rest, residue and remainder of my estate, both real and personal, of whatsoever the same may consist and wheresoever the same may be located, I give, devise and bequeath to CONNECTICUT BANK AND TRUST COMPANY, IN TRUST NEVERTHELESS, for the following uses and purposes:... (d) Upon the death of all of the beneficiaries hereunder, I direct that this Trust shall thereupon terminate, and the principal, together with any accumulation of income, be paid equally to the Board of Trustees of South Methodist Chruch and the Trustees of Manchester Memorial Hospital, both of Manchester, Connecticut, to be safely invested by each, and the income only therefrom to be used for the general uses and purposes of said Church and Hospital." Income unrestricted	The Last Will and Testament of Hazel S. Burgess dated July 20, 1959	Note: This fund was left to Manchester Memorial Hospital, but it is held by the ECHN Community Healthcare Foundation for the Hospital.	Request cy pres relief and transfer to the new Foundation
11-1.80	Raymond A. St. Laurent and Helen St. Laurent	$10,000	$10,000	Bequest under Article NINTH 2. of the Last Will and Testament of Helen E. St. Laurent dated July 13, 1989	Bequest of "...the sum of TEN THOUSAND ($10,000.00) DOLLARS each unto each of the following named institutions or foundations, the income only from each of said bequest to be used for the general uses and purposes of said institution or foundation, the fund for each to be in memory of RAYMOND A. ST. LAURENT and HELEN E. ST. LAURENT. ... 2. MANCHESTER MEMORIAL HOSPITAL, presently of 71 Haynes St., Manchester, Connecticut; ..." Income unrestricted	The Last Will and Testament of Helen E. St. Laurent dated July 13, 1989	Note: This fund was left to Manchester Memorial Hospital, but it is held by the ECHN Community Healthcare Foundation for the Hospital.	Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 6/30/15	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.81	Donald G. Piper and Hazel B. Piper	$1,161,399	$1,161,399	Devise under Article FOURTH of the Last Will and Testament of Hazel B. Piper dated November 30, 1990	Devise of residue of estate as follows: "FOURTH: All the rest, residue and remainder of my property, both real and personal, and of whatsoever nature, wherever the same may be located or found, which I may own or have the right to dispose of at my death (intending hereby to exercise any power of disposition or appointment that I may have at my death), I give, devise and bequeath unto MANCHESTER MEMORIAL HOSPITAL, of Manchester, Connecticut, in memory of DONALD G. PIPER and HAZEL B. PIPER, to be held in the Consolidated Investment Fund, the income only from which is to be used at the discretion of the Board of Trustees of the hospital for its general uses and purposes." Income unrestricted	The Last Will and Testament of Hazel B. Piper dated November 30, 1990	Note: This fund was left to Manchester Memorial Hospital, but it is held by the ECHN Community Healthcare Foundation for the Hospital.	Request cy pres relief and transfer to the new Foundation
Subtotal: Endowment for Benefit of MMH: Unrestricted Income		$1,285,023	$1,285,023					

Fund Number	Fund Name	Value of Original Gift	Total Market Value 6/30/15	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
	Endowment for Benefit of RGH: Restricted Income							
11-1.82	Harriet K. Maxwell Fund	$250,000	$250,000	Grant from the Harriet K. Maxwell Foundation dated May 11, 1998	Grant to the Hospital of $250,000 as follows: "On behalf of the Directors of the Harriet K. Maxwell Foundation, I am pleased to report that the Foundation has made a grant to Rockville Hospital in the aggregate amount of $400,000. This grant consists of two parts, namely, a grant of $250,000 to establish the Harriet K. Maxwell Fund, an endowment fund to provide for the normal maintenance and repair of the Maxwell Home and its grounds and a separate grant of $150,000 to pay for the major structural repairs to the Home which are considered essential for its preservation and continued use as an integral part of the Hospital. With regard to the $250,000 Fund, this grant is conditioned on the continued use of the Maxwell Home as a part of the Hospital; and that if the Home is not so used for a period of 24 consecutive months or if the Home is damaged or destroyed and not restored to its prior level of usefulness within a reasonable time thereafter, then the balance of the Fund shall be transferred to the George Maxwell Library of Rockville, Connecticut, to be held as an endowment fund for its general uses and purposes." Income restricted for the Maxwell House	Letter dated May 11, 1998, from Attorney William W. Graulty to Annette B. Leahy of the Hospital awarding the grant; letter of June 1, 1998, from Mr. Graulty to Ms. Leahy; letter of June 1 from Mr. Graulty to Ms. Leahy forwarding a corrected copy of the May 11, 1998 letter; and press release dated June 11, 1998	Note: This contains a gift over to the George Maxwell Library of Rockville if the Hospital no longer uses the Maxwell Home as part of the Hospital.	Gift over to the George Maxwell Library of Rockville

Fund Number	Fund Name	Value of Original Gift	Total Market Value 6/30/15	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.83	Majorie Risley Scholarship Fund	$32,289	$32,289	Established by gifts to the Hospital	Endowment fund restricted as follows: "The Majorie Risley Scholarship Fund is established with the following primary objective: To assist nurses with their continuing education programs. The money to be used would be for educational programs that will help the nurse maintain a high level or expertise. A second use for the money would be to bring educators to this hospital to bring educational programs to a group of nurses. The principal of the fund is to be invested with high interest in mind. The income only is to be used for the above purposes. The Director of Nurses will determine who is to receive the assistance. If she needs advice relative to who should receive assistance she will consult the committee members. The members are: George E. Risley; Bunny Whelton, Geraldine Strong and Margaret Connors, R.N." Income restricted for nursing education	Statement titled "Marjorie Risley Scholarship Fund" and dated February 1, 1982		Request cy pres relief and transfer to the new Foundation
Subtotal: Endowment for Benefit of RGH: Restricted Income		$282,289	$282,289					
Grand Total: ECHN Community Healthcare Foundation, Inc.		$1,567,312	$1,567,312					
GRAND TOTAL FOR ECHN		$6,941,933	$23,656,277					
Additional Information								

Fund Number	Fund Name	Value of Original Gift	Total Market Value 6/30/15	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.84	Katherine Sykes Bissell	_	—	Bequest under Article SEVENTH (a) of the Last Will and Testament of Katherine Sykes Bissell dated March 10, 1969 with two codicils	Seventh: (a) I give and bequeath the sum of Fifty Thousand Dollars ($50,000) to The Rockville General Hospital, Incorporated, of Rockville, Connecticut, in memory of my parents, Mr. and Mrs. Thomas W. Sykes, the income therefrom to be used for the general purposes of said Hospital.	Last Will and Testament of Katherine Sykes Bissell dated March 10, 1969; Codicil dated April 13, 1970: and Codicil dated April 28, 1972	Note: During its search of probate court records for original documentation, the Hospital found this Last Will and Testament, which includes a $50,000 bequest. This bequest is not separately booked or recorded on the Hospital's records, and the Hospital has not located any other records about this bequest.	

EXHIBIT Q11-1
ECHN: SPECIAL PURPOSE FUNDS - FUNDS 11-1.85 - 11-1.96

Notes:

1. The funds are held by ECHN Community HealthCare Foundation ("ECHN Foundation) for the benefit of Manchester Memorial Hospital ("MMH"), Rockville General Hospital ("RGH"), and Woodlake at Tolland ("Woodlake").
2. The names of the donors to various funds have been redacted.
3. The current fund balance of a given fund will generally be less than the total gifts to the fund because funds are being used on an onging basis for the specific purpose.

Fund Number	Fund Name	Fund Balance 6/30/15	Terms of Gift	Supporting Documentation	Proposed Handling of Fund
11-1.85	MMH: DeQuattro Cancer Center - Avis Lloyd Tree of Life	$95	Donors make a contribution for a leaf, dove or boulder to be added to the Tree of Life sculpture. Contributions are used for Survivorship Navigation and other services at the Cancer Center and are disbursed quarterly.	Fund profile with list of donations; copies of 2009 and 2012 brochures	To the extent there are funds remaining, request cy pres relief and transfer to the new Foundation
11-1.86	ECHN Foundation: Team Towanda Foundation	$3,923	For uninsured women over the age of 40 for mammography, breast ultrasounds, surgical consultations, and related services. The fund also provides pharmacy gift cards to purchase medical and personal care items for use after surgery or to purchase medication (Outpatient).	Fund profile with list of donations; copies of representative letters and communications with Team Towanda Foundation re gifts and uses	To the extent there are funds remaining, request cy pres relief and transfer to the new Foundation
11-1.87	ECHN Foundation: Employee Care Fund	$1,571	To provide confidential emergency assistance to employees in need; employee requests are made through a chaplain to the Fund. The Fund no longer solicits (the most recent appeal was in 2009); the existence of the Fund is well-known to employees, who make unsolicited contributions to it.	Fund profile with summary information	To the extent there are funds remaining, request cy pres relief and transfer to the new Foundation
11-1.88	ECHN Foundation: Breast and Cervical Cancer Program	$558	For outreach, education, enrollment, screening and diagnostic follow-up for underinsured women for cancer and heart disease, whether inpatient or outpatient.	Fund profile with list of donations; copy of representative fundraiser flyer from major donor (fire department) and documentation of gifts from another major donor (hospital volunteers)	To the extent there are funds remaining, request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Fund Balance 6/30/15	Terms of Gift	Supporting Documentation	Proposed Handling of Fund
11-1.89	MMH: Adult Ambulatory Administrative Education & Development	$2,492	To offset costs in excess of ECHN tuition reimbursement for the pursuit and completion of a Master's Degree related to the roles of Adult Ambulatory Behavioral Health Coordinator, Adult Ambulatory Behavioral Health Associate Director, or Adult Ambulatory Behavioral Health Director at Manchester Memorial Hospital. Costs may include tuition, books, supplies, travel, or any other miscellaneous expenses, including computer hardware and software.	Fund profile and list of recent gifts	To the extent there are funds remaining, request cy pres relief and transfer to the new Foundation
11-1.90	MMH: Drs' Campbell and Oh Trophies	$3,678	The fund maintains the trays for the Daniel Paul Purcell MD Memorial Golf Classic tournament (now called the ECHN Mason & Purcell Golf Classic), an annual fundraising event; It pays for, among other things, the engraving of the names of the low gross winners.	Fund profile	To the extent there are funds remaining, request cy pres relief and transfer to the new Foundation
11-1.91	Woodlake: Woodlake at Tolland Wishes Program	$1,573	These funds are used to grant "wishes" for long term care residents at Woodlake (long term care facility). Wishes have included a trip to NY, limo rides, luncheon trips, and special outings. Some gifts were made for listing names (honor/memorial) in the Woodlake at Tolland 10th Anniversary Program Book.	Fund profile with list of donations.	To the extent there are funds remaining, request cy pres relief and transfer to the new Foundation
11-1.92	ECHN Foundation: Van Fund	$4,200	Donations from members of the Business Alliance for Community Health to purchase a new van for ECHN.	Fund profile with list of donations; email re van	To the extent there are funds remaining, request cy pres relief and transfer to the new Foundation
11-1.93	RGH: Risley Fund	$3	Supports educational opportunities for nursing staff.	Fund profile; this is the income from the Marjorie Risley Scholarship endowment held by the ECHN Foundation.	To the extent there are funds remaining, request cy pres relief and transfer to the new Foundation
11-1.94	Doris Fields	$582	Funds are used to support the RGH Hospice unit as a memorial to Doris Fields.	Fund profile with list of memorial donations.	To the extent there are funds remaining, request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Fund Balance 6/30/15	Terms of Gift	Supporting Documentation	Proposed Handling of Fund
11-1.95	Woodlake: Resident Council Fund	$385	This account is funded by the residents of Woodlake at Tolland. The goal is to provide the residents a mechanism for self-expression and self-determination. The Resident Council is mandated by the State of Connecticut as a part of the Residents Bill of Rights. All monies are raised by the residents for the residents and used as determined by the residents of Woodlake.	Fund profile with list of donations	Continued use by Woodlake residents
GRAND TOTAL		$19,060			
Additional Information					
11-1.96	ECHN Foundation: $10,000 One Life Charitable Gift Annuity (Name of Annuitant withheld)	Current value of the residuum is $4,196.	If there is a value on termination, to be used for intensive care unit expansion fund	Charitable Gift Annuity Agreement	Gift of remainder interest in annuity. Present value of remainder will be held until the termination of the agreement; depending on the actual life of the donor, this arrangement could eventually become a liability rather then an asset. ECHN Foundation will explore options with the donor to terminate this arrangement at a fair value.

EXHIBIT Q11-1
ECHN: TRUSTS HELD BY OUTSIDE TRUSTEES - FUNDS 11-1.97 - 11-1.106

Note: The outside Trustee(s) will have primary responsibility for actions and decisions on the distribution of trust income/assets after ECHN ceases operations and will be responsible for requesting any necessary judicial cy pres relief. ECHN will support, to the extent possible and to the extent consistent with the terms of a given trust, the payment of trust income to the new Foundation to be used to promote the health of the ECHN communities.

Fund Number	Name of Trust	Market Value of Trust Held by Trustee 6/30/2015	Current Trustee	Terms of Trust	Supporting Documents	Notes
TRUSTS F/B/O MANCHESTER MEMORIAL HOSPITAL						
11-1.97	Barton Family Trust (Trust u/w Mary K. Barton)	$ 1,274,286.05	Bank of America	"FOURTH: If my sister, ANNA H. BARTON, does not survive me, then all the rest, residue and remainder of my estate, real, personal and mixed, together with any lapsed legacies, I give, devise and bequeath unto the SHAWMUT BANK, with offices in Hartford, Connecticut, or its successors, as Trustee of a certain trust to be known as the BARTON FAMILY TRUST. I ORDER AND DIRECT my Trustee ... to pay all of the net income thereof in convenient installments at least quarter/annually to or for the benefit of, the Manchester Memorial Hospital. If the Manchester Memorial Hospital or its lawful successor is no longer in existence, or if it is not then a charitable organization within the meaning of the Internal Revenue Code, the net income shall be distributed to one or more organizations selected by the trustee, each of which is a charitable organization as defined in Sections 170(c) and 2055(a) of the Internal Revenue Code of 1986, as amended from time to time, in such proportions among such organizations as the trustee shall decide."	Last Will and Testament of Mary K. Barton dated February 1, 1993	Note: This trust directs the trustee to shift the income to one or more charitable organizations if MMH or its lawful successor is no longer in existence.
11-1.98	The Addison L. Clark Fund (Trust u/w Luella C. Hale)	$155,282.57	Bank of America	"ARTICLE XI. I give to THE FIRST NATIONAL BANK OF HARTFORD the sum of Twenty Thousand Dollars ($20,000), in trust, however, to hold and manage, invest and reinvest, and to pay over the income derived therefrom to the TRUSTEES OF THE MANCHESTER MEMORIAL HOSPITAL, to be used for such general hospital charges and expenses as said Trustees shall deem best, said fund to be known as "THE ADDISON L. CLARK FUND." "	Last Will and Testament of of Luella C. Hale dated February 7, 1938	Note: This Will does not provide for another disposition if MMH no longer exists.

Fund Number	Name of Trust	Market Value of Trust Held by Trustee 6/30/2015	Current Trustee	Terms of Trust	Supporting Documents	Notes
11-1.99	The Willie T. Morton Fund (Trust u/w Willie T. Morton)	$227,912.31	Bank of America	"ELEVENTH: If the conditions set out in the two preceding clauses shall not be met with, and said sum of One Hundred Thousand (100,000) Dollars shall not be paid to said young Men's Christian Association or used for said The Morton Library Association, then I direct that said sum of One Hundred Thousand (100,000) Dollars, with accumulated interest, shall be disposed of by my said Trustee, as follows: . . . [Sections A-C direct that $20,000 be distributed to two trusts established for other charities and$10,000 given to the residue of the estate] D. The remainder of said sum of One Hundred Thousand (100,000) Dollars, I direct shall be held by my said Trustee, and one-third of said income shall be paid to the Young Men's Christian Association of Hartford, Connecticut; one-third to the Newington Home for Crippled Children of Newington, Connecticut; and one-third to the Memorial Hospital of Manchester, Connecticut. TWELFTH: [The residary estate] I give, devise and bequeath to The Hartford-Connecticut Trust Company, of Hartford, Connecticut, as Trustee, IN TRUST, for the uses and purposes and with the powers and subject to the provisions and limitations hereinafter set out: ...C. If at my death, neither my wife nor any descendants survive me; or if at the death or remarriage of my said wife, no descendants of mine should be living, or if there should be funds in my Trustee's hands under the provisions of sub-section B above and there should be no descendants of mine living at any time, then I direct that the funds in my Trustee's hands shall be used as follows: One-third of the income therefrom shall be paid to the Young Men's Christian Association of Manchester, or to The Morton Library Association of Manchester, whichever institution may take the funds under the provision of Clauses Ninth and Tenth of this Will; One-third of said income shall be paid to the Memorial Hospital of Manchester, Connecticut; and one-third of said income shall be paid to the Newington Home for Crippled Children. If neither the Young Men's Christian Association of Manchester nor The Morton Memorial Library receive the funds under the provisions of Sections Ninth and Tenth of this Will, then I direct that one-half of said income be paid to said Memorial Hospital of Manchester, and one-half said income be paid to the Newington Home for Crippled Children. I direct that the income so held and used for charitable purposes under the provisions of this Clause Twelfth shall be known as "The Willie T. Morton Fund." THIRTEENTH provides for an alternative dispoisiton of the income interest if any organization receiving income should cease to exist,	Last Will and Testament of Willie T. Morton dated February 27, 1924	Note: The trust provides for a gift over of the income interest if MMH ceases to exist.
11-1.100	Trust u/w Grace Robertson	$145,674.37	Bank of America	**Last Will and Testament signed August 20th, 1940.** ARTICLE VII: I give to The Manchester Trust Company, a Corporation under the laws of the State of Connecticut, and located in said town of Manchester, the sum of Forty Thousand ($40,000.00) Dollars, in trust, however, to take hold, manage, invest and reinvest, and to pay the net income therefrom to the Trustees of the Manchester Memorial Hospital, a Connecticut corporation, located in said Town of Manchester, to be used for general hospital purposes. **Codicil signed August 20th, 1940.** ARTICLE I: In case my estate does not amount to enough to pay all of the special bequests or gifts made in said will, it is my will that such special bequests and/or gifts be eliminated in the following order: . . . (g) Gift for the benefit of the Manchester Memorial Hospital, set forth in Article VII; to the end that all special bequests be paid in full with the exception of the seven gifts named in this Article and that those be paid in full, if the amount of my estate admits such payment, but if such payment cannot be made, then and in that event, so far as possible, bequests and/or gifts be paid as set forth; First to the Hospital; second to the Playgrounds; Third to the Manchester Y.M.C.A.; Fourth for Education; Fifth for Parks; Sixth to the Connecticut Humane Society; and Seventh to Thorsby Institute.	Last Will and Testament of Grace Robertson dated August 20, 1940; Codicil dated August 20, 1940; Codicil dated September 10, 1942: Codicil signed August 29, 1945; and Codicildated November 10, 1953	Note: This Will does not provide for another disposition if MMH no longer exists.

Fund Number	Name of Trust	Market Value of Trust Held by Trustee 6/30/2015	Current Trustee	Terms of Trust	Supporting Documents	Notes
11-1.101	Albert L. Crowell & Maytie Case Crowell Fund (Trust u/w Maytie Case Crowell)	$177,591.88	Bank of America	SIXTH: [This Article makes provision for the perpetuation of a memorial to the Testatrix's mother, Marietta Stanley Case, in the form of an Austin organ given by her family to South Methodist Church, in Manchester, Connecticut,. After reserves for a certain purpose have been accumulated], income from the trust estate herein provided for organ purposes may be distributed from time to time to Manchester Memorial Hospital for its general purposes, but provision for distribution to said Hospital shall not prevent the trustee from again accumulating and using income for organ purposes. SEVENTH: I give and bequeath the sum of fifteen thousand (15,000) dollars IN TRUST to said The Connecticut Bank and Trust Company, and in its successors in this trust upon the following trusts: Said trustee shall have power to take, hold, receive, sell, invest and reinvest this trust estate and the proceeds thereof in such investments as would be selected by a prudent investor, and it may also invest in a common trust fund managed by it; and after the payment of administration expenses it shall pay over the net income therefrom quarterly, or oftener in its discretion, in perpetuity, to The Manchester Memorial Hospital for its general purposes, this gift to be known as the Albert L. Crowell and Maytie Case Crowell Fund. Articles NINTH, ELEVENTH, THIRTEENTH and FOURTEEN provide for contingent addiitonal gifts to the Article SEVENTH trust.	Last Will and Testament of Maytie Case Crowell dated May 17, 1957	Note: This Will does not provide for another disposition if MMH no longer exists.
11-1.102	Trust u/w Andrew Ferguson	$3,816,726.59	Bank of America	ELEVENTH: All the rest, residue and remainder of my estate of every name and nature, both real and personal, including any lapsed or void legacies and devises, I give, devise and bequeath to THE CONNECTICUT BANK AND TRUST COMPANY, absolutely and in fee simple, BUT IN TRUST, NEVERTHELESS, to be held as a permanent fund in memory of ANDREW and ANN FERGUSON, for the benefit of MANCHESTER MEMORIAL HOSPITAL, of Manchester, Connecticut, and the net income therefrom, after the payment of all necessary expenses, including reasonable compensation to my said trustee, to be paid not less often than quarterly to said Manchester Memorial Hospital, for its general uses and purposes.	Last Will and Testament of Andrew Ferguson dated April 4, 1961	Note: This Will does not provide for another disposition if MMH no longer exists.

Fund Number	Name of Trust	Market Value of Trust Held by Trustee 6/30/2015	Current Trustee	Terms of Trust	Supporting Documents	Notes
11-1.103	Trust u/w Gertrude H. Rogers	$3,738,871.95	Original Trustees: Phoenix State Bank and Trust Company, and Robert S. Morris, of West Hartford, Connecticut	Article FIFTH creates a trust with $100 each month paid to a life beneficiary. The balance of the net income and, after the death of the life beneficaiary, the entire net income "shall be held, used and applied for the benefit of the Manchester Memorial Hospital, a charitable corporation located in said Manchester, for which this fund shall be held as a charitable use in perpetuity, subject to the following limitations: I direct that the net income from this fund shall be used and applied for the support and development of that department of said Hospital which shall be devoted to the medical or pathological service of that Hospital, and more specifically to its research and laboratory work, that is, any investigation towards the alleviation of illness, including payment of salaries of an adequate staff, and the installation and maintenance of proper equipment, to enable that hospital to furnish complete laboratory service of this kind to the staff of that Hospital and to the physicians of the Town of Manchester for their patients of that town, whether they are then patients of that Hospital or not. Accordingly, I direct that the net income each year shall only be disbursed to the said Hospital upon a budget for this department submitted by the Hospital to the trustees under this will and approved in writing by two competent physicians..." [The Will thereafter contains very long and detailed provisions about the physicians, the budget, and the use of funds.] My purpose in creating these limitations and conditions is to keep this fund a living force in building up the quality of medical service in that Hospital and in that community, through the establishment of highly competent technical service in research and laboratory work. If at any time the trustees of my estate shall be satisfied, after conferring with the disinterested physicians whose duty it shall then be to approve the budget as above provided, that The Manchester Memorial Hospital is not devoting said funds to the purposes for which the gift is made, or is not maintaining as adequate and competent a research and laboratory staff and department as the available income will permit, said trustees shall notify the Manchester Memorial Hospital to that effect and if the failure is not corrected within a reasonable time said trustees may terminate the right of The Manchester Memorial Hospital to receive further funds under this will and thereafter said trustees may apply the income of said fund for similar purposes at the Hartford Hospital in Hartford, Connecticut. [The section continues with the requirement that there shall be two trustees, and describes how trustees shall be appointed]. Article FIRST of the Second Codicil amends Article FIFTH but does not modify the requirement that if MMH does not use the funds as specified the trustees may terminate the right of MMH to receive further funds.	Last Will and Testament of Gertrude H. Rogers dated July 13, 1937; Codicil dated October 11, 1939; Codicil dated October 21, 1940.	Note: There is no specific gift over if MMH no longer exists as a charitable organization. The Will states that if MMH fails to use the gift as intended, the trustee may apply the income for similar purposes at Hartford Hospital.
	Subtotal: Manchester Memorial Hospital	$ 9,536,345.72				

Fund Number	Name of Trust	Market Value of Trust Held by Trustee 6/30/2015	Current Trustee	Terms of Trust	Supporting Documents	Notes
TRUSTS F/B/O ROCKVILLE GENERAL HOSPITAL						
11-1.104	Emma Dillon Rockville City Hospital Fund (Trust u/w Laurence M. Dillon)	$454,864.66	Bank of America	"9. I hereby give, devise and bequeath all the rest, residue and remainder of my estate, both real and personal, of whatsoever kind or character, including lapsed legacies and devises, and wheresoever situated, to THE CONNECTICUT BANK AND TRUST COMPANY, Hartford, Connecticut, as Trustee. Said Trustee shall hold, manage and control all of the aforesaid property as a trust estate, with all the rights and powers, and subject to the limitations, hereinafter enumerated, for the following uses and purposes: . . . [Part A creates a life estate for Mr. Dillon's cousin, and Part B provides that upon the death of the cousin, or if she does not survive him], the Trustee shall divide the corpus of the trust estate into two (2) equal parts, IN TRUST, NEVERTHELESS , for the following uses and purposes: 1) One of said parts, so divided, shall be set apart for the benefit of the ROCKVILLE CITY HOSPITAL, Rockville, Connecticut, its successors or assigns, in perpetuity, and the Trustee shall pay to it, or its successors or assigns, all of the net annual income derived from its said particular fund, in annual or other convenient installments. It is my wish that said fund be named the EMMA DILLON ROCKVILLE CITY HOSPITAL FUND in memorial of my beloved mother. Said net income shall be used for such general purposes as its governing board shall deem proper, and at is discretion. 2) The remaining second part, so divided, shall be set apart for the benefit of ST. BERNARD'S SOCIETY, INC. of Rockville, Connecticut . . . . In the event any or all the net income of this trust directed to be distributed to said ST. BERNARD'S SOCIETY, INC. is not distributable to said Society for a period of fifty (50) years from the date of my death for any reason, including a disclaimer by said income beneficiary, the net income of this second part shall be distributed to the ROCKVILLE CITY HOSPITAL, Rockville, Connecticut, its successors or assigns, until fifty (50) years from the date of my death, when the remaining net corpus and accretions of said remaining second part shall be paid over absolutely to said ST. BERNARD'S SOCIETY, INC., its successors or assigns.	Last Will and Testament of Laurence M. Dillon dated February 5, 1954	Note: The Will includes the language "its successors or assigns" after naming Rockville City Hospital
11-1.105	The Marguerite E. Moxon and Dorothy Moxon Yost Memorial Trust	$282,640.23	Bank of America	4. Use of Trust Fund. The Trustee shall distribute not less than annually all of the net income from the Trust as follows: One-half of said income to the Trustees of the Rockville General Hospital, Rockville, Connecticut, to be used by the Board of Trustees or other governing body for the benefit of such Rockville General Hospital solely for such capital improvements as the Board of Trustees or other governing body may see fit. The remaining one-half of said income to the Union Congregational Church, now located on Union Street, Rockville, Connecticut, to be used by the Board of Trustees or other governing body for the benefit of the Union Congregational Church in any manner it deems fit.	Trust Agreement dated April 2nd, 1982 between Marguerite E. Moxon and Dorothy Moxon Yost and the Connecticut Bank and Trust Company	Note: The Trust Agreement does not provide for another disposition if MMH no longer exists.
11-1.106	Trust u/w William E. Barton	$1,434,907.63	Bank of America	THIRD: All the rest, residue and remainder of my estate, real, personal and mixed, and wherever the same may be situated, I give, devise and bequeath in manner and form as follows, to wit: . . . [Section a) describes a gift in trust to ST. CATHERINE CEMETERY]. b) I give, devise and bequeath all the rest, residue and remainder of my estate unto the CONNECTICUT NATIONAL BANK, of Hartford, Connecticut, or its successors, as Trustee. I order and direct my trustee to invest and reinvest all the assets in the trust account as it in its absolute discretion deems fit and to pay therefrom all the net income thereof unto my two sisters, ANNA H. BARTON and MARY K. BARTON, both of the Town of South Windsor, for so long as they shall live. Upon their death, I order and direct that all of the net income thereof be paid over and distributed unto the ROCKVILLE GENERAL HOSPITAL, of Rockville, Connecticut, to be used by it as it deems fit.	Last Will and Testament of William E. Barton dated December 9, 1988	Note: The Will does not provide for another disposition if MMH no longer exists.
Subtotal: Rockville General Hospital		$2,172,412.52				
	GRAND TOTAL	$ 11,708,758.24				

EXHIBIT Q 11-2 – UNDERLYING DOCUMENTATION FOR ALL FUNDS

BULK FILE ONLY

EXHIBIT Q 11-2

FUNDS 11-1.1 TO 11-1.106

LIST OF ENDOWMENT AND OTHER CHARITABLE FUNDS

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11-1.47	Ruth T. Britton Fund	1293
11-1.48	William B. and Li□ie Lathrop Sprague Fund	1299
11-1.49	George S. Doane	1307
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EXHIBIT Q 11-2

Fund 11-1.1

Dwight W. Blish Fund

WILL 122 B Cleaveland Legal Blank Office, Publishers, Hartford, Conn.

Be It Known to all Persons, THAT I, Dwight W. Blish of the Town of Manchester in the County of Hartford in the State of Connecticut being of lawful age, of sound and disposing mind, memory and judgment, do hereby make, publish and declare this to be my last Will and Testament, hereby revoking all previous wills and codicils by me made.

First: I direct that all my just debts and funeral expenses be paid by my executor hereinafter named.

Second: I give to the town of Manchester the sum of One Hundred Dollars, in trust however, to invest the same and to use the income therefrom for the perpetual care of my burial plot in the East Cemetery in said Manchester.

Third: I give to my wife Alice E. C. Blish and to my son Hayward C. Blish all my wearing apparel, watches, jewelry, household furnishings, furniture, tools and my automobile.

Fourth: All the rest and residue of my property both real and personal and whereever situated I give, devise and bequeath to The Manchester Trust Company of said Manchester, in trust however, to take, hold, invest and reinvest the same and to use the income therefrom for the support and maintenance of my said wife and son or the survivor of them. In case the income from said trust fund is not sufficient for the comfortable support and maintenance of my said wife and son then I authorize said trustee to use any or all of the principal for said purpose. I direct said trustee to pay the funeral expenses of my said son from said trust fund and in the event that there should not be funds available for the funeral expenses of my said wife I direct said trustee to also pay her funeral expenses. It being my desire that my said wife and son shall always have a home of their own during their lifetime I hereby direct said trustee upon the written request of my said wife to sell the house occupied by her and my son and to purchase another home for her upon like request. Unless so requested by my said wife the house occupied by her and my son shall not be sold. I authorize and empower said trustee to sell all other real estate owned by me at the time of my death if it shall deem best. At the death of my said wife and son I give whatever property may then remain in the hands of said trustee to The Manchester Memorial Hospital to be held by the trustees of said hospital as a trust fund to be known as the Dwight

I Appoint The Manchester Trust Company
of the Town of Manchester County of Hartford
and State of Connecticut executor of this my Last Will and Testament

In Witness Whereof I have hereunto set my hand and seal at said Manchester
on the 6 day of September A. D., One Thousand, Nine Hundred and twenty-three.

Dwight W. Blish (L. S.)

Signed, sealed, published and declared by the said Dwight W. Blish
as and for his Last Will and Testament, in presence of us who at h is request, in his presence, and in
the presence of each other have hereunto subscribed our names as witnesses, on the 6 day
of September A. D., 1923.

Thomas K. Clarke
Raymond R. Bowers
William S. Hyde
Witnesses.

State of Connecticut, } ss. Manchester September 6 A. D. 1923.
County of Hartford }

We the within named Thomas K. Clarke and Raymond R. Bowers
being duly sworn, make affidavit and say: That we severally attested the within and foregoing Will of the within named testator and subscribed the same in his presence and at his request and in the presence of each other; that the said testator signed, published and declared the said instrument as and for his last Will and Testament in our presence on the 6 day of September A. D., 1923; and at the time of execution of said will, said testator was more than eighteen years of age and of sound mind, memory and judgment and under no improper influence or restraint to the best of our knowledge and belief, and we make this affidavit at the request of said testator.

Thomas K. Clarke
Raymond R. Bowers

State of Connecticut, } ss. Manchester September 6 A. D. 1923.
County of Hartford }

Then personally appeared before me a Notary Public duly qualified to administer oaths.

Thomas K. Clarke
and Raymond R. Bowers
and subscribed and made oath to the truth of the foregoing affidavit.

William S. Hyde
Notary Public.
~~Justice of the Peace.~~
~~Commissioner of Superior Court for~~ County.

KNOW ALL MEN BY THESE PRESENTS that I, Dwight W. Blish, of the Town of Manchester, County of Hartford, and State of Connecticut, being of lawful age, of sound and disposing mind, memory and judgment, do hereby make, publish and declare this to be a Codicil to my Last Will and Testament, dated September 6, 1923.

I.

I appoint The Manchester Trust Company, a Connecticut corporation located in said Manchester, Executor of this my Last Will and Testament.

In all other respects I hereby ratify and confirm said Will.

IN WITNESS WHEREOF I have heretunto set my hand and seal at said Manchester, on the 3rd day of July, A.D., One Thousand Nine Hundred and Thirty-three.

Dwight W. Blish (L.S.)

Signed, sealed, published and declared by the said Dwight W. Blish as and for a codicil to his Last Will and Testament, in presence of us, who at his request, in his presence, and in the presence of each other have hereunto subscribed our names as witnesses, on the 3rd day of July, A.D., 1933.

Elsie E. Nielsen
Louis H. Mastie
Witnesses
Robert E. Hathaway

State of Connecticut : ss. Manchester, July 3rd A.D.,1933.
County of Hartford :

We the within named Elsie E. Nielsen, Louis H. Mastie and Robert E. Hathaway being duly sworn, make affidavit and say: That we severally attested the within and foregoing Codicil of the within named testator, and subscribed the same in his presence and at his request and in the presence of each other; that the said testator signed, published and declared the said instrument as and for a Codicil to his last Will and Testament in our presence on the 3rd day of July, A.D., 1933; and at the time of execution

-2-

of said Codicil, said testator was more than eighteen years of age and of sound mind, memory and judgment and under no improper influence or restraint to the best of our knowledge and belief, and we make this affidavit at the request of said testator.

Elin C. Nielsen
Louis H. Marte
Robert E. Hathaway

State of Connecticut : ss. Manchester, ~~June~~ July 3rd A.D., 1933.
County of Hartford :

Then personally appeared before me a Commissioner of Superior Court, duly qualified to administer oaths.

Elin C. Nielsen
Louis H. Marte
and Robert E. Hathaway

and subscribed and made oath to the truth of the foregoing affidavit.

Harold C. Alvord
NOTARY PUBLIC

EXHIBIT Q 11-2

Fund 11-1.2

John & Eliza Carpenter

ARTHUR ANDERSEN LLP

THE MANCHESTER MEMORIAL HOSPITAL

FINANCIAL STATEMENTS

AS OF SEPTEMBER 30, 1996 AND 1995

TOGETHER WITH

REPORT OF INDEPENDENT PUBLIC ACCOUNTANTS

ECHN Proposed Asset Purchase by PMH
Submitted October 13, 2015

THE MANCHESTER MEMORIAL HOSPITAL

BALANCE SHEETS

SEPTEMBER 30, 1996 AND 1995

ASSETS	1996	1995
CURRENT ASSETS:		
Cash and cash equivalents	$ 11,195,218	$ 4,815,148
Assets limited as to use required for current liabilities	1,336,424	1,339,924
Accounts receivable, less allowance of $3,219,000 in 1996 and $4,195,000 in 1995	14,254,759	17,408,055
Other accounts receivable	527,152	110,473
Inventories of supplies	454,705	401,832
Prepaid insurance and other expenses	289,004	216,194
Due from related entities	378,501	127,053
Total current assets	28,435,763	24,418,679
ASSETS LIMITED AS TO USE, net of current portion:		
By Board of Trustees	21,989,954	20,374,985
Assets held in trust for estimated self-insurance liabilities	8,810,621	7,926,764
Assets under bond indenture	857,350	863,159
Total assets limited as to use	31,657,925	29,164,908
INVESTMENTS	7,624,105	6,855,136
UNAMORTIZED BOND ISSUE EXPENSES	1,135,001	1,235,599
PROPERTY AND EQUIPMENT, at cost:		
Land	1,051,326	1,051,326
Land improvements	817,298	817,298
Buildings and building improvements	32,941,893	32,918,537
Major movable equipment	32,092,964	30,436,010
Fixed equipment	22,815,650	22,652,060
	89,719,131	87,875,231
Less - accumulated depreciation	51,733,156	47,299,424
	37,985,975	40,575,807
CONSTRUCTION IN PROGRESS	3,248,534	1,925,742
Total property and equipment, net	41,234,509	42,501,549
Total assets	$110,087,303	$104,175,671

LIABILITIES AND NET ASSETS	1996	1995
CURRENT LIABILITIES:		
Accounts payable	$ 3,675,596	$ 2,553,392
Connecticut sales and receipts tax payable	5,038,911	4,088,296
Due to third-party agencies	8,340,046	7,101,383
Accrued salaries and wages, payroll taxes and amounts withheld from employees' compensation	3,613,472	3,229,530
Accrued pension and other postretirement benefits	516,000	223,386
Accrued interest payable	341,423	344,924
Current maturities of long-term debt	1,296,936	1,295,998
Total current liabilities	22,823,384	18,836,889
ESTIMATED SELF-INSURANCE LIABILITIES	5,611,602	6,218,097
ACCRUED PENSION AND OTHER POSTRETIREMENT BENEFITS, net of current portion	7,760,393	8,262,027
LONG-TERM DEBT, less current maturities	21,360,260	22,657,194
COMMITMENTS AND CONTINGENCIES		
NET ASSETS:		
Unrestricted	50,504,887	46,216,894
Temporarily restricted	655,939	611,932
Permanently restricted	1,370,838	1,370,838
Total net assets	52,531,664	48,201,664
Total liabilities and net assets	$110,087,303	$104,175,671

The accompanying notes are an integral part of these financial statements.

	MANCHESTER MEMORIAL HOSPITAL				
	ENDOWNMENT FUNDS POOLED				
			9/30/1995	9/30/2001	9/30/2013
			Original	Original	Original
	Date of	Donation Description	Amount	Amount	Amount
	Donation		of Gift	of Gift	of Gift
		UNRESTRICTED INCOME FUNDS			
1	3/35	DWIGHT BLISH	$19,841.35	$19,920.00	$19,920.00
2		JOHN & ELIZA CARPENTER	$2,555.00	$2,555.00	$2,555.00
3		HELEN G CHAPMAN	$5,000.00	$5,000.00	$5,000.00
4		WILLIAM H CONTES	$129.00	$129.00	$129.00
5		GRACE K DART	$4,007.00	$4,007.00	$4,007.00
6		GRACE L HOUSE	$2,500.00	$2,500.00	$2,500.00
7		JOHN & CAROLINE PORTER	$7,464.00	$7,464.00	$7,464.00
8	11/57	WILLIAM & MARY RICE	$122,361.19	$122,361.19	$122,361.19
9		ROBERT & FLORCILA STANLEY	$3,000.00	$3,000.00	$3,000.00
10	5/61	GEORGE & ROSE STROUT	$128,043.30	$128,043.30	$128,043.30
11		MINNIE R STRICKLAND	$2,511.00	$2,511.00	$2,511.00
12		ARTHUR & CARRIE ELLIS	$5,000.00	$5,000.00	$5,000.00
13	7/40	RALPH & LULU PINNEY	$41,375.25	$41,375.25	$41,375.25
14		SOPHIE & SAMUAL DISKAN*			
15		THOMAS & RONALD FERGUSON*			
16		RAYMOND GRISLEE JR*			
17		EMIL L G HOLENTHAL	$179.00	$179.00	$179.00
18		GEO W &CF BIDWELL*			
19		EVA BIDWELL HARRIS*			
20		JW & MR CHENEY	$75,000.00	$75,000.00	$75,000.00
21	12/63	HC CHENEY	$543,561.81	$543,561.81	$543,561.81
22		HEBERT DEWEY	$1,498.00	$1,498.00	$1,498.00
23		JUNE DEWEY	$936.00	$936.00	$936.00
		DONALD G. PIPER AND HAZEL B. PIPER	$0.00	$0.00	$75,000.00
		DONALD G. PIPER AND HAZEL B. PIPER	$0.00	$0.00	$75,000.00
24	3/93	HAZEL S BURGESS	$113,623.92	$113,623.92	under Foundation
25	5/95	HELEN ST LAURENT	$10,000.00	$10,000.00	under Foundation
		TOTAL UNRESTRICTED	$1,088,585.82	$1,088,664.47	$1,115,040.55
		LESS UNRESTRICTED FUND BALANCE			
		ADJUSTED UNRESTRICTED			
		RESTRICTED INCOME FUNDS			
		FREE BED:			
26	1/60	DRAKE BED FUND	$90,499.84	$90,499.84	$90,499.84
27	5/31	LOREN GARDNER	$25,000.00	$25,000.00	$25,000.00
28		MATTIE HILLS PRESTON	$8,000.00	$8,000.00	$8,000.00
29		P O BOYNTON	$923.00	$923.00	$923.00
	09/23/97	ERNA LOOMIS		$196,394.42	$196,394.42
		SUBTOTAL FREE BED	$124,422.84	$320,817.26	$320,817.26
30		ELSIE C DISHER	$151,579.19	$151,579.19	$151,579.19
31		THOMAS D TROTTER	$128.00	$128.00	$128.00
32	11/57	WILLIAM & REBECCA WRIGHT	$6,123.63	$6,123.63	$6,123.63
		TOTAL RESTRICTED	$157,830.82	$157,830.82	$157,830.82
		TOTAL POOLED INVESTMENTS	$1,370,839.48	$1,567,312.55	$1,593,688.63
		HELD AT FOUNDATION:			
		HAZEL BURGESS			$113,623.92
		HELEN ST. LAURENT			$10,000.00
		HAZEL B. PIPER			$1,161,399.20
			$0.00	$0.00	$1,285,023.12
		INTEREST IN TRUST ASSETS	$0.00	$0.00	$5,700,198.92
		TOTAL PERM RESTRICTED	$1,370,839.48	$1,567,312.55	$8,578,910.67
		TOTAL PER AUDITED FINANCIAL STATEMENTS	$1,370,838.00	$1,567,311.00	$8,578,909.00
		VARIANCE	$1.48	$1.55	$1.67

EXHIBIT Q 11-2

Fund 11-1.3

Helen G. Chapman

KNOW ALL MEN BY THESE PRESENTS, That I, HELEN G. CHAPMAN, of Manchester, in the State of Connecticut, being of sound and disposing mind and memory, do hereby make, publish and declare the following to be my last will and testament, hereby revoking all former wills by me made, that is to say:

FIRST: I direct that all legacy, inheritance, succession and transfer taxes levied or imposed by the State of Connecticut or by the United States, or by any other state or country, upon my estate or upon any gift or devise under this will, or upon any legatee on account of any gift under this will, shall be paid by my executors out of my general estate and charged and allowed as an item of the expense of administration of my estate.

SECOND: I give the sum of Ten Thousand Dollars ($10,000) IN TRUST to the Hartford National Bank and Trust Company, a national banking association located in Hartford, Connecticut, and to its successors in this trust, upon the following trusts:

Said trustee shall have power of sale, investment and reinvestment of said trust fund and, after paying the expenses of said trust, it shall pay over the net income of said trust fund quarterly or oftener in its discretion to my half sister, Mrs. Jennie C. Ela, of Manchester, Connecticut, during the remainder of her life, and at her death said trust shall cease and said trustee shall pay over and distribute the principal of said trust estate as then constituted in equal shares to Jeannette Ela Talcott and Lucy Ela Cramer, who are daughters of said Jennie C. Ela, to be theirs absolutely and free of any trust. If either of said two daughters shall not then be living but shall have died leaving issue then living, said trustee shall pay over the share of the one so dying with issue to such issue then living, per stirpes, to be theirs absolutely and free of any trust.

THIRD: I give to said Hartford National Bank and Trust

Helen G. Chapman

Company, Trustee under a trust agreement made by Helen G. Chapman and Mary O. Chapman with said Bank, dated October 31, 1929, for the benefit of Mrs. Lucy Ela Cramer and her children, the sum of Five Thousand Dollars ($5,000), to be added to the trust now held by said trustee under said trust agreement.

FOURTH: I give the sum of Five Thousand Dollars ($5,000) to the Memorial Hospital, of Manchester, Connecticut, to be held by it in perpetuity, with power of investment, sale and reinvestment, and to apply the income only for the support of the Hospital maintained by it in the town of Manchester.

FIFTH: I give the sum of Twenty-five Hundred Dollars ($2500) to the Ecclesiastical Society connected with the Center Congregational Church of Manchester, Connecticut, to be held by

Dollars ($2000) to said Ecclesiastical Society, to be applied by it toward its debt.

These two gifts to the said Ecclesiastical Society are made upon the express condition that neither I nor my estate

Dollars ($1,000), with power of investment and reinvestment, the income only to be used for the care and improvement of our family

I give to George Clarke, of Manchester, the sum of Fifteen Hundred Dollars ($1500) in recognition of faithful service.

I give to Willis C. Woodruff, now living on Middle Turnpike, Manchester, Connecticut, the sum of Five Hundred Dollars ($500).

I give to Mrs. Lina Runer, of 35 Division Street, Manchester, the sum of Seven Hundred Dollars ($700).

I give to Carl I. Anderson, now in our employ, the sum of Five Hundred Dollars ($500).

I give to each of the household maids who shall be in our employ at the time of my death as a full time employee, and who shall have been so employed for at least one year prior thereto the sum of Two Hundred Dollars ($200).

EIGHTH: I give the sum of Two Thousand Dollars ($2,000) to the Austen Riggs Foundation, Incorporated, of Stockbridge, Massachusetts, to be used and applied by it from time to time toward the payment of services which it may render to persons who otherwise would be unable to have the benefit of such treatment.

NINTH: I give the sum of Two Thousand Dollars ($2,000) to Cromwell Hall, a corporation located in Cromwell, Connecticut, to be used and applied by it from time to time toward the payment of services which it may render to persons who otherwise would be unable to have the benefit of such treatment.

TENTH: All the rest, residue and remainder of my property, of whatever nature, real and personal, and wherever situated, I give, devise and bequeath to my sister, Mary O. Chapman, if she shall survive me for a period of six months, to be hers absolutely.

ELEVENTH: In case my said sister, Mary O. Chapman, shall not survive me for a period of six months, then and in that event only, I make the following disposition of the residue of my estate otherwise given to her by the preceding paragraph:

(a) I give and bequeath to my half sister, Mrs. Jennie C.

Helen G. Chapman } witness
Wallace W. Brown } witness
Spencer Rogers

Ela, as an estate for life, all my right, title and interest as then constituted in and to the land and buildings comprising our home on Forest Street in said Manchester if she shall elect to occupy the same and maintain it during the remainder of her life, with the further obligation of paying taxes, insurance premiums and repairs.

[redacted] sister shall not elect, within six months [redacted] this devise of a life estate, this gift [redacted] shall not take effect and, in lieu thereof, I give and bequeath to her granddaughter, Dorothy Talcott Beal, a life estate in the same property and upon the same terms, provided she shall elect within three months after the gift becomes available to her to accept this life estate and, if neither my said half sister, [redacted] nor her granddaughter, Dorothy Talcott Beal, [redacted] gifts shall not [redacted] divided interest [redacted] Bank and [redacted] trust, upon the following trusts:

Said trustee shall sell said premises and hold the proceeds as a special fund in trust, to pay the income of said fund to said Jennie C. Ela during the remainder of her natural [redacted]

[redacted] Beal shall elect to accept the devise of the life estate, then upon the termination of that life estate I direct that my executor shall sell said premises and divide the proceeds in the same way as is provided in the preceding paragraph hereof.

I further direct that my executor shall keep said home open for six months or more after my death so that the same may

be ready and available for the life tenant in case either said Jennie C. Ela or Dorothy Talcott Beal shall elect to accept this gift of a life estate.

If said Jennie C. Ela or Dorothy Talcott Beal shall elect to accept said life estate of said home, I also give to that one who makes such election the use for life of all my right, title and interest in and to the household furniture and furnishings in that home as then existing, and I provide that she shall not be obligated to give a bond as life tenant.

In case neither of them shall elect to accept that life estate, or, upon the termination of the life estate, if one of them elects to accept it, I give all my right, title and interest as then constituted in said household furniture and furnishings to said Dorothy Talcott Beal, if she shall then be living, and if she shall not be living I give the same to her sister, Eleanor Talcott Orloff. In both cases the gift shall be absolute, but, without limiting the foregoing gift or imposing any trust or condition thereon, I express the hope that said Dorothy Talcott Beal or Eleanor Talcott Orloff, as the case may be, shall dispose of a portion of said articles in accordance with my wishes as she may know them to be from a memorandum or otherwise.

(b) I give, devise and bequeath to Miss Gertrude H. Rogers, of Manchester, Connecticut, all my interest as then constituted in the real estate situated on the Middle Turnpike, so-called, in Manchester, known as "The Farm", together with all personal property then owned by me and situated thereon and used in connection with the same; my intent being to give to her all my interest as then constituted in the entire farm property, both real and personal, to be hers absolutely.

(c) I give, devise and bequeath all the rest, residue and remainder of my estate, both real and personal and wherever situated, including all lapsed legacies and devises, in the contingency above stated that my sister shall not survive me for a period of six months, IN TRUST to said Hartford National Bank and

Helen G. Chapman { Charles Willis Ross / William H. Brown / Spencer Gross } witness

[redacted]

Trust Company, and to its successors in this trust, upon the following trusts:

Said trustee shall have power to sell, invest and reinvest said trust estate from time to time according to its best judgment, without being limited to so-called trust investments, and shall [redacted] in accordance with the following

[redacted] tions and other institutions of a public and charitable or benevolent nature, operating for the moral, physical or social betterment of people, as said trustee shall select, provided that no officer, member or employee of any such institution shall receive any pecuniary profit from the operations thereof except reasonable compensation for services rendered in effecting one or more of such purposes or as a proper beneficiary of its strictly charitable purposes.

And in the exercise of such power of selection I authorize and empower said trustee, subject to the terms of this trust, to disburse as soon as properly can be done, the entire fund, principal and income, in gift to such [redacted]

[redacted]

be after the fund is distributed to it.

TWELFTH: I hereby nominate and appoint said Hartford National Bank and Trust Company and my sister, Mary O. Chapman, to be the executors of this will. So far as I am able, I hereby excuse them from giving any probate bonds as such executors.

IN WITNESS WHEREOF, I have hereunto set my hand and seal,

ECF N Proposed Asset Purchase by PMH
Submitted October 13, 2015

declaring this to be my last will and testament, this 1st day of July, 1938.

Helen G. Chapman (L.S.)

Signed, sealed, published and declared by said testatrix, Helen G. Chapman, as and for her last will and testament, in the presence of us, the undersigned, who in her presence and in the presence of each other, at her request, have hereunto set our names as witnesses, this 1st day of July, 1938.

Charles Welles Gross Hartford, Conn.
Wallace W. Brown West Hartford, Conn.
Spencer Gross Hartford, Conn.

State of Connecticut)
) ss: Hartford, July 1st 1938.
County of Hartford)

Then and there personally appeared the above named Charles Welles Gross, Wallace W. Brown and Spencer Gross who, being duly sworn, depose and say that they witnessed the execution of the foregoing will of said testatrix, Helen G. Chapman; that she subscribed said will and declared the same to be her last will and testament in their presence; that they thereafter subscribed the same as witnesses in the presence of said testatrix and in the presence of each other and at the request of said testatrix; that said testatrix at the time of the execution of said will appeared to them to be of full age and of sound and disposing mind and memory; and that they make this affidavit at the request of said testatrix.

Charles Welles Gross
Wallace W. Brown
Spencer Gross

Subscribed and sworn to this 1st day of July, 1938, before me

Esther T. Johnson
Notary Public.

MMH Hospital - Helen G Chapman Fund

Will of Helen G. Chapman - Fourth Paragraph

I give the sum of Five Thousand ($5000) Dollars to the Manchester Memorial Hospital, of Manchester Connecticut, to be held by it in perpetuity, with power of investment, sale and re-investment, and to apply the income only for the support of the Hospital maintained & kept in the Town of Manchester

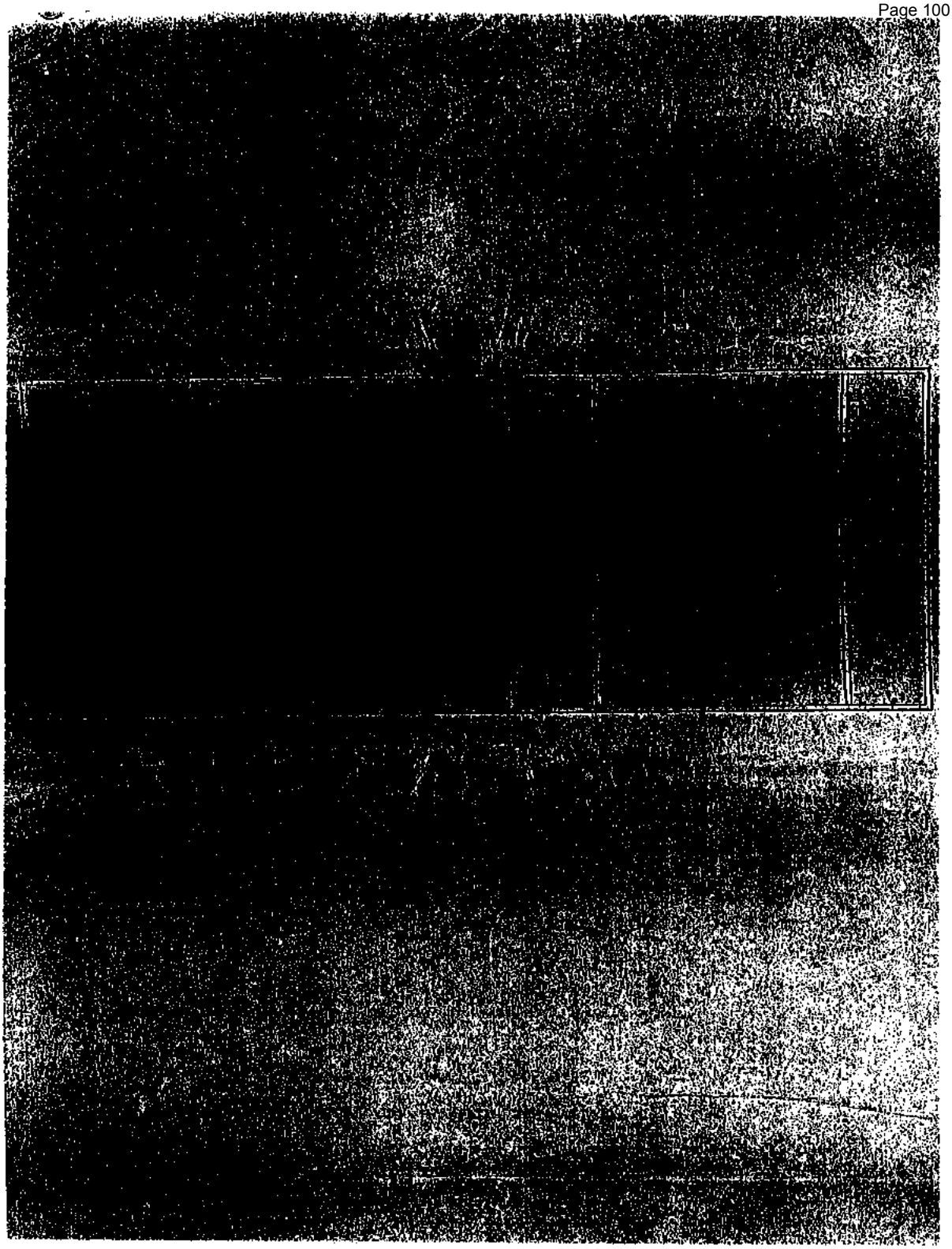

EXHIBIT Q 11-2

Fund 11-1.4

William H. Coates
(Costes)

Secretary.
F. A. Cheney

REGULAR MEETING, AUGUST 1925

The regular monthly meeting of the Trustees was held August 12 at 4:30 P.M. Present Messrs. P. Cheney, Robertson, Burr, Cornell, Watkins, and Hyde, and Mrs. Coburn, Mrs. Crowell and Miss Cheney. W.S. Hyde was elected Secretary pro tem.

It was voted to install an Oilomatic Oil Heater in the laundry, at a cost of $900.00.

The resignation of Dr. Borden, a member of the consulting staff, was accepted with regret.

A verbal report on the condition of the Elsie Cheney Disher legacy was made.

A report was given by the Manchester Trust Company, Executor of the will of William H. Coates, of a gift of $500.00, the interest only to be used for hospital purposes.

It was voted to request the attending medical staff to hold a special meeting to pass upon the status of Dr. Caldwell.

It was voted to return to Dr. Moran his check which he left for his expenses at the hospital.

The meeting adjourned at 6:15 P.M.

W. S. Hyde

Secretary pro tem.

MANCHESTER MEMORIAL HOSPITAL

ENDOWMENT FUNDS

From "Appendix A - Report to Finance Committee"

Boynton:	"...furnishing of hospital facilities to persons then not able to pay...."
Sophie Diskan and Samual	Diskan Fund: "... at the discretion of the Board of Trustees for general hospital purposes."
William H. Costes:	"..... as the trustees of said hospital may deem best."
Grace Kingsbury Dart:	"..... for the general running expenses of said Hospital."
Thomas and Ronald Ferguson:	in hospital's Memorial Fund
Raymond Goslee, Jr.:	in hospital's Memorial Fund

EXHIBIT Q 11-2

Fund 11-1.5

Grace K. Dart

Last Will and Testament

OF

Grace Kingsbury Dart.

Dated December 7 A. D. 1931.
Presented in Court, July 12, 1943.
Ordered Heard, July 17, 1943.

[redacted]

William J. Hyde Judge

Will proved, approved, admitted to probate, ordered recorded and kept on file, July 17, 1943.

~~Recorded on Page xxx~~ ~~Act~~

William J. Hyde Judge

PROBATE RECORD.

Recorded vol. 72, Page 470,

By [signature]

Clerk ~~Judge~~

1/2 dy copies

WILL No. 17 B Cleaveland Legal Blank Office, Hartford, Conn.

Be it known to all Persons, THAT I, Grace Kingsbury Dart, of the Town of Manchester, in the County of Hartford, in the State of Connecticut, being of lawful age, of sound and disposing mind, memory and judgment, do hereby make, publish and declare this to be my last Will and Testament, hereby revoking all previous wills and codicils by me made.

ARTICLE I.

I direct that all my just debts and funeral expenses including Ten ($10.00) Dollars for the Minister officiating at my funeral and Five ($5.00) for each bearer be paid by my Executor hereinafter named.

ARTICLE II.

I give and bequeath to The Manchester Trust Company, a Connecticut Corporation, located in said Manchester, the sum of Five Hundred ($500.00) Dollars, in trust, however, to hold, manage, invest and reinvest the same and to use the income therefrom for the perpetual care and upkeep of Henry A Slater's lot in the Northwest or Buckland Cemetery, in said Manchester,

ARTICLE III.

I give and bequeath to said The Manchester Trust Company, the sum of Five Hundred ($500.00) Dollars, in trust, however, to hold, manage, inves and reinvest the same and to use the income therefrom for the perpetual care and upkeep of Adron Dart's lot in the Elmwood Cemetery, in Vernon Center, Connecticut, provided that if a Cemetery Association be formed at any time in the future by the owners of lots in said Cemetery, said Association shall be substituted for said The Manchester Trust Company as Trustee of said fund

ARTICLE IV.

I give, devise and bequeath to my half-brother Samuel E. Dart, the sum of Five Hundred ($500.00) Dollars to be his absolutely.

ARTICLE V.

I give, devise and bequeath to my cousin Bertha Dart, the sum of Two Hundred and Fifty ($250.00) Dollars, to be hers absolutely.

I also give and bequeath to the said Bertha Dart all of my household furniture, jewelry and personal effects and all the contents of my house except my bank books, securities and money. It is my will that none of the contents of my said house shall be sold at public auction by any of the beneficiaries of my will.

ARTICLE VI.

All the rest, residue and remainder of my property, both real and personal, wherever it may be situated and of whatsoever it may consist I direct be divided into two (2) equal parts.

The first of said equal parts, I give, devise and bequeath to The Manchester Memorial Hospital, a Connecticut Corporation, located in said Manchester, to take, hold, manage, invest and reinvest and to use the income therefrom for the general running expenses of said Hospital.

The second of said equal parts I give, devise and bequeath to The Missionary Society of Connecticut, a Connecticut Corporation, located in Hartford, Connecticut, to take, hold, manage, invest and reinvest and the principal of said gift to be added to the "Everest Fund," so-called, which is now held by said Society and the income therefrom to be used for the purposes as designated by the founders of said fund.

I Appoint said The Manchester Trust Company, a Connecticut Corporation, located in the Town of Manchester, County of Hartford, and State of Connecticut, executor of this my Last Will and Testament

In Witness Whereof, I have hereunto set my hand and seal at said Manchester, on the 7 day of December, A. D., One Thousand, Nine Hundred and thirty-one.

Grace Kingsbury Dart [Seal]

Signed, sealed, published and declared by the said Grace Kingsbury Dart as and for her Last Will and Testament, in presence of us at her request, in her presence, and in the presence of each other have hereunto subscribed our names as witnesses, on the 7 day of December, A. D. 19 31.

Witnesses	Addresses
Dorothy L. Russell	
Robert J. Gorman	
Raymond P. Bowers	

State of Connecticut, County of Hartford, ss. Manchester, December 7, A. D. 19 31.

We the within named Dorothy L. Russell and Robert J. Gorman

being duly sworn, make affidavit and say: That we severally attested the within and foregoing Will of the within named testatrix and subscribed the same in her presence and at her request and in the presence of each other; that the said testatrix signed, published and declared the said instrument as and for her last Will and Testament in our presence on the 7 day of December, A. D., 19 31; and at the time of execution of said will, said testatrix was more than eighteen years of age and of sound mind, memory and judgment and under no improper influence or restraint to the best of our knowledge and belief, and we make this affidavit at the request of said testatrix.

Dorothy L. Russell

Robert J. Gorman

State of Connecticut, County of Hartford, ss. Manchester, December 7 A. D., 19 31.

Then personally appeared before me a Notary Public, duly qualified to administer oaths.

Dorothy L. Russell

and Robert J. Gorman

and subscribed and made oath to the truth of the foregoing affidavit

Raymond P. Bowers
Notary Public

EXHIBIT Q 11-2

Fund 11-1.6

The Grace L. House Fund

WILL 122 B CLEAVELAND LEGAL BLANK OFFICE, Hartford, Conn.

Be It Known to all Persons, THAT I, CHARLES E. HOUSE

of the Town of MANCHESTER in the County of HARTFORD

in the State of CONNECTICUT being of lawful age, of sound and disposing mind, memory and judgment, do hereby make, publish and declare this to be my last Will and Testament, hereby revoking all previous wills and codicils by me made.

I.

I direct that all my just debts and expenses be paid by my executors hereinafter named.

II.

I give and bequeath to my grandson, Charles Staver House, the sum of Five Thousand Dollars, to him and his heirs forever.

III.

I give and bequeath to my grand-daughter, Emily Louise House, the sum of Five Thousand Dollars, to her and her heirs forever.

IV.

I give and bequeath to my son, Herbert B. House the sum of Five Thousand Dollars, in trust however, to have, hold, manage, invest and to reinvest until my granddaughter Laura C. House becomes twenty-one years of age, or until such time as she may marry before attaining the age of twenty-o years. When my said grand-daughter Laura C. House becomes twenty-one year of age or marries prior to arriving at that age, I direct that said trus shall cease and be determinated and upon said termination, I give said trust fund to my said grand-daughter, Laura C. House, to be hers absolute

V.

I give and bequeath to The Ecclesiastical Society of Manchester (connect ed with The Center Congregational Church so-called) Three Thousand Dolla to be held by said Society as a perpetual fund, the income of which I direct be used for the current expenses of said Church or for the benev- olences connected therewith. I make this gift in memory of my deceased wife Grace L. House, and said gift is to be known as the " Grace L. House Fund".

VI.

I give and bequeath to The Manchester Memorial Hospital, a Connecticut corporation, located in said Manchester, the sum of Twenty-five Hundred Dollars, to be held by said Hospital as a permanent fund, and to be know as "The Grace L. House Fund". The income therefrom is to be used for the running expenses of said Hospital.

VII.

I give and bequeath to Mrs. Jennie S. Ferris of said Manchester the sum of Five Hundred Dollars, in token of my heartfelt appreciation of her faithfulness and efficiency in her care of my home.

VIII.

I direct that all succession taxes and inheritance taxes and all charges of a like nature be paid from the corpus of my estate and that all beque herein provided for shall be net.

IX.

All the remainder of my property, both real and personal, of whatsoever the same may consist and whereever it may be situated, I give, devise and beques to my beloved son, Herbert B. House, to be his absolutely, forever.

I Appoint my son Herbert B.House and my grandson Charles S.House, bot of the Town of Manchester County of Hartford and State of Connecticut as joint executors of this my Last Will and Testament without bonds.

In Witness Whereof I have hereunto set my hand and seal at said Manchester on the 4th day of May A. D., One Thousand, Nine Hundred and Thirty-three

Charles E House (L. S.)

Signed, sealed, published and declared by the said Charles E.House as and for his Last Will and Testament, in presence of us who at his request, in his presence, and in the presence of each other have hereunto subscribed our names as witnesses, on the 4th day of May A. D., 19 33.

L. B Heathaway
Olive B Hathaway
Sadie Curran
Witnesses.

State of Connecticut, }
County of Hartford } ss. Manchester, May 4th *A. D. 1933.*

We the within named Sadie Curran and Olive B Hathaway

being duly sworn, make affidavit and say: That we severally attested the within and foregoing Will of the within named testator and subscribed the same in his presence and at his request and in the presence of each other; that the said testator signed, published and declared the said instrument as and for his last Will and Testament in our presence on the 4th day of May A. D., 19 33; and at the time of execution of said will, said testator was more than eighteen years of age and of sound mind, memory and judgment and under no improper influence or restraint to the best of our knowledge and belief, and we make this affidavit at the request of said testator.

Sadie Curran
Olive B Hathaway

State of Connecticut, }
County of Hartford } ss. Manchester, May 4th *A. D. 19* 33.

Then personally appeared before me a Notary Public duly qualified to administer oaths.

Sadie Curran

and Olive B Hathaway

and subscribed and made oath to the truth of the foregoing affidavit.

Charles R Heathaway
Notary Public.
Justice of the Peace.

Commissioner of Superior Court ..... *County.*

1

EXHIBIT Q 11-2

Fund 11-1.7

The John Porter & Caroline E. Porter Fund

Samuel Slavkin, Notary Public.

Accepted June 19th, 1941.

LAST WILL AND TESTAMENT AND CODICIL OF JOHN PORTER
LATE OF HARTFORD, DECEASED.

KNOW ALL MEN BY THESE PRESENTS, That I, JOHN PORTER, of Hartford, Connecticut, being of sound and disposing mind and memory, do make, publish and declare the following to be my last will and testament, hereby revoking all former wills by me made, that is to say:

FIRST: If before my death I shall not have purchased a cemetery lot in Cedar Hill Cemetery, I direct that my executors shall purchase one which shall be satisfactory to my wife, Caroline E. Porter, if she is then living, and I also direct that my executors shall erect a suitable monument on said lot which shall be satisfactory to my wife.

SECOND: I direct that all inheritance, succession, legacy and transfer taxes levied or imposed by the State of Connecticut, or by the United States, or by any other state or country, upon any property or upon any gift or devise passing under this will, shall be paid by my executors out of the residue of my estate and charged and allowed as an item of the expense of administration thereof.

THIRD: I give, devise and bequeath to my wife, Caroline E. Porter, the house and grounds comprising our home known as 39 Woodside Circle in the City of Hartford, to be hers absolutely. I also give and bequeath to my said wife all the household furniture and furnishings contained in said home, including pictures, paintings, rugs, draperies, tableware, silverware, library and all other ornaments; also my automobiles and their accessories. I also give and bequeath to my said wife my watch and jewelry.

Without imposing any trust or condition upon this gift, I request that she will dispose of said jewelry, or a portion thereof, in accordance with my wishes as she may know them to be either from a letter left with this will, a memorandum or otherwise.

FOURTH: I direct that there be paid to my confidential business secretary, William H. McCoy, of Hartford, the sum of One Hundred and Thirty Dollars ($130) every month after my death during the remainder of the life of said William H. McCoy.

FIFTH: In appreciation of long and faithful service I give to my chauffeur, Fred O. Barton, the sum of Twenty-five Hundred Dollars ($2500).

In addition to the foregoing I direct that there shall be paid to him Two Hundred Dollars ($200) each year after my death until the total of the original gift and these annual payments shall aggregate Five Thousand Dollars ($5,000). If he shall die either before or after my death and before the entire sum of Five Thousand Dollars ($5,000) shall have been paid to him, I direct that such amount as shall not have been paid to him at his death shall thereafter be paid to his wife, if living, in quarterly installments of Seventy-five Dollars ($75) each until such balance shall have been fully paid or until her death whichever event shall first occur.

SIXTH: I give to Marshall P. Deasy, of Hartford, the sum of Ten Thousand Dollars ($10,000) if he shall survive me. If he shall not survive me I direct my executors to use said sum of Ten Thousand Dollars ($10,000) in the purchase of an annuity for the benefit of his wife or children, giving my executors full power and discretion to determine the character of the annuity and to designate the annuitants. In addition to the foregoing I direct that there shall be paid to said Marshall P. Deasy the sum of One Hundred Dollars ($100) [illegible] and thereafter to his wife, [illegible] shall survive him.

SEVENTH: I give to my [illegible] Connecticut, the sum of Ten Thousand Dollars ($10,000) if he shall survive me. If he shall not survive me I direct my executors to use said sum of Ten Thousand Dollars ($10,000) in the purchase of an annuity for the benefit of his wife or children, giving my executors full power and discretion to determine the character of the annuity and to designate the annuitants.

EIGHTH: All the rest, residue and remainder of my estate, real and personal and wherever situated, including any lapsed legacies, subject to the obligation to continue annuity payments, if any, under the preceding paragraphs of this will, I give, devise and bequeath IN TRUST to my wife, Caroline E. Porter, Charles Welles Cross, of Hartford, and the Hartford National Bank and Trust Company, a national banking association located in Hartford, as trustees, and to their successors in this trust, to hold the same upon the conditions and for the uses hereinafter stated:

I hereby expressly authorize the trustees of the trust herein created to sell and convey any property real and personal which shall at any time be a part of said trust estate and to invest and reinvest said trust fund according to their best judgment and discretion in such property, investments and securities, whether real or personal, as said trustees shall deem proper and whether the same be of the character and class regarded by law as

investments for trust funds or not, and to take second purchase money mortgages in part payment for such amounts and on such terms as they may deem for the best interests of my estate. I also authorize said trustees to mortgage said real estate according to their best judgment; to execute mortgage notes as trustees binding my trust estate without liability on their part individually; and to lease any real estate comprising said trust estate on such terms and for such periods of time as they may deem best although said leases may run beyond the probable duration of said trust.

I further direct that in the matter of sale of any of the trust estate, whether real or personal, or in the matter of the mortgage of real estate or in the leasing of real estate, a majority of my said trustees shall have full power and authority to act and to execute and deliver the necessary deeds or other instruments with the same force and effect as though signed by all the trustees.

Said trustees shall pay the net income of said trust estate quarterly or oftener in their discretion to my wife, Caroline E. Porter, during the remainder of her natural life. In addition to the foregoing gift of income, I direct that upon the written requests of my wife, Caroline E. Porter, said trustees shall pay to her from time to time such sums out of the principal of said trust estate as she may designate; provided, however, that not more than Ten Thousand Dollars ($10,000) of principal shall be paid to her in any one calendar year under this provision.

Upon the death of my wife said trust shall cease, except that I provide that my said surviving trustees shall be authorized and empowered to continue said trust without making distribution thereof for a period of not to exceed five years to enable them to liquidate said trust to the best advantage, and upon the termination of said trust on or before the expiration of said period of five years after the death of my said wife, said surviving trustees shall divide, distribute and pay over said trust estate in the following proportions and to the following persons or corporations, (it being my intention that distribution shall be made by my said surviving trustees without the appointment of distributors and that the judgment of my said surviving trustees as to the values and as to the manner of distribution shall be final):

(a) I give to Gaylord Farm Association, Incorporated, a Connecticut corporation, the sum of Five Thousand Dollars ($5,000), to be used for the support and maintenance of the Gaylord Farm Sanitarium conducted and operated by it in Wallingford in said State;

I give to the Gilead Cemetery Association, located in the village of Gilead, in the Town of Hebron, Connecticut, the sum of Two Thousand Dollars ($2,000), to be held by it as a separate fund in perpetuity, with power of investment and reinvestment, the income only to be used for the care and upkeep of its cemetery in Gilead.

I give to the Gilead Hall Association Corporation, a corporation located in the Town of Hebron, Connecticut, if at that time said corporation shall be actively engaged in the maintenance and operation of Gilead Hall in the village of Gilead in the Town of Hebron, the sum of Two Thousand Dollars ($2,000), to be held by it as a separate fund, with power of investment and reinvestment, the income only to be used for the support of said Gilead Hall thus maintained by it; provided that my said surviving trustees in the exercise of their sole and uncontrolled judgment shall decide that said Gilead Hall is then being operated for the benefit of the inhabitants of the village of Gilead so that this gift will operate for the benefit of that village.

(b) One-half of the balance of said trust estate as then constituted, less an amount equal to one-half of the total withdrawals from the principal of said trust estate made by Caroline E. Porter during her lifetime in accordance with the power hereinbefore given to her, I give to such one or more of her brothers or sisters or their descendants, or to such person or persons (other than herself) named as legatees in my will, or their descendants, or to such religious, charitable or benevolent corporations as she in the exercise of this special or limited power may by her last will and testament designate and appoint, and in case my said wife, Caroline E. Porter, shall not exercise this limited or special power of appointment, I give said portion to the person or persons who would be entitled at her death under the laws of the State of Connecticut to receive the intestate estate, if any, of said Caroline E. Porter.

(c) The other one-half of the balance of said trust estate as then constituted, plus an amount equal to one-half of the totals withdrawals from the principal of said trust estate made by Caroline E. Porter during her lifetime in accordance with the power hereinbefore given to her, I give as follows:

Thirty-five per cent. (35%) thereof I give to my nephew, James P. Cosley, of London, Freeborn County, Minnesota, if he shall then be living, and if he shall not then be living I give said portion to his wife, Ida Cosley, if she shall then be living, and if neither my said nephew, James P. Cosley, or his wife, Ida Cosley, shall then be living I give said portion, per stirpes, to his issue then living, to be theirs absolutely, free of any trust.

Fifteen per cent. (15%) thereof I give to said Mrs. Ida Cosley, wife of said James P. Cosley, if she shall then be living and if she shall not then be living I give said portion to her husband, my nephew, James P. Cosley, if he shall then be living, and if neither the said Ida Cosley nor her husband, James P. Cosley, shall then be living I give said portion, per stirpes, to her issue then living, to be theirs absolutely, free of any trust.

Fifteen per cent. (15%) thereof I give, per stirpes, to the issue then living of my said nephew, James P. Cosley and his wife, Ida Cosley, to be theirs absolutely, free of any trust.

Two and one-half per cent. (2½%) thereof I give to Marshall P. Deasy, of Hartford, if he shall then be living, and if he shall not then be living one-half of the amount which would otherwise be paid to him I give to his wife, Mrs. Elsie P. Deasy, if she shall then be living, and the other one-half thereof (or all thereof in case his said wife, Elsie P. Deasy, shall not then be living) I give in equal shares to the children then living of said Marshall P. Deasy and his wife, Elsie P. Deasy, to be theirs absolutely and free of any trust.

Two and one-half per cent. (2½%) thereof I give to my cousin, Jasper Ward Porter, of

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Submitted October 16, 2015

give said portion to his wife, Nettie A. Porter, if she shall then be living, and if neither said Jeeper Ward Porter nor his wife above named shall then be living, I give said portion to my wife's sister, Mabel S. Wetherell, of Hartford, if she shall then be living, in either case to be theirs absolutely, free of any trust.

Five per cent. (5%) thereof I give to said Mabel S. Wetherell if she shall then be living and if she shall not then be living I give said portion to her sister, Mrs. Florence Cunningham, of Hartford, if she shall then be living, in either case to be theirs absolutely and free of any trust.

Two and one-half per cent. (2½%) thereof I give to my wife's sister, Mrs. Lila Tryon, of New Haven, Connecticut, if she shall then be living and if she shall not then be living I give said portion to her husband, Clarence B. Tryon, if he shall then be living, in either case to be theirs absolutely and free of any trust.

Two and one-half per cent. (2½%) thereof I give to the said Clarence B. Tryon if he shall then be living and if he shall not then be living, I give said portion to his said wife, Mrs. Lila Tryon, if she shall then be living, in either case to be theirs absolutely and free of any trust.

Twenty per cent. (20%) thereof, to which shall be added any portion which by virtue of death may not pass under the foregoing paragraphs of the second half of said fund, I give in equal shares to the following fourteen charitable institutions, in each instance to be known as "The John Porter and Caroline E. Porter Fund", to be held in perpetuity, with power of investment and reinvestment, the income only to be used for the support of the institutions hereinafter named, viz:

1. The Hartford Hospital, of Hartford, Connecticut, for the support of its general Hospital.
2. The Hartford Hospital, of Hartford, Connecticut, for the support of that department of its work known as the Old Peoples Home.
3. St. Francis Hospital, of Hartford, Connecticut.
4. The American School for the Deaf, of West Hartford, Connecticut.
5. The Travelers Aid Society, of Hartford, Connecticut.
6. The Newington Home for Crippled Children, Incorporated, of Newington, Connecticut.
7. The Salvation Army, Incorporated, to be used for the support of its work in Hartford, Connecticut.
8. The Salvation Army, Incorporated, to be used for the support of its work in Manchester, Connecticut.
9. The Young Men's Christian Association of Hartford.
10. The Young Women's Christian Association of Hartford.
11. The Hartford Chapter of the American Red Cross, of Hartford.
12. The Connecticut Institute for the Blind, of Hartford.
13. The Manchester Memorial Hospital, of Manchester.
14. The Masonic Charity Foundation of Connecticut, a corporation specially chartered by the State of Connecticut, for the support of the Masonic Home now maintained by it in Wallingford, Connecticut.

NINTH: I hereby nominate and appoint my wife, Caroline E. Porter, Charles Welles Cross, of Hartford, and Hartford National Bank and Trust Company, a national banking association located in Hartford, to be the executors of this will and, so far as I am able, I hereby excuse them from giving any probate bonds as such executors or as trustees under this will.

I hereby expressly authorize my executors to sell and convey any property, real or personal, which shall be a part of my estate; to take second purchase money mortgages in part payment for such amounts and on such terms as they may deem for the best interest of my estate; to mortgage my real estate according to their best judgment; to execute mortgage notes as executors binding my estate without liability on their part individually, and to lease any real estate comprising said trust estate on such terms and for such periods of time as they may deem best although such leases may run beyond the probable duration of the period of settlement of my estate.

I further direct that in the matter of sale of my estate, whether real or personal, or in the matter of execution of mortgage deeds and notes, or in the leasing of real estate, a majority of my executors shall have full power and authority to act and to execute and deliver mortgage deeds or other instruments with the same force and effect as though signed by all the executors.

The foregoing powers given to my executors and similar powers given to my trustees in the Eighth paragraph of this will are given because of the fact that a considerable portion of my estate is invested in real estate suitable for business purposes which will require the making of leases and on which are mortgages which may mature and will have to be renewed and because in the sale of such properties it may be necessary to take back a second mortgage for a part of the purchase price, and it is my intention that my executors and my trustees shall have all the powers which I would have if living, to the end that said estate may be conserved and said real estate may be ultimately disposed of whenever my executors or my trustees shall deem it advisable to do so.

In connection with the exercise of said powers I have included as one of my executors and one of my trustees my attorney, Charles Welles Cross, in order that he may have a part particularly in the handling of all real estate matters affecting my estate, and I expressly direct that in case said Charles Welles Cross shall not qualify either as executor or as trustee, or for any reason shall later cease to act, the Court of Probate for the District of Hartford having jurisdiction of my estate shall in such event appoint a successor trustee or executor and, without limiting the power of the Court, I suggest that in such case the executor or trustee appointed in his stead shall be one of the members of the firm of which he is now the senior partner, and that such successor executor and trustee shall likewise be excused from giving bonds.

I authorize and empower my executors or my trustees in each instance to use any securities then held by my estate in payment in whole or in part of any legacies or distributive shares

ECHN Proposed Asset Purchase by PMH
Submitted October 16, 2015

of the persons named in this will to whom at that time they shall be under obligation to pay stated sums at periodic intervals in lieu of the obligation to continue to make such payments hereunder, and in any such case the purchase of an annuity, which will give such legatee the same payments for the same period of time as hereinbefore specified, shall relieve my estate from further obligation to such annuitant or annuitants in respect thereto.

If in the opinion of my executors it may become necessary or desirable to have an ancillary executor of my estate appointed in ancillary proceedings in Massachusetts because I shall at the time of my death own real estate in Massachusetts, I desire that the Third National Bank and Trust Company of Springfield, Massachusetts, be so appointed. In view, however, of the fact that the greater portion of my estate is given in trust, I direct that the Third National Bank and Trust Company, of Springfield, Massachusetts, shall confer with my executors in Connecticut as to all major problems affecting the real estate in Massachusetts and that, subject to such approval by my Connecticut executors, or a majority of them, to be evidenced by their endorsement of any deed or lease, the ancillary executor in Massachusetts shall have the same powers hereinbefore conferred upon my Connecticut executors as to Massachusetts real estate.

Inasmuch as I own an undivided interest with my wife in real estate in Florida, I hereby nominate, constitute and appoint my said wife, Caroline E. Porter, and E. L. Lockhart, attorney-at-law, of Miami Beach, Florida, to be the ancillary executors of my estate in Florida, and, so far as I am able, I hereby excuse my said wife and the said E. L. Lockhart from giving any probate bonds as such ancillary executors.

IN WITNESS WHEREOF, I have hereunto set my hand and seal, declaring this to be my last will and testament, this 4th day of November, 1936.

John Porter (L.S.)

Signed, sealed, published and declared by said testator, John Porter, as and for his last will and testament, in the presence of us, the undersigned, who in his presence and in the presence of each other, at his request, have hereunto set our names as witnesses, this 4th day of November, 1936.

J. Harold Williams — Hartford, Conn.
Willis C. Parsons — Hartford, Conn.
Reese H. Harris, Jr. — West Hartford, Conn.

State of Connecticut)
) as: Hartford, November 4, 1936.
County of Hartford)

Then and there personally appeared the above named J. Harold Williams, Willis C. Parsons and Reese H. Harris Jr., who, being duly sworn, depose and say that they witnessed the execution of the foregoing will of said testator, John Porter, that he subscribed said will and declared the same to be his last will and testament in their presence; that they thereafter subscribed the same as witnesses in the presence of said testator and in the presence of each other and at the request of said testator; that said testator at the time of the execution of said will appeared to them to be of full age and of sound and disposing mind and memory; and that they make this affidavit at the request of said testator.

J. Harold Williams
Willis C. Parsons
Reese H. Harris, Jr.

Subscribed and sworn to
this 4th day of November, 1936,
before me,
Esther T. Johnson, Notary Public (SEAL)

[illegible] CODICIL

KNOW ALL MEN BY THESE PRESENTS, that I, JOHN PORTER, of Hartford, Connecticut, being of sound and disposing mind and memory, do make, publish and declare the following to be a first codicil to my last will and testament, dated the 4th day of November, 1936, that is to say:

FIRST: I revoke the Sixth paragraph of my said will, dated November 4, 1936, and, in lieu thereof, I provide as follows:

I give to Marshall P. Deasy, of Hartford, the sum of Ten Thousand Dollars ($10,000) if he shall survive me. If he shall not survive me I direct my executors to use said sum of Ten Thousand Dollars ($10,000) in the purchase of an annuity for the benefit of his wife or children, giving my executors full power and discretion to determine the character of the annuity and to designate the annuitants. In addition to the foregoing, I direct that there shall be paid to said Marshall P. Deasy the sum of Two Hundred and Fifty Dollars ($250) per month from the date of my death during the remainder of his life, and if his wife, Elsie P. Deasy, shall survive him I direct that there shall be paid to her after his death the sum of One Hundred Dollars ($100) per month during the remainder of her life.

SECOND: Whereas, in the Fourth paragraph of my said will I have given to my secretary, William H. McCoy, a stated sum per month for each month after my death during the remainder of his life, and whereas, in the Fifth paragraph of my said will I have given to my chauffeur, Fred O. Barton, or his wife, a stated sum per year until a stated sum has been paid, and whereas, in the preceding paragraph of this codicil I have given to [illegible] Deasy [illegible]

...Society the continuing obligation to make monthly or yearly payments thereafter, ... the case may be, under the preceding gifts through the purchase of an annuity contract ... committed payments of premiums on life insurance, or by the payment to the annuitant of ... agreed sum or sums in each case.

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THIRD: Except as altered hereby, I hereby republish and reaffirm my said will dated ...ember 4, 1936.

IN WITNESS WHEREOF, I have hereunto set my hand and seal, declaring this to be a first ...dicil to my last will and testament dated November 4, 1936, this 4th day of November, ...

John Porter. (L.S.)

Signed, sealed, published and declared by said testator, John Porter, as and for a first ...dicil to his last will and testament dated the 4th day of November, 1936, which, except ...ltered by said codicil, is also republished; in the presence of us, the undersigned, who ...e presence and in the presence of each other, at his request have hereunto set our ...es as witnesses, this 4th day of November A.D. 1937.

Willis O. Parsons Hartford, Conn.

Spencer Cross Hartford, Conn.

Father T. Johnson Wethersfield, Conn.

State of Connecticut)
) ss. Hartford, November 4th, 1937.
County of Hartford)

Then and there personally appeared the above named Willis O. Parsons, Spencer Cross ...Father T Johnson who, being duly sworn, depose and say that they witnessed the execu... of the foregoing codicil or said testator, John Porter, that he subscribed said codicil ...declared the same to be a first codicil to his last will and testament, dated November ...1936, in their presence; that they thereafter subscribed the same as witnesses in the presence of said testator and in the presence of each other and at the request of said testator; that said testator at the time of the execution of said codicil appeared to them ...be of full age and of sound and disposing mind and memory, and that she made this ...codicil at the request of said testator.

Willis O. Parsons

Spencer Cross

Father T. Johnson

...scribed and sworn before me this 4th ...
...November, 1937. Before me,

Charles W. Gross Notary Public (SEAL)

...ed, approved and admitted to Probate June 30th, A.D. 1941.

LAST WILL AND TESTAMENT OF IGNATZ RADOMSKI OR IGNACY RADOMSKI OR IGNATZ RADOMSKY
LATE OF HARTFORD, DECEASED.

LAST WILL AND TESTAMENT

BE IT KNOWN TO ALL PERSONS, THAT I, IGNATZ RADOMSKI of the Town of Hartford, County ...Hartford and State of Connecticut, being of lawful age, of sound and disposing mind, ...mory and judgment, do hereby make, publish and declare this to be my last Will and Testa...ment, hereby revoking all previous Wills and Codicils by me made:-

1. I direct my executor hereinafter named to pay all my just debts and funeral ...expenses as soon after my death as may be convenient.

2. I devise, bequeath and appoint to my wife LADISLAVIA B. RADOMSKI, my one-family ...house and real property known as #36 Stedman Street, located in the Town of Hartford, County ...of Hartford, State of Connecticut to be her's absolutely and in fee simple.

3. I devise, bequeath and appoint to my wife, LADISLAVIA B. RADOMSKI any and all ...sums that I now have or may later have on deposit at the SOCIETY FOR SAVINGS BANK and the ...HARTFORD BANK both located in the Town and County of Hartford, State of Connecticut.

4. I devise, bequeath and appoint to my wife LADISLAVIA B. RADOMSKI all my furni... and personal property contained in the premises of decedent at the time of my death.

5. In the event of the death of my wife LADISLAVIA B. RADOMSKI before my death, I devise, bequeath and appoint to my son HAROLD all of the aforesaid real estate, furniture and personal property.

6. In the event of the death of my wife LADISLAVIA B. RADOMSKI and my son HAROLD before my death, I devise, bequeath and appoint to my daughter, ELIZABETH ...(now married) all of the aforesaid real estate, furniture and personal property.

7. I direct my executor hereinafter named to pay all my just debts and funeral ...expenses as soon after my death as may be convenient.

8. I devise, bequeath and appoint to my wife LADISLAVIA B. RADOMSKI, my one-family ...house and real property known as #36 Stedman Street, located in the Town of Hartford, County ...of Hartford, State of Connecticut to be her's absolutely and in fee simple.

9. I devise, bequeath and appoint to my wife, LADISLAVIA B. RADOMSKI any and all ...sums that I now have or may later have on deposit at the SOCIETY FOR SAVINGS BANK and the ...HARTFORD BANK both located in the Town and County of Hartford, State of Connecticut.

10. I devise, bequeath and appoint to my wife LADISLAVIA B. RADOMSKI all my furni... and personal property contained in the premises of decedent at the time of my death.

11. In the event of the death of my wife LADISLAVIA B. RADOMSKI before my death, I devise, bequeath and appoint to my son HAROLD all of the aforesaid real estate, furniture and personal property.

12. In the event of the death of my wife LADISLAVIA B. RADOMSKI and my son HAROLD before my death, I devise, bequeath and appoint to my daughter, ELIZABETH ...(now married) all of the aforesaid real estate, furniture and personal property.

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KNOW ALL MEN BY THESE PRESENTS, That I, CAROLINE E. PORTER, of the Town and County of Hartford and State of Connecticut, being of sound and disposing mind and memory, do make, publish and declare the following to be my last will and testament, hereby revoking all former wills by me made, that is to say:

FIRST: I direct that all inheritance, succession, legacy, estate and transfer taxes levied or imposed by the State of Connecticut, or by the United States, or by any other state or country, upon any property of mine passing under this will, shall be paid by my executors out of the residue of my estate and charged and allowed as an item of the expense of administration thereof.

SECOND: I direct that my executors shall procure a marker to conform to that now placed at my husband's grave in Cedar Hill Cemetery, which shall bear my name and dates of birth and death. I also direct my executors to procure for my burial a casket and burial vault of the same quality as the casket and vault procured for my husband's burial.

I give the sum of Five Thousand Dollars ($5,000) to Cedar Hill Cemetery, a Connecticut corporation located in Hartford, Connecticut, to be held by it as a permanent fund, with power of investment and reinvestment, the income only to be expended in the care of the John Porter lot in said cemetery, including the proper upkeep of monument and markers, the cutting of grass, and the planting and care of flowers and flowering shrubs. Any income not required for such purposes may be expended for the general upkeep of said Cemetery, preferably in the neighborhood of said lot.

I give to my sister, Lila B. Tryon, the right to be buried in said John Porter lot. I direct either my executors or my trustees to place a suitable marker at my said sister's grave if it is not feasible for her executor or administrator to do so.

If I have not attended to these matters in my lifetime,

I direct that at the expense of my estate my executors shall place suitable markers at the graves of my sister Mabel F. Wetherell and my brother-in-law Clarence Tryon in said John Porter lot and at the grave of my brother William Wetherell in Manchester.

THIRD: (a) I give to my sister, Florence V. Cunningham, my three-stone diamond ring, my antique gold bracelet, my cameo pin, my cameo ring, my linen, and my wearing apparel, except my remaining jewelry.

(b) I give to my sister, Iva M. Ingraham, my lady's gold watch and my chain of gold beads.

(c) I give to my nephew, C. John Sperry, the sum of Two Thousand Dollars ($2,000), my books, and any automobile or automobiles of which I may be the owner at the time of my death, with all accessories thereto.

(d) I give to Eunice Sperry, wife of said C. John Sperry, the sum of Two Thousand Dollars ($2,000), my diamond sapphire pin, and my diamond and ruby pin.

(e) I give to my grandniece, Mary-Lou Sperry, my large solitaire diamond ring and the sum of Three Thousand Dollars ($3,000).

(f) I give to my grandniece, Martha Sperry, my diamond platinum watch, my diamond and sapphire ring, and the sum of Three Thousand Dollars ($3,000).

(g) I give to my grandniece, Susan Sperry, my diamond lavaliere with necklace attached, my small solitaire diamond ring, and the sum of Three Thousand Dollars ($3,000).

(h) I give and bequeath in equal shares to such of said Mary-Lou Sperry, said Martha Sperry and said Susan Sperry as shall survive me my silverware, my bric-a-brac, and any jewelry not elsewhere bequeathed in this will, including any lapsed legacies of jewelry.

(i) I give to my niece, Helen Henry, the sum of Three Thousand Dollars ($3,000).

(j) I give to my niece, Ethel Crough, the sum of Three Thousand Dollars ($3,000).

(k) I give to my nephew, Ralph Ingraham, the sum of

Two Thousand Dollars ($2,000).

(h) I give to my nephew, Edward Ingraham, the sum of Two Thousand Dollars ($2,000).

(i) I give to my nephew, Vincent Ingraham, the sum of Two Thousand Dollars ($2,000).

(j) I give to my niece, Doris Isham, the sum of Three Thousand Dollars ($3,000).

(k) I give to my nephew, William Ingraham, the sum of Two Thousand Dollars ($2,000).

(l) I give to Ida Goslee, widow of my husband's nephew James P. Goslee, the sum of Three Thousand Dollars ($3,000).

(m) I give to my husband's grandnephew, Richard Goslee, the platinum watch and chain and gold wrist watch which formerly belonged to my husband.

(n) I give to my husband's grandnephew, John Goslee, the three-stone diamond ring which formerly belonged to my husband.

FOURTH: I give the sum of Five Thousand Dollars ($5,000) to Anthony DeNaio, of 7 Mohegan Drive, West Hartford.

I give the sum of One Thousand Dollars ($1,000) to Mrs. Jane Sutton.

I give the sum of Five Thousand Dollars ($5,000) to Robert Costin, if he shall be in my employ at the time of my death.

I give the sum of Three Thousand Dollars ($3,000) to Mrs. Emma Lord, if she shall be in my employ at the time of my death.

I give the sum of Three Thousand Dollars ($3,000) to George Lord, if he shall be in my employ at the time of my death.

FIFTH: (a) If my sister, Iva M. Ingraham shall survive me, I direct that my executors shall set apart the sum of Twenty-five Thousand Dollars ($25,000) for which there shall be purchased by them a refundable annuity, payable to her in monthly installments of One Hundred Dollars ($100) each so long as she shall live, or until the total of Twenty-five Thousand Dollars ($25,000) has been paid to her, whichever shall first occur.

(b) If my sister, Florence V. Cunningham, shall survive me, I direct that my executors shall set apart the sum of Twenty-five

Thousand Dollars ($25,000) for which there shall be purchased by them a refundable annuity, payable to her in monthly installments of One Hundred Dollars ($100) each so long as she shall live, or until the total of Twenty-five Thousand Dollars ($25,000) has been paid to her, whichever shall first occur.

(c) If Mrs. Alice Wetherell, my brother's widow, shall survive me, I direct that my executors shall set apart the sum of Twenty-five Thousand Dollars ($25,000) for which there shall be purchased by them a refundable annuity, payable to her in monthly installments of One Hundred Dollars ($100) each so long as she shall live, or until the total of Twenty-five Thousand Dollars ($25,000) has been paid to her, whichever shall first occur.

SIXTH: By the will of my deceased husband, John Porter, who died June 21, 1941, the residue of his estate was given to me in trust for my life and at my death, by Article Eighth, Paragraph (b), I was also given a special or limited power of appointment over one-half of the balance of said trust estate as constituted at the time of my death, which power of appointment gave me the right to give to such one or more of my brothers or sisters, or their descendants, or to such person or persons (other than myself) named as legatees in his will, or their descendants, or to such religious, charitable or benevolent corporations as I in the exercise of said special or limited power of appointment may by my last will and testament designate and appoint. Accordingly, exercising such special or limited power of appointment thus given to me by my late husband, I nominate and appoint one of my sisters and certain religious, charitable and benevolent institutions hereinafter named to receive out of said one-half of said residuary estate of my late husband, John Porter, the following gifts, to wit:

(a) The sum of Fifteen Thousand Dollars ($15,000) to my sister, Florence V. Cunningham. This gift shall be satisfied in full before any other gifts in this clause Sixth are paid in whole or in part. If my said sister shall not survive me, then said sum shall be added to her estate.

(b) The sum of Twenty-five Thousand Dollars ($25,000) to The Connecticut Humane Society, a corporation specially chartered under the laws of the State of Connecticut and located in said Hartford.

(c) The sum of Twenty-five Thousand Dollars ($25,000) to The Newington Home and Hospital for Crippled Children, a charitable corporation located in Newington.

(d) The sum of Twenty-five Thousand Dollars ($25,000) to the Hartford Hospital, a charitable corporation located in Hartford.

The legacies contained in sub-divisions (b), (c) and(d) hereof are given in memory of my deceased husband, John Porter, and said gifts are to be held by the respective donees in each case as a permanent fund, with power of investment and reinvestment, the income to be used and applied for the general purposes of the donee.

(e) The sum of Twenty-five Thousand Dollars ($25,000) to The Center Congregational Church, Incorporated, of Manchester, Connecticut, to be held by it as a permanent fund in memory of my father, Arthur James Wetherell, and my mother, Mary Bidwell Wetherell, both deceased, former residents of the town of Manchester, with power of investment and reinvestment in such securities as would be selected by a prudent investor, the income only to be used for the support and maintenance of said Church.

(f) The balance of said one-half of said residuary estate over which I have such limited or special power of appointment shall be distributed by said trustees in equal shares to the following fourteen charitable institutions, constituting the same fourteen charitable institutions designated in the final portion of the Eighth article of the last will and testament of my said husband, John Porter, in each instance to be known as "The John Porter and Caroline E. Porter Fund", to be held in perpetuity, with power of investment and reinvestment, the income only to be used for the support of the

institutions hereinafter named, viz:

1. The Hartford Hospital, of Hartford, Connecticut, for the support of its general hospital;

2. The Hartford Hospital, of Hartford, Connecticut, for the support of that department of its work known as Jefferson House.

3. St. Francis Hospital, of Hartford, Connecticut;

4. The American School at Hartford for the Deaf, of West Hartford, Connecticut;

5. The Travelers Aid Society, of Hartford, Connecticut;

6. The Newington Home and Hospital for Crippled Children, of Newington, Connecticut;

7. The Salvation Army, Incorporated, to be used for the support of its work in Hartford, Connecticut;

8. The Salvation Army, Incorporated, to be used for the support of its work in Manchester, Connecticut;

9. The Young Man's Christian Association of Hartford;

10. The Young Women's Christian Association of Hartford;

11. The Hartford Chapter of the American Red Cross, of Hartford;

12. The Connecticut Institute for the Blind, of Hartford;

13. The Manchester Memorial Hospital, of Manchester, Connecticut;

14. The Masonic Charity Foundation of Connecticut, a corporation specially chartered by the State of Connecticut, for the support of the Masonic Home now maintained by it in Wallingford, Connecticut.

SEVENTH: All the rest, residue and remainder of my estate of whatever nature, both real and personal and wheresoever situate, I give, devise and bequeath IN TRUST to my trustees hereinafter named and to their successors in this trust upon the following trusts:

Said trustees shall have power to take, hold, receive, sell, invest and reinvest this trust estate in such investments as would be chosen by a prudent investor, including a common

trust fund managed by the corporate trustee. They shall pay over the net income of the trust estate, in equal shares, quarterly or oftener in their discretion, to or for the benefit of my sisters, Lila B. Tryon and Florence V. Cunningham, and the survivor of them, until both of my said sisters shall have died. My trustees shall have power to pay from time to time in the sole uncontrolled discretion of my trustees, excluding my sister, Florence V. Cunningham, to or for the benefit of my said sisters or either of them (without obligation to equalize) such portion or portions of the principal of this trust estate as they may deem necessary or advisable for their comfortable care, support and maintenance, or in case of their illness. I direct that said trustees shall be liberal in making such principal payments.

Upon the death of the last survivor of my said sisters this trust shall cease and my trustees shall pay over the principal of the trust estate, as then constituted, absolutely and free of trust, in equal shares, to the following:

Said Hartford Hospital;

Said Newington Home and Hospital for Crippled Children;

Said The Connecticut Institute for the Blind;

Said The Hartford Chapter of the American Red Cross, and

The Humane Society of Greater Miami, having an office at 2101 N.W. 95th Street, Miami, Florida.

EIGHTH: I nominate, constitute and appoint Hartford National Bank and Trust Company, a national banking association located in Hartford, Connecticut, my sister Florence V. Cunningham, my nephew C. John Sperry, and Spencer Gross of Hartford, Connecticut, to be the executors and trustees of this will.

I nominate, constitute and appoint such of my said executors as can qualify under Florida law to be the ancillary executors of my estate in Florida.

In the event that none of my said executors can qualify as executors in Florida, or should none of them elect so to

qualify, then I nominate, constitute and appoint E. L. Lockhart, of Miami Beach, Florida, to be the ancillary executor of my estate in Florida.

I hereby exoune all executors and trustees from giving any probate or other bond as such executors and trustees in any jurisdiction for any purpose, including qualification as executors and trustees and sale of real estate.

I authorize and empower my executors to mortgage, lease, sell and convey any real estate, or interest in real estate, of which I may be the owner at the time of my death in any jurisdiction, on such terms and conditions as they may deem wise.

I authorize any of my executors and trustees to empower any other of my executors and trustees to act for them at any time and from time to time.

IN WITNESS WHEREOF, I have hereunto set my hand and seal, declaring this to be my last will and testament, this 2nd day of July, 1956.

Caroline E. Porter (L.S.)

Signed, sealed, published and declared by said testatrix, Caroline E. Porter, as and for her last will and testament, in the presence of us, the undersigned, who in her presence and in the presence of each other, at her request, have hereunto set our names as witnesses, this 3rd day of July, 1956.

Walter T. Johnson Kensington, Conn.
James W. Bailey Kensington, Conn.
Wellington L. Burke Willimantic, Conn.

State of Connecticut } ss: Hartford, July 3, 1956.
County of Hartford }

Then and there personally appeared the above named Walter T. Johnson, James W. Bailey and Wellington L. Burke who, being duly sworn, depose and say that they witnessed the

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execution of the foregoing will of said testatrix, Caroline E. Porter; that she subscribed said will and declared the same to be her last will and testament in their presence; that they thereafter subscribed the same as witnesses in the presence of said testatrix and in the presence of each other and at the request of said testatrix; that said testatrix at the time of the execution of said will appeared to them to be of full age and of sound and disposing mind and memory; and that they make this affidavit at the request of said testatrix.

Subscribed and sworn to
this 3rd day of July,
1956, before me

Spencer Gross
Notary Public.

Esther T. Johnson
Janet W. Bailey
Wellington R. Burnel

HARTFORD NATIONAL BANK AND TRUST COMPANY
Established 1792
HARTFORD 15, CONNECTICUT

JOHN H. McBRIDE
VICE PRESIDENT AND TRUST OFFICER

May 23, 1958

Mr. Robert E. Hathaway, Trust Officer
The Manchester Trust Company
Manchester, Connecticut

Dear Bob:

The provisions in the two Porter Wills, pertaining to Manchester Memorial Hospital, are as follows:

Paragraph Eighth of Will of John Porter:

"(e) The other one-half of the balance of said trust estate as then constituted, plus an amount equal to one-half of the total withdrawals from the principal of said trust estate made by Caroline E. Porter during her lifetime in accordance with the power hereinbefore given to her, I give as follows:

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"Twenty per cent. (20%) thereof, to which shall be added any portion which by virtue of death may not pass under the foregoing paragraphs of the second half of said fund, I give in equal shares to the following fourteen charitable institutions, in each instance to be known as "The John Porter and Caroline E. Porter Fund", to be held in perpetuity, with power of investment and reinvestment, the income only to be used for the support of the institutions hereinafter named, viz.:

****

"13. The Manchester Memorial Hospital, of Manchester, Connecticut."

Will of Caroline E. Porter:

"SIXTH: By the will of my deceased husband, John Porter, who died June 21, 1941, the residue of his estate was given to me in trust for my life and at my death, by Article Eighth, Paragraph (b), I was also given a special or limited power of appointment over one-half of

Mr. Robert E. Hathaway, Trust Officer
The Manchester Trust Company --2-- May 23, 1958

"the balance of said trust estate as constituted at the time of my death, which power of appointment gave me the right to give to such one or more of my brothers or sisters, or their descendants, or to such person or persons (other than myself) named as legatees in his will, or their descendants, or to such religious, charitable or benevolent corporations as I in the exercise of said special or limited power of appointment may by my last will and testament designate and appoint. Accordingly, exercising such special or limited power of appointment thus given to me by my late husband, I nominate and appoint one of my sisters and certain religious, charitable and benevolent institutions hereinafter named to receive out of said one-half of said residuary estate of my late husband, John Porter, the following gifts, to wit:

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"(f) The balance of said one-half of said residuary estate over which I have such limited or special power of appointment shall be distributed by said trustees in equal shares to the following fourteen charitable institutions, constituting the same fourteen charitable institutions designated in the final portion of the Eighth article of the last will and testament of my said husband, John Porter, in each instance to be known as "The John Porter and Caroline E. Porter Fund", to be held in perpetuity, with power of investment and reinvestment, the income only to be used for the support of the institutions hereinafter named, viz:

****

"13. The Manchester Memorial Hospital, of Manchester, Connecticut;"

Sincerely yours,

JHM:glk

[redacted]

EXHIBIT Q 11-2

Fund 11-1.8

William & Mary Rice Fund

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LAST WILL AND TESTAMENT OF
RICHARD W. RICE, LATE OF HARTFORD, DECEASED.

W I L L

OF

RICHARD W. RICE.

I, RICHARD W. RICE, of the Town of Hartford, County of Hartford, and State of Connecticut, being of sound and disposing mind and memory, do hereby make, publish and declare the following to be my last will and testament, hereby revoking all former wills by me made.

FIRST. I direct that all my just debts and the proper charges against my estate be paid by my executrix hereinafter named.

SECOND. I give and bequeath to the Superintendent of the East Cemetery, South Manchester, Connecticut, and to his successors in office, the sum of Five Hundred Dollars, in trust, however, to invest and keep the same invested and to apply and use the income therefrom for the perpetual care of the Rice family burial lot in said cemetery.

THIRD. I give, devise and bequeath to my sister, Lucy M. Ringrose, of South Manchester, Connecticut, all of my right, title and interest in and to the old homestead in South Manchester, Connecticut, to her and her heirs forever.

FOURTH. All of the rest, residue and remainder of my property, of whatever kind and nature and wheresoever situated, I give, devise and bequeath to my wife, Susie G. Rice, in trust, to hold, manage and control the same, and to pay the income therefrom to herself, the said Susie G. Rice, and in addition so much of the principal as in her judgment is necessary for her proper care, maintenance and support. Upon the death of my wife this trust shall cease, and the principal thereof, or so much of said principal as remains, and all accumulations thereto, I give, devise and bequeath to The Hartford-Connecticut Trust Company, a duly organized corporation under the laws of the State of Connecticut and located in Hartford, Connecticut, in trust, to hold, manage and control the same, and to pay the income therefrom at least quarterly in each year to my sister, Lucy M. Ringrose, of South Manchester, Connecticut, during the remainder of her natural life. And from and after the death of my said sister, my trustee, The Hartford-Connecticut Trust Company, shall hold the trust fund and the future income of the same, upon trust, to pay the income of said trust fund at least quarterly in each year to my nephew, Kenneth H. Ringrose, son of my said sister, during the remainder of his natural life. Upon the death of my said nephew, this trust shall cease, and the principal thereof, and all accumulations thereto, I give, devise and bequeath to the Manchester Memorial Hospital, of Manchester, Connecticut, in trust, to be known as the William and Mary Rice Fund, the income therefrom to be used for the purposes and uses of said Hospital.

FIFTH. I appoint my wife, Susie G. Rice, executrix of this will and request that no bonds be required of her either as executrix or trustee hereunder.

IN WITNESS WHEREOF, I have hereunto set my hand and seal at Hartford, Connecticut, this 11th day of April, 1924.

Richard W Rice (L.S.)

Signed, sealed, published and declared as and for his last will and testament by the within named testator, Richard W. Rice, in our presence, who in his presence, and at his request, and in the presence of each other, have hereunto subscribed our names as witnesses.

Margaret McGurk	Hartford,	Conn
Katherine Flannigan	"	"
Edward J Myers.	Hartford.	Conn.

STATE OF CONNECTICUT,)
DISTRICT OF HARTFORD,) ss. Probate Court, December 6, A.D. 1924.

I, Edward J. Myers of Hartford being duly sworn, make affidavit and say that Richard W. Rice of Hartford, now deceased, signed the instrument hereto annexed bearing date the 11th day of April, A.D. 1924, and declared the same to be his Last Will and Testament in my presence and in the presence of Margaret McGurk and Katherine Flannigan whose names appear thereon as witnesses, at Hartford on said 11th day of April, A.D. 1924; that he was at the time of signing said instrument more than 18 years of age and of sound mind; and that each of said witnesses signed said instrument so subscribed by said Richard W. Rice at his request, in his presence, and in the presence of each other.

Edward J Myers.

Subscribed and sworn to the day and year above written before me,
Mary E. F. Cunningham, Notary Public.

Proved, approved and admitted to Probate, December 5th, 1924.

LAST WILL AND TESTAMENT OF
MICHELE VASQUENZA, LATE OF HARTFORD, DECEASED.

WILL OF MICHELE VASQUENZA

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I, Michele Vasquenza, of the Town, County of Hartford, and State of Connecticut, being of sound and disposing mind and memory, hereby make this my last will and testament, intending hereby to revoke all previous wills by me heretofore made.

FIRST:- I direct that all my just debts and funeral expenses be paid by my executrix hereinafter named, as soon after my death as may by her be found convenient.

SECOND:- I give, devise and bequeath to my beloved wife Maria Cristina Vasquenza, if she shall survive me, the use and income during her natural life, of all my property both real and personal, whatsoever the same may consist of or wheresoever the same may be situated. I also give her, if she shall deem it necessary the right and power to sell, mortgage, or in any way dispose of any real estate that I may own or possess at the time of my decease, with the proviso that if my wife is obliged to sell said real estate she shall set aside in some local bank a sum equal to the cash bequests hereinafter made.

THIRD:- I give, devise and bequeath to my beloved daughter Francesca Vasquenza Caperino, of the Town, County of Hartford, and State of Connecticut, the sum of FIVE HUNDRED ($500.00) DOLLARS to belong to her absolutely, which sum is to be paid at the death of my wife. But in the event of the decease of my beloved daughter Francesca Vasquenza Caperino, prior to my death, or wife's, death, I then give, devise and bequeath, this sum FIVE HUNDRED ($500.00) DOLLARS to the children of my beloved daughter, share and share alike.

FOURTH:- I give, devise and bequeath to my beloved daughter Antonia Vasquenza Festa, of the Town, County of Hartford, and State of Connecticut, the sum of FIVE HUNDRED ($500.00) DOLLARS to belong to her absolutely, which sum is to be paid at the death of my wife. But in the event of the decease of my beloved daughter Antonia Vasquenza Festa, prior to my death, or wife's death, I then give, devise and bequeath this sum FIVE HUNDRED ($500.00) DOLLARS to the children of my beloved daughter, share and share alike.

FIFTH:- I give, devise and bequeath to be beloved sons Francesco Vasquenza and Vincenzo Vasquenza, both of the Town, County of Hartford, and State of Connecticut, all the remainder and residue of my estate both real and personal whatsoever the same may consist of or wheresoever the same may be situated, to belong to them absolutely, share and share alike. But in the event of the decease of either of my sons, prior to my death, or wife's death, then the same shall go the his children, share and share alike, and if no children survive, then the same shall go to the surviving son.

SIXTH:- I nominate, and appoint my beloved wife Maria Cristina Vasquenza executrix of this my last will and testament.

IT WITNESS WHEREOF, I have hereunto set my hand and seal at Hartford, aforesaid this twenty-first day of November A. D. 1923.

Michele X Vasquenzo (L.S.)
His mark

Signed, sealed, published and declared by the above named testator, Michele Vasquenza, to be his last will and testament, in the presence of us, who in his presence and at his request, and the presence of each other, have hereunto subscribed our names as witnesses.

Thomas V Campbell	Hartford	Conn.
Frieda M. Levy	Hartford	Conn.
Francis J Conti	Hartford.	Conn.

STATE OF CONNECTICUT,)
DISTRICT OF HARTFORD,)ss. Probate Court, December 3, A.D. 1924.

I, Francis J. Conti of Hartford being duly sworn, make affidavit and say that Michele Vasquenza of Hartford, now deceased, signed the instrument hereto annexed bearing date the 21st day of November, A. D. 1923, and declared the same to be his Last Will and

EXHIBIT Q 11-2

Fund 11-1.9

Robert N. and Florella Stanley Trust Fund

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WILL No. 17 B Cleaveland Legal Blank Office, Hartford, Conn.

Be it known to all Persons, THAT I, Flora May Stanley, of the Town of Manchester, in the County of Hartford, in the State of Connecticut, being of lawful age, of sound and disposing mind, memory and judgment, do hereby make, publish and declare this to be my last Will and Testament, hereby revoking all previous wills and codicils by me made.

ARTICLE I.

I direct that all my just debts and funeral expenses be paid by my Executor hereinafter named.

ARTICLE II.

I give to the Town of Manchester, a Municipal corporation located in said Hartford County, the sum of Two Hundred ($200.00) Dollars, in trust however, to take, hold and invest the same and to use the income therefrom for the perpetual care of my burial lot in the East Cemetery, in said Manchester.

ARTICLE III.

I give to my cousin, Rosalie H. Burtelle the sum of Twenty-five Hundred ($2500.00) Dollars; to Luline H. Chamberlain the sum of Two Thousand ($2,000.00 Dollars; and to my cousin Myrtle H. Lyndler, the sum of Twenty-five Hundred ($2500.00) Dollars.

ARTICLE IV.

I give to Florence S. Murray, daughter of said Luline H. Chamberlain; to Earl S. Warner, son of Florence S. Murray; to Albert L. Crowell; to Maytie Case Crowell; to Earline Wheelock; to Richard S. Carpenter; to Ever Ready Circle of Kings Daughters; and to my cousins Lucien C. Stanley; Mabel Stanley Carpenter; Evelyn Wheelock; Merton Wheelock; Mattie Wheelock, and Robert Hayes Wheelock, to each of them, the sum of Five Hundred ($500.00) Dollars.

ARTICLE V.

I give to The Manchester Memorial Hospital, a Connecticut corporation, located in said Manchester, the sum of Three Thousand ($3,000.00) Dollars, to be known as the Robert N. and Florella Stanley Trust Fund, to be added to the Endowment Fund of said hospital, and the income to be used for such purposes as the Trustees may deem best.

ARTICLE VI.

I give to my cousin Myrtle L. Lyndler all my jewelry which belonged to my grandmother. All other jewelry I give to the said Evalyn Wheelock.

ARTICLE VII.

In the event that there shall not be sufficient funds to pay the foregoing bequests in full, then it is my will that each legatee receive such proportion of the whole of my estate as the sum herein bequeathed to such beneficiary bears to the sum total of my estate herein to be divided.

ARTICLE VIII.

I give to the Trustees of the South Methodist Episcopal Church of said Manchester the sum of Two Thousand ($2,000.00) Dollars, or so much thereof as may remain after the payment of all legacies herein given, debts, funeral expenses and administration expenses, to be held in trust however, and the income therefrom to be used for such Church purposes as said Trustees shall deem best.

ARTICLE IX.

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I give to my said cousin Myrtle L. Lyndler the life use of all my silverware, furniture and other household effects, together with the life use of any real estate owned by me at the time of my death. At the death of said Myrtle L. Lyndler I give, devise and bequeath said silverware furniture, household effects and real estate to Earl Stanley Warner.

ARTICLE X.

All the residue of my property, of whatsoever the same may consist or wheresoever it may be situated, I give, devise and bequeath to my cousins, Rosalie H. Burtelle and Myrtle L. Lyndler.

ARTICLE XI.

All legacy and succession taxes which may be payable in respect of the bequests and devises in this Will contained, I direct to be paid out of my residuary estate.

497 I Appoint The Manchester Trust Company, a Connecticut corporation, located in
~~of~~ the Town of Manchester, County of Hartford,
and State of Connecticut, executor of this my Last Will and Testament

In Witness Whereof, I have hereunto set my hand and seal at said Manchester,
on the 2nd day of December, A. D., One Thousand, Nine Hundred and forty.

Flora May Stanley [Seal]

Signed, sealed, published and declared by the said Flora May Stanley
as and for her Last Will and Testament, in presence of us at her request, in her presence, and in the presence of each other have hereunto subscribed our names as witnesses, on the 2nd day of December, A. D. 19 40.

Witnesses	*Addresses*
Dorothy L Russell	
Margaret R Dwire	
William J Ayde	

State of Connecticut, }
County of Hartford, } ss. Manchester, December 2nd, A. D. 19 40.

We the within named Dorothy L. Russell and Margaret R. Dwire,

being duly sworn, make affidavit and say: That we severally attested the within and foregoing Will of the within named testatrix and subscribed the same in her presence and at her request and in the presence of each other; that the said testatrix signed, published and declared the said instrument as and for her last Will and Testament in our presence on the 2nd day of December, A. D., 19 40; and at the time of execution of said will, said testatrix was more than eighteen years of age and of sound mind, memory and judgment and under no improper influence or restraint to the best of our knowledge and belief, and we make this affidavit at the request of said testatrix.

Dorothy L. Russell
Margaret R Dwire

498 State of Connecticut, }
County of Hartford, } ss. Manchester, December 2nd, A. D., 19 40.

Then personally appeared before me a Notary Public duly qualified to administer oaths.

Dorothy L. Russell

and Margaret R. Dwire

and subscribed and made oath to the truth of the foregoing affidavit

William J Ayde
Notary Public
~~Justice of the Peace~~

~~Commissioner of Superior Court for~~ County

Will proved, approved and admitted to probate, June 4, 1954.

Judge.

EXHIBIT Q 11-2

Fund 11-1.10

George W. Strant and Rose B. Strant Memorial Fund

[redacted]

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L A S T W I L L A N D T E S T A M E N T ,

I, ROSE B. STRANT, of the Town of Manchester, in the County of Hartford, in the State of Connecticut, being of lawful age, of sound and disposing mind, memory and judgment, do hereby make, publish and declare this to be my last WILL AND TESTAMENT, hereby revoking all previous wills and codicils by me made.

FIRST: I direct that my funeral expenses and all my debts, (except such as shall be secured by mortgage at the time of my death) be paid from my personal estate.

SECOND: All of the rest, residue and remainder of my estate, both real and personal, of whatsoever the same may consist and wheresoever the same may be located, I give, devise and bequeath to my beloved husband, GEORGE W. STRANT, to have and to hold for and during the term of his natural life. I give unto my said husband the full power and authority to invade and to use and to consume all or any portion of my estate as he may deem necessary for his proper maintenance, support and general welfare. I hereby specifically exempt my husband from the filing of any bond in connection herewith.

Upon the death of my said husband, GEORGE W. STRANT, I direct that my estate shall be paid over and distributed to such person or persons or to the estate of my husband in such manner and proportions as my said husband may designate and appoint in his Last Will and Testament. The power of appointment hereby granted to my said husband shall be exercisable by him alone.

THIRD: Upon the death of my said husband, GEORGE W. STRANT, and in the event that he shall default in the exercise of the power of appointment hereinbefore granted to him, I direct that all of my estate then remaining be distributed as follows:

1. I give and bequeath the sum of Two Thousand ($2,000.00) Dollars to THE MANCHESTER TRUST COMPANY, IN TRUST NEVERTHELESS, for

[redacted]

E
Submitted October 13, 2015

the following uses and purposes, to wit:

a. To take, hold, receive, manage, control, invest and reinvest the same. To pay the income from said trust at such times as my trustee shall determine to my cousin, MATTIE PALMER, of Portland, Connecticut, for and during the term of her natural life, and to pay or use and expend so much of the principal of said trust as the trustee, in its sole and absolute discretion, shall deem necessary and proper for the care, comfort, support and maintenance of my cousin, MATTIE PALMER, of Portland, Connecticut, for and during the term of her natural life. Payments of principal by the said trustee to and for the benefit of my said cousin, MATTIE PALMER, shall be in such amounts and proportions and in such manner and at such times as the said trustee, in its sole and absolute discretion, shall deem necessary for her best interests and welfare.

b. Upon the death of my said cousin, MATTIE PALMER, I direct that ~~said trust shall thereupon~~ terminate and that the principal of said trust, together with any unpaid income, be paid to the MANCHESTER MEMORIAL HOSPITAL, of Manchester, Connecticut, to be added to its endowment fund and the income only from which is to be used for the general purposes of said hospital.

c. If my said cousin, MATTIE PALMER, shall predecease me, then in that event, I give and bequeath ~~said Two Thousand~~ ($2,000.00) Dollars to the MANCHESTER MEMORIAL HOSPITAL, to be used as set forth above.

2. I give and bequeath my antique rocking chair covered with needlepoint to RUTH FINLEY BARLOW, of Rockville, Connecticut, daughter of Elizabeth Finley.

3. I give and bequeath the sum of One Thousand ($1,000.00) Dollars each to RUTH FINLEY BARLOW, of Rockville, Connecticut and WILLIAM FINLEY, of Somers, Connecticut, children of Elizabeth Finley.

[redacted]

4. I give and bequeath the sum of Two Thousand ($2,000.00) Dollars to the NEWINGTON HOME FOR CRIPPLED CHILDREN, of Newington, Connecticut, to be used for the general purposes of said home.

5. I give and bequeath the sum of Two Thousand ($2,000.00) Dollars to the CONNECTICUT HUMANE SOCIETY, of Hartford, Connecticut, to be used for the general purposes of said society.

6. I give and bequeath the sum of Five Thousand ($5,000.00) Dollars to the MANCHESTER MEMORIAL HOSPITAL, to be added to its endowment fund and to be known as the George W. Strant and Rose B. Strant Memorial Fund, the income only from which is to be used for the general purposes of said hospital.

7. I give and bequeath my grandfather clock to MINOT FRYER, JR., of St. Louis, Missouri.

8. I give and bequeath the sum of Two Thousand ($2,000.00) Dollars to the WOMEN'S FEDERATION OF THE CENTER CONGREGATIONAL CHURCH, of Manchester, Connecticut, to be used for the general purposes of said federation.

9. I give and bequeath the sum of Ten Thousand ($10,000.00) Dollars in memory of my father and mother, to the CENTER CONGREGATIONAL CHURCH, of Manchester, Connecticut, to be added to its endowment fund, and to be known as the Humphrey L. Shurtleff and Calista Shurtleff Memorial Fund, the income only from which shall be used for the general purposes of said church.

11. I give and bequeath the sum of Two Thousand ($2,000.00) Dollars to CAROLINE STRANT, of Coventry, Connecticut.

FOURTH: I direct that all of the rest, residue and remainder of my estate be divided into three (3) equal parts and be distributed as follows:

a. Two (2) of said parts I give and bequeath to the MANCHESTER MEMORIAL HOSPITAL, of Manchester, Connecticut, to be added to its endowment fund and to be known as the George W. Strant and Rose B. Strant Memorial Fund, the income only from which is to be used for the general purposes of said hospital.

E
Submitted October 13, 2015

b. One (1) of said parts I give and bequeath to the NEWINGTON HOME FOR CRIPPLED CHILDREN, of Newington, Connecticut, to be added to its endowment fund and to be known as the George W. Strant and Rose B. Strant Memorial Fund, the income only from which is to be used for the general purposes of said home.

FIFTH: I further direct that estate, succession and inheritance taxes payable to any state or federal government on any of the legacies hereinbefore set forth, or on the share or portion of my estate passing to any legatee or beneficiary under the terms of this my Last Will and Testament be considered an administration expense and paid for out of the residuary funds of my estate. I further direct that any proration of such taxes be eliminated.

SIXTH: I make, constitute and appoint my husband, GEORGE W. STRANT, of the Town of Manchester, County of Hartford, and State of Connecticut executor of this my Last Will and Testament. In the event that my said husband, shall predecease me or shall be unable or shall refuse to act as such executor, then, in that event, I make, constitute and appoint JOHN R. MROSEK, of said Town of Manchester executor of this my Last Will and Testament. I direct that no bonds shall be required of either of them in such capacity.

IN WITNESS WHEREOF I have hereunto set my hand and seal at Manchester, Connecticut on this 22nd day of December A.D. 1954.

Rose B Strant (L.S.)

Signed, sealed, published and declared by the said ROSE B. STRANT as and for her Last Will and Testament, in presence of us, who at her request, in her presence, and in the presence of each other have hereunto subscribed our names as witnesses, on the 22nd day of December A.D. 1954.

Witnesses.

[redacted]

Submitted October 13, 2015

( )

STATE OF CONNECTICUT,)
) ss. Manchester December 22, A.D.1954
County of Hartford)

We the within named Frank J. Miller, Thomas K. Clarke and Marian M. Kilpatrick being duly sworn, make affidavit and say: That we severally attested the within and foregoing Will of the within named testatrix and subscribed the same in her presence and at her request and in the presence of each other; that the said testatrix signed, published and declared the said instrument as and for her last Will and Testament in our presence on the 22nd day of December A.D., 1954; and at the time of execution of said will, said testatrix was more than eighteen years of age and of sound mind, memory and judgment and under no improper influence or restraint to the best of our knowledge and belief, and we make this affidavit at the request of said testatrix.

Frank J. Miller

Thomas K. Clarke

Marian M. Kilpatrick

STATE OF CONNECTICUT,)
) ss. Manchester December 22, A.D.1954
County of Hartford)

Then personally appeared before me Bernice A. Borg duly qualified to administer oaths.

Frank J. Miller

Thomas K. Clarke

and Marian M. Kilpatrick

and subscribed and made oath to the truth of the foregoing affidavit.

Bernice A. Borg
Commissioner of the Superior Court
Notary Public

Will proved, approved and admitted to probate, November 21, 1958 John M. Walley Judge

****

[redacted]

Submitted October 13, 2015

EXHIBIT Q 11-2

Fund 11-1.11

Minnie R. Strickland

Mt Hospital - Minnie R Strickland ~~58979~~ 58926 1919

LAST WILL AND TESTAMENT

BE IT KNOWN TO ALL PERSONS, THAT I, Minnie R. Strickland, of the Town of Manchester in the County of Hartford in the State of Connecticut being of lawful age, of sound and disposing mind, memory and judgment, do hereby make, publish and declare this to be my last Will and Testament, hereby revoking all previous wills and codicils by me made.

ARTICLE I.

I direct that all my just debts and funeral expenses be paid by my Executor hereinafter named.

ARTICLE II.

I give to my sister, Addie J. Lathrop, at present residing at 215 Newbury Street, Hartford, Conn., my gold watch, gold thimble, silver butter knife, sugar-tong, Japanese cup and saucer, Japanese plate; a vase originally belonging to my mother, my small lamp with marble vase, my circular embroidered linen table cloth, my needle point stool and my mahogany colored chest.

ARTICLE III.

I give to my niece, Lois P. Kay, at present residing at 62 Yale Avenue, Middlebury, Conn., my silver candelabra, my Red and White quilt, my brass lamp with beaded shade and lunch clothe embroidered by her mother.

ARTICLE IV.

I give to my nephew and his wife, Mr. and Mrs. Walton E. Charter, at present residing at 439 Campfield Avenue, Hartford, Conn., my Hoover electric cleaner and attachments, nine Olsen rugs, my crocheted green Afghan, my brass ash receiver, my silver soup ladle, my silver pie knife, my jewelry consisting of one small diamond crescent, cameo brooch, four small gold pins, silver bar pin, rings, Richelieu pearl beads, pink chrystal beads, white chrystal beads, gold and chrystal beads, blue chrystal beads and string of black jet beads.

ARTICLE V.

I give to Mrs. Rose E. Muller, at present residing at 33 Crown Street, Hartford, Conn., my diamond ring, my crocheted afghan in living room, my silver nut spoon, my souvenir silver spoon, my silver teapot, one dozen silver bouillon spoons, eight bread and butter spreaders, two vases, one green and gold, the other plain green, my chocolate jar, my hand painted china and One Hundred ($100.00) Dollars in cash.

ARTICLE VI.

I give to Mr. and Mrs. Charles D. Strickland, at present residing

at 168 Main Street, Manchester, Conn., my lace tablespread, my Philco Radio and Two Hundred ($200.00) Dollars in cash.

ARTICLE VII.

I give to Mr. and Mrs. Calvin Maro Strickland, at present residing at 11 Oak Place, Manchester, Conn., my two blue rugs in living room, my rust colored lounge and arm chair, my General Electric Refrigerator and One Hundred ($100.00) Dollars in cash.

ARTICLE VIII.

I give to Janet Lee Strickland, daughter of Merton and Grace W. Strickland now residing at 57 May Street, in said Hartford, Conn., my lace bed spread.

ARTICLE IX

I direct that all the rest and residue of my property of whatever kind and wherever situated shall be divided into three (3) equal parts:

I give one of said equal parts to the Manchester Memorial Hospital; of Manchester, Conn., to be added to the Endowment Fund of said Hospital;

I give one of said equal parts to the Second Congregational Church, Incorporated, of said Manchester, to be used for the purpose of adding the necessary parish-house facilities to the present church property.

I give one of said equal parts to my said nephew, Walton E. Charter.

I APPOINT The Manchester Trust Company, A Connecticut Corporation of the Town of Manchester County of Hartford and State of Connecticut executor of this my Last Will and Testament

.....

IN WITNESS WHEREOF, I have hereunto set my hand and seal at said Manchester on the 29th day of June A.D., One Thousand, Nine Hundred and forty-two.

.....Minnie R. Strickland.....(Seal)

Signed, sealed, published and declared by the said Minnie R. Strickl as and for her Last Will and Testament, in the presence of us, who at her request, in her presence, and in the presence of each other have hereunto subscribed our names as witnesses, on the 29th day of June A.D. 1942.

Witnesses	Addresses
Theresa H. Sapienza	.....
Robert E. Hathaway	.....
William S. Hyde	.....

State of Connecticut)
) ss: Manchester, June 29, A.D. 1942.
County of Hartford)

We the within named Theresa H. Sapienza and Robert E. Hathaway being duly sworn, make affidavit and say: That we severally attested the within and foregoing Will of the within named testatrix and subscribed the same in her presence and at her request and in the presence of each other; that the said testatrix signed, published and declared the said instrument as and for her last Will and Testament in our presence on the 29th day of June A.D., 1942; and at the time of execution of said will, said testatrix was more than eighteen years of age and of sound mind, memory and judgment and under no improper influence or restraint to the best of our knowledge and belief, and we make this affidavit at the request of said testatrix.

.....Theresa H. Sapienza

.....Robert E. Hathaway

.....

State of Connecticut)
) ss: Manchester, June 29, A.D. 1942.
County of Hartford)

Then personally appeared before me a Notary Public duly qualified to administer oaths,

.....Theresa H. Sapienza

and .....Robert E. Hathaway

.....

and subscribed and made oath to the truth of the foregoing affidavit

.....William S. Hyde

Notary Public

EXHIBIT Q 11-2

Fund 11-1.12

Arthur B. and Carrie E. Ellis Trust Fund

WILL No. 17 B Cleaveland Legal Blank Office, Hartford, Conn.

Be it known to all Persons, THAT I, Carrie E. Ellis, of the Town of Manchester, in the County of Hartford, in the State of Connecticut, being of lawful age, of sound and disposing mind, memory and judgment, do hereby make, publish and declare this to be my last Will and Testament, hereby revoking all previous wills and codicils by me made.

ARTICLE I.

I direct that all my just debts, funeral expenses and all Succession and Inheritance taxes be paid out of the corpus of my Estate by my Executor hereinafter named.

ARTICLE II.

All the rest and residue of my property, of whatever kind and wherever situated, I give, devise and bequeath to my husband, Arthur B. Ellis, if he shall survive me.

ARTICLE III.

In case my said husband shall not survive me, then I give to the proper officers of the Buckingham Congregational Church the sum of Ten Thousand ($10,000.00) Dollars, in trust however, to hold and invest the same and to use the income therefrom for such Church purposes as its officers may deem best; and to the proper officers of the Gilead Congregational Church of Hebron, Connecticut, the sum of Ten Thousand ($10,000.00) Dollars, in trust however, to hold and invest the same and to use the income therefrom for such Church purposes as its officers may deem best.

ARTICLE IV.

I give to The Manchester Memorial Hospital of said Manchester, the sum of Five Thousand ($5,000.00) Dollars, to be added to the Endowment Fund of said hospital and to be known as "The Arthur B. and Carrie E. Ellis Trust Fund", the income therefrom to be used for such hospital purposes as its Trustees may desire.

ARTICLE V.

I give to my sister Julia R. Farr any money which may be deposited in the Farmington Savings Bank at the time of my death.

ARTICLE VI.

Kathryn J. King of Unionville, Connecticut, is indebted to me in the sum of Twenty-six Hundred ($2600.00) Dollars, secured by a mortgage. If it shall not be paid at the time of my death I hereby discharge said obligation and direct my Executor to release the same.

ARTICLE VII.

I give to my grand-nephew, Kenneth W. Ellis, the sum of Five Thousand ($5,000.00) Dollars.

ARTICLE VIII.

I give to Josiah Spiller and Ethel Spiller, of East Hartford, Connecticut, the sum of Five Hundred ($500.00) Dollars each.

ARTICLE IX.

All the rest and residue of my property, of whatever kind and wherever situated, I give, devise and bequeath to my nephew Asa W. Ellis, and to my niece Clara M. Ellis, share and share alike.

I Appoint my said husband, Arthur B. Ellis,
of the Town of Manchester, County of Hartford,
and State of Connecticut, executor of this my Last Will and Testament
without bond.

In Witness Whereof, I have hereunto set my hand and seal at said Manchester
on the 9th day of February A. D., One Thousand, Nine Hundred and forty.

Carrie E. Ellis [Seal]

Signed, sealed, published and declared by the said Carrie E. Ellis
as and for her Last Will and Testament, in presence of us at her request, in her presence, and in the presence of each other have hereunto subscribed our names as witnesses, on the 9th day of February A. D. 1940.

Witnesses *Addresses*

Margaret R. Dwire
Dorothy L. Russell
William J. Hyde

State of Connecticut, }
County of Hartford, } ss. Manchester, February 9th. A. D. 19 40.

We the within named Margaret R. Dwire and Dorothy L. Russell
being duly sworn, make affidavit and say: That we severally attested the within and foregoing Will of the within named testatrix and subscribed the same in her presence and at her request and in the presence of each other; that the said testatrix signed, published and declared the said instrument as and for her last Will and Testament in our presence on the 9th day of February, A. D., 19 40.; and at the time of execution of said will, said testatrix was more than eighteen years of age and of sound mind, memory and judgment and under no improper influence or restraint to the best of our knowledge and belief, and we make this affidavit at the request of said testatrix.

Margaret R. Dwire
Dorothy L. Russell

State of Connecticut, }
County of Hartford, } ss. Manchester, February 9th., A. D., 19 40.

Then personally appeared before me a Notary Public duly qualified to administer oaths.

Margaret R. Dwire
and Dorothy L. Russell
and subscribed and made oath to the truth of the foregoing affidavit

William J. Hyde
Notary Public

~~Commissioner of Superior Court for~~ County

C O D I C I L

BE IT KNOWN TO ALL PERSONS, That I, Carrie E. Ellis, of the Town of Manchester, County of Hartford, in the State of Connecticut, being of lawful age, of sound and disposing mind, memory and judgment, do hereby make, publish and declare this to be a codicil to my Last Will and Testament, dated February 9, 1940.

I APPOINT The Manchester Trust Company, a Connecticut corporation located in the Town of Manchester, County of Hartford, and State of Connecticut, Executor of my Last Will and Testament. In all other respects I hereby confirm and ratify said Will.

IN WITNESS WHEREOF I have hereunto set my hand and seal at said Manchester, on the 8th. day of October, A.D., One Thousand, Nine Hundred and Forty-two.

Carrie E. Ellis

Signed, sealed, published and declared by the said Carrie E. Ellis, as and for a codicil to her Last Will and Testament, in the presence of us, who at her request, in her presence, and in the presence of each other have hereunto subscribed our names as witnesses, on the 8th. day of October, A.D., 1942.

Witnesses	Addresses
Dorothy L Russell	
Margaret R Dwire	
William J Hyde	

****

STATE OF CONNECTICUT)
: ss. Manchester, October 8th., A.D., 1942.
COUNTY OF HARTFORD)

We the within named Margaret R. Dwire and Dorothy L. Russell, being duly sworn, make affidavit and say: That we severally attested the within and foregoing codicil to the Last Will of the within named testatrix and subscribed the same in her presence and at her request and in the presence of each other; that the said testatrix signed, published and declared

[redacted]

EC
Submitted October 13, 2015

the said instrument as and for a codicil to her Last Will and Testament in our presence on the 8th. day of October, A.D., 1942; and at the time of execution of said codicil, said testatrix was more than eighteen years of age and of sound mind, memory and judgment and under no improper influence or restraint to the best of our knowledge and belief, and we make this affidavit at the request of said testatrix.

Dorothy L. Russell

Margaret R. Dowie

STATE OF CONNECTICUT)
: ss. Manchester, October 8th, A.D.,1942.
COUNTY OF HARTFORD)

Then personally appeared before me, a Notary Public, duly qualified to administer oaths.

Dorothy L. Russell

and Margaret R. Dowie

and subscribed and made oath to the truth of the foregoing affidavit.

William J. Hyde
Notary Public.

[redacted]

EXHIBIT Q 11-2

Fund 11-1.13

Ralph and Lula Pinney Fund

ECHN Proposed Asset Purchase by PMH
Submitted October 13, 2015

5P926/

State of Connecticut

DISTRICT OF HARTFORD

PROBATE COURT.

ESTATE OF
LULA M. PINNEY OR LULU M. PINNEY OR MRS. LULA M. PINNEY OR MRS. LULU M. PINNEY OR LULU M. RAMSDEN PINNEY, late of
GLASTONBURY
DECEASED.

PLAIN

Copy

of

WILL

MMH - Pinney "Hot 58-98-61

I, Lula M. Pinney, of the Town of Glastonbury, County of Hartford, and State of Connecticut, being of sound and disposing mind, memory, and judgment, do hereby make, publish, and declare this to be my LAST WILL AND TESTAMENT, hereby revoking all previous wills and codicils by me made.

1st. I give to Miss Harriet Welson of Hartford and Woodstock my emerald and diamond ring.

2nd. I give to Miss Edna G. Somers of West Haven my large single diamond, my Green Clover Leaf pin, and My diamond and sapphire pin.

3rd. I give to Marion Dean of Glastonbury my white enamel pin.

4th. I give to my Aunt, Alice W. Brown, my pearl crescent pin.

5th. I give to my husband, Ralph G. Pinney, my thirteen (13) stone ring, and my eleven (11) stone pin, to be his if he wishes them, and if not, request that they be sold and the proceeds given to some worthy object. I also give to my said husband the use of all my household furniture as long as he wishes them. My diamond and sapphire ring belongs to him.

6th. I direct that the sum of Two Hundred ($200.) Dollars be set aside and placed in trust as a permanent fund, the income to be used and applied for the care and maintenance of the Sanford Keeney Cemetery Lot in the East Cemetery but of Manchester. If there be a Cemetery Association which has the care of said Cemetery, I direct that said fund be paid over to it in trust for the purposes aforesaid.

7th. All the rest, residue, and remainder of my estate I direct shall be divided in equal portions and I give to my husband, Ralph G. Pinney, the use of one-half (½) thereof during his life and the use of the remaining one-half (½) to my Aunt, Alice W. Brown, during her life.

Upon the death of either, and both, I give, devise, and bequeath the principal of said estate as follows: One-

half (½) to the Manchester Memorial Hospital as a permanent fund to be known as the Ralph and Lula Pinney Fund, the income of which Fund to be used and applied for the general purposes of said hospital, but as I am now maintaining a room in said hospital in memory of Sanford Keeney, I direct that so much of said income as may be required shall be used and applied towards the maintenance of said room. The other one-half (½) I give, devise, and bequeath to the Children's Aid Society of Hartford, The Newington Home For Crippled Children, The Hartford Hospital, and the First Church of Christ (Congregational) of Glastonbury, to each one-quarter (¼) thereof, as a permanent fund, the funds to the Children's Aid Society, Newington Home For Crippled Children, and Hartford Hospital to be known as the Ralph and Lula Pinney Fund, and the fund to the Church to be known as the Lula M. Pinney Fund, the income of said funds to be applied for the general purposes of each of said institutions, respectively.

I appoint William H. Wright of Fargo, North Dakota, to be executor of this my LAST WILL AND TESTAMENT and direct that no bonds be required of him.

IN TESTIMONY WHEREOF, I have hereunto set my hand and seal at Hartford, Connecticut, this 13th day of May, 1924.

Lula M. Pinney. L.S.

Signed, sealed, published, and declared by the above named testatrix, Lula M. Pinney, to be her LAST WILL AND TESTAMENT in our presence, who in her presence, at her request, and in the presence of each other, have hereunto subscribed our names as witnesses.

Bernard J Ackerman

Helen V. Strauss

Ralph M. Grant

EXHIBIT Q 11-2

Fund 11-1.14

Emil L. G. Hohenthal

June 16, 1953

In accordance with action taken at meeting of Trustees held on May 19, 1953, the Budget Committee had met on June 9 and studied the proposal to increase ward rates prior to July 1, 1953. It was reported that the cost of giving bed, board, and general nursing care to a ward patient was $13.60 per day. The rates in effect were $10.00 per day for service ward patient and $11.25 for a private ward patient. It was recommended by the Budget Committee that, effective as of June 29, 1953, service ward rates and private ward rates be increased to $12.50 per day.
It was Voted: To accept the recommendation of the Budget Committee.

Other subjects discussed were:

1. Financial problems involved in the revision of the contract with Dr. Platz, Anaesthesiologist.
2. Additional financial requirements to provide Nursing Department with 5% increment in compensation voted by Board of Trustees on September 23, 1952 to be effective for the year commencing October 1, 1953.
3. Request from employees of The Manchester Memorial Hospital for
   (a) Forty hour week
   (b) Payment by hospital of their Blue Cross premium (not including Connecticut Medical Service)
   (c) Provision for a retirement plan in addition to the present Social Security Arrangement.

It was decided that Items 1, 2 and 3 as stated above would be taken up when preparing the financial budget for the fiscal year commencing October 1, 1953.

Report of Insurance Committee
The following quotations were reported for boiler insurance:
1. Mutual Boiler Machinery Company of Boston . . . $2,358. for three years, premium to be paid in three parts.
2. Hartford Steam Boiler . . . $2,676. for three years, premium to be paid in a lump sum.

In view of the excellent service given by the Hartford Steam Boiler Company -
It was Voted: To continue the policy with Hartford Steam Boiler, and to try to obtain a reduced rate.

Report of Bowen Fund
Amount of subscriptions from November 1, 1952 to date - $9,035.05.

Report of Finance Committee (Report of invested funds and classification of investments as of March 30, 1953 distributed to Trustees)
The following recommendations were submitted:
1. That we use the proceeds from other funds to bring the accounts listed below up to the original amount:

	Original Amount	Present Amount
William H. Coates Fund	$ 500.00	$ 273.51
Darling Fund	1,000.00	452.95
E.L.G. Hohenthal Fund	750.00	403.77

2. That cash as shown in the Report of Invested Funds be deposited in mutual savings banks at an interest rate of 2½% or more.

3. Not to exercise the right to purchase one share of Cheney Brothers' common stock at $11.00 per share for each 10 shares held in the endowment fund.

4. To foreclose on mortgage of Elverne and Erma Harmsen, 44 Prospect Street - $1,000.

5. That all mortgage investments be at 5% interest, no mortgage to exceed $5,000. or more than one-half of appraisal value of property.

It was voted: To accept the report of the Finance Committee and make the recommendations submitted and as listed above effective.

ARTHUR ANDERSEN LLP

THE MANCHESTER MEMORIAL HOSPITAL

FINANCIAL STATEMENTS

AS OF SEPTEMBER 30, 1996 AND 1995

TOGETHER WITH

REPORT OF INDEPENDENT PUBLIC ACCOUNTANTS

THE MANCHESTER MEMORIAL HOSPITAL

BALANCE SHEETS

SEPTEMBER 30, 1996 AND 1995

ASSETS	1996	1995
CURRENT ASSETS:		
Cash and cash equivalents	$ 11,195,218	$ 4,815,148
Assets limited as to use required for current liabilities	1,336,424	1,339,924
Accounts receivable, less allowance of $3,219,000 in 1996 and $4,195,000 in 1995	14,254,759	17,408,055
Other accounts receivable	527,152	110,473
Inventories of supplies	454,705	401,832
Prepaid insurance and other expenses	289,004	216,194
Due from related entities	378,501	127,053
Total current assets	28,435,763	24,418,679
ASSETS LIMITED AS TO USE, net of current portion:		
By Board of Trustees	21,989,954	20,374,985
Assets held in trust for estimated self-insurance liabilities	8,810,621	7,926,764
Assets under bond indenture	857,350	863,159
Total assets limited as to use	31,657,925	29,164,908
INVESTMENTS	7,624,108	6,855,136
UNAMORTIZED BOND ISSUE EXPENSES	1,135,001	1,235,599
PROPERTY AND EQUIPMENT, at cost:		
Land	1,051,326	1,051,326
Land improvements	817,298	817,298
Buildings and building improvements	32,941,093	32,916,537
Major movable equipment	32,092,964	30,436,010
Fixed equipment	22,815,650	22,652,060
	89,719,131	87,875,231
Less - accumulated depreciation	51,733,156	47,299,424
	37,985,975	40,575,807
CONSTRUCTION IN PROGRESS	3,248,534	1,925,742
Total property and equipment, net	41,234,509	42,501,549
Total assets	$110,087,303	$104,175,871

LIABILITIES AND NET ASSETS	1996	1995
CURRENT LIABILITIES:		
Accounts payable	$ 3,675,596	$ 2,553,392
Connecticut sales and receipts tax payable	5,039,911	4,088,296
Due to third-party agencies	8,340,046	7,101,363
Accrued salaries and wages, payroll taxes and amounts withheld from employees' compensation	3,613,472	3,229,530
Accrued pension and other postretirement benefits	516,000	223,386
Accrued interest payable	341,423	344,924
Current maturities of long-term debt	1,296,936	1,295,998
Total current liabilities	22,823,384	18,836,889
ESTIMATED SELF-INSURANCE LIABILITIES	5,611,602	6,216,097
ACCRUED PENSION AND OTHER POSTRETIREMENT BENEFITS, net of current portion	7,760,393	8,262,027
LONG-TERM DEBT, less current maturities	21,360,260	22,657,194
COMMITMENTS AND CONTINGENCIES		
NET ASSETS:		
Unrestricted	50,504,887	46,218,894
Temporarily restricted	655,939	611,932
Permanently restricted	1,370,838	1,370,838
Total net assets	52,531,664	48,201,664
Total liabilities and net assets	$110,087,303	$104,175,871

The accompanying notes are an integral part of these financial statements.

	MANCHESTER MEMORIAL HOSPITAL				
	ENDOWNMENT FUNDS POOLED				
			9/30/1995	9/30/2001	9/30/2013
			Original	Original	Original
	Date of	Donation Description	Amount	Amount	Amount
	Donation		of Gift	of Gift	of Gift
		UNRESTRICTED INCOME FUNDS			
1	3/35	DWIGHT BLISH	$19,841.35	$19,920.00	$19,920.00
2		JOHN & ELIZA CARPENTER	$2,555.00	$2,555.00	$2,555.00
3		HELEN G CHAPMAN	$5,000.00	$5,000.00	$5,000.00
4		WILLIAM H CONTES	$129.00	$129.00	$129.00
5		GRACE K DART	$4,007.00	$4,007.00	$4,007.00
6		GRACE L HOUSE	$2,500.00	$2,500.00	$2,500.00
7		JOHN & CAROLINE PORTER	$7,464.00	$7,464.00	$7,464.00
8	11/57	WILLIAM & MARY RICE	$122,361.19	$122,361.19	$122,361.19
9		ROBERT & FLORCILA STANLEY	$3,000.00	$3,000.00	$3,000.00
10	5/61	GEORGE & ROSE STROUT	$128,043.30	$128,043.30	$128,043.30
11		MINNIE R STRICKLAND	$2,511.00	$2,511.00	$2,511.00
12		ARTHUR & CARRIE ELLIS	$5,000.00	$5,000.00	$5,000.00
13	7/40	RALPH & LULU PINNEY	$41,375.25	$41,375.25	$41,375.25
14		SOPHIE & SAMUAL DISKAN*			
15		THOMAS & RONALD FERGUSON*			
16		RAYMOND GRISLEE JR*			
17		EMIL J. G HOLENTHAL	$179.00	$179.00	$179.00
18		GEO W &CF BIDWELL*			
19		EVA BIDWELL HARRIS*			
20		JW & HR CHENEY	$75,000.00	$75,000.00	$75,000.00
21	12/63	HC CHENEY	$543,561.81	$543,561.81	$543,561.81
22		HEBERT DEWEY	$1,498.00	$1,498.00	$1,498.00
23		JUNE DEWEY	$936.00	$936.00	$936.00
		DONALD G. PIPER AND HAZEL B. PIPER	$0.00	$0.00	$75,000.00
		DONALD G. PIPER AND HAZEL B. PIPER	$0.00	$0.00	$75,000.00
24	3/93	HAZEL S BURGESS	$113,623.92	$113,623.92	under Foundation
25	5/95	HELEN ST LAURENT	$10,000.00	$10,000.00	under Foundation
		TOTAL UNRESTRICTED	$1,088,585.82	$1,088,664.47	$1,115,040.55
		LESS UNRESTRICTED FUND BALANCE			
		ADJUSTED UNRESTRICTED			
		RESTRICTED INCOME FUNDS			
		FREE BED:			
26	1/60	DRAKE BED FUND	$90,499.84	$90,499.84	$90,499.84
27	5/31	LOREN GARDNER	$25,000.00	$25,000.00	$25,000.00
28		MATTIE HILLS PRESTON	$8,000.00	$8,000.00	$8,000.00
29		P O BOYNTON	$923.00	$923.00	$923.00
	09/23/97	ERNA LOOMIS		$196,394.42	$196,394.42
		SUBTOTAL FREE BED	$124,422.84	$320,817.26	$320,817.26
30		ELSIE C DISHER	$151,579.19	$151,579.19	$151,579.19
31		THOMAS D TROTTER	$128.00	$128.00	$128.00
32	11/57	WILLIAM & REBECCA WRIGHT	$6,123.63	$6,123.63	$6,123.63
		TOTAL RESTRICTED	$157,830.82	$157,830.82	$157,830.82
		TOTAL POOLED INVESTMENTS	$1,370,839.48	$1,567,312.55	$1,593,688.63
		HELD AT FOUNDATION:			
		HAZEL BURGESS			$113,623.92
		HELEN ST. LAURENT			$10,000.00
		HAZEL B. PIPER			$1,161,399.20
			$0.00	$0.00	$1,285,023.12
		INTEREST IN TRUST ASSETS	$0.00	$0.00	$5,700,198.92
		TOTAL PERM RESTRICTED	$1,370,839.48	$1,567,312.55	$8,578,910.67
		TOTAL PER AUDITED FINANCIAL STATEMENTS	$1,370,838.00	$1,567,311.00	$8,578,909.00
		VARIANCE	$1.48	$1.55	$1.67

EXHIBIT Q 11-2

Fund 11-1.15

George Wells Cheney and Harriet Richmond Cheney Memorial Fund

M Hospital - George Wells Cheney & Harriet Richmond Ch
Memorial Fund

Memorial Cheney Memorial Fund

WILL

of

LOUIS R. CHENEY

I, LOUIS R. CHENEY, of Hartford, Connecticut, do make, publish declare this to be my Last Will and Testament, hereby revoking all wills tofore made by me.

FIRST: I direct that all my just debts and expenses be fully and that all succession, legacy, estate and transfer taxes be paid out of residue of my estate as an expense in the settlement thereof.

SECOND: I give and bequeath my Benjamin Cheney clock, my Dr. J Richmond desk, Silas Cheney mirror, Captain Timothy Cheney rifle and sabe my nephew, George Wells Cheney.

THIRD: I give, devise and bequeath to my daughter, Eliza Chen Roberts, all real estate which I may own at the time of my death in the C of Hartford, in the State of Connecticut, together with all contents of a buildings thereon, including my automobiles, jewelry and clothing except clock, desk, mirror, rifle and saber, and except the furniture belonging my step-daughters. If my said daughter should die before me, I then giv devise and bequeath said real estate, contents and effects to my granddau Elizabeth Roberts Bockstoce.

FOURTH: I give, devise and bequeath to my granddaughter, Eliz beth Roberts Bockstoce, all real estate which I may own at the time of my death at York, Maine, together with the contents of the buildings on such property, except certain furniture belonging to my step-children, and exc my Charles Young clock.

FIFTH: I give and bequeath said Charles Young clock to the Yo Harbor (Maine) Reading Room.

SIXTH: I give and bequeath the sum of One Thousand (1,000) Dol lars to Elsie Johnson and the sum of Six Hundred (600) Dollars to Arthur Falls, and the sum of Four Hundred (400) Dollars each to Ruth Carlson and Betty Becher, provided each is in my service at the time of my death.

SEVENTH: I direct my Executors to divide all the rest, residue and remainder of my property both real and personal, and wheresoever situa including any property over which I may have power of disposal or appoint-

~~[illegible] Hundred and Fifteen (115)~~

ment, into One Hundred Fifty-five (155) equal parts, and I give, bequeath and devise said parts as follows:

A. Forty (40) of said parts to my nephew, George Wells Cheney, if l survives me, or if he does not survive me, to his son, George Wells Chene Jr., if he survives me.

B. Ten (10) of said parts to Henry C. Robinson of West Hartford, C ecticut, in memory of his grandfather, Henry C. Robinson, who, in my esti tion was the grandest man I ever knew.

C. Ten (10) of said parts to the Manchester Memorial Hospital as a memorial to my father and mother, George Wells Cheney and Harriet Richmon Cheney, to be held as a separate fund and the income only used for the ge purposes of said Hospital.

D. Ten (10) of said parts to the Hartford-Connecticut Trust Compan as Trustee, to hold in Trust, and direct that the net income of said Trus Fund shall be paid to my stepson, Robert Crain, during his natural life, after his death to his widow, Maxine Crain, for her natural life, and on death I direct the Trustee to pay the principal of said Trust Fund equall per stirpes to the then living children, and descendants of deceased chil born to the said Robert and Maxine Crain;

PROVIDED, That after the death of Robert Crain the said Maxine Crai said children and descendants, if any, shall relinquish any and all titl claim or interest she or they may have in "Springdale Farm" located in Mc gomery County, Maryland, conveyed in trust to Henry Gilligan for the use, certain conditions, of Robert Crain, his wife, and children, if any, by d dated December 10, 1941, and recorded in the Land Records of Montgomery County, Maryland, in Liber No.870, at folio 156. Upon the death of Maxi Crain, if she and Robert Crain have no living children or descendants, o her refusal to relinquish any title, claim or interest she may have in s farm, or if said children and descendants, if any, shall refuse to relin their claim to said farm, I direct my said Trustee to pay the principal said Trust Fund in equal portions to the grandchildren, then living, of deceased wife, Margaret Bennett Cheney. The right of any beneficiary t

ceive such income or principal shall not be anticipated or assignable, n in any event applicable to the payment of his or her debts, and for this pose the Trustee may withhold and accumulate at its discretion any or al income payments.

E. Ten (10) of said parts each to my step-children,- Bennett Crai Eleanor McPeck and Margaret Pittroff, if each survive me, or if either o not, equally to the children of such deceased surviving me, or if either no children surviving me, per stirpes to the descendants then living of late wife, Margaret Bennett Cheney.

F. Ten (10) of said parts to the Newington Home for Crippled Chi Newington, Connecticut, which institution shall use the income only for general purposes.

G. Ten (10) of said parts to the Institute of Living (Hartford H Hartford, Connecticut, which institution shall use the income only for general purposes.

H. Ten (10) of said parts to The Visiting Nurse Association of H ford, Connecticut, which association shall use the income only for its general purposes.

I. Ten (10) of said parts to the Young Men's Christian Associati Hartford, Connecticut, which association shall use the income only for general purposes.

J. Ten (10) of said parts to Mrs. Sally Johnson (Mrs. William Ch Johnson) of Washington, D. C., who wrote the most beautiful "Tribute to Margaret".

K. Five (5) of said parts to Richard Platt as Trustee, to use th come and so much of the principal thereof as he shall see fit for the c and education of his son, Louis Richmond Cheney Platt, until he reaches age of twenty-one (21) years, when so much of said fund as may then rem shall be paid over as a vested interest to said Louis Richmond Cheney P

In the event of the lapse before my death of any of the gifts indi in the preceding paragraphs of this Clause Seventh, I direct the Execut reduce the number of shares to be set out accordingly, so that for inst if George Wells Cheney and his son should die before me that instead of Hundred Fifty-five (155) parts set out that One Hundred and Fifteen (11

parts be set out for division among the other beneficiaries.

EIGHTH: I appoint my daughter, Eliza Cheney Roberts and The ford-Connecticut Trust Company as Executors of this Will and direct that such Executor and that no Trustee under this Will be required to give bc I give my Executors and any Trustee named in this Will the following dis tionary powers;

To make all divisions and distributions required under this Will, cluding any revaluations and allocations necessary in connection therew to sell at public or private sale, with or without option for cash or p chase money mortgage, and to exchange, partition or lease any and all i terest in real or personal property; and to continue to hold any invest ment made by me and to invest and reinvest in such property, real or pe nal, as they shall deem wise without being limited to investments autho for trust funds by the laws of the State of Connecticut.

I make no further provision for my daughter, Eliza, as she has bee vided for from her mother's estate.

IN WITNESS WHEREOF, I have hereunto set my hand and seal and subscribed these presents, and do make, publish and declare the same as for and to be my Last Will and Testament in the presence of the witnes attesting and subscribing the same at my request, this 22nd day of Feb A. D., 1944.

Louis R. Cheney (L.S.)

SIGNED, SEALED, PUBLISHED AND DECLARED by LOUIS R. CHENEY, t Testator above named, as and for and to be his Last Will and Testament the presence of us, who, at his request, and in his presence, and in t sence of each other, have hereunto subscribed our names as witnesses, 22nd day of February A.D.1944.

Laurent C. Deming	of	New York City
Elsie A. Johnson	of	Hartford, Conn.
Helen E. Musson	of	New York City

EXHIBIT Q 11-2

Fund 11-1.16

Helen Campbell Cheney Fund

I. HELEN CAMPBELL CHENEY, of Manchester, Connecticut, do hereby make, publish and declare this to be my last will and testament, hereby revoking all other wills and codicils heretofore made by me.

First: I direct that all my funeral expenses and just debts, except those secured by mortgage on real estate, shall be duly paid.

Second: I direct that all legacy, succession, inheritance, transfer and estate taxes levied or assessed upon or with respect to any property which is included as part of my gross estate for the purpose of any such tax, whether or not such property passes under this will, shall be paid by my Executor out of my estate in the same manner as an expense of administration and shall not be prorated or apportioned among or charged against the respective devisees, legatees, beneficiaries, transferees or other recipients nor charged against any property passing or which may have passed to any of them and that my Executor shall not be entitled to reimbursement for any portion of any such tax from any person.

Third: I give and bequeath to The Cheney Cemetery Association, Incorporated, the sum of Three Thousand Dollars ($3,000) to hold the same and to invest and reinvest the same at its discretion without limitation to trust investments so-called, for the following uses and purposes: The income earned by said sum shall be expended as needed for the perpetual care and maintenance of my husband's and my lot in the cemetery grounds of said Association, including the planting and replacement of shrubs and weeding, and any income not so expended shall be used as needed for the perpetual care and maintenance of the cemetery grounds of said Association in general; and the principal of said sum shall be expended only if necessary for the repair or replacement of the monuments on said lot of my husband and myself should they be

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that no such statutes shall be applicable to the foregoing bequest and further that said The Cheney Cemetery Association, Incorporated shall not be required to file any annual account of this trust to the Probate Court of the District of Manchester.

Fourth: I direct that my Executor shall segregate from my other property all property which I received from the estate of my late husband, Philip Cheney, except any of his household furniture and furnishings and personal effects, and I direct my Executor to pay over all such property in equal shares and I so give, devise and bequeath the same to the following nieces and nephew of my husband: Georgiana Dorey Grant, Ednah Cheney Dorey Benner, Helen Bayne Knapp, Elizabeth Bayne Blackburn and Thomas Langdon Cheney, Jr., provided, however, that if any of said nieces or nephew of my husband shall have previously died leaving issue living at my death, the share of the one so dying shall be paid, per stirpes, to his or her issue, and if any one of said nieces or nephew of my husband shall have previously died leaving no issue me surviving, his or her share shall be paid to the others of said nieces and nephew of my husband or their issue, per stirpes, as the case may be. In case of doubt as to whether any property was received by me from the estate of my husband, the decision of my Executor shall be final. Part of the property received by me from the estate of my husband was the real estate (land and buildings thereon) known as No. 50 Forest Street, Manchester, Connecticut. I anticipate that said above-mentioned nieces and nephew of my husband will wish to sell this real estate, but before doing so, I suggest that they satisfy themselves that no other nephews or nieces of my husband

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I declare that by the phrase "all property which I received from the estate of my late husband" I mean all property, including any substituted property, received by me from my husband's estate as devisee, legatee or beneficiary under my husband's will and owned by me at my death, but not property purchased by me from my husband's estate for a valuable consideration nor as noted above any of his household furniture and furnishings and personal effects.

Fifth: I give and bequeath to Henry E. McCone, of West Hartford, Connecticut, John H. Stearns, of West Hartford, Connecticut, and Alice G. Conway, of West Hartford, Connecticut, and the survivors or survivor of them, all of my household furniture and furnishings and I express the wish that they will dispose of certain of said articles in accordance with my wishes as they may know them to be and as they may be set forth in any memorandum or memoranda which I may leave for their guidance and will sell the remainder of said articles and add the proceeds to the residue of my estate to be disposed of in accordance with article Sixth of this will. In expressing this wish I realize that I am not creating any legal restriction upon them, but I am confident that they will comply with my wishes.

Sixth: All the rest, residue and remainder of my estate, both real and personal and wherever situated, I direct my Executor to divide into three (3) equal parts and to transfer and pay over said three (3) equal parts and I so give, devise and bequeath the same as follows:

(a) Two (2) of said equal parts to The Rhode Island Hospital, a hospital corporation organized and existing under the

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only to be used and applied for the benefit of said Hospital in such manner as the Trustees of said Hospital may in their discretion determine. If, in the judgment of said Trustees, it seems wise, I would be pleased if One Thousand Dollars ($1,000) from said income be used annually for the work of the Hospital's Social Service Department, in which I have had a deep interest for many years.

(b) One (1) of said equal parts to Manchester Memorial Hospital, a hospital corporation organized and existing under the laws of the State of Connecticut and located in said Manchester, to be held as a permanent fund in memory of my husband, Philip Cheney, with power of investment and reinvestment, the income only to be used and applied for the benefit of said Hospital in such manner as the Trustees of said Hospital may in their discretion determine.

Seventh: I hereby confer upon my Executor full power and authority in its absolute discretion and without application to court but subject always to such restrictions as are specifically stated in this will and with due consideration of my wishes as expressed in this will

(1) To sell and convey any real or personal property at any time forming part of my estate and not specifically bequeathed or devised in this will;

(2) To settle, adjust, compound or dispose of on any terms, and with or without allowing or obtaining any time or receiving or giving any security, claims and demands belonging to or made against me or my estate;

(3) To effect any division under this will or any codicil [illegible] money and to that end

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(4) To pay over any legacy given to a minor by this will or any codicil hereto to a parent or guardian of the person of the minor, and the receipt of such parent or guardian shall be a sufficient voucher and discharge to my Executor for all payments so made by it.

Eighth: I nominate and appoint Hartford National Bank and Trust Company to be Executor of this my last will and testament. If for any reason the settlement of my estate is delayed for more than one year after my death, I direct that no interest shall be paid upon the gifts made in this will or in any codicil hereto.

IN WITNESS WHEREOF, I have hereunto set my hand and seal at Hartford, Connecticut, this 29th day of June, 1960.

Helen Campbell Cheney (L.S.)

Signed, sealed, published and declared by the above-named testatrix, HELEN CAMPBELL CHENEY, as and for her last will and testament in the presence of us, who at her request, in her presence and in the presence of each other, have hereunto subscribed our names as witnesses.

John C. Parsons of Hartford, Conn.

Doris DeW. Hellyar of Middletown, Conn.

Margaret C. Olson of Collinsville, Conn.

STATE OF CONNECTICUT }
COUNTY OF HARTFORD } ss.: Hartford, June 29, 1960

The within-named John C. Parsons, Doris DeW. Hellyar and Margaret C. Olson, being duly sworn, do depose and say:

disposition of real and personal property; that she voluntarily signed said will and declared the same to be her last will and testament, in the presence of the three subscribing witnesses thereto and that this affidavit is made at the request of the testatrix.

[illegible]

Doris DeW. Hellyer

Margaret C. [illegible]

Subscribed and sworn to
this 29th day of June
1960, before me,

Margaret P. Hall
Notary Public

Will proved, approved and admitted to probate, May 7, 1962.

[illegible] Judge

****

EXHIBIT Q 11-2

Fund 11-1.17

Albert (Herbert) Dewey

ARTHUR ANDERSEN LLP

THE MANCHESTER MEMORIAL HOSPITAL

FINANCIAL STATEMENTS

AS OF SEPTEMBER 30, 1996 AND 1995

TOGETHER WITH

REPORT OF INDEPENDENT PUBLIC ACCOUNTANTS

THE MANCHESTER MEMORIAL HOSPITAL

BALANCE SHEETS

SEPTEMBER 30, 1996 AND 1995

ASSETS	1996	1995
CURRENT ASSETS:		
Cash and cash equivalents	$ 11,195,218	$ 4,815,148
Assets limited as to use required for current liabilities	1,336,424	1,339,924
Accounts receivable, less allowance of $3,219,000 in 1996 and $4,195,000 in 1995	14,254,759	17,408,055
Other accounts receivable	527,152	110,473
Inventories of supplies	454,705	401,832
Prepaid insurance and other expenses	269,004	216,194
Due from related entities	378,501	127,053
Total current assets	28,435,763	24,418,679
ASSETS LIMITED AS TO USE, net of current portion:		
By Board of Trustees	21,989,954	20,374,985
Assets held in trust for estimated self-insurance liabilities	8,810,621	7,926,764
Assets under bond indenture	857,350	863,159
Total assets limited as to use	31,657,925	29,164,908
INVESTMENTS	7,624,105	6,855,136
UNAMORTIZED BOND ISSUE EXPENSES	1,135,001	1,235,599
PROPERTY AND EQUIPMENT, at cost:		
Land	1,051,326	1,051,326
Land improvements	817,298	817,298
Buildings and building improvements	32,941,893	32,918,537
Major movable equipment	32,092,964	30,436,010
Fixed equipment	22,815,650	22,652,060
	89,719,131	87,875,231
Less - accumulated depreciation	51,733,156	47,299,424
	37,985,975	40,575,807
CONSTRUCTION IN PROGRESS	3,248,534	1,925,742
Total property and equipment, net	41,234,509	42,501,549
Total assets	$110,087,303	$104,175,871

LIABILITIES AND NET ASSETS	1996	1995
CURRENT LIABILITIES:		
Accounts payable	$ 3,675,596	$ 2,553,392
Connecticut sales and receipts tax payable	5,039,911	4,088,296
Due to third-party agencies	8,340,046	7,101,363
Accrued salaries and wages, payroll taxes and amounts withheld from employees' compensation	3,613,472	3,229,530
Accrued pension and other postretirement benefits	516,000	223,386
Accrued interest payable	341,423	344,924
Current maturities of long-term debt	1,296,936	1,295,998
Total current liabilities	22,823,384	18,836,889
ESTIMATED SELF-INSURANCE LIABILITIES	5,611,602	6,218,097
ACCRUED PENSION AND OTHER POSTRETIREMENT BENEFITS, net of current portion	7,760,393	8,262,027
LONG-TERM DEBT, less current maturities	21,360,260	22,657,194
COMMITMENTS AND CONTINGENCIES		
NET ASSETS:		
Unrestricted	50,504,887	46,218,894
Temporarily restricted	655,939	611,932
Permanently restricted	1,370,838	1,370,838
Total net assets	52,531,664	48,201,664
Total liabilities and net assets	$110,087,303	$104,175,871

The accompanying notes are an integral part of these financial statements.

	MANCHESTER MEMORIAL HOSPITAL				
	ENDOWNMENT FUNDS POOLED				
			9/30/1995	9/30/2001	9/30/2013
			Original	Original	Original
	Date of	Donation Description	Amount	Amount	Amount
	Donation		of Gift	of Gift	of Gift
		UNRESTRICTED INCOME FUNDS			
1	3/35	DWIGHT BLISH	$19,841.35	$19,920.00	$19,920.00
2		JOHN & ELIZA CARPENTER	$2,555.00	$2,555.00	$2,555.00
3		HELEN G CHAPMAN	$5,000.00	$5,000.00	$5,000.00
4		WILLIAM H CONTES	$129.00	$129.00	$129.00
5		GRACE K DART	$4,007.00	$4,007.00	$4,007.00
6		GRACE L HOUSE	$2,500.00	$2,500.00	$2,500.00
7		JOHN & CAROLINE PORTER	$7,464.00	$7,464.00	$7,464.00
8	11/57	WILLIAM & MARY RICE	$122,361.19	$122,361.19	$122,361.19
9		ROBERT & FLORCILA STANLEY	$3,000.00	$3,000.00	$3,000.00
10	5/61	GEORGE & ROSE STROUT	$128,043.30	$128,043.30	$128,043.30
11		MINNIE R STRICKLAND	$2,511.00	$2,511.00	$2,511.00
12		ARTHUR & CARRIE ELLIS	$5,000.00	$5,000.00	$5,000.00
13	7/40	RALPH & LULU PINNEY	$41,375.25	$41,375.25	$41,375.25
14		SOPHIE & SAMUAL DISKAN*			
15		THOMAS & RONALD FERGUSON*			
16		RAYMOND GRISLEE JR*			
17		EMIL L G HOLENTHAL	$179.00	$179.00	$179.00
18		GEO W &CF BIDWELL*			
19		EVA BIDWELL HARRIS*			
20		JW & HR CHENEY	$75,000.00	$75,000.00	$75,000.00
21	12/63	HC CHENEY	$543,561.81	$543,561.81	$543,561.81
22		HEBERT DEWEY	$1,498.00	$1,498.00	$1,498.00
23		JUNE DEWEY	$936.00	$936.00	$936.00
		DONALD G. PIPER AND HAZEL B. PIPER	$0.00	$0.00	$75,000.00
		DONALD G. PIPER AND HAZEL B. PIPER	$0.00	$0.00	$75,000.00
24	3/93	HAZEL S BURGESS	$113,623.92	$113,623.92	under Foundation
25	5/95	HELEN ST LAURENT	$10,000.00	$10,000.00	under Foundation
		TOTAL UNRESTRICTED	$1,088,585.82	$1,088,664.47	$1,115,040.55
		LESS UNRESTRICTED FUND BALANCE			
		ADJUSTED UNRESTRICTED			
		RESTRICTED INCOME FUNDS			
		FREE BED:			
26	1/60	DRAKE BED FUND	$90,499.84	$90,499.84	$90,499.84
27	5/31	LORRN GARDNER	$25,000.00	$25,000.00	$25,000.00
28		MATTIE HILLS PRESTON	$8,000.00	$8,000.00	$8,000.00
29		P O BOYNTON	$923.00	$923.00	$923.00
	09/23/97	ERNA LOOMIS		$196,394.42	$196,394.42
		SUBTOTAL FREE BED	$124,422.84	$320,817.26	$320,817.26
30		ELSIE C DISHER	$151,579.19	$151,579.19	$151,579.19
31		THOMAS D TROTTER	$128.00	$128.00	$128.00
32	11/57	WILLIAM & REBECCA WRIGHT	$6,123.63	$6,123.63	$6,123.63
		TOTAL RESTRICTED	$157,830.82	$157,830.82	$157,830.82
		TOTAL POOLED INVESTMENTS	$1,370,839.48	$1,567,312.55	$1,593,688.63
		HELD AT FOUNDATION:			
		HAZEL BURGESS			$113,623.92
		HELEN ST. LAURENT			$10,000.00
		HAZEL B. PIPER			$1,161,399.20
			$0.00	$0.00	$1,285,023.12
		INTEREST IN TRUST ASSETS	$0.00	$0.00	$5,700,198.92
		TOTAL PERM RESTRICTED	$1,370,839.48	$1,567,312.55	$8,578,910.67
		TOTAL PER AUDITED FINANCIAL STATEMENTS	$1,370,838.00	$1,567,311.00	$8,578,909.00
		VARIANCE	$1.48	$1.55	$1.67

MANCHESTER MEMORIAL HOSPITAL
DEVELOPMENT COMMITTEE
Tuesday, June 30, 1981

PRESENT: Mrs. Snyder; Messrs. Ferguson, R. Smith, Kenney, Dobkin, Johnson, Getzewich, Beck; Dr. Karns

The meeting was held to determine the appropriate memorial designations for bequests and memorial bequests received prior to the start of the Prescription '84 fund-raising drive. The committee members were presented with a list of available memorials for review.

The following determinations were made:

Bequest of Ruth E. Peck - $141,128.77
the possibility of designating the Rehabilitation Unit
"In memory of Ruth E. Peck and R. Raymond Peck"

Bequest of Shirley H. Gustafson - $15,000.00
Anesthesiologist Work Room
"In memory of C.G. Edwin Gustafson and
Shirley H. Gustafson"

Bequest of Jane N. Dewey - $5,000.00
Nurses' Lounge in Surgical Suite
"In memory of Hilma N. Dillon and Emily D. Coburn"

Bequest of Albert T. Dewey - $8,000.00
Vestibule on Second Floor East Building (244)
"Gift of Albert T. and Jane N. Dewey"

The Committee also decided that some considered thought should be given to some of the larger bequests, so that an appropriate location reflecting the unsolicited and sizeable generosity of the bequests could be selected. Therefore, further thought would be given to the Bequest of Parker Soren ($100,000) and the Bequest of Andrew Ferguson ($1 million endowment fund).

In addition, arrangements would be made to contact Mrs. Alexander Jarvis to determine a memorial location for her husband's bequest ($25,000) and Mrs. John Mrosek to pick a location to recognize gifts made in her husband's memory ($23,851.00).

It had been determined in 1980 that Dr. Lundberg, Sr., would have his $10,000 bequest memorialized in the Medical Library. The Development Office has been in touch with Dr. Lundberg, Jr., on this matter and awaiting the forwarding of a photograph of Dr. Lundberg, Sr., to be included with the memorial plaque.

Respectfully submitted,

Andrew A. Beck, Director
Public Relations and Development

July 2, 1981

EXHIBIT Q 11-2

Fund 11-1.18

Jane (June) Dewey

ARTHUR ANDERSEN LLP

THE MANCHESTER MEMORIAL HOSPITAL

FINANCIAL STATEMENTS

AS OF SEPTEMBER 30, 1996 AND 1995

TOGETHER WITH

REPORT OF INDEPENDENT PUBLIC ACCOUNTANTS

THE MANCHESTER MEMORIAL HOSPITAL

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SEPTEMBER 30, 1996 AND 1995

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		VARIANCE	$1.48	$1.55	$1.67

MANCHESTER MEMORIAL HOSPITAL
DEVELOPMENT COMMITTEE
Tuesday, June 30, 1981

PRESENT: Mrs. Snyder; Messrs. Ferguson, R. Smith, Kenney, Dobkin, Johnson, Getzewich, Beck; Dr. Karns

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Respectfully submitted,

Andrew A. Beck, Director
Public Relations and Development

July 2, 1981

EXHIBIT Q 11-2

Fund 11-1.19

The Loren Gardner Fund

District of New Haven ss. Probate Court, May 20th, 1931

The within and foregoing instrument purporting to be the last will and testament of Cora Lockwood Tibbetts late of East Haven in said District, deceased, having been presented for probate and all parties interested in the probate thereof,- having signed and filed in this Court a written waiver of notice of the hearing thereon,- said instrument is proved, approved and allowed as the last will and testament of said deceased, and ordered to be recorded.

John L.Gilson Judge

----------o----------

Ella C.Livermore

I, Ella C.Livermore of New Haven, in the County of New Haven and State of Connecticut, do make, publish and declare this my last will and testament, hereby revoking all wills heretofore made by me,

FIRST: I direct my executor, hereinafter named, to pay my just debts and funeral expenses out of my estate and I further direct my said executor to pay out of my estate all succession, inheritance, estate and transfer taxes, and all other taxes which may be legally assessed upon my estate or any part thereof, or upon any legacy herein contained, without charging the same to or diminishing any legacy herein given because of any tax or taxes.

SECOND: I direct that my remains be cremated and that my ashes be buried beside the grave of my late husband, Frederick W.Hills, in Spring Grove Cemetery in Hartford, Connecticut.

THIRD: I give and bequeath to my executor hereinafter named a sum sufficient but not in excess of five thousand dollars ($5,000) and direct my said executor to apply said sum to the erection of a suitable monument in the family burial lot of my father, Loren Gardner, in the cemetery at South Manchester, Connecticut, suitably inscribed upon which shall be the names and dates of birth and death of my said father, Loren Gardner, my mother, Amanda Wells Gardner, and such of their descendants and their descendants' wives as may be buried in said burial lot, unless I shall have in my lifetime erected or otherwise provided for the erection of such a monument,

FOURTH: I give and bequeath twenty five thousand dollars ($25,000) to the Hartford Hospital a corporation specially chartered by the State of Connecticut, located in Hartford in said State, in memory of my late husband, Frederick W.Hills, to be held by said Hospital as a fund to be known as The Frederick W.Hills Fund, the income therefrom to be

used for the proper uses of said Hospital. I request, but do not make it a condition, that the income, or so much as may be necessary, be applied to the maintenance of a free bed in said Hospital for poor patients.

FIFTH: I give and bequeath twenty five thousand dollars ($25,000) to the Manchester Memorial Hospital, a corporation specially chartered by the State of Connecticut, located at South Manchester in said State, in memory of my father, Loren Gardner, to be held by said Hospital as a fund to be known as The Loren Gardner Fund, the income therefrom to be used for the proper uses of said Hospital. I request, but do not make it a condition, that the income, or so much as may be necessary, be applied to the maintenance of a free bed in said Hospital for poor patients.

SIXTH: I give and bequeath my ring with a large sapphire in a platinum and diamond setting, to my grandniece, Emily B.Hendricks, of Ann Arbor, Michigan.

SEVENTH: In memory of my father, Loren Gardner, I give and bequeath the sum of three thousand dollars ($3,000) to the South Manchester Methodist Episcopal Church, an ecclesiastical corporation, located in South Manchester, Connecticut.

EIGHTH: I direct my executor hereinafter named to sell all of my real estate, wherever situated, and to receive, hold and distribute the proceeds as though they were a part of my personal estate, and I expressly authorize my said executor and its successors to convey my said real estate and sell the same for cash or for bonds or notes or mortgage or other securities, or for cash and securities.

NINTH: I direct my executor to establish out of my estate, in cash or securities, or both, the following funds;

(a) A fund of the value, so near as may be, of twenty thousand dollars ($20,000) for the benefit of my niece Lena A.Gilbert, of New Haven, Connecticut.

(b) A fund of the value so near as may be, of twenty thousand dollars ($20,000) for the benefit of my niece Elsa G. Quick, of Minneapolis, Minnesota.

(c) A fund of the value so near as may be, of twenty thousand dollars ($20,000) for the benefit of my nephew, George W.Hendricks of Daytona, Florida.

(d) A fund of the value, so near as may be of ten thousand dollars ($10,000) for the benefit of my nephew, Edwin F.Gardner of New Haven, Connecticut.

(e) A fund of the value, so near as may be, of three thousand dollars ($3,000) for the benefit of Harriet Hills, of New Haven, Connecticut.

(f) A fund sufficient to produce an annual income of six hundred dollars ($600.00) for the benefit of Valentine N.Bagley of the City of New York.

TENTH: I give and bequeath the funds described in the ninth article hereof to The Second National Bank of NewHaven, a national banking association, duly authorized and empowered to act as executor and trustee, located in and having its principal office for the transaction of business in the City of New Haven and State of Connecticut, in trust, however, for the following uses and purposes:

(a) To hold and manage said funds and property during the period of the existence of the hereinafter stated trusts, with full power to retain existing investments, to sell, exchange, or otherwise dispose of all or any part thereof whether real or personal either for cash or upon credit and for such prices and upon such terms and conditions as to the said trustee shall seem proper, and to borrow money and to mortgage or hypothecate said property or any part thereof to secure such borrowings, and to make, execute and deliver all necessary or convenient deeds, conveyances, mortgages and bills of sale thereof, and such other instruments as shall be necessary or convenient for the purposes hereof, and to pay all taxes and charges thereon and to invest and reinvest the proceeds, increment, emoluments and income of said property in stocks, bonds, securities and other property real or personal whether or not the same shall be legal investments for trustees, and said trustee shall not be liable because of the character of such investments, and to collect the income therefrom, and to retain as principal in said trust all increases in the value of securities and property held in said trust whether or not such increases are realized by sale, exchange or other disposition and to likewise retain, as part of the principal of said trust fund, shares of stock received by way of stock dividends, and the proceeds of the sale or other disposition of stock rights. Purchasers from my said trustee or its successor, shall not be liable for, or required to follow, the application or disposition by said trustee of any sums paid to said trustee.

(b) I direct my said trustee to pay over to my niece, Lena A.Gilbert, during her lifetime, the net income of said fund hereinbefore established for her benefit, and upon her death to assign, transfer and pay

over the principal of said fund and any income accumulated thereon to her surviving issue, in equal shares if more than one, per stirpes and not per capita, free and discharged of all trusts; but if my said niece shall not leave issue her surviving, my said trustee shall transfer, assign and pay over the principal of said trust fund and any income accumulated thereon to such person or persons as shall be entitled to receive the residue of my estate hereunder, free and discharged of trust.

(c) I direct my said trustee to pay over to my niece, Elue G. Quick, of Minneapolis, Minnesota, during her lifetime, the net income of said fund hereinbefore established for her benefit, and upon her death to assign, transfer and pay over the principal of said fund and any income accumulated thereon to her surviving issue, in equal shares if more than one, per stirpes and not per capita, free and discharged of all trusts; but if my said niece shall not leave issue her surviving, my said trustee shall transfer, assign and pay over the principal of said trust fund and any accumulated income thereon to such person or persons as shall be entitled to receive the residue of my estate hereunder, free and discharged of trust.

(d) I direct my said trustee to pay over to my nephew, George W.Hendricks, during his lifetime, the net income of said fund hereinbefore established for his benefit, and upon his death to assign, transfer and pay over the principal of said trust fund and any income accumulated thereof to his surviving issue, in equal shares if more than one, per stirpes and not per capita, free and discharged of all trusts; but if my said nephew shall not leave issue him surviving, my said trustee shall transfer, assign and pay over the principal of said trust fund and any income accumulated thereon to such person or persons as shall be entitled to receive the residue of my estate hereunder, free and discharged of trust.

(e) I direct my said trustee to pay over to my nephew, Edwin F.Gardner, during his lifetime the net income of said fund established for his benefit, and after his death to pay said net income to my niece, Lena A.Gilbert, during her lifetime and upon her death, or upon the death of my said nephew if she shall not survive him, my said trustee shall assign, transfer and pay over the principal of said fund and any income accumulated thereon to the surviving issue of my said niece Lena A.Gilbert, in equal shares if more than one, per stirpes and not per capita, free and discharged of trust; but if my said niece shall not leave issue her surviving and also surviving my said nephew Edwin F.Gardner, at the death of the survivor

of my said nephew Edwin F. Gardner and my niece Lena A. Gilbert, my said trustee shall transfer, assign and pay over the principal of said trust fund and any income accumulated thereon to such person or persons as shall be entitled to receive the residue of my estate hereunder, free and discharged of trust.

(f) I direct my said trustee to pay over to Harriet Hills, of New Haven, during her lifetime, the net income of said fund established for her benefit and after her death my said trustee shall transfer assign and pay over the principal of said trust fund and any income accumulated thereon, to such person or persons as shall be entitled to receive the residue of my estate hereunder, free and discharged of trust.

(g) I direct my said trustee to pay over to Valentine N. Bagley from the income of the said fund hereinbefore established for his benefit, during his lifetime, six hundred dollars ($600.) per annum, in quarterly instalments, and at his death my said trustee shall transfer, assign and pay over the principal of said trust fund and any income accumulated thereon, to such person or persons as shall be entitled to receive the residue of my estate hereunder, free and discharged of trust.

ELEVENTH: I give, bequeath and devise all the rest, residue and remainder of my property, of every kind and character and wheresoever located, including lapsed legacies, if any, to my said nieces, Lena A.Gilbert, and Elue G. Quick and my said nephews George W.Hendricks and Edwin F.Gardner, in equal shares, provided, however, that if one or more of them shall have died leaving issue such issue shall take its parent's share in equal shares per stirpes and not per capita.

TWELFTH: Should any legatee hereinbefore named contest this will, I hereby revoke his or her legacy and such legatee or legatees so contesting this will shall take no benefit herein, but such legacy, legacies or benefits shall be a part of the residue of my estate and disposed of therewith as hereinbefore provided.

THIRTEENTH: I direct and authorize my executor hereinafter named and my trustee to make any and all distributions herein provided.

FOURTEENTH: I hereby appoint said The Second National Bank of New Haven to be the executor of this my last will and testament, with power to sell, convey, lease and mortgage any part or all of the property, real or personal, of my estate not herein specifically devised, and I direct that my said executor shall not be required to give any bond or other security

for the faithful performance of its duties as such executor in any State or States where it may be necessary or convenient to make proof of this my will.

IN WITNESS WHEREOF, I have hereunto set my hand and seal to this my last will and testament, at New Haven, in the County of New Haven this 12th day of October 1929.

Ella C.Livermore (L.S.)

Signed, sealed, published and declared by the within named testatrix, Ella C.Livermore, to be her last will and testament, in the presence of us and each of us, who, in her presence and in the presence of each other and at her request, have hereunto subscribed our names as witnesses.

W.Martha Kraft 230 Winthrop Ave., New Haven, Conn.
Curtis K.Thompson 28 Smith St., West Haven, Conn,
Avery Tompkins 16 Pauline Ave., West Haven, Ct.

STATE OF CONNECTICUT
COUNTY OF NEW HAVEN ss. PROBATE COURT

In the Matter of the Probate of the last will and testament of Ella C. Livermore late of New Haven in said District, deceased.

DEPOSITION OF SUBSCRIBING WITNESS

Curtis K.Thompson of West Haven being duly sworn and examined before the Probate Court for the District of New Haven, deposes and says:

I was acquainted with said Ella C.Livermore now deceased.

That the subscription of the name of said decedent, at the end of the instrument now shown to me, and offered for probate as the last will and testament of the said Ella C.Livermore deceased, and bearing date the 12th day of October in the year one thousand nine hundred and twenty nine was made by the said decedent at the town of New Haven in the presence of myself and the other subscribing witnesses.

Thatat the time of making such subscription the said decedent declared the said instrument so subscribed by her to be her last will and testament and I thereupon signed my name as a witness, at the end of said instrument, at the request of said decedent, and in her presence. I also saw said W.Martha Kraft and Avery Tompkins the other subscribing witnesses, sign their names as witnesses at the end of said will, and know that they did so at the request and in the presence of said decedent.

That the said decedent, at the time of executing the said instrument, was over the age of eighteen years, and to the best of my knowledge and belief of sound mind and memory, and not under any restraint, and

competent in every respect to make a Will.

Curtis K.Thompson

Subscribed and sworn to this 13th day of March 1931, before me,

Clifford B.Sturges Asst. Clerk of the

Probate Court for the District of New Haven

District of New Haven ss. Probate Court, May 1st, 1931

The within and foregoing instrument purporting to be the last will and testament of Ella C.Livermore late of New Haven in said District, deceased, having been presented for probate and all parties interested, in the probate thereof,- having had notice of the hearing thereon,- said instrument is proved, approved and allowed as the last will and testament of said deceased, and ordered to be recorded.

John L.Gilson Judge

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George Tyler alias George T.Fifield

I, George Tyler Fifield, of New Haven, Connecticut, make this my will.

SECTION FIRST: I give, devise and bequeath all my property of every description of whatsoever the same may consist, or wheresoever situated, to my wife, May Florence Elliott Fifield, absolutely, to have and to hold the same to her, her heirs and assigns forever.

SECOND: If my wife should die before me, in that case I give and bequeath five hundred ($500) dollars to the Poor Fund of the Dwight Place Congregational Church, of New Haven, Connecticut, to be applied to the charitable uses of said fund in such manner as those administering such fund may direct; and all the remainder of my property, belonging to me at my decease, I give, devise and bequeath in case my said wife should die before me, to her sisters and brother, Emma Jane Elliott Johnston, Lewis Augustus Elliott and Louise Augusta Elliott, to be divided equally between them, share and share alike; or if any of them have died before me, leaving issue, the issue to take the share of such decedent and if any of them have died before me, leaving no issue, I give the share of such decedent or decedents, per stirpes to the others or other, or their issue in case of the decease of one leaving issue.

THIRD: I nominate and appoint my said wife May Florence Elliott Fifield, executrix of this will with power to sell and dispose of any of the property at her discretion during the settlement of this estate, and

EXHIBIT Q 11-2

Fund 11-1.20

Donald G. Piper and Hazel B. Piper Memorial

I, **HAZEL B. PIPER**, presently of the Town of Manchester, County of Hartford and State of Connecticut, make this Will, hereby revoking all Wills and Codicils heretofore made by me.

FIRST: I direct that my Executor hereinafter named, shall pay all of my just debts, expenses of last illness and funeral expenses as soon after my death as possible, with the exception that any debt owed by me which is secured by mortgage or by any other lien on my real or personal property may be continued for an indefinite period in the discretion of my Executor. I hereby direct that all legacy, succession, inheritance, transfer and estate taxes, levied or assessed upon or with respect to any property which is included as part of my gross estate for the purpose of any such tax, shall be paid by my Executor out of the residue of my estate as an expense of administration and shall not be prorated or apportioned among or charged against the respective devisees, legatees, beneficiaries, transferees or other recipients, nor charged against any property passing or which may have passed to any of them and that my Executor shall not be entitled to reimbursement for any portion of any such tax from any such person.

SECOND: I give and bequeath the sum of **ONE THOUSAND AND 00/100 ($1,000.00) DOLLARS** unto **ALICE FERRY**, presently of 237 Pine Lake Drive, Coventry, Connecticut, if she survives me.

THIRD: I give and bequeath unto **GERALDINE D. CLAXON**, presently of 1000 Burlington Avenue North, Apartment 310, St. Petersburg, Florida 33705, if she survives me, the sum of **SIX THOUSAND AND 00/100 ($6,000.00) DOLLARS** together with the following described rings of mine:

(1) Yellow gold ring with opal and diamonds;

(2) White gold ring with seven (7) diamonds and two (2) emeralds;

(3) White gold wedding band with diamonds (with extension); and

(4) White gold larger diamond ring with cluster around it (with extension).

FOURTH: All the rest, residue and remainder of my property, both real and personal, and of whatsoever nature, wherever the same may be located or found, which I may own or have the right to dispose of at my death (intending hereby to exercise any power of disposition or appointment that I may

have at my death), I give, devise and bequeath unto MANCHESTER MEMORIAL HOSPITAL, of Manchester, Connecticut, in memory of DONALD G. PIPER and HAZEL B. PIPER, to be held in the Consolidated Investment Fund, the income only from which is to be used at the discretion of the Board of Trustees of the hospital for its general uses and purposes.

FIFTH: For purposes of this Will, a person shall not be considered to survive another if he shall die within thirty (30) days of the death of such other.

SIXTH: I may desire to dispose of certain articles of personal property to other persons in which event I shall leave a memorandum or memoranda with this, my last Will and Testament. Such memoranda are not intended to change the nature of any gift or bequest herein which is absolute.

SEVENTH: I nominate and appoint PAUL R. MARTE, presently of Manchester, Connecticut, to be the Executor of this, my last Will and Testament. In the event he is unable or unwilling to accept such appointment, then I nominate and appoint THE CONNECTICUT BANK AND TRUST COMPANY, presently of Hartford, Connecticut to act as Executor. I further direct that no bond be required of any of them in such capacity or in connection with the sale of any real estate in my estate by any court or judge.

EIGHTH: In addition to the usual powers, I give my Executor full discretionary power and authority with respect to the property of the estate as follows:

To sell or resell the whole or any part of the property, real or personal, for cash or upon such terms as to payment as may be deemed advisable, and to execute and deliver any deed, bill of sale, conditional bill of sale, or other document necessary or convenient to effect a sale;

To borrow funds for any purpose which may be deemed proper, and to pledge the whole or any part of the property to secure the payment of such loan;

To compromise claims by or against the estate;

To make in cash, or in property at such value as shall be fixed, any distribution required, and to determine the distributees upon such evidence as shall be deemed proper;

The enumeration of the foregoing specific powers shall not be construed as a limitation of general powers.

IN WITNESS WHEREOF, I, the said HAZEL B. PIPER, herewith set my hand and seal to this, my last Will and Testament, typewritten on three (3) sheets of paper (including the attestation clause, signatures of witnesses and self-proving

affidavit) upon the margin of each one of which I have also written my name, this 30th day of November, nineteen hundred and ninety.

Hazel B. Piper (L.S.)

signed by the within named Testatrix, HAZEL B. PIPER, and by her declared to be her Will in our presence, who sign as witnesses in her presence, and in the presence of each other, and at her request, this 30th day of November, A.D. 1990.

Carol M. LaRosa of Manchester, Connecticut

Debra C. Daniels of Manchester, Connecticut

STATE OF CONNECTICUT)
) ss. Manchester November 30th, A.D. 1990
COUNTY OF HARTFORD)

The within named, Carol M. LaRosa and Debra C. Daniels being duly sworn, do depose and say: That they witnessed the within Will of the within named Testatrix, and subscribed the same in her presence, in the presence of each other and at her request; That said Testatrix, at the time of signing said Will, appeared to them to be of full age and of sound and disposing mind and memory and competent to make testamentary disposition of real and personal property; That she voluntarily signed said Will and declared the same to be her Last Will and Testament in the presence of the said two subscribing witnesses thereto, and that this Affidavit is made at the request of the said Testatrix.

Carol M. LaRosa

Debra C. Daniels

Subscribed and Sworn to this
30th day of November, A.D. 1990,
before me.

W. David Keith
Commissioner of the Superior Court

EXHIBIT Q 11-2

Fund 11-1.21

Donald G. Piper and Hazel B. Piper Memorial

I, HAZEL B. PIPER, presently of the Town of Manchester, County of Hartford and State of Connecticut, make this Will, hereby revoking all Wills and Codicils heretofore made by me.

FIRST: I direct that my Executor hereinafter named, shall pay all of my just debts, expenses of last illness and funeral expenses as soon after my death as possible, with the exception that any debt owed by me which is secured by mortgage or by any other lien on my real or personal property may be continued for an indefinite period in the discretion of my Executor. I hereby direct that all legacy, succession, inheritance, transfer and estate taxes, levied or assessed upon or with respect to any property which is included as part of my gross estate for the purpose of any such tax, shall be paid by my Executor out of the residue of my estate as an expense of administration and shall not be prorated or apportioned among or charged against the respective devisees, legatees, beneficiaries, transferees or other recipients, nor charged against any property passing or which may have passed to any of them and that my Executor shall not be entitled to reimbursement for any portion of any such tax from any such person.

SECOND: I give and bequeath the sum of ONE THOUSAND AND 00/100 ($1,000.00) DOLLARS unto ALICE PERRY, presently of 237 Pine Lake Drive, Coventry, Connecticut, if she survives me.

THIRD: I give and bequeath unto GERALDINE D. CLAXON, presently of 1000 Burlington Avenue North, Apartment 310, St. Petersburg, Florida 33705, if she survives me, the sum of SIX THOUSAND AND 00/100 ($6,000.00) DOLLARS together with the following described rings of mine:

(1) Yellow gold ring with opal and diamonds;

(2) White gold ring with seven (7) diamonds and two (2) emeralds;

(3) White gold wedding band with diamonds (with extension); and

(4) White gold larger diamond ring with cluster around it (with extension).

FOURTH: All the rest, residue and remainder of my property, both real and personal, and of whatsoever nature, wherever the same may be located or found, which I may own or have the right to dispose of at my death (intending hereby to exercise any power of disposition or appointment that I may

have at my death), I give, devise and bequeath unto MANCHESTER MEMORIAL HOSPITAL, of Manchester, Connecticut, in memory of DONALD G. PIPER and HAZEL B. PIPER, to be held in the Consolidated Investment Fund, the income only from which is to be used at the discretion of the Board of Trustees of the hospital for its general uses and purposes.

FIFTH: For purposes of this Will, a person shall not be considered to survive another if he shall die within thirty (30) days of the death of such other.

SIXTH: I may desire to dispose of certain articles of personal property to other persons in which event I shall leave a memorandum or memoranda with this, my last Will and Testament. Such memoranda are not intended to change the nature of any gift or bequest herein which is absolute.

SEVENTH: I nominate and appoint PAUL R. MARTH, presently of Manchester, Connecticut, to be the Executor of this, my last Will and Testament. In the event he is unable or unwilling to accept such appointment, then I nominate and appoint THE CONNECTICUT BANK AND TRUST COMPANY, presently of Hartford, Connecticut to act as Executor. I further direct that no bond be required of any of them in such capacity or in connection with the sale of any real estate in my estate by any court or judge.

EIGHTH: In addition to the usual powers, I give my Executor full discretionary power and authority with respect to the property of the estate as follows:

To sell or resell the whole or any part of the property, real or personal, for cash or upon such terms as to payment as may be deemed advisable, and to execute and deliver any deed, bill of sale, conditional bill of sale, or other document necessary or convenient to effect a sale;

To borrow funds for any purpose which may be deemed proper, and to pledge the whole or any part of the property to secure the payment of such loan;

To compromise claims by or against the estate;

To make in cash, or in property at such value as shall be fixed, any distribution required, and to determine the distributees upon such evidence as shall be deemed proper;

The enumeration of the foregoing specific powers shall not be construed as a limitation of general powers.

IN WITNESS WHEREOF, I, the said HAZEL B. PIPER, herewith set my hand and seal to this, my last Will and Testament, typewritten on three (3) sheets of paper (including the attestation clause, signatures of witnesses and self-proving

affidavit) upon the margin of each one of which I have also written my name, this 30th day of November, nineteen hundred and ninety.

Hazel B. Piper (L.S.)

Signed by the within named Testatrix, HAZEL B. PIPER, and by her declared to be her Will in our presence, who sign as witnesses in her presence, and in the presence of each other, and at her request, this 30th day of November, A.D. 1990.

Carol M. LaRosa of Manchester, Connecticut

Debra C. Daniels of Manchester, Connecticut

STATE OF CONNECTICUT)
) ss. Manchester November 30th, A.D. 1990
COUNTY OF HARTFORD)

The within named, Carol M. LaRosa and Debra C. Daniels being duly sworn, do depose and say: That they witnessed the within Will of the within named Testatrix, and subscribed the same in her presence, in the presence of each other and at her request; That said Testatrix, at the time of signing said Will, appeared to them to be of full age and of sound and disposing mind and memory and competent to make testamentary disposition of real and personal property; That she voluntarily signed said Will and declared the same to be her Last Will and Testament in the presence of the said two subscribing witnesses thereto, and that this Affidavit is made at the request of the said Testatrix.

Carol M. LaRosa

Debra C. Daniels

Subscribed and Sworn to this
30th day of November, A.D. 1990,
before me.

W. David Keith
Commissioner of the Superior Court

EXHIBIT Q 11-2

Fund 11-1.22

Drake Fund

I, KEITH DRAKE QUINBY, of West Hartford, Connecticut, make this my last will and testament, hereby revoking any and all wills and codicils heretofore made by me.

FIRST: I direct that the expenses of my funeral and all my just debts, except such as are secured by mortgage at the time of my death, be paid as promptly as is reasonably possible.

SECOND: I direct that my Executors cause a suitable marker to be placed on my grave.

THIRD: I give and bequeath to my Executors hereinafter named all my household furniture, furnishings, supplies, clothing, jewelry and other articles of personal adornment, in full confidence that they will dispose of such property in accordance with my wishes.

FOURTH: I give and bequeath the sum of Two Thousand (2000) Dollars to Emma Maud Purvis, to her absolutely.

FIFTH: I give and bequeath to sum of Two Thousand (2000) Dollars to Estelle Eunice Quimby, to her absolutely.

SIXTH: I give and bequeath the sum of Five Hundred (500) Dollars to The United Thank Offering of the Women's Auxiliary of the Protestant Episcopal Church.

SEVENTH: I give and bequeath to the Trinity Chapter, Hartford, Connecticut, of the Daughters of the King, the sum of One Hundred (100) Dollars. If the Trinity Chapter should not be in existence at the time of my death, I give and bequeath said sum to the Rector, Wardens and Vestry of the Parish of Trinity Church, Hartford, Connecticut, to become a part of its Endowment Fund.

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EIGHTH: All the rest, residue and remainder of my estate, both real and personal and wheresoever the same may be situated, I give, devise and bequeath to Carlos S. Holcomb, of New Hartford, Connecticut, and Hartford National Bank and Trust Company, of Hartford, Connecticut, IN TRUST, nevertheless, upon the following uses and trusts:

(a) The Trustees shall pay from the net income the sum of Twenty Five (25) Dollars a month to Susan Kellam during her life. The Trustees shall divide the balance of the net income or the whole thereof if Susan Kellam is not living, equally between Estelle Eunice Quimby and Emma Maud Purvis, or the survivor of them, during their respective lives. At the death of this survivor, the Trustees shall increase the payments to Susan Kellam, if she is then living, from Twenty Five (25) Dollars to Fifty (50) Dollars per month. The Trustees may expend such portion of the principal as may be necessary in their discretion for the proper care and maintenance of Estelle Eunice Quimby and Emma Maud Purvis.

(b) Upon the death of the last survivor of Susan Kellam, Estelle Eunice Quimby and Emma Maud Purvis, I direct that my Trustees pay:

(1) To Elizabeth Connell, the sum of One Thousand (1000) Dollars.

(2) To Elizabeth Jones, the sum of One Thousand (1000) Dollars.

(3) To Estelle Moore, the sum of One Thousand (1000) Dollars.

(4) To Alice Fones, the sum of One Thousand (1000) Dollars.

(5) To Christine Morris, the sum of One Thousand (1000) Dollars.

If any of the above mentioned legatees shall not be living,

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them I direct that such legacy shall be paid to the United Thank Offering of the Woman's Auxiliary of the Protestant Episcopal Church in memory of such legatee.

(6) To the Rector, Wardens and Vestry of the Parish of Trinity Church, Hartford, Connecticut, the sum of Two Thousand (2000) Dollars to become a part of its Endowment Fund.

(c) The balance of the funds after the payment of the aforementioned legacies, the Trustees shall divide into ten (10) equal parts and I give, devise and bequeath said parts as follows:

(1) Two (2) of said parts to the General Theological Seminary, in the City and State of New York in memory of my beloved husband, Henry Quimby, an alumnus of said institution. Said fund shall be known as "The Quimby Scholarship" and the income therefrom shall be used for scholarship purposes.

(2) Two (2) of said parts to the Manchester Public Hospital, of Manchester, Connecticut, in memory of my father and mother, Levi Drake and Julia Pease Drake, the income therefrom to be used to support a bed in said hospital. It is my wish that said fund shall be known as the "Drake Bed Fund" and I request that the nomination to this bed be vested in the governing body of the Congregational Church in North Manchester, Connecticut, of which my parents were members for many years.

(3) One (1) of said parts to The Newington Home for Crippled Children, a corporation organized under the laws of the State of Connecticut and located at Newington, Connecticut, in memory of my daughter, Edith Salisbury Quimby, for the general purposes of the corporation.

(4) Two (2) parts to the National Council of the Protestant Episcopal Church in memory of my sisters-in-law, Olive Ethel Quimby, Estelle Eunice Quimby and Emma Maud Purvis, for missionary work of the Church.

(5) One (1) part to the Church Pension Fund of the Protestant Episcopal Church in memory of my father-in-law and mother-in-law, Thomas Willis Quimby and Emma Jane Quimby, and my brother-in-law, the Reverend David Thomas Quimby.

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(6) One (1) part to the Trustees of Donations of the Protestant Episcopal Church in the Diocese of Massachusetts, to be held for the benefit of the needy and sick of St. John's Church, Lowell, Massachusetts. This bequest is given in memory of my husband, Henry Quimby, former Rector of said Parish. Should St. John's Church cease to function as a separate parish, then this fund, or so much thereof as remains, I give, devise and bequeath to the Rector, Wardens and Vestry of the Parish of Trinity Church, Hartford, Connecticut, to become a part of its Endowment Fund.

(7) One (1) part to the Trustees of Donations of the Protestant Episcopal Church in the Diocese of Massachusetts to be used for the benefit of St. John's Church, Lowell, Massachusetts. This bequest is given in memory of my husband, Henry Quimby, former Rector of said Parish. Should St. John's Church cease to function as a separate parish, then I give, devise and bequeath so much as remains to the National Council of the Protestant Episcopal Church for the missionary work of the Church.

(d) The Trustees shall have the power to sell, convey, mortgage and lease any property in said trust upon such terms as they may deem advisable; to retain in trust any and all securities which shall come to them as a part of my estate; to invest and reinvest any of the funds of the trust in such securities as the Trustees may deem advisable, without being limited to investments prescribed or authorized by the laws of the State of Connecticut or any other jurisdiction; to exercise any right or option by subscription or otherwise which may attach to or arise from any property held in trust; to join in any plan involving the merger, reorganization or structural change of any corporation, including the right to deposit the securities of such corporation on such terms as they may approve and the right to receive any securities, cash or property in exchange for the securities of such corporation when the Trustees hold the stocks, bonds or other

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securities or interest in the corporation involved; to vote any corporate stock belonging to the trust estate through the individual trustee or the officers of the corporate trustee or by proxy, with or without power of substitution, and to execute proxies to one or more nominees; to determine what funds shall constitute income and what funds shall constitute principal, but in making such determination the Trustees are to observe the following rules:

1. Stock dividends are to be considered as principal and not income.

2. Liquidation dividends are to be considered as principal and not income.

3. Extra cash dividends and money received from the sale of rights to subscribe to stock are to be considered as income, but whether or not such rights shall be sold or taken up shall be left to the sole discretion of the Trustees.

In addition to the foregoing, but nonise in limitation thereof, the Trustees shall have the power in relation to any securities or property held in trust which any individual would have when holding the same in an individual capacity.

NINTH: If Susan Kellam and my sisters-in-law, Estelle Monica Quimby and Emma Maud Purvis, should all predecease me, then I direct my Executors to distribute the rest, residue and remainder of my estate in the same manner as set forth in Article Eighth, subsections (b) and (c), free of the trust created under Article Eighth.

TENTH: I direct that all inheritance, succession, collateral, transfer and estate taxes, levied or assessed upon or with respect to any property which is included as a part of my gross estate for the purpose of any such tax, shall be paid by my Executors out of my estate in the same manner as an expense of administration and shall not be prorated or apportioned among or charged against the respective devisees, legatees, beneficiaries, transferees or other recipients, nor charged against any property passing or which may have passed to

any of them, and that my Executors shall not be entitled to reimbursement for any portion of any such tax from any person. 564

ELEVENTH: I appoint Carlos S. Holcomb, of New Hartford, Connecticut, and Hartford National Bank and Trust Company, of Hartford, Connecticut, as Executors of this will. I authorize and empower my Executors to sell, convey, mortgage and lease, without order of the Probate Court, any real or personal property or interest therein of which I may die possessed. I direct that my Executors and my Trustees shall make any distribution, which may be necessary under the terms of this will, in money or in kind, or partly in money and partly in kind, including securities, real property or undivided interests in real or personal property, making the necessary equalization in cash, at values to be determined by my Executors or Trustees.

IN WITNESS WHEREOF I have hereunto set my hand and seal at Hartford, Connecticut, this 7th day of September, A. D. 1949.

Edith Drake Quimby (L.S.)

Signed, Sealed, Published and Declared by the above-named testatrix, Edith Drake Quimby, to be her last will and testament in our presence, who, in her presence and at her request and in the presence of each other, have hereunto subscribed our names as witnesses.

Harry W. Kellogg, Jr. of West Hartford, Conn.
Ellen C. Strom " West Hartford, Conn.
[illegible] " Hartford, Conn.

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State of Connecticut }
County of Hartford } ss Hartford, September 7th, 1949

Then and there personally appeared the within-named:

Ellen C. Strom

and Estelle J. Cherlin

who, being duly sworn, depose and say that they witnessed the execution of the within will of the within-named testatrix, Edith Drake Quimby; that said Edith Drake Quimby subscribed said will and declared it to be her last will and testament in their presence and in the presence of Harry W. Hultgren, Jr.; that thereafter they and the said Harry W. Hultgren, Jr., subscribed said will as witnesses in the presence of said testatrix and at her request and in the presence of each other; that at the time of the execution of said will, said testatrix appeared to them to be of full age and of sound mind and memory and that they make this affidavit at her request.

Ellen C. Strom

Estelle J. Cherlin

Subscribed and sworn to before me this 7th day of September, A. D. 1949.

Harry W. Hultgren, Jr.
Commissioner of the Superior Court

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I, EDITH DRAKE QUIMBY, of West Hartford, Connecticut, make this Codicil to my last will and testament dated September 7, 1949.

FIRST: I hereby revoke sub-section (a) of Article Eighth of said will and in lieu thereof I insert the following paragraph:

(a) The Trustees shall pay over from the net income the sum of Fifty (50) Dollars a month to Susan Kellam during her life and shall pay the sum of Two Hundred (200) Dollars a month in equal shares to Estelle Eunice Quimby and Emma Maud Purvis, or the survivor of them, during their respective lives. The Trustees may hold, accumulate or add to the principal the balance of said net income after said payments. The Trustees may expend such portion of the principal as may be necessary in their discretion for the proper care and maintenance of Estelle Eunice Quimby, Emma Maud Purvis and Susan Kellam.

SECOND: I hereby republish and confirm my said will in all respects except as altered by this Codicil.

IN WITNESS WHEREOF I have hereunto set my hand and seal at Hartford, Connecticut, this 4th day of October, A. D. 1950.

Edith Drake Quimby (L.S.)

Signed, Sealed, Published and Declared by the above-named testatrix, Edith Drake Quimby, to be a Codicil to her last will and testament dated September 7, 1949, in our presence, who, in her presence and at her request, and in the presence of each other, have

-1-

hereunto subscribed our names as witnesses at Hartford, Connecticut, this 4th day of October, A. D. 1950. 567

Richard T. Steele of West Hartford Conn.
Ellen C. Strom " West Hartford, Conn.
Estelle S. Oberlin " Hartford 5, Conn.

STATE OF CONNECTICUT } ss Hartford, October 4th A.D.1950.
COUNTY OF HARTFORD }

Then and there personally appeared the within-named:

Ellen C. Strom
and Estelle S. Oberlin

who, being duly sworn, depose and say that they witnessed the execution of the within Codicil to the Will of Edith Drake Quimby; that said Edith Drake Quimby subscribed the same and declared it to be a Codicil to her last will and testament dated September 7, 1949, in their presence and in the presence of Richard T. Steele; that thereafter they and the said Richard T. Steele subscribed said Codicil as witnesses in the presence of said testatrix and at her request and in the presence of each other; that at the time of the execution of said Codicil, said testatrix appeared to them to be of full age and of sound mind and memory and that they make this affidavit at her request.

Ellen C. Strom
Estelle S. Oberlin

Subscribed and sworn to before me this 4th day of October, A. D. 1950.

Richard T. Steele
Commissioner of the Superior Court.

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EXHIBIT Q 11-2

Fund 11-1.23

The Mattie Hills Preston Free Bed Endowment

ECHN Proposed Asset Purchase by PMH
Submitted October 13, 2015

LAST WILL & TESTAMENT

of

James M. Preston

Dated April 3, 1924

Presented in Court, May 31, 1938, with waiver of notice. Waiver accepted, will proved, approved and admitted to probate. Ordered recorded and kept on file, May 31, 1938.

William S. Hyde
Judge

Recorded Vol. 65, Page 337,

Clerk

The Hartford-Connecticut Trust Company

HARTFORD, - CONN.

I, James M. Preston , of the Town of Manchester, Connecticut, do make, publish and declare this instrument as and for my last Will and Testament hereby revoking all wills by me at any time heretofore made.

FIRST: I direct the payment of all my just debts and funeral expenses by my executor hereinafter named.

SECOND: I give and bequeath to my wife, Mattie Hills Preston, if she survives me, all of my household furniture, wearing apparel and other personal articles and personal effects of all kinds, to be hers absolutely.

THIRD: Except as above specified, I give, devise and bequeath all of my property, both real and personal, to The Hartford-Connecticut Trust Company of Hartford, Connecticut, in trust, however, for the following purposes: to wit, To hold, manage and invest said property within the limits of the law pertaining to trust estates and pay over the income thereof and so much of the principal as necessity may require, to my wife, Mattie Hills Preston, so long as she shall live and remain unmarried.

FOURTH: In the event of the remarriage of my said wife the trust hereinbefore created shall terminate and the trustee shall set off to my said wife one-third (1/3) of the trust fund to be her absolute property.

FIFTH: Upon the death of my said wife the trust shall terminate and upon its termination, whether because of her death or remarriage, the trust fund, except for the portion to be set out to her as above specified in case of her remarriage, shall be disposed of as follows:-

(a) There shall be paid therefrom to the Manchester Memorial Hospital of Manchester, Connecticut, the sum of Eight Thousand ($8,000) Dollars, the same to be held by said Hospital in trust and the income thereof applied for the maintenance of a free bed, such endowment to be known as "The Mattie Hills Preston Free Bed Endowment."

(b) Out of funds remaining after the foregoing payment, there shall be paid so far as the amount of the trust fund may permit, to the Second Congregational Church of South Windsor, Connecticut, the sum of Five Thousand ($5,000) Dollars, the same to be held by said Church in trust and

the income thereof to be applied to any legitimate work of the Church, the fund to be called "The Frances Skinner Preston Fund."

(c) Out of funds remaining after the foregoing payments, there shall be paid, as far as the amount of the trust may permit, to the Salvation Army, Incorporated, South Manchester, Connecticut, Corps, the sum of Five Thousand ($5,000) Dollars, the same to be held by it in trust and the income thereof applied to any legitimate work of the said South Manchester Corps.

(d) Out of funds remaining after the foregoing payments, there shall be paid to the Connecticut Childrens Aid Society the sum of Five Thousand ($5,000) Dollars, the same to be held by it in trust and the income thereof applied to any legitimate work of the Society.

(e) Out of funds remaining after the foregoing payments, there shall be paid to the Manchester Memorial Hospital aforesaid, a second bequest of the sum of Eight Thousand ($8,000) Dollars, the same to be held by it in trust and the income thereof applied for the maintenance of a free bed, said endowment to be known as "The Janes Preston Free Bed Endowment." If, owing to the small amount which may perhaps be available to apply on this bequest, said Manchester Memorial Hospital is unwilling to accept the same for the purposes indicated, this payment shall become inoperative and such money or other property as would have been available therefor shall be disposed of in accordance with the provision of sub-dividion (f) of this Clause of my will.

(f) After all of the above payments to be made at the termination of the trust have been fully provided for (except as the payment described in sub-division (e) may prove impracticable, or any other payment may fail to be accepted by the beneficiary) all the remaining property of the trust, if any, not used in connection with said payments, shall be paid over to the Missionary Society of Connecticut, a corporation of that State located in Hartford, to be used as its proper officers may deem appropriate.

SIXTH: I nominate and appoint The Hartford-Connecticut Trust Company aforesaid to be executor of this my will and trustee of the trust

fund hereinbefore established and I give to my said executor and trustee full power and authority in either capacity to sell and convey any real estate which may form a portion of my estate or of said trust fund provided, however, that if this power of sale is to be exercised during the lifetime of my said wife (she being still unmarried) this power shall be exercised only with her written consent to be evidenced by her joining in such deed or deeds of conveyance as may be made by my said executor or trustee.

IN WITNESS WHEREOF I have subscribed and do publish and declare this instrument as and for my last Will and Testament, in presence of the witnesses attesting the same at my request this 3rd day of April 1924.

James M. Preston (L.S.)

Subscribed, sealed, published and declared by the said testator, James M. Preston, as and for his last Will and Testament, in our presence, who, at his request, in his presence and in the presence of each other, have hereunto subscribed our names as witnesses this 3rd day of April 1924.

Helen A. Ulrich — Hartford, Conn.

M. Catherine Harris — Hartford, Conn.

Charles C. Knox — Hartford, Conn.

[redacted]

STATE OF CONNECTICUT,)
) ss. Hartford, April 3, 1924.
COUNTY OF HARTFORD,)

The within named Helen G. Ulrich, M. Catherine Harris and Charles C. Russo, being duly sworn, do depose and say: That they witnessed the within Will of the within named Testator, James M. Preston, and subscribed the same in his presence, in the presence of each other and at his request: That said Testator, at the time of signing said Will, was of full age and of sound and disposing mind and memory, and competent to make testamentary disposition of real and personal property: That he voluntarily signed said Will and declared the same to be his Last Will and Testament, in the presence of the said three subscribing witnesses thereto, and that this affidavit is made at the request of the Testator.

Helen G. Ulrich
M. Catherine Harris
Charles C. Russo

Subscribed and sworn to this 3rd day of April, A. D., 1924, before me,

Lincoln Fenn
Notary Public

EXHIBIT Q 11-2

Fund 11-1.24

F. O. Boynton

ARTHUR ANDERSEN LLP

THE MANCHESTER MEMORIAL HOSPITAL

FINANCIAL STATEMENTS

AS OF SEPTEMBER 30, 1996 AND 1995

TOGETHER WITH

REPORT OF INDEPENDENT PUBLIC ACCOUNTANTS

THE MANCHESTER MEMORIAL HOSPITAL

BALANCE SHEETS

SEPTEMBER 30, 1996 AND 1995

ASSETS	1996	1995
CURRENT ASSETS:		
Cash and cash equivalents	$ 11,195,218	$ 4,815,148
Assets limited as to use required for current liabilities	1,336,424	1,339,924
Accounts receivable, less allowance of $3,219,000 in 1996 and $4,195,000 in 1995	14,254,759	17,408,055
Other accounts receivable	527,152	110,473
Inventories of supplies	454,705	401,832
Prepaid insurance and other expenses	289,004	216,194
Due from related entities	378,501	127,053
Total current assets	28,435,763	24,418,679
ASSETS LIMITED AS TO USE, net of current portion:		
By Board of Trustees	21,989,954	20,374,985
Assets held in trust for estimated self-insurance liabilities	8,810,621	7,926,764
Assets under bond indenture	857,350	863,159
Total assets limited as to use	31,657,925	29,164,908
INVESTMENTS	7,624,105	6,855,136
UNAMORTIZED BOND ISSUE EXPENSES	1,135,001	1,235,599
PROPERTY AND EQUIPMENT, at cost:		
Land	1,051,326	1,051,326
Land improvements	817,298	817,298
Buildings and building improvements	32,941,893	32,918,537
Major movable equipment	32,092,964	30,436,010
Fixed equipment	22,815,650	22,652,060
	89,719,131	87,875,231
Less - accumulated depreciation	51,733,156	47,299,424
	37,985,975	40,575,807
CONSTRUCTION IN PROGRESS *	3,248,534	1,925,742
Total property and equipment, net	41,234,509	42,501,549
Total assets	$110,087,303	$104,175,871

LIABILITIES AND NET ASSETS	1996	1995
CURRENT LIABILITIES:		
Accounts payable	$ 3,675,596	$ 2,553,392
Connecticut sales and receipts tax payable	5,039,911	4,080,296
Due to third-party agencies	8,340,046	7,101,363
Accrued salaries and wages, payroll taxes and amounts withheld from employees' compensation	3,613,472	3,229,530
Accrued pension and other postretirement benefits	516,000	223,386
Accrued interest payable	341,423	344,924
Current maturities of long-term debt	1,296,936	1,295,998
Total current liabilities	22,823,384	18,836,889
ESTIMATED SELF-INSURANCE LIABILITIES	5,611,602	6,218,097
ACCRUED PENSION AND OTHER POSTRETIREMENT BENEFITS, net of current portion	7,760,393	8,262,027
LONG-TERM DEBT, less current maturities	21,360,260	22,657,194
COMMITMENTS AND CONTINGENCIES		
NET ASSETS:		
Unrestricted	50,504,887	46,218,894
Temporarily restricted	655,939	611,932
Permanently restricted	1,370,838	1,370,838
Total net assets	52,531,664	48,201,664
Total liabilities and net assets	$110,087,303	$104,175,871

The accompanying notes are an integral part of these financial statements.

	MANCHESTER MEMORIAL HOSPITAL				
	ENDOWNMENT FUNDS POOLED				
			9/30/1995	9/30/2001	9/30/2013
			Original	Original	Original
	Date of	Donation Description	Amount	Amount	Amount
	Donation		of Gift	of Gift	of Gift
		UNRESTRICTED INCOME FUNDS			
1	3/35	DWIGHT BLISH	$19,841.35	$19,920.00	$19,920.00
2		JOHN & ELIZA CARPENTER	$2,555.00	$2,555.00	$2,555.00
3		HELEN G CHAPMAN	$5,000.00	$5,000.00	$5,000.00
4		WILLIAM H CONTES	$129.00	$129.00	$129.00
5		GRACE K DART	$4,007.00	$4,007.00	$4,007.00
6		GRACE L HOUSE	$2,500.00	$2,500.00	$2,500.00
7		JOHN & CAROLINE PORTER	$7,464.00	$7,464.00	$7,464.00
8	11/57	WILLIAM & MARY RICE	$122,361.19	$122,361.19	$122,361.19
9		ROBERT & FLORCILA STANLEY	$3,000.00	$3,000.00	$3,000.00
10	5/61	GEORGE & ROSE STROUT	$128,043.30	$128,043.30	$128,043.30
11		MINNIE R STRICKLAND	$2,511.00	$2,511.00	$2,511.00
12		ARTHUR & CARRIE ELLIS	$5,000.00	$5,000.00	$5,000.00
13	7/40	RALPH & LULU PINNEY	$41,375.25	$41,375.25	$41,375.25
14		SOPHIE & SAMUAL DISKAN*			
15		THOMAS & RONALD FERGUSON*			
16		RAYMOND GRISLEE JR*			
17		EMIL & G HOLENTHAL	$179.00	$179.00	$179.00
18		GEO W &CF BIDWELL*			
19		EVA BIDWELL HARRIS*			
20		JW & HR CHENEY	$75,000.00	$75,000.00	$75,000.00
21	12/63	HC CHENEY	$543,561.81	$543,561.81	$543,561.81
22		HEBERT DEWEY	$1,498.00	$1,498.00	$1,498.00
23		JUNE DEWEY	$936.00	$936.00	$936.00
		DONALD G. PIPER AND HAZEL B. PIPER	$0.00	$0.00	$75,000.00
		DONALD G. PIPER AND HAZEL B. PIPER	$0.00	$0.00	$75,000.00
24	3/93	HAZEL S BURGESS	$113,623.92	$113,623.92	under Foundation
25	5/95	HELEN ST LAURENT	$10,000.00	$10,000.00	under Foundation
		TOTAL UNRESTRICTED	$1,088,585.82	$1,088,664.47	$1,115,040.55
		LESS UNRESTRICTED FUND BALANCE			
		ADJUSTED UNRESTRICTED			
		RESTRICTED INCOME FUNDS			
		FREE BED:			
26	1/60	DRAKE BED FUND	$90,499.84	$90,499.84	$90,499.84
27	5/31	LOREN GARDNER	$25,000.00	$25,000.00	$25,000.00
28		MATTIE HILLS PRESTON	$8,000.00	$8,000.00	$8,000.00
29		P O BOYNTON	$923.00	$923.00	$923.00
	09/23/97	ERNA LOOMIS		$196,394.42	$196,394.42
		SUBTOTAL FREE BED	$124,422.84	$320,817.26	$320,817.26
30		ELSIE C DISHER	$151,579.19	$151,579.19	$151,579.19
31		THOMAS D TROTTER	$128.00	$128.00	$128.00
32	11/57	WILLIAM & REBECCA WRIGHT	$6,123.63	$6,123.63	$6,123.63
		TOTAL RESTRICTED	$157,830.82	$157,830.82	$157,830.82
		TOTAL POOLED INVESTMENTS	$1,370,839.48	$1,567,312.55	$1,593,688.63
		HELD AT FOUNDATION:			
		HAZEL BURGESS			$113,623.92
		HELEN ST. LAURENT			$10,000.00
		HAZEL B. PIPER			$1,161,399.20
			$0.00	$0.00	$1,285,023.12
		INTEREST IN TRUST ASSETS	$0.00	$0.00	$5,700,198.92
		TOTAL PERM RESTRICTED	$1,370,839.48	$1,567,312.55	$8,578,910.67
		TOTAL PER AUDITED FINANCIAL STATEMENTS	$1,370,838.00	$1,567,311.00	$8,578,909.00
		VARIANCE	$1.48	$1.55	$1.67

State of Connecticut

CLARINE NARDI RIDDLE
ATTORNEY GENERAL

Office of The Attorney General
55 ELM STREET
P.O. BOX 120
HARTFORD, CT 06101
TELECOPIER (203) 566-1704

HOSPITAL BED FUND TRUSTS:

A Survey of Free Bed Funds in Connecticut Hospitals Provided Through Donations From the Public

A Report By:

Clarine Nardi Riddle
Attorney General
State of Connecticut

David E. Ormstedt
Assistant Attorney General
Chief Public Charities Unit

Janet A. Spaulding
Assistant Attorney General

June, 1990

MANCHESTER MEMORIAL HOSPITAL

F.O. Boynton

I give and bequeath to the Manchester Memorial Hospital of Manchester, Connecticut, . . . all the rest, residue and remainder of my estate, to be held as a separate and permanent fund and the income thereof to be used for the general purposes of the hospital with special reference to the furnishing of hospital facilities to persons then not able to pay for the service so rendered. Report to Finance Committee, undated.

Drake Fund

Two (2) of said parts to the Manchester Public Hospital of Manchester, Connecticut, in memory of my father and mother, Levi Drake and Julia Pease Drake, the income therefrom to be used to support a bed in said hospital. It is my wish that said fund shall be known as the "Drake Fund" and I request that the nomination to this bed be vested in the governing body of the Congregational Church in North Manchester, Connecticut, of which my parents were members for many years. Will of Edith Drake Quimby of West Hartford, CT.

MANCHESTER MEMORIAL HOSPITAL

ENDOWMENT FUNDS

From "Appendix A - Report to Finance Committee"

Boynton:	"...furnishing of hospital facilities to persons then not able to pay...."
Sophie Diskan and Samual Diskan Fund:	"... at the discretion of the Board of Trustees for general hospital purposes."
William H. Costes:	".... as the trustees of said hospital may deem best."
Grace Kingsbury Dart:	".... for the general running expenses of said Hospital."
Thomas and Ronald Ferguson:	in hospital's Memorial Fund
Raymond Goslee, Jr.:	in hospital's Memorial Fund

EXHIBIT Q 11-2

Fund 11-1.25

Erna W. Loomis

RECEIVED
APR 0 8 1997
MANCHESTER PROBATE COURT

VOL 539 PAGE 741

LOOMIS, ERNA W.

WILL

OF

ERNA W. LOOMIS

I, ERNA W. LOOMIS, also known as ERNA WESTHAVER LOOMIS , of Manchester, Connecticut, declare this my Will, and I revoke any prior will or codicil.

ARTICLE I

My beloved spouse, ROBERT GEORGE LOOMIS, has predeceased me and I leave no issue. My beloved cousins are: MARION E. LANGILLE who is married to JOHN H. LANGILLE, both of Halifax, Nova Scotia, Canada; LOGAN GRADY who is married to EDRIS GRADY, both of Boutillier's Point, Halifax, Nova Scotia; and MILDRED LANGILLE of Fauxburg, Nova Scotia, Canada, wife of my late cousin WALTER LANGILLE.

My beloved friends are PHILIP C. FROH and MARCIA FROH of Manchester, Connecticut, and JAMES E. DOUGAN and THERESA H. DOUGAN of Manchester, Connecticut.

ARTICLE II

I direct that all my enforceable debts (other than claims of any mortgagee) be paid as soon as practicable after my death. My estate shall be primarily liable for my funeral, medical and estate administration expenses.

ARTICLE III

I direct that all estate, inheritance, transfer, succession, legacy and other similar taxes, including any interest and penalties thereon, which shall become payable upon or with respect to any and all property required to be included in my taxable estate under the provisions of any tax law, whether or not passing under this will or any codicil hereto, shall be paid out of my residuary estate as an administration expense, without proration or apportionment against any legatee devisee, beneficiary, transferee, or other recipient of such property.

ARTICLE IV

I give all my tangible personal property, and fire, theft or other insurance policies covering such property to those INDIVIDUALS who survive me and who are named herein in Article V of this Will. My executors shall divide such property among them in equal shares as far as practicable. All storage or delivery costs shall be paid by my estate.

PLEPLER, BARLOW AND RUEL
ATTORNEYS AT LAW
172 EAST CENTER STREET
MANCHESTER, CT
06040-5291
PHONE (203) 646-4081
JURIS NO. 01640

VOL 539 PAGE 742

I direct the attention of my Executors and my family to any memoranda which I may leave for their guidance in dividing and disposing of my tangible property.

ARTICLE V

I give, devise and bequeath the residue of my estate, both real and personal, of whatever kind, however held and wherever situated, as follows:

A. The sum of TWENTY-FIVE THOUSAND ($25,000) DOLLARS in equal shares to MARCIA FROH and PHILIP C. FROH, or to the survivor of them in the event that only one of them survives me, to be theirs, his or hers absolutely and forever.

B. The sum of TWENTY-FIVE THOUSAND ($25,000) DOLLARS in equal shares to JAMES E. DOUGAN and THERESA H. DOUGAN, or to the survivor of them in the event that only one of them survives me, to be theirs, his or hers absolutely and forever.

C. The sum of FIVE THOUSAND ($5,000) DOLLARS to ELIZABETH BABARA, who is presently living with me and caring for me in my home in Manchester, Connecticut.

D. The sum of TEN THOUSAND ($10,000) DOLLARS in equal shares to MARION E. and JOHN H. LANGILLE of Halifax, Nova Scotia, Canada, or to the survivor of them in the event that only one of them survives me, to be theirs, his or hers absolutely and forever.

E. The sum of TEN THOUSAND ($10,000) DOLLARS to BEATRICE KNICKLE of Mahone Bay, Nova Scotia, Canada, to be hers absolutely and forever.

F. The sum of TEN THOUSAND ($10,000) DOLLARS in equal shares to LOGAN GRADY and EDRIS GRADY of Boutillier's Point, Halifax County, Nova Scotia, Canada, or all to the survivor of them in the event that only one of them survives me, to be theirs, his or hers absolutely and forever.

G. The sum of TEN THOUSAND ($10,000) DOLLARS to MILDRED LANGILLE of Fauxburg, Nova Scotia, Canada, to be hers absolutely and forever.

H. The sum of TWENTY FIVE THOUSAND ($25,000) DOLLARS to THE FRIENDS OF MOUNT ALLISON UNIVERSITY, INC., of New York, New York, to be held in trust and the income only to be used for a student scholarship at MOUNT ALLISON UNIVERSITY, successive recipients to be in the sole and absolute discretion of the Administrator of said Fund, to be known as the ERNA WESTHAVER LOOMIS SCHOLARSHIP.

I. The sum of TWENTY FIVE THOUSAND ($25,000) DOLLARS to the M.I.T. ALUMNI FUND, Class of 1929, of THE MASSACHUSETTS INSTITUTE OF TECHNOLOGY, of Cambridge, Massachusetts, to be added to the ROBERT G. LOOMIS FUND, and held and administered in accordance with its terms.

Erna W. Loomis

PLEPLER, BARLOW AND RUEL
ATTORNEYS AT LAW
72 EAST CENTER STREET
MANCHESTER, CT
06040-5291
PHONE (203) 646-4081
JURIS NO 01840

VOL 539 PAGE 743

J. The sum of TWENTY-FIVE THOUSAND ($25,000) DOLLARS to THE MANCHESTER SCHOLARSHIP FOUNDATION, INC., of Manchester, Connecticut, to be held in trust for the following uses and purposes:

To hold, manage, invest and reinvest said trust fund, to be known as THE ERNA AND ROBERT LOOMIS SCHOLARSHIP FUND, and to collect the rents, interest, dividends and other income therefrom, and after the payment of all lawful charges to pay over the income only therefrom for scholarships annually for the benefit of graduates of Manchester High School, Manchester, Connecticut, who have graduated in the top twenty (20) percent of their graduating class, and who have been admitted to a four year college or university or to Manchester Community College, located in Manchester, Connecticut, the annual recipients of said scholarships to be chosen on the basis of need, character and responsiblity by the Trustees of the Fund.

K. The sum of TWENTY-FIVE THOUSAND ($25,000) DOLLARS to the TRUSTEES of SOUTH UNITED METHODIST CHURCH of Manchester, Connecticut, to be known as the ERNA AND ROBERT LOOMIS FUND, and held in trust, the income only to be used for a need of the church.

L. The sum of TWENTY-FIVE THOUSAND ($25,000) DOLLARS to MANCHESTER MEMORIAL HOSPITAL of Manchester, Connecticut, to be held in trust, the income only to be included in any program providing for the payment of anyone's expenses who cannot otherwise afford the same.

M. The sum of TWENTY-FIVE THOUSAND ($25,000) DOLLARS to MARY CHENEY LIBRARY of Manchester, Connecticut, to be held in trust, and the income only to be used for the purchase of books.

N. The sum of TWENTY-FIVE THOUSAND ($25,000) DOLLARS to the MANCHESTER HIGH SCHOOL LIBRARY of Manchester, Connecticut, to be held in trust, and the income only to be used for the purchase of books.

O. The sum of TWENTY-FIVE THOUSAND ($25,000) DOLLARS to the LUNENBERG HIGH SCHOOL of Lunenberg, Nova Scotia, Canada, to be held in trust and known as the ERNA WESTHAVER LOOMIS SCHOLARSHIP FUND, the income only to be used for scholarships annually for the benefit of graduates of Lunenberg High School, who have graduated in the top twenty (20) percent of their graduating class, and who have been admitted to a four year college or university, the annual recipients of said scholarships to be chosen on the basis of need, character and responsiblity.

P. The sum of TWENTY-FIVE THOUSAND ($25,000) DOLLARS to the BOLTON HIGH SCHOOL LIBRARY of Bolton, Connecticut, to be held in trust, and the income only to be used for the purchase of books.

Q. The sum of TEN THOUSAND ($10,000) DOLLARS to the NEWINGTON CHILDREN'S HOSPITAL of Newington, Connecticut, to be held in trust, the income only to be used for child therapy programs of said hospital, and not for building purposes or the purchase of equipment.

Erna W. Loomis

PLEPLER, BARLOW AND RUEL
ATTORNEYS AT LAW
72 EAST CENTER STREET
MANCHESTER, CT
06040-5291
PHONE (203) 646-4061
JURIS NO. 01840

R. All of my property thereafter remaining is to be divided into the following four (4) equal parts:

1. One of said parts shall be added to my bequest to THE FRIENDS OF MOUNT ALLISON UNIVERSITY, INC. under Article V, Paragraph H of this Will, and held and administered in accordance with its terms.

2. The second of said parts is to be added to my bequest to the TRUSTEES of SOUTH UNITED METHODIST CHURCH under Article V, Paragraph K of this Will and held and administered in accordance with its terms.

3. The third of said parts is to be added to my bequest to the MANCHESTER SCHOLARSHIP FOUNDATION, INC. under Article V, Paragraph J of this Will and held and administered in accordance with its terms.

4. The fourth of said parts is to be added to my bequest to MANCHESTER MEMORIAL HOSPITAL, under Article V, Paragraph L of this Will and held and administered in accordance with its terms.

ARTICLE VI

I appoint MARCIA FROH and FLEET BANK, N.A. as co-executors of my Will.

I direct that no surety bond shall be required of any fiduciary under my Will.

My fiduciaries and their successors shall have all of the powers contained in the Connecticut Fiduciary Powers Act (C.G.S. Section 45a-234) as amended at the date of my signature to this Will and any other powers granted by law.

ARTICLE VII

If any beneficiary under this Will shall not survive me for a period of thirty (30) days, I direct that such beneficiary shall be deemed not to have survived me. My estate shall in all respects be administered and distributed in accordance with this direction.

IN WITNESS WHEREOF, I have unto this, my Will, subscribed my name this 20th day of July, 1992, at Manchester, Connecticut.

Eunice W. Loomis

P. W. Loomis

PLEPLER, BARLOW

SUBSCRIBED, PUBLISHED and DECLARED by ERNA W. LOOMIS, the testatrix, as her Will, in our presence. At her request in her presence and in the presence of each other, we have subscribed our names as witnesses this 20th day of July, 1992.

Elaine S. Law of Manchester, Ct
Elaine S. Law

Donna M. Jordan of Manchester, Ct.
Donna M. Jordan

STATE OF CONNECTICUT)
) ss: Manchester
COUNTY OF HARTFORD)

The subscribing witnesses, being duly sworn, say that they witnessed the execution of the Will of the testatrix, ERNA W. LOOMIS; that said testatrix subscribed, published and declared the same to be her Will in their presence; that they thereafter subscribed the Will as witnesses in her presence, at her request, and in the presence of each other; that at the time of the execution of said Will, the testatrix appeared to them to be of full age and of sound mind and memory, and not under any restraint or in any respect incompetent to make a Will; and that they make this affidavit at her request this 20th day of July, 1992.

Erna W. Loomis

Elaine S. Law
Elaine S. Law

Donna M. Jordan
Donna M. Jordan

Subscribed and sworn to before me this 20th day of July, 1992.

Malcolm F. Barlow
Malcolm F. Barlow
Commissioner of the Superior Court

LEPLER, BARLOW AND RUEL
ATTORNEYS AT LAW
1 EAST CENTER STREET
MANCHESTER, CT
06040-5291
PHONE (203) 646-4081
JURIS NO 01840

EXHIBIT Q 11-2

Fund 11-1.26

Elsie Cheney Disher
(Sophie H. Cheney)

M.M.H. - Disher Fund

589261
~~588911~~

FROM TRUST AGREEMENT OF ELSIE C. DISHER

the remainder in equal shares to the Manchester Memorial Hospital of Manchester, Connecticut, and to ----------. The gift to the Manchester Memorial Hospital is to be held as a permanent fund, in memory of my mother, the income thereof to be used so far as is necessary for the support of a private room in said Hospital, to be known as the "Sophie H. Cheney Room", said room in the discretion of the Hospital ~~authorities to be~~ used for the benefit of worthy cases of special need. Any balance of the income not necessary for the foregoing purpose shall be used by the Hospital authorities for the general purposes of the Hospital. I request that said authorities use a portion of the income for the erection of a suitable tablet in said room to be inscribed with an appropriate reference to my said mother and to her general benefactions to the community.

EXHIBIT Q 11-2

Fund 11-1.27

Sanford Keeney

58926/

State of Connecticut
DISTRICT OF HARTFORD
PROBATE COURT.

ESTATE OF
LULA M. PINNEY OR LULU M. PINNEY OR MRS. LULA M. PINNEY OR MRS. LULU M. PINNEY OR LULU M. RAMSDEN PINNEY, late of
GLASTONBURY
DECEASED.

PLAIN
Copy
of
WILL

PMH - Pinney "Hot" 58926

I, Lula M. Pinney, of the Town of Glastonbury, County of Hartford, and State of Connecticut, being of sound and disposing mind, memory, and judgment, do hereby make, publish, and declare this to be my LAST WILL AND TESTAMENT, hereby revoking all previous wills and codicils by me made.

1st. I give to Miss Harriet Welson of Hartford and Woodstock my emerald and diamond ring.

2nd. I give to Miss Edna G. Somers of West Haven my large single diamond, my Green Clover Leaf pin, and My diamond and sapphire pin.

3rd. I give to Marion Dean of Glastonbury my white enamel pin.

4th. I give to my Aunt, Alice W. Brown, my pearl crescent pin.

5th. I give to my husband, Ralph G. Pinney, my thirteen (13) stone ring, and my elewen (11) stone pin, to be his if he wishes them, and if not, request that they be sold and the proceeds given to some worthy object. I also give to my said husband the use of all my household furniture as long as he wishes them. My diamond and sapphire ring belongs to him.

6th. I direct that the sum of Two Hundred ($200.) Dollars be set aside and placed in trust as a permanent fund, the income to be used and applied for the care and maintenance of the Sanford Keeney Cemetery Lot in the East Cemetery hxt of Manchester. If there be a Cemetery Association which has the care of said Cemetery, I direct that said fund be paid over to it in trust for the purposes aforesaid.

7th. All the rest, residue, and remainder of my estate I direct shall be divided in equal portions and I give to my husband, Ralph G. Pinney, the use of one-half (½) thereof during his life and the use of the remaining one-half (½) to my Aunt, Alice W. Brown, during her life.

Upon the death of either, and both, I give, devise, and bequeath the principal of said estate as follows: One-

half (½) to the Manchester Memorial Hospital as a permanent fund to be known as the Ralph and Lula Pinney Fund, the income of which Fund to be used and applied for the general purposes of said hospital, but as I am now maintaining a room in said hospital in memory of Sanford Keeney, I direct that so much of said income as may be required shall be used and applied towards the maintenance of said room. The other one-half (½) I give, devise, and bequeath to the Children's Aid Society of Hartford, The Newington Home For Crippled Children, The Hartford Hospital, and the First Church of Christ (Congregational) of Glastonbury, to each one-quarter (¼) thereof, as a permanent fund, the funds to the Children's Aid Society, Newington Home For Crippled Children, and Hartford Hospital to be known as the Ralph and Lula Pinney Fund, and the fund to the Church to be known as the Lula M. Pinney Fund, the income of said funds to be applied for the general purposes of each of said institutions, respectively.

I appoint William H. Wright of Fargo, North Dakota, to be executor of this my LAST WILL AND TESTAMENT and direct that no bonds be required of him.

IN TESTIMONY WHEREOF, I have hereunto set my hand and seal at Hartford, Connecticut, this 13th day of May, 1924.

Lula M. Pinney. L.S.

Signed, sealed, published, and declared by the above named testatrix, Lula M. Pinney, to be her LAST WILL AND TESTAMENT in our presence, who in her presence, at her request, and in the presence of each other, have hereunto subscribed our names as witnesses.

Bernard J Ackerman

Helen V. Strauss

Ralph M. Grant

EXHIBIT Q 11-2

Fund 11-1.28

Thomas D. Trotter Memorial Fund

63

LAST WILL AND TESTAMENT,

I, THOMAS D. TROTTER of the Town of Manchester, County of Hartford in the State of Connecticut, being of lawful age, of sound and disposing mind, memory and judgment, do hereby make, publish and declare this to be my last Will and Testament, hereby revoking all previous wills and codicils by me made.

ITEM I: I direct my Executor hereinafter named to pay my just debts, [redacted] if at the time of my death be secured by mortgage, if any, and my funeral and testamentary expenses.

ITEM II: I give and bequeath to my beloved wife, MARTHA ANN TROTTER, the sum of Two Thousand (2,000) Dollars to be hers absolutely and forever.

ITEM III: I give and bequeath to my grandson, RICHARD LEE TROTTER, the sum of Two Thousand (2,000) Dollars. I direct that my son, WOODROW T. TROTTER hold this bequest in trust for RICHARD'S benefit, and I authorize and empower the trustee to apply for RICHARD'S benefit so much of the income and principal thereof as shall, from time to time, in the absolute and uncontrolled discretion of the trustee, or any successor trustee, be deemed necessary for RICHARD'S future education, and when he has obtained the age of twenty-five (25) years, to pay over and to transfer to him absolutely the remaining corpus or capital of this bequest, but in the event that he shall die without having attained the age of twenty-five (25) years, I give and bequeath the said remaining corpus or capital to my son, WOODROW T. TROTTER.

ITEM IV: I give and bequeath to my granddaughter, SUSAN JANE TROTTER, the sum of Two Thousand (2,000) Dollars. I direct that my son, WOODROW T. TROTTER hold this bequest in trust for SUSAN'S benefit, and I authorize and empower the trustee to apply for SUSAN'S benefit so much of the income and principal thereof as shall, from time to time, in the absolute and uncontrolled discretion of the trustee, or any successor trustee, be deemed necessary for SUSAN'S future education, and when she has obtained the age of twenty-five (25) years, to pay over and to transfer to her absolutely the remaining corpus or capital of this bequest, but in the event that she shall die without having attained the age of twenty-five (25) years, I give

END OF THIS PAGE

[redacted]

Submitted October 13, 2015

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Continued from previous page.

and bequeath the said remaining corpus or capital to my son, WOODROW T. TROTTER.

ITEM V: I give and bequeath to my daughter-in-law, DOROTHY TROTTER, the sum of Fifteen Hundred (1,500) Dollars to be hers absolutely

[redacted] TROTTER, the sum of Fifteen Hundred (1,500) Dollars, my lake lot located at Amston Lake, and all my shares of stock in the First National Bank of Manchester and the Odd Fellows Independent Lodge No. 31 to be his absolutely and forever.

Thomas D Trotter

ITEM VII: I give and bequeath to the MANCHESTER MEMORIAL HOSPITAL, Manchester, Connecticut, the sum of Five Hundred (500) Dollars to be known as the Thomas D. Trotter Memorial Fund, and I direct that only the income from this fund is to be used, in the absolute and uncontrolled discretion of the supervisor of said hospital, in some way for the benefit of the children patients.

ITEM VIII: I desire and direct that all pecuniary legacies and bequests hereinbefore mentioned be paid and satisfied out of my personal estate only.

ITEM IX: All the rest, residue and remainder of my property, both real and personal, which I may own at the date of my death or to which or any interest in which I may at the time of my death be entitled, including any property over which I may then have power of appointment, I give, devise and bequeath to my beloved [redacted] for and during the term of her natural life. I direct that this bequest be held in trust for her benefit by my son, WOODROW T. TROTTER, and I direct that he serve without bond.

ITEM X: Upon the death of my said wife, or if my said wife shall predecease me, I give, devise and bequeath all said property described in ITEM IX hereinabove, to my son, WOODROW T. TROTTER, to be his absolutely and forever.

END OF THIS PAGE

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Submitted October 13, 2015

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I Appoint my son, WOODROW T. TROTTER of the Town of Manchester, County of Hartford and State of Connecticut executor of this my Last Will and Testament, and I direct that he be exempt from giving any official bond, as executor or trustee under any items hereinbefore.

In Witness Whereof I have hereunto set my hand and seal at said Manchester, Connecticut on the 20th day of January, A.D., One Thousand

Thomas D Trotter (L.S.)

Signed, sealed, published and declared by the said THOMAS D. TROTTER, as and for his Last Will and Testament, in presence of us, who at his request, in his presence, and in the presence of each other have hereunto subscribed our names as witnesses, on the 20th day of January, A.D., 1951

Elizabeth A. Topliff, 54 Union Place, Manchester, Conn.
Thomas F Herrick 206 Center St Man } -witnesses.
Wesley Dyke, 13 Birnell St, Manchester, Conn

State of Connecticut, }
County of Hartford } ss. Manchester, January 20, A.D. 1951

We the within named Elizabeth A. Topliff & Thomas F. Herrick being duly sworn, make affidavit and say: That we severally attested the within and foregoing Will of the within named Testator and subscribed the same in his presence and at his request and in the presence of each other; that the said testator signed, published and declared the said instrument as and for his last Will and Testament in our presence on the 20th day of January, A.D., 1951; and at the time of execution of said will, said testator was more than eighteen years of age and of sound mind, memory and judgment and under no improper influence or restraint to the best of our knowledge and belief, and we make this affidavit at the request of said testator.

Elizabeth A. Topliff
Thomas F Herrick

- 3 -

State of Connecticut)
) ss. Manchester, January 20, A.D., 1951
County of Hartford)

Then personally appeared before me , a Notary Public, duly qualified to administer oaths.

[redacted] and subscribed and made oath to the truth of the foregoing affidavit.

Notary Public

Will of Thomas D. Trotter, dated January 20, 1951, and Codicil thereto, dated March 14, 1958 presented in Court July 20, 1959. Will and Co-dicil proved, approved and admitted to probate, July 20, 1959

Judge.

****

+

[redacted]

[redacted]

EXHIBIT Q 11-2

Fund 11-1.29

William and Rebecca J. Wright Fund

ECHN Proposed Asset Purchase by PMH
Submitted October 13, 2015

Will

OF

REBECCA J. WRIGHT

Dated May 22d **A. D. 1948**

Presented in Court, Sept. 21, 1950, Ordered Heard, Oct. 13, 1950.

Judge

Will proved, approved and admitted to probate, ordered recorded and kept on file, and The Manchester Trust Co. appointed as executor October 13, 1950.

Judge

Recorded Vol. 87, Page 353

Clerk

CHARLES N. CROCKETT
ATTORNEY AT LAW

Last Will and Testament.

I, REBECCA J. WRIGHT

of the Town of Manchester in the County of Hartford,

in the State of Connecticut, being of lawful age, of sound and disposing mind, memory and judgment, do hereby make, publish and declare this to be my last Will and Testament, hereby revoking all previous wills and codicils by me made.

ARTICLE I

I direct my Executor to pay my funeral expenses, expenses of my last illness, and just debts, except those secured by mortgage, and to pay as an administration expense all succession, legacy, estate, transfer and inheritance taxes, and all taxes attributable to insurance, jointly owned property, any interest in property taxable as if it were a part of my estate, or transfer made by me.

ARTICLE II

I give devise and bequeath the sum of Two Hundred Fifty and no/100 ($250) Dollars to the Town of Manchester for the purpose of perpetual care of the James Crockett lot located in the East Cemetery.

ARTICLE III

I give and bequeath my household furniture and furnishings, clothing, jewelry and all other articles of household or personal use to my brother, Alexander Crockett of Manchester, Connecticut.

ARTICLE IV

All the rest, residue and remainder of my property both real and personal and of whatsoever nature, wheresoever the same may be located or found, which I may own or have the right to dispose of at my death, I give, devise and bequeath to The Manchester Trust Company of Manchester, Connecticut, its successor or successors, as Trustee, to be held in TRUST and administered as follows:

I direct my said Trustee to pay over to my brother, Alexander Crockett, from the income of said Trust, the sum of Seventy-five and no/100 ($75.00) Dollars per month during his life, upon the death of my said brother or upon my death, if he should die before me, I direct that this trust shall cease and terminate and I direct that my said Trustee liquidate the Trust and that the proceeds therefrom be added

to the residue. In the event my said brother should die before me, I direct my Executor, without the requirement of setting up the Trust, to distribute the funds designated for the Trust directly to the remainder men thereof as hereinafter set forth. I direct my Trustee to divide all funds in its hands into three (3) equal shares and I direct my Trustee to pay over one (1) of said shares to The Manchester Memorial Hospital of Manchester, Connecticut, and that said share shall be kept intact as an endowment fund and that the income therefrom shall be used in the fight against Cancer, and that said share or fund shall be known as the William and Rebecca J. Wright Fund. I direct my said Trustee to pay over the two (2) remaining shares to The Salvation Army Territorial Headquarters, New York, New York, and that these two (2) shares be kept intact as an endowment fund and that the income therefrom shall be divided equally between the Salvation Army Training College and Salvation Army Missionary work, and that such endowment fund shall be known as the William and Rebecca J. Wright Fund.

I Appoint THE MANCHESTER TRUST COMPANY .
of the Town of Manchester County of Hartford
and State of Connecticut executor of this my Last Will and Testament

In Witness Whereof I have hereunto set my hand and seal at said
Manchester, Connecticut on the 26th day of May
A. D., One Thousand Nine Hundred and Forty-eight.

Rebecca J. Wright L. S.

Signed, sealed, published and declared by the said REBECCA J. WRIGHT as and for her Last Will and Testament, in presence of us, who at her request, in her presence, and in the presence of each other have hereunto subscribed our names as witnesses, on the 26th day of May A. D., 1948.

Lillian B. Farrand
Eleanor D. Johnson
Charles N. Crockett
} Witnesses.

State of Connecticut,
County of Hartford } ss. Manchester, May 26th A. D. 1948

We the within named Lillian B. Farrand and Eleanor D. Johnson being duly sworn, make affidavit and say: That we severally attested the within and foregoing Will of the within named testatrix and subscribed the same in her presence and at her request and in the presence of each other; and in the presence of the third subscribing witness; that the said testatrix signed, published and declared the said instrument as and for her last Will and Testament in our presence on the 26th day of May A. D., 1948; and at the time of execution of said will, said testatrix was more than eighteen years of age and of sound mind, memory and judgment and under no improper influence or restraint to the best of our knowledge and belief, and we make this affidavit at the request of said testatrix.

Lillian B. Farrand
Eleanor D. Johnson

State of Connecticut,
County of Hartford } ss. Manchester, May 26th A. D. 1948

Then personally appeared before me a Commissioner of Superior Court duly qualified to administer oaths.

Lillian B. Farrand
and Eleanor D. Johnson
and subscribed and made oath to the truth of the foregoing affidavit.

Charles N. Crockett
Notary Public
Justice of the Peace
County.

Commissioner of Superior Court for Hartford

EXHIBIT Q 11-2

Fund 11-1.30

Interest in the Estate of Raymond F. Damato

LAST WILL AND TESTAMENT

I, **RAYMOND F. DAMATO**, of the Town of Manchester, County of Hartford and State of Connecticut, being of lawful age, of sound and disposing mind, memory and judgment, do hereby make, publish and declare this to be my Last Will and Testament, hereby revoking all previous wills and codicils by me made.

FIRST

I hereby direct that my Executor hereinafter named pay all my funeral expenses and just debts, except such as shall at the time of my decease be secured by mortgage, if any, as soon as conveniently may be after my decease.

SECOND

I direct that all inheritance, succession, estate, legacy and transfer taxes that may be assessed or imposed upon or with respect to any property passing under this Will or any property not passing under this Will shall be paid out of my estate as an expense of

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administration and shall not be prorated or apportioned among or charged against any legatee or devisee under this Will or any person owning or receiving any property not passing under this Will, and my Executor shall not be entitled to reimbursement for any portion of any such tax from any such person.

THIRD

I give and devise to **NANCY L. SCOTT**, of Manchester, Connecticut, either my real property known as 27 Homestead Street in Manchester, Connecticut, or my real property known as 24 Homestead Street in Manchester, Connecticut. Said **NANCY L. SCOTT** shall deliver written notice to my Executor, hereinafter named, as to which of said properties she elects to take, within ninety (90) days of the date of the appointment of my Executor. My Executor may also require that the said **NANCY L. SCOTT** execute a writing in a form recordable on the Manchester Land Records memorializing her election. The real property which the said **NANCY L. SCOTT** shall not elect to take, shall pass under Article Seventh hereunder.

Y, BOTTICELLO
I'BRIEN, P.C.
RNEYS AT LAW
ST CENTER STREET
.STER, CT 06040
0) 648-3500

FOURTH

I give and bequeath to the following individuals and organizations, the items or amounts set forth in this paragraph after their respective names:

A. To **JOHN J. (JACKIE) WILLIS**, of Manchester, Connecticut, the sum of Forty Thousand ($40,000.00) Dollars.

B. To **JAMES McCAVANAGH**, of Manchester, Connecticut, the sum of Twenty-Five Thousand ($25,000.00) Dollars.

C. To **REBECCA JONES**, of Coventry, Connecticut, the sum of Twenty-Five Thousand ($25,000.00) Dollars.

D. To **ARNOLD LERCH**, of Coventry, Connecticut, the sum of Ten Thousand ($10,000.00) Dollars.

E. To **GARY HOLLISTER**, of Tolland, Connecticut, the sum of Ten Thousand ($10,000.00) Dollars.

F. To **MARY WATERS**, of Manchester, Connecticut, the sum of One Hundred Thousand ($100,000.00) Dollars.

G. To **FULL GOSPEL INTERDENOMINATIONAL CHURCH**, of Manchester, Connecticut, the sum of Five Thousand ($5,000.00) Dollars.

H. To **KARIN CARLSON** of Bolton, Connecticut, the sum of Two Thousand-Five Hundred ($2,500.00) Dollars.

I. To **JAMSHID MARVASTI, M.D.**, of Manchester, Connecticut, the sum of Ten Thousand ($10,000.00) Dollars.

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neys at Law
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ter, CT 06040
) 646-3500

If any of said beneficiaries named in this Article shall predecease me, then the bequest to said beneficiary shall lapse.

In the event that the total monetary bequests in this Article shall exceed Five (5%) of my gross estate, then the total amount to be distributed to the beneficiaries named in this Article shall be reduced to Five (5%) of my gross estate, and each monetary bequest shall be reduced on a pro rata basis.

FIFTH

I give and bequeath to the following individuals, all of whom are presently employed by me or have been previously employed by me the sum of Five Hundred ($500.00) Dollars for each year that the respective beneficiary was employed by me. Those individuals are: **SHARON O'CONNELL, KAY BROWN, MARY WATERS** and **RUSSELL DYAK.**

I also direct that my Executor pay to any other individuals who are employed by me at the time of my death and are not named in this Article, the sum of Five Hundred ($500.00) Dollars for each year that they may have been employed by me.

If any of said beneficiaries named in this Article shall predecease me, then the bequest to said beneficiary shall lapse.

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In the event that the total bequests in this Article shall exceed Five (5%) of my gross estate, then the total amount to be distributed to the beneficiaries named in this Article shall be reduced to Five (5%) of my gross estate, and each bequest shall be reduced on a pro rata basis.

SIXTH

I give, devise and bequeath Four Million ($4,000,000.00) Dollars, IN TRUST, to **BARRY W. BOTTICELLO**, as Trustee, who shall establish and administer separate trusts for each of the beneficiaries named hereinbelow, in accordance with the respective percentages, set forth below, of the assets which are subject to this Article Sixth. Each trust shall be subject to and governed by the terms and provisions set forth more particularly below:

A. Twenty (20%) percent thereof IN TRUST for the benefit of **NANCY L. SCOTT**, presently of Manchester, Connecticut;

B. Fifteen (15%) percent thereof IN TRUST for the benefit of **JANICE DABATE**, presently of Manchester Connecticut;

C. Five (5%) percent thereof IN TRUST for the benefit of **LAURIE GARDNER**, presently of Manchester, Connecticut;

D. Eight and one-third (8 1/3%) percent thereof IN TRUST for the benefit of **RICHARD DABATE**, presently of Manchester, Connecticut;

E. Two and one-half (2 1/2%) percent thereof IN TRUST for the benefit of **DAVID J. ROSSETTO**, presently of Mystic, Connecticut;

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F. Two and one-half (2 1/2%) percent thereof IN TRUST for the benefit of **CAROL ROSSETTO**, presently of New York, New York;

G. Eight and one-third (8 1/3%) percent thereof IN TRUST for the benefit of **TERRY WILSINSKI**, presently of Manchester, Connecticut;

H. Ten (10%) percent thereof IN TRUST for the benefit of **JOANIE BONI**, presently of Simsbury, Connecticut;

I. Ten (10%) percent thereof IN TRUST for the benefit of **CAROL ST. GERMAINE**, presently of Manchester, Connecticut;

J. Eight and one-third (8 1/3%) percent thereof IN TRUST for the benefit of **SANDRA BIDWELL**, presently of Manchester, Connecticut;

K. Ten (10%) percent of thereof IN TRUST for the benefit of **JUDY ANDERSON**, presently of Manchester, Connecticut.

(i) I direct my Trustee, hereinabove named, to establish and administer separate trusts for each of the above-named individuals. During the lifetime of each beneficiary, my Trustee shall hold, manage, invest and reinvest the Trust property and pay to such beneficiaries, or expend on his or her behalf, so much of the net income thereof as the Trustee in the Trustee's sole discretion deems advisable for his or her support, maintenance, education and/or needs in connection with any physical or mental disability. Said distributions shall be made not less

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frequently than quarterly. Any of that income not so paid or applied shall from time to time be added to principal.

(ii) Upon the death of any above-named beneficiary the Trustee shall distribute the then remaining Trust of said deceased beneficiary, as it shall then be constituted, absolutely and free of trust, to those beneficiaries and in the respective percentages set forth in Article Seventh of this my Last Will and Testament.

(iii) Said Trustee may employ counsel or other agents in the discharge of the Trustee' duties and determine and pay to them and himself reasonable compensation.

(iv) I hereby incorporate by reference the powers listed in Section 45a-234 and Sections (1), (2), (3), (5), (7), (9), (10), (11), (12), (14), (15), (16), (17), (18), (19), (20), (21), (22), (23), (24), (25), (26) and (27) of Section 45a-235 of the Connecticut General Statutes, as the same may be amended from time to time, and I direct that the Trustee is authorized to exercise all powers and rights listed therein.

(v) The Trustee shall hold and manage the property as separate Trust Funds, invest and re-invest the same in such loans, stocks, bonds,

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securities and real estate as the Trustee deems proper and suitable for the investment of Trust Funds, being restricted only to those investments that a reasonably prudent Trustee would make. The Trustee shall have the continuing, absolute, discretionary power to deal with any property, real or personal, held in Trust, as freely as I might in the handling of my own affairs. Such power may be exercised without prior or subsequent approval of any court or judicial authority, and no person dealing with the Trustee shall be required to inquire into the Trustee's power to act.

(vi) The Trustee shall have the power to accumulate or withhold the income. The income is expressly given for the support of the beneficiaries or his or her family. The Trustee shall have full, exclusive and sole discretion as to the manner in which the provisions and terms of said Trust shall be carried out, and the Trustee's discretion in all matters pertaining thereto, or to any interpretations of matters or questions arising out of said Trust, shall be final and conclusive. I direct that the said **BARRY W. BOTTICELLO**, be not required to furnish bond in the capacity of Trustee under this article. In the event

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that the said **BARRY W. BOTTICELLO** shall predecease me, or be for any reason unable to serve as Trustee, then I appoint **THOMAS A. ROBINSON**, currently of Manchester, Connecticut, to serve as Trustee and I direct that he be not required to furnish bond in the capacity as Trustee under this Article.

If any of the beneficiaries named in this Article Sixth shall predecease me, then his or her share shall be distributed among those of said beneficiaries named in sub-paragraphs A through K who shall survive me, in proportion to their shares as set forth in this Article.

SEVENTH

I give, devise and bequeath all the rest, residue and remainder of my property, both real and personal, of which I shall die seized and possessed, wherever situated, as follows:

A. 15% to **ST. BRIDGET CHURCH**, of Manchester, Connecticut to be used at the discretion of the Pastor and Finance Committee for general church purposes.

B. 10% to **ST. BRIDGET SCHOOL**, of Manchester, Connecticut to be used solely for capital expenditures.

C. 20% to **MANCHESTER COMMUNITY COLLEGE**, of Manchester, Connecticut.

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D. 20% to **MANCHESTER MEMORIAL HOSPITAL**, of Manchester, Connecticut.

E. 15% to the **MANCHESTER SCHOLARSHIP FOUNDATION, INC.**, of Manchester, Connecticut.

F. 5% to **EAST CATHOLIC HIGH SCHOOL**, of Manchester, Connecticut.

G. 5% to the **AMERICAN HEART ASSOCIATION**, of Wallingford, Connecticut.

H. 5% to the **AMERICAN CANCER SOCIETY**, of Wallingford, Connecticut.

I. 5% to the **MANCHESTER AREA CONFERENCE OF CHURCHES**, Manchester, Connecticut.

Except as set forth in the individual bequests above, the bequests subject to this Paragraph shall be unrestricted in purpose and left to the discretion of the governing board of each of the respective charitable organizations.

EIGHTH

I appoint **BARRY W. BOTTICELLO**, of Manchester, Connecticut, to be the Executor of this, my Last Will and Testament, and I direct that he be not required to furnish bond in such capacity. In the event that **BARRY W. BOTTICELLO** predeceases me or is unable or

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unwilling to act as Executor under this Article, then I nominate, constitute and appoint **THOMAS F. SCANLON,** presently of Glastonbury, Connecticut as Successor Executor of this, my Last Will and Testament, and I direct that he be not required to furnish bond in such capacity. I hereby incorporate by reference the powers listed in Section 45a-234 and Sections (1), (2), (3), (5), (7), (9), (10), (11), (12), (14), (15), (16), (17), (18), (19), (20), (21), (22), (23), (24), (25), (26) and (27) of Section 45a-235 of the Connecticut General Statutes, as the same may be amended from time to time, and I direct that my Executor is authorized to exercise all powers and rights listed therein.

In Witness Whereof, I have hereunto set my hand and seal at Manchester, Connecticut, on the 7th day of July, 2009.

RAYMOND F. DAMATO

Signed, sealed, published and declared by the said **RAYMOND F. DAMATO** as and for his Last Will and Testament, in the presence of us, who at his request, and in his presence,

BOTTICELLO
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and in the presence of each other have hereunto subscribed our names as witnesses, on the 7th day of July, 2009.

WITNESSES

Rachael F. Kiss

Phyllis B. Swanson

STATE OF CONNECTICUT)
) ss. Manchester July 7, 2009
COUNTY OF HARTFORD)

We, the within named Rachael F. Kiss and Phyllis B. Swanson, being duly sworn, make affidavit and say: That we severally attested the within and foregoing Will of **RAYMOND F. DAMATO** and subscribed the same in his presence and at his request and in the presence of each other; that **RAYMOND F. DAMATO** signed, published and declared the said instrument as and for his Last Will and Testament in our presence on the 7th day of July, 2009, and at the time of execution of said Will, **RAYMOND F. DAMATO** was more than eighteen years of

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age and of sound mind, memory and judgment and under no improper influence or restraint to the best of our knowledge and belief, and we make this affidavit at his request.

Rachael F. Kiss

Phyllis B. Swanson

STATE OF CONNECTICUT)
) ss. Manchester July 7, 2009
COUNTY OF HARTFORD)

Then personally appeared before me, Theresa S. Galica, duly qualified to administer oaths, Rachael F. Kiss and Phyllis B. Swanson, and subscribed and made oath to the truth of the foregoing affidavit.

Theresa S. Galica
Commissioner of Superior Court
Notary Public
My Commission Expires: 11/30/2013

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FIRST CODICIL TO

LAST WILL AND TESTAMENT OF

RAYMOND F. DAMATO

I, RAYMOND F. DAMATO, of the Town of Manchester, County of Hartford and State of Connecticut, do make, publish and declare this to be my First Codicil to my Last Will and Testament executed by me on July 7, 2009, in the presence of Rachael E. Kiss and Phyllis B. Swanson.

I revoke and annul Article Fourth of my said Will; and in lieu thereof I substitute the following:

FOURTH

I give and bequeath to the following individuals and organizations, the items or amounts set forth in this paragraph after their respective names:

A. To **JOHN J. (JACKIE) WILLIS**, of Manchester, Connecticut, the sum of Forty Thousand ($40,000.00) Dollars.

B. To **JAMES McCAVANAGH**, of Manchester, Connecticut, the sum of Twenty-Five Thousand ($25,000.00) Dollars.

C. To **REBECCA JONES**, formerly of Coventry, Connecticut, the sum of Twenty-Five Thousand ($25,000.00) Dollars.

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D. To **ARNOLD LERCH**, of Coventry, Connecticut, the sum of Ten Thousand ($10,000.00) Dollars.

E. To **GARY HOLLISTER**, of Tolland, Connecticut, the sum of Ten Thousand ($10,000.00) Dollars.

F. To **FULL GOSPEL INTERDENOMINATIONAL CHURCH**, of Manchester, Connecticut, the sum of Five Thousand ($5,000.00) Dollars.

G. To **KARIN CARLSON** of Bolton, Connecticut, the sum of Two Thousand-Five Hundred ($2,500.00) Dollars.

H. To **JAMSHID MARVASTI, M.D.**, of Manchester, Connecticut, the sum of Ten Thousand ($10,000.00) Dollars.

In all other respects I ratify and confirm all of the provisions of my said Will dated July 7, 2009.

IN WITNESS WHEREOF, I have subscribed my name to this my First Codicil to my Last Will and Testament in the presence of the persons witnessing it at my request this 29th day of April, 2010, at Manchester, Connecticut.

RAYMOND F. DAMATO

The foregoing instrument was signed, published and declared by **RAYMOND F. DAMATO**, the testator, to be the First Codicil to his Last Will and Testament, in our presence,

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and we at his request and in the presence of each other have hereunto subscribed our names as witnesses this 29th day of April, 2010, at Manchester, Connecticut.

Barry W. Botticello, of the Town of Manchester, Connecticut

Barbara Castelli

Barbara Castelli, of the Town of Vernon, Connecticut

STATE OF CONNECTICUT)
) ss. Manchester April 29, 2010
COUNTY OF HARTFORD)

Then and there personally appeared the within named Barry W. Botticello and Barbara Castelli, who being duly sworn depose and say that they witnessed the execution of the within Codicil of **RAYMOND F. DAMATO**; that **RAYMOND F. DAMATO** subscribed said Codicil and declared in their presence the same to be a First Codicil to the Last Will and Testament executed by him on the 7th day of July, 2009; that they thereafter subscribed the same as witnesses in the presence of said testator and in the presence of each other and at the request of **RAYMOND F. DAMATO**; that **RAYMOND F. DAMATO** at the time of the

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execution of said Codicil appeared to them to be of full age and of sound mind and memory and that they made this affidavit at the request of **RAYMOND F. DAMATO.**

Barry W. Botticello

Barbara Castelli

STATE OF CONNECTICUT)
) ss. Manchester April 29, 2010
COUNTY OF HARTFORD)

Then personally appeared before me, Theresa S. Galica, duly qualified to administer oaths, Barry W. Botticello and Barbara Castelli and subscribed and made oath to the truth of the foregoing affidavit.

Theresa S. Galica
Notary Public
My Commission Expires: 11/30/2013

THERESA S. GALICA
NOTARY PUBLIC
MY COMMISSION EXPIRES NOV. 30, 2013

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SECOND CODICIL TO

LAST WILL AND TESTAMENT OF

RAYMOND F. DAMATO

I, **RAYMOND F. DAMATO**, of the Town of Manchester, County of Hartford and State of Connecticut, do make, publish and declare this to be my Second Codicil to my Last Will and Testament executed by me on July 7, 2009, in the presence of Rachael F. Kiss and Phyllis B. Swanson.

I hereby add the following as Article Ninth of my said Will:

NINTH

I expect that my real estate holdings will be liquidated after my death at such time and in such manner as my Executors hereinabove named deem fit.

I hereby direct that my Executors, as named in Article Eighth above, and any other persons or entities who may be named as Successor Executors list any of my real estate located within in the State of Connecticut that is to be sold, with McCavanagh Real Estate Corporation of Manchester, Connecticut, or any other company or entity of which James P. McCavanagh currently of Manchester, Connecticut, is a principal. Residential properties shall be listed at a

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commission of six (6%) percent and apartment and other commercial properties at a commission of ten (10%) percent.

In the event that the said James P. McCavanagh shall predecease me or shall not be actively engaged in the business of selling real estate, then my fiduciaries may list properties for sale with such persons and/or companies as they may choose.

In all other respects I ratify and confirm all of the provisions of my said Will dated July 7, 2009 and my First Codicil to my Last Will and Testament dated April 29, 2010.

IN WITNESS WHEREOF, I have subscribed my name to this my Second Codicil to my Last Will and Testament in the presence of the persons witnessing it at my request this 11th day of February, 2011, at Manchester, Connecticut.

RAYMOND F. DAMATO

The foregoing instrument was signed, published and declared by RAYMOND F. DAMATO, the testator, to be the Second Codicil to his Last Will and Testament, in our

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presence, and we at his request and in the presence of each other have hereunto subscribed our names as witnesses this 11th day of February, 2011, at Manchester, Connecticut.

Thomas A. Robinson , of the Town of Manchester, Connecticut

Stephen T. Penny, of the Town of Manchester, Connecticut

STATE OF CONNECTICUT)
) ss. Manchester February 11, 2011
COUNTY OF HARTFORD)

Then and there personally appeared the within named THOMAS A. ROBINSON and STEPHEN T. PENNY, who being duly sworn depose and say that they witnessed the execution of the within Codicil of **RAYMOND F. DAMATO**; that **RAYMOND F. DAMATO** subscribed said Codicil and declared in their presence the same to be a Second Codicil to the Last Will and Testament executed by him on the 7th day of July, 2009; that they thereafter subscribed the same as witnesses in the presence of said testator and in the presence of each other and at the request of **RAYMOND F. DAMATO**; that **RAYMOND F. DAMATO** at the

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time of the execution of said Codicil appeared to them to be of full age and of sound mind and memory and that they made this affidavit at the request of RAYMOND F. DAMATO.

Thomas A. Robinson

Stephen T. Penny

STATE OF CONNECTICUT)
) ss. Manchester February 11, 2011
COUNTY OF HARTFORD)

Then personally appeared before me, LAURIE A. ADAMS, duly qualified to administer oaths, THOMAS A. ROBINSON and STEPHEN T. PENNY and subscribed and made oath to the truth of the foregoing affidavit.

Laurie A. Adams
Notary Public
My Commission Expires: 11/30/14

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EXHIBIT Q 11-2

Fund 11-1.31

Life Insurance Policy
(Name of Insured Withheld)

MAY 23 2014

National Life Group®

National Life Insurance Company®

Annual Statement

May 20, 2014

#BWNCDPH
MANCHESTER MEMORIAL HOSPITAL
ATTN NINA KRUSE ECHN FOND
71 HAYNES ST
MANCHESTER CT 06040-4131

Policy Information

Policy Number:
Insured:
Anniversary Date: May 20, 2014
Owner: Manchester Memorial Hospital

Policy Coverages on Anniversary Date

Base Policy Face Amount:	$50,000.00
Paid-up Additions from Dividends:	$34,345.00
Terminal Dividend:	$1,500.00
Total Death Benefit:	$85,845.00
NET CASH VALUE:	$55,638.52

The net cash value includes cash values plus any accumulated dividends and interest earnings minus any loan balances and loan interest charges on the Anniversary Date.

Dividend Information

$863.95 was used to purchase Dividend Additions of $1,178.00

Loan Information *(This is not a bill)*

Total Loan:	$0.00
Interest Rate:	5.00 %
Loan Interest:	$0.00

Your variable loan rate beginning May 20, 2014, will be 5.00 %.

Premium Information *(This is not a bill)*

Base Policy Annual Premium:	$1,685.00
Total Annual Policy Premium:	$1,685.00

Facility Processed Asset Purchase by PMI
Submitted October 13, 2015

EXHIBIT Q 11-2

Fund 11-1.32

Alice Farmer Bissell Fund

7PBAa

VOL. 56

DISTRICT OF ELLINGTON

APPLICATION FOR WAIVER OF 5-DAY LAW & BLOOD TEST
To the Probate Court for the District of Ellington:

MATTER OF MARRIAGE OF MARGUERITE EDWARDS of Vernon, Conn. and THOMAS V. EDWARDS of Vernon, Conn.

We, Marguerite Edwards and Thomas V. Edwards, hereby make application to said Court of Probate for a decision in writing that our marriage should be celebrated without delay and that such decision is in accordance with public policy and the provisions of Chapter 147 of the Public Acts of 1929, and for the following reason, to wit: that the five day requirement and a delay in the celebration of our marriage would be a source of great embarrassment.

Dated at Rockville, this 16th day of February, 1942.

(signed) Mrs. Marguerite Edwards
(signed) Thomas V. Edwards

Subscribed and sworn to before me this 16th day of February, 1942.
(signed) Elsie M.Neff, Notary Public (seal)

A true copy Attest: Elsie M. Neff. Clerk

WAIVER
State of Connecticut }
District of Ellington } ss. Rockville, February 16, 1942

PROBATE COURT.

Present, Hon. Francis T. O'Loughlin, Judge.

Pursuant to the provisions of Section 1595c of the cumulative supplement of the General Statutes, January Sessions 1931, 1933, 1935, State of Connecticut, Marguerite Edwards of Vernon, Connecticut and Thomas V. Edwards of Vernon, Connecticut persons intending to intermarry, appeared before me in said Court in Rockville, this 16th day of February, A.D. 1942, and after hearing evidence by them presented, I am of the opinion that public policy requires that the intended marriage between said parties should be performed forthwith and that the blood test of persons intending to intermarry in said State of Connecticut as provided in subsection B of said section should be dispensed with and the same is hereby dispensed with; and that the five-days statutory notice required under subsection c of said section should be dispensed with and the same is hereby dispensed with.

Dated at Rockville, in the State of Connecticut, this 16th day of February, 1942.

(signed) F. T. O'Loughlin, Judge of Probate for the District of Ellington.

A true copy Attest: Elsie M. Neff. Clerk

APPLICATION FOR PROBATE OF WILL & WAIVER
To the Probate Court for the District of Ellington STATE OF CONNECTICUT:

ESTATE OF ARTHUR T. [redacted] late of Vernon in said District, deceased.

The subscriber represents that Arthur T. [redacted] last dwelt and was domiciled in the town of Vernon in said District, and died on the 5th day of February A.D. 1942, possessed of goods and estate in said District remaining to be administered, leaving no widow; that said decedent left him surviving no children or descendants of deceased children or heirs-at-law except those whose names and addresses are given below--

Name	Residence	Relationship
Lebbeus F. [redacted]	74 Prospect St., Rockville, Conn.	son
Emily [redacted] Swindells	" "	daughter

none of whom are under any disability or incapacity and that the said deceased left a will herewith presented for probate wherein Lebbeus F. Bissell and Emily [redacted] Swindells are named as executors; and that said will has never been revoked by the subsequent marriage of decedent, birth or adoption of children, or otherwise.

Wherefore your petitioner pray that said will may be proved, approved, allowed and admitted to probate and letters testamentary on said estate may be granted to the executors therein named.

(signed) Emily [redacted] Swindells

Subscribed and sworn to this 9th day of February 1942, before me,
(signed) F. T. O'Loughlin, Judge.

The undersigned being with the petitioner all the heirs-at-law and next of kin of said deceased, accept service and waive notice of the pendency of the foregoing application and of the time and place set for hearing thereon.
(signed) Lebbeus F. [redacted]

A true copy Attest: Elsie M. Neff Clerk

WILL

I, ARTHUR T. [redacted] of the City of Rockville in the Town of Vernon and State of Connecticut, do make, publish and declare this instrument as and for my last will and testament hereby revoking all wills and codicils by me at any time heretofore made.

First: I direct that all my just debts and funeral expenses be fully paid as soon as may be after my death.

Second: If my daughter, Emily [redacted] Swindells, is living at the time of my death, I give, devise and bequeath to my said daughter, to her, her heirs and assigns forever absolutely, my home No. 74 Prospect Street in Rockville, including the grounds, residence and other buildings, together with the contents thereof, including my automobiles and personal effects; and my one-half interest in the summer cottage on Shore Avenue, Eastern Point, Groton, Connecticut, including the contents thereof, together with the land and its appurtenances, my said daughter owning the other half interest in said summer cottage.

In the event that my said daughter is not living at my death then I give, devise and bequeath the property disposed of by this Article of my will to my son, Lebbeus F. [redacted] to him, his heirs and assigns forever, if he is living at the time of my death.

(Continued over)

ECHN Proposed Asset Purchase by PMH
Submitted October 13, 2015

(Continued from Page 86 - Estate of Arthur T. Bissell)

Third: I give and bequeath to the Union Congregational Church of Christ, Rockville, Connecticut, the sum of Five Thousand Dollars ($5,000) to be kept as a separate and permanent fund in memory of my wife, Alice Farmer Bissell, and to be known as the Alice Farmer Bissell Fund, the net income thereof to be used for the general expenses of said Church.

Fourth: I give and bequeath to the Rockville City Hospital the sum of Twenty-five Thousand Dollars ($25,000) to be kept as a permanent fund in memory of my wife, Alice Farmer Bissell, and to be known as the Alice Farmer Bissell Fund. The net income from said fund shall be used and applied for the general purposes of said Hospital.

Fifth: All the rest, residue and remainder of my estate, real and personal, whatsoever and wheresoever situated, I give, devise and bequeath, in equal shares, to my son, Lebbeus F. Bissell, and my daughter, Emily Bissell Swindells, the issue, if any, of either of my said children who dies before me to receive the share to which my such deceased child would have been entitled if living, and if there are no such issue who survive me, such share to be added to the other shares, provided however that if both my son and daughter are deceased at my death leaving no issue of either then surviving, that then and in that event I dispose of said rest, residue and remainder as follows, that is to say:

I give and bequeath to Leslie Boyd Farmer of Washington, D.C., the sum of Ten Thousand Dollars ($10,000) or if he be not then living, to his children equally, and the sum of Ten Thousand Dollars ($10,000) To Alice Farmer Vernlund, of Sunset Farm, West Hartford, Connecticut, or if she be not living at my death, to her children equally; and all the balance of said rest, residue and remainder to said Rockville City Hospital to be added to the fund provided in the Fourth Article of this will, and expended as therein provided.

Sixth: I nominate and appoint my said son, Lebbeus F. Bissell, and my said daughter, Emily Bissell Swindells, to be Executors of this my will and I hereby excuse my said Executors, in so far as I am able, from giving any bonds in that capacity. If either of my said Executors should die before me, or for any other reason fail to qualify in that capacity, I nominate and appoint The Hartford-Connecticut Trust Company of Hartford, Connecticut, to be Co-Executor instead, and if both the Executors originally named should fail to qualify, I nominate and appoint said The Hartford-Connecticut Trust Company to be sole executor. I give to my said Executors, including the substituted Executor named in case it is acting, full power and authority, according to their discretion, to sell and convey any real estate which may form a portion of my estate.

IN WITNESS WHEREOF I have hereunto set my hand and seal at Hartford, Connecticut, this 1st day of September, A.D. 1932.

(signed) Arthur T. Bissell (L.S.)

Signed, sealed, published and declared as his last will and testatment by Arthur T. Bissell, the above named testator, in the presence of us who, at his request, in his presence and in the presence of each other have hereto subscribed our names as witnesses.

(signed) Francis W. Cole Hartford, Conn.
(signed) John C. Parsons Hartford, Conn.
(signed) Winifred Camp Hartford, Conn.

STATE OF CONNECTICUT :
: ss. Hartford, February 7, 1942.
COUNTY OF HARTFORD :

I, the undersigned, John C. Parsons, of Hartford, Connecticut, being duly sworn, depose and say:

That I witnessed the will and the execution thereof, of Arthur T. Bissell, of Rockville, Connecticut, dated and executed the 1st day of September, 1932 and subscribed the same in his presence and in the presence of Francis W. Cole and Winifred Camp and that I and said Francis W. Cole and Winifred Camp subscribed the same at his request; that said testator, Arthur T. Bissell, at the time of signing said will appeared to be of full age and of sound and disposing mind and memory and competent to make testamentary disposition of real and personal property; that he voluntarily signed said will and declared the same to be his last will and testament in the presence of myself and said Francis W. Cole and said Winifred Camp, the three subscribing witnesses.

(signed) John C. Parsons

Subscribed and sworn to this 7th day of February, 1942, before me

(signed) Margaret C. Hald, Notary Public (seal)

A true copy Attest: Clerk

DECREE ADMITTING WILL & ORDERS

At a Court of Probate holden at Vernon, in and for the District of Ellington, in the County of Tolland, State of Connecticut, on the 11th day of February A.D. 1942

Present, Hon. Francis T. O'Loughlin, Judge.

ESTATE OF ARTHUR T. BISSELL late of Vernon in said District, deceased.

Upon the application of Emily Bissell Swindells of Rockville praying that an instrument in writing purporting to be the last will and testament of said deceased be admitted to probate and that letters testomentary on said estate be granted as per application on file more fully appears;

This Court for cause shown, viz: that all parties known to be interested in said estate, other than the petitioner, and legally capable of acting, have signed and filed in Court a written waiver of notice, dispenses with notice of the pendency of said application, and of a hearing thereon.

After due hearing had, this Court finds that said deceased last dwelt and was domiciled in the town of Vernon in said District, and died testate on the 5th day of February A.D. 1942; that the instrument referred to in said application was duly executed by the testator as and for his last will and testament and that he was at the time of executing the same of lawful age and of sound mind and memory. It is therefore considered by this Court that said will is duly proved and the same is proved and approved. Whereupon letters testamentary on said estate are granted to Emily Bissell Swindells and Lebbeus F. Bissell who on the 11th day of February, 1942 appeared in Court, accepted said trust, and gave bond jointly with Aetna Casualty and Surety Company as surety in the penal sum of One Thousand (1,000) Dollars, which is accepted and approved by this Court and ordered to be recorded and kept on file. (Recorded in Vol. 7 of Bonds, page 273.)

ORDERED, That twelve months from the 11th day of February, 1942 be and the same are allowed the Executors within which to settle said estate.

ORDERED, That six months from the 11th day of February, 1942 be and the same are limited and allowed for the creditors to bring in their claims against said estate, and

(Continued over)

EXHIBIT Q 11-2

Fund 11-1.33

Frances Taylor Maxwell Memorial Fund

1400 mx 348

KNOW ALL MEN BY THESE PRESENTS:

THAT I, FLORENCE PARSONS MAXWELL, of the Town of Hartford, County of Hartford and State of Connecticut, do hereby make, publish and declare this to be as and for my last will and testament, hereby revoking all former wills, testaments and codicils heretofore by me made.

FIRST: I direct my executors hereinafter named to pay all my just debts and funeral expenses and all the expenses of settlement of my estate; and to pay as an administration expense all inheritance, succession, transfer and death taxes imposed by this or any other state, or by the United States, or by any foreign country, upon or with respect to any property required to be included in my gross estate for the purpose of computation of any such tax, without recovery or reimbursement either from the holders of any such property or from any legatee or devisee under this will.

SECOND: I give and bequeath to my daughters, PRISCILLA MAXWELL ENDICOTT of New York City, and HARRIET MAXWELL VEIASI of Hartford, Connecticut, all of my household furniture and furnishings, articles of personal and household use and adornment and all other tangible personal property that I may own at my decease, absolutely, to be delivered to them against their joint receipt.

THIRD: I give and bequeath to my grandson, MAXWELL HELDING of West Hartford, Connecticut the sum of Ten Thousand Dollars ($10,000.), absolutely. I request that he distribute or expend the same in accordance with a memorandum that I will leave with this my will, but I impose no duty upon him, legal or equitable, so to do.

FOURTH: I give and bequeath to my nephew, HERMAN PARSONS SMITH of Pascoedale, Rhode Island, the sum of Thirty Thousand Dollars ($30,000.), absolutely and in fee simple, but in trust, nevertheless, for the following uses and purposes, to wit:

To divide the same into two (2) equal shares, and

(a) To hold, manage and control one of said shares and after the payment of all necessary expenses, to apply so much of the income and/or principal of said shares for the support, education, maintenance and benefit of his son, STEWART SMITH, during the term of his natural life, as he in his sole discretion may deem proper, with power to add to the principal any income therefrom unexpended in any year or to hold the same as income for future expenditure. It is my wish that the beneficiary of this share be given the very best of care during his lifetime. Upon the death of said STEWART SMITH, I direct that whatever may remain of the principal of said share together with any accumulations thereon shall be added to the remaining share if his father be then living, or, if his father be not then living, paid over to his brother, ERIC COATES SMITH, free and clear of any and all trusts.

(b) To hold, manage and control the remaining share and after the payment of all necessary expenses, to pay over the net income thereof to himself during the term of his natural life. Upon the decease of my said nephew, I direct that this share with any additions thereto by reason of the provisions of this will and any accumulations thereon shall be paid over to his son, ERIC COATES SMITH, free and clear of any and all trusts.

I direct that said EMERSON PARSONS SMITH be excused from giving bonds as trustee of this trust and, in the event of his death, resignation or disability or that he should for any reason fail to qualify and act as trustee, that HARTFORD NATIONAL BANK AND TRUST COMPANY, a corporation under the National Bank Act located in the Town and County of Hartford and State of Connecticut, be appointed trustee in his place and stead with all the powers and discretion herein given to him.

FIFTH: I give and bequeath to my niece, MARY GRIST PARSONS of Jamestown, Rhode Island, the sum of One Thousand Dollars

($1,000.), absolutely.

SIXTH: I give and bequeath to my niece, ANN COULTER PARSONS of East Greenwich, Rhode Island, the sum of One Thousand Dollars ($1,000.), absolutely.

SEVENTH: I give and bequeath to my niece, MARGARET GRANT SMITH of Pawtucket, Rhode Island, the sum of One Thousand Dollars ($1,000.), absolutely.

EIGHTH: I give and bequeath to my niece, GERTRUDE SMITH PARSONS of Quincy, Massachusetts, the sum of One Thousand Dollars ($1,000.), absolutely.

NINTH: I give and bequeath to LLOYD S. HAYDEN of New Britain, Connecticut, the sum of One Thousand Dollars ($1,000.), absolutely.

TENTH: I give and bequeath to said HARTFORD NATIONAL BANK AND TRUST COMPANY the sum of Thirty-five Thousand Dollars ($35,000.), absolutely, but in trust, nevertheless, to hold, manage and control the same and after the payment of all necessary expenses including reasonable compensation to my said trustee to pay over the net income thereof not less often than quarterly to MARGARET SHINE, who has been in my employ for many years, during the term of her natural life, with power whenever in the sole judgment of my said trustee it may be necessary or desirable to use principal for her comfortable maintenance and support, to pay over, apply or expend so much of the principal as my said trustee in its sole discretion may deem proper for such purposes. After the death of said MARGARET SHINE said principal sum shall be paid over to the trustee of, and added to, the trust created by paragraph FOURTEENTH of my will of the residue of my estate.

ELEVENTH: I give and bequeath to my grandson, BRADFORD MAXWELL ENDICOTT of Dedham, Massachusetts, if living at the time of my death, the sum of Twenty Thousand Dollars ($20,000.), absolutely. In the event of his death prior to my own, I direct that said sum shall be paid over to his issue per stirpes; and if

he leave no such issue then surviving to his wife, BIRDIT CARSTENSEN MEDICOTT, absolutely.

TWELFTH: I give and bequeath to my granddaughter, PRISCILLA MEDICOTT MOULTON of Darien, Connecticut, if living at the time of my death, the sum of Twenty Thousand Dollars ($20,000.), absolutely. In the event of her death prior to my own, I direct that said sum shall be paid to her issue PER STIRPES; and if she leave no such issue then surviving to BRADFORD MAXWELL MEDICOTT, or, if he be not then living to his issue, absolutely.

THIRTEENTH: I give and bequeath to RUTH RUSSELL BELDING, wife of my grandson, MAXWELL BELDING of West Hartford, the sum of Five Thousand Dollars ($5,000.), absolutely.

FOURTEENTH: All the rest, residue and remainder of my estate of every name and nature, real and personal, including any lapsed or void legacies or devises and any property over which I may hold a power of appointment, I direct my executors hereinafter named to divide into six (6) equal shares:

(a) One (1) of said shares I give, devise and bequeath in equal portions to the children of my said grandson, MAXWELL BELDING, who shall be living at the time of my decease and to the issue of any child of his who shall then be deceased, the issue of any such deceased child to take the parent's share, absolutely; provided, however, that if any of said beneficiaries shall be under the age of twenty-one (21) years at my decease, then I direct that the portion of such beneficiary be retained by said HARTFORD NATIONAL BANK AND TRUST COMPANY, as trustee, and that the income and/or principal of such portion or so much thereof as my trustee shall determine be used in the discretion of my said trustee for the care, education, benefit and support of such beneficiary until such beneficiary shall attain the age of twenty-one (21) years, when all of such portion then in the

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hands of such trustee shall be paid over and delivered to him or to her.

(b) I give, devise and bequeath one (1) of said shares to said HARTFORD NATIONAL BANK AND TRUST COMPANY, absolutely and in fee simple, but in trust, nevertheless, to hold, manage and control the same and after the payment of all necessary expenses including reasonable compensation to my said trustee, to pay over, apply or expend for the benefit of my granddaughter, VIRGINIA BELDING, of the Town of Vernon, so much of the net income thereof as my said trustee shall in its sole discretion deem proper, with power whenever in the sole judgment of my said trustee it may be necessary or desirable to use the principal of said trust fund for the comfortable maintenance and support of my said granddaughter, to pay over, apply or expend so much of said principal as my said trustee in its sole discretion may deem proper for such purposes, and with power to add to the principal thereof any income therefrom unexpended in any year, or to retain the same as income for future expenditure. Upon the death of said VIRGINIA BELDING, I direct my said trustee to divide the principal of said trust fund into two equal portions. One (1) such portion shall be paid over to ROCKVILLE CITY HOSPITAL, an eleemosynary corporation of Connecticut located in Rockville, the principal to be kept safely invested and known as the FRANCIS TAYLOR HASWELL MEMORIAL FUND, and the net income only used for its general uses and purposes. The remaining portion shall be paid over to THE NEWINGTON HOME AND HOSPITAL FOR CRIPPLED CHILDREN, Newington, Connecticut, the principal to be kept safely invested and the net income only used for its general uses and purposes.

(c) I give, devise and bequeath two (2) of said shares to said HARTFORD NATIONAL BANK AND TRUST COMPANY, absolutely and in fee simple, but in trust, nevertheless, to hold, manage and control the same and after the payment of all necessary

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expenses including reasonable compensation to my said trustee, to pay over the net income thereof not less often than quarterly to my said daughter, PRISCILLA MAXWELL MEDICOTT, during the term of her natural life, with power whenever in the sole judgment of my said trustee it may be necessary or desirable to use the principal of said trust fund for the comfortable maintenance and support of my said daughter, to pay over, apply or expend so much of said principal as my said trustee in its sole discretion may deem proper for such purposes; and after her decease to distribute the same amongst one or more members of a class consisting of her lawful issue, in such proportions, with such limitations, and subject to such trusts and conditions as my said daughter may direct and appoint by any last will and testament duly executed by her. Said appointment shall not be deemed ineffectual because said last will and testament may make no specific reference to the power granted hereunder, or because said last will and testament may have been executed prior to the date hereof. In default of such appointment, such shares shall be divided among and paid over to the lawful issue of my said daughter equally, per stirpes and not per capita; and if there be no lawful issue of my said daughter then surviving, such shares shall be transferred and paid over to my issue then surviving equally, per stirpes; provided, however, that if any trust fund is then held under the provisions hereof for the benefit of any beneficiary to whom such distribution is to be made, the share to which such beneficiary would otherwise be entitled shall be added to such trust fund so held for such beneficiary as aforesaid, the fund so added to follow the disposition of the fund to which it is added in all respects, both as to income and as to principal.

(d) I give, devise and bequeath two (2) of said shares to said HARTFORD NATIONAL BANK AND TRUST COMPANY, absolutely and

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in fee simple, but in trust, nevertheless, to hold, manage and control the same and after the payment of all necessary expenses including reasonable compensation to my said trustee, to pay over the net income thereof not less often than quarterly to my said daughter, HARRIET MAXWELL VEISSI, during the term of her natural life, with power whenever in the sole judgment of my said trustee it may be necessary or desirable to use the principal of said trust fund for the comfortable maintenance and support of my said daughter, to pay over, apply or expend so much of said principal as my said trustee in its sole discretion may deem proper for such purposes. Upon the death of said HARRIET MAXWELL VEISSI, I direct that the principal of said trust fund shall be paid over to such corporation or corporations organized under the laws of the State of Connecticut and operated exclusively for religious, charitable, scientific, literary or educational purposes, no part of the net earnings of which inures to the benefit of any private stockholder or individual and no substantial part of the activities of which is carrying on propaganda or otherwise attempting to influence legislation, as she may by will appoint; and in default of such appointment my trustee shall divide such principal into two (2) equal portions and pay over one (1) of said portions to HARTFORD HOSPITAL, an eleemosynary corporation of Connecticut, the principal to be kept safely invested and known as the FRANCIS TAYLOR MAXWELL MEMORIAL FUND and the net income only used for its general uses and purposes; and my said trustee shall continue to hold the remaining portion in trust for the public charitable uses and upon the terms and conditions contained and expressed in the resolution and declaration heretofore adopted by the Board of Directors of said Hartford National Bank and Trust Company, creating THE HARTFORD FOUNDATION FOR PUBLIC GIVING and all the provisions thereof are hereby incorporated herein.

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FIFTEENTH: Where in this will it is provided that any trust estate be divided into separate shares or trusts to be administered for the benefit of two (2) or more beneficiaries the trustee may, nevertheless, for the purpose of management or investment, treat the entire estate, or some portions thereof, as a whole, with each beneficiary having an undivided interest therein; provided that where in such case distribution is required to be made to one beneficiary prior to the time distribution is made to another, the trustee may distribute to such beneficiary his or her proportionate part of said trust from any part of the entire trust estate, taking into consideration the value at that time of the trust property and any advancement or underpayment therefrom received by the beneficiary to whom distribution is thus made.

During the continuance of any trust herein created I authorize my said trustee to retain, sell, convey and transfer real and personal estate, and to invest and reinvest in any securities (including common stocks and any common trust fund held by my trustee) or property that such trustee in its or his or her discretion may deem proper, without regard to laws governing the investment of trust funds, and to determine and vary from time to time the proportion of the trusts to be invested in evidences of debt and the proportion thereof in equities or other property; to exercise any right or option of subscription or otherwise attached to or which at any time may belong or be given to the holders of any stocks, bonds, securities or other instruments in the nature thereof forming part of the trust estate; to give proxies to vote shares of stock in any corporation at any time held in said estate; to unite with other owners of property or securities similar to any which may be held at any time in the estate in carrying out any plan for the

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consolidation, merger, dissolution, liquidation, foreclosure, lease or sale of the property of any corporation, company or association, the securities of which may form a portion of these trusts, or the incorporation, reincorporation or reorganization thereof, or the readjustment of the capital or financial structure thereof; to deposit any such securities in accordance with such plan; to pay any assessments, expenses and sums of money which it may deem expedient or which may be required with reference to any such plan; to register and hold securities or other property in the name of a nominee provided such nominee is the nominee of a corporate trustee hereunder or in the name of such corporate trustee as trustee, without further designation, or in the name of such corporate trustee individually, without any words indicating its fiduciary capacity, without liability other than for any loss which may result from such securities or other property being registered or held in such manner instead of in its name as trustee of these trusts; to execute leases on the whole or any portion of any property held in such trusts for such period of time as the trustee may deem for the best interests of said estate, even though the term of such lease may extend beyond the life of said trusts; to improve and develop any real estate at any time held in said trusts; to borrow money and to mortgage, pledge or hypothecate any real or personal property in any trust as security therefor; to abandon, adjust, arbitrate, compromise and otherwise deal with and settle claims in favor of or against the trust estate; to retain, without liability for loss or depreciation resulting from such retention, original property, real or personal, at any time received by it from my executors hereinafter named for such time as such trustee shall deem best, although such property may not be of the character prescribed by law, or by the terms of this instrument, for the investment of other trust funds, and although it represents a large percentage of the total property of this

estate; and if non-income producing property is retained, then upon the sale, exchange or other disposition of such property, to make a reasonable apportionment of the proceeds between income and principal so as to make up for the loss of income during the period of retention of the unproductive property; to set up such reserves for depreciation or other purposes as such trustee in its or his or her judgment may deem advisable for the protection of any trust (but the omission so to do shall not be evidence of neglect on the part of the trustee); to determine what receipts shall be deemed to be principal and what shall be income and what disbursements shall be charged to each and in what proportions; to make any divisions necessary or convenient hereunder and any valuations incidental thereto; and to apply income for the benefit of any beneficiary in lieu of paying the same over to him or to her. Whenever any portion of said estate is to be divided and paid over, such payments may be made in property or in cash or partly in each at the trustee's discretion. Each trustee may employ and compensate, out of the principal or income of the trust estate as it or my individual trustees shall deem proper, agents, brokers, attorneys and assistants deemed by it or my individual trustees to be necessary or proper for the administration of any trust. The trustee shall pay to the beneficiary entitled to the next successive estate dividends declared but not paid and interest or other income accrued but not received. If any beneficiary shall be under the age of twenty-one (21) years at the time when an outright distribution to such beneficiary is authorized and directed under the terms of this will, then I request, that the part of such beneficiary be retained by my trustee and that the income and/or principal of such part (or such portion thereof as my trustee shall determine) be used in the discretion of my said trustee for the care, education, benefit and support of such

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beneficiary until such beneficiary attains the age of twenty-one (21) years when all of the part of such beneficiary then in the hands of such trustee shall be paid and delivered to such beneficiary.

SIXTEENTH: In the event that any devisee, legatee or beneficiary under this will shall disclaim in whole or in part any interest given to him by the terms hereof, then I direct that such interest or so much thereof as such devisee, legatee or beneficiary shall have disclaimed shall pass forthwith to those persons or institutions who would have been entitled to receive the same if the devisee, legatee or beneficiary filing such disclaimer had died on the date of such disclaimer.

SEVENTEENTH: I hereby constitute and appoint said HARTFORD NATIONAL BANK AND TRUST COMPANY, my said daughter, HARRIET MAXWELL VEISSI, and my said grandson, MAXWELL BELDING, to be executors of this my will, with power of sale of real and personal property and to borrow money and to mortgage, pledge or hypothecate any real or personal property in my estate as security therefor, and to abandon, adjust, arbitrate, compromise and otherwise deal with and settle claims in favor of or against the estate as they shall deem best. I authorize them to pay any pecuniary amounts hereunder in property or securities at their own valuations, or partly in property and partly in cash. I direct that so far as is legally possible my individual executors be excused from giving bonds in connection with the administration of my estate and I authorize them or either of them at any time and from time to time to empower said HARTFORD NATIONAL BANK AND TRUST COMPANY to act, sign and seal for them as such executors.

In the event of the death, resignation or disability of either or both of my individual executors, or that they or either of them should for any reason fail to qualify and act as

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such executors, then I direct that the remaining executor or executors named herein act with all the powers and discretion hereinbefore given to all.

IN WITNESS WHEREOF, I have hereunto set my hand and seal at Hartford, Connecticut this 24 day of December

A. D. 1956.

Florence Parsons Maxwell (L.S.)

Signed, sealed, published and declared to be as and for her last will and testament by the above named testatrix, FLORENCE PARSONS MAXWELL, in our presence who in her presence and in the presence of each other and at her request have hereunto subscribed our names as attesting witnesses at Hartford aforesaid this 24th day of February A. D. 1956.

Name	Residence
Sylvia J. Dietz	Hartford Conn
Joan V. Horan	Hartford Conn.
Helen W. Gerson	Hartford, Conn

STATE OF CONNECTICUT }
COUNTY OF HARTFORD } ss.: Hartford, February 24, 1956

The within named Sylvia J. Dietz, Joan V. Horan and Helen W. Gerson, being duly sworn, depose and say that they witnessed the within will of the within named testatrix, FLORENCE PARSONS MAXWELL, and subscribed the same in her presence and at her request and in the presence of each other; that the said FLORENCE PARSONS MAXWELL at the time of the execution of said will appeared to them to be of full age and of sound mind and memory; that she signed said will and declared the same to be her last will and testament in their presence; and that they make this affidavit at the request of said testatrix.

Sylvia J. Dietz
Joan V. Horan
Helen W. Gerson

Subscribed and sworn to at the request of the within named testatrix, FLORENCE PARSONS MAXWELL, the day and year first above written, before me,

[signature]
Notary Public

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KNOW ALL MEN BY THESE PRESENTS:

THAT I, FLORENCE PARSONS MAXWELL, of the Town of Hartford, County of Hartford, and State of Connecticut, do make, publish and declare this to be as and for a first codicil to my last will and testament heretofore made by me and dated February 24, 1956.

FIRST: I hereby revoke Article SEVENTEENTH of my said will and in place thereof, my will is as follows:

"SEVENTEENTH: I hereby constitute and appoint said HARTFORD NATIONAL BANK AND TRUST COMPANY, to be executor of this my will, with power of sale of real and personal property and to borrow money and to mortgage, pledge or hypothecate any real or personal property in my estate as security therefor, and to abandon, adjust, arbitrate, compromise and otherwise deal with and settle claims in favor of or against the estate as it shall deem best. I authorize it to pay any pecuniary amounts hereunder in property or securities at its own valuations, or partly in property and partly in cash. I authorize my said executor to exercise the same powers whether acting as executor or trustee."

SECOND: As altered by this codicil I hereby republish and confirm my said will in all respects.

IN WITNESS WHEREOF, I have hereunto set my hand and seal at Hartford, Connecticut this [illegible] day of April, A. D. 1959.

Florence Parsons Maxwell

Signed, sealed, published and declared to be as and for a first codicil to her last will and testament by the above named testatrix, FLORENCE PARSONS MAXWELL, in our presence who in her presence and in the presence of each other and at her request

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have hereunto subscribed our names as attesting witnesses at Hartford aforesaid this 9th day of April, A. D. 1959.

Name	Residence
Lillian M. Stone	West Hartford, Conn.
Marion C. Sachaklian	West Hartford, Conn.
George H. Day	Farmington, Conn.

PROVED, APPROVED and ADMITTED to PROBATE THIS 3rd DAY of October 1964

JUDGE

STATE OF CONNECTICUT, DISTRICT OF HARTFORD, } ss.

Probate Court, Town of Hartford.
October 19, 1964.

Then and there personally appeared the within named George H. Day who being duly sworn depose and say that he witnessed the execution of the within and of the within named testatrix; codicil dated April 9, 1959, of the Florence Parsons Maxwell; that said Florence Parsons Maxwell subscribed said codicil to said will, a codicil to said will and testament in his presence—and in the presence of Lillian M. Stone and Marion C. Sachaklian—that said George H. Day and Lillian M. Stone and Marion C. Sachaklian thereafter subscribed the same as witnesses in the presence of said testatrix and in the presence of each other and at the request of said testatrix; that the said testatrix at the time of the execution of said codicil appeared to him to be of full age and of sound mind and memory and competent in every respect to make a codicil; and that he makes this affidavit—after the decease of said testatrix at the request of Hartford National Bank and Trust Company, named—assessor of the will of said testatrix.

Dated this 19th day of October, 1964

George H. Day

Subscribed and sworn to the day and year above written before me,

PROVED, APPROVED and ADMITTED to PROBATE THIS 30th DAY of October, 1964

Elizabeth K. Colman

Judge—Assistant Clerk
Commissioner of the Superior Court—Notary Public

JUDGE

EXHIBIT Q 11-2

Fund 11-1.34

Stephen Goodale and Emeret Scott Risley Fund

DISTRICT OF ELLINGTON

(Continued from Page 361 - Estate of May Risley Adams)

The undersigned being with the petitioner all the heirs-at-law and next of kin of said deceased, accept service and waive notice of the pendency of the foregoing application and of the time and place set for hearing thereon.
(signed) Gertrude S. Colburn

A true copy Attest: Elsie M. Neff Clerk

LAST WILL AND TESTAMENT

I, MAY RISLEY ADAMS of the Town of Vernon, County of Tolland and State of Connecticut, being of lawful age, of sound and disposing mind, memory and judgment, do hereby make, publish and declare this to be my last Will and Testament, hereby revoking all previous wills and codicils by me made.

FIRST: I direct that all my just debts and funeral expenses be paid and discharged by my Executor hereinafter named.

SECOND: I direct my Executor hereinafter named to cause the headstone, placed at my grave in the Stephen G. Risley lot in the Grove Hill Cemetery, in said Town of Vernon, to be suitable inscribed as follows: "May R. Adams", and to inscribe on the monument on the said Stephen G. Risley lot, the date of my death and my age. I further direct my said Executor to cause the words "Perpetual Care" to be suitable cut on the monument on said lot.

THIRD: I give and bequeath unto the TOWN OF VERNON the sum of One Thousand Dollars, IN TRUST, However, to hold and manage the same with full power of investment and reinvestment and to apply the net income thereof to the proper care and maintenance of the Stephen G. Risley lot in the grounds of said Cemetery, including the preservation and repair of the monument, grave markers and other structures thereon. Should the net income be more than sufficient for the purposes aforesaid, any excess may be used for the care and maintenance of the John Wrisley lot which is situated directly opposite the said Stephen G. Risley lot.

FOURTH: I give and bequeath unto MARION L. BUTLER of Rockville, Connecticut, the sum of Two Thousand Dollars; to be hers, absolutely.

FIFTH: I give and bequeath unto EMILY BISSELL SWINDELLS of said Rockville, the sum of Two Thousand Dollars; to be hers, absolutely.

SIXTH: I give and bequeath unto the UNION CONGREGATIONAL CHURCH of said Rockville, the sum of One Thousand Dollars, for the establishment of a fund to be known as the May R. and Frank M. Adams Fund, the income thereof to be used for the general uses and purposes of said Church.

SEVENTH: I give and bequeath unto said UNION CONGREGATIONAL CHURCH, the sum of Five Hundred Dollars, in memory of Esther Langdon Adams (mother of Frank Mark Adams), for the establishment of a fund to be known as the Esther Langdon Adams Fund, the income thereof to be used for the general uses and purposes of said Church.

EIGHTH: I give and bequeath unto the ST. JOHN'S EPISCOPAL CHURCH of said Rockville, the sum of One Thousand Dollars, for the establishment of a fund to be known as the May R. And Frank M. Adams Fund, the income thereof to be used for the general uses and purposes of said Church.

NINTH: I give and bequeath unto THE ROCKVILLE CITY HOSPITAL, INC. of said Rockville, the sum of Ten Thousand Dollars, in memory of my father and mother, Stephen Goodale Risley, M.D. and Emeret Scott Risley, for the establishment of a fund to be known as the Stephen Goodale Risley and Emeret Scott Risley Fund, the income thereof to be used for the general uses and purposes of said Hospital; together with the diploma of my late father, Stephen Goodale Risley, M.D., and my John Hamilton clock, made in Glasgow, Scotland, before 1720.

TENTH: I give and bequeath unto my second cousin MISS LENA EUNEGIA McINTOSH (daughter of Ethan and Lottie McIntosh), of East Longmeadow, Massachusetts, if living at the time of my death, the sum of Five Hundred Dollars, absolutely.

ELEVENTH: I give and bequeath unto my second cousin ELIZABETH ADAMS JENKS WALTER of 4 Orchard Street, Adams, Massachusetts (daughter of Mr. and Mr. Edwin Jenks and widow of Ellery Walter), if living at the time of my death, the sum of One Thousand Dollars, absolutely.

TWELFTH: I give and bequeath unto IDA ZAHNER of said Rockville, if she is in my employ at the time of my death, or in the event that she is not in my employ at the time of my death, then only in the event that she was forced and obliged to leave my employby reason of her own sickness, the sum of Twenty-five Thousand Dollars; together with my "Corona Zephyr" typewriter with the green cover, one of my radios whichever she may choose, and twelve silver teaspoons marked "R"; to be hers, absolutely.

THIRTEENTH: I give and bequeath unto THE ROCKVILLE PUBLIC LIBRARY of said Rockville, the sum of Two Thousand Dollars, in order that said Library may purchase new books for the use of said Library. All books purchased from either the income or principal, or both, or said sum shall be marked and labelled "Risley-Adams Fund".

THIRTEENTH: I give and bequeath unto CORINNE SYKES SPENCER of said Rockville, the sum of Five Hundred Dollars; to be hers, absolutely.

FOURTEENTH: I give and bequeath unto my goddaughter MISS JOSEPHINE STUART ADAMS of 66 Sorrento Street, Springfield, Massachusetts, (Half-sister of Frank Mark Adams) the sum of Five Thousand Dollars; to be hers, absolutely.

FIFTEENTH: I give and bequeath unto my first cousin GERTRUDE S. COLBURN of 2 Sagamore Street, Lynn, Massachusetts, the sum of Five Thousand Dollars; to be hers, absolutely.

SIXTEENTH: I give and bequeath unto my second cousin MISS MILDRED COLBURN of 2 Sagamore Street, Lynn, Massachusetts, (daughter of my cousin, Mrs. Clifton Colburn) the sum of Five Thousand Dollars; to be hers, absolutely.

SEVENTEENTH: I give and bequeath unto MRS. FRANCIS L. BURDICK of Esterdale Farm. Hampton, Virginia, the sum of One Hundred Dollars; to be hers, absolutely.

EIGHTEENTH: I give and bequeath unto SARAH M. HAMMOND of said Rockville, the sum of Five Hundred Dollars; to be hers, absolutely.

NINETEENTH: I give and bequeath unto said MARION L. BUTLER and EMILY BISSELL SWINDELLS, or to the survivor of them, all of my household furniture, furnishings, linen, silver and plate, glassware and crockery, pictures, books, bric-a-brac and fixtures, including all household implements and effects used in or about my home at 38 Park Street, in said Rockville, not hereinbefore specifically bequeathed, together with all my articles of wearing apparel and clothing, and all my articles of jewelry; to be theirs, absolutely. Without intending to qualify the absolutely character of this bequest, I hereby express the hope that they will distribute those of said articles, in such manner, as I may indicate by a written memorandum which I have prepared and left with this my Last Will and Testament in my safe deposit box duly addressed to said Marion L. Butler and Emily Bissell Swindells.

(Continued over)

DISTRICT OF ELLINGTON

(Continued from Page 326 - Estate of May Risley Adams)

TWENTIETH: It is my express wish and desire that said MARION L. BUTLER and EMILY BISSELL SWINDELLS take charge of my home and personal affairs, under the supervision and direction of my Executor, until such time as distribution of my estate is made inaccordance with the terms of this my last Will and Testament.

TWENTY-FIRST: All the rest, residue and remainder of all my property, of every description, both real and personal, of whatsoever the same may consist or wheresoever it may be situated, I give, devise and bequeath unto said THE ROCKVILLE CITY HOSPITAL, INC., in order that the same may be added to and become a part of the Stephen Goodale Risley and Emeret Scott Risley Fund, which is established in paragraph Ninth of this my last Will and Testament.

TWENTY-SECOND: In the event that any bequests or legacies under the terms of this will, other than that provided for in the residuary clause of this will, shall for any reason lapse or fail to take effect, it is my wish that the same become a part of the rest, residue and remainder of my estate and be distributed in accordance with the terms of Paragraph Twenty-first of my will.

TWENTY-THIRD: If my estate shall prove to be insufficient to permit the payment of all legacies in full, I direct that the legacies to MARION L. BUTLER, EMILY BISSELL SWINDELLS, ST. JOHN'S EPISCOPAL CHURCH and IDA ZAHNER, in Paragraphs Fourth, Fifth, Eighth, and Twelfth, respectively, of this my last Will and Testament, shall have a preference and be paid in full prior to the payment in part or in full of any other legacy in favor of any other legatee herein enumerated.

TWENTY-FOURTH: I direct that all succession, inheritance and transfer taxes which would be payable on account of the legacies provided in this will, shall be paid out of the residue of my estate so that said several legacies shall be net for their full amount to the said several legatees.

I Appoint DONALD C. FISK of the Town of Ellington, Connecticut, to be the Executor of my Last Will and Testament, and I authorize and empower him to sell and convey any real estate or interest therein that I may own at my decease. In the event of his death prior to my own, or his inability to serve as such Executor, then I appoint THE HARTFORD-CONNECTICUT TRUST COMPANY, ROCKVILLE BRANCH, of said Rockville, to be such Executor, with like authority to sell and convey real estate.

IN WITNESS WHEREOF, I have hereunto set my hand and seal at said Rockville, on the 26th day of February, A.D. One Thousand Nine Hundred and Forty-four.

(signed) May Risley Adams (L.S.)

Signed, sealed, published and declared by the said MAY RISLEY ADAMS, as and for her Last Will and Testament, in presence of us, who at her request, in her presence, and in the presence of each other have hereunto subscribed our names as witnesses, on t he 26th day of February, A.D. 1944.

(signed) Mary B. Lippincott)
(signed) Mary A. Whittlesey) Witnesses
(signed) Roy C. Ferguson M.D.)

STATE OF CONNECTICUT)
) ss. Vernon February 26th, A.D. 1944.
COUNTY OF TOLLAND)

We the within named Mary B. Lippincott, Mary A. Whittlesey and Roy C. Ferguson, M.D., all of said Town of Vernon, being duly sworn, make affidavit and say: That we severally attested the within and foregoing Will of the within named testatrix and subscribed the same in her presence and at her request and in the presence of each other; that the said testatrix signed, published and declared the said instrument as and for her last Will and Testament in our presence on the 26th day of February, A.D. 1944; and at the time of execution of said will, said testatrix was more than eighteen years of age and of sound mind, memory and judgment and under no improper influence or restraint to the best of our knowledge and belief, and we make this affidavit at the request of said testatrix.

(signed) Mary B. Lippincott
(signed) Mary A. Whittlesey
(signed) Roy C. Ferguson, MD.

STATE OF CONNECTICUT)
) ss. Vernon February 26th, A.D. 1944
COUNTY OF TOLLAND)

Then personally appeared before me a notary public duly qualified to administer oaths
Mary B. Lippincott
Mary A. Whittlesey
and Roy C. Ferguson, M.D.
and subscribed and made oath to the truth of the foregoing affidavit.

(signed) Jane Pereszewska, Notary Public (seal)

A true copy Attest: Clerk

DECREE ADMITTING WILL & ORDERS

At a Court of Probate holden at Vernon, in and for the District of Ellington, in the County of Tolland, State of Connecticut, on the 2nd day of September, A.D. 1949.

Present, Hon. Thomas F. Rady, Judge.

ESTATE OF MAY RISLEY ADAMS or MAY R. ADAMS, late of Vernon in said District, deceased.

Upon the application of Gertrude S. Colburn of Lynn, Mass. praying that an instrument in writing purporting to be the last will and testament of said deceased be admitted to probate and that letters testamentary on said estate be granted as per application on file more fully appears;

This Court for cause shown, viz: that all parties known to be interested in said estate consist of the petitioner who is legally capable of acting, have signed and filed in Court a written waiver of notice, dispenses with notice of the pendency of said application, and of a hearing thereon.

After due hearing had, this Court further finds that said deceased last dwelt and was domiciled in the town of Vernon in said District, and died testate on the 28th day of August, A.D. 1949; that the instrument referred to in said application was duly executed by the testator as and for her last will and testament and that she was at the time of executing the same of lawful age and of sound mind and memory. It is therefore considered by this Court that said will is duly proved and the same is proved and approved. Whereupon letters testamentary on said estate are granted to Donald C. Fisk who on the 2nd day of September, 1949 appeared in Court, accepted said trust, and gave bond jointly

(Continued over)

ECHN Proposed Asset Purchase by PMH
Submitted October 13, 2015

EXHIBIT Q 11-2

Fund 11-1.35

United German Society Fund

File

ROCKVILLE CITY HOSPITAL

Source and Terms of Funds Held

Alvah N. Bolding Fund #73041 - Bequest u/w Alvah N. Bolding - Permanent Endowment - Income for general purposes.

Terms of Will - "To be used and expended for the purposes indicated in the Will of William H. Prescott, as they may deem most advisable."

Alice Farmer Bissell Fund #73051 - Bequest under the Will of Arthur T. Bissell - Permanent Endowment - Income for general purposes.

Terms of Will - Fourth: I give and bequeath to the Rockville City Hospital the sum of Twenty-five Thousand Dollars ($25,000) to be kept as a permanent fund in memory of my wife, Alice Farmer Bissell, and to be known as the Alice Farmer Bissell Fund. The net income from said fund shall be used and applied for the general purposes of said Hospital.

Ruth T. Britton Fund #73061 - Bequest u/w Ruth Talcott Britton - Permanent Endowment - Income for general purposes.

Terms of Will - "in trust to keep said sum safely invested, and to use and apply the income for the general purposes of said Hospital at the discretion of its trustees."

Consolidated Fund #73081 - This fund represents all bequests of $3,000 or less left with no instructions as to use. Principal is considered permanent endowment - Income is used for general expenses of the Hospital.

George S. Doane Fund #73101 - No record found of source of this fund. Principal is considered permanent endowment - all income is used for expenses of the Hospital.

General Fund #73121 - This fund represents small gifts and bequests which were unrestricted as to use of principal or income. Principal is considered unrestricted - Income is used for general expenses of the Hospital.

Lenore Henry Fund #73141 - Bequest u/w E. Stevens Henry - Permanent endowment - Income for general purposes.

Terms of Will - Ninth: I give and bequeath to the Hospital to be established in Rockville under the provisions of the Will of the late William H. Prescott to be known as the "Rockville City Hospital." This bequest is to constitute a special endowment fund of Fifty Thousand Dollars ($50,000) to be set apart and known as the Maud Henry Fund in memory of my deceased daughter, Maud. I likewise give and bequeath Fifty Thousand Dollars ($50,000) to said Hospital also to be set apart as a separate endowment fund and known as the "Lenore Henry" Fund in memory of my deceased daughter, Lenore. The income of these two funds is to be used for the maintenance of said Hospital. My Executors are directed to provide for this fund by selecting and transferring from my estate to trustees or duly authorized agent of said Hospital certain bonds or savings bank deposits of the par value of One Hundred Thousand Dollars ($100,000), and I further direct that whenever reinvestments become necessary or advisable such reinvestments shall be limited and confined to securities legal for savings banks of Connecticut or in deposits in savings banks.

Maud Henry Fund #73161 - Bequest u/w E. Stevens Henry - Permanent endowment - Income for general purposes. (For terms of will, see Lenore Henry Fund)

J. Alice Maxwell Fund #73171 - Bequest u/w J. Alice Maxwell - Permanent endowment - Income for general purposes.

> Terms of Will - NINTH: To ROCKVILLE CITY HOSPITAL, in Rockville, Connecticut, I give, devise and bequeath four of said equal parts of my said residuary estate in trust to use the income thereof for the general purposes of the said Hospital.

John and Martha Kress Fund #73181 - Bequest under will of Martha Kress - This fund was left for a special purpose. In accordance with the instructions of the Board of Trustees of the Hospital, income accumulates and is transferred to principal for reinvestment.

> Terms of Will - "To be used for the purpose of equipping, furnishing, and maintaining a room in said Hospital to be known and called the "John and Martha Kress Room".

Edgar Keney Fund #73201 - No record found of source of this fund. It is believed to have been left for a special purpose. In accordance with the instructions of the Board of Trustees of the Hospital, income accumulates and is transferred to principal for reinvestment.

Francis T. Maxwell Fund #73211 - This fund is considered permanent endowment. Income is used for general purposes. The fund consists of the proceeds of a $50,000 life insurance policy on the life of Francis T. Maxwell, plus gifts by Mr. Maxwell during his life of 50 shares Phoenix Insurance Company and 200 shares Hartford Gas Company. These gifts of stock were restricted to use of income for general purposes and principal to be used only toward a new hospital.

Harriet K. Maxwell Fund #73221 - Bequest under will of Harriet K. Maxwell - outright legacy - income is used for general expenses of the Hospital.

> Terms of Will - Third: "----and unto the Rockville City Hospital of Rockville, Connecticut, the sum of Five Thousand Dollars ($5,000)

Robert Maxwell Fund #73241 - Bequest u/w Robert Maxwell - outright legacy - income is used for general expenses of the Hospital. (The will gave discretion to executors to devote sum of $100,000 "in such manner as they may deem suitable for the benefit of said residents of Rockville and vicinity". One Hundred Thousand Dollars ($100,000) was paid to Rockville City Hospital per final account of executors.)

William A. and Caroline E. Metcalf Fund #73251 - Bequest u/w Caroline E. Steele Metcalf - Permanent endowment - Income for general purposes.

> Terms of Will - NINTH: All the rest, residue and remainder of my estate, of whatsoever nature and whereesoever situated, I give, bequeath and devise to the Trustees of The Rockville City Hospital, Inc., a charitable corporation organized and existing under the laws of the State of Connecticut, and owning and operating a hospital in said Town of Vernon, in trust, nevertheless, to hold invest and reinvest the same and to use the income thereof for the general uses and purposes of said Hospital as said Trustees shall see fit. Said trust shall be known as the William S. and Caroline E. Metcalf Fund.

William Maxwell Fund #73261 - This fund consists of the following:

Cash gifts by Mr. Maxwell during 1936 to 1938	$14,000.00
Proceeds of life insurance (1939)	61,472.99
Request under 14th clause of will	96,246.01
	$171,719.00

Terms of Will - FOURTEENTH: To ROCKVILLE CITY HOSPITAL, in Rockville, Connecticut, I give, devise and bequeath four of said equal parts of my said residuary estate in trust to use the income thereof for the general purposes of said Hospital.

Charles Phelps Free Bed Fund #73271 - Gift of $10,000 from Mrs. Elsie S. Phelps - Permanent endowment - Income for special purposes. Any amount of this fund in excess of $10,000 represents accumulated income and is considered available if necessary.

Terms of Gift

"1. For the benefit of any members of my household staff or their families who may be in need of the services which the fund can provide.

2. For the general use and benefit of the residents of the City of Rockville.

The fund, aside from the small conditions which I wish to impose for the benefit of my household staff, which will fall within the income limitations of the fund, will be managed by the Board of Trustees and Finance Committee of The Rockville City Hospital with full powers of sale, investment and reinvestment."

Celia E. Prescott Fund #73281 - This fund was left for a special purpose. In accordance with the instructions of the Board of Trustees of the Hospital, income accumulates and is transferred to principal for reinvestment.

Terms of Gift

$10,000. for free bed in honor of Francis and Eliza Porter Keeney
$ 5,000. for free bed in memory of Francis Keney Prescott
$ 400. for furnishing a room in memory of Jane E. Newcomb

George Palmer Charter Fund #73291 - Bequest under Second and Seventeenth Clauses of Will of George Palmer Charter - permanent endowment - income for general purposes.

Terms of Will

SECOND

I give and bequeath to the Rockville City Hospital, located in the city of Rockville, State of Connecticut, the sum of Ten Thousand (10,000) dollars, in trust, however, for the following uses and purposes, namely: The governing body of said hospital shall invest said sum of $10,000 and the annual income of said sum shall be used for the general maintenance of said Hospital.

George Palmer Charter Fund #73291 continued

SEVENTEENTH

All the rest, residue and remainder of my estate, of whatsoever nature and wheresoever situated which I may own or have the right to dispose of at the time of my decease, I give, devise and bequeath in equal proportions, share and share alike to the Rockville City Hospital located in the city of Rockville, State of Connecticut, and to the Cyril and Julia C. Johnson Memorial Hospital, Inc. located at Stafford Springs, State of Connecticut, in trust each of said hospitals shall invest the sums derived under this Article of my last Will and Testament and the annual income of said sums shall be used for the general maintenance of each of said hospitals.

William H. Prescott Fund #73301 - Bequest u/w William H. Prescott. Permanent endowment - income for general purposes.

Terms of Will -

"13. I give and bequeath to Francis T. Maxwell, Arthur T. Bissell, J. Alice Maxwell, A. N. Belding and Thomas W. Sykes, all of Rockville, Connecticut, the sum of Fifty Thousand Dollars ($50,000) in perpetual trust to them and their successors in office, for the purpose of establishing and maintaining at said city of Rockville, a general hospital for the sick, to be open and available to all residents of the said City of Rockville, and of such portion of the immediate vicinity thereof contiguous and adjacent thereto, as in the judgment of said Board of Trustees may be deemed wise and advisable, subject to such rules and regulations concerning admission to said hospital as said trustees and their successors in office may, from time to time, establish.

Said trustees and their successors in office shall have power to receive property by gift or otherwise, and to purchase land and erect buildings for the purpose of carrying out the provisions of this trust.

The general management and oversight of said hospital, including the character and method of treatment therein to be established, shall be vested wholly in said Board of Trustees and their successors in office..

Said Board may elect a President, Vice-President, Secretary and Treasurer, and such other executive officers as they may deem necessary or advisable to carry out the purpose of this trust, including a superintendent of said institution. All vacancies in said Board arising from any cause, shall be filled by appointment of the surviving trustees.

William H. Prescott Fund #73301-continued

Terms of Will-continued

> The Board of Trustees shall have power, from time to time, to make by-laws defining the duties of said officers and superintendent, the method of calling meetings of the Trustees and other by-laws relative to the management and government of the same. Provided, however, that, if at any time before my decease, I shall make provision for the transfer of the sum of fifty thousand dollars ($50,000) to the above named, as trustees for the purpose of inaugurating the establishment of a City Hospital, thereby substantially carrying out the provisions of this paragraph of my will, then and in that event, I revoke this paragraph of the same relating to said Hospital, and declare it inoperative, but otherwise to remain in full force and effect."

(1949)

Stephen Goodale Risley and Emeret Scott Risley Fund #73311 - Bequest u/ Ninth and Twenty-first clauses of Will of May H. Adams - permanent endowment - income for general purposes.

Terms of Will

> "NINTH: I give and bequeath unto THE ROCKVILLE CITY HOSPITAL, INC. of said Rockville, the sum of Ten Thousand Dollars, in memory of my father and mother, Stephen Goodale Risley, M.D. and Emeret Scott Risley, for the establishment of a fund to be known as the Stephen Goodale Risley and Emeret Scott Risley Fund, the income thereof to be used for the general uses and purposes of said Hospital."
>
> "TWENTY-FIRST: All the rest, residue and remainder of all my property, of every description, both real and personal, of whatsoever the same may consist or wheresoever it may be situated, I give, devise and bequeath unto said THE ROCKVILLE CITY HOSPITAL, INC. in order that the same may be added to and become a part of the Stephen Goodale Risley and Emeret Scott Risley Fund, which is established in Paragraph Ninth of this my last Will and Testament."

($79,688.80)

Rockville Chapter American Red Cross Fund #73321 - Gift from Rockville Chapter of American Red Cross - considered permanent endowment - income is used for general expenses of the Hospital.

William B. and Lizzie Lathrop Sprague Fund #73341 - Bequest u/w Lizzie Lathrop Sprague - considered permanent endowment - income is used for general expenses of the Hospital.

Terms of Will

> "--to be known as the William B. and Lizzie Lathrop Sprague Fund"

Swindells Fund #73351 - This fund represents donations received from the Swindells Foundation. Income and/or principal may be used for care of deserving persons or used for general hospital expenses. Surplus income is transferred to principal.

Fred Talcott Fund #73361 - Bequest u/w Fred Talcott - considered permanent endowment - income for general purposes.

Terms of Will

"SIXTEENTH: Whereas one William H. Prescott of said Rockville, now deceased, in and by his will bequeathed a large sum of money towards the support and maintenance of a hospital to be thereafterwards established in said Rockville, and it is my desire to make a contribution towards the erection and establishment of such hospital. I give and bequeath to the persons who at the time of my decease may be the custodians of the said fund, bequeathed as aforesaid by said Prescott, the sum of five thousand dollars to be used by them or their successors in such trust towards the erection and establishment of such hospital."

"TWENTIETH:——Upon the decease of the last survivor of the aforesaid beneficiaries under this trust I direct that one-half part of all the trust estate and property then remaining in the hands of my said trustee be by it made over to the persons mentioned in the sixteenth clause of this my will as the custodians of the William H. Prescott Fund, or to the persons who at the termination of this trust may be such custodians, to be applied towards the establishment of the hospital in said Rockville proposed or contemplated in the will of said Prescott, but if such hospital shall then be already established then said one-half of said trust estate and property shall be by said trustee made over to such hospital to be used by it for its uses and purposes."

Trumbull Chapter, D.A.R. Fund #73301 - Gift from Trumbull Chapter, D.A.R. - considered permanent endowment - income to be used for free bed, Sabra Trumbull Daughters to have preference, or any deserving person, to be decided by Hospital Trustees and Advisory Board of Sabra Trumbull Chapter. Any unused income is added to principal.

United German Society Fund #73391 - Gift from United German Society - considered permanent endowment - income is used for general expenses of the Hospital.

November 24, 1952

Florence R. Whitlock Fund #73371 - Bequest under will of Florence R. Whitlock (1953) - $13,351.35, a permanent endowment. Income for free bed or beds. Terms of will:

"2...The remaining four-tenths (4/10ths) of said residue, I give, devise and bequeath to the Rockville City Hospital for the purpose of establishing a free bed or beds in said Hospital in memory of my mother, Anna Shelton Whitlock."

Betsey C. Tucker Fund #73360 - Bequest under will of Betsy C. Tucker (1955) - $2,000, a permanent endowment. Income for free bed. Terms of will:

"Second: I give and bequeath to The Rockville City Hospital of Rockville, Connecticut, Two Thousand (2,000) Dollars to be its absolutely and forever. This bequest is to be used by said Hospital as an endowment for the partial maintenance of a free bed in said Hospital."

Anna M. and Albert H. Bilson Fund #745081 - Bequest under will of Anna M. Bilson of $10,371.08 as follows: (January 22, 1957)

"NINTH: All the rest, residue and remainder of my Estate, both real and personal of whatsoever nature and wheresoever situated is to be sold and one-half of the proceeds are to be given to the Union Congregational Church of Christ, Inc. to be known as the Anna M. Bilson and Albert H. Bilson Fund. I direct the trustees of said Church to lawfully invest said legacy and to use the income therefrom for the general uses and purposes of said Church. The remaining one-half thereof I give and devise unto the Rockville City Hospital, Inc. of the Town of Vernon to be known as the Anna & Albert Bilson Fund. I direct the trustees of said Hospital to lawfully invest said legacy, and to use the income therefrom for the general uses and purposes of said Hospital.

EXHIBIT Q 11-2

Fund 11-1.36

William H. Prescott

[redacted]rate Court for the District of Ellington:

[redacted]Charles W. Marsh late of Vernon in said District, deceased.

[redacted]er administratrix, on the estate of said deceased, after the acceptance of [redacted]ccount, hereby makes return:

[redacted]oneys and properties of every description, in her hands or control, as such [redacted]rix, have been paid over and distributed by her to the persons entitled thereto, [redacted]nce with law and the orders of said Court; and that so far as she has any know- [redacted]said estate is now fully administered and settled.

Augusta A. Marsh, Administratrix.

[redacted]Vernon this 18th day of February 1908.

[redacted]d subscribed before me.

John E. Fahey, Judge.

[redacted]. Attest: John E. Fahey Judge.

[redacted]WILLIAM H. PRESCOTT. Will. Proved, Approved, and Admitted to Probate February [redacted]1908.

[redacted]EN BY THESE PRESENT, That I William H. Prescott, of the City of Rockville, County [redacted]and and State of Connecticut, being of sound and disposing mind and memory, do make [redacted]blish this my last will and testament, hereby revoking all previous wills by me made.

[redacted]ive, devise and bequeath my property and estate in manner following, viz:-

[redacted]I direct that all of my just debts be paid by my executors hereinafter named.

[redacted]I give to my wife Celia E. Prescott the use of the dwelling house, stable and the [redacted]which we now occupy on Park Street in Rockville, for and during the period of her [redacted]life.

[redacted]her decease I give the use of said dwelling house, stable and premises to my son, [redacted]Keeney Prescott of Ellington, Connecticut, for and during the period of his natural [redacted]

[redacted]his decease I order and direct that said dwelling house, stable and premises shall [redacted]into the residuum of my estate, and be disposed of as hereinafter provided.

[redacted]also give to my said wife absolutely and forever all of my household furniture, fur- [redacted]ings, silver and plate, glass ware and crockery, linen, pictures, books, bric-a-brac and [redacted]es, and all household implements and effects; also all the horses, harnesses, carriages, [redacted]robes, grain and hay, ordinarily kept and contained in said stable on Park Street.

[redacted]also give to my said wife absolutely, the sum of fifty thousand dollars ($50,000) or [redacted]equivalent in stock and bonds or other personal securities.

[redacted]order and direct my executors and trustees, hereinafter named, to create and set aside [redacted]my estate, a trust fund of fifty thousand dollars ($50,000) for the benefit of my said [redacted]and I direct that she shall receive the interest, income and avails thereof, to be paid [redacted]by said trustees quarterly, or more frequently if deemed by them advisable, for and [redacted]the period of her natural life: at her decease, I direct that the principal sum there- [redacted]pass into the residuum of my estate, and be disposed of as hereinafter provided.

[redacted]I give to my son, Francis Keeney Prescott of Ellington, Connecticut, the sum of [redacted]and dollars absolutely.

[redacted]to Arthur T. Bissell of Rockville, Connecticut, trustee in trust for my said son, [redacted]Prescott, the sum of fifty thousand dollars ($50,000) for the following pur- [redacted]to hold, manage, invest and reinvest said sum of fifty thousand dollars ($50, [redacted]form and insuch securities or property as he may deem best and to apply the net [redacted]therefrom for the benefit and support of my said son, Francis Keeney Prescott,

E[redacted]ase by PMH
Submitted October 15, 2015

(continued from page 137)

for and during the period of his natural life; and I order and direct that at [illegible] said sum of fifty thousand dollars ($50,000) shall pass into the residuum of my [illegible] and be disposed of as hereinafter provided.

I also give to my said son the dwelling house and premises situated on North [illegible] Street in the town of Ellington, where he now resides, absolutely, together with all [illegible] furniture, furnishings, silver, crockery, glass ware, bric-a-brac and household imple[illegible] and effects therein contained.

4. I give to my daughter, Eliza Prescott Childs of Holyoke, Massachusetts, the [illegible] of fifty thousand dollars ($50,000) absolutely.

I order and direct my executors and trustees, hereinafter named, to create and [illegible] aside out of my estate, a trust fund of fifty thousand dollars ($50,000) for the bene[illegible] of my said daughter, Eliza Prescott Childs, and I direct that she shall receive for and during the period of her natural life, the interest, income, and avails thereof, to [illegible] paid to her by said trustees quarterly, or more frequently if deemed by them advisab[illegible]

5. I give to Annie R. Prescott, wife of Francis Keeney Prescott of Ellington, Connecticut, the use and income of five thousand dollars ($5000), for and during the [illegible] iod of her natural life, to be held in trust for her; and at her death I direct that [illegible] principal of said trust fund shall pass into the residuum of my estate and be disposed [illegible] as hereinafter provided.

6. I give to my son-in-law, Thomas S. Childs of Holyoke, Massachusetts, the sum [illegible] five thousand dollars ($5000) absolutely.

7. I give to my brother Charles B. Prescott of Holyoke, Massachusetts, the sum [illegible] five thousand dollars ($5000) absolutely.

8. I give to Fannie Prescott Blake, daughter of James T. Prescott of Springfield, Massachusetts, the sum of five thousand dollars ($5000) absolutely.

9. I give to Abbie Ladd Clough of Concord, New Hampshire, the use and income of five thousand dollars ($5000), for and during the period of her natural life: I direct that upon her decease the principal sum be equally divided among the children of John Martin Ladd, late of Lowdon, New Hampshire, deceased, whose given names I do not recollect; the issue of any deceased child to take the parents share.

10. I give to Mary C. F. Tuttle of Pittsfield, New Hampshire, the use and income of two thousand dollars ($2000), for and during the period of her natural life; at her death, I give the principal sum to her grandsons, Hiram Tuttle Folsom and Charles Bak[illegible] Folsom, both of Pittsfield, New Hampshire, absolutely; they to share equally.

11. I give to Anna C. Read of Bloomington, Illinois, the sum of One thousand dol[illegible] ($1000) absolutely, provided she be living at the time of my decease; otherwise, I di[illegible] that said one thousand dollars ($1000) shall pass into the residuum of my estate, to [illegible] disposed of as hereinafter provided.

12. I give to Robert Blackmore of Rockville, Connecticut, now in my employ, so [illegible] money as will be necessary to release and discharge the present mortgage indebtedness owing by him to the Rockville Building and Loan Society, and secured by a mortgage upon his dwelling house.

13. I give and bequeath to Francis T. Maxwell, Arthur T. Bissell, J. Alice Maxwell, A. E. Belding and Thomas W. Sykes, all of Rockville, Connecticut, the sum of fifty thousand dollars ($50,000) in perpetual trust to them and their successors in office, for [illegible]

(continued on page 139)

(continued from page 139)

establishing and maintaining at said city of Rockville, a general hospital for
be open and available to all residents of the said city of Rockville, and of
of the immediate vicinty thereof contiguous and adjacent thereto, as in the
said Board of Trustees may be deemed wise and advisable, subject to such rules
ons concerning admission to said hospital as said trustees and their successors
may from time to time, establish.

rustees and their successors in office shall have power to receive property by
herwise, and to purchase land and erect buildings for the purpose of carrying
sions of this trust.

eneral management and oversight of said hospital, including the character and
reatment therein to be established, shall be vested wholly in said Board of
and their successors in office.

Board may elect a President, Vice-President, Secretary, and Treasurer, and such
ecutive officers as they may deem necessary or advisable to carry out the purpose
st, including a superintendent of said institution. All vacancies in said Board
om any cause, shall be filled by appointment of the surviving trustees.

ard of Trustees shall have power, from time to time, to make by-laws defining
of said officers and superintendent, the method of calling meetings of the
and other by-laws relative to the management and goverment of the same.

ed, however, that, if at any time before my decease, I shall make provision for
er of the sum of fifty thousand dollars ($50,000) to the above named, as Trustees
rpose of inaugurating the establishment of a City Hospital, thereby substantially
out the provisions of this paragraph of my will, then and in that event, I revoke
graph of the same relating to said Hospital, and declare it inoperative, but other-
main in full force and effect.

I give the use and improvement, interest and avails of all the rest, residue and
of my property and estate, both real and personal, of every description and where-
ever situated, including any legacies or bequests which may for any reason lapse or fail to
take effect, to my said wife, Celia E. Prescott, for and during the period of her natural
life.

At her death I give the use, improvement, interest and avails of one half of the rest,
residue, residuum and remainder of my estate, as above described, to my son, Francis Keeney
Prescott, for and during the period of his natural life; and I give the use, improvement,
interest and avails of the other or remaining one half of the rest, residue, residuum, and
remainder of my estate to my daughter, Eliza Prescott Childs of Holyoke, Massachusetts, for
and during the period of her natural life.

At the death of my said son, Francis Keeney Prescott, I give the said one-half of
residuum of my estate, in which he has the life interest, to those of his children who
at the time of his death, then living, the same to be divided among them equally, share
and share alike,

Provided, however, that they have reached, at that time, the age of twenty-five (25)
years; otherwise, I direct and order that said principal sum, to wit, the one-half of said
residuum of my estate in which I have given to my said son, the life interest only, shall
remain in trust by the Trustees hereinafter named, as a trust fund until such time as the
children of my said son, Francis Keeney Prescott, shall reach the age of twenty-five years,
and their share of the principal shall be given them absolutely. Meaning and intending here-
by that in the event of the death of my said son, Francis Keeney Prescott, those of his

(continued on page 140)

(continued form page 139)

children who are at that time of the age of twenty-five years, shall rec... proportion of said estate, and those of less age then that named shall re... avails thereof to be expended for their benefit by the trustees hereinaf... shall deem advisable, until they also have obtained the required age.

16. At the death of my said daughter, Eliza Prescott Childs, I giv... of the residuum of my estate, in which she has the life interest, to thos... who are at the time of her decease then living, the same to be dibided am... share and share alike.

Provided, however, that they have reached at that time the age of twe... years; otherwise, I order and direct that said principal sum, to wit, the ... residuum of my estate, in which I have given to my said daughter the life inter... shall be held in trust by the trustees hereinafter named, as a trust fund until ... as the children of my said daughter, Eliza Prescott Childs, shall reach the age of ... five years, when their share of the principal shall be given them absolutely. Meanin... intending hereby that in the event of the death of my said daughter, Eliza Prescott C... those of her children who are at that time of the age of twenty-five years shall r... his or her proportion of said estate, and those of less age then that named shall rec... only the avails thereof to be expended for their benefit by the Trustees hereinafte... as they shall deem advisable, until they also shall have obtained the required age.

17. I direct that my Trustees, hereinafter named, set aside out of my estate th... of ten thousand dollars ($10,000), as a trust fund, and that the income and avails tho... be paid to Frank Keeney of said Rockville, and to his successors in office, as compens... for his services as one of the executors and trustees hereinafter appointed.

At the final settlement of my estate, and when the purpose for which said fund ... raised no longer exists, I direct that the same shall pass into the residuum of my e... to be disposed of as above indicated.

I herein constitute and appoint Frank Keeney of Rockville, Connecticut, Thomas S. ... Childs of Holyoke, Massachusetts, and Francis Keeney Prescott of Ellington, Connecti... executors of this my last will and testament. And I also constitute and appoint the s... Frank Keeney, Thomas S. Childs and Francis Keeney Prescott, trustees of the various ... and trust funds named in this will and raised by the terms thereof, except that ce... trust and trust fund of fifty thousand dollars ($50,000) given to Arthur T. Bissell, J... terms of Paragraph third of this will; and also excepting the trust and trust fund o... fifty thousand dollars ($50,000), given to Francis T. Maxwell, Arthur T. Bissell, J... Maxwell, A. N. Belding, and Thomas W. Sykes, by the terms of paragraph thirteen (13) ... of this will.

IN WITNESS WHEREOF, I have hereunto set my hand and seal at said Rockville, Conn... on the seventeenth day of January A. D., one thousand nine hundred and eight.

William H. Prescott. (L.S.)

Signed, sealed, published and declared by the said William H. Prescott as and f... his Last Will and Testament, in presence of us who at his request, in his presence, ... in the presence of each other have hereunto subscribed our names as witnesses on the ... enteenth day of January A. D. 1908.

Charles Phelps.
Jane E. Newcomb.
Katherine Houlihan.
} Witnesses.

A true copy. Attest: John E. Sahey Jr

DISTRICT OF ELLINGTON

(Continued from Page 537)

on said 13 day of June A. D. 1917; that she was at the time of signing said ins... ment more than 16 years of age and of sound mind; and that each of said witness... signed said instrument so subscribed by said Celia E. Prescott, at her request, i... presence, and in the presence of each other.

Charles Phelps.

Subscribed and sworn to the day and year first above written in open court before me.

John E. Fahey, Judge.

A true copy Attest: M P Lennard Cl...

Know all Men by these Presents, That I, Celia E. Prescott, of the city of Rockvill... County of Tolland and State of Connecticut, being of sound and disposing mind and ... do make and publish this my last will and testament, hereby revoking all previous w... and codicils by me made.

I give, devise and bequeath my property and estate, both real and personal, i... manner following, namely:

1. I direct that all of my just debts be paid by my executors hereinafter nam...

2. I give to the town of Vernon, in perpetual trust, the sum of Five Hundred ... (500.) Dollars, directing that the income and avails thereof be used annually for the ... care and maintenance of my family burial lot in Grove Hill Cemetery at Rockville; fu... ther directing that, if in the judgment of the caretaker of said cemetary all of said ... income in a given year be not needed for such service then that portion of said income ... not used or needed therefor may be applied by him for the general care and maintenance ... said cemetery.

3. I give to my daughter, Eliza Prescott Childs, wife of Thomas Southworth ... Childs of Holyoke, Massachusetts, the sum of Two Thousand (2,000) Dollars in cash, to ... disposed of by her in accordance with special written directions now in her possession...

4. I also give to my said daughter, Eliza Prescott Childs., the following ar... ticles of personal property, absolutely;

picture of "Castle Rock" by A. F. Richards,
Picture of Francis Keeney by C. E. Prescott,
picture of Apples and Grapes by C. E. Prescott,
picture of Red and White Roses, by C. E. Porter,
picture of California Mountain, by McGirney,
one large rug in parlor,
one large and small Kerman rug in Aunt Jane's room,
one grey California rug,
all jewelry and personal ornaments not otherwise disposed of,
all articles of personal wearing apparel,
the large solid silver tea tray,
all furniture and furnishings in the Cabin, so called, situated on Snipsic Lake,
all of my bedding, mattresses, linen, table linen, laces, one pair of And-irons, formerly belonging to my mother.
one Minton white and gold dinner set,
one dozen green and gold plates,
one-half dozen painted place plates
one large blue and gold vase, (Colcort)
one vase in cabinet, Girl with the Wheat,
Ivory minature of myself,

together with all articles of personal property remaining in my house and not otherwise disposed of.

6. I give to my son-in-law, Thomas Southworth Childs of Holyoke, Massachusetts, the use and income of the sum of Five Thousand (5,000) Dollars, lawful money of the United States, for and during the period of his natural life. At his death I give said principal sum of Five Thousand (5,000) Dollars to the trustees of the Rockville City Hospital, in trust, for the benefit of said hospital, that the same may be added to the endowment fund provided for in the will of my late husband, William H. Prescott, for the purpose of establishing and maintaining said proposed hospital.

I also give to the said Thomas Southworth Child the sum of One Thousand (1,000) Dollars, lawful money of the United States, also my horse, harness, carriages,

DISTRICT OF ELLINGTON

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igh, saddle, blankets and stable equipment; also one small picture entitled rning News" by Mueller, absolutely.

6. I give to Prescott Childs, son of Thomas Southworth Childs of Holyoke, sachusetts, the following articles of personal property, absolutely;
the tall clock on the stairs at my home,
small antique table purchased by me at Lakeville,
large vase with painting of girl on parlor mantel;
large rug in front chamber;
engraving of Evangeline and Father;
painting entitled "The Young Mother" by Franz Charles;
large painting of Peonies by C. E. Porter;
small portrait of William E. Prescott by Hoffman;
painting of Apples, by C. E. Prescott,
"Sheep"by Taite;
Prescott and Pitkin Genealogies;
Washington Irving's Works, fifteen (15) volumes;
one opal and diamond stick pin;
one small diamond ring, single stone, the first one given to me by my late husband;
Loving Cup presented to my late husband by the Rockville Golf Club.

7. I give to Benjamin Willis Childs, son of Thomas Southworth Childs of Holyoke, sachusetts, the following articles of personal property, absolutely;
one mahogany carved chest;
one mahogany cabinet in parlor;
one mahogany chair with slender arms and legs;
one Blue Tiffany Vase;
one Florentine plaque and pitcher to match;
one oblong carved mahogany table;
one dozen china plates with design of pinks;
one half dozen souvernier tea spoons;
picture--"Old Man" by Rider;
picture, "Snipsic Lake" by C. E. Prescott;
copy of Titian's Flora;
small picture of cows;
works of Rudyard Kipling
Illustrated Bible in three or four volumes;
"Old Cottage Bible" formerly belonging to Francis Keeney;
my engagement ring (small cluster);
short gold chain with bar;
picture by Percival D. Luce;
Vase Queen Louise;
one dozen silver coffee cups and saucers.

8. I give to Thomas Southworth Childs, Jr., son of Thomas Southworth Childs of lyoke, Massachusetts, the following articles of personal property; absolutely:
all of the furniture in the front chamber at my residence, excepting the rugs and pictures otherwise disposed of;
one dozen English China plates-- colored border;
one-half dozen silver spoons (Souvenier);
picture- "Dutch Mother and Baby" in library;
picture- "Old House" by Paine;
picture- "Morning Glories" by C. E. Prescott;
Crayon of "Lake George";
Works of Oliver Wendell Holmes, fifteen (15 Volumes)
Bible given by the late J. N. Stickney to William E. Prescott;
one cluster diamond pin;
one plain gold ring;
one silver ice cream set.

9. I give to Annie E. Prescott, widow of my son, the late Francis Keeney Prescott, the use and income of the sum of Five Thousand (5,000) Dollars, lawful money of e United States, for and during the period of her natural life. At her death I give id principal sum of Five Thousand (5,000) Dollars to the trustees of the Rockville ty Hospital, in trust, for the benefit of said hospital, the same to be added to the dowment fund provided for in the will of my late husband, William E. Prescott, for purpose of establishing and maintaining said proposed hospital.
I give to said Annie E. Prescott the sum of One Thousand (1,000) Dollars, absotely; also the following articles of personal property, absolutely:
picture of Girl with Oranges, painted by C. E. Prescott;
old fashioned plated silver service;
rugs in chamber over dining room.

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(Continued from Page 539)

10. I give to my grandson, William Henry Prescott of Rockville, Connecticut, the following articles of personal property, absolutely;
the clock in room over dining room;
mahogany desk and four chairs matching the same, in library;
large easy chair and small table;
one octagonal table in library;
large Persian rug;
small rug;
bronze horse;
ivory minature of William H. Prescott;
cut glass lamp and shade given me by my late son;
Francis Keeney Prescott;
"Marine Picture", by Tyler;
engraving, "Washington Irving and his Friends;"
"Spirit of '76", by C. E. Prescott
"Italian Girl" by Rompiani;
"Snipe" by Alexander Pope;
Stoddards Lectures complete;
"Men of Mark in Connecticut,";
The World's Best Literature;
one single stone diamond ring, (the best one)
one silver pitcher market W. H. P.
one dozen silver tea spoons (Souvernier)

11. I give to my granddaughter, Celia Keeney Prescott of Rockville, Connecticut, the following articles of personal property, absolutely;
one Baby Grand Piano with bench and chair;
dark blue and gold plates, cups and saucers in mahogany cabinet)
solid silver tea service without tray;
two teaspoons marked E. Porter;
one solid silver vase presented me by Sabra Trumbull Chapter, D.A.R.;
one-half of the solid silver flat or table pieces, grape design, marked C.E.P;
one small tea table in dining room;
one dozen plates, Thistle pattern;
one Marine picture by Britcher;
one picture, "Cherries" by C. E. Porter;
Litary Works of George Elliott;
one sapphire and diamond ring;
Chinese rug in upper hall;
one Japanese bowl

12. I give to my granddaughter, Lucy Marin Prescott, of Rockville, Connecticut, the following articles of personal property, absolutely;
picture of Tambourine Girl;
the red and brown rug in lower front hall of my residence;
all of the furniture in library chamber;
picture "Marigold and Zinnas" by C. E. Prescott;
picture, Girl gathering Lilies, etching;
picture, "An English Street" by Waters;
picture, "Bowl of Strawberries" by C. E. Porter;
one-half of the flat or table silver ware, grape design, marked C. E. P.
two silver candle sticks, formerly given me by Lucy M. Prescott, of Holyoke;
silver mustard pot, formerly given me by Lucy M. Prescott, of Holyoke;
set of Russian plates, cups and saucers;
Young Folks Library, composed of twelve (12) volumes;
one opal and diamond ring;
one cut glass ice cream dish with twelve cut glass sauce dishes;
mahogany table situated in third story front room of my residence.
Sheffield platters marked C. E. P.

13. I give to my granddaughter, Georgiana Lincoln Prescott, of Rockville, Connecticut, the following articles of personal property, absolutely;
two small rugs in parlor at my residence;
one silver plated tray marked C. E. P.
one tea pot, cream and sugar bowl,-- (Gorham ware)
Royal Worcester, ice cream set, platter and twelve square plates,
(yellow and white);
one brass bed stead and bedding;
picture by Verplank Birney;
engraving of "Queen Louise";
small oil picture in upper hall;
twelve books from my library from those not otherwise disposed of, to be selected by my daughter, Eliza Prescott Childs;

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gold watch given me by my daughter
long heavy gold chain;
small amethyst seal ring;
onyx pin set with two small diamonds;
gilt clock and ornaments to match;
one large chop plate and one dozen small plates to match.

14. I give to each of my grandchildren, William H. Prescott, Celia Keeney escott, Lucy Martin Prescott and Georgiana Lincoln Prescott, children of my late n, Francis Keeney Prescott, of Rockville, Connecticut, and to Prescott Childs, Ben- in Willis Childs, and Thomas Southworth Childs, Jr., children of Thomas Southworth ilds of Holyoke, Massachusetts, each the sum of Five Hundred (500) Dollars, absolutely be paid by my executors hereinafter named, to each individual child when such child ill have reached the age of twenty years.

15. I give to my brother, Frank Keeney of Rockville, Connecticut, the use and ome of Five Thousand (5,000) Dollars, for and during the period of his natural life. this death I give said principal sum of Five Thousand (5,000.) Dollars to the trus- s of the Rockville City Hospital, in trust, to be added to the endowment fund pro- ed for in the will of my late husband, William H. Prescott, for the purpose of es- lishing and maintaining said proposed hospital.

I also give to said Frank Keeney, the portraits of my father and mother, Francis Eliza Porter Keeney, painted by G. A. Hoffman.

16. I give to Emma B. Keeney, wife of said Frank B. Keeney, the sum of Two ndred (200.) Dollars, absolutely.

17. I give to Clara Cole Keeney, widow of my late brother Edgar Keeney, the m of Two Hundred (200.) Dollars, absolutely.

18. I give to Ernest A. Keeney, and Bertha Dean Keeney, his wife of Burnside, nnecticut, each the sum of Five Hundred (500.) Dollars, absolutely.

19. I give to Gladys G. Keeney, daughter of Frank Keeney of Rockville, Connec- ut, the sum of Five Hundred (500.) Dollars, absolutely.

20. I give to John T. Henderson and Maud T. Henderson, his wife, of Hartford, nnecticut, each the sum of Five Hundred (500.) Dollars, absolutely.

21. I give to Louis Keeney Newcomb and Zella Newcomb, his wife, of Providence, de Island, each the sum of Five Hundred, (500.) Dollars, absolutely.

22. I give to Joseph Parsons Prescott of Holyoke, Massachusetts, the sum of Hundred (200.) Dollars, absolutely.

23. I give the sum of Two Hundred (200.) Dollars, absolutely to each of the llowing named persons; to wit, Charles A. Clark and Katherine Clark, his wife; escott, Katherine, Virginia and Joseph, their children, of Northampton, Massachusetts

24. I give to Fanny Prescott Bluke of Springfield, Massachusetts, the sum of ree Hundred (300.) Dollars, absolutely.

25. I give to James Harvey Porter and his wife of Wilmington, California, each e sum of Two Hundred and Fifty (250.) Dollars, absolutely.

26. I give to Mrs. Alice Russell of South Manchester, Connecticut, the sum of ree Hundred (300.) Dollars, absolutely.

27. I give to William J. Remig, and his wife, Alice Russell Remig of South nchester, Connecticut, each the sum of One Hundred (100.) Dollars, absolutely.

28. I give to Martin Lambecher of Rockville, Connecticut, the sum of Five Hun- ed (500.) Dollars, absolutely.

29. I give to Robert Blackmore of Rockville, Connecticut, now in my emply, the m of One Thousand (1,000) Dollars, absolutely.

30. I give to Katherine Houlihan, now in my employ, the sum of Eight Hundred 00.) Dollars, absolutely.

31. I give to Clara Mueller, now in my domestic employ, the sum of Five Hundred 00.) Dollars, absolutely.

DISTRICT OF ELLINGTON

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32. I give to P. J. Donegan, the sum of Four Hundred (400.) Dollars, absolutely.

33. I give to Edwin G. Butler, of Rockville, Connecticut, and to Thomas Sherworth Childs of Holyoke, Massachusetts, and to Martin Laubscher of Rockville, Connecticut, trustees, the sum of Twenty-Eight Thousand (28,000) Dollars, in trust, for the following purpose, namely; to set apart as a separate fund and to hold, invest and invest, as occasion may require, for the benefit of all of my grandchildren hereinbefore named, being the children of my late son, Francis Keeney Prescott and of my daughter Eliza Porter Childs,

And I order and direct that the income, profits and avails of said trust fund be used and expended by said trustees for the education and improvement of my said grandchildren, or the survivors of them, each and all, that they may be instructed in those general branches most essential to good citizenship.

And I further authorize and empower the said trustees to use and employ such part of the principal of this trust fund as they, in their wise judgment may deem advisable, if the same, or any part thereof, be needed for the better care and education of said grandchildren; or the survivors of them; the principal sum, however, or any part thereof is to be used only in case that the income proves insufficient in the judgment of the trustees for the purposes indicated in this paragraph. And I further order and direct that when my oldest surviving grandchild reaches the age of twenty-three years the trustees above named shall pay to such grandchild that proportionate amount of the principal sum then remaining which would be equal to that portion which such child would be entitled to receive in an equal division at that time of the principal sum among those grandchildren then surviving.

And I further direct that each child in succession as it reaches the age of twenty-three years shall receive that proportionate amount of the trust fund then remaining as such child would be entitled to receive in an equal division of the fund if then distributed.

34. I give to the trustees of the said Rockville City Hospital for the benefit of the same, the sum of Ten Thousand (10,000.) Dollars, for the establishment of a free bed in honor of my late father and mother, Francis and Eliza Porter Keeney, and I request that in the use of the same preference be given, if occasion arises, to any of the descendants of the Keeney family.

I also give to the trustees of said Hospital for the benefit of the same, the large oil portrait of my husband, the late William H. Prescott, painted by Child of New York.

I also give to the trustees of the said hospital, for the benefit of the same, the sum of Five Thousand (5,000.) Dollars, for the establishment of a free bed in loving memory of my late son, Francis Keeney Prescott.

I also give to the trustees of said Hospital, for the benefit of the same, the sum of Four Hundred (400.) Dollars, for the furnishing of a room in said proposed Hospital in memory of my sister, the late Jane E. Newcomb.

35. I give to the "Doane Orphanage" so called, a charitable institution for neglected children, located in the town of Long Meadow, Massachusetts, the sum of Five Hundred (500.) Dollars, absolutely.

36. I give to the trustees of the George Sykes Manual Training School, an institution for manual training provided for by the will of the late George Sykes, and to be established in the city of Rockville, the sum of Five Thousand (5,000.) Dollars, in perpetual trust, the income thereof to be appropriated by the said trustees and their successors for the purpose establishing a free scholarship in said institution on such terms and under such conditions as they may deem in their judgment most advisable; with the alternative, however, that if the conditions upon which said school are established render such free scholarship in their judgment unnecessary or inadvisable, then said trustees may apply and appropriate the income of said fund for such other purpose or purposes connected with the management of said school as they, the said trustees may deem advisable.

37. I give to the "Union Ecclesiastical Society" of Rockville, Connecticut, the sum of One Thousand (1,000) Dollars in perpetual trust, the income thereof to be applied by the proper officers of said society to the relief and needs of the poor of the parish of said Ecclesiastical Society.

38. I give to the "Rockville Public Library" of Rockville, Connecticut, the sum of One Thousand (1,000) Dollars, in perpetual trust, the income thereof to be expended by the proper officers of said Library in such manner, and for such purposes as they may deem advisable.

DISTRICT OF ELLINGTON

(Continued from Page 543)

39. I give to Sabra Trumbull Chapter of the Daughters of the American Revolution of Rockville, Connecticut, the sum of One Thousand (1,000.) Dollars, in trust, the income thereof to be devoted to general benevolent work, preferably to be exercised within the limits of the city of Rockville; provided, however that if for any cause said Chapter of the Daughters of the American Revolution should disband or be dissolved, then, and in that event, I give said principal sum of One Thousand (1,000.) Dollars, to the trustees of the proposed general Hospital for the sick of Rockville, hereinbefore referred to, in perpetual trust, the income thereof to be used and appropriated for the support and maintenance of said institution.

40. I give to the Visiting Nurse Association of Rockville, Connecticut, the sum of One Thousand (1,000.) Dollars, absolutely.

41. All of the rest and residue of my property and estate, both real and personal, of whatsoever kind and wherever found, including any and all legacies that may lapse or for any reason fail to take effect, I give, devise and bequeath to my daughter, Eliza Prescott Childs, wife of Thomas Southworth Childs of Holyoke, Massachusetts, and to the children of my son, the late Francis Keeney Prescott, namely;- William H. Prescott, Celia Keeney Prescott, Lucy Martin Prescott and Georgiana Lincoln Prescott; intending hereby to give to my said daughter, one-half of said residuum absolutely, and to said grand children one-half, who are to share and share alike, absolutely.

In the event of the decease of any of said grandchildren, being the children of my son , the late Francis Keeney Prescott, and leaving issue at the time of said distribution, I then direct that such issue shall take the parents share.

I herein Constitute and Appoint Edwin C. Butler of Rockville, Connecticut, Thomas Southworth Childs of Holyoke, Massachusetts, and Martin Laubacher of Rockville, Connecticut, Executors of this my Last Will and Testament.

In Witness Whereof I have hereunto set my hand and seal at said Rockville, on the thirteenth day of June A. D. One Thousand Nine Hundred and Seventeen.

Celia E. Prescott (L.S.)

Signed, sealed, published and declared by the said Celia E. Prescott as, and for her last will and testament, in presence of us who at her request, in her presence and in the presence of each other have hereunto subscribed our names as witnesses on the 13th day of June A. D. 1917.

Charles Phelps }
Thomas F. Noone } Witnesses.
Lena I. Heim }

A true copy Attest: M P Leonard Clerk.

To the Probate Court for the District of Ellington.

Estate of Lizzie Schrier late of Vernon, in said District, deceased.

The subscriber represents that Lizzie Schrier last dwelt in the town of Vernon in said District, and died on the 29th day of November A. D. 1921, possessed of goods and estate remaining to be administered, leaving as her only heirs-at-law, and next of kin, the persons whose names, residences, and relationship to the deceased are as follows, viz:

Names	Residences	Relationship
Elizabeta Fox,	Oregon City, Oregon	Sister
John H. Yost,	Rockville, Conn.	Nephew
Fred " Yost	" "	"
Lizzie Yost	" "	Niece
Bertha Kramer	" "	"
William H. Yost	" "	Nephew
Estella Kibbe	Ellington, "	Niece
Lizzie Carroll	Rockville, "	"
Bertha Haun	Hartford, "	"
Emma Nemette	Hyde Park, Mass.	"
Katie Austin	West Springfield, Mass	"

ECHN Proposed Asset Purchase by PMH
Submitted October 13, 2015

EXHIBIT Q 11-2

Fund 11-1.37

William Maxwell Fund

APPLICATION FOR PROBATE OF WILL AND RETURN OF NOTICE
To the Probate Court for the District of Ellington

ESTATE OF WILLIAM MAXWELL late of Rockville, Connecticut, in said District, deceased.

The subscriber represents that William Maxwell last dwelt and had his domicile in the town of Rockville in said District, and died on the 27th day of July 1939, possessed of goods and estate in said District remaining to be administered, leaving no widow, ; that said decedent left him surviving no children or descendants of deceased children or father or mother or brother or sister or descendants of deceased brothers or sisters or other heirs-at-law except those whose names and addresses are given below--

Name	Residence	Relationship
Miss J. Alice Maxwell	Rockville, Conn.	Sister
Colonel Francis T. Maxwell	Rockville, Conn.	Brother

that the decedent left a will and two codicils herewith presented for probate wherein J. Alice Maxwell, Francis T. Maxwell and The Hartford-Conn. Trust Company are named as executors and that said will has never been revoked either by the subsequent birth of children or otherwise.

Wherefore subscriber prays that said will may be proved, approved, allowed and admitted to probate and that letters testamentary issue to the executors herein named

Dated at Rockville this 31st day of July, 1939
The Hartford-Connecticut Trust Company
By (signed) J. H. Bartholomew, Jr, Trust Officer

Subscribed and sworn to this 31st day of July, 1939 before me
(signed) Hazel K. Cawte, Notary Public

The undersigned being heirs-at-law and next of kin of said decedent hereby appear in good faith and unite in the foregoing application and waive any and all notice of a hearing thereon.

(signed) J. Alice Maxwell
(signed) Francis T. Maxwell

A true copy

Attest: Helen Kempenich, Asst. Clerk

ACCEPTANCE OF TRUST
To the Court of Probate for the District of Ellington

ESTATE OF WILLIAM MAXWELL, late of Rockville, in said District, deceased.

The subscribers, having been named Executors in the Will of the above named decedent, hereby appear in this Court and accept said trust.

Dated at Rockville, Connecticut, July 31, 1939.
(signed) J. Alice Maxwell
(signed) Francis T. Maxwell
The Hartford-Connecticut Trust Company
by (signed) J. H. Bartholomew, Jr, Trust Officer

A true copy

Attest: Helen Kempenich, Asst. Clerk

LAST WILL AND TESTAMENT OF WILLIAM MAXWELL

I, WILLIAM MAXWELL, of the City of Rockville, State of Connecticut, do hereby make, publish and declare the following as and for my Last Will and Testament:

FIRST: I revoke each and every Will and Codicil heretofore by me at any time made.

SECOND: To VISITING NURSE ASSOCIATION, in Rockville, Connecticut, I give and bequeath the sum of One thousand dollars ($1,000).

THIRD: To THE AMERICAN BOARD OF COMMISSIONERS FOR FOREIGN MISSIONS I give and bequeath the sum of Two thousand dollars ($2,000).

FOURTH: To the CONGREGATIONAL HOME MISSIONARY SOCIETY I give and bequeath the sum of Two thousand dollars ($2,000).

FIFTH: To MANHATTAN EYE, EAR AND THROAT HOSPITAL I give and bequeath the sum of One thousand dollars ($1,000).

SIXTH: To TUSKEGEE INSTITUTE I give and bequeath the sum of One thousand dollars ($1,000).

SEVENTH: To my EXECUTORS hereinafter named or the survivor of them, I give and bequeath the sum of Sixty thousand dollars ($60,000) absolutely. Without intending to qualify the absolute character of this bequest, I hereby express the hope that they or the survivor of them will distribute said sum among such of my friends, relatives, domestic servants in my employ at the time of my death, and my business associates in such manner and amounts as I may indicate by a written memorandum, or, failing such memorandum, as my said Executors or the survivor of them shall determine.

EIGHTH: To my sister, J. ALICE MAXWELL, I give and bequeath all books, furniture, rugs, pictures, silverware, household effects, horses, carriages, harnesses, automobiles, jewelry, wearing apparel, domestic supplies, and all other articles of personal or household use or adornment wherever located.

NINTH: To my brother, FRANCIS T. MAXWELL, I give and devise all my interest in the property situated on Chestnut Street, in Ellington and Vernon, in the State of Connecticut.

TENTH: To my sister, J. ALICE MAXWELL, I give and devise all my interest in the property on Union Street, occupied by my said sister and myself as our residence, and all the real estate connected therewith on Union, Main and Village Streets, and all my block of tenements on Main Street, and the property known as the "Einseidel property" on Village Street, and also the stable property, all situated in the City of Rockville and State of Connecticut; also all the real estate owned by me and situated in the rear of the Public Library in the said City of Rockville, and the property adjoining the same on Prospect Street; also the property formerly known as the "Grant property," which adjoins my said residence property on Union Street.

(Continued from Page 88 - Estate of William Maxwell, deceased)

ELEVENTH: All the rest, residue and remainder of my property, real and personal, of every kind, nature and description and wheresoever situated, I direct my Executors to divide into one hundred equal parts, which I give, devise and bequeath as hereinafter provided.

TWELFTH: To my TRUSTEES hereinafter named I give, devise and bequeath six of said equal parts of my said residuary estate IN TRUST NEVERTHELESS to invest and reinvest the same and keep the same invested and to collect and receive the rents, issues and income thereof and to pay the net income thereof ~~and to pay the net income thereof~~ to my sister J. ALICE MAXWELL for and during the term of her natural life, and upon her death, to pay the said net income to my brother FRANCIS T. MAXWELL for and during the term of his natural life. Upon the death of the survivor of my said brother and sister, the said trust shall cease and terminate, and I thereupon give, devise and bequeath the said trust fund to YALE UNIVERSITY of New Haven, Connecticut, to be held as a separate fund and the income thereof to be used for the benefit of the academic department of the said Yale University.

THIRTEENTH: To ROCKVILLE PUBLIC LIBRARY in Rockville, Connecticut, I give, devise and bequeath four of said equal parts of my said residuary estate in trust to use the income thereof for the general purposes of the said Library.

FOURTEENTH: To ROCKVILLE CITY HOSPITAL in Rockville, Connecticut, I give, devise and bequeath four of said equal parts of my said residuary estate in trust to use the income thereof for the general purposes of said Hospital.

FIFTEENTH: To UNION CONGREGATIONAL CHURCH OF CHRIST in Rockville, Connecticut, I give, devise and bequeath four of said equal parts of my said residuary estate in trust to use the income thereof for the general purposes of said Church.

SIXTEENTH: To my TRUSTEES hereinafter named I give, devise and bequeath eighty-two of said equal parts of my said residuary estate IN TRUST NEVERTHELESS to invest and reinvest the same and to keep the same invested and to collect and receive the rents, issues and income thereof and, during the joint lives of my brother FRANCIS T. MAXWELL and my sister J. ALICE MAXWELL to pay over two-thirds of the net income thereof to my said sister J. Alice Maxwell and one-third of the net income thereof to my said brother Francis T. Maxwell, and from and after the death of either my said brother or my said sister, to pay the whole of said net income to the survivor of them. Upon the death of the survivor of my said brother and sister, I direct my Trustees to dispose of the said eighty-two equal parts of my said residuary estate as follows:

(a) To my niece, PRISCILLA MAXWELL ENDICOTT, I give, devise and bequeath twenty-one of said equal parts absolutely, and, in the event that she shall have previously died, I give, devise and bequeath the said twenty-one equal parts in equal shares per stirpes to her surviving issue, and, if she shall leave no issue then surviving, I give, devise and bequeath the same in equal shares per stirpes to the then-living grandchildren and issue of deceased grandchildren of my brother Francis T. Maxwell.

(b) To my TRUSTEES hereinafter named I give, devise and bequeath twenty-one of said equal parts IN TRUST NEVERTHELESS to invest and reinvest the same and to keep the same invested and to collect and receive the rents, issues and income thereof and to pay over the net income thereof to my niece, HARRIET K. MAXWELL, for and during the term of her natural life, and upon her death I give, devise and bequeath the said trust fund in equal shares per stirpes to the then-living grandchildren and issue of deceased grandchildren of my brother Francis T. Maxwell.

(c) To my TRUSTEES hereinafter named I give, devise and bequeath ten of said equal parts IN TRUST NEVERTHELESS to invest and reinvest the same and to keep the same invested and to collect and receive the rents, issues and income thereof and to accumulate the net income thereof for the benefit of MAXWELL BELDING, a grandson of my brother Francis T. Maxwell, until the said Maxwell Belding shall attain the age of twenty-one years, and thereupon to pay over to the said Maxwell Belding all of said accumulated income and thereafter to pay to the said Maxwell Belding the net income of said trust fund until he shall attain the age of thirty years, whereupon my Trustees shall pay over the capital of said trust fund to the said Maxwell Belding absolutely. In the event that the said Maxwell Belding should die before attaining the age of thirty years, I give, devise and bequeath the capital of said trust fund upon his death in equal shares to his surviving children, and, in the event that he should leave no children him surviving, I give, devise and bequeath the same in equal shares per stirpes to the then-surviving grandchildren and issue of deceased grandchildren of my brother Francis T. Maxwell.

(d) To my TRUSTEES hereinafter named I give, devise and bequeath ten of said equal parts IN TRUST NEVERTHELESS to invest and reinvest the same and to keep the same invested and to collect and receive the rents, issues and income thereof and to accumulate the net income thereof for the benefit of VIRGINIA BELDING, a granddaughter of my brother Francis T. Maxwell, until the said Virginia Belding shall attain the age of twenty-one years, and thereupon to pay over to the said Virginia Belding all of said accumulated income and thereafter to pay to the said Virginia Belding the net income of said trust fund until she shall attain the age of thirty years, whereupon my Trustees shall pay over the capital of said trust fund to the said Virginia Belding absolutely. In the event that the said Virginia Belding should die before attaining the age of thirty years, I give, devise and bequeath the capital of said trust fund upon her death in equal shares to her surviving children, and, in the event that she should leave no children her surviving, I give, devise and bequeath the same in equal shares per stirpes to the then-surviving grandchildren and issue of deceased grandchildren of my brother Francis T. Maxwell.

(e) To my TRUSTEES hereinafter named I give, devise and bequeath ten of said equal parts IN TRUST NEVERTHELESS to invest and reinvest the same and to keep the same invested and to collect and receive the rents, issues and income thereof and to accumulate the net income thereof for the benefit of BRADFORD ENDICOTT, a grandson of my brother Francis T. Maxwell, until the said Bradford Endicott shall attain the age of twenty-one years, and thereupon to pay over to the said Bradford Endicott all of said accumulated income and thereafter to pay to the said Bradford Endicott the net income of said trust fund until he shall attain the age of thirty years, whereupon my Trustees shall pay over the capital of said trust fund to the said Bradford Endicott absolutely. In the event that the said Bradford Endicott should

(Continued from Page 89 - Estate of William Maxwell, deceased)

die before attaining the age of thirty years, I give, devise and bequeath the capital of said trust fund upon his death in equal shares to his surviving children, and, in the event that he should leave no children him surviving, I give, devise and bequeath the same in equal shares per stirpes to the then-surviving grandchildren and issue of deceased grandchildren of my brother Francis T. Maxwell.

(f) To my TRUSTEES hereinafter named I give; devise and bequeath ten of said equal parts IN TRUST NEVERTHELESS to invest and reinvest the same and to keep the same invested and to collect and receive the rents, issues and income thereof and to accumulate the net income thereof for the benefit of PRISCILLA ENDICOTT, a granddaughter of my brother Francis T. Maxwell, until the said Priscilla Endicott shall attain the age of twenty-one years, and thereupon to pay over to the said Priscilla Endicott all of said accumulated income and thereafter to pay to the said Priscilla Endicott the net income of said trust fund until she shall attain the age of thirty years, whereupon my Trustees shall pay over the capital of said trust fund to the said Priscilla Endicott absolutely. In the event that the said Priscilla Endicott should die before attaining the age of thirty years, I give, devise and bequeath the capital of said trust fund upon her death in equal shared to her surviving children, and, in the event that she should leave no children her surviving, I give, devise and bequeath the same in equal shares per stirpes to the then-surviving grandchildren and issue of deceased grandchildren of my brother Francis T. Maxwell.

SEVENTEENTH: I direct the payment out of my residuary estate of all succession, inheritance, estate and transfer taxes and death duties which may be levied or assessed upon or against any and all of the foregoing legacies, devises and transfers of property or upon my estate as a whole.

EIGHTEENTH: I nominate, constitute and appoint my brother, FRANCIS T. MAXWELL, my sister, J. ALICE MAXWELL, and the HARTFORD CONNECTICUT TRUST COMPANY as and to be the EXECUTORS of this my Last Will and Testament and the TRUSTEES of the trusts herein created, and in the event that either my said brother or my said sister should for any reason fail to qualify or cease to act as such Executor or as such Trustee, I nominate, constitute and appoint in his or her place and stead as such Executor or as such Trustee or both, as the case may be, my friend FREDERICK N. BELDING. I direct that no security shall be required of any of said individuals or of said Trust Company for the faithful performance of his, her or its duties as such Executor or as such Trustee and that no surety shall be required on any bond that may be given by any of them as Executor or as Trustee in any state or country in which my Will may be filed or proved.

To my said Executors and the survivor of them I give and grant full power and authority to sell any and all real estate which I may own at the time of my death and which is not specifically devised hereunder, either at public or private sale, and either for cash or on credit, or partly for cash and partly on credit, securing the payment of so much of the purchase price as remains on credit by mortgage on the property sold.

I also authorize my Executors and the survivor of them to make payment of all bequests and trusts provided for in this Will by setting apart and distributing to said legatees and to the trustees of said trusts any stocks, bonds or other securities in which my estate may be invested at the time of my death, in such manner and in such amounts as my said Executors, or the survivor of them, may prefer and at the market values of such securities, such market values to be conclusively determined by my said Executors, and also to distribute my residuary estate at like valuations by turning over to the legatees and trustees entitled thereto such securities and investments as shall remain after the payment of all expenses and legacies and trusts hereinbefore provided for; but nothing herein contained shall be deemed to prohibit the sale of any personal property owned by me at the time of my death and not herein specifically bequeathed, if my Executors shall desire to sell the same.

I authorize my Trustees to continue the investment of any trust or any part thereof in such securities and property as they may receive from my Executors, as aforesaid, although such securities and property may not be of the kind or class authorized by law for the investment of trust funds. I also authorize my Trustees to invest and reinvest any trust fund or any part thereof in any stocks, bonds or securities or real estate which they may deem advisable, and I direct that in making such investments my Trustees shall not be limited to investments of the kind authorized by law for the investment of trust funds. I also authorize my Trustees to become parties to the reorganization, consolidation or merger of any corporation the securities of which may form a part of any trust and for such purpose I direct that they shall have full authority to execute any agreement or instrument necessary and to make any necessary payments, loans or advances and to take any further steps necessary to effect the same, including the deposit, surrender and exchange of any securities which they may deem advisable in connection therewith.

I authorize my Trustees to sell any real estate which may form a part of any trust herein created either for cash or on credit or partly for cash and partly on credit, securing the payment of so much of the purchase money as remains on credit by mortgage on the property sold, and I authorize and empower my said Trustees to lease any of the real estate belonging to any trust for any term or terms of years and for such rental and upon such conditions as they may deem expedient.

In case any trust fund created under this Will shall at any time contain interest-bearing securities having a value above par, I authorize the payment of the interest in full to the beneficiary of the income and exonerate the Trustee or Trustees from all liability to retain a portion of such interest as a sinking fund for the reimbursement of principal.

I hereby expressly exempt my Executors from any obligation to file any inventory or account, any laws to the contrary notwithstanding.

In WITNESS WHEREOF I have hereunto set my hand and affixed my seal on this 8th day of February in the year One thousand nine hundred and thirty-six.

(signed) William Maxwell

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DISTRICT OF ELLINGTON

(Continued from Page 90 - Estate of William Maxwell, deceased.)

Signed, sealed, published and declared by the above-named Testator as and for his Last Will and Testament in our presence, who, at his request and in his presence and in the presence of one another, have hereunto subscribed our names as witnesses, in the Borough of Manhattan, City and State of New York, on the day and year last above written. This will consists of nine typewritten pages exclusive of this page, each initialed by the Testator.

(signed) Thomas B. Gilchrist, residing at Lawrence Park West, Bronxville, N.Y.
(signed) E. Aldrich Kniffin, residing at 205 East 78th St. N.Y., N.Y.
(signed) William G. Fennell, residing at 164 W.86th St., N.Y. City

STATE OF NEW YORK, COUNTY OF NEW YORK, (s,s.:

The within-named Thomas B. Gilchrist, E. Aldrich Kniffin and William G. Fennell being severally duly sworn, depose and say, that they witnessed the foregoing willof the within-named testator, William Maxwell, and subscribed the same in his presence and at his request and in the presence of one another; that the said William Maxwell at the time of the execution of such will appeared to them to be of full age and of sound mind and memory, and that he signed the said will and declared the same to be his Last Will and Testament in their presence, and that they make this affidavit at the request of the said testator.

(signed) Thomas B. Gilchrist
(signed) E. Aldrich Kniffin
(signed) William G. Fennell

Subscribed and sworn to before me at the request of the within-named testator, William Maxwell, on the 8th day of February, 1936.

(signed) J. W. Nelson, Notary Public No. 40, Bronx County. Ctf. Filed N.Y. County No. 239. Commission Expires March 30, 1937.

A true copy Attest: Elsie M. Nyff Clerk

CODICIL TO LAST WILL AND TESTAMENT OF WILLIAM MAXWELL

I, WILLIAM MAXWELL, of the City of Rockville and State of Connecticut, do hereby make, publish and declare the following as and for a Codicil to my Last Will and Testament bearing date the 8th day of February, 1936:

FIRST: To my sister, J. ALICE MAXWELL, I give and devise all my right, title and interest in and to the certain lots or parcels of real property, in which the graves of members of my family are located, situated in the Grove Hill Cemetery in the City of Rockville, Town of Vernon and State of Connecticut, and all other real property adjacent thereto and used in connection therewith, and together being hereinafter referred to as "family burial ground." In the event that my said sister should predecease me, I give and devise the same to the said GROVE HILL CEMETERY, IN TRUST to retain and maintain the same in perpetuity as a burial ground for such members of our family as are already interred therein and for my said sister and myself.

SECOND: To my said sister, J. ALICE MAXWELL, I give and bequeath the sum of Thirty thousand dollars ($30,000) in the event she should survive me, and, in the event that she should predecease me, I give and bequeath the sum of Forty-five thousand dollars($45,000) to HARTFORD-CONNECTICUT TRUST COMPANY, its successor or successors, IN TRUST NEVERTHELESS, to invest and reinvest the same and collect and receive the income thereof and to apply so much of said income as may be deemed necessary within the discretion of my Trustee, from time to time, to the proper and suitable maintenance and care of the said "family burial ground", together with the markers, monuments, trees, shrubbery, walls, bridges, paths, and all other structures and vegetation thereon, until such time as the Town of Vernon, or City of Rockville, or other municipal corporation shall assume the entire financial responsibility for the care, maintenance and control of the said Grove Hill Cemetery, including all of the real property referred to in Article FIRST hereof. In the event that the net income of said trust should at any time, in the discretion of my Trustee, be deemed insufficient to provide for the proper and suitable maintenance and care of said "family burial ground" as aforesaid, by reason of storms or other emergency or for any other reason, I authorize my Trustee to use and apply such part of the principal of said trust as my Trustee in its discretion shall deem advisable for the purpose aforesaid. Should the net income of said trust at any time, in the opinion of my Trustee, exceed the requirements of caring for said "family burial ground" as aforesaid, I direct that such excess income shall be paid over in the discretion of my Trustee to the ROCKVILLE PUBLIC LIBRARY, situated in the said Town of Vernon. Should the financial responsibility of caring for the said Grove Hill Cemetery be assumed as aforesaid by the said Town of Vernon or City of Rockville or other municipal corporation and by reason thereof the income of said trust fund or any part thereof shall no longer be necessary for the proper and suitable maintenance and care of said "family burial ground" as aforesaid, I direct my Trustee to pay over and distribute to ROCKVILLE PUBLIC LIBRARY all of the principal and accumulated income of said trust fund that by reason of such situation shall no longer be required for the maintenance of said "family burial ground."

THIRD: Except as modified by this Codicil, I hereby ratify and confirm my said Last Will and Testament.

IN WITNESS WHEREOF I have hereunto set my hand and affixed my seal this 3rd day of December in the year One thousand nine hundred and thirty-eight.

(signed) William Maxwell (Seal)

Signed, sealed, published and declared by the above-named Testator as and for a Codicil to his Last Will and Testament in our presence, who, at his request and in his presence and in the presence of one another, have hereunto subscribed our names as witnesses, in the Borough of Manhattan, City and State of New York, on the day and year last above written.

(signed) Robert J. Thompson residing at 1721 Linden St. Brooklyn, N.Y.
(signed) Maxine Cernes residing at 225 E. 54 St., N.Y.C.
(signed) E. A. Kniffin residing at 205 E. 78th St. N.Y.C.

VOL. 54

DISTRICT OF ELLINGTON

(Continued from Page 91 - Estate of William Maxwell, deceased)

STATE OF CONNECTICUT, DISTRICT OF ELLINGTON ss. Probate Court July 31, A.D. 1939

I, E. A. Kniffin of New York City being duly sworn, make affidavit and say that William Maxwell of Rockville, Connecticut, now deceased, signed the instrument hereto annexed bearing date the 3rd day of December A.D. 1938 and declared the same to be a Codicil to his Last Will and Testament in my presence and in the presence of Robert J. Thompson and Maxine Carnes whose names appear thereon as witnesses, at New York City on said 3rd day of December A.D. 1938; that he was at the time of signing said instrument more than 18 years of age and of sound mind; and that each of said witnesses signed said instrument so subscribed by said William Maxwell at his request, in his presence, and in the presence of each other.

(signed) E. A. Kniffin

Subscribed and sworn to the day and year above written in open Court before me,

(signed) F. T. O'Loughlin, Judge

[illegible]

A true copy Attest: Elsie M. Neff Clerk

SECOND CODICIL TO LAST WILL AND TESTAMENT OF WILLIAM MAXWELL

I, WILLIAM MAXWELL, of the City of Rockville and State of Connecticut, having made, published and declared my Last Will and Testament bearing date the 8th day of February, 1936, and a codicil thereto bearing date the 3d day of December, 1938, do hereby make, publish and declare the following as and for a second codicil to my said Last Will and Testament:

FIRST: In the event that, upon the termination of any of the trusts provided for in Article SIXTEENTH of my said Last Will and Testament, there should be no issue of my brother, Francis T. Maxwell, then living, entitled under the provisions of my said will to the capital of such trust, then and in such event I give, devise and bequeath the capital of any such trust in equal shares to ROCKVILLE PUBLIC LIBRARY, ROCKVILLE CITY HOSPITAL and UNION CONGREGATIONAL CHURCH OF CHRIST, all situated in the City of Rockville and State of Connecticut.

SECOND: Except as modified by this codicil, I hereby ratify and confirm my said Last Will and Testament and codicil thereto.

IN WITNESS WHEREOF I have hereunto set my hand and affixed my seal on the 3rd day of January in the year One Thousand nine hundred and thirty-nine.

(signed) William Maxwell (Seal)

Signed, sealed, published and declared by WILLIAM MAXWELL, the above-named testator, as and for the second codicil to his Last Will and Testament in our presence who, at his request and in his presence and in the presence of one another, have hereunto subscribed our names as witnesses in the Borough of Manhattan, City and State of New York, on the day and year last above written.

(signed) Curtis R. Southwick residing at 104-36 196 St. Hollis, L.I., N.Y.
(signed) E. A. Kniffin residing at 205 East 78th St. N.Y.C.
(signed) T. R. Webb residing at 419 W. 119 St. N.Y.C.

STATE OF NEW YORK, COUNTY OF NEW YORK, ss.:

The within named Curtis R. Southwick, E. A. Kniffin and T. R. Webb, being severally duly sworn, depose and say that they witnessed the foregoing codicil to the will of the within-named testator, William Maxwell, and subscribed the same in his presence and at his request and in the presence of one another; that the said William Maxwell at the time of the execution of such codicil appeared to them to be of full age and of sound mind and memory, that he signed the said codicil and declared the same to be the second codicil to his Last Will and Testament in their presence and that they make this affidavit at the request of the said testator.

(signed) C. R. Southwick
(signed) E. A. Kniffin
(signed) T. R. Webb

Subscribed and sworn to at the request of the within-named testator William Maxwell on the 3rd day of January, 1939.

(signed) E. A. Hegblom, Notary Public (Seal)

A true Copy Attest: Elsie M. Neff Clerk

DECREE ADMITTING WILL & ORDERS

At a Court of Probate held at Vernon, within and for the District of Ellington, County of Tolland, State of Connecticut, on the 31st day of July, 1939

Present, Hon. Francis T. O'Loughlin, Judge

ESTATE OF WILLIAM MAXWELL, late of Vernon in said District, deceased.

Upon the application of The Hartford-Connecticut Trust Company of Hartford Conn. praying that an instrument in writing purporting to be the last will and testament of said deceased, and codicils thereunto, be admitted to probate and that letters testamentary on said estate be granted as per application on file more fully appears;

This Court for cause shown, viz: that all parties known to be interested in said estate and legally capable of acting have signed and filed in Court a written waiver of notice, dispenses with notice of the pendency of said application, and of a hearing thereon.

File

ROCKVILLE CITY HOSPITAL

Source and Terms of Funds Held

Alvah N. Belding Fund #73041 - Legacy u/w Alvah N. Belding - Permanent Endowment - Income for general purposes.

Terms of Will - "To be used and expended for the purposes indicated in the Will of William H. Prescott, as they may deem most advisable."

Alice Farmer Bissell Fund #73051 - Bequest under the Will of Arthur T. Bissell - Permanent Endowment - Income for general purposes.

Terms of Will - Fourth: I give and bequeath to the Rockville City Hospital the sum of Twenty-five Thousand Dollars ($25,000) to be kept as a permanent fund in memory of my wife, Alice Farmer Bissell, and to be known as the Alice Farmer Bissell Fund. The net income from said fund shall be used and applied for the general purposes of said Hospital.

Ruth T. Britton Fund #73061 - Bequest u/w Ruth Talcott Britton - Permanent Endowment - Income for general purposes.

Terms of Will - "In trust to keep said sum safely invested, and to use and apply the income for the general purposes of said Hospital at the discretion of its trustees."

Consolidated Fund #73081 - This fund represents all bequests of $3,000 or less left with no instructions as to use. Principal is considered permanent endowment - Income is used for general expenses of the Hospital.

George S. Doane Fund #73101 - No record found of source of this fund. Principal is considered permanent endowment - all income is used for expenses of the Hospital.

General Fund #73121 - This fund represents small gifts and bequests which were unrestricted as to use of principal or income. Principal is considered unrestricted - Income is used for general expenses of the Hospital.

Lenore Henry Fund #73141 - Bequest u/w E. Stevens Henry - Permanent endowment - Income for general purposes.

Terms of Will - Ninth: I give and bequeath to the Hospital to be established in Rockville under the provisions of the Will of the late William H. Prescott to be known as the "Rockville City Hospital." This bequest is to constitute a special endowment fund of Fifty Thousand Dollars ($50,000) to be set apart and known as the Maud Henry Fund in memory of my deceased daughter, Maud. I likewise give and bequeath Fifty Thousand Dollars ($50,000) to said Hospital also to be set apart as a separate endowment fund and known as the "Lenore Henry" Fund in memory of my deceased daughter, Lenore. The income of these two funds is to be used for the maintenance of said Hospital. My Executors are directed to provide for this fund by selecting and transferring from my estate to trustees or duly authorized agent of said Hospital certain bonds or savings bank deposits of the par value of One Hundred Thousand Dollars ($100,000), and I further direct that whenever reinvestments become necessary or advisable such reinvestments shall be limited and confined to securities legal for savings banks of Connecticut or in deposits in savings banks.

Maud Henry Fund #73161 - Bequest u/w E. Stevens Henry - Permanent endowment - Income for general purposes. (For terms of will, see Lenore Henry Fund)

J. Alice Maxwell Fund #73171 - Bequest u/w J. Alice Maxwell - Permanent endowment - Income for general purposes.

> Terms of Will - NINTH: To ROCKVILLE CITY HOSPITAL, in Rockville, Connecticut, I give, devise and bequeath four of said equal parts of my said residuary estate in trust to use the income thereof for the general purposes of the said Hospital.

John and Martha Kress Fund #73181 - Bequest under will of Martha Kress - This fund was left for a special purpose. In accordance with the instructions of the Board of Trustees of the Hospital, income accumulates and is transferred to principal for reinvestment.

> Terms of Will - "To be used for the purpose of equipping, furnishing, and maintaining a room in said Hospital to be known and called the "John and Martha Kress Room".

Edgar Keney Fund #73201 - No record found of source of this fund. It is believed to have been left for a special purpose. In accordance with the instructions of the Board of Trustees of the Hospital, income accumulates and is transferred to principal for reinvestment.

Francis T. Maxwell Fund #73211 - This fund is considered permanent endowment. Income is used for general purposes. The fund consists of the proceeds of a $50,000 life insurance policy on the life of Francis T. Maxwell, plus gifts by Mr. Maxwell during his life of 50 shares Phoenix Insurance Company and 200 shares Hartford Gas Company. These gifts of stock were restricted to use of income for general purposes and principal to be used only toward a new hospital.

Harriet K. Maxwell Fund #73281 - Bequest under will of Harriet K. Maxwell - outright legacy - income is used for general expenses of the Hospital.

> Terms of Will - Third: "----and unto the Rockville City Hospital of Rockville, Connecticut, the sum of Five Thousand Dollars ($5,000)

Robert Maxwell Fund #73241 - Bequest u/w Robert Maxwell - outright legacy - income is used for general expenses of the Hospital. (The will gave discretion to executors to devote sum of $100,000 "in such manner as they may deem suitable for the benefit of said residents of Rockville and vicinity". One Hundred Thousand Dollars ($100,000) was paid to Rockville City Hospital per final account of executors.)

William A. and Caroline E. Metcalf Fund #73251 - Bequest u/w Caroline E. Steele Metcalf - Permanent endowment - Income for general purposes.

> Terms of Will - NINTH: All the rest, residue and remainder of my estate, of whatsoever nature and wheresoever situated, I give, bequeath and devise to the Trustees of The Rockville City Hospital, Inc., a charitable corporation organized and existing under the laws of the State of Connecticut, and owning and operating a hospital in said Town of Vernon, in trust, nevertheless, to hold invest and reinvest the same and to use the income thereof for the general uses and purposes of said Hospital as said Trustees shall see fit. Said trust shall be known as the William S. and Caroline E. Metcalf Fund.

William Maxwell Fund #73261 - This fund consists of the following:

Cash gifts by Mr. Maxwell during 1936 to 1938	$14,000.00
Proceeds of life insurance (1939)	61,472.99
Bequest under 14th clause of will	96,246.01
	$171,719.00

Terms of Will - FOURTEENTH: To ROCKVILLE CITY HOSPITAL, in Rockville, Connecticut, I give, devise and bequeath four of said equal parts of my said residuary estate in trust to use the income thereof for the general purposes of said Hospital.

Charles Phelps Free Bed Fund #73271 - Gift of $10,000 from Mrs. Elsie S. Phelps - Permanent endowment - Income for special purposes. Any amount of this fund in excess of $10,000 represents accumulated income and is considered available if necessary.

Terms of Gift

"1. For the benefit of any members of my household staff or their families who may be in need of the services which the fund can provide.

2. For the general use and benefit of the residents of the City of Rockville.

The fund, aside from the small conditions which I wish to impose for the benefit of my household staff, which will fall within the income limitations of the fund, will be managed by the Board of Trustees and Finance Committee of The Rockville City Hospital with full powers of sale, investment and reinvestment."

Celia E. Prescott Fund #73281 - This fund was left for a special purpose. In accordance with the instructions of the Board of Trustees of the Hospital, income accumulates and is transferred to principal for reinvestment.

Terms of Gift

$10,000.	for free bed in honor of Francis and Eliza Porter Keeney
$ 5,000.	for free bed in memory of Francis Keney Prescott
$ 400.	for furnishing a room in memory of Jane E. Newcomb

George Palmer Charter Fund #73291 - Request under Second and Seventeenth Clauses of Will of George Palmer Charter - permanent endowment - income for general purposes.

Terms of Will

SECOND

I give and bequeath to the Rockville City Hospital, located in the city of Rockville, State of Connecticut, the sum of Ten Thousand (10,000) dollars, in trust, however, for the following uses and purposes, namely: The governing body of said hospital shall invest said sum of $10,000 and the annual income of said sum shall be used for the general maintenance of said Hospital.

George Palmer Charter Fund #73291 continued

SEVENTEENTH

All the rest, residue and remainder of my estate, of whatsoever nature and wheresoever situated which I may own or have the right to dispose of at the time of my decease, I give, devise and bequeath in equal proportions, share and share alike to the Rockville City Hospital located in the city of Rockville, State of Connecticut, and to the Cyril and Julia C. Johnson Memorial Hospital, Inc. located at Stafford Springs, State of Connecticut, in trust each of said hospitals shall invest the sums derived under this Article of my last Will and Testament and the annual income of said sums shall be used for the general maintenance of each of said hospitals.

William H. Prescott Fund #73301 - Bequest u/w William H. Prescott. Permanent endowment - income for general purposes.

Terms of Will -

"13. I give and bequeath to Francis T. Maxwell, Arthur T. Bissell, J. Alice Maxwell, A. N. Belding and Thomas W. Sykes, all of Rockville, Connecticut, the sum of Fifty Thousand Dollars ($50,000) in perpetual trust to them and their successors in office, for the purpose of establishing and maintaining at said city of Rockville, a general hospital for the sick, to be open and available to all residents of the said City of Rockville, and of such portion of the immediate vicinity thereof contiguous and adjacent thereto, as in the judgment of said Board of Trustees may be deemed wise and advisable, subject to such rules and regulations concerning admission to said hospital as said trustees and their successors in office may, from time to time, establish.

Said trustees and their successors in office shall have power to receive property by gift or otherwise, and to purchase land and erect buildings for the purpose of carrying out the provisions of this trust.

The general management and oversight of said hospital, including the character and method of treatment therein to be established, shall be vested wholly in said Board of Trustees and their successors in office.

Said Board may elect a President, Vice-President, Secretary and Treasurer, and such other executive officers as they may deem necessary or advisable to carry out the purpose of this trust, including a superintendent of said institution. All vacancies in said Board arising from any cause, shall be filled by appointment of the surviving trustees.

William H. Prescott Fund #73301-continued

Terms of Will-continued

> The Board of Trustees shall have power, from time to time, to make by-laws defining the duties of said officers and superintendent, the method of calling meetings of the Trustees and other by-laws relative to the management and government of the same. Provided, however, that, if at any time before my decease, I shall make provision for the transfer of the sum of fifty thousand dollars ($50,000) to the above named, as trustees for the purpose of inaugurating the establishment of a City Hospital, thereby substantially carrying out the provisions of this paragraph of my will, then and in that event, I revoke this paragraph of the same relating to said Hospital, and declare it inoperative, but otherwise to remain in full force and effect."

Stephen Goodale Risley and Emeret Scott Risley Fund #73311 (1949) - Bequest u/ Ninth and Twenty-first clauses of Will of May R. Adams - permanent endowment - income for general purposes.

Terms of Will

> "NINTH: I give and bequeath unto THE ROCKVILLE CITY HOSPITAL, INC. of said Rockville, the sum of Ten Thousand Dollars, in memory of my father and mother, Stephen Goodale Risley, M.D. and Emeret Scott Risley, for the establishment of a fund to be known as the Stephen Goodale Risley and Emeret Scott Risley Fund, the income thereof to be used for the general uses and purposes of said Hospital."
>
> "TWENTY-FIRST: All the rest, residue and remainder of all my property, of every description, both real and personal, of whatsoever the same may consist or wheresoever it may be situated, I give, devise and bequeath unto said THE ROCKVILLE CITY HOSPITAL, INC. in order that the same may be added to and become a part of the Stephen Goodale Risley and Emeret Scott Risley Fund, which is established in Paragraph Ninth of this my last Will and Testament." ($79,688.80)

Rockville Chapter American Red Cross Fund #73321 - Gift from Rockville Chapter of American Red Cross - considered permanent endowment - income is used for general expenses of the Hospital.

William B. and Lizzie Lathrop Sprague Fund #73341 - Bequest u/w Lizzie Lathrop Sprague - considered permanent endowment - income is used for general expenses of the Hospital.

Terms of Will

> "---to be known as the William B. and Lizzie Lathrop Sprague Fund".

Swindells Fund #73351 - This fund represents donations received from the Swindells Foundation. Income and/or principal may be used for care of deserving persons or used for general hospital expenses. Surplus income is transferred to principal.

Fred Talcott Fund #73361 - Bequest u/w Fred Talcott - considered permanent endowment - income for general purposes.

Terms of Will

"SIXTEENTH: Whereas one William H. Prescott of said Rockville, now deceased, in and by his will bequeathed a large sum of money towards the support and maintenance of a hospital to be thereafterwards established in said Rockville, and it is my desire to make a contribution towards the erection and establishment of such hospital. I give and bequeath to the persons who at the time of my decease may be the custodians of the said fund, bequeathed as aforesaid by said Prescott, the sum of five thousand dollars to be used by them or their successors in such trust towards the erection and establishment of such hospital."

"TWENTIETH:----Upon the decease of the last survivor of the aforesaid beneficiaries under this trust I direct that one-half part of all the trust estate and property then remaining in the hands of my said trustee be by it made over to the persons mentioned in the sixteenth clause of this my will as the custodians of the William H. Prescott Fund, or to the persons who at the termination of this trust may be such custodians, to be applied towards the establishment of the hospital in said Rockville proposed or contemplated in the will of said Prescott, but if such hospital shall then be already established then said one-half of said trust estate and property shall be by said trustee made over to such hospital to be used by it for its uses and purposes."

Trumbull Chapter, D.A.R. Fund #73381 - Gift from Trumbull Chapter, D.A.R. - considered permanent endowment - income to be used for free bed, Sabra Trumbull Daughters to have preference, or any deserving person, to be decided by Hospital Trustees and Advisory Board of Sabra Trumbull Chapter. Any unused income is added to principal.

United German Society Fund #73391 - Gift from United German Society - considered permanent endowment - income is used for general expenses of the Hospital.

November 24, 1952

Florence R. Whitlock Fund #73371 - Bequest under will of Florence R. Whitlock (1953) - $13,351.35, a permanent endowment. Income for free bed or beds. Terms of will:

"2...The remaining four-tenths (4/10ths) of said residue, I give, devise and bequeath to the Rockville City Hospital for the purpose of establishing a free bed or beds in said Hospital in memory of my mother, Anna Shelton Whitlock."

Betsey C. Tucker Fund #73360 - Bequest under will of Betsy C. Tucker (1955) - $2,000, a permanent endowment. Income for free bed. Terms of will:

"Second: I give and bequeath to The Rockville City Hospital of Rockville, Connecticut, Two Thousand (2,000) Dollars to be its absolutely and forever. This bequest is to be used by said Hospital as an endowment for the partial maintenance of a free bed in said Hospital."

Anna M. and Albert H. Bilson Fund #745081 - Bequest under will of Anna M. Bilson of $10,371.08 as follows: (January 22, 1957)

"NINTH: All the rest, residue and remainder of my Estate, both real and personal of whatsoever nature and wheresoever situated is to be sold and one-half of the proceeds are to be given to the Union Congregational Church of Christ, Inc. to be known as the Anna M. Bilson and Albert H. Bilson Fund. I direct the trustees of said Church to lawfully invest said legacy and to use the income therefrom for the general uses and purposes of said Church. The remaining one-half thereof I give and devise unto the Rockville City Hospital, Inc. of the Town of Vernon to be known as the Anna & Albert Bilson Fund. I direct the trustees of said Hospital to lawfully invest said legacy, and to use the income therefrom for the general uses and purposes of said Hospital.

Following the meeting of the Corporators, a meeting of the Trustees of the Rockville City Hospital, Inc. was held, those present being:

Lebbeus F. Bissell
Roy C. Ferguson
Donald C. Fisk
John R. Gottier
Frank E. Hardenbergh
Claude A. Mills
John S. Mason

Lebbeus F. Bissell, president, presided.

The minutes of the previous meeting on January 15, 1952 were read and approved.

It was voted that the Secretary cast one ballot for the following officers for the ensuing year, or until their successors are chosen:

President	Lebbeus F. Bissell
Vice-President	Claude A. Mills
Secretary	John S. Mason
Treasurer	Hartford-Connecticut Trust Co. (Rockville Branch)

The ballot was cast and the chairman declared them elected.

It was voted that the Secretary cast one ballot for the following to serve as Executive Committee for the ensuing year or until their successors are chosen:

Lebbeus F. Bissell
Frank E. Hardenbergh
Roy C. Ferguson

The ballot was cast and the Chairman declared them elected.

It was voted that the Secretary cast one ballot for the following to serve as Finance Committee for the ensuing year or until their successors are chosen:

Lebbeus F. Bissell
Claude A. Mills
Donald C. Fisk

The ballot was cast and the Chairman declared them elected.

It was voted that the Secretary cast one ballot for the following to serve as Auditors for the ensuing year or until their successors are chosen:

Frank E. Hardenbergh
Claude A. Mills
John R. Gottier

The ballot was cast and the Chairman declared them elected.

The Treasurer's report for the period 1 September 1951 through 1 September 1952 was read and discussed, and it was voted that same be accepted and placed on file.

Upon motion duly made and seconded, it was voted to adjust the salaries of the Superintendent and Manager.

The proposed changes in the Funds, submitted by the Treasurer, were discussed, and upon motion duly made and seconded, it was voted that the Hartford-Connecticut Trust Co. be authorized to make the following changes in accordance with the following resolutions:

"WHEREAS, Rockville City Hospital has certain endowment funds which are maintained in separate accounts and it is desired to combine said funds for bookkeeping and investment purposes, and

WHEREAS, it appears from the terms under which such funds were established that such funds may be properly combined.

Now therefore, it is

VOTED: That the Treasurer be authorized and instructed to establish two new funds under the title Memorial Funds Unrestricted and Memorial Funds Restricted, respectively.

It is also

VOTED: That January 15, 1953 shall be established as the date for the combination of three separate funds (listed below) under the title of the new "Memorial Funds Unrestricted". The original book value of each of the separate funds shall be reaffirmed as the Memorial value of each of such endowments, and the January 15, 1953 book value of the investments comprising these three funds shall be carried over into the new "Memorial Funds Unrestricted" as the book value of the combined investments.

General Fund
Harriet K. Maxwell Fund
Swindells Fund

It is also

VOTED: That January 15, 1953 shall be established as the date of the new combination of ten separate funds (listed below) under the title of the new "Memorial Funds Restricted". The original book value of each of the separate funds shall be reaffirmed as the Memorial value of each of such endowments, and the January 15, 1953 book value of the investments comprising these ten funds shall be carried over into the new "Memorial Funds Restricted" as the book value of the combined investments.

Purchase by PMH

Alvah S. Belding Fund
Ruth T. Britton Fund
Consolidated Fund
George S. Doane Fund
J. Alice Maxwell Fund
William A. and Caroline E. Metcalf Fund
George Palmer Charter Fund
Rockville Chapter ARC Fund
William B. and Lizzie Lathrop Sprague Fund
Edgar Feeney Fund

It is also

VOTED: That securities and cash of the William Maxwell Fund having a market value as of October 9, 1952 of $107,346.29 be carried over from the William Maxwell Fund to the new "Memorial Funds Unrestricted", and the value of $75,472.99 be affirmed as the Memorial value of the William Maxwell gifts in the "Memorial Funds Unrestricted". The present book values of the securities transferred to the "Memorial Funds Unrestricted" shall be carried over to that Fund at the same book values."

Upon motion duly made and seconded, it was voted that the Finance Committee be authorized to rule on the proposed shift in some of the investments as recommended by the Hartford-Connecticut Trust Co.

Upon motion duly made and seconded it was voted that Lebbeus F. Bissell, Trustee of said Hospital, be authorized and directed to sign all and any applications, bonds and all other necessary papers pertaining to the Alcohol Tax Free Permit in behalf of said Hospital for the purpose of obtaining alcohol free of tax for use by the Hospital.

ed Asset Purchase by PMH
ber 13, 2015

Mr. Williams was called into the meeting and gave a report on the hospital operations.

There being no further business, the meeting was adjourned at 11:18.

Attest:

John S. Pearson
Secretary

EXHIBIT Q 11-2

Fund 11-1.38

Cora Lloyd Smith Fund

LAST WILL AND TESTAMENT,

I, CORA LLOYD SMITH of the Town of Vernon in the County of Tolland ~~in the State of~~ Connecticut, being of lawful age, of sound and disposing mind, memory and judgment, do hereby make, publish and declare this to be my last Will and Testament, hereby revoking all previous wills and codicils by me made.

FIRST: I will and direct that all my just debts and funeral expenses be paid and discharged by my Executor hereinafter named.

SECOND: I direct my Executor hereinafter named to place upon my grave on the Lloyd cemetery lot in the Grove Hill Cemetery, in said town of Vernon, a marker similar in design and type to the markers on said cemetery lot; and I further direct my Executor to cause suitable inscriptions to be placed on said marker.

THIRD: I give and bequeath unto my daughter ANITA WEIR BOLLINGER of Chicago, Illinois, the sum of Five Hundred Dollars, if living at the time of my death; to be hers, absolutely.

FOURTH: I give and bequeath unto ANNA FITZGERALD of said town of Vernon, the sum of One Hundred Dollars; to be hers, absolutely.

FIFTH: I give and bequeath unto BESSIE FITZGERALD of said town of Vernon, the sum of One Hundred Dollars; to be hers, absolutely.

SIXTH: All the rest, residue and remainder of all my property, both real and personal, of whatsoever the same may consist or wheresoever it may be situated, I give, devise and bequeath unto THE HARTFORD-CONNECTICUT TRUST COMPANY of said town of Vernon, and to its successor or successors, IN TRUST, however, to hold, invest and reinvest the same as to my said trustee shall seem to be for the best interests of my estate, to collect the income thereof and after paying all proper charges therefrom, to pay the net income in quarterly instalments or oftener, at the discretion of my said trustee, to or for the benefit of my husband CLARENCE SMITH, so long as he shall live.

If and in the event said income is insufficient to support my said husband, in sickness, in a reasonable and proper manner, I direct my said trustee to pay from time to time, during his sickness, so much of the principal of said trust fund as it may, in its discretion, deem proper and necessary for my said husband's proper and suitable care.

Upon the death of my said husband CLARENCE SMITH, I direct that said trust shall cease and terminate, and I give, devise and bequeath said trust fund remaining at said time, as follows, to wit:

(a) One-half thereof unto THE UNION CONGREGATIONAL CHURCH OF CHRIST, INC. of said town of Vernon, to be known as the Cora Lloyd Smith Fund. I direct the trustees of said Church to lawfully invest said legacy and to use the income therefrom for the general uses and purposes of said Church.

(b) The remaining one-half thereof unto THE ROCKVILLE CITY HOSPITAL, INC. of said town of Vernon, to be known as the Cora Lloyd Smith Fund. I direct the trustees of said Hospital to lawfully invest said legacy and to use the income therefrom for the general uses and purposes of said Hospital.

SEVENTH: If and in the event that both my brother IRWIN F. B. LLOYD and his son IRWIN LLOYD, Jr. of Hartford, Connecticut, or either of them, desire to be buried in said Grove Hill Cemetery, it is my express wish that they be buried in the Bown family lot, in said Grove Hill Cemetery, title to which stands in my name.

I APPOINT my said husband CLARENCE SMITH of the Town of Vernon County of Tolland and State of Connecticut executor of this my Last Will and Testament

IN WITNESS WHEREOF I have hereunto set my hand and seal at said Vernon on the 10th day of May A. D., One Thousand Nine Hundred and Forty.

Cora Lloyd Smith. L S

Signed, sealed, published and declared by the said CORA LLOYD SMITH as and for her Last Will and Testament, in presence of us, who at her request, in her presence, and in the presence of each other have hereunto subscribed our names as witnesses, on the 10th day of May A. D., 1940

Francis H. Burke MD
Florence H Ziegler
Jane Doreszewska
} Witnesses.

State of Connecticut, } ss.
Probate District of Hartford. }

I, WILLIAM S. LOCKE, Clerk of the Court of Probate for the District of Hartford, in said State, and keeper of the seal thereof, do certify that the within constitutes a true copy of the last will and testament of CORA LLOYD SMITH or CORA E. LLOYD WEIR SMITH, late of Hartford, in said District, deceased, as appears by the records and files of said Court.

In Witness Whereof, I have hereunto affixed the seal of said Court and subscribed my name at Hartford, this 18th day of March, 19 47.

William S. Locke Clerk.

State of Connecticut, } ss.
Probate District of Hartford. }

I, RUSSELL Z. JOHNSTON, Judge of the Court of Probate for the District of Hartford, in said State, do hereby certify that WILLIAM S. LOCKE, whose name is subscribed to the above attestation, was, at the time of signing the same, and still is, Clerk of said Court, and that said attestation is in due form of law.

In Witness Whereof, I have hereunto subscribed my name at Hartford, this 18th day of March 1947.

State of Connecticut, } ss.
Probate District of Hartford. }

Russell Z. Johnston Judge.

I, WILLIAM S. LOCKE, Clerk of the Court of Probate for the District of Hartford, in said State, and keeper of the seal thereof, do certify that the signature of RUSSELL Z. JOHNSTON to the preceding certificate is genuine and that he is the duly elected and qualified Judge of said Court of Probate for the District of Hartford.

In Witness Whereof, I have hereunto affixed the seal of said Court and subscribed my name at Hartford, this 18th day of March, 19 47.

William S. Locke Clerk.

ECHN Probate Image Purchase by PMH
Submitted October 13, 2015

EXHIBIT Q 11-2

Fund 11-1.39

Bruno E. and Maud J. Doss

SEE CODICIL ATTAC

RECORD COPY

Circulated on: 4-30-59
By: [illegible]

LAST WILL AND TESTAMENT

I, BRUNO E. DOSS, of the Town of Vernon, County of Tolland, and State of Connecticut, being of lawful age, of sound and disposing mind, memory and judgment, do hereby make, publish and declare this to be my Last Will and Testament, hereby revoking all previous wills and codicils by me made.

FIRST: I direct my Executor hereinafter named to pay my funeral expenses and just debts, and I hereby direct that all legacy, succession, inheritance, transfer and estate taxes shall be paid by my Executor out of my estate in the same manner as an expense of administration and shall not be prorated or apportioned among or charged against the respective devisees, legatees, beneficiaries, transferees or other recipients, except as hereinafter set forth, nor charged against any property passing or which may have passed to any of them and that my Executor shall not be entitled to reimbursement for any portion of any such tax from any person.

SECOND: All the rest, residue and remainder of my estate, of every nature and kind wheresoever the same may be situated, I give, devise and bequeath to my Trustee, hereinafter named, in trust however, to invest and reinvest the same, and pay the net income therefrom, not less frequently than quarterly, if convenient, to my wife, MAUD J. DOSS, so long as she shall live. Anything herein contained to the contrary notwithstanding, my Trustee may at any time and from time to time pay over to my said wife so much or all of the principal of this trust for her benefit as my Trustee in its absolute discretion deems advisable and the judgment of my Trustee as to the amount of such payments and the advisability thereof shall be final and conclusive upon all persons interested or who may become interested in such trust.

If my said Trustee should deem it necessary or advisable to purchase or sell stocks or bonds comprising any portion of said trust, then it is my wish that

Carl O. Bruchard 5/4/59

Stephen E. Ketcham
Attorney At Law
Henry Building
Rockville, Conn.

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said transactions be carried on through the brokerage firm of COOLEY & CO., 100 Pearl Street, Hartford, Connecticut, and preferably through NORMAN SPENCER, if he is there affiliated.

THIRD: Upon the death of my said wife I direct my said Trustee, hereinafter named, to pay over and deliver the then remaining principal of said trust estate to my Executor hereinafter named to divide as hereinafter set forth and which principal I give, devise and bequeath and direct my Executor to distribute as follows:

a. Subject to sub-paragraph "e" of this Paragraph Third, I bequeath Three Thousand (3,000) Dollars in cash, to my said Trustee hereinafter named in trust however, for the following purpose: to invest and reinvest the same and use the net income therefrom to provide a fund to be known as the BRUNO E. DOSS ROCKVILLE HIGH SCHOOL ATHLETIC FUND, and the proceeds of which shall be spent for the purpose or purposes agreed upon by the current Principal and athletic coaches (both male and female) of the Rockville High School, and to be in conjunction with athletic activities of the school. I direct that said purpose or purposes be something other than normal current expenses of the athletic program and to the end that this fund should not be used directly or indirectly to affect the normal town budget allocation for athletic activities. Otherwise, I give to them a wide discretion.

b. Subject to sub-paragraph "e" of this Paragraph Third, I bequeath the sum of Five Thousand (5,000) Dollars in cash to Yale University in trust for the following purpose: To manipulate said money in its discretion, to the end that a fund be provided to be known as the BRUNO E. DOSS SCHOLARSHIP FUND for the aid and assistance of needy and deserving students, with the understanding that all loans from said fund are to be repaid, if possible, when said students are able to do so. It is my wish that preference be given to boys living in Tolland County.

Carol A. Bouchard 5/4/56

Stephen E. Ketcham
Attorney At Law
Henry Building
Rockville, Conn.

c. Subject to sub-paragraph "e" of this Paragraph Third, I bequeath the sum of Five Thousand (5,000) Dollars in cash to the UNIVERSITY OF CONNECTICUT in trust for the following purpose: To manipulate said money in its discretion, to the end that a fund be provided to be known as the BRUNO E. DOSS SCHOLARSHIP FUND for the aid and assistance of needy and deserving students, with the understanding that all loans from said fund are to be repaid, if possible, when said students are able to do so. It is my wish that preference be given to boys living in Tolland County.

d. Subject to sub-paragraph "e" of this Paragraph Third, I bequeath Ten Thousand (10,000) Dollars in cash to ROCKVILLE CITY HOSPITAL, INC., in trust for the following purpose: To set up a fund to be known as BRUNO E. DOSS and MAUD J. DOSS fund; to invest and reinvest the same in its discretion and to pay over only the income therefrom, at least annually, to the ROCKVILLE CITY HOSPITAL, INC. GENERAL OPERATING EXPENSE ACCOUNT.

Carol A. Buchard 5/4/56

e. In the event that at my death my records should show that sub-paragraphs "a", "b", "c" and "d" of this Paragraph Third have been carried out, in whole or in part by me prior to my death, then in that event, I direct that the provisions as set forth in said sub-paragraphs shall be diminished to the extent that they have been carried out.

f. All the rest, residue and remainder of my estate of every nature and kind wheresoever the same may be situated after the payment of all administration expenses, I give, devise and bequeath to my sons, PHILIP G. DOSS, of 88 Grand Avenue, Rockville, Connecticut, and LEON F. DOSS, of 17 Washington Place, Bloomfield, New Jersey, in equal shares, to be theirs, absolutely. However, in the event either of my said sons should not be alive at the time of distribution hereunder then in that event I give, devise and bequeath such son's share, in equal shares, to his children who are alive

Stephen E. Ketcham
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at the time of distribution hereunder. However, in the event either of my said sons should not be alive at the time of distribution hereunder and should have no children alive at the time of distribution hereunder, then in that event, I give such son's share to the wife which he had at the time of his death, provided she is alive at the time of distribution hereunder. However, in the event either of my said sons should not be alive at the time of distribution hereunder and should have no children alive at the time of distribution and if he had no wife at the date of his death who is alive at the time of distribution hereunder, then in that event, I give, devise and bequeath the share of the son not alive at the time of distribution hereunder to the surviving son if he be alive at the time of distribution hereunder, or his children or his wife, as aforesaid.

FOURTH: I hereby permit my said wife, MAUD J. DOSS, to turn over to my trustee as set forth in Paragraph Second of this my will any property both real and personal which the said trustee shall be willing to accept and to have said property thereby increase the principal of said trust and be thereafter controlled by said trustee and disposed of as set forth in this my Will.

FIFTH: I nominate and appoint THE CONNECTICUT BANK AND TRUST COMPANY, of Hartford, Connecticut, to be the Executor of this my Last Will and Testament and to be the Trustee of each and every trust not otherwise provided for in this Will, and I direct that it shall serve in both of said capacities without being required to furnish any bonds or other security for the faithful performance of its duties as such.

SIXTH: I authorize and empower my said Executor and my said Trustee in addition to the powers and discretions hereinbefore specifically mentioned and those conferred upon it by law and unless herein expressly prohibited, the following power and authority which may be exercised by it, in either or both capacities, at any time and from time to time, as it shall in its absolute

Carl G. Bruckner 5/4/56

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discretion deem advisable and without the necessity of obtaining any order or orders from the Probate Court in which this Will is probated; to hold and retain all or any part of the investments or other property of which my estate shall consist at the time of my death, or at the time of the receipt thereof by my Trustee from my Executor, as long as it may deem advisable; to change investments from time to time, and to invest and reinvest any funds in my estate or any trust created hereby, whether principal or income, and whether original or subsequent, in such investments as it may deem advisable, without being limited to the class of property or securities in which Executors or Trustees are or may hereafter be authorized by law to invest funds, it being my intention to give my Executor and Trustee the same power of investment and reinvestment which I myself possess with respect to my own funds; to sell and convey at public or private sale, to mortgage or to lease under such terms and conditions and for such period of time as my Executor or Trustee may deem best, even though such period may or will extend beyond the settlement of my estate or the duration of any trust, any and all property, whether real or personal, of which I may die seized or possessed or which may at any time come into the hands of my said Executor or Trustee; to divide or distribute my estate and the securities or other property of any trust created hereby, to make such division or distribution wholly or partly in kind and at such valuations as it may deem proper, and its selection of securities or other property and its valuations placed thereon shall be final and conclusive upon all parties at interest; to vote by proxy or in person with respect to any securities forming part of my estate or of any trust created hereby, to deposit any such securities under any plan of reorganization, merger, or exchange that it may approve, to accept the new securities which may be offered under any such plan, to pay any and all assessments levied or imposed under any such plan, to delegate

Carol L. Buckland 5/4/16

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to any committee formed to protect the interests of holders of such securities such powers as it shall deem advisable and, generally, to take all action with respect to any such securities as it might or could take as absolute owner thereof; to hold and administer the trusts created hereby in one or more consolidated funds, in whole or in part, in which the separate trusts shall have undivided interests; to exercise all power and authority including any discretion, conferred in this Will, with respect to all accumulations of income; and to compromise, adjust and settle any claim, debt or obligation which may be owing from or to, or be made against or in behalf of my estate or any trust hereby created.

I authorize and empower the Trustee of each trust created hereby, in its sole and uncontrolled discretion, to decide what is principal, what is income and what is net income, and to determine whether expenses shall be paid from principal or from income.

SEVENTH and LAST: I direct that this Will shall not be revoked by any future marriage by me, birth to me, or adoption by me of any child or children.

IN WITNESS WHEREOF, I have hereunto set my hand and seal at Rockville, Connecticut, on the 4th day of May, A. D., One Thousand Nine Hundred and Fifty-Six.

Bruno E. Doss (L.S.)

Signed, sealed, published and declared by the said BRUNO E. DOSS as and for his Last Will and Testament, in presence of us, who at his request, in his presence, and in the presence of each other have hereunto subscribed our names as witnesses, on the 4th day of May, A. D., 1956.

Carol A. Bouchard)
E. George G[illegible]) Witnesses
Werner O. [illegible])

Carol A. Bouchard 5/4/56

Stephen E. Keyman
Attorney At Law
Henry Building
Rockville, Conn.

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Submitted October 13, 2015

STATE OF CONNECTICUT:
: ss. Vernon
COUNTY OF TOLLAND :

May 4, A.D. 1956

We the within named Carol A. Bouchard, E. George Gorsky and Werner O. Kunzli,

being duly sworn, make affidavit and say: That we severally attested the within and foregoing Will of the within named testator and subscribed the same in his presence and at his request and in the presence of each other; that the said testator signed, published and declared the said instrument as and for his Last Will and Testament in our presence on the 4th day of May, A. D. 1956; and at the time of execution of said will, said testator was more than eighteen years of age and of sound mind, memory and judgment and under no improper influence or restraint to the best of our knowledge and belief, and we make this affidavit at the request of said testator.

Carol A. Bouchard

E. George Gorsky

Werner O. Kunzli

Carol A. Bouchard 5/4/56

STATE OF CONNECTICUT:
: ss. Vernon
COUNTY OF TOLLAND :

May 4, A. D. 1956

Then personally appeared before me, Stephen E. Ketcham, duly qualified to administer oaths.

Carol A. Bouchard

E. George Gorsky

and Werner O. Kunzli

and subscribed and made oath to the truth of the foregoing affidavit.

Stephen E. Ketcham
Commissioner of the Superior Court

STEPHEN E. KETCHAM
Attorney At Law
Henry Building
Rockville, Conn.

Note: Each page of the original of this Will is identified by the following signature of Carol A. Bouchard. Carol A. Bouchard 5/4/56

CODICIL TO WILL OF BRUNO E. DOSS

I, BRUNO E. DOSS, of the Town of Vernon, in the County of Tolland, in the State of Connecticut, make this Codicil to my Last Will and Testament dated May 4, 1956.

WHEREAS I now desire to change sub-paragraph "d" in Paragraph Third of said Last Will and Testament; add sub-paragraph "dd" in said Paragraph Third of said Last Will and Testament, which will immediately follow sub-paragraph "d" of said Paragraph Third of said Last Will and Testament; and add to sub-paragraph "e" of said Paragraph Third in said Last Will and Testament, NOW THEREFORE,

I direct that sub-paragraph "d" of said Paragraph Third read as follows:

d. Subject to sub-paragraph "e" (as amended by this Codicil) of Paragraph Third, I bequeath Eight Thousand (8,000) Dollars in cash to ROCKVILLE CITY HOSPITAL, INC., in trust for the following purpose: To set up a fund to be known as BRUNO E. DOSS and MAUD J. DOSS fund; to invest and reinvest the same in its discretion and to pay over only the income therefrom, at least annually, to the ROCKVILLE CITY HOSPITAL, INC. GENERAL OPERATING EXPENSE ACCOUNT.

I direct that sub-paragraph "dd" be added to said Paragraph Third, immediately following Sub-Paragraph "d" of said Paragraph Third of said Last Will and Testament as follows:

dd. Subject to sub-paragraph "e" of said Paragraph Third (as amended by this Codicil), I bequeath Two Thousand (2,000) Dollars in cash to the UNION CONGREGATIONAL CHURCH, of Rockville, Connecticut, and direct that it be used for its BUILDING FUND, either to pay existing debts or to pay for further improvements or building.

I direct that sub-paragraph "e" of said Paragraph Third now read as follows:

e. In the event that at my death my records should show that sub-paragraphs "a", "b", "c", "d" and "dd" of this Paragraph Third have been carried out, in whole or in part by me prior to my death, then in that event, I direct that the provisions as set forth in said sub-paragraphs shall be diminished to the extent that they have been carried out.

I hereby republish and confirm my said Last Will and Testament, with the changes and additions thereto, as aforesaid.

IN WITNESS WHEREOF, I have hereunto set my hand and seal at Rockville, Connecticut, on the 17th day of June, A. D., One Thousand Nine Hundred and Fifty-Seven.

Bruno E. Doss (L.S.)

Signed, sealed, published and declared by the said BRUNO E. DOSS as and for a codicil to his Last Will and Testament, dated May 4, 1956, in the presence of us, who at his request, in his presence, and in the presence of each other have hereunto subscribed our names as witnesses, on the 17th day of June, A.D. 1957.

Witnesses	Addresses
Carol A. Bouchard	Rockville, Connecticut
Shirley E. Whitehead	Rockville, Connecticut
Werner O. Kunzli	Tolland, Connecticut

STATE OF CONNECTICUT:
: ss. Vernon
COUNTY OF TOLLAND :

June 17, A.D. 1957

We the within named Carol A. Bouchard, Shirley E. Whitehead and Werner O. Kunzli being duly sworn, make affidavit and say: That we severally attested the within and foregoing Codicil to the Last Will and Testament of the within named testator and subscribed the same in his presence and at his request and in the presence of each other; that the said testator signed, published and declared the said

...en E. Estocar
...torney At Law
...leary Building
...ckville, Conn.

instrument as and for the Codicil to his Last Will and Testament in our presence on the 17th day of June, A. D., 1957; and at the time of execution of said Codicil said testator was more than eighteen years of age and of sound mind, memory and judgment and under no improper influence or restraint to the best of our knowledge and belief, and we make this affidavit at the request of said testator.

Carol A Bouchard

Shirley E. Whitehead

Werner O. Kunzli

STATE OF CONNECTICUT: ss. Vernon

COUNTY OF TOLLAND : June 17, A.D. 1957

Then personally appeared before me, Stephen E. Ketcham, duly qualified to administer oaths.

Carol A. Bouchard

Shirley E. Whitehead

and Werner O. Kunzli

and subscribed and made oath to the truth of the foregoing affidavit.

Commissioner of the Superior Court

Stephen E. Ketcham
Attorney At Law
Henry Building
Rockville, Conn.

SECOND CODICIL TO WILL OF BRUNO E. DOSS

I, BRUNO E. DOSS, of the Town of Vernon, County of Tolland, and State of Connecticut, make this Second Codicil to my Last Will and Testament dated May 4, 1956.

WHEREAS I now desire to delete sub-paragraph "a" of Paragraph Third of said Last Will and Testament, NOW THEREFORE

I direct that sub-paragraph "a" of said Paragraph Third of my Last Will and Testament be deleted and be of no further force and effect.

I hereby republish and confirm my said Last Will and Testament, as changed by the Codicil dated June 17, 1957 and by this Second Codicil.

IN WITNESS WHEREOF, I have hereunto set my hand and seal at Rockville, Connecticut, on the 14th day of October, A. D., One Thousand Nine Hundred and Fifty-Eight.

Bruno E. Doss (L. S.)

Signed, sealed, published and declared by the said BRUNO E. DOSS as and for a second codicil to his Last Will and Testament, dated May 4, 1956, in the presence of us, who at his request, in his presence, and in the presence of each other have hereunto subscribed our names as witnesses, on the 14th day of October, A. D., 1958.

Witnesses	Addresses
Judith A. Sullivan	Vernon, Connecticut
Shirley E. Whitehead	Vernon, Connecticut
Doris A. Weller	Vernon, Connecticut

STATE OF CONNECTICUT:
: ss. Vernon
COUNTY OF TOLLAND :

October 14, A. D., 1958

We the within named Judith A. Sullivan, Shirley E. Whitehead, and Doris A. Weller,

being duly sworn, make affidavit and say: That we severally attested within and foregoing Codicil to the Last Will and Testament of the within named

Stephen E. Ensman
Attorney At Law
Neary Building
Rockville, Conn.

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Submitted October 13, 2015

testator and subscribed the same in his presence and at his request and in the presence of each other; that the said testator signed, published and declared the said instrument as and for the Second Codicil to his Last Will and Testament in our presence on the 14th day of October, A. D., 1956; and at the time of execution of said Second Codicil said testator was more than eighteen years of age and of sound mind, memory and judgment and under no improper influence or restraint to the best of our knowledge and belief, and we make this affidavit at the request of said testator.

Judith A. Sullivan

Shirley E. Whitehead

Doris A. Weller

STATE OF CONNECTICUT:
: ss. Vernon
COUNTY OF TOLLAND :

October 14, A. D., 1958

Then personally appeared before me, Stephen E. Ketcham duly qualified to administer oaths.

Judith A. Sullivan

Shirley E. Whitehead

and Doris A. Weller

and subscribed and made oath to the truth of the foregoing affidavit.

Stephen E. Ketcham
Commissioner of the Superior Court

Stephen E. Ketcham
Attorney At Law
Henry Building
Rockville, Conn.

ECHN Proposed Asset Purchase by PMH
Submitted October 13, 2015

THIRD CODICIL TO WILL OF BRUNO E. DOSS

I, BRUNO E. DOSS, of the Town of Vernon, County of Tolland, and State of Connecticut, make this Third Codicil to my Last Will and Testament dated May 4, 1956.

WHEREAS I now desire to change sub-paragraph "f" in Paragraph Third of said Last Will and Testament, NOW THEREFORE

I direct said sub-paragraph "f" of Paragraph Third of my Last Will and Testament be deleted and become null and void, and the following be substituted in its place and stead.

f. All the rest, residue and remainder of my estate, of every nature and kind, and wheresoever the same may be situated, after the payment of all Administration Expenses, I give, devise and bequeath as follows:

1. Ten Thousand (10,000) Dollars thereof to my son, LEON F. DOSS, of 17 Washington Place, Bloomfield, New Jersey, to be his, absolutely. However, in the event my said son, LEON F. DOSS, should not be alive at the time of distribution hereunder, then in that event I give and bequeath said Ten Thousand (10,000) Dollars, in equal shares, to his children who are alive at the time of distribution hereunder. However, in the event my said son, LEON F. DOSS should not be alive at the time of distribution hereunder, and should have no children alive at the time of distribution hereunder, then in that event I give and bequeath said Ten Thousand (10,000) Dollars to the wife which he had at the time of his death, provided she is alive at the time of distribution hereunder. In the event my said son, LEON F. DOSS, should not be alive at the time of distribution hereunder, and should have no children alive at the time of distribution, and he had no wife at the time of his death alive at the time of distribution hereunder, then in that event, I give, devise and bequeath said Ten Thousand (10,000) Dollars to my son, PHILIP G. DOSS of 27 Summit Road, Vernon, Connecticut, if he be alive at the time of

Stephen E. Kerkman
Attorney At Law
Henry Building
Rockville, Conn.

IN WITNESS WHEREOF, I have hereunto set my hand and seal at Rockville, Connecticut, on the 22nd day of January, A. D., One Thousand Nine Hundred and Fifty-Nine.

Bruno E. Doss (L. S.)

Signed, sealed, published and declared by the said BRUNO E. DOSS as and for a third codicil to his Last Will and Testament, dated May 4, 1956, in the presence of us, who at his request, in his presence, and in the presence of each other have hereunto subscribed our names as witnesses on the 22nd day of January, A. D., 1959.

Witnesses	Addresses
Dorothy E. Woodworth	Tolland, Connecticut
Judith A. Sullivan	Vernon, Connecticut
E. George Gorsky	Ellington, Connecticut

STATE OF CONNECTICUT:
: ss. Vernon
COUNTY OF TOLLAND :
January 22nd, A. D., 1959

We the within named Dorothy E. Woodworth, Judith A. Sullivan and E. George Gorsky,

being duly sworn, make affidavit and say: That we severally attested the within and foregoing Third Codicil to the Last Will and Testament of the within named testator and subscribed the same in his presence and at his request and in the presence of each other; that the said testator signed, published and declared the said instrument as and for the Third Codicil to his Last Will and Testament in our presence on the 22nd day of January, A. D., 1959; and at the time of execution of said Third Codicil said testator was more than eighteen years of age and of sound mind, memory and judgment and under no improper influence or restraint to the best of our knowledge and belief, and we make this affidavit at the request of said testator.

Dorothy E. Woodworth
Judith A. Sullivan
E. George Gorsky

Stephen E. Sullivan
Attorney At Law
Henry Building
Rockville, Conn.

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Submitted October 13, 2015

STATE OF CONNECTICUT:
: ss. Vernon
COUNTY OF TOLLAND :

January 22, A. D., 1959

Then personally appeared before me, Stephen E. Ketcham, duly qualified to administer oaths,

Dorothy E. Woodworth

Judith A. Sullivan

and E. George Gorsky

and subscribed and made oath to the truth of the foregoing affidavit.

Stephen E. Ketcham
Commissioner of the Superior Court

Stephen E. Ketcham
Attorney At Law
Henry Building
Rockville, Conn.

EXHIBIT Q 11-2

Fund 11-1.40

Eva Noble Wood Fund

CONFIDENTIAL

LAST WILL AND TESTAMENT

of

EVA NOBLE WOOD

I, EVA NOBLE WOOD, of the Town of Vernon, County of Tolland and State of Connecticut, being of lawful age, of sound and disposing mind, memory and judgment, do hereby make, publish and declare this to be my Last Will and Testament, hereby revoking all previous wills and codicils by me made.

FIRST: I direct my Executor to pay my funeral expenses and just debts, except secured or mortgage debts, and that all legacy, succession, inheritance, transfer and estate taxes, levied or assessed upon or with respect to any property which is included as part of my gross estate for the purpose of determining any such tax shall be paid by my Executor out of my estate in the same manner as an expense of administration and shall not be prorated or apportioned among or charged against the respective devisees, legatees, beneficiaries, transferees or other recipients nor charged against any property passing or which may have passed to any of them and that my Executor shall not be entitled to reimbursement for any portion of any such tax from any person.

SECOND: I give and bequeath to my niece EDITH F. MOREHOUSE, of Norwich, Connecticut, each and all of the following articles, which formerly belonged to my mother; my silver tea set with the quilted effect, my set of silver spoons, my Haviland china dinner set and my gold watch.

THIRD: I give and bequeath to my husband, HOWARD I. WOOD, of the said Town of Vernon, all my household furniture, furnish-

ings, linen, silver and plate glassware and crockery, pictures, books, bric-a-brac and fixtures, including all household implements and effects used in or about my home in said Town of Vernon, not hereinbefore specifically bequeathed.

FOURTH: I give and bequeath unto the UNION CONGREGATIONAL CHURCH OF CHRIST, INC.. of the said Town of Vernon, the sum of Three Thousand (3,000) Dollars, to be held by said Church and the income from said sum is to be used for its general uses and purposes and said sum is to be known as the Mr. and Mrs. S. Tracy Noble Fund.

FIFTH: I give and bequeath unto the ROCKVILLE CITY HOSPITAL, INC., of said Town of Vernon, the sum of One Thousand (1,000) Dollars to be held by said Hospital and the income from said sum to be used for its general uses and purposes and said sum is to be known as the Eva Noble Wood Fund.

SIXTH: All the rest, residue and remainder of all my property, both real and personal, of whatsoever the same may consist and wheresoever the same may be situated, I give, devise and bequeath to THE CONNECTICUT BANK AND TRUST COMPANY, of Hartford, Connecticut, IN TRUST nevertheless, to hold, manage, invest and reinvest and to pay the net income thereof as hereinafter set forth, and further and in addition thereto, I authorize and empower the said Trustee to pay to my said husband, HOWARD I. WOOD, from time to time, so much of the principal of said Trust as it may in its sole and uncontrolled discretion deem necessary to maintain or assist my said husband in comfort, in sickness and in health, having regard to the condition and standard of living to which he was accustomed

during my lifetime. Throughout the duration of the trust hereinabove created, the Trustee is authorized and empowered to pay so much or none of the net income thereof to or among one or more of the following persons: (1) my husband, HOWARD I. WOOD, (2) my niece, EDITH F. MOREHOUSE, (3) my nephew, CROSLEY J. FITTON, and (4) the then living issue of my said niece and nephew (whether the parents of such issue are living or dead) in such amounts and proportions as my said Trustee in its sole and absolute discretion shall deem advisable from time to time without regard to equality of distribution. Any income not so disbursed shall be incorporated into the principal of the trust fund as an integral part thereof to be held, administered and distributed in accordance with all the terms, conditions and limitations applying thereto. Upon the death of my said husband, or upon my death, if he shall not survive me, the Trustee shall divide the corpus of said Trust Estate into two shares to be disposed of as follows:

A. One such share shall be held by said Trustee for the benefit of my niece, EDITH F. MOREHOUSE, of Norwich, Connecticut. The Trustee shall pay to my said niece, or expend in her behalf, so much of the net income derived from her particular share, as the Trustee may deem advisable to provide properly for her maintenance, welfare and comfort. Upon the death of my said niece her share shall be divided into as many equal shares as there are children of hers then living and deceased children of hers leaving issue then surviving. The Trustee shall pay to each of such children of my niece, EDITH F. MOREHOUSE then living, so much of the income derived from his or her particular share as the Trustee may deem advisable to provide properly for his or her maintenance, educa-

tion, welfare and comfort. The Trustee shall pay to the issue of such deceased children of my said niece the share of said deceased child in equal shares, per stirpes and free of trust. Upon the death of each of said living children of my said niece, the Trustee shall pay his or her share to his or her issue surviving in equal shares, per stirpes and not per capita, free of trust.

B. One such share shall be held by said Trustee for the benefit of my nephew, CROSLEY J. FITTON, of West Hartford, Connecticut. The Trustee shall pay to my said nephew, or expend in his behalf, so much of the net income derived from his particular share as the Trustee may deem advisable to provide properly for his maintenance, welfare and comfort. Upon the death of my said nephew his share shall be divided into as many equal shares as there are children of his then living and deceased children of his leaving issue then surviving. The Trustee shall pay to each of such children of my said nephew, CROSLEY J. FITTON, then living, so much of the income derived from his or her particular share as the Trustee may deem advisable to provide properly for his or her maintenance, education, welfare and comfort. The Trustee shall pay to the issue of such deceased children of my said nephew the share of said deceased child in equal shares, per stirpes and free of trust. Upon the death of each of said living children of my said nephew the Trustee shall pay his or her share to his or her issue surviving in equal shares, per stirpes and not per capita, and free of trust.

C. I hereby authorize and empower the Trustee in its sole and absolute discretion at any time and from time to time, to disburse from the principal of any of the trust estates created

herein such amounts as it may deem advisable to provide adequately and properly for any emergency or extraordinary expense of the current income beneficiary thereof, his or her spouse and children, including, but not by way of limitation, expenses incurred by reason of illness, disability and education. In determining the amounts of principal to be so disbursed, the Trustee shall take into consideration any other income or property which such income beneficiary may have from any other source; and the Trustee's discretion shall be conclusive as to the advisability of any such disbursement and the same shall not be questioned by anyone. For all sums so disbursed the Trustee shall have full acquittance.

D. Anything herein elsewhere to the contrary notwithstanding all property of the trust estates created herein as described in this paragraph shall finally be distributed not later than twenty-one (21) years after date of death of the last survivor of the group composed of myself, my husband, HOWARD I. WOOD, and those of my nieces and nephews and/or descendants who are living at the time of my death, and if, at the expiration of such period any part of the trust estate remains undistributed, the same shall immediately vest in and be distributed to the persons then entitled to receive the income from the aforementioned trust estate in the proportion that they are so entitled.

SEVENTH: In the event that any bequests or legacies under the terms of this Will, other than those provided for in the residuary clause hereof, shall for any reason lapse or fail to take effect, then the same shall be and become a part of the rest, residue and remainder of my estate, and shall be distributed in accordance with

the terms of paragraph Sixth hereof.

EIGHTH: Without intending in any manner to limit or qualify any provision, bequest or devise of this my Last Will and Testament, I hereby express the opinion that it might be desirable that my husband, if living at my death, should create a trust inter vivos for his own benefit, of his own estate, since increasing age and infirmity might detract from his ability successfully to manage his estate during declining years.

NINTH: I authorize and empower my Executor and Trustee to make all divisions and distributions provided for under this Will; to sell at public or private sale to any purchaser, with or without option for cash and to exchange, lease or mortgage any interest in real or personal property; to invest and reinvest such property, real or personal, as it shall deem wise without being limited to investments authorized for Trust funds by the laws of the State of Connecticut; to borrow money by mortgage, on collateral or otherwise; and to register securities in its own name or in the name of its nominee.

TENTH: I nominate and appoint THE CONNECTICUT BANK AND TRUST COMPANY, of Hartford, Connecticut, to be Executor of this my Last Will and Testament.

IN WITNESS WHEREOF I have hereunto set my hand and seal at said Vernon, on the 18th day of June A.D., One Thousand Nine Hundred and Sixty-four.

_____ (L.S.)

Signed, sealed, published and declared by the said EVA NOBLE WOOD, as and for her Last Will and Testament, in presence of us, who at her request, in her presence, and in the presence of each other have hereunto subscribed our names as witnesses, on the 18th day of June A.D., 1964.

Witnesses

STATE OF CONNECTICUT } ss. Vernon June 18th,A.D.,1964
COUNTY OF TOLLAND }

We the within named JUDITH A. SULLIVAN, of Vernon, Connecticut, MADELYN M. LUCE, of Tolland, Connecticut, and MARJORIE S. BRADY, of Ellington, Connecticut,

being duly sworn, make affidavit and say: That we severally attested the within and foregoing Will of the within named Testatrix and subscribed the same in her presence and at her request and in the presence of each other; that the said Testatrix signed, published and declared the said instrument as and for her last Will and Testament in our presence on the 18th day of June, A. D. 1964; and at the time of execution of said Will, said Testatrix was more than eighteen years of age and of sound mind, memory and judgment and under no improper influence or restraint to the best of our knowledge and belief, and we make this affidavit at the request of said Testatrix.

- 8 -

STATE OF CONNECTICUT)
) SS. Vernon June 18th, A.D., 1964
COUNTY OF TOLLAND)

Then personally appeared before me, DONALD B. CALDWELL, duly qualified to administer oaths.

JUDITH A. SULLIVAN

MADELYN M. LUCE

and MARJORIE S. BRADY

and subscribed and made oath to the truth of the foregoing affidavit.

Commissioner of the Superior Court

EXHIBIT Q 11-2

Fund 11-1.41

Maud Henry

2003-231

File
RGH Bequests under E. Steve Henry

File
30-45570

Be it known to all persons, that I Edward Stevens Henry of the Town of Vernon, County of Tolland, and State of Connecticut being of lawful age of sound and disposing mind memory and judgment do hereby make, publish and declare this to be my last will and testament, hereby revoking all previous wills and codicils by me made.

First
I will and direct that all my just debts be promptly paid, together with funeral charges and reasonable expenses for settling my estate.

Second
I make the following personal bequests, viz. I give and bequeath to my grand daughter Lucina Ackerly Ten thousand dollars $10,000. to her absolutely

I give and bequeath my sister Abby E. Henry One thousand dollars $1000. to her absolutely

I give and bequeath my sister Esther Henry One thousand dollars $1000. to her absolutely

I give and bequeath my sister Kate Henry Gough One thousand dollars $1000. to her absolutely

I give and bequeath my sister Mattie Henry Peck One thousand dollars $1000. to her absolutely

I give and bequeath my niece, Mary L. Gough Five hundred dollars $500. to her absolutely

I give and bequeath my niece Lara Andrews Crandall Five hundred dollars $500. to her absolutely.

I give and bequeath my nephew John Stevens Dewey Five hundred dollars $500. to him absolutely

I give and bequeath my grand niece Maud E. Dewey Five hundred dollars $500. to her absolutely.

Third
I give and bequeath my sister Abby E. Henry for her use and benefit the annual sum of Six hundred Dollars $600. to be paid as hereinafter provided during and for her natural life. I likewise give and bequeath my sister Esther Henry for her use and benefit the annual sum of Six hundred dollars $600. to be paid as hereinafter provided, during and

for her natural life. Reference is made to the eleventh paragraph of this will wherein provisions are made for the payment of these two annuities-

Fourth
I give and bequeath my long time friend and faithful employee Roger J. Murphy the real estate located at the corner of Saint Bernards Terrace and Cottage Street- together with all appurtenances connected therewith. This property is bounded North by land of Dennis McCarthy- East by Cottage Street South by Middle Terrace- West by land of Estate of G. W. Ransom- To him the said Murphy his heirs and assigns forever-

Fifth
I give and bequeath to the "Rockville Public Library", a corporation organized under the laws of the State of Connecticut One thousand dollars $1000. to be added to the endowment fund of that institution

Sixth
I give and bequeath to the Town of Vernon One thousand dollars $1000. in trust- The same to be deposited in a Connecticut Savings Bank and the income only used in providing from time to time scholarship prizes for the most efficient students in the several classes of the "Rockville High School". These prizes are to be awarded by the Principal of said High School under the supervision of the Superintendent of schools in the Town of Vernon-

Seventh
I give and bequeath to the Connecticut Agricultural College One Thousand dollars $1000. to be deposited in a Connecticut Savings Bank, and the income only used in providing prizes to be awarded to the most efficient students at the discretion of the President of the College

Eighth
I give and bequeath the "Connecticut Historical Society" a corporation under the laws of the State of Connecticut Five hundred dollars $500.

Ninth
I give and bequeath to the Hospital to be established in Rockville under the provisions of the will of the late William H. Prescott to be known as the "Rockville City Hospital" This bequest is to constitute a special endowment fund of Fifty thousand dollars $50,000. to be set apart and

known as the Maud Henry fund in memory of my deceased daughter Maud. I likewise give and bequeath Fifty thousand dollars $50,000. to said Hospital also to be set apart as a separate endowment fund and known as the "Lenore Henry" fund in memory of my deceased daughter Lenore. The income of these two funds is to be used for the maintenance of said Hospital. My Executors are directed to provide for this fund by selecting and transfering from my Estate to trustees or duly authorized agent of said Hospital, certain bonds or Savings Bank deposits of the par value of One hundred thousand dollars $100,000, and I further direct that whenever reinvestments become necessary or advisable such reinvestments shall be limited and confined to securities legal for the Savings Banks of Connecticut- or in deposits in Savings Banks

Tenth

I give devise and bequeath to Fayette Lodge No 69 Free and Accepted Masons of Rockville, certain real estate located on Park Street, Rockville- Bounded and described as follows. North by land of Estate of William H. Prescott-West by land of the Town of Vernon - South by a line two feet north of the north line of Henry Building- and East by Park Street- to said Fayette Lodge its successors and assigns forever

Eleventh

I give and bequeath to the Town of Vernon its successors and assigns forever the real estate known as the "Henry Building" said real estate being bounded North by land devised in the foregoing paragraph to Fayette Lodge No 69, Free and Accepted Masons-East by Park Street- South by Park Place and West by land of the Town of Vernon, this devise and bequest is however made upon the express conditions and stipulations that the net income derived from the rentals of said Henry Building shall after strict compliance with the conditions and reservations hereinafter stated be applied and used for the care, maintenance, improvement and enlargement, of Grove Hill Cemetery in said Vernon and for no other purpose except as hereinafter stated and under said conditions and reservations said property shall be under the supervision and control of legally appointed Agents of said Town of Vernon. This devise is further made subject to the follow-

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ing conditions and stipulations and shall not become effective until and unless all of these stated conditions and reservations are accepted and approved by the legal voters of the Town of Vernon, at a meeting duly warned and held for that stated purpose, Wherein the Town of Vernon shall explicitly accept all of the conditions of this devise and authorize the payment of the several annuities hereinbefore stated in the third paragraph of this will- viz An annuity of Six hundred dollars $600, to be paid my sister Abby E. Henry during and for the period of her natural life- Also an annuity of $600. Six hundred dollars to be paid my sister Esther Henry during and for the period of her natural life. It is further stipulated that the Treasurer of the Town of Vernon shall be authorized and directed by a vote of said town to pay each of aforesaid legatees Abby E. Henry and Esther Henry the sum of three hundred dollars $300. Semi-annually on demand of my sisters so that each shall receive her annuity as before conditioned. It is further provided that after the death of either of my before named sisters her annuity shall cease but that the surviving sister shall continue to receive an annuity of Six hundred dollars as hereinbefore provided.

Twelfth

I give devise and bequeath, thirty thousand dollars $30,000. for the construction of a Mortuary Chapel, to be located at or near the west entrance of Grove Hill Cemetery said Mortuary Chapel is to be erected under the supervision of my Executors upon a site approved by them and when completed is to become the property of the Town of Vernon- This said Mortuary Chapel is to be known as the "Lucina Memorial". It is further provided that a part of this bequest not exceeding Five thousand dollars $5000. may at the discretion of my Executors be used for the construction of a gateway at the west entrance of said Cemetery- and when completed shall likewise become the property of the Town of Vernon- The material used in the construction of both Mortuary Chapel and gateway the selection of a competent architect and the approval of said architect's design, the lettering of contracts for construction, supervision and payments for

construction, shall rest entirely with my Executors-

Thirteenth

I give, devise and bequeath to the City of Rockville a certain tract of land located on Fox Hill in said Rockville, for public use as a Park and pleasure grounds or as sites for strictly public buildings and grounds connected therewith, jointly, and severally, one or both. These Lands are more accurately described in a Warranty deed to me given by Sophronia and Clara Simons dated the 8th day of January, A.D. 1891, and recorded in Vernon Records of Lands Vol 29 Page 445. I further include in this devise and subject to the same conditions all other lands owned by me adjacent to and situated South and West of the first named tract. These additional lands are situated North of South Street and of lands of sundry owners and West by High Street and lands of sundry owners. No part of the lands so devised to said City of Rockville are to be sold or used for other than public purposes.

I also give and bequeath to said City of Rockville Twenty five thousand dollars- $25000. to be expended in improving the aforesaid lands after a competent landscape architect has made definite plans and sketches for thorough and comprehensive work- especially having in view a suitable location for the proposed Rockville City Hospital hereinbefore referred to in this will. This gift or devise is not to become effective until accepted and authorized by a legally called meeting of the voters of the City of Rockville

Fourteenth

I give and bequeath One hundred thousand dollars- $100000- to constitute a Trust Fund to be set apart and in custody of the "Security Trust Company" of Hartford or in some other Connecticut Trust Company to be determined by Executors. The net income of said trust fund shall if my wife survives me be paid to my said wife Lucina E. Henry in quarterly installments so long as she lives, other clauses herein notwithstanding. If my said wife does not survive me then upon my death, and if she does survive me then upon her death, this trust fund shall thereupon accumulate, if my grand daughter Lucina Ackerly, is then living until she attains the age of twenty five years

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and then and thereafter the original fund and its accumulations up to the time she attains the age of twenty five years shall be deemed to be the principal of said trust fund, the net income of said principal after said Lucina Ackerly attains the age of twenty five years, as aforesaid shall be paid to my said grandaughter Lucina Ackerly in quarterly installments, for and during the period of her natural life. Upon the death of said Lucina Ackerly the entire principal fund then remaining I give, devise and bequeath to the Rockville City Hospital hereinbefore referred to, and the same shall thereupon become part of the endowment fund of that institution, absolutely and forever, it being my intention and will that said Rockville City Hospital shall have and possess all the rest residue and remainder of the said trust fund and the principal aforesaid to it absolutely and forever

Fifteenth

The rest residue and remainder of my estate both real and personal of whatever description and wherever found I devise give and bequeath to my well loved wife Lucina E. Henry to her and her heirs and assigns absolutely and forever, and I constitute my said wife residuary legatee in case any of the before mentioned devises and bequests should fail or are not accepted as conditioned and stipulated.

Sixteenth

I direct that all succession, inheritance and transfer taxes which would be payable on account of the legacies other than residuary legacies hereinbefore given, shall be paid out of the residue of my estate, so that said several legacies shall be net for their full amounts, to the said several legatees.

Seventeenth

I constitute and appoint my wife Lucina E. Henry my Executrix together with my personal friends John E. Fisk and George W. Randall both of Rockville, as Executors of this my last will and testament. I also direct that bonds are not to be required of the aforesaid Executors. My Executors are to be allowed reasonable time to carry out the several provisions of my will in paying the several legacies and bequests hereinbefore mentioned. I however urge that my estate be settled as promptly as possible without unnecessary loss to my Estate or undue injury to any

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beneficiary-

Eighteenth I will and direct that should any of the provisions herein made fail or be held void invalid or inefectual for any reason whatever then it is my will that no other provisions of this testament be affected or invalidated but that the remaining provisions shall be construed as if such invalid provisions or conditions were not herein contained-

In Witness Whereof I have hereunto set my hand and seal at said town of Vernon on the twenty second day of April A.D. One thousand nine hundred and fourteen.

Edward Stevens Henry (L.S.)

Signed sealed published and declared by the said Edward Stevens Henry as and for his Last Will and Testament in the presence of us who at his request in his presence and in the presence of each other have hereunto subscribed our names as witnesses on the 22nd day of April A.D.1914

Henry L. Nobbe
Joseph M. Donovan
Dennis J. McCarthy

BE IT KNOWN TO ALL PERSONS, That I, E. Stevens Henry of the town of Vernon, County of Tolland, State of Connecticut, being of lawful age, of sound and disposing mind, memory and judgment, do hereby make, publish and declare this to be a codicil to my last will and testament bearing date of April 22, 1914.

WHEREAS, since the execution of said will I have become desirous of changing paragraph tenth of said will wherein it devised certain lands to Fayette Lodge No. 69, Free and Accepted Masons of Rockville,-

NOW, THEREFORE, I hereby revoke and cancel, declare null and void, said devise and paragraph, and in lieu thereof I give, devise and bequeath as follows, to wit:

10 A. I give, devise and bequeath to Fayette Lodge No. 69, Free and Accepted Masons of Rockville, Connecticut, the sum of THREE THOUSAND DOLLARS for the uses and purposes of said lodge, to it and to its successors and assigns, absolutely and forever.

10 B. I give, devise and bequeath to the People's Savings Bank of said Rockville, a legal corporation, organized and existing under the laws of the State of Connecticut, having an office and principal place of business in said Rockville, and to its successors and assigns, absolutely and forever, certain real estate situate on Park Street in said Rockville, bounded northerly by land of the estate of William H. Prescott; easterly by Park Street; westerly by land of the town of Vernon; southerly by a straight line out twenty-seven inches northerly of the face of the brick on the north side of the Henry Building, so called, said line to be reckoned as if no chimney or other projection were on the north side of said Henry Building; but, other clauses herein notwithstanding, said gift, bequest and devise to said bank is made subject to the following conditions and requirements, to wit:

That said bank shall, within a reasonable time after my death, pay to my estate the sum of three thousand dollars to be in the nature of a purchase price, for which price a deed from my estate of said real

estate shall be given to said bank, its successors and assigns, which deed shall be conditioned that said real estate shall revert to my estate in case said bank fails to cause to be erected, within five years from the time of my decease, a building on said land, the whole or a part of said building to be for the use and occupancy of said bank; all rents for said real estate shall belong to my estate up to and until said deed shall be given; and I hereby authorize and empower my executors in behalf of my estate to make, execute and deliver said deed in manner aforesaid.

All other paragraphs in my said will shall remain in full force and effect, and I hereby republish and confirm my said will, except as aforesaid.

IN WITNESS WHEREOF I have hereunto set my hand and seal at said Rockville, on the 3rd. day of March, A.D., 1920.

E. Stevens Henry (L.S.)

SIGNED, sealed, published and declared by the said E. Stevens Henry as and for the codicil to his last will and testament, in presence of us who at his request, in his presence and in the presence of each other have hereunto subscribed our names as witnesses, on the 3rd day of March, A.D. 1920.

Thomas F. Garvan
William A. Howell } WITNESSES.
Roger J. Murphy

EXHIBIT Q 11-2

Fund 11-1.42

Lenore Henry

2003-231 File RGH Bequests under E. Steve Henry File 30-45570

Be it known to all persons, that I Edward Stevens Henry of the Town of Vernon, County of Tolland, and State of Connecticut being of lawful age of sound and disposing mind memory and judgment do hereby make, publish and declare this to be my last will and testament, hereby revoking all previous wills and codicils by me made.

First
I will and direct that all my just debts be promptly paid, together with funeral charges and reasonable expenses for settling my estate.

Second
I make the following personal bequests, viz. I give and bequeath to my grand daughter Lucina Ackerly Ten thousand dollars $10,000. to her absolutely

I give and bequeath my sister Abby E. Henry One thousand dollars $1000. to her absolutely

I give and bequeath my sister Esther Henry One thousand dollars $1000. to her absolutely

I give and bequeath my sister Kate Henry Gough One thousand dollars $1000. to her absolutely

I give and bequeath my sister Mattie Henry Peck One thousand dollars $1000. to her absolutely

I give and bequeath my niece, Mary L. Gough Five hundred dollars $500, to her absolutely

I give and bequeath my niece Lara Andrews Crandall Five hundred dollars $500. to her absolutely.

I give and bequeath my nephew John Stevens Dewey Five hundred dollars $500. to him absolutely

I give and bequeath my grand niece Maud E. Dewey Five hundred dollars $500. to her absolutely.

Third
I give and bequeath my sister Abby E. Henry for her use and benefit the annual sum of Six hundred Dollars $600. to be paid as hereinafter provided during and for her natural life. I likewise give and bequeath my sister Esther Henry for her use and benefit the annual sum of Six hundred dollars $600. to be paid as hereinafter provided, during and

for her natural life. Reference is made to the eleventh paragraph of this will wherein provisions are made for the payment of these two annuities-

Fourth
I give and bequeath my long time friend and faithful employee Roger J. Murphy the real estate located at the corner of Saint Bernards Terrace and Cottage Street- together with all appurtenances connected therewith. This property is bounded North by land of Dennis McCarthy- East by Cottage Street South by Middle Terrace- West by land of Estate of G. W. Ransom- To him the said Murphy his heirs and assigns forever-

Fifth
I give and bequeath to the "Rockville Public Library", a corporation organized under the laws of the State of Connecticut One thousand dollars $1000. to be added to the endowment fund of that institution

Sixth
I give and bequeath to the Town of Vernon One thousand dollars $1000. in trust- The same to be deposited in a Connecticut Savings Bank and the income only used in providing from time to time scholarship prizes for the most efficient students in the several classes of the "Rockville High School". These prizes are to be awarded by the Principal of said High School under the supervision of the Superintendent of schools in the Town of Vernon-

Seventh
I give and bequeath to the Connecticut Agricultural College One Thousand dollars $1000. to be deposited in a Connecticut Savings Bank, and the income only used in providing prizes to be awarded to the most efficient students at the discretion of the President of the College

Eighth
I give and bequeath the "Connecticut Historical Society" a corporation under the laws of the State of Connecticut Five hundred dollars $500.

Ninth
I give and bequeath to the Hospital to be established in Rockville under the provisions of the will of the late William H. Prescott to be known as the "Rockville City Hospital" This bequest is to constitute a special endowment fund of Fifty thousand dollars $50,000. to be set apart and

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known as the Maud Henry fund in memory of my deceased daughter Maud. I likewise give and bequeath Fifty thousand dollars $50,000. to said Hospital also to be set apart as a separate endowment fund and known as the "Lenore Henry" fund in memory of my deceased daughter Lenore. The income of these two funds is to be used for the maintenance of said Hospital. My Executors are directed to provide for this fund by selecting and transfering from my Estate to trustees or duly authorized agent of said Hospital, certain bonds or Savings Bank deposits of the par value of One hundred thousand dollars $100,000. and I further direct that whenever reinvestments become necessary or advisable such reinvestments shall be limited and confined to securities legal for the Savings Banks of Connecticut- or in deposits in Savings Banks

Tenth

I give devise and bequeath to Fayette Lodge No 69 Free and Accepted Masons of Rockville, certain real estate located on Park Street, Rockville- Bounded and described as follows. North by land of Estate of William H. Prescott-West by land of the Town of Vernon - South by a line two feet north of the north line of Henry Building- and East by Park Street- to said Fayette Lodge its successors and assigns forever

Eleventh

I give and bequeath to the Town of Vernon its successors and assigns forever the real estate known as the "Henry Building" said real estate being bounded North by land devised in the foregoing paragraph to Fayette Lodge No 69, Free and Accepted Masons-East by Park Street- South by Park Place and West by land of the Town of Vernon, this devise and bequest is however made upon the express conditions and stipulations that the net income derived from the rentals of said Henry Building shall after strict compliance with the conditions and reservations hereinafter stated be applied and used for the care, maintenance, improvement and enlargement, of Grove Hill Cemetery in said Vernon and for no other purpose except as hereinafter stated and under said conditions and reservations said property shall be under the supervision and control of legally appointed Agents of said Town of Vernon. This devise is further made subject to the follow-

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ing conditions and stipulations and shall not become effective until and unless all of these stated conditions and reservations are accepted and approved by the legal voters of the Town of Vernon, at a meeting duly warned and held for that stated purpose. Wherein the Town of Vernon shall explicitly accept all of the conditions of this devise and authorize the payment of the several annuities hereinbefore stated in the third paragraph of this will- viz An annuity of Six hundred dollars $600. to be paid my sister Abby E. Henry during and for the period of her natural life- Also an annuity of $600. Six hundred dollars to be paid my sister Esther Henry during and for the period of her natural life. It is further stipulated that the Treasurer of the Town of Vernon shall be authorized and directed by a vote of said town to pay each of aforesaid legatees Abby E. Henry and Esther Henry the sum of three hundred dollars $300. Semi-annually on demand of my sisters so that each shall receive her annuity as before conditioned. It is further provided that after the death of either of my before named sisters her annuity shall cease but that the surviving sister shall continue to receive an annuity of Six hundred dollars as hereinbefore provided.

Twelfth

I give devise and bequeath, thirty thousand dollars $30,000. for the construction of a Mortuary Chapel, to be located at or near the west entrance of Grove Hill Cemetery said Mortuary Chapel is to be erected under the supervision of my Executors upon a site approved by them and when completed is to become the property of the Town of Vernon- This said Mortuary Chapel is to be known as the "Lucina Memorial". It is further provided that a part of this bequest not exceeding Five thousand dollars $5000. may at the discretion of my Executors be used for the construction of a gateway at the west entrance of said Cemetery- and when completed shall likewise become the property of the Town of Vernon- The material used in the construction of both Mortuary Chapel and gateway the selection of a competent architect and the approval of said architect's design, the lettering of contracts for construction, supervision and payments for

construction, shall rest entiraly with my Executors-

Thirteenth

I give, devise and bequeath to the City of Rockville a certain tract of land located on Fox Hill in said Rockville, for public use as a Park and pleasure grounds or as sites for strictly public buildings and grounds connected therewith, jointly, and severally, one or both. These lands are more accurately described in a Warranty deed to me given by Sophronia and Clara Simons dated the 8th day of January, A.D. 1891, and recorded in Vernon Records of Lands Vol 29 Page 445. I further include in this devise and subject to the same conditions all other lands owned by me adjacent to and situated South and West of the first named tract. These additional lands are situated North of South Street and of lands of sundry owners and West by High Street and lands of sundry owners. No part of the lands so devised to said City of Rockville are to be sold or used for other than public purposes.

I also give and bequeath to said City of Rockville Twenty five thousand dollars- $25000. to be expended in improving the aforesaid lands after a competent landscape architect has made definite plans and sketches for thorough and comprehensive work- especially having in view a suitable location for the proposed Rockville City Hospital hereinbefore referred to in this will. This gift or devise is not to become effective until accepted and authorized by a legally called meeting of the voters of the City of Rockville

Fourteenth

I give and bequeath One Hundred thousand dollars- $100000- to constitute a Trust Fund to be set apart and in custody of the "Security Trust Company" of Hartford or in some other Connecticut Trust Company to be determined by Executors. The net income of said trust fund shall if my wife survives me be paid to my said wife Lucina E. Henry in quarterly installments so long as she lives, other clauses herein notwithstanding. If my said wife does not survive me then upon my death, and if she does survive me then upon her death, this trust fund shall thereupon accumulate, if my grand daughter Lucina Ackerly, is then living until she attains the age of twenty five years

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and then and thereafter the original fund and its accumulations up to the time she attains the age of twenty five years shall be deemed to be the principal of said trust fund, the net income of said principal after said Lucina Ackerly attains the age of twenty five years, as aforesaid shall be paid to my said grandaughter Lucina Ackerly in quarterly installments, for and during the period of her natural life. Upon the death of said Lucina Ackerly the entire principal fund then remaining I give, devise and bequeath to the Rockville City Hospital hereinbefore referred to, and the same shall thereupon become part of the endowment fund of that institution, absolutely and forever, it being my intention and will that said Rockville City Hospital shall have and possess all the rest residue and remainder of the said trust fund and the principal aforesaid to it absolutely and forever

Fifteenth

The rest residue and remainder of my estate both real and personal of whatever description and wherever found I devise give and bequeath to my well loved wife Lucina E. Henry to her and her heirs and assigns absolutely and forever, and I constitute my said wife residuary legatee in case any of the before mentioned devises and bequests should fail or are not accepted as conditioned and stipulated.

Sixteenth

I direct that all succession, inheritance and transfer taxes which would be payable on account of the legacies other than residuary legacies hereinbefore given, shall be paid out of the residue of my estate, so that said several legacies shall be net for their full amounts, to the said several legatees.

Seventeenth

I constitute and appoint my wife Lucina E. Henry my Executrix together with my personal friends John E. Fisk and George W. Randall both of Rockville, as Executors of this my last will and testament. I also direct that bonds are not to be required of the aforesaid Executors. My Executors are to be allowed reasonable time to carry out the several provisions of my will in paying the several legacies and bequests hereinbefore mentioned. I however urge that my estate be settled as promptly as possible without unnecessary loss to my Estate or undue injury to any

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beneficiary-

Eighteenth
I will and direct that should any of the provisions herein made fail or be held void invalid or inefectual for any reason whatever then it is my will that no other provisions of this testament be affected or invalidated but that the remaining provisions shall be construed as if such invalid provisions or conditions were not herein contained-

In Witness Whereof I have hereunto set my hand and seal at said town of Vernon on the twenty second day of April A.D. One thousand nine hundred and fourteen.

Edward Stevens Henry (L.S.)

Signed sealed published and declared by the said Edward Stevens Henry as and for his Last Will and Testament in the presence of us who at his request in his presence and in the presence of each other have hereunto subscribed our names as witnesses on the 22nd day of April A.D.1914

Henry L. Noble
Joseph M. Donovan
Dennis J. McCarthy

BE IT KNOWN TO ALL PERSONS, That I, E. Stevens Henry of the town of Vernon, County of Tolland, State of Connecticut, being of lawful age, of sound and disposing mind, memory and judgment, do hereby make, publish and declare this to be a codicil to my last will and testament bearing date of April 22, 1914.

WHEREAS, since the execution of said will I have become desirous of changing paragraph tenth of said will wherein it devised certain lands to Fayette Lodge No. 69, Free and Accepted Masons of Rockville,-

NOW, THEREFORE, I hereby reveke and cancel, declare null and void, said devise and paragraph, and in lieu thereof I give, devise and bequeath as follows, to wit:

10 A. I give, devise and bequeath to Fayette Lodge No. 69, Free and Accepted Masons of Rockville, Connecticut, the sum of THREE THOUSAND DOLLARS for the uses and purposes of said lodge, to it and to its successors and assigns, absolutely and forever.

10 B. I give, devise and bequeath to the People's Savings Bank of said Rockville, a legal corporation, organized and existing under the laws of the State of Connecticut, having an office and principal place of business in said Rockville, and to its successors and assigns, absolutely and forever, certain real estate situate on Park Street in said Rockville, bounded northerly by land of the estate of William H. Prescott; easterly by Park Street; westerly by land of the town of Vernon; southerly by a straight line out twenty-seven inches northerly of the face of the brick on the north side of the Henry Building, so called, said line to be reckoned as if no chimney or other projection were on the north side of said Henry Building; but, other clauses herein notwithstanding, said gift, bequest and devise to said bank is made subject to the following conditions and requirements, to wit:

That said bank shall, within a reasonable time after my death, pay to my estate the sum of three thousand dollars to be in the nature of a purchase price, for which price a deed from my estate of said real

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estate shall be given to said bank, its successors and assigns, which deed shall be conditioned that said real estate shall revert to my estate in case said bank fails to cause to be erected, within five years from the time of my decease, a building on said land, the whole or a part of said building to be for the use and occupancy of said bank; all rents for said real estate shall belong to my estate up to and until said deed shall be given; and I hereby authorize and empower my executors in behalf of my estate to make, execute and deliver said deed in manner aforesaid.

All other paragraphs in my said will shall remain in full force and effect, and I hereby republish and confirm my said will, except as aforesaid.

IN WITNESS WHEREOF I have hereunto set my hand and seal at said Rockville, on the 3rd. day of March, A.D., 1920.

E. Stevens Henry (L.S.)

SIGNED, sealed, published and declared by the said E. Stevens Henry as and for the codicil to his last will and testament, in presence of us who at his request, in his presence and in the presence of each other have hereunto subscribed our names as witnesses, on the 3rd day of March, A.D. 1920.

Thomas F. Garvan
William A. Howell } WITNESSES.
Roger J. Murphy

EXHIBIT Q 11-2

Fund 11-1.43

George Palmer Charter Fund

ROCKVILLE CITY HOSPITAL

Source and Terms of Funds Held

Alvah N. Belding Fund #73041 - Bequest u/w Alvah N. Belding - Permanent Endowment - Income for general purposes.

Terms of Will - "To be used and expended for the purposes indicated in the Will of William H. Prescott, as they may deem most advisable."

Alice Farmer Bissell Fund #73051 - Bequest under the Will of Arthur T. Bissell - Permanent Endowment - Income for general purposes.

Terms of Will - Fourth: I give and bequeath to the Rockville City Hospital the sum of Twenty-five Thousand Dollars ($25,000) to be kept as a permanent fund in memory of my wife, Alice Farmer Bissell, and to be known as the Alice Farmer Bissell Fund. The net income from said fund shall be used and applied for the general purposes of said Hospital.

Ruth T. Britton Fund #73061 - Bequest u/w Ruth Talcott Britton - Permanent Endowment - Income for general purposes.

Terms of Will - "in trust to keep said sum safely invested, and to use and apply the income for the general purposes of said Hospital at the discretion of its trustees."

Consolidated Fund #73081 - This fund represents all bequests of $3,000 or less left with no instructions as to use. Principal is considered permanent endowment - Income is used for general expenses of the Hospital.

George S. Doane Fund #73101 - No record found of source of this fund. Principal is considered permanent endowment - all income is used for expenses of the Hospital.

General Fund #73121 - This fund represents small gifts and bequests which were unrestricted as to use of principal or income. Principal is considered unrestricted - Income is used for general expenses of the Hospital.

Lenore Henry Fund #73141 - Bequest u/w E. Stevens Henry - Permanent endowment - Income for general purposes.

Terms of Will - Ninth: I give and bequeath to the Hospital to be established in Rockville under the provisions of the Will of the late William H. Prescott to be known as the "Rockville City Hospital." This bequest is to constitute a special endowment fund of Fifty Thousand Dollars ($50,000) to be set apart and known as the Maud Henry Fund in memory of my deceased daughter, Maud. I likewise give and bequeath Fifty Thousand Dollars ($50,000) to said Hospital also to be set apart as a separate endowment fund and known as the "Lenore Henry" Fund in memory of my deceased daughter, Lenore. The income of these two funds is to be used for the maintenance of said Hospital. My Executors are directed to provide for this fund by selecting and transferring from my estate to trustees or duly authorized agent of said Hospital certain bonds or savings bank deposits of the par value of One Hundred Thousand Dollars ($100,000), and I further direct that whenever reinvestments become necessary or advisable such reinvestments shall be limited and confined to securities legal for savings banks of Connecticut or in deposits in savings banks.

Maud Henry Fund #73161 - Bequest u/w E. Stevens Henry - Permanent endowment - Income for general purposes. (For terms of will, see Lenore Henry Fund)

J. Alice Maxwell Fund #73171 - Bequest u/w J. Alice Maxwell - Permanent endowment - Income for general purposes.

> Terms of Will - NINTH: To ROCKVILLE CITY HOSPITAL, in Rockville, Connecticut, I give, devise and bequeath four of said equal parts of my said residuary estate in trust to use the income thereof for the general purposes of the said Hospital.

John and Martha Kress Fund #73181 - Bequest under will of Martha Kress - This fund was left for a special purpose. In accordance with the instructions of the Board of Trustees of the Hospital, income accumulates and is transferred to principal for reinvestment.

> Terms of Will - "To be used for the purpose of equipping, furnishing, and maintaining a room in said Hospital to be known and called the "John and Martha Kress Room".

Edgar Kenoy Fund #73201 - No record found of source of this fund. It is believed to have been left for a special purpose. In accordance with the instructions of the Board of Trustees of the Hospital, income accumulates and is transferred to principal for reinvestment.

Francis T. Maxwell Fund #73211 - This fund is considered permanent endowment. Income is used for general purposes. The fund consists of the proceeds of a $50,000 life insurance policy on the life of Francis T. Maxwell, plus gifts by Mr. Maxwell during his life of 50 shares Phoenix Insurance Company and 200 shares Hartford Gas Company. These gifts of stock were restricted to use of income for general purposes and principal to be used only toward a new hospital.

Harriet K. Maxwell Fund #73221 - Bequest under will of Harriet K. Maxwell - outright legacy - income is used for general expenses of the Hospital.

> Terms of Will - Third: "----and unto the Rockville City Hospital of Rockville, Connecticut, the sum of Five Thousand Dollars ($5,000)

Robert Maxwell Fund #73241 - Bequest u/w Robert Maxwell - outright legacy - income is used for general expenses of the Hospital. (The will gave discretion to executors to devote sum of $100,000 "in such manner as they may deem suitable for the benefit of said residents of Rockville and vicinity". One Hundred Thousand Dollars ($100,000) was paid to Rockville City Hospital per final account of executors.)

William A. and Caroline E. Metcalf Fund #73251 - Bequest u/w Caroline E. Steele Metcalf - Permanent endowment - Income for general purposes.

> Terms of Will - NINTH: All the rest, residue and remainder of my estate, of whatsoever nature and wheresoever situated, I give, bequeath and devise to the Trustees of The Rockville City Hospital, Inc., a charitable corporation organized and existing under the laws of the State of Connecticut, and owning and operating a hospital in said Town of Vernon, in trust, nevertheless, to hold invest and reinvest the same and to use the income thereof for the general uses and purposes of said Hospital as said Trustees shall see fit. Said trust shall be known as the William S. and Caroline E. Metcalf Fund.

William Maxwell Fund #73261 - This fund consists of the following:

Cash gifts by Mr. Maxwell during 1936 to 1938	$14,000.00
Proceeds of life insurance (1939)	61,472.99
Bequest under 14th clause of will	96,246.01
	$171,719.00

Terms of Will - FOURTEENTH: To ROCKVILLE CITY HOSPITAL, in Rockville, Connecticut, I give, devise and bequeath four of said equal parts of my said residuary estate in trust to use the income thereof for the general purposes of said Hospital.

Charles Phelps Free Bed Fund #73271 - Gift of $10,000 from Mrs. Elsie S. Phelps - Permanent endowment - Income for special purposes. Any amount of this fund in excess of $10,000 represents accumulated income and is considered available if necessary.

Terms of Gift

"1. For the benefit of any members of my household staff or their families who may be in need of the services which the fund can provide.

2. For the general use and benefit of the residents of the City of Rockville.

The fund, aside from the small conditions which I wish to impose for the benefit of my household staff, which will fall within the income limitations of the fund, will be managed by the Board of Trustees and Finance Committee of The Rockville City Hospital with full powers of sale, investment and reinvestment."

Celia E. Prescott Fund #73281 - This fund was left for a special purpose. In accordance with the instructions of the Board of Trustees of the Hospital, income accumulates and is transferred to principal for reinvestment.

Terms of Gift

$10,000. for free bed in honor of Francis and Eliza Porter Keeney
$ 5,000. for free bed in memory of Francis Keney Prescott
$ 400. for furnishing a room in memory of Jane E. Newcomb

George Palmer Charter Fund #73291 - Bequest under Second and Seventeenth Clauses of Will of George Palmer Charter - permanent endowment - income for general purposes.

Terms of Will

SECOND

I give and bequeath to the Rockville City Hospital, located in the city of Rockville, State of Connecticut, the sum of Ten Thousand (10,000) dollars, in trust, however, for the following uses and purposes, namely: The governing body of said hospital shall invest said sum of $10,000 and the annual income of said sum shall be used for the general maintenance of said Hospital.

George Palmer Charter Fund #73291 continued

SEVENTEENTH

All the rest, residue and remainder of my estate, of whatsoever nature and wheresoever situated which I may own or have the right to dispose of at the time of my decease, I give, devise and bequeath in equal proportions, share and share alike to the Rockville City Hospital located in the city of Rockville, State of Connecticut, and to the Cyril and Julia C. Johnson Memorial Hospital, Inc. located at Stafford Springs, State of Connecticut, in trust each of said hospitals shall invest the sums derived under this Article of my last Will and Testament and the annual income of said sums shall be used for the general maintenance of each of said hospitals.

William H. Prescott Fund #73301 - Bequest u/w William H. Prescott. Permanent endowment - income for general purposes.

Terms of Will -

"13. I give and bequeath to Francis T. Maxwell, Arthur T. Bissell, J. Alice Maxwell, A. N. Belding and Thomas W. Sykes, all of Rockville, Connecticut, the sum of Fifty Thousand Dollars ($50,000) in perpetual trust to them and their successors in office, for the purpose of establishing and maintaining at said city of Rockville, a general hospital for the sick, to be open and available to all residents of the said City of Rockville, and of such portion of the immediate vicinity thereof contiguous and adjacent thereto, as in the judgment of said Board of Trustees may be deemed wise and advisable, subject to such rules and regulations concerning admission to said hospital as said trustees and their successors in office may, from time to time, establish.

Said trustees and their successors in office shall have power to receive property by gift or otherwise, and to purchase land and erect buildings for the purpose of carrying out the provisions of this trust.

The general management and oversight of said hospital, including the character and method of treatment therein to be established, shall be vested wholly in said Board of Trustees and their successors in office..

Said Board may elect a President, Vice-President, Secretary and Treasurer, and such other executive officers as they may deem necessary or advisable to carry out the purpose of this trust, including a superintendent of said institution. All vacancies in said Board arising from any cause, shall be filled by appointment of the surviving trustees.

William H. Prescott Fund #73301-continued

Terms of Will-continued

> The Board of Trustees shall have power, from time to time, to make by-laws defining the duties of said officers and superintendent, the method of calling meetings of the Trustees and other by-laws relative to the management and government of the same. Provided, however, that, if at any time before my decease, I shall make provision for the transfer of the sum of fifty thousand dollars ($50,000) to the above named, as trustees for the purpose of inaugurating the establishment of a City Hospital, thereby substantially carrying out the provisions of this paragraph of my will, then and in that event, I revoke this paragraph of the same relating to said Hospital, and declare it inoperative, but otherwise to remain in full force and effect."

(1949)

Stephen Goodale Risley and Emeret Scott Risley Fund #73311 - Bequest u/ Ninth and Twenty-first clauses of Will of May R. Adams - permanent endowment - income for general purposes.

Terms of Will

> "NINTH: I give and bequeath unto THE ROCKVILLE CITY HOSPITAL, INC. of said Rockville, the sum of Ten Thousand Dollars, in memory of my father and mother, Stephen Goodale Risley, M.D. and Emeret Scott Risley, for the establishment of a fund to be known as the Stephen Goodale Risley and Emeret Scott Risley Fund, the income thereof to be used for the general uses and purposes of said Hospital."
>
> "TWENTY-FIRST: All the rest, residue and remainder of all my property, of every description, both real and personal, of whatsoever the same may consist or wheresoever it may be situated, I give, devise and bequeath unto said THE ROCKVILLE CITY HOSPITAL, INC. in order that the same may be added to and become a part of the Stephen Goodale Risley and Emeret Scott Risley Fund, which is established in Paragraph Ninth of this my last Will and Testament."

($79,688.80)

Rockville Chapter American Red Cross Fund #73321 - Gift from Rockville Chapter of American Red Cross - considered permanent endowment - income is used for general expenses of the Hospital.

William B. and Lizzie Lathrop Sprague Fund #73341 - Bequest u/w Lizzie Lathrop Sprague - considered permanent endowment - income is used for general expenses of the Hospital.

Terms of Will

> "--to be known as the William B. and Lizzie Lathrop Sprague Fund".

Swindells Fund #73351 - This fund represents donations received from the Swindells Foundation. Income and/or principal may be used for care of deserving persons or used for general hospital expenses. Surplus income is transferred to principal.

Fred Talcott Fund #73361 - Bequest u/w Fred Talcott - considered permanent endowment - income for general purposes.

Terms of Will

"SIXTEENTH: Whereas one William H. Prescott of said Rockville, now deceased, in and by his will bequeathed a large sum of money towards the support and maintenance of a hospital to be thereafterwards established in said Rockville, and it is my desire to make a contribution towards the erection and establishment of such hospital. I give and bequeath to the persons who at the time of my decease may be the custodians of the said fund, bequeathed as aforesaid by said Prescott, the sum of five thousand dollars to be used by them or their successors in such trust towards the erection and establishment of such hospital."

"TWENTIETH:——Upon the decease of the last survivor of the aforesaid beneficiaries under this trust I direct that one-half part of all the trust estate and property then remaining in the hands of my said trustee be by it made over to the persons mentioned in the sixteenth clause of this my will as the custodians of the William H. Prescott Fund, or to the persons who at the termination of this trust may be such custodians, to be applied towards the establishment of the hospital in said Rockville proposed or contemplated in the will of said Prescott, but if such hospital shall then be already established then said one-half of said trust estate and property shall be by said trustee made over to such hospital to be used by it for its uses and purposes."

Trumbull Chapter, D.A.R. Fund #73301 - Gift from Trumbull Chapter, D.A.R. - considered permanent endowment - income to be used for free bed, Sabra Trumbull Daughters to have preference, or any deserving person, to be decided by Hospital Trustees and Advisory Board of Sabra Trumbull Chapter. Any unused income is added to principal.

United German Society Fund #73391 - Gift from United German Society - considered permanent endowment - income is used for general expenses of the Hospital.

November 24, 1952

Florence R. Whitlock Fund #73371 - Bequest under will of Florence R. Whitlock (1953) - $13,351.35, a permanent endowment. Income for free bed or beds. Terms of will:
"2...The remaining four-tenths (4/10ths) of said residue, I give, devise and bequeath to the Rockville City Hospital for the purpose of establishing a free bed or beds in said Hospital in memory of my mother, Anna Shelton Whitlock."

Betsey C. Tucker Fund #73360 - Bequest under will of Betsy C. Tucker (1955) - $2,000, a permanent endowment. Income for free bed. Terms of will:
"Second: I give and bequeath to The Rockville City Hospital of Rockville, Connecticut, Two Thousand (2,000) Dollars to be its absolutely and forever. This bequest is to be used by said Hospital as an endowment for the partial maintenance of a free bed in said Hospital."

Anna M. and Albert H. Bilson Fund #745081 - Bequest under will of Anna M. Bilson of $10,371.08 as follows: (January 22, 1957)
"NINTH: All the rest, residue and remainder of my Estate, both real and personal of whatsoever nature and wheresoever situated is to be sold and one-half of the proceeds are to be given to the Union Congregational Church of Christ, Inc. to be known as the Anna M. Bilson and Albert H. Bilson Fund. I direct the trustees of said Church to lawfully invest said legacy and to use the income therefrom for the general uses and purposes of said Church. The remaining one-half thereof I give and devise unto the Rockville City Hospital, Inc. of the Town of Vernon to be known as the Anna & Albert Bilson Fund. I direct the trustees of said Hospital to lawfully invest said legacy, and to use the income therefrom for the general uses and purposes of said Hospital.

EXHIBIT Q 11-2

Fund 11-1.44

Anna & Albert Bilson Fund

continued from page 208 - Estate of Anna M. [redacted]

of Tolland, State of Connecticut, on the 24th day of January A.D. 1956.
Present, HON. THOMAS F. RADY, Judge.

ESTATE OF ANNA M. [redacted] late of Vernon deceased.
Upon the application of Henrietta Yost of Rockville praying that an instrument in writing purporting to be the last will and testament of said deceased be admitted to probate and that letters testamentary of administration with the will annexed, on said estate be granted as per application on file more fully appears, it is

ORDERED, That said application be heard and determined at the Probate Office in Vernon in said District, on the 3rd day of February, 1956 at 10.30 o'clock in the forenoon; and that notice of the pendency of said application and of the time and place set for said hearing thereon be given to all persons known to be interested in said estate by causing a true copy of this order to be sent by certified mail, postage prepaid to, or left with, each of the persons named in said application, except petitioners all at least eight days before the day set for said hearing.

By the Court,
(signed) Elsie M. Neff, Clerk

At a Court of Probate holden at Vernon, in and for the district of Ellington, in the County of Tolland, State of Connecticut, on the 3rd day of February A.D. 1956.
Present, HON. THOMAS F. RADY, Judge.

ESTATE OF ANNA M. [redacted] late of Vernon in said District, deceased.
Return is made that notice of the pendency of the application for the probate of the last will and testament of said deceased and of the time and place set for a hearing thereon, has been duly given to all persons known to be interested in said estate as directed by the foregoing order of this Court which return this Court finds to be true and accepts. After due hearing had this Court finds that said deceased last dwelt and was domiciled in the town of Vernon in said District, and died testate on the 12th day of January, AD 1956 that the instrument referred to in said application was duly executed by the testatrix as and for her last will and testament and that she was at the time of executing the same of lawful age and of sound mind and memory. It is therefore considered by this Court that said will is duly proved and the same is proved and approved. Whereupon letters testamentary on said estate are granted to Oscar F. Menge who on the 3rd day of February, 1956, appeared in Court, accepted said trust, and gave bond jointly with The Equitable Fire & Marine Insurance Co. as surety in the penal sum of Five Thousand (5,000) Dollars, which is accepted and approved by this Court and ordered to be recorded and kept on file. (Recorded in Vol. 9 of Bonds, pages 361.)

ORDERED, That twelve months from the 3rd day of February, 1956 be and the same are allowed the Executor within which to settle said estate.

ORDERED, That six months from the 3rd day of February, 1956 be and the same are limited and allowed for the creditors to bring in their claims against said estate and the said Executor is directed to give public notice to the creditors to bring in their claims within said time allowed, by posting a copy of this order upon the public sign-post nearest to the place where the deceased last dwelt within said town, and by publishing the same once in some newspaper having a circulation in said Probate District within thirty days from the date of this order and return make to this Court of the notice given, and of a list of all claims presented within said time.

ORDERED, That two months from the 3rd day of February, 1956 be and the same are allowed the Executor within which to make, or cause to be made, a true and perfect inventory of all the estate of said deceased, both real and personal, including choses in action. And this Court appoints Henrietta Yost and Hedwig Engelman, disinterested persons, appraisers under oath, to appraise said estate, and return make to this Court within said time allowed.

(signed) Thomas F. Rady, Judge.

RETURN OF NOTICE
To the Probate Court of the District of Ellington

ESTATE OF ANNA M. [redacted] of the Town of Vernon, in said District, deceased.
The subscriber hereby makes return that pursuant to an order of said Court, made on the 24th day of January, 1956 she caused a copy of said order to be sent by certified mail to each of the following named persons on the 24th day of January, 1956. Mrs. Beatrice Krueger, 3632 E. Lincoln Ave., Sacramento 18, California; Mr. August Kirchner, 4025-33rd St. Sacramento 20, California, Mrs. Emma Michel, P.O. Box 35, Winters, Calif.; Mr. George Schaefer, South St., Rockville, Conn.; Mr. Allan Schaefer, Hale St. Ext., Rockville, Conn.; Mr. William Schaefer, Bronwell Ave., Hartford, Conn.; Mrs. Eleanora Mohr, 348 E.Middle Turnpike, Manchester, Conn.; Mrs. Gisela Miller, Broad Brook,Rd., Hazardville, Conn.; Mrs. Henrietta Yost, Snipsic View Heights, Rockville, Conn.; Mrs. Eva Kossick, Grove St., Rockville, Conn.; Miss Alice Goehring, Grant Ave., Stafford Springs, Conn.; Mrs. Amelia Schlaf, Orchard St., Rockville, Conn.; Mr. Oscar Menge, 121 High St., Rockville, Conn.

(signed) Hazel M. Carter, Asst Clerk

Subscribed and sworn to before me this 24th day of January, 1956.

(signed) Elsie M. Neff, Clerk

LAST WILL AND TESTAMENT

I, ANNA M. [redacted] of the Town of Vernon, City of Rockville, County of Tolland, and State of Connecticut, being of lawful age, of sound and disposing mind, memory and judgment, do hereby make, publish and declare this to be my Last Will and Testament, hereby revoking all previous wills and codicils by me made.

FIRST: I direct that all my just debts and funeral expenses shall be fully paid and satisfied by my Executor herein after named.

SECOND: I hereby direct that all legacy, succession, inheritance, transfer and estate taxes levied or assessed upon with respect to any property which is included as part of my gross estate for the purpose of any such taxes shall be paid by my Executor out of my estate in the same manner as an expense of administration and shall not be prorated or apportioned among or charged against the respective devisees, legatees, beneficiaries, transferees and other recipients or charged against any property passing or which may have passed to any of them and that my Executor shall not exercise any privilege of reimbursement for any portion of any such tax from any person.

THIRD: I give, and bequeath unto Stanley Bakuski of the Town of Vernon the sum of ONE HUNDRED ($100) DOLLARS.

FOURTH: I give and bequeath unto Walter Leonard of said Town of Vernon the sum of TWO HUNDRED ($200) DOLLARS for the kindness he has rendered to me.

FIFTH: I give and bequeath unto my niece Beatrice E. Krieger of Sacramento, California, 3632 E. Lincoln Avenue, 18, the sum of ONE HUNDRED ($100) DOLLARS.

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continued from page 209 - Estate of Anna M. Bilson

SIXTH: I give and bequeath unto my brother, August Kirchner of 816 Charles Avenue 2, Del Paso Heights, Sacramento, California, the sum of ONE HUNDRED ($100) DOLLARS.

SEVENTH: I give and bequeath the sum of ONE ($1.00) DOLLAR to each of my following nieces and nephews: George Schaefer, Allan Schaefer, William Schaefer, Thomas Kirchner, Eva Kossick, Alice Gorhring, Amelia Schlaf, Elenora Mohr, Gisela Miller, Lucile Gorhring, and also my sister Emma Michel of Winters, California. I give and bequeath all of my jewelry to Beverley Yost of the Town of Vernon. I give and bequeath to Henrietta Yost all of my bedding, linens, and silver, and any antiques that I may have and possess.

EIGHT: I give and bequeath unto the Athenium Memorial in Hartford, Connecticut, my Staffordshire Poodle Dog Statues.

NINTH: All the rest, residue, and remainder of my estate, both real and personal of whatsoever nature and wheresoever situated is to be sold and one-half of the proceeds are to be given to the Union Congregational Church of Christ, Inc. to be known as the Anna M. Bilson and Albert H. Bilson Fund. I direct the trustees of said Church to lawfully invest said legacy and to use the income therefrom for the general uses and purposes of said Church. The remaining one-half thereof I give and devise unto the Rockville City Hospital, Inc., of the Town of Vernon to be known as the Anna & Albert Bilson Fund. I direct the trustees of said Hospital to lawfully invest said legacy, and to use the income therefrom for the general uses and purposes of said Hospital.

TENTH: I hereby nominate and appoint Reverend George S. Brookes to be Executor of this my Last Will and Testament, and I request that no bond shall be required of him, and he shall have power to sell real estate, real or personal at public or private sale and he should be paid in the sum of ONE HUNDRED ($100) DOLLARS at least for the work in settlement of my estate. I also desire to have Reverend George S. Brookes officiate at my funeral and the funeral directed by William H. Yost of Stafford Springs who is to have charge of all funeral arrangements, expenses to cost $700.00 using a cement vault and place the inscription on the monument in the Albert Bilson family lot in Grove Hill Cemetery in the said Town of Vernon. In the event said Reverend George S. Brookes shall have died, I nominate Oscar Menge to serve as Executor without bond.

IN WITNESS WHEREOF, I have hereunto set my hand and seal at Hartford, Connecticut on the 3rd day of October A.D. 1952.

(signed) Anna M. Bilson L.S.

Signed, sealed, published and declared by the said ANNA M. BILSON, Testator, as and for her Last Will and Testament, in our presence, who at her request, in her presence and in the presence of each other, have hereunto subscribed our names as witnesses at Hartford, Connecticut, this 3rd day of October A.D. 1952.

(signed) Nelie Satryb of Rockville, Connecticut
(signed) Theresa C. Roy of Hartford, Connecticut
(signed) Beverly Byrnes of Hartford, Connecticut

STATE OF CONNECTICUT)
COUNTY OF HARTFORD) ss. Hartford, October 3rd A.D. 1952

We, the subscribing witnesses to the foregoing Will, make solemn oath that ANNA M. BILSON, the said Testator, signed and sealed the foregoing instrument in our presence and in the presence of each other, and that at the time of executing this Will, the said Testator was, to the best of our knowledge and belief, of sound and disposing mind and memory and free from all undue influence. This affidavit is made and signed at the request of ANNA M. BILSON.

(signed) Nelie Satryb
(signed) Theresa C. Roy
(signed) Beverly Byrnes

Subscribed and sworn to this 3rd day of October A.D. 1952, before me

(signed) Henry C. Stone,
Commissioner of the Superior Court

APPLICATION FOR LETTERS OF ADMINISTRATION
To the Probate Court for the District of Ellington:

ESTATE OF MARGARET MARKERT late of Vernon in said District, deceased.

The subscriber represents that Margaret Markert last dwelt in the Town of Vernon in said District, and died on the 10th day of January A.D. 1956, possessed of goods and estate in said District remaining to be administered, leaving no husband; that said decedent left as her only heirs-at-law and next of kin, the persons whose names, residences and relationship to the deceased are as follows, viz:

NAME	RESIDENCE	RELATIONSHIP
Louise Markert Finne	214½ W. Main St., Meriden, Conn	sister
Anna Elizabeth Spillane	24 Prospect St. Milford, N.H.	sister
Everett Wanegar	R.F.D. 2, Doyle Rd., Rockville, Conn	children of Mary
Leroy F. Wanegar	absent & unheard of for over 7 years	Kington, dec'd sister

and that said deceased left no will.

Wherefore your petitioner prays that letters of administration on said estate may be granted to Everett E. Wanegar.

Dated at Rockville, Conn. this 13th day of January A.D. 1956.

(signed) Louise M. Finne
(signed) Ruth S. Anderson

ORDER OF NOTICE

At a Court of Probate holden at Vernon, in and for the District of Ellington, in the County of Tolland, State of Connecticut, on the 19th day of January, 1956.

Present, HON. I. TILDEN JEWETT, Acting Judge.

ESTATE OF MARGARET MARKERT, late of Vernon in said District, deceased.

Upon the application of Louise M. Finne and Ruth S. Anderson praying that letters of administration on said estate be granted as per application on file more fully appears; it is

ORDERED, That said application be heard and determined at the Probate Office in Vernon (Rockville) in said District, on the 25th day of January, 1956, at eleven o'clock in the forenoon; and that notice of the pendency of said application, and of the time and place of hearing thereon, be given to all persons known to be interested in said estate, including Leroy F. Wanegar, nephew of said deceased, whose whereabouts are unknown, his legatees, devisees, heirs-at-law, next of kin, widow and legal representatives, by causing a true copy of this order to be published once in some newspaper having a circulation in said District and sent by certified mail, postage prepaid, to each of the following named persons at least five days before the day set for said hearing: Mrs. Louise Markert Finne,

EXHIBIT Q 11-2

Fund 11-1.45

Alvah N. Belding Fund

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DISTRICT OF ELLINGTON

To the Probate Court for the District of Ellington

Estate of Alvah N. Belding late of Vernon, in said District, deceased.

The subscriber represents that Alvah N. Belding last dwelt in the town o in said District, and died on the 16th day of December, A. D. 1925, possessed and estate remaining to be administered, leaving as his only heirs-at-law, and kin, the persons whose names, residences, and relationship to the deceased are follows:

Names.	Residences.	Relati
Florence Belding Nuckols	Pelham Manor, N. Y.	Dau
Frederick Horton Belding	Rockville, Conn.	Gr

none of whom are under any disability or incapacity and that the said deceased will herewith presented for probate, wherein Frederick N. Belding and Henry W. are named as executors.

Wherefore your petitioner prays that said will may be proved, approved, al admitted to probate and letters testamentary on said estate may be granted to t therein named.

Frederick N. Belding
Henry W. Nuckols

Subscribed and sworn to this 22nd day of December, 1925, before me

John E. Faney, Judge.

The undersigned being with the petitioner all the heirs-at-law and next of said deceased, accepts service and waives notice of the pendency of the foregoi cation and of the time and place set for hearing thereon.

Florence Belding Nuc

A true copy

Attest: Gertrude L. Keating Cl

At a Court of Probate holden at Vernon, in and for the District of Ellington, on day of December, A. D. 1925.

Present, John E. Faney, Judge.

Estate of Alvah N. Belding, late of Vernon, in said district, deceased.

Upon the application of Frederick N. Belding of Rockville, Connecticut, and Nuckols of Pelham Manor, New York, praying that an instrument in writing purportin the last will and testament of said deceased (and codicil thereunto) be admitted hate, and that letters testamentary be granted on said estate, as per application more fully appears;

This Court for cause shown, viz: that all parties known to be interested in s tate have signed and filed in Court a written waiver of notice dispenses with noti the pendency of said application. After hearing the parties with their evidence t Court finds the allegations of said application to be true, and that said instrume duly executed by the Testator for his last will and testament, that he was at the executing the same of lawful age and of sound mind and memory. It is therefore co by this Court that said Will and codicil are duly proved, and the same are proved, and ordered to be recorded and kept on file. Whereupon letters testamentary on sa tate are granted to Frederick N. Belding of said Rockville, and Henry W. Nuckols o Pelham Manor, who on the 22nd day of December, 1925, appeared in Court, accepted sa trust, and gave Bond Jointly with Farley B. Leonard of said Rockville, as surety in penal sum of Five Thousand ($5,000) Dollars, which is accepted and approved by this and ordered to be recorded and kept on file. (Recorded in Vol. 5 of Bonds, page 20 Ordered, That twelve months from the 22nd day of December, 1925, be and the same ar allowed the Executors within which to settle said estate.

Ordered, That six months from the 22nd day of December, 1925, be and the same are l and allowed for the creditors to bring in their claims against said estate, and the Executors are directed to give public notice to the creditors to bring in their cla within said time allowed, by posting a copy of this order upon the public sign-post est to the place where the deceased last dwelt within said town, and by publishing same once in some newspaper having a circulation in said Probate District within te from the date of this order and return make to this court of the notice given, and list of all claims presented within said time.

Ordered, That two months from the 22nd day of December, 1925, be and the same are a the Executor within which to make, or cause to be made, a true and perfect inventor all the estate of said deceased, both real and personal, including choses in action this Court appoints Frederick N. Holt and Farley B. Leonard, disinterested persons, praisers under oath, to appraise said estate, and return make to this Court within time allowed.

John E. Faney, Judge.

A true copy

Attest: Gertrude L. Keating Cl

ECHN Proposed Asset Purchase by PMH
Submitted October 13, 2015

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DISTRICT OF ELLINGTON

All Men By These Presents, That I, Alvah H. Belding, of the City of Rockville, County Tolland and State of Connecticut, being of sound and disposing mind and memory do make my last will and testament, hereby revoking all former wills and codicils by me made. I give, devise and bequeath my property and estate, both real and personal, in manner following, namely:-

1. I direct that all of my just debts and expenses be paid and discharged with convenient speed by my executors hereinafter named.

2. I give to my son, Frederick Norton Belding of Rockville, Connecticut, my dwelling house, stable and curtilage, being the premises which I now occupy on Talcott Avenue, in the city of Rockville, together with the household furniture, furnishings, draperies, pictures, silver-ware, linen and bric-a-brac and household implements, with the exception of a few articles included in the above which have previously been disposed of to my daughter, Florence M. Ruckols, also my horses, carriages, harness, robes, sleighs, hay and grain, automobiles, equipment and utensils used in connection with my residence, together with the vacant building lot nearly opposite my premises and situated on Davis Street, south of the premises of A. Leroy Martin, and containing about two acres of land, absolutely and in fee simple.

3. I give to my son, Frederick Norton Belding or Rockville, Connecticut, Henry W. Ruckols of Pelham Manor, New York, W. P. Metherington, F. W. Howard and W. B. Read of Belding, Michigan, Trustees, the sum of Forty Thousand (40,000.) Dollars, in trust, to and their successors in office for the purpose of building and establishing at the village of Belding, Michigan, a public circulating library for the benefit of the general public under such rules, regulations and restrictions as the trustees thereof in their judgment may deem advisable, having in mind the welfare and convenience of the reading public.

The general management and oversight of said public library shall be vested in said board of Trustees and in their successors in office, which may elect of their number a president, vice-president, secretary and treasurer, and such other executive officers as they may deem necessary. All vacancies upon said board for any cause shall be filled by appointment of the surviving trustees.

4. I give and bequeath to the trustees of the Rockville City Hospital of Rockville, Connecticut, the sum of Three Thousand (3,000.) Dollars to be used and expended by them for the purposes indicated in the will of the late William H. Prescott regarding the establishment of a City Hospital, as they may deem most advisable.

5. I give to Frederick Norton Belding of Rockville, Connecticut, Trustee, the sum of Ten Thousand (10,000) Dollars, in trust, for the following purpose:- to take, invest, reinvest and manage the same, and collect the income and avails thereof and pay such income regularly to Hettie M. Remick of Newton Center, Massachusetts, for, and during the term of her natural life; directing that said payments be made at regular periods as the trustee in his best judgment may determine, having in mind the character of the investment, the income therefrom and the convenience of the beneficiary. At the decease of the said Hettie M. Remick, I order and direct that my said trustee pay Five Thousand (5,000.) Dollars of the said principal sum, to the trustees or the proper officials of the Baptist Church located at Belding, Michigan, to be used by said trustees or said officials for the best interest of said Church as shall be determined by said trustees or officials or their successors in office. The remaining Five Thousand (5,000.) Dollars of said principal sum I give to Frederick Norton Belding of Rockville, Connecticut and Clarence M. Ruckols of Pelham Manor, New York, trustees in trust, for the following purpose: To hold, invest, re-invest and manage for the benefit of a proposed town or village hospital at Belding, Michigan, until such time as a permanent organization may be created for the establishment of said city or town hospital, when, and in that event, my said trustees are directed to pay over to the proper officials of said proposed hospital, the sum of Five Thousand (5,000.) Dollars, to be used and expended for the best interest of said hospital institution as the trustees or managers thereof may in their best judgment deem most advisable.

6. I give the following sums of money to the following named persons, absolutely and forever; to wit,

To my nephew, Hiram H. Vincent, of Orleans, Michigan, the sum of One Thousand (1,000.) Dollars.

To my nephew, Robert M. Remick, of Newton Center, Massachusetts, the sum of One Thousand (1,000.) Dollars.

To my niece, Marion B. Merrick of Shelbourne Falls, Massachusetts, the sum of One Thousand, Five Hundred (1,500.) Dollars.

To each of my nieces, Lucille Elizabeth, and Dorothy Belding Merrick, daughters of C. H. Merrick of said Rockville, the sum of One Thousand (1,000.) Dollars.

To C. C. Warren, of Rockville, Connecticut, in recognition of his faithful services, the sum of Five Thousand (5,000.) Dollars.

To Elmer L. Reed, of Rockville, Connecticut, the sum of Five Hundred (500.)

To each of the following named persons now engaged in my domestic employment the sum of Two Hundred and Fifty (250) Dollars:- Richard Winkler, Caroline Church, Delia [illegible] Herman, all at present of the city of Rockville, Connecticut,

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(Continued from page 339) (Will of Alvah H. Belding)

8. I give to the Town of Vernon, Connecticut, the sum of Three Hundred ($300.) Dollars in perpetual trust, the interest and income thereof to be expended for the care, ... ment and maintenance of my family burial lot in Grove Hill Cemetery, in the City of Rockville.

9. All the rest, residue and remainder of my property and estate, both real and personal, of whatsoever kind and wherever found, remaining after the above provisions, including any legacies or bequests which may for any reason lapse or fail to take effect, I give, devise and bequeath to my son and daughter, Frederick Horton Belding, of Rockville, Connecticut, and Florence H. Nuckols of Pelham Manor, New York, to be divided equally between them share and share alike, provided, however, that in the event of the death of either my son, Frederick Horton Belding or my daughter, Florence H. Nuckols, occurring before my decease, then, I give to the survivor all of such rest, residue and remainder of my estate.

10. I herein constitute and appoint my son Frederick Horton Belding, of Rockville, Connecticut, and my son-in-law, Henry W. Nuckols, of Pelham Manor, New York, to be executors of this my last will and testament, and I direct that they be not required to give bonds.

11. I hereby especially authorize and empower my executors above named, to sell and dispose of any portion or all of my real estate, whenever in their best judgment such sales will be advisable for the best interest of my estate and to execute and deliver good and sufficient deeds therefor.

In Witness Whereof I have hereunto set my hand and seal at Rockville, in the State of Connecticut, this Fourth day of October, A. D., One Thousand Nine Hundred and Sixteen.

Alvah H. Belding (L.S.)

Signed, sealed and declared to be his last Will and Testament by the above named Testator, Alvah H. Belding, in the presence of us, who in his presence, at his request and in the presence of each other have hereunto subscribed our names as witnesses on the Fourth day of October, 1916.

Charles Phelps)
Lena I. Hein)Witnesses.
Dwight B. Gardner)

State of Connecticut,)
District of Ellington,) ss. Probate Court, Rockville, December 22, A.D. 1923.

I, Dwight B. Gardner of Rockville, Connecticut, being duly sworn, make affidavit and say that Alvah H. Belding of Rockville, Connecticut, now deceased, signed the instrument hereto annexed, bearing date the 4th day of October, A. D. 1916, and declared the same to be his Last Will and Testament in my presence and in the presence of Charles Phelps and Lena I. Hein, whose names appear thereon as witnesses, at Rockville on said 4th day of October, A. D. 1916; that he was at the time of signing said instrument more than 18 years of age and of sound mind; and that at his request, in his presence, and in the presence of each other, each of said witnesses signed said instrument so subscribed by said Alvah H. Belding.

Dwight B. Gardner

Subscribed and sworn to the day and year first above written in open Court before me.

John D. Fihe, Judge.

A true copy

Attest: Ruth L. Keating Clerk

I, Alvah H. Belding, of the City of Rockville, Tolland County, Connecticut, do make and declare this to be my Codicil, hereby expressly confirming my last Will and Testament made on the 4th day of October, 1916, and making additional provisions as follows, namely:

I give and bequeath to the Rockville National Bank, a banking and trust institution located in the city of Rockville, Tolland County, Connecticut, Trustee, One hundred and eighty (180) shares of preferred stock of the United States Steel Corporation, in trust nevertheless, for the following purposes namely:-

1. I direct that the income, avails and profits accruing from said shares of stock shall be paid in quarterly payments by the Trustee aforesaid, to Cornelius C. Warren, of the City of Rockville, Tolland County, Connecticut, and now in his employ, for and during the period of his natural life.

2. I make this provision in addition to any other which may have been made in his interests.

3. At the decease of the said Cornelius C. Warren, I give and bequeath said One Hundred and eighty (180) shares of stock of the United States Steel Corporation, with any avails thereof, or additions thereto, that may have been left unexpended at the time of the decease of the said Cornelius C. Warren, to the "Alvah H. Belding Library", located at Belding, Michigan, absolutely.

4. In the event of the death of the said Cornelius C. [illegible] then recall the trust and give and bequeath

ECHN Proposed Asset Purchase by PMH
Submitted October 13, 2015

EXHIBIT Q 11-2

Fund 11-1.46

Frederick W. Bradley

APPLICATION FOR PROBATE OF WILL
To the Probate Court for the District of Ellington

ESTATE OF FREDERICK W. BRADLEY late of Vernon in said District, deceased.

The subscriber represents that Frederick W. Bradley last dwelt in the Town of Vernon in said District, and died on the 25th day of August A.D. 1956, possessed of goods and estate in said District remaining to be administered, leaving a widow whose name and residence is Ellen A. Bradley, 5 Pleasant St., Rockville, Connecticut and whose marriage to the deceased took place October 1896; that said decedent left as his only heirs-at-law, and next of kin the persons whose names, residences, and relationship to the deceased are as follows, viz:

NAME	RESIDENCE	RELATIONSHIP
Ellen A. Bradley	5 Pleasant Street, Rockville, Conn	wife

and that said deceased left a will dated June 22, 1948 herewith presented for probate wherein The Hartford-Connecticut Trust Company, Rockville Branch is named executor;

Wherefore your petitioner prays that said will may be proved, approved, allowed and admitted to probate, and letters testamentary on said estate may be granted to the executor herein named.

Dated at Rockville, Conn. this 27th day of August A.D. 1956.

(signed) Ellen A. Bradley

The undersigned, being all the heirs-at-law, next of kin, and devisees and legatees interested in the foregoing petition, accept service and waive notice of the pendency of the foregoing petition and ask for the appointment of The Hartford-Connecticut Trust Company as Executor.

(signed) Ellen A. Bradley

DECLINATION OF TRUST
To the Probate Court for the District of Ellington:

Re: Last Will and Testament of FREDERICK W. BRADLEY, of Vernon, Connecticut

The subscriber, being named Executor under the provisions of the Last Will and Testament of said Frederick W. Bradley, hereby indicates his intention of inability to act as such Executor, and hereby declines to accept said trust.

Dated at Rockville, Connecticut, this 12th day of May, 1952.

(signed) George Arnold Jr.

ACCEPTANCE OF TRUST
To the Probate Court for the District of Ellington in the State of Connecticut

ESTATE OF FREDERICK W. BRADLEY, late of Rockville, in said District, deceased.

ACCEPTANCE OF TRUST

The Connecticut Bank and Trust Company having been named as Executor of the Last Will and Testament of the above named Decedent, hereby appears in Court and accepts said Trust.

Dated at Rockville, Connecticut, this 27th day of August, 1956.

The Connecticut Bank and Trust Company
by (signed) W. S. Harrison, asst. trust officer

DECREE ADMITTING WILL and ORDERS
At a Court of Probate holden at Vernon, in and for the District of Ellington, in the County of Tolland, State of Connecticut, on the 27th day of August A.D. 1956.

Present, HON. THOMAS F. RADY, Judge.

ESTATE OF FREDERICK W. BRADLEY a.k.a. FRED W. BRADLEY late of Vernon in said District, deceased.

Upon the application of Ellen A. Bradley of Rockville, Conn. praying that an instrument in writing purporting to be the last will and testament of said deceased be admitted to probate and that letters testamentary on said estate be granted as per application on file more fully appears.

This Court for cause shown, viz: that all parties known to be interested insaid estate consist of the petitioner who is legally capable of acting, have signed and filed in Court a written waiver of notice, dispenses with notice of the pendency of said application and of a hearing thereon.

After due hearing had this Court finds that said deceased last dwelt and was domiciled in the town of Vernon in said District, and died testate on the 25th day of August A.D. 1956; that the instrument referred to in said application was duly executed by the testator as and for his last will and testament and that he was at the time of executing the same of lawful age and of sound mind and memory. It is therefore considered by this Court that said will is duly proved and the same is proved and approved. Whereupon letters testamentary on said estate are granted to The Connecticut Bank and Trust Company*who on the 27th day of August, 1956 appeared in Court and accepted said trust. * by its duly authorized assistant trust officer.

ORDERED, That twelve months from the 27th day of August, 1956 be and the same are allowed the Executor within which to settle said estate.

ORDERED, That six months from the 27th day of August, 1956 be and the same are limited and allowed for the creditors to bring in their claims against said estate, and the said Executor is directed to give public notice to the creditors to bring in their claims within said time allowed, by posting a copy of this order upon the public sign-post nearest to the place where the deceased last dwelt within said town, and by publishing the same once in some newspaper having a circulation in said Probate District within thirty days from the date of this order and return make to this Court of the notice given, and of a list of all claims presented within said time.

ORDERED, That two months from the 27th day of August, 1956 be and the same are allowed the Executor within which to make, or cause to be made, a true and perfect inventory of all the estate of said deceased, both real and personal, including choses in action. And this Court appoints John Gottier and J. Everett North, disinterested persons, appraisers under oath, to appraise said estate, and return make to this Court within said time allowed.

(signed) Thomas F. Rady, Judge.

LAST WILL AND TESTAMENT

I, FREDERICK W. BRADLEY of the Town of Vernon, County of Tolland and State of Connecticut, being of lawful age, of sound and disposing mind, memory and judgment, do hereby make publish and declare this to be my last Will and Testament, hereby revoking all previous wills and codicils by me made.

FIRST: I direct that all my just debts and funeral expenses be paid and discharged by

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Connecticut, to hold, manage, invest and reinvest said sum as a perpetual trust and to use the income therefrom for the care and maintenance of my cemetery lot and markers in the Grove Hill Cemetery, in said Town of Vernon.

THIRD: I give, devise and bequeath my real estate, consisting of a tract of land with the buildings thereon, known and designated as No. 5 Pleasant Street, in said Town of Vernon, (said real estate having been deeded to me from the Estate of Lorenzo Webster, by an Administrator's Deed dated January 2, 1907 and recorded in the Vernon Land Records, volume 37, Page 578) to my wife ELLEN A. BRADLEY, if living at the time of my death. If and only in the event my said wife predecease me, then and only in that event, I give, devise and bequeath said real estate, with the buildings thereon, bequeathed to her in this Third Paragraph, unto my wife's sister MARY A. LEE of 5 Pleasant Street, in said Town of Vernon; to her, her heirs and assigns, absolutely and forever.

FOURTH: I release and forgive to EDITH HULBURT of Somers, Connecticut, a certain note secured by a mortgage for the sum of Two Thousand Dollars, made by her to me upon her property situated in said Town of Somers, or so much of said mortgage note as may remain owing to me at the time of my death and all the interest thereon, and I direct that her mortgage note shall be cancelled and given up to her, and the said mortgage released and discharged of record.

FIFTH: I give and bequeath unto MYRTIE E. BROOKS of said Town of Vernon, if living at the time of my death, the sum of One Thousand Dollars.

SIXTH: I give, devise and bequeath my business known as the F.W. Bradley Lumber Yard, situated at 19 Grove Street, in said Town of Vernon; together with the land and buildings thereon; also together with all articles of personal property situated within said buildings or upon said premises, including all trucks, lumber, mason's supplies and roofing, comprising all the stock in said lumber yard or in transit, including office equipment and fixtures, and together with all book accounts pertaining to and arising from the business transactions of the business known as said F.W. Bradley Lumber Yard, unto FRED W. LEE of Bradley Drive, in said Town of Vernon, and CHRISTINE E. ZIEBARTH BURNES of said Bradley Drive, share and share alike; to them, their heirs and assigns, absolutely and forever.

SEVENTH: I give and bequeath unto my nephew CLIFTON S. BRADLEY of said Town of Vernon, the sum of Two Thousand Dollars. If he should die before me, I direct that the bequest payable to him shall be paid to his heirs at law, surviving me.

EIGHTH: I release and forgive to my said nephew CLIFTON S. BRADLEY and his wife WILMA B. BRADLEY of said Town of Vernon, a certain note secured by a mortgage for the sum of Four Thousand Dollars, made by them to me upon their property situated in said Town of Vernon, or so much of said mortgage note as may remain owing to me at the time of my death and all the interest thereon, and I direct that their said mortgage note shall be cancelled and given up to them and the said mortgage released and discharged of record.

NINTH: I give and bequeath unto WILLIAM FELBER of said Town of Vernon, my yard foreman, if living and still in my employ at the time of my death, the sum of Two Thousand Dollars; to him, absolutely and forever.

TENTH: I give and bequeath unto JOHN BOCK of said Town of Vernon, if living and still in my employ at the time of my death, the sum of One Thousand Dollars; to him, absolutely and forever.

ELEVENTH: I give and bequeath unto FRED GRUENIG of said Town of Vernon, if living and still in my employ at the time of my death, the sum of One Thousand Dollars; to him, absolutely and forever.

TWELFTH: I give and bequeath unto JUSTIN CARVER of said Town of Vernon, if living and still in my employ at the time of my death, the sum of One Thousand Dollars; to him, absolutely and forever.

THRITEENTH: I give and bequeath unto the ROCKVILLE BAPTIST CHURCH of said Town of Vernon, the sum of Two Thousand Dollars, to be used for its general uses and purposes.

FOURTEENTH: I give and bequeath unto THE ROCKVILLE CITY HOSPITAL, INC. of said Town of Vernon, the sum of Two Thousand Dollars, in memory of the donor and I direct that said sum be added to the endowment fund of said Hospital, the income thereof to be used for its general uses and purposes.

FIFTEENTH: All the rest, residue and remainder of all my property, both real and personal, of whatsoever the same may consist or wheresoever it may be situated, I give devise and bequeath as follows, to wit:

1. One-half thereof unto my said wife ELLEN A. BRADLEY, if living at the time of my death. If and only in the event of her death, prior to my own, then and only in that event, I give, devise and bequeath said part, being one-half of said rest, residue and remainder of my estate, as follows, to wit:

(a) One-fifth thereof unto my wife's sister ROSALIE F.A. WILLIAMS of East Douglas, Massachusetts. If she should die before me, I direct that the bequest payable to her shall be paid to her heirs at law, surviving me.

(b) One-fifth thereof unto my said wife's sister MARY A. LEE. If she should die before me, I direct that the bequest payable to her shall be paid to her heirs at law, surviving me.

(c) One-fifth thereof unto my wife's niece ROSALIE E. WILLIAMS of East Douglas, Massachusetts. If she should die before me, I direct that the bequest payable to her shall be paid to her heirs at law surviving me.

(d) One-fifth thereof unto my wife's niece RUTH A. CHRISTOPHER of West Haven, Connecticut. If she should die before me, I direct that the bequest payable to her shall be paid to her heirs at law, surviving me.

(e) The remaining one-fifth thereof unto my wife's niece ELIZABETH S. LEE of said Town of Vernon. If she should die before me, I direct that the bequest payable to her shall be paid to her heirs at law, surviving me.

2. One-fourth thereof unto my said niece CHRISTINE B. ZIEBARTH BURNES. If she should die before me, I direct that the bequest payable to her shall be paid to her heirs at law, surviving me.

3. One-sixteenth thereof unto CLIFTON STEDMAN BRADLEY (son of Clifton S. Bradley), of said Town of Vernon. If he should die before me, I direct that the bequest payable to him shall be paid to his heirs at law, surviving me.

4. One-sixteenth thereof unto JAMES DANIEL BRADLEY (son of Clifton S. Bradley), of said Town of Vernon. If he should die before me, I direct that the bequest payable to him shall be paid to his heirs at law, surviving me.

5. One-sixteenth thereof unto CLIFTON EVERETT BRADLEY (son of Clifton S. Bradley), of Glastonbury, Connecticut. If he should die before me, I direct that the bequest payable to him shall be paid to his heirs at law, surviving me.

6. The remaining one-sixth thereof unto MADELINE BELL ZIEBARTH of Manchester, Connecticut. If she should die before me, I direct that the bequest payable to her shall be paid to her heirs at law, surviving me.

SIXTEENTH: I direct that all succession, inheritance and transfer taxes which would be payable on account of the legacies, other than residuary legacies hereinbefore given

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shall be paid out of the residue of my estate so that said several legacies shall be net for their full amount to the said several legatees.

I appoint GEORGE ARNOLD, Jr. of said Town of Vernon, Executor of this my last Will and Testament. In the event of the death of said George Arnold, Jr. before me, or his inability to act as such Executor, I appoint THE HARTFORD-CONNECTICUT TRUST COMPANY, ROCKVILLE BRANCH, of said Town of Vernon, Executor of this my last Will and Testament.

IN WITNESS WHEREOF I have hereunto set my hand and seal at said Vernon, on the 22nd day of June A.D., One Thousand Nine Hundred and Forty-eight.

(signed) Frederick W. Bradley (L.S.)

Signed, sealed, published and declared by the said FREDERICK W. BRADLEY as and for his last Will and Testament, in presence of us, who at his request, in his presence, and in the presence of each other have hereunto subscribed our names as witnesses, on the 22nd day of June A.D., 1948.

(signed) Jane Dereszewska
(signed) Eleanor Baskowski } Witnesses
(signed) Arthur A. Koss

STATE OF CONNECTICUT
COUNTY OF TOLLAND } ss. Vernon June 22nd, A.D, 1948

We the within named Jane Dereszewska, Eleanor Baskowski and Arthur A. Koss, all of said Town of Vernon, being duly sworn, make affidavit and say: That we severally attested the within and foregoing Will of the within named testator and subscribed the same in his presence and at his request and in the presence of each other; that the said testator signed published and declared the said instrument as and for his last Will and Testament in our presence on the 22nd day of June A.D., 1948; and at the time of execution of said Will, said testator was more than eighteen years of age and of sound mind, memory and judgment and under no improper influence or restraint to the best of our knowledge and belief, and we make this affidavit at the request of said testator.

(signed) Jane Dereszewska
(signed) Eleanor Baskowski
(signed) Arthur A. Koss

STATE OF CONNECTICUT
COUNTY OF TOLLAND } ss. Vernon June 22nd A.D., 1948

Then personally appeared before me a notary public duly qualified to administer oaths, Jane Dereszewska
Eleanor Baskowski
and Arthur A. Koss,
and subscribed and made oath to the truth of the foregoing affidavit

(signed) Donald C'Fisk, Notary Public

INVENTORY - for Tax Purposes Only
To the Court of Probate in and for the District of Ellington, in the State of Connecticut:

ESTATE OF PEGGY U. DONNENFELD late of Vernon in said District, deceased.

The following is a true and perfect inventory of said estate:-

An Undivided one-half interest in and to a certain piece or parcel of land with all buildings thereon situated in the Town of Vernon, County of Tolland and State of Connecticut, bounded and described in Warranty Survivorship Deed from William E. Russell and Germaine F. Russell dated September 8, 1953 and recorded in the Vernon Land Records, Vol. 97, Page 239. $ 5,950.00

Less one-half of mortgage Feb. 9, 1956 4,600.00

$ 1,350.00

(signed) Dee I. Donnenfeld, Administrator

Subscribed and sworn to this 10th day of July, 1956, before me,

(signed) Elsie M. Neff, Clerk

We certify that we have appraised said estate as above set forth and that the values given are true to the best of our knowledge and belief.

(signed) Patricia K. Rothman
(signed) Helen P. Pomeroy } Appraisers

On the 10th day of July, 1956, the appraisers above named appeared before me and made oath that they would faithfully discharge their duties as such appraisers according to law.

(signed) Elsie M. Neff, Clerk

Accepted and ordered recorded and filed, this 23rd day of July, 1956.

(signed) Thomas F. Rady, Judge.

STATE OF CONNECTICUT
OFFICE OF TAX COMMISSIONER

ESTATE OF PEGGY U. DONNENFELD

This is to certify that for inheritance taxation purposes, the statutory period of sixty days required under the statute before the inventory and appraisal can be accepted by the Probate Court is hereby waived in the above estate. Ther is no objection to the acceptance and approval of the inventory and inventory for tax purposes only and appraisal dated July 10th 1956.

Dated at Hartford, Connecticut, this 12th day of July 1956.

JOHN L. SULLIVAN, Tax Commissioner,
by (signed) Frederic W. Dauch
First Assistant Tax Commissioner

INVENTORY
To the Court of Probate in and for the District of Ellington, in the State of Connecticut:

ESTATE OF PEGGY U. DONNENFELD, late of Vernon in said District, deceased.

The following is a true and perfect inventory of said estate:

1950 Studebaker 2 door sedan July Issue N.A.D.A. $135.00

(signed) Dee I. Donnenfeld, Administrator

Subscribed and sworn to this 10th day of July 1956, before me

(signed) Elsie M. Neff, Clerk

We certify that we have appraised said estate as above set forth and that the values given are true to the best of our knowledge and belief.

Appraisers } (signed) Laurence R. Scranton
Pres. Scranton Motors, Inc. Rockville,
(signed) Bernard L. Satryb Office Sec

EXHIBIT Q 11-2

Fund 11-1.47

Ruth T. Britton Fund

941JDZ

DISTRICT OF ELLINGTON

I, Ruth Talcott Britton, of Talcottville, Vernon, Connecticut, being of sound and disposing mind, memory and understanding, do make, publish and declare this to be my Last Will and Testament, hereby revoking all other wills heretofore made by me.

FIRST: I direct that all my just debts and funeral expenses be paid as soon as conveniently can be after my decease, and that all succession, legacy, transfer or inheritance taxes be paid by my Executor out of the residue of my estate as an expense in the settlement thereof.

SECOND: I give and bequeath to Jennie Gardner Gillette, of Jacksonville, Florida, all of my jewelry not hereinafter otherwise disposed of, all of my clothing, and all other articles of personal use or adornment, together with the sum of Ten Thousand (10,000) Dollars. If the said Jennie Gardner Gillette shall predecease me, I give and bequeath said articles to her daughter, Pamilla, and said sum of Ten Thousand (10,000) Dollars to her daughter, Pamilla, and her son, Gardner T. Gillette, share and share alike.

THIRD: I give to The Hartford-Connecticut Trust Company, of Hartford, Connecticut, the sum of One Thousand (1,000) Dollars, IN TRUST, NEVERTHELESS, to keep the same safely invested, and to use so much of the income thereof as may be necessary for the proper care of my family lot in Mt. Hope Cemetery in said Talcottville, and for the care and repair of the monuments and gravestones on said lot, and to use any surplus income toward the general care of said Cemetery.

FOURTH: I give to the American Missionary Association, Incorporated by an act of the Legislature of the State of New York, the sum of Ten Thousand (10,000) Dollars.

FIFTH: I give to the American Board of Commissioners for Foreign Missions, incorporated in Massachusetts in 1812, the sum of Ten Thousand (10,000) Dollars.

SIXTH: I give to the Women's Board of Foreign Missions, Inc. with headquarters in Boston, Massachusetts, the sum of Five Thousand (5,000) Dollars.

SEVENTH: I give to the Congregational Home Missionary Society, with headquarters now at 287 Fourth Avenue, New York City, the sum of Five Thousand (5,000) Dollars.

EIGHTH: I give to the Talcottville Congregational Church, Inc., of Talcottville, Town of Vernon, Connecticut, the sum of One Thousand (1,000) Dollars absolutely, but I suggest that said sum be set aside and kept safely invested and that the income therefrom shall be used in helping to pay the general church expenses, not intending, however, by this suggestion to make said sum a permanent trust fund.

NINTH: I give to the Missionary Society of Connecticut, the sum of Two Thousand (2,000) Dollars.

TENTH: I give to The Hartford Dispensary, of Hartford, Connecticut, the sum of One Thousand (1,000) Dollars.

ELEVENTH: I give to The Hartford Hospital, of said Hartford, the sum of Five Thousand (5,000) Dollars, IN TRUST, NEVERTHELESS, the principal to be kept safely invested and the income used for the general purposes of said Hospital at the discretion of its trustees.

TWELFTH: I give to The Hartford-Connecticut Trust Company, of Hartford, Connecticut, and to its successor or successors, the sum of Five Thousand (5,000) Dollars, IN TRUST, NEVERTHELESS, to use and apply the income thereof at the discretion of the trustee for the benefit of the school or schools in the village of Talcottville, in said Town of Vernon, Connecticut.

THIRTEENTH: I give to the Talcottville Congregational Church, Inc., of said Talcottville, the sum of Five Thousand (5,000) Dollars, IN TRUST, NEVERTHELESS, to use and expend the net income thereof in such manner, at such times and in such amounts as the pastor and deacons of said church in their discretion may determine, for the benefit of any needy person or persons living in the parish of said church, whether members or attendants of said church or not, and to use and apply any balance of income not required for that purpose for any of the charitable or missionary activities of said church. If the said church shall ever cease to conduct or maintain a place of public worship in said Town, said fund of Five Thousand (5,000) Dollars shall be and become the property of the Missionary Society of Connecticut, to be held in trust by said Missionary Society, and the income to be used in furtherance of said Society's purposes.

FOURTEENTH: I give to The Talcott Brothers Company, of said Talcottville, IN TRUST, NEVERTHELESS, the sum of Five Thousand (5,000) Dollars, to use and apply the income at the discretion of the Trustee for village improvement work especially for establishing and maintaining tennis courts and recreation grounds in the village of Talcottville. If the said, The Talcott Brothers Company should disolve or for any reason cease or abandon its corporate activities in said village of Talcottville, said fund of Five Thousand (5,000) Dollars shall be and become the property of the Town of Vernon, or of such other town as shall then include said village as the same now exists, to be held in trust by such town and the income to be applied toward the same purposes as hereinbefore described.

FIFTEENTH: I give to the Young Women's Christian Association, of Hartford, Connecticut, the sum of One Thousand (1,000) Dollars.

SIXTEENTH: I give to the Rockville Hospital, of Rockville, in the Town of Vernon, Connecticut, the sum of Five Thousand (5,000) Dollars, IN TRUST, NEVERTHELESS, to keep said sum safely invested, and to use and apply the income for the general purposes of said Hospital at the discretion of its trustees.

SEVENTEENTH: I direct that the legacies given and bequeathed under Clauses third to sixteenth hereof, both inclusive, shall be paid in preference and priority to all other pecuniary legacies given and bequeathed by this my last Will and Testament.

EIGHTEENTH: I give and bequeath the following sums of money, to wit;

To Robert Starr, Jr., son of Dr. Robert Starr, of South Windsor, Connecticut, the sum of Five Hundred (500) Dollars.

To Gardner T. Gillette, son of the Rev. Edwin C. Gillette, of Jacksonville, Florida, the sum of Two Thousand (2,000) Dollars.

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DISTRICT OF ELLINGTON

(Continued from page 42) (Will of Ruth Talcott Britton)

To Morris H. Talcott of Talcottville, Connecticut, the sum of Five Thousand (5,000) Dollars.

To my housekeeper, Mrs. Hattie Damon, if she shall be in my employ at the time of my death, the sum of Five Hundred (500) Dollars.

NINETEENTH: I give and bequeath to my nephew, John G. Talcott, Jr. of said Talcottville, the sum of Five Thousand (5,000) Dollars and my pearl brooch and pearl earrings, formerly owned by his grandmother, Rosa J. Talcott.

TWENTIETH: I give and bequeath to Pamilla Gillette, of Jacksonville, Florida, the sum of Two Thousand (2,000) Dollars, and my wrist watch set with diamonds.

TWENTY-FIRST: I give and bequeath to my sister-in-law, Harriet Ward Britton, the sum of Two Thousand Five Hundred (2,500) Dollars, my platinum diamond bar pin and my jade bead necklace.

TWENTY-SECOND: I give and bequeath to The Hartford-Connecticut Trust Company, of Hartford, Connecticut, the sum of Fifty Thousand (50,000) Dollars, IN TRUST, NEVERTHELESS, with power to receive the same in whole or in part in securities which I may own at the time of my death as hereinafter provided, to hold or sell such securities, to invest any cash in said trust without being bound by statutory provisions with respect to investments made by trustees, and to dispose of the income and principal as hereinafter provided.

A. I direct the trustee to pay at reasonable intervals, the net income of said trust to my step-son John D. Britton as long as he shall continue to live.

B. Upon the death of the said John D. Britton, I authorize, empower and direct the trustee to distribute said trust fund equally to The Hartford Branch, Woman's Board of Missions and The Woman's Congregational Home Missionary Union of Connecticut, each of said organizations to hold IN TRUST the amount so received by it and to devote the income to the furtherance of its general purposes.

TWENTY-THIRD: I give and bequeath to The Hartford-Connecticut Trust Company of Hartford, Connecticut, the sum of Fifty Thousand (50,000) Dollars, IN TRUST, NEVERTHELESS with like powers as those granted to said Company as trustee under the twenty-second Clause hereof, and I direct the Trustee to hold and dispose of the income and principal of the trust hereby created as follows.

A. I direct the trustee to pay, at reasonable intervals, the net income of said trust to my step-son Kenneth P. Britton as long as he shall continue to live.

B. Upon the death of said Kenneth P. Britton, I authorize, empower and direct the trustee to distribute said trust fund equally to The Hartford Branch, Woman's Board of Missions and The Woman's Congregational Home Missionary Union of Connecticut, each of said organizations to hold IN TRUST the amount so received by it and to devote the income to the furtherance of its general purposes.

TWENTY-FOURTH: I give and bequeath the following articles of my personal property, to wit;

To Florence White Talcott, my ring set with three pearls and my ring set with three large diamonds.

To my step-son John D. Britton, my silver tea service and my diamond bracelet.

To my step-son Kenneth P. Britton, my solitare diamond engagement ring.

To May Gurley Betts, wife of Edgar H. Betts, of Troy, New York, my aquamarine necklace.

To Mrs. Kate Beebe Negus of Brooklyn, N.Y., my diamond bar pin with sapphires.

To Ely M. T. Ryder of Yonkers, New York, my minature of Captain Ely Morgan and the large gilt Colonial mirror now hanging in the hall of my home at Talcottville, being the mirror that came from Ellington.

TWENTY-FIFTH: All the furniture, jewelry and other articles of household or personal use or adornment which I received from my husband, Charles O. Britton, during his life time or which I may be entitled to receive from his estate, and not hereinbefore otherwise disposed of, I give and bequeath to my step-sons, John D. Britton and Kenneth P. Britton, to be divided between them in such manner as they may determine.

If either of my said two stepsons shall predecease me, I give and bequeath said articles to the survivor of them.

TWENTY-SIXTH: I give to my brother, John G. Talcott, all my shares of stock in The Talcott Brothers Company, and all my right and interest in the partnership known as Talcott Brothers I also give, devise and bequeath to my said brother, John G. Talcott, my real estate in Talcottville, Connecticut, however bounded and described, with the buildings thereon and appurtenances thereto, together with my automobiles and accessories, also all household furniture and effects not hereinbefore otherwise disposed of.

If my said brother, John, shall not survive me, I give, devise and bequeath all said stock, interest in the partnership, real estate and personal property and effects to such of his children and descendants of deceased children as shall survive me, equally and per stirpes.

TWENTY-SEVENTH: All the rest, residue and remainder of my property, both real and personal of which I may die seized or possessed, or to which or any interest in which I may at the time of my death be entitled, including any property over which I may have power of disposal or appointment at the time of my death, I give, devise and bequeath to my brother, John G. Talcott.

If my said brother shall predecease me, I give, devise and bequeath said residue, equally and per stirpes to such of his children and descendants of deceased children as may survive me.

(Continued from page 43) [Will of Ruth Talcott Britton]

** TWENTY-EIGHTH: I appoint my said brother, John G. Talcott, and my step-son, John D. Britton, and The Hartford-Connecticut Trust Company, of Hartford, Connecticut, to be CO-Executors of this my Last Will and Testament. I request that no bond be required of either of said Executors or of any institution, church or corporation to which any funds are given in trust under this will. I authorize my Executors in the exercise of their sole discretion to pay any pecuniary legacies herein bequeathed, in whole or in part, in cash or in securities of my estate at market value as of the first day of the calendar month in which such legacies are paid. The income on all funds given in trust shall commence to accrue only from the time when such funds are paid over by the Executors to the Trustees. If for any reason either or both of said individual Executors named should fail to qualify and act as Executors hereof, or should die or resign after so qualifying, I appoint the others or other named as Executors to be the actual Executors of this my Will, with all the powers hereinbefore granted to the three together.

IN WITNESS WHEREOF, I have hereunto set my seal and have subscribed these presents, and do make, publish and declare the same as and for and to be my Last Will and Testament in the presence of the witnesses attesting and subscribing the same at my request ** this 12th day of March, A.D., 1924, "my step-son, John D. Britton, and" being added before execution.

Ruth Talcott Britton (L.S.)

Signed, sealed, published and declared by Ruth Talcott Britton, the Testatrix above named, as and for and to be her Last Will and Testament in the presence of us, who at her request and in her presence and in the presence of each other have hereunto subscribed our names as witnesses this 12th day of March, A. D., 1924.

Anna C. Jessen of East Hartford, Conn.
Helen G. Ulrich of Hartford Conn.
Charles C. Russ of Hartford, Conn.

State of Connecticut,)
County of Hartford,) ss. Hartford, March 12, 1924.

The within named Anna C. Jessen, Helen G. Ulrich and Charles C. Russ, being duly sworn, do depose and say: That they witnessed the within Will of the within named Testatrix, Ruth Talcott Britton and subscribed the same in her presence, in the presence of each other and at her request: That said Testatrix, at the time of signing said Will, was of full age and of sound and disposing mind and memory, and competent to make testamentary disposition of real and personal property: That she voluntarily signed said Will and declared the same to be her Last Will and Testament, in the presence of the said three subscribing witnesses thereto, and that this affidavit is made at the request of the Testatrix.

Anna C. Jessen
Helen G. Ulrich
Charles C. Russ

Subscribed and sworn to this 12th day of March, A. D., 1924, before me,
William C. Bose Notary Public

A true copy Attest: Asst. Clerk

I, Ruth Talcott Britton, of Talcottville in the Town of Vernon, Connecticut, do make, publish and declare this instrument as and for a Codicil to my Last Will and Testament dated March 12, 1924.

FIRST: Believing that the disposition made in Clause Second of my said will of jewelry, clothing and other articles of personal use and adornment will impose an undue burden upon Jennie Gardner Gillette or her daughter Pamilla, and that it is more appropriate that the distribution of such articles be a function of my more immediate relatives, I hereby revoke so much of Clause Second as refers to such jewelry, clothing and articles of personal use and adornment and direct that they be disposed of as a part of my residuary estate passing to my brother John G. Talcott, and if he predeceases me to such of his children and descendants of deceased children as may survive me equally and per stirpes. The provisions of this codicil shall not operate to alter or amend the bequest of Ten Thousand ($10,000) Dollars to said Jennie Gardner Gillette if living and to her daughter and son if she is not living.

SECOND: Except as herein modified, all the provisions of my said will are hereby ratified and confirmed.

IN WITNESS WHEREOF, I have subscribed and do publish and declare this instrument as and for a Codicil to my Last Will and Testament dated March 12, 1924, in presence of the witnesses attesting the same at my request this 16th day of September A. D. 1927.

Ruth Talcott Britton (L.S.)

Subscribed, sealed, published and declared by the said testatrix, Ruth Talcott Britton, as and for a Codicil to her Last Will and Testament, in our presence, who, at her request,

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DISTRICT OF ELLINGTON

(Continued from page 44) (First Codicil to the Will of Ruth Talcott Britton)

in her presence and in the presence of each other, have hereunto subscribed our names as witnesses this 16th day of September A. D. 1927.

Helen G. Ulrich	Hartford Conn.
Mary D Callahan	" "
Charles C. Russ	" "

State of Connecticut,)
County of Hartford.) ss. Hartford, September 16th. 1927.

The within named Helen G. Ulrich Mary D. Callahan and Charles C. Russ, being duly sworn, do depose and say: That they witnessed the within Codicil to the Will of the within named Testatrix, Ruth Talcott Britton, and subscribed the same in her presence, in the presence of each other and at her request: That said Testatrix, at the time of signing said Codicil was of full age and of sound and disposing mind and memory, and competent to make testamentary disposition of real and personal property: That she voluntarily signed said Codicil and declared the same to be a Codicil to her Last Will and Testament, in the presence of the said three subscribing witnesses thereto, and that this affidavitis made at the request of the Testatrix.

Helen G. Ulrich
Mary D. Callahan
Charles C. Russ

Subscribed and sworn to this 16th day of September, A. D., 1927, before me,
Beatrice A. Secor Notary Public.

A true copy Attest: Asst. Clerk

I, Ruth Talcott Britton, of Talcottville in the Town of Vernon, Connecticut, do make, publish and declare this instrument as and for a Second Codicil to my Will dated March 12, 1924 and the First Codicil thereto dated September 16, 1927.

FIRST: It is my belief that the provisions of Clauses Twenty-second and Twenty-third of my said will in which I make bequests to my step-sons John D. Britton and Kenneth P. Britton respectively, in the form of income of certain trust funds are not in this respect appropriate and being desirous of amplifying the benefits to them from these bequests I hereby revoke said Clauses Twenty-second and Twenty-third in their entirety and in lieu thereof I direct that the sum of One Hundred Thousand ($100,000) Dollars therein disposed of shall constitute two outright bequests of Fifty Thousand ($50,000) Dollars each to my step-son John D. Britton and my step-son Kenneth P. Britton respectively.

In case either of my said step-sons should die before me the issue, if there are any who survive me of my said deceased step-son shall receive, in equal shares per stirpes, the bequest which such deceased step-son would have received if living, and failing such issue such bequest shall be added to the bequest to my other step-son or to the issue of such other step-son who survive me if such other step-son has also previously died. If both of my said step-sons should die before me leaving no issue of either who survive me the One Hundred Thousand ($100,000) Dollars which they would have received if living shall be divided in equal shares between the Hartford Branch Woman's Board of Missions and the Woman's Congregational Home Missionary Union of Connecticut.

SECOND: The bequests contained in this codicil, as well as in the previous codicil, shall be entitled to the benefits of the provisions of Clause First of my said will charging inheritance and similar taxes on my residuary estate.

THIRD: Except as herein modified all of the provisions of my said will as amended by said first codicil are hereby ratified and confirmed.

IN WITNESS WHEREOF, I have subscribed and do publish and declare this instrument as and for a Second Codicil to my Last Will and Testament dated March 12, 1924 in presence of the witnesses attesting the same at my request this 26th day of January, A. D. 1929.

Ruth Talcott Britton (L.S.)

Subscribed, sealed, published and declared by the said testatrix, Ruth Talcott Britton, as and for a Codicil to her Last Will and Testament, in our presence, who, at her request, in her presence and in the presence of each other, have hereunto subscribed our names as witnesses this 26th day of January, A. D. 1929.

Helen G. Ulrich	Hartford Conn.
Marjorie H. Andrews	" "
Charles C. Russ	" "

State of Connecticut,)
County of Hartford.) ss. Hartford, January 26th, 1929.

The within named Helen G. Ulrich Marjorie H. Andrews and Charles C. Russ, being duly sworn, do depose and say: That they witnessed the within Codicil to Will of the within named Testatrix, Ruth Talcott Britton, and subscribed the same in her presence, in the presence of each other and at her request: That said Testatrix, at the time of signing said Codicil was of full age and of sound and disposing mind and memory, and

DISTRICT OF ELLINGTON

(Continued from page 45) (Second Codicil to Will of Ruth Talcott Britton)

competent to make testamentary disposition of real and personal property: That she voluntarily signed said Codicil and declared the same to be a Codicil to her Last Will and Testament, in the presence of the said three subscribing witnesses thereto, and that this affidavit is made at the request of the Testatrix.

Helen G. Ulrich
Marjorie H. Andrews
Charles C. Russ.

Subscribed and sworn to this 26th day of January, A. D., 1929, before me,
Christine McConnell Notary Public.

A true copy Attest: Asst. Clerk

To the Probate Court for the District of Ellington:

Estate of Thomas H. McDonnell late of Vernon, in said District, deceased.

The subscriber hereby makes return that pursuant to the order of said Court, made on the 24th day of March, 1930, directing him to sell such right, title and interest as said deceased had at the time of his death in certain real estate, as by said order on record more fully appears, he on the 2nd day of April, 1930, sold the same at private sale to Edward J. Weber of Rockville, Connecticut, for the sum of Eightee Hundred (1600.00) Dollars, in cash,

Roger J. Murphy Administrator.

Subscribed and sworn to this 3rd day of April, 1930, before me
John E. Fahey Notary Public.

A true copy Attest: Asst. Clerk

To the Court of Probate in and for the District of Ellington, in the State of Connecticut:

Estate of William Dunlap late of Vernon, in said District, deceased.

The following is a true and perfect inventory of said estate:

An undivided one-half interest in a certain tract of land, with the buildings thereon, situated on Webster and Lawrence Streets, in the City of Rockville, Town of Vernon, County of Tolland, State of Connecticut, fully bounded and described in two deeds recorded in said Vernon Land Records Vol. 46, Page 125, and Vol. 50, Page 122. $2,500.00

A certain tract of land, with the buildings thereon, situated in Vernon Avenue, in said City of Rockville, fully bounded and described in a deed recorded in said Vernon Land Records Vol. 57, Page 53. 5,200.00

An undivided one-half interest in a certain tract of land, with the buildings thereon, known as 225 East Main Street, in said City of Rockville, fully bounded and described in a deed recorded in said Vernon Land Records Vol. 57, Page 151. 2,000.00

Mortgage note of Peter and Estia Roavazino of said Vernon, dated February 5, 1927, in the sum of Six Hundred (600) Dollars, recorded in Vernon Land Records Vol. 58, Page 359. Interest paid to December 3, 1929. 600.00

Mortgage note of Peter and Estia Roavazino of said Vernon, dated February 5, 1927, in the sum of One Thousand (1000) Dollars, recorded in Vernon Land Records Vol. 54, Pages 368-9. Interest paid to December 3, 1929. Six Hundred (600) Dollars paid on principal. 400.00

Mortgage note of Edward W. Menzel, dated February 5, 1927, in the sum of Fifteen Hundred (1500) Dollars, recorded in Ellington Land Records, Vol. 36, Page 195, assumed by Mary Dennick and Sofi Skowisz. One Hundred Dollars paid on principal. Interest paid to Feb'y 5th 1930 1,400.00

5 Shares Fidelity Phenix Fire Insurance Company of New York, Ctf. #F33964 Par 10 @ 78.50 392.50

1 Share The American Hardware Corp., New Britain, Conn. Ctf. #A12127 Par 25 61.50

Deposit, Savings Bank of Rockville, Conn., #19207 240.50

Total $12,794.50

William J. Dunlap Administrator.

Subscribed and sworn to this 4th day of April, 1930, before me,
John E. Fahey Notary Public.

We certify that we have appraised said estate as above set forth and that the values given are true to the best of our knowledge and belief.

Thomas F. Garvan }
Edward H. Dowding } Appraisers

On the 4th day of April, 1930, the appraisers above named appeared before me and made oath that they would faithfully discharge their duties as such appraisers according to law.

John E. Fahey Notary Public.

A true copy Attest: Asst. Clerk

EXHIBIT Q 11-2

Fund 11-1.48

William B. and Lizzie Lathrop Sprague Fund

WILL 122 B. CLEAVELAND LEGAL BLANK OFFICE, PUBLISHERS, HARTFORD, CONN.

SPRAGUE, LIZZIE L. 0280

Be It Known to all Persons, THAT I, Lizzie L. Sprague of the Town of Andover in the County of Tolland in the State of Connecticut being of lawful age, of sound and disposing mind, memory and judgment, do hereby make, publish and declare this to be my last Will and Testament, hereby revoking all previous wills and codicils by me made.

I direct my Executors to pay all my just debts and expenses, including all taxes, so that each legacy shall be a net gift, free from any tax.

I give devise and bequeath to George A. Merritt and Sarah Bailey Merritt all the real estate located in the town of Andover, Conn. that may belong to my estate together with all buildings thereon standing, and all live stock, vehicles, tools and contents of barns and sheds and all furniture and household effects in the dwelling house, except such articles as I may hereinafter dispose of, all of which is subject to the following expressed and implied conditions. Viz: that Julia A. Coleman shall have good care and support, in health and in sickness, and occupy the same room she now occupies, during her natural life or as long and at such intervals as she may desire, free of any expense to her and without her being expected to do any labor in return for such care and support.

I give to my dear friend Julia A. Coleman in trust Five thousand ($5000.00) dollars, she is to receive the income from same during her natural life in recognition of her kindness to me and my husband during past years at her decease said principal sum of Five thousand dollars shall go to the Rockville City Hospital of Rockville Conn. the same to be known as the Wm. R. and Lizzie Lathrop

Sprague Fund

I give to the following named persons one thousand dollars each, Robert Sprague Mayo, (Son of Dr Nelson S. Mayo) Hubbard Sprague Hayes, (Son of Rev. Wm. H. Hayes) Dewilda Hutchinson - Wm. Sherman Bishop Fred A. Hunt and his wife Jennie Hunt, or the survivor May Sprague Simonds.

To the following named persons I give Five Hundred dollars each, Viz:- Julia A. Perkins - Emily Sarvant Pierce of Nittery Depot, Maine, Mabel Holmes Hunt - Clayton E. Hunt - Harry Daggett (Son of H. Colvin Daggett) Elizabeth Sprague Rockwell - Janet Chadwick Smith Annie E. Merritt - Edwin H. Hick and Imogene Hick or the survivor

~~To the following named persons I give Two Hundred dollars each, Viz: Elizabeth Sumner - Ella Sumner Janet Sumner - Edith Maxwell (of So. Manchester Ct.) Ruth Abby Wright - Willard E. Fuller - Anna Olgar and Mary Lindholm, each~~

To the following named persons I give Two Hundred dollars each, Viz Elizabeth Sumner - Ella Sumner Janet Sumner. Edith Maxwell (of So Manchester Ct) Ruth Abby Wright - Willard E. Fuller - Anna Olgar and Mary Lindholm, each.

I give to Louis B. Whitcomb all he may be indebted to me.

I give to Joseph Provinson all that he may be indebted to me.

I give and bequeath to the town of Andover, in trust, one thousand ($1000.-) dollars, the same to be deposited in the Savings Bank of Rockville, Ann. and kept there, the income of the same to be paid semi-annually to the directors of the Andover Library association

for the general benefit of the Library.
The same to be known as the Wm. B. and
Lizzie Kathrop Sprague Library fund.
I give and bequeath to the treasurer of the
county of Tolland, in trust, One thousand
($1,000.) dollars, the same to be deposited in
the Savings Bank of Rockville, Conn. the
income of the same to be paid semi-
annually to the Superintendent of the Tolland
county Temporary Home, to be used for the
pleasure and enjoyment of the children in
said Home, the same to be known as the
Wm. B. and Lizzie Kath. of Sprague fund.
I give and bequeath to Edward Everett
Sprague of Flushing, Long Island, N.Y. the
Tall clock made by D. Burnap for his
grandfather, and in case he does not
survive me I give said clock to his son
Wm. B. Sprague
I give and bequeath to Wray Sprague Simonds
my watch and Chain, Diamond Pin and
Ring
all the rest and remainder of my estate including all
lapsed legacies & devises into four equal parts and
give one part to Edwin R. Hutchinson one

If they do not all survive me
I direct the amount to be divided
equally among the survivors

I Appoint Charles F. Brunner and George C. Thrush of the Town of Bolton and Andover County of Tolland and State of Connecticut executors of this my Last Will and Testament and request that no bonds be required by the Probate Court.

In Witness Whereof I have hereunto set my hand and seal at said Andover on the 5 day of February A. D., One Thousand, Nine Hundred and Twenty one

L. S.

Signed, sealed, published and declared by the said Virginia L. Strong as and for her Last Will and Testament, in presence of us who at her request, in her presence, and in the presence of each other have hereunto subscribed our names as witnesses, on the 5th day of February A. D., 1920

Witnesses.

State of Connecticut, County of Tolland } ss. Andover February 5 A. D. 1920

We the within named Cornelia M. Brunner and Albert Stanley MacDonald

being duly sworn, make affidavit and say: That we severally attested the within and foregoing Will of the within named testatrix and subscribed the same in her presence and at her request and in the presence of each other; that the said testatrix signed, published and declared the said instrument as and for her last Will and Testament in our presence on the 5 day of February A. D., 1920; and at the time of execution of said will, said testatrix was more than eighteen years of age and of sound mind, memory and judgment and under no improper influence or restraint to the best of our knowledge and belief, and we make this affidavit at the request of said testatrix

State of Connecticut, County of Tolland } ss. Andover February 5 A. D. 1920

Then personally appeared before me Frederick Brunner duly qualified to administer oaths.

and Albert Stanley MacDonald and subscribed and made oath to the truth of the foregoing affidavit.

Notary Public.
Justice of the Peace.

Commissioner of Superior Court for ..... County.

5000 8-8 20

Rockville, Conn., Feb. 18, 1924

The adjourned Annual Meeting of the Trustees of The Rockville City [illegible] was held this day in the Directors' Room of The Savings [illegible] of Rockville, F. T. Maxwell, President, in the Chair.

The minutes of the last annual meeting were read and approved.

The Treasurer's report was also read and approved.

The following Trustees were elected by ballot as officers for [illegible] year ensuing:-

F. T. Maxwell,	President,
E. G. Butler,	Vice President,
A. T. Bissell,	Secretary,
The Rockville National Bank,	Treasurer,
J. Alice Maxwell and E. G. Butler,	Auditors,
A. N. Belding, F. T. Maxwell and A. T. Bissell,	Finance Committee.

A Legacy of $5,000. was received during the year from the [illegible] of Wm. B. and Lizzie Lathrop Sprague.

Meeting dissolved.

Attest:

A. T. Bissell

Secretary.

October 16th, 1923

Copy of Paragraph in Will of
Estate of Lizzie Lathrop Sprague

...ive to my dear friend, Julia A. Coleman, in trust Five
...($5,000.) dollars. She is to receive the income from same
...her natural life in recognition of her kindness to me and my
...during past years at her decease said principal sum of
...thousand dollars shall go to The Rockville City Hospital of
...ville, Conn., the same to be known as The Wm. B. and Lizzie
...op Sprague Fund.

...ate of Connecticut, SS. Tolland County,
...Probate Court, District of Andover.

Bolton, September 27, 1923.

I, J. White Summer, Judge of said Court, hereby certify that
...within and foregoing is a true copy of a clause in the Will of
...ale E. Sprague late of Andover in said district deceased said
...Will was proved approved and admitted to Probate March 14, 1922 and
...recorded in Andover Probate Records, Vol. 38, Page 248.

Attest:

(Signed) J. White Summer,

Judge

Attest:

A. T. Bissell

Secretary

EXHIBIT Q 11-2

Fund 11-1.49

George S. Doane

ROCKVILLE CITY HOSPITAL

Source and Terms of Funds Held

Alvah N. Belding Fund #73041 - Bequest u/w Alvah N. Belding - Permanent Endowment - Income for general purposes.

> Terms of Will - "To be used and expended for the purposes indicated in the Will of William H. Prescott, as they may deem most advisable."

Alice Farmer Bissell Fund #73051 - Bequest under the Will of Arthur T. Bissell - Permanent Endowment - Income for general purposes.

> Terms of Will - Fourth: I give and bequeath to the Rockville City Hospital the sum of Twenty-five Thousand Dollars ($25,000) to be kept as a permanent fund in memory of my wife, Alice Farmer Bissell, and to be known as the Alice Farmer Bissell Fund. The net income from said fund shall be used and applied for the general purposes of said Hospital.

Ruth T. Britton Fund #73061 - Bequest u/w Ruth Talcott Britton - Permanent Endowment - Income for general purposes.

> Terms of Will - "in trust to keep said sum safely invested, and to use and apply the income for the general purposes of said Hospital at the discretion of its trustees."

Consolidated Fund #73081 - This fund represents all bequests of $3,000 or less left with no instructions as to use. Principal is considered permanent endowment - Income is used for general expenses of the Hospital.

George S. Doane Fund #73101 - No record found of source of this fund. Principal is considered permanent endowment - all income is used for expenses of the Hospital.

General Fund #73121 - This fund represents small gifts and bequests which were unrestricted as to use of principal or income. Principal is considered unrestricted - Income is used for general expenses of the Hospital.

Lenore Henry Fund #73141 - Bequest u/w E. Stevens Henry - Permanent endowment - Income for general purposes.

> Terms of Will - Ninth: I give and bequeath to the Hospital to be established in Rockville under the provisions of the Will of the late William H. Prescott to be known as the "Rockville City Hospital." This bequest is to constitute a special endowment fund of Fifty Thousand Dollars ($50,000) to be set apart and known as the Maud Henry Fund in memory of my deceased daughter, Maud. I likewise give and bequeath Fifty Thousand Dollars ($50,000) to said Hospital also to be set apart as a separate endowment fund and known as the "Lenore Henry" Fund in memory of my deceased daughter, Lenore. The income of these two funds is to be used for the maintenance of said Hospital. My Executors are directed to provide for this fund by selecting and transferring from my estate to trustees or duly authorized agent of said Hospital certain bonds or savings bank deposits of the par value of One Hundred Thousand Dollars ($100,000), and I further direct that whenever reinvestments become necessary or advisable such reinvestments shall be limited and confined to securities legal for savings banks of Connecticut or in deposits in savings banks.

Maud Henry Fund #73161 - Bequest u/w E. Stevens Henry - Permanent endowment - Income for general purposes. (For terms of will, see Lenore Henry Fund)

J. Alice Maxwell Fund #73171 - Bequest u/w J. Alice Maxwell - Permanent endowment - Income for general purposes.

> Terms of Will - NINTH: To ROCKVILLE CITY HOSPITAL, in Rockville, Connecticut, I give, devise and bequeath four of said equal parts of my said residuary estate in trust to use the income thereof for the general purposes of the said Hospital.

John and Martha Kress Fund #73181 - Bequest under will of Martha Kress - This fund was left for a special purpose. In accordance with the instructions of the Board of Trustees of the Hospital, income accumulates and is transferred to principal for reinvestment.

> Terms of Will - "To be used for the purpose of equipping, furnishing, and maintaining a room in said Hospital to be known and called the "John and Martha Kress Room".

Edgar Keney Fund #73201 - No record found of source of this fund. It is believed to have been left for a special purpose. In accordance with the instructions of the Board of Trustees of the Hospital, income accumulates and is transferred to principal for reinvestment.

Francis T. Maxwell Fund #73211 - This fund is considered permanent endowment. Income is used for general purposes. The fund consists of the proceeds of a $50,000 life insurance policy on the life of Francis T. Maxwell, plus gifts by Mr. Maxwell during his life of 50 shares Phoenix Insurance Company and 200 shares Hartford Gas Company. These gifts of stock were restricted to use of income for general purposes and principal to be used only toward a new hospital.

Harriet K. Maxwell Fund #73221 - Bequest under will of Harriet K. Maxwell - outright legacy - income is used for general expenses of the Hospital.

> Terms of Will - Third: "----and unto the Rockville City Hospital of Rockville, Connecticut, the sum of Five Thousand Dollars ($5,000)

Robert Maxwell Fund #73241 - Bequest u/w Robert Maxwell - outright legacy - income is used for general expenses of the Hospital. (The will gave discretion to executors to devote sum of $100,000 "in such manner as they may deem suitable for the benefit of said residents of Rockville and vicinity". One Hundred Thousand Dollars ($100,000) was paid to Rockville City Hospital per final account of executors.)

William A. and Caroline E. Metcalf Fund #73251 - Bequest u/w Caroline E. Steele Metcalf - Permanent endowment - Income for general purposes.

> Terms of Will - NINTH: All the rest, residue and remainder of my estate, of whatsoever nature and wheresoever situated, I give, bequeath and devise to the Trustees of The Rockville City Hospital, Inc., a charitable corporation organized and existing under the laws of the State of Connecticut, and owning and operating a hospital in said Town of Vernon, in trust, nevertheless, to hold invest and reinvest the same and to use the income thereof for the general uses and purposes of said Hospital as said Trustees shall see fit. Said trust shall be known as the William S. and Caroline E. Metcalf Fund.

William Maxwell Fund #73261 - This fund consists of the following:

Cash gifts by Mr. Maxwell during 1936 to 1938	$14,000.00
Proceeds of life insurance (1939)	61,472.99
Bequest under 14th clause of will	96,246.01
	$171,719.00

Terms of Will - FOURTEENTH: To ROCKVILLE CITY HOSPITAL, in Rockville, Connecticut, I give, devise and bequeath four of said equal parts of my said residuary estate in trust to use the income thereof for the general purposes of said Hospital.

Charles Phelps Free Bed Fund #73271 - Gift of $10,000 from Mrs. Elsie S. Phelps - Permanent endowment - Income for special purposes. Any amount of this fund in excess of $10,000 represents accumulated income and is considered available if necessary.

Terms of Gift

"1. For the benefit of any members of my household staff or their families who may be in need of the services which the fund can provide.

2. For the general use and benefit of the residents of the City of Rockville.

The fund, aside from the small conditions which I wish to impose for the benefit of my household staff, which will fall within the income limitations of the fund, will be managed by the Board of Trustees and Finance Committee of The Rockville City Hospital with full powers of sale, investment and reinvestment."

Celia E. Prescott Fund #73281 - This fund was left for a special purpose. In accordance with the instructions of the Board of Trustees of the Hospital, income accumulates and is transferred to principal for reinvestment.

Terms of Gift

$10,000. for free bed in honor of Francis and Eliza Porter Keeney
$ 5,000. for free bed in memory of Francis Keney Prescott
$ 400. for furnishing a room in memory of Jane E. Newcomb

George Palmer Charter Fund #73291 - Bequest under Second and Seventeenth Clauses of Will of George Palmer Charter - permanent endowment - income for general purposes.

Terms of Will

SECOND

I give and bequeath to the Rockville City Hospital, located in the city of Rockville, State of Connecticut, the sum of Ten Thousand (10,000) dollars, in trust, however, for the following uses and purposes, namely: The governing body of said hospital shall invest said sum of $10,000 and the annual income of said sum shall be used for the general maintenance of said Hospital.

George Palmer Charter Fund #73291 continued

SEVENTEENTH

All the rest, residue and remainder of my estate, of whatsoever nature and wheresoever situated which I may own or have the right to dispose of at the time of my decease, I give, devise and bequeath in equal proportions, share and share alike to the Rockville City Hospital located in the city of Rockville, State of Connecticut, and to the Cyril and Julia C. Johnson Memorial Hospital, Inc. located at Stafford Springs, State of Connecticut, in trust each of said hospitals shall invest the sums derived under this Article of my last Will and Testament and the annual income of said sums shall be used for the general maintenance of each of said hospitals.

William H. Prescott Fund #73301 - Bequest u/w William H. Prescott. Permanent endowment - income for general purposes.

Terms of Will -

"13. I give and bequeath to Francis T. Maxwell, Arthur T. Bissell, J. Alice Maxwell, A. N. Belding and Thomas W. Sykes, all of Rockville, Connecticut, the sum of Fifty Thousand Dollars ($50,000) in perpetual trust to them and their successors in office, for the purpose of establishing and maintaining at said city of Rockville, a general hospital for the sick, to be open and available to all residents of the said City of Rockville, and of such portion of the immediate vicinity thereof contiguous and adjacent thereto, as in the judgment of said Board of Trustees may be deemed wise and advisable, subject to such rules and regulations concerning admission to said hospital as said trustees and their successors in office may, from time to time, establish.

Said trustees and their successors in office shall have power to receive property by gift or otherwise, and to purchase land and erect buildings for the purpose of carrying out the provisions of this trust.

The general management and oversight of said hospital, including the character and method of treatment therein to be established, shall be vested wholly in said Board of Trustees and their successors in office.

Said Board may elect a President, Vice-President, Secretary and Treasurer, and such other executive officers as they may deem necessary or advisable to carry out the purpose of this trust, including a superintendent of said institution. All vacancies in said Board arising from any cause, shall be filled by appointment of the surviving trustees.

William H. Prescott Fund #73301-continued

Terms of Will-continued

> The Board of Trustees shall have power, from time to time, to make by-laws defining the duties of said officers and superintendent, the method of calling meetings of the Trustees and other by-laws relative to the management and government of the same. Provided, however, that, if at any time before my decease, I shall make provision for the transfer of the sum of fifty thousand dollars ($50,000) to the above named, as trustees for the purpose of inaugurating the establishment of a City Hospital, thereby substantially carrying out the provisions of this paragraph of my will, then and in that event, I revoke this paragraph of the same relating to said Hospital, and declare it inoperative, but otherwise to remain in full force and effect."

(1949)

Stephen Goodale Risley and Emeret Scott Risley Fund #73311 - Bequest u/ Ninth and Twenty-first clauses of Will of May R. Adams - permanent endowment - income for general purposes.

Terms of Will

> "NINTH: I give and bequeath unto THE ROCKVILLE CITY HOSPITAL, INC. of said Rockville, the sum of Ten Thousand Dollars, in memory of my father and mother, Stephen Goodale Risley, M.D. and Emeret Scott Risley, for the establishment of a fund to be known as the Stephen Goodale Risley and Emeret Scott Risley Fund, the income thereof to be used for the general uses and purposes of said Hospital."
>
> "TWENTY-FIRST: All the rest, residue and remainder of all my property, of every description, both real and personal, of whatsoever the same may consist or wheresoever it may be situated, I give, devise and bequeath unto said THE ROCKVILLE CITY HOSPITAL, INC. in order that the same may be added to and become a part of the Stephen Goodale Risley and Emeret Scott Risley Fund, which is established in Paragraph Ninth of this my last Will and Testament."

($79,688.80)

Rockville Chapter American Red Cross Fund #73321 - Gift from Rockville Chapter of American Red Cross - considered permanent endowment - income is used for general expenses of the Hospital.

William B. and Lizzie Lathrop Sprague Fund #73341 - Bequest u/w Lizzie Lathrop Sprague - considered permanent endowment - income is used for general expenses of the Hospital.

Terms of Will

> "--to be known as the William B. and Lizzie Lathrop Sprague Fund"

Swindells Fund #73351 - This fund represents donations received from the Swindells Foundation. Income and/or principal may be used for care of deserving persons or used for general hospital expenses. Surplus income is transferred to principal.

Fred Talcott Fund #73361 - Bequest u/w Fred Talcott - considered permanent endowment - income for general purposes.

Terms of Will

"SIXTEENTH: Whereas one William H. Prescott of said Rockville, now deceased, in and by his will bequeathed a large sum of money towards the support and maintenance of a hospital to be thereafterwards established in said Rockville, and it is my desire to make a contribution towards the erection and establishment of such hospital. I give and bequeath to the persons who at the time of my decease may be the custodians of the said fund, bequeathed as aforesaid by said Prescott, the sum of five thousand dollars to be used by them or their successors in such trust towards the erection and establishment of such hospital."

"TWENTIETH:——Upon the decease of the last survivor of the aforesaid beneficiaries under this trust I direct that one-half part of all the trust estate and property then remaining in the hands of my said trustee be by it made over to the persons mentioned in the sixteenth clause of this my will as the custodians of the William H. Prescott Fund, or to the persons who at the termination of this trust may be such custodians, to be applied towards the establishment of the hospital in said Rockville proposed or contemplated in the will of said Prescott, but if such hospital shall then be already established then said one-half of said trust estate and property shall be by said trustee made over to such hospital to be used by it for its uses and purposes."

Trumbull Chapter, D.A.R. Fund #73381 - Gift from Trumbull Chapter, D.A.R. - considered permanent endowment - income to be used for free bed, Sabra Trumbull Daughters to have preference, or any deserving person, to be decided by Hospital Trustees and Advisory Board of Sabra Trumbull Chapter. Any unused income is added to principal.

United German Society Fund #73391 - Gift from United German Society - considered permanent endowment - income is used for general expenses of the Hospital.

November 24, 1952

Florence R. Whitlock Fund #73371 - Bequest under will of Florence R. Whitlock (1953) - $13,351.35, a permanent endowment. Income for free bed or beds. Terms of will:

"2...The remaining four-tenths (4/10ths) of said residue, I give, devise and bequeath to the Rockville City Hospital for the purpose of establishing a free bed or beds in said Hospital in memory of my mother, Anna Shelton Whitlock."

Betsey C. Tucker Fund #73360 - Bequest under will of Betsy C. Tucker (1955) - $2,000, a permanent endowment. Income for free bed. Terms of will:

"Second: I give and bequeath to The Rockville City Hospital of Rockville, Connecticut, Two Thousand (2,000) Dollars to be its absolutely and forever. This bequest is to be used by said Hospital as an endowment for the partial maintenance of a free bed in said Hospital."

Anna M. and Albert H. Bilson Fund #745081 - Bequest under will of Anna M. Bilson of $10,371.08 as follows: (January 22, 1957)

"NINTH: All the rest, residue and remainder of my Estate, both real and personal of whatsoever nature and wheresoever situated is to be sold and one-half of the proceeds are to be given to the Union Congregational Church of Christ, Inc. to be known as the Anna M. Bilson and Albert H. Bilson Fund. I direct the trustees of said Church to lawfully invest said legacy and to use the income therefrom for the general uses and purposes of said Church. The remaining one-half thereof I give and devise unto the Rockville City Hospital, Inc. of the Town of Vernon to be known as the Anna & Albert Bilson Fund. I direct the trustees of said Hospital to lawfully invest said legacy, and to use the income therefrom for the general uses and purposes of said Hospital.

Rockville, Conn., Jan. 20, 1953

Following the meeting of the Corporators, a meeting of the Trustees of the Rockville City Hospital, Inc. was held, those present being:

Lebbeus F. Bissell
Roy C. Ferguson
Donald C. Fisk
John R. Gottier
Frank E. Hardenbergh
Claude A. Mills
John S. Mason

Lebbeus F. Bissell, president, presided.

The minutes of the previous meeting on January 15, 1952 were read and approved.

It was voted that the Secretary cast one ballot for the following officers for the ensuing year, or until their successors are chosen:

President	Lebbeus F. Bissell
Vice-President	Claude A. Mills
Secretary	John S. Mason
Treasurer	Hartford-Connecticut Trust Co. (Rockville Branch)

The ballot was cast and the chairman declared them elected.

It was voted that the Secretary cast one ballot for the following to serve as Executive Committee for the ensuing year or until their successors are chosen:

Lebbeus F. Bissell
Frank E. Hardenbergh
Roy C. Ferguson

The ballot was cast and the Chairman declared them elected.

It was voted that the Secretary cast one ballot for the following to serve as Finance Committee for the ensuing year or until their successors are chosen:

Lebbeus F. Bissell
Claude A. Mills
Donald C. Fisk

The ballot was cast and the Chairman declared them elected.

It was voted that the Secretary cast one ballot for the following to serve as Auditors for the ensuing year or until their successors are chosen:

Frank E. Hardenbergh
Claude A. Mills
John R. Gottier

The ballot was cast and the Chairman declared them elected.

The Treasurer's report for the period 1 September 1951 through 1 September 1952 was read and discussed, and it was voted that same be accepted and placed on file.

Upon motion duly made and seconded, it was voted to adjust the salaries of the Superintendent and Manager.

The proposed changes in the Funds, submitted by the Treasurer, were discussed, and upon motion duly made and seconded, it was voted that the Hartford-Connecticut Trust Co. be authorized to make the following changes in accordance with the following resolutions:

"WHEREAS, Rockville City Hospital has certain endowment funds which are maintained in separate accounts and it is desired to combine said funds for bookkeeping and investment purposes, and

WHEREAS, it appears from the terms under which such funds were established that such funds may be properly combined.

Now therefore, it is

VOTED: That the Treasurer be authorized and instructed to establish two new funds under the title Memorial Funds Unrestricted and Memorial Funds Restricted, respectively.

It is also

VOTED: That January 15, 1953 shall be established as the date for the combination of three separate funds (listed below) under the title of the new "Memorial Funds Unrestricted". The original book value of each of the separate funds shall be reaffirmed as the Memorial value of each of such endowments, and the January 15, 1953 book value of the investments comprising these three funds shall be carried over into the new "Memorial Funds Unrestricted" as the book value of the combined investments.

General Fund
Harriet K. Maxwell Fund
Swindells Fund

It is also

VOTED: That January 15, 1953 shall be established as the date of the new combination of ten separate funds (listed below) under the title of the new "Memorial Funds Restricted". The original book value of each of the separate funds shall be reaffirmed as the Memorial value of each of such endowments, and the January 15, 1953 book value of the investments comprising these ten funds shall be carried over into the new "Memorial Funds Restricted" as the book value of the combined investments.

Purchase by PMH

Alvah T. Belding Fund
Ruth T. Britton Fund
Consolidated Fund
George S. Doane Fund
J. Alice Maxwell Fund
William A. and Caroline E. Metcalf Fund
George Palmer Charter Fund
Rockville Chapter ARC Fund
William B. and Lizzie Lathrop Sprague Fund
Edgar Feeney Fund

It is also

VOTED: That securities and cash of the William Maxwell Fund having a market value as of October 9, 1952 of $107,346.29 be carried over from the William Maxwell Fund to the new "Memorial Funds Unrestricted", and the value of $75,472.99 be affirmed as the Memorial value of the William Maxwell gifts in the "Memorial Funds Unrestricted". The present book values of the securities transferred to the "Memorial Funds Unrestricted" shall be carried over to that Fund at the same book values."

Upon motion duly made and seconded, it was voted that the Finance Committee be authorized to rule on the proposed shift in some of the investments as recommended by the Hartford-Connecticut Trust Co.

Upon motion duly made and seconded it was voted that Lebbeus P. Bissell, Trustee of said Hospital, be authorized and directed to sign all and any applications, bonds and all other necessary papers pertaining to the Alcohol Tax Free Permit in behalf of said Hospital for the purpose of obtaining alcohol free of tax for use by the Hospital.

ed Asset Purchase by PMH
ober 13, 2015

Mr. McInnis was called into the meeting and gave a report on the hospital operations.

There being no further business, the meeting was adjourned at 11:18.

Attest:

John L. Mason
Secretary

EXHIBIT Q 11-2

Fund 11-1.50

Edgar Keney
(Keeney)

F-2

ROCKVILLE CITY HOSPITAL

Source and Terms of Funds Held

Alvah N. Bolding Fund #73041 - Bequest u/w Alvah N. Bolding - Permanent Endowment - Income for general purposes.

Terms of Will - "To be used and expended for the purposes indicated in the Will of William H. Prescott, as they may deem most advisable."

Alice Farmer Bissell Fund #73051 - Bequest under the Will of Arthur T. Bissell - Permanent Endowment - Income for general purposes.

Terms of Will - Fourth: I give and bequeath to the Rockville City Hospital the sum of Twenty-five Thousand Dollars ($25,000) to be kept as a permanent fund in memory of my wife, Alice Farmer Bissell, and to be known as the Alice Farmer Bissell Fund. The net income from said fund shall be used and applied for the general purposes of said Hospital.

Ruth T. Britton Fund #73061 - Bequest u/w Ruth Talcott Britton - Permanent Endowment - Income for general purposes.

Terms of Will - "in trust to keep said sum safely invested, and to use and apply the income for the general purposes of said Hospital at the discretion of its trustees."

Consolidated Fund #73081 - This fund represents all bequests of $3,000 or less left with no instructions as to use. Principal is considered permanent endowment - Income is used for general expenses of the Hospital.

George S. Doane Fund #73101 - No record found of source of this fund. Principal is considered permanent endowment - all income is used for expenses of the Hospital.

General Fund #73121 - This fund represents small gifts and bequests which were unrestricted as to use of principal or income. Principal is considered unrestricted - Income is used for general expenses of the Hospital.

Lenore Henry Fund #73141 - Bequest u/w E. Stevens Henry - Permanent endowment - Income for general purposes.

Terms of Will - Ninth: I give and bequeath to the Hospital to be established in Rockville under the provisions of the Will of the late William H. Prescott to be known as the "Rockville City Hospital." This bequest is to constitute a special endowment fund of Fifty Thousand Dollars ($50,000) to be set apart and known as the Maud Henry Fund in memory of my deceased daughter, Maud. I likewise give and bequeath Fifty Thousand Dollars ($50,000) to said Hospital also to be set apart as a separate endowment fund and known as the "Lenore Henry" Fund in memory of my deceased daughter, Lenore. The income of these two funds is to be used for the maintenance of said Hospital. My Executors are directed to provide for this fund by selecting and transferring from my estate to trustees or duly authorized agent of said Hospital certain bonds or savings bank deposits of the par value of One Hundred Thousand Dollars ($100,000), and I further direct that whenever reinvestments become necessary or advisable such reinvestments shall be limited and confined to securities legal for savings banks of Connecticut or in deposits in savings banks.

Maud Henry Fund #73161 - Bequest u/w E. Stevens Henry - Permanent endowment - Income for general purposes. (For terms of will, see Lenore Henry Fund)

J. Alice Maxwell Fund #73171 - Bequest u/w J. Alice Maxwell - Permanent endowment - Income for general purposes.

> Terms of Will - NINTH: To ROCKVILLE CITY HOSPITAL, in Rockville, Connecticut, I give, devise and bequeath four of said equal parts of my said residuary estate in trust to use the income thereof for the general purposes of the said Hospital.

John and Martha Kress Fund #73181 - Bequest under will of Martha Kress - This fund was left for a special purpose. In accordance with the instructions of the Board of Trustees of the Hospital, income accumulates and is transferred to principal for reinvestment.

> Terms of Will - "To be used for the purpose of equipping, furnishing, and maintaining a room in said Hospital to be known and called the "John and Martha Kress Room".

Edgar Keney Fund #73201 - No record found of source of this fund. It is believed to have been left for a special purpose. In accordance with the instructions of the Board of Trustees of the Hospital, income accumulates and is transferred to principal for reinvestment.

Francis T. Maxwell Fund #73211 - This fund is considered permanent endowment. Income is used for general purposes. The fund consists of the proceeds of a $50,000 life insurance policy on the life of Francis T. Maxwell, plus gifts by Mr. Maxwell during his life of 50 shares Phoenix Insurance Company and 200 shares Hartford Gas Company. These gifts of stock were restricted to use of income for general purposes and principal to be used only toward a new hospital.

Harriet K. Maxwell Fund #73221 - Bequest under will of Harriet K. Maxwell - outright legacy - income is used for general expenses of the Hospital.

> Terms of Will - Third: "----and unto the Rockville City Hospital of Rockville, Connecticut, the sum of Five Thousand Dollars ($5,000)

Robert Maxwell Fund #73241 - Bequest u/w Robert Maxwell - outright legacy - income is used for general expenses of the Hospital. (The will gave discretion to executors to devote sum of $100,000 "in such manner as they may deem suitable for the benefit of said residents of Rockville and vicinity". One Hundred Thousand Dollars ($100,000) was paid to Rockville City Hospital per final account of executors.)

William A. and Caroline E. Metcalf Fund #73251 - Bequest u/w Caroline E. Steele Metcalf - Permanent endowment - Income for general purposes.

> Terms of Will - NINTH: All the rest, residue and remainder of my estate, of whatsoever nature and wheresoever situated, I give, bequeath and devise to the Trustees of The Rockville City Hospital, Inc., a charitable corporation organized and existing under the laws of the State of Connecticut, and owning and operating a hospital in said Town of Vernon, in trust, nevertheless, to hold invest and reinvest the same and to use the income thereof for the general uses and purposes of said Hospital as said Trustees shall see fit. Said trust shall be known as the William S. and Caroline E. Metcalf Fund.

William Maxwell Fund #73261 - This fund consists of the following:

Cash gifts by Mr. Maxwell during 1936 to 1938	$14,000.00
Proceeds of life insurance (1939)	61,472.99
Bequest under 14th clause of will	96,246.01
	$171,719.00

Terms of Will - FOURTEENTH: To ROCKVILLE CITY HOSPITAL, in Rockville, Connecticut, I give, devise and bequeath four of said equal parts of my said residuary estate in trust to use the income thereof for the general purposes of said Hospital.

Charles Phelps Free Bed Fund #73271 - Gift of $10,000 from Mrs. Elsie S. Phelps - Permanent endowment - Income for special purposes. Any amount of this fund in excess of $10,000 represents accumulated income and is considered available if necessary.

Terms of Gift

"1. For the benefit of any members of my household staff or their families who may be in need of the services which the fund can provide.

2. For the general use and benefit of the residents of the City of Rockville.

The fund, aside from the small conditions which I wish to impose for the benefit of my household staff, which will fall within the income limitations of the fund, will be managed by the Board of Trustees and Finance Committee of The Rockville City Hospital with full powers of sale, investment and reinvestment."

Celia E. Prescott Fund #73281 - This fund was left for a special purpose. In accordance with the instructions of the Board of Trustees of the Hospital, income accumulates and is transferred to principal for reinvestment.

Terms of Gift

$10,000.	for free bed in honor of Francis and Eliza Porter Keeney
$ 5,000.	for free bed in memory of Francis Keney Prescott
$ 400.	for furnishing a room in memory of Jane E. Newcomb

George Palmer Charter Fund #73291 - Bequest under Second and Seventeenth Clauses of Will of George Palmer Charter - permanent endowment - income for general purposes.

Terms of Will

SECOND

I give and bequeath to the Rockville City Hospital, located in the city of Rockville, State of Connecticut, the sum of Ten Thousand (10,000) dollars, in trust, however, for the following uses and purposes, namely: The governing body of said hospital shall invest said sum of $10,000 and the annual income of said sum shall be used for the general maintenance of said Hospital.

George Palmer Charter Fund #73291 continued

SEVENTEENTH

All the rest, residue and remainder of my estate, of whatsoever nature and wheresoever situated which I may own or have the right to dispose of at the time of my decease, I give, devise and bequeath in equal proportions, share and share alike to the Rockville City Hospital located in the city of Rockville, State of Connecticut, and to the Cyril and Julia C. Johnson Memorial Hospital, Inc. located at Stafford Springs, State of Connecticut, in trust each of said hospitals shall invest the sums derived under this Article of my last Will and Testament and the annual income of said sums shall be used for the general maintenance of each of said hospitals.

William H. Prescott Fund #73301 - Bequest u/w William H. Prescott. Permanent endowment - income for general purposes.

Terms of Will -

"13. I give and bequeath to Francis T. Maxwell, Arthur T. Bissell, J. Alice Maxwell, A. N. Belding and Thomas W. Sykes, all of Rockville, Connecticut, the sum of Fifty Thousand Dollars ($50,000) in perpetual trust to them and their successors in office, for the purpose of establishing and maintaining at said city of Rockville, a general hospital for the sick, to be open and available to all residents of the said City of Rockville, and of such portion of the immediate vicinity thereof contiguous and adjacent thereto, as in the judgment of said Board of Trustees may be deemed wise and advisable, subject to such rules and regulations concerning admission to said hospital as said trustees and their successors in office may, from time to time, establish.

Said trustees and their successors in office shall have power to receive property by gift or otherwise, and to purchase land and erect buildings for the purpose of carrying out the provisions of this trust.

The general management and oversight of said hospital, including the character and method of treatment therein to be established, shall be vested wholly in said Board of Trustees and their successors in office.

Said Board may elect a President, Vice-President, Secretary and Treasurer, and such other executive officers as they may deem necessary or advisable to carry out the purpose of this trust, including a superintendent of said institution. All vacancies in said Board arising from any cause, shall be filled by appointment of the surviving trustees.

William H. Prescott Fund #73301-continued

Terms of Will-continued

> The Board of Trustees shall have power, from time to time, to make by-laws defining the duties of said officers and superintendent, the method of calling meetings of the Trustees and other by-laws relative to the management and government of the same. Provided, however, that, if at any time before my decease, I shall make provision for the transfer of the sum of fifty thousand dollars ($50,000) to the above named, as trustees for the purpose of inaugurating the establishment of a City Hospital, thereby substantially carrying out the provisions of this paragraph of my will, then and in that event, I revoke this paragraph of the same relating to said Hospital, and declare it inoperative, but otherwise to remain in full force and effect."

(1949)

Stephen Goodale Risley and Emeret Scott Risley Fund #73311 - Bequest u/ Ninth and Twenty-first clauses of Will of May H. Adams - permanent endowment - income for general purposes.

Terms of Will

> "NINTH: I give and bequeath unto THE ROCKVILLE CITY HOSPITAL, INC. of said Rockville, the sum of Ten Thousand Dollars, in memory of my father and mother, Stephen Goodale Risley, M.D. and Emeret Scott Risley, for the establishment of a fund to be known as the Stephen Goodale Risley and Emeret Scott Risley Fund, the income thereof to be used for the general uses and purposes of said Hospital."

($79,688.80)

> "TWENTY-FIRST: All the rest, residue and remainder of all my property, of every description, both real and personal, of whatsoever the same may consist or whereesoever it may be situated, I give, devise and bequeath unto said THE ROCKVILLE CITY HOSPITAL, INC. in order that the same may be added to and become a part of the Stephen Goodale Risley and Emeret Scott Risley Fund, which is established in Paragraph Ninth of this my last Will and Testament."

Rockville Chapter American Red Cross Fund #73321 - Gift from Rockville Chapter of American Red Cross - considered permanent endowment - income is used for general expenses of the Hospital.

William B. and Lizzie Lathrop Sprague Fund #73341 - Bequest u/w Lizzie Lathrop Sprague - considered permanent endowment - income is used for general expenses of the Hospital.

Terms of Will

> "--to be known as the William B. and Lizzie Lathrop Sprague Fund"

Swindells Fund #73351 - This fund represents donations received from the Swindells Foundation. Income and/or principal may be used for care of deserving persons or used for general hospital expenses. Surplus income is transferred to principal.

Fred Talcott Fund #73361 - Bequest u/w Fred Talcott - considered permanent endowment - income for general purposes.

Terms of Will

"SIXTEENTH: Whereas one William H. Prescott of said Rockville, now deceased, in and by his will bequeathed a large sum of money towards the support and maintenance of a hospital to be thereafterwards established in said Rockville, and it is my desire to make a contribution towards the erection and establishment of such hospital. I give and bequeath to the persons who at the time of my decease may be the custodians of the said fund, bequeathed as aforesaid by said Prescott, the sum of five thousand dollars to be used by them or their successors in such trust towards the erection and establishment of such hospital."

"TWENTIETH:----Upon the decease of the last survivor of the aforesaid beneficiaries under this trust I direct that one-half part of all the trust estate and property then remaining in the hands of my said trustee be by it made over to the persons mentioned in the sixteenth clause of this my will as the custodians of the William H. Prescott Fund, or to the persons who at the termination of this trust may be such custodians, to be applied towards the establishment of the hospital in said Rockville proposed or contemplated in the will of said Prescott, but if such hospital shall then be already established then said one-half of said trust estate and property shall be by said trustee made over to such hospital to be used by it for its uses and purposes."

Trumbull Chapter, D.A.R. Fund #73301 - Gift from Trumbull Chapter, D.A.R. - considered permanent endowment - income to be used for free bed, Sabra Trumbull Daughters to have preference, or any deserving person, to be decided by Hospital Trustees and Advisory Board of Sabra Trumbull Chapter. Any unused income is added to principal.

United German Society Fund #73391 - Gift from United German Society - considered permanent endowment - income is used for general expenses of the Hospital.

November 24, 1952

Florence R. Whitlock Fund #73371 - Bequest under will of Florence R. Whitlock (1953) - $13,351.35, a permanent endowment. Income for free bed or beds. Terms of will:
"2...The remaining four-tenths (4/10ths) of said residue, I give, devise and bequeath to the Rockville City Hospital for the purpose of establishing a free bed or beds in said Hospital in memory of my mother, Anna Shelton Whitlock."

Betsey C. Tucker Fund #73360 - Bequest under will of Betsy C. Tucker (1955) - $2,000, a permanent endowment. Income for free bed. Terms of will:
"Second: I give and bequeath to The Rockville City Hospital of Rockville, Connecticut, Two Thousand (2,000) Dollars to be its absolutely and forever. This bequest is to be used by said Hospital as an endowment for the partial maintenance of a free bed in said Hospital."

Anna M. and Albert H. Bilson Fund #745081 - Bequest under will of Anna M. Bilson of $10,371.08 as follows: (January 22, 1957)
"NINTH: All the rest, residue and remainder of my Estate, both real and personal of whatsoever nature and wheresoever situated is to be sold and one-half of the proceeds are to be given to the Union Congregational Church of Christ, Inc. to be known as the Anna M. Bilson and Albert H. Bilson Fund. I direct the trustees of said Church to lawfully invest said legacy and to use the income therefrom for the general uses and purposes of said Church. The remaining one-half thereof I give and devise unto the Rockville City Hospital, Inc. of the Town of Vernon to be known as the Anna & Albert Bilson Fund. I direct the trustees of said Hospital to lawfully invest said legacy, and to use the income therefrom for the general uses and purposes of said Hospital.

Rockville, Conn., Jan. 20, 1953

Following the meeting of the Corporators, a meeting of the Trustees of the Rockville City Hospital, Inc. was held, those present being:

Lebbeus F. Bissell
Roy C. Ferguson
Donald C. Fisk
John R. Gottier
Frank E. Hardenbergh
Claude A. Mills
John S. Mason

Lebbeus F. Bissell, president, presided.

The minutes of the previous meeting on January 15, 1952 were read and approved.

It was voted that the Secretary cast one ballot for the following officers for the ensuing year, or until their successors are chosen:

President	Lebbeus F. Bissell
Vice-President	Claude A. Mills
Secretary	John S. Mason
Treasurer	Hartford-Connecticut Trust Co. (Rockville Branch)

The ballot was cast and the chairman declared them elected.

It was voted that the Secretary cast one ballot for the following to serve as Executive Committee for the ensuing year or until their successors are chosen:

Lebbeus F. Bissell
Frank E. Hardenbergh
Roy C. Ferguson

The ballot was cast and the Chairman declared them elected.

It was voted that the Secretary cast one ballot for the following to serve as Finance Committee for the ensuing year or until their successors are chosen:

Lebbeus F. Bissell
Claude A. Mills
Donald C. Fisk

The ballot was cast and the Chairman declared them elected.

It was voted that the Secretary cast one ballot for the following to serve as Auditors for the ensuing year or until their successors are chosen:

Frank E. Hardenbergh
Claude A. Mills
John R. Gottier

The ballot was cast and the Chairman declared them elected.

The Treasurer's report for the period 1 September 1951 through 1 September 1952 was read and discussed, and it was voted that same be accepted and placed on file.

Upon motion duly made and seconded, it was voted to adjust the salaries of the Superintendent and Manager.

The proposed changes in the Funds, submitted by the Treasurer, were discussed, and upon motion duly made and seconded, it was voted that the Hartford-Connecticut Trust Co. be authorized to make the following changes in accordance with the following resolutions:

"WHEREAS, Rockville City Hospital has certain endowment funds which are maintained in separate accounts and it is desired to combine said funds for bookkeeping and investment purposes, and

WHEREAS, it appears from the terms under which such funds were established that such funds may be properly combined.

Now therefore, it is

VOTED: That the Treasurer be authorized and instructed to establish two new funds under the title Memorial Funds Unrestricted and Memorial Funds Restricted, respectively.

It is also

VOTED: That January 15, 1953 shall be established as the date for the combination of three separate funds (listed below) under the title of the new "Memorial Funds Unrestricted". The original book value of each of the separate funds shall be reaffirmed as the Memorial value of each of such endowments, and the January 15, 1953 book value of the investments comprising these three funds shall be carried over into the new "Memorial Funds Unrestricted" as the book value of the combined investments.

General Fund
Harriet K. Maxwell Fund
Swindells Fund

It is also

VOTED: That January 15, 1953 shall be established as the date of the new combination of ten separate funds (listed below) under the title of the new "Memorial Funds Restricted". The original book value of each of the separate funds shall be reaffirmed as the Memorial value of each of such endowments, and the January 15, 1953 book value of the investments comprising these ten funds shall be carried over into the new "Memorial Funds Restricted" as the book value of the combined investments.

Purchase by PMH

Alvah S. Belding Fund
Ruth T. Britton Fund
Consolidated Fund
George S. Doane Fund
J. Alice Maxwell Fund
William A. and Caroline E. Metcalf Fund
George Palmer Charter Fund
Rockville Chapter ARC Fund
William B. and Lizzie Latrop Sprague Fund
Edgar Feeney Fund

It is also

VOTED: That securities and cash of the William Maxwell Fund having a market value as of October 9, 1952 of $107,346.29 be carried over from the William Maxwell Fund to the new "Memorial Funds Unrestricted", and the value of $75,472.99 be affirmed as the Memorial value of the William Maxwell gifts in the "Memorial Funds Unrestricted". The present book values of the securities transferred to the "Memorial Funds Unrestricted" shall be carried over to that fund at the same book values."

Upon motion duly made and seconded, it was voted that the Finance Committee be authorized to rule on the proposed shift in some of the investments as recommended by the Hartford-Connecticut Trust Co.

Upon motion duly made and seconded it was voted that Lobdell F. Bissell, Trustee of said Hospital, be authorized and directed to sign all and any applications, bonds and all other necessary papers pertaining to the Alcohol Tax Free Permit in behalf of said Hospital for the purpose of obtaining alcohol free of tax for use by the Hospital.

Mr. Williams was called into the meeting and gave a report on the hospital operations.

There being no further business, the meeting was adjourned at 11:18.

Attest:

John S. Mason
Secretary

EXHIBIT Q 11-2

Fund 11-1.51

Rockville Chapter
American Red Cross Fund

Rockville, Conn., January 29, 1920.

Annual Meeting of the Trustees of the Rockville City was held at the residence of William Maxwell on Union F. T. Maxwell, President, in the Chair.

The minutes of the last annual meeting were read and ap-

Edwin G. Butler was elected Trustee to fill the vacancy by the death of Mr. F. J. Regan.

It was voted:

That the Committee representing the Visiting Nurse Association be called upon to raise funds for the amount of Thirty Thousand Dollars, to be used for the reconstruction of the Hospital Building on Prospect Street for an emergency hospital, and when such funds are available, to proceed in the work.

It was voted:

That resolutions be drawn up on the death of Francis Regan, a former Trustee; a copy forwarded to members of the family and same published in Rockville Newspapers.

The following Trustees were elected by ballot as officers for the year ensuing:-

F. T. Maxwell, President,
E. G. Butler, Vice President,
A. T. Bissell, Secretary & Treasurer,
J. Alice Maxwell & E.G. Butler, Auditors,
A. N. Belding, F.T. Maxwell, and A. T. Bissell,
Finance Committee.

The following Trustees were present at the meeting:-
F. T. Maxwell, J. Alice Maxwell and A. T. Bissell.

The following gifts to the Hospital were made during the year:

Rockville Chapter American Red Cross Society	$ 4,000.
3 shares Stock First National Bank of Rockville from Estate of Sabra A. Stoughton	$ 300.
Estate of Rosa G. Weston	$ 50.

The following resolutions were approved and adopted, viz:

Whereas - In the inscrutable wisdom of a divine providence our friend and fellow member, Mr. Francis J. Regan, has been removed by death from the Board of Trustees of the Rockville City Hospital, the members of the Board hereby adopt the following resolutions:

Resolved; That we in this way express our realization of our loss in Mr. Regan's death; that we miss his advice and interest in the plans for a hospital to which we have given so much thought and on which we have spent so much time and that we also express our appreciation of the help he gave us in services, money and supplies for the emergency hospital during the epidemic a year ago.

Resolved - that these resolutions be placed on the records of the Board of Trustees of the Rockville City Hospital and a copy sent to his family.

F. T. Maxwell,

J. Alice Maxwell,

A. N. Belding,

A. T. Bissell,

E. G. Butler,

Meeting dissolved,

Attest:

A T Bissell Secretary.

ROCKVILLE CITY HOSPITAL

Source and Terms of Funds Held

Alvah N. Balding Fund #73041 - Bequest u/w Alvah N. Balding - Permanent Endowment - Income for general purposes.

Terms of Will - "To be used and expended for the purposes indicated in the Will of William H. Prescott, as they may deem most advisable."

Alice Farmer Bissell Fund #73051 - Bequest under the Will of Arthur T. Bissell - Permanent Endowment - Income for general purposes.

Terms of Will - Fourth: I give and bequeath to the Rockville City Hospital the sum of Twenty-five Thousand Dollars ($25,000) to be kept as a permanent fund in memory of my wife, Alice Farmer Bissell, and to be known as the Alice Farmer Bissell Fund. The net income from said fund shall be used and applied for the general purposes of said Hospital.

Ruth T. Britton Fund #73061 - Bequest u/w Ruth Talcott Britton - Permanent Endowment - Income for general purposes.

Terms of Will - "In trust to keep said sum safely invested, and to use and apply the income for the general purposes of said Hospital at the discretion of its trustees."

Consolidated Fund #73081 - This fund represents all bequests of $3,000 or less left with no instructions as to use. Principal is considered permanent endowment - Income is used for general expenses of the Hospital.

George S. Doane Fund #73101 - No record found of source of this fund. Principal is considered permanent endowment - all income is used for expenses of the Hospital.

General Fund #73121 - This fund represents small gifts and bequests which were unrestricted as to use of principal or income. Principal is considered unrestricted - Income is used for general expenses of the Hospital.

Lenore Henry Fund #73141 - Bequest u/w E. Stevens Henry - Permanent endowment - Income for general purposes.

Terms of Will - Ninth: I give and bequeath to the Hospital to be established in Rockville under the provisions of the Will of the late William H. Prescott to be known as the "Rockville City Hospital." This bequest is to constitute a special endowment fund of Fifty Thousand Dollars ($50,000) to be set apart and known as the Maud Henry Fund in memory of my deceased daughter, Maud. I likewise give and bequeath Fifty Thousand Dollars ($50,000) to said Hospital also to be set apart as a separate endowment fund and known as the "Lenore Henry" Fund in memory of my deceased daughter, Lenore. The income of these two funds is to be used for the maintenance of said Hospital. My Executors are directed to provide for this fund by selecting and transferring from my estate to trustees or duly authorized agent of said Hospital certain bonds or savings bank deposits of the par value of One Hundred Thousand Dollars ($100,000), and I further direct that whenever reinvestments become necessary or advisable such reinvestments shall be limited and confined to securities legal for savings banks of Connecticut or in deposits in savings banks.

Maud Henry Fund #73161 - Bequest u/w E. Stevens Henry - Permanent endowment - Income for general purposes. (For terms of will, see Lenore Henry Fund)

J. Alice Maxwell Fund #73171 - Bequest u/w J. Alice Maxwell - Permanent endowment - Income for general purposes.

> Terms of Will - NINTH: To ROCKVILLE CITY HOSPITAL, in Rockville, Connecticut, I give, devise and bequeath four of said equal parts of my said residuary estate in trust to use the income thereof for the general purposes of the said Hospital.

John and Martha Kress Fund #73181 - Bequest under will of Martha Kress - This fund was left for a special purpose. In accordance with the instructions of the Board of Trustees of the Hospital, income accumulates and is transferred to principal for reinvestment.

> Terms of Will - "To be used for the purpose of equipping, furnishing, and maintaining a room in said Hospital to be known and called the "John and Martha Kress Room".

Edgar Keney Fund #73201 - No record found of source of this fund. It is believed to have been left for a special purpose. In accordance with the instructions of the Board of Trustees of the Hospital, income accumulates and is transferred to principal for reinvestment.

Francis T. Maxwell Fund #73211 - This fund is considered permanent endowment. Income is used for general purposes. The fund consists of the proceeds of a $50,000 life insurance policy on the life of Francis T. Maxwell, plus gifts by Mr. Maxwell during his life of 50 shares Phoenix Insurance Company and 200 shares Hartford Gas Company. These gifts of stock were restricted to use of income for general purposes and principal to be used only toward a new hospital.

Harriet K. Maxwell Fund #73221 - Bequest under will of Harriet K. Maxwell - outright legacy - income is used for general expenses of the Hospital.

> Terms of Will - Third: "----and unto the Rockville City Hospital of Rockville, Connecticut, the sum of Five Thousand Dollars ($5,000)

Robert Maxwell Fund #73241 - Bequest u/w Robert Maxwell - outright legacy - income is used for general expenses of the Hospital. (The will gave discretion to executors to devote sum of $100,000 "in such manner as they may deem suitable for the benefit of said residents of Rockville and vicinity". One Hundred Thousand Dollars ($100,000) was paid to Rockville City Hospital per final account of executors.)

William A. and Caroline E. Metcalf Fund #73251 - Bequest u/w Caroline E. Steele Metcalf - Permanent endowment - Income for general purposes.

> Terms of Will - NINTH: All the rest, residue and remainder of my estate, of whatsoever nature and wheresoever situated, I give, bequeath and devise to the Trustees of The Rockville City Hospital, Inc., a charitable corporation organized and existing under the laws of the State of Connecticut, and owning and operating a hospital in said Town of Vernon, in trust, nevertheless, to hold invest and reinvest the same and to use the income thereof for the general uses and purposes of said Hospital as said Trustees shall see fit. Said trust shall be known as the William S. and Caroline E. Metcalf Fund.

William Maxwell Fund #73261 - This fund consists of the following:

Cash gifts by Mr. Maxwell during 1936 to 1938	$14,000.00
Proceeds of life insurance (1939)	61,472.99
Bequest under 14th clause of will	96,246.01
	$171,719.00

Terms of Will - FOURTEENTH: To ROCKVILLE CITY HOSPITAL, in Rockville, Connecticut, I give, devise and bequeath four of said equal parts of my said residuary estate in trust to use the income thereof for the general purposes of said Hospital.

Charles Phelps Free Bed Fund #73271 - Gift of $10,000 from Mrs. Elsie S. Phelps - Permanent endowment - Income for special purposes. Any amount of this fund in excess of $10,000 represents accumulated income and is considered available if necessary.

Terms of Gift

"1. For the benefit of any members of my household staff or their families who may be in need of the services which the fund can provide.

2. For the general use and benefit of the residents of the City of Rockville.

The fund, aside from the small conditions which I wish to impose for the benefit of my household staff, which will fall within the income limitations of the fund, will be managed by the Board of Trustees and Finance Committee of The Rockville City Hospital with full powers of sale, investment and reinvestment."

Celia E. Prescott Fund #73281 - This fund was left for a special purpose. In accordance with the instructions of the Board of Trustees of the Hospital, income accumulates and is transferred to principal for reinvestment.

Terms of Gift

$10,000. for free bed in honor of Francis and Eliza Porter Keeney
$ 5,000. for free bed in memory of Francis Keney Prescott
$ 400. for furnishing a room in memory of Jane E. Newcomb

George Palmer Charter Fund #73291 - Bequest under Second and Seventeenth Clauses of Will of George Palmer Charter - permanent endowment - income for general purposes.

Terms of Will

SECOND

I give and bequeath to the Rockville City Hospital, located in the city of Rockville, State of Connecticut, the sum of Ten Thousand (10,000) dollars, in trust, however, for the following uses and purposes, namely: The governing body of said hospital shall invest said sum of $10,000 and the annual income of said sum shall be used for the general maintenance of said Hospital.

George Palmer Charter Fund #73291 continued

SEVENTEENTH

All the rest, residue and remainder of my estate, of whatsoever nature and wheresoever situated which I may own or have the right to dispose of at the time of my decease, I give, devise and bequeath in equal proportions, share and share alike to the Rockville City Hospital located in the city of Rockville, State of Connecticut, and to the Cyril and Julia C. Johnson Memorial Hospital, Inc. located at Stafford Springs, State of Connecticut, in trust each of said hospitals shall invest the sums derived under this Article of my last Will and Testament and the annual income of said sums shall be used for the general maintenance of each of said hospitals.

William H. Prescott Fund #73301 - Bequest u/w William H. Prescott. Permanent endowment - income for general purposes.

Terms of Will -

"13. I give and bequeath to Francis T. Maxwell, Arthur T. Bissell, J. Alice Maxwell, A. N. Belding and Thomas W. Sykes, all of Rockville, Connecticut, the sum of Fifty Thousand Dollars ($50,000) in perpetual trust to them and their successors in office, for the purpose of establishing and maintaining at said city of Rockville, a general hospital for the sick, to be open and available to all residents of the said City of Rockville, and of such portion of the immediate vicinity thereof contiguous and adjacent thereto, as in the judgment of said Board of Trustees may be deemed wise and advisable, subject to such rules and regulations concerning admission to said hospital as said trustees and their successors in office may, from time to time, establish.

Said trustees and their successors in office shall have power to receive property by gift or otherwise, and to purchase land and erect buildings for the purpose of carrying out the provisions of this trust.

The general management and oversight of said hospital, including the character and method of treatment therein to be established, shall be vested wholly in said Board of Trustees and their successors in office.

Said Board may elect a President, Vice-President, Secretary and Treasurer, and such other executive officers as they may deem necessary or advisable to carry out the purpose of this trust, including a superintendent of said institution. All vacancies in said Board arising from any cause, shall be filled by appointment of the surviving trustees.

William H. Prescott Fund #73301-continued

Terms of Will-continued

The Board of Trustees shall have power, from time to time, to make by-laws defining the duties of said officers and superintendent, the method of calling meetings of the Trustees and other by-laws relative to the management and government of the same. Provided, however, that, if at any time before my decease, I shall make provision for the transfer of the sum of fifty thousand dollars ($50,000) to the above named, as trustees for the purpose of inaugurating the establishment of a City Hospital, thereby substantially carrying out the provisions of this paragraph of my will, then and in that event, I revoke this paragraph of the same relating to said Hospital, and declare it inoperative, but otherwise to remain in full force and effect."

Stephen Goodale Risley and Emeret Scott Risley Fund #73311 (1949) - Bequest u/ Ninth and Twenty-first clauses of Will of May R. Adams - permanent endowment - income for general purposes.

Terms of Will

"NINTH: I give and bequeath unto THE ROCKVILLE CITY HOSPITAL, INC. of said Rockville, the sum of Ten Thousand Dollars, in memory of my father and mother, Stephen Goodale Risley, M.D. and Emeret Scott Risley, for the establishment of a fund to be known as the Stephen Goodale Risley and Emeret Scott Risley Fund, the income thereof to be used for the general uses and purposes of said Hospital."

"TWENTY-FIRST: All the rest, residue and remainder of all my property, of every description, both real and personal, of whatsoever the same may consist or whereesoever it may be situated, I give, devise and bequeath unto said THE ROCKVILLE CITY HOSPITAL, INC. in order that the same may be added to and become a part of the Stephen Goodale Risley and Emeret Scott Risley Fund, which is established in Paragraph Ninth of this my last Will and Testament." ($79,688.80)

Rockville Chapter American Red Cross Fund #73321 - Gift from Rockville Chapter of American Red Cross - considered permanent endowment - income is used for general expenses of the Hospital.

William B. and Lizzie Lathrop Sprague Fund #73341 - Bequest u/w Lizzie Lathrop Sprague - considered permanent endowment - income is used for general expenses of the Hospital.

Terms of Will

"--to be known as the William B. and Lizzie Lathrop Sprague Fund".

Swindells Fund #73351 - This fund represents donations received from the Swindells Foundation. Income and/or principal may be used for care of deserving persons or used for general hospital expenses. Surplus income is transferred to principal.

Fred Talcott Fund #73361 - Bequest u/w Fred Talcott - considered permanent endowment - income for general purposes.

Terms of Will

"SIXTEENTH: Whereas one William H. Prescott of said Rockville, now deceased, in and by his will bequeathed a large sum of money towards the support and maintenance of a hospital to be thereafterwards established in said Rockville, and it is my desire to make a contribution towards the erection and establishment of such hospital. I give and bequeath to the persons who at the time of my decease may be the custodians of the said fund, bequeathed as aforesaid by said Prescott, the sum of five thousand dollars to be used by them or their successors in such trust towards the erection and establishment of such hospital."

"TWENTIETH:——Upon the decease of the last survivor of the aforesaid beneficiaries under this trust I direct that one-half part of all the trust estate and property then remaining in the hands of my said trustee be by it made over to the persons mentioned in the sixteenth clause of this my will as the custodians of the William H. Prescott Fund, or to the persons who at the termination of this trust may be such custodians, to be applied towards the establishment of the hospital in said Rockville proposed or contemplated in the will of said Prescott, but if such hospital shall then be already established then said one-half of said trust estate and property shall be by said trustee made over to such hospital to be used by it for its uses and purposes."

Trumbull Chapter, D.A.R..Fund #73381 - Gift from Trumbull Chapter, D.A.R. - considered permanent endowment - income to be used for free bed, Sabra Trumbull Daughters to have preference, or any deserving person, to be decided by Hospital Trustees and Advisory Board of Sabra Trumbull Chapter. Any unused income is added to principal.

United German Society Fund #73391 - Gift from United German Society - considered permanent endowment - income is used for general expenses of the Hospital.

November 24, 1952

Florence R. Whitlock Fund #73371 - Bequest under will of Florence R. Whitlock (1953) - $13,351.35, a permanent endowment. Income for free bed or beds. Terms of will:

"2...The remaining four-tenths (4/10ths) of said residue, I give, devise and bequeath to the Rockville City Hospital for the purpose of establishing a free bed or beds in said Hospital in memory of my mother, Anna Shelton Whitlock."

Betsey C. Tucker Fund #73360 - Bequest under will of Betsy C. Tucker (1955) - $2,000, a permanent endowment. Income for free bed. Terms of will:

"Second: I give and bequeath to The Rockville City Hospital of Rockville, Connecticut, Two Thousand (2,000) Dollars to be its absolutely and forever. This bequest is to be used by said Hospital as an endowment for the partial maintenance of a free bed in said Hospital."

Anna M. and Albert H. Bilson Fund #745081 - Bequest under will of Anna M. Bilson of $10,371.08 as follows: (January 22, 1957)

"NINTH: All the rest, residue and remainder of my Estate, both real and personal of whatsoever nature and wheresoever situated is to be sold and one-half of the proceeds are to be given to the Union Congregational Church of Christ, Inc. to be known as the Anna M. Bilson and Albert H. Bilson Fund. I direct the trustees of said Church to lawfully invest said legacy and to use the income therefrom for the general uses and purposes of said Church. The remaining one-half thereof I give and devise unto the Rockville City Hospital, Inc. of the Town of Vernon to be known as the Anna & Albert Bilson Fund. I direct the trustees of said Hospital to lawfully invest said legacy, and to use the income therefrom for the general uses and purposes of said Hospital.

EXHIBIT Q 11-2

Fund 11-1.52

Fred Talcott Fund

I, Fred Talcott, of the City and County of Providence in the State of Rhode Island, hereby revoking all other and former Wills by me made, do make this my last will and testament in manner following, that is to say,

FIRST. I give and bequeath to my wife, Helen E. Talcott, in lieu of her dower out of my estate, the sum of twenty-five thousand dollars. I also give and bequeath to her all my household goods, furniture and supplies, pictures, table ware, silver ware, books, household ornaments and furnishings.

SECOND. I give and bequeath to my brother, Phineas Talcott of the City of Rockville in the State of Connecticut, the sum of fifteen thousand dollars. And further I direct my executor to transfer and make over to him all mortgage deeds together with the mortgage notes thereby secured, which may belong to me at the time of my decease, in which mortgage deeds the name of my said brother appears as mortgagee and in which mortgage deeds the property described as mortgaged is located in the State of Rhode Island, excepting from this bequest to my said brother however any mortgage which I may hold upon real estate situate upon Sabin Street in said Providence.

THIRD. I give and bequeath to Hannah K. Talcott, the widow of my brother, Allyn K. Talcott late of said Rockville, deceased, the sum of five thousand dollars, if she be living at the time of my decease.

FOURTH. I give and bequeath to my cousin, George Talcott of said Rockville, the sum of five thousand dollars if he be living at the time of my decease, and if he be not then living then I give and bequeath said sum of five thousand dollars to his son, Phineas W. Talcott, if he be then living.

FIFTH. I give and bequeath to my cousin, E. Belle Robbins of

Wetherefield, in said State of Connecticut, the sum of four thousand dollars.

SIXTH. I give and bequeath to my sister-in-law, Annie Bryant, wife of Charles F. Bryant of Wollaston in the Commonwealth of Massachusetts, the sum of two thousand dollars.

SEVENTH. I give and bequeath to my brother-in-law, Reverend Ernest N. Bullock, of Roswell, New Mexico, the sum of two thousand dollars.

EIGHTH. I give and bequeath to LeFavour H. Bosworth of said Providence, the sum of one thousand dollars.

NINTH. I give and bequeath to Thomas Sellew of said Providence, the sum of one thousand dollars.

TENTH. I give and bequeath to Sidney S. Blaisdell of said Providence, the sum of one thousand dollars.

ELEVENTH. I give and bequeath to Del Towle and his wife, Lizzie G. Towle, of Salem in said Commonwealth of Massachusetts, or in case of the decease of either of them prior to my decease then to the survivor of them, the sum of one thousand dollars.

TWELFTH. In recognition of faithful services, I give and bequeath to Herbert Gould and to James Degnan now in the employ of the Rhode Island Label Works in said Providence, in which I am interested, the sum of three thousand dollars each and I give and bequeath to each of the other employees of said Label Works who at the time of my decease shall then have been in its employ for a period of five years or more, a sum of money which shall be equivalent to twelve weeks wages at the rate which they may then be receiving. The moneys to be paid to said employees shall be paid to them at such times and in such installments as my executor hereinafter named may deem advisable: Provided that any moneys to which the two employees, William McMahon and Louis LaRock, may be entitled under this clause shall be paid to the Superintendent and Foreman, said James Degnan, to be by him so applied for the benefit of the said two employees, McMahon and LaRock, and their families as he in his sole discretion may deem advisable.

Said Rhode Island Label Works is incorporated and is the purchaser of, and is now carrying on, the business which I formerly carried on under the same name, and fpr the purposes of this bequest I direct that the time for which said employees may have been in my employ shall be added to the time for which they shall at my decease have been in the employ of said corporation and that such employment by me be considered in their favor the same as though they had been for the entire time in the employ of the said corporation.

THIRTEENTH. I give and bequeath to the Rhode Island Hospital, incorporated by an act of the General Assembly passed at the January Session, 1863, and located in the City of Providence in said State, the sum of two thousand dollars, for its uses and purposes.

FOURTEENTH. I give and bequeath to the Congregational Church and Society of Vernon Centre in said State of Connecticut, the sum of five hundred dollars, for the general uses and purposes of said church.

FIFTEENTH. I give and bequeath to the Broadway United Presbyterian Church on Broadway in said Providence, the sum of five hundred dollars, to be applied to the general uses and purposes of that particular church.

SIXTEENTH. Whereas one William H. Prescott of said Rockville, now deceased, in and by his will bequeathed a large sum of money towards the support and maintenance of a hospital to be thereafterwards established in said Rockville, and it is my desire to make a contribution towards the erection and establishment of such hospital. I give and bequeath to the persons who at the time of my decease may be the custodians of the said fund, bequeathed as aforesaid by said Prescott, the sum of five thousand dollars to be used by them or their successors in such trust towards the erection and establishment of such hospital.

SEVENTEENTH. In case my personal estate shall not be sufficient to satisfy all the aforegoing legacies in full, then I direct that my executor shall sell any real estate which may belong to me at the time of

my decease, or such part thereof as may be necessary, and apply so much of the proceeds thereof to the satisfaction of said legacies as shall be necessary to satisfy them in full, and in case my personal estate together with the proceeds of the sale of my said real estate shall be sufficient to satisfy said legacies in full, then I direct that all of them, except said legacy to said Rhode Island Hospital, shall abate ratably.

EIGHTEENTH. In case it shall be found necessary to sell the real estate which may belong to me at the time of my decease, under the aforegoing provision, then I hereby authorize and empower my executor hereinafter named, or any administrator with the will annexed, for the time being, to sell any part or the whole of such real estate in its or his discretion and upon any sale or sales thereof, to make, execute and deliver to the purchaser or purchasers thereof such deed or deeds or other conveyances as shall vest in such purchaser or purchasers, his, her or their heirs and assigns, a good title to such real estate in fee simple. No purchaser under this power shall be required to look after the application of the purchase money.

NINETEENTH. In case of the death of any of the aforesaid beneficiaries under this my will prior to my decease, I direct that the legacy or devise, herein given to such deceased beneficiary, shall thereupon lapse, except where in any bequest or devise I have otherwise provided.

TWENTIETH. All the rest, residue and remainder of my estate and property, whatsoever and wheresoever, which shall belong to me at the time of my decease I give, devise and bequeath to the Industrial Trust Company, a banking corporation having a place of business in said Providence, to its use, but in trust nevertheless for the uses, purposes and trusts following, that is to say,

Upon trust to take possession of the same and receive the rents, profits and income therefrom with power to invest and reinvest the same, and all other of my personal estate, in its discretion and to

lease from time to time any real estate which shall belong to me at the time of my decease for such times and on such terms as it may deem advisable, to apply the said rents, profits and income to the payment of all taxes, assessments, insurance, repairs and other necessary charges and expenses whatsoever upon said real estate or incident to the care and management of the same, including a just compensation to said trustee for its services, and to pay three-fifth parts of the net income of said trust to my wife, said Helen E. Talcott, during her life and one-fifth part thereof to my said brother, Phineas Talcott, during his life and the remaining one-fifth part thereof to said Hannah K. Talcott during her life. In case of the death of my brother, said Phineas Talcott, leaving my wife and said Hannah K. Talcott him surviving, then I direct that three-fifth parts of the then share of my said brother in said income shall be paid to my wife and the remaining two-fifth parts thereof to said Hannah K. Talcott, and in case of the death of either my wife or of said Hannah K. Talcott thereafterwards, or in case only one of them shall survive my said brother then the entire then share of my said brother in said income shall be paid to the survivor of them. In case of the death of said Hannah K. Talcott leaving my wife and my said brother, Phineas, her surviving, then I direct that three-fifth parts of the then share of said Hannah K. Talcott in said income shall be paid to my wife and the remaining two-fifth parts thereof to my said brother, and in case of the death of either my wife or of my said brother thereafterwards, or in case only one of them shall survive said Hannah K. Talcott, then the entire then share of said Hannah K. Talcott in said income shall be paid to the survivor of them. In case of the death of my wife, leaving my said brother, Phineas, and said Hannah K. Talcott her surviving then I direct that the then share of my wife in said income shall be paid in equal shares to my said brother and to said Hannah K. Talcott and if only one of them shall survive my wife or in case of the death of either of them thereafter-

wards then the entire then share of my wife in said income shall be paid to the survivor of them.

Upon the decease of the last survivor of the aforesaid beneficiaries under this trust I direct that one-half part of all the trust estate and property then remaining in the hands of my said trustee be by it made over to the persons mentioned in the sixteenth clause of this my will as the custodians of the William H. Prescott Fund, or to the persons who at the termination of this trust may be such custodians, to be applied towards the establishment of the hospital in said Rockville proposed or contemplated in the will of said Prescott, but if such hospital shall then be already established then said one-half part of said trust estate and property shall be by said trustee made over to such hospital to be used by it for its uses and purposes.

I direct that four-tenths of said remaining portion of said trust estate and property be made over by said trustee to the Rhode Island Hospital, mentioned in the thirteenth clause of this my will, for its uses and purposes, and that the remaining one-tenth part of said trust estate and property be made over by said trustee to The Providence District Nursing Association, a charitable corporation having its headquarters in said Providence, for its uses and purposes.

I hereby authorize and empower my said trustee, in case it shall at any time deed it advisable, to sell either at public auction or private sale the whole or any part of said trust estate and property and upon any sale of any real estate at any time under this power I hereby authorize and empower my said trustee to execute and deliver to the purchaser or purchasers thereof such deed or deeds or other conveyances as shall vest in such purchaser or purchasers a good and valid title thereto in fee simple. No purchaser or purchasers under this power shall be required to see to the application of the

purchase money nor be required to inquire into the advisability of making any sale.

TWENTY-FIRST. I nominate and appoint said Industrial Trust Company sole executor of this my last will and testament.

In Testimony Whereof, I have hereunto set my hand and affixed my seal at said Providence this 16th day of January, A. D. 1917.

Fred Talcott

Signed, sealed, published and declared by Fred Talcott as and for his last will and testament, in our presence, who here, at his request, in his presence, and in the presence of each other, hereunto set our names as witnesses.

William S. Flynn

A. W. Flynn

William A. Morgan

EXHIBIT Q 11-2

Fund 11-1.53

J. Alice Maxwell Fund

DISTRICT OF ELLINGTON

(Continued from Page 394 - Estate of J. Alice Maxwell)

ORDERED, That twelve months from the 7th day of May, 1942 be and the same are allowed the executors within which to settle said estate.

ORDERED, That six months from the 7th day of May, 1942, be and the same are limited and allowed for the creditors to bring in their claims against said estate, and the said Executors are directed to give public notice to the creditas to bring in their claims within said time allowed, by posting a copy of this order upon the public sign-post nearest to the place where the deceased last dwelt within said town, and by publishing the same once in some newspaper having a circulation in said Probate District within fifteen days from the date of this order and return make to this Court of the notice given and of a list of all claims presented within said time.

ORDERED, That two months from the 15th day of April, 1942, be and the same are allowed the Executors within which to make, or cause to be made, a true and perfect inventory of all the estate of said deceased, both real and personal, including choses in action, and this Court appoints J. P. Cameron and Francis S. Nettleton, disinterested persons, appraisers under oath, to appraise said estate and return make to this Court within said time allowed.

(signed) Francis T. O'Loughlin, Judge.

A true copy Attest: Elsie M. Neff Clerk

WILL

I, J. ALICE MAXWELL, of the City of Rockville, State of Connecticut, do hereby make, publish and declare the following as and for my Last Will and Testament:

FIRST: I revoke each and every will and codicil heretofore by me at any time made.

SECOND: To my brother, FRANCIS T. MAXWELL, and my friend, THOMAS B. GILCHRIST, and the survivor of them, I give and bequeath the sum of Sixty thousand dollars ($60,000) and all my jewelry, furs, clothing, table linen, bed linen, and articles of a personal or family nature and such other articles as they in their discretion shall deem unsalable or unsuitable for sale. Without intending to qualify the absolute character of this bequest, I express the hope that they or the survivor of them will distribute the said sum of money and the said jewelry, furs, clothing, linen and other articles of personal property among such of my relatives, friends, servants in my employ at the time of my death, and other individuals and institutions, in such manner and amounts as I may indicate by a written memorandum or failing such memorandum as they or the survivor of them shall determine to be in accordance with what they believe to be my wishes. In case of any uncertainty as to the items of personal property covered by this bequest, the decision of my Executors shall be final and controlling for all purposes.

THIRD: To ROCKVILLE PUBLIC LIBRARY, in Rockville, Connecticut, I give and bequeath the four oil portraits of my Kellogg ancestors which are now hanging in the second floor hall of my residence in Rockville, Connecticut, and the portrait of my mother hanging in the billiard room of my said residence, each of which pictures is identified by a label pasted on the back thereof.

FOURTH: To VISITING NURSE ASSOCIATION, in Rockville, Connecticut, I give and bequeath the sum of One thousand dollars ($1,000).

FIFTH: To GROVE HILL CEMETERY, in the City of Rockville, Town of Vernon and State of Connecticut, I give and devise all my right, title and interest in and to the certain lots or parcels of real property situated in said Cemetery in which the graves of my brother William Maxwell and other members of my family are located and all other real property adjacent thereto and used in connection therewith, which together are hereinafter referred to as "family burial ground", IN TRUST NEVERTHELESS, to hold and maintain the same in perpetuity as a burial ground for such members of our family as are already interred therein and for myself, it being my wish that no other person or persons be interred therein after my death.

SIXTH: To THE HARTFORD-CONNECTICUT TRUST COMPANY, its successor or successors, I give and bequeath the sum of Forty-five thousand dollars ($45,000), IN TRUST NEVERTHELESS, to invest and reinvest the same and keep the same invested and to collect and receive the income thereof and to apply so much of said income as may be deemed necessary within the discretion of my Trustee, from time to time, to the proper and suitable maintenance and care of the said "family burial ground", together with the markers, monuments, trees, shrubbery, walls, bridges, paths and other structures and vegetation thereon, until such time as the Town of Vernon, or City of Rockville, or other municipal corporation shall assume the entire financial responsibility for the care, maintenance and control of the said Grove Hill Cemetery, including all of the real property referred to in Article FIFTH hereof. In the event that the net income of said trust should at any time, in the discretion of my Trustee, be deemed insufficient to provide for the proper and suitable maintenance and care of said "family burial ground", as aforesaid, by reason of storms or other emergency or for any other reason, I authorize my Trustee to use and apply such part of the principal of said trust as my Trustee in its discretion shall deem advisable for the purpose aforesaid. Should the net income of said trust at any time, in the opinion of my Trustee, exceed the requirements of caring for said "family burial ground", as aforesaid, I direct that such excess income shall be paid over in the discretion of my Trustee to ROCKVILLE PUBLIC LIBRARY. Should the financial responsibility of caring for the said Grove Hill Cemetery be assumed as aforesaid by the said Town of Vernon or City of Rockville or other municipal corporation and, by reason thereof, the income of said trust fund or any part thereof no longer be necessary for the proper and suitable maintenance and care of said "family burial ground", as aforesaid, I direct my Trustee to pay over and distribute to ROCKVILLE PUBLIC LIBRARY all or such part of the principal and accumulated income of said trust fund which, by reason of such situation, shall no longer be required for the maintenance of said "family burial ground", as aforesaid.

SEVENTH: All the rest, residue and remainder of my property, real and personal, of every kind, nature and description and wheresoever situated, I direct my Executors to divide into one hundred equal parts, which I give, devise and bequeath as hereinafter provided.

EIGHTH: To ROCKVILLE PUBLIC LIBRARY, in Rockville, Connecticut, I give, devise and bequeath four of said equal parts of my said residuary estate in trust to use the income thereof for the general purposes of the said Library.

NINTH: To ROCKVILLE CITY HOSPITAL, in Rockville, Connecticut, I give, devise and bequeath four of said equal parts of my said residuary estate in trust to use the income thereof for the general purposes of said Hospital.

(Continued over)

ECHN Proposed Asset Purchase by PMH
Submitted October 13, 2015

(Continued from Page 395 - Estate of J. Alice Maxwell)

TENTH: To my TRUSTEES, hereinafter named, I give, devise and bequeath ninety-two of said equal parts of my said residuary estate, IN TRUST NEVERTHELESS, to invest and reinvest the same and keep the same invested and to collect and receive the rents, issues and income thereof, and, after paying all proper expenses in connection with the administration thereof, to pay over the net income thereof to my brother FRANCIS T. MAXWELL, for and during the term of his natural life. Upon the death of my said brother, I direct my Trustees to dispose of the said ninety-two equal parts of my said residuary estate as follows:

(a) To my Trustees, hereinafter named, I give, devise and bequeath twenty-four of said equal parts, IN TRUST NEVERTHELESS, to invest and reinvest the same and to keep the same invested and to collect and receive the rents, issues and income thereof and to pay over the net income thereof to my niece PRISCILLA MAXWELL ENDICOTT, for and during the term of her natural life, and upon her death I give, devise and bequeath the said trust fund in equal shares per stirpes to the grandchildren and lawful issue of deceased grandchildren of my brother Francis T. Maxwell.

(b) To my TRUSTEES, hereinafter named, I give, devise and bequeath twenty-four of said equal parts, IN TRUST NEVERTHELESS, to invest and reinvest the same and to keep the same invested and to collect and receive the rents, issues and income thereof and to pay over the net income thereof to my niece HARRIET K. MAXWELL WEISSI, for and during the term of her natural life, and upon her death I give, devise and bequeath the said trust fund in equal shares per stirpes to the grandchildren and lawful issue of deceased grandchildren of my brother Francis T. Maxwell.

(c) To my TRUSTEES, hereinafter named, I give, devise and bequeath eleven of said equal parts, IN TRUST NEVERTHELESS, to invest and reinvest the same and to keep the same invested and to collect and receive the rents, issues and income thereof and to accumulate the net income thereof for the benefit of MAXWELL BELDING, a grandson of my brother Francis T. Maxwell, until the said Maxwell Belding shall attain the age of twenty-one years, and thereupon to pay over to the said Maxwell Belding all of said accumulated income of said trust fund until he shall attain the age of thirty years, whereupon my Trustees shall pay over the capital of said trust fund to the said Maxwell Belding absolutely. In the event that the said Maxwell Belding should die before attaining the age of thirty years, I give, devise and bequeath the capital of said trust, upon his death, in equal shares to his surviving children, and, in the event that he should leave no children him surviving, I give, devise and bequeath the same to his sister VIRGINIA BELDING if living, and if not living, then to her children then living, in equal shares, and in the event that neither the said Virginia Belding nor any children of the said Virginia Belding should survive the said Maxwell Belding, I give, devise and bequeath the same in equal shares per stirpes to the then-living grandchildren and lawful issue of deceased grandchildren of my brother Francis T. Maxwell.

(d) To my TRUSTEES, hereinafter named, I give, devise and bequeath eleven of said equal parts, IN TRUST NEVERTHELESS, to invest and reinvest the same and to keep the same invested and to collect and receive the rents, issues and income thereof and to accumulate the net income thereof for the benefit of VIRGINIA BELDING, a granddaughter of my brother Francis T. Maxwell, until the said Virginia Belding shall attain the age of Twenty-one years, and thereupon to pay over to the said Virginia Belding all of said accumulated income and thereafter to pay to the said Virginia Belding the net income of said trust fund until she shall attain the age of thirty years, whereupon my Trustees shall pay over the capital of said trust fund to the said Virginia Belding absolutely. In the event that the said Virginia Belding should die before attaining the age of thirty years, I give, devise and bequeath the capital of said trust, upon her death, in equal shares to her surviving children, and, in the event that she should leave no children her surviving, I give, devise and bequeath the same to her brother MAXWELL BELDING if living, and if not living, then to his children then living, in equal shares, and in the event that neither the said Maxwell Belding nor any children of the said Maxwell Belding should survive the said Virginia Belding, I give, devise and bequeath the same in equal shares per stirpes to the then-living grandchildren and lawful issue of deceased grandchildren of my brother Francis T. Maxwell.

(e) To my TRUSTEES, hereinafter named, I give, devise and bequeath eleven of said equal parts, IN TRUST NEVERTHELESS, to invest and reinvest the same and to keep the same invested and to collect and receive the rents, issues and income thereof and to accumulate the net income thereof for the benefit of BRADFORD ENDICOTT, a grandson of my brother Francis T. Maxwell, until the said Bradford Endicott shall attain the age of twenty-one years, and thereupon to pay over to the said Bradford Endicott all of said accumulated income and thereafter to pay to the said Bradford Endicott the net income of said trust fund until he shall attain the age of thirty years, whereupon my Trustees shall pay over the capital of said trust fund to the said Bradford Endicott absolutely. In the event that the said Bradford Endicott should die before attaining the age of thirty years, I give, devise and bequeath the capital of said trust, upon his death, in equal shares to his surviving children, and, in the event that he should leave no children him surviving, I give, devise and bequeath the same to his sister PRISCILLA ENDICOTT if living, and if not living, then to her children then living, in equal shares, and in the event that neither the said Priscilla Endicott nor any children of the said Priscilla Endicott should survive the said Bradford Endicott, I give, devise and bequeath the same in equal shares per stirpes to the then-living grandchildren and lawful issue of deceased grandchildren of my brother Francis T. Maxwell.

(f) To my TRUSTEES, hereinafter named, I give, devise and bequeath eleven of said equal parts, IN TRUST NEVERTHELESS, to invest and reinvest the same and to keep the same invested and to collect and receive the rents, issues and income thereof and to accumulate the net income thereof for the benefit of PRISCILLA ENDICOTT, a granddaughter of my brother Francis T. Maxwell, until the said Priscilla Endicott shall attain the age of twenty-one years, and thereupon to pay over to the said Priscilla Endicott all of said accumulated income and thereafter to pay to the said Priscilla Endicott the net income of said trust fund until she shall attain the age of thirty years, whereupon my Trustees shall pay over the capital of said trust fund to the said Priscilla Endicott absolutely. In the event that the said Priscilla Endicott should die before attaining the age of thirty years, I give, devise and bequeath the capital of said trust, upon her death, in equal shares to her surviving children, and, in the event that she should leave no children her surviving, I give, devise and bequeath the same to her brother BRADFORD ENDICOTT if living, and if not living, then to his children then living, in equal shares, and in the event that neither the said Bradford Endicott nor any children of the said Bradford Endicott should survive the said Priscilla Endicott, I give, devise and bequeath the same in equal shares per stirpes to the then-living grandchildren and lawful issue of deceased grandchildren of my brother Francis T. Maxwell.

ELEVENTH: If, upon the termination of any of the trusts hereinbefore provided for in Article TENTH hereof, there should be no issue of my brother Francis T. Maxwell

(Continued over)

(Continued over)

then living, and entitled under the provisions of my will to the capital of such trust, then, in such event, I give, devise and bequeath the capital of any such trust in equal shares to ROCKVILLE PUBLIC LIBRARY and ROCKVILLE CITY HOSPITAL, both situated in the City of Rockville and State of Connecticut.

TWELFTH: I direct the payment out of my residuary estate of all succession, inheritance, estate and transfer taxes and death duties which may be levied or assessed upon or against any and all of the foregoing legacies, devises and transfers of property or upon my estate as a whole.

THIRTEENTH: I nominate, constitute and appoint my brother FRANCIS T. MAXWELL, my friend THOMAS B. GILCHRIST, and THE HARTFORD-CONNECTICUT TRUST COMPANY as and to be the EXECUTORS of this my Last Will and Testament and the TRUSTEES of the trusts herein created. In the event that either the said Francis T. Maxwell or the said Thomas B. Gilchrist should for any reason fail to qualify or cease to act as such Executor or as such Trustee, I nominate, constitute and appoint in his place and stead as such Executor or as such Trustee, or both, as the case may be, FRED N. BELDING, the son-in-law of my said brother Francis T. Maxwell. I direct that no security shall be required of any of said individuals or of said Trust Company for the faithful performance of his or its duties as such Executor or as such Trustee and that no surety shall be required on any bond that may be given by any of them as Executor or as Trustee in any state or country in which my Will may be filed or proved.

J.A.M. To my Executors and the survivor of them, I give and grant full power and authority to sell any and all real estate which I may own at the time of my death, either at public or private sale, and either for cash or on credit, partly for cash and partly on credit, securing the payment of so much of the purchase price as remains on credit by mortgage on the property sold.

I also authorize my Executors and the survivor of them to make payment of all bequests and trusts provided for in this Will by setting apart and distributing to said legatees and trusts any stocks, bonds or other securities in which my estate may be invested at the time of my death, in such manner and in such amounts as my said Executors, or the survivor of them, may determine and at the market values of such securities, such market values to be conclusively determined by my said Executors, and also to distribute my residuary estate by like valuations, by turning over to the legatees and trustees entitled thereto such securities and investments as shall remain available therefor; but nothing herein contained shall be deemed to prohibit the sale of any personal property owned by me at the time of my death and not herein specifically bequeathed, if my Executors shall desire to sell the same.

I authorize my Trustees to continue the investment of any trust or any part thereof in such securities and property as they may receive from my Executors, as aforesaid, although such securities and property may not be of the kind or class authorized by law for the investment of trust funds. I also authorize my Trustees to invest and reinvest any trust fund or any part thereof in any stocks, bonds or securities or real estate which they may deem advisable, and direct that in making such investments my
JA.M. Trustees shall not be limited to investments of the kind authorized by law for the investment of trust funds. I also authorize my Trustees to become parties to the reorganization, consolidation or merger of any corporation the securities of which may form a part of any trust and for such purpose I direct that they shall have full authority to execute any agreement or instrument necessary and to make any necessary payments, loans or advances and to take any further steps necessary to effect the same, including the deposit, surrender and exchange of any securities which they may deem advisable in connection therewith.

I authorize my Trustees to sell any real estate which may form a part of any trust herein created either for cash or on credit or partly for cash and partly on credit, securing the payment of so much of the purchase money as remains on credit by mortgage on the property sold, and I authorize and empower my said Trustees to lease any of the real estate belonging to any trust for any term or terms of years and for such rental and upon such conditions as they may deem expedient.

In case any trust fund created under this Will shall at any time contain interest-bearing securities having a value above par, I authorize the payment of the interest in full to the beneficiary of the income and exonerate the Trustee or Trustees from all liability to retain a portion of such interest as a sinking fund for the reimbursement of principal.

I expressly exempt my Executors from any obligation to file any inventory or account, any laws to the contrary notwithstanding.

J.A.M. I direct that my Executors and Trustees shall be compensated for their services in the amounts and at the rates and in the manner prescribed by the statutes of the State of New York now in effect providing for compensation of executors and trustees, in like manner as if my estate were being administered in the State of New York in accordance with the laws of such State.

IN WITNESS WHEREOF I have hereunto set my hand and affixed my seal this 28th day of March, in the year of our Lord One thousand nine hundred forty-one.

(signed) J. Alice Maxwell (L.S.)

Signed, sealed, published and declared by the above-named Testatrix as and for her Last Will and Testament in our presence, who, at her request and in her presence and in the presence of one another, have hereunto subscribed our names as witnesses, on the day and year last above written. This Will consists of eleven typewritten pages exclusive of this page, each initialed by the Testatrix.

(signed) Thomas B. Gilchrist Jr. residing at 175 East 62nd St., New York City
(signed) Daniel E. Woodhull Jr. residing at 7 Beverly Gardens, Bronxville, N.Y.
(signed) Frank H. Platt residing at 64 East 86th St., New York, N. Y.

STATE OF NEW YORK)
COUNTY OF NEW YORK) ss.:

The within-named Thomas B. Gilchrist, Jr., Daniel E. Woodhull, Jr. and Frank H. Platt being severally duly sworn, depose and say, that they witnessed the foregoing will of the within-named testatrix, J. Alice Maxwell, and subscribed the same in her prescense and at her request and in the presence of one another; that the said J. Alice Maxwell at the time of the execution of such will appeared to them to be of full age and of sound mind and memory, and that she signed the said will and declared the same to be her Last Will and Testament in their presence, and that they make this affidavit at the reques of said testatrix.

(signed) Thomas B. Gilchrist, Jr.
(signed) Daniel E. Woodhull Jr.
(signed) Frank H. Platt.

(Continued over)

(Continued from Page 397 - Estate of J. Alice Maxwell.

Subscribed and sworn to before me at the request of the within-named testatrix, J. Alice Maxwell, on the 28th day of March, 1941.

(signed) Ruth M. O'Brien
(NOTARY PUBLIC New York Co. Clk. #92,
Reg. #2-0-163 Commission expires March 30, 1942)

A true copy Attest: Elsie M. Neff. Clerk

CODICIL

KNOW ALL MEN BY THESE PRESENTS, That I, J. ALICE MAXWELL, of the City of Rockville, County of Tolland, and State of Connecticut, being of sound and disposing mind and memory, do make, publish and declare the following to be a first codicil to my last will and testament, dated the 28th day of March, 1941, as the result of the recent death of my beloved brother, Francis T. Maxwell:

FIRST: I revoke the gift in the Second article of my said will to my brother, Francis T. Maxwell, and Thomas B. Gilchrist, and the survivor of them, of the sum of Sixty Thousand Dollars ($60,000) and articles of jewelry, wearing apparel, household furnishings and articles of a personal or family nature, and other articles as therein stated, and in lieu thereof I give the same sum of Sixty Thousand Dollars ($60,000) and all the articles specified in said Second article to Frederick N. Belding, of Rockville (whose wife was a daughter of my brother, Francis T. Maxwell), Howard W. Bennett, of Manchester, and Jeremiah H. Bartholomew, Jr. of West Hartford, and the survivors or survivor of them, upon the same terms and with the same hope as expressed in said Second article. I further provide that while all three are living the decision of any two of them shall be effective and conclusive to dispose of such articles.

SECOND: I revoke the appointment of my brother, Francis T. Maxwell and said Thomas B. Gilchrist contained in the Thirteenth article of said will to act as executors and trustees of the trusts created in said will other than the trust to The Hartford-Connecticut Trust Company in the Sixth article thereof, and in lieu thereof I nominate, constitute and appoint said Frederick N. Belding, said Howard W. Bennett and The Hartford-Connecticut Trust Company to be the executors of my said last will and testament and the trustees of each of the trusts therein created, other than said trust in the Sixth article, and I direct that no security shall be required of either of said individuals, or of said Trust Company, for the faithful performance of his or its duties as such executor or as such trustee, and that no surety shall be required on any bond that may be given by any of them as executor or as trustee in any state or country in which my will may be filed or proved. I also give to said executors named in this codicil, and to them as trustees, all the powers and authority given to my executors and trustees in and by the Thirteenth article of said will.

I further revoke the last two paragraphs of said article Thirteenth of said will, in which I attempt to exempt my executors from any obligation to file any inventory or account and in which I direct that my executors and trustees shall be compensated for their services in the amounts and at the rates prescribed by the statutes of the State of New York.

THIRD: Except as altered hereby, I hereby republish and reaffirm my said will dated March 28, 1941.

IN WITNESS WHEREOF, I have hereunto set my hand and seal, declaring this to be a first codicil to my last will and testament dated the 28th day of March, 1941, this instrument being executed this 17th day of April, 1942.

(signed) J. Alice Maxwell (L.S.)

Signed, sealed, published and declared by said testatrix, J. Alice Maxwell, as and for a first codicil to her last will and testament dated March 28, 1941, which, except as altered by said codicil, she also republished, in the presence of us, the undersigned, who in her presence and in the presence of each other, at her request, have hereunto set our names as witnesses, this 17th day of April, 1942.

(signed) Charles Welles Gross Hartford, Conn.
(signed) Roy C. Ferguson M D Rockville Conn
(signed) Eleanor A. Reynolds Lyme, Conn.

State of Connecticut)
)ss: Rockville, April 17, 1942
County of Tolland)

Then and there personally appeared the above named Charles Welles Gross, Roy C. Ferguson M. D. & Eleanor A. Reynolds who, being duly sworn, depose and say that they witnessed the execution of the foregoing codicil of said testatrix, J. Alice Maxwell; that she subscribed said codicil and declared the same to be a first codicil to her last will and testament dated March 28, 1941, in their presence; that they thereafter subscribed the same as witnesses in the presence of said testatrix and in the presence of each other, and at the request of said testatrix; that said testatrix at the time of the execution of said codicil appeared to them to be of full age and of sound and disposing mind and memory; and that they make this affidavit at the request of said testatrix.

(signed) Charles Welles Gross
Subscribed and sworn to (signed) Roy C. Ferguson, M D ROckville
this 17th day of April, (signed) Eleanor A. Reynolds
1942, before me
(signed) Spencer Gross, Notary Public (seal)

A true copy Attest: Elsie M. Neff. Clerk

TO THE PROBATE COURT FOR THE DISTRICT OF ELLINGTON:

ESTATE OF J. ALICE MAXWELL, late of Rockville, in the Town of Vernon, in said District, deceased.

PETITION OF THOMAS B. GILCHRIST TO VACATE, SET ASIDE AND REVOKE A PURPORTED ORDER OF THIS COURT

1. Petitioner is a resident of Bronxville, in the County of Westchester, and State of New York.

2. On or about May 7, 1942 there was filed in this Court and offered for probate a will of said deceased dated March 28, 1941, and on or about said day there was further offered for probate a purported codicil of said deceased bearing date the 17th day of April, 1942.

3. Petitioner, Thomas B. Gilchrist, is a person interested in said estate in that by the Second Clause of said will the testatrix bequeathed to her brother, Francis T. Maxwell, and to the petitioner, Thomas B. Gilchrist, and the survivor of them, the sum of sixty Thousand Dollars ($60,000) and certain articles of tangible personal prop-

(continued over)

ECHN Proposed Asset Purchase by PMH
Submitted October 13, 2015

EXHIBIT Q 11-2

Fund 11-1.54

William A. and Caroline E. Metcalf Fund

DISTRICT OF ELLINGTON

LAST WILL AND TESTAMENT,

I, CAROLINE E. STEELE METCALF of the Town of Vernon in the County of Tolland in the State of Connecticut, being of lawful age, of sound and disposing mind, memory and judgment, do hereby make, publish and declare this to be my last Will and Testament, hereby revoking all previous wills and codicils by me made.

FIRST: I will and direct that my just debts and funeral expenses be paid as soon after my decease as is reasonably convenient.

SECOND: I give and bequeath the sum of Five Hundred (500) Dollars to the Town of Bolton in the County of Tolland and State of Connecticut, to hold, manage, invest and reinvest said sum as a perpetual trust and to use the income therefrom for the care and maintenance of the John F. Steele and Sanford Steele lots in the Belknap Cemetery in said Town of Bolton.

THIRD: I give and bequeath the sum of Five Thousand (5000) Dollars to the Trustees of the Methodist Church of Rockville, Connecticut, in trust, nevertheless, to hold, manage, invest and reinvest said sum, and to use the income therefrom to assist in defraying the general current expenses of said Church; and if said Church should disband, dissolve or otherwise cease to exist as such Church, then I direct said Trustees to pay said sum and the accrued and unexpended interest thereon, if any, to the Southern New England Conference of the Methodist Church, in trust, to hold, manage, invest and reinvest said sum, and to use the income therefrom for the maintenance, support, relief and care of the retired ministers or their widows of said Conference, known as "Conference Claimants".

In either of said purposes, this trust shall be known as the W. A. Metcalf and Caroline E. Metcalf Fund.

FOURTH: I give and bequeath the sum of One Thousand (1000) Dollars to Arthur H. Metcalf, of the town of Tolland in said County of Tolland, brother of my deceased husband if living at my death.

FIFTH: I give and bequeath the sum of One Thousand (1000) Dollars to my brother, Charles S. Steele, of Yonkers, New York, if living at my death.

SIXTH: I give and bequeath unto Homer C. Waltz of said town of Vernon, my safe, as a gift in memory of William A. Metcalf, my late dear husband and a good friend of said Homer C. Waltz.

SEVENTH: I give and bequeath all of my wearing apparel, and all the furniture, bric-a-brac and articles of like nature in my house including my sewing machine and electric refrigerator to Caroline K. Metcalf of said town of Tolland. Without intending to qualify the absolute character of this bequest, I hereby express the hope that said Caroline K. Metcalf will distribute said articles among such of my friends, relations or others, in such manner as I may indicate by a written memorandum, or failing such memorandum, as said Caroline K. Metcalf shall determine.

EIGHTH: I give and bequeath unto George E. Metcalf of said town of Tolland, the sum of Ten Thousand (10,000) Dollars, to him, his heirs and assigns, absolutely and forever. Without intending to qualify the absolute character of this bequest, I hereby express the hope that said George E. Metcalf will use the same in providing for an education for his son Harold Joseph Metcalf, and also in making an easier life for himself.

It is my wish and desire, and I make this bequest in the sincere hope and belief, that the said George E. Metcalf will take good and sufficient care of Anna L. Metcalf, during her life.

NINTH: All the rest, residue and remainder of my estate of whatsoever nature and wheresoever situated, I give, bequeath and devise to the Trusteesof the Rockville City Hospital, Inc., a charitable corporation organized and existing under the laws of the State of Connecticut, and owning and operating a hospital in said town of Vernon, in trust, nevertheless, to hold, invest and reinvest the same and to use the income thereof for the general uses and purposes of said Hospital as said Trustees shall see fit. Said trust shall be known as the William A. and Caroline E. Metcalf Fund.

I APPOINT The Hartford-Connecticut Trust Company, Rockville Branch of the Town of Vernon County of Tolland and State of Connecticut executor of this my Last Will and Testament.

IN WITNESS WHEREOF I have hereunto set my hand and seal at said Vernon on the 13th day of February, A.D., One Thousand Nine Hundred and Forty-one.

(signed) Caroline E. Steele Metcalf (L.S.)

Signed, sealed, published and declared by the said CAROLINE E. STEELE METCALF as and for her Last Will and Testament, in presence of us, who at her request, in her presence, and in the presence of each other have hereunto subscribed our names as witnesses on the 13th day of February, A.D. 1941.

(signed) Harry H. Lugg)
(signed) Mrs. Joseph Bonan)Witnesses.
(signed) Florence M. Ziegler)

STATE OF CONNECTICUT,)
)ss. Vernon, February 13th, A.D. 1941.
County of Tolland,)

We the within named Harry H. Lugg, Mrs. Joseph Bonan and Florence M. Ziegler, all of said town of Vernon, being duly sworn, make affidavit and say: That we severally attested the within and foregoing Will of the within named testatrix and subscribed the same in her presence and at her request and in the presence of each other; that the said testatrix signed, published and declared the said instrument as and for her last Will and Testament in our presence on the 13th day of February, A.D., 1941; and at the time of execution of said will, said testatrix was more than eighteen years of age and of sound mind, memory and judgment and under no improper influence or restraint to the best of our knowledge and belief, and we make this affidavit at the request of said testatrix.

(signed) Harry H. Lugg
(signed) Mrs. Joseph Bonan
(signed) Florence M. Ziegler

STATE OF CONNECTICUT,)
)ss. Vernon, February 13th, A. D. 1941.
County of Tolland,)

Then personally appeared before me a notary public duly qualified to administer oaths Harry H. Lugg
Mrs. Joseph Bonan
and Florence M. Ziegler
and subscribed and made oath to the truth of the foregoing affidavit.

(signed) Jane Dereszewska, Notary Public

A true copy

Attest: Clerk

ECHN Proposed Asset Purchase by PMH
Submitted October 13, 2015

DISTRICT OF ELLINGTON

CODICIL TO WILL OF CAROLINE E. STEELE METCALF

I, CAROLINE E. STEELE METCALF of the Town of Vernon, County of Tolland and State of Connecticut, do hereby make this Codicil to my last Will and Testament dated the 13th day of February, 1941.

1. WHEREAS, by the Fourth Paragraph of my said Will, I gave and bequeathed "the sum of One Thousand (1000) Dollars to Arthur H. Metcalf, of the Town of Tolland in said County of Tolland, brother of my deceased husband, if living at my death", and

WHEREAS, since the execution of said Will, said Arthur H. Metcalf has passed away.

NOW I DO HEREBY REVOKE said legacy and in lieu thereof I give and bequeath the amount of said legacy, being One Thousand (1000) Dollars to the Trustees of the Methodist Church of Rockville, Connecticut, in trust, nevertheless, to hole, manage, invest and reinvest said sum, and to use the income therefrom to assist in defraying the general current expenses of said Church; and if said Church should disband, dissolve or otherwise cease to exist as such Church, then I direct said Trustees to pay said sum and the accrued and unexpended interest thereof, if any, to the Southern New England Conference of the Methodist Church, in trust, to hold, manage, invest and reinvest said sum, and to use the income therefrom for the maintenance, support, relief and care of the retired ministers or their widows of said Conference, known as "Conference Claimants". In either of said purposes, this trust shall be known as the W. A. Metcalf and Caroline E. Metcalf Fund.

2. WHEREAS, by the Fifth Paragraph of my said Will, I gave and bequeathed "the sum of One Thousand (1000) Dollars to my brother, Charles S. Steele, of Yonkers, New York, if living at my death", and

WHEREAS, since the execution of said Will, my said brother, Charles S. Steele, has passed away.

NOW I DO HEREBY REVOKE said legacy and in lieu thereof I give and bequeath the amount of said legacy, being One Thousand (1000) Dollars, as follows, to wit:

The sum of Five Hundred (500) Dollars to the ROCKVILLE CHAPTER of the AMERICAN RED CROSS, of Rockville, Connecticut;
The sum of Three Hundred (300) Dollars to the ROCKVILLE PUBLIC HEALTH NURSING ASSOCIATION, of said Rockville; and
The sum of Two Hundred (200) Dollars to the AMERICAN FOUNDATION FOR THE BLIND, Inc. of 15 West 16th Street, New York, New York.

3. I HEREBY republish and confirm my said Will in all respects except as altered by this Codicil.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal at said Vernon, this 19th day of April, A.D. 1944.

(signed) Caroline E. Steele Metcalf (L.S.)

Signed, sealed and declared to be the Codicil to her last Will and Testament dated the 13th day of February, 1941, by the said CAROLINE E. STEELE METCALF, in the presence of us, who, in her presence, and at her request, and in the presence of each other, have hereunto subscribed our names as witnesses at said Vernon, this 19th day of April, A.D. 1944.

(signed) Jane Dereszewska)
(signed) Constance Lucas)Witnesses.
(signed) Arthur A. Koss)

STATE OF CONNECTICUT)
)ss. Vernon April 19th, A.D. 1944
COUNTY OF TOLLAND)

We the within named Jane Dereszewska and Constance Lucas, both of said Vernon, and Arthur A. Koss of the Town of Stafford, Connecticut, being duly sworn, make affidavit and say: That we severally attested the within and foregoing Codicil to the last Will and Testament of the within named testatrix and subcribed the same in her presence and at her request and in the presence of each other; that the said testatrix signed, published and declared the said instrument as and for the Codicil to her last Will and Testament in our presence on the 19th day of April, A.D. 1944; and at the time of execution of said Codicil, said testatrix was more than eighteen years of age and of sound mind, memory and judgment and under no improper influence or restraint to the best of our knowledge and belief, and we make this affidavit at the request of said testatrix.

(signed) Jane Dereszewska
(signed) Constance Lucas
(signed) Arthur A. Koss

STATE OF CONNECTICUT)
)ss. Vernon April 19th, A.D. 1944
COUNTY OF TOLLAND)

Then personally appeared before me a notary public duly qualified to administer oaths.

Jane Dereszewska
Constance Lucas
and Arthur A. Koss
and subscribed and made oath to the truth of the foregoing affidavit.

(signed) Donald C. Fisk, Notary Public

A true copy

Attest: Celia M. Neff Clerk

To the Probate Court for the District of Ellington:

ANNUAL ACCOUNT of The Hartford-Connecticut Trust Company, successor to the Rockville National Bank, Adm'r. d.b.n. and Trustee of the Estate of CELIA E. PRESCOTT, late of Vernon, deceased, from Sept. 17, 1946 to Sept. 17, 1947.

Inventory, Sept. 17, 1946	General Fund	$ 2,232.36
	Annie Prescott Trust	5,000.00
		$ 7,232.36
General Fund:	Inventory, Sept. 17, 1946	$ 2,232.36
	Income on hand, Sept. 17, 1946	.13

EXHIBIT Q 11-2

Fund 11-1.55

E. Stevens Henry

2000-231

File
RGH Bequests under E. Steve Henry

FILE
30-X5570

Be it known to all persons, that I Edward Stevens Henry of the Town of Vernon, County of Tolland, and State of Connecticut being of lawful age of sound and disposing mind memory and judgment do hereby make, publish and declare this to be my last will and testament, hereby revoking all previous wills and codicils by me made.

First
I will and direct that all my just debts be promptly paid, together with funeral charges and reasonable expenses for settling my estate.

Second
I make the following personal bequests, viz. I give and bequeath to my grand daughter Lucina Ackerly Ten thousand dollars $10,000. to her absolutely

I give and bequeath my sister Abby E. Henry One thousand dollars $1000. to her absolutely

I give and bequeath my sister Esther Henry One thousand dollars $1000. to her absolutely

I give and bequeath my sister Kate Henry Gough One thousand dollars $1000. to her absolutely

I give and bequeath my sister Mattie Henry Peck One thousand dollars $1000. to her absolutely

I give and bequeath my niece, Mary L. Gough Five hundred dollars $500. to her absolutely

I give and bequeath my niece Lara Andrews Crandall Five hundred dollars $500. to her absolutely.

I give and bequeath my nephew John Stevens Dewey Five hundred dollars $500. to him absolutely

I give and bequeath my grand niece Maud E. Dewey Five hundred dollars $500. to her absolutely.

Third
I give and bequeath my sister Abby E. Henry for her use and benefit the annual sum of Six hundred Dollars $600. to be paid as hereinafter provided during and for her natural life. I likewise give and bequeath my sister Esther Henry for her use and benefit the annual sum of Six hundred dollars $600. to be paid as hereinafter provided, during and

for her natural life. Reference is made to the eleventh paragraph of this will wherein provisions are made for the payment of these two annuities-

Fourth
I give and bequeath my long time friend and faithful employee Roger J. Murphy the real estate located at the corner of Saint Bernards Terrace and Cottage Street- together with all appurtenances connected therewith. This property is bounded North by land of Dennis McCarthy- East by Cottage Street South by Middle Terrace- West by land of Estate of G. W. Ransom- To him the said Murphy his heirs and assigns forever-

Fifth
I give and bequeath to the "Rockville Public Library", a corporation organized under the laws of the State of Connecticut One thousand dollars $1000. to be added to the endowment fund of that institution

Sixth
I give and bequeath to the Town of Vernon One thousand dollars $1000. in trust- The same to be deposited in a Connecticut Savings Bank and the income only used in providing from time to time scholarship prizes for the most efficient students in the several classes of the "Rockville High School". These prizes are to be awarded by the Principal of said High School under the supervision of the Superintendent of schools in the Town of Vernon-

Seventh
I give and bequeath to the Connecticut Agricultural College One Thousand dollars $1000. to be deposited in a Connecticut Savings Bank, and the income only used in providing prizes to be awarded to the most efficient students at the discretion of the President of the College

Eighth
I give and bequeath the "Connecticut Historical Society" a corporation under the laws of the State of Connecticut Five hundred dollars $500.

Ninth
I give and bequeath to the Hospital to be established in Rockville under the provisions of the will of the late William H. Prescott to be known as the "Rockville City Hospital" This bequest is to constitute a special endowment fund of Fifty thousand dollars $50,000. to be set apart and

ECHN Proposed Asset Purchase by PMH
Submitted October 13, 2015

known as the Maud Henry fund in memory of my deceased daughter Maud. I likewise give and bequeath Fifty thousand dollars $50,000. to said Hospital also to be set apart as a separate endowment fund and known as the "Lenore Henry" fund in memory of my deceased daughter Lenore. The income of these two funds is to be used for the maintenance of said Hospital. My Executors are directed to provide for this fund by selecting and transfering from my Estate to trustees or duly authorized agent of said Hospital, certain bonds or Savings Bank deposits of the par value of One hundred thousand dollars $100,000, and I further direct that whenever reinvestments become necessary or advisable such reinvestments shall be limited and confined to securities legal for the Savings Banks of Connecticut- or in deposits in Savings Banks

Tenth

I give devise and bequeath to Fayette Lodge No 69 Free and Accepted Masons of Rockville, certain real estate located on Park Street, Rockville- Bounded and described as follows. North by land of Estate of William H. Prescott-West by land of the Town of Vernon - South by a line two feet north of the north line of Henry Building- and East by Park Street- to said Fayette Lodge its successors and assigns forever

Eleventh

I give and bequeath to the Town of Vernon its successors and assigns forever the real estate known as the "Henry Building" said real estate being bounded North by land devised in the foregoing paragraph to Fayette Lodge No 69, Free and Accepted Masons-East by Park Street- South by Park Place and West by land of the Town of Vernon, this devise and bequest is however made upon the express conditions and stipulations that the net income derived from the rentals of said Henry Building shall after strict compliance with the conditions and reservations hereinafter stated be applied and used for the care, maintenance, improvement and enlargement, of Grove Hill Cemetery in said Vernon and for no other purpose except as hereinafter stated and under said conditions and reservations said property shall be under the supervision and control of legally appointed Agents of said Town of Vernon. This devise is further made subject to the follow-

ing conditions and stipulations and shall not become effective until and unless all of these stated conditions and reservations are accepted and approved by the legal voters of the Town of Vernon, at a meeting duly warned and held for that stated purpose. Wherein the Town of Vernon shall explicitly accept all of the conditions of this devise and authorize the payment of the several annuities hereinbefore stated in the third paragraph of this will- viz An annuity of Six hundred dollars $600. to be paid my sister Abby E. Henry during and for the period of her natural life- Also an annuity of $600. Six hundred dollars to be paid my sister Esther Henry during and for the period of her natural life. It is further stipulated that the Treasurer of the Town of Vernon shall be authorized and directed by a vote of said town to pay each of aforesaid legatees Abby E. Henry and Esther Henry the sum of three hundred dollars $300. Semi-annually on demand of my sisters so that each shall receive her annuity as before conditioned. It is further provided that after the death of either of my before named sisters her annuity shall cease but that the surviving sister shall continue to receive an annuity of Six hundred dollars as hereinbefore provided.

Twelfth

I give devise and bequeath, thirty thousand dollars $30,000. for the construction of a Mortuary Chapel, to be located at or near the west entrance of Grove Hill Cemetery said Mortuary Chapel is to be erected under the supervision of my Executors upon a site approved by them and when completed is to become the property of the Town of Vernon- This said Mortuary Chapel is to be known as the "Lucina Memorial". It is further provided that a part of this bequest not exceeding Five thousand dollars $5000. may at the discretion of my Executors be used for the construction of a gateway at the west entrance of said Cemetery- and, when completed shall likewise become the property of the Town of Vernon- The material used in the construction of both Mortuary Chapel and gateway the selection of a competent architect and the approval of said architect's design, the lettering of contracts for construction, supervision and payments for

construction, shall rest entirely with my Executors-

Thirteenth

I give, devise and bequeath to the City of Rockville a certain tract of land located on Fox Hill in said Rockville, for public use as a Park and pleasure grounds or as sites for strictly public buildings and grounds connected therewith, jointly, and severally, one or both. These lands are more accurately described in a Warranty deed to me given by Sophronia and Clara Simons dated the 8th day of January, A.D. 1891, and recorded in Vernon Records of Lands Vol 29 Page 445. I further include in this devise and subject to the same conditions all other lands owned by me adjacent to and situated South and West of the first named tract. These additional lands are situated North of South Street and of lands of sundry owners and West by High Street and lands of sundry owners. No part of the lands so devised to said City of Rockville are to be sold or used for other than public purposes.

I also give and bequeath to said City of Rockville Twenty five thousand dollars- $25000. to be expended in improving the aforesaid lands after a competent landscape architect has made definite plans and sketches for thorough and comprehensive work- especially having in view a suitable location for the proposed Rockville City Hospital hereinbefore referred to in this will. This gift or devise is not to become effective until accepted and authorized by a legally called meeting of the voters of the City of Rockville

Fourteenth

I give and bequeath One hundred thousand dollars- $100000- to constitute a Trust Fund to be set apart and in custody of the "Security Trust Company" of Hartford or in some other Connecticut Trust Company to be determined by Executors. The net income of said trust fund shall if my wife survives me be paid to my said wife Lucina E. Henry in quarterly instalments so long as she lives, other clauses herein notwithstanding. If my said wife does not survive me then upon my death, and if she does survive me then upon her death, this trust fund shall thereupon accumulate, if my grand daughter Lucina Ackerly, is then living until she attains the age of twenty five years

and then and thereafter the original fund and its accumulations up to the time she attains the age of twenty five years shall be deemed to be the principal of said trust fund, the net income of said principal after said Lucina Ackerly attains the age of twenty five years, as aforesaid shall be paid to my said grandaughter Lucina Ackerly in quarterly installments, for and during the period of her natural life. Upon the death of said Lucina Ackerly the entire principal fund then remaining I give, devise and bequeath to the Rockville City Hospital hereinbefore referred to, and the same shall thereupon become part of the endowment fund of that institution, absolutely and forever, it being my intention and will that said Rockville City Hospital shall have and possess all the rest residue and remainder of the said trust fund and the principal aforesaid to it absolutely and forever

Fifteenth

The rest residue and remainder of my estate both real and personal of whatever description and wherever found I devise give and bequeath to my well loved wife Lucina E. Henry to her and her heirs and assigns absolutely and forever, and I constitute my said wife residuary legatee in case any of the before mentioned devises and bequests should fail or are not accepted as conditioned and stipulated.

Sixteenth

I direct that all succession, inheritance and transfer taxes which would be payable on account of the legacies other than residuary legacies hereinbefore given, shall be paid out of the residue of my estate, so that said several legacies shall be net for their full amounts, to the said several legatees.

Seventeenth

I constitute and appoint my wife Lucina E. Henry my Executrix together with my personal friends John E. Fisk and George W. Randall both of Rockville, as Executors of this my last will and testament. I also direct that bonds are not to be required of the aforesaid Executors. My Executors are to be allowed reasonable time to carry out the several provisions of my will in paying the several legacies and bequests hereinbefore mentioned. I however urge that my estate be settled as promptly as possible without unnecessary loss to my Estate or undue injury to any

ECHN Proposed Asset Purchase by PMH
Submitted October 13, 2015

beneficiary-

Eighteenth

I will and direct that should any of the provisions herein made fail or be held void invalid or inefectual for any reason whatever then it is my will that no other provisions of this testament be affected or invalidated but that the remaining provisions shall be construed as if such invalid provisions or conditions were not herein contained-

In Witness Whereof I have hereunto set my hand and seal at said town of Vernon on the twenty second day of April A.D. One thousand nine hundred and fourteen.

Edward Stevens Henry (L.S.)

Signed sealed published and declared by the said Edward Stevens Henry as and for his Last Will and Testament in the presence of us who at his request in his presence and in the presence of each other have hereunto subscribed our names as witnesses on the 22nd day of April A.D.1914

Henry L. Nobbe
Joseph M. Donovan
Dennis J. McCarthy

BE IT KNOWN TO ALL PERSONS, That I, E. Stevens Henry of the town of Vernon, County of Tolland, State of Connecticut, being of lawful age, of sound and disposing mind, memory and judgment, do hereby make, publish and declare this to be a codicil to my last will and testament bearing date of April 28, 1914.

WHEREAS, since the execution of said will I have become desirous of changing paragraph tenth of said will wherein it devised certain lands to Fayette Lodge No. 69, Free and Accepted Masons of Rockville,-

NOW, THEREFORE, I hereby revoke and cancel, declare null and void, said devise and paragraph, and in lieu thereof I give, devise and bequeath as follows, to wit:

10 A. I give, devise and bequeath to Fayette Lodge No. 69, Free and Accepted Masons of Rockville, Connecticut, the sum of THREE THOUSAND DOLLARS for the uses and purposes of said lodge, to it and to its successors and assigns, absolutely and forever.

10 B. I give, devise and bequeath to the People's Savings Bank of said Rockville, a legal corporation, organized and existing under the laws of the State of Connecticut, having an office and principal place of business in said Rockville, and to its successors and assigns, absolutely and forever, certain real estate situate on Park Street in said Rockville, bounded northerly by land of the estate of William H. Prescott; easterly by Park Street; westerly by land of the town of Vernon; southerly by a straight line out twenty-seven inches northerly of the face of the brick on the north side of the Henry Building, so called, said line to be reckoned as if no chimney or other projection were on the north side of said Henry Building; but, other clauses herein notwithstanding, said gift, bequest and devise to said bank is made subject to the following conditions and requirements, to wit:

That said bank shall, within a reasonable time after my death, pay to my estate the sum of three thousand dollars to be in the nature of a purchase price, for which price a deed from my estate of said real

estate shall be given to said bank, its successors and assigns, which deed shall be conditioned that said real estate shall revert to my estate in case said bank fails to cause to be erected, within five years from the time of my decease, a building on said land, the whole or a part of said building to be for the use and occupancy of said bank; all rents for said real estate shall belong to my estate up to and until said deed shall be given; and I hereby authorize and empower my executors in behalf of my estate to make, execute and deliver said deed in manner aforesaid.

All other paragraphs in my said will shall remain in full force and effect, and I hereby republish and confirm my said will, except as aforesaid.

IN WITNESS WHEREOF I have hereunto set my hand and seal at said Rockville, on the 3rd. day of March, A.D., 1920.

E. Stevens Henry (L.S.)

SIGNED, sealed, published and declared by the said E. Stevens Henry as and for the codicil to his last will and testament, in presence of us who at his request, in his presence and in the presence of each other have hereunto subscribed our names as witnesses, on the 3rd day of March, A.D. 1920.

Thomas F. Garvan
William A. Howell } WITNESSES.
Roger J. Murphy

EXHIBIT Q 11-2

Fund 11-1.56

Trumbull Chapter DAR

WHEREAS, under the provisions of Section 2, Article IX of the By-laws of Sabra Trumbull Chapter, D.A.R. the Advisory Board of the Sabra Trumbull Chapter is given the power to manage all business connected with the Free Bed Fund given by the Chapter to the Rockville City Hospital, Inc., and

WHEREAS, the records of said Chapter, as well as the records of said Advisory Board, do not disclose that any definite regulations have been decided upon or adopted concerning the use of a free bed at said Hospital other than preference to a Daughter and limiting the expenditures to income from said fund.

NOW, THEREFORE, at a meeting of the Advisory Board of the Sabra Trumbull Chapter held on December 4 1954, the following regulations were adopted concerning the expenditures of the income of the Free Bed Fund established with the Rockville City Hospital, Inc.:

(1) The income from said Fund was established for the benefit of Sabra Trumbull Daughters who shall always have preference in its use.

(2) Payments of a portion or the whole of approved applicants' bills from said income shall be made to the Rockville City Hospital only on the first of the months of January, April, July and October of each year.

(3) If the income of any quarter is insufficient to pay the bill or bills incurred by approved applicants during the quarter for which the income was derived, then the income is to be prorated against the total indebtedness for the quarter.

(4) In the event that on January first of each year there remains an unexpended balance of the income from said fund, the

Advisory Board may if it so decides used the whole thereof or any part thereof in reimbursing Daughters for any portion or the whole of the balance it became necessary for them to pay or incur for a hospital bed at the Rockville City Hospital not previously paid from the income of the Fund by reason of inadequate income during any quarter.

(5) If on January first of each year it is found that the income from the calendar year just elapsed exceeds the expenditures and obligations incurred then in that event the Advisory Board may use the unexpended balance or a portion thereof in paying bills owing for a bed in said hospital by deserving and needy people or they may reimburse such deserving and needy people for a portion or the whole of a bill for a bed in the Rockville City Hospital that they have paid.

(6) Whatever income that is not used in any calendar year shall be applied to the principal of said Fund.

(7) These regulations are to become effective on January 1st, 1955.

ROCKVILLE CITY HOSPITAL

Trumbull Chapter DAR Fund

List of Investments

3,000 U. S. A. Sav. Bd. G, Reg. 2 1/2%, April 1956	$3,000.00
40 sh. Travelers Insurance Co. at 2265,$8,290-(Bk.Value)	90,600.00
Rockville Savings Bank	4,614.80
	$ 98,214.80

Statement of Income Account

Receipts

9/30/54	Balance on Hand	$ 1,876.43
3/14/55	40 shs. Travelers Insurance Co.	140.00
4/1/55	$3,000 U.S.A. Sav. Bd. G, Reg. 2½%,April 1956	37.50
4/11/55	Rockville Savings Bank	57.68
		$ 2,111.61

Disbursements

12/2/54	Rockville City Hosp.,Bd. & care of member from October 3 to October 30th	405.00
12/29/54	The Connecticut Bank & Trust Co.,Rockville Office credit account Rockville City Hosp. for distribution as directed by Trumbull Chapter DAR.	1,471.43
4/30/55	Balance on hand	235.18
		$ 2,111.61

Mrs. Donald C. Fisk
Ellington Avenue
Rockville, Connecticut

May 29, 1962

Board of Trustees
Rockville City Hospital
Rockville, Connecticut

Gentlemen:

As you know the Sabra Trumbull Chapter, D.A.R., has been formally disbanded.

As a result of this action there are two matters which concern the Rockville City Hospital. The first is the permanent endowment for a "free bed" fund. I understand, from Mr. Joseph McMannus, that the Connecticut Bank and Trust Company, the fiduciary of this fund, knows of the dissolution of the Sabra Trumbull Chapter and that the bank will continue to maintain the fund with the discretion in you, as trustees, to choose beneficiaries. The former members of the Sabra Trumbull Chapter will appreciate any preference which you may choose to give to them or to other D.A.R. members as beneficiaries of this fund.

The second matter of which you are advised is that under section 39 of the will of Celia E. Prescott, late of Rockville, the trustees of the Hospital are the

remaindermen of a one thousand dollar ($1,000) bequest. Therefore, I enclose herewith bank book no. 40260 of the Savings Bank of Rockville evidencing a deposit in that amount which now belongs to the trustees of the hospital subject to the trust provision set forth in the copy of section 39 of Mrs. Prescott's will which is appended to the bank book.

Very truly yours,

Mrs. Donald C. Fisk

ILLE, CONN.

THOMAS S. CHILDS
MARTIN LAUBSCHER

COPY OF SECTION 39 OF THE WILL OF THE LATE CELIA E. PRESCOTT, DATED JUNE 13, 1917.

39. --I give to Sabra Trumbull Chapter of the Daughters of the American Revolution of Rockville, Connecticut, the sum of One Thousand (1,000.) Dollars, in trust the income thereof to be devoted to general benevolent work, preferably to be exercised within the limits of the city of Rockville; provided, however that if for any cause said chapter of the Daughters of the American Revolution should disband or be dissolved, then, and in that event, I give said principal sum of One Thousand (1,000.) Dollars, to the trustees of the proposed general Hospital for the sick of Rockville, hereinbefore referred to, in perpetual trust, the income thereof to be used and appropriated for the support and maintenande of said institution.

: Laws of the State of Connecticut.

Balance on hand May 1, 1954	2519	70
Receipts	1082	91
Total	3602	61
Disbursements	1080	28
Balance on hand May 1, 1955	2522	33

Chapter Funds

Celia E. Prescott Fund	1036	66
Continental Congress Delegate Fund	1053	61
Connecticut Bank and Trust Co.	430	06
	2522	33

Mrs. Arce C. Peterson Treas.

Accounts audited and found correct.
May 6, 1955
Catherine D. Moran, Auditor

EXHIBIT Q 11-2

Fund 11-1.57

Celia E. Prescott Fund

DISTRICT OF ELLINGTON

(Continued from Page 537)

on said 13 day of June A. D. 1917; that she was at the time of signing said instrument more than 16 years of age and of sound mind; and that each of said witnesses signed said instrument so subscribed by said Celia E. Prescott, at her request, in presence, and in the presence of each other.

Charles Phelps.

Subscribed and sworn to the day and year first above written in open court before me.

John E. Fahey, Judge.

A true copy Attest: W. P. Kennard

Know all Men by these Presents, That I, Celia E. Prescott, of the city of Rockville County of Tolland and State of Connecticut, being of sound and disposing mind and do make and publish this my last will and testament, hereby revoking all previous and codicils by me made.

I give, devise and bequeath my property and estate, both real and personal, manner following, namely:

1. I direct that all of my just debts be paid by my executors hereinafter

2. I give to the town of Vernon, in perpetual trust, the sum of Five Hundred (500.) Dollars, directing that the income and avails thereof be used annually for the care and maintenance of my family burial lot in Grove Hill Cemetery at Rockville; further directing that, if in the judgment of the caretaker of said cemetery all of said income in a given year be not needed for such service then that portion of said income not used or needed therefor may be applied by him for the general care and maintenance said cemetery.

3. I give to my daughter, Eliza Prescott Childs, wife of Thomas Southworth Childs of Holyoke, Massachusetts, the sum of Two Thousand (2,000) Dollars in cash, to disposed of by her in accordance with special written directions now in her possession

4. I also give to my said daughter, Eliza Prescott Childs,, the following articles of personal property, absolutely;

picture of "Castle Rock" by A. F. Richards,
Picture of Francis Keeney by C. E. Prescott,
picture of Apples and Grapes by C. E. Prescott,
picture of Red and White Roses, by C. E. Porter,
picture of California Mountain, by McBirney,
one large rug in parlor,
one large and small Kerman rug in Aunt Jane's room,
one grey California rug,
all jewelry and personal ornaments not otherwise disposed of,
all articles of personal wearing apparel,
the large solid silver tea tray,
all furniture and furnishings in the Cabin, so called, situated on Shipsic Lake,
all of my bedding, mattresses, linen, table linen, laces, one pair of And-irons, formerly belonging to my mother.
one Minton white and gold dinner set.
one dozen green and gold plates,
one-half dozen painted place plates
one large blue and gold vase, (Col.ort)
one vase in cabinet, Girl with the Wheat,
Ivory minature of myself,

together with all articles of personal property remaining in my house and not otherwise disposed of.

5. I give to my son-in-law, Thomas Southworth Childs of Holyoke, Massachusetts, the use and income of the sum of Five Thousand (5,000) Dollars, lawful money of the United States, for and during the period of his natural life. At his death I give said principal sum of Five Thousand (5,000) Dollars to the trustees of the Rockville City Hospital, in trust, for the benefit of said hospital, that the same may be added to the endowment fund provided for in the will of my late husband, William H. Prescott, for the purpose of establishing and maintaining said proposed hospital.

I also give to the said Thomas Southworth Childs the sum of One Thousand (1,000) Dollars, lawful money of the United States, also my horse, harness, carriages,

DISTRICT OF ELLINGTON

ntinued from Page 638)

igh, saddle, blankets and stable equipment; also one small picture entitled rning News" by Mueller, absolutely.

6. I give to Prescott Childs, son of Thomas Southworth Childs of Holyoke, achusetts, the following articles of personal property, absolutely;
the tall clock on the stairs at my home,
small antique table purchased by me at Lakeville,
large vase with painting of girl on parlor mantel;
large rug in front chamber;
engraving of Evangeline and Father;
painting entitled "The Young Mother" by Franz Charles;
large painting of Peonies by C. E. Porter;
small portrait of William H. Prescott by Hoffman;
painting of Apples, by C. E. Prescott,
"Sheep"by Taits;
Prescott and Pitkin Genealogies;
Washington Irving's Works, fifteen (15) volumes;
one opal and diamond stick pin;
one small diamond ring, single stone, the first one given to me by my late husband;
Loving Cup presented to my late husband by the Rockville Golf Club.

7. I give to Benjamin Willis Childs, son of Thomas Southworth Childs of Holyoke, achusetts, the following articles of personal property, absolutely;
one mahogany carved easel;
one mahogany cabinet in parlor;
one mahogany chair with slender arms and legs;
one Blue Tiffany Vase;
one Florentine plaque and pitcher to match;
one oblong carved mahogany table;
one dozen china plates with design of pinks;
one half dozen souvernier tea spoons;
picture--"Old Man" by Rider;
picture, "Snipsic Lake" by C. E. Prescott;
copy of Titian's Flora;
small picture of cows;
works of Rudyard Kipling
Illustrated Bible in three or four volumes;
"Old Cottage Bible" formerly belonging to Francis Kesney;
my engagement ring (small cluster);
short gold chain with bar;
picture by Percival D. Luce;
Vase Queen Louise;
one dozen silver coffee cups and saucers.

8. I give to Thomas Southworth Childs, Jr., son of Thomas Southworth Childs of lyoke, Massachusetts, the following articles of personal property; absolutely;
all of the furniture in the frontchamber at my residence, excepting the rugs and pictures otherwise disposed of;
one dozen English China plates-- colored border;
one-half dozen silver spoons (Souvenier);
picture- "Dutch Mother and Baby" in library;
picture- "Old House" by Paine;
picture- "Morning Glories" by C. E. Prescott;
Crayon of "Lake George";
Works of Oliver Wendell Holmes, fifteen (15 Volumes)
Bible given by the late J. N. Stickney to William H. Prescott;
one cluster diamond pin;
one plain gold ring;
one silver ice cream set.

9. I give to Annie R. Prescott, widow of my son, the late Francis Kesney Prestt, the use and income of the sum of Five Thousand (5,000) Dollars, lawful money of e United States, for and during the period of her natural life. At her death I give id principal sum of Five Thousand (5,000) Dollars to the trustees of the Rockville ty Hospital, in trust, for the benefit of said hospital, the same to be added to the dowment fund provided for in the will of my late husband, William H. Prescott, for e purpose of establishing and maintaining said proposed hospital.
I give to said Annie R. Prescott the sum of One Thousand (1,000) Dollars, absoteiy; also the following articles of personal property, absolutely;
picture of Girl with Oranges, painted by C. E. Prescott;
old fashioned plated silver service;
rugs in chamber over dining room.

(Continued from Page 539)

10. I give to my grandson, William Henry Prescott of Rockville, Connecticut, the following articles of personal property, absolutely;
the clock in room over dining room;
mahogany desk and four chairs matching the same, in library;
large easy chair and small table;
one octagonal table in library;
large Persian rug;
small rug;
bronze horse;
ivory minature of William H. Prescott;
cut glass lamp and shade given me by my late son;
Francis Keeney Prescott;
"Marine Picture", by Tyler;
engraving, "Washington Irving and his Friends;"
"Spirit of '76", by C. E. Prescott
"Italian Girl" by Rompiani;
"Snipe" by Alexander Pope;
Stoddards Lectures complete;
"Men of Mark in Connecticut,";
The World's Best Literature;
one single stone diamond ring, (the best one)
one silver pitcher market W. H. P.
one dozen silver tea spoons (Souvernier)

11. I give to my granddaughter, Celia Keeney Prescott of Rockville, Connecticut, the following articles of personal property, absolutely;
one Baby Grand Piano with bench and chair;
dark blue and gold plates, cups and saucers in mahogany cabinet)
solid silver tea service without tray;
two teaspoons marked E. Porter;
one solid silver vase presented me by Sabra Trumbull Chapter, D.A.R.;
one-half of the solid silver flat or table pieces.grape design, marked C.E.P;
one small tea table in dining room;
one dozen plates, Thistle pattern;
one Marine picture by Britcher;
one picture, "Cherries" by C. E. Porter;
Litary Works of George Elliott;
one Sapphire and diamond ring;
Chinese rug in upper hall;
one Japanese bowl

12. I give to my granddaughter, Lucy Marin Prescott, of Rockville, Connecticut, the following articles of personal property, absolutely;
picture of Tambouring Girl;
the red and brown rug in lower front hall of my residence;
all of the furniture in library chamber;
picture "Marigold and Zinnea" by C. E. Prescott;
picture, Girl gathering Lilies, etching;
picture, "An English Street" by Waters;
picture, "Bowl of Strawberries" by C. E. Porter;
one-half of the flat or table silver ware, grape design, marked C. E. P.
two silver candle sticks, formerly given me by Lucy E. Prescott, of Holyoke;
silver mustard pot, formerly given me by Lucy E. Prescott, of Holyoke;
set of Russian plates, cups and saucers;
Young folks Library, composed of twelve (12) volumes;
one opal and diamond ring;
one cut glass ice cream dish with twelve cut glass sauce dishes;
mahogany table situated in third story front room of my residence.
Sheffield platters marked C. E. P.

13. I give to my granddaughter, Georgiana Lincoln Prescott, of Rockville, Connecticut, the following articles of personal property, absolutely;
two small rugs in parlor at my residence;
one silver plated tray marked C. E. P.
one tea pot, cream and sugar bowl,-- (Gorham ware)
Royal Worcester, ice cream set, platter and twelve square plates, (yellow and white);
one brass bed stead and bedding;
picture by Verplank Birney;
engraving of "Queen Louise";
small oil picture in upper hall;
twelve books from my library from those not otherwise disposed of, to be selected by my daughter, Eliza Prescott Childs;

ECHN Proposed Asset Purchase by PMH
Submitted October 13, 2015

DISTRICT OF ELLINGTON

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gold watch given me by my daughter
long heavy gold chain;
small amethyst seel ring;
onyx pin set with two small diamonds;
gilt clock and ornaments to match;
one large chop plate and one dozen small plates to match.

14. I give to each of my grandchildren, William H. Prescott, Celia Keeney escott, Lucy Martin Prescott and Georgiana Lincoln Prescott, children of my late n, Francis Keeney Prescott, of Rockville, Connecticut, and to Prescott Childs, Ben- in Willis Childs, and Thomas Southworth Childs, Jr., children of Thomas Southworth ilds of Holyoke, Massachusetts, each the sum of Five Hundred (500) Dollars, absolutely be paid by my executors hereinafter named, to each individual child when such child ll have reached the age of twenty years.

15. I give to my brother, Frank Keeney of Rockville, Connecticut, the use and ome of Five Thousand (5,000) Dollars, for and during the period of his natural life. his death I give said principal sum of Five Thousand (5,000.) Dollars to the trus- s of the Rockville City Hospital, in trust, to be added to the endowment fund pro- ed for in the will of my late husband, William H. Prescott, for the purpose of es- lishing and maintaining said proposed hospital.

I also give to said Frank Keeney, the portraits of my father and mother, Francis Eliza Porter Keeney, painted by G. A. Hoffman.

16. I give to Emma B. Keeney, wife of said Frank B. Keeney, the sum of Two ndred (200.) Dollars, absolutely.

17. I give to Clara Cole Keeney, widow of my late brother Edgar Keeney, the of Two Hundred (200.) Dollars, absolutely.

18. I give to Ernest A. Keeney, and Bertha Dean Keeney, his wife of Burnside, nnecticut, each the sum of Five Hundred (500.) Dollars, absolutely.

19. I give to Gladys C. Keeney, daughter of Frank Keeney of Rockville, Connec- ut, the sum of Five Hundred (500.) Dollars, absolutely.

20. I give to John T. Henderson and Maud T. Henderson, his wife, of Hartford, nnecticut, each the sum of Five Hundred (500.) Dollars, absolutely.

21. I give to Louis Keeney Newcomb and Zella Newcomb, his wife, of Providence, de Island, each the sum of Five Hundred, (500.) Dollars, absolutely.

22. I give to Joseph Parsons Prescott of Holyoke, Massachusetts, the sum of Hundred (200.) Dollars, absolutely.

23. I give the sum of Two Hundred (200.) Dollars, absolutely to each of the llowing named persons; to wit, Charles A. Clark and Katherine Clark, his wife; escott, Katherine, Virginia and Joseph, their children, of Northampton, Massachusetts

24. I give to Fanny Prescott Blake of Springfield, Massachusetts, the sum of ree Hundred (300.) Dollars, absolutely.

25. I give to James Harvey Porter and his wife of Wilmington, California, each e sum of Two Hundred and Fifty (250.) Dollars, absolutely.

26. I give to Mrs. Alice Russell of South Manchester, Connecticut, the sum of ree Hundred (300.) Dollars, absolutely.

27. I give to William J. Remig, and his wife, Alice Russell Remig of South nchester, Connecticut, each the sum of One Hundred (100.) Dollars, absolutely.

28. I give to Martin Laubacher of Rockville, Connecticut, the sum of Five Hun- ed (500.) Dollars, absolutely.

29. I give to Robert Blackmore of Rockville, Connecticut, now in my emply, the of One Thousand (1,000) Dollars, absolutely.

30. I give to Katherine Houlihan, now in my employ, the sum of Eight Hundred 0.) Dollars, absolutely.

31. I give to Clara Mueller, now in my domestic employ, the sum of Five Hundred 0.) Dollars, absolutely.

(Continued from Page 541)

32. I give to P. J. Donegan, the sum of Four Hundred (400.) Dollars, absolutely.

33. I give to Edwin C. Butler, of Rockville, Connecticut, and to Thomas Hopworth Childs of Holyoke, Massachusetts, and to Martin Laubscher of Rockville, Connecticut, trustees, the sum of Twenty-Eight Thousand (28,000) Dollars, in trust, for the following purpose, namely; to set apart as a separate fund and to hold, invest and reinvest, as occasion may require, for the benefit of all of my grandchildren hereinafter named, being the children of my late son, Francis Keeney Prescott and of my daughter Eliza Porter Childs,

And I order and direct that the income, profits and avails of said trust fund be used and expended by said trustees for the education and improvement of my said grandchildren, or the survivors of them, each and all, that they may be instructed in those general branches most essential to good citizenship.

And I further authorize and empower the said trustees to use and employ such part of the principal of this trust fund as they, in their wise judgment may deem advisable, if the same, or any part thereof, be needed for the better care and education of said grandchildren; or the survivors of them: the principal sum, however, or any part thereof is to be used only in case that the income proves insufficient in the judgment of the trustees for the purposes indicated in this paragraph. And I further order and direct that when my oldest surviving grandchild reaches the age of twenty-three years the trustees above named shall pay to such grandchild that proportionate amount of the principal sum then remaining which would be equal to that portion which such child would be entitled to receive in an equal division at that time of the principal sum among those grandchildren then surviving.

And I further direct that each child in succession as it reaches the age of twenty-three years shall receive that proportionate amount of the trust fund then remaining as such child would be entitled to receive in an equal division of the fund if then distributed.

34. I give to the trustees of the said Rockville City Hospital for the benefit of the same, the sum of Ten Thousand (10,000.) Dollars, for the establishment of a free bed in honor of my late father and mother, Francis and Eliza Porter Keeney, and I request that in the use of the same preference be given, if occasion arises, to any of the descendants of the Keeney family.

I also give to the trustees of said Hospital for the benefit of the same, the large oil portrait of my husband, the late William H. Prescott, painted by Child of New York.

I also give to the trustees of the said hospital, for the benefit of the same, the sum of Five Thousand (5,000.) Dollars, for the establishment of a free bed in loving memory of my late son, Francis Keeney Prescott.

I also give to the trustees of said Hospital, for the benefit of the same, the sum of Four Hundred (400.) Dollars, for the furnishing of a room in said proposed Hospital in memory of my sister, the late Jane E. Newcomb.

35. I give to the "Boone Orphanage" so called, a charitable institution for neglected children, located in the town of Long Meadow, Massachusetts, the sum of Five Hundred (500.) Dollars, absolutely.

36. I give to the trustees of the George Sykes Manual Training School, an institution for manual training provided for by the will of the late George Sykes, and to be established in the city of Rockville, the sum of Five Thousand (5,000.) Dollars, in perpetual trust, the income thereof to be appropriated by the said trustees and their successors for the purpose establishing a free scholarship in said institution on such terms and under such conditions as they may deem in their judgment most advisable; with the alternative, however, that if the conditions upon which said school are established render such free scholarship in their judgment unnecessary or inadvisable, then said trustees may apply and appropriate the income of said fund for such other purpose or purposes connected with the management of said school as they, the said trustees may deem advisable.

37. I give to the "Union Ecclesiastical Society" of Rockville, Connecticut, the sum of One Thousand (1,000) Dollars in perpetual trust, the income thereof to be applied by the proper officers of said society to the relief and needs of the poor of the parish of said Ecclesiastical Society.

38. I give to the "Rockville Public Library" of Rockville, Connecticut, the sum of One Thousand (1,000) Dollars, in perpetual trust, the income thereof to be expended by the proper officers of said Library in such manner, and for such purposes as they may deem advisable.

DISTRICT OF ELLINGTON

(Continued from Page 642)

39. I give to Sabra Trumbull Chapter of the Daughters of the American Revolution of Rockville, Connecticut, the sum of One Thousand (1,000.) Dollars, in trust, the income thereof to be devoted to general benevolent work, preferably to be exercised within the limits of the city of Rockville; provided, however that if for any cause said Chapter of the Daughters of the American Revolution should disband or be dissolved, then, and in that event, I give said principal sum of One Thousand (1,000.) Dollars, to the trustees of the proposed general Hospital for the sick of Rockville, hereinbefore referred to, in perpetual trust, the income thereof to be used and appropriated for the support and maintenance of said institution.

40. I give to the Visiting Nurse Association of Rockville, Connecticut, the sum of One Thousand (1,000.) Dollars, absolutely.

41. All of the rest and residue of my property and estate, both real and personal, of whatsoever kind and wherever found, including any and all legacies that may lapse or for any reason fail to take effect, I give, devise and bequeath to my daughter, Eliza Prescott Childs, wife of Thomas Southworth Childs of Holyoke, Massachusetts, and to the children of my son, the late Francis Keeney Prescott, namely;- William H. Prescott, Celia Keeney Prescott, Lucy Martin Prescott and Georgiana Lincoln Prescott; intending hereby to give to my said daughter, one-half of said residuum absolutely, and to said grand children one-half, who are to share and share alike, absolutely.

In the event of the decease of any of said grandchildren, being the children of my son , the late Francis Keeney Prescott, and leaving issue at the time of said distribution, I then direct that such issue shall take the parents share.

I herein Constitute and Appoint Edwin G. Butler of Rockville, Connecticut, Thomas Southworth Childs of Holyoke, Massachusetts, and Martin Laubscher of Rockville, Connecticut, Executors of this my Last Will and Testament.

In Witness Whereof I have hereunto set my hand and seal at said Rockville, on the thirteenth day of June A. D. One Thousand Nine Hundred and Seventeen.

Celia E. Prescott (L.S.)

Signed, sealed, published and declared by the said Celia E. Prescott as, and for her last will and testament, in presence of us who at her request, in her presence and in the presence of each other have hereunto subscribed our names as witnesses on the 13th day of June A. D. 1917.

Charles Phelps)
Thomas F. Moone) Witnesses.
Lane I. Hein)

A true copy Attest: M P Leonard Clerk.

To the Probate Court for the District of Ellington.

Estate of Lizzie Schrier late of Vernon, in said District, deceased.

The subscriber represents that Lizzie Schrier last dwelt in the town of Vernon in said District, and died on the 29th day of November A. D. 1917, possessed of goods and estate remaining to be administered, leaving as her only heirs-at-law, and next of kin, the persons whose names, residences, and relationship to the deceased are as follows, viz:

Names	Residences	Relationship
Elizabeth Fox,	Oregon City, Oregon	Sister
John H. Yost,	Rockville, Conn.	Nephew
Fred " Yost	" "	"
Lizzie Yost	" "	Niece
Bertha Kramer	" "	"
William H. Yost	" "	Nephew
Stella Kibbe	Ellington, "	Niece
Lizzie Carroll	Rockville, "	"
Bertha Haun	Hartford, "	"
Emma Womette	Hyde Park, Mass.	"
Katie Austin	West Springfield, Mass	"

EXHIBIT Q 11-2

Fund 11-1.58

Charles Phelps
Free Bed Fund

ROCKVILLE CITY HOSPITAL

Source and Terms of Funds Held

Alvah N. Belding Fund #73041 - Bequest u/w Alvah N. Belding - Permanent Endowment - Income for general purposes.

Terms of Will - "To be used and expended for the purposes indicated in the Will of William H. Prescott, as they may deem most advisable."

Alice Farmer Bissell Fund #73051 - Bequest under the Will of Arthur T. Bissell - Permanent Endowment - Income for general purposes.

Terms of Will - Fourth: I give and bequeath to the Rockville City Hospital the sum of Twenty-five Thousand Dollars ($25,000) to be kept as a permanent fund in memory of my wife, Alice Farmer Bissell, and to be known as the Alice Farmer Bissell Fund. The net income from said fund shall be used and applied for the general purposes of said Hospital.

Ruth T. Britton Fund #73061 - Bequest u/w Ruth Talcott Britton - Permanent Endowment - Income for general purposes.

Terms of Will - "in trust to keep said sum safely invested, and to use and apply the income for the general purposes of said Hospital at the discretion of its trustees."

Consolidated Fund #73081 - This fund represents all bequests of $3,000 or less left with no instructions as to use. Principal is considered permanent endowment - Income is used for general expenses of the Hospital.

George S. Deane Fund #73101 - No record found of source of this fund. Principal is considered permanent endowment - all income is used for expenses of the Hospital.

General Fund #73121 - This fund represents small gifts and bequests which were unrestricted as to use of principal or income. Principal is considered unrestricted - Income is used for general expenses of the Hospital.

Lenore Henry Fund #73141 - Bequest u/w E. Stevens Henry - Permanent endowment - Income for general purposes.

Terms of Will - Ninth: I give and bequeath to the Hospital to be established in Rockville under the provisions of the Will of the late William H. Prescott to be known as the "Rockville City Hospital." This bequest is to constitute a special endowment fund of Fifty Thousand Dollars ($50,000) to be set apart and known as the Maud Henry Fund in memory of my deceased daughter, Maud. I likewise give and bequeath Fifty Thousand Dollars ($50,000) to said Hospital also to be set apart as a separate endowment fund and known as the "Lenore Henry" Fund in memory of my deceased daughter, Lenore. The income of these two funds is to be used for the maintenance of said Hospital. My Executors are directed to provide for this fund by selecting and transferring from my estate to trustees or duly authorized agent of said Hospital certain bonds or savings bank deposits of the par value of One Hundred Thousand Dollars ($100,000), and I further direct that whenever reinvestments become necessary or advisable such reinvestments shall be limited and confined to securities legal for savings banks of Connecticut or in deposits in savings banks.

Maud Henry Fund #73161 - Bequest u/w E. Stevens Henry - Permanent endowment - Income for general purposes. (For terms of will, see Lenore Henry Fund)

J. Alice Maxwell Fund #73171 - Bequest u/w J. Alice Maxwell - Permanent endowment - Income for general purposes.

> Terms of Will - NINTH: To ROCKVILLE CITY HOSPITAL, in Rockville, Connecticut, I give, devise and bequeath four of said equal parts of my said residuary estate in trust to use the income thereof for the general purposes of the said Hospital.

John and Martha Kress Fund #73181 - Bequest under will of Martha Kress - This fund was left for a special purpose. In accordance with the instructions of the Board of Trustees of the Hospital, income accumulates and is transferred to principal for reinvestment.

> Terms of Will - "To be used for the purpose of equipping, furnishing, and maintaining a room in said Hospital to be known and called the "John and Martha Kress Room".

Edgar Keney Fund #73201 - No record found of source of this fund. It is believed to have been left for a special purpose. In accordance with the instructions of the Board of Trustees of the Hospital, income accumulates and is transferred to principal for reinvestment.

Francis T. Maxwell Fund #73211 - This fund is considered permanent endowment. Income is used for general purposes. The fund consists of the proceeds of a $50,000 life insurance policy on the life of Francis T. Maxwell, plus gifts by Mr. Maxwell during his life of 50 shares Phoenix Insurance Company and 200 shares Hartford Gas Company. These gifts of stock were restricted to use of income for general purposes and principal to be used only toward a new hospital.

Harriet K. Maxwell Fund #73221 - Bequest under will of Harriet K. Maxwell - outright legacy - income is used for general expenses of the Hospital.

> Terms of Will - Third: "----and unto the Rockville City Hospital of Rockville, Connecticut, the sum of Five Thousand Dollars ($5,000)

Robert Maxwell Fund #73241 - Bequest u/w Robert Maxwell - outright legacy - income is used for general expenses of the Hospital. (The will gave discretion to executors to devote sum of $100,000 "in such manner as they may deem suitable for the benefit of said residents of Rockville and vicinity". One Hundred Thousand Dollars ($100,000) was paid to Rockville City Hospital per final account of executors.)

William A. and Caroline E. Metcalf Fund #73251 - Bequest u/w Caroline E. Steele Metcalf - Permanent endowment - Income for general purposes.

> Terms of Will - NINTH: All the rest, residue and remainder of my estate, of whatsoever nature and wheresoever situated, I give, bequeath and devise to the Trustees of The Rockville City Hospital, Inc., a charitable corporation organized and existing under the laws of the State of Connecticut, and owning and operating a hospital in said Town of Vernon, in trust, nevertheless, to hold invest and reinvest the same and to use the income thereof for the general uses and purposes of said Hospital as said Trustees shall see fit. Said trust shall be known as the William S. and Caroline E. Metcalf Fund.

William Maxwell Fund #73261 - This fund consists of the following:

Cash gifts by Mr. Maxwell during 1936 to 1938	$14,000.00
Proceeds of life insurance (1939)	61,472.99
Bequest under 14th clause of will	96,246.01
	$171,719.00

Terms of Will - FOURTEENTH: To ROCKVILLE CITY HOSPITAL, in Rockville, Connecticut, I give, devise and bequeath four of said equal parts of my said residuary estate in trust to use the income thereof for the general purposes of said Hospital.

Charles Phelps Free Bed Fund #73271 - Gift of $10,000 from Mrs. Elsie S. Phelps - Permanent endowment - Income for special purposes. Any amount of this fund in excess of $10,000 represents accumulated income and is considered available if necessary.

Terms of Gift

"1. For the benefit of any members of my household staff or their families who may be in need of the services which the fund can provide.

2. For the general use and benefit of the residents of the City of Rockville.

The fund, aside from the small conditions which I wish to impose for the benefit of my household staff, which will fall within the income limitations of the fund, will be managed by the Board of Trustees and Finance Committee of The Rockville City Hospital with full powers of sale, investment and reinvestment."

Celia E. Prescott Fund #73201 - This fund was left for a special purpose. In accordance with the instructions of the Board of Trustees of the Hospital, income accumulates and is transferred to principal for reinvestment.

Terms of Gift

$10,000. for free bed in honor of Francis and Eliza Porter Keeney
$ 5,000. for free bed in memory of Francis Keney Prescott
$ 400. for furnishing a room in memory of Jane E. Newcomb

George Palmer Charter Fund #73291 - Bequest under Second and Seventeenth Clauses of Will of George Palmer Charter - permanent endowment - income for general purposes.

Terms of Will

SECOND

I give and bequeath to the Rockville City Hospital, located in the city of Rockville, State of Connecticut, the sum of Ten Thousand (10,000) dollars, in trust, however, for the following uses and purposes, namely: The governing body of said hospital shall invest said sum of $10,000 and the annual income of said sum shall be used for the general maintenance of said Hospital.

George Palmer Charter Fund #73291 continued

SEVENTEENTH

All the rest, residue and remainder of my estate, of whatsoever nature and wheresoever situated which I may own or have the right to dispose of at the time of my decease, I give, devise and bequeath in equal proportions, share and share alike to the Rockville City Hospital located in the city of Rockville, State of Connecticut, and to the Cyril and Julia C. Johnson Memorial Hospital, Inc. located at Stafford Springs, State of Connecticut, in trust each of said hospitals shall invest the sums derived under this Article of my last Will and Testament and the annual income of said sums shall be used for the general maintenance of each of said hospitals.

William H. Prescott Fund #73301 - Bequest u/w William H. Prescott. Permanent endowment - income for general purposes.

Terms of Will -

"13. I give and bequeath to Francis T. Maxwell, Arthur T. Bissell, J. Alice Maxwell, A. N. Belding and Thomas W. Sykes, all of Rockville, Connecticut, the sum of Fifty Thousand Dollars ($50,000) in perpetual trust to them and their successors in office, for the purpose of establishing and maintaining at said city of Rockville, a general hospital for the sick, to be open and available to all residents of the said City of Rockville, and of such portion of the immediate vicinity thereof contiguous and adjacent thereto, as in the judgment of said Board of Trustees may be deemed wise and advisable, subject to such rules and regulations concerning admission to said hospital as said trustees and their successors in office may, from time to time, establish.

Said trustees and their successors in office shall have power to receive property by gift or otherwise, and to purchase land and erect buildings for the purpose of carrying out the provisions of this trust.

The general management and oversight of said hospital, including the character and method of treatment therein to be established, shall be vested wholly in said Board of Trustees and their successors in office.

Said Board may elect a President, Vice-President, Secretary and Treasurer, and such other executive officers as they may deem necessary or advisable to carry out the purpose of this trust, including a superintendent of said institution. All vacancies in said Board arising from any cause, shall be filled by appointment of the surviving trustees.

William H. Prescott Fund #73301-continued

Terms of Will-continued

The Board of Trustees shall have power, from time to time, to make by-laws defining the duties of said officers and superintendent, the method of calling meetings of the Trustees and other by-laws relative to the management and government of the same. Provided, however, that, if at any time before my decease, I shall make provision for the transfer of the sum of fifty thousand dollars ($50,000) to the above named, as trusteesfor the purpose of inaugurating the establishment of a City Hospital, thereby substantially carrying out the provisions of this paragraph of my will, then and in that event, I revoke this paragraph of the same relating to said Hospital, and declare it inoperative, but otherwise to remain in full force and effect."

(1949)

Stephen Goodale Risley and Emeret Scott Risley Fund #73311 - Bequest u/ Ninth and Twenty-first clauses of Will of May R. Adams - permanent endowment - income for general purposes.

Terms of Will

"NINTH: I give and bequeath unto THE ROCKVILLE CITY HOSPITAL, INC. of said Rockville, the sum of Ten Thousand Dollars, in memory of my father and mother, Stephen Goodale Risley, M.D. and Emeret Scott Risley, for the establishment of a fund to be known as the Stephen Goodale Risley and Emeret Scott Risley Fund, the income thereof to be used for the general uses and purposes of said Hospital."

"TWENTY-FIRST: All the rest, residue and remainder of all my property, of every description, both real and personal, of whatsoever the same may consist or wheresoever it may be situated, I give, devise and bequeath unto said THE ROCKVILLE CITY HOSPITAL, INC. in order that the same may be added to and become a part of the Stephen Goodale Risley and Emeret Scott Risley Fund, which is established in Paragraph Ninth of this my last Will and Testament."

($79,688.80)

Rockville Chapter American Red Cross Fund #73321 - Gift from Rockville Chapter of American Red Cross - considered permanent endowment - income is used for general expenses of the Hospital.

William B. and Lizzie Lathrop Sprague Fund #73341 - Bequest u/w Lizzie Lathrop Sprague - considered permanent endowment - income is used for general expenses of the Hospital.

Terms of Will

"---to be known as the William B. and Lizzie Lathrop Sprague Fund".

Swindells Fund #73351 - This fund represents donations received from the Swindells Foundation. Income and/or principal may be used for care of deserving persons or used for general hospital expenses. Surplus income is transferred to principal.

Fred Talcott Fund #73361 - Bequest u/w Fred Talcott - considered permanent endowment - income for general purposes.

Terms of Will

"SIXTEENTH: Whereas one William H. Prescott of said Rockville, now deceased, in and by his will bequeathed a large sum of money towards the support and maintenance of a hospital to be thereafterwards established in said Rockville, and it is my desire to make a contribution towards the erection and establishment of such hospital. I give and bequeath to the persons who at the time of my decease may be the custodians of the said fund, bequeathed as aforesaid by said Prescott, the sum of five thousand dollars to be used by them or their successors in such trust towards the erection and establishment of such hospital."

"TWENTIETH:——Upon the decease of the last survivor of the aforesaid beneficiaries under this trust I direct that one-half part of all the trust estate and property then remaining in the hands of my said trustee be by it made over to the persons mentioned in the sixteenth clause of this my will as the custodians of the William H. Prescott Fund, or to the persons who at the termination of this trust may be such custodians, to be applied towards the establishment of the hospital in said Rockville proposed or contemplated in the will of said Prescott, but if such hospital shall then be already established then said one-half of said trust estate and property shall be by said trustee made over to such hospital to be used by it for its uses and purposes."

Trumbull Chapter, D.A.R. Fund #73381 - Gift from Trumbull Chapter, D.A.R. - considered permanent endowment - income to be used for free bed, Sabra Trumbull Daughters to have preference, or any deserving person, to be decided by Hospital Trustees and Advisory Board of Sabra Trumbull Chapter. Any unused income is added to principal.

United German Society Fund #73391 - Gift from United German Society - considered permanent endowment - income is used for general expenses of the Hospital.

November 24, 1952

Florence R. Whitlock Fund #73371 - Bequest under will of Florence R. Whitlock (1953) - $13,351.35, a permanent endowment. Income for free bed or beds. Terms of will:
"2...The remaining four-tenths (4/10ths) of said residue, I give, devise and bequeath to the Rockville City Hospital for the purpose of establishing a free bed or beds in said Hospital in memory of my mother, Anna Shelton Whitlock."

Betsey C. Tucker Fund #73360 - Bequest under will of Betsy C. Tucker (1955) - $2,000, a permanent endowment. Income for free bed. Terms of will:
"Second: I give and bequeath to The Rockville City Hospital of Rockville, Connecticut, Two Thousand (2,000) Dollars to be its absolutely and forever. This bequest is to be used by said Hospital as an endowment for the partial maintenance of a free bed in said Hospital."

Anna M. and Albert H. Bilson Fund #745081 - Bequest under will of Anna M. Bilson of $10,371.08 as follows: (January 22, 1957)
"NINTH: All the rest, residue and remainder of my Estate, both real and personal of whatsoever nature and wheresoever situated is to be sold and one-half of the proceeds are to be given to the Union Congregational Church of Christ, Inc. to be known as the Anna M. Bilson and Albert H. Bilson Fund. I direct the trustees of said Church to lawfully invest said legacy and to use the income therefrom for the general uses and purposes of said Church. The remaining one-half thereof I give and devise unto the Rockville City Hospital, Inc. of the Town of Vernon to be known as the Anna & Albert Bilson Fund. I direct the trustees of said Hospital to lawfully invest said legacy, and to use the income therefrom for the general uses and purposes of said Hospital.

EXHIBIT Q 11-2

Fund 11-1.59

Winchell-Foster

THE FIRST NATIONAL BANK OF DENVER

DENVER 17, COLORADO

EUGENE R. EAGAN
TRUST DEPARTMENT

July 31, 19[illegible]

Mrs. Virginia J. Yaskulka
Superintendent
Rockville City Hospital, Inc.
Rockville, Connecticut

#7472201
Winchell-Foster Free Bed Fund

Re: Estate of Minnie Foster Riley

Dear Mrs. Yaskulka:

In accordance with your letter of July 28, I am enclosing the following extract from Mrs. Riley's Last Will and Testament for your records: to wit,

> "ARTICLE THIRD: I give and bequeath the following property or sums of money as set forth in the Article THIRD of my will, as follows:
>
> (j) The sum of Fifteen Thousand ($15000) Dollars to the Rockville City Hospital of Rockville, Connecticut, as a permanent fund to be known as the "Winchell-Foster Free Bed Fund" in memory of my grandparents, Cyrus and Hester Winchell, and my parents, Wilbur and Mary Edna Foster, and which sum shall be held and invested and reinvested as the governing body of said Hospital shall, in its sole discretion deem best, and the income from which shall be used for the maintenance of a free bed in said Hospital".

In response to paragraph 4 of your letter regarding the nearest relative, I am sorry to say that I do not know who the person might be who would qualify as "the nearest relative". As you know, Mrs. Riley's only son predeceased her and left surviving no issue. I will give you the name of his wife and you may write to her if it pleases you to do so; it is, Mrs. Dorothy Neilson Riley, P.O. Box 288, Stonington, Connecticut.

We wish to thank you for your prompt reply and the information you submitted therein.

Very truly yours,

Eugene R. Eagan

Eugene R. Eagan

ERE/jst

EXHIBIT Q 11-2

Fund 11-1.60

Betsey C. Tucker

WILL No. 17 Cleaveland Legal Blank Service, Hartford, Conn.

Last Will and Testament

Be it known to all Persons, THAT I, Betsey C. Tucker, wife of Ernest E. Tucker, of the Town of Tolland in the County of Tolland in the State of Connecticut being of lawful age, of sound and disposing mind, memory and judgment, do hereby make, publish and declare this to be my last Will and Testament, hereby revoking all previous wills and codicils by me at any time heretofore made.

FIRST

I direct that all of my just debts and funeral expenses shall be paid by my Executor hereinafter named.

SECOND

I give, ~~devise~~ and bequeath to The Rockville City Hospital, of Rockville, Connecticut, Two Thousand (2000) Dollars to be its absolutely and forever. This bequest is to be used by said Hospital as an endowment for the partial maintenance of a free bed in said Hospital.

THIRD

I give, ~~devise~~ and bequeath to Modeste E. Dubay of 72 East St., Rockville, Connecticut, the sum of One Hundred (100) Dollars, to be hers absolutely and forever.

FOURTH

I give, ~~devise~~ and bequeath to Alice G. Clough of 72 East St., Rockville, Connecticut, the sum of One Hundred (100) Dollars, to be hers absolutely and forever.

FIFTH

I give, ~~devise~~ and bequeath to Lillian Randall of 72 East St., Rockville, Connecticut, the sum of One Hundred (100) Dollars, to be hers absolutely and forever.

SIXTH

I give, ~~devise~~ and bequeath to Selena E. Williams of 40 Pleasant St., Revere, Massachusetts, the sum of Two Hundred (200) Dollars, to be hers absolutely and forever.

SEVENTH

I give, ~~devise~~ and bequeath to Edith S. Mason, of Dublin, New Hampshire, the sum of Two Hundred (200) Dollars to be hers absolutely and forever.

EIGHTH

I give, ~~devise~~ and bequeath to Erva B. Doyle, of Tolland, Connecticut, the sum of Two Hundred (200) Dollars, to be hers absolutely and forever.

NINTH

All the rest, residue and remainder of my estate of whatsoever nature and whereasoever situated, which I may own or have the right to dispose of at the time of my decease, I give, devise and bequeath to my husband, Ernest E. Tucker of said Tolland, to be his absolutely and forever.

TENTH

The omission of my two nieces, Mary E. Willard and Mildred Ballou, as participants in my estate, is intentional, since both of them are residuary legatees under the will of my mother, Louise B. Willard, late of Rockville, Connecticut, deceased.

JUL 19 '90 08:36 P.3/3

VOL. 22 PAGE 371

I Appoint my husband, Ernest E. Tucker,
of the Town of Tolland County of Tolland
and State of Connecticut executor of this my Last Will and Testament

In Witness Whereof, I have hereunto set my hand and seal at said Tolland
on the 21st day of June A. D., One Thousand, Nine Hundred and forty-nine

Betsey C. Tucker [Seal]

Signed, sealed, published and declared by the said Betsey C. Tucker
as and for her Last Will and Testament, in the presence of us, who at her request, in her presence, and in the presence of each other have hereunto subscribed our names as witnesses, on the 21st day of June A. D. 1949.

Witnesses	Addresses
Elsie C. Schulze	Rockville, Conn
Anna K. Young	Tolland, Conn
George V. Smith	Willington, Conn.

State of Connecticut, County of Tolland } ss. Tolland, June 21st, A. D. 1949

We the within named Elsie C. Schulze and Anna K. Young

being duly sworn, make affidavit and say: That we severally attested the within and foregoing Will of the within named testatrix and subscribed the same in her presence and at her request and in the presence of each other, and the said testatrix signed, published and declared the foregoing instrument as and for her last Will and Testament in our presence on the 21st day of June A. D. 1949, and at the time of execution of said will, said testatrix was more than eighteen years of age and of sound mind, memory and judgment and under no improper influence or restraint to the best of our knowledge and belief. and we make this affidavit at the request of said testatrix.

Elsie C. Schulze

Anna K. Young

State of Connecticut, County of Tolland } ss. Tolland, June 21st, A. D. 1949

Then personally appeared before me Commissioner of Superior Court duly qualified to administer oaths.

Elsie C. Schulze

and Anna K. Young

and subscribed and made oath to the truth of the foregoing affidavit

George V. Smith

Commissioner of Superior Court Tolland County

EXHIBIT Q 11-2

Fund 11-1.61

Anna Shelton Whitlock

DISTRICT OF ELLINGTON

(Continued from Page 195 - Estate of Florence R. Whitlock)

The Hartford-Connecticut Trust Company
By (signed) M. C. Seymour, Trust Offic

A true copy

Attest: Ellen M. Duff

DECREE GRANTING ADMINISTRATION, ADMITTING WILL & ORDERS

At a Court of Probate holden at Vernon, in and for the District of Ellington, in County of Tolland, State of Connecticut, on the 31st day of January A.D. 1952.

Present, Hon. Thomas F. Rady, Judge.

ESTATE OF FLORENCE R. WHITLOCK, late of Vernon in said District, dec'd.

Return is made that notice of the pendency of the application for the of the last will and testament of said deceased and of the time and place setting thereon, has been duly given to all persons known to be interested in said directed by the foregoing order of this Court which return this Court finds to and accepts. After due hearing had, this Court finds that said deceased last was domiciled in the town of Vernon in said District, and died testate on the January A.D. 1952; that the instrument referred to in said application was du by the testatrix as and for her last will and testament and that she was at executing the same of lawful age and of sound mind and memory. It is therefor ed by this Court that said will is duly proved and the same is proved and app Whereupon letters of administration on said estate, with the will annexed, ar to The Hartford-Connecticut Trust Co., who on the 31st day of January, 1952 a Court by its trust officer, M. C. Seymour, and accepted said trust.

ORDERED, That twelve months from the 31st day of January, 1952 be a are allowed the Administrator c.t.a. within which to settle said estate.

ORDERED, That six months from the 31st day of January, 1952 be and are limited and allowed for the creditors to bring in their claims against sai and the said Administrator c.t.a. is directed to give public notice to the bring in their claims within said time allowed, by posting a copy of this ord public sign-post nearest to the place where the deceased last dwelt within sa and by publishing the same once in some newspaper having a circulation in sai District within fifteen days from the date of this order and return make to of the notice given, and of a list of all claims presented within said time

ORDERED, That two months from the 31st day of January, 1952, be and are allowed the Administrator within which to make, or cause to be made, a tru feet inventory of all the estate of said deceased, both real and personal, i choses in action. And this Court appoints Jack Levin and Robert W. Murphy disinterested persons, appraisers under oath, to appraise said estate, and return mak Court within said time allowed.

(signed) Thomas F. Rady, Judge.

A true copy

Attest: Ellen M. Duff

LAST WILL AND TESTAMENT

I, Florence R. Whitlock, of Rockville, in the Town of Vernon, Connecticut, do lish and declare this instrument as and for my last Will and Testament hereby all wills by me at any time heretofore made.

1. I direct the payment of my just debts and funeral expenses and the expen tling my estate by my Executor hereinafter named; and I further direct my to cause a suitable inscription to be placed on the family monument in Grove tery, Rockville, Connecticut.

2. All the rest and residue of my estate, real and personal, whatsoever and situated, I give, devise and bequeath to The Rockville National Bank of Rockville, Connecticut, in trust, to hold and manage, with full power of investment and reinvestment subject to the laws of the State of Connecticut governing the investment of and to pay unto my father, Harlow R. Whitlock, the income, profits and avails rest and residue for and during the period of his natural life, and if such sufficient to give my said father a comfortable support in sickness and in direct my said Trustee to pay to my said father so much of the principal of and residue as may be necessary to furnish him with such support.

Upon the death of my said father, and the payment of all funeral expenses, I direct that the remainder of said rest and residue be divided into equal parts, which ten (10) equal parts shall be disposed of as follows:

One-tenth (1/10th) to the Rockville Public Library, the income there used for the purchase of books.

One-tenth (1/10th) to the Rockville Visiting Nurse Association, the thereof to be used for the purposes of the Association.

One-tenth (1/10th) to the Town of Vernon, the same to be deposited the savings banks of Rockville, and the income thereof to be used forprizes Seventh and Eighth grades of the East School, for excellence in school work in relation to the awarding of such prizes to be left to the Superintendent and Teachers of these grades.

One-tenth (1/10) to the Town of Vernon, the same to be deposited savings banks of Rockville and the income thereof to be used for a first prize to the two scholors whose stading in the high school has been the four years.

Two-tenths (2/10ths) to St. John's Episcopal Church of Rockville to be used for general church purposes, in memory of my father and mother Whitlock and Anna Shelton Whitlock.

The remaining Four-tenths (4/10ths) of said residue, I give, devise queath to the Rockville City Hospital for the purpose of establishing a in said Hospital in memory of my mother, Anna Shelton Whitlock.

I appoint The Rockville National Bank of Rockville, Connecticut, this my Last Will and Testament.

In witness Whereof, I have hereunto set my hand and seal at said on the 28th day of August, A.D., One Thousand, Nine Hundred and Twenty-nine.

(signed) Florence R. Whitlock (L.S.)

Signed, sealed, published and declared by the said Florence R. Whitlock as Last Will and Testament, in presence of us who at her request, in her presence the presence of each other have hereunto subscribed our names as witnesses

ECHN Proposed Asset Purchase by PMH
Submitted October 13, 2015

DISTRICT OF ELLINGTON

[illegible] Page 196 - Estate of Florence R. Whitlock)

[illegible]ticut,)
[illegible]) ss. Rockville, August 28, A.D. 1929.

[illegible] within named Oswald Saenger, Edith T. Casati and Gertrude L. Keating, [illegible] do depose and say: That they witnessed the within Will of the within [illegible] Florence R. Whitlock, and subscribed the same in her presence, and in [illegible] each other and at her request; That said Testatrix, at the time of sign- [illegible] was of full age and of sound and disposing mind and memory, and competent [illegible]tary disposition of real and personal property; That she voluntarily [illegible] and declared the same to be her Last Will and Testament, in the presence [illegible] subscribing witnesses thereto, and that this affidavit is made at the [illegible] Testatrix.

(signed) Oswald Saenger
(signed) Edith T. Casati
(signed) Gertrude L. Keating

[illegible]scribed and sworn to this 28th day of August, A.D., 1929, before me,
(signed) John E. Fahey, Notary Public.

Attest: Edw M. Neff Clerk

[illegible] the estate of) ON ACCOUNTING Doherty, Joshua L. XC4 969 844
[illegible] minor) ANNUAL ACCOUNT

FIRST

[illegible] guardian charges herself as follows, which is full and true statement [illegible] of each and every article or item of property and the value thereof, and [illegible] every sum of money, either principal or interest, received by her as fiduciary [illegible] minor during the period from 1-11-51 to 1-11-52

RECEIPTS

SOURCE OF RECEIPT	AMOUNT
Rec'd from Veterans Adm.	$41.00
" " " "	41.00
" " " "	41.00
" " " "	41.00
Interest	18.42
Rec'd from Veterans Adm.	41.00
" " " "	41.00
" " " "	41.00
" " " "	41.00
" " " "	41.00
" " " "	41.00
Interest	23.40
Rec'd from Veterans Adm.	41.00
Rec'd from Est. of N. A. Doherty	60.50
Rec'd from Veterans Adm.	41.00
[illegible] as of beginning of this accounting period	1877.25
Total	$ 2471.57

SECOND

[illegible] Guardian prays allowance for the following, which is a full and true state- [illegible] vouchers of all disbursements during the period from Jan. 11, 1951 to Jan.

DISBURSEMENTS

PURPOSE FOR WHICH EXPENDITURE WAS MADE	AMOUNT
NONE	NONE

SUMMARY

[illegible] Guardian charges herself with $2471.57
[illegible] Guardian prays allowance for $ none
[illegible] balance of $2471.57 is on deposit as follows:
[illegible]57 in the Savings Bank of Rockville, Conn.

[illegible]NECTICUT)
[illegible]AND) ss. Feb. 18, 1952

[illegible] Madeline Doherty Butler, being duly sworn, do depose and say that I am the [illegible] the estate of Lawrence Doherty, minor; that the foregoing account and inven- [illegible] to the best of my knowledge and belief, a full and true statement of my [illegible] disbursements on account of my ward, and of all moneys and other personal [illegible] have come to my hands since Jan. 11, 1951, and of the value of all such [illegible] together with a full and true statement and account of the manner in which I [illegible] of the same, and of all property remaining in my hands at the present time, [illegible] and true description of the amount and nature of each investment made by me [illegible] 1951, and that I do not know of any error or omission.

(signed) Madeline Doherty Butler

[illegible]scribed and sworn to before me this 18th day of Feb, 1952
(signed) A. P. Whalen, Notary Public (seal)

[illegible]cepted and ordered recorded and filed,
(signed) Thomas F. Rady, Judge.

Attest: Edw M. Neff Clerk

[illegible] of the estate of) ON ACCOUNTING DOHERTY, Joshua L. XC4 969 844
[illegible]ERTY, Minor) ANNUAL ACCOUNT

FIRST

[illegible] guardian charges herself as follows, which is a full and true statement [illegible]tion of each and every article or item of property and the value thereof, and [illegible] every sum of money, either principal or interest, received by her as fiduciary [illegible] minor during the period from 1-11-51 to 1-11-52

RECEIPTS

[illegible]	SOURCE OF RECEIPT	AMOUNT
1951	Rec'd from Veterans Adm.	$ 41.00
1951	" " " "	41.00
1951	" " " "	41.00
1951	" " " "	41.00
1951	Interest	19.54
1951	Rec'd from Veterans Adm.	41.00
1951	" " " "	41.00
1951	" " " "	41.00
1951	" " " "	41.00
1951	" " " "	41.00
1951	" " " "	41.00

EC[illegible] Purchase by PMH
Submitted October 13, 2015

EXHIBIT Q 11-2

Fund 11-1.62

Elsie Sykes Phelps
Free Bed Fund

goods and estate in said District remaining to be administered leaving no husband surviving and whose marriage to the deceased took place; and as her only heirs at law and next of kin the persons whose names, residences and relationship to the deceased are as follows:

Name	Residence	Relationship
Mrs. Dorothy Phelps Jones	4377 Beulah Drive, LaCanada, California	Daughter
Mrs. Mildred Phelps Jones	18 Stratford Road, West Hartford, Conn.	"

all of whom, except as otherwise indicated above, are still living and none of whom, except as hereinbefore stated, are under any disability or incapacity; and that said deceased left a will herewith presented for probate, dated September 28, 1955 wherein Horace Walker Jones, Jr. and The Connecticut Bank and Trust Company (formerly The Hartford Connecticut Trust Company) are named as executors and that said will has never been revoked by subsequent marriage, birth of child or otherwise.

Wherefore the subscribers pray that said will may be approved, allowed and admitted to probate, that Horace W. Jones, Jr. and The Connecticut Bank and Trust Company the executors therein named may be approved as such and that letters testamentary issue to them.

Dated at Hartford, Connecticut this 6th day of July 1965.

(signed) Horace W. Jones, Jr.

Subscribed and sworn to this 6th day of July, 1965, before me

(signed) W.S. Harrison, Notary Public

The undersigned being the heirs at law and next of kin of said deceased waive notice of the hearing on the foregoing application.

(signed) Mrs. Dorothy Phelps Jones
(signed) Mildred Phelps Jones

ACCEPTANCE OF TRUST
TO THE PROBATE COURT FOR THE DISTRICT OF ELLINGTON IN THE STATE OF CONNECTICUT

ESTATE OF ELSIE SYKES PHELPS late of Rockville, in said District, deceased.
ACCEPTANCE OF TRUST

Horace Walker Jones, Jr. and The Connecticut Bank and Trust Company having been named as Executors of the Last Will and Testament of the above named decedent hereby appear in Court and accept said trust.

Dated at Hartford, Connecticut, this 7th day of July A.D. 1965.

(signed) Horace Walker Jones, Jr.
Horace Walker Jones, Jr.
The Connecticut Bank and Trust Company
by /s/ W.S Harrison, Trust Officer

DECREE ADMITTING WILL AND ORDERS
At a Court of Probate holden at Vernon, in and for the District of Ellington, in the County of Tolland, State of Connecticut, on the 8th day of July, A.D. 1965.
Present, HON. THOMAS F. RADY, Judge.

ESTATE OF ELSIE SYKES PHELPS, late of Vernon in said District, deceased.

Upon the application of Horace W. Jones, Jr. of W. Hartford praying that an instrument in writing purporting to be the last will and testament of said deceased be admitted to probate and that letters testamentary on said estate be granted as per application on file more fully appears.

This Court for cause shown, viz: that all parties known to be interested in said estate and legally capable of acting, have signed and filed in Court a written waiver of notice, dispenses with notice of the pendency of said application, and of a hearing thereon.

After due hearing had this Court finds that said deceased last dwelt and was domiciled in the town of Vernon in said District, and died testate on the 27th day of June A.D. 1965; that the instrument referred to in said application was duly executed by the testatrix as and for her last will and testament and that she was at the time of executing the same of lawful age and of sound mind and memory. It is therefore considered by this Court that said will is duly proved and the same is proved and approved. Whereupon letters testamentary on said estate are granted to Horace Walker Jones, Jr. and The Connecticut Bank & Trust Company, formerly The Hartford Connecticut Bank Trust Company appeared in Court and accepted said trust and the will excuses said Horace Walker Jones, Jr. from furnishing bond.

ORDERED, That twelve months from the 8th day of July, 1965 be and the same are allowed the Executors within which to settle said estate.

ORDERED, That six months from the 8th day of July, 1965 be and the same are limited and allowed for the creditors to bring in their claims against said estate and the said Executors are directed to give public notice to the creditors to bring in their claims within said time allowed, by posting a copy of this order upon the public sign-post nearest to the place where the deceased last dwelt within said town and by publishing the same once in some newspaper having a circulation in said Probate District within thirty days from the date of this order and return make to this Court of the notice given, and of a list of all claims presented within said time.

ORDERED, That two months from the 8th day of July, 1965 be and the same are allowed the Executors within which to make, or cause to be made, a true and perfect inventory of all the estate of said deceased, both real and personal, including choses in action. And this Court appoints W.Thurston Rowley and Robert C.Terwilliger disinterested persons, appraisers under oath, to appraise said estate, and return make to this Court within said time allowed.

(signed) Thomas F Rady, Judge.

LAST WILL AND TESTAMENT

I, ELSIE SYKES PHELPS, of Rockville, Connecticut, make this my Last Will and Testament, hereby revoking all wills and codicils heretofore made by me.

ARTICLE I: I direct my Executors to pay my funeral expenses and just debts

PHELPS JONES:

(c) My 3-stone diamond ring to my daughter, MILDRED PHELPS JONES;

(d) My diamond bow know pin to DORA BROWN ROCKWELL, wife of Charles B.Rockwell, of Springfield, Massachusetts;

(e) My solitiare engagement ring to CURTIS PHELPS JONES, son of Horace W. Jones, Jr., of West Hartford, Connecticut;

(f) All remaining jewelry, including lapsed gifts of jewelry and all of my wearing apparel, I give and bequeath in equal shares to my said daughters, DOROTHY PHELPS JONES and MILDRED PHELPS JONES, or all to the survivor of them in the event that only one of them shall survive me, to be theirs or hers absolutely.

ARTICLE III: I make bequests to the following individuals, in each case as an absolute gift to the donee, if he or she shall survive me, and in the event any one or more of said donees shall not survive me, the gift which he or she would have received if living shall become a part of my residuary estate to be distributed as hereinafter provided if no other provision is made for such contingency:

(a) To my son-in-law, HORACE WALKER JONES, Jr. one hundred and sixty (160) shares of common stock of the Stanley Works, one hundred and sixty (160) shares of the common stock of The Manufacturers Trust Company and two hundred and forty (240) shares of the capital stock of the Standard Oil Company of California, if living, and if he is not living at the time of my death, then to my said daughter DOROTHY PHELPS JONES, forty (40) shares of common stock of The Stanley Works, forty (40) shares of common stock of The Manufacturers Trust Company and sixty (60) shares of the capital stock of the Standard Oil Company of California, and to my said daughter MILDRED PHELPS JONES, one hundred and twenty (120) shares of common stock of The Stanley Works, one hundred and twenty (120) shares of the common stock of The Manufacturers Trust Company and one hundred and eighty (180) shares of the capital stock of the Standard Oil Company of California;

(b) To my said daughter, DOROTHY PHELPS JONES, fifty (50) shares of the common stock of E.I. du Pont de Nemours Company, five hundred (500) shares of the common stock of The Connecticut Light and Power Company and three hundred (300) shares of the capital stock of The Travelers Insurance Company;

(c) To my said daughter, MILDRED PHELPS JONES, fifty (50) shares of the common stock of E.I. du Pont de Nemours Company, five hundred (500) shares of the common stock of The Connecticut Light and Power Company, three hundred and fifty (350) shares of the capital stock of The Travelers Insurance Company and eighty (80) shares of the common stock of General Electric Company, and if she is not living at the time of my death, then to my said daughter, DOROTHY PHELPS JONES, two hundred (200) shares of the capital stock of The Travelers Insurance Company and eighty (80) shares of the common stock of General Electric Company;

(d) To DR. ROY C. FERGUSON, 57 Union Street, Rockville, Connecticut, the sum of Five Hundred Dollars ($500.00);

(e) To REV. PERCY E. THOMAS, formerly of Evanston, Illinois, the sum of Two Thousand Dollars ($2,000.00);

(f) To CHARLES B. ROCKWELL and DORA BROWN ROCKWELL, of Springfield, Massachusetts, the sum of Two Thousand Five Hundred Dollars ($2,500) each, or, if either of them not living at the time of my death, Five Thousand Dollars ($5,000) to the survivor of them;

(g) To each employee in my service at the time of my death other than Joseph Quinn, the following:

To each employee who has been in my service for not more than five years, the sum of One Hundred Dollars (100) for each year he or she has been in my employ; to each employee who has been in my employ for more than five years, the sum of One Thousand Dollars ($1000);

(h) To CORINNE SYKES SPENCER, daughter of David A. Sykes, of Rockville, Connecticut, the sum of One Thousand Dollars ($1,000).

ARTICLE IV: I make the following bequests:

(a) To the TRUSTEES OF THE GEORGE SYKES MANUAL TRAINING SCHOOL, located in said Rockville, and to their successors in office, one hundred (100) shares of the capital stock of The Travelers Insurance Company as an absolute gift for the instruction of boys in manual labor, including drafting, carpentering, plumbing, all kinds of electrical work, physical culture, and all other branches of manual training commonly taught in such schools;

(b) To the ROCKVILLE PUBLIC LIBRARY, of said Rockville, ten (10) shares of the capital stock of The Travelers Insurance Company as an absolute gift for its general purposes:

(c) To the ROCKVILLE CITY HOSPITAL, of said Rockville, founded by the late William H. Prescott of said Rockville, fifty (50) shares of the capital stock of The Travelers Insurance Company, and I direct that the Trustees of said Hospital add the same to the permanent endowment of a free bed for said Rockville City Hospital, such gift to be called the "Elsie Sykes Phelps Free Bed Fund";

(d) To the VERNON METHODIST CHURCH, of Vernon, Connecticut, ten (10) shares of the capital sotck of The Travelers Insurance Company as an absolute gift for the general purposes of said Church, this gift being in memory of Charles Phelps and Rev. Benjamin Phelps;

(e) To the ROCKVILLE VISITING NURSE ASSOCIATION, of said Rockville, ten (10) shares of the capital stock of The Travelers Insurance Company as an absolute gift for its general purposes;

(f) To the UNION CONGREGATIONAL CHURCH OF CHRIST, of said Rockville, fifty (50) shares of the capital stock of The Travelers Insurance Company for its general purposes.

ARTICLE V: I give and bequeath to said CHARLES B. ROCKWELL and DORA B. ROCKWELL, or to the survivor of them, a portrait painting by Gabriel Max "The Princess," and to DOROTHY K. SNIDER, of Bloomfield, Connecticut, my Shrirer painting, "Arabian Scene."

ARTICLE VI: I give, devise and bequeath to JOSEPH QUINN, of said Rockville, the sum of Sixty-one Hundred Dollars ($6,100) and the real estate, with the cottage thereon, known as the "gardener's cottage," at 81 Prospect Street and the lot adjacent thereto in said Rockville, to be his absolutely, if he shall survive me. In the event that said Joseph Quinn shall not survive me, said real estate shall become a part of my residuary estate to be distributed as hereinafter provided.

ARTICLE VII: I give and bequeath to my said daughters, DOROTHY PHELPS JONES and MILDRED PHELPS JONES, such of my household furniture and furnishings, including tableware, silverware, books, pictures, ornaments and household stores, automobile, or automobiles, with their accessories, owned by me at the time of my death, and any and all other personal

ARTICLE VIII: I give and bequeath twenty-five (25) shares of the capital stock of The Travelers Insurance Company to my grandson, CHARLES PHELPS JONES, namesake of my husband, Charles Phelps, if he shall survive me and shall have reached the age of twenty-one (21) years at the time of my death, but if he shall survive me but shall not then have reached such age, said stock shall be added to the principal of the trust estate set up by me by voluntary trust indenture for the benefit of my said grandson, Charles Phelps Jones, with The Hartford-Connecticut Trust Company, as Trustee, dated December 5, 1936, and administered and distributed as a portion thereof.

ARTICLE IX: I give and bequeath two hundred)200) shares of the capital stock of The Travelers Insurance Company to my grandson, HORACE WALKER JONES, 4th, born February 28, 1946, if he shall survive me and shall have reached the age of twenty-one (21) years at the time of my death, but if he shall survive me but shall not then have reached such age, said stock shall be added to the principal of the trust estate set up by me by voluntary trust indenture for the benefit of my said grandson, Horace Walker Jones, 4th, with The Hartford-Connecticut Trust Company,as Trustee, dated April 22, 1949, and administered and distributed as a portion thereof.

ARTICLE X: I give and bequeath two hundred (200) shares of the capital stock of The Travelers Insurance Company to my granddaughter, SARAH SYKES JONES, born February 18, 1949, if she shall survive me and shall have reached the age of twenty-one (21) years at the time of my death, but if she shall survive me but shall not then have reached such age, such stock shall be added to the principal of the trust estate set up by me by voluntary trust indenture for the benefit of my said granddaughter, Sarah Sykes Jones, with The Hartford-Connecticut Trust Company, as Trustee, dated April 22, 1949, and administered and distributed as a portion thereof.

ARTICLE XI: I give and bequeath to THE CONNECTICUT BANK AND TRUST COMPANY, of Hartford, Connecticut, the sum of Five Thousand Dollars ($5,000) I N TRUST, for the following uses and purposes:

To expend so much of the net income as in the judgment of my said Trustee may be necessary or advisable for the care, maintenance and upkeep of the Phelps family burial lot in Grove Hill Cemetery, in said Rockville, including the mausoleum thereon erected, with special direction to repair, point up, and clean, when necessary, the stone-work of said structure, and to do all things necessary for the permanent care, repair and upkeep of said lot and monument; to place a wreath of flowers at the door of the Phelps mausoleum in said Cemetery, and at the monument on the lot in said Cemetery of my late father, George Sykes, on Memorial Day of each year. It is my hope and expectation that my Trustee will consult with my daughter Mildred Phelps Jones during her lifetime and ability to act.

ARTICLE XII: I give and bequeath to said THE CONNECTICUT BANK AND TRUST COMPANY the sum of Twenty-five Thousand Dollars ($25,000)

I N T R U S T

for the following uses and purposes:

(a) To pay to or expend for the benefit of said JOSEPH QUINN the sum of One Hundred and Seventy-five Dollars ($175.00) per month for and during the term of his natural life and to charge the sum against the principal of said trust; and, in addition thereto, to pay to or expend for his benefit so much of the principal as in the judgment of my said Trustee may be necessary for his comfort and support;

(b) To pay over to my said daughters DOROTHY PHELPS JONES and MILDRED PHELPS JONES in equal shares the entire principal of the trust fund and accumulated income upon the death of the said Joseph Quinn free and discharged of the trust. If either of them is not then living, her issue shall take her share per stirpes; if either die without issue then to the survivor of them; and, if no survivor, to the issue of the other of them.

ARTICLE XIII: All of the rest, residue and remainder of my property, both real and personal and of whatsoever nature, whether the same may be located or found, including any and all lapsed legacies or devises, I give, devise and bequeath to my said daughters, DOROTHY PHELPS JONES and MILDRED PHELPS JONES, in equal shares absolutely, and if either of them is not living at the time of my death, then to her issue per stirpes; if either die without issue, then to the survivor of them; and, if no survivor, to the issue of the other of them.

ARTICLE XIV: In the event that from any cause my estate shall at the time of my death be insufficient for the payment in full of all the legacies and devises in this will contained, I direct that the legacies to my said daughters, Dorothy Phelps Jones and Mildred Phelps Jones, and my said son-in-law, Horace Walker Jones, Jr., contained in ARTICLE III, sub-sections (a), (b) and (c), and ARTICLE VII of this Will shall be paid in full, and that all other legacies and devises in this Will contained shall proportionately abate so far as may be necessary to meet the conditions of my estate.

ARTICLE XV: I hereby nominate, constitute and appoint said THE CONNECTICUT BANK AND TRUST COMPANY, HORACE WALKER JONES, JR. and SAMUEL H. SNIDER, Executors of this my Last Will and Testament. I direct that no bond be required of said Horace Walker Jones, Jr. and said Samuel H.Snider as executors by any court or Judge.

In the event that either Horace Walker Jones, Jr. or Samuel H Snider is unable or unwilling to act as executor, I direct that no successor be appointed to him and that the remaining executors shall act as executors and shall have all the powers and duties herein conferred upon my said executors, and if both of them are unable or unwilling to act, then The Connecticut Bank and Trust Company, shall act as sole executor with the same rights, duties and discretionary powers herein conferred upon my said executors.

I hereby authorize my Executors and Trustee to sell, mortgage and convey the whole or any part of my estate not specifically devised and the whole or any part of said trust funds whether real or personal, at public or private sale, for cash or upon such terms as to payment as may be deemed advisable, and to execute and deliver such deeds and other instruments as may be necessary to vest title in the purchaser, without any obligation or liability on the part of the purchaser to see to the application of the purchase money; to determine whether any moneys are to be considered as income or principal, and whether any expenses are to be paid from income or principal; to pay any or all expenses for the protection and maintenance of real estate and for care, storage, transportation and delivery of personal property out of the principal of my estate as an administration expense; to continue to hold any property, real or personal, which is a part of my estate at the time of my death, for such period of time as shall be deemed to be for the best interests of my estate; to invest and reinvest any trust fund in any property or security, including non-income-producing property, common and other corporate stocks, and common trust funds

my Executors will select such securities as will be approved by the respective legatees; to pay any legacies of cash or personal property at any time after the expiration of one month after the approval of my will by the court of probate; to pay over the net income of the trust to the respective beneficiaries at least quarterly; to favor any life beneficiary over the remaindermen in any conflict of interests between the life beneficiaries and remaindermen, provided that in the judgment of my Trustee it is prudent to do so; and to make in cash or in property or in both at such value as either my Executors or my Trustee shall fix any and all divisions and distributions of my estate and any fund held in trust whenever distribution is required including any revaluations and allocations necessary in connection therewith.

I direct my Executors to make such adjustments in the number of shares of stock hereinbefore bequeathed as may be necessary or appropriate in the event of a merger, recapitalization, reorganization, increase or decrease in the capital of any such corporation between the date of this Will and the date of my death.

I direct that the full amount received as interest upon any bonds owned by me at the time of my death which may be appraised above their par value or which may be received by the Trustees at a valuation above the par value, or which shall have been at any time bought by the Trustees at a premium, shall be accounted for as income and paid to persons entitled to such income without regard as to the rate of interest which would be actually received upon such bond if held to maturity, or without regard to their appraised value or cost, and if such bonds are paid or sold and the amount realized is less than the appraised value or cost, the loss shall be charged against the principal as a proper diminution of principal.

The words "child or children," "descendants" and "issue" as used in this Will are intended to mean not only heirs of the blood but also children by adoption or descendants of any adopted person.

IN WITNESS WHEREOF I have hereunto set my hand and seal this 28th day of September, 1955.

(signed) Elsie Sykes Phelps _____ L.S.

Signed, Sealed, Published and Declared as and for her Last Will and Testament, by the above-named Testatrix, ELSIE SYKES PHELPS, in our presence, and we in her presence and in the presence of each other, and at her request, have hereunto subscribed our names as witnesses this 28th day of September, 1955.

/s/ Diana H. Roos of Hartford, Conn.
/s/ Elizabeth T. Bill of Hartford, Conn.
/s/ Frances E. Newton of Simsbury, Conn.

STATE OF CONNECTICUT } ss. Rockville, September 28, 1955
COUNTY OF TOLLAND }

The within named Diana H. Roos, Elizabeth T. Bill, Frances E. Newton being duly sworn, do depose and say;

That they witnessed the within will of the within named Testatrix, ELSIE SYKES PHELPS, and subscribed the same in her presence, in the presence of each other, and at her request; That said Testatrix, at the time of signing said will, appeared to them to be of full age and of sound and disposing mind and memory, and competent to make testamentary dispostion of real and personal property; That she voluntarily signed said will and declared the same to be her last will and testament, in the presence of the said three subscribing witnesses thereto, and that this affidavit is made at the request of the Testatrix

(signed) Diana H Roos
(signed) Elizabeth T. Bill
(signed) Frances E Newton

Subscribed and Sworn To this 28th day of September, 1955, before me
(signed) Melvin C. Seymour, Notary Public

INVENTORY
TO THE COURT OF PROBATE IN AND FOR THE DISTRICT OF ELLINGTON, IN THE STATE OF CONNECTICUT

ESTATE OF PATRICIA ELLEN DANEHY and DEBRA ANN DANEHY, of Ellington in said District minors.

The following is a true and perfect inventory of said estate:

Deposit - The Savings Bank of Rockville #87,754 for Debra Ann Bal. Apr. 5, 1963 Interest not added on book.	1500.00
Deposit - The Savings Bank of Rockville #87,755 for Patricia Ellen Danehy Bal. Apr. 5, 1963 Interest not added on book	1500.00

(signed) Thomas F. Danehy, Guardian

Accepted and ordered recorded and filed, this 26th day of August 1965.
(signed) Thomas F Rady, Judge.

APPLICATION FOR PROBATE OF WILL
TO THE PROBATE COURT FOR THE DISTRICT OF ELLINGTON:

ESTATE OF META ENES WEBER late of Vernon owning property in said District, deceased.

The subscriber represents that Meta Enes Weber last dwelt and had her domicile in the Town of Vernon in said District and died on the 30th day of June 1965, possessed of goods and estate insaid District remaining to be administered leaving no husband surviving and as her only heirs at law and next of kin the persons whose names, residences and relationship to the deceased are as follows:

Name	Residence	Relationship
William Norman Enes	53 Crestview Rd., Mountain Lakes, N.J.	nephew

and that said deceased left a will herewith presented for probate, dated March 20, 1959 wherein Gilbert Charles Weber is named executor; and that said will has never been revoked by subsequent marriage, birth of child or otherwise.

EXHIBIT Q 11-2

Fund 11-1.63

John and Martha Kress Fund

none of whom, except as hereinbefore stated, are under any disability or [illegible] and that said deceased left a will herewith presented for probate, wherein Simmonite is named as executrix.

Wherefore your petitioner prays that said will may be proved, approved admitted to probate and letters testamentary on said estate may be granted trix therein named.

Lillian K. Simmonite.

Subscribed and sworn to this 26th day of February 1920 before me.

John E. Fahey, Judge.

The undersigned being all the heirs-at-law and next of kin of said dec service and waive notice of the pendency of the foregoing application and and place set for hearing thereon.

Arthur J. Kress.

A true copy

Attest: M. P. Leonard.

At a Court of Probate holden at Vernon, in and for the District of Ellingt 26th day of February A. D. 1920.

Present, John E. Fahey, Judge.

Estate of Martha M. Kress late of Vernon, in said district, deceased.

Upon the application of Lillian K. Simmonite, of Bridgeport, Conn., an instrument in writing purporting to be the last will and testament of sai be admitted to probate, and that letters testamentary be granted on said application on file more fully appears;

This Court for cause shown, viz: that all parties known to be interest estate have signed and filed in Court a written waiver of notice dispensed of the pendency of said application. After hearing the parties with their this Court finds the allegations of said application to be true, and that ment was duly executed by the Testatrix for her last will and testament, at the time of executing the same of lawful age and of sound mind and memo therefore considered by this Court that said will is duly proved, and the sa proved, approved, and ordered to be recorded and kept on file. Whereupon testamentary on said estate, are granted to Lillian K. Simmonite who on the February, appeared in Court, accepted said trust, and gave Bond jointly wit Kress as surety in the penal sum of Five Hundred (500) dollars, which is ad approved by this Court, and ordered to be recorded and kept on file. (Reco Vol. 4 of Bonds, page)

Ordered, That twelve months from the 26th day of February 1920 be and are allowed the Executrix, within which to settle said estate.

Ordered, That six months from the 26th day of February be and the same and allowed for the creditors to bring in their claims against said estate; said Executrix is directed to give public notice to the creditors to bring claims within said time allowed, by posting a copy of this order upon the post nearest to the place where the deceased last dwelt within said town, and lishing the same once in some newspaper having a circulation in said Probat within ten days from the date of this order and return make to this court of tice given, and of a list of all claims presented within said time.

Ordered, That two months from the 26th day of February be, and the same the Executrix within which to make, or cause to be made, a true and perfect of all the estate of said deceased, both real and personal, including choses action, and this Court appoints

Martin Laubscher and John Kuhnly

disinterested persons, appraisers under oath, to appraise said estate, and to this Court within said time allowed.

John E. Fahey, Judge.

A true copy

Attest: M. P. Leonard Asst.

Be it Known to all Persons, That I, Martha M. Kress, of the Town of Bridgep County of Fairfield, in the State of Connecticut, being of lawful age, of sou disposing mind, memory and judgment, do hereby make, publish and declare this last Will and Testament, hereby revoking all previous wills and codicils by

First: I give to my daughter, Lillian Kress Simmonite, of said Bridgep diamond ring and my diamond earrings, to have the use and enjoyment of the during the term of her natural life; and it is my will that at the death of daughter said ring shall be and become the absolute property of my granddaughter H. Kress, and that at said time said earrings shall be and become the absolute of my granddaughter, Mildred K. Kress, said named granddaughters being the ch my son, Arthur J. Kress, of Ellington, Connecticut.

DISTRICT OF ELLINGTON --

nd: I give and bequeath all my other jewelry and all my household furniture
rnishings, my wearing apparel, and musical instruments to my said daughter,
Kress Simmonite, to her and her heirs and assigns forever.
I give and bequeath the sum of Five Hundred Dollars to The Union Congre-
Ecclesiastical Society, of Rockville, Connecticut, to be used in the erection
ement of of the parish house hereafter to be built by said Society
I give and bequeath the sum of Five Hundred Dollars to the Rockville City
to be used for the purpose of equipping, furnishing and maintaining a room in
pital to be known and called the "John and Martha Kress room."
All the rest, residue and remainder of my property, real and personal, I
vise and bequeath to my said children, Lillian Kress Simmonite and Arthur J.
heir heirs and assigns forever, share and share alike.
point my said daughter, Lillian Kress Simmonite of the Town of Bridgeport,
Fairfield and State of Connecticut, executrix of this my Last Will and Testa-
direct that no bond be required of her as such executrix.
Witness Whereof I have hereunto set my hand and seal at said Vernon, on the 3rd
April, A. D. One Thousand, Nine Hundred and eighteen.

Martha M. Kress (L.S.)

d, sealed, published and declared by the said ~~Lillian Kress Simmonite~~ Martha M. Kress
or her last will and testament, in presence of us who at her request, in her
and in the presence of each other have hereunto subscribed our names as
on the third day of April A. D. 1918.

~~Martha M. Kress~~
Lyman Twining Tingier)
William A. Howell) Witnesses.
Walter H. Robinson)

Connecticut,)
) ss. Vernon, April 3, A. D. 1918.
Tolland)

e the within named Lyman Twining Tingier, William A. Howell and Walter H.
being duly sworn, make affidavit and say: That we severally attested the
and foregoing Will of the within named testatrix and subscribed the same in
sence and at her request and in the presence of each other; that the said tes-
signed, published and declared the said instrument as and for her last Will and
, in our presence on the 3 day of April, A. D. 1918; and at the time of exe-
said will, said testatrix was more than eighteen years of age of sound mind,
and judgment and under no improper influence or restraint to the best of our
e and belief, and we make this affidavit at the request of said testatrix.

Lyman Twining Tingier,)
William A. Howell,)
Walter H. Robinson,)

Connecticut)
) ss. Vernon, April 3, A. D. 1918.
Tolland)

hen personally appeared before me, a Notary Public, duly qualified to
oaths.

Lyman Twining Tingier
William A. Howell
and Walter H. Robinson

ribed and made oath to the truth of the foregoing affidavit.

John E. Fisk, Notary Public.

Attest: M Leonard Asst.Clerk.

bate held at Vernon, within and for the District of Ellington, on the
y 1920.

Present, John E. Fahey, Judge.

Kress late of Vernon in said District deceased.

resented to said court that Martha M. Kress Executor of the will of
on the 28th day of January 1920 without completing the settlement
all parties interested in said estate being present in court, this
ing doth appoint Lillian K. Simmonite, daughter of said John and
dministratrix d.b.n., c.t.a. on said estate.
Lillian K. Simmonite accepted said trust, and gave bond jointly with
said town of Ellington, Connecticut, in the penal sum of Five Hundred
is accepted and approved by this court, and ordered to be recorded
of Bonds, page 370.

John E. Fahey, Judge.

Attest: M Leonard, Asst.Clerk.

E[illegible]set Purchase by PMH
Submitted October 13, 2015

EXHIBIT Q 11-2

Fund 11-1.64

Julia and Percy Baker Family Memorial Fund

WILL

OF

PERCY W. BAKER

I, Percy W. Baker, of Vernon, Connecticut, make, publish and declare this to be my last will and testament and hereby revoke all of my prior wills and codicils.

ARTICLE I: Payment of Taxes. I direct that all legacy, succession, inheritance, transfer and estate taxes payable with respect to property included in my gross estate for the purpose of any such tax excepting, however, any property with respect to which I have been granted a power of appointment, shall be paid out of my estate in the same manner as an expense of administration and shall not be prorated or apportioned among or charged to the respective devisees, legatees, beneficiaries, transferees or other recipients nor charged against any property passing or that may have passed to any of them, whether under this will or otherwise. I further direct that my estate shall not be entitled to reimbursement for any portion of any such tax from any such person.

PWB ARTICLE II: Bequests.

(1) I give and bequeath the sum of $5,000.00 to EMERSON S. ABORN of 18 Meadowbrook Road, Ellington, Connecticut, to be his, absolutely.

(2) I give and bequeath the sum of $5,000.00 to SHERWOOD H. ABORN of 13 Esther Avenue, Ellington, Connecticut, to be his, absolutely.

(3) I give and bequeath the sum of $5,000.00 to HAZEL CONNOR of 24 Lucian Street, Manchester, Connecticut, to be hers, absolutely.

(4) I give and bequeath the sum of $5,000.00 to SHIRLEY TOWNSEND of P. O. Box 1327, Clarksville, VA 23927, to be hers, absolutely.

(5) I give and bequeath the sum of $5,000.00 to EVELYN SALZER of 325 Kelly Road, Apt. 8, Vernon, Connecticut, to be hers, absolutely.

(6) I give and bequeath the sum of $2,000.00 to MARGARET PARKER of Welles Village, Vernon, Connecticut, to be hers, absolutely.

(7) I give and bequeath the sum of $1,000.00 to LINDSAY TAYLOR of 100 Talcott Avenue, Rockville, Connecticut, to be hers, absolutely.

(8) I give and bequeath the sum of $2,000.00 to PAMELA TAYLOR of 100 Talcott Avenue, Rockville, Connecticut,

to be hers, absolutely.

(9) I give and bequeath the sum of $3,000.00 to GEORGE TAYLOR of 100 Talcott Avenue, Rockville, Connecticut, to be his, absolutely.

ARTICLE III: Residue. All the rest, residue and remainder of my property, real and personal, of whatever nature and wherever situated, I give, devise and bequeath as follows:

(a) Twenty (20) per cent to be held in trust to establish a fund known as the Julia and Percy Baker Family Memorial Fund. Said fund is to be used for the upkeep and physical maintenance of the Rockville General Hospital, Rockville, Connecticut. The physical maintenance of the Hospital by said fund is defined to include items such as painting, roof repairs, furnace repairs or replacement carpet repairs or replacement, or any other repairs or replacement of existing fixtures so as to keep the Hospital in good physical condition.

The intent is that the principal of the fund so established and known as the Julia and Percy Baker Family Memorial Fund not be invaded. Only interest or other income generated by the Fund shall be used for purposes of physical maintenance, and the corpus of said fund is not to be invaded by the Trustee.

(b) Eighty (80) per cent to be held in trust to establish a fund known as the Julia and Percy Baker Family Memorial Fund. Said fund is to be used for the upkeep and physical maintenance of the Union Congregational Church of Rockville Connecticut. The physical maintenance of the Church by said fund is defined to include items such as painting, roof repairs, furnace repairs or replacement, carpet repairs or replacement, or any other repairs or replacement of existing fixtures so as to keep the Church in good physical condition.

The intent is that the principal of the fund so established and known as the Julia and Percy Baker Family Memorial Fund not be invaded. Only interest or other income generated by the Fund shall be used for purposes of physical maintenance, and the corpus of said Fund is not to be invaded by the Trustee.

ARTICLE IV: Powers. In addition to all statutory, inherent and implied powers, I give my Executor and my Trustee and any Successor Executor and Trustee full discretionary power and authority:

to retain, without liability for loss or depreciation resulting from such retention, any property, real or personal, received by them, including without limitation any investment received by them regardless of the percentage of assets represented thereby and whether or not productive of income; to invest and reinvest from time to time all or any part of the property in such stocks, common or preferred (including, without

limitation, the shares and other securities of any corporation related thereof), common trust funds, bonds, debentures, notes, securities, life insurance and annuity contracts, or other real or personal property as they may select; and to make and change such investments from time to time as they deem proper;

to sell, grant options to purchase, exchange and alter property held in my estate or as part of any trust, real or personal, at any price that they shall consider represents an adequate consideration and upon any terms that they shall deem advisable;

to lease property on any terms and conditions and for any period although extending beyond the period of any trust; to insure, improve, repair, alter and partition real estate; to erect or raze improvements; to grant easements; and to subdivide and dedicate to public use;

to cause any of the investments that may be delivered to or acquired by them to be issued, held or registered in their name, in negotiable form, in the name of a nominee or in any form in which title will pass by delivery; and any corporation or its transfer agent may presume conclusively that said nominee is the actual owner of securities submitted for transfer;

to exercise in person or by proxy, all voting, option, subscription, reorganization, consolidation, merger and liquidation rights and all other rights and privileges of whatever nature incident, appurtenant or pertaining to securities in my estate, in trust, or to which I am otherwise entitled and in connection therewith to enter into any covenant or agreement binding the estate or trust and to purchase any new securities issued as a result of or in connection with any such act;

to settle, compromise, contest or abandon claims or demands in favor of or against my estate or trust;

to borrow money, assume indebtedness, extend mortgages and encumber by mortgage or pledge although extending beyond the period of any trust;

to distribute any property distributable to a minor hereunder directly to the minor or to the minor's parent or guardian for the minor's benefit or to any person as custodian for the minor under the Uniform Gifts to Minors act of any state or in any other manner deemed to be for the minor's benefit, and the written receipt of the person receiving any such distribution shall be a full and complete discharge;

to lend funds to, sell assets to, purchase assets from, borrow from, accept contributions from and otherwise deal (in the case of my Trustee) with my estate and (in the case of my Executor) with any trust created hereunder in any manner that my Executor and Trustee shall determine to be proper; provided, however, that my Trustee shall not use or lend for the payment of any taxes, liabilities, debts or any other claims or charges against my estate any portion of any payment from an employee or self-employed benefit plan payable to my Trustee if such use or loan would subject such payment to inclusion in my gross estate for Federal estate tax purposes;

to select property to be allocated to any separate trust created herein or distributed in satisfaction of any gift provided for hereunder, without any duty of impartiality with respect to the income tax basis of such property; provided however, that such power shall not be exercised in a manner that will result in the loss of, or decrease in, any Federal estate tax deduction;

to hold the principal of two or more trusts created

hereunder in one or more consolidated funds in which the separate shares shall have undivided interests.

ARTICLE V: Executor and Trustee. I appoint WILLIAM E. HALL of Coventry, Connecticut, to be my Executor. I direct that only a nominal bond be required of him to act in such capacity.

I hereby designate that the Chairman of the Union Congregational Church Business Committee at the time of my death will be the Trustee of the Trust herein created for the Union Congregational Church. It is my intention that the successor Chairman of said Committee will become the successor Trustee under this Will. I direct that only a nominal bond be required of any Trustee to act in such capacity.

ARTICLE VI: Miscellaneous Provisions. For the purposes of this will a person who does not survive me by fifteen days shall be deemed to have predeceased me.

Neither the gender nor the number (singular or plural) of any word shall be construed to exclude another gender or number when a different gender or number would be appropriate.

The underlined captions set forth in this will at the beginning of the various ARTICLES are for convenience of reference only and shall not be deemed to define or limit the provisions contained in said ARTICLES or to affect in any way their construction or application.

PMB To the extent that any property or interest in property is disclaimed, such property or interest shall pass as if the disclaiming beneficiary had predeceased me.

If I own property that is subject to administration outside the state of my domicile, I authorize my Executor to pay the taxes and expenses of that administration from the assets of my domiciliary estate.

It is my intention that the provisions of this will shall be construed under the laws of the State of Connecticut.

ARTICLE VII: Omission. I intentionally omit any provision for my sister, JULIA H. BAKER, as she has sufficient means to provide for herself.

IN WITNESS WHEREOF, I have hereunto set my hand and seal on June 22, 1990.

Percy W Baker L.S.

Percy W. Baker

Signed, sealed, published and declared by the above-named Percy W. Baker as and for his last will and testament in the presence of us, who at his request, in his presence and in the presence of each other have hereunto subscribed our names as witnesses.

Claire C. Hart of Stafford Springs, Ct.
Claire C. Hart

Jean C DuPont of Stafford Spring, Ct.
Jean C. DuPont

STATE OF CONNECTICUT)
) ss. Vernon June 22, 1990
COUNTY OF TOLLAND)

We, the undersigned, being duly sworn do depose and say that we witnessed the execution by Percy W. Baker of his will and subscribed the same in his presence, in the presence of each other and at his request; that at the time of signing said will he appeared to us to be of full age, of sound and disposing mind and memory and competent to make testamentary disposition of real and personal property; that he voluntarily signed said will and declared it to be his last will and testament in our presence; and that this affidavit is made at his request.

Claire C. Hart
Claire C. Hart

Jean C. DuPont
Jean C. DuPont

PWB

Subscribed and sworn to before me this 22nd day of June 1990.

Faith B. Gerber
Faith B. Gerber
Notary Public
My commission expires 3/31/94

This will consists of 5 pages, all of which have been initialed by the testator.

-5-

FIRST CODICIL

OF

PERCY W. BAKER

I, PERCY W. BAKER, of the Town of Vernon, County of Tolland and State of Connecticut, do make, publish and declare this to be the first codicil to the last will and testament executed by me on June 22, 1990, in the presence of Claire C. Hart and Jean C. DuPont.

1. I revoke and annul the bequest of $5,000.00 made to EMERSON S. ABORN in ARTICLE II (1) of my said will.

In all other respects I ratify and confirm all of the provisions of my said will dated June 22, 1990.

IN WITNESS WHEREOF, I have subscribed my name to this the first codicil of my last will and testament said codicil consisting of this and one preceding typewritten page, and for the purpose of identification I have initialed each such page, in the presence of the persons witnessing it at my request this 26th day of April, 1995 at Rockville, Connecticut.

Percy W. Baker

The foregoing instrument, consisting of this and one preceding typewritten page was signed, published and declared by Percy W. Baker, the testator, to be the first codicil to his last will and testament, in our presence, and we at his request and in his presence and in the presence of each other have hereunto subscribed our names as witnesses this 26th day of April 1995, at Rockville, Connecticut.

Jean C. DuPont of Stafford Springs, CT
Stafford Springs, CT

Lynn A. Bancroft of East Windsor, CT
East Windsor, CT

STATE OF CONNECTICUT)
) ss. Rockville, April 26, 1995
COUNTY OF TOLLAND)

Then and there personally appeared the within named Jean C. DuPont and Lynn A. Bancroft who being duly sworn depose and say that they witnessed the execution of the within codicil of the within named testator; that said Percy W. Baker subscribed said codicil and declared in their presence the same to be a first codicil to the last will and testament executed by him on the 22nd day of June, 1990; and that they thereafter subscribed the same as witnesses in the presence of said testator and in the presence of each other and at the request of said testator; that the said testator at the time of the execution of said codicil appeared to them to be of full age and of sound mind and memory and that they make this affidavit at the request of said testator, Percy W. Baker.

Jean C. DuPont

Lynn A. Bancroft

Subscribed and sworn to before me this 26th day of April, 1995.

Commissioner of Superior Court
Notary Public

My Commission Exp. Aug. 31, 1999

SECOND CODICIL

OF

PERCY W. BAKER

I, PERCY W. BAKER, of the Town of Vernon, County of Tolland and State of Connecticut, being of lawful age, of sound and disposing mind, memory and judgment, do hereby make, publish and declare this to be the SECOND CODICIL to the LAST WILL AND TESTAMENT executed by me on June 22, 1990, in the presence of Claire C. Hart and Jean C. Dupont and FIRST CODICIL executed by me on April 26, 1995 in the presence of Jean C. Dupont and Lynn A. Bancroft.

1. I revoke and annul the bequest of $5,000.00 made to EMERSON S. ABORN in ARTICLE II (1) of my said will.

2. I revoke ARTICLE V and substitute in lieu thereof the following:

ARTICLE V: Executor and Trustee. I appoint MARTIN B. BURKE, of Vernon, Connecticut, to by my Executor. I direct that only a nominal bond be required of him to act in such capacity.

I hereby designate that the Chairman of the Union Congregational Church Business Committee at the time of my death will be the Trustee of the Trust herein created for the Union Congregational Church. It is my intention that the successor Chairman of said Committee will become the successor Trustee under this Will. I direct that only a nominal bond be required of any Trustee to act in such capacity.

In all other respects, I ratify and confirm all of the provisions of my said Will dated June 22, 1990 and First Codicil dated April 26, 1995.

IN WITNESS WHEREOF, I have subscribed my name to this the SECOND CODICIL to my LAST WILL AND TESTAMENT, in the presence of the persons witnessing it at my request this 16th day of May, 1997, at Vernon, Connecticut.

Percy W. Baker

Percy W. Baker

The foregoing instrument, consisting of this typewritten page, was signed, published and declared by Percy W. Baker to be the SECOND CODICIL to his LAST WILL AND TESTAMENT, in our presence, and we, at his request, and in his presence and in the presence of each other, have hereunto subscribed our names as witnesses this 16th day of May, 1997, at Vernon, Connecticut.

Richard H. Dewey of Stafford Springs, Connecticut
Richard H. Dewey Stafford Springs, CT

Patricia R. Hays of Windsor, CT
Patricia R. Hays Windsor, CT

STATE OF CONNECTICUT)

) ss. Vernon

COUNTY OF TOLLAND)

This 16th day of May, 1997, then and there personally appeared the within named Richard H. Dewey and Patricia R. Hays who, being duly sworn, depose and say that they witnessed the execution of the within Codicil of the within named Testator; that said Percy W. Baker subscribed said Codicil and declared the same to be the SECOND CODICIL to his LAST WILL AND TESTAMENT in their presence; that they thereafter subscribed the same as witnesses in the presence of said Testator and in the presence of each other and at the request of said Testator; that the said Testator at the time of the execution of said Codicil appeared to them to be of full age and of sound mind, memory and judgment; and that they make this affidavit at the request of said Testator, PERCY W. BAKER.

Richard H. Dewey
Richard H. Dewey

Patricia R. Hays
Patricia R. Hays

Subscribed and sworn to before me this 16th day of May, 1997.

Lynn A. Bancroft
Lynn A. Bancroft
Notary Public

My Commission Exp. Aug. 31, 1999

EXHIBIT Q 11-2

Fund 11-1.65

Faith S. Schortmann Fund

09/30/2010 THU 11:00 FAX [illegible] ECHN DEVELOPMENT [illegible]

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Last Will and Testament

I, FAITH S. SCHORTMANN, a.k.a. FAITH L. SCHORTMANN, of the Town of Ellington, County of Tolland, and State of Connecticut, hereby make, publish and declare this to be my Last Will and Testament, hereby revoking all previous Wills and Codicils by me made.

ARTICLE I

I direct that all my enforceable debts, administration and funeral expenses be paid as soon as practicable after my death. In the event that any property or interest in property passing under this Will, by operation of law, or otherwise, shall be encumbered by mortgage or lien, or shall be hypothecated and/or pledged to secure any obligation, my Co-Executors (hereinafter defined to include any successor or substitute Executor, Executrix, Administrator or Administratrix), in their sole and absolute discretion, may, but need not, charge such mortgage, lien, or security interest against, pay the same from or purchase the underlying obligation with, assets of my estate.

ARTICLE II

I direct that my Co-Executors pay, as an expense of administration, out of my residuary estate, without apportionment, all federal and state estate, inheritance and succession taxes (including any interest and penalties) incurred by reason of my death in respect of all property required to be included in my gross estate for the purpose of such taxes, whether such property passes under this Will or otherwise, (excepting, however, any property over which I have a power of appointment, which property shall be liable to my Co-Executors for that amount of the taxes beyond which would have been assessed, had such property not been included in my taxable estate), without contribution by any recipient of any such property.

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ARTICLE III

I hereby give and bequeath to my nieces, MARILYN SKINNER CHASE, of Coventry, Connecticut, and DIANNE MCLAUGHLIN, of Somers, Connecticut, in approximately equal shares as they shall mutually agree, the following items of tangible personal property: my cut glass collection, my pink globe lamp, all my china, my china buffet closet, all my silverware and all my jewelry owned by me at the time of my death.

ARTICLE IV

To the individuals listed below, I hereby give and bequeath the following:

A. To my sister-in-law, ELEANOR I. SKINNER, of Vernon, Connecticut, my collection of owls and my collection of music boxes;

B. To my brother, LEROY B. SKINNER, of Vernon, Connecticut, all my tangible personal property (except business interests, partnership interests, United States bonds, treasury certificates, stocks, securities and cash on hand or on deposit), which is located in the basement of my personal residence at the time of my death; and

C. To my sister-in-law, PHYLLIS SKINNER, all the rest of my tangible personal property (except business interests, partnership interests, United States bonds, treasury certificates, stocks, securities and cash on hand or on deposit) owned by me at the time of my death.

If any of the individual beneficiaries named in this Article IV shall not survive me, the bequest to such individual(s) shall lapse and same shall become part of my residuary estate, hereinafter disposed of.

I may leave a memorandum of my wishes regarding the ultimate disposition of some or all of such property, and I would hope that my wishes as to the disposition of such property would be respected, insofar as those wishes are made known, but such

memorandum shall not affect the absolute nature of these bequests.

ARTICLE V

I hereby give and bequeath to my brother, LEROY B. SKINNER, and my sister-in-law, ELEANOR I. SKINNER, or unto the survivor of them, all stock of Northeast Utilities owned by me at the time of my death. In the event both LEROY B. SKINNER and ELEANOR I. SKINNER shall predecease me, then this bequest shall lapse and shall become part of my residuary estate, hereinafter disposed of.

ARTICLE VI

I hereby give and bequeath to ROCKVILLE GENERAL HOSPITAL, INC., located in Vernon, Connecticut, the proceeds of all my investments with the IDS Financial Services, Inc., and its related companies, to be held as a separate fund known as the FAITH S. SCHORTMANN FUND. Said Fund shall be restricted, and the Board of Trustees or other governing body of said ROCKVILLE GENERAL HOSPITAL, INC., shall invest and reinvest such Fund in any manner it deems appropriate, but shall use or expend only the income therefrom (without invasion of the principal of said Fund) for such purposes directly related to the operation and/or improvement of the maternity and nursery facilities of said ROCKVILLE GENERAL HOSPITAL, INC., in whatever manner it deems appropriate.

ARTICLE VII

To the organizations listed below, I hereby give and bequeath the following:

A. To the CONNECTICUT STATE GRANGE, ORDER OF PATRONS OF HUSBANDRY, CHAPTER 52, of Vernon, Connecticut, the sum of FIVE HUNDRED DOLLARS ($500.00);

B. To the AMERICAN LEGION AUXILIARY DOBSOZ ERTFL HOBAR HANSEN, UNIT 14, of Vernon, Connecticut, the sum of FIVE HUNDRED DOLLARS ($500.00);

FILED

C. To the ROCKVILLE GENERAL HOSPITAL AUXILIARY, of Vernon, Connecticut, the sum of FIVE HUNDRED DOLLARS ($500.00); and

D. To the VISITING NURSES ASSOCIATION, of Vernon, Connecticut, the sum of FIVE HUNDRED DOLLARS ($500.00).

These bequests are unrestricted, and the Board of Trustees or other governing body of each such organization may use and expend its bequest for its benefit in any manner it deems appropriate.

ARTICLE VIII

I hereby give, devise and bequeath all the rest, residue and remainder of the property which I may own at the time of my death, real, personal and mixed, of whatsoever nature and wheresoever situated, including all property which I may acquire or become entitled to after the execution of this Will, (hereinafter referred to as my "residuary estate"), as follows:

A. FORTY-FIVE PERCENT (45%) of my said residuary estate to ROCKVILLE GENERAL HOSPITAL, INC., of Vernon, Connecticut, to be added to and become a part of the FAITH S. SCHORTMANN FUND, to be used and expended in accordance with the terms of Article VI of this, my Last Will and Testament;

B. FORTY-FIVE PERCENT (45%) of my said residuary estate to my brother, LEROY B. SKINNER, and my sister-in-law, ELEANOR I. SKINNER, or unto the survivor of them, to be theirs absolutely. In the event both LEROY B. SKINNER and ELEANOR I. SKINNER shall predecease me, then this legacy shall lapse and shall pass instead to the other then living beneficiaries or existing organization taking under this Article VIII, allocated in accordance with and in proportion to each such beneficiary's respective share of my residuary estate as set forth under this Article VIII;

C. FIVE PERCENT (5%) of my said residuary estate to the Trustees under a certain Trust Indenture by and between

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GEORGE R. SKINNER, JR. (a.k.a. RAYMOND SKINNER) as Donor and ELEANOR I. SKINNER and FAITH S. SCHORTMANN as Trustees, dated October 19, 1960, said Trust being for the benefit of my brother, GEORGE R. SKINNER, JR. Such percentage of my residuary estate shall be added to the principal of the Trust created under said Trust Indenture, including any amendments thereto, to be held, administered and distributed in all respects as an integral part thereof. In the event GEORGE R. SKINNER, JR., shall predecease me, then this legacy to the Trustees of said Trust Indenture shall lapse and shall pass instead to the other then living beneficiaries or existing organization taking under this Article VIII, allocated in accordance with and in proportion to each such beneficiary's respective share of my residuary estate as set forth in this Article VIII; and

D. FIVE PERCENT (5%) of my said residuary estate to my sister-in-law, PHYLLIS SKINNER, provided, however, in the event PHYLLIS SKINNER shall predecease me, then her then living issue shall take, per stirpes, the share of my residuary estate she would have taken, has she survived me.

ARTICLE IX

At the time of the execution of this Will, I am widowed and have no children.

ARTICLE X

If any person named or referred to in this my Will and I shall die under such circumstances that it is difficult or impossible to determine who predeceased the other, then I direct that the terms and provisions of this my Will shall be construed as though I had survived such other person and that my estate shall be administered and distributed in all respects accordingly.

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ARTICLE XI

I hereby incorporate by reference the "Fiduciary Powers Act", as set forth in Connecticut General Statutes, Sec. 45-100e, and grant to my Co-Executors (including any successor Executor or Executrix herein named) the powers enumerated therein.

ARTICLE XII

I hereby appoint my brother, LEROY B. SKINNER, of the Town of Vernon, County of Tolland, and State of Connecticut, and my sister-in-law, ELEANOR I. SKINNER, of the Town of Vernon, County of Tolland, and State of Connecticut, Co-Executors of this my Last Will and Testament, to serve without bond insofar as the laws of any state in which my estate is administered allow. In the event that either of them is unable or unwilling to act, or continue to act, in such capacity, then the remaining Co-Executor shall act alone as the Executor or Executrix, as the case may be, of this, my Last Will and Testament.

IN WITNESS WHEREOF, I have hereunto set my hand and seal at Vernon, Connecticut, on the 21st day of November, A.D., One Thousand Nine Hundred Ninety.

Faith L. Schortmann
FAITH S. SCHORTMANN

Faith L. Schortmann
FAITH L. SCHORTMANN

Signed, sealed, published and declared by the said FAITH S. SCHORTMANN, a.k.a. FAITH L. SCHORTMANN, as and for her Last Will and Testament in the presence of us, who at her request, and in the presence of each other have hereunto subscribed our names as witnesses, on the 21st day of November, A.D., 1990.

Brian J. Couturier — 14 Belmont Rd. East Hartford CT
Brian J. Couturier

William J. Dakin — Boston Hill Rd, Andover, CT

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STATE OF CONNECTICUT)
) ss. Vernon November 21, 1990
COUNTY OF TOLLAND)

We, the within named, Brian J. Couturier and William J. Dakin, being duly sworn, depose and say: That we severally attested the within and foregoing Will of the within named Testatrix and subscribed the same in her presence and at her request and in the presence of each other; that the said Testatrix signed, published and declared the said instrument as and for her Last Will and Testament in our presence on the 21st day of November, A.D., 1990; and at the time of the execution of said Will, said Testatrix was more than eighteen years of age and of sound mind, memory and judgement and under no improper influence or restraint to the best of our knowledge and belief, and we make this affidavit at the request of said Testatrix.

Brian J. Couturier

William J. Dakin

STATE OF CONNECTICUT)
) ss. Vernon November 21, 1990
COUNTY OF TOLLAND)

Then and there personally appeared before me, Colleen M. McCarthy, duly qualified to administer oaths

Brian J. Couturier
and William J. Dakin
and subscribed and made oath to the truth of the foregoing affidavit.

Colleen M. McCarthy
Commissioner of Superior Court

EXHIBIT Q 11-2

Fund 11-1.66

Swindells Fund

DISTRICT OF ELLINGTON

(Continued from page 276) (Estate Frederick W. Swindells)

accepted said trust, and gave bond jointly with The Aetna Casualty & Surety Company of Hartford, Connecticut, as surety in the penal sum of Ten Thousand (10,000) Dollars, which is accepted and approved by this Court and ordered to be recorded and kept on file.
(Recorded in Vol. 6 of Bonds, page 143)
Ordered, That twelve months from the 5th day of October, 1931, be and the same are allowed the Executors within which to settle said estate.
Ordered, That six months from the 5th day of October, 1931, be and the same are limited and allowed for the creditors to bring in their claims against said estate, and the said Executors are directed to give public notice to the creditors to bring in their claims within said time allowed, by posting a copy of this order upon the public sign-post nearest to the place where the deceased last dwelt within said town, and by publishing the same once in some newspaper having a circulation in said Probate District within fifteen days from the date of this order and return make to this Court of the notice given, and of a list of all claims presented within said time.
Ordered, That two months from the 5th day of October, 1931, be and the same are allowed the Executors within which to make, or cause to be made, a true and perfect inventory of all the estate of said deceased, both real and personal, including choses in action. And this Court appoints Hugh T. Bass and Ernest H. Cady, Jr., disinterested persons, appraisers under oath, to appraise said estate, and return make to this Court within said time allowed.

By order of Court, John E. Fahey Clerk.

A true copy Attest: Asst. Clerk

To the Probate Court for the District of Ellington:

Estate of Frederick W. Swindells, late of Rockville, in said District, deceased.

The subscribers, having been appointed Executors of the will of said deceased, hereby accept said trust and agree to execute the same.
Dated this 5th day of October, 1931.

Annie Swindells
Frederick Swindells
Hartford National Bank and Trust Company,
By William B. Dana Associate Trust Officer.

A true copy Attest: Asst. Clerk

I, Frederick W. Swindells, of Rockville, Connecticut, hereby make the following as my last will and testament, hereby revoking all former wills by me made.

First: I appoint my father, Frederick Swindells, my mother, Annie Swindells, and Hartford National Bank and Trust Company, a national banking association, located in Hartford, Connecticut, Executors of this will. I relieve my father and mother from the necessity of furnishing bonds as Executors. I authorize my Executors and their successor or successors to sell and convey any property, real and personal, which may form part of my estate. All succession, inheritance, transfer, legacy and estate taxes shall be paid from my estate as administration expenses.

Second: All my articles of personal and household use and adornment, including household effects and all property of whatever nature that may be located in my home or homes at the time of my death, except cash and securities, if any, I give to my father, Frederick Swindells, and to my mother, Annie Swindells, in equal portions, or to the survivor thereof. In case neither my father nor my mother survive me, I give the same to my Trustees named in paragraph Sixth of this will in equal portions with the request that they make such disposition thereof as in their opinion would meet my wishes.

Third: I give to my wife, Lois W. Swindells, the life use of one-third of my estate upon furnishing by her of a proper probate bond for the protection of the principal of the same.

Fourth: I give to said Hartford National Bank and Trust Company and its successor or successors the sum of Twenty Thousand (20,000) Dollars, authorizing my Executors to use for that purpose securities at their valuation. Said fund shall be held by said Hartford National Bank and Trust Company as a trust fund with powers and duties in respect thereto as follows:

(a) To sell and convey the same.

(b) To invest and reinvest the proceeds of such sale or sales at the sole discretion of my Trustee without restriction to trust investments so-called.

(c) To collect the income thereof and, after paying all proper charges therefrom, to pay to or for the benefit of George M. Allen of Rockville, Connecticut, said net income in quarterly installments or oftener at the discretion of my Trustee so long as he shall live.

(Continued over)

DISTRICT OF ELLINGTON

(Continued from page 277) (Estate Frederick W. Swindells)

Fifth: I give to said Hartford National Bank and Trust Company, its successor or successors, the sum of Twenty Thousand (20,000) Dollars, authorizing my Executors to use for that purpose securities at their valuation, in trust, however, for the following uses and purposes:

(a) To sell and convey the same.

(b) To invest and reinvest the proceeds of such sale or sales at the sole discretion of my Trustee without restriction to trust investments so-called.

(c) To collect the income thereof and, after paying all proper charges therefrom, to pay the net income to or for the benefit of Edna May Henry, who has been in my family as a ward, in quarterly installments or oftener at the discretion of my Trustee, so long as she shall live.

Sixth: All the rest and residue of my property and estate, together with all property and estate over which I may have the power of appointment by the will of my father, Frederick Swindells, of Rockville, Connecticut, and/or by his said trust instrument, I give, devise and bequeath to Hartford National Bank and Trust Company and to The Travelers Bank and Trust Company, corporations located in Hartford, Connecticut, in equal amounts, to be held by said trust companies respectively, as Trustees, with powers and duties as follows:

(a) Their powers and duties in reference to the investment and management of said trust funds shall be those set forth in clauses (a) and (b) of paragraph Fourth of this will. Said Trustees shall collect the income of said respective trust funds, and, after paying all proper charges therefrom, shall pay the net income thereof in semi-annual installments or oftener at their discretion to charitable corporations or societies incorporated for the relief of sick and suffering poor children, and/or for the relief of sick suffering and indigent, aged men and women, and/or for the support of public and charitable hospitals. I direct that each of said Trustees shall select such corporations from time to time depending upon the work of the corporations for the charities aforesaid and the needs and scope of their work. I give to such Trustees the widest discretion in this matter for I am aware that the disposition of funds held for charitable purposes intended to be administered in perpetuity must necessarily change from time to time. I intend to be definite in my instructions within the requirements of law and yet give to my Trustees freedom of disposition of such income within such defined limits. The ultimate beneficiaries of this charity shall be poor and suffering individuals. I prefer that the almoner corporations or societies which are the immediate administrators of such charities shall be few rather than numerous, for it does not seem to me wise that there should be a scramble among charitable corporations or societies for the distribution of the funds above constituted. Said trust funds are to be known as the Swindells Charitable Foundations.

In Testimony Whereof I have hereunto set my hand and seal at Truro N.S., this 15 day of October 1930.

Frederick W. Swindells (L.S.)

Signed, sealed, published and declared to be as and for his last will and testament by the above named testator, Frederick W. Swindells, in our presence who in his presence and in the presence of each other and at his request have hereunto subscribed our names as attesting witnesses at Truro Nova Scotia aforesaid this 15th day of October, 1930.

Name.	Residence.
Harold F. Bethel	Truro Nova Scotia
Preston J Wilcox	Truro Nova Scotia
Percy W Tupper	Truro Nova Scotia

Province of Nova Scotia)
County of Colchester) ss. Truro Nova Scotia October 15th 1930.

The within Harold F. Bethel Preston J. Wilcox and Percy W. Tupper, being duly sworn, depose and say that they witnessed the within will of the within named testator, Frederick W. Swindells, and subscribed the same in his presence and at his request and in the presence of each other; that said Frederick W. Swindells at the time of the execution of said will appeared to them to be of full age and of sound mind and memory; that he signed said will and declared the same to be his last will and testament in their presence; and that they make this affidavit at the request of such testator.

Harold F Bethel
Preston J Wilcox
Percy W Tupper

Subscribed and sworn to at the request of the within named testator, Frederick W. Swindells, the day and year first above written, before me,

H. O. Maclatchy
Notary Public.
Nova Scotia

(Seal)

A true copy Attest Gertrude L. Keating Asst. Clerk

HARTFORD NATIONAL BANK AND TRUST COMPANY

HARTFORD, CONNECTICUT

Trust Department

October 24, 1933

The Rockville City Hospital
45 Prospect Street
Rockville, Connecticut

Gentlemen:

F. W. SWINDELLS CHARITABLE FOUNDATION

As you may know, this company and the Travelers Bank and Trust Company are Trustees of the Charitable Foundation created by the will of the late Frederick W. Swindells.

Under the provisions of his will the income from this fund is distributed from time to time to hospitals and charitable organizations for the care of the poor and suffering, which organizations are selected by the Trustees.

We feel that it is entirely fitting a contribution should be made to the Hospital in Rockville, which was Mr. Swindell's residence, and we are accordingly enclosing herewith a check to your order for $500. We understand that you will receive a similar check from the Travelers Bank and Trust Company.

Will you be good enough to acknowledge receipt of this?

Very truly yours,

Signed:
William B. Dana
ASSOCIATE TRUST OFFICER

WBD:MLF

HARTFORD, CONNECTICUT

Department

October 24, 1933.

Rockville City Hospital,
Rockville, Connecticut.

Gentlemen:

The Travelers Bank and Trust Company is trustee for one-half of a fund known as the F. W. Swindells Charitable Foundation created in the will of F. W. Swindells, late of Rockville, Connecticut. One of the specific purposes of this trust fund is "for the support of public and charitable hospitals".

Mr. Frederick Swindells of Rockville, in advising with us as to the disposition of certain amounts of income now on hand, suggests that we send an amount of $500 to your institution for the general uses and purposes of your institution. We are accordingly enclosing our check for this amount, payable to the Rockville City Hospital and will ask you to sign the enclosed receipt and return it to us.

Very truly yours,

Signed:

John B. Bolles
Assistant Secretary

Rockville, Connecticut, January 27, 1936

The annual meeting of the Trustees of The Rockville City Hospital was held this day in the Directors' Room of The Hartford-Connecticut Trust Company, "Rockville Branch", F. N. [illegible], Vice-President, in the Chair.

The minutes of the last annual meeting were read and approved.

The treasurer's report was also read and approved and voted to be placed on file.

The report of the Superintendent was read and approved.

The report of J. Everett North, Auditor of Agnes H. Lazzerin, Superintendent's report, was also read and approved.

Additional report of the Secretary is as follows:

"The Rockville City Hospital has been particularly favored during the past year in the gift of funds as follows:

Gift of the Rockville Athletic Association (deposited in State Savings Bank, Hartford)	$ 981.86
Gift of United Polish Societies (deposited in People's Savings Bank, Rockville)	$ 383.32
Gift of Florence P. Maxwell, Francis T. Maxwell, and Priscilla Endicott (for Nurses' Home) (disbursed on Nurses' Home remodeling $7,544.54)	$7,600.00
Gift of William Maxwell (not yet invested)	$4,500.00
Income received from F. W. Swindells Charitable Foundation	$ 500.00

The Nurses' Home, under the gratuitous supervision of George Arnold, Jr., has been thoroughly remodeled, the major items being the installation of new heating apparatus, new plumbing and fixtures, new floors laid, the entire interior painted and papered. A number of ladies contributed to the Home, articles of furniture and draperies. Mr. Francis T. Maxwell contributed an electric refrigerator. Workmen have made reduction in the amount of their bills for services rendered. The result of these contributions has given to the Hospital a Nurses' Home that is ideal in every respect and much enjoyed by the nurses.

The Trustees much appreciate the interest that has been shown by different individuals in bringing about these conditions.

The sterilizing outfit at the Hospital, which has been in use for a number of years, has arrived at a condition that necessitates frequent repairs. It has been deemed advisable that it be replaced with a new outfit, the installing of which is now in process at an estimated cost of $2,000."

Voted to instruct our Treasurer to consolidate all of the investments of the special "Funds" of less than $5,000., unless it shall conflict with the terms of the will or the wishes of the donor.

Voted to instruct our Treasurer that before such consolidation is made, that any income that has been allowed to accumulate in any of our funds be transferred to the "General Fund", unless such increase is called for by the terms of the will or the wishes of the donor.

Voted that the Treasurer withdraw any legacies or special gifts that may at present be carried in the "General Fund", and that the same be specially designated as are the other special funds, selecting such investments from the General Fund as the Treasurer may deem best.

Voted that our Treasurer keep a list of the names of the donors and amount of each gift that make up the Consolidated Invested Funds, to be kept with the same.

Voted that we approve the sale of securities and investments that have been made by the Finance Committee or the Treasurer during the past year as shown in the Treasurer's report.

Voted to sell one and 45/55ths shares General Motors Common held by the Robert Maxwell Fund, being a dividend received from the E. I. DuPont deNemours Co. Common.

The following Trustees were elected by ballot as officers for the year ensuing:

F. T. Maxwell	President
F. N. Belding	Vice-President
A. T. Bissell	Secretary
The Hartford-Connecticut Trust Co. "Rockville Branch"	Treasurer
F. N. Belding, George Arnold, Jr. and L. F. Bissell	Auditors
F. N. Belding, F. T. Maxwell and A. T. Bissell	Finance Committee

The following Trustees were present at the meeting:

F. N. Belding
A. T. Bissell
George Arnold, Jr.
Lebbeus F. Bissell

The following named persons are Trustees of The Rockville City Hospital:

F. T. Maxwell
F. N. Belding
A. T. Bissell
George Arnold, Jr.
Lebbeus F. Bissell

Meeting dissolved,

Attest:

A. T. Bissell

Secretary.

January 21, 1941

Following the adjourned meeting of the corporators of The Rockville City Hospital, Inc. this day, a meeting of the Trustees was held.

Those present were:

Arthur T. Bissell
George Arnold, Jr.
Lebbeus F. Bissell
Donald C. Fisk
Frederick H. Holt, representing The Hartford-Connecticut Trust Company, Rockville Branch, Treasurer.

Mr. George Arnold, Jr. was elected chairman, due to the absence of Francis T. Maxwell and Frederick N. Belding.

The minutes of the previous annual meeting held on January 16, 1940 and a special meeting of the trustees held on December 19, 1940 were read, approved and accepted.

The Treasurer's report was read by Mr. Frederick H. Holt and was accepted.

Five gifts were received through the year, namely:

$3,000.00 from the Estate of Charlotte Howell; $103,413.25 from the Estate of the late Fred Talcott; $1000.00 from the Sabra Trumbull Chapter of the Daughters of the American Revolution; $9700.00 from Mr. Francis T. Maxwell; $500.00 from the Frederick W. Swindells Charitable Foundation. Mr. Holt also stated that there had been an additional $13,500.00 received from the Fred Talcott Estate between the completing of the Treasurer's report and the date of this meeting.

A vote of appreciation of the very generous gift of Francis

T. Maxwell in the amount of $9700.00 to the Rockville City Hospital was ordered placed on record.

The report of the auditors - George Arnold, Jr., Frederick N. Belding and Lebbeus F. Bissell - was accepted.

The report of Kenneth M. White, auditor for the accounts of Mrs. Agnes H. Lazzerin, Superintendent of the Hospital, was accepted and ordered placed on file.

The report of Agnes H. Lazzerin, Superintendent of the Hospital was accepted and ordered placed on file.

The report of Margaret E. Ronan, X-Ray Technician was accepted and ordered placed on file.

The report of Margaret E. Fay, Laboratory Technician was accepted and ordered placed on file.

It was voted that the Secretary cast one ballot for the following officers for the ensuing year, or until their successors are chosen:

President	Francis T. Maxwell
Vice-President	Frederick N. Belding
Secretary	Donald C. Fisk
Treasurer	The Hartford-Connecticut Trust Company, Rockville Branch

The ballot was cast and the chairman declared them elected.

It was voted that the Secretary cast one ballot for the following to serve as Executive Committee for the ensuing year, or until their successors are chosen:

Francis T. Maxwell
Arthur T. Bissell
George Arnold, Jr.

The ballot was cast and the chairman declared them elected.

It was voted that the Secretary cast one ballot for the following to serve as Finance Committee for the ensuing year, or until their successors are chosen:

Francis T. Maxwell
Frederick N. Belding
Arthur T. Bissell

The ballot was cast and the chairman declared them elected.

It was voted that the Secretary cast one ballot for the following to serve as Auditors for the ensuing year, or until their successors are chosen:

George Arnold, Jr.
Frederick N. Belding
Lebbeus F. Bissell

The ballot was cast and the chairman declared them elected.

A general discussion of the accounts receivable was had and it was voted that Donald C. Fisk make recommendations to George Arnold, Jr. and Lebbeus F. Bissell as to those accounts in which, in his opinion, actions should be instituted for the collection thereof.

It was voted that the Finance Committee appoint an auditor for the accounts of Agnes H. Lazzerin, Superintendent of the Hospital.

A report by Lebbeus F. Bissell was made concerning certain differences between Agnes H. Lazzerin, Superintendent of the Hospital, and some of the doctors on the staff of the Rockville City Hospital, and a general discussion was had concerning the same.

No other business coming before the meeting, same was adjourned.

Attest: Donald C. Fisk
Secretary

F-2

ROCKVILLE CITY HOSPITAL

Source and Terms of Funds Held

Alvah N. Belding Fund #73041 - Bequest u/w Alvah N. Belding - Permanent Endowment - Income for general purposes.

Terms of Will - "To be used and expended for the purposes indicated in the Will of William H. Prescott, as they may deem most advisable."

Alice Farmer Bissell Fund #73051 - Bequest under the Will of Arthur T. Bissell - Permanent Endowment - Income for general purposes.

Terms of Will - Fourth: I give and bequeath to the Rockville City Hospital the sum of Twenty-five Thousand Dollars ($25,000) to be kept as a permanent fund in memory of my wife, Alice Farmer Bissell, and to be known as the Alice Farmer Bissell Fund. The net income from said fund shall be used and applied for the general purposes of said Hospital.

Ruth T. Britton Fund #73061 - Bequest u/w Ruth Talcott Britton - Permanent Endowment - Income for general purposes.

Terms of Will - "in trust to keep said sum safely invested, and to use and apply the income for the general purposes of said Hospital at the discretion of its trustees."

Consolidated Fund #73081 - This fund represents all bequests of $3,000 or less left with no instructions as to use. Principal is considered permanent endowment - Income is used for general expenses of the Hospital.

George S. Doane Fund #73101 - No record found of source of this fund. Principal is considered permanent endowment - all income is used for expenses of the Hospital.

General Fund #73121 - This fund represents small gifts and bequests which were unrestricted as to use of principal or income. Principal is considered unrestricted - Income is used for general expenses of the Hospital.

Lenore Henry Fund #73141 - Bequest u/w E. Stevens Henry - Permanent endowment - Income for general purposes.

Terms of Will - Ninth: I give and bequeath to the Hospital to be established in Rockville under the provisions of the Will of the late William H. Prescott to be known as the "Rockville City Hospital." This bequest is to constitute a special endowment fund of Fifty Thousand Dollars ($50,000) to be set apart and known as the Maud Henry Fund in memory of my deceased daughter, Maud. I likewise give and bequeath Fifty Thousand Dollars ($50,000) to said Hospital also to be set apart as a separate endowment fund and known as the "Lenore Henry" Fund in memory of my deceased daughter, Lenore. The income of these two funds is to be used for the maintenance of said Hospital. My Executors are directed to provide for this fund by selecting and transferring from my estate to trustees or duly authorized agent of said Hospital certain bonds or savings bank deposits of the par value of One Hundred Thousand Dollars ($100,000), and I further direct that whenever reinvestments become necessary or advisable such reinvestments shall be limited and confined to securities legal for savings banks of Connecticut or in deposits in savings banks.

Maud Henry Fund #73161 - Bequest u/w E. Stevens Henry - Permanent endowment - Income for general purposes. (For terms of will, see Lenore Henry Fund)

J. Alice Maxwell Fund #73171 - Bequest u/w J. Alice Maxwell - Permanent endowment - Income for general purposes.

> Terms of Will - NINTH: To ROCKVILLE CITY HOSPITAL, in Rockville, Connecticut, I give, devise and bequeath four of said equal parts of my said residuary estate in trust to use the income thereof for the general purposes of the said Hospital.

John and Martha Kress Fund #73181 - Bequest under will of Martha Kress - This fund was left for a special purpose. In accordance with the instructions of the Board of Trustees of the Hospital, income accumulates and is transferred to principal for reinvestment.

> Terms of Will - "To be used for the purpose of equipping, furnishing, and maintaining a room in said Hospital to be known and called the "John and Martha Kress Room".

Edgar Kenny Fund #73201 - No record found of source of this fund. It is believed to have been left for a special purpose. In accordance with the instructions of the Board of Trustees of the Hospital, income accumulates and is transferred to principal for reinvestment.

Francis T. Maxwell Fund #73211 - This fund is considered permanent endowment. Income is used for general purposes. The fund consists of the proceeds of a $50,000 life insurance policy on the life of Francis T. Maxwell, plus gifts by Mr. Maxwell during his life of 50 shares Phoenix Insurance Company and 200 shares Hartford Gas Company. These gifts of stock were restricted to use of income for general purposes and principal to be used only toward a new hospital.

Harriet K. Maxwell Fund #73221 - Bequest under will of Harriet K. Maxwell - outright legacy - income is used for general expenses of the Hospital.

> Terms of Will - Third: "----and unto the Rockville City Hospital of Rockville, Connecticut, the sum of Five Thousand Dollars ($5,000)

Robert Maxwell Fund #73241 - Bequest u/w Robert Maxwell - outright legacy - income is used for general expenses of the Hospital. (The will gave discretion to executors to devote sum of $100,000 "in such manner as they may deem suitable for the benefit of said residents of Rockville and vicinity". One Hundred Thousand Dollars ($100,000) was paid to Rockville City Hospital per final account of executors.)

William A. and Caroline E. Metcalf Fund #73251 - Bequest u/w Caroline E. Steele Metcalf - Permanent endowment - Income for general purposes.

> Terms of Will - NINTH: All the rest, residue and remainder of my estate, of whatsoever nature and wheresoever situated, I give, bequeath and devise to the Trustees of The Rockville City Hospital, Inc., a charitable corporation organized and existing under the laws of the State of Connecticut, and owning and operating a hospital in said Town of Vernon, in trust, nevertheless, to hold invest and reinvest the same and to use the income thereof for the general uses and purposes of said Hospital as said Trustees shall see fit. Said trust shall be known as the William S. and Caroline E. Metcalf Fund.

William Maxwell Fund #73261 - This fund consists of the following:

Cash gifts by Mr. Maxwell during 1936 to 1938	$14,000.00
Proceeds of life insurance (1939)	61,472.99
Bequest under 14th clause of will	96,246.01
	$171,719.00

Terms of Will - FOURTEENTH: To ROCKVILLE CITY HOSPITAL, in Rockville, Connecticut, I give, devise and bequeath four of said equal parts of my said residuary estate in trust to use the income thereof for the general purposes of said Hospital.

Charles Phelps Free Bed Fund #73271 - Gift of $10,000 from Mrs. Elsie S. Phelps - Permanent endowment - Income for special purposes. Any amount of this fund in excess of $10,000 represents accumulated income and is considered available if necessary.

Terms of Gift

"1. For the benefit of any members of my household staff or their families who may be in need of the services which the fund can provide.

2. For the general use and benefit of the residents of the City of Rockville.

The fund, aside from the small conditions which I wish to impose for the benefit of my household staff, which will fall within the income limitations of the fund, will be managed by the Board of Trustees and Finance Committee of The Rockville City Hospital with full powers of sale, investment and reinvestment."

Celia E. Prescott Fund #73281 - This fund was left for a special purpose. In accordance with the instructions of the Board of Trustees of the Hospital, income accumulates and is transferred to principal for reinvestment.

Terms of Gift

$10,000. for free bed in honor of Francis and Eliza Porter Keeney
$ 5,000. for free bed in memory of Francis Keney Prescott
$ 400. for furnishing a room in memory of Jane E. Newcomb

George Palmer Charter Fund #73291 - Bequest under Second and Seventeenth Clauses of Will of George Palmer Charter - permanent endowment - income for general purposes.

Terms of Will

SECOND

I give and bequeath to the Rockville City Hospital, located in the city of Rockville, State of Connecticut, the sum of Ten Thousand (10,000) dollars, in trust, however, for the following uses and purposes, namely: The governing body of said hospital shall invest said sum of $10,000 and the annual income of said sum shall be used for the general maintenance of said Hospital.

George Palmer Charter Fund #73291 continued

SEVENTEENTH

All the rest, residue and remainder of my estate, of whatsoever nature and wheresoever situated which I may own or have the right to dispose of at the time of my decease, I give, devise and bequeath in equal proportions, share and share alike to the Rockville City Hospital located in the city of Rockville, State of Connecticut, and to the Cyril and Julia C. Johnson Memorial Hospital, Inc. located at Stafford Springs, State of Connecticut, in trust each of said hospitals shall invest the sums derived under this Article of my last Will and Testament and the annual income of said sums shall be used for the general maintenance of each of said hospitals.

William H. Prescott Fund #73301 - Bequest u/w William H. Prescott. Permanent endowment - income for general purposes.

Terms of Will -

"13. I give and bequeath to Francis T. Maxwell, Arthur T. Bissell, J. Alice Maxwell, A. N. Belding and Thomas W. Sykes, all of Rockville, Connecticut, the sum of Fifty Thousand Dollars ($50,000) in perpetual trust to them and their successors in office, for the purpose of establishing and maintaining at said city of Rockville, a general hospital for the sick, to be open and available to all residents of the said City of Rockville, and of such portion of the immediate vicinity thereof contiguous and adjacent thereto, as in the judgment of said Board of Trustees may be deemed wise and advisable, subject to such rules and regulations concerning admission to said hospital as said trustees and their successors in office may, from time to time, establish.

Said trustees and their successors in office shall have power to receive property by gift or otherwise, and to purchase land and erect buildings for the purpose of carrying out the provisions of this trust.

The general management and oversight of said hospital, including the character and method of treatment therein to be established, shall be vested wholly in said Board of Trustees and their successors in office.

Said Board may elect a President, Vice-President, Secretary and Treasurer, and such other executive officers as they may deem necessary or advisable to carry out the purpose of this trust, including a superintendent of said institution. All vacancies in said Board arising from any cause, shall be filled by appointment of the surviving trustees.

William H. Prescott Fund #73301-continued

Terms of Will-continued

The Board of Trustees shall have power, from time to time, to make by-laws defining the duties of said officers and superintendent, the method of calling meetings of the Trustees and other by-laws relative to the management and government of the same. Provided, however, that, if at any time before my decease, I shall make provision for the transfer of the sum of fifty thousand dollars ($50,000) to the above named, as trustees for the purpose of inaugurating the establishment of a City Hospital, thereby substantially carrying out the provisions of this paragraph of my will, then and in that event, I revoke this paragraph of the same relating to said Hospital, and declare it inoperative, but otherwise to remain in full force and effect."

(1949)

Stephen Goodale Risley and Emeret Scott Risley Fund #73311 - Bequest u/ Ninth and Twenty-first clauses of Will of May H. Adams - permanent endowment - income for general purposes.

Terms of Will

"NINTH: I give and bequeath unto THE ROCKVILLE CITY HOSPITAL, INC. of said Rockville, the sum of Ten Thousand Dollars, in memory of my father and mother, Stephen Goodale Risley, M.D. and Emeret Scott Risley, for the establishment of a fund to be known as the Stephen Goodale Risley and Emeret Scott Risley Fund, the income thereof to be used for the general uses and purposes of said Hospital."

"TWENTY-FIRST: All the rest, residue and remainder of all my property, of every description, both real and personal, of whatsoever the same may consist or wheresoever it may be situated, I give, devise and bequeath unto said THE ROCKVILLE CITY HOSPITAL, INC. in order that the same may be added to and become a part of the Stephen Goodale Risley and Emeret Scott Risley Fund, which is established in Paragraph Ninth of this my last Will and Testament."

($79,688.80)

Rockville Chapter American Red Cross Fund #73321 - Gift from Rockville Chapter of American Red Cross - considered permanent endowment - income is used for general expenses of the Hospital.

William B. and Lizzie Lathrop Sprague Fund #73341 - Bequest u/w Lizzie Lathrop Sprague - considered permanent endowment - income is used for general expenses of the Hospital.

Terms of Will

"---to be known as the William B. and Lizzie Lathrop Sprague Fund".

Swindells Fund #73351 - This fund represents donations received from the Swindells Foundation. Income and/or principal may be used for care of deserving persons or used for general hospital expenses. Surplus income is transferred to principal.

Fred Talcott Fund #73361 - Bequest u/w Fred Talcott - considered permanent endowment - income for general purposes.

Terms of Will

"SIXTEENTH: Whereas one William H. Prescott of said Rockville, now deceased, in and by his will bequeathed a large sum of money towards the support and maintenance of a hospital to be thereafterwards established in said Rockville, and it is my desire to make a contribution towards the erection and establishment of such hospital. I give and bequeath to the persons who at the time of my decease may be the custodians of the said fund, bequeathed as aforesaid by said Prescott, the sum of five thousand dollars to be used by them or their successors in such trust towards the erection and establishment of such hospital."

"TWENTIETH:----Upon the decease of the last survivor of the aforesaid beneficiaries under this trust I direct that one-half part of all the trust estate and property then remaining in the hands of my said trustee be by it made over to the persons mentioned in the sixteenth clause of this my will as the custodians of the William H. Prescott Fund, or to the persons who at the termination of this trust may be such custodians, to be applied towards the establishment of the hospital in said Rockville proposed or contemplated in the will of said Prescott, but if such hospital shall then be already established then said one-half of said trust estate and property shall be by said trustee made over to such hospital to be used by it for its uses and purposes."

Trumbull Chapter, D.A.R. Fund #73381 - Gift from Trumbull Chapter, D.A.R. - considered permanent endowment - income to be used for free bed, Sabra Trumbull Daughters to have preference, or any deserving person, to be decided by Hospital Trustees and Advisory Board of Sabra Trumbull Chapter. Any unused income is added to principal.

United German Society Fund #73391 - Gift from United German Society - considered permanent endowment - income is used for general expenses of the Hospital.

November 24, 1952

Florence R. Whitlock Fund #73371 - Bequest under will of Florence R. Whitlock (1953) - $13,351.35, a permanent endowment. Income for free bed or beds. Terms of will:

"2...The remaining four-tenths (4/10ths) of said residue, I give, devise and bequeath to the Rockville City Hospital for the purpose of establishing a free bed or beds in said Hospital in memory of my mother, Anna Shelton Whitlock."

Betsey C. Tucker Fund #73360 - Bequest under will of Betsy C. Tucker (1955) - $2,000, a permanent endowment. Income for free bed. Terms of will:

"Second: I give and bequeath to The Rockville City Hospital of Rockville, Connecticut, Two Thousand (2,000) Dollars to be its absolutely and forever. This bequest is to be used by said Hospital as an endowment for the partial maintenance of a free bed in said Hospital."

Anna M. and Albert H. Bilson Fund #745081 - Bequest under will of Anna M. Bilson of $10,371.08 as follows: (January 22, 1957)

"NINTH: All the rest, residue and remainder of my Estate, both real and personal of whatsoever nature and wheresoever situated is to be sold and one-half of the proceeds are to be given to the Union Congregational Church of Christ, Inc. to be known as the Anna M. Bilson and Albert H. Bilson Fund. I direct the trustees of said Church to lawfully invest said legacy and to use the income therefrom for the general uses and purposes of said Church. The remaining one-half thereof I give and devise unto the Rockville City Hospital, Inc. of the Town of Vernon to be known as the Anna & Albert Bilson Fund. I direct the trustees of said Hospital to lawfully invest said legacy, and to use the income therefrom for the general uses and purposes of said Hospital.

EXHIBIT Q 11-2

Fund 11-1.67

Harriet K. Maxwell Fund

Rockville, Conn., Jan. 20, 1953

Following the meeting of the Corporators, a meeting of the Trustees of the Rockville City Hospital, Inc. was held, those present being:

Lebbeus F. Bissell
Roy C. Ferguson
Donald C. Fisk
John R. Gottier
Frank E. Hardenbergh
Claude A. Mills
John S. Mason

Lebbeus F. Bissell, president, presided.

The minutes of the previous meeting on January 15, 1952 were read and approved.

It was voted that the Secretary cast one ballot for the following officers for the ensuing year, or until their successors are chosen:

President	Lebbeus F. Bissell
Vice-President	Claude A. Mills
Secretary	John S. Mason
Treasurer	Hartford-Connecticut Trust Co. (Rockville Branch)

The ballot was cast and the chairman declared them elected.

It was voted that the Secretary cast one ballot for the following to serve as Executive Committee for the ensuing year or until their successors are chosen:

Lebbeus F. Bissell
Frank E. Hardenbergh
Roy C. Ferguson

The ballot was cast and the Chairman declared them elected.

It was voted that the Secretary cast one ballot for the following to serve as Finance Committee for the ensuing year or until their successors are chosen:

Lebbeus F. Bissell
Claude A. Mills
Donald C. Fisk

The ballot was cast and the Chairman declared them elected.

It was voted that the Secretary cast one ballot for the following to serve as Auditors for the ensuing year or until their successors are chosen:

Frank E. Hardenbergh
Claude A. Mills
John R. Gottier

The ballot was cast and the Chairman declared them elected.

The Treasurer's report for the period 1 September 1951 through 1 September 1952 was read and discussed, and it was voted that same be accepted and placed on file.

Upon motion duly made and seconded, it was voted to adjust the salaries of the Superintendent and Manager.

The proposed changes in the Funds, submitted by the Treasurer, were discussed, and upon motion duly made and seconded, it was voted that the Hartford-Connecticut Trust Co. be authorized to make the following changes in accordance with the following resolutions:

"WHEREAS, Rockville City Hospital has certain endowment funds which are maintained in separate accounts and it is desired to combine said funds for bookkeeping and investment purposes, and

WHEREAS, it appears from the terms under which such funds were established that such funds may be properly combined.

Now therefore, it is

VOTED: That the Treasurer be authorized and instructed to establish two new funds under the title Memorial Funds Unrestricted and Memorial Funds Restricted, respectively.

It is also

VOTED: That January 15, 1953 shall be established as the date for the combination of three separate funds (listed below) under the title of the new "Memorial Funds Unrestricted". The original book value of each of the separate funds shall be reaffirmed as the Memorial value of each of such endowments, and the January 15, 1953 book value of the investments comprising these three funds shall be carried over into the new "Memorial Funds Unrestricted" as the book value of the combined investments.

General Fund
Harriet K. Maxwell Fund
Swindells Fund

It is also

VOTED: That January 15, 1953 shall be established as the date of the new combination of ten separate funds (listed below) under the title of the new "Memorial Funds Restricted". The original book value of each of the separate funds shall be reaffirmed as the Memorial value of each of such endowments, and the January 15, 1953 book value of the investments comprising these ten funds shall be carried over into the new "Memorial Funds Restricted" as the book value of the combined investments.

Release by PMH

Alvah T. Belding Fund
Ruth T. Britton Fund
Consolidated Fund
George S. Doane Fund
J. Alice Maxwell Fund
William A. and Caroline E. Metcalf Fund
George Palmer Charter Fund
Rockville Chapter ARC Fund
William B. and Lizzie Lathrop Sprague Fund
Edgar Feeney Fund

It is also

VOTED: That securities and cash of the William Maxwell Fund having a market value as of October 9, 1952 of $107,346.29 be carried over from the William Maxwell Fund to the new "Memorial Funds Unrestricted", and the value of $75,472.99 be affirmed as the Memorial value of the William Maxwell gifts in the "Memorial Funds Unrestricted". The present book values of the securities transferred to the "Memorial Funds Unrestricted" shall be carried over to that Fund at the same book values."

Upon motion duly made and seconded, it was voted that the Finance Committee be authorized to rule on the proposed shift in some of the investments as recommended by the Hartford-Connecticut Trust Co.

Upon motion duly made and seconded it was voted that Lobdell F. Bissell, Trustee of said Hospital, be authorized and directed to sign all and any applications, bonds and all other necessary papers pertaining to the Alcohol Tax Free Permit in behalf of said Hospital for the purpose of obtaining alcohol free of tax for use by the Hospital.

sed Asset Purchase by PMH
ober 13, 2015

Mr. Williams was called into the meeting and gave a report on the hospital operations.

There being no further business, the meeting was adjourned at 11:18.

Attest:

John L. Mason
Secretary

F-2

ROCKVILLE CITY HOSPITAL

Source and Terms of Funds Held

Alvah N. Belding Fund #73041 - Bequest u/w Alvah N. Belding - Permanent Endowment - Income for general purposes.

> Terms of Will - "To be used and expended for the purposes indicated in the Will of William H. Prescott, as they may deem most advisable."

Alice Farmer Bissell Fund #73051 - Bequest under the Will of Arthur T. Bissell - Permanent Endowment - Income for general purposes.

> Terms of Will - Fourth: I give and bequeath to the Rockville City Hospital the sum of Twenty-five Thousand Dollars ($25,000) to be kept as a permanent fund in memory of my wife, Alice Farmer Bissell, and to be known as the Alice Farmer Bissell Fund. The net income from said fund shall be used and applied for the general purposes of said Hospital.

Ruth T. Britton Fund #73061 - Bequest u/w Ruth Talcott Britton - Permanent Endowment - Income for general purposes.

> Terms of Will - "in trust to keep said sum safely invested, and to use and apply the income for the general purposes of said Hospital at the discretion of its trustees."

Consolidated Fund #73081 - This fund represents all bequests of $3,000 or less left with no instructions as to use. Principal is considered permanent endowment - Income is used for general expenses of the Hospital.

George S. Doane Fund #73101 - No record found of source of this fund. Principal is considered permanent endowment - all income is used for expenses of the Hospital.

General Fund #73121 - This fund represents small gifts and bequests which were unrestricted as to use of principal or income. Principal is considered unrestricted - Income is used for general expenses of the Hospital.

Lenore Henry Fund #73141 - Bequest u/w E. Stevens Henry - Permanent endowment - Income for general purposes.

> Terms of Will - Ninth: I give and bequeath to the Hospital to be established in Rockville under the provisions of the Will of the late William H. Prescott to be known as the "Rockville City Hospital." This bequest is to constitute a special endowment fund of Fifty Thousand Dollars ($50,000) to be set apart and known as the Maud Henry Fund in memory of my deceased daughter, Maud. I likewise give and bequeath Fifty Thousand Dollars ($50,000) to said Hospital also to be set apart as a separate endowment fund and known as the "Lenore Henry" Fund in memory of my deceased daughter, Lenore. The income of these two funds is to be used for the maintenance of said Hospital. My Executors are directed to provide for this fund by selecting and transferring from my estate to trustees or duly authorized agent of said Hospital certain bonds or savings bank deposits of the par value of One Hundred Thousand Dollars ($100,000), and I further direct that whenever reinvestments become necessary or advisable such reinvestments shall be limited and confined to securities legal for savings banks of Connecticut or in deposits in savings banks.

Maud Henry Fund #73161 - Bequest u/w E. Stevens Henry - Permanent endowment - Income for general purposes. (For terms of will, see Lenore Henry Fund)

J. Alice Maxwell Fund #73171 - Bequest u/w J. Alice Maxwell - Permanent endowment - Income for general purposes.

> Terms of Will - NINTH: To ROCKVILLE CITY HOSPITAL, in Rockville, Connecticut, I give, devise and bequeath four of said equal parts of my said residuary estate in trust to use the income thereof for the general purposes of the said Hospital.

John and Martha Kress Fund #73181 - Bequest under will of Martha Kress - This fund was left for a special purpose. In accordance with the instructions of the Board of Trustees of the Hospital, income accumulates and is transferred to principal for reinvestment.

> Terms of Will - "To be used for the purpose of equipping, furnishing, and maintaining a room in said Hospital to be known and called the "John and Martha Kress Room".

Edgar Keney Fund #73201 - No record found of source of this fund. It is believed to have been left for a special purpose. In accordance with the instructions of the Board of Trustees of the Hospital, income accumulates and is transferred to principal for reinvestment.

Francis T. Maxwell Fund #73211 - This fund is considered permanent endowment. Income is used for general purposes. The fund consists of the proceeds of a $50,000 life insurance policy on the life of Francis T. Maxwell, plus gifts by Mr. Maxwell during his life of 50 shares Phoenix Insurance Company and 200 shares Hartford Gas Company. These gifts of stock were restricted to use of income for general purposes and principal to be used only toward a new hospital.

Harriet K. Maxwell Fund #73281 - Bequest under will of Harriet K. Maxwell - outright legacy - income is used for general expenses of the Hospital.

> Terms of Will - Third: "---and unto the Rockville City Hospital of Rockville, Connecticut, the sum of Five Thousand Dollars ($5,000)

Robert Maxwell Fund #73241 - Bequest u/w Robert Maxwell - outright legacy - income is used for general expenses of the Hospital. (The will gave discretion to executors to devote sum of $100,000 "in such manner as they may deem suitable for the benefit of said residents of Rockville and vicinity". One Hundred Thousand Dollars ($100,000) was paid to Rockville City Hospital per final account of executors.)

William A. and Caroline E. Metcalf Fund #73251 - Bequest u/w Caroline E. Steele Metcalf - Permanent endowment - Income for general purposes.

> Terms of Will - NINTH: All the rest, residue and remainder of my estate, of whatsoever nature and wheresoever situated, I give, bequeath and devise to the Trustees of The Rockville City Hospital, Inc., a charitable corporation organized and existing under the laws of the State of Connecticut, and owning and operating a hospital in said Town of Vernon, in trust, nevertheless, to hold invest and reinvest the same and to use the income thereof for the general uses and purposes of said Hospital as said Trustees shall see fit. Said trust shall be known as the William S. and Caroline E. Metcalf Fund.

William Maxwell Fund #73261 - This fund consists of the following:

Cash gifts by Mr. Maxwell during 1936 to 1938	$14,000.00
Proceeds of life insurance (1939)	61,472.99
Bequest under 14th clause of will	96,246.01
	$171,719.00

Terms of Will - FOURTEENTH: To ROCKVILLE CITY HOSPITAL, in Rockville, Connecticut, I give, devise and bequeath four of said equal parts of my said residuary estate in trust to use the income thereof for the general purposes of said Hospital.

Charles Phelps Free Bed Fund #73271 - Gift of $10,000 from Mrs. Elsie S. Phelps - Permanent endowment - Income for special purposes. Any amount of this fund in excess of $10,000 represents accumulated income and is considered available if necessary.

Terms of Gift

"1. For the benefit of any members of my household staff or their families who may be in need of the services which the fund can provide.

2. For the general use and benefit of the residents of the City of Rockville.

The fund, aside from the small conditions which I wish to impose for the benefit of my household staff, which will fall within the income limitations of the fund, will be managed by the Board of Trustees and Finance Committee of The Rockville City Hospital with full powers of sale, investment and reinvestment."

Celia E. Prescott Fund #73281 - This fund was left for a special purpose. In accordance with the instructions of the Board of Trustees of the Hospital, income accumulates and is transferred to principal for reinvestment.

Terms of Gift

$10,000. for free bed in honor of Francis and Eliza Porter Keeney
$ 5,000. for free bed in memory of Francis Keney Prescott
$ 400. for furnishing a room in memory of Jane E. Newcomb

George Palmer Charter Fund #73291 - Bequest under Second and Seventeenth Clauses of Will of George Palmer Charter - permanent endowment - income for general purposes.

Terms of Will

SECOND

I give and bequeath to the Rockville City Hospital, located in the city of Rockville, State of Connecticut, the sum of Ten Thousand (10,000) dollars, in trust, however, for the following uses and purposes, namely: The governing body of said hospital shall invest said sum of $10,000 and the annual income of said sum shall be used for the general maintenance of said Hospital.

George Palmer Charter Fund #73291 continued

SEVENTEENTH

All the rest, residue and remainder of my estate, of whatsoever nature and wheresoever situated which I may own or have the right to dispose of at the time of my decease, I give, devise and bequeath in equal proportions, share and share alike to the Rockville City Hospital located in the city of Rockville, State of Connecticut, and to the Cyril and Julia C. Johnson Memorial Hospital, Inc. located at Stafford Springs, State of Connecticut, in trust each of said hospitals shall invest the sums derived under this Article of my last Will and Testament and the annual income of said sums shall be used for the general maintenance of each of said hospitals.

William H. Prescott Fund #73301 - Bequest u/w William H. Prescott. Permanent endowment - income for general purposes.

Terms of Will -

"13. I give and bequeath to Francis T. Maxwell, Arthur T. Bissell, J. Alice Maxwell, A. N. Belding and Thomas W. Sykes, all of Rockville, Connecticut, the sum of Fifty Thousand Dollars ($50,000) in perpetual trust to them and their successors in office, for the purpose of establishing and maintaining at said city of Rockville, a general hospital for the sick, to be open and available to all residents of the said City of Rockville, and of such portion of the immediate vicinity thereof contiguous and adjacent thereto, as in the judgment of said Board of Trustees may be deemed wise and advisable, subject to such rules and regulations concerning admission to said hospital as said trustees and their successors in office may, from time to time, establish.

Said trustees and their successors in office shall have power to receive property by gift or otherwise, and to purchase land and erect buildings for the purpose of carrying out the provisions of this trust.

The general management and oversight of said hospital, including the character and method of treatment therein to be established, shall be vested wholly in said Board of Trustees and their successors in office.

Said Board may elect a President, Vice-President, Secretary and Treasurer, and such other executive officers as they may deem necessary or advisable to carry out the purpose of this trust, including a superintendent of said institution. All vacancies in said Board arising from any cause, shall be filled by appointment of the surviving trustees.

William H. Prescott Fund #73301-continued

Terms of Will-continued

> The Board of Trustees shall have power, from time to time, to make by-laws defining the duties of said officers and superintendent, the method of calling meetings of the Trustees and other by-laws relative to the management and government of the same. Provided, however, that, if at any time before my decease, I shall make provision for the transfer of the sum of fifty thousand dollars ($50,000) to the above named, as trustees for the purpose of inaugurating the establishment of a City Hospital, thereby substantially carrying out the provisions of this paragraph of my will, then and in that event, I revoke this paragraph of the same relating to said Hospital, and declare it inoperative, but otherwise to remain in full force and effect."

(1949)

Stephen Goodale Risley and Emeret Scott Risley Fund #73311 - Bequest u/ Ninth and Twenty-first clauses of Will of May R. Adams - permanent endowment - income for general purposes.

Terms of Will

> "NINTH: I give and bequeath unto THE ROCKVILLE CITY HOSPITAL, INC. of said Rockville, the sum of Ten Thousand Dollars, in memory of my father and mother, Stephen Goodale Risley, M.D. and Emeret Scott Risley, for the establishment of a fund to be known as the Stephen Goodale Risley and Emeret Scott Risley Fund, the income thereof to be used for the general uses and purposes of said Hospital."
>
> "TWENTY-FIRST: All the rest, residue and remainder of all my property, of every description, both real and personal, of whatsoever the same may consist or wheresoever it may be situated, I give, devise and bequeath unto said THE ROCKVILLE CITY HOSPITAL, INC. in order that the same may be added to and become a part of the Stephen Goodale Risley and Emeret Scott Risley Fund, which is established in Paragraph Ninth of this my last Will and Testament."

($79,688.80)

Rockville Chapter American Red Cross Fund #73321 - Gift from Rockville Chapter of American Red Cross - considered permanent endowment - income is used for general expenses of the Hospital.

William B. and Lizzie Lathrop Sprague Fund #73341 - Bequest u/w Lizzie Lathrop Sprague - considered permanent endowment - income is used for general expenses of the Hospital.

Terms of Will

> "---to be known as the William B. and Lizzie Lathrop Sprague Fund".

Swindells Fund #73351 - This fund represents donations received from the Swindells Foundation. Income and/or principal may be used for care of deserving persons or used for general hospital expenses. Surplus income is transferred to principal.

Fred Talcott Fund #73361 - Bequest u/w Fred Talcott - considered permanent endowment - income for general purposes.

Terms of Will

"SIXTEENTH: Whereas one William H. Prescott of said Rockville, now deceased, in and by his will bequeathed a large sum of money towards the support and maintenance of a hospital to be thereafterwards established in said Rockville, and it is my desire to make a contribution towards the erection and establishment of such hospital. I give and bequeath to the persons who at the time of my decease may be the custodians of the said fund, bequeathed as aforesaid by said Prescott, the sum of five thousand dollars to be used by them or their successors in such trust towards the erection and establishment of such hospital."

"TWENTIETH:——Upon the decease of the last survivor of the aforesaid beneficiaries under this trust I direct that one-half part of all the trust estate and property then remaining in the hands of my said trustee be by it made over to the persons mentioned in the sixteenth clause of this my will as the custodians of the William H. Prescott Fund, or to the persons who at the termination of this trust may be such custodians, to be applied towards the establishment of the hospital in said Rockville proposed or contemplated in the will of said Prescott, but if such hospital shall then be already established then said one-half of said trust estate and property shall be by said trustee made over to such hospital to be used by it for its uses and purposes."

Trumbull Chapter, D.A.R. Fund #73301 - Gift from Trumbull Chapter, D.A.R. - considered permanent endowment - income to be used for free bed, Sabra Trumbull Daughters to have preference, or any deserving person, to be decided by Hospital Trustees and Advisory Board of Sabra Trumbull Chapter. Any unused income is added to principal.

United German Society Fund #73391 - Gift from United German Society - considered permanent endowment - income is used for general expenses of the Hospital.

November 24, 1952

Florence R. Whitlock Fund #73371 - Bequest under will of Florence R. Whitlock (1953) - $13,351.35, a permanent endowment. Income for free bed or beds. Terms of will:

"2...The remaining four-tenths (4/10ths) of said residue, I give, devise and bequeath to the Rockville City Hospital for the purpose of establishing a free bed or beds in said Hospital in memory of my mother, Anna Shelton Whitlock."

Betsey C. Tucker Fund #73360 - Bequest under will of Betsy C. Tucker (1955) - $2,000, a permanent endowment. Income for free bed. Terms of will:

"Second: I give and bequeath to The Rockville City Hospital of Rockville, Connecticut, Two Thousand (2,000) Dollars to be its absolutely and forever. This bequest is to be used by said Hospital as an endowment for the partial maintenance of a free bed in said Hospital."

Anna M. and Albert H. Bilson Fund #745081 - Bequest under will of Anna M. Bilson of $10,371.08 as follows: (January 22, 1957)

"NINTH: All the rest, residue and remainder of my Estate, both real and personal of whatsoever nature and wheresoever situated is to be sold and one-half of the proceeds are to be given to the Union Congregational Church of Christ, Inc. to be known as the Anna M. Bilson and Albert H. Bilson Fund. I direct the trustees of said Church to lawfully invest said legacy and to use the income therefrom for the general uses and purposes of said Church. The remaining one-half thereof I give and devise unto the Rockville City Hospital, Inc. of the Town of Vernon to be known as the Anna & Albert Bilson Fund. I direct the trustees of said Hospital to lawfully invest said legacy, and to use the income therefrom for the general uses and purposes of said Hospital.

EXHIBIT Q 11-2

Fund 11-1.68

Robert Maxwell Fund

DISTRICT OF ELLINGTON

(Continued from Page 570)

Whereupon letters testamentary are granted to J. Alice Maxwell, Francis T. Maxwell and William Maxwell, the executors named in said will who on the 30th day of April 1920, appeared in Court, accepted said trust, and gave Bond jointly with The National Surety Company of New York as surety in the penal sum of Five Thousand dollars, which is accepted and approved by this Court, and ordered to be recorded and kept on file. (Recorded in Vol. 4 of Bonds, page 585)

Ordered, That twelve months from the 30th day of April 1920 be and the same are allowed the Executors, within which to settle said estate.

Ordered, That six months from the 30th day of April 1920 be and the same are limited and allowed for the creditors to bring in their claims against said estate, and the said Executors are directed to give public notice to the creditors to bring in their claims within said time allowed, by posting a copy of this order upon the public signpost nearest to the place where the deceased last dwelt within said town, and by publishing the same once in some newspaper having a circulation in said Probate District within ten days from the date of this order and return make to this court of the notice given, and of a list of all claims presented within said time.

Ordered, That two months from the 30th day of April 1920, be and the same are allowed the Executors within which to make, or cause to be made, a true and perfect inventory of all the estate of said deceased, both real and personal, including choses in action. And this Court appoints Charles Phelps and Kenneth Adams disinterested persons, appraisers under oath, to appraise said estate, and return make to this Court within said time allowed.

John E. Fahey, Judge.

Attest: M Bernard Clerk.

A true copy

I, Robert Maxwell, of the City of Rockville, State of Connecticut, being of sound and disposing mind and memory, do hereby make, publish and declare this to be my last will and testament, hereby revoking all other wills by me at any time heretofore made:

First: I give and bequeath unto the Rockville Public Library, the sum of Twenty-five thousand dollars ($25,000.)

Second: I give and bequeath unto my Executors hereinafter named, or the survivors or survivor of them, the sum of One hundred thousand dollars ($100,000.), to be devoted by them to the establishment and maintenance of a suitable building or buildings, grounds and equipment in the City of Rockville, State of Connecticut, where the residents of the City of Rockville and vicinity may, without charge and without regard to race or religion, obtain healthful exercise, recreation, amusement and instruction, or, in the discretion of my Executors, the said principal sum or the income thereof, or both, to be devoted by them in such other manner as they may deem suitable for the benefit of the said residents of Rockville and vicinity.

Third: I give and bequeath unto those persons who may be at the time of my death the trustees of the George Sykes Manual Training School, the sum of Fifty thousand dollars ($50,000.), or such part thereof as my said Ex-Executors may approve, and the balance thereof, if any, shall fall into and become a part of my residuary estate.

Fourth: I give and bequeath unto the New York Association for improving the condition of the poor the sum of Ten Thousand dollars ($10,000.), to be applied by them in furtherance of the work conducted by such Association known as "Sea Breeze", and now located at Coney Island, New York, or to the general uses and purposes of said Association AS the Board of Managers of said Association may determine.

Fifth: I give and bequeath unto William Sargent now in my employ as butler, the sum of Five thousand dollars ($5,000.), provided that he shall be in my employ at the time of my death, but if he should not be in my employ at that time, I give and bequeath unto him the sum of Two Thousand dollars ($2,000.) only.

Sixth: I give and bequeath unto Frederick Rogers, now in my employ as butler, the sum of Five thousand dollars ($5,000.), provided that he shall be in my employ at the time of my death.

Seventh: I give and bequeath unto my Executors hereinafter named, or the survivor of them, the sum of Seventy-five thousand dollars ($75,000.), absolutely. Without intending to qualify the absolute character of this bequest I hereby express the hope that they will distribute this sum among such of my friends, relatives, domestic servants in my employ at the time of my death, and my associates in the Hockanum Association, provided such Association is in existence at the time of my death, in such manner and amounts as my brother William Maxwell, with the advice of his co-executors, shall determine.

Eighth: I give, devise and bequeath unto my Executors hereinafter named, the survivors or survivor of them, the sum of Three hundred thousand dollars ($300,000.), in trust, to invest and reinvest the same and keep the same invested, and to collect the rents, issues and profits thereof and to pay the net income to my sister, J. Alice Maxwell, for and during the term of her natural life and upon her death to pay the said income in equal shares to my brothers, Francis T. Maxwell and William Maxwell, for and during their respective natural lives, and to the survivor of them during his natural life, if one of my brothers die before my said sister, and to pay the whole of

(Continued from Page 572)

such income to the survivor of my said brothers during his life on the death of either of my said brothers after my sister's death; and upon the death of the last survivor of the said J. Alice Maxwell, Francis T. Maxwell and William Maxwell, the said trust shall cease and terminate, and I give, devise and bequeath the said trust fund to Yale University, of New Haven, Connecticut, to be known as the "Robert Maxwell Fund", and the income thereof to be used for the purpose of paying or aiding in the payment of salaries of professors in the academic department, or at the option of the corporation the fund may be used for the establishment of one or more professorships in the academic department, and the unexpended income not required for such purpose used in the payment or as an aid in the payment of salaries of other professors in the academic department.

Ninth: I give and bequeath the sum of Ten thousand dollars ($10,000.) to each of my nieces, Helen Maxwell, Priscilla Maxwell, and Harriet Kellogg Maxwell.

Tenth: I give and bequeath all interest which I may have at the time of my death in the copartnership known as The Hockanum Association to my brothers, Frances T. Maxwell and William Maxwell, and direct that my Executors shall be under no obligation to collect my interest in the said firm or to cause a liquidation of the partnership or of my interest therein, but that such copartnership interest shall pass to my brothers on my death.

Eleventh: I give and bequeath unto my brother, William Maxwell, a sufficient number of shares of the preferred and common stock which I may own at the time of my death in The Hockanum Mills Company, or in such other corporation or corporations firm or firms as may succeed to the property and business of said The Hockanum Mills Company, so that the shares of stock or interest of my said brother, William Maxwell in the said The Hockanum Mills Company, or its successor or successors, together with the interest which he may own therein at the time of my death, shall be equal to the shares or interest therein of my brother Francis T. Maxwell, at the time of my death; all the rest, residue and remainder of my shares of preferred and common stock in said The Hockanum Mills Company or other my interest therein, or in its successor of successors, I give, devise and bequeath in equal shares to my brother, William Maxwell, my brother Francis T. Maxwell, and my sister J. Alice Maxwell.

Twelfth: All the rest, residue and remainder of my property, real and personal, of every nature and kind, I give, devise and bequeath to my sister, J. Alice Maxwell, and my brothers Francis T. Maxwell and William Maxwell, to be divided equally among them and to be their absolute property. Without intending to qualify the absolute character of this devise and bequest, I request my said sister and brothers to donate to the Metropolitan Museum of Art and to such of my close personal friends as they may select such of my objects of art, tapestries, furniture, rugs and other personal effects as they may choose. I especially recommend that my brother, William Maxwell, supervise and direct such distribution. All my correspondence and papers, both of a personal or business nature, I give unto my brother William Maxwell, if living, for such disposition as he may think proper.

Thirteenth: I hereby nominate and appoint as the Executors of this my Will, my said sister, J. Alice Maxwell, and my brothers, Frances T. Maxwell and William Maxwell, and I direct that no security be required of them or either of them for the faithful performance of their duties as such, nor shall any surety be required on any bond to be given by them. I also exempt them from any obligation to give bond or security on any bond in their capacity as trustees of any trust herein created.

And for the purpose of making provision for the payment of my debts and legacies or otherwise to carry out the provisions of this will and to make distribution of my estate, I authorize and empower my executors and any administrator who may be appointed of this my will to sell any real estate which I may own at the time of my death and which is not specifically devised hereunder, at public or private sale, either for cash or on credit, or partly for cash and partly on credit, securing the payment of so much of the purchase money as remains on credit by mortgage on the property sold.

I authorize my Executors to allot, in setting apart the trust fund herein created, investments which I may leave at the time of my death at valuations to be fixed by my Executors; and I authorize the trustees to retain such investments in the trust fund. I prescribe that such trustees shall not be limited in the investment of the said trust fund by the rules of the law governing investment of trust funds, but it may be invested in such securities or property as they may deem advantageous.

I hereby authorize my trustees to sell any real estate which may form part of the trust herein created either for cash or on credit, or partly for cash and partly on credit, securing the payment of so much of the purchase money as remains on credit by mortgage on the property sold.

I authorize and empower my said trustees to lease any of the real estate which may belong to said trust for any term or terms of years and upon such rental and conditions as they may deem expedient.

Fourteenth: In case of the death, resignation or refusal to act of any of the executors and trustees herein named or appointed, pursuant to this power I empower the remaining Executors or Executor, trustee or trustees, by instrument in writing to appoint as co-executor or co-trustee hereunder any individual or trust company who may be qualified to act hereunder; and the person or corporation so appointed shall have and possess all the powers and in all respects exercise the duties of such executor and trustee under this will in like manner as if he or it had been herein named as such executor or trustee.

ECHN Proposed Asset Purchase by PMH
Submitted October 13, 2015

DISTRICT OF ELLINGTON

(Continued from Page 572)

I hereby expressly exempt my executors and trustees from any obligation to file an inventory or to account, any laws to the contrary notwithstanding.

I expressly exempt my Executors from all liability whatsoever for failure to collect any debt or obligation which may be owing to me at the time of my death and I hereby forgive, cancel and discharge any such debt or obligation, or portion thereof, which my Executors shall decide not to collect or enforce.

Fifteenth: In case the trust fund herein created shall contain interest-bearing securities having a value above par, I authorize the payment of the interest in full to the beneficiary of the income, and exonerate my trustees from all liability to retain a portion of such interest as a sinking-fund for re-imbursement of principal.

Sixteenth: I direct that all succession, inheritance or transfer taxes upon the devises, legacies and bequests made in Article First to Eleventh, inclusive, of this my will shall be paid by my Executors out of my residuary estate.

In Witness Whereof I have hereunto set my hand seal this 21" day of November, in the year One thousand nine hundred and nineteen.

Robert Maxwell (L.S.)

Signed, sealed, published and declared by the above-named testator as and for his last Will and Testament in the presence of us, who at his request and in his presence and in the presence of one another have hereunto subscribed our names as witnesses at the Borough of Manhattan, City and State of New York on the day and year last above mentioned.

Thomas B. Gilchrist, residing 9106 Ridge Boulevard, Brooklyn, N. Y.
Edgar W. Freeman, residing at Plainfild, N. J.
Stewart W. Bowers, residing at 49 West 57th St. N. Y. C.

State of New York :
: ss
County of New York :

The within named, Thomas B. Gilchrist, Edgar W. Freeman and Stewart W. Bowers, being duly sworn, depose and say, that they witnessed the will of the within named testator, Robert Maxwell, and subscribed the same in his presence and at his request and in the presence of one another; that the said Robert Maxwell at the time of the execution of such will appeared to them to be of full age and of sound mind and memory and that he signed the said will and declared the same to be his last will and testament in their presence, and that they make this affidavit at the request of said testator.

Subscribed and sworn to at the request of the within named testator, Robert Maxwell on November 21st 1919.

Thomas B. Gilchrist
Edgar W. Freeman
Stewart W. Bowers.

Russell Stiles, Notary Public, for Westchester County
Certificate filed in N. Y. County N. Y. County No. 424,
Register No. 10354.
My commission expires March 30, 1920.

A true copy Attest: M P Leonard Clerk.

At a Court of Probate held at Vernon, within and for the District of Ellington, on the 6th day of May 1920.

Present, John E. Fahey, Judge.

Estate of Lorenzo Webster late of Vernon, in said District, deceased.

Dwight C. Woodruff of Fitchburg, Massachusetts is hereby appointed guardian ad litem of the estate of Dwight C. Woodruff, Jr., during the pendency of the acceptance of the final account of Lyman Twining Tingier, deceased, as trustee of the estate of said Lorenzo Webster, and the appointment of a trustee in succession to said Lyman Twining Tingier, deceased.

John E. Fahey, Judge.

A true copy Attest: M P Leonard Clerk.

At a Court of Probate held at Vernon, within and for the District of Ellington, on the 4th day of May 1920.

Present, John E. Fahey, Judge.

Estate of Lorenzo Webster late of Vernon in said district.

The administrator of the estate of Lyman T. Tingier, deceased, trustee of said estate appeared in court and filed his decedents account with the estate of said Lorenzo Webster. And all parties known to be interested in said estate being present or represented in court, and accepting said account, said account is hereby accepted, allowed and ordered to be recorded and filed.

Judge.

A true copy Attest: M P Leonard Clerk.

EC Proposed Asset Purchase by PMH
Submitted October 13, 2015

EXHIBIT Q 11-2

Fund 11-1.69

F. Maxwell Memorial

Florence Parsons Maxwell, Frederick N. Belding and The Trav
st Company having been named Executor of the will of FRANCIS T. MAXW
kville, deceased, hereby appear in said Court and accept such appoi
(signed) Florence Parsons Maxwell
(signed) Frederick N. Belding
THE TRAVELERS BANK & TRUST
by (signed) John B. Bolles, Trust Offic

tford, Connecticut
il 15, 1942

rue copy Attest: Clerk

POINTMENT OF GUARDIAN AD LITEM
a Court of Probate held at Vernon, within and for the District of Ellingt
lland, State of Connecticut, on the 15th day of April 1942
Present, Hon. Francis T. O'Loughlin, Judge.

ESTATE OF FRANCIS T. MAXWELL, late of Vernon in said District, d

Frederick N. Belding of Rockville, Conn. is hereby appointed gua
tem of Maxwell Belding and Virginia Belding, minor grandchildren of said de
pear for and protect their interests during the settlement of said estate.
(signed) F. T. O'Loughlin, Judge.

true copy Attest: Clerk

ST WILL AND TESTAMENT

FRANCIS T. MAXWELL Dated, May 15, 1940

I, FRANCIS T. MAXWELL, of the City of Rockville and State of Connec
ereby make, publish and declare the following as and for my LAST WILL AND TES
ereby revoking all other wills and codicils by me made.

FIRST: I direct the payment of all my just debts and funeral expen
s convenient after my death.

SECOND: To my wife, FLORENCE PARSONS MAXWELL, I give and devise my
ouse with the stable and other buildings appurtenant thereto and the land upon
ame are erected, situated on Ellington Avenue, Prospect, North Park and Clif
n the towns of Vernon and Ellington, in the State of Connecticut, to have an
he same to her, her heirs, and assigns, forever. I also give and bequeath to
ife all my household furniture, supplies, utensils, fixtures, works of art,
earing apparel, jewelry, farming utensils and personal effects, and all othe
f personal or domestic use or adornment, relying upon my said wife to give t
laughters as shall survive me any of such articles of personal property as a
direct that my said wife shall have the privilege of accepting all or any
roperty devised and bequeathed to her by the provisions of this Article of
hat any part of said property that my said wife may not accept shall fall in
ome a part of my residuary estate.

THIRD: To my wife, FLORENCE PARSONS MAXWELL, and my daughters, PR
AXWELL ENDICOTT and HARRIET K. MAXWELL VEISSI, and to the survivor of them,
bequeath the sum of fifty thousand dollars ($50,000), as joint tenants. Witho
to qualify the absolute character of this bequest, it is my hope that my said
daughters, or such of them as shall survive me, will distribute the said sum
of our friends, relatives, domestic servants in my employ at the time of my dea
business associates and institutions in such manner and amounts as I may indica
written memorandum, or, failing such memorandum, as my said wife and daughters
vivors or survivor of them shall determine.

FOURTH: To each of my grandchildren, MAXWELL M. BELDING, VIRGINIA B
BRADFORD MAXWELL ENDICOTT and PRISCILLA ENDICOTT, I give and bequeath the sum o
Thousand dollars ($10,000).

FIFTH: To my TRUSTEES hereinafter named I give and bequeath all th
of stock which I may own at the time of my death in The Hartford-Connecticut Tru
any IN TRUST NEVERTHELESS to hold the same for and during the lifetime of my sis
ALICE MAXWELL and to collect and receive the dividends and income thereof and th
pay over and distribute in quarterly installments to my said sister for and duri
period of her life. Upon her death I direct that the said shares of stock and a
property into which the said shares of stock or the proceeds thereof or any part
shall have been converted shall fall into and become a part of my residuary est

SIXTH: To CONNECTICUT HISTORICAL SOCIETY of Hartford, Connecticut,
and bequeath the sum of Five thousand dollars ($5,000), in trust, to invest and
the same and apply the income thereof to any of its purposes that the Directors
ees thereof may deem advisable.

SEVENTH: To CONNECTICUT CHILDREN'S AID SOCIETY of Hartford, Connecti
give and bequeath the sum of Five thousand dollars ($5,000), in trust, to invest
invest the same and apply the income thereof to any of its purposes that the Dire
or Trustees thereof may deem advisable.

EIGHTH: To CONNECTICUT HUMANE SOCIETY of Hartford, Connecticut, I giv
bequeath the sum of Five thousand dollars ($5,000), in trust, to invest and reinv
same and apply the income thereof to any of its purposes that the Directors or Tru
thereof may deem advisable.

thereof may deem
Rockville, Conn

TENTH: To CIT
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ELEVENTH: To
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TWELFTH: To
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SAINT BERNARD'S ROM
VANGELICAL LUTHERAN
URCH, VERNON CENTER C
in Rockville.

THIRTEENTH:
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rust shall be divide
h to ROCKVILLE CITY

FOURTEENTH:
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FIFTEENTH:
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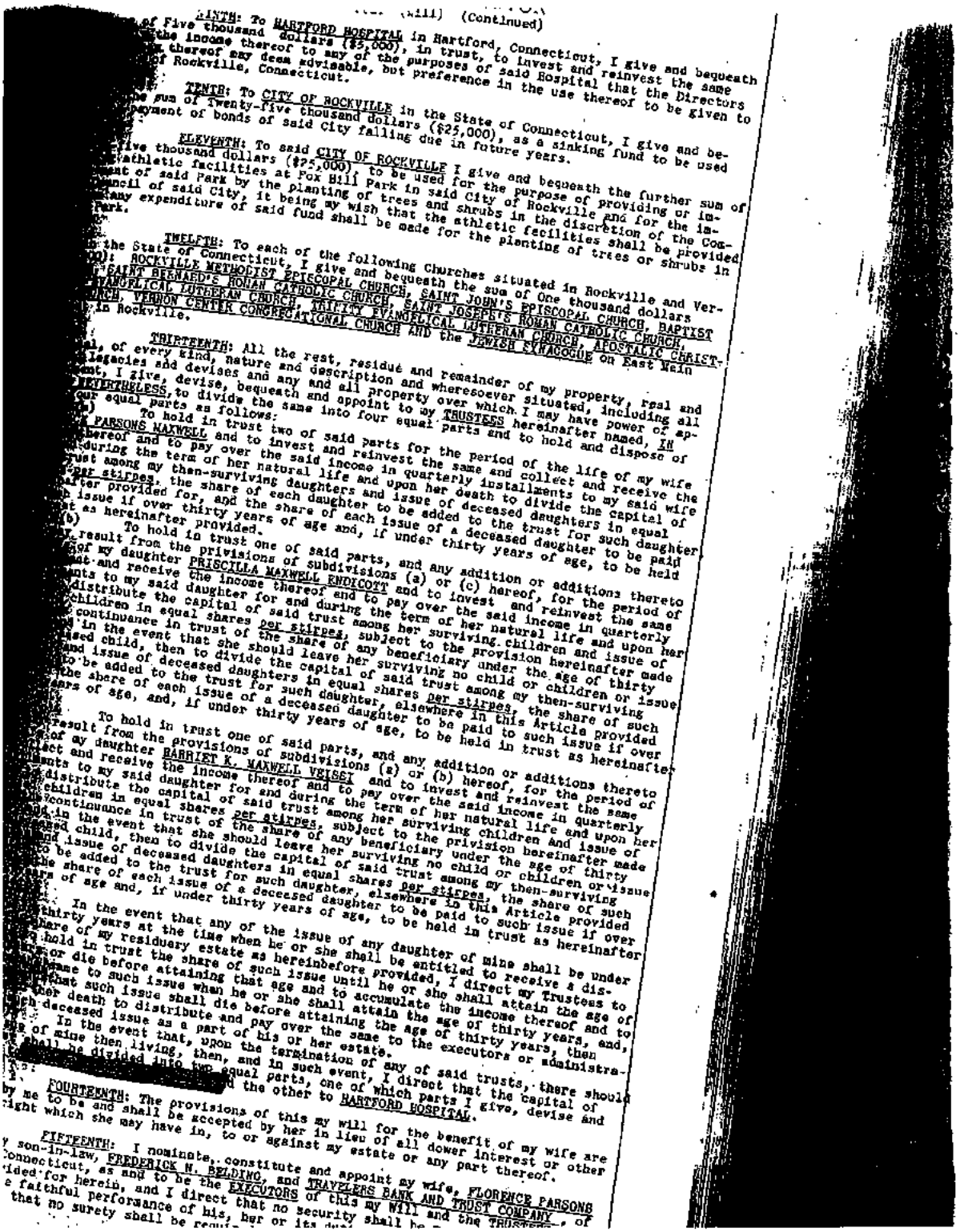
e and that no surety



NINTH: To HARTFORD HOSPITAL in Hartford, Connecticut, I give and bequeath
of Five thousand dollars ($5,000), in trust, to invest and reinvest the same
the income thereof to any of the purposes of said Hospital that the Directors
thereof may deem advisable, but preference in the use thereof to be given to
of Rockville, Connecticut.

TENTH: To CITY OF ROCKVILLE in the State of Connecticut, I give and be-
the sum of Twenty-five thousand dollars ($25,000), as a sinking fund to be used
payment of bonds of said City falling due in future years.

ELEVENTH: To said CITY OF ROCKVILLE I give and bequeath the further sum of
five thousand dollars ($25,000) to be used for the purpose of providing or im-
athletic facilities at Fox Hill Park in said City of Rockville and for the im-
ent of said Park by the planting of trees and shrubs in the discretion of the Com-
ncil of said City, it being my wish that the athletic facilities shall be provided
any expenditure of said fund shall be made for the planting of trees or shrubs in
Park.

TWELFTH: To each of the following Churches situated in Rockville and Ver-
the State of Connecticut, I give and bequeath the sum of One thousand dollars
00): ROCKVILLE METHODIST EPISCOPAL CHURCH, SAINT JOHN'S EPISCOPAL CHURCH, BAPTIST
SAINT BERNARD'S ROMAN CATHOLIC CHURCH, SAINT JOSEPH'S ROMAN CATHOLIC CHURCH,
ANGELICAL LUTHERAN CHURCH, TRINITY EVANGELICAL LUTHERAN CHURCH, APOSTALIC CHRIST-
URCH, VERNON CENTER CONGREGATIONAL CHURCH AND the JEWISH SYNAGOGUE on East Main
in Rockville.

THIRTEENTH: All the rest, residue and remainder of my property, real and
al, of every kind, nature and description and wheresoever situated, including all
legacies and devises and any and all property over which I may have power of ap-
ment, I give, devise, bequeath and appoint to my TRUSTEES hereinafter named, IN
NEVERTHELESS, to divide the same into four equal parts and to hold and dispose of
our equal parts as follows:

(a) To hold in trust two of said parts for the period of the life of my wife
PARSONS MAXWELL and to invest and reinvest the same and collect and receive the
thereof and to pay over the said income in quarterly installments to my said wife
during the term of her natural life and upon her death to divide the capital of
rust among my then-surviving daughters and issue of deceased daughters in equal
PER stirpes, the share of each daughter to be added to the trust for such daughter
after provided for, and the share of each issue of a deceased daughter to be paid
h issue if over thirty years of age and, if under thirty years of age, to be held
t as hereinafter provided.

(b) To hold in trust one of said parts, and any addition or additions thereto
result from the privisions of subdivisions (a) or (c) hereof, for the period of
of my daughter PRISCILLA MAXWELL ENDICOTT and to invest and reinvest the same
nt and receive the income thereof and to pay over the said income in quarterly
nts to my said daughter for and during the term of her natural life and upon her
distribute the capital of said trust among her surviving children and issue of
children in equal shares per stirpes, subject to the provision hereinafter made
continuance in trust of the share of any beneficiary under the age of thirty
in the event that she should leave her surviving no child or children or issue
sed child, then to divide the capital of said trust among my then-surviving
and issue of deceased daughters in equal shares per stirpes, the share of such
to be added to the trust for such daughter, elsewhere in this Article provided
the share of each issue of a deceased daughter to be paid to such issue if over
ars of age, and, if under thirty years of age, to be held in trust as hereinafter

(c) To hold in trust one of said parts, and any addition or additions thereto
result from the provisions of subdivisions (a) or (b) hereof, for the period of
of my daughter HARRIET K. MAXWELL VEISEY and to invest and reinvest the same
ect and receive the income thereof and to pay over the said income in quarterly
nts to my said daughter for and during the term of her natural life and upon her
distribute the capital of said trust among her surviving children and issue of
children in equal shares per stirpes, subject to the provision hereinafter made
continuance in trust of the share of any beneficiary under the age of thirty
in the event that she should leave her surviving no child or children or issue
sed child, then to divide the capital of said trust among my then-surviving
and issue of deceased daughters in equal shares per stirpes, the share of such
to be added to the trust for such daughter, elsewhere in this Article provided
the share of each issue of a deceased daughter to be paid to such issue if over
ars of age and, if under thirty years of age, to be held in trust as hereinafter

In the event that any of the issue of any daughter of mine shall be under
thirty years at the time when he or she shall be entitled to receive a dis-
hare of my residuary estate as hereinbefore provided, I direct my Trustees to
hold in trust the share of such issue until he or she shall attain the age of
or die before attaining that age and to accumulate the income thereof and to
ame to such issue when he or she shall attain the age of thirty years, and,
that such issue shall die before attaining the age of thirty years, then
er death to distribute and pay over the same to the executors or administra-
h deceased issue as a part of his or her estate.

In the event that, upon the termination of any of said trusts, there should
of mine then living, then, and in such event, I direct that the capital of
shall be divided into two equal parts, one of which parts I give, devise and
[redacted] and the other to HARTFORD HOSPITAL.

FOURTEENTH: The provisions of this my will for the benefit of my wife are
by me to be and shall be accepted by her in lieu of all dower interest or other
right which she may have in, to or against my estate or any part thereof.

FIFTEENTH: I nominate, constitute and appoint my wife, FLORENCE PARSONS
y son-in-law, FREDERICK N. BELDING, and TRAVELERS BANK AND TRUST COMPANY
Connecticut, as and to be the EXECUTORS of this my Will and the TRUSTEES of
ided for herein, and I direct that no security shall be
e faithful performance of his, her or its
that no surety shall be

Estate of Francis T. Maxwell, deceased.

To my Executors and the survivor of them I give and grant full authority to sell any and all real property, which I may own at the time of which is not specifically devised hereunder, either at public or private for cash or on credit or partly for cash and partly on credit, securing much of the purchase price as may remain on credit by mortgage on the pro authorize my Executors or the survivor of them to make payment in full of bequests of more than Two thousand dollars ($2,000) provided for in this ting apart and distributing to the respective legatees any stocks, bonds p ities in which my estate may be invested at the time of my death, except inbefore specifically bequeathed, in such manner and such amounts as my Executors may det the survivor of them may prefer, and at such values as my Executors may fix distribute my residuary estate in like manner; but nothing herein contained ed to prohibit the sale of any personal property owned by me at the time of not herein specifically bequeathed, if my Executors shall desire to sell the

F.T.M. I authorize my Trustees to sell any and all real property which may form a part of any of said trusts either at public or private sale and for cash or on credit or partly for cash and partly on credit, securing the paym much of the purchase price as may remain on credit by mortgage on the proper authorize my said Trustees to receive from my Executors in lieu of cash any p urities, investments or property real or personal inwhich my estate or any p may be invested at the time of my death and to retain such securities, inves property or any part thereof, in their discretion, and to sell the same and proceeds thereof in such securities, investments or property as they shall and proper without being limited to the class or type of investments in which may be authorized to invest trust funds by the law of any State having juris my estate or the administration of any trust provided for herein. I direct idends, whether extraordinary or ordinary, in stock or cash, as well as the sale of any rights of subscription to stocks or bonds shall be regarded as shall be distributed by my Trustees as income of the trust to which the same purtenant. I authorize my Trustees to become parties to the reorganization, tion or merger of any corporation the securities of which may form a part herein provided for, and for such purpose I direct that they shall have ful execute any agreement necessary and to make any necessary payments, loans to take any further steps necessary to affect the same, including the depo

F.T.M. and exchange of any securities which they may deem desirable in connection also direct that my Trustees shall not be required to create a sinking fund any loss to the principal of any trust which may result from the purchase o ities at a premium.

SIXTEENTH: I direct that all succession, inheritance, estate taxes upon the devises, legacies, bequests and trusts provided for in this upon any property or the transfer thereof passing by reason of my death sh out of my residuary estate.

IN WITNESS WHEREOF I have hereunto set my hand and affixed 15th day of May in the year One thousand nine hundred and forty.

(signed)Francis T. Maxwell (s

Signed, sealed, published and declared by FRANCIS T. MAXWELL, the Testator above-named, as and for his Last Will and Testament in our presence, who, at his request, in his presence and in the presence of one another, have hereunto subscribed our names as attesting witnesses at the Borough of Manhattan, in the City and State of New York, the day and year last above written. This will consists of nine pages exclusive of this page, each initialed by the Testator.

(signed)Thomas B. Gilchrist residing at Lawrence Park Way, Bron
(signed)E.A. Kniffin residing at No. 1435 Lexington Ave.,
(signed)Frank H. Platt residing at 64 East 86th St., New Yo

STATE OF NEW YORK, }
COUNTY OF NEW YORK, } ss.:

The above named Thomas B. Gilchrist, E. A. Kniffin a being severally duly sworn, depose and say that they witnessed the forego within Testator, Francis T. Maxwell, and subscribed the same in his pre request and in the presence of one another; that the said Francis T. time of the execution of such will appeared to them to be of full age and memory, and that he signed the said will and declared the same to and Testament in their presence, and that they make this affidavit at said Testator.

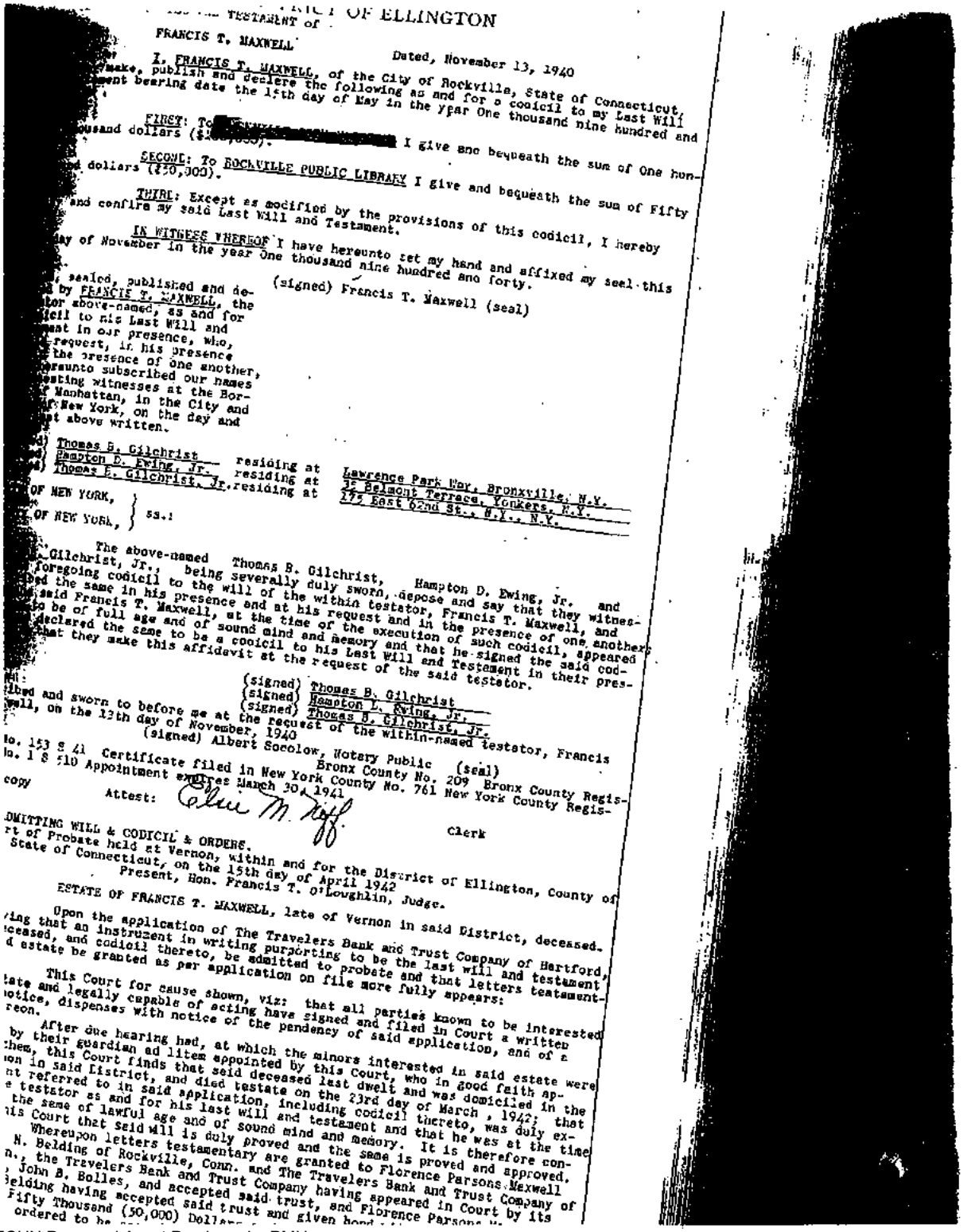
(signed) Thomas B. Gilchrist
(signed) E. A. Kniffin
(signed) Frank H. Platt

Subscribed and sworn to before me, at the request of the within-named T. Maxwell, on the 15th day of May, 1940.
(signed) Albert Socolow, Notary Public (seal)
Bronx County No. 209 Bron
New York County No. 761 New Yor

ters' No. 153 S 41 Certificate Filed in New York County No.
ter's No. 1 S 510 Appointment expires March 30, 1941

Attest: Clerk

A true copy



...TESTAMENT of ... OF ELLINGTON

FRANCIS T. MAXWELL

Dated, November 13, 1940

I, FRANCIS T. MAXWELL, of the City of Rockville, State of Connecticut, ...make, publish and declare the following as and for a codicil to my Last Will ...ment bearing date the 15th day of May in the year One thousand nine hundred and ...

FIRST: To [redacted] I give and bequeath the sum of One hun...ousand dollars ($...).

SECOND: To ROCKVILLE PUBLIC LIBRARY I give and bequeath the sum of Fifty ...d dollars ($50,000).

THIRD: Except as modified by the provisions of this codicil, I hereby ...and confirm my said Last Will and Testament.

IN WITNESS WHEREOF I have hereunto set my hand and affixed my seal this ...day of November in the year One thousand nine hundred and forty.

(signed) Francis T. Maxwell (seal)

...sealed, published and de... by FRANCIS T. MAXWELL, the ...tor above-named, as and for ...icil to his Last Will and ...ment in our presence, who, ...request, in his presence ...the presence of one another, ...hereunto subscribed our names ...esting witnesses at the Bor... of Manhattan, in the City and ...of New York, on the day and ...ar above written.

...) Thomas B. Gilchrist residing at Lawrence Park Way, Bronxville, N.Y.
...) Hampton D. Ewing, Jr. residing at 35 Belmont Terrace, Yonkers, N.Y.
...) Thomas B. Gilchrist, Jr. residing at 175 East 62nd St., N.Y., N.Y.

...OF NEW YORK, }
...OF NEW YORK, } ss.:

The above-named Thomas B. Gilchrist, Hampton D. Ewing, Jr. and ...Gilchrist, Jr., being severally duly sworn, depose and say that they witnes... foregoing codicil to the will of the within testator, Francis T. Maxwell, and ...ed the same in his presence and at his request and in the presence of one another ...said Francis T. Maxwell, at the time of the execution of such codicil, appeared ...to be of full age and of sound mind and memory and that he signed the said cod... declared the same to be a codicil to his Last Will and Testament in their pres... that they make this affidavit at the request of the said testator.

(signed) Thomas B. Gilchrist
(signed) Hampton D. Ewing, Jr.
(signed) Thomas B. Gilchrist, Jr.

...ibed and sworn to before me at the request of the within-named testator, Francis ...well, on the 13th day of November, 1940

(signed) Albert Socolow, Notary Public (seal)

...No. 153 S 41 Certificate filed in Bronx County No. 209 Bronx County Regis...
...No. 1 S 510 Appointment expires March 30, 1941 ter No. 761 New York County Regis...

copy

Attest: Clerk

...MITTING WILL & CODICIL & ORDERS.

...rt of Probate held at Vernon, within and for the District of Ellington, County of ...State of Connecticut, on the 15th day of April 1942

Present, Hon. Francis T. O'Loughlin, Judge.

ESTATE OF FRANCIS T. MAXWELL, late of Vernon in said District, deceased.

Upon the application of The Travelers Bank and Trust Company of Hartford, ...ving that an instrument in writing purporting to be the last will and testament ...ceased, and codicil thereto, be admitted to probate and that letters testament... ...d estate be granted as per application on file more fully appears:

This Court for cause shown, viz: that all parties known to be interested ...tate and legally capable of acting have signed and filed in Court a written ...notice, dispenses with notice of the pendency of said application, and of a ...reon.

After due hearing had, at which the minors interested in said estate were ...by their guardian ad litem appointed by this Court, who in good faith ap... ...them, this Court finds that said deceased last dwelt and was domiciled in the ...ion in said District, and died testate on the 23rd day of March , 1942; that ...nt referred to in said application, including codicil thereto, was duly ex... ...e testator as and for his last will and testament and that he was at the time ...the same of lawful age and of sound mind and memory. It is therefore con... ...his Court that said will is duly proved and the same is proved and approved.

Whereupon letters testamentary are granted to Florence Parsons Maxwell ...N. Belding of Rockville, Conn. and The Travelers Bank and Trust Company of ..., the Travelers Bank and Trust Company having appeared in Court by its ..., John B. Bolles, and accepted said trust, and Florence Parsons M... ...Belding having accepted said trust and given bond ... Fifty Thousand (50,000) Dollars ... ordered to be ...

DISTRICT OF ELLINGTON

ACCEPTANCE OF TRUST
To the Probate Court for the District of Ellington in the State of Connecticut

ESTATE OF FRANCIS T. MAXWELL, late of Rockville in said District, deceased.

Florence Parsons Maxwell, Frederick N. Belding and The Travelers Bank and Trust Company having been named Executor of the will of FRANCIS T. MAXWELL, late of Rockville, deceased, hereby appear in said Court and accept such appointment.

(signed) Florence Parsons Maxwell
(signed) Frederick N. Belding
THE TRAVELERS BANK & TRUST COMPANY
by (signed) John B. Bolles, Trust Officer

Hartford, Connecticut
April 15, 1942

A true copy Attest: Clerk

APPOINTMENT OF GUARDIAN AD LITEM
At a Court of Probate held at Vernon, within and for the District of Ellington, County of Tolland, State of Connecticut, on the 15th day of April 1942
Present, Hon. Francis T. O'Loughlin, Judge.

ESTATE OF FRANCIS T. MAXWELL, late of Vernon in said District, deceased.

Frederick N. Belding of Rockville, Conn. is hereby appointed guardian ad litem of Maxwell Belding and Virginia Belding, minor grandchildren of said deceased, to appear for and protect their interests during the settlement of said estate.

(signed) F. T. O'Loughlin, Judge.

A true copy Attest: Clerk

LAST WILL AND TESTAMENT
of
FRANCIS T. MAXWELL Dated, May 15, 1940

I, FRANCIS T. MAXWELL, of the City of Rockville and State of Connecticut, do hereby make, publish and declare the following as and for my LAST WILL AND TESTAMENT, hereby revoking all other wills and codicils by me made.

FIRST: I direct the payment of all my just debts and funeral expenses as soon as convenient after my death.

SECOND: To my wife, FLORENCE PARSONS MAXWELL, I give and devise my dwelling house with the stable and other buildings appurtenant thereto and the land upon which the same are erected, situated on Ellington Avenue, Prospect, North Park and Cliff Streets, in the towns of Vernon and Ellington, in the State of Connecticut, to have and to hold the same to her, her heirs, and assigns, forever. I also give and bequeath to my said wife all my household furniture, supplies, utensils, fixtures, works of art, automobiles, wearing apparel, jewelry, farming utensils and personal effects, and all other articles of personal or domestic use or adornment, relying upon my said wife to give to such of my daughters as shall survive me any of such articles of personal property as she may desire. I direct that my said wife shall have the privilege of accepting all or any part of the property devised and bequeathed to her by the provisions of this Article of my will and that any part of said property that my said wife may not accept shall fall into and become a part of my residuary estate. F.T.M.

THIRD: To my wife, FLORENCE PARSONS MAXWELL, and my daughters, PRISCILLA MAXWELL ENDICOTT and HARRIET K. MAXWELL VEISSI, and to the survivor of them, I give and bequeath the sum of Fifty thousand dollars ($50,000), as joint tenants. Without intending to qualify the absolute character of this bequest, it is my hope that my said wife and daughters, or such of them as shall survive me, will distribute the said sum among such of our friends, relatives, domestic servants in my employ at the time of my death, and business associates and institutions in such manner and amounts as I may indicate by a written memorandum, or, failing such memorandum, as my said wife and daughters or the survivors or survivor of them shall determine.

FOURTH: To each of my granchildren, MAXWELL M. BELDING, VIRGINIA BELDING, BRADFORD MAXWELL ENDICOTT and PRISCILLA ENDICOTT, I give and bequeath the sum of Ten Thousand dollars ($10,000). F.T.M.

FIFTH: To my TRUSTEES hereinafter named I give and bequeath all the shares of stock which I may own at the time of my death in The Hartford-Connecticut Trust Company IN TRUST NEVERTHELESS to hold the same for and during the lifetime of my sister J. ALICE MAXWELL and to collect and receive the dividends and income thereof and the same to pay over and distribute in quarterly installments to my said sister for and during the period of her life. Upon her death I direct that the said shares of stock and any and all property into which the said shares of stock or the proceeds thereof or any part thereof shall have been converted shall fall into and become a part of my residuary estate.

SIXTH: To CONNECTICUT HISTORICAL SOCIETY of Hartford, Connecticut, I give and bequeath the sum of Five thousand dollars ($5,000), in trust, to invest and reinvest the same and apply the income thereof to any of its purposes that the Directors or Trustees thereof may deem advisable.

SEVENTH: To CONNECTICUT CHILDREN'S AID SOCIETY of Hartford, Connecticut, I give and bequeath the sum of Five thousand dollars ($5,000), in trust, to invest and reinvest the same and apply the income thereof to any of its purposes that the Directors or Trustees thereof may deem advisable.

EIGHTH: To CONNECTICUT HUMANE SOCIETY of Hartford, Connecticut, I give and bequeath the sum of Five thousand dollars ($5,000), in trust, to invest and reinvest the same and apply the income thereof to any of its purposes that the Directors or Trustees

DISTRICT OF ELLINGTON

Estate of Francis T. Maxwell, deceased. (Will) (Continued)

F.T.M. NINTH: To HARTFORD HOSPITAL in Hartford, Connecticut, I give and bequeath the sum of Five thousand dollars ($5,000), in trust, to invest and reinvest the same and apply the income thereof to any of the purposes of said Hospital that the Directors or Trustees thereof may deem advisable, but preference in the use thereof to be given to residents of Rockville, Connecticut.

TENTH: To CITY OF ROCKVILLE in the State of Connecticut, I give and bequeath the sum of Twenty-five thousand dollars ($25,000), as a sinking fund to be used for the payment of bonds of said City falling due in future years.

ELEVENTH: To said CITY OF ROCKVILLE I give and bequeath the further sum of Twenty-five thousand dollars ($25,000), to be used for the purpose of providing or improving athletic facilities at Fox Hill Park in said City of Rockville and for the improvement of said Park by the planting of trees and shrubs in the discretion of the Common Council of said City, it being my wish that the athletic facilities shall be provided before any expenditure of said fund shall be made for the planting of trees or shrubs in said Park.

TWELFTH: To each of the following Churches situated in Rockville and Vernon in the State of Connecticut, I give and bequeath the sum of One thousand dollars ($1,000): ROCKVILLE METHODIST EPISCOPAL CHURCH, SAINT JOHN'S EPISCOPAL CHURCH, BAPTIST CHURCH, SAINT BERNARD'S ROMAN CATHOLIC CHURCH, SAINT JOSEPH'S ROMAN CATHOLIC CHURCH, FIRST EVANGELICAL LUTHERAN CHURCH, TRINITY EVANGELICAL LUTHERAN CHURCH, APOSTALIC CHRISTIAN CHURCH, VERNON CENTER CONGREGATIONAL CHURCH AND the JEWISH SYNAGOGUE on East Main
F.T.M. Street in Rockville.

THIRTEENTH: All the rest, residue and remainder of my property, real and personal, of every kind, nature and description and wheresoever situated, including all lapsed legacies and devises and any and all property over which I may have power of appointment, I give, devise, bequeath and appoint to my TRUSTEES hereinafter named, IN TRUST NEVERTHELESS, to divide the same into four equal parts and to hold and dispose of said four equal parts as follows:

(a) To hold in trust two of said parts for the period of the life of my wife FLORENCE PARSONS MAXWELL and to invest and reinvest the same and collect and receive the income thereof and to pay over the said income in quarterly installments to my said wife for and during the term of her natural life and upon her death to divide the capital of said trust among my then-surviving daughters and issue of deceased daughters in equal shares per stirpes, the share of each daughter to be added to the trust for such daughter hereinafter provided for, and the share of each issue of a deceased daughter to be paid to such issue if over thirty years of age and, if under thirty years of age, to be held in trust as hereinafter provided.

(b) To hold in trust one of said parts, and any addition or additions thereto that may result from the privisions of subdivisions (a) or (c) hereof, for the period of the life of my daughter PRISCILLA MAXWELL ENDICOTT and to invest and reinvest the same and collect and receive the income thereof and to pay over the said income in quarterly
F.T.M. installments to my said daughter for and during the term of her natural life and upon her death to distribute the capital of said trust among her surviving children and issue of deceased children in equal shares per stirpes, subject to the provision hereinafter made as to the continuance in trust of the share of any beneficiary under the age of thirty years, and in the event that she should leave her surviving no child or children or issue of a deceased child, then to divide the capital of said trust among my then-surviving daughter and issue of deceased daughters in equal shares per stirpes, the share of such daughter to be added to the trust for such daughter, elsewhere in this Article provided for, and the share of each issue of a deceased daughter to be paid to such issue if over thirty years of age, and, if under thirty years of age, to be held in trust as hereinafter provided.

(c) To hold in trust one of said parts, and any addition or additions thereto that may result from the provisions of subdivisions (a) or (b) hereof, for the period of the life of my daughter HARRIET K. MAXWELL VEISSI and to invest and reinvest the same and collect and receive the income thereof and to pay over the said income in quarterly installments to my said daughter for and during the term of her natural life and upon her death to distribute the capital of said trust among her surviving children and issue of deceased children in equal shares per stirpes, subject to the privision hereinafter made as to the continuance in trust of the share of any beneficiary under the age of thirty years, and in the event that she should leave her surviving no child or children or issue of a deceased child, then to divide the capital of said trust among my then-surviving daughter and issue of deceased daughters in equal shares per stirpes, the share of such
F.T.M. daughter to be added to the trust for such daughter, elsewhere in this Article provided for, and the share of each issue of a deceased daughter to be paid to such issue if over thirty years of age and, if under thirty years of age, to be held in trust as hereinafter provided.

(d) In the event that any of the issue of any daughter of mine shall be under the age of thirty years at the time when he or she shall be entitled to receive a distributive share of my residuary estate as hereinbefore provided, I direct my Trustees to continue to hold in trust the share of such issue until he or she shall attain the age of thirty years or die before attaining that age and to accumulate the income thereof and to pay over the same to such issue when he or she shall attain the age of thirty years, and, in the event that such issue shall die before attaining the age of thirty years, then upon his or her death to distribute and pay over the same to the executors or administrators of such deceased issue as a part of his or her estate.

(e) In the event that, upon the termination of any of said trusts, there should be no issue of mine then living, then, and in such event, I direct that the capital of such trust shall be divided into two equal parts, one of which parts I give, devise and bequeath to ROCKVILLE CITY HOSPITAL and the other to HARTFORD HOSPITAL.

FOURTEENTH: The provisions of this my will for the benefit of my wife are intended by me to be and shall be accepted by her in lieu of all dower interest or other claim or right which she may have in, to or against my estate or any part thereof.

F.T.M. FIFTEENTH: I nominate, constitute and appoint my wife, FLORENCE PARSONS MAXWELL, my son-in-law, FREDERICK N. BELDING, and TRAVELERS BANK AND TRUST COMPANY, of Hartford, Connecticut, as and to be the EXECUTORS of this my Will and the TRUSTEES of the trusts provided for herein, and I direct that no security shall be required of any of

DISTRICT OF ELLINGTON

Estate of Francis T. Maxwell, deceased. (Will) (Continued)

To my Executors and the survivor of them I give and grant full power and authority to sell any and all real property, which I may own at the time of my death and which is not specifically devised hereunder, either at public or private sale and either for cash or on credit or partly for cash and partly on credit, securing the payment of so much of the purchase price as may remain on credit by mortgage on the property sold. I authorize my Executors or the survivor of them to make payment in full or in part of all bequests of more than Two thousand dollars ($2,000) provided for in this my will, by setting apart and distributing to the respective legatees any stocks, bonds or other securities in which my estate may be invested at the time of my death, except such as are hereinbefore specifically bequeathed, in such manner and such amounts as my said Executors or the survivor of them may prefer, and at such values as my Executors may determine, and to distribute my residuary estate in like manner; but nothing herein contained shall be deemed to prohibit the sale of any personal property owned by me at the time of my deathand not herein specifically bequeathed, if my Executors shall desire to sell the same.

F.T.M. I authorize my Trustees to sell any and all real property which at any time may form a part of any of said trusts either at public or private sale and either for cash or on credit or partly for cash and partly on credit, securing the payment of so much of the purchase price as may remain on credit by mortgage on the property sold. I authorize my said Trustees to receive from my Executors in lieu of cash any and all securities, investments or property real or personal inwhich my estate or any part thereof may be invested at the time of my death and to retain such securities, investments or property or any part thereof, in their discretion, and to sell the same and reinvest the proceeds thereof in such securities, investments or property as they shall deem suitable and proper without being limited to the class or type of investments in which trustees may be authorized to invest trust funds by the law of any State having jurisdiction over my estate or the administration of any trust provided for herein. I direct that all dividends, whether extraordinary or ordinary, in stock or cash, as well as the proceeds of sale of any rights of subscription to stocks or bonds shall be regarded as income and shall be distributed by my Trustees as income of the trust to which the same shall be appurtenant. I authorize my Trustees to become parties to the reorganization, consolidation or merger of any corporation the securities of which may form a part of any trust herein provided for, and for such purpose I direct that they shall have full authority to execute any agreement necessary and to make any necessary payments, loans or advances and F.T.M. to take any further steps necessary to effect the same, including the deposit, surrender and exchange of any securities which they may deem desirable in connection therewith. I also direct that my Trustees shall not be required to create a sinking fund to make good any loss to the principal of any trust which may result from the purchase of any securities at a premium.

SIXTEENTH: I direct that all succession, inheritance, estate or transfer taxes upon the devises, legacies, bequests and trusts provided for in this my will or upon any property or the transfer thereof passing by reason of my death shall be paid out of my residuary estate.

IN WITNESS WHEREOF I have hereunto set my hand and affixed my seal this 15th day of May in the year One thousand nine hundred and forty.

(signed)Francis T. Maxwell (seal)

Signed, sealed, published and declared by FRANCIS T. MAXWELL, the Testator above-named, as and for his Last Will and Testament in our presence, who, at his request, in his presence and in the presence of one another, have hereunto subscribed our names as attesting witnesses at the Borough of Manhattan, in the City and State of New York, the day and year last above written. This will consists of nine pages exclusive of this page, each initialed by the Testator.

(signed)Thomas B. Gilchrist residing at Lawrence Park Way, Bronxville, N.Y.
(signed)E.A. Kniffin residing at No. 1435 Lexington Ave., N.Y.C.
(signed)Frank H. Platt residing at 64 East 86th St., New York, N.Y.

STATE OF NEW YORK, }
} ss.:
COUNTY OF NEW YORK, }

The above named Thomas B. Gilchrist , E. A. Kniffin and Frank H. Platt being severally duly sworn, depose and say that they witnessed the foregoing will of the within Testator, Francis T. Maxwell, and subscribed the same in his presence and at his request and in the presence of one another; that the said Francis T. Maxwell at the time of the execution of such will appeared to them to be of full age and of sound mind and memory, and that he signed the said will and declared the same to be his Last Will and Testament in their presence, and that they make this affidavit at the request of the said Testator.

(signed) Thomas B. Gilchrist
(signed) E. A. Kniffin
(signed) Frank H. Platt

Subscribed and sworn to before me, at the request of the within-named Testator, Francis T. Maxwell, on the 15th day of May, 1940.

(signed) Albert Socolow, Notary Public (seal)
Bronx County No. 209 Bronx County Registers' No. 153 S 41 Certificate Filed in New York County No. 761 New York County Registeris No. 1 S 510 Appointment expires March 30, 1941

A true copy Attest: Clerk

VOL. 56

DISTRICT OF ELLINGTON

CODICIL TO LAST WILL AND TESTAMENT of

FRANCIS T. MAXWELL Dated, November 13, 1940

I, FRANCIS T. MAXWELL, of the City of Rockville, State of Connecticut, do hereby make, publish and declare the following as and for a codicil to my Last Will and Testament bearing date the 15th day of May in the year One thousand nine hundred and forty.

FIRST: To ROCKVILLE CITY HOSPITAL I give and bequeath the sum of One hundred thousand dollars ($100,000).

SECOND: To ROCKVILLE PUBLIC LIBRARY I give and bequeath the sum of Fifty thousand dollars ($50,000).

THIRD: Except as modified by the provisions of this codicil, I hereby ratify and confirm my said Last Will and Testament.

IN WITNESS WHEREOF I have hereunto set my hand and affixed my seal this 13th day of November in the year One thousand nine hundred and forty.

(signed) Francis T. Maxwell (seal)

Signed, sealed, published and declared by FRANCIS T. MAXWELL, the Testator above-named, as and for a codicil to his Last Will and Testament in our presence, who, at his request, in his presence and in the presence of one another, have hereunto subscribed our names as attesting witnesses at the Borough of Manhattan, in the City and State of New York, on the day and year last above written.

(signed) Thomas B. Gilchrist residing at Lawrence Park Way, Bronxville, N.Y.
(signed) Hampton D. Ewing, Jr. residing at 35 Belmont Terrace, Yonkers, N.Y.
(signed) Thomas B. Gilchrist, Jr. residing at 175 East 62nd St., N.Y., N.Y.

STATE OF NEW YORK,)
) ss.:
COUNTY OF NEW YORK,)

The above-named Thomas B. Gilchrist, Hampton D. Ewing, Jr. and Thomas B. Gilchrist, Jr., being severally duly sworn, depose and say that they witnessed the foregoing codicil to the will of the within testator, Francis T. Maxwell, and subscribed the same in his presence and at his request and in the presence of one another; that the said Francis T. Maxwell, at the time of the execution of such codicil, appeared to them to be of full age and of sound mind and memory and that he signed the said codicil and declared the same to be a codicil to his Last Will and Testament in their presence and that they make this affidavit at the request of the said testator.

(signed) Thomas B. Gilchrist
(signed) Hampton D. Ewing, Jr.
(signed) Thomas B. Gilchrist, Jr.

Subscribed and sworn to before me at the request of the within-named testator, Francis T. Maxwell, on the 13th day of November, 1940

(signed) Albert Socolow, Notary Public (seal)
Bronx County No. 209 Bronx County Register's No. 153 S 41 Certificate filed in New York County No. 761 New York County Register's No. 1 S 510 Appointment expires March 30, 1941

A true copy Attest: Clerk

DECREE ADMITTING WILL & CODICIL & ORDERS.

At a Court of Probate held at Vernon, within and for the District of Ellington, County of Tolland, State of Connecticut, on the 15th day of April 1942

Present, Hon. Francis T. O'Loughlin, Judge.

ESTATE OF FRANCIS T. MAXWELL, late of Vernon in said District, deceased.

Upon the application of The Travelers Bank and Trust Company of Hartford, Conn. praying that an instrument in writing purporting to be the last will and testament of said deceased, and codicil thereto, be admitted to probate and that letters testamentary on said estate be granted as per application on file more fully appears:

This Court for cause shown, viz: that all parties known to be interested in said estate and legally capable of acting have signed and filed in Court a written waiver of notice, dispenses with notice of the pendency of said application, and of a hearing thereon.

After due hearing had, at which the minors interested in said estate were represented by their guardian ad litem appointed by this Court, who in good faith appeared for them, this Court finds that said deceased last dwelt and was domiciled in the Town of Vernon in said District, and died testate on the 23rd day of March, 1942; that the instrument referred to in said application, including codicil thereto, was duly executed by the testator as and for his last will and testament and that he was at the time of executing the same of lawful age and of sound mind and memory. It is therefore considered by this Court that said will is duly proved and the same is proved and approved. Whereupon letters testamentary are granted to Florence Parsons Maxwell and The Travelers Bank and Trust Company of

DISTRICT OF ELLINGTON

Estate of Francis T. Maxwell (Decree Admitting Will & Codicil,& Orders) (Continued)

same are allowed the executors within which to settle said estate.

ORDERED, That six months from the 15th day of April, 1942 be and the same are limited and allowed for the creditors to bring in their claims against said estate, and the said Executors are directed to give public notice to the creditors to bring in their claims within said time allowed, by posting a copy of this order upon the public sign-post nearest to the place where the deceased last dwelt within said town, and by publishing the same once in some newspaper having a circulation in said Probate District within fifteen days from the date of a list of all claims presented within said time.

ORDERED, That two months from the 15th day of April, 1942, be and the same are allowed the Executors within which to make, or cause to be made, a true and perfect inventory of all the estate of said deceased, both real and personal, including choses in action. And this Court appoints George Arnold and Louis C. Edwards disinterested persons, appraisers under oath, to appraise said estate and return make to this Court within said time allowed.

(signed) Francis T. O'Loughlin, Judge.

A true copy Attest: Clerk

APPLICATION FOR EXTENSION OF TIME TO FILE INVENTORY
To the Probate Court for the District of Ellington in the State of Connecticut

ESTATE OF FRANCIS T. MAXWELL, late of Rockville in said District, deceased.

The subscriber represents that

1. It is an executor of the will of said deceased.
2. It is unable to complete an inventory and appraisal of said estate within two months after its qualification as executor because of extensive research necessary into the manner of description of certain real estate holdings as well as appraisal of large security holdings, and further because the appraisers of said estate have not yet been appointed by the Judge of Probate

WHEREFORE, your applicant prays this Court to extend the time for lodging such inventory with this Court for a period of two months.

Dated this thirteenth day of June, 1942.

THE TRAVELERS BANK AND TRUST COMPANY,
By (signed) John B. Bolles, Trust Officer

A true copy Attest: Clerk

EXTENSION OF TIME TO FILE INVENTORY
At a Court of Probate held at Vernon, within and for the District of Ellington, County of Tolland, State of Connecticut on the 15th day of June 1942
Present, Hon. Francis T. O'Loughlin, Judge.

ESTATE OF FRANCIS T. MAXWELL, late of Vernon in said District, deceased.

Upon the application of one of the executors of the will of Francis T. Maxwell for an extension of time within which to file the inventory of said estate,

This Court finds that the allegations of said application are true and the time for filing the inventory in said estate is hereby extended for two months until August 15, 1942.

(signed) F. T. O'Loughlin, Judge.

A true copy Attest: Clerk

APPLICATION FOR LETTERS OF ADMINISTRATION AND WAIVERS
To the Probate Court for the District of Ellington, State of Connecticut:

ESTATE OF BARCHLEY H. KLOTER, late of Vernon in said District, deceased.

The subscriber represents that BARCHLEY H. KLOTER last dwelt and was domiciled in the town of Vernon in said District, and died on the 2nd day of July A.D. 1942, possessed of goods and estate in said District remaining to be administered, leaving a widow, whose name and residence is Esther D. Kloter, 38 Hammond St., Rockville, Conn. and whose marriage to the deceased took place after 1877; that said decedent left him surviving no children or descendants of deceased children or heirs-at-law except those whose names and addresses are given below:-

Name	Residence	Relationship
Phyllis Reinhardt	215-07-111th Road Queens Village, Long Island, N.Y.	daughter
Shirley Schmitt (19)	121-4-192nd St., St. Albans, Long Island, N.Y.	"
Edward Kloter	38 Hammond St., Rockville, Conn.	son

none of whom, except as hereinbefore stated, are under any disability or incapacity and that the said deceased no will.

Wherefore your petitioner prays that letters of administration on said estate may be granted to Esther D. Kloter.

(signed) Esther D. Kloter
(signed) Phyllis Reinhardt

Subscribed and sworn to this 6th day of July, 1942, before me,
(signed) F. T. O'Loughlin, Judge

EXHIBIT Q 11-2

Fund 11-1.70

Memorial Funds

Rockville, Conn., Jan. 20, 1953

Following the meeting of the Corporators, a meeting of the Trustees of the Rockville City Hospital, Inc. was held, those present being:

Lebbeus F. Bissell
Roy C. Ferguson
Donald C. Fisk
John R. Gottier
Frank E. Hardenbergh
Claude A. Mills
John S. Mason

Lebbeus F. Bissell, president, presided.

The minutes of the previous meeting on January 15, 1952 were read and approved.

It was voted that the Secretary cast one ballot for the following officers for the ensuing year, or until their successors are chosen:

President	Lebbeus F. Bissell
Vice-President	Claude A. Mills
Secretary	John S. Mason
Treasurer	Hartford-Connecticut Trust Co. (Rockville Branch)

The ballot was cast and the chairman declared them elected.

It was voted that the Secretary cast one ballot for the following to serve as Executive Committee for the ensuing year or until their successors are chosen:

Lebbeus F. Bissell
Frank E. Hardenbergh
Roy C. Ferguson

The ballot was cast and the Chairman declared them elected.

It was voted that the Secretary cast one ballot for the following to serve as Finance Committee for the ensuing year or until their successors are chosen:

Lebbeus F. Bissell
Claude A. Mills
Donald C. Fisk

The ballot was cast and the Chairman declared them elected.

It was voted that the Secretary cast one ballot for the following to serve as Auditors for the ensuing year or until their successors are chosen:

Frank E. Hardenbergh
Claude A. Mills
John R. Gottier

The ballot was cast and the Chairman declared them elected.

The Treasurer's report for the period 1 September 1951 through 1 September 1952 was read and discussed, and it was voted that same be accepted and placed on file.

Upon motion duly made and seconded, it was voted to adjust the salaries of the Superintendent and Manager.

The proposed changes in the Funds, submitted by the Treasurer, were discussed, and upon motion duly made and seconded, it was voted that the Hartford-Connecticut Trust Co. be authorized to make the following changes in accordance with the following resolutions:

"WHEREAS, Rockville City Hospital has certain endowment funds which are maintained in separate accounts and it is deemed to combine said funds for bookkeeping and investment purposes, and

WHEREAS, it appears from the terms under which such funds were established that such funds may be properly combined.

Now therefore, it is

VOTED: That the Treasurer be authorized and instructed to establish two new funds under the title Memorial Funds Unrestricted and Memorial Funds Restricted, respectively.

It is also

VOTED: That January 15, 1953 shall be established as the date for the combination of three separate funds (listed below) under the title of the new "Memorial Funds Unrestricted". The original book value of each of the separate funds shall be reaffirmed as the Memorial value of each of such endowments, and the January 15, 1953 book value of the investments comprising these three funds shall be carried over into the new "Memorial Funds Unrestricted" as the book value of the combined investments.

General Fund
Harriet K. Maxwell Fund
Swindells Fund

It is also

VOTED: That January 15, 1953 shall be established as the date of the new combination of ten separate funds (listed below) under the title of the new "Memorial Funds Restricted". The original book value of each of the separate funds shall be reaffirmed as the Memorial value of each of such endowments, and the January 15, 1953 book value of the investments comprising these ten funds shall be carried over into the new "Memorial Funds Restricted" as the book value of the combined investments.

Release by PMH

Alvah S. Belding Fund
Ruth T. Britton Fund
Consolidated Fund
George S. Doane Fund
J. Alice Maxwell Fund
William A. and Caroline E. Metcalf Fund
George Palmer Charter Fund
Rockville Chapter ARC Fund
William B. and Lizzie Lathrop Sprague Fund
Edgar Tenney Fund

It is also

VOTED: That securities and cash of the William Maxwell Fund having a market value as of October 9, 1952 of $107,346.29 be carried over from the William Maxwell Fund to the new "Memorial Funds Unrestricted", and the value of $75,472.99 be affirmed as the Memorial value of the William Maxwell gifts in the "Memorial Funds Unrestricted". The present book values of the securities transferred to the "Memorial Funds Unrestricted" shall be carried over to that fund at the same book values."

Upon motion duly made and seconded, it was voted that the Finance Committee be authorized to rule on the proposed shift in some of the investments as recommended by the Hartford-Connecticut Trust Co.

Upon motion duly made and seconded it was voted that Lebbeus F. Bissell, Trustee of said Hospital, be authorized and directed to sign all and any applications, bonds and all other necessary papers pertaining to the Alcohol Tax Free Permit in behalf of said Hospital for the purpose of obtaining alcohol free of tax for use by the Hospital.

sed Asset Purchase by PMH
ober 13, 2015

Mr. Adams was called into the meeting and gave a report on the hospital operations.

There being no further business, the meeting was adjourned at 11:18.

Attest:

John L. Mason
Secretary

KING AND CALDWELL
ATTORNEYS AT LAW
3 PARK STREET
ROCKVILLE, CONNECTICUT

January 24, 1968

Robert C. Hector, Executive Director
State of Connecticut Health and Education
Facilities Authority
State Office Building, Room 587
Hartford, Connecticut

Re: Rockville General Hospital, Inc. Endowment Funds

Dear Mr. Hector:

Pursuant to our telephone conversation I have reviewed the endowment funds held by the Rockville General Hospital with Wilson Keithline of the Trust Department of The Connecticut Bank and Trust Company.

As a result we have developed the following information:

Total Endowment Funds of the Hospital

Consolidated Investment Fund	$ 3,420,000.00
L. Henry Fund	73,000.00
M. Henry Fund	87,000.00
Memorial Funds Restricted	275,000.00
Memorial Funds Unrestricted	298,000.00
Rockville Mutual Fire Fund.	585,000.00
Suspense Account	4,000.00
	$ 4,742,000.00

You will note that we have rounded off the figures here to even thousands. I have attempted to divide our total funds into three categories--1. Definitely Unrestricted Funds
2. Definitely Restricted Funds
3. Questionable Funds

Those three categories are as follows: (Once again in some cases the figures have been rounded off to the nearest thousand so that the figures included in the above three groupings will not necessarily total $4,742,000.00 but they should be within $2,000 or $3,000.)

KING AND CALDWELL
ATTORNEYS AT LAW
3 PARK STREET
ROCKVILLE, CONNECTICUT

1. Definitely Unrestricted Funds

Rockville Mutual Fire Fund	$	585,000.00
Memorial Funds Unrestricted		298,000.00
J. and M. Kress Fund		2,000.00
F. Talcott Fund		137,600.00
Maxwell Fund		165,500.00
Bernice H. Sykes Fund		89,200.00
Total	$	1,277,300.00

2. Definitely Restricted Funds

Memorial Funds Restricted	$	275,000.00
L. Henry Fund		73,000.00
M. Henry Fund		87,000.00
Alice Farmer Bissell Fund		1,708,200.00
Charles Phelps Free Bed Fund		14,100.00
Risley Funds		410,600.00
Trumbull Chapter, D.A.R. Fund		147,300.00
United German Fund		10,000.00
W. H. Prescott Fund		258,500.00
A. S. Whitlook Free Bed Fund		18,800.00
Winchell Foster Free Bed Fund		15,400.00
Betsey Tucker Free Bed Fund		1,600.00
Eva Wood Fund		600.00
Bruno Doss et ux Fund		5,900.00
Elsie S. Phelps Fund		5,600.00
Total	$	3,027,000.00

3. Questionable Funds

C. E. Prescott Fund	$	95,200.00
F. T. Maxwell Fund		32,500.00
W. Maxwell Fund		305,200.00
Total	$	432,900.00

The totals therefore are as follows:

1. Definitely Unrestricted Funds		1,277,300.00
2. Definitely Restricted Funds		3,027,000.00
3. Questionable Funds		432,900.00
4. Suspense		4,000.00
Total	$	4,741,200.00

KING AND CALDWELL
ATTORNEYS AT LAW
3 PARK STREET
ROCKVILLE, CONNECTICUT

The funds listed as "Definitely Restricted" are done so after a review of the documents setting up these funds. Either these funds were left for a specific use, such as furnishing a free bed, or were left in perpetual trust with specific instructions that only income was to be used by the Hospital. There are several funds included in these "Definitely Restricted" Funds for which supporting documents cannot be found or are not available. Actually these are minor in nature and with no documentation it is impossible for the trustees to make use of the principal.

Because there are only three "Questionable" Funds, I will go into a little detail concerning them. The C. E. Prescott Fund consisted of an original testamentary gift of $15,000 in perpetual trust with the income to be used for the purposes of the Hospital. In addition, there was a $400 unrestricted gift which could be used. Therefore, of the total present value of the C. E. Prescott gift of $95,200, a fractional part amounting to 400/15,400ths might be available.

In the F. T. Maxwell Funds there were some gifts of stock which apparently were not restricted in use. However, it appears from the records of the Bank that we have already used up the portion of this fund which was unrestricted.

The W. Maxwell Fund was made up of an original gift of $14,000 in cash and $61,472 on an insurance policy. These amounts did not carry any restrictions. Also included in this fund, however, was a testamentary gift of $96,200 which definitely was restricted. Therefore, there may be available to us in that fund a fraction of the present value in the same ratio as the unrestricted funds were to the total value of the gifts when made.

Before advising the trustees to make use of any of these "Questionable" Funds, especially the larger W. Maxwell Fund, I am presently of the opinion that I would require Court approval. It should also be made clear that the figures used here are market values as of September, 1967 and therefore subject to some change, although I understand that the market value today is very close to that we used in September.

Of our total funds 59% are made up of common stock and local Hartford Insurance Companies. Approximately 25% is in Travelers Insurance Company. The Bank does not feel that there would be any difficulty in transferring securities between Restricted Accounts and Unrestricted Accounts. However, it appears that no matter how we look at it most of the securities are going to be Insurance stocks.

KING AND CALDWELL
ATTORNEYS AT LAW
3 PARK STREET
ROCKVILLE, CONNECTICUT

January 24, 1968
Page 4

I trust that this is the information you want. The finance committee of the Hospital has available to it the last statement issued by The Connecticut Bank and Trust Company and I am sure this could be made readily available.

If there is any further information which I can develop for either your office or the auditing firm, I would be very happy to do so.

Very truly yours,

Donald B. Caldwell

DBC:m
cc: W. Wilson Keithline
Frederick Hallcher
Lebbeus F. Bissell
John F. Mirabito

EXHIBIT Q 11-2

Fund 11-1.71

Mary E. Snyder

continued from page 117 - Estate of Mary E Snyder

admitted to probate and letters testamentary on said estate may be granted to the executor herein named.

Dated at Hartford this 8th day of June, A.D 1959.

The Connecticut Bank and Trust Company
by (signed) C. H. Gustafson - Assistant Trust Officer

The undersigned, being all the heirs-at-law, next of kin, and devisees and legatees interested in the foregoing petition, accept service and waive notice of the pendency of the foregoing petition and ask for the appointment of The Connecticut Bank & Trust Company as Executor.

(signed) Ida E Schanze

ACCEPTANCE OF TRUST
TO THE PROBATE COURT FOR THE DISTRICT OF ELLINGTON IN THE STATE OF CONNECTICUT

ESTATE OF MARY E. SNYDER, late of Vernon, in said District, deceased.

ACCEPTANCE OF TRUST

The Connecticut Bank and Trust Company having been named Executor of the Last Will and Testament of the above named decedent hereby appears in Court and accepts said trust.

Dated at Hartford, Connecticut this 8th day of June, 1959.

The Connecticut Bank and Trust Company
(signed) C H. Gustafson
Assistant Trust Officer

DECREE ADMITTING WILL AND ORDERS

At a Court of Probate holden at Vernon, in and for the District of Ellington, in the County of Tolland, State of Connecticut, on the 8th day of June A.D 1959.

Present, HON. THOMAS F. RADY, Judge.

ESTATE OF MARY E. SNYDER late of Vernon in said District, deceased.

Upon the application of The Connecticut Bank and Trust Co. of Hartford, Conn. praying that an instrument in writing purporting to be the last will and testament of said deceased and codicil thereunto, be admitted to probate and that letters testamentary on said estate be granted as per application on file more fully appears.

This Court for cause shown, viz: that all parties known to be interested in said estate, other than the petitioner, and legally capable of acting, have signed and filed in Court a written waiver of notice, dispenses with notice of the pendency of said application and of a hearing thereon.

After due hearing had this Court finds that said deceased last dwelt and was domiciled in the town of Vernon in said District, and died testate on the 2nd day of June A.D. 1959; that the instrument referred to in said application, including codicils thereunto, was duly executed by the testatrix as and for her last will and testament and that she was at the time of executing the same of lawful age and of sound mind and memory. It is therefore considered by this Court that said will is duly proved and the same is proved and approved. Whereupon letters testamentary on said estate are granted to The Connecticut Bank and Trust Company who on the 8th day of June, 1959 appeared in Court, accepted said trust by C.H.Gustafson, Assistant Trust Officer.

ORDERED, That twelve months from the 8th day of June, 1959 be and the same are allowed the Executor within which to settle said estate.

ORDERED, That six months from the 8th day of June, 1959 be and the same are limited and allowed for the creditors to bring in heir claims against said estate, and the said Executor is directed to give public notice to the creditors to bring in their claims within said time allowed, by posting a copy of this order upon the public sign-post nearest to the place where the deceased last dwelt within said town, and by publishing the same once in some newspaper having a circulation in said Probate District within thirty days from the date of this order and return m ake to this Court of the notice given, and of a list of all claims presented within said time.

ORDERED, That two months from the 8th day of June, 1959 be and the same are allowed the Executor within which to make, or cause to be made, a true and perfect inventory of all the estate of said deceased, both real and personal, including choses in action. And this Court appoints Raymond R Reid of Manchester and Bernie Cantor of Rockville, disinterested persons, appraisers under oath, to appraise said estate, and return make to this Court within said time allowed.

(signed) Thomas F Rady, Judge.

LAST WILL AND TESTAMENT

I, MARY E. SNYDER of the Town of Vernon, in the County of Tolland and State of Connecticut, being of lawful age, of sound and disposing mind, memory and judgment, do hereby make, publish and declare this to be my last Will and Testament, hereby revoking all previous wills and codicils by me made.

FIRST: I direct that all my just debts and funeral expenses be paid and discharged by my Executor hereinafter named.

SECOND: I give and bequeath unto ANNA HALL of High Street, Rockville, in said Town of Vernon, the sum of One Hundred Dollars; to be hers, absolutely.

THIRD: I give and bequeath unto MARY ANN BACKOFEN of Hale Street Extension, Rockville, in said Town of Vernon, the sum of One Hundred Dollars; to be hers, absolutely.

FOURTH: I give and bequeath unto MAUDE FULLER of 51½ Willard Street, Hartford, Connecticut, the sum of Fifty Dollars; to be hers, absolutely.

FIFTH: I give and bequeath unto the UNION CONGREGATIONAL CHURCH of Rockville, in said Town of Vernon, in memory of my late mother Mary I. Snyder, my late sister Flora C. Snyder and in my memory, the sum of Five Hundred Dollars, the income therefrom to be used for the general uses and purposes of said Church.

SIXTH: All the rest, residue and remainder of all my property, both real and personal, of whatsoever the same may consist or wheresoever it may be situated, I direct be divided into thirty-five equal shares and distributed as follows, to wit:

(a) Three equal shares to IDA SCHANZE of 16 Cedar Street, in said Rockville; to be hers, absolutely.

(b) One equal share to WILLIAM G. SNYDER of 1 N. Spruce Street, Colorado Springs, Colorado, if living at the time of my death; to be his absolutely. In the event he shall predecease me, then I direct that said one equal share be paid to his children, in equal shares.

continued from page 118 - Estate of Mary E Snyder

(c) Three equal shares to ARTHUR H. PICKHARDT and Mary PICKHARDT, of 42 Briggs Street, New London, Connecticut, or to the survivof of them, share and share alike, if living at the time of my death. In the event that both shall predecease me, then I direct that said three equal shares be paid to their children, in equal shares.

(d) Three equal shares to ALICE PICKHARDT BARTLETT of 339 Columbus Avenue, Meriden, Connecticut, if living at the time of my death; to be hers, absolutely. In the event she shall predecease me, then I direct that said three equal shares be paid to her children, in equal shares.

(e) Two equal shares to BERNARD ERTEL and AGNES ERTEL of 35 Fox Hill Drive, in said Rockville, or to the survivor of them, share and share alike, if living at the time of my death. In the event that both shall predecease me, then I direct that said two equal shares be paid to their children, in equal shares.

(f) Two equal shares to HARRY ERTEL and GENEVIEVE ERTEL of 22 North Park Street, in said Rockville, or to the survivor of them, share and share alike, if living at the time of my death. In the event that both shall predecease me, then I direct that said two equal shares be paid to their children, in equal shares.

(g) One equal share to GERTRUDE KINGSTON of 11 Lawrence Street, in said Rockville, if living at the time of my death; to be hers, absolutely. In the event that she shall predecease me, then I direct that said one equal share be paid to her children, in equal shares

(h) One equal share to MARTIN SCHEETS of 7 Hammond Street, in saidRockville; to be his, absolutely.

(i) One equal share to HAROLD SCHEETS of 7 Hammond Street, in said Rockville; to be his absolutely.

(j) One equal share to MOSES KLOTER of 16 Cedar Street, in said Rockville; to be his, absolutely.

(k) One equal share to ANNA BACKOFEN of Hale Street Extension, in said Rockville, if living at the time of my death; to be hers, absolutely. In the event she shall predecease me, then I direct that said one equal share be paid to her children, in equal shares

(l) One-fourth of one equal share to MRS. THEODORE SHENDERA of Meriden, Connecticut, if living at the time of my death; to be hers, absolutely. In the event she shall predeceas me, then I direct that said one-fourth of one equal share be paid to her children, in equal shares.

(m) One-fourth of one equal share to WILLIAM ERTEL and ANNA ERTEL of 50 Lawrence Stre in said Rockville, or to the survivor of them, share and share alike.

(n) One-fourth of one equal share to FRED ERTEL and MARY ERTEL of Earl Street, Rockville, in said Town of Vernon, or to the survivor of them, share and share alike.

(o) One-fourth of one equal share to EDWIN ERTEL and MARY ERTEL of 21 King Street, Rockville, in said Town of Vernon, or to the survivor of them, share and share alike.

(p) One-fourth of one equal share to RAYMOND ERTEL and FLORENCE ERTEL of 29 Vernon Avenue, Rockville, in said Town of Vernon, or to the survivor of them, share and share alike.

(q) One-fourth of one equal share to ARTHUR ERTEL and MARY ERTEL of Bradley Drive, Rockville, in said Town of Vernon, or to the survivor of them, share and share alike.

(r) One-fourth of one equal share to ROSE ERTEL of 102 Grove Street, Rockville, in said Town of Vernon; to her, absolutely.

(s) One-fourth of one equal share to THEODORE MAY and AGNES MAY of 7 Harlow Street, Rockville, in said Town of Vernon, or to the survivor of them, share and share alike.

(t) One-fourth of one equal share to LOUISA ERTEL of 102 Grove Street, Rockville, in said Town of Vernon; to be hers, absolutely.

(u) One-fourth of one equal share to GERTRUDE ERTEL of 102 Grove Street, Rockville, in said Town of Vernon; to be hers, absolutely.

(v) One-fourth of one equal share to MRS. JENNIE WARD of Broad Brook, Connecticut; to be hers, absolutely.

(w) One-fourth of one equal share to DANIEL KERR and MARY KERR of 43 Lawrence Street, Rockville, in said Town of Vernon, or to the survivor them, share and share alike.

(x) One equal share to the SALVATION ARMY of Manchester, Connecticut, in memory of my late sister Flora C.Snyder and in my memory, for its general uses and purposes.

(y) One equal share to THE NEWINGTON HOME AND HOSPITAL FOR CRIPPLED CHILDREN of Newington, Connecticut, in memory of my late sister Flora C Snyder and in my memory, for its general uses and purposes.

(z) One equal share to the CHRISTIAN HERALD CHILDREN'S HOME, MONTLAWN, 27 East 39th Street, New York 16, New York, in memory of my late sister Flora C.Snyder and in my memory, for its general uses and purposes.

(aa) One equal share to the BOWERY MISSION, New York, New York in memory of my late sister Flora C Snyder and in my memory, for its general uses and purposes.

(bb) One equal share to the AMERICAN CANCER SOCIETY of the State of Conecticut, in memory of my late sister Flora C Snyder and in my memory, for its general uses and purposes.

(cc) One equal share to the POLIO FUND of the State of Connecticut, in memory of my late sister Flora C. Snyder and in my memory, for its general uses and purposes.

(dd) One equal share to the HEART FUND of the State of Connecticut, in memory of my late sister Flora C. Snyder and in my memory, for its general uses and purposes.

(ee) One equal share to the ARTHRITIS FUND of the State of Connecticut, in memory of my late sister Flora C Snyder and in my memory, for its general uses and purposes.

(ff) One equal share to the CEREBRAL PALSY FUND of the State of Connecticut, in memory of my late sister Flora C.Snyder and in my memory, for its general uses and purposes.

(gg) One equal share to the CONNECTICUT INSTITUTE FOR THE BLIND of Hartford, Connecticut, in memory of my late sister Flora C Snyder and in my memory, for its general uses and purposes.

(hh) One equal share to the ROCKVILLE CITY HOSPITAL, INC. of said Rockville, in memory of my late sister Flora C Snyder and in my memory, for its general uses and purposes.

(ii) One equal share to the BOARD OF HOME MISSIONS OF CONGREGATIONAL CHURCHES of 287 Fourth Avenue, New York 10, New York, in memory of my late sister Flora C. Snyder and in my memory , for the its general uses and purposes.

(jj) One equal share to the TUBERCULOSIS ASSOCIATION, INC. of the State of Connecticut, in memory of my late sister Flora C. Snyder and in my memory, for its general uses and purposes.

In the event any of the legatees named in this rest, residue and remainder clause of my will shall predecease me and provision has not been made in this clause for the deceased legatee's share and by reason thereof any legacy shall lapse, I direct that all such lapsed legacies shall become a part of the rest, residue and remainder of my property and be divided amongst the surviving legatees and those for whom provision is made in the event of the death of any legatees in the proportionate share, as set forth in said clause, to each of said legatee, save however those legacies in this Sixth Paragraph, subsections (x) to (ii) inclusive.

ECHN Proposed Asset Purchase by PMH
Submitted October 13, 2015

continued from page 119 - Estate of Mary E Snyder

I Appoint THE CONNECTICUT BANK AND TRUST COMPANY of Hartford, Connecticut, Executor of this my Last Will and Testament.

IN WITNESS WHEREOF I have hereunto set my hand and seal at said Town of Vernon, on the 20th day of May A.D., One Thousand Nine Hundred and Fifty-five.

(signed) Mary E.Snyder (L.S.)

Signed, sealed, published and declared by the said MARY E. SNYDER as and for her Last Will and Testament, in presence of us, who at her request, in her presence, and in the presence of each other have hereunto subscribed our names as witnesses, on the 20th day of May A.D., 1955.

(signed) Jane Dereszewska
(signed) Margaret B. Kernan } Witnesses.
(signed) Robert D. King

STATE OF CONNECTICUT } ss. Vernon May 20th A.D., 1955
COUNTY OF TOLLAND }

We the within named Jane Dereszewska and Margaret B. Kernan both of said Town of Vernon, and Robert D. King of Tolland, Connecticut being duly sworn, make affidavit and say: That we severally attested the within and foregoing Will of the within named testatrix and subscribed the same in her presence and at her request and in the presence of each other; that the said testatrix signed, published and declared the said instrument as and for her Last Will and Testament in our presence on the 20th day of May A.D., 1955; and at the time of execution of said Will, said testatrix was more than eighteen years of age and of sound mind, memory and judgment and under no improper influence or restraint to the best of our knowledge and belief, and we make this affidavit at the request of said testatrix.

(signed) Jane Dereszewska
(signed) Margaret B. Kernan
(signed) Robert D. King

STATE OF CONNECTICUT } ss. Vernon May 20th A.D., 1955.
COUNTY OF TOLLAND }

Then personally appeared before me, a notary public, duly qualified to administer oaths.

Jane Dereszewska
Margaret B Kernan
and Robert D King
and subscribed and made oath to the trust of the foregoing affidavit.

(signed) Donald C.Fisk, Notary Public

CODICIL TO WILL OF MARY E. SNYDER

I, MARY E. SNYDER of the Town of Vernon, in the County of Tolland, in the State of Connecticut, being of sound and disposing mind and memory, do hereby make, publish and declare this to be my Codicil to my last Will and Testament of May 20th, 1955, the paragraphs to be numbered as follows:

1. SIXTH: I give and bequeath to each of the following the sum of One Hundred Dollars each: DR. JOHN E. FLAHERTY of 42 Elm Street, Rockville, Connecticut; MABEL MORGANSON of 52 Hammond Street, in said Rockville; MARY GREGUS of 25 Talcott Avenue, in said Rockville; CLARA KIBBE of 19 Elm Street, in said Rockville; and MARY HALLORAN of 14 Hammond Street, in said Rockville; to be theirs, absolutely.

2. SEVENTH: I give and bequeath unto ANNA BACKOFEN of Hale Street Extension, in said Rockville, and IDA SCHANZE of 16 Cedar Street, in said Rockville, all of the articles of my household furniture, furnishings, linen, china ware, silver and plate, glassware, pictures, bric-a-brac and fixtures, including all household implements and effects used in and about my home in said Town of Vernon. Without intending to qualify the absolute character of this bequest, I hereby express the hope that they will distribute those of my said articles and in the manner therein provided as I may indicate by a written memorandum which I have prepared and addressed to said Anna Backofen and Ida Schanze.

3. I HEREBY direct that the paragraph numbered "Sixth" in my said last Will and Testament of May 20th, 1955, shall be changed to and become paragraph Eighth.

4. I HEREBY republish and confirm my said Will in all respects except as altered by this Codicil.

IN WITNESS WHEREOF I have hereunto set my hand and affixed my seal at Rockville, Connecticut, this 27th day of May, A.D. 1957.

(signed) Miss Mary E.Snyder L.S.

Signed, sealed and declared to be a Codicil to her last Will and Testament dated the 20th day of May, 1955, by the said MARY E. SNYDER, in the presence of us, who in her presence, and at her request, and in the presence of each other, have hereunto subscribed our names as witnesses at said Rockville, this 27th day of May, A.D 1957.

(signed) Elizabeth Blatter
(signed) Donald B.Caldwell } Witnesses
(signed) Robert D King

STATE OF CONNECTICUT } ss. Town of Vernon May 27th, 1957
COUNTY OF TOLLAND }

We the within named Elizabeth Blatter of said Town of Vernon, Donald B.Caldwell of the Town of Manchester, Connecticut, and Robert D. King of the Town of Tolland, Connecticut, being duly sworn, make affidavit and say: That we severally attested the within and foregoing Codicil to the last Will and Testament of the within named testatrix and subscribed the same in her presence and at her request and in the presence of each other; that the said testatrix signed, published and declared the said instrument as and for the Codicil to her last Will and Testament in our presence on the 27th day of May A.D 1957; and at the time of execution of said Codicil, said testatrix was more than eighteen years of age and of sound mind, memory and judgment and under no improper influence or restraint to the best of our knowledge and belief, and we make this affidavit at the request of said testatrix.

(signed) Elizabeth Blatter
(signed) Donald B.Caldwell
(signed) Robert D. King

STATE OF CONNECTICUT } ss. Town of Vernon May 27th, 1957
COUNTY OF TOLLAND }

Then personally appeared before me a notary public, duly qualified to administer oaths.

Elizabeth Blatter
Donald B. Caldwell

EXHIBIT Q 11-2

Fund 11-1.72

Charles F. Batz

ROCKVILLE GENERAL HOSPITAL

31 Union Street ❖ Vernon, Connecticut 06066
Phone (203) 872-5100 ❖ Fax (203) 872-6056

April 1, 1993

Miss Emma Batz
97 Shenipsit Street
Rockville, CT 06066

Dear Miss Batz:

Thank you so much for your phone call this afternoon. It was a pleasure to talk with you.

We are very pleased to learn that your brother, Charles, has included Rockville Hospital in his will. The hospital is honored to be included in a will -- a privilege rightfully reserved for family and cherished friends or charities. His thoughtfulness is very much appreciated.

Do have a wonderful trip to Switzerland -- it sounds like a perfectly delightful vacation, and one which you well deserve.

Sincerely,

Judy

Judy Spillane
Development Manager

ROCKVILLE GENERAL HOSPITAL

31 Union Street ❖ Vernon, Connecticut 06066
Phone (203) 872-5100 ❖ Fax (203) 872-6056

August 5, 1994

Miss Emma M. Batz
97 Shenipsit Street
Ellington, CT 06029

Dear Miss Batz:

I want to thank you for the gift of $4,000 which you have donated to the hospital from the estate of your brother, Charles F. Batz. I regret that circumstances prevented me from meeting with you on Friday afternoon to express my gratitude in person. You, and your brother, are very generous.

Rockville Hospital is very fortunate to have a friend like you. I understand that your connection with the hospital goes way back. Your gifts over the years have helped us in many ways; and the hours which you donated as a volunteer were much appreciated.

As a community hospital, it is a special pleasure to have many friends in the community – folks like yourself who have seen Rockville Hospital grow and who have supported that process, folks who have received care here and who are generous in helping us to serve others.

I will be delighted to inform the Board of Trustees of this gift, and together with them to determine the best use for these funds.

With sincere thanks,

- no will in the files
- it appears that the hospital had no prior knowledge of this gift when Emma Batz delivered it

Barry G. Beeman
President and
Chief Executive Officer

ROCKVILLE GENERAL HOSPITAL

31 Union Street ❖ Vernon, Connecticut 06066
Phone (203) 872-5100 ❖ Fax (203) 872-6056

August 5, 1994

Miss Emma M. Batz
97 Shenipsit Street
Ellington, CT 06029

Dear Miss Batz:

I have just learned from Mr. Beeman of a $4,000 bequest from the estate of Charles F. Batz. You are very kind to donate this amount to Rockville Hospital.

On behalf of the Board of Trustees, I thank you and assure you that we will give careful consideration to the best use of your gift. Unrestricted gifts are especially appreciated, since they allow us to put the money where it is most needed at a given time.

We thank you for your thoughtful generosity.

Yours truly,

Raymond Lefurge, Jr.
Chairman
Board of Trustees

ROCKVILLE GENERAL HOSPITAL

31 Union Street ❖ Vernon, Connecticut 06066
Phone (203) 872-5100 ❖ Fax (203) 872-6056

August 5, 1994

Miss Emma Batz
97 Shenipsit Street
Ellington, CT 06029

Dear Emma:

It was a real pleasure to chat with you this afternoon. Thanks for sharing all of the great stories of your travels!

I have told Mr. Beeman of the $4,000 bequest from your brother's estate -- Emma you certainly are being generous!

Thanks for stopping by, it is always good to see you.

Sincerely,

Judy Spillane
Development Manager

P.S. I gave the payment on your bill to the Cashier and returned the raffle tickets to Barbara Jaconski.

LAST WILL AND TESTAMENT
OF
CHARLES F. BATZ VOL. 207 PAGE 018

I, CHARLES F. BATZ, of the Town of Ellington, County of Tolland and State of Connecticut, being of lawful age, of sound and disposing mind, memory and judgment, do hereby make, publish and declare this to be my Last Will and Testament, hereby revoking all previous wills and codicils by me made.

ARTICLE ONE

I direct that all my last illness, funeral expenses and just debts, except those secured by mortgage of real estate, be paid as soon after my death as may be found convenient. I direct that all inheritance, legacy, succession or estate duties or taxes which shall become payable in respect of any property or interest, whether or not passing under my Will or any Codicil which I may hereafter execute, or in respect of any transfer lawfully taxable that I may have made, shall be payable out of my residuary estate.

ARTICLE TWO

I give and bequeath all my household furniture and furnishings, to my sister, EMMA M. BATZ, of Ellington, Connecticut, absolutely; and if she shall not so survive me, then to my cousins, ROBERT N. BEAVERSTOCK and DOROTHY B. GESSAY, both of Ellington, Connecticut, to them or the survivor of them at my death, in equal shares, absolutely.

ARTICLE THREE

I give and bequeath:

A) The sum of TWO THOUSAND FIVE HUNDRED ($2,500.00) DOLLARS TO WALTER W. GESSAY, of Ellington, Connecticut, absolutely.
B) The sum of TWO THOUSAND FIVE HUNDRED ($2,500.00) DOLLARS to DOROTHY B. GESSAY, of said Ellington, absolutely.
C) The sum of TWO THOUSAND FIVE HUNDRED ($2,500.00) DOLLARS to ROBERT N. BEAVERSTOCK, of said Ellington, absolutely.
D) The sum of TWO THOUSAND FIVE HUNDRED ($2,500.00) DOLLARS to MARILYN G. WHITE and BETHANY WHITE, both of said Ellington, to them or the survivor of them, in equal shares, absolutely.
E) The sum of ONE THOUSAND ($1,000.00) DOLLARS to FRANCES FILIP, of Vernon, Connecticut, absolutely.
F) The sum of TWO THOUSAND ($2,000.00) DOLLARS to CHARLES SCHAEFFER of Ellington, Connecticut, absolutely.
G) The sum of TWO THOUSAND FIVE HUNDRED ($2,500.00) DOLLARS to ROBERT ABORN and CAROL ABORN, of Plainville, Connecticut, to them or the survivor of them, in equal shares, absolutely.
H) The sum of THREE THOUSAND ($3,000.00) DOLLARS to JENNIFER TRAYNOR of Farmington, Connecticut, KATHY ABORN of Plainville, Connecticut, and DEBORAH ABORN of Plainville, Connecticut, to them or the survivor of them, in equal shares, absolutely.
I) The sum of TWO THOUSAND FIVE HUNDRED ($2,500.00) DOLLARS to ST. LUKE CHURCH, of said Ellington, absolutely.

If any of the above should not survive me, the bequest to that person shall lapse and shall pass as part of the rest and residue of my estate as hereinafter set forth.

J. DONALD SHANNON
ATTORNEY AT LAW
SOUTH FIELD CORNERS
P. O. BOX 307
SOMERS, CT 06071
(203) 749-3628

ARTICLE FOUR

I give and devise my undivided one-half (1/2) interest in and to the real estate, situated in said Ellington, on the westerly side of the highway known as Shenipsit Street, consisting of my residence, known as 97 Shenipsit Street, together with forty-six (46) acres, more or less, to the said TOWN OF ELLINGTON; said acreage to be allowed to grow wild, with walking trails to be maintained as a nature preserve for educational and conservation purposes for the benefit and enjoyment of the public, subject, however, to a life estate in favor of my said sister, EMMA M. BATZ.

I direct that my said sister shall not be required to account for or repair any waste, injury or damage to, or depreciation of, such real estate, or shall she be required to maintain any insurance of any kind with respect to said property, and I direct that my said sister shall not be required to furnish a bond or other security for the safe-keeping thereof, nor to account to any Court.

Upon the death of my said sister, or upon my death if she should not survive me, I direct that all structures on said real estate, other than the residence, be demolished and/or removed from the premises.

ARTICLE FIVE

All of the rest, residue and remainder of my estate to my said sister, EMMA M. BATZ, absolutely; and if she shall not so survive/me then I direct that said rest, residue and remainder be divided into four (4) equal parts, and one of such parts be distributed to each of the following, absolutely:

A) ROCKVILLE GENERAL HOSPITAL, INC., of Rockville-Vernon, Connecticut

B) THE ROCKVILLE PUBLIC HEALTH NURSING ASSOCIATION, INC., of Rockville-Vernon, Connecticut

C) THE HALL MEMORIAL LIBRARY, of Ellington, Connecticut; and

D) THE ROCKVILLE PUBLIC LIBRARY, of Rockville-Vernon, Connecticut.

ARTICLE SIX

I authorize my Executrix/Alternate Executor, hereinafter named, to sell, exchange, assign, transfer or convey any real estate or personal property held in my estate, not otherwise herein disposed of, at public or private sale, at such time and price and upon such terms and conditions, including credit, as she/he may determine, without Probate Court approval.

J. DONALD SHANNON
ATTORNEY AT LAW
SOUTH FIELD CORNERS
P. O. BOX 307
SOMERS, CT 06071
(203) 749-3035

I APPOINT EMMA M. BATZ of the Town of Ellington, County of Tolland and State of Connecticut, Executrix of this my Last Will and Testament, and in the event my said Executrix does not qualify or having qualified shall die or resign, then in such event I appoint ROBERT N. BEAVERSTOCK, of Ellington, Connecticut, Alternate Executor of this my Last Will and Testament; and I direct that my Executrix and/or Alternate Executor be permitted to serve without bond or surety thereon.

IN WITNESS WHEREOF, I have hereunto set my hand and seal at said Ellington, Connecticut, on the 2nd day of November, A.D., One Thousand Nine Hundred and Ninety-Two.

Charles P. Batz L.S.

CHARLES P. BATZ

J. DONALD SHANNON
ATTORNEY AT LAW
SOUTH FIELD CORNERS
P. O. BOX 307
SOMERS, CT 06071
(203) 749-3025

Signed, sealed, published and declared by the said VOL. 207 PAGE 021

Charles F. Batz as and for

his Last Will and Testament, in presence of us, who at his request, in his presence, and in the presence of each other have hereunto subscribed our names as witnesses, on the

2nd day of November, A. D., 1992

Ethel Therrien of Ellington, Conn

Deborah D Therrien of Ellington, Conn } Witnesses

State of Connecticut,
County of Tolland } ss. Ellington November 2, A. D. 19 92

We the within named Ethel Therrien and Deborah D. Therrien

being duly sworn, depose and say: That we severally attested the within and foregoing Will of the within named testator and subscribed the same in his presence and at his request and in the presence of each other; that the said testator signed, published and declared the said instrument as and for his last Will and Testament in our presence on the 2nd day of November A. D., 19 92 ; and at the time of execution of said will, said testator was more than eighteen years of age and of sound mind, memory and judgment and under no improper influence or restraint to the best of our knowledge and belief, and we make this affidavit at the request of said testator.

Ethel Therrien

Deborah D. Therrien

State of Connecticut,
County of Tolland } ss. Ellington November 2, A. D. 19 92

Then personally appeared before me J. Donald Shannon duly qualified to administer oaths

Ethel Therrien

and Deborah D. Therrien

and subscribed and made oath to the truth of the foregoing affidavit.

J. D. Shannon

J. D. Shannon Notary Public

Commissioner of Superior Court

INVENTORY
PC-440 REV. 12/85
(PRC-18)

STATE OF CONNECTICUT
COURT OF PROBATE
[Type or Print in black ink.]

RECORDED:
VOL. 207 PAGE 028

TO: COURT OF PROBATE, DISTRICT OF ELLINGTON — DISTRICT NO. 048

ESTATE OF
CHARLES F. BATZ
Hereinafter referred to as the *Decedent/Ward*.

DATE OF APPT. AS FIDUCIARY: 1/7/93

FIDUCIARY *[Include position of trust]*
Emma M. Batz - Executrix

DATE OF DEATH, if DECEDENT'S ESTATE: 11/16/92

☒ REGULAR INVENTORY ☐ SUPPLEMENTAL, SUBSTITUTE, ETC.

PAGE 1 OF 1

INSTRUCTIONS: LIST ASSETS IN THE FOLLOWING CATEGORIES IN THE ORDER GIVEN AND THE MANNER DESCRIBED: (1) REAL PROPERTY: give complete LEGAL DESCRIPTION (copy from deed), show fair market value, balance of unpaid mortgages and net value of interest. (2) STOCKS AND BONDS: show number of shares, description, value per share and total value. (3) ALL OTHER PERSONAL PROPERTY: show account number for all bank accounts; for other personal property use best description available. DECEDENTS' ESTATES: list non-survivorship assets only; use date of death values. ALL OTHER ESTATES: use date of appointment values.

ITEM NO.	$
1. An undivided one-half interest in and to Real Estate situated in the Town of Ellington, Connecticut, known as 97 Shenipsit Street, consisting of single family dwelling with outbuildings and 44 acres of land more or less. (See Attached Appraisal).	105,000.00
Appraised Value — TOTAL INTEREST $210,000.00 — UNDIVIDED ONE-HALF $105,000.00	
Assessed Value: 181,900.00 — 90,950.00	
(Reference: Ellington Land Records Volume 126, Page 150).	
2. People's Savings Bank Account #58 5154 06	124.84
3. Fleet Bank Checking Account	1,891.88
4. Savings Bank of Rockville Account #04 0000 32906	5,262.56
5. Fleet Bank Account #1040272732	40,636.01
6. Miscellaneous Personal Property	250.00
GRAND TOTAL	$ 153,165.29

Emma M. Batz
Emma M. Batz — Fiduciary's Signature

SUBSCRIBED AND SWORN TO BEFORE ME this 3rd day of February, 19 93.

J. D'Shannon
[illegible], Asst. Clerk, Notary Public, Comm. Sup. Ct.

INVENTORY
PC-440

COVER SHEET
ADMINISTRATION ACCOUNT
DECEDENTS ESTATE
PC-241 REV. 2-85
(PRC-42)

STATE OF CONNECTICUT
COURT OF PROBATE
[Type or Print]

RECORDED:
VOL. 207 PAGE 031

To: Court of Probate, District of Ellington District No. 048

ESTATE OF
CHARLES F. BATZ
, deceased

FIDUCIARY'S NAME	POSITION OF TRUST
Emma M. Batz	Executrix

The fiduciary hereby exhibits this account to said court for allowance and makes oath that the same is a true and complete account of all receipts and disbursements made in said capacity.

The fiduciary represents that: all claims allowed against said estate have been fully paid: there are no claims now outstanding against the estate; and there are no heirs nor distributees other than those listed in the Application for Administration or Probate of Will, or in the schedule of proposed distribution.

The fiduciary, therefore, makes application for an ascertainment of heirs and distributees and an order of distribution in accordance with the schedule of proposed distribution attached hereto. (Conn. Probate Practice Book. Rule 6.13)

[For simple estates, use PC-242. For other estates, use this sheet for summation only and attach appropriate schedules. Attach Affidavit of Heirs, if required by the court.]

Dr.	Inventory		$153,165.29
	Blue Cross Refund		37.11
	Contribution by Emma M. Batz		14,718.25
			$167,920.65
Cr.	Funeral Expenses		$4,502.53
	St. Bernard's Cemetery		325.00
	Inscription on Marker		70.00
	Claims Per List on File		66.12
	Completed Bequests Per Will - Article Three		21,000.00
	Administration Expenses (Schedule A)		8,707.00
	Estate on Hand for Distribution		
	Real Estate - Undivided One-Half Interest (as per Inventory) to Town of Ellington subject to Life Estate in Emma M. Batz at Inventory Value	$105,000.00	
	Galaxy Fund to Emma M. Batz	28,000.00	
	Misc. Personal Property to Emma M. Batz	250.00	133,250.00
			$167,920.65

SCHEDULE A
Administration Expenses

Journal Inquirer	$235.94
Matthew Allen, Realty Appaisal	225.00
Vernon Town Clerk, Death Notices	30.00
Postage, Including Registered Mail	64.46
Tax Collector, Town of Ellington	299.07
J. Donald Shannon, Legal Fee	2,960.00
Commissioner of Revenue Services	4,373.97
Probate Court, District of Ellington	518.56
	$8,707.00

THIS ACCOUNT CONSISTS OF (2) PAGES.	DATE 7/13/93	Emma M Batz Fiduciary
SUBSCRIBED AND SWORN TO BEFORE ME	DATE 7/13/93	J. D. Shannon Asst. Clerk/Comm. Sup. Court

ECHN Proposed Asset Purchase by PMH
Submitted October 13, 2015

EXHIBIT Q 11-2

Fund 11-1.73

Francis J. Gregory

Last Will

and

Testament

of

FRANCIS J. GREGORY

FLAHERTY, BURKE & MARDER
ATTORNEYS AT LAW
351 MERLINE ROAD
VERNON, CONNECTICUT 06066

ECHN Proposed Asset Purchase by PMH
Submitted October 13, 2015

LAST WILL AND TESTAMENT

I, FRANCIS J. GREGORY, of the Town of Tolland, County of Tolland and State of Connecticut, being of lawful age, of sound and disposing mind, memory and judgment, do hereby make, publish and declare this to be my LAST WILL AND TESTAMENT, hereby revoking all previous wills and codicils by me made.

FIRST

I direct my Executrix, hereinafter named, to pay all my just debts and funeral expenses, except debts secured by mortgage, all expenses as to the settlement of my estate, and all inheritance and succession taxes which may become due.

SECOND

All of my estate, both real and personal, and of whatsoever kind and nature and wherever situate or being, of which I may die seized or possess or to which I may be entitled at the time of my death, I give, devise and bequeath to my wife, MARY V. GREGORY, if she be living for the space of thirty (30) days after my death, to have and to hold the same absolutely, to her and her heirs and assigns forever.

THIRD

In the event that my wife, MARY V. GREGORY, shall either die before me or not survive me for the space of thirty (30) days, then I give and bequeath the following sums to the individuals and institutions listed below:

1. To The Saint Joseph's Abbey located in Spencer, Massachus the sum of THREE HUNDRED ($300.00) DOLLARS for a series of Gregorian Masses for the repose of my soul.

2. To MARY JUSTICE, 105 Park Street, Pawtucket, Rhode Island, the sum of FIVE THOUSAND ($5,000.00) DOLLARS.

3. To ROSEMARY HARRIS, P.O. Box 6, Northboro, Massachusetts, the sum of FIVE THOUSAND ($5,000.00) DOLLARS.

4. To LAWRENCE F. MERLINO, 43 Rhodes Road, Tolland, Connecticut, the sum of FIVE THOUSAND ($5,000.00) DOLLARS.

5. To FRANCIS MERLINO, 4401 West Rose Lane, Glendale, Arizona, the sum of THREE THOUSAND ($3,000.00) DOLLARS.

6. To THOMAS MERLINO, 2259 Crossbough Drive, Toledo, Ohio, the sum of THREE THOUSAND ($3,000.00) DOLLARS.

7. To RICHARD MERLINO, 17 Elizabeth Lane, Tolland, Connecticut, the sum of THREE THOUSAND ($3,000.00) DOLLARS.

8. To GAIL GREGORY FINNEGAN, 10 Blanding Avenue, West Barrington, Rhode Island, the sum of THREE THOUSAND ($3,000.00) DOLLARS.

9. To ROBERT GREGORY, 10 Blanding Avenue, West Barrington, Rhode Island, the sum of THREE THOUSAND ($3,000.00) DOLLARS.

10. To JUDITH GREGORY, 10 Blanding Avenue, West Barrington, Rhode Island, the sum of THREE THOUSAND ($3,000.00) DOLLARS.

FOURTH

All of the rest, residue and remainder of my estate, wherever it may be found, shall be distributed equally among the following:

St. Lawrence Seminary, Mt. Calvary, Wisconsin,

Seraphic Mass Association, Pittsburgh, Pennsylvania,

St. Jude's Children's Hospital, Memphis, Tennessee,

Rockville General Hospital, Rockville, Connecticut,

The Jimmy Fund, Boston, Massachusetts,

St. Matthew's Church, Tolland, Connecticut.

FIFTH

I hereby grant to my Executrix, in addition to the general powers conferred upon her by law, the following:

A. To continue, settle or discontinue, or to incorporate any business or partnership in which I may be interested.

B. To continue to hold any property, real and personal, and other [illegible] including but not limited to stocks, bonds, real estate and investments, in the form in which it shall be at the time of my death without regard to the limitations imposed by law.

C. To sell, lease, pledge, mortgage, transfer, exchange, convert, or otherwise dispose of, or grant options with respect to any and all property at any time forming part of my estate, in such manner, at such time or times, for such purposes, for such prices and upon such terms, credits and conditions as may be deemed advisable.

D. To exercise rights to subscribe to or convert securities.

E. To vote, in person or by general proxy, any and all stock in any and all corporations at any and all meetings of stockholders for any and all purposes without any limitations whatsoever.

F. To compromise any claim by or against the estate upon such terms as may be deemed advisable.

G. To make distribution in cash or in kind or partly in each.

SIXTH

I APPOINT my wife, MARY V. GREGORY, of the Town of Tolland, County of Tolland and State of Connecticut, Executrix of this, my LAST WILL AND TESTAMENT, and so far as I am able, I hereby excuse her from giving any probate bond as such Executrix. If for any reason my said wife, MARY V. GREGORY, is unable to act at Executrix, then in that event I appoint the CONNECTICUT BANK AND TRUST COMPANY to act as such Executor of this Will.

IN WITNESS WHEREOF, I have subscribed my name to this my WILL AND TESTAMENT, consisting of this and three (3) preceding typewritten pages, and for the purpose of identification, I have initialed each such page in the presence of the persons witnessing it at my request, this 16th day of March, 1979, at Vernon, Connecticut.

FRANCIS J. GREGORY L.S.

The foregoing instrument, consisting of this and three (3) preceding typewritten pages, was signed, published and declared by FRANCIS J. GREGORY to be his LAST WILL AND TESTAMENT in our presence, and we, at his request and in his presence and in the presence of each other, have hereunto subscribed our names as witnesses, this 16th day of March, 1979, at Vernon, Connecticut.

Marion H. Moore of Tolland, Connecticut

Phoebe A. Smith of Vernon, Connecticut

STATE OF CONNECTICUT)
) ss. Vernon
COUNTY OF TOLLAND)

This 16th day of March, 1979, then and there personally appeared the within-named Marion H. Moore and Phoebe A. Smith who, being duly sworn, depose and say that they witnessed the execution of the within Will of the within named Testator; that the said FRANCIS J. GREGORY subscribed said Will and declared the same to be his LAST WILL AND TESTAMENT in their presence; that they thereafter subscribed the same as witnesses in

the presence of said Testator and in the presence of each other and at the request of said Testator; that the said Testator at the time of the execution of said Will appeared to them to be of full age and of sound mind, memory and judgment; and that they make this affidavit at the request of said Testator, FRANCIS J. GREGORY.

Marion H. Moore

Phoebe A. Smith

Subscribed and sworn to before me, this 16th day of March, 1979.

Leo B. Flaherty, Jr.
Commissioner of the Superior Court

EXHIBIT Q 11-2

Fund 11-1.74

John A. Duell

VOL. 208 PAGE 219

LAST WILL AND TESTAMENT

OF

JOHN A. DUELL

I, JOHN A. DUELL, of the Town of Tolland, in the County of Tolland, in the State of Connecticut, being of lawful age, of sound and disposing mind, memory and judgment, do hereby make, publish and declare this to be my Last Will and Testament, hereby revoking all previous Wills and Codicils by me made.

FIRST: I direct my Executrix to pay my funeral expenses and just debts, except secured or mortgage debts, and that all legacy, succession, inheritance, transfer and estate taxes, levied or assessed upon or with respect to any property which is included as part of my gross estate for the purpose of determining any such tax, shall be paid by my Executrix out of my estate in the same manner as an expense of administration and shall not be prorated or apportioned among or charged against the respective devisees, legatees, beneficiaries, transferees or other recipients nor charged against any property passing or which may have passed to any of them and that my Executrix shall not be entitled to reimbursement for any portion of any such tax from any person.

SECOND: I hereby give and bequeath unto FIRST LUTHERAN CHURCH of Ellington, Connecticut, the sum of FIVE THOUSAND ($5,000) DOLLARS, for its general use and purpose.

THIRD: I hereby give and bequeath unto ROCKVILLE GENERAL HOSPITAL of Rockville, Connecticut, the sum of FIVE THOUSAND ($5,000) DOLLARS, for its general use and purpose.

John A. Duell

FOURTH: I give, devise and bequeath all of the rest, residue and remainder of my property, both real and personal, of whatsoever the same may consist and wheresoever the same may be situated, to the following of my nieces and nephews, in equal shares, as follows:

(A) One-Seventh (1/7) share of said rest, residue and remainder unto my niece, LOUISE HELLER, presently of Manchester, Connecticut. In the event my said niece, LOUISE HELLER, should predecease me, then this share shall be divided equally among the surviving named nieces and nephews.

(B) One-Seventh (1/7) share of said rest, residue and remainder unto my nephew, OTTO HELLER, presently of Manchester, Connecticut, per stirpes.

(C) One-Seventh (1/7) share of said rest, residue and remainder unto my nephew, ROBERT DUELL, presently of Princeton, New Jersey, per stirpes.

(D) One-Seventh (1/7) share of said rest, residue and remainder unto my nephew, EDWARD DUELL, presently of Ellington, Connecticut, per stirpes.

(E) One-Seventh (1/7) share of said rest, residue and remainder unto my nephew, RALPH DUELL, presently of Tolland, Connecticut, per stirpes.

(F) One-Seventh (1/7) share of said rest, residue and remainder unto my niece, MILDRED HOTZ, presently of Bedford, Ohio, per stirpes.

(G) One-Seventh (1/7) share of said rest, residue and remainder unto my niece, JULIANA FREY, presently of Tolland, Connecticut, per stirpes.

FIFTH and LAST: I nominate, constitute and appoint my said niece, LOUISE HELLER, presently of Manchester, Connecticut, Executrix of this, my Last Will and Testament, with full power of disposition, management and sale with respect to both real and personal property belonging to me, including the power to borrow money for any purpose incidental to the administration of my estate with or without a mortgage or pledge of estate property and to have and exercise all of the fiduciary powers

John A Duell

enumerated in Section 45-100e of the Connecticut General Statutes, Revision 1958, as amended, which powers are incorporated herein by reference. I also authorize my Executrix to make any division of my estate required by this, my Last Will and Testament, and to determine what property shall be included in each share thereof and the value of such property; and the division and determination so made by my Executrix shall be final and conclusive upon all interested parties.

I further direct that my Executrix be excused from posting bond or security insofar as I have the power to excuse.

In the event said LOUISE HELLER shall die, resign or be unable or unwilling to serve as such Executrix, then I direct that OTTO HELLER, presently of Manchester, Connecticut, shall serve as sole Executor in the same manner and with the same above stated powers, also to serve without bond.

IN WITNESS WHEREOF, I have hereunto set my hand and seal to this, My Last Will and Testament, consisting of this page and Two (2) preceding pages each of which I have signed at Vernon, Connecticut, this 14th day of September, A.D., 1988.

John A. Duell L.S.
JOHN A. DUELL

Signed, sealed, published, and declared by the said JOHN A. DUELL as and for his Last Will and Testament, in presence of us, who at his request, in his presence, and in the presence of each other have hereunto subscribed our names as witnesses, on the 14th day of September, A.D., 1988.

Elizabeth G. Murphy
Elizabeth G. Murphy

Charlene L. Lallier
Charlene L. Lallier

DuBEAU & RYAN ...

VOL. 208 PAGE 222

STATE OF CONNECTICUT)
)ss. Vernon September 14, 1988
COUNTY OF TOLLAND)

We the within named Elizabeth G. Murphy, of the Town of Vernon, and Charlene L. Lallier, of the Town of Coventry, both of the County of Tolland and State of Connecticut

being duly sworn, make affidavit and say: That we severally attested the within and foregoing Will of the within named Testator and subscribed the same in his presence and at his request and in the presence of each other; that the said Testator signed, published and declared the said instrument as and for his Last Will and Testament in our presence on the 14th day of September, A.D., 1988 and at the time of the execution of said Will, said Testator was more than eighteen years of age and of sound mind, memory and judgment and under no improper influence or restraint to the best of our knowledge and belief, and we make this affidavit at the request of said Testator.

Elizabeth G. Murphy

Charlene L. Lallier

STATE OF CONNECTICUT)
)ss. Vernon September 14, 1988
COUNTY OF TOLLAND)

Then personally appeared before me, ROBERT C. DuBEAU, duly qualified to administer oaths.

Elizabeth G. Murphy

and Charlene L. Lallier
and subscribed and made oath to the truth of the foregoing affidavit.

Robert C. DuBeau,
Commissioner of the
Superior Court

EXHIBIT Q 11-2

Fund 11-1.75

Edna O. Rider

LAST WILL AND TESTAMENT

I, EDNA O. RIDER, of the Town of Vernon, County of Tolland and State of Connecticut, being of lawful age, of sound and disposing mind, memory and judgment, do hereby make, publish and declare this to be my LAST WILL AND TESTAMENT, hereby revoking all previous wills and codicils by me made.

FIRST: I direct my Co-Executrices, hereinafter named, to pay all my just debts and funeral expenses, except debts secured by mortgage, all expenses as to the settlement of my estate and all inheritance and succession taxes which may become due and to pay the same from the residuary estate without apportionment.

SECOND: To the individuals and institutions listed below, I bequeath the following:

A. To the SERAPHIC MASS ASSOCIATION, ST. AUGUSTINE'S MONASTERY, presently located at 220 37th Street, Pittsburgh, Pennsylvania, 15201, the sum of One Hundred Eighty ($180.00) Dollars for two (2) sets of Gregorian masses for the repose of my soul.

B. To RUTH FREY of 19 Windemere Avenue, Rockville, Connecticut, if she shall survive me, the sum of Five Thousand ($5,000.00) Dollars; if not, then to her husband, LEO FREY, if he shall survive me.

C. To FRANCIS H. BURKE of 45 Park Street, Rockville, Connecticut, if he shall survive me, the sum of Five Thousand ($5,000.00) Dollars; if not, then to his wife, BERNICE BURKE, if she shall survive me.

D. To MARY JANE DEMPSEY of Bolton Road, Vernon, Connecticut, if she shall survive me, the sum of Five Thousand ($5,000.00) Dollars.

E. To my niece, ELIZABETH OATES MARCOTTE of 5 Derbyshire Court, Bethesda, Maryland, if she shall survive me, the sum of Two Thousand ($2,000.00) Dollars.

F. To my cousin, FRANCES KINSELLAR of Broadbrook, Connecticut, if she shall survive me, the sum of Two Thousand ($2,000.00) Dollars.

G. To my cousin, MARIANNE THOMAS of 1078 New Britain Avenue, West Hartford, Connecticut, if she shall survive me, the sum of Two Thousand ($2,000.00) Dollars.

H. To IRENE DOWD and FRANCIS DOWD of 32 Middle Road, Ellington, if they shall survive me, the sum of Five Thousand ($5,000.00) Dollars, or the whole thereof to the survivor of them.

I. To my grand-nephew, JOHN RIDER, and JOAN RIDER of 34 Prospect Street, Rockville, if they shall survive me, the sum of One Thousand ($1,000.00) Dollars, or the whole thereof to the survivor of them.

J. To MAE D. CHAPMAN of 64 Reservoir Road, Rockville, if she shall survive me, the sum of Five Hundred ($500.00) Dollars.

K. To HAZEL CARTER of 17 Franklin Street, Rockville, if she shall survive me, the sum of Five Hundred ($500.00) Dollars.

L. To MARY BUCHANAN of 156 Union Street, Rockville, if she shall survive me, the sum of Five Hundred ($500.00) Dollars.

M. To IRENE DOWD of 32 Middle Road, Ellington, the sum of One Thousand ($1,000.00) Dollars, to be used for the benefit of my niece, MARY ANN CAMPBELL, of Mansfield, if my niece shall survive me.

N. To IRENE DOWD of 32 Middle Road Ellington, if she shall survive me, my set of Royal Worcester Bone China Normandie Pattern.

THIRD: I give, devise and bequeath all the rest, residue and remainder of the property which I may own at the time of my death, real, personal and mixed, of whatsoever nature and wheresoever situated, as follows:

A. The sum of Ten Thousand ($10,000.00) Dollars to the ROCKVILLE GENERAL HOSPITAL of Rockville, Connecticut to be used and expended for the benefit of such hospital in any manner it deems appropriate.

B. All the balance of the rest, residue and remainder is to be divided into eleven (11) equal parts to be distributed as follows:

1. One (1) part to RUTH FREY, if she shall survive me, and if not, to her husband, LEO FREY, if he shall survive me.
2. One (1) part to FRANCIS H. BURKE, if he shall survive me, and if not, to his wife, BERNICE BURKE, if she shall survive me.
3. One part (1) to MARY JANE DEMPSEY, if she shall survive me.
4. One (1) part to my niece, ELIZABETH OATES MARCOTTE, if she shall survive me.
5. One (1) part to my cousin, MARIANNE THOMAS, if she shall survive me.

6. One (1) part to my cousin, FRANCES KINSELLAR, if she shall survive me.

7. One (1) part to IRENE DOWD and FRANCIS DOWD, if they shall survive me, or the whole thereof to the survivor of them.

8. One (1) part to JOHN RIDER and JOAN RIDER, if they shall survive me, or the whole thereof to the survivor of them.

9. One part (1) to MAE D. CHAPMAN, if she shall survive me.

10. One part (1) to HAZEL CARTER, if she shall survive me.

11. One part (1) to MARY BUCHANAN, if she shall survive me.

C. In the event that any beneficiary shall predecease me, then his or her share shall be divided equally among the other surviving residuary beneficiaries in this Article Third, Paragraph B. above.

FOURTH: I hereby nominate and appoint RUTH FREY, presently of 19 Windemere Avenue, Rockville and IRENE DOWD, presently of 32 Middle Road, Ellington, as Co-Executrices of this Will. I give and grant to any of my fiduciaries powers provided for by the Connecticut Fiduciary Powers Act. To the full extent that I can effectively do so, I relieve each fiduciary under this Will from any obligation, in any jurisdiction to furnish any bond or other security or to obtain the approval of any court before applying, distributing, selling or otherwise dealing with any property.

IN WITNESS WHEREOF, I have subscribed my name to this my LAST WILL AND TESTAMENT, consisting of this and two (2) preceding typewritten pages, this 1st day of April, 1982.

Edna O. Rider L.S.
EDNA O. RIDER

The foregoing instrument, consisting of this and two (2) preceding typewritten pages, was signed, published and declared by EDNA O. RIDER, the Testatrix, to be her LAST WILL AND TESTAMENT, in our presence, and we, at her request and in her

presence and in the presence of each other have hereunto subscribed our names as witnesses, this 1st day of April , 1982.

Claire C. Hart of Stafford Springs, Conn.
Claire C. Hart Stafford Springs, Connecticut

Sophie M. Flamm of Rockville, Conn.

STATE OF CONNECTICUT)
) ss. Vernon
COUNTY OF TOLLAND)

This 1st day of April , 1982, then and there personally appeared the within named Claire C. Hart and SOPHIE M FLAMM , who, being duly sworn, depose and say that they witnessed the execution of the within Will of the within named Testatrix; that said EDNA O. RIDER subscribed said Will and declared the same to be her LAST WILL AND TESTAMENT in their presence; that they thereafter subscribed the same as witnesses in the presence of said Testatrix and in the presence of each other and at the request of said Testatrix; that the said Testatrix at the time of the execution of said Will appeared to them to be of full age and of sound mind, memory and judgment and that they make this affidavit at the request of said Testatrix, EDNA O. RIDER.

Claire C. Hart
Claire C. Hart
Sophie M. Flamm

Subscribed and sworn to before me this 1st day of April , 1982.

Martin B. Burke
Commissioner of the Superior Court

EXHIBIT Q 11-2

Fund 11-1.76

Barbara J. Sadrozinski

RECEIVED
MAY 0 3 199-
MANCHESTER TOWN CLERK

VOL 507 PAGE 209

LAST WILL AND TESTAMENT

I, **BARBARA J. SADROZINSKI**, of the Town of Manchester, County of Hartford and State of Connecticut, being of lawful age, of sound and disposing mind, memory and judgment, do hereby make, publish and declare this to be my Last Will and Testament, hereby revoking all previous wills and codicils by me made.

Barbara J. Sadrozinski

FIRST

I hereby direct that my Executor hereinafter named pay all my funeral expenses and just debts, except such as shall at the time of my decease be secured by mortgage, if any, as soon as conveniently may be after my decease.

SECOND

I direct that all inheritance, succession, estate, legacy and transfer taxes that may be assessed or imposed upon or with respect to any property passing under this Will or any property not passing under this Will shall be paid out of my estate as an expense of administration and shall not be prorated or apportioned among or charged against any legatee or devisee under this Will or any person owning or receiving any property not passing under this Will, and my Executor shall not be entitled to reimbursement for any portion of any such tax from any such person.

PENNY, BOTTICELLO
O'BRIEN & HIGGINS
ATTORNEYS AT LAW
202 WEST CENTER STREET
MANCHESTER, CT 06040
(203) 646-3500

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THIRD

I give, devise and bequeath all the rest, residue and remainder of my property, both real and personal, of which I shall die seized and possessed, wherever situated, as follows:

A. Twenty (20%) percent thereof to **THE VISITING NURSE AND HOME CARE OF MANCHESTER, INC.**, of Manchester, Connecticut, to be its absolutely and forever;

B. Twenty (20%) percent thereof to **ROCKVILLE GENERAL HOSPITAL, INC.**, of Vernon, Connecticut, to be its absolutely and forever;

C. Twenty (20%) percent thereof to my cousin, **JEAN TARCA**, of Meriden, Connecticut, or to her issue, per stirpes, if she predeceases me, to be hers absolutely and forever;

D. Twenty (20%) thereof to **WILLIAM C. GLODE**, of Mansfield, Connecticut, or to his issue, per stirpes, if he predeceases me, to be his absolutely and forever; and

E. Twenty (20%) thereof to **HENRY F. GLODE**, of Manchester, Connecticut, or to his issue, per stirpes, if he predeceases me, to be his absolutely and forever.

FOURTH

I appoint **JAMES M. HIGGINS, JR.**, of Tolland, Connecticut, to be the Executor of this my Last Will and Testament, and I direct that he be not required to furnish bond in such capacity.

In Witness Whereof, I have hereunto set my hand and seal at Manchester, Connecticut, on the 22nd day of January, 1993.

Barbara J. Sadrozinski
BARBARA J. SADROZINSKI

PENNY, BOTTICELLO
O'BRIEN & HIGGINS
ATTORNEYS AT LAW
202 WEST CENTER STREET
MANCHESTER, CT 06040
(203) 646-3500

VOL. 507 PAGE 211

Signed, sealed, published and declared by the said **BARBARA J. SADROZINSKI** as and for her Last Will and Testament, in the presence of us, who at her request, and in her presence, and in the presence of each other have hereunto subscribed our names as witnesses, on the 22nd day of January, 1993.

WITNESSES

Donna M. Kurapkot

Kathryn D. Flori

State of Connecticut)
) ss. Manchester January 22, 1993
County of Hartford)

We, the within named Donna M. Kurapkot and Kathryn D. Flori, being duly sworn, make affidavit and say: That we severally attested the within and foregoing Will of **BARBARA J. SADROZINSKI** and subscribed the same in her presence and at her request and in the presence of each other; that **BARBARA J. SADROZINSKI** signed, published and declared the said instrument as and for her Last Will and Testament in our presence on the 22nd day of January, 1993, and at the time of execution of said Will, **BARBARA J. SADROZINSKI** was more than eighteen years of age and of sound mind, memory and judgment and under no improper influence or restraint to the best of our knowledge and belief, and we make this affidavit at her request.

Donna M. Kurapkot

Kathryn D. Flori

State of Connecticut)
) ss. Manchester January 22, 1993
County of Hartford)

Then personally appeared before me, Barry W. Botticello, duly qualified to administer oaths, Donna M. Kurapkot and Kathryn D. Flori, and subscribed and made oath to the truth of the foregoing affidavit.

Barry W. Botticello
Commissioner of Superior Court

PENNY, BOTTICELLO
O'BRIEN & HIGGINS
ATTORNEYS AT LAW
202 WEST CENTER STREET
MANCHESTER, CT 06040
(203) 646-3500

EXHIBIT Q 11-2

Fund 11-1.77

$9,603.46 Two-Life Survivor Charitable Gift Annuity
(Names of Annuitants Withheld)

ROCKVILLE GENERAL HOSPITAL

TWO-LIFE SURVIVOR CHARITABLE GIFT ANNUITY AGREEMENT
USING JOINT PROPERTY

both residing at

hereinafter called the "Donors") for the purpose, in part, of supporting Rockville General Hospital hereby transfer $396.54 and 428 SHARES NORTHEAST UTILITIES jointly held by them with a gift value of $9,603.46 to Rockville General Hospital in the Town of Vernon in the State of Connecticut, a not-for-profit Corporation located in Vernon, Connecticut, (hereinafter referred to as "the Hospital") in exchange for which the Hospital agrees to pay to the Donors jointly for their lives and thereafter to the survivor of them for his or her life, an annual annuity of $740.00 in quarterly payments of $185.00 on the 1st day of April, July, October and January, which payments shall commence on APRIL 1, 1994.

The obligation to pay the Annuity shall terminate with, and no amount shall be payable for any period subsequent to, the last payment made immediately preceding the death of the survivor of the Donors.

Notwithstanding the foregoing provisions, the Donors shall each have the right, by a provision in his or her Last Will and Testament duly admitted to probate and expressly referring to this Agreement, to revoke and terminate the survivorship annual payments for the surviving Donor attributable to the deceased Donor's one-half interest in the property transferred under this agreement. If either of the Donors shall revoke or terminate the survivorship annuity payments for the other Donor attributable to the revoking Donor's one-half interest in the joint property transferred under this Agreement, the Hospital shall, commencing on the payment date next succeeding the revoking Donor's death, pay to the other Donor an annual annuity of $370.00 (instead of $740.00).

This annuity is nonassignable and, except as expressly provided in this Agreement, is irrevocable. This Agreement shall be governed by the laws of the State of Connecticut.

#1 167.50
#2 185.00
10-9970-74661 352.50

In Witness Whereof, Rockville General Hospital and the Donor have executed this Agreement in duplicate on this 20TH day of DECEMBER, 1993.

The Trustees of Rockville General Hospital

in the Town of Vernon in the

State of Connecticut

By: Edward C. Crawford

Edward C. Crawford
Vice President
Chief Financial Officer

By

By

EXHIBIT Q 11-2

Fund 11-1.78

$10,000 Two-Life Survivor Charitable Gift Annuity
(Names of Annuitants Withheld)

ROCKVILLE GENERAL HOSPITAL
31 Union Street ❖ Vernon, Connecticut 06066
Phone (203) 872-5100 ❖ Fax (203) 872-6056

TWO-LIFE SURVIVOR CHARITABLE GIFT ANNUITY AGREEMENT

USING JOINT PROPERTY

both residing at

06066 (hereinafter called the "Donors") for the purpose, in part, of supporting Rockville General Hospital hereby transfer $10,000 to Rockville General Hospital in the Town of Vernon in the State of Connecticut, a not-for-profit Corporation located in Vernon, Connecticut, (hereinafter referred to as "the Hospital") in exchange for which the Hospital agrees to pay to the Donors jointly for their lives and thereafter to the survivor of them for his or her life, an annual annuity of $670.00 in quarterly payments of $167.50 on the 1st day of April, July, October and January, which payments shall commence on APRIL 1, 1994.

The obligation to pay the Annuity shall terminate with, and no amount shall be payable for any period subsequent to, the last payment made immediately preceding the death of the survivor of the Donors.

Notwithstanding the foregoing provisions, the Donors shall each have the right, by a provision of his or her Last Will and Testament duly admitted to probate and expressly referring to this Agreement, to revoke and terminate the survivorship annual payments for the surviving Donor attributable to the deceased Donor's one-half interest in the property transferred under this agreement. If either of the Donors shall revoke or terminate the survivorship annuity payments for the other Donor attributable to the revoking Donor's one-half interest in the joint property transferred under this Agreement, the Hospital shall, commencing on the payment date next succeeding the revoking Donor's death, pay to the other Donor an annual annuity of $335.00 (instead of $670.00).

This annuity is nonassignable and, except as expressly provided in this Agreement, is irrevocable. This Agreement shall be governed by the laws of the State of Connecticut.

ROCKVILLE GENERAL HOSPITAL

In Witness Whereof, Rockville General Hospital and the Donor have executed this Agreement in duplicate on this 3rd day of NOVEMBER, 1994.

The Trustees of Rockville General Hospital

in the Town of Vernon in the

State of Connecticut

By

By: Edward C. Crawford
Vice President
Chief Financial Officer

By

EXHIBIT Q 11-2

Fund 11-1.79

Hazel Burgess

FORMBANK REGISTERED U.S. PAT. OFF.
Tuttle Law Print, Publishers, Rutland, Vt.

Last Will and Testament.

I, HAZEL S. BURGESS,

of the Town of Manchester, in the County of Hartford,

in the State of Connecticut, being of lawful age, of sound and disposing mind, memory and judgment, do hereby make, publish and declare this to be my last Will and Testament, hereby revoking all previous wills and codicils by me made.

FIRST: I direct that my funeral expenses and all debts, except debts secured by mortgage on real estate, if any, be paid. I also direct that all legacy, succession, inheritance, transfer and estate taxes, levied or assessed upon or with respect to any property which is included as part of my gross estate for the purpose of any such tax, shall be paid by my Executor out of my estate in the same manner as an expense of administration and shall not be prorated or apportioned among, or charged against the respective devisees, legatees, beneficiaries, transferees or other recipients nor charged against any property passing, or which may have passed to any of them, and that my Executor shall not be entitled to reimbursement for any portion of any such tax from any person.

SECOND: I give and bequeath to my nephew, Lockhart B. Rogers, all my household furniture, furnishings, and personal effects. If he shall not survive me then I give such property to my sister-in-law, Bertha S. Burgess.

THIRD: All the rest, residue and remainder of my estate, both real and personal, of whatsoever the same may consist and wheresoever the same may be located, I give, devise and bequeath to CONNECTICUT BANK AND TRUST COMPANY, IN TRUST NEVERTHELESS, for the following uses and purposes:

(a) To take, hold, receive, manage, control, invest and reinvest the same, in such stocks, bonds, securities and bank accounts as my said Trustee, in the exercise of its discretion, shall deem proper or advisable, without regard to any statutory limitation upon the investment of trust funds.

(b) To pay one-half (½) of the net income to my sister-in-law, BERTHA S. BURGESS, of Manchester, Connecticut, during her life, or to use and apply the same for her benefit, so long as she shall live. Upon her death, the Trustee shall continue the payment of one-half (½) of the net income to my brother, WILLIAM T. BURGESS,

of Manchester, Connecticut, if he shall then be living, and to continue said payments so long as he shall live. If, in the sole discretion of the Trustee, the best interests of my brother will be served by the use and application of such income for his benefit, rather than by payment directly to him, I direct that such payments be so used or applied. Upon the death of my brother, or if he shall have predeceased my sister-in-law, then upon the death of my sister-in-law, I direct that such payment of one-half (½) of the net income be made to my nephew, LOCKHART B. ROGERS, or be used or applied for his benefit, for life.

(c) To pay one-half (½) of the net income to my nephew, LOCKHART B. ROGERS, of Cambridge, Massachusetts, or to use and apply the same for his benefit, during his life and for so long as he shall live. If either my sister-in-law or brother shall be living at the death of my nephew, whether the same shall occur prior to or subsequent to my death, I direct that such income be paid to the Board of Trustees of South Methodist Church and the Trustees of Manchester Memorial Hospital, both of Manchester, Connecticut, equally, and used by them for the general purposes of said institutions. Such income shall be paid until the death of both my sister-in-law and brother.

(d) Upon the death of all of the beneficiaries hereunder, I direct that this Trust shall thereupon terminate, and the principal, together with any accumulation of income, be paid equally to the Board of Trustees of South Methodist Church and the Trustees of Manchester Memorial Hospital, both of Manchester, Connecticut, to be safely invested by each, and the income only therefrom to be used for the general uses and purposes of said Church and Hospital.

Signed, sealed, published and declared by the said HAZEL S. BURGESS as and for her Last Will and Testament, in presence of us, who at her request, in her presence, and in the presence of each other have hereunto subscribed our names as witnesses, on the 20th day of July, A. D., 1959

Bernice A. Borg
Gertrude C Royce
Alice Wilson
Witnesses.

State of Connecticut,
County of Hartford
ss. Manchester July 20, A. D. 1959

We the within named Bernice A. Borg, Gertrude C. Royce and Alice Wilson,

being duly sworn, make affidavit and say: That we severally attested the within and foregoing Will of the within named testatrix and subscribed the same in her presence and at her request and in the presence of each other; that the said testatrix signed, published and declared the said instrument as and for her last Will and Testament in our presence on the 20th day of July A. D., 1959 ; and at the time of execution of said will, said testatrix was more than eighteen years of age and of sound mind, memory and judgment and under no improper influence or restraint to the best of our knowledge and belief, and we make this affidavit at the request of said testatrix.

Bernice A. Borg
Gertrude C. Royce
Alice Wilson

State of Connecticut,
County of Hartford
ss. Manchester July 20A. D. 1959

Then personally appeared before me John R. Mrosek duly qualified to administer oaths.

Bernice A. Borg
Gertrude C. Royce
and Alice Wilson

and subscribed and made oath to the truth of the foregoing affidavit.

John R. Mrosek
~~Notary Public~~
~~Justice of the Peace~~
Commissioner of Superior Court

EXHIBIT Q 11-2

Fund 11-1.80

Raymond A. St. Laurent and Helen St. Laurent

MAY 10 2000 2:55 PM FR CUMMINGS & LOCKWOOD

COPY

I, HELEN E. ST. LAURENT, also known as HELEN ELIZA ST. LAURENT, presently of the Town of Manchester, County of Hartford and State of Connecticut, make this Will, hereby revoking all Wills and Codicils heretofore made by me.

FIRST: I direct that my Executor hereinafter named, shall pay all of my just debts, expenses of last illness and funeral expenses as soon after my decease as possible, with the exception that any debt owed by me which is secured by mortgage or by any other lien on my real or personal property may be continued for an indefinite period in the discretion of my Executor. I hereby direct that all legacy, succession, inheritance, transfer and estate taxes, levied or assessed upon or with respect to any property which is included as part of my gross estate for the purpose of any such tax, shall be paid by my Executor out of the residue of my estate as an expense of administration and shall not be prorated or apportioned among or charged against the respective devisees, legatees, beneficiaries, transferees or other recipients, nor charged against any property passing or which may have passed to any of them and that my Executor shall not be entitled to reimbursement for any portion of any such tax from any such person.

SECOND: All of my household furniture and furnishings, articles of personal adornment and other tangible personal property, I give and bequeath unto my Executor hereinafter named, to be distributed by him in accordance with my wishes. Failing such notice of my desires, then to be distributed at the discretion of my Executor.

THIRD: I give and bequeath the sum of ONE THOUSAND ($1,000.00) DOLLARS each unto each of the following named individuals and/or grandnieces and grandnephews who shall survive me:

1. PRISCILLA POOR, presently of Vinalhaven, Maine;
2. JOANNE JONES, presently of Vinalhaven, Maine;
3. LESLIE ALLEN, presently of Bridgewater, Nova Scotia, Canada;
4. BRADLEY ALLEN, presently of Bridgewater, Nova Scotia, Canada;
5. ASHLEY ALLEN, presently of Bridgewater, Nova Scotia, Canada;
6. STEVEN ALLEN, presently of Bridgewater, Nova Scotia, Canada;
7. ANDREW DAVIS, presently of Toronto, Canada;
8. MEGAN DAVIS, presently of Toronto, Canada.

FOURTH: I give and bequeath the sum of TWO THOUSAND ($2,000.00) DOLLARS each unto each of the following named individuals who shall survive me:

1. GEORGE A. F. LUNDBERG, III, presently of West Hartford, Connecticut;

2. CHARLES B. LUNDBERG, presently of East Hartford, Connecticut;

3. JULIE LUNDBERG CAMERON, presently of Philadelphia, Pennsylvania;

4. KATE LUNDBERG, presently of Manchester, Connecticut;

5. PAUL R. MARTE, JR., presently of Manchester, Connecticut;

6. PETER H. MARTE, presently of Fairfield, Connecticut;

7. SUSAN P. MARTE, presently of Manchester, Connecticut.

FIFTH: I give and bequeath the sum of THREE THOUSAND ($3,000.00) DOLLARS each unto each of the following named individuals or couples who shall survive me:

1. FRANK CROWLEY and ALICE CROWLEY, both presently of 57 Gerard Street, Manchester, Connecticut, or the surviving one of them;

2. EMMA MORELLI, presently of 32 Munro Street, Manchester, Connecticut;

3. CATHERINE POOR, presently of Vinalhaven, Maine;

4. PETER CHARTIER, presently of Sherbrooke, Quebec, Canada;

5. JOHN CHARTIER, presently of Sherbrooke, Quebec, Canada;

6. ROBERT CHARTIER, presently of Sherbrooke, Quebec, Canada;

7. HELEN WOOD, presently of Lake Megantic, Quebec, Canada.

SIXTH: I give and bequeath the sum of FIVE THOUSAND ($5,000.00) DOLLARS each unto each of the following named individuals or couples who shall survive me:

1. SALLY H. MARTE, presently of 176 West Vernon Street, Manchester, Connecticut;

2. CHESTER ADAMS and BETTY ADAMS, both presently of East Stoneham, Maine, or the surviving one of them;

3. CAMILLE CHARTIER and GEORGINE CHARTIER, both presently of Sherbrooke, Quebec, Canada, or the surviving one of them.

SEVENTH: I give and bequeath the sum of FIVE THOUSAND ($5,000.00) DOLLARS to CENTER LOVELL CONGREGATIONAL CHURCH, presently of Center Lovell, Maine, the income only to be used for its general uses and purposes in memory of RAYMOND A. ST. LAURENT and HELEN E. ST. LAURENT.

EIGHTH: I give and bequeath the sum of TEN THOUSAND ($10,000.00) DOLLARS each unto each of the following named individuals who shall survive me:

1. MARJORIE MARTE, presently of 22 Benton Street, Manchester, Connecticut;

2. GEORGE FLYNN, presently of 160 Kenyon Street, Hartford, Connecticut;

3. LOIS W. LUNDBERG, presently of 264 Boulder Road, Manchester, Connecticut.

NINTH: I give and bequeath the sum of TEN THOUSAND ($10,000.00) DOLLARS each unto each of the following named institutions or foundations, the income only from each of said bequest to be used for the general uses and purposes of said institution or foundation, the fund for each to be in memory of RAYMOND A. ST. LAURENT and HELEN E. ST. LAURENT.

1. CENTER CONGREGATIONAL CHURCH, presently of 11 Center Street, Manchester, Connecticut;

2. MANCHESTER MEMORIAL HOSPITAL, presently of 71 Haynes Street, Manchester, Connecticut;

3. MANCHESTER SCHOLARSHIP FOUNDATION, presently of Manchester, Connecticut.

TENTH: I give and bequeath the sum of TWENTY FIVE THOUSAND ($25,000.00) DOLLARS unto my sister-in-law, ALICE ST. LAURENT, presently of Guilford, New Hampshire.

In the event my said sister-in-law shall predecease me and shall leave a child or children surviving, then and in that event, I direct that such child or children, equally, of such deceased sister-in-law of mine, shall take the share which she would have if living, per stirpes.

ELEVENTH: I give and bequeath the sum of FIFTY THOUSAND ($50,000.00) DOLLARS unto MASSACHUSETTS INSTITUTE OF TECHNOLOGY, an institution of higher education, with its principal office in Cambridge, Massachusetts, AS TRUSTEE, NEVERTHELESS, to be held IN TRUST and administered as follows:

A. To pay over to, or use for the care, comfort and support of my sister-in-law, GRACE McIVOR MACKENZIE, presently of Pugwash, Nova Scotia, for and during her life, all of the net income from said Trust in installments which shall be at least quarterly.

B. Upon the death of my said sister-in-law, or upon my death if she shall predecease me, I direct that said sum, or the then principal remaining in said Trust shall be paid over and delivered, free from Trust, to the said MASSACHUSETTS INSTITUTE OF TECHNOLOGY, to be added by it to the RAYMOND A. and HELEN E. ST. LAURENT FACULTY FUND as more fully set forth in Memorandum of Gift for said Fund dated June 7, 1983, and to be administered in accordance with the terms and for the purposes therein contained.

TWELFTH: I give and bequeath the sum of TWO HUNDRED THOUSAND ($200,000.00) DOLLARS each unto each of the following named nieces of mine, being:

1. JOAN MACKENZIE DAVIS, presently of Toronto, Canada;
2. HELEN MACKENZIE ALLEN, presently of Bridgewater, Nova Scotia, Canada.

In the event either of my said nieces shall predecease me and shall leave a child or children surviving, then and in that event, I direct that such child or children, equally, of such deceased niece of mine, shall take the share which the parent would have taken if living. If either of my said nieces shall predecease me leaving no issue surviving, then I direct my remaining niece shall take said deceased niece's share.

THIRTEENTH: All the rest, residue and remainder of my property, both real and personal, and of whatsoever nature, wherever the same may be located or found, which I may own or have the right to dispose of at my death (intending hereby to exercise any power of disposition or appointment that I may have at my death), I give, devise and bequeath unto

the said MASSACHUSETTS INSTITUTE OF TECHNOLOGY, to be added to the said RAYMOND A. and HELEN E. ST. LAURENT FACULTY FUND, as set forth in Article Eleventh above and used in accordance with the terms and conditions contained therein.

FOURTEENTH: For purposes of this Will, a person shall not be considered to survive another if he shall die within thirty (30) days of the death of such other.

FIFTEENTH: I may desire to dispose of certain articles of personal property to other persons in which event I shall leave a memorandum or memoranda with this, my last Will and Testament. Such memoranda are not intended to change the nature of any gift or bequest herein which is absolute.

SIXTEENTH: I nominate and appoint PAUL R. MARTE, presently of Manchester, Connecticut, to be the Executor of this, my last Will and Testament. In the event he is unable or unwilling to accept such appointment, then I nominate and appoint CONNECTICUT NATIONAL BANK, presently of Hartford, Connecticut, to act as Executor. I further direct that no bond be required of any of them in such capacity or in connection with the sale of any real estate in my estate by any court or judge.

SEVENTEENTH: In addition to the usual powers, I give my Executor full discretionary power and authority with respect to the property of the estate as follows:

Sell or resell the whole or any part of the property, real or personal, for cash or upon such terms as to payment as they may deem advisable and to execute and deliver any deed, bill of sale, conditional bill of sale, or other document necessary or convenient to effect a sale;

Invest and reinvest in any real or personal property or security, including common and other corporate stocks, and common trust funds, which they shall deem proper without restriction to investments approved by law for fiduciaries;

Set reserves out of income for the payment of taxes, assessments, insurance, repairs, fees and other expenses;

Lease the whole or any part of the property, real or personal, for such periods and upon such terms as they may deem proper, and to pledge the whole or any part of the property to secure the payment of such loan;

Borrow funds for any purpose they may deem proper, and to pledge the whole or any part of the property to secure the payment of such loan;

Enter into and perform any plan or agreement in to the merger or reorganization of any corporation the securities of ll be a part of the property;

Make in cash, or in property at such value as they shall fix, any distribution required, and to determine the distributees upon such evidence as they shall deem proper;

Exercise any rights to subscribe to or convert securities, and for the purpose of providing funds for such securities, to pledge any part of this property;

Vote any shares of stock in person or by proxy, and to assert or waive any stockholder's right or privileges in respect thereto, and to exercise all the powers given in this instrument to the same unrestricted extent as if they were the absolute owners of such shares of stock or other securities, provided however, that the rights and privileges aforesaid shall be exercised with a view to the benefit and advantage of the property;

Determine in any doubtful case which funds shall be classed as income or principal and which expenses shall be chargeable to income or to principal;

Pay out of principal any tax upon gains on sales of securities or other property or upon securities or other property received which, for the purpose of any income tax shall be considered income, but which under the provisions of law or of this instrument shall be considered principal;

Purchase and/or maintain and/or sell residential properties for occupancy, rent free, by any of the beneficiaries hereunder, and/or their spouses, and to pay all taxes and assessments, expenses of maintaining the properties, premiums of insurance on such residences, including insurance to cover liability for accidents to persons on such properties, and to make such purchases or payments out of principal or income as the Trustee in his sole discretion, shall determine;

Compromise claims by or against the trusts or estate.

IN WITNESS WHEREOF, I, the said HELEN E. ST. LAURENT, herewith set my hand and seal to this, my last Will and Testament, typewritten on seven (7) sheets of paper (including the attestation clause, signatures of witnesses and self-proving affidavit) upon the margin of each one of which I have also written my name, this 13th day of July, nineteen hundred and eighty-nine.

Helen E. St. Laurent (L.S.)
Helen E. St. Laurent

Signed by the within named Testatrix, HELEN E. ST. LAURENT, and by her declared to be her Will in our presence, who sign as witnesses in her presence, and in the presence of each other, and at her request, this 13th day of July, A.D. 1989.

Debra C Daniels of Manchester, Connecticut
Debra C. Daniels

Laura L. Albert of Manchester, Connecticut
Laura L. Albert

STATE OF CONNECTICUT)
) ss. Manchester July 13th , A.D. 1989
COUNTY OF HARTFORD)

The within named, Debra C. Daniels and Constance L. Albert being duly sworn, do depose and say: That they witnessed the within Will of the within named Testatrix, and subscribed the same in her presence, in the presence of each other and at her request; That said Testatrix, at the time of signing said Will, appeared to them to be of full age and of sound and disposing mind and memory and competent to make testamentary disposition of real and personal property; That she voluntarily signed said Will and declared the same to be her Last Will and Testament in the presence of the said two subscribing witnesses thereto, and that this affidavit is made at the request of the said Testatrix.

Debra C. Daniels
Debra C. Daniels

Constance L. Albert
Constance L. Albert

Subscribed and Sworn to this 13th day of July, A.D. 1989, before me.

Thomas S. Fiorentino
Commissioner of the Superior Court

EXHIBIT Q 11-2

Fund 11-1.81

Donald G. Piper and Hazel B. Piper

I, **HAZEL B. PIPER**, presently of the Town of Manchester, County of Hartford and State of Connecticut, make this Will, hereby revoking all Wills and Codicils heretofore made by me.

FIRST: I direct that my Executor hereinafter named, shall pay all of my just debts, expenses of last illness and funeral expenses as soon after my death as possible, with the exception that any debt owed by me which is secured by mortgage or by any other lien on my real or personal property may be continued for an indefinite period in the discretion of my Executor. I hereby direct that all legacy, succession, inheritance, transfer and estate taxes, levied or assessed upon or with respect to any property which is included as part of my gross estate for the purpose of any such tax, shall be paid by my Executor out of the residue of my estate as an expense of administration and shall not be prorated or apportioned among or charged against the respective devisees, legatees, beneficiaries, transferees or other recipients, nor charged against any property passing or which may have passed to any of them and that my Executor shall not be entitled to reimbursement for any portion of any such tax from any such person.

SECOND: I give and bequeath the sum of **ONE THOUSAND AND 00/100 ($1,000.00) DOLLARS** unto **ALICE FERRY**, presently of 237 Pine Lake Drive, Coventry, Connecticut, if she survives me.

THIRD: I give and bequeath unto **GERALDINE D. GLAXON**, presently of 1000 Burlington Avenue North, Apartment 310, St. Petersburg, Florida 33705, if she survives me, the sum of **SIX THOUSAND AND 00/100 ($6,000.00) DOLLARS** together with the following described rings of mine:

(1) Yellow gold ring with opal and diamonds;

(2) White gold ring with seven (7) diamonds and two (2) emeralds;

(3) White gold wedding band with diamonds (with extension); and

(4) White gold larger diamond ring with cluster around it (with extension).

FOURTH: All the rest, residue and remainder of my property, both real and personal, and of whatsoever nature, wherever the same may be located or found, which I may own or have the right to dispose of at my death (intending hereby to exercise any power of disposition or appointment that I may

have at my death), I give, devise and bequeath unto MANCHESTER MEMORIAL HOSPITAL, of Manchester, Connecticut, in memory of DONALD G. PIPER and HAZEL B. PIPER, to be held in the Consolidated Investment Fund, the income only from which is to be used at the discretion of the Board of Trustees of the hospital for its general uses and purposes.

FIFTH: For purposes of this Will, a person shall not be considered to survive another if he shall die within thirty (30) days of the death of such other.

SIXTH: I may desire to dispose of certain articles of personal property to other persons in which event I shall leave a memorandum or memoranda with this, my last Will and Testament. Such memoranda are not intended to change the nature of any gift or bequest herein which is absolute.

SEVENTH: I nominate and appoint PAUL R. MARTH, presently of Manchester, Connecticut, to be the Executor of this, my last Will and Testament. In the event he is unable or unwilling to accept such appointment, then I nominate and appoint THE CONNECTICUT BANK AND TRUST COMPANY, presently of Hartford, Connecticut to act as Executor. I further direct that no bond be required of any of them in such capacity or in connection with the sale of any real estate in my estate by any court or judge.

EIGHTH: In addition to the usual powers, I give my Executor full discretionary power and authority with respect to the property of the estate as follows:

To sell or resell the whole or any part of the property, real or personal, for cash or upon such terms as to payment as may be deemed advisable, and to execute and deliver any deed, bill of sale, conditional bill of sale, or other document necessary or convenient to effect a sale;

To borrow funds for any purpose which may be deemed proper, and to pledge the whole or any part of the property to secure the payment of such loan;

To compromise claims by or against the estate;

To make in cash, or in property at such value as shall be fixed, any distribution required, and to determine the distributees upon such evidence as shall be deemed proper;

The enumeration of the foregoing specific powers shall not be construed as a limitation of general powers.

IN WITNESS WHEREOF, I, the said HAZEL B. PIPER, herewith set my hand and seal to this, my last Will and Testament, typewritten on three (3) sheets of paper (including the attestation clause, signatures of witnesses and self-proving

affidavit) upon the margin of each one of which I have also written my name, this 30th day of November, nineteen hundred and ninety.

Hazel B. Piper (L.S.)

Signed by the within named Testatrix, HAZEL B. PIPER, and by her declared to be her Will in our presence, who sign as witnesses in her presence, and in the presence of each other, and at her request, this 30th day of November, A.D. 1990.

Carol M. LaRosa of Manchester, Connecticut

Debra C. Daniels of Manchester, Connecticut

STATE OF CONNECTICUT)
) ss. Manchester November 30th, A.D. 1990
COUNTY OF HARTFORD)

The within named, Carol M. LaRosa and Debra C. Daniels being duly sworn, do depose and say: That they witnessed the within Will of the within named Testatrix, and subscribed the same in her presence, in the presence of each other and at her request; That said Testatrix, at the time of signing said Will, appeared to them to be of full age and of sound and disposing mind and memory and competent to make testamentary disposition of real and personal property; That she voluntarily signed said Will and declared the same to be her Last Will and Testament in the presence of the said two subscribing witnesses thereto, and that this Affidavit is made at the request of the said Testatrix.

Carol M. LaRosa

Debra C. Daniels

Subscribed and Sworn to this
30th day of November, A.D. 1990,
before me.

W. David Keith
Commissioner of the Superior Court

EXHIBIT Q 11-2

Fund 11-1.82

Harriet K. Maxwell Fund

OFFICES OF

WILLIAM W. GRAULTY

WILLIAM W. GRAULTY
ATTORNEY AT LAW

ELAINE H. LELAURIN
ACCOUNT MANAGER
TRUST & ESTATE SERVICES

65 LA SALLE ROAD
P. O. BOX 271395
WEST HARTFORD, CONNECTICUT 06127-1395

(860) 521-5694
FAX: (860) 521-7247

May 11, 1998

MAY 19 1998

Ms. Annette B. Leahy
Chief Operating Officer
Rockville General Hospital
31 Union Street
Vernon, CT 06066

Re: HARRIET K. MAXWELL FOUNDATION GRANT
Dear Annette:

On behalf of the Directors of the Harriet K. Maxwell Foundation, I am pleased to report that the Foundation has made a grant to Rockville Hospital in the aggregate amount of $450,000. This grant consists of two parts, namely, a grant of $250,000 to establish the Harriet K. Maxwell Fund, an endowment fund to provide for the normal maintenance and repair of the Maxwell Home and its grounds and a separate grant of $150,000 to pay for the major structural repairs to the Home which are considered essential for its preservation and continued use as an integral part of the Hospital.

With regard to the $250,000 Fund, this grant is conditioned on the continued use of the Maxwell Home as a part of the Hospital; and that if the Home is not so used for a period of 24 consecutive months or if the Home is damaged or destroyed and not restored to its prior level of usefulness within a reasonable time thereafter, then the balance of the Fund shall be transferred to the George Maxwell Library of Rockville, Connecticut, to be held as an endowment fund for its general uses and purposes.

I would be pleased to discuss any aspects of this grant with you or your associates. I would like to talk with you at your convenience about the timing of the funding of this two-part grant.

WILLIAM W. GRAULTY

Ms. Annette B. Leahy
May 11, 1998
Page 2

On behalf of the Board members, I would like to say again how pleased we are to be able to continue Mrs. Maxwell's support of the Hospital, particularly the maintenance and repair of the Maxwell house. I hope that in announcing this grant to your Board and hospital family you will stress that it basically reflects the continuation of her interest in the Hospital and the preservation of the unique family Home.

Sincerely yours,

William W. Graulty

WWG/ll

OFFICES OF

WILLIAM W. GRAULTY

WILLIAM W. GRAULTY
ATTORNEY AT LAW

ELAINE H. LELAURIN
ACCOUNT MANAGER
TRUST & ESTATE SERVICES

65 LA SALLE ROAD
P. O. BOX 271395
WEST HARTFORD, CONNECTICUT 06127-1395

(860) 521-5694
FAX: (860) 521-7247

June 1, 1998

Ms. Annette B. Leahy
Chief Operating Officer
Rockville General Hospital
31 Union Street
Vernon, CT 06066

Re: HARRIET K. MAXWELL FOUNDATION

Dear Annette:

I have not heard from either Mr. Werkoscoski or Mr. Stahelski following our telephone conversation of last week. Since I have the funds available and I think they should be put to work, I am taking the liberty of sending you two separate checks from the Foundation in full payment of the grants we have made to the Rockville General Hospital.

The first check in the amount of $250,000 is for the Harriet K. Maxwell Memorial Fund, the annual pay out therefrom to be used for the general maintenance and repair of the Maxwell Home and its grounds.

The second check in the amount of $150,000 represents the grant to pay for the three major structural repairs to the Home, all as outlined in the correspondence I received from Mr. Lou Grimaldi. With regard to the expenditure of this grant, the Foundation would like to receive a final report when the funds are fully expended. Based on my understanding of the projects, I expect we will have a report before the end of the current calendar year.

With regard to the endowment fund, I have avoided using the term "income therefrom" since I know that the Hospital's endowment funds are being managed on a total return basis and that the annual spending policy for your endowment funds will provide the cash flow to carry out the objective of this fund, namely, providing for the normal maintenance and repair of the Maxwell Home.

WILLIAM W. GRAULTY

Ms. Annette B. Leahy
June 1, 1998
Page 2

Please keep in touch and let us know how everything is going.

Sincerely yours,

William W. Graulty

WWG/ll

Enclosures

OFFICES OF

WILLIAM W. GRAULTY

WILLIAM W. GRAULTY
ATTORNEY AT LAW

ELAINE H. LeLAURIN
ACCOUNT MANAGER
TRUST & ESTATE SERVICES

65 LA SALLE ROAD
P. O. BOX 271395
WEST HARTFORD, CONNECTICUT 06127-1395

(860) 521-5694
FAX: (860) 521-7247

June 1, 1998

Ms. Annette B. Leahy
Chief Operating Officer
Rockville General Hospital
31 Union Street
Vernon, CT 06066

Re: HARRIET K. MAXWELL FOUNDATION GRANTS

Dear Annette:

In preparing the correspondence to you today in which Bill encloses the two Foundation checks, I noticed an error in his letter directed to you of May 11. Therefore, I am enclosing a corrected copy of the first page of said letter. The dollar amount in the first sentence of the letter dated May 11 should have read "$400,000" rather than $450,000.

I apologize for any inconvenience this may have caused you.

Sincerely,

Laurel

Laurel Letendre, Secretary
Harriet K. Maxwell Foundation

/ll

Enclosure

OFFICES OF

WILLIAM W. GRAULTY

WILLIAM W. GRAULTY
ATTORNEY AT LAW

ELAINE H. LELAURIN
ACCOUNT MANAGER
TRUST & ESTATE SERVICES

65 LA SALLE ROAD
P. O. BOX 271395
WEST HARTFORD, CONNECTICUT 06127-1395

(860) 521-5694
FAX: (860) 521-7247

May 11, 1998

Ms. Annette B. Leahy
Chief Operating Officer
Rockville General Hospital
31 Union Street
Vernon, CT 06066

Re: HARRIET K. MAXWELL FOUNDATION GRANT

Dear Annette:

On behalf of the Directors of the Harriet K. Maxwell Foundation, I am pleased to report that the Foundation has made a grant to Rockville Hospital in the aggregate amount of $400,000. This grant consists of two parts, namely, a grant of $250,000 to establish the Harriet K. Maxwell Fund, an endowment fund to provide for the normal maintenance and repair of the Maxwell Home and its grounds and a separate grant of $150,000 to pay for the major structural repairs to the Home which are considered essential for its preservation and continued use as an integral part of the Hospital.

With regard to the $250,000 Fund, this grant is conditioned on the continued use of the Maxwell Home as a part of the Hospital; and that if the Home is not so used for a period of 24 consecutive months or if the Home is damaged or destroyed and not restored to its prior level of usefulness within a reasonable time thereafter, then the balance of the Fund shall be transferred to the George Maxwell Library of Rockville, Connecticut, to be held as an endowment fund for its general uses and purposes.

I would be pleased to discuss any aspects of this grant with you or your associates. I would like to talk with you at your convenience about the timing of the funding of this two-part grant.

HARRIET K. MAXWELL
FOUNDATION, INC.

418

51-7010/2111 1

June 1, 19 98

PAY TO THE ORDER OF ROCKVILLE GENERAL HOSPITAL---------- $ 250,000.00

TWO HUNDRED FIFTY THOUSAND and 00/100 DOLLARS

WEBSTER BANK

Webster Plaza, Waterbury, CT 06702

FOR Harriet K. Maxwell Fund

William W Sunney Pres.

⑆211170101⑆10 8000394544⑈ 0418

HARRIET K. MAXWELL
FOUNDATION, INC.

41

51-7010/2111

June 1, 19 98

PAY TO THE ORDER OF ROCKVILLE GENERAL HOSPITAL---------- $ 150,000.0

ONE HUNDRED FIFTY THOUSAND and 00/100 DOLLARS

WEBSTER BANK

Webster Plaza, Waterbury, CT 06702

FOR Maxwell Home Repairs

William W Sunney Pres.

⑆211170101⑆10 8000394544⑈ 0419

6-4
Checks giving to Richard Werkowski
LP

Maxwell Belding is nephew
invite Graulty & Maxwells & Beldings

Bronze plaque re: this

Rockville General Hospital
31 Union Street ❖ Vernon, Connecticut 06066
Phone 860/872-5100 ❖ Fax 860/872-6056

CONTACT: Joanne Donaghue
Office: 860/533-3403
Home: 860/659-8418

FOR IMMEDIATE RELEASE
June 11, 1998

Rockville General Hospital Receives Endowment and Major Gift from Maxwell Foundation

Vernon, CT -- Rockville General Hospital announced today that it has received two major gifts – one an outright gift and the other a permanent endowment – from the Harriet K. Maxwell Foundation. Combined, the two gifts total $400,000.

Both gifts are restricted by the donor for use in maintaining and improving the exterior of the Maxwell Mansion, the historic building that serves as the entryway to the hospital.

An outright gift in the amount of $150,000 will be used for immediate improvements to the exterior of the Maxwell Mansion, including repairs to its tile roof and its many distinctive chimneys.

Income from a permanent endowment gift in the amount of $250,000 will be used for ongoing maintenance and repairs to the exterior of the Maxwell Mansion and its grounds.

The Harriet K. Maxwell Foundation has been a major donor to Rockville General Hsopital in the past. In 1992, it made a generous gift of $175,000 which funded extensive restoration work to the Maxwell Mansion. This work included painting, window repairs and replacement, improvements to the air conditioning system to permit removal of air conditioners on the front face of the building, and improvements to the wrought iron fencing that surrounds the hospital campus.

--More--

AN AFFILIATE OF ECHN
Eastern Connecticut Health Network, Inc.

Harriet Maxwell was also a major donor to the Rockville General Hospital Auxiliary, underwriting the cost of an ornate, highly-detailed dollhouse replica of the Maxwell Mansion. The dollhouse became the centerpiece of a successful fundraising effort by the RGH Auxiliary.

Harriet K. Maxwell was the niece of the Maxwell Mansion's last occupants, brother and sister Francis and J. Alice Maxwell. A native of Rockville, Mrs. Maxwell moved west as an adult, living for many years in Santa Barbara, California and Carefree, Arizona. She maintained local ties through her charitable foundation located in West Hartford, which supported causes of interest to Mrs. Maxwell. Mrs. Maxwell died in December 1996 at the age of 93.

The Maxwell Mansion was originally the home of Mr. and Mrs. George Maxwell. Designed by the noted architect Charles Platt, construction began on the 52-room mansion in 1900 and was completed in 1904. It was a private residence until 1945, when it was sold to what was then known as Rockville City Hospital. In the 50 years since, Rockville General Hospital has grown considerably, adding wings, adjacent buildings and community-based sites. Today, the Maxwell Mansion houses administrative offices but no clinical services. Rockville General Hospital enjoys a distinctive, non-institutional hospital entryway by having this historic home as its front door.

David Engelson, Chairman of the Community Relations and Development Committee for Rockville General Hospital and a trustee of Eastern Connecticut Health Network said today "we could not be more delighted with this wonderful gift. Mrs. Maxwell's support continues a tradition of community service and philanthropy by the Maxwell family that goes back for generations. The permanent endowment will allow us to maintain our beautiful 'front door' into the future. All of us in the Rockville General Hospital family are extremely grateful to Mrs. Maxwell and to the board of her Foundation."

-30-

EXHIBIT Q 11-2

Fund 11-1.83

Marjorie Risley Scholarship Fund

Rockville General Hospital

MARJORIE RISLEY SCHOLARSHIP FUND

The Marjorie Risley Scholarship Fund is established with the following primary objective:

To assist nurses with their continuing education programs. The money to be used would be for educational programs that will help the nurse maintain a high level of expertise.

A second use for the money would be to bring educators to this hospital to bring educational programs to a group of nurses.

The principal of the fund is to be invested with high interest in mind. The income only is to be used for the above purposes.

The Director of Nurses will determine who is to receive the assistance. If she needs advice relative to who should receive assistance she will consult the committee members. The members are:

George E. Risley

Bunny Whelton

Geraldine Strong

Margaret Connors, R.N.

February 1, 1982

31 UNION STREET • ROCKVILLE, CONNECTICUT 06066 • TELEPHONE: (203) 872-0501

RISLEY, in Vernon, Marjorie (Brown) Risley, 54, of 278 Lake St., died Tuesday (July 21) at Rockville General Hospital. She was the wife of George E. Risley. Born in Stafford Springs, she was a lifelong resident of Vernon. She was a member of First Congregational Church of Vernon. Besides her husband, she leaves her mother, Mrs. Dorothy C. Brown of Rockville; two daughters, Mrs. Bunny R. Whelton and Mrs. Robin R. Parks, both of Vernon; a brother, Scott G. Brown of Vernon; three sisters, Mrs. Marion B. Brown of Vernon, Mrs. Dorothy B. Luetjean of Ellington, Miss Beverly J. Brown of Cromwell; and two grandchildren, Heather and Daniel Whelton. Funeral services will be Friday, 11 a.m., at First Congregational Church of Vernon. Burial will be in East Windsor Hill Cemetery. Calling hours: Thursday, 2-4 and 7-9 p.m., at Ladd Funeral Home, 19 Ellington Ave., Rockville. Donations may be made to the Marjorie B. Risley Scholarship Fund, in care of Rockville General Hospital. The fund will be used to further the education of the staff and their children.

EXHIBIT Q 11-2

Fund 11-1.84

Katherine Sykes Bissell

VOL 94 PAGE 421

LAST WILL AND TESTAMENT

OF

1972

KATHERINE SYKES BISSELL

I, KATHERINE SYKES BISSELL, of Rockville, Town of Vernon, County of Tolland and State of Connecticut, being of sound and disposing mind and memory, do make, publish and declare this to be my Last Will and Testament, hereby revoking all former wills and codicils by me heretofore made.

FIRST: I direct my Executors to pay my just debts, and my funeral and administration expenses; and I further direct said Executors to pay all the estate, inheritance, succession, legacy and transfer taxes imposed by and made payable under the laws of the United States or this State or any other state or country by reason of my death, and to charge such payments against the residue of my estate as an administration expense; and I further direct that such tax payments shall not be prorated or apportioned among or charged against the respective devisees, legatees, beneficiaries, transferees or other recipients or be charged against any property passing or which may have passed to any of them; and I further direct that my Executors shall not be entitled to reimbursement for any portion of any such tax payments from any such person.

SECOND: I give and bequeath to my husband, Lebbeus F. Bissell, all of my household goods and furnishings, and other personal articles and effects and any automobiles which may be registered in my name at the time of my death, to be retained or disposed of by him as he may deem most in accordance with

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my wishes which I shall have made known to him. If my said husband shall not survive me, then I give and bequeath all said personal property to my sons, Marcus C. Mason, Jr., of Winnetka, Illinois, and John S. Mason, of Vernon, Connecticut, to be similarly retained or disposed of by them as they may deem most in accordance with my said wishes.

THIRD: I give and devise the real property located on Ellington Avenue, Ellington, Connecticut, and on Tyler Avenue, Eastern Point, Groton, Connecticut, if I shall be the owner of any such real property at the time of my death, to my said husband, Lebbeus F. Bissell, to be his absolutely and forever, if he shall survive me; but if my said husband shall not survive me, then I give and devise said real property equally to my said sons, Marcus C. Mason, Jr., and John S. Mason, to be theirs absolutely and forever, in equal shares as Tenants in Common.

FOURTH: I give and bequeath the sum of Forty Thousand Dollars ($40,000) to my said son, Marcus C. Mason, Jr., and to my daughter-in-law, Josephine T. Mason, in equal shares, absolutely and forever; but if either of them shall not survive me, then I give and bequeath all of said sum to the survivor of them. In the event neither of them shall survive me, then I give and bequeath all of said sum to the issue of said Marcus C. Mason, Jr., and said Josephine T. Mason, who shall be living at the time of my death, per stirpes, absolutely and forever.

FIFTH: I give and bequeath the sum of Twenty Thousand Dollars ($20,000) to my said son, John S. Mason, absolutely and

forever; but if he shall not survive me, then I give and bequeath all of said sum to the issue of the marriage of said John S. Mason and Emily Lowry Mason, who shall be living at the time of my death, per stirpes, absolutely and forever.

SIXTH: I give and bequeath the sum of Twenty Thousand Dollars ($20,000) to my great granddaughter, Katherine Bissell Porter, absolutely and forever. In the event she shall not survive me, then I direct this bequest shall pass instead to her mother, Joan T. Porter, to be hers absolutely and forever.

SEVENTH: (a) I give and bequeath the sum of Fifty Thousand Dollars ($50,000) to The Rockville General Hospital, Incorporated, of Rockville, Connecticut, in memory of my parents, Mr. and Mrs. Thomas W. Sykes, the income therefrom to be used for the general purposes of said Hospital.

(b) I give and bequeath the sum of Three Thousand Dollars ($3,000) to Vassar College, located in Poughkeepsie, New York, to be used for the general purposes of said College.

EIGHTH: I give and bequeath the sum of Five Thousand Dollars ($5,000) to Ida Zahner, if she shall be in my employ at the time of my death, to be hers absolutely and forever; but if said Ida Zahner shall not be in my employ at such time, this bequest shall lapse and pass instead with the residue of my estate.

NINTH: (a) I give and bequeath, absolutely and forever, the sum of Twenty Thousand Dollars ($20,000) to my grandson, John S. Mason, Jr., if he shall survive me, but if he shall not survive me, to his issue, per stirpes, who survive me, but if neither he nor any of his issue shall survive me, this bequest shall lapse and pass instead with the residue of my estate under Paragraph TWELFTH hereof.

(b) I give and bequeath, absolutely and forever, the sum of Twenty Thousand Dollars ($20,000) to my grandson, Thomas S. Mason, if he shall survive me, but if he shall not survive me, to his issue, per stirpes, who survive me, but if neither he nor any of his issue shall survive me, this bequest shall

lapse and pass instead with the residue of my estate under Paragraph TWELFTH hereof.

TENTH: (a) I give and bequeath, absolutely and forever, the sum of Twenty Thousand Dollars ($20,000) to my grandson, Marcus C. Mason, III, if he shall survive me, but if he shall not survive me, to his issue, per stirpes, who survive me, but if neither he nor any of his issue shall survive me, this bequest shall lapse and pass instead with the residue of my estate under Paragraph TWELFTH hereof.

(b) I give and bequeath, absolutely and forever, the sum of Twenty Thousand Dollars ($20,000) to my grandson, Edwin T. Mason, if he shall survive me, but if he shall not survive me, to his issue, per stirpes, who survive me, but if neither he nor any of his issue shall survive me, this bequest shall lapse and pass instead with the residue of my estate under Paragraph TWELFTH hereof.

ELEVENTH: (a) I give and bequeath, absolutely and forever, the sum of Twenty Thousand Dollars ($20,000) to my granddaughter, Joan T. Porter, if she shall survive me, but if she shall not survive me, to her issue, per stirpes, who survive me, but if neither she nor any of her issue shall survive me, this bequest shall lapse and pass instead with the residue of my estate under Paragraph TWELFTH hereof.

(b) I give and bequeath, absolutely and forever, the sum of Twenty Thousand Dollars ($20,000) to my granddaughter, Sara M. Ellison, if she shall survive me, but if she shall not survive me, to her issue, per stirpes, who survive me, but if neither she nor any of her issue shall survive me, this bequest shall lapse and pass instead with the residue of my estate under Paragraph TWELFTH hereof.

(c) I give and bequeath, absolutely and forever, the sum of Twenty Thousand Dollars ($20,000) to my granddaughter, Jane L. Mason, if she shall survive me, but if she shall not sur-

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vive me, to her issue, per stirpes, who survive me, but if neither she nor any of her issue shall survive me, this bequest shall lapse and pass instead with the residue of my estate under Paragraph TWELFTH hereof.

TWELFTH: I give and bequeath all the rest, residue and remainder of my property, both real and personal, wheresoever situate, and whether acquired before or after the execution of this Will, (hereinafter called the "Trust Estate"), to The Connecticut Bank and Trust Company, a Connecticut banking corporation located in Hartford, Connecticut, (hereinafter called the "Trustee"), IN TRUST, HOWEVER, for the following uses and purposes:

(a) To pay to, or expend for the benefit of, my said husband, Lebbeus F. Bissell, so much of the annual net income from the Trust Estate and so much of the principal thereof as the Trustee shall deem to be in the best interest of my said husband, for his most comfortable maintenance and support during his life. In connection with making such payments, the Trustee shall be generous in exercising its discretion and shall take into consideration such factors as the cost of living and the impact of Federal, State and local taxes upon the net spendable funds of my said husband, and the Trustee is hereby exonerated from any liability in connection with making such payments in the exercise of its absolute discretion. The Trustee shall add to the principal of the Trust Estate and invest and distribute as a part thereof, any part of the annual net income therefrom not expended under the terms of this subparagraph. Anything herein to the contrary notwithstanding, my said husband shall have the right at any time during his life, exercisable by a written instrument filed with the Trustee during his lifetime, or by Will, to appoint, in trust or otherwise, all or any part of the Trust Estate to my issue, or any of them, in such proportions and amounts as he shall, in his

sole judgment determine; provided, however, the exercise of no such power shall be effective unless it shall make specific reference to said power hereby created.

(b) Upon the death of my said husband, in the event he shall not have effectively exercised the power of appointment hereinabove conferred as to all of the Trust Estate, or if he shall not survive me, upon my death, the Trustee shall divide all of the principal of the Trust Estate, as it is then constituted, into two (2) parts, one for my said son, Marcus C. Mason, Jr., and his issue, and the other for my said son, John S. Mason, and his issue.

(1) The Trustee shall pay to, or expend for the benefit of, my said son, Marcus C. Mason, Jr., so much of the annual net income from his part of the Trust Estate as determined, and so much of the principal thereof as the Trustee shall deem to be in the best interest of said Marcus C. Mason, Jr., for his most comfortable maintenance and support during his life. In making expenditures for my said son hereunder, the Trustee is to be guided by the same factors as are hereinabove enumerated in subparagraph (a) with respect to my said husband. The Trustee shall add to the principal of this part of the Trust Estate, and invest and distribute as a part thereof any part of the annual net income therefrom not expended under the terms hereof. Anything herein to the contrary notwithstanding, after the death of my said husband, said Marcus C. Mason, Jr., shall have the power at any time during his life, exercisable by a written instrument filed with the Trustee during his lifetime, or by Will, to appoint in trust or otherwise, all or any part of his part of the Trust Estate to his issue, or any of them, in such

proportions and amounts as he shall, in his sole judgment, determine; provided, however, that no exercise of such power shall be effective unless it shall make specific reference hereto.

(2) Upon the death of said Marcus C. Mason, Jr. if he shall survive my said husband, or if he shall not survive my said husband, upon the death of my said husband, or if neither of them shall survive me, upon my death, the Trustee shall divide said part of the Trust Estate, as it is then constituted, into as many equal portions as there shall be children of said Marcus C. Mason, Jr., either living at that time or deceased and represented by then living issue, and forthwith shall pay over and distribute one such portion, free of any trust, to each of said living children who shall then have reached the age of thirty-five (35), and one such portion to the then living issue, per stirpes, of each of said children who shall previously have died, and shall set out one such portion to be continued in trust for each remaining child. Thereafter, the Trustee shall pay over to, or expend for the benefit of, each such remaining child so much of the annual net income from his said portion and so much of the principal thereof as the Trustee, in its sole judgment, shall deem advisable for the maintenance, support and education of such child and shall accumulate and add to the principal of each said portion any part

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of the annual net income therefrom not expended under the terms hereof. As each such remaining child shall reach the age of twenty-five (25), or shall have reached such age, the Trustee shall pay over and distribute to him one-third (1/3) of the net balance of his said portion, free of any trust, and as each such remaining child shall reach the age of thirty (30), or shall have reached such age, in addition to the amount distributable to him at the age of twenty-five (25), the Trustee shall pay over and distribute to him one-half (1/2) of the net balance of his said portion, free of any trust, and as each such remaining child shall reach the age of thirty-five (35), the Trustee shall pay over and distribute to him all of the net balance of his said portion, free of any trust. In the event any such remaining child shall die before receiving all of his said portion, then upon the death of such child, the Trustee shall pay over and distribute all of his said portion, as it is then constituted, to his then living issue, per stirpes, free of any trust, but if there shall be no issue of such child then living, the Trustee shall divide such child's portion, as it is then constituted, into as many equal parts as there shall be at that time children of said Marcus C. Mason, Jr., either living or deceased and represented by then living issue, and shall pay over and distribute, free of any trust, one such part to each of said living children who already shall have reached the age of thirty-five (35), and one such

proportions and amounts as he shall, in his sole judgment, determine; provided, however, that no exercise of such power shall be effective unless it shall make specific reference hereto.

(2) Upon the death of said Marcus C. Mason, Jr. if he shall survive my said husband, or if he shall not survive my said husband, upon the death of my said husband, or if neither of them shall survive me, upon my death, the Trustee shall divide said part of the Trust Estate, as it is then constituted, into as many equal portions as there shall be children of said Marcus C. Mason, Jr., either living at that time or deceased and represented by then living issue, andforthwith shall pay over and distribute one such portion, free of any trust, to each of said living children who shall then have reached the age of thirty-five (35), and one such portion to the then living issue, per stirpes, of each of said children who shall previously have died, and shall set out one such portion to be continued in trust for each remaining child. Thereafter, the Trustee shall pay over to, or expend for the benefit of, each such remaining child so much of the annual net income from his said portion and so much of the principal thereof as the Trustee, in its sole judgment, shall deem advisable for the maintenance, support and education of such child and shall accumulate and add to the principal of each said portion any part

part to the then living issue, per stirpes, of each of said children who previously shall have died, and shall add one of such parts to each of the portions then held in trust hereunder for said living children who have not then reached the age of thirty-five (35), the same to be held and administered in trust as to principal and income, and ultimately distributed, in the same manner as herein provided with respect to the original portion to which such part is so added. All amounts distributable hereunder shall be computed after the deduction of all proper expenses and charges.

(3) If at any time after the last to die of myself, my said husband and my said son, Marcus C. Mason, Jr., there shall be no living issue of said Marcus C. Mason, Jr., the Trustee shall add all of the principal of this part of the Trust Estate, as it is then constituted, to the trust under subparagraph (c) of this Paragraph TWELFTH of this, my Last Will and Testament, to be held, administered and distributed as therein provided.

(4) The Trust hereby created in this subparagraph (b) shall terminate in any event and every final distribution or payment of this part of the principal of the Trust Estate shall be made not later than twenty (20) years after the death of the last survivor of my said husband, Lebbeus F. Bissell, my said son, Marcus C. Mason, Jr., and the issue of said Marcus C. Mason, Jr., who shall be living at the time of my

death, in case said trust shall not have terminated previously in accordance with the terms hereof; and in the event of the termination of this trust in accordance herewith, the Trustee shall pay over and distribute this part of the Trust Estate, as it is then constituted, to the persons who would be entitled thereto as hereinbefore provided had the youngest child of said Marcus C. Mason, Jr. reached the age of thirty-five (35).

(c) (1) Upon the death of my said husband, in the event he shall not have effectively exercised the power of appointment hereinabove conferred, as to all of the Trust Estate, or if he shall not survive me, upon my death, the Trustee shall pay to, or expend for the benefit of my son, John S. Mason, during his life, all of the annual net income from his part of the Trust Estate.

(2) Upon the death of said John S. Mason if he shall survive my said husband, or if he shall not survive my said husband, upon the death of my said husband, or if neither of them shall survive me, upon my death, the Trustee shall divide said part of the Trust Estate, as it is then constituted, into as many equal portions as there shall be children of the marriage of said John S. Mason to said Emily Lowry Mason, either living at that time or deceased and represented by then living issue, and forthwith shall pay over and distribute

one such portion, free of any trust, to each of said living children who shall then have reached the age of thirty-five (35), and one such portion to the then living issue, per stirpes, of each of said children who shall previously have died, and shall set out one such portion to be continued in trust for each remaining child. Thereafter, the Trustee shall pay over to, or expend for the benefit of, each such remaining child so much of the annual net income from his said portion and so much of the principal thereof as the Trustee, in its sole judgment, shall deem advisable for the maintenance, support and education of such child, and shall accumulate and add to the principal of each said portion any part of the annual net income therefrom not expended under the terms hereof. As each such remaining child shall reach the age of twenty-five (25), or shall have reached such age, the Trustee shall pay over and distribute to him one-third (1/3) of the net balance of his said portion, free of any trust, and as each such remaining child shall reach the age of thirty (30), or shall have reached such age, in addition to the amount distributable to him at the age of twenty-five (25), the Trustee shall pay over and distribute to him one-half (1/2) of the net balance of his said portion, free of any trust, and as each such remaining child shall reach the age of thirty-five (35), the Trustee shall pay over and distribute to him all of the net balance of his said portion, free of any trust. In the event

any such remaining child shall die before receiving all of his said portion, then upon the death of such child, the Trustee shall pay over and distribute all of his said portion, as it is then constituted, to his then living issue, per stirpes, free of any trust, but if there shall be no issue of such child then living, the Trustee shall divide said child's portion, as it is then constituted, into as many equal parts as there shall be at that time children of the marriage of said John S. Mason to said Emily Lowry Mason, either living or deceased and represented by then living issue, and shall pay over and distribute, free of any trust, one such part to each of said living children who already shall have reached the age of thirty-five (35), and one such part to the then living issue, per stirpes, of each of said children who previously shall have died, and shall add one of such parts to each of the portions then held in trust for said living children who have not then reached the age of thirty-five (35), the same to be held and administered in trust as to principal and income and ultimately distributed in the same manner as herein provided with respect to the original portion to which such part is so added. All amounts distributable hereunder shall be computed after deduction of all proper expenses and charges.

(3) If at any time after the last to die of myself, my said husband and my said son, John S. Mason, there shall be no living issue of the marriage of said John S. Mason

to said Emily Lowry Mason, the Trustee shall add all of the principal of the Trust Estate, as it is then constituted, to the trust under subparagraph (b) of this Paragraph TWELFTH of this, my Last Will and Testament, to be held, administered and distributed as therein provided.

THIRTEENTH: In addition to any powers hereinbefore conferred upon it, the Trustee under this, my Last Will and Testament, shall have the following powers and authority:

(a) To retain without liability for loss or depreciation resulting from such retention, original property, whether real or personal, received by it from my estate for such period as to it shall seem best, although such property may not be of the character prescribed by law or by the terms of this Will for the investment of trust funds, and without regard to what percentage of the total value of the Trust Estate such original property represents.

(b) To invest and reinvest from time to time in such stocks, common or preferred, bonds, debentures, notes, securities, or other property, either of the class or kind now or hereafter ordinarily approved or held to be lawful for the investment of trust funds, or not, as the Trustee, in its absolute discretion, may select, and to make and change such investments from time to time according to its discretion; to con-

tinue to hold any stock, securities, or other property which it may receive hereunder, and to invest in property located outside the State of Connecticut.

(c) To pay all lawful taxes, all charges and other expenses properly incident to the management of the Trust Estate, and to make returns for Federal and State income tax purposes and to settle and compromise any and all claims which may from time to time arise in connection therewith.

(d) To make any divisions and payments pursuant to the terms of these trusts, using cash, securities, or other property of whatever nature and in whatever proportions the Trustee, in its judgment, shall deem appropriate; and the judgment of the Trustee shall be final.

(e) To exercise in person or by proxy, all voting, option, subscription, reorganization, consolidation, merger and liquidation rights, and all other rights and privileges of whatsoever nature incident, appurtenant or pertaining to securities in the Trust Estate, and, in connection therewith, to enter into any covenant or agreement binding the Trust Estate, and to purchase any new securities issued as a result of, or in connection with, any such act.

(f) To determine, in its absolute and uncontrolled discretion, whether any money or other property coming into its hands is part of the principal of the Trust Estate, or the gross income therefrom, or the net income available for distribution thereunder, and to apportion between principal and in-

come any loss or expenditures which, in its opinion, should be apportioned, and which as to the Trustee may seem just and equitable; and any such determination as between principal and income so made by the Trustee in good faith shall be conclusive and binding upon all beneficiaries or other persons interested in the Trust Estate.

(g) To manage and control the Trust Estate and to sell, exchange, lease, rent, assign, transfer or otherwise dispose of all or any part thereof, real or personal, upon such terms and conditions as it may, in its discretion, deem proper, without requesting permission from any Probate Court.

FOURTEENTH: As a matter of convenience to the beneficiaries, the Trustee hereunder may be changed at any time and a successor corporate Trustee appointed by my said husband during his lifetime, and thereafter, with respect to each portion of the Trust Estate, by the person entitled to receive income from such portion at the time of such change, including the personal representative of any such person who is then legally incompetent. Such power shall be exercised by giving written notice to the then Trustee and to the successor Trustee and upon the acceptance of the trusts by the successor Trustee and the transfer to the successor Trustee of the Trust Estate, or the portion thereof as the case may be, said then Trustee shall cease to be Trustee of the Trust Estate, or portion, and the successor Trustee shall become and thereafter be Trustee thereof, to serve in the same manner and with the same powers.

FIFTEENTH: I nominate, constitute and appoint my said husband, Lebbeus

F. Bissell and my said sons, Marcus C. Mason, Jr., and John S. Mason, Executors of this, my Last Will and Testament, all to serve without requirement of bond, with full power of disposition, management and dealing with respect to both real and personal property belonging to me in order to carry out the administration hereof. I authorize my Executors to make any division of my estate required by this, my Last Will and Testament, and to determine what property shall be included in each share thereof and the value of such property; and the division and determination so made by my Executors shall be final and conclusive upon all interested parties. I also authorize my Executors to join my said husband or his estate in the filing of any Federal income tax return for any year for which I have not filed such return prior to my death, and also to consent to any gifts made by my said husband as being made half by me for the purpose of the Federal gift tax law; and my Executors may take such action even though it may result in additional liabilities for my estate. If my said husband and/or my said sons shall die, resign, or be unable or unwilling to act as an Executor hereof, then I direct that the remaining or surviving Executors, as the case may be, shall serve as sole Executor or Executors, as the case may be, to act in the same manner and with the same powers.

SIXTEENTH: Reference herein to said The Connecticut Bank and Trust Company shall include any corporation or association which may succeed to its trust business.

IN WITNESS WHEREOF, I have hereunto set my hand and seal,

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declaring this to be my Last Will and Testament, this 10th day of Mar., A.D. 1969.

Katherine S. Bissell.

Signed, sealed, published and declared by the said Testatrix, KATHERINE SYKES BISSELL, as and for her Last Will and Testament, in the presence of us, who, at her request, in her presence and in the presence of each other, have hereunto subscribed our names as witnesses this 10th day of March, A.D. 1969.

Witnesses	Addresses
Judy M. Herman	East Hartford, Conn.
[illegible]	Winsted, Conn.
Sherry A. Brown	Manchester, Conn.

STATE OF CONNECTICUT)
: ss. Hartford, March 10th, A.D. 1969
COUNTY OF HARTFORD)

We, the undersigned, being duly sworn, depose and say that we witnessed the execution of the foregoing Will of the said Testatrix, KATHERINE SYKES BISSELL; that she subscribed said Will and declared the same to be her Last Will and Testament in our presence; that we thereafter subscribed the same as witnesses in the presence of said Testatrix and in the presence of each other and at the request of said Testatrix; that said Testatrix at the time of the execution of said Will appeared to us to be of full age and of sound and disposing mind and memory and under no improper influence or restraint; and that we make this affidavit at the request of said Testatrix.

Judy M. Herman
[illegible]
Sherry A. Brown

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STATE OF CONNECTICUT)
: ss. Hartford, March 10th , A.D. 1969
COUNTY OF HARTFORD)

Then and there personally appeared before me, John H. Reid, duly qualified to administer oaths, Judy M Herman, Linda G. Brynton and Shirley R. Bevens, and subscribed and made oath to the truth of the foregoing affidavit.

John H Reid
Commissioner of the Superior Court

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FIRST CODICIL
TO
LAST WILL AND TESTAMENT
OF
KATHERINE SYKES BISSELL

I, KATHERINE SYKES BISSELL, of Rockville, Town of Vernon, County of Tolland and State of Connecticut, being of sound and disposing mind and memory, do make, publish and declare this to be the First Codicil to my Last Will and Testament dated March 10, 1969.

FIRST: I hereby revoke Paragraph SEVENTH (b) of my said Last Will and Testament in its entirety.

SECOND: I hereby reaffirm in all other respects my said Last Will and Testament dated March 10, 1969.

IN WITNESS WHEREOF, I have hereunto set my hand and seal, declaring this to be the First Codicil to my Last Will and Testament dated March 10, 1969, this 13th day of April, A.D. 1970.

Katherine S. Bissell (LS)

Signed, sealed, published and declared by the said Testatrix, KATHERINE SYKES BISSELL, as and for the First Codicil to her Last Will and Testament dated March 10, 1969, in the presence of us, who, at her request, in her presence and in the presence of each other, have hereunto subscribed our names as witnesses this 13th day of April, A.D. 1970.

Witnesses	Addresses
Pamela L. Cramer	New Britain, Conn.
Evelyn O. Cobey	Middletown, Conn.
Jane A. Bertram	Wethersfield, Conn.

We, the undersigned, being duly sworn, depose and say that we wit-

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nessed the execution of the foregoing Codicil to the Last Will and Testament of the said Testatrix, KATHERINE SYKES BISSELL; that she subscribed said Codicil and declared the same to be the First Codicil to her Last Will and Testament dated March 10, 1969, in our presence; that we thereafter subscribed the same as witnesses in the presence of said Testatrix and in the presence of each other and at the request of said Testatrix; that said Testatrix at the time of the execution of said Codicil appeared to us to be of full age and of sound and disposing mind and memory and under no improper influence or restraint; and that we make this affidavit at the request of said Testatrix.

Pamela E. Cramer

Evelyn A Costey

Julie A. Burtnett

STATE OF CONNECTICUT)
: ss. Hartford April 13, A.D. 1970
COUNTY OF HARTFORD)

Then and there personally appeared before me, John E Mann Jr, duly qualified to administer oaths, Pamela E Cramer, Evelyn A Costey and Julie A. Burtnett, and subscribed and made oath to the truth of the foregoing affidavit.

John E Mann Jr
Commissioner of the Superior Court

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SECOND CODICIL
TO
LAST WILL AND TESTAMENT
OF
KATHERINE SYKES BISSELL

I, KATHERINE SYKES BISSELL, of the Town of Vernon, County of Tolland and State of Connecticut, being of sound and disposing mind and memory, do make, publish and declare this to be the Second Codicil to my Last Will and Testament, dated March 10, 1969.

FIRST: Paragraph FIRST of my said Last Will and Testament is hereby renumbered Paragraph FIRST (a), and the following new Paragraph FIRST (b) is hereby added to my said Last Will and Testament:

"FIRST: (b) It is my understanding that Paragraph NINTH (a) (2) of the Last Will and Testament of my late husband, Lebbeus F. Bissell, dated March 24, 1972, grants to me a testamentary general power of appointment over the Marital Trust Estate created in Paragraph NINTH (a) of said Last Will and Testament. I hereby exercise the said power of appointment by directing that the share of any estate, inheritance, succession, legacy and transfer taxes assessed or imposed by reason of my death which is attributable to the inclusion in my estate for the purposes of such taxes of any part of the principal of said Marital Trust Estate, shall be charged against said Marital Trust Estate rather than the residue of my estate, notwithstanding the provisions of Paragraph FIRST (a) of this Will. In determining the amount of such taxes, the principal of said Marital Trust Estate shall be deemed to be the portion of my said es-

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tate taxable in the highest applicable tax bracket."

SECOND: I hereby reaffirm in all other respects my said Last Will and Testament, dated March 10, 1969.

IN WITNESS WHEREOF, I have hereunto set my hand and seal, declaring this to be the Second Codicil to my Last Will and Testament, dated March 10, 1969, this 28 day of April, A. D. 1972.

Her

Katherine Sykes Bissell

Mark

Signed, sealed, published and declared by the said Testatrix, KATHERINE SYKES BISSELL, as and for the Second Codicil to her Last Will and Testament, dated March 10, 1969, in the presence of us, who, at her request, in her presence and in the presence of each other, have hereunto subscribed our names as witnesses this 28 day of April, A. D. 1972.

Witnesses	Addresses
Andrew Davies Jr.	Rockville Conn.
Morris Davies	Vernon Conn.
Margaret L. Zawada	Ellington Conn.

We, the undersigned, being duly sworn, depose and say that we witnessed the execution of the foregoing Codicil to the Last Will and Testament of the said Testatrix, KATHERINE SYKES BISSELL; that she subscribed said Codicil and declared the same to be the Second Codicil to her Last Will and Testament dated March 10, 1969, in our presence; that we thereafter subscribed the same as witnesses in the presence of said Testatrix; that said Testatrix at the time of the execution of said Codicil appeared to us to be of full age and of sound and disposing mind and memory and under no improper

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influence or restraint; and that we make this affidavit at the request of said Testatrix.

Andrew Davies Jr.
Morris Davies
Margaret G. Zowada

STATE OF CONNECTICUT)
: ss. Vernon April 28, A.D. 1972
COUNTY OF TOLLAND)

Then and there personally appeared before me, John S. Mason Jr., duly qualified to administer oaths, Andrew Davies Jr., Morris Davies and Margaret G. Zowada, and subscribed and made oath to the truth of the foregoing affidavit.

John S. Mason Jr.
Commissioner of the Superior Court

GENERAL WAIVER
PRC 18 NEW & 71

STATE OF CONNECTICUT
COURT OF PROBATE
(Type or print)

TO: Court of Probate, District of Ellington District No.

ESTATE OF [illegible]

Katherine Sykes Bissell

DATE OF APPLICATION

An application having been presented to the Court praying that

- [ ] LETTERS OF ADMINISTRATION be granted on said estate.
- [x] AN INSTRUMENT IN WRITING PURPORTING TO BE THE LAST WILL AND TESTAMENT AND CODICILS thereto, if any, of said deceased be proved, approved, allowed and admitted to probate and letters testamentary be issued.
- [ ] THE FIDUCIARY be granted PERMISSION TO SELL real property.
- [ ] THE FIDUCIARY be granted PERMISSION TO MORTGAGE real property.
- [ ] THE FIDUCIARY be granted PERMISSION TO SETTLE A DOUBTFUL OR DISPUTED CLAIM.
- [ ] (other, specify)

WHEREAS, the undersigned are persons interested in said matter and entitled to notice of a hearing upon said application in said Court;

NOW, THEREFORE, each of the undersigned represents that he has examined said application and related documents and hereby waives notice of hearing upon the said application and has no objection to the granting and approval thereof.

SIGNED PARTY IN INTEREST	SUBSCRIBED AND SWORN TO BEFORE ME: (Judge, Ass't Clerk, ~~Notary Public~~, Comm. of Sup. Court) (NOTE: If Notary, show date when commission expires.)	DATE
John S. Mason	John S. Mason Jr. Commissioner	6/28/72
× Marcus C. Mason, Jr.	Marcus C. Mason Jr.	
	John S. Mason Jr. Commissioner	6/28/72

EXHIBIT Q 11-2

Fund 11-1.85

MMH:
DeQuattro Cancer Center – Avis Lloyd Tree of Life

The Avis M. Lloyd Fund

Fund Information

Fund ID:	M-Lloyd	Is Inactive?	No
Fund Description:	The Avis M. Lloyd Fund	Is Restricted?	Yes
Start Date:		Date Added:	1/18/2002
End Date:		Added By:	ksantasiere
Fund Category:	MMH Temporarily Restricted	Last Changed On:	3/13/2014
Overall Goal:	$0.00	Last Changed By:	Mary McGoldrick
		Import ID:	04107-054-0000294

Notes:
Can be used for the purposes of Survivorship Navigation and all it entails.

Each quarter, $1,250 will be transferred from the Avis Lloyd Fund to the Survivorship Fund by Chris Pelletier in Finance, as per the instructions of Mary Wilson.

Campaigns

Campaign ID	Campaign Description	Start Date	End Date	Overall Goal
AF	Annual Fund			$650,000.00

Appeals

Appeal ID	Appeal Description	Start Date	End Date	Overall Goal
07 DEQ Tree	07 DEQ Tree of Life	10/5/2006		$1,000.00
09 TOL	09 Tree of Life	10/1/2008	9/30/2009	$3,000.00

Attributes

Attribute Category	Description	Short Desc.	Date
Director/Manager	Kris Popovitch/Donna Cameron		4/9/2012
Vice President	Kate Sims		4/9/2012

Gift History

Constituent Name	Date	Gift Type	Fund	Amount	Balance
	3/16/2009	Cash	M-Lloyd	$35.00	$0.00
	12/19/2007	MG Pay-Cash	M-Lloyd	$300.00	$0.00
	8/11/2009	Cash	M-Lloyd	$50.00	$0.00
	8/7/2012	Cash	M-Lloyd	$100.00	$0.00
	12/10/2009	Cash	M-Lloyd	$100.00	$0.00
	11/29/2005	Cash	M-Lloyd	$80.00	$0.00
	11/1/2005	Cash	M-Lloyd	$25.00	$0.00
	1/29/2004	Cash	M-Lloyd	$100.00	$0.00
	10/12/2004	Cash	M-Lloyd	$100.00	$0.00
	11/1/2005	Cash	M-Lloyd	$25.00	$0.00
	12/22/2005	Cash	M-Lloyd	$300.00	$0.00
	6/23/2003	Cash	M-Lloyd	$100.00	$0.00
	12/10/2003	Cash	M-Lloyd	$100.00	$0.00
	9/30/2003	Cash	M-Lloyd	$275.00	$0.00
	6/21/2004	Cash	M-Lloyd	$300.00	$0.00
	6/28/2005	Cash	M-Lloyd	$300.00	$0.00
	12/22/2008	Cash	M-Lloyd	$300.00	$0.00

10/4/2013	Cash	M-Lloyd	$600.00	$0.00
8/22/2003	Cash	M-Lloyd	$100.00	$0.00
11/7/2005	Cash	M-Lloyd	$100.00	$0.00
8/22/2006	Cash	M-Lloyd	$100.00	$0.00
10/21/2005	Cash	M-Lloyd	$15.00	$0.00
6/5/2006	Cash	M-Lloyd	$100.00	$0.00
9/9/2003	Cash	M-Lloyd	$100.00	$0.00
9/9/2003	Cash	M-Lloyd	$100.00	$0.00
10/25/2005	Cash	M-Lloyd	$20.00	$0.00
5/29/2012	Cash	M-Lloyd	$100.00	$0.00
3/12/2009	Cash	M-Lloyd	$40.00	$0.00
6/5/2006	Cash	M-Lloyd	$100.00	$0.00
10/16/2003	Cash	M-Lloyd	$100.00	$0.00
5/7/2009	Cash	M-Lloyd	$100.00	$0.00
7/28/2009	Cash	M-Lloyd	$300.00	$0.00
4/30/2014	Cash	M-Lloyd	$100.00	$0.00
12/10/2009	Cash	M-Lloyd	$100.00	$0.00
10/26/2005	Cash	M-Lloyd	$50.00	$0.00
2/5/2004	Cash	M-Lloyd	$25.00	$0.00
3/11/2009	Cash	M-Lloyd	$25.00	$0.00
11/16/2004	Cash	M-Lloyd	$100.00	$0.00
2/20/2012	Cash	M-Lloyd	$1,000.00	$0.00
10/26/2005	Cash	M-Lloyd	$25.00	$0.00
3/12/2009	Cash	M-Lloyd	$25.00	$0.00
12/26/2007	Cash	M-Lloyd	$100.00	$0.00
3/21/2001	Cash	M-Lloyd	$125.00	$0.00
3/21/2001	Cash	M-Lloyd	$125.00	$0.00
10/26/2005	Cash	M-Lloyd	$70.00	$0.00
8/10/2005	Cash	M-Lloyd	$50.00	$0.00
12/22/2005	Cash	M-Lloyd	$50.00	$0.00
10/26/2005	Cash	M-Lloyd	$50.00	$0.00
7/27/2009	Cash	M-Lloyd	$100.00	$0.00
4/19/2005	Cash	M-Lloyd	$100.00	$0.00
4/2/2009	Cash	M-Lloyd	$50.00	$0.00
3/18/2009	Cash	M-Lloyd	$100.00	$0.00
3/12/2009	Cash	M-Lloyd	$100.00	$0.00
4/2/2009	Cash	M-Lloyd	$50.00	$0.00
8/27/2012	Cash	M-Lloyd	$100.00	$0.00
1/22/2004	Cash	M-Lloyd	$40.00	$0.00
12/30/2005	Cash	M-Lloyd	$100.00	$0.00
10/26/2005	Cash	M-Lloyd	$25.00	$0.00
2/28/2007	Cash	M-Lloyd	$25.00	$0.00
4/3/2007	Cash	M-Lloyd	$20.00	$0.00
5/1/2007	Cash	M-Lloyd	$25.00	$0.00
12/26/2007	Cash	M-Lloyd	$25.00	$0.00
10/10/2007	Cash	M-Lloyd	$20.00	$0.00
5/30/2007	Cash	M-Lloyd	$40.00	$0.00
7/31/2007	Cash	M-Lloyd	$35.00	$0.00
11/26/2007	Cash	M-Lloyd	$25.00	$0.00
12/31/2004	Cash	M-Lloyd	$30.00	$0.00
9/8/2009	Cash	M-Lloyd	$25.00	$0.00
1/12/2010	Cash	M-Lloyd	$20.00	$0.00
11/22/2010	Cash	M-Lloyd	$20.00	$0.00
11/30/2009	Cash	M-Lloyd	$20.00	$0.00
7/30/2009	Cash	M-Lloyd	$20.00	$0.00
3/25/2009	Cash	M-Lloyd	$100.00	$0.00
1/22/2004	Cash	M-Lloyd	$25.00	$0.00

Fund Profile

1/22/2004	Cash	M-Lloyd	$300.00	$0.00
2/16/2004	Cash	M-Lloyd	$100.00	$0.00
11/21/2008	Cash	M-Lloyd	$300.00	$0.00
6/22/2006	Cash	M-Lloyd	$300.00	$0.00
7/6/2005	Cash	M-Lloyd	$100.00	$0.00
10/26/2005	Cash	M-Lloyd	$25.00	$0.00
2/15/2001	Cash	M-Lloyd	$15.00	$0.00
12/8/2005	Cash	M-Lloyd	$25.00	$0.00
11/1/2005	Cash	M-Lloyd	$25.00	$0.00
2/3/2006	Cash	M-Lloyd	$25.00	$0.00
2/3/2006	Cash	M-Lloyd	$25.00	$0.00
2/15/2001	Cash	M-Lloyd	$25.00	$0.00
1/22/2004	Cash	M-Lloyd	$25.00	$0.00
6/7/2004	Cash	M-Lloyd	$300.00	$0.00
12/8/2005	Cash	M-Lloyd	$25.00	$0.00
2/25/2005	Cash	M-Lloyd	$25.00	$0.00
3/12/2009	Cash	M-Lloyd	$20.00	$0.00
10/26/2005	Cash	M-Lloyd	$25.00	$0.00
9/29/2006	Cash	M-Lloyd	$100.00	$0.00
12/5/2005	Cash	M-Lloyd	$40.00	$0.00
2/25/2005	Cash	M-Lloyd	$25.00	$0.00
1/22/2004	Cash	M-Lloyd	$100.00	$0.00
3/28/2005	Cash	M-Lloyd	$100.00	$0.00
12/5/2007	Cash	M-Lloyd	$358.76	$0.00
6/17/2004	Cash	M-Lloyd	$115.00	$0.00
10/11/2004	Cash	M-Lloyd	$100.00	$0.00
6/23/2003	Cash	M-Lloyd	$100.00	$0.00
6/23/2003	Cash	M-Lloyd	$100.00	$0.00
2/25/2005	Cash	M-Lloyd	$25.00	$0.00
10/25/2005	Cash	M-Lloyd	$25.00	$0.00
2/1/2006	Cash	M-Lloyd	$50.00	$0.00
12/18/2012	Cash	M-Lloyd	$100.00	$0.00
10/14/2003	Cash	M-Lloyd	$100.00	$0.00
9/18/2003	Cash	M-Lloyd	$200.00	$0.00
10/26/2005	Cash	M-Lloyd	$180.00	$0.00
11/16/2005	Cash	M-Lloyd	$15.00	$0.00
11/1/2005	Cash	M-Lloyd	$25.00	$0.00
6/23/2003	Cash	M-Lloyd	$200.00	$0.00
4/25/2007	Cash	M-Lloyd	$100.00	$0.00
4/17/2006	Cash	M-Lloyd	$100.00	$0.00
10/31/2008	Cash	M-Lloyd	$100.00	$0.00
10/31/2008	Cash	M-Lloyd	$200.00	$0.00
12/22/2005	Cash	M-Lloyd	$100.00	$0.00
7/27/2007	Cash	M-Lloyd	$200.00	$0.00
1/20/2004	Cash	M-Lloyd	$25.00	$0.00
11/3/2003	Cash	M-Lloyd	$100.00	$0.00
6/16/2009	Cash	M-Lloyd	$100.00	$0.00
4/18/2005	Cash	M-Lloyd	$100.00	$0.00
4/18/2005	Cash	M-Lloyd	$100.00	$0.00
12/4/2005	Cash	M-Lloyd	$200.00	$0.00
12/22/2008	Cash	M-Lloyd	$100.00	$0.00
12/22/2008	Cash	M-Lloyd	$100.00	$0.00
2/19/2001	Cash	M-Lloyd	$50.00	$0.00
1/24/2005	Cash	M-Lloyd	$100.00	$0.00

1/11/2005	Cash	M-Lloyd	$200.00	$0.00
1/11/2005	Cash	M-Lloyd	$200.00	$0.00
1/11/2005	Cash	M-Lloyd	$200.00	$0.00
3/6/2008	Cash	M-Lloyd	$100.00	$0.00
2/1/2006	Cash	M-Lloyd	$20.00	$0.00
12/18/2006	Cash	M-Lloyd	$300.00	$0.00
12/22/2005	Cash	M-Lloyd	$200.00	$0.00
8/27/2008	Cash	M-Lloyd	$200.00	$0.00
6/14/2004	Cash	M-Lloyd	$20.00	$0.00
3/8/2001	Cash	M-Lloyd	$20.00	$0.00
9/23/2008	Cash	M-Lloyd	$100.00	$0.00
8/18/2009	Cash	M-Lloyd	$300.00	$0.00
8/18/2003	Cash	M-Lloyd	$300.00	$0.00
8/7/2007	Cash	M-Lloyd	$600.00	$0.00
2/15/2001	Cash	M-Lloyd	$25.00	$0.00
1/12/2004	Cash	M-Lloyd	$100.00	$0.00
1/15/2004	Cash	M-Lloyd	$100.00	$0.00
4/12/2004	Cash	M-Lloyd	$100.00	$0.00
8/24/2009	Cash	M-Lloyd	$300.00	$0.00
2/17/2009	Cash	M-Lloyd	$100.00	$0.00
12/10/2003	Cash	M-Lloyd	$100.00	$0.00
9/27/2007	Cash	M-Lloyd	$300.00	$0.00
1/22/2004	Cash	M-Lloyd	$200.00	$0.00
2/16/2004	Cash	M-Lloyd	$30.00	$0.00
3/21/2001	Cash	M-Lloyd	$25.00	$0.00
9/14/2007	Cash	M-Lloyd	$200.00	$0.00
2/16/2004	Cash	M-Lloyd	$200.00	$0.00
2/8/2005	Cash	M-Lloyd	$100.00	$0.00
8/11/2006	Cash	M-Lloyd	$100.00	$0.00
7/28/2003	Cash	M-Lloyd	$100.00	$0.00
12/22/2005	Cash	M-Lloyd	$25.00	$0.00
8/7/2009	Cash	M-Lloyd	$35.00	$0.00
4/4/2005	Cash	M-Lloyd	$20.00	$0.00
5/16/2005	Cash	M-Lloyd	$300.00	$0.00
3/17/2009	Cash	M-Lloyd	$25.00	$0.00
10/26/2005	Cash	M-Lloyd	$50.00	$0.00
1/12/2004	Cash	M-Lloyd	$100.00	$0.00
1/12/2004	Cash	M-Lloyd	$100.00	$0.00
1/12/2004	Cash	M-Lloyd	$300.00	$0.00
10/31/2013	Cash	M-Lloyd	$100.00	$0.00
6/30/2004	Cash	M-Lloyd	$100.00	$0.00
5/2/2007	Cash	M-Lloyd	$100.00	$0.00
3/16/2009	Cash	M-Lloyd	$25.00	$0.00
2/16/2004	Cash	M-Lloyd	$25.00	$0.00
11/2/2009	Cash	M-Lloyd	$200.00	$0.00
2/15/2001	Cash	M-Lloyd	$25.00	$0.00
3/17/2009	Cash	M-Lloyd	$50.00	$0.00
9/1/2004	Cash	M-Lloyd	$50.00	$0.00
9/1/2004	Cash	M-Lloyd	$50.00	$0.00
3/2/2005	Cash	M-Lloyd	$100.00	$0.00
3/21/2001	Cash	M-Lloyd	$25.00	$0.00
6/23/2003	Cash	M-Lloyd	$300.00	$0.00
9/24/2003	Cash	M-Lloyd	$50.00	$0.00
11/1/2005	Cash	M-Lloyd	$200.00	$0.00
12/8/2005	Cash	M-Lloyd	$100.00	$0.00
6/11/2004	Cash	M-Lloyd	$25.00	$0.00
12/10/2003	Cash	M-Lloyd	$300.00	$0.00

2/3/2006	Cash	M-Lloyd	$100.00	$0.00
10/16/2003	Cash	M-Lloyd	$100.00	$0.00
6/21/2001	Cash	M-Lloyd	$25.00	$0.00
10/26/2005	Cash	M-Lloyd	$25.00	$0.00
7/19/2005	Cash	M-Lloyd	$300.00	$0.00
1/27/2004	Cash	M-Lloyd	$100.00	$0.00
6/7/2005	Cash	M-Lloyd	$300.00	$0.00
12/22/2005	Cash	M-Lloyd	$20.00	$0.00
11/1/2005	Cash	M-Lloyd	$100.00	$0.00
8/28/2003	Cash	M-Lloyd	$200.00	$0.00
10/16/2003	Cash	M-Lloyd	$100.00	$0.00
11/7/2005	Cash	M-Lloyd	$50.00	$0.00
3/17/2009	Cash	M-Lloyd	$50.00	$0.00
2/15/2001	Cash	M-Lloyd	$50.00	$0.00
1/8/2008	Cash	M-Lloyd	$300.00	$0.00
11/1/2005	Cash	M-Lloyd	$50.00	$0.00
2/15/2001	Cash	M-Lloyd	$25.00	$0.00
2/15/2001	Cash	M-Lloyd	$10.00	$0.00
9/7/2004	Cash	M-Lloyd	$100.00	$0.00
11/14/2005	Cash	M-Lloyd	$100.00	$0.00
4/26/2005	Cash	M-Lloyd	$50.00	$0.00
2/1/2006	Cash	M-Lloyd	$25.00	$0.00
11/19/2007	Cash	M-Lloyd	$200.00	$0.00
2/1/2006	Cash	M-Lloyd	$50.00	$0.00
6/23/2003	Cash	M-Lloyd	$200.00	$0.00
7/10/2012	Cash	M-Lloyd	$300.00	$0.00
5/2/2014	Cash	M-Lloyd	$600.00	$0.00
6/11/2004	Cash	M-Lloyd	$100.00	$0.00
11/1/2005	Cash	M-Lloyd	$100.00	$0.00
11/1/2005	Cash	M-Lloyd	$50.00	$0.00
7/8/2009	Cash	M-Lloyd	$200.00	$0.00
12/31/2012	Cash	M-Lloyd	$100.00	$0.00
5/8/2007	Cash	M-Lloyd	$100.00	$0.00
5/8/2007	Cash	M-Lloyd	$100.00	$0.00
6/11/2004	Cash	M-Lloyd	$100.00	$0.00
7/23/2004	Cash	M-Lloyd	$100.00	$0.00
5/24/2004	Cash	M-Lloyd	$100.00	$0.00
3/31/2014	Cash	M-Lloyd	$300.00	$0.00
9/7/2005	Cash	M-Lloyd	$100.00	$0.00
11/1/2005	Cash	M-Lloyd	$20.00	$0.00
12/11/2012	Cash	M-Lloyd	$20.00	$0.00
12/22/2005	Cash	M-Lloyd	$150.00	$0.00
3/21/2001	Cash	M-Lloyd	$50.00	$0.00
8/18/2014	Cash	M-Lloyd	$114.50	$0.00
10/21/2005	Cash	M-Lloyd	$10.00	$0.00
7/28/2003	Cash	M-Lloyd	$100.00	$0.00
9/21/2007	Cash	M-Lloyd	$300.00	$0.00
3/25/2009	Cash	M-Lloyd	$10.00	$0.00
4/29/2009	Cash	M-Lloyd	$25.00	$0.00
10/26/2005	Cash	M-Lloyd	$25.00	$0.00
1/15/2004	Cash	M-Lloyd	$300.00	$0.00
3/17/2009	Cash	M-Lloyd	$5.00	$0.00

11/16/2005	Cash	M-Lloyd	$20.00	$0.00
2/5/2004	Cash	M-Lloyd	$50.00	$0.00
1/5/2004	Cash	M-Lloyd	$200.00	$0.00
5/16/2001	Cash	M-Lloyd	$50.00	$0.00
8/28/2003	Cash	M-Lloyd	$100.00	$0.00
8/28/2003	Cash	M-Lloyd	$100.00	$0.00
8/30/2004	Cash	M-Lloyd	$100.00	$0.00
2/8/2005	Cash	M-Lloyd	$20.00	$0.00
7/28/2003	Cash	M-Lloyd	$100.00	$0.00
7/28/2003	Cash	M-Lloyd	$100.00	$0.00
3/8/2001	Cash	M-Lloyd	$5.00	$0.00
11/1/2005	Cash	M-Lloyd	$25.00	$0.00
2/25/2005	Cash	M-Lloyd	$20.00	$0.00
2/1/2006	Cash	M-Lloyd	$5.00	$0.00
5/19/2004	Cash	M-Lloyd	$200.00	$0.00
6/17/2004	Cash	M-Lloyd	$100.00	$0.00
6/17/2004	Cash	M-Lloyd	$100.00	$0.00
5/10/2005	Cash	M-Lloyd	$100.00	$0.00
3/12/2009	Cash	M-Lloyd	$50.00	$0.00
11/1/2005	Cash	M-Lloyd	$50.00	$0.00
7/2/2007	Cash	M-Lloyd	$300.00	$0.00
9/29/2003	Cash	M-Lloyd	$100.00	$0.00
7/28/2003	Cash	M-Lloyd	$300.00	$0.00
8/12/2004	Cash	M-Lloyd	$300.00	$0.00
6/6/2012	Cash	M-Lloyd	$100.00	$0.00
7/30/2009	Cash	M-Lloyd	$40.00	$0.00
3/7/2007	Cash	M-Lloyd	$100.00	$0.00
2/10/2012	Cash	M-Lloyd	$100.00	$0.00
2/25/2004	Cash	M-Lloyd	$25.00	$0.00
3/16/2009	Cash	M-Lloyd	$100.00	$0.00
3/12/2009	Cash	M-Lloyd	$100.00	$0.00
7/8/2004	Cash	M-Lloyd	$300.00	$0.00
4/24/2001	Cash	M-Lloyd	$25.00	$0.00
3/8/2004	Cash	M-Lloyd	$200.00	$0.00
2/8/2005	Cash	M-Lloyd	$100.00	$0.00
11/1/2005	Cash	M-Lloyd	$50.00	$0.00
10/25/2005	Cash	M-Lloyd	$25.00	$0.00
2/15/2001	Cash	M-Lloyd	$25.00	$0.00
2/16/2004	Cash	M-Lloyd	$100.00	$0.00
1/29/2004	Cash	M-Lloyd	$100.00	$0.00
10/26/2005	Cash	M-Lloyd	$15.00	$0.00
8/22/2005	Cash	M-Lloyd	$300.00	$0.00
10/26/2005	Cash	M-Lloyd	$20.00	$0.00
9/30/2003	Cash	M-Lloyd	$25.00	$0.00
6/23/2003	Cash	M-Lloyd	$100.00	$0.00
11/14/2005	Cash	M-Lloyd	$25.00	$0.00
10/25/2005	Cash	M-Lloyd	$25.00	$0.00
12/22/2005	Cash	M-Lloyd	$45.00	$0.00
10/6/2005	Cash	M-Lloyd	$200.00	$0.00
8/21/2003	Cash	M-Lloyd	$100.00	$0.00
8/21/2003	Cash	M-Lloyd	$100.00	$0.00
8/21/2003	Cash	M-Lloyd	$100.00	$0.00
4/1/2009	Cash	M-Lloyd	$25.00	$0.00
6/23/2003	Cash	M-Lloyd	$100.00	$0.00
6/23/2003	Cash	M-Lloyd	$100.00	$0.00
10/4/2013	Cash	M-Lloyd	$1,000.00	$0.00

11/1/2005	Cash	M-Lloyd	$200.00	$0.00
11/7/2005	Cash	M-Lloyd	$25.00	$0.00
10/26/2005	Cash	M-Lloyd	$20.00	$0.00
12/10/2003	Cash	M-Lloyd	$100.00	$0.00
6/8/2004	Cash	M-Lloyd	$100.00	$0.00
2/1/2006	Cash	M-Lloyd	$25.00	$0.00
10/24/2003	Cash	M-Lloyd	$300.00	$0.00
12/14/2012	Cash	M-Lloyd	$25.00	$0.00
11/1/2005	Cash	M-Lloyd	$300.00	$0.00
11/21/2008	Cash	M-Lloyd	$100.00	$0.00
3/17/2009	Cash	M-Lloyd	$100.00	$0.00
9/19/2008	Cash	M-Lloyd	$100.00	$0.00
1/22/2004	Cash	M-Lloyd	$25.00	$0.00
8/28/2012	Cash	M-Lloyd	$200.00	$0.00
3/12/2009	Cash	M-Lloyd	$25.00	$0.00
3/25/2009	Cash	M-Lloyd	$40.00	$0.00
8/12/2009	Cash	M-Lloyd	$100.00	$0.00
11/24/2008	Cash	M-Lloyd	$200.00	$0.00
11/24/2008	Cash	M-Lloyd	$200.00	$0.00
8/11/2006	Cash	M-Lloyd	$500.00	$0.00
6/13/2007	Cash	M-Lloyd	$300.00	$0.00
7/8/2003	Cash	M-Lloyd	$100.00	$0.00
10/25/2005	Cash	M-Lloyd	$50.00	$0.00
1/22/2004	Cash	M-Lloyd	$50.00	$0.00
5/27/2004	Cash	M-Lloyd	$250.00	$0.00
5/27/2004	Cash	M-Lloyd	$250.00	$0.00
5/14/2004	Cash	M-Lloyd	$100.00	$0.00
7/28/2005	Cash	M-Lloyd	$300.00	$0.00
7/2/2007	MG Write Off	M-Lloyd	$300.00	$0.00
2/15/2001	Cash	M-Lloyd	$25.00	$0.00
3/8/2004	Cash	M-Lloyd	$200.00	$0.00
2/28/2005	Cash	M-Lloyd	$25.00	$0.00
11/1/2005	Cash	M-Lloyd	$100.00	$0.00
3/12/2009	Cash	M-Lloyd	$25.00	$0.00
3/21/2001	Cash	M-Lloyd	$30.00	$0.00
6/23/2003	Cash	M-Lloyd	$300.00	$0.00
6/23/2003	Cash	M-Lloyd	$300.00	$0.00
6/23/2003	Cash	M-Lloyd	$300.00	$0.00
6/23/2003	Cash	M-Lloyd	$900.00	$0.00
2/5/2004	Cash	M-Lloyd	$300.00	$0.00
3/15/2005	Cash	M-Lloyd	$25.00	$0.00
1/21/2005	Cash	M-Lloyd	$25.00	$0.00
3/14/2001	Cash	M-Lloyd	$60.00	$0.00
8/28/2003	Cash	M-Lloyd	$100.00	$0.00
9/24/2003	Cash	M-Lloyd	$50.00	$0.00
10/21/2005	Cash	M-Lloyd	$300.00	$0.00
8/28/2007	Cash	M-Lloyd	$100.00	$0.00
12/10/2008	Cash	M-Lloyd	$100.00	$0.00
12/10/2008	Cash	M-Lloyd	$100.00	$0.00
11/21/2008	Cash	M-Lloyd	$100.00	$0.00
5/23/2008	Cash	M-Lloyd	$100.00	$0.00
4/24/2007	Cash	M-Lloyd	$100.00	$0.00
7/31/2009	Cash	M-Lloyd	$300.00	$0.00
9/9/2009	Cash	M-Lloyd	$100.00	$0.00
1/14/2005	Cash	M-Lloyd	$200.00	$0.00
12/5/2005	Cash	M-Lloyd	$200.00	$0.00

Fund Profile

9/21/2004	Cash	M-Lloyd	$100.00	$0.00
4/18/2005	Cash	M-Lloyd	$100.00	$0.00
6/21/2012	Cash	M-Lloyd	$200.00	$0.00
4/8/2009	Cash	M-Lloyd	$100.00	$0.00
2/23/2009	Cash	M-Lloyd	$100.00	$0.00
2/1/2006	Cash	M-Lloyd	$25.00	$0.00

2009 Brochure

The Avis M. Lloyd Tree of Life is a beautiful bronze sculpture in the John A. DeQuattro Community Cancer Center that provides donors the opportunity to support cancer patients while honoring family and friends. Proceeds from the purchase of an engraved dove, boulder or 2" x 4" leaf will be used by the Avis M. Lloyd Fund to provide services at the Cancer Center such as: lay navigator to greet and assist cancer patients, valet attendant, dietician, social worker and financial services for patients in need. Created by the family members of Avis M. Lloyd, the Tree of Life honors the memory of loved ones such as Mrs. Lloyd but also celebrates the current lives of family and friends by honoring birthdays, anniversaries, marriages, retirements or other special occasions.

Please fill out the form and mail with check or credit card information to:
ECHN Community Healthcare Foundation, Inc.
71 Haynes Street, Manchester, CT 06040

Please call ECHN Community Healthcare Foundation with questions at (860) 647-4753

Tree of Life Order Form

☐ Enclosed is a check made payable to:
ECHN Community Healthcare Foundation, Inc.
or
☐ I wish to charge my gift of $_____ to my
__ VISA __ MasterCard __ American Express
Credit Card Account
#_____
Exp. Date_____
Signature (required for Credit Card)
_____
Name_____
Address_____
City_____
State_____ Zip_____
Phone (____) _____

I wish to inscribe the following:

____ Brass colored leaf(s) at $100 each
____ Silver colored leaf(s) at $200 each
____ Copper colored leaf(s) at $300 each
____ Dove at $600 each
____ Boulder at $1,000 each

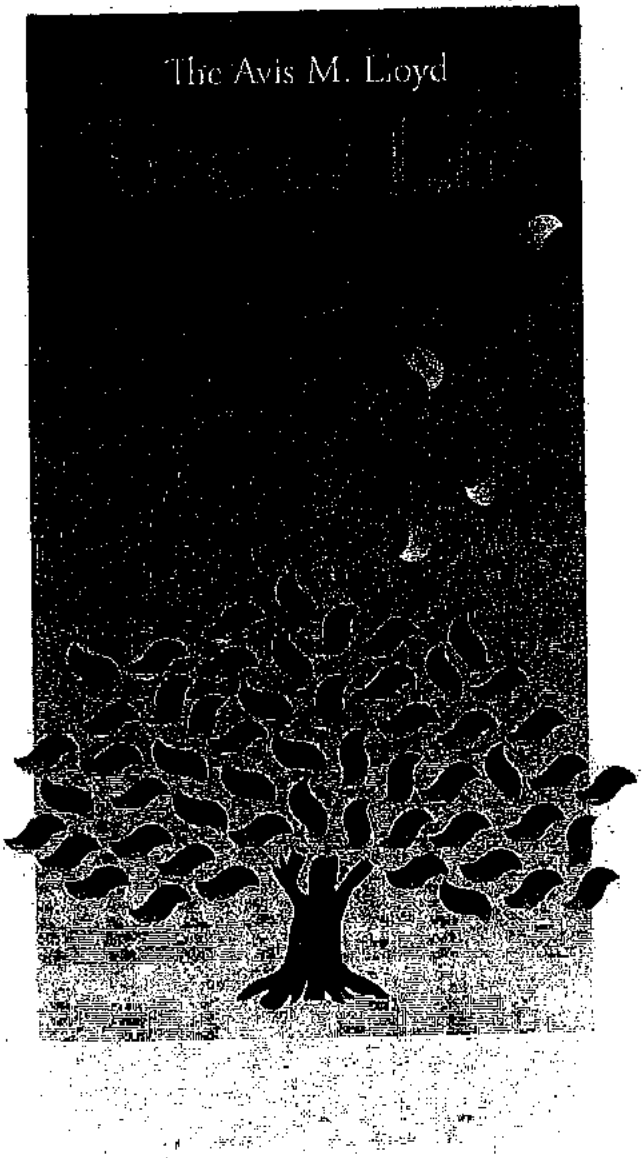
Your gift is tax deductible to the extent allowed by law.

Please do not exceed 89 letters or spaces
Inscription (please print):
_____
_____
_____
_____

Please send notification of this gift to:
Name_____
Address_____
City_____
State_____ Zip_____

For additional gifts, please attach orders on a separate piece of paper. Please feel free to make copies of this form.

The John A. DeQuattro Community Cancer Center provides a beautiful, comfortable and efficient space in which to deliver care to patients and families dealing with a diagnosis of cancer. The center is equipped to serve nursing home, bed bound, wheelchair bound, and ambulatory patients by offering comprehensive diagnosis, treatment, psychological support, supportive care, and long-term follow-up care. In addition to these medical services, the center offers patients convenient access to integrated medicine therapies, a healing garden, a resource center, a spiritual room, boutique and food court.



ECHN community healthcare FOUNDATION

71 Haynes Street, Manchester, CT 06040
www.echn.org/giving

ECHN community healthcare FOUNDATION

2012 Brochure

The Avis M. Lloyd Tree of Life is a beautiful bronze sculpture in the John A. DeQuattro Cancer Center that provides donors the opportunity to support cancer patients while honoring family and friends. Proceeds from the purchase of an engraved dove, boulder or 2" x 4" leaf will be used by the Avis M. Lloyd Fund to provide services at the Cancer Center such as "lay navigator" to greet and assist cancer patients, valet attendant, dietician, social worker and financial services for patients in need. Created by the family members of Avis M. Lloyd, the Tree of Life honors the memory of loved ones such as Mrs. Lloyd, but also celebrates the current lives of family and friends by honoring birthdays, anniversaries, marriages, retirements or other special occasions.

Please fill out the form and mail with check or credit card information to:
ECHN Community Healthcare Foundation, Inc.
71 Haynes Street, Manchester, CT 06040

Please call ECHN Community Healthcare Foundation with questions at (860) 647-4755

Tree of Life Order Form

☐ Enclosed is a check made payable to:
ECHN Community Healthcare Foundation, Inc.
or

☐ I wish to charge my gift of $_____ to my
__ VISA __ MasterCard __ American Express
Credit Card Account
#_____
Exp. Date_____
Signature (required for Credit Card)
_____

Name_____
Address_____
City_____
State_____ Zip_____
Phone (____) _____

I wish to inscribe the following:

____ Brass colored leaf at $100 each
____ Silver colored leaf at $200 each
____ Copper colored leaf at $300 each
____ Dove at $600 each
____ Boulder at $1,000 each

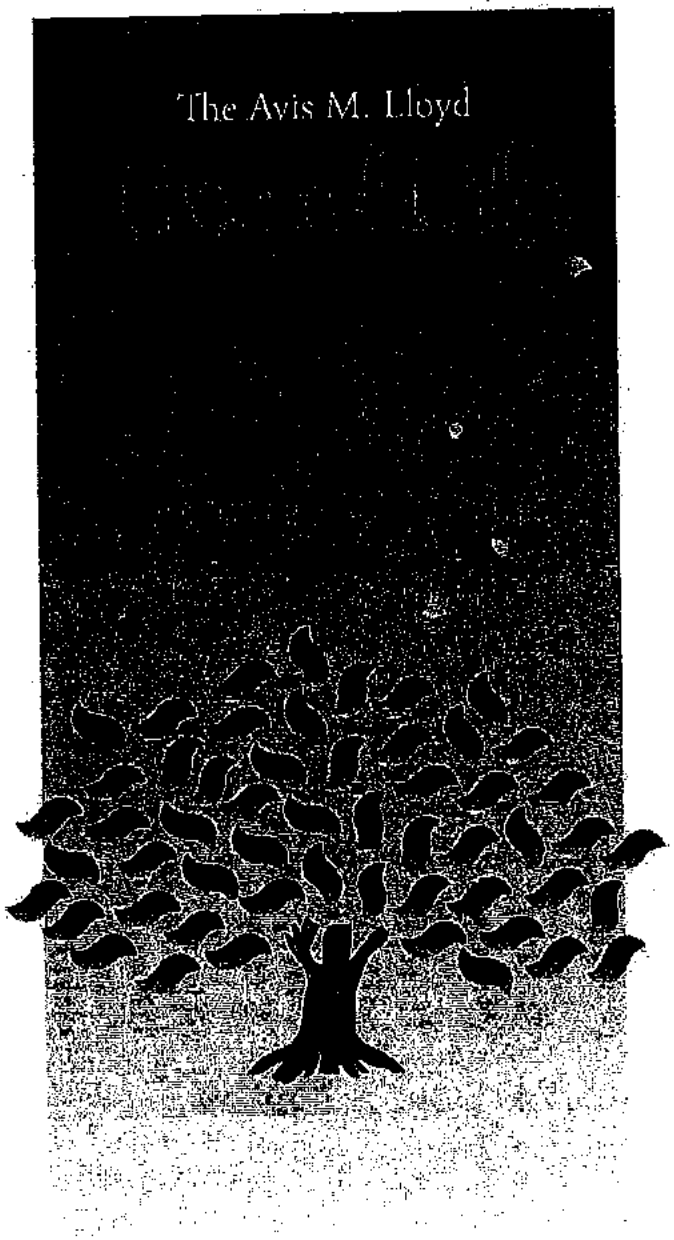
Your gift is tax deductible to the extent allowed by law.

Please do not exceed 89 letters or spaces
Inscription (please print):
_____
_____
_____
_____

Please send notification of this gift to:
Name_____
Address_____
City_____
State_____ Zip_____

For additional gifts, please attach orders on a separate piece of paper. Please feel free to make copies of this form.

The John A. Dempsey Cancer Center provides a beautiful, comfortable and efficient space in which to deliver care to patients and families dealing with a diagnosis of cancer. The center is equipped to serve nursing home, bed bound, wheelchair bound, and ambulatory patients by offering comprehensive diagnosis, treatment, psychological support, supportive care, and long-term follow-up care. In addition to these medical services, the center offers patients convenient access to integrative medicine therapies, a healing garden, a resource center, a greenhouse, boutique and food court.



COMMISSION ON CANCER
APPROVALS PROGRAM
AMERICAN COLLEGE OF SURGEONS

ECHN community healthcare FOUNDATION

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ECHN community healthcare FOUNDATION

EXHIBIT Q 11-2

Fund 11-1.86

ECHN Foundation:
Team Towanda Foundation

Fund Profile
E-BC-TW

ECHN Breast Cancer, Team Towanda Fund

Fund Information

Fund ID:	E-BC-TW	Is Inactive?	No
Fund Description:	ECHN Breast Cancer, Team Towanda Fu	Is Restricted?	Yes
Start Date:		Date Added:	11/9/2004
End Date:		Added By:	llewis
Fund Category:	ECHN Temporarily Restricted	Last Changed On:	4/5/2012
Overall Goal:	$0.00	Last Changed By:	Mary McGoldrick
		Import ID:	04107-543-0000000481

Notes:
To be used for donations made specifically to Team Towanda; can be used for uninsuredwomen over the age of 40 for mammography, breast ultrasounds and surgical consultations. The fund also provides pharmacy gift cards to purchase personal care items for use after surgery or to purchase medication (Outpatient)

Campaigns

Campaign ID	Campaign Description	Start Date	End Date	Overall Goal
ECHN	ECHN			$0.00

Attributes

Attribute Category	Description	Short Desc.	Date
Director/Manager	Debra Martin/Donna Cameron		4/5/2012
Vice President	Kate Sims		4/5/2012

Gift History

Constituent Name	Date	Gift Type	Fund	Amount	Balance
	4/3/2013	Cash	E-BC-TW	$10.00	$0.00
	10/27/2011	Cash	E-BC-TW	$10.00	$0.00
	12/20/2010	Cash	E-BC-TW	$5.00	$0.00
	8/10/2010	Cash	E-BC-TW	$5.00	$0.00
	5/21/2010	Cash	E-BC-TW	$5.00	$0.00
	12/4/2008	Cash	E-BC-TW	$5.00	$0.00
	10/20/2007	Cash	E-BC-TW	$5.00	$0.00
	12/31/2013	Cash	E-BC-TW	$10,000.00	$0.00
	2/7/2013	Cash	E-BC-TW	$750.00	$0.00
	6/25/2012	Cash	E-BC-TW	$15,000.00	$0.00
	12/31/2011	Cash	E-BC-TW	$1,700.00	$0.00
	10/27/2011	Cash	E-BC-TW	$1,466.00	$0.00
	5/10/2011	Pay-Cash	E-BC-TW	$10,000.00	$0.00
	1/25/2011	Cash	E-BC-TW	$232.50	$0.00
	1/20/2010	Cash	E-BC-TW	$247.50	$0.00
	1/12/2009	Cash	E-BC-TW	$20,167.50	$0.00
	2/13/2008	Cash	E-BC-TW	$15,000.00	$0.00
	1/29/2008	Cash	E-BC-TW	$337.50	$0.00
	10/2/2007	Cash	E-BC-TW	$1,500.00	$0.00
	1/9/2007	Cash	E-BC-TW	$3,000.00	$0.00
	11/8/2006	Cash	E-BC-TW	$30.00	$0.00
	11/8/2006	Cash	E-BC-TW	$322.50	$0.00
	6/1/2006	Cash	E-BC-TW	$2,363.50	$0.00

Fund Profile
E-BC-TW

3/16/2006	Cash	E-BC-TW	$157.50	$0.00
12/21/2005	Cash	E-BC-TW	$4,000.00	$0.00
11/14/2005	Cash	E-BC-TW	$1,240.00	$0.00
9/20/2005	Cash	E-BC-TW	$465.00	$0.00
2/11/2005	Cash	E-BC-TW	$487.50	$0.00
12/7/2004	Cash	E-BC-TW	$556.50	$0.00
11/15/2004	Cash	E-BC-TW	$3,000.00	$0.00

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2130

TEAM TOWANDA FOUNDATION
P.O. BOX 290185
WETHERSFIELD, CT 06129-0185

51-309/111

12/06/13

PAY TO THE ORDER OF Stan Kontogiannis $ **10,000.00

Ten Thousand and 00/100********** DOLLARS

Stan Kontogiannis
ECHN Community Foundation
71 Haynes St.
Manchester, CT 06040

AUTHORIZED SIGNATURE

MEMO Cookbook Matching for 2012

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CONNECTICUT

JUN 22 2012

TEAM TOWANDA FOUNDATION
P.O. BOX 290185
WETHERSFIELD, CT 06129-0185

51-309/111

05/21/12

PAY TO THE ORDER OF ECHN Community Foundation $ **15,000.00

Fifteen Thousand and 00/100********** DOLLARS

ECHN Community Foundation
71 Haynes St.
Manchester, CT 06040

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MEMO Towanda Fund

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Team Towanda
FOUNDATION

FRIENDS • WARRIORS
in the fight against BREAST CANCER

February 21, 2012

ECHN Community Foundation
Stan Kontogiannis
Corporate and Foundations Relations Officer
71 Haynes Street
Manchester, CT 06040

Dear Stan,

Team Towanda Foundation is pleased to inform you that ECHN Community Foundation will be the beneficiary of half of the net proceeds from our April 28 FUNdraiser. This event is attended by over 500 women from the Greater Hartford area and is always a very successful and fun event.

We will be in touch with you soon after the event to let you know how much the gift will be.

Like you, we are all hoping and praying that 2012 will be "The Year of the Cure". In the meantime, remember Towanda's battle cry: FIGHT & PRAY & LIVE & LAUGH & LOVE!

Sincerely,

Ellen Hollister

Ellen Hollister

FEB 23 2012

teamtowanda@yahoo.com • www.teamtowanda.org
PO Box 290185 • Wethersfield, CT 06129-0185
phone 860.257.9225 • fax 860.257.9225

2085

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TEAM TOWANDA FOUNDATION
P.O. BOX 290185
WETHERSFIELD, CT 06129-0185

51-309/111

12/29/11

DEC 3 0 2011

PAY TO THE ORDER OF ECHN Community Foundation $ **1,700.00

One Thousand Seven Hundred and 00/100********** DOLLARS

ECHN Community Foundation
71 Haynes St.
Manchester, CT 06040

MEMO Towanda Fund/Cookbook matching sales

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Eastern Connecticut

A $10,000 Grant To ECHN From Team Towanda Foundation

Regional

Submitted by Rosemary Mariocchio, ECHN, on 2011-05-23.

The Team Towanda Foundation recently presented a check in the amount of $10,000 to Eastern Connecticut Health Network (ECHN) in support of its Breast Care Collaborative/Early Detection Program.

The funds will provide approximately 125 mammogram screenings, as well as breast ultrasounds and gift cards to help purchase medical supplies required after surgery (if needed), for uninsured women. Team Towanda is also donating approximately 250 cookbooks for Early Detection Program mastectomy patients. The value of this gift is $4,000.

In addition, the Team Towanda Foundation has given ECHN a challenge to sell up to $5,000 worth of their latest cookbook, Towanda Celebrates with her Bosom Buddies: Another Towanda Cookbook ($20 each). The challenge extends to the end of 2011. If ECHN meets this challenge, Team Towanda will not only donate the $5,000 from the sale of the cookbooks but will also match it with another $5,000 grant.

If you are interested in learning more about ECHN's Early Detection Program or to purchase a copy of the Team Towanda cookbook, please call 860-672-6365. More information about the Team Towanda Foundation and its services can be found on their website at www.teamtowanda.org.



Property of the Eastern Connecticut Healthcare Foundation

Lynne Lantagne (Team Towanda), Judith Melohnett (President, Team Towanda Foundation), Stan Kontoglannis (ECHN Corporate & Foundation Relations Officer), Donna Cameron (Oncology Nurse Navigator, ECHN Eastern Connecticut Cancer Institute), Alison Caxide (Team Towanda), and Debbie Garten (Team Towanda).

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CONNECTICUT NEWS

Numbers Of Homeless Children Increase

American Cancer Society Declares Poverty A Carcinogen

Hartford Housing Authority Remaking Itself Into A Force For Homeownership

Community College Chancellor Retires One Day, Rehired The Next

Middletown Council Approves Joining Mattabassett District

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8. Divers At Massachusetts Lake Find Body Believed To Be Missing Suffield Man
9. Hartford Housing Authority Remaking Itself Into A Force For Homeownership
10. East Hartford Firefighter Charged With Harassment

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OCT 27 2011

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TEAM TOWANDA FOUNDATION
P.O. BOX 290186
WETHERSFIELD, CT 06129-0185

51-309/111

10/26/11

PAY TO THE ORDER OF ECHN Community Foundation $ **1,466.00

One Thousand Four Hundred Sixty-Six and 00/100********** DOLLARS

ECHN Community Foundation
71 Haynes St.
Manchester, CT 06040

Ellen Heller
AUTHORIZED SIGNATURE

MEMO Towanda Fund/Cookbook matching sales

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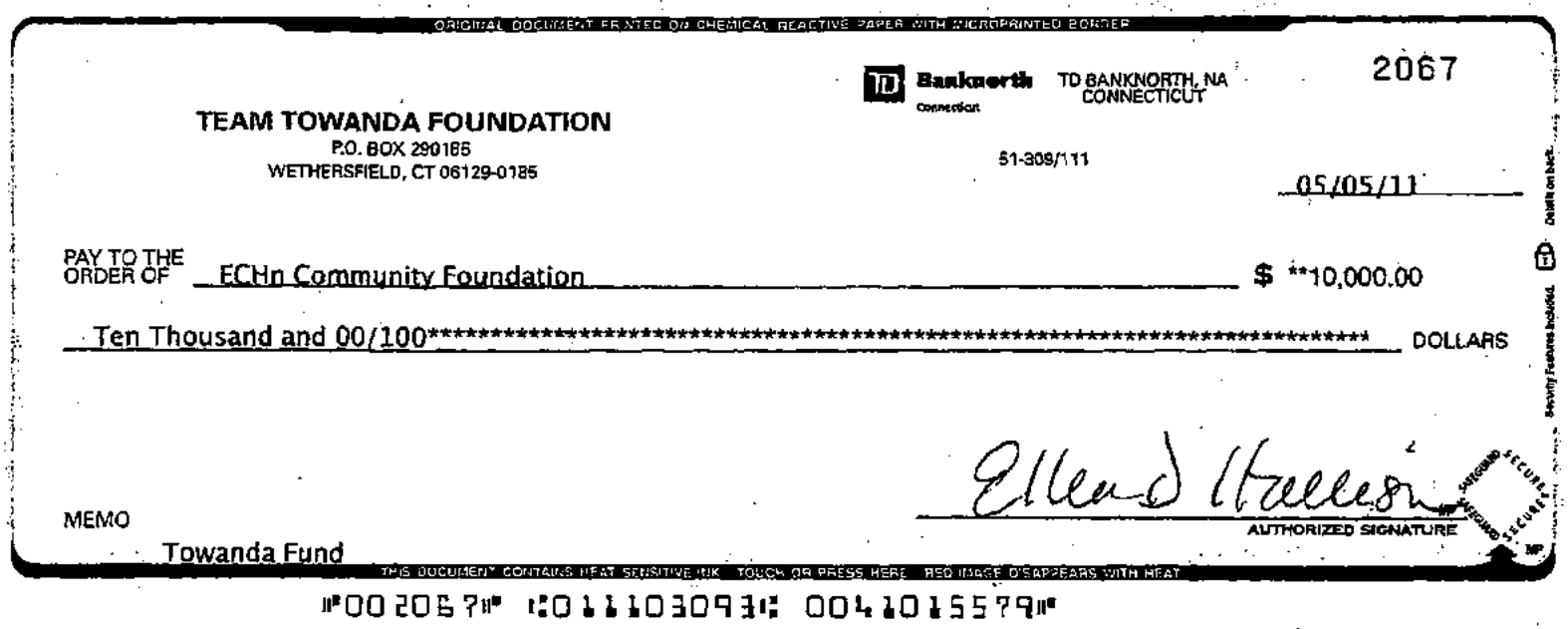

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TEAM TOWANDA FOUNDATION
P.O. BOX 290185
WETHERSFIELD, CT 06129-0185

51-309/111

05/05/11

PAY TO THE ORDER OF ECHn Community Foundation $ **10,000.00

Ten Thousand and 00/100********** DOLLARS

Security Features Included. Details on back.

MEMO
Towanda Fund

AUTHORIZED SIGNATURE

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Team Towanda

FOUNDATION

FRIENDS • WARRIORS
in the fight against BREAST CANCER

TEAM TOWANDA FOUNDATION
PROPOSED DONATION TO ECHN
Calendar Year 2011

SUMMARY OF DONATIONS:

$10,000 donation to Towanda Fund

$5,000 Value of 250 cookbooks donated to ECHN for them to sell

$5,000 Maximum matching donation if ECHN sells 250 cookbooks

$4,000 value of cookbooks donated for mastectomy patients - estimated at 200 books

Notes:

For each cookbook sold, we will donate $20 cash up to a maximum of $5000

To achieve maximum donation amount, ECHN would sell 250 of ***either*** cookbook

teamtowanda@yahoo.com • www.teamtowanda.org
PO Box 290185 • Wethersfield, CT 06129-0185
phone 860.257.9225 • fax 860.257.9225

Team Towanda Foundation

P.O. BOX 290185
WETHERSFIELD, CT
06129-0185

T 860-257-9225
F 860-257-9225
email: teamtowanda@yahoo.com
website: www.teamtowanda.org

February 4, 2008

Ms. Debra Martin
ECHN
Fitch Building, 26B Union Street
Vernon, CT 06066

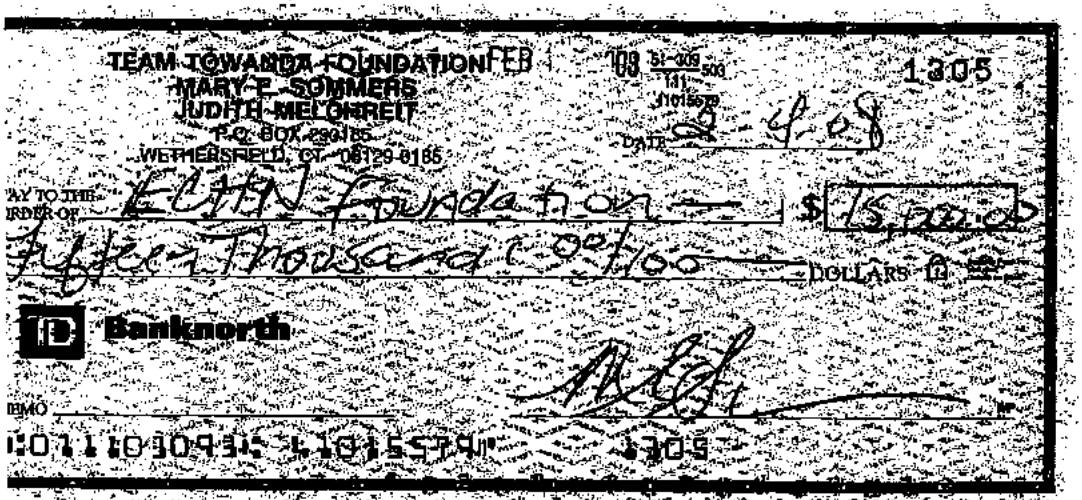
Dear Debra:

Team Towanda Foundation is pleased to make a $15,000 donation to the Towanda Fund administered by the ECHN Foundation. As you know, so many people have contributed to Team Towanda's efforts to provide mammograms and breast related services to the uninsured, underserved population of the Greater Hartford area. This donation is possible as a result of sales of the Charge of the Casserole Cavalry- The Official Towanda Cookbook, proceeds from the 2007 TTF FUNdraiser, memorial and thanksgiving gifts, as well as a number of smaller fundraisers held to benefit TTF projects and the women we serve.

We look forward to partnering with ECHN again in 2008 to support all the Pink Ribbon Warriors.

In Hope and Strength we offer you our very Breast Regards for the coming year!

Judith G. Melchreit
President, Team Towanda Foundation



BREAST CANCER

EXHIBIT Q 11-2

Fund 11-1.87

ECHN Foundation:
Employee Care Fund

Fund Profile
E-CF

the ECHN Care Fund

Fund Information

Fund ID:	E-CF	Is Inactive?	No
Fund Description:	the ECHN Care Fund	Is Restricted?	No
Start Date:	3/12/2004	Date Added:	3/12/2004
End Date:		Added By:	llewis
Fund Category:	ECHN Temporarily Restricted	Last Changed On:	1/13/2012
Overall Goal:	$0.00	Last Changed By:	Mary McGoldrick
		Import ID:	04107-054-0000000461

Notes:
ECHN Care Fund set up by Maryanne Geertsma for funds received that are disbursed by her, donated by employees

Appeals

Appeal ID	Appeal Description	Start Date	End Date	Overall Goal
06 Employee Care	06 Employee Care Appeal			$0.00
07 Care	07 Employee Care Appeal	10/5/2006		$3,000.00
09 Care	09 Employee Care Appeal	10/1/2008	9/30/2009	$0.00
09 MEC	09 Medical Executive Committtee Ap	3/20/2009	9/30/2009	$0.00

Fund Summary

First/Latest/Greatest

	Date	Amount	Type	Constituent	Fund
First	3/12/2004	$23.10	Cash		E-CF
Latest	10/1/2014	$50.00	Pledge		E-CF
Greatest	9/6/2007	$8,000.00	Cash	ECHN Cookbook Sales	E-CF

Average:	$140.74	Total gifts:	2611	Mode:	$50.00
Median:	$40.00	Total donors:	557		

Goal

Total committed:	$273,555.36
Overall goal:	$0.00
Over (under):	$273,555.36
Percent of goal:	0.00%

Breakdown

Calendar Year	Received	Pledged	Paid	Written Off	Balance	Total Committed
<all>	$166,940.30	$108,177.82	$92,359.16	$1,491.24	$14,255.90	$273,555.36
After 12/2014	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
01/2014 - 12/2014	$1,596.30	$12,913.79	$2,787.47	$12.18	$12,913.79	$17,297.56
01/2013 - 12/2013	$18,201.97	$16,062.69	$18,732.58	$663.04	$1,288.11	$38,222.66
01/2012 - 12/2012	$31,372.44	$23,344.27	$21,168.34	$90.20	$54.00	$52,594.78
Prior to 01/2012	$115,769.59	$55,857.07	$49,670.77	$725.82	$0.00	$165,440.36

EXHIBIT Q 11-2

Fund 11-1.88

ECHN Foundation:
Breast and Cervical Cancer Program

Fund Profile
E-BRCCP

the ECHN Breast & Cervical Cancer Program

Fund Information

Fund ID:	E-BRCCP	Is Inactive?	No
Fund Description:	the ECHN Breast & Cervical Cancer Progr	Is Restricted?	Yes
Start Date:	12/20/2005	Date Added:	12/20/2005
End Date:		Added By:	jczaporowski
Fund Category:	ECHN Temporarily Restricted	Last Changed On:	4/5/2012
Overall Goal:	$0.00	Last Changed By:	Mary McGoldrick
		Import ID:	04107-543-0000000518

Notes:
Funding used for anything related to outreach, education, enrollment, screening and diagnostic follow-up for underinsured women for cancer and heart disease, both in-patient and out-patient.

Campaigns

Campaign ID	Campaign Description	Start Date	End Date	Overall Goal
ECHN	ECHN			$0.00

Attributes

Attribute Category	Description	Short Desc.	Date
Director/Manager	Debra Martin/Donna Cameron		4/5/2012
Vice President	Kate Sims		4/5/2012

Gift History

Constituent Name	Date	Gift Type	Fund	Amount	Balance
	6/3/2010	Cash	E-BRCCP	$125.00	$0.00
	12/27/2012	Cash	E-BRCCP	$250.00	$0.00
	12/19/2012	Cash	E-BRCCP	$250.00	$0.00
	10/7/2010	Cash	E-BRCCP	$115.40	$0.00
	11/17/2010	Cash	E-BRCCP	$75.00	$0.00
	5/10/2011	Cash	E-BRCCP	$40.00	$0.00
	11/30/2010	Cash	E-BRCCP	$5.00	$0.00
	9/26/2012	Write Off	E-BRCCP	$20.00	$0.00
	11/23/2011	Pay-Cash	E-BRCCP	$20.00	$0.00
	2/11/2011	Pay-Cash	E-BRCCP	$20.00	$0.00
	9/23/2010	Pay-Cash	E-BRCCP	$40.00	$0.00
	7/14/2010	Pay-Cash	E-BRCCP	$40.00	$0.00
	5/11/2010	Pay-Cash	E-BRCCP	$40.00	$0.00
	3/15/2010	Pay-Cash	E-BRCCP	$40.00	$0.00
	1/29/2010	Pay-Cash	E-BRCCP	$40.00	$0.00
	12/30/2011	Pay-Cash	E-BRCCP	$110.00	$0.00
	3/31/2012	Pay-Cash	E-BRCCP	$130.00	$0.00
	9/30/2012	Pay-Cash	E-BRCCP	$130.00	$0.00
	12/30/2012	Cash	E-BRCCP	$10.00	$0.00
	6/30/2012	Pay-Cash	E-BRCCP	$130.00	$0.00
	8/23/2013	Cash	E-BRCCP	$275.00	$0.00
	3/28/2006	Cash	E-BRCCP	$500.00	$0.00
	8/12/2009	Cash	E-BRCCP	$300.00	$0.00
	11/8/2010	Cash	E-BRCCP	$1.00	$0.00

Fund Profile
E-BRCCP

11/8/2010	Cash	E-BRCCP	$10.00	$0.00
11/22/2006	Cash	E-BRCCP	$3,550.00	$0.00
12/18/2007	Cash	E-BRCCP	$4,450.26	$0.00
7/28/2009	Cash	E-BRCCP	$4,649.02	$0.00
11/17/2010	Cash	E-BRCCP	$20.00	$0.00
11/17/2010	Cash	E-BRCCP	$40.00	$0.00
10/13/2010	Cash	E-BRCCP	$60.00	$0.00
10/20/2010	Pay-Cash	E-BRCCP	$194.29	$0.00
8/3/2011	Cash	E-BRCCP	$20.00	$0.00
2/11/2011	Cash	E-BRCCP	$25.00	$0.00
2/25/2011	Cash	E-BRCCP	$20.00	$0.00
12/21/2005	Cash	E-BRCCP	$3,000.00	$0.00
3/5/2007	Cash	E-BRCCP	$300.00	$0.00
5/13/2009	Cash	E-BRCCP	$300.00	$0.00
8/13/2013	Cash	E-BRCCP	$100.00	$0.00
2/17/2009	Cash	E-BRCCP	$20.00	$0.00
9/24/2010	Cash	E-BRCCP	$20.00	$0.00
10/24/2012	Cash	E-BRCCP	$50.00	$0.00
9/19/2013	Cash	E-BRCCP	$50.00	$0.00
10/14/2011	Cash	E-BRCCP	$100.00	$0.00
12/20/2010	Cash	E-BRCCP	$25.00	$0.00
11/26/2013	Cash	E-BRCCP	$3,000.00	$0.00
7/19/2012	Pay-Cash	E-BRCCP	$3,000.00	$0.00
12/21/2011	Pay-Cash	E-BRCCP	$3,000.00	$0.00
6/8/2006	Cash	E-BRCCP	$20,000.00	$0.00
5/13/2010	Cash	E-BRCCP	$3,000.00	$0.00
10/6/2011	Cash	E-BRCCP	$250.00	$0.00
4/13/2011	Cash	E-BRCCP	$51.00	$0.00
2/16/2011	Cash	E-BRCCP	$8.28	$0.00
10/21/2008	Pay-Cash	E-BRCCP	$185.51	$0.00
10/20/2010	Pay-Cash	E-BRCCP	$147.75	$0.00
10/12/2010	Cash	E-BRCCP	$53.00	$0.00
11/17/2010	Cash	E-BRCCP	$10.00	$0.00
6/21/2012	Cash	E-BRCCP	$1,000.00	$0.00
2/28/2011	Cash	E-BRCCP	$25.00	$0.00
3/24/2010	Cash	E-BRCCP	$50.00	$0.00
10/15/2013	Cash	E-BRCCP	$14.70	$0.00
11/22/2013	Cash	E-BRCCP	$10.50	$0.00
2/27/2014	Cash	E-BRCCP	$6.30	$0.00
2/10/2014	Cash	E-BRCCP	$16.80	$0.00
5/21/2013	Cash	E-BRCCP	$27.13	$0.00
8/19/2013	Cash	E-BRCCP	$27.30	$0.00
8/28/2012	Cash	E-BRCCP	$146.23	$0.00
5/1/2012	Cash	E-BRCCP	$97.49	$0.00
4/3/2012	Cash	E-BRCCP	$77.99	$0.00
12/29/2011	Cash	E-BRCCP	$77.99	$0.00

Fund Profile
E-BRCCP

10/28/2011	Cash	E-BRCCP	$116.99	$0.00
7/26/2011	Cash	E-BRCCP	$116.99	$0.00
8/7/2007	Cash	E-BRCCP	$3.98	$0.00
12/16/2008	Cash	E-BRCCP	$39.15	$0.00
4/8/2014	Cash	E-BRCCP	$120.01	$0.00
11/19/2013	Cash	E-BRCCP	$180.01	$0.00
4/10/2013	Cash	E-BRCCP	$48.55	$0.00
2/14/2012	Cash	E-BRCCP	$9.00	$0.00
2/7/2012	Cash	E-BRCCP	$30.00	$0.00
1/15/2013	Cash	E-BRCCP	$73.01	$0.00
11/19/2012	Cash	E-BRCCP	$219.73	$0.00
8/6/2013	Cash	E-BRCCP	$120.00	$0.00
6/10/2013	Cash	E-BRCCP	$179.97	$0.00
4/14/2008	Cash	E-BRCCP	$2.95	$0.00
8/7/2008	Cash	E-BRCCP	$23.54	$0.00
8/12/2008	Cash	E-BRCCP	$234.90	$0.00
8/27/2008	Cash	E-BRCCP	$39.15	$0.00
9/23/2008	Cash	E-BRCCP	$39.15	$0.00
10/27/2008	Cash	E-BRCCP	$13.07	$0.00
10/31/2008	Cash	E-BRCCP	$39.15	$0.00
11/24/2008	Cash	E-BRCCP	$39.15	$0.00
1/15/2009	Cash	E-BRCCP	$7.43	$0.00
1/27/2009	Cash	E-BRCCP	$39.15	$0.00
4/29/2009	Cash	E-BRCCP	$7.39	$0.00
5/5/2011	Cash	E-BRCCP	$77.99	$0.00
1/8/2008	Cash	E-BRCCP	$1.88	$0.00
11/1/2007	Cash	E-BRCCP	$2.22	$0.00
2/19/2009	Cash	E-BRCCP	$200.00	$0.00
3/24/2011	Cash	E-BRCCP	$200.00	$0.00
2/23/2010	Cash	E-BRCCP	$200.00	$0.00
3/4/2008	Cash	E-BRCCP	$200.00	$0.00

Fund Profile
E-BRCCP

2/20/2007	Cash	E-BRCCP	$200.00	$0.00
2/10/2011	Cash	E-BRCCP	$20.00	$0.00
1/23/2012	Cash	E-BRCCP	$40.00	$0.00
12/30/2005	Cash	E-BRCCP	$40.00	$0.00

Join us at Chili's on October 2, 2013!

Professional Firefighters of Manchester
IAFF Local 1579
Tip-A-Firefighter Night

250 Buckland Street
Manchester, CT
5pm - 9pm
To benefit the Breast Care Collaborative Fund at ECHN
Celebrity Appearances & Prizes!

*****WITH THIS FLYER*****
Chili's will donate an additional
<u>10%</u> of their sales to our fundraiser!!!

ECHN community healthcare FOUNDATION

Chip Atzbach
Co-Chair Tip A Firefighter
Professional Firefighters of Manchester Local 1579

"Through our Tip A Firefighter Night The ManchesterFirefighters Union Local 1579 decided to keep the fundraising effort local. With ECHN and the DeQuattro Cancer Center having a large footprint in our community it really wasn't a hard decision where to focus our efforts"

"Our Pink T-shirt campaign is part of a National Program thru the International Association of Firefighters-IAFF in which Locals throughout the country sell and wear the Pink T-Shirts for the month if October and all profits go to Support Breast Cancer Research"

"We've had tremendous feedback from both the community and from Chili's that we are already planning on a similar effort next year"

Date: 8/4/2010
Type: Background/Personal
Description: Coffe Cart history

Title:
Author: Debra McCaig

The coffee cart was started in 1996. The suggestion was brought to the Volunteer Office by a cancer survivor who was a volunteer. The first donation was for $10,000 to the building fund for the Cancer Center. The coffee cart has donated about $500,000 over the past 14 years towards cancer programs. This year we funded the Early Detection Program, Breast Care Collaborative, Oncology Education and the start of a survivorship program.

EXHIBIT Q 11-2

Fund 11-1.89

MMH:
Adult Ambulatory Administrative Education & Development

Fund Profile
M-BH-AED

the MMH Behavioral Health Adult Ambulatory Administrative Education & Developme

Fund Information

Fund ID:	M-BH-AED	Is Inactive?	No
Fund Description:	the MMH Behavioral Health Adult Ambul	Is Restricted?	Yes
Start Date:	7/19/2013	Date Added:	7/19/2013
End Date:		Added By:	Mary McGoldrick
Fund Category:	MMH Temporarily Restricted	Last Changed On:	7/19/2013
Overall Goal:	$0.00	Last Changed By:	Mary McGoldrick
		Import ID:	04107-543-0000000666

Notes:
To offset any and all excess costs in excess of ECHN tuition reimbursement, for the pursuit and completion of a Master's Degree related to the roles of Adult Ambulatory Behavioral Health Coordinator, Adult Ambulatory Behavioral Health Associate Director, or Adult Ambulatory Behavioral Health Director at Manchester Memorial Hospital. Costs may include tuition, books, supplies, travel, or any other miscellaneous expenses, including computer hardware and software. Release of funds can be made in advance of course completion, and may be based on estimates for a book/supply fund maintained by the institution for use in future semesters.

Attributes

Attribute Category	Description	Short Desc.	Date
Director/Manager	Walter Payne/Tom King		7/19/2013
Vice President	Mary Powers		7/19/2013

Gift History

Constituent Name	Date	Gift Type	Fund	Amount	Balance
	10/4/2013	Pay-Cash	M-BH-AED	$974.72	$0.00
	12/29/2013	Pay-Cash	M-BH-AED	$200.00	$0.00
	9/23/2014	Write Off	M-BH-AED	$2,300.00	$0.00
	9/29/2014	Pledge	M-BH-AED	$778.07	$778.07

EXHIBIT Q 11-2

Fund 11-1.90

MMH:
Drs.' Campbell and Oh Trophies

Fund Profile
M-DPTR

Dr's. Campbell & OH Trophies

Fund Information

Fund ID:	M-DPTR	Is Inactive?	No
Fund Description:	Dr's. Campbell & OH Trophies	Is Restricted?	No
Start Date:		Date Added:	8/3/2011
End Date:		Added By:	Mary McGoldrick
Fund Category:		Last Changed On:	4/10/2012
Overall Goal:	$0.00	Last Changed By:	Mary McGoldrick
		Import ID:	04107-543-0000000624

Notes:
The fund M-DPTR is to maintain the trays each year including the engraving of the low gross winners at the Daniel Paul Purcell MD Memorial Golf Classic tournament now titled the ECHN Mason & Purcell Golf Classic

Attributes

Attribute Category	Description	Short Desc.	Date
Director/Manager	Richard Silvia		4/10/2012
Vice President	Nina Kruse		4/10/2012

EXHIBIT Q 11-2

Fund 11-1.91

Woodlake:
Woodlake at Tolland Wishes Program

Fund Profile
WL-WW

the Woodlake at Tolland Wishes Program

Fund Information

Fund ID:	WL-WW	Is Inactive?	No
Fund Description:	the Woodlake at Tolland Wishes Program	Is Restricted?	No
Start Date:	2/3/2003	Date Added:	2/4/2003
End Date:		Added By:	llewis
Fund Category:	WAT Temporarily Restricted	Last Changed On:	4/13/2012
Overall Goal:	$0.00	Last Changed By:	Mary McGoldrick
		Import ID:	04107-054-0000000391

Notes:
These funds are used to grant "wishes" for long term care residents at Woodlake. Wishes include trip to NY, Limo Rides, Luncheon trips, and special outings.

Gifts made for listing names - honor/memorial in the Woodlake at Tolland 10th Anniversary Program Book.

Changed to WAT to coincide with Lilly's wishes.

Formerly WAT-Woodlake Wishes. Renamed by M. Linker 7/20.

Appeals

Appeal ID	Appeal Description	Start Date	End Date	Overall Goal
05WW	05 Woodlake Wishes	12/1/2004		$0.00

Attributes

Attribute Category	Description	Short Desc.	Date
Director/Manager	Ellen D'Alessandro		4/13/2012
Vice President	Ellen Belanger		4/13/2012

Gift History

Constituent Name	Date	Gift Type	Fund	Amount	Balance
	8/22/2013	Cash	WL-WW	$25.00	$0.00
	5/5/2010	Cash	WL-WW	$10.00	$0.00
	4/28/2011	Cash	WL-WW	$10.00	$0.00
	3/21/2006	Cash	WL-WW	$25.00	$0.00
	7/15/2004	Cash	WL-WW	$50.00	$0.00
	12/19/2007	Cash	WL-WW	$20.00	$0.00
	12/31/2011	Cash	WL-WW	$180.00	$0.00
	4/10/2006	Cash	WL-WW	$25.00	$0.00
	12/18/2003	Cash	WL-WW	$25.00	$0.00
	9/18/2003	Cash	WL-WW	$136.50	$0.00
	9/29/2006	Cash	WL-WW	$15.00	$0.00
	4/28/2011	Cash	WL-WW	$10.00	$0.00
	3/24/2004	Cash	WL-WW	$50.00	$0.00
	1/24/2005	Cash	WL-WW	$50.00	$0.00

Fund Profile
WL-WW

3/22/2012	Cash	WL-WW	$15.00	$0.00
11/9/2011	Cash	WL-WW	$50.00	$0.00
5/26/2005	Cash	WL-WW	$20.00	$0.00
10/27/2011	Cash	WL-WW	$200.00	$0.00
11/24/2003	Cash	WL-WW	$25.00	$0.00
6/2/2005	Cash	WL-WW	$100.00	$0.00
4/28/2011	Cash	WL-WW	$10.00	$0.00
12/31/2011	Cash	WL-WW	$100.00	$0.00
9/30/2004	Cash	WL-WW	$12.50	$0.00
9/30/2004	Cash	WL-WW	$12.50	$0.00
1/5/2004	Cash	WL-WW	$25.00	$0.00
5/5/2010	Cash	WL-WW	$20.00	$0.00
10/21/2008	Pay-Cash	WL-WW	$114.88	$0.00
10/10/2006	Cash	WL-WW	$25.00	$0.00
8/3/2007	Cash	WL-WW	$25.00	$0.00
4/13/2013	Cash	WL-WW	$50.00	$0.00
9/20/2006	Cash	WL-WW	$25.00	$0.00
10/25/2006	Cash	WL-WW	$100.00	$0.00
6/11/2009	Cash	WL-WW	$100.00	$0.00
5/27/2008	Cash	WL-WW	$25.00	$0.00
8/7/2006	Cash	WL-WW	$25.00	$0.00
4/28/2011	Cash	WL-WW	$5.00	$0.00
5/5/2010	Cash	WL-WW	$5.00	$0.00
12/31/2011	Cash	WL-WW	$150.00	$0.00
12/21/2004	Cash	WL-WW	$25.00	$0.00
12/31/2011	Cash	WL-WW	$50.00	$0.00
2/25/2004	Cash	WL-WW	$50.00	$0.00
3/13/2013	Cash	WL-WW	$50.00	$0.00
12/21/2004	Cash	WL-WW	$50.00	$0.00
7/31/2007	Cash	WL-WW	$25.00	$0.00
9/26/2006	Cash	WL-WW	$25.00	$0.00
10/10/2006	Cash	WL-WW	$20.00	$0.00
11/15/2005	Cash	WL-WW	$600.00	$0.00
10/17/2003	Cash	WL-WW	$420.00	$0.00
11/28/2005	Cash	WL-WW	$25.00	$0.00
10/14/2003	Cash	WL-WW	$25.00	$0.00
12/26/2006	Cash	WL-WW	$100.00	$0.00
12/12/2003	Cash	WL-WW	$200.00	$0.00
1/10/2005	Cash	WL-WW	$100.00	$0.00
12/29/2005	Cash	WL-WW	$50.00	$0.00
12/29/2005	Cash	WL-WW	$50.00	$0.00
3/7/2013	Cash	WL-WW	$40.00	$0.00
8/3/2007	Cash	WL-WW	$50.00	$0.00
10/17/2003	Cash	WL-WW	$25.00	$0.00
12/31/2011	Cash	WL-WW	$50.00	$0.00
11/7/2006	Cash	WL-WW	$25.00	$0.00
10/18/2011	Cash	WL-WW	$80.00	$0.00
5/5/2010	Cash	WL-WW	$10.00	$0.00
7/10/2012	Cash	WL-WW	$5.00	$0.00
4/28/2011	Cash	WL-WW	$5.00	$0.00
8/9/2007	Cash	WL-WW	$25.00	$0.00
8/3/2007	Cash	WL-WW	$20.00	$0.00
7/10/2012	Cash	WL-WW	$5.00	$0.00
5/5/2010	Cash	WL-WW	$10.00	$0.00
8/3/2007	Cash	WL-WW	$15.00	$0.00
10/31/2006	Cash	WL-WW	$100.00	$0.00

Fund Profile
WL-WW

11/17/2005	Cash	WL-WW	$10.00	$0.00
3/22/2013	Cash	WL-WW	$50.00	$0.00
5/5/2010	Cash	WL-WW	$10.00	$0.00
4/28/2011	Cash	WL-WW	$60.00	$0.00
5/5/2010	Cash	WL-WW	$55.00	$0.00
7/10/2012	Cash	WL-WW	$70.00	$0.00
3/21/2007	Cash	WL-WW	$100.00	$0.00
9/29/2006	Cash	WL-WW	$15.00	$0.00
5/2/2006	Cash	WL-WW	$300.00	$0.00
11/14/2011	Cash	WL-WW	$50.00	$0.00
1/18/2006	Cash	WL-WW	$25.00	$0.00
11/28/2005	Cash	WL-WW	$50.00	$0.00
4/28/2011	Cash	WL-WW	$10.00	$0.00
12/21/2004	Cash	WL-WW	$50.00	$0.00
5/14/2008	Cash	WL-WW	$25.00	$0.00
4/28/2004	Cash	WL-WW	$65.00	$0.00
10/12/2011	Cash	WL-WW	$75.00	$0.00
10/18/2011	Cash	WL-WW	$20.00	$0.00
5/23/2008	Cash	WL-WW	$25.00	$0.00
3/11/2013	Cash	WL-WW	$25.00	$0.00
8/7/2007	Cash	WL-WW	$25.00	$0.00
7/10/2012	Cash	WL-WW	$10.00	$0.00
11/2/2006	Cash	WL-WW	$50.00	$0.00
10/10/2011	Cash	WL-WW	$100.00	$0.00
5/5/2010	Cash	WL-WW	$10.00	$0.00
5/5/2010	Cash	WL-WW	$10.00	$0.00
4/28/2011	Cash	WL-WW	$5.00	$0.00
7/1/2004	Cash	WL-WW	$15.00	$0.00
8/3/2007	Cash	WL-WW	$25.00	$0.00
8/7/2006	Cash	WL-WW	$20.00	$0.00
2/11/2003	Cash	WL-WW	$30.00	$0.00
1/9/2004	Cash	WL-WW	$100.00	$0.00
12/21/2004	Cash	WL-WW	$25.00	$0.00
8/21/2013	Cash	WL-WW	$50.00	$0.00
7/8/2013	MG Pay-Cash	WL-WW	$50.00	$0.00
9/5/2006	Cash	WL-WW	$100.00	$0.00
4/28/2011	Cash	WL-WW	$10.00	$0.00
12/13/2005	Cash	WL-WW	$50.00	$0.00
1/9/2004	Cash	WL-WW	$10.00	$0.00
8/12/2004	Cash	WL-WW	$50.00	$0.00
7/20/2006	Cash	WL-WW	$50.00	$0.00
9/26/2006	Cash	WL-WW	$10.00	$0.00
12/21/2004	Cash	WL-WW	$150.00	$0.00
3/26/2013	Cash	WL-WW	$150.00	$0.00
7/31/2007	Cash	WL-WW	$100.00	$0.00
8/7/2006	Cash	WL-WW	$20.00	$0.00
12/31/2011	Cash	WL-WW	$250.00	$0.00
2/2/2006	Cash	WL-WW	$50.00	$0.00
4/2/2013	Cash	WL-WW	$25.00	$0.00
3/22/2013	Cash	WL-WW	$50.00	$0.00
8/3/2007	Cash	WL-WW	$25.00	$0.00
7/24/2007	Cash	WL-WW	$50.00	$0.00
9/30/2011	Pay-Cash	WL-WW	$1,000.00	$0.00
12/31/2011	Cash	WL-WW	$50.00	$0.00
12/21/2004	Cash	WL-WW	$50.00	$0.00

Fund Profile
WL-WW

9/26/2006	Cash	WL-WW	$15.00	$0.00
10/21/2008	Pay-Cash	WL-WW	$86.87	$0.00
12/31/2011	Cash	WL-WW	$50.00	$0.00
5/12/2004	Cash	WL-WW	$15.00	$0.00
10/20/2004	Cash	WL-WW	$1,041.50	$0.00
11/8/2006	Cash	WL-WW	$1,189.00	$0.00
11/8/2006	Cash	WL-WW	$15.75	$0.00
10/14/2011	Cash	WL-WW	$50.00	$0.00
12/31/2011	Cash	WL-WW	$25.00	$0.00
3/24/2004	Cash	WL-WW	$15.00	$0.00
4/24/2004	Cash	WL-WW	$77.00	$0.00
11/24/2003	Cash	WL-WW	$50.00	$0.00
10/17/2003	Cash	WL-WW	$50.00	$0.00
5/5/2010	Cash	WL-WW	$5.00	$0.00
3/28/2013	Cash	WL-WW	$100.00	$0.00
4/28/2004	Cash	WL-WW	$65.00	$0.00
8/9/2007	Cash	WL-WW	$25.00	$0.00
2/5/2003	Cash	WL-WW	$250.00	$0.00
1/18/2006	Cash	WL-WW	$25.00	$0.00
1/18/2006	Cash	WL-WW	$10.00	$0.00
11/1/2010	Cash	WL-WW	$170.00	$0.00
7/31/2007	Cash	WL-WW	$100.00	$0.00
12/21/2004	Cash	WL-WW	$50.00	$0.00
6/2/2005	Cash	WL-WW	$50.00	$0.00
3/13/2012	Cash	WL-WW	$25.00	$0.00
8/19/2007	Cash	WL-WW	$25.00	$0.00
6/2/2005	Cash	WL-WW	$50.00	$0.00
1/18/2006	Cash	WL-WW	$15.00	$0.00
9/18/2003	Cash	WL-WW	$50.00	$0.00
5/19/2008	Cash	WL-WW	$100.00	$0.00
4/17/2006	Cash	WL-WW	$50.00	$0.00
4/23/2003	Cash	WL-WW	$200.00	$0.00
3/10/2003	Cash	WL-WW	$25.00	$0.00
5/5/2010	Cash	WL-WW	$5.00	$0.00
4/28/2011	Cash	WL-WW	$5.00	$0.00
7/10/2012	Cash	WL-WW	$5.00	$0.00
8/22/2006	Cash	WL-WW	$10.00	$0.00
2/5/2003	Cash	WL-WW	$50.00	$0.00
8/7/2006	Cash	WL-WW	$25.00	$0.00
3/7/2013	Cash	WL-WW	$50.00	$0.00
3/13/2012	Cash	WL-WW	$25.00	$0.00
10/14/2011	Cash	WL-WW	$35.00	$0.00
4/28/2011	Cash	WL-WW	$5.00	$0.00
5/5/2010	Cash	WL-WW	$10.00	$0.00
4/22/2005	Cash	WL-WW	$60.00	$0.00
1/9/2004	Cash	WL-WW	$100.00	$0.00
12/23/2004	Cash	WL-WW	$85.00	$0.00
10/17/2003	Cash	WL-WW	$27.61	$0.00
5/7/2009	Cash	WL-WW	$20.00	$0.00
9/26/2006	Cash	WL-WW	$20.00	$0.00
1/18/2006	Cash	WL-WW	$100.00	$0.00
10/18/2011	Cash	WL-WW	$100.00	$0.00
5/26/2008	Cash	WL-WW	$500.00	$0.00
5/12/2008	Cash	WL-WW	$200.00	$0.00

EXHIBIT Q 11-2

Fund 11-1.92

ECHN Foundation:
Van Fund

Fund Profile
E-VAN

the ECHN Van Fund

Fund Information

Fund ID:	E-VAN	Is Inactive?	No
Fund Description:	the ECHN Van Fund	Is Restricted?	Yes
Start Date:		Date Added:	5/23/2014
End Date:		Added By:	Mary McGoldrick
Fund Category:		Last Changed On:	6/18/2014
Overall Goal:	$0.00	Last Changed By:	Mary McGoldrick
		Import ID:	04107-543-0000000671

Notes:
Created to track donations to a fund started by BACH members to purchase a new van for ECHN.

Gift History

Constituent Name	Date	Gift Type	Fund	Amount	Balance
	6/4/2014	Cash	E-VAN	$570.73	$0.00
	6/18/2014	Pay-Cash	E-VAN	$500.00	$0.00

Date: 5/23/2014 **Title:**
Type: Text (Letter, Email) **Author:**
Description: Re: Van Purchase

I'll commit to $[redacted]

From: Kontogiannis, Stan
Sent: Friday, May 23, 2014 10:26 AM

Cc: Kruse, Nina
Subject: Re: ECHN Van

http://www.lynchtoyota.com/certified/Toyota/2011-Toyota-Sienna-02a4c4670a0a006400745fa029ef0e18.htm

Dear CRC members,

I wanted to follow up with you regarding a discussion that came from our group a few months ago regarding purchasing a van to be used by ECHN for the benefit of both the patients. I have spoken to Mike Lynch and we have selected a certified used van which costs $23,995 with 34,725 miles. Mike has offered to give us that van at $19,700. Thank you Mike!

One of the benefactors of this van would be the Clinical Day School to use the van to transport patients to our Partial Hospital and Intensive Outpatient Programs during the school year and to and from the Programs in the summer. These are 3 and 4 hour programs for adolescents who need more intensive treatment than outpatient but do not need inpatient level of care.
The Clinical Day School currently has 36 adolescents in the Program and transport all of them. We will the use the van Monday- Friday.
2) Another potential use will be for when ECHN conducts health fairs in the community to transport the necessary staff and equipment.

The following commitments have been pledged:
$5,000 from [redacted]
THIS BRINGS OUR REQUESTED TOTAL NEEDED TO: $14,700.
I wanted to ask (one last time) to make the commitment. This stemmed from the fact that we were able to raise the necessary funds to complete the BH activity/dining room. Please feel free to email me personally today a commitment if you are ready and moving forward to Nina Kruse at (nkruse@echn.org <mailto:nkruse@echn.org>).
Thank you again for all your support,

Stan

EXHIBIT Q 11-2

Fund 11-1.93

RGH:
Risley Fund

Fund Profile
R-RIS

RGH-Risley Fund

Fund Information

Fund ID:	R-RIS	Is Inactive?	No
Fund Description:	RGH-Risley Fund	Is Restricted?	Yes
Start Date:		Date Added:	8/15/2003
End Date:		Added By:	llewis
Fund Category:	RGH Temporarily Restricted	Last Changed On:	4/23/2012
Overall Goal:	$0.00	Last Changed By:	Mary McGoldrick
		Import ID:	04107-054-0000000446

Notes:
Supports educational opportunites for the nursing staff.

Campaigns

Campaign ID	Campaign Description	Start Date	End Date	Overall Goal
RGH	Rockville General Hospital			$0.00

Attributes

Attribute Category	Description	Short Desc.	Date
Director/Manager	Mary Powers		4/23/2012
Vice President	Deb Parker		4/23/2012

EXHIBIT Q 11-2

Fund 11-1.94

Doris Fields

Fund Profile
R-DFIELDS

RGH Doris Fields -Hospice

Fund Information

Fund ID:	R-DFIELDS	Is Inactive?	No
Fund Description:	RGH Doris Fields -Hospice	Is Restricted?	Yes
Start Date:	3/20/2006	Date Added:	3/20/2006
End Date:		Added By:	jczaporowski
Fund Category:	RGH Temporarily Restricted	Last Changed On:	4/13/2012
Overall Goal:	$0.00	Last Changed By:	Mary McGoldrick
		Import ID:	04107-543-0000000525

Notes:
The Doris Fields Fund was money donated in memory of Doris Fields - this money is to be used to support the RGH Hospice unit is such a way as to provide a memorial to Doris Fields.

Campaigns

Campaign ID	Campaign Description	Start Date	End Date	Overall Goal
RGH	Rockville General Hospital			$0.00

Attributes

Attribute Category	Description	Short Desc.	Date
Director/Manager	Mary Powers/Phil Candito		4/13/2012
Vice President	Deb Parker		4/13/2012

Gift History

Constituent Name	Date	Gift Type	Fund	Amount	Balance
	3/27/2006	Cash	R-DFIELDS	$50.00	$0.00
	4/5/2006	Cash	R-DFIELDS	$100.00	$0.00
	4/5/2006	Cash	R-DFIELDS	$25.00	$0.00
	3/23/2006	Cash	R-DFIELDS	$100.00	$0.00
	5/2/2006	MG Pay-Cash	R-DFIELDS	$100.00	$0.00
	3/23/2006	Cash	R-DFIELDS	$25.00	$0.00
	3/27/2006	Cash	R-DFIELDS	$50.00	$0.00
	4/17/2006	Cash	R-DFIELDS	$100.00	$0.00
	3/23/2006	Cash	R-DFIELDS	$50.00	$0.00
	4/24/2006	Cash	R-DFIELDS	$40.00	$0.00
	4/26/2006	Cash	R-DFIELDS	$30.00	$0.00
	4/24/2006	Cash	R-DFIELDS	$25.00	$0.00
	4/10/2006	Cash	R-DFIELDS	$100.00	$0.00
	3/27/2006	Cash	R-DFIELDS	$10.00	$0.00

Gift Detail and Summary Report
R-DFIELDS

ECHN Proposed Asset Purchase by PMH
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Constituent Name	Date	Fund Description	Cash	Stocks	Pledge Bal	MG Pledge Bal
	5/2/2006	RGH Doris Fields -H	$100.00	$0.00	$0.00	$0.00
	4/26/2006	RGH Doris Fields -H	$30.00	$0.00	$0.00	$0.00
	4/24/2006	RGH Doris Fields -H	$40.00	$0.00	$0.00	$0.00
	4/24/2006	RGH Doris Fields -H	$25.00	$0.00	$0.00	$0.00
	4/17/2006	RGH Doris Fields -H	$100.00	$0.00	$0.00	$0.00
	4/10/2006	RGH Doris Fields -H	$100.00	$0.00	$0.00	$0.00
	4/5/2006	RGH Doris Fields -H	$100.00	$0.00	$0.00	$0.00
	4/5/2006	RGH Doris Fields -H	$25.00	$0.00	$0.00	$0.00
	3/27/2006	RGH Doris Fields -H	$50.00	$0.00	$0.00	$0.00
	3/27/2006	RGH Doris Fields -H	$50.00	$0.00	$0.00	$0.00
	3/27/2006	RGH Doris Fields -H	$10.00	$0.00	$0.00	$0.00
	3/23/2006	RGH Doris Fields -H	$100.00	$0.00	$0.00	$0.00
	3/23/2006	RGH Doris Fields -H	$25.00	$0.00	$0.00	$0.00
	3/23/2006	RGH Doris Fields -H	$50.00	$0.00	$0.00	$0.00
		Grand Totals:	**$805.00**	**$0.00**	**$0.00**	**$0.00**

14 Gift(s) listed
14 Donor(s) listed

EXHIBIT Q 11-2

Fund 11-1.95

Woodlake:
Resident Council Fund

Fund Profile
WL-RCF

WAT-Resident Council Fund

Fund Information

Fund ID:	WL-RCF	Is Inactive?	No
Fund Description:	WAT-Resident Council Fund	Is Restricted?	Yes
Start Date:		Date Added:	1/22/2002
End Date:		Added By:	ksantasiere
Fund Category:	WAT Temporarily Restricted	Last Changed On:	4/13/2012
Overall Goal:	$0.00	Last Changed By:	Mary McGoldrick
		Import ID:	04107-054-0000317

Notes:
The fund is an account funded by the residents of Woodlake at Tolland. The goal is to provide the residents a mechanism for self-expression and self-determination. All residents are automatically members of the council and have a right to participate in elections and other activities. The duty of the council is to represent their constituents at the meetings. The Resident Council is mandated by the State of Connecticut as a part of the Reisdents Bill of Rights. All monies are raised by the residents, for the residents and voted how to be utilized by the residents of Woodlake.

Campaigns

Campaign ID	Campaign Description	Start Date	End Date	Overall Goal
WAT	Woodlake at Tolland			$0.00

Attributes

Attribute Category	Description	Short Desc.	Date
Director/Manager	Laurie Alves		4/13/2012
Vice President	Ellen Belanger		4/13/2012

Gift History

Constituent Name	Date	Gift Type	Fund	Amount	Balance
	2/22/2007	Cash	WL-RCF	$115.05	$0.00
	3/13/2007	Cash	WL-RCF	$139.00	$0.00
	5/30/2014	Cash	WL-RCF	$20.00	$0.00
	6/16/2014	Cash	WL-RCF	$10.00	$0.00
	9/24/2001	Cash	WL-RCF	$25.00	$0.00
	10/25/2001	Cash	WL-RCF	$50.00	$0.00
	9/24/2001	Cash	WL-RCF	$20.00	$0.00
	5/28/2014	Cash	WL-RCF	$20.00	$0.00
	9/24/2001	Cash	WL-RCF	$25.00	$0.00
	10/7/2005	Cash	WL-RCF	$50.00	$0.00
	9/24/2001	Cash	WL-RCF	$20.00	$0.00
	5/29/2014	Cash	WL-RCF	$25.00	$0.00
	9/24/2001	Cash	WL-RCF	$350.00	$0.00
	9/24/2001	Cash	WL-RCF	$20.00	$0.00
	9/24/2001	Cash	WL-RCF	$25.00	$0.00
	5/30/2014	Cash	WL-RCF	$25.00	$0.00
	6/18/2014	Cash	WL-RCF	$25.00	$0.00
	7/8/2014	Cash	WL-RCF	$25.00	$0.00

EXHIBIT Q 11-2

Fund 11-1.96

ECHN Foundation:
$10,000 One-Life Charitable Gift Annuity
(Name of Annuitant Withheld)

ECHN Community HealthCare Foundation, Inc.
GIFT ANNUITY AGREEMENT

One Life - Donor is the Annuitant
Immediate Payments

This Agreement is made between, _____
06074 (hereinafter "the Donor"), and the ECHN Community HealthCare Foundation, Inc., 71 Haynes St. Manchester, CT 06040 (hereinafter "the Foundation").

1. **Transfer of Property by Donor**
The Foundation certifies that the Donor, as an evidence of his desire to support the work of the Foundation and to make a charitable gift, on December 31st, 2006 contributed to the Foundation the property described in Schedule A attached hereto, the fair market value of which is $10,000.

2. **Payment of Annuity**
In consideration of the property transferred by the Donor, the Foundation shall pay an annual annuity of $640.00 from the date of this Agreement and shall pay such amount to the Annuitant as described herein, so long as she is living.

3. **Payment Dates; First Installment**
The annuity shall be paid in quarterly installments of $160.00. The first installment shall be payable on March 31, 2007 in the amount of $160.00 which is the first full quarterly payment and any prorated payment based on number of days in the initial payment period. Subsequent installments beginning on June 30, 2007 and continuing every quarter thereafter shall be in the full amount of $160.00.

4. **Identification and Birth Date of Annuitant**
The Donor has identified the Annuitant of this CGA as
Annuitant's date of birth is

5. **Irrevocability; Non-assignability; Termination**
This annuity is irrevocable and non-assignable, except that it may be assigned to the Foundation. The Foundation's obligation under this Agreement shall terminate with the regular payment preceding the Annuitant's death.

6. **Uses and Purposes of Gift**
Upon the Foundation's satisfaction of its obligation under this Agreement, an amount equal to the residuum of the gift shall be used by the Foundation for Enhancements to the ICU Unit at Manchester Memorial Hospital.

7. **Entire Agreement; Governing Law**
This Agreement, together with Schedule A attached hereto, constitutes the entire agreement of the parties. This Agreement shall be governed by the laws of the State of Connecticut.

This Agreement is effective as of December 31st, 2006.

DONOR:

ECHN Community HealthCare Foundation, Inc.

By: _____

Sondra Lintelmann-Dellaripa
Vice President, Development

10-2003-00200
10-9470-74661

JAN 2 9 2007

Gift Annuity Agreement Between
and
the ECHN Community HealthCare Foundation, Inc.

SCHEDULE A

Description of Property

Personal check for $10,000.

EXHIBIT Q 11-2

Fund 11-1.97

Barton Family Trust
(Trust u/w Mary K. Barton)

Unrestricted

LAST WILL AND TESTAMENT

OF

MARY K. BARTON

KNOW ALL MEN BY THESE PRESENCE, that I, **MARY K. BARTON**, of the Town of South Windsor, County of Hartford and State of Connecticut, being of lawful age, of sound and disposing mind, memory and judgment, do hereby make, publish and declare this to be my Last Will and Testament, hereby revoking all previous Wills and Codicils by me at any time heretofore made.

FIRST: I direct my Co-executors, hereinafter named, to pay my just debts, except such as at the time of my death may be secured by mortgage, if any, and my funeral and administration expenses, and I further direct my said Co-executors to pay all the estate, inheritance, succession, legacy and transfer taxes imposed by and made payable under the laws of the United States or this State or any other state or country by reason of my death, and to charge such payments against the residue of my estate as an administration expense, and I further direct that such payments shall not be prorated or apportioned among or charged against the respective devisees, legatees, beneficiaries, transferees or other recipients or be charged against any property passing or which may have passed to any of them.

SECOND: All the rest, residue and remainder of my estate, real personal and mixed, and wheresoever the same may be situated, of which I may die seized or possessed, or to which I may in any manner be entitled at the time of my death, I give, devise and bequeath unto my sister, **ANNA H. BARTON**, to be hers absolutely and forever and provided she shall survive me.

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THIRD: In the event that my sister, ANNA H. BARTON, does not survive me, then in that event, I give and bequeath unto the following named individuals, if living at the time of my death, the sums set opposite their names, to be theirs absolutely and forever:

A.	Stanley Colney & Natalie Colney Or the survivor Southington, CT	$3,000.00
B.	Anastasia Dondero South Windsor, CT	$3,000.00
C.	Richard West & Virginia West Or the survivor Canton Center, CT	$3,000.00
D.	Barry West & Elaine West Or the survivor Camas, Washington	$3,000.00
E.	Stanley Waldron & Viola Waldron Or the survivor South Windsor, CT	$3,000.00
F.	Catherine Wialy Reilly 46 Enfield Terr., Enfield, CT	$1,000.00
G.	Anna Wialy Thompsonville, CT	$1,000.00
H.	Nancy Gill Dorchester, MA	$1,000.00
I.	Sophie Kupchunos South Windsor, CT	$1,000.00
J.	St. Catherines Church Broad Brook, CT	$3,000.00
K.	St. Margaret Mary Church South Windsor, CT	$3,000.00
L.	Irving R. Trinks & Nancy Trinks Or the survivor Griffin Road, South Windsor, CT	$3,000.00
M.	Robert S. Starr, III & Edith Starr Or the survivor South Windsor, CT	$3,000.00
N.	Miriam (Baker) Steere Providence, Rhode Island	$1,000.00

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O. Joseph Belazaras & Albina Belazaras $3,000.00
Or the survivor
South Windsor, CT

P Adam Wisniewski & Cecelia Wisniewski $2,000.00
Or the survivor
South Windsor, CT

Q. Marjorie Files Harvey $1,000.00
Kennebunk, Maine

R. Nancy Colney, $1,000.00
Southington, CT

S. Elizabeth West $1,000.00
Canton Center, CT

T. Gertrude Perry $1,000.00
Tariffville, CT

FOURTH: If my sister, ANNA H. BARTON, does not survive me, then all the rest, residue and remainder of my estate, real, personal and mixed, together with any lapsed legacies, I give, devise and bequeath unto the SHAWMUT BANK, with offices in Hartford, Connecticut, or its successors, as Trustee of a certain trust to be known as the BARTON FAMILY TRUST.

I ORDER AND DIRECT my Trustee to invest and re-invest all the assets in the trust account as it, in its absolute discretion, deems fit and to pay all of the net income thereof in convenient installments at least quarter/annually to or for the benefit of, the Manchester Memorial Hospital.

If the Manchester Memorial Hospital or its lawful successor is no longer in existence, or if it is not then a charitable organization within the meaning of the Internal Revenue Code, the net income shall be distributed to one or more organizations selected by the trustee, each of which is a charitable organization as defined in Sections 170(c) and 2055(a) of the Internal Revenue Code of 1986, as

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amended from time to time, in such proportions among such organizations as the trustee shall decide.

FIFTH: In addition to all powers granted by law to my trustee, the trustee shall have the additional powers enumerated herein:

1. To retain for any period of time without limitation, and without liability for loss or depreciation in value, any property transferred to the trustee, including partnership interests (whether general, special, or limited), even though the trustee could not properly purchase the property as a trust investment and though its retention might violate principles of investment diversification;

2. To sell at public or private sale, wholly or partly for cash or on credit, contract to sell, grant or exercise options to buy, convey, transfer, exchange, or lease (for a term within or extending beyond the term of the trust) any real or personal property of the trust, and to partition, dedicate, grant easements in or over, subdivide, improve, and remodel, repair, or raze improvements on any real property of the trust, and in general to deal otherwise with the trust property in such manner, for such prices, and on such terms and conditions as any individual might do as outright owner of the property;

3. To borrow money at interest rates then prevailing from any individual, bank, or other source, and to create security interests in the trust property by mortgage, pledge, or otherwise;

4. To invest in bonds, common or preferred stocks, notes, real estate mortgages, common trust funds, shares of

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regulated investment companies (including any participation in an investment company registered under the Investment Company Act of 1940 for which the corporate trustee or an affiliate of the corporate trustee is acting as investment advisor, custodian or administrator), currencies, partnership interests (whether general, special, or limited), or other securities or property, real or personal, domestic or foreign, without being limited by any statute or rule of law governing investment by trustees;

5. To exercise in person or by general or limited proxy all voting and other rights, powers, and privileges and to take all steps to realize all benefits with respect to stocks or other securities and to enter into or oppose, alone or with others, voting trusts, mergers, consolidations, foreclosures, liquidations, reorganizations, or other changes in the financial structure of any corporation;

6. To cause any security or other property to be held, without disclosure of any fiduciary relationship, in the name of the trustee, in the name of a nominee, or in unregistered form;

7. To pay all expenses incurred in the administration of the trust, including reasonable compensation to any trustee, and to employ or appoint and pay reasonable compensation to accountants, depositaries, investment counsel, attorneys, attorneys-in-fact, and agents (with or without discretionary powers);

8. To deal with the fiduciary or fiduciaries of any other trust or estate, even though the trustee is also the

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fiduciary or one of the fiduciaries of the other trust or estate;

9. To compromise or abandon any claim in favor of or against the trust;

10. To execute instruments of any kind, including instruments containing covenants and warranties binding upon and creating a charge against the trust property and containing provisions excluding personal liability;

11. To perform all other acts necessary for the property management, investment, and distribution of the trust property.

12. To the extent that such requirements can legally be waived, no trustee hereunder shall ever be required to give bond or security as trustee, or to qualify before, be appointed by or account to any court, or to obtain the order or approval of any court with respect to the exercise of any power or discretion granted in this instrument;

13. The trustee's exercise or nonexercise of powers and discretions in good faith shall be conclusive on all persons. No person paying money or delivering property to the trustee hereunder shall be required or privileged to see to its application. The certificate of the trustee that the trustee is acting according to this instrument shall fully protect all persons dealing with a trustee.

I NOMINATE AND APPOINT my friend EDITH STARR, of South Windsor, Connecticut and THE SHAWMUT BANK with offices in Hartford, Connecticut, as Co-Executors of this my Last Will and Testament. Neither Executor under this Will shall be required to furnish bond or other security as Executor for their qualification.

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In addition to all powers granted by law I give my Co-executors power, exercisable in their discretion and without court order, to retain, sell (at public or private sale), exchange, lease for any term (even though commencing in the future or extending beyond the date of final distribution of my estate), mortgage, pledge, or otherwise deal for any purpose with the property, real or personal, from time to time comprising my estate, for such consideration and on such terms (with or without security) as my Co-executors shall determine, to borrow money for any purpose, at interest rates then prevailing, from any individual, bank of other source, irrespective of whether that lender is then acting as Co-executor to invest in any property whatsoever to compromise or abandon any claims in favor of or against my estate; to hold any property in the name of a nominee or in bearer form; to employ accountants, depositaries, attorneys, and agents (with or without discretionary powers); to execute contracts, notes, confines, and other instruments, including instruments containing covenants and warranties binding upon and creating a charge against my estate, and containing provisions excluding personal liability; to make distributions wholly in cash or in kind, or partly in cash.

I direct that the compensation of the corporate executor, if any, shall be in accordance with its published schedule of fees as in effect at the time the services are rendered, and compensation due the Co-Executrix, being in accordance with the standard practice in force as of the time of my death.

ECHN Proposed Asset Purchase by PMH
Submitted October 13, 2015

IN WITNESS WHEREOF, I have hereunto set my hand and seal at the Town of West Hartford, Connecticut, this 1st day of February, A.D., 1993.

Mary K. Barton

Signed, Sealed, Published and declared by the said MARY K. BARTON, as and for her last Will and Testament, in the presence of us, who at her request, in her presence and in the presence of each other, have hereunto subscribed our names as witnesses on the 1st day of February, A.D., 1993.

WITNESSES ADDRESSES

Eileen M Scott of West Hartford

[illegible] of [illegible]

STATE OF CONNECTICUT)
: ss. West Hartford
COUNTY OF HARTFORD)

We, the within named Eileen M Scott and [illegible], being duly sworn, make affidavit and say: That we severally attested the within and foregoing Will of the within named Testatrix and subscribed the same in her presence, and at her request and in the presence of each other; that the said Testatrix signed, published and declared the said instrument as and for her Last Will and Testament in our presence on the 1st day of February, A.D., 1993, and at the time of execution of said Will, said Testatrix was more than eighteen years of age and of sound mind, memory and judgment, and under no improper influence or restraint to the best of our knowledge and belief, and we make this affidavit at the request of said Testatrix.

Eileen M Scott

[illegible]

STATE OF CONNECTICUT)
: ss. West Hartford
COUNTY OF HARTFORD)

Then personally appeared before me, EDWARD R. KUEHN, duly qualified to administer oaths.

and [illegible] subscribed and make oath to the truth of the foregoing affidavit

Commissioner of the Superior Court

EXHIBIT Q 11-2

Fund 11-1.98

The Addison L. Clark Fund
(Trust u/w Luella C. Hale)

W I L L

. . . .

I, LUELLA C. HALE, now residing in the Town of East Hartford, County of Hartford, and State of Connecticut, hereby revoking any and all Wills and Codicils by me heretofore made, do make, publish and declare this to be my last Will and Testament.

ARTICLE I. I direct that all of my just debts and funeral expenses shall be paid by my Executor hereinafter named as soon as may be possible after my death, and I further direct that all Inheritance, Transfer and Succession Taxes be paid by my Executor out of residue of my estate and that specific legacies be paid in full to the beneficiaries.

ARTICLE II. I give to THE FIRST NATIONAL BANK OF HARTFORD, a corporation organized under the laws of the United States of America, located in the City of Hartford, in the County and State aforesaid, the sum of Fifty Thousand Dollars ($50,000), in trust however, to take, hold invest and reinvest the same and to pay the income therefrom to my nephew, ARTHUR R. BREWER, of Hockanum, Connecticut. Upon the death of my said nephew, Arthur R. Brewer, the trust herein created shall cease and be determined, and the fund then in my said Trustee's hands shall be paid over as a part of the residue of my estate.

ARTICLE III. I give the sum of Ten Thousand Dollars ($10,000) to my half brother, BURTON G. BREWER, of the Village of Hockanum, Town of East Hartford, Connecticut, to be his absolutely; or in the event that he should predecease me, then I give said sum of Ten Thousand Dollars ($10,000) to ARTHUR R. BREWER, to be his absolutely.

ARTICLE IV. I give the sum of Thirty Thousand Dollars ($30,000), my clothing and household furniture to OLIVE L. SCHOENBORN, daughter of Leroy E. Hale, of Burnside, Connecticut, to be hers absolutely.

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ARTICLE V. I give to LUELLA CLARK HALE, daughter of Leroy E. Hale, of Rockville, Connecticut, the sum of One Thousand Dollars ($1,000) and my cluster diamond ring.

ARTICLE VI. I give and devise to FREDERICK HOLLAND, of East Hartford, Connecticut, all of the right, title and interest which I may have at the time of my decease in and to a certain piece or parcel of land, with the buildings thereon and furnishings thereof, located at the corner of Silver Lane and Knollwood Road in the Town of East Hartford, County of Hartford and State of Connecticut, known as No. 5 Knollwood Road; and I further give to the said FREDERICK HOLLAND the sum of Thirty Thousand Dollars ($30,000), to be his absolutely.

ARTICLE VII. I give the sum of Fifteen Thousand Dollars ($15,000) to EMMELINE CHIPMAN, of Manchester, Connecticut; and the sum of Five Thousand Dollars ($5,000) to DOROTHY THORPE, of South Manchester, Connecticut, to be theirs absolutely.

ARTICLE VIII. I give the sum of Ten Thousand Dollars ($10,000) to IDA M. CARPENTER, of Bolton, Connecticut, or her heirs; to be theirs absolutely.

ARTICLE IX. I give the sum of Five Thousand Dollars ($5,000) to each of the following:

ETHEL TOURTELLOTT, of Putnam, Connecticut, or her heirs, and MABEL CLARK ANDREWS, of Glastonbury, Connecticut, or her heirs; to be theirs absolutely.

ARTICLE X. I give to REBECCA CLARK FLYNT, widow of Rufus Flynt, of Palmer, Massachusetts, my diamond brooch; and I give to DOROTHY LANDER, daughter of Cooper Robeson, my solitarie diamond ring; and I further give to the said REBECCA CLARK FLYNT and the said DOROTHY LANDER, to each of them, the sum of Thirty Thousand Dollars ($30,000).

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ARTICLE XI. I give to THE FIRST NATIONAL BANK OF HARTFORD the sum of Twenty Thousand Dollars ($20,000), in trust, however, to hold and manage, invest and reinvest, and to pay over the income derived therefrom to the TRUSTEES OF THE MANCHESTER MEMORIAL HOSPITAL, to be used for such general hospital charges and expenses as said Trustees shall deem best, said fund to be known as "THE ADDISON L. CLARK FUND."

ARTICLE XII. I give to THE FIRST NATIONAL BANK OF HARTFORD the sum of Six Thousand Dollars ($6,000), in trust, however, to hold and manage, invest and reinvest, and to pay over the income therefrom to THE NEWINGTON HOME FOR CRIPPLED CHILDREN, located at Newington, Connecticut, or by whatever other name it may be known, to be used for the general charges and expenses of said Home, said fund to be known and designated as "THE LUELLA CLARK HALE MEMORIAL FUND."

ARTICLE XIII. I give to THE FIRST NATIONAL BANK OF HARTFORD the sum of Six Thousand Dollars ($6,000), in trust, however, to hold and manage, invest and reinvest, and to pay over the income therefrom to THE CONNECTICUT HUMANE SOCIETY, to be used for the general charges and expenses of said Society.

ARTICLE XIV. I give to THE FIRST NATIONAL BANK OF HARTFORD the sum of Six Thousand Dollars ($6,000), in trust, however, to hold and manage, invest and reinvest, and to pay over the income therefrom to THE CONNECTICUT INSTITUTE FOR THE BLIND, located in Hartford, Connecticut, to be used for the general charges and expenses of said institution.

ARTICLE XV. I give to said THE FIRST NATIONAL BANK OF HARTFORD the sum of Three Hundred Dollars ($300), in trust, however, to hold and manage, invest and reinvest, and to use the income therefrom for the perpetual care of the cemetery lots of Addison L. Clark and Justus W. Hale, located in the South Manchester Cemetery.

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ARTICLE XVI. I direct my Executor hereinafter named to procure and erect at my grave a suitable headstone.

ARTICLE XVII. I give and devise all of the rest, residue and remainder of my property, real and personal, of which I may die seized or possessed or in which I may have an interest at the time of my death, wherever the same may be located or found, to THE FIRST NATIONAL BANK OF HARTFORD, in trust, nevertheless, to hold and manage, invest and reinvest, and the income from such fund to be disbursed in accordance with the provisions of the resolution adopted by said Trustee providing for the establishment of "THE HARTFORD FOUNDATION FOR PUBLIC GIVING."

ARTICLE XVIII. I NOMINATE AND APPOINT THE FIRST NATIONAL BANK OF HARTFORD Executor of this, my last Will, and I authorize and empower my said Executor to settle any of the legacies provided in my Will by delivering to the legatee property or securities in its hands of the fair value of the amount of the legacy, without further accountability therefor.

IN WITNESS WHEREOF, I have hereunto set my hand and seal at Hartford, Connecticut, this 7th day of February, 1938.

Luella C. Hale (L.S.)

Signed, sealed, published and declared by the above Testatrix, LUELLA C. HALE, as and for her last Will and Testament in our presence and in the presence of each of us, who, at her request, in her presence and in the presence of each other, have hereunto subscribed our names as witnesses.

Christina K. Brand	of	Hartford, Conn.
Carlos S. Holcomb	of	West Hartford Conn.
John J. Wurdig	of	Bloomfield, Conn.

State of Connecticut,)
:ss. Hartford, February 7th, 1938
County of Hartford,)

We, two of the above named witnesses, Christina K. Brand and Carlos S. Holcomb, being duly sworn, depose and say that we, together with the above named John J. Wurdig, witnessed the foregoing Will of the foregoing named Testatrix, LUELLA C. HALE, and all three of us subscribed the same in her presence and in the presence of each other, and at her request; that at the time of the execution of said Will the said Testatrix, LUELLA C. HALE, appeared to us to be of full age and of sound mind and memory and under no undue influence or restraint to the best of our knowledge and belief; that she signed said Will and declared the same to be her last Will and Testament in our presence and in the presence of the said John J. Wurdig, and that we make this affidavit at the request of the said Testatrix, LUELLA C. HALE.

Christina K. Brand

Carlos S. Holcomb

Subscribed and sworn to by the foregoing named witnesses at the request of the foregoing named Testatrix, LUELLA C. HALE, on the day and at the place above written, before me

John J. Wurdig
Justice of the Peace

EXHIBIT Q 11-2

Fund 11-1.99

The Willie T. Morton Fund
(Trust u/w Willie T. Morton)

Extra copy

Certified copy

WS

PLEASE RETURN TO
THE HARTFORD-CONNECTICUT TRUST COMPANY
TRUST DEPARTMENT
HARTFORD 15, CONN.

PLEASE RETURN TO
THE HARTFORD-CONNECTICUT TRUST COMPANY
TRUST DEPARTMENT
HARTFORD 15, CONN.

LAST WILL and TESTAMENT

of

WILLIE T. MORTON

Will proved and approved and admitted to probate May 2, 1925, in the Probate Court for the District of Manchester, Connecticut. : : :

I, WILLIE T. MORTON, of Manchester, Connecticut, being of sound and disposing mind, memory and understanding, do make, publish and declare this to be my Last Will and Testament, hereby revoking all other wills heretofore made by me.

FIRST: Whereas I have made provision for my present wife by agreement executed before my marriage under which the sum of Twenty Thousand (20,000) Dollars will be paid to my said wife as a claim upon my estate, I now hereby confirm said agreement and I have taken the same into consideration in the provisions set out in this will.

SECOND: I direct that all my just debts and funeral expenses be paid as soon as conveniently can be after my decease, and that all succession, legacy, transfer or inheritance taxes be paid by my Executor out of the residue of my estate as an expense in the settlement thereof.

THIRD: I request that my funeral be conducted by the Manchester Lodge of Masons, No. 73, A. F. & A. M., of which I am a member.

FOURTH: I give and bequeath to each child of mine that may survive me the sum of Twenty Thousand (20,000) Dollars; but if any such child should be under the age of twenty-five (25) years at the date of my death, I direct that the legacy to such child shall be held by The Hartford-Connecticut Trust Company, of Hartford, Connecticut, as Trustee, IN TRUST; and I further direct that said Trustee shall use the income or part of the principal, if necessary in its judgment, for the care, support and education of such child until such child shall reach the age of twenty-five (25) years; and I direct that when such child shall reach the age of twenty-five (25) years, all of said funds then remaining in said Trustee's hands shall be paid, transferred and delivered to such child. If any such child should die before reaching the age of twenty-five (25) years, I direct that all funds then held for such child by my said Trustee shall be distributed equally to the children of such child by my said Trustee; and if there be no children of such child then living, I direct that said fund shall be added to the residue of my estate.

FIFTH: During the life of my brother, John E. Morton, I entered into a verbal agreement with him by which my brother agreed to make no will and to allow his entire property to pass to me as his next-of-kin, and in consideration of the same I agreed to make certain bequests by my will, these bequests being the ones hereinafter set out as such.

SIXTH: I hereby direct my Executor to expend, or cause to be expended a sum not to exceed Fifteen Thousand (15,000) Dollars for the erection of a new monument and for the repair or replacement of headstones, and for grading and other improvements on the Morton family lot in the cemetery at Windsorville, Connecticut, where my father, mother and brothers are buried. It is my will that my Executor need not expend the exact sum of Fifteen Thousand (15,000) Dollars, but shall use its discretion in such expenditure. This is in accordance with the agreement with my brother referred to in the Fifth Clause.

SEVENTH: I give and bequeath to my wife, Laura B. Morton, all articles of household or personal use or adornment and any automobiles which I may own at the date of my death, wherever the same may be located.

EIGHTH: I give and bequeath to The Hartford-Connecticut Trust Company, of Hartford, Connecticut, as Trustee, IN TRUST, the sum of One Hundred Ten Thousand (110,000) Dollars, the same to be held, managed and disposed of as hereinafter provided:—

A. I direct that my Executor may pay said sum of One Hundred Ten Thousand (110,000) Dollars in cash or securities; and if paid in securities, the same shall be valued by my said Executor at the market rate at the date of payment, but all mortgages shall for this purpose be delivered at their face value.

B. I direct that the sum of Twenty Thousand (20,000) Dollars shall be set apart by my Trustee, and the income therefrom shall be paid to my cousin, Miss Julia A. E. Buck, of Glenolden, Pennsylvania, during her life; and upon her death, or if she should predecease me, then upon my death, I direct that the said income shall be paid to Mrs. David Winters, aunt of my said cousin, who lives with her, during the life of said Mrs. Winters. Such income shall be paid semi-annually, or oftener, at the discretion of my said Trustee, or may be applied for the care, comfort and support of the recipient of said income. Upon the death of the survivor of said Miss Julia A. E. Buck and said Mrs. David Winters, or upon my death if they should both predecease me, I direct that said sum shall be added to the rest and residue of my estate.

C. I direct that the sum of Ten Thousand (10,000) Dollars shall be set apart by my Trustee, and the income therefrom shall be paid semi-annually, or oftener, in the discretion of said Trustee, to the Methodist Church, of Windsorville, Connecticut, said income to be used by said church for its general purposes.

D. I direct that the sum of Five Thousand (5,000) Dollars shall be set apart by my Trustee, and the income therefrom shall be paid semi-annually, or oftener, in the discretion of said Trustee, to the Second Congregational Church, of Manchester, Connecticut.

E. I direct that the sum of Ten Thousand (10,000) Dollars shall be set apart by my Trustee, and the income therefrom shall be paid semi-annually, or oftener, in the discretion of said Trustee, to the Salvation Army, of South Manchester, Connecticut.

F. I direct that the sum of Five Thousand (5,000) Dollars shall be set apart by my Trustee, and the income therefrom shall be paid semi-annually, or oftener, in the discretion of said Trustee, to the Manchester Lodge of Masons, No. 73, A. F. & A. M., of which I am a member.

G. I direct that the sum of Five Thousand (5,000) Dollars shall be set apart by my Trustee, and the income therefrom shall be paid semi-annually, or oftener, in the discretion of said Trustee, to the Temple Chapter, No. 3, Order of Eastern Star, of Manchester, Connecticut, of which I am a member.

H. I direct that my said Trustee shall set apart the sum of Forty Thousand (40,000) Dollars, and the income therefrom shall be paid by my said Trustee semi-annually, or oftener, in its discretion, to the East Windsor Cemetery Association, or to the Town of East Windsor, at the discretion of my said Trustee, such income to be used by said cemetery association or said town for making improvements in and beautifying and maintaining the Windsorville Cemetery. Said cemetery association or town after using said income shall render annually a written report to my Trustee of the use of said income, and my said Trustee shall annually examine said cemetery and ascertain the use made of said income. Should my said Trustee in any year determine that said income is not being employed in a profitable manner as above provided, I direct that it shall make other arrangements for the use of the income of said fund for making improvements in, beautifying and maintaining said cemetery. This bequest is in accordance with the agreement with my brother referred to in the Fifth Clause.

I. I direct that my said Trustee shall set apart the sum of Five Thousand (5,000) Dollars, and shall use the income therefrom each year in maintaining and beautifying the Morton family lot in the Windsorville Cemetery, where my father and mother are buried, and the stones and monuments of said lot. This may be expended for annual care, improvements, of any type, trees, bushes, or flowers, or improvements or replacement of stones, in the discretion of my Trustee. This is in accordance with the agreement with my brother referred to in the Fifth Clause.

J. I direct that my said Trustee shall set apart the sum of Ten Thousand (10,000) Dollars, and shall pay the income semi-annually, or oftener, in its discretion, to my cousin, Ethel M. Hall, of Mystic, Connecticut, during her life, or my said Trustee may use said income for the care, comfort and support of my said cousin. Upon the death of my said cousin, said fund shall be added to the residue of my estate.

K. I hereby authorize and empower my said Trustee to hold any securities which may be received from my estate, or to sell the same and invest and reinvest any fund in its hands without being restricted by the laws or statutes of this or any other State, but I admonish my said Trustee to hol din mind at all times the security of the principal of such trust funds rather than the rate of income. Under the present conditions, I would advise the investment of said funds in first mortgages suitable for the investment of saings bank funds.

NINTH: I give and bequeath to The Hartford-Connecticut Trust Company, as Trustee, IN TRUST, the sum of One Hundred Thousand Dollars ($100,000), and I direct that the same be paid to said Trustee in cash or securities, and if paid in securities, the same shall be valued by my Executor at the market rate at the date of payment. I direct that if a Young Men's Christian Association of Manchester be in existence at the time of my death, or if one be formed after my death, and such Young Men's Christian Association in existence at my death or formed after my death shall comply with the conditions hereinafter set out, then my said Trustee shall pay such Young Men's Christian Association said sum of One Hundred Thousand (100,000) Dollars, with any accumulated interest. The conditions of this bequest to such Young Men's Christian Association are that it shall, within eight years after my death, obtain a suitable lot within one-quarter mile of Depot Square, Manchester, and erect thereon a suitable building for the work of such Young Men's Christian Association, the plans and location of such building to be approved by my said Trustee, the same to be substantially completed within eight years after my death; also that before commencing the erection of such building, said Young Men's Christian Association shall raise an additional sum of at least Ten Thousand (10,000) Dollars, the same to be held by the Association and safely invested and form the nucleus of an endowment fund. Should said Young Men's Christian Association secure said lot, said endowment fund, and obtain plans, approved by my said Trustee, and commence

the erection of such building so that there is a reasonable expectation of the completion of the same within eight years from the date of my death, then I authorize and empower my said Trustee to make payments from time to time during the erection of such building of reasonable parts of said sum of One Hundred Thousand (100,000) Dollars, to be used for payments on said building. I direct, however, that no payments be made to such Young Men's Christian Association or for such building previous to five years from the date of my death. It is my wish and desire that such Young Men's Christian Association shall cause to be engraved in a conspicuous place in the interior of said building in large gilt letters at least four (4) inches high, these words "Given in Memory of John E. and Willie T. Morton."

TENTH: In case the conditions set out in the preceding clause are not met with, and said sum of One Hundred Thousand Dollars ($100,000) is not paid to the Young Men's Christian Association in Manchester, then and in that event, I direct that if an association shall be formed in said Manchester within ten (10) years from the date of my death, to be known as The Morton Library Association, for the purpose of securing and obtaining a free circulating and reference library similar to the library now maintained in the City of Hartford, then I direct that my said Trustee shall utilize said sum of One Hundred Thousand (100,000) Dollars as follows: The sum of between Fifty Thousand (50,000) Dollars and Seventy-five Thousand (75,000) Dollars shall be used by my said Trustee for securing a lot and the erection of a library building, such lot and building to be secured and built by my said Trustee in conference with said Library Association, and to be the property of said Library Association; and the sum of Twenty-five Thousand (25,000) Dollars shall be expended for the purchase of books for said library by my said Trustee, also in conference with said Library Association, said books to be the property of said Library Association; and the remainder of said fund, with any accumulated income, shall be held by my said Trustee and the income therefrom be paid semi-annually, or oftener, to said Library Association for the care and maintenance of the same.

I direct that my said Trustee in holding any funds under this clause or the preceding clause, shall invest the same in the same manner as provided for in the Eighth Clause, Paragraph K, and while holding said fund pending the payment of the same to the Young Men's Christian Association, or the use of the same for The Morton Library Association, I direct that all income shall be accumulated and added to the principal.

ELEVENTH: If the conditions set out in the two preceding clauses shall not be met with, and said sum of One Hundred Thousand (100,000) Dollars shall not be paid to said Young Men's Christian Association or used for said The Morton Library Association, then I direct that said sum of One Hundred Thousand (100,000) Dollars, with accumulated interest, shall be disposed of by my said Trustee, as follows:—

A. I direct that the sum of Ten Thousand (10,000) Dollars shall be added to the trust fund hereinbefore provided for in Clause Eighth, Paragraph E, for the Salvation Army of South Manchester, the same to be held under the terms and conditions as set out in said Clause Eight, Paragraph E.

B. I direct that the sum of Ten Thousand (10,000) Dollars shall be added to the trust fund hereinbefore provided for in Clause Eighth, Paragraph C, for the Methodist Church, of Windsorville, Connecticut, the same to be held under the terms and conditions as set out in Clause Eighth, Paragraph C.

C. I direct that the sum of Ten Thousand (10,000) Dollars shall be added to the residue of my estate to be disposed of in the same manner as herein provided for said residue.

D. The remainder of said sum of One Hundred Thousand (100,000) Dollars, I direct shall be held by my said Trustee, and one-third of said income shall be paid to the Young Men's Christian Association of Hartford, Connecticut; one-third to the Newington Home for Crippled Children of Newington, Connecticut; and one-third to the Memorial Hospital of Manchester, Connecticut.

TWELFTH: All the rest, residue and remainder of my property, both real and personal of which I may die seized or possessed, or to which or any interest in which I may at the time of my death be entitled, including any property over which I may have power of disposal or appointment at the time of my death, I give, devise and bequeath to The Hartford-Connecticut Trust Company, of Hartford, Connecticut, as Trustee, IN TRUST, for the uses and purposes and with the powers and subject to the provisions and limitations hereinafter set out:—

A. I direct that my said Trustee shall set apart one-third of said residue as a fund for my said wife; and I further provide that my said Trustee shall pay the income from said fund to my wife during her life or as long as she shall remain my widow. Upon the death of my said wife, or upon her remarriage should she remarry, or upon my death should my said wife predecease me, I direct that said fund shall be added to the fund hereinafter provided for my said children and my descendants, and if there be no descendants of mine living upon the death or remarriage of my said wife, or upon my death should my said wife predecease me, I direct that said fund be added to the fund hereinafter provided in sub-section C of this clause for the Manchester Y. M. C. A. or The Mor-

ton Library, The Memorial Hospital of Manchester and the Newington Home for Crippled Children.

B. I direct that my said Trustee shall set apart two-thirds of said residue as a fund for my children, if any, and I direct that my said Trustee shall divide said fund into equal parts counting one equal part for any child of mine that shall survive me and one equal part for the issue as a group of any child that may have predeceased me leaving issue living at my death. I direct that one of said parts shall be held for each of my children surviving me and the income therefrom shall be used by my said Trustee for the care, support and education of such child until such child reaches the age of 25 years when all funds in said part then in the hands of my said Trustee shall be paid, transferred and delivered to such child. If any child should die before reaching the age of 25 years, then I direct that the part set aside for such child shall be divided equally among any children of such child surviving such child; and failing any such children, I direct that such part shall be added equally to the parts of any other children, and if there be no descendants of mine then living, I direct that such part shall be added to the fund hereinafter provided by sub-section C for the Young Men's Christian Association of Manchester or The Morton Library and the Memorial Hospital of Manchester and the Newington Home for Crippled Children. I direct that one of said parts shall be distributed by my Trustee, per stirpes, among the issue of any child of mine that may have predeceased me leaving issue living at my death.

C. If at my death, neither my wife nor any descendants survive me; or if at the death or remarriage of my said wife, no descendants of mine should be living, or if there should be funds in my Trustee's hands under the provisions of sub-section B above and there should be no descendants of mine living at any time, then I direct that the funds in my Trustee's hands shall be used as follows: One-third of the income therefrom shall be paid to the Young Men's Christian Association of Manchester, or to The Morton Library Association of Manchester, whichever institution may take the funds under the provisions of Clauses Ninth and Tenth of this Will; One-third of said income shall be paid to the Memorial Hospital of Manchester, Connecticut; and one-third of said income shall be paid to the Newington Home for Crippled Children. If neither the Young Men's Christian Association of Manchester nor The Morton Memorial Library receive the funds under the provisions of Sections Ninth and Tenth of this Will, then I direct that one-half of said income be paid to said Memorial Hospital of Manchester, and one-half of said income be paid to the Newington Home for Crippled Children. I direct that the income so held and used for charitable purposes under the provisions of this Clause Twelfth shall be known as "The Willie T. Morton Fund."

THIRTEENTH: In the event that any of the organizations receiving bequests or income under this Will shall change their names or become amalgamated with other organizations, then it is my will that the organization under such changed name or amalgamation shall be substituted for the original beneficiary provided such substituted beneficiary shall carry on substantially the same work as the beneficiary named herein.

In the event that any organization receiving a bequest or income under this Will should cease to exist, or it should be determined by my said Trustee that it has ceased to carry on substantially the type of work undertaken at the date of my death, then I direct that the fund bequeathed to such organization or held for it shall be held by said Trustee and the income paid to the Young Men's Christian Association of Manchester or The Morton Library Association of Manchester, whichever may receive said One Hundred Thousand Dollar $100,000) fund. If neither said Young Men's Christian Association or said The Morton Library Association receives said One Hundred Thousand Dollar ($100,000) fund, then in such event, I direct that the said funds referred to in the preceding sentence shall be added to the rest and residue of my estate.

FOURTEENTH: In the event that any person should contest the validity of this Will in any respect, whether it be one of the beneficiaries named herein or any other person, then as far as I am able to do so, I direct that the cost of such contest shall be borne entirely by the person making the same and that none of his legal expenses be paid from my estate. I authorize and direct my Executor to use every means to maintain the validity of this Will and to use any and all funds necessary for such purpose. If any legatee or devisee under this Will shall take legal steps to prevent the probate of this Will, or any codicil hereto, or shall dispute the same by opposing such Will or codicil in the Probate Court or in any other court, or shall in any way be concerned in contesting the same, then I revoke any legacy or devise to such legatee or devisee and cut off such legatee or devisee from any share or interest in this Will or any codicil thereto; and I direct that said legacy or devise so revoked shall fall into the residue of my estate.

FIFTEENTH: I nominate and appoint The Hartford-Connecticut Trust Company, of Hartfrod, Connecticut, to be Executor of this my Last Will and Testament; and I authorize and empower my said Executor to sell any real estate or interest in real estate which I may own at the time of my death except any real estate specifically devised; and I direct that my said Executor and my said Trustee shall not be required to file any bond in this or any other State. I further provide that the legacies under this Will shall not be payable for a period of two years from the date of my death unless my Executor shall determine that the same can be paid previously without the sacrifice or loss by sale of any securities or property in my estate.

SIXTEENTH: I authorize and empower my said Executor and my said Trustee to borrow money at any time on such terms as they respectively approve, and to pledge any securities or property in their respective hands as security for such loan.

IN WITNESS WHEREOF, I have hereunto set my seal and have subscribed these presents, and do make, publish and declare the same as and for and to be my Last Will and Testament in the presence of the witnesses attesting and subscribing the same at my request this 27th day of February, A. D. 1924.

Willie T. Morton (L. S.)

Signed, sealed, published and declared by WILLIE T. MORTON, the Testator above named, as and for and to be his Last Will and Testament in the presence of us, who at his request and in his presence and in the presence of each other have hereunto subscribed our names as witnesses this 27th day of February, A. D. 1924.

Clement Scott	of	Hartford, Conn.
M. Catherine Harris	of	Hartford, Conn.
Elizabeth J. Hall	of	Wethersfield, Conn.

STATE OF CONNECTICUT, }
COUNTY OF HARTFORD, } ss. Hartford, Feb. 27th, 1924.

The within named Clement Scott, M. Catherine Harris and Elizabeth J. Hall being duly sworn, do depose and say: That they witnessed the within Will of the within named Testator, WILLIE T. MORTON, and subscribed the same in his presence, in the presence of each other and at his request: That said Testator, at the time of signing said Will, was of full age and of sound and disposing mind and memory, and competent to make testamentary disposition of real and personal property: That he voluntarily signed said Will and declared the same to be his Last Will and Testament, in the presence of the said three subscribing witnesses thereto, and that this affidavit is made at the request of the Testator.

Clement Scott
M. Catherine Harris
Elizabeth J. Hall

Subscribed and sworn to this 27th
day of February, A. D. 1924,
before me,
Arthur N. Stiles
(Seal) Notary Public

The above and foregoing is a true copy of the original will of Willie T. Morton, late of Manchester, Connecticut, deceased, and filed in the Probate Court for the District of Manchester,

We hereby guarantee that the foregoing is a true and correct copy of the original instrument, duly executed: which is on file in the court of probate.

ATTEST:
THE HARTFORD-CONNECTICUT TRUST CO.

Clerk of the Probate Court,
District of Manchester.

TRUST OFFICER
ASSISTANT SECTETARY

EXHIBIT Q 11-2

Fund 11-1.100

Trust u/w Grace Robertson

Grace Robertson

BE IT KNOWN TO ALL PERSONS, That I, GRACE ROBERTSON, of the Town of Manchester, in the County of Hartford, in the State of Connecticut, being of lawful age, of sound and disposing mind, memory and judgment, do hereby make, publish and declare this to be my last Will and Testament, hereby revoking all previous wills and codicils by me made.

ARTICLE I

I direct that all my just debts and funeral expenses be paid by my Executor hereinafter named and to pay from the corpus of my estate all succession taxes, inheritance taxes, penalty taxes and all taxes and charges of like nature.

ARTICLE II

I give to my niece, Marion E. Robertson, my dining room furniture set consisting of chairs, table and sideboard.

ARTICLE III

I give to my niece, Jessie C. Robertson, my bedroom set consisting of bedstead, bureau, chairs and two mirrors. Also my paintings except the one mentioned in Article IV of this instrument.

ARTICLE IV

I give to my niece, Eleanor M. Robertson, my piano, my parlor Davenport and the oil painting owned by me and executed by Charles Warren Eaton.

ARTICLE V

All my other household furniture, furnishings, bric-a-brac, pictures, books and all other articles of like nature, I give to the children of my two brothers, William and Herbert, to be theirs absolutely, and to be divided as they may agree.

ARTICLE VI

I give to each of my nephews and nieces, Five Thousand ($5,000.00) Dollars, absolutely. In case any nephew or niece predeceases me leaving child or children, I give to such child or children the sum which their parent would have taken, had he or she outlived me.

ARTICLE VII

I give to The Manchester Trust Company, a Corporation under the laws of the State of Connecticut, and located in said town of Manchester, the sum of Forty Thousand ($40,000.00) Dollars, in trust, however, to take hold, manage, invest and reinvest, and to pay the net income therefrom to the Trustees of the Manchester Memorial Hospital, a Connecticut corporation, located in said Town of Manchester, to be used for general hospital purposes.

ARTICLE VIII

I give to the said The Manchester Trust Company, Ten Thousand ($10,000.00) Dollars, in trust, however, to hold, manage, invest and reinvest, and to pay the income therefrom to the Trustees of The Manchester Y.M.C.A., or to whatever body, by whatever name,

which has charge of the "White Property" so-called, now occupied by said The Manchester Y.M.C.A.

ARTICLE IX

I give to said The Manchester Trust Company, Ten Thousand ($10,000.00) Dollars, in trust, however, to hold, manage, invest and reinvest, and to pay the income therefrom to whatever person or persons or whatever body, by whatever name, which has charge of the "Playgrounds" provided by my father, John T. Robertson, and located near Edward Street, in said Manchester. Said Playgrounds now stand of record in the name of myself and of my brother, William W. Robertson.

Grace Robertson

The above trust funds included in this Article and in the preceding Article (the benefit of which is given to The Manchester Y.M.C.A. and for said Playgrounds) shall continue so long as the "White Property" so-called and said Playgrounds are made use of for purposes like or similar to the uses now made of them. In case, however, the activities to which each or either is now devoted shall be discontinued in substance and permanently, then I direct that the trust herein created for the benefit of said The Manchester Y.M.C.A., its successors by whatever name, and for the benefit of said Playground, shall cease and be determined and whatever remains of said trust funds, I direct be disbursed as residue of my estate.

ARTICLE X

I give to said The Manchester Trust Company, Ten Thousand ($10,000.00) Dollars in trust, however, to hold, manage, invest and reinvest and to pay the net income therefrom to my aunt, Mrs. Nellie M. Powell, now living at No. 186 Prospect Street, Willimantic, Connecticut, during the term of her natural life. At her death, I direct that said trust cease and be determined, and whatever remains of said trust fund, I direct become a portion of the residue of my estate to be disposed of as hereinafter provided.

ARTICLE XI

I give to said The Manchester Trust Company Five Thousand ($5,000.00) Dollars, in trust, however, to hold, manage, invest and reinvest, and to pay the net income therefrom to the Second Congregational Church of Manchester, Connecticut, a Church Corporation, located in said Manchester, said income to be used by said Church as a part of its apportionment for Home and Foreign Missions.

ARTICLE XII

I give to said The Manchester Trust Company, Five Thousand ($5,000.00) Dollars, in trust, however, to hold, manage, invest and reinvest, and to pay the net income therefrom to the Second Congregational Church of Manchester, Connecticut, a Church Corporation, located in said Manchester, said income to be used by said Church for general purposes.

ARTICLE XIII

I give to The Connecticut Children's Aid Society, a Corporation under the laws of the State of Connecticut, located in Hartford, Connecticut, Five Thousand ($5,000.00) Dollars, absolutely.

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ARTICLE XIV

I give to the Newington Home For Crippled Children, a Connecticut Corporation, located in Newington, Connecticut, Five Thousand ($5,000.00) Dollars, absolutely.

ARTICLE XV

I give to the Thorsby Institute, located at Thorsby, Alabama, One Thousand ($1,000.00) Dollars, absolutely.

ARTICLE XVI

I give to the Connecticut Humane Society, a Connecticut Corporation, incorporated April 14, 1881, having its principal office in Hartford, Connecticut, Five Thousand ($5,000.00) Dollars absolutely.

ARTICLE XVII

I give to said The Manchester Trust Company, Five Thousand ($5,000.00) Dollars, in trust, however, to hold, manage, invest and reinvest and to pay the net income therefrom to the Board of Park Commissioners, of the Town of Manchester, or by whatever name such Park Commissioners may be known, to be expended toward the upkeep and beautifying of public parks in said Manchester.

ARTICLE XVIII

I give to The Manchester Trust Company, Thirty Thousand ($30,000.00) Dollars, in trust, however, to hold, manage, invest and reinvest, and to expend the net income therefrom for the following purposes: One-fourth (1/4) of said net income is to be used for defraying the whole or a portion of the expenses of some worthy girl or girls living in said Manchester in a High School in said Manchester; One-fourth (1/4) of said net income is to be used for defraying the whole or a portion of the expense of some worthy boy or boys, living in said Manchester, in a High School in said Manchester; One-fourth (1/4) of said net income is to be used for defraying the whole or a portion of the expenses of some worthy girl or girls, living in said Manchester, in college; One-fourth (1/4) of said net income is to be used for defraying the whole or a portion of the expense of some worthy boy or boys, living in said Manchester, in college. Designation of the beneficiaries of the funds provided in this Article is to be made by the Board of Education of the Town of Manchester. In the event of change of the official title or designation of the Board of Education, the successor or successors shall succeed to the authority of designation of beneficiaries, meaning hereby to vest such authority with the body having at any particular time the general duties now devolving upon said Board of Education and relating to both grade school and/or high school.

Beneficiaries of this fund must be boys and girls whose parents are unable financially to continue such offspring in school or in college. It shall not be obligatory to expend the whole or any part of the annual income from said fund in any one year; but if there does not appear to be need for immediate use of said income the same may be allowed to accumulate until it becomes advisable to make use of the same.

Grace Robertson

In determining upon a beneficiary or beneficiaries of the funds provided in this Article, it is my will that preference be given to boys and girls residents of the territory now known as the Eighth School District.

ARTICLE XIX

I give to my brother, Herbert F. Robertson, the sum of Fifty Thousand ($50,000.00) Dollars absolutely.

ARTICLE XX

All the remainder of my property, both real and personal, of whatsoever the same may consist and wheresoever it may be situated, I direct shall be divided into two (2) equal parts. One of said parts I give to my brother Herbert F. Robertson absolutely; the other of said parts I give to the children of my brother, William W. Robertson, to be divided among them, share and share alike.

I nominate and appoint The Manchester Trust Company, its successor or successors, to be the Executor of this my last Will and Testament.

IN WITNESS WHEREOF I have hereunto set my hand and seal at said Manchester, on the 20th day of August, A.D., One Thousand Nine Hundred and Forty.

Grace Robertson (L.S.)

Signed, Sealed, published and declared by the said Grace Robertson, as and for her last Will and Testament, in presence of us who at her request and in her presence, and in the presence of each other, have hereunto subscribed our names as witnesses on the 20th day of August, A.D., 1940.

Witnesses:

Harold C. Alvord

Clin N. Mason

Robert E. Hathaway

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State of Connecticut)
; ss. Manchester, August 20, A.D., 1940.
County of Hartford)

We the within named Harold G. Alvord, Robert E. [illegible]

[illegible]

being duly sworn, make affidavit and say: That we severally attested the within and foregoing Will of the within named testatrix, and subscribed the same in her presence and at her request and in the presence of each other; that the said testatrix signed, published and declared the said instrument as and for her last Will and Testament, in our presence on the 20th day of August, A.D., 1940; and at the time of execution of said Will, said testatrix was more than eighteen years of age, and of sound mind, memory, and judgment and under no improper influence or restraint to the best of our knowledge and belief, and we make this affidavit at the request of said testatrix.

Harold G. Alvord

Robert E. Hathaway

Elin M. Nixon

State of Connecticut)
; ss. Manchester, August 20, A.D., 1940
County of Hartford)

Then personally appeared before me, a Notary Public, duly qualified to administer oaths.

Harold G. Alvord

Robert E. Hathaway

and Elin M. Nixon

and subscribed and made oath to the truth of the foregoing affidavit.

Louis Hamel

Notary Public

C O D I C I L

BE IT KNOWN TO ALL PERSONS, That I, GRACE ROBERTSON, of the Town of Manchester, County of Hartford, and State of Connecticut, being of lawful age, of sound and disposing mind, memory and judgment, do hereby make, publish and declare this to be a Codicil to my last Will and Testament, dated August 20, 1940, In all other respects I hereby ratify and confirm my said Last Will and Testament.

ARTICLE I.

I hereby revoke article XIX of said Will wherein I bequeathed $50,000.00 to my brother Herbert F. Robertson.

ARTICLE II.

I give to The Manchester Trust Company, a Connecticut corporation located in said Manchester, the sum of Fifty Thousand ($50,000.00) Dollars, in trust however, to hold and invest the same and to pay the net income therefrom to my brother Herbert F. Robertson so long as he shall live. If in the opinion of said Trustee the income from said trust fund shall not be sufficient, together with any other income which my said brother may have, to provide for his proper maintenance and support, then I hereby authorize said Trustee to pay to my said brother such portions of the principal of said Trust Fund as it shall deem proper. The decision of said Trustee as to such payments shall be final. At the death of my said brother said Trust Fund shall cease and I give whatever may remain of said Trust Fund to the children of my brothers, William W. Robertson and Herbert F. Robertson, share and share alike.

If any of the children of my brothers Herbert F. Robertson or William W. Robertson shall die before my said brother Herbert F. Robertson, leaving issue, then the share of such child so pre-deceasing my said brother Herbert F. Robertson, shall be divided among such issue, per stirpes.

IN WITNESS WHEREOF I have hereunto set my hand and seal at said Manchester, on the 10 day of September, A.D., 1942.

Grace Her Robertson (L.S.)
Mark

Signed, Sealed, published and declared by the said Grace Robertson, as and for a codicil to her Last Will and Testament, in the presence of us, who at her request, and in her presence, and in the presence of each other, have hereunto subscribed our names as witnesses, on the 10 day of September, A.D., 1942.

WITNESSES:

Harold C. Alvord

Theresa H. Sapienza

Robert E. Hathaway

[redacted]

[redacted]

[redacted]

STATE OF CONNECTICUT)
: ss. Manchester, August 20, A.D., 19[illegible]
COUNTY OF HARTFORD)

With the within named Harold C. Alvord, Ellin [illegible] Mason

and Robert E. Hathaway

being duly sworn, make affidavit and say: That we severally attested the within and foregoing Codicil of the within named Testatrix, and subscribed the same in her presence, and at her request and in the presence of each other; that the said Testatrix signed, published and declared the said Instrument as and for a Codicil to her Last Will and Testament, in our presence, on the 20th day of August, A.D., 19[illegible]; and at the time of execution of said Codicil, said Testatrix was more than eighteen years of age, and of sound, mind, memory and judgment and under no improper influence or restraint to the best of our knowledge and belief, and we make this affidavit at the request of said Testatrix.

Harold C. Alvord

Robert E. Hathaway

Ellin N. Mason

State of Connecticut)
: ss. Manchester, August 20, 19[illegible]
County of Hartford)

Then personally appeared before me a Notary Public duly qualified to administer oaths.

Harold C. Alvord

Robert E. Hathaway

and Ellin N. Mason

and subscribed and made oath to the truth of the foregoing affidavit.

Louis H. Marte
Notary Public

STATE OF CONNECTICUT)
: ss. Manchester, September 10, A.D., 1942
COUNTY OF HARTFORD)

We the within named Theresa Lapinga
and Robert E. Hathaway
being duly sworn, make affidavit and say: That we severally attested the within and foregoing Codicil of the within named testatrix, and subscribed the same in her presence, and at her request, and in the presence of each other; that the said testatrix signed, published and declared the said Instrument as and for a Codicil to her Last Will and Testament, in our presence, on the 10th day of September A.D., 1942; and at the time of execution of said Codicil, said Testatrix was more than eighteen years of age, and of sound mind, memory and judgment and under no improper influence or restraint to the best of our knowledge and belief, and we make this affidavit at the request of said Testatrix.

Theresa Lapinga
Robert E. Hathaway

STATE OF CONNECTICUT)
: ss. Manchester September 10, A.D. 1942.
COUNTY OF HARTFORD)

Then personally appeared before me a Notary Public duly qualified to administer oaths.

Theresa Lapinga
Robert E. Hathaway

and

and subscribed and made oath to the truth of the foregoing affidavit.

Notary Public.

CODICIL

BE IT KNOWN TO ALL PERSONS, That I, GRACE ROBERTSON, of the Town of Manchester, County of Hartford, and State of Connecticut, being of lawful age, of sound and disposing mind, memory and judgment, do hereby make, publish and declare this to be a Codicil to my Last Will and Testament dated August 20th., 1940.

I.

I hereby revoke Article IX of my said Last Will and Testament.

II.

I hereby ratify and confirm all the other provisions of my said Last Will and Testament, together with any codicils to the same heretofore made.

IN WITNESS WHEREOF I have hereunto set my hand and seal at said Manchester, on the 29 day of August, A.D., One Thousand Nine Hundred and Forty-five.

Her
Grace X Robertson (L.S.)
Mark

Signed, Sealed, published and declared by the said Grace Robertson, as and for a codicil to her Last Will and Testament, in presence of us who at her request and in her presence, and in the presence of each other, have hereunto subscribed our names as witnesses on the 29 day of August, A.D., 1940.

Witnesses:

[signature]

R. B. Hathaway

R. E. Hathaway

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STATE OF CONNECTICUT)
: ss. Manchester, August __, A.D.,1946.
COUNTY OF HARTFORD)

We the within named _____

_____,

being duly sworn, make affidavit and say: That we severally attested the within and foregoing codicil to the Last Will and Testament of the within named testatrix, and subscribed the same in her presence and at her request, and in the presence of each other; that the said testatrix signed, published and declared the said instrument as and for a codicil to her Last Will and Testament, in our presence on the __ day of August, A.D., 1946; and at the time of execution of said codicil, said testatrix was more than eighteen years of age, and of sound mind, memory, and judgment and under no improper influence or restraint to the best of our knowledge and belief, and we make this affidavit at the request of said testatrix.

_____

_____

_____

STATE OF CONNECTICUT)
: ss. Manchester, August __, A.D.,1946
COUNTY OF HARTFORD)

Then personally appeared before me, a Notary Public, duly qualified to administer oaths,

_____

_____

and _____

and subscribed and made oath to the truth of the foregoing affidavit.

_____
Notary Public.

C O D I C I L

KNOW ALL PERSONS, That, I, GRACE ROBERTSON, of the Town of Manchester, County of Hartford and State of Connecticut, being of lawful age, of sound and disposing mind, memory and judgment, do hereby make, publish and declare this to be a Codicil to my Last Will and Testament, dated August 20, 1940. In all other respects I hereby ratify and confirm my said Last Will and Testament.

I

I hereby revoke ARTICLE VIII of my said Last Will and Testament.

II

I give to the said Manchester Trust Company, ONE THOUSAND AND NO/100 ($1,000.00) DOLLARS, in trust, however, to hold, manage, invest and reinvest, and to pay the income therefrom to the Trustees of the said Manchester Y.M.C.A. so long as the Trustees of the said Manchester Y.M.C.A. shall use or cause to be used the Y.M.C.A. building for recreational purposes. However, should the Manchester Y.M.C.A. cease to exist or should the said Manchester Y.M.C.A. cease to use or cause to be used the Manchester Y.M.C.A. building for recreational purposes, I then direct that in either event that said trust cease and be determined and that the residue of said Trust shall revert to the residue of my estate.

III

I hereby revoke ARTICLE XV of my said Last Will and Testament.

IV

I give to the Thorsby Institute located at Thorsby, Alabama, the sum of ONE THOUSAND AND NO/100 ($1,000.00) DOLLARS. However, should said Thorsby Institute cease to exist before my death, I direct that said sum shall revert to the residue of my estate.

IN WITNESS WHEREOF, I have hereunto set my hand and seal at said Manchester on the 10th day of November, A.D., 1945.

Grace (Her X mark) Robertson (L.S.)

Signed, Sealed, published and declared by the said GRACE ROBERTSON, as and for a Codicil to her Last Will and Testament,

CHARLES S. CROCKETT
ATTORNEY AT LAW
MANCHESTER, CONN.

In the presence of us, who at her request, and in her presence, and in the presence of each other, have hereunto subscribed our names as witnesses on the 10th day of November, A.D., 1953.

WITNESSES:

Maude M. Shearer

Robert E. Hathaway

Charles N. Crockett

STATE OF CONNECTICUT } SS. Manchester, November 10th A.D. 1953.
COUNTY OF HARTFORD }

We the within named Maude M. Shearer and Robert E. Hathaway being duly sworn, make affidavit and say: That we severally attested the within and foregoing Codicil of the within named testatrix, and subscribed the same in her presence, and at her request and in the presence of each other; and in the presence of the third subscribing witness; that the said testatrix signed, published and declared the said Instrument as and for a Codicil to her Last Will and Testament, in our presence, on the 10th day of November, A.D., 1953; and at the time of execution of said Codicil, said testatrix was more than eighteen years of age, and of sound mind, memory and judgment and under no improper influence or restraint to the best of our knowledge and belief, and we make this affidavit at the request of said testatrix.

Maude M. Shearer

Robert E. Hathaway

STATE OF CONNECTICUT } SS. Manchester, November 10th A.D. 1953.
COUNTY OF HARTFORD }

Then personally appeared before me a Commissioner of the Superior Court duly qualified to administer oaths.

Maude M. Shearer

Robert E. Hathaway

and _____

and subscribed and made oath to the truth of the foregoing affidavit.

Charles N. Crockett
Commissioner of the Superior Court
for Hartford County

CHARLES N. CROCKETT
ATTORNEY AT LAW
[illegible]
HARTFORD CONN.

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State of Connecticut } ss Probate Court March 18, 1958.
District of Manchester }

Will of Grace Robertson dated August 20, 1940 and First, Second, Third and Fourth Codicils thereto dated August 20, 1940, September 10, 1942, August 29, 1945 and November 10, 1953 respectively, presented in Court March 5, 1958. Ordered Heard March 18, 1958. Will and First, Second and Third and Fourth Codicils proved, approved, admitted to probate, ordered recorded and kept on file, and The Manchester Trust Company approved as executor.

John R. Wallace
Judge.

I, Madeline B. Ziebarth, Clerk of the Probate Court, in and for the District of Manchester hereby certify the within and foregoing to be a true photostat copy of the original Will, dated August 20, 1940 and the First, Second, Third and Fourth Codicils thereto, dated August 20, 1940, September 10, 1942, August 29, 1945 and November 10, 1953 respectively of Grace Robertson on file in this Court.

Attest: Madeline B. Ziebarth
Clerk.

EXHIBIT Q 11-2

Fund 11-1.101

Albert L. Crowell & Maytie Case Crowell Fund
(Trust u/w Maytie Case Crowell)

[redacted]

Unrestricted ART. 7 30207664D

KNOW ALL MEN BY THESE PRESENTS That I, MAYTIE CASE CROWELL, of Highland Park, in the Town of Manchester, County of Hartford and State of Connecticut, being of sound and disposing mind and memory, do make, publish and declare the following to be my last will and testament, hereby revoking all former wills by me made, that is to say:

FIRST: I direct that all my funeral expenses and just debts, except those secured by mortgage on real estate, shall be fully paid and satisfied by my executors hereinafter named.

SECOND: I hereby direct that all legacy, succession, inheritance, transfer and estate taxes levied or assessed upon or with respect to any property which is included as part of my gross estate for the purpose of any such tax, shall be paid by my executors out of my estate in the same manner as an expense of administration, and shall not be prorated nor apportioned among nor charged against the respective devisees, legatees, beneficiaries, transferees or other recipients, nor charged against any property passing or which may have passed to any of them, and that my executors shall not exercise any privilege of reimbursement for any portion of any such tax from any person.

THIRD: I give and bequeath to my niece, Eleanor Case Belden, and Anna C. Sampson, or to the survivor of them in the event that only one of them shall survive me, such of my household furniture and furnishings, including tableware, silverware, books, pictures, ornaments and household stores; my wearing apparel and articles of personal use and adornment, my jewelry including precious stones, and my automobile and all accessories thereto, as they or she may select and shall notify my executors that they desire, such notification to be given to my executors within six months after my death; any remaining articles of personal property which they or she may fail to select, I direct my executors to sell and to add the net proceeds of sale to my residuary estate to be distributed as hereinafter provided. It is my wish that in connection with such sale or sales there be no publicity as to the previous ownership of the tangible personal property to be sold.

I give and bequeath the sum of twenty thousand (20,000) dolla
son, F. Gay Hastings, of Winnetka, Illinois, to be his absolutely
survive me, otherwise I give and bequeath the sum of five thousand
(5,000) dollars to his wife, Miriam Hastings, to be hers absolutely if she shall
survive me, and the remaining fifteen thousand (15,000) dollars (or all of said
sum of twenty thousand (20,000) dollars in the event neither the said F. Gay
Hastings nor Miriam Hastings shall survive me) I give and bequeath to his issue
surviving me in equal shares per stirpes to be theirs absolutely, but if there sh
be no issue of the said F. Gay Hastings surviving me said remaining sum of
fifteen thousand (15,000) dollars (or all of said sum of twenty thousand (20,000)
dollars in the event neither the said F. Gay Hastings nor Miriam Hastings, nor
any issue of theirs, shall survive me, as the case may be) shall be added to the
principal of the trust estate hereinafter established in Article SEVENTH and
administered as a portion thereof.

FIFTH: I give and bequeath the sum of twenty thousand (20,000) dollars
to my foster son, John M. Hastings, of New York City, New York, to be his
absolutely if he shall survive me, otherwise I give and bequeath the sum of five
thousand (5,000) dollars to his wife, Bea Hastings, to be hers absolutely if she
shall survive me, and the remaining fifteen thousand (15,000) dollars (or all of
said sum of twenty thousand (20,000) dollars in the event neither the said John M
Hastings nor Bea Hastings shall survive me) I give and bequeath to his issue
surviving me in equal shares per stirpes to be theirs absolutely; but if there
shall be no issue of the said John M. Hastings surviving me said remaining sum
of fifteen thousand (15,000) dollars (or all of said sum of twenty thousand (20,00
dollars in the event neither the said John M. Hastings nor Bea Hastings, nor
any issue of theirs, shall survive me, as the case may be) shall be added to the
principal of the trust estate hereinafter established in Article SEVENTH and
administered as a portion thereof.

SIXTH: In order to provide a further fund for the perpetuation of the
memorial to my mother, Marietta Stanley Case, in the form of an Austin organ
given by our family to South Methodist Church, in Manchester, Connecticut, in
1925, and in recognition of an additional gift of ten thousand (10,000) dollars in

trust made in 1929 in memory of my brother, Raymond Stanley Case, for the maintenance of said organ and for the support of the musical program of said Church, I give and bequeath the sum of ten thousand (10,000) dollars IN TRUST to The Connecticut Bank and [redacted] banking corporation organized a existing under the laws of [redacted] necticut and located in the Town and County of Hartford, [redacted] its successors in this trust upon the following trusts:

[redacted] power to take, hold, receive, sell, invest and reinvest this trust estate and the proceeds thereof in such investments as would be selected by a prudent investor, and it may also invest in a common trust fund managed by it; and after the payment of administration expenses it shall accumulate the net income as a portion of said trust, and such portion or portions, or all of said fund, may be used by the trustee from time to time, as it in its sole [redacted] may determine after conference with Clifton C. Brainerd of Hartford, Connecticut, during his lifetime and ability to act, and the chief officer for the time being of the Austin Organ Company, of Hartford, Connecticut, if there shall be such an officer, and if not, then after conference with such other person as the trustee in its sole uncontrolled discretion may consider competent to advise it, for the making of major repairs to, or rebuilding of the present or any future organ, in the South Methodist Church, in Manchester, Connecticut, during such time as said church building shall be used for religious purposes.

In the event said church may in the future amalgamate with any other Protestant church or churches, and the Austin organ now in the South Methodist Church shall be used by the amalgamated church, or a new organ for said church shall have been purchased and such new organ shall be used by the amalgamated church, the trust estate and the accumulations thereon may be used for the purpose of making major repairs to, or rebuilding said organ, for use in the amalgamated church; after reserves in such amount as the trustee shall consider adequate shall have been accumulated for the purposes herein specified, income from the trust estate herein provided for organ purposes may be distributed from time to time to the Manchester Memorial Hospital for its general purposes, but

[redacted] said Hospital shall not prevent the trustee from [redacted] for organ purposes. In the event said [redacted] entirely discontinued and shall not amalgamate [redacted], and the members of said Church shall disband, [redacted] disbanding of the members of the amalgamated church, [redacted] cease and terminate and the principal thereof, together with [redacted] undistributed income, shall be added to the principal of the [redacted] hereinafter established in Article SEVENTH and administered as a [redacted]

In the event of any question as to whether said South Methodist Church has amalgamated with any other church or churches, or whether it shall have entirely discontinued its functions and the members of said Church shall be disbanded, the decision and determination of the trustee as to what actually took place shall be binding and conclusive upon all parties hereunder. It is my hope and suggestion that the memorial plate now on said Austin organ shall remain in perpetual [redacted] Marietta Stanley Case.

SEVENTH: I give and bequeath the sum of fifteen thousand (15,000) dollars IN TRUST to said The Connecticut Bank and Trust Company, and to its successors in this trust upon the following trusts:

Said trustee shall have power to take, hold, receive, sell, invest and reinvest this trust estate and the proceeds thereof in such investments as would be selected by a prudent investor, and it may also invest in a common trust fund managed by it; and after the payment of administration expenses it shall pay over the net income therefrom quarterly, or oftener in its discretion, in perpetuity, to The Manchester Memorial Hospital for its general purposes, this gift to be known as the Albert L. Crowell and Maytie Case Crowell Fund.

EIGHTH: I give and bequeath the sum of twenty-five hundred (2500) dollars IN TRUST to said The Connecticut Bank and Trust Company, and to its successors in this trust upon the following trusts:

Said trustee shall have power to take, hold, receive, sell, invest and reinvest this trust estate and the proceeds thereof in such investments as would be selected by a prudent investor, and subject to the payment of administration

expenses, so much of the income shall be used from time to time as in the discretion of the trustee may be needed or desirable to pay the expenses of perpetual care and upkeep of Lot #9A, and the periodical care of the stones thereon, in the East Cemetery, in said Manchester. Any unused income may be added from time to time, in the discretion of the trustee, to principal, or the same may be retained as a reserve for future use.

NINTH: In the event that either Sydney W. Strickland, or his wife, Louis Strickland, shall survive me, I give and bequeath the sum of eleven thousand (11,000) dollars IN TRUST to said The Connecticut Bank and Trust Company, and to its successors in this trust upon the following trusts:

Said trustee shall have power to take, hold, receive, sell, invest and reinvest this trust estate and the proceeds thereof in such investments as would be selected by a prudent investor, and it may also invest in a common trust fund managed by it; and after the payment of administration expenses it shall pay the sum of two hundred fifty (250) dollars quarterly to or for the benefit of the said Sydney W. Strickland for and during the remainder of his natural life, or until the principal of the trust estate is exhausted; and upon and after his death in the event that he shall survive me and the principal of the trust estate shall not have been exhausted prior to his death, or upon my death in the event that he shall not survive me, said trustee shall distribute the sum of two hundred fifty (250) dollars quarterly to or for the benefit of his wife, Louisa Strickland, for and during the remainder of her natural life, or until the principal of the trust estate is exhausted; and in the event that the net income payable hereunder shall be less than two hundred fifty (250) dollars in any quarterly period, my trustee is authorized to pay to the then beneficiary of the trust out of the corpus of the trust the difference between such net income and two hundred fifty (250) dollars quarterly.

Subject to said life estates in favor of the said Sydney W. Strickland and Louisa Strickland, the remainder interests in said trust fund shall be added

principal of the trust estate hereinabove established in Article SEVENTH and administered as a portion thereof.

TENTH: I give and devise to my niece, Eleanor Case Belden, the real estate consisting of the land with the dwelling thereon occupied by me as my home, known as 720 Spring Street, Manchester, Connecticut, and the other buildings and improvements thereon, which were acquired by me from my deceased husband's estate, and bounded and described as follows:

Northwesterly by Spring Street, about five hundred six and eight-tenths (506.8) feet; northeasterly by land of the Highland Park Water Company, about six hundred eighty and one one-hundredths (680.01) feet; southerly by the high water mark of the reservoir of Case Brothers; and southwesterly by other property of mine herein devised to Anna C. Sampson, about two hundred eighty-two (282) feet.

I also give and bequeath to my said niece all shares of the capital stock of the Highland Park Water Company owned by me at the time of my death, said real estate and personal property to be hers absolutely.

ELEVENTH: In the event Anna C. Sampson shall survive me, I give, devise and bequeath to her the real estate owned by me in said Manchester known as 712 Spring Street, and bounded and described as follows:

Northwesterly by Spring Street, two hundred eighty-one (281) feet; northeasterly by other land of mine, constituting my home acquired by me from the estate of my deceased husband, Albert L. Crowell; southeasterly by the high water mark of the upper reservoir, so-called, belonging to Case Brothers, Inc.; southwesterly by land now or formerly of said Case Brothers, Inc. Being the same land conveyed to me by deed of A. Willard Case dated October 5, 1916, recorded in Manchester Land Records in Volume 57 at Page 256.

Provided, however, that if the said Sydney W. Strickland and Louisa Strickland, or either of them, shall survive me, I give to them, or to such survivor, the privilege of occupying West Lodge for the period of one year from the date of my death, and during such occupancy my executors shall pay the taxes, insurance premiums and water rents with respect to all of said real estate, and said executors shall also pay for any minor repairs to said property during said period, this privilege in said Sydney W. Strickland and Louisa Strickland, and the survivor of them, of occupying said premises to be a charge upon said real estate.

TWELFTH: All remaining real estate owned by me at the time of my death, including all remainder interests in the premises known as 712 Spring Street, Manchester, Connecticut, in the event the said Anna C. Sampson shall

not survive me, I give, devise and bequeath to my said niece, Eleanor Case Belden, to be hers absolutely.

THIRTEENTH: I give and bequeath the following sums to the following individuals, in each case as an absolute gift to the donee if he or she shall survive me, otherwise said sum shall become a part of my residuary estate to be distributed as hereinafter provided, except as otherwise specifically stated:

(a) Ten thousand (10,000) dollars to Anna C. Sampson;

(b) Twenty-five hundred (2500) dollars to my grandnephew, Richard Case Belden;

(c) Twenty-five hundred (2500) dollars to my grandnephew, Jonathan Cas Belden;

(d) One thousand (1,000) dollars to Brooke R. Hastings, daughter of F. Gay Hastings;

(e) One thousand (1,000) dollars to Thomas Hastings, son of said F. Gay [redacted];

(f) One thousand (1,000) dollars to my cousin, Mabel Stanley Carpenter, of said Manchester;

(g) Five hundred (500) dollars to Richard Carpenter, son of Mabel Stanley Carpenter;

(h) Five hundred (500) dollars to Janet C. Reinhorn, daughter of Mabel Stanley Carpenter;

(i) One thousand (1,000) dollars in equal shares to Chester F. Crowell and Mildred Crowell or all of said sum to the survivor in the event only one of them shall survive me. If neither the said Chester F. Crowell nor Mildred Crowell shall survive me, I give and bequeath said sum of one thousand (1,000) dollars to The Connecticut Bank and Trust Company, Trustee, to be added to the fund provided in Article SEVENTH of this will for the benefit of The Manchester Memorial Hospital;

(j) Five hundred (500) dollars to my cousin, Franklyn C. Parker;

(k) One thousand (1,000) dollars in equal shares to J. Thurston Noe and his wife, Mabel Noe, of South Orange, New Jersey, or all to the survivor of

them in the event that only one of them shall survive me, in appreciation of their thoughtful consideration of Mr. Crowell and me:

(l) Five hundred (500) dollars to Annie M. Ware, of Boston, Massachusetts;

(m) Five hundred (500) dollars to my godson, Richard Whiting Riker, of said Manchester;

(n) An additional gift of Seven thousand (7,000) dollars to the said Anna C. Sampson, in appreciation of her kindness and in part consideration for using her own automobile for transporting me to various places during our last years together.

FOURTEENTH: All of the rest, residue and remainder of my estate of whatsoever nature both real and personal and wheresoever situate, including any and all lapsed legacies and devises, I give, devise and bequeath as follows:

(a) One-fifth thereof to my said niece, Eleanor Case Belden, to be hers absolutely if she shall survive me, but if she shall not survive me, then to her issue surviving me, in equal shares per stirpes, to be their's absolutely. I make no further provision for my said niece, other than as also provided in other sections of this will, in view of the fact that she received from me the sum of ten thousand (10,000) dollars in the year 1940.

(b) One-fifth thereof to the said Anna C. Sampson to be hers absolutely if she shall survive me, but if she shall not survive me said one-fifth portion shall be added to the principal of the trust estate hereinabove in Article SEVENTH constituted for the benefit of The Manchester Memorial Hospital, and administered as a portion thereof.

(c) One-fifth thereof to the said F. Gay Hastings to be his absolutely if he shall survive me, otherwise to his issue surviving me in equal shares per stirpes, to be theirs absolutely, but if he shall leave no issue surviving me then said one-fifth portion shall be added to the principal of the trust estate hereinabove in Article SEVENTH constituted for the benefit of The Manchester Memorial Hospital, and administered as a portion thereof.

(d) One-fifth thereof to the said John M. Hastings to be his absolutely if he shall survive me, otherwise to his issue surviving me in equal shares per stirpes, to be theirs absolutely, but if he shall leave no issue surviving me then

[redacted] portion shall be added to the principal of the trust estate herein- [redacted] in Article SEVENTH constituted for the benefit of The Manchester Memor [redacted]ospital, and administered as a portion thereof.

(e) One-fifth thereof to be added to the principal of the trust estate hereinabove in Article SEVENTH constituted for the benefit of The Manchester Memo Hospital, and administered as a portion thereof.

FIFTEENTH: I hereby nominate, constitute and appoint said The Connecticut Bank and Trust Company and L. Richard Belden, of West Hartford, Connecticut, to be the executors of this my last will and testament, and I hereby excuse the said L. Richard Belden from giving any probate bond or bonds in whatever connection and for whatever purpose, including qualification in such capacity and sale of real estate.

I authorize and empower my said executors to make the division of the residue of my estate and to determine of what each of said portions shall consist whether cash and/or securities and/or other property and the respective valuations thereof, and the determination and division so made by said executors shal be final and conclusive upon all the residuary legatees and devisees.

I authorize and empower my said executors to sell and convey any real estate which I may own at the time of my death at such time or times, and upon such terms and conditions whether for all cash, or part cash and part credit secured by mortgage, as they may deem to be for the best interests of my estate, except that the real estate hereinabove specifically devised shall not be sold without the consent of the specific devisee as evidenced by his or her joining in the deed of conveyance.

I also authorize and empower my said trustee in each instance to receive and accept from my said executors on account of the gift to it establishing such trust, any property, real or personal, comprising my estate which said trustee in its discretion shall elect to take over from my said executors at its reasonable value at the time of such transfer, such value to be fixed by said executors and trustee.

Subject to approval of the Probate Court, the trustee shall be entitled reasonable compensation for administering the above trusts, and is hereby au zed and empowered, in its sole uncontrolled discretion, to pay its compensat for administering the trusts either out of the income from the trust estate or of the principal thereof, or to apportion and pay its said compensation partly out of income and partly out of principal of the trust estate, and the judgment the trustee as to the manner of paying its said compensation either out of the income or out of the principal, or in apportioning the same partly out of each shall be final and conclusive upon all persons and parties in interest hereunde

In making any division or distribution of the principal of the trusts abo provided for, the trustee shall have full power, authority and discretion to make such division or distribution, and to employ for that purpose cash, secu or other property of whatever nature and in whatever proporti it may deem appropriate; and the judgment of the trustee as to the value and nature of the property so to be divided, apportioned or paid over shall be final.

I direct my executors to pay to the Connecticut General Life Insurance Company of Hartford, Connecticut, for the account of the said Sydney W. Strickland, such sum of money as shall be necessary to cause Policy #434794 issued the life of the said Sydney W. Strickland by said company to be a fully paid up life insurance policy, such funds to be taken from my residuary estate, provid however, that this provision shall not be construed to authorize or direct my executors to repay any loan made against said policy, which loan shall be repaic by the insured.

I authorize and direct my executors to pay to Sydney W. Strickland if he shall survive me otherwise to his wife, Louisa, if she shall survive me the sum of two hundred fifty (250) dollars quarterly commencing as of the date of m death and continuing until the trust provided for their benefit in Article NINTH of my will shall be set up and the income therefrom be made available for them and the payments made under this provision shall be from the residue of my estate.

[illegible]ESS WHEREOF I have hereunto set my hand and seal declaring [illegible] last will and testament this 17th day of May, 1957.

Maytie Case Crowell (L.S.)

Signed, sealed, published and declared by said testatrix, Maytie Case Crowell, as and for her last will and testament, in the presence of us the undersigned, who in her presence, and in the presence of each other, at her request, have hereunto set our names as witnesses this 17th day of May, 1957.

J Harold Williams — Hartford Conn.
Helen M. Walker — Simsbury, Conn
Helen Damstrom — Bolton, Conn.

State of Connecticut)
) ss:
County of Hartford)

Hartford, May 17, 1957

Then and there personally appeared the above named Harold Williams, Helen M. Walker and [illegible] Damstrom who, being duly sworn, depose and say that they witnessed the execution of the foregoing will of said testatrix, Maytie Case Crowell; that she subscribed said will and declared the same to be her last will and testament in their presence; that they thereafter subscribed the same as witnesses in the presence of said testatrix, and in the presence of each other, and at the request of said testatrix; that said testatrix at the time of the execution of said [illegible] appeared to them to be of full age and of sound and disposing mind and memory; and that they make this affidavit at the request of said testatrix.

Subscribed and sworn to this 17th day of May, 1957, before me

Esther T. Johnson
Notary Public

J Harold Williams
Helen M. Walker
Helen Damstrom

ECHN Pr[redacted]
Submitted[redacted]

EXHIBIT Q 11-2

Fund 11-1.102

Trust u/w Andrew Ferguson

K N O W A L L M E N B Y T H E S E P R E S E N T S:

THAT I, ANDREW FERGUSON, of the Town of Manchester, County of Hartford and State of Connecticut, do hereby make, publish and declare this to be as and for my last will and testament, hereby revoking all former wills, testaments and codicils heretofore by me made.

FIRST: I direct my executor hereinafter named to pay all my just debts (except that the payment of any mortgage indebtedness shall be in the discretion of my said executor) and funeral expenses and all the expenses of settlement of my estate; and to pay as an administration expense all inheritance, succession, transfer and death taxes imposed by this or any other state, or by the United States, or by any foreign country, upon or with respect to any property required to be included in my gross estate for the purpose of computation of any such tax, without recovery or reimbursement either from the holders of any such property or from any legatee or devisee under this will.

SECOND: I direct my executor hereinafter named to cause a monument to be erected over my grave in the Wright Lot in East Cemetery in Manchester as nearly like the stone which is at my wife's grave as is possible. I further direct my executor to pay such sum to said cemetery as may be required to provide perpetual care for said lot.

THIRD: I give, devise and bequeath my home at 19 Brookfield Street, Manchester, Connecticut, together with the lot upon which the same stands and all furniture and furnishings therein contained to SOUTH METHODIST EPISCOPAL CHURCH, of Manchester, for its general uses and purposes.

FOURTH: I give and bequeath to my sister, MARGARET KEYES, of said Manchester, the sum of Two Thousand Five Hundred

COPY

Dollars ($2,500) absolutely, if she shall survive me. In the event that she shall predecease me, the same shall become part of the residue of my estate.

FIFTH: I give and bequeath to my sister, ANNIE E. LAILEY, of Norwood, Massachusetts, the sum of Two Thousand Five Hundred Dollars ($2,500) absolutely, if she shall survive me. In the event that she shall predecease me, the same shall become part of the residue of my estate.

SIXTH: I give and bequeath to my nephews THOMAS F. FERGUSON and WALTER R. FERGUSON, of Manchester, the sum of Two Thousand Five Hundred Dollars ($2,500) each, absolutely.

SEVENTH: I give and bequeath the sum of One Thousand Dollars ($1,000) to each of the following named persons absolutely, viz:

GRACE B. ABORN, of Crystal Lake, Connecticut

EDITH DWYER, of Manchester, Connecticut

RAYMOND H. HARTZ, of Hartford, Connecticut

ANNIE I. SMITH, of Manchester, Connecticut

EIGHTH: I give and bequeath the sum of Five Hundred Dollars ($500) to each of the following named persons absolutely, viz:

RAYMOND R. BROWN, of Arlington, Vermont

MERRILL ROSIER, of Hartford, Connecticut

DAVID SOLLY, of West Hartford, Connecticut

ALBERT W. SPRAGUE, of Wethersfield, Connecticut

NINTH: I give and bequeath the sum of Five Thousand Dollars ($5,000) to THE NEWINGTON HOME AND HOSPITAL FOR CRIPPLED CHILDREN, an eleemosynary corporation of Connecticut for its general uses and purposes.

TENTH: I give and bequeath to each of the following named religious corporations for their general uses and purposes

the sums set after their respective names, viz:

SOUTH METHODIST EPISCOPAL CHURCH OF MANCHESTER	$5,000.00
CENTER CONGREGATIONAL CHURCH OF MANCHESTER	5,000.00
ST. MARY'S EPISCOPAL CHURCH OF MANCHESTER	5,000.00
TALCOTTVILLE CONGREGATIONAL CHURCH OF TALCOTTVILLE	5,000.00
UNITED METHODIST CHURCH OF BOLTON	1,000.00
VERNON METHODIST CHURCH OF VERNON	1,000.00

ELEVENTH: All the rest, residue and remainder of my estate of every name and nature, both real and personal, including any lapsed or void legacies and devises, I give, devise and bequeath to THE CONNECTICUT BANK AND TRUST COMPANY, absolutely and in fee simple, BUT IN TRUST, NEVERTHELESS, to be held as a permanent fund ~~in memory of ANDREW and ANN FERGUSON~~, for the benefit of MANCHESTER MEMORIAL HOSPITAL, of Manchester, Connecticut, and the net income therefrom, after the payment of all necessary expenses, including reasonable compensation to my said trustee, to be paid not less often than quarterly to said Manchester Memorial Hospital, for its general uses and purposes.

TWELFTH: During the continuance of the trust herein created, I authorize my said trustee to retain, sell, convey and transfer real and personal estate, and to invest and reinvest in any securities (including common stocks and any common trust fund held by the trustee) or property that it in its sole discretion may deem proper, without regard to laws governing the investment of trust funds and to determine and vary from time to time the proportion of the trust to be invested in evidences of debt and the proportion thereof in equities or other property; to exercise any right or option of subscription or otherwise attached to or which at any time may belong or be given to the holders of any stocks, bonds, securities or other instruments in the nature

thereof forming part of the trust estate; to give proxies to vote shares of stock in any corporation at any time held in said estate; to unite with other owners of property or securities similar to any which may be held at any time in the trust estate to carry out any plan for the consolidation, merger, dissolution, liquidation, foreclosure, lease or sale of the property of any corporation, company or association, the securities of which may form a portion of the trust, or the incorporation, reincorporation or reorganization thereof, or the readjustment of the capital or financial structure thereof; to deposit any such securities in accordance with such plan; and to pay any assessments, expenses and sums of money which it shall deem expedient, or which may be required, with reference to any such plan; to register and hold securities or other property in the name of a nominee provided such nominee is the nominee of a corporate trustee hereunder or in the name of The Connecticut Bank and Trust Company as trustee, without further designation, or individually, without any words indicating its fiduciary capacity, without liability other than for any loss which may result from such securities or other property being registered or held in such manner instead of in its name as trustee of this trust; to borrow money and to mortgage, pledge or hypothecate any real or personal property in any trust as security therefor; to abandon, adjust, arbitrate, compromise and otherwise deal with and settle claims in favor of or against the trust estate; and to determine what receipts shall be deemed to be principal and what shall be income and what disbursements shall be charged to each and in what proportions.

THIRTEENTH: I hereby constitute and appoint said THE CONNECTICUT BANK AND TRUST COMPANY to be executor of this my will with power of sale of real and personal property and to borrow money and to mortgage, pledge or hypothecate any real or personal

property in my estate as security therefor and to abandon, adjust, arbitrate, compromise and otherwise deal with and settle claims in favor of or against the estate as it shall deem best. I authorize my executor to pay any pecuniary amounts in property or securities at its own valuations or to pay the same partly in property and partly in cash. I further authorize my said executor to exercise the same powers with reference to control, management and disposition, whether acting as executor or as trustee.

IN WITNESS WHEREOF, I have hereunto set my hand and seal at Hartford, Connecticut, this 4th day of April, A. D. 1961.

Andrew Ferguson (L.S.)

Signed, sealed, published and declared to be as and for his last will and testament by the above named testator, ANDREW FERGUSON, in our presence, who in his presence and in the presence of each other and at his request have hereunto subscribed our names as attesting witnesses at Hartford aforesaid this 4th day of April, A. D. 1961.

Name	Residence
Edna C. Hollowich	Hartford, Conn.
Priscilla A. Holman	West Hartford, Conn.
Anita C. Sheridan	East Hartford, Conn.

STATE OF CONNECTICUT)
COUNTY OF HARTFORD) ss.: Hartford April 4th 1961

The within named Edna C. Hollowich, Priscilla A. Holman and Anita C. Sheridan being duly sworn, depose and say that they witnessed the within will of the within named testator, ANDREW FERGUSON, and subscribed the same in his presence and at his request and in the presence of

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each other; that the said ANDREW FERGUSON at the time of the execution of said will, appeared to them to be of full age and of sound mind and memory; that he signed said will and declared the same to be his last will and testament in their presence; and that they make this affidavit at the request of said testator.

Edna C. Lollirich

Priscilla A. Holman

Anita C. Sheridan

Subscribed and sworn to at the request of the within named testator, ANDREW FERGUSON, the day and year above written, before me

Jonas N. Day

Notary Public

EXHIBIT Q 11-2

Fund 11-1.103

Trust u/w Gertrude H. Rogers

RECORD COPY [redacted] Rogers Fund

KNOW ALL MEN BY THESE PRESENTS, That I, GERTRUDE H. ROGERS, of South Manchester, in the Town of Manchester, County of Hartford and State of Connecticut, being of sound and disposing mind and memory, do make, publish and declare the following to be my last will and testament, hereby revoking all former wills by me made, that is to say:

FIRST: I desire and direct the payment of all my just debts and funeral expenses; and I further direct that a small headstone like the others on my family lot shall be erected over my grave and that the family monument shall be suitably marked to record my death.

SECOND: I direct that all succession, inheritance, legacy, and transfer taxes on any gift under this will shall be paid by my executors and charged and allowed as an item of expense of administration.

THIRD: I give to the Town of Manchester the sum of Two Hundred Dollars ($200), the same to be held in trust and to expend the income therefrom, and that only, in the care and maintenance of the burial lot in the Center Burying Ground where my parents and brother are buried.

FOURTH: I give all my wearing apparel, jewelry and articles of personal use and adornment to my friend, Helen G. Chapman, of South Manchester, absolutely and without imposing any trust. It is my desire that she shall keep, give, sell or otherwise dispose of the same in accordance with my wishes should the same be expressed in a memorandum or letter addressed to her;, or, should there be no such memorandum or letter, in accordance with my wishes as she may know them to be or as it may seem best to her.

FIFTH: All the rest, residue and remainder of my estate, of whatever nature, real and personal and wherever situated, I give, devise and bequeath IN TRUST to the Phoenix State Bank and

Trust Company, a corporation located in Hartford, Connecticut, and Robert S. Merris, of West Hartford, Connecticut, and to their successors in this trust, upon the following trusts;

Said trustees shall have the power to hold or to sell any and all of my estate, real and personal, and to invest and reinvest the proceeds from time to time, without being limited to so-called trust investments. I definitely mean by this that the proceeds may be invested and reinvested in securities of that type commonly known as "business men's risks" or better. After paying all expenses and prior charges connected with my estate, I direct that the net income shall be held, used and applied for the following purposes:

As a first charge against said income I direct that said trustees shall pay to Alice Hewitt, if she shall be in my employ at the time of my death, the sum of One Hundred Dollars ($100) each month during the remainder of her life in recognition of long, thoughtful and generous service to me.

Until the death of said Alice Hewitt the balance of the net income each year and after the death of said Alice Hewitt the entire net income shall be held, used and applied for the benefit of the Manchester Memorial Hospital, a charitable corporation located in said Manchester, for which this fund shall be held as a charitable use in perpetuity, subject to the following limitations: First I direct that the net income from this fund shall be used and applied for the support and development of that department of said Hospital which shall be devoted to the medical or pathological service of that Hospital, and more specifically to its research and laboratory work, that is, any investigation towards the alleviation of illness, including payment of salaries of an adequate staff, and the installation and maintenance of proper equipment, to enable that hospital to furnish complete laboratory service of this kind to the staff of that Hospital and to the physicians of the Town of Manchester for their patients of that town, whether they are then patients of that Hospital or not. Accordingly, I direct that the net income each year shall only be disbursed to

the said Hospital upon a budget for this department submitted by the Hospital to the trustees under this will and approved in writing by two competent physicians, to be chosen as follows: //

In the first instance such budget shall be submitted to and approved in writing by Dr. Isaac W.Kingsbury, of Hartford, and Dr. Howard Boyd, of Manchester. If either of them shall not be living or shall decline, or shall later die or cease to act, the other of the two shall appoint another competent physician to act with him, and thereafter in case of death, resignation or other failure to act, in each case the remaining member shall appoint another competent physician to act with him from time to time, each such appointment to be in writing filed with the trustees under this will. In case for any reason this method of appoint - ment of the two physicians who shall approve such budget shall fail, the trustees under this will are hereby empowered and directed to appoint two competent physicians who, upon accepting the appointment, shall have all the powers herein given the two physicians named by me and their successors, and said physicians are hereby authorized and directed to pass upon the budget submitted by the Hospital authorities for the department herein provided for, and said two physicians, whether appointed by either of the methods herein indicated, shall have absolute control over the expenditure of the budget approved by them. If either of said two physicians after appointment by said trustees and acceptance of the position shall later die or cease to act, the other of the two is authorized to appoint another competent physician to act with him, and thereafter succession shall be provided for as hereinbefore provided in the case of the successors to the physicians originally named.

Furthermore, I direct that in connection with the submission of a budget the Hospital shall also submit annually or oftener to the trustees under this will written accounts showing how the moneys paid by the trustees in the preceding period in accordance with the approved budget have been expended.

I further direct that in each annual report to the Probate

Court covering the administration of this trust the trustee shall indicate the names of the physicians who have approved the budget for that year. My purpose in creating these limitations and conditions is to keep this fund a living force in building up the quality of medical service in that Hospital and in that community, through the establishment of a highly competent technical service in research and laboratory work.

If at any time the trustees of my estate shall be satisfied, after conferring with the disinterested physicians whose duty it shall then be to approve the budget as above provided, that The Manchester Memorial Hospital is not devoting said funds to the purposes for which the gift is made, or is not maintaining as adequate and competent a research and laboratory staff and department as the available income will permit, said trustees shall notify the Manchester Memorial Hospital to that effect and if the failure is not corrected within a reasonable time said trustees may terminate the right of The Manchester Memorial Hospital to receive further funds under this will and thereafter said trustees may apply the income of said fund for similar purposes at the Hartford Hospital, in Hartford, Connecticut.

I further direct that there shall always be two trustees of this residuary estate, one of whom shall be a trust company or a national bank located in Hartford County and the other of whom shall be an individual resident in that County who shall be experienced in matters relating to the investment of trust funds and not connected with the Bank which is the co-trustee.

In case of any vacancy in the office of the corporate trustee the individual trustee then in office shall nominate the successor corporate trustee subject to the approval of the Court of Probate for the District of Manchester, and in case of any vacancy in the office of the individual trustee the Board of Directors of the corporate trustee shall nominate the individual trustee, subject to the approval of the Judge of Probate for the District of Manchester.

I hereby excuse said Robert S. Morris and any successor

individual trustee who shall be appointed in accordance with the foregoing provisions from giving any probate bonds as such trustee.

SIXTH: In making the foregoing disposition of my property I am conscious of the fact that I have no near relatives who are in any way entitled to look to me for support or who have any legal, moral or equitable claim upon me, and I am actuated by the desire to dispose of my estate in such a way that it shall be a permanent and substantial benefit to the people of the Town of Manchester and vicinity.

SEVENTH: I nominate and appoint my friend, George H. Pitney, of the Town of Manchester, and said Phoenix State Bank and Trust Company to be the executors of this will and, so far as I am able, I hereby excuse them and each of them from giving any probate bonds as such executors, and I authorize and empower them as such executors to sell and convey any real estate of which I may die seized.

In case said George H. Pitney shall not qualify or later shall be unable to act as executor or shall resign, I nominate and appoint said Robert S. Morris to be the executor with the Bank in his stead and with the same powers. So far as I am able, I also excuse said Robert S. Morris from giving any probate bonds as such executor.

I request that my executors will confer with my friends, Helen C. Chapman and Mary O. Chapman, or the survivor, as to the disposal of my household furniture and furnishings, including rugs, carpets, draperies, pictures, paintings, ornaments, silverware and books, and I accordingly direct my executors to give such articles to such person or persons as said Helen C. Chapman and Mary O. Chapman, or the survivor, shall designate and appoint, or in their discretion to sell such articles, as they may deem best.

IN WITNESS WHEREOF, I have hereunto set my hand and seal,

declaring this to be my last will and testament, this 13th day of July, 1937.

Gertrude H. Rogers (L.S.)

Signed, sealed, published and declared by said testatrix, Gertrude H. Rogers, as and for her last will and testament in the presence of us, the undersigned, who in her presence and in the presence of each other, at her request, have hereunto set our names as witnesses, this 13th day of July, 1937.

Willis G. Parsons	Hartford, Conn.
Beatrice B. Forster	East Hartford, Conn.
Madeline C. Philbrick	Hartford, Conn.

State of Connecticut)
) ss. Hartford, July 13th, 1937.
County of Hartford)

Then and there personally appeared the above named Willis G. Parsons, Beatrice B. Forster, and Madeline C. Philbrick who, being duly sworn, depose and say that they witnessed the execution of the foregoing will of said testatrix, Gertrude H. Rogers; that she subscribed said will and declared the same to be her last will and testament in their presence; that they thereafter subscribed the same as witnesses in the presence of said testatrix and in the presence of each other and at the request of said testatrix; that said testatrix at the time of the execution of said will appeared to them to be of full age and of sound and disposing mind and memory; and that they make this affidavit at the request of said testatrix.

Subscribed and sworn to
this 13th day of July,
1937, before me

Esther T. Johnson
Notary Public
Seal

Willis G. Parsons
Beatrice B. Forster
Madeline C. Philbrick

KNOW ALL MEN BY THESE PRESENTS, That I, GERTRUDE H. ROGERS, of Manchester, Connecticut, being of sound and disposing mind and memory, do make, publish and declare the following to be a first codicil to my last will and testament, dated July 13, 1937, that is to say:

FIRST: In view of the death of my friend, Helen G. Chapman, I revoke the gift to her in the Fourth article of my said will of all my wearing apparel, jewelry and articles of personal use and adornment, and, in lieu thereof, I give all such articles to my friend, Mary O. Chapman, of Manchester, absolutely and without imposing any trust, but with the same desire as is expressed in the Fourth article of my will as to disposing of some of these articles.

SECOND: Except as altered hereby, I hereby republish and reaffirm my said will, dated the 13th day of July, 1937.

IN WITNESS WHEREOF, I have hereunto set my hand and seal this 11th day of October, 1939, declaring this to be a first codicil to my last will and testament dated the 13th day of July, 1937.

Gertrude H. Rogers (L.S.)

Signed, sealed, published and declared by said testatrix, Gertrude H. Rogers, as and for a first codicil to her last will and testament dated the 13th day of July, 1937, which, except as altered by said codicil, she also republished, in the presence of us, the undersigned, who in her presence and in the presence of each other, at her request, have hereunto set our names as witnesses, this 11th day of October, 1939.

Charles Welles Gross	Hartford, Conn.
Willis G. Parsons	West Hartford, Conn.
Spencer Gross	Hartford, Conn.

State of Connecticut)
) ss. Hartford, October 11, 1939.
County of Hartford)

Then and there personally appeared the above named Charles Welles Gross, Willis C. Parsons and Spencer Gross who, being duly sworn, depose and say that they witnessed the execution of the foregoing codicil of said testatrix, Gertrude H. Rogers; that she subscribed said codicil and declared the same to be a first codicil to her last will and testament dated July 13, 1937, in their presence; that they thereafter subscribed the same as witnesses in the presence of said testatrix and in the presence of each other and at the request of said testatrix; that said testatrix at the time of the execution of said codicil appeared to them to be of full age and of sound and disposing mind and memory; and that they make this affidavit at the request of said testatrix.

Subscribed and sworn to
this 11th day of October,
1939, before me

Esther T. Johnson

Notary Public

Seal

Charles Welles Gross

Willis C. Parsons

Spencer Gross

KNOW ALL MEN BY THESE PRESENTS, That I, GERTRUDE H. ROGERS, of Manchester, Connecticut being of sound and disposing mind and memory, do make, publish and declare the following to be a second codicil to my last will and testament dated July 13, 1937, as modified by a first codicil thereto dated October 11, 1939, that is to say:

FIRST: Desiring to be more specific in the provisions as to the expenditure of income of the residuary trust for the benefit of The Manchester Memorial Hospital, I hereby revoke that portion of the Fifth article of my said will (which gives the residue in trust principally for the benefit of The Manchester Memorial Hospital) as is contained in the fifth paragraph thereof, which fifth paragraph begins with the words "I direct that the net income from this fund shall be used" and ends with the words "approved in writing by two competent physicians, to be chosen as follows:", and, in lieu thereof, I provide as follows, the substituted provision to be inserted in the original will in the same position so that it will be followed immediately by the provisions in the original will for the choice of competent physicians, viz:

"I direct that the net income from this fund shall not be used and applied towards meeting the general running expenses of said Hospital or of its laboratory which would be incurred in the ordinary operation of that Hospital, but that such net income shall be used and applied only for the development and support of research and laboratory work to be maintained by the medical and pathological service of that Hospital, particularly for investigation towards the alleviation of illness, including payment of salaries of an adequate staff and the installation and maintenance of proper equipment, to enable that Hospital to furnish, for a fee, in each case within the means of the patient, complete laboratory service of this kind to the staff of that Hospital and to the physicians of the Town of Manchester for

their patients of that town, whether they are then patients of that Hospital or not, - it being my intention that the income of this Fund shall be used only for specialized technical work, and accordingly I direct that the net income each year shall only be disbursed within the foregoing limitations to the said Hospital upon a budget for this department submitted by the Hospital to the Trustees under this will and approved in writing by two competent physicians, to be chosen as follows:"

SECOND: Except as altered hereby, I hereby reaffirm and republish my said will dated July 13, 1937, as modified by the first codicil thereto dated October 11, 1939.

IN WITNESS WHEREOF, I have hereunto set my hand and seal, this 21st day of October 1940, declaring this to be a second codicil to my last will and testament dated July 13, 1937.

Gertrude H. Rogers (L.S.)

Signed, sealed, published and declared by said testatrix, Gertrude H. Rogers, as and for a second codicil to her last will and testament dated July 13, 1937, which, except as altered by said codicil and by a first codicil thereto dated the 11th day of October, 1939, she also republished, in the presence of us, the undersigned, who in her presence and in the presence of each other, at her request, have hereunto set our names as witnesses, this 21st day of October, 1940.

Charles Welles Gross	Hartford, Conn.
Spencer Gross	Hartford, Conn.
Reese H. Harris, Jr.	West Hartford, Conn.

State of Connecticut)
) ss. Hartford, October 21, 1940.
County of Hartford)

Then and there personally appeared the above named Charles Welles Gross, Spencer Gross and Reese H. Harris, Jr. who, being duly sworn, depose and say that they witnessed the execution of the foregoing codicil of said testatrix, Gertrude H.

Rogers; that she subscribed said codicil and declared the same to be a second codicil to her last will and testament, dated July 13, 1937, in their presence; that they thereafter subscribed the same as witnesses in the presence of said testatrix and in the presence of each other, and at the request of said testatrix; that said testatrix at the time of the execution of said codicil appeared to them to be of full age and of sound and disposing mind and memory; and that they make this affidavit at the request of said testatrix.

Subscribed and sworn to
this 21st day of October,
1940, before me

Esther T. Johnson

Notary Public

Seal

Charles Welles Gross

Spencer Gross

Reese H. Harris, Jr.

EXHIBIT Q 11-2

Fund 11-1.104

Emma Dillon Rockville City Hospital Fund
(Trust u/w Laurence M. Dillon)

2/14/14
Laurence Dillon Jr
30-2414140

Unrestricted

FILE COPY

LAST WILL AND TESTAMENT

I, LAURENCE M. DILLON, of the Town of Vernon, County of Tolland and State of Connecticut, being of lawful age, of sound and disposing mind, memory and judgment, do hereby make, publish and declare this to be my last Will and Testament, hereby revoking all previous wills and codicils by me made.

1. I authorize and direct my Executor to purchase and place a footstone upon my grave, within one year after my death, which shall be appropriately inscribed with my date of birth, i.e. September 10, 1874, and date of death.

2. I direct that my Executor pay out of my residuary estate, without apportionment, all estate, inheritance and like taxes imposed by the government of the United States, or any state or territory thereof, in respect of all property required to be included in my gross estate for estate or like tax purposes by any of such governments, whether the property passes under this Will or otherwise, without contribution by any recipient of any such property.

3. No interest shall be paid on any general pecuniary legacy in my Will.

4. I give and bequeath to ANNA L. DEVLIN, of 91 Union Street, Rockville, Connecticut, if she shall survive me, the sum of FIVE HUNDRED ($500) DOLLARS, absolutely.

5. I give and bequeath all the books in my residence at 22 Davis Avenue, Rockville, Connecticut, to the ROCKVILLE HIGH SCHOOL LIBRARY, Loveland Hill, in the Town of Vernon, Connecticut, absolutely.

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6. I give and bequeath to my cousin AGNES M SMITH, now living in the Fairfax Apartments, 43rd and Locusts Streets, Philadelphia, Pennsylvania, the picture of my grandfather John Hagan and grandmother Sarah Hagan, located in the sitting room of my home, and the heavily plated antique silver tea set, absolutely.

7. I give and bequeath all my personal clothing to ST. BERNARD'S SOCIETY, INC., of Rockville, Connecticut, absolutely.

8. I direct my Executor to sell my real estate located at 22 Davis Avenue, Rockville, Connecticut, as soon after my decease as may be practicable, and I give and bequeath the proceeds of such sale to my Trustee, herein named, IN TRUST, NEVERTHELESS, as part of the trust corpus, for the uses and purposes hereinafter provided.

9. I hereby give, devise and bequeath all the rest, residue and remainder of my estate, both real and personal, of whatsoever kind or character, including lapsed legacies and devises, and wheresoever situated, to THE CONNECTICUT BANK AND TRUST COMPANY, Hartford, Connecticut, as Trustee. Said Trustee shall hold, manage and control all of the aforesaid property as a trust estate, with all the rights and powers, and subject to the limitations, hereinafter enumerated, for the following uses and purposes:-

A. The Trustee shall collect the income from the property comprising the trust estate, pay all taxes and incidental expenses of the trust, and pay all the net annual income derived therefrom, in monthly or other convenient installments, to or for the benefit of my said cousin, AGNES M. SMITH, so long as she shall live.

1) I hereby authorize and empower the Trustee to disburse from the principal of the trust herein created such amounts as it, in its sole discre-

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RMAN AND CASEY

tion, may deem advisable, to provide adequately and properly for any extraordinary expense my said cousin may be put to by reason of illness or disability.

B. Upon the death of my said cousin, or if she shall not survive me, the Trustee shall divide the corpus of the trust estate into two (2) equal parts, IN TRUST, NEVERTHELESS, for the following uses and purposes:-

1) One of said parts, so divided, shall be set apart for the benefit of the ROCKVILLE CITY HOSPITAL, Rockville, Connecticut, its successors or assigns, in perpetuity, and the Trustee shall pay to it, or its successors or assigns, all of the net annual income derived from its said particular fund, in annual or other convenient installments. It is my wish that said fund be named the EMMA DILLON ROCKVILLE CITY HOSPITAL FUND in memorial of my beloved mother. Said net income shall be used for such general purposes as its governing board shall deem proper, and at its discretion.

2) The remaining second part, so divided, shall be set apart for the benefit of ST. BERNARD'S SOCIETY, INC. of Rockville, Connecticut, its successors or assigns, and the Trustee shall pay to it, or its successors or assigns, all of the net annual income derived therefrom, in annual or other convenient installments for a term of fifty (50) years from the date of my death, when the remaining net corpus and accretions, if any, shall be distributed to ST. BERNARD'S SOCIETY, INC., outright and free of trust, to be used for such charitable, religious or educational purposes as its governing authority may deem proper. It is my wish that this fund be named the EMMA DILLON CHARITY FUND in memorial of my beloved mother. In the event any or all of the net income of this trust directed to be distributed to said ST. BERNARD'S SOCIETY, INC. is not distributable to said Society for a period of fifty (50) years from the date of my death for any reason, including a disclaimer by said income beneficiary, the net income of this second part shall be distributed to the ROCKVILLE CITY HOSPITAL,

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Rockville, Connecticut, its successors or assigns, until fifty (50) years from the date of my death, when the remaining net corpus and accretions of said remaining second part shall be paid over absolutely to said ST. BERNARD'S SOCIETY, INC., its successors or assigns.

10. I authorize my Executor and also my Trustee (including any substitute or successor personal representative or Trustee) in its discretion, with respect to all property, real and personal, at any time forming part of my estate or any trust, without limitation by reason of enumeration and in addition to powers conferred by law, to:

A. To compromise, settle, or adjust any claim or demand by or against my estate or any trust and to agree to any rescission or modification of any contract or agreement.

B. To retain any security or other property owned by me at the time of my death, so long as such retention appears advisable, to exchange any such security or property for other securities or properties and to retain such items received in exchange. I have confidence in the securities owned by me at the time of my death and no sale thereof shall be made solely in order to diversify investments.

C. To sell, exchange, assign, transfer and convey any security or property, real or personal, held in my estate or in any trust fund, at public or private sale, at such time and price and upon such terms and conditions (including credit) as it may determine.

D. To invest and reinvest in such stocks, bonds and other securities and properties as it may deem advisable including stocks and unsecured obligations, undivided interests, interests in investment trusts, mutual funds, common trust funds, and leases, all without diversification as to kind or amount without being restricted in any way by any statute or court decision (now or hereafter existing) regulating or limiting investments by fiduciaries.

E. To register and carry any property in its own name or in the name

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of its nominee or to hold it unregistered, but without hereby increasing or decreasing its liability as fiduciary.

F. To sell or exercise any "rights" issued on any securities held in my estate or in any trust fund hereunder.

G. To consider and treat as corpus all dividends payable in stock, all dividends in liquidation and all "rights" issued on securities; and to consider and treat as income all other dividends received (except those declared and payable as of a "record date" preceding my death, which shall be considered and treated as corpus).

H. To charge or credit to corpus any premiums and discounts on securities purchased at more or less than par.

I. To vote in person or by proxy any stock or securities held, and to grant such proxies and powers of attorney to such person or persons as it may deem proper.

J. To consent to and participate in any plan for the liquidation, reorganization, consolidation or merger of any corporation, any security of which is held.

K. To borrow money (from itself individually or from others) upon such terms and conditions as it may determine and to mortgage and pledge estate and trust assets as security for the repayment thereof.

L. Whenever required or permitted to divide and distribute my estate or any trust created hereunder to make such division or distribution in money or in kind or partly in money and partly in kind; and to exercise all power herein conferred, after the termination of any trust until the same is fully distributed.

M. To employ accountants, attorneys and such agents as it may deem advisable; to pay reasonable compensation for their services and to charge same to (or apportion same between) income and principal as it may deem proper.

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N. To hold two or more trusts or other funds in one or more consolidated

funds, in which the separate trusts or funds shall have undivided interests.

11. I appoint THE CONNECTICUT BANK AND TRUST COMPANY, Hartford, Connecticut, to be the Executor of this my Will and Trustee of all trusts created hereunder.

IN WITNESS WHEREOF, I have hereunto set my hand and seal at Rockville, Connecticut, on the 5th day of February 1964.

Laurence M. Dillon (L.S.

Signed, sealed, published and declared by the said LAURENCE M. DILLON as and for his Last Will and Testament, in the presence of us, who at his request, in his presence, and in the presence of each other, have hereunto subscribed our names as witnesses, on the 5th day of February 1964.

Eva G. Wheeler

Arlene B. Spiller

Stanley J. Budarz

STATE OF CONNECTICUT
ss. Rockville February 5th, 1964
COUNTY OF TOLLAND

We the within named Eva G. Wheeler, Arlene B. Spiller and Stanley J. Budarz, being duly sworn, make affidavit and say: That we severally attested the within and foregoing Will of the within named testator and subscribed the same in his presence and at his request and in the presence of each other; that the said testator signed, published and declared the said instrument as and for his last Will and Testament in

Law offices
ACKERMAN AND CASEY

our presence on the 5th day of February 1964; and at the time of execution of said Will, said testator was more than eighteen years of age and of sound mind, memory and judgment and under no improper influence or restraint to the best of our knowledge and belief, and we make this affidavit at the request of said testator.

Eva G. Wheeler
Arlene B. Miller
Stanley J. Budarz

STATE OF CONNECTICUT
ss. Rockville February 5th, 1964
COUNTY OF TOLLAND

Then personally appeared before me, Bernard J. Ackerman, duly qualified to administer oaths,

Eva G. Wheeler
Arlene B. Miller
and Stanley J. Budarz

and subscribed and made oath to the truth of the foregoing affidavit.

Bernard J. Ackerman
Commissioner of Superior Court

W OFFICES
AN AND CASEY

EXHIBIT Q 11-2

Fund 11-1.105

The Marguerite E. Moxon and Dorothy Moxon Yost Memorial Trust

Extra copy

TRUST AGREEMENT

THIS TRUST AGREEMENT made and entered into this 2nd day of April 1982 by and between MARGUERITE E. MOXON and DOROTHY MOXON YOST both of the Town of Vernon, County of Tolland and State of Connecticut (hereinafter referred to as the Settlors), and THE CONNECTICUT BANK AND TRUST COMPANY, a banking corporation having trust powers, organized and existing under the laws of the State of Connecticut and having its principal place of business in Hartford, Connecticut (hereinafter referred to as the Trustee), whereby

The Trustee agrees to hold the property transferred, or which may be transferred, hereunder by the Settlors or by other persons, by gift, devise, bequest or other means, for the following uses and purposes:

1. Name of the Trust. The name of the Trust shall be The Marguerite E. Moxon and Dorothy Moxon Yost Memorial Trust.

2. Purpose of Trust. The purposes of this Trust are to devote and apply the income of this property by this instrument vested in the Connecticut Bank and Trust Company and hereinafter which may be added to the Trust by gift, devise, bequest or other means exclusively for charitable, religious, scientific purposes, by contributions to the organizations hereinafter named, duly authorized to carry on charitable, scientific and/or educational activities; provided, however, that no part of this Trust Fund shall inure to the benefit of any private shareholder or individual and no part of the direct or indirect activities of this Trust shall consist of carrying on propaganda, or otherwise attempting to influence legislation, or of participating in, or intervening in (including the publication or distribution of statements), any political campaign on behalf of any candidate for public office. Notwithstanding any other provision hereof, this Trust shall not conduct or carry on any activities not permitted to be conducted or carried on by an organization exempt under Section 501(c)(3) of the Internal Revenue Code and its Regulations as they now exist or as they may hereafter be amended, or by an organization contributions to which are deductible under Section 170(c)(2) of such Code and Regulations as they now exist or as they may hereafter be amended.

3. Trust Fund. The property to constitute this trust as herein provided shall consist of the property set forth in the Schedule hereunto attached and such other corporate shares, bonds, securities, property and assets, as the creators of this Trust or anyone else may, from time to time, hereinafter

ECHN Proposed Asset Purchase by PMH
Submitted October 13, 2015

transfer to the Connecticut Bank and Trust Company as Trustee, and be accepted by it. Such shares, securities, property, and assets as shall be transferred to the Connecticut Bank and Trust Company shall be held by it, in Trust, and disposed of as hereinafter provided.

4. Use of Trust Fund. The Trustee shall distribute not less than annually all of the net income from the Trust as follows:

One-half of said income to the Trustees of the Rockville General Hospital, Rockville, Connecticut, to be used by the Board of Trustees or other governing body for the benefit of such Rockville General Hospital solely for such capital improvements as the Board of Trustees or other governing body may see fit.

The remaining one-half of said income to the Union Congregational Church, now located on Union Street, Rockville, Connecticut, to be used by the Board of Trustees or other governing body for the benefit of the Union Congregational Church in any manner it deems fit.

5. Trustee's Powers. In the administration of this Trust and of the Trust Fund, the Trustee shall have all powers and authority necessary or available to carry out the purposes of this Trust and, without limiting the generality of the foregoing, shall have the following powers and authority, all subject, however, to the condition that no power or authority shall be exercised by the Trustee in any manner or for any purpose whatsoever which may not be exercised by an organization which is tax exempt or by an organization donations to which are deductible from taxable income to the extent allowed by the provisions of the Internal Revenue Code and other applicable legislation and regulations as they now exist or may hereafter be amended:

A. To retain, without liability for loss or depreciation resulting from said retention, any property, real or personal, received by it hereunder for such time as it shall deem advisable, although said property may not be of the character prescribed by law for the investment of trust assets and although it represents a large percentage of any trust established hereunder;

B. To sell, transfer and convey, grant options to purchase, exchange and alter assets, real or personal, of the trust at any price which the Trustee, acting in good faith, shall consider represents an adequate consideration in money or money's worth, and upon any terms which the Trustee shall deem advisable;

C. To invest and reinvest all funds from time to time available for investment in any kind of property, real or personal, including, without limitation, bonds, interests in common trust funds, interests in investment trusts, stock of any class, mortgages and other investments in property, as it shall deem advisable irrespective of any rules of law governing the investment of trust funds and of the usual policies of diversification of trust investments, and to exercise any stock options possessed by the Settlors at their death;

D. To cause any of the investments which may be delivered to or acquired by the Trustee to be issued, held or registered in the name of the Trustee, in negotiable form, in the name of a nominee or in any form in which title will pass by delivery; and any corporation or its transfer agent may presume conclusively that said nominee is the actual owner of securities submitted for transfer;

E. To vote in person or by proxy any securities held in the trust and, in such connection to delegate powers, discretionary or otherwise, for any purpose to one or more nominees or proxies with or without power of substitution and to make assignments to and deposits with committees, trustees, agents, depositaries and other representatives; to retain any investments received in exchange in any reorganization or recapitalization;

F. To settle, compromise, contest or abandon claims or demands in favor of or against any trust, and the discretion of the Trustee in this respect shall be conclusive and binding;

G. To borrow money, assume indebtedness, extend mortgages and encumber by mortgage or pledge although extending beyond the period of the trust;

H. To determine the market value of any investment of the trust for any purpose on the basis of such quotations, evidence, data or information as the Trustee may deem pertinent and reliable; to distribute in cash or in kind upon partial or final distribution.

I. To pay all costs, charges and expenses of administration of the trust and to receive reasonable compensation for its services and to charge such compensation to income and/or principal;

J. To employ such servants, agents, attorneys, accountants, investment counsel and professional advisors as may be reasonably required or desirable in managing, protecting and investing the trust, and to pay them reasonable compensation;

K. To terminate any trust hereunder by distributing to the then income beneficiary of such trust and entire principal thereof absolutely and free of trust if the Trustee deems the continuance of such trust is not warranted in view of the size of the trust.

L. The Trustee shall not be required to furnish any bond or surety.

6. This Trust is intended to qualify as a charitable trust, as defined in the Internal Revenue Code. The Trustee is authorized to amend the provisions of this instrument in such manner and to such extent as it deems advisable to comply with the requirements of the Code and Regulations thereunder to qualify as such a charitable trust.

IN WITNESS WHEREOF, the Settlors have hereunto set their hands and seals, and the Trustee has caused this Agreement to be executed by its duly authorized officer on the day and year first above written.

Signed, sealed and delivered
in the presence of:

Ellen M. Laert as to all

Ruth A. Grell as to all

Marguerite E. Moxon (LS)
Marguerite E. Moxon, Settlor

Dorothy Moxon Yost (LS)
Dorothy Moxon Yost, Settlor

CONNECTICUT BANK AND TRUST COMPANY

By [signature]

Its Vice President
Trustee

STATE OF CONNECTICUT

COUNTY OF TOLLAND

On this the 2d day of April, 1982 before me, the undersigned officer, personally appeared MARGUERITE E. MOXON and DOROTHY MOXON YOST, known to me to be the persons whose names are subscribed to the within instrument and acknowledged that they executed the same for the purposes therein contained.

In witness whereof I hereunto set my hand and official seal.

Edward Lavitt

Commissioner of the Superior Court

STATE OF CONNECTICUT

COUNTY OF TOLLAND

On this the 2nd day of April, 1982, before me, the undersigned officer, personally appeared Charles L Hanscom who acknowledged that he is the Vice President of The Connecticut Bank and Trust Company, Trustee under the foregoing Trust Agreement and that as such officer being authorized to do so, he executed said Trust Agreement for the purposes therein contained in the name of said Bank as such Trustee.

In witness whereof I hereunto set my hand and official seal.

Edward Lavitt

Commissioner of the Superior Court

EXHIBIT Q 11-2

Fund 11-1.106

Trust u/w William E. Barton

William E. Barton

Unrestricted

The Last Will and Testament of

WILLIAM E. BARTON

LAW OFFICES
KUEHN, SCOTT & LYNCH, P.C.
888 FARMINGTON AVENUE
WEST HARTFORD, CT 06107-2401

a) Unto my two sisters, ANNA H. BARTON and MARY K. BARTON, or the survivor of them, both of the said Town of South Windsor, I give, devise and bequeath my home together with all of the household furniture furnishings and personal effects contained therein and the approximate six (6) acres of land upon which it stands, located in the said Town of South Windsor, to be theirs absolutely and forever, share and share alike.

b) Unto my two sisters, ANNA H. BARTON and MARY K. BARTON, or the survivor of them, I give, devise and bequeath my undivided one-third (1/3) interest in the real estate I own jointly with them, consisting of approximately forty (40) acres with all improvements thereon, to be theirs absolutely and forever, share and share alike.

c) Unto the [redacted] of Rockville, Connecticut, I give and bequeath the sum of TEN THOUSAND ($10,000.00) DOLLARS to be its absolutely and forever, to be used by it as it deems fit.

d) Unto the NEWINGTON CHILDREN'S HOSPITAL, of Newington, Connecticut, I give and bequeath the sum of FIVE HUNDRED ($500.00) DOLLARS to be its absolutely and forever, to be used by it as it deems fit.

e) Unto the CONNECTICUT HUMANE SOCIETY, of Newington, Connecticut, I give and bequeath the sum of FIVE HUNDRED ($500.00) DOLLARS to be its absolutely and forever, to be used by it as it deems fit.

f) Unto JOSEPH BELAZARAS, of South Windsor, Connecticut, I give and bequeath the sum of THREE THOUSAND ($3,000.00) DOLLARS to be his absolutely and forever, and provided he shall survive me, and if not, then I give and

LAW OFFICES
KLEHN, SCOTT
AND LYNCH, P.C.
[illegible]

bequeath the said THREE THOUSAND ($3,000.00) DOLLARS unto his wife, ALBINA BELAZARAS, also of the said Town of South Windsor.

g) Unto my friends, STANLEY AND VIOLA WALDRON, or their survivor, of South Windsor, Connecticut, I give and bequeath the sum of ONE THOUSAND ($1,000.00) DOLLARS to be theirs absolutely and forever.

THIRD: All the rest, residue and remainder of my estate, real, personal and mixed, and wherever the same may be situated, I give, devise and bequeath in manner and form as follows, to wit:

a) I give and bequeath ONE HUNDRED THOUSAND ($100,000.00) DOLLARS thereof unto the CONNECTICUT NATIONAL BANK, of Hartford, Connecticut, or its successors, as Trustee to hold in trust for the benefit of ST. CATHERINE CEMETERY, in East Windsor, Connecticut.

I order and direct my trustee to invest and reinvest all the assets in the trust account as it in its absolute discretion deems fit and to pay therefrom, to or for the benefit of ST. CATHERINE CEMETERY, all of the net income thereof to be used for the general up-keep and improvement of said cemetery and for the purchase of additional cemetery land, if needed.

b) I give, devise and bequeath all the rest, residue and remainder of my estate unto the CONNECTICUT NATIONAL BANK, of Hartford, Connecticut, or its successors, as Trustee.

I order and direct my trustee to invest and reinvest all the assets in the trust account as it in its absolute discretion deems fit and to pay therefrom all the net income thereof unto my two sisters, ANNA H. BARTON and MARY K. BARTON, both of the Town of South Windsor, for so long as they shall live. [redacted] net income thereof be [redacted] and distributed unto the ROCKVILLE GENERAL HOSPITAL, of

LAW OFFICES
KUEHN, SCOTT
AND LYNCH, P.C.
[redacted]
WEST HARTFORD, CT
06107-2101
(203) 236-2871

Rockville, Connecticut, to be used by it as it deems fit.

I HEREBY NOMINATE AND APPOINT the CONNECTICUT NATIONAL BANK of Harford, Connecticut, or its successors, as Executor of this my Last Will and Testament with all of the powers authorized by the Connecticut Fiduciary's Power Act, as it now exists or as it might be amended.

IN WITNESS WHEREOF, I have hereunto set my hand and seal at the Town of South Windsor, Connecticut, this 9th day of December, A.D. 1988.

William E. Barton

Signed, Sealed, Published and Declared by the said WILLIAM E. BARTON, as and for his Last Will and Testament, in the presence of us, who at his request, in his presence and in the present of each other, have hereunto subscribed our names as witnesses of the 9th day of December, A.D., 1988.

WITNESSES	ADDRESSES
Barbara Symington	of East Hartford, CT
[illegible]	of South Windsor, CT

STATE OF CONNECTICUT)
) ss.
COUNTY OF HARTFORD)

December 9, 1988

We, the within named Barbara Symington and [illegible], being duly sworn, make affidavit and say: That we severally attested the within and foregoing Will or the within named Testator, and subscribed the same in his presence, and at his request, and in the presence of each other; that the said Testator signed, published and declared the said instrument as and for his Last Will and Testament in our

LAW OFFICES
KUEHN, SCOTT
AND LYNCH, P.C.
960 FARMINGTON AVENUE
WEST HARTFORD, CT
06107-2101
(203) 236-3973

presence on the 9th day of December, A.D., 1988; and at the time of execution of said Will, said Testator was more than eighteen years of age and of sound mind, memory and judgement, and under no improper influence or restraint to the best of our knowledge and belief, and we make this affidavit at the request of said Testator.

Barbara Symington

Shelley B. Z.

STATE OF CONNECTICUT)
) ss. South Windsor
COUNTY OF HARTFORD)

December 9, 1988

Then personally appeared before me, EDWARD R. KUEHN, duly qualified to administer oaths,

Barbara Symington

and Shelley B. Z.

subscribed and made oath to the truth of the foregoing affidavit.

Edward R. Kuehn

Commissioner of the Superior Court

LAW OFFICES
KUEHN SCOTT
AND LYNCH P.C.
[illegible]
WEST HARTFORD CT
[illegible]
[illegible]

William E. Barton

Unrestricted

The Last Will and Testament of WILLIAM E. BARTON

LAW OFFICES
KUEHN, SCOTT & LYNCH, P.C.
888 FARMINGTON AVENUE
WEST HARTFORD, CT 06107-2981

a) Unto my two sisters, ANNA H. BARTON and MARY K. BARTON, or the survivor of them, both of the said Town of South Windsor, I give, devise and bequeath my home together with all of the household furniture furnishings and personal effects contained therein and the approximate six (6) acres of land upon which it stands, located in the said Town of South Windsor, to be theirs absolutely and forever, share and share alike.

b) Unto my two sisters, ANNA H. BARTON and MARY K. BARTON, or the survivor of them, I give, devise and bequeath my undivided one-third (1/3) interest in the real estate I own jointly with them, consisting of approximately forty (40) acres with all improvements thereon, to be theirs absolutely and forever, share and share alike.

c) Unto the [redacted] of Rockville, Connecticut, I give and bequeath the sum of TEN THOUSAND ($10,000.00) DOLLARS to be its absolutely and forever, to be used by it as it deems fit.

d) Unto the NEWINGTON CHILDREN'S HOSPITAL, of Newington, Connecticut, I give and bequeath the sum of FIVE HUNDRED ($500.00) DOLLARS to be its absolutely and forever, to be used by it as it deems fit.

e) Unto the CONNECTICUT HUMANE SOCIETY, of Newington, Connecticut, I give and bequeath the sum of FIVE HUNDRED ($500.00) DOLLARS to be its absolutely and forever, to be used by it as it deems fit.

f) Unto JOSEPH BELAZARAS, of South Windsor, Connecticut, I give and bequeath the sum of THREE THOUSAND ($3,000.00) DOLLARS to be his absolutely and forever, and provided he shall survive me, and if not, then I give and

LAW OFFICES
KUEHN, SCOTT
AND LYNCH, P.C.
[illegible] FARMINGTON AVENUE
WEST HARTFORD CT
[illegible]
[illegible]

bequeath the said THREE THOUSAND ($3,000.00) DOLLARS unto his wife, ALBINA BELAZARAS, also of the said Town of South Windsor.

g) Unto my friends, STANLEY AND VIOLA WALDRON, or their survivor, of South Windsor, Connecticut, I give and bequeath the sum of ONE THOUSAND ($1,000.00) DOLLARS to be theirs absolutely and forever.

THIRD: All the rest, residue and remainder of my estate, real, personal and mixed, and wherever the same may be situated, I give, devise and bequeath in manner and form as follows, to wit:

a) I give and bequeath ONE HUNDRED THOUSAND ($100,000.00) DOLLARS thereof unto the CONNECTICUT NATIONAL BANK, of Hartford, Connecticut, or its successors, as Trustee to hold in trust for the benefit of ST. CATHERINE CEMETERY, in East Windsor, Connecticut.

I order and direct my trustee to invest and reinvest all the assets in the trust account as it in its absolute discretion deems fit and to pay therefrom, to or for the benefit of ST. CATHERINE CEMETERY, all of the net income thereof to be used for the general up-keep and improvement of said cemetery and for the purchase of additional cemetery land, if needed.

b) I give, devise and bequeath all the rest, residue and remainder of my estate unto the CONNECTICUT NATIONAL BANK, of Hartford, Connecticut, or its successors, as Trustee.

I order and direct my trustee to invest and reinvest all the assets in the trust account as it in its absolute discretion deems fit and to pay therefrom all the net income thereof unto my two sisters, ANNA H. BARTON and MARY K. BARTON, both of the Town of South Windsor, for so long as they shall live. [redacted] [redacted] and distributed unto the ROCKVILLE GENERAL HOSPITAL, of

LAW OFFICES
KUEHN, SCOTT
AND LYNCH, P.C.
[redacted]
WEST HARTFORD CT
06107 2191
(203) 236 2871

Rockville, Connecticut, to be used by it as it deems fit.

I HEREBY NOMINATE AND APPOINT the CONNECTICUT NATIONAL BANK of Harford, Connecticut, or its successors, as Executor of this my Last Will and Testament with all of the powers authorized by the Connecticut Fiduciary's Power Act, as it now exists or as it might be amended.

IN WITNESS WHEREOF, I have hereunto set my hand and seal at the Town of South Windsor, Connecticut, this 9th day of December, A.D. 1988.

William E. Barton [redacted]

Signed, Sealed, Published and Declared by the said WILLIAM E. BARTON, as and for his Last Will and Testament, in the presence of us, who at his request, in his presence and in the present of each other, have hereunto subscribed our names as witnesses of the 9th day of December, A.D., 1988.

WITNESSES	ADDRESSES
Barbara Symington	of East Hartford, CT
[illegible]	of South Windsor, CT

STATE OF CONNECTICUT)
) ss.
COUNTY OF HARTFORD)

December 9, 1988

We, the within named Barbara Symington and [illegible], being duly sworn, make affidavit and say: That we severally attested the within and foregoing Will or the within named Testator, and subscribed the same in his presence, and at his request, and in the presence of each other; that the said Testator signed, published and declared the said instrument as and for his Last Will and Testament in our

LAW OFFICES
KUEHN, SCOTT
AND LYNCH, P.C.
[illegible] FARMINGTON AVENUE
WEST HARTFORD CT
06107 2101
(203) 736 2073

presence on the 9th day of December, A.D., 1988; and at the time of execution of said Will, said Testator was more than eighteen years of age and of sound mind, memory and judgement, and under no improper influence or restraint to the best of our knowledge and belief, and we make this affidavit at the request of said Testator.

Barbara Symington

[signature]

STATE OF CONNECTICUT)
) ss. South Windsor
COUNTY OF HARTFORD)

December 9, 1988

Then personally appeared before me, EDWARD R. KUEHN, duly qualified to administer oaths,

Barbara Symington

and [signature]
subscribed and made oath to the truth of the foregoing affidavit.

[signature]
Commissioner of the Superior Court

LAW OFFICES
KUEHN SCOTT
AND LYNCH P.C.
[illegible]
WEST HARTFORD CT
[illegible]
[illegible]

EXHIBIT Q11-3 - ECHN COMMUNITY FOUNDATION BALANCE SHEET

ECHN Community HealthCare Foundation, Inc. (Exhibit Q11-3)
NET ASSETS - SCHEDULE 2.02(n)
AS OF JUNE 30, 2015

	ECHN Community Healthcare Foundation, Inc.	Reported on Exhibit Q11-1	Add'l Assets Held by the Foundation
ASSETS			
CURRENT ASSETS:			
Cash and cash equivalents	$ 1,089,597		$ 1,089,597
Due from affiliated entities	-		-
Prepaid expenses	16,419		16,419
Pledges Receivable	138,775		138,775
Total current assets	1,244,791		1,244,791
ASSETS WHOSE USE IS LIMITED:			
Donor restricted investments	2,156,893	1,590,569	566,324
Board designated investments	15,114,188		15,114,188
Total assets whose use is limited, net of current portion	17,271,081		15,680,512
TOTAL ASSETS	$ 18,515,872	$ 1,590,569	$ 16,925,303
LIABILITIES, EQUITY AND NET ASSETS			
CURRENT LIABILITIES:			
Accounts payable and accrued expenses	$ 33,688		$ 33,688
Due to affiliated entities	211,726		211,726
Total current liabilities	245,414		245,414
OTHER LIABILITIES:			
Charitable Gift Annuity (expected future payments)	2,937		2,937
Total long-term liabilities	2,937		2,937
Total liabilities	248,351		248,351
TOTAL NET ASSETS "	**$ 18,267,521**	**$ 1,590,569**	**$ 16,676,952**
NET ASSETS:			
Unrestricted	2,634,629		2,634,629
Temporarily restricted	14,065,580	23,257	14,042,323
Permanently restricted	1,567,312	1,567,312	-
Total net assets	$ 18,267,521	$ 1,590,569	$ 16,676,952

EXHIBIT Q13-1 - PROJECTED FINANCIALS TO DUFF & PHELPS

ECHN
5 YEAR PRO FORMA
FY 2013 - FY 2017

INCOME STATEMENT

	Audited FY 2013	Audited FY 2014	Projected FY 2015	Projected FY 2016	Projected FY 2017	Projected FY 2018	Projected FY 2019
Net Patient Revenue	$298,979,957	$299,755,216	$302,867,770	$300,594,032	$304,864,530	$310,068,048	$316,152,030
Operating Expenses:							
Salaries/Temporary Help	$163,729,402	$162,727,445	$156,292,474	$150,021,693	$150,778,127	$153,793,689	$156,869,563
Fringe Benefits	$47,592,094	$43,859,398	$47,762,750	$50,610,250	$49,260,250	$49,710,250	$50,160,250
Supplies	$100,342,397	$104,034,396	$97,399,555	$98,399,555	$99,383,551	$100,377,386	$101,381,160
Physician Fees	$0	$0	$14,605,651	$14,605,651	$15,043,821	$15,495,135	$15,959,989
Depreciation	$12,290,822	$12,196,877	$11,958,956	$11,958,956	$11,958,956	$11,958,956	$11,958,956
Interest	$3,900,483	$3,764,488	$3,570,511	$3,570,511	$3,570,511	$3,570,511	$3,570,511
Total Operating Expenses	$327,855,198	$326,582,604	$331,589,897	$329,166,616	$329,995,215	$334,905,928	$339,900,429
Other Operating Revenue	$16,246,803	$15,384,388	$20,995,796	$20,118,796	$20,118,796	$20,118,796	$20,118,796
Joint Venture Income	$2,113,663	$2,478,522	$2,311,296	$2,311,296	$2,357,522	$2,404,672	$2,452,766
Public Support	$1,614,319	$1,163,883	$1,265,801	$1,265,801	$1,265,801	$1,265,801	$1,265,801
Net Assets Released	$1,871,227	$833,650	$913,370	$913,370	$913,370	$913,370	$913,370
Realized Gains	$5,584,750	$7,812,247	$36,261	$36,261	$36,261	$36,261	$36,261
Interest Income	$1,556,974	$1,327,419	$193,759	$193,759	$193,759	$193,759	$193,759
Total Other Operating Revenue	$28,987,736	$29,000,109	$25,716,283	$24,839,283	$24,885,509	$24,932,660	$24,980,753
Net Operating Income/(Loss)	$112,495	$2,172,721	($3,005,844)	($3,733,301)	($245,176)	$94,780	$1,232,354
Non-Operating Exp's	($2,138,589)	($2,125,751)	($2,394,868)	($1,500,000)	($500,000)	($500,000)	($500,000)
Excess Rev's (Exp's)	($2,026,094)	$46,970	($5,400,712)	($5,233,301)	($745,176)	($405,220)	$732,354
EBITDA	$14,165,211	$16,008,335	$10,128,755	$10,296,166	$14,784,291	$15,124,247	$16,261,821

ECHN
5 YEAR PRO FORMA
FY 2013 - FY 2017

CASHFLOW	Audited FY 2013	Audited FY 2014	Projected FY 2015	Projected FY 2016	Projected FY 2017	Projected FY 2018	Projected FY 2019
Sources:							
Depreciation	$12,290,822	$12,196,877	$11,958,956	$11,958,956	$11,958,956	$11,958,956	$11,958,956
Interest Expense	$3,900,483	$3,764,488	$3,570,511	$3,570,511	$3,570,511	$3,570,511	$3,570,511
Release of Funds	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000
HITECH/MU Funds	($2,630,000)	$877,000	$877,000	$877,000	$0	$0	$0
JV Non-Cash	($1,056,832)	($1,239,261)	($1,155,648)	($1,155,648)	($1,178,761)	($1,202,336)	($1,226,383)
Revenue Cycle Improvement	$2,926,000	$2,380,000	$0	$0	$0	$0	$0
Non-Operating Exp's	($2,138,589)	($2,125,751)	($2,394,868)	($1,500,000)	($500,000)	($500,000)	($500,000)
Uses:							
Debt Service	($10,736,658)	($11,630,719)	($10,240,828)	($10,370,606)	($10,370,606)	($10,370,606)	($10,370,606)
Pension Expense	$3,250,000	$4,800,000	$3,800,000	$5,800,000	$3,700,000	$3,400,000	$3,100,000
Pension Funding	($3,000,000)	($150,000)	($970,000)	($1,840,000)	($3,540,000)	($4,130,000)	($4,660,000)
Capital	($5,000,000)	($5,000,000)	($5,000,000)	($5,000,000)	($5,000,000)	($5,000,000)	($5,000,000)
Projected Surplus/(Lost) Cash Position	($1,082,279)	$7,045,355	($1,560,721)	($393,088)	($605,076)	($1,178,696)	($895,169)
Cumulative Cash Position Surplus	($1,082,279)	$5,963,076	$4,402,355	$4,009,267	$3,404,191	$2,225,495	$1,330,327
COVENANTS							
Debt Service Coverage Ratio (System)	1.32	1.38	1.27	1.37	1.44	1.39	1.42
Debt Service Coverage Ratio (incl. Pensio	1.34	1.78	1.27	1.37	1.44	1.39	1.42
Days Cash on Hand (System)	79.2	87.7	76.4	78.4	77.9	76.1	75.2
Days Cash on Hand (OG)	84.7	95.3	81.3	83.6	83.1	81.0	80.2
TOTAL EBITDA for DEBT SERVICE	$14,165,211	$16,008,335	$10,128,755	$10,296,166	$14,784,291	$15,124,247	$16,261,821
ANNUAL DEBT	($10,736,658)	($11,630,719)	($10,240,828)	($10,370,606)	($10,370,606)	($10,370,606)	($10,370,606)
MIN EBITDA for DEBT SERVICE	$13,420,823	$14,538,399	$12,801,035	$12,963,258	$12,963,258	$12,963,258	$12,963,258
NET INCOME "CUSHION"	$744,388	$1,469,936	($2,672,280)	($2,667,092)	$1,821,033	$2,160,989	$3,298,563

ECHN
5 YEAR PRO FORMA
FY 2013 - FY 2017

	Audited FY 2013	Audited FY 2014	Projected FY 2015	Projected FY 2016	Projected FY 2017	Projected FY 2018	Projected FY 2019
Sources:							
Net Income	$112,495	$2,172,721	($3,005,844)	($3,733,301)	($245,176)	$94,780	$1,232,354
Add: Depreciation & Interest	$16,191,305	$15,961,365	$15,529,467	$15,529,467	$15,529,467	$15,529,467	$15,529,467
EBITDA	$16,303,800	$18,134,086	$12,523,623	$11,796,166	$15,284,291	$15,624,247	$16,761,821
Add/Less: Other Adj's	($1,899,421)	$891,988	($1,673,516)	($778,648)	($678,761)	($702,336)	($726,383)
Add: Pension FAS Expense	$3,250,000	$4,800,000	$3,800,000	$5,800,000	$3,700,000	$3,400,000	$3,100,000
ADJ EBITDA	$17,654,380	$23,826,074	$14,650,107	$16,817,518	$18,305,530	$18,321,911	$19,135,438
Uses:							
Debt Service	$10,736,658	$11,630,719	$10,240,828	$10,370,606	$10,370,606	$10,370,606	$10,370,606
Pension Funding	$3,000,000	$150,000	$970,000	$1,840,000	$3,540,000	$4,130,000	$4,660,000
Capital	$5,000,000	$5,000,000	$5,000,000	$5,000,000	$5,000,000	$5,000,000	$5,000,000
Cash Surplus / (Shortfall)	($1,082,279)	$7,045,355	($1,560,721)	($393,088)	($605,076)	($1,178,696)	($895,169)
	$17,654,380	$23,826,074	$14,650,107	$16,817,518	$18,305,530	$18,321,911	$19,135,438
% Used for Debt Service	60.8%	48.8%	69.9%	61.7%	56.7%	56.6%	54.2%
% Used for Pension	17.0%	0.6%	6.6%	10.9%	19.3%	22.5%	24.4%
% Used for Debt + Pension	77.8%	49.4%	76.5%	72.6%	76.0%	79.1%	78.5%

ECHN
5 YEAR PRO FORMA
FY 2013 - FY 2017

	Audited FY 2013	Audited FY 2014	Projected FY 2015	Projected FY 2016	Projected FY 2017	Projected FY 2018	Projected FY 2019
Statement of Changes in Cashflow							
Changes in Operating Activities							
Excess of Revenues > Expenses	$112,495	$2,172,721	($3,005,844)	($3,733,301)	($245,176)	$94,780	$1,232,354
Non Core Expenses	($2,138,589)	($2,125,751)	($2,394,868)	($1,500,000)	($500,000)	($500,000)	($500,000)
Depreciation and amortization	$12,290,822	$12,196,877	$11,958,956	$11,958,956	$11,958,956	$11,958,956	$11,958,956
Income on Joint Ventures	($2,113,663)	($2,478,522)	($2,311,296)	($2,311,296)	($2,357,522)	($2,404,672)	($2,452,766)
Pension Expense	$3,250,000	$4,800,000	$3,800,000	$5,800,000	$3,700,000	$3,400,000	$3,100,000
Pension Funding	($3,000,000)	($150,000)	($970,000)	($1,840,000)	($3,540,000)	($4,130,000)	($4,660,000)
Restricted Funds Released	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000
Receipt of HITECH Funds	($2,630,000)	$877,000	$877,000	$877,000	$0	$0	$0
A/R (Rev Cycle)	$2,926,000	$2,380,000	$0	$0	$0	$0	$0
Net Cash from Operating Activities	$9,697,065	$18,672,325	$8,953,948	$10,251,359	$10,016,258	$9,419,064	$9,678,544
Changes in Investing Activities							
Purchases of PPE	($11,000,000)	($11,000,000)	($11,000,000)	($11,000,000)	($11,000,000)	($11,000,000)	($11,000,000)
Investments in New Services	$0	$0	$0	$0	$0	$0	$0
Distributions from Joint Ventures	$1,056,832	$1,239,261	$1,155,648	$1,155,648	$1,178,761	$1,202,336	$1,226,383
Net Cash from Investing Activities	($9,943,169)	($9,760,739)	($9,844,352)	($9,844,352)	($9,821,239)	($9,797,664)	($9,773,617)
Changes in Financing Activities							
Principal Payments on LT Debt	($6,836,175)	($7,866,231)	($6,670,317)	($6,800,095)	($6,800,095)	($6,800,095)	($6,800,095)
Proceeds from Borrowings	$6,000,000	$6,000,000	$6,000,000	$6,000,000	$6,000,000	$6,000,000	$6,000,000
Net Cash from Financing Activities	($836,175)	($1,866,231)	($670,317)	($800,095)	($800,095)	($800,095)	($800,095)
Change in Cash	($1,082,279)	$7,045,355	($1,560,721)	($393,088)	($605,076)	($1,178,696)	($895,169)

EXHIBIT Q13-2 - FINANCIAL SUMMARY OF JOINT VENTURES

ECHN Joint Venture Activity

Distributions	**FY 2013**	**FY 2012**	**FY 2011**	**FY 2010**
ECHN Parent				
Ambulance Service of Manchester	1,150,000	1,050,000	1,300,000	900,000
ECHN Enterprises				
Haynes St Med Associates I	20,055	18,909	13,294	11,689
Haynes St Med Associates II	48,750	45,000	22,500	-
Evergreen Medical I	88,000	60,000	33,000	27,000
Evergreen Medical II	46,000	35,500	18,250	5,500
MMH				
GI Joint Venture	450,000	350,000	525,000	200,000
Evergreen Imaging	-	95,000	60,000	9,000
Total Distributions	**1,802,805**	**1,654,409**	**1,972,044**	**1,153,189**

Income	**FY 2013**	**FY 2012**	**FY 2011**	**FY 2010**
RGH				
Tolland Imaging	28,110	32,750	(24,939)	(5,416)
NRRON	53,165	236,091	(6,174)	321,346
ECHN Parent				
Walden BH	22,580	-	-	-
Ambulance Service of Manchester	1,426,958	1,352,486	1,120,236	1,323,714
VNHSC	-	652,809	227,662	172,080
ECHN Enterprises				
Haynes St Med Associates I	23,572	(31,257)	41,959	2,843
Haynes St Med Associates II	33,219	55,535	(48,541)	(397)

Evergreen Medical I	87,319	17,029	23,582	15,780
Evergreen Medical II	(269)	(51,479)	28,325	(34,560)
MMH				
GI Joint Venture	345,654	365,869	326,735	379,549
NRRON	53,165	236,091	(6,174)	321,345
Tolland Imaging	28,110	32,750	(24,939)	(5,416)
Medical Practice Partners	37,070	(124,968)	32,480	(335,843)
Evergreen Imaging	-	157,783	115,954	94,512
Total Income	**2,138,653**	**2,931,489**	**1,806,166**	**2,249,537**

ECHN Joint Venture Activity

Distributions	6/30/2014	6/30/2015	9/30/2014
ECHN Parent			
Ambulance Service of Manchester	600,000	800,000	1,000,000
ECHN Enterprises			
Haynes St Med Associates I	15,471	14,898	20,630
Haynes St Med Associates II	39,375	39,375	52,499
Evergreen Medical I	76,250	78,750	102,500
Evergreen Medical II	35,000	36,000	47,000
MMH			
GI Joint Venture	325,000	-	425,000
Total Distributions	**1,091,096**	**969,023**	**1,647,629**

Income	6/30/2014	6/30/2015	9/30/2014
RGH			
Tolland Imaging	60,370	90,000	89,904
NRRON	217,353	80,000	190,872
ECHN Parent			
Walden BH	(5,821)	-	(1,455)
Metro	(41,196)	24,518	(54,225)
Ambulance Service of Manchester	837,695	1,018,173	1,026,411
Aetna	141,353	(42,691)	188,996
ECHN Enterprises			
Haynes St Med Associates I	24,506	15,471	20,244
Haynes St Med Associates II	49,564	39,375	65,410
Evergreen Medical I	66,759	78,750	108,866
Evergreen Medical II	38,188	36,000	70,834
MMH			
GI Joint Venture	280,000	190,000	491,890
NRRON	217,353	80,000	190,872
Tolland Imaging	60,370	90,000	89,905
Total Income	**1,946,494**	**1,699,596**	**2,478,524**

Joint Venture Net Assets

			JV Equity 9/30/2014	ECHN B/S 9/30/2014	ECHN Net Income / (Loss) 9/30/2014	Joint Venture EBITDA 9/30/2014	EBITDA @ 6x	JV Equity 3/31/2015	ECHN B/S 3/31/2015
Metro	Ambulance Co's	50%	(23,958)	-	(54,225)	(54,462)	(326,772)	(29,896)	-
Aetna	Ambulance Co's	50%	3,922,991	1,961,496	188,996	495,936	2,975,616	3,861,375	1,930,688
ASM	Ambulance Co's	50%	7,597,455	3,798,727	1,026,411	1,355,963	8,135,775	8,959,714	4,479,857
Walden	Behavioral Health Outpt	16%	1,190,586	196,135	(1,455)	10,366	62,195	1,190,586	196,447
Evergreen Endo *	GI Center	50%	429,991	359,698	491,891	565,547	3,393,279	477,514	238,757
Tolland Imaging	Imaging Center	70%	544,026	380,818	179,810	238,046	1,428,277	734,818	514,373
NRRON	Cancer Center	50%	13,196,779	6,598,390	381,743	506,689	3,040,131	13,380,644	6,690,322
Haynes St Med Associates I	Real Estate/MOB	23%	654,308	149,808	20,243	46,896	281,374	654,308	149,808
Haynes St Med Associates II	Real Estate/MOB	15%	1,651,467	249,744	65,410	186,919	1,121,513	1,651,467	249,744
Evergreen Medical I	Real Estate/MOB	20%	1,494,315	264,503	108,866	130,389	782,333	1,494,315	264,503
Evergreen Medical II	Real Estate/MOB	20%	2,728,808	583,419	70,834	205,715	1,234,292	2,728,808	583,419
Total			**33,386,768**	**14,542,738**	**2,478,524**	**3,688,002**	22,128,012	**35,103,653**	**15,297,917**

* As of 9/30/14 Evergreen Endo paid distribution but had not released check

ECHN Share on Evergreen B/S	234,698
Outstanding Distribution	125,000
	359,698

EXHIBIT Q16-1 - CURRENT HOSPITAL SERVICES

List of ECHN's Current Service Lines and Service Locations

As of July 27, 2015

M = Service falls under Manchester Memorial Hospital *R = Service falls under Rockville General Hospital* *J = Service provided through a joint venture affiliate* *A=Services provided through a wholly owned affiliate*	**Manchester Memorial Hospital** 71 Haynes Street Manchester		**Rockville General Hospital** 31 Union Street Vernon		1707 Boston Turnpike Coventry	11 Pinney Street Ellington	175 West Road Ellington	622 Hebron Avenue Glastonbury	43 Woodland Street Hartford	100 Haynes Street Manchester	130 Hartford Road Manchester	150 North Main Street Manchester	360 Tolland Turnpike Manchester	2400 Tamarack Avenue South Windsor	2600 Tamarack Avenue South Windsor	2800 Tamarack Avenue South Windsor	6 Fieldstone Commons Tolland	26 Shenipsit Lake Road Tolland	428 Hartford Turnpike Vernon	47 Hartford Turnpike Vernon	8 Keynote Drive Vernon
Service (by Service Line)	**IP**	**OP**	**IP**	**OP**	Outpatient Service Locations																
Behavioral Health Services																					
Adult Behavioral Health Inpatient Services	M	M(1)																			
Adult Behavioral Health Outpatient Services		M										M									
Adult Partial Hospitalization Program												M									
Adolescent Inpatient Services	M	M(1)																			
Child and Adolescent Outpatient Services		M		R																	
Child and Adolescent Partial Hospitalization Program		M																			
Clinical Day School		M																			
Crisis Services		M		R																	
Eating Disorders Program				R										J							
Cardiac, Vascular, & Neurology Services																					
Cardiac Diagnostic Testing (i.e. Echo, EKG, etc.)	M	M	R	R																	
Cardiac Rehabilitation		M		R																	
Cardio Pulmonary Services	M	M	R	R																	
Heart Failure Clinic		M																			
Medical Cardiology	M	M	R	R																	
Medical Neurology	M	M	R	R																	
Sleep Lab		M																			
SPECT (Cardiac Nuclear Medicine)	M	M	R	R																	
Stress Lab	M	M	R	R																	
Telemetry Monitoring	M	M	R	R																	
Telestroke Services	M	M	R	R																	
Emergency Services																					
Emergency Department	M	M	R	R																	
Urgent Care																R					
General Acute Care Services																					
General Medical/Surgical Care	M	M(1)	R	R(1)																	
Medical/Surgical Intensive Care Unit (ICU)	M	M(1)	R	R(1)																	
Other Special Care Unit (SCU)	M	M(1)	R	R(1)																	
Pediatric Medical/Surgical Care(2)	M	M(1)	R	R(1)																	
Laboratory Services																					
Laboratory	M	M	R	R	M		M	M	M	M	M		M	M	M	M	M		M		
Phlebotomy	M	M	R	R	M		R	M	M	M	M		M	M	M	M	R		M		
Medical Imaging Services																					
Bone Density								M							R		J				
CT Scan	M	M	R	R												R	J				
Diagnostic Radiology (x-ray)	M	M	R	R				M								R	J				
Interventional Radiology	M	M	R	R																	
Mammography		M		R				M							R		J				
MRI	M	M	R	R												R	J				
Nuclear Medicine	M	M	R	R																	
PET Scan		M																			
Ultrasound	M	M	R	R											R	R	J				

List of ECHN's Current Service Lines and Service Locations

As of July 27, 2015

M = Service falls under Manchester Memorial Hospital
R = Service falls under Rockville General Hospital
J = Service provided through a joint venture affiliate
A=Services provided through a wholly owned affiliate

Service (by Service Line)	Manchester Memorial Hospital 71 Haynes Street Manchester		Rockville General Hospital 31 Union Street Vernon		Outpatient Service Locations																	
	IP	OP	IP	OP	1707 Boston Turnpike Coventry	11 Pinney Street Ellington	175 West Road Ellington	622 Hebron Avenue Glastonbury	43 Woodland Street Hartford	100 Haynes Street Manchester	130 Hartford Road Manchester	150 North Main Street Manchester	360 Tolland Turnpike Manchester	2400 Tamarack Avenue South Windsor	2600 Tamarack Avenue South Windsor	2800 Tamarack Avenue South Windsor	6 Fieldstone Commons Tolland	26 Shenipsit Lake Road Tolland	428 Hartford Turnpike Vernon	47 Hartford Turnpike Vernon	8 Keynote Drive Vernon
Metabolic Services																						
Diabetes Management		M																				
Dialysis	M	M	R	R																		
Nutritional Services	M	M	R	R											R							
Oncology services																						
Chemotherapy	M	M																				
Oncology services	M	M	R	R						M												
Radiation Oncology										J												
Rehabilitation Services																						
Occupational Therapy	M	M	R	R												M				R		
Physical Therapy	M	M	R	R		R		M								M				R		
Speech Therapy	M	M	R	R																		
Surgical Services																						
Colorectal	M	M	R	R																		
Endoscopy	M	M	R	R										J								
General Surgery	M	M	R	R																		
Gynecology	M	M	R	R																		
Joint Replacement	M																					
Minimally Invasive	M	M	R	R																		
Ophthalmology	M	M	R	R																		
Oral and Maxofacial Surgery	M	M	R	R																		
Orthopedic	M	M	R	R																		
Otolaryngology (Ear, Nose and Throat)	M	M	R	R																		
Plastic and Reconstructive	M	M	R	R																		
Robotic	M	M																				
Spine/Neurosurgery	M	M	R	R																		
Thoracic	M	M	R	R																		
Urology	M	M	R	R																		
Vascular	M	M	R	R																		
Wound Care	M	M	R																			
Women and Infant Services																						
Breast Ultrasound	M	M	R	R											R		J					
Breast Ultrasound Biopsy	M	M	R	R											R							
Maternity Care Center (Prenatal Care)				R																		
Neonatal Intensive Care Unit (Level III NICU)	M																					
Obstetrics	M	M(1)																				
Stereotactic Breast Biopsy															R							
Other - Miscellaneous Services																						
Community Health Education		M		R						M					R	R						
Complementary and Alternative Medicine Services	M	M	R	R				M		M					R							
Home Care Services																						A
Hospice	M		R																			A
Long-Term Care																		A				
Occupational Medicine																M						
Short-Term Rehabilitation																		A				

(1) Patients may receive outpatient observation services on one of the designated inpatient units.
(2) Manchester Memorial Hospital and Rockville General Hospital do not have dedicated units for inpatient pediatric services. Patients age 14 years and older receive inpatient services on the adult medical/surgical units

ECHN: System Service Locations[3]

Street	Site	Town	State	Zipcode
1707 Boston Turnpike	Meadowbrook Plaza	Coventry	CT	06238
11 Pinney Street	ECHN Rehabilitation Services at the Ellington Y	Ellington	CT	06029
175 West Road	ECHN Medical Offices	Ellington	CT	06029
622 Hebron Avenue	Glastonbury Wellness Center	Glastonbury	CT	06033
43 Woodland Street	Medical Office Building at Gothic Park	Hartford	CT	06105
100 Haynes Street	John A. DeQuattro Cancer Center	Manchester	CT	06040
130 Hartford Road	Manchester Medical Offices	Manchester	CT	06040
150 North Main Street	ECHN Medical Office Building	Manchester	CT	06042
360 Tolland Turnpike	Tolland Turnpike, East Point	Manchester	CT	06040
71 Haynes Street	Manchester Memorial Hospital	Manchester	CT	06040
2400 Tamarack Avenue	Evergreen Walk	South Windsor	CT	06074
2600 Tamarack Avenue	Women's Center for Wellness	South Windsor	CT	06074
2800 Tamarack Avenue	CorpCare Occupational Health	South Windsor	CT	06074
2800 Tamarack Avenue	ECHN Medical Office Building at Evergreen Walk	South Windsor	CT	06074
2800 Tamarack Avenue	Evergreen Imaging Center	South Windsor	CT	06074
2800 Tamarack Avenue	Urgent Care at South Windsor	South Windsor	CT	06074
6 Fieldstone Commons	ECHN Medical Offices	Tolland	CT	06084
26 Shenipsit Lake Road	Woodlake at Tolland Nursing and Rehabilitation Center	Tolland	CT	06084
31 Union Street	Rockville General Hospital	Vernon	CT	06066
428 Hartford Turnpike	Hartford Turnpike	Vernon	CT	06066
47 Hartford Turnpike	The Rehab Center at Big Sky Fitness	Vernon	CT	06066
8 Keynote Drive	Visiting Nurse and Health Services of Connecticut	Vernon	CT	06066

(3) A listing of the Eastern Connecticut Medical Professionals Foundation, Inc. (ECMPF) primary care and specialty care locations will be submitted in the Change of Ownership CON application for ECMPF.

As of July 27, 2015

EXHIBIT Q16-2 SUPPLEMENTAL CON APPLICATION FORMS: ACQUISITION OF EQUIPMENT

Supplemental CON Application Form

Acquisition of Equipment

Conn. Gen. Stat. § 19a-638(a)(10),(11)

Applicant: Eastern Connecticut Health Network, Inc. and Prospect Medical Holdings, Inc.

Project Name: Acquisition of Manchester Memorial Hospital's MRI, PET/CT and CT scanners as part of the Proposed Asset Purchase of Eastern Connecticut Health Network, Inc. by Prospect Medical Holdings, Inc.

Affidavit

Applicant: Eastern Connecticut Health Network, Inc. and Prospect Medical Holdings, Inc.

Project Title: Acquisition of Manchester Memorial Hospital's MRI, PET/CT and CT scanners as part of the Proposed Asset Purchase of Eastern Connecticut Health Network, Inc. by Prospect Medical Holdings, Inc.

I, Peter J. Karl (*Name*), President and Chief Executive Officer (*Position – CEO or CFO*)

of Eastern Connecticut Health Network, Inc. (*Facility Name*) being duly sworn, depose and state that the said facility complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Peter J Karl
Signature

10/9/15
Date

Subscribed and sworn to before me on October 9, 2015

Yvonne Johnson
Notary Public/Commissioner of Superior Court

Yvonne Johnson, Notary Public
My Commission Expires Jan. 31, 2017

My commission expires: _____

Affidavit

Applicant: Eastern Connecticut Health Network, Inc. and Prospect Medical Holdings, Inc.

Project Title: Acquisition of Manchester Memorial Hospital's MRI, PET/CT and CT scanners as part of the Proposed Asset Purchase of Eastern Connecticut Health Network, Inc. by Prospect Medical Holdings, Inc.

I, Samuel S. Lee (Name), Chief Executive Officer (Position – CEO or CFO)

of Prospect Medical Holdings, Inc. (Facility Name) being duly sworn, depose and state that the said facility complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Signature _____ Date 10/9/2015

Subscribed and sworn to before me on _____

_____

Notary Public/Commissioner of Superior Court

My commission expires: _____

Pls. see attached certificate

JURAT

A notary public or other officer completing this Certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California
County of Los Angeles

Subscribed and sworn to (or affirmed) before me on this 9th day of October, 2015,

by Sang Bum Lee -

proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

ELAINE M. LUCAS
Commission # 2064193
Notary Public - California
Los Angeles County
My Comm. Expires May 9, 2018

Signature E. Lucas (Seal)

1. Project Description: Acquisition of Equipment

Overview of Project:

Manchester Memorial Hospital ("MMH") in Manchester, Connecticut provides a broad range of imaging services including computed tomography ("CT"), interventional radiology, mammography, magnetic resonance imaging ("MRI"), nuclear medicine, positron emission tomography with computed tomography ("PET/CT"), ultrasound, ultrasound biopsies and general radiography (x-ray).

Eastern Connecticut Health Network, Inc. ("ECHN"), the parent company of MMH, has now entered into an agreement (the "Asset Purchase") with Prospect Medical Holdings, Inc. ("PMH") with the intent to sell substantially all of ECHN's assets to PMH or one or more affiliates of PMH. As part of the proposed Asset Purchase, a subsidiary of PMH that will continue the operations of MMH will acquire the MRI, PET/CT and both CT scanners currently operated by MMH. [1]

Following the Asset Purchase, there will be no change in operations or services offered by MMH as a result of ECHN transferring its interests to PMH. MMH will continue to offer the same level of care to the same communities that have historically been served by MMH. The Applicants do not anticipate any changes to the patient population or payor mix at MMH or any adverse impact on the communities' access to MRI and CT services.

a. Provide the manufacturer, model and number of slices/tesla strength of the proposed scanner (as appropriate to each piece of equipment).

Response:

Equipment	*Manufacturer*	*Model*	*Slices/Strength*
CT	Siemens	Somatom Sensation	16-Slice
CT	Siemens	Somatom Perspective	64-Slice
MRI	GE	Sigma L	1.5 Tesla (fixed, closed)
PET/CT	GE	GE Discovery DST-600	4-Slice

[1] MMH contracts with an outside vendor to provide PET/CT services two-days per week utilizing a mobile PET/CT unit. PMH intends to continue providing PET/CT services utilizing a part-time mobile unit following the Asset Purchase.

b. List each of the Applicant's sites and the imaging modalities currently offered by location.

Response:

MMH is located at 71 Haynes Street in Manchester, Connecticut.

Imaging services provided at this location include:

- CT scans
- General radiography (x-ray)
- Interventional radiology
- Mammography
- MRI
- Nuclear medicine
- PET/CT scans
- Ultrasound
- Ultrasound biopsies

Additionally, MMH provides bone densitometry, mammography and x-ray services at its Glastonbury Wellness Center at 622 Hebron Avenue in Glastonbury, Connecticut.

2. Clear Public Need

a. Complete **Table A** for each piece of equipment of the type proposed currently operated by the Applicant at each of the Applicant's sites.

TABLE A
EXISTING EQUIPMENT OPERATED BY THE APPLICANT

Provider Name/Address	Service	Days/Hours of Operation[1]	Utilization (SCANS)[2] *July 2014 – June 2015*
Manchester Memorial Hospital 71 Haynes Street Manchester, CT 06040	CT (16-Slice)	Monday-Friday 8:00am to 7:00pm Saturday 8:00am to 12:00pm	16,370
	CT (64-Slice)		
	MRI (1.5 T, Closed)	Monday-Friday 8:00am to 6:00pm Saturday 8:00am to 12:00pm	2,733
	PET/CT (4-Slice)	Monday and Wednesday 8:00am to 4:00pm	341

(1) CT services are available for inpatient and emergent patients twenty-four hours per day, seven days a week.
(2) Utilization by specific CT scanner is not tracked in ECHN's data warehouse; total CT utilization has been provided.

b. Provide the rationale for locating the proposed equipment at the proposed site;

Response:

The Applicants are proposing to transfer the existing MRI, PET/CT and CT scanners at the Haynes Street location to a subsidiary of PMH that will continue the operations of MMH as part of part of the proposed Asset Purchase. The current need for the acquisition of the imaging equipment by PMH will be driven by changes to ECHN at the corporate level related to the proposed Asset Purchase. Following the Asset Purchase, there will be no change in the location of services or the specific services offered by EIC as a result of ECHN transferring its interests to PMH.

3. Actual and Projected Volume

a. Complete the following tables for the past three fiscal years ("FY"), current fiscal year ("CFY"), and first three projected FYs of the proposal, for each of the Applicant's existing and proposed pieces of equipment (of the type proposed, at the proposed location only). In **Table B**, report the units of service by piece of equipment, and in **Table C**, report the units of service by type of exam (e.g. if specializing in orthopedic, neurosurgery, or if there are scans that can be performed on the proposed scanner that the Applicant is unable to perform on its existing scanners).

TABLE B

TABLE B-1: HISTORICAL, CURRENT AND PROJECTED VOLUME BY PIECE OF EQUIPEMENT- CT

Patient Type[1]	Actual Volume			CFY Actual Volume[2]	CFY Annualized Volume[3]	Projected Volume[4]			
	FY 2012	FY 2013	FY 2014	FY 2015	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Emergent	6,491	6,567	7,084	5,613	7,484	7,484	7,484	7,484	7,484
Inpatient	3,819	4,161	4,004	2,830	3,773	3,773	3,773	3,773	3,773
Outpatient	5,820	4,922	4,972	3,741	4,988	4,988	4,988	4,988	4,988
Total:	**16,130**	**15,650**	**16,060**	**12,184**	**16,245**	**16,245**	**16,245**	**16,245**	**16,245**

TABLE B-2: HISTORICAL, CURRENT AND PROJECTED VOLUME BY PIECE OF EQUIPEMENT- MRI

Patient Type[1]	Actual Volume			CFY Actual Volume[2]	CFY Annualized Volume[3]	Projected Volume[4]			
	FY 2012	FY 2013	FY 2014	FY 2015	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Emergent	187	150	213	163	217	217	217	217	217
Inpatient	519	619	609	375	500	500	500	500	500
Outpatient	2,587	2,176	1,955	1,535	2,047	2,047	2,047	2,047	2,047
Total:	**3,293**	**2,945**	**2,777**	**2,073**	**2,764**	**2,764**	**2,764**	**2,764**	**2,764**

TABLE B-3: HISTORICAL, CURRENT AND PROJECTED VOLUME BY PIECE OF EQUIPEMENT- PET/CT

Patient Type[1]	Actual Volume			CFY Actual Volume[2]	CFY Annualized Volume[3]	Projected Volume[4]			
	FY 2012	FY 2013	FY 2014	FY 2015	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Emergent	0	0	0	0	0	0	0	0	0
Inpatient	1	2	6	4	5	5	5	5	5
Outpatient	469	499	392	242	323	323	323	323	323
Total:	**470**	**501**	**398**	**246**	**328**	**328**	**328**	**328**	**328**

(1) Scan volume attributed to patient type as designated at time of discharge.
(2) Current fiscal year actual volume from October 1, 2014 through June 30, 2015.
(3) Actual volume for the first nine months of the current fiscal year annualized over twelve months.
(4) First year of the proposal (following Asset Purchase) will be FY 2017.

TABLE C – COMPUTED TOMOGRAPHY (CT)

TABLE C-1: HISTORICAL, CURRENT AND PROJECTED VOLUME BY TYPE OF SCAN - CT

Emergent	Actual Volume			CFY Actual Volume[1]	CFY Annualized Volume[2]	Projected Volume[3]			
	FY 2012	FY 2013	FY 2014	FY 2015	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Abdomen	11	11	23	26	35	35	35	35	35
Abdomen/Pelvis	2,149	2,193	2,359	1,774	2,365	2,365	2,365	2,365	2,365
Chest/Thorax	569	525	631	491	655	655	655	655	655
Head/Neck	3,557	3,666	3,854	3,157	4,209	4,209	4,209	4,209	4,209
Lower Extremity	52	64	94	81	108	108	108	108	108
Pelvis	44	25	29	21	28	28	28	28	28
Thoracic/Lumbar	84	56	65	38	51	51	51	51	51
Upper Extremity	22	25	25	23	31	31	31	31	31
Other	3	2	4	2	3	3	3	3	3
Total	**6,491**	**6,567**	**7,084**	**5,613**	**7,484**	**7,484**	**7,484**	**7,484**	**7,484**
Inpatient	**Actual Volume**			**CFY Actual Volume[1]**	**CFY Annualized Volume[2]**	**Projected Volume[3]**			
	FY 2012	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**
Abdomen	63	61	61	36	48	48	48	48	48
Abdomen/Pelvis	1,192	1,320	1,279	886	1,181	1,181	1,181	1,181	1,181
Chest/Thorax	860	931	878	668	891	891	891	891	891
Head/Neck	1,269	1,475	1,439	1,011	1,348	1,348	1,348	1,348	1,348
Lower Extremity	74	96	101	75	100	100	100	100	100
Pelvis	36	32	33	17	23	23	23	23	23
Thoracic/Lumbar	35	35	34	27	36	36	36	36	36
Upper Extremity	18	17	16	12	16	16	16	16	16
Other	272	194	163	98	131	131	131	131	131
Total	**3,819**	**4,161**	**4,004**	**2,830**	**3,773**	**3,773**	**3,773**	**3,773**	**3,773**
Outpatient	**Actual Volume**			**CFY Actual Volume[1]**	**CFY Annualized Volume[2]**	**Projected Volume[3]**			
	FY 2012	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**
Abdomen	269	250	246	167	223	223	223	223	223
Abdomen/Pelvis	1,776	1,540	1,568	1,192	1,589	1,589	1,589	1,589	1,589
Chest/Thorax	1,680	1,676	1,626	1,250	1,667	1,667	1,667	1,667	1,667
Head/Neck	979	899	954	774	1,032	1,032	1,032	1,032	1,032
Lower Extremity	50	58	54	49	65	65	65	65	65
Pelvis	60	38	47	33	44	44	44	44	44
Thoracic/Lumbar	68	47	58	58	77	77	77	77	77
Upper Extremity	58	51	52	38	51	51	51	51	51
Other	880	363	367	180	240	240	240	240	240
Total	**5,820**	**4,922**	**4,972**	**3,741**	**4,988**	**4,988**	**4,988**	**4,988**	**4,988**

TABLE C-1: HISTORICAL, CURRENT AND PROJECTED VOLUME BY TYPE OF SCAN - CT

Total	Actual Volume			CFY Actual Volume[1]	CFY Annualized Volume[2]	Projected Volume[3]			
	FY 2012	FY 2013	FY 2014	FY 2015	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Abdomen	343	322	330	229	305	305	305	305	305
Abdomen/Pelvis	5,117	5,053	5,206	3,852	5,136	5,136	5,136	5,136	5,136
Chest/Thorax	3,109	3,132	3,135	2,409	3,212	3,212	3,212	3,212	3,212
Head/Neck	5,805	6,040	6,247	4,942	6,589	6,589	6,589	6,589	6,589
Lower Extremity	176	218	249	205	273	273	273	273	273
Pelvis	140	95	109	71	95	95	95	95	95
Thoracic/Lumbar	187	138	157	123	164	164	164	164	164
Upper Extremity	98	93	93	73	97	97	97	97	97
Other	1,155	559	534	280	373	373	373	373	373
Total	**16,130**	**15,650**	**16,060**	**12,184**	**16,245**	**16,245**	**16,245**	**16,245**	**16,245**

(1) Scan volume attributed to patient type as designated at time of discharge.
(2) Current fiscal year actual volume from October 1, 2014 through June 30, 2015.
(3) Actual volume for the first nine months of the current fiscal year annualized over twelve months.
(4) First year of the proposal (following Asset Purchase) will be FY 2017.

TABLE C – MAGNETIC RESONANCE IMAGING (MRI)

TABLE C-2: HISTORICAL, CURRENT AND PROJECTED VOLUME BY TYPE OF SCAN – MRI

Emergent	Actual Volume			CFY Actual Volume[1]	CFY Annualized Volume[2]	Projected Volume[3]			
	FY 2012	FY 2013	FY 2014	FY 2015	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Abdomen	0	1	3	3	4	4	4	4	4
Chest/Thorax	0	0	0	0	0	0	0	0	0
Head/Neck	112	98	136	107	143	143	143	143	143
Lower Extremity	10	14	11	9	12	12	12	12	12
Pelvis	1	2	1	0	0	0	0	0	0
Thoracic/Lumbar	63	34	62	37	49	49	49	49	49
Upper Extremity	1	1	0	7	9	9	9	9	9
Total	**187**	**150**	**213**	**163**	**217**	**217**	**217**	**217**	**217**
Inpatient	**Actual Volume**			**CFY Actual Volume[1]**	**CFY Annualized Volume[2]**	**Projected Volume[3]**			
	FY 2012	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**
Abdomen	40	43	49	26	35	35	35	35	35
Chest/Thorax	2	1	0	0	0	0	0	0	0
Head/Neck	303	397	360	232	309	309	309	309	309
Lower Extremity	85	79	87	49	65	65	65	65	65
Pelvis	4	8	7	11	15	15	15	15	15
Thoracic/Lumbar	71	79	88	51	68	68	68	68	68
Upper Extremity	14	12	18	6	8	8	8	8	8
Total	**519**	**619**	**609**	**375**	**500**	**500**	**500**	**500**	**500**
Outpatient	**Actual Volume**			**CFY Actual Volume[1]**	**CFY Annualized Volume[2]**	**Projected Volume[3]**			
	FY 2012	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**
Abdomen	122	126	120	96	128	128	128	128	128
Chest/Thorax	6	8	2	6	8	8	8	8	8
Head/Neck	949	863	831	713	951	951	951	951	951
Lower Extremity	592	425	330	233	311	311	311	311	311
Pelvis	27	44	41	41	55	55	55	55	55
Thoracic/Lumbar	499	466	439	314	419	419	419	419	419
Upper Extremity	392	244	192	132	176	176	176	176	176
Total	**2,587**	**2,176**	**1,955**	**1,535**	**2,047**	**2,047**	**2,047**	**2,047**	**2,047**

TABLE C-2: HISTORICAL, CURRENT AND PROJECTED VOLUME BY TYPE OF SCAN – MRI

Total	Actual Volume			CFY Actual Volume[1]	CFY Annualized Volume[2]	Projected Volume[3]			
	FY 2012	FY 2013	FY 2014	FY 2015	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Abdomen	162	170	172	125	167	167	167	167	167
Chest/Thorax	8	9	2	6	8	8	8	8	8
Head/Neck	1,364	1,358	1,327	1,052	1,403	1,403	1,403	1,403	1,403
Lower Extremity	687	518	428	291	388	388	388	388	388
Pelvis	32	54	49	52	69	69	69	69	69
Thoracic/Lumbar	633	579	589	402	536	536	536	536	536
Upper Extremity	407	257	210	145	193	193	193	193	193
Total	**3,293**	**2,945**	**2,777**	**2,073**	**2,764**	**2,764**	**2,764**	**2,764**	**2,764**

(1) Scan volume attributed to patient type as designated at time of discharge.
(2) Current fiscal year actual volume from October 1, 2014 through June 30, 2015.
(3) Actual volume for the first nine months of the current fiscal year annualized over twelve months.
(4) First year of the proposal (following Asset Purchase) will be FY 2017.

TABLE C – POSITRON EMISSION TOMOGRAPHY WITH COMPUTED TOMOGRAPHY (PET/CT)

TABLE C-3: HISTORICAL, CURRENT AND PROJECTED VOLUME BY TYPE OF SCAN – PET/CT

Emergent	Actual Volume			CFY Actual Volume[1]	CFY Annualized Volume[2]	Projected Volume[3]			
	FY 2012	FY 2013	FY 2014	FY 2015	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Brain Image	0	0	0	0	0	0	0	0	0
Skull to Mid-Thigh	0	0	0	0	0	0	0	0	0
Whole Body	0	0	0	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Inpatient	**Actual Volume**			**CFY Actual Volume[1]**	**CFY Annualized Volume[2]**	**Projected Volume[3]**			
	FY 2012	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**
Brain Image	0	0	0	0	0	0	0	0	0
Skull to Mid-Thigh	1	2	6	4	5	5	5	5	5
Whole Body	0	0	0	0	0	0	0	0	0
Total	**1**	**2**	**6**	**4**	**5**	**5**	**5**	**5**	**5**
Outpatient	**Actual Volume**			**CFY Actual Volume[1]**	**CFY Annualized Volume[2]**	**Projected Volume[3]**			
	FY 2012	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**
Brain Image	1	0	1	1	1	1	1	1	1
Skull to Mid-Thigh	466	498	391	240	320	320	320	320	320
Whole Body	2	1	0	1	1	1	1	1	1
Total	**469**	**499**	**392**	**242**	**323**	**323**	**323**	**323**	**323**
Total	**Actual Volume**			**CFY Actual Volume[1]**	**CFY Annualized Volume[2]**	**Projected Volume[3]**			
	FY 2012	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**
Brain Image	1	0	1	1	1	1	1	1	1
Skull to Mid-Thigh	467	500	397	244	325	325	325	325	325
Whole Body	2	1	0	1	1	1	1	1	1
Total	**470**	**501**	**398**	**246**	**328**	**328**	**328**	**328**	**328**

(1) Scan volume attributed to patient type as designated at time of discharge.
(2) Current fiscal year actual volume from October 1, 2014 through June 30, 2015.
(3) Actual volume for the first nine months of the current fiscal year annualized over twelve months.
(4) First year of the proposal (following Asset Purchase) will be FY 2017.

b. Provide a detailed explanation of all assumptions used in the derivation/ calculation of the projected volume by scanner and scan type.

Response:

The average monthly volume experienced during the first nine months of FY 2015 was annualized over twelve months to determine the volume projection for FY 2015. Volume projections by scanner and scan type assumes that utilization will remain constant at FY 2015 levels through FY 2019.

c. Explain any increases and/or decreases in the volume reported in the tables above.

Response:

Recent efforts by insurance carriers to direct patients to "preferred providers" has increased dramatically in recent years. Patients have become more aware of the cost of care as a result of higher co-pays and high-deductible health plans. This increased awareness, combined with insurance carrier efforts to direct patients to lower cost providers, has resulted in a decline in volume for hospital-based services, including MRI and CT services.

d. Provide a breakdown, by town, of the volumes provided in **Table D** for the most recently completed FY.

Response:

Please see Table D below for the CT, MRI and PET/CT scan volume for FY 2014 by town.

TABLE D
UTILI□ATION (SCANS) BY TOWN (FY 2014) - CT

Town	CT	MRI	PET/CT
Andover	145	35	3
Ashford	53	14	2
Avon	2	1	0
Berlin	9	1	0
Bethel	0	1	0
Bloomfield	52	5	0
Bolton	347	89	7
Bridgeport	4	0	0
Bristol	13	2	1
Brookfield	1	0	0
Brooklyn	1	0	0
Burlington	4	0	0
Canterbury	0	2	3
Canton	1	0	0
Chaplin	10	5	0
Cheshire	1	0	0
Clinton	1	0	0
Colchester	48	18	0
Colebrook	1	0	0
Columbia	65	23	3
Coventry	452	96	20
Cromwell	14	2	2
Deep River	8	2	0
Derby	1	0	0
East Granby	12	4	2
East Haddam	4	2	0
East Hampton	18	3	1
East Hartford	2,307	319	27
East Haven	2	0	0
East Lyme	4	0	0
East Windsor	253	40	6
Eastford	5	1	0
Ellington	236	64	22
Enfield	133	24	9
Essex	2	0	0
Fairfield	1	0	0
Farmington	8	0	0
Franklin	0	1	0

Town	CT	MRI	PET/CT
Glastonbury	473	74	11
Granby	6	1	0
Greenwich	2	0	0
Griswold	1	0	0
Guilford	3	0	0
Hamden	4	0	0
Hampton	4	3	0
Hartford	200	29	0
Hartland	1	0	0
Hebron	135	28	7
Killingly	4	1	1
Lebanon	18	10	1
Litchfield	1	0	0
Manchester	6,875	1,230	100
Mansfield	86	24	2
Marlborough	35	9	0
Meriden	10	2	0
Middlefield	0	1	0
Middletown	29	5	4
Milford	2	1	1
Montville	4	0	0
Naugatuck	3	0	0
New Britain	46	7	0
New Haven	8	1	0
New London	1	1	0
Newington	22	4	1
Newtown	1	0	0
North Branford	2	0	0
North Canaan	1	0	0
Old Saybrook	1	0	0
Orange	2	0	0
Plainville	2	0	0
Plymouth	1	0	0
Pomfret	2	0	0
Portland	8	1	0
Putnam	4	1	1
Rocky Hill	24	9	2
Salem	2	2	0

Town	CT	MRI	PET/CT
Shelton	1	0	0
Simsbury	5	0	0
Somers	29	6	4
South Windsor	1,394	167	37
Southington	8	3	0
Stafford/Union	115	23	15
Sterling	2	0	0
Stonington	3	0	0
Stratford	1	0	0
Suffield	14	1	0
Thomaston	0	1	0
Thompson	3	2	0
Tolland	369	62	24
Torrington	0	2	0
Trumbull	2	0	0
Vernon	1,064	189	62
Wallingford	1	0	0
Waterbury	3	0	0
Waterford	0	1	0
West Hartford	38	13	0
West Haven	1	0	0
Westbrook	1	0	0
Wethersfield	38	2	1
Willington	83	15	3
Windham	81	19	0
Windsor	156	20	3
Windsor Locks	76	4	3
Wolcott	5	0	0
Woodstock	4	4	0
Other State	322	42	7
Total	**16,060**	**2,777**	**398**



Supplemental CON Application Form
Acquisition of Equipment
Conn. Gen. Stat. § 19a-638(a)(10),(11)

Applicant: Eastern Connecticut Health Network, Inc. and Prospect Medical Holdings, Inc.

Project Name: Acquisition of Rockville General Hospital's MRI and CT scanner as part of the Proposed Asset Purchase of Eastern Connecticut Health Network, Inc. by Prospect Medical Holdings, Inc.

Affidavit

Applicant: Eastern Connecticut Health Network, Inc. and Prospect Medical Holdings, Inc.

Project Title: Acquisition of Rockville General Hospital's MRI and CT scanner as part of the Proposed Asset Purchase of Eastern Connecticut Health Network, Inc. by Prospect Medical Holdings, Inc.

I, Peter J. Karl (*Name*), President and Chief Executive Officer (*Position – CEO or CFO*)

of Eastern Connecticut Health Network, Inc. (*Facility Name*) being duly sworn, depose and state that the said facility complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Peter J Karl
Signature

10/9/15
Date

Subscribed and sworn to before me on October 9, 2015

Yvonne Johnson
Notary Public/Commissioner of Superior Court

My commission expires: Yvonne Johnson, Notary Public My Commission Expires Jan. 31, 2017

Affidavit

Applicant: Eastern Connecticut Health Network, Inc. and Prospect Medical Holdings, Inc.

Project Title: Acquisition of Rockville General Hospital's MRI and CT scanner as part of the Proposed Asset Purchase of Eastern Connecticut Health Network, Inc. by Prospect Medical Holdings, Inc.

I, Samuel S. Lee (Name), Chief Executive Officer (Position – CEO or CFO)

of Prospect Medical Holdings, Inc. (Facility Name) being duly sworn, depose and state that the said facility complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Signature _____ Date 10/9/2015

Subscribed and sworn to before me on _____

_____

Notary Public/Commissioner of Superior Court

My commission expires: _____

Pls. see attached certificate.

JURAT

A notary public or other officer completing this Certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California
County of Los Angeles

Subscribed and sworn to (or affirmed) before me on this 9th day of October, 2015,

by Sang Bum Lee -

proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

ELAINE M. LUCAS
Commission # 2064193
Notary Public - California
Los Angeles County
My Comm. Expires May 9, 2018

Signature E. Lucas (Seal)

1. Project Description: Acquisition of Equipment

Overview of Project:

Rockville General Hospital ("RGH") in Vernon, Connecticut provides a broad range of imaging services on its hospital campus including computed tomography ("CT"), interventional radiology, mammography, magnetic resonance imaging ("MRI"), nuclear medicine, ultrasound, ultrasound biopsies and general radiography (x-ray).

Eastern Connecticut Health Network, Inc. ("ECHN"), the parent company of RGH, has now entered into an agreement (the "Asset Purchase") with Prospect Medical Holdings, Inc. ("PMH") with the intent to sell substantially all of ECHN's assets to PMH or one or more affiliates of PMH. As part of the proposed Asset Purchase, a PMH subsidiary that will continue the operations of RGH will acquire the MRI, and CT scanner currently operated by RGH on the hospital campus.

Following the Asset Purchase, there will be no change in operations or services offered by RGH as a result of ECHN transferring its interests to PMH. RGH will continue to offer the same level of care to the same communities that have historically been served by RGH. The Applicants do not anticipate any changes to the patient population or payor mix at RGH or any adverse impact on the communities' access to MRI and CT services.

a. Provide the manufacturer, model and number of slices/tesla strength of the proposed scanner (as appropriate to each piece of equipment).

Response:

Equipment	*Manufacturer*	*Model*	*Slices/Strength*
CT	Siemens	Somatom Emotion	16-Slice
MRI	Siemens	Symphony Maestro Class	1.5 Tesla (fixed, closed)

b. List each of the Applicant's sites and the imaging modalities currently offered by location.

Response:

RGH is located at 31 Union Street in Vernon, Connecticut.

Imaging services provided at this location include:

- CT scans
- General radiography (x-ray)
- Interventional radiology
- Mammography
- MRI
- Nuclear medicine
- Ultrasound
- Ultrasound biopsies

RGH also provides bone densitometry, mammography, stereotactic biopsies, ultrasounds and ultrasound biopsies at its Women's Center for Wellness located at 2600 Tamarack Avenue in South Windsor, Connecticut. Additionally, RGH provides CT, MRI, ultrasound and x-ray services at Evergreen Imaging Center in South Windsor.[1]

2. Clear Public Need

a. Complete **Table A** for each piece of equipment of the type proposed currently operated by the Applicant at each of the Applicant's sites.

TABLE A
EXISTING EQUIPMENT OPERATED BY THE APPLICANT

Provider Name/Address	Service	Days/Hours of Operation(1)	Utilization (SCANS) *July 2014 – June 2015*
Rockville General Hospital 31 Union Street Vernon, CT 06066	CT (16-slice)	Monday-Friday 8:00am to 6:00pm	8,175
	MRI (1.5 T, Closed)	Monday-Friday 9:00am to 4:00pm	1,508

(1) CT services are available for inpatient and emergent patients twenty-four hours per day, seven days a week.

b. Provide the rationale for locating the proposed equipment at the proposed site;

[1] Please see the separate Supplemental CON Application Form for more information on the Acquisition of RGH's off-site MRI and CT scanner as part of the proposed Asset Purchase of ECHN by PMH.

Response:

The Applicants are proposing to transfer the existing MRI and CT scanners at the Union Street location to a subsidiary of the PMH that will continue the operations of RGH as part of part of the proposed Asset Purchase. The current need for the acquisition of the imaging equipment by PMH will be driven by changes to ECHN at the corporate level related to the proposed Asset Purchase. Following the Asset Purchase, there will be no change in the location of services or the specific services offered by RGH as a result of ECHN transferring its interests to PMH.

3. Actual and Projected Volume

   a. Complete the following tables for the past three fiscal years (FY), current fiscal year (CFY), and first three projected FYs of the proposal, for each of the Applicant's existing and proposed pieces of equipment (of the type proposed, at the proposed location only). In **Table B**, report the units of service by piece of equipment, and in **Table C**, report the units of service by type of exam (e.g. if specializing in orthopedic, neurosurgery, or if there are scans that can be performed on the proposed scanner that the Applicant is unable to perform on its existing scanners).

TABLE B

TABLE B-1: HISTORICAL, CURRENT AND PROJECTED VOLUME BY PIECE OF EQUIPEMENT- CT

Patient Type[1]	Actual Volume			CFY Actual Volume[2]	CFY Annualized Volume[3]	Projected Volume[4]			
	FY 2012	FY 2013	FY 2014	FY 2015	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Emergent	3,665	3,540	3,813	2,982	3,976	3,976	3,976	3,976	3,976
Inpatient	1,815	1,806	1,705	1,357	1,809	1,809	1,809	1,809	1,809
Outpatient	2,514	2,532	2,288	1,811	2,415	2,415	2,415	2,415	2,415
Total:	**7,994**	**7,878**	**7,806**	**6,150**	**8,200**	**8,200**	**8,200**	**8,200**	**8,200**

TABLE B-2: HISTORICAL, CURRENT AND PROJECTED VOLUME BY PIECE OF EQUIPEMENT- MRI

Patient Type[1]	Actual Volume			CFY Actual Volume[2]	CFY Annualized Volume[3]	Projected Volume[4]			
	FY 2012	FY 2013	FY 2014	FY 2015	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Emergent	127	116	123	103	137	137	137	137	137
Inpatient	234	272	194	189	252	252	252	252	252
Outpatient	1,385	1,249	1,118	829	1,105	1,105	1,105	1,105	1,105
Total:	**1,746**	**1,637**	**1,435**	**1,121**	**1,495**	**1,495**	**1,495**	**1,495**	**1,495**

(1) Scan volume attributed to patient type as designated at time of discharge.
(2) Current fiscal year actual volume from October 1, 2014 through June 30, 2015.
(3) Actual volume for the first nine months of the current fiscal year annualized over twelve months.
(4) First year of the proposal (following Asset Purchase) will be FY 2017.

TABLE C – COMPUTED TOMOGRAPHY (CT)

TABLE C-1: HISTORICAL, CURRENT AND PROJECTED VOLUME BY TYPE OF SCAN - CT

Emergent	Actual Volume			CFY Actual Volume[1]	CFY Annualized Volume[2]	Projected Volume[3]			
	FY 2012	FY 2013	FY 2014	FY 2015	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Abdomen	16	11	16	9	12	12	12	12	12
Abdomen/Pelvis	1,283	1,223	1,297	993	1,324	1,324	1,324	1,324	1,324
Chest/Thorax	299	288	338	273	364	364	364	364	364
Head/Neck	1,951	1,926	2,070	1,613	2,151	2,151	2,151	2,151	2,151
Lower Extremity	34	42	34	44	59	59	59	59	59
Pelvis	17	10	11	7	9	9	9	9	9
Thoracic/Lumbar	53	28	33	30	40	40	40	40	40
Upper Extremity	10	11	12	11	15	15	15	15	15
Other	2	1	2	2	3	3	3	3	3
Total	**3,665**	**3,540**	**3,813**	**2,982**	**3,976**	**3,976**	**3,976**	**3,976**	**3,976**
Inpatient	**Actual Volume**			**CFY Actual Volume[1]**	**CFY Annualized Volume[2]**	**Projected Volume[3]**			
	FY 2012	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**
Abdomen	21	14	20	25	33	33	33	33	33
Abdomen/Pelvis	528	525	532	428	571	571	571	571	571
Chest/Thorax	392	407	365	308	411	411	411	411	411
Head/Neck	643	688	654	490	653	653	653	653	653
Lower Extremity	46	42	32	35	47	47	47	47	47
Pelvis	22	11	15	4	5	5	5	5	5
Thoracic/Lumbar	71	61	38	29	39	39	39	39	39
Upper Extremity	13	4	9	6	8	8	8	8	8
Other	79	54	40	32	43	43	43	43	43
Total	**1,815**	**1,806**	**1,705**	**1,357**	**1,809**	**1,809**	**1,809**	**1,809**	**1,809**
Outpatient	**Actual Volume**			**CFY Actual Volume[1]**	**CFY Annualized Volume[2]**	**Projected Volume[3]**			
	FY 2012	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**
Abdomen	144	122	141	88	117	117	117	117	117
Abdomen/Pelvis	764	680	758	556	741	741	741	741	741
Chest/Thorax	688	685	647	527	703	703	703	703	703
Head/Neck	478	531	495	427	569	569	569	569	569
Lower Extremity	19	26	27	19	25	25	25	25	25
Pelvis	39	24	24	16	21	21	21	21	21
Thoracic/Lumbar	67	58	51	34	45	45	45	45	45
Upper Extremity	18	18	25	14	19	19	19	19	19
Other	297	388	120	130	173	173	173	173	173
Total	**2,514**	**2,532**	**2,288**	**1,811**	**2,415**	**2,415**	**2,415**	**2,415**	**2,415**

TABLE C-1: HISTORICAL, CURRENT AND PROJECTED VOLUME BY TYPE OF SCAN - CT

Total	Actual Volume			CFY Actual Volume[1]	CFY Annualized Volume[2]	Projected Volume[3]			
	FY 2012	FY 2013	FY 2014	FY 2015	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Abdomen	181	147	177	122	163	163	163	163	163
Abdomen/Pelvis	2,575	2,428	2,587	1,977	2,636	2,636	2,636	2,636	2,636
Chest/Thorax	1,379	1,380	1,350	1,108	1,477	1,477	1,477	1,477	1,477
Head/Neck	3,072	3,145	3,219	2,530	3,373	3,373	3,373	3,373	3,373
Lower Extremity	99	110	93	98	131	131	131	131	131
Pelvis	78	45	50	27	36	36	36	36	36
Thoracic/Lumbar	191	147	122	93	124	124	124	124	124
Upper Extremity	41	33	46	31	41	41	41	41	41
Other	378	443	162	164	219	219	219	219	219
Total	**7,994**	**7,878**	**7,806**	**6,150**	**8,200**	**8,200**	**8,200**	**8,200**	**8,200**

(1) Scan volume attributed to patient type as designated at time of discharge.
(2) Current fiscal year actual volume from October 1, 2014 through June 30, 2015.
(3) Actual volume for the first nine months of the current fiscal year annualized over twelve months.
(4) First year of the proposal (following Asset Purchase) will be FY 2017.

TABLE C – MAGNETIC RESONANCE IMAGING (MRI)

TABLE C-2: HISTORICAL, CURRENT AND PROJECTED VOLUME BY TYPE OF SCAN – MRI

Emergent	Actual Volume			CFY Actual Volume[1]	CFY Annualized Volume[2]	Projected Volume[3]			
	FY 2012	FY 2013	FY 2014	FY 2015	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Abdomen	0	0	0	0	0	0	0	0	0
Chest/Thorax	0	0	0	0	0	0	0	0	0
Head/Neck	66	60	76	68	91	91	91	91	91
Lower Extremity	11	9	11	7	9	9	9	9	9
Pelvis	0	1	0	2	3	3	3	3	3
Thoracic/Lumbar	45	46	34	25	33	33	33	33	33
Upper Extremity	5	0	2	1	1	1	1	1	1
Other	0	0	0	0	0	0	0	0	0
Total	**127**	**116**	**123**	**103**	**137**	**137**	**137**	**137**	**137**
Inpatient	**Actual Volume**			**CFY Actual Volume[1]**	**CFY Annualized Volume[2]**	**Projected Volume[3]**			
	FY 2012	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**
Abdomen	13	17	15	14	0	0	0	0	0
Chest/Thorax	0	0	0	1	1	1	1	1	1
Head/Neck	153	174	119	126	168	168	168	168	168
Lower Extremity	31	28	20	18	24	24	24	24	24
Pelvis	1	0	5	4	5	5	5	5	5
Thoracic/Lumbar	34	47	30	24	32	32	32	32	32
Upper Extremity	2	6	5	2	3	3	3	3	3
Other	0	0	0	0	0	0	0	0	0
Total	**234**	**272**	**194**	**189**	**252**	**252**	**252**	**252**	**252**
Outpatient	**Actual Volume**			**CFY Actual Volume[1]**	**CFY Annualized Volume[2]**	**Projected Volume[3]**			
	FY 2012	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**
Abdomen	62	74	74	50	0	0	0	0	0
Chest/Thorax	3	3	10	6	8	8	8	8	8
Head/Neck	568	523	485	341	455	455	455	455	455
Lower Extremity	236	209	185	140	187	187	187	187	187
Pelvis	28	13	17	11	15	15	15	15	15
Thoracic/Lumbar	346	312	257	212	283	283	283	283	283
Upper Extremity	138	109	89	69	92	92	92	92	92
Other	4	6	1	0	0	0	0	0	0
Total	**1,385**	**1,249**	**1,118**	**829**	**1,105**	**1,105**	**1,105**	**1,105**	**1,105**

TABLE C-2: HISTORICAL, CURRENT AND PROJECTED VOLUME BY TYPE OF SCAN – MRI

Total	Actual Volume			CFY Actual Volume[1]	CFY Annualized Volume[2]	Projected Volume[3]			
	FY 2012	FY 2013	FY 2014	FY 2015	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Abdomen	75	91	89	64	85	85	85	85	85
Chest/Thorax	3	3	10	7	9	9	9	9	9
Head/Neck	787	757	680	535	713	713	713	713	713
Lower Extremity	278	246	216	165	220	220	220	220	220
Pelvis	29	14	22	17	23	23	23	23	23
Thoracic/Lumbar	425	405	321	261	348	348	348	348	348
Upper Extremity	145	115	96	72	96	96	96	96	96
Other	4	6	1	0	0	0	0	0	0
Total	**1,746**	**1,637**	**1,435**	**1,121**	**1,495**	**1,495**	**1,495**	**1,495**	**1,495**

(1) Scan volume attributed to patient type as designated at time of discharge.
(2) Current fiscal year actual volume from October 1, 2014 through June 30, 2015.
(3) Actual volume for the first nine months of the current fiscal year annualized over twelve months.
(4) First year of the proposal (following Asset Purchase) will be FY 2017.

b. Provide a detailed explanation of all assumptions used in the derivation/ calculation of the projected volume by scanner and scan type.

Response:

The average monthly volume experienced during the first nine months of FY 2015 was annualized over twelve months to determine the volume projection for FY 2015. Volume projections by scanner and scan type assume that utilization will remain constant at FY 2015 levels through FY 2019.

c. Explain any increases and/or decreases in the volume reported in the tables above.

Response:

Recent efforts by insurance carriers to direct patients to "preferred providers" have increased dramatically in recent years. Patients have become more aware of the cost of care as a result of higher co-pays and high-deductible health plans. This increased awareness, combined with insurance carrier efforts to direct patients to lower cost providers, has resulted in a decline in volume for hospital-based services, including MRI and CT services.

d. Provide a breakdown, by town, of the volumes provided in **Table D** for the most recently completed FY.

Response:

Please see Table D below for the CT and MRI scan volume for FY 2014 by town.

TABLE D
UTILI□ATION (SCANS) BY TOWN (FY 2014) - CT

Town	CT	MRI
Andover	24	4
Ashford	65	10
Avon	1	0
Berlin	1	1
Bloomfield	9	0
Bolton	42	7
Bristol	3	0
Brookfield	1	0
Burlington	1	0
Canterbury	0	2
Canton	9	0
Chaplin	11	0
Cheshire	1	0
Clinton	5	0
Colchester	5	4
Columbia	9	4
Coventry	221	26
Cromwell	2	0
Deep River	1	0
East Granby	5	1
East Haddam	1	0
East Hartford	112	23
East Haven	1	0
East Lyme	1	0
East Windsor	212	27
Eastford	0	1
Ellington	1,045	230
Enfield	116	13
Farmington	2	2
Glastonbury	25	3
Granby	6	1
Griswold	1	0
Groton	3	0
Guilford	3	1
Hampton	6	0
Hartford	42	7
Hebron	13	3

Town	CT	MRI
Killingly	1	3
Lebanon	9	1
Ledyard	2	3
Manchester	412	65
Mansfield	80	15
Marlborough	3	4
Meriden	6	2
Middletown	8	5
Montville	3	0
New Britain	8	1
New London	2	0
Newington	17	3
Norwalk	1	0
Norwich	2	0
Old Saybrook	2	0
Orange	1	0
Plainfield	3	0
Plainville	1	0
Pomfret	1	1
Portland	2	0
Preston	1	0
Putnam	3	0
Rocky Hill	7	1
Salisbury	1	0
Simsbury	9	0
Somers	103	15
South Windsor	289	31
Southington	2	0
Sprague	2	0
Stafford /Union	246	70
Stratford	2	0
Suffield	8	5
Tolland	919	129
Vernon	3,202	636
Voluntown	2	0
Wallingford	1	0
Waterbury	6	3

Town	CT	MRI
Watertown	2	0
West Hartford	9	0
Wethersfield	7	3
Willington	148	31
Windham	20	5
Windsor	21	2
Windsor Locks	35	6
Wolcott	1	0
Woodbridge	3	0
Woodstock	2	0
Other State	184	25
Total	**7,806**	**1,435**



Supplemental CON Application Form
Acquisition of Equipment
Conn. Gen. Stat. § 19a-638(a)(10),(11)

Applicant: Eastern Connecticut Health Network, Inc. and Prospect Medical Holdings, Inc.

Project Name: Acquisition of Rockville General Hospital's off-site MRI and CT scanner as part of the Proposed Asset Purchase of Eastern Connecticut Health Network, Inc. by Prospect Medical Holdings, Inc.

Affidavit

Applicant: Eastern Connecticut Health Network, Inc. and Prospect Medical Holdings, Inc.

Project Title: Acquisition of Rockville General Hospital's off-site MRI and CT scanner as part of the Proposed Asset Purchase of Eastern Connecticut Health Network, Inc. by Prospect Medical Holdings, Inc.

I, Peter J. Karl (*Name*), President and Chief Executive Officer (*Position – CEO or CFO*)

of Eastern Connecticut Health Network, Inc. (*Facility Name*) being duly sworn, depose and state that the said facility complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Peter J. Karl
Signature

10/9/15
Date

Subscribed and sworn to before me on October 9, 2015

Yvonne Johnson
Notary Public/Commissioner of Superior Court

My commission expires: Yvonne Johnson, Notary Public My Commission Expires Jan. 31, 2017

Affidavit

Applicant: Eastern Connecticut Health Network, Inc. and Prospect Medical Holdings, Inc.

Project Title: Acquisition of Rockville General Hospital's off-site MRI and CT scanner as part of the Proposed Asset Purchase of Eastern Connecticut Health Network, Inc. by Prospect Medical Holdings, Inc.

I, Samuel S. Lee (*Name*), Chief Executive Officer (*Position – CEO or CFO*)

of Prospect Medical Holdings, Inc. (*Facility Name*) being duly sworn, depose and state that the said facility complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Signature

10/9/2015
Date

Subscribed and sworn to before me on _____

Notary Public/Commissioner of Superior Court

My commission expires: _____

Ph. see attached certificate.

JURAT

A notary public or other officer completing this Certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California
County of Los Angeles

Subscribed and sworn to (or affirmed) before me on this 9th day of October, 2015,

by Sang Bum Lee -

proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

ELAINE M. LUCAS
Commission # 2064193
Notary Public - California
Los Angeles County
My Comm. Expires May 9, 2018

Signature E. Lucas (Seal)

1. Project Description: Acquisition of Equipment

Overview of Project:

Evergreen Imaging Center ("EIC") is a diagnostic testing facility in South Windsor, Connecticut that provides a range of imaging services including general radiography, ultrasound, computed tomography ("CT") scanning and magnetic resonance imaging ("MRI").

EIC, which has been in operation since May 25, 2006, was originally established as a joint venture partnership between Eastern Connecticut Health Network, Inc. ("ECHN") and Eastern Connecticut Imaging, P.C. ("ECI") (Docket Number 03-30172-CON). On March 8, 2012, ECHN and ECI received regulatory approval to transfer ownership and control entirely to ECHN (Docket Number 11-31736-CON). Effective June 4, 2012, EIC became a department of Rockville General Hospital ("RGH"), a subsidiary of ECHN.

ECHN has now entered into an agreement (the "Asset Purchase") with Prospect Medical Holdings, Inc. ("PMH") with the intent to sell substantially all of ECHN's assets to PMH or one or more affiliates of PMH. As part of the proposed Asset Purchase, PMH will acquire the off-site MRI and CT scanner operated by RGH at EIC.

Following the Asset Purchase, there will be no change in operations or services offered by EIC as a result of ECHN transferring its interests to PMH. EIC will continue to offer the same level of care to the same communities that have historically been served by EIC. The Applicants do not anticipate any changes to the patient population to be served or to the payor mix at EIC or any adverse impact on the communities' access to MRI and CT services.

a. Provide the manufacturer, model and number of slices/tesla strength of the proposed scanner (as appropriate to each piece of equipment).

Response:

MRI: Siemans Magnatom Symphony (1.5 Tesla, short-bore, closed)
CT: Somatom Emotion 6 (6-slice)

b. List each of the Applicant's sites and the imaging modalities currently offered by location.

Response:

EIC is located at 2800 Tamarack Avenue in South Windsor, CT.

Imaging services provided at this location include CT, general radiography (x-ray), MRI and ultrasound.

2. Clear Public Need

a. Complete **Table A** for each piece of equipment of the type proposed currently operated by the Applicant at each of the Applicant s sites.

TABLE A
E ISTING EQUIPMENT OPERATED BY THE APPLICANT

Provider Name/Address	Service	Days/Hours of Operation	Utilization (SCANS) *July 2014 – June 2015*
Rockville General Hospital d/b/a Evergreen Imaging Center 2800 Tamarack Avenue, Suite 002 South Windsor, CT 06074	CT (6-Slice)	Monday Friday 8:00 am to 4:30 pm	1,799
	MRI (1.5 T, Closed)	Monday Friday 8:00 am to 4:30 pm	1,274

b. Provide the rationale for locating the proposed equipment at the proposed site;

Response:

The Applicants are proposing to transfer the existing MRI and CT scanner at the Tamarack Avenue location to a subsidiary of PMH that will continue to operate RGH as part of part of the proposed Asset Purchase. The need to establish MRI and CT services in South Windsor was clearly demonstrated in Docket Number 03-30172-CON. The current need for the acquisition of the imaging equipment by PMH will be driven by changes to ECHN at the corporate level related to the proposed Asset Purchase. Following the Asset Purchase, there will be no change in the location of services or the specific services offered by EIC as a result of ECHN transferring its interests to PMH.

3. Actual and Projected Volume

a. Complete the following tables for the past three fiscal years (FY), current fiscal year (CFY), and first three projected FYs of the proposal, for each of the Applicant s existing and proposed pieces of equipment (of the type proposed, at the proposed location only). In **Table B**, report the units of service by piece of equipment, and in **Table C**, report the units of service by type of exam (e.g. if specializing in orthopedic, neurosurgery, or if there are scans that can be performed on the proposed scanner that the Applicant is unable to perform on its existing scanners).

TABLE B
HISTORICAL, CURRENT, AND PROJECTED VOLUME, BY EQUIPMENT UNIT

Equipment	Actual Volume (Last 3 Completed FYs)			CFY Actual Volume[1]	CFY Annualized Volume[2]	Projected Volume (First 3 Full Operational FYs)[3]			
	FY 2012	FY 2013	FY 2014	FY 2015	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
CT	1,812	1,584	1,771	1,338	1,784	1,784	1,784	1,784	1,784
MRI	1,949	1,313	1,270	951	1,268	1,268	1,268	1,268	1,268

TABLE C
HISTORICAL, CURRENT, AND PROJECTED VOLUME, BY TYPE OF SCAN/E□AM

CT Scan Volume	Actual Volume (Last 3 Completed FYs)			CFY Actual Volume[1]	CFY Annualized Volume[2]	Projected Volume (First 3 Full Operational FYs)[3]			
	FY 2012	FY 2013	FY 2014	FY 2015	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Abdomen	119	112	126	81	108	108	108	108	108
Abdomen/Pelvis	595	461	546	428	571	571	571	571	571
Chest/Thorax	346	307	343	285	380	380	380	380	380
Head/Neck	640	600	660	454	605	605	605	605	605
Lower Extremity	17	12	13	15	20	20	20	20	20
Pelvis	24	26	29	16	21	21	21	21	21
Thoracic/Lumbar	59	57	41	41	55	55	55	55	55
Upper Extremity	10	9	13	18	24	24	24	24	24
Total	**1,812**	**1,584**	**1,771**	**1,338**	**1,784**	**1,784**	**1,784**	**1,784**	**1,784**

MRI Scan Volume	Actual Volume (Last 3 Completed FYs)			CFY Actual Volume[1]	CFY Annualized Volume[2]	Projected Volume (First 3 Full Operational FYs)[3]			
	FY 2012	FY 2013	FY 2014	FY 2015	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Abdomen	30	34	31	35	47	47	47	47	47
Chest/Thorax	120	112	89	61	81	81	81	81	81
Head/Neck	615	437	439	279	372	372	372	372	372
Lower Extremity	424	291	254	220	293	293	293	293	293
Pelvis	26	22	29	18	24	24	24	24	24
Thoracic/Lumbar	562	303	308	243	324	324	324	324	324
Upper Extremity	172	114	120	95	127	127	127	127	127
Total	**1,949**	**1,313**	**1,270**	**951**	**1,268**	**1,268**	**1,268**	**1,268**	**1,268**

[1] Current fiscal year actual volume from October 1, 2014 through June 30, 2015.
[2] Actual volume for the first nine months of the current fiscal year annuali□ed over twelve months.
[3] First year of the proposal (following Asset Purchase) will be FY 2017.

b. Provide a detailed explanation of all assumptions used in the derivation/ calculation of the projected volume by scanner and scan type.

Response:

The average monthly volume experienced during the first nine months of FY 2015 was annualized over twelve months to determine the volume projection for FY 2015. Volume projections by scanner and scan type assumes that utilization will remain constant at FY 2015 levels through FY 2019.

c. Explain any increases and/or decreases in the volume reported in the tables above.

Response:

MRI and CT volumes experienced a decline from FY 2012 to FY2013. Following the transition of EIC to RGH, reimbursement levels for imaging services at EIC became more consistent with those of a hospital outpatient department. Around that same time, efforts by insurance carriers to direct patients to preferred providers increased dramatically. Patients have become more aware of the cost of care as a result of higher co-pays and high-deductible health plans. This increased awareness, combined with insurance carrier efforts to direct patients to lower cost providers, has resulted in a decline in volume for hospital-based services, including MRI and CT services.

d. Provide a breakdown, by town, of the volumes provided in **Table D** for the most recently completed FY.

Response:

Please see Table D below for the CT and MRI scan volume for FY 2014 by town.

TABLE D
UTILI□ATION (SCANS) BY TOWN (FY 2014)

Town	CT	MRI
Andover	12	17
Ashford	8	9
Avon	2	0
Berlin	0	2
Bloomfield	5	3
Bolton	41	26
Bozrah	0	1
Bristol	3	0
Brooklyn	1	0
Canton	1	0
Chaplin	1	0
Cheshire	0	1
Colchester	4	3
Columbia	5	5
Coventry	43	28
Cromwell	4	1
Danbury	1	0
East Granby	3	1
East Haddam	1	0
East Hampton	0	1
East Hartford	81	71
East Lyme	1	2
East Windsor	71	42
Eastford	1	2
Ellington	96	79
Enfield	28	14
Essex	0	1
Farmington	1	0
Glastonbury	19	22
Granby	3	2
Haddam	0	2
Hamden	0	1
Hampton	3	3
Hartford	13	10
Hebron	16	12
Lebanon	3	0
Lyme	2	1
Manchester	354	266
Mansfield	13	10
Marlborough	1	2
Middletown	2	2
Montville	1	1
New Britain	1	0
New Haven	0	1
Newington	3	5
Norwich	2	0
Old Saybrook	1	0
Plainville	2	1
Portland	0	1
Rocky Hill	4	4
Simsbury	3	2
Somers	7	6
South Windsor	531	296
Southington	1	1
Stafford/Union	18	24
Stratford	1	0
Suffield	2	7
Tolland	45	44
Torrington	1	2
Vernon	219	164
Voluntown	1	0
Wallingford	1	1
Waterbury	4	0
Watertown	0	1
West Hartford	5	5
Wethersfield	4	3
Willington	6	15
Windham	3	4
Windsor	21	15
Windsor Locks	17	13
Woodstock	1	0
Other State	23	12
Total	**1,771**	**1,270**

EXHIBIT Q22-1 - COMMUNITY HEALTH NEEDS ASSESSMENT PLAN FOR MMH

Manchester Memorial Hospital

An affiliate of Eastern Connecticut Health Network

Community Health Needs Assessment Implementation Plan

2013

I. INTRODUCTION

Manchester Memorial Hospital (MMH), as part of the Eastern Connecticut Health Network (ECHN), dedicates millions of dollars and thousands of staff hours to activities that enhance the overall health and wellness of its 19-town service area with special focus on the unmet needs of financially disadvantaged and underserved populations.

MMH primarily serves the Connecticut towns of Manchester, South Windsor, Bolton, Coventry, Andover, Ellington, Tolland, Vernon, and Willington. Its secondary service area includes the towns of Ashford, Somers, Stafford, Union, East Hartford, East Windsor, Glastonbury, Hebron, Columbia and Mansfield. The service areas contain municipalities in Hartford, Tolland and Windham Counties.

In 2013, MMH collaborated with Rockville General Hospital, also an affiliate of ECHN, to conduct a comprehensive community health needs assessment (CHNA). The goals of the assessment were:

- To identify current and future healthcare needs in the community
- To improve and strengthen programs and services provided to address them

The CHNA process was led by an Oversight Committee that included members of the organization with established relationships with community groups and agencies.

Data collected for the CHNA included:

- Health, social, and demographic data specific to MMH's service area obtained from local public health agencies, national health associations and other data sources.
- Health behavior information collected from 1,047 residents who responded to a community survey.
- Input from 12 community stakeholders from local organizations invested in the health of underserved populations.

Once all data was collected and analyzed, the Oversight Committee identified and prioritized the service area's key health needs and developed an implementation strategy to respond to the needs.

This document details the priority health needs that were identified and the implementation plan developed to address them.

II. IDENTIFIED AREAS OF NEED

Analysis of the CHNA data identified the following areas of need:

A. Heart Disease Incidence

Heart disease remains the #1 cause of death in the state and nation. Incidence rates in the service area are similar to national rates. High blood pressure and high cholesterol were the two health conditions most reported among the CHNA survey respondents.

B. Cancer Incidence

Cancer continues to be the second leading cause of death in the MMH service area, in Connecticut, and in the United States. Incidence rate estimates for Cancer (All Sites) and Breast for the total service area are above that of the nation. Prostate and Colon & Rectum cancer rates for the Total Service Area are above both the state and the nation.

C. Diabetes Incidence

Estimated diabetes prevalence rates for 2017 show an alarming increase in the total service area, while state and national estimates remain at or near 2012 rates. An estimated 60,000 to 93,000 adults have undiagnosed diabetes.

D. Arthritis Incidence

There is a higher incidence of arthritis, chronic lower back pain, lower back pain, and neck pain in the service area when compared with national prevalence rates among individuals over the age of 18 years of age.

E. Alzheimer's disease Incidence

There is a higher incidence of Alzheimer's disease among service area residents over the age of 65 compared to national incident rate estimates.

F. Multiple Sclerosis Incidence

The incidence rate of Multiple Sclerosis is higher in the service area when compared to national figures.

G. Substance Abuse

Community stakeholders reported drug and alcohol abuse to be a serious problem in the service area.

H. Childhood Lead Screening

Fewer children in the service area are being screened for lead compared to state percentages but the percentage of children with elevated level levels in the service area remain lower than the state rate.

III. THE PRIORITY NEEDS

The Oversight Committee prioritized the CHNA's identified health needs based primarily on the size and severity of a particular need, and also took into account the hospital's ability to impact the need, and the availability of resources that exist to address it. Based on these criteria, the following health needs were given the highest priority:

- Heart Disease Incidence
- Cancer Incidence
- Diabetes Incidence
- Arthritis Incidence

IV. STRATEGIES TO ADDRESS PRIORITY NEEDS

The overall goal in addressing each priority needs is to 1. Reduce the preventable risk factors that contribute to incidence of the respective health issue and 2. Promote quality of life for those diagnosed. Each set of strategies will target the broader population with special focus on the financially disadvantaged and underserved populations.

A. Strategies to Address Heart Disease Incidence:

- Educate the public about managing lifestyle behaviors that impact diet, blood pressure, cholesterol, weight, physical activity, and stress.
    - Offer free community health educational lecture and seminar programs presented by hospital medical and clinical staff.
    - Include educational information in each issue of *Better Being*, ECHN's free community magazine distributed to approximately 155,000 households in service area.
    - Participate in community health fairs throughout service area where free blood pressure, cholesterol, body fat composition analysis and educational resources will be shared.
    - Launch the "Freedom from Smoking" smoking cessation program
    - Provide nutrition counseling services
    - Offer integrative medicine programs for stress reduction
- Provide information and services to individuals diagnosed with heart disease to help them best manage their symptoms
    - Offer free "Heart Talk" community program for people living with heart failure

- Promote cardiac rehabilitation services to restore people who have had a heart condition or heart surgery to the highest possible physiological, emotional, social, and vocational level.

B. Strategies to Address Cancer Incidence:

- Monitor reports of newly- diagnosed cancer cases in the service area using the National Cancer Center Data Base (NCDB) to identify significant changes, trends or abnormal activity.
- Educate the public about managing lifestyle behaviors that impact cancer risks
  - Cancer Community Outreach Community will coordinate free community health educational lecture and seminar programs.
  - Include educational information in each issue of *Better Being*, ECHN's free community magazine distributed to approximately 155,000 households in service area.
  - Participate in community health fairs throughout service area.
  - Launch the "Freedom from Smoking" smoking cessation program
- Provide free screenings in the community and access to follow-up care
- Offer comprehensive support programs for cancer survivors and caregivers
  - Oncology Nurse Navigator and Survivorship Navigators services
  - Annual Cancer Survivors Day event
  - Regular support group meetings
  - Cancer Caregiver Workshops

C. Strategies to Address Diabetes Incidence:

- Raise awareness of diabetes preventable risk factors and educate the public on ways to manage lifestyle behaviors that affect them including diet, weight and physical activity
  - Offer free community health educational lecture and seminar programs presented by hospital medical and clinical staff.
  - Include educational information in each issue of *Better Being*, ECHN's free community magazine distributed to approximately 155,000 households in service area.

  - Participate in community health fairs throughout service area where free glucose tests are conducted and educational resources are shared.

- Offer Diabetes Self Management Program and Nutrition Counseling for individuals already diagnosed with diabetes.

D. Strategies to Address Arthritis Incidence:

- Educate the public about ways to help prevent or slow the progression of arthritis and manage the symptoms of joint pain.
  - Offer free community health educational lecture and seminar programs presented by hospital medical and clinical staff.
  - Include educational information in each issue of *Better Being*, ECHN's free community magazine distributed to approximately 155,000 households in service area.
  - Participate in community health fairs throughout service area.
- Offer free program to help individuals with arthritis prepare for hip or knee replacement surgery and achieve the best outcome.
- Develop a comprehensive surgical spine program to support individuals experiencing chronic neck and back pain including symptom management and perioperative care.

E. Community Collaboration

An important component of these strategies will be collaboration with community resources including service area town health and human services agencies, schools, senior centers, Chamber of Commerce members, homeless shelters, community physicians as well as ECHN affiliates Rockville General Hospital, Visiting Nurse & Health Services of CT, and Woodlake at Tolland.

F. Measuring the Impact

Measureable impact of the above strategies will take time to materialize, however ongoing analysis of hospital utilization data for specific diagnoses, enrollment in hospital-sponsored education or disease management programs, feedback from community partners and reassessing community health needs in three years will assist in the evaluation of strategy effectiveness.

V. IDENFITIED NEEDS THAT WILL NOT BE ADDRESSED

The hospital will not address the following health needs that were outlined in the community health needs assessment:

- Alzheimer's disease Incidence
- Multiple Sclerosis Incidence
- Substance Abuse
- Childhood Lead Screening

In discussing and prioritizing all of the identified health needs, the Oversight Committee determined that these needs were already being addressed by other healthcare agencies and providers. Additionally, some community needs fall outside the scope of the expertise and resources of the hospital.

VI. APPROVAL

The strategies detailed in this implementation plan have been reviewed and approved by the ECHN's Strategic Planning Committee, including members of its Board of Trustees and the organization's President and Chief Executive Officer:

Milton Doremus
Chair, Strategic Planning Committee
Member, Board of Trustees
Eastern Connecticut Health Network

August 21, 2013
Date

Peter J. Karl
President and Chief Executive Officer,
Eastern Connecticut Health Network

August 21, 2013
Date

EXHIBIT Q22-2 - COMMUNITY HEALTH NEEDS ASSESSMENT PLAN FOR RGH

Rockville General Hospital

An affiliate of Eastern Connecticut Health Network

Community Health Needs Assessment Implementation Plan

2013

I. INTRODUCTION

Rockville General Hospital (RGH), as part of the Eastern Connecticut Health Network (ECHN), dedicates millions of dollars and thousands of staff hours to activities that enhance the overall health and wellness of its 19-town service area with special focus on the unmet needs of financially disadvantaged and underserved populations.

RGH primarily serves the Connecticut towns of Manchester, Vernon, Ellington, Tolland, Willington, Manchester, South Windsor, Bolton, Coventry and Andover. Its secondary service area includes the towns of Ashford, Somers, Stafford, Union, East Hartford, East Windsor, Glastonbury, Hebron, Columbia and Mansfield. The service areas contain municipalities in Hartford, Tolland and Windham Counties.

In 2013, RGH collaborated with Manchester Memorial Hospital, also an affiliate of ECHN, to conduct a comprehensive community health needs assessment (CHNA). The goals of the assessment were:

- To identify current and future healthcare needs in the community
- To improve and strengthen programs and services provided to address them

The CHNA process was led by an Oversight Committee that included members of the organization with established relationships with community groups and agencies.

Data collected for the CHNA included:

- Health, social, and demographic data specific to RGH's service area obtained from local public health agencies, national health associations and other data sources.
- Health behavior information collected from 1,047 residents who responded to a community survey.
- Input from 12 community stakeholders from local organizations invested in the health of underserved populations.

Once all data was collected and analyzed, the Oversight Committee identified and prioritized the service area's key health needs and developed an implementation strategy to respond to the needs.

This document details the priority health needs that were identified and the implementation plan developed to address them.

II. IDENTIFIED AREAS OF NEED

Analysis of the CHNA data identified the following areas of need:

A. Heart Disease Incidence

Heart disease remains the #1 cause of death in the state and nation. Incidence rates in the service area are similar to national rates. High blood pressure and high cholesterol were the two health conditions most reported among the CHNA survey respondents.

B. Cancer Incidence

Cancer continues to be the second leading cause of death in the RGH service area, in Connecticut, and in the United States. Incidence rate estimates for Cancer (All Sites) and Breast for the total service area are above that of the nation. Prostate and Colon & Rectum cancer rates for the Total Service Area are above both the state and the nation.

C. Diabetes Incidence

Estimated diabetes prevalence rates for 2017 show an alarming increase in the total service area, while state and national estimates remain at or near 2012 rates. An estimated 60,000 to 93,000 adults have undiagnosed diabetes.

D. Arthritis Incidence

There is a higher incidence of arthritis, chronic lower back pain, lower back pain, and neck pain in the service area when compared with national prevalence rates among individuals over the age of 18 years of age.

E. Alzheimer's disease Incidence

There is a higher incidence of Alzheimer's disease among service area residents over the age of 65 compared to national incident rate estimates.

F. Multiple Sclerosis Incidence

The incidence rate of Multiple Sclerosis is higher in the service area when compared to national figures.

G. Substance Abuse

Community stakeholders reported drug and alcohol abuse to be a serious problem in the service area.

H. Childhood Lead Screening

Fewer children in the service area are being screened for lead compared to state percentages but the percentage of children with elevated level levels in the service area remain lower than the state rate.

III. THE PRIORITY NEEDS

The Oversight Committee prioritized the CHNA's identified health needs based primarily on the size and severity of a particular need, and also took into account the hospital's ability to impact the, and availability of resources that exist to address it. Based on these criteria, the following health needs were given the highest priority:

- Heart Disease Incidence
- Cancer Incidence
- Diabetes Incidence
- Arthritis Incidence

IV. STRATEGIES TO ADDRESS PRIORITY NEEDS

The overall goal in addressing each priority needs is to 1. Reduce the preventable risk factors that contribute to incidence of the respective health issue and 2. Promote quality of life for those diagnosed. Each set of strategies will target the broader population with special focus on the financially disadvantaged and underserved populations.

Strategies to Address Heart Disease Incidence:

- Educate the public about managing lifestyle behaviors that impact diet, blood pressure, cholesterol, weight, physical activity, and stress.
    - Offer free community health educational lecture and seminar programs presented by hospital medical and clinical staff.
    - Include educational information in each issue of *Better Being*, ECHN's free community magazine distributed to approximately 155,000 households in service area.
    - Participate in community health fairs throughout service area where free blood pressure, cholesterol, body fat composition analysis and educational resources will be shared.
    - Launch the "Freedom from Smoking" smoking cessation program
    - Provide nutrition counseling services
    - Offer integrative medicine programs for stress reduction
- Provide information and services to individuals diagnosed with heart disease to help them best manage their symptoms
    - Offer free "Heart Talk" community program for people living with heart failure

- Promote cardiac rehabilitation services to restore people who have had a heart condition or heart surgery to the highest possible physiological, emotional, social, and vocational level.

Strategies to Address Cancer Incidence:

- Monitor reports of newly- diagnosed cancer cases in the service area using the National Cancer Center Data Base (NCDB) to identify significant changes, trends or abnormal activity.
- Educate the public about managing lifestyle behaviors that impact cancer risks
  - Cancer Community Outreach Community will coordinate free community health educational lecture and seminar programs.
  - Include educational information in each issue of *Better Being*, ECHN's free community magazine distributed to approximately 155,000 households in service area.
  - Participate in community health fairs throughout service area.
  - Launch the "Freedom from Smoking" smoking cessation program
- Provide free screenings through the community and access to follow-up care
- Offer comprehensive support programs for cancer survivors and caregivers
  - Oncology Nurse Navigator and Survivorship Navigators services
  - Annual Cancer Survivors Day event
  - Regular support group meetings
  - Cancer Caregiver Workshops

Strategies to Address Diabetes Incidence:

- Raise awareness of diabetes preventable risk factors and educate the public on ways to manage lifestyle behaviors that affect them including diet, weight and physical activity
  - Offer free community health educational lecture and seminar programs presented by hospital medical and clinical staff.
  - Include educational information in each issue of *Better Being*, ECHN's free community magazine distributed to approximately 155,000 households in service area.

    - Participate in community health fairs throughout service area where free glucose tests are conducted and educational resources are shared.

- Offer Diabetes Self Management Program and Nutrition Counseling for individuals already diagnosed with diabetes.

Strategies to Address Arthritis Incidence:

- Educate the public about ways to help prevent or slow the progression of arthritis and manage the symptoms of joint pain.
    - Offer free community health educational lecture and seminar programs presented by hospital medical and clinical staff.
    - Include educational information in each issue of *Better Being*, ECHN's free community magazine distributed to approximately 155,000 households in service area.
    - Participate in community health fairs throughout service area.
- Offer free program to help individuals with arthritis prepare for hip or knee replacement surgery and achieve the best outcome.
- Develop a comprehensive surgical spine program to support individuals experiencing chronic neck and back pain including symptom management and perioperative care.

Community Collaboration

An important component of these strategies is collaboration with community resources including service area town health and human services agencies, schools, senior centers, Chamber of Commerce members, homeless shelters, community physicians as well as ECHN affiliates Manchester Memorial Hospital, Visiting Nurse & Health Services of CT, and Woodlake at Tolland.

Measuring the Impact

Measureable impact of the above strategies will take time to materialize, however ongoing analysis of hospital utilization data for specific diagnoses, enrollment in hospital-sponsored education or disease management programs, feedback from community partners and reassessing community health needs in three years will assist in the evaluation of strategy effectiveness.

V. IDENFITIED NEEDS THAT WILL NOT BE ADDRESSED

The hospital will not address the following health needs that were outlined in the community health needs assessment:

- Alzheimer's disease Incidence
- Multiple Sclerosis Incidence
- Substance Abuse
- Childhood Lead Screening

In discussing and prioritizing all of the identified health needs, the Oversight Committee determined that these needs were already being addressed by other healthcare agencies and providers. Additionally, some community needs fall outside the scope of the expertise and resources of the hospital.

VI. APPROVAL

The strategies detailed in this implementation plan have been reviewed and approved by the ECHN's Strategic Planning Committee, including members of its Board of Trustees and the organization's President and Chief Executive Officer:

Milton Doremus
Chair, Strategic Planning Committee
Member, Board of Trustees
Eastern Connecticut Health Network

August 21, 2013
Date

Peter J. Karl
President and Chief Executive Officer,
Eastern Connecticut Health Network

August 21, 2013
Date

EXHIBIT Q25-1 - CURRICULUM VITAE: ECHN

PETER J. KARL

243 Feldspar Ridge
Glastonbury, Connecticut 06033
(W) (860) 930-2698
(H) (860) 633-8773

(W) pkarl@echn.org
(H) DKRNOR@optonline.net

SUMMARY OF QUALIFICATIONS:

Seasoned chief executive officer with extensive experience in creating new programs and services in small and large not-for-profit Hospital Systems. Well experienced in reengineering initiatives inclusive of significant cost reduction initiatives and program realignment. Strengths include medical staff relations, team building, operations and financial management. A strategic thinker with the ability to grow existing programs, implement new initiatives and operationalize all types of projects, both small and large. In addition, well experienced in funding projects through various avenues; including, but not limited to, joint ventures, REITs, fundraising, short and long term financing, operational surplusô and non-performing asset sales.

PROFESSIONAL BACKGROUND:

July 2004-Present

Eastern Connecticut Health Network (ECHN): Manchester, CT

Eastern Connecticut Health Network is a 320 million dollar health system formed in 1995 consisting of two acute care hospitals (305 beds and 102 beds), a 130 bed long term care facility, VNA/Home Care agency, several free-standing satellite facilities, real estate arm, Physician employment company and various joint ventures (Ambulance Company, Radiation Oncology, Cardiac Catheterization laboratory, Occupational Medicine, Imaging Centers, GI Center, PHO).

December 2004-Present

Eastern Connecticut Health Network: Manchester, CT
President and Chief Executive Officer

- Led organization to first profit in several years in 2005
- Subsequent profits in 2006, 2008, 2009, 2010, 2011, 2012
- Developed new strategic plan comprised of physician partnering, demographic growth, patient quality and financial stability
- Hired 125 new physicians since 2005
- Established NICU services

- Matured hospitalist program, hired orthopedic, general surgeon and GI hospitalists
- Grew physician employment subsidiary from $3 million to $24 million
- Built and opened 2 new free-standing imaging joint ventures
- Acquired competing Imaging Center
- Built and opened new free-standing GI joint venture
- Relocated and expanded Womenôs Health center
- Constructed new 30 bed Intensive Care Unit
- Constructed new 30 bed addition to LTC facility
- Partnered with physicians to create successful PHO
- Built new 30,000 square foot cancer center
- Formed Physician Strategic Council to gain ñnon-leadershipò physician support
- Established combined Board of Trustee and Physician retreats resulting in cohesive relationships between Trustees, Physicians and Senior Management
- Currently leading an effort to partner with large tertiary or quaternary system in preparation for the PPACA

July 2004-
December 2004

Eastern Connecticut Health Network: Manchester, CT
Executive Vice President and Chief Operating Officer

- Hired as successor to existing CEO

October 1999-
June 2004

ST. JOSEPHôS HEALTHCARE SYSTEM (SJHS): Paterson, New Jersey

St. Josephôs Healthcare System is a newly formed system consisting of a 792-bed tertiary, inner city medical center; a 229-bed acute care community institution; a 120-bed Long Term Care Facility; and a Visiting Nurse and Hospice Care corporation.

March 2001-
June 2004

ST. JOSEPHôS WAYNE HOSPITAL: Wayne, New Jersey
President

- Chief Executive responsible for 229 bed acute care hospital with $70 million operating budget
- In first 10 months reduced annual operating losses from $10.6 million to $1.15 million against a budgeted loss of $3.5 million; through reduction in costs, contract renegotiation and improved revenue.
- Achieved $885K profit in 2002
- Recruited new Senior Management Team
- Recruited 45 new physicians on staff
- Developed 5 year turn-around plan and operational ñstrategic planò
- Contracted for Full-time MRI Services (6/01)

- Opened new Senior Acute Care Unit (8/01)
- Launched New Diabetes Program (6/02)
- Worked closely with Executive Director of Foundation and Foundation Board and launched a $3.5 million Capital Campaign (9/02)
  - $1.2 million secured to date
- Lead organization to achieving a score of 95 on JCAHO survey
- Opened new 20-bed Comprehensive Acute Rehabilitation Unit (11/02)
- Developed and opened new Cardiac Catheterization Laboratory (2/03)

March 2001-
June 2004

ST. JOSEPHôS HEALTHCARE SYSTEM
Senior Vice President, Operations

- Executive Management Team Member

March 2001 – January 2003

- Led System-wide $7.0 million non-labor cost reduction initiative
  - Consolidated Pathology Services between both campuses
  - Contracted with single Pharmacy distributor
  - Consolidated Supply Chain and contracted with single GPO
  - Consolidated IT Departments
- ñSystemò responsibilities for the following departments:
  - Radiology Services
  - Pathology
  - Supply Chain

October 1999-
March 2001

ST. JOSEPHôS HOSPITAL & MEDICAL CENTER: Paterson, New Jersey
Vice President, Clinical Services

Recruited by a new management team to develop "Centers of Excellence" for St. Joseph's Hospital and Medical Center

- Administratively responsible for several clinical departments of the 792-bed tertiary care center, to include:
  - Anesthesia Services
  - Cardiology
  - Cardiac Surgery
  - Rehabilitation
  - Radiology
  - Pathology
  - Pharmacy
  - Mobile Intensive Care Unit
  - Orthopedics
  - Medicine
  - Oncology

  - Designed and developed an off-site comprehensive 7,500 square foot Diagnostic Imaging Center (opened 2/03)

- Developed and led a Cardiac Services Task Force to define strategically how Cardiology should be positioned in the institution and community. Created a Department of Cardiovascular Services comprised of both Cardiology and Cardiac Surgery under single leadership

- Assisted the Cardiac Task Force with designing an extensive floor plan to ñcarve-outò Cardiovascular Services from other overlapping hospital departments

August 1991-
October 1999

STAMFORD HEALTH SYSTEM: Stamford, Connecticut

Stamford Health System: A small health system consisting of a 305 bed hospital, several off-site for profit and not-for-profit entities, a Long Term Care Facility, a CCRC and a 235,000 square foot Ambulatory Care Facility

May 1997-
October 1999

STAMFORD HEALTH SYSTEM:
Project Manager, CS2000 Reengineering Initiative

- Administratively responsible for system-wide reengineering initiative to include:
- Formation of an internal consulting department
- Selection of a nationally renowned reengineering firm
- Development of a five year financial forecast to project Health Systemôs future viability
- Benchmarked SHS against other similar institutions to establish Service, Cost and Quality targets
- Established a cost reduction target of $17-20 million (12-15% of operating costs)
  - Coordinated both Labor and Non-Labor reductions

- Coordinated and oversaw merger and closure of competing hospital; inclusive of merging staff, analyzing direct and indirect costs, and ñramp downò of all hospital services

- Part of Executive Team that designed and developed a $70 million, 235,000 square foot ambulatory care facility

- Worked extensively with Vice President of Foundation to raise capital for new expansion project, including several ñnamingò opportunities

August 1996-
October 1999

STAMFORD HEALTH SYSTEM: Stamford, Connecticut
Vice President, Ambulatory Services

- Administratively responsible for successful operations of the following Business Units and Departments:

- Imaging Services; to include 2 Healthcare facilities and 2 Free-Standing Centers; combined performing in excess of 130,000 procedures annually.
- Comprehensive Cancer Center; to include an independent Medical Oncology, P.C. and integrated Radiation Oncology Department.
- Free-Standing, For-Profit Retail Pharmacy
- Free-Standing, For-Profit Surgical Center performing in excess of 5,600 procedures annually.
- LLC Partnership in an independent IV Home Therapy and Home Care Company in Central Connecticut.
- Adult, General Care, Ambulatory Services Clinic at 2 Health Care Facilities, combined totaling in excess of 45,000 visits annually.
- Free-Standing Pediatric Ambulatory Care Clinic.

February 1991-
August 1996
THE STAMFORD HOSPITAL: Stamford, Connecticut
Director, Radiological Services

July 1986-
Feb 1991
ST. JOSEPH MEDICAL CENTR: Stamford, Connecticut
Radiology Administrator

July 1983-
July 1986
ST. AGNES HOSPITAL: White Plains, New York
Chief Radiologic Technologist (1984-1986)
Assistant Chief Radiologic Technologist (1983-1984)
Staff Technologist (1983)

EDUCATIONAL BACKGROUND

1994-
1996
UNIVERSITY OF NEW HAVEN: Connecticut
Master of Business Administration (M.B.A.) Degree

1983
DANBURY HOSPITAL SCHOOL OF RADIOLOGIC TECHNOLOGY
Certificate in Radiologic Technology

1979-
1983
SALEM COLLEGE: West Virginia
Bachelor of Science (B.S.) Degree in Management

AFFILIATIONS, COMMUNITY PROJECTS & AWARDS

American Registry Radiologic Technology
Member of Connecticut Hospital Association
Member of American College of Healthcare Executives
1999: Board Member of independent Federally Qualified Health Clinic
2002: Chairman of American Heart Walk for Bergen-Passaic Counties
2005/6: CHA Finance Committee
2007: Board Member, CHA Diversified Network Services
2009: Honorary Chair, Manchester Community College Fundraising Event
2009-present: AHA Regional 1 Policy Board

2010: Received Grassroots Champion Award in Washington, D.C.
2011: Manchester Community College Board of Trustees Merit Award
2011-present: Secretary, CHA Board of Directors
2011-present: Guest Lecturer UConn School of Business
2011-present: UConn School of Business Advisory Board
2011-present: Chairman, CHA Committee on Government
2012: UCONN School of Business Healthcare Management Service Award

COMPUTER SKILLS

- P.C. and Macintosh Systems.

PERSONAL PROFILE

- Married, 3 children: Joseph, Daniel and Victoria

REFERENCES

- References furnished upon request

DENNIS P. MCCONVILLE

80 CHILSTONE LANE
MANCHESTER, CT, 06040
(860) 646-1225
denpmcc@gmail.com

PROFESSIONAL EXPERIENCE

EASTERN CONNECTICUT HEALTH NETWORK, INC., MANCHESTER, CT

Senior Vice President Chief Strategy Officer, January 2014 - Present

Senior Vice President for Strategic Planning, Marketing & Communications, April 2007 – January 2014

Vice President for Strategic and Operational Planning, March 2000 – April 2007

- RESPONSIBILITIES: Strategic planning, business development, marketing, communications, public relations, government affairs, physician relations, property management, community health education and benefit reporting for a non-profit health care system with net revenues of $330 million created in 1995 with the merger of two acute care community hospitals having a total of 351 licensed beds, Manchester Memorial Hospital and Rockville General Hospital, and subsidiary corporations including a sub-acute and skilled nursing facility, women's wellness center, a medical foundation, and multiple community-based outpatient services facilities and multiple joint venture companies.
- STRATEGIC PLANNING: Staffing the Board of Trustees initiative to affiliate with a larger regional healthcare system including the evaluation, planning, due diligence, communication plans and regulatory approvals. Developed and oversaw the implementation of three network strategic plans. Created service line plans for women's health, cancer care, surgical services and musculoskeletal services. Collaborated with the Chief Information Officer and produced an information technology strategic plan. Oversaw three community health needs assessments of the network service area. Produced facility master plans and campus plans for two hospitals that included a cancer center. Working closely with the Senior Vice President for Medical Affairs, implemented medical staff development plans including a network primary care strategy. Developed and implemented a network medical access center strategy. Planning for system-wide response to address healthcare payment reform and population health management working closely with Senior Vice President & Chief Medical Officer to further develop ECHN's continuum of care aligning acute, post-acute and community-based care.
- BUSINESS DEVELOPMENT: Established two startup imaging joint venture companies with physicians and other hospital partners. Negotiated the purchase of five physician practices. Formed four real estate joint ventures to develop and build five medical facilities. Obtained regulatory approvals, including certificates of need, for multiple health care services and facilities.
- MARKETING: Managed the development and implementation of a corporate branding campaign and strategic marketing campaigns including a digital media strategy for ECHN and its subsidiary corporations.
- COMMUNICATIONS: Corporate spokesperson for ECHN including crisis communications for union efforts to organize employees and the closure of a hospital maternity service. Lead sponsor of a multidisciplinary team

for internal communication strategy.

- PROJECT MANAGEMENT: Planned, managed and completed multiple facility projects totaling over $100 million including: a major hospital upgrade project, emergency departments, operating rooms, a cancer center, an intensive care unit, hospital-based and ambulatory gastroenterology centers, off-site sterile processing center, ambulatory dialysis center, imaging centers, a behavioral health building, women's health center, and multiple community medical access centers. Worked with the Chief Information Officer to expand the system fiber optic network to all offsite facilities.
- PHYSICIAN RECRUITMENT: Managed the recruitment of 28 physicians for independent physician practices and the ECHN employed physician group practice. Spearheaded a new physician relations program that increased physician retention.

Director, Operational & Strategic Planning, February 1998 - March 2000

- RESPONSIBILITIES: Responsible for business planning, project management, facilities planning, and program development.
- ACHIEVEMENTS: Conducted market share analyses and an extensive community health needs assessment, strategic planning initiatives, maternal and neonatal services and dialysis services studies. Presented community health assessment findings to trustees, medical staff, management staff, staff of nineteen towns, and community and state legislative leaders.

Director of Cardiology, Pulmonary, and Rehabilitation Services, June 1995 - February 1998

- RESPONSIBILITIES: Responsible for leadership and operations management for multiple departments including: physical therapy, occupational therapy, speech therapy, respiratory services, pulmonary laboratory, cardiac stress testing laboratory, cardiac and pulmonary rehabilitation programs, EKG, holter monitor scanning and EEG services.
- ACHIEVEMENTS: Established a sleep study program, designed and implemented a cardiac event monitoring service, established an outreach respiratory and pulmonary rehabilitation program contracted to area skilled nursing facilities, obtained professional service agreements with oxygen/durable medical equipment companies for respiratory equipment teaching in the home, completed a conversion to a CPT-based coding system for rehabilitation services charging, and established a satellite rehabilitation facility with aquatic therapy services at the Glastonbury Wellness Center, Glastonbury, CT.

MANCHESTER MEMORIAL HOSPITAL, MANCHESTER, CT

Evening Administrator, Nursing Services, June 1987 - June 1995

- RESPONSIBILITIES: Responsible as the on-site administrator for the hospital and for clinical nursing services.
- ACHIEVEMENTS: Led a team that developed and implemented a nursing patient care delivery system for nursing.

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER, HARTFORD, CT

Supervisor, Nursing Services, August 1980 - June 1987

- Responsible for clinical supervision of nursing services for critical care and step-down patient care units.

Nurse Clinician, Cardiac Rehabilitation Services, February 1980 - August 1980

- Coordinated and supervised a multidisciplinary cardiac rehabilitation program for patients following myocardial infarction, coronary artery bypass graft surgery and heart valve replacement surgery.

Assistant Nurse Manager, Medical Surgical Intensive Care Unit, February 1979 - February 1980

- Supervised and cared for patients with acute multi-system illnesses, trauma injuries and major surgery.

Staff Registered Nurse, Coronary Intensive Care Unit, July 1977 - February 1979

- Cared for patients with acute cardiovascular disorders**.**

EDUCATION

RENSSELAER AT HARTFORD, HARTFORD, CT

Master of Science in Health Care Management, June 1995

EASTERN CONNECTICUT STATE UNIVERSITY, WILLIMANTIC, CT

Bachelor of Science Degree, Business Administration, June 1984

SAINT FRANCIS HOSPITAL SCHOOL OF NURSING, HARTFORD, CT

Diploma, Nursing, June 1977

GOVERNANCE AND COMMUNITY ACTIVITIES

Chairman of ECHN Enterprises Board of Trustees (ECHN's for-profit subsidiary) (2000-Present)

Chairman, Board of Directors, Northeast Regional Radiation Oncology Network, Inc. (2013-Present)

President, Tolland Imaging Center, LLC, Tolland, CT (2008–2010), (2013-Present)

Managing Director, Evergreen Imaging Center, LLC, South Windsor, CT (2005-2010)

Board of Directors, Chamber of Commerce, South Windsor, CT (2006–2009)

Board of Directors, Visiting Nurse and Health Services of Connecticut, Vernon, CT (2000-2008)

Vice President and Director, The Rockville Downtown Association, (2001-2005)

LICENSURE

State of Connecticut Registered Nursing License

PROFESSIONAL ASSOCIATIONS

Society for Healthcare Strategy and Market Development of the American Hospital Association

New England Society for Healthcare Strategy

New England Society for Healthcare Communications

Mary E. Powers
87 Grant Hill Rd, Tolland, CT 06084
860-872-6782
marypowers@sbcglobal.net

Objective

Profile

- One year experience Senior Vice President, Patient Care Services
- Two years experience Vice President, Patient Care Services
- Six years experience as Director, Patient Care Services.
- Goal-oriented individual with strong leadership capabilities.
- Organized, highly motivated, and detail-directed problem solver.
- Proven ability to work in unison with staff, physicians, and nursing units throughout the organization.

Education

D.N.P. student-Leadership Cohort, American Sentinel University-expected completion February 2015

M.S.N., Management, University of Hartford 2004
B.S.N., Cum Laude, Central Connecticut State University 2000
Diploma R.N., Saint Francis School of Nursing 1982

Relevant Experience & Accomplishments

Leadership

- ICD-10 Implementation Project
- Meaningful Use Steering Committee
- High Reliability Steering Committee
- Cost Reduction Efficiency Workgroup, co-lead of the group that developed staffing metrics for all direct patient care area.
- Value Based Purchasing Steering Committee
- Service Line development

Projects

- Heart Failure Patient Education Program
- Primary Stroke Designation (team member)
- Implementation of Bedside Medication Verification
- Oversight of new physiological monitoring equipment throughout both hospitals

Committees

- Operating Committee-Chair
- Clinical Practice Committee
- Readmission Committee-Chair (Heart failure, COPD, Pneumonia)
- Stroke Committee-member

Employment	**Senior Vice President, Patient Care Services,** *Eastern Connecticut Health Network* • Direct Reports-Oncology, Behavioral Health, Cardiovascular/Neurology Service Line Directors, Pharmacy, Medical Surgical Nursing and Nursing Informatics • Oversight Sound Physicians-hospitalist contracted service	*2013-presen*
	Vice President, Patient Care Services, *Eastern Connecticut Health Network* • Direct Reports-Oncology, Behavioral Health, Cardiovascular/Neurology Service Line Directors, Pharmacy, Medical Surgical Nursing and Nursing Informatics	*2011-2013*
	Director, Patient Care Services, *Eastern Connecticut Health Network* • Nursing Informatics Liaison • Nursing Quality Representative • Direct Reports-Nursing Education Manager, Nursing supervisors, and Nurse manager of ICU and Medical-Surgical unit	*2007-2011*
	Clinical Nurse Manager , *Rockville General Hospital* • Oversees the day to day operations of a 9 bed Intensive Care Unit and a 38 bed Medical-Surgical Unit. • Oversees approximately 58 ftes	*1999-2007*
	Nursing Supervisor/Resource Nurse, *Rockville General Hospital* • Responsible for placing patients within the hospital on the off shifts. • Resource person for any clinical issues that arose. • Responsible for managing staffing concerns that developed on the off shifts.	*1993-1999*
	Staff Nurse, *Intensive Care Unit*, Rockville General Hospital • Direct patient care for critically ill adults.	*1987-1999*
	Staff Nurse, *Medical Floor*, Rockville General Hospital • Direct patient care for acutely ill adults.	*1982-1987*
Community Involvement	**Board Member** Northeast Region Radiation Oncology **Board Member-**Walden Behavioral Care	
License & Certifications	**Registered Nurse License** **Nurse Executive Advanced, Board Certified,** *Professional certification* **Role Excellence in Leadership,** *Post Master certificate, Villanova University*	

JOEL J. REICH, MD, MMM, FACEP, FACPE, CPE

OFFICE: Department of Medical Affairs
Eastern Connecticut Health Network
71 Haynes Street
Manchester, CT 06040
jreich@echn.org

EMPLOYMENT

1999-present
Senior Vice President for Medical Affairs/Chief Medical Officer
Eastern Connecticut Health Network, Manchester, CT

1997-1999
Chair/Senior Medical Director
Department of Emergency and Ambulatory Care Services
Eastern Connecticut Health Network, Manchester, CT

1984-1997
Chair/Medical Director
Department of Emergency and Ambulatory Care Services
Manchester Memorial Hospital, Manchester, CT

1984-1999
Medical Director
Town of Manchester Emergency Medical Services, Manchester, CT

1981-1984
Attending Physician-Emergency Medicine
The George Washington University Medical Center, Washington, DC

ACADEMIC APPOINTMENTS

2014-present
Adjunct Instructor-Health & Medical Informatics
Rabb School of Continuing Studies, Brandeis University, Waltham, MA

2011-present
Clinical Associate Professor- Emergency Medicine
University of New England College of Medicine, Biddeford, ME

1987-2000
Assistant Clinical Professor-Emergency Medicine
Department of Traumatology and Emergency Medicine, University of Connecticut, Farmington, CT

1982-1984
Assistant Professor-Emergency Medicine
The George Washington University Medical Center, Washington, DC

1981-1982
Instructor-Emergency Medicine
The George Washington University Medical Center, Washington, DC

BUSINESS EXPERIENCE

1993-2005
The Gluten-Free Pantry, Inc., Glastonbury, CT

LICENSURE

State of Connecticut (1984-present)

CERTIFICATION

Graduate Certificate, Health and Medical Informatics (2013)
Health IT Leadership Certification, American College of Physician Executives (2012)
Board Certified, American Board of Emergency Medicine (ABEM) (Recertified 2010)
Fellow, American College of Physician Executives (FACPE)

Certified Physician Executive (CPE), The Certifying Commission in Medical Management
Fellow, American College of Emergency Physicians (FACEP)

POSTGRADUATE CLINICAL TRAINING

1979-1981
Emergency Medicine Residency (PGY II and III)
Georgetown University Joint Residency Program, Washington, DC

1978-1979
Internal Medicine (PGY I)
The George Washington University Medical Center, Washington, DC

EDUCATION

2014
Online Instructor Training, Rabb School of Continuing Studies, Brandeis University, Waltham, MA

2010-2013
M.S., Health & Medical Informatics, Rabb School of Continuing Studies, Brandeis University, Waltham, MA

2002-2003
M.M.M. (Master of Medical Management), Hein School of Public Policy and Management, Carnegie Mellon University, Pittsburgh, PA

1974-1978
M.D., School of Medicine, SUNY at Buffalo, Buffalo, NY

1973-1974
M.S. (Technology and Human Affairs), Sever Institute of Technology, Washington University, St. Louis, MO. Thesis: Telemedicine: The Assessment of an Evolving Health Care Technology
www.eric.ed.gov/PDFS/ED095883.pdf

1969-1973
B.A. (Biology), Brandeis University, Waltham, MA

PROFESSIONAL ACTIVITIES

Clinically Integrated Network of Eastern Connecticut (CINECT)
Chief Medical Officer (2014-present)
Board of Directors (2014-present)

Brandeis University Graduate Professional Studies Advisory Board: Health and Medical Informatics (2013-present)

Quinnipiac University School of Medicine Mentoring Program (2013-present)

Connecticut Hospital Association
Board of Trustees (2005-2011)
BOT Committee on Human Resources (Chair 2006-2011)
Advisory Committee on Transfer of Patients with Advance Directives (Chair: 1993-1997)

Connecticut Healthcare Insurance Company (CHIC)
Board of Directors (2006-present)
Claims Committee (2009-present)

Eastern Connecticut Medical Professionals Foundation (Multispecialty physician group)
Board of Directors (2000-present)

Eastern Connecticut Physician Hospital Organization (ECPHO)
Board of Directors (2005-present)

Ambulance Service of Manchester
Board of Directors (2000-present)

State of Connecticut EMS Advisory Board (1992-2002)
Chair (1997-2001)
Vice Chair (2001-2002)
Dedicated Funding Committee (Chair: 1993-1995)
Trauma Committee and Hospital Trauma Peer Review Sub-Committee (1994-1996)
Director Search Committee (1992-1993)

Town of Manchester EMS Council
Chair (1984-1999)

Town of South Windsor EMS Commission (1988-1993)

North Central Connecticut EMS Council
President (1990-1992)
Board of Directors (1987-present)
Medical Advisory Committee (1984-1999; Co-chair: 1994-1995)
University of Connecticut Health Center-Manchester Memorial Hospital
Paramedic Training Course (Co-Director) (1986-1988)
Towns of Manchester, Bolton, Coventry, Glastonbury, South Windsor
Medical Director, EMT Certification and Recertification (1984-1999)

AWARDS
Star Award: Core Values (ECHN)
Volunteer Service Award (Habitat for Humanity)
Public Service Award (State of Connecticut Governor EMS Advisory Board)
Richard H. Meny Award (NCCEMS)

COMMUNITY ACTIVITIES
Camp Merriwood (Girl Scouts), Medical Advisor (1985-1999)
Habitat for Humanity (1994-2007)
Manchester CPR Project, Medical Director (1985-1999)
Manchester Road Race, Medical Director (1989-1999)
Primary Health Care Task Force, Town of Manchester (1993-1995)
Visiting Nurse Association of Manchester, Physician Advisor (1992-1995)

LEGISLATIVE INITIATIVES
DNR (Do Not Resuscitate) Transfer state law and regulations
Emergency Care federal regulations: Prudent Layperson definition of emergency condition.

PROFESSIONAL SOCIETY MEMBERSHIPS
American College of Physician Executives (ACPE)
Council of Fellows (2005-2009)
Healthcare Information and Management Services Society (HIMSS)
Association of Medical Directors of Information Services (AMDIS)
American College of Healthcare Executives (ACHE)
American College of Emergency Physicians (ACEP)
Emergency Medical Services Committee (1994-1997)
American College of Emergency Physicians, ey Contact Program (Barbara ennelly, D-CT), 1992-1997
Connecticut College of Emergency Physicians (CCEP)
Board of Directors (1985-1992)
Alternate Councilor to ACEP (1991-1995)
American Telemedicine Association (ATA)
American Medical Association (AMA)
Hartford County Medical Association (HCMA)
Tolland County Medical Association (TCMA)
Connecticut State Medical Society (CSMS)

PRESENTATIONS AND PUBLICATIONS

PRESENTATIONS

- "The Views of Healthcare Industry Stakeholders", Healthcare Leadership Panel , 2014 National Association for Home Care & Hospice (NAHC) Financial Management Conference & Exposition, Chicago, IL, July 2014.
- "Accountable Care's Leadership and Governance Challenges", "eynote Panel, National Healthcare CMO/CMIO Summit 2014, Las Vegas, NV, March 2014.
- "Roadmap: Emerging Roles, Priorities and the Need for Cross-Functional/Cross-Institutional Partnerships", Closing "eynote, HTRAC (HealthTech Research Advisory Council), Washington DC, November 2013.
- "The Future in Healthcare", The Business Alliance for Community Health (BACH). Manchester, CT, August 2013.
- "It Takes a Village to Grow a Network", Brookings-Dartmouth ACO Learning Network: What's Next for Measuring & Improving Care in ACOs" Washington, DC, April 2013.
- "HIT Challenges of Accountable Care", 2011 Meditech Physician Forum, Canton, MA, October 2011.
- "10 Things to Do" if You are Not One of Those Famous Clinics: Aligning your Hospital with Your Physicians", World Health Congress Leadership Summit on Clinical Integration, Fairfax, VA, December 2010.
- "5 Ways to Hospital-Physician Quality" Webinar. HCPRO, November 2009.
- "The Dynamic State of Physician-Hospital Alignment: Using Collaboration and Strategy to Drive Success", American College of Healthcare Executives (ACHE) 2009 Congress on Healthcare Leadership, Chicago, IL, March 2009.
- "Alignment Strategies", South Shore PHO, S. Weymouth, MA, July 2008.
- "Primary Care Alignment Strategies", New England Society for Healthcare Strategy (NESHS) Spring Conference: Magic in the Minefield: Physician Alignment and You", Westborough, MA, May 2008.
- "The Dynamic State of Physician-Hospital Alignment: Practical Strategies to Ensure Your Success", American College of Physician Executives (ACPE) Spring Institute, New York, NY, April 2008.
- "Advance Directives", Eastern Connecticut Health Network, Manchester, CT, October 2005.
- "Create an Emergency Department Observation Unit for the 21st Century", Observation Units for the Emergency Department, Lake Buena Vista, FL, November 1998.
- "Automatic External Defibrillation Training Seminar", American Red Cross, Farmington, CT, November 1998.
- "The Cardiovascular Patient in the Emergency Department", Catastrophic Injuries and Cutting Edge Issues, American Bar Association, Amelia Island, FL, February 1998.
- "The DNR Transfer System", Connecticut Hospital Association, Wallingford, CT, May 1997.
- "Emergency Department Design for the 21st Century: Ten Emerging Trends in Emergency Medicine Practice", South Jersey Hospital System, Vineland, New Jersey, November 1996.
- "How to Design an Emergency Department for the Year 2000", Clinician's Update: 1997 (Presented by Washington Hospital Center), New Orleans, LA, September 1996; University of Connecticut, Farmington, CT, November 1996.
- "Complaints, Complainers, and Risk: How to Stay out of Trouble in the E.D.", Grand Rounds, University of Connecticut Emergency Medicine Residency Program, April 1996; Yale University, New Haven, CT, October 1996.
- "Implementation of a Statewide Trauma System in Connecticut," Connecticut Hospital Association, Wallingford, CT, April 1995.
- "Medical Control-On-Line", EMS Medical Control Course, University of Connecticut Health Center, Farmington, CT, October 1990; October 1994; October 1995; October 1996.
- "The EMS System. Does It Make A Difference"", EMS: Your Decision, A Workshop for Government Officials, Hartford, CT, June 1988.
- "Communication, The Essence of Medical Control", Physicians' Base Station Symposium, Wallingford, CT, October 1986; April 1988.
- "Medical Control: Who's In Charge"" and "Emergency Department and Ambulatory Care Centers", Connecticut EMS: A System of Challenge and Change, State of Connecticut Office of Emergency Medical Services, Cromwell, CT, March 1987.
- "Recognition and Management of Cyclic Antidepressant Overdose", St. Vincent's Medical Center, Bridgeport, CT, November 1986.
- "My Ups and Downs: Falls in the Elderly", Geriatric Emergencies, Manchester, CT, March 1986.
- "Marketing the Emergency Department, Emergency Nurses Association (ENA), Manchester, CT, October 1985.
- "Spider Bites", Pitfalls and Pearls Conference, Washington, DC, May 1984.

"Softball: The Summer Epidemic", R. Shesser, M. Smith, J.J. Reich, S. Edelstein, University Association for Emergency Medicine (UAEM), Boston, MA, June 1983.
"Emergency Medicine Residency Training Programs", Society for Teachers of Emergency Medicine (STEM), Boston, MA, June 1983.
"From Basin-to-Basin: Fish Toxin Poisoning", Pitfalls and Pearls Conference, Washington, DC, April 1983 and Toxindromes Conference, Washington, DC, December 1983.
"Paramedic Telecommunications", DCFD Emergency Ambulance Service Training, Washington, DC, April 1981; September 1981.
"Arrhythmias in Tricyclic Antidepressant Overdose", Pitfalls and Pearls Conference, Washington, DC, December 1981; April 1982.
"EMS Communications", Physician's Base Station Symposium, American College of Emergency Physicians, Washington, DC, April 1982; June 1982.

EDUCATIONAL LECTURES, PROGRAMS AND COURSES
Health & Medical Informatics Leadership: online graduate level course (in preparation, 2014)
Legal Pitfalls of Healthcare System Reform: online lecture (2014)
Healthcare Management and Organi□ational Leadership: Physician Leaders (2013)
Introduction to Health Informatics (2013)
Introduction to US Health Policy (2012 & 2013)
DNR Transfer System Training Program (1997)
Pre-hospital 12-Lead ECG Training Program (1996)
First Responder Defibrillation Program (1995)
EMT-Epinephrine Training Program (1989)
EMT-Defibrillation Training Program (1988)
"Immuni□e and Protect Your Child" (consultant to WHO pre-production group, 1976)

PUBLICATIONS
McNulty A, Reich JJ. Survey and interviews examine relationships between physicians and hospitals. Physician Executive, September-October 2008:48-50.
Reich JJ: "Observation Unit Design" in Graff L (ed). Observation Units: Implementation and Management Strategies. Dallas, TX, American College of Emergency Physicians, 1998.
Turbiak TW, Reich JJ, "Bacterial Infections" in Rosen P, et al (eds). Emergency Medicine (Third Edition), St. Louis, MO, C.V. Mosby Co., 1992; (Fourth Edition), St. Louis, MO, C.V. Mosby Co., 1998.
Reich JJ: "Nontraumatic ear disorders" in Howell JM, et al (eds) Emergency Medicine, Philadelphia, PA, Saunders, 1998.
Turbiak TW, Reich JJ: "Bacterial Infections" in Rund D, et al (eds): Essentials Of Emergency Medicine, St. Louis, MO, C.V. Mosby Co., 1996.
Calabro J, Rivera EJ, Reich JJ, □rohmer JR, Balcombe J: Provision of emergency medical care for crowds. American College of Emergency Physicians, 1996.
Gabram SGA, Libby MCN, Jacobs LM, Atweh N, DeGutis L, Reich JJ, Ryan N, Thomas RG, □elman J. Peer Review of On-Scene Air Medical Triage in Connecticut. Connecticut Medicine, 1994; 58:3-12.
Turbiak TW, Reich JJ: "ENT Emergencies" in Stine RJ and Marcus RH (eds). Practical Approach To Emergency Medicine (Second Edition), Boston, MA, Little Brown & Co, 1994.
Turbiak TW, Reich JJ: "Sudden hearing loss" in Harwood-Nuss A, et al (eds). The Clinical Practice of Emergency Medicine, Philadelphia, PA, J.B. Lippincott Co, 1990.
Reich JJ: Ear infections. Emergency Clinics of North America 1987; 5:227-242.
Reich JJ, Turbiak TW: "Ear Emergencies" in Stair T, (eds). Eye, Ear, Nose Mouth and Throat Emergencies, Rockville, MD, Aspen Systems Corporation, 1986.
Reich JJ, Turbiak TW: "Ear Emergencies" in Stair T, (eds.). Topics in Emergency Medicine: ENT Emergencies, Rockville, MD, Aspen Systems Corporation, 1984.
Reich JJ: "Telemedicine: The Assessment of an Evolving Health Care Technology" Report Numbers: RCT-74□4 and THA 7416 Center for Development Technology. St. Louis, MO (National Technical Information Service. [N74-76939], 1974). www.eric.ed.gov□PDFS□ED095883.pdf

PRODUCTIVITY SOFTWARE EXPERIENCE
Microsoft Office: Word, Excel, Access, Outlook

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EXPERIENCE

Eastern Connecticut Health Network January 2, 2013 -present
Manchester, Connecticut
Senior Vice President and General Counsel

Integrated not for profit community health care delivery system serving 19 towns in eastern Connecticut through a network of facilities including two community hospitals, skilled nursing and rehabilitation center, multi-specialty physician group, visiting nurse service and cancer center.

Responsibilities:

- Manage all litigation and legal functions of the system
- Maintain contract compliance under Stark and Anti-□ickback Statute
- Negotiate EMR and other IT licensing
- Handle contract negotiations with payors, vendors and strategic partners, including physician groups, DME vendors and care coordination entities
- Manage legal aspects of employee relations and employee benefits
- Handle legal matters relating to medical staff functions and patient care
- Ongoing legal and regulatory advice to CEO, CFO, CMO, CCO and other senior management
- Select, monitor and manage outside counsel
- Board of Trustees legal advisor on not for profit and charitable foundation board governance matters
- Legal advisor to compliance and privacy functions, including HIPAA Privacy and Security Rule

APS Healthcare 2008-2012
White Plains, New York
Senior Vice President, Chief Legal Officer and Corporate Secretary

Privately held specialty health care services□health information technology company furnishing data analysis, data stratification, care coordination and disease management services for persons with complex and chronic care needs. Company also furnished health□wellness and mental health services to public health (TANF, ABD, ADHC) programs and employer-sponsored benefit plans. Operations throughout the United States and Puerto Rico.

Responsibilities:

- Managed all legal functions of the company
- Managed DOJ □ui tam litigation, negotiation of CIA and subse□uent CIA compliance
- Managed legal intellectual property protection strategy (work-for-hire, patent, trademark, licensing)
- Managed legal aspects of agreements with all customers and vendors
- Managed legal aspects of employee relations and employee benefits, including employee stock plan
- Handled contract negotiations with strategic partners
- Supervised legal aspects of mergers and ac□uisitions activities
- Supervised maintenance of corporate operating licenses
- Ongoing legal, regulatory and corporate governance advice to CEO, CFO, COO and senior management
- Selected, monitored and managed outside counsel
- Corporate Secretary, handling all corporate resolutions, bylaws amendments and maintenance of other

corporate governance documents.
- Reorganized/relocated all legal functions in 2008 subsequent to purchase of company from prior owner
- Supervised institution of contract electronic imaging process 2008-09
- Supervised compliance and privacy functions

Liberty Health System, Inc. 2006-2008
Jersey City, New Jersey
Senior Vice President and General Counsel

Not for profit New Jersey safety net hospital/health services system comprised of 3 hospitals and 14 business units across 10 sites.

Responsibilities:

- As system's first in-house General Counsel, created internal legal function.
- Managed legal aspects of hospital system turnaround under supervision of New Jersey regulatory authorities
- Managed legal aspects of closure of one of three system hospitals and of disaffiliation with federally qualified health center
- Instituted corporate compliance program, including documentation of Stark and anti-kickback compliance for physician contracting and leasing arrangements, and revisions to Code of Conduct
- Led system-wide physician re-contracting initiative for approximately 185 physicians
- Managed legal aspects of ongoing physician recruitment initiatives and vendor, outsourcing and managed care contracts
- Negotiated contract with strategic medical center partner for perinatal/neonatal services
- Handled all legal real estate matters, including physician office building construction
- Managed insurance and risk management function
- Managed all formal and informal dispute resolution processes, including litigation, malpractice matters, lawsuits against health insurers, employment claims and investigations, patient care and patient rights issues, reports to professional licensing entities, and other regulatory reporting
- Revamped hospital bylaws and reincorporated and reconstituted hospital boards to realign hospital and parent board functions
- Advisor to all HR functions; handled all legal employment/severance related matters
- Ongoing corporate governance advice to hospital and parent boards
- Ongoing legal and regulatory advice to CEO, CFO, COO and all other senior management
- Selected, monitored and managed outside counsel
- As Board of Trustees legal advisor, attended and provided advice in Board meetings for parent and subsidiary hospitals, and furnished ongoing counsel to Board on corporate governance. Handled all corporate resolutions, bylaws amendments and maintenance of other corporate governance documents.

WellPoint/WellChoice./Empire Blue Cross and Blue Shield 1993-2006
New York, New York
Associate General Counsel, Vice President Risk Management, Chief Privacy Officer, 2002-2006
Vice President and Associate General Counsel, 2000- 2002
Assistant Vice President and Associate Counsel, 1996-2000
Director and Associate Counsel, 1993-1996

Largest health insurance company in New York State, serving 5.2 million members.

Responsibilities:

- Negotiated major human resources, outsourcing, benefits, hospital and ancillary provider contracts
- Lead Counsel for e-business subsidiary NexxtHealth set up and incorporated company, handled all legal functions, negotiated all contracts licensing agreements, created and implemented stock option plan
- Risk Management Attorney Officer
    - Created and implemented corporate-wide safety policy and safety committees, thereby decreasing workers compensation claims
    - Obtained 74 million 9 11 World Trade Center insurance recovery. Corporation attained funds to rectify disaster-related damage to operations
    - Managed error and omissions recovery (approximately 4 million) in national class action
    - Conducted complex and sensitive litigation, managed litigation attorneys
    - Designed insurance portfolio for newly public company
- Chief Privacy Officer
    - Implemented federal HIPAA law and state information security laws
    - Managed all privacy breach investigations, compliance and contracting issues
    - Developed and co-chaired corporate Cross Functional Privacy Security Committee
- Corporate employment, benefits, labor and ERISA counsel
    - Managed downsi ing of organi ation from 10,000 to 5,000 employees, negotiated numerous senior executive severance agreements, and investigated and resolved numerous employment claims, all at minimal legal liability.
    - Handled conversion of 500 million pension to cash balance plan, retiree benefit changes, and ensuing legal challenges.
    - Implemented all legal changes to employee benefit programs (e.g. Health Savings Accounts).
    - Interim Senior VP, Human Resources and Services. Maintained continuity in Human Resource function during two management transitions.

Vladeck, Waldman, Elias & Engelhard, P.C., New York, New York
Associate, 1986-1989; 1990-1993
Practice in labor, employment and employee benefits law. Negotiation, litigation, arbitration and representation before government agencies. Handled cases from inception through appeal.

Cleary, Gottlieb, Steen & Hamilton, New York, New York
Associate, 1989-1990
General corporate practice, including complex commercial and real estate transactions, corporate financing and securities law compliance.

Honorable H. Lee Sarokin, United States District Court District of New Jersey (now retired) Newark, New Jersey
Law Clerk, 1985 -1986

Honorable Robert S. Vance, United States Court of Appeals, Eleventh Circuit (now deceased) Birmingham, Alabama
Law Clerk, 1984 - 1985

EDUCATION

Harvard Law School, J.D. June 1984, cum laude,
Editor, Harvard Law Review, Legal Writing Instructor, Teaching Assistant

Wesleyan University, M.A.L.S. May 1981, Major: Literature

Yale University, B.A. May 1978, summa cum laude, Major: Literature

BAR ADMISSIONS

New York, New Jersey, Connecticut, S.D.N.Y., E.D.N.Y.

PROFESSIONAL AFFILIATIONS

Member, New York State Bar Association Health Law Section Public Health and Medical Device & Biotechnology Committees
Former Member and Chair, New York City Bar Association Health Law Committee
Member, American Health Lawyers Association
Member, New Jersey Bar Association Health Law Section
Member, Connecticut Bar Association Health Law Committee

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Senior Vice President of Finance & Chief Financial Officer

Healthcare Financial Executive with nearly 30 years of progressive experience, including 10 years as the top finance decision-maker or second in command of a □300 million dollar healthcare system □ 25 years in management. Skilled in financial reporting and analysis, accounting, strategic planning & financial forecasting, budgeting, reimbursement, managed care, treasury functions, captive and insurance oversight, revenue cycle, materials management, health information management and information technology. Demonstrated ability to lead key initiatives, manage professional staff, foster teamwork and build consensus, strategic thought, and achieve goals. Respect of peers for commitment, passion, attention to detail, integrity, and accountability.

Executive Performance

Extensive interaction with Hospital Executives and Board Members. Providing financial results; fiscal and strategic analysis; insight and recommendations on strategic issues and planning. Presents financial reports□results to all Boards (system Board and all Affiliate Boards) as well as to Finance Committee, Investment Committee, Audit Committee and Planning.

Integral part of, and participant in, the annual development of the Hospital□s strategic plan.

□ey member of the System Ac□uisition Team comprised of Board members and Hospital Executives.

Restructured the Finance Department to improve overall customer service (internally and externally) and performance.

Integrated the Finance Department into clinical areas to facilitate an understanding of both clinical and financial perspectives on issues.

Cultivated strong collaborative relationships with all c-suite personnel and board members staffed to Finance, Audit and Investment Committees.

Restructuring, stabili□ing Information Services for the transition years prior to ac□uisition.

Employment

Eastern Connecticut Health Network, Inc. • June 2010 – Present, Manchester, CT
Senior Vice President of Finance & Information Services, Chief Financial Officer

Areas of Responsibility & Committees:
Same basic areas of responsibility and staffing to various boards and committees as I held as VP of Finance with the following differences: Report directly to the CEO and now staffed to the Planning Committee and ISSO (Information Systems & Services Oversight) Committee. Also one of two senior team members that have Captive oversight and reporting.

Key Accomplishments:

The last two plus years working to craft a seller□s needs list and vet out an ac□uirer to best position the organi□ation for many future decades of providing □uality healthcare services to the community.

□eeping the system financially viable to get through the next few years until it is ac□uired without breaching any bond covenants, at worse, but with a higher objective of being able to continue independent should ac□uisition efforts fall through

Worked closely with the CEO as part of a □grassroots□effort to bring attention to and eventually garner pension funding relief via the Pension Relief Act (passed in 2010 and again in 2012) by lobbying our federal legislators down in Washington □made several trips to discuss face to face. This made a substantial difference to our financial future by bringing about more reasonable pension funding obligations.

Worked on another lobbying effort via the Affordable Care Act to bring about additional funding to our two hospitals that □ualify for Urban Medicare Dependent Hospital status; still on-going

Financially positioned the System to meet its budgeted surplus target in 2010-12 after raising the financial bar at the beginning of the three year run to prepare to meet the financial challenges of Pension Protection Act and other regulatory changes.

Joined the Chief Financial Officer Roundtable organi□ation □approximately 100-150 healthcare CFO□s from around the country participate.

Eastern Connecticut Health Network, Inc. • January 2004 – May 2010, Manchester, CT

Vice President of Finance

□300 million healthcare network with two acute care community-based Hospitals with 351 beds and Subsidiaries including; 100 Bed Skilled Nursing Facility, Diagnostic Imaging Center for Women, Fundraising □Arm□, Real Estate Company, Captive Insurance Company and over 20 Physician Practices. Also hold interests in the following joint ventures: Visiting Nurse Company, two Ambulance Companies, Cancer Center, Gastroenterology Free-Standing Facility, and two Free-Standing Imaging Centers.

Areas of Responsibility:
Reports directly to the C.F.O. Directs a finance team of over 110 employees. General accounting, corporate accounting, G.A.A.P. compliance, accounts payable, payroll, treasury, cash management, internal control, tax exempt bond compliance, taxes, external and regulatory reporting, financial analysis and reporting, long range financial planning, budgeting, reimbursement, managed care, revenue cycle improvement, revenue compliance, and financial information systems. Performance oversight of Patient Access, Centrali□ed Scheduling and Patient Accounting areas.

Board Committees:
System Board, Affiliate Boards, Finance Committee, Audit Committee, and the Pension and Investment Committee.

Key Accomplishments:

Point person on establishing the System□s financial targets for the next 3-5 years during President Staff Retreat in 2007. First year of new financial vision was FY 2008 □financial target of □8 million from operations was met.

Architect of the change to the paid leave benefit program in FY 2008 which netted nearly □2 million in operational savings.

At forefront of re-charting financial course considering current economic crisis and challenges. Financial goals to remain intact but course to follow has changed and plans have been drafted and will be implemented shortly.

Have been part of team that lead changes to Pension benefits, moving from defined benefit (except for a small few meeting age and tenure criteria) to defined contribution plan to save the system millions in potential funding re□uirements in future years. Have already reali□ed annual expense savings or expense avoidance with the change for FY 2009.

Improved Revenue Cycle Performance 5 years running while absorbing responsibility of all Managed Care oversight and negotiations while staffing kept flat and in some cases reduced as part of overall hospital □belt-tightening□measures.

Directed the issuance and□or refunding of just under □100 million tax exempt bond offerings for a variety of hospital renovations at both sites spanning the last 10 years through Connecticut□s funding agency, CHEFA.

Have also successfully secured other CHEFA sponsored financing (Easy Loan and Easy Lease) to procure other critical clinical equipment needs.

Realized $100,000 annually in additional Medicare Revenue by reviewing and correcting Medicare underpayments related to transfer DRGs.

Increased managed care rates significantly over the past five years by tough negotiating tactics, and through tactical price increases. Have also negotiated several large settlements with major managed care payers on past years underpayments.

Have been at the point working with Clinical and Operational Leadership on initiatives to squeeze expenses out of the system. In FY 2007, identified $6 million in salary and non-salary expense reduction opportunities that were eventually implemented to achieve full annual benefit for FY 20008. Working with team again in current fiscal year on CRI (cost reduction initiative) to reduce annual expenses by another $4 million.

Serve as member along with Senior VP of Patient Care and VP of Quality on LEAN. LEAN is simply a process of reducing waste – wasted time, wasted energy, and wasted steps. The end game is to improve the efficiency and delivery of a service, to reduce cost and to improve throughput. We have earmarked annually 6-8 initiatives (starting in FY 2007).

Serve as member along with Senior VP of Human Resources and VP of Operations on FHT (Financial Health Team). Collaborative approach to monitor and help manage poor financial performers in the organization at all levels. Eventually can be used as a tool to weed out continued inability to manage financial performance/budget.

Worked closely with the ED on post implementation monitoring of a new system designed to better track patients through the ED throughput process, improved documentation, and track supply utilization and charge capture.

Co-sponsored evaluation and eventually purchase of Surgery Compass software license to identify Operating Room Service trends and cost saving opportunities along service lines or specific to surgeons.

Worked on financial feasibility analysis on the following: new ICU, expansion of Skilled Nursing Facility from 100 beds to 130 beds, move of Women's Wellness Center to new site and acquisition of two digital units, new Wound Care program with hyperbaric chambers, sale of outpatient Dialysis site, Gastroenterology Joint Venture, and two Imaging Joint Ventures.

Eastern Connecticut Health Network, Inc.

Senior Director of Finance (2002-2003)
Reported directly to the Vice President of Finance. Scope of oversight applicable to entire system – hospitals and affiliates. Areas of responsibility included: accounting, budgets, accounts payable, and payroll. Provided reporting and analytical support to Executives, Clinical Chairs, Administrators, Department Managers and Clinicians.

Director of Finance for Hospitals (2000-2001)
Reported directly to the Vice President of Finance. Scope of oversight applicable to the two hospitals. Areas of responsibility included: accounting, budgets, accounts payable, and payroll. Provided reporting and analytical support to Executives, Clinical Chairs, Administrators, Department Managers and Clinicians.

Director of Finance for Affiliates (1998-2000)
Reported to the Vice President of Finance and the Administrator of the Skilled Nursing Facility. Scope of oversight applicable to SNF and two other affiliates (Women's Center for Wellness and Physician Practices). Areas of responsibility included: accounting, budgets, external audits, reimbursement, cost reporting, managed care, accounts payable, payroll and other financial analysis. Presented financial results to the affiliate Boards.

Hartford Hospital • July 1989 – November 1998, Hartford, CT

An 867 bed tertiary and teaching hospital affiliated with the University of Connecticut Medical School.

Patient Accounts Manager (1994-1998)
Reported directly to the Director of Patient Financial Services. Departmental liaison to Finance on all reporting metrics. Oversight for Remittance Processing & Cashiers Office, and Self-Pay Unit. Was instrumental in the development and

implementation of automated remittance processing and posting for Medicare, Medicaid, Anthem and several other managed care payer remittances.

Accounting Supervisor (1989-1993)
Reported directly to the Accounting Manager. Primary responsibilities included the month end close calendar and journal entry processing, review of all intercompany transactions and loans, and all fund accounting.

Mount Auburn Hospital • January 1985 – June 1989, Cambridge, MA

A 191 Bed regional teaching hospital closely affiliated with Harvard Medical School.

Assistant Controller (1988-1989)
Reported directly to the Controller. Primary responsibilities included the month end close calendar and all journal entry processing.

Senior Accountant (1987-1988)
Reported directly to the Controller. Primary responsibilities included the month end close calendar and all journal entry processing. Assisted Budget/Reimbursement Department as needed.

Accounts Payable Manager (1986-1987)
Reported directly to the Controller. Responsible for oversight and direction of Accounts Payable staff of four. Department previously lacked organization. Continued to maintain accounting responsibilities.

Staff Accountant (1985-1986)
Reported directly to the Accounting Manager. Assisted Finance Department in various ways including: statistical reporting, cost reporting, budgeting, month end close and analysis, and year end audit requirements.

Education

Boston University • 2013
EMBA -- Executive Master's Business Administration

Eastern Connecticut State University • 1984
Bachelor of Science – Business, Concentration in Accounting.

Gregory M. Williams, CPA
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SUMMARY

Senior Executive and former business owner with profit and loss experience, a strategic orientation and ability to develop and implement short and long range business strategies in key roles. Key roles included Senior Vice President of Network Services of a two hospital health system, President of a $3 billion in sales financial services firm, Vice President of Strategy and Business Development and Chief Financial Officer of a Fortune 100 financial services firm. My strengths include a focus on people orientated processes, results driven leadership focused on maximizing revenue and earnings growth as well as developing, coaching and mentoring people providing them with upward mobility.

PROFESSIONAL EXPERIENCE

Eastern Connecticut Health Network, Inc. 2013 ï present
Responsible for $25.1 million (revenue) health network owned physician group, $3.9 million (revenue) gastroenterology endoscopy center joint venture, $3.5 million (revenue) managed services company, network wide medical staff development planning, physician recruiting and physician relations:

- Led transition to Medical Foundation model.
- Designed and implemented work rvu physician compensation model.
- Led staff and physicians through cultural change process associated with work rvu compensation ï achieved 10% productivity growth in year 1.
- Successfully obtained ñMeaningful Useò stage 1 and 2 incentives.
- Achieved or exceeded FY 2013 and FY 2014 productivity, quality and financial goals.

Medical Practice Partners, LLC, Vernon, CT 2010 ï present
President, physician service company providing medical billing services, electronic medical record selection, contracting, installation, training, go live and support services:

- On behalf of a $12 million (revenue) physician group, negotiated the transition of their medical billing company to a joint venture with a health system. The negotiation process, company formation and transition process led to becoming President of the new entity.
- Over the course of three years, successfully led the company:
  - Through 40% managed turnover and creation of new positions and opportunities.
  - CAGR in revenue of 5.5% during largest health care reform period and industry consolidation.
  - Annual improvement in net income from a loss of ($473.6k) in 2010 to a gain of $377.9k in 2014.
  - Expansion of services from medical billing to electronic medical record consulting & support, IT service & support, human resource management, bookkeeping and employee leasing. Excluding leased employees, FTEôs remain flat with initial year despite growth in revenue and services.
- Recruited (2011) Vice President Operations to groom and became day to day leader of organization in 2013.

KMA Wealth Management, LLC, Tolland, CT 2003 - 2013
Managing Member of a full service fee-based financial planning and business consulting firm serving business owners, medical practices and professionals and corporate executives.

MassMutual Financial Group, Springfield, MA 1998 ï 2003

President, MML Investors Services, Inc., MML Distributors, Inc. and MML Insurance Agency (2002 ï 2003)
Responsible for all MassMutual retail and wholesale broker dealers and insurance brokerage organizations. MML Investors ranks in top three of insurance affiliated broker dealers:

- Defined organizational vision, fit within the enterprise and key strategic initiatives leading to:
  - Approval of $2 million technology and workflow investment into the business for 2004.
  - Significant role in the successful recruiting of field management talent and financial services professionals.
  - By realigning staff, increased productivity and created opportunities for professional development resulting in a 13% increase in operating margin.
  - Achieved 2003 sales goal of over $3 billion and earnings target despite challenging economic environment.
  - Implementation of a rigorous people development process with succession planning as a primary focus and long term career paths.
- Built very strong, respected relationships with both internal and external key senior executives of product and service providers leading to significant financial support and field satisfaction.
- Managed complex legal and regulatory proceedings.
- Served as primary liaison with field committees representing 85 general agents and 4,000 registered representatives.

Vice President – Field Management Development (2002)

- Developed a vision and implemented new programs to strengthen existing agency management and acquire field management talent to drive accelerated revenue growth and reduced costs. Key member of management team reporting to head of Retail Distribution.
  - Presented acquisition strategy to MassMutualôs CEO and senior management team to gain approval for investment.
  - Successfully transitioned five top talent field managers.
  - Created an agency management candidate profile and development curriculum.
  - Designed and delivered a new compensation plan for sales management ï a 12 month project, $8 million investment on time and within budget.
  - Hired top talent successor to assume full responsibility going forward.

Vice President – Strategy and Business Development (2000 ï 2002)

- Led and developed the first Individual Insurance Group (IIG - Life, Disability Income and Long Term Care Insurance products and Retail and Institutional Distribution) multi-year Strategic Plan and one year Business Plan:
  - Operated as Chief of Staff to Executive Vice President of IIG to assure achievement of committed targets.
  - First holistic multi-year strategic plan including all product lines and distribution organizations.
  - Facilitated sensitive debates on allocation of resources between business heads.
- Senior project manager in the strategic review of the Career Agency System:
  - Evaluated the future of the distribution system: invest in it, harvest it over time or to abandon it in favor of other distribution channels beginning with evaluation of enterprise long term growth objectives and impact of product portfolio, technology, processes, workflows, communications and economics.
  - Evaluation led to a $60 million investment into the Career Agency System through 16 large scale projects. Oversaw the 16 project managers to ensure the projects were delivered on time and within budget.
  - Established very productive relationships with key field managers and home office managers through extensive and sensitive discussions.

2nd Vice President – Chief Financial Officer, Chief Accounting Officer (1998 ï 2000)

- Created a business analysis organization focused on financial, competitive and operations analysis, market positioning and capital investment decisions.
- Improved and broadened skills and competencies within the financial organization through talent acquisition and development opportunities.
- Developed and implemented GAAP accounting and improved quarterly closing process:
  - Significant reduction in time to close books.
  - Developed timely, accurate and useful management reporting for senior business heads to aid in business decision making.
  - Installed new reserve calculation system and process.
  - Developed highly effective relationships with key business executives to demonstrate value of financial talent partnering with line of business executives.

CIGNA – Executive Development Program, Bloomfield, CT 1993 ï 1998

Rotation assignments in Retirement business, Individual Life and Annuity business and multiple corporate roles:

- Leadership role in divestiture of Individual Life and Annuity business to Lincoln Financial.
- Liaison with Rating Agencies for all CIGNA divisions.

PriceWaterhouseCoopers, Hartford, CT 1990 - 1993

- Staff and management roles on audit engagements in the insurance, banking and non-profit business segments.

EDUCATION & LICENSES

BS Accounting, Southern New Hampshire University, Manchester NH
Certified Public Accountant & Personal Financial Specialist (PFS)
National Association of Securities Dealers Series 7, 24 and 66 registrations, Connecticut and Massachusetts
Life, Accident, Health and Long Term Care Connecticut and Massachusetts Insurance Producer Licenses

AFFILIATIONS

American Society of CPAôs
Connecticut Society of CPAôs
President & Executive Board Member -Tolland Country Chamber of Commerce
Tolland Economic Community Development Corporation **Board Member**
Town of Tolland Economic Development Commission **Chair**
Executive Director and Treasurer of Tolland Youth Baseball League

CURRICULUM VITAE

Name:	Pamela Lewis
Home Address:	306 Grandview Drive Glastonbury, CT 06033
Business Address:	OB-GYN Group of Eastern Connecticut, P.C. 360 Tolland Turnpike, Suite 3B Manchester, CT 06042-1759
Business Phone:	(860)6461660
EMAIL:	plewis@obgyneasternct.com; plewis372@gmail.com
Cell Phone:	(860)930-6806
Citizenship:	American (USA)
Marital Status:	Single

Education

1979-1982	Southeastern Massachusetts University, North Dartmouth, MA. B.S in Biology, High Distinction
1984-1988	University of Miami School of Medicine M.D.
1989-1990	Internship, Department of Obstetrics and Gynecology Mount Sinai Hospital, Hartford, CT
1990-1993	Resident, Department of Obstetrics and Gynecology Mount Sinai Hospital, Hartford, CT

Employment

1993-Present — Managing Partner, OBGYN Group of Eastern Connecticut, P.C
Manchester, CT

2006-Present — Managing Partner

- Administrative responsibilities
- Review collections and the billing Department
- Negotiations of HMO contracts

Hospital Appointments

2014- Present — ECHN President, Medical Staff

- Chair, Medical Executive Committee
- Member ECHN Board of Trustees

2013-present Associate Director, ECHN Medical Education
- Assist the Director , ECHN Medical Education

2012-2013 ECHN Vice President, Medical Staff
- Affiliation Work Group
- Chair, Quality Improvement Council
  - Presentation: Retrospective Review of 3rd and 4th Degree Tears in OB Patients at Manchester Memorial Hospital

2011-present Clerkship Director, ECHN/UNECOM Medical Student Program

2008-2011 ECHN Chair, Department of Obstetrics and Gynecology
- Organization of multidisciplinary conferences
- Integration of Mock Stimulation Programs
- QA and Peer Review
- Administrative responsibilities
- Development of the FBC Safety and Quality Committee
- Medical Executive Committee
- Medical Peer Review Committee
- Surgical Leadership Committee

2014-present Clinically Integrate Network of Eastern Connecticut (CINECT)

2011-2012 ECHN PHO President
- ACO Development Committee

2010 ECHN PHO Vice President

Hospital Affiliations

1997-present Active Staff, Eastern Connecticut Health Network
Manchester, CT

1993-1997 Active Staff, Manchester Memorial Hospital
Manchester, CT

Academic Appointments

2011- Present Assistant Professor of Clinical Obstetrics and Gynecology at the University of New England College of Osteopathic Medicine

1988-1989 Research Assistant, Department of Obstetrics and Gynecology
University of Miami School of Medicine Dr. Mary J O' Sullivan

6/1986 Research Assistant, Department of Pediatrics

	University of Miami School of Medicine Dr. Donald Vernon
6/1985-8/1985	Cardio-Pulmonary Technician Florida Medical Center, Ft Lauderdale, FL Randy Guessetto - Director
1982-1984	Research Assistant, Department of Pulmonary Medicine University of Miami School of Medicine Lee Frank, PhD, MD
6/1982-9/1982	Volunteer Emergency Room Florida Medical Center, Ft. Lauderdale, FL

Memberships

2001-2002	President, Greater Hartford Obstetrical and Gynecological Society
1993-Present	American College of Obstetricians and Gynecologists Fellow
1993-Present	Hartford County Medical Society
1993-Present	New England OB/GYN Society

Special Courses

- Colposcopy and Laser Certification
- Neonatal Resuscitation Certification

Licensure/Certification

Licensure: Connecticut
Certification: Board certified December 1995
Honors and Awards: Resident Research Award May 1991, 1992, 1993
American Lung Association Pulmonary Summer Scholarship: July 1986

Publications

Frank, L., Lewis, P., Garcia-Pons, T: Intrauterine growth-retarded rat Pups show increased susceptibility to pulmonary oxygen toxicity. Pediatric Research Vol. 19 No.3, 1985. Pp.569-574

Frank, L., Lewis, P. Sosenko, I: Dexamethosone stimulation of fetal rat Lung antioxidant enzyme activity in parallel with surfactant Stimulation. Pediatrics Vol. 75 No. 3, March 1985. Pp569-574.

Publications Continued

Sosenko,I., Lewis, P., Frank, L: Metyrapone delays surfactant and Antioxidant enzyme maturation in developing rat lung. Pediatric Research Vol.20 No 7, 1986. Pp672-675.

Vernon, D., Holzman,B., Lewis, P: Respiratory failure in children with AIDS-related complex. Pediatrics Vol. 82 No.2, August: 1988. pp.223-228.

Lashgari, M., Lewis, P.: A Comparison of cold knife, co2 laser and Electrosurgical Loop Conization in the treatment of cervical Intraepithelial Neoplasia. Journal of Gynecologic Surgery 1994.

Abstracts

Frank, L., Lewis, P., Sosenko, I: Dexamethasone stimulates rat lung Antioxidant enzyme activity in parallel with surfactant stimulation. Pediatric Research 18; 1771 A.1984.

Frank, L., Neriishi, K, Lewis, P., Sio, R: Prolongation of tolerance to Pulmonary oxygen toxicity by castration of young male rats. Pediatric Research 18:137 A. 1984.

Sosenko, I., Lewis, P., Frank, L: Metyrapone delays maturation of fetal lung Surfactant and antioxidant enzyme: are both under endogenous Glucocorticoid control? Pediatric Research 19: 1839 A. 1985.

Vernon, D., Lewis, P., Holzman, B: Acute respiratory failure in children With Acquired Immune Deficiency Syndrome: Causes and Implications. Critical Care Medicine 15: No 4, April 1987, p412. Presented at the 16th Annual Scientific and Educational Symposium of Society for Critical Care Medicine, May 26-29, 1987, Anaheim, Ca.

Scorza, W., Lewis, P., Vintzileos, A: Qualitative Physical and Chemical Changes of Infected Amniotic Fluid in an vitro study. Presented at The Society of Perinatal Obstetricians Meeting. Orlando, FL, February 1992.

Lewis, P., Morel, M., Scotti, R: Heterotopic intrauterine and Tubal Ectopic Pregnancy complicated by Pulmonary Embolus. JOURNAL Of Reproductive Medicine Vol.39 May 1994 No.5 pp 417-418.

Lewis, P., Mendelovici, R., Scotti, R: A Case Report of Invasive Mole with Uterine Rupture. Journal of Gynecologic Surgery Vol.10 No.2 pp 89-91.

M. Maher Suede, MD.FACS.

272 Main Street
Manchester, CT. 06042
Tel: 860-4322100
Fax: 860-4325330
Email: mahersuede@yahoo.com
Website: suedesurgicalcare.com

PERSONAL

Board Certified in the field of General Surgery, in addition to having a large experience in Advanced Laparoscopic Surgery, and a great interest in breast, thyroid, and varicose veins surgery.
Currently, practicing General and Advanced Laparoscopic and Robotic Surgery in Manchester, Connecticut.

EDUCATION

- 12/2007 passed the **Recertification Exam of the American Board of Surgery.**
- 10/2006 attended **Laparoscopic Hand Assisted Colon Surgery Workshop**, at the University of Massachusetts, Shrewsbury, Massachusetts.
- 7/2006 attended **Laparoscopic Intestinal Surgery Workshop**, at the Lahey Clinic, Burlington, Massachusetts.
- 5/2003 attended an intensive course in **Advanced Laparoscopic Surgery** at the University of Strasbourg, Strasbourg, France.
- 10/1999 received the certification of the **American Board of Surgical Critical Care.**
- 11/1998 received the certification of the **American Board of General Surgery.**
- 7/1997-6/1998 **Fellowship in Surgical Critical Care**, at Hartford Hospital, University of Connecticut, Hartford, Connecticut.
- 7/1993-6/1997 **General Surgery Residency**, at New York Methodist Hospital, an affiliate of Cornell University, Brooklyn, New York.
- 7/1991-6/1993 **General Surgery Residency**, at Monmouth Medical Center, New Jersey.
- 3/1991 Received the **ECFMG Certificate.**
- 3/1990-3/1991 **Worked as a research and clinical associate**, at the Division of Pediatric Surgery, at Harbor-UCLA Medical Center, Torrance, California.
- 8/1989 **Graduated from Damascus University School of Medicine.**

EMPLOYMENT:

- 7/1997-9/1999 Attending physician in Surgical Critical Care at Saint Francis Hospital, Hartford, Connecticut. During that period I had the responsibility of managing all aspects of critical surgical and trauma patients in a 12 bed SICU and a 6 bed intermediate care unites, at a level one trauma center, with a busy general, vascular and thoracic surgical services.
- 1/2000- 2/2005 Private General Surgery practice at Cham Clinic Damascus, Syria.

Practicing In a multi-specialty group, with a busy urgent care, in the center of Damascus city, and operating in many of the city's private hospitals.

- 10/2000- 4/2002 served as the Director of Surgical Critical care, Al-Assad University Hospital, Damascus, Syria.

In which I had the duty of managing a three unit surgical intensive care, that included cardiothoracic, neurosurgical and a general surgical unit.

- 3/2005- 6/2008, Private Practice in General Surgery, with Dr. Laureen Rubino, MD. Manchester, Connecticut.
- 6/2008- 3/2010 General Surgery, at Eastern Connecticut Health Network Health Services.
- 4/2010- present General Surgery private practice at Suede Surgical Care LLC.

Professional Society Membership:

Fellow of the American College of Surgeons.
Fellow of the American Society of breast surgeons.

Hospital Affiliation:

- Manchester Memorial Hospital, Manchester, Connecticut.
- Rockville General Hospital, Rockville, Connecticut.
- Saint Francis Hospital, Hartford, Connecticut.

References

- **Leslie Wise, MD.**
  Chairman Department of Surgery
  New York Methodist Hospital
  506 Sixth Street
  Brooklyn, NY. 11215
  Tel: 718-780 3000
- **Kevin Keating, MD.**
  Program Director
  Surgical Critical Care
  Hartford Hospital
  80 Seymour Street
  Hartford, CT.06102
  Tel: 860-545 5000

- **Dr. Joel Reich, MD.**
  Senior Vice President of Medical Affairs.
  Manchester Memorial Hospital
  71 Haynes Street
  Manchester, CT. 06040
  Tel: 860-6461222

EXHIBIT Q25-2 Biographical Profiles: PMH

RESPONSE TO QUESTION #25
BIOGRAPHICAL SUMMARIES

Sam Lee is Chairman of the Board of Directors and Chief Executive Officer ("CEO") of Prospect Medical Holdings, Inc. ("PMH"). Mr. Lee was appointed as PMH's CEO on March 19, 2008 and as Chairman of PMH's board of directors on May 14, 2008. Mr. Lee was previously appointed as a member of PMH's board of directors and as CEO of Alta Hospitals System, LLC ("Alta Hospitals"), the current corporate hospital segment and a subsidiary of PMH, on August 8, 2007. In 1998, Mr. Lee co-founded Alta Hospitals (formerly Alta Healthcare System, Inc.) with David Topper (see below) after acquiring seven (7) Los Angeles area hospitals from Paracelsus Healthcare Corporation ("Paracelsus"). Previously, he served as the President of Alta Hospitals from January 2002 until PMH acquired Alta Hospitals. Mr. Lee's background involves healthcare and technology related private equity investment management, operational leadership, entrepreneurship, mergers and acquisitions, and leveraged financing for various corporations. Prior to joining Alta Hospitals, Mr. Lee was a General Partner with Kline Hawkes & Co., a $500 million private equity firm located in Brentwood, California, that focuses on healthcare, technology, and business services.

David Topper is President of Alta Hospitals, a position he has served since 2007. He previously served as Alta Hospitals' CEO and a member of its Board of Directors between 1998 and 2007. In 1998, Mr. Topper co-founded Alta Hospitals with Mr. Lee. Prior to his involvement with Alta Hospitals, Mr. Topper served as Senior Vice President of Development and Hospital Operations for Paracelsus. Additionally, Mr. Topper has held healthcare executive management positions as a Hospital Administrator with Ramada Medical Corporation and as a Regional Vice President with Community Psychiatric Centers.

Dr. Mitchell Lew is President of PMH. Previously, Dr. Lew served as CEO of PMS since May 2012 and as the designated physician shareholder since February 1, 2013. He served as the Chief Medical Officer for PMS from December 2008 through December 2012. Prior to joining PMS, Dr. Lew was the CEO of Genesis HealthCare of Southern California, Inc. ("Genesis") from 1999 to 2006. In November 2005, Genesis was acquired by a company affiliated with PMS. From 1991 to 2001, Dr. Lew was the President of Lew Medical Group Inc., a medical group in which he also maintained a medical practice specializing in General Obstetrics and Gynecology.

Stephen O'Dell is Senior Vice President, Coordinated Regional Care for PMH. In this role, Mr. O'Dell leads the Company in its efforts to integrated our regional delivery systems among physicians, hospitals and payors. He is responsible for the development, implementation and oversight of the Company's coordinated regional care delivery systems in each of its regional markets. Prior to joining PMH, Mr. O'Dell served as Senior Vice President, Growth and Corporate Development, at Molina Healthcare. Before that, Mr. O'Dell held managed care senior executive positions with Blue Cross Blue Shield, United Healthcare, FHP International and First Consulting Group.

Steven Aleman is Chief Financial Officer of PMH, a position he has held since 2013. Prior to that appointment, Mr. Aleman, who is a certified public accountant, served as PMH's Vice President, Finance and Development since August 2010. Between May 2009 and July 2010, Mr. Aleman served as the CFO of SCH at Culver City, formerly known as Brotman Medical Center, Inc., a hospital subsidiary of PMH. From July 2008 through April 2009, Mr. Aleman held the position of Vice President of Internal Audit at PMH. Between 1998 and 2008, Mr. Aleman served in several positions ending as the Staff Vice President of Compliance with Wellpoint, Inc.

Ellen Shin, Esq. is General Counsel and Secretary of PMH, a position she has held since 2008. Ms. Shin is responsible for overseeing the legal and regulatory affairs of PMH and its affiliates, including corporate governance, regulatory compliance, litigation, transactions, government affairs and public policy activities. Prior to serving in her current position, Ms. Shin was the General Counsel and Secretary of Alta Hospitals from June 2006 to March 2008, where she oversaw the sale of Alta Hospitals to PMH. Prior to joining Alta, Ms. Shin was in private practice at several national and regional law firms in Los Angeles, California.

Cindra Syverson is Senior Vice President, Chief Human Resources Officer. Previously, Ms. Syverson spent seven years with Seattle-based Providence Health System as the corporate SVP, Chief Human Resources Officer. She also was the principle consultant of Syverson Consulting, Inc., which supported organizations talent and success management strategies, human resource operations improvement, culture change management and employee engagement and labor relations strategies. She has also held senior executive human resources positions with St. Joseph Health System, and PacifcCare/FHP.

Von Crockett is Senior Vice President, Corporate Development of PMH. Prior to that appointment, Mr. Crockett served as the Chief Executive Officer of SCH at Culver City from 2009 to 2012. Prior to joining SCH at Culver City, Mr. Crockett was the President and Chief Executive Officer, beginning in 2007, of Centinela Hospital Medical Center, a hospital with 369 licensed beds, 500 affiliated physicians, 1,500 staff and $260 Million annual net revenue, located in Los Angeles, California. From 2004 into 2007, Mr. Crockett served as the System Chief Operating Officer of Centinela Freeman Health System in Los Angeles, California. Between 2002 and 2004, he served first as the Chief Operating Officer and then the Chief Executive Officer for Doctors Medical Center San-Pablo/Pinole in San Pablo, California. He also served as the Chief Financial Officer of Sutter Healthcare, in Antioch, California, and Sharp Healthcare Corporation, in San Diego, California, from 2000 through 2002 and 1991-1999, respectively. Prior to those positions, he served in several finance related positions within the industry.

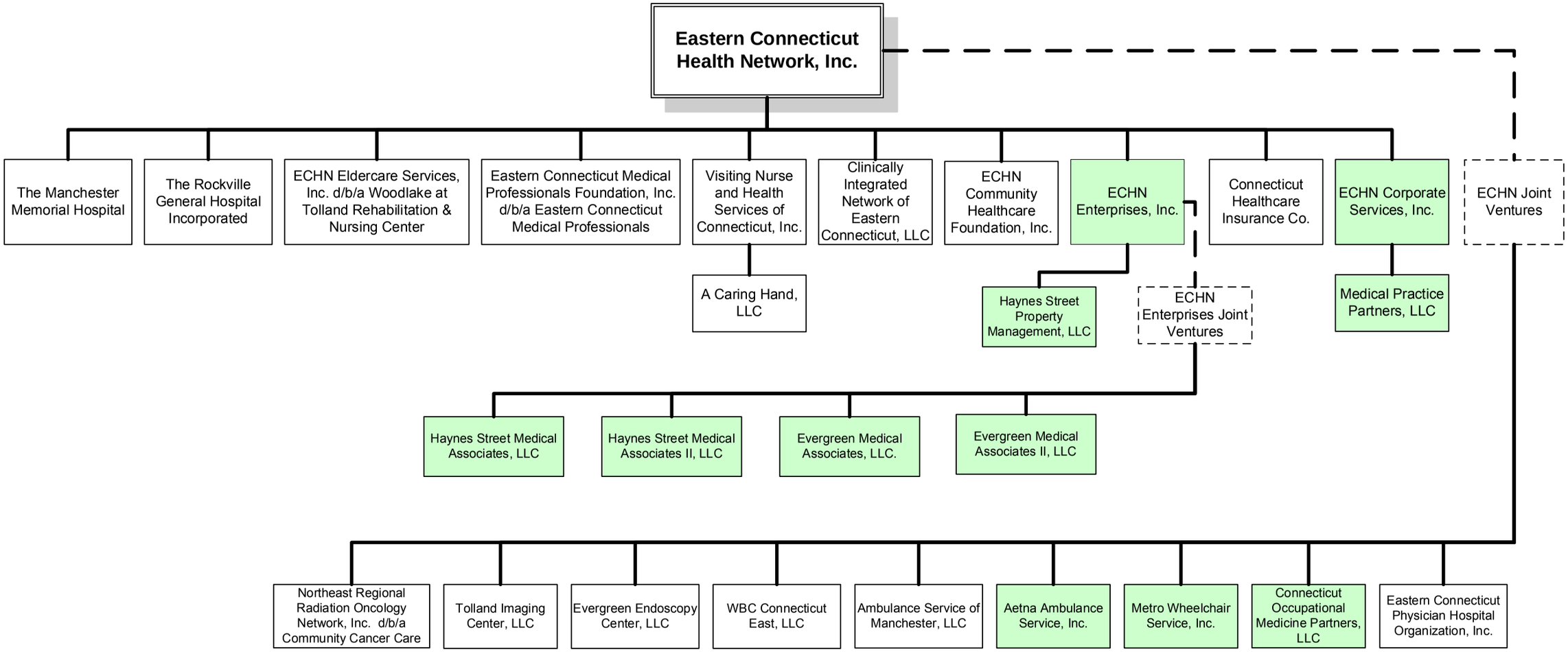
Thomas Reardon is the President of Prospect East Hospital Advisory Services, Inc. He was previously the Managing Member of Transition Healthcare Company, LLC and CEO of multi-hospital systems. He is also a faculty member of the Harvard School of Public Health; on many boards, including Harvard Medical Center and CRICO, the off-shore

insurer for MIT, Harvard University and the Harvard teaching hospitals. Lastly, he is the Chairman of the Board of the Massachusetts Eye and Ear Infirmary, Senior partner in a large national law firm, Chairman of the Law Department, Chairman & CEO of healthcare consulting subsidiary and member of the Executive Committee.

Hoyt Sze is Vice President, Chief Compliance Officer and Privacy Officer for PMH. Mr. Sze oversees and manages the compliance and privacy programs for the Company and its affiliates. Previously, Mr. Sze was a partner at McDermott Will & Emery LLP, a deputy federal public defender at the Office of the Federal Public Defender and an associate at Latham & Watkins.

Jonathan J. Spees is Senior Vice President, Mergers and Acquisitions for PMH. Previously, Mr. Spees was Senior Vice President with The Camden Group, where he was National practice leader for mergers, acquisitions and affiliations. Prior to The Camden Group, Mr. Spees was CFO for the University of Southern California's Keck Hospital of USC and USC Norris Cancer Hospital. Mr. Spees has also held positions as Senior Executive Vice President, Corporate Development and Finance, and a Founder of Merit Health Systems, LLC, a hospital management company; Managing Member of Abacus Ventures, LLC, and Managing Director of Shamrock Investments, LLC (both private investment and investment banking firms specializing in corporate finance and mergers and acquisitions in the healthcare industry); Associate Director of Corporate Development for American Medical International; and audit manager and designated healthcare industry specialist for Deloitte Haskins +Sells, one of the eight largest public accounting firms worldwide at that time. Mr. Spees is also a Certified Public Accountant.

EXHIBIT Q27-1 - ECHN'S ORGANIZATIONAL CHART PRIOR TO ASSET PURCHASE



For Profit Entity

Updated August 2015

EXHIBIT Q27-2 - POST ASSET PURCHASE ORGANIZATIONAL CHART

Post Asset Purchase Organizational Chart: Prospect ECHN, Inc. and Affiliates

DRAFT FOR DISCUSSION

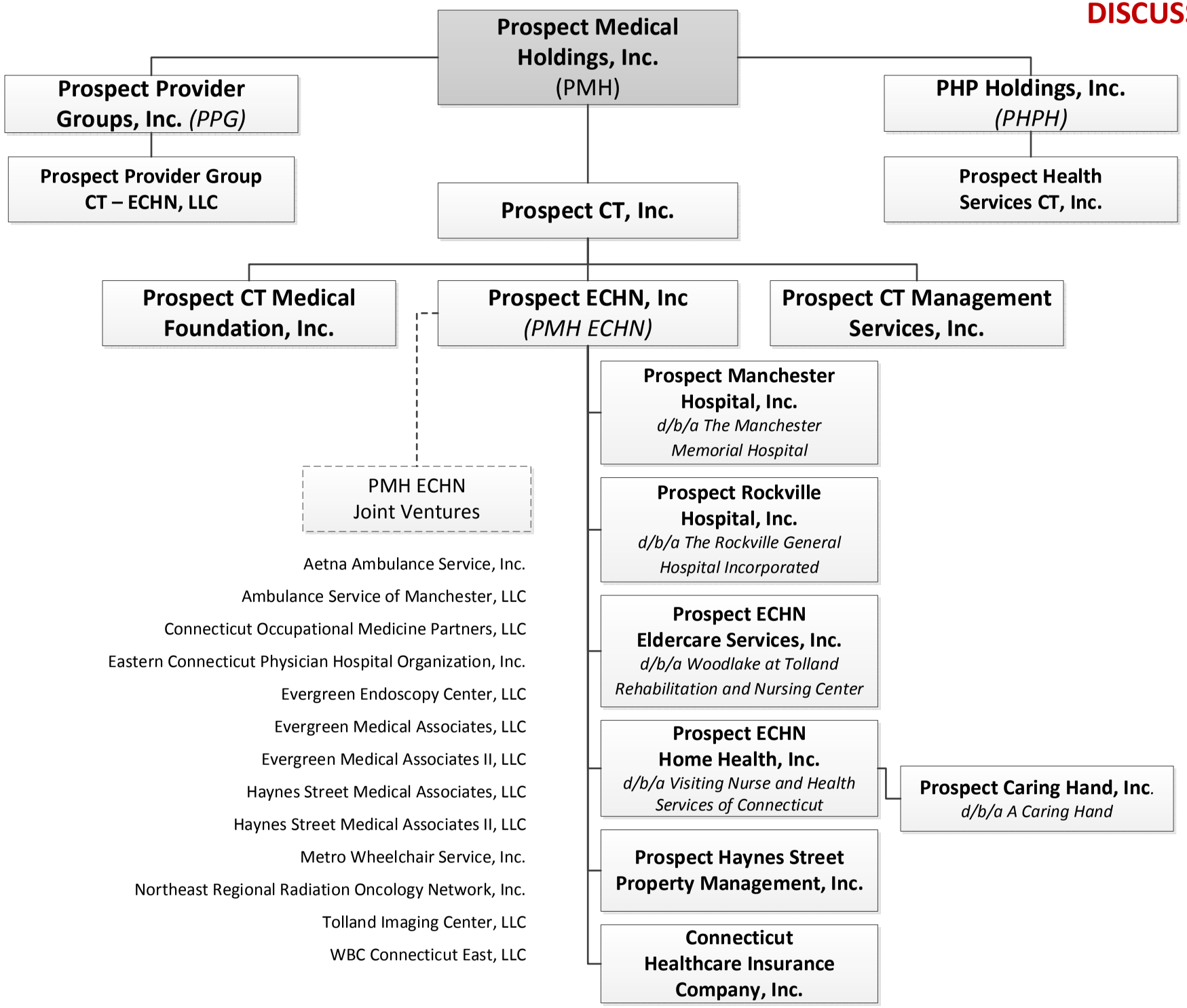


EXHIBIT Q37-1 - FINANCIAL WORKSHEET (C) FOR ECHN, MMH, RGH AND PMH

Sale of Non-Profit Hospital to For-Profit Entity

Name Entity: ECHN

Financial Worsheet (C):

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

LINE	Total Entity:	(1) FY 2014 Actual Results	(2) FY 2017 Projected W/out CON	(3) FY 2017 Projected Incremental	(4) FY 2017 Projected With CON	(5) FY 2018 Projected W/out CON	(6) FY 2018 Projected Incremental	(7) FY 2018 Projected With CON	(8) FY 2019 Projected W/out CON	(9) FY 2019 Projected Incremental	(10) FY 2019 Projected With CON
	Description										
A.	**OPERATING REVENUE**										
1	Total Gross Patient Revenue	$929,318,695	$927,844,907	$17,635,006	$945,479,913	$945,508,033	$28,243,993	$973,752,026	$964,300,815	$38,852,980	$1,003,153,795
2	Less: Allowances	$613,774,825	$611,398,847	$12,229,890	$623,628,737	$623,626,824	$19,589,415	$643,216,239	$636,099,361	$26,948,940	$663,048,301
3	Less: Charity Care	$4,833,207	$4,824,900	$75,815	$4,900,715	$4,921,398	$122,094	$5,043,492	$5,019,826	$168,374	$5,188,200
4	Less: Other Deductions	$739,349	$696,698	$0	$696,698	$710,632	$0	$710,632	$724,844	$0	$724,844
	Net Patient Service Revenue	**$309,971,314**	**$310,924,462**	**$5,329,301**	**$316,253,763**	**$316,249,179**	**$8,532,484**	**$324,781,663**	**$322,456,784**	**$11,735,666**	**$334,192,450**
5	Medicare	$112,234,172	$116,032,810	$1,955,888	$117,988,698	$118,019,923	$3,134,443	$121,154,366	$120,336,517	$4,313,000	$124,649,517
6	Medicaid	$48,469,631	$49,778,976	$776,499	$50,555,475	$50,631,462	$1,234,950	$51,866,412	$51,625,299	$1,693,402	$53,318,701
7	CHAMPUS & TriCare	$1,895,490	$1,872,728	$19,948	$1,892,676	$1,904,799	$31,962	$1,936,761	$1,942,188	$43,975	$1,986,163
8	Other	$0		$0	$0		$0	$0		$0	$0
	Total Government	**$162,599,293**	**$167,684,514**	**$2,752,335**	**$170,436,849**	**$170,556,184**	**$4,401,355**	**$174,957,539**	**$173,904,004**	**$6,050,377**	**$179,954,381**
9	Commercial Insurers	$137,108,151	$134,248,284	$2,485,974	$136,734,258	$136,547,345	$3,984,510	$140,531,855	$139,227,611	$5,483,046	$144,710,657
10	Uninsured	$666,816	$529,477	$11,120	$540,597	$538,544	$17,931	$556,475	$549,115	$24,741	$573,856
11	Self Pay	$4,893,477	$4,077,244	$0	$4,077,244	$4,147,068	$0	$4,147,068	$4,228,470	$0	$4,228,470
12	Workers Compensation	$4,507,382	$4,084,401	$79,872	$4,164,273	$4,154,348	$128,687	$4,283,035	$4,235,893	$177,502	$4,413,395
13	Other	$196,195	$300,543	$0	$300,543	$305,689	$0	$305,689	$311,690	$0	$311,690
	Total Non-Government	**$147,372,021**	**$143,239,949**	**$2,576,966**	**$145,816,915**	**$145,692,994**	**$4,131,128**	**$149,824,122**	**$148,552,779**	**$5,685,289**	**$154,238,068**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$309,971,314**	**$310,924,463**	**$5,329,301**	**$316,253,764**	**$316,249,178**	**$8,532,483**	**$324,781,661**	**$322,456,783**	**$11,735,666**	**$334,192,449**
14	Less: Provision for Bad Debts	$10,216,094	$6,059,932	$112,360	**$6,172,292**	$6,181,131	$180,494	**$6,361,625**	$6,304,753	$248,637	**$6,553,390**
	Net Patient Service Revenue less provision for bad debts	**$299,755,220**	**$304,864,530**	**$5,216,941**	**$310,081,471**	**$310,068,048**	**$8,351,990**	**$318,420,038**	**$316,152,031**	**$11,487,029**	**$327,639,060**
15	Other Operating Revenue	$28,166,459	$15,972,139	($152,102)	**$15,820,037**	$16,019,290	($152,102)	**$15,867,188**	$16,067,383	($26,102)	**$16,041,281**
17	Net Assets Released from Restrictions	$833,650	$913,370	($913,370)	**$0**	$913,370	($913,370)	**$0**	$913,370	($913,370)	**$0**
	TOTAL OPERATING REVENUE	**$328,755,329**	**$321,750,039**	**$4,151,469**	**$325,901,508**	**$327,000,708**	**$7,286,518**	**$334,287,226**	**$333,132,784**	**$10,547,557**	**$343,680,341**
B.	**OPERATING EXPENSES**										
1	Salaries and Wages	$162,727,445	$150,778,127	$1,410,518	$152,188,645	$153,793,689	$2,257,113	$156,050,802	$156,869,563	$3,103,708	$159,973,271
2	Fringe Benefits	$43,859,398	$49,260,250	($284,122)	$48,976,128	$49,710,250	$324,373	$50,034,623	$50,160,250	$639,204	$50,799,454
3	Physicians Fees	$14,478,331	$15,043,821	$0	$15,043,821	$15,495,135	$0	$15,495,135	$15,959,989	$0	$15,959,989
4	Supplies and Drugs	$34,194,649	$35,677,473	($913,733)	$34,763,740	$36,034,248	($474,183)	$35,560,065	$36,394,590	($34,635)	$36,359,955
5	Depreciation and Amortization	$12,196,877	$11,958,956	$714,285	$12,673,241	$11,958,956	$1,428,571	$13,387,527	$11,958,956	$2,142,857	$14,101,813
6	Provision for Bad Debts-Other[b]	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
7	Interest Expense	$3,764,488	$3,570,511	($2,847,514)	$722,997	$3,570,511	($2,925,174)	$645,337	$3,570,511	($2,978,049)	$592,462
8	Malpractice Insurance Cost	$3,807,147	$3,922,507	$0	$3,922,507	$3,961,732	$0	$3,961,732	$4,001,350	$0	$4,001,350
9	Lease Expense	$6,622,257	$6,371,114	$0	$6,371,114	$6,434,825	$0	$6,434,825	$6,499,173	$0	$6,499,173
10	Other Operating Expenses	$44,932,012	$45,412,457	($451,595)	$44,960,862	$45,946,581	($3,616)	$45,942,965	$46,486,047	$444,362	$46,930,409
	TOTAL OPERATING EXPENSES	**$326,582,604**	**$321,995,216**	**($2,372,161)**	**$319,623,055**	**$326,905,927**	**$607,084**	**$327,513,011**	**$331,900,429**	**$3,317,447**	**$335,217,876**
	Provision for Income Taxes[c]			$2,426,950	**$2,426,950**		$2,635,170	**$2,635,170**		$3,344,235	**$3,344,235**
	Earnings Before Interest, Taxes, Depreciation & Amortization **(EBITDA)**	**$18,134,090**	**$15,284,290**	**$4,390,401**	**$19,674,691**	**$15,624,248**	**$5,182,831**	**$20,807,079**	**$16,761,822**	**$6,394,918**	**$23,156,740**
	INCOME / (LOSS) FROM OPERATIONS	**$2,172,725**	**($245,177)**	**$4,096,680**	**$3,851,503**	**$94,781**	**$4,044,264**	**$4,139,045**	**$1,232,355**	**$3,885,875**	**$5,118,230**
	NON-OPERATING INCOME / REVENUE	($2,125,751)	($500,000)	$0	**($500,000)**	($500,000)	$0	**($500,000)**	($500,000)	$0	**($500,000)**
	NET INCOME / EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSES	**$46,974**	**($745,177)**	**$4,096,680**	**$3,351,503**	**($405,219)**	**$4,044,264**	**$3,639,045**	**$732,355**	**$3,885,875**	**$4,618,230**

Sale of Non-Profit Hospital to For-Profit Entity

Name Entity: ECHN

Financial Worsheet (C):

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

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
LINE	**Total Entity:**	**FY 2014**	**FY 2017**	**FY 2017**	**FY 2017**	**FY 2018**	**FY 2018**	**FY 2018**	**FY 2019**	**FY 2019**	**FY 2019**
		Actual	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**
	Description	**Results**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**
C.	**Retained Earnings/ Net Assets, beginning of year**	**$85,849,149**	**$67,059,776**	**$0**	**$67,059,776**	**$66,314,599**	**$4,096,680**	**$70,411,279**	**$65,909,381**	**$8,140,943**	**$74,050,324**
	Retained Earnings / Net Assets, end of year	**$77,693,789**	**$66,314,599**	**$4,096,680**	**$70,411,279**	**$65,909,381**	**$8,140,943**	**$74,050,324**	**$66,641,736**	**$12,026,818**	**$78,668,554**
	Principal Payments	$7,235,595	$6,382,582	($6,382,582)	**$0**	$6,771,353	($6,771,353)	**$0**	$6,058,092	($6,058,092)	**$0**
D.	**PROFITABILITY SUMMARY**										
1	Hospital Operating Margin	**0.7%**	**-0.1%**	**98.7%**	**1.2%**	**0.0%**	**55.5%**	**1.2%**	**0.4%**	**36.8%**	**1.5%**
2	Hospital Non Operating Margin	**-0.7%**	**-0.2%**	**0.0%**	**-0.2%**	**-0.2%**	**0.0%**	**-0.1%**	**-0.2%**	**0.0%**	**-0.1%**
3	Hospital Total Margin	**0.0%**	**-0.2%**	**98.7%**	**1.0%**	**-0.1%**	**55.5%**	**1.1%**	**0.2%**	**36.8%**	**1.3%**
E.	**FTEs**	**2,298**	2,117	21	**2,138**	2,117	32	**2,149**	2,117	44	**2,161**
F.	**VOLUME STATISTICS[d]**										
1	Inpatient Discharges	11,451	11,202	213	**11,415**	11,202	325	**11,527**	11,202	438	**11,640**
2	Outpatient Visits	2,052,425	2,085,348	2,170	**2,087,518**	2,085,348	4,340	**2,089,688**	2,085,348	6,510	**2,091,858**
	TOTAL VOLUME	**2,063,876**	**2,096,550**	**2,383**	**2,098,933**	**2,096,550**	**4,665**	**2,101,215**	**2,096,550**	**6,948**	**2,103,498**

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

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c]Provide the amount of income taxes as defined by the Internal Revenue Services for for-profit entities.

[d]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

Sale of Non-Profit Hospital to For-Profit Entity

Name Entity: MMH

Financial Worsheet (C):

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

LINE	Total Entity:	(1) FY 2014 Actual Results	(2) FY 2017 Projected W/out CON	(3) FY 2017 Projected Incremental	(4) FY 2017 Projected With CON	(5) FY 2018 Projected W/out CON	(6) FY 2018 Projected Incremental	(7) FY 2018 Projected With CON	(8) FY 2019 Projected W/out CON	(9) FY 2019 Projected Incremental	(10) FY 2019 Projected With CON
	Description										
A.	**OPERATING REVENUE**										
1	Total Gross Patient Revenue	$601,959,668	$596,688,762	$13,369,792	$610,058,554	$606,832,471	$20,855,080	$627,687,551	$618,362,288	$28,340,367	$646,702,655
2	Less: Allowances	$421,521,668	$413,239,291	$9,259,305	$422,498,596	$420,264,359	$14,443,273	$434,707,632	$428,249,382	$19,627,240	$447,876,622
3	Less: Charity Care	$2,411,263	$2,391,895	$53,594	$2,445,489	$2,432,557	$83,600	$2,516,157	$2,478,776	$113,606	$2,592,382
4	Less: Other Deductions	$0	$0		$0	$0	$0	$0	$0	$0	$0
	Net Patient Service Revenue	**$178,026,737**	**$181,057,576**	**$4,056,893**	**$185,114,469**	**$184,135,555**	**$6,328,207**	**$190,463,762**	**$187,634,130**	**$8,599,521**	**$196,233,651**
5	Medicare	$63,378,038	$65,681,589	$1,471,704	$67,153,293	$66,798,176	$2,295,660	$69,093,836	$68,067,341	$3,119,617	$71,186,958
6	Medicaid	$27,585,570	$28,518,872	$639,012	$29,157,884	$29,003,692	$996,773	$30,000,465	$29,554,763	$1,354,534	$30,909,297
7	CHAMPUS & TriCare	$664,283	$671,526	$15,047	$686,573	$682,942	$23,471	$706,413	$695,918	$31,895	$727,813
8	Other	$0	$0		$0	$0	$0	$0	$0	$0	$0
	Total Government	**$91,627,891**	**$94,871,987**	**$2,125,763**	**$96,997,750**	**$96,484,811**	**$3,315,904**	**$99,800,715**	**$98,318,022**	**$4,506,046**	**$102,824,068**
9	Commercial Insurers	$83,212,124	$83,336,142	$1,867,283	$85,203,425	$84,752,856	$2,912,711	$87,665,567	$86,363,160	$3,958,139	$90,321,299
10	Uninsured	$413,470	$344,838	$7,727	$352,565	$350,700	$12,053	$362,753	$357,364	$16,378	$373,742
11	Self Pay	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
12	Workers Compensation	$2,773,252	$2,504,610	$56,120	$2,560,730	$2,547,188	$87,539	$2,634,727	$2,595,585	$118,959	$2,714,544
13	Other	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Total Non-Government	**$86,398,846**	**$86,185,589**	**$1,931,130**	**$88,116,719**	**$87,650,744**	**$3,012,303**	**$90,663,047**	**$89,316,108**	**$4,093,476**	**$93,409,584**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$178,026,737**	**$181,057,576**	**$4,056,893**	**$185,114,469**	**$184,135,555**	**$6,328,207**	**$190,463,762**	**$187,634,130**	**$8,599,522**	**$196,233,652**
14	Less: Provision for Bad Debts	$5,822,470	$3,657,793	$81,969	**$3,739,762**	$3,719,975	$127,845	**$3,847,820**	$3,790,655	$173,731	**$3,964,386**
	Net Patient Service Revenue less provision for bad debts	**$172,204,267**	**$177,399,783**	**$3,974,924**	**$181,374,707**	**$180,415,579**	**$6,200,362**	**$186,615,941**	**$183,843,475**	**$8,425,790**	**$192,269,265**
15	Other Operating Revenue	$16,853,888	$10,846,346	($140,125)	**$10,706,221**	$11,063,272	($140,125)	**$10,923,147**	$11,284,538	($14,125)	**$11,270,413**
17	Net Assets Released from Restrictions	$486,908	$776,365	($776,365)	**$0**	$776,365	($776,365)	**$0**	$776,365	($776,365)	**$0**
	TOTAL OPERATING REVENUE	**$189,545,063**	**$189,022,494**	**$3,058,434**	**$192,080,928**	**$192,255,217**	**$5,283,872**	**$197,539,089**	**$195,904,378**	**$7,635,300**	**$203,539,678**
B.	**OPERATING EXPENSES**										
1	Salaries and Wages	$83,606,297	$80,068,003	$1,080,696	$81,148,699	$81,669,364	$1,685,741	$83,355,105	$83,302,751	$2,290,786	$85,593,537
2	Fringe Benefits	$25,720,253	$28,485,372	($186,999)	$28,298,373	$28,770,225	$330,795	$29,101,020	$29,057,928	$554,925	$29,612,853
3	Physicians Fees	$9,813,958	$10,339,627	$0	$10,339,627	$10,649,816	$0	$10,649,816	$10,969,310	$0	$10,969,310
4	Supplies and Drugs	$25,775,974	$24,410,603	($901,009)	$23,509,594	$24,654,709	($593,572)	$24,061,137	$24,901,256	($286,136)	$24,615,120
5	Depreciation and Amortization	$7,116,905	$7,114,038	$488,896	$7,602,934	$7,114,038	$977,792	$8,091,830	$7,114,038	$1,466,689	$8,580,727
6	Provision for Bad Debts-Other[b]	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
7	Interest Expense	$2,589,201	$2,353,201	($2,175,156)	$178,045	$2,353,201	($2,252,816)	$100,385	$2,353,201	($2,305,691)	$47,510
8	Malpractice Insurance Cost	$2,774,065	$2,858,122	$0	$2,858,122	$2,886,703	$0	$2,886,703	$2,915,570	$0	$2,915,570
9	Lease Expense	$2,328,809	$2,251,371	$0	$2,251,371	$2,273,885	$0	$2,273,885	$2,296,623	$0	$2,296,623
10	Other Operating Expenses	$25,584,097	$25,802,892	($419,554)	$25,383,338	$26,060,921	($94,582)	$25,966,339	$26,321,531	$230,389	$26,551,920
	TOTAL OPERATING EXPENSES	**$185,309,559**	**$183,683,229**	**($2,113,126)**	**$181,570,103**	**$186,432,862**	**$53,358**	**$186,486,220**	**$189,232,208**	**$1,950,962**	**$191,183,170**
	Provision for Income Taxes[c]			$4,254,950	**$4,254,950**		$4,482,606	**$4,482,606**		$5,030,134	**$5,030,134**
	Earnings Before Interest, Taxes, Depreciation & Amortization **(EBITDA)**	**$13,941,610**	**$14,806,503**	**$3,485,300**	**$18,291,803**	**$15,289,594**	**$3,955,490**	**$19,245,084**	**$16,139,409**	**$4,845,336**	**$20,984,745**
	INCOME / (LOSS) FROM OPERATIONS	**$4,235,504**	**$5,339,265**	**$916,610**	**$6,255,875**	**$5,822,355**	**$747,908**	**$6,570,263**	**$6,672,171**	**$654,204**	**$7,326,375**
	NON-OPERATING INCOME / REVENUE	($1,743,322)	($380,000)		**($380,000)**	($380,000)		**($380,000)**	($380,000)		**($380,000)**
	NET INCOME / EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSES	**$2,492,182**	**$4,959,265**	**$916,610**	**$5,875,875**	**$5,442,355**	**$747,908**	**$6,190,263**	**$6,292,171**	**$654,204**	**$6,946,375**

Sale of Non-Profit Hosptal to For-Profit Entity

Name Entity: MMH

Financial Worsheet (C):

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

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
LINE	**Total Entity:**	**FY 2014**	**FY 2017**	**FY 2017**	**FY 2017**	**FY 2018**	**FY 2018**	**FY 2018**	**FY 2019**	**FY 2019**	**FY 2019**
		Actual	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**
	Description	**Results**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**
C.	**Retained Earnings/ Net Assets, beginning of year**	**$37,731,740**	**$29,692,165**	**$0**	**$29,692,165**	**$34,651,429**	**$916,610**	**$35,568,039**	**$40,093,784**	**$1,664,518**	**$41,758,302**
	Retained Earnings / Net Assets, end of year	**$24,798,417**	**$34,651,429**	**$916,610**	**$35,568,039**	**$40,093,784**	**$1,664,518**	**$41,758,302**	**$46,385,955**	**$2,318,722**	**$48,704,677**
	Principal Payments	$4,145,905	$4,234,565	($4,234,565)	**$0**	$4,781,812	($4,781,812)	**$0**	$4,061,758	($4,061,758)	**$0**
D.	**PROFITABILITY SUMMARY**										
1	Hospital Operating Margin	**2.3%**	**2.8%**	**30.0%**	**3.3%**	**3.0%**	**14.2%**	**3.3%**	**3.4%**	**8.6%**	**3.6%**
2	Hospital Non Operating Margin	**-0.9%**	**-0.2%**	**0.0%**	**-0.2%**	**-0.2%**	**0.0%**	**-0.2%**	**-0.2%**	**0.0%**	**-0.2%**
3	Hospital Total Margin	**1.3%**	**2.6%**	**30.0%**	**3.1%**	**2.8%**	**14.2%**	**3.1%**	**3.2%**	**8.6%**	**3.4%**
E.	**FTEs**	**1,177**	1,052	16	**1,068**	1,052	24	**1,076**	1,052	33	**1,085**
F.	**VOLUME STATISTICS[d]**										
1	Inpatient Discharges	9,110	9,043	181	**9,224**	9,043	271	**9,314**	9,043	362	**9,405**
2	Outpatient Visits	1,631,301	1,651,094	1,640	**1,652,734**	1,651,094	3,280	**1,654,374**	1,651,094	4,920	**1,656,014**
	TOTAL VOLUME	**1,640,411**	**1,660,137**	**1,821**	**1,661,958**	**1,660,137**	**3,551**	**1,663,688**	**1,660,137**	**5,282**	**1,665,419**

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

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c]Provide the amount of income taxes as defined by the Internal Revenue Services for for-profit entities.

[d]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

Sale of Non-Profit Hospital to For-Profit Entity

Name Entity: RGH

Financial Worsheet (C):

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

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
LINE	**Total Entity:**	**FY 2014**	**FY 2017**	**FY 2017**	**FY 2017**	**FY 2018**	**FY 2018**	**FY 2018**	**FY 2019**	**FY 2019**	**FY 2019**
		Actual	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**
	Description	**Results**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**
A.	**OPERATING REVENUE**										
1	Total Gross Patient Revenue	$227,300,072	$231,499,118	$4,265,214	$235,764,332	$235,434,603	$7,388,913	$242,823,516	$239,907,860	$10,512,613	$250,420,473
2	Less: Allowances	$154,781,564	$161,231,756	$2,970,585	$164,202,341	$163,972,696	$5,146,142	$169,118,838	$167,088,177	$7,321,700	$174,409,877
3	Less: Charity Care	$1,188,543	$1,206,052	$22,221	$1,228,273	$1,226,555	$38,494	$1,265,049	$1,249,859	$54,768	$1,304,627
4	Less: Other Deductions	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Net Patient Service Revenue	**$71,329,965**	**$69,061,310**	**$1,272,408**	**$70,333,718**	**$70,235,352**	**$2,204,277**	**$72,439,629**	**$71,569,824**	**$3,136,145**	**$74,705,969**
5	Medicare	$25,494,325	$26,279,589	$484,184	$26,763,773	$26,726,342	$838,783	$27,565,125	$27,234,142	$1,193,383	$28,427,525
6	Medicaid	$7,614,784	$7,462,245	$137,487	$7,599,732	$7,589,103	$238,177	$7,827,280	$7,733,296	$338,868	$8,072,164
7	CHAMPUS & TriCare	$300,295	$266,022	$4,901	$270,923	$270,544	$8,491	$279,035	$275,684	$12,080	$287,764
8	Other	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Total Government	**$33,409,404**	**$34,007,855**	**$626,572**	**$34,634,427**	**$34,585,989**	**$1,085,451**	**$35,671,440**	**$35,243,123**	**$1,544,331**	**$36,787,454**
9	Commercial Insurers	$36,237,003	$33,580,104	$618,691	$34,198,795	$34,150,966	$1,071,799	$35,222,765	$34,799,834	$1,524,907	$36,324,741
10	Uninsured	$252,693	$184,169	$3,393	$187,562	$187,300	$5,878	$193,178	$190,859	$8,363	$199,222
11	Self Pay	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
12	Workers Compensation	$1,430,865	$1,289,181	$23,752	$1,312,933	$1,311,098	$41,148	$1,352,246	$1,336,008	$58,543	$1,394,551
13	Other	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Total Non-Government	**$37,920,561**	**$35,053,455**	**$645,836**	**$35,699,291**	**$35,649,363**	**$1,118,825**	**$36,768,188**	**$36,326,701**	**$1,591,813**	**$37,918,514**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$71,329,965**	**$69,061,310**	**$1,272,408**	**$70,333,718**	**$70,235,352**	**$2,204,276**	**$72,439,628**	**$71,569,824**	**$3,136,144**	**$74,705,968**
14	Less: Provision for Bad Debts	$2,801,283	$1,649,516	$30,391	**$1,679,907**	$1,677,558	$52,649	**$1,730,207**	$1,709,431	$74,906	**$1,784,337**
	Net Patient Service Revenue less provision for bad debts	**$68,528,682**	**$67,411,794**	**$1,242,017**	**$68,653,811**	**$68,557,795**	**$2,151,628**	**$70,709,423**	**$69,860,393**	**$3,061,239**	**$72,921,632**
15	Other Operating Revenue	$6,342,519	$2,093,797	($11,977)	**$2,081,820**	$2,135,673	($11,977)	**$2,123,696**	$2,178,387	($11,977)	**$2,166,410**
17	Net Assets Released from Restrictions	$49,147	$77,636	($77,636)	**$0**	$77,636	($77,636)	**$0**	$77,636	($77,636)	**$0**
	TOTAL OPERATING REVENUE	**$74,920,348**	**$69,583,227**	**$1,152,404**	**$70,735,631**	**$70,771,104**	**$2,062,015**	**$72,833,119**	**$72,116,415**	**$2,971,626**	**$75,088,041**
B.	**OPERATING EXPENSES**										
1	Salaries and Wages	$32,460,253	$29,718,015	$329,822	$30,047,837	$30,312,375	$571,372	$30,883,747	$30,918,622	$812,922	$31,731,544
2	Fringe Benefits	$9,360,797	$10,717,021	($97,123)	$10,619,898	$10,824,191	($6,422)	$10,817,769	$10,932,433	$84,279	$11,016,712
3	Physicians Fees	$3,728,005	$4,439,562	$0	$4,439,562	$4,572,749	$0	$4,572,749	$4,709,932	$0	$4,709,932
4	Supplies and Drugs	$9,776,421	$9,752,308	($12,724)	$9,739,584	$9,849,831	$119,389	$9,969,220	$9,948,330	$251,501	$10,199,831
5	Depreciation and Amortization	$3,281,014	$3,234,649	$225,389	$3,460,038	$3,234,649	$450,779	$3,685,428	$3,234,649	$676,168	$3,910,817
6	Provision for Bad Debts-Other[b]	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
7	Interest Expense	$689,882	$672,358	($672,358)	($0)	$672,358	($672,358)	($0)	$672,357.89	($672,358)	($0)
8	Malpractice Insurance Cost	$1,033,082	$1,064,385	$0	$1,064,385	$1,075,029	$0	$1,075,029	$1,085,780	$0	$1,085,780
9	Lease Expense	$1,013,626	$1,212,722	$0	$1,212,722	$1,224,849	$0	$1,224,849	$1,237,098	$0	$1,237,098
10	Other Operating Expenses	$10,816,575	$9,080,177	($32,041)	$9,048,136	$9,170,979	$90,966	$9,261,945	$9,262,689	$213,973	$9,476,662
	TOTAL OPERATING EXPENSES	**$72,159,655**	**$69,891,198**	**($259,035)**	**$69,632,163**	**$70,937,011**	**$553,726**	**$71,490,737**	**$72,001,890**	**$1,366,485**	**$73,368,375**
	Provision for Income Taxes[c]			$419,357	**$419,357**		$607,900	**$607,900**		$766,359	**$766,359**
	Earnings Before Interest, Taxes, Depreciation & Amortization **(EBITDA)**	**$6,731,589**	**$3,599,036**	**$964,470**	**$4,563,506**	**$3,741,100**	**$1,286,710**	**$5,027,810**	**$4,021,532**	**$1,608,951**	**$5,630,483**
	INCOME / (LOSS) FROM OPERATIONS	**$2,760,693**	**($307,971)**	**$992,082**	**$684,111**	**($165,908)**	**$900,389**	**$734,481**	**$114,525**	**$838,782**	**$953,307**
	NON-OPERATING INCOME / REVENUE	($378,564)	($105,000)		**($105,000)**	$105,000		**$105,000**	$105,000		**$105,000**
	NET INCOME / EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSES	**$2,382,129**	**($412,971)**	**$992,082**	**$579,111**	**($60,908)**	**$900,389**	**$839,481**	**$219,525**	**$838,782**	**$1,058,307**

Sale of Non-Profit Hospital to For-Profit Entity

Name Entity: RGH

Financial Worsheet (C):

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

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
LINE	Total Entity:	FY 2014 Actual	FY 2017 Projected	FY 2017 Projected	FY 2017 Projected	FY 2018 Projected	FY 2018 Projected	FY 2018 Projected	FY 2019 Projected	FY 2019 Projected	FY 2019 Projected
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
C.	**Retained Earnings/ Net Assets, beginning of year**	**$31,052,463**	**$25,587,845**	**$0**	**$25,587,845**	**$25,174,874**	**$992,082**	**$26,166,956**	**$25,113,967**	**$1,892,471**	**$27,006,438**
	Retained Earnings / Net Assets, end of year	**$28,334,302**	**$25,174,874**	**$992,082**	**$26,166,956**	**$25,113,967**	**$1,892,471**	**$27,006,438**	**$25,333,492**	**$2,731,253**	**$28,064,745**
	Principal Payments	$874,828	$984,173	($984,173)	**$0**	$1,110,055	($1,110,055)	**$0**	$1,132,025		**$1,132,025**
D.	**PROFITABILITY SUMMARY**										
1	Hospital Operating Margin	**3.7%**	**-0.4%**	**86.1%**	**1.0%**	**-0.2%**	**43.7%**	**1.0%**	**0.2%**	**28.2%**	**1.3%**
2	Hospital Non Operating Margin	**-0.5%**	**-0.2%**	**0.0%**	**-0.1%**	**0.1%**	**0.0%**	**0.1%**	**0.1%**	**0.0%**	**0.1%**
3	Hospital Total Margin	**3.2%**	**-0.6%**	**86.1%**	**0.8%**	**-0.1%**	**43.7%**	**1.2%**	**0.3%**	**28.2%**	**1.4%**
E.	**FTEs**	**405**	348	5	**353**	348	8	**356**	348	11	**359**
F.	**VOLUME STATISTICS[d]**										
1	Inpatient Discharges	2,341	2,159	32	**2,191**	2,159	54	**2,213**	2,159	76	**2,235**
2	Outpatient Visits	421,124	434,254	530	**434,784**	434,254	1,060	**435,314**	434,254	1,590	**435,844**
	TOTAL VOLUME	**423,465**	**436,413**	**562**	**436,975**	**436,413**	**1,114**	**437,527**	**436,413**	**1,666**	**438,079**

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.
[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.
[c]Provide the amount of income taxes as defined by the Internal Revenue Services for for-profit entities.
[d]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

FY 2015 and FY 2016 Projected Results (Reference)

LINE	Total Entity: / Description	ECHN FY 2015 Projected Results	MMH FY 2015 Projected Results	RGH FY 2015 Projected Results	ECHN FY 2016 Projected Results	MMH FY 2016 Projected Results	RGH FY 2016 Projected Results
A.	**OPERATING REVENUE**						
1	Total Gross Patient Revenue	$919,861,607	$594,394,400	$229,450,128	$911,417,931	$588,450,456	$228,302,877
2	Less: Allowances	$605,465,288	$411,650,321	$159,804,700	$599,410,635	$407,533,818	$159,005,677
3	Less: Charity Care	$4,778,075	$2,382,698	$1,195,377	$4,730,294	$2,358,871	$1,189,400
4	Less: Other Deductions	$689,936	$0	$0	$683,037	$0	$0
	Net Patient Service Revenue	**$308,928,308**	**$180,361,381**	**$68,450,051**	**$306,593,965**	**$178,557,767**	**$68,107,801**
5	Medicare	$115,287,873	$65,429,033	$26,046,989	$114,416,727	$64,774,743	$25,916,754
6	Medicaid	$49,459,392	$28,409,212	$7,396,197	$49,085,664	$28,125,120	$7,359,216
7	CHAMPUS & TriCare	$1,860,705	$668,944	$263,667	$1,846,645	$662,255	$262,349
8	Other	$0	$0	$0	$0	$0	$0
	Total Government	**$166,607,970**	**$94,507,189**	**$33,706,853**	**$165,349,036**	**$93,562,117**	**$33,538,319**
9	Commercial Insurers	$133,386,403	$83,015,701	$33,282,888	$132,378,500	$82,185,544	$33,116,474
10	Uninsured	$526,077	$343,512	$182,539	$522,102	$340,077	$181,626
11	Self Pay	$4,051,067	$0	$0	$4,020,456	$0	$0
12	Workers Compensation	$4,058,179	$2,494,979	$1,277,771	$4,027,514	$2,470,029	$1,271,382
13	Other	$298,613	$0	$0	$296,357	$0	$0
	Total Non-Government	**$142,320,339**	**$85,854,192**	**$34,743,198**	**$141,244,929**	**$84,995,650**	**$34,569,482**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$308,928,309**	**$180,361,381**	**$68,450,051**	**$306,593,965**	**$178,557,767**	**$68,107,801**
14	Less: Provision for Bad Debts	$6,060,538	$3,643,728	$1,643,173	$5,999,933	$3,607,291	$1,626,741
	Net Patient Service Revenue less provision for bad debts	**$302,867,770**	**$176,717,653**	**$66,806,878**	**$300,594,032**	**$174,950,476**	**$66,481,059**
15	Other Operating Revenue	$16,802,913	$11,023,919	$2,128,076	$15,925,913	$10,633,672	$2,052,742
17	Net Assets Released from Restrictions	$913,370	$646,366	$78,358	$913,370	$776,365	$91,337
	TOTAL OPERATING REVENUE	**$320,584,053**	**$188,387,937**	**$69,013,312**	**$317,433,315**	**$186,360,513**	**$68,625,139**
B.	**OPERATING EXPENSES**						
1	Salaries and Wages	$156,292,474	$82,578,386	$30,649,768	$150,021,693	$79,275,251	$29,423,777
2	Fringe Benefits	$47,762,750	$27,704,116	$10,423,090	$50,610,250	$29,366,363	$11,048,475
3	Physicians Fees	$14,605,651	$10,038,473	$4,310,255	$14,605,651	$10,038,473	$4,310,255
4	Supplies and Drugs	$34,974,486	$23,929,618	$9,560,149	$35,324,231	$24,168,914	$9,655,751
5	Depreciation and Amortization	$11,958,956	$7,114,038	$3,234,649	$11,958,956	$7,114,038	$3,234,649
6	Provision for Bad Debts-Other[b]	$0	$0	$0	$0	$0	$0
7	Interest Expense	$3,570,511	$2,451,251	$700,373	$3,570,511	$2,353,201	$672,358
8	Malpractice Insurance Cost	$3,845,218	$2,801,806	$1,043,413	$3,883,671	$2,829,824	$1,053,847
9	Lease Expense	$6,245,578	$2,207,010	$1,188,827	$6,308,033	$2,229,080	$1,200,715
10	Other Operating Expenses	$44,334,273	$25,294,474	$8,901,262	$44,883,620	$25,547,418	$8,990,275
	TOTAL OPERATING EXPENSES	**$323,589,897**	**$184,119,170**	**$70,011,785**	**$321,166,616**	**$182,922,561**	**$69,590,101**
	Provision for Income Taxes[c]						
	Earnings Before Interest, Taxes, Depreciation & Amortization **(EBITDA)**	**$12,523,623**	**$13,834,056**	**$2,936,549**	**$11,796,166**	**$12,905,191**	**$2,942,045**
	INCOME / (LOSS) FROM OPERATIONS	**($3,005,844)**	**$4,268,767**	**($998,473)**	**($3,733,301)**	**$3,437,952**	**($964,962)**
	NON-OPERATING INCOME / REVENUE	($2,394,868)	($1,672,972)	($468,022)	($1,500,000)	($1,140,000)	($315,000)

FY 2015 and FY 2016 Projected Results (Reference)

LINE	Total Entity:	ECHN FY 2015 Projected Results	MMH FY 2015 Projected Results	RGH FY 2015 Projected Results	ECHN FY 2016 Projected Results	MMH FY 2016 Projected Results	RGH FY 2016 Projected Results
	Description						
	NET INCOME / EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSES	**($5,400,712)**	**$2,595,795**	**($1,466,495)**	**($5,233,301)**	**$2,297,952**	**($1,279,962)**
C.	**Retained Earnings/ Net Assets, beginning of year**	**$77,693,789**	**$24,798,417**	**$28,334,302**	**$72,293,077**	**$27,394,212**	**$26,867,807**
	Retained Earnings / Net Assets, end of year	**$72,293,077**	**$27,394,212**	**$26,867,807**	**$67,059,776**	**$29,692,165**	**$25,587,845**
	Principal Payments	$7,086,082	$4,883,195	$881,957	$7,163,415	$4,924,258	$926,631
D.	**PROFITABILITY SUMMARY**						
1	Hospital Operating Margin	**-2.4%**	**8.1%**	**-2.6%**	**-3.0%**	**6.1%**	**-2.5%**
2	Hospital Non Operating Margin	**-1.9%**	**-3.2%**	**-1.2%**	**-1.2%**	**-2.0%**	**-0.8%**
3	Hospital Total Margin	**-4.3%**	**4.9%**	**-3.8%**	**-4.3%**	**4.0%**	**-3.4%**
E.	**FTEs**	**2,240**	**1,140**	**377**	**2,117**	**1,052**	**348**
F.	**VOLUME STATISTICS**[d]						
1	Inpatient Discharges	10,927	8,768	2,159	11,202	9,043	2,159
2	Outpatient Visits	2,085,348	1,651,094	434,254	2,085,348	1,651,094	434,254
	TOTAL VOLUME	**2,096,275**	**1,659,862**	**436,413**	**2,096,550**	**1,660,137**	**436,413**

EXHIBIT Q38-1 - ASSUMPTIONS UTILIZED IN DEVELOPING FINANCIAL WORKSHEET (C)

Assumptions utilized in developing Financial Worksheet (C)

General

- The closing date for the proposed asset purchase will be October 1, 2016 (the first day of FY 2017).
- The "Without CON" columns of the Financial Worksheet (columns 2, 5, and 8) provide the financial statistics for the existing ECHN, MMH and RGH entities without approval of the proposed asset purchase.
- The "With CON" columns of the Financial Worksheet (columns 4, 7 and 10) provide the financial statistics for the new PMH ECHN, Prospect Manchester Hospital ("Prospect MMH") and Prospect Rockville Hospital ("Prospect RGH").
- A separate Financial Worksheet for PMH ECHN, showing the Actual FY 2014 Results, is not applicable as the new entity does not currently exist and will not be formed unless the proposed asset purchase is approved.
- The projections do not include the effect of recently announced increases in the Hospital Tax.

Revenues

- Net patient service revenue will increase 1.5% each year due to managed care rate increases without the CON, and 3% each year with the CON due to increases in managed care rates and utilization.
- The overall net revenue payer mix for ECHN, MMH and RGH will remain constant at the percent distribution observed in FY2015 with and without the CON:

Payer	ECHN	MMH	RMH
Non-Government	48%	49%	51%
Medicare	37%	36%	38%
Medicaid	16%	16%	11%
Other Government	1%	0%	0%

- Other operating revenue:
    - Without the CON, other operating revenue will increase 0.3% each year beginning in FY 2017.
    - With the CON, other operating revenue will decrease 0.7% in FY 2017 due to the loss of investment income following the asset purchase. After FY 2017, other operating revenue will increase 0.3% each year with the CON.
    - Joint venture income will increase 2% each year after FY 2016 with or without the CON.
- Net assets released from restriction
    - The net assets released from restriction will remain constant at the amount projected for FY 2015 without the CON.
    - With the CON, net assets released from restriction are eliminated following ECHN's conversion to a for-profit entity.

Expenses

- Salaries, wages and fringe benefits:
    - Salaries and wages will increase 2.0% each year without the CON and 2.5% each year with the CON based on a 60% variable staffing rate and as a result of the projected increase in FTEs to support volume growth through FY 2019.
    - The expense associated with fringe benefits will increase 3% each year due to the annual increase and medical premiums without the CON.
    - With the CON, PME ECHN will attain some savings in the medical premium expense due to the economies of scale inherent in a larger organization and expects fringe benefits to increase only 2% per year despite the increase in FTEs.
- Physician fees are projected to increase 3% each year with or without the CON.
- Supplies and drugs:
    - Without the CON, supplies and drugs will increase 1% each year due to inflation[1].
    - With the CON, PMH ECHN expects to attain some savings in the expense base for supplies and drugs due to the economies of scale inherent in a larger organization. The reduced expense base for supplies and drugs will increase more than 2% each year due to inflation and increased utilization that is projected with the CON.
- Depreciation, amortization and interest:
    - Depreciation, amortization and interest expenses will remain constant beginning in FY 2015 without the CON.
    - Per the terms of the APA, PMH has agreed to a capital commitment of $75,000,000 within five years of closing. Capital expenditures for the first three years with the CON will result in a 5-6% increase in depreciation and amortization expense.
    - Interest expense is decreased beginning in FY 2017 due to the reduction ECHN's current bond payment obligation. The remaining interest expense, associated with existing capital leases that will be assigned to PMH ECHN, will continue to decrease each year through FY 2019.
- Bad Debt Expense remains flat as a percentage of net revenue from the current year, FY 2015 with or without the CON.
- Malpractice insurance cost and lease expense will increase 1% each year due to inflation with or without the CON.
- Other operating expense:
    - Other operating expenses will increase 1% each year due to inflation without the CON.

[1] The United States Department of Labor Bureau of Labor Statistics has reported a 0.2□ decrease in the Consumer Price Index for the last 12 months ending in August, 2015.
Source: http:□□www.bls.gov□news.release□cpi.nr0.htm

- With the CON, PMH ECHN expects to attain $1 million in savings in the expense base for other operating expenses each year due to the economies of scale inherent in a larger organization. The reduced expense base for other operating expenses will increase 2% each year due to increased utilization and inflation.

- PMH property and sales taxes have been assumed to be abated for 2017 to 2019

- Provision for income taxes remains zero without the CON. With the CON, PMH ECHN utilized a 42% combined corporate tax rate which is consistent with the rate utilized at other PMH entities.

Full-Time Equivalents (FTEs)

- Efforts to improve employee productivity currently underway at ECHN, MMH and RGH will decrease the number of FTEs utilized in FY 2014 to the levels budgeted for each entity in FY 2016.

- The projected FTEs at ECHN (2,117), MMH (1,052) and RGH (348) without the CON are based on the number of FTEs budgeted for FY 2016 and will remain constant at this level through FY 2019 without the CON.

- The FTEs projected for PMH ECHN, Prospect MMH and Prospect RGH will increase to accommodate the anticipated growth in service utilization as a result of implementing PMH's CRC model of care delivery.

Volume Statistics

- Inpatient discharges and outpatient visits for FY 2017, FY 2018 and FY 2019 will remain constant at the levels projected in ECHN's FY 2016 budget without the CON.

- With CON approval, inpatient discharges and outpatient visits will increase by the percentages listed below as a result of implementing PMH's CRC model of care delivery:

Entity	Volume Statistics	Projected Growth with CON Authorization		
		FY 2017	FY 2018	FY 2019
PMH ECHN	Inpatient Discharges	1.9%	2.9%	3.9%
	Outpatient Visits	0.1%	0.2%	0.3%
Prospect MMH	Inpatient Discharges	2.0%	3.0%	4.0%
	Outpatient Visits	0.1%	0.2%	0.3%
Prospect RGH	Inpatient Discharges	1.5%	2.5%	3.5%
	Outpatient Visits	0.1%	0.2%	0.4%

Assumptions for FY 2016

ECHN

Revenues

- $1.2 million net patient revenue increase due to new/expanded programs planned for FY 2016
- $2.1 million cut in Medicare reimbursement due to wage index adjustment
- Medicare reimbursement reduced due to one-time adjustment in FY 2015
- Reduction of meaningful use funds. FY 2015 is the 4th year of the 4 year payment plan implemented by Medicare
- Joint Ventures consistent with FY 2015 performance

Expenses

- $8.8 million salary and benefit expense decrease resulting from workforce efficiency efforts
- $220K reduction in salary expense associated with implementation of mid-level practitioner model at urgent care location in South Windsor
- $1.9 million increase in money match
- $2 million increase in pension expense
- $1.0 million increase in pension funding
- Bad debt expense remains consistent as a percent of net patient service revenues
- $500K reduction in the state provider tax beginning in FY 2016
- Non-operating expenses (related to acquisition) reduced in FY 2016
- Other one-time FY 2015 adjustments eliminated; write down of reserves

MMH

Revenues

- $1.2 million net patient revenue increase due to new/expanded programs planned for FY 2016
- $1.55 million cut in Medicare reimbursement due to wage index adjustment
- Medicare reimbursement reduced due to one-time adjustment in FY 2015
- Reduction of meaningful use funds. FY 2015 is the 4th year of the 4 year payment plan implemented by Medicare
- Joint Ventures consistent with FY 2015 performance

Expenses

- $5.8 million salary and benefit expense decrease resulting from workforce efficiency efforts
- $1.3 million increase in money match
- $1.35 million increase in pension expense
- $700K increase in pension funding
- Bad debt expense remains consistent as a percent of net patient service revenues
- $1.6 million reduction in the state provider tax beginning in FY 2016
- Non-operating expenses (related to acquisition) reduced in FY 2016
- Other one-time FY 2015 adjustments eliminated; write down of reserves

RGH

Revenues

- $1.2 million net patient revenue increase due to new/expanded programs planned for FY 2016
- $550K cut in Medicare reimbursement due to wage index adjustment
- Medicare reimbursement reduced due to one-time adjustment in FY 2015
- Reduction of meaningful use funds. FY 2015 is the 4th year of the 4 year payment plan implemented by Medicare
- Joint Ventures consistent with FY 2015 performance

Expenses

- $3 million salary and benefit expense decrease resulting from workforce efficiency efforts
- $220K reduction in salary expense associated with implementation of mid-level practitioner model at urgent care location in South Windsor
- $600K increase in money match
- $650K increase in pension expense
- $300K increase in pension funding
- Bad debt expense remains consistent as a percent of net patient service revenues
- $1.1 million increase in the state provider tax beginning in FY 2016
- Non-operating expenses (related to acquisition) reduced in FY 2016
- Other one-time FY 2015 adjustments eliminated; write down of reserves

EXHIBIT Q42-1 - STAFFING ATTACHMENT I (2015)

Staffing Attachment I - FY 2015

Name of Hospital Unit or Department	Service	Hospital	Average Nursing Staff[1] to Patient Ratio			Average RN to Patient Ratio			Average Nursing[2] Hours per Patient Day (NHPPD)	NHPPD Target
			Shift #1 AM	Shift #2 PM	Shift #3 Overnight	Shift #1 AM	Shift #2 PM	Shift #3 Overnight		
01-6074 ICU	ICU	RGH	1:1.5	1:2.0	1:2.0	1:2.0	1:2.0	1:2.0	14.47	14.00
01-6076 B II	Med/Surg	RGH	1:3.0	1:3.0	1:4.0	1:4.8	1:4.8	1:6.0	8.03	8.00
01-6144 B II South	Med/Surg	RGH	1:0.5	1:0.5	1:0.5	1:1.0	1:1.0	1:1.0	8.50	8.00
01-5060 Emergency Department	ED	RGH	1:3.8	1:3.2	1:1.9	1:5.7	1:5.1	1:3.7	2.50	2.20
80-5075 Obstetrical Services - Labor & Delivery	OB	MMH	1:1-2	1:1-2	1:1-2	1:1-2	1:1-2	1:1-2	10.06	10.80
80-5075 Obstetrical Services - Postpartum [3]	OB/NB	MMH	1:3-5	1:3-5	1:3-5	1:3-4	1:3-4	1:3-4		
80-5079 NICU [4]	NICU	MMH	1:2-3	1:2-3	1:2-3	1:2-3	1:2-3	1:2-3	12.87	14.00
80-6165 Adult Inpatient	Psych	MMH	1:3.6	1:3.6	1:6.3	1:6.3	1:6.3	1:12.5	6.27	7.40
80-6170 Adolescent Inpatient	Psych	MMH	1:2.5	1:2.5	1:5.0	1:5.0	1:5.0	1:5.0	9.59	10.10
80-6220 Second East	Med/Surg	MMH	1:2.8	1:2.8	1:4.4	1:4.4	1:5.5	1:7.3	8.12	8.00
80-6225 ICU	ICU	MMH	1:1.7	1:1.9	1:1.9	1:2.1	1:2.5	1:2.1	14.94	14.00
80-6230 Special Care Unit	Med/Surg	MMH	1:2.3	1:2.8	1:3.5	1:3.5	1:3.5	1:4.7	9.28	9.00
80-6265 Third North	Med/Surg	MMH	1:2.6	1:3.0	1:4.5	1:4.5	1:4.5	1:6.0	8.50	8.00
80-9912 Third West	Med/Surg	MMH	1:0.5	1:0.5	1:0.5	1:1.0	1:1.0	1:1.0	4.20	n/a[5]
80-5060 Emergency Department	ED	MMH	1:4.7	1:4.0	1:2.0	1:7.6	1:6.8	1:2.8	2.10	2.20

Nursing Staff/RN to Patient Ratios: The staff to patient ratios were calculated by dividing the actual average daily census for the unit or department for FY 2015 through June by the number of nursing staff (or RN) full-time equivalents that would be required to care for patients on the unit given the actual average number of patients present on the unit.

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

Footnotes:

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

(2) Nursing hours per patient day should include all nursing staff as defined in #1 above. As reported in ECHN internal WHPPD Report for June 2015.

(3) Mother and baby are counted as one patient in Postpartum area (i.e. 1 nurse to 3 or 4 mother/baby pairs depending on patient accuity)

(4) Number of patients per nursing staff depends on patient acuity.

(5) Third West is used as an obstetrics overflow unit to accommodate postpartum patients when demand for labor and delivery beds on the maternity unit is at or near the unit's capacity. No NHPPD targets are set for Third West.

EXHIBIT Q42-2 - STAFFING ATTACHMENT II (PROJECTED)

Staffing Attachment II

Assumes volume demands, patient acuity, staff experience levels, and technology consistent with FY2015 budgeted projections

Year 1 with CON Authorization (FY 2017)

Name of Hospital Unit or Department	Service	Hospital	Average Nursing Staff[1] to Patient Ratio			Average RN to Patient Ratio		
			Shift #1 AM	Shift #2 PM	Shift #3 Overnight	Shift #1 AM	Shift #2 PM	Shift #3 Overnight
01-6074 ICU	ICU	RGH	1:1.5	1:2.0	1:2.0	1:2.0	1:2.0	1:2.0
01-6076 B II	Med/Surg	RGH	1:3.0	1:3.0	1:4.0	1:4.8	1:4.8	1:6.0
01-6144 B II South	Med/Surg	RGH	1:0.5	1:0.5	1:0.5	1:1.0	1:1.0	1:1.0
01-5060 Emergency Department	ED	RGH	1:3.8	1:3.2	1:1.9	1:5.7	1:5.1	1:3.7
80-5075 Obstetrical Services - Labor & Delivery	OB	MMH	1:1-2	1:1-2	1:1-2	1:1-2	1:1-2	1:1-2
80-5075 Obstetrical Services - Postpartum [3]	OB/NB	MMH	1:3-5	1:3-5	1:3-5	1:3-4	1:3-4	1:3-4
80-5079 NICU [4]	NICU	MMH	1:2-3	1:2-3	1:2-3	1:2-3	1:2-3	1:2-3
80-6165 Adult Inpatient	Psych	MMH	1:3.6	1:3.6	1:6.3	1:6.3	1:6.3	1:12.5
80-6170 Adolescent Inpatient	Psych	MMH	1:2.5	1:2.5	1:5.0	1:5.0	1:5.0	1:5.0
80-6220 Second East	Med/Surg	MMH	1:2.8	1:2.8	1:4.4	1:4.4	1:5.5	1:7.3
80-6225 ICU	ICU	MMH	1:1.7	1:1.9	1:1.9	1:2.1	1:2.5	1:2.1
80-6230 Special Care Unit	Med/Surg	MMH	1:2.3	1:2.8	1:3.5	1:3.5	1:3.5	1:4.7
80-6265 Third North	Med/Surg	MMH	1:2.6	1:3.0	1:4.5	1:4.5	1:4.5	1:6.0
80-9912 Third West	Med/Surg	MMH	1:0.5	1:0.5	1:0.5	1:1.0	1:1.0	1:1.0
80-5060 Emergency Department	ED	MMH	1:4.7	1:4.0	1:2.0	1:7.6	1:6.8	1:2.8

Year 2 with CON Authorization (FY 2018)

Name of Hospital Unit or Department	Service	Hospital	Average Nursing Staff[1] to Patient Ratio			Average RN to Patient Ratio		
			Shift #1 AM	Shift #2 PM	Shift #3 Overnight	Shift #1 AM	Shift #2 PM	Shift #3 Overnight
01-6074 ICU	ICU	RGH	1:1.5	1:2.0	1:2.0	1:2.0	1:2.0	1:2.0
01-6076 B II	Med/Surg	RGH	1:3.0	1:3.0	1:4.0	1:4.8	1:4.8	1:6.0
01-6144 B II South	Med/Surg	RGH	1:0.5	1:0.5	1:0.5	1:1.0	1:1.0	1:1.0
01-5060 Emergency Department	ED	RGH	1:3.8	1:3.2	1:1.9	1:5.7	1:5.1	1:3.7
80-5075 Obstetrical Services - Labor & Delivery	OB	MMH	1:1-2	1:1-2	1:1-2	1:1-2	1:1-2	1:1-2
80-5075 Obstetrical Services - Postpartum [3]	OB/NB	MMH	1:3-5	1:3-5	1:3-5	1:3-4	1:3-4	1:3-4
80-5079 NICU [4]	NICU	MMH	1:2-3	1:2-3	1:2-3	1:2-3	1:2-3	1:2-3
80-6165 Adult Inpatient	Psych	MMH	1:3.6	1:3.6	1:6.3	1:6.3	1:6.3	1:12.5
80-6170 Adolescent Inpatient	Psych	MMH	1:2.5	1:2.5	1:5.0	1:5.0	1:5.0	1:5.0
80-6220 Second East	Med/Surg	MMH	1:2.8	1:2.8	1:4.4	1:4.4	1:5.5	1:7.3
80-6225 ICU	ICU	MMH	1:1.7	1:1.9	1:1.9	1:2.1	1:2.5	1:2.1
80-6230 Special Care Unit	Med/Surg	MMH	1:2.3	1:2.8	1:3.5	1:3.5	1:3.5	1:4.7
80-6265 Third North	Med/Surg	MMH	1:2.6	1:3.0	1:4.5	1:4.5	1:4.5	1:6.0
80-9912 Third West	Med/Surg	MMH	1:0.5	1:0.5	1:0.5	1:1.0	1:1.0	1:1.0
80-5060 Emergency Department	ED	MMH	1:4.7	1:4.0	1:2.0	1:7.6	1:6.8	1:2.8

Year 3 with CON Authorization (FY 2019)

Name of Hospital Unit or Department	Service	Hospital	Average Nursing Staff[1] to Patient Ratio			Average RN to Patient Ratio		
			Shift #1 AM	Shift #2 PM	Shift #3 Overnight	Shift #1 AM	Shift #2 PM	Shift #3 Overnight
01-6074 ICU	ICU	RGH	1:1.5	1:2.0	1:2.0	1:2.0	1:2.0	1:2.0
01-6076 B II	Med/Surg	RGH	1:3.0	1:3.0	1:4.0	1:4.8	1:4.8	1:6.0
01-6144 B II South	Med/Surg	RGH	1:0.5	1:0.5	1:0.5	1:1.0	1:1.0	1:1.0
01-5060 Emergency Department	ED	RGH	1:3.8	1:3.2	1:1.9	1:5.7	1:5.1	1:3.7
80-5075 Obstetrical Services - Labor & Delivery	OB	MMH	1:1-2	1:1-2	1:1-2	1:1-2	1:1-2	1:1-2
80-5075 Obstetrical Services - Postpartum [3]	OB/NB	MMH	1:3-5	1:3-5	1:3-5	1:3-4	1:3-4	1:3-4
80-5079 NICU [4]	NICU	MMH	1:2-3	1:2-3	1:2-3	1:2-3	1:2-3	1:2-3
80-6165 Adult Inpatient	Psych	MMH	1:3.6	1:3.6	1:6.3	1:6.3	1:6.3	1:12.5
80-6170 Adolescent Inpatient	Psych	MMH	1:2.5	1:2.5	1:5.0	1:5.0	1:5.0	1:5.0
80-6220 Second East	Med/Surg	MMH	1:2.8	1:2.8	1:4.4	1:4.4	1:5.5	1:7.3
80-6225 ICU	ICU	MMH	1:1.7	1:1.9	1:1.9	1:2.1	1:2.5	1:2.1
80-6230 Special Care Unit	Med/Surg	MMH	1:2.3	1:2.8	1:3.5	1:3.5	1:3.5	1:4.7
80-6265 Third North	Med/Surg	MMH	1:2.6	1:3.0	1:4.5	1:4.5	1:4.5	1:6.0
80-9912 Third West	Med/Surg	MMH	1:0.5	1:0.5	1:0.5	1:1.0	1:1.0	1:1.0
80-5060 Emergency Department	ED	MMH	1:4.7	1:4.0	1:2.0	1:7.6	1:6.8	1:2.8

Footnotes:

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

(2) Nursing hours per patient day should include all nursing staff as defined in #1 above.

(3) Mother and baby are counted as one patient in Postpartum area (i.e. 1 nurse to 3 or 4 mother/baby pairs depending on patient accuity)

(4) Number of patients per nursing staff depends on patient acuity.

EXHIBIT Q44-1 - ANCILLARY CAREGIVER STAFFING ATTACHMENT (2015 AND PROJECTED)

Average Weekly Hours for Ancillary Caregivers

(1) Average hours per week calculated based on actual "regular" and "overtime" hours as reported in the HR Information System
(2) Ancillary Caregivers provided below include nursing staff assigned to departments that do not utilize a worked hour per patient day statistic
(3) Average Weekly Hours based on FY2015 YTD actual hours through June 27, 2015
(4) Assumes average hours per week will remain at FY 2015 year-to-date levels for the first 3 years after the asset purchase

Manchester Memorial Hospital	Average Hours per Week[1]	Projected Average Hours per Week[4]			
Ancillary Caregiver by Department [2]	FY 2015[3]	FY 2016	FY 2017	FY 2018	FY 2019
Advanced Practice Registered Nurse					
30-9928 - Neonatal Services	91	91	91	91	91
30-9941 - Gastroenterology Services	69	69	69	69	69
80-6174 - MMH Behavioral Health - Adolescent Outpatient Services	24	24	24	24	24
Care Manager					
80-5171 - MMH Wound Care Center	70	70	70	70	70
80-6485 - MMH Care Management	283	283	283	283	283
Certified Registered Nurse Anesthetist					
80-5165 - MMH OR	116	116	116	116	116
Clinician					
80-5216 - MMH Interventional Radiology	73	73	73	73	73
80-6150 - MMH Behavioral Health - Adult Partial Hospital Program	256	256	256	256	256
80-6165 - MMH Behavioral Health - Adult Inpatient Unit	116	116	116	116	116
80-6170 - MMH Behavioral Health - Adolescent Inpatient Unit	31	31	31	31	31
80-6172 - MMH Behavioral Health - Adult Outpatient Services	255	255	255	255	255
Crisis Worker					
30-9944 - Crisis Services	201	201	201	201	201
CT Technologist					
80-5030 - MMH CT Scan	248	248	248	248	248
Diabetes Educator					
80-5035 - MMH Diabetes Self Management	20	20	20	20	20
Dialysis Technician					
Multiple Inpatient Units	15	15	15	15	15
Emergency Department Physician					
80-5061 - MMH Emergency Department	546	546	546	546	546
Endoscopy Assistant					
80-5065 - MMH Endoscopy	161	161	161	161	161
Interventional Radiology Technologist					
80-5216 - MMH Interventional Radiology	40	40	40	40	40

Average Weekly Hours for Ancillary Caregivers

(1) Average hours per week calculated based on actual "regular" and "overtime" hours as reported in the HR Information System
(2) Ancillary Caregivers provided below include nursing staff assigned to departments that do not utilize a worked hour per patient day statistic
(3) Average Weekly Hours based on FY2015 YTD actual hours through June 27, 2015
(4) Assumes average hours per week will remain at FY 2015 year-to-date levels for the first 3 years after the asset purchase

Manchester Memorial Hospital	Average Hours per Week[1]	Projected Average Hours per Week[4]			
Ancillary Caregiver by Department [2]	FY 2015[3]	FY 2016	FY 2017	FY 2018	FY 2019
Lactation Consultant					
80-5078 - MMH Perinatal Education	41	41	41	41	41
Licensed Practical Nurse					
80-5060 - MMH Emergency Department	51	51	51	51	51
80-5171 - MMH Wound Care Center	70	70	70	70	70
80-6400 - MMH Ambulatory Services Center	19	19	19	19	19
Manager Rehab Svcs					
80-7230 - MMH Physical Therapy (Glastonbury)	46	46	46	46	46
Mental Health Counselor					
80-6160 - MMH Behavioral Health - Adolescent Partial Hospital Program	60	60	60	60	60
MRI Technologist					
80-5110 - MMH MRI	82	82	82	82	82
MRI/CT Scan Tech Aide					
80-5110 - MMH MRI	34	34	34	34	34
Nuclear Medicine Technologist					
80-5125 - MMH Nuclear Medicine	90	90	90	90	90
Nurse Practitioner					
80-6926 - MMH CorpCare	29	29	29	29	29
Occupational Health Nurse					
80-6926 - MMH CorpCare	20	20	20	20	20
Occupational Therapist					
80-5150 - MMH Occupational Therapy	28	28	28	28	28
80-5306 - MMH Occupational Therapy (South Windsor)	33	33	33	33	33
80-6160 - MMH Behavioral Health - Adolescent Partial Hospital Program	30	30	30	30	30
80-6165 - MMH Behavioral Health - Adult Inpatient Unit	26	26	26	26	26
80-6174 - MMH Behavioral Health - Adolescent Outpatient Services	3	3	3	3	3
Occupational Therapy Assistant					
80-6165 - MMH Behavioral Health - Adult Inpatient Unit	33	33	33	33	33

Average Weekly Hours for Ancillary Caregivers

(1) Average hours per week calculated based on actual "regular" and "overtime" hours as reported in the HR Information System
(2) Ancillary Caregivers provided below include nursing staff assigned to departments that do not utilize a worked hour per patient day statistic
(3) Average Weekly Hours based on FY2015 YTD actual hours through June 27, 2015
(4) Assumes average hours per week will remain at FY 2015 year-to-date levels for the first 3 years after the asset purchase

Manchester Memorial Hospital	Average Hours per Week[1]	Projected Average Hours per Week[4]			
Ancillary Caregiver by Department [2]	FY 2015[3]	FY 2016	FY 2017	FY 2018	FY 2019
Operating Room Technician					
80-5165 - MMH OR	353	353	353	353	353
Patient Care Assistant					
80-5165 - MMH OR	237	237	237	237	237
80-6400 - MMH Ambulatory Services Center	35	35	35	35	35
Phlebotomist					
80-5100 - MMH Lab	692	692	692	692	692
80-7140 - MMH Lab - Patient Service Center	387	387	387	387	387
Physical Therapist					
80-5200 - MMH Physical Therapy	201	201	201	201	201
80-5305 - MMH Physical Therapy (South Windsor)	102	102	102	102	102
80-7230 - MMH Physical Therapy (Glastonbury)	32	32	32	32	32
Physical Therapy Assistant					
80-5200 - MMH Physical Therapy	31	31	31	31	31
80-5305 - MMH Physical Therapy (South Windsor)	61	61	61	61	61
80-7230 - MMH Physical Therapy (Glastonbury)	44	44	44	44	44
Physician					
30-9908 - Hospitalists	601	601	601	601	601
30-9928 - Neonatal Services	56	56	56	56	56
30-9976 - Wound Care	20	20	20	20	20
80-5061 - MMH Emergency Department	35	35	35	35	35
80-5165 - MMH OR	314	314	314	314	314
80-5216 - MMH Interventional Radiology	48	48	48	48	48
80-6926 - MMH CorpCare	29	29	29	29	29
80-9135 - Medical Education Faculty	71	71	71	71	71
Physician Assistant					
30-9922 - Orthopedic Services	179	179	179	179	179
30-9928 - Neonatal Services	37	37	37	37	37
30-9972 - OB/GYN Services	15	15	15	15	15
30-9953 - General Surgery Services	175	175	175	175	175
80-5061 - MMH Emergency Department	453	453	453	453	453
Polysomnographic Technician					
80-5230 - MMH Sleep Lab	185	185	185	185	185

Average Weekly Hours for Ancillary Caregivers

(1) Average hours per week calculated based on actual "regular" and "overtime" hours as reported in the HR Information System
(2) Ancillary Caregivers provided below include nursing staff assigned to departments that do not utilize a worked hour per patient day statistic
(3) Average Weekly Hours based on FY2015 YTD actual hours through June 27, 2015
(4) Assumes average hours per week will remain at FY 2015 year-to-date levels for the first 3 years after the asset purchase

Manchester Memorial Hospital	Average Hours per Week[1]	Projected Average Hours per Week[4]			
Ancillary Caregiver by Department [2]	FY 2015[3]	FY 2016	FY 2017	FY 2018	FY 2019
Psychiatric Technician					
80-6165 - MMH Behavioral Health - Adult Inpatient Unit	427	427	427	427	427
80-6170 - MMH Behavioral Health - Adolescent Inpatient Unit	123	123	123	123	123
Psychiatrist					
80-6150 - MMH Behavioral Health - Adult Partial Hospital Program	33	33	33	33	33
80-6172 - MMH Behavioral Health - Adult Outpatient Services	44	44	44	44	44
80-9135 - Medical Education Faculty	13				
Radiological Technologist					
80-5215 - MMH Diagnostic Radiology	388	388	388	388	388
80-6926 - MMH CorpCare	39	39	39	39	39
80-7060 - MMH Glastonbury Diagnostic Center	31	31	31	31	31
Registered Dietician					
80-5035 - MMH Diabetes Self Management	51	51	51	51	51
Registered Nurse					
80-5010 - MMH Cardiac Rehab	60	60	60	60	60
80-5060 - MMH Emergency Department	1,060	1,060	1,060	1,060	1,060
80-5065 - MMH Endoscopy	281	281	281	281	281
80-5160 - MMH Ambulatory Medical	160	160	160	160	160
80-5165 - MMH OR	554	554	554	554	554
80-5171 - MMH Wound Care Center	65	65	65	65	65
80-5175 - MMH PACU	255	255	255	255	255
80-5245 - MMH Stress Lab	52	52	52	52	52
80-6400 - MMH Ambulatory Services Center	327	327	327	327	327
Rehab Aide					
80-5200 - MMH Physical Therapy	68	68	68	68	68
Resident/Intern Physician					
80-9135 - Medical Education Faculty	840	840	840	840	840
Respiratory Therapist					
80-5015 - MMH Cardio-Pulmonry	428	428	428	428	428
Respiratory Therapy Assistant					
80-5015 - MMH Cardio-Pulmonry	53	53	53	53	53

Average Weekly Hours for Ancillary Caregivers

(1) Average hours per week calculated based on actual "regular" and "overtime" hours as reported in the HR Information System
(2) Ancillary Caregivers provided below include nursing staff assigned to departments that do not utilize a worked hour per patient day statistic
(3) Average Weekly Hours based on FY2015 YTD actual hours through June 27, 2015
(4) Assumes average hours per week will remain at FY 2015 year-to-date levels for the first 3 years after the asset purchase

Manchester Memorial Hospital	Average Hours per Week[1]	Projected Average Hours per Week[4]			
Ancillary Caregiver by Department [2]	FY 2015[3]	FY 2016	FY 2017	FY 2018	FY 2019
Retractor Holder					
80-5165 - MMH OR	74	74	74	74	74
School Nurse					
80-6171 - MMH Behavioral Health - Adolescent Education	27	27	27	27	27
Social Worker					
80-6171 - MMH Behavioral Health - Adolescent Education	46	46	46	46	46
80-6485 - MMH Care Management	4	4	4	4	4
Sonographer					
80-5024 - MMH Echocardiogrphy	72	72	72	72	72
Speech Pathologist					
80-5220 - MMH Speech & Hearing	36	36	36	36	36
Student Nurse					
80-5060 - MMH Emergency Department	0	0	0	0	0
Surgical Prep Technician					
80-7145 - MMH Lab - Surgical Pathology	45	45	45	45	45
Therapist					
80-6160 - MMH Behavioral Health - Adolescent Partial Hospital Program	108	108	108	108	108
80-6174 - MMH Behavioral Health - Adolescent Outpatient Services	38	38	38	38	38
Ultrasonographer					
80-5255 - MMH Ultrasound	182	182	182	182	182
Woman's Health Nurse Navigator					
80-5260 - MMH Breast Center	34	34	34	34	34
Wound Care Technician					
80-5171 - MMH Wound Care Center	20	20	20	20	20

Average Weekly Hours for Ancillary Caregivers

(1) Average hours per week calculated based on actual "regular" and "overtime" hours as reported in the HR Information System.
(2) Ancillary Caregivers provided below include nursing staff assigned to departments that do not utilize a worked hour per patient day statistic.
(3) Average Weekly Hours based on FY2015 YTD actual hours through June 27, 2015 (39 weeks)
(4) Assumes average hours per week will remain at FY 2015 year-to-date levels for FY2016 and the first 3 years after the asset purchase.

Rockville General Hospital	Average Hours per Week[1]	Projected Average Hours per Week[4]			
Ancillary Caregiver by Department [2]	FY 2015[3]	FY 2016	FY 2017	FY 2018	FY 2019
Care Manager					
01-6085 - RGH Care Management	104	104	104	104	104
Certified Registered Nurse Anesthetist					
01-5165 - RGH OR	39	39	39	39	39
Clinician					
01-5216 - RGH Interventional Radiology	53	53	53	53	53
CT Technologist					
01-5030 - RGH CT Scans	78	78	78	78	78
01-5218 - RGH Evergreen Imaging Center	27	27	27	27	27
Dialysis Technician					
Multiple Inpatient Units	10	10	10	10	10
Dietitian					
01-6201 - RGH Women's Center for Wellness	2	2	2	2	2
Endoscopy Assistant					
01-5065 - RGH Endoscopy	64	64	64	64	64
Interventional Radiology Technologist					
01-5216 - RGH Interventional Radiology	75	75	75	75	75
Licensed Practical Nurse					
01-5063 - Urgent Care (South Windsor)	35	35	35	35	35
Manager Rehab Svcs					
01-5200 - RGH Physical Therapy	35	35	35	35	35
Massage Therapist					
01-6201 - RGH Women's Center for Wellness	5	5	5	5	5
MRI Technologist					
01-5110 - RGH MRI	62	62	62	62	62
01-5218 - RGH Evergreen Imaging Center	36	36	36	36	36
MRI/CT Scan Tech Aide					

Average Weekly Hours for Ancillary Caregivers

(1) Average hours per week calculated based on actual "regular" and "overtime" hours as reported in the HR Information System.
(2) Ancillary Caregivers provided below include nursing staff assigned to departments that do not utilize a worked hour per patient day statistic.
(3) Average Weekly Hours based on FY2015 YTD actual hours through June 27, 2015 (39 weeks)
(4) Assumes average hours per week will remain at FY 2015 year-to-date levels for FY2016 and the first 3 years after the asset purchase.

Rockville General Hospital	Average Hours per Week[1]	Projected Average Hours per Week[4]			
Ancillary Caregiver by Department [2]	FY 2015[3]	FY 2016	FY 2017	FY 2018	FY 2019
01-5110 - RGH MRI	21	21	21	21	21
Nuclear Medicine Technologist					
01-5125 - RGH Nuclear Medicine	65	65	65	65	65
Nurse Practitioner					
01-5077 - RGH Maternity Care Center	19	19	19	19	19
Occupational Therapist					
01-5150 - RGH Occupational Therapy	16	16	16	16	16
01-6121 - RGH Occupational Therapy (Vernon)	13	13	13	13	13
Occupational Therapy Assistant					
01-5150 - RGH Occupational Therapy	16	16	16	16	16
Operating Room Technician					
01-5165 - RGH OR	159	159	159	159	159
Patient Care Assistant					
01-5165 - RGH OR	115	115	115	115	115
Phlebotomist					
01-5100 - RGH Lab	450	450	450	450	450
Physical Therapist					
01-5200 - RGH Physical Therapy	106	106	106	106	106
01-5202 - RGH Physical Therapy (Ellington)	57	57	57	57	57
01-6118 - RGH Physical Therapy (Vernon)	66	66	66	66	66
Physician					
01-5063 - Urgent Care (South Windsor)	61	61	61	61	61
01-5165 - RGH OR	107	107	107	107	107
01-5216 - RGH Interventional Radiology	48	48	48	48	48
30-9908 - Hospitalists	336	336	336	336	336
Physician Assistant					
30-9922 - Orthopedic Services	60	60	60	60	60
30-9953 - General Surgery Services	59	59	59	59	59

Average Weekly Hours for Ancillary Caregivers

(1) Average hours per week calculated based on actual "regular" and "overtime" hours as reported in the HR Information System.
(2) Ancillary Caregivers provided below include nursing staff assigned to departments that do not utilize a worked hour per patient day statistic.
(3) Average Weekly Hours based on FY2015 YTD actual hours through June 27, 2015 (39 weeks)
(4) Assumes average hours per week will remain at FY 2015 year-to-date levels for FY2016 and the first 3 years after the asset purchase.

Rockville General Hospital	Average Hours per Week[1]	Projected Average Hours per Week[4]			
Ancillary Caregiver by Department [2]	FY 2015[3]	FY 2016	FY 2017	FY 2018	FY 2019
Psychiatrist					
01-6168 - RGH OP Behaviroal Health (Child & Adol)	15	15	15	15	15
Radiological Technologist					
01-5215 - RGH Diagnostic Radiology	344	344	344	344	344
01-5218 - RGH Evergreen Imaging Center	73	73	73	73	73
01-6201 - RGH Women's Center for Wellness	180	180	180	180	180
Radiological Technologist Aid					
01-6201 - RGH Women's Center for Wellness	12	12	12	12	12
Registered Nurse					
01-5010 - RGH Cardiac Rehab	55	55	55	55	55
01-5060 - RGH Emergency Department	636	636	636	636	636
01-5063 - Urgent Care (South Windsor)	31	31	31	31	31
01-5065 - RGH Endoscopy	163	163	163	163	163
01-5077 - RGH Maternity Care Center	18	18	18	18	18
01-5165 - RGH OR	194	194	194	194	194
01-5175 - RGH PACU	96	96	96	96	96
01-5245 - RGH Stress Lab	22	22	22	22	22
01-6082 - RGH ODS	150	150	150	150	150
01-6201 - RGH Women's Center for Wellness	3	3	3	3	3
Rehab Aide					
01-5200 - RGH Physical Therapy	63	63	63	63	63
Resident/Intern Physician					
01-9135 - Medical Education Faculty	38	38	38	38	38
Respiratory Therapist					
01-5015 - RGH Cardio-Pulmonry	248	248	248	248	248
Respiratory Therapy Assistant					
01-5015 - RGH Cardio-Pulmonry	6	6	6	6	6
Sonographer					
01-5024 - RGH Echocardiogrphy	31	31	31	31	31
Speech Pathologist					

Average Weekly Hours for Ancillary Caregivers

(1) Average hours per week calculated based on actual "regular" and "overtime" hours as reported in the HR Information System.
(2) Ancillary Caregivers provided below include nursing staff assigned to departments that do not utilize a worked hour per patient day statistic.
(3) Average Weekly Hours based on FY2015 YTD actual hours through June 27, 2015 (39 weeks)
(4) Assumes average hours per week will remain at FY 2015 year-to-date levels for FY2016 and the first 3 years after the asset purchase.

Rockville General Hospital	Average Hours per Week[1]	Projected Average Hours per Week[4]			
Ancillary Caregiver by Department [2]	FY 2015[3]	FY 2016	FY 2017	FY 2018	FY 2019
01-5220 - RGH Speech & Hearing	19	19	19	19	19
Student Nurse					
01-5060 - RGH Emergency Department	7	7	7	7	7
Therapist					
01-6168 - RGH OP Behaviroal Health (Child & Adol)	19	19	19	19	19
Ultrasonographer					
01-5218 - RGH Evergreen Imaging Center	41	41	41	41	41
01-5255 - RGH Ultrasound	118	118	118	118	118
01-6201 - RGH Women's Center for Wellness	104	104	104	104	104

EXHIBIT Q47-1 - STATEMENTS OF DEFICIENCY – FILED ELECTRONICALLY ONLY

PMH Response to Question 47
Summary of Statements of Deficiency/ Plans of Correction
PMH-Owned Rhode Island Hospital Facilities

ST. JOSEPH HEALTH SERVICES OF RHODE ISLAND – COMPLAINT VALIDATION SURVEY

On June 23, 2014, a complaint validation survey at St. Joseph Health Services of Rhode Island was completed by the Rhode Island Department of Health (the "DOH"). Several deficiencies were noted involving the failure to implement hospital policies for "Medical Marijuana;" "Documented Informed Consent for AIDS/HIV and Confidentiality;" "Patient Search Policy;" "Constant Observation;" "Universal Protocol Policy;" "Annual Performance Competency Review Process;" and failure to report reportable incidents, in writing, to the DOH within 72 hours of incident. The complaints were substantiated. Corrective actions were implemented and a plan of correction was submitted to and accepted by the DOH.

ST. JOSEPH'S HEALTH SERVICES OF RHODE ISLAND – COMPLAINT VALIDATION SURVEY

On March 6, 2013, a complaint validation survey was completed by the DOH. Several deficiencies were noted involving the failure to implement hospital policies for "Constant Observation;" "Fall Precaution Policy;" failure to provide care, in accordance with community standard, for bowel care; failure to ensure less restrictive interventions and/or alternatives had been employed and ineffective prior to chemically restraining a patient; and failure to report reportable incidents, in writing, to the DOH within 72 hours of incident. The complaints were substantiated. Corrective actions were implemented and a plan of correction was submitted to and accepted by the DOH.

ROGER WILLIAMS MEDICAL CENTER – COMPLAINT VALIDATION SURVEY

On August 20, 2013, a complaint validation survey was completed by the DOH. Several deficiencies were noted to include failure to report reportable incidents, in writing, to the DOH within 72 hours of incident; failure to perform peer review on a reportable incident; and failure to submit a follow-up report to the DOH following a reported incident. The complaints were substantiated. Corrective actions were implemented and a plan of correction was submitted to and accepted by the DOH.

St. Joseph Health Services of Rhode Island

WWW.SAINTJOSEPHRI.COM

200 HIGH SERVICE AVENUE
NORTH PROVIDENCE, RI 02904
(401) 456-3000

August 29, 2014

Raymond Rusin, Chief
RI Department of Health,
Division of facilities Regulation
3 Capitol Hill
Providence, RI 02908
In Hand

Re: HOS00110, survey completed 6/23/2014

Dear Mr. Rusin:

Enclosed please find Prospect CharterCARE SJHSRI's Plan of Correction for citations received on August 15, 2014, in the Statement of Deficiencies from the Rhode Island Department of Health, for a visit May 22, 2014 through June 23, 2014.

Sincerely,

Thomas Hughes, FACHE
President
Prospect CharterCARE SJHSRI
200 High Service Ave
North Providence, RI 02904
Attachment

cc Catherine Lynn, RN

PRINTED: 03/28/2013
FORM APPROVED
RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HOS00110	A. BUILDING:_____ B. WING_____	C 6/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST. JOSEPH HEALTH SERVICES OF RI	200 HIGH SERVICE AVENUE NORTH PROVIDENCE, RI 02904

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Z 0	INITIAL COMMENTS A State complaint investigation survey, a follow-up (*EJ0011, 6/20/14) to previous State complaint investigation survey, and an 'Other' State licensure survey (DDWN11, 6/20/14) were conducted at this facility. Prior deficiencies are recited, and deficiencies relative to the State complaint investigation survey and the 'Other' State licensure survey are also cited.	Z0		
Z 160	ORGANIZATION & MANAGEMENT 12.2 Organization 12.2 Each hospital department and service shall maintain: a) clearly written definitions of its organization, authority, responsibility and relationships; b) written patient care policies and procedures; and c) written provision for systematic evaluation of programs and services. This Requirement is not met as evidenced by: Based on record review, staff interview, and review of hospital policies, it has been determined that the hospital failed to implement the following policies: 1. "Medical Marijuana", for 1 of 1 relevant sample patients, ID #4; 2. "Documented Informed Consent For AIDS/HIV and Confidentiality", for 5 of 5 relevant sample patients, ID#'s 6, 39, 40, 41 and 42; 3. "Patient Search Policy", for 1 of 1 relevant sample patients, ID #18; 4. "Constant Observation", for 3 of 4 relevant sample patients, ID #'s 2, 27, and 34; 5. "Universal Protocol Policy", for 1 of 6 relevant	Z 160		

Facilities Regulation
PROVIDER REPRESENTATIVE'S SIGNATURE Thomas Hughes TITLE President, Prospect CharterCARE SJHSRI (X6) DATE 8/29/14

ECHN Proposed Asset Purchase by PMH
Submitted October 13, 2015

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FORM APPROVED

RI Department of Health

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Z 160	Continue From page 1 sample patients, ID # 26; 6. "Annual Performance Competency Review Process", for 6 of 12 relevant sample employees, ID's A, B, C, D, E and F. Findings are as follows: I.The hospital policy, "Medical Marijuana", dated 10/2012, under "Policy Statement" states, under item b: "If the patient is determined to be a licensed card holder, the material in question will be sent home with the patient or the patient's family. In the event that no family members are available to receive the material, it will be disposed of and destroyed...The pharmacist will contact the patient's prescriber to recommend Marinol (dronabinol) as an oral, FDA (Food and Drug Administration) approved alternative medication to use while the patient is admitted." Review of the clinical record for patient ID #4 reveals that the patient was admitted to the hospital on 3/14/13 for a psychiatric evaluation. The patient presented with a Medical Marijuana Card, and a small amount of marijuana. The patient told staff that there was no significant other to remove the marijuana from the facility, therefore the marijuana was disposed of in the presence of the patient and pharmacy staff in accordance with hospital policy. The record lacked evidence that the patient's physician was contacted by a hospital pharmacist to recommend Marinol during the patient's admission in accordance with the hospital policy.	Z 160	**I. Hospital Policy: Medical Marijuana (#04-953-281)** a. Members of Pharmacy staff will complete and read & sign the above policy and related departmental specific notes of process. **MOS: 100% compliance.** Signature pages will be submitted to Risk Mgt. b. RNs (hospital) will complete read & sign of above policy and departmental specific notes of process. **MOS: 100% compliance.** Read and sign recording will be kept electronically by Nsg Ed. A report will be generated & submitted to Risk Mgt (staff who performed the read & sign.) c. Security Guards will complete a read & sign of above policy and departmental specific notes of process. **MOS: 100% compliance.** Signature pages will be submitted to Risk Mgt. d. **Audit:** All charts of patients admitted with Medical Marijuana will be audited for 6 months to determine compliance with hospital policy and appropriate documentation of intervention & notification to Dir/Mgrs Pharmacy. If goal achieved, a determination will be made as to need for further audits. **MOS: 100% compliance.**	**Pt Safety/ Ethics & P & T Committees** 9/30/2014 10/15/2014 10/15/2014 11/1/2014 – 5/1/2015

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Z 160	Continued From page 2 During an interview on 5/27/14 at approximately 2 PM with the Lead Operational Pharmacist, who was present when the marijuana was destroyed, it was revealed that contact with the patient's physician regarding prescribing Marinol did not occur. II. The hospital policy, "Documented Informed Consent for AIDS/HIV and Confidentiality", dated 3/2011, under "Policy", item A states: "AIDS tests will only be done with the documented informed consent of the patient..." A review of the clinical record for patient ID #6 reveals the patient was admitted to the facility on 8/2/13 with a question of stroke. While in the hospital the patient had blood work completed which included testing for HIV (human immunodeficiency virus). The medical record lacked evidence of documentation of an informed consent of the HIV testing in accordance with hospital policy. When interviewed on 6/12/14 at approximately 8:30 AM, the ordering physician revealed, "I may have discussed the HIV testing with the patient, but I did not document it; there is an informed consent policy, I usually write it in the record." Review of 4 additional relevant clinical records for patient ID #s 39, 40, 41 and 42 revealed no evidence that informed consent for HIV testing had been obtained in accordance with hospital policy.	Z 160	**II. Hospital Policy: "Documented Informed Consent for AIDS/HIV & Confidentiality" (#04-711-41 aka IP & IC Manual A-2b)** a. Revise above policy to include required HIV Consent Form to be completed by ordering MD/LIP & signed by MD/LIP & patient. Prepare & attach a new HIV Consent Form to be used (available in Meditech.) Add a verification process for completion of above Consent Form & counseling/education prior to HIV test order to be placed in Meditech & accepted. **MOS: Completion of Policy revisions & prepare Consent Form by 10/1/14.** Once above policy is completed, the HIV (Aids) Tests Umbrella Plan IP & IC Manual A-2f will be revised accordingly. b. Create stop gap in Meditech to prevent HIV testing without compliance with policy requirements. **MOS: Completion in Meditech 10/15/14 to begin 11/15/14.** c. Focused physician and healthcare worker education in high volume areas re: policy revisions & stop gap. Areas include: ED, BH, SJHSRI clinics, & Infectious Disease: • MDs/LIPs & MD (involved in citation) • Nurses & Unit secretaries - Skills Fair • SJHSRI Clinic (RN, LPN, MA, Unit secretaries) – Skills Fair **MOS: 100% completion by high volume**	**Patient Safety Committee** 10/1/2014 10/15/2014 10/15/2014 – 11/15/2014

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PROVIDER REPRESENTATIVE'S SIGNATURE . Thomas Hughes . TITLE President, Prospect CharterCARE SJHSRI . . (X6) DATE

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Z 160	Continued From page 3 III. The hospital policy, Patient Search Policy", dated 8/2010, under "Procedure", Item II, "Patient Search" states: "A patient search is performed by two people in the following circumstances: any patient who demonstrates symptoms which suggests the use of contraband drugs." "The patient search is performed as follows": Item b. "The patient removes clothes and will be placed in a hospital gown and the staff member searches the clothing item..." Review of the clinical record for patient ID #18 revealed that the patient was brought to the ED (emergency department) by EMS (emergency medical services). The patient had been found in respiratory arrest after injecting heroin. The patient regained consciousness after treatment. The physician's clinical impression was "heroin overdose". While being monitored in the ED, the patient became unresponsive. The patient responded to	Z 160	**MDs/LIPs, MD involved in citations & healthcare workers of above areas.** Sign-in sheets/report will be submitted to Risk Mgt. d. **Audit:** All HIV orders entered into Meditech (answer: yes & no) will be reviewed monthly for 3 months. If healthcare worker has to contact MD/LIP for consent, it will be tracked & MD/LIP will be re-educated. If compliance goal is reached, a random audit will continue as appropriate. **MOS: 100% compliance.** **III. Hospital Policy: "Patient Search" (C- 52)** a. Revise above policy to eliminate "Emergency Department", as searches will be detailed in a newly created Risk Assessment Policy & obtain approval. **MOS: Policy will be revised.** b. Draft policy "Emergency Risk Assessment for Behavioral Health Patients" (Risk Assessment Policy) & attached "Emergency Risk Assessment Guide." Risk Assessment to be completed by MDs &/or ED Clinicians - for all patients presenting with psychiatric concerns, substance abuse issues, detox requests &/or overdoses. To be piloted in ED before final approval. **MOS: Pilot implemented.** c. Risk Assessment created in Meditech for ED Clinicians and ED RNs to access & document on patients that meet the policy requirements. **MOS: Risk Assessment completed in Meditech.** d. Risk Assessment created in the EMR for MDS/LIPs to access & documentation on patients that meet policy requirements. This documentation comes with color coding in Meditech & with visual representation	12/1/2014 – 2/1/2015 **Patient Safety Committee** 9/30/2014 Pilot began 6/1/2014 – 10/1/2014 Clinicians: 8/18/2014 RNs: 10/30/2014 8/31/2014

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Z 160	Continued From page 4 treatment. The physician's note reveals, "Patient states s/he found a bag of drugs on the way to the bathroom and used them in the bathroom. Patient still has pants on so it is possible that something was in a pocket..." When interviewed on 6/17/14 at approximately 11:30 AM, the ED Chief revealed, "I feel the care was not optimal, the patient should have been searched." It was determined that the patient was allowed to keep pants on while wearing a hospital gown, and a search for contrabands had not been performed in accordance with the hospital policy. IV. The hospital policy, "Constant Observation", dated 6/2013, under "Policy" states:	Z 160	outside patient's rooms for staff awareness of risk level. **MOS: Risk Assessment completed in EMR.** e. Emergency Risk Assessment Guide will be posted in LSU & Core of ED – quick reference. f. Education provided on above pilot policy & Emergency Risk Assessment Guide for: o ED Clinicians (also documentation) o ED MDs/LIPs (also documentation) o ED RNs o ED CNAs o Security guards **MOS: 100% compliance.** Signature sheets/reports of attendance of all will be submitted to Risk Mgt. For staff who float to the ED, a just in time read & sign will be used. g. Final revision & approval of Risk Assessment Policy - apply to ED. h. **Audits:** Review of completions of the Risk Assessments performed in the ED: o All Risk Assessments completed by ED Clinicians will be reviewed by Access Manager/Lead Clinician for 6 months. If goal achieved, random audits will be determined. o 30 Risk Assessments completed by MDs/LIPs will be reviewed by ED MDs monthly for 3 months. If goal is achieved, random audits will be determined. **MOS: 100% compliance with new Risk Assessment Policy.** **IV. Hospital Policy "Constant Observation" (N-7)**	9/1/2014 8/13/2014 10/1/2014 9/30/2014 9/30/2014 9/30/2014 11/30/2014 12/1/2014 – 5/1/2015 12/1/2014 – 3/1/2015 **Patient Safety Committee**

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Z 160	Continued From page 5 "It is hospital policy to institute a level of Constant Observation for the patient who manifests one or more of the following criteria": Item #2 "Imminent threat to physical or emotional well-being including but not limited to: Reported suicidal/homicidal ideation's." Under, "Definitions", it states: "Constant observation – process of visually monitoring (observing) a patient at all times, regardless of patient activity; goal is to prevent patient from leaving hospital and from causing injury to self or others; may be used with or without patient being in physical restraints." Under, "Procedure", item 5b it states: "Remain with the patient at all times including bathroom visits (door will be left cracked with consideration for privacy but must be visual) and when patients appear to be sleeping focus on visibility of mouth and hands, maintain no more than arms length distance unless otherwise directed..." 1. Review of clinical record for patient ID #2 revealed that the patient was on 1:1 observation. On 4/9/14 at approximately 7:30 AM, the patient could not be found. A search was conducted and the patient was found unharmed at approximately 8:00 AM, in a lower cabinet in the television room. During an interview on 5/28/14 at approximately 3 PM with the Director of Behavioral Health, it was revealed that the person who was assigned to	Z 160	a. Draft Risk Assessment Policy, as well as Meditech and EMR Risk Assessment documentation. Referred to in III a - e. Risk Assessment to be piloted in ED before final approval. Risk Assessment - addresses complex situations (sexual trauma, psychosis & complex grief.) ED to practice Trauma-Informed Care – allow patients self-determination, if appropriate, ability of patient to contract for safety (CFS) with psychiatrically-trained clinician. Risk Assessment addresses: disrobement, searches, medications, restraints & patient's ability to CFS thus negating need for 1:1 observation. b. Education concerning Risk Assessment Policy & documentation is discussed above in III f. c. Final approval of new Risk Assessment Policy - see III g. above. d. Edit and complete revisions of Constant Observation Policy (N-7) to reflect new Risk Assessment Policy," since Risk Assessment will address clinical needs of patient & determine the patient's immediate needs {medication, restraints, disrobement (forcible or not) after negotiations, as well as need for 1:1 or patient's ability to CFS. If patient is able to CFS in ED, then a 1:1 observation will not be required.} In addition, the Constant Observation 1:1 Report Form attached to policy was revised 6/5/2014 to meet the needs of BH Units to provide an increased level of communication between RN & constant observer to better meet patient's needs. It identifies specific behaviors & effective interventions, enhancing & encouraging	See III above See III above See III above 9/2/2014 - 10/14/2014

Facilities Regulation
PROVIDER REPRESENTATIVE'S SIGNATURE Thomas Hughes TITLE President, Prospect CharterCARE SJHSRI (X6) DATE

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Submitted October 13, 2015

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Z 160	Continued From page 6 the constant observation monitoring of the patient went to assist other staff when another patient had fallen. It was at this time that patient ID #2 was left unattended. The hospital investigation determined that based on the review of surveillance video, the patient was in the lower cabinet for approximately 27 minutes. 2. Review of the clinical record for patient ID #27 revealed that the patient presented to the ED after an attempted drug overdose. The patient has a psychiatric history of greater than 20 suicide attempts. The documented patient complaint was "major depression and suicidal ideas". The patient was triaged and placed in Room 7. The plan was for the patient to have a psychiatric evaluation. At approximately 11:55 AM, the patient eloped from the ED. A search by security staff found the patient standing at a bus stop across the street from the hospital. The patient was safely brought back to the hospital ED, and placed in the LSU (low stimulus unit) on 1:1 observation. During an interview on 6/16/14 at approximately 9 AM, the Risk Manager revealed that with hospital investigation the triage nurse had reported that the LSU was full when the patient arrived. It was also reported that the patient should have been on a 1:1 upon arrival to the ED, but there was not enough staff and no bed available in the LSU. When interviewed on 6/18/14 at approximately 1:30 PM, the ED nurse who cared for the patient revealed that the patient stated s/he wanted to	Z 160	therapeutic rapport between constant observer and the patient. This will become part of the policy for all units. e. Due to new ED policy concerning Risk Assessment, described above, the following policies will be revised & approved: • N-7 Constant Observation • N-19 Suicide Precautions • N-21 Elopement. f. Education of policy revisions of N-7, N-19 & N-21 for RNs & CNAs: • Mandatory Skills Fair. **MOS: 100% compliance with attendance with the exception of those who are on LOAs from the organization.** Sign-in sheets or Reports on attendance will be submitted to Risk Mgt. g. Any ED patient requiring a psychiatric evaluation is no longer allowed to use the hallway bathroom with 2 exit doors (in the core) but instead must use the bathroom in LSU. h. **BH Units (including 3 South, Geri Psych Unit):** Education of clinical staff on Constant observation policy and Constant Observation Report Form as follows: • CNAs educated at CNA skills Fair • BH Staff (RNs & CNAs) at Mandatory BH Skills Fair **MOS: 100% compliance with attendance.** Sign-in sheets or Report of attendance will be submitted to Risk Mgt. Any staff that does not attend by said date must complete training through Nsg Ed intranet with competency exam. Sign-in sheets to be submitted to Risk Mgt.	9/2/2014 – 10/14/2014 10/15/14 – 10/31/2014 5/1/2014 6/26/2014 7/2/2014 8/29/2014

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PROVIDER REPRESENTATIVE'S SIGNATURE Thomas Hughes TITLE President, Prospect CharterCARE SJHSRI (X6) DATE

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Z 160	Continued From page 7 commit suicide. However, the patient was left in a room without 1:1 supervision, reportedly due to a lack of sufficient staff. 3. Review of the clinical record for patient ID# 34 reveals the patient was brought to the ED via EMS for making suicidal statements to his/her father. The patient has a past suicidal attempt in December of 2013. Review of the triage notes reveals the patient did express feelings of depression and thoughts of harming self. The patient was placed on suicide precautions and 1:1 observation. At approximately 2:15 AM the patient was accompanied to the bathroom by the registered nurse. While in the bathroom, the patient opened the other door to the bathroom and fled the ED. The local police were notified, found the patient, and brought him/her back to the ED. During an interview on 6/18/14 at approximately 10 AM with the Risk Manager, she revealed the patient was placed in the "core" area of the ED on arrival. A hallway bathroom was used that has 2 doors, one of which goes to the waiting area. Surveillance video shows the patient was escorted to the bathroom by the RN. The patient was allowed to close the door completely, putting the patient out of view of the RN and security officer. The patient then fled out of the other door leading to the waiting area. The patient was not in full view of staff in accordance with the hospital policy.	Z 160	i. **BH Units:** Educational program developed for BH Skills Fair will be reviewed during BH orientation for new hires. Also on the intranet. j. **3 South Audit:** Documentations of all patients on 1:1 observation will be reviewed for 3 months for compliance; then documentation of 50% of patients who are on 1:1 observation will be reviewed for compliance and will continue to be audited until goal is reached. **MOS: 100% compliance.** k. Hire consultant & hospital staff (ED & 3 South) to participate in RCA & corrective action plan on constant observation of patients	8/29/2014 8/1/2014 – 11/1/2014 11/1/2014 until compliance is reached. Submit name to DOH – await approval

Facilities Regulation
PROVIDER REPRESENTATIVE'S SIGNATURE Thomas Hughes TITLE President, Prospect CharterCARE SJHSRI (X6) DATE

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Z 160	Continued From page 8 V. The hospital policy, "Universal Protocol Policy", dated 9/2012, under "Marking the Operative Site", states: "All patients having an invasive procedure/surgical procedure that involve laterality…will have their site marked." "The surgeon will mark the site with his initials. The exception to this is Spinal level, which will be completed as follows: Skin marked at the level of the procedure (e.g. cervical, thoracic, lumbar) The skin mark indicates anterior vs. posterior and right vs. left." Under, "Time-out Process," it states: "An incision will not be made until the circulating nurse or procedure assistant and physician/dentist together along with the SRNA/CRNA/Anesthesiologist (student registered nurse anesthetist/certified registered nurse anesthetist) (if appropriate) actively verifies the surgical information. The physician will initiate "time-out" for the verification process. All staff involved in the procedure (Physician, Anesthesia, Circulating Nurse, Scrub Tech) will pause, take a time-out to verify: The correct patient The correct procedure Correct site/side (confirmed with consent by RN/licensed provider) Physician's initials on procedure site/side visible after prepping and draping, can we see the mark?"	Z160	**V. Hospital Policy: "Universal Protocol" (#04-953-130)** a. Education completed re: Universal Protocol and forms used provided to Radiology Staff. **MOS: 100% compliance** Copies of sign in sheet provided to Risk Management. b. Same education provided to 4 Radiologists (who perform IR procedures.) c. Hospital wide Universal Protocol in-service which includes: PowerPoint presentation, handouts & post test. **MOS: 100% mandatory attendance by Anesthesia & Diagnostic Imaging Depts and 100% completion of post test.** Sign-in sheets & post tests to be submitted to Risk Mgt. Also invited to attend: OR staff, ED, Critical Care, Endoscopy & other areas of the hospital. d. Mandatory Universal Protocol in-service will be provided to new anesthesia group - sub contractor – anticipated start date 12/2014. **MOS: 100% compliance with attendance & completion of post test.** Sign in sheet & post tests submitted to Risk Management. e. Mandatory Universal Protocol in-service to be part of orientation in the following clinical areas: Diagnostic Imaging, OR, & Endoscopy. **MOS: 100% compliance with attendance & completion of post test.**	**Patient Safety Committee** 10/14/2013 10/2013 9/10/2014 Anticipated 12/2014 10/1/2014

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Z 160	Continued From page 9 Review of the clinical record for patient ID# 26 reveals on 5/22/13 the patient underwent a lumbar and sacral dorsal rami block for right lower back pain. The procedure documentation reveals, "Left L5 (lumbar) and sacral L1, L2, L3 and L4 dorsal rami block." The procedure documentation by the physician revealed that at the conclusion of the procedure, it was realized that a left sided injection was performed. This was done despite documentation in the patient's history and physical that his/her pain was principally right sided. Informed consent was for a right sided injection. It was confirmed with the patient that the right side was to be done. Review of the Procedure Assessment/Plan lacks evidence that the site was verified and marked. During an interview on 6/13/14 at approximately 12:15 PM, the Risk Manager revealed in the hospital investigation that it was realized that those involved in the procedure did not actively participate during the time-out. During the time-out, the radiological technician and physician had started the procedure, and the nurse was doing paperwork. There were no site markings in accordance with hospital policy. Additionally, the "Universal Protocol checklist Non-Operating Room" documentation was not used. When interviewed on 6/17/14 at approximately 12:30 PM, the Chief of Anesthesia revealed the site should have been marked per hospital protocol. During the time-out, everyone is to stop what they are doing and listen to the physician at this time; all in the room should participate during	Z160	f. When applicable, mandatory Universal Protocol in-service will be provided to new professional service groups as their contracts commence g. **Audit:** All needle puncture procedures in Special Procedures, Interventional Radiology, Mammography & Ultrasound will be completed monthly for compliance with the policy for 6 months. If goal is achieved random auditing will be determined. **MOS: 100% compliance.**	Anticipated 1/2015 11/1/2014 – 5/1/2015

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Z 160	Continued From page 10 the time out. During an interview on 6/18/14 at approximately 2:20 PM, the Radiological Technician revealed, "when we do a time out or briefing we should all be in the room. I was not in the room when the time-out was done; I was in the control room entering patient information into the computer." The physician and the nurse were in the room and did the time-out without the technician being present. VI. The hospital policy, "Annual Competency Based Evaluation System", dated 7/2010, under "Procedure" item B states: "It is the responsibility of the department manager/supervisor to document performance and assess competency on an ongoing basis on an evaluation and meet with their employees as soon as possible." Also, review of the hospital policy dated 4/2013, entitled "Annual Performance Competency Review Process," under "Policy Statement," states: "A documented annual Performance Review is required of all CharterCARE Health Partner employees in a budgeted position, employees in a per diem position who work 350 or more hours in a year, as well as contracted staff and volunteers..." Review of 6 out of 12 employee files lacked evidence of an annual performance evaluation, (Employee ID's A, B, C, D, E and F).	Z160	**VI. Hospital Policy: "Annual Competency Based Evaluation System" (#HR-600-00021-0)** a. All evaluations for non-union employees - due by October 30th each year. All Evaluations for union employees are completed by employee anniversary date. **MOS: 98% compliance for 2013.** b. Managers have ability to access compliance report in Meditech. In addition, HR Generalists will send out reminders on a bi-weekly basis. **MOS: HR reminders will be sent to Managers biweekly starting 8/29/2014.** c. Revise above policy to include Performance Improvement Process (PIP.) **MOS: Policy revisions completed by 9/1/2014.** d. HR will provide mandatory training sessions for all of leadership on: • 4 step performance review process	**Members of Prospect CharterCARE Sr Leadership/ & BOT** Effective October 2013 Immediately Start 8/29/2014 9/1/2014 9/30/2014

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Z 160	Continued From page 11 ID's A & B lacked an annual performance evaluation for 2012. ID C lacked an annual performance evaluation for 2011 and 2012. ID's D & F lacked an annual performance evaluation for 2012. ID E lacked an annual performance evaluation for 2012 and 2013. When interviewed on 6/4/14 at approximately 2:30 PM, the Vice President of Human Resources revealed that the policy is for annual evaluations, and efforts have been made over the years to enforce this policy.	Z 160	◦ Utilization of Meditech for accessing reports on compliance with performance reviews. **MOS: 100% compliance with attendance.** Sign – in sheets to be submitted to Risk Mgt. e. Corrective actions will be issued to Mgrs/Supervisors/Dirs who are not in 100% compliance after 10/30/2014, as well as hold their merit, if applicable. **MOS: 90% compliance** **Audit:** Compliance reports will be updated monthly. Copy of audit reports will be submitted to Risk Mgt. HR will provide the corrective action template and recommendations to Dir/VP accordingly. PIPs issued will be submitted to Risk Mgt for continued tracking.	12/30/2014
Z940	PATIENT CARE SERVICES 34.8 Reportable Incidents 34.8 Any reportable incident occurring on or after June 30, 1994 shall be reported in writing to the Department of Health within seventy-two (72) hours of when the hospital has reasonable cause to believe an incident has occurred. Any incident(s) occurring prior to June 30, 1994 need not be reported. This Requirement is not met as evidenced by: Based on document review and staff interview, it has been determined that the hospital failed to report, in writing to the licensing agency, reportable incidents within 72 hours for 5 of 18 relevant sample patients (ID#'s 26, 29, 30, 36 and 38).	Z940	**Patient Care Services 34.8 Reportable Incidents** a. Identify units involved in citation (late reporting) in RL 6 & to Risk Mgt (pager) (for specific events/harm levels) & reasons. **MOS: Complete identification.** b. Review past DOH reporting audits 8/1/2013 – 7/1/2014 to identify: units involved & common reasons for late reporting. **MOS: Complete list of reasons.** c. Speak with members of Nursing Safety Council about (late reporting) to determine reasons & obtain suggestions for easier frontline reports. Include suggestions in further education & changes.	**Patient Safety Committee** 8/19/2014 9/30/2014 9/30/2014

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Z940	Continued From page 12 Findings are as follows: 1. A reportable incident occurring for patient ID# 26 on 5/22/13 was not reported to the licensing agency until 5/28/13. 2. A reportable incident occurring for patient ID# 29 on 12/30/13 was not reported to the licensing agency until 1/7/14. 3. A reportable incident occurring for patient ID# 30 on 11/7/13 was not reported to the licensing agency until 11/18/13. 4. A reportable incident occurring for patient ID# 36 on 10/31/13 was not reported to the licensing agency until 11/6/13. 5. A reportable incident occurring for patient ID# 38 on 12/8/13 was not reported to the licensing agency until 1/30/14. During an interview on 6/20/14 at approximately 1:30 PM with the Risk Manager, she was unable to provide evidence that the above incidents were reported to the licensing agency within 72 hours as required, and indicated that she frequently gets these reports late from staff.	Z940	d. Hire consultant & participate in RCA & corrective action plan on timely reporting to DOH. e. Educate clinical staff on units identified re: positive, non-punitive aspect of RL 6 & use of RL 6 to promote culture of safety; near miss events - importance of entering near misses, learning tool & way to improve safe patient care; types of events to report & importance of timely reporting. o How to enter an RL 6 report, necessary information needed & how to classify harm. o Types of events to report (specific examples for specialized depts), circumstances Risk Mgt should be paged & include examples of "Near Misses" where incidents have been prevented by RL 6 reporting. **MOS: 90% compliance in attendance.** f. Create mandatory education packet for clinical staff concerning types of events to report in RL 6, timeliness of reporting & severity scores to be completed during orientation along with post-test. Work with Nsg Ed on integration of this mandatory education into clinical orientation & to be tracked with all mandatory orientation requirements. g. Work with Nsg Ed re: training of clinical staff during nsg orientation on how to enter an RL 6 & the plan for implementation. h. Risk Mgt to create list for leaders & clinical staff on when Risk Mgt should be paged (event types & particular severity levels) & provide to Mgrs. **MOS: Complete list.**	Submit name to DOH - await approval 10/30/2014 11/30/2014 12/1/2014 11/30/2014 9/30/2014

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Z940	Continued From page 13	Z940		
			i. In addition to Risk Mgt's usual availability to support leadership with RL 6 technical issues Risk Mgt will schedule quarterly meetings with Mgrs/Directors/various Nursing Practice Councils to support & assist staff with RL 6. **MOS: 100% compliance with scheduling mtgs.**	12/1/2014
			j. Explore with RL Solutions whether Risk Mgt staff can receive automatic notification via email if an RL 6 is entered with severity level of E or greater. If so, change profiles of Risk Mgt staff.	9/30/2014
			k. **Audit:** All reporting to DOH will be reviewed for date & timeliness reported in RL 6; how Risk Mgt was notified, date report sent to DOH & timeliness; if not timely DOH report, why – RM, unit or other issue; & specific reason. Copies of audit findings will be sent to Mgrs/Directors, Practice Council Steering Committee, CNO & President.	9/30/2014 – 3/30/2015
			MOS: All units will be at 100% compliance with on time reporting in RL 6 & to RM.	3/30/2015
			MOS: Risk Mgt will be at 100% compliance with reporting to DOH.	3/30/2015

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St. Joseph Health Services of Rhode Island

WWW.SAINTJOSEPHRI.COM

200 HIGH SERVICE AVENUE
NORTH PROVIDENCE, RI 02904
(401) 456-3000

April 22, 2013

Raymond Rusin, Chief
RI Department of Health, Division of Facilities Regulations
Three Capitol Hill
Providence, RI 02908
In Hand with Return Receipt

RE: HOS00110, survey completed 3/6/2013

Dear Mr. Rusin:

Documents:

Enclosed please find St. Joseph Health Services of RI's Plan of Correction for citations received in the Statement of Deficiencies from the Rhode Island Department of Health for a survey beginning on January 22, 2013 that was completed March 6, 2013.

In addition, I would like to acknowledge Madeline Vincent & her staff who will be meeting with Pat Nadle on Thursday, April 25, 2013 to enhance our attached Action Plan.

Sincerely,

Kenneth Belcher
President & CEO
St. Joseph Health Services of RI

Attachment

cc: Madeline Vincent
Michael Conklin
Kim O'Connell, Esquire
Patricia Nadle

Hand deliver to Raymond Rusin, Chief, Action Plan for HOS00110, survey completed 3/6/2013 on Monday, April 22, 2013.

Austin Power

NAME

4/22/13

DATE

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Z 0	INITIAL COMMENTS A State complaint investigation survey, an "Other" State survey (1ON111, 3/06/13), and a follow-up to a State complaint investigation survey (*J07112, 3/06/13) were conducted at this facility. Prior deficiencies were recited and deficiencies were cited relative to the State complaint investigation and the "Other" State survey.	Z0	**In order to maintain gains for all ongoing monitoring below, adjustments of Action Plans will be made as necessary.**	
Z 160	ORGANIZATION & MANGEMENT 12.2 Organization 12.2 Each hospital department and service shall maintain: a) clearly written definitions of its organization, authority, responsibility and relationships; b)written patient care policies and procedures; and c) written provision for systematic evaluation of programs and services. This Requirement is not met as evidenced by: cBased on record review, staff interview , and review of hospital policies, it was determined that the hospital failed to implement the policy entitled "Constant Observation" for 1 of 3 relevant sample patients (ID #'s 8, 15, 29, 30 and 32). Findings are as follows: 1. A review of the hospital policy entitled "Constant Observation," under "Policy" states: "It is hospital policy to institute a level of Constant Observation for the patient who manifests one or more of the following criteria: Imminent threat to physical or emotional	Z 160	**<u>Elopement of SI Pt on Constant Observation:</u>** 1. ED will utilize a CNA identified from the CNA pool, who will to fill the role of constant observer 24/7, if needed. **MOS: Target 100%** -Confirm availability and utilization of CNA as constant observer from staffing sheets for 1 mth. 2. Review & revise Constant Observation Policy #N-7 in conjunction w/ Suicide Precautions Policy #N-19 & Elopement of Patients Policy # N-21 (along with Security Elopement policy #B-002) to meet best practice guidelines and will include but not be limited to: (define 1 to 1 v. line of site & other types of observation; remove contradictions from policy; add section for non-clinical observer; revise decision algorithm; & develop consistent documentation tool to be utilized by constant observer.) 3. Education of revisions of N-7, N-19, & N-21 for all areas that may have a pt on constant observation: {ED, Housewide	5/31/13 Pt. Safety: 6/13/13 5/31/13 6/30/13

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Kenneth Allen President/CEO 4/22/13

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Z 160	Continue From page 1 well-being (Suicidal or Violent Behavior Precautions) including but not limited to: Reported suicidal/homicidal ideation's." Under "Procedure" it states: "At no time should the patient be left alone or unobserved (exception: diagnostic testing)" A review of the clinical record for patient ID #49 revealed that the patient was transported to the hospital via EMS (Emergency Medical Services) for a psychiatric evaluation after a hanging attempt. The patient was evaluated by behavioral health services, and the case was discussed with a hospital psychiatrist. It was determined that the patient would be admitted for suicidal ideation. Physician's orders while in the ED revealed the patient to be placed on "one to one" constant observation. A review of the ED physician's note revealed "Appropriate security watch urgently ordered by me after the patient's arrival in ED; patient is a potential danger to self." Review of the ED documentation revealed that at approximately 9:30 AM the patient eloped from the hospital. The police were notified, and the patient was located and returned to the hospital. During an interview on 2/21/13 at approximately 9:30 AM with the Director or Security; he reported that the SO (Security Officer) assigned to constant observation of the patient was "watching 3 rooms at that time". He further reported that the patient was on constant observation for suicidal and elopement risk, and "should have been 1:1 with the officer". Additionally, the officer should not have been watching other	Z 160	(include per diem & float staff RNs, CNAs & MHWs), & Security.} **MOS: 90 - 100% Compliance** –Read & Sign policies which will be documented in API tracking software. 4. Develop annual mandatory competency for constant observation re: role, intention, requirements & documentation. This competency will be completed by: All ED staff, security, & float staff who work in ED. **MOS: 90-100% Compliance** - Completion of competency. **MOS: 100% Compliance** **Audit 100% charts/ mth for 3 mths** to determine if suicidal/homicidal pts are actually placed on constant observation & documentation complete. Also, audit all elopements from ED to insure no pts were SI/HI or certified at time of elopement for 3 mths. 5. All ED staff will complete 8 hrs of CPI training initially & recert thereafter: (RNs, CNAs, Security, & Float Staff). Plan developed to insure new staff hired to work in ED will be trained w/in 3 mths of hire. **MOS: 100% Compliance** Current staff will successfully complete 8 hrs of CPI training **50% by 6-30-13; 75% by 7-31-13; & 100% by 12-18-13.** 6. Low Stimulus Unit (LSU) will be adequately staffed to allow this area to be open & available to BH pts where there will be enhanced security presence & monitoring by staff. **MOS: 90% Compliance** **Audit** dates & times that LSU is **not** open for **3 mths** to determine reason(s).	Pt. Safety: 7/11/13 7/31/13 & Yearly Pt. Safety: 9/13/13 8/31/13 Pt. Safety: 9/12/13; 10/10/13 & 11/14/13 12/18/13 Pt. Safety: 9/12/13; 10/10/13 & 1/2014 5/31/13 Pt. Safety: 7/11/13, 9/12/13 & 10/10/13

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Z 160	Continued From page 2 patients at that time". The hospital failed to provide 1:1 constant observation in accordance with physician's orders and hospital policy. II. A review of the hospital policy entitled "Fall Precaution Policy, " states under "Policy Statement": "Every adult patient will be assessed for risk of falling on presentation to the Emergency Department and on admission. Reassessment will be completed at least daily; on transfer from one unit to another; following a fall or more frequently as determined by patient status." Under "Policy" it states: Item #3 "Under the direction of the Registered Nurse, the High Risk Interventions will be implemented for patients who are assessed to be a High Fall Risk based on a Schmid score – 3 or greater. The following actions are required to initiate the program: (a) The Kardex will be stamped High Fall Risk; the numerical score result from the Schmid assessment and the date that assessment was completed will also be entered. (b) Patients who have been assessed to be at High Fall Risk will be further identified by placing a yellow bracelet and yellow slipper socks on the patient." Under "Post Fall Management," it states: Item #6. "Notify the attending physician and the	Z 160	7. Further Education will be provided w/ a mandatory quiz/competency for all RNs. **MOS: 100% Compliance** Completion of competency. **Patient Falls:** 1. Reviewed & revised Fall Prevention Protocol Policy # N-41- improve nsg comprehension of protocol. **-Policy approval** - Nsg Admin. 2. In EMR, add additional queries to safety assessment interventions. 3. In order to be scheduled for work post 6/01/13, all staff must document –Read & Sign revised policy (RNs, CNAs, & MHWs, including PD staff). **MOS: 100%** Required to Read & Sign which will be documented in API Tracking software. 4. Mandatory education for RNs, CNAs & MHWs on policy w/ emphasis on interventions associated w/ high v. low risk assess & documentation (during Skills Weeks) w/quiz. **MOS: 100% Compliance - Staff take quiz.** **Nsg Mgrs Audit: 5 records/wk/unit for 30 days-then mthly** (Documentation of interventions & did intervention fulfill intent) **until Compliance is 100%.** Then auditing will be reassessed. 5. Mandatory Education of Pharm staff on Schmid Fall Risk Assess & meds.	Fall 2013 4/26/13 4/26/13 5/30/13 Pt. Safety: 6/13/13 5/30/13 Pt. Safety: 6/13/13 Pt. Safety: 7/11/13, 9/12/13, 10/10/13 5/13/13

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	HOS00110	A. BUILDING:_____ B. WING_____	03/06/2013

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Z 160	Continued From page 3 family of the fall. This notification can be completed during regular business hours providing the patient has not been injured." Item #7. "Reassess fall risk; review fall prevention interventions that were in place, it any, and modify plan of care as indicated." Item #8. "Document that the patient has fallen on the Kardex, in the SAFETY/RISK FACTOR SECTION and include date and time." 1. A review of the clinical record for patient ID #15 revealed a 76-year-old developmentally delayed patient who was transferred to the hospital from a group home after falling and sustaining a bruise to the right thigh and hip area. The patient was noted to have right sided back pain with swelling and a contusion. Record review indicates a Schmid Fall Risk assessment done in the ED (emergency department) scored the patient as 4 – indicating a "High" falls risk. There lacked evidence of a yellow bracelet or yellow socks placed on the patient in accordance with hospital policy. Additionally, while in the ED on 6/7/12 at approximately 11:30 PM, the patient was being assisted to a wheelchair by a nursing assistant, and suffered a fall which resulted in a fractured femur. Review of the patient's Kardex lacked evidence of the date and time of the fall, and the numerical score from the Schmid Assessment. There also lacked evidence of a falls reassessment after the fall, or any modification to the patient's plan of care. 2. A review of the clinical record for patient ID #32 reveals that the patient was brought to the hospital after tripping and falling at home. The	Z 160	**MOS: Competency Test.** 6. RPh will attend post fall huddles or rev meds w/in 24 hrs post fall. **-RPh interventions tracked & trended** in Meditech - ID if meds contributed to fall. The interventions will be used to determine if med patterns require education & revisions. 7. External expert on geriatric pharm & meds associated w/ falls will be brought in. Goal: to enhance the current Pharm Dept's efforts in conjunction with BH Unit practitioners & staff to provide evidence – based med guidelines for this pt population. **MOS:** Once the suggested guidelines have been created, utilization of guidelines will be initiated in effort to reduce variations. 8. Interactive educational sessions w/ nursing leader of a local skilled facility who has implemented a successful fall reduction plan- initially w/ Falls Comm, then to wider hospital audience. **MOS: Monitor** Fall Rates measured on all hosp units, including ED & outpt areas- Ongoing. **Target: 20% ↓ # of falls 12/2013.** 9. Focus Groups w/ ED, 3S & 4S staff to ID barriers to successfully ↓ # of falls & severity of injuries & address/correct/eliminate barriers as appropriate. **- Report findings** from Focus Groups along w/ resolution(s) or if unable to resolve, discuss next steps. Apply resolutions to other units as appropriate. -**Monitor** individual Unit Fall Rates- Ongoing.	Starting 5/14/13 Pt Safety: Monthly P&T: Ongoing Visit: 7/17/13 Pt. Safety: 9/12/13 for 6 Mths P&T: 9/2013 & Ongoing 6/22/13 - Falls Comm; & 12/30/13 - hosp audience Falls Comm. & Pt. Safety: Mthly 5/30/13 Falls Comm. & Pt. Safety: 6/13/13 Mthly

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Z 160	Continued From page 4 patient was complaining of right knee and hip pain as well as lower back pain. Although the Schmid Fall Risk assessment completed while in the ED revealed a score of 2 (low), the patient's fall risk was documented as "High," indicating that yellow socks and bracelet should be placed on the patient. The patient's ambulatory status was noted to be documented as "unable to ambulate". A "Standard Initial Care" ID Band was applied to the patient. There lacked evidence of a yellow band and yellow socks being placed on the patient. While in the ED the patient suffered a fall in the bathroom while being assisted to the toilet by a Registered Nurse. The patient complained of discomfort in the right lower leg. The patient was lifted from the floor back to a wheelchair and brought back to bed. Review of the ED nursing documentation reveals that the patient complained of right lower leg pain, with the anterior leg slightly red and warm to touch. Motrin was given for pain. The clinical record lacked evidence of a falls reassessment after the fall, with no new falls interventions and evidence that the family was notified of the fall. 3. A review of the clinical record for patient ID #8 revealed a 6/8/12 Schmid Fall Risk assessment which indicates a score of 2, a low risk for falls. At approximately 10:55 PM on 6/9/12 the patient fell while going to the bathroom, hitting her head. Review of the patient's Kardex reveals that the yellow bracelet and yellow slipper socks were not placed on the patient until 6/10/12 at 8:00 AM. The patient "Activity Assessment" following the fall on 6/10/12 at 8:00 AM indicates that the patient activity was "up ad lib." The Kardex also revealed a Schmid Fall Risk reassessment was not done until 6/10/12 at approximately 11:14 AM	Z 160	10. Develop plan & implement expansion of participation in post fall huddles & completion of fall huddle form. **MOS:** **Audit 100% of falls/mth** to determine if a post fall huddle is conducted & if post fall huddle form is completed. **Target 20% ↑/mth. Target: > 90% by 12/2013.** 11. Integrate info into post falls assess in Meditech & MERs. **MOS:** **Audit MERs falls reports weekly** - Insure Mgt completion of Registration/Discovery & Q/PI pgs of MERs. **Target: 20% ↑/mth until 95%.** Note: An additional recommendation is being made to require all Geriatric Psychiatry RNs to complete Geriatric Nursing classes offered through CharterCARE Continuum of Care, beginning 9/2013, with the goal of successful completion of Gerontological Nsg Certification Exam by said RNs by 12/2014	6/22/13 Falls Comm. & Pt. Safety: 7/11/13 & Mthly Pt. Safety: 7/11/13 & Mthly

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Z 160	Continued From page 5 and indicates a score of 3 (high), however the Fall Risk is noted to be "low". 4. A review of the clinical record for patient ID #29 revealed that the patient was brought to the ED on 6/4/12 after an unwitnessed fall at nursing home. Review of the Schmid Fall Risk completed in the ED reveals a score of 5, indicating that the patient is a "High" falls risk. The ED documentation also indicates the patient has had multiple falls. The record reveals that a "Standard Initial Care" ID bracelet was placed on the patient. There lacked evidence of a yellow bracelet and yellow socks being placed on the patient in accordance with hospital policy. Review of the patient's Kardex lacked evidence of numerical score of the Schmid Assessment, and also lacked a date and time the assessment was done. 5. A review of the clinical record of patient ID #30 reveals that the patient was brought to the ED from a nursing home for projectile vomiting. The Schmid Fall Risk completed in the ED indicates the patient is a "High" falls risk with a numerical score of 3. A "Standard Initial Care" ID Band was applied. There is no evidence of a yellow band and yellow socks being applied to the patient. When interviewed on 2/19/13 at approximately 11 AM, the Director of Nursing Services and the Clinical Manager of the Emergency Department reported that appropriate interventions for falls risk were not in this patient's chart, and that more interventions should have been put in place, and also indicated there was no reassessment after the patient fell. During an interview with the Risk Manager on 2/27/13 at approximately 11:00 AM, it was	Z 160		

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Z 160	Continued From page 6 reported that if a patient scores "High" on a Falls Risk Assessment, the falls risk should not be documented as "Low."	Z 160		
Z 370	PATIENT CARE SERVICES 19.6 PATIENT CARE MANAGEMENT 19.6 The hospital shall provide care and services to all patients in accordance with the prevailing community standard of care. This Requirement is not met as evidenced by: Based on record review and staff interview it has been determined that the facility failed to provide care in accordance with community standards, for 3 of 8 patients reviewed (ID #'s 26, 43 and 59), relative to assessment of bowel function on admission and ongoing throughout the hospital stay, and offering laxatives in accordance with standards of care. Findings are as follows: 1. A review of the clinical record for patient ID #26 revealed a 56-year-old admitted to the behavioral health unit on 8/28/12 from a long term care facility with SI (suicidal ideation) and depression. The patient has a past medical history of schizophrenia, seizure disorder, GERD (gastroesophageal reflux disease) and recurrent problems with constipation. A medical consult was performed on 8/31/12. The physical exam revealed a "distended abdomen" and "no normal bowel sounds." A review of the patient's bowel movement record reveals that from 8/29/12 – 9/2/12 (5 days) the patient did not move his bowels, and the PRN (as needed) order for Milk of Magnesia (MOM) was	Z 370	**Assess & Monitor Bowel Function:** 1. Set clear expectations & rev expectations of documentation re: completing bowel assess initially & every shift w/ all RNs of 2 Center. o Rev offer/use of PRN meds in relation indications from bowel assess. **MOS: 100%** of 2 Center RNs will attend mtg re: expectations of bowel assess (sign in sheets.) 2. Mgt will deal w/ findings from audits re: non- compliance by counseling individuals or review & education collectively as appropriate. **MOS: Audit 100% of charts/wk for 3 mth** re: assess of bowel functioning each shift & use of PRN laxatives, as needed **until 95 – 100% compliance; then audit 5 charts/mth - Ongoing.** 3. Add date of last bowel movement to shift - shift Hand Off Report Form. **MOS: 100% of 2 Center RNs** will be educated on revision to shift - shift report form. (sign in sheets.) **MOS: 100% Compliance. Audit observations of 5 Hand offs (on each shift) /mth until 100% compliance** and periodically for hardwiring the process.	5/31/13 Pt. Safety: 6/13/13 6/30/13 Pt. Safety: 7/11/13, 9/12/13 & 10/10/13 5/13/13 Pt. Safety: 6/13/13 6/30/13 Pt. Safety: 7/11/13, 9/12/13 & 10/10/13

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Z 370	Continued From page 7 not administered. On the evening of 9/2/12 the patient vomited and was noted to have a markedly distended abdomen. An abdominal film revealed "extensive small bowel and colonic detention with stool in the rectal vault". The impression revealed "the findings may be chronic but this raises the concern of distal colonic obstruction." 2. A review of the clinical record for patient ID #43 reveals an admission to the hospital on 2/4/13 for increased depression. The patient has a physician's order for MOM 30 ml (milliliters) daily, PRN (as needed) for constipation. The patient's bowel movement record revealed that the patient did not move bowels on 2/8 2/9 and 2/10. The MAR (Medication Administration Record) for this patient lacked evidence that the PRN MOM was administered. The patient was discharged on 2/11/13. 3. A review of the clinical record for patient ID #59 reveals an admission to the hospital on 2/13/13 for depression and SI (suicidal ideation). The patient had a physician's order for MOM 30 ml daily, PRN for constipation. The patient's bowel movement record reveals that the patient did not move bowels on 2/14, 2/15 and 2/16. Review of the MAR for this patient lacked evidence that the PRN MOM was administered as ordered. When interviewed on 2/12/13 at approximately 1:30 PM, the Clinical Nursing Manager for the unit, reported that the expectation is for the nurse to assess the patient for bowel sounds and to check what medications are ordered for the patient. She indicated that the MOM should have been administered after the second or third day if no bowel movement.	Z 370		

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Z 375	PATIENT CARE SERVICES 19.7 PATIENT CARE MANAGEMENT 19.7 Medical Restraints: In acute medical and pre/post-surgical care, a patient shall be free from physical and chemical restraint that is not medically necessary. A restraint shall only be used if needed to improve the patient's well-being and only if less restrictive interventions have been determined to be ineffective to protect the patient or others from harm. Behavioral Restraints: A patient shall be free from seclusion or restraint imposed as a means of coercion, discipline, convenience or retaliation by staff. Seclusion or restraint employed for behavior management shall only be used in emergency situations if needed to ensure the patient's or other's physical safety and less restrictive interventions have been determined to be ineffective. 19.7.1 Restraints/seclusion use shall be prescribed in writing and signed by a physician or other licensed practitioner acting within his/her scope of practice and permitted by the hospital to order restraints/seclusion. The type and duration of restraints/seclusion shall be specified. Standing or "on an as needed basis" (i.e., PRN) orders shall not be permitted. 19.7.2 Restraints/seclusion, if used, shall be addressed in the written treatment plan for the patient. 19.7.3 Restraints/seclusion use shall be based on an assessment of the patient, implemented in the least restrictive manner possible, implemented in accordance with safe and appropriate restraining techniques, and discontinued at the earliest possible time. 19.7.4 The condition of a restrained/secluded patient shall be continually assessed, monitored, and revaluated.	Z 375	**Use of a Chemical Restraint in The ED:** 1. All ED staff including RNs, LIPs & MDs will Read & Sign Restraint Seclusion & Restraint Alternatives Policy #04.953.282. **MOS: 100% Compliance** (sign in sheets.) 2. Develop education re: definition of chem restraint; ways to approach pt inclusive of MH Laws (vol v. invol admin of med); providing guideline scripts for staff; what to do when a pt lacks capacity; clarifying use of a chem restraint in ED; & appropriate documentation of a chem restraint. This event will be presented as a case study. Points to consider: use of chem. restraint; Pt. Rts; & alternative methods. 3. All ED RNs, LIPs & MDs will attend & participate in above education. **MOS: 100% Compliance** (sign in sheets.) 4. Develop & present 4 case studies (ED scenarios) at clinical mtgs w/ all RN staff where staff actively present scenarios & participate in discussion of ways to handle additional situations. **MOS: 100% Compliance** (sign in sheets.) 5. Pharm will conduct a 14 day retrospective review of Haldol use in ED to obtain baseline of Haldol utilization & provide data to ED Mgr, who w/ assistance of Med Dir of ED, will review the data to insure there are no trends involving Haldol use for chem restraint. 6. Current restraint audit tool will now include appropriate use of chem restraints as well as	5/31/13 Pt. Safety: 6/13/13 5/31/13 6/30/13 Pt. Safety: 7/11/13 7/31/13 Pt. Safety: 9/12/13 5/6/13 6/30/13 6/30/13

Facilities Regulation

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Z 375	Continued From page 9 This Requirement is not met as evidenced by: Based on review of the clinical record and staff interview it has been determined that the hospital failed to ensure that less restrictive interventions and/or alternatives had been employed and ineffective prior to chemically restraining 1 of 6 patients with a change in mental status. (ID#6) Findings are as follows: A review of the clinical record for patient ID #6 reveals a transport to the hospital on 9/9/12 from an Assisted Living Facility (ALF) for a change in mental status. Review of the COC (Continuity of Care) form from the ALF revealed "Patient change in mental status. Acting out upon staff and other residents even after PRN (as needed) Ativan given". The patient has a past medical history of HTN (hypertension), Bipolar disorder, Parkinsonism and Schizophrenia. The patient was placed on constant observation in the ED, and was evaluated by a behavioral health center. The assessment indicated that an inpatient admission would not be appropriate as the "...pt does not appear to be exhibiting extreme behaviors that are out of norm. Pt does not meet inpatient criteria at this time." The patient remained in the ED until his discharge on 9/10/12. The ED record reveals that the patient's behavior during his observation period was "alert and oriented and often times sleeping". When awake, the patient was noted to have appropriate behavior and was "relaxed and cooperative". On 9/10/12 at approximately 1920 (7:20 PM) the patient was noted to be yelling and swearing regarding not leaving the hospital. The patient requested to stay in the hospital "because he	Z 375	phys restraints. **MOS:** **Audit 100% of restraints used** (including chem restraint use) **in ED/mth for a min of 3 mths until compliance is 100%.** Then determination to be made for future monitoring.	Pt. Safety: 9/12/13

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Z 375	Continued From page 10 likes it better here". Record documentation revealed "MD in to talk with Pt. and was yelled at. MD ordered 10mg Haldol IM (intramuscular) and given." The patient was noted to continue to yell and was subsequently administered 2 mg of Ativan and 50 mg of Dipenhydramine IM as ordered. The Haldol was administered at 7 PM and the Ativan and Dipenhydramine were both administered at 7:19 PM. The patient left the facility at 7:40 PM. When interviewed on 1/25/13 at approximately 12:30 PM, the nurse who administered the medications indicated the patient was fine during the shift. It was when the patient was told that he/she would be returning to the ALF that he/she became verbal and argumentative, but not physically aggressive. The nurse revealed that the patient calmed down after administration of all above medications, and remained non-combative and cooperative while waiting for the ambulance. Interview on 1/29/13 at 1:00 PM with the PA (Physician's Assistant) who ordered the medication, revealed that the patient was calm and non-combative, and receiving his regularly scheduled medications. The patient reportedly only became agitated when EMS (Emergency Medical Services) arrived, at which point the patient began yelling and escalated and was unable to calm down; he was medicated and did calm down after about 10 minutes. When asked if any of the patient's discharge medications were changed, the PA stated "no, all of the patient's medications he was receiving before coming to the ED remained the same". When interviewed on 1/31/13 at 9:00 AM, the licensed clinical social worker from the behavioral health center who evaluated the patient indicated	Z 375		

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Z 375	Continued From page 11 that the patient's behavior was fine, he was cooperative, non combative and not physically aggressive. It was based on this evaluation that the patient was deemed appropriate to discharge back to the ALF. There was no evidence that the patient had been physically aggressive or combative during his stay in the ED. There was no evidence that alternative or less restrictive methods were tried prior to administering the chemical restraint.	Z 375		
10	PATIENT CARE SERVICES 34.8 Reportable Incidents 34.8 Any reportable incident occurring on or after June 30, 1994 shall be reported in writing to the Department of Health within seventy-two (72) hours of when the hospital has reasonable cause to believe an incident has occurred. Any incident(s) occurring prior to June 30, 1994 need not be reported. This Requirement is not met as evidenced by: Based on review of hospital occurrence reports submitted to the Department of Health, and staff interview, it was determined that the hospital failed to report to the licensing agency, within 72 hours, reportable incidents/event for 5 of 18 relevant sample patients (ID #'s 52, 55, 61, 62 and 63) Findings are as follows: 1. A reportable incident occurring for patient ID #52 on 12/4/12 was not reported to the licensing agency until 12/15/12. 2. A reportable incident occurring for patient ID #55 on 11/16/12 was not reported to the licensing	Z 940	**Late Reporting of Incidents (Crowley Bill) to DOH:** 1. Review & revise Incident Reporting Policy #03-957-03. 2. Review & revise Hosp Incident/Events Reporting to RI DOH Policy #01-950-83. 3. Develop & present Education at Nsg Leadership & Nsg Supervisors re: revisions to policies; types of events to be reported & importance of timely reporting in MERs by end of shift; & type of info initially needed to include in MERs. RM will provide Talking Points for Mgrs re: Types of events/incidents reportable w/in 24-72 hrs of event; Mgr/Dir/ Supervisor to page RM for all incidents resulting in major harm/death/a sentinel events and call or voice msg RM for all events that result in moderate harm; & all depts w/ paper MR to provide copies of applicable sections of MR to RM via fax w/in 24 hrs of a reportable incident. **MOS: 100 % Compliance** - Attendance (sign in sheets.)	5/31/13 5/31/13 6/30/13 Pt. Safety: 7/11/13

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	HOS00110	A. BUILDING:_____ B. WING_____	03/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST. JOSEPH HEALTH SERVICES OF RI	200 HIGH SERVICE AVENUE NORTH PROVIDENCE, RI 02904

(X) ID PREFEX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC INDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z 940	Continued From page 12 agency until 11/30/12. 3. A reportable incident occurring for patient ID #61 on 8/7/12 was not reported to the licensing agency until 9/25/12. 4. A reportable event occurring for patient ID #62 on 9/26/12 was not reported to the licensing agency until 10/3/12. Continued From page 12 5. A reportable incident occurring for patient ID #63 on 9/14/12 was not reported to the licensing agency until 10/3/12. During an interview on 3/5/13 at approximately 1:30 PM with the Risk Manager, she was unable to provide evidence that the above incidents/event were reported to the licensing agency within 72 hours.	Z 940	4. Nsg Mgrs/Dir hold staff mtgs w/RNs to rev presentation presented at Leadership, Read & Sign policies & have all RNs complete a PP competency & quiz on types of incidents that should be reported in MERs including but not limited to "Crowley Bill" DOH reportable incidents & timely reporting in MERs during shift in which incident occurred. **MOS: 100% Compliance of Nsg units** – hold meeting w/ RNs (minutes from mtgs.) **MOS: 100% of all RNs** will Read & Sign policies which will be documented in API tracking software. **MOS: 100% Compliance**- all RNs complete PP & quiz, which will be documented in API tracking software. 5. RM to provide Education to specific areas w/ high non-compliance identified by baseline audits. Areas of non-compliance will be identified by baseline audit of 100% of DOH reports - 4th Q 2012 & 1st Q 2013. 6. Claims Coord/ MERs Adm will increase hrs from 20 to 40 hr/week in RM Dept - taking on responsibilities that do not require clinical judgment. 7. RM Dept will only include essential elements in initial report/notification to DOH. **MOS: 95% - 100% Compliance**-timely reporting to DOH. **Audit: 100% of DOH** reports/mth for untimeliness of reporting & reasons. Develop action plans accordingly.	7/31/13 Pt. Safety: 9/12/13 Pt. Safety: 9/12/13 Audits: 7/11/13 Pt. Safety: 7/11/13 5/1/13 Ongoing Pt. Safety: 7/11/13 & Mthly until 95-100%

Facilities Regulation

Department of Health
Three Capitol Hill
Providence, RI 02908-5097
TTY: 711
www.health.ri.gov

Received
SEP 30 2013
Kenneth H. Belcher
President / CEO

September 24, 2013

Mr. Kenneth Belcher, President/CEO
Roger Williams Medical Center
825 Chalkstone Avenue
Providence, RI 02908

Dear Mr. Belcher:

This office has received the Plan of Correction for the deficiencies cited as a result of our review completed on August 20, 2013. The provisions and time frames for your corrective action is determined to be acceptable.

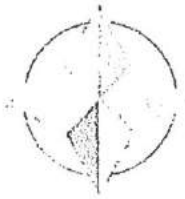
Please note that a member of the Facilities Regulation staff will make an unannounced site visit to the hospital to ensure compliance has been achieved.

If you have any questions, please contact Madeline Vincent at 401-222-2566.

Sincerely,

Raymond Rusin, Chief
Facilities Regulation
(401) 222-2566

MV



WWW.CHARTERCARE.ORG

CharterCARE
HEALTH PARTNERS

September 13, 2013

Raymond Rusin
Chief Facilities Regulation
Department of Health
Three Capitol Hill
Providence, RI 02908-5097

RE: Investigation completed on August 20, 2013

Dear Mr. Rusin:

This is in response to your correspondence to me dated August 29, 2013 in regards to our hospital not being in compliance with the Rules and Regulations for Licensing of Hospitals and corresponding citations noted on the enclosed Statement of Deficiencies (State Form).

Please see our plan of correction on the State Form (Provider's Plan of Correction) with the date of completion, signed and dated as per your request.

Should you have any questions please feel free to call myself at 456-2025 or Joyce Hackley, Director, Risk Management at 456-2405.

Sincerely,

Kenneth H. Belcher
President/CEO

PRINTED 03/23/2011
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HOS00108	A. BUILDING _____ B. WING _____	8/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROGER WILLIAMS MEDICAL CENTER	825 CHALKSTONE AVENUE PROVIDENCE RI 02908

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDEBYFULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIFICENCY	(X5) COMPLETION DATE
Z 115	ORGANIZATION & MANAGEMENT 9.5 Quality Improvement	Z 115	**Plan:** All reportable incidents under 23-17-40 Hospital Event Reporting will be reported to the Department of Health (DOH) within seventy-two (72) hours. All incidents will be presented to the appropriate committee within the hospital and have a peer review performed, with notification back to the DOH within 6 months from the date of the initial report. **Do:** **Patient ID #33** related to an incident occurring on 12/5/2012 was brought to the appropriate peer review committee on August 29, 2013. Once the peer review is received it will be presented to the peer review committee and the DOH will be notified of the outcome of the internal review as soon as the information is made available as is our usual practice. **Check:** Committee minutes will reflect the discussion by the members of the peer review and the outcome. Follow-up report will be sent to the DOH via Health's secured web file repository. Confirmation of file will be attached to hospital copy of the Follow-up report that was sent. A log will be kept in Risk Management to track the date of the incident, date sent to the DOH, date incident brought to the peer review committee and date closed.	10/18/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE CEO | (X6) DATE 9/13/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HOS00108	A. BUILDING _____ B. WING	8/20/13

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROGER WILLIAMS MEDICAL CENTER	825 CHALKSTONE AVENUE PROVIDENCE RI 02908

Z 940	PATIENT CARE SERVICES 34.8 Reportable Incidents	Z 940	**Plan:** All reportable incidents under 23-17-40 Hospital Event Reporting will be reported to the Department of Health (DOH) within seventy-two (72) hours of when the hospital has reasonable cause to believe an incident has occurred. **Do :** **Patient ID #'s 15, 34, 35, 36 & 37** and all other incidents that the hospital decides to report to our malpractice insurance carrier will be reported to the DOH within 72 hours of us reporting the incident to our malpractice insurer unless the incident met one of the reporting requirements other than "reported to the malpractice insurance carrier". We will explain in the brief description of the Hospital Incident reporting form the reason for the difference in the date of the report and the incident date. Our records reveal that **ID#37** has a date of incident of 10/4/12; decision made to report to our malpractice insurer as a precautionary measure on 10/24/12 and reported to the DOH on 10/24/12. Hospital Incident reporting form asked to be resent to the DOH on 11/2/12. See attachment #1. **Check:** Documentation of the reason that the date of the incident and the reported date are greater than 72 hours within the brief description of the Hospital Incident reporting form. A log will be kept in Risk Management to track the date incident was reported to the malpractice insurer and the date the incident was reported to the DOH when the date reported to the DOH is greater than 72 hours from the date of the incident.	9/26/13

CEO 7/13/15

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED 03/23/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HOS00108	A. BUILDING _____ B. WING _____	8/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROGER WILLIAMS MEDICAL CENTER	825 CHALKSTONE AVENUE PROVIDENCE RI 02908

Z 950	PATIENT CARE SERVICES 34.10 Reportable Incidents	Z950	**Plan:** The hospital shall notify the licensing agency of the outcome of the internal review as soon as this information is available but no later than six (6) months after the initial report. **Do:** A "Follow-up Report" will be submitted to the licensing agency within the six (6) month time period after the submission of the initial report via Health's secured web file repository. **Check:** Monthly follow-up calls and written correspondence to all peer reviewers if the review has not been received to date. Documentation of actions will be kept with all individual incident minutes. Untimely return of the peer review by the requested reviewer will be reported to the Quality Department every three months and will be tied to the OPPE process which is tied to the reappointment process.	9/26/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: P Melcher — TITLE: CEO — (X6) DATE: 9/13/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Department of Health
Three Capitol Hill
Providence, RI 02908-5097
TTY: 711
www.health.ri.gov

Received
SEP 03 2013
Kenneth H. Belcher
President / CEO

August 29, 2013

Mr. Kenneth Belcher, Administrator
Roger Williams Medical Center
825 Chalkstone Avenue
Providence, RI 02908

Re: Investigation completed on August 20, 2013

Dear Mr Belcher:

This letter is a follow-up to an investigation completed at Roger Williams Medical Center on August 20, 2013. This visit included, but was not limited to, investigation of complaints regarding allegations of non-compliance.

Please note the following results for the related Intake ID number (see roster):

RI00027232 - Unsubstantiated
RI00027802 - Unsubstantiated
RI00028701 - Unsubstantiated
RI00029009 - Unsubstantiated
RI00029236 - Unsubstantiated
RI00029502 - Unsubstantiated
RI00029734 - Unsubstantiated
RI00029790 - Unsubstantiated
RI00030644 - Unsubstantiated
RI00030846 - Unsubstantiated
RI00030991 - Unsubstantiated
RI00031101 - Unsubstantiated
RI00031152 - Substantiated, no deficiency
RI00031646 - Unsubstantiated
RI00032154 - Unsubstantiated
RI00033013 - Unsubstantiated
RI00033520 - Unsubstantiated
RI00033622 - Unsubstantiated
RI00033744 - Substantiated, no deficiency
RI00033825 - Unsubstantiated
RI00033936 - Unsubstantiated
RI00034203 - Unsubstantiated
RI00035588 - Unsubstantiated
RI00035803 - Unsubstantiated

This survey found that your facility was not in compliance with the Rules and Regulations for Licensing of Hospitals and citations are noted on the enclosed Statement of Deficiencies (State Form). A plan of correction is required and must be submitted to this office by September 13, 2013. Please enter, in the right hand column of the State Form (Provider's Plan of Correction), your response to each citation with a date of completion (X5 complete date), sign (X6 Date) and return to this office by September 13, 2013.

Your Plan of Correction must contain the following:

· What corrective actions will be accomplished for those patients/situations found to have been affected by the deficient practice;

· How you will identify other patients/situations having the potential to be affected by the same deficient practice and what corrective action will be taken;

· What measures will be put into place of what systemic changes you will make to ensure that the deficient practice does not recur; and,

· How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.

If you have any questions regarding this issue, please call Deborah Massaniso RN SNCE at 401-222-4529..

Thank you for the courtesy extended to our survey staff during this investigation.

Sincerely,

Raymond Rusin, Chief
Facilities Regulation

DM

RI Department of Health

FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HOS00108	A. BUILDING: _____ B. WING _____	08/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROGER WILLIAMS MEDICAL CENTER	825 CHALKSTONE AVENUE PROVIDENCE, RI 02908

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z 0	INITIAL COMMENTS An 'Other' State licensure survey and a State complaint investigation survey (67DO11, 8/30/13) were conducted at this facility. Deficiencies were cited relative to the 'Other' State licensure survey.	Z 0		
Z 115	ORGANIZATION & MANAGEMENT 9.5 Quality Improvement 9.5 All medical and surgical services performed in the hospital shall be evaluated for appropriateness in diagnosis and treatment. The evaluation shall include peer review of individual cases. The hospital shall maintain records of peer reviews, documenting the case(s) reviewed, focus of each review, findings, conclusions, any actions taken, and any follow-up on actions taken. This Requirement is not met as evidenced by: Based on document review and staff interview, it was determined the hospital failed to ensure that a peer review was performed to evaluate for appropriateness in diagnosis and treatment for 1 of 4 relevant sample patients (ID #33). Findings are as follows: The hospital was unable to provide evidence of a peer review for patient ID #33 related to an incident occurring on 12/5/2012. Interview on 8/19/2013 at approximately 12 PM with the Director of Risk Management, revealed a peer review had not been obtained.	Z 115		
Z 940	PATIENT CARE SERVICES 34.8 Reportable Incidents 34.8 Any reportable incident occurring on or	Z 940		

Facilities Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROGER WILLIAMS MEDICAL CENTER	825 CHALKSTONE AVENUE PROVIDENCE, RI 02908

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z 940	Continued From page 1 after June 30, 1994 shall be reported in writing to the Department of Health within seventy-two (72) hours of when the hospital has reasonable cause to believe an incident has occurred. Any incident(s) occurring prior to June 30, 1994 need not be reported. This Requirement is not met as evidenced by: Based on review of hospital occurrence reports submitted to the Department of Health and staff interview, it was determined that the hospital failed to report to the licensing agency, within 72 hours, reportable incidents for 5 of 7 relevant sample patients (ID #s 15, 34, 35, 36 and 37). Findings are as follow: 1. A reportable incident occurring for patient ID # 15 on 9/28/2012 was not reported to the licensing agency until 10/30/2012. 2. A reportable incident occurring for patient ID # 34 on 11/2/2012 was not reported until 11/16/2012. 3. A reportable incident occurring for patient ID # 35 on 9/11/2012 was not reported until 9/21/2012. 4. A reportable incident occurring for patient ID # 36 on 9/19/2012 was not reported until 10/10/2012. 5. A reportable incident occurring for patient ID # 37 on 10/4/2012 was not reported until 10/24/2012. During an interview with the Director of Risk Management on 8/19/2013 at approximately 12 PM, she was unable to provide evidence that the	Z 940		

RI Department of Health

FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HOS00108	A. BUILDING: _____ B. WING _____	08/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z 940	Continued From page 2 above incidents were reported to the licensing agency within the required 72 hours.	Z 940		
Z 950	PATIENT CARE SERVICES 34.10 Reportable Incidents 34.10 The hospital shall ensure an appropriate committee or multidisciplinary group conducts peer review for all reportable incidents. The hospital shall notify the licensing agency of the outcome of the internal review as soon as this information is available but in no case later than six (6) months after the initial report and if the findings determine that the incident was within the normal range of outcomes, no further action shall be required. This Requirement is not met as evidenced by: Based on review of hospital reportable incidents and staff interview, it was determined that the hospital failed to notify the licensing agency, no later than 6 months after the initial report, of the outcome of the peer review for 1 of 7 relevant sample patients (ID #6) Findings are as follows: A review of the hospital's incident reports filed with the Department of Health revealed that the hospital reported the incident, but failed to submit to the licensing agency the " Follow-up Report" within the required time frame of 6 months. A " Follow-up Report " for an incident occurring on 1/4/2012, was not made available to the licensing agency until 8/12/2012. During an interview on 8/19/2013 at approximately 12 PM, the Director of Risk Management was unable to provide evidence that	Z 950		

RI Department of Health

FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HOS00108	A. BUILDING: _____ B. WING _____	08/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROGER WILLIAMS MEDICAL CENTER	825 CHALKSTONE AVENUE PROVIDENCE, RI 02908

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z 950	Continued From page 3 a "Follow-up Report" had been submitted to the licensing agency within the 6 month time frame as required.	Z 950		

EXHIBIT Q48-1 - CHARITY AND BAD DEBT POLICIES

TITLE: **Financial Assistance / Charity Care** **Policy: 500**

TOPIC

Financial Assistance Charity Care

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

PURPOSE

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

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

POLICY:

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

A. Patient
    a. Services are provided under charity care only when deemed medically necessary and after patients are found to have met all financial criteria based on the disclosure of proper information and documentation.
    b. Any patient who believes that they are ualified may apply for financial assistance under the hospitals charity care policy or discount policy.
    c. Patients are expected to contribute payment for care based on their individual financial situation; therefore, each case will be reviewed separately.
    d. Charity Care is not considered an alternative option to payment and patients may be assisted in finding other means of payment or financial assistance before approval for charity care.
    e. Uninsured patients who are believed to have the financial ability to purchase health insurance may be encourage to do so in order to ensure healthcare accessibility and overall well-being.
B. Hospital

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

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

PROCEDURE

a. Services Eligible Under This Policy
i. The following healthcare services are eligible for charity:
1. Emergency medical services provided in an emergency room setting;
2. Services for a condition which, if not promptly treated, would lead to an adverse change in the health status of an individual;
3. Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting; and
4. Medically necessary services, evaluated on a case-by-case basis at ECHN s discretion.

b. Eligibility for Charity Care
1. Eligibility for Charity Care will be based on an individual s assessment of financial need.
2. Re uires an application process.
3. We expect cooperation from patients and guardians.
4. May rely upon publicly available information and resources to determine the financial resources of the patient or a potential guardian.
5. Include a review of the patient s outstanding accounts receivable for prior services rendered and the patient s payment history.
6. The need for financial assistance shall be re-evaluated every six months or at any time additional information relevant to the eligibility of the patient for charity care becomes known.

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

D. ASSESSMENT PROCESS
1. The application must be fully completed and signed by the patient responsible party

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

i. The level of Charity Care provided will be determined based on the Federal Poverty Level in effect (please refer to the current year's sliding scale).
ii. Once a patient has been granted financial assistance, that patient shall not receive any future bills based on undiscounted gross charges.

E. COLLECTION PRACTICES FOR CHARITY CARE PATIENTS

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

DEFINITIONS

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

a. Charity Care means free or discounted health care services rendered by a hospital to persons who cannot afford to pay, including but not limited to, care to the uninsured patient or patients who are expected to pay all or part of a hospital bill based on income guidelines and other financial criteria set forth in statute or in the hospital's charity care policies on file at OCHA.
b. Emergency Care: Immediate care which is necessary to prevent putting the patient's health in serious jeopardy, serious impairment to bodily functions, and serious dysfunction of any organs or parts.
c. Family: Using the Census Bureau definition, a group of two or more people who reside together and who are related by birth, marriage, or adoption. According to Internal revenue Services rules, if the patient claims someone as a dependant on their income tax return, they may be considered a dependent for purposed of the provision of financial assistance.
d. Family Income: family income is determined using the census Bureau definition, which uses the following income when computing federal poverty guidelines.
    i. Includes earnings, unemployment compensation, workers compensation, Social security, Supplemental security Income, public assistance, veterans payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income form estates, trusts, educational assistance, alimony, child support, assistance form outside the household, and other miscellaneous sources.
    ii. Noncash benefits (such as food stamps and housing subsidies) do not count.
    iii. Determined on a before-tax basis
    iv. If a person lives with a family, includes the income of all family members (non-relatives, such as housemates do not count)
e. Medically Necessary: hospital services or care rendered (both inpatient and outpatient) to a patient in order to diagnose, alleviate, correct, cure or prevent the onset or worsening of conditions that endanger

life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, or result in overall illness or infirmity.

f. Presumptive: other financial assistance, not charity care.

g. Underinsured: Patients who carry insurance of have third party assistance to help pay for medical services, but who accrue or have the likelihood of accruing out-of-pocket expenses which exceed their financial ability.

h. Uninsured: means a patient who is without health insurance for whom the payer responsible for payment of the bill for hospital services rendered is the patient, the patient's parent or guardian or another responsible person, who is not a third party payer and who is not subsequently reimbursed by another payer for the cost of any of the services rendered to the patient. A patient shall not be classified an uninsured patient, is such subsequent reimbursement takes place.

i. Urgent Care: Services necessary in order to avoid the onset of illness or injury, disability, death, or serious impairment or dysfunction if treated within 12 hours.

ATTACHMENTS: A

INDIVIDUAL RESPONSIBLE FOR REVISION: Director Patient Financial Services

ORIGINATED: 07/29/02 REVISION DATE: 8/1/05
8/3/07
9/20/10
11/26/12
04/15/13
08/20/14

Notice of Availability for Uncompensated Care

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

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

Family Gross Income Levels

2015 Federal Poverty Guidelines	125%	150%	175%	200%	250%	300%	400%

% of Write Off	100%	90%	80%	70%	60%	50%	40%
Family Size							
1	14,713	17,655	20,598	23,540	29,425	35,310	47,080
2	19,913	23,895	27,878	31,860	39,825	47,790	63,720
3	25,113	30,135	35,158	40,180	50,225	60,270	80,360
4	30,313	36,375	42,438	48,500	60,625	72,750	97,000
5	35,513	42,615	49,718	56,820	71,025	85,230	113,640
6	40,713	48,855	56,998	65,140	81,425	97,710	130,280
7	45,913	55,095	64,278	73,460	91,825	110,190	146,920
8	51,113	61,335	71,558	81,780	102,225	122,670	163,560

Add 4,160 for each additional member

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

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

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

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

Source Federal Register Income Poverty Guidelines

Revised 2 03 2015

TITLE: Credit & Collection / Bad Debt

APPROVING AUTHORITY: Director, Patient Financial Services

DATE: 02/02/14

TOPIC

The Credit & Collection Bad Debt policy for ECHN - Manchester Memorial and Rockville General Hospitals Patient Financial Services.

PURPOSE

To ensure that collection efforts are administered for self-pay deductibles co-pays, co-insurances, and other outstanding patient due balances. ECHN will extend collection efforts which are reasonable and compliant with state and federal guidelines on the pursuit of patient due balances and referral to a collection agency.

POLICY

ECHN is committed to assuring that bad debt write-off will take place only after exhausting all reasonable follow-up efforts for the collection of a unpaid debt. This collections process includes billing third party payers (insurance carriers, etc), direct billing, dunning, and phone calls to the patient guarantor, as well as referral to outside collection agencies.

PROCEDURE

The following guidelines will apply for patients with no insurance or for self pay balances after insurance has paid.

1. Once the charging and coding process concludes, a final bill will be generated and sent to the third party payer for payment. If the patient does not have health insurance (registered as Self-Pay) an itemized statement will be sent directly to the patient for payment.
    a. After the initial bill has generated self-pay encounters are referred to an outsourced vendor (American Adjustment Bureau) which acts as an extension of the business office and handles all Self-Pay balances.
        i. Registered Self Pay is sent to the Outsourced Vendor at day 1.
        ii. Self Pay after insurance is sent to the Outsourced Vendor 1 day after insurance (primary, secondary, or tertiary) has paid the claim.
        iii. The outsourced vendor (American) receives a daily electronic billing file as self pay claims are generated to initiate account resolution actives.
        iv. The outsourced vendor submits a daily acknowledgement file to the hospital to confirm receipt of the assigned inventory. The acknowledgment file is posted on the Early Out folder in the business office shared drive.
2. In accordance with hospital policy, self-pay patients receive:
    a. A series of four (4) statements at approximately 30-day intervals and a pre-collect letter final notice at approximately 15 days after the 4th statement, from the outsourced self-pay vendor (American).
    b. Automated outbound call campaigns are approximately at 30 day intervals to contact patient guarantor to resolve outstanding accounts.

c. The statements include dunning messages which are progressive in informing the patients of their obligation, and include notices that the account may be referred to a collection agency if the balance remains outstanding.

Note: At any point along the self-pay collection cycle a patient can inquire and/or request to be considered for a charity care discount. Signage is posted in all Registration and Customer Service areas and all patient statement include information instructing them on the methods of accessing financial counseling assistance. Financial assistance may include charity care, payment arrangements, or other applicable programs.

d. ECHN currently applies an uninsured discount of 30 on all self-pay accounts (uninsured patients registered as self pay) at the time of billing with the exception of a few outpatient services that have been set up with established discounted rates.(Cardiac Rehab Phase III, Massage Therapy) The hospital s billing and accounts receivable system automatically discounts the account at the time of bill generation.
e. ECHN will approve payment arrangements for patients who agree to a minimum of 50 and the monthly payment will be determined by the total amount due and the number of months contracted, which does not extend more than 24 months. Management has the authority to make exceptions to the policy on a case-by-case basis for special circumstances. ECHN is not re uired to accept patient-initiated payment arrangements and may refer accounts for collection if the patient is unwilling to make acceptable payment arrangements or has defaulted on ECHN approved payment plans.

3. Account balances which have not been resolved after a series of 4 patient statements and a pre-collect notice during the dunning cycle becomes eligible for bad debt write-off.
    a. Bad debt ualification criteria an account may be referred to collection if it meets one or more of the following;
        i. Self-pay balance not paid 120 days after bill date when all reasonable follow-up efforts have been exhausted.
        ii. Guarantor has received 4 statements and a pre-collect letter
        iii. No reasonable response from the patient
        iv. No payment has been received and no financing could be arranged to pay the account in full in the previous 120 days despite at least four contacts with the responsible party.
        v. Guarantor has defaulted on an agree to payment plan.
        vi. Exclusions to this protocol are mail returns, small balances write off (under 5.00), unresolved patient disputes or billing issues and bankruptcy discharges, which may result in early placement to bad debt or early discharge of an account.
4. Any outstanding balances that pertain to a self pay or self pay after insurance that all dunning is complete; the outsourcing vendor (American) sends a monthly electronic file to ECHN for bad debt review and referral to outside bad debt agencies. This report identifies those accounts which have progressed through the complete billing cycle and are ready to be written off to Bad Debt.
5. ECHN reviews the potential bad debt file for any accounts that are not eligible for bad debt write off due to established criteria. The accounts are reviewed for any insurance balances, active pay plans, and accounts with recent payments. Once the pre-collect accounts have been determined, the self-pay collector is changed in Meditech.
6. The collector is changed to reflect the corresponding assignment of the bad debt to one of two contracted collection agents. Claim inventory is split alphabetically with patient last names beginning with letter A L being associated to American adjustment Bureau (PC-AMER) and letter M being assigned to Transcontinental Credit (PC-TRANS).

7. The account balance is subsequently removed from the active accounts receivable and at month end, the system will automatically write off accounts to the assigned collectors agencies and becomes part of the bad debt receivable.
8. Accounts are refered to collections agencies on a monthly basis. The electronic inventory files are sent to the contracted collection agencies to pursue recoveries of the referred accounts.

EXHIBIT Q50-1 OHCA FINANCIAL STATISTICS REPORT (ECHN)

OHCA Financial Statistics Report (April FY 2015 and April FY 2014)

	Manchester Memorial Hospital				Rockville General Hospital				Eastern CT Health Network			
	MTD		YTD		MTD		YTD		MTD		YTD	
	April FY 2015	April FY 2014	April FY 2015	April FY 2014	April FY 2015	April FY 2014	April FY 2015	April FY 2014	April FY 2015	April FY 2014	April FY 2015	April FY 2014
A. Operating Performance												
Operating Margin	3.42%	2.33%	3.57%	2.51%	-13.96%	9.12%	-2.30%	2.81%	0.79%	1.14%	-0.72%	0.06%
Non-Operating Margin	-1.39%	-0.93%	-0.76%	-0.73%	-1.05%	0.92%	-0.53%	-0.46%	-0.99%	-0.29%	-0.57%	-0.50%
Total Margin	2.03%	1.40%	2.81%	1.77%	-15.01%	10.04%	-2.83%	2.35%	-0.20%	0.85%	-1.29%	-0.44%
Bad Debt as % of Gross Revenue	1.04%	0.36%	-0.80%	-1.38%	1.36%	-0.47%	-0.87%	-1.46%	-1.13%	0.24%	-0.87%	-1.43%
B. Liquidity												
Current Ratio	1.22	1.42	1.22	1.42	1.59	1.58	1.59	1.58	1.41	1.44	1.41	1.44
Days Cash on Hand	21	26	21	26	59	60	62	63	68	69	68	69
Days in Net Accounts Receivable	58	69	57	71	62	56	59	64	53	60	55	62
Average Payment Period	62	53	62	54	43	49	45	51	67	67	67	67
C. Leverage and Capital Structure												
Long-term Debt to Equity	1.99	1.81	1.99	1.81	0.89	0.75	0.89	0.75	1.10	0.97	1.10	0.97
Long-term Debt to Capitalization	67	64	67	64	47	43	47	43	66	60	66	60
Unrestricted Cash to Debt	1.10	1.12	9.15	8.05	(1.68)	2.99	2.48	9.25	0.69	0.96	3.50	4.72
Times Interest Earned Ratio	6.17	5.55	6.74	5.46	(7.09)	19.38	3.49	9.26	4.89	5.42	3.77	4.26
Debt Service Coverage Ratio	N/A	N/A	2.06	2.09	N/A	N/A	2.06	6.35	N/A	N/A	1.47	1.34
Equity Financing Ratio	17.00	20.33	17.00	20.33	36.24	41.24	36.24	41.24	28.65	32.31	28.65	32.31
D. Additional Statistics												
Income from Operations	$524,440	$366,228	$3,956,421	$2,731,983	($740,830)	$625,951	($919,757)	$1,199,243	$218,259	$322,618	($1,383,244)	$115,266
Revenue Over/(Under) Expense	$311,503	$220,185	$3,113,577	$1,932,213	($796,462)	$688,802	($1,133,123)	$1,002,909	($55,329)	$241,621	($2,464,839)	($868,751)
EBITDA	$1,309,252	$1,227,836	$9,598,450	$8,558,123	($415,336)	$969,760	$1,395,062	$3,633,232	$1,501,766	$1,715,953	$7,802,522	$9,714,570
Cash from Operations	$13,513,734	$14,544,783	$98,258,373	$101,738,600	$5,353,076	$6,139,390	$38,957,663	$40,889,892	$24,009,535	$25,982,575	$171,655,026	$178,226,586
Cash and Cash Equivalents	$10,295,050	$12,671,112	$10,295,050	$12,671,112	$11,419,505	$11,724,844	$11,419,505	$11,724,844	$47,876,439	$50,099,968	$47,876,439	$50,099,968
Net Working Capital	$6,702,330	$11,036,221	$6,702,330	$11,036,221	$4,887,597	$5,491,959	$4,887,597	$5,491,959	$20,953,663	$23,449,437	$20,953,663	$23,449,437
Unrestricted Assets	$11,984,385	$17,953,082	$11,984,385	$17,953,082	$21,902,044	$26,861,096	$21,902,044	$26,861,096	$57,236,804	$71,460,840	$57,236,804	$71,460,840
Credit Ratings (S&P, FITCH, and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

OHCA Financial Statistics Report (May FY 2015 and May FY 2014)

	Manchester Memorial Hospital				Rockville General Hospital				Eastern CT Health Network			
	MTD		YTD		MTD		YTD		MTD		YTD	
	May FY 2015	May FY 2014	May FY 2015	May FY 2014	May FY 2015	May FY 2014	May FY 2015	May FY 2014	May FY 2015	May FY 2014	May FY 2015	May FY 2014
A. Operating Performance												
Operating Margin	-7.73%	7.72%	2.27%	3.21%	7.12%	-8.47%	-1.05%	1.45%	-2.03%	1.69%	-0.88%	0.27%
Non-Operating Margin	-1.13%	-1.24%	-0.80%	-0.80%	-0.77%	0.96%	-0.56%	-0.29%	-0.79%	-0.53%	-0.59%	-0.51%
Total Margin	-8.85%	6.48%	1.47%	2.41%	6.36%	-7.51%	-1.62%	1.16%	-2.81%	1.16%	-1.48%	-0.24%
Bad Debt as % of Gross Revenue	0.08%	3.91%	-0.69%	-0.68%	1.98%	4.64%	-0.51%	-0.68%	0.50%	3.56%	-0.70%	-0.78%
B. Liquidity												
Current Ratio	1.23	1.40	1.23	1.40	1.46	1.51	1.46	1.51	1.40	1.44	1.40	1.44
Days Cash on Hand	24	30	23	31	66	59	63	61	68	70	68	70
Days in Net Accounts Receivable	60	61	54	66	58	67	60	63	54	58	52	59
Average Payment Period	63	56	63	57	52	50	50	51	67	67	67	67
C. Leverage and Capital Structure												
Long-term Debt to Equity	2.12	1.70	2.12	1.70	0.88	0.75	0.88	0.75	1.11	0.96	1.11	0.96
Long-term Debt to Capitalization	68	63	68	63	47	43	47	43	67	60	67	60
Unrestricted Cash to Debt	(0.87)	2.21	8.23	10.09	2.01	(0.45)	4.43	8.80	0.16	1.04	3.67	5.76
Times Interest Earned Ratio	(1.69)	9.78	5.70	6.00	12.32	(3.09)	4.67	7.87	2.46	5.83	3.61	4.46
Debt Service Coverage Ratio	N/A	N/A	1.76	2.36	N/A	N/A	2.83	5.45	N/A	N/A	1.27	1.19
Equity Financing Ratio	15.96	21.14	15.96	21.14	36.00	41.16	36.00	41.16	28.35	32.36	28.35	32.36
D. Additional Statistics												
Income from Operations	($1,109,951)	$1,314,909	$2,846,470	$4,046,892	$434,118	($494,085)	($485,638)	$705,159	($547,558)	$489,881	($1,930,802)	$605,147
Revenue Over/(Under) Expense	($1,271,561)	$1,103,362	$1,842,016	$3,035,575	$387,371	($438,257)	($745,751)	$564,652	($760,675)	$335,046	($3,225,514)	($533,705)
EBITDA	($337,888)	$2,173,868	$9,260,562	$10,731,992	$757,841	($153,584)	$2,152,904	$3,479,649	$726,791	$1,893,312	$8,529,313	$11,607,882
Cash from Operations	$13,005,347	$15,330,703	$111,263,720	$117,069,303	$5,258,693	$5,946,463	$44,216,356	$46,836,354	$22,921,648	$26,023,753	$194,576,674	$204,250,338
Cash and Cash Equivalents	$11,464,779	$14,818,339	$11,464,779	$14,818,339	$11,551,997	$11,419,880	$11,551,997	$11,419,880	$48,911,690	$51,446,057	$48,911,690	$51,446,057
Net Working Capital	$7,077,895	$11,136,116	$7,077,895	$11,136,116	$4,177,800	$4,860,159	$4,177,800	$4,860,159	$20,305,942	$23,314,145	$20,305,942	$23,314,145
Unrestricted Assets	$10,295,985	$19,677,841	$10,295,985	$19,677,841	$22,109,783	$26,782,030	$22,109,783	$26,782,030	$56,252,314	$71,472,637	$56,252,314	$71,472,637
Credit Ratings (S&P, FITCH, and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

OHCA Financial Statistics Report (June FY 2015 and June FY 2014)

	Manchester Memorial Hospital				Rockville General Hospital				Eastern CT Health Network			
	MTD		YTD		MTD		YTD		MTD		YTD	
	June FY 2015	June FY 2014	June FY 2015	June FY 2014	June FY 2015	June FY 2014	June FY 2015	June FY 2014	June FY 2015	June FY 2014	June FY 2015	June FY 2014
A. Operating Performance												
Operating Margin	2.86%	3.29%	2.34%	3.22%	-17.69%	-1.94%	-2.68%	1.08%	-2.17%	0.38%	-1.02%	0.28%
Non-Operating Margin	-1.33%	-0.62%	-0.86%	-0.78%	-1.33%	-0.49%	-0.64%	-0.31%	-1.04%	-0.46%	-0.64%	-0.50%
Total Margin	1.54%	2.67%	1.48%	2.44%	-19.02%	-2.44%	-3.32%	0.77%	-3.20%	-0.09%	-1.66%	-0.22%
Bad Debt as % of Gross Revenue	-0.01%	-0.77%	-0.62%	-0.69%	-2.04%	-0.56%	-0.69%	-0.67%	-0.17%	-0.77%	-0.64%	-0.78%
B. Liquidity												
Current Ratio	1.21	1.37	1.21	1.37	1.42	1.50	1.42	1.50	1.38	1.45	1.38	1.45
Days Cash on Hand	28	32	28	32	61	63	63	65	70	73	70	73
Days in Net Accounts Receivable	50	61	50	60	67	64	59	64	51	56	51	56
Average Payment Period	68	59	68	59	50	53	51	55	70	67	70	67
					0							
C. Leverage and Capital Structure												
Long-term Debt to Equity	2.15	1.68	2.15	1.68	0.92	0.76	0.92	0.76	1.13	0.96	1.13	0.96
Long-term Debt to Capitalization	68	63	68	63	48	43	48	43	67	60	67	60
Unrestricted Cash to Debt	0.97	1.26	8.94	11.25	(2.10)	0.35	2.26	8.93	0.09	0.71	3.70	6.53
Times Interest Earned Ratio	5.82	6.64	5.72	6.06	(9.15)	3.05	3.04	7.20	2.30	4.57	3.46	4.47
Debt Service Coverage Ratio	N/A	N/A	1.75	2.38	N/A	N/A	1.66	5.00	N/A	N/A	1.37	1.05
Equity Financing Ratio	15.58	21.06	15.58	21.06	34.83	40.51	34.83	40.51	27.75	32.51	27.75	32.51
D. Additional Statistics												
Income from Operations	$439,667	$511,964	$3,286,077	$4,558,856	($882,134)	($117,005)	($1,367,773)	$588,152	($574,005)	$104,435	($2,504,807)	$709,582
Revenue Over/(Under) Expense	$236,126	$416,052	$2,078,082	$3,451,627	($948,233)	($146,571)	($1,693,986)	$418,079	($849,044)	($24,611)	($4,074,558)	($558,316)
EBITDA	$1,216,442	$1,289,254	$10,476,944	$12,021,246	($557,685)	$217,517	$1,587,420	$3,697,164	$693,333	$1,400,976	$9,222,646	$13,008,858
Cash from Operations	$13,015,037	$14,775,083	$124,278,756	$131,844,387	$4,874,855	$5,980,838	$49,091,211	$52,817,192	$22,688,920	$25,406,000	$217,265,594	$229,656,339
Cash and Cash Equivalents	$13,688,879	$15,562,160	$13,688,879	$15,562,160	$11,582,698	$12,328,783	$11,582,698	$12,328,783	$50,752,017	$53,097,698	$50,752,017	$53,097,698
Net Working Capital	$6,990,534	$10,750,740	$6,990,534	$10,750,740	$3,949,878	$5,192,295	$3,949,878	$5,192,295	$19,954,169	$23,533,469	$19,954,169	$23,533,469
Unrestricted Assets	$10,332,402	$19,803,312	$10,332,402	$19,803,312	$21,079,299	$26,504,447	$21,079,299	$26,504,447	$55,151,034	$71,537,431	$55,151,034	$71,537,431
Credit Ratings (S&P, FITCH, and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

EXHIBIT Q51-1 - IRS TAX FORM 990 FILED BY MMH FOR TAX YEAR 2014

Caution: Forms printed from within Adobe Acrobat products may not meet IRS or state taxing agency specifications. When using Acrobat 5.x products, uncheck the "Shrink oversized pages to paper size" and uncheck the "Expand small pages to paper size" options, in the Adobe "Print" dialog. When using Acrobat 6.x and later products versions, select "None" in the "Page Scaling" selection box in the Adobe "Print" dialog.

CLIENT'S COPY

CARRYOVER DATA TO 2014

Name	Employer Identification Number
MANCHESTER MEMORIAL HOSPITAL	06-0646710

Based on the information provided with this return, the following are possible carryover amounts to next year.

FEDERAL NET OPERATING LOSS	797,404.
FEDERAL AMT NET OPERATING LOSS	797,404.
CT NET OPERATING LOSS	796,404.

319341
05-01-13

TAX RETURN FILING INSTRUCTIONS

** FORM 990 PUBLIC DISCLOSURE COPY **

FOR THE YEAR ENDING

SEPTEMBER 30, 2014

Prepared for	MANCHESTER MEMORIAL HOSPITAL 71 HAYNES STREET MANCHESTER, CT 06040
Prepared by	CROWE HORWATH, LLP 175 POWDER FOREST DRIVE SIMSBURY, CT 06089
Amount due or refund	NOT APPLICABLE
Make check payable to	NOT APPLICABLE
Mail tax return and check (if applicable) to	NOT APPLICABLE
Return must be mailed on or before	NOT APPLICABLE
Special Instructions	THIS RETURN HAS BEEN PREPARED FOR ELECTRONIC FILING. IF YOU WISH TO HAVE IT TRANSMITTED ELECTRONICALLY TO THE IRS, PLEASE SIGN, DATE, AND RETURN FORM 8879-EO TO OUR OFFICE. WE WILL THEN SUBMIT THE ELECTRONIC RETURN TO THE IRS. DO NOT MAIL A PAPER COPY OF THE RETURN TO THE IRS. RETURN FORM 8879-EO TO US BY AUGUST 17, 2015.

300941
05-01-13

Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations)

▶ **Do not enter Social Security numbers on this form as it may be made public.**

▶ **Information about Form 990 and its instructions is at** *www.irs.gov/form990*

OMB No. 1545-0047

2013

Open to Public Inspection

A For the 2013 calendar year, or tax year beginning OCT 1, 2013 **and ending** SEP 30, 2014

B Check if applicable:
- ☐ Address change
- ☐ Name change
- ☐ Initial return
- ☐ Termin-ated
- ☐ Amended return
- ☐ Applica-tion pending

C Name of organization
MANCHESTER MEMORIAL HOSPITAL

Doing Business As

Number and street (or P.O. box if mail is not delivered to street address) | Room/suite
71 HAYNES STREET

City or town, state or province, country, and ZIP or foreign postal code
MANCHESTER, CT 06040

F Name and address of principal officer: PETER J. KARL
SAME AS C ABOVE

D Employer identification number
06-0646710

E Telephone number
860-646-1222

G Gross receipts $ 193,724,875.

H(a) Is this a group return for subordinates? ☐ Yes ☒ No

H(b) Are all subordinates included? ☐ Yes ☐ No
If "No," attach a list. (see instructions)

H(c) Group exemption number ▶

I Tax-exempt status: ☒ 501(c)(3) ☐ 501(c) ( ) ◀ (insert no.) ☐ 4947(a)(1) or ☐ 527

J Website: ▶ WWW.ECHN.ORG

K Form of organization: ☒ Corporation ☐ Trust ☐ Association ☐ Other ▶

L Year of formation: 1920 **M** State of legal domicile: CT

Part I Summary

Activities & Governance

1 Briefly describe the organization's mission or most significant activities: MANCHESTER MEMORIAL HOSPITAL IS A 249 BED HOSPITAL OFFERING VARIOUS HEALTHCARE SERVICES, INCLUDING

2 Check this box ▶ ☐ if the organization discontinued its operations or disposed of more than 25% of its net assets.

3	Number of voting members of the governing body (Part VI, line 1a)	3	18
4	Number of independent voting members of the governing body (Part VI, line 1b)	4	12
5	Total number of individuals employed in calendar year 2013 (Part V, line 2a)	5	1805
6	Total number of volunteers (estimate if necessary)	6	345
7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a	921,833.
b	Net unrelated business taxable income from Form 990-T, line 34	7b	-69,384.

Revenue

		Prior Year	Current Year
8	Contributions and grants (Part VIII, line 1h)	3,158,530.	6,038,927.
9	Program service revenue (Part VIII, line 2g)	181,137,247.	180,798,739.
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	2,801,853.	4,533,864.
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	913,163.	885,580.
12	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	188,010,793.	192,257,110.

Expenses

13	Grants and similar amounts paid (Part IX, column (A), lines 1-3)	14,650.	8,600.
14	Benefits paid to or for members (Part IX, column (A), line 4)	0.	0.
15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	111,568,140.	109,326,548.
16a	Professional fundraising fees (Part IX, column (A), line 11e)	0.	0.
b	Total fundraising expenses (Part IX, column (D), line 25) ▶ 0.		
17	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	77,341,310.	76,798,781.
18	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	188,924,100.	186,133,929.
19	Revenue less expenses. Subtract line 18 from line 12	-913,307.	6,123,181.

Net Assets or Fund Balances

		Beginning of Current Year	End of Year
20	Total assets (Part X, line 16)	174,154,774.	161,754,391.
21	Total liabilities (Part X, line 26)	136,423,034.	136,955,974.
22	Net assets or fund balances. Subtract line 21 from line 20	37,731,740.	24,798,417.

Part II Signature Block

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than officer) is based on all information of which preparer has any knowledge.

Sign Here

▶ Signature of officer — Date

▶ MICHAEL D. VEILLETTE, CHIEF FINANCIAL OFFICER
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check if self-employed	PTIN
BETH A. THURZ			☐	P00346435

Firm's name ▶ CROWE HORWATH, LLP — Firm's EIN ▶ 35-0921680

Firm's address ▶ 175 POWDER FOREST DRIVE
SIMSBURY, CT 06089 — Phone no. 860-678-9200

May the IRS discuss this return with the preparer shown above? (see instructions) ☒ Yes ☐ No

SEE SCHEDULE O FOR ORGANIZATION MISSION STATEMENT CONTINUATION

Part III Statement of Program Service Accomplishments

Check if Schedule O contains a response or note to any line in this Part III X

1 Briefly describe the organization's mission:
MANCHESTER MEMORIAL HOSPITAL IS A 249 BED HOSPITAL OFFERING VARIOUS HEALTHCARE SERVICES TO ALL MEMBERS OF THE COMMUNITY, INCLUDING THE INDIGENT AND UNDERSERVED.

2 Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? ..... Yes X No
If "Yes," describe these new services on Schedule O.

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services? ..... Yes X No
If "Yes," describe these changes on Schedule O.

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses. Section 501(c)(3) and 501(c)(4) organizations are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported.

4a (Code:) (Expenses $ 24,263,258. including grants of $) (Revenue $ 16,047,583.)
INPATIENT SERVICES - MANCHESTER MEMORIAL HOSPITAL OFFERS COMPREHENSIVE MEDICAL SERVICES IN A 249 BED ACCUTE CARE COMMUNITY HOSPITAL, WITH A TOTAL OF 9,110 INPATIENTS TREATED IN FISCAL YEAR 2014. SERVICES ARE OFFERED TO THE COMMUNITY, REGARDLESS OF ANY INDIVIDUAL'S ABILITY TO PAY.

4b (Code:) (Expenses $ 15,913,062. including grants of $) (Revenue $ 31,187,561.)
LABORATORY - WE ARE CAP ACCREDITED AND OFFER A WIDE RANGE OF CLINICAL TESTING PROCEDURES USING STATE-OF-THE-ART INSTRUMENTS TO PROVIDE TIMELY, ACCURATE RESULTS. OUR BOARD CERTIFIED PATHOLOGISTS UTILIZE STATE OF THE ART AUTOMATED EQUIPMENT PROVIDING RAPID TURNAROUND TIME, AND INTEGRATION OF TEST RESULTS WITH MEDICAL RECORDS.

4c (Code:) (Expenses $ 12,706,301. including grants of $) (Revenue $ 33,300,224.)
EMERGENCY DEPARTMENT - EMERGENCY CARE IS OFFERED 24 HOURS PER DAY, AND PROVIDES NEEDED EMERGENCY MEDICAL CARE TO THE COMMUNITY, REGARDLESS OF ANY INDIVIDUAL'S ABILITY TO PAY.

4d Other program services (Describe in Schedule O.)
(Expenses $ 96,879,540. including grants of $ 8,600.) (Revenue $ 99,341,538.)

4e Total program service expenses ▶ 149,762,161.

Part IV Checklist of Required Schedules

			Yes	No
1	Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? *If "Yes," complete Schedule A*	1	X	
2	Is the organization required to complete *Schedule B, Schedule of Contributors*?	2	X	
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? *If "Yes," complete Schedule C, Part I*	3		X
4	**Section 501(c)(3) organizations.** Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? *If "Yes," complete Schedule C, Part II*	4	X	
5	Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? *If "Yes," complete Schedule C, Part III*	5		X
6	Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? *If "Yes," complete Schedule D, Part I*	6		X
7	Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? *If "Yes," complete Schedule D, Part II*	7		X
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? *If "Yes," complete Schedule D, Part III*	8		X
9	Did the organization report an amount in Part X, line 21, for escrow or custodial account liability; serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? *If "Yes," complete Schedule D, Part IV*	9		X
10	Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? *If "Yes," complete Schedule D, Part V*	10	X	
11	If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable.			
a	Did the organization report an amount for land, buildings, and equipment in Part X, line 10? *If "Yes," complete Schedule D, Part VI*	11a	X	
b	Did the organization report an amount for investments - other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VII*	11b	X	
c	Did the organization report an amount for investments - program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VIII*	11c	X	
d	Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part IX*	11d	X	
e	Did the organization report an amount for other liabilities in Part X, line 25? *If "Yes," complete Schedule D, Part X*	11e	X	
f	Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? *If "Yes," complete Schedule D, Part X*	11f	X	
12a	Did the organization obtain separate, independent audited financial statements for the tax year? *If "Yes," complete Schedule D, Parts XI and XII*	12a	X	
b	Was the organization included in consolidated, independent audited financial statements for the tax year? *If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional*	12b	X	
13	Is the organization a school described in section 170(b)(1)(A)(ii)? *If "Yes," complete Schedule E*	13		X
14a	Did the organization maintain an office, employees, or agents outside of the United States?	14a		X
b	Did the organization have aggregate revenues or expenses of more than $10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at $100,000 or more? *If "Yes," complete Schedule F, Parts I and IV*	14b		X
15	Did the organization report on Part IX, column (A), line 3, more than $5,000 of grants or other assistance to or for any foreign organization? *If "Yes," complete Schedule F, Parts II and IV*	15		X
16	Did the organization report on Part IX, column (A), line 3, more than $5,000 of aggregate grants or other assistance to or for foreign individuals? *If "Yes," complete Schedule F, Parts III and IV*	16		X
17	Did the organization report a total of more than $15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? *If "Yes," complete Schedule G, Part I*	17		X
18	Did the organization report more than $15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? *If "Yes," complete Schedule G, Part II*	18	X	
19	Did the organization report more than $15,000 of gross income from gaming activities on Part VIII, line 9a? *If "Yes," complete Schedule G, Part III*	19		X
20a	Did the organization operate one or more hospital facilities? *If "Yes," complete Schedule H*	20a	X	
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	20b	X	

Part IV Checklist of Required Schedules *(continued)*

			Yes	No
21	Did the organization report more than $5,000 of grants or other assistance to any domestic organization or government on Part IX, column (A), line 1? *If "Yes," complete Schedule I, Parts I and II*	21		X
22	Did the organization report more than $5,000 of grants or other assistance to individuals in the United States on Part IX, column (A), line 2? *If "Yes," complete Schedule I, Parts I and III*	22	X	
23	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? *If "Yes," complete Schedule J*	23	X	
24a	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than $100,000 as of the last day of the year, that was issued after December 31, 2002? *If "Yes," answer lines 24b through 24d and complete Schedule K. If "No", go to line 25a*	24a	X	
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	24b		X
c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	24c		X
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	24d		X
25a	**Section 501(c)(3) and 501(c)(4) organizations.** Did the organization engage in an excess benefit transaction with a disqualified person during the year? *If "Yes," complete Schedule L, Part I*	25a		X
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? *If "Yes," complete Schedule L, Part I*	25b		X
26	Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? If so, complete Schedule L, Part II	26		X
27	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? *If "Yes," complete Schedule L, Part III*	27		X
28	Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions):			
a	A current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	28a		X
b	A family member of a current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	28b		X
c	An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? *If "Yes," complete Schedule L, Part IV*	28c	X	
29	Did the organization receive more than $25,000 in non-cash contributions? *If "Yes," complete Schedule M*	29	X	
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? *If "Yes," complete Schedule M*	30		X
31	Did the organization liquidate, terminate, or dissolve and cease operations? *If "Yes," complete Schedule N, Part I*	31		X
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? *If "Yes," complete Schedule N, Part II*	32		X
33	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? *If "Yes," complete Schedule R, Part I*	33		X
34	Was the organization related to any tax-exempt or taxable entity? *If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1*	34	X	
35a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	35a	X	
b	If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? *If "Yes," complete Schedule R, Part V, line 2*	35b	X	
36	**Section 501(c)(3) organizations.** Did the organization make any transfers to an exempt non-charitable related organization? *If "Yes," complete Schedule R, Part V, line 2*	36		X
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? *If "Yes," complete Schedule R, Part VI*	37		X
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? **Note.** All Form 990 filers are required to complete Schedule O	38	X	

Part V Statements Regarding Other IRS Filings and Tax Compliance

Check if Schedule O contains a response or note to any line in this Part V ☐

				Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable	1a	383		
b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable	1b	0		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	1c		X	
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	2a	1805		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns?	2b		X	
	Note. If the sum of lines 1a and 2a is greater than 250, you may be required to *e-file* (see instructions)				
3a	Did the organization have unrelated business gross income of $1,000 or more during the year?	3a		X	
b	If "Yes," has it filed a Form 990-T for this year? *If "No," to line 3b, provide an explanation in Schedule O*	3b		X	
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?	4a			X
b	If "Yes," enter the name of the foreign country: ▶ _____ See instructions for filing requirements for Form TD F 90-22.1, Report of Foreign Bank and Financial Accounts.				
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?	5a			X
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	5b			X
c	If "Yes," to line 5a or 5b, did the organization file Form 8886-T?	5c			
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?	6a			X
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?	6b			
7	**Organizations that may receive deductible contributions under section 170(c).**				
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?	7a			X
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?	7b			
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?	7c			X
d	If "Yes," indicate the number of Forms 8282 filed during the year	7d			
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	7e			X
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?	7f			X
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?	7g			
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	7h			
8	**Sponsoring organizations maintaining donor advised funds and section 509(a)(3) supporting organizations.** Did the supporting organization, or a donor advised fund maintained by a sponsoring organization, have excess business holdings at any time during the year?	8			
9	**Sponsoring organizations maintaining donor advised funds.**				
a	Did the organization make any taxable distributions under section 4966?	9a			
b	Did the organization make a distribution to a donor, donor advisor, or related person?	9b			
10	**Section 501(c)(7) organizations.** Enter:				
a	Initiation fees and capital contributions included on Part VIII, line 12	10a			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	10b			
11	**Section 501(c)(12) organizations.** Enter:				
a	Gross income from members or shareholders	11a			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.)	11b			
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?	12a			
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year	12b			
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**				
a	Is the organization licensed to issue qualified health plans in more than one state?	13a			
	Note. See the instructions for additional information the organization must report on Schedule O.				
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	13b			
c	Enter the amount of reserves on hand	13c			
14a	Did the organization receive any payments for indoor tanning services during the tax year?	14a			X
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O*	14b			

Part VI Governance, Management, and Disclosure *For each "Yes" response to lines 2 through 7b below, and for a "No" response to line 8a, 8b, or 10b below, describe the circumstances, processes, or changes in Schedule O. See instructions.*

Check if Schedule O contains a response or note to any line in this Part VI X

Section A. Governing Body and Management

				Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year	1a	18		
	If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O.				
b	Enter the number of voting members included in line 1a, above, who are independent	1b	12		
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	2		X	
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors, or trustees, or key employees to a management company or other person?	3			X
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4			X
5	Did the organization become aware during the year of a significant diversion of the organization's assets?	5			X
6	Did the organization have members or stockholders?	6		X	
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	7a		X	
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	7b		X	
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:				
a	The governing body?	8a		X	
b	Each committee with authority to act on behalf of the governing body?	8b		X	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses in Schedule O*	9			X

Section B. Policies *(This Section B requests information about policies not required by the Internal Revenue Code.)*

			Yes	No
10a	Did the organization have local chapters, branches, or affiliates?	10a		X
b	If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes?	10b		
11a	Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?	11a	X	
b	Describe in Schedule O the process, if any, used by the organization to review this Form 990.			
12a	Did the organization have a written conflict of interest policy? *If "No," go to line 13*	12a	X	
b	Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	12b	X	
c	Did the organization regularly and consistently monitor and enforce compliance with the policy? *If "Yes," describe in Schedule O how this was done*	12c	X	
13	Did the organization have a written whistleblower policy?	13	X	
14	Did the organization have a written document retention and destruction policy?	14	X	
15	Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision?			
a	The organization's CEO, Executive Director, or top management official	15a	X	
b	Other officers or key employees of the organization	15b	X	
	If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions).			
16a	Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year?	16a	X	
b	If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements?	16b	X	

Section C. Disclosure

17 List the states with which a copy of this Form 990 is required to be filed ▶ CT

18 Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.

☐ Own website ☐ Another's website ☒ Upon request ☐ Other *(explain in Schedule O)*

19 Describe in Schedule O whether (and if so, how), the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.

20 State the name, physical address, and telephone number of the person who possesses the books and records of the organization: ▶

NICHOLAS JAMIESON - 860-646-1222
320 MAIN STREET, MANCHESTER, CT 06040

Part VII Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

Check if Schedule O contains a response or note to any line in this Part VII ☐

Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

1a Complete this table for all persons required to be listed. Report compensation for the calendar year ending with or within the organization's tax year.

- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation. Enter -0- in columns (D), (E), and (F) if no compensation was paid.
- List all of the organization's **current** key employees, if any. See instructions for definition of "key employee."
- List the organization's five **current** highest compensated employees (other than an officer, director, trustee, or key employee) who received reportable compensation (Box 5 of Form W-2 and/or Box 7 of Form 1099-MISC) of more than $100,000 from the organization and any related organizations.
- List all of the organization's **former** officers, key employees, and highest compensated employees who received more than $100,000 of reportable compensation from the organization and any related organizations.
- List all of the organization's **former directors or trustees** that received, in the capacity as a former director or trustee of the organization, more than $10,000 of reportable compensation from the organization and any related organizations.

List persons in the following order: individual trustees or directors; institutional trustees; officers; key employees; highest compensated employees; and former such persons.

☐ Check this box if neither the organization nor any related organization compensated any current officer, director, or trustee.

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) DENNIS O'NEILL, MD	1.00									
CHAIRMAN	4.00	X		X				0.	0.	0.
(2) ROBIN MURDOCK MEGGERS	1.00									
VICE CHAIR	2.00	X		X				0.	0.	0.
(3) MICHELE CONLON, MD	1.00									
SECRETARY	2.00	X		X				0.	0.	0.
(4) JOSEPH F. JEAMEL, JR.	1.00									
TREASURER	2.00	X		X				0.	0.	0.
(5) GORDON BRODIE, MD	1.00									
TRUSTEE	2.00	X						0.	0.	0.
(6) THOMASINA CLEMONS	1.00									
TRUSTEE	2.00	X						0.	0.	0.
(7) ANTHONY DISTEFANO, MD	1.00									
TRUSTEE	3.00	X						0.	0.	0.
(8) MILTON DOREMUS	1.00									
TRUSTEE	2.00	X						0.	0.	0.
(9) JOY DORIN	1.00									
TRUSTEE	2.00	X						0.	0.	0.
(10) DAVID GONCI	1.00									
TRUSTEE	2.00	X						0.	0.	0.
(11) REBECCA JANENDA	1.00									
TRUSTEE	2.00	X						0.	0.	0.
(12) LENORA WILLIAMS, MD	1.00									
TRUSTEE	2.00	X						0.	0.	0.
(13) PETER J. KARL	33.00									
PRESIDENT AND CEO	27.00	X		X				1,123,212.	0.	122,724.
(14) LOUISE ENGLAND	1.00									
TRUSTEE	3.00	X						0.	0.	0.
(15) DONALD GENOVESI	1.00									
TRUSTEE	2.00	X						0.	0.	0.
(16) KATHLEEN A. O'NEILL	1.00									
TRUSTEE	3.00	X						0.	0.	0.
(17) KEITH J. WOLFF	1.00									
TRUSTEE	2.00	X						0.	0.	0.

Part VII **Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees** *(continued)*

(A) Name and title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(18) ERIC KLOTER	1.00									
TRUSTEE	2.00	X						0.	0.	0.
(19) PAMELA LEWIS, MD	1.00									
TRUSTEE	2.00	X						0.	0.	0.
(20) KEVIN G. MURPHY	33.00									
EVP, TREASURER (THROUGH OCT 2013)	27.00			X				605,651.	0.	26,680.
(21) MICHAEL D. VEILLETTE	33.00									
SVP, CHIEF FINANCIAL OFFICER	27.00			X				441,275.	0.	58,896.
(22) DEBORAH GOGLIETTINO	33.00									
SVP, HUMAN RESOURCES	27.00				X			350,668.	0.	46,611.
(23) DENNIS MCCONVILLE	33.00									
SVP, STRATEGIC PLANNING	27.00				X			325,180.	0.	93,680.
(24) DEBORAH PARKER	33.00									
EVP, CHIEF CLINICAL OFFICER	27.00				X			439,801.	0.	58,046.
(25) JOEL REICH, MD	33.00									
SVP, MEDICAL AFFAIRS	27.00				X			522,615.	0.	136,948.
(26) CHARLES COVIN	33.00									
VP AND CIO (THROUGH NOV 2013)	27.00				X			158,898.	0.	32,253.
1b Sub-total ▶								3,967,300.	0.	575,838.
c Total from continuation sheets to Part VII, Section A ▶								2,706,058.	0.	346,563.
d Total (add lines 1b and 1c) ▶								6,673,358.	0.	922,401.

2 Total number of individuals (including but not limited to those listed above) who received more than $100,000 of reportable compensation from the organization ▶ 135

		Yes	No
3 Did the organization list any **former** officer, director, or trustee, key employee, or highest compensated employee on line 1a? *If "Yes," complete Schedule J for such individual*	3		X
4 For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than $150,000? *If "Yes," complete Schedule J for such individual*	4	X	
5 Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? *If "Yes," complete Schedule J for such person*	5		X

Section B. Independent Contractors

1 Complete this table for your five highest compensated independent contractors that received more than $100,000 of compensation from the organization. Report compensation for the calendar year ending with or within the organization's tax year.

(A) Name and business address	(B) Description of services	(C) Compensation
ALL-PHASE ENTERPRISES, INC., 191 WEST STAFFORD ROAD, STAFFORD SPRINGS, CT 06076	CONTRACTOR SERVICES	1,363,279.
SODEXO, 9801 WASHINGTON BLVD, GAITHERSBURG, MD 20878	DIETARY SERVICES	1,323,311.
MED ASSETS, INC. PO BOX 405652, ATLANTA, GA 30384	ENVIRONMENTAL SERVICES	1,252,058.
GRIFFIN YORK & KRAUSE 121 RIVER FRONT DRIVE, MANCHESTER, NH 03102	ADVERTISING SERVICES	1,179,437.
ARUP LABORATORIES, INC. PO BOX 27964, SALT LAKE CITY, UT 84127	LABORATORY SERVICES	977,151.

2 Total number of independent contractors (including but not limited to those listed above) who received more than $100,000 of compensation from the organization ▶ 42

SEE PART VII, SECTION A CONTINUATION SHEETS

Part VII **Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees** *(continued)*

(A) Name and title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (check all that apply)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(27) LEONA CROSSKEY	33.00									
VP, QUALITY	27.00				X			177,688.	0.	73,043.
(28) ROBERT CARROLL, MD	33.00									
MED DIR, EMERGENCY DEPARTMENT	27.00				X			449,483.	0.	34,371.
(29) JOYCE TICHY	33.00									
GENERAL COUNSEL	27.00				X			355,681.	0.	28,863.
(30) JAMES CASTELLONE, MD	60.00									
ASST. MED DIR, EMERGENCY DEPT						X		379,840.	0.	34,371.
(31) ANDREAS BOJKO, MD	60.00									
EMERGENCY DEPT PHYSICIAN						X		323,486.	0.	90,985.
(32) SCOTT BROWN, MD	60.00									
DOCTOR						X		341,301.	0.	33,691.
(33) TAI TRAN, MD	60.00									
EMERGENCY DEPT PHYSICIAN						X		312,907.	0.	16,954.
(34) THEODORE SHERRY, MD	60.00									
EMERGENCY DEPT PHYSICIAN						X		365,672.	0.	34,285.
Total to Part VII, Section A, line 1c								2,706,058.		346,563.

Part VIII Statement of Revenue

Check if Schedule O contains a response or note to any line in this Part VIII

			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512 - 514
Contributions, Gifts, Grants and Other Similar Amounts	1a Federated campaigns	1a				
	b Membership dues	1b				
	c Fundraising events	1c	250,818.			
	d Related organizations	1d				
	e Government grants (contributions)	1e	1,642,053.			
	f All other contributions, gifts, grants, and similar amounts not included above	1f	4,146,056.			
	g Noncash contributions included in lines 1a-1f: $					
	h **Total.** Add lines 1a-1f		6,038,927.			
		Business Code				
Program Service Revenue	2a PATIENT SERVICE REVENUE	622110	172,204,267.	172,204,267.		
	b OTHER HEALTHCARE REVENUE	621500	8,594,472.	7,672,639.	921,833.	
	c					
	d					
	e					
	f All other program service revenue					
	g **Total.** Add lines 2a-2f		180,798,739.			
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)		838,306.			838,306.
	4 Income from investment of tax-exempt bond proceeds					
	5 Royalties					
		(i) Real / (ii) Personal				
	6a Gross rents: 548,813. /					
	b Less: rental expenses: 890,267. /					
	c Rental income or (loss): -341,454. /					
	d Net rental income or (loss)		-341,454.			-341,454.
		(i) Securities / (ii) Other				
	7a Gross amount from sales of assets other than inventory: 3,695,558. /					
	b Less: cost or other basis and sales expenses: 0. /					
	c Gain or (loss): 3,695,558. /					
	d Net gain or (loss)		3,695,558.			3,695,558.
	8a Gross income from fundraising events (not including $ 250,818. of contributions reported on line 1c). See Part IV, line 18	a 70,725.				
	b Less: direct expenses	b 182,822.				
	c Net income or (loss) from fundraising events		-112,097.			-112,097.
	9a Gross income from gaming activities. See Part IV, line 19	a				
	b Less: direct expenses	b				
	c Net income or (loss) from gaming activities					
	10a Gross sales of inventory, less returns and allowances	a 561,984.				
	b Less: cost of goods sold	b 394,676.				
	c Net income or (loss) from sales of inventory		167,308.			167,308.
	Miscellaneous Revenue	**Business Code**				
	11a CAFETERIA REVENUE	722210	952,311.			952,311.
	b AUXILIARY REVENUE	900099	219,512.			219,512.
	c					
	d All other revenue					
	e **Total.** Add lines 11a-11d		1,171,823.			
	12 **Total revenue.** See instructions.		192,257,110.	179,876,906.	921,833.	5,419,444.

Part IX Statement of Functional Expenses

Section 501(c)(3) and 501(c)(4) organizations must complete all columns. All other organizations must complete column (A).

Check if Schedule O contains a response or note to any line in this Part IX ☐

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to governments and organizations in the United States. See Part IV, line 21				
2 Grants and other assistance to individuals in the United States. See Part IV, line 22	8,600.	8,600.		
3 Grants and other assistance to governments, organizations, and individuals outside the United States. See Part IV, lines 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	3,451,504.		3,451,504.	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7 Other salaries and wages	80,154,792.	60,917,642.	19,237,150.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	3,430,948.	2,916,306.	514,642.	
9 Other employee benefits	16,682,291.	14,179,947.	2,502,344.	
10 Payroll taxes	5,607,013.	4,765,961.	841,052.	
11 Fees for services (non-employees):				
a Management	129,579.		129,579.	
b Legal	130,206.		130,206.	
c Accounting	103,146.		103,146.	
d Lobbying				
e Professional fundraising services. See Part IV, line 17				
f Investment management fees				
g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Sch O.)	5,540,530.	3,324,318.	2,216,212.	
12 Advertising and promotion	100,461.		100,461.	
13 Office expenses	592,462.	296,231.	296,231.	
14 Information technology	221,174.	110,587.	110,587.	
15 Royalties				
16 Occupancy	3,680,705.	3,128,599.	552,106.	
17 Travel	32,122.	27,304.	4,818.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	159,753.	135,790.	23,963.	
20 Interest	2,589,201.	2,589,201.		
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	7,116,905.	6,049,369.	1,067,536.	
23 Insurance	2,149,561.	1,827,127.	322,434.	
24 Other expenses. Itemize expenses not covered above. (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a MEDICAL SUPPLIES/EQUIPM	28,089,792.	28,089,792.		
b ECHN ALLOCATION	10,206,118.	6,123,671.	4,082,447.	
c PHYSICIAN FEES	9,851,497.	9,851,497.		
d DUE DILIGENCE	1,490,211.	1,266,679.	223,532.	
e All other expenses	4,615,358.	4,153,540.	461,818.	
25 **Total functional expenses.** Add lines 1 through 24e	186,133,929.	149,762,161.	36,371,768.	0.
26 **Joint costs.** Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here ▶ ☐ if following SOP 98-2 (ASC 958-720)				

Part X Balance Sheet

Check if Schedule O contains a response or note to any line in this Part X ☐

			(A) Beginning of year		(B) End of year
Assets	1	Cash - non-interest-bearing	12,239,488.	1	9,361,439.
	2	Savings and temporary cash investments		2	
	3	Pledges and grants receivable, net		3	
	4	Accounts receivable, net	27,182,276.	4	25,099,884.
	5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L		5	
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instr). Complete Part II of Sch L		6	
	7	Notes and loans receivable, net		7	
	8	Inventories for sale or use	3,245,125.	8	3,873,042.
	9	Prepaid expenses and deferred charges	2,316,130.	9	2,357,425.
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D — 10a: 197,198,532.			
	b	Less: accumulated depreciation — 10b: 141,480,890.	54,574,351.	10c	55,717,642.
	11	Investments - publicly traded securities	14,768,541.	11	12,613,293.
	12	Investments - other securities. See Part IV, line 11	11,580,018.	12	15,240,292.
	13	Investments - program-related. See Part IV, line 11	10,780,266.	13	11,172,492.
	14	Intangible assets		14	
	15	Other assets. See Part IV, line 11	37,468,579.	15	26,318,882.
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)	174,154,774.	16	161,754,391.
Liabilities	17	Accounts payable and accrued expenses	21,391,578.	17	21,842,838.
	18	Grants payable		18	
	19	Deferred revenue		19	
	20	Tax-exempt bond liabilities	42,014,127.	20	40,768,601.
	21	Escrow or custodial account liability. Complete Part IV of Schedule D		21	
	22	Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L		22	
	23	Secured mortgages and notes payable to unrelated third parties	19,189,304.	23	19,344,527.
	24	Unsecured notes and loans payable to unrelated third parties		24	
	25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D	53,828,025.	25	55,000,008.
	26	**Total liabilities.** Add lines 17 through 25	136,423,034.	26	136,955,974.
Net Assets or Fund Balances		**Organizations that follow SFAS 117 (ASC 958), check here ▶ ☒ and complete lines 27 through 29, and lines 33 and 34.**			
	27	Unrestricted net assets	27,759,929.	27	11,344,473.
	28	Temporarily restricted net assets	1,392,902.	28	974,762.
	29	Permanently restricted net assets	8,578,909.	29	12,479,182.
		Organizations that do not follow SFAS 117 (ASC 958), check here ▶ ☐ and complete lines 30 through 34.			
	30	Capital stock or trust principal, or current funds		30	
	31	Paid-in or capital surplus, or land, building, or equipment fund		31	
	32	Retained earnings, endowment, accumulated income, or other funds		32	
	33	Total net assets or fund balances	37,731,740.	33	24,798,417.
	34	Total liabilities and net assets/fund balances	174,154,774.	34	161,754,391.

Form **990** (2013)

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10-29-13

Part XI Reconciliation of Net Assets

Check if Schedule O contains a response or note to any line in this Part XI X

1	Total revenue (must equal Part VIII, column (A), line 12)	1	192,257,110.
2	Total expenses (must equal Part IX, column (A), line 25)	2	186,133,929.
3	Revenue less expenses. Subtract line 2 from line 1	3	6,123,181.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	37,731,740.
5	Net unrealized gains (losses) on investments	5	-2,551,501.
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain in Schedule O)	9	-16,505,003.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	24,798,417.

Part XII Financial Statements and Reporting

Check if Schedule O contains a response or note to any line in this Part XII X

			Yes	No
1	Accounting method used to prepare the Form 990: ☐ Cash ☒ Accrual ☐ Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O.			
2a	Were the organization's financial statements compiled or reviewed by an independent accountant? If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both: ☐ Separate basis ☐ Consolidated basis ☐ Both consolidated and separate basis	2a		X
b	Were the organization's financial statements audited by an independent accountant? If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both: ☐ Separate basis ☐ Consolidated basis ☒ Both consolidated and separate basis	2b	X	
c	If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O.	2c	X	
3a	As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?	3a	X	
b	If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits	3b	X	

Form 990 (2013)

SCHEDULE A (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.

▶ **Attach to Form 990 or Form 990-EZ.**

▶ **Information about Schedule A (Form 990 or 990-EZ) and its instructions is at** *www.irs.gov/form990.*

OMB No. 1545-0047

2013

Open to Public Inspection

Name of the organization	**Employer identification number**
MANCHESTER MEMORIAL HOSPITAL	06-0646710

Part I Reason for Public Charity Status (All organizations must complete this part.) See instructions.

The organization is not a private foundation because it is: (For lines 1 through 11, check only one box.)

1 ☐ A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**

2 ☐ A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E.)

3 ☒ A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**

4 ☐ A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state: _____

5 ☐ An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II.)

6 ☐ A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**

7 ☐ An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II.)

8 ☐ A community trust described in **section 170(b)(1)(A)(vi).** (Complete Part II.)

9 ☐ An organization that normally receives: (1) more than 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions - subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See **section 509(a)(2).** (Complete Part III.)

10 ☐ An organization organized and operated exclusively to test for public safety. See **section 509(a)(4).**

11 ☐ An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2). See **section 509(a)(3).** Check the box that describes the type of supporting organization and complete lines 11e through 11h.

a ☐ Type I **b** ☐ Type II **c** ☐ Type III - Functionally integrated **d** ☐ Type III - Non-functionally integrated

e ☐ By checking this box, I certify that the organization is not controlled directly or indirectly by one or more disqualified persons other than foundation managers and other than one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2).

f If the organization received a written determination from the IRS that it is a Type I, Type II, or Type III supporting organization, check this box ☐

g Since August 17, 2006, has the organization accepted any gift or contribution from any of the following persons?

		Yes	No
(i)	A person who directly or indirectly controls, either alone or together with persons described in (ii) and (iii) below, the governing body of the supported organization? **11g(i)**		
(ii)	A family member of a person described in (i) above? **11g(ii)**		
(iii)	A 35% controlled entity of a person described in (i) or (ii) above? **11g(iii)**		

h Provide the following information about the supported organization(s).

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1-9 above or IRC section (see instructions))	(iv) Is the organization in col. (i) listed in your governing document?		(v) Did you notify the organization in col. (i) of your support?		(vi) Is the organization in col. (i) organized in the U.S.?		(vii) Amount of monetary support
			Yes	No	Yes	No	Yes	No	
Total									

Part II **Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)**

(Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 **Total.** Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 **Public support.** Subtract line 5 from line 4.						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.)						
11 **Total support.** Add lines 7 through 10						

12 Gross receipts from related activities, etc. (see instructions) 12

13 **First five years.** If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here** ..... ▶ ☐

Section C. Computation of Public Support Percentage

14 Public support percentage for 2013 (line 6, column (f) divided by line 11, column (f)) ..... 14 %

15 Public support percentage from 2012 Schedule A, Part II, line 14 ..... 15 %

16a **33 1/3% support test - 2013.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ..... ▶ ☐

b **33 1/3% support test - 2012.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ..... ▶ ☐

17a **10% -facts-and-circumstances test - 2013.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ..... ▶ ☐

b **10% -facts-and-circumstances test - 2012.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ..... ▶ ☐

18 **Private foundation.** If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ..... ▶ ☐

Part III Support Schedule for Organizations Described in Section 509(a)(2)

(Complete only if you checked the box on line 9 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 **Total.** Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of $5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b						
8 **Public support** (Subtract line 7c from line 6.)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(f) Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.)						
13 **Total support.** (Add lines 9, 10c, 11, and 12.)						

14 **First five years.** If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here** ▶ ☐

Section C. Computation of Public Support Percentage

15 Public support percentage for 2013 (line 8, column (f) divided by line 13, column (f))	15	%
16 Public support percentage from 2012 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17 Investment income percentage for **2013** (line 10c, column (f) divided by line 13, column (f))	17	%
18 Investment income percentage from **2012** Schedule A, Part III, line 17	18	%

19a **33 1/3% support tests - 2013.** If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

b **33 1/3% support tests - 2012.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

20 **Private foundation.** If the organization did not check a box on line 14, 19a, or 19b, check this box and see instructions ▶ ☐

Part IV **Supplemental Information.** Provide the explanations required by Part II, line 10; Part II, line 17a or 17b; and Part III, line 12. Also complete this part for any additional information. (See instructions).

Schedule B (Form 990, 990-EZ, or 990-PF)
Department of the Treasury
Internal Revenue Service

Schedule of Contributors

▶ Attach to Form 990, Form 990-EZ, or Form 990-PF.
▶ Information about Schedule B (Form 990, 990-EZ, or 990-PF) and its instructions is at *www.irs.gov/form990* .

OMB No. 1545-0047

2013

Name of the organization	Employer identification number
MANCHESTER MEMORIAL HOSPITAL	06-0646710

Organization type (check one):

Filers of:	Section:
Form 990 or 990-EZ	☒ 501(c)(3) (enter number) organization
	☐ 4947(a)(1) nonexempt charitable trust **not** treated as a private foundation
	☐ 527 political organization
Form 990-PF	☐ 501(c)(3) exempt private foundation
	☐ 4947(a)(1) nonexempt charitable trust treated as a private foundation
	☐ 501(c)(3) taxable private foundation

Check if your organization is covered by the **General Rule** or a **Special Rule.**
Note. Only a section 501(c)(7), (8), or (10) organization can check boxes for both the General Rule and a Special Rule. See instructions.

General Rule

☒ For an organization filing Form 990, 990-EZ, or 990-PF that received, during the year, $5,000 or more (in money or property) from any one contributor. Complete Parts I and II.

Special Rules

☐ For a section 501(c)(3) organization filing Form 990 or 990-EZ that met the 33 1/3% support test of the regulations under sections 509(a)(1) and 170(b)(1)(A)(vi) and received from any one contributor, during the year, a contribution of the greater of **(1)** $5,000 or **(2)** 2% of the amount on (i) Form 990, Part VIII, line 1h, or (ii) Form 990-EZ, line 1. Complete Parts I and II.

☐ For a section 501(c)(7), (8), or (10) organization filing Form 990 or 990-EZ that received from any one contributor, during the year, total contributions of more than $1,000 for use *exclusively* for religious, charitable, scientific, literary, or educational purposes, or the prevention of cruelty to children or animals. Complete Parts I, II, and III.

☐ For a section 501(c)(7), (8), or (10) organization filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions for use *exclusively* for religious, charitable, etc., purposes, but these contributions did not total to more than $1,000. If this box is checked, enter here the total contributions that were received during the year for an *exclusively* religious, charitable, etc., purpose. Do not complete any of the parts unless the **General Rule** applies to this organization because it received *nonexclusively* religious, charitable, etc., contributions of $5,000 or more during the year ..... ▶ $ _____

Caution. An organization that is not covered by the General Rule and/or the Special Rules does not file Schedule B (Form 990, 990-EZ, or 990-PF), but it **must** answer "No" on Part IV, line 2, of its Form 990; or check the box on line H of its Form 990-EZ or on its Form 990-PF, Part I, line 2, to certify that it does not meet the filing requirements of Schedule B (Form 990, 990-EZ, or 990-PF).

Name of organization	Employer identification number
MANCHESTER MEMORIAL HOSPITAL	06-0646710

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
1		$ 710,221.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
2		$ 102,004.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
3		$ 100,235.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
4		$ 50,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
5		$ 37,223.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
6		$ 34,976.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization	Employer identification number
MANCHESTER MEMORIAL HOSPITAL	06-0646710

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
7		$ 30,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
8		$ 16,404.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
9		$ 15,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
10		$ 12,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
11		$ 11,450.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
12		$ 10,125.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization	Employer identification number
MANCHESTER MEMORIAL HOSPITAL	06-0646710

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
13		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
14		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
15		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
16		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
17		$ 10,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
18		$ 6,500.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization	Employer identification number
MANCHESTER MEMORIAL HOSPITAL	06-0646710

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
19		$ 6,055.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
20		$ 6,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
21		$ 5,737.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
22		$ 5,500.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
23		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
24		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization	Employer identification number
MANCHESTER MEMORIAL HOSPITAL	06-0646710

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
25		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
26		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
27		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
28		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
29		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
30		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization	Employer identification number
MANCHESTER MEMORIAL HOSPITAL	06-0646710

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
31		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
32		$ 5,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
33		$ 83,675.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
34		$ 505,904.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
35		$ 209,855.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
36		$ 104,306.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization	Employer identification number
MANCHESTER MEMORIAL HOSPITAL	06-0646710

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
37		$ 650,078.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
38		$ 30,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
39		$ 31,767.	Person [ ] Payroll [ ] Noncash [X] (Complete Part II for noncash contributions.)
40		$ 12,475.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization	Employer identification number
MANCHESTER MEMORIAL HOSPITAL	06-0646710

Part II **Noncash Property** (see instructions). Use duplicate copies of Part II if additional space is needed.

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
39	VACCINES	$ 31,767.	09/30/14
		$	
		$	
		$	
		$	
		$	
		$	

Name of organization	Employer identification number
MANCHESTER MEMORIAL HOSPITAL	06-0646710

Part III *Exclusively* religious, charitable, etc., individual contributions to section 501(c)(7), (8), or (10) organizations that total more than $1,000 for the year. Complete columns **(a)** through **(e) and** the following line entry. For organizations completing Part III, enter the total of *exclusively* religious, charitable, etc., contributions of **$1,000 or less** for the year. (Enter this information once.) ▶ $_____

Use duplicate copies of Part III if additional space is needed.

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

SCHEDULE C
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Political Campaign and Lobbying Activities

For Organizations Exempt From Income Tax Under section 501(c) and section 527

▶ **Complete if the organization is described below.** ▶ **Attach to Form 990 or Form 990-EZ.**
▶ **See separate instructions.** ▶ **Information about Schedule C (Form 990 or 990-EZ) and its instructions is at** *www.irs.gov/form990.*

OMB No. 1545-0047

2013

Open to Public Inspection

If the organization answered "Yes," to Form 990, Part IV, line 3, or Form 990-EZ, Part V, line 46 (Political Campaign Activities), then

- Section 501(c)(3) organizations: Complete Parts I-A and B. Do not complete Part I-C.
- Section 501(c) (other than section 501(c)(3)) organizations: Complete Parts I-A and C below. Do not complete Part I-B.
- Section 527 organizations: Complete Part I-A only.

If the organization answered "Yes," to Form 990, Part IV, line 4, or Form 990-EZ, Part VI, line 47 (Lobbying Activities), then

- Section 501(c)(3) organizations that have filed Form 5768 (election under section 501(h)): Complete Part II-A. Do not complete Part II-B.
- Section 501(c)(3) organizations that have NOT filed Form 5768 (election under section 501(h)): Complete Part II-B. Do not complete Part II-A.

If the organization answered "Yes," to Form 990, Part IV, line 5 (Proxy Tax) or Form 990-EZ, Part V, line 35c (Proxy Tax), then

- Section 501(c)(4), (5), or (6) organizations: Complete Part III.

Name of organization	Employer identification number
MANCHESTER MEMORIAL HOSPITAL	06-0646710

Part I-A Complete if the organization is exempt under section 501(c) or is a section 527 organization.

1 Provide a description of the organization's direct and indirect political campaign activities in Part IV.
2 Political expenditures ▶ $
3 Volunteer hours

Part I-B Complete if the organization is exempt under section 501(c)(3).

1 Enter the amount of any excise tax incurred by the organization under section 4955 ▶ $
2 Enter the amount of any excise tax incurred by organization managers under section 4955 ▶ $
3 If the organization incurred a section 4955 tax, did it file Form 4720 for this year? ☐ Yes ☐ No
4a Was a correction made? ☐ Yes ☐ No
b If "Yes," describe in Part IV.

Part I-C Complete if the organization is exempt under section 501(c), except section 501(c)(3).

1 Enter the amount directly expended by the filing organization for section 527 exempt function activities ▶ $
2 Enter the amount of the filing organization's funds contributed to other organizations for section 527 exempt function activities ▶ $
3 Total exempt function expenditures. Add lines 1 and 2. Enter here and on Form 1120-POL, line 17b ▶ $
4 Did the filing organization file **Form 1120-POL** for this year? ☐ Yes ☐ No
5 Enter the names, addresses and employer identification number (EIN) of all section 527 political organizations to which the filing organization made payments. For each organization listed, enter the amount paid from the filing organization's funds. Also enter the amount of political contributions received that were promptly and directly delivered to a separate political organization, such as a separate segregated fund or a political action committee (PAC). If additional space is needed, provide information in Part IV.

(a) Name	**(b)** Address	**(c)** EIN	**(d)** Amount paid from filing organization's funds. If none, enter -0-.	**(e)** Amount of political contributions received and promptly and directly delivered to a separate political organization. If none, enter -0-.

Part II-A **Complete if the organization is exempt under section 501(c)(3) and filed Form 5768 (election under section 501(h)).**

A Check ▶ ☐ if the filing organization belongs to an affiliated group (and list in Part IV each affiliated group member's name, address, EIN, expenses, and share of excess lobbying expenditures).

B Check ▶ ☐ if the filing organization checked box A and "limited control" provisions apply.

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)	(a) Filing organization's totals	(b) Affiliated group totals
1a Total lobbying expenditures to influence public opinion (grass roots lobbying)		
b Total lobbying expenditures to influence a legislative body (direct lobbying)		
c Total lobbying expenditures (add lines 1a and 1b)		
d Other exempt purpose expenditures		
e Total exempt purpose expenditures (add lines 1c and 1d)		
f Lobbying nontaxable amount. Enter the amount from the following table in both columns.		

If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:
Not over $500,000	20% of the amount on line 1e.
Over $500,000 but not over $1,000,000	$100,000 plus 15% of the excess over $500,000.
Over $1,000,000 but not over $1,500,000	$175,000 plus 10% of the excess over $1,000,000.
Over $1,500,000 but not over $17,000,000	$225,000 plus 5% of the excess over $1,500,000.
Over $17,000,000	$1,000,000.

g Grassroots nontaxable amount (enter 25% of line 1f)		
h Subtract line 1g from line 1a. If zero or less, enter -0-		
i Subtract line 1f from line 1c. If zero or less, enter -0-		

j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year? ☐ **Yes** ☐ **No**

4-Year Averaging Period Under Section 501(h)
(Some organizations that made a section 501(h) election do not have to complete all of the five columns below. See the instructions for lines 2a through 2f on page 4.)

Lobbying Expenditures During 4-Year Averaging Period

Calendar year (or fiscal year beginning in)	(a) 2010	(b) 2011	(c) 2012	(d) 2013	(e) Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column(e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

Schedule C (Form 990 or 990-EZ) 2013

Part II-B **Complete if the organization is exempt under section 501(c)(3) and has NOT filed Form 5768 (election under section 501(h)).**

For each "Yes," response to lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.	(a) Yes	(a) No	(b) Amount
1 During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
a Volunteers?		X	
b Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		X	
c Media advertisements?		X	
d Mailings to members, legislators, or the public?		X	
e Publications, or published or broadcast statements?		X	
f Grants to other organizations for lobbying purposes?		X	
g Direct contact with legislators, their staffs, government officials, or a legislative body?		X	
h Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		X	
i Other activities?	X		38,034.
j Total. Add lines 1c through 1i			38,034.
2a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		X	
b If "Yes," enter the amount of any tax incurred under section 4912			
c If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

Part III-A **Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6).**

			Yes	No
1	Were substantially all (90% or more) dues received nondeductible by members?	1		
2	Did the organization make only in-house lobbying expenditures of $2,000 or less?	2		
3	Did the organization agree to carry over lobbying and political expenditures from the prior year?	3		

Part III-B **Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6) and if either (a) BOTH Part III-A, lines 1 and 2, are answered "No," OR (b) Part III-A, line 3, is answered "Yes."**

1	Dues, assessments and similar amounts from members	1	
2	Section 162(e) nondeductible lobbying and political expenditures **(do not include amounts of political expenses for which the section 527(f) tax was paid).**		
a	Current year	2a	
b	Carryover from last year	2b	
c	Total	2c	
3	Aggregate amount reported in section 6033(e)(1)(A) notices of nondeductible section 162(e) dues	3	
4	If notices were sent and the amount on line 2c exceeds the amount on line 3, what portion of the excess does the organization agree to carryover to the reasonable estimate of nondeductible lobbying and political expenditure next year?	4	
5	Taxable amount of lobbying and political expenditures (see instructions)	5	

Part IV **Supplemental Information**

Provide the descriptions required for Part I-A, line 1; Part I-B, line 4; Part I-C, line 5; Part II-A (affiliated group list); Part II-A, line 2; and Part II-B, line 1. Also, complete this part for any additional information.

PART II-B, LINE 1, LOBBYING ACTIVITIES:

THE CONNECTICUT HOSPITAL ASSOCIATION (CHA) HAS DETERMINED THAT FOR ITS FISCAL YEAR THAT $27,812 OF ITS MEMBERSHIP DUES FROM MANCHESTER MEMORIAL HOSPITAL WERE USED FOR LOBBYING PURPOSES. THE TOTAL LOBBYING PORTION FROM THE AMERICAN HOSPITAL ASSOCIATION (AHA) FOR MANCHESTER MEMORIAL HOSPITAL WAS $10,222.

SCHEDULE D (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

▶ Complete if the organization answered "Yes," to Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.
▶ Attach to Form 990.
▶ Information about Schedule D (Form 990) and its instructions is at www.irs.gov/form990

OMB No. 1545-0047

2013

Open to Public Inspection

Name of the organization
MANCHESTER MEMORIAL HOSPITAL

Employer identification number
06-0646710

Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts. Complete if the organization answered "Yes" to Form 990, Part IV, line 6.

		(a) Donor advised funds	(b) Funds and other accounts
1	Total number at end of year		
2	Aggregate contributions to (during year)		
3	Aggregate grants from (during year)		
4	Aggregate value at end of year		

5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? ☐ Yes ☐ No

6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit? ☐ Yes ☐ No

Part II Conservation Easements. Complete if the organization answered "Yes" to Form 990, Part IV, line 7.

1 Purpose(s) of conservation easements held by the organization (check all that apply).
☐ Preservation of land for public use (e.g., recreation or education)
☐ Protection of natural habitat
☐ Preservation of open space
☐ Preservation of an historically important land area
☐ Preservation of a certified historic structure

2 Complete lines 2a through 2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year.

		Held at the End of the Tax Year
a	Total number of conservation easements	2a
b	Total acreage restricted by conservation easements	2b
c	Number of conservation easements on a certified historic structure included in (a)	2c
d	Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register	2d

3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year ▶ _____

4 Number of states where property subject to conservation easement is located ▶ _____

5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds? ☐ Yes ☐ No

6 Staff and volunteer hours devoted to monitoring, inspecting, and enforcing conservation easements during the year ▶ _____

7 Amount of expenses incurred in monitoring, inspecting, and enforcing conservation easements during the year ▶ $ _____

8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)? ☐ Yes ☐ No

9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements.

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets.

Complete if the organization answered "Yes" to Form 990, Part IV, line 8.

1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items.

b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items:

(i) Revenues included in Form 990, Part VIII, line 1 ▶ $ _____

(ii) Assets included in Form 990, Part X ▶ $ _____

2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items:

a Revenues included in Form 990, Part VIII, line 1 ▶ $ _____

b Assets included in Form 990, Part X ▶ $ _____

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets *(continued)*

3 Using the organization's acquisition, accession, and other records, check any of the following that are a significant use of its collection items (check all that apply):

a ☐ Public exhibition
b ☐ Scholarly research
c ☐ Preservation for future generations
d ☐ Loan or exchange programs
e ☐ Other

4 Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII.

5 During the year, did the organization solicit or receive donations of art, historical treasures, or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection? ☐ Yes ☐ No

Part IV Escrow and Custodial Arrangements. Complete if the organization answered "Yes" to Form 990, Part IV, line 9, or reported an amount on Form 990, Part X, line 21.

1a Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X? ☐ Yes ☐ No

b If "Yes," explain the arrangement in Part XIII and complete the following table:

		Amount
c Beginning balance	1c	
d Additions during the year	1d	
e Distributions during the year	1e	
f Ending balance	1f	

2a Did the organization include an amount on Form 990, Part X, line 21? ☐ Yes ☐ No

b If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided in Part XIII ☐

Part V Endowment Funds. Complete if the organization answered "Yes" to Form 990, Part IV, line 10.

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance	10,402,048.	9,747,173.	8,023,690.	8,100,283.	7,537,396.
b Contributions	34,372.				
c Net investment earnings, gains, and losses	838,838.	1,854,875.	1,723,483.	-76,593.	562,887.
d Grants or scholarships					
e Other expenditures for facilities and programs		1,200,000.			
f Administrative expenses	1,199.				
g End of year balance	11,274,059.	10,402,048.	9,747,173.	8,023,690.	8,100,283.

2 Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:

a Board designated or quasi-endowment ▶ 84.22 %
b Permanent endowment ▶ 14.14 %
c Temporarily restricted endowment ▶ 1.64 %

The percentages in lines 2a, 2b, and 2c should equal 100%.

3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by:

	Yes	No
(i) unrelated organizations (3a(i))		X
(ii) related organizations (3a(ii))	X	
b If "Yes" to 3a(ii), are the related organizations listed as required on Schedule R? (3b)	X	

4 Describe in Part XIII the intended uses of the organization's endowment funds.

Part VI Land, Buildings, and Equipment.

Complete if the organization answered "Yes" to Form 990, Part IV, line 11a. See Form 990, Part X, line 10.

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		1,429,966.		1,429,966.
b Buildings		93,173,174.	52,705,390.	40,467,784.
c Leasehold improvements		1,687,509.	405,054.	1,282,455.
d Equipment		97,204,134.	87,550,148.	9,653,986.
e Other		3,703,749.	820,298.	2,883,451.
Total. Add lines 1a through 1e. *(Column (d) must equal Form 990, Part X, column (B), line 10(c).)* ▶				55,717,642.

Schedule D (Form 990) 2013

Part VII Investments - Other Securities.

Complete if the organization answered "Yes" to Form 990, Part IV, line 11b. See Form 990, Part X, line 12.

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1) Financial derivatives		
(2) Closely-held equity interests		
(3) Other		
(A) FUNDS HELD UNDER BOND		
(B) INDENTURE	4,151,976.	END-OF-YEAR MARKET VALUE
(C) BENEFICIAL INTEREST IN		
(D) TRUST ASSETS	9,599,529.	END-OF-YEAR MARKET VALUE
(E) FUNDS HELD IN TRUST FOR		
(F) EST SELF INSURANCE LIAB	1,488,787.	END-OF-YEAR MARKET VALUE
(G)		
(H)		
Total. (Col. (b) must equal Form 990, Part X, col. (B) line 12.) ▶	15,240,292.	

Part VIII Investments - Program Related.

Complete if the organization answered "Yes" to Form 990, Part IV, line 11c. See Form 990, Part X, line 13.

(a) Description of investment	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1) INTEREST IN NET ASSTS OF		
(2) ECHN COMMUNITY HEALTHCARE		
(3) FOUNDATION, INC.	7,323,190.	END-OF-YEAR MARKET VALUE
(4) INVESTMENTS IN JOINT		
(5) VENTURES	3,849,302.	COST
(6)		
(7)		
(8)		
(9)		
Total. (Col. (b) must equal Form 990, Part X, col. (B) line 13.) ▶	11,172,492.	

Part IX Other Assets.

Complete if the organization answered "Yes" to Form 990, Part IV, line 11d. See Form 990, Part X, line 15.

(a) Description	(b) Book value
(1) DUE FROM AFFILIATES	20,255,956.
(2) ESTIMATED SETTLEMENTS DUE FROM THIRD PARTY PAYERS	4,139,819.
(3) OTHER	1,923,107.
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 15.) ▶	26,318,882.

Part X Other Liabilities.

Complete if the organization answered "Yes" to Form 990, Part IV, line 11e or 11f. See Form 990, Part X, line 25.

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) CONDITIONAL RETIREMENT ASSET	
(3) OBLIGATIONS	279,796.
(4) OTHER CURRENT LIABILITIES	2,653,756.
(5) ESTIMATED SELF INSURANCE	
(6) LIABILITIES	6,835,215.
(7) ACCRUED PENSION AND POST	
(8) RETIREMENT BENEFITS	35,620,305.
(9) DUE TO AFFILIATES	5,322,021.
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶	55,000,008.

2. Liability for uncertain tax positions. In Part XIII, provide the text of the footnote to the organization's financial statements that reports the organization's liability for uncertain tax positions under FIN 48 (ASC 740). Check here if the text of the footnote has been provided in Part XIII [X]

Part XI Reconciliation of Revenue per Audited Financial Statements With Revenue per Return.

Complete if the organization answered "Yes" to Form 990, Part IV, line 12a.

1	Total revenue, gains, and other support per audited financial statements			1	189,545,063.
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12:				
a	Net unrealized gains on investments	2a			
b	Donated services and use of facilities	2b			
c	Recoveries of prior year grants	2c			
d	Other (Describe in Part XIII.)	2d	1,405,860.		
e	Add lines **2a** through **2d**			2e	1,405,860.
3	Subtract line **2e** from line **1**			3	188,139,203.
4	Amounts included on Form 990, Part VIII, line 12, but not on line 1:				
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a			
b	Other (Describe in Part XIII.)	4b	4,117,907.		
c	Add lines **4a** and **4b**			4c	4,117,907.
5	Total revenue. Add lines **3** and **4c.** *(This must equal Form 990, Part I, line 12.)*			5	192,257,110.

Part XII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return.

Complete if the organization answered "Yes" to Form 990, Part IV, line 12a.

1	Total expenses and losses per audited financial statements			1	187,052,881.
2	Amounts included on line 1 but not on Form 990, Part IX, line 25:				
a	Donated services and use of facilities	2a			
b	Prior year adjustments	2b			
c	Other losses	2c			
d	Other (Describe in Part XIII.)	2d	918,952.		
e	Add lines **2a** through **2d**			2e	918,952.
3	Subtract line **2e** from line **1**			3	186,133,929.
4	Amounts included on Form 990, Part IX, line 25, but not on line 1:				
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a			
b	Other (Describe in Part XIII.)	4b			
c	Add lines **4a** and **4b**			4c	0.
5	Total expenses. Add lines **3** and **4c.** *(This must equal Form 990, Part I, line 18.)*			5	186,133,929.

Part XIII Supplemental Information.

Provide the descriptions required for Part II, lines 3, 5, and 9; Part III, lines 1a and 4; Part IV, lines 1b and 2b; Part V, line 4; Part X, line 2; Part XI, lines 2d and 4b; and Part XII, lines 2d and 4b. Also complete this part to provide any additional information.

PART V, LINE 4:

THE PRINCIPAL AND INCOME FROM THE UNRESTRICTED ENDOWMENT FUNDS AND THE INCOME FROM THE TERM ENDOWMENTS ARE FOR CAPITAL AND OPERATING NEEDS OF MANCHESTER MEMORIAL HOSPITAL. THE INCOME FROM THE PERMANENT ENDOWMENTS AND PRINCIPAL FROM THE TERM ENDOWMENTS ARE FOR THE USE OF MANCHESTER MEMORIAL HOSPITAL AS RESTRICTED BY THE DONORS.

PART X, LINE 2:

THE HOSPITAL ACCOUNTS FOR UNCERTAIN TAX POSITIONS IN ACCORDANCE WITH PROVISIONS OF FASB ASC 740, "INCOME TAXES," WHICH PROVIDES A FRAMEWORK FOR HOW COMPANIES SHOULD RECOGNIZE, MEASURE, PRESENT AND DISCLOSE UNCERTAIN TAX POSITIONS IN THEIR FINANCIAL STATEMENTS. THE

Part XIII Supplemental Information *(continued)*

HOSPITAL MAY RECOGNIZE THE TAX BENEFIT FROM AN UNCERTAIN TAX POSITION ONLY IF IT IS MORE LIKELY THAN NOT THAT THE TAX POSITION WILL BE SUSTAINED ON EXAMINATION BY THE TAXING AUTHORITIES, BASED ON THE TECHNICAL MERITS OF THE POSITION.

THE HOSPITAL DOES NOT HAVE ANY UNCERTAIN TAX POSITIONS AS OF SEPTEMBER 30, 2014 AND 2013. AS OF SEPTEMBER 30, 2014 AND 2013, THE HOSPITAL DID NOT RECORD ANY PENALTIES OR INTEREST ASSOCIATED WITH UNCERTAIN TAX POSITIONS. THE HOSPITAL'S PRIOR THREE TAX YEARS ARE OPEN AND SUBJECT TO EXAMINATION BY THE INTERNAL REVENUE SERVICE.

PART XI, LINE 2D - OTHER ADJUSTMENTS:

COST OF GOODS SOLD - GIFT SHOP	394,676.
NET RENTAL LOSS	341,454.
NET ASSETS RELEASED FROM RESTRICTIONS FOR OPERATIONS	486,908.
FUNDRAISING EVENT EXPENSES	182,822.
TOTAL TO SCHEDULE D, PART XI, LINE 2D	1,405,860.

PART XI, LINE 4B - OTHER ADJUSTMENTS:

TEMPORARILY RESTRICTED CONTRIBUTIONS AND INVESTMENT INCOME	366,157.
PERMAMENTLY RESTRICTED CONTRIBUTIONS AND INVESTMENT INCOME	3,751,750.
TOTAL TO SCHEDULE D, PART XI, LINE 4B	4,117,907.

PART XII, LINE 2D - OTHER ADJUSTMENTS:

COST OF GOODS SOLD - GIFT SHOP	394,676.
NET RENTAL LOSS	341,454.
FUNDRAISING EVENT EXPENSES	182,822.
TOTAL TO SCHEDULE D, PART XII, LINE 2D	918,952.

Part XIII Supplemental Information *(continued)*

Part X Other Liabilities. See Form 990, Part X, line 25.

(a) Description of liability	(b) Amount
DUE TO THIRD PARTY PAYERS	4,285,117.
MARKET VALUE SWAP	3,798.

SCHEDULE G
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information Regarding Fundraising or Gaming Activities

Complete if the organization answered "Yes" to Form 990, Part IV, lines 17, 18, or 19, or if the organization entered more than $15,000 on Form 990-EZ, line 6a.

▶ **Attach to Form 990 or Form 990-EZ.**

▶ **Information about Schedule G (Form 990 or 990-EZ) and its instructions is at** *www.irs.gov/form990*

OMB No. 1545-0047

2013

Open To Public Inspection

Name of the organization

MANCHESTER MEMORIAL HOSPITAL

Employer identification number

06-0646710

Part I **Fundraising Activities.** Complete if the organization answered "Yes" to Form 990, Part IV, line 17. Form 990-EZ filers are not required to complete this part.

1 Indicate whether the organization raised funds through any of the following activities. Check all that apply.

- **a** ☐ Mail solicitations
- **b** ☐ Internet and email solicitations
- **c** ☐ Phone solicitations
- **d** ☐ In-person solicitations
- **e** ☐ Solicitation of non-government grants
- **f** ☐ Solicitation of government grants
- **g** ☐ Special fundraising events

2 a Did the organization have a written or oral agreement with any individual (including officers, directors, trustees or key employees listed in Form 990, Part VII) or entity in connection with professional fundraising services? ☐ **Yes** ☐ **No**

b If "Yes," list the ten highest paid individuals or entities (fundraisers) pursuant to agreements under which the fundraiser is to be compensated at least $5,000 by the organization.

(i) Name and address of individual or entity (fundraiser)	**(ii)** Activity	**(iii)** Did fundraiser have custody or control of contributions? Yes	No	**(iv)** Gross receipts from activity	**(v)** Amount paid to (or retained by) fundraiser listed in col. **(i)**	**(vi)** Amount paid to (or retained by) organization
Total ▶						

3 List all states in which the organization is registered or licensed to solicit contributions or has been notified it is exempt from registration or licensing.

Part II **Fundraising Events.** Complete if the organization answered "Yes" to Form 990, Part IV, line 18, or reported more than $15,000 of fundraising event contributions and gross income on Form 990-EZ, lines 1 and 6b. List events with gross receipts greater than $5,000.

		(a) Event #1 HEALIUM BALL (event type)	(b) Event #2 (event type)	(c) Other events NONE (total number)	(d) Total events (add col. (a) through col. (c))
Revenue	1 Gross receipts	321,543.			321,543.
	2 Less: Contributions	250,818.			250,818.
	3 Gross income (line 1 minus line 2)	70,725.			70,725.
Direct Expenses	4 Cash prizes				
	5 Noncash prizes				
	6 Rent/facility costs	7,500.			7,500.
	7 Food and beverages	65,310.			65,310.
	8 Entertainment	15,550.			15,550.
	9 Other direct expenses	94,462.			94,462.
	10 Direct expense summary. Add lines 4 through 9 in column (d)			▶	182,822.
	11 Net income summary. Subtract line 10 from line 3, column (d)			▶	-112,097.

Part III **Gaming.** Complete if the organization answered "Yes" to Form 990, Part IV, line 19, or reported more than $15,000 on Form 990-EZ, line 6a.

		(a) Bingo	(b) Pull tabs/instant bingo/progressive bingo	(c) Other gaming	(d) Total gaming (add col. (a) through col. (c))
Revenue	1 Gross revenue				
Direct Expenses	2 Cash prizes				
	3 Noncash prizes				
	4 Rent/facility costs				
	5 Other direct expenses				
	6 Volunteer labor	☐ Yes ____ % ☐ No	☐ Yes ____ % ☐ No	☐ Yes ____ % ☐ No	
	7 Direct expense summary. Add lines 2 through 5 in column (d)			▶	
	8 Net gaming income summary. Subtract line 7 from line 1, column (d)			▶	

9 Enter the state(s) in which the organization operates gaming activities: _____

a Is the organization licensed to operate gaming activities in each of these states? ☐ Yes ☐ No

b If "No," explain: _____

10a Were any of the organization's gaming licenses revoked, suspended or terminated during the tax year? ☐ Yes ☐ No

b If "Yes," explain: _____

11 Does the organization operate gaming activities with nonmembers? ☐ Yes ☐ No

12 Is the organization a grantor, beneficiary or trustee of a trust or a member of a partnership or other entity formed to administer charitable gaming? ☐ Yes ☐ No

13 Indicate the percentage of gaming activity operated in:

a The organization's facility	**13a**	%
b An outside facility	**13b**	%

14 Enter the name and address of the person who prepares the organization's gaming/special events books and records:

Name ▶ _____

Address ▶ _____

15a Does the organization have a contract with a third party from whom the organization receives gaming revenue? ☐ Yes ☐ No

b If "Yes," enter the amount of gaming revenue received by the organization ▶ $ _____ and the amount of gaming revenue retained by the third party ▶ $ _____ .

c If "Yes," enter name and address of the third party:

Name ▶ _____

Address ▶ _____

16 Gaming manager information:

Name ▶ _____

Gaming manager compensation ▶ $ _____

Description of services provided ▶ _____

☐ Director/officer ☐ Employee ☐ Independent contractor

17 Mandatory distributions:

a Is the organization required under state law to make charitable distributions from the gaming proceeds to retain the state gaming license? ☐ Yes ☐ No

b Enter the amount of distributions required under state law to be distributed to other exempt organizations or spent in the organization's own exempt activities during the tax year ▶ $

Part IV **Supplemental Information.** Provide the explanations required by Part I, line 2b, columns (iii) and (v), and Part III, lines 9, 9b, 10b, 15b, 15c, 16, and 17b, as applicable. Also complete this part to provide any additional information (see instructions).

SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

▶ Complete if the organization answered "Yes" to Form 990, Part IV, question 20.
▶ Attach to Form 990. ▶ See separate instructions.
▶ Information about Schedule H (Form 990) and its instructions is at www.irs.gov/form990 .

OMB No. 1545-0047

2013

Open to Public Inspection

Name of the organization

MANCHESTER MEMORIAL HOSPITAL

Employer identification number

06-0646710

Part I Financial Assistance and Certain Other Community Benefits at Cost

		Yes	No
1a Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	1a	X	
b If "Yes," was it a written policy?	1b	X	
2 If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. ☐ Applied uniformly to all hospital facilities ☐ Applied uniformly to most hospital facilities ☐ Generally tailored to individual hospital facilities			
3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.			
a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing *free* care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: ☐ 100% ☐ 150% ☐ 200% ☒ Other 125 %	3a	X	
b Did the organization use FPG as a factor in determining eligibility for providing *discounted* care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: ☐ 200% ☐ 250% ☐ 300% ☐ 350% ☒ 400% ☐ Other _____ %	3b	X	
c If the organization used factors other than FPG in determining eligibility, describe in Part VI the income based criteria for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.			
4 Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	4	X	
5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a		X
b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b		
c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?	5c		
6a Did the organization prepare a community benefit report during the tax year?	6a	X	
b If "Yes," did the organization make it available to the public?	6b	X	

Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)		1,000	675,395.	97,991.	577,404.	.31%
b Medicaid (from Worksheet 3, column a)		44,576	35168336.	27000727.	8167609.	4.39%
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs		45,576	35843731.	27098718.	8745013.	4.70%
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)	24	105,167	1180159.	80,037.	1100122.	.59%
f Health professions education (from Worksheet 5)	13	446	3359486.	1031481.	2328005.	1.25%
g Subsidized health services (from Worksheet 6)	5	6,075	6143894.	3413247.	2730647.	1.47%
h Research (from Worksheet 7)	2	0	275,691.	0.	275,691.	.15%
i Cash and in-kind contributions for community benefit (from Worksheet 8)	11	13,134	220,298.	19,600.	200,698.	.11%
j **Total.** Other Benefits	55	124,822	11179528.	4544365.	6635163.	3.57%
k **Total.** Add lines 7d and 7j	55	170,398	47023259.	31643083.	15380176.	8.27%

Part II Community Building Activities Complete this table if the organization conducted any community building activities during the tax year, and describe in Part VI how its community building activities promoted the health of the communities it serves.

		(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1	Physical improvements and housing						
2	Economic development	1		1,543.		1,543.	.00%
3	Community support	4	1,100	1688753.	1547956.	140,797.	.08%
4	Environmental improvements						
5	Leadership development and training for community members						
6	Coalition building	6		20,884.		20,884.	.01%
7	Community health improvement advocacy	1		5,472.		5,472.	.00%
8	Workforce development	6	156	434,535.	309,825.	124,710.	.07%
9	Other						
10	Total	18	1,256	2151187.	1857781.	293,406.	.16%

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

			Yes	No
1	Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1	X	
2	Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount	2 5,822,470.		
3	Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit	3 2,411,263.		
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.			

Section B. Medicare

5	Enter total revenue received from Medicare (including DSH and IME)	5	48,584,349.
6	Enter Medicare allowable costs of care relating to payments on line 5	6	53,675,235.
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7	-5,090,886.
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: ☐ Cost accounting system ☒ Cost to charge ratio ☐ Other		

Section C. Collection Practices

9a	Did the organization have a written debt collection policy during the tax year?	9a	X	
b	If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI	9b	X	

Part IV Management Companies and Joint Ventures (owned 10% or more by officers, directors, trustees, key employees, and physicians - see instructions)

(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %

Part V Facility Information

Section A. Hospital Facilities
(list in order of size, from largest to smallest)

How many hospital facilities did the organization operate during the tax year? 1

Name, address, primary website address, and state license number	Licensed hospital	Gen. medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
1 MANCHESTER MEMORIAL HOSPITAL 71 HAYNES STREET MANCHESTER, CT 06040 00048	X	X		X			X			

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

(Complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)

Name of hospital facility or facility reporting group MANCHESTER MEMORIAL HOSPITAL

If reporting on Part V, Section B for a single hospital facility only: line number of hospital facility (from Schedule H, Part V, Section A) 1

			Yes	No
Community Health Needs Assessment (Lines 1 through 8c are optional for tax years beginning on or before March 23, 2012)				
1	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 9	1	X	
	If "Yes," indicate what the CHNA report describes (check all that apply):			
a	[X] A definition of the community served by the hospital facility			
b	[X] Demographics of the community			
c	[X] Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	[X] How data was obtained			
e	[X] The health needs of the community			
f	[X] Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	[X] The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	[X] The process for consulting with persons representing the community's interests			
i	[X] Information gaps that limit the hospital facility's ability to assess the community's health needs			
j	[ ] Other (describe in Section C)			
2	Indicate the tax year the hospital facility last conducted a CHNA: 20 12			
3	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	3	X	
4	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	4	X	
5	Did the hospital facility make its CHNA report widely available to the public?	5	X	
	If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a	[X] Hospital facility's website (list url): WWW.ECHN.ORG			
b	[ ] Other website (list url):			
c	[X] Available upon request from the hospital facility			
d	[X] Other (describe in Section C)			
6	If the hospital facility addressed needs identified in its most recently conducted CHNA, indicate how (check all that apply as of the end of the tax year):			
a	[X] Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA			
b	[X] Execution of the implementation strategy			
c	[ ] Participation in the development of a community-wide plan			
d	[ ] Participation in the execution of a community-wide plan			
e	[ ] Inclusion of a community benefit section in operational plans			
f	[ ] Adoption of a budget for provision of services that address the needs identified in the CHNA			
g	[X] Prioritization of health needs in its community			
h	[X] Prioritization of services that the hospital facility will undertake to meet health needs in its community			
i	[ ] Other (describe in Section C)			
7	Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If "No," explain in Section C which needs it has not addressed and the reasons why it has not addressed such needs	7		X
8a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	8a		X
b	If "Yes" to line 8a, did the organization file Form 4720 to report the section 4959 excise tax?	8b		
c	If "Yes" to line 8b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)* MANCHESTER MEMORIAL HOSPITAL

			Yes	No
Financial Assistance Policy				
	Did the hospital facility have in place during the tax year a written financial assistance policy that:			
9	Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	9	X	
10	Used federal poverty guidelines (FPG) to determine eligibility for providing *free* care?	10	X	
	If "Yes," indicate the FPG family income limit for eligibility for free care: 125 %			
	If "No," explain in Section C the criteria the hospital facility used.			
11	Used FPG to determine eligibility for providing *discounted* care?	11	X	
	If "Yes," indicate the FPG family income limit for eligibility for discounted care: 400 %			
	If "No," explain in Section C the criteria the hospital facility used.			
12	Explained the basis for calculating amounts charged to patients?	12	X	
	If "Yes," indicate the factors used in determining such amounts (check all that apply):			
a	[X] Income level			
b	[ ] Asset level			
c	[X] Medical indigency			
d	[ ] Insurance status			
e	[ ] Uninsured discount			
f	[ ] Medicaid/Medicare			
g	[ ] State regulation			
h	[ ] Residency			
i	[X] Other (describe in Section C)			
13	Explained the method for applying for financial assistance?	13	X	
14	Included measures to publicize the policy within the community served by the hospital facility?	14	X	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	[ ] The policy was posted on the hospital facility's website			
b	[X] The policy was attached to billing invoices			
c	[X] The policy was posted in the hospital facility's emergency rooms or waiting rooms			
d	[X] The policy was posted in the hospital facility's admissions offices			
e	[ ] The policy was provided, in writing, to patients on admission to the hospital facility			
f	[X] The policy was available on request			
g	[ ] Other (describe in Section C)			
Billing and Collections				
15	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained actions the hospital facility may take upon non-payment?	15	X	
16	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:			
a	[ ] Reporting to credit agency			
b	[ ] Lawsuits			
c	[ ] Liens on residences			
d	[ ] Body attachments			
e	[ ] Other similar actions (describe in Section C)			
17	Did the hospital facility or an authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP?	17		X
	If "Yes," check all actions in which the hospital facility or a third party engaged:			
a	[ ] Reporting to credit agency			
b	[ ] Lawsuits			
c	[ ] Liens on residences			
d	[ ] Body attachments			
e	[ ] Other similar actions (describe in Section C)			

Part V Facility Information *(continued)* MANCHESTER MEMORIAL HOSPITAL

18 Indicate which efforts the hospital facility made before initiating any of the actions listed in line 17 (check all that apply):

- **a** ☐ Notified individuals of the financial assistance policy on admission
- **b** ☐ Notified individuals of the financial assistance policy prior to discharge
- **c** ☐ Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills
- **d** ☐ Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy
- **e** ☐ Other (describe in Section C)

Policy Relating to Emergency Medical Care

		Yes	No
19 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?	19	X	

If "No," indicate why:

- **a** ☐ The hospital facility did not provide care for any emergency medical conditions
- **b** ☐ The hospital facility's policy was not in writing
- **c** ☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)
- **d** ☐ Other (describe in Section C)

Charges to Individuals Eligible for Assistance under the FAP (FAP-Eligible Individuals)

20 Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.

- **a** ☐ The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged
- **b** ☐ The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged
- **c** ☐ The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged
- **d** ☒ Other (describe in Section C)

21 During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Section C.	21		X
22 During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? If "Yes," explain in Section C.	22		X

Schedule H (Form 990) 2013

Part V **Facility Information** *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A, " "Facility B," etc.

MANCHESTER MEMORIAL HOSPITAL:

PART V, SECTION B, LINE 3: AS PART OF ITS CHNA, MMH INVITED COMMUNITY AGENCIES AND ORGANIZATIONS THROUGHOUT THE SERVICE AREA, REPRESENTING A VARIETY OF MEDICALLY UNDERSERVED, LOW-INCOME AND MINORITY POPULATIONS, TO PARTICIPATE IN AN ONLINE SURVEY, WHICH ASKED QUESTIONS ABOUT WHAT THE INDIVIDUALS PERCEIVED TO BE HEALTHY AND UNHEALTHY ABOUT THE COMMUNITY, WHAT THEIR PERCEPTION IS OF MMH AND THE PROGRAMS AND SERVICES IT OFFERS, AND WHAT MMH CAN DO TO IMPROVE THE HEALTH AND QUALITY OF LIFE IN THE COMMUNITY. AGENCIES AND ORGANIZATIONS RESPONDING TO THE SURVEY INCLUDED THE DEPARTMENT OF PUBLIC HEALTH WIC PROGRAM, COMMUNITY CHILD GUIDANCE CLINIC, VERNON YOUTH SERVICES BUREAU, TOWN OF ELLINGTON HUMAN SERVICES, TOWN OF MANCHESTER HEALTH DEPARTMENT, TOWN OF ANDOVER ELDER SERVICES, MAPLE STREET SCHOOL IN VERNON, VERNON ADULT EDUCATION, INDIAN VALLEY YMCA, AND MARC, INC.

MANCHESTER MEMORIAL HOSPITAL:

PART V, SECTION B, LINE 4: THE CHNA WAS CONDUCTED BY EASTERN CONNECTICUT HEALTH NETWORK, WHICH INCLUDES MANCHESTER MEMORIAL HOSPITAL AND ROCKVILLE GENERAL HOSPITAL.

MANCHESTER MEMORIAL HOSPITAL:

PART V, SECTION B, LINE 5D: HTTP://WWW.ECHN.ORG/ABOUT-ECHN/COMMUNITY-BENEFIT-REPORTING.ASPX

Part V **Facility Information** *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A, " "Facility B," etc.

MANCHESTER MEMORIAL HOSPITAL:

PART V, SECTION B, LINE 7: AFTER REVIEWING THE CHNA DATA, THE OVERSIGHT COMMITTEE IDENTIFIED EIGHT HEALTH AREAS OF NEED (HEART DISEASE INCIDENCE, CANCER INCIDENCE, DIABETES INCIDENCE, ARTHRITIS INCIDENCE, ALZHEIMER'S DISEASE INCIDENCE, MULTIPLE SCLEROSIS INCIDENCE, SUBSTANCE ABUSE AND CHILDHOOD LEAD SCREENING), HOWEVER IT WAS DETERMINED THAT ALL NEEDS COULD NOT BE ADDRESSED BASED ON THE HOSPITAL'S ABILITY TO IMPACT THE NEEDS AND THE AVAILABILITY OF RESOURCES THAT EXIST TO ADDRESS THEM. THE FOLLOWING HEALTH NEEDS WERE IDENTIFIED AS THE HIGHEST PRIORITY: HEART DISEASE INCIDENCE, CANCER INCIDENCE, DIABETES INCIDENCE AND ARTHRITIS INCIDENCE.

THE HOSPITAL WILL NOT ADDRESS THE FOLLOWING HEALTH NEEDS THAT WERE OUTLINED IN THE COMMUNITY HEALTH NEEDS ASSESSMENT: ALZHEIMER'S DISEASE INCIDENCE, MULTIPLE SCLEROSIS INCIDENCE, SUBSTANCE ABUSE AND CHILDHOOD LEAD SCREENING. IN DISCUSSING AND PRIORITIZING ALL OF THE IDENTIFIED HEALTH NEEDS, THE OVERSIGHT COMMITTEE DETERMINED THAT THESE NEEDS WERE ALREADY BEING ADDRESSED BY OTHER HEALTHCARE AGENCIES AND PROVIDERS. ADDITIONALLY, SOME COMMUNITY NEEDS FALL OUTSIDE THE SCOPE OF THE EXPERTISE AND RESOURCES OF THE HOSPITAL.

MANCHESTER MEMORIAL HOSPITAL:

PART V, SECTION B, LINE 12I: FAMILY SIZE IS USED WITH INCOME LEVEL.

MANCHESTER MEMORIAL HOSPITAL:

Part V **Facility Information** *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A, " "Facility B," etc.

PART V, SECTION B, LINE 20D: CHARGES ARE UNIFORMLY SET FOR ALL PATIENTS REGARDLESS OF PAYOR AND CHARITY CARE DISCOUNT IS APPLIED BASED ON INCOME.

Part V **Facility Information** *(continued)*

Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

(list in order of size, from largest to smallest)

How many non-hospital health care facilities did the organization operate during the tax year? 0

Name and address	Type of Facility (describe)

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

PART II, COMMUNITY BUILDING ACTIVITIES:

MANCHESTER MEMORIAL HOSPITAL (MMH), AS PART OF EASTERN CONNECTICUT HEALTH NETWORK, PROMOTES THE HEALTH OF THE COMMUNITIES IT SERVES BY COMMITTING THE EXPERTISE AND RESOURCES OF THE ORGANIZATION TO A NUMBER OF COMMUNITY BUILDING ACTIVITIES THAT SUPPORT ASSOCIATIONS, BUSINESSES, PROGRAMS, INITIATIVES AND OTHER VALUABLE LOCAL COMMUNITY ASSETS. THROUGH GRANTS PROVIDED BY THE FEDERAL AND STATE GOVERNMENTS, MMH OFFERS FREE SUPPORT PROGRAMS TO CHILDREN AND THEIR FAMILIES TO PROMOTE POSITIVE FAMILY LIFE SKILLS AND CHILD DEVELOPMENT. IN FY 2014, THESE PROGRAMS BENEFITED 995 INDIVIDUALS WITH MMH PROVIDING NEARLY $133,000 OF IN-KIND RESOURCES AND SERVICES. OTHER COMMUNITY BUILDING ACTIVITIES INCLUDE SERVING ON THE BOARD AND EXECUTIVE COMMITTEE OF REGIONAL CHAMBERS OF COMMERCE IN SUPPORT OF THE LOCAL BUSINESS INDUSTRY; HOSTING ART EXHIBITS OF THE MANCHESTER ART ASSOCIATION; WORKING WITH THE MANCHESTER VETERANS COUNCIL TO HONOR VETERANS IN AN ANNUAL VETERANS DAY CEREMONY FOR THE COMMUNITY; PARTNERING WITH THE LOCAL SCHOOL SYSTEMS AND COLLEGES IN VARIOUS WORKFORCE DEVELOPMENT PROGRAMS; PROVIDING VOCATIONAL SERVICES TO RESIDENTS; SERVING ON THE AMERICAN HOSPITAL ASSOCIATION'S REGIONAL POLICY

Part VI Supplemental Information *(Continuation)*

BOARD; THE DEPARTMENT OF PUBLIC HEALTH'S OFFICE OF EMERGENCY MEDICAL SERVICE MEDICAL ADVISORY COMMITTEE, THE CONNECTICUT EMS ADVISORY BOARD, THE CONNECTICUT EMS ADVISORY COMMITTEE, THE REGIONAL MEDICAL ADVISORY COMMITTEE, THE REGIONAL ED STANDARDS BOARD, THE STATE EMS EDUCATION AND TRAINING COMMITTEE, EMS CLINICAL COORDINATORS AND NUMEROUS COMMUNITY COALITIONS THAT ADDRESS ADOLESCENT BEHAVIORAL HEALTH CONCERNS. AS A RESULT OF THESE ACTIVITIES, THERE HAS BEEN IMPROVED COLLABORATION AMONG COMMUNITY PROVIDERS AND OTHERS INVOLVED IN PROVIDING SERVICES TO CHILDREN, ADOLESCENTS AND THEIR FAMILIES AND OTHER ADULTS.

PART III, LINE 4:

THE HOSPITAL PROVIDES FOR A PROVISION FOR BAD DEBTS. FOR RECEIVABLES ASSOCIATED WITH SERVICES PROVIDED TO PATIENTS WHO HAVE THIRD-PARTY COVERAGE, THE HOSPITAL ANALYZES CONTRACTUALLY DUE AMOUNTS AND PROVIDES AN ALLOWANCE FOR DOUBTFUL ACCOUNTS AND A PROVISION FOR BAD DEBTS (FOR EXAMPLE, FOR EXPECTED UNCOLLECTIBLE DEDUCTIBLES AND COPAYMENTS ON ACCOUNTS FOR WHICH THE THIRD-PARTY PAYER HAS NOT YET PAID, OR FOR PAYERS WHO ARE KNOWN TO BE HAVING FINANCIAL DIFFICULTIES THAT MAKE THE REALIZATION OF AMOUNTS DUE UNLIKELY). FOR RECEIVABLES ASSOCIATED WITH SELF-PAY PATIENTS (WHICH INCLUDES BOTH PATIENTS WITHOUT INSURANCE AND PATIENTS WITH DEDUCTIBLE AND CO-PAYMENT BALANCES DUE FOR WHICH THIRD-PARTY COVERAGE EXISTS FOR PART OF THE BILL), THE HOSPITAL RECORDS A SIGNIFICANT PROVISION FOR BAD DEBTS IN THE PERIOD OF SERVICE ON THE BASIS OF ITS PAST EXPERIENCE, WHICH INDICATES THAT MANY PATIENTS ARE UNABLE OR UNWILLING TO PAY THE PORTION OF THEIR BILL FOR WHICH THEY ARE FINANCIALLY RESPONSIBLE. FOR UNINSURED PATIENTS THAT DO NOT QUALIFY FOR FINANCIAL ASSISTANCE, THE HOSPITAL OFFERS A DISCOUNT OFF ITS STANDARD RATES FOR SERVICES PROVIDED. THE DIFFERENCE BETWEEN THE DISCOUNTED RATES AND THE AMOUNTS ACTUALLY

Part VI **Supplemental Information** *(Continuation)*

COLLECTED AFTER ALL REASONABLE COLLECTION EFFORTS HAVE BEEN EXHAUSTED IS WRITTEN OFF AGAINST THE ALLOWANCE FOR DOUBTFUL ACCOUNTS IN THE PERIOD THEY ARE DETERMINED UNCOLLECTIBLE.

PART III, LINE 8:

THE HOSPITAL PROVIDES QUALITY HEALTH CARE TO ALL, REGARDLESS OF THEIR ABILITY TO PAY. CHARITY CARE IS PROVIDED TO THOSE WHO ARE ELIGIBLE BASED ON MMH'S POLICY. MMH ALSO INCURS UNPAID COSTS FOR GOVERNMENT PROGRAMS BECAUSE REIMBURSEMENT IS NOT SUFFICIENT TO COVER COSTS ASSOCIATED WITH MEDICARE AND MEDICAID PATIENTS. THE ORGANIZATION'S MEDICARE COST REPORT WAS USED TO CALCULATE ACTUAL COSTS REPORTED ON PART III, LINE 6. THE ACCESS TO HEALTHCARE BY PATIENTS COVERED BY MEDICARE IS A FUNDAMENTAL PART OF THE HOSPITAL'S COMMUNITY BENEFIT PROGRAM.

PART III, LINE 9B:

INTERNAL AND EXTERNAL COLLECTION POLICIES AND PROCEDURES TAKE INTO ACCOUNT THE EXTENT TO WHICH A PATIENT IS QUALIFIED FOR CHARITY CARE OR DISCOUNTS. IN ADDITION, PATIENTS WHO QUALIFY FOR PARTIAL DISCOUNTS ARE REQUIRED TO MAKE A GOOD FAITH EFFORT TO HONOR PAYMENT AGREEMENTS WITH THE HOSPITAL, INCLUDING PAYMENT PLANS AND DISCOUNTED HOSPITAL BILLS. MMH IS COMMITTED TO WORKING WITH PATIENTS TO RESOLVE THEIR ACCOUNTS, AND AT ITS DISCRETION, MAY PROVIDE EXTENDED PAYMENT PLANS TO ELIGIBLE PATIENTS. MMH WILL NOT PURSUE LEGAL ACTION FOR NON-PAYMENT OF BILLS AGAINST CHARITY CARE PATIENTS WHO HAVE COOPERATED WITH THE HOSPITAL TO RESOLVE THEIR ACCOUNTS AND HAVE DEMONSTRATED THEIR INCOME AND/OR ASSETS ARE INSUFFICIENT TO PAY MEDICAL BILLS.

PART VI, LINE 2:

Part VI **Supplemental Information** *(Continuation)*

IN 2013, MMH COLLABORATED WITH ROCKVILLE GENERAL HOSPITAL, ALSO AN AFFILIATE OF ECHN, TO CONDUCT A COMPREHENSIVE COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA). THE GOALS OF THE ASSESSMENT WERE: TO IDENTIFY CURRENT AND FUTURE HEALTHCARE NEEDS IN THE COMMUNITY AND TO IMPROVE AND STRENGTHEN PROGRAMS AND SERVICES PROVIDED TO ADDRESS THEM.

THE CHNA PROCESS WAS LED BY AN OVERSIGHT COMMITTEE THAT INCLUDED MEMBERS OF THE ORGANIZATION WITH ESTABLISHED RELATIONSHIPS WITH COMMUNITY GROUPS AND AGENCIES. DATA COLLECTED FOR THE CHNA INCLUDED: HEALTH, SOCIAL, AND DEMOGRAPHIC DATA SPECIFIC TO MMH'S SERVICE AREA OBTAINED FROM LOCAL PUBLIC HEALTH AGENCIES, NATIONAL HEALTH ASSOCIATIONS AND OTHER DATA SOURCES; HEALTH BEHAVIOR INFORMATION COLLECTED FROM 1,047 RESIDENTS WHO RESPONDED TO A COMMUNITY SURVEY; INPUT FROM 12 COMMUNITY STAKEHOLDERS FROM LOCAL ORGANIZATIONS INVESTED IN THE HEALTH OF UNDERSERVED POPULATIONS.

ONCE ALL DATA WAS COLLECTED AND ANALYZED, THE OVERSIGHT COMMITTEE IDENTIFIED AND PRIORITIZED THE SERVICE AREA'S KEY HEALTH NEEDS AND DEVELOPED AN IMPLEMENTATION STRATEGY TO RESPOND TO THE NEEDS.

PART VI, LINE 3:

THE HOSPITAL COMMUNICATES THE AVAILABILITY OF FINANCIAL ASSISTANCE THROUGH NOTICES POSTED IN PUBLIC AREAS AROUND THE HOSPITAL, ON THE PATIENT BILLS, ON OUR WEBSITE, AND SELECTED PRE-SCHEDULED SERVICES TO ENSURE THAT THE FINANCIAL CAPACITY OF PEOPLE WHO NEED HEALTHCARE SERVICES DOES NOT PREVENT THEM FROM SEEKING OR RECEIVING CARE.

PART VI, LINE 4:

MANCHESTER MEMORIAL HOSPITAL, AS PART OF EASTERN CONNECTICUT

Part VI **Supplemental Information** *(Continuation)*

HEALTH NETWORK, SERVES A 19-TOWN PRIMARY AND SECONDARY SERVICE AREA LOCATED EAST OF THE CONNECTICUT RIVER IN NORTHERN CONNECTICUT WITH MUNICIPALITIES IN HARTFORD, TOLLAND AND WINDHAM COUNTIES. THE PRIMARY SERVICE AREA INCLUDES ANY TOWN WHERE TOTAL INPATIENT AND NEWBORN DISCHARGES ARE GREATER THAN OR EQUAL TO 20 PERCENT AND INCLUDES THE TOWNS OF MANCHESTER, SOUTH WINDSOR, BOLTON, COVENTRY, ANDOVER, ELLINGTON, TOLLAND, VERNON/ROCKVILLE AND WILLINGTON. THE SECONDARY SERVICE AREA INCLUDES ANY TOWN WHERE TOTAL INPATIENT AND NEWBORN DISCHARGES ARE GREATER THAN OR EQUAL TO FIVE PERCENT AND LESS THAN 20 PERCENT AND INCLUDES THE TOWNS OF ASHFORD, SOMERS, STAFFORD, UNION, EAST HARTFORD, EAST WINDSOR, GLASTONBURY, HEBRON, COLUMBIA AND MANSFIELD.

BASED ON DATA COLLECTED IN 2013, THE POPULATION OF THE ENTIRE SERVICE AREA IS 341,000; 49% MALE, 51% FEMALE. THE MEDIAN AGE OF RESIDENTS IS 39.5 YEARS WITH 33.3% OF THE POPULATION 50 YEARS OR OLDER. THE RACE OF THE RESIDENTS IS PREDOMINANTLY WHITE (80%) FOLLOWED BY BLACK/AFRICAN AMERICAN (8.3%), OTHER/MULTI-RACE (6.1%) AND ASIAN (5.3%). APPROXIMATELY 91.5% PERCENT OF THE POPULATION HAS A HIGH SCHOOL DEGREE AND 35.6% PERCENT HAVE A BACHELOR'S DEGREE OR HIGHER. THE MEDIAN HOUSEHOLD INCOME FOR THE SERVICE AREA IS $82,075 PER YEAR. JUST UNDER 8% OF HOUSEHOLDS HAVE ANNUAL INCOME AT THE FEDERAL POVERTY RATE. THE UNEMPLOYMENT RATE IS 7.4% AND THE AVERAGE HOUSEHOLD SIZE IS 2.61 PEOPLE.

PART VI, LINE 5:

COMMUNITY HEALTH EDUCATION INITIATIVES AND PROGRAMS ARE OFFERED TO THE COMMUNITY AND INCLUDE FREE COMMUNITY HEALTH EDUCATIONAL PROGRAMS, EDUCATION IN BETTER BEING (A FREE COMMUNITY WELLNESS MAGAZINE), PARTICIPATION IN COMMUNITY HEALTH FAIRS, THE DEVELOPMENT OF "FREEDOM FROM

Part VI Supplemental Information *(Continuation)*

SMOKING" SMOKING CESSATION PROGRAM, NUTRITION COUNSELING SERVICES, INTEGRATIVE MEDICINE PROGRAMS FOR STRESS REDUCTION, A "HEART TALK" COMMUNITY PROGRAM FOR PEOPLE LIVING WITH HEART FAILURE, THE PROMOTION OF CARDIAC REHABILITATION SERVICES, FREE CANCER SCREENINGS, ONCOLOGY NURSE NAVIGATOR AND SURVIVORSHIP NAVIGATORS SERVICES, ANNUAL CANCER SURVIVORS DAY EVENT, REGULAR CANCER SUPPORT GROUP MEETINGS, CANCER CAREGIVER WORKSHOPS, DIABETES SELF-MANAGEMENT PROGRAM, NUTRITION COUNSELING FOR INDIVIDUALS ALREADY DIAGNOSED WITH DIABETES, FAMILY SUPPORT GROUPS FOR FAMILIES WHO ARE DEALING WITH BEHAVIORAL HEALTH OR ADDICTION ISSUES, WOMEN'S HEALTH PRESENTATIONS IN THE COMMUNITY, TEEN SMOKING PREVENTION LECTURES AT AREA SCHOOLS, AND OTHER LECTURE PRESENTATIONS. THE EDUCATION PROGRAMS INCLUDE EDUCATING THE PUBLIC ABOUT MANAGING LIFESTYLE BEHAVIORS THAT IMPACT DIET, BLOOD PRESSURE, CHOLESTEROL, WEIGHT, PHYSICAL ACTIVITY, STRESS, CANCER RISKS, DIABETES AND ARTHRITIS. PROGRAMS ALSO INCLUDED LACTATION CONSULTING SERVICES AND A GROCERY STORE TOUR TO EDUCATE RESIDENTS ABOUT HEALTHY SHOPPING HABITS.

FREE HEALTH SCREENINGS INCLUDING DIABETIC FOOT CHECKS, MAMMOGRAMS, BLOOD PRESSURE, BONE DENSITY, GLUCOSE READINGS, INJURY SCREENINGS, VITAL SIGN CHECKS AND MEDICAL EXAMS ARE OFFERED IN THE COMMUNITY, TARGETING UNINSURED/UNDERINSURED POPULATIONS.

HEALTHCARE SUPPORT SERVICES ARE PROVIDED BY THE HOSPITAL TO INCREASE ACCESS AND QUALITY OF CARE TO INDIVIDUALS IN NEED. EFFORTS INCLUDE FREE TRANSPORTATION TO BEHAVIORAL HEALTH PATIENTS, ASSISTANCE TO ENROLL IN PUBLIC PROGRAMS, REFERRALS TO SOCIAL SERVICES AND PHYSICIANS ACCEPTING MEDICAID OR OTHER GOVERNMENT PROGRAMS, AND FREE LIFELINE PERSONAL RESPONSE SYSTEM SERVICE.

Part VI **Supplemental Information** *(Continuation)*

PARTNERING WITH LOCAL EDUCATIONAL INSTITUTIONS, MANCHESTER MEMORIAL HOSPITAL PROVIDES A CLINICAL SETTING FOR PHYSICIANS, NURSES, RADIOLOGIC TECHNICIANS, RESPIRATORY TECHNICIANS AND PHYSICAL THERAPISTS AND OTHERS FROM THE UNIVERSITY OF NEW ENGLAND COLLEGE OF OSTEOPATHIC MEDICINE, UNIVERSITY OF CONNECTICUT, MANCHESTER COMMUNITY COLLEGE, CENTRAL CONNECTICUT STATE UNIVERSITY, GOODWIN COLLEGE, CAPITAL COMMUNITY COLLEGE, ST. JOSEPH'S COLLEGE, QUINNIPIAC UNIVERSITY, UNIVERSITY OF HARTFORD, NAUGATUCK VALLEY COMMUNITY COLLEGE, CAMBRIDGE COLLEGE, SPRINGFIELD TECHNICAL COMMUNITY COLLEGE AND EASTERN CONNECTICUT STATE UNIVERSITY.

SPECIFIC RESEARCH INITIATIVES CONDUCTED BY THE HOSPITAL INCLUDE MAINTENANCE OF A CANCER REGISTRY DATABASE AND AN INSTITUTIONAL REVIEW COMMITTEE. FINANCIAL AND IN-KIND SERVICES AND GOODS ARE DONATED TO COMMUNITY GROUPS AND OTHER NOT FOR PROFIT ORGANIZATIONS INCLUDING PATIENT MEALS, LOCAL FUNDRAISERS, FACILITY SPACE TO HOST BLOOD DRIVES AND HEALTH SUPPORT GROUPS ORGANIZATIONS' MEETINGS.

PART VI, LINE 6:

MANCHESTER MEMORIAL HOSPITAL (MMH) IS AN AFFILIATE OF EASTERN CONNECTICUT HEALTH NETWORK (ECHN), A HEALTH CARE SYSTEM SERVING 19 TOWNS IN EASTERN CONNECTICUT. THE ECHN NETWORK OF AFFILIATES INCLUDES:

MANCHESTER MEMORIAL HOSPITAL, A COMMUNITY HOSPITAL LICENSED FOR 249 BEDS AND 34 BASSINETS, THAT OFFERS MEDICAL AND SURGICAL SERVICES, 24-HOUR EMERGENCY CARE, MEDICAL IMAGING, A MODERN FAMILY BIRTHING CENTER AND NEONATOLOGY SERVICES, REHABILITATION SERVICES, A CERTIFIED SLEEP DISORDERS CENTER, INTENSIVE CARE SUITES, A WOUND HEALING CENTER WITH HYPERBARIC THERAPY, HOSPICE CARE, DIABETES SELF-MANAGEMENT PROGRAM, CARDIAC &

Part VI **Supplemental Information** *(Continuation)*

PULMONARY REHABILITATION, A COMPREHENSIVE RANGE OF ADOLESCENT AND ADULT INPATIENT AND OUTPATIENT BEHAVIORAL HEALTH SERVICES, NUTRITION COUNSELING, LABORATORY SERVICES, MEDICAL EDUCATION (FAMILY MEDICINE RESIDENCY & INTERNSHIP PROGRAM; UNECOM MEDICAL STUDENTS; AND CONTINUING EDUCATION) AND THE EASTERN CONNECTICUT CANER INSTITUTE AT THE JOHN A. DEQUATTRO CANCER CENTER.

ROCKVILLE GENERAL HOSPITAL, A COMMUNITY HOSPITAL LICENSED FOR 102 BEDS, THAT OFFERS INPATIENT AND OUTPATIENT MEDICAL AND SURGICAL SERVICES, AMBULATORY (ONE-DAY) SURGERY, 24-HOUR EMERGENCY CARE, MEDICAL IMAGING, CARDIAC & PULMONARY REHABILITATION, PHYSICAL REHABILITATION, HOSPICE CARE, A MATERNITY CARE CENTER, OUTPATIENT ADOLESCENT BEHAVIORAL HEALTH SERVICES, AND LABRATORY SERVICES.

WOODLAKE AT TOLLAND, A 130-BED LONG-TERM SKILLED NURSING CARE AND SHORT-TERM REHABILITATION FACILITY THAT OFFERS CUSTOMIZED REHABILITATION TREATMENT SERVICES INCLUDING JOINT REPLACEMENT REHABILITATION, ORTHOPEDIC POST-HOSPITAL CARE, STROKE/NEUROLOGICAL REHAB, POST MEDICAL/SURGICAL RECONDITIONING, PRE-DISCHARGE HOME EVALUATIONS, PATIENT AND FAMILY INSTRUCTION, AND PERSONALIZED, PROGRESSIVE, AND INTERDISCIPLINARY CARE PLANS.

EASTERN CONNECTICUT MEDICAL PROFESSIONALS (ECMPF) FOUNDATION, INC., A MULTI-SPECIALTY PHYSICIAN GROUP PRACTICE THAT OFFERS A FULL RANGE OF HEALTHCARE SERVICES, INCLUDING PRIMARY AND SPECIALTY CARE IN THE TOWNS OF EAST HARTFORD, ELLINGTON, MANCHESTER, SOUTH WINDSOR, TOLLAND AND VERNON/ROCKVILLE.

Part VI **Supplemental Information** *(Continuation)*

GLASTONBURY WELLNESS CENTER COMBINES FITNESS AND MEDICAL SERVICES UNDER ONE ROOF, INCLUDING PHYSICIAN PRACTICES, LABORATORY DRAW SERVICES, MEDICAL IMAGING DIAGNOSTIC SERVICES, AND REHABILITATION SERVICES.

ECHN MEDICAL BUILDINGS AT EVERGREEN WALK (SOUTH WINDSOR):

2400 TAMARACK AVENUE OCCUPANTS INCLUDE EVERGREEN ENDOSCOPY CENTER, CENTRAL CONNECTICUT GASTROENTEROLOGY, THE COLON & RECTAL SURGEONS OF GREATER HARTFORD, AND ECMP PRIMARY CARE PHYSICIANS, RHEUMATOLOGY PHYSICIANS, WALDEN BEHAVIORAL CARE EATING DISORDERS CLINIC, AND LABORATORY SERVICES.

2600 TAMARACK AVENUE INCLUDES THE WOMEN'S CENTER FOR WELLNESS, ECHN BREAST CARE COLLABORATIVE, AND THE OB/GYN GROUP OF EASTERN CONNECTICUT.

2800 TAMARACK AVENUE HOUSES EVERGREEN IMAGING CENTER, ECHN REHABILITATION SERVICES, A LABORATORY DRAW STATION, AND A SERIES OF MEDICAL PRACTICES (INCLUDING ORTHOPEDIC SURGERY, OPHTHALMOLOGY, AND OTOLARYNGOLOGY), CORPCARE, AND SOUTH WINDSOR URGENT CARE.

ECHN MANCHESTER MEDICAL OFFICE BUILDINGS:

150 NORTH MAIN STREET OFFERS A VARIETY OF ADULT BEHAVIORAL HEALTH SERVICES.

130 HARTFORD ROAD, OFFERING PRIMARY CARE AND LABORATORY SERVICES.

AN URGENT CARE CENTER LOCATED IN SOUTH WINDSOR.

Part VI **Supplemental Information** *(Continuation)*

VISITING NURSE & HEALTH SERVICES OF CONNECTICUT, PROVIDES AT-HOME NURSING CARE AND HOSPICE CARE.

ECHN HAS 392 PHYSICIANS (307 ACTIVE, 42 COURTESY, 15 CONSULTING, 28 PART-TIME), 77 ALLIED HEALTH PROFESSIONALS, 10 MEDICAL DEPARTMENTS AND 16 SERVICES AS WELL AS 15 UNIVERSITY OF NEW ENGLAND COLLEGE OF OSTEOPATHIC MEDICINE THIRD-YEAR MEDICAL STUDENTS AVAILABLE TO CARE FOR THE COMMUNITY.

PART VI, LINE 7, LIST OF STATES RECEIVING COMMUNITY BENEFIT REPORT:
CT

SCHEDULE H, ADDITIONAL INFORMATION:
MANCHESTER MEMORIAL HOSPITAL IS A NOT-FOR-PROFIT 249-BED ACUTE CARE HOSPITAL THAT PROVIDES INPATIENT, OUTPATIENT AND EMERGENCY CARE SERVICES FOR RESIDENTS OF MANCHESTER, CT AND SURROUNDING TOWNS. THE HOSPITAL IS A SUBSIDIARY OF EASTERN CONNECTICUT HEALTH NETWORK, INC., WHICH WAS FORMED IN 1995 BY A MERGER OF MMH CORP. AND ROCKVILLE AREA HEALTH SERVICES, INC. ECHN WAS ORGANIZED TO PROVIDE A BROADER HEALTH CARE SYSTEM FOR THE SURROUNDING COMMUNITIES WITH QUALITY MEDICAL CARE AT A REASONABLE COST AND TO FOSTER AN ENVIRONMENT CONDUCIVE TO HEALTH AND WELL BEING WHETHER IN THE HOME OR IN THE COMMUNITY.

MANCHESTER MEMORIAL HOSPITAL PATIENTS NOT HAVING INSURANCE COVERING EMERGENCY OR OTHER MEDICALLY QUALIFIED CARE (UNINSURED PATIENTS), AS WELL AS UNDERINSURED PATIENTS, SUBJECT TO INCOME LIMITS AND FAMILY SIZE RECEIVE FREE OR DISCOUNTED CARE. MANCHESTER MEMORIAL HOSPITAL DOES NOT PURSUE COLLECTION OF AMOUNTS DETERMINED TO QUALIFY AS CHARITY CARE. CHARGES FOR CARE PROVIDED TO PATIENTS ARE DETERMINED BY ESTABLISHED

Part VI **Supplemental Information** *(Continuation)*

RATES, SUBJECT TO POSSIBLE ADJUSTMENTS OR DISCOUNTS FOR LOW INCOME PATIENTS; CONTRACTUAL DISCOUNTS, OR DISCOUNTS FOR PATIENTS WHO MEET CERTAIN CRITERIA UNDER ITS CHARITY CARE POLICIES. CHARITY CARE FOR FY 2014 WAS $2,411,263 FOR 1,000 TOTAL APPROVED APPLICANTS.

EXPENSES RELATED TO SERVICES PERFORMED FOR PATIENTS OF MANCHESTER MEMORIAL HOSPITAL CONTRIBUTE IMPORTANTLY TO ITS EXEMPT PURPOSE BECAUSE THE EXPENSES ARE INCURRED IN THE DIAGNOSIS, CURE, MITIGATION, TREATMENT AND PREVENTION OF DISEASE, AND FOR MEDICAL PURPOSES AFFECTING THE STRUCTURE OR FUNCTION OF THE HUMAN BODY.

MANCHESTER MEMORIAL HOSPITAL PROVIDED NEEDED MEDICAL CARE TO THE COMMUNITY REGARDLESS OF ANY INDIVIDUAL'S ABILITY TO PAY. NINE THOUSAND ONE HUNDRED TEN (9,110) INPATIENTS WERE CARED FOR IN FY14 REPRESENTING 44,106 PATIENT DAYS. TWO HUNDRED FORTY FIVE THOUSAND SEVEN HUNDRED THIRTY-SEVEN (245,737) OUTPATIENT VISITS WERE RECORDED.

INCLUDED IN THE 9,110 INPATIENTS WERE 5,896 GOVERNMENT RELATED PATIENTS. THE GOVERNMENT INPATIENTS FALL INTO THE FOLLOWING GROUPS:

MEDICARE	2,876
MEDICARE MANAGED CARE	808
MEDICAID	2,180
CHAMPUS	32
TOTAL GOV PATIENTS	5,896
TOTAL NON GOV PATIENTS	3,214
TOTAL PATIENTS	9,110

Part VI **Supplemental Information** *(Continuation)*

INCLUDED IN THE 245,737 OUTPATIENT VISITS WERE 141,327 GOVERNMENT RELATED VISITS. THE VISITS ARE A PRODUCT OF GROSS REVENUE RELATIONSHIP TO TOTAL VISITS. THE GOVERNMENT VISITS FALL INTO THE FOLLOWING GROUPS:

MEDICARE	75,076
MEDICARE MANAGED CARE	26,447
MEDICAID	38,882
CHAMPUS	922
TOTAL GOV PATIENTS	141,327
TOTAL NON GOV PATIENTS	104,410
TOTAL OUTPATIENT VISITS	245,737

THE HOSPITAL PROVIDED UNCOMPENSATED CARE TO 44,576 MEDICAID PATIENTS FOR A NET COMMUNITY BENEFIT AMOUNT OF $8,168,000 AFTER MEDICAID REIMBURSEMENT.

SCHEDULE I
(Form 990)

Department of the Treasury
Internal Revenue Service

Grants and Other Assistance to Organizations, Governments, and Individuals in the United States

Complete if the organization answered "Yes" to Form 990, Part IV, line 21 or 22.

▶ **Attach to Form 990.**

▶ **Information about Schedule I (Form 990) and its instructions is at** *www.irs.gov/form990.*

OMB No. 1545-0047

2013

Open to Public Inspection

ECHN Proposed Asset Purchase by PMH
Submitted October 13, 2015

Name of the organization
MANCHESTER MEMORIAL HOSPITAL

Employer identification number
06-0646710

Part I **General Information on Grants and Assistance**

1 Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? ..... [X] Yes [ ] No

2 Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States.

Part II **Grants and Other Assistance to Governments and Organizations in the United States.** Complete if the organization answered "Yes" to Form 990, Part IV, line 21, for any recipient that received more than $5,000. Part II can be duplicated if additional space is needed.

1 (a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance

2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table ..... ▶

3 Enter total number of other organizations listed in the line 1 table ..... ▶

Part III **Grants and Other Assistance to Individuals in the United States.** Complete if the organization answered "Yes" to Form 990, Part IV, line 22. Part III can be duplicated if additional space is needed.

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of non-cash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of non-cash assistance
SCHOLARSHIPS	8	8,600.	0.		

Part IV **Supplemental Information.** Provide the information required in Part I, line 2, Part III, column (b), and any other additional information.

PART I, LINE 2:

THE SCHOLARSHIPS ARE AWARED TO ECHN EMPLOYEES WISHING TO FURTHER THEIR NURSING EDUCATION OR BECOME A NURSE. THE PRIMARY PURPOSE IS TO PROVIDE FINANCIAL ASSISTANCE TO ECHN EMPLOYEES ENROLLED IN AN ACCREDITED NURSING PROGRAM THAT LEADS TO BECOMING A REGISTERED NURSE. FURTHERMORE, A PORTION OF THE FUNDS MAY BE AWARDED TO AN ECHN REGISTERED NURSE TO ASSIST THAT PERSON IN OBTAINING AN ADVANCED DEGREE. SCHOLARSHIPS ARE AWARDED BASED ON THE DETERMINATION OF A NURSING SCHOLARSHIP COMMITTEE. NURSING STUDENTS WHO NEED FINANCIAL ASSISTANCE TO COMPLETE THEIR EDUCATION AND WHO

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Part IV Supplemental Information

DEMONSTRATE SCHOLASTIC ABILITY AND PROFESSIONAL PROMISE ARE ELIGIBLE IF THEY ARE AN EMPLOYEE OF AN ECHN AFFILIATE, AT LEAST 20 HOURS PART-TIME OR FULL-TIME, FOR AT LEAST ONE YEAR; AND CURRENTLY ENROLLED IN AN ACCREDITED TRADITIONAL OR NON-TRADITIONAL NURSING PROGRAM. BACCALAUREATE APPLICANTS MUST HAVE COMPLETED THE 2ND YEAR OF A 4-YEAR PROGRAM AND ASSOCIATE DEGREE APPLICANTS MUST HAVE COMPLETED ALL PREREQUISITES AND BE ACCEPTED INTO A NURSING PROGRAM. IN MAKING THE AWARDS, THE COMMITTEE USES JOB PERFORMANCE EVALUATION AND RECOMMENDATION, GRADE POINT AVERAGE AND PROFESSIONAL GOALS. IN ADDITION, THE NUMBER OF CREDITS IN WHICH AN APPLICANT IS ENROLLED AND THE COST PER CREDIT IS FACTORED INTO ANY AWARD. IF AWARDED A SCHOLARSHIP, THE RECIPIENT AGREES TO MAINTAIN EMPLOYMENT, WHETHER FULL OR PART-TIME, AT AN AFFILIATE OF ECHN FOR A MINIMUM OF ONE YEAR. AWARDS ARE MAILED DIRECTLY TO THE EDUCATIONAL INSTITUTION.

SCHEDULE J (Form 990)

Department of the Treasury
Internal Revenue Service

Compensation Information

For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 23.**
▶ **Attach to Form 990.** ▶ **See separate instructions.**
▶ **Information about Schedule J (Form 990) and its instructions is at** *www.irs.gov/form990*

OMB No. 1545-0047

2013

Open to Public Inspection

Name of the organization

MANCHESTER MEMORIAL HOSPITAL

Employer identification number

06-0646710

Part I Questions Regarding Compensation

			Yes	No
1a	Check the appropriate box(es) if the organization provided any of the following to or for a person listed in Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.			
	☐ First-class or charter travel	☐ Housing allowance or residence for personal use		
	☐ Travel for companions	☐ Payments for business use of personal residence		
	☐ Tax indemnification and gross-up payments	☐ Health or social club dues or initiation fees		
	☐ Discretionary spending account	☐ Personal services (e.g., maid, chauffeur, chef)		
b	If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain	1b		
2	Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, and officers, including the CEO/Executive Director, regarding the items checked in line 1a?	2		
3	Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.			
	☒ Compensation committee	☒ Written employment contract		
	☒ Independent compensation consultant	☒ Compensation survey or study		
	☐ Form 990 of other organizations	☒ Approval by the board or compensation committee		
4	During the year, did any person listed in Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:			
a	Receive a severance payment or change-of-control payment?	4a	X	
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	4b	X	
c	Participate in, or receive payment from, an equity-based compensation arrangement?	4c		X
	If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.			
	Only section 501(c)(3) and 501(c)(4) organizations must complete lines 5-9.			
5	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:			
a	The organization?	5a		X
b	Any related organization?	5b		X
	If "Yes" to line 5a or 5b, describe in Part III.			
6	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:			
a	The organization?	6a		X
b	Any related organization?	6b		X
	If "Yes" to line 6a or 6b, describe in Part III.			
7	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described in lines 5 and 6? If "Yes," describe in Part III	7		X
8	Were any amounts reported in Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III	8		X
9	If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	9		

Part II **Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees.** Use duplicate copies if additional space is needed.

For each individual whose compensation must be reported in Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions, on row (ii). Do not list any individuals that are not listed on Form 990, Part VII.

Note. The sum of columns (B)(i)-(iii) for each listed individual must equal the total amount of Form 990, Part VII, Section A, line 1a, applicable column (D) and (E) amounts for that individual.

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation reported as deferred in prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
(1) PETER J. KARL	(i)	572,400.	550,812.	0.	97,575.	25,149.	1,245,936.	360,237.
PRESIDENT AND CEO	(ii)	0.	0.	0.	0.	0.	0.	0.
(2) KEVIN G. MURPHY	(i)	347,516.	178,255.	79,880.	9,505.	17,175.	632,331.	154,642.
EVP, TREASURER (THROUGH OCT 2013)	(ii)	0.	0.	0.	0.	0.	0.	0.
(3) MICHAEL D. VEILLETTE	(i)	306,037.	135,238.	0.	36,975.	21,921.	500,171.	58,014.
SVP, CHIEF FINANCIAL OFFICER	(ii)	0.	0.	0.	0.	0.	0.	0.
(4) DEBORAH GOGLIETTINO	(i)	222,929.	127,739.	0.	29,790.	16,821.	397,279.	71,339.
SVP, HUMAN RESOURCES	(ii)	0.	0.	0.	0.	0.	0.	0.
(5) DENNIS MCCONVILLE	(i)	207,957.	117,223.	0.	82,752.	10,928.	418,860.	68,020.
SVP, STRATEGIC PLANNING	(ii)	0.	0.	0.	0.	0.	0.	0.
(6) DEBORAH PARKER	(i)	294,718.	145,083.	0.	35,251.	22,795.	497,847.	73,202.
EVP, CHIEF CLINICAL OFFICER	(ii)	0.	0.	0.	0.	0.	0.	0.
(7) JOEL REICH, MD	(i)	338,385.	184,230.	0.	119,923.	17,025.	659,563.	109,131.
SVP, MEDICAL AFFAIRS	(ii)	0.	0.	0.	0.	0.	0.	0.
(8) CHARLES COVIN	(i)	151,398.	7,500.	0.	20,292.	11,961.	191,151.	0.
VP AND CIO (THROUGH NOV 2013)	(ii)	0.	0.	0.	0.	0.	0.	0.
(9) LEONA CROSSKEY	(i)	150,246.	27,442.	0.	55,175.	17,868.	250,731.	0.
VP, QUALITY	(ii)	0.	0.	0.	0.	0.	0.	0.
(10) ROBERT CARROLL, MD	(i)	376,654.	72,829.	0.	12,750.	21,621.	483,854.	0.
MED DIR, EMERGENCY DEPARTMENT	(ii)	0.	0.	0.	0.	0.	0.	0.
(11) JOYCE TICHY	(i)	257,881.	97,800.	0.	7,650.	21,213.	384,544.	0.
GENERAL COUNSEL	(ii)	0.	0.	0.	0.	0.	0.	0.
(12) JAMES CASTELLONE, MD	(i)	332,421.	47,419.	0.	12,750.	21,621.	414,211.	0.
ASST. MED DIR, EMERGENCY DEPT	(ii)	0.	0.	0.	0.	0.	0.	0.
(13) ANDREAS BOJKO, MD	(i)	319,986.	3,500.	0.	69,369.	21,616.	414,471.	0.
EMERGENCY DEPT PHYSICIAN	(ii)	0.	0.	0.	0.	0.	0.	0.
(14) SCOTT BROWN, MD	(i)	338,801.	2,500.	0.	12,059.	21,632.	374,992.	0.
DOCTOR	(ii)	0.	0.	0.	0.	0.	0.	0.
(15) TAI TRAN, MD	(i)	305,407.	7,500.	0.	8,639.	8,315.	329,861.	0.
EMERGENCY DEPT PHYSICIAN	(ii)	0.	0.	0.	0.	0.	0.	0.
(16) THEODORE SHERRY, MD	(i)	362,672.	3,000.	0.	12,669.	21,616.	399,957.	0.
EMERGENCY DEPT PHYSICIAN	(ii)	0.	0.	0.	0.	0.	0.	0.

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Part III Supplemental Information

Provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

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PART I, LINE 3:

THE BOARD OF TRUSTEES (THE "BOARD") APPOINTS AN EXECUTIVE COMPENSATION COMMMITTEE (THE "COMMITTEE") AND HAS DELEGATED THE RESPONSIBILITY OF COMPLETING AN ANNUAL MARKET ANALYSIS OF THE CEO'S COMPENSATION AND OTHER SENIOR EXECUTIVES AND COMPLETION OF THE CEO'S ANNUAL PERFORMANCE REVIEW.

THE EVALUATION OF THE CEO IS AN IMPORTANT RESPONSIBILITY OF THE BOARD AND IS CRITICAL TO THE GOVERNANCE RESPONSIBILITIES OF THE BOARD. THE EXECUTIVE COMPENSATION COMMITTEE SOLICITS FEEDBACK ABOUT THE PERFORMANCE OF THE CEO FROM EVERY ACTIVE BOARD MEMBER WHICH WHEN RECEIVED IS ANALYZED AND REVIEWED BY THE MEMBERS OF THE COMMITTEE. THE CEO COMPLETES A SELF-EVALUATION AND AN EVALUATION FOR ALL ELIGIBLE MEMBERS OF THE SENIOR LEADERSHIP TEAM, WHO COMPLETE BOTH A SELF-EVALUATION AND A PEER EVALUATION. THE RESULTS OF THE ASSESSMENTS COMPLETED BY MEMBERS OF THE SENIOR LEADERSHIP TEAM ARE REVIEWED BY THE CEO WHO DISCUSSES THE RESULTS WITH THE MEMBERS OF THE COMMITTEE ON AN ANNUAL BASIS.

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Part III Supplemental Information

Provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

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THE EXECUTIVE COMPENSATION COMMITTEE IN COLLABORATION WITH THE CEO EVALUATES AND APPROVES ORGANIZATIONAL PERFORMANCE OBJECTIVES BOTH ON AN ANNUAL AND LONG TERM BASIS AND FOCUSES ON THOSE GOALS WITH THE GREATEST IMPACT TO THE ORGANIZATION'S STRATEGY AND MISSION. THE COMMITTEE ENSURES AN ANNUAL REVIEW OF THE CEO'S PERFORMANCE IN RELATION TO THESE GOALS; REVIEWS THE TALLY SHEETS TO UNDERSTAND THE ECONOMICS OF THE EMPLOYEE BENEFITS; RETAINS AND ENSURES THE INDEPENDENCE OF ITS EXTERNAL CONSULTANTS AND ADVISORS AND INVOLVES RELEVANT ORGANIZATIONAL RESOURCES AS APPROPRIATE TO CARRY OUT ITS RESPONSIBILITIES.

THE COMMITTEE ENSURES TRANSPARENCY AND DISCLOSURE TO THE BOARD BY PRESENTING THE RESULTS OF THE ANNUAL PERFORMANCE AND MARKET REVIEWS PROVIDING THE BOARD WITH THE OPPORTUNITY FOR FURTHER INPUT AND CONSIDERATION AND ASKING THAT THE BOARD TAKE ACTION ON THE RECOMMENDATION OF THE COMMITTEE IF THE RECOMMENDATION IS APPROPRIATE. THE BOARD HAS THE OPPORTUNITY TO CHANGE ANY RECOMMENDATIONS OF THE COMMITTEE IF IT SO DESIRES. MEMBERS OF THE BOARD AND OF THE COMMITTEE WHO MAY BE INTERESTED PARTIES ARE ASKED TO RECUSE THEMSELVES FROM ANY REQUIRED VOTES TO AVOID CONFLICTS OF INTEREST. THE COMMITTEE ENSURES THAT THE PROCESS MEETS

Part III Supplemental Information

Provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

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COMPLIANCE STANDARDS.

PART I, LINES 4A-B:

LINE 4A, SEVERANCE PAYMENT:

KEVIN MURPHY - $79,880

LINE 4B, SUPPLEMENTAL NONQUALIFIED RETIREMENT PLAN:

PETER KARL - $84,825

MICHAEL VEILLETTE - $24,225

DEBORAH GOGLIETTINO - $17,625

DEBORAH PARKER - $22,501

DENNIS MCCONVILLE - $15,975

JOEL REICH - $25,845

PART I, QUESTIONS 5A, 5B, 6A AND 6B:

THE ECHN EXECUTIVE INCENTIVE COMPENSATION PLAN IS A PLAN THAT HAS BEEN DEVELOPED, REVIEWED AND IS ANNUALLY APPROVED BY MEMBERS OF THE BOARD EXECUTIVE COMPENSATION COMMITTEE WITH CONSULTANT THIRD PARTY OVERSIGHT.

Part III Supplemental Information

Provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

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THE PLAN ESTABLISHES GOALS IN 4 AREAS OF PERFORMANCE: SYSTEM-WIDE FINANCIAL PERFORMANCE BASED ON PROFIT FROM OPERATIONS, TWO QUALITY OUTCOMES IN CLINICAL CORE MEASURES AND PATIENT SATISFACTION AND AN INDIVIDUAL GOAL (WHICH HAS A SEPARATE MEASUREMENT FOR TEAM ASSESSMENT) FOR EACH MEMBER OF THE INCENTIVE PROGRAM.

THERE IS NO EXECUTIVE COMPENSATION TIED TO THE REVENUES OF THE REPORTING ORGANIZATION OR OTHER RELATED ENTITIES. THERE IS EXECUTIVE COMPENSATION TIED TO THE NET EARNINGS (INCOME FROM OPERATIONS), AS NOTED IN THE PRIOR PARAGRAPH, HOWEVER IT IS ONE OF FOUR PERFORMANCE LEVERS THAT DETERMINE THE LEVEL OF COMPENSATION. THE AGGREGATE NET EARNINGS OF THE ECHN "SYSTEM" NOT ANY ONE REPORTING ORGANIZATION OR RELATED ENTITIES OF ECHN DETERMINE THIS COMPENSATION. SO TO CONCLUDE, THE ANSWER TO THESE 4 QUESTIONS IS "NO" WITH THE CLARIFICATION THAT IT IS THE PERFORMANCE OF THE ENTIRE SYSTEM AS A WHOLE THAT DETERMINES EXECUTIVE COMPENSATION, NOT ONE REPORTING ORGANIZATION OR A RELATED ENTITY.

Part III Supplemental Information

Provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

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MEMBERS OF THE INCENTIVE PROGRAM INCLUDE THE FOLLOWING:

POSITION TITLE - KEY EMPLOYEE NAME

PRESIDENT AND CEO - PETER J. KARL

SVP, CHIEF FINANCIAL OFFICER - MICHAEL D. VEILLETTE

SVP, HUMAN RESOURCES - DEBORAH GOGLIETTINO

SVP, STRATEGIC PLANNING - DENNIS MCCONVILLE

SVP, CHIEF CLINICAL OFFICER - DEBORAH PARKER

SVP, MEDICAL AFFAIRS - JOEL REICH, M.D.

VP QUALITY - LEONA CROSSKEY

MED. DIR. EMERGENCY DEPARTMENT - ROBERT CARROLL, M.D.

PART II

THE SALARY INFORMATION PROVIDED WITHIN SCHEDULE J

REPRESENTS CALENDAR YEAR 2013 WAGES AND BENEFITS. AS COMPARED TO THE

PRIOR YEAR RETURN, THE MAJOR CHANGES ARE:

THE LONG TERM RETENTION BENEFIT REACHED MATURITY UPON THE COMPLETION OF

THE FOUR YEAR VESTING PERIOD. THIS BENEFIT WAS PAID IN 2013 AND WAS

Part III Supplemental Information

Provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

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FOR VESTING YEARS ENDED 9/30/10, 9/30/11, 9/30/12 AND 9/30/13. THREE OF THE FOUR VESTED YEARS WERE REPORTED AS DEFERRED INCOME IN PRIOR RETURNS ON SCHEDULE J - LINE F (COMPENSATION REPORTED AS DEFERRED IN PRIOR FORM 990).

IN CALENDAR YEAR 2013 WE IMPLEMENTED A FURLOUGH PROGRAM WHICH MEANT THAT EXECUTIVES RECEIVED AN UNPAID WEEK OF VACATION. THIS APPROXIMATED A 2% PAY REDUCTION.

ANOTHER CHANGE TO PRIOR YEAR'S COMPENSATION IS THAT THE MONEY MATCH PROGRAM WAS REINSTATED IN CALENDAR YEAR 2013.

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SCHEDULE K (Form 990)
Department of the Treasury
Internal Revenue Service

Supplemental Information on Tax-Exempt Bonds

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.
▶ Attach to Form 990. ▶ See separate instructions. ▶ Information about Schedule K (Form 990) and its instructions is at www.irs.gov/form990.

OMB No. 1545-0047
2013
Open to Public Inspection

Name of the organization: MANCHESTER MEMORIAL HOSPITAL

Employer identification number: 06-0646710

Part I Bond Issues SEE PART VI FOR COLUMNS (A) AND (F) CONTINUATIONS

	(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pooled financing	
							Yes	No	Yes	No	Yes	No
A	STATE OF CONNECTICUT HEALTH & EDL FACS AUTH R	06-0806186	20774UAZ8	11/09/05	37579404.	ADVANCE REFUND AND DEFEASE A POR		X		X		X
B	STATE OF CONNECTICUT HEALTH & EDL FACS AUTH R	06-0806186	NONEAVAIL	05/14/09	15250000.	WOODLAKE EXPANSION, EQUIPM		X		X		X
C	STATE OF CONNECTICUT HEALTH & EDL FACS AUTH R	06-0806186	20774U5W1	12/21/10	20145000.	REDEEM PRIOR ISSUE AND FUND IN		X		X		X
D												

Part II Proceeds

		A	B	C	D
1	Amount of bonds retired				
2	Amount of bonds legally defeased				
3	Total proceeds of issue	37,579,404.	15,250,000.	20,145,000.	
4	Gross proceeds in reserve funds	3,556,957.		1,065,002.	
5	Capitalized interest from proceeds				
6	Proceeds in refunding escrows	32,759,288.	9,966,919.	17,048,821.	
7	Issuance costs from proceeds	632,013.	305,000.	402,900.	
8	Credit enhancement from proceeds	631,146.		92,225.	
9	Working capital expenditures from proceeds				
10	Capital expenditures from proceeds		4,978,081.		
11	Other spent proceeds			1,536,052.	
12	Other unspent proceeds				
13	Year of substantial completion	2006	2009	2011	
		Yes / No	Yes / No	Yes / No	Yes / No
14	Were the bonds issued as part of a current refunding issue?	No	Yes	Yes	
15	Were the bonds issued as part of an advance refunding issue?	Yes	No	No	
16	Has the final allocation of proceeds been made?	Yes	Yes	Yes	
17	Does the organization maintain adequate books and records to support the final allocation of proceeds?	Yes	Yes	Yes	

Part III Private Business Use

		A	B	C	D
		Yes / No	Yes / No	Yes / No	Yes / No
1	Was the organization a partner in a partnership, or a member of an LLC, which owned property financed by tax-exempt bonds?	No	No	No	
2	Are there any lease arrangements that may result in private business use of bond-financed property?	No	No	No	

ECHN Proposed Asset Purchase by PMH
Submitted October 13, 2015

Part III Private Business Use *(Continued)*

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
3a Are there any management or service contracts that may result in private business use of bond-financed property?		X		X		X		
b If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?								
c Are there any research agreements that may result in private business use of bond-financed property?		X		X		X		
d If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?								
4 Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government ▶	.00 %		.00 %		.00 %			%
5 Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government ▶	.00 %		.00 %		.00 %			%
6 Total of lines 4 and 5	.00 %		.00 %		.00 %			%
7 Does the bond issue meet the private security or payment test?	X		X		X			
8a Has there been a sale or disposition of any of the bond-financed property to a non-governmental person other than a 501(c)(3) organization since the bonds were issued?		X		X		X		
b If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of	%		%		%			%
c If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2?								
9 Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1.141-12 and 1.145-2?		X		X		X		

Part IV Arbitrage

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
1 Has the issuer filed Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate?	X			X		X		
2 If "No" to line 1, did the following apply?								
a Rebate not due yet?				X	X			
b Exception to rebate?			X			X		
c No rebate due?				X		X		
If you checked "No rebate due" in line 2c, provide in Part VI the date the rebate computation was performed								
3 Is the bond issue a variable rate issue?		X	X		X			
4a Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?		X	X			X		
b Name of provider			TD BANK					
c Term of hedge			5.0000000					
d Was the hedge superintegrated?			X					
e Was the hedge terminated?			X					

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Part IV **Arbitrage** *(Continued)*

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
5a Were gross proceeds invested in a guaranteed investment contract (GIC)?		X		X		X		
b Name of provider								
c Term of GIC								
d Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied?								
6 Were any gross proceeds invested beyond an available temporary period?		X		X		X		
7 Has the organization established written procedures to monitor the requirements of section 148?	X		X		X			

Part V **Procedures To Undertake Corrective Action**

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
Has the organization established written procedures to ensure that violations of federal tax requirements are timely identified and corrected through the voluntary closing agreement program if self-remediation is not available under applicable regulations?	X		X		X			

Part VI **Supplemental Information.** Provide additional information for responses to questions on Schedule K (see instructions).

SCHEDULE K, PART I, BOND ISSUES:
(A) ISSUER NAME: STATE OF CONNECTICUT HEALTH & EDL FACS AUTH REV SERIES C
(F) DESCRIPTION OF PURPOSE:
ADVANCE REFUND AND DEFEASE A PORTION OF THE SERIES 2000A BONDS (C)

(A) ISSUER NAME: STATE OF CONNECTICUT HEALTH & EDL FACS AUTH REV SERIES D
(F) DESCRIPTION OF PURPOSE:
WOODLAKE EXPANSION, EQUIPMENT PURCHASE, REFUNDING PRIOR ISSUE (SER D)

(A) ISSUER NAME: STATE OF CONNECTICUT HEALTH & EDL FACS AUTH REV SERIES E
(F) DESCRIPTION OF PURPOSE:
REDEEM PRIOR ISSUE AND FUND INTEREST RATE SWAP TERMINATION PAYMENTS

SCHEDULE K, SUPPLEMENTAL INFORMATION:
DATE OF LAST ARBITRAGE REBATE CALCULATION:
SERIES C REBATE COMPUTATION WAS DONE 11/9/2010.

THE HEDGE SWAP ARRANGEMENT FOR THE SERIES D ISSUE WAS TERMINATED IN MAY 2014.

THE SERIES D ISSUE WAS REISSUED ON MAY 9, 2014 FOR $13,872,000. THIS REPRESENTED A REISSUANCE OF THE BONDS. NO PROCEEDS WERE REALIZED FROM THE DELIVERY OF THE ISSUE.

SEE PART VI SUPPLEMENTAL INFORMATION SHEET

Part VI **Supplemental Information.** Provide additional information for responses to questions on Schedule K (see instructions) *(Continued)*

THE SERIES C BONDS WERE ISSUED AFTER 12/31/02 TO REFUND BONDS ISSUED BEFORE 1/1/03. AS A RESULT, LINES 1 - 9 OF PART III ARE NOT REQUIRED TO BE COMPLETED.

THE $1,536,052 ON LINE 11 COLUMN C REPRESENTS THE FEES TO TERMINATE THE HEDGES/SWAPS.

ECHN Proposed Asset Purchase by PMH
Submitted October 13, 2015

SCHEDULE L (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Transactions With Interested Persons

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 25a, 25b, 26, 27, 28a, 28b, or 28c, or Form 990-EZ, Part V, line 38a or 40b.

▶ Attach to Form 990 or Form 990-EZ. ▶ See separate instructions.

▶ Information about Schedule L (Form 990 or 990-EZ) and its instructions is at *www.irs.gov/form990.*

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Open To Public Inspection

Name of the organization

MANCHESTER MEMORIAL HOSPITAL

Employer identification number

06-0646710

Part I Excess Benefit Transactions (section 501(c)(3) and section 501(c)(4) organizations only).

Complete if the organization answered "Yes" on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b.

1 (a) Name of disqualified person	(b) Relationship between disqualified person and organization	(c) Description of transaction	(d) Corrected? Yes	(d) Corrected? No

2 Enter the amount of tax incurred by the organization managers or disqualified persons during the year under section 4958 ▶ $

3 Enter the amount of tax, if any, on line 2, above, reimbursed by the organization ▶ $

Part II Loans to and/or From Interested Persons.

Complete if the organization answered "Yes" on Form 990-EZ, Part V, line 38a or Form 990, Part IV, line 26; or if the organization reported an amount on Form 990, Part X, line 5, 6, or 22.

(a) Name of interested person	(b) Relationship with organization	(c) Purpose of loan	(d) Loan to or from the organization? To	(d) From	(e) Original principal amount	(f) Balance due	(g) In default? Yes	(g) No	(h) Approved by board or committee? Yes	(h) No	(i) Written agreement? Yes	(i) No
Total ▶ $												

Part III Grants or Assistance Benefiting Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 27.

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of assistance	(d) Type of assistance	(e) Purpose of assistance

Part IV Business Transactions Involving Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 28a, 28b, or 28c.

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
DR. DENNIS O'NEILL & DR. M	SEE PART V	405,912.	SEE PART V		X
KATHLEEN O'NEILL	SEE PART V	0.	SEE PART V		X
ANTHONY DISTEFANO MD	SEE PART V	0.	SEE PART V		X
WILSON VEGA	SEE PART V	229,776.	SEE PART V		X

Part V Supplemental Information

Provide additional information for responses to questions on Schedule L (see instructions).

SCH L, PART IV, BUSINESS TRANSACTIONS INVOLVING INTERESTED PERSONS:

(A) NAME OF PERSON: DR. DENNIS O'NEILL & DR. MICHELE CONLON

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

SEE PART V SEE NOTE (1)

(C) AMOUNT OF TRANSACTION $ 405,912.

(D) DESCRIPTION OF TRANSACTION: SEE PART V

ECPC CONTRACTS WITH ECHN, INC. TO PROVIDE PATHOLOGY SERVICES AND LAB MANAGEMENT SERVICES TO MMH AND RGH. ALL PAYMENTS MADE TO ECPC ARE FOR PURPOSES OF OPERATING THE BUSINESS AND MAINTAINING OPERATING CASHFLOW; PAYMENTS ARE NOT DIRECTLY TO ANY OF THE OWNERS.

(E) SHARING OF ORGANIZATION REVENUES? = NO

(A) NAME OF PERSON: KATHLEEN O'NEILL

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

SEE PART V SEE NOTE (2)

(C) AMOUNT OF TRANSACTION $ -0-

(D) DESCRIPTION OF TRANSACTION: SEE PART V

(E) SHARING OF ORGANIZATION REVENUES? = NO

(A) NAME OF PERSON: ANTHONY DISTEFANO MD

Part V Supplemental Information

Complete this part to provide additional information for responses to questions on Schedule L (see instructions).

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

SEE PART V SEE NOTE (3)

(C) AMOUNT OF TRANSACTION $ -0-

(D) DESCRIPTION OF TRANSACTION: SEE PART V

SALARY PAID TO LIZANNE DISTEFANO AS AN EMPLOYEE OF RGH.

(E) SHARING OF ORGANIZATION REVENUES? = NO

(A) NAME OF PERSON: WILSON VEGA

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

SEE PART V SEE NOTE (4)

(C) AMOUNT OF TRANSACTION $ 229,776.

(D) DESCRIPTION OF TRANSACTION: SEE PART V

CBS CONTRACTS WITH ECHN, INC. TO PROVIDE COPIER SERVICES TO MMH AND RGH.

(E) SHARING OF ORGANIZATION REVENUES? = NO

SCHEDULE L, PART IV COLUMN (B)

(1) MMH TRUSTEES EACH OWNING MORE THAN 5% OF EASTERN CONNECTICUT PATHOLOGY CONSULTANTS, PC (ECPC).

(2) MMH TRUSTEE AND THE WIFE OF DR. DENNIS O'NEILL, TRUSTEE FOR ALL AFFILIATES, WHO HAS A REPORTABLE TRANSACTION AS NOTED ABOVE.

(3) MMH TRUSTEE AND SPOUSE OF LIZANNE DISTEFANO, WHO IS EMPLOYED BY ROCKVILLE GENERAL HOSPITAL, A RELATED ENTITY TO MMH.

(4) FORMER MMH TRUSTEE AND PRESIDENT OF CONNECTICUT BUSINESS SYSTEMS (CBS).

Part V Supplemental Information

Complete this part to provide additional information for responses to questions on Schedule L (see instructions).

SCHEDULE L, PART IV COLUMN (C)

LINE 1: PAYMENT OF $405,912 FROM MMH IS TO ECPC AND NOT DIRECTLY TO ANY OF THE OWNERS OF ECPC.

LINE 3: SALARY OF $19,191 PAID BY RGH. MMH DID NOT MAKE ANY PAYMENTS.

LINE 4: PAYMENT OF $229,776 FROM MMH TO CBS AND NOT DIRECTLY TO WILSON VEGA.

SCHEDULE M (Form 990)

Department of the Treasury
Internal Revenue Service

Noncash Contributions

▶ **Complete if the organizations answered "Yes" on Form 990, Part IV, lines 29 or 30.**
▶ **Attach to Form 990.**
▶ **Information about Schedule M (Form 990) and its instructions is at** *www.irs.gov/form990*

OMB No. 1545-0047

2013

Open to Public Inspection

Name of the organization

MANCHESTER MEMORIAL HOSPITAL

Employer identification number

06-0646710

Part I Types of Property

		(a) Check if applicable	(b) Number of contributions or items contributed	(c) Noncash contribution amounts reported on Form 990, Part VIII, line 1g	(d) Method of determining noncash contribution amounts
1	Art - Works of art				
2	Art - Historical treasures				
3	Art - Fractional interests				
4	Books and publications				
5	Clothing and household goods				
6	Cars and other vehicles				
7	Boats and planes				
8	Intellectual property				
9	Securities - Publicly traded				
10	Securities - Closely held stock				
11	Securities - Partnership, LLC, or trust interests				
12	Securities - Miscellaneous				
13	Qualified conservation contribution - Historic structures				
14	Qualified conservation contribution - Other				
15	Real estate - Residential				
16	Real estate - Commercial				
17	Real estate - Other				
18	Collectibles				
19	Food inventory				
20	Drugs and medical supplies	X	1	31,767.	COST
21	Taxidermy				
22	Historical artifacts				
23	Scientific specimens				
24	Archeological artifacts				
25	Other ▶ ( )				
26	Other ▶ ( )				
27	Other ▶ ( )				
28	Other ▶ ( )				

				Yes	No
29	Number of Forms 8283 received by the organization during the tax year for contributions for which the organization completed Form 8283, Part IV, Donee Acknowledgement	29	0		
30a	During the year, did the organization receive by contribution any property reported in Part I, lines 1 - 28, that it must hold for at least three years from the date of the initial contribution, and which is not required to be used for exempt purposes for the entire holding period?	30a			X
b	If "Yes," describe the arrangement in Part II.				
31	Does the organization have a gift acceptance policy that requires the review of any non-standard contributions?	31			X
32a	Does the organization hire or use third parties or related organizations to solicit, process, or sell noncash contributions?	32a			X
b	If "Yes," describe in Part II.				
33	If the organization did not report an amount in column (c) for a type of property for which column (a) is checked, describe in Part II.				

Part II **Supplemental Information.** Provide the information required by Part I, lines 30b, 32b, and 33, and whether the organization is reporting in Part I, column (b), the number of contributions, the number of items received, or a combination of both. Also complete this part for any additional information.

SCHEDULE O (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

Complete to provide information for responses to specific questions on Form 990 or 990-EZ or to provide any additional information.

▶ **Attach to Form 990 or 990-EZ.**

▶ **Information about Schedule O (Form 990 or 990-EZ) and its instructions is at** *www.irs.gov/form990*

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Open to Public Inspection

Name of the organization: MANCHESTER MEMORIAL HOSPITAL

Employer identification number: 06-0646710

FORM 990, PART I, LINE 1, DESCRIPTION OF ORGANIZATION MISSION:

INPATIENT, OUTPATIENT AND EMERGENCY CARE SERVICES TO ALL MEMBERS OF THE COMMUNITY, INCLUDING THE INDIGENT AND UNDERSERVED.

FORM 990, PART III, LINE 4D, OTHER PROGRAM SERVICES:

SEE SCHEDULE H, PART VI

EXPENSES $ 96,879,540. INCL GRANTS OF $ 8,600. REVENUE $ 99,341,538.

FORM 990, PART VI, SECTION A, LINE 2:

BOARD MEMBERS DENNIS O'NEILL AND MICHELE CONLON ARE BUSINESS PARTNERS.

FORM 990, PART VI, SECTION A, LINE 6:

ECHN IS THE SOLE MEMBER OF THE ORGANIZATION.

FORM 990, PART VI, SECTION A, LINE 7A:

ECHN HAS THE AUTHORITY TO ELECT TRUSTEES AND OFFICERS AND APPOINT COMMITTEE MEMBERS.

FORM 990, PART VI, SECTION A, LINE 7B:

ECHN HAS VARIOUS POWERS INCLUDING BUT NOT LIMITED TO: APPROVING ALL OPERATING AND CAPITAL BUDGETS, CONTROLLING THE INVESTMENT OF FUNDS, LOCATION OF SERVICES, AGREEMENTS AND TRANSACTIONS, AFFILIATIONS, CHANGES, AMENDMENTS, OR RESTATEMENTS OF CERTIFICATES OF INCORPORATION AND BYLAWS, ADOPTING A SYSTEM-WIDE VISION AND STRATEGIC PLANS, AND APPROVING DEBT BORROWINGS.

Name of the organization: MANCHESTER MEMORIAL HOSPITAL

Employer identification number: 06-0646710

FORM 990, PART VI, SECTION B, LINE 11:

PRIOR TO FILING THE 990, THE FOLLOWING STEPS ARE TAKEN: 1) THE ACCOUNTING MANAGER, TOGETHER WITH OTHER MEMBERS OF THE FINANCE DEPARTMENT, CONDUCT A REVIEW OF THE 990 ALONG WITH A REVIEW AND RECONCILIATION OF THE 990 TO THE AUDITED FINANCIAL STATEMENTS; 2) THE ACCOUNTING MANAGER CONDUCTS AN EXTENSIVE REVIEW AND DISCUSSION OF THE 990 WITH THE CPA FIRM THAT PREPARES THE RETURN; 3) AN ELECTRONIC COPY OF THE 990 IS MADE AVAILABLE TO THE AUDIT AND CORPORATE COMPLIANCE COMMITTEE OF THE BOARD OF TRUSTEES (THE GOVERNING BOARD), AND SENIOR MANAGEMENT OF THE ORGANIZATION, FOR REVIEW.

FORM 990, PART VI, SECTION B, LINE 12C:

ANNUALLY, THE CORPORATE COMPLIANCE/INTERNAL AUDIT DEPARTMENT PROVIDES TO OFFICERS, DIRECTORS, OR TRUSTEES AND KEY EMPLOYEES THE ORGANIZATION'S CONFLICT OF INTEREST POLICY AND DISCLOSURE STATEMENT. EACH INDIVIDUAL IS REQUIRED TO RETURN TO THE DEPARTMENT A SIGNED DOCUMENT, ACKNOWLEDGING RECEIPT OF THE POLICY AND DISCLOSURE STATEMENT AND DISCLOSE ANY INTERESTS THAT COULD GIVE RISE TO CONFLICTS. A SUMMARY OF THE DISCLOSURES IS SHARED WITH THE CHAIRMAN OF THE BOARD OF TRUSTEES AND WITH THE AUDIT AND CORPORATE COMPLIANCE COMMITTEE OF THE BOARD. INDIVIDUALS WHO ARE IDENTIFIED AS HAVING A CONFLICT OF INTEREST ARE PROHIBITED FROM PARTICIPATING IN THE GOVERNING BODIES' DELIBERATIONS AND DECISIONS RELATED TO THE TRANSACTION. THE RETURNED STATEMENTS ARE RETAINED BY THE CORPORATE COMPLIANCE/INTERNAL AUDIT DEPARTMENT.

FORM 990, PART VI, SECTION B, LINE 15:

THE COMPENSATION COMMITTEE TAKES THE FOLLOWING STEPS WITH AN INDEPENDENT COMPENSATION CONSULTANT (1) REVIEWS DATA RELATED TO CURRENT

Name of the organization: MANCHESTER MEMORIAL HOSPITAL
Employer identification number: 06-0646710

MARKET VALUES CONSISTENT FOR ORGANIZATION'S EXECUTIVES BY REVIEW OF COMPENSATION LEVELS AND PLANS CONSISTENT WITH HOSPITALS AND HEALTH SYSTEMS OF COMPARABLE SIZE AND LOCATION; (2) COMPLETES A REVIEW OF DATA ON CURRENT AND FUTURE PLANS FOR THE ORGANIZATION, INCLUDING STRUCTURE AND JOB DESCRIPTIONS; (3) REVIEWS AND APPROVES AND RECOMMENDS SALARY RANGES FOR EACH POSITION, ALONG WITH RELATED BENEFITS; (4) REVIEWS AND APPROVES A TIERED EXECUTIVE STRUCTURE WITH APPROPRIATE INCENTIVE OPPORTUNITY, BENEFITS AND COMPENSATION. THE LAST COMPENSATION REVIEW OCCURRED 12/18/2013.

FORM 990, PART VI, SECTION C, LINE 19:
THE ORGANIZATION, WILL, UPON REQUEST, ALLOW FOR REVIEW OF GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY, AND MOST RECENT ANNUAL AUDITED FINANCIAL STATEMENTS AT AN OFFICE OF THE ORGANIZATION.

FORM 990, PART XI, LINE 9, CHANGES IN NET ASSETS:

CHANGE IN BENEFICIAL INTEREST IN TRUSTS	148,523.
CHANGE IN INTEREST RATE SWAP AGREEMENT	8,379.
PENSION AND POSTRETIREMENT RELATED ADJUSTMENTS	-5,366,133.
NET TRANSFER FROM/(TO) AFFILIATES	-11,295,772.
TOTAL TO FORM 990, PART XI, LINE 9	-16,505,003.

FORM 990, PART XI, LINE 2C:
THE ECHN AUDIT COMMITTEE ASSUMES RESPONSIBILITY FOR OVERSIGHT OF THE AUDIT OF ITS FINANCIAL STATEMENTS AND SELECTION OF AN INDEPENDENT ACCOUNTANT. THERE HAVE BEEN NO CHANGES IN THESE PROCESSES SINCE THE PRIOR YEAR.

SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

▶Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.

▶ Attach to Form 990. ▶ See separate instructions.

▶Information about Schedule R (Form 990) and its instructions is at www.irs.gov/form990.

OMB No. 1545-0047

2013

Open to Public Inspection

ECHN Proposed Asset Purchase by PMH
Submitted October 13, 2015

Name of the organization

MANCHESTER MEMORIAL HOSPITAL

Employer identification number

06-0646710

Part I **Identification of Disregarded Entities** Complete if the organization answered "Yes" on Form 990, Part IV, line 33.

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity

Part II **Identification of Related Tax-Exempt Organizations** Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related tax-exempt organizations during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	(g) No
EASTERN CONNECTICUT HEALTH NETWORK, INC - 22-2546079, 71 HAYNES STREET, MANCHESTER, CT 06040	INTEGRATED HEALTH CARE SYSTEM PARENT CO	CONNECTICUT	501(C)3	11C, TYPE III	N/A		X
ROCKVILLE GENERAL HOSPITAL - 06-0653151 31 UNION STREET ROCKVILLE, CT 06066	HOSPITAL	CONNECTICUT	501(C)3	3	ECHN	X	
ECHN COMMUNITY HEALTHCARE FOUNDATION, INC - 22-2546080, 71 HAYNES STREET, MANCHESTER, CT 06040	FUNDRAISING/SUPPORT	CONNECTICUT	501(C)3	7	ECHN	X	
ECHN ELDERCARE SERVICE, INC - 06-1149193 26 SHENIPSIT LAKE ROAD TOLLAND, CT 06084	SKILLED NURSING FACILITY	CONNECTICUT	501(C)3	9	ECHN	X	

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For Paperwork Reduction Act Notice, see the Instructions for Form 990. **Schedule R (Form 990) 2013**

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09-12-13 LHA

Part II **Continuation of Identification of Related Tax-Exempt Organizations**

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled organization? Yes	(g) No
EASTERN CONNECTICUT MEDICAL PROFESSIONAL FOUNDATION, INC. - 22-2546079, 71 HAYNES STREET, MANCHESTER, CT 06040	PHYSICIAN SERVICES	CONNECTICUT	501(C)3	3	ECHN	X	
VISITING NURSE & HEATLH SERVICES OF CT, INC. - 06-0646795, 8 KEYNOTE DRIVE, VERNON, CT 06066	HOME HEALTHCARE SERVICES	CONNECTICUT	501(C)3	9	ECHN	X	

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Submitted October 13, 2015

Part III **Identification of Related Organizations Taxable as a Partnership** Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related organizations treated as a partnership during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership
MEDICAL PRACTICE PARTNERS, LLC - 27-1498877, P.O. BOX 3830, VERNON, CT 06066	BILLING AND PRACTICE MANAGEMENT SERVICES	CT	N/A	N/A	N/A	N/A	N/A		N/A	N/A		N/A

Part IV **Identification of Related Organizations Taxable as a Corporation or Trust** Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related organizations treated as a corporation or trust during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity? Yes	(i) No
ECHN ENTERPRISE, INC. - 22-2546828 71 HAYNES STREET MANCHESTER, CT 06040	REAL ESTATE HOLDING	CT	N/A	C CORP	N/A	N/A	N/A	X	
HAYNES STREET PROPERTY MANAGEMENT, LLC - 22-2546028, 71 HAYNES STREET, MANCHESTER, CT 06040	REAL ESTATE PROPERTY MANAGEMENT	CT	N/A	C CORP	N/A	N/A	N/A	X	
ECHN CORPORATE SERVICES - 27-1596320 71 HAYNES STREET MANCHESTER, CT 06040	BILLING AND OTHER PRACTICE MANAGEMENT SERVICES	CT	N/A	C CORP	N/A	N/A	N/A	X	
CONNECTICUT HEALTHCARE INSURANCE COMPANY - 98-0623043, PO BOX 1109, GRAND CAYMAN, CAYMAN ISLANDS	CAPTIVE INSURANCE	CAYMAN ISLANDS	N/A	C CORP	N/A	N/A	N/A	X	

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Part V **Transactions With Related Organizations** Complete if the organization answered "Yes" on Form 990, Part IV, line 34, 35b, or 36.

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Note. Complete line 1 if any entity is listed in Parts II, III, or IV of this schedule.

			Yes	No
1	During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?			
a	Receipt of **(i)** interest **(ii)** annuities **(iii)** royalties or **(iv)** rent from a controlled entity	1a		X
b	Gift, grant, or capital contribution to related organization(s)	1b	X	
c	Gift, grant, or capital contribution from related organization(s)	1c		X
d	Loans or loan guarantees to or for related organization(s)	1d		X
e	Loans or loan guarantees by related organization(s)	1e		X
f	Dividends from related organization(s)	1f		X
g	Sale of assets to related organization(s)	1g		X
h	Purchase of assets from related organization(s)	1h		X
i	Exchange of assets with related organization(s)	1i		X
j	Lease of facilities, equipment, or other assets to related organization(s)	1j	X	
k	Lease of facilities, equipment, or other assets from related organization(s)	1k	X	
l	Performance of services or membership or fundraising solicitations for related organization(s)	1l	X	
m	Performance of services or membership or fundraising solicitations by related organization(s)	1m	X	
n	Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)	1n		X
o	Sharing of paid employees with related organization(s)	1o		X
p	Reimbursement paid to related organization(s) for expenses	1p		X
q	Reimbursement paid by related organization(s) for expenses	1q	X	
r	Other transfer of cash or property to related organization(s)	1r	X	
s	Other transfer of cash or property from related organization(s)	1s		X

2 If the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered relationships and transaction thresholds.

	(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1)	CONNECTICUT HEALTHCARE INSURANCE COMPANY	B	1,200,005.	CASH TRANSFER
(2)	EASTERN CT MEDICAL PROFESSIONALS FOUNDATION	J	223,132.	MARKET VALUE
(3)	HAYNES STREET PROPERTY MANAGEMENT	K	170,574.	MARKET VALUE
(4)	EASTERN CT MEDICAL PROFESSIONALS FOUNDATION	K	104,952.	MARKET VALUE
(5)	EASTERN CT HEALTH NETWORK	L	86,904.	COST
(6)	ECHN COMMUNITY HEALTHCARE FOUNDATION, INC.	M	128,814.	COST

Part V **Continuation of Transactions With Related Organizations** (Schedule R (Form 990), Part V, line 2)

(a) Name of other organization	(b) Transaction type (a-r)	(c) Amount involved	(d) Method of determining amount involved
(7) EASTERN CT HEALTH NETWORK	M	20,590,993.	COST
(8) ECHN ELDERCARE SERVICES, INC.	Q	2,332,308.	CASH TRANSFER
(9) ECHN COMMUNITY HEALTHCARE FOUNDATION, INC.	Q	1,957,338.	CASH TRANSFER
(10) EASTERN CT MEDICAL PROFESSIONALS FOUNDATION	R	4,937,674.	CASH TRANSFER
(11)			
(12)			
(13)			
(14)			
(15)			
(16)			
(17)			
(18)			
(19)			
(20)			
(21)			
(22)			
(23)			
(24)			

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Part VI **Unrelated Organizations Taxable as a Partnership** Complete if the organization answered "Yes" on Form 990, Part IV, line 37.

Provide the following information for each entity taxed as a partnership through which the organization conducted more than five percent of its activities (measured by total assets or gross revenue) that was not a related organization. See instructions regarding exclusion for certain investment partnerships.

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Predominant income (related, unrelated, excluded from tax under section 512-514)	(e) Are all partners sec. 501(c)(3) orgs.? Yes	(e) No	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership

Part VII Supplemental Information

Provide additional information for responses to questions on Schedule R (see instructions).

TAX RETURN FILING INSTRUCTIONS

FORM 990-T

FOR THE YEAR ENDING

SEPTEMBER 30, 2014

Prepared for	MANCHESTER MEMORIAL HOSPITAL 71 HAYNES STREET MANCHESTER, CT 06040
Prepared by	CROWE HORWATH, LLP 175 POWDER FOREST DRIVE SIMSBURY, CT 06089
Amount due or refund	NO AMOUNT IS DUE.
Make check payable to	NO AMOUNT IS DUE.
Mail tax return and check (if applicable) to	DEPARTMENT OF THE TREASURY INTERNAL REVENUE SERVICE CENTER OGDEN, UT 84201-0027
Return must be mailed on or before	AS SOON AS POSSIBLE.
Special Instructions	THE RETURN SHOULD BE SIGNED AND DATED.

300941
05-01-13

Form **990-T**

Exempt Organization Business Income Tax Return
(and proxy tax under section 6033(e))

For calendar year 2013 or other tax year beginning OCT 1, 2013 , and ending SEP 30, 2014 .

▶ **Information about Form 990-T and its instructions is available at** *www.irs.gov/form990t.*

▶ **Do not enter SSN numbers on this form as it may be made public if your organization is a 501(c)(3).**

OMB No. 1545-0687

2013

Open to Public Inspection for 501(c)(3) Organizations Only

Department of the Treasury
Internal Revenue Service

A ☐ Check box if address changed

B Exempt under section
☒ 501(c)(3)
☐ 408(e) ☐ 220(e)
☐ 408A ☐ 530(a)
☐ 529(a)

Print or Type

Name of organization (☐ Check box if name changed and see instructions.)
MANCHESTER MEMORIAL HOSPITAL

Number, street, and room or suite no. If a P.O. box, see instructions.
71 HAYNES STREET

City or town, state or province, country, and ZIP or foreign postal code
MANCHESTER, CT 06040

D Employer identification number (Employees' trust, see instructions.)
06-0646710

E Unrelated business activity codes (See instructions.)
621500

C Book value of all assets at end of year
160577232.

F Group exemption number (See instructions.) ▶

G Check organization type ▶ ☒ 501(c) corporation ☐ 501(c) trust ☐ 401(a) trust ☐ Other trust

H Describe the organization's primary unrelated business activity. ▶ NON-HOSPITAL LABORATORY SERVICES

I During the tax year, was the corporation a subsidiary in an affiliated group or a parent-subsidiary controlled group? ▶ ☒ Yes ☐ No

If "Yes," enter the name and identifying number of the parent corporation. ▶ SEE STATEMENT 2

J The books are in care of ▶ NICHOLAS JAMIESON Telephone number ▶ 860-646-1222

Part I Unrelated Trade or Business Income

			(A) Income	(B) Expenses	(C) Net
1a	Gross receipts or sales 6,568,698. b Less returns and allowances 5,646,865. c Balance ▶	1c	921,833.		
2	Cost of goods sold (Schedule A, line 7)	2			
3	Gross profit. Subtract line 2 from line 1c	3	921,833.		921,833.
4a	Capital gain net income (attach Form 8949 and Schedule D)	4a			
b	Net gain (loss) (Form 4797, Part II, line 17) (attach Form 4797)	4b			
c	Capital loss deduction for trusts	4c			
5	Income (loss) from partnerships and S corporations (attach statement)	5			
6	Rent income (Schedule C)	6			
7	Unrelated debt-financed income (Schedule E)	7			
8	Interest, annuities, royalties, and rents from controlled organizations (Sch. F)	8			
9	Investment income of a section 501(c)(7), (9), or (17) organization (Schedule G)	9			
10	Exploited exempt activity income (Schedule I)	10			
11	Advertising income (Schedule J)	11			
12	Other income (See instructions; attach schedule.)	12			
13	**Total.** Combine lines 3 through 12	13	921,833.		921,833.

Part II Deductions Not Taken Elsewhere (See instructions for limitations on deductions.)

(Except for contributions, deductions must be directly connected with the unrelated business income.)

14	Compensation of officers, directors, and trustees (Schedule K)			14	
15	Salaries and wages			15	376,271.
16	Repairs and maintenance			16	
17	Bad debts			17	
18	Interest (attach schedule)			18	
19	Taxes and licenses			19	
20	Charitable contributions (See instructions for limitation rules.)			20	
21	Depreciation (attach Form 4562)	21			
22	Less depreciation claimed on Schedule A and elsewhere on return	22a		22b	
23	Depletion			23	
24	Contributions to deferred compensation plans			24	
25	Employee benefit programs			25	
26	Excess exempt expenses (Schedule I)			26	
27	Excess readership costs (Schedule J)			27	
28	Other deductions (attach schedule) SEE STATEMENT 1			28	614,946.
29	**Total deductions.** Add lines 14 through 28			29	991,217.
30	Unrelated business taxable income before net operating loss deduction. Subtract line 29 from line 13			30	-69,384.
31	Net operating loss deduction (limited to the amount on line 30) SEE STATEMENT 3			31	
32	Unrelated business taxable income before specific deduction. Subtract line 31 from line 30			32	-69,384.
33	Specific deduction (Generally $1,000, but see instructions for exceptions.)			33	
34	**Unrelated business taxable income.** Subtract line 33 from line 32. If line 33 is greater than line 32, enter the smaller of zero or line 32			34	-69,384.

Part III Tax Computation

35	**Organizations Taxable as Corporations.** See instructions for tax computation. Controlled group members (sections 1561 and 1563) check here ▶ [X] **See instructions** and:		
a	Enter your share of the $50,000, $25,000, and $9,925,000 taxable income brackets (in that order): (1) $ (2) $ (3) $		
b	Enter organization's share of: **(1)** Additional 5% tax (not more than $11,750) $ **(2)** Additional 3% tax (not more than $100,000) $		
c	Income tax on the amount on line 34 ▶	35c	0.
36	**Trusts Taxable at Trust Rates.** See instructions for tax computation. Income tax on the amount on line 34 from: [ ] Tax rate schedule or [ ] Schedule D (Form 1041) ▶	36	
37	**Proxy tax.** See instructions ▶	37	
38	Alternative minimum tax	38	
39	**Total.** Add lines 37 and 38 to line 35c or 36, whichever applies	39	0.

Part IV Tax and Payments

40a	Foreign tax credit (corporations attach Form 1118; trusts attach Form 1116)	40a			
b	Other credits (see instructions)	40b			
c	General business credit. Attach Form 3800	40c			
d	Credit for prior year minimum tax (attach Form 8801 or 8827)	40d			
e	**Total credits.** Add lines 40a through 40d			40e	
41	Subtract line 40e from line 39			41	0.
42	Other taxes. Check if from: [ ] Form 4255 [ ] Form 8611 [ ] Form 8697 [ ] Form 8866 [ ] Other (attach schedule)			42	
43	**Total tax.** Add lines 41 and 42			43	0.
44a	Payments: A 2012 overpayment credited to 2013	44a			
b	2013 estimated tax payments	44b			
c	Tax deposited with Form 8868	44c			
d	Foreign organizations: Tax paid or withheld at source (see instructions)	44d			
e	Backup withholding (see instructions)	44e			
f	Credit for small employer health insurance premiums (Attach Form 8941)	44f			
g	Other credits and payments: [ ] Form 2439 [ ] Form 4136 [ ] Other Total ▶	44g			
45	**Total payments.** Add lines 44a through 44g			45	
46	Estimated tax penalty (see instructions). Check if Form 2220 is attached ▶ [ ]			46	
47	**Tax due.** If line 45 is less than the total of lines 43 and 46, enter amount owed ▶			47	0.
48	**Overpayment.** If line 45 is larger than the total of lines 43 and 46, enter amount overpaid ▶			48	0.
49	Enter the amount of line 48 you want: **Credited to 2014 estimated tax** ▶ **Refunded** ▶			49	

Part V Statements Regarding Certain Activities and Other Information (see instructions)

		Yes	No
1	At any time during the 2013 calendar year, did the organization have an interest in or a signature or other authority over a financial account (bank, securities, or other) in a foreign country? If YES, the organization may have to file Form TD F 90-22.1, Report of Foreign Bank and Financial Accounts. If YES, enter the name of the foreign country here ▶		X
2	During the tax year, did the organization receive a distribution from, or was it the grantor of, or transferor to, a foreign trust? If YES, see instructions for other forms the organization may have to file.		X
3	Enter the amount of tax-exempt interest received or accrued during the tax year ▶ $		

Schedule A - Cost of Goods Sold. Enter method of inventory valuation ▶ N/A

1	Inventory at beginning of year	1		6	Inventory at end of year	6	
2	Purchases	2		7	**Cost of goods sold.** Subtract line 6 from line 5. Enter here and in Part I, line 2	7	
3	Cost of labor	3					
4a	Additional section 263A costs (att. schedule)	4a		8	Do the rules of section 263A (with respect to property produced or acquired for resale) apply to the organization?	Yes	No
b	Other costs (attach schedule)	4b					X
5	**Total.** Add lines 1 through 4b	5					

Sign Here

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

▶ Signature of officer | Date | ▶ CHIEF FINANCIAL OFFICER Title

May the IRS discuss this return with the preparer shown below (see instructions)? [X] Yes [ ] No

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check [ ] if self-employed	PTIN
BETH A. THURZ				P00346435

Firm's name ▶ CROWE HORWATH, LLP — Firm's EIN ▶ 35-0921680

Firm's address ▶ 175 POWDER FOREST DRIVE SIMSBURY, CT 06089 — Phone no. 860-678-9200

Schedule C - Rent Income (From Real Property and Personal Property Leased With Real Property) (see instructions)

1. Description of property

(1)
(2)
(3)
(4)

	2. Rent received or accrued		3(a) Deductions directly connected with the income in columns 2(a) and 2(b) (attach schedule)
	(a) From personal property (if the percentage of rent for personal property is more than 10% but not more than 50%)	(b) From real and personal property (if the percentage of rent for personal property exceeds 50% or if the rent is based on profit or income)	
(1)			
(2)			
(3)			
(4)			
Total	0.	0.	

(c) **Total income.** Add totals of columns 2(a) and 2(b). Enter here and on page 1, Part I, line 6, column (A) ▶ 0.

(b) **Total deductions.** Enter here and on page 1, Part I, line 6, column (B) ▶ 0.

Schedule E - Unrelated Debt-Financed Income (see instructions)

	1. Description of debt-financed property	2. Gross income from or allocable to debt-financed property	3. Deductions directly connected with or allocable to debt-financed property	
			(a) Straight line depreciation (attach schedule)	(b) Other deductions (attach schedule)
(1)				
(2)				
(3)				
(4)				

	4. Amount of average acquisition debt on or allocable to debt-financed property (attach schedule)	5. Average adjusted basis of or allocable to debt-financed property (attach schedule)	6. Column 4 divided by column 5	7. Gross income reportable (column 2 x column 6)	8. Allocable deductions (column 6 x total of columns 3(a) and 3(b))
(1)			%		
(2)			%		
(3)			%		
(4)			%		
				Enter here and on page 1, Part I, line 7, column (A).	Enter here and on page 1, Part I, line 7, column (B).
Totals ▶				0.	0.
Total dividends-received deductions included in column 8 ▶					0.

Schedule F - Interest, Annuities, Royalties, and Rents From Controlled Organizations (see instructions)

	1. Name of controlled organization	2. Employer identification number	Exempt Controlled Organizations 3. Net unrelated income (loss) (see instructions)	4. Total of specified payments made	5. Part of column 4 that is included in the controlling organization's gross income	6. Deductions directly connected with income in column 5
(1)						
(2)						
(3)						
(4)						

Nonexempt Controlled Organizations

	7. Taxable Income	8. Net unrelated income (loss) (see instructions)	9. Total of specified payments made	10. Part of column 9 that is included in the controlling organization's gross income	11. Deductions directly connected with income in column 10
(1)					
(2)					
(3)					
(4)					
				Add columns 5 and 10. Enter here and on page 1, Part I, line 8, column (A).	Add columns 6 and 11. Enter here and on page 1, Part I, line 8, column (B).
Totals ▶				0.	0.

Schedule G - Investment Income of a Section 501(c)(7), (9), or (17) Organization
(see instructions)

1. Description of income	2. Amount of income	3. Deductions directly connected (attach schedule)	4. Set-asides (attach schedule)	5. Total deductions and set-asides (col. 3 plus col. 4)
(1)				
(2)				
(3)				
(4)				
	Enter here and on page 1, Part I, line 9, column (A).			Enter here and on page 1, Part I, line 9, column (B).
Totals ▶	0.			0.

Schedule I - Exploited Exempt Activity Income, Other Than Advertising Income
(see instructions)

1. Description of exploited activity	2. Gross unrelated business income from trade or business	3. Expenses directly connected with production of unrelated business income	4. Net income (loss) from unrelated trade or business (column 2 minus column 3). If a gain, compute cols. 5 through 7.	5. Gross income from activity that is not unrelated business income	6. Expenses attributable to column 5	7. Excess exempt expenses (column 6 minus column 5, but not more than column 4).
(1)						
(2)						
(3)						
(4)						
	Enter here and on page 1, Part I, line 10, col. (A).	Enter here and on page 1, Part I, line 10, col. (B).				Enter here and on page 1, Part II, line 26.
Totals ▶	0.	0.				0.

Schedule J - Advertising Income (see instructions)

Part I Income From Periodicals Reported on a Consolidated Basis

1. Name of periodical	2. Gross advertising income	3. Direct advertising costs	4. Advertising gain or (loss) (col. 2 minus col. 3). If a gain, compute cols. 5 through 7.	5. Circulation income	6. Readership costs	7. Excess readership costs (column 6 minus column 5, but not more than column 4).
(1)						
(2)						
(3)						
(4)						
Totals (carry to Part II, line (5)) ▶	0.	0.				0.

Part II Income From Periodicals Reported on a Separate Basis (For each periodical listed in Part II, fill in columns 2 through 7 on a line-by-line basis.)

1. Name of periodical	2. Gross advertising income	3. Direct advertising costs	4. Advertising gain or (loss) (col. 2 minus col. 3). If a gain, compute cols. 5 through 7.	5. Circulation income	6. Readership costs	7. Excess readership costs (column 6 minus column 5, but not more than column 4).
(1)						
(2)						
(3)						
(4)						
Totals from Part I	0.	0.				0.
	Enter here and on page 1, Part I, line 11, col. (A).	Enter here and on page 1, Part I, line 11, col. (B).				Enter here and on page 1, Part II, line 27.
Totals, Part II (lines 1-5) ▶	0.	0.				0.

Schedule K - Compensation of Officers, Directors, and Trustees (see instructions)

1. Name	2. Title	3. Percent of time devoted to business	4. Compensation attributable to unrelated business
(1)		%	
(2)		%	
(3)		%	
(4)		%	
Total. Enter here and on page 1, Part II, line 14 ▶			0.

SCHEDULE O (Form 1120)
(Rev. December 2012)
Department of the Treasury
Internal Revenue Service

Consent Plan and Apportionment Schedule for a Controlled Group

▶ Attach to Form 1120, 1120-C, 1120-F, 1120-FSC, 1120-L, 1120-PC, 1120-REIT, or 1120-RIC.
▶ Information about Schedule O (Form 1120) and its instructions is available at www.irs.gov/form1120.

OMB No. 1545-0123

Name	Employer identification number
MANCHESTER MEMORIAL HOSPITAL	06-0646710

Part I Apportionment Plan Information

1 Type of controlled group:
- **a** ☐ Parent-subsidiary group
- **b** ☒ Brother-sister group
- **c** ☐ Combined group
- **d** ☐ Life insurance companies only

2 This corporation has been a member of this group:
- **a** ☒ For the entire year.
- **b** ☐ From _____ , until _____ .

3 This corporation consents and represents to:
- **a** ☒ Adopt an apportionment plan. All the other members of this group are adopting an apportionment plan effective for the current tax year which ends on SEPTEMBER 30, 2014 , and for all succeeding tax years.
- **b** ☐ Amend the current apportionment plan. All the other members of this group are currently amending a previously adopted plan, which was in effect for the tax year ending _____ , and for all succeeding tax years.
- **c** ☐ Terminate the current apportionment plan and not adopt a new plan. All the other members of this group are not adopting an apportionment plan.
- **d** ☐ Terminate the current apportionment plan and adopt a new plan. All the other members of this group are adopting an apportionment plan effective for the current tax year which ends on _____ , and for all succeeding tax years.

4 If you checked box 3c or 3d above, check the applicable box below to indicate if the termination of the current apportionment plan was:
- **a** ☐ Elected by the component members of the group.
- **b** ☐ Required for the component members of the group.

5 If you did not check a box on line 3 above, check the applicable box below concerning the status of the group's apportionment plan (see instructions).
- **a** ☐ No apportionment plan is in effect and none is being adopted.
- **b** ☐ An apportionment plan is already in effect. It was adopted for the tax year ending _____ , and for all succeeding tax years.

6 If all the members of this group are adopting a plan or amending the current plan for a tax year after the due date (including extensions) of the tax return for this corporation, is there at least one year remaining on the statute of limitations from the date this corporation filed its amended return for such tax year for assessing any resulting deficiency? See instructions.
- **a** ☐ Yes.
  - (i) ☐ The statute of limitations for this year will expire on _____ .
  - (ii) ☐ On _____ , this corporation entered into an agreement with the Internal Revenue Service to extend the statute of limitations for purposes of assessment until _____ .
- **b** ☐ No. The members may not adopt or amend an apportionment plan.

7 Required information and elections for component members. Check the applicable box(es) (see instructions).
- **a** ☐ The corporation will determine its tax liability by applying the maximum tax rate imposed by section 11 to the entire amount of its taxable income.
- **b** ☐ The corporation and the other members of the group elect the FIFO method (rather than defaulting to the proportionate method) for allocating the additional taxes for the group imposed by section 11(b)(1).
- **c** ☐ The corporation has a short tax year that does not include December 31.

Part II **Taxable Income Apportionment** (See instructions)

Caution: Each total in Part II, column (g) for each component member must equal taxable income from Form 1120, page 1, line 30 or the comparable line of such member's tax return.

	(a) Group member's name and employer identification number		(b) Tax year end (Yr-Mo)	Taxable Income Amount Allocated to Each Bracket (c) 15%	(d) 25%	(e) 34%	(f) 35%	(g) **Total** (add columns (c) through (f))
1	MANCHESTER MEMORIAL HOSPITAL	06-0646710	14-09	0.	0.	0.		0.
2	ECHN CORPORATE SERVICES	27-1596320	14-09	0.	0.	0.		0.
3	ROCKVILLE GENERAL HOSPITAL	06-0653151	14-09	0.	0.	0.		0.
4	ECHN ENTERPRISES, INC & SUBSIDIARY	22-2546828	14-09	0.	0.	0.		0.
5								
6								
7								
8								
9								
10								
11								
12								
Total								

ECHN Proposed Asset Purchase by MMH
Submitted October 13, 2015

Part III **Income Tax Apportionment** (See instructions)

(a) Group member's name	Income Tax Apportionment (b) 15%	(c) 25%	(d) 34%	(e) 35%	(f) 5%	(g) 3%	(h) Total income tax (combine lines (b) through (g))
1 MANCHESTER MEMORIAL HOSPITAL	0.	0.	0.				
2 ECHN CORPORATE SERVICES	0.	0.	0.				
3 ROCKVILLE GENERAL HOSPITAL	0.	0.	0.				
4 ECHN ENTERPRISES, INC & SUBSIDIARY	0.	0.	0.				
5							
6							
7							
8							
9							
10							
11							
12							
Total							

ECHN Proposed Asset Purchase by MH
Submitted October 13, 2015

Part IV **Other Apportionments** (See instructions)

	(a) Group member's name	Other Apportionments (b) Accumulated earnings credit	(c) AMT exemption amount	(d) Phaseout of AMT exemption amount	(e) Penalty for failure to pay estimated tax	(f) Other
1	MANCHESTER MEMORIAL HOSPITAL	0.	0.	0.	0.	0.
2	ECHN CORPORATE SERVICES	0.	9,550.	35,813.	0.	0.
3	ROCKVILLE GENERAL HOSPITAL	0.	14,287.	53,576.	0.	0.
4	ECHN ENTERPRISES, INC & SUBSIDIARY	0.	16,163.	60,611.	0.	0.
5						
6						
7						
8						
9						
10						
11						
12						
Total			40,000.	150,000.		

ECHN Proposed Asset Purchase by JMH
Submitted October 13, 2015

MANCHESTER MEMORIAL HOSPITAL 06-0646710

Statement of Consent to Apportionment Plan
Under IRC Sec. 179(d)(6). As amended.

The undersigned corporations hereby consent to the following apportionment plan with respect to December 31, 2013
Under Internal Revenue Code Section 179(d)(6), as amended by P.L. 97-34, as it applies to tax years beginning after December 31, 1980.

Group Member's Name and Employer Identification Number		Tax Year End	Section 179 Apportionment	
			Cost of Property	Expensed Cost
1. MANCHESTER MEMORIAL HOSPITAL	06-0646710	09/30/14	0.	0.
2. ECHN CORPORATE SERVICES	27-1596320	09/13/14	216,309.	500,000.
3. ROCKVILLE GENERAL HOSPITAL	06-0653151	09/30/14	0.	0.
4. ECHN ENTERPRISES, INC & SUBSIDIARY	22-2546828	09/30/14	0.	0.
5.				
6.				

The original of this election is filed with the Internal Revenue Service at: OGDEN, UT
together with the tax return of _____
filing for a taxable year including December 31. All other corporations are including a copy of this consent with their returns.

1. _____
(Name of corporation) By Title

2. _____
(Name of corporation) By Title

3. _____
(Name of corporation) By Title

4. _____
(Name of corporation) By Title

5. _____
(Name of corporation) By Title

6. _____
(Name of corporation) By Title

313781
05-01-13

Form **4626**
Department of the Treasury
Internal Revenue Service

Alternative Minimum Tax - Corporations

▶ Attach to the corporation's tax return.
▶ Information about Form 4626 and its separate instructions is at www.irs.gov/form4626.

OMB No. 1545-0175

2013

Name: MANCHESTER MEMORIAL HOSPITAL

Employer identification number: 06-0646710

Note: See the instructions to find out if the corporation is a small corporation exempt from the alternative minimum tax (AMT) under section 55(e).

1	Taxable income or (loss) before net operating loss deduction		1	-69,384.
2	**Adjustments and preferences:**			
a	Depreciation of post-1986 property		2a	
b	Amortization of certified pollution control facilities		2b	
c	Amortization of mining exploration and development costs		2c	
d	Amortization of circulation expenditures (personal holding companies only)		2d	
e	Adjusted gain or loss		2e	
f	Long-term contracts		2f	
g	Merchant marine capital construction funds		2g	
h	Section 833(b) deduction (Blue Cross, Blue Shield, and similar type organizations only)		2h	
i	Tax shelter farm activities (personal service corporations only)		2i	
j	Passive activities (closely held corporations and personal service corporations only)		2j	
k	Loss limitations		2k	
l	Depletion		2l	
m	Tax-exempt interest income from specified private activity bonds		2m	
n	Intangible drilling costs		2n	
o	Other adjustments and preferences		2o	
3	Pre-adjustment alternative minimum taxable income (AMTI). Combine lines 1 through 2o		3	-69,384.
4	**Adjusted current earnings (ACE) adjustment:**			
a	ACE from line 10 of the ACE worksheet in the instructions	4a: -69,384.		
b	Subtract line 3 from line 4a. If line 3 exceeds line 4a, enter the difference as a negative amount (see instructions)	4b: 0.		
c	Multiply line 4b by 75% (.75). Enter the result as a positive amount	4c:		
d	Enter the excess, if any, of the corporation's total increases in AMTI from prior year ACE adjustments over its total reductions in AMTI from prior year ACE adjustments (see instructions). **Note:** You **must** enter an amount on line 4d (even if line 4b is positive)	4d:		
e	ACE adjustment. • If line 4b is zero or more, enter the amount from line 4c • If line 4b is less than zero, enter the **smaller** of line 4c or line 4d as a negative amount		4e	0.
5	Combine lines 3 and 4e. If zero or less, stop here; the corporation does not owe any AMT		5	-69,384.
6	Alternative tax net operating loss deduction (see instructions) STATEMENT 4		6	
7	**Alternative minimum taxable income.** Subtract line 6 from line 5. If the corporation held a residual interest in a REMIC, see instructions		7	
8	**Exemption phase-out** (if line 7 is $310,000 or more, skip lines 8a and 8b and enter -0- on line 8c):			
a	Subtract $150,000 from line 7 (if completing this line for a member of a controlled group, see instructions). If zero or less, enter -0-	8a:		
b	Multiply line 8a by 25% (.25)	8b:		
c	Exemption. Subtract line 8b from $40,000 (if completing this line for a member of a controlled group, see instructions). If zero or less, enter -0-		8c	
9	Subtract line 8c from line 7. If zero or less, enter -0-		9	
10	Multiply line 9 by 20% (.20)		10	
11	Alternative minimum tax foreign tax credit (AMTFTC) (see instructions)		11	
12	Tentative minimum tax. Subtract line 11 from line 10		12	
13	Regular tax liability before applying all credits except the foreign tax credit		13	
14	**Alternative minimum tax.** Subtract line 13 from line 12. If zero or less, enter -0-. Enter here and on Form 1120, Schedule J, line 3, or the appropriate line of the corporation's income tax return		14	

JWA **For Paperwork Reduction Act Notice, see separate instructions.** Form **4626** (2013)

317001
11-26-13

Adjusted Current Earnings (ACE) Worksheet

▶ See ACE Worksheet Instructions.

1	Pre-adjustment AMTI. Enter the amount from line 3 of Form 4626				1	-69,384.
2	ACE depreciation adjustment:					
a	AMT depreciation			2a		
b	ACE depreciation:					
	(1) Post-1993 property	2b(1)				
	(2) Post-1989, pre-1994 property	2b(2)				
	(3) Pre-1990 MACRS property	2b(3)				
	(4) Pre-1990 original ACRS property	2b(4)				
	(5) Property described in sections 168(f)(1) through (4)	2b(5)				
	(6) Other property	2b(6)				
	(7) Total ACE depreciation. Add lines 2b(1) through 2b(6)			2b(7)		
c	ACE depreciation adjustment. Subtract line 2b(7) from line 2a				2c	
3	Inclusion in ACE of items included in earnings and profits (E&P):					
a	Tax-exempt interest income			3a		
b	Death benefits from life insurance contracts			3b		
c	All other distributions from life insurance contracts (including surrenders)			3c		
d	Inside buildup of undistributed income in life insurance contracts			3d		
e	Other items (see Regulations sections 1.56(g)-1(c)(6)(iii) through (ix) for a partial list)			3e		
f	Total increase to ACE from inclusion in ACE of items included in E&P. Add lines 3a through 3e				3f	
4	Disallowance of items not deductible from E&P:					
a	Certain dividends received			4a		
b	Dividends paid on certain preferred stock of public utilities that are deductible under section 247			4b		
c	Dividends paid to an ESOP that are deductible under section 404(k)			4c		
d	Nonpatronage dividends that are paid and deductible under section 1382(c)			4d		
e	Other items (see Regulations sections 1.56(g)-1(d)(3)(i) and (ii) for a partial list)			4e		
f	Total increase to ACE because of disallowance of items not deductible from E&P. Add lines 4a through 4e				4f	
5	Other adjustments based on rules for figuring E&P:					
a	Intangible drilling costs			5a		
b	Circulation expenditures			5b		
c	Organizational expenditures			5c		
d	LIFO inventory adjustments			5d		
e	Installment sales			5e		
f	Total other E&P adjustments. Combine lines 5a through 5e				5f	
6	Disallowance of loss on exchange of debt pools				6	
7	Acquisition expenses of life insurance companies for qualified foreign contracts				7	
8	Depletion				8	
9	Basis adjustments in determining gain or loss from sale or exchange of pre-1994 property				9	
10	**Adjusted current earnings.** Combine lines 1, 2c, 3f, 4f, and 5f through 9. Enter the result here and on line 4a of Form 4626				10	-69,384.

FORM 990-T OTHER DEDUCTIONS STATEMENT 1

DESCRIPTION	AMOUNT
OUTSIDE LABS	200,137.
RED CROSS CHARGES	60,561.
SUPPLIES	252,334.
OTHER	101,914.
TOTAL TO FORM 990-T, PAGE 1, LINE 28	614,946.

FORM 990-T PARENT CORPORATION'S NAME AND IDENTIFYING NUMBER STATEMENT 2

CORPORATION'S NAME	IDENTIFYING NO
EASTERN CONNECTICUT HEALTH NETWORK, INC.	22-2546079

FORM 990-T NET OPERATING LOSS DEDUCTION STATEMENT 3

TAX YEAR	LOSS SUSTAINED	LOSS PREVIOUSLY APPLIED	LOSS REMAINING	AVAILABLE THIS YEAR
09/30/04	261,338.	56,898.	204,440.	204,440.
09/30/05	43,130.	0.	43,130.	43,130.
09/30/06	151,249.	0.	151,249.	151,249.
09/30/07	161,951.	0.	161,951.	161,951.
09/30/12	54,809.	0.	54,809.	54,809.
09/30/13	112,441.	0.	112,441.	112,441.
NOL CARRYOVER AVAILABLE THIS YEAR			728,020.	728,020.

FORM 4626 ALTERNATIVE MINIMUM TAX NOL DEDUCTION STATEMENT 4

TAX YEAR	LOSS SUSTAINED	LOSS PREVIOUSLY APPLIED	LOSS REMAINING
09/30/04	261,338.	56,898.	204,440.
09/30/05	43,130.	0.	43,130.
09/30/06	151,249.	0.	151,249.
09/30/07	161,951.	0.	161,951.
09/30/12	54,809.	0.	54,809.
09/30/13	112,441.	0.	112,441.
AMT NOL CARRYOVER AVAILABLE THIS YEAR			728,020.

Form 8868 (Rev. 1-2014) Page **2**

- If you are filing for an **Additional (Not Automatic) 3-Month Extension, complete only Part II** and check this box ▶ X

Note. Only complete Part II if you have already been granted an automatic 3-month extension on a previously filed Form 8868.

- If you are filing for an **Automatic 3-Month Extension, complete only Part I** (on page 1).

Part II **Additional (Not Automatic) 3-Month Extension of Time.** Only file the original (no copies needed).

Enter filer's identifying number, see instructions

Type or print File by the due date for filing your return. See instructions.	Name of exempt organization or other filer, see instructions.	Employer identification number (EIN) or
	MANCHESTER MEMORIAL HOSPITAL	06-0646710
	Number, street, and room or suite no. If a P.O. box, see instructions.	Social security number (SSN)
	71 HAYNES STREET	
	City, town or post office, state, and ZIP code. For a foreign address, see instructions.	
	MANCHESTER, CT 06040	

Enter the Return code for the return that this application is for (file a separate application for each return) 0 1

Application Is For	Return Code	Application Is For	Return Code
Form 990 or Form 990-EZ	01		
Form 990-BL	02	Form 1041-A	08
Form 4720 (individual)	03	Form 4720 (other than individual)	09
Form 990-PF	04	Form 5227	10
Form 990-T (sec. 401(a) or 408(a) trust)	05	Form 6069	11
Form 990-T (trust other than above)	06	Form 8870	12

STOP! Do not complete Part II if you were not already granted an automatic 3-month extension on a previously filed Form 8868.

- The books are in the care of ▶ NICHOLAS JAMIESON
  320 MAIN STREET - MANCHESTER, CT 06040
  Telephone No. ▶ 860-646-1222 Fax No. ▶
- If the organization does not have an office or place of business in the United States, check this box ▶ ☐
- If this is for a Group Return, enter the organization's four digit Group Exemption Number (GEN) _____. If this is for the whole group, check this box ▶ ☐. If it is for part of the group, check this box ▶ ☐ and attach a list with the names and EINs of all members the extension is for.

4 I request an additional 3-month extension of time until AUGUST 15, 2015.

5 For calendar year _____, or other tax year beginning OCT 1, 2013, and ending SEP 30, 2014.

6 If the tax year entered in line 5 is for less than 12 months, check reason: ☐ Initial return ☐ Final return ☐ Change in accounting period

7 State in detail why you need the extension
ADDITIONAL TIME IS REQUIRED TO PREPARE A COMPLETE AND ACCURATE TAX RETURN, AND TO ALLOW ADEQUATE TIME FOR THE BOARD TO REVIEW PRIOR TO FILING.

8a	If this application is for Forms 990-BL, 990-PF, 990-T, 4720, or 6069, enter the tentative tax, less any nonrefundable credits. See instructions.	8a	$	0.
b	If this application is for Forms 990-PF, 990-T, 4720, or 6069, enter any refundable credits and estimated tax payments made. Include any prior year overpayment allowed as a credit and any amount paid previously with Form 8868.	8b	$	0.
c	**Balance due.** Subtract line 8b from line 8a. Include your payment with this form, if required, by using EFTPS (Electronic Federal Tax Payment System). See instructions.	8c	$	0.

Signature and Verification must be completed for Part II only.

Under penalties of perjury, I declare that I have examined this form, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete, and that I am authorized to prepare this form.

Signature ▶ Title ▶ CPA Date ▶

Form **8868** (Rev. 1-2014)

323842
12-31-13

Department of Revenue Services
State of Connecticut
PO Box 5014
Hartford CT 06102-5014
(Rev. 12/13)

Form CT-990T EXT

Application for Extension of Time to File Unrelated Business Income Tax Return

See instructions. Complete this return in blue or black ink only.

2013

Enter Income Year Beginning ▶ OCT 1 **, 2013, and Ending ▶** SEP 30, 2014

Taxpayer (Please type or print)	Organization name *(please type or print)* MANCHESTER MEMORIAL HOSPITAL	**CT Tax Registration Number** 6279384-000
	Address Number and street PO Box 71 HAYNES STREET	**DRS use only** - - 20
	City or town State ZIP code MANCHESTER, CT 06040	**Federal Employer ID Number (FEIN)** 06-0646710

Request for six-month extension of time to file Form CT-990T only

Enter above the beginning and ending dates of the organization's income year, Connecticut Tax Registration Number, and FEIN.

Check type of organization: [X] Corporation [ ] Domestic trust [ ] Foreign trust [ ] Other

An application for an extension to file **Form CT-990T**, with payment of tax tentatively believed to be due, must be submitted whether or not an application for federal extension has been approved.

I request a **six-month extension** of time to file **Form CT-990T**, *Connecticut Unrelated Business Income Tax Return,* for calendar year 2013, or until 08/17/15 for fiscal year ending 09/30/14 .

A federal extension will be requested on federal Form 8868, Application for Extension of Time to File an Exempt Organization Return, for calendar year 2013, or fiscal year beginning OCTOBER 1 , 2013, and ending SEPTEMBER 30, 201 . [X] Yes [ ] No

If **No,** the reason for the Connecticut extension is _____

Notification will be sent only if extension request is denied

Tentative Return

Computation

1.	Tentative amount of tax due for this income year, including surtax if applicable. See instr.			1.		00
2.	*Reserved for future use*			2.		
3.	Total amount of tax due for this income year: Enter amount from Line 1			3.		00
4a.	Tax credits	4a	00			
4b.	Payments of estimated tax	4b	00			
4c.	Overpayment from prior year	4c	00			
4.	Total tax credits and payments: Add Lines 4a, 4b, and 4c			4.		00
5.	**Balance due with this return:** Subtract Line 4 from Line 3 ▶			5.	0	00

Make check payable to **Commissioner of Revenue Services.** Write the organization's Connecticut Tax Registration Number and "2013 Form CT-990T EXT" on the check and attach it to the return.

Mail this return to: Department of Revenue Services
State of Connecticut
PO Box 5014
Hartford CT 06102-5014

Visit the DRS **Taxpayer Service Center (TSC)** at **www.ct.gov/TSC** to pay this return electronically.

www.ct.gov/DRS TSC Taxpayer Service Center

Declaration: I declare under penalty of law that I have examined this return (including any accompanying schedules and statements) and, to the best of my knowledge and belief, it is true, complete, and correct. I understand the penalty for willfully delivering a false return or document to the Department of Revenue Services (DRS) is a fine of not more than $5,000, imprisonment for not more than five years, or both. The declaration of a paid preparer other than the taxpayer is based on all information of which the preparer has any knowledge.

Name of officer or fiduciary *(print)*	Signature of officer or fiduciary	Date
MICHAEL D. VEILLETTE		

Officer's email address *(print)*

Title CHIEF FINANCIAL OFFICER	Telephone number 860-646-1222	
Paid preparer's signature	Date	Preparer's SSN or PTIN P00346435
Firm's name and address SASLOW LUFKIN & BUGGY, LLP 175 POWDER FOREST DRIVE SIMSBURY, CT 06089	FEIN 06-1533253	Telephone number 860-678-9200

1019 341911 12-04-13

TAX RETURN FILING INSTRUCTIONS

CONNECTICUT FORM CT-990T

FOR THE YEAR ENDING

SEPTEMBER 30, 2014

Prepared for	MANCHESTER MEMORIAL HOSPITAL 71 HAYNES STREET MANCHESTER, CT 06040
Prepared by	CROWE HORWATH, LLP 175 POWDER FOREST DRIVE SIMSBURY, CT 06089
Amount due or refund	NO PAYMENT REQUIRED
Make check payable to	NOT APPLICABLE
Mail tax return and check (if applicable) to	DEPARTMENT OF REVENUE SERVICES STATE OF CONNECTICUT PO BOX 5014 HARTFORD, CT 06102-5014
Return must be mailed on or before	PLEASE MAIL AS SOON AS POSSIBLE.
Special Instructions	THE RETURN SHOULD BE SIGNED AND DATED BY AN AUTHORIZED INDIVIDUAL.

300941
05-01-13

Department of Revenue Services
State of Connecticut
PO Box 5014
Hartford CT 06102-5014
(Rev. 12/13)

Form CT-990T
Connecticut Unrelated Business Income Tax Return

Page 2036 **2013**

Complete this return in blue or black ink only.

Enter Income Year Beginning ▶ OCTOBER 1 , 2013, and Ending ▶ SEPTEMBER 30, 2014

Taxpayer (Please type or print)	Organization name *(please type or print)*	CT Tax Registration Number
	MANCHESTER MEMORIAL HOSPITAL	6279384-000
	Address Number and street PO Box	DRS use only
	71 HAYNES STREET	- - 20
	City or town State ZIP code	Federal Employer ID Number (FEIN)
	MANCHESTER, CT 06040	06-0646710

Check and Complete All Applicable Boxes If the organization is annualizing its income check here ▶ ☐

Change of: ☐ Mailing address ☐ Closing month (Attach explanation.) **Return status:** ☐ Amended return ☐ Initial return ☐ Final return

If final return: ☐ Dissolved ☐ Withdrawn ☐ Merged/reorganized: Enter survivor's CT Tax Reg. Number. _____

Type of organization: ▶ ☒ Corporation ▶ ☐ Domestic trust ▶ ☐ Foreign trust ▶ ☐ Other: Explain _____

1. Date unrelated trade or business began in Connecticut: _____
2. Nature of unrelated trade or business income activity: NON-HOSPITAL LABORATORY SERVICES
3. **Corporation only:** Enter state of incorporation: _____ Date of organization: _____

Date qualified in Connecticut if not incorporated in Connecticut:

- Attach a Complete Copy of Form 990-T Including all Schedules as Filed With the Internal Revenue Service -

Computation of Income

1. Federal unrelated business taxable income from 2013 federal Form 990-T, Part II, Line 34	▶	1	-69,384 00
2. Federal net operating loss deduction from 2013 federal Form 990-T, Part II, Line 31	▶	2	00
3. Federal deduction for Connecticut tax on unrelated business taxable income	▶	3	00
4. **Total:** Add Lines 1, 2, and 3	▶	4	-69,384 00
5. Refund or credit for overpayment of Connecticut tax included in federal unrelated business taxable income	▶	5	00
6. Unrelated business taxable income: Subtract Line 5 from Line 4	▶	6	-69,384 00

Computation of Tax

1. Unrelated business taxable income from Line 6 above. **If 100% Connecticut, enter also on Line 3**	▶	1	-69,384 00
2. Apportionment fraction from *Schedule A*, Line 5, page 2. Carry to six places	▶	2	
3. Connecticut unrelated business taxable income: Line 1 **or** Line 1 multiplied by Line 2	▶	3	-69,384 00
4. Operating loss carryover from *Schedule B*, Line 14 on page 2	▶	4	00
5. Income subject to tax: Subtract Line 4 from Line 3	▶	5	-69,384 00
6. **Tax:** Multiply Line 5 by 7.5% (.075)	▶	6	00

Computation of Amount Payable

1. Tax: Include surtax if applicable. See instructions	▶	1	00
2. *Reserved for future use*	▶	2	
3. Total Tax: Enter the amount from Line 1	▶	3	00
4. Tax credits from **Form CT-1120K**, Part III, Line 9. **Do not exceed amount on Line 1**	▶	4	00
5. Balance of tax payable: Subtract Line 4 from Line 3. If zero or less, enter "0."	▶	5	0 00
6a. Paid with application for extension from **Form CT-990T EXT**	▶	6a	00
6b. Paid with estimates from **Forms CT-990T ESA, ESB, ESC,** & **ESD**	▶	6b	00
6c. Overpayment from prior year	▶	6c	00
6. **Tax Payments:** Enter the total of Lines 6a, 6b, and 6c	▶	6	00
7. Balance of tax due (overpaid): Subtract Line 6 from Line 5	▶	7	0 00
8. Add Penalty ▶ (8a) _____ Interest ▶ (8b) _____ **CT-1120I** Interest ▶ (8c) _____		8	00
9. Amount to be credited to 2014 estimated tax ▶ (9a) Refunded ▶ (9b)		9	00

For a faster refund, use Direct Deposit by completing Lines 9c, 9d, and 9e.

9c. Checking ▶ ☐ Savings ▶ ☐ 9d. Routing number ▶ _____

9e. Account number ▶ 9f. Will this refund go to a bank account outside the U.S.? ▶ ☐ Yes

10. **Balance due with this return:** Add Line 7 and Line 8	▶	10	0 00

Visit the DRS website at **www.ct.gov/TSC** to pay electronically. www.ct.gov/DRS **TSC** Taxpayer Service Center

Mail to: Dept. of Revenue Services, State of Connecticut, PO Box 5014, Hartford CT 06102-5014

Make check payable to: Commissioner of Revenue Services

Declaration: I declare under penalty of law that I have examined this return (including any accompanying schedules and statements) and, to the best of my knowledge and belief, it is true, complete, and correct. I understand the penalty for willfully delivering a false return or document to the Department of Revenue Services (DRS) is a fine of not more than $5,000, imprisonment for not more than five years, or both. The declaration of a paid preparer other than the taxpayer is based on all information of which the preparer has any knowledge.

Sign Here	Name of officer or fiduciary *(print)*	Signature of officer or fiduciary	Date
	MICHAEL D. VEILLETTE		
	Officer's email address *(print)*		May DRS contact the preparer shown below about this return? See instructions. ☒ Yes ☐ No
Keep a copy of this return for your records.	Title: CHIEF FINANCIAL OFFICER	Telephone number: 860-646-1222	
	Paid preparer's signature	Date	Preparer's SSN or PTIN: P00346435
	Firm's name and address: CROWE HORWATH, LLP 175 POWDER FOREST DRIVE SIMSBURY, CT 06089	FEIN: 35-0921680	Telephone number: 860-678-9200

1019

341901 12-04-12

Schedule A - Unrelated Business Income Apportionment: See instructions.

Complete this schedule if the taxpayer's unrelated trade or business is conducted at a regular place of business outside Connecticut.

Factor	Item	Column A Connecticut		Column B Everywhere		Column C Divide Column A by Column B. Carry to six places
Property (Average value)	1. (a) Inventories		00		00	
	(b) Tangible property		00		00	
	(c) Real property		00		00	
	(d) Capitalized rent		00		00	
	1. Total		00		00	
Receipts	2. (a) Sales of tangibles		00		00	
	(b) Services		00		00	
	(c) Rentals		00		00	
	(d) Other		00		00	
	2. Total		00		00	
Wages, salaries, and other compensation	**3. Total**		00		00	
	4. **Total:** Add Lines 1, 2, and 3 in Column C.					
	5. Apportionment fraction: Divide Line 4 by number of factors used. Enter here; on *Schedule C*, Line 4; and also on front page, *Computation of Tax*, Line 2.					

Schedule B - Connecticut Apportioned Operating Loss Carryover Applied to 2013

1. 2000 Connecticut net operating loss available for use in 2013	1.		00
2. 2001 Connecticut net operating loss available for use in 2013	2.		00
3. 2002 Connecticut net operating loss available for use in 2013	3.		00
4. 2003 Connecticut net operating loss available for use in 2013	4.	204,440	00
5. 2004 Connecticut net operating loss available for use in 2013	5.	43,130	00
6. 2005 Connecticut net operating loss available for use in 2013	6.	151,249	00
7. 2006 Connecticut net operating loss available for use in 2013	7.	161,951	00
8. 2007 Connecticut net operating loss available for use in 2013	8.		00
9. 2008 Connecticut net operating loss available for use in 2013	9.		00
10. 2009 Connecticut net operating loss available for use in 2013	10.		00
11. 2010 Connecticut net operating loss available for use in 2013	11.		00
12. 2011 Connecticut net operating loss available for use in 2013	12.	53,809	00
13. 2012 Connecticut net operating loss available for use in 2013	13.	112,441	00
14. **Total:** Add Lines 1 through 13. Enter here and on *Computation of Tax*, Line 4	14.	727,020	00

Schedule C - Computation of Net Operating Loss Carryforward

1. Enter amount from *Computation of Income*, Line 6, if less than zero	1.	-69,384	00
2. Add back specific deduction from 2013 federal Form 990-T, Part II, Line 33	2.		00
3. Subtotal: Add Line 1 and Line 2	3.	-69,384	00
4. Apportionment fraction from *Schedule A*, Line 5	4.		
5. 2013 Connecticut net operating loss available for carryforward: Line 3 or Line 3 multiplied by Line 4	5.	-69,384	00

EXHIBIT Q51-2 - IRS TAX FORM 990 FILED BY RGH FOR TAX YEAR 2014

Caution: Forms printed from within Adobe Acrobat products may not meet IRS or state taxing agency specifications. When using Acrobat 5.x products, uncheck the "Shrink oversized pages to paper size" and uncheck the "Expand small pages to paper size" options, in the Adobe "Print" dialog. When using Acrobat 6.x and later products versions, select "None" in the "Page Scaling" selection box in the Adobe "Print" dialog.

CLIENT'S COPY

CARRYOVER DATA TO 2014

Name	Employer Identification Number
ROCKVILLE GENERAL HOSPITAL	06-0653151

Based on the information provided with this return, the following are possible carryover amounts to next year.

FEDERAL NET OPERATING LOSS	49,054.
FEDERAL AMT NET OPERATING LOSS	57,510.
CT NET OPERATING LOSS	46,054.

TAX RETURN FILING INSTRUCTIONS

** FORM 990 PUBLIC DISCLOSURE COPY **

FOR THE YEAR ENDING

SEPTEMBER 30, 2014

Prepared for	ROCKVILLE GENERAL HOSPITAL 31 UNION STREET ROCKVILLE, CT 06066
Prepared by	CROWE HORWATH, LLP 175 POWDER FOREST DRIVE SIMSBURY, CT 06089
Amount due or refund	NOT APPLICABLE
Make check payable to	NOT APPLICABLE
Mail tax return and check (if applicable) to	NOT APPLICABLE
Return must be mailed on or before	NOT APPLICABLE
Special Instructions	THIS RETURN HAS BEEN PREPARED FOR ELECTRONIC FILING. IF YOU WISH TO HAVE IT TRANSMITTED ELECTRONICALLY TO THE IRS, PLEASE SIGN, DATE, AND RETURN FORM 8879-EO TO OUR OFFICE. WE WILL THEN SUBMIT THE ELECTRONIC RETURN TO THE IRS. DO NOT MAIL A PAPER COPY OF THE RETURN TO THE IRS. RETURN FORM 8879-EO TO US BY AUGUST 17, 2015.

300941
05-01-13

Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations)

▶ **Do not enter Social Security numbers on this form as it may be made public.**

▶ **Information about Form 990 and its instructions is at** *www.irs.gov/form990*

OMB No. 1545-0047

2013

Open to Public Inspection

A For the 2013 calendar year, or tax year beginning OCT 1, 2013 **and ending** SEP 30, 2014

B Check if applicable:
- ☐ Address change
- ☐ Name change
- ☐ Initial return
- ☐ Termin-ated
- ☐ Amended return
- ☐ Applica-tion pending

C Name of organization
ROCKVILLE GENERAL HOSPITAL

Doing Business As

Number and street (or P.O. box if mail is not delivered to street address) | Room/suite
31 UNION STREET

City or town, state or province, country, and ZIP or foreign postal code
ROCKVILLE, CT 06066

F Name and address of principal officer: PETER J. KARL
SAME AS C ABOVE

D Employer identification number
06-0653151

E Telephone number
(860)646-1222

G Gross receipts $ 75,532,670.

H(a) Is this a group return for subordinates? ☐ Yes ☒ No

H(b) Are all subordinates included? ☐ Yes ☐ No
If "No," attach a list. (see instructions)

H(c) Group exemption number ▶

I Tax-exempt status: ☒ 501(c)(3) ☐ 501(c) ( ) ◀ (insert no.) ☐ 4947(a)(1) or ☐ 527

J Website: ▶ WWW.ECHN.ORG

K Form of organization: ☒ Corporation ☐ Trust ☐ Association ☐ Other ▶

L Year of formation: 1921 **M** State of legal domicile: CT

Part I Summary

Activities & Governance

1 Briefly describe the organization's mission or most significant activities: ROCKVILLE GENERAL HOSPITAL IS A 102 BED HOSPITAL OFFERING VARIOUS HEALTHCARE SERVICES TO ALL MEMBERS

2 Check this box ▶ ☐ if the organization discontinued its operations or disposed of more than 25% of its net assets.

3	Number of voting members of the governing body (Part VI, line 1a)	3	18
4	Number of independent voting members of the governing body (Part VI, line 1b)	4	11
5	Total number of individuals employed in calendar year 2013 (Part V, line 2a)	5	600
6	Total number of volunteers (estimate if necessary)	6	92
7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a	634,450.
b	Net unrelated business taxable income from Form 990-T, line 34	7b	0.

Revenue

		Prior Year	Current Year
8	Contributions and grants (Part VIII, line 1h)	522,104.	482,157.
9	Program service revenue (Part VIII, line 2g)	71,750,291.	70,852,420.
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	2,355,445.	3,398,470.
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	260,020.	298,088.
12	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	74,887,860.	75,031,135.

Expenses

13	Grants and similar amounts paid (Part IX, column (A), lines 1-3)	0.	0.
14	Benefits paid to or for members (Part IX, column (A), line 4)	0.	0.
15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	41,534,240.	41,821,049.
16a	Professional fundraising fees (Part IX, column (A), line 11e)	0.	0.
b	Total fundraising expenses (Part IX, column (D), line 25) ▶ 0.		
17	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	30,758,310.	30,726,037.
18	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	72,292,550.	72,547,086.
19	Revenue less expenses. Subtract line 18 from line 12	2,595,310.	2,484,049.

Net Assets or Fund Balances

		Beginning of Current Year	End of Year
20	Total assets (Part X, line 16)	76,543,854.	74,786,945.
21	Total liabilities (Part X, line 26)	45,491,391.	46,452,643.
22	Net assets or fund balances. Subtract line 21 from line 20	31,052,463.	28,334,302.

Part II Signature Block

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than officer) is based on all information of which preparer has any knowledge.

Sign Here

▶ Signature of officer — Date

▶ MICHAEL D. VEILLETTE, CHIEF FINANCIAL OFFICER
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check if self-employed	PTIN
BETH A. THURZ			☐	P00346435

Firm's name ▶ CROWE HORWATH, LLP — Firm's EIN ▶ 35-0921680

Firm's address ▶ 175 POWDER FOREST DRIVE
SIMSBURY, CT 06089 — Phone no. 860-678-9200

May the IRS discuss this return with the preparer shown above? (see instructions) ☒ Yes ☐ No

SEE SCHEDULE O FOR ORGANIZATION MISSION STATEMENT CONTINUATION

Part III Statement of Program Service Accomplishments

Check if Schedule O contains a response or note to any line in this Part III X

1 Briefly describe the organization's mission:
ROCKVILLE GENERAL HOSPITAL IS A 102 BED HOSPITAL OFFERING VARIOUS HEALTHCARE SERVICES TO ALL MEMBERS OF THE COMMUNITY, INCLUDING THE INDIGENT AND UNDERSERVED.

2 Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? ..... Yes X No
If "Yes," describe these new services on Schedule O.

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services? ..... Yes X No
If "Yes," describe these changes on Schedule O.

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses. Section 501(c)(3) and 501(c)(4) organizations are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported.

4a (Code:) (Expenses $ 13,877,241. including grants of $) (Revenue $ 6,417,818.)
INPATIENT SERVIES - ROCKVILLE GENERAL HOSPITAL OFFERS COMPREHENSIVE MEDICAL SERVICES IN A 102 BED ACUTE CARE COMMUNITY HOSPITAL, WITH A TOTAL OF 2,341 INPATIENTS TREATED IN FISCAL YEAR 2014. SERVICES ARE OFFERED TO THE COMMUNITY, REGARDLESS OF ANY INDIVIDUAL'S ABILITY TO PAY.

4b (Code:) (Expenses $ 7,244,844. including grants of $) (Revenue $ 8,308,721.)
RADIOLOGY - A WIDE RANGE OF IMAGING DIAGNOSTIC AND TREATMENT SERVICES ARE OFFERED, INCLUDING X-RAYS, CT SCANS, MRI, PET, ULTRASOUND, NUCLEAR MEDICINE, AND MAMMOGRAPHY.

4c (Code:) (Expenses $ 9,686,383. including grants of $) (Revenue $ 18,682,010.)
EMERGENCY DEPARTMENT - EMERGENCY CARE IS OFFERED 24 HOURS PER DAY, AND PROVIDES NEEDED EMERGENCY MEDICAL CARE TO THE COMMUNITY, REGARDLESS OF ANY INDIVIDUAL'S ABILITY TO PAY.

4d Other program services (Describe in Schedule O.)
(Expenses $ 29,355,424. including grants of $) (Revenue $ 36,809,421.)

4e Total program service expenses ▶ 60,163,892.

Part IV Checklist of Required Schedules

			Yes	No
1	Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? *If "Yes," complete Schedule A*	1	X	
2	Is the organization required to complete *Schedule B, Schedule of Contributors*?	2	X	
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? *If "Yes," complete Schedule C, Part I*	3		X
4	**Section 501(c)(3) organizations.** Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? *If "Yes," complete Schedule C, Part II*	4	X	
5	Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? *If "Yes," complete Schedule C, Part III*	5		X
6	Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? *If "Yes," complete Schedule D, Part I*	6		X
7	Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? *If "Yes," complete Schedule D, Part II*	7		X
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? *If "Yes," complete Schedule D, Part III*	8		X
9	Did the organization report an amount in Part X, line 21, for escrow or custodial account liability; serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? *If "Yes," complete Schedule D, Part IV*	9		X
10	Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? *If "Yes," complete Schedule D, Part V*	10	X	
11	If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable.			
a	Did the organization report an amount for land, buildings, and equipment in Part X, line 10? *If "Yes," complete Schedule D, Part VI*	11a	X	
b	Did the organization report an amount for investments - other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VII*	11b		X
c	Did the organization report an amount for investments - program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VIII*	11c	X	
d	Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part IX*	11d	X	
e	Did the organization report an amount for other liabilities in Part X, line 25? *If "Yes," complete Schedule D, Part X*	11e	X	
f	Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? *If "Yes," complete Schedule D, Part X*	11f	X	
12a	Did the organization obtain separate, independent audited financial statements for the tax year? *If "Yes," complete Schedule D, Parts XI and XII*	12a	X	
b	Was the organization included in consolidated, independent audited financial statements for the tax year? *If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional*	12b	X	
13	Is the organization a school described in section 170(b)(1)(A)(ii)? *If "Yes," complete Schedule E*	13		X
14a	Did the organization maintain an office, employees, or agents outside of the United States?	14a		X
b	Did the organization have aggregate revenues or expenses of more than $10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at $100,000 or more? *If "Yes," complete Schedule F, Parts I and IV*	14b		X
15	Did the organization report on Part IX, column (A), line 3, more than $5,000 of grants or other assistance to or for any foreign organization? *If "Yes," complete Schedule F, Parts II and IV*	15		X
16	Did the organization report on Part IX, column (A), line 3, more than $5,000 of aggregate grants or other assistance to or for foreign individuals? *If "Yes," complete Schedule F, Parts III and IV*	16		X
17	Did the organization report a total of more than $15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? *If "Yes," complete Schedule G, Part I*	17		X
18	Did the organization report more than $15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? *If "Yes," complete Schedule G, Part II*	18		X
19	Did the organization report more than $15,000 of gross income from gaming activities on Part VIII, line 9a? *If "Yes," complete Schedule G, Part III*	19		X
20a	Did the organization operate one or more hospital facilities? *If "Yes," complete Schedule H*	20a	X	
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	20b	X	

Part IV Checklist of Required Schedules *(continued)*

			Yes	No
21	Did the organization report more than $5,000 of grants or other assistance to any domestic organization or government on Part IX, column (A), line 1? *If "Yes," complete Schedule I, Parts I and II*	21		X
22	Did the organization report more than $5,000 of grants or other assistance to individuals in the United States on Part IX, column (A), line 2? *If "Yes," complete Schedule I, Parts I and III*	22		X
23	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? *If "Yes," complete Schedule J*	23	X	
24a	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than $100,000 as of the last day of the year, that was issued after December 31, 2002? *If "Yes," answer lines 24b through 24d and complete Schedule K. If "No", go to line 25a*	24a	X	
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	24b		X
c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	24c		X
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	24d		X
25a	**Section 501(c)(3) and 501(c)(4) organizations.** Did the organization engage in an excess benefit transaction with a disqualified person during the year? *If "Yes," complete Schedule L, Part I*	25a		X
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? *If "Yes," complete Schedule L, Part I*	25b		X
26	Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? If so, complete Schedule L, Part II	26		X
27	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? *If "Yes," complete Schedule L, Part III*	27		X
28	Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions):			
a	A current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	28a		X
b	A family member of a current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	28b		X
c	An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? *If "Yes," complete Schedule L, Part IV*	28c	X	
29	Did the organization receive more than $25,000 in non-cash contributions? *If "Yes," complete Schedule M*	29		X
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? *If "Yes," complete Schedule M*	30		X
31	Did the organization liquidate, terminate, or dissolve and cease operations? *If "Yes," complete Schedule N, Part I*	31		X
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? *If "Yes," complete Schedule N, Part II*	32		X
33	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? *If "Yes," complete Schedule R, Part I*	33		X
34	Was the organization related to any tax-exempt or taxable entity? *If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1*	34	X	
35a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	35a	X	
b	If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? *If "Yes," complete Schedule R, Part V, line 2*	35b	X	
36	**Section 501(c)(3) organizations.** Did the organization make any transfers to an exempt non-charitable related organization? *If "Yes," complete Schedule R, Part V, line 2*	36		X
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? *If "Yes," complete Schedule R, Part VI*	37		X
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? **Note.** All Form 990 filers are required to complete Schedule O	38	X	

Part V **Statements Regarding Other IRS Filings and Tax Compliance**

Check if Schedule O contains a response or note to any line in this Part V ☐

				Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable	1a	156		
b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable	1b	0		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	1c		X	
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	2a	600		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns?	2b		X	
	Note. If the sum of lines 1a and 2a is greater than 250, you may be required to *e-file* (see instructions)				
3a	Did the organization have unrelated business gross income of $1,000 or more during the year?	3a		X	
b	If "Yes," has it filed a Form 990-T for this year? *If "No," to line 3b, provide an explanation in Schedule O*	3b		X	
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?	4a			X
b	If "Yes," enter the name of the foreign country: ▶ _____ See instructions for filing requirements for Form TD F 90-22.1, Report of Foreign Bank and Financial Accounts.				
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?	5a			X
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	5b			X
c	If "Yes," to line 5a or 5b, did the organization file Form 8886-T?	5c			
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?	6a			X
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?	6b			
7	**Organizations that may receive deductible contributions under section 170(c).**				
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?	7a			X
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?	7b			
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?	7c			X
d	If "Yes," indicate the number of Forms 8282 filed during the year	7d			
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	7e			X
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?	7f			X
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?	7g			
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	7h			
8	**Sponsoring organizations maintaining donor advised funds and section 509(a)(3) supporting organizations.** Did the supporting organization, or a donor advised fund maintained by a sponsoring organization, have excess business holdings at any time during the year?	8			
9	**Sponsoring organizations maintaining donor advised funds.**				
a	Did the organization make any taxable distributions under section 4966?	9a			
b	Did the organization make a distribution to a donor, donor advisor, or related person?	9b			
10	**Section 501(c)(7) organizations.** Enter:				
a	Initiation fees and capital contributions included on Part VIII, line 12	10a			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	10b			
11	**Section 501(c)(12) organizations.** Enter:				
a	Gross income from members or shareholders	11a			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.)	11b			
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?	12a			
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year	12b			
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**				
a	Is the organization licensed to issue qualified health plans in more than one state?	13a			
	Note. See the instructions for additional information the organization must report on Schedule O.				
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	13b			
c	Enter the amount of reserves on hand	13c			
14a	Did the organization receive any payments for indoor tanning services during the tax year?	14a			X
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O*	14b			

Part VI Governance, Management, and Disclosure *For each "Yes" response to lines 2 through 7b below, and for a "No" response to line 8a, 8b, or 10b below, describe the circumstances, processes, or changes in Schedule O. See instructions.*

Check if Schedule O contains a response or note to any line in this Part VI X

Section A. Governing Body and Management

				Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year	1a	18		
	If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O.				
b	Enter the number of voting members included in line 1a, above, who are independent	1b	11		
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	2		X	
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors, or trustees, or key employees to a management company or other person?	3			X
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4			X
5	Did the organization become aware during the year of a significant diversion of the organization's assets?	5			X
6	Did the organization have members or stockholders?	6		X	
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	7a		X	
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	7b		X	
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:				
a	The governing body?	8a		X	
b	Each committee with authority to act on behalf of the governing body?	8b		X	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses in Schedule O*	9			X

Section B. Policies *(This Section B requests information about policies not required by the Internal Revenue Code.)*

			Yes	No
10a	Did the organization have local chapters, branches, or affiliates?	10a		X
b	If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes?	10b		
11a	Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?	11a	X	
b	Describe in Schedule O the process, if any, used by the organization to review this Form 990.			
12a	Did the organization have a written conflict of interest policy? *If "No," go to line 13*	12a	X	
b	Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	12b	X	
c	Did the organization regularly and consistently monitor and enforce compliance with the policy? *If "Yes," describe in Schedule O how this was done*	12c	X	
13	Did the organization have a written whistleblower policy?	13	X	
14	Did the organization have a written document retention and destruction policy?	14	X	
15	Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision?			
a	The organization's CEO, Executive Director, or top management official	15a	X	
b	Other officers or key employees of the organization	15b	X	
	If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions).			
16a	Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year?	16a	X	
b	If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements?	16b	X	

Section C. Disclosure

17 List the states with which a copy of this Form 990 is required to be filed ▶ CT

18 Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.

☐ Own website ☐ Another's website ☒ Upon request ☐ Other *(explain in Schedule O)*

19 Describe in Schedule O whether (and if so, how), the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.

20 State the name, physical address, and telephone number of the person who possesses the books and records of the organization: ▶

NICHOLAS JAMIESON - (860)646-1222
320 MAIN STREET, MANCHESTER, CT 06040

Part VII Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

Check if Schedule O contains a response or note to any line in this Part VII ☐

Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

1a Complete this table for all persons required to be listed. Report compensation for the calendar year ending with or within the organization's tax year.

- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation. Enter -0- in columns (D), (E), and (F) if no compensation was paid.
- List all of the organization's **current** key employees, if any. See instructions for definition of "key employee."
- List the organization's five **current** highest compensated employees (other than an officer, director, trustee, or key employee) who received reportable compensation (Box 5 of Form W-2 and/or Box 7 of Form 1099-MISC) of more than $100,000 from the organization and any related organizations.
- List all of the organization's **former** officers, key employees, and highest compensated employees who received more than $100,000 of reportable compensation from the organization and any related organizations.
- List all of the organization's **former directors or trustees** that received, in the capacity as a former director or trustee of the organization, more than $10,000 of reportable compensation from the organization and any related organizations.

List persons in the following order: individual trustees or directors; institutional trustees; officers; key employees; highest compensated employees; and former such persons.

☐ Check this box if neither the organization nor any related organization compensated any current officer, director, or trustee.

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) DENNIS O'NEILL, MD	1.00									
CHAIRMAN	4.00	X		X				0.	0.	0.
(2) ROBIN MURDOCK MEGGERS	1.00									
VICE CHAIR	2.00	X		X				0.	0.	0.
(3) MICHELE CONLON, MD	1.00									
SECRETARY	2.00	X		X				0.	0.	0.
(4) JOSEPH F. JEAMEL, JR.	1.00									
TREASURER	2.00	X		X				0.	0.	0.
(5) GORDON BRODIE, MD	1.00									
TRUSTEE	2.00	X						0.	0.	0.
(6) THOMASINA CLEMONS	1.00									
TRUSTEE	2.00	X						0.	0.	0.
(7) ANTHONY DISTEFANO, MD	1.00									
TRUSTEE	3.00	X						0.	0.	0.
(8) MILTON DOREMUS	1.00									
TRUSTEE	2.00	X						0.	0.	0.
(9) JOY DORIN	1.00									
TRUSTEE	2.00	X						0.	0.	0.
(10) DAVID GONCI	1.00									
TRUSTEE	2.00	X						0.	0.	0.
(11) REBECCA JANENDA	1.00									
TRUSTEE	2.00	X						0.	0.	0.
(12) LENORA WILLIAMS, MD	1.00									
TRUSTEE	2.00	X						0.	0.	0.
(13) PETER J. KARL	13.00									
PRESIDENT AND CEO	47.00	X		X				0.	1,123,212.	122,724.
(14) LOUISE ENGLAND	1.00									
TRUSTEE	3.00	X						0.	0.	0.
(15) DONALD GENOVESI	1.00									
TRUSTEE	2.00	X						0.	0.	0.
(16) KATHLEEN A. O'NEILL	1.00									
TRUSTEE	3.00	X						0.	0.	0.
(17) KEITH J. WOLFF	1.00									
TRUSTEE	2.00	X						0.	0.	0.

Part VII **Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees** *(continued)*

(A) Name and title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(18) ERIC KLOTER	1.00									
TRUSTEE	2.00	X						0.	0.	0.
(19) PAMELA LEWIS, MD	1.00									
TRUSTEE	2.00	X						0.	0.	0.
(20) KEVIN G. MURPHY	13.00									
EVP, TREASURER (THROUGH OCT 2013)	47.00			X				0.	605,651.	26,680.
(21) MICHAEL D. VEILLETTE	13.00									
SVP, CHIEF FINANCIAL OFFICER	47.00			X				0.	441,275.	58,896.
(22) DEBORAH GOGLIETTINO	13.00									
SVP, HUMAN RESOURCES	47.00				X			0.	350,668.	46,611.
(23) DENNIS MCCONVILLE	13.00									
SVP, STRATEGIC PLANNING	47.00				X			0.	325,180.	93,680.
(24) DEBORAH PARKER	13.00									
EVP, CHIEF CLINICAL OFFICER	47.00				X			0.	439,801.	58,046.
(25) JOEL REICH, MD	13.00									
SVP, MEDICAL AFFAIRS	47.00				X			0.	522,615.	136,948.
(26) CHARLES COVIN	13.00									
VP AND CIO (THROUGH NOV 2013)	47.00				X			0.	158,898.	32,253.
1b Sub-total ▶								0.	3,967,300.	575,838.
c Total from continuation sheets to Part VII, Section A ▶								1,211,951.	982,852.	315,513.
d Total (add lines 1b and 1c) ▶								1,211,951.	4,950,152.	891,351.

2 Total number of individuals (including but not limited to those listed above) who received more than $100,000 of reportable compensation from the organization ▶ 29

		Yes	No
3 Did the organization list any **former** officer, director, or trustee, key employee, or highest compensated employee on line 1a? *If "Yes," complete Schedule J for such individual*	3		X
4 For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than $150,000? *If "Yes," complete Schedule J for such individual*	4	X	
5 Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? *If "Yes," complete Schedule J for such person*	5		X

Section B. Independent Contractors

1 Complete this table for your five highest compensated independent contractors that received more than $100,000 of compensation from the organization. Report compensation for the calendar year ending with or within the organization's tax year.

(A) Name and business address	(B) Description of services	(C) Compensation
ARUP LABORATORIES, INC. PO BOX 27964, SALT LAKE CITY, UT 84127	LAB SERVICES	384,619.
SODEXO, 9801 WASHINGTONIAN BLVD, GAITHERSBURG, MD 20878	DIETARY SERVICES	365,333.
CONNECTICUT HOSPITAL ASSOCIATION PO BOX 90, WALLINGFORD, CT 06492	VARIOUS SERVICES	274,514.
PATHOLOGY & LABORATORY SERVICES LLC 41 WILD DUCK ROAD, WILTON, CT 06897	LAB SERVICES	261,428.
CONTINENTAL CONNECTICUT LITHOTRIPSY, LLC 2014 LITHO PLACE, FAYETTEVILLE, NC 28304	LITHOTRIPSY SERVICES	214,500.

2 Total number of independent contractors (including but not limited to those listed above) who received more than $100,000 of compensation from the organization ▶ 17

SEE PART VII, SECTION A CONTINUATION SHEETS

Part VII **Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees** *(continued)*

(A) Name and title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (check all that apply)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(27) LEONA CROSSKEY	13.00									
VP, QUALITY	47.00				X			0.	177,688.	73,043.
(28) ROBERT CARROLL, MD	13.00									
MED DIR, EMERGENCY DEPARTMENT	47.00				X			0.	449,483.	34,371.
(29) JOYCE TICHY	13.00									
GENERAL COUNSEL	47.00				X			0.	355,681.	28,863.
(30) DAVID NEUHAUS, MD	60.00									
MEDICAL DIRECTOR						X		329,061.	0.	13,733.
(31) ELLEN G. NEUHAUS, MD	60.00									
MEDICAL DIRECTOR						X		214,598.	0.	79,545.
(32) ALEXIS CORDIANO	60.00									
URGENT CARE PHYSICIAN						X		243,883.	0.	29,218.
(33) LINA HWANG	60.00									
URGENT CARE PHYSICIAN						X		220,731.	0.	29,238.
(34) MARIELA PODOLSKI	60.00									
PSYCHIATRIST						X		203,678.	0.	27,502.
Total to Part VII, Section A, line 1c								1,211,951.	982,852.	315,513.

Part VIII Statement of Revenue

Check if Schedule O contains a response or note to any line in this Part VIII ☐

			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512 - 514
Contributions, Gifts, Grants and Other Similar Amounts	1a Federated campaigns	1a				
	b Membership dues	1b				
	c Fundraising events	1c				
	d Related organizations	1d				
	e Government grants (contributions)	1e	239,460.			
	f All other contributions, gifts, grants, and similar amounts not included above	1f	242,697.			
	g Noncash contributions included in lines 1a-1f: $					
	h **Total.** Add lines 1a-1f		482,157.			
		Business Code				
Program Service Revenue	2a PATIENT SERVICE REVENUE	622110	68,528,682.	68,528,682.		
	b OTHER HEALTHCARE REVENUE	621500	2,323,738.	1,689,288.	634,450.	
	c					
	d					
	e					
	f All other program service revenue					
	g **Total.** Add lines 2a-2f		70,852,420.			
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)		416,729.			416,729.
	4 Income from investment of tax-exempt bond proceeds					
	5 Royalties					
		(i) Real / (ii) Personal				
	6a Gross rents	510,402.				
	b Less: rental expenses	471,336.				
	c Rental income or (loss)	39,066.				
	d Net rental income or (loss)		39,066.			39,066.
		(i) Securities / (ii) Other				
	7a Gross amount from sales of assets other than inventory	2,981,741.				
	b Less: cost or other basis and sales expenses	0.				
	c Gain or (loss)	2,981,741.				
	d Net gain or (loss)		2,981,741.			2,981,741.
	8a Gross income from fundraising events (not including $ _____ of contributions reported on line 1c). See Part IV, line 18	a				
	b Less: direct expenses	b				
	c Net income or (loss) from fundraising events					
	9a Gross income from gaming activities. See Part IV, line 19	a				
	b Less: direct expenses	b				
	c Net income or (loss) from gaming activities					
	10a Gross sales of inventory, less returns and allowances	a 47,015.				
	b Less: cost of goods sold	b 30,199.				
	c Net income or (loss) from sales of inventory		16,816.			16,816.
	Miscellaneous Revenue	**Business Code**				
	11a CAFETERIA REVENUE	722210	242,206.			242,206.
	b					
	c					
	d All other revenue					
	e **Total.** Add lines 11a-11d		242,206.			
	12 **Total revenue.** See instructions.		75,031,135.	70,217,970.	634,450.	3,696,558.

Part IX Statement of Functional Expenses

Section 501(c)(3) and 501(c)(4) organizations must complete all columns. All other organizations must complete column (A).

Check if Schedule O contains a response or note to any line in this Part IX ☐

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to governments and organizations in the United States. See Part IV, line 21				
2 Grants and other assistance to individuals in the United States. See Part IV, line 22				
3 Grants and other assistance to governments, organizations, and individuals outside the United States. See Part IV, lines 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	1,444,529.		1,444,529.	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7 Other salaries and wages	31,015,724.	26,363,365.	4,652,359.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	936,082.	795,670.	140,412.	
9 Other employee benefits	6,605,655.	5,614,807.	990,848.	
10 Payroll taxes	1,819,059.	1,546,200.	272,859.	
11 Fees for services (non-employees):				
a Management				
b Legal				
c Accounting	84,611.		84,611.	
d Lobbying				
e Professional fundraising services. See Part IV, line 17				
f Investment management fees				
g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Sch O.)	2,493,945.	1,496,366.	997,579.	
12 Advertising and promotion	79,428.		79,428.	
13 Office expenses	181,728.	90,864.	90,864.	
14 Information technology	84,188.	42,094.	42,094.	
15 Royalties				
16 Occupancy	1,992,985.	1,694,037.	298,948.	
17 Travel	3,486.	2,963.	523.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	50,527.	42,948.	7,579.	
20 Interest	689,882.	689,882.		
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	3,281,013.	2,788,861.	492,152.	
23 Insurance	1,018,752.	865,939.	152,813.	
24 Other expenses. Itemize expenses not covered above. (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a MEDICAL SUPPLIES	10,460,091.	10,460,091.		
b ECHN ALLOCATION	4,719,670.	2,831,802.	1,887,868.	
c PHYSICIAN FEES	2,967,449.	2,967,449.		
d DUE DILIGENCE	420,135.		420,135.	
e All other expenses	2,198,147.	1,870,554.	327,593.	
25 **Total functional expenses.** Add lines 1 through 24e	72,547,086.	60,163,892.	12,383,194.	0.
26 **Joint costs.** Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here ▶ ☐ if following SOP 98-2 (ASC 958-720)				

Part X Balance Sheet

Check if Schedule O contains a response or note to any line in this Part X ☐

				(A) Beginning of year		(B) End of year
Assets	1	Cash - non-interest-bearing		1,059,290.	1	1,772,696.
	2	Savings and temporary cash investments			2	
	3	Pledges and grants receivable, net			3	
	4	Accounts receivable, net		10,269,970.	4	10,900,702.
	5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L			5	
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instr). Complete Part II of Sch L			6	
	7	Notes and loans receivable, net			7	
	8	Inventories for sale or use		1,467,009.	8	1,325,483.
	9	Prepaid expenses and deferred charges		276,211.	9	201,349.
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 87,059,847.			
	b	Less: accumulated depreciation	10b 61,358,971.	27,654,664.	10c	25,700,876.
	11	Investments - publicly traded securities		14,693,132.	11	14,606,911.
	12	Investments - other securities. See Part IV, line 11		3,353,476.	12	3,392,939.
	13	Investments - program-related. See Part IV, line 11		6,825,019.	13	7,088,738.
	14	Intangible assets			14	
	15	Other assets. See Part IV, line 11		10,945,083.	15	9,797,251.
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)		76,543,854.	16	74,786,945.
Liabilities	17	Accounts payable and accrued expenses		6,096,840.	17	6,181,391.
	18	Grants payable			18	
	19	Deferred revenue			19	
	20	Tax-exempt bond liabilities		23,587,019.	20	22,968,770.
	21	Escrow or custodial account liability. Complete Part IV of Schedule D			21	
	22	Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L			22	
	23	Secured mortgages and notes payable to unrelated third parties		802,316.	23	1,368,697.
	24	Unsecured notes and loans payable to unrelated third parties			24	
	25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D		15,005,216.	25	15,933,785.
	26	**Total liabilities.** Add lines 17 through 25		45,491,391.	26	46,452,643.
Net Assets or Fund Balances		**Organizations that follow SFAS 117 (ASC 958), check here ▶ [X] and complete lines 27 through 29, and lines 33 and 34.**				
	27	Unrestricted net assets		26,773,989.	27	24,211,838.
	28	Temporarily restricted net assets		561,463.	28	549,043.
	29	Permanently restricted net assets		3,717,011.	29	3,573,421.
		Organizations that do not follow SFAS 117 (ASC 958), check here ▶ ☐ and complete lines 30 through 34.				
	30	Capital stock or trust principal, or current funds			30	
	31	Paid-in or capital surplus, or land, building, or equipment fund			31	
	32	Retained earnings, endowment, accumulated income, or other funds			32	
	33	Total net assets or fund balances		31,052,463.	33	28,334,302.
	34	Total liabilities and net assets/fund balances		76,543,854.	34	74,786,945.

Part XI Reconciliation of Net Assets

Check if Schedule O contains a response or note to any line in this Part XI X

1	Total revenue (must equal Part VIII, column (A), line 12)	1	75,031,135.
2	Total expenses (must equal Part IX, column (A), line 25)	2	72,547,086.
3	Revenue less expenses. Subtract line 2 from line 1	3	2,484,049.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	31,052,463.
5	Net unrealized gains (losses) on investments	5	-1,874,522.
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain in Schedule O)	9	-3,327,688.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	28,334,302.

Part XII Financial Statements and Reporting

Check if Schedule O contains a response or note to any line in this Part XII X

			Yes	No
1	Accounting method used to prepare the Form 990: ☐ Cash ☒ Accrual ☐ Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O.			
2a	Were the organization's financial statements compiled or reviewed by an independent accountant? If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both: ☐ Separate basis ☐ Consolidated basis ☐ Both consolidated and separate basis	2a		X
b	Were the organization's financial statements audited by an independent accountant? If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both: ☐ Separate basis ☐ Consolidated basis ☒ Both consolidated and separate basis	2b	X	
c	If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O.	2c	X	
3a	As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?	3a		X
b	If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits	3b		

SCHEDULE A (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.

▶ **Attach to Form 990 or Form 990-EZ.**

▶ **Information about Schedule A (Form 990 or 990-EZ) and its instructions is at** *www.irs.gov/form990.*

OMB No. 1545-0047

2013

Open to Public Inspection

Name of the organization	**Employer identification number**
ROCKVILLE GENERAL HOSPITAL	06-0653151

Part I Reason for Public Charity Status (All organizations must complete this part.) See instructions.

The organization is not a private foundation because it is: (For lines 1 through 11, check only one box.)

1 ☐ A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**

2 ☐ A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E.)

3 ☒ A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**

4 ☐ A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state: _____

5 ☐ An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II.)

6 ☐ A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**

7 ☐ An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II.)

8 ☐ A community trust described in **section 170(b)(1)(A)(vi).** (Complete Part II.)

9 ☐ An organization that normally receives: (1) more than 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions - subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See **section 509(a)(2).** (Complete Part III.)

10 ☐ An organization organized and operated exclusively to test for public safety. See **section 509(a)(4).**

11 ☐ An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2). See **section 509(a)(3).** Check the box that describes the type of supporting organization and complete lines 11e through 11h.

a ☐ Type I **b** ☐ Type II **c** ☐ Type III - Functionally integrated **d** ☐ Type III - Non-functionally integrated

e ☐ By checking this box, I certify that the organization is not controlled directly or indirectly by one or more disqualified persons other than foundation managers and other than one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2).

f If the organization received a written determination from the IRS that it is a Type I, Type II, or Type III supporting organization, check this box ☐

g Since August 17, 2006, has the organization accepted any gift or contribution from any of the following persons?

		Yes	No
(i)	A person who directly or indirectly controls, either alone or together with persons described in (ii) and (iii) below, the governing body of the supported organization? **11g(i)**		
(ii)	A family member of a person described in (i) above? **11g(ii)**		
(iii)	A 35% controlled entity of a person described in (i) or (ii) above? **11g(iii)**		

h Provide the following information about the supported organization(s).

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1-9 above or IRC section (see instructions))	(iv) Is the organization in col. (i) listed in your governing document? Yes	(iv) No	(v) Did you notify the organization in col. (i) of your support? Yes	(v) No	(vi) Is the organization in col. (i) organized in the U.S.? Yes	(vi) No	(vii) Amount of monetary support
Total									

LHA **For Paperwork Reduction Act Notice, see the Instructions for Form 990 or 990-EZ.**

Schedule A (Form 990 or 990-EZ) 2013

332021
09-25-13

Part II **Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)**

(Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 **Total.** Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 **Public support.** Subtract line 5 from line 4.						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.)						
11 **Total support.** Add lines 7 through 10						

12 Gross receipts from related activities, etc. (see instructions) 12

13 **First five years.** If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here** ..... ▶ ☐

Section C. Computation of Public Support Percentage

14 Public support percentage for 2013 (line 6, column (f) divided by line 11, column (f)) ..... 14 %

15 Public support percentage from 2012 Schedule A, Part II, line 14 ..... 15 %

16a **33 1/3% support test - 2013.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ..... ▶ ☐

b **33 1/3% support test - 2012.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ..... ▶ ☐

17a **10% -facts-and-circumstances test - 2013.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ..... ▶ ☐

b **10% -facts-and-circumstances test - 2012.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ..... ▶ ☐

18 **Private foundation.** If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ..... ▶ ☐

Schedule A (Form 990 or 990-EZ) 2013

Part III Support Schedule for Organizations Described in Section 509(a)(2)

(Complete only if you checked the box on line 9 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 **Total.** Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of $5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b						
8 **Public support** (Subtract line 7c from line 6.)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(f) Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.)						
13 **Total support.** (Add lines 9, 10c, 11, and 12.)						

14 **First five years.** If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here** ▶ ☐

Section C. Computation of Public Support Percentage

15 Public support percentage for 2013 (line 8, column (f) divided by line 13, column (f))	15	%
16 Public support percentage from 2012 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17 Investment income percentage for **2013** (line 10c, column (f) divided by line 13, column (f))	17	%
18 Investment income percentage from **2012** Schedule A, Part III, line 17	18	%

19a **33 1/3% support tests - 2013.** If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

b **33 1/3% support tests - 2012.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

20 **Private foundation.** If the organization did not check a box on line 14, 19a, or 19b, check this box and see instructions ▶ ☐

Part IV **Supplemental Information.** Provide the explanations required by Part II, line 10; Part II, line 17a or 17b; and Part III, line 12. Also complete this part for any additional information. (See instructions).

Schedule B (Form 990, 990-EZ, or 990-PF)
Department of the Treasury
Internal Revenue Service

Schedule of Contributors

▶ Attach to Form 990, Form 990-EZ, or Form 990-PF.
▶ Information about Schedule B (Form 990, 990-EZ, or 990-PF) and its instructions is at *www.irs.gov/form990* .

OMB No. 1545-0047

2013

Name of the organization	Employer identification number
ROCKVILLE GENERAL HOSPITAL	06-0653151

Organization type (check one):

Filers of:	Section:
Form 990 or 990-EZ	☒ 501(c)(3) (enter number) organization
	☐ 4947(a)(1) nonexempt charitable trust **not** treated as a private foundation
	☐ 527 political organization
Form 990-PF	☐ 501(c)(3) exempt private foundation
	☐ 4947(a)(1) nonexempt charitable trust treated as a private foundation
	☐ 501(c)(3) taxable private foundation

Check if your organization is covered by the **General Rule** or a **Special Rule.**
Note. Only a section 501(c)(7), (8), or (10) organization can check boxes for both the General Rule and a Special Rule. See instructions.

General Rule

☒ For an organization filing Form 990, 990-EZ, or 990-PF that received, during the year, $5,000 or more (in money or property) from any one contributor. Complete Parts I and II.

Special Rules

☐ For a section 501(c)(3) organization filing Form 990 or 990-EZ that met the 33 1/3% support test of the regulations under sections 509(a)(1) and 170(b)(1)(A)(vi) and received from any one contributor, during the year, a contribution of the greater of **(1)** $5,000 or **(2)** 2% of the amount on (i) Form 990, Part VIII, line 1h, or (ii) Form 990-EZ, line 1. Complete Parts I and II.

☐ For a section 501(c)(7), (8), or (10) organization filing Form 990 or 990-EZ that received from any one contributor, during the year, total contributions of more than $1,000 for use *exclusively* for religious, charitable, scientific, literary, or educational purposes, or the prevention of cruelty to children or animals. Complete Parts I, II, and III.

☐ For a section 501(c)(7), (8), or (10) organization filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions for use *exclusively* for religious, charitable, etc., purposes, but these contributions did not total to more than $1,000. If this box is checked, enter here the total contributions that were received during the year for an *exclusively* religious, charitable, etc., purpose. Do not complete any of the parts unless the **General Rule** applies to this organization because it received *nonexclusively* religious, charitable, etc., contributions of $5,000 or more during the year ..... ▶ $ _____

Caution. An organization that is not covered by the General Rule and/or the Special Rules does not file Schedule B (Form 990, 990-EZ, or 990-PF), but it **must** answer "No" on Part IV, line 2, of its Form 990; or check the box on line H of its Form 990-EZ or on its Form 990-PF, Part I, line 2, to certify that it does not meet the filing requirements of Schedule B (Form 990, 990-EZ, or 990-PF).

Name of organization	Employer identification number
ROCKVILLE GENERAL HOSPITAL	06-0653151

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
1		$ 50,514.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
2		$ 30,025.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
3		$ 17,885.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
4		$ 14,262.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
5		$ 5,239.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
6		$ 123,873.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization	Employer identification number
ROCKVILLE GENERAL HOSPITAL	06-0653151

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
7		$ 93,737.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
8		$ 30,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization	Employer identification number
ROCKVILLE GENERAL HOSPITAL	06-0653151

Part II **Noncash Property** (see instructions). Use duplicate copies of Part II if additional space is needed.

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		$	

Name of organization | **Employer identification number**

ROCKVILLE GENERAL HOSPITAL | 06-0653151

Part III *Exclusively* **religious, charitable, etc., individual contributions to section 501(c)(7), (8), or (10) organizations that total more than $1,000 for the year.** Complete columns **(a)** through **(e) and** the following line entry. For organizations completing Part III, enter the total of *exclusively* religious, charitable, etc., contributions of **$1,000 or less** for the year. (Enter this information once.) ▶ $_____

Use duplicate copies of Part III if additional space is needed.

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

SCHEDULE C (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Political Campaign and Lobbying Activities

For Organizations Exempt From Income Tax Under section 501(c) and section 527

▶ **Complete if the organization is described below.** ▶ **Attach to Form 990 or Form 990-EZ.**
▶ **See separate instructions.** ▶ **Information about Schedule C (Form 990 or 990-EZ) and its instructions is at** *www.irs.gov/form990.*

OMB No. 1545-0047

2013

Open to Public Inspection

If the organization answered "Yes," to Form 990, Part IV, line 3, or Form 990-EZ, Part V, line 46 (Political Campaign Activities), then

- Section 501(c)(3) organizations: Complete Parts I-A and B. Do not complete Part I-C.
- Section 501(c) (other than section 501(c)(3)) organizations: Complete Parts I-A and C below. Do not complete Part I-B.
- Section 527 organizations: Complete Part I-A only.

If the organization answered "Yes," to Form 990, Part IV, line 4, or Form 990-EZ, Part VI, line 47 (Lobbying Activities), then

- Section 501(c)(3) organizations that have filed Form 5768 (election under section 501(h)): Complete Part II-A. Do not complete Part II-B.
- Section 501(c)(3) organizations that have NOT filed Form 5768 (election under section 501(h)): Complete Part II-B. Do not complete Part II-A.

If the organization answered "Yes," to Form 990, Part IV, line 5 (Proxy Tax) or Form 990-EZ, Part V, line 35c (Proxy Tax), then

- Section 501(c)(4), (5), or (6) organizations: Complete Part III.

Name of organization	Employer identification number
ROCKVILLE GENERAL HOSPITAL	06-0653151

Part I-A Complete if the organization is exempt under section 501(c) or is a section 527 organization.

1 Provide a description of the organization's direct and indirect political campaign activities in Part IV.
2 Political expenditures ▶ $
3 Volunteer hours

Part I-B Complete if the organization is exempt under section 501(c)(3).

1 Enter the amount of any excise tax incurred by the organization under section 4955 ▶ $
2 Enter the amount of any excise tax incurred by organization managers under section 4955 ▶ $
3 If the organization incurred a section 4955 tax, did it file Form 4720 for this year? ☐ Yes ☐ No
4a Was a correction made? ☐ Yes ☐ No
b If "Yes," describe in Part IV.

Part I-C Complete if the organization is exempt under section 501(c), except section 501(c)(3).

1 Enter the amount directly expended by the filing organization for section 527 exempt function activities ▶ $
2 Enter the amount of the filing organization's funds contributed to other organizations for section 527 exempt function activities ▶ $
3 Total exempt function expenditures. Add lines 1 and 2. Enter here and on Form 1120-POL, line 17b ▶ $
4 Did the filing organization file **Form 1120-POL** for this year? ☐ Yes ☐ No
5 Enter the names, addresses and employer identification number (EIN) of all section 527 political organizations to which the filing organization made payments. For each organization listed, enter the amount paid from the filing organization's funds. Also enter the amount of political contributions received that were promptly and directly delivered to a separate political organization, such as a separate segregated fund or a political action committee (PAC). If additional space is needed, provide information in Part IV.

(a) Name	**(b)** Address	**(c)** EIN	**(d)** Amount paid from filing organization's funds. If none, enter -0-.	**(e)** Amount of political contributions received and promptly and directly delivered to a separate political organization. If none, enter -0-.

Part II-A **Complete if the organization is exempt under section 501(c)(3) and filed Form 5768 (election under section 501(h)).**

A Check ▶ ☐ if the filing organization belongs to an affiliated group (and list in Part IV each affiliated group member's name, address, EIN, expenses, and share of excess lobbying expenditures).

B Check ▶ ☐ if the filing organization checked box A and "limited control" provisions apply.

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)	(a) Filing organization's totals	(b) Affiliated group totals
1a Total lobbying expenditures to influence public opinion (grass roots lobbying)		
b Total lobbying expenditures to influence a legislative body (direct lobbying)		
c Total lobbying expenditures (add lines 1a and 1b)		
d Other exempt purpose expenditures		
e Total exempt purpose expenditures (add lines 1c and 1d)		
f Lobbying nontaxable amount. Enter the amount from the following table in both columns.		
g Grassroots nontaxable amount (enter 25% of line 1f)		
h Subtract line 1g from line 1a. If zero or less, enter -0-		
i Subtract line 1f from line 1c. If zero or less, enter -0-		

If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:
Not over $500,000	20% of the amount on line 1e.
Over $500,000 but not over $1,000,000	$100,000 plus 15% of the excess over $500,000.
Over $1,000,000 but not over $1,500,000	$175,000 plus 10% of the excess over $1,000,000.
Over $1,500,000 but not over $17,000,000	$225,000 plus 5% of the excess over $1,500,000.
Over $17,000,000	$1,000,000.

j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year? ☐ **Yes** ☐ **No**

4-Year Averaging Period Under Section 501(h)
(Some organizations that made a section 501(h) election do not have to complete all of the five columns below. See the instructions for lines 2a through 2f on page 4.)

Lobbying Expenditures During 4-Year Averaging Period

Calendar year (or fiscal year beginning in)	(a) 2010	(b) 2011	(c) 2012	(d) 2013	(e) Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column(e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

Schedule C (Form 990 or 990-EZ) 2013

Part II-B Complete if the organization is exempt under section 501(c)(3) and has NOT filed Form 5768 (election under section 501(h)).

For each "Yes," response to lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.	(a) Yes	(a) No	(b) Amount
1 During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
a Volunteers?		X	
b Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		X	
c Media advertisements?		X	
d Mailings to members, legislators, or the public?		X	
e Publications, or published or broadcast statements?		X	
f Grants to other organizations for lobbying purposes?		X	
g Direct contact with legislators, their staffs, government officials, or a legislative body?		X	
h Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		X	
i Other activities?	X		22,106.
j Total. Add lines 1c through 1i			22,106.
2a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		X	
b If "Yes," enter the amount of any tax incurred under section 4912			
c If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

Part III-A Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6).

			Yes	No
1	Were substantially all (90% or more) dues received nondeductible by members?	1		
2	Did the organization make only in-house lobbying expenditures of $2,000 or less?	2		
3	Did the organization agree to carry over lobbying and political expenditures from the prior year?	3		

Part III-B Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6) and if either (a) BOTH Part III-A, lines 1 and 2, are answered "No," OR (b) Part III-A, line 3, is answered "Yes."

1	Dues, assessments and similar amounts from members	1	
2	Section 162(e) nondeductible lobbying and political expenditures **(do not include amounts of political expenses for which the section 527(f) tax was paid).**		
a	Current year	2a	
b	Carryover from last year	2b	
c	Total	2c	
3	Aggregate amount reported in section 6033(e)(1)(A) notices of nondeductible section 162(e) dues	3	
4	If notices were sent and the amount on line 2c exceeds the amount on line 3, what portion of the excess does the organization agree to carryover to the reasonable estimate of nondeductible lobbying and political expenditure next year?	4	
5	Taxable amount of lobbying and political expenditures (see instructions)	5	

Part IV Supplemental Information

Provide the descriptions required for Part I-A, line 1; Part I-B, line 4; Part I-C, line 5; Part II-A (affiliated group list); Part II-A, line 2; and Part II-B, line 1. Also, complete this part for any additional information.

PART II-B, LINE 1, LOBBYING ACTIVITIES:

THE CONNECTICUT HOSPITAL ASSOCIATION (CHA) HAS DETERMINED THAT FOR ITS FISCAL YEAR THAT $17,725 OF ITS MEMBERSHIP DUES FROM ROCKVILLE GENERAL HOSPITAL WERE USED FOR LOBBYING PURPOSES. THE TOTAL LOBBYING PORTION FROM THE AMERICAN HOSPITAL ASSOCIATION (AHA) FOR ROCKVILLE GENERAL HOSPITAL WAS $4,381.

SCHEDULE D (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

▶ Complete if the organization answered "Yes," to Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.
▶ Attach to Form 990.
▶ Information about Schedule D (Form 990) and its instructions is at *www.irs.gov/form990*

OMB No. 1545-0047

2013

Open to Public Inspection

Name of the organization
ROCKVILLE GENERAL HOSPITAL

Employer identification number
06-0653151

Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts. Complete if the organization answered "Yes" to Form 990, Part IV, line 6.

		(a) Donor advised funds	(b) Funds and other accounts
1	Total number at end of year		
2	Aggregate contributions to (during year)		
3	Aggregate grants from (during year)		
4	Aggregate value at end of year		

5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? ☐ Yes ☐ No

6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit? ☐ Yes ☐ No

Part II Conservation Easements. Complete if the organization answered "Yes" to Form 990, Part IV, line 7.

1 Purpose(s) of conservation easements held by the organization (check all that apply).
- ☐ Preservation of land for public use (e.g., recreation or education)
- ☐ Preservation of an historically important land area
- ☐ Protection of natural habitat
- ☐ Preservation of a certified historic structure
- ☐ Preservation of open space

2 Complete lines 2a through 2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year.

		Held at the End of the Tax Year
a	Total number of conservation easements	2a
b	Total acreage restricted by conservation easements	2b
c	Number of conservation easements on a certified historic structure included in (a)	2c
d	Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register	2d

3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year ▶ _____

4 Number of states where property subject to conservation easement is located ▶ _____

5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds? ☐ Yes ☐ No

6 Staff and volunteer hours devoted to monitoring, inspecting, and enforcing conservation easements during the year ▶ _____

7 Amount of expenses incurred in monitoring, inspecting, and enforcing conservation easements during the year ▶ $ _____

8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)? ☐ Yes ☐ No

9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements.

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets.

Complete if the organization answered "Yes" to Form 990, Part IV, line 8.

1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items.

b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items:

(i) Revenues included in Form 990, Part VIII, line 1 ▶ $ _____

(ii) Assets included in Form 990, Part X ▶ $ _____

2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items:

a Revenues included in Form 990, Part VIII, line 1 ▶ $ _____

b Assets included in Form 990, Part X ▶ $ _____

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets *(continued)*

3 Using the organization's acquisition, accession, and other records, check any of the following that are a significant use of its collection items (check all that apply):

a ☐ Public exhibition
b ☐ Scholarly research
c ☐ Preservation for future generations
d ☐ Loan or exchange programs
e ☐ Other

4 Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII.

5 During the year, did the organization solicit or receive donations of art, historical treasures, or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection? ☐ Yes ☐ No

Part IV Escrow and Custodial Arrangements. Complete if the organization answered "Yes" to Form 990, Part IV, line 9, or reported an amount on Form 990, Part X, line 21.

1a Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X? ☐ Yes ☐ No

b If "Yes," explain the arrangement in Part XIII and complete the following table:

		Amount
c Beginning balance	1c	
d Additions during the year	1d	
e Distributions during the year	1e	
f Ending balance	1f	

2a Did the organization include an amount on Form 990, Part X, line 21? ☐ Yes ☐ No

b If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided in Part XIII ☐

Part V Endowment Funds. Complete if the organization answered "Yes" to Form 990, Part IV, line 10.

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance	11,605,016.	10,707,116.	9,113,580.	9,026,890.	8,595,357.
b Contributions					8,524.
c Net investment earnings, gains, and losses	939,011.	1,197,900.	1,593,536.	86,690.	423,119.
d Grants or scholarships					
e Other expenditures for facilities and programs		300,000.			
f Administrative expenses	5,935.				110.
g End of year balance	12,538,092.	11,605,016.	10,707,116.	9,113,580.	9,026,890.

2 Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:

a Board designated or quasi-endowment ▶ 87.44 %
b Permanent endowment ▶ 8.62 %
c Temporarily restricted endowment ▶ 3.94 %

The percentages in lines 2a, 2b, and 2c should equal 100%.

3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by:

		Yes	No
(i) unrelated organizations	3a(i)		X
(ii) related organizations	3a(ii)	X	
b If "Yes" to 3a(ii), are the related organizations listed as required on Schedule R?	3b	X	

4 Describe in Part XIII the intended uses of the organization's endowment funds.

Part VI Land, Buildings, and Equipment.

Complete if the organization answered "Yes" to Form 990, Part IV, line 11a. See Form 990, Part X, line 10.

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		644,006.		644,006.
b Buildings		46,966,729.	28,913,918.	18,052,811.
c Leasehold improvements		1,563,538.	642,282.	921,256.
d Equipment		37,057,163.	31,308,014.	5,749,149.
e Other		828,411.	494,757.	333,654.
Total. Add lines 1a through 1e. *(Column (d) must equal Form 990, Part X, column (B), line 10(c).)* ▶				25,700,876.

Schedule D (Form 990) 2013

Part VII Investments - Other Securities.

Complete if the organization answered "Yes" to Form 990, Part IV, line 11b. See Form 990, Part X, line 12.

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1) Financial derivatives		
(2) Closely-held equity interests		
(3) Other		
(A)		
(B)		
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		
Total. (Col. (b) must equal Form 990, Part X, col. (B) line 12.) ▶		

Part VIII Investments - Program Related.

Complete if the organization answered "Yes" to Form 990, Part IV, line 11c. See Form 990, Part X, line 13.

(a) Description of investment	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1) INTEREST IN NET ASSETS OF		
(2) ECHN COMMUNITY HEALTHCARE		
(3) FOUNDATION, INC.	3,599,134.	END-OF-YEAR MARKET VALUE
(4) INVESTMENTS IN JOINT		
(5) VENTURES	3,489,604.	COST
(6)		
(7)		
(8)		
(9)		
Total. (Col. (b) must equal Form 990, Part X, col. (B) line 13.) ▶	7,088,738.	

Part IX Other Assets.

Complete if the organization answered "Yes" to Form 990, Part IV, line 11d. See Form 990, Part X, line 15.

(a) Description	(b) Book value
(1) DUE FROM AFFILIATES	7,879,728.
(2) OTHER	1,769,088.
(3) ESTIMATED SETTLEMENTS DUE FROM THIRD PARTY PAYERS	148,435.
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 15.)* ▶	9,797,251.

Part X Other Liabilities.

Complete if the organization answered "Yes" to Form 990, Part IV, line 11e or 11f. See Form 990, Part X, line 25.

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) ESTIMATED SELF INSURANCE	
(3) LIABILITIES	3,566,892.
(4) ACCRUED PENSION AND POSTRETIREMENT	
(5) BENEFITS	10,369,950.
(6) CONDITIONAL ASSET RETIREMENT	
(7) OBLIGATION	132,211.
(8) DUE TO THIRD PARTY PAYERS	1,132,410.
(9) OTHER CURRENT LIABILITIES	732,322.
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 25.)* ▶	15,933,785.

2. Liability for uncertain tax positions. In Part XIII, provide the text of the footnote to the organization's financial statements that reports the organization's liability for uncertain tax positions under FIN 48 (ASC 740). Check here if the text of the footnote has been provided in Part XIII [X]

Schedule D (Form 990) 2013

Part XI Reconciliation of Revenue per Audited Financial Statements With Revenue per Return.

Complete if the organization answered "Yes" to Form 990, Part IV, line 12a.

1	Total revenue, gains, and other support per audited financial statements			1	74,920,348.
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12:				
a	Net unrealized gains on investments	2a			
b	Donated services and use of facilities	2b			
c	Recoveries of prior year grants	2c			
d	Other (Describe in Part XIII.)	2d	79,346.		
e	Add lines **2a** through **2d**			2e	79,346.
3	Subtract line **2e** from line **1**			3	74,841,002.
4	Amounts included on Form 990, Part VIII, line 12, but not on line 1:				
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a			
b	Other (Describe in Part XIII.)	4b	190,133.		
c	Add lines **4a** and **4b**			4c	190,133.
5	Total revenue. Add lines **3** and **4c.** *(This must equal Form 990, Part I, line 12.)*			5	75,031,135.

Part XII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return.

Complete if the organization answered "Yes" to Form 990, Part IV, line 12a.

1	Total expenses and losses per audited financial statements			1	72,538,219.
2	Amounts included on line 1 but not on Form 990, Part IX, line 25:				
a	Donated services and use of facilities	2a			
b	Prior year adjustments	2b			
c	Other losses	2c			
d	Other (Describe in Part XIII.)	2d	30,199.		
e	Add lines **2a** through **2d**			2e	30,199.
3	Subtract line **2e** from line **1**			3	72,508,020.
4	Amounts included on Form 990, Part IX, line 25, but not on line 1:				
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a			
b	Other (Describe in Part XIII.)	4b	39,066.		
c	Add lines **4a** and **4b**			4c	39,066.
5	Total expenses. Add lines **3** and **4c.** *(This must equal Form 990, Part I, line 18.)*			5	72,547,086.

Part XIII Supplemental Information.

Provide the descriptions required for Part II, lines 3, 5, and 9; Part III, lines 1a and 4; Part IV, lines 1b and 2b; Part V, line 4; Part X, line 2; Part XI, lines 2d and 4b; and Part XII, lines 2d and 4b. Also complete this part to provide any additional information.

PART V, LINE 4:

THE PRINCIPAL AND INCOME FROM THE UNRESTRICTED ENDOWMENT FUNDS AND THE INCOME FROM THE TERM ENDOWMENTS ARE FOR CAPITAL AND OPERATING NEEDS OF ROCKVILLE GENERAL HOSPITAL. THE INCOME FROM THE PERMANENT ENDOWMENTS AND PRINCIPAL FROM THE TERM ENDOWMENTS ARE FOR THE USE OF ROCKVILLE GENERAL HOSPITAL AS RESTRICTED BY THE DONORS.

PART X, LINE 2:

THE HOSPITAL ACCOUNTS FOR UNCERTAIN TAX POSITIONS IN ACCORDANCE WITH PROVISIONS OF FASB ASC 740, "INCOME TAXES," WHICH PROVIDES A FRAMEWORK FOR HOW COMPANIES SHOULD RECOGNIZE, MEASURE, PRESENT AND DISCLOSE UNCERTAIN TAX POSITIONS IN THEIR FINANCIAL STATEMENTS. THE

Part XIII Supplemental Information *(continued)*

HOSPITAL MAY RECOGNIZE THE TAX BENEFIT FROM AN UNCERTAIN TAX POSITION ONLY IF IT IS MORE LIKELY THAN NOT THAT THE TAX POSITION WILL BE SUSTAINED ON EXAMINATION BY THE TAXING AUTHORITIES, BASED ON THE TECHNICAL MERITS OF THE POSITION.

THE HOSPITAL DOES NOT HAVE ANY UNCERTAIN TAX POSITIONS AS OF SEPTEMBER 30, 2014 AND 2013. AS OF SEPTEMBER 30, 2014 AND 2013, THE HOSPITAL DID NOT RECORD ANY PENALTIES OR INTEREST ASSOCIATED WITH UNCERTAIN TAX POSITIONS. THE HOSPITAL'S PRIOR THREE TAX YEARS ARE OPEN AND SUBJECT TO EXAMINATION BY THE INTERNAL REVENUE SERVICE.

PART XI, LINE 2D - OTHER ADJUSTMENTS:

COST OF GOODS SOLD - GIFT SHOP	30,199.
NET ASSETS RELEASED FROM RESTRICTIONS USED FOR OPERATIONS	49,147.
TOTAL TO SCHEDULE D, PART XI, LINE 2D	79,346.

PART XI, LINE 4B - OTHER ADJUSTMENTS:

CHANGE IN TEMPORARILY RESTRICTED NET ASSETS	151,067.
NET RENTAL INCOME	39,066.
TOTAL TO SCHEDULE D, PART XI, LINE 4B	190,133.

PART XII, LINE 2D - OTHER ADJUSTMENTS:

COST OF GOODS SOLD - GIFT SHOP	30,199.

PART XII, LINE 4B - OTHER ADJUSTMENTS:

NET RENTAL INCOME	39,066.

SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

▶ Complete if the organization answered "Yes" to Form 990, Part IV, question 20.
▶ Attach to Form 990. ▶ See separate instructions.
▶ Information about Schedule H (Form 990) and its instructions is at www.irs.gov/form990 .

OMB No. 1545-0047

2013

Open to Public Inspection

Name of the organization
ROCKVILLE GENERAL HOSPITAL

Employer identification number
06-0653151

Part I Financial Assistance and Certain Other Community Benefits at Cost

		Yes	No
1a Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	1a	X	
b If "Yes," was it a written policy?	1b	X	
2 If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. [X] Applied uniformly to all hospital facilities [ ] Applied uniformly to most hospital facilities [ ] Generally tailored to individual hospital facilities			
3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.			
a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing *free* care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: [ ] 100% [ ] 150% [ ] 200% [X] Other 125 %	3a	X	
b Did the organization use FPG as a factor in determining eligibility for providing *discounted* care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: [ ] 200% [ ] 250% [ ] 300% [ ] 350% [X] 400% [ ] Other _____ %	3b	X	
c If the organization used factors other than FPG in determining eligibility, describe in Part VI the income based criteria for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.			
4 Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	4	X	
5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a		X
b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b		
c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?	5c		
6a Did the organization prepare a community benefit report during the tax year?	6a	X	
b If "Yes," did the organization make it available to the public?	6b	X	

Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)		305	345,867.	12,330.	333,537.	.46%
b Medicaid (from Worksheet 3, column a)		15,197	12017145.	7341234.	4675911.	6.45%
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs		15,502	12363012.	7353564.	5009448.	6.91%
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)	16	41,614	196,766.	989.	195,777.	.27%
f Health professions education (from Worksheet 5)	10	250	404,702.	63,807.	340,895.	.47%
g Subsidized health services (from Worksheet 6)	6	2,082	1317644.	476,954.	840,690.	1.16%
h Research (from Worksheet 7)	1	0	13,668.	0.	13,668.	.02%
i Cash and in-kind contributions for community benefit (from Worksheet 8)	4	634	26,874.	3,000.	23,874.	.03%
j **Total.** Other Benefits	37	44,580	1959654.	544,750.	1414904.	1.95%
k **Total.** Add lines 7d and 7j	37	60,082	14322666.	7898314.	6424352.	8.86%

Part II Community Building Activities Complete this table if the organization conducted any community building activities during the tax year, and describe in Part VI how its community building activities promoted the health of the communities it serves.

		(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1	Physical improvements and housing						
2	Economic development	1	0	706.		706.	.00%
3	Community support	3	45	11,438.		11,438.	.02%
4	Environmental improvements						
5	Leadership development and training for community members						
6	Coalition building	3	0	4,070.		4,070.	.01%
7	Community health improvement advocacy	1	0	2,376.		2,376.	.00%
8	Workforce development	1	13	480.		480.	.00%
9	Other						
10	Total	9	58	19,070.		19,070.	.03%

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

			Yes	No
1	Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1	X	
2	Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount	2 2,801,283.		
3	Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit	3 1,188,545.		
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.			

Section B. Medicare

5	Enter total revenue received from Medicare (including DSH and IME)	5	18,789,990.
6	Enter Medicare allowable costs of care relating to payments on line 5	6	20,914,145.
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7	-2,124,155.
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: ☐ Cost accounting system ☒ Cost to charge ratio ☐ Other		

Section C. Collection Practices

9a	Did the organization have a written debt collection policy during the tax year?	9a	X	
b	If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI	9b	X	

Part IV Management Companies and Joint Ventures (owned 10% or more by officers, directors, trustees, key employees, and physicians - see instructions)

(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %

Part V Facility Information

Section A. Hospital Facilities
(list in order of size, from largest to smallest)

How many hospital facilities did the organization operate during the tax year? 1

Name, address, primary website address, and state license number	Licensed hospital	Gen. medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
1 ROCKVILLE GENERAL HOSPITAL 31 UNION STREET VERNON, CT 06066 00036	X	X		X			X			

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

(Complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)

Name of hospital facility or facility reporting group ROCKVILLE GENERAL HOSPITAL

If reporting on Part V, Section B for a single hospital facility only: line number of hospital facility (from Schedule H, Part V, Section A) 1

			Yes	No
Community Health Needs Assessment (Lines 1 through 8c are optional for tax years beginning on or before March 23, 2012)				
1	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 9	1	X	
	If "Yes," indicate what the CHNA report describes (check all that apply):			
a	[X] A definition of the community served by the hospital facility			
b	[X] Demographics of the community			
c	[X] Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	[X] How data was obtained			
e	[X] The health needs of the community			
f	[X] Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	[X] The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	[X] The process for consulting with persons representing the community's interests			
i	[X] Information gaps that limit the hospital facility's ability to assess the community's health needs			
j	[ ] Other (describe in Section C)			
2	Indicate the tax year the hospital facility last conducted a CHNA: 20 12			
3	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	3	X	
4	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	4	X	
5	Did the hospital facility make its CHNA report widely available to the public?	5	X	
	If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a	[X] Hospital facility's website (list url): WWW.ECHN.ORG			
b	[ ] Other website (list url):			
c	[X] Available upon request from the hospital facility			
d	[X] Other (describe in Section C)			
6	If the hospital facility addressed needs identified in its most recently conducted CHNA, indicate how (check all that apply as of the end of the tax year):			
a	[X] Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA			
b	[X] Execution of the implementation strategy			
c	[ ] Participation in the development of a community-wide plan			
d	[ ] Participation in the execution of a community-wide plan			
e	[ ] Inclusion of a community benefit section in operational plans			
f	[ ] Adoption of a budget for provision of services that address the needs identified in the CHNA			
g	[X] Prioritization of health needs in its community			
h	[X] Prioritization of services that the hospital facility will undertake to meet health needs in its community			
i	[ ] Other (describe in Section C)			
7	Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If "No," explain in Section C which needs it has not addressed and the reasons why it has not addressed such needs	7		X
8a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	8a		X
b	If "Yes" to line 8a, did the organization file Form 4720 to report the section 4959 excise tax?	8b		
c	If "Yes" to line 8b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)* ROCKVILLE GENERAL HOSPITAL

			Yes	No
Financial Assistance Policy				
	Did the hospital facility have in place during the tax year a written financial assistance policy that:			
9	Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	9	X	
10	Used federal poverty guidelines (FPG) to determine eligibility for providing *free* care?	10	X	
	If "Yes," indicate the FPG family income limit for eligibility for free care: 125 %			
	If "No," explain in Section C the criteria the hospital facility used.			
11	Used FPG to determine eligibility for providing *discounted* care?	11	X	
	If "Yes," indicate the FPG family income limit for eligibility for discounted care: 400 %			
	If "No," explain in Section C the criteria the hospital facility used.			
12	Explained the basis for calculating amounts charged to patients?	12	X	
	If "Yes," indicate the factors used in determining such amounts (check all that apply):			
a	[X] Income level			
b	[ ] Asset level			
c	[X] Medical indigency			
d	[ ] Insurance status			
e	[ ] Uninsured discount			
f	[ ] Medicaid/Medicare			
g	[ ] State regulation			
h	[ ] Residency			
i	[X] Other (describe in Section C)			
13	Explained the method for applying for financial assistance?	13	X	
14	Included measures to publicize the policy within the community served by the hospital facility?	14	X	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	[ ] The policy was posted on the hospital facility's website			
b	[X] The policy was attached to billing invoices			
c	[X] The policy was posted in the hospital facility's emergency rooms or waiting rooms			
d	[X] The policy was posted in the hospital facility's admissions offices			
e	[ ] The policy was provided, in writing, to patients on admission to the hospital facility			
f	[X] The policy was available on request			
g	[ ] Other (describe in Section C)			
Billing and Collections				
15	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained actions the hospital facility may take upon non-payment?	15	X	
16	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:			
a	[ ] Reporting to credit agency			
b	[ ] Lawsuits			
c	[ ] Liens on residences			
d	[ ] Body attachments			
e	[ ] Other similar actions (describe in Section C)			
17	Did the hospital facility or an authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP?	17		X
	If "Yes," check all actions in which the hospital facility or a third party engaged:			
a	[ ] Reporting to credit agency			
b	[ ] Lawsuits			
c	[ ] Liens on residences			
d	[ ] Body attachments			
e	[ ] Other similar actions (describe in Section C)			

Part V Facility Information *(continued)* ROCKVILLE GENERAL HOSPITAL

18 Indicate which efforts the hospital facility made before initiating any of the actions listed in line 17 (check all that apply):

- **a** ☐ Notified individuals of the financial assistance policy on admission
- **b** ☐ Notified individuals of the financial assistance policy prior to discharge
- **c** ☐ Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills
- **d** ☐ Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy
- **e** ☐ Other (describe in Section C)

Policy Relating to Emergency Medical Care

		Yes	No
19 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?	19	X	

If "No," indicate why:

- **a** ☐ The hospital facility did not provide care for any emergency medical conditions
- **b** ☐ The hospital facility's policy was not in writing
- **c** ☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)
- **d** ☐ Other (describe in Section C)

Charges to Individuals Eligible for Assistance under the FAP (FAP-Eligible Individuals)

20 Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.

- **a** ☐ The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged
- **b** ☐ The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged
- **c** ☐ The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged
- **d** ☒ Other (describe in Section C)

21 During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Section C.	21		X
22 During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? If "Yes," explain in Section C.	22		X

Part V **Facility Information** *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A, " "Facility B," etc.

ROCKVILLE GENERAL HOSPITAL:

PART V, SECTION B, LINE 3: AS PART OF ITS CHNA, RGH INVITED COMMUNITY AGENCIES AND ORGANIZATIONS THROUGHOUT THE SERVICE AREA, REPRESENTING A VARIETY OF MEDICALLY UNDERSERVED, LOW-INCOME AND MINORITY POPULATIONS, TO PARTICIPATE IN AN ONLINE SURVEY, WHICH ASKED QUESTIONS ABOUT WHAT THE INDIVIDUALS PERCEIVED TO BE HEALTHY AND UNHEALTHY ABOUT THE COMMUNITY, WHAT THEIR PERCEPTION IS OF RGH AND THE PROGRAMS AND SERVICES IT OFFERS, AND WHAT RGH CAN DO TO IMPROVE THE HEALTH AND QUALITY OF LIFE IN THE COMMUNITY. AGENCIES AND ORGANIZATIONS RESPONDING TO THE SURVEY INCLUDED THE DEPARTMENT OF PUBLIC HEALTH WIC PROGRAM, COMMUNITY CHILD GUIDANCE CLINIC, VERNON YOUTH SERVICES BUREAU, TOWN OF ELLINGTON HUMAN SERVICES, TOWN OF MANCHESTER HEALTH DEPARTMENT, TOWN OF ANDOVER ELDER SERVICES, MAPLE STREET SCHOOL IN VERNON, VERNON ADULT EDUCATION, INDIAN VALLEY YMCA, AND MARC, INC.

ROCKVILLE GENERAL HOSPITAL:

PART V, SECTION B, LINE 4: THE CHNA WAS CONDUCTED BY EASTERN CONNECTICUT HEALTH NETWORK, WHICH INCLUDES MANCHESTER MEMORIAL HOSPITAL AND ROCKVILLE GENERAL HOSPITAL.

ROCKVILLE GENERAL HOSPITAL:

PART V, SECTION B, LINE 5D: HTTP://WWW.ECHN.ORG/ABOUT-ECHN/COMMUNITY-BENEFIT-REPORTING.ASPX

Part V **Facility Information** *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A, " "Facility B," etc.

ROCKVILLE GENERAL HOSPITAL:

PART V, SECTION B, LINE 7: AFTER REVIEWING THE CHNA DATA, THE OVERSIGHT COMMITTEE IDENTIFIED EIGHT HEALTH AREAS OF NEED (HEART DISEASE INCIDENCE, CANCER INCIDENCE, DIABETES INCIDENCE, ARTHRITIS INCIDENCE, ALZHEIMER'S DISEASE INCIDENCE, MULTIPLE SCLEROSIS INCIDENCE, SUBSTANCE ABUSE AND CHILDHOOD LEAD SCREENING), HOWEVER IT WAS DETERMINED THAT ALL NEEDS COULD NOT BE ADDRESSED BASED ON THE HOSPITAL'S ABILITY TO IMPACT THE NEEDS AND THE AVAILABILITY OF RESOURCES THAT EXIST TO ADDRESS THEM. THE FOLLOWING HEALTH NEEDS WERE IDENTIFIED AS THE HIGHEST PRIORITY: HEART DISEASE INCIDENCE, CANCER INCIDENCE, DIABETES INCIDENCE AND ARTHRITIS INCIDENCE.

ROCKVILLE GENERAL HOSPITAL:

PART V, SECTION B, LINE 12I: FAMILY SIZE IS USED WITH INCOME LEVEL.

ROCKVILLE GENERAL HOSPITAL:

PART V, SECTION B, LINE 20D: CHARGES ARE UNIFORMLY SET FOR ALL PATIENTS REGARDLESS OF PAYOR AND CHARITY CARE DISCOUNT IS APPLIED BASED ON INCOME.

Part V **Facility Information** *(continued)*

Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

(list in order of size, from largest to smallest)

How many non-hospital health care facilities did the organization operate during the tax year? 0

Name and address	Type of Facility (describe)

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

PART II, COMMUNITY BUILDING ACTIVITIES:

ROCKVILLE GENERAL HOSPITAL (RGH), AS PART OF EASTERN CONNECTICUT HEALTH NETWORK (ECHN), PROMOTES THE HEALTH OF THE COMMUNITIES IT SERVES BY COMMITTING THE EXPERTISE AND RESOURCES OF THE ORGANIZATION TO A NUMBER OF COMMUNITY BUILDING ACTIVITIES THAT SUPPORT ASSOCIATIONS, BUSINESSES, PROGRAMS, INITIATIVES AND OTHER VALUABLE LOCAL COMMUNITY ASSETS. COMMUNITY BUILDING ACTIVITIES INCLUDE SERVING ON THE BOARD AND EXECUTIVE COMMITTEE OF REGIONAL CHAMBERS OF COMMERCE IN SUPPORT OF THE LOCAL BUSINESS INDUSTRY; PARTNERING WITH THE LOCAL SCHOOL SYSTEMS AND COLLEGES IN VARIOUS WORKFORCE DEVELOPMENT PROGRAMS; SERVING ON THE VERNON SCHOOL READINESS COUNCIL, THE CANCER COMMUINITY OUTREACH COMMITTEE AND THE AMERICAN HOSPITAL ASSOCIATION'S REGIONAL POLICY BOARD; AND NUMEROUS COMMUNITY COALITIONS THAT ADDRESS ADOLESCENT BEHAVIORAL HEALTH CONCERNS. AS A RESULT OF THESE ACTIVITIES, THERE HAS BEEN IMPROVED COLLABORATION AMONG COMMUNITY PROVIDERS AND OTHERS INVOLVED IN PROVIDING SERVICES TO CHILDREN, ADOLESCENTS AND THEIR FAMILIES AND OTHER ADULTS.

PART III, LINE 4:

Part VI Supplemental Information *(Continuation)*

THE HOSPITAL PROVIDES FOR A PROVISION FOR BAD DEBTS. FOR RECEIVABLES ASSOCIATED WITH SERVICES PROVIDED TO PATIENTS WHO HAVE THIRD-PARTY COVERAGE, THE HOSPITAL ANALYZES CONTRACTUALLY DUE AMOUNTS AND PROVIDES AN ALLOWANCE FOR DOUBTFUL ACCOUNTS AND A PROVISION FOR BAD DEBTS (FOR EXAMPLE, FOR EXPECTED UNCOLLECTIBLE DEDUCTIBLES AND COPAYMENTS ON ACCOUNTS FOR WHICH THE THIRD-PARTY PAYER HAS NOT YET PAID, OR FOR PAYERS WHO ARE KNOWN TO BE HAVING FINANCIAL DIFFICULTIES THAT MAKE THE REALIZATION OF AMOUNTS DUE UNLIKELY). FOR RECEIVABLES ASSOCIATED WITH SELF-PAY PATIENTS (WHICH INCLUDES BOTH PATIENTS WITHOUT INSURANCE AND PATIENTS WITH DEDUCTIBLE AND CO-PAYMENT BALANCES DUE FOR WHICH THIRD-PARTY COVERAGE EXISTS FOR PART OF THE BILL), THE HOSPITAL RECORDS A SIGNIFICANT PROVISION FOR BAD DEBTS IN THE PERIOD OF SERVICE ON THE BASIS OF ITS PAST EXPERIENCE, WHICH INDICATES THAT MANY PATIENTS ARE UNABLE OR UNWILLING TO PAY THE PORTION OF THEIR BILL FOR WHICH THEY ARE FINANCIALLY RESPONSIBLE. FOR UNINSURED PATIENTS THAT DO NOT QUALIFY FOR FINANCIAL ASSISTANCE, THE HOSPITAL OFFERS A DISCOUNT OFF ITS STANDARD RATES FOR SERVICES PROVIDED. THE DIFFERENCE BETWEEN THE DISCOUNTED RATES AND THE AMOUNTS ACTUALLY COLLECTED AFTER ALL REASONABLE COLLECTION EFFORTS HAVE BEEN EXHAUSTED IS WRITTEN OFF AGAINST THE ALLOWANCE FOR DOUBTFUL ACCOUNTS IN THE PERIOD THEY ARE DETERMINED UNCOLLECTIBLE.

PART III, LINE 8:

THE HOSPITAL PROVIDES QUALITY HEALTH CARE TO ALL, REGARDLESS OF THEIR ABILITY TO PAY. CHARITY CARE IS PROVIDED TO THOSE WHO ARE ELIGIBLE BASED ON RGH'S POLICY. THE HOSPITAL ALSO INCURS UNPAID COSTS FOR GOVERNMENT PROGRAMS BECAUSE REIMBURSEMENT IS NOT SUFFICIENT TO COVER COSTS ASSOCIATED WITH MEDICARE AND MEDICAID PATIENTS. THE ORGANIZATION'S MEDICARE COST REPORT WAS USED TO CALCULATE ACTUAL COSTS REPORTED ON PART

Part VI Supplemental Information *(Continuation)*

III, LINE 6. THE ACCESS TO HEALTHCARE BY PATIENTS COVERED BY MEDICARE IS A FUNDAMENTAL PART OF THE HOSPITAL'S COMMUNITY BENEFIT PROGRAM.

PART III, LINE 9B:

INTERNAL AND EXTERNAL COLLECTION POLICIES AND PROCEDURES TAKE INTO ACCOUNT THE EXTENT TO WHICH A PATIENT IS QUALIFIED FOR CHARITY CARE OR DISCOUNTS. IN ADDITION, PATIENTS WHO QUALIFY FOR PARTIAL DISCOUNTS ARE REQUIRED TO MAKE A GOOD FAITH EFFORT TO HONOR PAYMENT AGREEMENTS WITH ECHN, INCLUDING PAYMENT PLANS AND DISCOUNTED HOSPITAL BILLS. RGH IS COMMITTED TO WORKING WITH PATIENTS TO RESOLVE THEIR ACCOUNTS, AND AT ITS DISCRETION, MAY PROVIDE EXTENDED PAYMENT PLANS TO ELIGIBLE PATIENTS. RGH WILL NOT PURSUE LEGAL ACTION FOR NON-PAYMENT OF BILLS AGAINST CHARITY CARE PATIENTS WHO HAVE COOPERATED WITH THE HOSPITAL TO RESOLVE THEIR ACCOUNTS AND HAVE DEMONSTRATED THEIR INCOME AND/OR ASSETS ARE INSUFFICIENT TO PAY MEDICAL BILLS.

PART VI, LINE 2:

IN 2013, RGH COLLABORATED WITH MANCHESTER MEMORIAL HOSPITAL, ALSO AN AFFILIATE OF ECHN, TO CONDUCT A COMPREHENSIVE COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA). THE GOALS OF THE ASSESSMENT WERE: TO IDENTIFY CURRENT AND FUTURE HEALTHCARE NEEDS IN THE COMMUNITY AND TO IMPROVE AND STRENGTHEN PROGRAMS AND SERVICES PROVIDED TO ADDRESS THEM.

THE CHNA PROCESS WAS LED BY AN OVERSIGHT COMMITTEE THAT INCLUDED MEMBERS OF THE ORGANIZATION WITH ESTABLISHED RELATIONSHIPS WITH COMMUNITY GROUPS AND AGENCIES. DATA COLLECTED FOR THE CHNA INCLUDED: HEALTH, SOCIAL, AND DEMOGRAPHIC DATA SPECIFIC TO RGH'S SERVICE AREA OBTAINED FROM LOCAL PUBLIC HEALTH AGENCIES, NATIONAL HEALTH ASSOCIATIONS AND OTHER DATA SOURCES;

Part VI **Supplemental Information** *(Continuation)*

HEALTH BEHAVIOR INFORMATION COLLECTED FROM 1,047 RESIDENTS WHO RESPONDED TO A COMMUNITY SURVEY; INPUT FROM 12 COMMUNITY STAKEHOLDERS FROM LOCAL ORGANIZATIONS INVESTED IN THE HEALTH OF UNDERSERVED POPULATIONS.

ONCE ALL DATA WAS COLLECTED AND ANALYZED, THE OVERSIGHT COMMITTEE IDENTIFIED AND PRIORITIZED THE SERVICE AREA'S KEY HEALTH NEEDS AND DEVELOPED AN IMPLEMENTATION STRATEGY TO RESPOND TO THE NEEDS.

PART VI, LINE 3:

THE HOSPITAL COMMUNICATES THE AVAILABILITY OF FINANCIAL ASSISTANCE THROUGH NOTICES POSTED IN PUBLIC AREAS AROUND THE HOSPITAL, ON THE PATIENT BILLS, ON OUR WEBSITE, AND SELECTED PRE-SCHEDULED SERVICES TO ENSURE THAT THE FINANCIAL CAPACITY OF PEOPLE WHO NEED HEALTHCARE SERVICES DOES NOT PREVENT THEM FROM SEEKING OR RECEIVING CARE.

PART VI, LINE 4:

ROCKVILLE GENERAL HOSPITAL, PART OF EASTERN CONNECTICUT HEALTH NETWORK, SERVES A 19-TOWN PRIMARY AND SECONDARY SERVICE AREA LOCATED EAST OF THE CONNECTICUT RIVER IN NORTHERN CONNECTICUT WITH MUNICIPALITIES IN HARTFORD, TOLLAND AND WINDHAM COUNTIES. THE PRIMARY SERVICE AREA INCLUDES ANY TOWN WHERE TOTAL INPATIENT AND NEWBORN DISCHARGES ARE GREATER THAN OR EQUAL TO 20 PERCENT AND INCLUDES THE TOWNS OF MANCHESTER, SOUTH WINDSOR, BOLTON, COVENTRY, ANDOVER, ELLINGTON, TOLLAND, VERNON/ROCKVILLE AND WILLINGTON. THE SECONDARY SERVICE AREA INCLUDES ANY TOWN WHERE TOTAL INPATIENT AND NEWBORN DISCHARGES ARE GREATER THAN OR EQUAL TO FIVE PERCENT AND LESS THAN 20 PERCENT AND INCLUDES THE TOWNS OF ASHFORD, SOMERS, STAFFORD, UNION, EAST HARTFORD, EAST WINDSOR, GLASTONBURY, HEBRON, COLUMBIA AND MANSFIELD.

BASED ON DATA COLLECTED IN 2013, THE POPULATION OF THE ENTIRE SERVICE AREA IS 341,000; 49% MALE, 51% FEMALE. THE MEDIAN AGE OF RESIDENTS IS 39.5 YEARS WITH 33.3% OF THE POPULATION 50 YEARS OR OLDER. THE RACE OF THE RESIDENTS IS PREDOMINANTLY WHITE (80%) FOLLOWED BY BLACK/AFRICAN AMERICAN (8.3%), OTHER/MULTI-RACE (6.1%) AND ASIAN (5.3%). APPROXIMATELY 91.5% PERCENT OF THE POPULATION HAS A HIGH SCHOOL DEGREE AND 35.6% PERCENT HAVE A BACHELOR'S DEGREE OR HIGHER. THE MEDIAN HOUSEHOLD INCOME FOR THE SERVICE AREA IS $82,075 PER YEAR. JUST UNDER 8% OF HOUSEHOLDS HAVE ANNUAL INCOME AT THE FEDERAL POVERTY RATE. THE UNEMPLOYMENT RATE IS 7.4% AND THE AVERAGE HOUSEHOLD SIZE IS 2.61 PEOPLE.

PART VI, LINE 5:
COMMUNITY HEALTH EDUCATION INITIATIVES AND PROGRAMS ARE OFFERED TO THE COMMUNITY AND INCLUDE FREE COMMUNITY HEALTH EDUCATIONAL PROGRAMS, EDUCATION IN BETTER BEING (A FREE COMMUNITY WELLNESS MAGAZINE), PARTICIPATION IN COMMUNITY HEALTH FAIRS, NUTRITION COUNSELING SERVICES, INTEGRATIVE MEDICINE PROGRAMS FOR STRESS REDUCTION, A "HEART TALK" COMMUNITY PROGRAM FOR PEOPLE LIVING WITH HEART FAILURE, THE PROMOTION OF CARDIAC REHABILITATION SERVICES, ONCOLOGY NURSE NAVIGATOR AND SURVIVORSHIP NAVIGATORS SERVICES, ANNUAL CANCER SURVIVORS DAY EVENT, REGULAR CANCER SUPPORT GROUP MEETINGS, CANCER CAREGIVER WORKSHOPS, DIABETES SELF-MANAGEMENT PROGRAM, NUTRITION COUNSELING FOR INDIVIDUALS ALREADY DIAGNOSED WITH DIABETES, A PRESENTATION ON HEART HEALTH TO ELEMENTARY SCHOOL STUDENTS, A NEW MOTHER'S SUPPORT GROUP AND OTHER LECTURE PRESENTATIONS. THE EDUCATION PROGRAMS INCLUDE EDUCATING THE PUBLIC ABOUT MANAGING LIFESTYLE BEHAVIORS THAT IMPACT DIET, BLOOD PRESSURE, CHOLESTEROL, WEIGHT, PHYSICAL ACTIVITY, STRESS, CANCER RISKS, DIABETES AND

Part VI **Supplemental Information** *(Continuation)*

ARTHRITIS.

FREE HEALTH SCREENINGS INCLUDING DIABETIC FOOT CHECKS, MAMMOGRAMS, HEART DISEASE SCREENINGS, BLOOD PRESSURE, BONE DENSITY, GLUCOSE READINGS, INJURY SCREENINGS, VITAL SIGN CHECKS, MASSAGE THERAPY AND MEDICAL EXAMS ARE OFFERED IN THE COMMUNITY, TARGETING UNINSURED/UNDERINSURED POPULATIONS.

HEALTHCARE SUPPORT SERVICES ARE PROVIDED BY THE HOSPITAL TO INCREASE ACCESS AND QUALITY OF CARE TO INDIVIDUALS IN NEED. EFFORTS INCLUDE FREE TRANSPORTATION TO BEHAVIORAL HEALTH PATIENTS, ASSISTANCE TO ENROLL IN PUBLIC PROGRAMS, REFERRALS TO SOCIAL SERVICES AND PHYSICIANS ACCEPTING MEDICAID OR OTHER GOVERNMENT PROGRAMS, AND FREE LIFELINE PERSONAL RESPONSE SYSTEM SERVICE.

PARTNERING WITH LOCAL EDUCATIONAL INSTITUTIONS, ROCKVILLE GENERAL HOSPITAL PROVIDES A CLINICAL SETTING FOR PHYSICIANS, NURSES, RADIOLOGIC TECHNICIANS, RESPIRATORY TECHNICIANS AND PHYSICAL THERAPISTS AND OTHERS FROM THE UNIVERSITY OF NEW ENGLAND COLLEGE OF OSTEOPATHIC MEDICINE, UNIVERSITY OF CONNECTICUT, MANCHESTER COMMUNITY COLLEGE, CENTRAL CONNECTICUT STATE UNIVERSITY, CAPITAL COMMUNITY COLLEGE, SPRINGFIELD TECHNICAL COMMUNITY COLLEGE, UNIVERSITY OF ST. JOSEPH, UNIVERSITY OF HARTFORD, BRANFORD HALL, GOODWIN COLLEGE, STONE ACADEMY, AND EASTERN CONNECTICUT STATE UNIVERSITY.

SPECIFIC RESEARCH INITIATIVES CONDUCTED BY THE HOSPITAL INCLUDE MAINTENANCE OF A CANCER REGISTRY DATABASE AND AN INSTITUTIONAL REVIEW COMMITTEE. FINANCIAL AND IN-KIND SERVICES AND GOODS ARE DONATED TO COMMUNITY GROUPS AND OTHER NOT FOR PROFIT ORGANIZATIONS INCLUDING PATIENT

Part VI Supplemental Information *(Continuation)*

MEALS, LOCAL FUNDRAISERS, FACILITY SPACE TO HOST BLOOD DRIVES AND HEALTH SUPPORT GROUPS ORGANIZATIONS' MEETINGS, AND A BABY SHOWER FOR NEEDY FAMILIES IN THE COMMUNITY.

PART VI, LINE 6:

ROCKVILLE GENERAL HOSPITAL (RGH) IS AN AFFILIATE OF EASTERN CONNECTICUT HEALTH NETWORK (ECHN), A HEALTH CARE SYSTEM SERVING 19 TOWNS IN EASTERN CONNECTICUT. THE ECHN NETWORK OF AFFILIATES INCLUDES:

MANCHESTER MEMORIAL HOSPITAL, A COMMUNITY HOSPITAL LICENSED FOR 249 BEDS AND 34 BASSINETS, THAT OFFERS MEDICAL AND SURGICAL SERVICES, 24-HOUR EMERGENCY CARE, MEDICAL IMAGING, A MODERN FAMILY BIRTHING CENTER AND NEONATOLOGY SERVICES, REHABILITATION SERVICES, A CERTIFIED SLEEP DISORDERS CENTER, INTENSIVE CARE SUITES, A WOUND HEALING CENTER WITH HYPERBARIC THERAPY, HOSPICE CARE, DIABETES SELF-MANAGEMENT PROGRAM, CARDIAC & PULMONARY REHABILITATION, A COMPREHENSIVE RANGE OF ADOLESCENT AND ADULT INPATIENT AND OUTPATIENT BEHAVIORAL HEALTH SERVICES, NUTRITION COUNSELING, LABORATORY SERVICES, AND THE EASTERN CONNECTICUT CANCER INSTITUTE AT THE JOHN A. DEQUATTRO CANCER CENTER. ROCKVILLE GENERAL HOSPITAL, A COMMUNITY HOSPITAL LICENSED FOR 102 BEDS, THAT OFFERS MEDICAL AND SURGICAL SERVICES, 24-HOUR EMERGENCY CARE, MEDICAL IMAGING, CARDIAC & PULMONARY REHABILITATION, PHYSICAL REHABILITATION, HOSPICE CARE, A MATERNITY CARE CENTER FOR UNINSURED WOMEN, OUTPATIENT ADOLESCENT BEHAVIORAL HEALTH SERVICES, AND LABORATORY SERVICES.

WOODLAKE AT TOLLAND IS A SKILLED NURSING & REHABILITATION CENTER, A 130-BED LONG-TERM SKILLED NURSING CARE AND SHORT-TERM REHABILITATION FACILITY. CUSTOMIZED REHABILITATION TREATMENT SERVICES INCLUDE JOINT

Part VI Supplemental Information *(Continuation)*

REPLACEMENT REHABILITATION, ORTHOPEDIC POST-HOSPITAL CARE, STROKE/NEUROLOGICAL REHAB, POST MEDICAL/SURGICAL RECONDITIONING, AND PERSONALIZED, PROGRESSIVE, AND INTERDISCIPLINARY CARE SERVICES.

EASTERN CONNECTICUT MEDICAL PROFESSIONALS (ECMPF) FOUNDATION, INC., A MULTI-SPECIALTY PHYSICIAN GROUP PRACTICE THAT OFFERS A FULL RANGE OF HEALTHCARE SERVICES, INCLUDING PRIMARY AND SPECIALTY CARE IN THE TOWNS OF EAST HARTFORD, ELLINGTON, MANCHESTER, SOMERS, SOUTH WINDSOR, TOLLAND AND VERNON/ROCKVILLE. GLASTONBURY WELLNESS CENTER COMBINES FITNESS AND MEDICAL SERVICES UNDER ONE ROOF, INCLUDING PHYSICIAN PRACTICES, LABORATORY DRAW SERVICES, MEDICAL IMAGING DIAGNOSTIC SERVICES, AND REHABILITATION SERVICES. ECHN MEDICAL BUILDINGS AT EVERGREEN WALK (SOUTH WINDSOR); 2400 TAMARACK AVENUE OCCUPANTS INCLUDE EVERGREEN ENDOSCOPY CENTER, CENTRAL CONNECTICUT GASTROENTEROLOGY, THE COLON & RECTAL SURGEONS OF GREATER HARTFORD, AND ECMP PRIMARY CARE, RHEUMATOLOGY PHYSICIANS, WALDEN BEHAVIORAL CARE EATING DISORDERS CLINIC, AND LABORATORY SERVICES. 2600 TAMARACK AVENUE INCLUDES THE WOMEN'S CENTER FOR WELLNESS, ECHN BREAST CARE COLLABORATIVE, AND THE OB/GYN GROUP OF EASTERN CONNECTICUT. 2800 TAMARACK AVENUE HOUSES EVERGREEN IMAGING CENTER, ECHN REHABILITATION SERVICES, A LABORATORY DRAW STATION, AND A SERIES OF MEDICAL PRACTICES, INCLUDING ORTHOPEDIC SURGERY, OTOLARYNGOLOGY (ENT), AND GENERAL SURGERY, CORPCARE, AND SOUTH WINDSOR URGENT CARE. ECHN MANCHESTER MEDICAL OFFICE BUILDINGS: 150 NORTH MAIN STREET OFFERS A VARIETY OF BEHAVIORAL HEALTH SERVICES. VISITING NURSE & HEALTH SERVICES OF CONNECTICUT PROVIDES AT-HOME NURSING CARE AND HOSPICE CARE. ECHN HAS 432 PHYSICIANS (317 ACTIVE, 65 COURTESY, 12 CONSULTING, 38 PART-TIME), 83 ALLIED HEALTH PROFESSIONALS, 10 MEDICAL DEPARTMENTS AND 16 SERVICES AS WELL AS 15 UNIVERSITY OF NEW ENGLAND COLLEGE OF OSTEOPATHIC MEDICINE THIRD-YEAR MEDICAL STUDENTS AVAILABLE TO

Part VI **Supplemental Information** *(Continuation)*

CARE FOR THE COMMUNITY.

PART VI, LINE 7, LIST OF STATES RECEIVING COMMUNITY BENEFIT REPORT:

CT

SCHEDULE H, ADDITIONAL INFORMATION:

THE ROCKVILLE GENERAL HOSPITAL, INC. IS A NOT-FOR-PROFIT 102-BED ACUTE CARE HOSPITAL THAT PROVIDES INPATIENT, OUTPATIENT AND EMERGENCY CARE SERVICES FOR RESIDENTS OF VERNON-ROCKVILLE, CT AND SURROUNDING TOWNS. THE HOSPITAL IS A SUBSIDIARY OF THE EASTERN CONNECTICUT HEALTH NETWORK, INC., WHICH WAS FORMED IN 1995 BY A MERGER OF MMH CORP. AND ROCKVILLE AREA HEALTH SERVICES, INC. ECHN WAS ORGANIZED TO PROVIDE A BROADER HEALTH CARE SYSTEM FOR THE SURROUNDING COMMUNITIES WITH QUALITY MEDICAL CARE AT A REASONABLE COST AND TO FOSTER AN ENVIRONMENT CONDUCIVE TO HEALTH AND WELL BEING WHETHER IN THE HOME OR IN THE COMMUNITY.

ROCKVILLE GENERAL HOSPITAL PATIENTS NOT HAVING INSURANCE COVERING EMERGENCY OR OTHER MEDICALLY QUALIFIED CARE (UNINSURED PATIENTS), AS WELL AS UNDERINSURED PATIENTS, SUBJECT TO INCOME LIMITS AND FAMILY SIZE RECEIVE FREE OR DISCOUNTED CARE. ROCKVILLE GENERAL HOSPITAL DOES NOT PURSUE COLLECTION OF AMOUNTS DETERMINED TO QUALIFY AS CHARITY CARE. CHARGES FOR CARE PROVIDED TO PATIENTS ARE DETERMINED BY ESTABLISHED RATES, SUBJECT TO POSSIBLE ADJUSTMENTS OR DISCOUNTS FOR LOW INCOME PATIENTS; CONTRACTUAL DISCOUNTS, OR DISCOUNTS FOR PATIENTS WHO MEET CERTAIN CRITERIA UNDER ITS CHARITY CARE POLICIES. CHARITY CARE FOR FY 2014 WAS $1,188,545 FOR 305 APPROVED APPLICANTS.

Part VI Supplemental Information *(Continuation)*

EXPENSES RELATED TO SERVICES PERFORMED FOR PATIENTS OF ROCKVILLE GENERAL HOSPITAL CONTRIBUTE IMPORTANTLY TO ITS EXEMPT PURPOSE BECAUSE THE EXPENSES ARE INCURRED IN THE DIAGNOSIS, CURE, MITIGATION, TREATMENT AND PREVENTION OF DISEASE, AND FOR MEDICAL PURPOSES AFFECTING THE STRUCTURE OR FUNCTION OF THE HUMAN BODY.

ROCKVILLE GENERAL HOSPITAL PROVIDED NEEDED MEDICAL CARE TO THE COMMUNITY REGARDLESS OF ANY INDIVIDUAL'S ABILITY TO PAY. TWO THOUSAND THREE HUNDRED FORTY-ONE (2,341) INPATIENTS WERE CARED FOR IN FY14 REPRESENTING 11,155 PATIENT DAYS. ONE HUNDRED TWENTY-THREE THOUSAND SEVEN HUNDRED THIRTY-FOUR (123,734) OUTPATIENT VISITS WERE RECORDED.

INCLUDED IN THE 2,341 INPATIENTS WERE 1,852 GOVERNMENT RELATED PATIENTS. THE GOVERNMENT INPATIENTS FALL INTO THE FOLLOWING GROUPS:

MEDICARE	1,120
MEDICARE MANAGED CARE	404
MEDICAID	317
CHAMPUS	11
TOTAL GOV PATIENTS	1,852
TOTAL NON GOV PATIENTS	489
TOTAL PATIENTS	2,341

INCLUDED IN THE 123,734 OUTPATIENT VISITS WERE 56,579 GOVERNMENT RELATED VISITS. THE VISITS ARE A PRODUCT OF GROSS REVENUE RELATIONSHIP TO TOTAL VISITS. THE GOVERNMENT VISITS FALL INTO THE

Part VI **Supplemental Information** *(Continuation)*

FOLLOWING GROUPS:

MEDICARE	25,879
MEDICARE MANAGED CARE	9,495
MEDICAID	20,510
CHAMPUS	695
TOTAL GOV PATIENTS	56,579
TOTAL NON GOV PATIENTS	67,155
TOTAL OUTPATIENT VISITS	123,734

THE HOSPITAL PROVIDED UNCOMPENSATED CARE TO 15,197 MEDICAID PATIENTS FOR A NET COMMUNITY BENEFIT AMOUNT OF $4,676,000 AFTER MEDICAID REIMBURSEMENT.

SCHEDULE J (Form 990)

Department of the Treasury
Internal Revenue Service

Compensation Information

For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 23.**
▶ **Attach to Form 990.** ▶ **See separate instructions.**
▶ **Information about Schedule J (Form 990) and its instructions is at** *www.irs.gov/form990*

OMB No. 1545-0047

2013

Open to Public Inspection

Name of the organization

ROCKVILLE GENERAL HOSPITAL

Employer identification number

06-0653151

Part I Questions Regarding Compensation

			Yes	No
1a	Check the appropriate box(es) if the organization provided any of the following to or for a person listed in Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.			
	☐ First-class or charter travel	☐ Housing allowance or residence for personal use		
	☐ Travel for companions	☐ Payments for business use of personal residence		
	☐ Tax indemnification and gross-up payments	☐ Health or social club dues or initiation fees		
	☐ Discretionary spending account	☐ Personal services (e.g., maid, chauffeur, chef)		
b	If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain	1b		
2	Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, and officers, including the CEO/Executive Director, regarding the items checked in line 1a?	2		
3	Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.			
	☒ Compensation committee	☒ Written employment contract		
	☒ Independent compensation consultant	☒ Compensation survey or study		
	☐ Form 990 of other organizations	☒ Approval by the board or compensation committee		
4	During the year, did any person listed in Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:			
a	Receive a severance payment or change-of-control payment?	4a	X	
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	4b	X	
c	Participate in, or receive payment from, an equity-based compensation arrangement?	4c		X
	If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.			
	Only section 501(c)(3) and 501(c)(4) organizations must complete lines 5-9.			
5	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:			
a	The organization?	5a		X
b	Any related organization?	5b		X
	If "Yes" to line 5a or 5b, describe in Part III.			
6	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:			
a	The organization?	6a		X
b	Any related organization?	6b		X
	If "Yes" to line 6a or 6b, describe in Part III.			
7	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described in lines 5 and 6? If "Yes," describe in Part III	7		X
8	Were any amounts reported in Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III	8		X
9	If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	9		

Part II **Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees.** Use duplicate copies if additional space is needed.

For each individual whose compensation must be reported in Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions, on row (ii). Do not list any individuals that are not listed on Form 990, Part VII.

Note. The sum of columns (B)(i)-(iii) for each listed individual must equal the total amount of Form 990, Part VII, Section A, line 1a, applicable column (D) and (E) amounts for that individual.

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation reported as deferred in prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
(1) PETER J. KARL	(i)	0.	0.	0.	0.	0.	0.	0.
PRESIDENT AND CEO	(ii)	572,400.	550,812.	0.	97,575.	25,149.	1,245,936.	360,237.
(2) KEVIN G. MURPHY	(i)	0.	0.	0.	0.	0.	0.	0.
EVP, TREASURER (THROUGH OCT 2013)	(ii)	347,516.	178,255.	79,880.	9,505.	17,175.	632,331.	154,642.
(3) MICHAEL D. VEILLETTE	(i)	0.	0.	0.	0.	0.	0.	0.
SVP, CHIEF FINANCIAL OFFICER	(ii)	306,037.	135,238.	0.	36,975.	21,921.	500,171.	58,014.
(4) DEBORAH GOGLIETTINO	(i)	0.	0.	0.	0.	0.	0.	0.
SVP, HUMAN RESOURCES	(ii)	222,929.	127,739.	0.	29,790.	16,821.	397,279.	71,339.
(5) DENNIS MCCONVILLE	(i)	0.	0.	0.	0.	0.	0.	0.
SVP, STRATEGIC PLANNING	(ii)	207,957.	117,223.	0.	82,752.	10,928.	418,860.	68,020.
(6) DEBORAH PARKER	(i)	0.	0.	0.	0.	0.	0.	0.
EVP, CHIEF CLINICAL OFFICER	(ii)	294,718.	145,083.	0.	35,251.	22,795.	497,847.	73,202.
(7) JOEL REICH, MD	(i)	0.	0.	0.	0.	0.	0.	0.
SVP, MEDICAL AFFAIRS	(ii)	338,385.	184,230.	0.	119,923.	17,025.	659,563.	109,131.
(8) CHARLES COVIN	(i)	0.	0.	0.	0.	0.	0.	0.
VP AND CIO (THROUGH NOV 2013)	(ii)	151,398.	7,500.	0.	20,292.	11,961.	191,151.	0.
(9) LEONA CROSSKEY	(i)	0.	0.	0.	0.	0.	0.	0.
VP, QUALITY	(ii)	150,246.	27,442.	0.	55,175.	17,868.	250,731.	0.
(10) ROBERT CARROLL, MD	(i)	0.	0.	0.	0.	0.	0.	0.
MED DIR, EMERGENCY DEPARTMENT	(ii)	376,654.	72,829.	0.	12,750.	21,621.	483,854.	0.
(11) JOYCE TICHY	(i)	0.	0.	0.	0.	0.	0.	0.
GENERAL COUNSEL	(ii)	257,881.	97,800.	0.	7,650.	21,213.	384,544.	0.
(12) DAVID NEUHAUS, MD	(i)	299,061.	30,000.	0.	12,750.	983.	342,794.	0.
MEDICAL DIRECTOR	(ii)	0.	0.	0.	0.	0.	0.	0.
(13) ELLEN G. NEUHAUS, MD	(i)	214,598.	0.	0.	58,968.	20,577.	294,143.	0.
MEDICAL DIRECTOR	(ii)	0.	0.	0.	0.	0.	0.	0.
(14) ALEXIS CORDIANO	(i)	243,883.	0.	0.	8,465.	20,753.	273,101.	0.
URGENT CARE PHYSICIAN	(ii)	0.	0.	0.	0.	0.	0.	0.
(15) LINA HWANG	(i)	220,731.	0.	0.	8,168.	21,070.	249,969.	0.
URGENT CARE PHYSICIAN	(ii)	0.	0.	0.	0.	0.	0.	0.
(16) MARIELA PODOLSKI	(i)	178,428.	25,250.	0.	6,923.	20,579.	231,180.	0.
PSYCHIATRIST	(ii)	0.	0.	0.	0.	0.	0.	0.

ECHN Proposed Asset Purchase by PMH
Submitted October 13, 2015

Part III Supplemental Information

Provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

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PART I, LINE 3:

THE BOARD OF TRUSTEES (THE "BOARD") APPOINTS AN EXECUTIVE COMPENSATION COMMITTEE (THE "COMMITTEE") AND HAS DELEGATED THE RESPONSIBILITY OF COMPLETING AN ANNUAL MARKET ANALYSIS OF THE CEO'S COMPENSATION AND OTHER SENIOR EXECUTIVES AND COMPLETION OF THE CEO'S ANNUAL PERFORMANCE REVIEW.

THE EVALUATION OF THE CEO IS AN IMPORTANT RESPONSIBILITY OF THE BOARD AND IS CRITICAL TO THE GOVERNANCE RESPONSIBILITIES OF THE BOARD. THE EXECUTIVE COMPENSATION COMMITTEE SOLICITS FEEDBACK ABOUT THE PERFORMANCE OF THE CEO FROM EVERY ACTIVE BOARD MEMBER WHICH WHEN RECEIVED IS ANALYZED AND REVIEWED BY THE MEMBERS OF THE COMMITTEE. THE CEO COMPLETES A SELF-EVALUATION AND AN EVALUATION FOR ALL ELIGIBLE MEMBERS OF THE SENIOR LEADERSHIP TEAM, WHO COMPLETE BOTH A SELF-EVALUATION AND A PEER EVALUATION. THE RESULTS OF THE ASSESSMENTS COMPLETED BY THE MEMBERS OF THE SENIOR LEADERSHIP TEAM ARE REVIEWED BY THE CEO WHO DISCUSSES THE RESULTS WITH THE MEMBERS OF THE COMMITTEE ON AN ANNUAL BASIS.

Part III Supplemental Information

Provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

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THE EXECUTIVE COMPENSATION COMMITTEE IN COLLABORATION WITH THE CEO EVALUATES AND APPROVES ORGANIZATIONAL PERFORMANCE OBJECTIVES BOTH ON AN ANNUAL AND LONG TERM BASIS AND FOCUSES ON THOSE GOALS WITH THE GREATEST IMPACT TO THE ORGANIZATION'S STRATEGY AND MISSION. THE COMMITTEE ENSURES AN ANNUAL REVIEW OF THE CEO'S PERFORMANCE IN RELATION TO THESE GOALS; REVIEWS THE TALLY SHEETS TO UNDERSTAND THE ECONOMICS OF THE EMPLOYEE BENEFITS; RETAINS AND ENSURES THE INDEPENDENCE OF ITS EXTERNAL CONSULTANTS AND ADVISORS AND INVOLVES RELEVANT ORGANIZATIONAL RESOURCES AS APPROPRIATE TO CARRY OUT ITS RESPONSIBILITIES.

THE COMMITTEE ENSURES TRANSPARENCY AND DISCLOSURE TO THE BOARD BY PRESENTING THE RESULTS OF THE ANNUAL PERFORMANCE AND MARKET REVIEWS PROVIDING THE BOARD WITH THE OPPORTUNITITY FOR FURTHER INPUT AND CONSIDERATION AND ASKING THAT THE BOARD TAKE ACTION ON THE RECOMMENDATION OF THE COMMITTEE IF THE RECOMMENDATION IS APPROPRIATE. THE BOARD HAS THE OPPORTUNITY TO CHANGE ANY RECOMMENDATIONS OF THE COMMITTEE IF IT SO DESIRES. MEMBERS OF THE BOARD AND OF THE COMMITTEE WHO MAY BE INTERESTED PARTIES ARE ASKED TO RECUSE THEMSELVES FROM ANY REQUIRED VOTES TO AVOID CONFLICTS OF INTEREST. THE COMMITTEE ENSURES THAT THE PROCESS MEETS

Part III Supplemental Information

Provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

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COMPLIANCE STANDARDS.

PART I, LINES 4A-B:

LINE 4A, SEVERANCE PAYMENT:

KEVIN MURPHY - $79,880

LINE 4B, SUPPLEMENTAL NONQUALIFIED RETIREMENT PLAN:

PETER KARL - $84,825

MICHAEL VEILLETTE - $24,225

DEBORAH GOGLIETTINO - $17,625

DEBORAH PARKER - $22,501

DENNIS MCCONVILLE - $15,975

JOEL REICH - $25,845

PART I, QUESTIONS 5A, 5B, 6A AND 6B:

THE ECHN EXECUTIVE INCENTIVE COMPENSATION PLAN IS A PLAN THAT HAS BEEN DEVELOPED, REVIEWED AND IS ANNUALLY APPROVED BY MEMBERS OF THE BOARD EXECUTIVE COMPENSATION COMMITTEE WITH CONSULTANT THIRD PARTY OVERSIGHT.

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Part III Supplemental Information

Provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

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THE PLAN ESTABLISHES GOALS IN 4 AREAS OF PERFORMANCE: SYSTEM-WIDE FINANCIAL PERFORMANCE BASED ON PROFIT FROM OPERATIONS, TWO QUALITY OUTCOMES IN CLINICAL CORE MEASURES AND PATIENT SATISFACTION AND AN INDIVIDUAL GOAL (WHICH HAS A SEPARATE MEASUREMENT FOR TEAM ASSESSMENT) FOR EACH MEMBER OF THE INCENTIVE PROGRAM.

THERE IS NO EXECUTIVE COMPENSATION TIED TO THE REVENUES OF THE REPORTING ORGANIZATION OR OTHER RELATED ENTITIES. THERE IS EXECUTIVE COMPENSATION TIED TO THE NET EARNINGS (INCOME FROM OPERATIONS), AS NOTED IN THE PRIOR PARAGRAPH, HOWEVER IT IS ONE OF FOUR PERFORMANCE LEVERS THAT DETERMINE THE LEVEL OF COMPENSATION. THE AGGREGATE NET EARNINGS OF THE ECHN "SYSTEM" NOT ANY ONE REPORTING ORGANIZATION OR RELATED ENTITIES OF ECHN DETERMINE THIS COMPENSATION. SO TO CONCLUDE, THE ANSWER TO THESE 4 QUESTIONS IS "NO" WITH THE CLARIFICATION THAT IT IS THE PERFORMANCE OF THE ENTIRE SYSTEM AS A WHOLE THAT DETERMINES EXECUTIVE COMPENSATION, NOT ONE REPORTING ORGANIZATION OR A RELATED ENTITY.

Part III Supplemental Information

Provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

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MEMBERS OF THE INCENTIVE PROGRAM INCLUDE THE FOLLOWING:

POSITION TITLE - KEY EMPLOYEE NAME

PRESIDENT AND CEO - PETER J. KARL

SVP, CHIEF FINANCIAL OFFICER - MICHAEL D. VEILLETTE

SVP, HUMAN RESOURCES - DEBORAH GOGLIETTINO

SVP, STRATEGIC PLANNING - DENNIS MCCONVILLE

SVP, CHIEF CLINICAL OFFICER - DEBORAH PARKER

SVP, MEDICAL AFFAIRS - JOEL REICH, M.D.

VP QUALITY - LEONA CROSSKEY

MED. DIR. EMERGENCY DEPARTMENT - ROBERT CARROLL, M.D.

PART II

THE SALARY INFORMATION PROVIDED WITHIN SCHEDULE J

REPRESENTS CALENDAR YEAR 2013 WAGES AND BENEFITS. AS COMPARED TO THE

PRIOR YEAR RETURN, THE MAJOR CHANGES ARE:

THE LONG TERM RETENTION BENEFIT REACHED MATURITY UPON THE COMPLETION OF

THE FOUR YEAR VESTING PERIOD. THIS BENEFIT WAS PAID IN 2013 AND WAS

Part III Supplemental Information

Provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

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FOR VESTING YEARS ENDED 9/30/10, 9/30/11, 9/30/12 AND 9/30/13. THREE OF THE FOUR VESTED YEARS WERE REPORTED AS DEFERRED INCOME IN PRIOR RETURNS ON SCHEDULE J - LINE F (COMPENSATION REPORTED AS DEFERRED IN PRIOR FORM 990).

IN CALENDAR YEAR 2013 WE IMPLEMENTED A FURLOUGH PROGRAM WHICH MEANT THAT EXECUTIVES RECEIVED AN UNPAID WEEK OF VACATION. THIS APPROXIMATED A 2% PAY REDUCTION.

ANOTHER CHANGE TO PRIOR YEAR'S COMPENSATION IS THAT THE MONEY MATCH PROGRAM WAS REINSTATED IN CALENDAR YEAR 2013.

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SCHEDULE K (Form 990)
Department of the Treasury
Internal Revenue Service

Supplemental Information on Tax-Exempt Bonds

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.
▶ Attach to Form 990. ▶ See separate instructions. ▶ Information about Schedule K (Form 990) and its instructions is at www.irs.gov/form990.

OMB No. 1545-0047
2013
Open to Public Inspection

Name of the organization: ROCKVILLE GENERAL HOSPITAL

Employer identification number: 06-0653151

Part I Bond Issues

SEE PART VI FOR COLUMNS (A) AND (F) CONTINUATIONS

	(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pooled financing	
							Yes	No	Yes	No	Yes	No
A	STATE OF CONNECTICUT HEALTH & EDL FACS AUTH R	06-0806186	20774UAZ8	11/09/05	37579404.	ADVANCE REFUND AND DEFEASE A POR		X		X		X
B	STATE OF CONNECTICUT HEALTH & EDL FACS AUTH R	06-0806186	NONEAVAIL	05/14/09	15250000.	WOODLAKE EXPANSION, EQUIPM		X		X		X
C	STATE OF CONNECTICUT HEALTH & EDL FACS AUTH R	06-0806186	20774U5W1	12/21/10	20145000.	REDEEM PRIOR ISSUE AND FUND IN		X		X		X
D												

Part II Proceeds

		A	B	C	D
1	Amount of bonds retired				
2	Amount of bonds legally defeased				
3	Total proceeds of issue	37,579,404.	15,250,000.	20,145,000.	
4	Gross proceeds in reserve funds	3,556,957.		1,065,002.	
5	Capitalized interest from proceeds				
6	Proceeds in refunding escrows	32,759,288.	9,966,919.	17,048,821.	
7	Issuance costs from proceeds	632,013.	305,000.	402,900.	
8	Credit enhancement from proceeds	631,146.		92,225.	
9	Working capital expenditures from proceeds				
10	Capital expenditures from proceeds		4,978,081.		
11	Other spent proceeds			1,536,052.	
12	Other unspent proceeds				
13	Year of substantial completion	2006	2009	2011	
		Yes / No	Yes / No	Yes / No	Yes / No
14	Were the bonds issued as part of a current refunding issue?	No	Yes	Yes	
15	Were the bonds issued as part of an advance refunding issue?	Yes	No	No	
16	Has the final allocation of proceeds been made?	Yes	Yes	Yes	
17	Does the organization maintain adequate books and records to support the final allocation of proceeds?	Yes	Yes	Yes	

Part III Private Business Use

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
1	Was the organization a partner in a partnership, or a member of an LLC, which owned property financed by tax-exempt bonds?		X		X		X		
2	Are there any lease arrangements that may result in private business use of bond-financed property?		X		X		X		

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Part III Private Business Use *(Continued)*

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
3a Are there any management or service contracts that may result in private business use of bond-financed property?		X		X		X		
b If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?								
c Are there any research agreements that may result in private business use of bond-financed property?		X		X		X		
d If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?								
4 Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government ▶	.00 %		.00 %		.00 %			%
5 Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government ▶	.00 %		.00 %		.00 %			%
6 Total of lines 4 and 5	.00 %		.00 %		.00 %			%
7 Does the bond issue meet the private security or payment test?	X		X		X			
8a Has there been a sale or disposition of any of the bond-financed property to a non-governmental person other than a 501(c)(3) organization since the bonds were issued?		X		X		X		
b If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of	%		%		%			%
c If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2?								
9 Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1.141-12 and 1.145-2?		X		X		X		

Part IV Arbitrage

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
1 Has the issuer filed Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate?	X			X		X		
2 If "No" to line 1, did the following apply?								
a Rebate not due yet?				X	X			
b Exception to rebate?			X			X		
c No rebate due?				X		X		
If you checked "No rebate due" in line 2c, provide in Part VI the date the rebate computation was performed								
3 Is the bond issue a variable rate issue?		X	X		X			
4a Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?		X	X			X		
b Name of provider			TD BANK					
c Term of hedge			5.0000000					
d Was the hedge superintegrated?			X					
e Was the hedge terminated?			X					

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Part IV **Arbitrage** *(Continued)*

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
5a Were gross proceeds invested in a guaranteed investment contract (GIC)?		X		X		X		
b Name of provider								
c Term of GIC								
d Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied?								
6 Were any gross proceeds invested beyond an available temporary period?		X		X		X		
7 Has the organization established written procedures to monitor the requirements of section 148?	X		X		X			

Part V **Procedures To Undertake Corrective Action**

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
Has the organization established written procedures to ensure that violations of federal tax requirements are timely identified and corrected through the voluntary closing agreement program if self-remediation is not available under applicable regulations?	X		X		X			

Part VI **Supplemental Information.** Provide additional information for responses to questions on Schedule K (see instructions).

SCHEDULE K, PART I, BOND ISSUES:
(A) ISSUER NAME: STATE OF CONNECTICUT HEALTH & EDL FACS AUTH REV SERIES C
(F) DESCRIPTION OF PURPOSE:
ADVANCE REFUND AND DEFEASE A PORTION OF THE SERIES 2000A BONDS (C)

(A) ISSUER NAME: STATE OF CONNECTICUT HEALTH & EDL FACS AUTH REV SERIES D
(F) DESCRIPTION OF PURPOSE:
WOODLAKE EXPANSION, EQUIPMENT PURCHASE, REFUNDING PRIOR ISSUE (SER D)

(A) ISSUER NAME: STATE OF CONNECTICUT HEALTH & EDL FACS AUTH REV SERIES E
(F) DESCRIPTION OF PURPOSE:
REDEEM PRIOR ISSUE AND FUND INTEREST RATE SWAP TERMINATION PAYMENTS

SCHEDULE K, SUPPLEMENTAL INFORMATION:
DATE OF LAST ARBITRAGE REBATE CALCULATION:
SERIES C REBATE COMPUTATION WAS DONE 11/9/2010.

THE HEDGE SWAP ARRANGEMENT FOR THE SERIES D ISSUE WAS TERMINATED IN MAY 2014.

THE SERIES D ISSUE WAS REISSUED ON MAY 14, 2014 FOR $13,872,000. THIS REPRESENTED A REISSUANCE OF THE BONDS. NO PROCEEDS WERE REALIZED FROM THE DELIVERY OF THIS ISSUE.

SEE PART VI SUPPLEMENTAL INFORMATION SHEET

Part VI **Supplemental Information.** Provide additional information for responses to questions on Schedule K (see instructions) *(Continued)*

THE SERIES C BONDS WERE ISSUED AFTER 12/31/02 TO REFUND BONDS ISSUED BEFORE 1/1/03. AS A RESULT, LINES 1 - 9 OF PART III ARE NOT REQUIRED TO BE COMPLETED.

THE $1,536,052 ON LINE 11 COLUMN C REPRESENTS THE FEES TO TERMINATE THE HEDGES/SWAPS.

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Submitted October 13, 2015

SCHEDULE L (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Transactions With Interested Persons

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 25a, 25b, 26, 27, 28a, 28b, or 28c, or Form 990-EZ, Part V, line 38a or 40b.

▶ Attach to Form 990 or Form 990-EZ. ▶ See separate instructions.

▶ Information about Schedule L (Form 990 or 990-EZ) and its instructions is at *www.irs.gov/form990.*

OMB No. 1545-0047

2013

Open To Public Inspection

Name of the organization

ROCKVILLE GENERAL HOSPITAL

Employer identification number

06-0653151

Part I Excess Benefit Transactions (section 501(c)(3) and section 501(c)(4) organizations only).

Complete if the organization answered "Yes" on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b.

1 **(a)** Name of disqualified person	**(b)** Relationship between disqualified person and organization	**(c)** Description of transaction	**(d)** Corrected? Yes	No

2 Enter the amount of tax incurred by the organization managers or disqualified persons during the year under section 4958 ▶ $

3 Enter the amount of tax, if any, on line 2, above, reimbursed by the organization ▶ $

Part II Loans to and/or From Interested Persons.

Complete if the organization answered "Yes" on Form 990-EZ, Part V, line 38a or Form 990, Part IV, line 26; or if the organization reported an amount on Form 990, Part X, line 5, 6, or 22.

(a) Name of interested person	**(b)** Relationship with organization	**(c)** Purpose of loan	**(d)** Loan to or from the organization? To	From	**(e)** Original principal amount	**(f)** Balance due	**(g)** In default? Yes	No	**(h)** Approved by board or committee? Yes	No	**(i)** Written agreement? Yes	No
Total ▶ $												

Part III Grants or Assistance Benefiting Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 27.

(a) Name of interested person	**(b)** Relationship between interested person and the organization	**(c)** Amount of assistance	**(d)** Type of assistance	**(e)** Purpose of assistance

Part IV Business Transactions Involving Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 28a, 28b, or 28c.

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
DR. DENNIS O'NEILL & DR. M	SEE PART V	228,326.	SEE PART V		X
KATHLEEN O'NEILL	SEE PART V	0.	SEE PART V		X
ANTHONY DISTEFANO MD	SEE PART V	19,191.	SEE PART V		X
WILSON VEGA	SEE PART V	90,742.	SEE PART V		X

Part V Supplemental Information

Provide additional information for responses to questions on Schedule L (see instructions).

SCH L, PART IV, BUSINESS TRANSACTIONS INVOLVING INTERESTED PERSONS:

(A) NAME OF PERSON: DR. DENNIS O'NEILL & DR. MICHELE CONLON

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

SEE PART V SEE NOTE (1)

(C) AMOUNT OF TRANSACTION $ 228,326.

(D) DESCRIPTION OF TRANSACTION: SEE PART V

ECPC CONTRACTS WITH ECHN, INC. TO PROVIDE PATHOLOGY SERVICES AND LAB MANAGEMENT SERVICES TO MMH AND RGH. ALL PAYMENTS MADE TO ECPC ARE FOR PURPOSES OF OPERATING THE BUSINESS AND MAINTAINING OPERATING CASHFLOW; PAYMENTS ARE NOT DIRECTLY TO ANY OF THE OWNERS.

(E) SHARING OF ORGANIZATION REVENUES? = NO

(A) NAME OF PERSON: KATHLEEN O'NEILL

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

SEE PART V SEE NOTE (2)

(C) AMOUNT OF TRANSACTION $ -0-

(D) DESCRIPTION OF TRANSACTION: SEE PART V

(E) SHARING OF ORGANIZATION REVENUES? = NO

(A) NAME OF PERSON: ANTHONY DISTEFANO MD

Part V Supplemental Information

Complete this part to provide additional information for responses to questions on Schedule L (see instructions).

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

SEE PART V SEE NOTE (3)

(C) AMOUNT OF TRANSACTION $ 19,191.

(D) DESCRIPTION OF TRANSACTION: SEE PART V

SALARY PAID TO LIZANNE DISTEFANO AS AN EMPLOYEE OF RGH.

(E) SHARING OF ORGANIZATION REVENUES? = NO

(A) NAME OF PERSON: WILSON VEGA

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

SEE PART V SEE NOTE (4)

(C) AMOUNT OF TRANSACTION $ 90,742.

(D) DESCRIPTION OF TRANSACTION: SEE PART V

CBS CONTRACTS WITH ECHN, INC. TO PROVIDE COPIER SERVICES TO MMH AND RGH.

(E) SHARING OF ORGANIZATION REVENUES? = NO

SCHEDULE L, PART IV, COLUMN (B):

(1) RGH TRUSTEES EACH OWNING MORE THAN 5% OF EASTERN CONNECTICUT PATHOLOGY CONSULTANTS, PC (ECPC).

(2) RGH TRUSTEE AND THE WIFE OF DR. DENNIS O'NEILL, TRUSTEE FOR ALL AFFILIATES, WHO HAS A REPORTABLE TRANSACTION AS NOTED ABOVE.

(3) RGH TRUSTEE AND SPOUSE OF LIZANNE DISTEFANO, WHO IS EMPLOYED BY ROCKVILLE GENERAL HOSPITAL.

(4) FORMER RGH TRUSTEE AND PRESIDENT OF CONNECTICUT BUSINESS SYSTEMS (CBS).

Part V Supplemental Information

Complete this part to provide additional information for responses to questions on Schedule L (see instructions).

SCHEDULE L, PART IV, COLUMN (C):

LINE 1: PAYMENT OF $228,326 FROM RGH IS TO ECPC AND NOT DIRECTLY TO ANY OF THE OWNERS OF ECPC.

LINE 4: PAYMENT OF $90,742 FROM RGH TO CBS AND NOT DIRECTLY TO WILSON VEGA.

SCHEDULE O (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

Complete to provide information for responses to specific questions on Form 990 or 990-EZ or to provide any additional information.

▶ Attach to Form 990 or 990-EZ.

▶ Information about Schedule O (Form 990 or 990-EZ) and its instructions is at *www.irs.gov/form990*

OMB No. 1545-0047

2013

Open to Public Inspection

Name of the organization: ROCKVILLE GENERAL HOSPITAL

Employer identification number: 06-0653151

FORM 990, PART I, LINE 1, DESCRIPTION OF ORGANIZATION MISSION:

OF THE COMMMUNITY, INCLUDING THE INDIGENT AND UNDERSERVED.

FORM 990, PART III, LINE 4D, OTHER PROGRAM SERVICES:

SEE SCHEDULE H, PART VI

EXPENSES $ 29,355,424. INCLUDING GRANTS OF $ 0. REVENUE $ 36,809,421.

FORM 990, PART VI, SECTION A, LINE 2:

BOARD MEMBERS DENNIS O'NEILL AND MICHELE CONLON ARE BUSINESS

PARTNERS.

FORM 990, PART VI, SECTION A, LINE 6:

ECHN IS THE SOLE MEMBER OF THE ORGANIZATION.

FORM 990, PART VI, SECTION A, LINE 7A:

ECHN HAS THE AUTHORITY TO ELECT TRUSTEES AND OFFICERS AND

APPOINT COMMITTEE MEMBERS.

FORM 990, PART VI, SECTION A, LINE 7B:

ECHN HAS VARIOUS POWERS INCLUDING BUT NOT LIMITED TO:

APPROVING ALL OPERATING AND CAPITAL BUDGETS, CONTROLLING THE INVESTMENT OF FUNDS, LOCATION OF SERVICES, AGREEMENTS AND TRANSACTIONS, AFFILIATIONS, CHANGES, AMENDMENTS, OR RESTATEMENTS OF CERTIFICATES OF INCORPORATION AND BYLAWS, ADOPTING A SYSTEM-WIDE VISION AND STRATEGIC PLANS, AND APPROVING DEBT BORROWINGS.

Name of the organization: ROCKVILLE GENERAL HOSPITAL

Employer identification number: 06-0653151

FORM 990, PART VI, SECTION B, LINE 11:

PRIOR TO FILING THE 990, THE FOLLOWING STEPS ARE TAKEN: 1) THE ACCOUNTING MANAGER, TOGETHER WITH OTHER MEMBERS OF THE FINANCE DEPARTMENT, CONDUCT A REVIEW OF THE 990 ALONG WITH A REVIEW AND RECONCILIATION OF THE 990 TO THE AUDITED FINANCIAL STATEMENTS; 2) THE ACCOUNTING MANAGER CONDUCTS AN EXTENSIVE REVIEW AND DISCUSSION OF THE 990 WITH THE CPA FIRM THAT PREPARES THE RETURN; 3) AN ELECTRONIC COPY OF THE 990 IS MADE AVAILABLE TO THE AUDIT AND CORPORATE COMPLIANCE COMMITTEE OF THE BOARD OF TRUSTEES (THE GOVERNING BOARD), AND SENIOR MANAGEMENT OF THE ORGANIZATION, FOR REVIEW.

FORM 990, PART VI, SECTION B, LINE 12C:

ANNUALLY, THE CORPORATE COMPLIANCE/INTERNAL AUDIT DEPARTMENT PROVIDES TO OFFICERS, DIRECTORS, OR TRUSTEES AND KEY EMPLOYEES THE ORGANIZATION'S CONFLICT OF INTEREST POLICY AND DISCLOSURE STATEMENT. EACH INDIVIDUAL IS REQUIRED TO RETURN TO THE DEPARTMENT A SIGNED DOCUMENT, ACKNOWLEDGING RECEIPT OF THE POLICY AND DISCLOSURE STATEMENT AND DISCLOSE ANY INTERESTS THAT COULD GIVE RISE TO CONFLICTS. A SUMMARY OF THE DISCLOSURES IS SHARED WITH THE CHAIRMAN OF THE BOARD OF TRUSTEES AND WITH THE AUDIT AND CORPORATE COMPLIANCE COMMITTEE OF THE BOARD. INDIVIDUALS WHO ARE IDENTIFIED AS HAVING A CONFLICT OF INTEREST ARE PROHIBITED FROM PARTICIPATING IN THE GOVERNING BODIES' DELIBERATIONS AND DECISIONS RELATED TO THE TRANSACTION. THE RETURNED STATEMENTS ARE RETAINED BY THE CORPORATE COMPLIANCE/INTERNAL AUDIT DEPARTMENT.

FORM 990, PART VI, SECTION B, LINE 15:

THE COMPENSATION COMMITTEE TAKES THE FOLLOWING STEPS WITH AN INDEPENDENT COMPENSATION CONSULTANT (1) REVIEWS DATA RELATED TO CURRENT MARKET VALUES CONSISTENT FOR ORGANIZATION'S EXECUTIVES BY REVIEW OF

Name of the organization: ROCKVILLE GENERAL HOSPITAL
Employer identification number: 06-0653151

COMPENSATION LEVELS AND PLANS CONSISTENT WITH HOSPITALS AND HEALTH SYSTEMS OF COMPARABLE SIZE AND LOCATION; (2) COMPLETES A REVIEW OF DATA ON CURRENT AND FUTURE PLANS FOR THE ORGANIZATION, INCLUDING STRUCTURE AND JOB DESCRIPTIONS; (3) REVIEWS AND APPROVES AND RECOMMENDS SALARY RANGES FOR EACH POSITION, ALONG WITH RELATED BENEFITS; (4) REVIEWS AND APPROVES A TIERED EXECUTIVE STRUCTURE WITH APPROPRIATE INCENTIVE OPPORTUNITY, BENEFITS, AND COMPENSATION. THE LAST COMPENSATION REVIEW OCCURRED 12/18/2013.

FORM 990, PART VI, SECTION C, LINE 19:
THE ORGANIZATION, WILL, UPON REQUEST, ALLOW FOR REVIEW OF OUR GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY AND MOST RECENT AUDITED FINANCIAL STATEMENTS AT AN OFFICE OF THE ORGANIZATION.

FORM 990, PART XI, LINE 9, CHANGES IN NET ASSETS:

CHANGE IN BENEFICIAL INTEREST IN TRUSTS	-143,590.
PENSION AND POSTRETIREMENT RELATED ADJUSTMENTS	-1,072,107.
NET TRANSFER FROM/(TO) AFFILIATES	-2,111,991.
TOTAL TO FORM 990, PART XI, LINE 9	-3,327,688.

FORM 990, PART XI, LINE 2C:
THE ECHN AUDIT COMMITTEE ASSUMES RESPONSIBILITY FOR OVERSIGHT OF THE AUDIT OF ITS FINANCIAL STATEMENTS AND SELECTION OF AN INDEPENDENT ACCOUNTANT. THERE HAVE BEEN NO CHANGES IN THESE PROCESSES SINCE THE PRIOR YEAR.

SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

▶Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.

▶ Attach to Form 990. ▶ See separate instructions.

▶Information about Schedule R (Form 990) and its instructions is at www.irs.gov/form990.

OMB No. 1545-0047

2013

Open to Public Inspection

ECHN Proposed Asset Purchase by PMH
Submitted October 13, 2015

Name of the organization

ROCKVILLE GENERAL HOSPITAL

Employer identification number

06-0653151

Part I **Identification of Disregarded Entities** Complete if the organization answered "Yes" on Form 990, Part IV, line 33.

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity

Part II **Identification of Related Tax-Exempt Organizations** Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related tax-exempt organizations during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	(g) Section 512(b)(13) controlled entity? No
EASTERN CONNECTICUT HEALTH NETWORK, INC. - 22-2546079, 71 HAYNES STREET, MANCHESTER, CT 06040	INTERGRATED HEALTHCARE SYSTEM PARENT CO	CONNECTICUT	501(C)3	11C, TYPE III	N/A		X
MANCHESTER MEMORIAL HOSPITAL - 06-0646710 71 HAYNES STREET MANCHESTER, CT 06040	HOSPITAL	CONNECTICUT	501(C)3	3	ECHN	X	
ECHN COMMUNITY HEALTHCARE FOUNDATION, INC. - 22-2546080, 71 HAYNES STREET, MANCHESTER, CT 06040	FUNDRAISING/SUPPORT	CONNECTICUT	501(C)3	7	ECHN	X	
ECHN ELDERCARE SERVICES, INC - 06-1149193 26 SHENIPSIT LAKE ROAD TOLLAND, CT 06084	SKILLED NURSING FACILITY	CONNECTICUT	501(C)3	9	ECHN	X	

Page 2111

For Paperwork Reduction Act Notice, see the Instructions for Form 990. **Schedule R (Form 990) 2013**

Part II **Continuation of Identification of Related Tax-Exempt Organizations**

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled organization? Yes	(g) No
EASTERN CONNECTICUT MEDICAL PROFESSIONAL FOUNDATION, INC. - 22-2546079, 71 HAYNES STREET, MANCHESTER, CT 06040	PHYSICIAN SERVICES	CONNECTICUT	501(C)3	3	ECHN	X	
VISITING NURSE & HEALTH SERVICES OF CT, INC. - 06-0646795, 8 KEYNOTE DRIVE, VERNON, CT 06066	HOME HEALTHCARE SERVICES	CONNECTICUT	501(C)3	9	ECHN	X	

ECHN Proposed Asset Purchase by PMH
Submitted October 13, 2015

ECHN Proposed Asset Purchase by PMH
Submitted October 13, 2015

Part III **Identification of Related Organizations Taxable as a Partnership** Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related organizations treated as a partnership during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership
MEDICAL PRACTICE PARTNERS - 27-1498877, P.O. BOX 3830, VERNON, CT 06066	BILLING AND PRACTICE MANAGEMENT SERVICES	CT	N/A	N/A	N/A	N/A	N/A		N/A	N/A		N/A

Part IV **Identification of Related Organizations Taxable as a Corporation or Trust** Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related organizations treated as a corporation or trust during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity? Yes	(i) No
ECHN ENTERPRISES,INC - 22-2546828 71 HAYNES STREET MANCHESTER, CT 06040	REAL ESTATE HOLDING	CT	N/A	C CORP	N/A	N/A	N/A	X	
HAYNES STREET PROPERTY MANAGEMENT, LLC - 22-2546028, 71 HAYNES STREET, MANCHESTER, CT 06040	REAL ESTATE PROPERTY MANAGEMENT	CT	N/A	C CORP	N/A	N/A	N/A	X	
ECHN CORPORATE SERVICES - 27-1596320 71 HAYNES STREET MANCHESTER, CT 06040	BILLING AND OTHER PRACTICE MANAGEMENT SERVICES	CT	N/A	C CORP	N/A	N/A	N/A	X	
CONNECTICUT HEALTHCARE INSURANCE COMPANY - 98-0623043, PO BOX 1109, GRAND CAYMAN, CAYMAN ISLANDS	CAPTIVE INSURANCE	CAYMAN ISLANDS	N/A	C CORP	N/A	N/A	N/A	X	

Part V **Transactions With Related Organizations** Complete if the organization answered "Yes" on Form 990, Part IV, line 34, 35b, or 36.

ECHN Proposed Asset Purchase by PMH
Submitted October 13, 2015

Note. Complete line 1 if any entity is listed in Parts II, III, or IV of this schedule.

			Yes	No
1	During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?			
a	Receipt of **(i)** interest **(ii)** annuities **(iii)** royalties or **(iv)** rent from a controlled entity	1a		X
b	Gift, grant, or capital contribution to related organization(s)	1b		X
c	Gift, grant, or capital contribution from related organization(s)	1c		X
d	Loans or loan guarantees to or for related organization(s)	1d		X
e	Loans or loan guarantees by related organization(s)	1e		X
f	Dividends from related organization(s)	1f		X
g	Sale of assets to related organization(s)	1g		X
h	Purchase of assets from related organization(s)	1h		X
i	Exchange of assets with related organization(s)	1i		X
j	Lease of facilities, equipment, or other assets to related organization(s)	1j	X	
k	Lease of facilities, equipment, or other assets from related organization(s)	1k		X
l	Performance of services or membership or fundraising solicitations for related organization(s)	1l	X	
m	Performance of services or membership or fundraising solicitations by related organization(s)	1m	X	
n	Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)	1n		X
o	Sharing of paid employees with related organization(s)	1o		X
p	Reimbursement paid to related organization(s) for expenses	1p		X
q	Reimbursement paid by related organization(s) for expenses	1q	X	
r	Other transfer of cash or property to related organization(s)	1r	X	
s	Other transfer of cash or property from related organization(s)	1s		X

2 If the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered relationships and transaction thresholds.

	(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1)	EASTERN CT MEDICAL PROFESSIONALS FOUNDATION	J	65,532.	MARKET VALUE
(2)	ECHN COMMUNITY HEALTHCARE FOUNDATION, INC.	M	60,122.	COST
(3)	EASTERN CT HEALTH NETWORK	M	8,190,076.	COST
(4)	ECHN ELDERCARE SERVICES, INC.	Q	2,173,464.	CASH TRANSFER
(5)	ECHN COMMUNITY HEALTHCARE FOUNDATION, INC.	Q	68,527.	CASH TRANSFER
(6)	EASTERN CT MEDICAL PROFESSIONALS FOUNDATION	R	2,116,146.	CASH TRANSFER

ECHN Proposed Asset Purchase by PMH
Submitted October 13, 2015

Part VI **Unrelated Organizations Taxable as a Partnership** Complete if the organization answered "Yes" on Form 990, Part IV, line 37.

Provide the following information for each entity taxed as a partnership through which the organization conducted more than five percent of its activities (measured by total assets or gross revenue) that was not a related organization. See instructions regarding exclusion for certain investment partnerships.

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Predominant income (related, unrelated, excluded from tax under section 512-514)	(e) Are all partners sec. 501(c)(3) orgs.? Yes	(e) No	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership

Part VII Supplemental Information

Provide additional information for responses to questions on Schedule R (see instructions).

TAX RETURN FILING INSTRUCTIONS

FORM 990-T

FOR THE YEAR ENDING

SEPTEMBER 30, 2014

Prepared for	ROCKVILLE GENERAL HOSPITAL 31 UNION STREET ROCKVILLE, CT 06066
Prepared by	CROWE HORWATH, LLP 175 POWDER FOREST DRIVE SIMSBURY, CT 06089
Amount due or refund	NO AMOUNT IS DUE.
Make check payable to	NO AMOUNT IS DUE.
Mail tax return and check (if applicable) to	DEPARTMENT OF THE TREASURY INTERNAL REVENUE SERVICE CENTER OGDEN, UT 84201-0027
Return must be mailed on or before	AS SOON AS POSSIBLE.
Special Instructions	THE RETURN SHOULD BE SIGNED AND DATED.

300941
05-01-13

Form **990-T**

Exempt Organization Business Income Tax Return
(and proxy tax under section 6033(e))

For calendar year 2013 or other tax year beginning OCT 1, 2013 , and ending SEP 30, 2014 .

▶ **Information about Form 990-T and its instructions is available at** *www.irs.gov/form990t.*

▶ **Do not enter SSN numbers on this form as it may be made public if your organization is a 501(c)(3).**

OMB No. 1545-0687

2013

Open to Public Inspection for 501(c)(3) Organizations Only

Department of the Treasury
Internal Revenue Service

A ☐ Check box if address changed

B Exempt under section
☒ 501(c)(3)
☐ 408(e) ☐ 220(e)
☐ 408A ☐ 530(a)
☐ 529(a)

C Book value of all assets at end of year 74,786,945.

Print or Type

Name of organization (☐ Check box if name changed and see instructions.)
ROCKVILLE GENERAL HOSPITAL

Number, street, and room or suite no. If a P.O. box, see instructions.
31 UNION STREET

City or town, state or province, country, and ZIP or foreign postal code
ROCKVILLE, CT 06066

D Employer identification number (Employees' trust, see instructions.)
06-0653151

E Unrelated business activity codes (See instructions.)
621500

F Group exemption number (See instructions.) ▶

G Check organization type ▶ ☒ 501(c) corporation ☐ 501(c) trust ☐ 401(a) trust ☐ Other trust

H Describe the organization's primary unrelated business activity. ▶ NON-HOSPITAL LABORATORY SERVICES

I During the tax year, was the corporation a subsidiary in an affiliated group or a parent-subsidiary controlled group? ▶ ☒ Yes ☐ No

If "Yes," enter the name and identifying number of the parent corporation. ▶ SEE STATEMENT 2

J The books are in care of ▶ NICHOLAS JAMIESON Telephone number ▶ (860)646-1222

Part I Unrelated Trade or Business Income		(A) Income	(B) Expenses	(C) Net
1a Gross receipts or sales 2,130,155. b Less returns and allowances 1,495,705. c Balance ▶	1c	634,450.		
2 Cost of goods sold (Schedule A, line 7)	2			
3 Gross profit. Subtract line 2 from line 1c	3	634,450.		634,450.
4a Capital gain net income (attach Form 8949 and Schedule D)	4a			
b Net gain (loss) (Form 4797, Part II, line 17) (attach Form 4797)	4b			
c Capital loss deduction for trusts	4c			
5 Income (loss) from partnerships and S corporations (attach statement)	5			
6 Rent income (Schedule C)	6			
7 Unrelated debt-financed income (Schedule E)	7			
8 Interest, annuities, royalties, and rents from controlled organizations (Sch. F)	8			
9 Investment income of a section 501(c)(7), (9), or (17) organization (Schedule G)	9			
10 Exploited exempt activity income (Schedule I)	10			
11 Advertising income (Schedule J)	11			
12 Other income (See instructions; attach schedule.)	12			
13 **Total.** Combine lines 3 through 12	13	634,450.		634,450.

Part II Deductions Not Taken Elsewhere (See instructions for limitations on deductions.)
(Except for contributions, deductions must be directly connected with the unrelated business income.)

14 Compensation of officers, directors, and trustees (Schedule K)	14		
15 Salaries and wages	15		257,653.
16 Repairs and maintenance	16		
17 Bad debts	17		
18 Interest (attach schedule)	18		
19 Taxes and licenses	19		
20 Charitable contributions (See instructions for limitation rules.)	20		
21 Depreciation (attach Form 4562) 21			
22 Less depreciation claimed on Schedule A and elsewhere on return 22a	22b		
23 Depletion	23		
24 Contributions to deferred compensation plans	24		
25 Employee benefit programs	25		
26 Excess exempt expenses (Schedule I)	26		
27 Excess readership costs (Schedule J)	27		
28 Other deductions (attach schedule) SEE STATEMENT 1	28		232,922.
29 **Total deductions.** Add lines 14 through 28	29		490,575.
30 Unrelated business taxable income before net operating loss deduction. Subtract line 29 from line 13	30		143,875.
31 Net operating loss deduction (limited to the amount on line 30) SEE STATEMENT 3	31		143,875.
32 Unrelated business taxable income before specific deduction. Subtract line 31 from line 30	32		0.
33 Specific deduction (Generally $1,000, but see instructions for exceptions.)	33		
34 **Unrelated business taxable income.** Subtract line 33 from line 32. If line 33 is greater than line 32, enter the smaller of zero or line 32	34		0.

Part III Tax Computation

35	**Organizations Taxable as Corporations.** See instructions for tax computation. Controlled group members (sections 1561 and 1563) check here ▶ [X] **See instructions** and:		
a	Enter your share of the $50,000, $25,000, and $9,925,000 taxable income brackets (in that order): (1) $ 0. (2) $ 0. (3) $ 0.		
b	Enter organization's share of: **(1)** Additional 5% tax (not more than $11,750) $ 0. **(2)** Additional 3% tax (not more than $100,000) $ 0.		
c	Income tax on the amount on line 34 ▶	35c	0.
36	**Trusts Taxable at Trust Rates.** See instructions for tax computation. Income tax on the amount on line 34 from: [ ] Tax rate schedule or [ ] Schedule D (Form 1041) ▶	36	
37	**Proxy tax.** See instructions ▶	37	
38	Alternative minimum tax	38	
39	**Total.** Add lines 37 and 38 to line 35c or 36, whichever applies	39	0.

Part IV Tax and Payments

40a	Foreign tax credit (corporations attach Form 1118; trusts attach Form 1116)	40a			
b	Other credits (see instructions)	40b			
c	General business credit. Attach Form 3800	40c			
d	Credit for prior year minimum tax (attach Form 8801 or 8827)	40d			
e	**Total credits.** Add lines 40a through 40d			40e	
41	Subtract line 40e from line 39			41	0.
42	Other taxes. Check if from: [ ] Form 4255 [ ] Form 8611 [ ] Form 8697 [ ] Form 8866 [ ] Other (attach schedule)			42	
43	**Total tax.** Add lines 41 and 42			43	0.
44a	Payments: A 2012 overpayment credited to 2013	44a			
b	2013 estimated tax payments	44b			
c	Tax deposited with Form 8868	44c			
d	Foreign organizations: Tax paid or withheld at source (see instructions)	44d			
e	Backup withholding (see instructions)	44e			
f	Credit for small employer health insurance premiums (Attach Form 8941)	44f			
g	Other credits and payments: [ ] Form 2439 [ ] Form 4136 [ ] Other Total ▶	44g			
45	**Total payments.** Add lines 44a through 44g			45	
46	Estimated tax penalty (see instructions). Check if Form 2220 is attached ▶ [ ]			46	
47	**Tax due.** If line 45 is less than the total of lines 43 and 46, enter amount owed ▶			47	0.
48	**Overpayment.** If line 45 is larger than the total of lines 43 and 46, enter amount overpaid ▶			48	0.
49	Enter the amount of line 48 you want: **Credited to 2014 estimated tax** ▶ **Refunded** ▶			49	

Part V Statements Regarding Certain Activities and Other Information (see instructions)

		Yes	No
1	At any time during the 2013 calendar year, did the organization have an interest in or a signature or other authority over a financial account (bank, securities, or other) in a foreign country? If YES, the organization may have to file Form TD F 90-22.1, Report of Foreign Bank and Financial Accounts. If YES, enter the name of the foreign country here ▶		X
2	During the tax year, did the organization receive a distribution from, or was it the grantor of, or transferor to, a foreign trust? If YES, see instructions for other forms the organization may have to file.		X
3	Enter the amount of tax-exempt interest received or accrued during the tax year ▶ $		

Schedule A - Cost of Goods Sold. Enter method of inventory valuation ▶ N/A

1	Inventory at beginning of year	1		6	Inventory at end of year	6	
2	Purchases	2		7	**Cost of goods sold.** Subtract line 6 from line 5. Enter here and in Part I, line 2	7	
3	Cost of labor	3					
4a	Additional section 263A costs (att. schedule)	4a		8	Do the rules of section 263A (with respect to property produced or acquired for resale) apply to the organization?	Yes	No
b	Other costs (attach schedule)	4b					X
5	**Total.** Add lines 1 through 4b	5					

Sign Here

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

▶ Signature of officer | Date | ▶ CHIEF FINANCIAL OFFICER Title

May the IRS discuss this return with the preparer shown below (see instructions)? [X] Yes [ ] No

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check [ ] if self- employed	PTIN
BETH A. THURZ				P00346435

Firm's name ▶ CROWE HORWATH, LLP — Firm's EIN ▶ 35-0921680

Firm's address ▶ 175 POWDER FOREST DRIVE SIMSBURY, CT 06089 — Phone no. 860-678-9200

Schedule C - Rent Income (From Real Property and Personal Property Leased With Real Property) (see instructions)

1. Description of property

(1)
(2)
(3)
(4)

	2. Rent received or accrued		3(a) Deductions directly connected with the income in columns 2(a) and 2(b) (attach schedule)
	(a) From personal property (if the percentage of rent for personal property is more than 10% but not more than 50%)	(b) From real and personal property (if the percentage of rent for personal property exceeds 50% or if the rent is based on profit or income)	
(1)			
(2)			
(3)			
(4)			
Total	0.	0.	

(c) **Total income.** Add totals of columns 2(a) and 2(b). Enter here and on page 1, Part I, line 6, column (A) ▶ 0.

(b) **Total deductions.** Enter here and on page 1, Part I, line 6, column (B) ▶ 0.

Schedule E - Unrelated Debt-Financed Income (see instructions)

	1. Description of debt-financed property	2. Gross income from or allocable to debt-financed property	3. Deductions directly connected with or allocable to debt-financed property	
			(a) Straight line depreciation (attach schedule)	(b) Other deductions (attach schedule)
(1)				
(2)				
(3)				
(4)				

	4. Amount of average acquisition debt on or allocable to debt-financed property (attach schedule)	5. Average adjusted basis of or allocable to debt-financed property (attach schedule)	6. Column 4 divided by column 5	7. Gross income reportable (column 2 x column 6)	8. Allocable deductions (column 6 x total of columns 3(a) and 3(b))
(1)			%		
(2)			%		
(3)			%		
(4)			%		
				Enter here and on page 1, Part I, line 7, column (A).	Enter here and on page 1, Part I, line 7, column (B).
Totals ▶				0.	0.
Total dividends-received deductions included in column 8 ▶					0.

Schedule F - Interest, Annuities, Royalties, and Rents From Controlled Organizations (see instructions)

	1. Name of controlled organization	2. Employer identification number	Exempt Controlled Organizations 3. Net unrelated income (loss) (see instructions)	4. Total of specified payments made	5. Part of column 4 that is included in the controlling organization's gross income	6. Deductions directly connected with income in column 5
(1)						
(2)						
(3)						
(4)						

Nonexempt Controlled Organizations

	7. Taxable Income	8. Net unrelated income (loss) (see instructions)	9. Total of specified payments made	10. Part of column 9 that is included in the controlling organization's gross income	11. Deductions directly connected with income in column 10
(1)					
(2)					
(3)					
(4)					
				Add columns 5 and 10. Enter here and on page 1, Part I, line 8, column (A).	Add columns 6 and 11. Enter here and on page 1, Part I, line 8, column (B).
Totals ▶				0.	0.

Schedule G - Investment Income of a Section 501(c)(7), (9), or (17) Organization
(see instructions)

1. Description of income	2. Amount of income	3. Deductions directly connected (attach schedule)	4. Set-asides (attach schedule)	5. Total deductions and set-asides (col. 3 plus col. 4)
(1)				
(2)				
(3)				
(4)				
	Enter here and on page 1, Part I, line 9, column (A).			Enter here and on page 1, Part I, line 9, column (B).
Totals ▶	0.			0.

Schedule I - Exploited Exempt Activity Income, Other Than Advertising Income
(see instructions)

1. Description of exploited activity	2. Gross unrelated business income from trade or business	3. Expenses directly connected with production of unrelated business income	4. Net income (loss) from unrelated trade or business (column 2 minus column 3). If a gain, compute cols. 5 through 7.	5. Gross income from activity that is not unrelated business income	6. Expenses attributable to column 5	7. Excess exempt expenses (column 6 minus column 5, but not more than column 4).
(1)						
(2)						
(3)						
(4)						
	Enter here and on page 1, Part I, line 10, col. (A).	Enter here and on page 1, Part I, line 10, col. (B).				Enter here and on page 1, Part II, line 26.
Totals ▶	0.	0.				0.

Schedule J - Advertising Income (see instructions)

Part I Income From Periodicals Reported on a Consolidated Basis

1. Name of periodical	2. Gross advertising income	3. Direct advertising costs	4. Advertising gain or (loss) (col. 2 minus col. 3). If a gain, compute cols. 5 through 7.	5. Circulation income	6. Readership costs	7. Excess readership costs (column 6 minus column 5, but not more than column 4).
(1)						
(2)						
(3)						
(4)						
Totals (carry to Part II, line (5)) ▶	0.	0.				0.

Part II Income From Periodicals Reported on a Separate Basis (For each periodical listed in Part II, fill in columns 2 through 7 on a line-by-line basis.)

1. Name of periodical	2. Gross advertising income	3. Direct advertising costs	4. Advertising gain or (loss) (col. 2 minus col. 3). If a gain, compute cols. 5 through 7.	5. Circulation income	6. Readership costs	7. Excess readership costs (column 6 minus column 5, but not more than column 4).
(1)						
(2)						
(3)						
(4)						
Totals from Part I	0.	0.				0.
	Enter here and on page 1, Part I, line 11, col. (A).	Enter here and on page 1, Part I, line 11, col. (B).				Enter here and on page 1, Part II, line 27.
Totals, Part II (lines 1-5) ▶	0.	0.				0.

Schedule K - Compensation of Officers, Directors, and Trustees (see instructions)

1. Name	2. Title	3. Percent of time devoted to business	4. Compensation attributable to unrelated business
(1)		%	
(2)		%	
(3)		%	
(4)		%	
Total. Enter here and on page 1, Part II, line 14 ▶			0.

SCHEDULE O (Form 1120)
(Rev. December 2012)
Department of the Treasury
Internal Revenue Service

Consent Plan and Apportionment Schedule for a Controlled Group

▶ Attach to Form 1120, 1120-C, 1120-F, 1120-FSC, 1120-L, 1120-PC, 1120-REIT, or 1120-RIC.
▶ Information about Schedule O (Form 1120) and its instructions is available at www.irs.gov/form1120.

OMB No. 1545-0123

Name	Employer identification number
ROCKVILLE GENERAL HOSPITAL	06-0653151

Part I Apportionment Plan Information

1 Type of controlled group:
- **a** ☐ Parent-subsidiary group
- **b** ☒ Brother-sister group
- **c** ☐ Combined group
- **d** ☐ Life insurance companies only

2 This corporation has been a member of this group:
- **a** ☒ For the entire year.
- **b** ☐ From _____ , until _____ .

3 This corporation consents and represents to:
- **a** ☒ Adopt an apportionment plan. All the other members of this group are adopting an apportionment plan effective for the current tax year which ends on SEPTEMBER 30, 2014 , and for all succeeding tax years.
- **b** ☐ Amend the current apportionment plan. All the other members of this group are currently amending a previously adopted plan, which was in effect for the tax year ending _____ , and for all succeeding tax years.
- **c** ☐ Terminate the current apportionment plan and not adopt a new plan. All the other members of this group are not adopting an apportionment plan.
- **d** ☐ Terminate the current apportionment plan and adopt a new plan. All the other members of this group are adopting an apportionment plan effective for the current tax year which ends on _____ , and for all succeeding tax years.

4 If you checked box 3c or 3d above, check the applicable box below to indicate if the termination of the current apportionment plan was:
- **a** ☐ Elected by the component members of the group.
- **b** ☐ Required for the component members of the group.

5 If you did not check a box on line 3 above, check the applicable box below concerning the status of the group's apportionment plan (see instructions).
- **a** ☐ No apportionment plan is in effect and none is being adopted.
- **b** ☐ An apportionment plan is already in effect. It was adopted for the tax year ending _____ , and for all succeeding tax years.

6 If all the members of this group are adopting a plan or amending the current plan for a tax year after the due date (including extensions) of the tax return for this corporation, is there at least one year remaining on the statute of limitations from the date this corporation filed its amended return for such tax year for assessing any resulting deficiency? See instructions.
- **a** ☐ Yes.
  - (i) ☐ The statute of limitations for this year will expire on _____ .
  - (ii) ☐ On _____ , this corporation entered into an agreement with the Internal Revenue Service to extend the statute of limitations for purposes of assessment until _____ .
- **b** ☐ No. The members may not adopt or amend an apportionment plan.

7 Required information and elections for component members. Check the applicable box(es) (see instructions).
- **a** ☐ The corporation will determine its tax liability by applying the maximum tax rate imposed by section 11 to the entire amount of its taxable income.
- **b** ☐ The corporation and the other members of the group elect the FIFO method (rather than defaulting to the proportionate method) for allocating the additional taxes for the group imposed by section 11(b)(1).
- **c** ☐ The corporation has a short tax year that does not include December 31.

Part II **Taxable Income Apportionment** (See instructions)

Caution: Each total in Part II, column (g) for each component member must equal taxable income from Form 1120, page 1, line 30 or the comparable line of such member's tax return.

	(a) Group member's name and employer identification number		(b) Tax year end (Yr-Mo)	Taxable Income Amount Allocated to Each Bracket (c) 15%	(d) 25%	(e) 34%	(f) 35%	(g) **Total** (add columns (c) through (f))
1	ROCKVILLE GENERAL HOSPITAL	06-0653151	14-09	0.	0.	0.		0.
2	ECHN CORPORATE SERVICES, INC.	27-1596320	14-09	0.	0.	0.		0.
3	MANCHESTER MEMORIAL HOSPITAL	06-0646710	14-09	0.	0.	0.		0.
4	ECHN ENTERPRISES, INC. & SUBSIDIARY	22-2546828	04-09	0.	0.	0.		0.
5								
6								
7								
8								
9								
10								
11								
12								
Total								

ECHN Proposed Asset Purchase by MH
Submitted October 13, 2015

Part III **Income Tax Apportionment** (See instructions)

	(a) Group member's name	Income Tax Apportionment (b) 15%	(c) 25%	(d) 34%	(e) 35%	(f) 5%	(g) 3%	(h) Total income tax (combine lines (b) through (g))
1	ROCKVILLE GENERAL HOSPITAL	0.	0.	0.				
2	ECHN CORPORATE SERVICES, INC.	0.	0.	0.				
3	MANCHESTER MEMORIAL HOSPITAL	0.	0.	0.				
4	ECHN ENTERPRISES, INC. & SUBSIDIARY	0.	0.	0.				
5								
6								
7								
8								
9								
10								
11								
12								
Total								

ECHN Proposed Asset Purchase by MH
Submitted October 13, 2015

Part IV **Other Apportionments** (See instructions)

	(a) Group member's name	Other Apportionments (b) Accumulated earnings credit	(c) AMT exemption amount	(d) Phaseout of AMT exemption amount	(e) Penalty for failure to pay estimated tax	(f) Other
1	ROCKVILLE GENERAL HOSPITAL	0.	14,387.	53,576.	0.	0.
2	ECHN CORPORATE SERVICES, INC.	0.	9,550.	35,813.	0.	0.
3	MANCHESTER MEMORIAL HOSPITAL	0.	0.	0.	0.	0.
4	ECHN ENTERPRISES, INC. & SUBSIDIARY	0.	16,063.	60,611.	0.	0.
5						
6						
7						
8						
9						
10						
11						
12						
Total			40,000.	150,000.		

ECHN Proposed Asset Purchase by MH
Submitted October 13, 2015

ROCKVILLE GENERAL HOSPITAL 06-0653151

Statement of Consent to Apportionment Plan Under IRC Sec. 179(d)(6). As amended.

The undersigned corporations hereby consent to the following apportionment plan with respect to December 31, 2013 Under Internal Revenue Code Section 179(d)(6), as amended by P.L. 97-34, as it applies to tax years beginning after December 31, 1980.

Group Member's Name and Employer Identification Number		Tax Year End	Section 179 Apportionment	
			Cost of Property	Expensed Cost
1. ROCKVILLE GENERAL HOSPITAL	06-0653151	09/30/14	0.	0.
2. ECHN CORPORATE SERVICES, INC.	27-1596320	09/30/14	216,309.	500,000.
3. MANCHESTER MEMORIAL HOSPITAL	06-0646710	09/30/14	0.	0.
4. ECHN ENTERPRISES, INC. & SUBSIDIARY	22-2546828	09/30/04	0.	0.
5.				
6.				

The original of this election is filed with the Internal Revenue Service at: OGDEN, UT
together with the tax return of _____
filing for a taxable year including December 31. All other corporations are including a copy of this consent with their returns.

1. _____
(Name of corporation) By Title

2. _____
(Name of corporation) By Title

3. _____
(Name of corporation) By Title

4. _____
(Name of corporation) By Title

5. _____
(Name of corporation) By Title

6. _____
(Name of corporation) By Title

313781
05-01-13

Form **4626**
Department of the Treasury
Internal Revenue Service

Alternative Minimum Tax - Corporations

▶ Attach to the corporation's tax return.
▶ Information about Form 4626 and its separate instructions is at www.irs.gov/form4626.

OMB No. 1545-0175

2013

Name: ROCKVILLE GENERAL HOSPITAL

Employer identification number: 06-0653151

Note: See the instructions to find out if the corporation is a small corporation exempt from the alternative minimum tax (AMT) under section 55(e).

1	Taxable income or (loss) before net operating loss deduction			1	143,875.
2	**Adjustments and preferences:**				
a	Depreciation of post-1986 property			2a	
b	Amortization of certified pollution control facilities			2b	
c	Amortization of mining exploration and development costs			2c	
d	Amortization of circulation expenditures (personal holding companies only)			2d	
e	Adjusted gain or loss			2e	
f	Long-term contracts			2f	
g	Merchant marine capital construction funds			2g	
h	Section 833(b) deduction (Blue Cross, Blue Shield, and similar type organizations only)			2h	
i	Tax shelter farm activities (personal service corporations only)			2i	
j	Passive activities (closely held corporations and personal service corporations only)			2j	
k	Loss limitations			2k	
l	Depletion			2l	
m	Tax-exempt interest income from specified private activity bonds			2m	
n	Intangible drilling costs			2n	
o	Other adjustments and preferences			2o	
3	Pre-adjustment alternative minimum taxable income (AMTI). Combine lines 1 through 2o			3	143,875.
4	**Adjusted current earnings (ACE) adjustment:**				
a	ACE from line 10 of the ACE worksheet in the instructions	4a	143,875.		
b	Subtract line 3 from line 4a. If line 3 exceeds line 4a, enter the difference as a negative amount (see instructions)	4b	0.		
c	Multiply line 4b by 75% (.75). Enter the result as a positive amount	4c			
d	Enter the excess, if any, of the corporation's total increases in AMTI from prior year ACE adjustments over its total reductions in AMTI from prior year ACE adjustments (see instructions). **Note:** You **must** enter an amount on line 4d (even if line 4b is positive)	4d			
e	ACE adjustment. • If line 4b is zero or more, enter the amount from line 4c • If line 4b is less than zero, enter the **smaller** of line 4c or line 4d as a negative amount			4e	0.
5	Combine lines 3 and 4e. If zero or less, stop here; the corporation does not owe any AMT			5	143,875.
6	Alternative tax net operating loss deduction (see instructions) STATEMENT 4			6	129,488.
7	**Alternative minimum taxable income.** Subtract line 6 from line 5. If the corporation held a residual interest in a REMIC, see instructions			7	14,387.
8	**Exemption phase-out** (if line 7 is $310,000 or more, skip lines 8a and 8b and enter -0- on line 8c):				
a	Subtract $150,000 from line 7 (if completing this line for a member of a controlled group, see instructions). If zero or less, enter -0-	8a	0.		
b	Multiply line 8a by 25% (.25)	8b	0.		
c	Exemption. Subtract line 8b from $40,000 (if completing this line for a member of a controlled group, see instructions). If zero or less, enter -0-			8c	14,387.
9	Subtract line 8c from line 7. If zero or less, enter -0-			9	0.
10	Multiply line 9 by 20% (.20)			10	0.
11	Alternative minimum tax foreign tax credit (AMTFTC) (see instructions)			11	
12	Tentative minimum tax. Subtract line 11 from line 10			12	0.
13	Regular tax liability before applying all credits except the foreign tax credit			13	
14	**Alternative minimum tax.** Subtract line 13 from line 12. If zero or less, enter -0-. Enter here and on Form 1120, Schedule J, line 3, or the appropriate line of the corporation's income tax return			14	0.

JWA **For Paperwork Reduction Act Notice, see separate instructions.** Form **4626** (2013)

317001
11-26-13

Adjusted Current Earnings (ACE) Worksheet

▶ See ACE Worksheet Instructions.

1	Pre-adjustment AMTI. Enter the amount from line 3 of Form 4626				1	143,875.
2	ACE depreciation adjustment:					
a	AMT depreciation			2a		
b	ACE depreciation:					
	(1) Post-1993 property	2b(1)				
	(2) Post-1989, pre-1994 property	2b(2)				
	(3) Pre-1990 MACRS property	2b(3)				
	(4) Pre-1990 original ACRS property	2b(4)				
	(5) Property described in sections 168(f)(1) through (4)	2b(5)				
	(6) Other property	2b(6)				
	(7) Total ACE depreciation. Add lines 2b(1) through 2b(6)			2b(7)		
c	ACE depreciation adjustment. Subtract line 2b(7) from line 2a				2c	
3	Inclusion in ACE of items included in earnings and profits (E&P):					
a	Tax-exempt interest income			3a		
b	Death benefits from life insurance contracts			3b		
c	All other distributions from life insurance contracts (including surrenders)			3c		
d	Inside buildup of undistributed income in life insurance contracts			3d		
e	Other items (see Regulations sections 1.56(g)-1(c)(6)(iii) through (ix) for a partial list)			3e		
f	Total increase to ACE from inclusion in ACE of items included in E&P. Add lines 3a through 3e				3f	
4	Disallowance of items not deductible from E&P:					
a	Certain dividends received			4a		
b	Dividends paid on certain preferred stock of public utilities that are deductible under section 247			4b		
c	Dividends paid to an ESOP that are deductible under section 404(k)			4c		
d	Nonpatronage dividends that are paid and deductible under section 1382(c)			4d		
e	Other items (see Regulations sections 1.56(g)-1(d)(3)(i) and (ii) for a partial list)			4e		
f	Total increase to ACE because of disallowance of items not deductible from E&P. Add lines 4a through 4e				4f	
5	Other adjustments based on rules for figuring E&P:					
a	Intangible drilling costs			5a		
b	Circulation expenditures			5b		
c	Organizational expenditures			5c		
d	LIFO inventory adjustments			5d		
e	Installment sales			5e		
f	Total other E&P adjustments. Combine lines 5a through 5e				5f	
6	Disallowance of loss on exchange of debt pools				6	
7	Acquisition expenses of life insurance companies for qualified foreign contracts				7	
8	Depletion				8	
9	Basis adjustments in determining gain or loss from sale or exchange of pre-1994 property				9	
10	**Adjusted current earnings.** Combine lines 1, 2c, 3f, 4f, and 5f through 9. Enter the result here and on line 4a of Form 4626				10	143,875.

317021
05-01-13

FORM 990-T OTHER DEDUCTIONS STATEMENT 1

DESCRIPTION	AMOUNT
OUTSIDE LABS	8,543.
RED CROSS CHARGES	44,047.
SUPPLIES	162,222.
OTHER	18,110.
TOTAL TO FORM 990-T, PAGE 1, LINE 28	232,922.

FORM 990-T PARENT CORPORATION'S NAME AND IDENTIFYING NUMBER STATEMENT 2

CORPORATION'S NAME	IDENTIFYING NO
EASTERN CONNECTICUT HEALTH NETWORK, INC.	22-2546079

FORM 990-T NET OPERATING LOSS DEDUCTION STATEMENT 3

TAX YEAR	LOSS SUSTAINED	LOSS PREVIOUSLY APPLIED	LOSS REMAINING	AVAILABLE THIS YEAR
09/30/06	75,187.	75,187.	0.	0.
09/30/07	194,701.	114,719.	79,982.	79,982.
09/30/08	98,995.	0.	98,995.	98,995.
09/30/09	13,952.	0.	13,952.	13,952.
NOL CARRYOVER AVAILABLE THIS YEAR			192,929.	192,929.

FORM 4626 ALTERNATIVE MINIMUM TAX NOL DEDUCTION STATEMENT 4

TAX YEAR	LOSS SUSTAINED	LOSS PREVIOUSLY APPLIED	LOSS REMAINING
09/30/06	75,187.	75,187.	0.
09/30/07	194,701.	120,650.	74,051.
09/30/08	98,995.	0.	98,995.
09/30/09	13,952.	0.	13,952.
AMT NOL CARRYOVER AVAILABLE THIS YEAR			186,998.

Form 8868 (Rev. 1-2014) Page **2**

- If you are filing for an **Additional (Not Automatic) 3-Month Extension, complete only Part II** and check this box ▶ X

Note. Only complete Part II if you have already been granted an automatic 3-month extension on a previously filed Form 8868.

- If you are filing for an **Automatic 3-Month Extension, complete only Part I** (on page 1).

Part II **Additional (Not Automatic) 3-Month Extension of Time.** Only file the original (no copies needed).

Enter filer's identifying number, see instructions

Type or print File by the due date for filing your return. See instructions.	Name of exempt organization or other filer, see instructions.	Employer identification number (EIN) or
	ROCKVILLE GENERAL HOSPITAL	06-0653151
	Number, street, and room or suite no. If a P.O. box, see instructions.	Social security number (SSN)
	31 UNION STREET	
	City, town or post office, state, and ZIP code. For a foreign address, see instructions.	
	ROCKVILLE, CT 06066	

Enter the Return code for the return that this application is for (file a separate application for each return) 0 1

Application Is For	Return Code	Application Is For	Return Code
Form 990 or Form 990-EZ	01		
Form 990-BL	02	Form 1041-A	08
Form 4720 (individual)	03	Form 4720 (other than individual)	09
Form 990-PF	04	Form 5227	10
Form 990-T (sec. 401(a) or 408(a) trust)	05	Form 6069	11
Form 990-T (trust other than above)	06	Form 8870	12

STOP! Do not complete Part II if you were not already granted an automatic 3-month extension on a previously filed Form 8868.

- The books are in the care of ▶ NICHOLAS JAMIESON 320 MAIN STREET - MANCHESTER, CT 06040
  Telephone No. ▶ (860)646-1222 Fax No. ▶
- If the organization does not have an office or place of business in the United States, check this box ▶ ☐
- If this is for a Group Return, enter the organization's four digit Group Exemption Number (GEN) _____. If this is for the whole group, check this box ▶ ☐. If it is for part of the group, check this box ▶ ☐ and attach a list with the names and EINs of all members the extension is for.

4 I request an additional 3-month extension of time until AUGUST 15, 2015.

5 For calendar year _____, or other tax year beginning OCT 1, 2013, and ending SEP 30, 2014.

6 If the tax year entered in line 5 is for less than 12 months, check reason: ☐ Initial return ☐ Final return ☐ Change in accounting period

7 State in detail why you need the extension
ADDITIONAL TIME IS REQUIRED TO PREPARE A COMPLETE AND ACCURATE TAX RETURN, AND TO ALLOW ADEQUATE TIME FOR THE BOARD TO REVIEW PRIOR TO FILING.

8a	If this application is for Forms 990-BL, 990-PF, 990-T, 4720, or 6069, enter the tentative tax, less any nonrefundable credits. See instructions.	8a	$	0.
b	If this application is for Forms 990-PF, 990-T, 4720, or 6069, enter any refundable credits and estimated tax payments made. Include any prior year overpayment allowed as a credit and any amount paid previously with Form 8868.	8b	$	0.
c	**Balance due.** Subtract line 8b from line 8a. Include your payment with this form, if required, by using EFTPS (Electronic Federal Tax Payment System). See instructions.	8c	$	0.

Signature and Verification must be completed for Part II only.

Under penalties of perjury, I declare that I have examined this form, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete, and that I am authorized to prepare this form.

Signature ▶ Title ▶ CPA Date ▶

Form **8868** (Rev. 1-2014)

323842
12-31-13

TAX RETURN FILING INSTRUCTIONS

CONNECTICUT FORM CT-990T

FOR THE YEAR ENDING

SEPTEMBER 30, 2014

Prepared for	ROCKVILLE GENERAL HOSPITAL 31 UNION STREET ROCKVILLE, CT 06066
Prepared by	CROWE HORWATH, LLP 175 POWDER FOREST DRIVE SIMSBURY, CT 06089
Amount due or refund	NO PAYMENT REQUIRED
Make check payable to	NOT APPLICABLE
Mail tax return and check (if applicable) to	DEPARTMENT OF REVENUE SERVICES STATE OF CONNECTICUT PO BOX 5014 HARTFORD, CT 06102-5014
Return must be mailed on or before	PLEASE MAIL AS SOON AS POSSIBLE.
Special Instructions	THE RETURN SHOULD BE SIGNED AND DATED BY AN AUTHORIZED INDIVIDUAL.

300941
05-01-13

Department of Revenue Services
State of Connecticut
PO Box 5014
Hartford CT 06102-5014
(Rev. 12/13)

Form CT-990T
Connecticut Unrelated Business Income Tax Return

Page 2132 **2013**

Complete this return in blue or black ink only.

Enter Income Year Beginning ▶ OCTOBER 1 **, 2013, and Ending ▶** SEPTEMBER 30, 2014

Taxpayer (Please type or print)	Organization name *(please type or print)*	**CT Tax Registration Number**
	ROCKVILLE GENERAL HOSPITAL ▶	6701775-000
	Address Number and street PO Box	**DRS use only**
	31 UNION STREET ▶	- - 20
	City or town State ZIP code	**Federal Employer ID Number (FEIN)**
	ROCKVILLE, CT 06066 ▶	06-0653151

Check and Complete All Applicable Boxes If the organization is annualizing its income check here ▶ ☐

Change of: ☐ Mailing address ☐ Closing month (Attach explanation.) **Return status:** ☐ Amended return ☐ Initial return ☐ Final return

If final return: ☐ Dissolved ☐ Withdrawn ☐ Merged/reorganized: Enter survivor's CT Tax Reg. Number. _____

Type of organization: ▶ ☒ Corporation ▶ ☐ Domestic trust ▶ ☐ Foreign trust ▶ ☐ Other: Explain _____

1. Date unrelated trade or business began in Connecticut: _____
2. Nature of unrelated trade or business income activity: NON-HOSPITAL LABORATORY SERVICES
3. **Corporation only:** Enter state of incorporation: _____ Date of organization: _____

Date qualified in Connecticut if not incorporated in Connecticut:

- Attach a Complete Copy of Form 990-T Including all Schedules as Filed With the Internal Revenue Service -

Computation of Income

1. Federal unrelated business taxable income from 2013 federal Form 990-T, Part II, Line 34 ▶	1		00
2. Federal net operating loss deduction from 2013 federal Form 990-T, Part II, Line 31 ▶	2	143,875	00
3. Federal deduction for Connecticut tax on unrelated business taxable income ▶	3		00
4. **Total:** Add Lines 1, 2, and 3 ▶	4	143,875	00
5. Refund or credit for overpayment of Connecticut tax included in federal unrelated business taxable income ▶	5		00
6. Unrelated business taxable income: Subtract Line 5 from Line 4 ▶	6	143,875	00

Computation of Tax

1. Unrelated business taxable income from Line 6 above. **If 100% Connecticut, enter also on Line 3** ▶	1	143,875	00
2. Apportionment fraction from *Schedule A*, Line 5, page 2. Carry to six places ▶	2		
3. Connecticut unrelated business taxable income: Line 1 **or** Line 1 multiplied by Line 2 ▶	3	143,875	00
4. Operating loss carryover from *Schedule B*, Line 14 on page 2 ▶	4	143,875	00
5. Income subject to tax: Subtract Line 4 from Line 3 ▶	5		00
6. **Tax:** Multiply Line 5 by 7.5% (.075) ▶	6		00

Computation of Amount Payable

1. Tax: Include surtax if applicable. See instructions ▶	1		00
2. *Reserved for future use* ▶	2		
3. Total Tax: Enter the amount from Line 1 ▶	3		00
4. Tax credits from **Form CT-1120K**, Part III, Line 9. **Do not exceed amount on Line 1** ▶	4		00
5. Balance of tax payable: Subtract Line 4 from Line 3. If zero or less, enter "0." ▶	5	0	00
6a. Paid with application for extension from **Form CT-990T EXT** ▶	6a		00
6b. Paid with estimates from **Forms CT-990T ESA, ESB, ESC,** & **ESD** ▶	6b		00
6c. Overpayment from prior year ▶	6c		00
6. **Tax Payments:** Enter the total of Lines 6a, 6b, and 6c ▶	6		00
7. Balance of tax due (overpaid): Subtract Line 6 from Line 5 ▶	7	0	00
8. Add Penalty ▶ (8a) _____ Interest ▶ (8b) _____ **CT-1120I** Interest ▶ (8c) _____	8		00
9. Amount to be credited to 2014 estimated tax ▶ (9a) Refunded ▶ (9b)	9		00

For a faster refund, use Direct Deposit by completing Lines 9c, 9d, and 9e.

9c. Checking ▶ ☐ Savings ▶ ☐ 9d. Routing number ▶ _____

9e. Account number ▶ 9f. Will this refund go to a bank account outside the U.S.? ▶ ☐ Yes

10. **Balance due with this return:** Add Line 7 and Line 8 ▶	10	0	00

Visit the DRS website at **www.ct.gov/TSC** to pay electronically. www.ct.gov/DRS **TSC** Taxpayer Service Center

Mail to: Dept. of Revenue Services, State of Connecticut, PO Box 5014, Hartford CT 06102-5014

Make check payable to: Commissioner of Revenue Services

Declaration: I declare under penalty of law that I have examined this return (including any accompanying schedules and statements) and, to the best of my knowledge and belief, it is true, complete, and correct. I understand the penalty for willfully delivering a false return or document to the Department of Revenue Services (DRS) is a fine of not more than $5,000, imprisonment for not more than five years, or both. The declaration of a paid preparer other than the taxpayer is based on all information of which the preparer has any knowledge.

Sign Here	Name of officer or fiduciary *(print)*	Signature of officer or fiduciary	Date
	MICHAEL D. VEILLETTE		
	Officer's email address *(print)*		May DRS contact the preparer shown below about this return? See instructions. ☒ **Yes** ☐ **No**
Keep a copy of this return for your records.	Title: CHIEF FINANCIAL OFFICER	Telephone number: (860)646-1222	
	Paid preparer's signature	Date	Preparer's SSN or PTIN: P00346435
	Firm's name and address: CROWE HORWATH, LLP 175 POWDER FOREST DRIVE SIMSBURY, CT 06089	FEIN: 35-0921680	Telephone number: 860-678-9200

1019

341901 12-04-12

ECHN Proposed Asset Purchase by PMH
Submitted October 13, 2015

Schedule A - Unrelated Business Income Apportionment: See instructions.

Complete this schedule if the taxpayer's unrelated trade or business is conducted at a regular place of business outside Connecticut.

Factor	Item	Column A Connecticut		Column B Everywhere		Column C Divide Column A by Column B. Carry to six places
Property (Average value)	1. (a) Inventories		00		00	
	(b) Tangible property		00		00	
	(c) Real property		00		00	
	(d) Capitalized rent		00		00	
	1. Total		00		00	
Receipts	2. (a) Sales of tangibles		00		00	
	(b) Services		00		00	
	(c) Rentals		00		00	
	(d) Other		00		00	
	2. Total		00		00	
Wages, salaries, and other compensation	**3. Total**		00		00	
	4. **Total:** Add Lines 1, 2, and 3 in Column C.					
	5. Apportionment fraction: Divide Line 4 by number of factors used. Enter here; on *Schedule C*, Line 4; and also on front page, *Computation of Tax*, Line 2.					

Schedule B - Connecticut Apportioned Operating Loss Carryover Applied to 2013

1. 2000 Connecticut net operating loss available for use in 2013	1.		00
2. 2001 Connecticut net operating loss available for use in 2013	2.		00
3. 2002 Connecticut net operating loss available for use in 2013	3.		00
4. 2003 Connecticut net operating loss available for use in 2013	4.		00
5. 2004 Connecticut net operating loss available for use in 2013	5.		00
6. 2005 Connecticut net operating loss available for use in 2013	6.		00
7. 2006 Connecticut net operating loss available for use in 2013	7.	78,982	00
8. 2007 Connecticut net operating loss available for use in 2013	8.	97,995	00
9. 2008 Connecticut net operating loss available for use in 2013	9.	12,952	00
10. 2009 Connecticut net operating loss available for use in 2013	10.		00
11. 2010 Connecticut net operating loss available for use in 2013	11.		00
12. 2011 Connecticut net operating loss available for use in 2013	12.		00
13. 2012 Connecticut net operating loss available for use in 2013	13.		00
14. **Total:** Add Lines 1 through 13. Enter here and on *Computation of Tax*, Line 4	14.	189,929	00

Schedule C - Computation of Net Operating Loss Carryforward

1. Enter amount from *Computation of Income*, Line 6, if less than zero	1.		00
2. Add back specific deduction from 2013 federal Form 990-T, Part II, Line 33	2.		00
3. Subtotal: Add Line 1 and Line 2	3.		00
4. Apportionment fraction from *Schedule A*, Line 5	4.		
5. 2013 Connecticut net operating loss available for carryforward: Line 3 or Line 3 multiplied by Line 4	5.		00

EXHIBIT Q52-1 - COMMUNITY BUILDING ACTIVITIES DETAIL (2014)

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

	Activity Detail for FY 2014 (as reported on the 2013 Schedule H (for year ending 9/30/14)	Manchester Memorial Hospital	Rockville General Hospital
1	Physical improvements and housing	-	-
2	Economic development	1,543	706
	Tolland Chamber Board Participation	*1,399*	*706*
	Glastonbury Chamber Wellness Council Participation	*144*	
3	Community support	140,797	11,438
	Veteran's Day Ceremony, Veterans Dinner, etc.	*1,778*	*779*
	Emergency management and disaster preparedness drills and meetings-hurricaine drill, bed triage/patient overflow, active shooter drill, emergency supply, offsite drills	*5,330*	*10,407*
	Family Development Center Programs	*133,104*	
	Participation in Manchester Chamber of Commerce event and South Windsor Chamber of Commerce board meeting	*585*	*252*
4	Environmental improvements	-	-
5	Leadership development and training for community members	-	-
6	Coalition building	20,884	4,070
	Typical various levels of participation (representing Adolescent Behavioral Health) on the following boards/committees: **East of the River System of Care** (collaborative effort to coordinate adolescent behavioral health services to prevent system gaps that would prevent a child from obtaining the behavioral health services they need) **Vernon Public Schools** (meetings to examine what behavioral health services were available to the Vernon Public Schools either in their school in in collaboration with school services) **Vernon Community Network** (community workgroup that included Vernon social services and provided care to individuals of all ages) **System of Care** (Initiative to coordinate care of adolescents with extremely complex needs - objective was to facilitate dialogue between agencies to develop a community based plan that would support the patient) **Vernon Youth Meeting** (opportunity to share information on community-based behavioral health resources to support adolescents and their families with issues) **East Central Multidisciplinary Team** (Collaborative effort connecting law enforcement, mental health, medical, and DCF investigation processes intended to cause less harm to victims and minimizing re-victimization by having to go through their tragedy multiple times with these various entities) **Manchester Truancy Board** (participation on the now called Student Attendance Review Board - Collaboration with DCF, Juvenile Probation, Police, Mental Health, Local Agencies, Board of Education to address and offer various options for high-risk kids that are missing school) **Vernon Juvenile Review Board** (Diversion program to keep children and adolescents with low level arrests or citations who are referred to the Board out of the legal system) **Vernon Student Attendance Review Board** (collaboration with DCF, Juvenile Probation, Police, Mental Health, Local Agencies, Board of Education to address and offer various options for high-risk kids that are missing school)	*3,250*	
	Vernon School Readiness Council (council meetings, infant/toddler community practice meetings, Social-Emotional Peer Learning Pilot training)		*3,731*
	Community group participation (representing Emergency Services): *First Choice Health Centers, Inc. (Board Member and attendance at Performance Improvement meetings)*	*8,718*	
	Community group participation (representing MMH Trauma Center) on the following boards/committees: *Regional ED Standards* *Regional Medical Advisory Committee* *Regional MAC* *CT EMS Advisory Board* *EMS Clinical Coordinators* *CT EMS Education & Training* *Tolland Windham Mutual Aid*	*5,443*	

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

	Activity Detail for FY 2014 (as reported on the 2013 Schedule H (for year ending 9/30/14)	**Manchester Memorial Hospital**	**Rockville General Hospital**
	10 Steps to Successful Breast Feeding Collaborative	*1,862*	
	Manchester School Readiness Council-Council meetings and Health Team meetings	*816*	
	Represent ECHN on the Glastonbury Chamber of Commerce Wellness Council	*535*	
	Family Development Center Advisory Meeting Participation	*260*	*188*
	Health Fair Committee, Lifestyles Expo, Cancer Community Outreach		*151*
7	Community health improvement advocacy	5,472	2,376
	American Hospital Association Regional Policy Board participation	*5,472*	*2,376*
8	Workforce development	124,710	480
	Work training (helps patients find work in community following mental health episodes)	*115,766*	
	Legal department - work with interns and volunteers	*272*	
	Capital Community College Advisory Board Annual Meeting, MFRE Paramedic Interviews, Rockville High School mock interviews	*1,738*	
	Career Advancement Program (shadowing opportunities in the MMH ED for Manchester High School seniors interested in pursuing a career in healthcare)	*4,724*	
	Presentations to student interns about working in the Sleep Lab; intern rotations	*1,157*	
	Rockville High School mock interview days; Rockville High School School to Business Partnership meeting; orientation for parents of Allied Health Students; interviewing students and parent for Junior Volunteer summer program	*1,053*	*480*
9	Other	-	-
10	Total	293,406	19,070

EXHIBIT Q58-1 - PMH HOSPITAL ACQUISITIONS

Nix Health System

Texas San Antonio



- Nix Health System
  - Acute Care Hospital
  - Rural Acute Care Hospital
  - Psychiatric Hospital
  - Specialty Hospital
  - 19 Primary and Specialty Clinics
  - Medical Groups Under Development
  - Centers of Excellence:
    - Behavioral/ Psychiatric Center of Excellence
    - Orthopedic Surgery of Excellence
    - Bariatric Surgery Of Excellence





Record of Performance

Texas - Nix Health

- **Transaction completed on 2/1/12**
  - First Entry in Texas Market for Prospect Medical

- **Accomplishments Since Nix Acquisition**
  - Formed a Medical Group
  - Forming a Multi-Specialty IPA Integration with Behavioral Health
  - Expanded Behavioral Health services with addition of a 45 bed facility
  - Expanded Hospital-Based Outpatient Clinics
  - Purchase of Rural Hospital expanding the System
  - Converted Urgent Care Center to an Emergency Room
  - Entered into Risk Contracting with Major Insurers
  - Measurable Improvements in Quality Metrics

Prospect CharterCare Hospitals - RI



Our Lady of Fatima Hospital, a 278-bed acute care facility, is RI's only Catholic sponsored hospital providing an array of medical and surgical services.



Roger Williams Medical Center is a 220-bed acute care hospital and academic teaching and research affiliate of Boston University School of Medicine.



Elmhurst Extended Care is RI's only long-term facility affiliated with a hospital system and offers short-term, long-term and specialized elder care.



St. Joseph Health Center is a network of primary care programs and specialty services for underserved children and families.

Prospect CharterCare – Record of Performance



Entrance into Market

- Acquired system June 2014 (Two hospitals / Specialty Health Center / Nursing Home)

Project Commitments 2015 ($20M)

- Cancer Center
- Digestive Diseases Center
- Emergency Department
- Physician Practice Purchases

Proposed Service Lines

- OB
- Cardiac Cath



Model Implementation

- Quickly cleared regulatory hurdles to implement risk taking model
- Developed an IPA and recruited 105 PCPs / 270 specialists
- Negotiated risk contract with largest payer in state
- Medicare Select narrow network product with largest payer
- Went from 0 to 6,500 Medicare Advantage lives under population health management
- Grew from 20 to 81 providers
- $24M financial turnaround



What's Next – Road Ahead

- Coordinated Care Pilot Program accepted by State. Projected to carve costs out of State budget and generate savings to RI of $18M/3 years.
- A working model for Coordinated Care in the North East that can be used for further development
- Recognition by State's healthcare and political leaders for ability to transform the Healthcare Delivery Model

Bellflower and Tustin Hospitals

- **Transaction completed in May 2014**
  - Tustin Hospital - 177 Bed Facility
  - Bellflower - 80 Bed Facility

Both Hospitals had been closed for 1 year by the previous owner.

- **Accomplishments:**
  - Tustin:
    - Re-opening of Acute Care and Emergency Services.
    - Opened an Urgent Care
  - Bellflower:
    - Initial services include a 32 bed Behavioral unit.
    - Working with the community and local officials on a strategic plan for additional services.

Greer, Leslie

From: Martone, Kim
Sent: Tuesday, October 27, 2015 11:45 AM
To: Greer, Leslie
Cc: Lazarus, Steven; Riggott, Kaila; Roberts, Karen
Subject: FW: " Execs loot ECHN on eve of sale"

Leslie, this needs to be made part of the record for the CON application as public comment.

Kim

-----Original Message-----
From: Webmaster, DPH
Sent: Monday, October 26, 2015 3:09 PM
To: Martone, Kim
Subject: FW: " Execs loot ECHN on eve of sale"

The following inquiry came to us through the DPH Webmaster inbox:

-----Original Message-----
From: Don Tenerowicz [mailto:dtenerow@earthlink.net]
Sent: Saturday, October 24, 2015 1:48 PM
To: Attorney General <Attorney.General@ct.gov>; Harris, Jonathan <Jonathan.Harris@ct.gov>; Webmaster, DPH <Webmaster.DPH@ct.gov>; john.geragosian@cga.ct.gov; robert.ward@cga.ct.gov
Subject: " Execs loot ECHN on eve of sale"

TO: e-mail addresses listed above
Forward to Governor Malloy (could not find direct public e-mail address)

RE: Journal Inquirer Weekend
October 24-25 2016
Front Page: JI EXCLUSIVE
" Execs loot ECHN on eve of sale "

In the sale and Executive management of non-profit ECHN (Eastern Connecticut Health Network) to a for profit organization there needs to be State of CT oversight and approval of:

A. Executive salaries, bonus payments and other executive benefits. Specifically, what is the approval process by individual name and personal responsibility of executive financial benefits.

B. One time personal gains to be realized by the ECHN Executives as part of the sale to a for profit organization

C. In general, how will a for profit organization adhere to their commitment in the purchase of ECHN when a non-profit organization does not have the revenue to operate without a loss ?

Regards

Don Tenerowicz
Ellington CT

RECEIVED
APR - 4 2016
Office of
HEALTHCARE ACCESS

Kimberly Martone

Director of Operations

Office of Health Care Access

410 Capitol Avenue MS #13 HCA

P.O. Box 340308

Hartford, CT 06134-0308

Dear Ms. Martone,

I am writing in regards to the proposed sale of ECHN to Prospect Medical Holding

The present building was given to the town by a wealthy family. As such it is a legacy and has a special aura around it to people who live here. The employees live among us. They are our neighbors and friends. We know them, and they know us. This bond is special.

Over the years services have been cut and we keep hearing that the hospital is running in the red. At the same time, we have seen several expansions, and the enormous rise in Administrative compensation. Staffing has been cut, wages have not kept pace with inflation, yet the salaries of administrators and their perks have grown and grown. I know that the hospital has problems, but I believe that many of them are due to poor financial management and a series of awful decisions that have hurt the hospital and the community it serves.

The federal investigation into Prospect's hospitals in California is a real eye opener. The lapses are horrific yet the Prospect representatives seemed unmoved and felt that "we are addressing it" covered the matter. It doesn't. Perhaps being business men rather than medical people, they cannot appreciate the seriousness of these things. I could not trust this kind of operation to deliver my care.

Their presentation stressed the network of doctors for referral. We have that now. They also mentioned the Advisory Board that would recommend any needed changes. Where are the leaders who set policies and follow up on them? Where are the lines of authority? It sounds like chaos. These systems did not work at all in California. They also said that they would retain the present administrators even though these are the very people who ran the hospital into the ground.

I do not believe that community hospitals are dead. We have enough people in our area with enough healthcare needs to support RGH if it were prudently managed. An evaluation of needs would show that.

Yes, RGH has problems, but Prospect is not the answer.

Thank you for letting me have my say.

Sincerely,

Susan D. Loalbo

Susan D. Loalbo 5 Janet Lane Vernon, CT 06066

Greer, Leslie

From: Lazarus, Steven
Sent: Friday, October 30, 2015 2:38 PM
To: Matthews, Rebecca (RMatthews@wiggin.com) (RMatthews@wiggin.com); magsten@wiggin.com
Cc: Martone, Kim; Hansted, Kevin; Greer, Leslie; Cotto, Carmen
Subject: Re: DNs 15-32016-486 and 15-486-01 Completeness Letter Enclosed (Prospect/ECHN)

Dear Attorney Matthews,

Please see the attached copy of the Completeness Letter in the matter of the application regarding the proposed asset purchase of Eastern Connecticut Health Network Inc.'s by Prospect Medical Holdings, Inc., filed with the Office of the Attorney General (DN: 15-486-01) and the Office of Health Care Access (15-32016-486). If you have any questions, please do not hesitate to contact Gary Hawes (Office of the Attorney General's) at 860-808-5020 or gary.hawes@ct.gov or myself (see contact information below).

Sincerely,

Steve

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

STATE OF CONNECTICUT

OFFICE OF THE ATTORNEY GENERAL

DEPARTMENT OF PUBLIC HEALTH

GEORGE JEPSEN
ATTORNEY GENERAL

DR. JEWEL MULLEN
COMMISSIONER

October 30, 2015

VIA U.S. and ELECTRONIC MAIL
Jonathan Spees
Senior VP, Mergers and Acquisitions
Prospect Medical Holdings, Inc.
10780 Santa Monica Blvd., Suite 400
Los Angeles, CA 90025

Dennis P. McConville
Senior VP and Chief Strategy Officer
Eastern Connecticut Health Network, Inc.
71 Haynes Street
Manchester, CT 06040

Re: Eastern Connecticut Health Network, Inc. Proposed Asset Purchase by Prospect Medical Holdings, Inc.; OHCA Docket Number: 15-32016-486 and Attorney General Docket Number: 15-486-01

Dear Mr. Spees and Mr. McConville:

On October 13, 2015, the Application of Eastern Connecticut Health Network, Inc. ("ECHN"), including Manchester Memorial Hospital ("MMH") and Rockville General Hospital ("RGH"), and Prospect Medical Holdings, Inc. ("PMH") was filed with the Office of Health Care Access, Department of Public Health ("OHCA/DPH") and Office of the Attorney General ("OAG") for the transfer of substantially all of the assets of ECHN and its related affiliates to PMH or one or more of its affiliates.

The OAG and OHCA/DPH have determined that there are deficiencies in the Application that require clarification and/or additional production. Conn. Gen. Stat. § 19a-486a(d). Accordingly, please respond to the following questions and/or submit the following materials to the OAG and OHCA by December 29, 2015.

1. Page 23 of the Application and Section 2.05(b) of the proposed Asset Purchase Agreement ("APA") state that if ECHN obtains, prior to the Closing Date, an assumable loan in

an amount not to exceed $45 million to refinance certain of its outstanding bond liabilities (the "Refinancing Loan"), PMH will pay $115 million instead of $105 million for the assets of ECHN, subject to certain adjustments. The same section of the APA states that if ECHN obtains the Refinancing Loan and spends less than $10M on capital projects that could be counted toward the $75 million Commitment Amount under Section 5.18 of the APA, the purchase price of $115 million would be reduced by the difference between $10 million and the amount spent on such capital projects. With respect to these provisions, please answer the following:

a) Has ECHN obtained the Refinancing Loan and, if not, what is the status of its efforts in this regard and how likely is it that the Refinancing Loan will be obtained before the Closing Date?

b) If ECHN has obtained the Refinancing Loan, what is the loan amount, how much of the loan amount has been expended on capital projects as of the date of ECHN's response and what is the likelihood that $10 million of the new capital will be expended before the Closing Date?

c) Please provide detail on the improvements to ECHN's OB and Behavioral Health facilities that the $10 million is intended to be expended on.

2. Section 4 of the Letter of Intent ("LOI") states that the joint venture interests of ECHN subject to transfer to PMH, except for Metro Wheelchair Services, Inc., have been valued at a six (6) times multiple of FY2014 EBITDA.

a) Please explain how and why the parties determined the 6X multiple to be appropriate.

b) Please provide the aggregate value of the joint venture assets using this valuation method and the value ascribed to each individual joint venture asset under this methodology.

c) Please provide an update on the status of the transfer of these interests (e.g., for which joint ventures have the JV partners of ECHN agreed to a transfer if the asset purchase is consummated).

3. The LOI at Section 5 and the APA at Section 2.05(d) provide that if, on the Closing Date, ECHN has more than $77 million of liabilities under Scenario A (purchase price of $105 million) or $122 million of liabilities under Scenario B (purchase price of $115 million) other than long-term debt, PMH shall assume such excess liabilities provided it is reimbursed dollar-for-dollar by ECHN from its Available Cash (to the extent the Available Cash exceeds $1 million) and the $4.5 million Indemnity Reserve established under Section 9.8 of the APA. If the Indemnity Reserve is exhausted and there are still additional liabilities to assume, PMH will assume up to an additional $10 million of such liabilities and reduce its $75 million Commitment Amount by that amount. PMH also has the option to assume more than $10 million of ECHN's remaining debt and offset those additional amounts from the Commitment Amount. Please respond to the following questions regarding that option:

a) Do the figures in Table 8 of the Application (p. 88) reflect all liabilities of ECHN?

b) Did the parties consider a cap on reductions to the Commitment Amount?

c) If the answer to the above question is no, why was no such cap considered? If the answer is yes, why was no cap instituted?

4. Table 8 of the Application provides a net proceeds analysis of the funds payable to ECHN from the asset purchase. Please update the Assumed Liabilities and other line items of the table to reflect the net proceeds analysis under Scenarios A and B as of the date of your response to this Completeness Letter and confirm whether or not the line item for the underfunding of ECHN's pension plan will change between the date of your response and September 30, 2016. Please also:

a) Describe the cause and estimated amount of any other changes to the Assumed Liabilities line item amounts that may occur between the date of your response and the Closing Date.

b) Comment on the likelihood of the $75 Commitment Amount being substantially reduced under the terms of the APA given ECHN's unfunded pension liabilities, level of debt and declines in cash and cash equivalents as set forth in its FY 2014 financial statements and Table 8 of the Application.

c) If the $75 million Commitment Amount is substantially reduced by what means and under what timetable would the proposed capital projects described at page 31 of the Application be funded by PMH?

5. Please provide a copy of PMH's written response to the February 19, 2015 Request For Proposal set forth at Exhibit Q5 to the Application, including, without limitation, the responses to the questions and other items listed at pages 229 to 232 thereof from the Visions and Operations section to the section entitled Additional Information/Due Diligence Required .

6. The LOI provides in Section 9 that the parties agree to enter into a Consulting Agreement, to be effective 30 days after the parties have made any required Hart-Scott-Rodino Act filing, pursuant to which PMH "would provide operational support to ECHN's leadership." The parties also state that "ECHN agrees to reasonably consent to make recommended operational changes" pursuant to the Consulting Agreement. Please elaborate on the content and purpose of the Consulting Agreement by providing specific examples of the type of operational support that would be offered, the operational changes PMH is likely to make and provide a copy of the Consulting Agreement if one is available.

7. The Application at page 97 states that PMH will be seeking property and sales tax abatements post-closing for a transition period and that "such abatement is deemed critical to the overall success of the proposed transaction." In connection with these statements:

a) Please describe the length of the proposed transition period and the particulars of the abatement that will be sought.

b) Explain why the abatement is deemed critical to the overall success of the proposed transaction.

c) If PMH is unsuccessful in its negotiations for such an abatement, will there be any changes to the Commitment Amount or PMH's commitment, as noted on page 75, to ensure that MMH and RGH each maintains and adheres to ECHN's current policies regarding charity care, indigent care, community volunteer services and community benefits or adopts other policies that are at least as favorable to the community as ECHN's policies.

8. The LOI provides in Section 10 that Eastern Connecticut Physician Hospital Organization ("ECPHO") and Clinically Integrated Network of Eastern Connecticut ("CINECT") will enter into a 5-year management agreement with Coordinated Regional Care Group, Inc., a subsidiary of PMH, to implement PMH's Coordinated Regional Care ("CRC") strategy. Please provide the number of physicians currently participating in ECPHO and CINCET, respectively, describe any physician participation overlap between these two entities and detail the nature of the management services to be provided by the PMH subsidiary under the agreement. Also, provide a copy of the management agreement if available.

9. On page 26 of the Application, Applicants describe the CRC model as being "highly successful in aligning physicians with PMH hospitals and improving quality, efficiency and financial performance in California, and local versions of the model have been implemented in Texas and Rhode Island with similar success." The Application also states that the size of PMH's physician network in these three states encompasses approximately 8,900 physicians. With respect to these statements, please provide the following:

a) How many physicians participate in PMH's physician networks in California, Texas and Rhode Island, respectively?

b) Do the physician networks in each of these states operate as independent practice associations ("IPAs") that contract with a management services organization ("MSO") controlled by PMH or, if there are other models used, please describe the models and the states in which they are used.

c) How will the physician network that PMH seeks to establish in Connecticut differ from those developed in these other states?

d) For the CRC model developed for the Alta Los Angeles Hospitals in California, provide the number of physicians participating in PMH's physician network for each year from 2007 to present;

e) For the CRC model developed for the Southern California Healthcare System in California, provide the number of physicians participating in PMH's physician network for each year from 2009 to present;

f) For the CRC model developed for the Nix Health System in Texas, provide the . number of physicians participating in PMH's physician network for each year from 2012 to present; and

g) For the CRC model developed for the Prospect CharterCare Hospitals in Rhode Island, where applicants state in Exhibit Q58-1 that PMH developed an IPA and recruited 105 primary care physicians and 270 specialists, please state the number of physicians that were affiliated with these hospitals through IPAs or other physician organizations at the inception of the joint venture.

10. Elaborate on whether there is a standard CRC business plan that is used by PMH in the development of IPAs and what specific CRC policies, procedures and processes are implemented for recruiting purposes to reach target amounts of affiliated medical professionals.

11. PMH's prior hospital acquisitions in California, Texas and Rhode Island have been concentrated in high density urban markets. ECHN's service area population for 2020 is projected to be 356,046 residents. Explain how PMH's experience with the CRC model in high density urban markets will be adapted to a more rural market.

12. On page 76 of the Application and in Figure 3, Applicants indicate that from 2012 to 2014, in Texas and California, PMH reduced hospital bed days per thousand from 1,260 to 720, reduced length of stay from 5.1 days to 3.9 days, dropped admissions per thousand from 245 to 182 and reduced hospital readmissions within thirty days from 19% to 13% for Medicare Advantage participants. This data is provided as evidence of PMH's ability to operate its hospitals efficiently through the CRC model while avoiding unnecessary, inefficient and duplicative services and reducing medical errors. Using these same benchmarks (hospital bed days, length of stay, patient admissions and readmissions) please update Figure 3 to show whether similar reductions have been achieved across all patient populations for each of the healthcare systems owned by PMH in California and Texas over the past 3 years and for Prospect CharterCare Hospitals since 2014. Provide data and detailed explanations on the specific programs, policies and procedures under the CRC model that have been implemented in the PMH member hospitals to reduce hospital stays, admissions and medical errors.

13. On page 56 of the Application, Applicants state that "the transaction will allow ECHN the ability to adjust to a rapidly changing healthcare delivery environment and reinvest in itself to continuously improve care coordination, address continued improvement in quality and safety, expand and add needed services, recruit and retain physicians, and improve access to services across its service area." Please explain how implementation of the CRC model will facilitate the expansion and addition of needed services and improve access to services. Specifically focus on examples where PMH opened new outpatient facilities and developed new service lines for the hospitals it acquired in California, Rhode Island and Texas.

14. In reference to the "Local Board" as described on page 30 of the Application, please provide the following:

a) Elaborate on recommending authority of the respective Local Boards as described in Sections 5.18 (strategic capital plan), 5.21 (clinical quality matters), and 5.26 (strategic business plan) of the APA.

b) Please clarify how each respective Local Boards of MMH and RGH will function collaboratively in providing recommendations to PMH.

15. On page 66 of the Application, Applicants state that "PMH has already begun implementation efforts with respect to its CRC model for ECHN, including formation of an IPA and Board, review of regulatory requirements, discussions with payers and evaluation of the care delivery network." Please provide the following:

a) the status on the formation of the IPA and the Board;

b) the opportunities and impediments for utilizing the CRC model in Connecticut based on regulatory requirements;

c) the substance of discussions with payers; and

d) any reports on PMH's evaluation of the care delivery network.

16. On page 75 of the Application, Applicants disclose that "PMH and ECHN representatives have already met with leadership for Connecticut's Medicaid Program and expressed their desire to work under a risk-based arrangement to provide care to Medicaid recipients." Please provide an update on the status of these discussions. What impact, if any, would there be on the proposed asset purchase if Connecticut's Department of Social Services were to decide not to enter into risk-based arrangements with PMH?

17. In table format, provide historical volumes (three full fiscal years ("FY") and the current year-to-date) for the number of discharges and patient days, by service for MMH and RGH, respectively.

TABLE A
HISTORICAL AND CURRENT DISCHARGES

Service*	Actual Volume (Last 3 Completed FYs)			
	FY**	FY**	FY**	CFY***
Medical/Surgical Maternity Psychiatric Pediatric				
Total				

* Provide the number of discharges for each service listed (medical/Surgical, Maternity, Psychiatric, and Pediatric).

** Fill in years. In a footnote, identify the period covered by the Applicant's FY (e.g., July 1-June 30, calendar year, etc.).

*** For periods greater than 6 months, report annualized volume, identifying the number of actual months covered and the method of annualizing. For periods less than six months, report actual volume and identify the period covered.

TABLE B
HISTORICAL AND CURRENT PATIENT DAYS

Service*	Actual Volume (Last 3 Completed FYs)			
	FY**	FY**	FY**	CFY***
Medical/Surgical Maternity Psychiatric Pediatric				
Total				

* Provide the number of patient days for each service listed (medical/Surgical, Maternity, Psychiatric, and Pediatric).

** Fill in years. In a footnote, identify the period covered by the Applicant's FY (e.g., July 1- June 30, calendar year, etc.).

*** For periods greater than 6 months, report annualized volume, identifying the number of actual months covered and the method of annualizing. For periods less than six months, report actual volume and identify the period covered.

18. Complete the following tables for MMH and RGH, respectively, for the first three (full) fiscal years following the proposed asset purchase, if the first year is a partial year, include that as well.

TABLE C
PROJECTED DISCHARGES BY SERVICE

	Projected Volume			
Service*	FY**	FY**	FY**	FY**
Medical/Surgical Maternity Psychiatric Pediatric				
Total				

* Provide the number of discharges for each service listed (medical/Surgical, Maternity, Psychiatric, and Pediatric).

** If the first year of the proposal is only a partial year, provide the first partial year and then the first three full FYs. Add columns as necessary. In a footnote, identify the period covered by the Applicant's fiscal year FY (e.g., July 1- June 30, calendar year, etc.).

TABLE D
PROJECTED PATIENT DAYS BY SERVICE

Service*	Projected Volume			
	FY**	FY**	FY**	FY**
Medical/Surgical Maternity Psychiatric Pediatric				
Total				

* Provide the number of patient days for each service listed (medical/Surgical, Maternity, Psychiatric, and Pediatric).

** If the first year of the proposal is only a partial year, provide the first partial year and then the first three full FYs. Add columns as necessary. In a footnote, identify the period covered by the Applicant's fiscal year FY (e.g., July 1- June 30, calendar year, etc.).

a) Explain any increases and/or decreases in historical volumes reported in the tables above.

b) Provide a detailed explanation of all assumptions used in the derivation/calculation of the projected volume.

19. Please complete the following tables setting forth the number of physicians comprising Active and total members of the medical staffs (Active plus all other staff categories) for both MMH and RGH for the years listed below:

TABLE A
MMH

	2013	**2014**	**2015**
Active Staff			
Total Staff			

TABLE B
RGH

	2013	2014	2015
Active Staff			
Total Staff			

20. With respect to ECHN's Medical Foundation, please provide the number of physicians and other allied health professional participants for each year since the inception of the Foundation to the current year to date.

21. In accordance with the provisions of the Section 5.18 of the APA, PMH may direct some portion of the Commitment Amount to expenditures in support of the recruitment of the Hospitals' medical staff located in the Hospitals' Service Area. Please elaborate on the extent to which ECHN has had difficulty recruiting and/or maintaining medical staff in recent years and how and PMH's experience with the development of its CRC models of care in California, Texas and Rhode Island would demonstrate PMH's ability to effectively grow ECHN's physician network from the 39 community-based physicians and 16 allied health professionals reported to be currently employed by its medical foundation.

22. On page 70 of the Application, PMH and its affiliates commit to "continue support the CHNA [Community Health Needs Assessment] implementation plans [of ECHN] as they are rolled out through 2016." With respect to this statement, please respond to the following:

a) Please address whether PMH intends to conduct CHNAs after the closing and, if so, whether it intends to conduct them in a manner that meets the requirements of IRS Code Section 501(r), including conducting a CHNA at least once every three years and adopting an implementation strategy to address those identified needs.

b) Describe PMH's experience in conducting CHNAs subsequent to acquiring non-profit, tax-exempt hospitals, specifically, those hospitals located in California and Texas;

c) In 2013, MMH and RGH jointly conducted a CHNA. The CHNA identified four priority health needs including heart disease incidence, cancer incidence, diabetes incidence and arthritis incidence. Please provide, for years 2013 to present, the dates, locations, and number of free screenings ECHN conducted for the following:

i. Blood pressure screenings
ii. Cholesterol and/or body fat screenings
iii. Cancer screenings
iv. Diabetes glucose testing

d) On page 1783 of the Application, ECHN's CHNA identified additional priority needs, including addressing Alzheimer's, Multiple Sclerosis, substance abuse and childhood lead screening, that ECHN was not able to address due to limited resources. Please elaborate how PMH plans to address these additional identified areas of need.

23. Reference is made to the chart below concerning the amount of charity care provided by MMH and RGH from FY 2012 to FY 2014:

	FY 2012	FY 2013	FY 2014
MMH	$4,953,633	$3,908,882	$2,411,263
RGH	$2,192,753	$1,271,767	$1,188,543

* Source: OHCA Annual Report on the Financial Status of Connecticut's Short Term Acute Care Hospitals (Sept. 2015)

a) Please explain the reasons for the year over year declines in charity care provided by MMH and RGH.

b) Please provide the amount of charity care provided by each hospital for FY 2015.

c) Please describe how the proposed asset purchase with PMH can result in an increase in charity care provided by MMH and RGH, respectively, and cite to any examples from PMH's prior non-profit acute care hospital acquisitions where the amount of charity care (not total uncompensated care inclusive of bad debt) has increased from year to year post acquisition.

24. In reference to Table 9 at page 96 of the Application, Applicants identify $27,678 in community based clinical services and $412,862 in health care support services provided by MMH in FY 2014; in reference to Table 10 at page 97, Applicants identify $47,369 in health care support services provided by RGH in FY 2014; and, in reference to Table 11 at page 100, Applicants identify $140,797 and $124,710 in community support and workforce development expenditures by MMH in FY 2014. Please provide the following:

a) a breakout of the services and community building activities associated with each of these amounts;

b) details on the Early Head Start, Family Enrichment Services, Nurturing Families Network programs and the School-based Family Resources Centers' services provided by MMH's Family Development Center; and

c) details on the Workforce Development activities of MMH.

25. Applicants state that ECHN's present teaching arrangements with the University of New England College of Medicine for third year medical students, residents, and interns will be maintained. Please explain how these students, residents and interns are deployed within MMH, RGH and the towns served by ECHN to provide healthcare services and whether PMH plans any changes to how such medical students, residents, and interns are utilized.

26. On page 63 of the Application, Applicants cite that the "Rockville section of Vernon, where RGH is located, has been designated by the Health Resources and Services Administration as a Medically Underserved Population and the northwestern part of Mansfield has been designated as a Health Professional Shortage Area for Primary Medical Care. RGH, MMH and their System affiliates provide safety net services to this region of the State." Please explain specifically how the proposed transaction with PMH will continue to address the needs of these underserved areas by identifying those programs, services and collaborations with other community organizations that will continue post-closing and provide information on any plans for new programs, services and collaborations that will expand access to health care in these underserved areas.

27. With respect to Exhibits Q42-1, Q42-2 and Q44-1, please address the following:

a) Applicants project no change in Nurse Staff to Patient Ratios or the Average Weekly Hours for Ancillary Caregivers for three years following approval of the asset purchase. Reconcile how the asset purchase will achieve efficiencies and improve quality of care without corresponding adjustments to nurse to patient ratios and the hours of ancillary caregivers.

b) ECHN failed to meet budgeted targets for Average Nursing Hours per Patient Per Day in several categories yet no changes in Nursing Staff ratios for the first three years following approval of the asset purchase are projected. Explain why this is the case.

28. Please elaborate on the expected revenue growth for MMH and RGH associated with the use of the CRC model of care and provide specific examples from hospitals currently owned by PMH of actual savings realized post-acquisition in the various operating expense categories set forth in Financial Worksheet (C).

29. On page 78 of the Application, the Applicants indicate that "PMH has access to an existing corporate level credit facility in addition to its cash on hand." Name the credit facility, provide PMH's current credit rating and elaborate on the process associated with borrowing funds from this credit facility to fund any portion of the $75 million Commitment Amount in lieu of cash from MMH and RGH operations.

30. Elaborate on the financial feasibility to fund the $105 million (or $115 million) purchase price given PMH's declines in cash and cash equivalents, operating income, net income, and

realized deficits in Stockholder's equity from FY 2012 to 2014 reported in its FY 2014 audited financial statements as set forth at Exhibit Q8-1..

31. On page 907 of the Application, in PMH's Condensed Consolidated Statements of Operations, Applicants report significant growth in both Total Net Revenues and Total Operating Expenses for the nine months ending June 30, 2015 as compared to the same reporting period in 2014. Please explain the factors impacting these changes.

32. In reference to the priority capital projects identified by ECHN management on page 82 of the Application, provide their current estimated cost and, as applicable, the years beyond useful life for these assets.

33. With the understanding that the $75 million Commitment Amount has not been apportioned by hospital or other affiliates, please submit a preliminary capital investment plan that provides an approach on how PMH might distribute the $75 million by capital projects.

34. Provide an updated Exhibit Q8-2, providing PMH's FY 2015 unaudited financial statements to reflect twelve months of financial activity.

35. In reference to Financial Worksheet (C), Exhibit Q37, and the related Assumptions, at Exhibit Q38, for MMH, RGH and ECHN address the following:

a) Provide a revised Financial Worksheet (C) that will include projections of total revenue, expense and volume statistics without, incremental to and with the CON proposal for FYs 2015 and 2016. Provide the assumptions utilized in developing the projections and explain any projected losses from operations;

b) The Assumptions, listed under the other operating revenue section, indicate that joint venture income will increase 2% each year after FY 2016. Provide an itemized schedule of the other operating revenue amounts reported for FYs 2017, 2018 and 2019 without, incremental to and with the CON proposal, inclusive of joint venture income for all three entities; and

c) The Assumptions indicate that the asset purchase by PMH will allow MMH and RGH and their provider affiliates to benefit from economies of scale inherent of a large organization when purchasing supplies and services. In reference to this statement, explain the projected incremental increases in fringe benefits, supplies and drugs, and other expenses reported between FYs 2017 and 2019.

36. Please provide updated Financial Measurements/Indicators, Exhibit Q50-1, for the months of July, August and September 2015 and comparable months from the previous fiscal year for MMH and RGH, ECHN and PMH. Provide the methodology utilized to calculate the financial ratios on Sections A through C and an explanation for any decreases or increases that apply to any of the items listed on Section D between YTD FYs 2014 and 2015.

37. For each of PMH's five most recent acute care hospital acquisitions identified in Exhibit Q58-1 of the Application address the following:

a) Complete the following table:

Name	Total Capital Investments	Describe Improvements in Financial Performance			Total Cost Savings
		profits	liquidity	solvency	

b) Describe particular initiatives utilized to achieve the results described above;

c) Indicate how the financial performance improvements translated into lower health care costs; and

d) Indicate how the cost savings were due to economies of scale inherent of a larger organization; and

e) Since Exhibit Q58-1 contains no discussion of how these acquisitions improved the quality of health care for the hospital's service area, comment on each hospital's performance under the following CMS quality improvement programs since PMH first acquired the hospital (comparison to national, state and local performance standards as well as ECHN's current performance statistics is invited):

i. Hospital Inpatient Quality Reporting Program;
ii. Hospital Outpatient Quality Reporting Program;
iii. Hospital Value-Based Purchasing Program; and
iv. Hospital Readmissions Reduction Program.

38. On page 865 of the Application, PMH's FY 2014 audited financial statements, indicate that "*Patients without insurance are offered assistance in applying for Medicaid and other programs they may be eligible for, such as state disability. Patient advocates from the Company's Medical Eligibility Program ("MEP") screen patients in the Hospital and determine potential linkage to financial assistance programs. They also expedite the process of applying for these government programs.*" Elaborate on the MEP process and success record. Indicate whether this program will be available at MMH and RGH if the asset purchase is approved and consummated.

39. On page 92, Applicants were asked provide copies of the most recent CMS Statements of Deficiencies and Plans of Correction (CMS Form 2567) for all hospitals owned by PMH. Applicants provided only those statements pertaining to its Rhode Island hospitals. Please provide the requested information for PMH owned hospitals in Texas and California. Provide these documents in an electronic format only. PDF file on a CD to accompany the responses.

40. With respect to the proposed Asset Purchase Agreement, please provide the information contained in the following schedules: Schedule 2.01 (a) Owned Real Property; Schedule 2.01(b) Leased real property; Schedule 3.12 (c) Building Maintenance and Repairs; Schedule 3.12(g) Rent Roll; Schedule 3.12 Tenant Lease Encumbrances; Schedule 3.13(a) Environmental claims; Schedule 3.13 (b) Underground storage tanks and waste disposal; and Schedule 3.18 People in possession of owned property.

41. Please provide a full and complete listing of both owned and leased real property, including any real estate related to joint ventures.

42. With respect to Question 5, please provide any information and documents that are not attorney/client privileged or are protected by confidentiality agreements relating to any other offers to transfer assets or operations or change control of operations received by ECHN.

Please mail one (1) complete hard copy and one (1) complete electronic copy of the requested materials for approval to each of the following addresses:

Office of the Attorney General
55 Elm Street, P.O. Box 120
Hartford, Connecticut 06141-0120
Attn: Gary W. Hawes, AAG

Office of Health Care Access, Dept. of Public Health
410 Capitol Avenue
Hartford, Connecticut 06134
Attn: Steven W. Lazarus

After receipt of these requested materials, the OAG and OHCA shall review the submission to determine whether the application for approval is complete. If not, they shall provide written notice of any deficiencies within twenty (20) days of receipt of the information requested. Should you have any questions regarding these requests or any other issues relating to the Commissioner's and Attorney General's review, please do not hesitate to contact either Steven W. Lazarus at the Department of Public Health (860-418-7012; Steven.Lazarus@ct.gov) or Assistant Attorney General Gary W. Hawes at the Office of the Attorney General (860-808-5020; gary.hawes@ct.gov).

Very truly yours,

Gary W. Hawes
Assistant Attorney General
Office of the Attorney General

Very truly yours,

Kimberly Martone
Director of Operations
Office of Health Care Access

cc: Steven Lazarus (via electronic mail)
[Counsel of Record]

Greer, Leslie

From: Greer, Leslie
Sent: Thursday, November 12, 2015 3:52 PM
To: 'rmatthews@wiggin.com'; magsten@wiggin.com
Cc: Michele Volpe (mmv@bvmlaw.com); Lazarus, Steven; Cotto, Carmen; Riggott, Kaila; Hansted, Kevin; Martone, Kim; Hawes, Gary W.
Subject: DN: 15-32016-486 Additional Completeness Questions
Attachments: 32016-1.pdf

Attorney Matthews,
Please see the attached copy of additional Completeness Questions in the matter of the application regarding the proposed asset
purchase of Eastern Connecticut Health Network Inc.'s by Prospect Medical Holdings, Inc., filed with the Office of the Attorney General (DN: 15-486-01) and the Office of Health Care Access (15-32016-486). If you have any questions, please do not hesitate to contact Gary Hawes (Office of the Attorney General's) at (860)808-5020 gary.hawes@ct.gov or Steven Lazarus at (860) 418-7012 steven.lazarus@ct.gov

Sincerely,

Leslie M. Greer
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134
Phone: (860) 418-7013 Fax: (860) 418-7053
Website: www.ct.gov/ohca

STATE OF CONNECTICUT

OFFICE OF THE ATTORNEY GENERAL

DEPARTMENT OF PUBLIC HEALTH

GEORGE JEPSEN
ATTORNEY GENERAL

DR. JEWEL MULLEN
COMMISSIONER

November 12, 2015

VIA U.S. and ELECTRONIC MAIL
Jonathan Spees
Senior VP, Mergers and Acquisitions
Prospect Medical Holdings, Inc.
10780 Santa Monica Blvd., Suite 400
Los Angeles, CA 90025

Dennis P. McConville
Senior VP and Chief Strategy Officer
Eastern Connecticut Health Network, Inc.
71 Haynes Street
Manchester, CT 06040

Re: Eastern Connecticut Health Network, Inc. Proposed Asset Purchase by Prospect Medical Holdings, Inc.; OHCA Docket Number: 15-32016-486 and Attorney General Docket Number: 15-486-01

Dear Mr. Spees and Mr. McConville:

On October 13, 2015, the Application of Eastern Connecticut Health Network, Inc. ("ECHN"), including Manchester Memorial Hospital ("MMH") and Rockville General Hospital ("RGH"), and Prospect Medical Holdings, Inc. ("PMH") was filed with the Office of Health Care Access, Department of Public Health ("OHCA/DPH") and Office of the Attorney General ("OAG") for the transfer of substantially all of the assets of ECHN and its related affiliates to PMH or one or more of its affiliates.

On October 30, 2015, the OAG and OHCA/DPH determined that there were deficiencies in the Application that required clarification and/or additional production, and accordingly, send a list of additional questions to the Applicants. Conn. Gen. Stat. § 19a-486a(d).

Since October 30, 2015, our offices have heard reports that PMH may be up for sale. Initially, this information was reported on The Deal Pipeline's website on November 4, 2015 ("Prospect Medical Retains Morgan Stanley for a Sale"). We also saw a similar report on the

LBO Wire on November 5, 2015 ("Leonard Green Plans Sale of Prospect Medical Holdings"). Most recently, we saw a November 10, 2015, article in the Waterbury Republican that states that PMH is not for sale, but rather, is eyeing possible investors ("Prospect Sale 'Inaccurate' - Firm still Aims to Buy Waterbury Hospital").

Because PMH is the purchaser in the hospital conversion transaction presented to our offices for review, we have some additional questions for the Applicants.

1. Please confirm or deny the reports identified above and specifically explain the basis for the report.

2. Please describe Leonard Green & Partners and its present ownership stake and control of PMH.

3. If PMH is contemplating a sale, whether for a controlling or non-controlling interest in PMH, please explain the motivation and rationale for the sale.

4. If PMH is contemplating a sale, whether for a controlling or non-controlling interest in PMH, please explain the planned timeline for the sale.

5. If PMH is contemplating a sale, whether for a controlling or non-controlling interest in PMH, please explain the anticipated key terms and conditions of the sale.

6. If PMH is contemplating a sale, whether for a controlling or non-controlling interest in PMH, please explain how a sale would affect the planned acquisition of ECHN.

7. If PMH is contemplating a sale, whether for a controlling or non-controlling interest in PMH, please explain how the sale would affect the future operations of ECHN.

Please mail one (1) complete hard copy and one (1) complete electronic copy of the requested materials for approval to each of the following addresses:

Office of the Attorney General
55 Elm Street, P.O. Box 120
Hartford, Connecticut 06141-0120
Attn: Gary W. Hawes, AAG

Office of Health Care Access, Dept. of Public Health
410 Capitol Avenue
Hartford, Connecticut 06134
Attn: Steven W. Lazarus

Should you have any questions regarding these requests or any other issues relating to the Commissioner's and Attorney General's review, please do not hesitate to contact either Steven W. Lazarus at the Department of Public Health (860-418-7012; Steven.Lazarus@ct.gov) or Assistant Attorney General Gary W. Hawes at the Office of the Attorney General (860-808-5020; gary.hawes@ct.gov).

Very truly yours,

Gary W. Hawes
Assistant Attorney General
Office of the Attorney General

Very truly yours,

Kimberly Martone
Director of Operations
Office of Health Care Access

cc: Steven Lazarus (via electronic mail)
Counsel of Record

CERTIFICATE OF NEED

RESPONSE TO DEFICIENCIES DATED OCTOBER 30, 2015 AND NOVEMBER 12, 2015

Eastern Connecticut Health Network, Inc.
Proposed Asset Purchase by
Prospect Medical Holdings, Inc.

OHCA Docket Number: 15-31216-486
Attorney General Docket Number: 15-486-01

November 23, 2015

WIGGIN AND DANA

Counsellors at Law

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November 23, 2015

VIA HAND-DELIVERY

Office of the Attorney General
55 Elm Street
P.O. Box 120
Hartford, Connecticut 06141-0120
Attn: Gary W. Hawes, Assistant Attorney General

Office of Health Care Access
Department of Public Health
410 Capitol Avenue
Hartford, Connecticut 06134
Attn: Steven W. Lazarus, Health Care Analyst

Re: Eastern Connecticut Health Network, Inc.
Proposed Asset Purchase by Prospect Medical Holdings, Inc.
OHCA Docket Number: 15-31216-486
Attorney General Docket Number: 15-486-01

Dear Mr. Hawes and Mr. Lazarus:

Eastern Connecticut Health Network, Inc. and Prospect Medical Holdings, Inc. (the "Applicants") hereby submit the enclosed responses to the completeness questions issued by the Office of the Attorney General and the Office of Health Care Access in two separate letters to the Applicants: the first dated October 30, 2015 and the second dated November 12, 2015.

At your request, one (1) hard copy and one (1) electronic copy have been provided to each Office. Per the instructions in the letter dated October 30, 2015, the information requested in Question 39 of that letter has been provided only in electronic form.

If you have any questions or need anything further, please feel free to contact Rebecca Matthews at (203) 498-4502 or Melinda Agsten at (203) 498-4326. Thank you for your assistance in this matter.

Sincerely,

Wiggin and Dana LLP

By _____
Rebecca A. Matthews
Its Partner

By _____
Melinda A. Agsten
Its Partner

cc: Kevin Hansted, Staff Attorney, Department of Public Health Division of Office of Health Care Access
Kimberly Martone, Director of Operations, Department of Public Health Division of Office of Health Care Access
Perry Zinn Rowthorn, Deputy Attorney General, Office of the Attorney General
Dennis P. McConville, Senior Vice President and Chief Strategy Officer, Eastern Connecticut Health Network, Inc.
Thomas M. Reardon, President, Prospect Medical Holdings-East, Inc.
Frank Saidara, Vice President, Corporate Development, Prospect Medical Holdings, Inc.
Jonathan Spees, Senior Vice President, Corporate Development, Prospect Medical Holdings, Inc.
Joyce Tichy, Senior Vice President and General Counsel, Eastern Connecticut Health Network, Inc.
Michele M. Volpe, Esq., Bershtein, Volpe & McKeon, P.C

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On October 30, 2015 and November 12, 2015, Eastern Connecticut Health Network (□ECHN□) and Prospect Medical Holdings (□PMH□ and, together with ECHN, the □Applicants□) received correspondence from the Office of the Attorney General (□OAG□) and the Office of Health Care Access (□OHCA□) re□uesting additional clarification for certain deficiencies identified in the Application submitted on October 13, 2015. The Applicants□ response to the deficiencies identified on October 30, 2015 has been provided below; the Applicants□ response to the deficiencies identified on November 12, 2015 begins on page 2204:

1. Page 23 of the Application and Section 2.05(b) of the proposed Asset Purchase Agreement (□APA□) state that if ECHN obtains, prior to the Closing Date, an assumable loan in an amount not to exceed □45 million to refinance certain of its outstanding bond liabilities (the □Refinancing Loan□), PMH will pay □115 million instead of □105 million for the assets of ECHN, subject to certain adjustments. The same section of the APA states that if ECHN obtains the Refinancing Loan and spends less than □10M on capital projects that could be counted toward the □75 million Commitment Amount under Section 5.18 of the APA, the purchase price of □115 million would be reduced by the difference between □10 million and the amount spent on such capital projects. With respect to these provisions, please answer the following:

   a) Has ECHN obtained the Refinancing Loan and, if not, what is the status of its efforts in this regard and how likely is it that the Refinancing Loan will be obtained before the Closing Date□

      Response:

      ECHN has not obtained the Refinancing Loan. There are no plans to obtain the Refinancing Loan at this time, however ECHN reserves the right to pursue obtaining the proposed Refinancing Loan should the need arise prior to the Closing Date.

   b) If ECHN has obtained the Refinancing Loan, what is the loan amount, how much of the loan amount has been expended on capital projects as of the date of ECHN□s response and what is the likelihood that □10 million of the new capital will be expended before the Closing Date□

      Response:

      As stated in the response to Question 1a above, ECHN has not obtained the Refinancing Loan. ECHN is, however, seeking to secure a bank loan of □5 million to cover the cost of planned capital projects and, if received, expects to expend the full amount prior to the Closing Date. If the bank loan is secured, and the planned projects are completed prior to the closing, the purchase price will be

increased by $5 million to reflect the increased value of ECHN that will result from the investment in these planned capital projects and the Commitment Amount would be reduced by $5 Million. If the planned projects have not been completed by the time of the closing of the transaction, then an amount equal to $5 million minus the amount spent on such planned capital projects shall be transferred to PMH. In essence, PMH has agreed to pre-fund a portion of its Commitment Amount.

c) Please provide detail on the improvements to ECHN's OB and Behavioral Health facilities that the $10 million is intended to be expended on.

Response:

In February 2015, four physicians from Mansfield OB/GYN Associates joined the ECHN Medical staff and began performing deliveries at Manchester Memorial Hospital ("MMH"). The added demand for OB services increases the number of annual deliveries expected at MMH to 1,500 per year which has resulted in a need to add capacity to MMH's birthing center. To address this need, MMH has discussed a plan to add three labor delivery recovery and postpartum (LDRP) beds to the fifteen beds currently available. The addition of these LDRP beds will require the coordination of various relocations, including (i) the relocation of existing physician sleep rooms on the birthing unit to an adjacent area that will still provide the physicians with easy accessibility to the birthing center; and (ii) relocation of MMH's Health Information Management staff. The cost for the project has been estimated at $1.7 million. Although ECHN had initially planned to begin the project in the short term and to fund the project with proceeds from the planned Refinancing Loan, a decision has been made to further discuss the plans as part of the overall capital budget to be developed with PMH post-closing. In the meantime, ECHN will continue to utilize the Third West nursing unit as an obstetrics overflow to accommodate postpartum patients when demand for labor and delivery beds on the maternity unit is at or near the unit's capacity.

At Rockville General Hospital ("RGH"), designs have been developed to renovate the former maternity unit to accommodate up to 30 patients with behavioral health conditions. The cost of that project has been estimated to be $5 million. The Department of Public Health was consulted on the design in order to ensure that the unit would be compliant with current building codes to ensure the safety of this patient population. The unit will incorporate the finishes, hardware and security equipment recommended by the Department of Public Health. The renovations will begin in December and are expected to be completed by September 2016.

2. Section 4 of the Letter of Intent ("LOI") states that the joint venture interests of ECHN subject to transfer to PMH, except for Metro Wheelchair Services, Inc., have been valued at a six (6) times multiple of FY2014 EBITDA.

   a) Please explain how and why the parties determined the 6X multiple to be appropriate.

   Response:

   The parties determined the 6X multiple based on their substantial mergers and acquisitions industry experience, independent valuations of similar facilities at other PMH locations, and independent fair market valuations of the joint ventures which were completed by ECHN in 2014.

   b) Please provide the aggregate value of the joint venture assets using this valuation method and the value ascribed to each individual joint venture asset under this methodology.

   Response:

   Please refer to **Exhibit A** for a schedule showing the joint venture valuations as of September 30, 2014.

   c) Please provide an update on the status of the transfer of these interests (e.g., for which joint ventures have the JV partners of ECHN agreed to a transfer if the asset purchase is consummated).

   Response:

   The effort to obtain consents from joint venture partners to sell the joint venture interests of ECHN and its affiliates is ongoing. To date, consents have been obtained from Harford Hospital to permit the transfer of MMH's ownership interests in Ambulance Service of Manchester, LLC, Aetna Ambulance Service, Inc., and Metro Wheelchair Service, Inc.

   For the following joint ventures, meetings are being scheduled to formalize the consents requested by ECHN. Walden Behavioral Care has indicated its consent to the transfer of ECHN's membership in WBC East, LLC and this consent is in the process of being documented. The operating agreement for Evergreen

Endoscopy Center, LLC allows for ECHN to sell its membership in that company. The real estate joint venture members have consented to allow ECHN to sell its memberships in Haynes Street Medical Associates, LLC, Haynes Street Medical Associates II, LLC, Evergreen Medical Associates, LLC and Haynes Street Medical Associates II, LLC. The re□uest for consent to sell ECHN□s membership in Connecticut Occupational Partners, LLC (COMP) was raised at its recent Board Meeting and action will be taken at its next meeting.

Meetings for the member representatives of Northeast Regional Radiation Oncology Network, Inc. and the member representatives of Tolland Imaging Center, LLC have been scheduled to decide on the transfer of ownership interests of MMH and RGH in those companies.

3. The LOI at Section 5 and the APA at Section 2.05(d) provide that if, on the Closing Date, ECHN has more than □77 million of liabilities under Scenario A (purchase price of □105 million) or □122 million of liabilities under Scenario B (purchase price of □115 million) other than long-term debt, PMH shall assume such excess liabilities provided it is reimbursed dollar-for-dollar by ECHN from its Available Cash (to the extent the Available Cash exceeds □1 million) and the □4.5 million Indemnity Reserve established under Section 9.8 of the APA. If the Indemnity Reserve is exhausted and there are still additional liabilities to assume, PMH will assume up to an additional □10 million of such liabilities and reduce its □75 million Commitment Amount by that amount. PMH also has the option to assume more than □10 million of ECHN□s remaining debt and offset those additional amounts from the Commitment Amount. Please respond to the following □uestions regarding that option:

   a) Do the figures in Table 8 of the Application (p. 88) reflect all liabilities of ECHN□

      Response:

      The figures presented in Table 8 of the Application reflect both the liabilities to be assumed by PMH and the long-term debt liabilities to be paid off by ECHN at closing. ECHN may be left with some additional liabilities that are not paid at closing, including, for example, liabilities from prior Medicare and Medicaid cost reports. Because these liabilities are not known and are not being assumed by PMH, they are not reflected in the figures in Table 8.

   b) Did the parties consider a cap on reductions to the Commitment Amount□

Response:

It should be noted that if ECHN does not have sufficient cash to discharge all of its liabilities, ECHN will not be in a position to close the transaction. The parties conducted a forecast of cash at closing. Although the parties anticipate sufficient cash to enable ECHN to close, there is a possibility that ECHN will not have sufficient cash at time of the closing if there is a deterioration of ECHN's financial performance during the Certificate of Need and for-profit conversion process. As such the parties discussed and negotiated various alternatives to enable ECHN to close in the event that it did not have sufficient cash. A cap on the reductions to the Commitment Amount was discussed.

c) If the answer to the above question is no, why was no such cap considered? If the answer is yes, why was no cap instituted?

Response:

The Commitment Amount is part of the consideration and the purchase price for the assets of ECHN as described in the APA. Furthermore, any increase in the amount of liabilities assumed by PMH is considered an increase in the consideration and the purchase price for ECHN's assets.

After good faith negotiations between the parties, PMH agreed to increase the purchase price for the assets by $10 million in the event that ECHN does not have sufficient cash to close the transaction, which increase would be offset by a corresponding reduction in the Commitment Amount. This concession by PMH is significant because PMH essentially agreed to pay more for the assets of ECHN in the event that ECHN underperforms on its operations. In essence, PMH has agreed to potentially pay more for assets that would be worth less because of a deteriorating financial condition of ECHN. From an enterprise value perspective, and without taking the Commitment Amount into account, the purchase price offered by PMH exceeds the high value determined by Duff & Phelps by $32 million. If the Commitment Amount is taken into account, the total consideration exceeds the high enterprise value by $107 million. In the event that ECHN's operations deteriorate and, assuming that the enterprise value of ECHN does not change, PMH may potentially pay $42 million above ECHN's value (without taking the Commitment Amount into account). It is only due to an increase in purchase price and the exhaustion of all other sources of cash that the Commitment Amount may be reduced.

It should be noted that PMH views the Commitment Amount as the minimum that it would spend for capital expenditures at ECHN. If there is a need to spend more

on such projects that will contribute to ECHN's growth, PMH plans to make such additional capital investments.

4. Table 8 of the Application provides a net proceeds analysis of the funds payable to ECHN from the asset purchase. Please update the Assumed Liabilities and other line items of the table to reflect the net proceeds analysis under Scenarios A and B as of the date of your response to this Completeness Letter and confirm whether or not the line item for the underfunding of ECHN's pension plan will change between the date of your response and September 30, 2016. Please also:

Response:

An update of the Net Proceeds Analysis (Table 8), including the Assumed Liabilities and other line items, has been provided as **Exhibit B**.

With regard to the pension plan, the Applicants cannot determine at this time if the amount underfunded will increase or decrease between the date of the Applicants' response and September 30, 2016. This is primarily driven by the interest rate market which the Applicants are not able to predict.

a) Describe the cause and estimated amount of any other changes to the Assumed Liabilities line item amounts that may occur between the date of your response and the Closing Date.

Response:

The line items that ECHN expects to change between now and the Closing Date are Capital Leases and Long Term Debt. The budget for fiscal year 2016 has no provision for new debt (although the $5 million loan discussed in the response to Question 1 has been included in the estimates in Table 8 "Scenario B" already) nor does ECHN plan to incur new Capital Lease Obligations over the next fiscal year. ECHN plans to pay down the existing Capital Lease Obligations and Long Term Debt, so the expectation is to have the Capital Leases and Long Term Debt line items decrease between now and the Closing as outstanding principal payments are applied. The other line items to track are the net working capital "true-up" and cash and investments. When one increases the other is expected to decrease and vice versa, however the net of two should remain fairly consistent through the next year as ECHN manages to cash flow neutral. A reliable estimate of any changes to the captive and workers compensation programs is not feasible at this time, but the Applicants do not expect any material change in the amounts projected for these line items.

b) Comment on the likelihood of the $75 million Commitment Amount being substantially reduced under the terms of the APA given ECHN's unfunded pension liabilities, level of debt and declines in cash and cash equivalents as set forth in its FY 2014 financial statements and Table 8 of the Application.

Response:

It is difficult to forecast whether the pension underfunding amount will increase or decrease, but ECHN estimates that the amount of variation from what has been presented in Table 8 is not expected to change materially. In addition, ECHN FY 2016 budget does not include new debt and thus debt (both assumed and paid down at closing) will decrease. If any new debt is incurred, it will be debt that PMH is assuming and also adjusting the price accordingly. Finally, cash flow is budgeted to be neutral in FY 2016. Based on each of these different assumptions and projections, there would be no reduction to the capital commitment as there would be sufficient cash to pay down the outstanding debt not assumed.

c) If the $75 million Commitment Amount is substantially reduced by what means and under what timetable would the proposed capital projects described at page 31 of the Application be funded by PMH?

Response:

The capital projects described on page 31 of the Application are examples of capital projects that may be funded by PMH. After closing, PMH will develop a specific capital plan in consultation with the Local Boards and medical staff. This plan will prioritize capital projects and service improvements given the capital funding available. The goal will be to establish priorities based on maintaining or providing access to needed services that allow for the optimum care and coordination of care within and across the community. The plan and priorities will be evaluated periodically by PMH, and adjustments made based on changes in funding available and capital needs, with input from the Local Board and medical staff.

5. Please provide a copy of PMH's written response to the February 19, 2015 Request For Proposal set forth at Exhibit Q5 to the Application, including, without limitation, the responses to the questions and other items listed at pages 229 to 232 thereof from the Visions

and Operations section to the section entitled Additional Information Due Diligence Required.

Response:

Please refer **Exhibit C** for a copy of PMH's written response to the February 19, 2015 Request for Proposal.

6. The LOI provides in Section 9 that the parties agree to enter into a Consulting Agreement, to be effective 30 days after the parties have made any required Hart-Scott-Rodino Act filing, pursuant to which PMH "would provide operational support to ECHN's leadership." The parties also state that "ECHN agrees to reasonably consent to make recommended operational changes" pursuant to the Consulting Agreement. Please elaborate on the content and purpose of the Consulting Agreement by providing specific examples of the type of operational support that would be offered, the operational changes PMH is likely to make and provide a copy of the Consulting Agreement if one is available.

Response:

Attached as **Exhibit D** is a draft copy of the proposed Consulting Agreement. The purpose of the Consulting Agreement is to provide additional support to ECHN's management team to improve its operations and to prepare ECHN to implement PMH's Coordinated Regional Care strategy ("CRC"). For a complete description of support services, please refer to the Consulting Agreement. Please note that the Consulting Agreement has not yet commenced.

Under the terms of the Consulting Agreement, ECHN's Board and management will retain full authority over the operations of ECHN prior to Closing, and PMH will not have authority to make any operational changes during that time. PMH may make recommendations to ECHN, and if ECHN believes that the recommendations are reasonable, in the best interests of ECHN, and improve the operations of ECHN, then ECHN may implement such recommendations.

One key area that the parties intend to focus on during the consulting engagement is the foundational work required to implement CRC. CRC is the clinical integration among hospitals, physicians and other medical, social and community providers working closely with strategic partner health plans and other payers under a value-based, global risk reimbursement payment system to achieve the triple aim of improved patient care and experience, better patient health, and lower costs.

In anticipation of implementing CRC in Connecticut, PMH, has established a risk-taking entity called Prospect Health Service CT, Inc. and received licensure for the entity from the Connecticut Department of Insurance as a Preferred Provider Network.

7. The Application at page 97 states that PMH will be seeking property and sales tax abatements post-closing for a transition period and that "such abatement is deemed critical to the overall success of the proposed transaction." In connection with these statements:

   a) Please describe the length of the proposed transition period and the particulars of the abatement that will be sought.

   Response:

   As a for-profit health system, PMH will be expected to pay property taxes, sales taxes and income taxes post-closing. Even though PMH does not have the benefits of tax-exemption, PMH has committed to maintain and adhere to ECHN's current policies regarding charity care, indigent care, community volunteer services and community benefits or to adopt other policies that are at least as favorable to the community as ECHN's policies. In essence, PMH is not only required to provide the benefits generally expected from non-profit hospital operators, but is also required to pay the taxes described above even though similarly situated hospital operators would not be responsible for such taxes.

   Although PMH expects that implementation of the CRC model will result in an improved financial outlook for the current ECHN operations, these benefits will take time to realize. If taxes are imposed on PMH before any of these benefits can be obtained, there is a risk that the new tax burden could negatively affect the community in terms of jobs, local vendor payments and other factors which could outweigh the benefits from tax collections. Accordingly, PMH plans to work with the State and local communities to seek temporary relief from the new tax burden. This temporary relief has been deemed appropriate in other states in order to allow a hospital to re-gain its strength for the benefit of its employees and the communities that it serves before taking on the full tax burden.

   Seeking temporary tax relief is a process that necessarily involves the participation of all constituents. PMH is aware of pilot programs where cities receive funds from the State because they host non-profit entities. PMH is in the process of gathering facts that are necessary to formulate a fair proposal for all parties. As such, PMH, at this time, does not have any specific proposals that it can share. PMH will update this response once it has formulated a fair proposal.

   b) Explain why the abatement is deemed critical to the overall success of the proposed transaction.

Response:

Please refer to the response to Question 7a above for the Applicants explanation regarding the need for the abatements post-closing.

c) If PMH is unsuccessful in its negotiations for such an abatement, will there be any changes to the Commitment Amount or PMH s commitment, as noted on page 75, to ensure that MMH and RGH each maintains and adheres to ECHN s current policies regarding charity care, indigent care, community volunteer services and community benefits or adopts other policies that are at least as favorable to the community as ECHN s policies

Response:

PMH is proud of its history of providing health care services to underserved communities. PMH hopes that it will be able to negotiate a fair tax abatement plan that will place all healthcare providers on e ual competitive grounds. However, in the event that PMH is not successful in those negotiations, PMH will continue to honor all of its obligations under the APA (including but not limited to the Commitment Amount), to maintain ECHN s current policies regarding charity care and indigent care and will adopt policies that are at least as favorable to the community as ECHN s policies.

8. The LOI provides in Section 10 that Eastern Connecticut Physician Hospital Organi ation (ECPHO) and Clinically Integrated Network of Eastern Connecticut (CINECT) will enter into a 5-year management agreement with Coordinated Regional Care Group, Inc., a subsidiary of PMH, to implement PMH s Coordinated Regional Care (CRC) strategy. Please provide the number of physicians currently participating in ECPHO and CINECT, respectively, describe any physician participation overlap between these two entities and detail the nature of the management services to be provided by the PMH subsidiary under the agreement. Also, provide a copy of the management agreement if available.

Response:

ECPHO is a nonstock corporation with two members: ECHN and the Eastern Connecticut Individual Provider Group, Inc. (ECIPG). ECIPG is a separately incorporated nonstock corporation that represents two hundred and two (202) physicians in the communities served by ECHN. ECPHO provides administrative, purchasing and other services to its members, including contracting with insurers.

CINECT is a limited liability company, the sole member of which is ECHN. CINECT was formed in 2014 to address changes in the healthcare environment as a result of healthcare reform. The purpose of CINECT is to implement protocols and programs for healthcare providers that promote quality, coordination and efficiency in the delivery of healthcare and to provide management, purchasing and administrative and other services to subscribing providers. There are currently no physician members of CINECT and no contractual relationship between CINECT and ECIPG, so there is no overlap of any physician participation between ECPHO and CINECT. ECPHO continues to provide the management, administrative and other services to ECIPG and its physician members. ECHN and ECIPG had planned to transition these activities to CINECT to better address changes in the healthcare environment due to healthcare reform, but have put these plans on hold, pending the acquisition of ECHN by PMH.

Although a five-year management agreement among ECPHO, CINECT and the PMH Coordinated Regional Care Group was anticipated at the time the LOI was originally signed, the Applicants have since determined not to proceed with such an arrangement. Instead, PMH has established its own Independent Practice Association entity in Connecticut (Prospect Provider Group CT-ECHN, LLC, "PPGCTE") and a Preferred Provider Network/Health System Risk Taking entity (Prospect Health Services, CT, Inc.). These two organizations, through management services agreements with Prospect Medical Systems, Inc., will manage physician participation, risk contracting and care management activities for participating members. Physicians currently represented by ECIPG will make individual and independent decisions regarding their participation in PPGCTE.

The Risk Taking Entity and the Independent Practice Association Management Services Agreements have not been drafted at this time.

9. On page 26 of the Application, Applicants describe the CRC model as being "highly successful in aligning physicians with PMH hospitals and improving quality, efficiency and financial performance in California, and local versions of the model have been implemented in Texas and Rhode Island with similar success." The Application also states that the size of PMH's physician network in these three states encompasses approximately 8,900 physicians. With respect to these statements, please provide the following:

   a) How many physicians participate in PMH's physician networks in California, Texas and Rhode Island, respectively?

      Response:

      Please refer to **Exhibit E** for the number of physicians participating in PMH's physician networks in California, Texas and Rhode Island from 2012 to present.

Please note that the number of physicians reflected in this exhibit includes both fully contracted physicians and physicians who have entered into a Memorandum of Understanding ("MOU") with PMH. The MOUs are generally related to limited services by a physician, provide for a limited period of time for the provision of services and/or are limited to a particular patient for physicians who do not wish to be fully contracted with PMH.

PMH's contracting system is not able to distinguish between MOU physicians and fully contracted physicians. In order to determine how many physicians are fully contracted and how many are part of an MOU requires physical inspection of each agreement. Within the past year, such an exercise was performed to determine the approximate number of fully contracted physicians (8,900).

b) Do the physician networks in each of these states operate as independent practice associations ("IPAs") that contract with a management services organization ("MSO") controlled by PMH or, if there are other models used, please describe the models and the states in which they are used.

Response:

The physician networks for risk taking are all IPAs comprised of employed and independent physicians. The IPAs are managed by PMH-owned MSOs.

c) How will the physician network that PMH seeks to establish in Connecticut differ from those developed in these other states?

Response:

PMH will seek to replicate the same model in Connecticut.

d) For the CRC model developed for the Alta Los Angeles Hospitals in California, provide the number of physicians participating in PMH's physician network for each year from 2007 to present;

Response:

PMH manages its physician networks regionally and not by specific hospital. As such, PMH does not have separate networks for Alta Los Angeles Hospitals and Southern California Healthcare System. Please refer to **Exhibit E** for the number

of physicians participating in PMH's physician network in California for each year from 2012 to present.

Please be advised, PMH changed information technology data systems and data for years prior to 2012 are on legacy systems that are not readily available.

e) For the CRC model developed for the Southern California Healthcare System in California, provide the number of physicians participating in PMH's physician network for each year from 2009 to present;

Response:

Please see the Applicants' response to Question 9d above.

f) For the CRC model developed for the Nix Health System in Texas, provide the number of physicians participating in PMH's physician network for each year from 2012 to present; and

Response:

PMH received and implemented a risk-based contract in Texas approximately one year ago. PMH's network in Texas currently consists of 23 primary care practitioners and 594 specialists. The network remained stable and consistent over the past year.

g) For the CRC model developed for the Prospect CharterCare Hospitals in Rhode Island, where applicants state in Exhibit Q58-1 that PMH developed an IPA and recruited 105 primary care physicians and 270 specialists, please state the number of physicians that were affiliated with these hospitals through IPAs or other physician organizations at the inception of the joint venture.

Response:

There was no IPA at the CharterCARE Hospitals at the inception of the joint venture. Of the 375 physicians recruited to the IPA only 18 were employed by the CharterCARE Hospitals at the inception of the joint venture.

10. Elaborate on whether there is a standard CRC business plan that is used by PMH in the development of IPAs and what specific CRC policies, procedures and processes are implemented for recruiting purposes to reach target amounts of affiliated medical professionals.

Response:

PMH does have a standard business plan by which it approaches each new market. The initial plan entails three work streams that PMH begins working on simultaneously and soon after an acquisition Letter of Intent has been agreed upon with a health system such as EHCN. The three work streams are:

- Regulatory Infrastructure
- Provider Network Development
- Health Plan Engagement

The first two work streams are relevant to answering the question posed.

The first work stream addresses investigating and developing the Regulatory Infrastructure necessary in order for providers to assume and manage value-based risk contracts with health plans under our CRC model. In Connecticut that requires a license as a Preferred Provider Network ("PPN"). Prospect Health Services CT, Inc. received its license to transact business as a Preferred Provider Network from the Connecticut Insurance Commissioner on October 21, 2015.

The second work stream is Provider Network Development which entails identifying and beginning to contract with the provider network described in the PPN application and required by health plans in the market for our PPN to enter into value-based risk contracts. A critical component of this work stream is the development of the IPA affiliated with the health system, in this case ECHN. PMH has formed an IPA called Prospect Provider Group CT-ECHN, LLC. (PPCTE), which will be the ECHN-affiliated IPA. PMH is currently developing the participating agreements for the ECHN-affiliated physicians and will begin contracting the physicians into the IPA in the near future.

The PPN application requires that Prospect Health Service CT, Inc. comply with National Committee for Quality Assurance ("NCQA") network adequacy standards, so those are the standards that PMH will use to gauge the number and type of providers needed to contract in the IPA. PMH has identified the physicians affiliated with ECHN, many of whom already participate in another ECHN-affiliated physician organization. When the contracts are approved for use, PMH will begin contracting those physicians into the IPA. PMH will then recruit any additional providers necessary to meet the requirements of the value-based contracts negotiated with the health plans in Connecticut.

11. PMH's prior hospital acquisitions in California, Texas and Rhode Island have been concentrated in high density urban markets. ECHN's service area population for 2020 is projected to be 356,046 residents. Explain how PMH's experience with the CRC model in high density urban markets will be adapted to a more rural market.

Response:

It is important to note that PMH's operations in California are in four separate and distinct markets. The markets are as follows: (a) South Orange County; (b) Central Orange County; (c) Inland Empire; and (d) Los Angeles. While these counties are populous, the population is spread over a very large geographic area. For example, Orange County is over 948 square miles, the Inland Empire covers over 27,000 square miles, and Los Angeles is over 4,000 square miles. PMH provides services to distinct areas within each county and manages approximately 260,000 lives. PMH does not consider a market service area of 356,046 residents to be rural. PMH believes ECHN's service area is a good size and appropriate for implementation of CRC.

12. On page 76 of the Application and in Figure 3, Applicants indicate that from 2012 to 2014, in Texas and California, PMH reduced hospital bed days per thousand from 1,260 to 720, reduced length of stay from 5.1 days to 3.9 days, dropped admissions per thousand from 245 to 182 and reduced hospital readmissions within thirty days from 19% to 13% for Medicare Advantage participants. This data is provided as evidence of PMH's ability to operate its hospitals efficiently through the CRC model while avoiding unnecessary, inefficient and duplicative services and reducing medical errors. Using these same benchmarks (hospital bed days, length of stay, patient admissions and readmissions) please update Figure 3 to show whether similar reductions have been achieved across all patient populations for each of the healthcare systems owned by PMH in California and Texas over the past 3 years and for Prospect CharterCare Hospitals since 2014. Provide data and detailed explanations on the specific programs, policies and procedures under the CRC model that have been implemented in the PMH member hospitals to reduce hospital stays, admissions and medical errors.

Response:

The referenced data above is largely based on PMH's California experience.

In Texas, PMH's risk-based contract under the CRC model was implemented approximately one year ago. Trends are both encouraging and positive, but show room for improvement. CRC development requires education and training of physicians, patients and other providers across the healthcare continuum and takes several years to implement. PMH expects to achieve similar results in Texas to what has been accomplished in California over time.

Please note that results in California were achieved over two to three years. A summary of performance metrics for Texas can be found in the **Exhibit F.**

Please note that in Rhode Island, PMH began medical management under a risk-based contract in September 2015. As such, there is no data to report at this time. However, because of the programs and systems used, PMH is confident it can produce the same results in Rhode Island and Connecticut.

For an overview of PMH's programs and procedures, please see **Exhibit G**.

13. On page 56 of the Application, Applicants state that "the transaction will allow ECHN the ability to adjust to a rapidly changing healthcare delivery environment and reinvest in itself to continuously improve care coordination, address continued improvement in quality and safety, expand and add needed services, recruit and retain physicians, and improve access to services across its service area." Please explain how implementation of the CRC model will facilitate the expansion and addition of needed services and improve access to services. Specifically focus on examples where PMH opened new outpatient facilities and developed new service lines for the hospitals it acquired in California, Rhode Island and Texas.

Response:

Implementation of the CRC model necessarily requires that a full continuum of care be accessible and available to patients. As part of the implementation process, PMH reviews the services offered by its systems and seeks to enhance or expand services over time. To the extent that a PMH-affiliated system does not provide the full range of services, PMH seeks to add such services or to affiliate with other service providers for the provision of such services, as appropriate. PMH's focus initially will be to:

- Invest in Primary Care/Specialty practices through
  - Attractive physician models that reward quality and service
  - Participation in academic-affiliated residency programs

- Expand Ambulatory Offerings, such as
  - Urgent care facilities
  - Out-patient services/service lines
  - Primary care clinics

Examples of development activities in Texas include:

- Formation of an IPA
- Formation of a Multi-Specialty IPA – Including Integration with Behavioral Health doubling the Behavioral Health service capacity

- Expansion of Hospital-Based Outpatient Clinics
- Purchase of a rural hospital resulting in increased access to care
- Establishment of an Emergency Room; and
- Leasing and converting additional space for expansion of services

In Rhode Island PMH has accomplished the following:

- Purchased 28 primary care clinics, expanding access to care;
- Joint ventured on a radiation-oncology center;
- Expanded cardiac catheteri□ation services

California is a mature market for PMH. Efforts to improve access to services that have been recently accomplished (or are about to be accomplished) include the following:

- Purchased a closed hospital in South Orange County (which PMH reopened in September 2015) to better serve patients who are members of our owned or managed IPAs; and
- Will purchase primary care and multi-specialty clinics to increase access to care

All of the above are examples of service line expansions and improving access to care.

14. In reference to the □Local Board□as described on page 30 of the Application, please provide the following:

    a) Elaborate on recommending authority of the respective Local Boards as described in Sections 5.18 (strategic capital plan), 5.21 (clinical □uality matters), and 5.26 (strategic business plan) of the APA.

    Response:

    PMH and the management of the Hospitals will provide the respective Local Boards with the necessary information to make informed recommendations to PMH with respect to (i) a strategic capital plan (APA Section 5.18), (ii) clinical □uality matters (APA Section 5.21) and (iii) the Strategic Business Plan (APA Section 5.26). PMH will carefully consider the recommendations of the respective Local Boards in its deliberations on those matters, and will collaborate with the Local Boards to ensure that such recommendations are in the best interests of the Hospitals and the System. PMH and the local management of the Hospitals and the System will then seek to implement the recommendations and will provide timely updates to the Local Boards regarding such implementation. The role of the Local Boards will include oversight and responsibility for medical staff credentialing as well as □uality matters.

b) Please clarify how each respective Local Boards of MMH and RGH will function collaboratively in providing recommendations to PMH.

Response:

The Local Boards will be appointed upon the closing of the transaction, and it is anticipated that they will begin operations shortly thereafter. Since the time ECHN was formed, the hospital boards of MMH and RGH have met concurrently with the ECHN parent board. This arrangement ensures common focus for the system while also providing the mechanism for each hospital to handle formal governance business individually as necessary. PMH plans to continue this approach for the two Local Boards by appointing the same individuals to each and having them meet concurrently. As is currently the case with the ECHN Board, tenures on the Local Boards will be predetermined and limited in order to ensure that fresh perspectives are continuously present. PMH expects that the Local Boards will be comprised of community physicians who are active parts of the ECHN Medical staff along with other community members who have demonstrated an active commitment to ECHN s mission to enhance the health of its community. PMH will schedule regular standing meetings to update the Local Boards on clinical uality and strategic matters, to allow the Local Boards to provide feedback on health issues of concern to the community, and to provide a forum for the Local Boards to deliberate and formulate recommendations to PMH. Educational sessions will also be scheduled as appropriate and desired by the Local Boards. In order to ensure that the perspectives of the Local Boards are heard, representatives of PMH and the senior local managers of the System will either sit on both of the Local Boards or attend the meetings of both of the Local Boards. In this way the representatives will be able to facilitate coordination and collaboration among the members of the Local Boards with respect to making recommendations to PMH.

15. On page 66 of the Application, Applicants state that PMH has already begun implementation efforts with respect to its CRC model for ECHN, including formation of an IPA and Board, review of regulatory re uirements, discussions with payers and evaluation of the care delivery network. Please provide the following:

a) the status on the formation of the IPA and the Board;

Response:

The IPA legal entity has been formed as a limited liability company called Prospect Provider Group CT-ECHN, LLC. (PPGCTE). The Chair and the Board of the newly formed IPA are being selected currently and the Board will likely begin to meet in

December. Physician contracting will begin as soon as the Board has approved the participating physician agreements.

b) the opportunities and impediments for utili□ing the CRC model in Connecticut based on regulatory re□uirements;

Response:

The primary CRC regulatory re□uirement for providers assuming and managing value-based risk contracts in Connecticut is licensure as a Preferred Provider Network by the Connecticut Insurance Department. Prospect Health Services CT, Inc. received its license to transact business as a Preferred Provider Network from the Connecticut Insurance Commissioner on October 21, 2015. As such, PMH has already satisfied the main regulatory re□uirement necessary for implementing the CRC model in Connecticut.

That said, one potential impediment to fully implementing the CRC model across geographies is the restriction on the number of medical foundation entities per health system that exists under Connecticut law. Specifically, pursuant to □33-182bb(f) of the Connecticut medical foundation statute, □a hospital, health system or medical school may organi□e and be a member of no more than one medical foundation.□ This statutory restriction does not permit for the formation of separate medical foundation entities by a hospital system that owns multiple hospitals in wholly separate service areas. This restriction is a significant issue for hospital systems that operate in more than one market in that third party payers typically set contract rates, adjudicate claims or limit participation in certain risk sharing arrangements or incentives based on service area. PMH is seeking approval to own three hospitals in two different markets but will have to utili□e a single medical foundation even though the professionals employed in the medical foundation will be in two distinct markets. In order to participate in regionali□ed payer contracts or programs, a medical foundation formed by PMH will need to work with payers to allocate providers under different risk arrangements while maintaining a single tax identification number. Many payors do not have ready systems that can allocate providers to divisions within a single tax identification number, making population health management and risk-based contracting more difficult. There is no easy immediate solution to this problem and PMH□s plan is to try to work closely with payers to develop internal tracking mechanisms by the payer and PMH. However these unnecessary added administrative costs may defeat some of the healthcare savings of the risk model.

c) the substance of discussions with payers; and

Response:

PMH has had preliminary discussions with most of the major payers in Connecticut to introduce PMH's CRC model to them. They have all expressed the desire to work with PMH on value-based contracts such as those preferred in PMH's CRC model. To date, the discussions with payers have been introductory, rather than substantive. However, PMH is optimistic that the discussions will result in most payers embracing the skills and expertise that PMH brings to the Connecticut market in its CRC model.

d) any reports on PMH's evaluation of the care delivery network.

Response:

PMH does not have any written evaluations of the care delivery network. However, PMH filed an application for the Preferred Provider Network as a substantial component of the delivery network and PMH received its PPN license last month. PMH is pleased with ECHN's care delivery network and believes it will provide a substantial foundation for PMH's CRC model in Connecticut.

16. On page 75 of the Application, Applicants disclose that "PMH and ECHN representatives have already met with leadership for Connecticut's Medicaid Program and expressed their desire to work under a risk-based arrangement to provide care to Medicaid recipients." Please provide an update on the status of these discussions. What impact, if any, would there be on the proposed asset purchase if Connecticut's Department of Social Services were to decide not to enter into risk-based arrangements with PMH?

Response:

Since the initial meeting with the Department of Social Services, PMH has not met with representatives of that Department. PMH expects to meet with the Department in the near future. The Applicants would be disappointed if the Department of Social Services decided not to enter into a risk-based arrangement with PMH, but it would not have an impact on the proposed asset purchase.

17. In table format, provide historical volumes (three full fiscal years (FY) and the current year-to-date) for the number of discharges and patient days, by service for MMH and RGH, respectively.

TABLE A
HISTORICAL AND CURRENT DISCHARGES

Manchester Memorial Hospital	**Actual Volume** *(Last 3 Completed FYs)**			
	FY 2013	**FY 2014**	**FY 2015**	**CFY 2016 (October)**
Medical Surgical	5,433	5,223	4,685	407
Maternity	1,233	1,259	1,406	139
Psychiatric	1,444	1,372	1,313	123
Pediatric	1,232	1,256	1,402	135
Total	**9,342**	**9,110**	**8,806**	**804**

** Fiscal Year period runs from October 1 to September 30*
***Only reflects patients categorized as "Newborn" in ECHN's internal Daily Census Report*

Rockville General Hospital	**Actual Volume** *(Last 3 Completed FYs)**			
	FY 2013	**FY 2014**	**FY 2015**	**CFY 2016 (October)**
Medical Surgical	2,567	2,341	2,112	172
Maternity	0	0	0	0
Psychiatric	0	0	0	0
Pediatric	0	0	0	0
Total	**2,567**	**2,341**	**2,112**	**172**

** Fiscal Year period runs from October 1 to September 30*

TABLE B
HISTORICAL AND CURRENT PATIENT DAYS

Manchester Memorial Hospital	**Actual Volume** *(Last 3 Completed FYs)**			
	FY 2013	**FY 2014**	**FY 2015**	**CFY 2016 (October)**
Medical Surgical	29,363	26,169	22,040	1,799
Maternity	3,369	3,412	3,760	355
Psychiatric	10,277	10,866	10,745	890
Pediatric	3,657	3,653	4,147	438
Total	**46,666**	**44,100**	**40,692**	**3,482**

** Fiscal Year period runs from October 1 to September 30*
***Only reflects patients categorized as "Newborn" in ECHN's internal Daily Census Report*

Rockville General Hospital	**Actual Volume** *(Last 3 Completed FYs)**			
	FY 2013	**FY 2014**	**FY 2015**	**CFY 2016 (October)**
Medical Surgical	12,363	11,155	9,873	682
Maternity	0	0	0	0
Psychiatric	0	0	0	0
Pediatric	0	0	0	0
Total	**12,363**	**11,155**	**9,873**	**682**

** Fiscal Year period runs from October 1 to September 30*

18. Complete the following tables for MMH and RGH, respectively, for the first three (full) fiscal years following the proposed asset purchase, if the first year is a partial year, include that as well.

TABLE C
PROJECTED DISCHARGES BY SERVICE

Manchester Memorial Hospital	**Projected Volume with Proposed Asset Purchase***			
	FY 2016	**FY 2017**	**FY 2018**	**FY 2019**
Medical Surgical	4,665	4,846	4,936	5,027
Maternity	1,538	1,538	1,538	1,538
Psychiatric	1,370	1,370	1,370	1,370
Pediatric	1,533	1,533	1,533	1,533
Total	**9,043**	**9,224**	**9,314**	**9,405**

** Fiscal Year period runs from October 1 to September 30*
***Only reflects patients categorized as "Newborn" in ECHN's internal Daily Census Report*

Rockville General Hospital	**Projected Volume with Proposed Asset Purchase***			
	FY 2016	**FY 2017**	**FY 2018**	**FY 2019**
Medical Surgical	2,159	2,191	2,213	2,235
Maternity	0	0	0	0
Psychiatric	0	0	0	0
Pediatric	0	0	0	0
Total	**2,159**	**2,191**	**2,213**	**2,235**

** Fiscal Year period runs from October 1 to September 30*

TABLE D
PROJECTED PATIENT DAYS BY SERVICE

Manchester Memorial Hospital	**Projected Volume with Proposed Asset Purchase***			
	FY 2016	**FY 2017**	**FY 2018**	**FY 2019**
Medical Surgical	22,040	22,040	22,040	22,040
Maternity	3,760	3,760	3,760	3,670
Psychiatric	10,745	10,745	10,745	10,745
Pediatric	4,147	4,147	4,147	4,147
Total	**40,692**	**40,692**	**40,692**	**40,692**

** Fiscal Year period runs from October 1 to September 30*
***Only reflects patients categorized as "Newborn" in ECHN's internal Daily Census Report*

Rockville General Hospital	**Projected Volume with Proposed Asset Purchase***			
	FY 2016	**FY 2017**	**FY 2018**	**FY 2019**
Medical Surgical	9,873	9,873	9,873	9,873
Maternity	0	0	0	0
Psychiatric	0	0	0	0
Pediatric	0	0	0	0
Total	**9,873**	**9,873**	**9,873**	**9,873**

** Fiscal Year period runs from October 1 to September 30*

a) Explain any increases and/or decreases in historical volumes reported in the tables above.

Response:

The decreasing trend in total discharge volume experienced by MMH and RGH from FY 2013 through FY 2015 is, in part, due to an industry-wide trend to shift inpatient care to the outpatient setting.[1] ECHN's struggle to recruit and retain primary care physicians in the communities served by the Hospitals has also contributed to the decline in patient discharges at both facilities. MMH did experience an increase in maternity and pediatric (newborn) discharges and patient days beginning in FY 2015 when an established OB/GYN practice in the region joined ECHN's active medical staff.

Total patient days declined along with the decrease in discharges, but the Hospitals also experienced a decrease in the average length of stay ("LOS") during the same time period which further contributed to the decline in the patient day volume. Ongoing efforts to reduce patient lengths of stay and an industry-wide increase in observation status utilization are primary drivers behind the reduction in the average LOS.[2]

b) Provide a detailed explanation of all assumptions used in the derivation/calculation of the projected volume.

Response:

Inpatient discharges for FY 2016 were based on ECHN's internal budget for the current fiscal year and assumes that inpatient discharges will increase 2.5% from FY 2015 to FY 2016 (3% at MMH and 0% at RGH). The increase in discharges at MMH is directly related to the additional maternity and newborn volume that is expected with the addition of deliveries from the physicians from Mansfield OB/GYN Associates, who joined ECHN's Medical staff midway through FY 2015.

[1] The New Normal: Shift to Outpatient Care, Payer Pressure Hit Hospitals. Modern Healthcare, August 10, 2013. http://www.modernhealthcare.com/article/20130810/MAGAZINE/308109974

[2] Study: Hospital Observation Stays Increase 25 Percent in 3 Years. Kaiser Health News, June 4 2012. http://khn.org/news/study-hospital-observation-stays-increase-25-percent-in-3-years/

As presented in Exhibit Q38-1 (page 1851), with CON approval, total inpatient discharges are anticipated to increase after FY 2016 by the percentages listed below as a result of implementing PMH's CRC model of care delivery:

Entity	Volume Statistics	Projected Growth with CON Authorization		
		FY 2017	FY 2018	FY 2019
PMH ECHN	Inpatient Discharges	1.9%	2.9%	3.9%
	Outpatient Visits	0.1%	0.2%	0.3%
Prospect MMH	Inpatient Discharges	2.0%	3.0%	4.0%
	Outpatient Visits	0.1%	0.2%	0.3%
Prospect RGH	Inpatient Discharges	1.5%	2.5%	3.5%
	Outpatient Visits	0.1%	0.2%	0.4%

The model assumed that increased Medical/Surgical discharges at both facilities will be the primary driver of discharge growth, as both the maternity unit and behavioral health unit are operating at capacity and RGH does not provide either of these services at the present time. Based on this assumption, discharge volume for maternity, pediatric (newborn) and psychiatric services will remain constant at the levels projected for FY 2016 through FY 2019. Medical/Surgical discharges will increase each year, resulting in the overall growth presented in the table above. Efforts currently underway at ECHN, which have historically reduced Medical/Surgical LOS, will continue to reduce patient days through FY 2019 despite the increase in discharges. Based on the continuation of these efforts, it was assumed that patient days would remain at FY 2015 levels throughout the projection period.

19. Please complete the following tables setting forth the number of physicians comprising Active and total members of the medical staffs (Active plus all other staff categories) for both MMH and RGH for the years listed below:

TABLE E
MMH

	2013	**2014**	**2015***
Active Staff	297	308	303
Consulting	13	15	13
Courtesy	49	41	41
Part Time	34	29	36
Allied Health**	**83**	**80**	**93**
Total Physician Staff	**476**	**473**	**486**

** Medical staff totals as of October 31, 2015*

*** Non-physician medical staff personnel (i.e. APRN, Physician Assistant, etc.)*

TABLE F
RGH

	2013	**2014**	**2015***
Active Staff	297	308	303
Consulting	13	15	13
Courtesy	49	41	41
Part Time	34	29	36
Allied Health**	**83**	**80**	**93**
Total Physician Staff	**476**	**473**	**486**

** Medical staff totals as of October 31, 2015*

*** Non-physician medical staff personnel (i.e. APRN, Physician Assistant, etc.)*

Response:

Table E and Table F have been completed to show the number of physicians comprising each medical staff category for ECHN. MMH and RGH have utilized a single medical staff since 1997.

While the overall Medical staff participation total has remained relatively constant year to year, ECHN has struggled to retain individual providers, particularly primary care providers (family medicine and internal medicine):

Specialty	2013		2014		2015*	
	Add	Delete	Add	Delete	Add	Delete
Anesthesiology	4	12	6	5	11	5
Emergency Medicine	5	3	2	4	5	8
Family Medicine	**5**	**6**	**5**	**1**	**2**	**4**
Internal Medicine	**9**	**32**	**14**	**17**	**20**	**18**
Medical Imaging	1	11	3	2	0	1
Obstetrics & Gynecology	2	2	3	7	12	5
Pathology	0	0	0	0	0	0
Pediatrics	2	1	5	3	3	2
Psychiatry	4	4	5	7	2	1
Surgery	6	13	9	12	8	9
TOTAL	**38**	**84**	**52**	**58**	**63**	**53**

20. With respect to ECHN's Medical Foundation, please provide the number of physicians and other allied health professional participants for each year since the inception of the Foundation to the current year to date.

Response:

Table G below provides the number of physicians and other allied health professional participants for ECHN's Medical Foundation since its inception on November 17, 2011. It reflects the number of participants (individuals, not full-time equivalents) as of the calendar-year end-date (December 31) for each year requested.

The decline in the number of participants from 2013 to 2014 is primarily related to ECHN's decision to contract with a third party to provide hospitalist services at the Hospitals.

TABLE G
ECHN's Medical Foundation

	2011	2012	2013	2014	2015
Physicians	60	62	56	40	36
Allied Health Professionals	32	31	36	39	42
Medical Foundation Total	**92**	**93**	**92**	**79**	**78**

** Participant totals as of December 31 of each year except 2015 (totals as of 10/31/2015).*

21. In accordance with the provisions of the Section 5.18 of the APA, PMH may direct some portion of the Commitment Amount to expenditures in support of the recruitment of the Hospitals' medical staff located in the Hospitals' Service Area. Please elaborate on the extent to which ECHN has had difficulty recruiting and/or maintaining medical staff in recent years and how and PMH's experience with the development of its CRC models of care in California, Texas and Rhode Island would demonstrate PMH's ability to effectively grow ECHN's physician network from the 39 community-based physicians and 16 allied health professionals reported to be currently employed by its medical foundation.

Response:

ECHN works continuously to recruit physicians to its medical staff as physicians retire, move away or as needs for physician specialists are identified. The competition among healthcare systems to attract and employ physicians has been intensifying. It is well known that ECHN has been pursuing a transaction to join a larger health care organization. Current medical staff and potential recruits to the medical staff want to know ECHN's future. They want to know that ECHN will be joining an organization that will support their practices. The uncertainty caused by Tenet Healthcare's withdrawal from Connecticut and its planned venture with Yale New Haven Health System to acquire ECHN made an already uncertain healthcare landscape more uncertain. This has made the process of recruiting needed medical staff even more challenging.

Capital investments to support medical staff development are essential to the success of a health system like ECHN. ECHN has been strategic with its deployment of capital to develop medical offices in its communities which help to attract and retain primary and specialty care physicians. Future investments will be needed to develop additional ambulatory sites to house physician practices in the communities served by ECHN. Capital investments in equipment and technology are also important to recruit and support physicians on the medical staff. An example would be ECHN's purchase of robotic technology to assist with surgical procedures, technology that has become expected by today's surgeons.

ECHN has also been creative in establishing programs to recruit physicians. In 2013, ECHN established a Family Practice Graduate Medical Education (GME) Program to help train

primary care physicians with a goal of attracting medical residents to train with the medical staff, become familiar with the communities and practice opportunities at ECHN and encourage them join the medical staff following their post graduate studies. Having sufficient primary care physicians located throughout the service area is critical to effectively addressing the health of the patients served by the network.

For 2013-2014, the ECHN GME program included a total of eleven first year and second year family medicine residents. For 2014-2015, the program included a total of nineteen first year, second year and third year family medicine residents. One of four 2015 graduates joined the ECHN Medical staff. The current 2015-2016 class has a total of twenty-two family medicine residents. It is our hope that some of the six eligible graduates from the current third year class will join the medical staff. It is important to note that PMH supports the continuation of the GME program which will grow in its importance as a resource for primary care providers.

ECHN believes that PMH, through the development of its CRC model, will bring success in meeting the challenges of retaining and recruiting physicians needed for our communities. ECHN considers its physician staff to include all physician and allied health members of the ECHN Medical staff, both employed and independent physicians and allied health professionals, not just those community-based providers currently employed by the Eastern Connecticut Medical Professionals Foundation. The CRC Model will attract and align both employed and independent physicians with the health system and the payer community to the benefit of our patients. CRC is a patient and physician focused model. It is organi□ed to allow for strong physician governance of the Prospect Provider Group CT-ECHN, LLC (PPGCTE) that will result in the physician community having a central role in determining what health services are needed and developed by the health system for patients, as well as overseeing the service and □uality of care of delivered to patients by the PPGCTE. In addition to stronger leadership and governance opportunities, physicians will be supported with care management programs to effectively manage their patients with challenging chronic medical conditions, and to keep their patients well in the appropriate care settings. Finally, PMH brings significant value to physicians with its experience and success with risk-based payment arrangements which will continue to expand and replace the fee-for-service payment system healthcare services.

The value that PMH brings to physicians in the form of experience and competencies under risk-based payment arrangements; capital to invest in facilities, e□uipment, programs and technology; leadership and governance opportunities; and programs to assist in the management of patients will support and grow the ECHN Medical staff.

PMH is a physician friendly company that tries to accommodate physicians□ preferences for practicing medicine. Some physicians prefer to be employed, while others wish to remain independent but would like to work in a hospital environment where they know that independent physicians are valued. There is another subset of physicians who would like to remain independent but work in hospital-based clinics. PMH provides the full menu of

options to physicians. Furthermore, as described in the response to Question 10 above, PMH has been very successful at recruiting physicians, including the most recent success in establishing an IPA in Rhode Island with 105 primary care practitioners and 270 specialist physicians. Of the 105 primary care practitioners in Rhode Island, only 18 were previously employed by the CharterCare System.

22. On page 70 of the Application, PMH and its affiliates commit to "continue support the CHNA [Community Health Needs Assessment] implementation plans [of ECHN] as they are rolled out through 2016." With respect to this statement, please respond to the following:

    a) Please address whether PMH intends to conduct CHNAs after the closing and, if so, whether it intends to conduct them in a manner that meets the requirements of IRS Code Section 501(r), including conducting a CHNA at least once every three years and adopting an implementation strategy to address those identified needs.

       Response:

       PMH will support and implement ECHN's CHNA plans through 2016. For subsequent years, PMH will work closely with ECHN's Local Advisory Boards (comprised of local leaders and physicians) to help assess local community needs and develop effective plans to address such needs.

    b) Describe PMH's experience in conducting CHNAs subsequent to acquiring non-profit, tax-exempt hospitals, specifically, those hospitals located in California and Texas;

       Response:

       PMH has not been required by any state to conduct CHNAs. However, PMH works closely with its Local community advisory Boards (comprised of local physicians and community leaders) to help assess local community needs and develop effective plans to address such needs.

    c) In 2013, MMH and RGH jointly conducted a CHNA. The CHNA identified four priority health needs including heart disease incidence, cancer incidence, diabetes incidence and arthritis incidence. Please provide, for years 2013 to present, the dates, locations, and number of free screenings ECHN conducted for the following:

       i. Blood pressure screenings
       ii. Cholesterol and/or body fat screenings
       iii. Cancer screenings

iv. Diabetes glucose testing

Response:

A list of screenings and educational programs conducted by ECHN for each of the four priority health needs identified in the CHNA has been provided in **Exhibit H**.

d) On page 1783 of the Application, ECHN's CHNA identified additional priority needs, including addressing Alzheimer's, Multiple Sclerosis, substance abuse and childhood lead screening, that ECHN was not able to address due to limited resources. Please elaborate how PMH plans to address these additional identified areas of need.

Response:

PMH will reevaluate the healthcare needs of the community with input from the Local Boards as part of its overall planning process post-closing and expects to prioritize capital projects and service improvements based on hospital and community needs. The goal will be to establish priorities based on maintaining or providing access to needed services that allow for the optimum care and coordination of care within and across the community. Plans to address the priority needs in ECHN's service area will be developed post-closing once the priority needs have been confirmed or identified.

23. Reference is made to the chart below concerning the amount of charity care provided by MMH and RGH from FY 2012 to FY 2014:

	FY 2012	**FY 2013**	**FY 2014**
MMH	$4,953,633	$3,908,882	$2,411,263
RGH	$2,192,753	$1,271,767	$1,188,543

** Source: OHCA Annual Report on the Financial Status of Connecticut's Short Term Acute Care Hospitals (Sept. 2015)*

a) Please explain the reasons for the year over year declines in charity care provided by MMH and RGH.

Response:

Charity care amounts reported by hospitals in OHCA's annual filings report the financial assistance provided to a subset of uninsured patients that apply for charity care and qualify per the hospital financial assistance guidelines. With the implementation of the Affordable Care Act ("ACA") and the expansion of Medicaid eligibility, the number of uninsured patients seen by ECHN has decreased. In addition, following implementation of the ACA, ECHN contracted with an outside vendor to improve the identification of Medicaid eligible patients and to assist those patients with the application process. As a result of these factors, the number of patients who were uninsured and qualified for charity care decreased, which contributed to the reduction in charity care amounts reported to OHCA. More than 60% of the hospitals in Connecticut (including MMH and RGH) also reported a decrease in charity care.[3]

It is important to note that the charity care amounts referenced above only reflect gross revenue (charges) for the uninsured patient population treated by the Hospitals. It is also important to note that with more patients covered by the Medicaid Program, the community benefit reported to the IRS for MMH and RGH has increased, reflecting the uncovered costs for providing services to Medicaid beneficiaries. The level of community benefit provided by a nonprofit hospital is based on the expenses associated with financial assistance provided at cost, the unreimbursed Medicaid services, other community benefit and community building activities of the hospital.

The total community benefit amounts reported for FY 2014 increased 30% at MMH and 10% at RGH compared to FY 2012 levels, despite the impact of the ACA. While the amount of total community benefit reported by MMH in FY2014 was less than the totals reported in FY 2013 (a 4% decline), this was due to a change in IRS instructions effective for FY 2014 that required grant revenue to offset grant program costs. Without this change, the MMH Community Building Activities would have been $1,841,362 and the total community benefit amount would have been $17,221,538 (a 5% increase over FY 2013 amounts). Despite this IRS reporting change the community benefit amount reported for the two ECHN hospitals combined shows an increase in the community benefit totals from FY 2013 to FY 2014:

[3] OHCA Annual Report on the Financial Status of Connecticut's Short Term Acute Care Hospitals (Sept 2015), Table 3, page 10.

Total Community Benefit - MMH	**FY 2012**	**FY 2013**	**FY 2014**
Financial Assistance at Cost *IRS 990 Schedule H Part I, 7a*	□1,602,647	□1,162,736	□577,404
Unreimbursed Medicaid Services *IRS 990 Schedule H Part I, 7b*	□6,221,594	□8,753,602	□8,167,609
Other Community Benefits *IRS 990 Schedule H Part I, 7j*	□2,937,827	□4,670,039	□6,635,163
Community Building Activities *IRS 990 Schedule H Part II, 10*	□1,335,251	□1,760,601	□293,406
Total	**$12,097,319**	**$16,336,978**	**$15,673,582**

Total Community Benefit - RGH	**FY 2012**	**FY 2013**	**FY 2014**
Financial Assistance at Cost *IRS 990 Schedule H Part I, 7a*	□742,084	□367,583	□333,537
Unreimbursed Medicaid Services *IRS 990 Schedule H Part I, 7b*	□3,631,357	□3,505,315	□4,675,911
Other Community Benefits *IRS 990 Schedule H Part I, 7j*	□1,500,538	□1,747,298	□1,414,904
Community Building Activities *IRS 990 Schedule H Part II, 10*	□3,244	□2,901	□19,070
Total	**$5,877,223**	**$5,622,997**	**$6,443,422**

Total Community Benefit – ECHN	**$17,974,542**	**$21,959,975**	**$22,117,004**

ECHN treats patients regardless of their ability to pay for services and hospital policies regarding charity care have not changed. The hospitals continue to provide the same level of financial assistance to patients that □ualify based on need. PMH has committed to continue these ECHN policies. Medicaid expansion and the availability of low-cost insurance plans through the Health Insurance Exchange (created as a result of the ACA) have reduced the number of patients who □ualify for financial assistance at hospitals across Connecticut, including MMH and RGH. Despite this, ECHN has continued to increase the total amount of community benefit that it provides to patients in its service area.

b) Please provide the amount of charity care provided by each hospital for FY 2015.

Response:

In FY 2015, as projected for FY 2015 in Financial Worksheet C, MMH provided charity care in the amount of $2,382,698 and RGH provided charity care in the amount of $1,195,377.

c) Please describe how the proposed asset purchase with PMH can result in an increase in charity care provided by MMH and RGH, respectively, and cite to any examples from PMH's prior non-profit acute care hospital acquisitions where the amount of charity care (not total uncompensated care inclusive of bad debt) has increased from year to year post acquisition.

Response:

With the passage and implementation of the ACA, the amount of charity care for the industry as whole has been declining. As more people are insured, the need for charity care has decreased. PMH remains committed to providing charity care and to maintaining the charity care policies of MMH and RGH.

24. In reference to Table 9 at page 96 of the Application, Applicants identify $27,678 in community based clinical services and $412,862 in health care support services provided by MMH in FY 2014; in reference to Table 10 at page 97, Applicants identify $47,369 in health care support services provided by RGH in FY 2014; and, in reference to Table 11 at page 100, Applicants identify $140,797 and $124,710 in community support and workforce development expenditures by MMH in FY 2014. Please provide the following:

a) A breakout of the services and community building activities associated with each of these amounts;

Response:

A breakout of the services and community building activities associated with the referenced amounts is presented below:

Manchester Memorial Hospital

Community Based Clinical Services

Breast health information and screening events, oversight of the Early Detection Program [4]	□	26,546
Blood pressure and cardiac health screenings	□	204
Diabetic foot screenings	□	928
Total Community Based Clinical Services:	**$**	**27,678**

Health Care Support Services

Expenses associated with transportation for patients to outpatient behavioral health services provided at 150 North Main Street:		
Costs of bus passes and taxi service	□	24,006
Time spent for referrals to other programs for patients residing outside of ECHN service area	□	3,214
2014 Medicaid Referral Calls (70□ of expense allocated to MMH)	□	2,305
Lifeline □Free replacement buttons provided to clients	□	148
Nurse and survivorship navigator programs	□	334,474
Staff to assist patients in enrolling in Medicaid and other public assistance programs	□	48,715
Total Health Care Support Services:	**$**	**412,862**

[4] Grant funded program managed by ECHN□s Breast Care Collaborative which provides breast screenings and colonoscopies for the uninsured and underinsured.

Community Support

Expenses associated with hosting the Veteran□s Day dinner and Veteran□s Day ceremony at MMH	□	1,778
Emergency management and disaster preparedness meetings and drills (including simulated situations involving hurricane, bed triage□patient overflow, active shooter, emergency supply, etc.)	□	5,330
Family Development Center Programs *(see the response to Question 24b below for more information on these programs)*	□	133,104
Staff participation in Manchester Chamber of Commerce events and South Windsor Chamber of Commerce board meetings	□	585
Total Community Support:	**$**	**140,797**

Workforce Development

Workforce training, vocational services to residents to obtain integrated competitive employment	□	115,766
Legal department mentoring of interns and volunteers	□	272
Capital Community College Advisory Board Annual Meeting, Rockville High School student and paramedic mock interviews	□	1,738
Career Advancement Program for Manchester High School seniors	□	4,724
Sleep Lab presentations to students and intern rotations	□	1,157
Rockville High School to Business Partnership meeting; orientation for parents of Allied Health Students; interviewing students and parent for Junior Volunteer summer program	□	1,053
Total Workforce Development:	**$**	**124,710**

Please see the response to Question 24c below for more information on the workforce development activities at MMH.

Rockville General Hospital

Health Care Support Services

2014 Medicaid Referral Calls (30 of expense allocated to RGH)		988
Lifeline Free replacement buttons provided to clients		183
Staff to assist patients in enrolling in Medicaid and other public assistance programs		46,198
Total Health Care Support Services:	**$**	**47,369**

b) Details on the Early Head Start, Family Enrichment Services, Nurturing Families Network programs and the School-based Family Resources Centers services provided by MMH s Family Development Center; and

Response:

As discussed previously in the Applicants response to Question 52 of the CON application, MMH s Family Development Center operates programs for families needing support with parenting and other family issues. These programs are funded by state and federal grants. The 133,104 represents the in-kind contributions to the programs made by MMH.[5]

Additional information related to the specific programs has been provided below:

Early Head Start Program

The Early Head Start (EHS) program serves low-income children (birth to age three), pregnant women and their families residing in Manchester and or Vernon. A Family Development Educator (FDE) provides parent education, child development information and learning activities.

EHS provides families with opportunities to get involved in their child s education.

[5] In-kind contributions refer to the expenses incurred by MMH in support of the program including, but not limited to, rent, administrative overhead (human resources, payroll, accounting, legal, information technology, etc.), insurance and overall program administration.

Positive Parenting Program[6]

Positive Parenting Program (Triple P) is a Connecticut State Department of Children and Families funded grant program. Triple P is suitable for parents with concerns about a child's behavior or who wish to learn a variety of parenting skills that will promote the development and potential of their child or teenager.

Nurturing Families Network Programs

The Nurturing Families Network (NFN) is designed to help new parents and consists of: (i) home visitation which helps first-time parents get off to a great start with a new baby and provides infant development and care information; (ii) Nurturing Connections provides phone support to help first-time parents adjust to their first few weeks home with a new baby; and (iii) organizing parenting groups.

School-based Family Resource Center Services

The ECHN Family Resource Centers (FRC) offer education and support services for the entire family Services included child care, school-age care, parent-child playgroups, parent education, home visits, support for child care providers, positive youth development, adult education, resources and referrals to community services.

c) Details on the Workforce Development activities of MMH.

Response:

The majority of activities related to the Workforce Development activities of MMH are related to the organization's Work Source program. Work Source is a program designed to help people with mental illness and substance abuse achieve vocational success and social and economic independence. The program provides assistance in securing and maintaining competitive employment and educational opportunities.

25. Applicants state that ECHN's present teaching arrangements with the University Of New England College of Medicine for third year medical students, residents, and interns will be maintained. Please explain how these students, residents and interns are deployed within MMH, RGH and the towns served by ECHN to provide healthcare services and whether PMH plans any changes to how such medical students, residents, and interns are utilized.

[6] Family Enrichment Services was renamed Positive Parenting Program by the Department of Children and Families to reflect changes in the program curriculum.

Response:

PMH has committed to maintaining key clinical operations and community support including ECHN's University of New England College of Osteopathic Medicine ("UNECOM") medical student and other health professions teaching programs, and ECHN's graduate medical education programs. PMH does not have any plans to change how the medical students, residents and interns are utilized. Students, residents and interns will continue to be deployed to the Hospitals and communities served by ECHN utilizing a rotation structure that has been developed for each program:

Medical Students - In 2010, ECHN partnered with UNECOM to provide medical education and clinical opportunities at ECHN for sixteen of UNECOM's third year medical students. Students spend their entire third year of medical school in Connecticut and participate in the following clinical rotations:

- Family medicine
- Internal medicine (Hospitalist Service and Critical Care)
- Obstetrics and gynecology
- Pediatrics
- Psychiatry
- Surgery

Medical students also select rotations in the following areas to complete the third-year requirements for their program:

- Emergency medicine (hospital-based)
- Gastroenterology (inpatient and outpatient settings)
- Osteopathic manipulative medicine (outpatient setting)
- Otolaryngology (inpatient and outpatient settings)
- Pathology (inpatient setting)
- Radiology (inpatient setting)

Residents and Interns - In 2013, in response to the growing need for primary care providers, ECHN launched its own graduate medical education (GME) program that includes a family medicine residency program (twenty-four positions) and a rotating internship program (six positions). Residents and interns participate in the following clinical rotations:

- Hospital-based rotations
    - Hospitalist service (Family Medicine Inpatient Service)
    - Critical care
    - Emergency medicine
    - Geriatrics (completed at ECHN's Woodlake at Tolland)
    - Obstetrics

  - Pediatrics - completed at Connecticut Children's Medical Center ("CCMC")
  - Pediatric emergency medicine - completed at CCMC
  - Psychiatry
  - Surgery

- Community-based (outpatient) rotations
  - Cardiology
  - Dermatology
  - Family medicine
  - Gynecology
  - Nephrology
  - Ophthalmology
  - Orthopedics
  - Osteopathic manipulative medicine
  - Otolaryngology
  - Podiatry
  - Rheumatology
  - Sports medicine
  - Surgery

26. On page 63 of the Application, Applicants cite that the "Rockville section of Vernon, where RGH is located, has been designated by the Health Resources and Services Administration as a Medically Underserved Population and the northwestern part of Mansfield has been designated as a Health Professional Shortage Area for Primary Medical Care. RGH, MMH and their System affiliates provide safety net services to this region of the State." Please explain specifically how the proposed transaction with PMH will continue to address the needs of these underserved areas by identifying those programs, services and collaborations with other community organizations that will continue post-closing and provide information on any plans for new programs, services and collaborations that will expand access to health care in these underserved areas.

Response:

Services currently provided by ECHN at RGH and in the surrounding communities address the needs of Rockville's medically underserved population. RGH's emergency department has over 20,000 patient visits annually and nearly half of those patients come from the town of Vernon. The Maternity Care Center, located on the RGH campus, provides free maternity services to uninsured and underinsured women from Vernon and surrounding towns, including Manchester, Ellington, East Hartford and Mansfield. ECHN has established, through its medical foundation, a family medicine practice in Rockville within close proximity to RGH and another practice in Vernon, just a few miles from the Rockville section, to support the primary care needs of the area.

In Tolland, which is only a few miles from the northwestern border of Mansfield, ECHN offers laboratory services and has a number of specialists that see patients in a shared specialty suite at Fieldstone Commons. Also at this location is ECHN's joint venture imaging center Tolland Imaging Center which makes MRI, CT and other medical imaging services available to patients in a convenient outpatient setting. Several independent primary care physicians on the ECHN Medical staff practice at locations in Vernon, Tolland and Coventry, all of which offer a convenient source of primary care services for residents of northwestern Mansfield.

PMH has committed to keeping the Hospitals open for three years and has no plans to eliminate any services. No service line or service location changes are currently planned in connection with the proposed transaction, although it is expected that the ECHN ambulatory network will be expanded and services configured to promote the most efficient delivery of coordinated care following the closing. Through PMH's CRC model, PMH works closely with hospitals and affiliated medical groups for the benefit of every person who comes to them for care, building comprehensive networks of quality healthcare services that are designed to offer patients highly coordinated, personalized care and help them live healthier lives.

PMH will look to work with current service area providers such as Federally Qualified Health Centers in such underserved and health professional shortage areas to support their health care delivery efforts. PMH will also aggressively recruit physicians for these areas. PMH will also seek to expand services in these areas by establishing clinics urgent care centers and staffing such centers with either independent or employed physicians. There are no definitive plans at this time to add service locations for MMH or RGH. PMH will conduct a planning effort with the Local Boards post-closing to determine where there are opportunities to improve access, enhance services and introduce new programs that address identified health needs.

27. With respect to Exhibits Q42-1, Q42-2 and Q44-1, please address the following:

a) Applicants project no change in Nurse Staff to Patient Ratios or the Average Weekly Hours for Ancillary Caregivers for three years following approval of the asset purchase. Reconcile how the asset purchase will achieve efficiencies and improve quality of care without corresponding adjustments to nurse to patient ratios and the hours of ancillary caregivers.

Response:

PMH expects to implement cost and clinical efficiencies over time utilizing a planned and coordinated approach. Specific plans to address potential areas of opportunity that would impact patient census, patient acuity, staff experience levels and

technology utilized by caregivers have not been developed at this time, so staffing changes that would result related to these factors cannot be reasonably predicted. Furthermore, the parties have been careful to wait for the required antitrust approvals before making any post-closing plans, including any operational or capital plans.

Given these limitations, the projections presented in Exhibit Q42-2 (Staffing Attachment II) and Exhibit Q44-1 (Ancillary Caregiver Staffing Attachment) assumes volume demands (which would impact unit configuration and size), patient acuity, staff experience levels, and technology will remain constant during the projection period. During the first three full fiscal years following approval of the Asset Purchase (FY 2017, FY 2018, and FY 2019) staffing levels may begin to shift as PMH introduces best practices from its other hospitals and implements its CRC model, which is expected eventually to result in changes in patient acuity caused by improving population health and a shift in relative volumes of inpatient and outpatient services. PMH is committed to staffing levels that comply with ratios mandated by Connecticut state law, which implement best industry practices, and which take into account patient safety and acuity, employee safety and facility census.

b) ECHN failed to meet budgeted targets for Average Nursing Hours per Patient Day in several categories yet no changes in Nursing Staff ratios for the first three years following approval of the asset purchase are projected. Explain why this is the case.

Response:

The Nursing Hours per Patient Day (NHPPD) target is a metric used by nursing unit leaders to manage staffing levels and help them to respond to fluctuations in unit census. Unit census changes constantly and can vary significantly from day-to-day and hour-to-hour, making the decision of when to adjust staffing levels (and for how long) challenging. Factors including, but not limited to, the number of patients being admitted to or discharged from a unit, the acuity of patients on the unit and staff experience all influence decisions regarding staffing levels. Whether or not a unit has historically met NHPPD targets does not affect the Nursing Staff ratio guidelines for future years because the ratios are determined by the projected unit census and the Nursing Staff requirements at that census level.

PMH expects to implement cost and clinical efficiencies over time utilizing a planned and coordinated approach. Specific plans to address potential areas of opportunity that would impact patient census, patient acuity, staff experience levels and technology utilized by caregivers have not been developed at this time, so staffing changes that would result related to these factors cannot be reasonably predicted. Furthermore, the parties have been careful to wait for the required antitrust approvals before making any post-closing plans, including any operational or capital plans.

Given these limitations, comparable Staffing ratios were maintained until specific plans are developed

28. Please elaborate on the expected revenue growth for MMH and RGH associated with the use of the CRC model of care and provide specific examples from hospitals currently owned by PMH of actual savings realized post-acquisition in the various operating expense categories set forth in Financial Worksheet (C).

Response:

The implementation of CRC is not expected to cause a reduction in operating expense categories. The goal of CRC is reduce the overall cost of healthcare by increasing preventative care and early interventions, reducing re-admissions, reducing inpatient utilization and reducing emergency room visits. CRC achieves these objectives by incentivizing physicians and patients to appropriately use urgent cares centers and to keep patients compliant with various homebound and other wellness programs, and by keeping patients healthier so as to reduce the overall over-utilization of healthcare services. By achieving these objectives, the cost of healthcare will be reduced, including for such programs as Medicaid and Medicare.

In the state of Rhode Island, PMH projects to reduce the cost of care for a segment of the Medicaid population by 5%.

29. On page 78 of the Application, the Applicants indicate that "PMH has access to an existing corporate level credit facility in addition to its cash on hand." Name the credit facility, provide PMH's current credit rating and elaborate on the process associated with borrowing funds from this credit facility to fund any portion of the $75 million Commitment Amount in lieu of cash from MMH and RGH operations.

Response:

PMH has received credit upgrades by both Moody's and S&P in 2015. Moody's rates PMH's bonds as B1, while S&P rates PMH's bonds as B.

PMH has access to a revolving line of credit with Morgan Stanley that has been pre-approved. In order to draw on this line, PMH simply provides a 24 hour advance verbal notice to the lenders. The line of credit is available to fund the Commitment Amount if necessary.

30. Elaborate on the financial feasibility to fund the $105 million (or $115 million) purchase price given PMH's declines in cash and cash equivalents, operating income, net income, and realized deficits in Stockholder's equity from FY 2012 to 2014 reported in its FY 2014 audited financial statements as set forth at Exhibit Q8-1.

Response:

PMH's financial performance has demonstrated significant growth from 2012 to present:

PMH Financial Performance	2012	9 Months Ending 06/30/2015
Operating Income:	$80 Million	$82.3 Million
Net Income	$26 Million	$32 Million
Stockholders' Equity	$31 Million	$34 Million

The growth in Stockholders' Equity is net of a $100 million dividend paid in November 2012. Please refer to Exhibit Q8-2 of the CON application for more information pertaining PMH's stockholder equity.

Impacting 2014 reported financial and cash flow was the delay in revenue recognition of the California Quality Assurance Fee (SB 239) program. The associated revenue, EBITA and cash receipts could not be recognized until formal Federal approval of the program was received which occurred after the fiscal year-end.

Cash balances from 2012 to 2014 were impacted by the completion of multiple acquisitions paid with existing cash on the balance sheets. The cash consideration for these acquistions totaled in excess of $81 million. Additionally, during this time, the Due from Government payor receivable increased by more than $28 million, primarily due to the delay in funding the California Quality Assurance Fee program for the period of January 2014 to September 2014. Payments related to this program were subsequently received in 2015.

PMH has significant cash on hand to complete the transaction. As of September 30, 2015, PMH on consolidated basis had in excess of $110 million in funds available. Furthermore, PMH generates over $7.5 million in free cash flow per month. The amount of cash necessary to close the ECHN transaction is currently estimated to be approximately $28 million.

31. On page 907 of the Application, in PMH's Condensed Consolidated Statements of Operations, Applicants report significant growth in both Total Net Revenues and Total Operating Expenses for the nine months ending June 30, 2015 as compared to the same reporting period in 2014. Please explain the factors impacting these changes.

Response:

Revenue and expense growth for the nine months ended on June 30, 2015 as compared to the same reporting period in 2014 is due to the acquisition of CharterCARE in the state of Rhode Island and the recognition of payments from the California Quality Assurance Fee (SB 239) program.

32. In reference to the priority capital projects identified by ECHN management on page 82 of the Application, provide their current estimated cost and, as applicable, the years beyond useful life for these assets.

Response:

The following table contains cost estimates for the capital list identified by ECHN management. The years beyond useful life for the assets being replaced indicate the time since the asset was last being depreciated for accounting purposes and does not suggest that the assets are not in good working order.

	Estimated Cost	Estimated Years beyond useful financial life
Upgrades to emergency department for behavioral health patients (MMH)	$1.1M	N/A
Electronic medical record system (MMH & RGH)	$20M	N/A
Upgrades to nursing units (RGH)	$6.6M	N/A
Upgrades to nursing units (MMH)	$11M	N/A
Vessel sealing systems (MMH & RGH)	$0.6M	N/A
MRI replacement (MMH)	$1.6M	4
SPECT scanner replacement (MMH)	$0.4M	10

33. With the understanding that the $75 million Commitment Amount has not been apportioned by hospital or other affiliates, please submit a preliminary capital investment plan that provides an approach on how PMH might distribute the $75 million by capital projects.

Response:

The parties have not yet prepared a capital investment plan. ECHN and PMH have agreed to seek the input of the Local Boards and medical staff to produce a capital plan post-closing that will ultimately determine the capital projects and priorities. The parties have been careful to wait for the required antitrust approvals before making any post-closing plans, including any operational or capital plans.

In order to better position ECHN as a premier choice for healthcare in its community, PMH believes that it will need to continually evaluate the facilities and markets for future capital projects. Immediately post-closing, as a part of the strategic planning process, PMH would consider and evaluate market data and projections, current and proposed regulatory environments, operational and financial requirements, and capital expenditures models in the markets in which ECHN operates. This strategic planning process would be led by the local management team; however the resources of PMH would provide the necessary capital and expertise to enhance existing services and add new service lines.

Working with the local leadership, PMH will identify and prioritize the identified capital projects. PMH's objective is to implement growth initiatives for the benefit of the surrounding communities served by ECHN so long as that care can be delivered in a high quality and financially responsible manner.

34. Provide an updated Exhibit Q8-2, providing PMH's FY 2015 unaudited financial statements to reflect twelve months of financial activity.

Response:

PMH's FY 2015 unaudited financial statements reflecting twelve months of financial activity are not yet available as PMH's year-end financials cannot be disclosed publicly in draft form, particularly in light of the potential investment transaction at PMH corporate level, described more fully below (see response to the deficiencies identified by OAG and OHCA on November 12, 2015, beginning on page 2204, for more information on this investment transaction). The Applicants will provide a copy of the financial statements once the audited financials have been received and they have been publicly disclosed.

35. In reference to Financial Worksheet (C), Exhibit Q37, and the related Assumptions, at Exhibit Q38, for MMH, RGH and ECHN address the following:

a) Provide a revised Financial Worksheet (C) that will include projections of total revenue, expense and volume statistics without, incremental to and with the CON proposal for FYs 2015 and 2016. Provide the assumptions utilized in developing the projections and explain any projected losses from operations;

Response:

Financial Worksheet (C) has been revised to include projections of total revenue, expense and volume statistics without, incremental to and with the CON proposal for FY 2015 and FY 2016.

The FY 2015 projections are annualized statistics based on actual FY 2015 year-to-date amounts through July and were originally provided on pages 1846 and 1847 of the CON application submitted on October 13, 2015. Assumptions utilized in developing the FY 2016 projections can be found on pages 1852 and 1853 of the CON application.

Additionally, after reviewing the detail assembled for other operating revenue (requested in Question 35b below), it was brought to the Applicants' attention that the amounts for Public Support were not removed in the "with CON" scenario. This oversight has been corrected and the revised incremental amounts for other operating revenue are now reflected in the projections with CON approval presented on Financial Worksheet (C).

Please refer to **Exhibit I** for the revised version of Financial Worksheet (C) reflecting the changes described above.

ECHN is projecting declines in net patient revenues in FY 2015 and FY 2016 as a result of payer mix shifts to the exchanges and Medicaid. As discussed on page 36 of the CON application in the Applicants' response to Question 5, increases to the state hospital tax, Medicare wage index changes, and the continued evolution of the health spending accounts are additional factors behind ECHN's projected operating losses.

b) The Assumptions, listed under the other operating revenue section, indicate that joint venture income will increase 2% each year after FY 2016. Provide an itemized schedule of the other operating revenue amounts reported for FYs 2017, 2018 and 2019 without, incremental to and with the CON proposal, inclusive of joint venture income for all three entities; and

Response:

An itemized schedule of the other operating revenue amounts reported for FY 2015 through FY 2019 without, incremental to, and with the CON proposal, inclusive of joint venture income for all three entities has been provided in **Exhibit J**.

c) The Assumptions indicate that the asset purchase by PMH will allow MMH and RGH and their provider affiliates to benefit from economies of scale inherent of a large organization when purchasing supplies and services. In reference to this statement, explain the projected incremental increases in fringe benefits, supplies and drugs, and other expenses reported between FYs 2017 and 2019.

Response:

PMH believes that the costs to provide fringe benefits will decrease in the first full year of operation, because PMH is essentially self-insured for providing benefits and will therefore save on the profit portion of the premium generally paid to third parties in order to provide fringe benefits to employees. PMH estimates, however, that cost of providing fringe benefits will increase over time, as salaries and costs of providing benefits increase each year.

From a supplies perspective, PMH believes that through the economies of scale, the Hospitals will enjoy higher discounts for supplies and drugs as part of a larger organization in the first year. Subsequently, the Hospitals should be entitled to better discounts and pricing through better compliance with purchasing protocols. It should be noted, that if PMH is successful in future hospital acquisitions (whether within the state of Connecticut or outside), the Hospitals should receive better pricing as PMH's purchasing power increases.

36. Please provide updated Financial Measurements Indicators, Exhibit Q50-1, for the months of July, August and September 2015 and comparable months from the previous fiscal year for MMH and RGH, ECHN and PMH. Provide the methodology utilized to calculate the financial ratios on Sections A through C and an explanation for any decreases or increases that apply to any of the items listed on Section D between YTD FYs 2014 and 2015.

Response:

Please refer to **Exhibit K** for Financial Measurement Indicators for July, August and September 2015[7] and comparable months from the previous fiscal year for MMH, RGH and ECHN. Financial statistics for the entity which will acquire ECHN (Prospect ECHN, Inc.) are not available as the entity does not currently exist and will not be formed unless the proposed asset purchase is approved.

For the financial ratios on Sections A through C, the Applicants utilized the formulas provided by OHCA in the Twelve-month filing Report 185 to calculate all of the statistics with the exception of the following:

Statistic	Calculation Methodology Used
ECHN's Days Cash on Hand	(Cash + Board Designated Investments + Investments) ÷ (Operating Expenses - Depreciation) x 365 days
ECHN's Average Payment Period	Current Liabilities x 365 days ÷ (Operating Expenses - Depreciation)
ECHN's Long-term Debt to Capitalization	Long-term debt ÷ (Long-term debt + Unrestricted Net Assets)
ECHN's Debt Service Coverage Ratio	(Net Income + Depreciation + Interest Expense + Change in Swap value) ÷ Maximum Annual Debt Service

ECHN saw a deterioration in all of the financial indicators in Section D due mainly to lower government reimbursements, most notably from the State. In addition, ECHN saw a decrease in volume across many of the key inpatient and outpatient services provided by the hospitals which also contributed to the declines observed in these financial indicators.

37. For each of PMH's five most recent acute care hospital acquisitions identified in Exhibit Q58-1 of the Application address the following:

    a) Complete the following table:

[7] Financial statistics provided for September 2015 are based on the unaudited financials for MMH, RGH and ECHN available at the time of this submission. The Applicants will plan to submit an updated version of the September 2015 financials once the year-end audit has been completed and the final audited financial statements for FY 2015 are available.

Name	Total Capital Investments	Describe Improvements in Financial Performance			Total Cost Savings
		Profits	Liquidity	Solvency	

Response:

Please see **Exhibit L** for the completed Table.

b) Describe particular initiatives utilized to achieve the results described above;

Response:

With respect to Los Angeles Community Hospital at Bellflower and Foothill Regional Medical Center, the capital investments were for improvement to the plant and equipment to open the hospitals.

With respect to Nix, PMH made investments in creating an IPA, expanding outpatient clinics, opening an emergency room, expanding behavioral health capacity, and upgrading plant and equipment.

With respect to the CharterCARE, in only its first year of ownership, PMH has made investments in forming an IPA, forming a risk bearing entity, acquiring primary care clinics, and making upgrades to plant and equipment. PMH has committed to spending an additional $20 million on a cancer center, Digestive Diseases Center, expansion and upgrade to the emergency department and additional physician practice acquisitions.

c) Indicate how the financial performance improvements translated into lower health care costs; and

Response:

Initiatives implemented through the development of the CRC model of care will facilitate a more efficient care delivery model. CRC encourages providers to be more clinically integrated with other care givers and enables patients to receive the right care, with the highest levels of quality, in the most appropriate care setting. Through the development of the CRC and the attainment of these objectives, PMH will be successful reducing unnecessary re-admissions, inpatient

utilization, and emergency room visits which will translate into improved outcomes and lower health care costs for patients in the region.

d) Indicate how the cost savings were due to economies of scale inherent of a larger organization; and

Response:

As discussed in response to Question 28 above, the implementation of PMH's CRC will not cause a reduction in operating expense categories at a hospital. The goal of CRC is reduce the overall cost of healthcare by reducing re-admissions, reducing inpatient utilization and reducing emergency room visits. By achieving these objectives, PMH will reduce the cost of healthcare for such government programs as Medicaid and Medicare, but also to commercial insurers who elect to participate in risk-based contracts.

It should be noted that by affiliating with a larger organization, ECHN will benefit from economies of scale due to PMH's overall purchasing power. Post-acquisition, ECHN should realize benefits in lower supply costs, drug costs and costs related to consultants. By having ECHN participate in PMH's Group Purchasing Organization, ECHN will realize lower supply and drug costs. Furthermore, the resources of PMH will be made available to ECHN to assist ECHN in developing and implementing its strategic plans, whereas in the past, ECHN may have employed consultants to aid in such efforts.

e) Since Exhibit Q58-1 contains no discussion of how these acquisitions improved the quality of health care for the hospital's service area, comment on each hospital's performance under the following CMS quality improvement programs since PMH first acquired the hospital (comparison to national, state and local performance standards as well as ECHN's current performance statistics is invited):

i. Hospital Inpatient Quality Reporting Program;
ii. Hospital Outpatient Quality Reporting Program;
iii. Hospital Value-Based Purchasing Program; and
iv. Hospital Readmissions Reduction Program.

Response:

Please see **Exhibit M** for the quality report generated by the State of Rhode Island with respect to the CharterCare CON and conversion process. The report includes the historical quality metrics at the now current PMH hospitals.

Attached in the **Exhibit N** is an update of the quality metrics for 2014. Metrics for MMH and RGH are included in the exhibit. Additionally, please note that 2015 risk adjusted quality metrics have not been published.

Delivering quality care is of utmost importance in operating a hospital as well as the CRC model. As physicians are such an integral part of delivery of care, PMH believes that quality issues should be handled at a local level. The goals of the PMH Quality Program consist of achieving results in each of measures that are better than the national average, with the expectation of continuous improvement. The PMH Quality program is the accomplished through a joint process between the Medical staff leadership and Hospital leadership within each entity with oversight by the Local Governing Board. PMH provides overall leadership, coordination of best practice, and Policy and Procedures for Standardization of protocols.

38. On page 865 of the Application, PMH's FY 2014 audited financial statements, indicate that "*Patients without insurance are offered assistance in applying for Medicaid and other programs they may be eligible for, such as state disability. Patient advocates from the Company's Medical Eligibility Program ("MEP") screen patients in the Hospital and determine potential linkage to financial assistance programs. They also expedite the process of applying for these government programs.*" Elaborate on the MEP process and success record. Indicate whether this program will be available at MMH and RGH if the asset purchase is approved and consummated.

Response:

Uninsured patients who receive services at PMH-affiliated hospitals are interviewed by either employees or third party contractors to determine if such patients are entitled to benefits from a variety of financial assistance programs, most notably state Medicaid. With the expansion of Medicaid under the ACA, many patients who present as uninsured are not aware that they could potentially qualify for Medicaid. Through the interview process, PMH hospitals determine if such patients qualify for Medicaid and assist such patients with submitting the appropriate forms to the relevant state agencies. In California, PMH estimates the success rate on assisting patients to qualify for financial assistance programs to be approximately 60%. In Texas, this success rate is approximately 15%. The success rate is lower in Texas because Texas did not opt for Medicaid expansion as part of the ACA. PMH has just

recently instituted our MEP program in Rhode Island. As such, PMH has not had a chance to assess its success in Rhode Island.

39. On page 92, Applicants were asked provide copies of the most recent CMS Statements of Deficiencies and Plans of Correction (CMS Form 2567) for all hospitals owned by PMH. Applicants provided only those statements pertaining to its Rhode Island hospitals. Please provide the requested information for PMH owned hospitals in Texas and California. Provide these documents in an electronic format only. PDF file on a CD to accompany the responses.

Response:

Please see **Exhibit P** for the requested CMS Statements of Deficiencies. Documents have been provided in electronic format only as requested.

40. With respect to the proposed Asset Purchase Agreement, please provide the information contained in the following schedules: Schedule 2.01 (a) Owned Real Property; Schedule 2.01(b) Leased real property; Schedule 3.12 (c) Building Maintenance and Repairs; Schedule 3.12(g) Rent Roll; Schedule 3.12 Tenant Lease Encumbrances; Schedule 3.13(a) Environmental claims; Schedule 3.13 (b) Underground storage tanks and waste disposal; and Schedule 3.18 People in possession of owned property.

Response:

The APA schedules referenced above are documents that will be produced for Closing. Please see **Exhibit O** for responsive information describing ECHN owned real property, leased real property, building maintenance and repairs, rent rolls, tenant lease encumbrances, environmental claims, underground tanks and waste disposal. Schedule 3.18 to the APA (Exhibit Q3-2 of the CON submission, page 127) does not concern owned property; however, responsive information regarding this topic is being made available in **Exhibit O** under the title Owned Real Property. The information in **Exhibit O** is subject to change in the ordinary course of business prior to Closing.

41. Please provide a full and complete listing of both owned and leased real property, including any real estate related to joint ventures.

Response:

Please refer to the responsive information included in **Exhibit O** under the titles Owned Real Property and Leased Real Property for a listing of ECHN's owned and leased property.

The real property leased by the joint ventures is listed in the following table:

Joint Venture	Real Property
Ambulance Service of Manchester, LLC	275 New State Road, Manchester, CT 06042
Aetna Ambulance Service, Inc.	140 Van Block Avenue, Hartford, CT 06114
Connecticut Occupational Medicine Partners, LLC*	2800 Tamarack Avenue, South Windsor, CT 06074
Eastern Connecticut Physician Hospital Organization, Inc.	26 Haynes Street, Manchester, CT 06040
Evergreen Endoscopy Center, LLC	2400 Tamarack Avenue, South Windsor, CT 06074
Evergreen Medical Associates, LLC	2800 Tamarack Avenue, South Windsor, CT 06074
Evergreen Medical Associates II, LLC	2400 Tamarack Avenue, South Windsor, CT 06074 2600 Tamarack Avenue, South Windsor, CT 06074
Haynes Street Medical Associates, LLC	29 Haynes Street, Manchester, CT 06040
Haynes Street Medical Associates II, LLC	100 Haynes Street Manchester, CT 06040
Metro Wheelchair Service, Inc.	275 New State Road, Manchester, CT 06042
Northeast Regional Radiation Oncology Network, Inc.	100 Haynes Street, Manchester, CT 06040 142 Hazard Avenue, Enfield, CT 06082
Tolland Imaging Center, LLC	6 Fieldstone Commons, Tolland, CT 06084
WBC Connecticut East, LLC	2400 Tamarack Avenue, South Windsor, CT 06074

** Connecticut Occupational Medicine Partners, LLC provides management services for Manchester Memorial Hospital's CorpCare Program at this address.*

42. With respect to Question 5, please provide any information and documents that are not attorney-client privileged or are protected by confidentiality agreements relating to any other offers to transfer assets or operations or change control of operations received by ECHN.

Response:

As referenced in response to Question 5 of the Application, ECHN received three responses to its February 19, 2015 Request for Proposal (RFP). One was from a nonprofit system that proposed making a minority investment in ECHN, purchasing its home care agency and providing a management agreement for ECHN. A second was from a national nonprofit organization that was merging with a Connecticut nonprofit system and that proposed a member substitution pursuant to which it would become ECHN's corporate parent. The third proposal was from PMH to acquire all or substantially all of the assets of ECHN. As part of the RFP process, ECHN entered into confidentiality agreements with each of the respondents. As such, ECHN has committed to the respondents (other than PMH who has consented to disclose information about its response in connection with obtaining necessary regulatory approvals) to keep the details of those offers confidential. ECHN is not, therefore, permitted to provide any additional information or documentation on the offers received, other than the offer received from PMH (see response to Question 5 for the complete response received from PMH).

On November 12, 2015, ECHN and PMH received additional correspondence from the OAG and the OHCA requesting additional information regarding reports of a potential sale of PMH. The Applicants response to the deficiencies received on November 12, 2015 has been provided below:

1. Please confirm or deny the reports identified above and specifically explain the basis for the report.

   Response:

   Neither PMH nor any of its subsidiaries are affiliated with the Deal Pipeline s website or the LBO Wire. Therefore, we cannot explain how or why those particular reports were generated.

   We can confirm, however, that PMH has retained Morgan Stanley to review and assess additional sources of investment to support its overall growth strategy, and that PMH has been in discussions with additional investment groups to evaluate opportunities to partner during this next phase of the company s growth.

   PMH is a growing company that is performing very well and receives inquiries from interested investors. The company is not for sale to a strategic buyer such as another healthcare provider, health plan or health system. PMH is only considering its financial investment and investor options to support its plans for future growth.

2. Please describe Leonard Green & Partners and its present ownership stake and control of PMH.

   Response:

   About Leonard Green & Partners, L.P. (Leonard Green) - Source: www.leonardgreen.com

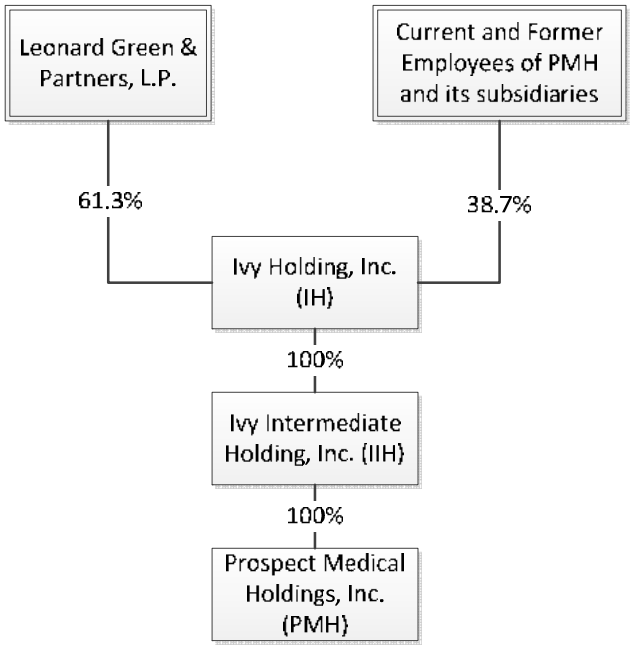
   Leonard Green is one of the nation s preeminent private equity firms with over 15 billion of private equity capital raised since its inception. Founded in 1989, the firm has invested in 76 companies in the form of traditional buyouts, going-private transactions, recapitalizations, growth capital investments, corporate carve-outs and selective public equity and debt positions. Based in Los Angeles, CA, Leonard Green invests in established companies that are leaders in their markets. [8]

   The affiliated investment funds of Leonard Green own approximately 61.3 of the common stock of Ivy Holding, Inc. (IH), a Delaware corporation which owns 100 of the stock in Ivy Intermediate Holding, Inc. (IIH). IIH is a Delaware corporation which owns 100 of the stock of PMH. IIH is a holding company for such stock ownership. It has no other assets,

[8] http: www.leonardgreen.com news 081415-Ellucian-n.pdf

liabilities or operations. Current and former employees of PMH and its subsidiaries own the remaining shares of IH stock.

Figure 1 Relationship of Leonard Green to PMH



Other healthcare related investments held by Leonard Green include CHG Healthcare Services, RestorixHealth and US Renal Care.

3. If PMH is contemplating a sale, whether for a controlling or non-controlling interest in PMH, please explain the motivation and rationale for the sale.

Response:

PMH is not for sale to a strategic buyer such as another healthcare provider, health plan or health system. PMH is only considering its financial investment and investor options to support its plans for future growth. The rationale for pursuing these potential partnerships is to secure a means of raising additional capital to support its existing operations and for further acquisitions in new and existing markets.

4. If PMH is contemplating a sale, whether for a controlling or non-controlling interest in PMH, please explain the planned timeline for the sale.

Response:

The engagement with Morgan Stanley to review and assess additional sources of investment for PMH will likely conclude within the next year. PMH will only proceed further with any additional investors if we find a partner that supports our current growth strategy. The engagement with Morgan Stanley may not yield any additional investment into the Company. This is an evaluation at this point in time.

5. If PMH is contemplating a sale, whether for a controlling or non-controlling interest in PMH, please explain the anticipated key terms and conditions of the sale.

Response:

At of the date of this response, there is no pending sale of PMH, and as a result, no terms and conditions.

6. If PMH is contemplating a sale, whether for a controlling or non-controlling interest in PMH, please explain how a sale would affect the planned acquisition of ECHN.

Response:

PMH's pursuit of additional investment partners will not affect the planned acquisition of ECHN. Capital funding associated with PMH's acquisition of ECHN is currently available. The rationale for pursuing additional investment partners at this time is to prepare the organization for future growth and to support PMH's overall growth strategy.

7. If PMH is contemplating a sale, whether for a controlling or non-controlling interest in PMH, please explain how the sale would affect the future operations of ECHN.

Response:

PMH's pursuit of additional investment partners will not affect the future operations of ECHN other than to support the overall growth of PMH which could also benefit ECHN as part of a growing system. PMH's short and long term strategy and focus on transforming the healthcare delivery model will not change. PMH will continue to focus on its current operations and will continue to invest in its hospitals, medical groups, CRC network and related business. The management of PMH will remain unchanged.

RESPONSE TO DEFICIENCIES
EXHIBIT A – Joint Venture Valuations

Joint Venture Valuations

	Ownership/ Membership	ECHN Net Income/(Loss) 9/30/2014	Joint Venture EBITDA 9/30/2014	EBITDA @6X
Metro Wheelchair Service, Inc.	50%	(54,225)	(54,462)	(326,772)
Aetna Ambulance Service, Inc.	50%	188,996	495,936	2,975,616
Ambulance Service of Manchester, LLC	50%	1,026,411	1,355,963	8,135,775
WBC Connecticut East, LLC	16%	(1,455)	10,366	62,195
Evergreen Endoscopy Center, LLC	50%	491,891	565,547	3,393,279
Tolland Imaging Center, LLC	70%	179,810	238,046	1,428,277
Northeast Regional Radiation Oncology Network, Inc.	50%	381,743	506,689	3,040,131
Haynes Street Medical Associates, LLC	23%	20,243	46,896	281,374
Haynes Street Medical Associates II, LLC	15%	65,410	186,919	1,121,513
Evergreen Medical Associates, LLC	20%	108,866	130,389	782,333
Evergreen Medical Associates II, LLC	20%	70,834	205,715	1,234,292
Total		**2,478,524**	**3,688,002**	**22,128,012**

RESPONSE TO DEFICIENCIES

EXHIBIT B - Table 8: Net Proceeds Analysis (Revised 11/4/2015)

Response to Deficiencies Question 4

Table 8: Net Proceeds Analysis

Assumes transaction will close on 09/30/2015

			Scenario B 9/30/2015	Scenario A 9/30/2015
ACQUISITION PRICE (EV)	A		$115,000,000	$105,000,000
ASSUMED LIABILITIES:				
Pension & Retiree Medical			($62,598,000)	($62,598,000)
Captive & Workers Comp.			($1,705,000)	($1,705,000)
Net Working Capital True-up			($9,107,000)	($9,107,000)
"Taxable" Long Term Debt			($45,000,000)	0
Capital Leases, Misc (FIN47)			($8,045,000)	($8,045,000)
TOTAL ACQ LIABILITIES	B		($126,455,000)	($81,455,000)
NET PROCEEDS (CASH to ECHN)	C	A+B	($11,455,000)	$23,545,000
CASH & INVESTMENTS (ECHN)	D		$58,214,000	$58,214,000
TOTAL CASH for DEBT PAYOFF	E	C+D	$46,759,000	$81,759,000
LONG TERM DEBT (Net AWUIL)	F		($42,696,000)	($77,696,000)
SURPLUS after DEBT DEFEASANCE	G	E+F	$4,063,000	$4,063,000
INDEMNITY RESERVE	H		($3,063,000)	($3,063,000)
SURPLUS for COMM. FOUNDATION	I	G+H	$1,000,000	$1,000,000

Updated November 4, 2015

RESPONSE TO DEFICIENCIES
EXHIBIT C - Request for Proposal Response (PMH)

PROSPECT MEDICAL HOLDINGS, INC.

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

VIA EMAIL ONLY

March 16, 2015

Mr. Dennis P. McConville
Senior Vice President and Chief Strategy Officer
Eastern Connecticut Health Network, Inc.
71 Haynes Street
Manchester, CT 06040

Dear Mr. McConville:

This letter sets forth the non-binding intent of Prospect Medical Holdings, Inc. ("Prospect") with respect to a proposed transaction in which Prospect, or a designated subsidiary, would acquire the assets of Eastern Connecticut Health Network (collectively "ECHN"). The following represents the basic framework of our proposal and, if acceptable to ECHN shall serve as a basis for a more formal Asset Purchase Agreement ("APA").

Pursuant to your request we have attached a revised draft APA and side letter. Please note that the revised draft APA, as well as the side letter, are subject to further diligence, which will require exchange of additional information. Furthermore, should you have any questions or wish to discuss any of the revisions, please do not hesitate to contact us.

Prior to responding to the requested proposal elements, we believe a brief background on Prospect would be helpful.

Prospect is an innovative healthcare services delivery company that is responding to the evolving healthcare environment through meaningful collaboration between physicians and hospitals. Prospect's proven track-record with hospital integration and growth is directly related to its collaborative and cooperative relationships with physicians on a hospital's medical staff to promote the quality and efficiency of patient care. Prospect believes that it will meet ECHN's transaction objectives due to its financial strength, proven population management expertise, and its strong management team of seasoned operating, marketing, contracting, financial and administrative executives that maintain a dedicated "*hands-on*" commitment to the delivery of quality, cost effective healthcare services.

Prospect provides quality, cost-efficient and coordinated healthcare services through our hospitals, clinics and physician networks in Southern California, Texas, and Rhode Island. We are also purchasing an additional hospital in New Jersey.

We conduct our business operations through two complementary segments: the hospital segment and the medical group segment. Through our hospital segment, we own and operate 13 acute care and behavioral hospitals, with a total of approximately 2,258 licensed beds, and a network of 32 specialty and primary care clinics. Our hospitals are located in diverse population areas within Southern California, Texas and Rhode Island and maintain significant market positions in the areas they serve. All of our facilities provide a comprehensive range of services tailored to their specific communities, including other area hospitals, physicians and health plans. We believe that our proven model has a number of competitive advantages, including a data-driven and cost-efficient platform that has enabled us to provide quality care to patients.

Through our medical group segment and hospitals, we manage the provision of healthcare services to approximately 260,000 enrollees of Health Maintenance Organizations ("HMOs") and other payers in Southern California through a network of approximately 8,900 primary care and specialty physicians. Based on our enrollment, our medical groups have a significant presence in Southern California and have long-term capitated contracts with nearly all major HMOs operating in the region. In addition to the medical group capitated enrollment, we also have contracts with affiliated medical groups and health plans which capitate our hospitals in Southern California for more than 30,000 members bringing our total lives under risk management to more than 300,000.

We align our hospitals and physicians under what we call coordinated regional care ("CRC"). CRC is the clinical integration among hospitals, physicians and other medical, social and community providers working closely with strategic partner health plans and other payers under a value-based, global risk reimbursement payment system to achieve the triple aim of improved patient care and experience, better patient health and lower costs. This has been a highly successful strategy for aligning physicians with our hospitals and improving the volume, quality, efficiency and financial performance of our system in California. We have implemented a similar, local version of the CRC strategy in our Texas and Rhode Island markets and have seen similar success.

We operate both our facilities and medical groups by applying highly disciplined, data-driven management to the provision of quality care to our patients. Through the in-depth analysis and application of various operational and financial metrics, we have been able to achieve a highly efficient cost structure across a diverse mix of payers and have been able to adapt to economic and regulatory changes. We believe the most cost-efficient and quality driven providers will succeed in this rapidly changing economic and regulatory environment. Furthermore, we believe the coordination of our facilities and medical groups creates an efficient healthcare delivery system that positions us well for the future of healthcare delivery.

Prospect currently owns the following hospitals:

- Los Angeles Community Hospital;
- Los Angeles Community Hospital at Bellflower;
- Norwalk Community Hospital;
- Southern California Hospital at Hollywood;
- Southern California Hospital at Van Nuys;
- Southern California Hospital at Culver City;
- Newport Specialty Hospital;
- Roger Williams Medical Center
- Our Lady of Fatima Hospital; and
- Nix Health (four campuses)

Furthermore, we believe that ECHN's vision for the future is compatible with Prospect's objectives in expanding into the Connecticut market. Prospect seeks to establish a quality healthcare delivery system in Connecticut with a continuum of services that would provide access to quality healthcare services to ECHN's surrounding communities on a cost efficient basis. We plan to employ a number of physician alignment strategies that will help ECHN to not only maintain its current market position but to grow its patient care services and enhance its market position. We also believe that Prospect's long and deep experience in population health management and coordinated regional care will make ECHN a leading healthcare provider in the state of Connecticut. Obviously, there is an enormous advantage to early adopters, which we believe we will be in the state of Connecticut.

Our interest in ECHN is based on its location in a very attractive market, its strong presence and commitment to its local community, its reputation for quality and service, and its significant potential for growth. We believe that this is the right opportunity for Prospect and plan to build upon ECHN's significant achievements as an essential community system.

Proposed Transaction

We propose to form one or more new entities to purchase all tangible and intangible assets owned or used by ECHN in the operation of the hospital and health delivery system. We contemplate that the assets would be conveyed and assigned free and clear of all liens, claims, charges or encumbrances. As a part of the transaction, Prospect expects to assume ECHN's pension liabilities.

Assuming that ECHN's consolidated balance sheet at closing would be free of all debt (including pension liabilities) and cash, Prospect is prepared to offer a total consideration of $180 million (based on ECHNS's financial statements as presented to date) for the assets of ECHN as described above. The consideration is broken down as follows:

Consideration for Assets	$105 million
Capital Commitment	$ 75 million
Total	$180 million

Please note that Prospect is amenable to and welcomes other potential transaction structures to be suggested by ECHN. Aside from acquisitions, Prospect has experience, and has had success, in structuring partnerships and joint ventures.

Vision and Operations

1. *How will affiliation with our organization help ECHN achieve its vision and goals?*

In order to better position ECHN as a premier choice for healthcare services in its community, we believe that we must continually evaluate the facilities and markets for future capital projects. Immediately upon the execution of the APA, as a part of our strategic planning process we would consider and evaluate market data and projections, current and proposed regulatory environments, operational and financial requirements, and capital expenditures models in the markets in which ECHN operates. Our strategic planning process would be led by the local management team; however the resources of Prospect would provide the necessary capital and expertise to enhance existing services and to add new service lines. Although we have not yet had an opportunity to review ECHN's strategic plan, we believe that we will build upon ECHN's plans.

We will form an integrated healthcare delivery system through the CRC model which will necessarily involve a physician engagement strategy with the goal of providing high quality care in an efficient manner. We plan to implement, as necessary and appropriate, value-based payments, bundled payments, accountable care, and clinical integration with physicians and other providers. This is a model we have successfully implemented in Southern California for many years and are in process of exporting to other markets such as Texas, Rhode Island and New Jersey. It is a model we would seek to establish in Connecticut.

2. *Based on your vision of the market, how can you help us improve the range of healthcare services available within the communities ECHN serves and access to those services?*

We recognize that meeting the long-term needs of ECHN's service area would require constant evaluation of the market to identify needed services to enhance growth. Growth strategies begin with a detailed assessment of the market to identify opportunities to add or expand healthcare services. ECHN's service lines would be identified and evaluated. Working with the local management team, and in consultation with local advisory boards, we will identify and prioritize the growth initiatives that make the most sense. It would be our objective to initiate growth initiatives for the benefit of the surrounding communities of the hospitals operated by ECHN so long as that care can be delivered in a high quality and financially responsible manner.

One of the key components of the CRC model is to build a coordinated network of providers that deliver the full range of services to a population for a value based payment. Of course it is preferable to have as many services delivered by owned and operated facilities as possible. However, it generally isn't possible or feasible to provide all services for such a population. We would use the CRC network development process to assist in the evaluation of those existing and new services best provided by ECHN and those that could be provided more advantageously by others.

As an example, since the closing of our transaction in Rhode Island on June 20, 2014, we have achieved the following in building our CRC model:

a. Formed a multi-specialty IPA with over 100 primary care providers;
b. Recruited a highly skilled team of vascular surgeons and bariatric surgeons;
c. Expanded the base of employed physicians;
d. Entered into a joint venture for outpatient radiation oncology;
e. Expanded out-patient clinics to outside our service area; and
f. Re-opened a closed Cath Lab.

In addition to the above, we are in the process of developing a digestive disease center, exploring the establishment of a hospital based surgical center, and developing a neurosciences center.

Prospect commits to spend $75 million in capital expenditures over 5 years to expand and enhance ECHN's market presence and growth. Such capital expenditures will be consistent with the strategic plan described in Question #1 above. We plan to commit sufficient funds in order to maintain and improve the physical plant and equipment at ECHN. Finally, we plan to commit sufficient capital to implement physician engagement strategies to align the incentives of physicians and ECHN.

As Prospect's first hospitals in Connecticut, our incentives are perfectly aligned to make ECHN the provider of choice in its service areas. As healthcare reform focuses on quality care delivered efficiently, ECHN is well positioned; and with Prospect's capital and resource commitments, ECHN will have the ability to expand on the quality healthcare services it provides to its surrounding communities.

3. *If you have facilities in ECHN's primary and secondary services areas or within the city of Hartford, how do you envision ECHN working with these facilities? What services, if any would you anticipated growing, adding, or eliminating at the local community level?*

As stated above, ECHN will be Prospect's first hospitals in the state of Connecticut. As such, we do not anticipate eliminating any services. In fact, our goal would be enhance and grow ECHN's service lines and market position within its communities.

4. *What governance or other changes would you propose to make to our medical staffs?*

Prospect would work with local advisory boards and ECHN's medical staff members to preserve the existing staff membership and the current privileges of each physician as well as the medical staff leadership. Furthermore, we believe that the delivery of quality healthcare services depends on quality physicians. It is our intention to attract and recruit quality physicians (both primary and specialty) in order to form a CRC network.

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

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

5. *What governance or other changes would you make to the medical foundation? What level of local governance or other changes would you make to the medical foundation? What level of local governance or influence would ECHN based providers or ECHN management has in the medical foundation*?

We believe that the delivery of healthcare is local in nature. As such we plan to organize and empower local governance boards comprised of local leaders and physicians to assist ECHN post transaction in the delivery of health care services. We anticipate that the local advisory boards would have oversight over the strategic direction and quality of health care services provided at ECHN facilities including the services provided by the physicians employed by the medical foundation. In addition, we will use our experience in working with physicians to improve the performance of the medical foundation. Finally, we will use the foundation as a cornerstone of our CRC strategy to improve the financial performance of the Foundation. Also see generally the response to question #4, above.

6. *How would a strategic transaction with your organization enhance ECHN's ability to attract and retain high quality physicians to the medical staff in ECHN's service area? Please discuss:*
    - *Your organization's processes and capabilities regarding physician recruitment and retention,*

- *Your organization's strategy for fostering clinical integration and alignment with employed and independent medical staff.*

Prospect does not have a standardized approach to physician recruitment and retention. We consider Prospect to be a physician friendly service operator. As such, we listen to our physicians and accommodate them to the extent reasonable. For example, certain physicians prefer to be employed. As such we will use the Medical Foundation for their employment. Some physicians prefer to remain independent in their practices, but would like to be free of the non-clinical aspects of running a practice. For such physicians, in our other markets have established hospital-based clinics to accommodate such physicians. We also form Independent Physician Associations ("IPAs"). Through our IPAs, both employed and independent physicians join together with the health system to contract with payers and participate in capitation, bundled payments and other value-based payment methodologies to improve their practice environment, performance and financial results. We use the health system aligned IPA as the vehicle for clinical and financial integration. Through value-based and risk contracting, we achieve financial integration between the health system and its aligned physicians. Through utilization review, quality improvement, clinical guideline development, pay for performance and data sharing and integration, we achieve clinic integration between the health system and its aligned physicians.

Clinical excellence and quality of care are the cornerstone of Prospect's philosophy with respect to the delivery of healthcare services. Prospect believes that quality healthcare services must be provided in a cost efficient manner. We believe that such model of a healthcare delivery system necessarily requires the input and participation of quality physicians who practice evidence-based medicine. Therefore, regardless of the physician engagement model, we incentivize physicians to provide high quality services through "pay-for-performance" standards that stress clinical integration and quality of services. We would employ the same approach at ECHN.

7. *How would the proposed affiliation enhance clinical quality, safety, service and patient satisfaction? Please describe the ways in which you measure quality and safety. Discuss how your hospitals perform in terms of CMS quality indicators and patient satisfaction.*

As stated above, quality of care is of paramount importance to Prospect. Attached for your convenience, is a list of quality awards that our hospitals and medical groups have recently received.

We intend to foster an environment that not only encourages quality of care but also rewards it.

Furthermore, as stated above, Prospect would work with local advisory boards to support any existing initiatives, develop new strategies and provide additional quality and safety expertise and protocols, as necessary, to enhance the quality of services at ECHN. The delivery of quality healthcare services requires constant and unwavering focus from all constituents. Through the

leadership of the local advisory boards and the local management team, we expect a tenacious focus on quality at ECHN post transaction.

As an example of our commitment to quality, we have attached a recent article regarding our cancer center in Rhode Island. The Cancer Center at Roger Williams Medical Center was recently classified by the Commission on Cancer as an Academic Comprehensive Cancer Care Program. Only 13% of the cancer programs accredited by the Commission on Cancer receive such designation.

The local advisory board, management and physician leaders at Roger Williams Medical Center thought that it was important for Roger Williams to earn such distinction. Prospect not only encouraged the pursuit of the designation, but also facilitated and provided all resources necessary to achieve such designation.

Finally, implementing the coordinated regional care model aligns physicians with the health system and measures the improvement in population health management as a result of the implementing value-based, risk contracts with payers. We integrate processes between the hospitals and its aligned physicians under those value-based contracts with payers that measure, manage and improve quality, utilization and efficiency metrics.

8. *Please describe your anticipated operational approach to ECHN, including anticipated operating efficiencies and cost avoidance, if any, resulting from the proposed transaction and any savings associated with such efficiencies/avoidance.*

We anticipate that by joining with Prospect, we can use our increased size in order to reduce costs related to supplies, pharmaceuticals and purchased services at ECHN. However, this transaction is not about the reduction of such costs or the elimination of duplicate services in order to avoid costs. We believe the true opportunity in this proposed business combination, aside from reductions in expenses, to be in the shared vision of the parties and the combined capabilities and expertise to execute on that vision and in particular growth opportunities.

As described above, Prospect has a well-developed integrated healthcare delivery network with a successful track record in population health management and accepting risk-based contracts, while delivering quality healthcare service. ECHN is a healthcare delivery network with all the necessary pieces to take the next steps in its evolution to accept more risk contracts and to immerse itself more in population health management. We believe that the synergies between the parties and the potential to implement best practices of each party across the Prospect-ECHN system will present far greater market growth opportunities.

As such, we intend to invest in ECHN's infrastructure and to develop scalable tools and technology to effectively manage the health of the population served by ECHN. It is our goal that ECHN to not only remain viable but be a leader in providing high safety and quality healthcare services at low cost to the community for the long-term. We will endeavor to form an integrated healthcare delivery model which will necessarily involve a physician engagement

strategy with the goal of providing high quality care in an efficient manner. We plan to implement, as necessary and appropriate, health reform required changes including, but not limited to: value-based payment, bundled payment, accountable care, and clinical integration with physicians and other providers.

9. *Please discuss the governance structure and continuing role of ECHN and/or the ECHN Board in the governance of the Health System, and if applicable, at your health system corporate level. Please describe your willingness to commit to the following roles as part of an affiliation agreement. Examples of comparable transactions where you have employed the proposed structure would be helpful.*

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

(A) Board Representation. Post-transaction, Prospect will appoint a local community advisory board. A significant and pre-determined number of the local advisory board shall be members of the local community and practicing physicians. Prospect would prefer that at least some members of the Board of Directors of ECHN agree to serve on such advisory boards at the local hospitals. A member of the board of directors of ECHN post transaction shall be a member of the local community governing advisory board. That way there is a direct communication between the advisory boards and the board of directors.

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

(i) make recommendations and suggestions with respect to medical staff credentialing;

(ii) provide input on policies and clinical programs;

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

(iv) provide input on operating and capital budgets;

(v) provide input and support physician recruitment efforts;

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

(vii) promote community health initiatives; and

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

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

In our most recent transaction in Rhode Island, each of the hospitals that were part of the transaction has local advisory boards. The compositions of the local advisory boards are local physicians and local community leaders. The local advisory boards have been indispensable in our efforts in Rhode Island. We welcome ECHN's input on this matter.

10. *Please indicate the senior management positions you would anticipate having at ECHN, as well as the roles and positions these individuals would have in the organization post-affiliation.*

We do not foresee any changes in the management of ECHN. It has been our practice and preference to rely on the existing strong management in place at the time of the transaction. In addition, Prospect will make all of its resources (both financial and human capital) available to ECHN management team in order to execute on the strategic plan and develop a healthcare delivery system with population health management and accountable care capabilities.

11. *Please describe your willingness, if requested, to commit to the following service enhancements and capital investments as part of an affiliation agreement. To the extent that some of these commitments are in the future and subject to changes in the market/context, please describe the requirements these initiatives have to meet in order to be implemented (e.g., an ROI within a period of time requirement, system Board approval, etc.). Additionally, to the extent there are capital investments required, please describe the structure of the capital pool(s) that these programs would be accessing and the mechanism for accessing them (e.g., would you segregate a certain capital pool for these programs over a period of time, would these programs be competing for capital with other facilities in your system, etc.).*

- ***Service Enhancements***

i. In addition to maintaining the services outlined in its template Agreement, ECHN anticipates developing, expanding or enhancing service in the following clinical areas. Please comment on how affiliation with your organization would support and enable clinical program development and/or

expansion, how you approach medical staffing, and/or facility and equipment enhancements for the following services:

1. *Enhancing and expanding Primary Care capabilities, in existing and new markets*
2. *Cardiovascular Services, including diagnostic and interventional catheterization, electrophysiology and pacemaker programs*
3. *Cancer Care, including medical oncology and specialty oncologic surgery*
4. *Bariatric Surgery*
5. *Orthopedics, with an emphasis on spine surgery and joint replacement surgery*
6. *Pain Management Service/Program*

ii. Maintaining joint ventures such as Tolland Imaging Center, Evergreen Endoscopy Center, Community Cancer Care and others.

- ***Capital Investments***
  - *i. Electronic Medical Record system replacement and implementation*
  - *ii. New care management capabilities and systems*
  - *iii. Building an ambulatory surgery center*
  - *iv. Transitioning capacity to private rooms*
  - *v. Upgrading and expanding OB and neonatal nursery*
  - *vi. Upgrading and expanding the inpatient operating rooms*
  - *vii. Renovating and expanding the radiology suite*
  - viii. *Investing in medical equipment*

It should be noted at the outset that hospitals and regional networks within the Prospect system do not compete against each other for capital. It is Prospect's practice to fund capital expenditures as are reasonable and necessary to foster an environment of growth and provision of quality healthcare services in each region. Therefore, how much Prospect spends on capital expenditures in its other regions will never have an impact on ECHN.

Furthermore, there is no set formula for approving of capital expenditures. We recognize a healthcare company's need to continually re-invest in its property, plant, equipment, and information systems. As stated above, immediately after the closing, we would embark on a strategic planning process involving the local management team and the local board. We understand that all of the items noted above are part of ECHN's strategic plan. We have not as of yet has the opportunity to review the plan. However, we intend to collaborate with the local management to prioritize ECHN's growth plans and capital expenditure needs and will use at a minimum the funds committed ($75 million) to fund such programs and improvements to

ECHN's infrastructure. If there's a need to spend more on such projects that will contribute to ECHN's growth, Prospect will make such an investment.

In addition please see our response to question #2 above illustrating the initiatives underway in Rhode Island for a transaction that closed on June 20, 2014 (less than one year ago)

12. *Please provide a detailed list of additional information required if selected to proceed with further due diligence.*

Attached please find a copy of due diligence request list.

13. *Please indicate the names of the financial, legal or other advisors who will be engaged in connection with the transaction.*

We have not yet hired any financial or legal advisors with respect to this transaction. We are in process of interviewing appropriate firms to assist us in this transaction. We will inform you of the firms that we ultimately hire as we move forward in this process.

14. *Upon the selection of a preferred acquirer/partner, ECHN intends to promptly negotiate a Definitive Agreement and consummate the transaction. Please discuss any corporate approvals required to complete the transaction, the time required for those approvals and any potential risks that could increase the time required or stop the process.*

Typically, we are able to complete our due diligence process within 30-45 days of receipt of all items requested in our due diligence list. Our process involves an in depth review of material documents, interviews with management and site visits by key personnel at Prospect.

This indication of interest has been approved by Prospect's senior management. Execution of a definitive agreement and completion of a transaction will require approval by the Prospect Board of Directors. Furthermore, the execution of the APA is subject to satisfactory completion of due diligence at Prospect's sole discretion and the closing of the proposed transaction is subject to any necessary and customary regulatory approvals.

15. *Please indicate any financing or other contingencies or material conditions to the consummation of the transaction, including any key assumptions in your valuation of ECHN that, if revised, could have a significant impact on the financial terms.*

Our proposal is not subject to any financing contingency. Prospect has the funds to consummate the proposed transaction.

16. *Describe the religious or ethical restrictions in detail.*

None

17. *Explain how ECHN would continue to meet the needs of its community in the event the restrictions apply.*

Does not apply.

We recognize that choosing a transaction partners involves more than financial considerations and legal structures. Our proposal is about preserving and enhancing a community resource in a way that honors ECHN's stated mission and vision.

Prospect is unique in the market place and is uniquely positioned to meet the challenges of the ever changing healthcare environment and thrive under healthcare reform. Although noted above, we believe it is important to reiterate that what distinguishes Prospect in the marketplace is its CRC model with the proven ability to effectively and profitably manage risk and value-based reimbursement, and bundled payments on behalf of our hospitals and medical groups while at the same time delivering a high quality of care. This unique structure allows managed care plans to focus on marketing; physicians to focus on patient care; and Prospect to coordinate population health management that ensures quality and efficiency.

This indication of interest is confidential and subject to the terms and conditions of our Confidentiality Agreement dated February 20, 2015.

The contacts for questions regarding our indication of interest are as follows:

Steve Aleman, Chief Financial Officer (steve.aleman@prospectmedical.com)
Frank Saidara Vice President (frank.saidara@prospectmedical.com)

Mr. Aleman and Mr. Saidara can be reached at 310.943.4500.

If you have any questions, please feel free to contact Messrs. Saidara or Aleman, or me.

We look forward to working with you.

Very truly yours,
PROSPECT MEDICAL HOLDINGS, INC.

Samuel S. Lee
Chief Executive Officer

Quality Awards

PROSPECT MEDICAL HOLDINGS, INC.
HOSPITAL QUALITY AWARDS
Wednesday, March 4, 2015
PROSPECT MEDICAL
California Association of Physician Groups – Standards of Excellence Program – Elite Status (2012-2014)
Citizens Choice Healthplan, HMO, Shooting Star Award Top Performer (2012)
Circle of Care Award from CalOptima (Health Plan), Health Educator, Paul Montanchez (2012)
Certificate of Outstanding Performance from Integrated Healthcare Association: 1. IT Enabled Systemness for groups Genesis, Prospect Medical Group, NWOC, Gateway Medical Group (2010) 2. Diabetes Registry and related activities for groups Genesis, Professional Care, NWOC, Gateway Medical Group (2010) 3.Meaningful Use of Health IT for groups – Genesis, Professional Care, NWOC, Gateway Medical Group (2011)
City of Anaheim recognized Prospect Medical for Community Service (2011)
Integrated Healthcare Association AMVI Medical Group - Pay for Performance (P4P) "Most Improved" award winner (2012)
Integrated Healthcare Association AMVI Medical Group - Certificate of Outstanding Performance - Meaningful Use of Health IT (2012)
DHMC - AMVI Medical Group, awarded a Certificate of Excellent HEDIS scores related to cardiovascular disease and diabetes (2012)
PROMED HEALTHCARE ADMINISTRATORS
California Association of Physician Groups – Standards of Excellence Program – Elite (2012)
Integrated Healthcare Association Pomona Valley Medical Group - Certificate of Outstanding Performance - Patient Assessment Survey (2012)
Dr. Prasad
Corporate Honorary Chair of the Arthritis Foundation I.E. Walk (June 2013)
LA Business Journal Healthcare Leadership Awards (Healthcare Advocate Award, Dr. Prasad was a finalist in the Healthcare Executive category). (April 2013)
LOS ANGELES Community Hospital/NORWALK Community Hospital (combined licensure)
Healthgrades Awards
America's Best 100 Hospitals
One of Healthgrades America's 100 Best Hospitals for Pulmonary Care (2013)
One of Healthgrades America's 100 Best Hospitals for Gastrointestinal Care (2013)
One of Healthgrades America's 100 Best Hospitals for Stroke Care (2014)
One of Healthgrades America's 100 Best Hospitals for General Surgery (2014)
Cardiac
Five-Star Recipient for Treatment of Heart Failure for 5 Years in a Row (2010 – 2014)
Neurosciences
Stroke Care Excellence Award for 7 Years in a Row (2008 – 2014)

Top 5% in the Nation for Treatment of Stroke for 5 Years in a Row (2010 – 2014)	
Five-Star Recipient for Treatment of Stroke for 7 Years in a Row (2008 – 2014)	
Orthopedic	
Five-Star Recipient for Hip Fracture Treatment (2014)	
Pulmonary	
Pulmonary Care Excellence Award for 2 Years in a Row (2013-2014)	
Top 5% in the Nation for Overall Pulmonary Care Services for 2 Years in a Row (2013-2014)	
Ranked #6 in California for Overall Pulmonary Services (2013)	
Top 10 in California for Overall Pulmonary Services (Ranked 6 in 2013)	
Five-Star Recipient for Overall Pulmonary Services (2013)	
Five-Star Recipient for Treatment of COPD for 10 Years in a Row (2005 – 2014)	
Five-Star Recipient for Treatment of Pneumonia for 2 Years in a Row (2013-2014)	
Gastrointestinal	
Gastrointestinal Care Excellence Award (2013)	
Top 5% in the Nation for Overall GI Services (2013)	
Ranked #6 in California for GI Services (2013)	
Top 10 in California for GI Services in 2013 (Ranked 6 in 2013)	
Five-Star Recipient for Treatment of GI Bleed for 2 Years in a Row (2013-2014)	
Five-Star Recipient for Treatment of Pancreatitis for 5 Years in a Row (2009 – 2013)	
Five-Star Recipient for Cholecystectomy (2013)	
General Surgery Excellence Award (2014)	
Top 5% in the Nation for General Surgery (2014)	
Five-Star Recipient for Esophageal/Stomach Surgeries (2014)	
Appendectomy	
Five-Star Recipient for Appendectomy for 2 Years in a Row (2013-2014)	
Critical Care	
Five-Star Recipient for Treatment of Sepsis for 9 Years in a Row (2006 – 2014)	
Five-Star Recipient for Treatment of Diabetic Acidosis and Coma (2013)	
Five-Star Recipient for Treatment of Respiratory Failure (2014)	
Maternity Care	
Five-Star Recipient for Maternity Care for 2 Years in a Row (2011 – 2012)	
GYN Surgery	
Five-Star Recipient for Gynecological Surgery (2012)	

CareChex Awards
Stroke Care - Top 10% Nationwide (2012)
Women's Health - Top 15% Nationwide (2012)
Gastrointestinal Care - Top 15% Nationwide (2012)
Bruce Grimshaw
2010 ACHE Regents Leadership Award
2013 ACHE Service Award
SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD
Healthgrades Awards
Pulmonary
Pulmonary Care Excellence Award for 10 Years in a Row (2005 – 2014)
Top 5% in the Nation for Overall Pulmonary Services for 2 Years in a Row (2013-2014)
Five-Star Recipient for Overall Pulmonary Services for 11 Years in a Row (2003 – 2013)
Five-Star Recipient for Treatment of COPD for 12 Years in a Row (2003 – 2014)
Five-Star Recipient for Treatment of Pneumonia (2013)
Gastrointestinal
Five-Star Recipient for Esophageal/Stomach Surgeries (2014)
Critical Care
Five-Star Recipient for Treatment of Sepsis for 9 Years in a Row (2006 – 2014)
CareChex Awards
Stroke Care - Top 15% Nationwide (2012)
Vascular Surgery - Top 10% Nationwide (2014)
SOUTHERN CALIFORNIA HOSPITAL AT CULVER CITY
Healthgrades Awards
Cardiac
Five-Star Recipient for Treatment of Heart Failure (2013)
Gastrointestinal
Five-Star Recipient for Treatment of Pancreatitis for 2 Years in a Row (2013-2014)
Critical Care
Five-Star Recipient for Treatment of Sepsis for 6 Years in a Row (2008 – 2013)

GYN Surgery
Five-Star Recipient for Gynecological Surgery for 2 Years in a Row (2011 – 2012)
Orthopedic
Five-Star Recipient for Hip Fracture Treatment (2014)
CareChex Awards
Women's Health - Top 10% Nationwide (2012)
NIX HEALTH
Healthgrades Awards
Hospital-Wide
Outstanding Patient Experience Award (2012)
Top 10% in the Nation for Outstanding Patient Experience (2012)
Appendectomy
Five-Star Recipient for Appendectomy for 4 Years in a Row (2010 – 2013)
Cardiac
Five-Star Recipient for Treatment of Heart Attack for 5 Years in a Row (2010 – 2014)
Critical Care
Five-Star Recipient for Treatment of Sepsis for 5 Years in a Row (2009 – 2013)
Gastrointestinal
Gastrointestinal Care Excellence Award (2015)
Gastrointestinal Care Excellence Award (2014)
Top 5% in the Nation for GI Medical Treatment (2014)
Top 10% in the Nation for Overall GI Services (2014)
Five-Star Recipient for Treatment of Bowel Obstruction (2014)
Five-Star Recipient for Gallbladder Removal Surgery for 4 Years in a Row (2011-2014)
Five-Star Recipient for Cholecystectomy for 3 Years in a Row (2011 – 2013)
Neurosciences
Five-Star Recipient for Treatment of Stroke for 4 Years in a Row (2011 – 2014)
Pulmonary
Five-Star Recipient for Treatment of COPD for 2 Years in a Row (2012 – 2013)
Joint Commission's Top Performers on Key Quality Measures™ (2012)

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Bariatric
Bariatric Surgery Center of Excellence by The American Society for Bariatric Surgery's (2011-2014)
OptumHealth Center of Excellence Designation for Bariatric Centers of Excellence Network (2011)
Five-Star for Bariatric Surgery (2010/2011, 2009/2010, 2008/2009, 2007/2008)
Five-Star Recipient for Overall Bariatric Surgery by Healthgrades (2013)
Bariatric Quality Program Accredited by The Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) 2014
Cardiovascular
Get with the Guidelines Gold Achievement Award by the American Heart Association (2010-2013)
CareChex Awards
Overall Hospital Care - Top 15% Nationwide (2012)
Overall Medical Care - Top 15% Nationwide (2012)
General Surgery - Top 10% San Antonio (2014)
Emergency Medicine
Dr. Gregory Roth, MD, CPE became a Certified Physician Executive (2014)
Executive Women's International San Antonio
Firm of the Year Award (2013)
Hospital-Wide
Top Improver Award Winner by Press Ganey Associates, Inc. (2011)
Bronze Award by Texas Hospital Quality Improvement Award (2014)
General Surgery Excellence Award (2015)
General Surgery Excellence Award (2014)
Texas Medical Foundation Health Quality Institute - Hospital Quality Improvement Award (2014)
Above and Beyond Award - Employer Support of the Guard and Reserve (2014)
Hyperbaric Medicine
Accreditation with Distinction from the Undersea and Hyperbaric Medical Society (2009-2014)
John Strieby
Graduate of the Masters in Leadership Program (2008)
Orthopedics
Blue Distinction Center for Knee and Hip Replacement® by Blue Cross and Blue Shield of Texas (2009-2013)

Institute of Quality Orthopedic Care for Total Joint Replacement by Aetna (2012-2013)
San Antonio Business Journal - Health Care Heroes
Elizabeth Llanas, RN, Health Care Heroes Health Care Provider (2013)
Peggy Perry, Health Care Heroes Volunteer (2012)
Adele Giles, Health Care Heroes Administrative Excellence (2011)
Sr. Stephanie Morales, Health Care Heroes Health Care Advocate (2011)
Dr. Robert Jimenez, Health Care Heroes Lifetime Achievement Award (2010)
Senior Health Center
Patient-Centered Medical Home, National Committee for Quality Assurance (2014)
Surgical Care
Joint Commission's Top Performers on Key Quality Measures™ (2012)
FATIMA/ST. JOSEPH
Patient Care Services
Director of Permformance Improvement is one of 21 contributors from across the country to the Nursing 2015 Drug Handbook
Joint Commission Accredited Hospital, (2015)
Joint Commission Accredited Hospital, 3 years (9/2011)
Joint Commission Certified for Advanced Primary Stroke Center, 2 years (9/2013)
Joint Commission Certified for Advanced Diabetes Center, 2 years (9/2013)
Joint Commission Disease Specific Certification for Diabetes (2014)
Joint Commission Certified for Joint Replacement-Hip, 2 years (9/2013)
Joint Commission Certified for Joint Replacement-Knee, 2 years (9/2013)
NDNQI (National Database of Nursing Quality Indicators from the American Nurses Association) for outstanding commitment to quality patient care (2014)
Designated a NICHE hospital, Nursing Improving the Care of Hospitalized Elders (2014)
Joint Commission Certified for Advanced Diabetes Center, 2 years (2014)
Pathway to Excellence Certification by the American Nurses Association (1/2015)
NICHE "Exemplar" status (2015)
Emergency Department
First senior-friendly emergency department opened (3/2013)
Rehabilitation
Comprehensive Integrated Inpatient Rehabilitation awarded January, 2012; expires January 2015
Stroke Specialty Program awarded January, 2012; expires January, 2015

Commission on the Accreditation of Rehabilitation Facilities (CARF) (recertified 2014)
Commission on the Accreditation of Rehabilitation Facilities (CARF) Stroke designation (2014)
Cancer Services
Cancer Services is STAR (Survivorship Training and Rehab) certified by Oncology Rehab Partners (3/2014)
Cancer Services – American College of Surgeons, Commission on Cancer Accredited (level to be determined) from March 2014 – March 2017
Infusion Therapy – All nurses certified by the Oncology Nursing Society for chemotherapy infusion, (4/2014)
Blood Bank
Certified by American Association of Blood Banks, AABB 4/1/14 – 3/31/16
College of American Pathologists (CAP), 2 years (9/13)
Infection Protection and Control Department
Marlene Fishman honored as a Knowledge Bar Expert at 41st APIC Annual Conference (6/2014)
Certificate of Improvement presented by Healthcentric Advisors to Our Lady of Fatima Hospital for 25% or Greater Relative Improvement Rate for *Clostridium difficile* Infection (CDI) LabID (June 2014)
Certificate of Participation presented by Healthcentric Advisors to Our Lady of Fatima Hospital for Participation in the CMS 10th Statement of Work (June 2014)
Rhode Island Department of Health recognition for supporting and contributing to the Department Quality Improvement efforts – to Marlene Fishman (2014)
Patient Safety Champion Award for joint efforts to decrease harm and improve the care delivered within St. Joseph Health Services of Rhode Island – to Marlene Fishman (2014)
Rhode Island Department of Health Certificates of Appreciation for participation in the Influenza Hospitalization Surveillance Network – to Our Lady of Fatima Infection Control Practitioners (2012 – 2013)
APIC Heroes of Infection Prevention Award for having successfully reduced infection, raised awareness, and improved the health and well-being of patients, healthcare workers, and the public - to Marlene Fishman Wolpert (2012)
ROGER WILLIAMS MEDICAL CENTER
Patient Care Services
Joint Commission Accredited Hospital, 3 years (9/2011)
Joint Commission Certified as Advanced Primary Stroke Center, 2 years (9/2013)
American Heart/Stroke Association's Silver Award for Advanced Primary Stroke Center's composite performance (3/2013)
Stroke and US News and World Report, "Best Hospitals" issue. (3/2013)
NDNQI (National Database of Nursing Quality Indicators) for outstanding commitment to Quality Patient Care (10/2013)
Palliative Care Program survey scheduled for June 13, 2014 to be first in state for certification by the Joint Commission (9/2013)

Emergency Department
Emergency Department, the states first senior-friendly emergency department (3/2013)
Bariatrics
Bariatric Surgery Center of Excellence by ASMBS (American Society for Metabolic and Bariatric Surgery) and SRC (Surgical Review Corporation) (12/2013)
Endoscopy
First hospital in RI to perform Endobronchial Ultrasound (EBUS) (8/2013)
Third hospital in the nation to offer Sedationless Colonoscopy (9/2013)
Orthopaedics
The Joint Commissions Gold Seal of Approval, total hip and knee replacement programs (2/2014)
Blue Cross/Blue Shield Blue Distinction Total Value Center for Spine Surgery and Hip & Knee Surgery (1/2014)
First hospital in RI to launch the American Orthopaedic Association's "Own the Bone program" (1/2014)
Cancer Center
18 Surg/Onc fellowship training programs, one of only two in New England (7/2013)
Cancer Program accreditation with commendation by the Commission on Cancer of the American College of Surgeons (10/2012)
National Marrow Donor Program approved Transplant Center (1/2014)
Foundation for the Accreditation of Cellular Therapy Accreditation for the Bone Marrow Unit
Commission on Cancer CCP Community Cancer program (October 2012 - October 2015)
National Accreditation Program for Breast Centers April 2013 – April 2016
Quality Oncology Practice Initiative Certification, American Society of Clinical Oncology October 2013 – October 2016
STAR Program Certification from Oncology Rehab Partners (2014)
Designated as a Academic Comprehensive Cancer Center (2/2015)
Behavioral Medicine
Optum Health recognition for ACE (Achievements in Clinical Excellence) program Behavioral Health (7/2013)
Optum Health - 2013 Achievements in Clinical Excellence in Behavioral Health Silver Level (7/2013)
Addiction Medicine
States only level 4 inpatient detox
American Hospital Association recognition for hosting Rally 4 Recovery Program (1/2014)
Geriatrics
Successfully pass annual FDA-MQSA (Mammography Quality Standards Act) facility inspection (8/2013)
Re-established Cardiac Catheterization Services (8/2013)
Redesignated as a NICHE (Nurses Improving Care for Healthsystem Elders) Hospital (9/2013)

OR
First hospital in state to conduct a Fire safety training with evacuation in the Operating Room, a training video has been developed from this session (10/2013)
Diagnostic Wing
ACR accreditation for CT Scanner (2/2014)
Certified as a Radiation Injury Treatment Network (8/2013)
Breast Health Clinic received American College of Radiology 3-year re-accreditation (8/2013)
Successfully pass annual FDA-MQSA (Mammography Quality Standards Act)
Re-established Cardiac Catheterization Services.
Pharmacy
Phaseal Safety Award: Pharmacy recognition of Chemotherapy Compounding Safety in the Northeast (10/2012)
Laboratory
CAP (College of American Pathologists) Certified, 2 years (12/2014)
AABB (American Association of Blood Bank), 3 years (10/2012)
Radiology
Accredited in Computed Tomography (CT) by the American College of Radiology (ACR) 3 years (2014)
ELMHURST
Joint Commission Accredited Hospital, 3 years (9/2014)

Article re Quality

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HEALTH CARE

Cancer Center at Roger Williams Medical Center receives new designation

ROGER WILLIAMS Medical Center's Cancer Center has been classified by the Commission on Cancer as an Academic Comprehensive Cancer Center Program.

By PBN Staff
Twitter: @ProvBusNews (http://twitter.com/ProvBusNews)

2/27/15

PROVIDENCE – The Cancer Center at Roger Williams Medical Center has been classified by the Commission on Cancer as an Academic Comprehensive Cancer Center Program, placing it among a select group of cancer centers in New England to hold the designation.

According to information from CharterCare Health Partners, of which Roger Williams Medical Center is an affiliate, 13 percent of the more than 1,500 Commission on Cancer-accredited cancer programs nationwide hold this designation.

Roger Williams met the following criteria from the Commission on Cancer to achieve the new classification:

- Provides postgraduate medical education in at least four program areas, including internal medicine and general surgery
- Records more than 500 newly diagnosed cancer cases each year
- Full range of diagnostic and treatment services either on-site or by referral
- Participates in cancer-related clinical research either by enrolling patients in cancer-related clinical trials or by referring patients for enrollment at another facility or through a physician's office.

"This designation is a reflection of both our academic and clinical efforts to provide better treatment for cancer patients in our region," Dr. N. Joseph Espat, director of the Cancer Center at Roger Williams, said in a statement. "More patients are coming to our cancer program, our residency and fellowship programs continue to provide excellent training for the next generation of physicians and our clinical trials are advancing research into diagnosis and treatment of cancer."

Kimberly O'Connell, president of Roger Williams, said the entire oncology team - including those involved with cancer teaching and research programs - has been involved is reaching this designation.

Dr. Steven Katz, chairman of the Roger Williams' Cancer Committee, said "innovative research programs" played a role in enabling the recognition.

"Our immunotherapy platforms promise to bring novel treatments to patients with limited options. We look forward to launching several new T cell trials for liver tumors in the coming year," Katz said.

The Commission on Cancer, a program of the American College of Surgeons, recognizes cancer care programs for their commitment to providing comprehensive patient-centered care. In Rhode Island, The Miriam Hospital and Rhode Island Hospital are also designated Academic Comprehensive Cancer Centers by the Commission on Cancer.

Due Diligence Document Checklist

Entity: ECHN & Affiliates (including JVs)

		GENERAL CORPORATE
A		**Minutes**
	1	Stockholders'/partnership meetings
	2	Board of Directors
	3	Board committees
B		**Charter Documents**
	1	Certificate of Incorporation/Partnership, as amended
	2	By-laws, as amended
C		**Corporate Organization**
	1	Officer & director lists
	2	Management structure organization chart
	3	Organization chart showing the Group, each subsidiary and affiliated partnership
	4	Stockholder or partnership list, including number of shares or units held
	5	Information regarding any subsidiaries of affiliated entities, i.e., ownership; management arrangement; acquisition documents
	6	Information regarding joint ventures or partnerships
	7	Agreements related to earnouts and contingency payments
	8	Material covenants against competition or exclusivity arrangements
	9	Shareholder agreements
D		**Capital Stock/Partnership Units**
	1	Stock records, stock ledgers
	2	Agreements relating to the purchase, repurchase, sale or issuance of securities/partnership units, including oral commitments to sell or issue securities/partnership units
	3	Agreements relating to voting of securities/partnership units and restrictive transfers
	4	Agreements relating to preemptive or other preferential rights to acquire securities/partnership units and any waivers thereof
	5	Documents relating to any conversion, recapitalization, reorganization or significant restructuring of the Group
E		**Business**
	1	Marketing or strategic plans
	2	Marketing brochures
	3	Policies and procedures
	4	List of any trademarks, trade names, copyrights, patents, service marks or other intellectual property rights, owned by or used in the business

Due Diligence Document Checklist

		Entity: ECHN & Affiliates (including JVs)
	5	Description of IT Systems
	6	List of physicians/providers by site& specialty
	7	Health plan audits & CAPs for last 12 months
F		**PHYSICIAN INFORMATION**
	1	Physician and physician extender census including name, hire date, status (full or part time), specialty
	2	Curriculum vitae (must include SSN, DOB, Medical School & year graduated)
	3	Copy of license & DEA for each physician
	4	Shareholder/Partner/Employed physician contracts
	5	Current IPA physician compensation arranagement and contracts
	6	Physician productivity reports for last fiscal year and current year: Gross charges & visits
	7	Physician and physician extender W-2s for last completed calendar year
	8	IPA physician contracts
	9	Encounter data by physician - Last two full calendar years
G		**MANAGEMENT & EMPLOYEES**
	1	Employment agreements and all other agreements with employees
	2	Consulting contracts
	3	Confidentiality or non-competition agreements
	4	List of all employees, headcount by function, describe current salary and wage program, including pay scales and forthcoming increases
	5	All employee compensation, bonus, profit-sharing plans, including deferred compensation, incentive, retirement, benefit or similar plans
	6	Description of all perquisites
	7	Employee manuals, handbooks, and other personnel policies
	8	Documents relating to any receivables from or payables to any employees/partners of the the Group
	9	Contracts with unions and other labor agreements
	10	Correspondence with any federal, state or local agencies regarding compliance with the U.S. Occupational Safety and Health Act or similar
H		**FINANCIAL & STATISTICAL**
	1	**Financial Statements**
	a	Audited statements, most recent three years

Due Diligence Document Checklist

	Entity: ECHN & Affiliates (including JVs)
b	Most recent unaudited interim financial statements (and the statements for the corresonding period of the previous fiscal year)
c	Last fiscal year and YTD detailed financial statements (income statement, balance sheet)
d	Detailed revenue breakdown for last fiscal year and current YTD, if not included above
e	Current year budget, including capital expenditure budget
f	Long range strategic/financial plan
g	Any reports, studies, and projections prepared internal or externally on the Group's finanical condition or planned operations
h	Significant correspondence with independent public accountants, including management letters in the last three years
i	Shared risk reconciliation reports and accrual schedules by HMO
j	IBNR analysis/lag study
k	Claims run: Dates of service 1/1/05 to 12/31/05 paid to date
l	Depreciation and amortization schedule
m	Aged accounts receivable schedule by payor
n	Aged accounts payable schedule
o	Accrued vacation and sick leave schedule
p	Complete inventory/asset listing
2	**Debt Financing**
a	All debt instruments, credit agreements and guarantees entered into by the Group and any of its affiliates, including lease financing, which are currently in effect
b	All material correspondence with lenders, including all compliance reports submitted by the Group or its designees
c	Any loans and guarantees of third party obligations
3	**Tax Matters**
a	Tax returns, most recent three years
b	Correspondence or notice from any foreign, federal, state or local taxing authority regarding any filed tax return (or any failure to file) including copies of all audit reports and descriptions of any pending tax audits by the IRS or other
c	Rulings, concessions, or the like which have been obtained from any federal or state taxing authority and which may apply to the Group's current or future operations
4	**Statistical & Other**
a	Last fiscal year and current YTD monthly HMO enrollment and capitation by plan
b	Last calendar year and current YTD inpatient days/1000 and SNF days/1000 for commercial, senior, and MediCal

Due Diligence Document Checklist

	Entity: ECHN & Affiliates (including JVs)
c	RAF Scores - Last two full calendar years
d	Encounter data submission
e	Pended claims report
f	Denials
g	Open auths report
h	P4P Reports
I	**CONTRACTS AND OTHER DOCUMENTS**
1	HMO, PPO or other third-party payor agreements, all other managed care agreements, and all proposals to enter into such agreements
2	Status/description of pending contractual changes related to the above
3	Hospital contracts- Include description of risk sharing agreements
4	Significant ancillary provider or professional services contracts
5	List of outside provider contracts with rates
6	Significant vendor contracts requiring more than $10,000 annual payments
7	Maintenance contracts for equipment, as well as all supply or service contracts and purchasing agreements
8	Outstanding guarantees, indemnities, or other similar agreements
J	**REAL PROPERTY**
1	Deeds
2	Leases of real property
3	Completed environmental surveys and assessments for all real property owned, leased or operated by the Group
4	Equipment financing documents, including leases
K	**RISK MANAGEMENT**
1	All insurance policies
2	List of all current or pending professional liability claims
3	List of closed claims for the past five years
4	Loss run reports from all insurance carriers for the past five years--Indicate closed claims
5	List of all current or pending workers' compensation claims
6	List of all current or pending litigation or investigation
7	Consent decrees, judgments, orders or settlement agreements which provided for ongoing covenants
8	Description of any outstanding judgments against the Group

Due Diligence Document Checklist

	Entity: ECHN & Affiliates (including JVs)
9	Actual and/or pending accusations, investigations and/or records of disciplinary action(s) by the Medical Board of California
10	Actual or pending hospital medical staff action
11	Information on any investigations, pending or threatened by any federal, state or local authority
12	Counsel's evaluation of pending litigation and any current litigation
13	Attorneys' letters to auditors
L	**REGULATORY INFORMATION**
1	All governmental (federal, state or local) licenses, titles, certificates, franchises, and permits necessary for the Group to conduct its business in compliance with applicable law, with expirations and renewal dates
2	List of all accreditations received by the Group and all professional or trade association memberships
3	Correspondence with any governmental agency requiring action by the Group which has not been taken or completed

RESPONSE TO DEFICIENCIES
EXHIBIT D - Interim Consulting Agreement (DRAFT)

INTERIM CONSULTING AGREEMENT

THIS INTERIM CONSULTING AGREEMENT (this "Agreement") is made and entered into as of the ___ day of October, 2015 (the "Effective Date") by and between Prospect Medical Holdings, Inc., a Delaware corporation ("Prospect," and collectively with its Affiliates (as defined below), "Advisor"), and Eastern Connecticut Health Network, Inc. a Connecticut non-stock corporation ("ECHN").

RECITALS

A. ECHN, together with its Affiliates (collectively, the "Company"), operate The Manchester Memorial Hospital and The Rockville General Hospital (the "Hospitals") which serve the needs of residents of the greater Manchester, Connecticut area.

B. On June 25, 2015, Advisor entered into a Letter of Intent with the Company, as amended by that certain Amendment No. 1 to Letter of Intent dated October ___, 2015 (as so amended, the "Letter of Intent"), which sets forth certain terms and conditions pursuant to which Advisor, or an Affiliate of Advisor, would acquire the businesses of the Company pursuant to the terms of a definitive Asset Purchase Agreement to be negotiated and entered into by ECHN and Advisor, the form of which is being filed in connection with the parties' application for a CON (as defined below) (the "Purchase Agreement"). Defined terms used but not defined herein shall have the meanings set forth in the Letter of Intent. References contained herein to Sections and Section numbers of the Purchase Agreement shall be deemed to refer to any successor provisions thereto, as the case may be.

C. The Letter of Intent provides, among other things, that the term of the Letter of Intent shall continue in effect until the earlier of (w) the execution by both parties of a definitive purchase agreement with respect to the matters set forth in the LOI, (x) thirty (30) days following the receipt by the parties of the proposed conditions or proposed settlement for certificate of need approval for the Hospitals by the Office of Healthcare Access of the Connecticut Department of Public Health ("OHCA"), (y) either the application for approval of the certificate of need by OHCA or the application for approval of the conversion of the Hospitals to a for-profit entity by the Attorney General of the State of Connecticut is withdrawn, and (z) June 30, 2016 (the "Expiration Date"). The Letter of Intent further provides that notwithstanding the foregoing, Prospect shall have the right (an "Extension Right"), exercisable upon prior written notice to ECHN and with the consent of ECHN, such consent to not be unreasonably withheld, to extend the Expiration Date by up to an additional thirty (30) days, if the foregoing regulatory approvals have not been received on or prior to thirty (30) days prior to the Expiration Date, in a form that Prospect has determined in good faith is on terms reasonably satisfactory to Prospect, and such failure to receive such approvals in satisfactory form is for reasons beyond the reasonable control of Prospect and without any fault on the part of Prospect. In addition, the Letter of Intent provides Prospect the right to exercise up to an aggregate of three (3) Extension Rights if the foregoing conditions to such exercise (including such consent of ECHN) are satisfied, and the Letter of Intent further states that the ECHN Board of Trustees shall be entitled to deny (i.e. withhold the required consent of ECHN) an Extension Right if it makes a good faith determination that the transaction is unlikely to close in the 90-Day period following June 30, 2016.

D. The Purchase Agreement is expected to set forth various conditions to Closing (including regulatory approvals), but pursuant to Connecticut law, the Purchase Agreement cannot be executed by the parties until receipt by the parties of the certificate of need approval for the Hospitals by OHCA and approval for the conversion of the Hospitals to a for-profit entity by the Office of the Attorney General of the State of Connecticut (the "CON Approvals").

E. Given the contracting restrictions imposed upon the parties by the State of Connecticut, the parties seek to confirm in writing that this Agreement is intended to continue until the closing of the transactions contemplated in the Letter of Intent (and, more specifically, in the Purchase Agreement) and that should this Agreement terminate, Advisor shall be entitled to be paid its Consulting Service Fees (as defined below) in accordance with, and to the extent provided by, Section 6.5 hereof.

F. Advisor, through its executives and other personnel, has certain experience and expertise in the management, operations, financial and administrative aspects of businesses like that of the Company.

G. Advisor is willing to provide certain consulting services, as described on Exhibit A hereto (the "Consulting Services"), with the objective of improving and otherwise benefitting the operations of the Company and the Hospitals during the time period from the Effective Date through the Closing of the Purchase Agreement, pursuant to the terms and conditions contained in this Agreement.

H. The Company seeks to confirm in writing Advisor's agreement to provide the Company with the Consulting Services between the Effective Date and the Closing Date (unless this Agreement is sooner terminated in accordance with the provisions of ARTICLE VI below).

NOW, THEREFORE, in consideration of the premises and mutual covenants set forth herein and other valuable consideration, the receipt and sufficiency of which are hereby acknowledged, and for their mutual reliance, the parties agree as follows:

ARTICLE I
RECITALS; AFFILIATES

1.1 Recitals. The recitals set forth above are hereby incorporated into this Agreement as if fully set forth in this ARTICLE I.

1.2 Affiliate. As used herein, "Affiliate" means, as to ECHN or Prospect, any person or entity that directly or indirectly controls, is controlled by, or is under common control with, as applicable, ECHN or Prospect and any successors or assigns of such person or entity; and the term "control" means possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of, as applicable, ECHN or Prospect whether through ownership of voting securities, by appointment of trustees, directors, and/or officers, by contract or otherwise.

ARTICLE II
OFFER OF CONSULTING SERVICES

2.1 Appointment; Provision of Services. For and during the Term (as defined in ARTICLE V below), the Company retains Advisor to provide the Consulting Services, and Advisor shall provide to the Company, with respect to the operation of the Hospitals and other programs and services carried on by the Company (collectively, the "Business"), those Consulting Services described on Exhibit A, as it may be amended from time to time, upon the terms and conditions as set forth herein.

2.2 Acceptance. Advisor hereby accepts such appointment by the Company and agrees that it will faithfully perform its duties and responsibilities hereunder.

2.3 Maintenance of Control. The Consulting Services entail recommendations to the Company regarding how to improve the operations and financial condition of the Company's Business. The Company agrees to reasonably consent to make operational changes recommended by Advisor. Nothing in this Agreement is intended to alter, weaken, displace or modify the authority of either (i) the Board of Trustees of the Company with respect to the ultimate oversight and governance of the Company, or (ii) the executive leadership of the Company with respect to day-to-day management of the Business and the assets and affairs of the Company. During the Term, the Board of Trustees of the Company shall exercise ultimate authority, supervision, direction and control over the business, policies, operation and assets of the Company, and shall retain the ultimate authority and responsibility regarding the powers, duties and responsibilities vested in the Board of Trustees of the Company by any and all applicable laws and regulations. The parties mutually acknowledge and agree that any Consulting Services provided pursuant to this Agreement are intended to constitute assistance and support to the Company's Board of Trustees and executive leadership, and are not intended and shall not be construed to grant Advisor any rights or interests in, nor decision-making authority with respect to, the Company or the Business, and the rights and interests of Advisor shall be limited to those expressly set forth herein or in the Purchase Agreement.

2.4 Input Into Company's Strategic Business Decisions. The Company, through its Chief Executive Officer, shall make Advisor aware of key strategic business decisions facing the Company that could compromise the Company's economic viability, marketability or competitive potential and shall elicit input from Advisor on said decisions.

2.5 Consulting Services Fee. During the Term, Fees payable to Advisor for the Consulting Services furnished hereunder shall accrue in an amount equal to two (2) percent of the Company's net patient revenue per month (cumulatively, the "Consulting Services Fee"). The Consulting Services Fee shall be deferred and payable to Consultant if and only if the Closing under the Purchase Agreement fails to occur as a result of a breach of the Purchase Agreement or Letter of Intent by the Company where such breach is willful and intentional by the Company and based on factors within the Company's control, in which such case the Consulting Services Fee shall be paid to Advisor pursuant to Section 6.5 hereunder. Notwithstanding anything to the contrary in this Agreement, the Consulting Services Fee shall be forgiven in its entirety and shall not be payable in any circumstance other than as set forth in the

immediately preceding sentence. If the Closing under the Purchase Agreement takes place, payment of the Consulting Services Fee shall be waived.

2.6 Company's Commitments. The Company shall provide Advisor with sufficient working space and other reasonable physical accommodations at the Facilities as appropriate to the Consulting Services, including access to telephones, facsimile machines, internet connections and copiers, to enable Advisor to fulfill its duties and responsibilities hereunder. The Company and its management staff shall provide timely responses to Advisor's requests for information (and other inquiries) to enable Advisor to perform the Consulting Services hereunder, and shall fully cooperate with Advisor in the fulfillment of Advisor's duties hereunder, including, without limitation, attending meetings and providing information, feedback and input to Advisor.

2.7 Liaisons. Advisor shall direct all inquiries regarding the Consulting Services, and provide all recommendations, reports and other matters relating to the Consulting Services, to Peter J. Carl, the Company's Chief Executive Officer, and/or such person(s) as he may from time to time designate. The Company shall direct all inquiries regarding the Consulting Services to Von Crockett at Prospect, and/or such person(s) as he may from time to time designate.

2.8 Access of Advisor; Patient Records.

(a) During the Term, Advisor shall be given complete access to the Company's records (including Patient Records as defined below), offices and Facilities, in order that it may carry out its obligations hereunder, subject to the confidentiality requirements relating to Patient Records and Confidential Information (as defined below).

(b) The Company shall maintain, to the fullest extent of the law, sole and exclusive responsibility for the preparation, storage and destruction of all patient medical records, clinical treatment plans, charts and similar documents generated in connection with the operation of the Business (collectively, the "Patient Records"). The Company shall assure that the Patient Records are prepared in compliance with all applicable federal, state and local laws and regulations. All Patient Records will be maintained by the Company and shall remain the property of the Company.

(c) To the extent permitted by law including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the standards or regulations promulgated thereunder, including the Privacy Standards and the Security Standards, as well as the federal Health Information Technology for Economic and Clinical Health Act (including any and all standards and regulations promulgated thereunder) and professional ethics regarding confidentiality and disclosure of medical information, the Company shall make such information available to Advisor to enable Advisor to perform its duties hereunder and for any and all other reasonable purposes. For the purposes of this Section 2.8, Advisor shall be referred to as the Company's Business Associate ("Business Associate"). As a Business Associate, Advisor agrees to enter into the Business Associate Agreement with the Company, attached hereto as Exhibit B.

ARTICLE III
[RESERVED]

ARTICLE IV
CONFIDENTIALITY; PROPRIETARY RIGHTS

4.1 Due to the highly competitive nature of the health care industry, disclosure of certain nonpublic, confidential or proprietary information including but not limited to Advisor s Proprietary Rights (as defined below), the Company s Proprietary Rights (as defined below), analyses, compilations, summaries, memoranda, studies, policy and procedure documentation information, uality assurance materials or other documents prepared by the Company or Advisor in connection with this Agreement or the Consulting Services provided hereunder (collectively, the Confidential Information) would be extremely damaging to the party that owns or has the right to such Confidential Information. The parties therefore agree to maintain the confidentiality of the other party s Confidential Information and to protect as a trade secret any portion of the other party s Confidential Information by using reasonable efforts to prevent any unauthori ed disclosure, copying, use, distribution, or transfer of possession of such Confidential Information. Each party agrees to maintain at least the same procedures regarding the other party s Confidential Information that it maintains with respect to its own Confidential Information, but in no event less than a reasonable standard of care. For purposes of this Agreement, Confidential Information shall not be deemed to include information and data: (a) rightfully previously known or ac uired by either party from a third party without a continuing restriction on use; (b) that is or becomes a part of the public domain through no breach of this Agreement by either party; (c) approved for release by written authori ation by the party who owns or has rights to the Confidential Information; (d) that is re uired to be disclosed by law; or (e) independently developed by either party.

4.2 The manuals, software, systems, methods, procedures, policies, controls, documents and pricing and the information relating thereto (including, without limitation, purchase orders and all form documents) and all information relating to Advisor and its Affiliates learned, ac uired or obtained by the Company and its Affiliates pursuant to this Agreement, including without limitation the financial condition, marketing plans, regulatory affairs and business strategies of Advisor or its Affiliates, employed or obtained by Advisor or its Affiliates, and all trademarks, service marks, trade names, copyrights and other proprietary rights in which Advisor or any of its Affiliates has any interest (collectively, Advisor s Proprietary Rights) are proprietary to Advisor and shall remain the property of Advisor or its Affiliates and are not, at any time during the Term or thereafter, to be utili ed, distributed, disseminated, copied or otherwise employed or ac uired by the Company, any of the Company s Affiliates, or their respective officers, directors, trustees, consultants, members, employees, shareholders, and agents, except as authori ed by Advisor in writing.

4.3 The manuals, software, systems, methods, procedures, policies, controls, documents and pricing and the information relating thereto (including, without limitation, purchase orders and all form documents) and all information relating to the Company and its

Affiliates learned, acquired or obtained by Advisor and its Affiliates pursuant to this Agreement, including without limitation the financial condition, marketing plans, regulatory affairs and business strategies of the Company or its Affiliates, employed or obtained by the Company or its Affiliates, and all trademarks, service marks, trade names, copyrights and other proprietary rights in which the Company or any of its Affiliates has any interest (collectively, "Company's Proprietary Rights") are proprietary to the Company and shall remain the property of the Company or its Affiliates and are not, at any time during the Term or thereafter, to be utilized, distributed, disseminated, copied or otherwise employed or acquired by Advisor, any of Advisor's Affiliates, or their respective officers, directors, trustees, contractors, members, employees, shareholders, and agents, except as authorized by the Company in writing.

4.4 Each party acknowledges that the breach of the provisions of this ARTICLE IV would cause irreparable injury to the non-breaching party that could not be adequately compensated by money damages. Accordingly, the non-breaching party may obtain a restraining order, injunction or other equitable relief prohibiting a breach or threatened breach of the provisions of this ARTICLE IV without the necessity of posting any bond or security whatsoever, in addition to any other legal or equitable remedies that may be available. In the event of a breach or threatened breach by either party of any of its obligations under this ARTICLE IV, the other party shall have the right, in addition to any other remedies that may be available to it, to obtain specific performance of the terms of this Agreement without posting any security or bond whatsoever.

4.5 If requested by court order or other legal process to disclose any information constituting Confidential Information, Advisor's Proprietary Rights or Company's Proprietary Rights, the party so requested shall promptly give notice of such request or requirement to the other party so that such party may, at its own cost and expense, seek an appropriate protective order or, in the alternative, waive compliance to the extent necessary to comply with such request if a protective order is not obtained. If a protective order or waiver is granted, the party to whom the request was made may disclose such information only to the extent required by such court order or other legal process or to the extent permitted by such waiver.

4.6 The provisions of this ARTICLE IV shall survive the termination of this Agreement, provided, however, this provision shall terminate upon the Closing of the Purchase Agreement. In that event, however, the parties shall continue to be subject to the terms and conditions of that certain Confidentiality and Non-Disclosure Agreement dated as of February 19, 2015, which shall remain in full force and effect in accordance with its terms.

ARTICLE V
TERM

The term of this Agreement shall commence on the Effective Date and shall continue until the Closing of the Purchase Agreement (the "Term"), unless sooner terminated in accordance with the provisions of ARTICLE VI below.

ARTICLE VI
TERMINATION

6.1 Termination by Either Party for Cause. If either party materially defaults in the performance of any material covenant, agreement, term or provision of this Agreement or the Letter of Intent to be performed by it and such material default continues for a period of thirty (30) days after written notice is delivered to the breaching party from the other party stating the specific default, then the non-breaching party may terminate this Agreement by giving written notice thereof to the breaching party; provided, however, that the non-breaching party shall not have the right to terminate under this Section 6.1 at the end of such thirty (30) day period so long as the breaching party has commenced a cure within such thirty (30) day period and thereafter diligently pursues such cure to completion, which shall be no later than sixty (60) days after the initial written notice.

6.2 Termination Upon Bankruptcy, Etc. If either party shall apply for or consent to the appointment of a receiver, trustee or li□uidator for it or for all or substantially all of its assets, file a voluntary petition in bankruptcy or admit in writing its inability to pay its debts as they become due, make a general assignment for the benefit of creditors, file a petition or any answer seeking reorgani□ation or arrangement with creditors or to take advantage of any insolvency law, or if an order, judgment or decree shall be entered by a court of competent jurisdiction, on the application of a creditor, adjudicating either party to be bankrupt or appointing a receiver, trustee or li□uidator of either party with respect to all or substantially all of the assets of either party, and such order, judgment or decree shall continue unstayed and in effect for any period of ninety (90) consecutive days, then this Agreement shall automatically terminate.

6.3 Termination Upon Dissolution of the Company, Termination of Letter of Intent or Termination of Purchase Agreement. This Agreement shall terminate immediately and automatically upon the first to occur of the following events:

(a) the Company files for voluntary dissolution;

(b) the Letter of Intent expires by it terms or is otherwise terminated; and

(c) the Purchase Agreement is terminated (in accordance with the provisions thereof) prior to a Closing of the transactions contemplated therein.

6.4 Regulatory Matters. If the performance by either party of any material covenant, agreement, term or provision of this Agreement would (a) result in the de-certification of a Hospital under any federal or state government program or by any other regulatory agency that would have a material adverse effect on the operation of the Business, (b) result in the loss of a Hospital□s accreditation, or (c) be in violation of any statute or regulation, or for any other reason be or become illegal and such violation or illegality would have a material adverse effect on the operation of the Business, and in any such event, the reason therefore cannot be corrected by good faith negotiations and effort of the parties hereto within sixty (60) days after written notice thereof (with the objective of keeping the financial intent of the parties hereunder materially the same), then either party may at its option terminate this Agreement.

6.5 Certain Rights Upon Termination.

(a) In the event of any of the following:

(i) upon the receipt of the CON Approvals, if (x) Advisor has executed a purchase agreement in the form of the Purchase Agreement and (y) ECHN willfully and intentionally fails to execute such purchase agreement within ten (10) days after Advisor's execution thereof; or

(ii) the parties having both executed a purchase agreement in substantially the form of the Purchase Agreement, if (x) all conditions to Closing (other than those that by their terms are to be satisfied by the actions to be taken at the Closing) have been satisfied by Advisor, but ECHN willfully and intentionally fails to close the transactions pursuant to Section 8.01 of the Purchase Agreement where such failure is based on factors within ECHN's control, or (y) ECHN willfully and intentionally breaches its obligations under Section 5.23 of the Purchase Agreement;

then, Advisor shall be paid by ECHN, within sixty (60) days after such termination and receipt of an invoice therefor, any accrued and unpaid Consulting Service Fees. For the avoidance of doubt, in all other event, including in the event a Closing occurs under the Purchase Agreement, Advisor shall not be entitled to receive any Consulting Service Fee hereunder.

(b) Subject always to the provision of Section 6.5(a), the termination of this Agreement for any reason shall be without prejudice to any payments or obligations that may have accrued or become due hereunder prior to the effective date of termination or that may become due after such termination.

6.6 Cessation of Use of Proprietary Rights Upon Termination. Upon termination of this Agreement, each party shall immediately discontinue the use of, and shall promptly return to the other party, as applicable, all Confidential Information (to the extent in tangible format) that was made available to such party by reason of its participation in this Agreement, including any copies that it may have in its possession or control.

6.7 Failure to Terminate. Failure to terminate this Agreement shall not waive any breach of this Agreement.

6.8 Survival. To the extent expressly set forth or contemplated in this Agreement, provisions of this Agreement shall survive the termination of this Agreement.

ARTICLE VII
LIABILITY, INDEMNIFICATION, PROFITABILITY AND INDEPENDENT CONTRACTOR

7.1 Limitation of Liability. Except for Advisor's gross negligence or willful misconduct, Advisor shall not by reason of this Agreement or any Consulting Services rendered pursuant to this Agreement have any liability in connection with the operation of the Business or

be deemed to have assumed any liabilities associated with or incident to the operation of the Business. All such liabilities shall remain with the Company. Without limiting the generality of the foregoing, Advisor shall have no liability for any breach of any obligation under this Agreement unless such breach shall constitute gross negligence or willful misconduct; it being understood that in such case of a breach of an obligation that does not constitute gross negligence or willful misconduct, the Company's sole remedies shall be to obtain damages pursuant to Section 15.1 below and/or to terminate this Agreement as provided herein.

7.2 Indemnification.

(a) The Company hereby agrees to defend, indemnify and hold harmless Advisor and its Affiliates, and their respective officers, directors, contractors, members, employees, shareholders, agents, successors and assigns (each, an "Advisor Indemnified Party"), from and against any and all liabilities, causes of action, damages, losses, demands, claims, penalties, judgments, costs and expenses (including, without limitation, reasonable attorneys' fees and related costs) of any kind or nature whatsoever that may be sustained or suffered by any Advisor Indemnified Party arising out of or resulting from (i) any breach by the Company of any of its representations, warranties, covenants, obligations or duties under this Agreement or (ii) the Company's gross negligence or willful misconduct.

(b) Advisor hereby agrees to defend, indemnify and hold harmless the Company, and its Affiliates, and their respective officers, directors, trustees, contractors, members, employees, shareholders, agents, successors and assigns (each a "Company Indemnified Party"), from and against any and all liabilities, causes of action, damages, losses, demands, claims, penalties, judgments, costs and expenses (including, without limitation, reasonable attorneys' fees and related costs) of any kind or nature whatsoever that may be sustained or suffered by any Company Indemnified Party arising out of or resulting from (i) the violation of state, federal, or local law, rules or regulations by Advisor, its directors, officers, agents, independent contractors and employees, which results in bodily injury or physical or actual and material damages or the imposition of a fine, penalty or other charge; or (ii) any breach by the Advisor, its directors, officers, agents, independent contractors or employees of any of its representations, warranties, covenants, obligations or duties under this Agreement; or (iii) the gross negligence or willful misconduct of Advisor, its directors, officers, agents, independent contractors or employees.

(c) The provisions of this Section 7.2 shall survive the termination of this Agreement.

7.3 No Representation of Profitability, Etc. Advisor does not guarantee or represent that operation of the Business will be profitable, or have a certain amount of revenues or cash flow. Except as otherwise expressly provided herein, Advisor shall not be liable for the Company's losses, whether from operation of the Business or otherwise.

7.4 Independent Contractor Status. Advisor does not under this Agreement act in any capacity other than as an independent contractor and does not, under this Agreement, act as principal in the operation of the Business, the Hospitals or any other facilities of the Company.

ARTICLE VIII
NON-SOLICITATION

8.1 Covenant Not To Solicit. During the Term and for a period of two (2) years after the Term (the "Non-Solicit Period"), each party shall not, and shall cause its Affiliates not to, directly or indirectly, (a) take any action that may induce any customer, employee, agent, contractor, or vendor of the other party (either individually or in the aggregate) to discontinue his, her or its affiliation with such other party, or (b) solicit or hire the employees or independent contractors of the other party or any Affiliate thereof without the prior written consent of such other party.

8.2 Equitable Relief. In the event of a breach or threatened breach by a party or any of its Affiliates of any of the obligations under this ARTICLE VIII, the other party shall be entitled, upon application to any court of proper jurisdiction, to a temporary restraining order or preliminary injunction to restrain and enjoin the breaching party and/or its Affiliates from such violation without prejudice as to any other remedies the non-breaching party may have at law or in equity. Each party agrees that, in the event of a violation by such party or an Affiliate thereof, it would be virtually impossible for the other party to calculate its monetary damages and that such other party would be irreparably harmed. If the non-breaching party seeks a temporary restraining order or preliminary injunction, such non-breaching party shall not be required to post any bond or other security with respect thereto, or, if, nonetheless, a bond is required, it may be posted without surety thereon. If any restriction contained in this ARTICLE VIII is held by any court to be unenforceable, or unreasonable, as to time, geographic area or business limitation, the parties agree that such provisions shall be and are hereby reformed to the maximum time, geographic area or business limitation permitted by applicable laws. The parties further agree that the remaining restrictions contained in this ARTICLE VIII shall be severable and shall remain in effect and shall be enforceable independently of each other. Each party specifically acknowledges, represents and warrants that the covenants set forth in this ARTICLE VIII are reasonable, necessary, and enforceable to protect the legitimate interests of the other party, and that such other party would not have entered into this Agreement in the absence of such covenants.

ARTICLE IX
REPRESENTATIONS AND WARRANTIES

9.1 Of Advisor. Advisor represents and warrants to the Company as follows:

(a) Advisor has been duly organized and validly exists as a corporation in good standing under the laws of the State of Delaware, with full corporate power to own its properties and to conduct its business under such laws.

(b) Advisor has the full corporate power and authority to execute and deliver this Agreement and to perform its obligations hereunder, and all necessary actions for the due authorization, execution, delivery and performance of this Agreement by Advisor have been duly taken. The individual executing this Agreement on behalf of Advisor is duly authorized and has the requisite power and authority to execute this Agreement.

(c) Neither the execution of this Agreement, the performance by Advisor under this Agreement, nor compliance by Advisor with any provision of this Agreement will conflict with or violate Advisor's articles of incorporation or bylaws, any agreements to which Advisor is a party, or any material provision of applicable federal, state and local laws, rules and regulations.

(d) Upon Advisor's execution of this Agreement, this Agreement shall constitute a valid and binding obligation of Advisor, enforceable in accordance with its terms.

(e) Neither Advisor, nor its Affiliates, employees, and agents (i) is currently excluded, debarred or otherwise ineligible to participate in any federal or state health care program, (ii) has been convicted of a criminal offense related to the provision of healthcare items and services, (iii) is under investigation or otherwise aware of any circumstances which may result in Advisor or any of its Affiliates, employees, or agents being excluded from participation in any federal or state health care program, (iv) is listed in the HHS/OIG List of Excluded Individuals (http://www.oig.hhs.gov/exclusions) ("LIEE"), the General Services Administration's List of Parties Excluded from Federal Programs (http://www.epls.gov), the National Practitioner Data Bank, or any similar federal or state database indicating that such individual is ineligible to perform the Consulting Services under this Agreement, or (v) is a Specially Designated National or a Blocked Person by the Office of the Foreign Asset Control of the U.S. Department of Treasury.

(f) Advisor will not employ or otherwise obtain the services of any individual to perform Consulting Services under this Agreement who is not legally authorized to work in the United States in the capacity indicated. In furtherance thereof, Advisor certifies that all persons assigned to work under this Agreement are legally authorized to work in the United States in the capacity they are serving under this Agreement and will provide any and all written documentation to support such certification. Advisor agrees that if the status of any such person changes during the term of the Agreement, it shall remove such person from performing Consulting Services under this Agreement. On no less than a monthly basis, Advisor shall screen each individual performing the Consulting Services under this Agreement in the manner recommended by the HHS/OIG May 8, 2013 Special Advisory Bulletin on the Effect of Exclusion from Participation in Federal Health Care Programs, and shall maintain a record of each such screening.

(g) Advisor will abide by any and all applicable federal and/or state employment statutes, rules and regulations including, without limitation, Title VII of the Civil Rights Act of 1964, the Equal Opportunity Act of 1972, the Age Discrimination in Employment Act of 1967, the Equal Pay Act of 1963, the National Labor Relations Act, the Fair Labor Standards Act, the Rehabilitation Act of 1973, and the Occupational Safety and Health Act of 1970, all as may be from time to time modified or amended.

(h) Advisor shall cooperate with the Company corporate compliance audits, reviews and investigations that relate to the services provided by Advisor under this Agreement. Advisor acknowledges that the Company has established a Corporate Compliance Plan ("CCP") and promotes a culture that fosters prevention, detection and resolution of instances of misconduct. Advisor shall cause all Advisor personnel performing the Consulting Services for the Company

to participate in the Company's initial corporate compliance and privacy training no later than thirty (30) days from the date such individual commences performing Services under this Agreement, and additionally in the Company's annual compliance and privacy training thereafter. The failure to complete such training within the designated time frame shall be cause for removal under this Agreement. Advisor shall additionally require all Advisor personnel furnishing the Consulting Services to sign and furnish to the Company the Certification and Acknowledgement attached to the ECHN Code of Conduct stating that such individual has read the ECHN Code of Conduct (available on the ECHN website at www.ECHN.org, About ECHN) and agrees to comply with all of its provisions.

(i) Advisor shall immediately notify ECHN's Compliance Officer of any violation of any applicable law, regulation, third party payor requirements or breach of ECHN's CCP of which Advisor or any of its employees or agents become aware of during the term hereof. Advisor shall instruct its employees and agents of this requirement.

(j) Advisor shall maintain and actively support, at all times during the term of this Agreement, a corporate compliance program that has been reasonably designed, implemented and enforced so that it generally will be effective in preventing and detecting criminal conduct and ethical lapses by Advisor, its agents and employees.

(k) Advisor shall cooperate with the Company in responding to or resolving any complaint, investigation, inquiry, or review initiated by a governmental agency or otherwise. Advisor shall cooperate with any insurance company providing protection to the Company in connection with the foregoing and shall, consistent with applicable law, fully follow the directions of the Company.

(l) Advisor has all rights, authorizations, and licenses necessary to provide any material furnished by Advisor to the Company, and that the material and the Company's use thereof, as authorized by this Agreement, shall not infringe, misappropriate, or otherwise violate the rights of any third party.

(m) Each of Advisor's employees, agents, or representatives assigned to perform under the Agreement shall have the proper skill, training, and background so as to be able to perform in a professional and workmanlike manner and that all work will be so performed in a manner compatible with Advisor's business operations at its premises.

(n) Advisor will not introduce into Advisor software, computer hardware or data any software that contains any "time-bombs," "usage authorization codes," or other codes or programming devices that might or might be used to access, modify, delete, damage, deactivate, or disable any of the Company's software, computer hardware, or data; nor will Advisor cause any of the Company's software, computer hardware or data to be infected with any "worms", "viruses", "Trojan horses" or other programs or programming devices that might be used to modify, delete, damage, deactivate or disable any of the Company's software, computer hardware or data.

9.2 Of the Company. The Company represents and warrants to Advisor as follows:

(a) The Company has been duly organi□ed and validly exists as a not-for-profit corporation in good standing under the laws of the State of Connecticut, with full limited power to own its properties and to conduct its business under such laws.

(b) The Company has the full corporate power and authority as a company to execute and deliver this Agreement and to perform its obligations hereunder, and all necessary actions for the due authori□ation, execution, delivery and performance of this Agreement by the Company have been duly taken. The individual executing this Agreement on behalf of the Company is duly authori□ed and has the re□uisite power and authority to execute this Agreement.

(c) Neither the execution of this Agreement, the performance by the Company under this Agreement, nor compliance by the Company with any provision of this Agreement will conflict with or violate the Company□s articles of incorporation, bylaws, any agreements to which the Company is a party, or any material provision of applicable federal, state and local laws, rules and regulations.

(d) Upon the Company□s execution of this Agreement, this Agreement shall constitute a valid and binding obligation of the Company, enforceable in accordance with its terms.

(e) Neither the Company, nor its Affiliates, employees, and agents (i) is currently excluded, debarred or otherwise ineligible to participate in any federal or state health care program, (ii) has been convicted of a criminal offense related to the provision of healthcare items and services, or (iii) is a Specially Designated National or a Blocked Person by the Office of the Foreign Asset Control of the U.S. Department of Treasury.

ARTICLE X
INSURANCE

10.1 Advisor□s Re□uired Coverage. During the Term hereof, Advisor shall maintain, at its own expense, workers□compensation coverage in accordance with statutory re□uirements for Advisor□s employees who provide services under this Agreement, and commercial general liability insurance and commercial auto insurance in an amount not less than One Million Dollars (□1,000,000) per occurrence and Three Million Dollars (□3,000,000) in the annual aggregate with insurance carriers duly licensed to conduct business in the State of Connecticut. In addition, Advisor shall maintain professional liability insurance and cyber liability insurance, each in an amount not less than One Million Dollars (□1,000,000) per occurrence and Three Million Dollars (□3,000,000) in the annual aggregate with insurance carriers duly licensed to conduct business in the State of Connecticut. The limits above may be satisfied by any combination of self insurance or umbrella policies, and Advisor may carry any insurance re□uired by this Agreement under a blanket policy.

10.2 The Company□s Re□uired Coverage. The Company shall maintain, at the Company□s expense, at all times during the Term: (a) workers□compensation coverage in accordance with statutory re□uirements for the Company□s employees; (b) commercial property

damage and fire hazard insurance written on full replacement value basis for all of the Company's assets and real property; (c) professional liability insurance covering the Company's employees who perform any work, duties, or obligations against claims for bodily injury, death, malpractice and property damage, which insurance shall provide coverage on a claims-made or occurrence basis with a per occurrence limit of not less than One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) in the annual aggregate; and (d) comprehensive commercial general liability insurance in an amount not less than One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) in the annual aggregate. The above limits may be satisfied by any combination of primary and excess or umbrella policies. The Company may carry any insurance required by this Agreement under a blanket policy. Advisor shall be an additional named insured under the Company's general liability insurance policy.

10.3 Certificates of Insurance. On the Effective Date and at any time upon request, each party shall provide the other party certificates of insurance evidencing the coverages required hereby, and shall notify the other party immediately of the cancellation, termination, or non-renewal of, or material change in, such insurance coverage.

ARTICLE XI
ARMS-LENGTH BARGAINING

The parties agree that the compensation provided herein has been determined in arm's-length bargaining and is consistent with fair market value in arm's length transactions and is not and has not been determined in a manner that takes into account the volume or value of any referrals or business otherwise generated for or with respect to the Hospitals or other facilities of the Company or between the parties or any of the undersigned persons or equity holders thereof for which payment may be made in whole or in part under Medicare or any state health care program or under any other payor program.

ARTICLE XII
ASSIGNMENT

Neither party shall, directly or indirectly, assign or otherwise transfer this Agreement, or any interest herein or obligation hereunder, without the prior written consent of the other party, which may be withheld in such other party's sole discretion. In no event may a party assign this Agreement unless the assignee shall have executed and delivered to the other party a written assumption of this Agreement in form and substance satisfactory to such other party in its sole discretion. Notwithstanding the foregoing, Advisor shall be permitted, without the consent of the Company, to assign this Agreement to any Affiliate of Advisor, but Advisor shall remain liable to the Company for the performance and satisfaction of all undertakings and commitments set forth herein.

ARTICLE XIII
NOTICES

All notices required or permitted hereunder shall be given in writing by actual delivery or by certified mail, postage prepaid or by nationally recognized overnight courier service. Notice shall be deemed given upon delivery, or if given by mail, upon receipt or if sent by next day delivery by a nationally recognized overnight courier service, on the next business day. Notice shall be delivered or mailed to the parties at the following addresses or at such other places as a party shall designate in writing:

If to the Company:	Eastern Connecticut Health Network, Inc. 71 Haynes Street Manchester, CT 06040 Attn: Peter J. Karl, President and Chief Executive Officer phone: e-mail:
with a copy (which shall not constitute notice) to:	Ropes & Gray LLP Prudential Tower 800 Boylston Street Boston, MA 02199-3600 Attn: Anne Ogilby Fax: 617-235-0234 Email: anne.ogilby@ropesgray.com
If to Advisor:	Prospect Medical Holdings, Inc. 10780 Santa Monica Boulevard, Suite 400 Los Angeles, CA 90025 Attention: Legal Department
with a copy (which shall not constitute	Epstein Becker & Green, P.C. One Gateway Center

notice) to: Newark, NJ 07102
Attention: Gary W. Herschman, Es□
phone: (973) 642-1900
email: gherschman@ebglaw.com
Attention: David E. Weiss, Es□
phone: (212) 351-4500
email: dweiss@ebglaw.com

ARTICLE XIV
RECORD ACCESS AND RETENTION

14.1 Access to Records. Each party hereto shall permit, and shall ensure that any subcontractor retained by it permits, the United States Department of Health and Human Services and General Accounting Office, or their authori□ed representatives, to review appropriate books and records relating to the performance hereunder to the extent re□uired under Section 1861(v)(1) of the Social Security Act, 42 U.S.C. Section 1395x(v)(1)(I), or any successor law or regulation for a period of four (4) years following the last day Advisor provided services hereunder. The access shall be provided in accordance with the provisions of Title 42, Code of Federal Regulations, Part 420, Subpart D.

14.2 Notification. Each party shall notify the other party immediately of the nature and scope of any re□uest for access to books and records described above and shall provide copies of any books, records or documents to the other party prior to the provision of same to any governmental agent to give such other party an opportunity to lawfully oppose such production of documents. Nothing herein shall be deemed to be a waiver of any applicable privilege (such as the attorney-client privilege) by either party.

ARTICLE XV
MISCELLANEOUS

15.1 Choice of Law; Dispute Resolution; Venue.

(a) Choice of Law. The parties agree that this Agreement shall be governed by and construed in accordance with the Laws of the State of Connecticut, without giving effect to any choice or conflict of law provision or rule thereof that would re□uire the application of any other law.

(b) Dispute Resolution. Except as provided in Section 15.2 below, in the event that any dispute, controversy or claim arises among the parties with respect to this Agreement, including as to the breach, termination or invalidity hereof (a □Dispute□), the parties shall attempt in good faith to resolve such Dispute promptly by negotiation (including at least one in-person meeting) over a period of not less than thirty (30) days, commencing upon one party□s delivery of a written notice of Dispute to the other party.

(c) Venue. In the event that any Dispute is not resolved through good faith negotiations as provided in Section 15.1(b) above, either party may submit the matter to a court

of law or equity through the filing of a claim. The Parties agree that, except as otherwise expressly provided in Section 15.2 below, venue for any and all claims associated with a Dispute between the Parties shall rest with the state courts of the State of Connecticut.

(d) Waiver of Jury Trial. EXCEPT AS PROVIDED IN SECTION 15.2 BELOW, EACH PARTY HEREBY IRREVOCABLY WAIVES ALL RIGHT TO TRIAL BY JURY IN ANY ACTION, PROCEEDING OR COUNTERCLAIM (WHETHER BASED ON CONTRACT, TORT OR OTHERWISE) ARISING OUT OF OR RELATING TO THIS AGREEMENT OR THE TRANSACTIONS CONTEMPLATED HEREBY OR THEREBY.

15.2 Injunctive Relief. Notwithstanding anything to the contrary contained herein, each party acknowledges and agrees that a party may seek, from a court of competent jurisdiction in the State of Connecticut, injunctive relief against a breaching party pursuant to Sections 4.4 and 8.2 above, without posting any bond or other undertaking.

15.3 Severability. Should any provision of this Agreement be found void or unenforceable, the remainder hereof nevertheless shall continue in full force and effect. A new provision shall be amended to this Agreement that is similar to the provision found unenforceable but which is enforceable.

15.4 Approval or Consent. Except as otherwise provided herein, whenever under any provisions of this Agreement, the approval or consent of either party is required, such approval or consent shall not be unreasonably withheld, conditioned or delayed.

15.5 Entire Agreement. This Agreement contains the entire agreement between the parties with respect to the subject matter hereof, and the parties expressly agree that this Agreement supersedes and rescinds any prior agreement between them (verbal or written) pertaining to the subject matter hereof.

15.6 No Third Party Beneficiary. Except as expressly provided in this Agreement, no person or entity that is not a party to this Agreement shall be a third party beneficiary of any rights or obligations hereunder or be entitled to enforce any of said rights or obligations.

15.7 Interpretation. The article and paragraph headings contained herein are for convenience of reference only, do not constitute part of this Agreement, and are not intended to define, limit or describe the scope of intent of any provision of this Agreement. All gender references used in this Agreement shall include all genders, and the singular shall include the plural and the plural shall include the singular whenever and as often as may be appropriate.

15.8 Force Majeure. Advisor shall not be deemed to be in violation of this Agreement, and shall not be liable for any resulting claims, losses, damages, expenses and liabilities if it is prevented, hindered or delayed, either directly or indirectly, from performing any of its obligations hereunder for any reason beyond its reasonable control, including without limitation labor disputes, fires, storms, earthquakes, acts of God, or any statute, regulation or rule of the federal government, any state or local government or any agency thereof.

15.9 Amendments; Course of Dealing. This Agreement may be amended or supplemented only in a writing signed by both parties. The failure of any party to enforce at any time any of the provisions of this Agreement shall in no way be construed to be a waiver of any such provision, nor in any way to affect the validity of this Agreement or any part hereof or the right of any party thereafter to enforce each and every such provision. No waiver of any breach of this Agreement shall be held to be a waiver of any other or subse□uent breach.

15.10 Cooperation; Further Assistance. From time to time, as and when reasonably re□uested by either party hereto, the other party will (at the expense of the re□uesting party) execute and deliver, or cause to be executed or delivered, all such documents, instruments and consents and will use reasonable efforts to take all such action as may be reasonably re□uested or necessary to carry out the intent and purpose of this Agreement.

15.11 Execution of this Agreement. The parties may execute this Agreement in counterparts, each of which shall be deemed an original and both of which together shall constitute but one and the same instrument. A signature delivered by facsimile or PDF shall be sufficient for all purposes between the parties.

[*signature page follows*]

IN WITNESS WHEREOF, the parties have executed this Agreement, through their duly authorized representatives, effective as of the date first above written.

ADVISOR:

PROSPECT MEDICAL HOLDINGS, INC., a Delaware corporation

By:_____
Name:
Title:

THE COMPANY:

EASTERN CONNECTICUT HEALTH NETWORK, INC., a Connecticut non-stock corporation

By:_____
Name:
Title:

EXHIBIT A
LIST OF CONSULTING SERVICES

In consideration of the payments to be made hereunder, Advisor shall from time to time and as appropriate provide, either directly or indirectly through one or more of its Affiliates, the following services to the Company:

1. Advise the Company regarding trends in the industry, make recommendations regarding new and/or expanded services and programs, physician alignment & recruitment, IT/EMR capabilities and improvements, technology implementation, ACOs and other reform-driven approaches, and managed care approaches.

2. Review, assess and provide recommendations regarding potential service consolidation and restructurings to achieve efficiencies.

3. Review, assess and provide recommendations regarding new clinical service lines, programs and locations.

4. Review, assess and provide recommendations regarding physician-alignment strategies, joint ventures and other strategic initiatives.

5. Advise the Company regarding expenditure and spending patterns, evaluate standard procurement lifecycle methodologies including working cash vs. discount modeling, invoice synchronization and vendor payment management. Such expenditures and contracts would include without limitation:

    - Third party service providers
    - Supply contracts
    - Contracts with outside contractors or consultants
    - Preventive maintenance with respect to equipment and building
    - Upkeep and maintenance of the physical facilities

6. Advise the Company regarding third-party reimbursement issues and consultation on such issues and compliance with all applicable reimbursement rules.

7. Assist the Company to develop, implement and maintain a compliance program that is committed to promoting, preventing, detecting and resolving instances of conduct that do not conform to federal or state laws.

8. Assist the Company to develop plans with respect to labor relations matters.

9. Review, assess and provide recommendations regarding a physician-led and focused clinical documentation program.

10. Review, assess and provide recommendations regarding the Company s case management program and length of stay initiatives.

11. Assist the Company to develop strategies with respect to cost accounting processes.

12. Provide other Consulting Services as mutually agreed upon in writing by the parties from time to time.

EXHIBIT B
BUSINESS ASSOCIATE AGREEMENT

THIS BUSINESS ASSOCIATE AGREEMENT (the "Business Associate Agreement") is made and entered into as of _____, 20____ (the "Effective Date"), by and between ("Business Associate"), and Eastern Connecticut Health Network, Inc. by and on behalf of its covered entity subsidiaries, affiliates and related organizations (collectively, the "Covered Entity").

RECITALS

WHEREAS, the Business Associate and Covered Entity have entered into and may enter into one or more agreements (the "Agreement(s)") under which the Business Associate performs or assists the Covered Entity with a function or activity involving the Use or Disclosure of Individually Identifiable Health Information;

WHEREAS, the Covered Entity and the Business Associate desire to comply with the requirements of regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

WHEREAS, the HIPAA Standards require that the Covered Entity obtain satisfactory assurances that the Business Associate will appropriately safeguard the Individually Identifiable Health Information Used or Disclosed by the Business Associate in the course of performing services pursuant to the Agreement(s).

NOW, THEREFORE, in consideration of the foregoing and the mutual promises and covenants herein contained, the parties agree as follows:

1. Definitions

a) HIPAA Rules shall mean the Privacy, Security, Breach Notification and Enforcement Rules at 45 C.F.R. Part 160 and Part 164.

b) The following terms Used in this business Associate Agreement shall have the same meaning as those terms defined in the HIPAA Standards: Business Associate, Covered Entity, Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required By Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

c) The Covered Entity and the Business Associate acknowledge and agree that capitalized terms Used, but not otherwise defined, herein are as defined in the HIPAA Standards;

2. Obligations and Activities of Business Associate

a) Business Associate shall not Use or further Disclose Protected Health Information other than as permitted or re□uired by this Business Associate Agreement or as re□uired by law.

b) Business Associate shall Use appropriate safeguards and comply with Subpart C of 45 C.F.R. Part 164 with respect to electronic protected health information, to prevent Use or Disclosure of the Protected Health Information not provided for by this Business Associate Agreement.

c) Business Associate shall immediately report to Covered Entity any Use or Disclosure of Protected Health Information or individually identifiable information not provided for by this Business Associate Agreement, including without limitation any Breach of Protected Health Information or Unsecured Protected Health Information as re□uired and any Security Incident of which the Business Associate becomes aware. Business Associate shall take any reasonable action necessary or re□uested by the Covered Entity to mitigate, to the extent practicable, any harmful effect that is known to Business Associate.

d) In the event of a Breach of Protected Health Information or Unsecured Protected Health Information, Business Associate□s notice to Covered Entity of such Breach shall include, to the extent possible, the identification of each Individual whose Protected Health Information has been, or is reasonably believed to have been, accessed, ac□uired, or disclosed. Business Associate shall also provide Covered Entity any other available information that the Covered Entity is re□uired to include in the notification to the Individual, even if such information becomes available after notification to the Individual, or take any reasonable action necessary as re□uested by the Covered Entity to assist Covered Entity in complying with any applicable Breach notification re□uirements.

e) Business Associate shall ensure that any agent of the Business Associate, including a subcontractor that creates, maintains transmits, or receives Protected Health Information on behalf of Covered Entity agrees to the same restrictions, conditions and re□uirements that apply through to Business Associate with respect to such information.

f) If the Business Associate maintains Protected Health Information in a Designated Record Set, the Business Associate shall:

(i) provide access or make available to Covered Entity Protected Health Information in a Designated Record Set, to Covered Entity or to an Individual, per Covered Entity□s direction in order to meet the re□uirements under 45 C.F.R. □164.524; and

(ii) make any amendment(s) to Protected Health Information in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 C.F.R. □164.526 at the re□uest of Covered Entity or an Individual in the time and manner designated by Covered Entity, or take other measures as necessary to satisfy Covered Entity□s obligations under 45 C.F.R. 164.526.

g) Business Associate shall maintain and make available to Covered Entity information pertaining to Disclosures of Protected Health Information by Business Associate to permit Covered Entity to respond to a request by an Individual for an accounting of Disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528. In the event that Business Associate receives a direct request from an Individual for an accounting of Disclosures of Protected Health Information made by Business Associate, Business Associate agrees to provide the Individual with such an accounting in accordance with 45 C.F.R. § 164.528.

h) To the extent Business Associate is to carry out one or more of Covered Entity's obligation(s) under Subpart E of 45 C.F.R. Part 164, Business Associate shall comply with the requirements of Subpart E that apply to Covered Entity in the performance of such obligation(s); and

i) Business Associate shall make internal practices, books, and records relating to the Use and Disclosure of Protected Health Information received from, or created, maintained or received by Business Associate on behalf of Covered Entity available to the Covered Entity or the Secretary, in a time and manner designated by the Covered Entity or the Secretary, for purposes of the Secretary determining Covered Entity's or Business Associate's compliance with the HIPAA Rules.

j) Business Associate shall implement and maintain safeguards as necessary to ensure that all Protected Health Information is Used or Disclosed only as authorized under the HIPAA Rules and this Business Associate Agreement. Business Associate agrees to assess potential risks and vulnerabilities to Protected Health Information in its possession and develop, implement and maintain the administrative, physical and technical safeguards required by the HIPAA Rules that protect the confidentiality, availability and integrity of the Protected Health Information that Business Associate creates, receives, maintains or transmits on behalf of the Covered Entity. These measures must be documented and kept current, and must include, at a minimum, those measures that fulfill the requirements outlined in the HIPAA Rules. Business Associate also agrees to implement policies and procedures that address Business Associate's compliance with applicable HIPAA Rules and its efforts to detect, prevent and mitigate the risks of identity theft resulting from the improper Use and/or Disclosure of an Individual's information.

k) In the event that Business Associate has knowledge of Covered Entity's breach of the HIPAA Rules, Business Associate agrees to notify Covered Entity and take reasonable steps to cure such breach.

l) Business Associate acknowledges that if it violates any of the requirements provided under this Business Associate Agreement, Business Associate will be subject to the same civil and criminal penalties that a Covered Entity would be subject to if such Covered Entity violated the same requirements.

3. Permitted Uses and Disclosures by Business Associate

a) Business Associate may Use or Disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Agreement(s), provided that such Use or Disclosure would not violate the HIPAA Rules if done by Covered Entity.

b) Business Associate may Use Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

c) Business Associate may Disclose Protected Health Information for the proper management and administration of the Business Associate, provided that Disclosures are Required by Law, or Business Associate obtains reasonable assurances from the person to whom the information is Disclosed that it will remain confidential and will be Used or further Disclosed only as Required by Law or for the purpose for which it was initially Disclosed to the recipient, and the recipient notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

d) Except as otherwise permitted by the HIPAA Rules, when using or disclosing Protected Health Information or responding to a request for Protected Health Information, Business Associate must limit such Protected Health Information, to the extent practicable, to a Limited Data Set, or if more information than a Limited Data Set is required, Business Associate agrees to make Uses and Disclosures and requests for protected health information consistent with the Minimum Necessary to accomplish the intended purpose of such Use, Disclosure, or request.

e) Except as otherwise permitted by the HIPAA Rules, Business Associate agrees that it will not directly or indirectly receive remuneration in exchange for any Protected Health Information unless Covered Entity has obtained from an Individual a valid authorization that includes a specification of whether the Protected Health Information can be further exchanged for remuneration by the entity receiving the Individual's Protected Health Information. When the Secretary issues the regulations that address the requirements of this Section and such regulations become effective, Business Associate shall comply with such regulations with respect to receiving remuneration in exchange for any Protected Health Information.

f) If an Individual requests that Business Associate restrict the Disclosure of the Individual's Protected Health Information to carry out treatment, payment, or health care operations, Business Associate agrees that it will comply with the requested restriction if, except as otherwise required by law, the Disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment), and the Protected Health Information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full.

g) Except as otherwise limited in this Business Associate Agreement, Business Associate may Use and Disclose Protected Health Information to provide Data Aggregation services to Covered Entity as permitted by 42 C.F.R. 164.504(e)(2)(i)(B).

4. Obligations of Covered Entity

a) Covered Entity shall provide Business Associate with the Notice of Privacy Practices that Covered Entity produces in accordance with 45 C.F.R. 164.520, as well as provide any changes to such Notice and the Business Associate shall comply with such Notice of Privacy Practices.

b) Covered Entity shall provide Business Associate with any changes in, or revocation of, permission by Individual to Use or Disclose Protected Health Information, if such changes affect Business Associate's permitted or required Uses and Disclosures.

c) Covered Entity shall notify Business Associate of any restriction to the Use or Disclosure of Protected Health Information that Covered Entity has agreed to in accordance with 45 C.F.R. 164.522.

d) Covered Entity shall not request Business Associate to Use or Disclose Protected Health Information in any manner that would not be permissible under the HIPAA Rules if done by Covered Entity.

5. Term and Termination

a) Term. The Term of this Business Associate Agreement shall be effective as of the Effective Date and shall terminate when all of the Protected Health Information provided by Covered Entity to Business Associate, or created, maintained, or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this Section.

b) Termination for Cause. Upon Covered Entity's knowledge of a material breach of this Business Associate Agreement by Business Associate, Covered Entity shall provide an opportunity for Business Associate to cure the breach or end the violation. Covered Entity shall terminate the Business Associate Agreement if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity. Covered Entity may immediately terminate the Business Associate Agreement if Business Associate has breached a material term of this Business Associate Agreement and cure is not possible, as determined by the Covered Entity in its reasonable discretion.

c) Effect of Termination.

(i) Except as provided in this subsection, upon termination of the Agreement(s) or this Business Associate Agreement, for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Entity, or created, maintained or received by Business Associate on behalf of Covered Entity that the Business Associate still maintains in any form. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.

(ii) In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon mutual agreement of the parties that return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this Business Associate Agreement to such Protected Health Information and limit further Uses and Disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

(iii) The parties hereto understand and agree that the terms of this Business Associate Agreement are reasonable and necessary to protect the interests of the Covered Entity and the Business Associate. The parties further agree that the Covered Entity would suffer irreparable harm if the Business Associate breached this Business Associate Agreement. Thus, in addition to any other rights or remedies, all of which shall be deemed cumulative, the Covered Entity shall be entitled to obtain injunctive relief to enforce the terms of this Business Associate Agreement.

(iv) Survival. The obligations of Business Associate under this Section shall survive the termination of this Business Associate Agreement.

6. Miscellaneous

a) Interpretation. Any ambiguity in this Business Associate Agreement shall be interpreted in a manner that permits the parties to comply with the HIPAA Rules.

b) No Private Cause of Action. This Business Associate Agreement is not intended to and does not create a private cause of action by any individual, other than the parties to this Business Associate Agreement, as a result of any claim arising out of the breach of this Business Associate Agreement, the HIPAA Standards or other state or federal law or regulation relating to privacy or confidentiality.

c) Amendment. Either party shall have the right to amend this Business Associate Agreement by providing written notice to the other party in order to bring it into compliance with any law or regulation enacted or promulgated regarding the protection of health information that is any way inconsistent with the terms of this Business Associate Agreement or interferes with either parties obligations with respect to the protection of health information.

d) Application of State Law. Where any applicable provision of Connecticut State law relates to the privacy of health information and is not preempted by HIPAA, as determined by application of the HIPAA Rules, the parties shall comply with the applicable provisions of Connecticut State law.

e) Severability. If any provision of this Business Associate Agreement shall be declared invalid or illegal for any reason whatsoever, then notwithstanding such invalidity or illegality, the remaining terms and provisions of this Business Associate Agreement shall remain in full force and effect in the same manner as if the invalid or illegal provision had not been contained herein, and such invalid, unenforceable or illegal provision shall be valid, enforceable and legal to the maximum extent permitted by law.

f) Governing Law. This Business Associate Agreement shall be interpreted, construed and governed according to the laws of the State of Connecticut. The parties agree that venue shall lie in Federal and State courts in the State in which the Covered Entity maintains its principal place of business, without regard to its conflicts of law principles, regarding any and all disputes arising from this Business Associate Agreement.

g) Notices. Any notice or other communication given pursuant to this Business Associate Agreement must be in writing and (i) delivered personally, (ii) delivered by overnight express, or (iii) sent by registered or certified mail, postage prepaid, to the address set forth below and shall be considered given upon delivery.

Chief Compliance and Privacy Officer

Eastern Connecticut Health Network

71 Haynes Street

Manchester, CT 06040

h) Indemnification. Without limitation to any indemnification obligation that Business Associate may have under the Agreement(s), Business Associate shall indemnify, hold harmless and defend Covered Entity from and against any and all claims, losses, liabilities, costs and other expenses resulting from, or relating to, the acts or omissions of Business Associate, its employees, agents, and subcontractors, in connection with any Use or Disclosure of Protected Health Information, Unsecured Protected Health Information, or an Individual's information not provided for by this Business Associate Agreement, including without limitation any Breach of Protected Health Information, Unsecured Protected Health Information, or an Individual's information or any expenses incurred by Covered Entity in providing required breach notifications.

IN WITNESS WHEREOF, the parties hereto have caused this Business Associate Agreement to be executed and delivered as of the day and year first above written.

COVERED ENTITY:	BUSINESS ASSOCIATE:
EASTERN CONNECTICUT HEALTH NETWOR□, INC.	PROSPECT MEDICAL HOLDINGS, INC.
BY: _____	BY: _____
NAME: _____	NAME: _____
ITS: _____	ITS: _____
DATE_____	DATE: _____

RESPONSE TO DEFICIENCIES
EXHIBIT E - Number of Physicians in PMH Network

Number of Physicians Participating in PMH's Physician Network by State

	Owned			
	2012	2013	2014	2015
Total PCP's (Contracted Only) - California	852	903	913	882
Total SP's (Contracted Only) - California	8,264	9,273	10,607	12,402
Total PCP's (Contracted Only) - Rhode Island				105
Total SP's (Contracted Only) - Rhode Island				270
Total PCP's (Contracted Only) - Texas				23
Total SP's (Contracted Only) - Texas				594
TOTAL PCP'S AND SP'S	**9,116**	**10,176**	**11,520**	**14,276**

Please note that the above data includes all fully contracted physicians and physicians who Prospect has Memorandum of Understandings for limited services and/or for a limited period of time and/or

PCP = Primary Care Physician

SP = Specialist

RESPONSE TO DEFICIENCIES
EXHIBIT F - PMH Performance Metrics (Texas)

Prospect Medical

12 Month Bed-Day Report - HMO Product Summary

Health Plan : ALL HEALTH PLANS

Location : PROSPECT HEALTH SERVICES-TEXAS

GOAL:

Senior: (900 / K)
Commercial: (125 / K)
Medi-Cal: (250 / K)
SPD: (400 / K)

PROSPECT HEALTH SERVICES-TEXAS

HMO Product		2015-01	2015-02	2015-03	2015-04	2015-05	2015-06	2015-07	2015-08	2015-09	2015-10	2015-11	2015-12	Total
SENIOR														
ACUTE	**Membership:**	1,617	1,611	1,626	1,465	1,439	1,430	1,378	1,320	1,317	1,339	0	0	14,542
	Admits:	31	28	32	20	24	22	23	17	18	14	0	0	229
	Days:	172	149	179	148	143	143	194	104	154	91	0	0	1,477
	Admits / 1000:	226	227	232	166	196	187	197	152	166	123	0	0	189
	Days / 1000:	1,252	1,206	1,296	1,229	1,170	1,217	1,658	928	1,423	800	0	0	1,218
	ALOS:	5.5	5.3	5.6	7.4	6.0	6.5	8.4	6.1	8.6	6.5	0	0	6.4
NON-ACUTE	**Membership:**	1,617	1,611	1,626	1,465	1,439	1,430	1,378	1,320	1,317	1,339	0	0	14,542
	Admits:	8	5	1	4	4	6	7	6	2	3	0	0	46
	Days:	219	200	137	103	120	93	181	173	54	50	0	0	1,330
	Admits / 1000:	58	40	7	33	33	51	60	54	18	26	0	0	38
	Days / 1000:	1,595	1,618	992	855	982	791	1,547	1,543	499	440	0	0	1,096
	ALOS:	27.4	40.0	137.0	25.8	30.0	15.5	25.9	28.8	27.0	16.7	0	0	28.9

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RESPONSE TO DEFICIENCIES
EXHIBIT G - PMH Programs and Procedures

PROSPECT MEDICAL
Quality Service ~ Quality Care



The Next Generation Healthcare System

THE PROSPECT MEDICAL DIFFERENCE: CARE PLUS

Care Management– Care Plus

What is Quality

- Simply put, health care quality is: getting the right care to the right patient at the right time every time.

Statement by: Carolyn Clancy MD, Director Agency for Health care Research and Quality, US Department of HHS.

Before: Committee on Finance, Subcommittee on Health Care; US Senate. Wednesday March 18, 2009.

http://www.hhs.gov/asl/testify/2009/03/t20090318b.html

Care Management– Care Plus

- What we do:
  - We improve patient outcomes & save lives with our innovative Care Plus Model for care coordination.
  - We embed specialized care teams into PCP practices & into the communities where our high-risk patients live.
  - Our medical-behavioral-social care model is executed across the care-continuum: any place of service, any time.
  - Seamless optimal care coordination & care transitions.
  - Leverage Complex Case Management, Palliative Care, Medication Therapy Management, & Home-based Care.
  - High-touch, high-service patient-centered approach.
  - Single operating platform with NCQA certified workflow.
  - Full Implementation with measurable results in 120 days.

Care Management– Care Plus

- What makes us special:
  - Our Care Model approach is Innovative & Effective.
  - Our Care Model drives Value.
  - Our Leaders are national experts in Care Coordination.
  - We are able to do this with all types of patients.
  - We specialize in highest-risk patients: chronic conditions, frail, disabled, homebound, severe mental illness, & end-of-life.
  - We also do this in all locations, geographies, & states.
  - We do this quickly, with minimum up-front investment.
  - We can reproduce, scale, & sustain.
  - Our results are compelling for all of our stakeholders.
  - Others are unable to replicate.

Care Management– Care Plus



- What this provides:

BETTER OUTCOMES

- Improved patient safety.
- Improved clinical quality of care.
- Saves lives due to care coordination.
- Better patient experience with improved satisfaction & retention.
- Better physician experience with improved satisfaction & retention.
- Dramatic reductions in avoidable hospital admissions.
- Dramatic reductions in hospital re-admissions.
- Dramatic reductions in population cost.
- Decrease in medical loss ratio (MLR): 70% - 85%.
- Increased savings from institutional & professional risk pools.

Care Management– Care Plus



- What this provides:

PATIENT VIEW

- VIP Concierge patient experience.
- I am healthier, safer, & living longer.
- Available caring PCP on any day that I need him/ her.
- Dedicated caring nurse to assist me whenever I need.
- Assistance in my home with medications, treatments, questions, or concerns; day or night or weekend or holiday.
- Transportation, appointments, community support, when I need.
- My care team knows me, & communicate with each other about my care needs and preferences.
- I will always get my care here.
- I will recommend Prospect to all of my family & friends.

Care Management– Care Plus



- What this provides:

PCP VIEW

- Improved clinical quality of care due to care coordination.
- Easier to care for complex patients.
- PCP is leader of care coordination team.
- Always available CM nurse, NP, social worker, pharmacist, or behavioral health (BH) specialist.
- Programs: Complex CM, Integrated BH, Inpatient CM (Hospital & SNF), Palliative Care, Homebound, Institutionalized (Long-term care).
- Transportation, medication delivery, care givers, community support
- Better care transitions to & from PCP.
- Better PCP experience with improved satisfaction & retention.
- Dramatic reduction in avoidable hospital admissions & re-admissions.
- Increased bonus & capitation payments to PCP.

Care Management– Care Plus



- What this provides:

HOSPITAL VIEW

- Improved patient safety.
- Improved clinical quality of care due to care coordination.
- Improved hospital throughput due to care coordination.
- Partners in moving from fee-for-service to value-based payment.
- Better alignment of physicians & health plans.
- Increased admissions from aligned physician referrals.
- Increased admissions from out-of-network hospital transfers.
- Better patient experience with improved satisfaction.
- Dramatic reductions in hospital re-admissions.
- Increased shared savings from institutional risk pools.

Care Management– Care Plus

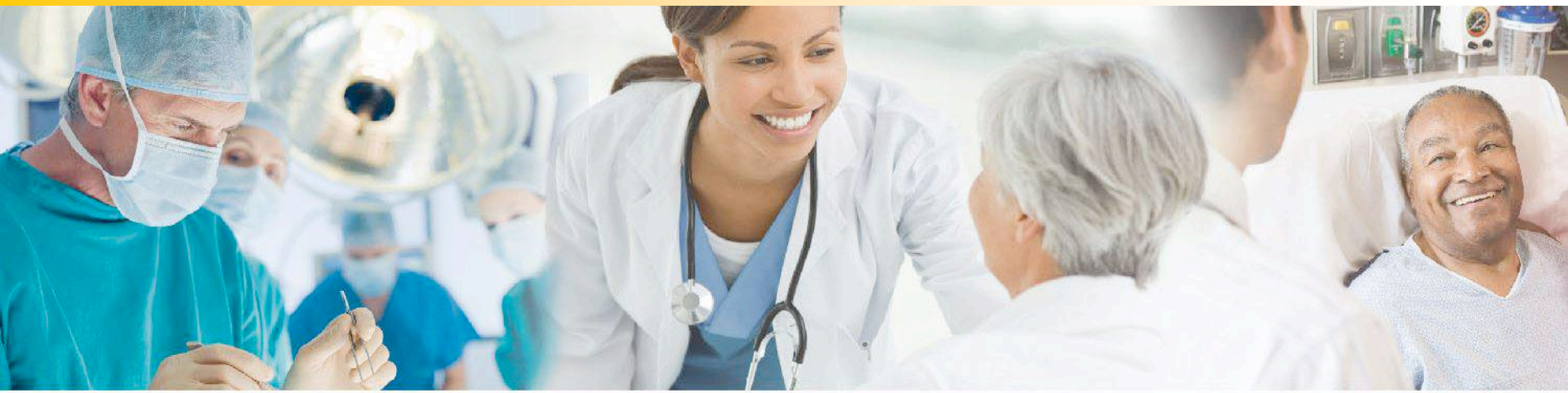


- What this provides:

HEALTHPLAN VIEW

- Improved clinical quality of care due to care coordination.
- Partners in population health management.
- Better alignment of physicians & hospitals.
- Delegate care coordination to Prospect, reduce G&A costs.
- Dramatic reductions in population cost.
- Reduced patient appeals & grievances.
- Decrease in medical loss ratio (MLR): 85%.
- Fixed budget & costs.
- Shift financial risk to Prospect

PROSPECT MEDICAL
Quality Service ~ Quality Care



Prospect Medical Group

Integrated Care Coordination Program

Care *Plus*-
High Intensity Care Management

- 24/7 Direct Telephonic Access
- Identification of patient admission drivers with development of specific actions plans
- Patient and Family Engagement of Care Plans
- Integrated Social Service coordination for members with psychosocial issues and placement issues
- Integrated Behavioral Health Management
- Disease Specific Action Plans and Self-Management
- Advance Care Planning
- Coordination of Ancillary Services/Physician Referrals

Care *Plus*- Palliative Care

- Outpatient Palliative Care Program
- Multidisciplinary team of physicians, RN, SW, chaplain, & pharmacist available 24/7
- Objectives are symptom management & reduce readmits
- Integrated with Prospect Care*Plus* Programs
- Goal to maximize care in home, then transition to hospice
- Screening LTC patients for palliative care & hospice

Care *Plus*-
Hospital Case Management

- Aggressive patient management & oversight
- Expectation of close monitoring of patients by rounding 2x per day until patient is discharged
- Medical Director rounds with CM & Hospitalist 2x per day
- Ability to direct patients from acute to preferred SNFs
- Ability to direct patients from acute to early Post DC Visit
- Close collaboration between Inpatient CM, SNF CM, Pharmacy, NP & PCP

Care *Plus*-
SNF Case Management

- Aggressive patient management
- Monitoring of patients by rounding 3-5x per week until patient is stable, then 2-3x per week
- Physician rounds supplemented by Prospect NPs
- Medical Director rounds with CM & SNFist 2x per week
- If patient's status deteriorates, transfer to network hospital
- Ability to direct patients from acute setting to preferred SNFs
- Direct patients from home or ED to preferred SNF for Therapy
- Close collaboration between Inpatient CM, SNF CM, Pharmacy, NP & PCP

Care *Plus*- Institutional (Long-Term Care)

- Patients to be seen weekly by Prospect SNFist/ NP
- Each facility assigned a dedicated SNFist & NP
- Each facility assigned a dedicated CM to assist in coordination of care
- Proactively manage ambulatory care sensitive conditions
  - Treat at SNF by converting patients from custodial to skilled LOC
  - Discontinue the practice of sending otherwise stable patients to hospital (IV Hydration, IV Antibiotics, Wound Care, etc.)
  - Advance Care Planning (DNR, DNH)

Care *Plus*- Utilization Management/ Referrals

- UM Program, Annual UM Plan, & UM Committee
- Utilization Measures, and related financial measures
  - Hospital Bed-days, Admits, ALOS
  - SNF Bed-days, Admits, ALOS
  - ER Visits
  - Specialty Referrals
  - Ambulatory Surgery Center Referrals
  - CT, MRI, PET Referrals
- Aggregate all data from provider referrals and claims, then analyze for improvement opportunities
- Detailed metric reporting for utilization & cost improvement
- Stream-lined, Effective process for provider requests for services, Referral review, Authorization, and Claims payment

Care *Plus*- Performance Programs/ QM

- Health Plan and Government based Quality Measures, and associated incentive payments
  - HEDIS
  - STARS
  - CMS ACO
  - CAHPS/ HOS
  - HCC/ RAF
- Collect data from health plans, labs, pharmacies, radiology, provider EHRs, and hospitals EHRs
- Aggregate all data, then analyze for improvement opportunities
- Detailed metric reporting for quality & RAF improvement
- Quality Program, Annual Quality Plan, & QM Committee

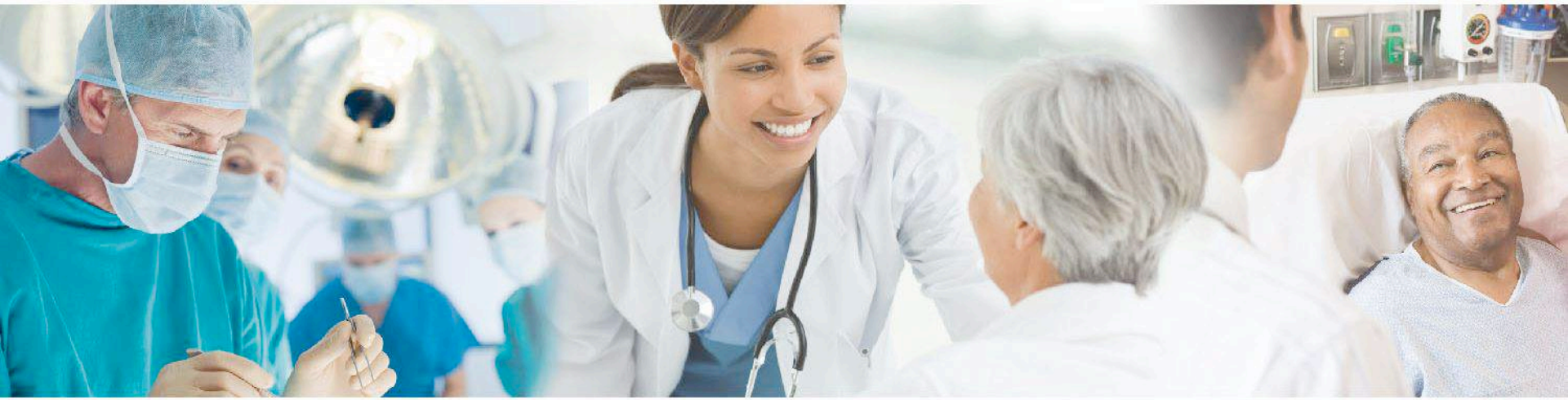
Care *Plus*- Homebound Program

- Mid-level providers NPs) with patient panels
- 24/7 direct telephonic access
- Expedited interventions for Pneumonia, COPD, CHF, Dehydration, & Cellulitis
- Hospital post-DC follow-up visits within 24 hr
- Same day urgent visits
- HCC risk assessment and STAR quality assessment
- NP Visit Notes to PCP
- Phone Communication with PCP & SCP for intervention

Care *Plus*- Pharmacy Program

- 24/7 Direct Telephonic Access with Pharmacist
- Telephonic Medication Therapy Management
- Disease Management Programs (DM & Anticoagulation)
- Post DC In-Home Medication Therapy Management
- LTC Medication Therapy Management
- Integrated with Inpatient & Outpatient Clinical Teams
- Patient Education and Assessment of Non Adherence

PROSPECT MEDICAL
Quality Service ~ Quality Care



Coordinated-Regional-Care: The Next Generation Healthcare System

Prospect Medical Directors

Care *Plus*-
High Intensity Case Management

PROSPECT MEDICAL DIRECTOR'S RESPONSIBILITIES

- High Intensity CM Case Rounds 2x weekly
- Target high risk patients: readmits, multiple co morbid conditions, functional impairment, cognitive decline, psychosocial issue
- Identify admission drivers, barriers and develop care plans with multidisciplinary team
- Use Care Plus programs: palliative or hospice team, pharmacy, high risk clinic, home visits or LTC visits by NP
- Focus on avoidance of ER visits or Hospital Admits
- Provide Strategic input to CM program

Care *Plus*- Palliative Care

PROSPECT MEDICAL DIRECTOR'S RESPONSIBILITIES

- Palliative Care Team Rounds 1x Weekly
- Palliative Care Physician consults, as needed
- Discuss Admits, Discharges, Change of Condition cases
- Recognize barriers, then develop home-based care plans
- Focus on Advance Care Planning & Hospice Conversions
- Focus on Symptom management
- Focus on avoidance of ER visits or Hospital Admits
- Provide Strategic input to Palliative Care programs

Care *Plus*- Hospital Case Management

PROSPECT MEDICAL DIRECTOR'S RESPONSIBILITIES

- Rounds AM and PM with Prospect concurrent review nurse
- Rounds daily with Hospitalists. Monthly Hospitalist JOCs.
- Focus on appropriateness of
  - Level of Care. Need for Inpatient Stay (OBS, IP, SNF, etc.).
  - Preferred Hospital (Low or high DRG, Per Diem, etc.)
  - Identify DC barriers. **Use Care Plus programs**.
  - Identify service delays: facility with payment denials vs provider
- Participate in Core Hospital JOCs
- Approve Tertiary Hospital transfers; then daily oversight
- Out-of-Network Hospital Rounds daily; Repatriation if able
- Provide Strategic input to Hospitalist & CM programs

Care *Plus*-
SNF Case Management

PROSPECT MEDICAL DIRECTOR'S RESPONSIBILITIES

- Biweekly SNF Rounds with Case Managers, NPs, & SNFists
- Quarterly JOC with Core SNFs. Develop higher standards for level of care & service in SNFs.
- Monthly SNFist Meetings
- DC planning for care transitions; Use of Care Plus programs
- Advance Care planning (ACP)
- Long Term Care planning (LTC)
- Provide Strategic input to SNF & LTC programs

Care *Plus*- UM & QI

PROSPECT MEDICAL DIRECTOR'S RESPONSIBILITIES

- Phone call discussions with physicians on specific requests
  - PCPs
  - Specialists
- Educational support to providers on EBM Standards & Goals
- Participate or Chair UM Committee
- Claims Review for key questions re: payment authorization
- Review Appeals & Grievances for authorization denials
- Provide Strategic input to Utilization Management program

Care *Plus*- Performance Programs & QM

PROSPECT MEDICAL DIRECTOR'S RESPONSIBILITIES

- Referral Review for a targeted complex service requests
- Office Meetings & Phone call discussions with physicians on Performance Programs
  - PCPs
  - Specialists
- Educational support to providers on Standards & Goals
  - Quality Measures (Pay4Performance, HEDIS, STARS, ACO)
  - Clinical Documentation for HCC/ RAF Scores
  - Tools for providers (Ascender, Reports, Training materials, Contacts)
  - Specific opportunities for Performance Improvement
- Participate or Chair QM Committee
- Provide Strategic input to Performance Programs

RESPONSE TO DEFICIENCIES
EXHIBIT H - ECHN Screenings and Educational Programs

Identified Community Health Need: Heart Disease Incidence

Fiscal Year 2013

Date	Screening/Education	Location	Number of People Served
Oct/Nov 2012	**Free blood pressure and cholesterol screenings** to employees	Manchester/Vernon	751
11/5/12	Free education program: "Keep the Beat: Lifestyle & Heart Health"	Manchester	16
11/29/12	Free education program: "Sodium Savvy: Making Health Choices	Manchester	13
2/1/13	**Free blood pressure/risk factor screening**	Manchester	30
2/1/13	**Free blood pressure/risk factor screening**	Vernon	20
2/27/13	Free education program: "Heart Health for Women"	Manchester	23
4/27/13	**Free blood pressure/risk factor screening**	South Windsor	25

Fiscal Year 2014

Date	Screening/Education	Location	Number of People Served
10/18/13	**Free blood pressure screenings at AHA Heart Walk**		undetermined
Oct/Nov 2013	**Free blood pressure and cholesterol screenings** to employees	Manchester/Vernon	691
2/7/14	**Free blood pressure/risk factor screening**	Vernon	30
2/10/14	Free education program: "Let's Talk About Your Ticker!"	Manchester	28
2/19/14	Free education program: "Understanding Hypertension: Break the Silence"	South Windsor	14
2/24/14	Free education program: "Heart Healthy Living in Children"	Manchester	60
6/1/14	**Free blood pressure screenings at health fair**	Manchester	55

Fiscal Year 2015

Date	Screening/Education	Location	Number of People Served
Oct/Nov 2014	**Free blood pressure and cholesterol screenings** to employees	Manchester/Vernon	850
11/15/14	**Free blood pressure, cholesterol & body mass screening**	Manchester	undetermined
11/18/14	**Free blood pressure, cholesterol & body mass screening**	East Hartford	undetermined
FY 2015	Heart Talk Support Group (meets monthly)	Vernon	

Identified Community Health Need: Cancer Incidence

Fiscal Year 2013

Date	Screening/Education	Location	Number of People Served
10/12/12	Free education program: "Nothing to Fear: The Truth About Colonoscopy Prep & Procedure"	Manchester	9
10/9/12	**Free mammogram screening to uninsured & underinsured women**	Vernon	51
10/9/12	**Free prostate screening**	Vernon	42
10/21/12	**Free mammogram event with Tolland Imaging Center & Big Y**	Tolland	10
10/24/12	Free education program: "Hereditary Cancer Genetics"	Manchester	19
2/19/13	Free education program: "Head & Neck Cancer: Early Detection is Key"	Manchester	9
3/4/13	Free education program: "Women & Colon Cancer"	Manchester	20
3/6/13	Free education program: "Prostate Screening: New Recommendation"	Manchester	19
4/27/13	**Free mammogram screenings to uninsured & underinsured woman**		53
5/6/13	**Free skin cancer screening**		48
5/17/13	Free program: Cancer Survivors Day Celebration	South Windsor	308
FY 2013	**Free breast and cervical screenings** (through Early Detection grant)		80
FY 2013	Free Smoking Prevention Outreach to middle schools	Vernon, Manchester, Tolland and Ellington	1,351

Fiscal Year 2014

Date	Screening/Education	Location	Number of People Served
Fall	Smoking cessation program: "Freedom From Smoking"	Manchester	11
10/1/2013	Free education program: "HPV & Oral Cancer: What's the Connection?"	South Windsor	10
10/19/13	**Free mammogram event with Tolland Imaging Center & Big Y**	Tolland	15
10/26/13	**Free mammogram screening**	South Windsor	17
11/18/13	Free education program: "I Have Dense Breasts: Now What?" (screening education)	South Windsor	27
Winter	Smoking cessation program: "Freedom From Smoking"	Manchester	3
3/12/14	Free education program: "Colon-ary Fun for Colon Cancer Awareness" (cooking demonstration)	Manchester	43

Date	Screening/Education	Location	Number of People Served
4/22/14	**Free mammogram screening event**	Glastonbury	1
5/7/14	**Free mammogram screening event**	South Windsor	1
5/21/14	**Free mammogram screening event**	Manchester	2
6/1/14	Free program: Cancer Survivors Day Celebration	Windsor	127
6/5/14	**Free mammogram screening event**	Vernon	1
FY 2014	**Free breast and cervical screenings** (through Early Detection grant)		234
FY 2014	Free Smoking Prevention Outreach to middle schools	Vernon, Manchester, Tolland and Ellington	478

Fiscal Year 2015

Date	Screening/Education	Location	Number of People Served
Fall	Smoking cessation program: "Freedom From Smoking"	Manchester/South Windsor	8
10/9/14	Free education program: "Emotional & Spiritual Self-Care	Manchester	25
10/23/14	Free education program: "Spirituality"	Manchester	21
Winter	Smoking cessation program: "Freedom From Smoking"	Manchester	6
4/1/15	Free education program: "Feeding the Body, Feeding the Soul"	Manchester	9
5/28/15	**Free mammography screening**	South Windsor	21
6/3/15	Free education program: "The Nuts and Bolts of Cancer Caregiving"	Manchester	3
6/7/15	Free program: Cancer Survivors Day Celebration	Windsor	372
6/17/15	Free education program: "When Cancer Can't Be Cured"	Manchester	9
8/6/15	Free education program: "Skin Lesions: Identification & Treatment Options"	South Windsor	35
FY 2015	**Free breast and cervical screenings** (through Early Detection grant)		143
FY 2015	Prostate Cancer Support Group (meets monthly)	Manchester	undertermined

Fiscal Year 2016

Date	Screening/Education	Location	Number of People Served
10/5/15	Free education program: "Encouraging Wellness in the Midst of Cancer"	Manchester	13
10/15/15	**Free Mammography screening**	South Windsor	55
Fall	Smoking cessation program: "Freedom From Smoking"	Manchester	3
10/26/15	Free education program: "Painting From the Heart" (for cancer patients and caregivers)	Manchester	12
11/2/15	Free education program: "Journaling Through the Cancer Journey"	Manchester	11
11/9/15	Free education program: "Creating Sacred Spaces" (for cancer patients and caregivers)	Manchester	
11/16/15	Free education program: "Skin Cancer: Detection, Prevention & Treatment Options"	South Windsor	
11/16/15	Free education program: "Palliative Cancer Care"	Manchester	

Identified Community Health Need: Diabetes Incidence

Fiscal Year 2013

Date	Screening/Education	Location	Number of People Served
10/17/12	Free education program: "Pre-diabetes: Making Changes That Will Last a Lifetime"	Manchester	64
Oct/Nov 2012	**Free glucose testing** for employees	Manchester/Vernon	751
11/4/12	**Free diabetic foot screening**	Manchester	16
11/8/12	Free education program: "Diabetes and the Eye"	South Windsor	11
2/18/13	**Free diabetic foot screening**	Manchester	15
4/9/13	Free education program at Manchester Senior Center	Manchester	75
5/6/13	**Free diabetic foot screening**	Manchester	18
8/5/13	**Free diabetic foot screening**	Manchester	15
FY 2013	Diabetes support group "Sweet Talk" - meets monthly	Manchester	undetermined

Fiscal Year 2014

Date	Screening/Education	Location	Number of People Served
10/9/13	Free education program: "Pre-Diabetes: Making Changes That Last a Lifetime"	Manchester	48
Oct/Nov 2013	**Free glucose testing** for employees	Manchester/Vernon	691
11/4/13	**Free diabetic foot screening**	Manchester	5
1/29/14	Free education program: "Pre-Diabetes: Making Changes That Last a Lifetime"	Manchester	42
3/8/14	**Free diabetic screening**	Manchester	13
6/9/14	**Free diabetic screening**	Manchester	20
8/6/2014	Free education program: "Pre-Diabetes: Making Changes That Last a Lifetime"	Manchester	38
9/15/14	**Free diabetic foot screening**	Manchester	18
FY 2014	Diabetes support group "Sweet Talk" - meets monthly	Manchester	undetermined

Fiscal Year 2015

Date	Screening/Education	Location	Number of People Served
10/14/14	Free education program: "Diabetes & Eye Health"	South Windsor	19
Oct/Nov 2014	**Free glucose testing** for employees	Manchester/Vernon	850
11/15/14	**Free glucose screening**	Manchester	undetermined
11/18/14	**Free glucose screening**	East Hartford	undetermined
12/3/14	Free education program: "Pre-Diabetes: Let's Take Action!"	South Windsor	53
12/8/14	**Free diabetic foot screening**	Manchester	13
3/3/15	Free education program: "Diabetes Made Simple!"	South Windsor	39
3/16/15	**Free diabetic foot screening**	Manchester	14
4/1/15	Free education program: "Pre-Diabetes: Let's Take Action!"	South Windsor	40
6/22/15	**Free diabetic foot screening**	Manchester	18
FY 2015	Diabetes support group "Sweet Talk" - meets monthly	Manchester	undetermined

Fiscal Year 2016

Date	Screening/Education	Location	Number of People Served
10/5/15	**Free diabetic foot screening**	Manchester	15
11/12/15	Free education program: "Just Keep Swimming: Dive In and Find Success Managing Your Diabetes"	Manchester	
12/9/15	Free education program: "Pre-Diabetes: Let's Take Action!"	South Windsor	

Identified Community Health Need: Arthritis Incidence

Fiscal Year 2013

Date	Screening/Education	Location	Number of People Served
5/22/13	Free education program: "Water Exercises for Arthritic Conditions"	Ellington	17
6/5/2013	Free education program: "Hip & Knee Arthritis: New Trends & Current Concepts"	Manchester	25

Fiscal Year 2014

Date	Screening/Education	Location	Number of People Served
10/30/13	Free education program: "Hip & Knee Arthritis: New Trends & Current Concepts"	Manchester	25
5/21/14	Free education program: "Understanding Rheumatoid Arthritis"	Manchester	30
6/19/14	Free education program: "Massage and Reiki for Arthritis Sufferers"	South Windsor	63

RESPONSE TO DEFICIENCIES
EXHIBIT I - Financial Worksheet C (Revised)

Sale of Non-Profit Hosptal to For-Profit Entity - REVISED

Name Entity: ECHN

Financial Worsheet (C):

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

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)
LINE	**Total Entity:**	**FY 2014 Actual**	**FY 2015 Projected**	**FY 2015 Projected**	**FY 2015 Projected**	**FY 2016 Projected**	**FY 2016 Projected**	**FY 2016 Projected**	**FY 2017 Projected**	**FY 2017 Projected**	**FY 2017 Projected**	**FY 2018 Projected**	**FY 2018 Projected**	**FY 2018 Projected**	**FY 2019 Projected**	**FY 2019 Projected**	**FY 2019 Projected**
	Description	**Results**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**
A.	**OPERATING REVENUE**																
1	Total Gross Patient Revenue	$929,318,695	$919,861,607	$0	$919,861,607	$911,417,931	$0	$911,417,931	$927,844,907	$17,635,006	$945,479,913	$945,508,033	$28,243,993	$973,752,026	$964,300,815	$38,852,980	$1,003,153,795
2	Less: Allowances	$613,774,825	$605,465,288	$0	$605,465,288	$599,410,635	$0	$599,410,635	$611,398,847	$12,229,890	$623,628,737	$623,626,824	$19,589,415	$643,216,239	$636,099,361	$26,948,940	$663,048,301
3	Less: Charity Care	$4,833,207	$4,778,075	$0	$4,778,075	$4,730,294	$0	$4,730,294	$4,824,900	$75,815	$4,900,715	$4,921,398	$122,094	$5,043,492	$5,019,826	$168,374	$5,188,200
4	Less: Other Deductions	$739,349	$689,936	$0	$689,936	$683,037	$0	$683,037	$696,698	$0	$696,698	$710,632	$0	$710,632	$724,844	$0	$724,844
	Net Patient Service Revenue	**$309,971,314**	**$308,928,308**	**$0**	**$308,928,308**	**$306,593,965**	**$0**	**$306,593,965**	**$310,924,462**	**$5,329,301**	**$316,253,763**	**$316,249,179**	**$8,532,484**	**$324,781,663**	**$322,456,784**	**$11,735,666**	**$334,192,450**
5	Medicare	$112,234,172	$115,287,873	$0	$115,287,873	$114,416,727	$0	$114,416,727	$116,032,810	$1,955,888	$117,988,698	$118,019,923	$3,134,443	$121,154,366	$120,336,517	$4,313,000	$124,649,517
6	Medicaid	$48,469,631	$49,459,392	$0	$49,459,392	$49,085,664	$0	$49,085,664	$49,778,976	$776,499	$50,555,475	$50,631,462	$1,234,950	$51,866,412	$51,625,299	$1,693,402	$53,318,701
7	CHAMPUS & TriCare	$1,895,490	$1,860,705	$0	$1,860,705	$1,846,645	$0	$1,846,645	$1,872,728	$19,948	$1,892,676	$1,904,799	$31,962	$1,936,761	$1,942,188	$43,975	$1,986,163
8	Other	$0	$0	$0	$0	$0	$0	$0		$0	$0		$0	$0		$0	$0
	Total Government	**$162,599,293**	**$166,607,970**	**$0**	**$166,607,970**	**$165,349,036**	**$0**	**$165,349,036**	**$167,684,514**	**$2,752,335**	**$170,436,849**	**$170,556,184**	**$4,401,355**	**$174,957,539**	**$173,904,004**	**$6,050,377**	**$179,954,381**
9	Commercial Insurers	$137,108,151	$133,386,403	$0	$133,386,403	$132,378,500	$0	$132,378,500	$134,248,284	$2,485,974	$136,734,258	$136,547,345	$3,984,510	$140,531,855	$139,227,611	$5,483,046	$144,710,657
10	Uninsured	$666,816	$526,077	$0	$526,077	$522,102	$0	$522,102	$529,477	$11,120	$540,597	$538,544	$17,931	$556,475	$549,115	$24,741	$573,856
11	Self Pay	$4,893,477	$4,051,067	$0	$4,051,067	$4,020,456	$0	$4,020,456	$4,077,244	$0	$4,077,244	$4,147,068	$0	$4,147,068	$4,228,470	$0	$4,228,470
12	Workers Compensation	$4,507,382	$4,058,179	$0	$4,058,179	$4,027,514	$0	$4,027,514	$4,084,401	$79,872	$4,164,273	$4,154,348	$128,687	$4,283,035	$4,235,893	$177,502	$4,413,395
13	Other	$196,195	$298,613	$0	$298,613	$296,357	$0	$296,357	$300,543	$0	$300,543	$305,689	$0	$305,689	$311,690	$0	$311,690
	Total Non-Government	**$147,372,021**	**$142,320,339**	**$0**	**$142,320,339**	**$141,244,929**	**$0**	**$141,244,929**	**$143,239,949**	**$2,576,966**	**$145,816,915**	**$145,692,994**	**$4,131,128**	**$149,824,122**	**$148,552,779**	**$5,685,289**	**$154,238,068**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$309,971,314**	**$308,928,309**	**$0**	**$308,928,309**	**$306,593,965**	**$0**	**$306,593,965**	**$310,924,463**	**$5,329,301**	**$316,253,764**	**$316,249,178**	**$8,532,483**	**$324,781,661**	**$322,456,783**	**$11,735,666**	**$334,192,449**
14	Less: Provision for Bad Debts	$10,216,094	$6,060,538	$0	**$6,060,538**	$5,999,933	$0	**$5,999,933**	$6,059,932	$112,360	**$6,172,292**	$6,181,131	$180,494	**$6,361,625**	$6,304,753	$248,637	**$6,553,390**
	Net Patient Service Revenue less provision for bad debts	**$299,755,220**	**$302,867,770**	**$0**	**$302,867,770**	**$300,594,032**	**$0**	**$300,594,032**	**$304,864,530**	**$5,216,941**	**$310,081,471**	**$310,068,048**	**$8,351,990**	**$318,420,038**	**$316,152,031**	**$11,487,029**	**$327,639,060**
15	Other Operating Revenue	$28,166,459	$16,802,913	$0	**$16,802,913**	$15,925,913	$0	**$15,925,913**	$15,972,139	($1,417,903)	**$14,554,236**	$16,019,290	($1,417,903)	**$14,601,387**	$16,067,383	($1,417,903)	**$14,649,480**
17	Net Assets Released from Restrictions	$833,650	$913,370	$0	**$913,370**	$913,370	$0	**$913,370**	$913,370	($913,370)	**$0**	$913,370	($913,370)	**$0**	$913,370	($913,370)	**$0**
	TOTAL OPERATING REVENUE	**$328,755,329**	**$320,584,053**	**$0**	**$320,584,053**	**$317,433,315**	**$0**	**$317,433,315**	**$321,750,039**	**$2,885,668**	**$324,635,707**	**$327,000,708**	**$6,020,717**	**$333,021,425**	**$333,132,784**	**$9,155,756**	**$342,288,540**
B.	**OPERATING EXPENSES**																
1	Salaries and Wages	$162,727,445	$156,292,474	$0	$156,292,474	$150,021,693	$0	$150,021,693	$150,778,127	$1,410,518	$152,188,645	$153,793,689	$2,257,113	$156,050,802	$156,869,563	$3,103,708	$159,973,271
2	Fringe Benefits	$43,859,398	$47,762,750	$0	$47,762,750	$50,610,250	$0	$50,610,250	$49,260,250	($284,122)	$48,976,128	$49,710,250	$324,373	$50,034,623	$50,160,250	$639,204	$50,799,454
3	Physicians Fees	$14,478,331	$14,605,651	$0	$14,605,651	$14,605,651	$0	$14,605,651	$15,043,821	$0	$15,043,821	$15,495,135	$0	$15,495,135	$15,959,989	$0	$15,959,989
4	Supplies and Drugs	$34,194,649	$34,974,486	$0	$34,974,486	$35,324,231	$0	$35,324,231	$35,677,473	($913,733)	$34,763,740	$36,034,248	($474,183)	$35,560,065	$36,394,590	($34,635)	$36,359,955
5	Depreciation and Amortization	$12,196,877	$11,958,956	$0	$11,958,956	$11,958,956	$0	$11,958,956	$11,958,956	$714,285	$12,673,241	$11,958,956	$1,428,571	$13,387,527	$11,958,956	$2,142,857	$14,101,813
6	Provision for Bad Debts-Other[b]	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
7	Interest Expense	$3,764,488	$3,570,511	$0	$3,570,511	$3,570,511	$0	$3,570,511	$3,570,511	($2,847,514)	$722,997	$3,570,511	($2,925,174)	$645,337	$3,570,511	($2,978,049)	$592,462
8	Malpractice Insurance Cost	$3,807,147	$3,845,218	$0	$3,845,218	$3,883,671	$0	$3,883,671	$3,922,507	$0	$3,922,507	$3,961,732	$0	$3,961,732	$4,001,350	$0	$4,001,350
9	Lease Expense	$6,622,257	$6,245,578	$0	$6,245,578	$6,308,033	$0	$6,308,033	$6,371,114	$0	$6,371,114	$6,434,825	$0	$6,434,825	$6,499,173	$0	$6,499,173
10	Other Operating Expenses	$44,932,012	$44,334,273	$0	$44,334,273	$44,883,620	$0	$44,883,620	$45,412,457	($451,595)	$44,960,862	$45,946,581	($3,616)	$45,942,965	$46,486,047	$444,362	$46,930,409
	TOTAL OPERATING EXPENSES	**$326,582,604**	**$323,589,897**	**$0**	**$323,589,897**	**$321,166,616**	**$0**	**$321,166,616**	**$321,995,216**	**($2,372,161)**	**$319,623,055**	**$326,905,927**	**$607,084**	**$327,513,011**	**$331,900,429**	**$3,317,447**	**$335,217,876**
	Provision for Income Taxes[c]		$0	$0	**$0**	$0	$0	**$0**	$0	$2,426,950	**$2,426,950**	$0	$2,635,170	**$2,635,170**		$3,344,235	**$3,344,235**
	Earnings Before Interest, Taxes, Depreciation & Amortization **(EBITDA)**	**$18,134,090**	**$12,523,623**	**$0**	**$12,523,623**	**$11,796,166**	**$0**	**$11,796,166**	**$15,284,290**	**$3,124,600**	**$18,408,890**	**$15,624,248**	**$3,917,030**	**$19,541,278**	**$16,761,822**	**$5,003,117**	**$21,764,939**
	INCOME / (LOSS) FROM OPERATIONS	**$2,172,725**	**($3,005,844)**	**$0**	**($3,005,844)**	**($3,733,301)**	**$0**	**($3,733,301)**	**($245,177)**	**$2,830,879**	**$2,585,702**	**$94,781**	**$2,778,463**	**$2,873,244**	**$1,232,355**	**$2,494,074**	**$3,726,429**
	NON-OPERATING INCOME / REVENUE	($2,125,751)	($2,394,868)	$0	**($2,394,868)**	($1,500,000)	$0	**($1,500,000)**	($500,000)	$0	**($500,000)**	($500,000)	$0	**($500,000)**	($500,000)	$0	**($500,000)**
	NET INCOME / EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSES	**$46,974**	**($5,400,712)**	**$0**	**($5,400,712)**	**($5,233,301)**	**$0**	**($5,233,301)**	**($745,177)**	**$2,830,879**	**$2,085,702**	**($405,219)**	**$2,778,463**	**$2,373,244**	**$732,355**	**$2,494,074**	**$3,226,429**

Sale of Non-Profit Hosptal to For-Profit Entity - REVISED

Name Entity: ECHN

Financial Worsheet (C):

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

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)
LINE	Total Entity:	FY 2014 Actual	FY 2015 Projected	FY 2015 Projected	FY 2015 Projected	FY 2016 Projected	FY 2016 Projected	FY 2016 Projected	FY 2017 Projected	FY 2017 Projected	FY 2017 Projected	FY 2018 Projected	FY 2018 Projected	FY 2018 Projected	FY 2019 Projected	FY 2019 Projected	FY 2019 Projected
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
C.	**Retained Earnings/ Net Assets, beginning of year**	**$85,849,149**	$77,693,789	**$0**	**$77,693,789**	$72,293,077	**$0**	**$72,293,077**	**$67,059,776**	**$0**	**$67,059,776**	**$66,314,599**	**$2,830,879**	**$69,145,478**	**$65,909,381**	**$5,609,341**	**$71,518,722**
	Retained Earnings / Net Assets, end of year	**$77,693,789**	$72,293,077	**$0**	**$72,293,077**	$67,059,776	**$0**	**$67,059,776**	**$66,314,599**	**$2,830,879**	**$69,145,478**	**$65,909,381**	**$5,609,341**	**$71,518,722**	**$66,641,736**	**$8,103,415**	**$74,745,151**
	Principal Payments	$7,235,595	$7,086,082	$0	**$7,086,082**	$7,163,415	$0	**$7,163,415**	$6,382,582	($6,382,582)	**$0**	$6,771,353	($6,771,353)	**$0**	$6,058,092	($6,058,092)	**$0**
D.	**PROFITABILITY SUMMARY**																
1	Hospital Operating Margin	**0.7%**	**-0.9%**	**0.0%**	**-0.9%**	**-1.2%**	**0.0%**	**-1.2%**	**-0.1%**	**98.1%**	**0.8%**	**0.0%**	**46.1%**	**0.9%**	**0.4%**	**27.2%**	**1.1%**
2	Hospital Non Operating Margin	**-0.7%**	**-0.8%**	**0.0%**	**-0.8%**	**-0.5%**	**0.0%**	**-0.5%**	**-0.2%**	**0.0%**	**-0.2%**	**-0.2%**	**0.0%**	**-0.2%**	**-0.2%**	**0.0%**	**-0.1%**
3	Hospital Total Margin	**0.0%**	**-1.7%**	**0.0%**	**-1.7%**	**-1.7%**	**0.0%**	**-1.7%**	**-0.2%**	**98.1%**	**0.6%**	**-0.1%**	**46.1%**	**0.7%**	**0.2%**	**27.2%**	**0.9%**
E.	**FTEs**	**2,298**	**2,240**	**-**	**2,240**	**2,117**	**-**	**2,117**	**2,117**	**21**	**2,138**	**2,117**	**32**	**2,149**	**2,117**	**44**	**2,161**
F.	**VOLUME STATISTICS**[d]																
1	Inpatient Discharges	11,451	10,927	-	**10,927**	11,202	-	**11,202**	11,202	213	**11,415**	11,202	325	**11,527**	11,202	438	**11,640**
2	Outpatient Visits	2,052,425	2,085,348	-	**2,085,348**	2,085,348	-	**2,085,348**	2,085,348	2,170	**2,087,518**	2,085,348	4,340	**2,089,688**	2,085,348	6,510	**2,091,858**
	TOTAL VOLUME	**2,063,876**	**2,096,275**	**0**	**2,096,275**	**2,096,550**	**0**	**2,096,550**	**2,096,550**	**2,383**	**2,098,933**	**2,096,550**	**4,665**	**2,101,215**	**2,096,550**	**6,948**	**2,103,498**

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

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c]Provide the amount of income taxes as defined by the Internal Revenue Services for for-profit entities.

[d]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

Sale of Non-Profit Hosptal to For-Profit Entity - REVISED

Name Entity: MMH

Financial Worsheet (C):

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

LINE	Total Entity:	(1) FY 2014 Actual	(2) FY 2015 Projected	(3) FY 2015 Projected	(4) FY 2015 Projected	(5) FY 2016 Projected	(6) FY 2016 Projected	(7) FY 2016 Projected	(8) FY 2017 Projected	(9) FY 2017 Projected	(10) FY 2017 Projected	(11) FY 2018 Projected	(12) FY 2018 Projected	(13) FY 2018 Projected	(14) FY 2019 Projected	(15) FY 2019 Projected	(16) FY 2019 Projected
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
A.	**OPERATING REVENUE**																
1	Total Gross Patient Revenue	$601,959,668	$594,394,400	$0	$594,394,400	$588,450,456	$0	$588,450,456	$596,688,762	$13,369,792	$610,058,554	$606,832,471	$20,855,080	$627,687,551	$618,362,288	$28,340,367	$646,702,655
2	Less: Allowances	$421,521,668	$411,650,321	$0	$411,650,321	$407,533,818	$0	$407,533,818	$413,239,291	$9,259,305	$422,498,596	$420,264,359	$14,443,273	$434,707,632	$428,249,382	$19,627,240	$447,876,622
3	Less: Charity Care	$2,411,263	$2,382,698	$0	$2,382,698	$2,358,871	$0	$2,358,871	$2,391,895	$53,594	$2,445,489	$2,432,557	$83,600	$2,516,157	$2,478,776	$113,606	$2,592,382
4	Less: Other Deductions	$0	$0	$0	$0	$0	$0	$0	$0		$0	$0	$0	$0	$0	$0	$0
	Net Patient Service Revenue	**$178,026,737**	**$180,361,381**	**$0**	**$180,361,381**	**$178,557,767**	**$0**	**$178,557,767**	**$181,057,576**	**$4,056,893**	**$185,114,469**	**$184,135,555**	**$6,328,207**	**$190,463,762**	**$187,634,130**	**$8,599,521**	**$196,233,651**
5	Medicare	$63,378,038	$65,429,033	$0	$65,429,033	$64,774,743	$0	$64,774,743	$65,681,589	$1,471,704	$67,153,293	$66,798,176	$2,295,660	$69,093,836	$68,067,341	$3,119,617	$71,186,958
6	Medicaid	$27,585,570	$28,409,212	$0	$28,409,212	$28,125,120	$0	$28,125,120	$28,518,872	$639,012	$29,157,884	$29,003,692	$996,773	$30,000,465	$29,554,763	$1,354,534	$30,909,297
7	CHAMPUS & TriCare	$664,283	$668,944	$0	$668,944	$662,255	$0	$662,255	$671,526	$15,047	$686,573	$682,942	$23,471	$706,413	$695,918	$31,895	$727,813
8	Other	$0	$0	$0	$0	$0	$0	$0	$0		$0	$0	$0	$0	$0	$0	$0
	Total Government	**$91,627,891**	**$94,507,189**	**$0**	**$94,507,189**	**$93,562,117**	**$0**	**$93,562,117**	**$94,871,987**	**$2,125,763**	**$96,997,750**	**$96,484,811**	**$3,315,904**	**$99,800,715**	**$98,318,022**	**$4,506,046**	**$102,824,068**
9	Commercial Insurers	$83,212,124	$83,015,701	$0	$83,015,701	$82,185,544	$0	$82,185,544	$83,336,142	$1,867,283	$85,203,425	$84,752,856	$2,912,711	$87,665,567	$86,363,160	$3,958,139	$90,321,299
10	Uninsured	$413,470	$343,512	$0	$343,512	$340,077	$0	$340,077	$344,838	$7,727	$352,565	$350,700	$12,053	$362,753	$357,364	$16,378	$373,742
11	Self Pay	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
12	Workers Compensation	$2,773,252	$2,494,979	$0	$2,494,979	$2,470,029	$0	$2,470,029	$2,504,610	$56,120	$2,560,730	$2,547,188	$87,539	$2,634,727	$2,595,585	$118,959	$2,714,544
13	Other	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Total Non-Government	**$86,398,846**	**$85,854,192**	**$0**	**$85,854,192**	**$84,995,650**	**$0**	**$84,995,650**	**$86,185,589**	**$1,931,130**	**$88,116,719**	**$87,650,744**	**$3,012,303**	**$90,663,047**	**$89,316,108**	**$4,093,476**	**$93,409,584**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$178,026,737**	**$180,361,381**	**$0**	**$180,361,381**	**$178,557,767**	**$0**	**$178,557,767**	**$181,057,576**	**$4,056,893**	**$185,114,469**	**$184,135,555**	**$6,328,207**	**$190,463,762**	**$187,634,130**	**$8,599,522**	**$196,233,652**
14	Less: Provision for Bad Debts	$5,822,470	$3,643,728	$0	**$3,643,728**	$3,607,291	$0	**$3,607,291**	$3,657,793	$81,969	**$3,739,762**	$3,719,975	$127,845	**$3,847,820**	$3,790,655	$173,731	**$3,964,386**
	Net Patient Service Revenue less provision for bad debts	**$172,204,267**	**$176,717,653**	**$0**	**$176,717,653**	**$174,950,476**	**$0**	**$174,950,476**	**$177,399,783**	**$3,974,924**	**$181,374,707**	**$180,415,579**	**$6,200,362**	**$186,615,941**	**$183,843,475**	**$8,425,790**	**$192,269,265**
15	Other Operating Revenue	$16,853,888	$11,023,919	$0	**$11,023,919**	$10,633,672	$0	**$10,633,672**	$10,846,346	($735,367)	**$10,110,979**	$11,063,272	($735,367)	**$10,327,905**	$11,284,538	($735,367)	**$10,549,171**
17	Net Assets Released from Restrictions	$486,908	$646,366	$0	**$646,366**	$776,365	$0	**$776,365**	$776,365	($776,365)	**$0**	$776,365	($776,365)	**$0**	$776,365	($776,365)	**$0**
	TOTAL OPERATING REVENUE	**$189,545,063**	**$188,387,937**	**$0**	**$188,387,937**	**$186,360,513**	**$0**	**$186,360,513**	**$189,022,494**	**$2,463,192**	**$191,485,686**	**$192,255,217**	**$4,688,630**	**$196,943,847**	**$195,904,378**	**$6,914,058**	**$202,818,436**
B.	**OPERATING EXPENSES**																
1	Salaries and Wages	$83,606,297	$82,578,386	$0	$82,578,386	$79,275,251	$0	$79,275,251	$80,068,003	$1,080,696	$81,148,699	$81,669,364	$1,685,741	$83,355,105	$83,302,751	$2,290,786	$85,593,537
2	Fringe Benefits	$25,720,253	$27,704,116	$0	$27,704,116	$29,366,363	$0	$29,366,363	$28,485,372	($186,999)	$28,298,373	$28,770,225	$330,795	$29,101,020	$29,057,928	$554,925	$29,612,853
3	Physicians Fees	$9,813,958	$10,038,473	$0	$10,038,473	$10,038,473	$0	$10,038,473	$10,339,627	$0	$10,339,627	$10,649,816	$0	$10,649,816	$10,969,310	$0	$10,969,310
4	Supplies and Drugs	$25,775,974	$23,929,618	$0	$23,929,618	$24,168,914	$0	$24,168,914	$24,410,603	($901,009)	$23,509,594	$24,654,709	($593,572)	$24,061,137	$24,901,256	($286,136)	$24,615,120
5	Depreciation and Amortization	$7,116,905	$7,114,038	$0	$7,114,038	$7,114,038	$0	$7,114,038	$7,114,038	$488,896	$7,602,934	$7,114,038	$977,792	$8,091,830	$7,114,038	$1,466,689	$8,580,727
6	Provision for Bad Debts-Other[b]	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
7	Interest Expense	$2,589,201	$2,451,251	$0	$2,451,251	$2,353,201	$0	$2,353,201	$2,353,201	($2,175,156)	$178,045	$2,353,201	($2,252,816)	$100,385	$2,353,201	($2,305,691)	$47,510
8	Malpractice Insurance Cost	$2,774,065	$2,801,806	$0	$2,801,806	$2,829,824	$0	$2,829,824	$2,858,122	$0	$2,858,122	$2,886,703	$0	$2,886,703	$2,915,570	$0	$2,915,570
9	Lease Expense	$2,328,809	$2,207,010	$0	$2,207,010	$2,229,080	$0	$2,229,080	$2,251,371	$0	$2,251,371	$2,273,885	$0	$2,273,885	$2,296,623	$0	$2,296,623
10	Other Operating Expenses	$25,584,097	$25,294,474	$0	$25,294,474	$25,547,418	$0	$25,547,418	$25,802,892	($419,554)	$25,383,338	$26,060,921	($94,582)	$25,966,339	$26,321,531	$230,389	$26,551,920
	TOTAL OPERATING EXPENSES	**$185,309,559**	**$184,119,170**	**$0**	**$184,119,170**	**$182,922,561**	**$0**	**$182,922,561**	**$183,683,229**	**($2,113,126)**	**$181,570,103**	**$186,432,862**	**$53,358**	**$186,486,220**	**$189,232,208**	**$1,950,962**	**$191,183,170**
	Provision for Income Taxes[c]		$0	$0	**$0**	$0	$0	**$0**		$4,254,950	**$4,254,950**		$4,482,606	**$4,482,606**		$5,030,134	**$5,030,134**
	Earnings Before Interest, Taxes, Depreciation & Amortization **(EBITDA)**	**$13,941,610**	**$13,834,056**	**$0**	**$13,834,056**	**$12,905,191**	**$0**	**$12,905,191**	**$14,806,503**	**$2,890,058**	**$17,696,561**	**$15,289,594**	**$3,360,248**	**$18,649,842**	**$16,139,409**	**$4,124,094**	**$20,263,503**
	INCOME / (LOSS) FROM OPERATIONS	**$4,235,504**	**$4,268,767**	**$0**	**$4,268,767**	**$3,437,952**	**$0**	**$3,437,952**	**$5,339,265**	**$321,368**	**$5,660,633**	**$5,822,355**	**$152,666**	**$5,975,021**	**$6,672,171**	**($67,038)**	**$6,605,133**
	NON-OPERATING INCOME / REVENUE	($1,743,322)	($1,672,972)	$0	**($1,672,972)**	($1,140,000)	$0	**($1,140,000)**	($380,000)		**($380,000)**	($380,000)		**($380,000)**	($380,000)		**($380,000)**
	NET INCOME / EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSES	**$2,492,182**	**$2,595,795**	**$0**	**$2,595,795**	**$2,297,952**	**$0**	**$2,297,952**	**$4,959,265**	**$321,368**	**$5,280,633**	**$5,442,355**	**$152,666**	**$5,595,021**	**$6,292,171**	**($67,038)**	**$6,225,133**

Sale of Non-Profit Hosptal to For-Profit Entity - REVISED

Name Entity: MMH
Financial Worsheet (C):

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

LINE	Total Entity:	(1) FY 2014 Actual Results	(2) FY 2015 Projected W/out CON	(3) FY 2015 Projected Incremental	(4) FY 2015 Projected With CON	(5) FY 2016 Projected W/out CON	(6) FY 2016 Projected Incremental	(7) FY 2016 Projected With CON	(8) FY 2017 Projected W/out CON	(9) FY 2017 Projected Incremental	(10) FY 2017 Projected With CON	(11) FY 2018 Projected W/out CON	(12) FY 2018 Projected Incremental	(13) FY 2018 Projected With CON	(14) FY 2019 Projected W/out CON	(15) FY 2019 Projected Incremental	(16) FY 2019 Projected With CON
	Description																
C.	**Retained Earnings/ Net Assets, beginning of year**	$37,731,740	$24,798,417	$0	$24,798,417	$27,394,212	$0	$27,394,212	$29,692,165	$0	$29,692,165	$34,651,429	$321,368	$34,972,797	$40,093,784	$474,034	$40,567,818
	Retained Earnings / Net Assets, end of year	$24,798,417	$27,394,212	$0	$27,394,212	$29,692,165	$0	$29,692,165	$34,651,429	$321,368	$34,972,797	$40,093,784	$474,034	$40,567,818	$46,385,955	$406,996	$46,792,951
	Principal Payments	$4,145,905	$4,883,195	$0	$4,883,195	$4,924,258	$0	**$4,924,258**	$4,234,565	($4,234,565)	**$0**	$4,781,812	($4,781,812)	**$0**	$4,061,758	($4,061,758)	**$0**
D.	**PROFITABILITY SUMMARY**																
1	Hospital Operating Margin	**2.3%**	**2.3%**	**0.0%**	**2.3%**	**1.9%**	**0.0%**	**1.9%**	**2.8%**	**13.0%**	**3.0%**	**3.0%**	**3.3%**	**3.0%**	**3.4%**	**-1.0%**	**3.3%**
2	Hospital Non Operating Margin	**-0.9%**	**-0.9%**	**0.0%**	**-0.9%**	**-0.6%**	**0.0%**	**-0.6%**	**-0.2%**	**0.0%**	**-0.2%**	**-0.2%**	**0.0%**	**-0.2%**	**-0.2%**	**0.0%**	**-0.2%**
3	Hospital Total Margin	**1.3%**	**1.4%**	**0.0%**	**1.4%**	**1.2%**	**0.0%**	**1.2%**	**2.6%**	**13.0%**	**2.8%**	**2.8%**	**3.3%**	**2.8%**	**3.2%**	**-1.0%**	**3.1%**
E.	**FTEs**	**1,177**	**1,140**	**0**	**1,140**	**1,052**	**0**	**1,052**	**1,052**	**16**	**1,068**	**1,052**	**24**	**1,076**	**1,052**	**33**	**1,085**
F.	**VOLUME STATISTICS**[d]																
1	Inpatient Discharges	9,110	8,768	0	**8,768**	9,043	0	**9,043**	9,043	181	**9,224**	9,043	271	**9,314**	9,043	362	**9,405**
2	Outpatient Visits	1,631,301	1,651,094	0	**1,651,094**	1,651,094	0	**1,651,094**	1,651,094	1,640	**1,652,734**	1,651,094	3,280	**1,654,374**	1,651,094	4,920	**1,656,014**
	TOTAL VOLUME	**1,640,411**	**1,659,862**	**0**	**1,659,862**	**1,660,137**	**0**	**1,660,137**	**1,660,137**	**1,821**	**1,661,958**	**1,660,137**	**3,551**	**1,663,688**	**1,660,137**	**5,282**	**1,665,419**

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.
[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.
[c]Provide the amount of income taxes as defined by the Internal Revenue Services for for-profit entities.
[d]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

Sale of Non-Profit Hosptal to For-Profit Entity - REVISED

Name Entity: RGH
Financial Worsheet (C):

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

LINE	Total Entity:	(1) FY 2014 Actual Results	(2) FY 2015 Projected W/out CON	(3) FY 2015 Projected Incremental	(4) FY 2015 Projected With CON	(5) FY 2016 Projected W/out CON	(6) FY 2016 Projected Incremental	(7) FY 2016 Projected With CON	(8) FY 2017 Projected W/out CON	(9) FY 2017 Projected Incremental	(10) FY 2017 Projected With CON	(11) FY 2018 Projected W/out CON	(12) FY 2018 Projected Incremental	(13) FY 2018 Projected With CON	(14) FY 2019 Projected W/out CON	(15) FY 2019 Projected Incremental	(16) FY 2019 Projected With CON
	Description																
A.	**OPERATING REVENUE**																
1	Total Gross Patient Revenue	$227,300,072	$229,450,128	$0	$229,450,128	$228,302,877	$0	$228,302,877	$231,499,118	$4,265,214	$235,764,332	$235,434,603	$7,388,913	$242,823,516	$239,907,860	$10,512,613	$250,420,473
2	Less: Allowances	$154,781,564	$159,804,700	$0	$159,804,700	$159,005,677	$0	$159,005,677	$161,231,756	$2,970,585	$164,202,341	$163,972,696	$5,146,142	$169,118,838	$167,088,177	$7,321,700	$174,409,877
3	Less: Charity Care	$1,188,543	$1,195,377	$0	$1,195,377	$1,189,400	$0	$1,189,400	$1,206,052	$22,221	$1,228,273	$1,226,555	$38,494	$1,265,049	$1,249,859	$54,768	$1,304,627
4	Less: Other Deductions	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Net Patient Service Revenue	**$71,329,965**	**$68,450,051**	**$0**	**$68,450,051**	**$68,107,801**	**$0**	**$68,107,801**	**$69,061,310**	**$1,272,408**	**$70,333,718**	**$70,235,352**	**$2,204,277**	**$72,439,629**	**$71,569,824**	**$3,136,145**	**$74,705,969**
5	Medicare	$25,494,325	$26,046,989	$0	$26,046,989	$25,916,754	$0	$25,916,754	$26,279,589	$484,184	$26,763,773	$26,726,342	$838,783	$27,565,125	$27,234,142	$1,193,383	$28,427,525
6	Medicaid	$7,614,784	$7,396,197	$0	$7,396,197	$7,359,216	$0	$7,359,216	$7,462,245	$137,487	$7,599,732	$7,589,103	$238,177	$7,827,280	$7,733,296	$338,868	$8,072,164
7	CHAMPUS & TriCare	$300,295	$263,667	$0	$263,667	$262,349	$0	$262,349	$266,022	$4,901	$270,923	$270,544	$8,491	$279,035	$275,684	$12,080	$287,764
8	Other	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Total Government	**$33,409,404**	**$33,706,853**	**$0**	**$33,706,853**	**$33,538,319**	**$0**	**$33,538,319**	**$34,007,855**	**$626,572**	**$34,634,427**	**$34,585,989**	**$1,085,451**	**$35,671,440**	**$35,243,123**	**$1,544,331**	**$36,787,454**
9	Commercial Insurers	$36,237,003	$33,282,888	$0	$33,282,888	$33,116,474	$0	$33,116,474	$33,580,104	$618,691	$34,198,795	$34,150,966	$1,071,799	$35,222,765	$34,799,834	$1,524,907	$36,324,741
10	Uninsured	$252,693	$182,539	$0	$182,539	$181,626	$0	$181,626	$184,169	$3,393	$187,562	$187,300	$5,878	$193,178	$190,859	$8,363	$199,222
11	Self Pay	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
12	Workers Compensation	$1,430,865	$1,277,771	$0	$1,277,771	$1,271,382	$0	$1,271,382	$1,289,181	$23,752	$1,312,933	$1,311,098	$41,148	$1,352,246	$1,336,008	$58,543	$1,394,551
13	Other	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Total Non-Government	**$37,920,561**	**$34,743,198**	**$0**	**$34,743,198**	**$34,569,482**	**$0**	**$34,569,482**	**$35,053,455**	**$645,836**	**$35,699,291**	**$35,649,363**	**$1,118,825**	**$36,768,188**	**$36,326,701**	**$1,591,813**	**$37,918,514**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$71,329,965**	**$68,450,051**	**$0**	**$68,450,051**	**$68,107,801**	**$0**	**$68,107,801**	**$69,061,310**	**$1,272,408**	**$70,333,718**	**$70,235,352**	**$2,204,276**	**$72,439,628**	**$71,569,824**	**$3,136,144**	**$74,705,968**
14	Less: Provision for Bad Debts	$2,801,283	$1,643,173	$0	**$1,643,173**	$1,626,741	$0	**$1,626,741**	$1,649,516	$30,391	**$1,679,907**	$1,677,558	$52,649	**$1,730,207**	$1,709,431	$74,906	**$1,784,337**
	Net Patient Service Revenue less provision for bad debts	**$68,528,682**	**$66,806,878**	**$0**	**$66,806,878**	**$66,481,059**	**$0**	**$66,481,059**	**$67,411,794**	**$1,242,017**	**$68,653,811**	**$68,557,795**	**$2,151,628**	**$70,709,423**	**$69,860,393**	**$3,061,239**	**$72,921,632**
15	Other Operating Revenue	$6,342,519	$2,128,076	$0	**$2,128,076**	$2,052,742	$0	**$2,052,742**	$2,093,797	($112,743)	**$1,981,054**	$2,135,673	($112,743)	**$2,022,930**	$2,178,387	($112,743)	**$2,065,644**
17	Net Assets Released from Restrictions	$49,147	$78,358	$0	**$78,358**	$91,337	$0	**$91,337**	$77,636	($77,636)	**$0**	$77,636	($77,636)	**$0**	$77,636	($77,636)	**$0**
	TOTAL OPERATING REVENUE	**$74,920,348**	**$69,013,312**	**$0**	**$69,013,312**	**$68,625,139**	**$0**	**$68,625,139**	**$69,583,227**	**$1,051,638**	**$70,634,865**	**$70,771,104**	**$1,961,249**	**$72,732,353**	**$72,116,415**	**$2,870,860**	**$74,987,275**
B.	**OPERATING EXPENSES**																
1	Salaries and Wages	$32,460,253	$30,649,768	$0	$30,649,768	$29,423,777	$0	$29,423,777	$29,718,015	$329,822	$30,047,837	$30,312,375	$571,372	$30,883,747	$30,918,622	$812,922	$31,731,544
2	Fringe Benefits	$9,360,797	$10,423,090	$0	$10,423,090	$11,048,475	$0	$11,048,475	$10,717,021	($97,123)	$10,619,898	$10,824,191	($6,422)	$10,817,769	$10,932,433	$84,279	$11,016,712
3	Physicians Fees	$3,728,005	$4,310,255	$0	$4,310,255	$4,310,255	$0	$4,310,255	$4,439,562	$0	$4,439,562	$4,572,749	$0	$4,572,749	$4,709,932	$0	$4,709,932
4	Supplies and Drugs	$9,776,421	$9,560,149	$0	$9,560,149	$9,655,751	$0	$9,655,751	$9,752,308	($12,724)	$9,739,584	$9,849,831	$119,389	$9,969,220	$9,948,330	$251,501	$10,199,831
5	Depreciation and Amortization	$3,281,014	$3,234,649	$0	$3,234,649	$3,234,649	$0	$3,234,649	$3,234,649	$225,389	$3,460,038	$3,234,649	$450,779	$3,685,428	$3,234,649	$676,168	$3,910,817
6	Provision for Bad Debts-Other[b]	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
7	Interest Expense	$689,882	$700,373	$0	$700,373	$672,358	$0	$672,358	$672,358	($672,358)	($0)	$672,358	($672,358)	($0)	$672,357.89	($672,358)	($0)
8	Malpractice Insurance Cost	$1,033,082	$1,043,413	$0	$1,043,413	$1,053,847	$0	$1,053,847	$1,064,385	$0	$1,064,385	$1,075,029	$0	$1,075,029	$1,085,780	$0	$1,085,780
9	Lease Expense	$1,013,626	$1,188,827	$0	$1,188,827	$1,200,715	$0	$1,200,715	$1,212,722	$0	$1,212,722	$1,224,849	$0	$1,224,849	$1,237,098	$0	$1,237,098
10	Other Operating Expenses	$10,816,575	$8,901,262	$0	$8,901,262	$8,990,275	$0	$8,990,275	$9,080,177	($32,041)	$9,048,136	$9,170,979	$90,966	$9,261,945	$9,262,689	$213,973	$9,476,662
	TOTAL OPERATING EXPENSES	**$72,159,655**	**$70,011,785**	**$0**	**$70,011,785**	**$69,590,101**	**$0**	**$69,590,101**	**$69,891,198**	**($259,035)**	**$69,632,163**	**$70,937,011**	**$553,726**	**$71,490,737**	**$72,001,890**	**$1,366,485**	**$73,368,375**
	Provision for Income Taxes[c]		$0	$0	**$0**	$0	$0	**$0**		$419,357	**$419,357**		$607,900	**$607,900**		$766,359	**$766,359**
	Earnings Before Interest, Taxes, Depreciation & Amortization **(EBITDA)**	**$6,731,589**	**$2,936,549**	**$0**	**$2,936,549**	**$2,942,045**	**$0**	**$2,942,045**	**$3,599,036**	**$863,704**	**$4,462,740**	**$3,741,100**	**$1,185,944**	**$4,927,044**	**$4,021,532**	**$1,508,185**	**$5,529,717**
	INCOME / (LOSS) FROM OPERATIONS	**$2,760,693**	**($998,473)**	**$0**	**($998,473)**	**($964,962)**	**$0**	**($964,962)**	**($307,971)**	**$891,316**	**$583,345**	**($165,908)**	**$799,623**	**$633,715**	**$114,525**	**$738,016**	**$852,541**
	NON-OPERATING INCOME / REVENUE	($378,564)	($468,022)	$0	**($468,022)**	($315,000)	$0	**($315,000)**	($105,000)		**($105,000)**	$105,000		**$105,000**	$105,000		**$105,000**
	NET INCOME / EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSES	**$2,382,129**	**($1,466,495)**	**$0**	**($1,466,495)**	**($1,279,962)**	**$0**	**($1,279,962)**	**($412,971)**	**$891,316**	**$478,345**	**($60,908)**	**$799,623**	**$738,715**	**$219,525**	**$738,016**	**$957,541**

Sale of Non-Profit Hosptal to For-Profit Entity - REVISED

Name Entity: RGH
Financial Worsheet (C):

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	Description																
C.	**Retained Earnings/ Net Assets, beginning of year**	**$31,052,463**	**$28,334,302**	**$0**	**$28,334,302**	**$26,867,807**	**$0**	**$26,867,807**	**$25,587,845**	**$0**	**$25,587,845**	**$25,174,874**	**$891,316**	**$26,066,190**	**$25,113,967**	**$1,690,939**	**$26,804,906**
	Retained Earnings / Net Assets, end of year	**$28,334,302**	**$26,867,807**	**$0**	**$26,867,807**	**$25,587,845**	**$0**	**$25,587,845**	**$25,174,874**	**$891,316**	**$26,066,190**	**$25,113,967**	**$1,690,939**	**$26,804,906**	**$25,333,492**	**$2,428,955**	**$27,762,447**
	Principal Payments	$874,828	$881,957	$0	**$881,957**	$926,631	$0	**$926,631**	$984,173	($984,173)	**$0**	$1,110,055	($1,110,055)	**$0**	$1,132,025		**$1,132,025**
D.	**PROFITABILITY SUMMARY**																
1	Hospital Operating Margin	**3.7%**	**-1.5%**	**0.0%**	**-1.5%**	**-1.4%**	**0.0%**	**-1.4%**	**-0.4%**	**84.8%**	**0.8%**	**-0.2%**	**40.8%**	**0.9%**	**0.2%**	**25.7%**	**1.1%**
2	Hospital Non Operating Margin	**-0.5%**	**-0.7%**	**0.0%**	**-0.7%**	**-0.5%**	**0.0%**	**-0.5%**	**-0.2%**	**0.0%**	**-0.1%**	**0.1%**	**0.0%**	**0.1%**	**0.1%**	**0.0%**	**0.1%**
3	Hospital Total Margin	**3.2%**	**-2.1%**	**0.0%**	**-2.1%**	**-1.9%**	**0.0%**	**-1.9%**	**-0.6%**	**84.8%**	**0.7%**	**-0.1%**	**40.8%**	**1.0%**	**0.3%**	**25.7%**	**1.3%**
E.	**FTEs**	**405**	**377**	**0**	**377**	**348**	**0**	**348**	**348**	**5**	**353**	**348**	**8**	**356**	**348**	**11**	**359**
F.	**VOLUME STATISTICS[d]**																
1	Inpatient Discharges	2,341	2,159	0	**2,159**	2,159	0	**2,159**	2,159	32	**2,191**	2,159	54	**2,213**	2,159	76	**2,235**
2	Outpatient Visits	421,124	434,254	0	**434,254**	434,254	0	**434,254**	434,254	530	**434,784**	434,254	1,060	**435,314**	434,254	1,590	**435,844**
	TOTAL VOLUME	**423,465**	**436,413**	**0**	**436,413**	**436,413**	**0**	**436,413**	**436,413**	**562**	**436,975**	**436,413**	**1,114**	**437,527**	**436,413**	**1,666**	**438,079**

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.
[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.
[c]Provide the amount of income taxes as defined by the Internal Revenue Services for for-profit entities.
[d]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

RESPONSE TO DEFICIENCIES
EXHIBIT J - Other Operating Revenue Detail

Other Operating Revenue Detail

Entity Name: ECHN

	FY 2015 Projected W/out CON	FY 2015 Projected Incremental	FY 2015 Projected With CON	FY 2016 Projected W/out CON	FY 2016 Projected Incremental	FY 2016 Projected With CON	FY 2017 Projected W/out CON	FY 2017 Projected Incremental	FY 2017 Projected With CON	FY 2018 Projected W/out CON	FY 2018 Projected Incremental	FY 2018 Projected With CON	FY 2019 Projected W/out CON	FY 2019 Projected Incremental	FY 2019 Projected With CON
Adolescent Education	$1,990,410	$0	$1,990,410	$1,990,410	$0	$1,990,410	$1,990,410	$0	$1,990,410	$1,990,410	$0	$1,990,410	$1,990,410	$0	$1,990,410
Behavioral Health	$408,035	$0	$408,035	$408,035	$0	$408,035	$408,035	$0	$408,035	$408,035	$0	$408,035	$408,035	$0	$408,035
Biomed Service Contract w/ Tolland Imaging (JV)	$140,667	$0	$140,667	$140,667	$0	$140,667	$140,667	$0	$140,667	$140,667	$0	$140,667	$140,667	$0	$140,667
Cafeteria Income	$965,455	$0	$965,455	$965,455	$0	$965,455	$965,455	$0	$965,455	$965,455	$0	$965,455	$965,455	$0	$965,455
Cancer Services - Salary Recovery from NRRON (JV)	$195,500	$0	$195,500	$195,500	$0	$195,500	$195,500	$0	$195,500	$195,500	$0	$195,500	$195,500	$0	$195,500
ECHN Allocation	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
ECMPF Revenue	$371,634	$0	$371,634	$371,634	$0	$371,634	$371,634	$0	$371,634	$371,634	$0	$371,634	$371,634	$0	$371,634
ECMPF Sound Revenue	$338,800	$0	$338,800	$338,800	$0	$338,800	$338,800	$0	$338,800	$338,800	$0	$338,800	$338,800	$0	$338,800
EHR Initiative Program	$868,039	$0	$868,039	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Gift Shop	$647,433	$0	$647,433	$647,433	$0	$647,433	$647,433	$0	$647,433	$647,433	$0	$647,433	$647,433	$0	$647,433
Grant Income	$1,741,542	$0	$1,741,542	$1,741,542	$0	$1,741,542	$1,741,542	$0	$1,741,542	$1,741,542	$0	$1,741,542	$1,741,542	$0	$1,741,542
HR - Wellness Program & Medicare Part D Subsidy	$468,715	$0	$468,715	$468,715	$0	$468,715	$468,715	$0	$468,715	$468,715	$0	$468,715	$468,715	$0	$468,715
Lab Services - Eastern CT Pathology	$1,313,440	$0	$1,313,440	$1,313,440	$0	$1,313,440	$1,313,440	$0	$1,313,440	$1,313,440	$0	$1,313,440	$1,313,440	$0	$1,313,440
Maintanance Cost Recovery Woodlake	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Miscellaneous Income	$95,627	$0	$95,627	$86,666	$0	$86,666	$86,666	$0	$86,666	$86,666	$0	$86,666	$86,666	$0	$86,666
MPP Billing Revenue	$2,305,526	$0	$2,305,526	$2,305,526	$0	$2,305,526	$2,305,526	$0	$2,305,526	$2,305,526	$0	$2,305,526	$2,305,526	$0	$2,305,526
Nursing/Perinatal Education	$69,584	$0	$69,584	$69,584	$0	$69,584	$69,584	$0	$69,584	$69,584	$0	$69,584	$69,584	$0	$69,584
Physician Hospital Organization	$331,559	$0	$331,559	$331,559	$0	$331,559	$331,559	$0	$331,559	$331,559	$0	$331,559	$331,559	$0	$331,559
Radiology Directorship - Tolland Imaging (JV)	$89,645	$0	$89,645	$89,645	$0	$89,645	$89,645	$0	$89,645	$89,645	$0	$89,645	$89,645	$0	$89,645
Rental Income	$350,197	$0	$350,197	$350,197	$0	$350,197	$350,197	$0	$350,197	$350,197	$0	$350,197	$350,197	$0	$350,197
UNECOM - Medical Education	$237,480	$0	$237,480	$237,480	$0	$237,480	$237,480	$0	$237,480	$237,480	$0	$237,480	$237,480	$0	$237,480
VNHSC (Flu Clinic/Health Promotions)	$66,508	$0	$66,508	$66,508	$0	$66,508	$66,508	$0	$66,508	$66,508	$0	$66,508	$66,508	$0	$66,508
Joint Venture Income	$2,311,296	$0	$2,311,296	$2,311,296	$0	$2,311,296	$2,357,522	$0	$2,357,522	$2,404,672	$0	$2,404,672	$2,452,766	$0	$2,452,766
Public Support	$1,265,801	$0	$1,265,801	$1,265,801	$0	$1,265,801	$1,265,801	($1,265,801)	$0	$1,265,801	($1,265,801)	$0	$1,265,801	($1,265,801)	$0
Realized Gains	$0	$0	$0	$0	$0	$0	$36,261	$0	$36,261	$36,261	$0	$36,261	$36,261	$0	$36,261
Interest Income	$230,020	$0	$230,020	$230,020	$0	$230,020	$193,759	($152,102)	$41,657	$193,759	($152,102)	$41,657	$193,759	($152,102)	$41,657
Total Other Operating Revenue	**$16,802,913**	**$0**	**$16,802,913**	**$15,925,913**	**$0**	**$15,925,913**	**$15,972,139**	**($1,417,903)**	**$14,554,236**	**$16,019,290**	**($1,417,903)**	**$14,601,387**	**$16,067,383**	**($1,417,903)**	**$14,649,480**

Other Operating Revenue Detail

Entity Name: MMH

	FY 2015 Projected W/out CON	FY 2015 Projected Incremental	FY 2015 Projected With CON	FY 2016 Projected W/out CON	FY 2016 Projected Incremental	FY 2016 Projected With CON	FY 2017 Projected W/out CON	FY 2017 Projected Incremental	FY 2017 Projected With CON	FY 2018 Projected W/out CON	FY 2018 Projected Incremental	FY 2018 Projected With CON	FY 2019 Projected W/out CON	FY 2019 Projected Incremental	FY 2019 Projected With CON
Adolescent Education	$1,790,410	$0	$1,790,410	$1,790,410	$0	$1,790,410	$1,826,218	$0	$1,826,218	$1,862,743	$0	$1,862,743	$1,899,997	$0	$1,899,997
Behavioral Health	$376,535	$0	$376,535	$376,535	$0	$376,535	$384,066	$0	$384,066	$391,747	$0	$391,747	$399,582	$0	$399,582
Biomed Service Contract w/ Tolland Imaging (JV)	$140,667	$0	$140,667	$140,667	$0	$140,667	$143,480	$0	$143,480	$146,350	$0	$146,350	$149,277	$0	$149,277
Cafeteria Income	$873,648	$0	$873,648	$873,648	$0	$873,648	$891,121	$0	$891,121	$908,943	$0	$908,943	$927,122	$0	$927,122
Cancer Services - Salary Recovery from NRRON (JV)	$195,500	$0	$195,500	$195,500	$0	$195,500	$199,410	$0	$199,410	$203,398	$0	$203,398	$207,466	$0	$207,466
ECHN Allocation	$901,129	$0	$901,129	$901,129	$0	$901,129	$919,152	$0	$919,152	$937,535	$0	$937,535	$956,285	$0	$956,285
ECMPF Revenue	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
ECMPF Sound Revenue	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
EHR Initiative Program	$429,536	$0	$429,536	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Gift Shop	$613,616	$0	$613,616	$613,616	$0	$613,616	$625,888	$0	$625,888	$638,406	$0	$638,406	$651,174	$0	$651,174
Grant Income	$1,529,803	$0	$1,529,803	$1,529,803	$0	$1,529,803	$1,560,399	$0	$1,560,399	$1,591,607	$0	$1,591,607	$1,623,439	$0	$1,623,439
HR - Wellness Program & Medicare Part D Subsidy	$468,715	$0	$468,715	$468,715	$0	$468,715	$478,089	$0	$478,089	$487,651	$0	$487,651	$497,404	$0	$497,404
Lab Services - Eastern CT Pathology	$1,313,441	$0	$1,313,441	$1,313,441	$0	$1,313,441	$1,339,711	$0	$1,339,711	$1,366,504	$0	$1,366,504	$1,393,834	$0	$1,393,834
Maintanance Cost Recovery Woodlake	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Miscellaneous Income	$29,342	$0	$29,342	$68,631	$0	$68,631	$85,706	$0	$85,706	$103,123	$0	$103,123	$120,888	$0	$120,888
MPP Billing Revenue	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Nursing/Perinatal Education	$69,584	$0	$69,584	$69,584	$0	$69,584	$70,976	$0	$70,976	$72,395	$0	$72,395	$73,843	$0	$73,843
Physician Hospital Organization	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Radiology Directorship - Tolland Imaging (JV)	$89,645	$0	$89,645	$89,645	$0	$89,645	$91,438	$0	$91,438	$93,267	$0	$93,267	$95,132	$0	$95,132
Rental Income	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
UNECOM - Medical Education	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
VNHSC (Flu Clinic/Health Promotions)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Joint Venture Income	$1,417,219	$0	$1,417,219	$1,417,219	$0	$1,417,219	$1,445,563	$0	$1,445,563	$1,474,475	$0	$1,474,475	$1,503,964	$0	$1,503,964
Public Support	$595,242	$0	$595,242	$595,242	$0	$595,242	$595,242	($595,242)	$0	$595,242	($595,242)	$0	$595,242	($595,242)	$0
Realized Gains	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Interest Income	$189,887	$0	$189,887	$189,887	$0	$189,887	$189,887	($140,125)	$49,762	$189,887	($140,125)	$49,762	$189,887	($140,125)	$49,762
Total Other Operating Revenue	**$11,023,919**	**$0**	**$11,023,919**	**$10,633,672**	**$0**	**$10,633,672**	**$10,846,346**	**($735,367)**	**$10,110,979**	**$11,063,272**	**($735,367)**	**$10,327,905**	**$11,284,538**	**($735,367)**	**$10,549,171**

Other Operating Revenue Detail

Entity Name: RGH

	FY 2015 Projected W/out CON	FY 2015 Projected Incremental	FY 2015 Projected With CON	FY 2016 Projected W/out CON	FY 2016 Projected Incremental	FY 2016 Projected With CON	FY 2017 Projected W/out CON	FY 2017 Projected Incremental	FY 2017 Projected With CON	FY 2018 Projected W/out CON	FY 2018 Projected Incremental	FY 2018 Projected With CON	FY 2019 Projected W/out CON	FY 2019 Projected Incremental	FY 2019 Projected With CON
Adolescent Education	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Behavioral Health	$31,500	$0	$31,500	$31,500	$0	$31,500	$32,130	$0	$32,130	$32,773	$0	$32,773	$33,428	$0	$33,428
Biomed Service Contract w/ Tolland Imaging (JV)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Cafeteria Income	$208,628	$0	$208,628	$208,628	$0	$208,628	$212,801	$0	$212,801	$217,057	$0	$217,057	$221,398	$0	$221,398
Cancer Services - Salary Recovery from NRRON (JV)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
ECHN Allocation	$355,646	$0	$355,646	$355,646	$0	$355,646	$362,759	$0	$362,759	$370,014	$0	$370,014	$377,414	$0	$377,414
ECMPF Revenue	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
ECMPF Sound Revenue	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
EHR Initiative Program	$438,503	$0	$438,503	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Gift Shop	$33,817	$0	$33,817	$33,817	$0	$33,817	$34,493	$0	$34,493	$35,183	$0	$35,183	$35,887	$0	$35,887
Grant Income	$193,670	$0	$193,670	$193,670	$0	$193,670	$197,543	$0	$197,543	$201,494	$0	$201,494	$205,524	$0	$205,524
HR - Wellness Program & Medicare Part D Subsidy	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Lab Services - Eastern CT Pathology	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Maintanance Cost Recovery Woodlake	$139,548	$0	$139,548	$139,548	$0	$139,548	$142,339	$0	$142,339	$145,186	$0	$145,186	$148,089	$0	$148,089
Miscellaneous Income	$13,964	$0	$13,964	$377,134	$0	$377,134	$387,184	$0	$387,184	$397,435	$0	$397,435	$407,892	$0	$407,892
MPP Billing Revenue	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Nursing/Perinatal Education	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Physician Hospital Organization	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Radiology Directorship - Tolland Imaging (JV)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Rental Income	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
UNECOM - Medical Education	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
VNHSC (Flu Clinic/Health Promotions)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Joint Venture Income	$587,431	$0	$587,431	$587,431	$0	$587,431	$599,180	$0	$599,180	$611,163	$0	$611,163	$623,386	$0	$623,386
Public Support	$100,766	$0	$100,766	$100,766	$0	$100,766	$100,766	($100,766)	$0	$100,766	($100,766)	$0	$100,766	($100,766)	$0
Realized Gains	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Interest Income	$24,602	$0	$24,602	$24,602	$0	$24,602	$24,602	($11,977)	$12,625	$24,602	($11,977)	$12,625	$24,602	($11,977)	$12,625
Total Other Operating Revenue	**$2,128,076**	**$0**	**$2,128,076**	**$2,052,742**	**$0**	**$2,052,742**	**$2,093,797**	**($112,743)**	**$1,981,054**	**$2,135,673**	**($112,743)**	**$2,022,930**	**$2,178,387**	**($112,743)**	**$2,065,644**

RESPONSE TO DEFICIENCIES
EXHIBIT K - OHCA Financial Statistics Report
(ECHN – July, August, September)

OHCA Financial Statistics Report (July FY 2015 and July FY 2014)

	Manchester Memorial Hospital				Rockville General Hospital				Eastern CT Health Network			
	MTD		YTD		MTD		YTD		MTD		YTD	
	July FY 2015	July FY 2014	July FY 2015	July FY 2014	July FY 2015	July FY 2014	July FY 2015	July FY 2014	July FY 2015	July FY 2014	July FY 2015	July FY 2014
A. Operating Performance												
Operating Margin	4.12%	3.32%	2.51%	3.23%	-3.13%	0.81%	-2.72%	1.05%	3.71%	0.89%	-0.98%	0.34%
Non-Operating Margin	-1.21%	-1.76%	-0.89%	-0.88%	-1.20%	-1.71%	-0.69%	-0.45%	-0.92%	-1.36%	-0.67%	-0.59%
Total Margin	2.91%	1.56%	1.62%	2.35%	-4.32%	-0.90%	-3.41%	0.60%	2.80%	-0.47%	-1.65%	-0.25%
Bad Debt as % of Gross Revenue	0.58%	0.38%	-0.61%	-0.66%	0.99%	0.35%	-0.72%	-0.63%	-0.76%	0.48%	-0.65%	-0.75%
B. Liquidity												
Current Ratio	1.16	1.31	1.16	1.31	1.54	1.50	1.54	1.50	1.38	1.40	1.38	1.40
Days Cash on Hand	19	28	13	20	66	61	45	45	65	70	65	70
Days in Net Accounts Receivable	53	59	38	43	62	55	42	41	52	55	38	40
Average Payment Period	62	54	43	39	48	47	32	34	64	70	64	70
C. Leverage and Capital Structure												
Long-term Debt to Equity	2.07	1.64	2.07	1.64	0.91	0.74	0.91	0.74	1.11	0.93	1.11	0.93
Long-term Debt to Capitalization	67	62	67	62	48	42	48	42	67	59	67	59
Unrestricted Cash to Debt	1.30	0.90	10.83	12.60	0.08	0.43	2.49	9.86	1.37	0.49	4.36	7.21
Times Interest Earned Ratio	6.75	5.72	5.82	6.03	2.44	4.94	2.99	6.96	7.70	4.40	3.49	4.46
Debt Service Coverage Ratio	N/A	N/A	1.42	1.83	N/A	N/A	0.92	2.66	N/A	N/A	1.40	1.16
Equity Financing Ratio	16.17	21.64	16.17	21.64	35.23	41.31	35.23	41.31	28.11	32.92	28.11	32.92
D. Additional Statistics												
Income from Operations	$633,053	$520,994	$3,919,130	$5,079,849	($166,895)	$49,602	($1,534,668)	$637,755	$1,033,957	$251,617	($2,648,012)	$961,199
Revenue Over/(Under) Expense	$446,906	$244,365	$2,524,988	$3,695,991	($230,700)	($55,083)	($1,924,686)	$362,997	$778,733	($133,319)	($4,472,987)	($691,635)
EBITDA	$1,413,261	$1,163,486	$11,890,204	$13,184,731	$149,301	$305,483	$1,744,517	$4,002,648	$2,291,661	$1,335,849	$10,337,145	$14,344,707
Cash from Operations	$14,290,215	$15,719,667	$144,426,487	$146,614,120	$5,527,405	$6,707,356	$57,671,830	$58,437,110	$24,789,135	$27,474,495	$250,965,459	$255,093,461
Cash and Cash Equivalents	$9,163,954	$13,849,738	$9,163,954	$13,849,738	$11,726,452	$12,105,457	$11,726,452	$12,105,457	$46,307,239	$51,231,181	$46,307,239	$51,231,181
Net Working Capital	$4,709,127	$8,495,203	$4,709,127	$8,495,203	$4,519,871	$4,689,471	$4,519,871	$4,689,471	$18,060,122	$20,490,665	$18,060,122	$20,490,665
Unrestricted Assets	$10,376,011	$19,815,466	$10,376,011	$19,815,466	$20,665,705	$26,324,679	$20,665,705	$26,324,679	$54,034,965	$71,217,658	$54,034,965	$71,217,658
Credit Ratings (S&P, FITCH, and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

OHCA Financial Statistics Report (August FY 2015 and August FY 2014)

	Manchester Memorial Hospital				Rockville General Hospital				Eastern CT Health Network			
	MTD		YTD		MTD		YTD		MTD		YTD	
	August FY 2015	August FY 2014	August FY 2015	August FY 2014	August FY 2015	August FY 2014	August FY 2015	August FY 2014	August FY 2015	August FY 2014	August FY 2015	August FY 2014
A. Operating Performance												
Operating Margin	4.05%	-3.59%	2.65%	2.64%	-2.38%	-0.70%	-2.69%	0.90%	-0.94%	-4.14%	-0.97%	-0.05%
Non-Operating Margin	-1.66%	-0.44%	-0.96%	-0.84%	-1.58%	-0.17%	-0.76%	-0.43%	-1.29%	-0.29%	-0.73%	-0.56%
Total Margin	2.39%	-4.03%	1.69%	1.80%	-3.96%	-0.87%	-3.46%	0.47%	-2.23%	-4.43%	-1.70%	-0.61%
Bad Debt as % of Gross Revenue	1.22%	-0.66%	-0.44%	-0.66%	1.21%	-0.84%	-0.55%	-0.65%	0.96%	-0.79%	-0.51%	-0.75%
B. Liquidity												
Current Ratio	1.19	1.19	1.19	1.19	1.48	1.69	1.48	1.69	1.36	1.39	1.36	1.39
Days Cash on Hand	23	27	15	19	72	62	46	43	66	67	66	67
Days in Net Accounts Receivable	56	64	39	44	64	63	42	44	57	60	39	41
Average Payment Period	67	61	45	44	52	44	34	30	65	67	65	67
C. Leverage and Capital Structure												
Long-term Debt to Equity	2.14	1.74	2.14	1.74	0.92	0.77	0.92	0.77	1.14	0.97	1.14	0.97
Long-term Debt to Capitalization	68	64	68	64	48	44	48	44	67	61	67	61
Unrestricted Cash to Debt	1.20	0.06	11.86	12.11	0.06	0.77	2.55	10.84	0.30	(0.08)	4.60	7.04
Times Interest Earned Ratio	6.91	1.53	6.41	5.64	2.68	5.33	2.96	6.81	3.45	0.91	3.49	4.16
Debt Service Coverage Ratio	N/A	N/A	1.50	1.68	N/A	N/A	0.91	2.72	N/A	N/A	1.41	1.06
Equity Financing Ratio	15.99	20.58	15.99	20.58	34.93	41.46	34.93	41.46	27.76	32.38	27.76	32.38
D. Additional Statistics												
Income from Operations	$597,835	($531,932)	$4,516,964	$4,547,917	($119,527)	($40,468)	($1,654,194)	$597,288	($240,325)	($1,110,535)	($2,888,337)	($149,336)
Revenue Over/(Under) Expense	$353,116	($597,128)	$2,878,103	$3,098,864	($198,666)	($50,522)	($2,123,350)	$312,476	($570,339)	($1,188,772)	($5,043,326)	($1,880,407)
EBITDA	$1,400,713	$316,488	$13,088,122	$13,501,219	$156,631	$307,715	$1,901,150	$4,310,364	$1,003,678	$275,706	$11,340,823	$14,620,413
Cash from Operations	$13,850,383	$14,385,361	$158,276,870	$160,999,481	$5,606,279	$5,677,456	$63,278,109	$64,114,566	$24,438,646	$24,966,839	$275,404,105	$280,060,300
Cash and Cash Equivalents	$10,094,581	$12,933,064	$10,094,581	$12,933,064	$11,578,760	$11,103,202	$11,578,760	$11,103,202	$47,023,731	$49,069,770	$47,023,731	$49,069,770
Net Working Capital	$5,603,489	$5,450,496	$5,603,489	$5,450,496	$4,023,147	$5,397,747	$4,023,147	$5,397,747	$17,639,012	$19,611,711	$17,639,012	$19,611,711
Unrestricted Assets	$10,308,640	$18,971,156	$10,308,640	$18,971,156	$20,279,098	$26,051,748	$20,279,098	$26,051,748	$53,344,364	$70,108,676	$53,344,364	$70,108,676
Credit Ratings (S&P, FITCH, and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

OHCA Financial Statistics Report (September FY 2015 and September FY 2014)

DRAFT BASED ON UNAUDITED RESULTS

	Manchester Memorial Hospital				Rockville General Hospital				Eastern CT Health Network			
	MTD		YTD		MTD		YTD		MTD		YTD	
	September FY 2015	September FY 2014	September FY 2015	September FY 2014	September FY 2015	September FY 2014	September FY 2015	September FY 2014	September FY 2015	September FY 2014	September FY 2015	September FY 2014
A. Operating Performance												
Operating Margin	17.81%	-1.98%	4.00%	2.26%	-0.66%	26.83%	-2.53%	3.70%	9.21%	2.28%	-0.13%	0.15%
Non-Operating Margin	0.00%	-1.87%	-0.87%	-0.93%	-1.44%	-1.16%	-0.82%	-0.51%	-0.30%	-1.37%	-0.69%	-0.63%
Total Margin	17.82%	-3.85%	3.13%	1.33%	-2.11%	25.67%	-3.35%	3.20%	8.91%	0.91%	-0.82%	-0.48%
Bad Debt as % of Gross Revenue	0.75%	-4.49%	-0.34%	-0.97%	0.50%	-7.75%	-0.46%	-1.23%	0.85%	0.66%	-0.39%	-0.64%
B. Liquidity												
Current Ratio	1.12	1.17	1.12	1.17	1.94	1.59	1.94	1.59	1.37	1.37	1.37	1.37
Days Cash on Hand	30	36	21	29	75	66	54	50	73	78	73	78
Days in Net Accounts Receivable	48	64	39	40	58	73	42	47	55	64	41	39
Average Payment Period	78	67	54	54	41	47	30	36	69	71	69	71
					0							
C. Leverage and Capital Structure												
Long-term Debt to Equity	3.72	2.03	3.72	2.03	1.08	0.83	1.08	0.83	1.37	1.06	1.37	1.06
Long-term Debt to Capitalization	79	67	79	67	52	45	52	45	76	65	76	65
Unrestricted Cash to Debt	4.26	(0.06)	15.48	11.20	0.38	6.98	3.05	17.41	2.43	0.88	6.76	7.68
Times Interest Earned Ratio	21.38	2.24	7.04	5.38	4.14	42.56	3.06	9.24	14.05	7.45	4.27	4.38
Debt Service Coverage Ratio	N/A	N/A	1.79	1.60	N/A	N/A	0.97	3.99	N/A	N/A	1.27	1.36
Equity Financing Ratio	8.83	16.28	8.83	16.28	30.95	37.96	30.95	37.96	22.08	28.81	22.08	28.81
D. Additional Statistics												
Income from Operations	$2,980,224	($312,411)	$7,497,189	$4,235,507	($35,560)	$2,163,409	($1,689,753)	$2,760,694	$2,461,753	$658,388	($426,584)	$509,052
Revenue Over/(Under) Expense	$2,980,415	($606,680)	$5,858,519	$2,492,184	($113,096)	$2,069,656	($2,236,445)	$2,382,130	$2,381,332	$263,708	($2,661,994)	($1,616,699)
EBITDA	$3,743,274	$440,393	$17,034,191	$13,941,613	$250,620	$2,421,228	$2,151,771	$6,774,667	$3,666,884	$1,850,004	$15,007,707	$16,470,417
Cash from Operations	$14,563,917	$14,901,325	$172,840,787	$175,900,806	$5,514,418	$5,768,359	$68,792,527	$69,882,925	$24,854,112	$25,589,485	$300,258,217	$305,649,785
Cash and Cash Equivalents	$13,188,728	$18,856,818	$13,188,728	$18,856,818	$13,081,652	$12,735,604	$13,081,652	$12,735,604	$53,111,506	$58,713,876	$53,111,506	$58,713,876
Net Working Capital	$4,127,089	$5,986,254	$4,127,089	$5,986,254	$6,725,388	$5,392,746	$6,725,388	$5,392,746	$21,095,237	$20,280,901	$21,095,237	$20,280,901
Unrestricted Assets	$1,126,292	$11,344,473	$1,126,292	$11,344,473	$16,813,993	$24,211,838	$16,813,993	$24,211,838	$42,021,427	$59,544,869	$42,021,427	$59,544,869
Credit Ratings (S&P, FITCH, and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

RESPONSE TO DEFICIENCIES
EXHIBIT L - PMH Capital Investments and Cost Savings Table

Table from Question 37a - Capital Investments and Cost Savings Table

Hospital	Describe Improvements in Financial Performance									
	Investments since Acquistion		Profitability		Liquidity		Solvency		Cost Savings	
Los Angeles Community Hospital at Bellflower	$ 3,646,633		N//A	(a)	N/A	(a)	N/A	(a)	N/A	(a)
Foothill Regional Medical Center	$ 7,912,807		N/A	(a)	N/A	(a)	N/A	(a)	N/A	(a)
Our Lady of Fatima Hospital	$ 11,321,376	(f)	$ 15,184,000	(g)	$ 4,976,828	(c)	$ 67,475,613	(c)	Marginal Cost per day reduced to $1,493 from $1,542	(d)
Roger Williams Medical Center	$ 11,321,376	(f)	$ 15,184,000	(g)	$ 4,976,828	(c)	$ 67,475,613	(c)	Marginal Cost per day reduced to $2,271 from $2,263	(d)
Nix Health System	$ 33,350,077		$ 20,867,000	(h)	$ 15,882,118		$ 63,789,134		Total Costs per day decreased to $1,444 from $1,584	(e)

(a) Both Los Angeles Community Hospital at Bellflower (Bellflower) and Foothill Regional Medical Center (Foothill) were closed prior to PMH acquisition
Bellflower re-opened in July 2015 and Foohill re-opened in September 2015. Both facilities were purchased in May 2014.

(b) Los Angeles Community Hospital at Bellflower is under common corporate ownership structure and license as Los Angeles Community Hospital and
Los Angeles Community Hospital at Norwalk. As such, liquidity and solvency for this campus includes financial information for all three campuses combined

(c) The profitability, liquidity and solvency of Our Lady of Fatima and Roger Williams Medical Center are reported on a consoldiated basis for the CharterCARE system
Prior to the acquisition, the liquidity of CharterCARE system was approximately a negative $2.5 million
Profitability is measured on an EBITDA basis and reported on a consolidated basis for the CharterCARE system

(d) Measured from June 2014 to May 2015

(e) Measured from Dember 2011 to September 2015. Prior to acquisition Nix did not compute Marginal cost per day.

(f) Total capital investment in Our Lay of Fatima and Roger Williams Medical Center (which comprise CharterCARE) is reported on a combined basis.
In addition to the amount already spent, we have committed to spend $20 million in addtion to what has already been spent
on (i) cancer center; (ii) Digestive Diseases Center; (iii) Emergency Department and (iv) physician practice acquisitions.

RESPONSE TO DEFICIENCIES
EXHIBIT M - PMH Quality Report from Rhode Island CON

CharterCare and Prospect Holdings Quality Review

Health Services Council

April 8, 2014

Mary Reich Cooper MD JD

No Conflicts of Interest

Statutory Authority and Background

RIGL 23-17-14.3 "Licensing of Health Care Facilities"

- The character, commitment, competence, and standing in the community of the proposed owners, operators, or directors of the health care facility;
- In cases of initial licensure or of proposed change in owner, operator, or lessee, the extent to which the facility will provide or will continue to provide, without material effect on its viability at the time of initial licensure or of change of owner, operator, or lessee, safe and adequate treatment for individuals receiving the health care facility's services;
- The extent to which the facility will provide or will continue to provide safe and adequate treatment for individuals receiving the health care facility's services; and
- The extent to which the facility will provide or will continue to provide appropriate access with respect to traditionally underserved populations and in consideration of the proposed continuation or termination of health care services by the health care facility.

Hospital Conversion Act 23-17.14-3 and 23-17.14-4

- Assure the viability of a safe, accessible, and affordable healthcare system that is available to all of the citizens of the state.
- Establish a process to review whether for-profit hospitals will maintain, enhance or disrupt the delivery of healthcare in the state and to monitor hospital performance to assure that standards for community benefit continue to be met.

Hospital Conversion Act 23-17.14-8

- Whether the character, commitment, competence, and standing in the community or any other proposed communities served by the proposed transacting parties is satisfactory.
- Whether sufficient safeguards are included to assure the affected community continued access to affordable care.

Hospital Conversion Act 23-17.14-8

- Whether the transacting parties have provided clear and convincing evidence that the new hospital will provide health care and appropriate access with respect to traditionally underserved populations in the affected community.
- Whether the conversion demonstrates that the public interest will be served considering the essential medical services needed to provide safe and adequate treatment, appropriate access and balanced health care delivery to the residents of the state.

Scope of Review

- Review of CEC Application
- Review of HCA Filing
- Internet Research and Review of Findings
  - WhyNotTheBest.org (aggregating medicare.gov/hospitalcompare)
  - Kaiser Family Foundation (kff.org)
  - Qualitycheck.org (Joint Commission), DNV.org, NursingHomeCompare, homehealthcompare
  - Other public documents
- Interviews with Leadership

Roger Williams

Roger Williams Medical Center is a general medical and surgical hospital in Providence, RI, with 177 beds. It is also a teaching hospital. Survey data for the latest year available shows 165,058 outpatient visits. The hospital had a total of 7,233 admissions. Its physicians performed 2,133 inpatient and 3,082 outpatient surgeries.

http://health.usnews.com/best-hospitals/area/ri/roger-williams-medical-center-6150160 accessed April 2, 2014 and file:///C:/Users/Mary/Downloads/Free_Hospital_Look_up___Roger_Williams_Medical_Center%20(1).pdf accessed April 6 2014

St. Joseph's

St. Joseph Health Services is a general medical and surgical hospital in North Providence, RI, with 231 beds. Survey data for the latest year available shows 229,153 outpatient visits. The hospital had a total of 7,924 admissions. Its physicians performed 1,694 inpatient and 5,426 outpatient surgeries.

http://health.usnews.com/best-hospitals/area/ri/st-joseph-health-services-6150091 accessed April 2, 2014 and file:///C:/Users/Mary/Downloads/Free_Hospital_Look_up__St_Joseph_Health_Services_of_Rhode_Island.pdf accessed April 6, 2014

Nix Health System

Nix Medical Center is a general medical and surgical hospital in San Antonio, TX, with 173 beds. Survey data for the latest year available shows that the hospital had a total of 7,751 admissions. Outpatient visits totaled 131, 709 Its physicians performed 1,775 inpatient and 3,546 outpatient surgeries.

http://health.usnews.com/best-hospitals/area/tx/nix-medical-center-6743070 accessed April 2, 2014 and file:///C:/Users/Mary/Downloads/Free_Hospital_Look_up__Nix_Health_Care_System.pdf accessed April 6, 2014

Nix Community Hospital

Community General Hospital is a general medical and surgical hospital in Dilley, TX, with 18 beds. Survey data for the latest year available shows that 5,383 outpatient visits. The hospital had a total of 647 admissions.

http://health.usnews.com/best-hospitals/area/tx/community-general-hospital-6740286 and file:///C:/Users/Mary/Downloads/Free_Hospital_Look_up___Nix_Community_General_Hospital.pdf accessed April 6, 2014

SoCal Culver City

(Brotman) is a general medical and surgical hospital in Culver City, CA, with 239 beds. Survey data for the latest year available shows 30,622 outpatients. The hospital had a total of 9,255 admissions. Its physicians performed 788 inpatient and 1,189 outpatient surgeries.

http://health.usnews.com/best-hospitals/area/ca/brotman-medical-center-6930540/details accessed March 30, 2014 and file:///C:/Users/Mary/Downloads/Free_Hospital_Look_up__Southern_California_Hospital_at_Culver_City.pdf accessed April 6, 2014

SoCal Hollywood

Hollywood Community Hospital (SoCal Hollywood) is a general medical and surgical hospital in Los Angeles, CA, with 45 beds, 3,081 admissions, and 5,668 outpatient visits.

http://health.usnews.com/best-hospitals/area/ca/hollywood-community-hospital-6930072 accessed April 2, 2014 and file:///C:/Users/Mary/Downloads/Free_Hospital_Look_up___Southern_California_Hospital_at_Hollywood.pdf accessed April 6 2014

SoCal Van Nuys

"SoCal Van Nuys located in Van Nuys, California is a 60-bed psychiatric hospital that provides acute inpatient and outpatient psychiatric services on a voluntary basis."

http://www.altacorp.com/altacorp/ accessed April 3, 2014

LA Community

LA Community is a general medical and surgical hospital in Los Angeles, CA, with 180 beds. Survey data for the latest year available shows that there were 23,337 outpatient visits. The hospital had a total of 8,393 admissions and 1586 births.

http://health.usnews.com/best-hospitals/area/ca/los-angeles-community-hospital-6930060 accessed April 2, 2014 and file:///C:/Users/Mary/Downloads/Free_Hospital_Look_up___Los_Angeles_Community_Hospital_at_Los_Angeles.pdf accessed April 6 2014

Norwalk Community

"Our hospital located in Norwalk, California is a 50-bed community hospital that offers a comprehensive range of medical and surgical services, including general acute care hospital services, inpatient and outpatient surgery, emergency room and general medical/surgical care and intensive care."

http://www.altacorp.com/altacorp/
accessed April 3, 2014

Framework: Institute of Medicine

- Safety
- Access
- Patient Centered Care
- Effectiveness
- Timeliness
- Efficiency

Crossing the Quality Chasm 2001

Accreditation

Review accreditation decisions for hospitals held by the transacting parties and determine if any adverse accreditation reviews have been identified and corrected.

Accreditation Decisions

- CharterCare
  - **St. Josephs: Joint Commission**
    - Hospital accredited 12/17/2011
    - Advanced Inpatient Diabetes 12/08/2012 1/75
    - Advanced Primary Stroke 12/04/2012 1/1024
    - Hip Replacement 12/12/2012 1/376
    - Knee Replacement 12/12/2012 1/379

http://www.qualitycheck.org/qualityreport.aspx?hcoid=5647 accessed 3/29/2014

Accreditation Decisions

- CharterCare
  - **Roger Williams: Joint Commission**
    - Hospital accredited 09/24/2011
    - Home Care 09/21/2011
    - Nursing Care Center 09/23/2011
    - Advanced Primary Stroke 03/21/2014 1/1024
    - Hip Replacement 02/11/2014 1/376
    - Knee Replacement 02/11/2014 1/379

    - Special Quality Awards
      - 2013 AHCA/NCAL Bronze - Commitment to Quality
      - 2013 Silver Get With The Guidelines - Stroke

http://www.qualitycheck.org/qualityreport.aspx?hcoid=5652# accessed 3/29/2014

Accreditation Decisions

- Prospect Medical Holdings
  - **Nix Health Care System: DNV**
    - Health System accredited 11/25/2013
  - **TX DSHS**
    - Behavioral Health through 12/31/2015
    - Health Care System through 12/31/2015
    - Specialty Health Center through 12/31/2015

http://dnvglhealthcare.com/hospitals?q=&c=&c=19211&prSubmit=Search&page=4 accessed April 2, 2014

http://www.dshs.state.tx.us/HFP/apps.shtm#hosp_gen_spec accessed March 30, 2014

Accreditation Decisions

- Prospect Medical Holdings
  - **Nix Community Hospital: Joint Commission (TJC)**
    - Hospital accredited 08/08/2013
  - **TX DSHS**
    - Community Hospital through 4/30/2015

http://www.qualitycheck.org/qualityreport.aspx?hcoid=546980 accessed March 30, 2014

http://www.dshs.state.tx.us/HFP/apps.shtm#hosp_gen_spec accessed March 30, 2014

Accreditation Decisions

- Prospect Medical Holdings
  - **SoCal Hollywood: DNV**
    - Hospital accredited 1/12/2014
  - **TJC**
    - Laboratory program accredited 9/13/2013
  - **CA DPH**: licensed through 2/24/2015

https://hfcis.cdph.ca.gov/LongTermCare/Facility.aspx?fac=930000064 accessed March 30 2014

http://dnvglhealthcare.com/hospitals?q=&c=&c=19173&prSubmit=Search&page=2 accessed April 2, 2014

http://www.qualitycheck.org/Consumer/searchResults.aspx?zip=90028&Select1=-1&dist=-1&provId=2&provIdtracker=2 accessed March 30, 2014

Accreditation Decisions

- Prospect Medical Holdings
  - **Los Angeles Community/Norwalk Community: DNV**
    - Hospital accredited 1/7/2014
  - **TJC** Laboratory accreditation 7/12/2013
  - **CA DPH** licensed through 3/14/2015

https://hfcis.cdph.ca.gov/LongTermCare/Facility.aspx?fac=930000085 accessed March 30, 2014

http://dnvglhealthcare.com/hospitals?q=&c=&c=19173&prSubmit=Search&page=2 accessed March 30, 2014

http://www.qualitycheck.org/qualityreport.aspx?hcoid=9923 accessed March 30 2014

Accreditation Decisions

- Prospect Medical Holdings
  - **SoCal Culver City: DNV**
    - Hospital accredited 1/12/2014
  - **TJC** No accreditations found; none necessary
  - **CA DPH** licensed through 2/24/2015

https://hfcis.cdph.ca.gov/LongTermCare/Facility.aspx?fac=930000015 accessed April 3, 2014

http://dnvglhealthcare.com/hospitals?q=&c=&c=19173&prSubmit=Search accessed March 30, 2014

http://www.qualitycheck.org/Consumer/searchPage2.aspx?zip=90232&Select1=-1&dist=-1 accessed March 30, 2014

Accreditation Decisions

- Prospect Medical Holdings
  - **Van Nuys: DNV**
    - Effective Date of Accreditation 1/12/2014
  - **TJC**: Laboratory Accreditation 9/13/2013
  - **CA DPH** licensed through 2/24/2015

https://hfcis.cdph.ca.gov/LongTermCare/Facility.aspx?fac=930000492 accessed April 3, 2014

http://dnvglhealthcare.com/hospitals?q=&c=&c=19173&prSubmit=Search&page=2 accessed March 30, 2014

http://www.qualitycheck.org/Consumer/searchResults.aspx?zip=91401&Select1=-1&dist=-1&provGrpId=2&provGrpIdtracker=2 accessed March 30, 2014

Quality Metrics

Review HospitalCompare Reports including federal measures of outcomes, patient satisfaction, efficiency, and safety, and benchmark using the Commonwealth Fund's benchmarking information, Why Not the Best®?

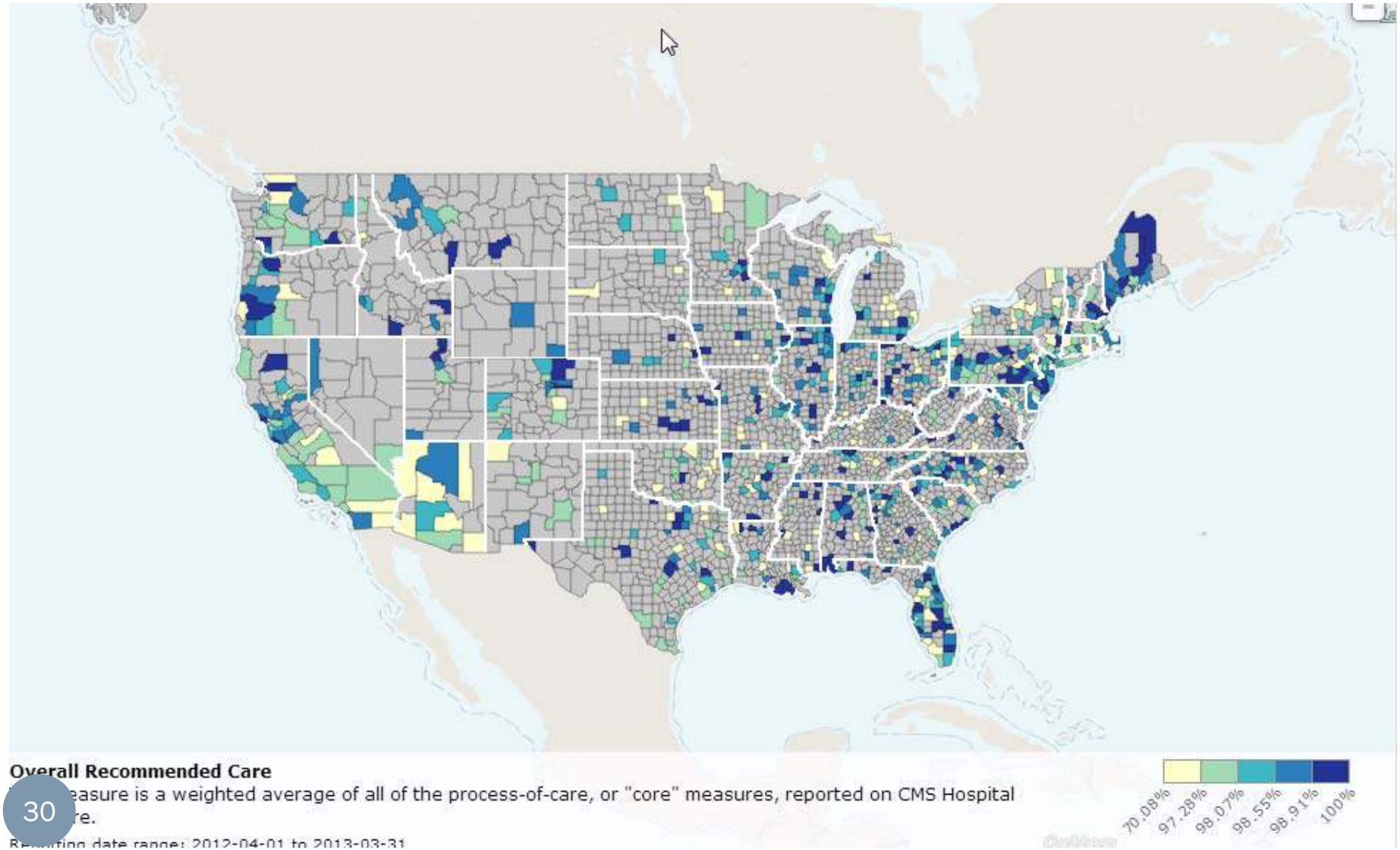
Data and Benchmarks
Overall Quality

WhyNotTheBest.org, accessed March 17, 2014, and April 2, 2014 based on data from hospitalcompare.medicare.gov through March 2013



THE COMMONWEALTH FUND
A Private Foundation Working Toward a High Performance Health System

Overall quality: national

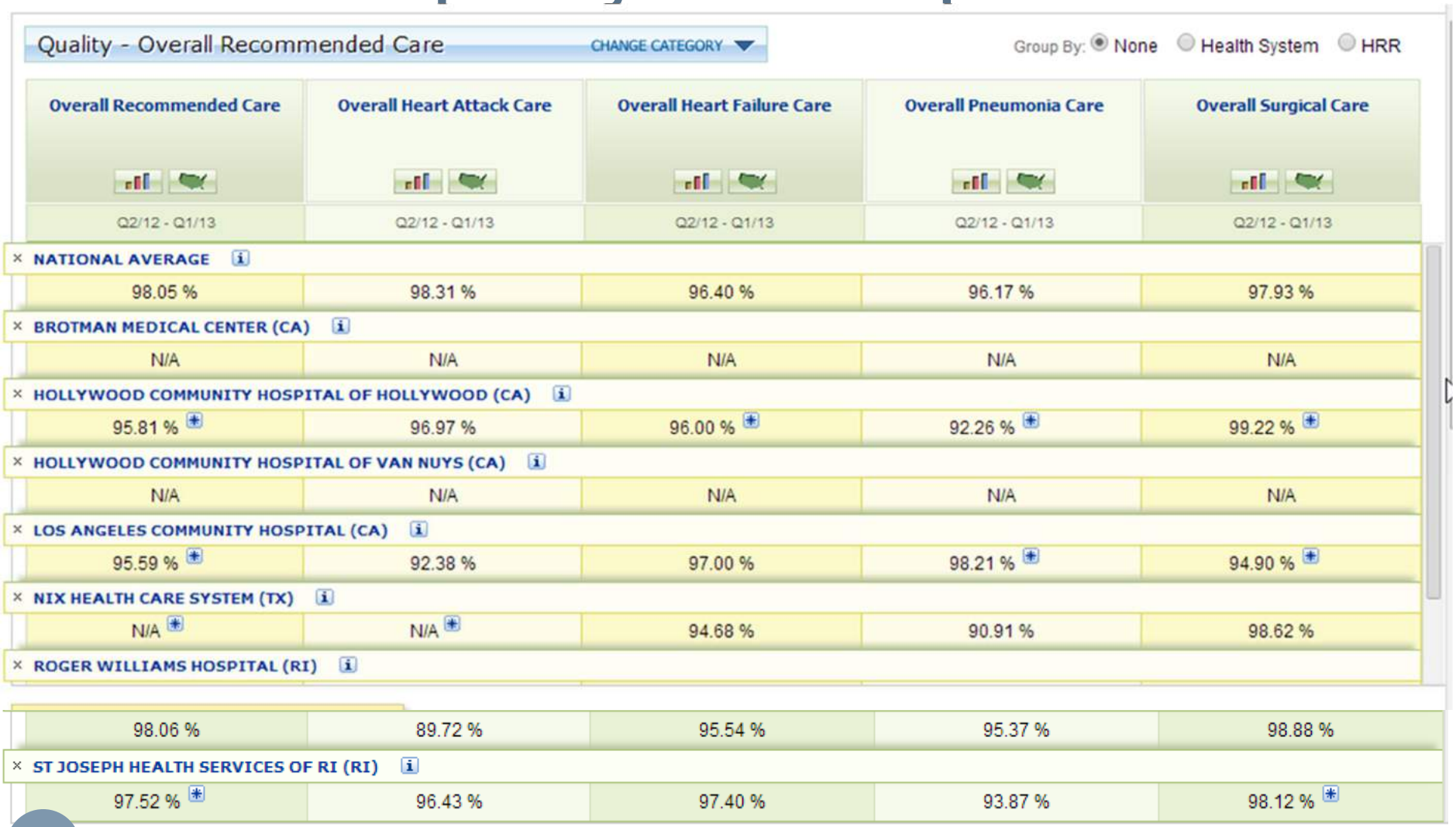


Overall quality: RI, CA, TX

Quality - Overall Recommended Care CHANGE CATEGORY

	Overall Recommended Care	Overall Heart Attack Care	Overall Heart Failure Care	Overall Pneumonia Care	Overall Surgical Care
	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13
NATIONAL AVERAGE	98.05 %	98.31 %	96.40 %	96.17 %	97.93 %
NATIONAL TOP 10%	99.55 %	100.00 %	100.00 %	99.58 %	99.63 %
CALIFORNIA (CA)	97.91 %	98.29 %	96.80 %	96.58 %	97.74 %
RHODE ISLAND (RI)	97.62 %	96.24 %	96.32 %	96.02 %	98.28 %
TEXAS (TX)	98.21 %	97.99 %	96.39 %	96.24 %	98.01 %

Overall quality: All Hospitals



Quality - Overall Recommended Care CHANGE CATEGORY

Group By: None Health System HRR

	Overall Recommended Care	Overall Heart Attack Care	Overall Heart Failure Care	Overall Pneumonia Care	Overall Surgical Care
	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13
NATIONAL AVERAGE	98.05 %	98.31 %	96.40 %	96.17 %	97.93 %
BROTMAN MEDICAL CENTER (CA)	N/A	N/A	N/A	N/A	N/A
HOLLYWOOD COMMUNITY HOSPITAL OF HOLLYWOOD (CA)	95.81 %	96.97 %	96.00 %	92.26 %	99.22 %
HOLLYWOOD COMMUNITY HOSPITAL OF VAN NUYS (CA)	N/A	N/A	N/A	N/A	N/A
LOS ANGELES COMMUNITY HOSPITAL (CA)	95.59 %	92.38 %	97.00 %	98.21 %	94.90 %
NIX HEALTH CARE SYSTEM (TX)	N/A	N/A	94.68 %	90.91 %	98.62 %
ROGER WILLIAMS HOSPITAL (RI)	98.06 %	89.72 %	95.54 %	95.37 %	98.88 %
ST JOSEPH HEALTH SERVICES OF RI (RI)	97.52 %	96.43 %	97.40 %	93.87 %	98.12 %

Overall quality: Roger Williams

Roger Williams Hospital
825 CHALKSTONE AVENUE
Providence, RI 02908

Quality - Overall Recommended Care CHANGE CATEGORY

	Q2/12-Q1/13	Q4/11-Q3/12	Q3/11-Q2/12	Q2/11-Q1/12	Q1/11-Q4/11	Q4/10-Q3/11	Q3/10-Q2/11	Q2/10-Q1/11
OVERALL RECOMMENDED CARE	98.06 %	97.39 %	96.34 % *	96.01 % *	95.19 % *	94.55 % *	94.59 % *	94.67 % *
OVERALL HEART ATTACK CARE	89.72 %	89.22 %	89.42 %	87.37 %	91.07 %	93.29 %	93.11 %	94.94 %
OVERALL HEART FAILURE CAR...	95.54 %	90.55 %	88.80 %	88.52 %	89.42 %	88.89 %	89.90 %	92.07 %
OVERALL PNEUMONIA CARE	95.37 %	95.38 %	96.15 %	97.35 %	90.74 % *	90.05 % *	90.40 % *	88.34 % *
OVERALL SURGICAL CARE	98.88 %	98.30 %	97.25 % *	97.02 % *	97.15 % *	96.54 % *	96.39 % *	96.42 % *

2361

Overall quality: St. Joseph

St Joseph Health Services Of Ri
200 HIGH SERVICE AVENUE
North Providence, RI 02904

Quality - Overall Recommended Care CHANGE CATEGORY

	Q2/12-Q1/13	Q4/11-Q3/12	Q3/11-Q2/12	Q2/11-Q1/12	Q1/11-Q4/11	Q4/10-Q3/11	Q3/10-Q2/11	Q2/10-Q1/11
OVERALL RECOMMENDED CARE	97.52 %	N/A	N/A	95.44 %	95.01 %	93.48 %	93.27 %	93.09 %
OVERALL HEART ATTACK CARE	96.43 %	N/A	N/A	93.44 %	97.31 %	97.80 %	98.52 %	99.42 %
OVERALL HEART FAILURE CAR...	97.40 %	94.42 %	91.27 %	89.09 %	89.02 %	89.62 %	89.88 %	90.64 %
OVERALL PNEUMONIA CARE	93.87 %	94.86 %	95.54 %	93.46 %	91.32 %	87.54 %	88.08 %	88.93 %
OVERALL SURGICAL CARE	98.12 %	97.79 %	97.96 %	96.97 %	97.15 %	96.22 %	95.50 %	94.75 %

Overall quality: Nix

Nix Health Care System
414 NAVARRO
San Antonio, TX 78205

Quality - Overall Recommended Care CHANGE CATEGORY

	Q2/12-Q1/13	Q4/11-Q3/12	Q3/11-Q2/12	Q2/11-Q1/12	Q1/11-Q4/11	Q4/10-Q3/11	Q3/10-Q2/11	Q2/10-Q1/11
OVERALL RECOMMENDED CARE	N/A*	N/A*	N/A*	N/A*	98.10 %*	97.66 %*	96.74 %*	N/A*
OVERALL HEART ATTACK CARE	N/A*	N/A*	N/A*	N/A*	96.75 %	97.41 %*	97.37 %*	N/A*
OVERALL HEART FAILURE CAR...	94.68 %	95.43 %	96.47 %	95.98 %	96.25 %	96.75 %*	96.50 %*	92.90 %*
OVERALL PNEUMONIA CARE	90.91 %	93.33 %	N/A*	93.75 %	96.30 %	94.77 %*	94.08 %*	93.83 %*
OVERALL SURGICAL CARE	98.62 %	98.72 %	99.03 %	98.40 %	98.35 %*	97.96 %*	96.97 %*	96.36 %*

2363

Overall quality: SoCal Hollywood

Hollywood Community Hospital Of Hollywood
6245 DE LONGPRE AVE
Hollywood, CA 90028

Quality - Overall Recommended Care CHANGE CATEGORY

	Q2/12-Q1/13	Q4/11-Q3/12	Q3/11-Q2/12	Q2/11-Q1/12	Q1/11-Q4/11	Q4/10-Q3/11	Q3/10-Q2/11	Q2/10-Q1/11
OVERALL RECOMMENDED CARE	95.81 %	N/A	N/A	N/A	N/A	N/A	N/A	N/A
OVERALL HEART ATTACK CARE	96.97 %	N/A	N/A	N/A	N/A	N/A	N/A	N/A
OVERALL HEART FAILURE CAR...	96.00 %	87.65 %	80.95 %	77.66 %	81.75 %	86.51 %	87.07 %	87.07 %
OVERALL PNEUMONIA CARE	92.26 %	85.42 %	87.88 %	N/A	67.28 %	62.23 %	59.53 %	60.00 %
OVERALL SURGICAL CARE	99.22 %	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Overall quality: LA Community

Los Angeles Community Hospital
4081 E OLYMPIC BLVD
Los Angeles, CA 90023

Quality - Overall Recommended Care CHANGE CATEGORY

	Q2/12-Q1/13	Q4/11-Q3/12	Q3/11-Q2/12	Q2/11-Q1/12	Q1/11-Q4/11	Q4/10-Q3/11	Q3/10-Q2/11	Q2/10-Q1/11
OVERALL RECOMMENDED CARE	95.59 %	94.68 %	85.62 %	75.97 %	71.44 %	65.69 %	65.32 %	66.28 %
OVERALL HEART ATTACK CARE	92.38 %	94.49 %	80.95 %	67.19 %	53.28 %	52.47 %	52.60 %	51.66 %
OVERALL HEART FAILURE CAR...	97.00 %	96.32 %	86.63 %	76.31 %	73.47 %	70.15 %	71.78 %	74.62 %
OVERALL PNEUMONIA CARE	98.21 %	94.12 %	91.00 %	90.32 %	76.70 %	63.08 %	60.00 %	56.25 %
OVERALL SURGICAL CARE	94.90 %	92.63 %	83.26 %	71.12 %	71.53 %	67.83 %	65.42 %	69.35 %

2365

Overall quality: SoCal Culver City

Brotman Medical Center
3828 DELMAS TERRACE
Culver City, CA 90232

Quality - Overall Recommended Care — CHANGE CATEGORY

	Q4/11-Q3/12	Q3/11-Q2/12	Q2/11-Q1/12	Q1/11-Q4/11	Q4/10-Q3/11	Q3/10-Q2/11	Q2/10-Q1/11	Q1/10-Q4/10
OVERALL RECOMMENDED CARE	98.29 %	96.24 %	92.35 %	89.36 %	82.05 %	80.25 %	79.36 %	78.98 %
OVERALL HEART ATTACK CARE	100.00 %	98.94 %	96.15 %	95.67 %	91.35 %	90.23 %	91.82 %	92.55 %
OVERALL HEART FAILURE CAR...	100.00 %	97.89 %	95.41 %	87.44 %	81.02 %	80.33 %	81.04 %	82.08 %
OVERALL PNEUMONIA CARE	100.00 %	98.88 %	94.27 %	89.59 %	77.22 %	76.69 %	77.35 %	78.14 %
OVERALL SURGICAL CARE	96.55 %	94.33 %	89.81 %	88.48 %	84.73 %	81.72 %	78.29 %	74.61 %

Overall quality: SoCal Van Nuys

No Data Available: Psychiatric Hospital Does Not Require Reporting

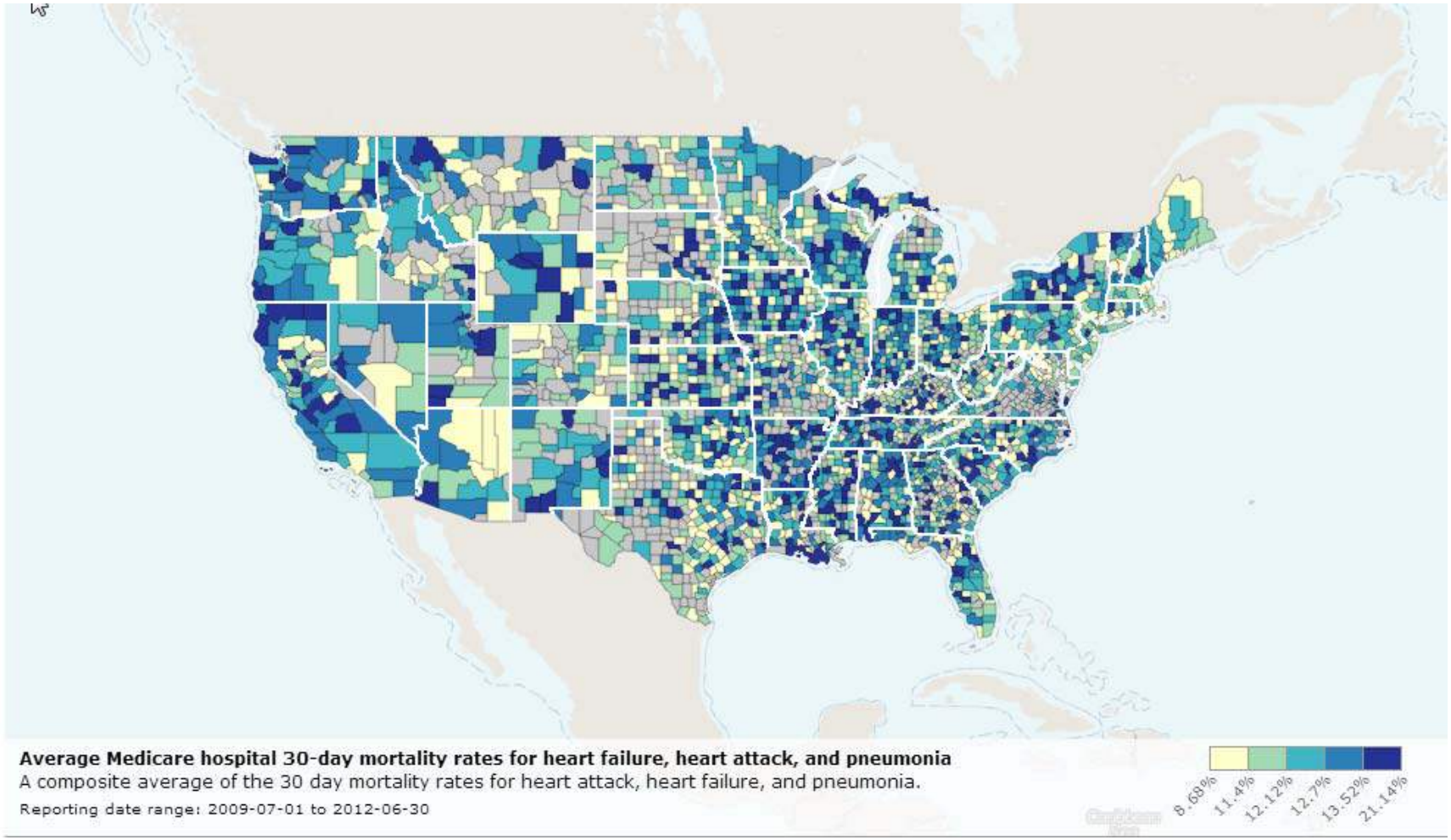
Data and Benchmarks
Mortality

WhyNotTheBest.org, accessed March 17, 2014 and April 2, 2014 based on data from hospitalcompare.medicare.gov through June 2012



THE COMMONWEALTH FUND
A Private Foundation Working Toward a High Performance Health System

Mortality: national



Mortality: RI, CA, TX

Mortality Rates — CHANGE CATEGORY

	Average Medicare hospital 30-day mortality rates for heart fail...	Heart Attack 30-Day Mortality Rate	Heart Failure 30-Day Mortality Rate	Pneumonia 30-Day Mortality Rate
	Q3/09 - Q2/12	Q3/09 - Q2/12	Q3/09 - Q2/12	Q3/09 - Q2/12
NATIONAL AVERAGE	12.31 %	15.20 %	11.70 %	11.90 %
NATIONAL TOP 10%	10.61 %	13.30 %	9.90 %	9.90 %
CALIFORNIA (CA)	12.01 %	14.89 %	11.23 %	11.68 %
RHODE ISLAND (RI)	12.38 %	14.48 %	12.12 %	11.85 %
TEXAS (TX)	12.09 %	15.39 %	11.61 %	11.69 %

*Value is a simple average of all the risk-adjusted rates for entities reporting within this region

Mortality: All Hospitals



Mortality Rates — CHANGE CATEGORY

Group By: None | Health System | HRR

Average Medicare hospital 30-day mortality rates for heart fail...	Heart Attack 30-Day Mortality Rate	Heart Failure 30-Day Mortality Rate	Pneumonia 30-Day Mortality Rate
Q3/09 - Q2/12	Q3/09 - Q2/12	Q3/09 - Q2/12	Q3/09 - Q2/12
NATIONAL AVERAGE			
12.31 % *	15.20 %	11.70 %	11.90 %
BROTMAN MEDICAL CENTER (CA)			
10.63 %	15.00 %	10.30 %	9.60 %
HOLLYWOOD COMMUNITY HOSPITAL OF HOLLYWOOD (CA)			
9.47 %	N/A *	10.10 %	9.20 %
HOLLYWOOD COMMUNITY HOSPITAL OF VAN NUYS (CA)			
N/A	N/A	N/A	N/A
LOS ANGELES COMMUNITY HOSPITAL (CA)			
9.30 %	14.40 %	9.50 %	7.40 % *
NIX HEALTH CARE SYSTEM (TX)			
10.54 %	13.90 %	10.00 %	9.70 %
ROGER WILLIAMS HOSPITAL (RI)			
12.06 %	16.10 %	10.90 %	10.90 %
ST JOSEPH HEALTH SERVICES OF RI (RI)			
12.88 %	15.50 %	11.90 %	13.00 %

Mortality: Roger Williams

Roger Williams Hospital
825 CHALKSTONE AVENUE
Providence, RI 02908

Mortality Rates CHANGE CATEGORY

	Q3/09-Q2/12	Q3/08-Q2/11	Q3/07-Q2/10	Q3/06-Q2/09
AVERAGE MEDICARE HOSPITAL...	12.06 %	12.21 %	12.37 %	N/A
HEART ATTACK 30-DAY MORTA...	16.10 %	16.30 %	17.50 %	16.00 %
HEART FAILURE 30-DAY MORT...	10.90 %	10.80 %	10.50 %	10.10 %
PNEUMONIA 30-DAY MORTALIT...	10.90 %	11.60 %	11.80 %	13.60 %

Mortality: St Joseph

St Joseph Health Services Of Ri
200 HIGH SERVICE AVENUE
North Providence, RI 02904

Mortality Rates — CHANGE CATEGORY

	Q3/09-Q2/12	Q3/08-Q2/11	Q3/07-Q2/10	Q3/06-Q2/09
AVERAGE MEDICARE HOSPITAL...	12.88 %	13.49 %	12.65 %	N/A
HEART ATTACK 30-DAY MORTA...	15.50 %	15.50 %	14.70 %	17.20 %
HEART FAILURE 30-DAY MORT...	11.90 %	11.90 %	12.10 %	12.30 %
PNEUMONIA 30-DAY MORTALIT...	13.00 %	14.60 %	12.50 %	11.90 %

Mortality: Nix

Nix Health Care System
414 NAVARRO
San Antonio, TX 78205

Mortality Rates CHANGE CATEGORY

	Q3/09-Q2/12	Q3/08-Q2/11	Q3/07-Q2/10	Q3/06-Q2/09
AVERAGE MEDICARE HOSPITAL...	10.54 %	10.65 %	11.08 %	N/A
HEART ATTACK 30-DAY MORTA...	13.90 %	14.00 %	14.30 %	13.90 %
HEART FAILURE 30-DAY MORT...	10.00 %	9.90 %	9.70 %	9.80 %
PNEUMONIA 30-DAY MORTALIT...	9.70 %	9.90 %	11.10 %	9.90 %

Mortality: SoCal Hollywood

Hollywood Community Hospital Of Hollywood

6245 DE LONGPRE AVE
Hollywood, CA 90028

Mortality Rates — CHANGE CATEGORY

	Q3/09-Q2/12	Q3/08-Q2/11	Q3/07-Q2/10	Q3/06-Q2/09
AVERAGE MEDICARE HOSPITAL...	9.47 %	10.50 %	10.41 %	N/A
HEART ATTACK 30-DAY MORTA...	N/A *	N/A *	N/A *	N/A
HEART FAILURE 30-DAY MORT...	10.10 %	N/A *	10.20 %	10.20 %
PNEUMONIA 30-DAY MORTALIT...	9.20 %	10.50 %	10.50 %	11.00 %

Mortality: LA Community

Los Angeles Community Hospital
4081 E OLYMPIC BLVD
Los Angeles, CA 90023

Mortality Rates — CHANGE CATEGORY

	Q3/09-Q2/12	Q3/08-Q2/11	Q3/07-Q2/10	Q3/06-Q2/09
AVERAGE MEDICARE HOSPITAL...	9.30 %	9.77 %	9.56 %	N/A
HEART ATTACK 30-DAY MORTA...	14.40 %	N/A *	N/A *	N/A
HEART FAILURE 30-DAY MORT...	9.50 %	8.90 %	9.00 %	10.00 %
PNEUMONIA 30-DAY MORTALIT...	7.40 % *	9.10 %	10.10 %	10.30 %

2376

Mortality: SoCal Culver City

Brotman Medical Center
3828 DELMAS TERRACE
Culver City, CA 90232

Mortality Rates — CHANGE CATEGORY

	Q3/09-Q2/12	Q3/08-Q2/11	Q3/07-Q2/10	Q3/06-Q2/09
AVERAGE MEDICARE HOSPITAL...	10.63 %	10.40 %	11.47 %	N/A
HEART ATTACK 30-DAY MORTA...	15.00 %	14.80 %	16.20 %	16.30 %
HEART FAILURE 30-DAY MORT...	10.30 %	9.50 %	11.00 %	10.30 %
PNEUMONIA 30-DAY MORTALIT...	9.60 %	9.70 %	10.00 %	9.90 %

Data and Benchmarks
Patient Experience

WhyNotTheBest.org, accessed March 17, 2014 and April 2, 2014 based on data from hospitalcompare.medicare.gov through March 2013



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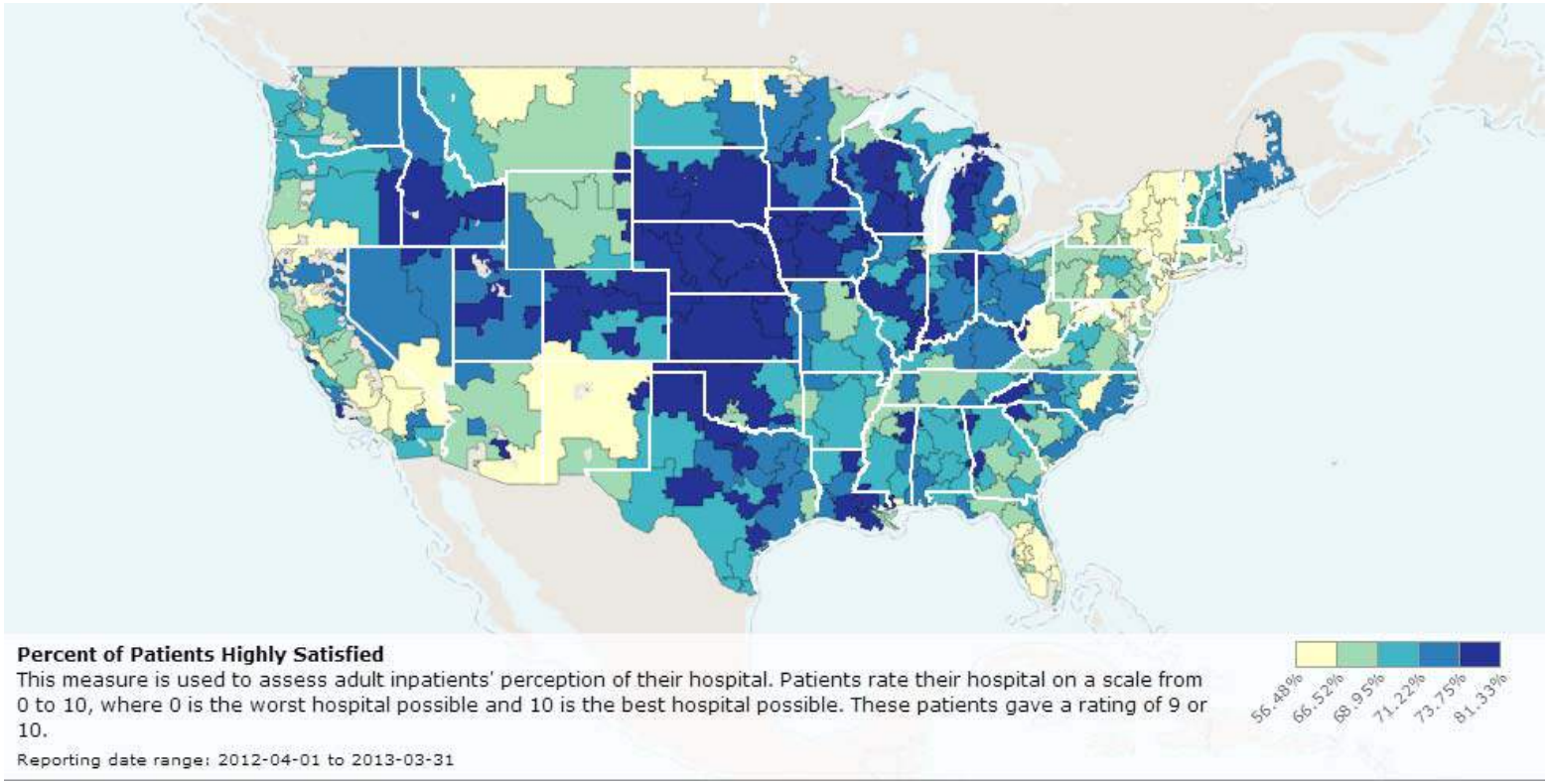
A Private Foundation Working Toward a High Performance Health System

Patient Experience: national



Percent of Patients Highly Satisfied
This measure is used to assess adult inpatients' perception of their hospital. Patients rate their hospital on a scale from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible. These patients gave a rating of 9 or 10.

Reporting date range: 2012-04-01 to 2013-03-31

Patient Experience: RI, CA, TX

Patient Experience (HCAHPS) CHANGE CATEGORY

	Percent of Patients Highl...	Doctors Always Communicat...	Nurses Always Communicate...	Patients Always Received ...	Staff Always Explained Ab...	Pain Was Always Well Cont...	Patient's Room Always Kep...	Patient's Room and Bathro...	Patients Given Informatio...	Patients Would Definitely...
	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13
× NATIONAL AVERAGE	70.06 %	81.37 %	78.42 %	67.03 %	63.80 %	70.56 %	60.59 %	72.87 %	84.82 %	70.78 %
× NATIONAL TOP 10%	81.00 %	88.00 %	85.00 %	79.00 %	72.00 %	77.00 %	73.00 %	83.00 %	90.00 %	82.00 %
× CALIFORNIA (CA)	67.31 %	77.65 %	73.95 %	61.21 %	60.85 %	68.41 %	50.87 %	70.33 %	82.89 %	69.53 %
× RHODE ISLAND (RI)	68.64 %	80.09 %	79.09 %	65.91 %	60.82 %	71.18 %	54.00 %	73.45 %	85.18 %	71.64 %
× TEXAS (TX)	72.60 %	83.28 %	79.23 %	68.93 %	65.67 %	72.54 %	67.98 %	74.25 %	84.58 %	72.93 %

Patient Experience: All Hospitals

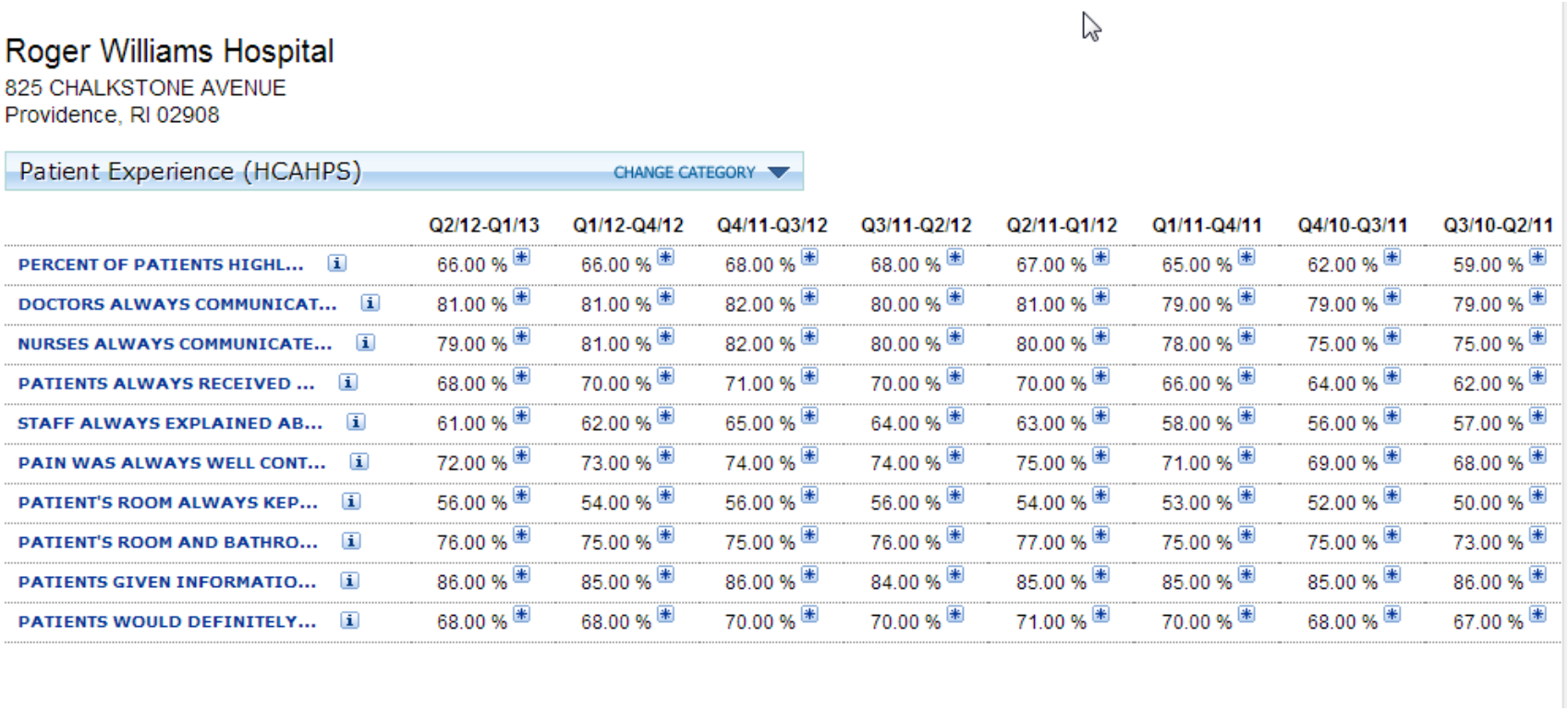


Patient Experience (HCAHPS) CHANGE CATEGORY

Group By: None Health System HRR

	Percent of Patients Highl...	Doctors Always Communicat...	Nurses Always Communicate...	Patients Always Received ...	Staff Always Explained Ab...	Pain Was Always Well Cont...	Patient's Room Always Kep...	Patient's Room and Bathro...	Patients Given Informatio...	Patients Would Definitely...
	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13
NATIONAL AVERAGE	70.06 %	81.37 %	78.42 %	67.03 %	63.80 %	70.56 %	60.59 %	72.87 %	84.82 %	70.78 %
BROTMAN MEDICAL CENTER (CA)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
HOLLYWOOD COMMUNITY HOSPITAL OF HOLLYWOOD (CA)	44.00 %	55.00 %	54.00 %	42.00 %	35.00 %	50.00 %	44.00 %	59.00 %	72.00 %	48.00 %
HOLLYWOOD COMMUNITY HOSPITAL OF VAN NUYS (CA)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
LOS ANGELES COMMUNITY HOSPITAL (CA)	47.00 %	64.00 %	61.00 %	45.00 %	47.00 %	58.00 %	40.00 %	56.00 %	70.00 %	43.00 %
NIX HEALTH CARE SYSTEM (TX)	75.00 %	84.00 %	79.00 %	58.00 %	67.00 %	72.00 %	65.00 %	78.00 %	82.00 %	75.00 %
ROGER WILLIAMS HOSPITAL (RI)	66.00 %	81.00 %	79.00 %	68.00 %	61.00 %	72.00 %	56.00 %	76.00 %	86.00 %	68.00 %
ST JOSEPH HEALTH SERVICES OF RI (RI)	66.00 %	80.00 %	82.00 %	68.00 %	63.00 %	73.00 %	60.00 %	68.00 %	89.00 %	65.00 %

Patient Experience: Roger Williams



Roger Williams Hospital
825 CHALKSTONE AVENUE
Providence, RI 02908

Patient Experience (HCAHPS) CHANGE CATEGORY

	Q2/12-Q1/13	Q1/12-Q4/12	Q4/11-Q3/12	Q3/11-Q2/12	Q2/11-Q1/12	Q1/11-Q4/11	Q4/10-Q3/11	Q3/10-Q2/11
PERCENT OF PATIENTS HIGHL...	66.00 %	66.00 %	68.00 %	68.00 %	67.00 %	65.00 %	62.00 %	59.00 %
DOCTORS ALWAYS COMMUNICAT...	81.00 %	81.00 %	82.00 %	80.00 %	81.00 %	79.00 %	79.00 %	79.00 %
NURSES ALWAYS COMMUNICATE...	79.00 %	81.00 %	82.00 %	80.00 %	80.00 %	78.00 %	75.00 %	75.00 %
PATIENTS ALWAYS RECEIVED ...	68.00 %	70.00 %	71.00 %	70.00 %	70.00 %	66.00 %	64.00 %	62.00 %
STAFF ALWAYS EXPLAINED AB...	61.00 %	62.00 %	65.00 %	64.00 %	63.00 %	58.00 %	56.00 %	57.00 %
PAIN WAS ALWAYS WELL CONT...	72.00 %	73.00 %	74.00 %	74.00 %	75.00 %	71.00 %	69.00 %	68.00 %
PATIENT'S ROOM ALWAYS KEP...	56.00 %	54.00 %	56.00 %	56.00 %	54.00 %	53.00 %	52.00 %	50.00 %
PATIENT'S ROOM AND BATHRO...	76.00 %	75.00 %	75.00 %	76.00 %	77.00 %	75.00 %	75.00 %	73.00 %
PATIENTS GIVEN INFORMATIO...	86.00 %	85.00 %	86.00 %	84.00 %	85.00 %	85.00 %	85.00 %	86.00 %
PATIENTS WOULD DEFINITELY...	68.00 %	68.00 %	70.00 %	70.00 %	71.00 %	70.00 %	68.00 %	67.00 %

Patient Experience: St Joseph

St Joseph Health Services Of Ri
200 HIGH SERVICE AVENUE
North Providence, RI 02904

Patient Experience (HCAHPS) CHANGE CATEGORY

	Q2/12-Q1/13	Q1/12-Q4/12	Q4/11-Q3/12	Q3/11-Q2/12	Q2/11-Q1/12	Q1/11-Q4/11	Q4/10-Q3/11
PERCENT OF PATIENTS HIGHL...	66.00 %	64.00 %	61.00 %	60.00 %	56.00 %	57.00 %	58.00 %
DOCTORS ALWAYS COMMUNICAT...	80.00 %	81.00 %	81.00 %	81.00 %	81.00 %	78.00 %	78.00 %
NURSES ALWAYS COMMUNICATE...	82.00 %	81.00 %	79.00 %	78.00 %	78.00 %	76.00 %	74.00 %
PATIENTS ALWAYS RECEIVED ...	68.00 %	68.00 %	64.00 %	63.00 %	63.00 %	61.00 %	59.00 %
STAFF ALWAYS EXPLAINED AB...	63.00 %	64.00 %	65.00 %	62.00 %	62.00 %	57.00 %	56.00 %
PAIN WAS ALWAYS WELL CONT...	73.00 %	72.00 %	72.00 %	71.00 %	72.00 %	71.00 %	68.00 %
PATIENT'S ROOM ALWAYS KEP...	60.00 %	61.00 %	58.00 %	56.00 %	55.00 %	52.00 %	51.00 %
PATIENT'S ROOM AND BATHRO...	68.00 %	70.00 %	71.00 %	71.00 %	75.00 %	70.00 %	67.00 %

Patient Experience: Nix

Nix Health Care System
414 NAVARRO
San Antonio, TX 78205

Patient Experience (HCAHPS) CHANGE CATEGORY

	Q2/12-Q1/13	Q1/12-Q4/12	Q4/11-Q3/12	Q3/11-Q2/12	Q2/11-Q1/12	Q1/11-Q4/11	Q4/10-Q3/11	Q3/10-Q2/11
PERCENT OF PATIENTS HIGHL...	75.00 %	75.00 %	74.00 %	75.00 %	74.00 %	72.00 %	72.00 %	72.00 %
DOCTORS ALWAYS COMMUNICAT...	84.00 %	84.00 %	82.00 %	82.00 %	81.00 %	81.00 %	83.00 %	84.00 %
NURSES ALWAYS COMMUNICATE...	79.00 %	80.00 %	78.00 %	78.00 %	76.00 %	77.00 %	78.00 %	80.00 %
PATIENTS ALWAYS RECEIVED ...	58.00 %	59.00 %	60.00 %	63.00 %	62.00 %	64.00 %	66.00 %	66.00 %
STAFF ALWAYS EXPLAINED AB...	67.00 %	67.00 %	66.00 %	66.00 %	64.00 %	64.00 %	62.00 %	64.00 %
PAIN WAS ALWAYS WELL CONT...	72.00 %	72.00 %	70.00 %	71.00 %	70.00 %	72.00 %	73.00 %	74.00 %
PATIENT'S ROOM ALWAYS KEP...	65.00 %	65.00 %	65.00 %	66.00 %	67.00 %	68.00 %	68.00 %	69.00 %
PATIENT'S ROOM AND BATHRO...	78.00 %	79.00 %	78.00 %	82.00 %	81.00 %	81.00 %	80.00 %	79.00 %
PATIENTS GIVEN INFORMATIO...	82.00 %	83.00 %	85.00 %	85.00 %	85.00 %	85.00 %	84.00 %	83.00 %
PATIENTS WOULD DEFINITELY...	75.00 %	74.00 %	73.00 %	74.00 %	73.00 %	73.00 %	74.00 %	74.00 %

Patient Experience: SoCal Hollywood

Hollywood Community Hospital Of Hollywood

6245 DE LONGPRE AVE
Hollywood, CA 90028

Patient Experience (HCAHPS) CHANGE CATEGORY

	Q2/12-Q1/13	Q1/12-Q4/12	Q4/11-Q3/12	Q3/11-Q2/12	Q2/11-Q1/12	Q1/11-Q4/11	Q4/10-Q3/11	Q3/10-Q2/11
PERCENT OF PATIENTS HIGHL...	44.00 %	42.00 %	39.00 %	42.00 %	36.00 %	38.00 %	42.00 %	40.00 %
DOCTORS ALWAYS COMMUNICAT...	55.00 %	57.00 %	56.00 %	60.00 %	64.00 %	57.00 %	61.00 %	60.00 %
NURSES ALWAYS COMMUNICATE...	54.00 %	54.00 %	53.00 %	59.00 %	55.00 %	50.00 %	54.00 %	53.00 %
PATIENTS ALWAYS RECEIVED ...	42.00 %	42.00 %	42.00 %	35.00 %	28.00 %	30.00 %	31.00 %	31.00 %
STAFF ALWAYS EXPLAINED AB...	35.00 %	35.00 %	30.00 %	41.00 %	45.00 %	29.00 %	33.00 %	34.00 %
PAIN WAS ALWAYS WELL CONT...	50.00 %	52.00 %	49.00 %	45.00 %	44.00 %	42.00 %	45.00 %	46.00 %
PATIENT'S ROOM ALWAYS KEP...	44.00 %	44.00 %	51.00 %	53.00 %	51.00 %	50.00 %	48.00 %	44.00 %
PATIENT'S ROOM AND BATHRO...	59.00 %	59.00 %	61.00 %	60.00 %	58.00 %	57.00 %	59.00 %	59.00 %
PATIENTS GIVEN INFORMATIO...	72.00 %	71.00 %	66.00 %	69.00 %	65.00 %	62.00 %	65.00 %	67.00 %
PATIENTS WOULD DEFINITELY...	48.00 %	48.00 %	47.00 %	47.00 %	45.00 %	43.00 %	49.00 %	49.00 %

Patient Experience: LA Community

Los Angeles Community Hospital
4081 E OLYMPIC BLVD
Los Angeles, CA 90023

Patient Experience (HCAHPS) CHANGE CATEGORY

	Q2/12-Q1/13	Q1/12-Q4/12	Q4/11-Q3/12	Q3/11-Q2/12	Q2/11-Q1/12	Q1/11-Q4/11	Q4/10-Q3/11	Q3/10-Q2/11
PERCENT OF PATIENTS HIGHL...	47.00 %	44.00 %	43.00 %	42.00 %	43.00 %	41.00 %	43.00 %	42.00 %
DOCTORS ALWAYS COMMUNICAT...	64.00 %	65.00 %	61.00 %	60.00 %	58.00 %	56.00 %	58.00 %	56.00 %
NURSES ALWAYS COMMUNICATE...	61.00 %	57.00 %	53.00 %	52.00 %	53.00 %	48.00 %	48.00 %	46.00 %
PATIENTS ALWAYS RECEIVED ...	45.00 %	45.00 %	49.00 %	50.00 %	42.00 %	40.00 %	42.00 %	40.00 %
STAFF ALWAYS EXPLAINED AB...	47.00 %	47.00 %	44.00 %	44.00 %	37.00 %	37.00 %	43.00 %	39.00 %
PAIN WAS ALWAYS WELL CONT...	58.00 %	55.00 %	48.00 %	47.00 %	47.00 %	45.00 %	48.00 %	45.00 %
PATIENT'S ROOM ALWAYS KEP...	40.00 %	42.00 %	50.00 %	54.00 %	52.00 %	47.00 %	47.00 %	42.00 %
PATIENT'S ROOM AND BATHRO...	56.00 %	59.00 %	67.00 %	69.00 %	64.00 %	61.00 %	62.00 %	64.00 %
PATIENTS GIVEN INFORMATIO...	70.00 %	68.00 %	66.00 %	64.00 %	66.00 %	69.00 %	69.00 %	66.00 %
PATIENTS WOULD DEFINITELY...	43.00 %	41.00 %	44.00 %	46.00 %	46.00 %	43.00 %	43.00 %	44.00 %

Patient Experience: SoCal Culver City

Brotman Medical Center
3828 DELMAS TERRACE
Culver City, CA 90232

Patient Experience (HCAHPS) CHANGE CATEGORY

	Q4/11-Q3/12	Q3/11-Q2/12	Q2/11-Q1/12	Q1/11-Q4/11	Q4/10-Q3/11	Q3/10-Q2/11	Q2/10-Q1/11	Q1/10-Q4/10
PERCENT OF PATIENTS HIGHL...	48.00 %	46.00 %	44.00 %	43.00 %	42.00 %	44.00 %	45.00 %	48.00 %
DOCTORS ALWAYS COMMUNICAT...	68.00 %	67.00 %	67.00 %	69.00 %	67.00 %	68.00 %	69.00 %	67.00 %
NURSES ALWAYS COMMUNICATE...	62.00 %	59.00 %	58.00 %	59.00 %	57.00 %	56.00 %	57.00 %	55.00 %
PATIENTS ALWAYS RECEIVED ...	45.00 %	43.00 %	39.00 %	39.00 %	36.00 %	35.00 %	38.00 %	39.00 %
STAFF ALWAYS EXPLAINED AB...	47.00 %	44.00 %	42.00 %	41.00 %	38.00 %	39.00 %	40.00 %	42.00 %
PAIN WAS ALWAYS WELL CONT...	59.00 %	56.00 %	56.00 %	56.00 %	57.00 %	59.00 %	59.00 %	56.00 %
PATIENT'S ROOM ALWAYS KEP...	47.00 %	44.00 %	43.00 %	46.00 %	43.00 %	45.00 %	46.00 %	44.00 %
PATIENT'S ROOM AND BATHRO...	58.00 %	56.00 %	55.00 %	56.00 %	56.00 %	57.00 %	59.00 %	58.00 %
PATIENTS GIVEN INFORMATIO...	68.00 %	66.00 %	65.00 %	64.00 %	62.00 %	63.00 %	64.00 %	67.00 %
PATIENTS WOULD DEFINITELY...	48.00 %	45.00 %	45.00 %	44.00 %	42.00 %	43.00 %	45.00 %	48.00 %

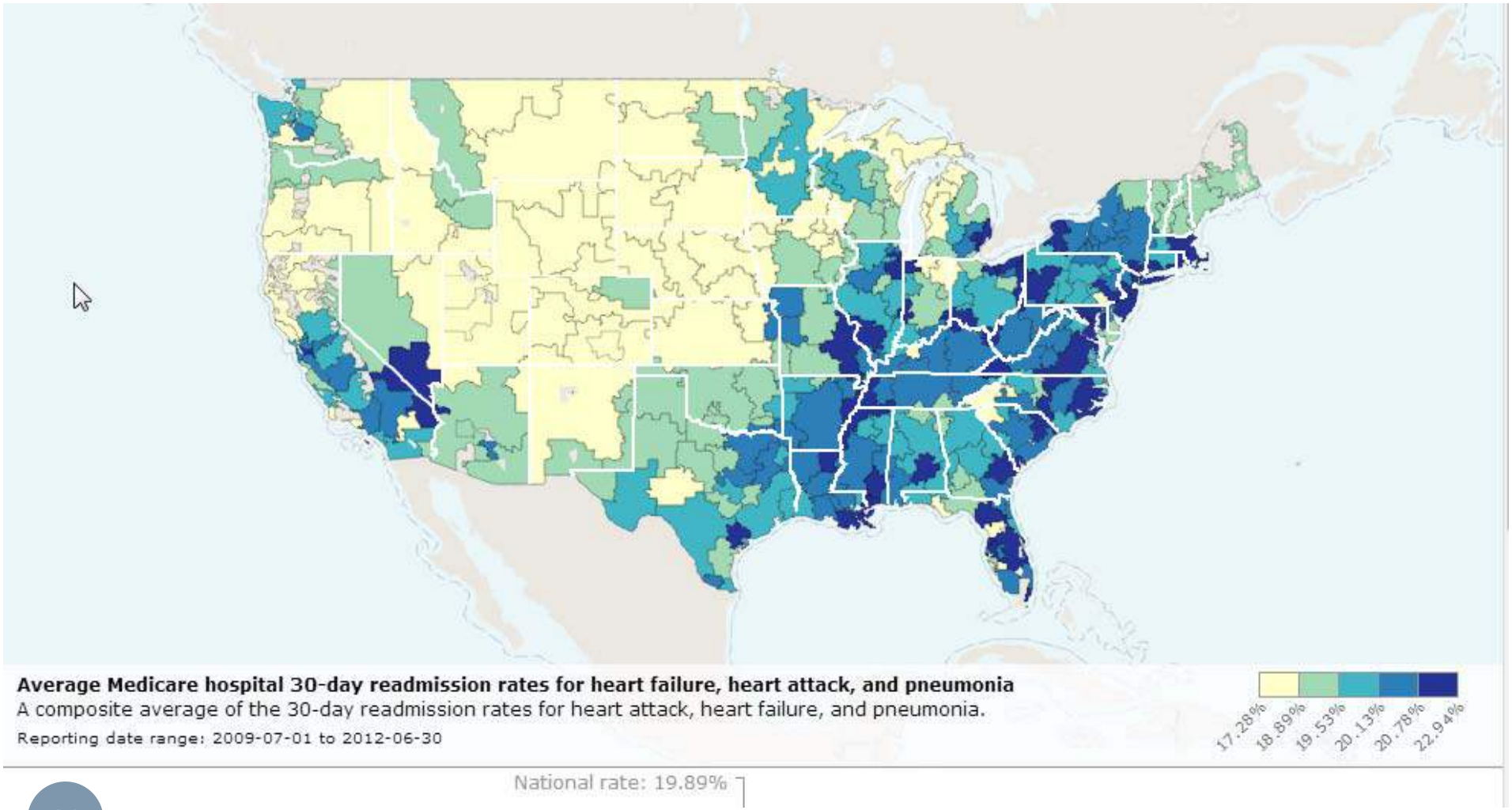
Data and Benchmarks
Readmissions

WhyNotTheBest.org, accessed March 17, 2014 and April 2, 2014 based on data from hospitalcompare.medicare.gov through March 2013



THE COMMONWEALTH FUND
A Private Foundation Working Toward a High Performance Health System

Readmissions: national



Readmissions: RI, CA, TX

Readmission Rates — CHANGE CATEGORY

	Average Medicare hospital 30-day readmission rates for heart fa...	Heart Attack Patients Readmitted to Hospital Within 30 Days	Heart Failure Patients Readmitted to Hospital Within 30 Days	Pneumonia Patients Readmitted to Hospital Within 30 Days
	Q3/09 - Q2/12	Q3/09 - Q2/12	Q3/09 - Q2/12	Q3/09 - Q2/12
NATIONAL AVERAGE	19.89 %	18.30 %	23.00 %	17.60 %
NATIONAL TOP 10%	17.80 %	16.90 %	20.90 %	15.90 %
CALIFORNIA (CA)	19.94 %	18.25 %	22.85 %	17.47 %
RHODE ISLAND (RI)	21.11 %	18.46 %	24.30 %	18.17 %
TEXAS (TX)	19.73 %	18.17 %	22.83 %	17.32 %

Readmissions: All Hospitals



Readmission Rates — CHANGE CATEGORY

Group By: None | Health System | HRR

Average Medicare hospital 30-day readmission rates for heart fa...	Heart Attack Patients Readmitted to Hospital Within 30 Days	Heart Failure Patients Readmitted to Hospital Within 30 Days	Pneumonia Patients Readmitted to Hospital Within 30 Days
Q3/09 - Q2/12	Q3/09 - Q2/12	Q3/09 - Q2/12	Q3/09 - Q2/12
NATIONAL AVERAGE			
19.89 % *	18.30 %	23.00 %	17.60 %
BROTMAN MEDICAL CENTER (CA)			
N/A	N/A	N/A	N/A
HOLLYWOOD COMMUNITY HOSPITAL OF HOLLYWOOD (CA)			
18.60 %	18.80 %	22.40 %	16.90 %
HOLLYWOOD COMMUNITY HOSPITAL OF VAN NUYS (CA)			
N/A	N/A	N/A	N/A
LOS ANGELES COMMUNITY HOSPITAL (CA)			
21.71 %	18.40 %	25.80 %	19.20 %
NIX HEALTH CARE SYSTEM (TX)			
20.29 %	18.00 %	22.90 %	17.00 %
ROGER WILLIAMS HOSPITAL (RI)			
19.66 %	18.00 %	23.50 %	16.90 %
ST JOSEPH HEALTH SERVICES OF RI (RI)			
22.54 %	19.30 %	25.20 %	20.30 %

Readmissions: Roger Williams

Roger Williams Hospital
825 CHALKSTONE AVENUE
Providence, RI 02908

Readmission Rates CHANGE CATEGORY

	Q3/09-Q2/12	Q3/08-Q2/11	Q3/07-Q2/10	Q3/06-Q2/09
AVERAGE MEDICARE HOSPITAL...	19.66 %	20.80 %	21.30 %	N/A
HEART ATTACK PATIENTS REA...	18.00 %	19.00 %	19.60 %	18.80 %
HEART FAILURE PATIENTS RE...	23.50 %	26.10 %	25.10 %	27.60 %
PNEUMONIA PATIENTS READMI...	16.90 %	16.90 %	18.20 %	18.70 %

Readmissions: St Joseph

St Joseph Health Services Of Ri
200 HIGH SERVICE AVENUE
North Providence, RI 02904

Readmission Rates CHANGE CATEGORY

	Q3/09-Q2/12	Q3/08-Q2/11	Q3/07-Q2/10	Q3/06-Q2/09
AVERAGE MEDICARE HOSPITAL...	22.54 %	23.56 %	22.89 %	N/A
HEART ATTACK PATIENTS REA...	19.30 %	20.10 %	21.00 %	22.00 %
HEART FAILURE PATIENTS RE...	25.20 %	26.70 %	25.90 %	25.80 %
PNEUMONIA PATIENTS READMI...	20.30 %	20.30 %	19.30 %	19.40 %

Readmissions: Nix

Nix Health Care System
414 NAVARRO
San Antonio, TX 78205

Readmission Rates — CHANGE CATEGORY

	Q3/09-Q2/12	Q3/08-Q2/11	Q3/07-Q2/10	Q3/06-Q2/09
AVERAGE MEDICARE HOSPITAL...	20.29 %	21.13 %	19.66 %	N/A
HEART ATTACK PATIENTS REA...	18.00 %	19.70 %	18.50 %	19.60 %
HEART FAILURE PATIENTS RE...	22.90 %	24.00 %	21.70 %	23.80 %
PNEUMONIA PATIENTS READMI...	17.00 %	18.10 %	17.90 %	17.60 %

Readmissions: SoCal Hollywood

Hollywood Community Hospital Of Hollywood

6245 DE LONGPRE AVE
Hollywood, CA 90028

Readmission Rates — CHANGE CATEGORY

	Q3/09-Q2/12	Q3/08-Q2/11	Q3/07-Q2/10	Q3/06-Q2/09
AVERAGE MEDICARE HOSPITAL...	18.60 %	19.72 %	21.10 %	N/A
HEART ATTACK PATIENTS REA...	N/A	N/A *	N/A *	N/A
HEART FAILURE PATIENTS RE...	22.40 %	25.70 %	26.10 %	26.20 %
PNEUMONIA PATIENTS READMI...	16.90 %	17.50 %	18.90 %	18.70 %

Readmissions: LA Community

Los Angeles Community Hospital
4081 E OLYMPIC BLVD
Los Angeles, CA 90023

Readmission Rates CHANGE CATEGORY

	Q3/09-Q2/12	Q3/08-Q2/11	Q3/07-Q2/10	Q3/06-Q2/09
AVERAGE MEDICARE HOSPITAL...	21.71 %	24.63 %	25.20 %	N/A
HEART ATTACK PATIENTS REA...	18.40 %	N/A *	N/A *	N/A
HEART FAILURE PATIENTS RE...	25.80 %	28.10 %	28.30 %	25.60 %
PNEUMONIA PATIENTS READMI...	19.20 %	21.30 %	21.90 %	20.30 %

Readmissions: SoCal Culver City

Brotman Medical Center
3828 DELMAS TERRACE
Culver City, CA 90232

Readmission Rates — CHANGE CATEGORY

	Q3/08-Q2/11	Q3/07-Q2/10	Q3/06-Q2/09
AVERAGE MEDICARE HOSPITAL...	22.49 %	22.75 %	N/A
HEART ATTACK PATIENTS REA...	19.80 %	19.10 %	20.20 %
HEART FAILURE PATIENTS RE...	24.40 %	26.30 %	28.50 %
PNEUMONIA PATIENTS READMI...	21.50 %	20.60 %	19.10 %

Additional Quality Areas

2398

Assessment and Findings

Review the service lines and clinical services delivered by the hospital to ascertain whether adequate resources will continue to be available for those services.

Assessment and Findings

Review bed availability, staffing, occupancy and maintenance of adequate resources to provide care.

Assessment and Findings

- Review Information Technology, including
  - Electronic Health Records' Platforms and Investments
  - Access to Health Information Exchanges
  - Meaningful Use Cert.
  - HIMSS Analytics

US EMR Adoption Model℠

Stage	Cumulative Capabilities	2008 Year End	2013 Q3
Stage 7	Complete EMR, CCD transactions to share data; Data warehousing; Data continuity with ED, ambulatory, OP	0.0%	2.2%
Stage 6	Physician documentation (structured templates), full CDSS (variance & compliance), full R-PACS	0.1%	11.1%
Stage 5	Closed loop medication administration	0.5%	20.9%
Stage 4	CPOE, Clinical Decision Support (clinical protocols)	3.1%	15.1%
Stage 3	Nursing/clinical documentation (flow sheets), CDSS (error checking), PACS available outside Radiology	18.7%	31.9%
Stage 2	CDR, Controlled Medical Vocabulary, CDS, may have Document Imaging; HIE capable	40.0%	8.4%
Stage 1	Ancillaries - Lab, Rad, Pharmacy - All Installed	17.4%	3.5%
Stage 0	All Three Ancillaries Not Installed	20.4%	6.9%

Data from HIMSS Analytics® Database © 2013 HIMSS Analytics N = 4237 N = 5437

HIMSS Analytics

Assessment and Findings

Review Public Health Indicators for the population served, including Kaiser Family Foundation, California Health Care Foundation, and other public data.

Assessment and Findings

Review additional external certifications such as Magnet, Baby Friendly, CARF, and Disease Management Certifications such as stroke, diabetes, et al.

Assessment and Findings

Review any available public citations for fraud and abuse as they pertain to provision of care.

Assessment and Findings

Review external grading agency reports as available, including but not limited to US News, Healthgrades, Leapfrog, and Consumer Reports.

Assessment and Findings

Review PSO participation and any public or submitted information about adverse events.

Assessment and Findings

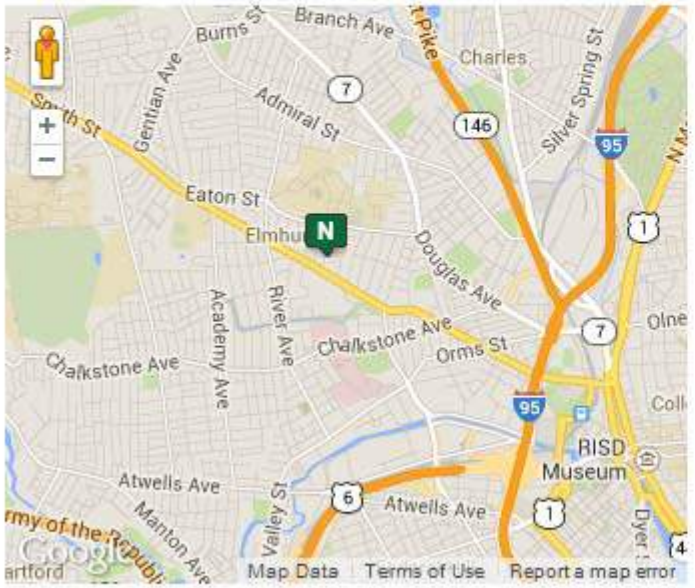
For any wholly-owned or affiliated nursing homes and other post-acute hospital care organizations, review nursing home compare, homecare compare and any submitted information.

Elmhurst Extended Care Facility

ELMHURST EXTENDED CARE FACILITY

50 MAUDE STREET
PROVIDENCE, RI 02908
(401) 456-2600

Add to my Favorites
Map and Directions



Nursing home information

- 206 Certified Beds
- Participates in ℹ: Medicare and Medicaid
- Ownership ℹ: Non profit - Corporation
- Automatic Sprinkler Systems ℹ in All Required Areas: Yes
- Not in a Continuing Care Retirement Community ℹ (CCRC)
- Not in a Hospital
- Resident Council Only ℹ

Star Rating Summary

Overall Rating ℹ	★★★★★ Above Average
Health Inspection ℹ	★★★★★ Below Average
Staffing ℹ	★★★★★ Above Average
Quality Measures ℹ	★★★★★ Much Above Average

http://www.medicare.gov/nursinghomecompare/results.html#s
xlat=0&lng=0&AspxAutoDetectCookieSupport=1
accessed April 3 2014

CharterCare Home Health Services

- **CharterCare Home Health Services performed at or above the national average for Home Health Care Agencies in all categories.**

http://www.medicare.gov/homehealthcompare/profile.html#profTab=2&ID=417029&state=RI&lat=0&lng=0&name=CharterCare accessed April 6 2014

Assessment and Findings

Review status of ACGME or AOA oversight and accreditation or citations of any training programs that exist.

Assessment and Findings

Review Quality Improvement activities.

Conclusion

Based on my review of all available material, my role and experience as an expert consultant in the six domains of Quality, and my review of the statutory requirements for a Change in Effective Control and Hospital Conversion, my opinion is that the transacting parties satisfy all the requirements identified in RIGL 23-17-14.3 "Licensing of Health Care Facilities" and HCA 23-17.14-3, 23-17.14-4 and 23-17.14-8 that pertain to a quality review.

RESPONSE TO DEFICIENCIES
EXHIBIT N - Quality Metrics for 2014

Prospect Medical Holdings

Outcome Measures

For the period of 1/1/14 - 12/31/14
Source: www.medicare.gov/hospitalcompare

Readmissions & Deaths Tab

Readmissions Reduction Program Measures: (Risk Adjusted)

	Rate of Unplanned Readmission by Medical Condition					
	COPD	**AMI**	**CHF**	**Pneumonia**	**Stroke**	**Hospital Wide**
LACH	No Diff	No Diff	No Diff	No Diff	No Diff	No Diff
SCH	No Diff	No Diff	No Diff	No Diff	No Diff	No Diff
Nix	No Diff	No Diff	No Diff	No Diff	No Diff	No Diff
RW	No Diff	No Diff	No Diff	No Diff	No Diff	No Diff
OLF	No Diff	No Diff	No Diff	No Diff	No Diff	No Diff
National Avg	20.2%	17.0%	22.0%	16.9%	12.7%	15.2%
MGH	No Diff	No Diff	No Diff	No Diff	No Diff	No Diff
RGH	No Diff	N/A(3)	No Diff	No Diff	No Diff	No Diff

30-Day Mortality: (Risk Adjusted)

	Death Rate by Medical Condition				
	COPD	**AMI**	**CHF**	**Pneumonia**	**Stroke**
LACH	No Diff	No Diff	No Diff	Better (2)	No Diff
SCH	Better (1)	No Diff	No Diff	Better (2)	No Diff
Nix	No Diff	No Diff	No Diff	No Diff	No Diff
RW	No Diff	No Diff	No Diff	No Diff	No Diff
OLF	No Diff	No Diff	No Diff	No Diff	No Diff
National Avg	7.7%	14.2%	11.6%	11.5%	14.8%
MGH	No Diff	No Diff	No Diff	No Diff	No Diff
RGH	No Diff	No Diff	No Diff	No Diff	No Diff

Complications Tab

Complications: (Risk Adjusted)

	Hip/Knee Surgery	Serious Complication	Deaths/Treat Comp.
LACH	N/A(3)	No Diff	No Diff
SCH	N/A(3)	No Diff	No Diff
Nix	No Diff	No Diff	No Diff
RW	No Diff	No Diff	No Diff
OLF	No Diff	No Diff	Worse
National Avg	3.1%	0.8%	11.8%
MGH	No Diff	No Diff	No Diff
RGH	No Diff	No Diff	N/A(3)

Healthcare-associated Infections: (Risk Adjusted)

	Central Line	Catherter	Surgical Site:Colon	MRSA	Intestinal
LACH	No Diff	Better	N/A	Worse	Better
SCH	No Diff	No Diff	No Diff	No Diff	No Diff
Nix	No Diff	Worse	No Diff	No Diff	Better
RW	No Diff	Worse	No Diff	No Diff	No Diff
OLF	No Diff	No Diff	No Diff	No Diff	No Diff
MGH	No Diff	No Diff	No Diff	No Diff	Better
RGH	No Diff	No Diff	N/A(4)	N/A(4)	No Diff

Key:

LAC - Los Angeles Community Hospital, and Norwalk Campus, CA
SCH - Southern California Hospital, Culver City, Hollywood and Van Nuys Campuses, CA
NIX - Nix Health System, TX
RW - Roger Williams Medical Center, RI
OLF - Our Lady of Fatima, RI
MGH - Manchester General Hospital, CT
RGH - Rockville General Hospital, CT

Prospect Medical Holdings

Timely and Effective Care Measures

For the period of 1/1/14 - 12/31/14

Source: www.medicare.gov/hospitalcompare

Timely and Effective Care Tab

Timely and Effective Care - Heart Attack and Pneumonia Care

	Asprin at Discharge - AMI	Statin At Discharge - AMI	Appr. Antibiotics - Pnem
LACH	100%	91%	73%
SCH	100%	100%	N/A(4)
Nix	100%	98%	92%
RW	98%	86%	100%
OLF	100%	85%	97%
National Avg	99.0%	99.0%	96.0%
MGH	100%	94%	95%
RGH	N/A(4)	N/A(4)	97%

Timely and Effective Care - Surgical Care

	O/P Antibiotic w/hour	I/P Antibiotic w/hour	Antibiotics stopped w/24 post	Trt to Prevent Blood Clots	Continue Beta Blockers	Removal of Urinary Cath
LACH	N/A(4)	71%	97%	76%	95%	100%
SCH	98%	96%	81%	98%	98%	96%
Nix	100%	99%	97%	100%	97%	95%
RW	95%	100%	98%	99%	97%	96%
OLF	98%	100%	99%	100%	99%	99%
National Avg	98.0%	99.0%	98.0%	100.0%	98.0%	98.0%
MGH	98%	99%	99%	100%	98%	100%
RGH	97%	100%	100%	100%	100%	100%

Timely and Effective Care - Emergency Department Care

	Avg wait time/Broken Bone	Left before being seen
LACH	56 minutes	1%
SCH	68 minutes	4%
Nix	41 minutes	4%
RW	69 minutes	3%
OLF	75 minutes	1%
National Avg	54 minutes	2%
MGH	60	3%
RGH	50	1%

Timely and Effective Care - Preventive Care

	Patients given Flue Shot	Health Workers Flue Shot
LACH	76%	74%
SCH	92%	64%
Nix	98%	95%
RW	80%	90%
OLF	92%	90%
National Avg	93.0%	84.0%
MGH	95%	94%
RGH	94%	97%

Timely and Effective Care - Stroke Care

	Preventive Anti-Clot/2 days	Anti-clot/2 days	Anti-Clot prior/discharge	Medicine to Lower CHL	Eval for Rehab
LACH	88%	87%	96%	86%	93%
SCH	100%	100%	100%	99%	100%
Nix	98%	91%	100%	88%	100%
RW	100%	91%	100%	95%	95%
OLF	98%	91%	98%	92%	95%

National Avg	98.0%	97.0%	99.0%	96.0%	98.0%
MGH	98%	91%	100%	97%	94%
RGH	100%	93%	100%	100%	100%

Timely and Effective Care - Blood Clot Prevention & Treatment

	Trx on same day	Trx on Day +1 ICU	Pat who did not receive Trx	Trx X2 Thinners	Written Edu. Materials
LACH	82%	93%	17%	93%	100%
SCH	91%	97%	0%	100%	100%
Nix	80%	81%	20%	97%	100%
RW	84%	93%	N/A(4)	94%	N/A(4)
OLF	86%	98%	8%	98%	100%
National Avg	92.0%	96.0%	6.0%	95.0%	89.0%
MGH	97%	98%	N/A(4)	98%	76%
RGH	94%	99%	N/A(4)	100%	88%

Use of Medical Imaging Tab

Timely and Effective Care - O/P

	O/P Breast Screening - Rad	O/P CT Chest Combo Scan	O/P CT Scans Abd Combo
LACH	N/A(4)	N/A(4)	N/A(4)
SCH	N/A(4)	0.0%	2.8%
Nix	8.7%	2.2%	11.2%
RW	2.1%	0.3%	14.9%
OLF	24.5%	0.0%	7.1%
National Avg	8.9%	2.4%	9.4%
MGH	14.7%	0.0%	3.1%
RGH	12.3%	0.6%	4.6%

Key:
LAC - Los Angeles Community Hospital, and Norwalk Campus, CA
SCH - Southern California Hospital, Culver City, Hollywood and Van Nuys Campuses, CA
NIX - Nix Health System, TX
RW - Roger Williams Medical Center, RI
OLF - Our Lady of Fatima, RI
MGH - Manchester General Hospital, CT
RGH - Rockville General Hospital, CT

RESPONSE TO DEFICIENCIES
EXHIBIT O Information Contained in Requested APA Schedules

Owned Real Property DRAFT

Last Updated: 10 16 2015

Owned Real Property Address	City	State	Zipcode	Property Description
17 Armory Street	Manchester	CT	06040	Residential
19 Armory Street	Manchester	CT	06040	Residential
319 Broad Street	Manchester	CT	06040	Thrift Shop/Commercial
460 Hartford Turnpike	Vernon	CT	06066	Commercial
18 Haynes Street	Manchester	CT	06040	Office Building/Commercial
26 Haynes Street	Manchester	CT	06040	Office Building/Commercial
36 Haynes Street	Manchester	CT	06040	Office Building/Commercial
44 Haynes Street	Manchester	CT	06040	Office Building/Commercial
56 Haynes Street	Manchester	CT	06040	Vacant lot
71-80 Haynes Street	Manchester	CT	06040	Hospital
37-97 Hemlock Street	Manchester	CT	06040	vacant land
314 Main Street	Manchester	CT	06040	Parking lot
320 Main Street	Manchester	CT	06040	Office Building/Commercial
353 Main Street	Manchester	CT	06040	Office Building/Commercial
945 Main Street	Manchester	CT	06040	Office Condominium
310-312 Main Street	Manchester	CT	06040	Mixed Use
190 Meadow Street	Lee	MA	01260	Time Share
150 North Main Street	Manchester	CT	06040	Office Building
72 Russell Street	Manchester	CT	06040	Residential
110 Russell Street	Manchester	CT	06040	Residential
26 Shenipsit Lake Road	Tolland	CT	06084	Elder Care/Commercial
62 So. Hawthorne Street	Manchester	CT	06040	vacant land
66 So. Hawthorne Street	Manchester	CT	06040	vacant land
11 South Alton Street	Manchester	CT	06040	Residential
77 South Alton Street	Manchester	CT	06040	vacant land
31 Union Street	Vernon	CT	06066	Hospital
35 Village Street	Vernon	CT	06066	vacant land
22-25-26 Village Street	Vernon	CT	06066	Vacant Building
8-11-12 Ward Street	Vernon	CT	06066	Vacant Land
70 West Middle Turnpike	Manchester	CT	06040	Residential
74 West Middle Turnpike	Manchester	CT	06040	Residential
88 West Main Street	Vernon	CT	06066	Parking lot
94 West Middle Turnpike	Manchester	CT	06040	Residential
98 West Middle Turnpike	Manchester	CT	06040	Residential
104 West Middle Turnpike	Manchester	CT	06040	Residential
108 West Middle Turnpike	Manchester	CT	06040	Residential
114 West Middle Turnpike	Manchester	CT	06040	Residential
28-34-40-46-50 West Middle Turnpike	Manchester	CT	06040	Parking lot

Leased Real Property DRAFT

Last Updated: 10 16 2015

Leased Real Property Address	City	State	Zipcode	Property Description
1707 Boston Turnpike	Coventry	CT	06238	Commercial
47 Hartford Turnpike	Vernon	CT	06066	Commercial
57 Hartford Turnpike	Vernon	CT	06066	Commercial
130 Hartford Road	Manchester	CT	06040	Commercial
428 Hartford Turnpike	Vernon	CT	06066	Commercial
428 Hartford Turnpike	Vernon	CT	06066	Commercial
29 Haynes Street	Manchester	CT	06040	Commercial
100 Haynes Street	Manchester	CT	06040	Commercial
100 Haynes Street	Manchester	CT	06040	Commercial
100 Haynes Street	Manchester	CT	06040	Commercial
622 Hebron Avenue	Glastonbury	CT	06033	Commercial
622 Hebron Avenue	Glastonbury	CT	06033	Commercial
28 Main Street	East hartford	CT	06118	Commercial
146 Merrow Road	Tolland	CT	06084	Commercial
11 Pinney Street	Ellington	CT	06029	Commercial
95 Somers Road/Somers Crossing	Somers	CT	06071	Commercial
2400 Tamarack Avenue	South Windsor	CT	06074	Commercial
2400 Tamarack Avenue	South Windsor	CT	06074	Commercial
2400 Tamarack Avenue	South Windsor	CT	06074	Commercial
2600 Tamarack Avenue	South Windsor	CT	06074	Commercial
2600 Tamarack Avenue	South Windsor	CT	06074	Commercial
2600 Tamarack Avenue	South Windsor	CT	06074	Commercial
2800 Tamarack Avenue	South Windsor	CT	06074	Commercial
2800 Tamarack Avenue	South Windsor	CT	06074	Commercial
2800 Tamarack Avenue	South Windsor	CT	06074	Commercial
2800 Tamarack Avenue	South Windsor	CT	06074	Commercial
2800 Tamarack Avenue	South Windsor	CT	06074	Commercial
2800 Tamarack Avenue	South Windsor	CT	06074	Commercial
2800 Tamarack Avenue	South Windsor	CT	06074	Commercial
2800 Tamarack Avenue	South Windsor	CT	06074	Commercial
2800 Tamarack Avenue	South Windsor	CT	06074	Commercial
2800 Tamarack Avenue	South Windsor	CT	06074	Commercial
2800 Tamarack Avenue	South Windsor	CT	06074	Commercial
2800 Tamarack Avenue	South Windsor	CT	06074	Commercial
2800 Tamarack Avenue	South Windsor	CT	06074	Commercial
2800 Tamarack Avenue	South Windsor	CT	06074	Commercial
2800 Tamarack Avenue	South Windsor	CT	06074	Commercial
360 Tolland Turnpike, Suite 3E	Manchester	CT	06040	Commercial
145 Union Street	Vernon	CT	06066	Commercial
43 West Main Street	Vernon	CT	06066	Parking Lot
175 West Road	Ellington	CT	06029	Commercial
43 Woodland Street, Suite 280	Hartford	CT	06105	Commercial

Building Maintenance and Repairs

DRAFT

Last Updated: 11 6 2015

Property Address	City	State	Zipcode	Property Description	Property Description
22-25-26 Village Street	Vernon	CT	06066	Vacant Historical Building	Polish American Club Building Fire Damage, No Working Building systems or Utilities, Not in Working Order

Rent Roll

DRAFT

Last Updated: 10/16/2015

Lease Address (Street, City, Zip)	Current Month Rental Payment	Outstanding Concessions	Tenant Deposits	Lease Commencement Date	Space Lease Expiration Date	Square Footage of Space Leased	Renewal Options Available to Tenant
17 Armory Street, manchester, CT 06040	$875.00	None	$975.00 - Security Dep.	2/1/2012	1/31/2016	1,532	yearly
19 Armory Street, Manchester, CT 06040	$950.00	None	$1050.00 - Security Dep.	6/1/2015	5/31/2016	1,920	yearly
1707 Boston Tpke., Coventry, CT 06238	$1,829.50	None	0	2/1/2006	1/31/2018	1,280	yearly
460 Hartford Tpke., Vernon, CT 06066	$26,100.88	Before 8/31/2016 install new carpet	$20789.66 - Security Dep.	9/1/2006	8/31/2021	10,616	yearly
460 Hartford Tpke., Vernon, CT 06066	$7,267.00	None	$6828.77 - Security Dep.	11/1/2009	10/31/2015	3,785	yearly
460 Hartford Tpke., Vernon, CT 06066	$5,259.77	None	0	9/1/2007	8/31/2016	2,980	yearly
18 Haynes Street, Manchester, CT 06040	$5,400.50	None	0	12/1/2012	11/30/2017	3,066	5 years
18 Haynes Street, Manchester, CT 06040	$1,950.00	None	0	4/1/2015	3/31/2016	1,075	yearly
18 Haynes Street, Manchester, CT 06040	$310.00	None	0	10/1/2014	9/30/2016	session	yearly
26 Haynes Street, Manchester, CT 06040	$1,334.02	None	0	12/1/2010	11/30/2015	750	yearly
36 Haynes Street, Manchester, CT 06040	$6,698.33	None	0	4/11/2013	3/31/2018	3,719	5 years
44 Haynes Street, Manchester, CT 06040	$3,091.75	None	0	2/1/2007	1/31/2016	1,523	yearly
71 Haynes Street, Manchester, CT 06040	$453.57	None	0	7/1/2006	1/29/2017	190	yearly
622 Hebron Ave., Suite 104B, Glastonbury, CT 06033	$5,000.82	None	$2617.71 - Security Dep.	2/1/2012	1/31/2022	1,997	yearly
622 Hebron Ave., Suite 104C, Glastonbury, CT 06033	$546.36	None	$325.00 - Security Dep.	2/1/2012	1/31/2017	1,215	yearly
622 Hebron Ave., Suite 201, Glastonbury, CT 06033	$9,480.78	None	$3720.21 - Security Dep.	2/1/2012	1/31/2022	2,588	yearly
28 Main Street, East Hartford, CT 06118	$5,578.10	None	0	8/1/2008	7/31/2017	3,672	yearly
310 Main Street, Manchester, CT 06040	$900.00	None	850.00 - Security Dep.	1/4/2010	12/31/2015	1,018	yearly
312 Main Street, Manchester, CT 06040	$450.00	None	0	2/28/2005	month to month		yearly
353 Main Street, Manchester, CT 06040	$10,250.33	None	0	5/9/2014	4/30/2017	5,348	yearly
353 Main Street, Manchester, CT 06040	$300.00	None	0	12/1/2014	11/30/2015	session	yearly
353 Main Street, Manchester, CT 06040	$1,487.33	None	0	10/1/2015	9/30/2016	776	yearly
945 Main Street, Manchester, CT 06040	$3,776.26	None	0	7/1/2012	6/30/2016	2,330	yearly
146 Merrow Road, Tolland, CT 06084	$11,802.15	None	0	9/1/2008	6/30/2016	5,163	yearly
146 Merrow Road, Tolland, CT 06084	$8,102.43	None	$7719.75 - Security Dep.	10/1/2006	6/30/2016	3,431	5 years
146 Merrow Road, Tolland, CT 06084	$4,966.66	None	$4608.00 - Security Dep.	9/1/2006	6/30/2016	2,048	5 years
146 Merrow Road, Tolland, CT 06084	$2,275.00	None	$2600.00 - Security Dep.	4/30/2007	8/31/2016	1,340	5 years
150 North Main Street, Manchester, CT 06040	$6,947.46	None	$2925.00 - Security Dep.	6/1/2005	4/30/2016	4,672	yearly
72 Russell Street, Manchester, CT 06040	$800.00	None	0	12/1/2014	11/30/2016	1,150	yearly
110 Russell Street, Manchester, CT 06040	$1,500.00	None	$1500.00 - Security Dep.	2/1/2007	11/30/2015	1,976	yearly
11 South Alton Street, Manchester, CT 06040	$925.00	None	$1025.00 - Security Dep.	9/1/2003	8/31/2016	1,080	yearly
145 Union Street, Vernon, CT 06066	$4,109.38	None	0	3/15/2012	3/31/2016	1,968	yearly
145 Union Street, Vernon, CT 06066	$1,561.15	None	0	4/1/2009	3/31/2016	532	yearly
70 West Middle Tpke., Manchester, CT 06040	$900.00	None	$900.00 - Security Dep.	9/1/2002	10/31/2016	1,080	yearly
74 West Middle Tpke., Manchester, CT 06040	$900.00	None	$1000.00 - Security Dep.	1/15/2006	1/31/2016	1,320	yearly
94 West Middle Tpke., Manchester, CT 06040	$900.00	None	$1000.00 - Security Dep.	6/1/2010	5/31/2016	1,080	yearly
98 West Middle Tpke., Manchester, CT 06040	$975.00	None	$1075.00 - Security Dep.	8/1/2012	7/31/2016	1,270	yearly
104 West Middle Tpke., Manchester, CT 06040	$925.00	None	$1025.00 - Security Dep.	6/1/2012	6/30/2016	1,080	yearly
108 West Middle Tpke., Manchester, CT 06040	$925.00	None	$1025.00 - Security Dep.	6/1/2009	5/31/2016	1,200	yearly
175 West Road, Ellington, CT 06029	$579.25	None	0	4/12/2010	4/30/2016	252	yearly

Tenant Lease Encumbrances

DRAFT

Last Updated: 10 16 2015

None.

Environmental Claims DRAFT

Last Updated: 10 16 2015

On April 28, 2011 an Emergency Incident Report was made to the State of Connecticut, Department of Environmental Protection as to an in-ground tank failure resulting in the release of #6 Fuel Oil (Petroleum) at Manchester Memorial Hospital, 71 Haynes Street, Manchester, Connecticut. All corrective action items completed with the installation of four monitoring wells. Water samples will be regularly monitored. First report after installation had no issues.

On February 13, 2014 the Department of Energy and Environmental Protection (DEEP) was contacted as to a possible break in an oil line resulting in the release of hydraulic fuel oil at 36 Haynes Street, Manchester, CT. The area of concern was excavated and no break in the pipe was found. DEEP determined that the leak occurred under the building and was un-recoverable as digging under the foundation would jeopardize the building structure. The excavated area was restored. There are no follow-up action items.

Underground Storage Tanks and Waste Disposal

DRAFT

Last Updated: 10/22/2015

Underground Storage Tank Inventory							
Address	**City**	**State**	**Zipcode**	**Location**	**Tank #**	**Capacity (Gallons)**	**Contents**
71 Haynes Street	Manchester	CT	06040	MMH	D1R1	20,000	Heating Oil (#2)
71 Haynes Street	Manchester	CT	06041	MMH	C1R1	4,000	Diesel Fuel
71 Haynes Street	Manchester	CT	06042	MMH	B1R1	6,000	Diesel Fuel
31 Union Street	Vernon	CT	06066	RGH	O1R1	20,000	Fuel Oil
31 Union Street	Vernon	CT	06066	RGH	D1R1	5,000	Diesel Fuel

Waste Disposal Location					
Address	**City**	**State**	**Zipcode**	**Property Description**	**Prpperty Type**
1707 Boston Turnpike	Coventry	CT	06238	Commercial	Leased Real Property
130 Hartford Road	Manchester	CT	06040	Commercial	Leased Real Property
47 Hartford Turnpike	Vernon	CT	06066	Commercial	Leased Real Property
57 Hartford Turnpike	Vernon	CT	06066	Commercial	Leased Real Property
428 Hartford Turnpike	Vernon	CT	06066	Commercial	Leased Real Property
460 Hartford Turnpike	Vernon	CT	06066	Commercial	Owned Real Property
29 Haynes Street	Manchester	CT	06040	Commercial	Leased Real Property
100 Haynes Street	Manchester	CT	06040	Commercial	Leased Real Property
18 Haynes Street	Manchester	CT	06040	Office Building/Commercial	Owned Real Property
36 Haynes Street	Manchester	CT	06040	Office Building/Commercial	Owned Real Property
71-80 Haynes Street	Manchester	CT	06040	Hospital	Owned Real Property
622 Hebron Avenue	Glastonbury	CT	06033	Commercial	Leased Real Property
28 Main Street	East hartford	CT	06118	Commercial	Leased Real Property
353 Main Street	Manchester	CT	06040	Office Building/Commerical	Owned Real Property
945 Main Street	Manchester	CT	06040	Office Condominium	Owned Real Property
146 Merrow Road	Tolland	CT	06084	Commercial	Leased Real Property
150 North Main Street	Manchester	CT	06040	Office Building	Owned Real Property
25 Oakland Road	South Windsor	CT	06074	Commercial	Leased Real Property
11 Pinney Street	Ellington	CT	06029	Commercial	Leased Real Property
26 Shenipsit Lake Road	Tolland	CT	06084	Elder Care/Commercial	Owned Real Property
95 Somers Road/Somers Crossing	Somers	CT	06071	Commercial	Leased Real Property
2400 Tamarack Avenue	South Windsor	CT	06074	Commercial	Leased Real Property
2600 Tamarack Avenue	South Windsor	CT	06074	Commercial	Leased Real Property
2800 Tamarack Avenue	South Windsor	CT	06074	Commercial	Leased Real Property
360 Tolland Turnpike, Suite 3E	Manchester	CT	06040	Commercial	Leased Real Property
145 Union Street	Vernon	CT	06066	Commercial	Leased Real Property
31 Union Street	Vernon	CT	06066	Hospital	Owned Real Property
175 West Road	Ellington	CT	06029	Commercial	Leased Real Property
43 Woodland Street, Suite 280	Hartford	CT	06105	Commercial	Leased Real Property

RESPONSE TO DEFICIENCIES
EXHIBIT P CMS Statements of Deficiency

RESPONSE TO DEFICIENCIES
EXHIBIT P CMS Statements of Deficiency

Los Angeles Community Hospital

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA930000085	A. BUILDING: _____ B. WING _____	C 07/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOS ANGELES COMMUNITY HOSPITAL	4081 E OLYMPIC BLVD LOS ANGELES, CA 90023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E 292	Continued From page 1 Findings: 1. Patient 1 was admitted to the facility on 4/29/15 with diagnoses that included high blood sugar levels, anemia (low concentration of red blood cells), and acute respiratory failure. Patient 2 was admitted to the facility on 6/15/15 with diagnoses that included seizure disorder. During an interview with the Director of Quality Management on 7/8/15 at 10:35 AM, she stated Patient 2 had been physically assaultive to two staff nurses when Patient 2 pulled the two nurse's hair on 6/20/15 while they were inside Patient 2's room, and also had tried to kick the social worker on 6/20/15. During this interview with the Director of Quality Management, she further stated that on 6/21/15, Patient 2 hit Patient 1 in the face and Patient 1 sustained a jaw fracture. During an interview with the Lead Social Worker on 7/8/15 at 10:40 AM, she stated on 6/20/15, she was working with Patient 2 in Patient 2's room, when the patient became agitated and upset, and kicked out at her. She stated Patient 2's foot grazed her breast area and stomach. During this interview, the social worker further stated that Patient 2 had a "sitter" for one-to-one supervision that day because of the patient's risk of leaving the facility against physician order. During an interview with RN 1 (Registered Nurse) on 7/8/15 at 10:55 AM, she stated on 6/20/15 around lunchtime, she took over one-to-one supervision of Patients 1 and 2. She stated she and another nurse were looking down at paperwork and Patient 2 grabbed both of their	E 292	***Monitoring*** Nursing Supervisors will monitor nursing units daily for appropriate ratio of sitters to patients as ordered by physicians. Any non-conformity will immediately be corrected and reported to the CNO. ***Responsible Persons*** Chief Nursing Officer	7/21/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA930000085	A. BUILDING: _____ B. WING _____	C 07/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOS ANGELES COMMUNITY HOSPITAL	4081 E OLYMPIC BLVD LOS ANGELES, CA 90023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E2145	Continued From page 6 safety or health of patients, personnel or visitors would be reported as soon as reasonably practical, whether by telephone or by telegraph, to the CDPH (California Department of Public Health). The policy indicated the reporting timeframe would be no later than five days after the adverse event had been detected. The P&P further indicated the facility's Quality Management Department would e-mail the regulatory supervisor at the CDPH as well as e-mailing the sender to validate the delivery. In addition, the hospital Quality Management Department would fax the report to CDPH and secure the fax confirmation sheet to be kept on file for validation purposes.	E2145		
E2243	T22 DIV5 CH1 ART7-70751(g) Medical Record Availability (g) Medical records shall be completed promptly and authenticated or signed by a physician, dentist or podiatrist within two weeks following the patient's discharge. Medical records may be authenticated by a signature stamp or computer key, in lieu of a physician's signature, only when that physician has placed a signed statement in the hospital administrative offices to the effect that he is the only person who: This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure Patient 2's EHR (electronic health record) was complete and contained a discharge summary within two weeks after Patient 2 was discharged. Findings:	E2243	E2243 Medical Record Availability ***Corrective Action*** The discharge summary for Patient 2 was completed on 07/08/15 and added to the patient's record immediately. To assure other patients' discharge summaries are completed within two weeks following discharge, the Director of Health Information Management is tracking completion of discharge summaries on a daily basis and notifying physicians when they have not been completed timely. ***Monitoring*** Rates of completion of discharge summaries within 2 weeks is monitored and reported at monthly Quality Council meetings. ***Responsible Persons*** Director of Health Information Management	7/31/15

Alta Los Angeles Hospitals, Inc.

Los Angeles Community Hospital
4081 East Olympic Blvd.
Los Angeles, CA 90023
(323) 267-0477
(323) 881-2611 Fax

Los Angeles Community Hospital
at Norwalk
13222 Bloomfield Avenue
Norwalk, CA 90650
(562) 863-4763
(562) 207-9721 Fax

Los Angeles Community Hospital
at Bellflower
9542 Artesia Blvd.
Bellflower, CA 90706
(562) 273-1800
(562) 273-1818 Fax

July 29, 2015

Ms. Renee Buell, Health Facilities Evaluator Nurse
State of California Department of Public Health
Licensing and Certification Program
State Facilities Section
625 E. Carnegie Dr., Suite 280
San Bernardino, CA 92408

Dear Ms. Buell:

Attached you will find our Plan of Correction related to your visit of July 9, 2015, during which you investigated an incident involving a patient who assaulted another patient.

We feel we have adequately addressed your findings in this Plan of Correction. However, please feel free to contact us if further information is needed.

Sincerely,

Barbara Studer, RN, MAOM, CPHQ
Corporate Director of Quality & Risk Management

ENC: Plan of Correction (2567)

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA930000085	A. BUILDING: _____ B. WING _____	C 07/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOS ANGELES COMMUNITY HOSPITAL	4081 E OLYMPIC BLVD LOS ANGELES, CA 90023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E 000	Initial Comments The following reflects the findings of the California Department of Public Health during the investigation of an entity reported incident. Entity Reported Incident: CA00449364 Representing the Department: 2091, HFEN The investigation is limited to the specific entity reported incident investigated and does not represent the findings of a full inspection of the facility. Three deficiencies were written for entity reported incident CA00449364	E 000		
E 292	T22 DIV5 CH1 ART3-70215(a)(2) Planning and Implementing Patient Care (a) A registered nurse shall directly provide: (2) The planning, supervision, implementation, and evaluation of the nursing care provided to each patient. The implementation of nursing care may be delegated by the registered nurse responsible for the patient to other licensed nursing staff, or may be assigned to unlicensed staff, subject to any limitations of their licensure, certification, level of validated competency, and/or regulation. This Statute is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide one-to-one supervision as ordered by the physician for three of three sampled patients (Patient 1, Patient 2, and Patient 3). This failure resulted in Patient 1 sustaining a jaw fracture after being hit in the face by Patient 2.	E 292	E 292 Planning & Implementing Patient Care – One-to-One Supervision ***Corrective Action*** Patient 1 was immediately placed in a room separate from Patient 2 after being hit by Patient 2. Patient 2's discharge to a mental health unit was expedited. Regarding one-to-one observation of Patient 3, the ordering physician was contacted to clarify whether 1:2 or 1:3 observation would be acceptable. The physician indicated that 1:3 observation would be acceptable. Computerized order entry now offers a "SITTER" option, where prior to this, "1:1 Observation" was the only available choice when a physician ordered observation of a patient. This became effective 7/21/15. To assure other patients are appropriately observed when sitters are ordered, the policy, "Sitter Usage, Assessment and implementation," was revised to include criteria for observation by sitters, to include 1:1, 1:2, 1:3, and 1:4 sitter-to-patient ratios. Nursing Supervisors were in-serviced on the revised policy on 7/21/15.	

Licensing and Certification Division
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: COO (X6) DATE: 7-29-15

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA930000085	A. BUILDING: _____ B. WING _____	C 07/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOS ANGELES COMMUNITY HOSPITAL	4081 E OLYMPIC BLVD LOS ANGELES, CA 90023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E 292	Continued From page 1 Findings: 1. Patient 1 was admitted to the facility on 4/29/15 with diagnoses that included high blood sugar levels, anemia (low concentration of red blood cells), and acute respiratory failure. Patient 2 was admitted to the facility on 6/15/15 with diagnoses that included seizure disorder. During an interview with the Director of Quality Management on 7/8/15 at 10:35 AM, she stated Patient 2 had been physically assaultive to two staff nurses when Patient 2 pulled the two nurse's hair on 6/20/15 while they were inside Patient 2's room, and also had tried to kick the social worker on 6/20/15. During this interview with the Director of Quality Management, she further stated that on 6/21/15, Patient 2 hit Patient 1 in the face and Patient 1 sustained a jaw fracture. During an interview with the Lead Social Worker on 7/8/15 at 10:40 AM, she stated on 6/20/15, she was working with Patient 2 in Patient 2's room, when the patient became agitated and upset, and kicked out at her. She stated Patient 2's foot grazed her breast area and stomach. During this interview, the social worker further stated that Patient 2 had a "sitter" for one-to-one supervision that day because of the patient's risk of leaving the facility against physician order. During an interview with RN 1 (Registered Nurse) on 7/8/15 at 10:55 AM, she stated on 6/20/15 around lunchtime, she took over one-to-one supervision of Patients 1 and 2. She stated she and another nurse were looking down at paperwork and Patient 2 grabbed both of their	E 292	***Monitoring*** Nursing Supervisors will monitor nursing units daily for appropriate ratio of sitters to patients as ordered by physicians. Any non-conformity will immediately be corrected and reported to the CNO. ***Responsible Persons*** Chief Nursing Officer	

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	CA930000085	A. BUILDING: _____ B. WING _____	C 07/09/2015

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E 292	Continued From page 2 hair. RN 1 stated Patient 2 had a one-to-one "sitter" for high risk of leaving the facility without physician order, and because the patient "gets aggressive." During this interview, RN 1 stated, "The next day was the fight between the patients. ... (Patient 2) hit ... (Patient 1) in the face." During an interview with CNA 1 (Certified Nurse Assistant) on 7/8/15 at 11:25 AM, stated that on 6/21/15, she was assigned to "sitter" duties for Patient 1 and Patient 2 who shared the same room. CNA 1 stated Patient 1 was coming out of the restroom inside the patient room when Patient 2 "went and hit ... (Patient 1)." During this interview, CNA 1 stated that she was aware of Patient 2 pulling the nurses hair the day before and was afraid of Patient 2, so she sat in a chair by the doorway to supervise Patients 1 and 2. During a review of the EHR (electronic health record) for Patient 1, Physician Orders dated 6/20/15 at 6:53 AM, indicated an order for "1:1 Observation". During a review of the EHR for Patient 1, Physician Orders dated 6/21/15 at 7:38 AM, indicated an order for "1:1 Observation". During a review of the EHR for Patient 1, Assessment and Care Note dated 6/21/15 at 1:45 PM, indicated Patient 1 "was found with blood and several cuts on lips due to trauma caused by patient next to her." During a review of the EHR for Patient 1, an X-ray result dated 6/21/15, indicated Patient 1 had a fracture of the left lower jaw. During a review of the EHR for Patient 2, Physician Orders dated 6/19/15 at 7:05 PM, and	E 292		

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E 292	Continued From page 3 6/20/15 at 3:41 PM, indicated order for "1:1 Observation". During a review of Patient 2's EHR, Assessment and Cares documentation by nursing staff, dated 6/20/15 at 10:14 AM, indicated Patient 2 had a "1:1 sitter." During a review of Patient 2's EHR, Assessment and Cares documentation by nursing staff, dated 6/20/15 at 4:00 PM, indicated "received pt (Patient 2) very aggressive Ativan given pt with 1:1 sitter monitoring pt." During a review of Patient 2's EHR, Assessment and Cares documentation by nursing staff, dated 6/21/15 at 3:20 PM, indicated "pt with 1:1 sitter became very aggressive starting punching another pt in the face, separated pts...working on transferring pt to a psych facility. Pt place on 5150 (a 72 hour hold for danger to others or danger to self)." 2. Patient 3 was admitted to the facility on 6/23/15 with diagnoses that included unsteady gait. During a random observation of unit 3, room 207, a medical/surgical unit, on 7/9/15 at 9:05 AM, a four-patient room was occupied by four male patients. A staff member was located inside the room and identified himself as a hospital "sitter. During an interview with this hospital "sitter" on 7/9/15 at 9:05 AM, he stated he was assigned to watch three of the four patients inside the room for the duration of his shift on 7/9/15. He stated he "occasionally is assigned one-to-one observation, but not today." He further stated he sits on a chair by the doorway unless one of the patients needs help. During this interview, the	E 292		

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E 292	Continued From page 4 "sitter" stated Patient 3 is being observed because of an unsteady gait and has a history of falling. During an interview with a RN supervisor on 7/9/15 at 9:25 AM, he reviewed Patient 3's EHR and located a physician order dated 7/9/15 for "1:1 Observation." During this interview, the RN supervisor stated the "sitter" for this date was assigned to Patient 3 and two other patients in the same room. He further stated that a 1:1 supervision order means one staff supervises one patient, but further stated implementation depends on the patient mobility in bed, and the staff member assigned to watch the patient may also be assigned more than one patient to observe. During a review of Patient 3's EHR, physician order dated 7/9/15 indicated, "1:1 Supervision" for history of falls and unsteady gait.	E 292		
E2145	T22 DIV5 CH1 ART7-70737(a) Reporting (a) Reportable Disease or Unusual Occurrences. All cases of reportable diseases shall be reported to the local health officer in accordance with Section 2500, Article 1, Subchapter 4, Chapter 4, Title 17, California Administrative Code. Any occurrence such as epidemic outbreak, poisoning, fire, major accident, disaster, other catastrophe or unusual occurrence which threatens the welfare, safety or health of patients, personnel or visitors shall be reported as soon as reasonably practical, either by telephone or by telegraph, to the local health officer and to the Department. The hospital shall furnish such other pertinent information related to such occurrences as the local health officer or the Department may	E2145	E 2145 Reporting ***Corrective Action*** At a staff meeting on 7/22/15, all Quality Management Department staff reviewed CDPH reporting requirements and the hospital's policy on unusual occurrence reporting, emphasizing the importance of immediately faxing a report and not relying on the U. S. mail to deliver a report within the 5-day reporting period. ***Monitoring*** Quality Management will report a minimum of quarterly to the Quality Council regarding the length of time from recognition of an unusual occurrence to the reporting to CDPH of an unusual occurrence. ***Responsible Persons*** Director of Quality & Risk Management	7/22/15

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E2145	Continued From page 5 require. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to report an unusual occurrence of a patient to patient altercation within 5 days to the California Department of Public Health according to the facility Policy and Procedure titled, "Reporting Unusual Occurrences to the California Department of Public Health." This failure had the potential to compromise and threaten the welfare, safety or health of patients. Findings: During an interview with the Director of Quality Management on 7/8/15 at 1:45 PM, she stated unusual incidents should be reported to CDPH (California Department of Public Health) within 5 days. During an interview with the Director of Quality Management on 7/9/15 9:00 AM, she stated the incident was not telephoned in or faxed to CDPH, but was only mailed to CDPH via United States Postal Service on 6/23/15 and "thought it would get to CDPH on time." During this interview, she reviewed the stamped date and time of July 2, 2015 at 3:20 PM that indicated when the facility report of unusual occurrence was received by CDPH. The facility P&P (Policy and Procedure) titled "Reporting Unusual Occurrences to the California Department of Public Health" dated August, 2007, indicated it was the policy of the facility to report unusual occurrences which threaten the welfare,	E2145		

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E2145	Continued From page 6 safety or health of patients, personnel or visitors would be reported as soon as reasonably practical, whether by telephone or by telegraph, to the CDPH (California Department of Public Health). The policy indicated the reporting timeframe would be no later than five days after the adverse event had been detected. The P&P further indicated the facility's Quality Management Department would e-mail the regulatory supervisor at the CDPH as well as e-mailing the sender to validate the delivery. In addition, the hospital Quality Management Department would fax the report to CDPH and secure the fax confirmation sheet to be kept on file for validation purposes.	E2145		
E2243	T22 DIV5 CH1 ART7-70751(g) Medical Record Availability (g) Medical records shall be completed promptly and authenticated or signed by a physician, dentist or podiatrist within two weeks following the patient's discharge. Medical records may be authenticated by a signature stamp or computer key, in lieu of a physician's signature, only when that physician has placed a signed statement in the hospital administrative offices to the effect that he is the only person who: This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure Patient 2's EHR (electronic health record) was complete and contained a discharge summary within two weeks after Patient 2 was discharged. Findings:	E2243	E2243 Medical Record Availability ***Corrective Action*** The discharge summary for Patient 2 was completed on 07/08/15 and added to the patient's record immediately. To assure other patients' discharge summaries are completed within two weeks following discharge, the Director of Health Information Management is tracking completion of discharge summaries on a daily basis and notifying physicians when they have not been completed timely. ***Monitoring*** Rates of completion of discharge summaries within 2 weeks is monitored and reported at monthly Quality Council meetings. ***Responsible Persons*** Director of Health Information Management	

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E2243	Continued From page 7 During a review of Patient 2's EHR on 7/8/15, the face sheet indicated Patient 2 was discharged from the facility on 6/21/15. During an interview with the Director of Health Information Management on 7/8/15 at 2:00 PM, 17 days after Patient 2 was discharged, he reviewed the EHR for Patient 2 and was unable to locate a discharge summary. He stated the discharge summary had not been dictated by the physician yet. He stated the summary should have been dictated and in the patient's EHR by this date. He further stated that staffing had been low for the department that handles the dictations. During an interview with the Director of Health Information Management on 7/8/15 at 2:55 PM, he stated he was aware the clinical record for Patient 2 was "delinquent and had been flagged." He stated the discharge summary for Patient 2 was being typed at the time of this interview. The facility policy and procedure titled "Discharge and Death Summaries" dated April, 2008, indicated the physician must dictate a concise discharge summary which recapitulated the significant findings and events of the patient's hospitalization and condition on discharge. The policy indicated it was the responsibility of the Health Information Services department to monitor medical records to ensure the proper documentation was present.	E2243		

DEPARTMENTOF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	555638	A. BUILDING 01 – **MAIN BUILDING 01** B. WING_____	01/12/2014

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K 000	INITIAL COMMENTS This facility was surveyed under the Life Safety Code NFPA 101, 2000 Edition, Chapter 19, Existing Health Care Occupancies, and other applicable codes. The following represents the findings of the California Department of Public Health during a Life Safety Code Survey. Representing the California Department of Public Health: Evaluator 14041, REHS, HFE I	K 000		
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: NFPA 72, 1999 Edition, 208.2.1 Manual fire alarm boxes shall be located throughout the protected area so that they are unobstructed and accessible. Based on observation and interview, the facility failed to ensure that the only manual pull fire alarm device located in the hospital's licensed area was immediately available and visible at all times.	K 050	**Corrective Action** 1. Fire drill conducted in SubAcute. (See Attachment C-1 through C-9.) 2. Inservice was given during the drill in regards to the location of the pull stations in the nurse's area free of any obstacles. (See Attachment C-1 through C-9.) 3. Signage was placed above the nurse station pull device for activating fire alarm. (See Attachments A&B). **Date of Implementation** Fire Drill & Education conducted 1/31/14. **Monitoring Process** All fire drills are reviewed in the EOC/Safety Committee that meets 4 times a year. **Responsible Person** Director of Facilities	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 2/17/14

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K 050	Continued From page 1 Finding: On January 11, 2014, at 1:20 p.m., the evaluator conducted an inspection and observation of the life safety code system fire alarm devices. The evaluator held an interview with Staff 2 regarding the Life Safety Code System. The evaluator asked Staff 2 how she would activate the fire alarm. She stated that there were no manual pull fire alarms in the area and the closest fire alarm box was located near the exit doors outside the licensed area of the hospital. The evaluator held an interview with the building supervisor and he stated, "There is a manual pull alarm located in the nurse station." The evaluator had previously inspected the nurse station and she did not see a manual pull fire alarm. The building supervisor directed the evaluator to a section of nurse station used for the patient monitors and the communication system. A licensed nurse relocated one of the monitors and the evaluator saw a manual pull fire alarm. The computer monitor hid the manual pull fire alarm from view or access and there was no signage or information that manual pull alarm was available in the licensed area of the hospital in case of fire emergency. A review of the fire drills revealed that no one had activated the manual pull alarm at any time. NFPA 101 LIFE SAFETY CODE STANDARD	K 050	**Corrective Action** 1. Fire drill conducted in SubAcute. (See Attachment C-1 through C-9.) 2. Inservice was given during the drill in regards to the location of the pull stations in the nurse's area free of any obstacles. (See Attachment C-1 through C-9.) 3. Signage was placed above the nurse station pull device for activating fire alarm. (See Attachments A&B). **Date of Implementation** Fire Drill & Education conducted 1/31/14. **Monitoring Process** All fire drills are reviewed in the EOC/Safety Committee that meets 4 times a year. **Responsible Person** Director of Facilities	
K 051 SS=D	A fire alarm system with approved components,	K 051		

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K 051	Continued From page 2 devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that all activated smoke detector locations were correctly identified on the main fire alarm panel, in case of a fire emergency. Finding: On January 11, 2014, at 11:11 a.m., the evaluator conducted an inspection and observed a test of the fire alarm system devices. The Building Supervisor activated the patients'	K 051	**Corrective Action** 1. Vendor was called for service. 2. Vendor found a smoke detector that was faulty and replaced. System was tested and all signals were good. (See Attachment D). **Date of Implementation** 1/24/14 **Monitoring Process** Fire alarm systems are tested periodically with reporting to the EOC/Safety Committee that meets 4 times/year. **Responsible Person** Director of Facilities	

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K 051	Continued From page 3 sleeping room smoke detectors. The smoke detector located in room 102 activated and the alarm sounded. The evaluator checked the fire alarm panel and the panel incorrectly identified sleeping room 107 vs. room 102. The evaluator held an interview with the Building Supervisor and he stated that he would have the fire alarm panel serviced as soon as possible. NFPA 101 LIFE SAFETY CODE STANDARD	K 051		
K 061 SS=D	Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the fire sprinkler alarm system was monitored and maintained. Finding: On January 11, 2014, at 11:45 a.m., the evaluator conducted an inspection of the fire sprinkler supervised system. An interview was held with the facility building employee and he stated that the fire sprinkler alarm only sounds when a fire sprinkler is activated or if the fire sprinkler system is drained. The evaluator requested and observed a test of the fire sprinkler system tamper switch. The employee turned off the system control valve that	K 061	**Corrective Action** 1. Vendor was called for service. 2. Vendor replaced tamper switch. Later tested and all signals were good. (See Attachment E-1.) **Date of Implementation** 2/10/14 **Monitoring Process** The sprinkler system is periodically tested and reports of such are shared with the EOC/Safety Committee that meets 4 times/year. **Responsible Person** Director of Facilities	

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K 061	Continued From page 4 is connected to the tamper switch, and no local alarm sounded. The fire sprinkler system tamper switch is designed to alert the facility staff when the fire sprinkler system water is shut off for repairs, inadvertently, or maliciously. The fire sprinkler system shall be electronically supervised to locally alert the facility staff regarding a fire sprinkler flow, tamper, or trouble at all times. An interview was held with the Building Supervisor and he stated that he would have the tamper switch serviced as soon as possible. NFPA 101 MISCELLANEOUS	K 061		
K 130 SS=D	OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: NFPA 72, 1999 Edition, 2-8.2.1 Manual fire alarm boxes shall be located throughout the protected area so that they are unobstructed and accessible. Based on observation and interview, the facility fail to ensure that the only manual pull fire alarm device located in the hospital's licensed area was immediately available at all times. Finding: The evaluator conducted an inspection of the facility's licensed area with one central nurse	K 130		

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K 130	Continued From page 5 station, three smoke compartments, and one manual pull alarm. An interview was held with Staff 2 and she stated that there was no manual pull alarm located in the licensed area and she guided the evaluator outside the smoke compartments to the nearest exit door. The door lead directly outside and the evaluator observed a manual pull fire alarm device located adjacent to the floor. An interview was held with the building engineer and he stated that there was a manual pull fire alarm within the licensed area located in the nurse station. The building engineer led the evaluator to the nurse station and pointed to a patient monitor on a counter top. A licensed nurse sitting nearby pushed aside the monitor to reveal a manual pull alarm that was hidden from view. The evaluator did not observe any signage or indication that a manual pull fire alarm was available in the nurse station in case of a fire emergency.	K 130	**Corrective Action** 1. Fire drill conducted in SubAcute. (See Attachment C-1 through C-9.) 2. Inservice was given during the drill in regards to the location of the pull stations in the nurse's area free of any obstacles. (See Attachment C-1 through C-9.) 3. Signage was placed above the nurse station pull device for activating fire alarm. (See Attachments A&B). **Date of Implementation** Fire Drill & Education conducted 1/31/14. **Monitoring Process** All fire drills are reviewed in the EOC/Safety Committee that meets 4 times a year. **Responsible Person** Director of Facilities	
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555638	A. BUILDING 01 - **MAIN BUILDING 01** B. WING_____	01/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOS ANGELES COMM HOSPITAL	4081 EAST OLYMPIC BLVD. LOS ANGELES, CA 90023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144	Continued From page 6 This STANDARD is not met as evidenced by: NFPA 110 Standard for Emergency and Standby Power Systems 1999 Edition 6-4.1 Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly. 6-4.1 Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (a) under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating (b) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. NFPA 110 Standard for Emergency and Standby Power Systems 99 Ed 6-2.1, At least two sets of instruction manuals for all major generator components of the EPSS shall be supplied by the manufacturer(s) of the EPSS and shall contain the following: (a) A detailed explanation of the operation of the system (b) Instructions for routine maintenance (c) Detailed repair instructions for the EPS and other major components of the EPSS (d) An illustrated parts list and part numbers (e) Illustrated and schematic drawings of electrical wiring systems, including operating and safety devices, control panels, instrumentation and annunciators NFPA 99, Chapter 3, Electrical System, 3-4.4.1.1, Maintenance and Testing of Alternate Power Source and Transfer Switches (b) 3 Test	K 144	**Corrective Action** Inservice was performed to all plant operations staff in regards to understanding proper testing of the emergency generator and proper documentation. (See Attachments E-2 and E-3.) **Date of Implementation** 2/11/14 **Monitoring Process** Generator testing is reported to the EOC/Safety Committee that meets 4 times/year. **Responsible Person** Director of Facilities	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555638	A. BUILDING 01 - **MAIN BUILDING 01** B. WING_____	01/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOS ANGELES COMM HOSPITAL	4081 EAST OLYMPIC BLVD. LOS ANGELES, CA 90023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144	Continued From page 7 Personnel. The scheduled tests shall be conducted by competent personnel. The tests are need to keep the machines ready to function and, in addition, serve to detect causes of malfunction and to train personnel in operating procedures….. The Occupational Safety and Health Administration (OSHA) mandates training in such areas as electrical safety, personal protective equipment, and hazard communication. Relevance to emergency generators should be determined. Based on observation, interview, and record review, the facility failed to ensure that the back up source of power, the generator, was tested and maintained in accordance with the operator manual and by a staff that was trained. The facility failed to ensure that the monthly generator test documentation was fully documented with all the pertinent information regarding the status of the generator. Finding: On January 11, 2014, at 10:30, the evaluator conducted an inspection of the facility's Life Safety Code System. A review of the emergency generator monthly test and maintenance records revealed no information regarding the condition or status of the generator other than check marks, and there was no generator operating manual available at the time of the survey. An interview was held with the Building Supervisor and he stated that there was no documentation regarding the training of the staff in charge of the generator monthly test available	K 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555638	A. BUILDING 01 - **MAIN BUILDING 01** B. WING_____	01/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOS ANGELES COMM HOSPITAL	4081 EAST OLYMPIC BLVD. LOS ANGELES, CA 90023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144	Continued From page 8 at the time of the survey. In case of a loss of normal power, the emergency back up generator shall be tested and maintained based on the manufacturer's recommendation, all information shall be documented on the generator's monthly test record, and the staff in charge of the monthly test shall be trained and competent.	K 144		

Attachment A



Attachment B



Attachment C-1

ALTA Healthcare

Los Angeles Community Hospital

4081 East Olympic Blvd., Los Angeles Ca 90023

EDUCATION
Training Records

DEPARTMENT: DATE:

TOPIC: Fire Drill / Practice Pull station Activation

SHIFT: LOCATION:

Reason For Class / In Service:

- [x] Mandatory
- [x] Hospital Wide
- [x] Department
- [x] Staff Needs / Request
- [x] Safety
- [x] Risk Management
- [ ] New Product / Procedure
- [ ] Patient Population /
- [ ] Infection Control
- [x] Performanace Improvement
- [x] Annual Update
- [x] Competency
- [ ] Equipment
- [ ] **Other:**

Teaching Methods:

- [ ] Video
- [ ] Slide Presentation
- [x] Lectures
- [ ] Demonstration
- [ ] **Other:**

Instructor: (i.e., Sales Rep., Person with Expertise On Subject):

Jose A. Barahona

Objective (By the Completion of the Class/In-Service the learner will be able to):

EMPLOYEES WILL KNOW LOCATION, AND HOW TO ALARM PULL STATION PREVENT FIRE FROM SPREADING

TRAINING OUTLINE: INFORMED STAFF ABOUT LOCATION OF OXYGEN SHUT OFF VALVE / LOCATION OF NEAREST FIRE

RESPOND TO REAL FIRE & / EVACUATION ROUTE / LOCATION OF AIR CONDITIONING THERMOSTAT / TYPES OF

FIRE EXTINGUISHERS / HOW TO REPORT FIRE / HOW TO USE FIRE EXTINGUISHER / HOW TO EVACUATE

Class Outline: (May attach outline if there is one available): *SCHEDULE AND TRAINING ADJUSTED TO COMPLY WITH CDPH FINDING REQUEST***

SEE ATTACHED: PAGE 3 TO 5

Evaluation:

- [ ] Quiz
- [ ] Written Evaluation
- [ ] Return Demonstration
- [x] Discussion
- [ ] **Other:**

INSTRUCTOR: Jose A. Barahona.

SIGNATURE: Jose A. Barahona. TIME 2:45 DATE: 1.31.14

ALTA Healthcare

Los Angeles Community Hospital
4081 East Olympic Blvd., Los Angeles Ca 90023

EDUCATION
Training Records

FIRE / LIFE SAFETY

The mission of Fire and Life Safety management is to support the hospital in maintaining a safe environment for our patient, Visitors, and employees.
In the entire field of fire life safety, nothing is more important than prevention!

Prepare For The Fire:

- Keep fire alarm pull boxes, fire extinguishers, sprinkler heads, and smoke detectors free from obstruction.
- Keep corridors, passageways and exits clear at all times.
- Know the locations of the nearest fire alarm pull boxes and fire extinguishers in your area.
- Know the location of the closest exits, evacuation routes and what to do in response to the fire alarm
- Keep work areas and storage rooms free from combustible clutter and debris.
- Report defective electrical equipment, blocked exits, stairways, and fire doors to your Supervisor.
- DO NOT BLOCK EXITS.

Possible causes of fires include:

- Electrical equipment and small appliances;
- combustible materials-such as paper, cardboard boxes, dirty linen – pile up;
- Carelessness with oxygen;
- Arson.
- Keep an eye out for all these problems, and report them as appropriate.

Types of Fire:

CLASS "A"
fires occur in combustible solids, like paper, linen, and clothing. Can be extinguish by water.

CLASS "B"
Fires involving flammable liquids, such as gasoline, oil, alcohol, benzine, etc., which are best extinguished by smothering. (This includes food on the stove fires.)

CLASS "C"
Fires involving electrical equipment, appliances and wiring in which the use of non-conductive extinguishing agent prevents injury.

THE MAJORITY OF LACH & NCH FIRE EXTINGUISHERS ARE: **ABC TYPE**

The Fire Response Plan – RACE

- **RESCUE / The highest priority are saving people's Lives**, the first step is to get everyone out of the room or area where the fire is. We are especially concerned about patients who can't take care of themselves. Employees and visitors with disabilities will also need special attention.
  When leaving the room be sure to shut the doors behind you. They should latch, but not lock, so the fire fighters can get in when they arrive.

- **ALARM / Activate alarm.** (Know Location of Nearest Pull Station) Activating alarm ensures that the building occupants are alerted to the emergency and fire department is notified. call the PBX operator to report the fire. Be sure to take this step immediately after rescuing, so that the appropriate emergency response personnel are notified and can start to the scene of the fire.

  In addition to the alarm, call the emergency number- 911

  DIRECT OPERATOR HOTLINE:
  LACH Ext. 555 NCH Ext. 77

- CONTAIN / The third step is to keep the fire – and smoke – from spreading. Close each door and window in the area.
  If fire threatens your area, initiate the following procedures:

  a. Turn off all fans, air-conditioning, exhaust fans, etc.
  b. Turn off all electrically operated equipment, however leave the lights on.
  c. In case of an electrical fire, power is to be turned off at the main switch.
  d. Keep telephone lines clear.
  e. Close all doors and windows.
  f. Use the fire extinguisher to suppress the fire only if you have been trained and it is safe to do so.
  g. Notify the Control Center when you are in readiness for evacuation.
  h. Standby for orders.

  If the fire is not in your area, be alert, be guided by the instructions of your area supervisor, or Director of Plant Operations.

  a. Area supervisors will direct activities of staff members within their units by:
     - Assigning personnel to take fire extinguishers and reporting to the scene of the fire.
     - Turning off all fans, air-conditioning, exhaust fans.
     - Turning off utilities as required.
     - Turning off oxygen shut-off valves as required.
     - Closing all doors and windows.
     - Standing by for further orders.

- EXTINGUISH / When you reach the fourth step, it is time to attempt to extinguish the fire, by using a fire extinguisher.

The steps to Putting Out a Fire – PASS

- PULL the pin. / Break the plastic tie by turning the pin like a key in a lock, and then pull the pin out. Don't squeeze the handle while doing this.

- AIM the hose, horn at the base of the fire. Water extinguisher will shoot 30-40 feet when fully charged. The other kinds require you to get up to 8-10 feet away, or even closer.

- SQUEEZE the handle.

- SWEEP the stream from side to side, covering the material that is burning.

Evacuation

It is important for each employee to know their department's specific evacuation procedures. If evacuation is required, give special attention to children and person with disabilities. Go to your appropriate relocation point and verify that everyone from your area is accounted for. If someone is missing, notify fire department personnel on scene.

C-4

Los Angeles Community Hospital

SHIFT:	DAY	✓
	SWING	
	NIGHT	

FIRE OBSERVATION REPORT

DATE: 1-31-14

OBSERVERS LOCATION: Sub Acute

☑ Simulated Situation ☐ Fire ☐ Smoke ☐ Other _____

CAUSE & SOURCE OF FIRE:

☐ Bed ☑ Wastebasket ☐ Electrical ☐ Laundry ☐ Medical Gas
☐ Explosion ☐ Paper ☐ Wood ☐ Other _____

EXTENT OF FIRE:

☐ Large ☑ Small

INSTRUCTIONS:
Place "yes" in the blank space if conditions are satisfactory and "no" in space if unsatisfactory.

SAFETY OF LIFE

Yes ☐ No ☑ Occupant removed from the room. Simulated
Yes ☑ No ☐ closed to fire room.

NOTIFICATION / COMMUNICATION

Yes ☑ No ☐ Did Staff sound the alarm when the fire was recognized?
Yes ☑ No ☐ Did Staff sound the alarm by pulling down on the alarm box?
Yes ☑ No ☐ Notification from fire area to the PBX
Yes ☐ No ☑ Was the Fire department called? By who? Simulated
Yes ☑ No ☐ Administrator Paged? By who? PBX
Yes ☑ No ☐ Was fire alarm audible?
Yes ☑ No ☐ Was the page audible? Was the location clear?
Yes ☑ No ☐ "All Clear" sounded to all departments?

ORDERS

Yes ☑ No ☐ Was on duty personnel reported to assigned area and remained for orders?
Yes ☑ No ☐ Was personnel stationed at the telephone for further orders?
Yes ☐ No ☑ Was personnel sent to meet and direct the Fire Department? Sim
Yes ☐ No ☑ Were elevators brought down and held on the main floor? Sim.

RETURN/REPORT TO FIRE LOCATION

Yes ☑ No ☐ Were all doors closed?
Yes ☑ No ☐ Were Fire Extinguishers taken to the to the fire area?
Yes ☑ No ☐ Did Staff simulate fire extinguishment?
Yes ☑ No ☐ Did Staff know their specific fire response duties?

EVACUATION

C.5

_____ Horizontal (at least one set of fire doors)
_____ Vertical
_____ Total
Yes ☑ No ☐ Was Staff prepared to evacuate the building?

PATIENT AND VISITOR SAFETY

Yes ☑ No ☐ Were all exits and passageways leading to exits kept clear?
Yes ☑ No ☐ Were Patients and visitors escorted to a safe area?
Yes ☑ No ☐ Did personnel assisted in calming Patients and visitors?

EQUIPMENT AND APPLIANCES

Yes ☐ No ☑ Were gas appliances turned off
Yes ☐ No ☑ Were electrical equipment shut down? (Not lights) Sin dato
Yes ☐ No ☑ was it necessary to shut off oxygen?
Yes ☐ No ☑ Were HVAC systems shut off

PROTECTION OF HOSPITAL SUPPLIES AND RECORDS

Yes ☑ No ☐ Were the narcotics cabinets locked?
Yes ☐ No ☐ Were all cash, books, ledgers, charts & files prepared for removal?

INTERIM LIFE SAFETY MEASURES (ILSMS) (Los Angeles Community Hospital)

Before actual fire or Fire Drill:

Yes ☐ No ☑ Did Engineering, Security, or Housekeeping personnel SHUT OFF the air conditioning unit switches in the corridor adjacent to room 105 and 106. Sin

After actual fire or Fire Drill:

Yes ☐ No ☑ Did Engineering, Security, or Housekeeping personnel TURNED the air conditioning unit switches in the corridor adjacent to room 105 and 106. Sin

REMARKS AND RECOMMENDATIONS

Note: Reports to be made out immediately after each drill by the unit/department supervisor
Reports shall be sent to the Director of Plant Operations

Comments: No issues to Report.

1.31.14 / 2:45
Date / Time

Jose A. Barahona / Engineer. / Jose A. Barahona
Name / Position /Title / Signature

C-6

ALTA Healthcare

Los Angeles Community Hospital

4081 East Olympic Blvd., Los Angeles Ca 90023

Fire Drill Critique

Date: 1-31-14		Shift: day		
Location	Sub Acute	Fire Dept. Notified	☐ YES	☑ NO
Coordinator	Mohammad Davani	Drill Started	2:15 pm	
Engineer	Jose Barahona	Drill Ended	2:45 pm	
Safety Officer	Jim Ruiz			

✓	TYPE of Fire	✓	In-service Training
X	A- Wood, Paper, Rubbish	X	Verbal Critique
	B- Flammable, Oil, Gas	√	Hand0ut Training Memos
	C- Electrical		
	D-		

✓	Initiator Response	✓	Department Response
	Called Fire Department (911) NO	√	Administration
√	Called Operator (Ex. ~~555~~) ~~777~~	√	Admitting
	Called Emergency (911) NO	√	Security
√	Pulled Fire Alarm Pull Station	√	Engineering / Safety Officer

✓	PBX Operator Response	✓	Equipment Response
√	Time Before Announcement	√	First Bells Sounded
√	3 Time "Code Red (Location)"	√	Door Closed and Latched
√	Notified Appropriate Personnel		Oxygen was Shut Off Simulated
√	3 Time "Code Red All Clear"	√	Alarm System Was Reset

GENERAL RESPONSE			
✓	PBX Operator Response	✓	Equipment Response
	Excellent		Slow
√	Good	√	Calm
	Fair		Exited
	Poor		Panic

OBSERVATION MADE FROM: Unit 3

SIGNATURE: Brian Mulloy TIME 2:45 DATE: 1-31-14

C-7

ALTA Healthcare

Los Angeles Community Hospital

4081 East Olympic Blvd., Los Angeles Ca 90023

EDUCATION
Training Records

ATTENDANCE RECORD:

Date: 1.31.14

No.	NAME (PLEASE PRINT)	TITLE / DEPARTMENT	SIGNATURE
1	SILVIA ARBOLEDA	HIS	[signature]
2	Remy Miranda	HIS	[signature]
3	Martha Marquez	S/A	Martha Marquez
4	M GONZALEZ	ICU	[signature]
5	HECTOR CASTILLO	CNA/SKA	[signature]
6	Uracha Pinto	S/A	[signature]
7	Ana Capristo	CNA	[signature]
8	W. GIMETE	RN / Unit IV	[signature]
9	RICHARD GONSALVES	LAB	[signature]
10	Christine Joh	Pharmacy	[signature]
11	Claudia Rivera	CNA	[signature]
12	OCTAVIO LUNA	C.S.	[signature]
13	[illegible]	[illegible]	[signature]
14	NELSON TOGA	LVN/S/A	[signature]
15	MEALY MIN	S/A	[signature]
16	Arnold Sanchez	LVN	[signature]
17	[illegible]	RN	[signature]
18	Victor Paz	RN	[signature]
19	PINKY LITUANAS	PT	[signature]
20	Cesar Lopez	S/A	[signature]
21	Cegan	PT-WC	[signature]
22	Brian Gutierrez	ENG	Brian Gutierrez
23			

C-8

Los Angeles Community Hospital

4081 East Olympic Blvd., Los Angeles Ca 90023

SHIFT:	DAY	✓
	SWING	
	NIGHT	

Fire Drill Attendance Sign Sheet

Date: 1.31.14	Time: 2:15	Location: Sub Acute.

No.	Name:	Department:	Fire Ext.
1	[illegible]	LAB	
2	Christine Joh	Pharmacy	
3	[illegible]	U-4	
4	[illegible]	M/S	
5	Antonio Salazar	Resp.	
6	Claudia Rivera	M/S	
7	OCTAVIO LUNA	C.S.	
8	[illegible]	Icy	
9	NELSON TOBAR	S/A	
10	Arnold Sanchez	LUN	
11	MEALY MIN	SA	
12	SHENAN MERZA	SA	
13	Melissa Acero	SA	
14	ANNA PASTORES	SA	
15	DANIELLE JAMES	SA	
16	PINKY LITUANAS	PT	
17	[illegible] SHIRTICK	ACC-SB	
18	Catherine [illegible]	PT-WC	

FIRE DRILL TOPIC:

C-9

Los Angeles Community Hospital

4081 East Olympic Blvd., Los Angeles Ca 90023

SHIFT:	DAY	✓
	SWING	
	NIGHT	

Fire Drill Attendance Sign Sheet

Date: 1.31.14	Time: 2:15	Location: Sub Acute

No.	Name:	Department:	Fire Ext.
1	BOCFERIA	PEDS	
2	Isabel Vindel	S/A	
3	[illegible]	[illegible]	
4	[illegible]	[illegible] S/A	
5	FLORENCIO CRUZ	S/A	yes
6	SILVIA ARBOLEDA	HIS	
7	Remy Miranda	HIS	yes
8	M Gonzalez	ICU	yes
9	Martha Marquez	S/A	yes
10	Ana Capristo	S/A	
11	Hector Castillo	S/A	
12	W. GIMETE	OB UNIT IV	[illegible]
13	David Gale	[illegible] S/A	[illegible]
14	MARIANO RESTO	[illegible]	
15	Eric Abarca	E.R.	
16	Caroline Henderson SKN	Tele	
17	[illegible]	ER	
18	Victor Paz [illegible]	[illegible]	

FIRE DRILL TOPIC:

Attachment D

MID VALLEY AUTOMATIC FIRE PROTECTION SYSTEMS, INC.

347 Paseo Sonrisa
Walnut, CA 91789
(909) 594-4060 FAX: No. (909) 595-9828
www.midvalleyfire.com

WORK ORDER

№ A14102

DATE: 1/24/14

CUSTOMER NAME: Los Angeles Community Hospital

ADDRESS: _____

CITY: Los Angeles STATE: CA ZIP: _____

JOB LOCATION: _____

WORK DONE BY: Mary + Jon

PO#: _____

Smoke detector trouble

QUANTITY	ITEM	DESCRIPTION	PRICE	TOTAL
		Need to replace smoke detector on 1st fl. Patient Rm. #5.		
		Replaced smoke detector and fire alarm is now Normal, System Normal,		
		Mary		
		Trouble shoot 2 HRS.		190.00
		Replace w/ new 2 HR. minimum		190.00
				380.00

SUMMARY OF INSPECTION: _____

X Josh A. Berkhoan
CUSTOMERS SIGNATURE

Attachment E-1

MID VALLEY AUTOMATIC FIRE PROTECTION SYSTEMS, INC.

347 Paseo Sonrisa
Walnut, CA 91789
(909) 594-4060 FAX: No. (909) 595-9828
www.midvalleyfire.com

WORK ORDER

№

Alta Hospitals

DATE: 2/10/14

CUSTOMER NAME: Fox - Los Angeles Community Hospital

ADDRESS: 4081 Olympic Bl.

CITY: Los Angeles STATE: Ca ZIP: 90023

Acct # WK50131

JOB LOCATION:

WORK DONE BY: Harry

PO#:

* Check Tamper *

QUANTITY	ITEM	DESCRIPTION	PRICE	TOTAL
1	OS+Y	* Checked existing tamper and it was not operational. I showed George Martinez and he agreed that existing tamper was not operational. I replaced with a new potter OS+Y tamper and tested zone 1. operational and normal. (Alter Tamper) → * I was also instructed that system was not monitored anymore by Simplex so I got acct. Info from John Martinez at our office and I reprogrammed silent knight dialer to our central station and tested. System normal. Acct # is WK50131 Harry		

SUMMARY OF INSPECTION:

CUSTOMERS SIGNATURE

E-2

ALTA Healthcare

Los Angeles Community Hospital
4081 East Olympic Blvd., Los Angeles Ca 90023

EDUCATION
Training Records

DEPARTMENT: **Engineering** DATE: **2-11-14**

TOPIC: Testing and documenting of Emergency Generator

SHIFT: **1st Shift (Day)** LOCATION: **Generator Area**

Reason For Class / In Service:

- [x] Mandatory
- [x] Hospital Wide
- [ ] Department
- [ ] Staff Needs / Request
- [ ] Safety
- [ ] Risk Management
- [ ] New Product / Procedure
- [ ] Patient Population /
- [ ] Infection Control
- [ ] Performanace Improvement
- [ ] Annual Update
- [ ] Competency
- [x] Equipment
- [ ] **Other:**

Teaching Methods:

- [ ] Video
- [ ] Slide Presentation
- [ ] Lectures
- [ ] Demonstration
- [ ] **Other:**

Instructor: (notified Engineering staff of location of Manuals):
A COPY OF GENERATOR MANUAL IS LOCATED AT THE ENGINEERING OFFICE AND INSIDE THE GENERATOR ENCLOSURE.

Objective (By the Completion of the Class/In-Service the learner will be able to):
1.UNDERSTANDING THE EMERGENCY GENERATOR TESTING PROCESS AND THE PROPER DOCUMENTATION OF THE RESULTS. WE MUST INDICATE PROPER LEVELS AND OR RESPONSES NOT ONLY CHECK MARKS.

Class Outline: (May attach outline if there is one available):
*******THIS IS TRAINING IS TO COMPLY WITH CDPH FINDING *******

Evaluation:

- [ ] Quiz
- [ ] Written Evaluation
- [ ] Return Demonstration
- [x] Discussion
- [ ] **Other:**

INSTRUCTOR: MARTIN RODRIGUEZ / JIM RUIZ /GEORGE MARTINEZ

E-3

ALTA Healthcare

Los Angeles Community Hospital

4081 East Olympic Blvd., Los Angeles Ca 90023

EDUCATION
Training Records

ATTENDANCE RECORD:

Date: February 11 2014

No.	NAME (PLEASE PRINT)	TITLE / DEPARTMENT	SIGNATURE
1	BENNY ANAYA	HVAC MECHANIC/ENG.	
2	Brian Gutierrez	ENG	Brian Gutierrez
3	HIPOLITO. ORTEGA	ENG	Hipolito Ortega
4	Jose A. Barchona	Eng.	Jose A Barchona
5	Jose Romero	Eng. Dept.	
6			
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RESPONSE TO DEFICIENCIES
EXHIBIT P CMS Statements of Deficiency

Newport Specialty Hospital
(Now called Foothill Regional Medical Center)

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555710	A. BUILDING _____ B. WING _____	04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWPORT SPECIALTY HOSPITAL D/P SNF	14662 Newport Ave, Tustin, CA 92780-6064 ORANGE COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	The following reflects the findings of the Department of Public Health during a Comp'aint Investigation visit: CLASS B CITATION – PATIENT CARE 06-2207-0011387-F Complaint(s): CA00434111 Representing the Department of Public Health: Surveyor ID # 27007, HFEN The inspection was limited to the specific facility event investigated and does not represent the find ngs of a full inspection of the facility. Accidents and Supervision F323 G. The facility must ensure that the resident environment remains as free of accident hazards as is possible, and each resident receives adequate supervision and assistance devices to prevent accidents The facility failed to ensure Resident 1 was as free from accident hazards as possible Resident 1 was nonverbal, had contractures to her arms and hands, and was unable to move her extremities On 1/18/15, while attempting to dry Resident 1's hair, LVN 1 left a hairdryer on and placed in close proximity to Resident 1's left hand A few hours later, a staff member noticed Resident 1 had sustained blisters from a second degree burn to her left hand and left shoulder. Review of an article titled Hair Dryer Burns in Children published in 1990, by the Official Journal of the American Academy of Pediatrics showed	F323 G	Corrective actions for the affected resident: • Upon discovery of Resident's skin impairment, the physician was called, orders obtained and treatment was immediately initiated. • Consults obtained from wound care nurse and Infectious Disease physician. • Facility conducted a thorough investigation, including interviews with all staff. • Family was immediately notified upon discovery, and kept apprised of the resident's condition, plan of care, and told of the facilities plans to conduct a formal investigation. • Hairdryer was immediately removed from patient room. Hairdryers to be kept at nurses' station and checked out for use with patients, January 2015. • Safety check of hairdryer was done by engineering, January 2015. • Treatment was successful, and no longer required as of 3/12/2015. Wound healed completely, and without any scaring. The Director of Nurses was responsible to ensure the above mentioned actions were taken.	1/18/2015 1/24/2015 2/3/2015 1/18/2015 1/19/2015 1/24/15 3/12/2015

Event ID 5OLP11 4/14/2015 9:01:57AM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

CSO 4/14/15

By signing this document, I am acknowledging receipt of the entire citation packet. Page(s) 1 thru 7

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

State-2567

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555730	A. BUILDING _____ B. WING _____	04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWPORT SPECIALTY HOSPITAL DIP SNF	14662 Newport Ave, Tustin, CA 92780-6064 ORANGE COUNTY

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	testing of home hairdryers was done to determine their heat output. At the highest heat settings, the hairdryers rapidly generated temperatures in excess of 110°C (230 degrees F). After the hairdryers were turned off, the protective grills maintained sufficient temperatures to cause full-thickness burns for up to 2 minutes. These cases and the results of testing demonstrate that hairdryers must be added to the list of known causes of accidental and non-accidental burns in children. www.medicinenet.com showed a first degree burn is superficial and causes local inflammation of the skin. Sunburns often are categorized as first degree burns. The inflammation is characterized by pain, redness, and a mild amount of swelling. The skin may be very tender to touch. A second degree burn is deeper than a first degree burn and in addition to the pain, redness and inflammation, there is also blistering of the skin. Clinical record review for Resident 1 was initiated on 3/16/15. Resident 1, a pediatric, was admitted to the facility on 11/29/08, with diagnoses including severe encephalopathy, quadriplegia, and near vegetative state. Review of the computerized note (untitled) dated 1/18/15, showed Resident 1 was identified to have blisters to her left hand. The "primary nurse and CNA are unaware of how it may have happened." Review of the Nursing Progress/Summary Notes dated 1/18/15 at 1500 hours, identified Resident 1	F323 G	How the facility will identify other residents having the potential to be affected by the same deficit practice and what corrective action will be taken: ▪ Routine daily skin assessments of all residents are performed by the primary nurse each shift. ▪ Weekly comprehensive skin assessments will be performed by charge nurse and monitored daily for any identified skin issue. ▪ Ongoing spot checks of Hair Dryer usage to ensure that proper usage techniques are followed. The Director of Nurses is ultimately responsible to ensure the above actions are taken. All resident skin assessments completed. No other residents affected.	1/18/2015 1/18/2015 4/22/15 LM ~~4/15/15~~ Ongoing 1/18/15 LM

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	555730	A. BUILDING _____ B. WING _____	04/13/2015

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	had blisters to her left hand. At 2000 hours, staff documented there were multiple open, weeping fluid blisters to her left hand. On 1/19/15 at 1030 hours, staff documented Resident 1 also had a small blister to her left shoulder. Review of Resident 1's physician's order dated 1/20/15 at 1015 hours showed to administer Motrin and Tylenol (alternate) every four hours for 48 hours for pain prophylaxis. On 1/22/15 at 1315 hours, a physician's order was received to administer Motrin 220 mg via GT every eight hours for four days for pain. Review of Resident 1's Comprehensive Skin Assessments showed the following: * On 1/18/15 at 1600 hours, showed blisters and redness to the dorsal aspect (back) of Resident 1's left hand. The photograph showed multiple raised, fluid filled blisters. Staff documented if the blister was to open to apply Bacitracin (antibiotic) ointment four times a day for 10 days. * On 1/20/15 at 1100 hours, Resident 1's left hand blisters opened and draining serous fluid. The affected area measured 6 cm (length) x 4 cm (width). Staff documented Bacitracin ointment was to be started after the C&S of the left hand blister drainage was obtained. The photograph showed some of the blisters had popped and others remained filled with fluid. * On 1/23/15 at 0900 hours, the left hand blisters and redness were present and continued to be	F323G	What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: • New Equipment Usage policy, effective January 2015. Emphasized using all unit equipment only for the manufacturer's intended purpose, and included mandatory education of patient families wishing to use facility equipment to participate in the care of their family member. • New Treatment of Hypothermia policy, effective January 2015. Outlines appropriate use of Bair Hugger for patient warming, appropriate heat settings, and guidelines for monitoring patient while Bair Hugger is in use. • Hairdryers were immediately removed from patient rooms. • New lower wattage, short shaft hairdryers were ordered for the unit, 4/15/2015. • Hair dryer competency to be completed by all nursing staff, applicable to their patient care role. (DSO) • All staff educated by DON and Quality & Risk Director about the use of equipment, treating hypothermia, as well as informed about hairdryer usage and the need to monitor families use of such equipment. Staff also encouraged to actively participate in ongoing investigation and unit improvement activities The Director of Nurses will be ultimately responsible to ensure the above written action plan is followed.	1/27/2015 1/27/2015 1/18/2015 4/22/15 LH ~~4/15/2015~~ 4/22/15 LH ~~4/16/2015~~ 2/3/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIF CATION NUMBER	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555730	A BUILDING _____ B WING _____	04/13/2015

NAME OF PROVIDER OR SUPPL ER	STREET ADDRESS CITY STATE ZIP CODE
NEWPORT SPECIALTY HOSPITAL D/P SNF	14662 Newport Ave, Tustin, CA 92780-6064 ORANGE COUNTY

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	treated with Bacitracin ointment. * On 1/26/15 at 1800 hours, Resident 1's left hand blisters were assessed to be a second degree burn * On 1/29/15 at 2000 hours, staff documented all of Resident 1's blisters had popped The treatment was changed to Silvadene cream (medication used to treat burns) daily and to cover with a non-stick dressing for seven days On 3/10/15 at 1000 hours, staff documented Resident 1's left hand wound had completely healed Review of Resident 1's Doctors' Progress Note dated 1/24/15, showed an evaluation was completed by an Infectious Disease Consultant The doctor documented Resident 1 had a recent appearance of blisters over the left dorsal hand and fingers, and to treat the blisters as a "second degree burn" injury. Review of a (untitled) document dated 3/11/15 at 1616 hours, showed on 2/5/15 the left hand (blisters) healing well and appeared to be in much less pain. Review of the Restorative Administration Record for January 2015 showed Resident 1 was to have PROM to her upper extremities and the application of bilateral elbow extensor splints for 12 hours a day five days per week However, the RNA documented on the reverse side of the sheet from 1/20/15 to 1/30/15, the PROM and left hand splint were not provided due to the resident's left hand	F323G	How the facility plans to monitor its performance to make sure that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for effectiveness: • Daily routine daily skin assessments will be performed by the primary nurse and documented in the resident's medical record. • Weekly comprehensive skin assessments will be performed by charge nurse and monitored daily for any identified skin issue. • Quarterly reports of the results of skin assessment and reassessments will be submitted to Peds Committee, Quality Patient Safety Committee, Medical Executive Committee, and Governing Board To continue through 2015 and evaluated during annual evaluation. • Hair dryer competency to be completed by all new hires, and annually. This will be performed by the DSD. A competency report of findings will be submitted to the Pediatric Medical Staff Committee, Medical Executive Committee, and Governing Board. • Weekly spot checks of hairdryer usage to be done by charge nurses and data collected for at least 6 months with reevaluation to determine the need to continue. Results to be reported to DON and Director of Quality/Risk Management on a monthly basis. The Director of Nurses will be ultimately responsible to ensure the above written action plan is followed.	Ongoing since 9/2014 Ongoing since 9/2014 4/22/15 LM ~~4/16/15~~ 4/22/15 LM ~~4/16/15~~ 4/22/15 LM ~~4/16/15~~

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wound.

On 3/16/15 at 1405 hours, Resident 1 was observed sitting in her wheelchair next to her bed. She was unable to respond to verbal commands. Her arms and hands were contracted and the top of her left hand had multiple skin (pigment) discolorations as a result of the burn.

On 3/16/15 at 1455 hours, Resident 1's attending physician was interviewed. The physician stated Resident 1 had limited movement in her extremities and required total assistance from the staff for all ADL care. When asked how Resident 1 sustained the burn to her left hand, the physician stated he could not think of anything "hot enough" to cause a burn, but the item would have to be very close (to the left hand).

An interview with RN 1 was conducted on 3/16/15 at 1540 hours. RN 1 stated Resident 1 was showered every day on the day shift. She stated the resident's hair was washed during the showers.

On 3/16/15 at 1550 hours, an interview was conducted with CNA 1. CNA 1 stated before the burn to the resident's left hand, the resident's family and staff used a hairdryer to dry the resident's hair. CNA 1 stated the hairdryer was stored in Resident 1's room but had been removed after the 1/18/15 incident.

On 3/16/15 at 1605 hours, an interview was conducted with LVN 1. LVN 1 stated she was assigned to work as a caregiver for Resident 1 on

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	1/18/15. LVN 1 stated on the morning of 1/18/15, she gave Resident 1 a shower and washed her hair. She stated while Resident 1 was still lying on the shower gurney, she took the hairdryer from Resident 1's bedside to dry the resident's hair. LVN 1 stated when she was going to dry the back of her hair, she took the hairdryer from her left hand and placed it down near the top of the gurney, on the left side, so she could raise Resident 1's head. She stated the hairdryer was remained on while she was repositioning the resident's head. LVN 1 stated Resident 1's arms/hands were contracted (when lying down the resident's hands were up by her head) and the heat from of the hairdryer was blowing in the direction toward the resident's left hand. When LVN 1 was asked if she thought the burn could have been caused by the hairdryer being left on and placed at the head of the shower gurney, she stated the hairdryer was "the only thing it could have been." When LVN 1 was asked if the burn to Resident 1's hand could have been prevented, she stated "yes." She stated she could have placed Resident 1 in a wheelchair before she dried her hair, like she had seen other CNAs do. When LVN 1 was asked if she was aware of Resident 1's left shoulder blister that was observed on 1/19/15, she stated "no." During an interview on 3/16/15 at 1635 hours, the DON stated Resident 1 required total care from the staff for all her ADL care. When asked how Resident 1 sustained the burn to her left hand, the DON stated she was unable to determine the cause. The DON stated since the incident to Resident 1's left hand, all hairdryers had been			

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removed from all residents' rooms and were to have a safety check by the Maintenance Director

The facility's failure had a direct or immediate relationship to the health safety or security of long-term health care facility residents

State of California--Health and Human Services Agency
Department of Public Health

KAREN L. SMITH, MD, MPH
Director and State Health Officer

EDMUND G. BROWN JR.
Governor

April 8, 2015

Barbara Schneider, Administrator
Newport Specialty Hospital
14662 Newport Avenue
Tustin, CA 92780

Dear Ms. Schneider:

FACILITY: Newport Specialty Hospital
ENTITY REPORTED INCIDENT NUMBER'S: CA00325828 and CA00329252

The purpose of this letter is to inform you of the results of our entity reported incident investigation's completed on March 24, 2015.

Attached you will find a Statement of Deficiencies and Plan of Correction (CMS 2567), indicating that no deficiencies were found during this investigation. Please sign and date this document and return it to the department. Please make a copy for your facility.

Sincerely,

Hang Nguyen

Hang Nguyen, RN, MSN
District Manager
Orange County District Office

HN/sd

Enclosure *(CMS 2567)*

Licensing and Certification Program, 681 S. Parker Street, Suite 200, Orange, CA 92868
Telephone: (714) 567-2906 / Fax: (714) 567-2815
Internet Address: www.cdph.ca.gov

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA06000013	A. BUILDING: _____ B. WING _____	C 03/24/2015

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NEWPORT SPECIALTY HOSPITAL	14662 NEWPORT AVENUE TUSTIN, CA 92780

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A 000	Initial Comments The following reflects the findings of the California Department of Public Health during the investigation of Entity Reported Incident No. CA00325828 and CA00329252. Inspection was limited to the specific Entity Reported Incident(s) investigated and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: Surveyor 2097, HFES. THE DEPARTMENT SUBSTANTIATED THE ENTITY REPORTED INCIDENTS THAT DID NOT CONSTITUTE A VIOLATION OF THE REGULATIONS.	A 000		
A 001	Informed Adverse Event Notification Health and Safety Code Section 1279.1 (c), "The facility shall inform the patient or the party responsible for the patient of the adverse event by the time the report is made." The CDPH verified that the facility informed the patient or the party responsible for the patient of the adverse event by the time the report was made.	A 001		
A 010	1279.1(b) HSC Section 1279 (b) For purposes of this section, "adverse event" includes any of the following: This Statute is not met as evidenced by:	A 010		

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 010	Continued From page 1	A 010		
A 031	1279.1(b)(4)(F) Stage 3 or 4 ulcer acquired after admission (b) For purposes of this section, "adverse event" includes any of the following: (4) Care management events, including the following: (F) A Stage 3 or 4 ulcer, acquired after admission to a health facility, excluding progression from Stage 2 to Stage 3 if Stage 2 was recognized upon admission. This Statute is not met as evidenced by:	A 031		

State of California-Health and Human Services Agency
California Department of Public Health

Ron Chapman, MD, MPH
Director & State Health Officer

EDMUND G. BROWN JR.
Governor

January 26, 2015

Letter 1

IMPORTANT NOTICE – PLEASE READ CAREFULLY

Lawrence Bottorff, Administrator
Newport Specialty Hospital
14662 Newport Avenue
Tustin, CA 92780

Dear Mr. Bottorff:

On January 15, 2015, an abbreviated survey for complaint no. 426078 was conducted at your facility by the California Department of Public Health, Licensing and Certification Program (State Agency), to determine if your facility was in compliance with federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs.

The enclosed Centers for Medicare and Medicaid Services (CMS) form, entitled "Statement of Deficiencies and Plan of Correction" (CMS-2567), documents that no deficiencies of participation requirements were identified during this visit. Please sign, date, and return this form to our office (see address below) by February 6, 2015.

If you have questions concerning the instructions contained in this letter, please contact Kathleen Davidson, District Administrator at 714-567-2906.

Sincerely,

Hang Nguyen

Hang Nguyen, RN
Orange County District Office

Enclosure: CMS-2567

HN/ap

Licensing and Certification, 681 S. Parker Street, Suite 200, Orange, CA 92868
Telephone: (714) 567-2906 / Fax: (714) 567-2815
Internet Address: www.cdph.ca.gov

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an ABBREVIATED SURVEY for investigation of COMPLAINT No: CA00426078. Inspection was limited to the specific complaints investigated and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: Surveyor 27007, HFEN. THE DEPARTMENT WAS ABLE TO PARTIALLY SUBSTANTIATE THE COMPLAINT ALLEGATION(S) AND FOUND NO VIOLATION OF THE REGULATIONS.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Barbara Dell | CEO | 1/21/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	555730	A. BUILDING _____ B. WING _____	09/30/2014

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000	INITIAL COMMENTS	F 000		

The following reflects the findings of the California Department of Public Health during a RECERTIFICATION survey.

Representing the California Department of Public Health: Surveyor 28950, HFEN; Surveyor 29767, HFEN; and Surveyor 34325, HFEN.

The surveyors entered the facility on 9/3/14 at 0730 hours. The census was 21.

This Plan of Correction constitutes my written credible allegation of compliance to the deficiencies noted.

GLOSSARY OF ABBREVIATIONS
BM - bowel movement
CDC - Centers for Disease Control and Prevention
C-diff - Clostridium difficile
cm - centimeter(s)
CNA - Certified Nurses Aide
CNO - Chief Nursing Officer
CPR - cardiopulmonary resuscitation
DSS - Dietary Service Supervisor
ESBL - Extended Spectrum Beta Lactamase
EMT - Emergency Medical Technician
GT - gastrostomy tube
H2O - water
H&P - History and Physical
IDT - Interdisciplinary Team
kg - kilogram(s)
LVN - Licensed Vocational Nurse
MAR - Medication Administration Record
mg - milligram(s)
MLT - Minimal Leak Test
MRSA - Methicillin Resistant Staphylococcus Aureus
P&P - Policy and Procedure
PEEP - Positive End Expiratory Pressure
PIP - Peak Inpiratory Pressure (the pressure

CS 1 LU 01 10 H02

ATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

CEO 10/16/14

eficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that afeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ng the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 llowing the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued m participation.

POC Accepted 10-20-14

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F 000	Continued From page 1 needed to provide each breath from the ventilator) RD - Registered Dietician RN - Registered Nurse RT - Respiratory Therapist/Respiratory Therapy UTI - Urinary Tract Infection VRE - Vancomycin Resistant Enterococcus	F 000	Resident 7 → Crib Resident E → Crib Resident H → Lo Boy	
F 221 SS=E	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, interview, review of the facility's P&P, and review of the manufacturer's specifications, the facility failed to ensure one of 10 sampled residents (Resident 7) and two non-sampled residents (Residents E and H) were free from a physical restraint. The facility failed to obtain the informed consents from the responsible parties regarding the risks and benefits of the Posey bed (an A-framed canopy system enclosure which when attached to a hospital bed, restricts the resident from exiting the bed. The sides of the canopy have zippered panels which can only be accessed from the outside). Failure to provide the information regarding the risks and benefits of the Posey bed restraint as well as any other alternative interventions posed the risk of the residents' responsible parties not having the necessary	F 221	**482.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS** **F221** Corrective Actions Taken for Affected Residents: *All residents in the Posey bed not meeting the manufactures height and weight recommendations were immediately removed from the Posey beds. 9/30/14 *Appropriate alternative measures have been deployed and others are being explored for residents not meeting the requirements for the Posey bed, including low boy beds, cribs, hospital beds and alternative enclosed beds. 9/4/14 ongoing *All physician orders for specialty beds have been reviewed with the Medical Director and revised as appropriate. 10/3/14	

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F 221	Continued From page 2 ~~information to make an informed decision~~ regarding the use of the Posey bed. The facility failed to follow the manufacturer's specifications for the use of the Posey bed. According to the manufacturer, the Posey bed is a restraint and improper use of the Posey bed could lead to serious injury or death. The Posey bed is "not intended for use with patients who weigh less than 46 pounds, or are shorter than 46 inches." Resident 7, E, and H did not meet the manufacturer's minimum height and weight requirements for the use of the Posey bed. This posed the risk of serious injury to the residents. The facility failed to attempt alternative measures prior to the implementation of the Posey bed restraint. This placed the residents at risk for an unnecessary restraint. The facility failed to develop a comprehensive plan of care to address the use of the Posey bed, including restraint free periods, therapeutic interventions to minimize decline in function, and a process for restraint reduction. This posed the risk for not receiving the appropriate care. The facility failed to ensure documentation in the weekly progress notes addressing the alternatives attempted other than the use of a Posey bed restraint as described in their P&P. This had the potential for unnecessary restraint for the residents. The facility failed to follow the physician's order regarding observing the restraint every 15 minutes. This had the potential for a serious injury not to be detected in a timely manner	F 221	* The remaining resident in a Posey bed had a signed inform consent in their record. for the use of the enclosed bed. 9/6/13 *The care plan for the remaining resident in a Posey Beds was updated and appears in the resident record. including discussion of restraint free periods and monthly assessment of ROM by Physical therapy. 10/5/14 *Monthly reviews in IDT will be done to re-evaluate the appropriateness of enclosed beds and less restrictive options will be explored for each resident. 10/16/14 *A new enclosed bed policy has been drafted and approved to address the specific handling and documentation of enclosed bed usage specific to the pediatric population. Evaluation of patient need for bed monthly and IDT review of less restrictive options. 10/14/14 *Pediatric staff was re-educated on the use of enclosed beds and the special charting requirements. (10/16/14) 10/16/14	

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F 221	Continued From page 3	F 221	Corrective Actions for Other Residents:	

Findings:

According to the facility's P&P titled Restraints - Physical dated 5/2014, a physical restraint is any device attached or adjacent to the resident's body which restricts the resident's freedom of movement. A physician's order must be obtained prior to the use of a restraint. Possible alternative measures other than the use of the restraint should be discussed with the resident or responsible party. If a restraint is needed, the nurse should contact the physician and initiate verification of informed consent. The care plan should be updated to reflect the needs of the resident. The weekly progress note shall address the need for the restraint, any alternatives to the restraint, any least restrictive measures other than the restraint, address the possibility of a restraint reduction and address how the resident can maintain his highest functional level.

1. On 9/3/14 at 1500 hours, Resident E was observed sitting up in bed. The resident's bed was enclosed with a mesh covering on top of the bed and around all sides. The mesh covering had a zippered area to allow the staff to provide the resident's care as needed while the resident was in the bed. The zipper was closed.

Clinical record review for Resident E was initiated on 9/10/14. Resident E was admitted to the facility on 11/5/13.

On 9/4/14, Resident E's height was 113.5 cm (44.7 inches) and weight was 21.3 kg (44.86 pounds).

Review of the physician's orders showed an order dated 5/16/14, for the use of a Posey bed to

*Residents will be reviewed monthly during the Interdisciplinary Team meeting. Discussion will include the appropriateness of beds, and to explore less restrictive bedding options. as long as Posey bed is in use. 10/16/14

*The records of all residents using enclosed beds will be audited monthly to ensure proper documentation is being followed. 10/10/14

*Quarterly fall risk assessment will be reviewed at the Interdisciplinary Team monthly meeting. 10/16/14

*All new orders for enclosed beds will be audited to ensure that all required elements are in place, including MD order, trial of less restrictive measures, signed consent and parent request for enclosed bed when appropriate. while Posey bed is in use. 10/5/14

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Review of the clinical record failed to show documentation an informed consent was obtained from Resident E's responsible party regarding the risks and benefits of the use of the Posey bed.

Documentation in the clinical record failed to show Resident E was thoroughly assessed for the need of the restraint and which alternative therapies had been implemented prior to the use of the Posey bed.

An interview and concurrent clinical record review with RN 1 was initiated on 9/10/14 at 1500 hours. When asked why Resident E was using the Posey bed, RN 1 stated Resident E could stand up and was in danger of falling out of bed. When asked if the resident had ever fallen out of bed since his admission to the facility, RN 1 stated no, but he was at risk of falling. When asked for documentation to show the informed consent was obtained to address the use of Resident E's Posey bed, RN 1 stated she would check the overflow files to find the consent. However, no documentation to show the informed consent was obtained was provided. RN 1 was unable to provide documentation showing alternative interventions had been attempted prior to the implementation of the Posey bed. RN 1 was unable to provide documentation to show Resident E was thoroughly assessed regarding the need for the Posey bed.

2. Clinical record review for Resident 7 was initiated on 9/3/14. Resident 7 was admitted to the facility on 3/28/14.

On 9/4/14, Resident 7's height was 106.5 cm (41.93 inches) and weight was 17.6 kg (38.72

*Findings will be included in quarterly PI reports and reported to Organization-Wide Quality Council for further actions as needed.

Person(s) Responsible:

Pediatric Director of Nursing (DON), Quality and Compliance Coordinator and DSD

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F 221	Continued From page 4 ~~replace the crib for safety purposes. Further~~ review of the clinical record showed a "Physician Order: Pediatric Sub-Acute Restraints" form dated 9/4/14. The documentation on the form showed the use of the Posey bed as a restraint for up to seven days. The form showed the definition of behavioral modification restraints included: "the use of physical or mechanical devices to involuntarily retain movement of the whole or a portion of the patient's body as a means for controlling his/her physical activity in order to protect him/her or others from injury. Patient restraints will be observed every 15 minutes." The area to document the status of the resident showed "fall risk." The area to document the reason for the implementation of the restraint order showed a check mark in the box indicating to "prevent the patient from climbing out of the bed/chair and injuring himself" and a check mark in the box indicating to "protect the patient from self-harm." Review of the care plan showed a care plan problem to address Resident E's need for a restraint. An entry dated 5/16/14, showed to replace the crib with a Posey bed for safety. The interventions included to monitor for ongoing need of environmental restraints and discontinue as change of condition warranted and as ordered, monitor the resident on the restraint, assess every two hours, and document on the restraint flow sheet. However, the plan of care failed to show the approaches to include observing the resident every 15 minutes for the use of the restraint as ordered, specific measures to address Resident E's climbing out of bed, and prior interventions to be attempted prior to the implementation of the Posey bed.	F 221	Measures/Systemic Changes: *Re-education was provided to the licensed nursing staff about the use of restraints and informed consent. 10/25/14 *Charge nurses and RNs have been re-educated on the charting requirements for Posey beds, including restraint documentation, signed consents, MD progress notes, care plans, and the re-evaluation of resident condition and options for less restrictive measures. 10/25/14 Monitoring: *Monthly audits are being conducted by the Quality and Compliance Coordinator of nursing documentation and includes charting requirements for Posey beds, including restraint documentation, signed consents MD progress notes, care plans, and the re-evaluation of resident condition and options for less restrictive measures *Audit results to be presented in monthly Interdisciplinary Team meetings.	

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pounds).

Review of the September 2014 recapitulated physician's orders failed to show an order for the use of the Posey bed. Further review of the clinical record showed a "Physician Order: Pediatric Sub-Acute Restraints" form dated 7/21/14. The type of restraint was documented as a Posey bed. The area to document the status of Resident 7 showed "over actively moves bilateral lower extremities out of the bed, kicking rails and constantly moves in bed." The instructions on the form showed restraints "will be observed every 15 minutes." Further review showed a "Physician Order : Pediatric Sub-Acute Restraints" form dated 9/4/14, showing the use of the Posey bed with the status of the Resident 7 documented as a "Fall Risk"

Review of the Doctors Progress Notes dated 7/21/14, showed an IDT conference was held and Resident 7 was doing well with no major issues over the month. The documentation failed to show the need for the Posey bed.

Review of the care plan failed to show a care plan problem to address the use of the Posey bed or a care plan problem to address Resident 7's behavior of "over actively moving of his lower extremities out of the bed, kicking the side rails, constantly moving in bed" or his risk for a fall.

Review of the Weekly Nursing Summary reports dated 8/25 and 8/18/14, failed to address any alternatives or least restrictive measures to be attempted prior to using the Posey bed for Resident 7.

On 9/4/14 at 0750, a Posey bed was observed in

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Room B which was designated for Resident 7. Resident 7 was out of the facility at the time.

An interview and concurrent clinical record review was conducted with RN 1 on 9/4/14 at 0800 hours. RN 1 verified the Posey bed was considered a restraint. RN 1 was unable to find an informed consent regarding the use of Resident 7's Posey bed. Furthermore, RN 1 was unable to find documentation showing Resident 7's responsible party had been informed of the risks and benefits of using a Posey bed as a restraint and had been provided information regarding alternative therapies.

A telephone interview was conducted with RN 1 on 9/9/14 at 1100 hours. When asked if ongoing assessments to address Resident 7's need for the Posey bed had been completed, RN 1 stated she was unable to find an assessment to address Resident 7's need for the Posey bed restraint. RN 1 stated the physician rewrote the order every 7 days and documented the status of the resident on the form. RN 1 further verified the Weekly Nursing Summary reports dated 8/25 and 8/18/14, failed to address the use of any alternative interventions or least restrictive measures to be attempted prior to using the Posey bed for Resident 7. RN 1 verified the physician's order form showed restraints to be observed every 15 minutes and stated the facility did not check the resident every 15 minutes when a restraint was ordered. The facility's P&P is to check the resident every two hours and document on the Restraint Flow sheet.

3. On 9/10/14 at 1430 hours, Resident H was observed in a Posey bed restraint with all the mesh covering zippered closed. Resident H was

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resting quietly with arms moving.

On 9/10/14, clinical record review was initiated for Resident H. Resident H was admitted to the facility on 5/6/14.

On 9/4/14, Resident H's height was 89 cm (35.04 inches) and weight was 13.5 kg (29.7 pounds).

A care plan problem to address the use of the Posey bed was not found in the clinical record.

Review of the Physician Order, Pediatric Sub -Acute Restraints form dated 9/4/14, showed the Posey Crib as the type of the restraint for "Spastic Movements".

An interview and concurrent clinical record review was conducted with RN 1 on 9/10/14 at 1445 hours. RN 1 verified Resident H's use of the Posey bed as a restraint. RN 1 was unable to find an informed consent to address the use of Resident H's Posey bed. Furthermore, RN 1 was unable to find documentation showing Resident H's responsible party had been informed of the risks and benefits of using a Posey bed as a restraint. RN 1 was unable to find a care plan problem to address the approaches including the staff needed to take when caring for Resident H while using the Posey bed restraint. RN 1 was also unable to find documentation an assessment to address Resident H's need for the Posey bed restraint had been completed. RN 1 stated there was no documentation found in the IDT notes dated 8/14/14, or in the Weekly Nursing Summary dated 8/28/14.

An interview by phone was conducted with the

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F 221	Continued From page 9 Medical Director on 9/10/14 at 1700 hours. The Medical Director stated he did not obtain the informed consent or speak to the family regarding the risks and benefits of the Posey bed restraints. The Medical Director state the nursing staff obtained the informed consent for restraints, psychoactive medications, and pain medications from the residents' responsible parties. He further stated he would talk to the family if they were in the facility or if the nurse informed him the family would like to speak to him. On 9/30/14 at 0905 hours, an interview and concurrent clinical record review was conducted with the CNO. The CNO verified the facility utilized the Posey bed model number 8070 as means of restraint for Residents 7, E, and H. The CNO verified Resident 7, E, and H's heights and weights were last obtained on 9/4/14. When the manufacturer's specifications regarding the minimum height and weight requirements for the use of the Posey bed was discussed, the CNO verified Residents 7, E, and H did not meet the manufacturer's specifications. When asked how the facility verified the use of the Posey beds was appropriate for these residents, the CNO stated the facility had been using the Posey beds for some time, and he was not aware of the manufacturer's specifications. When asked if the facility had attempted any other interventions such as a low bed and floor mats as an intervention prior to the implementation of the Posey beds, the CNO stated he needed to research other alternatives than the Posey beds.	F 221		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment	F 279		

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F 279	Continued From page 10 to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and clinical record review, the facility failed to update the plan of care to reflect the resident's current care needs for one of 10 sampled residents (Resident 6). Resident 6 had bilateral myringotomy tympanostomy tubes (tubes inserted into the eardrums to prevent accumulation of fluid in the middle ear) inserted on 8/26/14. Seven days later Resident 6 was started on antibiotics due to an ear infection. The facility failed to update the plan of care for Resident 6 to address the placement of the ear tubes and the current ear infection. This had the potential of Resident 6 not to receive the appropriate care he required to minimize or prevent complications.	F 279	**483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS** **F279** Resident 6 - Care plan was immediately revised. Corrective Actions Taken for Affected Residents: 10/10/14 Care plans for all Pediatric Sub-Acute residents have been reviewed and updated as appropriate to include all new MD orders and changes in resident conditions. (10/10/2014) Corrective Actions for Other Residents: 10/10/14 RN staff were assigned monthly auditing responsibility to ensure that care plans reflect services that are to be furnished to attain or maintain the resident's highest attainable physical, mental and psychosocial well-being, to reflect any changes in resident condition, and to immediately update any care plan found to be incomplete. Findings will be reported at the monthly RN/Charge Nurse meeting. 10/21/14	

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F 279	Continued From page 11 Findings: Clinical record review for Resident 6 was initiated on 9/3/14. Resident 6 was admitted to the facility on 1/22/10 and readmitted to the facility on 5/6/14. Review of the physician's order dated 8/20/14, showed the bilateral myringotomy typmpanostomy tubes were to be surgically inserted on 8/26/14. Further review of the clinical record showed an order dated 9/3/14, to administer an antibiotic for a right ear infection for seven days. The order also showed specific instructions regarding use of the Otwick ear sponge (sponge is used to administer antibiotic drops deep into the ear canal). Review of the care plan problem dated 10/11/12, to address Resident 6's bilateral ear cerumen (ear wax) failed to include the insertion of the ear tubes or the current ear infection and approaches needed to provide the appropriate care. An interview and concurrent clinical record review with RN 1 was conducted on 9/4/14 at 0810 hours. RN 1 was unable to find a care plan problem addressing Resident 6's ear tubes or current ear infection. RN 1 verified the finding and stated the plan of care needed to address these issues.	F 279	Measures/Systemic Changes: Patient load has been equally distributed to RNs for *Quarterly audits of care plans will be performed by the charge nurses and presented at the monthly IDT meetings. 10/16/14 *All RN staff received re-education of care plan policies and procedures and nursing responsibilities. 9/25/14 *Re-education of care plan policies and procedures and nursing responsibilities was done with all RN staff. 9/25/14 Monitoring: *Quarterly reports of monthly audit findings will be reported to the Organization-Wide Quality Council. Person(s) Responsible: Pediatric DON, Quality and Compliance Coordinator and DSD	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in	F 309		

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Review of the physician's order order dated 11/26/10, showed Resident 6 "may only OOF (out of facility) if two people with completed educational packet and valid CPR cards" were present. A physician's order dated 12/31/11, showed Resident 6 might go out of facility for six hours up to two times per week.

Review of the care plan showed a care plan problem to address Resident 6's family dynamics dated 1/22/10; however, it failed to address the physician's order regarding the need for two persons with completed educational packets and valid CPR cards to accompany Resident 6 for out of the facility passes.

Further review of the clinical record showed two American Heart Association Healthcare Provider CPR cards for Resident 6's family members issued on 10/2010, which had expired on 10/2012. No further documentation of current CPR card verification was found in the clinical record.

Review of the facility's form titled Out of Facility Release showed the facility and the physician were free from all responsibility in regards to the resident's condition during the resident's absence from the facility. Review of Resident 6's Out of Facility Release form dated 9/7/14, showed Resident 6's family member signed him out at 1400 hours, and returned Resident 6 to the facility at 2000 hours. Resident 6's family member also signed him out on 8/3, 8/10, 8/17, 8/24, and 9/1/14, for a period of approximately six hours each time. Further review of the Out of Facility Release form failed to show documentation of a second person being present during Resident 6's

requirements continue to be met, including current family education. CPR cards and other requirements per the MD order.

Measures/Systemic Changes:

*All parents requesting OOF privileges will be required to complete all education and other requirements before being granted OOF pass. 9/5/14

*Monthly audits of all residents that are eligible for OOF passes to ensure that all eligibility requirements have been met, including CPR card, other requirements per MD order. Facility will offer assistance to family members in finding locations and times to obtain required certifications. 10/1/14

*Parents will receive monthly reminder notices about impending expiration dates of CPR cards. 10/1/14

Monitoring:

*Monthly audits of all eligibility requirements, including current 10/1/14

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F 309	Continued From page 12	F 309	**483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING**	

accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on interview and clinical record review, the facility failed to follow the physician's order regarding the necessary medical training and supervision needed to ensure one of 10 sampled residents (Resident 6) was safe when taken out of the facility by the family. Resident 6 has a tracheostomy (a tube going from the front of the neck to the trachea to provide an air passage to help with breathing when the usual route for breathing is obstructed or impaired) due to a history of respiratory distress (not enough oxygen passes from the lungs into blood) A physician's order showed two people with valid CPR cards were needed to take Resident 6 out of the facility. The facility failed to follow the physician's order to ensure two people with valid CPR cards were present when taking Resident 6 out of the facility. This posed the risk of compromising Resident 6's health and safety during out of the facility passes.

Findings:

Clinical record review initiated on 9/3/14, showed Resident 6 was admitted to the facility on 1/22/10 and readmitted to the facility on 5/6/14. Resident 6 had a tracheostomy tube and GT (a tube placed through a surgical opening in the abdomen to the stomach for the purpose of feeding and medication administration) Resident 6 had diagnoses including anoxic encephalopathy (brain damage due to lack of oxygen) and respiratory failure.

F309

Corrective Actions Taken for Affected Residents:

*The affected resident family has been notified that their Out of Facility (OOF) pass are suspended until evidence of current CPR cards is presented. 9/3/14

*New Out of Facility Policy has been drafted and approved by the Medical Director to include guidelines about OOF passes and family requirements. 10/14/14

Corrective Actions for Other Residents:

*Immediate audit of all resident records was done. No others were found to be deficient. 9/3/14

*Monthly audits will be done of all residents that are eligible for OOF passes to ensure that all eligibility 10/1/14
throughout the year The need to continue audits will be determined at the annual evaluation.

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release from the facility as specified in the physician's order.

An interview with RN 1 was conducted on 9/4/14 at 0930 hours. RN 1 verified due to family dynamics, two people with valid CPR cards were necessary to accompany Resident 6 when he left the facility. RN 1 was unable to find documentation showing proof of current CPR cards of Resident 6's family members who had been taking Resident 6 out of the facility. Furthermore, she was unable to find a care plan problem to address Resident 6's needs when leaving the facility.

F 322 SS=D 483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS

Based on the comprehensive assessment of a resident, the facility must ensure that --

(1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and

(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.

F 309

CPR cards and other requirements per the MD order, certification expiration and review of OOF requests will be done.

*Parents will receive monthly reminder notices about impending expiration dates of CPR cards.

*Findings will be included in quarterly PI reports, and reported to Organization-Wide Quality Council. and re evaluated at the end of the year for the need to continue reporting.

F 322

Person(s) Responsible:

Pediatric DON, DSD, Quality and Compliance Director

483.25(G)(2) NG TREATMENT/ SERVICES – RESTORE EATING SKILLS

F322

Resident 5: immediate re evaluation by medical director. New treatment to started.

Corrective Actions Taken for Affected Residents:

*All residents were re-assessed for skin integrity. Skin monitoring sheets have been started for residents showing any alteration in skin integrity. 9/5/14

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview, clinical record review, and review of the facility's P&P, the facility failed to accurately assess the GT (tube surgically inserted through the abdominal wall into the stomach to deliver nutrition and medication) site for one of 10 sampled residents (Resident 5). Resident 5 was receiving treatments for redness at the GT site. The nurses failed to assess the GT site daily as specified in their P&P. The wound area continued to deteriorate. The nurses failed to notify the physician and provide ongoing assessments of the wound condition. This posed the risk of Resident 5 not receiving the appropriate care and treatment.

Findings

Review of the facility's P&P titled Assessment of Skin Breakdown dated May 2014, showed the skin and/or wounds will be reassessed daily. Assessment will include centimeter measurements, characteristics of the wound bed, surrounding skin and exudates, and presence of pain associated with the wound.

Clinical record review for Resident 5 was initiated on 9/3/14. Resident 5 was admitted to the facility on 3/13/07 and readmitted on 6/17/14. Resident 5 had a G/JT tube (a combination gastric and jejeunostomy tube. Tubes surgically inserted through the abdominal wall into the stomach and intestine to deliver nutrition and medication) which was leaking and became dislodged on 9/3/14, and replaced with a temporary catheter.

Review of the physician's order dated 8/13/14,

Corrective Actions for Other Residents:

*Skin integrity is assessed daily - Incidents of skin breakdown will be documented in the resident record and comprehensive skin assessment tool and shift reassessment tool initiated and MD notified. 9/5/14

*Initial assessment will be completed, including photo and measurements of skin breakdown or redness and will be documented on the comprehensive skin assessment sheet. Re-assessment will occur every shift until the issue has resolved. 10/14/14
Initial / weekly assessment - charge nurse.
Daily monitoring - primary licensed nurse.

*New wound measurement tools, and upgraded camera and photo printer have been ordered to help in charting and monitoring the progress of identified skin problems. 10/14/14

Measures/Systemic Changes:

New skin monitoring tool is in place to directly address and facilitate the special skin assessment needs of the pediatric population. 10/14/14

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F 322	Continued From page 17 and 0400 hours, the GT was leaking. Documentation describing the skin redness or condition was not found. There was no documentation the physician had been notified of the change in the condition regarding the GT leaking. On 9/3/14 at 2000 hours, the LVN documented the GT site was very red and excoriated down the left side of the abdomen but failed to show the size of the excoriation, the condition of the surrounding skin, or the presence of any signs of pain. There was no documentation showing the physician had been notified of the change in the condition of the resident's skin. On 9/4/14 at 1145 hours, an interview was conducted with RN 1. She stated she was not aware of the open area surrounding Resident 5's GT site, LVN 1 had just reported the redness to her. RN 1 stated it was LVN 1's responsibility to perform daily treatments and monitor the GT site. She further stated the nurses did not have a form to document their findings. When asked how she would determine if the redness was getting worse, RN 1 stated there was no way to tell if the redness was getting larger or worse. On 9/4/14 at 1520 hours, an interview was conducted with LVN 1. He stated the open area surrounding Resident 5's GT was not reported to him at change of shift. He further stated the facility policy was to report any open areas on the resident's skin to the Charge Nurse. LVN 1 was unable to provide documentation showing centimeter measurements, characteristics of the wound bed, surrounding skin and exudates, and presence of pain associated with the wound were assessed daily. LVN 1 stated Resident 5's GT site had been reddened for a long time, and the	F 322	*New skin monitoring tools are in place to directly address the special needs of the pediatric population. Person(s) Responsible: Pediatric DON/ DSD/Director of Quality and Compliance	10/14/14

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F 322	Continued From page 16 showed an order to apply 1/2 Maalox (an antacid medication used topically to dry the area) mixed with 1/2 hydrophilic cream (topical skin cream) to GT site redness twice daily for 30 days. On 9/4/14 at 1115 hours, LVN 1 was observed performing treatment for Resident 5's GT. A red, excoriated (damage or superficial loss of the surface of the skin), open area was noted surrounding Resident 5's GT, measuring approximately 4 cm x 2 cm. An additional crescent shaped excoriated area was observed to the left of the GT site. There was a clear liquid leaking from the GT site, which dripped down Resident 5's left abdomen. Review of the care plan showed a care plan problem to address Resident 5's nutrition dated 6/17/14. The approaches included to provide GT site care every shift and as needed; however, there was no documentation to show the type of treatment to be provided for the GT site. Further review of the care plan for Resident 5's failed to show a specific care plan problem to address the resident's skin redness/excoriation around the GT and the indicated treatment to address the leaking of fluid from the GT site. The Nursing Progress/Summary Notes for 8/30/14 at 2000 hours, showed the GT site was still red with excoriation. Further review of the documentation failed to show measurements of the size and location of the excoriation or presence of signs of pain. There was no documentation the physician was notified of the change in the condition of the resident. The entry for 9/2/14, showed at 0800 hours, the GT was intact and patent; at 1200 hours and 1600 hours the GT site was clean and dry; and at 2400 hours	F 322	*Shift skin monitoring tool revised to reflect the unique needs of the pediatric population. 10/15/14 *Skin monitoring/pain assessment will be done on all residents every shift, and skin sheets started for all residents with redness, excoriation or any other skin issues. by primary licensed nurse. 10/15/14 Monitoring: Weekly audits of skin monitoring tool is being done by the licensed nursing staff. *Unit DON will review report and assign staff to follow up on findings. *Summary of findings will be reported to MD at weekly IDT meetings. *Findings will be included in quarterly PI reports, and reported to the Organization-Wide Quality Council.	

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only place to document this would be in the Nursing Progress/Summary Notes.

On 9/4/14 at 1530 hours, a follow-up interview and concurrent clinical record review was conducted with RN 1. When asked who was responsible for assessing the effectiveness of the skin treatments, RN 1 stated it was the RN's responsibility to assess and measure any open areas on the skin of the resident and document on the "skin sheet." She confirmed there was no "skin sheet" for Resident 5's treatments of the redness surrounding his GT. RN 1 further stated the RNs did not monitor redness even if there was a treatment. The RNs only monitored open areas on the skin.

F 328 SS=E 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS

The facility must ensure that residents receive proper treatment and care for the following special services:
Injections;
Parenteral and enteral fluids;
Colostomy, ureterostomy, or ileostomy care;
Tracheostomy care;
Tracheal suctioning;
Respiratory care;
Foot care; and
Prostheses.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and clinical record review, the facility failed to provide proper treatment and care for the residents requiring ventilator (a machine used to provide assisted

F 322

Resident 2, 3, 4 & 5: Were immediately re assessed with involvement of Medical director. Settings were adjusted according to policy.

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483.25(K) TREATMENT/CARE FOR SPECIAL NEEDS

F328

F 328

Corrective Actions Taken for Affected Residents:

*All resident records were reviewed with the Medical Director and MD orders were updated to comply with Policy & Procedures in regards to vent settings and cuff pressures. 9/4/14

*All Cardio-Pulmonary staff were re-educated on Ventilator Alarm Policy CPS 340. as well as proper documentation of tracheostomy cuff pressures where appropriate. 9/4/14

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F 328	Continued From page 19 breathing when they can not breathe effectively on their own) support. *Ventilator alarm settings for four of 10 sampled residents (Residents 2, 3, 4, and 5) and six nonsampled residents (Residents B, C, D, E, F, and G) were set too high. Alarm settings alert the staff to potential problems between the ventilator and the residents. When the alarm setting is too high, early detection and troubleshooting of ventilator problems does not occur. * Physician's orders to check the tracheostomy [a surgically created opening through the front of the neck into the airway (trachea) which provides an air passage when the usual route for breathing is obstructed or impaired or when long term use of a ventilator is required] cuff (a balloon at the end of the tracheostomy tube) pressure every shift were not followed for two of 10 sampled residents (Residents 3 and 5). The tracheostomy cuff seals the lower airway to prevent excessive air leakage and ensure the ventilator delivers the correct volume of air to the lungs. If the cuff pressure is too high, damage to the surrounding tissue may occur. These had the potential for serious complications to go undetected and resolved timely. Findings 1. Residents 2, 3, 4, 5, B, C, D, E, F, and G had medical conditions requiring ventilator support. During the initial tour on 9/3/14 at 0750 hours, RT 4 stated the RT set the normal ventilator high pressure alarm at 10 to 15 cm H2O above the residents' PIPs.	F 328	*Orders for all residents receiving ventilator support have been reviewed by Cardio Pulmonary leads, and limits updated to reflect current vent settings and trach cuff pressures. 9/10/14 Corrective Actions for Other Residents: *All residents receiving mechanical ventilation were audited for ventilator alarm settings to insure that all are set according to policy CPS 340 (10cm-15cm above/or below set pressure). 9/10/14 Measures/Systemic Changes: *Audits of MD orders and Cardio Pulmonary charts will be conducted daily and deficiencies will be addressed immediately. Audit overall results will be included in the Performance Improvement reports will be reported quarterly to the Organization-Wide Quality Council. for ~~at-lea~~ one year, then re evaluated for need to continue. 10/16/14 *Alarm settings will be reviewed by the interdisciplinary team at the 10/16/14	

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Review of the physician's orders for Residents 2, 4, 5, B, C, D, E, F, and G showed the orders for the ventilator settings to include:

* Mode (refers to the method of inspiratory or breathing support from the ventilator).

* Tidal volume (the volume of gas exchanged during each breathe from the ventilator).

* Rate (the number of times per minute the ventilator pushes air into the lungs).

* PEEP (this ventilator pressure is applied at the end of expiration to hold the lungs open and thereby increase oxygenation in the lungs).

* Amount of oxygen (room air contains 21% oxygen. The physician may order more oxygen depending on the resident's condition).

* Pressure control (provides a set pressure during inspiration).

* Pressure support (a spontaneous mode of ventilation when the resident initiates every breathe and the ventilator delivers a preset pressure).

The physician's orders did not contain the orders for the high pressure alarm settings (a ventilator alarm is triggered when there is something wrong with the ventilator pressure, volume, or the rate of air being delivered. The high pressure alarm occurs if two consecutive breaths are limited because they reach the high pressure setting. Triggering of high pressure alarm is usually caused by coughing but may indicate the airway

monthly scheduled IDT meeting and modifications to orders will be made by the MD based on recommendations as appropriate.

Monitoring:

Alarm

*Audits will be conducted daily and deficiencies will be addressed immediately. Audit overall results will be included in the Performance Improvement reports for the department.

*Audit findings will be reviewed with Cardio Pulmonary staff in monthly staff meetings and/or posted for all to review.

Person(s) Responsible:

Respiratory Leads and Chief of Ancillary Services.

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is blocked. The high pressure alarm will continue to be triggered if pressures do not decrease below the high pressure setting. If the high pressure alarm is set too high, a potentially serious complication may not be detected timely because the ventilator alarm will be delayed.

For Resident 3, the physician's order included the mode, rate, pressure control, pressure support, PEEP, amount of oxygen, and setting for a high pressure alarm at 45 cm H2O.

Review of the 24 Hour Continuous Mechanical Ventilator Records for Residents 2, 3, 4, B, C, D, E, F, and G for August and early September 2014, showed the high pressure alarms were continuously set at 45 cm H2O. The 24 Hour Continuous Mechanical Ventilator Records for Resident 5 for August and early September 2014 showed the high pressure alarm was continuously set at 50 cm H2O.

Further review of the 24 Hour Continuous Mechanical Ventilator Records for August and early September 2014, showed the following:

* The PIP for Resident 2 ranged from 15 to 25 cm H2O (20-30 cm H2O below the high pressure alarm setting). On 8/28/14 at 1530 hours, the PIP for Resident 2 was recorded at 31 cm H2O (14 cm H2O below the high pressure alarm setting).

* The PIP for Resident 3 ranged from 15 to 25 cm H2O (20-30 cm H2O below the high pressure alarm setting).

*The PIP for Resident 4 ranged from 20 to 25 cm H2O (15-20 cm H2O below the high pressure alarm setting).

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* The PIP for Resident 5 ranged from 24 to 48 cm H2O (2-26 cm below the high pressure alarm setting of 50 cm H20).

* The PIP for Resident B ranged from 14 to 20 cm H2O (25-31 cm H20 below the high pressure alarm setting).

* The PIP for Resident C ranged from 8 to 25 cm H2O (20-37 cm below the high pressure alarm setting).

* The PIP for Resident D ranged from 16 to 20 cm H2O (25-29 cm H2O below the high pressure alarm setting) . On 8/24, 8/27, and 8/29/14, the PIP for Resident D was recorded at 30 and 31 cm H2O (14-15 cm H2O below the high pressure alarms setting).

* The PIP for Resident E ranged from 14 to 27 cm H2O (18-31 cm below the high pressure alarm setting).

* The PIP for Resident F ranged from 18 to 26 cm H2O (19-27 cm H2O below the high pressure alarm setting). On 8/31/14 at 1900 hours, the PIP for Resident F was recorded at 32 cm H2O (13 cm H2O below the high pressure alarm setting).

* The PIP for Resident G ranged from 16 to 24 cm H2O (21-29 cm H2O below the high pressure alarm setting).

Review of the facility's P&P titled Mechanical Ventilator Set-Up dated May 2014, showed recommended setting for the ventilator high pressure alarm is 45 cm H2O.

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During an interview with the Medical Director on 9/8/14 at 1330 hours, when asked if he approved the facility's P&P, the Medical Director stated he had reviewed and approved the facility's clinical P&P. When the facility's P&P for Mechanical Ventilator Set-up dated May 2014, showing a recommended setting for the high pressure alarm at 45 cm H2O was discussed, the Medical Director stated this P&P needed to be reviewed.

When the Medical Director was informed the RT staff had stated during the initial tour, the high pressure alarms should be set at 10 to 15 cm H2O above the residents' PIPs, the Medical Director stated in most cases, this would be the correct setting.

After the Medical Director was informed of the 24 Hour Continuous Mechanical Ventilator Records for three sampled and six nonsampled residents showed all of the ventilator high pressure alarms were set at 45 cc H2O despite the residents' varying PIPs, the Medical Director agreed the high pressure alarm was set to high

During an interview with RT 1 and the Director for Ancillary Services on 9/8/14 at 1530 hours, the findings from the 24 Hour Continuous Mechanical Ventilator Records for three sampled and six nonsampled residents were reviewed and showed all of the ventilator high pressure alarms were set at 45 cm H2O even though the residents' PIPs varied from 8 to 32 cm H2O. RT 1 and the Director for Ancillary Services agreed the high pressure alarms should have been set at 10 to 15 cm H20 above the residents' PIPs.

Review of the facility's P&P for the Ventilator Flow Sheet showed the department/team's approval

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 24 dated May 2014, and the approval by the Medical Executive Committee and the Board of Directors dated June 2014. The policy showed "...pressure alarms will be set by the RT at 10 cm - 15 cm above and/or below pressures ...unless specified by MD (medical doctor)." During an interview and review of the Ventilator Flow Sheet P&P with RT 1 and RT 2 on 9/10/14 at 1610 hours, the two RTs were asked why the Ventilator Flow Sheet P&P differed from the Mechanical Ventilator Set-Up P&P regarding the settings for the high pressure alarm. Neither RTs were able to answer. During a telephone interview with the Corporate RT on 9/10/14 at 1115 hours, the Corporate RT stated he was unaware of any P&P showing the recommended settings for the ventilator high pressure alarm at 45 cm H2O. When asked if the RT should be adjusting the high pressure alarm based on the resident's condition, the Corporate RT stated unless the physician had ordered the high pressure alarm to be set at a specific setting, the RT should be adjusting the high pressure alarm to be 10-20 cm H2O above the residents' PIPs. 2. According to Respiratory Board Review, tracheal tube cuffs seal off the lower airway which facilitates ventilator support without excessive gas leaks and minimizes aspiration into the lungs. The pressure used to inflate the cuff can cause damage to the surrounding tissues. If the cuff pressure is high enough to block off capillary blood flow it can cause ischemia, tissue ulceration, and necrosis. Capillary perfusion pressures range between 20-30 cm H2O. The goal is to keep the cuff pressure below these	F 328		

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levels.

According to the Respiratory Board Review, a MLT is used to measure cuff pressure and minimize the air leak around the tracheostomy cuff. The procedure outlined the technique to be used and recommended recording of the measured cuff pressure.

Review of the physician's orders for Resident 3 showed an order dated 1/22/14, to check the tracheostomy tube (cuff) pressure every shift and as needed and maintain the pressure at 18-20 cm H2O.

Review of the physician's orders for Resident 5 showed an order dated 6/17/14, to check the tracheostomy tube (cuff) pressure every shift and as needed and maintain the pressure at 18-20 cm H2O.

The Medical Director was the primary care physician for both Residents 3 and 5.

During an interview, concurrent clinical record review, and review of the facility's P&P with RT 1 and RT 2 on 9/10/14 at 1610 hours, the physician's orders and the 24 hour Mechanical Ventilator Record for Residents 3 and 5 were reviewed. The physician's orders showed to check the tracheostomy tube pressure every shift and as needed and maintain the pressure at 18-20 cm H2O. The designated area to document the cuff pressure on the 24 hour Mechanical Ventilator Record showed the MLT, however, the documentation failed to show the amount of pressure determined. RT 1 stated she had already spoken to the Medical Director about the order to check Residents 3's and 5's

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tracheostomy tube cuff pressures. RT 1 stated the Medical Director indicated the order needed to be clarified because the facility used the MLT to ensure the tracheostomy cuff was not overly inflated. RT 1 stated the RT was to record just "MLT" on the 24 hour Mechanical Ventilator Record, not the actual tracheostomy cuff pressure. Review of the facility's P&P titled Ventilator Flow Sheet dated May 2014, showed the various procedures for completing the data on the 24 hour Mechanical Ventilator Record. The section to document the cuff pressure showed "observed amount of pressure (cm of H2O/MLT/MOV minimal occluding volume) in ..tracheostomy tube cuff." RT 1 verified the RT's document of "MLT" under cuff pressure not the actual cuff pressure.

When the physician's order for checking the tracheostomy cuff pressure for Residents 3 and 5 were reviewed with RT 1, RT 1 agreed the order required documentation of the actual cuff pressure, not the "MLT."

RT 1 also agreed if the physician's orders needed to be clarified, the clarification should have been done at the time the order was written, not months later.

F 371 SS=E 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY

The facility must -
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities, and
(2) Store, prepare, distribute and serve food under sanitary conditions

F 328 **483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY**

F371

Corrective Actions Taken for Affected Residents:

*Immediate replacement of dented, discolored, pitted, bowed cookware was accomplished. 9/4/14

*Repair of the wall board, removal of the silver-colored tape and repair of the torn cove base was done. 10/6/14

("Cove base is a type of trim that is installed along the base of an interior wall where the wall meets the floor. It is primarily made of vinyl or rubber and is used to protect the base of a wall from damage and to provide a finished and more aesthetically pleasing look where it is installed.")

F 371

Corrective Actions for Other Residents:

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This REQUIREMENT is not met as evidenced by:
Based on observation and interview, the facility failed to complete preventive maintenance in the kitchen to decrease the likelihood of harborage sites for pest infestations. Additionally, multiple cooking pots had bowed bottoms and pitting on the inside of the pots. Bowed bottoms of the cooking pots had the potential for the pots to rock on the stove and spill hot contents onto the staff using them. Pots with pitting were more apt to leach aluminum into foods and gave food an off taste.

Findings:

During a tour of the kitchen on 9/8/14 at 1200 hours, with the RD and the DSS, the wall beneath the sinks near the puree station was tapped using a yardstick. The wall board was spongy and moveable when pressed with the yardstick. The moveable section was approximately four feet wide. Additionally, silver colored tape was observed on the linoleum coving next to the walk-in refrigerator. The RD and DSS agreed with these findings.

An observation was made of a pot on a stove burner which appeared to be leaning to one side. The pot contained approximately two inches of warm water. When the pot was touched it rocked from side to side. The bottom of the pot was bowed outward. The RD agreed with this finding.

During an inspection of all of the cooking

This deficiency has no direct impact on the Pediatric Sub Acute resident population; as the resident involved is the only one currently in residence that is able to take food PO (by mouth). All other residents of the Pediatric Sub Acute unit are NPO (nothing by mouth) and are fed exclusively by gastrostomy (GT) tube.

Measures/Systemic Changes:

*Nutrition Services will conduct daily inspections of the kitchen to identify problems, including cookware needing to be replaced, and to identify potential repairs needed for walls, coves, etc.. 9/5/14

Monitoring:

*Monthly Environment of Care rounds will be completed in the kitchen and include cookware needing to be replaced, and to identify potential repairs needed for walls, coves, etc..

*Kitchen checklist was revised to include cookware. 10/9/14

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equipment, eight large pots and three medium pots were observed having bowed bottoms. Two medium pots and one large pot were observed to have pitting in the bottom and sides. One large colander was dented and showed black discoloration on the outside bottom.

The RD agreed with these findings.

F 428 SS=D 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON

The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.

This REQUIREMENT is not met as evidenced by:
Based on interview and clinical record review, the facility failed to ensure the drug regimen review was completed and irregularities were reported for one of 10 sampled residents (Resident 8). Failure to review a medication ordered an excessive dose and make recommendations had the potential for this resident to have an adverse reaction or an overdose.

Findings:

Clinical record review for Resident 8 was initiated

F 371

Person(s) Responsible:

Director of Dietary and Director of Engineering

F 428

483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON

F428

Corrective Actions Taken for Affected Residents:

Resident 8:

*Physician's PRN (as needed) order for Ativan was changed to include a maximum 24 hours dose not to exceed 10 mg. 9/4/14

Corrective Actions for Other Residents:

*Review was completed of all residents with PRN Ativan orders, as well as other PRN orders, to ensure that maximum dose limits are included where needed. 9/5/14

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on 9/4/14. Resident 8 was admitted to the facility on _____with diagnoses including tuberous sclerosis [a rare genetic incurable disease that causes noncancerous (benign) lesions to grow in many parts of the body. It may effect the brain, lungs, and kidneys. Lesions in the brain can be associated with seizures, intellectual disability, learning disabilities or developmental delays] and seizures.

Review of the physician's orders showed an order dated 8/14/13, to administer lorazepam (anti-anxiety medication) 2 mg every four hours as needed for agitation (a total 24 hour dose equaling 12 mg). Review of the MAR for July and August 2014, showed no as needed doses of lorazepam had been given.

Review of Lexi-comp, an online drug reference for healthcare professionals showed the total oral dose of lorazepam ordered for anxiety disorders is 1 mg to 10 mg daily in divided doses; the usual dose is 2-6 mg daily in divided doses.

During a telephone interview with the pharmacist on 9/4/14 at 1600, the pharmacist stated she did the drug regimen review for the facility in July and August 2014. When asked if she had made any recommendations for the lorazepam 2 mg every four hours as needed ordered for Resident 8, the pharmacist stated she did not make any recommendations because Resident 8 had not received any doses of lorazepam in July 2014 or August 2014. When asked if the 2 mg dose was of concern, the pharmacist stated she was not concerned because Resident 8 had not received any doses in July 2014 or August 2014. When asked what would happen if a nurse gave the lorazepam as ordered and Resident 8 received

Measures/Systemic Changes:

*Review of findings with Omnicare (contracted pharmacy) for educational purposes was done to insure that pharmacist is able to identify order issues specific to PRN daily dosing limits in the future. 10/16/14

*Monthly review of the appropriateness of anti-psychotic medication dosing will be done at monthly IDT meetings. 10/16/14

*Monthly pharmacist review of each resident's medication regiment is being done. The monthly review report is forwarded to the Pediatric Sub-Acute DON and CNO. All recommendations requiring modification will be followed up by DON or designee with the MD for modification or clarification as needed 10/16/14

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Monitoring:

Monthly drug review is completed by pharmacy and reviewed at IDT meetings 9/28/14

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12 mg of lorazepam in 24 hours, the pharmacist responded that would be a change of condition and the nurse would have called the physician before giving all 12 mg in 24 hours. When reminded the physician's order for lorazepam did not contain any specific instructions to call the physician after a certain number of doses, the pharmacist agreed. When asked if the nurse followed the physician's order as written and did not question the dosing of lorazepam, then Resident 8 could receive 12 mg of lorazepam in a 24 hour period. The pharmacist agreed and stated she would do a recommendation in September 2014, to discontinue the lorazepam if no doses had been given.

During an interview with the Medical Director on 9/8/14 at 1330 hours, the order for lorazepam 2 mg every four hours as needed for agitation for Resident 8 and the findings in Lexi-comp for a total daily dose of lorazepam was 1 to 10 mg was reviewed. The Medical Director agreed with the potential for Resident 8 to receive 12 mg in 24 hours seemed to be an excessive dose and needed to be reviewed.

F 441 SS=F 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections

F 428

Unit DON will review report and assign staff to follow up on findings. 10/9/14

Summary of findings will be reported to MD at weekly IDT meetings. 10/11/14

Findings will be included in quarterly PI reports, and reported to the Organization-Wide Quality Council.

Person(s) Responsible:

DON/pharmacist

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F 441

483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS

F441

Corrective Actions Taken for Affected Residents:

*At the time of the survey the CNO/CIC (Certification in Infection Control) was the acting infection

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F 441	Continued From page 31 in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and clinical record review, the facility failed to maintain an infection control program designed to provide a safe and sanitary environment and help prevent the development and transmission of infections * The monthly infection control surveillance data was not complete for 10 of 10 months reviewed. This had the potential to not recognize infection trends.	F 441	control nurse while the position was being filled. A qualified infection control nurse was subsequently recruited and hired. Columns were added to the infection control log to indicate which McGeers Criteria were met including the clinical signs and symptoms. A column for antibiotic usage and rationale was also added. *All resident isolation status was reviewed and it was decided, in collaboration with the Medical Director and unit leadership, to initiate enhanced standard precautions on all residents pursuant to AFL 10-27. The new policy and procedure includes procedures for identification of and isolation of actual or potential C. diff infections. *Infection Control refresher and procedures for enhanced precautions were reviewed with the teacher from the school district.	10/10/14 10/8/14 10/16/14 10/15/14

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F 441	Continued From page 32	F 441	Corrective Actions for Other Residents:	

* The facility failed to use the infection control surveillance data to monitor the use of unnecessary antibiotics for conditions not meeting McGeer's Criteria (a symptom based criteria to identify true infections in long-term nursing facilities). In addition, the facility did not document the symptoms associated with infections, which was an important part of the McGeer's criteria. This had the potential for unnecessary use of antibiotics, which could contribute to the development of antibiotic resistant bacteria and could cause a secondary infection such as C-diff (a bacterium causing severe diarrhea).

* The facility failed to document any infection control surveillance for the months of January and February 2014. This had the potential for an infection outbreak to go unrecognized.

* Resident 5 had signs and symptoms of a C-diff infection. However, the facility did not implement isolation precautions while waiting for Resident 5's culture (a laboratory test taking approximately 72 hours to determine if infectious bacteria is present) was being processed. This had the potential for other residents to be exposed to infection.

* Teacher 1 did not follow proper infection control practices to minimize the risk of spread of infections in the facility.

Findings:

According to the CDC, each year in the United States at least 2 million people become infected with bacteria that are resistant to antibiotics and

*All residents are being reviewed daily and new potential infections and/or antibiotic usage is entered into the infection control log for further investigation. 9/8/14

*Enhanced standard precautions were initiated for all residents. A new policy and procedure was introduced and contained procedures for identification and isolation of actual and/or suspected C diff infections. All staff who enters resident rooms received in-service education regarding the new enhanced procedures. All EMT and other unscheduled non-staff individuals who enter resident rooms receive instruction upon arrival, prior to their interaction with the resident. 10/15/14

*Any new teachers and other scheduled non-staff individuals who enter resident rooms receive infection control instruction upon arrival, prior to their interaction with the resident. 10/15/14

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facility did not have an infection control nurse on staff.

Review of the Subacute Infection Control Logs which included the facility's infection control surveillance showed the log had columns for staff to document resident name, room number, presumptive diagnosis such as a UTI, infectious organism, if the resident was placed in isolation, any pertinent laboratory results, the treatment given and the dates the infection started and resolved. However, the log did not have a column or an area for staff to identify the resident's signs or symptoms of the infection (i.e. fever, cough or changes in the color of sputum or urine) as specified in McGeer's criteria. In addition, there was no area to document if the infection met McGeer's criteria and considered a true infection, which would help identify unnecessary antibiotic usage.

a. Review of the Subacute Infection Control Log for November 2013, showed a total of three infections documented for the month. Two of the infections were UTIs and one infection was pneumonia. Both UTI were identified to have cultures done. A culture is a test to determine the amount and type of bacteria present in the specimen, in this case urine. According to McGeer's criteria, the amount of bacteria present must be greater than 100,000 to be considered a true infection.

Further review of the Subacute Infection Control Logs showed incomplete documentation. For example:

* The column entitled "Pertinent Lab (laboratory) or X-ray Findings" showed no documentation

Monitoring:

*The infection control practitioner will prepare monthly summaries of the infection control log including antibiotic usage, infections using McGeer's criteria, isolation, trends, etc. The report will be reviewed by the unit Medical Director and CNO for completeness. The report along with a summary of other infection control monitors will be reported to the Organization-Wide Infection Control Committee and Quality Council on a quarterly basis unless there are significant opportunities for improvement noted in the interim.

*Results of monitoring adherence to enhanced standard precautions are presented monthly to the Pediatric Unit Medical Director and other leadership. The results are reported to the Organization-Wide Quality Council on a quarterly basis unless there are significant opportunities for improvement noted in the interim.

*Results of monitoring adherence to infection control standards are

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F 441	Continued From page 35 related to the results of the lab or x-ray done. Staff only documented a culture or x-ray had been done. b. Review of the Subacute Infection Control Logs for December 2013, March, April, May, June, July and August 2014, showed the following: * Under the area for pertinent laboratory findings, staff documented all the infections had either a culture or x-rays done. However, no results were identified to show if the bacteria counts were positive for a true infection, or an x-ray revealed a positive findings such as pneumonia. * All of the seven months of log failed to have documentation of each of the resident's signs or symptoms which would help determine if the resident had a true infection, or if it was treated with antibiotics unnecessarily. * The treatment column for these logs failed to consistently identify what medication was used to treat the infections. Of the 16 entries, only four were identified. In the treatment column staff had been documenting the route the medication was given (i.e. by mouth or intravenously), not the actual medication. c. Review of the Subacute Infection Control Logs for January and February 2014, showed the logs were blank. The CNO confirmed the logs were blank. He stated he did not fill out the logs for these two months. On 9/4/14 at 1400 hours, an interview was conducted with the CNO. The CNO was asked about the Subacute Infection Control Logs. The CNO stated he entered the data based on the	F 441	presented monthly to the Pediatric Unit Medical Director and other leadership. The results are reported to the organization-wide quality council on a quarterly basis unless there are significant opportunities for improvement noted in the interim. Person(s) Responsible: Infection Control Practitioner and Pediatric Sub-Acute DON.	

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culture reports he received from the nursing staff. He was asked based on the information provided on the Subacute Infection Control Logs, whether he could determine if the residents had a true infection or were being treated with unnecessary antibiotics. He stated based on the Subacute Infection Control Logs he could not determine this information. The CNO was asked if the facility was monitoring for the use of unnecessary antibiotics. The CNO stated, "No not yet." He also stated he had just hired an infection control nurse. The CNO was asked about the missing information, such as the culture results, resident specific signs and symptoms of the infection, and the medication used to treat the infection. The CNO verified he had not been documenting this information on the logs. He stated he was not aware this information was needed. He stated the infection control committee had last met in April 2014, and he had reported the infection control rates at that time. He stated he was not aware the unnecessary antibiotic usage should be part of the surveillance.

2.a. On 9/3/14 at 0745 hours, Resident 5 was observed in bed. A sign posted on the wall outside the room showed Resident 5 was on contact isolation precautions (isolation requiring staff to wear gown, gloves, and mask if they may come in contact with any body secretions or fluids).

Clinical record review for Resident 5 was initiated on 9/3/14. Resident 5 was readmitted to the facility on 6/17/14, with diagnoses including history of partial small bowel obstruction and history of recurrent intermittent ileus (disruption of the muscle contractions of the intestines stopping

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	555730	A. BUILDING _____ B. WING _____	09/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWPORT SPECIALTY HOSPITAL	14662 NEWPORT AVENUE TUSTIN, CA 92780

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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the movement of food and fluid through the digestive system). Resident 5 was ventilator dependent.

Review of the H&P dated 6/23/14, showed Resident 5 was to be placed on isolation.

Review of a care plan problem dated 6/17/14, addressed the Resident 5's infections of VRE, MRSA, and ESBL (multi-drug resistant organisms where the bacteria is resistant to many antibiotics) and contact isolation precautions.

Review of the physician's orders for Resident 5 failed to find an order for contact isolation.

Review of the facility P&P titled Infection Control dated 11/2010, showed the physician had to write an order on what extra precautions were necessary.

On 9/4/14 at 1100 hours, an interview with LVN 4 was conducted. LVN 4 was unable to find an order for contact isolation for Resident 5.

b. Further review of the physician's orders for Resident 5 showed an order dated 7/6/14, for stool culture for C-diff.

Review of the nursing progress summary notes dated 7/4/14, showed Resident 5 had a total of 9 BMs for that day. On 7/5/14, the resident had a total of 6 BMs for that day. On 7/6/14 at 1130 hours, staff documented Resident 5 has loose yellow stool, with a total of 6 BMs for that day.

On 9/8/14 at 1010 hours, an interview with RN 2 was conducted regarding Resident 5. RN 2 stated the resident's C-diff culture was obtained

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due to the resident experiencing more than normal BMs. She stated if a resident had C-diff due to the symptoms of more than normal loose BMs, they would have placed the resident in a private room. When asked if Resident 5 was transferred to a private room when the symptoms were observed. RN 2 stated, "No, he remained in the same room with his current roommate." RN 2 stated the roommate did not have any symptoms of C-diff.

c. On 9/8/14 at 0840 hours, two EMTs entered Resident 5's room with a gurney. EMT 1 was wearing gloves and a mask and EMT 2 was only wearing gloves. Neither EMTs were wearing a gown. The EMTs were accompanied by an RT from the EMT company. This RT was wearing a mask and gloves. In addition, the facility's RT 5 was in Resident 5's room and was observed to be wearing a gown, a mask, and gloves.

The RT from the EMT company stood at Resident 5's bedside on the nonventilator side of the bed. He turned on the portable ventilator located on the gurney, checked the ventilator settings, and then removed Resident 5 from the facility's ventilator and attached the resident to the portable ventilator.

EMT 1 was observed to lift Resident 5 off of the bed and placed her onto the gurney. Neither EMTs removed or changed their gloves or attempted to sanitize or wash their hands before they exited the resident's room.

The RT from the EMT company removed the gloves and a mask while inside the resident's room and used a sanitizing hand gel on his hands as he exited the room.

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F 441 Continued From page 39

During this observation, RT 5 did not provide any directions to either EMT company staff regarding the contact isolation precautions for Resident 5.

3. On 9/4/14 at 1030 hours, an observation was made of a teacher (Teacher 1) walking down the hallway holding a tray containing small cut pieces of purple tissue paper and a bottle of tacky glue. As the teacher was walking down the hallway, three small pieces of the tissue paper flew off of the tray and landed on the floor. Teacher 1 bent down, retrieved the pieces of tissue paper, and replaced the pieces back onto the tray. Teacher 1 continued down the hallway to Room A, placed the tray down on the isolation cart, and opened one drawer to retrieve an isolation gown.

However, before Teacher 1 retrieved a gown she was asked about the above observation. The teacher agreed this was the sequence of events. When asked what procedure she should have followed when the papers fell off of the tray. The teacher stated she should have discarded the pieces of tissue and washed her hands before proceeding on to a resident's room.

F 518 SS=E 483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS

The facility must train all employees in emergency procedures when they begin to work in the facility, periodically review the procedures with existing staff, and carry out unannounced staff drills using those procedures.

This REQUIREMENT is not met as evidenced by:

F 441

483.75(M)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURE/DRILLS

2011 OCT 15 P 1 04

F518

Corrective Actions Taken for Affected Residents:

This issue does not directly address resident life.

*All staff were re-educated about the Environment of Care (EOC), including emergency food/water, location of emergency equipment, location of emergency shut off valves, etc. 9/5/14

F 518

Corrective Actions for Other Residents:
This issue does not directly address resident life.

*All staff were re-educated about the Environment of Care (EOC), including emergency food/water, 10/16/14

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at least 23,000 people die each year as a direct result of these infections. Many more people die from other conditions that were complicated by an antibiotic-resistant infection. Studies indicate that 30-50% of antibiotics prescribed in hospitals are unnecessary or inappropriate. "There is no doubt that overprescribing and misprescribing is contributing to the growing challenges posed by C-diff and antibiotic-resistant bacteria." Most deaths related to antibiotic resistance happen in healthcare settings, such as hospitals and nursing homes. Studies demonstrate that improving prescribing practices in hospitals can not only help reduce rates of C-diff infection and antibiotic resistance but can also improve individual patient outcomes, all while reducing healthcare costs. A CDC analysis of data regarding antibiotics prescribed in hospitalized patients, showed a 30% reduction in use of broad-spectrum antibiotics would result in a 26% reduction in C-diff infections. In addition, improvement of physician antibiotic prescribing habits from overuse and incorrect use would also help to reduce antibiotic resistance.

According to Medscape.com, C-diff colitis results from a disturbance of the normal bacterial flora of the colon and the release of toxins that cause mucosal inflammation and damage. Antibiotic therapy is the key factor that alters the colonic flora causing C-diff infections.

1 An interview and concurrent clinical record review of the Subacute Infection Control Logs was initiated with the CNO on 9/4/14 at 1345 hours. The CNO stated the facility was using McGeer's criteria to determine the facility's infection rates. The CNO stated he was completing the logs monthly. He stated the

Measures/Systemic Changes:

*A dedicated/qualified infection control practitioner has been recruited and hired to oversee the infection control process. The infection control log has been modified to include the necessary information needed to properly monitor infections on the unit and detect trends in infections and/or antibiotic usage. 10/10/14 9/8/14

*Direct observation of adherence to enhanced standard precautions is being accomplished. A monitoring tool has been developed and will be used to perform direct observation of compliance to the precautions. 10/15/14 Monthly for 6 months and then quarterly thereafter with annual evaluation for need to continue.

*Direct Observation of adherence to infection control practices is being accomplished. A monitoring tool has been developed and will be used to perform direct observation of compliance. 10/15/14

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F 518	Continued From page 41 emergency fire alarm pull was located. She pointed to an oxygen/gas turn off valve located on the wall near the conference/activity room. However, the fire alarm pull was located near the entrance to the nursing unit. 4. On 9/8/14 at 1130 hours, an interview was conducted with RT 3 regarding emergency preparedness. He was able to identify the main gas supply and stated the red lever was the emergency gas shut off valve. However, when asked what the wrench hanging by the main gas supply was for, he stated it could be used to turn off the gas if the red lever broke. 5. During an interview with CNA 2 on 9/4/14 at 0710 hours, CNA 2 was able to locate the facility's main gas supply. When asked how the gas would be shut off in the event of a disaster, CNA 2 stated she would use the large wrench attached with a chain to the main gas supply. When asked where she would place the wrench, CNA 2 stated she was not sure since there were two bolts that could be turned. The Maintenance Director happened to pass by and was asked how to turn off the main gas supply. The Maintenance Director pointed to the bolt located near the ground and stated that was the correct bolt to turn to shut off the gas.	F 518	at all times with identification badge. Person(s) Responsible: Pediatric DSD. DON	

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F 518	Continued From page 40 Based on observation and interview, the facility failed to ensure five of six staff were knowledgeable about the facility's emergency procedures. This had the potential to place residents, staff, and visitors in danger in the event of an emergency. Findings: 1. On 9/8/14 at 1015 hours, an interview was conducted with the Activities Coordinator regarding emergency preparedness. When asked where the facility's emergency food and water supply were located. She stated she did not know. When asked where the emergency water shut off valve was located. The Activities Coordinator stated in the basement. She pointed to a green lever as the shut off valve. However, the emergency water shut off valve was located in an adjacent room and on a pipe near the ceiling. She was able to identify the main emergency gas shut off valve. However, when asked what the wrench hanging by the main gas supply was for, she stated she did not know. The wrench was needed to turn off the gas valve. 2. On 9/8/14 at 1030 hours, an interview was conducted with RN 2 regarding emergency preparedness. She was able to point out the main gas supply and stated the red lever was the emergency gas shut off valve. When asked what the wrench hanging by the main gas supply was for, she stated she did not know. 3. On 9/8/14 at 1100 hours, an interview was conducted with CNA 1 regarding emergency preparedness. When asked where the facility's emergency food supply was located. CNA 1 stated she did not know. When asked where the	F 518	location of emergency equipment, location of emergency shut off valves, etc. Measures/Systemic Changes: *Re-education of all staff on EOC, including facility tours. 10/16/14 *Signage was placed on the wall near the main gas shut off valve to instruct in conducting emergency shut off procedure. 10/16/14 *Staff provided with reference material outlining emergency procedures (badge buddies) to wear at all times with identification badge. 10/16/14 Monitoring: *Staff re-education of emergency procedure. 9/15/14 – ongoing *Monthly assessment of staff knowledge is done during EOC rounds and drills. evaluated by direct questions to and return answers by the staff. *Staff were provided with reference material outlining emergency procedures (badge buddies) to wear 10/14/15	

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NEWPORT SPECIALTY HOSPITAL	1468Z NEWPORT AVENUE TUSTIN, CA 92780

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K 000	INITIAL COMMENTS K3 BUILDING: 02 WING K6 PLAN APPROVAL 1998 K7 SURVEY UNDER: 2000 EXISTING STRUCTURE TYPE: ONE STORY, CONSTRUCTION TYPE (V) (111), FULLY SPRINKLERED The following reflects the find ngs of the California Department of Public Health, during an annual Life Safety Code recertification survey. The findings are in accordance with 42 CFR (Code of Federal Regulations) 483.70 (a) and NFPA (National Fire Protection Association) 101, Life Safety Code 2000 edition, Existing codes Representing the California Department of Public Health 26367 The facility is not in substantial compliance with 42 CFR 483.70 (a) for Long Term Care Facilities. Census = 22	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of res sting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping	K 018	**This Plan of Correction constitutes my written credible allegation of compliance to the deficiencies noted.** **NFP 101 Life Safety code Standard** **K018** Immediate Actions Taken: 9/9/2014 All brown rubber wedges were removed and discarded to allow proper un-impeded closure of the doors noted. All areas were reviewed and no other door hold open devices were found. Education was immediately provided to all staff present focusing on the need to maintain proper closure of all doors and the exclusion of hold open devices	

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are d sclosable 14 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

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K 018	Continued From page 1 the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain their corridor doors. This was evidenced by corridor doors that were impeded from closing. This could result in delay to contain smoke or fire to a room in the event of a fire. This affected 2 of 3 smoke compartments. NFPA 101, Life Safety Code, 2000 Edition 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1 3/4-in. (44-mm) thick, solid bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.	K 018	Systemic Changes: Education was provided to all staff 9/27/14 during a staff meeting to reinforce the proper function and of all doors in the hospital and that any hold open device that impedes the door from proper closure is forbidden. This will also be reinforced in the orientation of any new staff. Absence of hold open devices is included on the environment of care inspection tool and Charge nurse rounding tool. Monitoring: Absence of hold open devices is being monitored during monthly Safety Rounds as well as daily during charge nurse rounds. Results of the monitoring will be reported through the quality assurance reports at the Leadership Team meetings and the hospital Quality Assurance meeting at least quarterly in order to evaluate the POCs effectiveness. . Any deficiencies noted in the interim will be immediately corrected.	

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K 018	Continued From page 2	K 018		

Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.

NFPA 80, Standard for Fire Doors and Fire Windows, 1999 Edition
2-4.1.4. All closing mechanisms shall be adjusted to overcome the resistance of the latch mechanism so that positive latching is achieved on each door operation.

19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted

A 19.3.6.3.3 Doors should not be blocked open by furniture, door stops, chocks, tie backs, drop down or plunger type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches.

Findings:

During a tour of the facility with the Director of Plant Operations, and the Chief of Ancillary Services on 9/9/14, the doors in the facility were observed, and a staff person was interviewed

1. At 9:40 a.m., the self-closing corridor door to the Staff Break Room, was impeded from closing with a brown rubber wedge under the door.

2. At 10:59 a.m., the self-closing corridor door to Physical Therapy/Rehab, was impeded from

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K 018 Continued From page 3

closing with a brown rubber wedge under the door

3. At 11:00 a.m., the Director of Plant Operations said during an interview that he checked all of the doors yesterday and they were not wedged open.

K 025 NFPA 101 LIFE SAFETY CODE STANDARD
SS=E

Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4

This STANDARD is not met as evidenced by:
Based on observation, the facility failed to maintain the integrity of the fire resistance rated construction of its smoke barrier walls. This was evidenced by an unsealed penetration. This could result in the reduction in staff ability to protect in place due to smoke and fire. This affected 2 of 3 smoke compartments.

NFPA 101, Life Safety Code, 2000 Edition
19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour.

K 018

K 025

NFP 101 Life Safety code Standard

K025

Immediate Actions Taken:

The noted unsealed pipe penetration was sealed with the proper fire caulking. All other smoke barriers were inspected and no other unsealed penetrations were found. 9/9/14

Systemic Changes: 9/24/14

All work done above the ceiling by contractors and/or in-house personnel will be required to obtain an "above the ceiling work permit" that includes a final inspection of any work done to insure that any penetrations are properly sealed.

Monitoring:

All above the ceiling work will be monitored through the work permit process. Monthly life safety inspections will include observation of smoke barrier walls. Work permits and inspections will be reported through the quality assurance reports at the Leadership Team meetings and the

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K 025	Continued From page 4 Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor. Exception No. 2: * Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 has been provided for smoke compartments adjacent to the smoke barrier. 8.3.6.1 Pipes, conduits, ducts, cables, wires, air ducts, pneumatic tube and ducts, and similar building services equipment that pass through floors and smoke barriers shall be protected as follows: (1) The space between the penetrating item and the smoke barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed of the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (3) Where designs take transmission of vibration into consideration, any vibration isolation shall	K 025	hospital Quality Assurance meeting at least quarterly in order to evaluate the POCs effectiveness. Any deficiencies noted in the interim will be immediately corrected.	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555730	A. BUILDING _____ B. WING _____	09/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWPORT SPECIALTY HOSPITAL	14662 NEWPORT AVENUE TUSTIN, CA 92780

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 025	Continued From page 5 meet one of the following a. It shall be made on either side of the smoke barrier. b. It shall be made by an approved device that is designed for the specific purpose. Findings. During a tour of the facility with the Director of Plant Operations, and the Chief of Ancillary Services on 9/9/14, the smoke barrier walls were observed. At 12:49 p.m., there was an approximately 1/2 inch unsealed conduit pipe in the smoke barrier wall near Room 309. The Director of Plant Operations acknowledged the finding	K 025		
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by Based on observation and interview, the facility failed to maintain the smoke barrier doors. This was evidenced by a smoke barrier door that failed to latch. This could fail to contain smoke during a	K 027	**NFP 101 Life Safety code Standard** **K027** Immediate Actions Taken: 9/9/14 The door near room 307 was adjusted to insure proper latching. All other doors were checked and no others were found to be deficient. Systemic Changes: 9/22/14 All fire doors will be checked for proper latching with each fire drill (monthly) and each safety inspection (monthly). Any deficiencies will immediately be corrected.	

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K 027	Continued From page 6 fire. This affected 2 of 3 smoke compartments. NFPA 101, Life Safety Code, 2000 Edition 19.2.2.2.6* Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier, or hazardous area enclosure shall be permitted to be held open only by an automatic release device that complies with 7.2.1.8.2. The automatic sprinkler system, if provided, and the fire alarm system, and the systems required by 7.2.1.8.2 shall be arranged to initiate the closing action of all such doors throughout the smoke compartment or throughout the entire facility. 7.2.1.8.2 In any building of low or ordinary hazard contents, as defined in 6.2.2.2 and 6.2.2.3, or where approved by the authority having jurisdiction, doors shall be permitted to be automatic-closing, provided that the following criteria are met. (1) Upon release of the hold-open mechanism, the door becomes self-closing. (2) The release device is designed so that the door instantly releases manually and upon release becomes self-closing, or the door can be readily closed. (3) The automatic releasing mechanism or medium is activated by the operation of approved smoke detectors installed in accordance with the requirements for smoke detectors for door release service in NFPA 72, National Fire Alarm Code®. (4) Upon loss of power to the hold-open device, the hold-open mechanism is released and the door becomes self-closing. (5) The release by means of smoke detection of one door in a stair enclosure results in closing all doors serving that stair.	K 027	Monitoring: Results of the inspection and drills will be reported through the quality assurance reports at the Leadership Team meetings and the hospital Quality Assurance meeting at least quarterly in order to evaluate the POCs effectiveness.	

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K 027	Continued From page 7 Findings: During a tour of the facility with the Director of Plant Operations, and the Chief of Ancillary Services on 9/9/14, the facility smoke barrier doors were observed, and a staff person was interviewed. 1. At 11:07 a.m., the north smoke barrier door near Room 307 was not latching when tested. Two attempts were made without the door latching. 2. At 11:08 a.m., the Director of Plant Operations said during an interview that he checked all of the doors yesterday and they all worked.	K 027	**NFP 101 Life Safety code Standard** **K050**	
K 050 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on interview, the facility failed to prepare staff members to respond to emergency situations. This was evidenced by staff members that failed to know how to open a locked bathroom door and by not being aware of the facility protocols. This could result in facility staff	K 050	Immediate Actions Taken: 9/15/14 Remedial instruction was immediately provided to the staff members on the unit including the two that could not properly answer the questions. All other staff members present were given instruction as well. Systemic Changes: 9/15/14 Remedial instruction was given for all staff members. RACE, PASS, Code Red and unlocking of the bathroom doors is included in the annual competency assessment with return demonstration. Devices to open the bathroom doors are maintained in each Fire Extinguisher cabinet to facilitate.	

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K 050	Continued From page 8 not being prepared to respond to emergency evacuation with a person locked in a bathroom. This affected 3 of 3 smoke compartments. NFPA 101, Life Safety Code, 2000 Edition 19.7.1.3 Employees of health care occupancies shall be instructed in life safety procedures and devices. 19.7.2 Procedure in Case of Fire 19.7.2.1* For health care occupancies, the proper protection of patients shall require the prompt and effective response of health care personnel. The basic response required of staff shall include the removal of all occupants directly involved with the fire emergency, transmission of an appropriate fire alarm signal to warn other building occupants and summon staff, confinement of the effects of the fire by closing doors to isolate the fire area, and the relocation of patients as detailed in the health care occupancy's fire safety plan. 19.7.2.2 A written health care occupancy fire safety plan shall provide for the following (1) Use of alarms (2) Transmission of alarm to fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire 19.7.2.3 All health care occupancy personnel shall be instructed in the use of and response to fire alarms. In addition, they shall be instructed in the use of the code phrase to ensure transmission of an alarm under the following conditions (1) When the individual who discovers a fire must immediately go to the aid of an endangered	K 050	Monitoring: Staff knowledge of RACE, PASS, Code Red and unlocking of the bathroom doors is being monitored during monthly Safety Rounds and fire drills as well as periodically during leadership rounds. Results of the monitoring will be reported through the quality assurance reports at the Leadership Team meetings and the hospital Quality Assurance meeting at least quarterly in order to evaluate the POCs effectiveness. Any deficiencies noted in the interim will be immediately corrected.	

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K 050	Continued From page 9 person (2) During a malfunction of the building fire alarm system Personnel hearing the code announced shall first activate the building fire alarm using the nearest manual fire alarm box and then shall execute immediately their duties as outlined in the fire safety plan. Findings During a tour of the facility with the Director of Plant Operations, and the Chief of Ancillary Services on 9/9/14, staff members were interviewed. At 12:55 p.m., staff member 1 and staff member 2 were interviewed, and were asked to open a locked bathroom door to evacuate a person out of the room during a trash can fire. Two of two staff could not open the locked door and were unable to describe the facilities protocols RACE (Rescue, Alarm Confine, Extinguish), PASS (Pull, Aim, Squeeze, and Sweep), code word (Code RED). The door could be unlocked with a small key or a coin	K 050		
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by Based on document review and interview, the facility failed to maintain the fire sprinkler system.	K 062	**NFP 101 Life Safety code Standard** **K062** Immediate Actions Taken: 9/23/14 The fire sprinkler repairs listed were scheduled and completed on 9/23/2014	

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K 062	Continued From page 10 This was evidenced by documented failures of the sprinkler system during an inspect on by a licensed vendor and by the failure to conduct 1 of 4 quarterly test of the Inspector's Test Valve. This could resu l in the failure of the fire sprinkler system in the event of a fire. This affected 3 of 3 smoke compartments. NFPA 101, L fe Safety Code 2000 Edition 9 7 5 Maintenance and Testing. All automatic sprinkler and standp pe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based F re Protection Systems 4 6 12.1 Whenever or wherever any device, equ pment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by the authority having jurisdiction. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 1998 Edition 1-11.3 Corrective maintenance includes, but is not limited to, replacing loaded, corroded, or painted sprinklers; replacing missing or loose pipe hangers, cleaning clogged fire pump impellers, replacing valve seats and gaskets, restoring heat in areas subject to freezing temperatures where water-filled piping is installed, and replacing worn or missing fire hose or nozzles. 9-5.1.1 All valves shall be inspected quarterly	K 062	Systemic Changes: Annual fire sprinkler inspection and quarterly valve testing are scheduled on an ongoing basis by the Director of Plant Operations. A vendor was selected who will also calendar the required inspections and testing in their PM system.. Any corrective actions required as a result of the scheduled testing are performed as soon as possible following the testing. The testing schedule, results of the testing and any corrective actions required and performed are reported to and reviewed by hospital leadership and the Environment of Care Team by the Director of Plant Operations. Monitoring: The Annual fire sprinkler inspection and quarterly valve testing schedule, results of the testing and any corrective actions required and performed are monitored and reported through Leadership Team meetings and the hospital Quality Assurance and Environment of Care Team meetings at least quarterly in order to evaluate the POCs effectiveness. . Any deficiencies noted in the interim will be immediately corrected.	9/23/14

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K 062	Continued From page 11 The inspection shall verify that the valves are in the following condition: (a) In the open position (b) Not leaking (c) Maintaining downstream pressures in accordance with the design criteria (d) In good condition, with handwheels installed and unbroken 1-8.1 Records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. 2-2.1.1 Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint and physical damage and shall be installed in the proper orientation (e.g., upright, pendent, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, or in the improper orientation. Exception No. 1: Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown. 2-2.6 Alarm Devices. Alarm devices shall be inspected quarterly to verify that they are free of physical damage. Findings: During document review with the Director of Plant Operations and the Chief of Ancillary Services on 9/9/14, the sprinkler maintenance documents	K 062		

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K 062	Continued From page 12 were reviewed, repair documents were requested, and a staff member was interviewed. 1. At 9:57 a.m., there was no documented evidence of an Inspector's Test Valve test for the month of March 2014. The testing records provided the dates 6/17/14 and 1/13/14. 2. At 9:59 a.m., there was documented evidence that 29 sprinklers failed during an annual inspection on 6/6/14 by a licensed vendor. There was no evidence of repairs. The following items were identified as failed: a. 15 corroded sprinkler heads at the main entrance. b. 3 corroded sprinkler heads in the kitchen. c. 1 corroded sprinkler head in the basement. d. 2 corroded sprinkler heads at the south exit. e. 4 corroded sprinkler heads located at the west over hang. f. 2 corroded sprinkler heads at south exit (165 ssp 8 ft ceiling). g. 2 corroded sprinkler heads at west exit (165 ssp 8 ft ceiling). 3. At 10:02 a.m., the Director of Plant Operations said during an interview, that he has schedu'ed to have the sprinklers repaired tomorrow.	K 062		
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10	K 064	NFP 101 Life Safety code Standard K064 Immediate Actions Taken: 9/9/14 The dresser was removed and remedial instruction was immediately provided to all staff members on the unit in the proper clearance required to maintain access to all fire extinguishers.	

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K 064	Continued From page 13	K 064		

This STANDARD is not met as evidenced by:
Based on observation and interview, the facility failed to maintain its portable fire extinguishers. This was evidenced by a portable fire extinguisher that was obstructed from access. This could result in a delay of access to the fire extinguisher in the event of a fire. This affected 1 of 3 smoke compartments.

NFPA 101, Life Safety Code, 2000 Edition
9.7.4 Manual Extinguishing Equipment.
9.7.4.1* Where required by the provisions of another section of this Code, portable fire extinguishers shall be installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers.

NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition
1-6.3 Fire extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of fire. Preferably they shall be located along normal paths of travel, including exits from areas.

Findings:

During a tour of the facility with the Director of Plant Operations, and the Chief of Ancillary Services on 9/9/14, the portable fire extinguishers were observed, and staff was interviewed.

1. At 9:51 a.m. there was a fire extinguisher near the soiled utility Room/Bio-Hazard Room near shower B, that was impeded from access with a three drawer dresser in front of the device.

Systemic Changes: 9/25/14

Remedial instruction was given for all staff members in the proper clearance required to maintain access to all fire extinguishers. In addition, signage was placed on each fire extinguisher cabinet as a reminder.

Monitoring:

Proper clearance for all fire extinguishers is being monitored during monthly Safety Rounds as well as daily during charge nurse rounds. Results of the monitoring will be reported through the quality assurance reports at the Leadership Team meetings and the hospital Quality Assurance meeting at least quarterly in order to evaluate the POCs effectiveness. . Any deficiencies noted in the interim will be immediately corrected.

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K 064	Continued From page 14 2. At 9:52 a.m., the Director of Plant Operations said during an interview that the dresser should not be in front of the fire extinguisher. The Director of Plant Operations stated that it not there yesterday when he toured.	K 064		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9 1.2 This STANDARD is not met as evidenced by Based on observation and interview, the facility failed to maintain their electrical equipment and utilities. This was evidenced by a multi-plug power strip that was plugged into another multi-plug power strip, and by unidentified circuit breakers. This could result in an electrical fire and cause delay in locating a circuit breaker. This affected 1 of 3 smoke compartments. NFPA 101, Life Safety Code, 2000 Edition SECTION 9.1 UTILITIES 9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction. NFPA 70, National Electrical Code, 1999 Edition 240-4 Flexible cord, including tinsel cord and extension cords, and fixture wires shall be protected against overcurrent by either (a) or (b) (a) Ampacities. Flexible cord shall be protected by an overcurrent device in accordance with its ampacity as specified in Tables 400-5(A) and (B).	K 147	NFP 101 Life Safety code Standard K147 Immediate Actions Taken: 9/10/14 The improperly deployed multi-plug power strips were removed and all plugs and cords were re-done to insure that they were orderly and proper. Re Remedial instruction was immediately provided to the staff members on the unit. An Electrical contractor was hired to begin to work to trace electrical circuits 2, 5, 25 26, and 28 to label appropriately. Systemic Changes: 9/25/14 Remedial instruction was given for all staff members in the proper use when required of extension cords/multi-plug power strips. Whenever an extension cord or multi-plug power strip is needed, the plant operations department will inspect to insure proper usage. The electrical contractor will verify the hospital single line drawing and review each circuit to insure that they are all labeled correctly.	

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K 147	Continued From page 15 Fixture wire shall be protected against overcurrent in accordance with its ampacity as specified in Table 402-5. Supplementary overcurrent protection, as in Section 240-10, shall be permitted to be an acceptable means for providing this protection. 400-8 Unless specifically permitted in Section 400-7, flexible cord and cables shall not be used for the following. (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces (5) Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (6) Where installed in raceways, except as otherwise permitted in this Code 384-13. General. All panelboards shall have a rating not less than the minimum feeder capacity required for the load computed in accordance with Article 220. Panelboards shall be durably marked by the manufacturer with the voltage and the current rating and the number of phases for which they are designed and with the manufacturer's name or trademark in such a manner so as to be visible after installation, without disturbing the interior parts or wiring. All panelboard circuits and circuit modifications shall be legibly identified as to purpose or use on a circuit directory located on the face or board Findings:	K 147	Monitoring: The absence of improper usage of Multi-plug power strips and extension cords and the proper labeling of electrical circuits is being monitored during monthly Safety Rounds. Results of the monitoring will be reported through the quality assurance reports at the Leadership Team meetings and the hospital Quality Assurance meeting at least quarterly in order to evaluate the POCs effectiveness. . Any deficiencies noted in the interim will be immediately corrected.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147	Continued From page 16 During a tour of the facility with the Director of Plant Operations, and the Chief of Ancillary Services on 9/9/14, the electrical equipment and wiring were observed, and a staff person was interviewed. 1. At 9:47 a.m., there was a multi-plug power strip that was plugged into another multi-plug power strip under the desk of the nursing station 2. At 9:49 a.m., there were 6 of 42 circuit breakers that were not identified to their purpose. Circuits 2, 5, 6, 25, 26, and 28 were not labeled. 3. At 9:50 a.m., the Director of Plant Operations said during an interview, that he was working with Office of Statewide Health Planning and Development to correct the unmarked circuit breakers	K 147		

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA060001166	A. BUILDING _____ B. WING _____	C 08/18/2014

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A 000	Initial Comments The following reflects the findings of the California Department of Public Health during the investigation of COMPLAINT NUMBER: CA00408741. Inspection was limited to the specific complaint(s) investigated and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: Surveyor 1835, HFEN. Findings for Complaint Number: CA00408741. The complaint allegation(s) were substantiated and regulatory violations written at A001 and A017.	A 000	**This Plan of Correction constitutes my written credible allegation of compliance to the deficiency noted.**	
A 001	Informed Medical Breach Health and Safety Code Section 1280.15 (b)(2), " A clinic, health facility, agency, or hospice shall also report any unlawful or unauthorized access to, or use or disclosure of, a patient's medical information to the affected patient or the patient's representative at the last known address, no later than five business days after the unlawful or unauthorized access, use, or disclosure has been detected by the clinic, health facility, agency, or hospice." The CDPH verified that the facility informed the affected patient(s) or the patient's representative(s) of the unlawful or unauthorized access, use or disclosure of the patient's medical information.	A 001	**Health and Safety Code Section 1280.15(b)(2),** **A001** Immediate Actions Taken: As soon as the potential breach was identified, the Activity Coordinator (AC) was interviewed and placed on administrative suspension until the investigation was complete. The AC was asked if she had posted PHI on any social media for any patient at any time other than this one incident. The AC stated that there were no other	8/4/2014

Licensing and Certification Division
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 017	Continued From page 1	A 017	postings. Additionally the Facebook page was reviewed at the time and this was confirmed. The posting with the photo was removed from the AC's Facebook account at this time. The hospital Compliance Officer was notified who then informed the patient's representatives of the disclosure.	8/7/14
A 017	1280.15(a) Health & Safety Code 1280 (a) A clinic, health facility, home health agency, or hospice licensed pursuant to Section 1204, 1250, 1725, or 1745 shall prevent unlawful or unauthorized access to, and use or disclosure of, patients' medical information, as defined in subdivision (g) of Section 56.05 of the Civil Code and consistent with Section 130203. The department, after investigation, may assess an administrative penalty for a violation of this section of up to twenty-five thousand dollars ($25,000) per patient whose medical information was unlawfully or without authorization accessed, used, or disclosed, and up to seventeen thousand five hundred dollars ($17,500) per subsequent occurrence of unlawful or unauthorized access, use, or disclosure of that patients' medical information. For purposes of the investigation, the department shall consider the clinic's, health facility's, agency's, or hospice's history of compliance with this section and other related state and federal statutes and regulations, the extent to which the facility detected violations and took preventative action to immediately correct and prevent past violations from recurring, and factors outside its control that restricted the facility's ability to comply with this section. The department shall have full discretion to consider all factors when determining the amount of an administrative penalty pursuant to this section. This Statute is not met as evidenced by: Findings: Review of hospital documentation showed a breach involving Patient A, an incapacitated	A 017	<u>Systemic Changes:</u> HIPAA in-services were performed by the Compliance Officer for all staff. The Compliance Officer met with the AC for a one on one session. The use of social media and its potential for privacy violations was emphasized. A pamphlet titled "A Nurse's Guide to the Use of Social Media" was ordered from the National Council of State Boards of Nursing and shared with all patient care staff. The content of the Compliance Officer's in-services as well as the pamphlet is included in new employee orientation for all new employees. <u>Monitoring:</u> The staff has been requested to notify the leadership/supervisory team about any potential social media (or other) HIPAA violations immediately, either ones they committed or other staff may have committed. The leadership and supervisory teams will be reminded by the CNO/COO during monthly management meetings to reinforce this reporting requirement with their staff and query the staff during unit staff	9/2/14 9/2/14 9/2/14 ongoing

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A 017	Continued From page 2 minor, occurred on 8/2/14. On 8/4/14, the hospital's investigation showed a photo of Patient A was posted onto the Activity Coordinator's (AC) Facebook (a social network) account. The Facebook post of Patient A's photo showed it had been viewed by unauthorized "friends" of the AC. There were also comments posted between the parents of Patient A and the AC. Further review of the hospital's investigation showed an interview with the AC occurred on 8/4/14. The AC stated, when asked, she was aware taking the picture and posting it on Facebook violated privacy laws as well as hospital policy, but did it anyway for the parents. Patient A's disclosed PHI included a full face and torso picture which showed the tracheostomy dressing at his neck and the use of stabilization cushions. The picture portrays Patient A as a patient of the hospital as evidenced by the electrical socket in the wall behind the patient and the privacy curtains at each side. On 8/18/14 at 1132 hours, an informal telephone conference with the Chief Compliance Officer confirmed the breach occurred as documented. Additionally, it was confirmed there was no documentation found permitting the AC to photograph the patient for posting on a social network.	A 017	meetings. Any reports about potential violations are reported to the Compliance Officer and investigated in accordance with the usual compliance investigations procedure. Results are reported by the Compliance Officer to the Compliance Committee on a quarterly basis. Periodically the process will be assessed by the Compliance Committee to determine whether additional or different measures might be considered.	

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	555730	A. BUILDING _____ B. WING _____	C 08/08/2014

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F 000	INITIAL COMMENTS The following represents the findings of the California Department of Public Health during an ABBREVIATED survey for complaint No: CA00405575. The investigation was limited to the specific complaint investigated and does not represent the findings of a full investigation of the facility. Representing the California Department of Public Health: Pharmacist Consultant II, 32097 and Pharmacist Consultant II, 13095 The Pharmacist Consultants entered the facility on 7/22/14 at 1340 hours and reviewed three clinical records. THE DEPARTMENT WAS ABLE TO SUBSTANTIATE THE COMPLAINT ALLEGATIONS. Glossary: P&P: Policy and Procedure RPh: Facility Pharmacist RN: Registered Nurse MAR: Medication Administration Record	F 000	**This Plan of Correction constitutes my written credible allegation of compliance to the deficiencies noted.**	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 425	**483.60(1)(b) PHARMACEUTICAL SVC-ACCURATE PROCEDURES, RPH** **F425** Immediate Actions Taken: 1. Cephalexin was immediately administered to Resident 1 upon return from the outside appointment. Charge nurses will immediate notify the pharmacy upon receipt of any new medication order The charge nurse will call the pharmacy for any new order for anti-infectives, and drugs used for nausea, agitation, diarrhea or other	8/8/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

CEO | 8/22/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 425	Continued From page 1 A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility failed to implement their P&Ps to ensure resident safety as evidenced by: 1. Cephalexin (antibiotic used to treat infections) was not administered within four hours of the ordered time for Resident 1. This failure has the potential to result in a delay of treatment. 2. The pharmacy dispensed pediatric glycerin (laxative) suppositories instead of a dulcolax (laxative) suppository for Resident 2. This failure has the potential to result in a medication error. 3. A physician's medication order was not accurately transcribed for Resident 3. This failure has the potential to result in a medication error. 4. There was no accountability of the medications in the oral emergency kit (E-Kit) when it was left unlocked and there was no documentation of the	F 425	severe discomfort if not received within 2 hours to insure timely delivery. The medication will be administered immediately upon receipt. 2. All medications were reviewed to insure that there were no other errors in dispensing. All medications are verified with the MAR before administration. 3. The Transcription error was corrected before any incorrect doses were administered. All other new orders and recaps were reviewed to insure accurate transcription. No other errors were found. 4. The e-kit withdrawal form was immediately completed and the kit was locked with the appropriate lock and pharmacy notified for replacement. <u>Systemic Changes:</u> 1. E-kit contents were reviewed to insure that common anti-infectives, and drugs used for nausea, agitation, diarrhea or other severe discomfort are present and stocked. A meeting was held with the pharmacy to insure that any new stat or anti-infectives, and drugs used for nausea, agitation, diarrhea or other severe discomfort that are not present in the e-kit will be delivered by the pharmacy in a timely manner so that the medication can be administered	8/8/2014 8/8/2014 8/8/2014 8/19/2014

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F 425	Continued From page 2 medication removed from the kit found on the emergency medication log. This failure has a potential to result in a medication diversion or loss. Findings: 1. Review of the facility's P&P titled "Administration of Medication: General - Sub-Acute" dated 3/11, showed on page 4: anti-infectives and drugs used to treat severe pain, nausea, agitation, diarrhea, or other severe discomfort shall be available and administered within four hours of the time ordered. Clinical record review for Resident 1 was initiated on 8/4/14. Review of Resident 1's physician's orders showed cephalexin 250 mg was ordered on 8/2/14 at 1015 hours, for a possible infected ingrown hair on the left labia. Review of the facility's faxed confirmation showed the order was faxed to the pharmacy on 8/2/14 at 1025 hours, per the charge RN. Review of the Out of Facility Release form showed the resident was out of the facility on 8/2/14 between the 1500 and 2100 hours. Review of Resident 1's MAR showed cephalexin was administered at 2200 hours on 8/2/14, 11 hours and 45 minutes after the ordered time. During an interview on 8/4/14 at 1415 hours, RPh 1 stated the Pharmacy's documentation showed the order was received at 1115 hours. Cephalexin was delivered at 1800 hours. During an interview on 8/4/14 at 1220 hours, Charge RN 1 confirmed the cephalexin for Resident 1 was delivered from the pharmacy at	F 425	within the 4 hour time window. In-service education was conducted with the Charge Nurses. 2. It was noted that the two drugs in question were packaged very similarly. Glycerin suppositories and dulcolax suppositories were added to the look alike/sound alike alert list. A different brand of drug is being requested so that there is a greater contrast between the two packaging. 3. A new computer system is being deployed to reduce manual transcription of medication recaps and renewals. The 24 hour chart check policy and procedure was written and reviewed with the licensed nursing staff during a mandatory in-service education session. 4. In-service education was completed for all licensed nurses on the proper use of the e-kit. The e-kit review was added to the charge nurse checklist to insure that the proper procedures are being followed. <u>Monitoring:</u> 1. All orders for new stat or anti-infectives, and drugs used for nausea, agitation, diarrhea or other severe discomfort will be monitored for timely administration. The number of drugs administered within the 4 hour time frame divided by the number ordered will be	8/29/2014 8/29/2014 8/29/2014 8/29/2014

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F 425	Continued From page 3 1800 hours on 8/2/14 and administered at 2200 hours. 2. Inspection of medication cart 1 was initiated on 8/4/14 at 1205 hours. A clear medication bag labeled as containing a dulcolax suppository for Resident 2 was found in the medication cart. However, the content of the medication bag was identified as two pediatric glycerin suppositories. RN 1, RPh 1 and RPh 2 examined the bag labeled as dulcolax suppository for Resident 2 and acknowledged the bag contained pediatric glycerin suppositories. 3. Review of the facility's Administration P&P titled ADM-334 Transcription of Physician's Orders" dated 11/10, read: "Goal: To assure accuracy in transcription as well as coordination and implementation of therapeutic orders ....L. The physician must be notified of the inability to carry out an order if appropriate. A 24 hour chart check must be completed during the Night Shift to verify the accuracy and follow through of all orders written that day." Review of the facility's Nursing Services P&P titled NUR-232 Medication Administration, General Guidelines dated 11/10, read: "A. All medication orders must be ordered for a specific patient and include the name of drug, exact dosage ..." Review of the facility's Pharmacy P&P titled RX-173 Orders: Drugs dated 11/10, read: "All orders for drugs shall be written ....All orders for medications, procedures and devices shall be reviewed by a pharmacist." The clinical record for Resident 3 was reviewed	F 425	reported through the quality assurance reports at the Leadership Team meetings in order to evaluate the POCs effectiveness. Further changes will be implemented if necessary based on this evaluation. 2. All medications are verified by the licensed nurse to insure the proper medication is administered. Any discrepancies are immediately reported to the charge nurse and pharmacy. Each incidence will be reported through the quality assurance reports at the Leadership Team meetings in order to evaluate the POCs effectiveness. Further changes will be implemented if necessary based on this evaluation. 3. All Transcription errors found during the 24 hour chart check and/or pharmacist review will be immediately verified and corrected. Each incidence will be reported through the quality assurance reports at the Leadership Team meetings in order to evaluate the POCs effectiveness. Further changes will be implemented if necessary based on this evaluation. 4. Each entry into the e-kit will be monitored by the charge nurse. Each entry divided by the number of correctly processed entries will be reported through the quality assurance reports at the Leadership Team meetings in order	8/29/2014 8/29/2014 8/29/2014

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F 425	Continued From page 4 on 8/4/14 at 1500 hours. A hand-written physician's medication order for Baclofen (a muscle relaxant) dated on 8/3/14, showed an order for "Baclofen 10 milligram (mg) tab via gastrostomy tube (GT) every 6 hours for spasticity." Review of Resident 3's MAR on 8/4/14 at 1505 hours, showed the resident received a different amount of Baclofen than was ordered on 8/3/14. The medication order transcribed on Resident 3's MAR read: "Baclofen 10 mg tab take 2.5 tabs (25 mg) via G-Tube every 6 hours for spasticity." During an interview with Charge Nurse 2 on 8/4/14 at 1545 hours, Charge Nurse 2 confirmed the above order for Baclofen on Resident 3's MAR. In a concurrent interview with RN 1, the RN stated she transcribed the physician's medication order for the Baclofen in Resident 3's clinical record on 8/3/14. During the interview, RN 1 stated: "I gave this resident 25 mg of Baclofen this morning, but I must have been writing too fast when I wrote this order and I made this mistake." RN 1 further stated a second licensed nurse on the night shift of 8/3/14, reviewed the physician's medication order for Baclofen transcribed by RN 1. The second licensed nurse, who was responsible for reviewing all medication orders written during the day shift, did not catch the transcription error made by RN 1 earlier on 8/3/14, regarding Resident 3's Baclofen order. During an interview with Charge Nurse 2 and PIC on 8/4/14 at 1550 hours, they stated the physician's order, written by RN 1 for Resident 3's Baclofen, was not reviewed by the RPh. 4. Review of the facility's Pharmacy P&P titled	F 425	to evaluate the POCs effectiveness. Further changes will be implemented if necessary based on this evaluation.	

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F 425	Continued From page 5 Emergency Medication Supplies dated 01/01/13, showed the facility should complete the emergency box withdrawal form for documenting the resident and the medication used for the resident. On 8/7/14 at 1410 hours, the E-Kits were inspected in the medication room with the Charge Nurse, RPh 2 and the Nurse Manager. The oral E-kit was unlocked. Review of the Emergency Medication log inside the E-kit showed it was not completed. The Charge Nurse, RPh 2 and the Nurse Manager acknowledged the unlocked E-kit and that there was no documentation as to when the E-kit was opened, by whom and what medication was removed from the E-kit. The Charge Nurse stated the E-kit was opened during the night, and the night Charge Nurse notified the pharmacy that the E-Kit was opened per the change of shift report.	F 425		

RESPONSE TO DEFICIENCIES
EXHIBIT P CMS Statements of Deficiency

Southern California Hospital at Culver City

COUNTY OF LOS ANGELES
HEALTH FACILITIES DIVISION
3400 Aerojet Avenue, Suite 323
El Monte, CA 91731

FACSIMILE TRANSMISSION

ADDRESSEE:	ORIGINATOR:
NAME: Pamela Loo, RN Director of Quality **Attention:**	FROM: Rosario Grospe, RN, Senior HFEN Assistant Supervisor, Acute and Ancillary Unit
ORGANIZATION: Southern California Hosp at Culver City SNF DP	**Phone:** (626) 312-1129
CITY, STATE, & ZIP Culver City	FAX: (626) 927-9293
Telephone 310-836-7000 ext 1046	DATE 714/15
FAX #: 310-840-5426	PAGES INCLUDING COVER PAGE = 11

NOTES TO ADDRESSEE:

Attached is the ameded CMS 2567, Statement of Deficiencies and Plan of Correction for the Recertification Survey (LSC) completed 6/22/15. The hard copy will be mailed today. Please sign the Signature Requirement Notice and fax it back to our office as soon as possible.

Please submit the plan of correction on or before 7/24/15.

If you have any questions, please don't hesitate to call us.

Thank you, Rosario Grospe, Senior HFEN

Information contained in this facsimile message is privileged and confidential information intended for the use of the Addressee listed above.

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If you have received this FAX in error, please notify the sender immediately by telephone and destroy all documents received in error.

State of California—Health and Human Services Agency Department of Health Services

SIGNATURE REQUIREMENT NOTICE
(For Plan of Correction)

Notice to Licensee/Designee

The surveying state agency is required to obtain a signed plan of correction for deficiencies noted on the Statement of Deficiencies and Plan of Correction (Code of Federal Regulations, Title 42, Section 489.13; State Operations Manual, Section 2612; and California Health and Safety Code, Section 1280). By signing a plan of correction, a licensee or designee does not necessarily admit guilt of any alleged violation nor does this interfere with the right to contest or appeal any alleged violations on which the plan of correction is based or the same period for correction. It does acknowledge responsibility for compliance with licensing requirements, with appropriate requirements of the Medicare and Medi-Cal programs, that an exit conference was held during which the items listed were discussed, and that a copy of the deficiency/report and plan of correction was received.

Name of facility	City
Southern California Hosp at Culver City SNF/DP	Culver City

Copy of this notice received:

Licensee or designee signature	Date
Gerald B. Clute	7/20/15

Copy of this notice presented to licensee or designee:

Licensing Evaluator signature	Date
Rosario Grosse for Sin Lin Chang	7/13/15

Complaint Notice

If there should be disagreement between the Licensee or Designee and the Evaluator of the Survey Team on an interpretation of the regulations or a field decision, the Licensee of Designee may wish to call and discuss this with the District Licensing Supervisor.

Name of Licensing Supervisor	Telephone
Eric Stone, Program Manager	626-312-1142

Instructions

This notice is to be used with Plans of Correction for Skilled Nursing Facilities, Intermediate Care Facilities, Intermediate Care Facilities/Developmentally Disabled, Intermediate Care Facilities/Developmentally Disabled-Habilitative, Intermediate Care Facilities/Developmentally Disabled-Nursing, Congregate Living Health Facilities, Pediatric Day Health and Respite Care Facilities, and Hospitals with Distinct Part Skilled Nursing Facilities or Intermediate Care Facilities. It is to be signed by the licensee/designee and the licensing evaluator. A copy is left with the licensee/designee and the original is kept in the district office licensing file.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	555874		06/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during a re-certification survey. Representing the Department of Public Health: Surveyor 17030, RN, HFEN Surveyor 25524, RN, HFEN Surveyor 16281, REHS, HFE Total Resident Population 17 Total Resident Sample Size: 8 Highest Scope/Severity: E	F 000		
F 154 SS=E	483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the resident or the resident's representative had the right to be fully informed in advance of the risks and benefits of anti-antipsychotic and physical restraints to be administered to six (6) of eight (8) sampled residents (1, 2, 3, 4, 6, and 7). The facility failed	F 154	1. How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Corrective Action will be accomplished by the re-education of staff on the Restraints Policy and Procedure Application and monitoring SAA.049 and Consents PAT.037, completed on 7/19/2015. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. The SubAcute Unit at Southern California Hospital at Culver City (SCHCC) will identify other residents having the same potential for deficient practice by discussing restraint plan of care in interdisciplinary weekly rounds, and 100% monitoring of restraint documentation and informed consents, and will monitor them beginning August 1,2015 as process improvements and report it quarterly to quality council, medical executive committee and governing board.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Gerald [signature]	CEO	7/20/15

...y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ...her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555874	A. BUILDING 01 - BROTMAN MEDICAL CENTER DP SNF B. WING _____	06/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS This facility was surveyed under 42 CFR Part 483.70(a), Life Safety Code NFPA 101, 2000 Edition, Chapter 19, Existing Health Care Occupancies, and other applicable codes. Amended 7/14/15 Representing the Department of Public Health: Evaluator ID#16281 The following represents the findings of the Department of Public Health during a Life Safety Code Survey.	K 000		
K 050 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on record review, and interview, the facility failed to provide supporting documentation that the subacute staff participated in fire drills at least quarterly on each shift. The deficiency had the potential for staff to not be familiar with the facility's fire emergency plan, and not be prepared to put it in effect in the event of a	K 050	*Fire Drill reports* • No residents were affected by the deficient practice. • The Facility performs audits of all Fire Life Safety requirements on a monthly basis to ensure compliance. • An additional form has been added to the Fire Drill Critique package to document participation/attendance for all employees. The facilities Environment of Care committee meets regularly and fire drills are monitored and reviewed at these meetings. The hospital has also assigned the Vice President of Facilities to ensure that all Life safety & Environmental requirements are met. • Fire Drills are reported to the EOC Committee and any deficiencies will be corrected immediately. EOC reports quarterly to the Quality Council, Medical Executive Committee and the Governing Board. • Changes completed on 6/30/16	6/30/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

CEO | 7/20/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

SIGNATURE REQUIREMENT NOTICE
(For Plan of Correction)

Notice to Licensee/Designee

The surveying state agency is required to obtain a signed plan of correction for deficiencies noted on the Statement of Deficiencies and Plan of Correction (Code of Federal Regulations, Title 42, Section 488.13; State Operations Manual, Section 2612; and California Health and Safety Code, Section 1280). By signing a plan of correction, a licensee or designee does not necessarily admit guilt of any alleged violation nor does this interfere with the right to contest or appeal any alleged violations on which the plan of correction is based or the same period for correction. It does acknowledge responsibility for compliance with licensing requirements, with appropriate requirements of the Medicare and Medi-Cal programs, that an exit conference was held during which the items listed were discussed, and that a copy of the deficiency/report and plan of correction was received.

Name of facility	City
Southern California Hosp at Culver City SNF/DP	Culver City

Copy of this notice received:

Licensee or designee signature	Date

Copy of this notice presented to licensee or designee:

Licensing Evaluator signature	Date
Rosario Broyce for Sirlin Chang	7/13/15

Complaint Notice

If there should be disagreement between the Licensee or Designee and the Evaluator of the Survey Team on an interpretation of the regulations or a field decision, the Licensee of Designee may wish to call and discuss this with the District Licensing Supervisor.

Name of Licensing Supervisor	Telephone
Eric Stone, Program Manager	626-312-1142

Instructions

This notice is to be used with Plans of Correction for Skilled Nursing Facilities, Intermediate Care Facilities, Intermediate Care Facilities/Developmentally Disabled, Intermediate Care Facilities/Developmentally Disabled-Habilitative, Intermediate Care Facilities/Developmentally Disabled-Nursing, Congregate Living Health Facilities, Pediatric Day Health and Respite Care Facilities, and Hospitals with Distinct Part Skilled Nursing Facilities or Intermediate Care Facilities. It is to be signed by the licensee/designee and the licensing evaluator. A copy is left with the licensee/designee and the original is kept in the district office licensing file.

COUNTY OF LOS ANGELES
Public Health

CYNTHIA A. HARDING, M.P.H.
Interim Director

JEFFREY D. GUNZENHAUSER, M.D., M.P.H.
Interim Health Officer

ANGELO J. BELLOMO, REHS, QEP
Director of Environmental Health

TERRI S. WILLIAMS, REHS
Assistant Director of Environmental Health

5050 Commerce Drive
Baldwin Park, California 91706
TEL (626) 430-5100 · FAX (626) 813-3000

www.publichealth.lacounty.gov

BOARD OF SUPERVISORS

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Fifth District

Letter 4

IMPORTANT NOTICE - PLEASE READ CAREFULLY

July 13, 2015

Darrin Buckner, RN
Director of Subacute
Southern California Hosp At Culver City D/p Snf
3828 Delmas Terrace
Culver City, CA 90230

Dear Administrator:

On June 22, 2015, a standard annual Health and Life Safety Code survey was conducted at your facility by the California Department of Public Health, Licensing and Certification Program (Los Angeles Acute - South), to determine if your facility was in compliance with federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiency(ies) to be:

[ ] Isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the enclosed "Statement of Deficiencies and Plan of Correction" form, whereby corrections are required (D).

[x] A pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the enclosed "Statement of Deficiencies and Plan of Correction" form, whereby corrections are required (E).

The enclosed Centers for Medicare and Medicaid Services (CMS) form, entitled "Statement of Deficiencies and Plan of Correction" (CMS-2567), documents the deficiencies of participation requirements identified during this visit. All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations (CFR).

Plan of Correction (POC)

A POC for the deficiencies must be submitted within **ten (10) days from receipt of the CMS- 2567.** Failure to submit an acceptable POC by the due date will result in remedies being recommended for imposition by the CMS and/or the State Medicaid Agency effective as soon as notice requirements are met.

Your POC must be submitted on the enclosed CMS-2567 form and must contain the following:

- How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;
- How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system; and
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Agency.

Remedies will be recommended for imposition by the CMS Regional Office and/or the State Medicaid Agency if your facility has failed to achieve substantial compliance by .

Recommended Remedies

The remedies, which will be recommended if substantial compliance has not been achieved by July 23, 2015 , include the following:

[x] Civil money penalty of $ 150.00 , effective June 22, 2015 (§488.430).

We are also recommending to the CMS Regional Office and/or the State Medicaid Agency that your provider agreement be terminated on if substantial compliance is not achieved by that time.

Denial of Payment for New Admissions (DPNA)

Based on deficiencies cited during this survey and as authorized by CMS San Francisco Regional Office, we are giving formal notice of imposition of statutory DPNA effective September 22, 2015. This remedy will be effectuated on the stated date unless you demonstrate substantial compliance with an acceptable POC and subsequent revisit. This notice in no way limits the prerogative of CMS to impose discretionary DPNA at any appropriate time.

CMS Regional Office will notify your intermediary and the Medicaid Agency. If effectuated, denial of payment will continue until your facility achieves substantial Compliance or your provider agreement is terminated. Facilities are prohibited from billing those Medicare/Medicaid residents or their responsible parties during the denial period for services normally billed to Medicare or Medicaid.

Appeal Rights

If you disagree with the determination of noncompliance (and/or substandard quality of care, if applicable), you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in 42 CFR §498.40, et. seq. You may appeal the finding of noncompliance that led to an enforcement action, but not the enforcement action or remedy itself. A written request for hearing must be filed no later than 60 days from the date of receipt of this letter.

Such written request should be made directly to:

Attention: Ms. Karen Robinson
Departmental Appeals Board
Civil Remedies Division
Cohen Building, Room G-644
330 Independence Avenue S.W.
Washington, D.C. 20201

A request for hearing should identify specific issues, and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You may be represented at a hearing by counsel at your own expense.

Be sure to include a copy of this letter with your request to the Departmental Appeals Board. In addition, please forward a copy of your request to:

Attention: Paula Perse, Manager
Long Term Care Branch
Division of Survey and Certification
Centers for Medicare & Medicaid Services
90 7th Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

Alternatively, you can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at https://dab.efile.hhs.gov.

To file a new appeal using DAB E-File, you first need to register a new account by: (1) clicking **Register** on the DAB E-File home page; (2) entering the information requested on the "Register New Account" form; and (3) clicking **Register Account** at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he or she is a party or authorized representative. Once registered, you may file your appeal by:

-Clicking the **File New Appeal** link on the Manage Existing Appeals screen, then clicking Civil Remedies Division on the File New Appeal screen.
And,
-Entering and uploading the requested information and documents on the "File New Appeal-Civil Remedies Division" form.

At minimum, the Civil Remedies Division (CRD) requires a party to file a signed request for hearing and the underlying notice letter from CMS that sets forth the action taken and the party's appeal rights. All documents must be submitted in Portable Document Format ("PDF"). Any document, including a request for hearing, will be deemed to have been filed on a given day, if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day. A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the Administrative Law Judge, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service. More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E-File Procedures link on the File New Appeal Screen for CRD appeals.

If you choose to file your appeal electronically, please also send a copy of the hearing request to:

Attention: Paula Perse, Manager
Long Term Care Branch
Division of survey and Certification
Centers for Medicare & Medicaid Services
90 7th Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

Allegation of Compliance

If you believe these deficiencies have been corrected, you may submit your POC as your allegation of compliance to Eric Stone, Program Manager, California Department of Public Health, Licensing and Certification Program, Los Angeles Acute and Ancillary Unit - South, 3400 Aerojet Suite 323 El Monte, CA 91731. We may accept your POC as your allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy(ies) at that time.

If, upon a subsequent revisit or by other means it is determined your facility has not achieved substantial compliance, we will recommend the remedies previously mentioned in this letter be imposed by the CMS Regional Office beginning on June 22, 2105 and continue until substantial compliance is achieved. Additionally, the CMS Regional Office may impose a revised remedy(ies), based upon changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

Informal Dispute Resolution

In accordance with §488.331, you have one (1) opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and relevant information (evidence) as to why you are disputing those deficiencies to Suzette Leverett - Clark, RN Assistant Chief, California Department of Public Health, Licensing and Certification Division at 12440 East Imperial Highway Room 522, Norwalk, CA 90650.

This request must be sent during the same ten (10) days you have for submitting a POC for the cited deficiencies. An informal dispute resolution for the cited deficiencies will not delay the imposition of the recommended enforcement actions. A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

Should CMS determine that termination or any other remedy is warranted, they will provide you with a separate formal notification of that determination.

If you have questions concerning the instructions contained in this letter, please contact, Eric Stone, Program Manager, at (626) 312-1142.

Sincerely,

Nwamaka Oranusi, Acting Chief
Health Facilities Inspection Division

Rosario Quispe RN, Sr. HFEW for

Eric Stone, Program Manager
Acute and Ancillary Unit- South
3400 Aerojet Avenue Suite 323
Tel. (626) 312-1142 - Fax (626) 927-9293

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555674	A. BUILDING 01 - BROTMAN MEDICAL CENTER DP SNF B. WING _____	06/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

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K 147	Continued From page 9 (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (5) Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors. These Codes were not met as evidenced by: Based on observation and interview, the facility failed to ensure electrical wiring was in accordance with NFPA 70 National Electrical Code by having electrical cord run through a wall. The deficiency had the potential of not adhering to the provisions of NFPA 70 necessary for safety, and the practical safeguarding of persons, and property from hazards arising from the use of electricity. Findings: On 6/19/15 at 9:20 a.m., there was an electrical cord coming out of and entering a wall in the kitchen, above the dietary office room door. During an interview at the same time as the observation, the Dietician/Director of food & Nutrition stated that the electrical cord was connected to a video camera, but did not know why the wire was pulled out of, and back into the wall.	K 147	*Electrical Wiring* • No residents or staffs were affected by the said deficient practice. • The facility performs environmental rounds regularly and identifies deficiencies and reports the deficiencies to the Facilities Operations Center for repair. Environmental/Safety deficiencies are top priority and repairs are scheduled first. • The cable observed by the surveyor was identified as being video cable and is not high voltage and poses no electrical shock risk. The walls that the cable penetrates are not fire walls. • The facilities Environment of Care committee meets regularly and EOC audits are monitored and reviewed at these meetings. The hospital has also assigned the Vice President of Facilities to ensure that all Life safety & Environmental requirements are met. • Completed 6/24/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555874	A. BUILDING 01 - BROTMAN MEDICAL CENTER DP SNF B. WING _____	06/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

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K 140	Continued From page 8 log that included monitoring of the main and reserve liquid oxygen vessels' level and pressure readings. Earlier that morning at 9:10 a.m., the gauges at the main vessel had readings of 180 inches of water and 140 psi., and the gauges at the reserve vessel had readings of 108 inches of water and 135 psi. Both vessels were within their marked limits. Nine (9) of seventeen (17) residents were on nasal cannula or trach aerosol.	K 140		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: NFPA 70 National Electrical Code 1999 Edition 110-12. Mechanical Execution of Work. Electrical equipment shall be installed in a neat and workmanlike manner. 305-4.(h) Protection from Accidental Damage. Flexible cords and cables shall be protected from accidental damage. Sharp corners and projections shall be avoided. Where passing through doorways or other pinch points, protection shall be provided to avoid damage. 400-8. Uses not permitted. Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following:	K 147	*Electrical Wiring* • No residents or staffs were affected by the said deficient practice. • The facility performs environmental rounds regularly and identifies deficiencies and reports the deficiencies to the Facilities Operations Center for repair. Environmental/Safety deficiencies are top priority and repairs are scheduled first. • The cable observed by the surveyor was identified as being video cable and is not high voltage and poses no electrical shock risk. The walls that the cable penetrates are not fire walls. • The facilities Environment of Care committee meets regularly and EOC audits are monitored and reviewed at these meetings. The hospital has also assigned the Vice President of Facilities to ensure that all Life safety & Environmental requirements are met. • Completed 6/24/2015	

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K 140	Continued From page 7 Findings: 1. On 6/22/15 at 10:10 a.m., during document review, the Bulk Oxygen Source Evaluation Report Annual Inspection equipment checklist dated 12/30/14, indicated the following: The bulk primary system did not have a pressure switch for "Emergency Reserve in use". The signals were not wired to the master alarm panel(s). The source valve was not labeled. Source equipment was not free of leaks. The report also indicated a physical deficiency that reserve wires were cut at the pressure switch above the liquid gauge, and that the location of leakage was at the source valve. During an interview at the same time as the record review, the Director of Facilities stated that the physical deficiency listed on the report were wires that were cut because they use to be connected to the former fire alarm control panel (FACP), where it would activate an alarm if the oxygen was low at the bulk liquid oxygen vessels. That the new FACP does not activate an alarm when the oxygen is low at the vessels. That the there has never been an alarm system at the facility to monitor the operation and condition of the bulk oxygen source of supply and reserve. That the oxygen vessels did not send a signal to the liquid oxygen supplier/vendor when the vessels were low. That in lieu of the alarm, engineering staff conducted three rounds per day to monitor the oxygen tank and pressure levels at the gauges of the liquid oxygen vessels. Further document review revealed an engineering	K 140	*Source Valve labeled* • No residents were affected by the deficient practice. • The facility performs an annual medical gas deficiency audit annually and review by the Facilities Management staff. Any deficiencies found during the audit are prioritized and repaired in a timely manner. • The oxygen annual test is part of the quarterly EOC report and is reported to the EOC Committee, Quality Council, Medical Executive Committee and the Governing Board on a quarterly basis. • Completed 7/23/15 *Source equipment free of leaks* • No residents were affected by the deficient practice. • The facility performs an annual medical gas deficiency audit annually and review by the Facilities Management staff. Any deficiencies found during the audit are prioritized and repaired in a timely manner. • The oxygen annual test is part of the quarterly EOC report and is reported to the EOC Committee, Quality Council, Medical Executive Committee and the Governing Board on a quarterly basis. • The source leak was repaired 4/5/2015	

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K 140	Continued From page 6 for use only in an emergency. An actuating switch shall be connected to the master signal panels to indicate when, or just before, the reserve begins to supply the system. 4-3.1.2.2 Gas Warning Systems. (b) Master Alarms. 1. A master alarm system shall be provided to monitor the operation and condition of the source of supply, the reserve (if any), and the pressure of the main lines of all medical gas piping systems. 2. The master alarm system shall consist of two or more alarm panels located in two separate locations. One panel shall be located in the principal working area of the individual responsible for the maintenance of the medical gas piping systems and one or more panels shall be located to assure continuous surveillance during the working hours of the facility (e.g., the telephone switchboard, security office, or other continuously staffed location). This Standard was not met as evidenced by: Based on document review, interview, and observation, the facility staff failed to ensure the medical gas warning system was in accordance with NFPA 99 by not having medical gas master alarm panels with visible and audible alarms, and failed to ensure an emergency oxygen supply connection was present. The deficiency had the potential to not alarm the facility of a low oxygen tank level and pressure, and to not have a connection for emergency oxygen supply.	K 140	• No residents were affected by the deficient practice as the oxygen alarm is checked by the engineering staff three (3) per day and values are logged and reported to the Facilities Management staff. If oxygen levels are low, the oxygen supply company is called for service. • The facility performs environmental rounds regularly and identifies deficiencies and reports the deficiencies to the Facilities Operations Center for repair. Environmental/Safety deficiencies are top priority and repairs are scheduled first. • A master alarm system will be installed in two locations per NFPA 101 4.3.1.2.2. • The EOC committee meets at least (6) six times per year and environmental issues including oxygen systems and oxygen alarm systems are reported annually, which is then reported to the Quality Council, Medical Executive Committee and the Hospital Board. • The Master Alarm system will be an OSHPD project and require multiple disciplines for design. Estimated completion date 3/31/2016	

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K 130	Continued From page 5 Based on observation and interview, the facility failed to ensure a minimum of 6 spare sprinkler were maintained at the facility. The deficiency had the potential to not have spare sprinklers immediately available to help put the system back into service without delay, in the event a sprinkler was needed to be replaced because it has operated or has been damaged. Finding: On 6/22/15 at 3 p.m., there was one spare sprinkler in the spare sprinklers cabinet box in the sprinkler main riser room. At the time of the observation, during an interview, the Lead Man stated that the 5 missing spare sprinklers had been used during the installation of the sprinkler system.	K 130		
K 140 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Master alarm panels are in two separate locations and have audible and visible signals. There are high/low alarms for +/- 20% operating pressure. NFPA 99, 4.3.1.2.2 This STANDARD is not met as evidenced by: NFPA 99 Standard for Health Care Facilities 1999 Edition 4-3.1.1.7 Bulk Medical Gas Systems. (a) The bulk system shall consist of two sources of supply, one of which shall be a reserve supply	K 140	K 140 *Pressure Switch for "Emergency Reserve in Use"* • No residents were affected by the deficient practice. • The facility performs an annual medical gas deficiency audit annually and review by the Facilities Management staff. Any deficiencies found during the audit are prioritized and repaired in a timely manner. • The oxygen annual test is part of the quarterly EOC report and is reported to the EOC Committee, Quality Council, Medical Executive Committee and the Governing Board on a quarterly basis. • Installation of the emergency oxygen supply connection will be an OSHPD project and require design from a mechanical engineer for and OSHPD approval. Estimated completion date is 3/31/16.	3/31/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555874	A. BUILDING 01 - BROTMAN MEDICAL CENTER DP SNF B. WING _____	06/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 130	Continued From page 4 3-2.9.3 The stock of spare sprinklers shall include all types and ratings installed and shall be as follows: (1) For systems having less than 300 sprinklers - not fewer than 6 sprinklers (2) For systems with 300 to 1000 sprinklers - not fewer than 12 sprinklers (3) For systems with over 1000 sprinklers - not fewer than 24 sprinklers NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems 1998 Edition 2-4.1.4 A supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. The cabinet shall be so located that it will not be exposed to moisture, dust, corrosion, or a temperature exceeding 100 degrees Fahrenheit (38 degrees Celsius). 2-4.1.5 The stock of spare sprinklers shall be as follows: (a) For protected facilities having under 300 sprinklers - no fewer than 6 sprinklers (b) For protected facilities having 300 to 1000 sprinklers - no fewer than 12 sprinklers (c) For protected facilities having over 1000 sprinklers - no fewer than 24 sprinklers These requirements were not met as evidenced by:	K 130	*Supply of spare sprinkler heads* • No residents were affected by the deficient practice. • The facility performs environmental rounds regularly and identifies deficiencies and reports the deficiencies to the Facilities Operations Center for repair. Environmental/Safety deficiencies are top priority and repairs are scheduled first. • Fire sprinkler spare head check has been added to the "Environmental Rounds" list and will be checked during audit time. Based upon the finding fire sprinkler heads have been ordered. The facilities Environment of Care committee meets regularly and EOC audits are monitored and reviewed at these meetings. The hospital has also assigned the Vice President of Facilities to ensure that all Life safety & Environmental requirements are met. • EOC Audits are reported to the EOC Committee, Quality Council and the Governing Board on a quarterly basis. • Changes completed on 7/23/15	7/23/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555874	A. BUILDING 01 - BROTMAN MEDICAL CENTER DP SNF B. WING _____	06/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 077	Continued From page 3 Finding: On 6/22/15 at 10:10 a.m., during document review, the Bulk Oxygen Source Evaluation Report Annual Inspection equipment checklist dated 12/30/14, indicated that an emergency oxygen supply connection was not present. During an interview at the same time as the record review, the VP of Corporate Facilities Operations, stated that he had not seen an emergency oxygen supply connection for the facility's oxygen system. Nine (9) of seventeen (17) residents were on nasal cannula or trach aerosol.	K 077		
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: NFPA 13 Standard for the Installation of Sprinkler Systems 1999 Edition 3-2.9.1 A supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or have been damaged in any way can be promptly replaced. These sprinklers shall correspond to the types of temperature ratings of the sprinklers in the property. The sprinklers shall be kept in a cabinet located where the temperature to which they are subjected will at no time exceed 100 degrees Fahrenheit (38 degrees Celsius).	K 130	*Supply of spare sprinkler heads* • **No residents were affected by the deficient practice.** • **The facility performs environmental rounds regularly and identifies deficiencies and reports the deficiencies to the Facilities Operations Center for repair. Environmental/Safety deficiencies are top priority and repairs are scheduled first.** • **Fire sprinkler spare head check has been added to the "Environmental Rounds" list and will be checked during audit time. Based upon the finding fire sprinkler heads have been ordered. The facilities Environment of Care committee meets regularly and EOC audits are monitored and reviewed at these meetings. The hospital has also assigned the Vice President of Facilities to ensure that all Life safety & Environmental requirements are met.** • **EOC Audits are reported to the EOC Committee, Quality Council and the Governing Board on a quarterly basis.** • **Changes completed on 7/23/15**	7/23/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	556874	A. BUILDING 01 - BROTMAN MEDICAL CENTER DP SNF B. WING	06/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 077	Continued From page 2 This STANDARD is not met as evidenced by: NFPA 99 Standard for Health Care Facilities 1999 Edition 4-3.1.1.8 (h) Emergency Oxygen Supply Connection. Where the cryogenic oxygen supply is located outside of the building served, there shall be incorporated in the piping system and inlet for connecting a temporary auxiliary source of supply for emergency or maintenance situations. The inlet shall be located on the exterior of the building served and shall be physically protected to prevent tampering and unauthorized access. It shall be labeled "EMERGENCY LOW PRESSURE GASEOUS OXYGEN INLET." This connection shall be installed downstream of the shutoff valve on the main supply line [see 4-3.1.2.3(b)] and be suitably controlled with the necessary valves to allow emergency supply of oxygen and isolation of the piping to the normal source of supply. It shall have one check valve in the main line between the main line shutoff valve and the tee'd connection and one check valve between the tee'd connection and the emergency supply shutoff valve. [See Figure 4-3.1.1.8(h) and Figure 4-3.1.2.] This Standard was not met as evidenced by: Based on document review, and interview, the facility staff failed to ensure an emergency oxygen supply connection was present. The deficiency had the potential to not have a connection for emergency oxygen supply.	K 077	*Emergency oxygen supply connection* • No residents were affected by the deficient practice. • The facility performs an annual medical gas deficiency audit annually and review by the Facilities Management staff. Any deficiencies found during the audit are prioritized and repaired in a timely manner. • The oxygen annual test is part of the quarterly EOC report and is reported to the EOC Committee, Quality Council and the Governing Board on a quarterly basis. • Installation of the emergency oxygen supply connection will be an OSHPD project and require design from a mechanical engineer for and OSHPD approval. Estimated completion date is 3/31/16.	3/31/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	556874	A. BUILDING 01 - BROTMAN MEDICAL CENTER DP SNF B. WING _____	06/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 050	Continued From page 1 fire emergency. Findings: On 6/22/15 at 10 a.m., during record review of the facility's fire drill reports for the period of April 2014 through June 2015, it revealed there were 3 fire drill reports missing, for the following shifts and quarters: Swing shift - 3rd quarter of 2014. Night shift - 2nd,and 4th quarter of 2014. Further review of the fire drill reports revealed there was no documented evidence, such as participant signatures in the fire observation report, identifying sub acute staff participation in 5 fire drills, for the following shifts and dates: Day shift - 7/12/14, 8/10/14, 11/8/14, 1/31/15. Swing shift - 5/28/15. During an interview at the same time as the observation, the Lead Man stated that the Fire Observation Report was the only document staff would sign as evidence of participation in a fire drill. During record review, and by the end of the survey, the facility failed to provide the missing fire drills reports or documentation to review that would show participation of the subacute staff in the 5 fire drills.	K 050	*Fire Drill reports* • No residents were affected by the deficient practice. • The Facility performs audits of all Fire Life Safety requirements on a monthly basis to ensure compliance. • An additional form has been added to the Fire Drill Critique package to document participation/attendance for all employees. The facilities Environment of Care committee meets regularly and fire drills are monitored and reviewed at these meetings. The hospital has also assigned the Vice President of Facilities to ensure that all Life safety & Environmental requirements are met. • Fire Drills are reported to the EOC Committee and any deficiencies will be corrected immediately. EOC reports quarterly to the Quality Council, Medical Executive Committee and the Governing Board. • Changes completed on 5/30/15	6/30/15
K 077 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Piped in medical gas systems comply with NFPA 99, Chapter 4.	K 077	*Emergency oxygen supply connection* • No residents were affected by the deficient practice. • The facility performs an annual medical gas deficiency audit annually and review by the Facilities Management staff. Any deficiencies found during the audit are prioritized and repaired in a timely manner.	3/31/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555874	A. BUILDING 01 - BROTMAN MEDICAL CENTER DP SNF B. WING _____	06/22/2015

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SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS This facility was surveyed under 42 CFR Part 483.70(a), Life Safety Code NFPA 101, 2000 Edition, Chapter 19, Existing Health Care Occupancies, and other applicable codes. Amended 7/14/15 Representing the Department of Public Health: Evaluator ID#16261 The following represents the findings of the Department of Public Health during a Life Safety Code Survey.	K 000		
K 050 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on record review, and interview, the facility failed to provide supporting documentation that the subacute staff participated in fire drills at least quarterly on each shift. The deficiency had the potential for staff to not be familiar with the facility's fire emergency plan, and not be prepared to put it in effect in the event of a	K 050	*Fire Drill reports* • No residents were affected by the deficient practice. • The Facility performs audits of all Fire Life Safety requirements on a monthly basis to ensure compliance. • An additional form has been added to the Fire Drill Critique package to document participation/attendance for all employees. The facilities Environment of Care committee meets regularly and fire drills are monitored and reviewed at these meetings. The hospital has also assigned the Vice President of Facilities to ensure that all Life safety & Environmental requirements are met. • Fire Drills are reported to the EOC Committee and any deficiencies will be corrected immediately. EOC reports quarterly to the Quality Council, Medical Executive Committee and the Governing Board. • Changes completed on 6/30/15	6/30/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

SOUTHERN CALIFORNIA HEALTHCARE SYSTEM, INC.

Southern California Hospital at Culver City
3828 Delmas Terrace
Culver City, CA 90232
(310) 836-7000(310) 202-4141 Fax

July 21, 2015 **Via Fax 62 pages including this page**

Attention Rosario Grospe, RN Senior HFEN Assistant Supervisor, Acute and Ancillary Unit
California Department of Public Health
County of Los Angeles Health Facilities Division
3400 Aerojet Avenue, Suite 323
El Monte, CA 91731

Phone: 626-312-1129 **Fax 626-927-9293**

Re: 55874

POC Response to the 2567 from the Annual Health and Life Safety Code survey conducted on 6/22/15.

Sincerely,

Pamela Loo, Director of Quality
310-486-8911
Contact info: 310 836 7000 ext. 1046 cell: **310-486-8911**

Confidentiality Note: The documents accompanying this facsimile transmission may contain confidential information. The information is intended only for the use of the individuals or entity named above. If you are not the intended recipient or the person responsible for delivering it to the intended recipient, you are hereby notified that any disclosure, copying, distribution or use of the information contained in this transmission is strictly PROHIBITED. If you receive this transmission in error, please notify the sender immediately by telephone or by return fax and destroy this transmission, along with any attachments. Thank you.

State of California—Health and Human Services Agency

Department of Health Services

SIGNATURE REQUIREMENT NOTICE
(For Plan of Correction)

Notice to Licensee/Designee

The surveying state agency is required to obtain a signed plan of correction for deficiencies noted on the Statement of Deficiencies and Plan of Correction (Code of Federal Regulations, Title 42, Section 489.13; State Operations Manual, Section 2612; and California Health and Safety Code, Section 1280). By signing a plan of correction, a licensee or designee does not necessarily admit guilt of any alleged violation nor does this interfere with the right to contest or appeal any alleged violations on which the plan of correction is based or the same period for correction. It does acknowledge responsibility for compliance with licensing requirements, with appropriate requirements of the Medicare and Medi-Cal programs, that an exit conference was held during which the items listed were discussed, and that a copy of the deficiency/report and plan of correction was received.

Name of facility	City
Southern California Hosp at Culver City SNF/DP	Culver City

Copy of this notice received:

Licensee or designee signature	Date
Gerald B. Clute	7/20/15

Copy of this notice presented to licensee or designee:

Licensing Evaluator signature	Date
Rosario Grosse for Sin Lin Chang	7/13/15

Complaint Notice

If there should be disagreement between the Licensee or Designee and the Evaluator of the Survey Team on an interpretation of the regulations or a field decision, the Licensee of Designee may wish to call and discuss this with the District Licensing Supervisor.

Name of Licensing Supervisor	Telephone
Eric Stone, Program Manager	626-312-1142

Instructions

This notice is to be used with Plans of Correction for Skilled Nursing Facilities, Intermediate Care Facilities, Intermediate Care Facilities/Developmentally Disabled, Intermediate Care Facilities/Developmentally Disabled-Habilitative, Intermediate Care Facilities/Developmentally Disabled-Nursing, Congregate Living Health Facilities, Pediatric Day Health and Respite Care Facilities, and Hospitals with Distinct Part Skilled Nursing Facilities or Intermediate Care Facilities. It is to be signed by the licensee/designee and the licensing evaluator. A copy is left with the licensee/designee and the original is kept in the district office licensing file.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	555874		06/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during a re-certification survey. Representing the Department of Public Health: Surveyor 17030, RN, HFEN Surveyor 25524, RN, HFEN Surveyor 16281, REHS, HFE Total Resident Population 17 Total Resident Sample Size: 8 Highest Scope/Severity: E	F 000		
F 154 SS=E	483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the resident or the resident's representative had the right to be fully informed in advance of the risks and benefits of anti-antipsychotic and physical restraints to be administered to six (6) of eight (8) sampled residents (1, 2, 3, 4, 6, and 7). The facility failed	F 154	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* Corrective Action will be accomplished by the re-education of staff on the Restraints Policy and Procedure Application and monitoring SAA.049 and Consents PAT.037, completed on 7/19/2015. 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* The SubAcute Unit at Southern California Hospital at Culver City (SCHCC) will identify other residents having the same potential for deficient practice by discussing restraint plan of care in interdisciplinary weekly rounds, and 100% monitoring of restraint documentation and informed consents, and will monitor them beginning August 1,2015 as process improvements and report it quarterly to quality council, medical executive committee and governing board.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Gerald [signature]	CEO	7/20/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	555874	A. BUILDING 01 - BROTMAN MEDICAL CENTER DP SNF B. WING _____	06/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

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K 000	INITIAL COMMENTS This facility was surveyed under 42 CFR Part 483.70(a), Life Safety Code NFPA 101, 2000 Edition, Chapter 19, Existing Health Care Occupancies, and other applicable codes. Amended 7/14/15 Representing the Department of Public Health: Evaluator ID#16281 The following represents the findings of the Department of Public Health during a Life Safety Code Survey.	K 000		
K 050 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on record review, and interview, the facility failed to provide supporting documentation that the subacute staff participated in fire drills at least quarterly on each shift. The deficiency had the potential for staff to not be familiar with the facility's fire emergency plan, and not be prepared to put it in effect in the event of a	K 050	*Fire Drill reports* • No residents were affected by the deficient practice. • The Facility performs audits of all Fire Life Safety requirements on a monthly basis to ensure compliance. • An additional form has been added to the Fire Drill Critique package to document participation/attendance for all employees. The facilities Environment of Care committee meets regularly and fire drills are monitored and reviewed at these meetings. The hospital has also assigned the Vice President of Facilities to ensure that all Life safety & Environmental requirements are met. • Fire Drills are reported to the EOC Committee and any deficiencies will be corrected immediately. EOC reports quarterly to the Quality Council, Medical Executive Committee and the Governing Board. • Changes completed on 6/30/15	6/30/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

CEO 7/20/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 050	Continued From page 1 fire emergency. Findings: On 6/22/15 at 10 a.m., during record review of the facility's fire drill reports for the period of April 2014 through June 2015, it revealed there were 3 fire drill reports missing, for the following shifts and quarters: Swing shift - 3rd quarter of 2014. Night shift - 2nd,and 4th quarter of 2014. Further review of the fire drill reports revealed there was no documented evidence, such as participant signatures in the fire observation report, identifying sub acute staff participation in 5 fire drills, for the following shifts and dates: Day shift - 7/12/14, 8/10/14, 11/8/14, 1/31/15. Swing shift - 5/28/15. During an interview at the same time as the observation, the Lead Man stated that the Fire Observation Report was the only document staff would sign as evidence of participation in a fire drill. During record review, and by the end of the survey, the facility failed to provide the missing fire drills reports or documentation to review that would show participation of the subacute staff in the 5 fire drills.	K 050	*Fire Drill reports* • No residents were affected by the deficient practice. • The Facility performs audits of all Fire Life Safety requirements on a monthly basis to ensure compliance. • An additional form has been added to the Fire Drill Critique package to document participation/attendance for all employees. The facilities Environment of Care committee meets regularly and fire drills are monitored and reviewed at these meetings. The hospital has also assigned the Vice President of Facilities to ensure that all Life safety & Environmental requirements are met. • Fire Drills are reported to the EOC Committee and any deficiencies will be corrected immediately. EOC reports quarterly to the Quality Council, Medical Executive Committee and the Governing Board. • Changes completed on 6/30/15	6/30/15
K 077 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Piped in medical gas systems comply with NFPA 99, Chapter 4.	K 077	*Emergency oxygen supply connection* • No residents were affected by the deficient practice. • The facility performs an annual medical gas deficiency audit annually and review by the Facilities Management staff. Any deficiencies found during the audit are prioritized and repaired in a timely manner.	3/31/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 077	Continued From page 2 This STANDARD is not met as evidenced by: NFPA 99 Standard for Health Care Facilities 1999 Edition 4-3.1.1.8 (h) Emergency Oxygen Supply Connection. Where the cryogenic oxygen supply is located outside of the building served, there shall be incorporated in the piping system and inlet for connecting a temporary auxiliary source of supply for emergency or maintenance situations. The inlet shall be located on the exterior of the building served and shall be physically protected to prevent tampering and unauthorized access. It shall be labeled "EMERGENCY LOW PRESSURE GASEOUS OXYGEN INLET." This connection shall be installed downstream of the shutoff valve on the main supply line [see 4-3.1.2.3(b)] and be suitably controlled with the necessary valves to allow emergency supply of oxygen and isolation of the piping to the normal source of supply. It shall have one check valve in the main line between the main line shutoff valve and the tee'd connection and one check valve between the tee'd connection and the emergency supply shutoff valve. [See Figure 4-3.1.1.8(h) and Figure 4-3.1.2.] This Standard was not met as evidenced by: Based on document review, and interview, the facility staff failed to ensure an emergency oxygen supply connection was present. The deficiency had the potential to not have a connection for emergency oxygen supply.	K 077	*Emergency oxygen supply connection* • No residents were affected by the deficient practice. • The facility performs an annual medical gas deficiency audit annually and review by the Facilities Management staff. Any deficiencies found during the audit are prioritized and repaired in a timely manner. • The oxygen annual test is part of the quarterly EOC report and is reported to the EOC Committee, Quality Council and the Governing Board on a quarterly basis. • Installation of the emergency oxygen supply connection will be an OSHPD project and require design from a mechanical engineer for and OSHPD approval. Estimated completion date is 3/31/16.	3/31/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555874	A. BUILDING 01 - BROTMAN MEDICAL CENTER DP SNF B. WING _____	06/22/2015

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K 077	Continued From page 3 Finding: On 6/22/15 at 10:10 a.m., during document review, the Bulk Oxygen Source Evaluation Report Annual Inspection equipment checklist dated 12/30/14, indicated that an emergency oxygen supply connection was not present. During an interview at the same time as the record review, the VP of Corporate Facilities Operations, stated that he had not seen an emergency oxygen supply connection for the facility's oxygen system. Nine (9) of seventeen (17) residents were on nasal cannula or trach aerosol.	K 077		
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: NFPA 13 Standard for the Installation of Sprinkler Systems 1999 Edition 3-2.9.1 A supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or have been damaged in any way can be promptly replaced. These sprinklers shall correspond to the types of temperature ratings of the sprinklers in the property. The sprinklers shall be kept in a cabinet located where the temperature to which they are subjected will at no time exceed 100 degrees Fahrenheit (38 degrees Celsius).	K 130	*Supply of spare sprinkler heads* • No residents were affected by the deficient practice. • The facility performs environmental rounds regularly and identifies deficiencies and reports the deficiencies to the Facilities Operations Center for repair. Environmental/Safety deficiencies are top priority and repairs are scheduled first. • Fire sprinkler spare head check has been added to the "Environmental Rounds" list and will be checked during audit time. Based upon the finding fire sprinkler heads have been ordered. The facilities Environment of Care committee meets regularly and EOC audits are monitored and reviewed at these meetings. The hospital has also assigned the Vice President of Facilities to ensure that all Life safety & Environmental requirements are met. • EOC Audits are reported to the EOC Committee, Quality Council and the Governing Board on a quarterly basis. • Changes completed on 7/23/15	7/23/15

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K 130	Continued From page 4 3-2.9.3 The stock of spare sprinklers shall include all types and ratings installed and shall be as follows: (1) For systems having less than 300 sprinklers - not fewer than 6 sprinklers (2) For systems with 300 to 1000 sprinklers - not fewer than 12 sprinklers (3) For systems with over 1000 sprinklers - not fewer than 24 sprinklers NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems 1998 Edition 2-4.1.4 A supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. The cabinet shall be so located that it will not be exposed to moisture, dust, corrosion, or a temperature exceeding 100 degrees Fahrenheit (38 degrees Celsius). 2-4.1.5 The stock of spare sprinklers shall be as follows: (a) For protected facilities having under 300 sprinklers - no fewer than 6 sprinklers (b) For protected facilities having 300 to 1000 sprinklers - no fewer than 12 sprinklers (c) For protected facilities having over 1000 sprinklers - no fewer than 24 sprinklers These requirements were not met as evidenced by:	K 130	*Supply of spare sprinkler heads* • No residents were affected by the deficient practice. • The facility performs environmental rounds regularly and identifies deficiencies and reports the deficiencies to the Facilities Operations Center for repair. Environmental/Safety deficiencies are top priority and repairs are scheduled first. • Fire sprinkler spare head check has been added to the "Environmental Rounds" list and will be checked during audit time. Based upon the finding fire sprinkler heads have been ordered. The facilities Environment of Care committee meets regularly and EOC audits are monitored and reviewed at these meetings. The hospital has also assigned the Vice President of Facilities to ensure that all Life safety & Environmental requirements are met. • EOC Audits are reported to the EOC Committee, Quality Council and the Governing Board on a quarterly basis. • Changes completed on 7/23/15	7/23/15

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K 130	Continued From page 5 Based on observation and interview, the facility failed to ensure a minimum of 6 spare sprinkler were maintained at the facility. The deficiency had the potential to not have spare sprinklers immediately available to help put the system back into service without delay, in the event a sprinkler was needed to be replaced because it has operated or has been damaged. Finding: On 6/22/15 at 3 p.m., there was one spare sprinkler in the spare sprinklers cabinet box in the sprinkler main riser room. At the time of the observation, during an interview, the Lead Man stated that the 5 missing spare sprinklers had been used during the installation of the sprinkler system.	K 130		
K 140 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Master alarm panels are in two separate locations and have audible and visible signals. There are high/low alarms for +/- 20% operating pressure. NFPA 99, 4.3.1.2.2 This STANDARD is not met as evidenced by: NFPA 99 Standard for Health Care Facilities 1999 Edition 4-3.1.1.7 Bulk Medical Gas Systems. (a) The bulk system shall consist of two sources of supply, one of which shall be a reserve supply	K 140	K 140 *Pressure Switch for "Emergency Reserve in Use"* • No residents were affected by the deficient practice. • The facility performs an annual medical gas deficiency audit annually and review by the Facilities Management staff. Any deficiencies found during the audit are prioritized and repaired in a timely manner. • The oxygen annual test is part of the quarterly EOC report and is reported to the EOC Committee, Quality Council, Medical Executive Committee and the Governing Board on a quarterly basis. • Installation of the emergency oxygen supply connection will be an OSHPD project and require design from a mechanical engineer for and OSHPD approval. Estimated completion date is 3/31/16.	3/31/16

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K 140	Continued From page 6 for use only in an emergency. An actuating switch shall be connected to the master signal panels to indicate when, or just before, the reserve begins to supply the system. 4-3.1.2.2 Gas Warning Systems. (b) Master Alarms. 1. A master alarm system shall be provided to monitor the operation and condition of the source of supply, the reserve (if any), and the pressure of the main lines of all medical gas piping systems. 2. The master alarm system shall consist of two or more alarm panels located in two separate locations. One panel shall be located in the principal working area of the individual responsible for the maintenance of the medical gas piping systems and one or more panels shall be located to assure continuous surveillance during the working hours of the facility (e.g., the telephone switchboard, security office, or other continuously staffed location). This Standard was not met as evidenced by: Based on document review, interview, and observation, the facility staff failed to ensure the medical gas warning system was in accordance with NFPA 99 by not having medical gas master alarm panels with visible and audible alarms, and failed to ensure an emergency oxygen supply connection was present. The deficiency had the potential to not alarm the facility of a low oxygen tank level and pressure, and to not have a connection for emergency oxygen supply.	K 140	• No residents were affected by the deficient practice as the oxygen alarm is checked by the engineering staff three (3) per day and values are logged and reported to the Facilities Management staff. If oxygen levels are low, the oxygen supply company is called for service. • The facility performs environmental rounds regularly and identifies deficiencies and reports the deficiencies to the Facilities Operations Center for repair. Environmental/Safety deficiencies are top priority and repairs are scheduled first. • A master alarm system will be installed in two locations per NFPA 101.4.3.1.2.2. • The EOC committee meets at least (6) six times per year and environmental issues including oxygen systems and oxygen alarm systems are reported annually, which is then reported to the Quality Council, Medical Executive Committee and the Hospital Board. • The Master Alarm system will be an OSHPD project and require multiple disciplines for design. Estimated completion date 3/31/2016	

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K 140	Continued From page 7 Findings: 1. On 6/22/15 at 10:10 a.m., during document review, the Bulk Oxygen Source Evaluation Report Annual Inspection equipment checklist dated 12/30/14, indicated the following: The bulk primary system did not have a pressure switch for "Emergency Reserve in use". The signals were not wired to the master alarm panel(s). The source valve was not labeled. Source equipment was not free of leaks. The report also indicated a physical deficiency that reserve wires were cut at the pressure switch above the liquid gauge, and that the location of leakage was at the source valve. During an interview at the same time as the record review, the Director of Facilities stated that the physical deficiency listed on the report were wires that were cut because they use to be connected to the former fire alarm control panel (FACP), where it would activate an alarm if the oxygen was low at the bulk liquid oxygen vessels. That the new FACP does not activate an alarm when the oxygen is low at the vessels. That the there has never been an alarm system at the facility to monitor the operation and condition of the bulk oxygen source of supply and reserve. That the oxygen vessels did not send a signal to the liquid oxygen supplier/vendor when the vessels were low. That in lieu of the alarm, engineering staff conducted three rounds per day to monitor the oxygen tank and pressure levels at the gauges of the liquid oxygen vessels. Further document review revealed an engineering	K 140	*Source Valve labeled* • No residents were affected by the deficient practice. • The facility performs an annual medical gas deficiency audit annually and review by the Facilities Management staff. Any deficiencies found during the audit are prioritized and repaired in a timely manner. • The oxygen annual test is part of the quarterly EOC report and is reported to the EOC Committee, Quality Council, Medical Executive Committee and the Governing Board on a quarterly basis. • Completed 7/23/15 *Source equipment free of leaks* • No residents were affected by the deficient practice. • The facility performs an annual medical gas deficiency audit annually and review by the Facilities Management staff. Any deficiencies found during the audit are prioritized and repaired in a timely manner. • The oxygen annual test is part of the quarterly EOC report and is reported to the EOC Committee, Quality Council, Medical Executive Committee and the Governing Board on a quarterly basis. • The source leak was repaired 4/6/2015	

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K 140	Continued From page 8 log that included monitoring of the main and reserve liquid oxygen vessels' level and pressure readings. Earlier that morning at 9:10 a.m., the gauges at the main vessel had readings of 180 inches of water and 140 psi., and the gauges at the reserve vessel had readings of 108 inches of water and 135 psi. Both vessels were within their marked limits. Nine (9) of seventeen (17) residents were on nasal cannula or trach aerosol.	K 140		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: NFPA 70 National Electrical Code 1999 Edition 110-12. Mechanical Execution of Work. Electrical equipment shall be installed in a neat and workmanlike manner. 305-4.(h) Protection from Accidental Damage. Flexible cords and cables shall be protected from accidental damage. Sharp corners and projections shall be avoided. Where passing through doorways or other pinch points, protection shall be provided to avoid damage. 400-8. Uses not permitted. Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following:	K 147	*Electrical Wiring* • No residents or staffs were affected by the said deficient practice. • The facility performs environmental rounds regularly and identifies deficiencies and reports the deficiencies to the Facilities Operations Center for repair. Environmental/Safety deficiencies are top priority and repairs are scheduled first. • The cable observed by the surveyor was identified as being video cable and is not high voltage and poses no electrical shock risk. The walls that the cable penetrates are not fire walls. • The facilities Environment of Care committee meets regularly and EOC audits are monitored and reviewed at these meetings. The hospital has also assigned the Vice President of Facilities to ensure that all Life safety & Environmental requirements are met. • Completed 6/24/2015	

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K 147	Continued From page 9 (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (5) Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors. These Codes were not met as evidenced by: Based on observation and interview, the facility failed to ensure electrical wiring was in accordance with NFPA 70 National Electrical Code by having electrical cord run through a wall. The deficiency had the potential of not adhering to the provisions of NFPA 70 necessary for safety, and the practical safeguarding of persons, and property from hazards arising from the use of electricity. Findings: On 6/19/15 at 9:20 a.m., there was an electrical cord coming out of and entering a wall in the kitchen, above the dietary office room door. During an interview at the same time as the observation, the Dietician/Director of food & Nutrition stated that the electrical cord was connected to a video camera, but did not know why the wire was pulled out of, and back into the wall.	K 147	*Electrical Wiring* • No residents or staffs were affected by the said deficient practice. • The facility performs environmental rounds regularly and identifies deficiencies and reports the deficiencies to the Facilities Operations Center for repair. Environmental/Safety deficiencies are top priority and repairs are scheduled first. • The cable observed by the surveyor was identified as being video cable and is not high voltage and poses no electrical shock risk. The walls that the cable penetrates are not fire walls. • The facilities Environment of Care committee meets regularly and EOC audits are monitored and reviewed at these meetings. The hospital has also assigned the Vice President of Facilities to ensure that all Life safety & Environmental requirements are met. • Completed 6/24/2015	

COUNTY OF LOS ANGELES
Public Health

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Interim Director

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Interim Health Officer

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Letter 4

IMPORTANT NOTICE - PLEASE READ CAREFULLY

July 13, 2015

Darrin Buckner, RN
Director of Subacute
Southern California Hosp At Culver City D/p Snf
3828 Delmas Terrace
Culver City, CA 90230

Dear Administrator:

On June 22, 2015, a standard annual Health and Life Safety Code survey was conducted at your facility by the California Department of Public Health, Licensing and Certification Program (Los Angeles Acute - South), to determine if your facility was in compliance with federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiency(ies) to be:

[ ] Isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the enclosed "Statement of Deficiencies and Plan of Correction" form, whereby corrections are required (D).

[x] A pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the enclosed "Statement of Deficiencies and Plan of Correction" form, whereby corrections are required (E).

The enclosed Centers for Medicare and Medicaid Services (CMS) form, entitled "Statement of Deficiencies and Plan of Correction" (CMS–2567), documents the deficiencies of participation requirements identified during this visit. All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations (CFR).

Plan of Correction (POC)

A POC for the deficiencies must be submitted within **ten (10) days from receipt of the CMS- 2567.** Failure to submit an acceptable POC by the due date will result in remedies being recommended for imposition by the CMS and/or the State Medicaid Agency effective as soon as notice requirements are met.

Your POC must be submitted on the enclosed CMS-2567 form and must contain the following:

- How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;
- How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system; and
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Agency.

Remedies will be recommended for imposition by the CMS Regional Office and/or the State Medicaid Agency if your facility has failed to achieve substantial compliance by .

Recommended Remedies

The remedies, which will be recommended if substantial compliance has not been achieved by July 23, 2015 , include the following:

[x] Civil money penalty of $ 150.00 , effective June 22, 2015 (§488.430).

We are also recommending to the CMS Regional Office and/or the State Medicaid Agency that your provider agreement be terminated on if substantial compliance is not achieved by that time.

Denial of Payment for New Admissions (DPNA)

Based on deficiencies cited during this survey and as authorized by CMS San Francisco Regional Office, we are giving formal notice of imposition of statutory DPNA effective September 22, 2015. This remedy will be effectuated on the stated date unless you demonstrate substantial compliance with an acceptable POC and subsequent revisit. This notice in no way limits the prerogative of CMS to impose discretionary DPNA at any appropriate time.

CMS Regional Office will notify your intermediary and the Medicaid Agency. If effectuated, denial of payment will continue until your facility achieves substantial Compliance or your provider agreement is terminated. Facilities are prohibited from billing those Medicare/Medicaid residents or their responsible parties during the denial period for services normally billed to Medicare or Medicaid.

Appeal Rights

If you disagree with the **determination of noncompliance (and/or substandard quality of care, if applicable)**, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in 42 CFR §498.40, et. seq. You may appeal the finding of noncompliance that led to an enforcement action, but not the enforcement action or remedy itself. A written request for hearing must be filed no later than 60 days from the date of receipt of this letter.

Such written request should be made **directly** to:

Attention: Ms. Karen Robinson
Departmental Appeals Board
Civil Remedies Division
Cohen Building, Room G-644
330 Independence Avenue S.W.
Washington, D.C. 20201

A request for hearing should identify specific issues, and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You may be represented at a hearing by counsel at your own expense.

Be sure to include a copy of this letter with your request to the Departmental Appeals Board. In addition, please forward a copy of your request to:

Attention: Paula Perse, Manager
Long Term Care Branch
Division of Survey and Certification
Centers for Medicare & Medicaid Services
90 7th Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

Alternatively, you can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at https://dab.efile.hhs.gov.

To file a new appeal using DAB E-File, you first need to register a new account by: (1) clicking **Register** on the DAB E-File home page; (2) entering the information requested on the "Register New Account" form; and (3) clicking **Register Account** at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he or she is a party or authorized representative. Once registered, you may file your appeal by:

-Clicking the **File New Appeal** link on the Manage Existing Appeals screen, then clicking Civil Remedies Division on the File New Appeal screen.
And,
-Entering and uploading the requested information and documents on the "File New Appeal-Civil Remedies Division" form.

At minimum, the Civil Remedies Division (CRD) requires a party to file a signed request for hearing and the underlying notice letter from CMS that sets forth the action taken and the party's appeal rights. All documents must be submitted in Portable Document Format ("PDF"). Any document, including a request for hearing, will be deemed to have been filed on a given day, if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day. A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the Administrative Law Judge, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service. More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E-File Procedures link on the File New Appeal Screen for CRD appeals.

If you choose to file your appeal electronically, please also send a copy of the hearing request to:

Attention: Paula Perse, Manager
Long Term Care Branch
Division of survey and Certification
Centers for Medicare & Medicaid Services
90 7th Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

Allegation of Compliance

If you believe these deficiencies have been corrected, you may submit your POC as your allegation of compliance to Eric Stone, Program Manager, California Department of Public Health, Licensing and Certification Program, Los Angeles Acute and Ancillary Unit - South, 3400 Aerojet Suite 323 El Monte, CA 91731. We may accept your POC as your allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy(ies) at that time.

If, upon a subsequent revisit or by other means it is determined your facility has not achieved substantial compliance, we will recommend the remedies previously mentioned in this letter be imposed by the CMS Regional Office beginning on June 22, 2105 and continue until substantial compliance is achieved. Additionally, the CMS Regional Office may impose a revised remedy(ies), based upon changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

Informal Dispute Resolution

In accordance with §488.331, you have one (1) opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and relevant information (evidence) as to why you are disputing those deficiencies to Suzette Leverett - Clark, RN Assistant Chief, California Department of Public Health, Licensing and Certification Division at 12440 East Imperial Highway Room 522, Norwalk, CA 90650.

This request must be sent during the same ten (10) days you have for submitting a POC for the cited deficiencies. An informal dispute resolution for the cited deficiencies will not delay the imposition of the recommended enforcement actions. A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

Should CMS determine that termination or any other remedy is warranted, they will provide you with a separate formal notification of that determination.

If you have questions concerning the instructions contained in this letter, please contact, Eric Stone, Program Manager, at (626) 312-1142.

Sincerely,

Nwamaka Oranusi, Acting Chief
Health Facilities Inspection Division

Rosario Burgos RN, Sr. HFEW for

Eric Stone, Program Manager
Acute and Ancillary Unit- South
3400 Aerojet Avenue Suite 323
Tel. (626) 312-1142 - Fax (626) 927-9293

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555874	A. BUILDING _____ B. WING _____	06/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during a re-certification survey. Representing the Department of Public Health: Surveyor 17030, RN, HFEN Surveyor 25524, RN, HFEN Surveyor 16281, REHS, HFE Total Resident Population 17 Total Resident Sample Size: 8 Highest Scope/Severity: E	F 000		
F 154 SS=E	483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the resident or the resident's representative had the right to be fully informed in advance of the risks and benefits of anti-antipsychotic and physical restraints to be administered to six (5) of eight (8) sampled residents (1, 2, 3, 4, 6, and 7). The facility failed	F 154	1. How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Corrective Action will be accomplished by the re-education of staff on the Restraints Policy and Procedure Application and monitoring SAA.049 and Consents PAT.037, completed on 7/19/2015. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken The SubAcute Unit at Southern California Hospital at Culver City (SCHCC) will identify other residents having the same potential for deficient practice by discussing restraint plan of care in interdisciplinary weekly rounds, and 100% monitoring of restraint documentation and informed consents, and will monitor them beginning August 1, 2015 as process improvements and report it quarterly to quality council, medical executive committee and governing board.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 7/20/15

...deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ...r safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	555674	A. BUILDING _____ B. WING _____	06/20/2015

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SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

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F 154	Continued From page 1 to develop a written policy and procedure for informing the resident or the resident's representative the risks and benefits of the physical restraints. For Resident 1 and 6, the physician failed to obtain an informed consent from the authorized representative for the use of anti-antipsychotic and anti-depressant medications. For Resident 1, 2 and 7, the physician failed to obtain an informed consent from the resident or resident's representative for the physical restraints. This deficient practice had the potential for violating the resident's right to be fully informed in advance about the care. For Resident 3's blood transfusion, the physician failed to obtain an informed consent from the resident or resident's representative. For Residents 4's Peripherally Inserted Central Line, (PICC) line insertion, the physician failed to obtain an informed consent from the resident or resident's representative. For Resident 6's PICC line insertion and psychotropic medication, the physician failed to obtain an informed consent from the resident or resident's representative. This deficient practice had the potential for violating the resident's right to be fully informed in advance about the care. Findings: 1. During the initial tour of the unit with Registered Nurse (RN) 1 on June 19, 2015 at 8:30 a.m., Resident 1 was observed lying in bed with a PEG	F 154	3. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* 100% monitoring of restraint documentation and informed consents, and will monitor them beginning August 1, 2015 as process improvements and report it quarterly to Quality Council, Medical Executive Committee and Governing Board. 4. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* Discussions of residents on restraints plan of care in interdisciplinary weekly rounds, and 100% monitoring of restraint documentation and informed consents, and will monitor them beginning August 1, 2015 as process improvements and report it quarterly to quality council, medical executive committee and governing board.	7/19/15

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F 154	Continued From page 2 (Percutaneous endoscopic gastrostomy) tube (a tube passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate) and tracheostomy tube (a tube to be inserted allows a person to breathe without the use of his or her nose or mouth). Resident 1 was observed with soft wrist restraints applied on his wrists. According to RN 1, the resident was confused and was on soft wrist restraints to prevent the resident from pulling out the tracheostomy tube and PEG tube. a. A review of clinical record indicated Resident 1 was admitted to the facility on April 20, 2015 with diagnosis of intracranial hemorrhage (bleeding within the skull). The Minimum Data Set (MDS- assessment tool) dated April 27, 2015, indicated the resident was on persistant vegetative state (A disorder of consciousness in which patients with severe brain damage are in a state of partial arousal rather than true awareness). A review of the safety restraint order indicated the physician had ordered bilateral soft wrist restraints on April 20, 2015. A review of the entire clinical record indicated there was no documentation the resident's surrogate had been informed of the risks and benefits for the use of physical restraints. b. A review of the medication administration record indicated the physician had prescribed haldol (antipsychotic medication) since May 2, 2015 for Resident 1. The "Consent to Receive psychotropic	F 154	1. *How corrective action( ) will be accomplished for those residents found to have been affected by the deficient practice* Corrective Action will be accomplished by the re-education of staff on the Restraints Policy and Procedure Application and monitoring SAA.049 and Consents PAT.037, completed on 7/19/2015. 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* The SubAcute Unit at Southern California Hospital at Culver City (SCHCC) will identify other residents having the same potential for deficient practice by discussing restraint plan of care in interdisciplinary weekly rounds, and 100% monitoring of restraint documentation and informed consents, and will monitor them beginning August 1,2015 as process improvements and report it quarterly to quality council, medical executive committee and governing board. 3. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* 100% monitoring of restraint documentation and informed consents, and will monitor them beginning August 1, 2015 as process improvements and report it quarterly to Quality Council, Medical Executive Committee and Governing Board. 4. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* Discussions of residents on restraints plan of care in interdisciplinary weekly rounds, and 100% monitoring of restraint documentation and informed consents, and will monitor them beginning August 1,2015 as process improvements and report it quarterly to quality council, medical executive committee and governing board.	7/19/15

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F 154	Continued From page 3 Medications" dated May 2, 2015 was reviewed and indicated the physician and the nurse signed but there was no documented evidence that the physician had informed the surrogate the risks and benefits of the medication. During an interview on June 20, 2015 at 4 p.m., RN 1 stated the physician had not informed the surrogate of the risks and benefits of the medication. 2. During the initial tour of the unit with RN 1 on June 19, 2015 at 8:37 a.m., Resident 2 was observed lying in bed with a PEG tube and tracheostomy tube. According to RN 1, the resident was confused and was on soft wrist restraints to prevent the resident from pulling out the tracheostomy tube and PEG tube. A review of clinical record indicated Resident 2 was admitted to the facility on June 17, 2015 with diagnosis of intracranial hemorrhage (bleeding within the skull). A review of the safety restraint order indicated the physician had ordered bilateral soft wrist restraints on June 19, 2015. A review of the entire clinical record indicated there was no documentation that the resident's surrogate was informed of the risks and benefits for the use of physical restraints. 3. During the initial tour of the unit with RN 1 on June 19, 2015 at 8:48 a.m., Resident 7 was observed lying in bed with a PEG tube and tracheostomy tube. According to RN 1, the resident was confused and was on soft wrist restraints to prevent the resident from pulling out the tracheostomy tube and PEG tube.	F 154	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* Corrective Action will be accomplished by the re-education of staff on the Restraints Policy and Procedure Application and monitoring SAA.049 and Consents PAT.037, completed on 7/19/2015. 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* The SubAcute Unit at Southern California Hospital at Culver City (SCHCC) will identify other residents having the same potential for deficient practice by discussing restraint plan of care in interdisciplinary weekly rounds, and 100% monitoring of restraint documentation and informed consents, and will monitor them beginning August 1, 2015 as process improvements and report it quarterly to quality council, medical executive committee and governing board. 3. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* 100% monitoring of restraint documentation and informed consents, and will monitor them beginning August 1, 2015 as process improvements and report it quarterly to Quality Council, Medical Executive Committee and Governing Board. 4. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* Discussions of residents on restraints plan of care in interdisciplinary weekly rounds, and 100% monitoring of restraint documentation and informed consents, and will monitor them beginning August 1, 2015 as process improvements and report it quarterly to quality council, medical executive committee and governing board.	7/19/15

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F 154	Continued From page 4 A review of clinical record indicated Resident 7 was admitted to the facility on April 2, 2015 with diagnosis of respiratory failure (a condition in which not enough oxygen passes from the lungs into the blood). A review of the safety restraint order indicated the physician had ordered bilateral soft wrist restraints on April 2, 2015. A review of the entire clinical record indicated there was no documentation that the resident's surrogate had been informed of the risks and benefits for the use of physical restraints. During an interview on June 19, 2015 at 4:45 p.m., Employee 2 stated the physician had not informed the surrogate the risks and benefits of physical restraints. According to Employee 2, there was no policy and procedure developed for informing the resident/surrogate the risks and benefits of the physical restraints. 4. A review of the Admission Face sheet indicated Resident 3 was admitted to the facility on March 27, 2015, with diagnoses that included respiratory failure (a condition which not enough oxygen passes from your lungs into your blood). The Blood Component Requisition and Transfusion Record was dated June 9, 2015. The Informed Consent to Blood Transfusion form was dated April 9, 2015, was done by telephone, Resident 3's family member gave a consent, and the witness signed. However, there was no physician signature, date and time. There was no	F 154	*1. How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* Corrective Action will be accomplished by the re-education of staff on the Restraints Policy and Procedure Application and monitoring SAA.049 and Consents PAT.037, completed on 7/19/2015. *2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* The Sub Acute Unit at Southern California Hospital at Culver City (SCHCC) will identify other residents having the same potential for deficient practice by discussing restraint plan of care in interdisciplinary weekly rounds, and 100% monitoring of restraint documentation and informed consents, and will monitor them beginning August 1,2015 as process improvements and report it quarterly to quality council, medical executive committee and governing board.	7/19/15

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	555874	A. BUILDING _____ B. WING _____	06/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

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F 154	Continued From page 6 other consent for the blood transfusion on April 2015. A review of two (2) facility's policies indicated the following: a. The policy titled, "Blood Component Administration Protocol" dated November 28, 2014, indicated verify the resident had signed the informed consent and the physician had explained the risks and benefits of blood transfusion, alternatives to transfusion, and the right of the resident to refuse transfusion. b. The policy titled, "Blood Transfusion Consent" dated November 2012 indicated all patients receiving blood or blood products must be informed of the risks of such transfusion and must sign the consent. The treating physician must provide information to the patient or the patient's surrogate decision marker. The physician is responsible for documenting that the conversation took place. 5. A review of the Admission Face Sheet indicated Resident 4 was admitted to the facility on March 3, 2015 with diagnoses that included respiratory failure. The Authorization and Informed Consent to Surgery or Special Diagnostic or Therapeutic Procedures (page 1 of 6) indicated Peripherally Inserted Central Line (PICC- line is a long, thin, hollow tube that a doctor or nurse puts into a vein above the bend of your elbow. It is used to give you chemotherapy and other medicines). The Signatures for Surgery or Procedure Informed Consent (page 3 of 6) dated June 5, 2015 indicated Resident 4's family member gave a	F 154	*3. What measures will be put into place* 100% monitoring of restraint documentation and informed consents, and will monitor them beginning August 1, 2015 as process improvements and report it quarterly to Quality Council, Medical Executive Committee and Governing Board. *4. How the facility plans to monitor* Discussions of residents on restraints plan of care in interdisciplinary weekly rounds, and 100% monitoring of restraint documentation and informed consents, and will monitor them beginning August 1,2015 as process improvements and report it quarterly to quality council, medical executive committee and governing board. *5. Include dates when corrective action will be completed.* 7/19/15	7/19/15

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	566974	A. BUILDING _____ B. WING _____	06/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

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F 154	Continued From page 6 telephone consent. However, there was no physician's verification of informed consent which included the signature to indicate the risks, benefits, and alternatives were discussed with the resident and/or family member. A review of a facility's policy titled, "Peripherally Inserted Central Catheter" dated November 20, 2012, indicated the resident has the right to receive information on all aspects of care. Explanation should include the benefits, potential risks, and expected outcomes. 6. A review of the Admission Face Sheet indicated Resident 6 was admitted to the facility on April 9, 2015, with diagnoses that included respiratory failure. Resident 6 was able to make her needs known. a. The Authorization and Informed Consent to Surgery or Special Diagnostic or Therapeutic Procedures (page 1 of 6) indicated Computed Tomography Scan of the Abdomen with/without Contrast (CT or CAT scan is a noninvasive diagnostic imaging procedure that uses a combination of X-rays and computer technology to produce horizontal, or axial, images (often called slices) of the body. A computerized tomography (CT scan combines a series of X-ray images taken from different angles and uses computer processing to create cross-sectional images, or shows detailed images of any part of the body, including the bones, muscles, fat, organs, and blood vessels). The Signatures for Surgery or Procedure Informed Consent page 3 of 6 dated June 6, 2015 indicated Resident 6 gave consent. However, there was no physician's verification of informed consent which included signature to indicate that the risks,	F 154	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **Corrective Action will be accomplished by the re-education of staff on the Restraints Policy and Procedure Application and monitoring SAA.049 and Consents PAT.037, completed on 7/19/2015.** 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **The SubAcute Unit at Southern California Hospitals at Culver City (SCHCC) will identify other residents having the same potential for deficient practice by discussing restraint plan of care in interdisciplinary weekly rounds, and 100% monitoring of restraint documentation and informed consents, and will monitor them beginning August 1,2015 as process improvements and report it quarterly to quality council, medical executive committee and governing board.** 3. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **100% monitoring of restraint documentation and informed consents, and will monitor them beginning August 1, 2015 as process improvements and report it quarterly to Quality Council, Medical Executive Committee and Governing Board.** 4. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness. The PQCI is integrated into the quality assurance system* **Discussions of residents on restraints plan of care in interdisciplinary weekly rounds, and 100% monitoring of restraint documentation and informed consents, and will monitor them beginning August 1,2015 as process improvements and report it quarterly to quality council, medical executive committee and governing board.**	

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	556874	A. BUILDING _____ B. WING _____	06/20/2015

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F 154	Continued From page 7 benefits, and alternatives were discussed with the resident /or family member. b. The Consent to Receive Psychotropic Medications dated April 10, 2015 indicated Zoloft (antidepressant medication) 100 milligrams (mg) by mouth once a day and was signed by the resident and the licensed nurse. However, there was no physician signature on the consent.	F 154		
F 221 SS=E	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that three (3) of eight (8) sampled residents (1, 4 and 7) had the right to be free from any physical restraints and not required to treat the resident's medical symptoms. For Resident 1 and 7, the physician failed to authenticate the order for soft wrist restraint within 24 hours after the initiation of restraint. For Resident 4 and 7, the facility failed to attempt the less restrictive measures prior to the use of restraint. These deficient practices had the potential to violate the resident's right to be free from injury and had the potential for decreased mobility. Findings:	F 221	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **Corrective Action for F 221 will be accomplished by re-education of staff on policy SAA.049 Restraint Policy and Procedure and Monitoring on 7/19/2015. SCHCC will create a "Hard Stop in the EMR documentation" for nursing to document alternatives attempted before placing restraints, and use of least restrictive measures, by August 21, 2015. Medical Staff will receive re-education on Policy and Procedure regarding necessity of orders for restraint by a M.D. with date and time by 7/29/15.** 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **SCHCC will identify other residents having the potential to be affected by the same deficient practice after weekly Interdisciplinary Team (IDT) meetings. The Nursing Manager and MDS Coordinator will complete a 100% audit of "IDT" form for accuracy and completeness, starting July 21, 2015, and report any significant findings to Sub Acute Director.**	7/23/15

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F 221	Continued From page 8	F 221		

1. During the initial tour of the unit with Registered Nurse (RN) 1 on June 19, 2015 at 8:30 a.m., Resident 1 was observed lying in bed with a PEG (Percutaneous endoscopic gastrostomy) tube (a tube passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate) and tracheostomy tube (a tube to be inserted allows a person to breathe without the use of his or her nose or mouth). Resident 1 was observed with soft wrist restraints applied on his wrists. According to RN 1, the resident was confused and was on soft wrist restraints to prevent the resident from pulling out the tracheostomy tube and PEG tube.

A review of clinical record indicated Resident 1 was admitted to the facility on April 20, 2015, with diagnosis of intracranial hemorrhage (bleeding within the skull).

A review of the "Non-Behavioral restraint orders and flow sheet" dated April 20, 2015, indicated the physician had ordered bilateral soft wrist restraints to prevent the resident from pulling out tracheostomy tube and PEG tube. The order was countersigned by the physician. However, there was no documentation the physician had authenticated the order within 24 hours after the initiation of restraint for the following days: 5/29/15, 5/30/15, 6/3/15, 6/5/15, and 6/7/15 to 6/16/15. The less restrictive measures were attempted on 5/29/15 and 6/1/15.

2. During the initial tour of the unit with RN 1 on June 19, 2015 at 8:49 a.m., Resident 7 was observed lying in bed with a PEG tube and

3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur

SCHCC will identify other residents having the potential to be affected by the same deficient practice after weekly Interdisciplinary Team (IDT) meetings. The Nursing Manager and MDS Coordinator will complete a 100% audit of "IDT" form for accuracy and completeness, starting July 21, 2015, and report any significant findings to Sub Acute Director.

4. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system

The Nursing Manager and MDS Coordinator will complete a 100% audit of "IDT" form for accuracy and completeness, starting July 21, 2015, and report any significant findings to Sub Acute Director. Reports will be submitted quarterly to Quality Council, Medical Executive Committee and Governing Board.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555874	A. BUILDING _____ B. WING _____	06/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 9 tracheostomy tube. According to RN 1, the resident was confused and was on soft wrist restraints to prevent the resident from pulling out the tracheostomy tube and PEG tube. A review of clinical record indicated Resident 7 was admitted to the facility on April 2, 2015, with diagnosis of respiratory failure (a condition in which not enough oxygen passes from the lungs into the blood). A review of the "Non-Behavioral restraint orders and flow sheet" dated April 20, 2015, indicated the physician had ordered bilateral soft wrist restraints to prevent the resident from pulling out tracheostomy tube and PEG tube. The order was countersigned by the physician. However, there was no documentation the physician had authenticated the order within 24 hours after the initiation of restraint from June 12, 2015 to June 16, 2015. According to the facility's policies and procedures dated May 2015, titled, "Non-Behavioral Restraints:" "PROCEDURES 4.7 Alternatives to Restraint use 4.7.1 Safe, effective and the least restrictive protective measures will be employed based on the patient's assessed needs and history of effective and ineffective. 4.7.2 Companionship/supervision 4.7.3 Continuous observation, i.e., sitter or family member; 4.7.4 Diversion/physical activities (music, television); 4.7.5 pain relief/comfort measures (warmth, noise	F 221	*1. How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* Corrective Action for F 221 will be accomplished by re-education of staff on policy SAA.049 Restraint Policy and Procedure and Monitoring on 7/19/2015. SCHCC will create a "Hard Stop in the EMR documentation" for nursing to document alternatives attempted before placing restraints, and use of least restrictive measures, by August 31, 2015. Medical Staff will receive re-education on Policy and Procedure regarding necessity of orders for restraint by a M.D. with date and time by 7/23/15. *2. Identify Residents and Corrective action taken* SCHCC will identify other residents having the potential to be affected by the same deficient practice after weekly Interdisciplinary Team (IDT) meetings. The Nursing Manager and MDS Coordinator will complete a 100% audit of "IDT" form for accuracy and completeness, starting July 21, 2015, and report any significant findings to Sub Acute Director.	7/23/15

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F 221	Continued From page 10 level, etc.); 4.7.6 patient placement in room close to nurses' station; 4.7.7 Reality orientation/mental stimulation (music, television, reading materials); 4.7.8 Scheduled toileting. 4.7.9 Documentation in the patient's medical record will be reflect those times when less restrictive protective measures are attempted. 4.7.10 When less restrictive protective measures 4.8 Assessment and the Decision to Use restraints have been unsuccessful, or have been determined to be appropriate, restraints may be used. 4.8.3 Restraint will be employed only after less restrictive measure have been attempted and have failed to produce a desire outcome or have been found to be contraindicated. 4.10 Restraint Application without an Order 4.10.1 If an LIP (Licensed Independent Practitioner) is not available to issue a restraint order, a registered Nurse may initiate restraint use based on his/her appropriate assessment of the patient. The LIP is notified within 1-hour of the initiation of restraint, and a telephone order is obtained from the LIP and entered into the patient's record. The telephone order must be authenticated within 24-hours of the initial order." 3. During an initial tour on June 19, 2015, at 9:05 a.m., Resident 4 was lying in bed, his eyes closed, had a foley (indwelling) catheter, and soft wrist restraints were applied to both wrists. Licensed Vocational Nurse (LVN) 2 stated Resident 4 had bilateral soft restraints due to pulling out the tubes.	F 221	*3. Measures put into place.* SCHCC will identify other residents having the potential to be affected by the same deficient practice after weekly Interdisciplinary Team (IDT) meetings. The Nursing Manager and MDS Coordinator will complete a 100% audit of "IDT" form for accuracy and completeness, starting July 21, 2015, and report any significant findings to Sub Acute Director. *4. Monitoring performance to make sure that solutions are sustained.* The Nursing Manager and MDS Coordinator will complete a 100% audit of "IDT" form for accuracy and completeness, starting July 21, 2015, and report any significant findings to Sub Acute Director. Reports will be submitted quarterly to Quality Council, Medical Executive Committee and Governing Board. *5. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Agency.* 7/23/15	7/23/15

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F 221	Continued From page 11 a. A review of the Admission Face Sheet indicated Resident 4 was admitted to the facility on March 3, 2015, with diagnoses that included respiratory failure. The Minimum Data Set (MDS an assessment and care plan tool) dated March 10, 2015, indicated Resident 4 was totally dependent on the staff for activities of daily living such as dressing bed mobility, toileting, and bathing. The MDS Sections: Section G0400 indicated Resident 4 had impairment on both sides of his lower extremity. Section P-Restraints of the MDS assessment indicated Resident 4 had "limb restraints and were used daily." The Care Area Assessment (CAA) Worksheet dated March 10, 2015, indicated Resident 4 had episodes of confusion due to medical condition and diagnosis of dementia. A care plan for dementia will be developed. The CAA #3 "Limb Restraint Used in Bed" indicated Resident 4 was confused and at times had attempted to pull the tubing. The Care Area Assessment (CAA) Worksheet dated March 10, 2015, indicated to refer to the license nurses notes and documentation during the look back dated March 4, 2015 through March 10, 2015. There was no current documentation of Resident 4's behavior for the use of the soft wrist restraints. There were only the pre-printed Non-Behavioral Restraint Order and Flow Sheets which indicated checks. There was no documentation the RN had assessed the behavior that Resident 4 exhibited. During an electronic record review on June 20, 2015, at 11:40 a.m., RN 1 stated Resident 4's plan of care indicated the staff had been applying the wrist restraints on the resident since March	F 221	1. *How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice* **Corrective Action for F 221 will be accomplished by re-education of staff on policy SAA.049 Restraint Policy and Procedure and Monitoring on 7/19/2015. SCHCC will create a "Hard Stop in the EMR documentation" for nursing to document alternatives attempted before placing restraints, and use of least restrictive measures, by August 31, 2015. Medical Staff will receive re-education on Policy and Procedure regarding necessity of orders for restraint by a M.D. with date and time by 7/29/15.** 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **SCHCC will identify other residents having the potential to be affected by the same deficient practice after weekly Interdisciplinary Team (IDT) meetings. The Nursing Manager and MDS Coordinator will complete a 100% audit of "IDT" form for accuracy and completeness, starting July 21, 2015, and report any significant findings to Sub Acute Director.**	

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F 221	Continued From page 12 10, 2015. There was no documented evidence from the RN regarding other alternative measures used prior to the use of soft wrist restraints. A care plan titled, "Physical Restraint Limb secondary to varies at times to pull on cords and tubing, and fall risk." The staff approaches included refer to the IDT members for evaluation and recommendation of appropriate use of correct restraints. Attempt to use less restrictive devices on an ongoing basis. Quarterly assessment review and follow up by the IDT to ensure appropriateness of restraints. During an interview on June 20, 2105, at 10:45 a.m., RN 1 stated she had witnessed Resident 4 scratched himself when the bilateral soft restraints were removed. However, there was no documentation provided by the RN. A review of the Weekly IDT Notes dated May 26 through June 9, 2015, indicated no documented evidence the use of soft restraints was discussed in the IDT meeting. The Interdisciplinary Team (IDT) Conference Record Quarterly Review dated May 5, 2015, indicated the pre-printed box was checked off for bilateral soft restraints use to indicate the restraint was appropriate and necessary to manage Resident 4's safety needs. The IDT Conference Record had a section which indicated a discussion with the physician regarding the treatment plan without any changes made with	F 221	*3. What measures will be put into place or what system changes the facility will make to ensure that the deficient practice does not recur* **SCHCC will identify other residents having the potential to be affected by the same deficient practice after weekly Interdisciplinary Team (IDT) meetings. The Nursing Manager and MDS Coordinator will complete a 100% audit of "IDT" form for accuracy and completeness, starting July 21, 2015, and report any significant findings to Sub Acute Director.** *4. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **The Nursing Manager and MDS Coordinator will complete a 100% audit of "IDT" form for accuracy and completeness, starting July 21, 2015, and report any significant findings to Sub Acute Director. Reports will be submitted quarterly to Quality Council, Medical Executive Committee and Governing Board.**	

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F 221	Continued From page 13 the plan of care and/or discussed with physician regarding plan of care with new changes made. There was no documented evidence that Resident 4's physician was made aware of the continued use of the restraint. b. Review of the Non-Behavioral Restraint Order and Flow Sheet dated June 14, 2015 through June 19, 2015 indicated that on June 19, 2015 Resident 4 had been in restraints for 92 days. The Nursing- Clinical Assessment did not indicate the alternative/least restrictive measures attempted prior to the use of restraints.	F 221		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on a review of activity calendar and interview, the facility failed to provide an ongoing program of activities, designed to meet the interests and the physical, mental, and psychosocial well-being of the residents. There was no staff member conducting activities during the weekend as indicated by the facility's policy and procedure. This deficient practice had the potential for not meeting the residents' activity needs.	F 248	*1. How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **Activity Coordinator Designee will be hired for weekend coverage to meet a seven day per week coverage.** *2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **Staffing schedule will identify the potential and a designee Activities Coordinator will be assigned to cover the weekend.** *3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **Daily monitoring to ensure an Activity Coordinator or Designee is scheduled every day.** *4. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **Monitor staffing schedule daily. Outliers will be tracked and trended, then reported quarterly to Quality Council, Medical Executive Committee and Governing Board.**	

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F 248	Continued From page 14 Findings: A review of the Activity Calendar for May and June of 2015 indicated all variety of activities were scheduled seven days per week. During an interview with the Activity Coordinator on June 20, 2015 at 10:55 a.m., she stated there was no staff member who could coordinate the activities while she was off during the weekend. During an interview with Employee 2 on June 20, 2015 at 4 p.m., he stated the Activity Coordinator usually works 5 days per week (Monday to Friday) to coordinate and provide activities to the residents. Employee 2 stated there was no staff member conducting activities during the weekend. According to the facility's policy and procedure dated November 20, 2012, titled, "Activity Program-General Description": "4.2 Procedure 4.2.6 Activities are offered at hours convenient to the patient (i.e. morning, afternoon, some evenings and weekends) and involve the community when appropriate (in and out of he facility)."	F 248		
F 272 SS=C	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.	F 272	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **MDS Coordinator had consulted the facilities MDS Software Company Point Click Care for information on how to add dates and location to the Summary of the Care Area Assessment. Adding Dates and location to the Care Area Assessment to begin by 7/22/2015 when next Care Area Assessment is due.** 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **SCHCC will identify other residents having the potential to be affected by reviewing the Care Area Assessment at IDT meetings. Once identified, Care Area Assessment will be completed.**	

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F 272	Continued From page 15 A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility's licensed nurse failed to use the State specified RAI (Resident Assessment Instrument) in its entirety, when conducting an assessment of	F 272	*3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **MDS Coordinator had consulted the facilities MDS Software Company Point Click Care for information on how to add dates and location to the Summary of the Care Area Assessment. Adding Dates and location to the Care Area Assessment to begin by 7/22/2015 when next Care Area Assessment is due.** *4. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **This will be monitored weekly at the Interdisciplinary Team Meeting. Outliers will be tracked and trended, then reported quarterly to Quality Council, Medical Executive Committee and Governing Board.**	

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F 272	Continued From page 16 the needs of three (3) of eight (8)sampled residents (1, 7, and 8). The facility failed to conduct an MDS (Minimum Data Set, a standardized assessment and care planning tool) assessment with a CAA (Care Area Assessment) Summary Report that indicated the date of the CAA documentation (where information related to the CAA can be found) to help provide additional information for the development of an individualized care plan for Resident 1, 7, and 8. These deficient practices had the potential to result in not developing an individualized care plan to meet the resident's needs. Findings: 1. A review of clinical record indicated Resident 1 was admitted to the facility on April 20, 2015 with diagnosis of intracranial hemorrhage (bleeding within the skull). The MDS dated April 27, 2015 indicated the resident required total assistance in performing activities of daily living (ADLs), was incontinent of bowel and bladder, received nutrition and hydration via GT (gastrostomy tube, a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications), and was at risk for pressure sore development. A review of the CAA (Care Area Assessment) Summary dated April 30, 2015, indicated seven triggered care areas from the MDS findings that were problematic for the resident. These triggered care areas were urinary incontinence, falls, nutritional status, feeding tube, dehydration, pressure ulcer, and physical restraints. For the CAA Summary, the "Location and Date of CAA	F 272	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **MDS Coordinator had consulted the facilities MDS Software Company Point Click Care for information on how to add dates and location to the Summary of the Care Area Assessment. Adding Dates and location to the Care Area Assessment to begin by 7/22/2015 when next Care Area Assessment is due.** 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **SCHCC will identify other residents having the potential to be affected by reviewing the Care Area Assessment at IDT meetings. Once identified, Care Area Assessment will be completed.** 3. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **MDS Coordinator had consulted the facilities MDS Software Company Point Click Care for information on how to add dates and location to the Summary of the Care Area Assessment. Adding Dates and location to the Care Area Assessment to begin by 7/22/2015 when next Care Area Assessment is due.** 4. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **This will be monitored weekly at the Interdisciplinary Team Meeting. Outliers will be tracked and trended, then reported quarterly to Quality Council, Medical Executive Committee and Governing Board.**	

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F 272	Continued From page 17 Documentation" referred to CAA WS (Worksheet) dated April 15, 2015. However, the CAA WS did not provide documentation of the date and location where the assessment information could be found for the seven triggered areas. 2. A review of clinical record indicated Resident 7 was admitted to the facility on April 2, 2015 with diagnosis of respiratory failure (a condition in which not enough oxygen passes from the lungs into the blood). The MDS dated April 9, 2015 indicated the resident required total assistance in performing activities of daily living (ADLs), was incontinent of bowel, received nutrition and hydration via GT tube, and was at risk for pressure sore development. A review of the CAA (Care Area Assessment) Summary dated April 16, 2015, indicated nine triggered care areas from the MDS findings that were problematic for the resident. These triggered care areas were cognitive loss, communication, urinary incontinence, falls, nutritional status, feeding tube, dehydration, pressure ulcer, and physical restraints. For the CAA Summary, the "Location and Date of CAA Documentation" referred to CAA WS (Worksheet) dated April 15, 2015. However, the CAA WS did not provide documentation of the date and location where the assessment information could be found for the seven triggered areas. 3. A review of clinical record indicated Resident 8 was admitted to the facility on March 23, 2015 with diagnosis of respiratory failure. The resident expired on May 12, 2015.	F 272	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **MDS Coordinator had consulted the facilities MDS Software Company Point Click Care for information on how to add dates and location to the Summary of the Care Area Assessment. Adding Dates and location to the Care Area Assessment to begin by 7/22/2015 when next Care Area Assessment is due.** 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **SCHCC will identify other residents having the potential to be affected by reviewing the Care Area Assessment at IDT meetings. Once identified, Care Area Assessment will be completed.** 3. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **MDS Coordinator had consulted the facilities MDS Software Company Point Click Care for information on how to add dates and location to the Summary of the Care Area Assessment. Adding Dates and location to the Care Area Assessment to begin by 7/22/2015 when next Care Area Assessment is due.** 4. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **This will be monitored weekly at the Interdisciplinary Team Meeting. Outliers will be tracked and trended, then reported quarterly to Quality Council, Medical Executive Committee and Governing Board.**	

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F 272	Continued From page 18 The MDS dated March 30, 2015 indicated the resident required total assistance in performing activities of daily living (ADLs), was incontinent of bowel, received nutrition and hydration via GT (gastrostomy tube, a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications), and developed pressure sore. A review of the CAA (Care Area Assessment) Summary dated April 11, 2015, indicated five triggered care areas from the MDS findings that were problematic for the resident. These triggered care areas were urinary incontinence, nutritional status, feeding tube, dehydration, and pressure ulcer. For the CAA Summary, the "Location and Date of CAA Documentation" referred to CAA WS (Worksheet) dated April 10, 2015. However, the CAA WS did not provide documentation of the date and location where the assessment information could be found for the five triggered areas. On June 20, 2015 at 11:30 a.m., during an interview, MDS 1 stated the location of the date and assessment information for all triggered problem areas should have been documented.	F 272		
F 273 SS=D	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.)	F 273	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* Timely completion of the MDS Assessment within 14 days by the MDS Coordinator, the RN nursing manager will be certified in MDS 3.0 and Review MDS Comprehensive Assessment for completion in the correct time frame.	

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	555874	A. BUILDING _____ B. WING _____	06/20/2015

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F 273	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to conduct a comprehensive assessment within 14 days of admission for one (1) of eight sample residents (8). This deficient practice had the potential for an untimely assessment of the resident's needs. Findings: A review of the medical record indicated Resident 8 was admitted to the facility on March 23, 2015, with diagnosis of respiratory failure (a condition in which not enough oxygen passes from the lungs into the blood). A review of the admission Minimum Data Set (MDS) for Resident 8 indicated the assessment was completed on April 11, 2015, which was 19 days of admission to the facility. In an interview with MDS 1 on June 20, 2015 at 11:30 a.m., she stated the admission MDS for Resident 8 was not completed within 14 days.	F 273	2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **The certified RN nursing manager reviews the MDS Comprehensive Assessment for completion in the correct time frame.** 3. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* 4. **The certified RN nursing manager reviews the MDS Comprehensive Assessment for completion in the correct time frame.**	
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the	F 278	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **The facility RN nursing manager will become certified in MDS 3.0 and represent the MDS Coordinator.** 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **Identification of potential deficient practice will be made by reviewing MDS 3.0 certifications annually. HR will notify Director Sub Acute if Certification expires within 3 months.**	

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F 278	Continued From page 20 assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a registered nurse coordinated each assessment with the appropriate participation of health professionals for three (3) of eight (8) sampled residents (1, 7, and 8). This deficient practice had a potential for not providing appropriate assessment and interventions for residents. Findings: 1. A review of the clinical record indicated Resident 1 was admitted to the facility on April 20, 2015 with diagnosis of intracranial hemorrhage	F 278	*3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **The facility RN nursing manager will become certified in MDS 3.0 and represent the MDS Coordinator.** *4. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **Outliers will be tracked and trended, then reported quarterly to Quality Council, Medical Executive Committee and Governing Board.**	

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F 278	Continued From page 21 (bleeding within the skull). A review of the CAA (Care Area Assessment) Summary dated April 30, 2015, indicated it was completed by Licensed Vocational Nurse (LVN) 1 and coordinated by MDS (Minimum Data Set) Coordinator. 2. A review of the clinical record indicated Resident 7 was admitted to the facility on April 2, 2015 with diagnosis of respiratory failure (a condition in which not enough oxygen passes from the lungs into the blood). A review of the CAA (Care Area Assessment) Summary dated April 16, 2015, indicated it was completed by LVN 1 and coordinated by MDS Coordinator. 3. A review of the clinical record indicated Resident 8 was admitted to the facility on March 23, 2015 with diagnosis of respiratory failure. The resident expired on May 12, 2015. A review of the CAA (Care Area Assessment) Summary dated April 11, 2015, indicated it was completed by LVN 1 and coordinated by MDS Coordinator. During an interview with Employee 2 on June 20, 2015 at 4:40 p.m., he stated the MDS Coordinator is the Director of the ICU (Intensive Care Unit), who signed under the "Signature of RN Assessment Coordinator Verifying Assessment Completion" for each MDS assessment. According to Employee 2, the MDS Coordinator had no formal training in MDS assessment.	F 278	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **The facility RN nursing manager will become certified in MDS 3.0 and represent the MDS Coordinator.** 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **Identification of potential deficient practice will be made by reviewing MDS 3.0 certifications annually. HR will notify Director Sub Acute if Certification expires within 3 months.** 3. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **The facility RN nursing manager will become certified in MDS 3.0 and represent the MDS Coordinator.** 4. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **Outliers will be tracked and trended, then reported quarterly to Quality Council, Medical Executive Committee and Governing Board.**	

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F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility's staff failed to develop comprehensive care plans for two (2) of eight (8) sampled residents (8 and 9). There was no care plan developed to address the care area for Resident 8's "urinary incontinence/indwelling catheter," as indicated in the Care Area Assessment (CAA). For Resident 9, there was no care plan developed for the isolation precautions for clostridium difficile (a fatal health care bacterium that can cause symptoms ranging from diarrhea to life-threatening inflammation of the colon).	F 279	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **Re-education of staff on review of Policy and Procedure at IDT meetings and necessity of review of all Comprehensive Care Plan items weekly during interdisciplinary team meeting.** 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **Residents will be identified through medical record reviews at IDT meetings.** 3. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **Comprehensive Care Plan items are reviewed weekly during IDT meetings.** 4. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **Monitoring at IDT meetings. Outliers will be tracked and trended, then reported quarterly to Quality Council, Medical Executive Committee and Governing Board.**	

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F 279	Continued From page 23 This deficient practice has the potential for not providing appropriate interventions when there was no comprehensive care plan developed for the resident. Findings: 1. A review of Resident 8's medical record indicated the resident was admitted to the facility on March 23, 2015 with diagnosis of respiratory failure (a condition in which not enough oxygen passes from the lungs into the blood). The resident expired on May 12, 2015. According to the Section V (Care Area Assessment) of the MDS, "urinary incontinence/indwelling catheter" was a triggered area and a care plan was necessary to address the problem. A review of the CAA Summary Report dated April 11, 2015, for Resident 8 indicated the care area for "urinary incontinence/indwelling catheter" was triggered. A review of the care plans indicated there was no documentation a care plan was developed for "urinary incontinence/indwelling catheter." During an interview with Licensed Vocational Nurse (LVN) 1 on June 20, 2015, at 11:30 a.m., she stated a care plan should have been developed for "urinary incontinence/indwelling catheter."	F 279	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **Re-education of staff on review of Policy and Procedure at IDT meetings and necessity of review of all Comprehensive Care Plan items weekly during interdisciplinary team meeting.** 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **Residents will be identified through medical record reviews at IDT meetings.** 3. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **Comprehensive Care Plan items are reviewed weekly during IDT meetings.** 4. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **Monitoring at IDT meetings. Outliers will be tracked and trended, then reported quarterly to Quality Council, Medical Executive Committee and Governing Board.**	

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F 279	Continued From page 24 2. Resident 9 was admitted to the facility on April 10, 2015, with diagnoses that included pulmonary embolism (Pulmonary embolism is the sudden blockage of a major blood vessel in the lung, usually by a blood clot). During an initial tour on June 19, 2015, at 8:30 a.m., LVN 2 stated that Resident 9 was on isolation precautions for clostridium difficile (C. diff) (a fatal health care bacterium that can cause symptoms ranging from diarrhea to life-threatening inflammation of the colon). A review of the medical record on June 19, 2015 , at 2:35 p.m., indicated there was a plan of care titled, "Contact Isolation" dated April 17, 2015, for Methicillin Resistant Staphylococcus Aureus, MRSA (a bacteria that resists antibiotics) of the nares and Vancomycin Resistant Enterococci (VRE -are a type of bacteria called enterococci that have developed resistance to many antibiotics especially vancomycin) in the urine. However, there was no documented evidence of a care plan for managing C-Diff. A review of a laboratory result for Resident 9 dated June 17, 2015, indicated C-Diff "positive. "	F 279		
F 283 SS=B	483.20(l)(1)&(2) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to	F 283	1. *How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice* Will enforce the 14 day turn around for completion of discharge summaries. Completion of discharge summaries over 14 days Targeted date 60 days.	

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F 283	Continued From page 25 authorized persons and agencies, with the consent of the resident or legal representative. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to have a discharge summary that included a recapitulation of the resident's stay and a final summary of the resident's status, authenticated or signed and dated by the physician for completion within 14 days following discharge as indicated in the facility's policy and procedure for one of eight sampled residents (8). Findings: 1. A review of Resident 8's medical record indicated the resident was admitted to the facility on March 23, 2015. The resident expired on May 12, 2015. A review of the Discharge Summary indicated the discharge summary was dictated by the physician on June 20, 2015, which was 58 days after the resident expired. In addition, the Discharge Summary was not authenticated or signed by a physician. On June 20, 2015 at 11:50 a.m., during an interview with Employee 3, she stated the discharge summary was signed by the physician as of June 20, 2015. According to Employee 3, the discharge summary should be completed promptly and authenticated or signed by a physician within two (2) weeks following a patient's discharge. According to the facility's policy and procedure	F 283	*2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.* ***Discharge censuses are reviewed daily to identify deficiencies.*** **Will enforce the 14 day turn around for completion of discharge summaries. Completion of discharge summaries over 14 days Targeted date 60 days.** *3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **Will enforce the 14 day turn around for completion of discharge summaries. Completion of discharge summaries over 14 days Targeted date 60 days.** *4. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **Outliers will be tracked and trended, then reported quarterly to Quality Council, Medical Executive Committee and Governing Board.**	

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F 283	Continued From page 26 dated 8/12, titled, "Completion Requirements for the Medical Record": "4.1 Policy 4.1.2 medical records shall be completed promptly and authenticated or signed by a physician, dentist or podiatrist within two (2) weeks following a patient's discharge."	F 283		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to assess and re-assess the rashes for one (1) of eight (8) sampled residents (3). Resident 3 was identified with rashes and was treated with Clotrimazole 1% cream (antifungal topical ointment) and Hydrocortisone 1% ointment (corticosteroid) for 30 days, then 20 days later treated with Elimite cream (a scabicide agent that kills the scabies mite). The facility did not assess and re-assess the effectiveness and/or ineffectiveness of the treatment and the resident's response to the treatment. This deficient practice had the potential to result in	F 309	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **Re-education of staff on review of Policy and Procedure SAA at IDT meetings and necessity of review of all Comprehensive Care Plan items weekly during interdisciplinary team meeting.** 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **Residents will be identified through medical record reviews at IDT meetings.** 3. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **Comprehensive Care Plan items are reviewed weekly during IDT meetings.** 4. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **Monitoring at IDT meetings. Outliers will be tracked and trended, then reported quarterly to quality council, medical executive committee and governing board.**	

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F 309	Continued From page 27 recurring skin problems. Findings: During an initial tour, on June 19, 2015, Licensed Vocational Nurse (LVN) 2 stated Resident 3 was positive for Scabies last month. A review of the Admission Face Sheet indicated Resident 3 was admitted to the facility on March 27, 2015 with diagnoses that included respiratory failure (a condition which not enough oxygen passes from your lungs into your blood). A review of a Consultation dated May 1, 2015, indicated Resident 3 had a 3 day history of a rash. The resident was transferred from a skilled nursing facility. Resident 3 had a rash that began on her upper chest and left shoulder and subsequently spread to the back. The Assessment and Plan indicated probable folliculitis (common skin condition in which hair follicles become inflamed) and candidiasis (fungal infection). Per the nurses, the resident has improved on Clindamycin (treatment of acne vulgaris) and clotrimazole (is an antifungal medication commonly used in the treatment of fungal infections) use. Recommendation to continue both medications be applied twice daily on affected skin. The follow-up Dermatology Consultation dated May 15, 2015, indicated scabietic infestation cannot be ruled out and a skin scrapping was done. During an interview and clinical record review on June 19, 2015, at 11:40 a.m., Registered Nurse (RN) 1 stated the documentation of skin rashes	F 309	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **Re-education of staff on review of Policy and Procedure SAA at IDT meetings and necessity of review of all Comprehensive Care Plan items weekly during interdisciplinary team meeting.** 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **Residents will be identified through medical record reviews at IDT meetings.** 3. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **Comprehensive Care Plan items are reviewed weekly during IDT meetings.** 4. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **Monitoring at IDT meetings. Outliers will be tracked and trended, then reported quarterly to quality council, medical executive committee and governing board.**	

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F 309	Continued From page 28 was on April 2, 2015. RN 1 stated the rash was not specific to location and was not descriptive. RN 1 stated from April 2 through June 19, 2015, there was a diagnosis of Scabies. RN 1 stated that on May 19, 2015, there was documentation of a rash but was not descriptive and location of the rash was not specified. When asked for the location and description, RN 1 replied, "Yes, there should be location and description." Resident 3 had rashes since April 2, 2015 with treatments. When asked for an assessment and reassessment, RN 1 stated, "Yes, there should be an assessment and reassessment of the resident." RN 1 stated there should be a weekly progress notes. A review of an order titled, "Miscellaneous Nursing Order" dated May 15, 2015, indicated "ask Id and Dermatologist consultants to see her about worsening of her rash." A review of the Pathology Consultation to Rule Out Scabies dated collected May 15, 2015, indicated Resident 3 was positive for Scabies and the plan was to recommend further treatment. A plan of care titled, "Resident had diagnoses of Scabies" indicated the staff approaches included to observe for effectiveness of medication. There was no description where the scabies were located on Resident 3's body. There was no assessment and re-assessment of the scabies and response to Elimite treatment. During an interview on June 19, 2015, at 11:30 a.m., Employee 4 stated the staff should monitor the resident's skin for any conditions.	F 309	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **Re-education of staff on review of Policy and Procedure SAA at IDT meetings and necessity of review of all Comprehensive Care Plan items weekly during interdisciplinary team meeting.** 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **Residents will be identified through medical record reviews at IDT meetings.** 3. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **Comprehensive Care Plan items are reviewed weekly during IDT meetings.** 4. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **Monitoring at IDT meetings. Outliers will be tracked and trended, then reported quarterly to quality council, medical executive committee and governing board.**	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	555874	A. BUILDING _____ B. WING _____	06/20/2015

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F 309	Continued From page 29 A review of the Weekly IDT Notes dated May 19, 2015 did not indicate documentation of scabies. The nursing section was not completed. According to the instructions, any progress, changes, additional information with current condition since review date should be documented. During a concurrent interview with Employee 1 and Employee 4 on June 20, 2015, between 9:55 a.m. and 10:20 a.m., Employee 1 reviewed the clinical record and stated there was a progress note dated May 1, 2015 which indicated Resident 3 had a 3 day rash and the dermatologist consultant came on May 15, 2015. Employee 4 stated Resident 4 had skin symptoms more than a few weeks ago. Employee 4 further stated Resident 3's physician did not feel Resident 3 had Scabies. A review of the Medication Administration Record indicated the following orders: 1. Clotriazole 1% Cream (Lotromin) dated April 7, 2015, to be applied twice a day, to the rash on back, chest, neck, ad arms. 2. Clindamycin Phosphate 1% lotion (Cleocin T) dated April 29, 2015, applied twice a day. There was no indication were to apply. A review of a facility's policy and procedure titled, "Comprehensive Care Plan" dated January 2014 indicated the care plan will be revised weekly as part of the Interdisciplinary Team process. It will be incorporated into team meeting or by having the nurse review the care plan during the team 's	F 309	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **Re-education of staff on review of Policy and Procedure SAA at IDT meetings and necessity of review of all Comprehensive Care Plan items weekly during interdisciplinary team meeting.** 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **Residents will be identified through medical record reviews at IDT meetings.** 3. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **Comprehensive Care Plan items are reviewed weekly during IDT meetings.** 4. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **Monitoring at IDT meetings. Outliers will be tracked and trended, then reported quarterly to quality council, medical executive committee and governing board.**	

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F 309	Continued From page 30 reports.	F 309		
F 315 68=E	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure there was documented medical justification in the physician orders for the use of an indwelling urinary catheter (a flexible plastic tube inserted into the bladder used to drain urine) for three (3) of eight (8) sampled residents (2, 3 and 7). This deficient practice had the potential to result in urinary tract infection. Findings: 1. During the initial tour with Registered Nurse (RN) 1 on June 19, 2015 at 8:37 a.m., Resident 2 was observed resting in bed, and had an indwelling urinary catheter. RN 1 stated the resident was non-verbal. RN 1 further stated the resident's indwelling urinary catheter was due to the physician's request. According to RN 1, the	F 315	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **Change the CPOE order for Placement of Indwelling Catheters to include justification of Placement** 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **Residents will be identified through medical record reviews at IDT meetings.** 3. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **Change the CPOE order for Placement of Indwelling Catheters to include justification of Placement** 4. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **Review at IDT meetings. Outliers will be tracked and trended, then reported quarterly to Quality Council, Medical Executive Committee and Governing Board.**	

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F 315	Continued From page 31 resident had no urinary retention, neurogenic bladder, Stage III or VI pressure ulcers, or cancers. A review of clinical record indicated Resident 2 was admitted to the facility on June 17, 2015 with diagnosis of intracranial hemorrhage (bleeding within the skull). A review of the physician order indicated a Foley catheter had been prescribed for Resident 2 on 6/17/15. However, there was no medical justification in the physician order for the use of an indwelling catheter. During the interview with RN 1 on April 24, 2015 at 2:40 p.m., she stated there was no physician order for the indwelling catheter. 2. During the initial tour with RN 1 on June 19, 2015 at 8:49 a.m., Resident 7 was observed resting in bed, and had an indwelling urinary catheter. RN 1 stated the resident was confused. According to RN 1, the indwelling urinary catheter was used for Stage III ulcer on the sacral area. A review of clinical record indicated Resident 7 was admitted to the facility on April 2, 2015 with diagnosis of respiratory failure (a condition in which not enough oxygen passes from the lungs into the blood). A review of the physician order indicated a Foley catheter had been prescribed for Resident 7 on April 10, 2015. However, there was no medical justification in the physician order for the use of an indwelling catheter. There was no documentation the resident had been assessed	F 315	*1. How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **Change the CPOE order for Placement of Indwelling Catheters to include justification of Placement** *2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **Residents will be identified through medical record reviews at IDT meetings.** *3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **Change the CPOE order for Placement of Indwelling Catheters to include justification of Placement** *4. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **Review at IDT meetings. Outliers will be tracked and trended, then reported quarterly to Quality Council, Medical Executive Committee and Governing Board.**	

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F 315	Continued From page 32 as having urinary retention, neurogenic bladder, Stage III or VI pressure ulcers, or cancers. During an interview with RN 1 on June 20, 2015 at 9:35 a.m., she stated the Foley catheter was not medically indicated for Resident 7. During an interview with RN 2 on June 20, 2015 at 3:30 p.m., she stated the resident was assessed as having unstageable ulcer on the sacral area. A review of the urine specimen for urinalysis dated April 11, 2015 indicated the resident's urine had many bacteria. The urine specimen for culture dated April 14, 2015 indicated the resident's urine had more than 100,000 Proteus mirabilis (a Gram-negative facultative anaerobic, rod-shaped bacterium) CFU/ml (colony-forming unit per milliliter) (a measure of viable bacterial or fungal cells). According to the facility's policy and procedure dated March 2012, titled, "Urinary Tract Infection" " 3.0 Objectives 3.2 Criteria for urinary catherization include: 3.2.1 To relieve urinary tract obstruction 3.2.2 To permit bladder drainage in patients with neurogenic bladder dysfunction or retention 3.2.6 To maintain quality of life for terminally ill patients." 3. During an initial tour, on June 19, 2015, at 8:40	F 315	1. *How corrective action() will be accomplished for those residents found to have been effected by the deficient practice* **Change the CPOE order for Placement of Indwelling Catheters to include justification of Placement** 2. *How the facility will identify other residents having the potential to be effected by the same deficient practice and what corrective action will be taken* **Residents will be identified through medical record reviews at IDT meetings.** 3. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **Change the CPOE order for Placement of Indwelling Catheters to include justification of Placement** 4. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **Review at IDT meetings. Outliers will be tracked and trended, then reported quarterly to Quality Council, Medical Executive Committee and Governing Board.**	

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F 315	Continued From page 33 a.m., Licensed Vocational Nurse (LVN) 2 stated Resident 3 was on strict intake and output and had an indwelling catheter. A review of the Admission Face Sheet indicated Resident 3 was admitted to the facility on March 27, 2015. A physician's order dated March 27, 2015, indicated strict intake and output. The laboratory culture dated May 15, 2015, was positive for bacteria and urine was cloudy. During an interview on June 20, 2015 at 11:40 a.m., RN 1 stated the initial order for Resident 3's indwelling catheter (a tube which is inserted into the bladder to drain urine from the bladder into a bag) was on March 27, 2015 for strict intake and output. RN 1 reviewed the laboratory results and stated Resident 3 was positive for bacteria in the urine and was cloudy. RN 1 further stated there was no indication why Resident 3 continued to have the indwelling catheter (Resident 3 had the indwelling catheter for 84 days).	F 315		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	*1. How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **On the day of audit, once parts per million (PPM) was identified not at the correct PPM; the buckets were changed out immediately. In-service/re-education was provided to associates regarding proper PPM for sanitizer, when it should be checked, and by whom.** *2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **Adherence to the policy and procedure related to sanitizer bucket will be monitored as part of Quality Control Program. Outliers will be tracked and trended, then reported quarterly to Quality Council, Medical Executive Committee and Governing Board.** *3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **Adherence to the policy and procedure related to sanitizer bucket will be monitored as part of Quality Control Program. Outliers will be tracked and trended, then reported quarterly to Quality Council, Medical Executive Committee and Governing Board.**	

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F 371	Continued From page 34 This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to store and serve food under sanitary conditions by failing to ensure the presence of sanitizer in 2 sanitizer buckets, missing a light shield, and having ice build-up in a freezer. These deficiencies had the potential for contamination and adulteration of food. Findings: 1. On 6/19/15 at 9:34 a.m., there were two sanitizer buckets at the cafeteria service line. Each bucket contained liquid and a towel. The Dietician/Director of Food & Nutrition tested the liquid in the bucket by dipping orange color Hydrion Papers QT-40 into the liquid, the papers remained orange. During an interview, at the same time as the observation, the Dietician/Director of Food & Nutrition stated there should have been a 200 to 300 ppm sanitizer concentration in the sanitizer buckets, that the papers should have turned from orange to green in the presence of 200 to 300 ppm sanitizer concentration, and that he did not know why there was not a 200 to 300 ppm sanitizer concentration in the sanitizer bucket. 2. Between 9:34 a.m. and 10:30 a.m., the exterior walk in freezer was missing 1 of 2 light shields. During an interview, at the same time as the observation, the Dietician/Director of Food & Nutrition stated he was not aware of the missing light shield.	F 371	*4. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **Adherence to the policy and procedure related to sanitizer bucket will be monitored as part of Quality Control Program. Outliers will be tracked and trended, then reported quarterly to Quality Council, Medical Executive Committee and Governing Board.** *1. How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **Light shield replace immediately upon discovery.** *2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **Potential deficiencies will be identified at EOC rounds.** *3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **Regular and frequent monitoring during EOC rounds.**	

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F 371	Continued From page 35 3. Between 9:34 a.m. and 10:30 a.m., the exterior walk-in freezer had ice build-up at the ceiling, fan/blower, and floor. During an interview, at the same time as the observation, the Dietician/Director of Food & Nutrition stated that at one point water got into the freezer and expanded parts of the freezer and that could be why there is ice build-up.	F 371	4. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **Will monitor as part of our safety rounds and EOC rounds. Outliers will be tracked and trended, then reported quarterly to EOC, Quality Council, Medical Executive Committee and Governing Board.**	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their	F 441	1 *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **All cassettes with adhesive build up have been replaced. The new cassettes have label slots covered with clears. The patient labels with the backing will be inserted in the slots rather than affixed to the cassette. This process will prevent any use of adhesive.** 2 *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **Residents having the potential to be affected by the same deficient practice are identified when RN cleans the cassette before the next exchange. Cassettes with adhesive build up will be replaced. The new cassettes have label slots covered with clears. The patient labels with the backing will be inserted in the slots rather than affixed to the cassette.**	

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F 441	Continued From page 36 hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to implement its infection control policies and procedures. Two staff members were observed leaving the rooms with contact isolation residents with clostridium difficile (C. diff) (a bacterium that can cause symptoms ranging from diarrhea to life-threatening inflammation of the colon). The medication cassettes in the medication room were dirty with old adhesive markings of labels (old labels removed but the sticky part was not completely removed), brownish color dirt markings in/on the outside of the cassettes, and some names were faded. Resident 9, who was on isolation, had C-Diff. The registered nurse (RN) came out of the room without washing her hands with soap and water and used the key pad at the medication door and went in. Resident 3, who was on isolation, had C-Diff. The biomed technician went into the room with a cart and tool, to fix the television. Then as he was leaving the room used hand gel and he did not disinfect the equipment that he had brought into	F 441	*3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **Assessment has been made hospital wide. All old cassettes with adhesive buildup will be replaced with new cassettes. In addition, the cassettes are cleaned before the exchange take place daily.** *4 How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **The cleanliness of medication cassettes will be monitored as part of the monthly unit inspection conducted by a pharmacist. The result will be tracked and reported to the unit director and pharmacy director. Compliance reports will be submitted to Quality Council, Medical Executive Committee, and Governing Board.**	

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F 441	Continued From page 37 the room with proper disinfecting agents. This deficient practice had the potential to result in cross-contamination and spread of infection. Findings: During an initial tour, on June 19, 2015, at 8:35 a.m., Licensed Vocational Nurse (LVN) 2 stated that Resident 3 and 9 were on isolation precautions due to C-Diff. The following was observed: 1. Resident 9, was on isolation precautions for C-Diff. The RN was observed coming out of the room without washing her hands with soap and water. The RN 3 went to the keypad lock of the medication room, punch in the code, touched the door knob, and went into the medication room. The surveyor informed RN 3 that she did not wash her hands upon leaving Resident 9's room. RN 3 stated that she washed her hands in the medication room. 2. Resident 3, was on isolation precautions for C-Diff. The biomed technician went into the room with a cart and tool, to fix the television. Then as he was leaving the room, he used hand gel and he did not disinfect the equipment that he had brought into the room with proper disinfecting agents. The surveyor asked the biomed technician if he was informed to wash his hands with soap and water. He stated he was not informed he had to wash his hands with soap and water upon leaving the room. During an interview on, June 19, 2015, at 2:35 p.m., the Director of Laboratory and Patho stated	F 441	*1 How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **All cassettes with adhesive buildup have been replaced. The new cassettes have label slots covered with clears. The patient labels with the backing will be inserted in the slots rather than affixed to the cassette. This process will prevent any use of adhesive.** *2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **Residents having the potential to be affected by the same deficient practice are identified when RN cleans the cassette before the next exchange. Cassettes with adhesive build up will be replaced. The new cassettes have label slots covered with clears. The patient labels with the backing will be inserted in the slots rather than affixed to the cassette.** *3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **Assessment has been made hospital wide. All old cassettes with adhesive buildup will be replaced with new cassettes. In addition, the cassettes are cleaned before the exchange take place daily.** *4 How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **The cleanliness of medication cassettes will be monitored as part of the monthly unit inspection conducted by a pharmacist. The result will be tracked and reported to the unit director and pharmacy director. Compliance reports will be submitted to Quality Council, Medical Executive Committee, and Governing Board.**	

PRINTED: 07/13/2015
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555674	A. BUILDING _____ B. WING _____	06/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

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F 441	Continued From page 38 Resident 3 and 9 were both positive for C-Diff. 3. During a medication room inspection, on June 20, 2015, at 9:15 a.m., with three (3) licensed nurses present they verified that the cassettes were dirty and had adhesive build up of bio-burden. The licensed nurses stated that everyday pharmacy comes to deliver new medications, the labels on the cassettes were removed by pharmacy when the resident was discharged, and replaced with a new label. The licensed nurses further stated that it was pharmacy's responsibility to clean the cassettes. According to the Centers for Disease Control and Prevention (CDC) website indicated C-Diff is shed in the feces. Any surface that becomes contaminated with feces may serve as a reservoir for C-Diff spores-Diff spores are transferred to patients mainly via hands of healthcare personnel who have touched a contaminated surface or item. The CDC recommends to prevent transmission in hospital and other healthcare settings "perform hand hygiene" use of soap and water is more effective than alcohol based hand rubs. According to the facility's policy titled, "Isolation Guidelines" dated May 2016 indicated the purpose was to provide a safe environment by preventing the spread/transmission of infectious diseases throughout the facility. 4.2.4 Contact Precautions included C-Diff the transmission can be hand or skin to skin contact, or indirect contact (touching) with environmental surfaces or patient care items in the patient's environment.	F 441	*1 How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **All cassettes with adhesive build up have been replaced. The new cassettes have label slots covered with clears. The patient labels with the backing will be inserted in the slots rather than affixed to the cassette. This process will prevent any use of adhesive.** *2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **Residents having the potential to be affected by the same deficient practice are identified when RN cleans the cassette before the next exchange. Cassettes with adhesive build up will be replaced. The new cassettes have label slots covered with clears. The patient labels with the backing will be inserted in the slots rather than affixed to the** *3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **Assessment has been made hospital wide. All old cassettes with adhesive buildup will be replaced with new cassettes. In addition, the cassettes are cleaned before the exchange take place daily.** *4 How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **The cleanliness of medication cassettes will be monitored as part of the monthly unit inspection conducted by a pharmacist. The result will be tracked and reported to the unit director and pharmacy director. Compliance reports will be submitted to Quality Council, Medical Executive Committee, and Governing Board.**	

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SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

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F 441	Continued From page 39 According to the facility's policy titled, "Dispensing of Medication" dated October 2010 indicated individual bins shall be labeled with the patient's name and/or room number. All bins will be checked by the pharmacist. Cassettes shall be exchanged daily. Furthermore, the policy did not mention who would be responsible to ensure the cassettes were cleaned daily and on a needed basis.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a safe, functional, and sanitary environment by not covering dumpsters, having stagnated water, closet doors not working, having peeling paint, broken cover plate, and not notifying the Office of Statewide Health Planning and Developing (OSHPD) of new equipment installation. OSHPD monitors the construction, renovation, and seismic safety of hospitals, and skilled nursing facilities. The OSPHD reviews and inspects health facility construction projects, and enforces building standards, per the California Building Standards Code, as they relate to health facilities construction. These deficiencies had the potential for vermin	F 465	*1. How corrective action() will be accomplished for those residents found to have been effected by the deficient practice* **Lid closed and replaced immediately upon discovery. Purchase new dumpster.** *2. How the facility will identify other residents having the potential to be effected by the same deficient practice and what corrective action will be taken* **Potential deficiencies will be identified at daily rounds.** *3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **Regular and frequent monitoring during EOC rounds.** *4. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **Will monitor as part of our safety rounds and EOC rounds. Outliers will be tracked and trended, then reported quarterly to EOC, Quality Council, Medical Executive Committee and Governing Board.**	

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	555974	A. BUILDING _____ B. WING _____	06/20/2015

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SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

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F 485	Continued From page 40 breeding and harborage, un-usable closets, non-easily cleanable surface, electrical hazard, and un-safe equipment installation. Findings: 1. On 6/19/15 at 10:05 a.m., 2 of 3 dumpsters located behind the dietary department had 3 of 4 lids fully open. There was also an accumulation of trash, debris, and stagnated yellow/white water at the trash bin area. 2. Between 3:15 p.m. and 3:50 p.m., 3 resident rooms (372, 373, 375), had closets with sliding doors that were impeded from opening and closing freely. During an interview, at the same time as the observation, the Facilities Director stated that the closets' sliding doors were off their tracks, impeding the doors from opening and closing freely. 3. There was peeling paint at the wall behind bed A of room 375. 4. There was a broken electrical receptacle cover at a wall in the Hydrotherapy room. 5. At 10 a.m., there were 3 new 3 door reach in coolers installed at the kitchen without notifying the Office of Statewide Health Planning and Developing (OSHPD). During an interview, at the same time as the observation, the Dietician/Director of Food & Nutrition stated the coolers were installed last August (2014).	F 485	*Resident rooms closet doors...* • No residents were affected by the deficient practice. • The facility performs environmental rounds regularly and identifies deficiencies and reports the deficiencies to the Facilities Operations Center for repair. Environmental/Safety deficiencies are top priority and repairs are scheduled first. • Door hardware will be adjusted to ensure this will not reoccur. • Environmental rounds are performed regularly and reported to the Environment of Care committee, Quality Council Committee and the Hospital Board. *Peeling paint behind bed...* • No residents were affected by the deficient practice. • The facility performs environmental rounds regularly and identifies deficiencies and reports the deficiencies to the Facilities Operations Center for repair. Environmental/Safety deficiencies are top priority and repairs are scheduled first. • Facility damage happens and there is no way to ensure it does not reoccur. Additionally Sub-Acute staff has been informed to call Facilities and request repairs when damage occurs. • Environmental rounds are performed regularly and reported to the Environment of Care committee, Quality Council Committee and the Hospital Board. • Repairs completed by 7/23/15	

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F 465	Continued From page 41 During an interview, at 1:60 p.m., the VP Corporate Facilities Operations stated that he was not aware that there were new coolers in the kitchen, and that the facility probably did not have any OSHPD paperwork on their installation. Review of the 2013 OSHPD FREER manual, indicated that the installation of new kitchen equipment required a field visit.	F 465	*Broken electrical receptacle cover broken...* • No residents were affected by the deficient practice. • The facility performs environmental rounds regularly and identifies deficiencies and reports the deficiencies to the Facilities Operations Center for repair. Environmental/Safety deficiencies are top priority and repairs are scheduled first. • Facility damage happens and there is no way to ensure it does not reoccur. Sub-Acute staff has been informed to call Facilities and request repairs when damage occurs. • Environmental rounds are performed regularly and reported to the Environment of Care committee, Quality Council Committee and the Hospital Board. *Reach-in coolers install without OSHPD approval...* • No residents were affected by the deficient practice. • The facility performs environmental rounds regularly and identifies deficiencies and reports the deficiencies to the Facilities Operations Center for repair. • The Facilities Operations Department will contact the OSHPD ACO prior to installation of equipment based off of the OSHPD FREER manual. • Environmental rounds are performed regularly and reported to the Environment of Care committee, Quality Council Committee and the Hospital Board. • This is an OSHPD item and plans for installation require a structural engineer design an approved anchorage system for submittal to OSHPD. An evaluation of electrical loads will be performed to ensure electrical loads are in compliance with OSHPD/NEC requirements; if necessary an electrical engineer will also be engaged to provide plans to OSHPD. Estimated completion date is 12/31/15.	

COUNTY OF LOS ANGELES
HEALTH FACILITIES DIVISION
3400 Aerojet Avenue, Suite 323
El Monte, CA 91731

FACSIMILE TRANSMISSION

ADDRESSEE:	ORIGINATOR:
NAME: Pamela Loo, RN Director of Quality **Attention:**	FROM: Rosario Grospe, RN, Senior HFEN Assistant Supervisor, Acute and Ancillary Unit
ORGANIZATION: Southern California Hosp at Culver City SNF DP	**Phone:** (626) 312-1129
CITY, STATE, & ZIP Culver City	FAX: (626) 927-9293
Telephone 310-836-7000 ext 1046	DATE 714/15
FAX #: 310-840-5426	PAGES INCLUDING COVER PAGE = 11

NOTES TO ADDRESSEE:

Attached is the ameded CMS 2567, Statement of Deficiencies and Plan of Correction for the Recertification Survey (LSC) completed 6/22/15, The hard copy will be mailed today. Please sign the Signature Requirement Notice and fax it back to our office as soon as possible.

Please submit the plan of correction on or before 7/24/15.

If you have any questions, please don't hesitate to call us.

Thank you, Rosario Grospe, Senior HFEN

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	006874	A. BUILDING _____ B. WING _____	C 09/22/2014

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F 000	INITIAL COMMENTS The following reflects the finding of the Department of Public Health during a complaint investigation. Amended 10/22/14 Complaint Intake Number: CA00380633 Representing the Department of Public Health: Surveyor 16281, REHS, HFEI Surveyor 09452, RN, Sr. HFEN One Deficiency was issued for intake CA00380633.	F 000		
F 328 SSS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that 1 of 3 sample residents (Resident 1) received proper treatment and care in intravenous antibiotics therapy. Medical record review revealed there was no	F 328		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

M. [signature] | ADMINISTRATOR | 10/30/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555874	A. BUILDING _____ B. WING _____	C 08/22/2014

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SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

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F 328	Continued From page 1 documented evidence that the intravenous (IV) line was removed from Resident 1's arm at or before the resident was discharged from the facility. This deficient practice had the potential to result in bleeding and/or infection at the IV line site. Findings: On January 2, 2014 at 2:00 p.m., an investigation was conducted at the facility regarding allegation that the resident was discharged and left the hospital's transitional care unit with an IV still in the resident's arm. On January 3, 2014, between 8:00 a.m. and 1:30 p.m., a review of Resident 1's medical record revealed that there was no documented evidence the IV line was removed from the resident's arm before discharge from the facility. A review of a face/cover sheet disclosed Resident 1 was admitted to the facility on November 27, 2013, with diagnoses which included ankle wound and cellulitis. Cellulitis is a spreading bacterial infection just below the skin surface. A review of IV Site and Fluid Report dated November 28, 2013 at 8:40 p.m., indicated an IV Line was started on the resident's right arm. The IV site was discontinued on December 1, 2013 at 8:30 a.m. The Daily Focus Assessment Report dated December 3, 2013 at 6:15 p.m., indicated a PICC (peripherheral inserted central catheter-a from of intravenous access that can be used prolonged period of time), single lumen, was inserted on the resident's right upper arm and secured with "statlock."	F 328	Action: Education will be provided to TCU nursing staff on the following: a. The Policy and Procedure on discharging of patients to include the need for a nursing assessment to be performed the day of discharge. b. The procedure on the completion of the Patient Discharge Instructions form. Implementation Education will commence immediately with completion of all staff by November 21, 2014. Monitoring: 1. The provision of Education will be monitored by review of sign-in sheets to ensure 100% compliance of all staff, excluding those on MLOA. 2. The compliance of nursing assessment and the completion of discharge instructions will be monitored by a sample of 30 discharge charts or 100% if less than 30 per month; charts will be retrospectively reviewed for compliance with nursing assessment performed on day of discharge and completion of the Patient Discharge Instructions form. Monitoring will continue until 3 concurrent months of 100% compliance is achieved. Findings will be reported to the Quality Council on a quarterly basis. Responsible Person: ACNO and Director of Rehab Services	11/21//2014

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F 328	Continued From page 2 A review of the Medication Administration Record, and the Medication Administration History Report indicated the resident was administered Nafcillin antibiotics 1 gram and infused over 30 minutes every four hours by IV route with a start date of November 27, 2013 and a stop date of December 4, 2013 with a new stop date of December 7, 2013, and that the last dose of Nafcillin by route was administered on December 6, 2013. A review of a Physician Order dated December 6, 2013, indicated to discontinue Nafcillin after the last dose on the same day as the order. There was no order found for the discontinuation and removal of the IV line. A review of the Discharge Assessment/Summary report indicated the patient was discharged on December 9, 2013. The report had no indication if the IV line in the resident's are had been removed. A review of the Patient Discharge Instructions did not have a Discharge Summary and that there was no indication if the IV line had been removed. The Patient Discharge Instructions also did not have dated signatures of the caregiver, physician, patient/significant other and discharge coordinator at the signature/date area provided. A review of the medical record by the director of TCU (registered nurse) and the Director of Quality/Risk Management (registered nurse) revealed there was no documented evidence the IV line was removed from the resident's arm before being discharged from the facility.	F 328	Action: Education will be provided to TCU nursing staff on the following: A. Policy and Procedure on Intravenous Therapy and Peripherally Inserted Central Catheter Care and Maintenance. To include assurance that any appliances or tubes are removed per doctor's order. Implementation: Education will commence immediately with completion of all staff by November 21, 2014 Monitoring: 1. The provision of Education will be monitored by review of sign-in sheets to ensure 100% compliance of all staff, excluding those on MLOA. 2. Compliance will be monitored by a sample of 30 discharge charts or 100% if less than 30 per month; charts will be retrospectively reviewed for compliance with policy and procedure on Peripherally Inserted Central Catheter Care and Maintenance. Monitoring will continue until 3 concurrent months of 100% compliance is achieved. Findings will be reported to the Quality Council on a quarterly basis. Responsible Person(s): ACNO and Director of Rehab Services.	11/21/2014

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F 328	Continued From page 3 During an interview at the same time as the Record review, the Director of Quality/Risk Management stated that if there was a Discontinuation of the IV line and removal of the IV line, there should have been documentation in the medical record. The Director of Quality/Risk Management stated there was no documentation of a discontinuation or removal of the IV line in the record. Although there was a physician order for the discontinuation of the medication (Nafcillin), the Director of Quality/Risk Management stated she could not find a physician order for the discontinuation of the IV line and there should have been a physician order for the discontinuation of the IV line. The Director of Quality/Risk Management stated there was no reason why the IV line should not have been discontinued after the discontinuation of the antibiotic (Nafcillin) and that she could not find anything in the record of why the IV line should not have been removed. A review of the facility policy titled, "Intravenous Therapy-Initiation and Management of Peripheral Intravenous Lines" last reviewed November 20, 2012 indicated that a physician order was required for the discontinuing of IV therapy.	F 328		

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	555874	A. BUILDING _____ B. WING _____	03/09/2014

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F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during a recertification survey. Representing the Department of Public Health: Surveyor 14042 RN, HFEN Surveyor 25487, RN, HFEN Surveyor 14041, REHS, HFE I Total Population: 11 Total Sample Size: 8 Highest Scope and Severity: E	F 000		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the premises in a sanitary manner at all times. This deficient practice did not promote a sanitary and comfortable interior for the residents and had the potential to result in the spread of disease-causing organisms. Findings: On March 7 and 8, 2014 at 8:55 a.m., an inspection was conducted on the premises and the following were observed:	F 253		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (□6) DATE

Any deficiency statement ending with an asterisk (□) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

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F 253	Continued From page 1 a. missing vertical blind panels in residents' sleeping rooms, Room 371 (10 blind panels), 372 (seven blind panels), 373 (six blind panels), 374 (one blind panel), and Room 370 (eight blind panels); b. in the nurse station located on the 3rd floor, the restroom linoleum floor had a section replaced and glued to the existing linoleum with open blacken seams and a small trash receptacle was filled with fecal and urine soiled toilet paper that were clearly visible; c. the toilet base sealant was cracked with gaps and blacken in the resident room, Room 376; and d. two stained and blacken ceiling tiles located in the corridor and near resident room 374. On March 7, 2014, an inspection was conducted on the 3-floor kitchenette and a small double sink base cabinet storage compartment which was not locked was observed. The area was inspected and the following were also observed: a. mold throughout the base cabinet storage area; b. a badly rusted and dirty water filter with no installation date; c. one (1) of two (2) sink drain sealant was totally disintegrated and the water filter valve was leaking water; and d. the automatic icemaker with the water dispenser spout was encased with layers of unsanitary mineral deposit.	F 253		

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F 253	Continued From page 2 An interview was held with the Building Engineer and he stated he does not know when the water filter was installed and the lower cabinet is usually locked. On March 8, 2014 at 10:23 a.m., an interview was held with the Environmental Services and the staff in charge stated the staff could clean the base cabinet storage area because it was usually locked. The evaluator conducted an inspection of the dietary department and observed a two compartment sink used for food preparation. The evaluator inspected the waste water pipes and observed no air gap available at the time of survey. In case of sub-surface sewer system back-up, the sewage can back up into the sink and contaminate the food product held in the sink. On March 8, 20014, at the time of the exit, an interview was held with the staff in charge and he stated he will inform the building supervisor or housekeeping regarding the concerns as soon as possible.	F 253		
F 365 SS=D	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that food was	F 365	**Dietary Reponse:** Re-trained Dietician Staff on proper assessment of dentition of patients and recommendation of altered texture diets, as well as record documentation. Method for Follow-Up: Audits and reporting on non-conformity to Quality Council. **Nursing Response:** • Review of oral and dietary assessment indicates that 100% of the residents who have dentures wear it daily in the duration of the admission in the TCU. • Review of the weight record of 100% of the residents revealed no significant weight loss of 3-5% in the duration of admission.	4/23/14 4/25/14 4/24/14

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F 365	Continued From page 3 prepared in a form designed to meet individual needs for one of eight sampled residents (4). Resident 4 was missing his dentures and was unable to bite/chew his food. Dietary and nursing services failed to identify/assess the resident's need for a mechanically altered diet. This deficient practice had the potential to result in weight loss and further medical complications for the resident. Findings: On March 7, 2014 at 6:30 p.m., during an observation, Resident 4 was awake and alert while lying in bed. The resident's dinner tray was still on his overbed table. The dinner tray contained a roast beef sandwich on a roll. One half of the sandwich appeared as if the resident had attempted to bite it, but had only broken the roll and did not go through the meat. During a concurrent interview, Resident 4 stated he did not have much of an appetite. The resident further stated he lost his dentures at the acute facility he was recently transferred from; therefore, he could not eat the sandwich. A review of the clinical record indicated Resident 4 was admitted to the facility on March 5, 2014 with diagnoses that included lung cancer and diabetes. The MDS (Minimum Data Set, a standardized assessment and care planning tool) was still in the process of being completed. A review of the physician's admission orders dated March 6, 2014 included a diet order for 1800 calories ADA (diet plan devised by the American Diabetes Association) and Boost (a nutritional supplement drink).	F 365	• The Director of Nursing re-educated the nursing staff on recognizing, evaluating, and addressing the needs of every resident including but not limited to, the resident at risk or already experiencing impaired nutrition. • The Dietician was re-educated on ensuring that resident's therapeutic diet takes into account the residents clinical condition, and preferences when there is nutritional indication. • The Director of Nursing re-educated the interdisciplinary committee (IDT) members about including the oral assessment/status and ensure that resident has the appropriate/therapeutic diet order in the IDT weekly meeting. • The Director of Nursing or Designee to monitor 100% compliance through the IDT notes. Any issues of non-compliance will be addressed to the appropriate staff who will be required to submit a plan of action	4/28/14 4/28/14 4/28/14 4/28/14 & Ongoing

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F 365	Continued From page 4 According to the Daily Assessment Inquiry dated March 7, 2014, an initial dietary/nutritional assessment was conducted and the resident was assessed as having a diagnosis of lung cancer, a weight of 47.27 kg (kilograms), an ideal body weight of 70 kg, and being underweight. The initial assessment indicated the resident had a diet order 1800 calories ADA, Boost with meals and his nutritional intake was poor (less than 50%). The resident's nutritional related history indicated he had poor intake, no appetite, no food preferences at this time, only drinks Boost, and he was not appropriate for diet education due to poor po (mouth) intake. One of the nutritional interventions indicated that if the resident's intake did not meet 50% or greater, he may need more aggressive nutrition support. There was no documented evidence the assessment identified the resident's missing dentures. On March 9, 2014 at 10:30 a.m., during an interview with the Registered Dietitian (RD), she stated information regarding missing dentures of a resident was usually provided by the resident during interviews with staff. A review of the Intake/Output Reports indicated the resident's meal intake percentage on March 8 was 35% for lunch and 40% for dinner. On March 9, the resident ate 30% of his breakfast. On March 9, 2014 at 11 p.m., during an interview, the Charge Nurse stated there were no other intake records available for the resident. According to the facility's policy and procedure titled "Dietician Responsibilities," revised November 12, 2012, the primary responsibility of	F 365		

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F 365	Continued From page 5 the dietician is the nutritional care of the patient/resident to include assessment, planning, application and monitoring of each patient's/resident's nutritional and hydration status. There was no documented evidence the RD assessed Resident 4's need for a mechanically altered diet due to his missing dentures to make the food easier to chew and safely swallow.	F 365		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure that food are prepared and held under optimal and safe condition at all times. This deficient practice had the potential to result in foodborne illnesses and outbreaks. Findings: On March 7, 2014 at 6:02 p.m., an inspection of the dietary department was conducted and 2 (two) Mobile Refrigerated Air Screen units were	F 371	Procedural changes were put into effect requiring the doors to the refrigerators to remain closed. Submitted a request for additional refrigeration for the department to replace inoperable refrigerators. Method for Follow-Up: Monitor at each meal period refrigerated cold food temperatures. Report non-conformity to Quality Council.	

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F 371	Continued From page 6 observed. The staff were setting up the residents' food trays for dinner and the two equipment doors were in an open locked position. A concurrent interview was held with the dietary supervisor and she stated the units were designed to remain open for an maximum of 90 minutes under acceptable refrigerator temperature. When asked how long were the refrigerators' doors held open and where was the time log, the dietary supervisor looked around the kitchen and could not produce any time log documentation at the time of the survey. Upon inspection of the units' thermometers, their temperatures were both 42 degrees Fahrenheit. On March 8, 2014 at 1:35 p.m., an additional inspection of the dietary department was conducted and the two refrigerator unit doors were again observed held open during the end of the tray line operation. Upon inspection of the refrigerators' thermometers, the temperature was observed as 66 degrees Fahrenheit. The digital temperature display flashed "open" and there was no alarm that made a sound or alerted the staff at the time of observation. A concurrent interview was held with the dietary supervisor and she stated she would check when the two units' doors were first locked in an open position. The log indicated the tray line started at 11:30 and the dietary supervisor stated the doors should have been closed at 1:00 p.m. The dietary supervisor stated the staff should have monitored the time and the temperature of the refrigerator units at all times. According to the Mobile Refrigerated Air Screen operating literature, undated, "when operating	F 371		

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F 371	Continued From page 7 with door open, the display will show 'OPEn' and an internal count down timer will start. This unit will allow open door operation for a maximum of 90 minutes. If the door is open longer than the allowed 90 minutes, an open door alarm will be activated. Display will flash 'OPEn' and beep three times every ten seconds". The refrigerator units were observed to hold small plates of cakes, Boost Plus, glucose control milk, juices, and small containers of 3-bean salads. The refrigerator units open door log, temperature, and alarm were not being monitored as often as necessary to maintain safe food storage temperature.	F 371		
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in □483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	F 425	**Nursing Response:** • The Director of Nursing verified with the Director of Environment Services and the Director of Pharmacy that appropriate biohazard containers are available and emptied daily and as needed. • The Director of Nursing or designee will conduct Department Audit Round that includes Medication Room Inspection to ensure appropriate biohazard container is available and emptied as appropriate: • The Director of Nursing or designee to monitor 100% compliance to Medication Room inspection from the Department Audit Report Form until July 30, 2014. Any issue of non-compliance will be reported to the appropriate staff who will be required to submit an action plan.	4/25/14 4/29/14 & Ongoing Ongoing

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F 425	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to properly dispose the leftover or unused medications in accordance with the facility's policy and procedure for two randomly selected residents (9, 10). The medication nurse divided into half by using a pill-splitter the Prednisone tablet (a hormone to treat severe illness) for Resident 9 and the Rivaroxaban tablet (a medication used to prevent blood clots from forming after surgery) for Resident 10. The medication nurse improperly disposed the unused half of the medications in the sink and residents' trash cans. This deficient practice had the potential to result in unauthorized access of prescription medications that could be lethal. Findings: 1. On March 8, 2014 at 9:12 a.m., during a medication pass observation, Registered Nurse (RN) 1 prepared routine medications to be administered to Resident 9. RN 1 opened the pill-splitter and found an unidentifiable pill which she discarded in the medication room sink. She then obtained a tablet of five (5) milligrams of Prednisone (a hormone to treat severe illnesses), divided the tablet into half using the pill-splitter, and then discarded half of the tablet, which was equivalent to 2.5 milligrams, in the resident's trash can. At 10 a.m., during an interview, RN 1 stated she was not familiar with the facility's policy on documenting and properly discarding the leftover	F 425	• The Director of Nursing re-educated the licensed nurses about the policy on Return, Handling, and Disposal of Medication Waste. • Director of Nursing or designee will conduct random observation to licensed nurses on correct medication waste to ensure 100%. The findings of the observation will be used to educate the staff and identify issues for competency and educational needs of all licensed nurses. Progressive issues of non-compliance will be addressed by progressive disciplinary action.	4/28/14 4/29/14 & Ongoing

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F 425	Continued From page 9 or unused medications. A review of Resident 9's clinical record indicated the resident was admitted to the facility on January 20, 2014 with diagnoses which included polyneuropathy (damage to multiple nerves). A review of the physician's order dated March 7, 2014 indicated to administer Prednisone tablet 7.5 mg (milligrams) twice a day with meals. A review of the facility's policy and procedure titled "Return, Handling, and Disposal of Medication Waste," dated July 31, 2010, indicated the purpose of the policy is to ensure safe disposition of the medications and any opened unit dose or loose items shall be placed in the regular pharmaceutical waste containers. 2. On March 8, 2014 at 9:35 a.m., during a medication pass observation, Registered Nurse (RN) 1 prepared routine medications to be administered to Resident 10 which included two tablets of 10 mg (milligrams) of Rivaroxaban. RN 1 divided one of the two tablets into half by using the pill-splitter in order to administer 15 milligrams of the medication to the resident. RN 1 then discarded half of the tablet, which was equivalent to five (5) milligrams, in the resident's trash can. At 10 a.m., during an interview, RN 1 stated she was not familiar with the facility's policy on documenting and properly discarding the leftover or unused medications in the regular pharmaceutical waste containers. A review of Resident 10's clinical record indicated the resident was admitted to the facility on March	F 425		

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F 425	Continued From page 10 6, 2014 with diagnoses which included atrial fibrillation (abnormal heat beat) and deep vein thrombosis (DVT, a blood clot that forms in a vein deep in the body and when blood thickens it clumps together) requiring thromboprophylaxis (the prevention of blood clotting) medication. A review of the physician's order, dated March 8, 2014, indicated to administer Rivaroxaban 15 mg once a day as a thromboprophylaxis. A review of the facility's policy and procedure titled "Return, Handling, and Disposal of Medication Waste," dated July 31, 2010, indicated the purpose of the policy is to ensure safe disposition of the medications and any opened unit dose or loose items shall be placed in the regular pharmaceutical waste containers.	F 425		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection	F 441	**Nursing Response:** • Review of records of 100% of current residents revealed 0% nosocomial infection. • Review of the infection rate for the 1st quarter of 2014 revealed 0% nosocomial infection. • The Director of Nursing re-educated all staff about the policy on infection control through: Hand Hygiene Contact Precaution Use of Personal Protective Equipment	4/25/14 4/25/14 4/28/14

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F 441	Continued From page 11 (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement infection control practices for two of 10 sampled residents (1, 5). For Resident 1, the licenced nurse did not educate the family member to wash hands and wear personal protective equipment (PPE, protective items or garments worn to protect the body or clothing from hazards that can cause injury) before entering the contact precaution room, and to remove PPE and wash hands again before leaving the contact precaution room. For Resident 5, the licensed nurse did not wash hands after emptying a urinal filled with urine and before touching the resident's environment, such	F 441	• The Director of Nursing or designee will do 10 random observations to staff every month on the use of appropriate personal protective equipment to ensure 100% compliance. Any issues of non-compliance will be addressed to the individual staff and will be re-educated or given progressive disciplinary action • The Director of Nursing re-educated all licensed nurses about providing educational handout to patient and or family members and visitors on appropriate isolation precaution. • The Director of Nursing or designee to conduct chart review for the copy of the patient education handout until July 30, 2014 to ensure 100% compliance. Any issues of non-compliance will be addressed to the individual staff and will be re-educated or given progressive disciplinary action.	4/29/14 & Ongoing 4/28/14 4/28/14 & Ongoing

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F 441	Continued From page 12 as bedsheets and table. This failure increased the potential for spreading infections. Findings: 1. On March 7, 2014 at 5:15 p.m., during the initial tour of the facility in the presence of RN 2, a sign was observed posted outside Resident 1's room that indicated contact plus isolation (measures that are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or resident's environment) and for visitors to see the nurse before entering the room. A family member was in the resident's room and was not wearing any PPE while touching the resident's bedding and table with his bare hands. During the course of the observation, RN 2 saw the family member leave the room, but she did not stop him to give an instruction to wash his hands and wear PPE the next time he visited. The family member went to the activity room after leaving the resident's room and sat on a chair to make phone calls. The family member was still not instructed to wash his hands. At 6 p.m., during an interview, the family member stated he knew the resident had an infection in her stomach but he did not know he had to wash his hands before entering the resident's room, wear PPE while inside the room touching the resident and/or the resident's environment, remove his PPE before leaving the room, and wash his hands again before he touched anything else.	F 441	**Infection Control Response:** Surveillance of isolated patients is conducted daily and review of laboratory results are done daily. Positive laboratory results of critical organisms are reported by phone call to Director of Infection Control and to patient's nurse. In-services are scheduled for each unit to re-educate staff on appropriate standard and isolation precautions and appropriate PPE use. Education will include topics such as C.difficile and methods of transmission. Will retrain staff on hand hygiene techniques and launch a hand hygiene campaign to increase compliance. Staff will be reminded to inform and educate visitors on PPE use and hand hygiene. Appropriate reporting of incidences will be reviewed and employees observed breaching policies will be counseled and incident reports recorded. All clinical staff and EVS staff will be retrained on the appropriate handling, storage, processing, and transport of all linens. Method for Follow-Up: Infection control rounds and review of incident reports. Non-conformity will be reported to the Infection Control Committee and Quality Council.	4/25/14

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(□4) ID PREFI□ TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFI□ TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(□5) COMPLETION DATE
F 441	Continued From page 13 A review of the clinical record indicated Resident 1 was admitted to the facility on March 6, 2014 with diagnoses which included urosepsis (urinary infection that travels to the blood stream), Clostridium difficile infection (C. diff, an infection of the colon which may be transferred to residents through the hands of health care personnel who had contact with contaminated residents, their feces or environment), and anemia (a condition in which the body does not have enough healthy red blood cells to provide oxygen to body tissues). The MDS assessment was still in the process of being completed. According to the facility's policy and procedure titled "Isolation Guidelines," dated November 2012, transmission-based precaution, such as contact plus precautions, was to be used in conjunction with Standard Precautions which are measures to be used in all patients regardless of diagnosis when there is potential for contact with any body fluid, non-intact skin or mucous membranes. Contact plus precaution was to be used for patients known or suspected to have a disease spread by direct contact, such as Clostridium difficile. A review of the Contact Plus Isolation signage indicated to clean hands and then wear a gown and gloves when entering (the room), discard gown and gloves and then wash hands when exiting (the room), and wash hands with soap and water only. 2. On March 8, 2014 at 9:12 a.m., during the medication pass observation, Registered Nurse (RN) 1 entered Resident 5's room in order to	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(□1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(□2) MULTIPLE CONSTRUCTION	(□3) DATE SURVEY COMPLETED
	555874	A. BUILDING _____ B. WING _____	03/09/2014

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SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

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F 441	Continued From page 14	F 441		

administer the routine medications. After RN 1 administered all the oral (through the mouth) medications, she put on a pair of gloves, emptied the resident's urinal in the toilet, and without removing her gloves to wash her hands, she moved the overbed table to the side and uncovered the resident by pulling the linen sheet in order to administer Vancomycin (an antibiotic) enema (a procedure of introducing liquids into the rectum and colon via the anus through a tube).

During a concurrent interview, RN 1 stated she should have washed her hands after she emptied the urinal and before she touched the resident's environment.

A review of Resident 5's clinical record indicated the resident was admitted to the facility on February 28, 2014 with diagnoses which included methicillin-resistant staphylococcus aureus (MRSA, a bacteria responsible for several difficult-to-treat infections in humans) of the nares (nose) and Clostridium difficile (C. diff). The MDS assessment was still in the process of being completed.

A review of the physician's order, dated March 4, 2014, indicated the antibiotic was changed to Vancomycin enema 500 milligrams (mg) twice a day for seven (7) days and to place the resident on contact isolation for C. diff in the stool.

According to the facility's policy and procedure titled "Isolation Guidelines," dated November 2012, transmission-based precaution, such as contact plus precautions, was to be used in conjunction with Standard Precautions which are measures to be used in all patients regardless of diagnosis when there is potential for contact with

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F 441	Continued From page 15 any body fluid, non-intact skin or mucous membranes. Contact plus precaution was to be used for patients known or suspected to have a disease spread by direct contact, such as Clostridium difficile. Wearing gloves does not replace the need hand antisepsis and hand hygiene must be practiced after removing the gloves.	F 441		

RESPONSE TO DEFICIENCIES
EXHIBIT P CMS Statements of Deficiency

Southern California Hospital at Hollywood

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050135	A. BUILDING 01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD B. WING _____	02/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	6245 DE LONGPRE AVE HOLLYWOOD, CA 90028

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K 000	INITIAL COMMENTS This facility was surveyed under the Life Safety Code NFPA 101, 2000 Edition, Chapter 19, Existing Health Care Occupancies, and other applicable codes. The following represents the findings of the Department of Public Health during Life Safety Code Complaint Validation Survey at the Culver City Campus. Intake No: CA00429647 Representing the Department of Public Health: Surveyor 14041, REHS, CFI 1, HFE I Surveyor 16281, REHS, CFI 1, HFE I	K 000		
K 051	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4,9.6	K 051		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: INTERIM CEO — (X6) DATE: 5/29/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 051	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure that the 2 of 4 elevators Phase II firefighter operation were fully functional at all times. Finding: On February 3, 4, and 5, 2015, the evaluator conducted a complaint investigation into a fire / evacuation emergency. On February 5, 2015, the elevator requested the Pavilion elevator test and service documentation for all four elevators. The Building Engineer provided the service test documents and he explained that the State of California were slow in sending the current annual certificates. The evaluator reviewed the elevator documents and observed the following: North Elevator – the Phase II Operation failed from June 2014 through December 2014; the Staff Elevator – the Phase II Operation failed from August 2014 through December 2014; and the Service Elevator – the Phase II Operation failed from May 2, 2014 through July 16, 2014. The evaluator conducted a record review of the elevator's certificates posted and 2 of 2 elevators certificates were expired. One of the certificates expired on October 18, 2014 and the other	K 051	**Corrective Action:** Vendor, Liftech has corrected elevators to be. Phase II elevator testing has been inspected and permits have been renewed and obtained. **(Attachment #1 & #22)** **Date of Implementation:** 4/8/2015 **Monitoring Process:** Results of monitoring will be reported up to EOC and Quality Council on a quarterly basis. **Person Responsible:** Director of Facilities	04/08/2015

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K 051	Continued From page 2 expired on September 20, 2014. On February 13, 2014, at 11:30 a.m., the evaluator contacted the State of California, Department of Industrial Relations, Div of Occupational Safety & Health, and staff verified that the two elevators failed the Phase II annual test. The staff also stated that the facility was fined because the two elevators' Phase II were not repaired within the time period initially allowed, 5-weeks. The evaluator reviewed the fire incident report and it revealed that "Since the keys in the knox (security) box did not have the correct elevator recall key nor did security. Engineer T2 proceeded to recall elevators to the first floor and pull the "Emergency Stop" button in elevator panel." Under Phase I operation, elevators that are 25 feet or more above the main floor return either to a designated landing area or an alternate area. Phase I operation is activated either manually by a special key, or automatically by a fire alarm initiating device. The elevator Phase II operation is an override meant for firefighters after Phase I has been activated. Under the Phase II operation, firefighters can use a key-switch to operate the elevator, provided the hoistway is clear of smoke and the elevator has electricity.	K 051	**Corrective Action:** Upon review with the Culver City Fire Department Fire Inspector, Steve Poelstra, all necessary keys were in place inside knox box. Per request of the CCFD, an additional knox box has been ordered and approved; arrival pending **(Attachments #3 and #4).** **Date of Implementation:** April 7, 2015 **Monitoring Process:** Only CCFD has access to the knox boxes. Upon arrival of the additional knox box, CCFD will have to install and ensure all keys are in place. **Person Responsible:** Director of Facilities	4/27/2015
K 067	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2	K 067		

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K 067	Continued From page 3 This STANDARD is not met as evidenced by: NFPA 90A, Standard for the Installation of Air Conditioning and Ventilating Systems. 2-3.11.1 Egress Corridors in health care, detention and correctional and residential occupancies shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas. An air transfer opening(s) shall not be permitted in walls or in doors separating egress corridors from adjoining areas. Exception No. 1: Toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces opening directly onto the egress corridor. Exception No. 2: Where door clearances do not exceed those specified for fire doors in NFPA 80, Standard for Fire Doors and Fire Windows, air transfer caused by pressure differentials shall be permitted. Exception No. 3: Use of egress corridors as part of the engineered smoke control system. Exception No. 4: In detention and correctional occupancies with corridor separations of open construction (e.g. grating doors or grating partitions). 4-3.1 Smoke dampers shall be controlled by an automatic alarm initiating device. Smoke dampers shall be permitted to be positioned manually from a command station.	K 067		

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K 067	Continued From page 4 4-4.1 All automatic shutdown devices shall be tested annually. 4-4.3 Smoke detectors provided as required by 4-4.2 shall automatically stop their respective fan(s) on detecting the presence of smoke. NFPA 101 Code for Safety to Life from Fire in Buildings and Structures 2000 Edition 9.2.1 Air Conditioning, Heating, Ventilating Ductwork, and Related Equipment. Air conditioning, heating, ventilating ductwork, and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Warm Heating and Air-Conditioning Systems, as applicable, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction. 9.3.1* General. Smoke control systems, where required or permitted by Chapters 11 through 42, shall have an approved maintenance and testing program to ensure operational integrity. The purpose of such smoke control systems shall be to confine smoke to the general area of fire origin and maintain use of the means of egress system. 9.6.5.1 A fire alarm and control system, where required by another section of this Code, shall be arranged to actuate automatically the control functions necessary to make the protected premises safer for building occupants. 9.6.5.2 Where required by another section of this Code, the following functions shall be actuated by	K 067		

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K 067	Continued From page 5 the complete fire alarm system: (1) Release of hold-open devices for doors or other opening protectives (2) Stairwell or elevator shaft pressurization (3) Smoke management or smoke control systems (4) Emergency lighting control (5) Unlocking of doors 19.3.4.4 Emergency Control. Operation of any activating device in the required fire alarm system shall be arranged to accomplish automatically any control functions to be performed by that device. (See 9.6.5) 19.5.2.1 Heating, ventilating, and air conditioning shall comply with the provisions of Section 9.2 and shall be installed in accordance with the manufacturer's specifications. These codes and standards were not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an air handler automatically shut down with the presence of smoke. The facility failed to ensure that all automatic shutdown devices were tested annually. The facility used corridors as plenums. The deficiencies permitted, and had the potential to permit accelerated spread of smoke and gases during a fire. Findings: 1. On 2/3/15, a review of an OSHPD Fire and Life Safety Field Visit Report dated 2/2/15, indicated that on 1/29/15 a fire appeared to have damaged	K 067		

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K 067	Continued From page 6 the HVAC supply air-intake filter banks that apparently supply air to the 2nd, 4th, 5th, and 6th floor patient rooms. That the HVAC system did not automatically shut-down during the fire on 1/29/15 and the smoke from the fire was dispersed from the roof supply intake to other areas and floors of the building. On 2/3/15 at 12:05 p.m., during an interview the Project Manager stated that one of two air handlers (air handler 2) in the penthouse was affected by the fire, and that air handler 2 affected the 2nd, front 3rd SDU, 4th, 5th, and 6th floors that it served. At 2:10 p.m., Air handler 2 was observed to have fire, heat, and smoke damage. There was a duct detector located at the main supply duct coming form the air handler. The air handler was in the penthouse located at the 7th floor roof level. During an interview at the same time as the observation, the Project Manager and the Lead Man stated that the smoke from the fire should have activated the duct detectors to shut down both air handler 1 and 2. On 2/4/15 at at 11:05 a.m., during an interview, the Lead Man stated that every floor in the Pavilion had smoke dampers, and that there were two duct detectors in the main supply ducts located at the penthouse. That the way the system was suppose to function was that the duct detectors send a signal to the fire alarm control panel that activates the alarm and the panel sends a signal to the fire alarm air handler controls that shuts down the air handler motor. That on the day of the fire both air handler 1 and 2 had to be shut down manually at the air	K 067	**Corrective Action:** A new fire system is being installed **(Attachments #6 and #15)** which will immediately shut down air handlers, should the relays be pulled. Engineers have been instructed that relays are no longer to be pulled during fire alarm testing, as was common practice beforehand **(Attachment #7)**. New fire system is in final stages of testing. **Date of Implementation:** February 15, 2015 with an estimated completion date of May 30, 2015. **Monitoring Process:** Redesigned system will shut down air handlers should there be any attempt to pull or disable relays. **Person Responsible:** Vice President of Facilities Operations **Corrective Action** Air handler #1 is still in use, while air handler #2 has a temporary replacement. Air balancing for temporary unit not required per ACO Attachment #20 **(Attachment #8, 15, 16, 17, 18, 19, 20, 21, 23)**. **Date of Implementation:** Temporary air handler was installed on March 25, 2015. **Monitoring Process:** Testing will occur upon installation, with quarterly inspections thereafter. **(Attachment #2).** Results of monitoring will be reported up to EOC and Quality Council on a quarterly basis. **Person Responsible:** Director of Facilities **Corrective Action:** A new fire system is being installed **(Attachments #6 & #15)** which will immediately shut down air handlers, should the relays be pulled. Engineers have been instructed that relays are no longer to be pulled during fire alarm testing, as was common practice beforehand **(Attachment #7)**. New fire system is in final stages of testing. **Date of Implementation:** February 15, 2015 with an estimated completion date of June 15, 2015. **Monitoring Process:** Redesigned system will shut down air handlers should there be any attempt to pull or disable relays. **Person Responsible:** Vice President of Facilities	5/30/2015 3/25/2015 6/15/2015

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K 067	Continued From page 7 handlers, and that he did not know what part of the HVAC shut down system did not work. The Lead Man also stated that there were relays in the fire alarm air handlers control panel at the penthouse that could bi-pass the air handler shut down system so that the air handlers do no shut down when the fire alarm system was activated, and that only engineering knew about the relays. Between 11:05 a.m., and 12:40 p.m., the Corporate Vice President of Facilities Operations stated that the hospital engineers had not been asked about the relays. At 2:18 p.m., the Corporate Vice President of Facilities Operations stated that he had found out from the Engineer that the relays at the fire alarm air handlers control panel had been found pulled (unplugged). On 2/5/15 at 8:52 a.m., during an interview the Corporate Vice President of Facilities Operations stated that the 2nd shift Stationary Engineer had found the relays pulled. On 2/5/14 at 10:10 a.m., during an interview, the Lead Man stated that on the day of the fire (1/29/15) he heard a code red announced from the 3rd floor, that he went to the 3rd floor and saw smoke coming from the vents at the 3rd floor, that he went up to the penthouse and saw smoke coming from air handler 2, saw fire at the door of the air handler, and saw the air handler was still on, so he (manually) shut off the air handler. The Lead Man also stated that the engineers can pull the relays in the fire alarm air handlers control panel if a vendor is scheduled to conduct	K 067		

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K 067	Continued From page 8 a fire alarm test and then reconnect them after the test, that its was the practice when he came to the hospital, and its what they (engineering) have continued to do, that the relays have to be pulled otherwise air conditioning and heating is lost for the whole building and that there was no other reason to pull the relays. The Lead Man further stated that he asked the engineers to log whenever they pull and reconnect the relays, but did not know if the engineers log when they pull and reconnect the relays, that he did not know who the last person that pulled the relays was, that he asked the engineer who worked on the day of the fire, and the engineer told him he did not pull the relays. At 2:40 p.m., during an interview, the Lead Man stated that engineering was not logging when the relays in the fire alarm air handlers control panel were being pulled and reconnected. On 2/5/15, at 2:42 p.m., during an interview, the 2nd shift Stationary Engineer stated that on 1/29/15 he had arrived to the hospital at 1:30 p.m., after the fire, and discovered there had been a fire on the roof of the Pavilion. That around 5 p.m. the Lead Man asked him to go up to the penthouse to the fire alarm air handlers control panel to heck if the relays for air handlers 1 and 2 were installed in place. That upon opening the relay box he found both relays unplugged and laying at the bottom of the panel at which time he installed them in there place. The 2nd shift Stationary Engineer also sated he did not know who pulled the relays. 2. On 2/4/15 at 12:40 p.m., a review of fire alarm	K 067	**Corrective Action:** Engineering has been instructed that relays are never to be pulled, without exception. **(Attachment #7).** **Date of Implementation:** Staff meeting with education was held on February 5, 2015 **Monitoring Process:** The new fire system in place will automatically shut down air handlers should there be any attempt to pull or disable the relays. **Person Responsible:** Corporate VP of Facilities Operations	2/5/2015

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K 067	Continued From page 9 system inspection and test report dated 7/28/14, indicated there was no documented evidence that the duct detectors for air handlers 1 and 2 at the 7th floor penthouse were inspected and tested. During an interview, after reviewing the fire alarm system inspection and test report dated 7/28/14, the Corporate Vice President of Facilities Operations stated that he didn't see any evidence in the report that air handler one and two at the 7th floor penthouse were inspected and tested. During an interview, after reviewing the fire alarm system inspection and test reports dated 7/28/14, the Lead Man stated that the duct detectors on the air handlers were shut down devices that were tested annually, that per his review of the fire alarm inspection and test report dated 7/28/14, there was no evidence in the report that air handler 1 and 2 at the 7th floor penthouse were inspected and tested. The Lead Man also stated that when he received the fire alarm inspection and test report he review the deficiency sheet at the end of the report, but not review the rest of the report to check that all systems were tested, and that he should have reviewed the full report. A review of the facility's Fire Alarm and Inspection schedule for 2014 indicated that the smoke detection shut down devices for the HVAC system had an annual testing frequency and were supposed to be tested in July of 2014. On 2/5/15 at 1:15 p.m., review of the fire alarm system inspection and test report dated 4/24/13, indicated there was no documented evidence that the duct detectors for air handlers 1 and 2 at the 7th floor penthouse were inspected and tested.	K 067	**Corrective Action:** Vendor for testing is no longer being used; currently in the process of contracting a new vendor. Air handler #1 is still in use; air handler #2 has a temporary. Replacement. Air balancing for temporary unit not required per ACO Attachment #20 **(Attachment #8, 15, 16, 17, 18, 19, 20, 21, 23).** **Date of Implementation:** Implementation immediately upon installation of new fire system, an estimated date of June 15,2015 **Monitoring Process:** Testing will occur upon installation, with quarterly inspections thereafter **(Attachment #2).** Results of monitoring will be reported up to EOC and Quality Council on a quarterly basis. **Person Responsible:** Director of Facilities	6/15/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050135	A. BUILDING 01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD B. WING _____	02/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 067	Continued From page 10 During an interview, after reviewing the fire alarm system inspection and test report dated 4/24/13, the Lead Man stated that he he didn't see any evidence in the report that air handlers 1 and 2 at the 7th floor penthouse were inspected and tested. The last documented evidence of duct smoke detectors for air handler one and two being inspected was on 3/20/12. 3. On 2/5/15 between 10 a.m. and 12 a.m., the Lead Man stated that the tower building had plenums as part of the buildings air distribution system on some of the tower building floors , but that he would have to investigate to determine which floors had plenums. A review of the tower building's supply and exhaust conveyance document indicated that Tower floors 2, 4, 5, and 6 (T-2, T-4, T-5, and T-6) had plenums as part of the buildings air distribution system. On 2/17/15, between 2 p.m. and 4 p.m., the following condition existed in the Tower. At T-6, a Med-Detox unit, the air duct in the corridor was an open system with air blowing into the pen egress corridor space above the drop down suspended ceiling. There were no ducts branching out from the corridor air duct, and there were transfer openings in the egress corridor walls that separated patient rooms from the corridor. There were no ducts from the corridor duct to the patient rooms, and the egress corridor above the ceiling space was used as a portion of the supply air system serving the patient rooms.	K 067		

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	050135	A. BUILDING **01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD** B. WING _____	**02/05/2015**

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K 067	Continued From page 11 During an interview at the same time as the observation, the Lead Man stated that there were no ducts between the corridor duct and the rooms. That the air duct in the corridor was an open system with air blowing into the open corridor space above the suspended ceiling, with that open space used as a plenum. That the air movement went from the open corridor duct, to the open space plenum above the corridor ceiling, to the transfer openings in the egress corridor walls, pulled through the transfer openings into the rooms by the direction of air flow of the the exhaust vents in the rooms taking the air out of the rooms. T-6 is a Med-Detox unit that had patients and staff at the time of the observation. At T-5, the corridor had hard lid ceilings. During an interview at the same time as the observation, the Lead Man stated that the air supply at T-5 had the same type of plenum system as T-6. During an interview at the same time as the observation, the Corporate Vice President of Facilities Operations stated that T-5 was used last week as turn around space to house patients while the cleaning was done at the Pavilion. At T-4, the corridor had hard lid ceilings. During an interview at the same time as the observation, the Lead Man stated that the air supply at T-4 had the same type of plenum system as T-6. At the same time as the observation, during an interview, the Risk Manager stated that T-4 is not on the facility's license and is not used for patients.	K 067		

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K 067	Continued From page 12 At T-2 the air duct in the corridor above the drop down suspended ceiling was a closed system with ducts branching from the corridor duct to the patient rooms. During an interview at the same time as the observation, the Lead Man stated that T-2 was completely ducted and did not have a plenum as part of the floors air distribution system. The egress (exit) corridors of T-4, T-5, and T-6 were the same corridors used as a portion of the air supply (plenums). T-2, T-4, T-5, and T-6 were not sprinklered. T-2, T-4, T-5, and T-6 had smoke detectors in the corridors including at the elevator lobby. T-2, -5, and T-6 had smoke detectors in the rooms. T-4 did not have smoke detectors in the rooms. Per an e-mail dated 2/9/15, from the Corporate Vice President of Facilities Operations, there was an automatic fan shut down for T-2, T-4, T-5, and T-6 upon detection of smoke and activation of the building fire alarm system. Per CMS S&C-06-18 letter dated 5/26/06, NFPA 90A, "Installation of Air Conditioning and Ventilating Systems" document, 1999 Edition prohibits egress (exit) corridors in health care occupancies from being used as a portion of the supply, return or exhaust air system serving adjoining areas (5-3.11.1, 1999 ed.). This prohibits the corridor from being used as a plenum.	K 067	**Corrective Action:** As per CMS S&C-06-18 criteria, a waiver has been requested, citing a review of the fire alarm system pertaining to the corridor protection. The existing system, as installed and tested, contains full corridor coverage, with smoke detectors, and is interconnected to the existing ventilation system. **(Attachments #8, #9, #10, #11, #12, #15 and #24)** **Date of Implementation:** Compliance confirmed May 4, 2015 **Monitoring Process:** Newly designed fire system will automatically shut down at any attempt to pull or disable relays. Anticipated completion of new fire alarm system 5/30/15 **Person Responsible:** Director of Facilities	5/4/2015

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K 147	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: NFPA 70 National Electrical Code 1999 edition 110-3. Examination, Identification, Installation, and Use of Equipment (a) Examination. In judging equipment, considerations such as the following shall be evaluated: (3) Wire-bending and connection space (4) Electrical insulation (8) Other factors that contribute to the practical safeguarding of persons using or likely to come in contact with the equipment 110-12(c) Internal parts of electrical equipment, including busbars, wiring terminals, insulators, and other surfaces, shall not be damaged or contaminated by foreign materials such as paint, plaster, cleaners, abrasives, or corrosive residues. There shall be no damaged parts that may adversely affect safe operation or mechanical strength of the equipment such as parts that are broken; bent; cut; or deteriorated by corrosion, chemical action, or overheating. 310-2. (a) Insulated. Conductors shall be insulated. These codes were not met as evidenced by: Based on observation and interview, the facility failed to ensure 2 electrical cords were not compromised.	K 147		

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K 147	Continued From page 14 The deficient practices bypassed the safe use and maintenance of electrical cords and their safeguards against fire and electric shock. Findings: On 2/3/15, between 4:20 p.m. and 4:55 p.m., there were two extension cords connected to air scrubbers on the 3rd and 5th floors of the pavilion. Closer observation revealed the extension cords had damaged that consisted of their electrical cord protective jacket being pulled away from the plug, thereby exposing the electrical wiring beneath. During an interview at the same time as the observations, the Corporate Vice President of Facilities Operations stated damaged extension cords would be removed.	K 147	**Corrective Action:** Third party vendor removed air scrubber, along with damaged electrical cord. **Date of Implementation:** Removed immediately on 2/3/15. **Monitoring Process:** No monitoring necessary. **Person Responsible:** Director of Facilities	2/3/2015

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K 147	Continued From page 14 The deficient practices bypassed the safe use and maintenance of electrical cords and their safeguards against fire and electric shock. Findings: On 2/3/15, between 4:20 p.m. and 4:55 p.m., there were two extension cords connected to air scrubbers on the 3rd and 5th floors of the pavilion. Closer observation revealed the extension cords had damaged that consisted of their electrical cord protective jacket being pulled away from the plug, thereby exposing the electrical wiring beneath. During an interview at the same time as the observations, the Corporate Vice President of Facilities Operations stated damaged extension cords would be removed.	K 147	**Corrective Action:** Third party vendor removed air scrubber, along with damaged electrical cord. **Date of Implementation:** Removed immediately on 2/3/15. **Monitoring Process:** No monitoring necessary. **Person Responsible:** Director of Facilities	2/3/2015

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A 000	INITIAL COMMENTS The following represents the findings of the Department of Public Health during a Complaint Validation Survey at the Culver City Campus. Intake No.: CA00429647 Representing the Department of Public Health: Evaluator ID #14041, REHS, CFI 1, HFE I Evaluator ID #16281, REHS, CFI 1, HFE I	A 000	**A 700-1Corrective Action:** Hot work permit protocol has been revised **(Attachment # 1).** Project Manager no longer has authority to approve Hot Work permits. All permits must be approved by Facilities Director, or his designee. Contractor holds sole responsibility to notify IOR when presence is needed. Fire Watch has been conducted on 1/29/15, the day of the fire, albeit, incorrectly, by the contracting company MK Roofing. **(Attachment #2)** Contractor on site notice process has been implemented so that no contractor can have facility access without prior notification and approval by facilities director and project manager should IOR be required. Process includes description of work, area impacted with dates and times. See attachment 5 & 14. **Date of Implementation:** February 3, 2015 **Monitoring Process:** Fire Watch will be monitored and logged by SCHCC staff, rather than third party company. Fire Watch log sheet is attached to Hot Work policy and procedure. **Person Responsible:** Director of Facilities	2/3/2015
A 700	482.41 PHYSICAL ENVIRONMENT The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community. This CONDITION is not met as evidenced by: Based on observation, document review, and interview, the facility failed to meet the Condition of Participation in Physical Environment by failing to: 1. Maintain the physical plant in a manner that assured the safety and well-being of patients (Refer to A 701 and A 710). 2. Ensure the safety of patients and staff when the hospital failed to ensure the Inspector of Record was present during hot works construction (Refer to A 701). 3. Ensure the safety of patients and staff when the hospital failed to have an approved and effective Hot Work policy and procedure (Refer to A 701).	A 700	**A 710 Corrective Action:** A new fire system is being installed **(Attachment #6)** which will immediately shut down air handlers, should the relays be pulled. Engineers have been instructed that relays are no longer to be pulled during fire alarm testing, as was common practice beforehand **(Attachment #7)**. New fire system is in final stages of testing. **Date of Implementation:** February 15, 2015 with an estimated completion date of May 30, 2015. **Monitoring Process:** Redesigned system will shut down air handlers should there be any attempt to pull or disable relays. **Person Responsible:** Vice President of Facilities Operations	6/15/2015
			A 700-2 Corrective Action: Hot work permit protocol has been revised **(Attachment # 1).** Project Manager no longer has authority to approve Hot Work permits. All permits must be approved by Facilities Director, or his designee. Contractor holds sole responsibility to notify IOR when presence is needed. Fire Watch has been conducted on 1/29/15, the day of the fire, albeit, incorrectly, by the contracting company MK Roofing. **(Attachment #2)** Contractor on site notice process has been implemented so that no contractor can have facility access without prior notification and approval by facilities director and project manager should IOR be required. Process includes description of work, area impacted with dates and times. See attachment 5 & 14. **Date of Implementation:** February 3, 2015 **Monitoring Process:** Fire Watch will be monitored and logged by SCHCC staff, rather than third party company. Fire Watch log sheet is attached to Hot Work policy and procedure. **Person Responsible:** Director of Facilities	2/3/2015
			A 700-3 Corrective Action: Hot work permit protocol has been revised **(Attachment # 1).** Project Manager no longer has authority to approve Hot Work permits. All permits must be approved by Facilities Director, or his designee. Contractor holds sole responsibility to notify IOR when presence is needed. Fire Watch has been conducted on 1/29/15, the day of the fire, albeit, incorrectly, by the contracting company MK Roofing. **(Attachment #2)** Contractor on site notice process has been implemented so that no contractor can have facility access without prior notification and approval by facilities director and project manager should IOR be required. Process includes description of work, area impacted with dates and times. See attachment 5 & 14. **Date of Implementation:** February 3, 2015 **Monitoring Process:** Fire Watch will be monitored and logged by SCHCC staff, rather than third party company. Fire Watch log sheet is attached to Hot Work policy and procedure. **Person Responsible:** Director of Facilities	2/3/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Interim CEO — (X6) DATE: 5/29/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 700	Continued From page 1 4. Ensure the safety of patients and staff when the hospital failed to ensure relays at the fire alarm air handler shutoff control panel remained installed in place (Refer to A 701). 5. Ensure the safety of patients and staff when the hospital failed to ensure the air system operated continuously and provided balanced air-supply to patient rooms (Refer to A 701). 6. Ensure the safety of patients and staff when the hospital removed self-closing area separation fire doors from the fourth and fifth floors (Refer to A 701). 7. Ensure the safety of patients and staff when the hospital failed to ensure an air handler automatically shut down with the presence of smoke (Refer to A 710 and K 067). 8. Ensure the safety of patients and staff when the hospital failed to ensure that all automatic shutdown devices were tested annually (Refer to A 710 and K 067). 9. Ensure the safety of patients and staff when the hospital used egress corridors as plenums (Refer to A 710 and K 067). 10. Ensure the safety of patients and staff when the hospital failed to ensure electrical power cords were maintained intact (Refer to A 710 and K 147). 11. Ensure 2 of 4 elevators Phase II fire fighter operation were fully functional at all times (Refer to K 051).	A 700	**A 700-4 Corrective Action:** A new fire system is being installed **(Attachment #6 & 15)** which will immediately shut down air handlers, should the relays be pulled. Engineers have been instructed that relays are no longer to be pulled during fire alarm testing, as was common practice beforehand **(Attachment #7)**. New fire system is in final stages of testing. **Date of Implementation:** February 15, 2015 with an estimated completion date of June 15,, 2015. **Monitoring Process:** Redesigned system will shut down air handlers should there be any attempt to pull or disable relays. **Person Responsible:** Vice President of Facilities Operations **A700-5 Corrective Action:** A new fire system is being installed **(Attachment #6 & 15)** which will immediately shut down air handlers, should the relays be pulled. Engineers have been instructed that relays are no longer to be pulled during fire alarm testing, as was common practice beforehand **(Attachment #7)**. New fire system is in final stages of testing. **Date of Implementation:** February 15, 2015 with an estimated completion date of June 15,, 2015. **Monitoring Process:** Redesigned system will shut down air handlers should there be any attempt to pull or disable relays. **Person Responsible:** Vice President of Facilities Operations **A 700-6 Corrective Action:** Project for self-closing area separation fire doors has been opened with OSHPD and design has been approved **(Attachment #11).** Currently, the project is out for bids, with an anticipated award date of June 1, 2015 Anticipated completion date of July 15, 2015.. **Date of Implementation:** 1/30/2015 **Monitoring Process:** Fire Doors are inspected on a quarterly basis **(Attachment #12).** Results of monitoring will be reported up to EOC and Quality Council on a quarterly basis. **Person Responsible:** Corporate Vice President of Facilities Operations **A700-7 Corrective Action:** A new fire system is being installed **(Attachment #6 & 15)** which will immediately shut down air handlers, should the relays be pulled. Engineers have been instructed that relays are no longer to be pulled during fire alarm testing, as was common practice beforehand **(Attachment #7)**. New fire system is in final stages of testing. **Date of Implementation:** February 15, 2015 with an estimated completion date of June 15,, 2015. **Monitoring Process:** Redesigned system will shut down air handlers should there be any attempt to pull or disable relays. **Person Responsible:** Vice President of Facilities Operations **A700-8 Corrective Action:** A new fire system is being installed **(Attachment #6 & 15)** which will immediately shut down air handlers, should the relays be pulled. Engineers have been instructed that relays are no longer to be pulled during fire alarm testing, as was common practice beforehand **(Attachment #7)**. New fire system is in final stages of testing. **Date of Implementation:** February 15, 2015 with an estimated completion date of June 15,, 2015. **Monitoring Process:** Redesigned system will shut down air handlers should there be any attempt to pull or disable relays. **Person Responsible:** Vice President of Facilities Operations **A700-9 Corrective Action:** As per CMS S&C-06-18 criteria, a waiver has been requested, citing a review of the fire alarm system pertaining to the corridor protection. The existing system, as installed and tested, contains full corridor coverage, with smoke detectors, and is interconnected to the existing ventilation system. **(Attachments #9, #10, #11 and #12)** **Date of Implementation:** Compliance confirmed May 4, 2015 **Monitoring Process:** Newly designed fire system will automatically shut down at any attempt to pull or disable relays; receipt of waiver pending. **Person Responsible:** Director of Facilities	6/15/2015 6/15/2015 7/15/2015 6/15/2015 6/15/2015 5/4/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050135	A. BUILDING _____ B. WING _____	02/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	6245 DE LONGPRE AVE HOLLYWOOD, CA 90028

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 700	Continued From page 2 The cumulative effect of the systemic issues resulted in the facility's inability to ensure and provide a safe patient care environment.	A 700	**A 700-10 Corrective Action:** Third party vendor removed air scrubber, along with damaged electrical cord. **Date of Implementation:** Removed immediately on 2/3/15. **Monitoring Process:** No monitoring necessary. **Person Responsible:** Director of Facilities **A 700-11Corrective Action:** Third party vendor removed air scrubber, along with damaged electrical cord. **Date of Implementation:** Removed immediately on 2/3/15. **Monitoring Process:** No monitoring necessary. **Person Responsible:** Director of Facilities	2/3/2015 4/8/2015
A 701	482.41(a) MAINTENANCE OF PHYSICAL PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained such a manner that the safety and well-being of patients are assured. This STANDARD is not met as evidence by: Based on interview and document review, the hospital failed to assure a safe environment for the patients by not ensuring the IOR (Inspector of Record) was present during hot works construction done on the roof, failing to ensure two relays at the fire alarm air handler shutoff control panel remained installed in place, failing to have an approved and effective Hot Work policy and procedure, failure to provide an air system to operate continuously and provide balanced air-supply to patient rooms for the 2nd, front of 3rd (SDU), 4th, 5th, and 6th floors, removing self-closing area separation fire doors, and failing to ensure privacy curtains were in place. These deficient practices had the potential to have hot work construction being conducted in an unsafe manner, permitted the accelerated spread of smoke and gases during a fire, discontinued the provision of balanced air-supply to patient rooms on the 2nd, front of 4rd, 4th, 5th, and 6th floors, and affected the patients well-being, dignity and comfort while in the hospital. Findings:	A 701		

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A 701	Continued From page 3 1. On 2/3/15, a review of an OSHPD (Office of Statewide Health Planning & Development) Fire and Life Safety Field Visit Report dated 2/2/15, indicated that on 1/29/15 a fire occurred as a direct result of the scope of work for the "parapet" reconstruction project. That work being performed when the fire occurred was being performed without the knowledge or the presence of the Inspector of Record (IOR), as well as without an appropriate "Fire Watch." Review of the Inspector's Daily Report dated 3/4/14 from the IOR for the parapet roof repair project indicated that there was a kick off meeting with the roofing company, Corporate Project Manager, and the Special Instructor for preconstruction meeting. The report indicated that a minimum 48 hours notice was required for inspections. Review of the hot works permit dated 1/26/15, indicated there would be a parapet roof replacement at the roof of the pavilion. Review of the roofing company's fire watch log sheet dated 1/29/15, at 12 p.m., indicated the torch was started at "top of wing." Review of the Notice of Non-Conformance dated 1/29/15 (revised 1/30/15), from the IOR for the parapet roof repair project indicated that the contractor failed to notify the IOR that their intent was to perform hot work in order for the IOR to verify that a hot work permit had been obtained and posed in the direct area of work, confirm times allowed for hot work, verify that the interim life safety measures were in place, which included, fire extinguishers and required	A 701	**Corrective Action:** Hot work permit protocol has been revised **(Attachment # 1).** Project Manager no longer has authority to approve Hot Work permits. All permits must be approved by Facilities Director, or his designee. Contractor holds sole responsibility to notify IOR when presence is needed. Fire Watch has been conducted on 1/29/15, the day of the fire, albeit, incorrectly, by the contracting company MK Roofing. **(Attachment #2)** Contractor on site notice process has been implemented so that no contractor can have facility access without prior notification and approval by facilities director and project manager should IOR be required. Process includes description of work, area impacted with dates and times. **(See attachment 5 & 14).** **Date of Implementation:** February 3, 2015 **Monitoring Process:** Fire Watch will be monitored and logged by SCHCC staff, rather than third party company. Fire Watch log sheet is attached to Hot Work policy and procedure. **Person Responsible:** Director of Facilities	2/3/2015

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A 701	Continued From page 4 personnel available for fire watch for the entire duration of the work being performed. That without such notification, IOR was not scheduled to be onsite or aware of the work that needed to be observed. And that the contractor was in violation of CAC (California Administrative Code) Section 7-145. On 2/5/15 at 1:15 p.m., during an interview, the Director of Plant Operations stated the plant operations did not know the workers on the pavilion roof were going to use a torch. He further stated that when he knows there will be hot works he calls and ensures the IOR is present. Also, he would know if hot works are to be conducted because the vendors/contractors are suppose to notify him or the Lead Man before doing hot work, that usually the vendors/contractors notify the IOR first, and usually the IOR comes and stays the whole time the hot work is conducted. In addition, it was always the procedure for the vendors/contractors to notify plant operations before conducting hot work and that the vendors/contractors know they are suppose to report to plant operations first. 2. On 2/3/15, a review of an OSHPD Fire and Life Safety Field Visit Report dated 2/2/15, indicated that on 1/29/15 a fire appeared to have damaged the HVAC supply air-intake filter banks that apparently supply air to the 2nd , 4th, 5th , and 6th floor patient rooms. That the HVAC system did not automatically shut-down during the fire on 1/29/15 and the smoke from the fire was dispersed from the roof supply intake to other areas and floors of the building. On 2/4/15 at 11:05 a.m., during an interview, the	A 701	**Corrective Action:** All contractors must check in with Plant Engineering prior to starting any work, as well as signing out at the end of the work day. **(Attachment #3)**. A "Contractor on Site" notice must be sent out at least 24 hours in advance, preferably 48 hours when possible. **(Attachments #4 and #5).** **Date of Implementation:** February 3, 2015 **Monitoring Process:** Plant Engineering will establish and maintain a Contractor Sign IN/OUT Log for all contractors working on site. See Attachment #3. **Person Responsible:** Director of Facilities **Corrective Action:** A new fire system is being installed **(Attachment #6 & 15)** which will immediately shut down air handlers, should the relays be pulled. Engineers have been instructed that relays are no longer to be pulled during fire alarm testing, as was common practice beforehand **(Attachment #7)**. New fire system is in final stages of testing. **Date of Implementation:** February 15, 2015 with an estimated completion date of June 15, 2015. **Monitoring Process:** Redesigned system will shut down air handlers should there be any attempt to pull or disable relays. **Person Responsible:** Vice President of Facilities Operations	2/3/2015 6/15/2015

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A 701	Continued From page 5 Lead Man stated that the automatic shut down of the air handlers could be bi-passed by pulling (removing) the relays in the fire alarm air handler shutoff control panel. On 2/5/15 at 10:10 a.m., during an interview, the Lead Man stated that on the day of the fire (1/29/15), he heard a code red announced from the 3rd floor, that he went to the 3rd floor and saw smoke coming from vents at the 3rd floor, that he went up to the penthouse and saw smoke coming from air handler 2, and saw fire at the door of the air handler, and that he saw the air handler was still on, so he (manually) shut off the air handler. The Lead Man also stated that the engineers can pull the relays in the fire alarm air handlers control panel if a vendor is scheduled to conduct a fire alarm test and then reconnect them after the test, that it was the practice when he came to the hospital, and its what they (engineering) have continued to do, that the relays have to be pulled, otherwise air conditioning and heating is lost for the whole building and that there was no other reason to pull the relays. On 2/5/15 at 2:42 p.m., during an interview, the 2nd shift Stationary Engineer stated that on 1/29/15 he had arrived to the hospital at 1:30 p.m., after the fire, and discovered there had been a fire on the roof of the Pavilion. That around 5 p.m. the Lead Man asked asked him to go up to the penthouse to the fire alarm air handlers control panel to check if the relays for air handlers 1 and 2 were installed in place. That upon opening the relay box, he found both relays unplugged and laying at the bottom of the panel at which time he installed them in their place.	A 701	**Corrective Action:** A new fire system is being installed **(Attachment #6 & #15)** which will immediately shut down air handlers, should the relays be pulled. Engineers have been instructed that relays are no longer to be pulled during fire alarm testing, as was common practice beforehand **(Attachment #7)**. New fire system is in final stages of testing. **Date of Implementation:** February 15, 2015 with an estimated completion date of June 15, 2015. **Monitoring Process:** Redesigned system will shut down air handlers should there be any attempt to pull or disable relays. **Person Responsible:** Vice President of Facilities Operations	6/15/2015

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A 701	Continued From page 6 The 2nd shift Stationary Engineer, also stated he did not know who pulled the relays, and did not tell anyone that on Thursday (1/29/15) he had found the relays laying in the panel until the Lead Man asked him about it on Wednesday (2/4/15). On 2/5/15 at 2:45 p.m., during an interview, the Lead Man stated he did not know the relays were unplugged until Wednesday (2/4/15), when he asked the Stationary Engineer. That the last communication he had with the Stationary Engineer was on the day of the fire (1/29/15) and did not try to call the Stationary Engineer between that Thursday (1/29/15) and Wednesday (2/4/15). 3. On 2/3/15, a review of an OSHPD Fire and Life Safety Field Visit Report, dated 2/2/15, indicated that on 1/29/15 a fire occurred as a direct result of the scope of work for the parapet reconstruction project. That work being performed when the fire occurred was being performed without the knowledge or the presence of the IOR (Inspector of Record), as well as without an appropriate "Fire Watch". Review of the hot works construction permit dated 1/26/15 indicated there would be parapet roof replacement at the roof of the pavilion. Review of the roofing company's fire watch log sheet dated 1/29/15, at 12 p.m. indicated the torch was started at "top of wing." Review of the Notice of Non-Conformance dated 1/29/15 (revised 1/30/15) from the IOR for the parapet roof repair project indicated that the contractor failed to notify the Inspector of Record (IOR) that their intent was to perform hot work, in	A 701	**Corrective Action:** Hot work permit protocol has been revised **(Attachment # 1).** Project Manager no longer has authority to approve Hot Work permits. All permits must be approved by Facilities Director, or his designee. Contractor holds sole responsibility to notify IOR when presence is needed. Fire Watch has been conducted on 1/29/15, the day of the fire, albeit, incorrectly, by the contracting company MK Roofing. **(Attachment #2)** **Date of Implementation:** February 3, 2015 **Monitoring Process:** Fire Watch will be monitored and logged by SCHCC staff, rather than third party company. Fire Watch log sheet is attached to Hot Work policy and procedure. Results of monitoring will be reported up to EOC and Quality Council on a quarterly basis. **Person Responsible:** Director of Facilities	2/3/2015

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A 701	Continued From page 7 order for the IOR to verify that a hot work permit had been obtained and posted in the direct area of work, confirm times allowed for hot work, verify that the interim life safety measures were in place, which included, fire extinguishers and required personnel available for fire watch for the entire duration of the work being performed. On 2/5/15 at 1:15 p.m., during an interview, the Corporate Vice President of Plant Operations stated that plant operations did not know the workers on the pavilion roof were using a torch to put down roofing material. Also, the vendor/contractor did not contact plant operations or the IOR. On 2/5/15 at 1:15 p.m., during an interview, the Director of Plant Operations stated that plant operations did not know the workers on the pavilion roof were going to use a torch. The he would know if hot works are to be conducted because the vendor/contractor are suppose to notify him or the Lead Man before doing hotworks. That it was always the procedure for the vendors to notify plant operations before conducting hot works and that the vendors/contractors know they are suppose to report to plant operations first. Review of a document provided by the facility as a policy titled Hot Works, indicated there was no date of submittal to the governing body of the document and there was no effective date of the document. The document indicated that the purpose of the document was to maintain current policies and guidelines for Hot Work. The document did not indicate the procedure notifying the IOR when hot work would be performed, and did not indicate the procedure to ensure the	A 701	**Corrective Action:** Hot work permit protocol has been revised **(Attachment # 1).** Project Manager no longer has authority to approve Hot Work permits. All permits must be approved by Facilities Director, or his designee. Contractor holds sole responsibility to notify IOR when presence is needed. Fire Watch has been conducted on 1/29/15, the day of the fire, albeit, incorrectly, by the contracting company MK Roofing. **(Attachment #2)** **Date of Implementation:** February 3, 2015 **Monitoring Process:** Fire Watch will be monitored and logged by SCHCC staff, rather than third party company. Fire Watch log sheet is attached to Hot Work policy and procedure. Results of monitoring will be reported up to EOC and Quality Council on a quarterly basis. **Person Responsible:** Director of Facilities	2/3/2015

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A 701	Continued From page 8 facility was aware of hot work being performed. 4. On 2/3/15, a review of an OSHPD Fire and Life Safety Field Visit Report dated 2/2/15, indicated that on 1/29/15 a fire appeared to have damaged the HVAC supply air-intake filter banks that apparently supply air to the 2nd, 4th, 5th, and 6th floor patient rooms. That the HVAC system serving these rooms had been shut down pending repairs to the damaged system. On 2/3/15 at 12:05 p.m., during an interview, the Project Manager stated that one of two air handlers (air handler 2) in the penthouse was affected by the fire, and that air handler 2 affected patient rooms of the 2nd , front 3rd SDU, 4th, 5th, and 6th floors that it served. On 2/3/15 at 12:35 p.m., the Corporate Vice President of Facilities Operations stated that patient room temperatures were not being monitored and there was no plan if there was a change in temperature due to inclement weather. At 1:10 p.m., the Corporate Vice President of Facilities Operations stated that plant operations would begin monitoring patient room temperatures immediately. At 2:10 p.m., the Project Manager stated that scrubbers were placed in the corridors of the affected floors to clean and circulate the air. Between 4:15 p.m. and 5:20 p.m., HEPA (High Efficiency Particulate Air) filtration systems (air scrubbers) were observed at the 2nd, 3rd, 4th, 5th, and 6th floors.	A 701	**Corrective Action:** Vendor for testing is no longer being used; currently in the process of contracting a new vendor. Air handler #1 is still in use, while air handler #2 has a temporary replacement. Air balancing for temporary unit not required per ACO Attachment #20 **(Attachment # 8, 15, 16, 17, 18, 19, 20 & 21).** **Date of Implementation:** Implementation immediately upon installation of new fire system, an estimated date of May 30, 2015. **Monitoring Process:** Testing will occur upon installation, with quarterly inspections thereafter. **(Attachment # 9).** Results of monitoring will be reported up to EOC and Quality Council on a quarterly basis. **Person Responsible:** Director of Facilities **Corrective Action:** Temperature monitoring was immediately implemented for all patient rooms impacted by the fire-damaged air hander. **Date of Implementation:** February 3, 2015 **Monitoring Process:** Temperatures were gauged for ranges between 73°-77°, every 4 hours. Temperatures were monitored until air handler #2 temporary replacement was installed on March 25, 2015. **(Attachment # 10)** **Person Responsible:** Director of Facilities	6/15/2015 3/26/2015

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A 701	Continued From page 9 A letter from the hospital dated 2/3/15 indicated that due to to the fire on 1/29/15, air handler #2 that provides supply air to patient rooms on P2, P3 SDU, P4, P6 and P6 was off line. That air scrubbers were installed on each of the floors to clean and circulate the air. That all patient rooms on the affected floors would be monitored for temperature every four hours, twenty four hours a day to insure ambient temperatures were between the range of 73 and 77 degrees Fahrenheit, and that because there was no temperature control, windows would be open for fresh air ensuring screens were in place and additional blankets were deployed to each affected floor should temperatures cool. 5. On 2/5/15 at 8:52 a.m., in response to a request of the incident report from the local fire department, the Corporate Vice President of Facilities Operations stated that the local fire department would not have the report until two weeks after the date of the incident. Review of the local fire department report undated Fire Investigation Report regarding the fire incident at the hospital on 1/29/15, indicated in its summary that it was noted at the time of the fire, that self-closing area separation fire doors had been removed from the fourth and fifth floors, and that an OTC (Order to Comply) for replacement of the doors had been issued. 6. On 2/3/15 at 5:07 p.m., 9 patient rooms (210, 211, 212, 214, 216 A, 217 B, 219 B, 220 A, and 221 A) in 2nd floor Telemetry, were observed to be without privacy curtains. There were patients in the beds of the 9 rooms at the time of the observation.	A 701	**Corrective Action:** Project for self-closing area separation fire doors has been opened with OSHPD and design has been approved **(Attachment #11).** Currently, the project is out for bids, with an anticipated award date of June 1, 2015 Anticipated completion date of July 15, 2015. **Date of Implementation:** 1/30/2015 **Monitoring Process:** Fire Doors are inspected on a quarterly basis **(Attachment #12).** Results of monitoring will be reported up to EOC and Quality Council on a quarterly basis. **Person Responsible:** Corporate Vice President of Facilities Operations	7/15/2015

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A 701	Continued From page 10 Between 5:07 p.m. and 5:10 p.m., the Director of Environmental Services (EVS) stated that the curtains had been taken down to be sent away to be washed. That the curtains had arrived at 4 p.m., that EVS had been downstairs checking that the replacement curtains were not stained, and that the curtains were being hung now. On 2/5/15 at 10:35 a.m., the Director of EVS stated that on Tuesday (2/3/15), the privacy curtains were taken down because the patients were complaining that the curtains were stained. That she had the Lead EVS take the curtains down and had EVS staff gather the replacement curtains.	A 701	**Corrective Action:** Privacy curtains have been installed in rooms 210, 211, 212, 214, 216 A, 217 B, 219 B, 220 A, and 221 A on the 2nd floor, Pavilion Building. Curtains are not to be removed, unless replacement curtains are readily available and are able to be hung immediately afterwards. A policy titled "Privacy Curtain Cleaning" has been drafted and is pending review by the EOC, Quality Council and Medical Executive Committees, as well as the Governing Board **(Attachment #13).** **Date of Implementation:** February 3, 2015 **Monitoring Process:** EVS will monitor during daily rounds. Results of monitoring will be reported up to EOC and Quality Council on a quarterly basis. **Person Responsible:** Director of EVS	2/3/2015
A 710	482.41 (b)(1)(2)(3) LIFE SAFETY FROM FIRE (1) Except as otherwise provided in this section – (i) The hospital must meet the applicable provisions of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR Part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html Copies may be obtained from the National Fire Protection Association, 1 Battermarch Park, Quincy, MA 02269. If any changes in this edition	A 710		

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	050135	A. BUILDING _____ B. WING _____	02/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	6245 DE LONGPRE AVE HOLLYWOOD, CA 90028

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A 710	Continued From page 11 of the Code are incorporated by reference, CMS will publish notice in the Feral Register to announce the changes. (ii) Chapter 19.3.6.3.2, exception number 2 of the adopted edition of the LSC does not apply to hospitals. (2) After consideration of State survey agency findings, CMS may waive specific provisions of the Life Safety Code which, if rigidly applied, would result in unreasonable hardship upon the facility, but only if the waiver does not adversely affect the health and safety of the patients. (3) The provisions of the Life Safety Code do not apply in a State where CMS finds that a fire and safety code imposed by State law adequately protects patients in hospitals. This STANDARD is not met as evidenced by: Based on observation, interview, and document review, the facility failed to meet the applicable provisions of the Life Safety Code of the National Fire Protection Association (NFPA) including NFPA 70 National Electrical Code 1999 edition, NPA 90A, Standard for the Installation of Air Condition and Ventilating Systems, and NFPA 101 Code for Safety to Life from Fire in Buildings and Structures 2000 Edition, as indicated in tags K067 and K 147 of the Statement of Deficiencies. These codes and standards were not met as evidenced by: Based on observation, interview and document review, the hospital failed to ensure an air handler automatically shut down with the presence of smoke. The hospital failed to ensure that all	A 710		

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A 710	Continued From page 12 automatic shutdown devices were tested annually. The hospital used corridors as plenums. The hospital failed to ensure electrical power cords were maintained in tact. The deficiencies permitted, and had the potential to permit accelerated spread of smoke and gases during a fire, and bypassed the safe use and maintenance of electrical power cords and their safeguards against fire and electric shock.	A 710	**Corrective Action:** A new fire system is being installed **(Attachment #6 & #15)** which will immediately shut down air handlers, should the relays be pulled. Engineers have been instructed that relays are no longer to be pulled during fire alarm testing, as was common practice beforehand **(Attachment #7)**. New fire system is in final stages of testing. **Date of Implementation:** February 15, 2015 with an estimated completion date of June 15, 2015. **Monitoring Process:** Redesigned system will shut down air handlers should there be any attempt to pull or disable relays. **Person Responsible:** Vice President of Facilities Operations	6/15/2015

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□A 000□	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during the Follow-Up Visit to a Sampled Validation Survey completed on April 1, 2014. Representing the Department of Public Health: Surveyor 17030, RN, HFEN Surveyor 16281, REHS, HFE I Surveyor 10933, Nutritional Consultant Surveyor 17065, Nutritional Consultant Surveyor 25049, MD, Medical Consultant Surveyor 29775, MD, Medical Consultant Surveyor 28851, Pharm D, Pharmacy Consultant Surveyor 29643, RN, Nurse Consultant, L & C Infection Control On August 20, 2014, at 1:30 p.m., the survey team declared an Immediate Jeopardy (IJ) situation, in the presence of the Chief Executive Officer (CEO) of Culver City Campus, director of risk management, as a result of the facility□s failure: 1. To ensure flexible endoscopes were stored in accordance with the Association of Peri-Operative Registered Nurse (AORN) Recommended Practices. AORN is the National Recognized Standards (NRS) the hospital identified as the standard they followed. 2. To ensure re-usable surgical instruments were packaged and stored in accordance with the AORN Standards. On August 21, 2014, at 3:45 p.m., the IJ was abated in the presence of the director of risk	□A 000□	**Culver City** **1.) Corrective Actions:** The following was implemented to ensure flexible endoscopes are stored in accordance to the AORN recommended practices: The facility purchased and installed new vented scope cabinet **(Attachment 1)** and placed in a storage area back side of surgery with adequate ventilation for proper storage of scopes; all scopes now have tip protectors to ensure tips do not touch the cabinet; all scopes are tagged after processing with indication of next date to re-process if not in use. Surgical services provided education & in-service to staff on the use of enzymatic cleaners and proper measurements **(Attachment 6);** for scope re-processing; high-level disinfection, and included competency validation and return demonstrations **(Attachment 2).** **Date of Implementation:** Scope Cabinet installed 9-15-14; Education completed on August 12, 2014 and August 21, 2014. **Monitoring Process:** Monitoring managed by daily inspection of the scopes for next date of re-processing; Daily scopes monitoring include before and after each use to ensure proper placement in scope cabinet. Weekly monitoring of all scope procedures are performed to ensure completeness and accuracy of recoding in the log **(Attachment 3)**. Log compliance will be submitted to the Regulatory Compliance Committee & Quality Council to ensure compliance with AORN standards. **Person Responsible:** OR Team/Infection Control. **Hollywood** **1.) Corrective Actions:** The following was implemented to ensure flexible endoscopes are stored in accordance to the AORN recommended practices: The facility purchased and installed new vented scope cabinet and placed in a storage area back side of surgery with adequate ventilation for proper storage of scopes **(Attachment 4)**; all scopes now have tip protectors to ensure tips do not touch the cabinet; all scopes are tagged after processing with indication of next date to re-process if not in use. Surgical services provided education & in-service to staff on the use of enzymatic cleaners and proper measurements; for scope re-processing; high-level disinfection, and included competency validation and return demonstrations **(Attachment 5).** **Date of Implementation:** Scope Cabinet installed 9-8-14; Education completed on August 11, 2014 and August 20, 2014; and repeated September 22, 2014. **Monitoring Process:** Monitoring managed by daily inspection of the scopes for next date of re-processing; Daily scopes monitoring include before and after each use to ensure proper placement in scope cabinet. Weekly monitoring of all scope procedures are performed to ensure completeness and accuracy of recoding in the log **(Attachment 7).** Log compliance will be submitted to the Regulatory Compliance Committee & Quality Council to ensure compliance with AORN standards. **Person Responsible:** OR Team/Infection Control.	8/12/2014 8/21/2014 9/15/2014 8/11/2014 8/20/2014 9/8/2014 9/22/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (□6) DATE

Any deficiency statement ending with an asterisk (□) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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A 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during the Follow-Up Visit to a Sampled Validation Survey completed on April 1, 2014. Representing the Department of Public Health: Surveyor 17030, RN, HFEN Surveyor 16281, REHS, HFE I Surveyor 10933, Nutritional Consultant Surveyor 17065, Nutritional Consultant Surveyor 25049, MD, Medical Consultant Surveyor 29775, MD, Medical Consultant Surveyor 28851, Pharm D, Pharmacy Consultant Surveyor 29643, RN, Nurse Consultant, L & C Infection Control On August 20, 2014, at 1:30 p.m., the survey team declared an Immediate Jeopardy (IJ) situation, in the presence of the Chief Executive Officer (CEO) of Culver City Campus, director of risk management, as a result of the facility's failure: 1. To ensure flexible endoscopes were stored in accordance with the Association of Peri-Operative Registered Nurse (AORN) Recommended Practices. AORN is the National Recognized Standards (NRS) the hospital identified as the standard they followed. 2. To ensure re-usable surgical instruments were packaged and stored in accordance with the AORN Standards. On August 21, 2014, at 3:45 p.m., the IJ was abated in the presence of the director of risk	A 000	**Culver City** **2.) Corrective Actions:** The following was implemented to ensure re-usable surgical instruments (SI) are packed & stored in accordance with the AORN recommended practices: 1) All re-usable surgical instruments (SI) were re-processed, packaged, and stored in accordance to AORN standards; 2) bin dividers purchased to ensure packages are stored up-right on 9/5/2014 **(Attachment: 8)**. 3) 5 inch stringers were purchased to ensure SI are completely open for processing & implemented on 8/25/2014 **(Attachment: 9)**; 4). 3 M Comply cards purchased and placed into service to ensure tip and lock boxes in peel packs maintain an open position for sterilization on 8/26/14 **(Attachment: 10)**; 5). Purchased new biological incubator and indicator with corresponding supplies for sterilization on 10/10/14; 6). Provided education/in-service to staff on standards for processing, packaging and storing of SI, this includes competency validation and return demonstration **(Attachment 11)**. **Date of Implementation:** August 20, 2014 Immediate Staff Education SI re-processing completed **Monitoring Process:** Monitoring will be managed once bimonthly by Infection Control rounds with ORT or RN (**Attachment 12)** with compliance reported to the Regulatory Compliance Committee & Quality Council to ensure AORN standards are maintained. **Person Responsible:** Infection Control/OR Director **Hollywood** **2.) Corrective Actions:** The following was implemented to ensure re-usable surgical instruments (SI) are packed & stored in accordance with the AORN recommended practices: 1) All re-usable surgical instruments (SI) were re-processed, packaged, and stored in accordance to standards; 2) bin dividers purchased and installed to ensure packages are stored up-right 9/5/2014 (**Attachment 13)** . 3). new instrument trays to accommodate the 5-6 inch stringers that were purchased to ensure SI are completely open for processing 8/25/2014 **(Attachment 14**); 4) tip protectors purchased and placed to prevent tears and penetration of peel packs 9/9/2014; 5). Purchased new biological incubator and indicator with corresponding supplies for sterilization 9/8/2014; **(Attachment 15)** 6). Provided education/in-service to staff on standards for processing, packaging and storing of SI, this includes competency validation and return demonstration. **(Attachment 16)** **Date of Implementation**: August 20, 2014 Immediate Education SI re-processed; Education incubator/indicator September 24, 2014 and repeated October 8, 2014 with competency validation and return demonstration **(Attachment 17**) **Monitoring Process:** Monitoring will be managed during bi-weekly IC rounds with ORT **(Attachment 12)** with compliance reported to the Regulatory Compliance Committee & Quality Council to ensure AORN standards are maintained. **Person Responsible:** Infection Control/OR Team	8/20/2014 8/20/2014

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□A 000□	Continued From page 1 management and CEO of the facility's Culver City campus.	□A 000□	Continued on page 1a.	
□A 263□	482.21 QAPI The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by: Based on observation, record review, and interview, the hospital failed to develop, implement, and maintain an effective quality assurance performance improvement (QAPI) program as evidenced by: 1. Failure of the QAPI program to ensure the quality program assessed the effectiveness and processes of cleaning sterilizing and packaging surgical instruments, a deficiency found at the time of a validation survey three month earlier (Refer to A 283). 2. Failure of the QAPI to identify opportunities for improvement and change in the cleaning,	□A 263□	**1.) Corrective Actions (Surgical Instruments):** All re-usable surgical instruments (SI) were re-processed, packaged, and stored in accordance to AORN standards; bin dividers were purchased to ensure packages are stored up-right on 9/5/2014. 5 inch stringers were purchased to ensure SI tips and lock boxes are completely open for processing on 8/25/2014; 3M Comply cards purchased and placed into service to ensure tip and lock boxes in open position for sterilization of peel packs on 9/9/2014; Purchased new biological incubator and indicator with corresponding supplies for sterilization on 9/8/ 2014; Provided education/in-service to staff on standards for processing, packaging/storing of SI, the use of enzymatic cleaners/proper measurements for scope re-processing, and high-level disinfection to include competency validation and return demonstration **(Refer to A-000.1).** Revision to policy SCA.025 Selection and use of packing systems for sterilization with staff education (**Attachment 1)** **Date of Implementation:** Education completed August 11, 2014 and August 20, 2014 and repeated September 22, 2014 **Monitoring Process:** Monitoring will be conducted daily by the GI/OR Team and bi-weekly through IC rounds with RN or OR technician **(Refer to A-297 for attachment 1)** Compliance will be reported to the Regulatory Compliance Committee & Quality Council on a monthly basis for a minimum of 6 months or until target benchmarks of compliance is achieved to ensure the effectiveness of the processes for cleaning, sterilizing, packaging and storage of surgical instruments. Should variance from standard practice be identified, the hospital will take immediate action to improve performance, measure the success of the improvements, and monitor performance to ensure that the improvements are sustained. **Person Responsible**: Director of OR (or designee), Director of Infection Control (or designee), and Director of Quality **2).Corrective Actions (Colonoscopes):** Purchased and installed new ventilated scope cabinets and placed them in areas with adequate ventilation for proper storage of colonoscopes; all colonoscopes now have tip protectors to ensure tips do not touch the cabinets; all colonoscopes are tagged after processing to indicate the next date to re-process if not in use. Revision to policy SGI.006 Cleaning and disinfection of endoscopes with staff education (**Attachment 2)** **Date of Implementation:** Scope cabinet installed at Hollywood September 8, 2014; Scope cabinet installed at Culver City September 15, 2014	8/11/2014 8/20/2014 9/22/2014 9/8/2014 9/15/2014

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□A 263□	Continued From page 2 maintenance and storage of colonoscopes in order to reduce the risk of patient infections from an instrument contaminated by bacteria acquired from use on previous patients (Refer to A 283). 3. Failure to have an ongoing quality appraisal and performance improvement program that addressed the complexity and scope of Nutrition and Dietetic Services. This has resulted in failure to identify issues in safe food handling practices, food storage and sanitation all of which could result in foodborne illness. Additionally, departmental staff failed to recognize inadequacies in services that could lead to unmet patient nutritional needs (Refer to A 297). The cumulative effects of these systemic problems resulted in the facility inability to assure quality health care in a safe environment.	□A 263□	**Monitoring Process:** Monitoring utilizing daily inspection of colonoscopes for next date of re-processing and after each use to ensure proper placement in the scope cabinet. Weekly monitoring of all colonoscope procedures to ensure completeness and accuracy of log **(Refer to A-000.1).** Compliance will be reported to the Regulatory Compliance Committee & Quality Council on a monthly basis for a minimum period of 6 months or until targeted benchmarks of compliance is achieved and then periodically as indicated based on PI plan to ensure the effectiveness of the cleaning, maintenance, and storage of colonoscopes in an effort to mitigate potential infection risk. Should variance from standard practice be identified, the hospital will take immediate action to improve performance, measure the success of the improvements, and monitor performance to ensure that the improvements are sustained. **Person Responsible:** Director of OR (or designee), and Director of Infection Control (or designee), Director of Quality **3). Corrective Actions (Ongoing Quality Appraisal for Dietary Services):** The hospital has enhanced its QAPI program to reflect an on-going quality appraisal of the complexity and scope of Nutrition and Dietetic Services by calling for the daily and weekly monitoring of specific indicators that would detect concerns with food handling practices, food storage, sanitation, and unmet patient nutritional needs. Continued on page 3a.	
□A 283□	482.21(b)(2)(ii), (c)(1), (c)(3) QUALITY IMPROVEMENT ACTIVITIES (b) Program Data (2) □The hospital must use the data collected to - □ ..□ (ii) Identify opportunities for improvement and changes that will lead to improvement. (c) Program Activities (1) The hospital must set priorities for its performance improvement activities that-- (i) Focus on high-risk, high-volume, or problem-prone areas; (ii) Consider the incidence, prevalence, and severity of problems in those areas; and (iii) Affect health outcomes, patient safety, and quality of care.	□A 283□		

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{A 263}	Continued From page 2 maintenance and storage of colonoscopes in order to reduce the risk of patient infections from an instrument contaminated by bacteria acquired from use on previous patients (Refer to A 283). 3. Failure to have an ongoing quality appraisal and performance improvement program that addressed the complexity and scope of Nutrition and Dietetic Services. This has resulted in failure to identify issues in safe food handling practices, food storage and sanitation all of which could result in foodborne illness. Additionally, departmental staff failed to recognize inadequacies in services that could lead to unmet patient nutritional needs (Refer to A 297). The cumulative effects of these systemic problems resulted in the facility inability to assure quality health care in a safe environment.	{A 263}	Continued from page 3 The quality appraisal consists of monitoring activity outcomes data that is submitted to the hospital□s Regulatory Compliance Committee and to it Quality Council on a monthly basis. Monitoring activity consists of the following quality appraisals: (1) Correct consistency of pureed foods (pudding-like), (2) Food items evaluated for correct temperatures, (3) Food items evaluated for palatability, (4) Stock dishware/flatware used to serve patient meals, (5) Menu recipes followed verbatim, (6) Food items have a documented recipe, (7) Food recipes provide guidance on expected consistency of finished product, (8) Perishable food items dated w/opening and expiration dates, (9) Refrigerator storage space adequate (containers stored to allow ample air circulation), (10) Freezer storage temperature w/range (0 C or less), (11) Refrigerator storage temperature w/range (32F □41F), (12) Dry storage temperature w/range (50F □70F), (13) Menus have variety, (14) Planned menus available for special diets, (15) Menus meet the needs of the patients, (16) Recipe substitutions are evaluated for nutritional adequacy, (17) Food items are of proper portion sizes, (18) Enteral feeding administered per order, (19) Closed system used for Enteral feedings, (20) Feeding tubes are dated/timed, (21) Feeding tube □hang time□ w/policy, (22) Feeding tube records evidence actual volume delivered, (23) Diet orders administered per therapeutic spreadsheet, (24) Patients receive correct diet order, (25) Unclear diet orders are clarified, (26) Sanitation practices followed (gloves changed between tasks and hand hygiene), (27) Air gaps installed on sinks, (28) Proper protection used when disposing garbage, (29) Dry wiping cloths used to dry food production equipment. **Date of Implementation:** October 28, 2014 **Monitoring Process:** Monitoring activity outcomes data **(Attachment 3)** is submitted to the hospital□s Regulatory Compliance Committee on a weekly basis and to it Quality Council on a monthly basis. Further, monitoring activity outcomes data will be reported up to the hospital□s MEC and Governing Board on a quarterly basis. Should variance from standard practice be identified, the hospital will take immediate action to improve performance, measure the success of the improvements, and monitor performance to ensure that the improvements are sustained. **Person (s) Responsible:** Director of Quality; Director of Dietary Services; Director of Infection Prevention	10/28/2014

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□A 283□	Continued From page 3 (3) The hospital must take actions aimed at performance improvement and, after implementing those actions, the hospital must measure its success, and track performance to ensure that improvements are sustained. This STANDARD is not met as evidenced by: Based on interview and record review, the hospital failed to develop, implement, and maintain an effective quality assurance performance improvement (QAPI) program as evidenced by: 1. Failure of the QAPI to identify opportunities for improvement and change in the cleaning, maintenance and storage of colonoscopes in order to reduce the risk of patient infections from an instrument contaminated by bacteria acquired from use on previous patients. 2. Failure of the QAPI program to ensure the quality program assessed the effectiveness and processes of cleaning, sterilizing and packaging surgical instruments. Findings: 1. On August 20, 2014 at 2:00 p.m., an interview of Physician 1 and review of the facility's Quality Council Management Meeting Summary report dated July 17, 2014, in regards to the activities of the Performance Improvement Committee of the Quality Council failed to reveal evidence of activities to identify opportunities for improvement and change in the cleaning, maintenance, and	□A 283□	**1).Corrective Actions:** In an effort to mitigate the risk of patient infections from instruments (colonscopes) that may contain bacteria acquired from the use of a previous patient, the hospital has enhanced its QAPI program to reflect an on-going quality appraisal of the complexity and scope of its sterile processing activities that would identify opportunities for improvement in the change in the cleaning, maintenance, and storage of colonoscopes. The quality appraisal consists of monitoring activity outcomes data that is submitted to the hospital□s Regulatory Compliance Committee and to it Quality Council on a monthly basis. Monitoring activity consists of the following quality appraisals: (1) Flexible scopes hung in a secure vertical position housed in a ventilated cabinet, (2) Flexible scope tips contain protectors and do not touch cabinet wall, (3) Flexible scopes reprocessed before use if not used w/5 days. **Date of Implementation:** August 20, 2014 **Monitoring Process:** Monitoring activity outcomes data **(Attachment 1)** is submitted to the hospital□s Regulatory Compliance Committee and to it Quality Council on a monthly basis. Further, monitoring activity outcomes data will be reported up to the hospital□s MEC and Governing Board on a quarterly basis. Should variance from standard practice be identified, the hospital will take immediate action to improve performance, measure the success of the improvements, and monitor performance to ensure that the improvements are sustained. **Person (s) Responsible:** Director of Quality: Director of Operating Room; Director of Infection Prevention. **2). Corrective Actions:** In an effort to ensure the effectiveness of its processes for cleaning, sterilizing and packaging surgical instruments, the hospital has enhanced its QAPI program to reflect an on-going quality appraisal of the complexity and scope of its sterile processing activities that would identify opportunities for improvement in the management of re-usable surgical instruments to ensure that packing and storage is in accordance with AORN standards. The quality appraisal consists of monitoring activity outcomes data **(Attachment 2)** that is submitted to the hospital□s Regulatory Compliance Committee and to it Quality Council on a monthly basis. Monitoring activity consists of the following quality appraisals: (1) Surgical instrument pouches stored in vertical manner, (2) Forceps blades open; tips not touching; lock boxes open; instruments hung on proper stringer, (3) Supplies stored as per AORN guidelines (not stacked). **Date of Implementation:** August 20, 2014 **Monitoring Process:** Monitoring activity outcomes data is submitted to the hospital□s Regulatory Compliance Committee and to it Quality Council on a monthly basis. Further, monitoring activity outcomes data will be reported up to the hospital□s MEC and Governing Board on a quarterly basis. Should variance from standard practice be identified, the hospital will take immediate action to improve performance, measure the success of the improvements, and monitor performance to ensure that the improvements are sustained. **Person (s) Responsible:** Director of Quality; Director of Operating Room; Director of Infection Prevention.	8/20/2014 8/20/2014

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□A 283□	Continued From page 4 storage of colonoscopes in order to reduce the risk of patient infections from an instrument contaminated by bacteria acquired from use on previous patients. An interview of Physician 1 on the same date and time also failed to reveal evidence of the QAPI program to ensure the quality program assessed the effectiveness and processes of cleaning, sterilizing and packaging surgical instruments (Cross reference to A 749 and A 951).	□A 283□		
□A 297□	482.21(d) QAPI PERFORMANCE IMPROVEMENT PROJECTS As part of its quality assessment and performance improvement program, the hospital must conduct performance improvement projects. (1) The number and scope of-distinct improvement projects conducted annually must be proportional to the scope and complexity of the hospital's services and operations. (2) A hospital may, as one of its projects, develop and implement an information technology system explicitly designed to improve patient safety and quality of care. This project, in its initial stage of development, does not need to demonstrate measurable improvement in indicators related to health outcomes. □ (3) The hospital must document what quality improvement projects are being conducted, the reasons for conducting these projects, and the measurable progress achieved on these projects. (4) A hospital is not required to participate in a QIO cooperative project, but its own projects are required to be of comparable effort.	□A 297□	**Hollywood** **1.) Corrective Actions:** The hospital has enhanced its QAPI program to ensure that its Dietary performance improvement activities extend beyond patient satisfaction surveys and minimal clinical nutrition by calling for a more robust quality appraisal of those concerns which may expose patients to foodborne illnesses and malnutrition. The quality appraisal, designed to evaluate the full scope services, detect variance and identify on-going opportunities for improvement, consists of monitoring activity outcomes data that is submitted to the hospital□s Regulatory Compliance Committee and to it Quality Council on a monthly basis. Monitoring activity consists of the following quality appraisals. Dietary (1) Correct consistency of pureed foods (pudding-like), (2) Food items evaluated for correct temperatures, (3) Food items evaluated for palatability, (4) Stock dishware/flatware used to serve patient meals, (5) Menu recipes followed verbatim, (6) Food items have a documented recipe, (7) Food recipes provide guidance on expected consistency of finished product, (8) Perishable food items dated w/opening and expiration dates, (9) Refrigerator storage space adequate (containers stored to allow ample air circulation), (10) Freezer storage temperature w/range (0F or less), (11) Refrigerator storage temperature w/range (32F □ 41F), (12) Dry storage temperature w/range (50F □70F), (13) Menus have variety, (14) Planned menus available for special diets, (15) Menus meet the needs of the patients, (16) Recipe substitutions are evaluated for nutritional adequacy, (17) Food items are of proper portion sizes, (18) Enteral feeding administered per order, (19) Closed system used for Enteral feedings, (20) Feeding tubes are dated/timed, (21) Feeding tube □hang time□w/policy, (22) Feeding tube records evidence actual volume delivered, (23) Diet orders administered per therapeutic spreadsheet, (24) Patients receive correct diet order, (25) Unclear diet orders are clarified, (26) Sanitation practices followed (gloves changed between tasks and hand hygiene), (27) Air gaps installed on sinks, (28) Proper protection used when disposing garbage, (29) Dry wiping cloths used to dry food production equipment. **Date of Implementation:** October 24, 2014 **Monitoring Process:** Monitoring activity outcomes data is submitted to the hospital□s Regulatory Compliance Committee	10/24/2014

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□A 297□	Continued From page 5 This STANDARD is not met as evidenced by: Hollywood, Culver City and Van Nuys Campuses In an interview on 8/21/14 beginning at 9 a.m., with Staff A (Hospital Administrator), Staff L (Director .of Food Service), RD (Registered Dietitian) 1, 2, 3 and Staff W (Director, Quality) and concurrent review of performance indicators beginning January 2014 revealed the following improvement activities: 1. At the Hollywood campus, performance improvement activities were limited to data collected through patient satisfaction surveys that included the timeliness of meals served, food temperatures and overall rating of food. With respect to clinical nutrition, care data collection included the timeliness of Registered Dietitian (RD) assessment and accuracy of diet It was noted that for 2014 the hospital's goal was met for all elements; however, the follow up action was to continue to monitor, despite the lack of identification of opportunities for improvement No new activities were identified for improvement for the current year. RD 1 acknowledged that with the majority of these indicators the department was meeting or exceeding the departmental set thresholds. She also stated that within the last several years the department had not identified new issues that □ may warrant a performance improvement study. It was also noted, there was no evaluation of the effectiveness of food handling systems within the department There have been deficient practices in the areas of food service operation and clinical nutrition services identified by the survey team at the initial	□A 297□	and to it Quality Council on a monthly basis. Further, monitoring activity outcomes data will be reported up to the hospital□s MEC and Governing Board on a quarterly basis. Should variance from standard practice be identified, the hospital will take immediate action to improve performance, measure the success of the improvements, and monitor performance to ensure that the improvements are sustained. (**Attachment 1)** **Person (s) Responsible:** Director of Quality; Director of Dietary Services; Director of Infection Prevention. **Culver City** **2.) Corrective Actions:** The hospital has enhanced its QAPI program to ensure that it evaluates the full scope of Dietary services to ensure that **corrective action** is implemented when variance is detected and to ensure that an evaluation of the effectiveness of those **corrective action** interventions is performed. The hospital has implemented a quality appraisal that is designed to evaluate the full scope of services, detect variance and identify on-going opportunities for improvement. The quality appraisal is inclusive of on-going monitoring activity which consists of the reporting of outcomes to the hospital□s Regulatory Compliance Committee and to its Quality Council on a monthly basis. Monitoring activity consists of the following quality appraisals: (1) Correct consistency of pureed foods (pudding-like), (2) Food items evaluated for correct temperatures, (3) Food items evaluated for palatability, (4) Stock dishware/flatware used to serve patient meals, (5) Menu recipes followed verbatim, (6) Food items have a documented recipe, (7) Food recipes provide guidance on expected consistency of finished product, (8) Perishable food items dated w/opening and expiration dates, (9) Refrigerator storage space adequate (containers stored to allow ample air circulation), (10) Freezer storage temperature w/range (0F or less), (11) Refrigerator storage temperature w/range (32F □ 41F), (12) Dry storage temperature w/range (50F □ 70F), (13) Menus have variety, (14) Planned menus available for specia diets, (15) Menus meet the needs of the patients, (16) Recipe substitutions are evaluated for nutritional adequacy, (17) Food items are of proper portion sizes, (18) Enteral feeding administered per order, (19) Closed system used for Enteral feedings, (20) Feeding tubes are dated/timed, (21) Feeding tube □hang time□ w/policy, (22) Feeding tube records evidence actual volume delivered, (23) Diet orders administered per therapeutic spreadsheet, (24) Patients receive correct diet order, (25) Unclear diet orders are clarified, (26) Sanitation practices followed (gloves changed between tasks and hand hygiene), (27) Air gaps installed on sinks, (28) Proper protection used when disposing garbage, (29) Dry wiping cloths used to dry food production equipment. The hospital will continue to review its QAPI program for opportunities to further enhance it to target opportunities for improvement and mitigation of identified issues. **Date of Implementation**: October 24, 2014 **Monitoring Process:** Monitoring activity outcomes data is submitted to the hospital□s Regulatory Compliance Committee and to it Quality Council on a monthly basis. Further, monitoring activity outcomes data will be reported up to the hospital□s MEC and Governing Board on a quarterly basis.	10/24/2014

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□A 297□	Continued From page 6 and subsequent validation visits such as incorrec consistencies for pureed diet, equipment failures staff in competencies that could have been used to develop new performance improvement activities. 2. At the Culver City campus, review of the Performance Improvement document showed staff tracking the implementation of RD recommendations and timeliness of nutrition interventions. It was noted that while actions were put into effect in both of these instances, the effectiveness of the interventions were not fully evaluated, rather the follow up was to continue to monitor. The hospital failed to evaluate and implement **corrective actions** in areas where problems had been identified. It was also noted that since January 2014 the temperature of patient food at the time of service was reviewed and was found to be below the hospital goal. It was noted that proper refrigeration was the basis of the problem; however as of 8/21/14 the issue had not yet been fully resolved. 3. At the Van Nuys campus, the improvement activities included diet accuracy, overall rating of food, timely RD assessment, food temperatures and timeliness of meal service. It was noted that all the parameters with the exception of 1 month with respect to meal timeliness the facility met the goal for all elements. It was noted that overall the hospital failed to demonstrate a performance improvement program that fully represented the scope and nature of the departmental functions. While campus wide data was collected, the majority of the data did not demonstrate opportunities for improvement. It was also noted that in areas	□A 297□	Should variance from standard practice be identified, the hospital will take immediate action to improve performance, measure the success of the improvements, and monitor performance to ensure that the improvements are sustained. (**Attachment 1**) **Person (s) Responsible:** Director of Quality; Director of Dietary Services; Director of Infection Prevention. **Van Nuys** **3.) Corrective Actions:** The hospital has enhanced its QAPI program to ensure that it evaluates the full scope of Dietary services to ensure that **corrective action** is implemented when variance is detected and to ensure that an evaluation of the effectiveness of those **corrective action** interventions is performed. The hospital has implemented a quality appraisal that is designed to evaluate the full scope of services, detect variance and identify on-going opportunities for improvement. The quality appraisal is inclusive of on-going monitoring activity which consists of the reporting of outcomes to the hospital□s Regulatory Compliance Committee and to it Quality Council on a monthly basis. Monitoring activity consists of the following quality appraisals: (1) Correct consistency of pureed foods (pudding-like), (2) Food items evaluated for correct temperatures, (3) Food items evaluated for palatability, (4) Stock dishware/flatware used to serve patient meals, (5) Menu recipes followed verbatim, (6) Food items have a documented recipe, (7) Food recipes provide guidance on expected consistency of finished product, (8) Perishable food items dated w/opening and expiration dates, (9) Refrigerator storage space adequate (containers stored to allow ample air circulation), (10) Freezer storage temperature w/range (0F or less), (11) Refrigerator storage temperature w/range (32F □ 41F), (12) Dry storage temperature w/range (50F □ 70F), (13) Menus have variety, (14) Planned menus available for special diets, (15) Menus meet the needs of the patients, (16) Recipe substitutions are evaluated for nutritional adequacy, (17) Food items are of proper portion sizes, (18) Enteral feeding administered per order, (19) Closed system used for Enteral feedings, (20) Feeding tubes are dated/timed, (21) Feeding tube □hang time□ w/policy, (22) Feeding tube records evidence actual volume delivered, (23) Diet orders administered per therapeutic spreadsheet, (24) Patients receive correct diet order, (25) Unclear diet orders are clarified, (26) Sanitation practices followed (gloves changed between tasks and hand hygiene), (27) Air gaps installed on sinks, (28) Proper protection used when disposing garbage, (29) Dry wiping cloths used to dry food production equipment. The hospital will continue to review its QAPI program for opportunities to further enhance it to target opportunities for improvement and mitigation of identified issues. **Date of Implementation:** October 24, 2014 **Monitoring Process:** Monitoring activity outcomes data is submitted to the hospital□s Regulatory Compliance Committee and to it Quality Council on a monthly basis. Further, monitoring activity outcomes data will be reported up to the hospital□s MEC and Governing Board on a quarterly basis. Should variance from standard practice be identified, the hospital will take immediate action to improve performance, measure the success of the improvements, and monitor	10/24/2014

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□A 297□	Continued From page 7 where opportunities for improvement were identified, there were no timely interventions to mitigate the identified issue.	□A 297□	performance to ensure that the improvements are sustained. **(Attachment 1)** **Person (s) Responsible:** Director of Quality; Director of Dietary Services; Director of Infection Prevention.	
□A 500□	482.25(b) DELIVERY OF DRUGS In order to provide patient safety, drugs and biologicals must be controlled and distributed in accordance with applicable standards of practice, consistent with Federal and State law. This STANDARD is not met as evidenced by: Based on observations, interviews and records review, the facility failed to properly label the drawers of the fifth and fourth floors crash carts. This deficient practice had the potential to cause delay during an emergency situation that required the use of crash carts. Findings: Hollywood Campus On 8/18/14 at 10 a.m., on the fifth floor, during a crash cart inspection with Pharm 2 (director of pharmacy) , the contents of drawer □1 of the Crash Cart did not match the label affixed to the exterior of the drawer. Pharm 2 stated the nursing leadership was in the process of reorganizing the crash cart contents. At 10:20 a.m., during another crash cart inspection on the fourth floor with Pharm 2, Pharm 2 acknowledged that the label affixed to the exterior of the drawer□1 was also old and not accurate. A comparison of the crash cart content list and the label affixed to the drawers revealed that	□A 500□	**Hollywood** **1).Corrective Actions:** The fifth and fourth floor crash cart drawers have been labelled and updated with appropriate list of medications matching labels on medication drawers. Staff in servicing **(Attachment 1 & 2)** **Date of Implementation:** August 22, 2014 **Monitoring Process:** Monthly nursing unit inspection by pharmacy department to make sure medication list is in place and matches list of medications inside the crash cart. **(Attachment: 3)** **Person Responsible**: Pharmacy/ Nursing	8/22/2014

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□A 500□	Continued From page 8 three out of the thirty medications listed on the label were not on the content list. Also, one of out of the thirty medications was listed in a different strength. A review of the facility's policy and procedure, titled "Crash Cart," Number: PAT.058, dated 11/2012, indicated " ...the pharmacist shall check the drug and IV contents ... and apply a label to the outside of the cart ... A list of the crash cart medications□ shall be kept on the outside of the cart ... " This is a repeat deficiency from the sample validation survey completed on 4/1/14.	□A 500□		
□A 502□	482.25(b)(2)(i) SECURE STORAGE All drugs and biologicals must be kept in a secure area, and locked when appropriate. This STANDARD is not met as evidenced by: Based on observations, interviews and documents review, the facility failed to ensure medication storage areas are accessible only to the authorized facility staff. This deficient practice had the potential for unauthorized person to access medication storage areas. Findings: Hollywood Campus On 8/18/14 at 10:15 a.m. on the fifth floor, during an inspection of the medication room with Pharm 2 (director of pharmacy), the surveyor was able to push open the door to the medication room without deactivating the keypad lock on that door.	□A 502□	**Hollywood** **1).Corrective Actions:** Medication room locks were changed to card readers. Card readers were provided to authorized personnel only. **(Attachment 1)**. Policy (PHA0.24) for □Drug administration: Who may administer and have an access to medications□was updated in September 2014 **(Attachment 2)**. Staff in-service **(Attachment 3)** **Date of Implementation:** September 18, 2014 **Monitoring Process:** Monthly nursing unit inspection **(Attachment 4)** **Person Responsible:** Pharmacy/ Nursing	9/18/2014

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□A 502□	Continued From page 9 In addition, the access door from the nursing station leading to the medication room was not locked. According to the facility policy, titled, "Storage of Medications," Number: PHA.090, dated 10/2012, " ... Medications are to be stored in locked areas not accessible to unlicensed persons ... " In reference to the California Code of Regulations, Title 22, section 70263 (q) (8)," Drugs shall be accessible only to responsible personnel designated by the hospital ..." This is a repeat deficiency from the sample validation survey completed on 4/1/14.	□A 502□		
□A 504□	482.25(b)(2)(iii) ACCESS TO LOCKED AREAS Only authorized personnel may have access to locked areas. This STANDARD is not met as evidenced by: Based on observations, interviews and documents review, the facility failed to ensure the passcode to a locked area was kept secure. There was a passcode written on a limited access door that led to a medication storage area, which made the locked area no longer secured. Findings: On 8/18/14 at 10:40 a.m., on the third floor hallway, the surveyor noticed a door with a keypad lock and a sign "Clean utility." At the top right corner of the door, there was a group of four digits written on the surface. The surveyor	□A 504□	**Hollywood** **1).Corrective Actions**: Security code written on the third floor Clean Utility door was removed immediately. **(Attachment 1)** Third floor Clean Utility room locks were changed to card readers. Card readers were provided to authorized personnel only. **Date of Implementation**: August 18, 2014 **Monitoring Process:** Monthly nursing unit inspection **Person Responsible:** Nursing	8/18/2014

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□A 504□	Continued From page 10 pointed that out to the accompanying Pharm 2 (Director of Pharmacy), Pharm 2 said the four digits were the passcode to the keypad lock for that door. Pharm 2 then proceeded to punch in the code and opened the door. Behind the door, there was the Omnicell (an automated drug cabinet). Then, around the corner, there was the medication room that stored large volumes and other miscellaneous medications that were not stored inside the Omnicell. On 8/20/14, at 10:30 a.m., the Pharm 1 (Vice President Pharmacy Operations) confirmed that there was no policy and procedure on safeguarding the access codes to limited access areas.	□A 504□		
□A 618□	482.28 FOOD AND DIETETIC SERVICES The hospital must have organized dietary services that are directed and staffed by adequate qualified personnel. However, a hospital that has a contract with an outside food management company may be found to meet this Condition of Participation if the company has a dietitian who serves the hospital on a full-time, part-time, or consultant basis, and if the company maintains at least the minimum standards specified in this section and provides for constant liaison with the hospital medical staff for recommendations on dietetic policies affecting patient treatment. This CONDITION is not met as evidenced by: Based on observation, review of facility documents and staff interviews, the hospital failed to ensure that the food and dietetic department was organized in a manner appropriate to the scope and complexity of the food service	□A 618□		

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□A618□	Continued From page 11 operations. As a result of the deficient practices identified during August 18-21, 2014 inspection, the hospital failed to ensure that the department was organized in a manner to ensure that dietary services met the needs of all patients as evidenced by failure to: 1. Provide organized dietetic services as evidenced by findings of unsafe food handling practices (Refer to A 620, A628). 2. Ensure meal portions were accurate, menus and preparation methods were in compliance with nationally recognized practices (Refer to A 630). 3. Plan menus for all physician ordered diets (Refer to A 628). 4. Lack of an effective system to ensure that physician ordered diets were followed (Refer to A 628). 5. Ensure safe and effective food storage/production practices (Refer to A 620, A 749). 6. Ensure adequate food on hand for use in an emergency (Refer to A 701). 7. Failure to have an ongoing quality appraisal and performance improvement program that addressed the complexity and scope of Nutrition and Dietetic Services (Refer to A 267). 8. Ensure that there was adequate ventilation and proper temperature controls in the kitchen and dry food storage areas (Refer to A 726). 9. Failure to maintain refrigerators, freezers, plate warmer and supplies to an acceptable level of safety and quality (Refer to A724, A 726). The cumulative effects of these systemic problems resulted in the facility's inability of the	□A618□	**1). Corrective Actions:** unsafe food handling: As of 10-4-14, contracted food and dietetic services management company was secured to provide a consistent organized approach to services for FNS for all three campuses. This includes a consistent organized same policies, procedures and manuals used for all three campuses. In service was provided to staff in related to proper safe food handling per the 2013 Food Code. Competency of staff was assessed individually (1:1 competency assessment) **(Attachment 1 & 2)** Competency validation **(Attachment 3)** **Date of Implementation:** 6/20/2014 to 10/23/2014 **Monitoring Process:** Food handling practices are monitored monthly by Infection Control through kitchen inspection and observation of employee□s performance. **Person Responsible:** Directors of Food Service, RD, Infection Control. **2). Corrective Actions:** (Meal Portions accurate menus & preparation methods in compliance with nationally recognized standards) New menus have been implemented to include accurate portions and standardized recipes with preparation methods that meet nationally recognized standards. Food & Nutrition Policy FNS. B016 Standardized Recipes illustrating the requirement to use standardized recipes and the components of a recipe including preparation instructions has been adopted in all facilities under the license. The menus and nutritional analysis of menus were approved by the Pharmacy & Therapeutics committee, Med Executive Committee and Governing Board. Staff training included the reading of menu spreads, standardized recipes and portion control. (**Attachment 4)** **Date of Implementation**: August 22- September 16 2014 **Monitoring Process:** The meal portions and preparation methods were observed as part of the tray accuracy monitoring noting portion, taste and appearance. 100% of trays were monitored for accuracy during menu implementation until 90% or better accuracy was achieved **(Attachment 5)**. Ongoing monitoring of tray accuracy will continue to be monitored with a minimum of 100 trays per week as part of the department performance improvement program and appropriate action for compliance meets the standard of 97% trays meet accuracy standards. Results of monitoring and actions taken to improve compliance are reported monthly to the Facility Quality Council, Med Executive committee and Governing Board. **Person Responsible:** RD, Director of Dietary Department and Clinical Dietitian RD Continued on page 12a.	6/20/2014 8/22/2014

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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□A 618□	Continued From page 12 hospital's food and nutrition services to direct the staff in such a manner to ensure that the nutritional needs of the patients were met in accordance with the physician's orders and acceptable standard of practice.	□A618□		
□A 620□	482.28(a)(1) DIRECTOR OF DIETARY SERVICES The hospital must have a full-time employee who- (i) Serves as director of the food and dietetic services; (ii) Is responsible for daily management of the dietary services; and (iii) Is qualified by experience or training. This STANDARD is not met as evidenced by: Based on observations, review of hospital documents, and staff interviews, the facility failed to ensure that persons in the position of food service director demonstrated authority for the direction of the food and dietary service. There were deficient practices in all three campuses in the one or more of the following areas: safety practices for food handling, emergency food supplies, personnel performance, menu planning, purchasing of foods and supplies and quality assurance performance improvement (QAPI). Findings: Hollywood Campus 1. On 8/18/14 beginning at 11:45 a.m., Dietary Staff (DS) 2 was observed preparing pureed green beans. It was noted that he placed 4 cups of cooked green beans in the blender after which he added 16 ounces of fluid. He was then	□A 620□	**All Campuses** **Corrective Action:** For Culver City facility identified a Director of Food and Nutritional Services (RD); Hollywood facility identified a Director of Food and Nutritional Services (RD); Van Nuys facility identified a Director of Food and Nutritional Services (RD). All three directors have assumed the leadership role for dietary services. **Hollywood** **1). Corrective Action:** New menus have been implemented to include accurate portions and standardized recipes with preparation methods that meet nationally recognized standards. Staff has been in-serviced on proper preparation of menu items including purees and the use of thickeners and the importance of following standardized recipes. Competency testing and return demonstration has been conducted **(Attachment 1).** Food & Nutrition Policy FNS. B016 Standardized Recipes illustrating the requirement to use standardized recipes and the components of a recipe including preparation instructions has been implemented in all three facilities. The new menus and nutritional analysis of specified portions and standardized recipes with appropriate preparation methods were approved by the committees.	

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□A 620□	Continued From page 13 observed pouring the green beans into a steam pan. The resultant texture of the item was a grainy liquid resembling runny applesauce. Concurrent observation also noted that the pureed meat was of a similar consistency. OS 2 utilized a soup ladle to portion the pureed meat and vegetables into individual plastic cups. On 8/18/14 beginning at 11:30 a.m., meal production was observed. OS 2 was preparing green beans by draining them into a colander and placing them on the steam table. There was no observation for the addition of margarine or spices to the beans. At 12:15 p.m., meal distribution was observed. It was noted that the roast beef being served was surrounded by a clear broth-like fluid and the green beans appeared to have a dried exterior texture. Review of recipe titled, □Roast Beef□revealed that in addition to the meat the recipe called for 1 teaspoon of garlic powder and 1 teaspoon of black pepper for a 24 pound roast. While each of these spices could add flavor to the item, the quantity of 1 teaspoon each would have no discernable flavor once the item was cooked. Similarly the recipe titled, "Green Beans" called for 1 cup of margarine, 2-1/4 teaspoons of salt and % teaspoon of pepper for 75 servings. The amount of salt and pepper would have not have had any impact on the flavor of the food. On 8/18/14 at 1:05 p.m., as a result of these observations, a test tray for taste and temperature was completed. The temperatures of the items were as follows: roast beef 115□ (degrees) F (Fahrenheit), green beans - 110°F milk- 52□F and tapioca- 64°F. In addition to recording food temperatures each of the items was tasted. It was noted that the roast beef and	□A 620□	**Date of Implementation:** August 22- September 16 2014 **Monitoring Process:** The portions, appearance, taste and temperatures of menu items made using specified preparation methods are observed as part of the tray quality assessment monitoring **(Attachment: 2)**. Test tray quality assessments are performed at a minimum of 3-5 times per week and results are reported monthly to Quality. **Person Responsible:** RD, Director of Dietary Department and Clinical Dietitian RD	8/22/2014

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□A 620□	Continued From page 14 green beans were lukewarm. The roast beef was not tender and both the roast beef and green beans were bland. Similarly the items intended to be served cold such as the milk were warm. A test tray was also completed for the pureed items. It was noted that the items were grainy, watery (consistency of soup) with a bland flavor. In a follow up observation on 8/18/14 beginning at 5:15 p.m., the evening meal entree consisted of roasted chicken, garden rice and carrots. It was noted that the garden rice was substituted with plain white rice. It was also noted that the consistency of the pureed items was similar to the noon meal, a liquid consistenc y: A taste sampling was done on 8/18/14 at 5:45 p.m. It was noted that the carrots and pureed rice were watery and had no flavor. The pureed chicken had a gritty texture and was not flavorful either. In a concurrent interview Staff L (Director of Food Services) stated that she had substituted plain canned chicken for the roasted. The roasted chicken and canned pureed chicken were not similar in flavor. Pureeing the roasted chicken served to patients on a regular diet would have been more flavorful than the canned pureed chicken. Document review on 8/18/14 beginning at 5:45 p.m., of the pureed green bean recipe revealed that staff should have added a food thickener to the product. It was also noted that the recipe failed to provide any guidance on the expected consistency of the finished product. According to the Academy of Nutrition and Dietetics' Nutrition Care Manual titled, "Nutrition Therapy for Pureed Diet," "Food should be "pudding-like" ...Be sure that any pureed foods prepared in advance the consistency of pudding or moist mashed	□A 620□		

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□A 620□	Continued From page 15 potatoes." Under the heading Cooking Preparation Tips it states, "when pureeing or blenderizing foods, add as little fluid initially as possible." The issue with the preparation of incorrect consistency of pureed food was identified in the previous survey. Review of departmental document titled, "Garden Rice" dated 2/5/05 noted that the rice should have contained sauteed onions, bay leaves and chicken soup base. No explanation was provided as to why the recipe for "Garden Rice" was not followed. Review of departmental policy and procedure manual on 8/18/14 failed to reveal a policy for evaluation of temperature and palatability of food items. In a concurrent interview with Staff L at 5:35 p.m., she stated the expectation was that hot food was 140□F or greater when patients receive their trays and cold foods should be 41oF or below and acknowledged that the pureed items were not tasteful. She also stated that to her knowledge there was no departmental mechanism for evaluating the quality of patient meals□ She further stated she had identified the consistency of pureed items as an issue; however had not provided interventions or guidance to dietary staff on the proper preparation method and desired consistency for the pureed items. Disposable Plates During food distribution observations on 8/18/14 beginning at 3:35 p.m., all patient meals were plated using disposable plates, cups and flatware. In a concurrent interview with Staff L, she stated that staff told her the plate warmer was broken. The surveyor asked for an explanation of why a broken plate warmer would cause the hospital to	□A 620□	**Disposable Plates** **2). Corrective Action:** Available china ware in storage was put into service. Additional china plates and reusable meal tray service ware were purchased. The plate warmer was replaced **(Attachment 3).** Induction heated base unit and china plates, base and dome lids were replaced Additional stock is available to be used for increased patient census. **Date of Implementation:** 8/20/14 **Monitoring Process:** Observation of patient meal assembly to ensure that reusable service ware is used for all patients. Patient with restriction or safety concerns (exhibit aggressive behavior or isolation per policy) will be served in disposable dinnerware. **Person Responsible:** RD, Director of Dietary Department	8/20/2014

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□A 620□	Continued From page 16 utilize all disposable items. She was unable to explain the rationale in response to the use of plates in the absence of a plate warmer. She also acknowledged that during the past 2 weeks, when she took over the position, she had not observed a stock of any dishware or flatware. The use of the disposable plates does not enhance dignity and contributes to the inability to maintain food temperatures. Most food temperature maintenance systems usually includes the use of insulated container and plates that will either generate heat to keep food hot during delivery, or absorb heat to keep food cold during delivery. Disposable plates do not insulate or retain heat. Menu On 8/18/14 beginning at 5:30 p.m., it was noted that the dessert for the evening meal was listed as jello jewels. Concurrent trayline observation revealed patients received a cup portion of plain red jello. It was not clear what "jello jewels" meant on the menu and whether the menu was correctly served. In an interview with OS 3 and concurrent review of the departments' standardized recipes on 8/18/14 at 5:45 p.m., revealed that there was no recipe for this dessert item. Sanitation On 8/18/14 at 11:30 am, OS 2 was observed loading dirty trays with her gloved hands. She was also observed unloading clean trays with the same gloved hand. She was not observed to change gloves, wash her hands, and put on new gloves before proceeding to unload clean trays. A review of the hospital policy titled, "Disposable Glove Use" dated 4/25/12 indicated "Disposable gloves must be changed when dirty or ripped and	□A 620□	**Menu** **3). Corrective Action**: Menus have been implemented to include accurate portions and standardized recipes for all menu items that meet nationally recognized standards. **Date of Implementation:** September 4- September 16, 2014 **Monitoring Process:** 100% of trays are monitored for accuracy of menu implementation with 90% or better rate of compliance. Ongoing monitoring of tray will continue at a 100 trays per week as part of the department performance improvement program. The taste and temperature of patient meal trays is assessed through test tray quality assessment evaluations. Results of monitoring are reported to Quality. **Person Responsible:** RD, Director of Dietary Department and Clinical Dietitian RD **Sanitation** **4). Corrective Action:** Kitchen staff was trained on the policy of glove use and requirement to remove gloves and wash hands after handling dirty dishes and prior to handling clean dishes. Competency and return demonstration was conducted (**Attachment 4)**. Policy FNS F021 Disposable Glove Use. (**Attachment 5)** **Date of Implementation:** September 11, 2014 Oct 23, 2014 **Monitoring Process:** Competency and return demonstration on glove usage. Daily Management Food Service Rounds and the Monthly Infection Control rounding. **Person Responsible:** RD, Director of Dietary Department	9/4/2014 9/11/2014

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□A 620□	Continued From page 17 when moving from one task to another " . Culver City Campus Disposable Plates During food distribution observations on 8/19/14 beginning at 12 p.m., a large percentage of patient meals were delivered on disposable paper plates. In a concurrent interview with DS 7, he stated the patients on the behavioral health unit received paper products and as for the rest of the patients it would depend on the item. He also stated there was a limited number of non-disposable dishware. In an observation on 8/19/14 beginning at 2:45 p.m., there were less than 150 plates within the hospital. During the general dietetic observations on 8/20/14 beginning at 3:30p.m., there were greater than 10 cases of dishware in a chemical closet located in 'the loading dock area. In a concurrent interview with RD (Registered Dietitian) 3, he stated that the hospital planned to reopen the labor and delivery unit and planned to enhance the meal service for this unit. He was unable to verbalize why specifically this unit would receive non-disposable dishware, yet other inpatient units (with the exception of the behavioral health unit) would continue t6 receive disposable dishware. Hospital policy titled, "Patient Food Service" dated 5/14 noted that "Food shall be served ...with appropriate eating utensils ... " Hospital policy titled, "Objective for Patient- Resident Tray Service" dated 4/12 indicated " ...Equal emphasis will be placed on dining program regardless of the level of care." Food Storage During the food storage observation on 8/19/14 beginning at 2 p.m., there were issues	□A 620□	**Culver City** **1). Corrective Action:** Available china ware in storage was put into service. Additional china plates and reusable meal tray service ware were purchased (**Attachment1**). Additional stock is available to be used for increased patient census. **Date of Implementation:** 8/20/14 **Monitoring Process:** Observation of patient meal assembly to ensure that reusable service ware is used for all patients. Patient with restriction or safety concerns (exhibit aggressive behavior or isolation per policy) will be served in disposable dinnerware. **Person Responsible**: RD, Director of Dietary Department	8/20/2014

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□A 620□	Continued From page 18 surrounding storage and dating of perishable foods. In Refrigerator □1, there were vegetarian hot dogs opened, no date; liquid whole eggs that were thawed, undated; 3 cases of potatoes with manufacturers' guidance to keep frozen. It was also noted there were 2 cases of raw, thawed chicken that were pulled from the freezer on 8/12/14 with a use by date of 8/22/14 (10 days later). In a concurrent interview with RD 3, he was asked to describe the holding time for thawed, raw meat products. RD 3 stated he was unsure; however would refer to the food storage guidelines. He also stated that the expectation would be that all items are labeled and dated once opened. Concurrent review of departmental document titled, "Refrigerated Storage Life of Foods" dated 3/24/14 noted that thawed meats were not to be held for a period greater than 5 days. Department policy titled, "Food Supply and Storage" dated 11/12 noted that "Orange label must be used on all foods ...Items included on label: Date, ...Expiration Date, ... " Trays During the general kitchen observations on 8/19/14 beginning at 2:50 p.m., there were greater than 10 patient meal delivery trays that were cracked and had exposed metal edges. It would be the standard of practice to ensure that all patient meal delivery utensils be free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections (Food Code, 2013). Van Nuys Campus □ Food Storage During observation on 8/19/14 starting at 11:15 a.m., there were observed food storage concerns including inadequate refrigerator storage space,	□A 620□	**Food Storage** **2). Corrective Actions:** The open vegetarian hot dogs with no date were immediately discarded; liquid whole eggs that were thawed undated were discarded; 3 case of potatoes with manufacture guidance to keep frozen & 3 case of raw and thawed chicken that were pulled from freezer 8-12 to be used by 8-22-14 were discarded. All other food items in the kitchen were reviewed, labeled and dated per policy. Staff was in-serviced on labeling dating, food items and thawing with monitoring. **(Attachment-2 & 3)** **Date of Implementation:** August 19, 2014 **Monitoring Process:** Daily inspection by dietary management will be documented on the Supervisor Opening & Daily Check list **(Attachment 3)**. **Person Responsible:** RD, Director of Dietary Department and Executive Chef **Trays** **3). Corrective Actions:** Patient meal trays identified as being cracked with exposed metal edges were immediately removed from service. Replacement trays were removed from storage and put into service. Staff was in-serviced on identifying damaged trays and discarding them. **(Attachment 2)** **Date of Implementation:** October 23, 2014 **Monitoring Process:** The condition of trays will be observed as part of the Routine Infection Control (**Attachment 4**). **Person Responsible:** RD, Director of Dietary Department **Van Nuys** **1). Corrective Action:** Daily monitoring of all storage locations (refrigerators, freezers, and dry storage spaces) will be monitored by kitchen staff and recorded in a log. Rental of a refrigerator truck acting as a supplemental refrigerator storage space is replacing the out of order refrigerator on 9-5-14. **Date of Implementation:** August 22, 2014 **Monitoring Process:** Daily monitoring of refrigerated and frozen food storage locations and the dry food storage location. **Person Responsible:** RD, Director of Dietary Department	8/19/2014 10/23/2014 8/22/2014

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□A 620□	Continued From page 19 improper freezer storage temperatures, and improper dry food storage temperatures. Inadequate refrigerator space is evidenced by the stacking of food and plastic storage food containers on top of another in a manner that did not allow ample air circulation. There was another refrigerator that was labeled "Out of Order" dated 6/4/14. In an interview on 8/19/14 at 4:30p.m. with the Head of Plant Operations, he stated that two weeks earlier the hospital decided that repairing the refrigerator was not ideal because it was too expensive and replacement was more practical. One of the freezers (□5) was observed to read 23 degrees Fahrenheit. According to the hospital policy titled, "Food Storage" dated November 2012, " Frozen foods are stored in the freezer and the temperature is maintained at 0 degrees Fahrenheit or less. Produce is stored in the refrigerator and the temperature is maintained at 32 to 41 degrees Fahrenheit." Foods held at less than optimum temperatures could support the growth of microorganisms that promote spoilage and /or food borne illness. The impact of the inadequate refrigerated space was demonstrated when patients were served cottage cheese instead of milk for lunch on 8/19/14. According to the menu, the patients were to receive Tossed green salad, Baked Fish with lemon, parsley noodles, mixed vegetables, dinner roll, fresh fruit and milk for lunch. Trayline observation showed that patients were served all the items listed above and cottage cheese. In an interview with Staff L (Food Service Director), she explained that the substitution was due to refrigerator space issues. In addition, there were refrigerators/freezers stored in the dry storage	□A 620□	**Improper Freezer Storage Temperatures** **Corrective Action:** Interim measure included the attempted repair of existing freezers and the rental of a freezer truck. **(Attachment)** **Date of Implementation**: Freezer truck rented 8/21/2014 **Monitoring Process:** Daily monitoring of freezer food storage locations **Person Responsible:** RD, Director of Dietary Department, Director of Facilities Management **Corrective Action:** New Freezers were purchased and installed to replace the existing units. **Date of Implementation:** 8/29/2014 **Monitoring Process:** Daily monitoring of freezer food storage locations Monthly reporting of kitchen work order completion tracking to hospital administration. Observation of functionality via EOC rounding. Report of work order completion and Finding of EOC rounding on a monthly basis to Quality Council, Med Executive Committee and the Governing Board. **Person Responsible:** RD, Director of Dietary Department, Director of Facilities Management	8/21/2014 8/29/2014

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□A 620□	Continued From page 20 room emitting heat resulting in high room temperature. At 11:53 a.m. on 8/19/14, the temperature of the dry storage room was 88.6 degrees Fahrenheit. At 12:55 p.m., the temperature was 88 degrees Fahrenheit. The dry storage thermometer gauge had exceeded the graduated the 80 degree mark indicating that the room was warmer than 80 degrees. In a concurrent interview with Staff L, she stated that they do not monitor or keep logs of the dry storage room. According to the same policy described above, "All dry goods are stored in storeroom that is clean, dry and well ventilated ... " The dry storage room was not well-ventilated. The recommended temperature of dry storage by the Food and Drug Administration is between 50 to 70 degrees Fahrenheit. Improperly stored staple foods could result in poor quality such as deterioration of food products including rancidity and altered flavors. Menu Review of the menu for 8/18/14 through 8/19/14 for both Hollywood and Van Nuys Campuses showed continued lack of variety. Concerns with the menu were identified in the Statement of Deficiencies form the April 2014 survey. The patients continued to receive tossed salad every day at lunch. The patients on pureed diet continued to receive mashed potatoes every day for lunch and dinner. For example, at dinner on 8/19/14, the patients on pureed diet received double portions of the mashed potatoes to replace the dinner roll and steamed rice that patients on regular diets were served. In addition, green beans was offered to patients on renal diets for both lunch and dinner on 8/19/14.	□A 620□	**Improper Dry Food Storage Room Temperature** **Corrective Action:** Dry storage area temperatures are being monitored and recorded daily since August 20, 2014 **(Attachment: 1)**. To ensure FDA acceptable range of 50-70 degrees is maintained. **Date of Implementation:** 8/20/14 **Monitoring Process:** Daily monitoring of temperature of the dry food storage location. **Person Responsible:** RD, Director of Dietary Department, Director of Facilities Management **Van Nuys & Hollywood** **Menu** **Lack of Variety** **Corrective Actions**: Menus have been revised to include variety, color, and accurate portions per standardized recipes including purees per nationally recognized standards. Food & Nutrition Services Policy FNS C009 Patient Menu**.** Staff insserviced **(Attachment 2)** **Date of Implementation:** September 4- September 16, 2014 **Monitoring Process**: The revised menu is monitored by manager/supervisor during the tray quality assessment and the patient satisfaction rounds. **(Attachment 3)** **Person Responsible:** RD, Director of Dietary Department and Clinical Dietitian RD	8/20/2014 9/4/2014

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□A 620□	Continued From page 21 There was no written menu for patients on the vegetarian diet. Review of the Patient Diet Order List dated 8/19/14 showed there were two unsampled patients on vegetarian diets. Review of the menu showed that there was no planned menu for the vegetarian diet. Staff L stated in an interview on 8/19/14 that she had interviewed the patient and was "fine" with eggs and dairy. A lack of a planned menu could put the patient at risk of a diet that does not meet nutritional needs and the recommended daily allowance. Review of the hospital policy titled, "Patient Menus" dated 11/12 did not list the vegetarian diet as one of the diets on the patient menu but adds that "other diets as ordered by the physician will be provided for." The therapeutic spreadsheet which is used by dietary staff for the serving of food did not include the vegetarian diet.	□A 620□	**Lack of Vegetarian Options** **Corrective Actions:** A vegetarian menu was put into place with a variety of vegetarian options. The newly implemented menu and menu spread includes both Vegetarian and Vegan options. **Date of Implementation:** August 22, 2014 interim and permanent September 4- September 16 2014 **Monitoring Process:** The new vegetarian menu is monitored manager./supervisor during the tray quality assessment and the patient satisfaction rounds. **(Attachment 3)** **Person Responsible:** RD, Director of Dietary Department and Clinical Dietitian RD	8/22/2014 9/4/2014
□A 628□	482.28(b) DIETS Menus must meet the needs of the patients. This STANDARD is not met as evidenced by: Based on observation, review of hospital documents and staff interviews, the hospital failed to ensure that menus met the needs of two of eight patients (Patient 53 and 54) when substitutes prepared and offered were not of same nutritive value as the items that were originally planned. The hospital also failed to plan in advance menus for vegetarian and gluten-free diets; dietary staff failed to follow recipes to ensure that the nutritive value of the items were met. The lack of planning of menus in advance and failure to follow recipes put the patients at risk of receiving diets that may not be nutritionally balanced and lacking in variety.	□A 628□		

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□A 628□	Continued From page 22 Findings: Hollywood Campus During the trayline observation on 8/18/14 beginning at 11:30 a.m., there were two patients (Patient 53 and 54) one of whom had a physician ordered wheat free diet and the second with a physician ordered vegetarian diet. Wheat free diets are used to treat patients with gluten sensitivity (a protein found in grains). Gluten is found in a wide variety of foods and food additives (Mayo Clinic, 2014). It was noted that the patient with the wheat -free diet received a regular meal tray and the patient with the vegetarian diet received cottage cheese and fruit. In a concurrent interview with DS 2 (Dietary Staff), he stated that for wheat -free diets he would eliminate bread and vegetarian diets usually received items such as cottage cheese and fruit. He stated he did not have a menu spreadsheet for either of these items. In an interview on 8/18/14 at 2:30p.m., with Dietary Staff (DS) 5 she confirmed that the hospital did not have spreadsheets for gluten free or vegetarian diets. Culver City Campus During the food distribution observations on 8/19/14 beginning at 12 p.m., the substitute meal entree was a chicken enchilada. The enchilada contained chicken, corn tortilla, red sauce and a small amount of cheese melted on the top of the casserole. While there was visible chicken in the item, it did not appear that the amount of chicken was substantial in amount of protein for a main entree. It was also noted that the enchilada was cut into approximately 32 pieces and was served using a :□ cup serving.	□A628□	**Hollywood** **Corrective Action:** A vegetarian and wheat free menu was put into place with a variety of options. The newly implemented menu and menu spread includes both Vegetarian and Vegan as well as wheat free options. Food Service Staff have been inserviced on the menu spreadsheet **(refer to Attachment: A-620.1 attachment 1)**. **Date of Implementation:** August 22, 2014 - September 16, 2014 **Monitoring Process:** The new menus are monitored by manager/supervisor during the tray quality assessment and the patient satisfaction rounds. **Person Responsible:** RD, Director of Dietary Department and Clinical Dietitian RD **Culver City** **Corrective Actions:** Enchilada casserole recipe was reviewed and kitchen staff inservice to follow the standardized recipe without adjustments and proper portioning of the meal. **(Attachment 1)** **Date of Implementation:** October 23, 2014 **Monitoring Process:** Daily data collection on proper preparation and portioning of the recipes (**Attachment 2).** **Person Responsible:** RD, Director of Dietary Department and RD, Clinical Nutrition Manager	8/22/2014 10/23/2014

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□A 628□	Continued From page 23 Review of the standardized titled, "Chicken Enchilada" revealed that the recipe was intended for 24 servings. The recipe also called for greater than 2 pounds of cheese for 24 servings. While there was a light layer of melted cheese on top of the casserole there was no visible amount of cheese in the enchilada. In a concurrent interview with OS 3, she stated the chicken enchilada replaced a vegetarian entree on the menu. She also stated that likely the recipe substitution was not evaluated for nutritional adequacy rather was accepted primarily for patient acceptability. On 8/19/14 at 12:15 p.m., the edible protein was weighed and was noted to be 2 ounces. Review of departmental document showed the edible protein portion of the enchilada was 3 ounces. During an observation of food production activities on 8/19/14 beginning at 2:20 p.m., the dietary staff was preparing sandwiches for patient use. He was observed placing 3 slices of deli turkey with lettuce and 2 slices of bread. In a concurrent interview, OS 6 stated that the items would be used for a meal substitution on trayline as well as for patient snacks. On 8/20/14 at 3 p.m., OS 7 was asked to weight 3 slices of the deli turkey. It was noted the meat weighed 2 ounces. Review of the facility spreadsheet revealed that main entrees were to have 3 ounces of edible protein. Improper portion sizes would result in inadequate calories and protein which could impair wound healing resulting in longer hospital stays. The staff had failed to follow recipes and persons in position of authority had failed to ensure the recipes were followed to the menu met the	□A 628□	**Corrective Actions:** Staff was in-serviced on menu substitutions and the difference between nourishment items and meal items. **(Attachment 1 & 2)** **Date of Implementation:** October 23, 2014 **Monitoring Process**: Daily data collection on proper preparation and portioning by manager/supervisor (**Attachment 2**). **Person Responsible:** RD, Director of Dietary Department and RD, Clinical Nutrition Manager	10/23/2014

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A 628	Continued From page 24 nutritional needs of the patients. This is a repeat deficiency from the sampled validation survey on 4/1/14.	A628		
A 630	482.28(b)(2) DIETS Nutritional needs must be met in accordance with recognized dietary practices and in accordance with orders of the practitioner or practitioners responsible for the care of the patients. This STANDARD is not met as evidenced by: Based on observation, review of hospital documents and staff interviews, the hospital failed to ensure the nutritional needs of patients on pureed and diabetic diets (Patient 57, 58, 59, and 60) and two sample patients on tube feeding (Patient 55 and 56), in sample of eight, were in accordance with recognized practices and orders of the practitioner responsible for the care of patients. Tube feeding orders were not carried out correctly; recommended hang times for tube feeding orders were not followed, which could result in growth of microorganisms. The pureed diet was improperly prepared resulting in a watery consistency that could result in aspiration; improper preparation method also compromised the nutritive value of the food. Diabetic diets incorrectly translated to meet the caloric limits set by the physician in the diet order and unclear diet order was served without clarification with the physicians. This could result in patients receiving diets not in line with the therapy planned by the physician. Findings:	A630		

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□A 630□	Continued From page 25 Hollywood Campus 1. On 8/18/14 beginning at 6 p.m., Patient 55□s tube feeding was running at a rate of 40 cubic centimeters (cc- a metric unit of measure). Patient 55□s feeding was an open system feeding. An open system allows of addition of formula throughout the course of the day; whereas a closed system does not allow for the addition of formula (Critical Care Nutrition, 2011). It was also noted that the feeding was dated as 8/18/14; however the time the feeding was hung was not documented. It was also noted that 200 cc of formula remained in the feeding bag. In a concurrent interview and demonstration with RN 2 (Registered Nurse), she stated that she started the feeding at approximately 6 a.m., on 8/18/14. She also stated that she added 2 cans or the physician ordered supplement when the feeding was started. She further stated that when the feeding became depleted she would add additional cans of formula. In a concurrent observation of the enteral pump, the pump recorded of 112 cc□s of feeding delivered. RN 2 was unable to demonstrate the amount of feeding that was delivered since it was hung on 8/18/14 at 6 a.m. Review of patient intake/output records dated 8/18/14 noted that nursing staff documented that 40 cc□s of formula was delivered every hour. It was also noted that based on hospital documentation a total of 480 cc□s of formula was delivered. There was an inconsistency of 368 cc□s between the cumulative total of the enteral pump and the documentation in the electronic medical record. RN 33 was unable to describe the inconsistency. She also stated that she documented the physician□s order in the medical	□A 630□	**Hollywood** **1.) Corrective Actions**: All open-system tube feedings have been discontinued and switched to closed system feeding; education/in-service with return demonstration provided to staff to included: 1) new closed-system feeding, 2) tube feeding orders, 3) date and hang time of feeding, 4).water flushing and 5). Proper documentation in EMR to include accurate documentation of Intake and Output. Education inservice with return demonstration was provided to staff on August 23-Sept 17, 2014. (**Attachment 1**) **Date of Implementation:** Education for tube feeding occurred August 23, 2014- September 17, 2014; closed system implemented facility wide on September 16, 2014; RD education on diet list, entering diet orders, MD orders September 17- 29, 2014 **Monitoring process:** Nursing performs audits on tube feedings **Person Responsible:** Nursing department	8/23/2014 9/16/2014 9/17/2014

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□A 630□	Continued From page 26 record, rather than the actual amount of feeding delivered. There was also no documentation of water flushes that is necessary to clean out bags prior to the addition of new feeding. Failure to perform this function could result in feedings being hung for time periods that would support bacterial growth. 2. On 8/18/14 beginning at 6:30 p.m., Patient 56 had a physician ordered enteral feeding with a □rate of 40 cc's/hour. The enteral pump reading confirmed that the feeding was running at 40 cc's/hour. The feeding bag was dated 8/18/14 and timed at 6 a.m. The enteral pump revealed that 174 cc's of feeding were delivered□and there was 100 cc's left in the bag. Review of clinical record for Patient 56 showed documentation of 40 cc per hour not actual volume delivered. The documentation showed more feeding had been delivered, based on the amount shown on the pump. In a concurrent interview with RN 33 on 8/18/14 she was unable to explain the total amount of feeding that was delivered from the feeding bag since 6 a.m. when the bag was hung. It could not be determined whether or not the hospital was following physicians' orders. There was also no documentation of water flushes that is necessary to clean out bags prior to the addition of new feeding. Failure to perform this function could result in feedings being hung for time periods that would support bacterial	□A 630□		

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□A 630□	Continued From page 27 growth. The hospital failed to follow manufacturer's guidelines and standards of practice for the amount of time the open enteral formula could be hung at the patient's bedside (known as "hang time") by allowing hang times of up to 12 hours when manufacturer's guidelines were for no greater than 8 hours hang time. This failure had the likely potential to result in enteral formulas with unacceptable levels of bacteria delivered to the patients and result in infections in patients receiving enteral feedings. "The A.S.P.E.N. (American Society for Parenteral and Enteral Nutrition) Enteral Practice Recommendations provides the following hang time recommendations: For reconstituted powdered formula or a formula with additives, a 4-hour hang time is recommended; For a commercially sterile, liquid formulas decanted (poured) from a can or brik-pak (similar to a juice box), an 8-hour hang time is recommended. These hang time recommendations assume the formula is kept at room temperature and is subject to minimal handling and manipulation... This information also indicates that the bag and administration set (tubing) should be flushed with water before adding additional formula." 3. On 8/18/14 beginning at 11:45 a.m., OS 2 was observed preparing pureed green beans. OS 2 placed a cups of cooked green beans in the blender after which he added 16 ounces of fluid. He was then observed pouring the green beans into a steam pan. The resultant texture of the	□A 630□	**3.) Corrective Actions:** Education of kitchen staff provided on the use of thickeners in the preparation of puree diets. **(Attachment: 3 & 4)** **Date of Implementation:** August 22- September 16, 2014 **Monitoring Process:** The puree preparation methods are monitored by management observation during the preparation of the meal weekly. **Person Responsible:** RD, Director of Dietary Department and Clinical Dietitian RD	8/22/2014

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□A 630□	Continued From page 28 item was a grainy liquid resembling runny applesauce. Concurrent observation also noted that the pureed meat was of a similar consistency. During the trayline observation, OS 2 utilized a soup ladle to portion the pureed meat and vegetables into individual plastic cups. Excessive addition of food additives alters the nutritional value of the item. In a follow-up observation on 8/18/14 beginning at 5:15 p.m. of meal production activities, the consistency of the pureed items was similar to the noon meal, a liquid consistency. Review on 8/18/14 beginning at 5:45 p.m., of the pureed green bean recipe revealed there was no guidance to add additional liquid while preparing the items. The staff should have added a food thickener to the product. Additionally, the recipe failed to provide any guidance on the expected consistency of the finished product. According to the Academy of Nutrition and Dietetics' Nutrition Care Manual titled, "Nutrition Therapy for Pureed Diet," Food should be "pudding-like" ...Be sure that any pureed foods prepared in advance are the consistency of pudding or moist mashed potatoes." Under the heading , Cooking and Preparation Tips, "when pureeing or blenderizing foods, add as little fluid initially as possible." This is a repeat deficiency. Culver City Campus 4. During review of physician ordered diets on 8/19/14 beginning at 11:30 a.m., the diets for patients with diabetes was not consistent with what was transcribed to the electronic diet entry order system. The meals were plated as a carbohydrate consistent diet which utilized meal plans without specific calorie levels, but	□A 630□	**Culver City** **4). Corrective Actions:** Diet policy called C002 □Diet Orders□ was revised to provide more specific information on ordering diets including those used for diabetes reflecting consistent levels of carbohydrates throughout the day. **(Attachment 5)** **Date of Implementation:** Oct 15-17, 2014 **Monitoring Process:** Monitoring the accuracy of menu modifications including consistency of the carbohydrates meal plans using a sample of 30 menus per clerk is monitored quarterly. **(Attachment 6)** **Person Responsible:** RD, Director of Dietary Department & RD, Clinical Nutrition Manager	10/15/2014

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□A 630□	Continued From page 29 incorporated consistent levels of carbohydrate throughout the day. For example, if a physician ordered 1800 calorie American Diabetes Association (ADA) diet, the diet would get transcribed to a consistent carbohydrate meal pattern that offered 60 grams of carbohydrate (CHO) at breakfast and 75 grams of CHO at lunch and dinner. It was also noted that there was inconsistencies in how the physician ordered diabetic diets. For example, some of the 1800 calories diets were transcribed to a 4-5-5- meal pattern (indicating the number of carbohydrates per meal) and other 1800 calorie diets were transcribed as a "Diabetic Diet Consistent Carbohydrate" without an indication of the amount of carbohydrate at each meal. In an interview on 8/19/14 beginning at 3 p.m., with Registered Dietitian (RD) 2, she stated that she was aware that the diet orders were being translated and had developed a therapeutic spreadsheet for staff to follow; however she had not implemented it. On 8/21/14 at 5:45 p.m., the hospital provided a screenshot of the available electronic diet orders. The diabetic diet could only be ordered as a general "diabetic diet" and there was not the possibility to order it as a calorie specific or consistent carbohydrate diet. Hospital policy titled, "Diet Manual" dated 11/12 guided staff that the "diet order should be specified in terms of exact amount of restriction ... " It also noted that if the physician " is unsure of the terminology necessary for desired diet order, he/she should consult the Clinical Diet Manual ... " The policy did not reflect the practice within the department.	□A 630□		

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□A 630□	Continued From page 30 Additionally, referring to the diet manual would not have provided physicians additional guidance for ordering diabetic diets as the document provided clinical practice recommendations rather than guidance for ordering diabetic diets within the hospital. Review of hospital document titled, "Diet Report" dated 8/19/14 noted that there were greater than 20 patients who did not receive the correct diet order. 5. During trayline observation on 8/19/14 beginning at 12 p.m., the tray ticket for 3 random patients (Patients 57, 58 and 59) guided staff to plate 5 carbohydrate selections for the noon meal. It was noted that the meal plated on each of the trays consisted of 3.5 carbohydrate selections (pineapple salsa, sweet mashed potatoes, green beans and a garden salad) rather than the diet list designation of 5 carbohydrates. In an interview on 8/19/14 beginning at 3 p.m., with DS 8, whose position was responsible for diet accuracy, he stated that the departmental policy was that if patients did not select an adequate amount of carbohydrates additional food items should be marked to increase the carbohydrate content of the meal to hospital specified parameters. Review of the therapeutic spreadsheet for the noon meal on 8/19/14 revealed that if patients did not select menu items the maximum number of carbohydrates for the noon meal would be 4 carbohydrate choices. Hospital document titled, "Diet Report" dated 8/19/14 noted that a carbohydrate consistent pattern for an 1800 calorie diet was a meal pattern of 4-5-5 for breakfast, lunch and dinner respectively.	□A 630□	**5). Corrective Actions.** The Manual for Clinical Nutrition Management (Diet Manual) was revised to include the appropriate diet Addendums. This will ensure a practice related to menu creation, nutritional adequacy, and clinical nutrition practice. **(Attachment 7)** **Date of Implementation:** 9/10/2014 to 10/4/2014 **Monitoring Process:** The kitchen staff was inserviced on the use of diabetic diet ensuring consistency with levels of carbohydrates throughout the day. **(Attachment: 7)** **Person Responsible:** RD, Director of Dietary Department and RD, Clinical Nutrition Manager	9/10/2014

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A 630	Continued From page 31 Van Nuys 6. Clinical Record review showed when Patient 60 was admitted his physician ordered diet was a diabetic, No Added Salt: 2000 calories, Na (sodium) 2 gram. He was served according to the Diet order list dated 8/19/14 a 2000 calorie 2 gram Na diet. The diet as ordered has two levels of sodium restriction: NAS and 2 gram sodium. The NAS, or no-added-salt diet, involves restricting sodium intake to less than 4 grams, or 4,000 milligrams per day while the 2 gram sodium involves restricting sodium intake to 2000 milligrams. The standard of practice is to clarify conflicting or unclear orders. Clinical record review did not show any clarification in the diet order by either nursing staff or registered dietitian. DFS1 stated in an interview on 8/19/14 at 3:40 p.m. that the diet served was the diet that was ordered. 7. According to the menu on 8/19/14, the following items were served for lunch: Tossed salad, Lemon Fish, mixed vegetables, parsley noodles, fresh fruit and low fat milk. During a trayline observation, on 8/19/14 at 12:50 p.m., random observation showed a patient on double portions received 2 pieces of fish and same portion of noodles, vegetables and fruit. Staff K (Director of Food Service) who was	A 630	**Van Nuys** **6). Corrective Action:** Food & Nutrition Services policy FNS C002 Diet Orders was revised to include the approved diet orders. Training was provided to kitchen staff, nurses and physicians concerning the clarification of diet orders. **(Attachment 5)** **Date of Implementation:** 8/21/14 and on going **Monitoring Process:** Electronic MD diet orders are compared daily to the approved diet order for accuracy and monitored by manager/supervisor **(Attachment 10)** **Person Responsible:** R.D. Food Service Director, Clinical Dietitian, RD **7). Corrective Action:** A revised policy for double portion was implemented specifying the composition of a double portion diet as stated in Food & Nutrition Service Department P&P Manual FNS C013 Special Patient Meals and Services. Kitchen staff was inserviced on the policy on double portions. (**Addendum: 8)** **Date of Implementation:** 9/4/14 **Monitoring Process**: Supervisor/manager will monitor during tray preparation accuracy of the double diet portion. **(Attachment 9)** **Person Responsible:** R.D. Food Service Director, Clinical Dietitian, RD	8/21/2014 9/4/2014

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□A 630□	Continued From page 32 present during the observation confirmed the accuracy of the meal served. Staff M (Food Service Supervisor), in a concurrent interview, stated that the patient should have received double portions of the fish and starch. Review of the hospital policy titled, "Special Patient Meals and Services" dated 7/14 indicated "a patient on double will receive a double entree plate with all the components. Typically, a hot entree with starch, vegetable, dinner roll .... " Review of the Diet List dated 8/19/14 showed that there were eight patients who had double portion as part of their diet orders. The incorrect portion sizes would result in decrease calories and overall nutrient deficit. This is a repeat deficiency from the sample validation survey on 4/1/14.	□A 630□		
□A 700□	482.41 PHYSICAL ENVIRONMENT The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community. This CONDITION is not met as evidenced by: Based on observation, review of facility documents and staff interview, the facility failed to meet the Condition of Participation in Physical Environment by failing to: 1. Develop and maintain the physical plant in a manner that assured the safety and well-being of patients (Refer A 701).	□A 700□	**1). Corrective Actions:** The facilities have initiated a proactive system to conduct physical plant rounds covering all patient care and non-patient care areas to address maintenance issues. **Date of Implementation:** August 2014 **Monitoring Process:** Weekly monitoring physical plant rounds and Environment of Care rounds covering patient care and non-patient care areas. In addition, daily EVS environmental rounds and periodical terminal cleaning. **Person Responsible**: Director of Engineering	08/2014

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□A 700□	Continued From page 33 2. Ensure the safety of patients and staff when it failed to ensure there were appropriate plans in place to implement its emergency preparedness program and ensure that its emergency food was properly secured. Failure to ensure maintenance of the physical environment may compromise the medical status of patient and the ability for staff to care for patients (Refer to A 701). 3. Ensure that food service equipment was maintained to assure the safety and well-being of patients (Refer to A 701). 4. Ensure an effective approved water management plan to be implemented in a widespread disaster. Failure to ensure an effective approved water management plan may compromise the medical status of patients and the ability for staff to care for patients (Refer to A 703). The cumulative effect of these systemic issues resulted in the facility□s inability to ensure and provide a safe patient care environment.	□A 700□	**2). Corrective Actions:** The emergency policy and procedur was reinforced through education of dietary and physical plan staff. Education and inservice of the dietary and physical plan staff. **Date of Implementation:** October 23 2014 **Monitoring Process:** Monitor and Log Disaster food and water inventory quarterly. **Person Responsible:** Dietary and Engineering. **3). Corrective Actions**: Repairs will be done in a timely manner □same day or within 3 hours□and work orders will be processed by the Engineering Dept by priority. **Date of Implementation:** on-going. **Monitoring Process:** Work orders will be monitored daily by Engineering staff and repairs will be tracked through the work order system. **Person Responsible:** Dietary and Engineering **4). Corrective Actions:** The emergency preparedness policy and procedure on water management was reviewed and inserviced to the dietary staff and engineering. **Date of Implementation**: October 23, 2014 **Monitoring Process:** Water supplies will be monitored by dietary and engineering. **Person Responsible:** Director of Engineering, RD	10/23/2014 10/23/2014
□A 701□	482.41(a) MAINTENANCE OF PHYSICAL PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This STANDARD is not met as evidenced by: Based on observation, interview, and document review the hospital failed to ensure maintenance of the physical environment, and develop and maintain the physical plant in a manner that	□A 701□		

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□A 701□	Continued From page 34 reduced opportunities for self-harm and eliminating as many risk factors as possible in the patient's environment including fixtures that could be used as anchor points to tie to that can hold a person's weight and other conditions that could be used as opportunities for self-harm. The deficient practice had the potential to provide patients opportunities for self-harm, infection transmission, accident hazards, and rodent activity. Also, the hospital failed to ensure there were appropriate plans in place to implement its emergency preparedness program and ensure that its emergency food was properly secured. Improper storage of emergency food could result in misappropriation and loss of food items preventing use during a disaster. Findings: Hollywood campus On August 18, 2014 between 10:06 a.m. and 3:30 p.m., the following conditions existed at the Hollywood campus. 5th Floor 1. Room 509 had a 5 ft. by 4 ft. section of ceiling missing, and the room was being used for storage of Environmental Services (EVS) equipment and mattresses. During an interview at the same time as the observation, Staff D (Corporate Director of Facilities) stated the damage at the ceiling was	□A 701□	**Hollywood – 5th Floor** **1).Corrective Actions:** A permit was approved by OSHPD on September 19, 2014, Permit No. S141549-19-00 for the repair of the ceiling **(Attachment: 1)**. The OSHPD procedure of the repair is currently ongoing. **Date of Implementation**: Permit was granted on September 19, 2014. **Monitoring Process:** EOC rounds are conducted weekly on all patient care areas. **(Attachment: 2)** **Person Responsible:** Lead Engineer	9/19/2014

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□A 701□	Continued From page 35 caused by a water leak from the tube bundle of the boiler located above room 509. During an interview at the same time as the observation, Staff D stated the room was still on the license as a patient room. 2. The bathroom of room 509 had a loose toilet; missing toilet vertical flush pipe, the toilet bowl was stuffed passed the rim with paper, had a light fixture was falling off the wall, and the towel bar was missing. 1st floor □ 3. At Urgent Care there was an accumulation of dust and a bundled blood stained bandage with tape wedged at the top of the corridor door holding the door in the open position. Basement 4. In the Pre-Op room, a sink cabinet had missing laminate at a corner. During an interview at the same time as the observation, Staff N (Disaster Coordinator) stated he replaced the laminate at the edge of the cabinet's counter that the evaluator had pointed out on 4/1/14, and that laminate was being bought, and that the facility had a program to replace all the counters. 5. In the Pre Op room 3 of 3 gurneys had cracks in the upholstery, and 1 of 3 had a three inch tear	□A 701□	**2.).Corrective Actions:** The toilet bowl was replaced, the vertical flush valve pipe was installed, the room was cleaned, the light fixtures fixed, the towel bar replaced and the whole room repainted. **(Attachment: 3)** **Date of Implementation**: September 24, 2014 **Monitoring Process:** EOC rounds are conducted weekly in all patient care areas. **Person Responsible:** Lead Engineer **1st Floor** **3).Corrective Actions:** The tape wedge at the top of the corridor door was immediately removed and terminal cleaning was done in Urgent Care. Urgent Care staff was In-serviced on infection control and door propping **(Attachment 3)**. **Date of Implementation:** September 29, 2014 **Monitoring Process:** EOC rounds are conducted weekly in all patient care areas. **Person Responsible:** Lead Engineer **Basement** **4).Corrective Actions:** The Pre-Op room missing laminate was replaced **(Attachment 3)**. **Date of Implementation**: September 29, 2014 **Monitoring Process:** EOC rounds are conducted weekly in all patient care areas. **Person Responsible:** Lead Engineer **5).Corrective Actions:** The defective pads on the gurneys in Pre Op room 3 were replaced **(Attachment 3)**. **Date of Implementation:** October 7, 2014 **Monitoring Process:** EOC rounds are conducted weekly for all patient care areas. **Person Responsible**: Lead Engineer	9/24/2014 9/29/2014 9/29/2014 10/7/2014

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□A 701□	Continued From page 36 □through the upholstery visibly exposing the foam padding beneath. 6. In Operating Room (OR) 3, the □-ray box had missing paint and rust at the frame front of the box. During an interview at the same time as the observation, Staff C (CEO) stated that he could see the rust at the □-ray box. 7. In OR 3, a cabinet had missing laminate at the edge and doors. During an interview at the same time as the observation, Staff N stated the cabinet was part of the casement work to be replaced. 8. In OR 3, the ceiling surgical lamp arm had an accumulation of dust. During an interview at the same time as the observation, Staff C stated that the surgical lamp would be over the patient. 9. In OR 2, the □-ray box's front plexi glass was loose and had tape and adhesive on the glass and frame box. 10. In OR 2, there was tape placed across a thermostat. During an interview at the same time as the observation, Staff N stated that the thermostat was an old thermostat that was no longer in use, and that the thermostat and tape needed to be removed and replaced with a cover plate.	□A 701□	**6).Corrective Actions:** The □ ray box in OR 3 was refurbished. **(Attachment 3)** **Date of Implementation:** September 10, 2014 **Monitoring Process:** EOC rounds are conducted weekly on all patient care areas. **Person Responsible:** Lead Engineer	9/10/2014
			7).Corrective Actions: OR 3 the cabinet missing laminate a the edges and doors have been repaired(**Attachment 3 & 6** **Date of Implementation:** October 7, 2014 **Monitoring Process:** EOC rounds are conducted weekly for all patient care areas. **Person Responsible:** Lead Engineer	10/7/2014
			8).Corrective Actions: In OR 3 the ceiling surgical light arm and room had immediate terminal cleaning. **(Attachment 3 & 7)** **Date of Implementation:** September 10, 2014 **Monitoring Process**: EOC rounds are conducted weekly on all patient care areas. **Person Responsible**: Lead Engineer	9/10/2014
			9).Corrective Actions: In OR 2, the xray box plexi glass was replaced and fastened appropriately. **(Attachment 3)** **Date of Implementation**: September 24, 2014 **Monitoring Process**: EOC rounds is conducted weekly for all patient care areas. **Person Responsible:** Lead Engineer	9/24/2014
			10).Corrective Actions: In OR 2, Tape was removed from the thermostat and the thermostat in OR □2 was put back into service. **(Attachment 3)** **Date of Implementation:** September 11, 2014 **Monitoring Process:** EOC rounds are conducted weekly for all patient care areas. **Person Responsible:** Lead Engineer	9/11/2014

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□A 701□	Continued From page 37 11. In OR 1, the □-ray box□s front plexi glass was cracked, had tape and adhesive on the glass and frame box, and had a knotted electrical cord with accumulation of dust at the knotted area of the cord, and tape at the plug. During an interview at the same time as the observation, Staff N stated that the housekeeper was supposed to unknot the electrical cord to clean it. At the same time as the interview, Staff N unknotted the cord, which then fell into the biohazard bin, which was pointed out to the Disaster Coordinator. 12. The Decontamination Room had unpainted plaster at the wall under the announcement speaker. 13. The Sterilization Room had unpainted plaster at the wall next to the paper towel dispenser. During an interview at the same time as the observation, Staff N stated that they were in the process of painting, and that the problem of having unpainted wall with exposed plaster is that the wall cannot be cleaned. 14. In the Recovery Room, there was a cabinet with peeling paint. 15. In the Recovery Room, there was a dirty braided cord at the nurse call. During an interview at the same time as the observation, Staff N stated that the cord at the nurse call needed to be replaced because it was dirty.	□A 701□	**11).Corrective Actions:** In OR 1, the plexi glass on the □ ray box was replaced and the knotted electrical cord that fell in biohazardous bin was sanitized and secured to prevent tripping. **(Attachment 3)** **Date of Implementation:** September 12, 2014 **Monitoring Process:** EOC rounds are conducted weekly in all patient care areas. **Person Responsible:** Lead Engineer	9/12/2014
			12).Corrective Actions: The plaster on the wall in the Decontamination Room in Surgery Department was repainted. **(Attachment 3)** **Date of Implementation**: September 22, 2014 **Monitoring Process**: EOC rounds are conducted weekly for all patient care areas. **Person Responsible**: Lead Engineer	9/22/2014
			13).Corrective Actions: The plaster on the wall in the sterilization room, including the wall next to the paper towel dispenser, was repainted. **(Attachment 3)** **Date of Implementation**: September 22, 2014 **Monitoring Process**: EOC rounds are conducted weekly for all patient care areas. **Person Responsible**: Lead Engineer	9/22/2014
			14).Corrective Actions: The cabinets in the recovery room were repainted. **(Attachment 3 & 8)** **Date of Implementation**: September 25, 2014 **Monitoring Process**: EOC rounds are conducted weekly for all patient care areas. **Person Responsible**: Lead Engineer	9/25/2014
			15).Corrective Actions: The nurse call braided cord in the Recovery Room was replaced **(Attachment 3)**. **Date of Implementation**: Sept 5, 2014 **Monitoring Process**: EOC rounds are conducted weekly for all patient care areas. **Person Responsible**: Lead Engineer:	9/5/2014

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□A 701□	Continued From page 38 Van Nuys campus On August 19, 2014 between 8:30 a.m. and 3:30 p.m., the following conditions existed in the Van Nuys psychiatric campus. Station 1 There were fixtures throughout that could be used as anchor points to tie to that can hold a person's weight throughout the unit; including exposed plumbing pipes (water supply to toilet and sink drain line), standard faucets, and mortise hinges. 16. Patient rooms, including rooms 101, 102, 104, 105, 106, 107, 108, 109, and 110 had exposed plumbing pipes that could be used as anchors. Bathroom of room 103 was occupied during observation. Between 1:30 p.m. and 2:58 p.m., during an interview, the Lead Engineer stated that the anti-ligature plumbing covers for the P-traps would be installed no later than 3 weeks (9/12/14). At the same time during an interview, Staff B (Administrator) (Van Nuys campus) stated that the facility has two extra staff every day, in every unit monitoring the areas that could be used as anchors in every room, every 15 minutes, and that starting today (8/19/14) a monitoring form/log will be documented. 17. Patient rooms, including rooms 101, 102, 1d4, 105, 106, 107, 108, 109, and 110 had standard	□A 701□	**Van Nuys** **Station 1** **16).Corrective Actions**: P trap covers were installed in rooms 101, 102, 104, 105, 106, 107, 108, 109, 110 and including room 103 to cover the exposed plumbing pipes. **(Attachment)** **Date of Implementation**: completed September 12, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily.**(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing	9/12/2014

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□A 701□	Continued From page 39 mortise hinges that could be used as anchors. Between 1:30 p.m. and 2:58p.m., during an interview, Staff P (Lead Engineer) stated that the anti-ligature hinges would be installed no later than 5 weeks (9/26/14). At the same time during an interview, Staff B stated that the facility has two extra staff every day, in every unit monitoring the areas that could be used as anchors in every room, every 15 minutes, and that starting today (8/19/14) a monitoring form/log will be documented. 18. Room 101 had window blinds with an accessible cord. The cord could be used to tie onto an anchor point. 19. Shower room □4 and 5 standard mortise hinges that could be used as anchors. Between 1:30 p.m. and 2:58 p.m., during an interview, Staff P stated that the anti-ligature hinges would be installed no later than 5 weeks (9/26/14). At the same time during an interview, Staff B stated that the facility has two extra staff every day, in every unit monitoring the areas that could be used as anchors in every room, every 15 minutes, and that starting today (8/19/14) a monitoring form/log will be documented. 20. The dining room sink had a standard faucet and exposed plumbing that could be used as anchors.	□A 701□	**17). Corrective Actions**: A third party certified company was hired to replace mortise hinges with anti-ligature hinges in rooms 101, 102, 104, 105, 106, 107, 108, 109, 110. **(Attachment 17 -29)** Originally scheduled to be done by 9/26/14, the manufacturer needed additional time to complete the back order. **Date of Implementation**: Completed October 22, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. .**(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing **18). Corrective Actions**: Room 101 window blind accessible cord was shortened and the blinds were secured to the base of the window. **(Attachment 9a)** **Date of Implementation**: August 19, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly. .**(Attachment 2)** **Person Responsible**: Director of Engineering **19). Corrective Actions**: A third party certified company was hired to replace mortise hinges with anti-ligature hinges in Shower Room □4 & □5.(**Attachment 10).** Originally scheduled to be done by 9/26/14, the manufacturer needed additional time to complete the back order. **Date of Implementation**: October 22, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. **(Attachment 2)** **Person Responsible**: Director of Engineering & nursing **20). Corrective Actions**: The standard faucet on the dining room sink was replaced with anti-ligature faucet and the p-trap cover was installed. **(Attachment 11)** **Date of Implementation**: Faucet - August 19, 2014; P-Trap cover □ September 12, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. .**(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing	10/22/2014 8/19/2014 10/22/2014 8/19/2014 9/12/2014

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□A 701□	Continued From page 40 Between 1:30 p.m. and 2:58 p.m. during an interview Staff P stated that the anti-ligature plumbing covers for the P-traps would be installed no later than 3 weeks (9/12/14), and the anti-ligature faucets would be installed by the end of the day (8/19/14). At the same time during an interview, Staff B stated that the facility has two extra staff every day, in every unit monitoring the areas that could be used as anchors in every room, every 15 minutes, and that starting today (8/19/14) a monitoring form/log will be documented. 21. The dining room bathroom had a standard faucet, exposed plumbing, standard hinges, and a metal shelf that could be used as anchors. Between 1:30 p.m. and 2:58 p.m., during an interview, Staff P stated that the anti-ligature hinges would be installed no later than 5 weeks (9/26/14), the anti-ligature plumbing covers for the P-traps would be installed no later than 3 weeks (9/12/14), and the anti-ligature faucets would be installed by the end of the day (8/19/14). At the same time during an interview, Staff B stated that the facility has two extra staff every day, in every unit monitoring the areas that could be used as anchors in every room, every 15 minutes, and that starting today (8/19/14) a monitoring form/log will be documented. 22. The women's patient common bathroom had a standard faucet and exposed plumbing that could be used as anchors.	□A 701□	**21). Corrective Actions**: Dining room bathroom standard faucet was replaced with anti-ligature faucet, the p-trap cover was installed, the metal shelf was removed and a third party certified company was hired to replace mortise hinges with anti-ligature hinges **(Attachment 12)** **Date of Implementation**: Faucet □August 19, 2014; P-Trap cover □September 12, 2014 ; Metal Shelf removed □August 19, 2014; Anti-ligature hinges - September 26, 2014. **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. .**(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing **22).Corrective Actions**: Women□s patient common bathroom standard faucet was replaced with an anti-ligature faucet and the p □trap cover was installed to cover exposed plumbing. **Attachment 13)** **Date of Implementation**: Faucet □August 19, 2014; P-Trap cover □September 12, 2014. **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. .**(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing	8/19/2014 9/12/2014 9/26/2014 8/19/2014 9/12/2014

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□A 701□	Continued From page 41 Between 1:30 p.m. and 2:58p.m., during an interview, Staff P stated that the anti-ligature plumbing covers for the P-traps would be installed no later than 3 weeks (9/12/14), and the anti-ligature faucets would be installed by the end of the day (8/19/14). At the same time during an interview, Staff B stated that the□facility has two extra staff every day, in every unit monitoring the areas that could be used as anchors in every room, every 15 minutes, and that starting today (8/19/1.4) a monitoring form/log will be documented. 23. The men's patient common bathroom had standard faucet and exposed plumbing that could be used as anchors. Between 1:30 p.m. and 2:58p.m., during an interview, Staff P stated that the anti-ligature plumbing covers for the P-traps would be installed no later than 3 weeks (9/12/14), and the anti-ligature faucets would be installed by the end of the day (8/19/14). At the same time during an interview, Staff B stated that the facility has two extra staff every day, in every unit monitoring the areas that could be used as anchors in every room, every 15 minutes, and that starting today (8/19/14) a monitoring form/log will be documented. 24. Patient rooms, including rooms 101, 109, and 110 had loose toilets. 25. Patient rooms, rooms 108 and 109 loose sinks.	□A 701□	**. 23). Corrective Actions**: Men□s patient common bathroom standard faucet replaced with an anti-ligature faucet and the p □trap cover was installed to cover exposed plumbing. **Attachment 14)** **Date of Implementation**: Faucet □August 19, 2014; P-Trap cover □September 12, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. .**(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing **24). Corrective Actions**: Toilets in rooms 101, 109 & 110 were re-secured. **(Attachment 15)** **Date of Implementation**: August 19, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. .**(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing **25). Corrective Actions**: Sinks in room 108 & 109 were remounted and secured. **(Attachment 15a)** **Date of Implementation**: August 19, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. .**(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing	8/19/2014 9/12/2014 8/19/2014 8/19/2014

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□A 701□	Continued From page 42 26. Patient rooms, including rooms 101 and 107 had leaking plumbing at the toilet pipes. 27. Dining room bathroom had a water leak at the toilet plumbing. Station 2 There were fixtures throughout that could be used as anchor points to tie to that can hold a person's weight throughout the unit; including exposed plumbing pipes (water supply to toilet and sink drain line), standard faucets, and mortise hinges. 28. Patient rooms, including rooms 203, 205, 207, 209, 210,211,212, 213,214, 215, 217,218, 219,220, 222, and 226 had exposed plumbing pipes that could be used as anchors. Between 1:30 p.m. and 2:58 p.m. during an interview the Lead Engineer stated that the anti-ligature plumbing covers for the P-traps would be installed no later than 3 weeks (9/12/14). At the same time during an interview, Staff B stated that the facility has two extra staff every day, in every unit monitoring the areas that could be used as anchors in every room, every 15 minutes, and that starting today (8/19/14) a monitoring form/log will be documented. 29. Patient rooms, including rooms 215, 217, 219, 220, 222, and. 226 had standard faucets that could be used as anchors. Between 1:30p.m. and 2:58p.m. during an interview the Lead Engineer stated that	□A 701□	**26). Corrective Actions**: Toilet pipes in room 101 & 107 were replaced & repaired. **(Attachment 16)** **Date of Implementation**: August 19, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. .**(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing **27). Corrective Actions**: The dining room toilet plumbing pipes were repaired. **(Attachment 17)** **Date of Implementation**: August 19, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. .**(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing **Station 2** **28). Corrective Actions**: P trap covers were installed in rooms 203, 205, 207, 209, 210, 211, 212, 213, 214, 215, 217, 218, 219, 220, 222 and 226 to cover exposed plumbing. **(Attachment 18)** **Date of Implementation**: August 19, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. .**(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing **29). Corrective Actions**: The standard faucets were replaced with anti-ligature faucets in patient rooms 215, 217, 219, 220, 222, and 226. **(Attachment 19)** **Date of Implementation**: August 19, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. .**(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing	8/19/2014 8/19/2014 8/19/2014 8/19/2014

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□A 701	Continued From page 43 anti-ligature faucets would be installed by the end of the day (8/19/14). At the same time during an interview, Staff B stated that the facility has two extra staff every day, in every unit monitoring the areas that could be used as anchors in every room, every 15 minutes, and that starting today (8/19/14) a monitoring form/log will be documented. 30. The shaving room had a standard faucet that could be used as an anchor. 31. Patient rooms, including rooms 203, 205, 207, 209, 210, 211, 212,213,214,215,217,218, 219, 220, 222, and 226 had standard mortise hinges that could be used as anchors. Between 1:30 p.m. and 2:58 p.m., during an interview, Staff P stated that the anti-ligature hinges would be installed no later than 5 weeks (9/26/14). At the same time during an interview, Staff B stated that the facility has two extra staff every day, in every unit monitoring the areas that could be used as anchors in every room, every 15 minutes, and that starting today (8/19/14) a monitoring form/log will be documented. 32. Shower room □3 had mortise hinges that could be used as anchors. Between 1:30 p.m. and 2:58p.m., during an interview, Staff P stated that the anti-ligature hinges would be installed no later than 5 weeks (9/26/14). At the same time during an interview, Staff B	□A 701□	**30). Corrective Actions**: The standard faucet was replaced with an anti-ligature faucet in the shaving room. **(Attachment 20)** **Date of Implementation**: August 19, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. **(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing **31). Corrective Actions**: A third party certified company was hired to replace mortise hinges with anti-ligature hinges in rooms 203, 205, 207, 209, 210, 211, 212, 213, 214, 215, 217, 218, 219, 220, 222, and 226. **(Attachment 21).** Originally scheduled to be done by 9/26/14, the manufacturer needed additional time to complete the back order. **Date of Implementation**: October 22, 2014, **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. .**(Attachment 2) Person Responsible**: Director of Engineering & Nursing **32). Corrective Actions**: A third party certified company was hired to replace mortise hinges with anti-ligature hinges in Shower room □3. **(Attachment 22).** Originally scheduled to be done by 9/26/14, the manufacturer needed additional time to complete the back order. **Date of Implementation**: October 22, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. .**(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing	8/19/2014 10/22/2014 10/22/2014

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□A 701□	Continued From page 44 stated that the facility has two extra staff every day, in every unit monitoring the areas that could be used as anchors in every room, every 15 minutes, and that starting today (8/19/14) a monitoring form/log will be documented. 33. The observation room bathroom had exposed plumbing, and standard hinges at bathroom and room doors that could be used as anchors. Between 1:30 p.m. and 2:58p.m., during an interview, Staff P stated that the anti-ligature plumbing covers for the P-traps would be installed no later than 3 weeks (9/12/14), and that the anti-ligature hinges would be installed no later than 5 weeks (9/26/14). At the same time during an interview, Staff B stated that the facility has two extra staff every day, in every unit monitoring the areas that could be used as anchors in every room, every 15 minutes, and that starting today (8/19/14) a monitoring form/log will be documented. 34. Bathroom in patient room 212 had a loose toilet. 35. Bathroom in patient room 214 had a loose sink. 36. Station 2 Patient patio had an avocado tree with branches against and over the building roof line, creating access to the roof for potential rodent activity. Outpatient (Van Nuys campus)	□A 701□	**33). Corrective Actions**: A P trap cover was installed and a third party certified company was hired to replace mortise hinges with anti-ligature hinges in the observation room bathroom. **(Attachment 23).** Originally scheduled to be done by 9/26/14, the manufacturer needed additional time to complete the back order. **Date of Implementation**: October 22, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. .**(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing **34). Corrective Actions**: The toilet in room 212 was re-fastened and secured. **(Attachment 24)** **Date of Implementation**: August 19, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. .**(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing **35). Corrective Actions**: The sink in room 214 was re-fastened and secured. **(Attachment 24a)** **Date of Implementation**: August 19, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. **(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing **36). Corrective Actions**: The avocado tree branches at Station 2 patient patio were trimmed away from the building roof. **(Attachment 24b)** **Date of Implementation**: August 19, 2014 **Monitoring Process**: Security conducts daily monitoring of the grounds. **(Attachment 2)** **Person Responsible**: Security **Van Nuys** **Outpatient**	10/22/2014 8/19/2014 8/19/2014 8/19/2014

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□A 701□	Continued From page 45 37. Common Unisex bathroom by group meeting room II, had a standard faucet, exposed plumbing pipes and standard mortise hinges at the door that could be used as anchors. Between 1:30 p.m. and 2:58 p.m., during an interview, Staff P stated that the anti-ligature hinges would be installed no later than 5 weeks (9/26/14), the anti-ligature plumbing covers for the P-traps would be installed no later than 3 weeks (9/12/14), and the anti-ligature faucets would be installed by the end of the day (8/19/14). At the same time during an interview, Staff 8 stated that the facility has two extra staff every day, in every unit monitoring the areas that could be used as anchors in every room, every 15 minutes, and that starting today (8/19/14) a monitoring form/log will be documented. 38. Common Unisex bathroom by group meeting room II, had a water leak at the toilet's flush pipe. Culver City Campus Pavilion 6th floor Pavilion There were fixtures throughout that could be used as anchor- points to tie to that can hold a person's weight throughout the unit; including exposed plumbing pipes (water supply to toilet and sink drain line), standard faucets, and mortise hinges. 6th floor Unit A Psychiatric	□A 701□	**37). Corrective Actions**: The standard faucet was replaced with anti-ligature faucet and the p □trap cover was installed to cover exposed plumbing in the common unisex bathroom. A third party certified company was hired to replace mortise hinges with anti-ligature hinges also in the common unisex bathroom. **(Attachment 25)** **Date of Implementation**: Faucet □ August 19, 2014; P-Trap cover □ September 12, 2014; Anti-ligature hinges- October 22, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. **(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing **38). Corrective Actions**: Loose toilets in common room bathroom by group room II loose toilet bolts were replaced & tightened. **(Attachment 25a)** **Date of Implementation**: Bolts replaced & tightened 8/19/14 **Monitoring Process**: EOC monitoring is to be done by Engineering weekly and weekly monitoring by IOP staff. **(Attachment 2)** **Person Responsible**: Director of Engineering & Director of IOP **Culver City** **6th Floor Pavilion – Unit A** **39).Corrective Actions**: P trap covers were installed in rooms 605, 606, 607, 608 and 609 to cover the exposed plumbing pipes. **(Attachment 26)** **Date of Implementation**: September 19, 2014 **Monitoring Process**: Behavioral health is conducting daily inspection of patient rooms including checking of p trap covers. In addition the monitoring of p trap covers was also added to the Bi-annual check list of the Environment of Care rounds for patient care areas. **(Attachment 27)** **Person Responsible**: Director of BHU & Director of Engineering	8/19/2014 9/12/2014 10/22/2014 8/19/2014 9/19/2014

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□A 701□	Continued From page 46 On 8/20/14 between 8:30a.m. and 9:04a.m. the following conditions existed in 6th floor Psychiatric Unit A. 39. Patient rooms, including rooms 605, 606, 607, 608, and 609 had exposed plumbing pipes that could be used as anchors. 40. Patient rooms, including rooms 602, 604, 605, 606, 607, 608, and 609 had one ligature resistant mortise hinge, and three standard mortise hinges that could be used as anchors on the doors. 41. Shower room 1 had a make-shift safety grab bar. The grab bar had two 2 inch by 1/4 inch spaces between the bar & plate that could be used as an anchor. The shower room also had standard mortise hinges. 42. Shower room 4 had a make-shift safety grab bar. The grab bar had two spaces between the bar & plate that could be used as an anchor. There were also pluming extensions at the shower head pipe that could be used as an anchor. The shower room also had standard mortise hinges. 6th floor Unit B Psychiatric On 8/20/14 between 9:04a.m. and 9:30a.m. the following conditions existed in 6th floor Psychiatric Unit B. 43. Patient rooms, including rooms 622, 624, 625, 627, 628 and 629 had exposed plumbing pipes that could be used as anchors. 44. Patient rooms, including rooms 622, 623, 624,	□A 701□	**40).Corrective Actions**: A third party certified company replaced mortise hinges with anti-ligature hinges in rooms 602, 604, 605, 606, 607, 608 and 609. **(Attachment 28)** **Date of Implementation**: Completed October 22, 2014 **Monitoring Process**: Behavioral health conducting daily inspection of patient rooms including checking of door hinges. **(Attachment 27)** **Person Responsible**: Director of Engineering & Director of BHU **41).Corrective Actions**: Shower room 1: The safety grab bar was repaired and a third party certified company replaced mortise hinges with anti-ligature hinges. **(Attachment 28)** **Date of Implementation**: September 15, 2014 and October 22, 2014, respectively. **Monitoring Process**: Behavioral health conducting daily inspection of patient rooms/shower rooms including checking of safety grab bars and door hinges. **(Attachment 27)** **Person Responsible**: Director of Engineering & Director of BHU **42).Corrective Actions**: Shower room 4: The safety grab bar was repaired and a third party certified company replaced the mortise hinges with anti-ligature hinges. **(Attachment 29)** The plumbing extension at the shower head pipe was removed. **Date of Implementation**: Grab bar repaired - September 15, 2014; Hinges replaced □ October 22, 2014; Plumbing extension removed □ August 22, 2014 **Monitoring Process**: Behavioral health conducting daily inspection of patient rooms/shower rooms including checking the safety grab bars, the anti-ligature hinges and the shower room in general. **(Attachment 27)** **Person Responsible**: Director of Engineering& Director of BHU **6th Floor – Unit B Psychiatric** **43).Corrective Action**s: P trap covers were installed in rooms 622, 624, 625, 627, 628 and 629 to cover the exposed plumbing pipes. **(Attachment 30)** **Date of Implementation**: September 19, 2014 **Monitoring Process**: Behavioral health conducting daily inspection of patient rooms including checking of p trap covers. **(Attachment 27)** In addition the monitoring of p trap covers was also added to the Bi-annual check list of the Environment of Care rounds for patient care areas. **(Attachment 2)** **Person Responsible**: Director of BHU & Director of Engineering **44). Corrective Action**s: A third party certified company replaced the mortise hinges with anti-ligature hinges in rooms 622, 623, 624, 625, 627, 628 and 629. **(Attachment 31)** **Date of Implementation**: October 22, 2014 **Monitoring Process**: Behavioral health conducting daily inspection of patient rooms including checking of door hinges. **(Attachment 27)** **Person Responsible**: Director of Engineering & Director of BHU	10/22/2014 9/15/2014 10/22/2014 8/22/2014 9/15/2014 10/22/2014 9/19/2014 10/22/2014

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□A 701□	Continued From page 47 625, 627, 628 and 629 had one ligature resistant mortise hinge, and three standard mortise hinges that could be used as anchors on the doors. 45. The men's common bathroom by day room had a standard faucet and an exposed plumbing pipe (P-trap) under the sink that could be used as an anchor. 6th floor Unit C Psychiatric On 8/20/14 between 9:30a.m. and 9:45a.m. the following conditions existed in 6th floor Psychiatric Unit C. 46. Patient rooms, including rooms 630, 631, 632, 634, 635, and 639/day room had exposed plumbing pipes that could be used as anchors. 47. Patient rooms, including rooms 630, 631, 632, 634, 635, 636, and 639/day room had one ligature resistant mortise hinge, and three standard mortise hinges that could be used as anchors on the doors. 48. Patient rooms, including rooms 634, 635, and 639/day room had standard faucets that could be used as anchors. 49. Patient rooms 632 and 636 had missing soap dispensers. 50. Patient room 634 had a missing soap dispenser cover. 51. Room 636 (seclusion room) had an	□A 701□	**45) Corrective Action**s: The standard faucet in the men□s common bathroom was replaced with anti-ligature faucet and a p trap cover was installed to cover the exposed plumbing pipe under the sink. **(Attachment 32)** **Date of Implementation**: September 19, 2014 **Monitoring Process**: Behavioral health conducting daily inspection of patient rooms/bathrooms including checking of faucets and the p trap covers in the men□s common bathroom. **(Attachment 27 & 2)**. In addition the monitoring of p trap covers and anti-ligature faucets was also added to the Bi-annual check list of the Environment of Care rounds for patient care areas. **Person Responsible**: Director of Engineering & Director of BHU. **6th Floor – Unit C Psychiatric** **46). Corrective Action**s: P trap covers were installed in rooms 630, 631, 632, 634, 635 and 639 to cover the exposed plumbing pipes. **(Attachment 33)** **Date of Implementation**: September 19, 2014 **Monitoring Process**: Behavioral health is conducting daily inspection of patient rooms which includes checking of p trap covers. **(Attachment 27)** In addition the monitoring of p trap covers was also added to the Bi-annual check list of the Environment of Care rounds for patient care areas. **(Attachment 2)** **Person Responsible**: Director of BHU & Director of Engineering **47).Corrective Action**s: A third party certified company replaced the mortise hinges with anti-ligature hinges in rooms 630, 631, 632, 634, 635, 636 and 639. **(Attachment 31)** **Date of Implementation**: October 22, 2014 **Monitoring Process**: Behavioral health is conducting daily inspection of patient rooms which includes checking of door hinges. **(Attachment 27)** **Person Responsible**: Director of Engineering & Director of BHU **48).Corrective Action**s: The standard faucet was replaced with anti-ligature faucet in rooms. 634, 635 and 639. **(Attachment 34)** **Date of Implementation**: September 15, 2014 **Monitoring Process**: Behavioral health is conducting daily inspection of patient rooms which includes checking of faucets. **(Attachment 27).** The criteria to monitor anti-ligature faucets was also added to the check list of the Environment of Care rounds which is conducted twice a year in patient care areas. **(Attachment 2)** **Person Responsible**: Director of Engineering & Director of BHU **49).Corrective Action**s: Soap dispensers were installed in rooms 632 and 636. **(Attachment 35)** **Date of Implementation**: August 20, 2014 **Monitoring Process**: Behavioral health is conducting daily inspection of patient rooms which includes checking of soap dispensers. **(Attachment 27)** **Person Responsible**: Director of Engineering & Director of BHU **50).Corrective Action**s: A soap dispenser was installed in room 634. **(Attachment 36)** **Date of Implementation**: August 20, 2014 **Monitoring Process**: Behavioral health is conducting daily inspection of patient rooms which includes checking of soap dispensers. **(Attachment 27)** **Person Responsible**: Director of Engineering & Director of BHU **51).Corrective Action**s: Room 636 (seclusion room) was stripped and waxed removing the dirt around the foot of the bed	9/19/2014 9/19/2014 10/22/2014 9/15/2014 8/20/2014 8/20/2014

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□A 701□	Continued From page 48 accumulation of dirt around foot of the bed. 6th floor Unit D Psychiatric On 8/20/14 between 9:45a.m. and 10:05 a.m., the following conditions existed in 6th floor Psychiatric Unit D. 52. Patient rooms, including rooms 612, 614, 615, 616, 617, 619, 620, and 621 had exposed plumbing pipes that could be used as anchors. 53. Patient rooms; including rooms 610, 612, 614, 615, 616, 617, 619, 620, and 621 had one ligature resistant mortise hinge, and three standard mortise hinges that could be used as anchors on the doors. 54. Patient rooms, including rooms 620 and 621, had standard faucets that could be used as anchors. 55. Patient room 612 had a missing soap dispenser. 56. Patient room 612 had a gap between the edge of the sink counter and the wall. 57. Patient room 617 had a loose sink and damaged plaster at the wall around the sink. 58. Patient room 621 had peeling paint at the wall of the bathroom. 4th floor Rehabilitation Unit	□A 701□	**Date of Implementation**: August 20, 2014 **Monitoring Process**: Daily cleaning and rounding are conducted by EVS in the Psych Unit. In addition, detail cleaning is done every weekend. **(Attachment 37 & 38)** **Person Responsible**: Director of EVS **6th Floor – Unit D Psychiatric** **52).Corrective Action**s: P trap covers were installed in rooms 612, 614, 615, 616, 617, 619, 620 and 621 to cover the exposed plumbing pipes. **(Attachment 39)** **Date of Implementation**: September 19, 2014 **Monitoring Process**: Behavioral health is conducting daily inspection of patient rooms which includes checking of p trap covers. **(Attachment 27)** The criteria to monitor p trap covers was also added to the check list of the Environment of Care rounds which is conducted twice a year in patient care areas. **(Attachment 2)** **Person Responsible**: Director of BHU & Director of Engineering **53).Corrective Action**s: A third party certified company replaced mortise hinges with anti-ligature hinges in rooms 610, 612, 614, 615, 616, 617, 619, 620 and 621. **(Attachment 31)** **Date of Implementation**: October 22, 2014 **Monitoring Process**: Behavioral health is conducting daily inspection of patient rooms which includes checking of door hinges. **(Attachment 27)** **Person Responsible**: Director of Engineering & Director of BHU **54).Corrective Action**s: The standard faucet was replaced with anti-ligature faucet in room nos. 620 and 621. **(Attachment 40)** **Date of Implementation**: September 15, 2014 **Monitoring Process**: Behavioral health is conducting daily inspection of patient rooms which includes checking of faucets. **(Attachment 27)** The criteria to monitor anti-ligature faucets was also added to the check list of the Environment of Care rounds which is conducted twice a year in patient care areas. **(Attachment 2)** **Person Responsible**: Director of Engineering & Director of BHU **55).Corrective Action**s: A soap dispenser was installed in room 612. **(Attachment 41)** **Date of Implementation**: August 20, 2014 **Monitoring Process**: Behavioral health is conducting daily inspection of patient rooms which includes checking of soap dispensers. **(Attachment 27)** **Person Responsible**: Director of Engineering & Director of BHU **56).Corrective Action**s: Sink was remounted in room 612 which eliminated the gap between the edge of sink counter and the wall. **(Attachment 42)** **Date of Implementation**: August 26, 2014 **Monitoring Process**: Engineering conducts daily rounds covering all patient rooms in a week. **(Attachment 43)** **Person Responsible**: Director of Engineering **57).Corrective Action**s: Sink was remounted in room 617 and wall was patched and painted. **(Attachment 44)** **Date of Implementation**: August 20, 2014 **Monitoring Process**: Engineering conducts daily rounds covering all patient rooms in a week. **(Attachment 43)** **Person Responsible**: Director of Engineering **58).Corrective Action**s: The peeling paint was removed and the wall of the bathroom in room 621 was painted. **(Attachment 45)** **Date of Implementation**: August 21, 2014 **Monitoring Process**: Engineering conducts daily rounds covering all patient rooms in a week. **(Attachment 43)** **Person Responsible**: Director of Engineering	8/20/2014 9/19/2014 10/22/2014 9/15/2014 8/20/2014 8/26/2014 8/20/2014 8/21/2014

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□A 701	Continued From page 49 59. On 8/20/14 between 10:05 a.m. and 10:23 a.m., Room 423 had a broken diffuser at the wall mounted light fixture by the door. 60. At the construction separation between the back of the 4th floor and the rehabilitation unit at the front of the 4th floor, there was a 3 foot by 5 foot section missing from the gypsum board barrier at the separation. During an interview at the same time as the observation, Staff D stated that the gypsum board barrier is supposed to go all the way up to the ceiling. 3rd floor SICU (surgical intensive care unit) 61. On 8/20/14 at 10:23 a.m., room 332Ahad adhesive paper peeling off of the head wall mounted light fixture. 3rd floor CCU (critical care unit) 62. On 8/20/14 between the time of 10:30 a.m. and 10:40 a.m., the patient rooms' safety monitor was off at the nurses' station. During an interview at the same time as the observation RN (Registered Nurse) 3 stated monitor at the nurses' station was to monitor patients in rooms 333 A through 333L, that the monitor was off because the monitor did not work, and had not worked for a few months.	□A 701	**4th Floor Rehabilitation Unit** **59).Corrective Action**s: The light diffuser in room 423 was replaced. **(Attachment 46)** **Date of Implementation**: August 21, 2014 **Monitoring Process**: Engineering conducts daily rounds covering all patient rooms in a week. **(Attachment 47)** **Person Responsible**: Director of Engineering **60).Corrective Action**s: The 3 foot by 5 foot section of missing gypsum board was extended all the way up to the ceiling by the contractor. Construction crew and Engineering staff were given in-service on ILSM and Above Ceiling process. **(Attachment 48)** **Date of Implementation**: September 1, 2014 **Monitoring Process**: Monitoring for hazards posed by construction (**Attachment 48)** **Person Responsible**: Director of Engineering **3RD Floor SICU (Surgical Intensive Care Unit)** **61).Corrective Action**s: The adhesive paper was removed from the mounted light fixture in room 332A. **(Attachment 49)** **Date of Implementation**: August 27, 2014 **Monitoring Process**: Engineering conducts daily rounds covering all patient rooms in a week. **(Attachment 50)** **Person Responsible**: Director of Engineering **3rd Floor CCU (Critical Care Unit)** **62).Corrective Action**s: The cameras were repaired and safety monitors are back on and working in CCU. **Date of Implementation**. September 8, 2014 **Monitoring Process**: Charge nurse conducts daily monitoring using the Charge RN shift report tool. **(Attachment 51)** **Person Responsible**: Director of Nursing □Critical Care	8/21/2014 9/1/2014 8/27/2014 9/8/2014

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□A 701□	Continued From page 50 3rd floor ACU (ambulatory care unit) On 8/20/14 between 10:44 a.m. and 10:50 a.m. the following conditions existed in 3rd floor ACU. 63. There was damaged upholstery of couches in waiting area outside the □-ray room. 64. There was a one foot crack at the edge between the floor and wall in a stall of the women's common bathroom next to the waiting area outside the □-ray room. 2nd floor 65. On 8/20/14 between 11:02 a.m. and 11:35 a.m., 1 of 4 clean supplies carts was not covered in the clean supply room located across from the nurses' station. 2nd floor Southwest Telemetry 66. On 8/20/14 between 11:02 a.m. and 11:35 a.m., there was a chair in room 202 with torn upholstery. □ 2nd floor Southeast Telemetry On 8/20/14 between 11:02 a.m. and 11:35 a.m. the following conditions existed on the 2nd floor Telemetry Southeast Unit. 67. Room 220 was missing a shower head at the shower stall. 68. Room 220's shower mixing valve was	□A 701□	**3rd Floor ACU (Ambulatory Care Unit)** **63).Corrective Action**s: The damaged couches in the waiting area outside the □-ray room were removed and discarded. **(Attachment 52** **Date of Implementation**: October 21, 2014 **Monitoring Process**: Furniture pieces are checked for damages and tears during the Environment of Care rounds **(Attachment 53)** **Person Responsible**: Director of Engineering **64).Corrective Action**s: The one foot crack between the edge and floor in the stall of the women□s common bathroom next to waiting area outside of □-ray room was repaired **(Attachment 54)** **Date of Implementation**: September 17, 2014 **Monitoring Process**: Engineering conducts daily rounds covering all patient rooms in a week. **(Attachment 43)** **Person Responsible**: Director of Engineering **2nd Floor** **65). Corrective Action**s: Education of staff regarding clean supplies carts in clean supply room must be covered at all times. Charge Nurses to monitor compliance on each shift **(Attachment 55**). **Date of Implementation**: August 22, 2014 **Monitoring Process**: Charge Nurse Rounding on clean supplies cart covers being down and covering supplies at all times (**Attachment 56)** **Person Responsible**: Telemetry Nursing Director **2nd Floor Southwest Telemetry** **66). Corrective Action**s: Chair in room 202 was immediately removed from service and discarded. **(Attachment 57)** **Date of Implementation**: 8-20-14 was discarded. **Monitoring Process**: Charge Nurse & Staff educated to notify Environmental services to remove broken furniture & /or defective upholstery (**Attachment 55).** **Person Responsible**: Telemetry Nurse Director **2nd Floor Southeast Telemetry** **67).Corrective Action**s: The missing shower head in room 220 was replaced. **(Attachment 58)** **Date of Implementation**: August 20, 2014 **Monitoring Process**: Engineering conducts daily rounds covering all patient rooms in a week. **(Attachment 59)** **Person Responsible**: Director of Engineering **68).Corrective Action**s: The shower mixing valve in room 220 was re-reversed to correct water temperature. **(Attachment 60)** **Date of Implementation**: August 21, 2014 **Monitoring Process**: Engineering conducts daily rounds covering all patient rooms in a week. **(Attachment 59)** **Person Responsible**: Director of Engineering	10/21/2014 9/17/2014 8/22/2014 8/20/2014 8/20/2014 8/21/2014

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□A 701□	Continued From page 51 reversed. The patient in room 220 complained that there was no hot water at the shower. Troubleshooting by Staff P at the same time as the complaint revealed that the shower's mixing valve was reversed. 69. Room 221 had a three foot crack at shower stall wall. During an interview, at the same time as the observation Staff R (Lead Man) (for engineering) stated that they (the facility) did not want to replace the shower stall, but instead wanted to repair it. That they were still looking for a vendor to repair the crack at the shower stall wall, that he had called the vendor they usually use for repairs but not received a response, and that he had not called any other vendors. 70. Room 221 was missing a floor drain grate at the shower stall. 71. Room 221 had water leak at the flush pipe of the toilet. 1st floor Laboratory 72. On 8/20/14 at 11:35 a.m., there was a 3ft. by 3 ft. sign water damage and unpainted plaster at the ceiling above Centar machine in the main laboratory. Pharmacy 73. On 8/20/14 at 11:50 a.m., there were signs of water damage at 3 pharmacy ceiling light fixtures	□A 701□	**69**).**Corrective Action**s: The crack in the shower stall wall in room 221 was repaired. **(Attachment 61)** **Date of Implementation**: September 23, 2014 **Monitoring Process**: Engineering conducts daily rounds covering all patient rooms in a week. **(Attachment 59)** **Person Responsible**: Director of Engineering	9/23/2014
			70).Corrective Actions: The floor drain grate at the shower stall in room 221 was replaced. **(Attachment 62)** **Date of Implementation**: August 21, 2014 **Monitoring Process**: Engineering conducts daily rounds covering all patient rooms in a week. **(Attachment 59)** **Person Responsible**: Director of Engineering	8/21/2014
			71).Corrective Actions: The leaky flush pipe of the toilet in room 221 was replaced. **(Attachment 63)** **Date of Implementation**: August 21, 2014 **Monitoring Process**: Engineering conducts daily rounds covering all patient rooms in a week. **(Attachment 59)** **Person Responsible**: Director of Engineering	8/21/2014
			1st Floor **Laboratory** **72).Corrective Action**s: The ceiling above the Centaur machine in the Laboratory was repaired and painted. The pipe causing condensation was insulated. **(Attachment 64)** **Date of Implementation**: August 25, 2014 **Monitoring Process**: Weekly rounds are conducted by Engineering in non-patient room areas **(Attachment 65)**. Environment of Care rounds are conducted weekly covering patient care areas twice a year and non-patient care areas once a year. **Person Responsible**: Director of Engineering & EOC. **Pharmacy** **73).Corrective Action**s: The three Pharmacy light fixtures had light diffusors removed and ceiling assessed for water damage with repair. Brown stains removed off of the light fixtures. **(Attachment 66)** **Date of Implementation**: August 25, 2014	8/25/2014 8/25/2014

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□A 701□	□Continued From page 52 that included brown stains at the light diffusers and frames. Basement Operating Room (OR) 3 74. On 8/20/14 between 11:50 a.m. and 12:20 p.m.., sections of laminate were missing from the door of OR 3. Recovery Area 75. On 8/20/14 between 11:50 a.m. and 12:20 p.m., sections of laminate were missing from the nurses' station. Central Processing 76. On 8/20/14 between 11:50 a.m. and 12:20 p.m.,1 of 2 autoclaves in central processing was out of order. On 8/21/14 at 2:25p.m., during an interview Staff S (Biomed) stated that the autoclave had been out of service since 11/1/13. That he tried to repair it on 11/1/13 but it was beyond his knowledge and called a vendor, but had trouble with the vendor coming to the hospital because of the hospital's address was attached to a bankruptcy. He also stated that on 11/4/13 he found out the autoclave needed a new separator. That the vendor did not visit the facility until11/31/14, and that the purchase requisition for the separator was done on 12/10/13. That he has had the separator for a month and a half, but has had	□A 701□	**Monitoring Process**: Weekly rounds are conducted by Engineering in non-patient room areas. **(Attachment 65)**. Environment of Care rounds are conducted weekly covering patient care areas twice a year and non-patient care areas once a year. **Person Responsible**: Director of Engineering & EOC **Basement** **Operating Room (OR) 3** **74).Corrective Action**s: The laminate section on the door of OR□3 was repaired. **(Attachment 67).** **Date of Implementation**: August 28, 2014 **Monitoring Process**: Weekly rounds are conducted by Engineering in non-patient room areas **(Attachment 65).** Environment of Care rounds are conducted weekly covering patient care areas twice a year and non-patient care areas once a year. **Person Responsible**: Director of Engineering **Recovery Area** **75).Corrective Action**s: Laminate sections from the nurses□ station was repaired. **(Attachment 69)** **Date of Implementation**: September 9, 2014 **Monitoring Process**: Weekly rounds are conducted by Engineering in non-patient room areas **(Attachment 68)**. Environment of Care rounds are conducted weekly covering patient care areas twice a year and non-patient care areas once a year. **Person Responsible**: Director of Engineering **Central Processing** **76).Corrective Action**s: A third party Biomed Company was hired and put autoclave □2 back into service. **(Attachment 70)** **Date of Implementation**: September 2, 2014 **Monitoring Process**: Biomed conducts semi-annual preventative maintenance on medical equipment. **(Attachment 71)** **Person Responsible**: Biomed Engineer and Director of Engineering	8/28/2014 9/9/2014 9/2/2014

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□A 701□	Continued From page 53 trouble getting the vendor to visit the hospital for repair of the autoclave because of scheduling problems. That the vendor had started working on the autoclave today (8/21/14) and would be completed with the repair in 45 minutes, and should be up and running by Monday (8/25/14). He further stated that the nine month delay in getting the autoclave repaired was in trying to find the correct separator, and that it took a while to get a purchase order. That another reason it took so long was because he had other issues to take care of and did not have a full crew. The Asset"10249 history report had entries dated 11/1/13 that indicated that the unit would not hold steam, entry dated 1/31/14 that indicated unit was checked and found to not hold steam and was informed by the vendor that the unit needed a steam separator, and were waiting on parts. The purchase requisition dated 12/10/13, had a description of steam separator as the part requisitioned. The justification noted was that autoclave II was down due to cold condensation and not holding steam, and that the separator would eliminate the problem. Per the Biomed the purchase requisition is the request for his company to give him a purchase order. The request to purchase dated 8/8/14, indicated a request to purchase a steam separator for autoclave in central supply. The justification noted was that it was for a repair/installation, that autoclave had condensation problem and needed a steam separator installed to resolve the issue. Tower	□A 701□		

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□A 701□	Continued From page 54 6th Floor Detox Unit 77. On August 21, 2014 at 8:43a.m., in room 680, there was a missing cover at the toilet paper dispenser, there was an unpainted plaster patch at the wall next to the toilet, and there was black and green slime at the bed pan washer joint. Single Story Building Exterior West Side 78. OnAugust21, 2014 between 9:10a.m. and 9:35a.m. there were seven bins at the exterior west side of the single storage building. The area was accessible through an interior door with a radiation caution sign. Three of the seven bins had cracked and broken lids on them, and contained trash in clear plastic bags that were visible through the cracked and broken areas of the lids. One of the bags was untied and open, and another bag had an accumulation of moisture in the bag. Four of the seven bins had no lids, and were empty. During an interview at the same time as the observation Staff U (Chief Nuclear Medical Technician) stated that the waste in the bins was nuclear waste from tracers and that the area was a secured area where the nuclear waste was allowed to decay. Radioactive Laboratory 79. On August 21, 2014 at 11 a.m., in the	□A 701□	**Tower** **6th Floor Detox Unit** **77).Corrective Action**s: The toilet paper dispenser was replaced, wall was painted and alkaline deposit on the bed pan washer joint was cleaned in the restroom in room 680. **(Attachment 72)** **Date of Implementation**: August 26, 2014 **Monitoring Process**: Engineering conducts daily rounds covering all patient rooms in a week. **(Attachment 73)** **Single Story Building** **Exterior West Side** **78).Corrective Action**s: The cracked containers with broken lids have been removed and discarded. New covered containers have been purchased and relocated to a secured non-public area. **(Attachment 79)** **Date of Implementation**: September 1, 2014 **Monitoring Process**: On-going. **Person Responsible**: Director of Ancillary Services & Chief Nuclear Medicine Technologist **Radioactive Laboratory** **79). Corrective Action**s: The □bolts□on the exam table in the Nuclear Medicine exam suite have been replaced. **(Attachment 80)** **Date of Implementation**: September 1, 2014 **Monitoring Process**: On-going. **Person Responsible**: Director of Ancillary Services & Chief Nuclear Medicine Technologist	8/26/2014 9/1/2014 9/1/2014

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□A 701□	Continued From page 55 Radioactive Laboratory, (Nuclear Medicine □1) the examination table had two missing nylon fasteners replaced with metal bolts and nuts, with the end of the bolts facing up to where the patient would lie on the table. The end of one of the bolt had a sharp edge, and the nut was loose. 80. Hollywood Campus Emergency Preparedness During observation on 8/18/14 beginning at 10:45 a.m., the hospital's disaster preparedness was reviewed in the presence of Staff L (Director of Food Service). In a concurrent interview, she stated that the hospital was planning for a total of 200 patients and staff for a period of 4 days. She also stated the plan was to utilize dehydrated meal products. Review of the inventory revealed that currently the hospital had 125 meals on hand for approximately two days; however had planned to augment that supply with additionally stocked dry goods such as canned tuna. Review of current stock revealed there were 9 cans each weighing 5 pounds which would equate to 200 servings, a quantity for 1 meal. It is unclear how the hospital would implement the plan when there was no menu, staff guidance, recipes or evaluation of inventory to ensure the development of a comprehensive feeding plan that would meet the nutritional needs and could be implemented in the event of a disaster. In addition, additional review of 8/18/14 at 2:45p.m. of available fluid revealed that the hospital had insufficient quantities of dry milk. The plan as discussed would be inadequate to meet the hospital needs for four days. It was also noted that the dehydrated meal	□A 701□	**Hollywood** **80).Corrective Action**s: A plan was enacted to have on hand a minimum of 4 days of water & 7 days of foods and related supplies on hand based on population of 200. (100 licensed beds and 100 staff and others) as indicated by the policy. **(Attachment 74).** Disaster preparedness meeting minutes **(Attachment 75)** **Date of Implementation**: August 28, 2014 **Monitoring Process**: Monthly inventory inspection will be conducted. **(Attachment 76)** **Person Responsible**: Dietary Manager & Facility Management	8/28/2014

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□A 701□	Continued From page 56 products were stored in a house adjacent to the hospital building which was used as an office for engineering. There were no defined security actions taken to ensure the security of the supply. In an interview on 8/18/14 beginning at 4:30 p.m., with Staff N (Disaster Coordinator), he stated that he followed guidelines set forth by a specialty grant awarded to hospitals for disaster preparedness. He described the grant requested hospitals be self-sufficient for 3 days. He also stated that meetings were held with local hospitals and clinics; however, Staff N was unsure of the involvement of federal and/or local agencies with this hospital committee. Staff N was also asked to demonstrate membership/sponsorship of this committee. As of 8/21/14 at 2 p.m., the hospital was unable to demonstrate coordinated involvement at the local, state or federal level. There were also inconsistencies between hospital departments with respect to timeframes for self-sufficiency. This is a repeat deficiency from the sampled validation survey on April 1, 2014.	□A 701□		
□A 703□	482.41(a)(2) EMERGENCY GAS AND WATER There must be facilities for emergency gas and water supply. This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to have documented evidence of an approved system to provide emergency water and ensure an effective water management plan and supplies to be implemented in a widespread disaster.	□A 703□		

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□A 703□	Continued From page 57 This deficient practice had the potential to result in inadequate supply of drinking water and water for other purposes to all patients and staff during a disaster affecting the hospital and effectively meet the hydration and personal care needs of patients. Finding: On August 19, 2014 at 2:58p.m., during document review there was no approved written plan to provide emergency water as needed to provide care to inpatients and other persons who may come to the hospital in need of care. The facility provided a document that had a policy titled, Loss of Water Policy and procedure, Number: EMP.018, as documented evidence of a system to provide emergency water and ensure an effective water management and supplies to be implemented in a widespread disaster to effectively meet the hydration and personal care needs of patients and staff. Review of the document indicated it was not a policy in effect as evidenced by the lack of an effective date. The document indicated it had not been reviewed or approved by the EOC Committee, Quality Council, Medical Executive Committee, and Governing Body, as evidenced by a lack of dated signatures on the front page and in the Approval section (section 10.0). The document also indicated a failure to assign responsibility as evidenced by no person, department or entity identified in the Responsibility section (section 5.0). During an interview at the same time as the review, Staff D (Corporate Director of Facilities)	□A 703□	**Corrective Action**s: The Loss of Water Policy and Procedure was approved by the EOC Committee, Quality Council Committee, Medical Executive Committee and the Governing Board. **(Attachment 1)** **Date of Implementation**: EOC Committee: July 2014; Quality Council: September 2014; MEC: September 2014; Governing Board: September 2014 **Monitoring Process**: The policy will be reviewed annually and will be presented back to the committees tri-annually. **Person Responsible**: Director of Engineering	07/2014 9/2014

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□A 703□	Continued From page 58 stated the document had not yet been approved as policy, that it had only been approved by the EOC committee, was currently going through the Medical Executive Committee, and then would go to the Governing Board. This is a repeat deficiency from the sampled validation survey on April 1, 2014.	□A 703□		
□A 724□	482.41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This STANDARD is not met as evidenced by: Based on observation, review of hospital documents and staff interviews, the hospital failed to maintain its refrigerators, freezers,. plate warmer and supplies to ensure an acceptable level of safety and quality. Failures resulted in storage of food at unsafe food temperature range. Safe food temperature range is 0 degrees Fahrenheit and below for frozen items and 41 degrees and below for refrigerated items. Storage of food outside of these temperature ranges could result in growth of food borne illness causing microorganisms thereby endangering the safety of patients, staff and visitors. In addition, the use of disposable ware resulted in poor maintenance of food temperatures and unpalatable food. Findings: Hollywood Campus 1. During the initial tour on 8/18/14 beginning at 10 a.m., there was a significant ice build-up within	□A 724□		

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□A 724□	Continued From page 59 the walk-in freezer. There was a large piece of ice, measuring approximately 6" (inches) x 6" x 4," adhered to the metal shelving directly below the blower. Additionally there were pieces of ice measuring from 1" to 4" adhered to the floor, mats on the floor, a buildup of ice on the blower within the unit and a frozen condensation buildup on the air curtain (plastic strips that are adhered to the interior door frame to mitigate the escaping of the cold air). It was noted that the internal thermometer read 10□F. In a concurrent interview with Dietary Staff (OS) 3, "She stated that during the past 2 weeks the unit had not been functioning properly. She also stated that the hospital had several service calls, each vendor indicated the unit was fixed; however the issues persisted with no recent attempts to further address the issue. It was also noted that this temperature depicted an unacceptable temperature (which was designated as a red color) on the thermometer. A follow up observation on 8/18/14 at 12:30 p.m., and 4 p.m., noted the freezer temperature was consistently 32□F. It would be the standard of practice to ensure equipment was maintained in a manner to keep frozen foods frozen (Food Code, 2013). In a follow up interview on 8/19/14 at 12:30 p.m., with OS 3, she stated the previous evening a different vendor evaluated the unit. She further stated she was told the unit had significant issues; however it would not be able to be accurately evaluated until the unit was empty and defrosted. Review of the service work orders dated 7/19/14 noted that the door sweep and door curtain strip required replacement and it was also noted there was an electrical issue with the door frame heater	□A 724□	**Hollywood** **1).Corrective Action**s: A third party vendor repaired the walk-in freezer to meet the temperature requirement and to eliminate ice build ups. **(Attachment 1)** **Date of Implementation**: August 18, 2014 **Monitoring Process**: Dietary staff is monitoring the freezer and refrigerator temperature twice daily. **Person Responsible**: Dietary Manager and Plant Operations	8/18/2014

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□A 724□	Continued From page 60 wire. Review of completed work order dated 7/22/14 noted that 2 out of the 3 items were repaired. There was no documentation that the heater wire repair was completed. It was also noted that the most recent work order was dated 1 month prior; however the issue continued to be unresolved. In an interview on 8/18/14 beginning at 3:30 p.m., with Staff 18, he stated he was told by the vendor that the issue was fixed; however was unable to demonstrate an effective system to ensure that identified maintenance issues were fully resolved. Review of hospital submitted document titled, □Freezer Temperature□dated 8/20/14 noted that despite repair interventions on the evening of 8/18, and early morning hours of 8/19 and 8/20 the facility document titled, □Freezer Temperature Log□dated 8/20/14 demonstrated that 6 of 8 recorded temperatures were greater than 0°F, ranging from 1-35°F. Departmental policy titled, □Temperatures of Refrigerators and Freezers□dated 12/12 noted that □Freezer temperatures shall be 0°F or less.□ Hospital policy titled, □Work Order Request Procedures□dated 11/12 revealed that the Director of Plant Operations was the position accountable and responsible for monitoring and enforcement of the work order request procedures. It was also noted that the work order request form was an electronic system that was accessible on all hospital computers. The policy also depicted that urgent requests would be those that a lack of action would jeopardize the operation of the medical center and procedures for resolution of urgent issues would be corrected by the fastest means possible. Staff N (Disaster Coordinator) was unable to demonstrate the implementation of the work order system for this	□A 724□		

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□A 724□	Continued From page 61 issue. Departmental policy titled, "Management of the Environment of Care" dated 11/12 noted it was the responsibility of the department director as the position responsible for maintaining safety standards. Culver City Campus 1. During general food storage observations on 8/19/14 beg.inning at 2:20p.m., in walk-in refrigerator □2, there was a circular hole of the flooring measuring approximately 6" (inches) x 6 " x 2 " exposing the wood underneath the flooring. It was also noted that at the joint where the wall and flooring met, there were multiple areas where the metal wall material was covered by a brown rust-like material, the wall material was disintegrating, exposing the wood behind the wall. Additionally it was also noted that at the plastic coating of the food storage shelves was disintegrating, exposing a brown, rust-like material that could be wiped off. In a concurrent interview with RD 3 (Registered Dietitian), he stated that he had put a repair work order for the floor; however had not noted the exposed wood on the walls. He also stated he had no response from facility operations regarding an evaluation or proposed solution to the maintenance issue. Dietary document titled "Work Order" dated 7/14/14 (1 month earlier) revealed that while the issue was identified there was no activity with respect to completion of the request. The work order also noted that the hole presented a safety risk to staff and was unsanitary. The standard of practice would be to ensure that equipment remained free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections and was finished to have smooth welds and joints (Food Code, 2013).	□A 724□	**Culver City** **1a).Corrective Actions**: Work order was re-submitted for the circular hole in the floor of refrigerator □2. Repair has been completed. **(Attachment 2)** **Date of Implementation**: 8/21/14 **Monitoring Process**: Weekly monitoring of Work orders process. **(Attachment 3)** **Person Responsible**: RD, Director of Dietary Services & Director of Plant Management **1b) Corrective Actions**: Work order was submitted for refrigerator □2 and the repair of the joint where the wall and floor meet **(Attachment 4)** **Date of Implementation**: Work order submitted 8/21/14; repair completed on 10/21/14 **Monitoring Process**: Work orders are tracked with the FNS department for completion **Person Responsible**: RD, Director of Dietary Services & Director of Plant Management **1c) Corrective Actions**: Wiped off the brown rust like material. Replacement shelving has been ordered; will be installed upon receipt. **(Attachment 5)** **Date of Implementation**: 11/7/14 expected completion **Monitoring Process**: Work orders are tracked with the FNS department for completion. **Person Responsible**: RD, Director of Dietary Services & Director of Plant Management	8/21/2014 10/21/2014 11/7/2014

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	050135	A. BUILDING _____ B. WING _____	08/21/2014

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□A 724□	Continued From page 62 In an interview on 8/20/14 at 9:20a.m., with Staff C (CEO) and A (Administrator), they stated they were recently assigned to provide leadership to the hospital and acknowledged that they were notified during the survey the scope of maintenance issues in relationship to dietetic services. Departmental policy titled, "Repairs" dated 11/12 noted that once the department files a copy of written request in the department " 4.2.4 Maintenance Department initiates repairs within 24-48 hours ... " 2. During the food service observations on 8/19/14 beginning at 12:50 p.m., there was a patient refrigerator in the behavioral health unit. It was noted that in both the refrigerator and freezer there was a build-up of unidentifiable food products. It was also noted that the gaskets on the unit had a brown discoloration, resembling rust. Additionally the gaskets were partially torn and no longer fully adhered to the unit. 3. During general kitchen observations on 8/19/14 beginning at2:50 p.m., there were greater than 10 patient meal delivery trays that were cracked and had exposed metal edges. It would be the standard of practice to ensure that all patient meal delivery utensils be free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections (Food Code, 2013). Hospital policy titled, "Storage of Pots, Dishes, Flatware, Utensils" dated 11/12 noted that "All utensils ...equipment will be kept clean, maintained in good repair ..." 4. The plate warmer has been out of order prior to the first survey in April 2014. All patients are being served food on disposable Styrofoam	□A 724□	**2).Corrective Action**s: The Refrigerator in BHU was replaced. **(Attachment 6)** **Date of Implementation**: August 22, 2014 **Monitoring Process**: Behavioral Health conducts daily environmental rounds including inspection of refrigerators. **(Attachment 7)** **Person Responsible**: Director of BHU **3).Corrective Action**s: The meal delivery trays identified as being cracked with exposed metal edges were immediately removed from service and replaced with new ones from storage. **Date of Implementation**: August 19, 2014 **Monitoring Process**: The condition of patient meal service ware (including trays) will be observed as part of the Routine Infection Control and Food Safety Audit **(Attachment 8)**. **Person Responsible**: RD, Director of Dietary Department **4) Corrective Action**s: A new plate warmer was purchased, delivered and installed at Hollywood **(Attachment 9)** **Date of Implementation**: 9/17/2014 **Monitoring Process**: Equipment functionality is monitored via Plant Operation rounding and the work order process **Person Responsible**: RD, Director of Dietary Department and Director of Plant Management	8/22/2014 8/19/2014 9/17/2014

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□A 724□	Continued From page 63 plates. During food□distribution observations on 8/18/14 beginning at 3:35 p.m., all patient meals were plated using disposable plates, cups and flatware. In a concurrent interview with DS 3, she stated that staff told her the plate warmer was broken. The surveyor asked for an explanation of why a broken plate warmer would cause the hospital to utilize all disposable items. She was unable to explain the rationale. 5. In response to questions about the use of plates in the absence of a plate warmer, DS 3 also acknowledged that during the past 2 weeks (when she took over the position) she had not observed a stock of any dishware or flatware. Van Nuys 6. There was a refrigerator that was labeled "Out of Order" dated 6/4/14. In an interview on 8/19/14 at 4:30p.m. with the Head of Plant Operations, he stated that two weeks earlier the hospital decided that repairing the refrigerator was not ideal because it was too expensive and replacement was more practical. 7. One of the freezers (□5) was observed to read 23 degrees Fahrenheit. The recommended temperature for a freezer is 0 degrees Fahrenheit □ and below. During the survey, arrangements were being made to bring in a refrigerated truck to store the items. It was not clear how long this freezer had not been in good working order. This is a repeat deficiency from the sampled validation survey on 4/1/14.	□A 724□	**5) Corrective Action**s: Dishware and flatware stock implemented for use and purchases made for additional stock **(Attachment 10)** **Date of Implementation**: 9/5/14 **Monitoring Process**: A monthly inventory of china and reusable service ware is maintained at par levels required to meet the facility licensed bed capacity. **(Attachment 11)** **Person Responsible**: RD, Director of Dietary Department and Directors of Plant Management **Van Nuys** **6). Corrective Action**s: Upon further assessment, it was deemed that the refrigerator was repairable and was repaired by an outside vendor. **(Attachment 12)** **Date of Implementation**: October 14, 2014 **Monitoring Process**: Equipment monitoring is conducted by Dietary. **(Attachment 13a)** **Person Responsible**: Dietary **7). Corrective Action**s: A refrigerated truck was ordered to store the items when freezer □5 was observed to read 23 degrees Fahrenheit instead of 0 degrees Fahrenheit. **(Attachment 14)**. **Date of Implementation**: August 29, 2014 **Monitoring Process**: Equipment monitoring is conducted by Dietary **(Attachment 13)** **Person Responsible**: Dietary	9/5/2014 10/14/2014 8/29/2014
A 726	482.41(c)(4) VENTILATION, LIGHT,	A 726		

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A 726	Continued From page 64 TEMPERATURE CONTROLS There must be proper ventilation, light, and temperature controls in pharmaceutical, food preparation, and other appropriate areas. This STANDARD is not met as evidenced by: Based on observation, review of facility documents and staff interviews, the hospital faile to ensure that there was adequate ventilation an proper temperature controls in the kitchen and dry food storage areas. Findings: Hollywood campus 1. During the food production and distribution observations on 8/18/14 beginning at 11:40 a.m., Dietary Staff (OS) 2 was wiping perspiration from his forehead and continuing with food distribution activities without handwashing. It was also noted that the ambient room air temperature was 85□ (degrees) F (Fahrenheit). In a concurrent interview with OS 2, he stated that the room was always hot and that it was verbally mentioned to supervisory staff. He also stated that the only ventilation for the kitchen was an air vent located above the dishwasher. A follow up observation on 8/18/14 at 12:30 p.m., noted that the room temperature increased to 86.5□F. It was also noted that while there was air blowing from the vent, the air was not cool, rather was room temperature. In an interview on 8/18/14 beginning at 5:15 p.m., with Staff V (Engineering Staff), he stated that this was his second day with the campus as plant operations. He also stated that mid- afternoon an employee evaluated the unit and noted that the float which pumped water to the unit was broken. Staff V was unable to	A 726	**Hollywood** **1).Corrective Action**s: A third party vendor serviced the AC and swamp cooler that supplied the cafeteria and kitchen to meet an appropriate temperature. Staff inservices on hand hygiene **(Attachment 1 & 2)** **Date of Implementation**: 9/8/2014 **Monitoring Process**: Dietary conducts room temperature testing twice daily. **(Attachment 3)** **Person Responsible**: Dietary Manager	9/8/2014

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A 726	Continued From page 65 demonstrate that the ventilation in the kitchen was evaluated to ensure that it provided proper ventilation to dietetic services. A follow up observation on 8/18/14 at 5:35p.m., revealed an ambient air temperature in the kitchen of 86□F. 2. During the food storage observations on 8/18/14 beginning at 10:40 a.m., the ambient room temperature in the dry storage area was 74□F. It was noted that the dry storage area contained canned goods as well as dry goods such as crackers, cereals and bakery mixes. In a concurrent interview with Staff L (Director of Food Service), she stated that in accordance with the thermometer in the room the air temperature should be 70° F or below. She also acknowledged that the room thermometer gauge was in the "red" zone (for the thermometer) which depicted that the room was above the upper limit of 70□F. She also stated she was unsure of air supply to the dry storage area. It was also noted that while there was a vent in the room there was no air circulation. Van Nuys At 11:53 a.m. on 8/19/14, the ambient air temperature of the dry storage room was 88.6 degrees Fahrenheit (per surveyor thermometer). There was no visible thermometer hanging in the room. In response to the comment by the surveyor that the room seemed warm, Staff K placed a new room thermometer in the room. At 12:55 p.m., the temperature was 88 degrees Fahrenheit. The dry storage thermometer gauge had exceeded the graduated 80 degree mark indicating that the room was warmer than 80 degrees.	A 726	**2) Corrective Action**s: Storage area is now within standards of 50 to 70 degrees. Action taken to reach these temperatures includes hiring a third party certified vendor to adjust the dampers allowing the required air flow in the area. **(Attachment 1)** **Date of Implementation**: 8/25/14 **Monitoring Process**: Daily monitoring of Dry Food Storage temperatures to ensure compliance with Food Code 2013 of temperatures between 50-70 degrees. Department EOC Rounds and Monthly Infection Control and Food Safety Audits. **(Attachment 4 & 5)** **Person Responsible**: RD, Director of Dietary Department and Director of Plant Management **Van Nuys** **1) Corrective Action**s: The Dry Food storage area was moved to a location that did not contain a refrigerator/freezer unit. The Dry food storage area has been provided a thermometer with daily monitoring of temperatures to ensure compliance with Food Code 2013 temperatures range between 50-70 degrees **Date of Implementation**: 8/20/14 **Monitoring Process**: Daily monitoring of Dry Food Storage temperatures **(Attachment 6).** **Person Responsible**: RD, Director of Dietary Department and Directors of Plant Management	8/25/2014 8/20/2014

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A 726	Continued From page 66 Although there was an air vent in the room, there was a refrigerator/freezer in the room that generated heat possibly contributing to the high room temperature. In an interview with Staff K, she stated that they do not monitor or keep logs of the dry storage room. According to the same policy described above, "All dry goods are stored in storeroom that is clean, dry and well ventilated ... " The dry storage room was not well-ventilated. Improperly stored staple foods could result in poor quality such as deterioration of food products including rancidity and altered flavors. Foods held at less than optimum temperatures could support the growth of microorganisms that promote spoilage and /or food borne illness. Best practices guidelines would ensure dry food staples such as flour, crackers, cake mixes, seasonings, and canned goods should be stored in their original packages at an optimal range 50°F to 70□F. Higher temperatures speed up deterioration (Virginia, Clemson State and Ohio State Universities Cooperative Extension). While the hospital's policy titled, "Food Supply and Storage Procedures" dated 11/12 noted that dry storage areas may be maintained at temperatures ranging from 50-75□F, there were no standard of practice references to support the elevated temperature range. Departmental policy titled, "Surveillance, Prevention, and Control of Infection" dated 11/12 noted that "Adequate ventilation shall be provided in all storage areas ...Lighting, ventilation, and humidity shall be controlled to prevent the growth of microorganisms."	A 726		
□A 747□	482.42 INFECTION CONTROL	□A 747□		

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□A 747□	Continued From page 67 The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases. This CONDITION is not met as evidenced by: Based on observation, review of facility documents and staff interview, the facility failed to meet the Condition of Participation in Infection Control by failing to: 1. Provide a functional and sanitary environment for the provision of surgical services (Refer to A 749). 2. Ensure re-usable surgical instruments were sterilized and stored in accordance with the Association of Peri-Operative Registered Nurse (AORN) Standards. AORN is the National Recognized Standards (NRS) the hospital identified as the standard they followed (Refer to A 749). These deficient practices promote microbial growth and can result in contamination of sterile items. 3. Ensure effective systems for safe food handling to prevent food borne illness. This was evidenced by: a. the storing of food in refrigerators and freezers that were not maintaining temperatures by hospital policies and customary practices; b. not following tube feeding orders to prevent growth of microorganisms; c. failure to sanitize the ice machine as recommended by the	□A 747□	**1). Corrective Actions**□ Monitor sanitary environment of the surgical services; 1) areas free of clutter & non-essential storage, 2) monitor the function of terminal cleaning by EVS, 3) Operating room staff completed competencies on between case cleaning. **(Attachment 1 & 2)** **Date of Implementation**: 10/23/2014 **Monitoring Process**: Twice monthly infection control rounds to review cleanliness of Surgical Services Area **(Attachment 3).** **Person Responsible**: Surgery Department, Infection Control Department **2.) Culver City**: **Corrective Action**s; All re-usable surgical instruments (SI) were re-processed, packaged, and stored in accordance to AORN standards; bin dividers purchased to ensure packages are stored up-right on 9/5/2014. 5 inch stringers were purchased to ensure SI are completely open for processing & implemented on 8/25/2014; 3 M Comply cards purchased and placed into service to ensure tip and lock boxes in peel packs maintain an open position for sterilization on 8/26/14; Purchased new biological incubator and indicator with corresponding supplies for sterilization on 10/10/14 9/8/ 2014; Provided education/in-service to staff on standards for processing, packaging and storing of SI, this includes competency validation and return demonstration **(see Attachments-A-000.2)** **Date of Implementation**: Education SI re-processed August 20, 2014 **Monitoring Process**: Monitoring will be managed during bi-monthly Infection Control rounds with ORT or RN with compliance reported to the regulatory Compliance Committee. **Person Responsible**: Infection Control/OR Director; to be completed on the EOC log and will report results to the Regulatory Compliance Committee & Quality. **2.). Hollywood: Corrective Action**: (p.68)--Failure to ensure proper packaging and storage of re-usable surgical instruments: All surgical instruments were re-processed □during the time of the initial survey□and were packaged in a way that provided for adequate sterilant contact by adding fewer instruments in the trays, removing plastic peel pouches from the trays, adding larger stringers when needed, adding tip protectors and devices to keep instruments open during reprocessing. Storage practices were also changed to prevent overcrowding and storing peel pouches on edge. **(See Attachments-A-000.2 & Attachment 4)** **Date of Implementation**: August 21, 2014 **Monitoring Process**: Infection Control bi-monthly rounds in the Operating Room areas to review storage practices (implemented 9/18/14) **(Attachment 3)** **Person Responsible**: Infection Control Department, Surgical/Central Processing **3a). Culver City: Corrective Action**: In-services provided to staff on process for improperly functioning equipment. **(Attachment 5)** **Date of Implementation**: October 23, 2014.	10/23/2014 8/20/2014 8/21/2014 10/23/2014

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□A 747□	Continued From page 68 manufacturer; d. failure to install air gaps in all the sinks in the kitchen; e. use of wiping cloths to dry food production equipment; f. disposal of garbage without proper protection; g. the unloading of clean trays in the dish washing area with same gloves that had been used to load dirty trays. These deficient practices failed to promote operational processes that support safe food handling practices may result in exposure of patients to bacteria associated with foodborne illness. Foodborne illness may result in further compromising patients' medical status and in severe instances may result in death. The cumulative effects of these systemic issues resulted in the facility's inability to ensure and provide a safe patient care environment. This is a repeat deficiency from the sampled validation survey on April 1, 2014.	□A 747□	**Monitoring Process**: Monitored daily by dietary staff **(Attachment 5)** **Person Responsible**: Dietary Director/Supervisor **3a). Van Nuys: Corrective Action**: New refrigerators and freezers were ordered and have been installed. Repairs of existing refrigerators/freezers also being conducted. In-services provided to staff on process for improperly functioning equipment. Refrigerated truck was brought in during the interim to provide adequate refrigeration while repairs and installations are carried out **(Attachment 6)** **Date of Implementation**: August 20, 2014. **Monitoring Process**: Refrigerator & Freezer Temperatures monitored daily by dietary staff **Person Responsible**: RD Director Dietary Department **3a). Hollywood. Corrective Action**: Freezer and Refrigerators were repaired. Staff in-serviced on appropriate procedures to take when equipment malfunctions **(Attachment 6)** **Date of Implementation**: August 20, 2014. **Person Responsible**: RD Director Dietary Department **3b). Culver City** G-tube feeding orders not followed **Corrective Action**: Education and in-services provided to nursing staff. **(Attachment 7)** **Date of Implementation**: July 1, 2014 **Monitoring Process**: Monitored by nursing **(Attachment 8)** **Person Responsible**: Nursing Directors **3b). Hollywood**-G-tube feeding orders not followed **Corrective action** plan: all open feeding systems were eliminated and only the closed systems are being used to prevent the growth of microorganisms. Education and in-services provided to nursing staff **(Attachment 9)** **Date of Implementation**: 9/16/14 **Monitoring Process**: Monitored by nursing and dietitians **(Attachment 10)** **Person Responsible**: Nursing Services	8/20/2014 8/20/2014 07/01/2014 9/16/2014
□A 749□	482.42(a)(1) INFECTION CONTROL PROGRAM The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: On August 20, 2014, at 1:30p.m., the survey team declared an Immediate Jeopardy (IJ) situation, in the presence of the Chief Executive Officer (CEO) of the Culver City Campus, director	□A 749□	Continued on page 69a. **1). Culver City: Corrective Action**s: The following was implemented to ensure flexible endoscopes are stored in accordance with the AORN recommended practices: 1). Purchased and installed new vented scope cabinet and placed in area with adequate ventilation for proper storage of scopes; 2) all scopes now have tip protectors to ensure tips do not touch the cabinets; 3) all scopes are tagged after processing indicating next date to re-process if not in use.4). Provided education/in-service to staff for use of enzymatic cleaners and proper measurements; 5) for scope re-processing; high-level disinfection, this included competency validation and return demonstrations **(refer to Attachment A-000.1);** **Date of Implementation**: Scope Cabinet installed 9-15-14; Education completed on August 12, 2014 and August 21, 2014. **Monitoring Process**: Monitoring managed by daily inspection of the scopes for next date of re-processing; Daily scopes monitoring and after each use to ensure proper placement in scope cabinet; weekly monitoring of all scope procedure to ensure completeness and accuracy of log. Log compliance will be submitted to the Regulatory Compliance Committee & Quality Council to ensure compliance with AORN standards.	8/12/2014 8/21/2014 9/15/2014

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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A 747	Continued From page 67 .. 3. Ensure effective systems for safe food handling to prevent food borne illness. This was evidenced by: a. the storing of food in refrigerators and freezers that were not maintaining temperatures by hospital policies and customary practices; b. not following tube feeding orders to prevent growth of microorganisms; c. failure to sanitize the ice machine as recommended by the . Continued From page 68 .. manufacturer; d. failure to install air gaps in all the sinks in the kitchen; e. use of wiping cloths to dry food production equipment; f. disposal of garbage without proper protection; g. the unloading of clean trays in the dish washing area with same gloves that had been used to load dirty trays. These deficient practices failed to promote operational processes that support safe food handling practices may result in exposure of patients to bacteria associated with foodborne illness. Foodborne illness may result in further compromising patients' medical status and in severe instances may result in death. The cumulative effects of these systemic issues resulted in the facility's inability to ensure and provide a safe patient care environment. This is a repeat deficiency from the sampled validation survey on April 1, 2014.	A 747	**3c).Culver City Corrective Action**: Ice machine at the Culver City campus was sanitized according to manufacturer's recommendations. **(Attachment 5)**. Staff in-services on ice machine maintenance. **Date of Implementation**: October 23, 2014 **Monitoring Process**: Will be monitored through preventative maintenance schedule and during Infection Control Rounds **Person Responsible**: Engineering, Infection Control Department, Dietary Department	10/23/2014
			3c) Van Nuys Corrective Action: Ice machine was sanitized and placed on the Engineering Preventative Maintenance list for a regular sanitizing schedule. **(Attachment 11)** **Date of Implementation**: 10/27/14 **Monitoring Process**: Will be monitored through preventative maintenance schedule and during Infection Control Rounds **(Attachment 12)** **Person Responsible**: Director of Engineering, Infection Control	10/27/2014
			3c).Hollywood: Corrective Action: Ice machine was sanitized and placed on the Engineering Preventative Maintenance list for a regular sanitizing schedule. **(Attachment 13)** **Date of Implementation**: August 20, 2014 **Monitoring Process**: Will be monitored through preventative maintenance schedule and during Infection Control Rounds **(Attachment 12)** **Person Responsible**: Director of Engineering, Infection Control	8/20/2014
			3d) Culver City Corrective Action: Air gaps were installed in all food preparation sinks. Staff in-serviced on the purpose of air gaps. **(Attachment 14)** **Date of Implementation**: October 23, 2014 **Monitoring Process**: Bimonthly rounds with Infection Control and Dietary. **(Attachment 5)** **Person Responsible**: Engineering Department	10/23/2014 10/20/2014
			3d). Van Nuys Corrective Action: Air gaps were installed in all food prep sinks **(Attachment 15)** **Date of Implementation**: 10/20/14 **Monitoring process**: Bimonthly rounds with Infection Control and Dietary. **(Attachment 12)** **Person Responsible**: Director of Engineering	8/22/2014
			3d). Hollywood Corrective Action: Air gaps were installed in all food prep sinks. **(Attachment 16)** **Date of Implementation**: August 22, 2014 **Monitoring process**: Bimonthly rounds with Infection Control and Dietary. **(Attachment 12)** **Person Responsible**: Director of Engineering	10/22/2014
			3. e) Culver City Corrective Action: Education given to by Dietary supervisors regarding air drying all food production equipment **(Attachment 5)** **Date of Implementation**: 10/22/14 **Monitoring process**: Daily rounding by Dietary Supervisor, Bimonthly rounding by Infection Control and Dietary department **(Attachment 5)** **Person Responsible**: Director of Dietary, Director of Infection Control	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 747	Continued From page 67 .. 3. Ensure effective systems for safe food handling to prevent food borne illness. This was evidenced by: a. the storing of food in refrigerators and freezers that were not maintaining temperatures by hospital policies and customary practices; b. not following tube feeding orders to prevent growth of microorganisms; c. failure to sanitize the ice machine as recommended by the . Continued From page 68 .. manufacturer; d. failure to install air gaps in all the sinks in the kitchen; e. use of wiping cloths to dry food production equipment; f. disposal of garbage without proper protection; g. the unloading of clean trays in the dish washing area with same gloves that had been used to load dirty trays. These deficient practices failed to promote operational processes that support safe food handling practices may result in exposure of patients to bacteria associated with foodborne illness. Foodborne illness may result in further compromising patients' medical status and in severe instances may result in death. The cumulative effects of these systemic issues resulted in the facility's inability to ensure and provide a safe patient care environment. This is a repeat deficiency from the sampled validation survey on April 1, 2014.	A 747	**3e). Van Nuys Corrective Action**: Additional drying racks purchased and installed. Education given to by Dietary supervisors regarding air drying all food production equipment **(Attachment 17)** **Date of Implementation**: 10/27/14 **Monitoring Process**: Daily rounding by dietary supervisor (**Attachment 18)** **Person Responsible**: RD, Director of Dietary **3e). Hollywood Corrective Action**: Additional drying racks purchased and installed. Education given to by Dietary supervisors regarding air drying all food production equipment **(Attachment 19)** **Date of Implementation**: 10/19/14 **Monitoring process**: Daily rounding by dietary supervisor **(Attachment 18)** **Person Responsible**: RD, Director of Dietary **3f). Culver City Corrective action** plan: Staff education on the proper process of garbage disposal. **(Attachment 5)** **Date of Implementation**: October 23, 2014 **Monitoring Process**: Observations during Dietary supervisor rounds and bimonthly Infection Control rounds **(Attachment 5)** **Person Responsible**: Dietary Department, Infection Control Department **3f). Van Nuys Corrective action** plan: Staff were educated on the proper process of garbage disposal. Plastic aprons for wear during removal of garbage were purchased and put in place at. **(Attachment 20)** **Date of Implementation**: October 27, 2014 **Monitoring Process**: Observations during Dietary supervisor rounds and Infection Control rounds **(Attachment 12)** **Person Responsible**: RD, Director of Dietary **3g). Culver City Corrective Action**: In-service given on the proper use of gloves and hand hygiene when handling dirty and clean dishes. **(Attachment 5)** **Date of Implementation**: 10/27/14 **Monitoring Process**: Observations during Dietary Supervisor rounds, bimonthly Infection Control Rounds **(Attachment 5)** **Person Responsible**: Director of Dietary **3g). Van Nuys Corrective Action**: In-service given on the proper use of gloves and hand hygiene when handling dirty and clean dishes. **(Attachment 21)** **Date of Implementation**: 10/21/14 **Monitoring Process**: Observations during Dietary Supervisor rounds **(Attachment 18)** **Person Responsible**: RD, Director of Dietary **3g). Hollywood Corrective Action**: In-service given on the proper use of gloves and hand hygiene when handling dirty and clean dishes. **(Attachment 22)** **Date of Implementation**: 10/19/14 **Monitoring Process**: Observations during Dietary Supervisor rounds **(Attachment 18)** **Person Responsible**: RD, Director of Dietary	10/27/2014 10/19/2014

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□A 749□	Continued From page 69 of risk management, as a result of the facility's failure: 1. To ensure flexible endoscopes were stored in accordance with the Association of Peri-Operative Registered Nurse (AORN) Recommended Practices. AORN is the National Recognized Standards (NRS) the hospital identified as the standard they followed. 2. To ensure re-usable surgical instruments were packaged and stored in accordance with the AORN Standards. On August 21, 2014, at 3:45p.m., the IJ was abated in the presence of the director of risk management and CEO of the facility's Culver City campus. Based on observation, interview and record review, the facility failed to: 1. Ensure flexible endoscopes were stored in accordance with the Association of Peri-Operative Registered Nurse (AORN) Recommended Practices . AORN is the National Recognized Standards (NRS) the hospital identified as the standard they followed. 2. Ensure re-usable surgical instruments were packaged and stored in accordance with the Association of Peri-Operative Registered Nurse (AORN) Recommended Practices. 3. Perform one GI (Gastroenterology) Technician's competency in the use, care, and processing of flexible endoscopes and related equipment, and two CST (Central Surgical Technician)'s competency in the use of sterilization packaging systems and accessories.	□A 749□	**Person Responsible**: OR Team/Infection Control will be responsible for monitoring; Daily monitoring by GI/OR Team and weekly monitoring by Infection Control. **1). Hollywood**: **Corrective Action**: Failure to ensure flexible endoscopes were stored appropriately The following was implemented to ensure flexible endoscopes are stored in accordance with the AORN recommended practices: 1) A new scope cabinet was purchased that allows for all scopes to be hung vertically without touching each other or the bottom of the cabinet in accordance to the AORN recommended practice, 2) scope tip protectors that are breathable were purchased to protect tips where it was possible that the tip may touch the back of the cabinet or another scope, 3) Competency for GI processing and storage was conducted by the scope manufacturer, 4). all scopes are tagged with the processing date to ensure that they are processed within 5 days. **(Attachment 1)** **Date of Implementation**: September 8, 2014 (scope cabinet); August 12 & 21, 2014 & September 22, 2014 (competency) **Monitoring Process**: Biweekly Infection control rounds to review appropriate storage of equipment. **(Attachment 2)** **Person Responsible**: GI team, Infection Control **2). Culver City Corrective Action**s; All re-usable surgical instruments (SI) were re-processed, packaged, and stored in accordance to AORN standards; bin dividers purchased to ensure packages are stored up-right on 9/5/2014. 5 inch stringers were purchased to ensure SI are completely open for processing & implemented on 8/25/2014; 3 M Comply cards purchased and placed into service to ensure tip and lock boxes in peel packs maintain an open position for sterilization on 8/26/14; Purchased new biological incubator and indicator with corresponding supplies for sterilization on 10/10/14; Provided education/in-service to staff on standards for processing, packaging and storing of SI, this includes competency validation and return demonstration **(see Attachment A-000.2)** **Date of Implementation**: Education SI re-processed August 20, 2014. **Monitoring Process**: Monitoring will be managed during weekly Infection Control rounds with ORT or RN with compliance reported to the regulatory Compliance Committee. **Person Responsible**: Infection Control/OR Director; to be completed on the EOC log and will report results to the Regulatory Compliance Committee & Quality. **2) Hollywood Corrective Action**s: Paper-plastic pouches now stored in a vertical manner in accordance to AORN recommended practice. Bin dividers purchased to further aid this process, plastic, autoclavable devices are in use to ensure instruments stay open during the sterilization process. Process of use of peel-pouches changed to indicate that items are placed to allow sterilant contact and typically only 1 item placed per pouch (no more than two small items). Surgical trays were divided into several trays to ensure appropriate sterilant penetration. Larger trays were purchased to accommodate larger instruments that are more fully propped open **(Attachment 3)** **Date of Implementation**: 9/9/14 **Monitoring Process**: Infection Control biweekly rounds to review appropriate placement and use of paper-plastic pouches. Infection Control to randomly check trays prior to sterilization to ensure appropriate tray placement. **(Attachment 4)** **Person Responsible**: OR/Central Service Team, Infection Control Continued on page 70a.	8/12/2014 8/21/2014 9/8/2014 9/22/2014 8/20/2014 9/9/2014

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A 749	Continued From page 69 of risk management, as a result of the facility's failure: 1. To ensure flexible endoscopes were stored in accordance with the Association of Peri-Operative Registered Nurse (AORN) Recommended Practices. AORN is the National Recognized Standards (NRS) the hospital identified as the standard they followed. 2. To ensure re-usable surgical instruments were packaged and stored in accordance with the AORN Standards. On August 21, 2014, at 3:45p.m., the IJ was abated in the presence of the director of risk management and CEO of the facility's Culver City campus. Based on observation, interview and record review, the facility failed to: 1. Ensure flexible endoscopes were stored in accordance with the Association of Peri-Operative Registered Nurse (AORN) Recommended Practices . AORN is the National Recognized Standards (NRS) the hospital identified as the standard they followed. 2. Ensure re-usable surgical instruments were packaged and stored in accordance with the Association of Peri-Operative Registered Nurse (AORN) Recommended Practices. 3. Perform one GI (Gastroenterology) Technician's competency in the use, care, and processing of flexible endoscopes and related equipment, and two CST (Central Surgical Technician)'s competency in the use of sterilization packaging systems and accessories.	A 749	**3). Culver City Corrective Action**: Competencies were completed by the scope manufacturer for the one GI tech on the use, care and processing of flexible endoscopes. In-services with return demonstration performed on the two central service technicians on sterilization and processing of sterile instruments **(Attachment 5)** **Date of Implementation**: GI Lab Scope processing in-services, Aug 12 and Aug 21, Central processing in-service Aug 20, 2014 **Monitoring Process**: Audit of scope processing log with reporting to PI committee; infection control bimonthly OR rounding with spot checks for instrument sterilization and processing practices. **(Attachment 6)** **Person Responsible**: Nursing Services, Infection Control, OR Team **3). Hollywood Corrective Action**: Competencies were completed by the scope manufacturer for the one GI techs on the use, care and processing of flexible endoscopes. In-services were performed on the two central service technicians on sterilization and processing of sterile instruments. **(Attachment 7)** **Date of Implementation**: 9/22/14 (Scopes); 10/8/14 (Central Processing); **Monitoring Process**: Audit of scope processing log with reporting to PI committee; infection control biweekly OR rounding with spot checks for instrument sterilization and processing practices. **(Attachment 4)** **Person Responsible**: Nursing Services, Infection Control, OR Team	8/12/2014 8/20/20/2014 8/21/2014 9/22/2014 10/8/2014

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□A 749□	Continued From page 70 4. Develop those policies referred to infection control that conformed to AORN recommended practice guidelines. These deficient practices promote microbial growth and can result in contamination of sterile items. 5. Ensure there was an effective system for safe food handling to prevent food borne illness. This was evidenced by: a. the storing of food in refrigerators and freezers that were not maintaining temperatures by hospital policies and customary practices; b. not following tube feeding orders to prevent growth of microorganisms; c. failure to sanitize the ice machine as recommended by the manufacturer; d. failure to install air gaps in- all the sinks in the kitchen; e. failing to use of wiping cloths to dry food production equipment; f. failing to disposal of garbage without proper protection; g. the unloading of clean trays in the dish washing area with same gloves that had been used to load dirty trays. These deficient practices failed to promote operationa processes that support safe food handling practices may result in exposure of patients to bacteria associated with foodborne illness. Foodborne illness may result in further compromising patients' medical status and in severe instances may result in death. Findings:	□A 749□	**4). Culver City Corrective Action:** Policies reviewed and amended as needed to be more facility specific and conform to AORN recommendations. **(Attachment 8)** **Date of Implementation**: November 1, 2014 **Monitoring Process**: Annual review with tri-annual committee approval **Person Responsible**: Surgery Committee, Surgical Services Director, Nursing Services, Infection Control Team **4). Hollywood Corrective Action**: Policies reviewed and amended as needed to ensure infection control processes conform to AORN recommended practice guidelines. **(Attachment 8)** **Date of Implementation**: November 1, 2014 **Monitoring Process**: Annual review with tri-annual committee approval **Person Responsible**: Surgery Committee, Surgical Services Director, Nursing Administration, Infection Control Team **5a). Culver City Corrective Action**: In-services provided to staff on process of logging temperatures and the reporting of temperatures not meeting expected ranges per policy. **(Attachment 9)** **Date of Implementation**: October 23, 2014. **Monitoring Process**: Monitored daily by dietary staff **Person Responsible**: Dietary Director/Supervisor **5a). Van Nuys Corrective Action**: New refrigerators and freezers were ordered and have been installed. Repairs of existing refrigerators/freezers have been conducted. In-services provided to staff on process for improperly functioning equipment. Refrigerated truck was brought in during the interim to provide adequate refrigeration while repairs and installations are carried out. **(Attachment: 10)** **Date of Implementation**: August 20, 2014. **Monitoring Process**: Monitored daily by dietary staff **Person Responsible**: RD, Director of Dietary **5a). Hollywood Corrective Action**: Refrigerators were repaired. In-services provided to staff on process of logging temperatures and the reporting of temperatures not meeting expected ranges per policy. **(Attachment: 10)** **Date of Implementation**: August 20, 2014. **Monitoring Process**: Monitored daily by dietary staff **Person Responsible**: RD, Director of Dietary **5b). Culver City Corrective** Action: Education and in-services provided to nursing staff. **(Attachment 11)** **Date of Implementation**: October 23, 2014 **Monitoring Process**: Monitored by nursing and dieticians and reported monthly to PI committee **Person Responsible**: Nursing Directors **5b). Hollywood Corrective Action**: all open feeding systems were eliminated and only the closed systems are being used to prevent the growth of microorganisms. Education and in-services provided to nursing staff **(Attachment: 12)** **Date of Implementation**: 9/16/14 **Monitoring Process**: Monitored by nursing and dietitian and reported monthly to PI committee **(Attachment 12)** **Person Responsible**: Nursing Administration Continued on page 71a.	10/1/2014 10/1/2014 10/23/2014 8/20/2014 8/20/2014 10/23/2014 9/16/2014

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A 749	Continued From page 70 4. Develop those policies referred to infection control that conformed to AORN recommended practice guidelines. These deficient practices promote microbial growth and can result in contamination of sterile items. 5. Ensure there was an effective system for safe food handling to prevent food borne illness. This was evidenced by: a. the storing of food in refrigerators and freezers that were not maintaining temperatures by hospital policies and customary practices; b. not following tube feeding orders to prevent growth of microorganisms; c. failure to sanitize the ice machine as recommended by the manufacturer; d. failure to install air gaps in- all the sinks in the kitchen; e. failing to use of wiping cloths to dry food production equipment; f. failing to disposal of garbage without proper protection; g. the unloading of clean trays in the dish washing area with same gloves that had been used to load dirty trays. These deficient practices failed to promote operational processes that support safe food handling practices may result in exposure of patients to bacteria associated with foodborne illness. Foodborne illness may result in further compromising patients' medical status and in severe instances may result in death. Findings:	A 749	**5c). Culver City Corrective Action**: Ice machine was sanitized according to manufacturer's recommendations. (**Attachment 9**). Staff in-services on ice machine maintenance. (**Attachment 9**). **Date of Implementation**: October 23, 2014 **Monitoring Process**: Will be monitored through daily sanitation log and preventative maintenance schedule. Sanitation will also be monitored during bimonthly Infection Control and Dietary Rounds (**Attachment 9**). **Person Responsible**: Engineering, Infection Control Department, Dietary Department **5c). Van Nuys Corrective Action**: Ice machine was sanitized and placed on the Engineering Preventative Maintenance list for a regular sanitizing schedule. **(Attachment: 13)** **Date of Implementation**: 10/27/14 **Monitoring Process**: Will be monitored through preventative maintenance schedule and during Infection Control Rounds (**Attachment 14**). **Person Responsible**: Director of Engineering, Infection Control **5c). Hollywood Corrective Action**: Ice machine was sanitized and placed on the Engineering Preventative Maintenance list for a regular sanitizing schedule. **(Attachment: 15)** **Date of Implementation:** August 20, 2014 **Monitoring Process:** will be monitored through preventative maintenance schedule and during Infection Control Rounds **5d). Culver City Corrective Action**: Air gaps were installed in all food preparation sinks. (**Attachment: 16**). Staff in-serviced on the purpose of air gaps. (**Attachment: 17**). **Date of Implementation**: October 23, 2014 **Monitoring Process**: Bimonthly rounds with Infection Control and Dietary. (**Attachment: 18**). **Person Responsible**: Engineering Department, Infection Control Department, Dietary Department **5d). Van Nuys Corrective Action**: Air gaps were installed in all food prep sinks (**Attachment: 19**). **Date of Implementation**: 10/20/14 **Monitoring Process**: Bimonthly rounds with Infection Control and Dietary. (**Attachment: 18**). **Person Responsible**: Director of Engineering **5d). Hollywood Corrective Action**: Air gaps were installed in all food prep sinks. (**Attachment: 20**). **Date of Implementation**: August 22, 2014 **Monitoring Process**: Bimonthly rounds with Infection Control and Dietary. (**Attachment: 18**). **Person Responsible**: Director of Engineering **5e). Culver City Corrective Action**: Education given to by Dietary supervisors regarding air drying all food production equipment **(Attachment: 9)** **Date of Implementation**: 10/23/14 **Monitoring process**: Daily rounding by Dietary Supervisor, Biweekly rounding by Infection Control and Dietary departments **(Attachment: 9)** **Person Responsible**: Director of Dietary, Director of Infection Control **5e). Van Nuys Corrective Action**: Additional drying racks purchased and installed. Education given to by Dietary supervisors regarding air drying all food production equipment **(Attachment: 21)** **Date of Implementation**: 10/27/14 **Monitoring Process**: Daily rounding by dietary supervisor **Person Responsible**: RD, Director of Dietary	10/23/2014 10/27/2014 08/20/2014 10/23/2014 10/20/2014 8/22/2014 10/23/2014 10/27/2014

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A 749	Continued From page 70 4. Develop those policies referred to infection control that conformed to AORN recommended practice guidelines. These deficient practices promote microbial growth and can result in contamination of sterile items. 5. Ensure there was an effective system for safe food handling to prevent food borne illness. This was evidenced by: a. the storing of food in refrigerators and freezers that were not maintaining temperatures by hospital policies and customary practices; b. not following tube feeding orders to prevent growth of microorganisms; c. failure to sanitize the ice machine as recommended by the manufacturer; d. failure to install air gaps in- all the sinks in the kitchen; e. failing to use of wiping cloths to dry food production equipment; f. failing to disposal of garbage without proper protection; g. the unloading of clean trays in the dish washing area with same gloves that had been used to load dirty trays. These deficient practices failed to promote operational processes that support safe food handling practices may result in exposure of patients to bacteria associated with foodborne illness. Foodborne illness may result in further compromising patients' medical status and in severe instances may result in death. Findings:	A 749	**5e). Hollywood Corrective Action**: Additional drying racks purchased and installed. Education given to by Dietary supervisors regarding air drying all food production equipment **(Attachment: 21)** **Date of Implementation**: 10/19/14 **Monitoring process**: Daily rounding by dietary supervisor **Person Responsible**: RD, Director of Dietary **5f). Culver City Corrective Action:** Staff education on the proper process of garbage disposal. **(Attachment: 9)** **Date of Implementation**: October 23, 2014 **Monitoring Process**: Observations during Dietary supervisor rounds and bimonthly Infection Control rounds **(Attachment: 9)** **Person Responsible**: Dietary Department, Infection Control Department **5f). Van Nuys Corrective Action:** Staff was educated on the proper process of garbage disposal. Plastic aprons for wear during removal of garbage were purchased and put in place at. **(Attachment: 22)** **Date of Implementation**: October 27, 2014 **Monitoring Process**: Observations during Dietary supervisor rounds and Infection Control rounds **Person Responsible**: RD, Director of Dietary **5g). Culver City Corrective Action**: In-service given on the proper use of gloves and hand hygiene when handling dirty and clean dishes. **(Attachment: 9)** **Date of Implementation**: 10/23/14 **Monitoring Process**: Observations during Dietary Supervisor rounds, bimonthly Infection Control Rounds **(Attachment: 9)** **Person Responsible**: Director of Dietary, Director of Infection Control **5g). Van Nuys Corrective Action**: In-service given on the proper use of gloves and hand hygiene when handling dirty and clean dishes. **(Attachment: 23)** **Date of Implementation**: 10/21/14 **Monitoring Process**: Observations during Dietary Supervisor rounds **Person Responsible**: RD, Director of Dietary **5g). Hollywood Corrective Action**: In-service given on the proper use of gloves and hand hygiene when handling dirty and clean dishes. **(Attachment: 23)** **Date of Implementation**: 10/19/14 **Monitoring Process**: Observations during Dietary Supervisor rounds **Person Responsible**: RD, Director of Dietary	10/19/2014 10/23/2014 10/272014 10/23/2014 10/21/2014 10/19/2014

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□A 749□	Continued From page 71 Hollywood campus 1. During the tour with Registered Nurse (RN) 1 in the Semi-Restricted and Restricted area on August 18, 2014 between 1:10 p.m. and 3 p.m., the following were observed: There were four endoscopes, stored and hung in a vertical position, in a closed cabinet, adjacent to Sterile Supply Room. There was no venting to allow air circulation around the flexible endoscopes. Two (2) of four (4) endoscopes tips were in contact with the cabinet wall with no scope protectors. During an interview with Gastroenterology Technician (GI T) 1, at the same time of the observation, she stated the flexible endoscopes should be stored in a closed cabinet with venting allows air circulation around flexible endoscopes. During an interview with RN 1 on August 18, 2014 at 2:55p.m., she stated the flexible endoscopes should be hanging in a secure vertical position without contacting with the cabinet wall. According to Perioperative Standards and Recommended Practices for 2013 of the AORN, "Recommended Practices for Cleaning and Processing Flexible Endoscopes and Endoscope Accessories:" "Recommendation I□ Flexible endoscopes should be stored in a manner that protects the device from damage and minimizes microbial contamination. I□.a. Flexible endoscopes should be stored in a closed cabinet with venting allows air	□A 749□	**Hollywood** **1). Corrective Action**: A new scope cabinet was purchased that allows for all scopes to be hung vertically without touching each other or the bottom of the cabinet. In addition, scope tip protectors that are breathable were purchased to protect tips where it was possible that the tip may touch the back of the cabinet or another scope. Competency for GI processing and storage was conducted by the scope manufacturer. All scopes are tagged with the processing date to ensure that they are processed within 5 days. **(refer to Attachment: A-000.1)** **Date of Implementation**: September 8, 2014 (scope cabinet); September 22, 2014 (competency) **Monitoring Process**: Biweekly Infection control rounds to review appropriate storage of equipment. **Person Responsible**: GI team, Infection Control	9/8/2014

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□A 749□	Continued From page 72 circulation around Flexible endoscopes; hanging in a secure vertical position; with scope protectors applied if the protector does not interfere with the flexible endoscopes hanging straight or restrict the air movement around channel opening; I□.b. Flexible endoscopes should be reprocessed before use if unused for more than 5 days." Recommendation □III Personnel should demonstrate competency in the use, care, and processing of flexible endoscopes □and related equipment periodically and before new endoscopic equipment and/or accessories are introduced into the practice setting. 2. During the tour with RN 1 in the Semi-Restricted area and Restricted area on August 18,2014 between 10:25.m. and 11:33 a.m., the followings were observed: In OR□2: A. There were multiple blue bins with multiple paper-plastic pouch package of surgical instruments in the cabinet. The packages were not stored in a vertical manner in each bin. The packages were compressed in each bin. All instruments blades closed and tips touching. B. In a paper-plastic pouch package of two (2□ babcock forceps (used for graping in surgical procedures), one babcock stacked on another. These two (2) babcock forceps blades closed and tips touching. C. A laminectomy tray (instruments used for surgery on the back) also known as a Major Tray was ready for use in the operating room. Assembled in the tray:	□A 749□	**2A) .Corrective Action**s: Paper-plastic pouches now stored in a vertical manner. Bin dividers purchased to further aid this process **(refer to Attachment: A-000.1)** **Date of Implementation**: 9/5/14 **Monitoring Process**: Infection Control bimonthly rounds to review appropriate placement and use of paper-plastic pouches **Person Responsible**: Central processing team; Infection Control **2B). Corrective Action**s: Plastic, autoclavable devices are in use to ensure instruments stay open during the sterilization process. Process of use of peel-pouches changed to indicate that items are placed to allow sterilant contact and typically only 1 item placed per pouch (no more than two small items). **(refer to Attachment: A-000.2)** **Date of Implementation** 9/9/14 **Monitoring Process**: Infection Control bimonthly rounds to review use of paper-plastic pouches **Person Responsible**: Infection control; Central processing team **2C). Corrective Action**s: Surgical trays were divided into several trays to ensure appropriate sterilant penetration. Larger trays were purchased to accommodate larger instruments that are more fully propped open utilizing the 5 in instrument stringers. **(Attachment: refer to Attachment A-000-2)** **Date of Implementation**: 8/22/14; 9/12/14 (purchase of larger trays) **Monitoring Process**: Infection Control bimonthly rounds to review appropriate placement and use of paper-plastic pouches. Infection Control to randomly check trays prior to sterilization to ensure appropriate tray placement. **Person Responsible**: Central processing team; Infection Control	9/5/2014 9/9/2014 8/22/2014 9/12/2014

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□A 749□	Continued From page 73 On the stringer (typically, approximately a foot long 3 rod type device to assist with the positioning of instruments for sterilizing), 10 hinged instruments blades closed and tips touching. During an interview with Certified Scrub Technician (CST) 1 on August 18, 2014 at 11:01 a.m., she stated the surgical instruments should not be stacked on each other to allow sterilant penetration and direct contact with the item and surfaces. A subsequent interview with Staff I and RN 1 at the same time, both stated they were following event related sterility □Concept that the sterility of an item does not change with passing of time but nay be affected by particular event (eg, amount of handling), or environmental conditions (eg, temperature, humidity)□when processing and storing of sterile surgical instruments. Both RN 1 and CST 1 stated the supplies are incorrectly stored according to the AORN Standards. According to Perioperative Standards and Recommended Practices for 2013 of the AORN, "Recommended Practices for Selection and Use of packaging Systems for Sterilization:" "Recommendation I 1. Packaging systems should be appropriate for items being sterilized. The packaging system should: maintain sterility of package contents until opened; allow sterilant penetration and direct contact with the item and surfaces, and removal of the sterilant" Culver City campus	□A 749□		

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A 749	Continued From page 74 3. During the tour with RN 1 in the Semi-Restricted Area on August 20, 2014 between 11 a.m. and 12 p.m., the followings were observed: A. In Central Processing Room One C (Caesarean)-Section (a surgical procedure in which one or more incisions are made through a mother's abdomen and uterus to deliver one or more babies, or, rarely, to remove a dead fetus) tray (instruments used for surgery to deliver baby) was ready for use in the operating room. Assembled in the tray: On the stringer (typically, approximately a foot long 3 rod type device to assist with the positioning of instruments for sterilizing), multiple hinged instruments blades closed and tips touching. During an interview with CST 2 and 3 on August 18, 2014 at 11:01 a.m., both stated the surgical instruments should not be stacked on each other to allow sterilant penetration and direct contact with the item and surfaces. In Sterile Supply Room There were multiple cartons (boxes) on the 3rd shelf of the cabinet with multiple sterile supplies and multiple non-sterile supplies. There was no thermometer and humidity display in the Central Sterilization. There were multiple blue bins with multiple paper-plastic pouch package of surgical instruments in the cabinet. The packages were	A 749	**Culver City** **Central Processing Room** **3A). Corrective Actions**: 3 Instruments stringers have been replaced with 5 stringers to hold hinged instrument blades open and tips not touching to allow sterilant penetration and direct contact with the items and surfaces. **Date of Implementation** Aug.25, 2014 receipt of 5 stringers **(refer to Attachment: A-000.2)** **Monitoring Process**: Monitoring will be managed during bi-monthly rounds with IC and OR RN or ST Compliance Data will be reported through Regulatory Compliance Committee, IC and Quality. **Person Responsible**: Surgery Director and Director of Infection Control: **Sterile Supply Room** **3A). Corrective Actions**: All cartons have been removed from the sterile supply room. Non sterile and sterile items have been separated. A temperature and humidity gauge was present in the sterile supply room areas and readings are being recorded. Plastic paper pouch packages have been decompressed and stored in a vertical position in the blue bins. 3M comply cards are now utilized to keep instrument blades open and prevent tips from touching. **Date of Implementation**: Aug 21, 2014 cartons removed and Aug 26, 2014 3M comply cards received, Temperature and Humidity Gauge was installed on July 26, 2014. **Monitoring Process**: Monitoring will be managed during bi-monthly rounds with IC and OR RN or ST. Compliance data will be reported through Regulatory Compliance Committee, IC and Quality. **Person Responsible**: Infection Prevention/OR/CS team	8/25/2014 7/26/2014 8/21/2014 8/26/2014

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□A 749□	Continued From page 75 not stored in a vertical manner in each bin. The packages were compressed in each bin. All instruments blades closed and tips touching. B. In Sterile Central Supply Room a. There was one paper-plastic pouch package of surgical instrument (a retractor) with discoloration on the paper-plastic pouch. There was one paper-plastic pouch package of surgical instrument dated 10/5/9. b. There were multiple blue bins with multiple paper-plastic pouch package of surgical instrument compressed in each bin. During an interview with Staff G on August 20, 2014 at 11:26 a.m., she stated there should not be any sterile supplies in this room. A subsequent interview with Staff G and J at the same time, both stated they were using event related sterility (Concept that the sterility of an item does not change with passing of time but nay be affected by particular event (eg, amount of handling), or environmental conditions (eg, temperature, humidity). Staff I stated the supplies are incorrectly stored according to the AORN Standards. According to Staff G, the temperature and humidity in the Central Sterilization Room were not monitored and recorded. According to the facility's policy and procedure dated 9/11, titled "Storage and Rotation of Sterile Supplies:" 4.1.3. Shipping cartons must never be allowed in either a clean storage area or a sterile storage area, and these containers should never be used as storage containers within these areas."	□A 749□	**Sterile Central Supply Room** **3Ba). Corrective Action**s: Peel packed instruments have been removed from the Sterile Central Supply Room **Date of Implementation** Aug 21, 2014 **Monitoring Process**: Monitoring will be managed during bi-monthly rounds with IC, OR RN and CS staff member. Compliance data will be reported through Regulatory Compliance Committee, IC and Quality. **Person Responsible**: Infection Prevention/OR/CS team: **3Bb). Corrective Action**s: Plastic □paper pouch packages have been decompressed and stored in a vertical position in the blue bins. 3M comply cards are now utilized to keep instrument blades open and prevent tips from touching **Date of Implementation**: August 26, 2014 **Monitoring Process**: Monitoring will be managed during bi-monthly IC rounds with OR RN and CS staff member. Compliance data will be reported through Regulatory Compliance Committee, IC and Quality. **Person Responsible**: Infection Prevention/OR/CS team	8/21/2014 8/26/2014

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□A 749□	Continued From page 76 According to Perioperative Standards and Recommended Practices for 2013 of the AORN, "Recommended Practices for Selection and Use of packaging Systems for Sterilization:" "Recommendation I 1. Packaging systems should be appropriate for items being sterilized. The packaging system should: maintain sterility of package contents until opened; allow sterilant penetration and direct contact with the item and surfaces, and removal of the sterilant. Recommendation V 1. Paper-plastic pouch packages should be used only for small, lightweight, low-profile items (e.g., one or two clamps, scissors). Heavy metal instruments (e.g. drills, retractors, weighted vaginal speculums) should not be sterilized in peel pouches because problems (e.g., wet packages following sterilization) and sterility maintenance problems (e.g., package seal break) may occur. Recommendation VIII Sterilized packages should be considered sterile until an event occurs to compromise the package barrier integrity. 1. Health care organizations should determine the best methods and materials for packaging sterile items, based upon the anticipated storage, handling, and environmental events that may be encountered. Loss of sterility of a package sterile item is event related. An event must occur to compromise package content sterility. Even that may affect the sterility of a package include, but not limited to, multiple handling that leads to seal breakage or loss of package integrity; compression during storage;	□A 749□		

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□A 749□	Continued From page 77 storage conditions (e.g., type of shelving, cleanliness, temperature, humidity, traffic control)" On August 20, 2014, at 1:30 p.m., the survey team declared an Immediate Jeopardy (IJ) situation, in the presence of the Chief Executive Officer (CEO) of Culver City Campus, director of risk management, as a result of the facility's failure to ensure flexible endoscopes and endoscope accessories were stored in accordance with the AORN and to ensure re-usable surgical instruments were packaged and stored in accordance with AORN Standards. On August 20, 2014, at 9:30a.m., the facility submitted a letter to respond to the immediate Jeopardy, dated August 20, 2104, disclosed all flexible endoscopes had been relocated to a properly storage area. The facility's letter indicated all re-usable surgical instruments were resterilized, repackaged and stored in accordance with the AORN Standards. On August 21, 2014, at 9:30a.m., during the tour of the facility at the Hollywood Campus with Staff E (Administrator) and RN 1, the surveyor observed all flexible endoscopes had been stored in a properly storage area and all re-usable surgical instruments were resterilized, repackaged and stored in accordance with the AORN Standards. On August 21, 2014, at 1:05 p.m., during the tour of the facility at the Culver City Campus with Staff G (Director, Perioperative) and CST 3, the surveyor observed all re-usable surgical instruments were repackaged and stored in accordance with the AORN Standards. On August 21, 2014, at 3:45p.m., the IJ was abated	□A 749□		

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□A 749□	Continued From page 78 in the presence of the director of risk management and CEO of the facility's Culver City campus. Hollywood campus 4. During the tour with Registered Nurse (RN) 1 in the Non-Restricted area on August 18, 2014 between 10:10.m. and 10:25 a.m., the followings were observed: In Pre-Op room: There were three gurneys, with multiple cracks on the mattress on □1 gurney, and multiple small size of holes on the mattress of □2 gurney, and with a approximately 3 inches long cracks and a 3 inches long plastic tap over the edge of the mattress on □3 gurney. According to Perioperative Standards and Recommended Practices for 2013 of the AORN, "Recommended Practices for Environmental Cleaning:" "Recommendation II II.b.2. Damaged or worn coverings should be replaced." 5. During the tour with RN 1 in the Semi-Restricted area and Restricted area on August 18,2014 between 10:25.m. and 11:33 a.m., the followings were observed: In OR □2, there were a C-Arm (encompasses the actual □-ray source and image intensifier) and multiple sterile supplies. According to RN 1 at that time, she stated OR □2 had been used as a storage room, instead of an operating room. Culver City campus 6. During the tour with RN 1 in the Semi-Restricted Area on August 20, 2014 between 11 a.m. and 12 p.m., the followings were	□A 749□	**Hollywood** **4). Corrective Action**: All torn and cracked gurneys were removed from unit and disposed of. New gurneys were purchased with additional purchases made to promptly replace torn gurney mattresses as needed. **(Attachment: 30)** **Date of Implementation**: 8/21/14 **Monitoring Process**: Gurneys mattresses checked for tears and cracks during biweekly infection control rounds. **Person Responsible**: Surgical staff, Infection Control **5). Corrective Action**: All stored items removed from OR □2 and room set up as a functioning OR. **(Attachment: 24)** **Date of Implementation**: August 21, 2014 **Monitoring Process**: Infection control biweekly, OR rounds **Person Responsible**: Surgery Staff, Infection Control	8/21/2014 8/21/2014

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□A 749□	Continued From page 79 observed: In Central Processing Room In the Sterile Central Supply Room, there were multiple cartons on the 3rd shelf of the cabinet with multiple sterile supplies and multiple non-sterile supplies. There was no thermometer and humidity display in the Sterile Central Supply Room. During an interview with CST 4 on August 20, 2014 at 11:48 a.m., she stated the shipping cartons should never be allowed in either a clean storage area or a sterile storage area, Staff G and H stated there should be no sterile supply in this room. According to Staff G, the temperature and humidity in the Sterile Central Supply Room were not monitored and recorded. According to the facility's policy and procedure dated 9/11, titled, "Storage and Rotation of Sterile Supplies:" 4.1.3. Shipping cartons must never be allowed in either a clean storage area or a sterile storage area, and these containers should never be used as storage containers within these areas." According to Perioperative Standards and Recommended Practices for 2013 of the AORN, "Recommended Practices for Selection and Use of packaging Systems for Sterilization:" "Recommendation VIII 2. Sterile packages should be stored under environmentally controlled conditions. Sterile storage area temperature should be controlled and not exceed 75 degree F. The humidity should not exceed 70%." "Recommendation □I	□A 749□	**Culver City** **6). Corrective Actions**: All cartons have been removed from the sterile supply room. Non sterile and sterile items have been separated. A temperature and humidity gauge was in place in the Central Processing area and readings are being recorded. Staff education on the Temperature and Humidity in Central sterilization. **(Attachment 25)** **Date of Implementation** Aug 21, 2014 cartons removed; Temperature and Humidity Gauge was installed on July 26, 2014. **Monitoring Process**: Monitoring will be managed during bi-monthly rounds with IC and OR RN or ST. Compliance data will be reported through Regulatory Compliance Committee, IC and Quality. **(Attachment 26)** **Person Responsible**: Infection Prevention/OR/CS team **2). Corrective Actions**: A temperature and humidity gauge was placed in the Central Processing area and readings are being recorded. Education provided to ensure staff competency in the use of sterilization packing systems and accessories. **Date of Implementation** Temperature and Humidity Gauge was installed on July 26, 2014. Education occurred: 8-20-14 **Monitoring Process**: Monitoring will be managed during bi-monthly rounds with IC and OR RN or ST. Compliance data will be reported through Regulatory Compliance Committee, IC and Quality. **Person Responsible**: Infection Prevention/OR/CS team.	8/21/2014 7/26/2014 8/20/2014

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□A 749□	Continued From page 80 Personnel should demonstrate competency in the use of sterilization packaging systems and □ accessories. 3. Administrative personnel should periodically assess and document the competency of personnel in the use of packaging systems, according to hospital and department policy." 7. On August 18, 2014, Staff E was requested by the evaluator to provide GIT 1's competency in the use, care, and processing of flexible endoscopes and related equipment. However, as of the exit day (8/21/14), the facility could not provide the evaluator with GIT 1's competency in the use, care, and processing of flexible endoscopes and related equipment. 8. On August 20, 2014, Staff G was requested by the evaluator to provide CST 2, 3 and 4's competency in the use of sterilization packaging systems and accessories at the same time. However, as of the exit day (8/21/14), the facility could not provide the evaluator with CST 2, 3, and 4's competency in the use of sterilization packaging systems and accessories. 9. On August 21, 2014, the facility was requested to provide policies and procedures, titled, "cleaning and processing flexible endoscopes, selection and use of packaging systems for sterilization, use and storage of paper-plastic pouch package, and use and storage of containment device (eg, rigid container, instrument cases/cassettes, organizing trays)."	□A 749□	**3).Corrective Action**s: In-service with return demonstration in the use of packaging systems and accessories was completed on Aug.20, 2014. Administrative personnel will assess and document the competency of personnel on a quarterly basis in the use of packaging systems and accessories **Date of Implementation** In-service with return demonstration Aug.20, 2014, Quarterly competency assessments will begin Nov.1, 2014 **Monitoring Process**: Competencies will be conducted and documented on a quarterly basis for the use of packaging systems and accessories. **Person Responsible**: Director of Perioperative Services **7).Corrective Action**s: Competencies in the use, care and processing of flexible endoscopes and related equipment was completed on Aug. 12 and re-inserviced with return demonstration on Aug.21, 2014. Competencies with return demonstrations were also completed on 3/10/2014 as a part of the annual evaluation process. **(Attachment 27)** **Date of Implementation**: March 3/2014 annual competency, Inservices with competencies Aug. 12 and re-inservice Aug 21 with return demonstration **Monitoring Process**: Competencies will be conducted and documented on a quarterly basis for use, care, processing and storage of flexible endoscopes **Person Responsible**: Director of Perioperative Services **8).Corrective Action**s: Competencies in the use of sterilization packaging systems and accessories were completed on Aug 20.2014 for Central Supply techs. **(refer to Attachments for A-000.2)** **Date of Implementation** Aug 20, 2014 **Monitoring Process**: Competencies will be conducted and documented on a quarterly basis for sterilization packaging systems and accessories. Compliance data will be reported through Regulatory Compliance Committee, IC and Quality. **Person Responsible**: Director Perioperative Services **9).Corrective Action**s: Policies SGI. 006 □Cleaning and Disinfection of Endoscopes□and SCS.025 □Selection and Use of Packaging Systems for Sterilization □were reviewed and amended as needed to ensure infection control processes conform to AORN recommended practice guidelines and are facility specific**. (Attachment 28)** **Date of Implementation** Nov 1, 2014 **Monitoring Process**: Policies will be reviewed and revised to reflect current standards on an annual basis. **Person Responsible**: Surgery Committee, Surgical Services Director, Nursing Administration, Infection Control Team	8/20/2014 3/2014 8/12/2014 8/21/2014 8/20/2014 11/1/2014

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□A 749□	Continued From page 81 When reviewed the policies and procedures, these were found to be generic in nature, and intended to be used by any given facility, subsequently, not to be specifically identified, modified and operationalized to a specific facility's infection control. The evidence indicated that this facility had failed to develop and provide those aforementioned requested and operationalize any of these requested policies, that referred to infection control that conformed to AORN recommended practice guidelines, an accepted national standards and guidelines. Hollywood Campus 10. On August 18, 2014 beginning at4:30 p.m., the hospitals' maintenance of the dietetic departments' ice machine was reviewed with Staff 18 and Staff L (Director of Food Service). In a concurrent interview with Staff 18, he stated that the engineering department changed the water filter and vacuumed the air filter every few months. He stated they did not complete any additional tasks and that the dietary department was responsible for cleaning/sanitation. Staff L stated the department cleaned only the ice holding bin and wiped down outside of the machine. Review of manufacturers' guidance for preventive maintenance of the ice machine called for the regular cleaning/sanitation of internal ice producing components utilizing manufacturer specified chemicals. 11. During general kitchen observations on	□A 749□	**Hollywood Campus** **10). Corrective Action**: The manufacturer□s instructions for care and use of ice machines were identified and the Engineering staff used these to develop a cleaning protocol and checklist for the ice machines. The machines will be sanitized on a biannual basis and placed on the engineering preventative maintenance list for future servicing/sanitizing. **(Attachment: 29)** **Date of Implementation**: August 22, 2014 **Monitoring Process**: Listing of Ice machine sanitizing on preventative maintenance list. Review of ice machine documentation during Infection Control/ Dietary rounds. **Person Responsible**: Engineering Department, Infection Control, RD, Director of Dietary	8/22/2014

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□A 749□	Continued From page 82 8/18/14 beginning at 10:30 a.m., it was noted that there was no air gap in the food production sink. The standard of practice would be to ensure the existence of an air gap which is an unobstructed vertical space between the water outlet of food service equipment and the flood level of a fixture (Food Code, 2013). In a concurrent interview with DS (Dietary Staff) 5 she stated that a work order was generated for installation of the air gap; however she was unsure of the status of the work order. Review of facility document titled " Work Order Notification " dated 8/13/14 noted the request to "install a 1" gap in prep sink, cook sink and ice machine ... " It was also noted that on 8/14/14 the staff member assigned to the task indicated that action was taken and there was the installation of a "piping gap." The staff member who documented the work order as complete was unavailable for interview. 12. During food distribution observations on 8/18/24 from 11:30 a.m.-12:30 p.m., DS 2 was regularly using a single terry towel to wipe off food stuff from patient plates as well as the food production counter. The standard of practice would be to ensure that dry wiping cloths used for food wiping food be maintained solely for wiping food, be free of visible food particles and not be used for wiping food production surfaces (Food Code, 2013). Review of undated departmental policy and procedure manual revealed there was no policy in relationship to the proper use of wiping cloths. Culver City Campus 13. During general kitchen observation on August 19, 2014 beginning at 11:30 a.m., there was no air gap in the food production sink in the bakery area. In an interview on August 21, 2014 Staff L	□A 749□	**11). Corrective Action**: Air gaps were installed on all food prep sinks **(Attachment: 20)** **Date of Implementation**: 8/20/14 **Monitoring process**: Bimonthly rounds with Infection Control and Dietary. **Person Responsible**: Director of Engineering **12). Corrective Action**: Revision of Food & Nutrition Policy F018 Sanitizing Food Contact Surfaces requiring the use of disposable towels to be used for the purpose of improving plated food presentation by wiping off edges of plated foods. Each towel cannot be used for any other purpose. In-services conducted on discontinuation of use of terry towels on patient plates and initiation of. single-use disposable cloths. **(refer to Attachment: A-749.5 e Attachment 21)** **Date of Implementation**: 10/28/14 **Monitoring Process**: Observations by dietary supervisor/Director during tray line audits **Person Responsible**: RD, Director of Dietary **Culver City** **13).Corrective Action**s: Air gaps in the kitchen were verified to have been placed in all three food preparation sinks **(Attachment: 16)** **Date of Implementation**: 8/21/14 **Monitoring Process**: Facilities monitors maintenance issues via EOC rounds which are reported to Quality Council. **Person Responsible**: RD, Director of Dietary Department & Director, Plant Management	8/20/2014 10/28/2014 8/21/2014

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□A 749□	Continued From page 83 stated a work order was generated for engineering staff to fix to ensure that all sinks had the required air gap. She stated that 1 air gap was installed in the cold production area but did not verify completion of the work. This is a repeat deficiency from the sampled validation survey on 4/1/14.	□A 749□		
□A 940□	482.51 SURGICAL SERVICES If the hospital provides surgical services, the services must be well organized and provided in accordance with acceptable standards of practice. If outpatient surgical services are offered the services must be consistent in quality with inpatient care in accordance with the complexity of services offered. This CONDITION is not met as evidenced by: Based on observation, review of facility documents and staff interview, the facility failed to meet the Condition of Participation in Surgical Services by failing to: 1. Ensure the temperature and humidity were monitored in the autoclave room in accordance with recommendation from AAMI (Association for Advanced Medical Instrument) (Hollywood campus) (Refer to A 951). 2. Establish functional workflow patterns in the following order from potentially high contamination areas to clean areas in accordance with recommendation from AORN (Association of Peri-Operative Registered Nurse Standards. AORN is the National Recognized Standards (NRS) the hospital identified as the standard they followed (Hollywood campus)	□A 940□	**1). Corrective Action**: Temperature and humidity monitor placed in Central Processing area and temperature monitored and recorded daily according to AAMI recommendations. **(Attachment 1)**Any deviation from AAMI recommendations will be immediately reported to engineering for action. Follow up will be documented. Staff education occurred **(Attachment 2)** **Date of Implementation**: Monitor placed: October 1, 2014; Staff education on 9/24/14. **Monitoring Process**: Temperature and humidity log with compliance reported to Regulatory Compliance Committee & Quality Council **Person Responsible**: Surgery/Central processing staff//Engineering **2). Corrective Action**: Workflow patterns re-defined from high contamination areas to clean areas based on AORN recommendation as follow: instruments are pre-cleaned at the point of use, sprayed with enzymatic foam, transported with closed container into the decontamination room where instruments are decontaminated and cleaned; cleaned instruments are placed in a clean instrument tray, closed and cover and transported via clean cart to central processing through the side door (□2) to complete sterilization process. After completion of sterilization process, instruments are transported and taken out through door (□1) for storage in sterile area. Door □1 from Central processing into the main OR hallway is being used to remove sterilized equipment from central processing to the Surgical areas. Staff has been educated on the process. Revision to policy SCS.010 Flow pattern sterile processing area with staff education. **(Attachment: 3**) Staff Inservicing **(Attachment 4)** **Date of Implementation**: September 4, 2014 **Monitoring Process**: Periodic random monitoring. **Person Responsible**: Central processing team, Infection Control.	9/24/2014 10/1/2014 9/4/2014

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□A 940□	Continued From page 84 (Refer to A 951). The cumulative effects of these systemic issues resulted in the facility's inability to ensure and provide safe patient care environment. This is a repeat deficiency from the sampled validation survey on April 1, 2014.	□A 940□		
□A 951□	482.51(b) OPERATING ROOM POLICIES Surgical services must be consistent with needs and resources. Policies governing surgical care must be designed to assure the achievement and maintenance of high standards of medical practice and patient care. This STANDARD is not met as evidenced by: □ Based on observation, interview and record review, the facility failed to 1. Ensure the temperature and humidity were monitored in the autoclave room in accordance with recommendation from AAMI (Association for Advanced Medical Instrument) (Hollywood campus). 2. Establish functional workflow patterns from potentially high contamination areas to clean areas in accordance with recommendation from AORN (Association of Peri-Operative Registered Nurse Standards. AORN is the National Recognized Standards (NRS) the hospital identified as the standard they followed. This deficient practice promote microbial growth and can result in contamination of sterile items. Findings:	□A 951□		

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□A 951□	Continued From page 85 Hollywood campus Central Processing Room During the tour with Registered Nurse (RN) 1 in the Semi-Restricted and Restricted areas on August 18, 2014 between 1:10 p.m. and 3 p.m., the following were observed: 1. There was no thermometer and humidity display in the Central processing Room, where all surgical instruments trays were wrapped and sterilized in the steam autoclaves. According to Certified Scrub Technician (CST) 1, the temperature and humidity had not been monitored and recorded. There was no documentation that the temperature and humidity to the Central Processing Room had been monitored and recorded. During an interview with CST 1 on August 18, 2014 at 3 p.m., she stated that the temperature and humidity to the Central Processing Room had not been monitored and recorded. According to AAMI (Association for Advanced Medical Instrument) (2014) Chapter 3: Design Considerations "3.3.6.5 Temperature General work areas should have a temperature controlled between 20oc and 23□C (68□F and 73□F). The decontamination area should have a temperature controlled between 16□C and 18□C (60□F and 65□F). The temperature in sterilization equipment access rooms should be controlled between 24□C and 29□C (75□F and 85□F) or as recommended by the equipment manufacturer. The temperature in sterile storage and personnel support areas (e.g., toilets, showers, locker rooms) may be as high as 24□C (75□F). Independent monitors should be located in each	□A 951□	**1). Corrective Action**: Temperature and humidity monitor wa placed in Central Processing area. Temperature and humidit is monitored and recorded daily. Any deviation from established normal range of temperatures will be immediately reported to engineering for action. Follow up will be documented. Staff has been educated to the process. **(Attachment 1)** Processing personnel in each work area are responsible for monitoring and recording the temperature to ensure that the correct temperature is being achieved. **Date of Implementation**: October 1, 2014 **Monitoring Process**: Temperature and humidity log **(refer to A-940.2 attachment 1)** **Person Responsible**: Surgery/Central processing staff/Engineering	10/1/2014

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□A 951□	Continued From page 86 of the areas where temperature should be controlled; temperature should be recorded daily. Processing personnel in each work area are responsible for monitoring and recording the temperature to ensure that the correct temperature is being achieved." 2. The dirty surgical instruments were decontaminated in other room and transported into the entrance of the Central Processing Room for preparation, packaging , and sterilization processing. The surgical instruments were transported through the same entrance, where the decontaminated surgical instruments were transported into, and were distributed to the OR □1 for surgical procedures after they were sterilized in the steam autoclave. During an interview with RN 1 on August 18, 2014 at 3 p.m., she stated the functional workflow patterns should be following the order from potentially high contamination areas to clean areas. According to Perioperative Standards and Recommended Practices for 2013 of the AORN, "Sterilization :" "Recommendation III III.b.2. Functional workflow patterns should be established in the following order from potentially high contamination areas to clean areas: 1. Decontamination area, 2. Preparation and packaging, 3. Sterilization processing, 4. Sterile storage, and	□A951□	**2). Corrective Action**: Workflow re-defined as follow: instruments are pre-cleaned at the point of use, sprayed with enzymatic foam, transported with closed container into the decontamination room where instruments are decontaminated and cleaned; cleaned instruments are placed in a clean instrument tray, closed and cover and transported via clean cart to central processing through the side door (□2) to complete sterilization process. After completion of sterilization process, instruments are transported and taken out through door (□1) for storage in sterile area. Door □1 from Central processing into the main OR hallway is being used to remove sterilized equipment from central processing to the Surgical areas. Staff has been educated on the process **Attachment 2) Date of Implementation**: September 4, 2014 **Monitoring Process**: Periodic random monitoring. **Person Responsible**: Central processing team, Infection Control	9/4/2014

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□A 951□	Continued From page 87 5. Clean distribution On August 21, 2014, the facility was requested to provide policies and procedures, titled, "Functional workflow patterns." When reviewed the policies and procedures titled, "Flow pattern-Sterile Processing Areas," these was found not to be specifically identified, modified and operationalized to a surgical service. The evidence indicated that this facility had failed to develop and provide those aforementioned requested and operationalize any of the requested policy, that referred to surgical services that conformed to AORN recommended practice guidelines, an accepted national standards and guidelines. This is a repeat deficiency from the sampled validation survey on 4/1/14.	□A 951□		

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□K 000□	INITIAL COMMENTS This facility was surveyed under the Life Safety Code NFPA 101, 2000 Edition, Chapter 19, Existing Health Care Occupancies, and other applicable codes. Representing the Department of Public Health: Evaluator ID □16281, REHS, HFE I, REHS, CFII The following represents the findings of the Department of Public Health during a Life Safety Code Survey Follow-Up Visit pursuant to a Full Sample Validation Survey completed on April 1, 2014.	□K 000□		
□K 018□	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1% inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	□K 018□		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (□6) DATE

Any deficiency statement ending with an asterisk (□) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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□K 018□	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and interview, the hospital failed to ensure two corridor doors could resist the passage of smoke, and that there was no impediment to the closing of a corridor door. The deficiency had the potential to permit the passage of smoke, flame, or gases during a fire. Findings: Hollywood Campus Basement 1.) On August 18, 2014 at 11:30 a.m., the doctors' break/locker room had a □ □diameter penetration through the solid wood corridor door of at a fire rated exit corridor. During an interview at the same time as the observation, the Disaster Coordinator stated that the corridor was a fire rated exit corridor. This is a repeat deficiency; on 4/1/14, during a Sample Validation survey, the facility received a deficiency for having a corridor door in a condition that could not resist the passage of smoke. First Floor 2.) At 12:25 p.m., the Urgent Care door at a fire exit corridor was held fully open by a bundled bandage with tape wedged between the top of the door and door frame. This is a repeat deficiency; on 4/1/14 during a	□K 018□	**Hollywood Campus** **Basement** **1. Corrective Actions:** The corridor door was repaired on August 26, 2014. The Engineering Department has added the basement doors to their quarterly door inspection, which will be tracked using the Fire Door Quarterly Inspection Log **(Attachment 1).** All engineers were in-serviced on the policy titled □Fire Door□ for proper visual inspection of the doors. **(Attachment 2 and 3).** **Date of Implementation:** August 26, 2014. **Monitoring Process:** The basement corridor doors were added to Engineering□s quarterly monitoring. After 100% compliance is achieved in two consecutive quarters, monitoring will be complete. **Person Responsible:** Director of Engineering & Lead Engineer **First Floor** **2. Corrective Actions:** The Engineering Department held an in-service with the Urgent Care, EVS and Security staff on the current Fire Life Safety policies that prohibit the doors from being held open. **(Attachment 4 & 5)** **Date of Implementation:** Staffing in-service was held on August 26, 2014. The door will be monitored daily, beginning September 1, 2014.	8/26/2014 8/26/2014 9/1/2014

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□K 018□	Continued From page 2 sampled validation survey the facility received a deficiency for having a corridor door that was impeded from closing. Culver City Campus Pavilion 6th floor Unit C Psychiatric 3.) On 8/20/14 between 9:30a.m. and 9:45a.m., the Dutch corridor door at nurses station C had an aluminum floor threshold with no indication of a fire rating at the meeting edges of the upper and lower leaves. The door was not equipped with an astragal, a rabbet, or a bevel with the same fire rating as the door at the meeting edges of the upper and lower leaves. Closer observation revealed the labels that indicate the fire rating had been removed from the door and door frame. During an interview at the same time as the observation, the Nursing director of P6 (Psychiatric 6) stated, the metal piece (threshold) was placed there yesterday (8/19/14). This is a repeat deficiency; on 4/1/14 during a Sampled Validation survey, the facility received a deficiency for having a corridor Dutch door with no astragal.	□K 018□	Continued from page 2 **Monitoring Process:** The door will be monitored daily, beginning September 1, 2014 **(Attachment 6)**. The door will be monitored for thirty (30) consecutive days. After achieving 100% compliance for sixty (60) days, monitoring will be discontinued. **Person Responsible:** Director of Engineering & Lead Engineer. **Culver City Campus** **6th Floor Unit C** **3. Corrective Actions:** The Engineering Department contacted a third party certification company to re-rate and label the Dutch doors. An astragal was placed on the Dutch doors to achieve the proper certification. **Date of Implementation:** The Dutch doors were re-certified on October 8, 2014. **Monitoring Process:** During the first quarter, the Dutch door will be monitored for tampering, astragal placement and labeling. When 100% is reached continuous monitoring will occur as a part of EOC weekly rounds, covering patient care areas twice a year. **(Attachment 7)** **Person Responsible:** Director of Engineering & Lead Engineer.	10/8/2014
□K 025□	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at□ least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each	□K 025□		

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□K 025□	Continued From page 3 floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, the hospital failed to ensure smoke barriers were maintained with a half hour fire resistance by having missing gypsum board at corridor smoke barrier wall, and a penetration through a construction□ separation wall. The deficiency had the potential to reduce the time the corridor smoke barrier wall had to withstand a fire exposure, and permit the passage of smoke, flame, or gases through the construction separation wall during a fire. Findings: Van Nuys Campus Station 2 1.) On 8/19/14, at Station 2 15ft. a gypsum board was missing from one side of a corridor smoke barrier wall exposing the wood framing members. The area missing the gypsum board was located above the drop down ceiling, above the observation and dictation room, both of which had 20 minute rated fire doors. At the same time as the interview, the Head Engineer stated that the wall was a 30 minute rated fire wall that needed to have dry wall on	□K 025□	**Van Nuys Campus** **Station 2** **1. Corrective Actions:** The Engineering Department attained help from a third party for remediation of fire penetrations throughout the facility. The Engineering staff was also in-serviced on the use of the approved above ceiling work permit and quarterly fire wall and smoke penetration Inspection Preventive Maintenance. **Date of Implementation:** The work of remediation was completed on October 22, 2014. The Engineering staff was in-serviced on above ceiling work permits on August 25, 2014. **(Attachment 8, 9, 10, 11)** **Monitoring Process:** The Engineers will monitor their smoke and fire walls for penetrations on a quarterly basis **(Attachment 12).**	8/22/2014 10/22/2014

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□K 025□	Continued From page 4 both sides of the wall. Culver City Campus Pavilion 4th floor Rehabilitation Unit 2.) On 8/20/14 between 10:05 a.m. and 10:23 a.m., at the construction separation between the back of the 4th floor and the rehabilitation unit at the front of the 4th floor, there was a 3 foot by 5 foot section missing from the gypsum board barrier at the separation. During an interview at the same time as the observation, the Corporate Director of Facilities stated that the gypsum board barrier was supposed to go all the way up to the ceiling. This is a repeat deficiency; on 4/1/14 during a Sampled Validation survey, the facility received a deficiency for having unsealed penetrations through the gypsum board barrier at the construction separation between the back of the 4th floor and the rehabilitation unit at the front of the 4th floor.	□K 025□	Continued from page 4 The above ceiling work permit will be used for all work done above ceiling to monitor and assure fire walls are always 100% compliant. **Person Responsible:** Director of Engineering & Lead Engineer **Culver City Campus** **4th Floor Rehabilitation Unit** **2. Corrective Actions:** The Engineering Department repaired the fire penetrations throughout the facility. The Engineering staff was also in-serviced on the use of the approved above ceiling work permit and quarterly fire wall and smoke penetration Inspection Preventive Maintenance. **Date of Implementation:** The work of remediation was completed on August 25, 2014. The Engineers were in-serviced on above ceiling work, as well as fire and smoke wall penetration inspection preventive maintenance on the same date **(Attachment 13)** **Monitoring Process:** The Engineers will monitor their smoke and fire walls for penetrations on a quarterly basis **(Attachment 14).** The above ceiling work permit will be used for all work done above ceiling to monitor and assure fire walls are always 100% compliant. **Person Responsible:** Director of Engineering & Lead Engineer.	8/25/2014
□K 027□	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6,	□K 027□		

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	050135	A. BUILDING **01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD** B. WING _____	**08/21/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, □IP CODE
SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	**6245 DE LONGPRE AVE HOLLYWOOD, CA 90028**

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□K 027□	Continued From page 5 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation and interview, the hospital failed to ensure a cross corridor door automatically self closed when the fire alarm system was activated. The deficiency had the potential to permit the passage of smoke, flame, or gases during a fire, and permit drafts which could spread fire rapidly. Finding: Hollywood Campus First Floor On August 18, 2014 at 12:37 p.m., a cross corridor door located on the first floor, between Urgent Care and the kitchen, failed to close upon activation of the fire alarm system. Closer observation revealed the magnetically held door released upon activation of the fire alarm system, but failed to close. Further observation revealed the door was stuck to the floor. At the same time as the observation, the Corporate Director of Facilities stated that the door failed to close because of wax built up on the floor. At 1:20 p.m., after the wax build up was removed from the floor, the door was retested by again activating the fire alarm system. The door released from the magnetic holder and closed.	□K 027□	**Hollywood Campus** **First Floor** **1. Corrective Actions:** The Engineering Department in-serviced the EVS staff on the excessive use of wax and the need to pay extra attention to the cross corridor doors for assurance of proper closing. **Date of Implementation:** The EVS staff was in-serviced on August 18, 2014 **(Attachment 15).** **Monitoring Process:** The Engineering and EVS staff will monitor cross corridor doors for excessive wax. A floor cleaning schedule has been created for the monitoring of these doors. The floors will be monitored for two rounds of cleaning; monitoring will discontinue after two rounds of cleaning result in doors not sticking. **Person Responsible:** Director of Engineering & Lead Engineer	8/18/2014

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□K 027□	Continued From page 6 This is a repeat deficiency; on 4/1/14 during a Sampled Validation survey, the facility received a deficiency for the same cross corridor door not closing during a test of the fire alarm system.	□K 027□		
□K 052□	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: NFPA 72 National Fire Alarm Code, 1999 Edition 7-3.2 Testing. Testing shall be performed in accordance with the schedules in Chapter 7 or more often if required by the authority having jurisdiction. If automatic testing is performed at least weekly by a remotely monitored fire alarm control unit specifically listed for the application, the manual testing frequency shall be permitted to be extended to annual. Table 7-3.2 shall apply.	□K 052□		

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□K 052□	Continued From page 7 Exception: Devices or equipment that are inaccessible for safety considerations (for example, continuous process operations, energized electrical equipment, radiation, and excessive height) shall be tested during scheduled shutdowns if approved by the authority having jurisdiction but shall not be tested more than every 18 months. Table 7-3.2 Testing Frequencies 5. Batteries - Central Station Facilities c. Sealed Lead-Acid Type 1. Charger Test- Monthly, Quarterly 2. Discharge Test (30 minutes)- Monthly 3. Load Voltage Test - Monthly 6. Batteries - Fire Alarm System c. Sealed Lead-Acid Type 1. Charger Test - Annually 2. Discharge Test (30 minutes) -Annually 3. Load Voltage Test - Semiannually The Code was not met as evidenced by: Culver City Campus Based on document review, and interview, the hospital failed to ensure the batteries of the fire alarm system were tested at the frequencies indicated by NFPA 72. The deficiency had the potential to not supply backup power to the fire alarm system.	□K 052□		

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□K 052□	Continued From page 8 Finding: On August 21, 2014 at 10:30 a.m., during document review, there was no documented evidence the fire alarm system batteries were routinely tested. During an interview, at the same time as the document review, the Lead Man stated that the fire alarm system had sealed lead acid batteries, and that the load voltage tests of the batteries was not being conducted.	□K 052□	**Culver City Campus** **1. Corrective Actions:** The Engineering Department has revised their monthly preventive maintenance to include the monitoring and testing of the fire alarm batteries. The batteries will also be replaced after the second year of use. **Date of Implementation:** The policy and procedure was revised on August, 25, 2014. **Monitoring Process:** The Engineering staff will monitor the batteries on a monthly basis and replace every two years. **(Attachment 16).** **Person Responsible:** Director of Engineering & Lead Engineer	8/25/2014
□K 054□	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer□s specifications. 9.6.1.3 This STANDARD is not met as evidenced by: NFPA 72 National Fire Alarm Code 1999 Edition 2-1.3.2 In all cases, initiating devices shall be supported independently of their attachment to the circuit conductor. The Code was not met as evidenced by: Based on observation and interview, the hospital failed to ensure that a required smoke detector (initiating device) was maintained as required by having a dismounted smoke head suspended by its electrical wires. The deficiency had the potential to impair the operation of the initiating device circuit.	□K 054□		

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□K 054□	Continued From page 9 conceivably resulting in loss of life or property because of fire alarm failure. Copper used in wiring conductors is not formulated to serve as a mechanical support. Copper fatigues over time if placed under mechanical stress, resulting in increasing brittleness and increasing electrical resistance. Ultimately, the fatigued conductor either breaks or its resistance becomes too high to allow the initiating device to function properly. Finding: Culver City Campus Pavilion 6th floor Unit C Psychiatric On 8/20/14 between 9:30a.m. and 9:45a.m., in room 636, there was a smoke detector head that was detached from its base, supported only by its electrical wires. During an interview at the same time as the observation, the Director of Engineering acknowledged the smoke detector head was supported by its wires, and stated the head would be repaired to be supported by its base or it would be replaced. This is a repeat deficiency; on 4/1/14 during a Sampled Validation survey, the facility received a deficiency for having a smoke detector that was pulled of a wall.	□K 054□	**<u>Culver City Campus</u>** **<u>6th Floor Unit C Psychiatric</u>** **Corrective Actions:** The smoke detector in Room 636 was immediately remounted to its base. **Date of Implementation:** The smoke detector was remounted on August 20, 2014. **Monitoring Process:** The Engineering Department conducts weekly visual inspections to ensure secure mounting of smoke detectors. **(Attachment 17).** **Person Responsible:** Director of Engineering & Lead Engineer	8/20/2014
□K 130□	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY-NOT ON 2786	□K 130□		

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□K 130□	Continued From page 10 This STANDARD is not met as evidenced by: NFPA 99 Standard for Health Care Facilities 1999 Edition 4-3.1.1.1 Cylinder and Container Management. Cylinders in service and in storage shall be individually secured and located to prevent falling or being knocked over. 4-3.5.2.1(b)24. Even if they are considered empty, cylinders shall never be used as rollers, supports, or for any purpose other than that for which they are intended by the supplier. 4.3.5.2.2(b)2. If stored within the same enclosure, empty cylinders shall be segregated from full cylinders. Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed hurriedly. 8-3.1.11.2 Storage for nonflammable gases less than 3000 ft3 (85 m3). (h) Cylinder or container restraint shall meet 4-3.5.2.1(b)27. 4-3.5.2.1(b)27. Freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. These Standards was not met as evidenced by: Based on observation and interview, the hospital failed to ensure oxygen cylinders were properly chained or supported in proper cylinder stands or carts. The deficiency had the potential to create a	□K 130□		

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□K 130□	Continued From page 11 mechanical hazard. If a cylinder falls, the valve could snap off and/or if the cylinder is cracked open and the cylinder has a sudden, uncontrollable release of its contents, it could be propelled rapidly and/or violently. Findings: Culver City Campus Exterior Oxygen Cylinder Storage On August 21, 2014 at 9:10a.m. the following conditions existed at the exterior oxygen (02) cylinder storage area. 1.) Two 02 (a non-flammable gas) cylinders were lying on their sides on the ground with a metal hand truck on top of them. During an interview, at the same time as the observation, the Head Engineer stated that the cylinders should have been in racks, stands or secured by chains. 2.) One 02 cylinder was free standing and unsecured. During an interview, at the same time as the observation, the Head Engineer stated that the cylinder should have been in a rack, stand or secured by a chain. This is a repeat deficiency; on 4/1/14 during a Sample Validation survey, the facility received a deficiency for having free standing oxygen cylinders that were not supported or chained throughout the hospital, including the exterior oxygen storage area.	□K 130□	**Culver City Campus** **Exterior Cylinder Storage** **1. Corrective Actions:** The cylinders were immediately put back onto the appropriate rack. A daily surveillance procedure has been implemented to check for inappropriate or unsafe storage. Staff was in-serviced on O_2 tank safety, monitoring and surveillance. **(Attachment 18)** **Date of Implementation:** August 21, 2014. **Monitoring Process:** A twice daily check log has been implemented to ensure tanks are secured safely and in the appropriate locations. Monitoring log is effective starting October 1, 2014. **(Attachment 19)** **Person Responsible:** Respiratory Therapy Clinical Coordinator **2. Corrective Actions:** The cylinder was immediately put back onto the appropriate rack. Additional racks have been ordered to ensure O_2 cylinders throughout the facility will be properly secured. **Date of Implementation:** August 21, 2014. **Monitoring Process:** Cylinders are monitored during morning and afternoon daily rounds. **(Attachment 19)** **Person Responsible:** Respiratory Therapy Clinical Coordinator	8/21/2014 10/1/2014 8/21/2014

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	Continued From page 12		Continued from page 12	
□K 130□	3.) One Argon (a non-flammable gas) cylinder was free standing unsecured. During an interview, at the same time as the observation, the Head Engineer identified the cylinder as an argon cylinder and stated that the cylinder should have been in a rack, stand or secured by a chain. 4.) There were ten full 02 cylinders stored on the empty cylinder side of the cylinder storage area. A sign on the wall identified the section as the empty cylinder section of the 02 storage area. During an interview, at the same time as the observation, the Head Engineer identified the cylinders as full cylinders and stated that the should been stored on the full side.	□K 130□	**3. Corrective Actions:** The cylinder was immediately put back onto the appropriate rack. Additional racks have been ordered to ensure O_2 cylinders throughout the facility will be properly secured. **Date of Implementation:** August 21, 2014 **Monitoring Process:** Cylinders are monitored during morning and afternoon daily rounds. **(Attachment 19** **Person Responsible:** Respiratory Therapy Clinical Coordinator **4. Corrective Actions:** Areas for storage of full and empty tank in the tank storage cage have been clearly marked. Additional racks have been ordered to segregate full tanks from empty tanks. **Date of Implementation:** August 21, 2014 **Monitoring Process:** Cylinders are monitored during monitoring and afternoon daily rounds. **(Attachment 19)** **Person Responsible:** Respiratory Therapy Clinical Coordinator & Senior Transportation Coordinator	8/21/2014 8/21/2014
□K 147□	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: NFPA 70 National Electrical Code (NEC) 1999 Edition 400-8. Uses not permitted. Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure 400-9. Splices. Flexible cord shall be used only in continuous lengths without splice or tap where	□K 147□		

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□K 147□	Continued From page 13 initially installed in applications permitted by section 400-7(a). The repair of hard-service cord and junior hard-service cord (see Trade Name column in Table 400-4) No. 14 and larger shall permitted if conductors are spliced in accordance with Section 110-14-(b) and the completed splice retains the insulation, outer sheath properties, and usage characteristics of the cord being spliced. These requirements were not met as evidenced by: Based on observation and interview, the hospital had an extension cord in use as permanent wiring. The deficiency had the potential to present a fire safety hazard. The National Electrical Code (NEC) stipulates that temporary wiring is to be removed immediately upon completion of construction or other purpose (i.e. remodeling, maintenance, repair, and demolition) for which the wiring was installed. Finding: Culver City Campus Single Story Building On August 21, 2014, at 9:35a.m., there was an extension cord being used as permanent wiring at the exterior west side of the single story building. A mini drop amplifier was connected to the extension cord. During an interview, at the same time as the observation, the Lead Engineer stated that the	□K 147□	**Culver City Campus** **Single Story Building** **1. Corrective Actions:** The Engineering Department removed the extension cord and repaired the existing outlet at the location. The Engineering staff was in-serviced on the use of extension cords. **(Attachment 20)** **Date of Implementation:** Repairs to existing outlet were complete on August 21, 2014. Staff in-service was conducted on August 25, 2014. **Monitoring Process:** The receptacle will be monitored for the next two (2) months, after that, it will be monitored annually during EOC rounds. **Person Responsible:** Director of Engineering & Lead Engineer	8/21/2014 8/25/2014

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□K 147□	Continued From page 14 extension cord should not have been in use as permanent wiring. This is a repeat deficiency; on 4/1/14 during a Sampled Validation survey, the facility received a deficiency for using extension cords as permanent wiring.	□K 147□		

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	CA930000064	A. BUILDING: _____ B. WING: _____	C 07/09/2014

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E 000	Initial Comments The following reflects the findings of the Department of Public Health during a Complaint Investigation. Intake Number: CA00404848 Inspection was limited to the specific complaint investigation and does not represent the findings of a full inspection of the facility. Representing the Department of Public Health: Surveyor 16281 One deficiency was issued to intake CA00404848.	E 000		
E 2429	T22 DIV5 CH1 ART8-70855 Mechanical Systems Heating, air conditioning and ventilating systems shall be maintained in operating condition to provide a comfortable temperature and to meet the new construction requirements in effect at the time plans were approved for the facility. This Statute is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure the air conditioning equipment was maintained to provide a comfortable temperature, and failed to adhere to its Patient Room Temperature Control Policy by having temperatures in patient care areas that were outside the hospital's target temperature range. According to the Centers for Disease Control (CDC), Extreme Heat Prevention Guide – Part 1, last reviewed: May 31, 2012. Elderly people (65 years and older), infants and children and people	E 2429		

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E 2429	Continued From page 1 with chronic medical conditions are more prone to heat stress. Air-conditioning is the number one protective factor against heat-related illness and death. Finding: On July 17, 2012 at 2:30 p.m., a complaint visit was conducted at the hospital regarding a complaint allegation that the hospitals air conditioning system was not working. The hospital census was 64. At 2:45 p.m., the Disaster Coordinator stated that half the time he works as the hospital engineer. He stated that the facility had two chillers a 100 ton and a 15 ton. That the 100 ton chiller would sometimes shut off and turn on again, that it happened for three consecutive days and then it was decided to change the parts the air conditioning service vendor had recommended. That the parts were changed on the compressor yesterday (7/8/14) by the vendor. That it fixed the problems at first but that there were other problems such as holes in the water circulation pipe which were discovered in the process of servicing the chiller. He also stated that the whole hospital was affected by the problems with the 100 ton chiller except for the basement. That the last time the air conditioning was not working was Monday afternoon (7/7/14). Between a 3:15 p.m. and 4:07 p.m., on July 17, 2014, samples of room temperatures were taken by the Disaster Coordinator using a infrared temperature gun with a lowest temperature	E 2429	**Corrective Actions:** To assure prompt actions, the facility has hired a Lead Engineer to alleviate response time and management from the Disaster Coordinator. The facility has reached a maintenance agreement with a third party for monthly service to the chiller. In the event that the chiller goes down, the facility will call for portable units and also call the IOR to contact the CO for emergency approval process of an on-site temporary chiller as the repairs are completed. The facility has in-serviced the engineering department on the new policy, implemented in March 2014, and will be auditing findings on a bi-weekly basis. The facility has also implemented a preventive maintenance program, which will be performed on a quarterly basis. **Date of Implementation:** The Lead Engineer was hired on August 14, 2014. The third party agreement was implemented on September 19, 2014. In-services were conducted and audits began on August 25, 2014. Redline Air's quarterly preventive maintenance program will commence on September 18, 2014. **Monitoring Process:** Temperature Log is monitored bi-weekly. Engineering will be conducting mechanical rounds on a daily basis. Quarterly preventive maintenance program by Redline Air. **Person Responsible:** Lead Engineer and Engineering department.	8/14/2014 8/25/2014 9/18/2014 9/19/2014

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E2429	Continued From page 2 reading of 68.3 degrees Fahrenheit and the highest temperature reading of 80.0 degrees Fahrenheit as follows: 6th floor 1. The respiratory therapy room was 72.6 degrees Fahrenheit. 5th floor (Med Surge Unit) 2. Room 510 was 72.2 degrees Fahrenheit. 3. Room 505 was 70.9 degrees Fahrenheit. 4. Room 501 was 68.9 degrees Fahrenheit. 4th floor (Med Surge Unit) 5. Room 409 was 72.7 degrees Fahrenheit. 6. Room 406 was 71.0 degrees Fahrenheit. 7. Room 401 was 78.9 degrees Fahrenheit. 3rd floor 8. Room 307 part of the Med Surge Unit, was 70.9 degrees Fahrenheit. 9. The CCU was 80.0 degrees Fahrenheit. 10. The ICU was 68.3 degrees Fahrenheit. 11. Room 301 was 69.0 degrees Fahrenheit. 2nd floor (currently not occupied by patients) 12. Room 202 was 68.7 degrees Fahrenheit.	E 2429		

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E 2429	Continued From page 3 13. Room 201 was 72.4 degrees Fahrenheit. 1st floor 14. The Urgent Care room was 70.9 degrees Fahrenheit. 15. The kitchen was 73.2 degrees Fahrenheit. Basement 16. The corridor to surgery was 77.3 degrees Fahrenheit. Two of fourteen sampled rooms (401 and the CCU), and the surgery corridor were above the hospitals target temperature range. At the same time as the observation four of six patients interviewed (Patients 1, 2, 3 and 4) stated their rooms were hot or warm. Patient 1 stated, “It’s hot, it may be my because of my medication, but its better than the other day.” Patient 2 stated, “It’s warm in here.” Patient 3 stated, “Gets hot at night.” Patient 4 stated, “It’s hot in the room.” Also, at the same time as the observation, during an interview, the Disaster Coordinator stated that the temperature that was out of range in room 401 was a thermostat issue because the thermostat was set too high. Between 4:07 p.m. and 5:02 p.m., during document review, policy number UTL-086, titled,	E 2429		

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E 2429	Continued From page 4 "Patient Room Temperature Control," with an effective date of 3/20/2014 indicated that the heating, air conditioning, and ventilation systems shall be maintained in operating condition to provide a comfortable temperature based on Title 24 Mechanical Code (Ref. Table 325.0). The policy indicated that the target temperature range was 68 to 77 degrees (Fahrenheit) (Title 24, Table 325.0). The policy indicated that the objective was to establish an effective and compliant temperature control system that can be monitored in all general patient care areas of the facility, and indicated the procedure was that on the day determined readings would be taken and logged as part of the daily rounds on non-critical patient care areas. That the readings were to be taken from two points within the patient room, and at the bedside level for every HVAC unit service area, every two weeks, twice per day (7:00 a.m. and 2:00 p.m.) A review of the Daily Mechanical Inspections log from July 1 to 9, 2014, indicated that on July 2, 3, 5 and 6, 2014, the air conditioning was malfunctioning. A review of the Hospital wide Temperature Log for July 1, 2, 4, 5, 6, 7, 8 and 9, 2014, indicated that on July 2, 4, 5, 7, 6, 8, and 9 2014, the temperature in patient areas throughout the hospital were above the hospital's target temperature range of 68 to 77 degrees Fahrenheit. Per the log on July 2, 2014, at 9 a.m., the measured temperatures of 22 of 24 areas, including patient areas in the hospital were between 77.1 and 78.6 degrees Fahrenheit.	E 2429		

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E 2429	Continued From page 5 Per the log on July 4, 2014, at 11 a.m., the measured temperatures of 52 of 52 areas, including patient areas in the hospital were between 78.0 and 83.1 degrees Fahrenheit. Per the log on July 5, 2014, at 8 a.m., the measured temperatures of 59 of 59 areas, including patient areas in the hospital were between 79.0 and 83.1 degrees Fahrenheit. Per the log on July 6, 2014, at 11 a.m., the measured temperatures of 49 of 49 areas, patient areas in the hospital were between 79.0 and 85.1 degrees Fahrenheit. Per the log on July 7, 2014, time not indicated, the measured temperatures of 4 of 48 areas, including patient areas in the hospital were above the hospital's target temperature range. Room 305, and the third and fourth floor hallways, were 78 degrees Fahrenheit. Per a log on July 8, 2014, time not indicated, the measured temperatures of 3 of 51 areas, including patient areas in the hospital were above the hospital's target temperature range. Room 301, 410 and 506, were 78 degrees Fahrenheit. Per a second log on July 8, 2014, at 11:14 a.m., the measured temperatures of 60 of 63 areas, including patient areas in the hospital were between 78.1 and 88.8 degrees Fahrenheit. Per the log on July 9, 2014, time not indicated, the measured temperature of 2 of 51 areas, including patient areas in the hospital was above the hospital's target temperature range. Room 309 was 78 degrees Fahrenheit. The facility did not provide Hospital wide	E 2429		

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E 2429	Continued From page 6 Temperature Logs for July 3, 2014, or any other documented evidence temperature measurements of patient areas were taken, or that the hospital patient areas were within the hospital's target temperature range on July 3, 2014. At 2:50 p.m., during an interview, the Disaster Coordinator had stated that the temperature is usually monitored every day but that currently they were monitoring the temperature three times a day. There was no documented evidence provided the temperature was being monitored three times a day, evidence of daily monitoring twice a day was provided for 1 of 9 days, and evidence of daily monitoring once a day was provided for 7 of 9 days. The Disaster Coordinator was not aware that the hospital had a Patient Room Temperature Control policy. At 4:40 p.m., during an interview, the Chief Engineer stated that every morning he checks that the chiller is running at between 50 to 58 degrees Fahrenheit but that the patient rooms are only checked when the nurses call if there is a problem, and that the temperatures are not logged unless there is a problem. He also stated that the target temperature range he checks for is 60 to 72 degrees Fahrenheit. The Chief Engineer was not aware that the hospital had a Patient Room Temperature Control policy. A review of rental agreements dated July 2, 5, 6, and 7, 2014 indicated that twenty portable spot coolers (air conditioners) were rented by the hospital. During an interview, at the same time as the	A 2429		

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E 2429	Continued From page 7 document review, the Administrator stated that twenty nine portable spot coolers were rented and placed throughout the hospital, primarily in patient areas. A review of the description of work form from the air conditioning service vendor dated July 7, 2014, indicated the technician installed hot gas discharge thermostat and suction line freeze stat, rebuilt, reinstalled the compressor and aligned, evacuated, opened all valves, replaced liquid line driers, started system, set oil pressure safety at 25 psi and tested OK, system running good with 21 degree superheat – 6 degree subcooling and 60 psi net oil pressure, changed oil after one hour will return to change again. A review of the description of work form from the air conditioning service vendor dated July 8, 2014, indicated the technician ran flexible conduit and wiring from suction line freezes stat and discharge line T-stat at 180 degrees Fahrenheit and freeze stat at 40 degrees Fahrenheit, replaced bad condenser fan motor and fan blade, verified rotation and operations OK, monitored chiller operations, adjusted to unload at 59 psi, will return to change oil and driers.	E 2429		

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{A 000}	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during a focused revisit following a Complaint Validation Survey (Intake Number CA00429647) completed on 2/5/15 with Condition of Participation (CoP) CFR 482.41 Physical Environment not met. The focused revisit was completed on 6/4/15. Representing the Department of Public Health: Surveyor 16281, REHS, CFI 1, HFE I	{A 000}		
{A 701}	482.41(a) MAINTENANCE OF PHYSICAL PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This STANDARD is not met as evidenced by: Based on observation, interview, and document review, the hospital failed to provide a permanent air system to operate continuously and provide balanced air-supply to patient rooms for the 2nd, front of 3rd (SDU), 4th, 5th, and 6th floors, provide a Construction Final (CF) for the new temporary air handler and fire alarm control panel, and provide self-closing area separation fire doors. The deficiencies had the potential to permit the spread of smoke and gases during a fire, and not provide a permanent provision of balanced air-supply to patient rooms on the 2nd, front of 3rd, 4th, 5th, and 6th floors. Findings:	{A 701}	1. Corrective Action: The ability to remove relays that would allow bypass of the air handlers has been permanently eliminated. With the installation of the new fire panel, the relays are now designed to fail safe. This means that should someone remove or tamper with the relays, the air handlers will automatically shut down, which will immediately stop air flow in the ventilation system. The fire system has been fully tested by Culver City Fire Dept and Inspector of Record, to insure that in the event of a fire or smoke alarm, both the permanent and temporary air handler will shut down. Attachment's •OSHPD CO 8/19/2015 Certificate of Occupancy for use of Temporary Air Handler •OSHPD FV 6/30/15 indicating we will be able to obtain Construction Final once the replacement air handler is installed and temporary air handler is removed. •OSHPD Notice of Start of Construction for New Permanent Air Handler •OSHPD VR 6/3/15 indicating all devices have been tested	06/22/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{A 701}	Continued From page 1 1. On 6/4/15 the evaluator conducted a follow up visit for a complaint validation survey dated 2/5/15, for a fire that occurred on the roof, and at air handler 2 of the pavilion building on 1/29/15, during roofing work. Relays at the air handler control panel had been disconnected, permitting air handlers 1 and 2 to not shut down with the presence of smoke, dispersing smoke from the roof and air handler 2 to other areas and floors of the pavilion. On 6/4/15 at 10 a.m., during an interview, the VP of Corporate Facilities Operations stated that with the new design of the fire alarm control panel (FACP), if the relays are disconnected, air handler 1, and the replacement for air handler 2, when installed, will shut down and activate an alarm at the FACP. At 10:38 a.m., there was a new temporary air handler, and new ducting on the roof of the pavilion building. There was a work crew on the roof, a hot works permit #5218589 dated 6/2/15 with an expiration date of 6/5/15 at 4 p.m., for roofing patch back was posted on the air duct frame, and a fire watch was being conducted at the work site. During an interview at the same time as the observation, the VP of Corporate Facilities Operations stated that the air handler was temporary and could not be used as the permanent because it did not meet the seismic requirements of a permanent air handler, but that the new air ducting the temporary air handler was connected to was the new permanent ducting. At 10:50 a.m., during an interview, the Fire Alarm	{A 701}	•OSHPD FV 6/22/15 indicating OSHPD Fire Marshall issuing Occupancy for use of the Fire Alarm System •OSHPD CO Fire panel Certificate of Occupancy 6/22/15 2.Plan for Improvement: By making the modifications described above, the deficiency has been permanently corrected. 3.Expected Completion date: This is complete, please see attached Certificate of Occupancy from OSHPD. Project # S142962-19-00 4. Demonstrated hospital Improvement Actions: Not only has this deficiency been eliminated, the air handlers will immediately shut down should the relays be removed or tampered with. The fire panel will also alarm indicating a problem with a relay. 5. Responsible Person: Dean Morford, Director of Facilities Operations.	

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{A 701}	Continued From page 2 System Vendor/Technician present on site, stated that both relays at the air handler control panel are now wired fail safe so that if the relays are disconnected, air handler 1, and the replacement for air handler 2, when installed, will shut down and activate a visual and audible alarm at the FACP and annunciator panels located at the basement and lobby of the pavilion building, and PBX of the tower building. The Fire Alarm System Vendor/Technician also stated that the temporary air handler does not shut down when the relays are disconnected because that air handler is not controlled by the relays, but that the temporary air handler will shut down with the activation of any smoke detector in the building, and that once installed the permanent air handler replacing air handler 2 will be controlled by the relays, and will also shut down when the relays are disconnected. During an observation at the same time as the interview, engineering staff demonstrated the shutting down of air handler 1 by disconnecting a relay from the air handler control panel. At 1:25 p.m., during document review, there was an Office of Statewide Health Planning and Development (OSHPD) permit, and Certificate of Occupancy (CO) from the OSHPD Fire Life Safety Officer (FLSO) dated 5/28/15, but there was no Construction Final (CF) for the new temporary air handler. There was no documented evidence of submitted architect drawings, OSHPD permit, contracts, and completion timeline for the installation of the permanent air handler replacing air handler 2. There was an OSHPD Verified Compliance Report (VR) dated 6/3/15 for the replacement of the FACP, but there was no acceptance test and CF for the new FACP.	{A 701}		

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{A 701}	Continued From page 3 During an interview at the same time as the document review, the VP of Corporate Facilities Operations stated that there was not a CF for the new FACP because the hospital is waiting for the OSHPD FLSO for the CF. On 6/9/15, a copy of an OSHPD FLSO Field Visit (FV) dated 6/8/15, was provided by the VP of Corporate Facilities Operations, that indicated the FACP project was 80% complete, that with the exception of minor "punch-list" items the scope of work had been inspected and accepted by the Inspector of Record (IOR) and is ready for the required acceptance testing with the Authority Having Jurisdiction (AHJ) or OSHPD. That the OSHPD Fire Marshall has agreed to accept any testing that has been witnessed and accepted by personnel from the Culver City Fire Department in lieu of testing with the OSHPD Fire Marshall. 2. On 6/4/15 the evaluator conducted a follow up visit for a complaint validation survey dated 2/5/15. As a result of the complaint validation survey dated 2/5/15 it was revealed through review of the local fire departments undated Fire Investigation Report regarding a fire incident at the hospital on 1/29/15, that self-closing area separation fire doors had been removed from the fourth and fifth floors, and that an OTC (Order to Comply) for replacement of the doors had been issued. On 6/4/15 at 11:29 a.m., on the 5th floor, the VP of Corporate Facilities Operations identified a cross corridor door frame near room 533 as one of the areas where the doors were missing. There were no cross corridor doors within the door frame.	{A 701}	1. Corrective Action: A project to replace/install new door was opened with OSHPD. This project has been completed. The testing of the doors was included with the new fire panel project, conducted by the Culver City Fire Dept and Inspector of Record.	07/01/2015

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{A 701}	Continued From page 4 During an interview at the same time as the observation, the VP of Corporate Facilities Operations stated that construction on the fire doors should start in 3 weeks (6/25/15) and be completed by 7/6/15. At 11:42 a.m., on the 5th floor, the VP of Corporate Facilities Operations identified a cross corridor door frame near room 523 as one of the areas where the doors were missing. There were no cross corridor doors within the door frame. Between 11:42 a.m. and 12:07 p.m., on the 4th floor, the VP of Corporate Facilities Operations identified a cross corridor door frame near room 423 as one of the areas where the doors were missing. There were no cross corridor doors within the door frame. During document review, there was an application to OSHPD for the installation of cross-corridor doors at the second, third, fourth and fifth floors. Review of a Gantt chart for the installation of the doors indicated the installation of the doors would start on 6/18/15 on the 2nd floor, 6/29/15 on the 4th floor, and 7/2/15 on the 5th floor, and would finish on 6/18/15 on the 2nd floor, 7/1/15 on the 4th floor, and 7/6/15 on the 5th floor, with OSHPD final approvals between 7/7/15 and 7/13/15. On 6/5/15, a copy of purchase order for 6 doors and 3 frames, dated 6/5/15, was provided by the VP of Corporate Facilities Operations.	{A 701}	•OSHPD Application for New Project 1/30/15 •OSHPD Notice of Construction 4/31/15 •Door Order 6/5/15 •OSHPD CO 7/1/15 Certificate of Occupancy •Quarterly Door Inspection (Not due until 10/15) 2.Plan for Improvement The doors will be added to the Quarterly Door Inspection Program. 1st inspection will be October 2015. 3.Expected completion Date: Project is complete, please Certificate Occupancy Project # S150397-19-00- SCH Door Installation 4.Demonstrated hospital Improvement Actions: The doors have been added to the Quarterly Door Inspection Program. 5. Responsible person: Mark Stultz, Director of Facilities Operations.	
A 724	482.41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE	A 724		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050135	A. BUILDING _____ B. WING _____	R 06/04/2015

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A 724	Continued From page 5 Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This STANDARD is not met as evidenced by: Based on observation, and interview, the hospital staff failed to ensure the hospital was maintained to ensure an acceptable level of safety for patients, staff and visitors, by having a water leak at the ceiling of a nurses' station. The deficiency had the potential for the water with contaminants within it, from running through the area between the roof and the 6th floor ceiling, to act as a conductor of electricity, and the electrical wires and/or box touched by the water from the leak had the potential for electrical short, arcs and other failures. Findings: On 6/4/15 at 11:19 a.m., at the 6th floor nurses' station there was water leaking from above the drop down suspended ceiling into a receptacle below. Closer observation revealed the water was dripping from an electrical box containing wires that was connected to an electrical conduit. During an interview at the same time as the observation, the VP of Corporate Facilities Operations stated that the leak originated at the roof from a steam line for a boiler, and that it would be repaired in the afternoon. During another interview also at the same time as the observation, the Director of Facilities stated that the leak was discovered that morning.	A 724	1. Corrective Action: The temporary plan of correction was to place a pipe clamp on the leaking pipe and contain dripping water. The permanent solution involved obtaining a proposal from a vendor for repair of the 4" water line and faulty shutoff valve. Part of the process was to schedule a shutdown of the building heating system hot water. Attachments •Engineering work order 6/4/14 indicating work repair •RF MacDonald Proposal for repair 6/22/15 •Repair P.O. •RF MacDonald Work Ticket – indication repair completion 8/11. 2. Plan for improvement: Water leaks cannot be predicted, as leaks occur, the Facilities Operations Center is notified and a work order is generated to repair. 3. Expected Completion Date: Temporary repairs were completed on 6/4/2015. Permanent repairs were completed on 8/11/2015. Please see attached work orders, proposal for repair from R.F. MacDonald, Purchase Order to perform work and work order ticket form R.F. MacDonald. 4. Demonstrated Hospital Improvement Actions: Utility failures are reported to the EOC committee, EOC reports are reported to the Quality Council Committee. 5. Responsible Person(s): Dean Morford, Director of Facilities Operations, Mark Stultz, VP of Corporate Facilities Operations, and Toby Davis, Director of the Behavioral Health Unit.	06/04/2015

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{K 000}	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during a focused revisit following a Complaint Validation Life Safety Code Survey (Intake Number CA00429647) completed on 2/5/15 with Condition of Participation (CoP) CFR 482.41 Physical Environment not met. The focused revisit was completed on 6/4/15. Representing the Department of Public Health: Surveyor 16281, REHS, CFI 1, HFE I	{K 000}		
{K 067}	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: NFPA 90A, Standard for the Installation of Air Conditioning and Ventilating Systems. 2-3.11.1 Egress Corridors in health care, detention and correctional and residential occupancies shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas. An air transfer opening(s) shall not be permitted in walls or in doors separating egress corridors from adjoining areas. Exception No. 1: Toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary	{K 067}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{K 067}	Continued From page 1 spaces opening directly onto the egress corridor. Exception No. 2: Where door clearances do not exceed those specified for fire doors in NFPA 80, Standard for Fire Doors and Fire Windows, air transfer caused by pressure differentials shall be permitted. Exception No. 3: Use of egress corridors as part of the engineered smoke control system. Exception No. 4: In detention and correctional occupancies with corridor separations of open construction (e.g. grating doors or grating partitions). 4-3.1 Smoke dampers shall be controlled by an automatic alarm initiating device. Smoke dampers shall be permitted to be positioned manually from a command station. 4-4.1 All automatic shutdown devices shall be tested annually. 4-4.3 Smoke detectors provided as required by 4-4.2 shall automatically stop their respective fan(s) on detecting the presence of smoke. NFPA 101 Code for Safety to Life from Fire in Buildings and Structures 2000 Edition 9.2.1 Air Conditioning, Heating, Ventilating Ductwork, and Related Equipment. Air conditioning, heating, ventilating ductwork, and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems, or NFPA 90B, Standard for the Installation of Warm Air Heating and Air-Conditioning Systems, as	{K 067}		

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{K 067}	Continued From page 2 applicable, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction. 9.3.1* General. Smoke control systems, where required or permitted by Chapters 11 through 42, shall have an approved maintenance and testing program to ensure operational integrity. The purpose of such smoke control systems shall be to confine smoke to the general area of fire origin and maintain use of the means of egress system. 9.6.5.1 A fire alarm and control system, where required by another section of this Code, shall be arranged to actuate automatically the control functions necessary to make the protected premises safer for building occupants. 9.6.5.2 Where required by another section of this Code, the following functions shall be actuated by the complete fire alarm system: (1) Release of hold-open devices for doors or other opening protectives (2) Stairwell or elevator shaft pressurization (3) Smoke management or smoke control systems (4) Emergency lighting control (5) Unlocking of doors 19.3.4.4 Emergency Control. Operation of any activating device in the required fire alarm system shall be arranged to accomplish automatically any control functions to be performed by that device. (See 9.6.5.) 19.5.2.1 Heating, ventilating, and air conditioning shall comply with the provisions of Section 9.2 and shall be installed in accordance with the	{K 067}		

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{K 067}	Continued From page 3 manufacturer's specifications. These codes and standards were not met as evidenced by: Based on observation, interview and document review, the facility failed to failed to ensure that all automatic shutdown devices were tested annually. The facility used corridors as plenums. The deficiencies had the potential to permit accelerated spread of smoke and gases during a fire. Findings: 1. On 6/4/15 the evaluator conducted a follow up visit for a complaint validation survey dated 2/5/15, for a fire that occurred on the roof, and at air handler 2 of the pavilion building on 1/29/15. Relays at the air handler control panel were found to have been disconnected, permitting air handlers 1 and 2 to not shut down with the presence of smoke, dispersing smoke from the roof and air handler 2, to other areas and floors of the pavilion. During the complaint validation survey dated 2/5/15, review of fire alarm system inspection and test reports dated 7/28/14, and 4/24/13, indicated there was no documented evidence that the duct detectors for air handlers 1 and 2 at the 7th floor penthouse were inspected and tested. The last documented evidence of duct smoke detectors for air handler one and two being inspected was on 3/20/12. On 6/4/15 at 1:25 p.m., during document review, there was no documented evidence that the duct	{K 067}	1. Corrective Action: The ability to remove relays that would allow bypass of the air handlers has been permanently eliminated. With the installation of the new fire panel, the relays are now designed to fail safe. This means that s hould someone remove or tamper with the relays, the air handlers will automatically shut down, which will immediately stop air flow in the ventilation system. The fire system has been fully tested by Culver City Fire Dept and Inspector of Record, to insure that in the event of a fire or smoke alarm, both the permanent and temporary air handler will shut down. The new fire panel, smoke detectors, Fire dampers and smoke dampers were completely tested and signed off by the Culver City Fire Dept. Please see OSHPD Field Visit Report dated 6/22/15. Attachment's: •OSHPD CO 8/19/2015 Certificate of Occupancy for use of Temporary Air Handler •OSHPD FV 6/30/15 indicating we will be able to obtain Construction Final once the replacement air handler is installed and temporary air handler is removed.	06/22/2015

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{K 067}	Continued From page 4 detectors for air handlers at the 7th floor penthouse were inspected and tested. There was also no documented evidence of any inspection and testing of duct detectors for the new temporary air handler. During an interview, at the same time as the document review the VP of Corporate Facilities Operations stated that the Fire Alarm System Vendor/Technician has been testing the automatic shutdown devices continuously during the installation of the new fire alarm control panel and new temporary air handler, and that Fire Alarm System Vendor/Technician will retest the automatic shutdown devices again at the end of the project, and provide a written report. 2. On 6/4/15 the evaluator conducted a follow up visit for a complaint validation survey dated 2/5/15. As a result of the complaint validation survey dated 2/5/15 it was revealed through interview of the Lead Man, and review of the tower building's supply and exhaust conveyance document, that Tower floors 4, 5, and 6 (T-4, T-5, and T-6) had plenums as part of the buildings air distribution system. T-6, was a Med-Detox unit. T-5 had been used as turn around space to house patients while the cleaning from the fire incident was done at the Pavilion. T-4 was not on the facility's license and was not used for patients. T-2 was completely ducted and did not have a plenum as part of the floors air distribution system.	{K 067}	•OSHPD Notice of Start of Construction for New Permanent Air Handler. •OSHPD VR 6/3/15 indicating all devices have been tested •OSHPD FV 6/22/15 indicating OSHPD Fire Marshall issuing Occupancy for use of the Fire Alarm System. 2. Plan for Improvement: By making the modifications described above, the deficiency has been permanently corrected. 3. Expected Completion Date: This is complete, please see attached Certificate of Occupancy from OSHPD. Project # S142962-19-00 Issued by Fire Life Safety Officer. 4. Demonstrated Hospital Improvement Actions: Not only has this deficiency been eliminated, the air handlers will immediately shut down should the relays be removed or tampered with. The fire panel will also alarm indicating a problem with a relay. 5. Responsible Person(s): Dean Morford, Director of Facilities Operations, and Mark Stultz, VP of Corporate Facilities Operations.	

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{K 067}	Continued From page 5 The egress (exit) corridors of T-4, T-5, and T-6 were the same corridors used as a portion of the air supply (plenums). T-2, T-4, T-5, and T-6 were not sprinklered. T-2, T-4, T-5, and T-6 had smoke detectors in the corridors including at the elevator lobby. T-2, T-5, and T-6 had smoke detectors in the rooms. T-4 did not have smoke detectors in the rooms. On 6/4/15 at 1:25 p.m., during document review, OSHPD Verification Compliance Report dated 2/24/14 indicated that the Inspector of Record (IOR) inspected and tested the new fire alarm control panel and system in the "Tower Building" to be in full operation. That every device in the system had been tested and inspected for alarm, trouble, supervisory, ground fault, end of line voltage drop, air handler shut down, damper activation/operation, and dialer verification. During an interview, the VP of Corporate Facilities Operations stated that nothing had changed in the Tower building since the complaint validation survey dated 2/5/15. Per CMS S&C-06-18 letter dated 5/26/06, NFPA 90A, "Installation of Air Conditioning and Ventilating Systems" document, 1999 Edition prohibits egress (exit) corridors in health care occupancies from being used as a portion of the supply, return or exhaust air system serving adjoining areas (2-3.11.1, 1999 ed.). This prohibits the corridor from being used as a plenum.	{K 067}	1. Corrective Action: The hospital is requesting a variance for this deficiency. As per CMS S&C-06-18 criteria, citing a review of the fire alarm system pertaining to the corridor protection. The existing system, as installed and tested, contains full corridor coverage, with smoke detectors, and is interconnected to the existing ventilation system. Attachment •Description of Tower Building HVAC – Gevork Consulting Engineering 4/30/15. •Description of fire and smoke alarm interaction with ventilation System. 2. Plan for Improvement: The hospital is requesting a variance for this deficiency. 3. Expected Completion Date: The hospital is requesting a variance for this deficiency. 4. Demonstrated Hospital Improvement Actions: The mechanical system will be part of the annual fire system testing. 5. Responsible Person: Dean Morford, Director of Facilities.	04/30/2015

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{K 067}	Continued From page 6 The CMS S&C-06-18 letter dated 5/26/06, also indicated that in the cases where it is determined that the corridor is being used as a plenum and the deficiency is cited at tag K-067, a waiver may be granted. The letter further indicated that one of the criteria that should be used when considering the waiver request is that for partially sprinklered or unsprinklered buildings. if the zone with the corridor plenum is protected by a complete corridor smoke detection system, and there is provision for automatic fan shut down upon detection of smoke and activation of the building fire alarm system, a waiver may be recommended.	{K 067}		

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A 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during a Full Sampled Validation Survey. Representing the Department of Public Health: Surveyor 17030, RN, HFEN Surveyor 11683, RN HFEN Surveyor 25524, RN, HFEN Surveyor 16281, REHS, HFE I Surveyor 14041, REHS, HFE I Surveyor 10933, Nutritional Consultant Surveyor 25049, Nutritional Consultant Surveyor 25049, MD, Medical Consultant Surveyor 29775, MD, Medical Consultant Surveyor 28851, Pharm D, Pharmacy Consultant Surveyor 32022, Pharm D, Pharmacy Consultant Total Population: 315 Total Sample Size: 52 On March 26, 2014, at 4:20 p.m., the survey team declared an Immediate Jeopardy (IJ) situation, in the presence of the chief nursing officer, director of risk management, and administrator of facility□s Van Nuys campus, as a result of the facility□s failure: To ensure the patients received care in an environment that assured the safety of the well-being of the patients in the facility□s Psychiatric Unit 1 and Unit 2. On March 26, 2014, at 6 p.m., the IJ was abated in the presence of the director of risk management and administrator of the facility□s Van Nuys campus.	A 000		

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A 043	482.12 GOVERNING BODY There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ... This CONDITION is not met as evidenced by: Based on observation, interview, and record review, the facility□s Governing Body failed to provide oversight for the operations of the hospital by failing to meet the following Condition of Participation: 1. For Patient Rights by the facility□s inability to ensure and provide patients□rights in a safe patient care environment. (Refer to A 0115) 2. For Nursing Services the facility□s failure to provide nursing services in safe patient care environment (refer to A 0385) 3. For Pharmaceutical Services, the facility□s inability to ensure and provide Pharmacy services in a safe patient care environment. (Refer to A 0490) 4. Food and Dietetic Services, the facility's failure to provide organized dietetic services as evidenced by findings of unsafe food handling practices and inadequate supervision of the dietary department menus that were in compliance with nationally recognized practices, effective system to ensure that physician ordered diets were followed, adequate food and water were on hand for use in an emergency and policies and procedures, spreadsheets for the distribution of food. (refer to A 0618) 5. Physical Environment, the facility failed to	A 043	**ALL THREE CAMPUSES** **1-7). Corrective Actions**: Development of a roll up report **(see Addendum 1)** reflecting operations of the three campuses to ensure oversight and monitoring of Patient Right□s, Nursing Services, Pharmaceutical Services, Food and Dietetic Services, Physical Environment, Infection Control & Surgical Services. **Date of Implementation:** First report to Governing Board will be July 1, 2014. **Monitoring Process:** All three campuses will monitor and report indicators for Patient Right□s, Nursing Services, Pharmaceutical Services, Food and Dietetic Services, Physical Environment, Infection Control & Surgical Services. This report will be a standing agenda item for the three campuses. Report will be presented to the Quality Council, the Medical Executive Committee and the Governing Board. **Person Responsible:** Data gathering will occur by the appropriate Directors and reported to ACNO of each facility with the Quality Director and Executive CNO to aggregation and analysis data for final report through the committee process.	7/1/2014

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A 043	Continued From page 2 develop and maintain the physical plant in a manner that assured the safety of well-being of patients (Refer to A 0700) 6. Infection Control, the facility failed to develop an effective system for identifying, reporting and controlling infections on all three campuses. (Refer to A 0747) 7.Surgical Services, the facility□s inability to provide safe and effective surgical services. (Refer to A 0940) The cumulative effects of these systemic failures resulted in the hospital□s governing body inability to maintain appropriate oversight to assure quality health care in safe environment.	A 043	(continued from page 2)	
A 115	482.13 PATIENT RIGHTS A hospital must protect and promote each patient□s rights. This CONDITION is not met as evidenced by: Based on observation, interview and document review, the facility failed to meet the Condition of Participation in Patient Right by failing to: 1. Ensure that 1 of 52 sampled patients (Patient 27) had the right to participate in the implementation of her care (Refer to A 130). 2. Ensure the patients were provided personal privacy while receiving care in the facility as well as patient□s personal information for 1 of 52 sample patients and 2 randomly selected patients (Patients 53 and 60). This deficient practice violated the patient□s right to personal privacy during care and to personal information (Refer to A 143).	A 115	**ALL THREE CAMPUSES:** **1).Corrective Actions:** Revision to policy PAT.001 Admission Assessment/Interdisciplinary Plan of Care to strengthen patient participation in care planning including management of patient pain levels. **Date of Implementation:** Staff in servicing beginning on June 19, 2014 with expected completion in 30 days. **Monitoring Process:** Monitoring of patient participation in their plan of care will be incorporated into the Patient Right□s/Safety Rounds for the clinical areas of the three campuses. **Person Responsible:** Data gathering will occur by the appropriate Directors and reported to the Quality Director and Executive CNO for aggregation and analysis. **2).Corrective Actions**: Monitoring clinical units for maintaining patient privacy and access to patient health information (PHI). Computer Auto-logoff function enhanced to activate at 2 mins of inactivity across all three campuses. Implemented at Culver City on 3-26-14 and at Hollywood & Van Nuys will be completed on July 1, 2014. Audits performed by IT Dept are to reflect 100% compliance with maintaining 2 min auto-log off feature. **Date of Implementation:** Culver City implementation on March 26, 2014 & will be completed on July 1, 2014 for Hollywood & Van Nuys. **Monitoring Process:** Quarterly, the Culver City Security Specialist or technician will perform a review of the user templates in the McKesson Paragon Security application**.** Using the Logon Maintenance screen, Application Time-out values will be verified that they are set to 2 minutes for all clinical personnel who access patient information in open areas that would possibly compromise the privacy of patient data. The McKesson Paragon Security application is only accessible by the Information Systems personnel. Quarterly, the Hollywood & Van Nuys Security Specialist or technician will perform a similar review of the user templates in All Scripts. **Person Responsible:** Information Systems Directors	6/19/2014 3/26/2014

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	050135	A. BUILDING **01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD** B. WING _____	**04/01/2014**

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A 115	Continued From page 3 3. Ensure the patients received care in an environment that assured the safety of the well-being of the patients in the facility□s psychiatric Unit 1 and 2 by: a. Having locksets on the bathroom doors that were lockable from the inside and required an emergency key to unlock from the outside in the bathroom of Patient 45 in Unit 1 and 16 patient bathrooms in Unit 2 and placed the 34 patients residing in the 16 rooms at risk for harm/injury. b. Failing to provide a closer observation such as a 1:1 observation to Patient 45, who presented with acute suicidal ideation as per facility□s policies and procedures. Patient 45, who was identified as a suicide risk, was inside her bathroom and the door was locked. Patient 45 made two knots on both ends of a gown, placed it on top of the door sill and shut the door. Patient 45 locked the door when a staff member called out her name. The mental health worker tried to open the door, banged on the door and finally the door opened. The twisted gown and the patient slid to the floor. The patient was coughing and rubbing her neck. Patient 45 was transferred to a locked unit (Unit 2). (Refer to A 144) 4.Ensure that the staff protect each patient from any forms of abuse by ensuring the hospital staff had ongoing training program regarding abuse, neglect and related reporting requirements, including prevention, intervention, and detection. This deficient practice had the potential for not ensuring the patients are protected from all forms of abuse, neglect or harassment (Refer to A 145).	A 115	(Continued from page 3) **VAN NUYS** **3a) Corrective Actions:** All patients□bathroom locksets on both Unit 1 and Unit 2 were removed on 3/26/14 and new □pass through□door handle (non-lockable type) installed. Staff was in-serviced beginning 3/26/14 on the removal of □lockable type□door handles and replaced with the □non-lockable type □door handle on all patient bathroom doors to ensure patient safety. **Date of Implementation:** 3/26/14 **Monitoring Process:** On 4/16/14 we upgraded our visual inspection of the environment of care. We have implemented the □Licensed Staff EOC Safety Rounds□(coverage includes nurses station, contraband room, laundry room, etc.) and □Mental Health Worker EOC Safety Rounds□ (coverage includes all patients rooms and bathrooms). These rounds are done twice daily to ensure safety throughout the units. Electronic Service Requests are filled out and sent to Engineering Department for any repairs or concerns. **Person Responsible:** Director of Engineering and Director of Nursing **3b) Corrective Actions**: Revisions made to Policy BHU.053 Precautions (under □Van Nuys Facility Specific: Suicide Precaution□) to reflect the procedure (using the Suicide Potential Rating Scale) of which the Van Nuys facility had been following when assigning a level of suicide precautions during the patient□s admission process. **Date of Implementation**: 6/16/14 **Monitoring Process:** Staff will be in serviced on utilizing the □Suicide Precautions Documentation Monitoring Checklist□tool and the □Suicide Potential Rating Scale□ The checklist tool will be completed by the RN staff, given to the supervisor and/or nurse manager for monitoring when the need for a 1:1 with staff arises. This ensures that staff is utilizing both tools to take appropriate suicide precautions. **Person Responsible:** Nursing Director, Nurse Manager, and Supervisors **All Three Campuses** **4) Corrective Actions:** New hires will receive training regarding patient abuse, neglect, and reporting requirements as a part of their new hire onboarding process and at the New Hire Orientation (Initial Orientation Essentials 2014 and answer key. Existing employees at Culver City will receive the training as part of the Skills Fair which is held annually in the month of October; refer to the Culver City Skills Fair. For Hollywood and Van Nuys enhancement of the Annual Update Self-study guide, 2014 Annual update test, and Mandated abuse reporting training test. **Date of Implementation:** New hire training will begin with the next new hire orientation on Monday June 23, 2014 for Culver City. New hire training and test implemented on June 17, 2014. With Annual update sessions will commence in September, 2014 at Hollywood/Van Nuys locations. **Monitoring Process:** New hire orientation attendance is monitored through Human Resources and compliance with the Annual Skills Fair is monitored through the Education department. The Annual Skills fair will be held in October 2014. **Person Responsible:** Human Resources and Education departments.	3/26/2014 6/16/2014 6/17/2014 9/1/2014

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A 115	Continued From page 4 The cumulative effect of these systemic issues resulted in the facility□s inability to ensure and provide a safe patient care environment.	A 115		
A 130	482.13(B) (1) PATIENT RIGHTS PARTICIPATION IN CARE PLANNING The patient has the right to participate in the development and implementation of his or her plan of care. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure 1 of 52 sampled patients (Patient 27) had the right to participate in the implementation of her care. Patient 27 complained of back pain to Licensed Vocational Nurse (LVN) 2 and wanted a pain medication. According to Patient 27, LVN stated, □You have to wait. I was there to chart while you were sleeping.□Patient 27 stated LVN 2 refused to administer pain medication to her at that time of her request. This deficient practice failed to promote the right of the patient to participate in her care. Findings: During an interview with Patient 27 on March 24, 2014 at 5:20 p.m., she stated she complained of itching and back pain, pain scale was 10, (Pain scaled from 1 to 10 and 10 being the worst) to LVN 2 at 10:20 a.m. and wanted a pain medication. According to Patient 27, LVN stated, □You have to wait. I was there to chart while you were sleeping.□Patient 27 stated LVN 2 refused to administer pain medication to her at that time of her request.	A 130		

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A 130	Continued From page 5 The History and Physical report was reviewed and disclosed the patient was admitted on March 22, 2014, with left arm pain and history of end stage renal disease with hemodialysis treatment. According to the History and Physical report, the patient□s dialysis access was on her left upper arm. A review of the Physician□s Order Sheet disclosed □BenadryL 50 mg (milligram) IVP (intravenous PUSH) Q (every) 6 hour PRN (as needed) for itching□and □Dialudid 1 mg IVP Q 4 hours PRN for pain□were prescribed on March 22, 2014 at 6:30 a.m. The eMAR (electronic Medication Administration Record) was reviewed and disclosed that both Benadryl (for itching) and dialudid (for pain) were administered to Patient 27 at 11 a.m. During an interview with Staff R on March 24, 2014 at 5:45 p.m., he stated the facility would not tolerate LVN 2□s behavior for not allowing Patient 27 to participate in the implementation of her care.	A 130	(continued from page 5) **CULVER CITY** **Corrective Actions:** Policy PAT.001 Admission Assessment/Interdisciplinary Plan of Care strengthened to reflect the patient participation in their care planning. Re-Educate all nursing staff on patient□s to participate in the development and implementation of his/her pain management. Nursing staff to provide hourly rounds using the 5 □Ps□focuses on PAIN, POTTY, POSITION /PRIVACY and POSSESSIONS. All Nursing staff will complete Patient focused Sensitivity Training to include understanding of pain management. **Date of Implementation**: Policy to Medical Staff Dept. for Approval through Medicine Comm., Medical Exec Committee and Governing Board. Draft policy rolled out to staff June 18, 2014. Start education on 4/30/2014 full implementation within 30 days. **Monitoring Process:** Pt Liaison will conduct 30 random patient round observations per month to ensure 5 P□s, sensitivity, and privacy is done on each unit. Findings of the rounds will be reported to the specific nursing director for corrective action. A monthly report will be provided to the Quality Department monthly. **Person Responsible:** Nursing Leadership for each department.	4/30/2014 6/18/2014
A 143	482.13(c)(1) PATIENT RIGHTS: PERSNAL PRIVACY The patient has the right to personal privacy. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the patients were provided personal privacy while receiving care in the facility as well as patient□s personal information for 1 of 52 sample patients (Patient 22) and 2 randomly selected patients (Patients 53 and 60). This deficient practice violated the patient□s right to	A 143		

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A 143	Continued From page 6 personal privacy during care and to personal information. Findings: 1. On March 24, 2014, in the facility□s Hollywood campus, the following was observed: a. At 10 a.m., during the initial tour of the 3rd floor, a cart was left unattended. The cart contained a bottle labeled Lothalamate Meglumine Injections USPS Cysto-Conray IM II, a cardex with a patient name and date of birth, a marker, couple of alcohol pads and primary plumset. During an interview with the respiratory therapist (RT), he stated he should not have left the cart which contained medication, supplies and especially the cardex with the patient name and date of birth. He stated he left the cart and went to check on a patient prior to a procedure. b. At 11:35 a.m., during provision of care observation, Registered Nurse 9RN) 28 did not fully draw the privacy curtain when conducting a body check on the randomly selected patient (Patient 53). The patient was wearing a diaper and was exposed from the waist down. The patient was in view of staff members and people passing by and by the nurses station. During a concurrent interview, RN 28 stated the privacy curtain should have been drawn to provide the patient with privacy.	A 143	(Continued from page 6) **HOLLYWOOD** **1a). Corrective Actions**: Staff meeting and education held with Respiratory staff to include securing 02 tanks in proper and designated locations, ensure that no meds and patient identifiers are left on carts or EKG machines. **Date of Implementation:** March 25, 2014 **Monitoring Process:** Will be monitored by RT lead and RT staff daily and to be included in EOC rounds **Person Responsible:** Respiratory Department **1b). Corrective Actions**: Education provided to include Patient rights and privacy. EOC rounds on all nursing department, replaced any missing curtains and ensure appropriate size and length **Date of Implementation:** Education provided April 3-5, 2014; EOC/missing curtains replaced March 27, 2014 **Monitoring Process:** Monitoring will be managed through daily rounds and EOC rounds **Person Responsible:** Nursing leadership in each department and EOC members, ENG, EVS	3/25/2014 3/27/2014 4/3/2014

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A 143	Continued From page 7 c. At 2:30 p.m., during an initial tour of the Urgent Care Unit, there were five (5) patients awaiting for the disposition of their visits. Patient 22 was seen at 10:05 a.m. for pain on bilateral legs. The patient also manifested behavior such as talking out loud continuously with agitated features. During a concurrent interview, RN 29 stated the patient could have been provided a calmer and private environment at the time the patient was manifesting agitation and talking out loud to self. d. At 12:40 p.m., during an observation tour of the Medical/Surgical floor, the randomly selected patient (Patient 60) was lying in bed. The patient was exposed from the waist down, the patient was wearing a diaper, and was in full view of the facility staff members passing by the patient□s room. During a concurrent interview, RN 31, who was observed passing by patient□s room, stated she would be checking the patients for privacy issues as she was conducting her rounds. 2. In the facility□s Culver City campus, on March 25, 2014, at 9:50 a.m., during a tour of the unit, Patient 52 was observed in his room lying in bed. His hospital gown was raised up to his waist exposing his diapers, thighs and legs. RN 13 was observed seating by the hallway across from the patient□s room and working on	A 143	(Continued from page 7) **1c). Corrective Actions:** Waiting room created and triage room created in the urgent care to provide privacy and for those patients waiting for disposition and waiting to be seen. **Date of Implementation:** March 28, 2014 **Monitoring Process:** Monitoring will be managed by urgent care staff, nursing supervisor will perform hourly rounding in Urgent care **Person Responsible:** Nursing Leadership and EOC members, ENG **1d).Corrective Actions:** Education provided to include Patient rights and privacy. EOC rounds on all nursing department, replaced any missing curtains and ensure appropriate size and length. **Date of Implementation:** Education provided April 3-5, 2014; EOC/missing curtains replaced March 27, 2014 **Monitoring Process:** Monitoring will be managed through daily rounds and EOC rounds **Person Responsible:** Nursing leadership in each department, Environment of care, Engineering, & Environmental Services. **CULVER CITY** **2a) Corrective Actions**: Re-Educate all nursing staff on patient□s right to personal privacy and our responsibility to ensure patient privacy. Nursing staff will provide hourly round using the 5 □Ps□ focuses on PAIN, POTTY, POSITION /PRIVACY and POSSESSIONS. All Nursing staff will complete Patient focused Sensitivity Training and will receive a certificate upon completion. Patient Liaison will conduct daily rounds to ensure patient□s privacy rights are upheld. **Date of implementation**: Start education on 4/30/2014 full implementation on **Monitoring Process:** Pt liaison will conduct 30 patient round observations per month to ensure 5 P□s, sensitivity, and privacy is done on each unit. Findings of the rounds will be reported to the specific nursing director for corrective action. A monthly report will be reported to the Quality Department monthly. Super users are collecting data on pain scale prior and after receiving pain medication this information is also sent to the quality department monthly. **Person Responsible:** Nursing Leadership from each department **2b) Corrective Actions:** Policy PAT.025 Patient Rights and Responsibilities and Procedure strengthened to reflect the patient□s right to personal privacy. Computer Auto-logoff function enhanced to activate at 2 mins of inactivity. Implemented on 3-26-14. Audits performed by IT Dept. reflect 100% compliance with maintaining 2 min auto-log off feature. **Date of Implementation:** Revised policy to Medical Staff Dept. for Approval through Quality Council, Medicine Committee, Medical Exec Committee and Governing Board. Draft policy rolled out to staff June 18, 2014	3/28/2014 3/27/2014 4/3/2014 4/30/2014 6/18/2014

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A 143	Continued From page 8 the computer. The patient was in full view of the licensed nurse. The environmental staff and other facility staff members were observed passing by the hallway while patient lay exposed in view of them. RN 13 stood up and went to attend to a patient in another room and left the computer screen showing with a patient name, visit ID number and other information that relates to the patient. During a concurrent interview, RN 13 stated that she was not aware the patient was exposed. She further stated that she should have exited the computer screen with patient□s information before she went to another patient□s room.	A 143	(continued from page 8) **Monitoring Process**: On a quarterly basis, the Security Specialist or technician will perform a review of the user templates in the McKesson Paragon Security application. Through the Logon Maintenance screen, Application Time-out values will be verified that they are set to 2 minutes for all clinical personnel who must access patient information in open areas that would possibly compromise the privacy of patient data. The McKesson Paragon Security application is only accessible by the Information Systems personnel. **Person Responsible:** Nursing Leadership for each department; Information Systems Department Security Specialist or technician. **HOLLYWOOD** **Corrective Actions**: EMR Education/re-training provided to include utilizing □suspend□ function as manual log-off procedure. Computer Auto-logoff function will be enhanced to activate at 2 mins of inactivity, target date of completion in 30 days July 17, 2014. Re-education started June 18, 2014 will be completed June 30, 2014. **Date of Implementation**: Education provided April 16, 2014 full implementation May 6, 2014 and target date as of July 17, 2014 after upgrade; re-education started June 18, 2014 to be completed June 30, 2014 **Monitoring Process:** Audits by IT Dept. to reflect 100% compliance with maintaining 2 min auto-log off feature.	4/16/2014
A 144	482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: On March 26, 2014, at 4:20 p.m., the survey team declared an Immediate Jeopardy (IJ) situation, in the presence of the chief nursing officer, director of risk management, and administrator of facility□s Van Nuys campus, as a result of the facility□s failure: To ensure the patients received care in an environment that assured the safety of the well-being of the patient□s in the facility□s Psychiatric Unit 1 and 2. On March 26, 2014, at 6 p.m., the IJ was abated in the presence of the director of risk management and the administrator of the facility□s	A 144		

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A 144	Continued From page 9 Van Nuys campus. Based on observation, interview and record review, the facility failed to ensure the patients received care in an environment that assured the safety of the well-being of the patients in the facility□s psychiatric Unit 1 and 2 by: 1. Having locksets on the bathroom doors that were lockable from the inside and required an emergency key to unlock from the outside in the bathroom of Patient 45 in Unit 1 and 16 patient bathrooms in Unit 2 and laced the 34 patients residing in the 16 rooms at risk for harm/injury. 2. Failing to provide a closer observation such as a 1:1 observation to Patient 45, who presented with acute suicidal ideation as per facility□s policies and procedures. Patient 45, who was identified as a suicide risk, was inside her bathroom and the door was locked. Patient 45 made two knots on both ends of a gown, placed it on top of the door sill and shut the door Patient 45 locked the door when a staff member called out her name. The mental health worker tried to open to door, banged on the door and finally the door opened. The twisted gown and the patient slid to the floor. The patient was coughing and rubbing her neck. Patient 45 was transferred to a locked unit (Unit 2). Findings: 1. On March 24, 2014, at 11:20 a.m., during an initial tour of the activity room of the locked unit (Unit 2) in the facility□s psychiatric campus, Patient 45 was observed sitting in a chair and talking with another patient. During an	A 144	(Continued from page 9) **Van Nuys** **1).Corrective Actions:** All patients□bathroom locksets on both Unit 1 and Unit 2 were removed on 3/26/14 and new □pass through□door handle (non-lockable type) installed. Staff was in-serviced beginning 3/26/14 on the removal of □lockable type□door handles and replaced with the □non-lockable type □door handle on all patient bathroom doors to ensure patient safety. **Date of Implementation:** 3/26/14 **Monitoring Process:** Since 4/16/14 we upgraded our visual inspection of the environment of care. We have implemented the □Licensed Staff EOC Safety Rounds□(coverage includes nurses station, contraband room, laundry room, etc.) and □Mental Health Worker EOC Safety Rounds□(coverage includes all patients rooms and bathrooms). These rounds are done twice daily to ensure safety throughout the units. Electronic Service Requests are filled out and sent to Engineering Department for any repairs or concerns. **Person Responsible:** Director of Engineering and Director of Nursing **2).Corrective Actions:** Policy PAT.025 Patient Rights and Responsibilities and Procedure strengthened to reflect the patient□s right to receive care in a safe setting. Revision made to Policy BHU.053 Precautions (under □Van Nuys Facility Specific: Suicide Precaution□) to reflect the procedure (using the Suicide Potential Rating Scale) of which the Van Nuys facility will follow when assigning a level of suicide precautions during the patient□s admission process. **Date of Implementation**: 6/16/14 **Monitoring Process:** Staff will be in serviced on utilizing the □Suicide Precautions Documentation Monitoring Checklist□tool and the □Suicide Potential Rating Scale□The checklist tool will be completed by the RN staff, given to the supervisor and/or nurse manager for monitoring when the need for a 1:1 with staff arises. This ensures that staff is utilizing both tools to take appropriate suicide precautions. **Person Responsible:** Nursing Director, Nurse Manager, and Supervisors	3/26/2014 6/16/2014

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A 144	Continued From page 10 interview at the same time of the observation, Mental Health Worker (MHW) 1 stated Patient 45 was on a 1:1 (observed by one staff member at all times) observation because the patient had attempted to hang herself on Friday (March 21, 2014). On March 24, 2014, Patient 45□s medical record was reviewed. The Admission Psych Note Nursing dated March 20, 2014, at 4:52 p.m., disclosed Patient 45 was admitted from an acute care hospital via ambulance, on a voluntary status, and her chief complaint was depression with suicidal ideations and plan to overdose. Patient 45□s mental status included uncooperative, guarded, eye contact was inconsistent, hopeless/helpless, depressed, anxious, irritable, and with a flat affect. The Interdisciplinary Patient Progress Record dated March 21, 2014, at 5 a.m., disclosed □Patient appeared to sleep well through the night. Patient had no signs of distress. Continue to monitor for safety.□ The interdisciplinary Patient Progress Record dated March 21, 2014, at 11:05 a.m., disclosed □Patient had very poor visibility in the milieu.□Patient 45□s mood was blunt (failure of a person to display emotion affect) and depressed. Patient 45 ate breakfast then went to her room to sleep. Patient 45 refused group therapy despite the prompts, non-social with peers, guarded, and suspicious on approach. The interdisciplinary Patient Progress Record dated March 21, 2014, at 6 p.m., disclosed Patient 45 was noted with episodes of crying and anxious. Patient 45 required prompting with her	A 144		

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A 144	Continued From page 11 medications and to attend group therapy. Her appearance was unkempt and disheveled. Patient 45 had poor grooming. The staff indicated □will continue to monitor for safety.□ A review of the facility□s report disclosed an incident occurred on March 21, 2014, at 8:15 p.m., in Unit 1 (open unit) in Patient 45□s bathroom. MHW 2 was conducting visual inspection of Patient 45□s room and Patient 45 was not in the room. Patient 45 was in the bathroom and the door was locked. MHW 2 observed part of Patient 45□s gown was hanging at the top of the door. As MHW 2 approached the bathroom door, he called out Patient 45□s name. The door was completely locked and he (MHW 2) was unable to open the door. MHW 2 heard a loud thump sound coming from the bathroom and heard gurgling sounds coming from Patient 45. MHW 2 yelled, □Code Blue, Nurse□as he banged on the bathroom door. The bathroom door opened and Patient 45 □landed on the floor.□A nurse came in the room and assessed Patient 45. The Interdisciplinary Patient Progress Record documented by the Registered Nurse (RN) dated March 21, 2014, at 8:10 p.m., disclosed Patient 45 was inside her bathroom and the door was locked. Patient 45 made two (2) knots on both ends of a gown, placed it on top of the door sill and shut the door. As the MHW attempted to call her name, Patient 45 locked the door. Patient 45 made a loud thump sound and began making choking sounds. Code Blue (life threatening medical emergency) was called. The MHW continued to try to open the door, banged on the door and finally the door opened. The twisted gown and the patient slid to the floor. Patient 45	A 144		

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A 144	Continued From page 12 was coughing and rubbing her neck. Patient 45 was awake and responding that she was able to breathe. The physician was notified and Patient 45 was transferred to Unit 2 (locked unit). On March 24, 2014, at 12:25 p.m., during an interview with Staff H (assistant chief nursing officer), he stated Patient 45 was placed on 1:1 observation for safety and the action plan for the incident was pending. Staff H stated there were no changes to the lock of the bathroom door of Patient 45. An interview with Staff H and Staff M (maintenance supervisor) was conducted on March 25, 2014, between the hours of 8:45 a.m. and 11:20 a.m. When asked about how to prevent this incident from occurring, Staff H stated there was no action plan yet until the quality/risk department reviews the incident. At 11:20 a.m., Staff M stated he was aware of Patient 45□s incident. Staff M stated that there was a □pin□key at the nurses□station to unlock the patients□bathrooms. Staff M stated that after the renovation in this unit, there was no written policy regarding the use of pin key to the patients□bathrooms. Staff M further stated the nurses were aware and should have communicated to each other. Staff M stated, □I told the use of the pin key to one nurse and I assumed she would pass it on to other nurses.□ On March 25, 2014, between the hour or 8:45 a.m. and 9 a.m., an observation of Room 108□s bathroom door revealed a lockset on the bathroom door that was lockable from the inside. During a concurrent interview, RN 8 stated the □pin□key was kept in the Medication Room and at the nurses□station. When asked to show the □pin□	A 144		

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A 144	Continued From page 13 key, RN 8 did not present the key to the surveyor. On March 25, 2014, between the hours of 8:30 a.m. and 11:00 a.m., the patient room bathrooms in Unit 2 (locked unit), including those in Rooms 203, 205, 207, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 222, 226, had locksets on the bathroom doors that were lockable from the inside and required an emergency key to unlock them from the outside. On March 25, 2014, between the hour 10:15 a.m. and 11:00 a.m., during interviews of two RN at Unit 2 nurses station, RN 23 stated we don□t have the pin (emergency key) and RN 24 stated, □I don□t know where the pin is.□ A review of the facility□s census list for March 24, 2014 for Unit 2 (locked unit) disclosed there were 34 patients residing in the sixteen (16) patient rooms of Unit 2 (Rooms 203, 205, 207, 209, 210, 211, 212, 213, 214, 215, 217, 218, 219, 220, 222 and 226). Each patient room had a bathroom. The census lists indicated that for the census on March 24, 2014, there were 20 patients in Unit 1 and 35 patients in Unit 2. For the census on March 25, 2014, there were 16 patients in Unit 1 and 33 patients in Unit 2. For the census on March 26, 2014, there were 21 patients in Unit 1 and 35 patients in Unit 2. On March 26, 2014, at 4:20 p.m., the survey team declared an Immediate Jeopardy situation, in the	A 144		

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A 144	Continued From page 14 presence of the chief nursing officer director of risk management, and administrator of facility□s Van Nuys campus, as a result of the facility□s failure to ensure the patients received care in an environment that assured the safety of the well-being of the patients in the facility□s psychiatric campus by not having locksets on the bathroom doors that were lockable form the inside and required an emergency key to unlock from the outside. On March 26, 2014 at 5:35 p.m., the administrator provided photographs of room 108□s bathroom with the lock removed. On March 26, 2014, at 6 p.m., the IJ was abated in the presence of the director of risk management and the administrator of Van Nuys campus. A review of the facility□s letter to the Immediate Jeopardy, dated March 26, 2014, disclosed one (1) patient bathroom on Unit 1 (room 108) and sixteen (16) patient bathrooms on Unit 2 (locked unit), in which the door, when locked from the inside, could not easily be opened from the outside without a special key. The staff did not have access to the key and that they had to contact maintenance to open the door. The facility□s letter indicated the corrective actions included removing the door locks from 16 patient bathrooms on Unit 2 (locked unit). The staff would be inserviced on the short term plan beginning the evening of March 26 2014. On March 27, 2014, at 10:15 a.m., during a tour of the facility at the Van Nuys campus with the hospital administrator and the vice president of	A 144		

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A 144	Continued From page 15 pharmacy operations ,the surveyors observed that all bathroom door locks in the patient rooms of Unit 1 and 2 have been removed. The hospital administrator started new locks were ordered. 2. On March 24, 2014, Patient 45□s medical record was reviewed. The Admission Psych Note Nursing dated March 20, 2014, at 4:52 p.m., disclosed Patient 45 was admitted from an acute care hospital via ambulance, on a voluntary status, and her chief complaint was depression with suicidal ideations and plan to overdose. Patient 45□s mental status included uncooperative, guarded, eye contact was inconsistent, hopeless/helpless, depressed, anxious, irritable, and with a flat affect. The Interdisciplinary Patient Progress Record dated March 21, 2014, at 5 a.m., disclosed □Patient appeared to sleep well through the night. Patient had no signs of distress. Continue to monitor for safety.□ The Interdisciplinary Patient Progress Record dated March 21, 2014, at 11:05 a.m., disclosed □Patient had very poor visibility in the milieu□ Patient 45□s mood was blunt (failure of a person to display emotion affect) and depressed. Patient 45 ate breakfast then went to her room to sleep. Patient 45 refused group therapy despite the prompts, non-social with peers, guarded, and suspicious on approach. The Interdisciplinary Patient Progress Record dated March 21, 2014, at 6 p.m., indicated Patient 45 was noted with episodes of crying and anxious. Patient 45 required prompting with her	A 144		

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A 144	Continued From page 16 medications and to attend group therapy. Her appearance was unkempt and disheveled. Patient 45 had poor grooming. The staff indicated □will continue to monitor for safety.□ A review of the facility□s report disclosed an incident occurred on March 21, 2014, at 8:15 p.m., in Unit 1 (open unit) in Patient 45□s bathroom. MHW 2 was conducting visual inspection of Patient 45□s room and Patient 45 was not in the room. Patient 45 was in the bathroom and the door was locked. MHW 2 observed part of Patient 45□s gown was hanging at the top of the door. As MHW 2 approached the bathroom door, he called out Patient 45□s name. The door was completely locked and he (MHW 2) was unable to open the door. MHW 2 heard a loud thump sound coming from the bathroom and heard gurgling sounds coming from Patient 45. MHW 2 yelled, □Code Blue, Nurse□as he banged on the bathroom door. The bathroom door opened and Patient 45 □landed on the floor.□A nurse came in the room and assessed Patient 45. The Interdisciplinary Patient Progress Record documented by the Registered Nurse (RN) dated March 21, 2014, at 8:10 p.m., disclosed Patient 45 was inside her bathroom and the door was locked. Patient 45 made two (2) knots on both ends of a gown, placed it on top of the door sill and shut the door. As the MHW attempted to call her name, Patient 45 locked the door. Patient 45 made a loud thump sound and began making choking sounds. Code Blue (life threatening medical emergency) was called. The MHW continued to try to open the door, banged on the door and finally the door opened. The twisted gown and the patient slid to the floor.	A 144		

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A 144	Continued From page 17 Patient 45 was coughing and rubbing her neck. Patient 45 was awake and responding that she was able to breathe. The physician was notified and Patient 45 was transferred to Unit 2. According to the Admission Psych Note Nursing dated March 20, 2014, at 4:52 p.m., Patient 45 was screened for suicide risk. Patient 45□s suicide total score was 13. The Risk Screen section of the Admission Psych Note dated March 20, 2014, indicated the score from 10 to 19 is under □Suicide Precaution 1□which indicated the patient required every 15 minutes monitoring. A review of the Patient Close Observation Status dated March 21, 2014 from 12 a.m. to 11:45 a.m. to 8:15 p.m., revealed the staff conducted a visual inspection to Patient 45 every 15 minutes, instead of a 1 to 1 observation. Additionally, the Admission Psych Note Nursing dated March 20, 2014, at 4:52 p.m., indicated Patient 45 had recent (acute) previous attempts of suicide ideation within the past 36 hours, prior to admission. According to the facility□s policy and procedure titled, □Admission Criteria,□dated November 2012, under General Admission Procedures Section 4.2.57. disclosed any patient that presented with acute suicidal ideation and required a 1:1 based on the suicide potential rating scale, shall be admitted to a unit with a staff member present as 1:1 observation. A review of the facility□s policy and procedure titled, □Precautions□dated November 2012, stipulated the purpose of the policy was to assure heightened awareness of special identified	A 144		

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A 144	Continued From page 18 circumstances that could impact patient safety. The objectives of the policy included to assess each patient for suicide potential and to provide monitoring accordingly to the level of determined suicide risk. The procedure for Suicide Precaution (SP) 4.2.14 disclosed the patients who scored at an intermediate risk for Suicide Precaution with a score of 10 to 19 shall have closer observations initiated. The precaution will be noted as □Suicide Precaution 1.□ An email communication from Staff B (corporate vice president/quality risk management) dated April 9, 2014, at 4:22 p.m., disclosed closer observations meant that the patient would have 1 to 1 observation.	A 144		
A 145	482.13(c)(3) PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT The patient has the right to be free from all forms of abuse or harassment. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that the staff protect each patient from any forms of abuse by ensuring the hospital staff had ongoing training regarding abuse, neglect and related reporting requirements, including prevention, intervention, and detection. This deficient practice had the potential for not ensuring the patients are protected from all forms of abuse, neglect or harassment. Findings: On March 24, 2014, at 11:02 a.m., a review of the employee files indicated that 2 of 5 files did not	A 145	**ALL THREE CAMPUSES** **Corrective Actions:** New hires will receive training regarding patient abuse, neglect, and reporting requirements as a part of their new hire onboarding process and at the New Hire Orientation (Initial Orientation Essentials 2014 and answer key. Existing employees at Culver City will receive the training as part of the Skills Fair which is held annually in the month of October; refer to the Culver City Skills Fair.For Hollywood and Van Nuys enhancement of the Annual Update Self-study guide, 2014 Annual update test, and Mandated abuse reporting training test**.** **Date of Implementation**: New hire training will begin with the next new hire orientation on Monday June 23, 2014 for Culver City. New hire training and test implemented on June 17, 2014. Annual update sessions will commence in September, 2014 at Hollywood/Van Nuys locations. **Monitoring Process:** New hire orientation attendance is monitored through Human Resources and compliance with the Annual Skills Fair is monitored through the Education department. The Annual Skills fair will be held in October 2014. **Person Responsible:** Human Resources and Education departments.	6/17/2014

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A 145	Continued From page 19 have documentation that the employees received ongoing abuse training. During an interview with Human Resources Staff 1, she stated the employees had abuse training during their initial orientation. She further stated there was no ongoing training after orientation which provided all employees with information regarding abuse prevention. In addition, the employee files indicated some employees were hired in 2003 and 2008 and there was no ongoing training for abuse and neglect, and related reporting requirements. An email communication dated April 9, 2014, at 4:22 p.m., from Staff B (corporate vice president/quality risk management) provided two (2) POLICIES AND PROCEDURES ON Domestic Violence Assessment and Reporting dated April 2007 and Social Services dated November 2012. However, there was no documented evidence that addressed staff training on abuse prevention on an ongoing basis.	A 145	(Continued from page 19)	
A 385	482.23 NURSING SERVICES The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by: Based on observation, interview and document review, the facility failed to meet the Condition of Participation in Nursing Services by failing to: 1. Having a monitor technician to provide continuous electrocardiographic (ECG) monitoring for 10 patients that required ECG telemetry monitoring (continuous monitoring of a	A 385	**Culver City** **1).Corrective Actions:** Effective immediately (6-12-14) ICU, CCU & SDU are consistently staffed with a Monitor Tech 24 hours a day/7 days a week for all units with cardiac monitors or Telemetry systems. The Monitor Tech for each unit is reflected on the Staffing Assignment record for each shift **.**The Staffing Matrix guiding staffing levels has been adjusted to ensure monitor tech for ICU, CCU & SDU for each shift. **Date of Implementation:** June 12, 2014 **Monitoring Process:** Daily review of staffing to ensure Monitor Tech for each functioning ICU & CCU each shift. **Person Responsible:** Nursing Director of Critical Care Units & House Supervisors.	6/12/2014

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A 385	Continued From page 20 patient□s heart rate and rhythm at a remote location) in the Critical Care Unit (CCU) and Surgical Intensive Care Unit (ICU). This deficient practice had the potential for not detecting abnormal heart rhythm timely which could result to life threatening heart condition that required immediate intervention (Refer to A 392). 2. Provide non-pharmacological interventions for managing Patient 22□s pain (Refer to A 395). This deficient practice had the potential for not meeting the physical and mental needs of the patient. 3. Ensure Patient 24□s bedside did not have medications and supplies for a wound treatment. This deficient practice had the potential for administering the cleanser and supplies for the treatment of Patient 24□s wound which may not be concordance with the physician□s order (Refer to A 395). 4. Document the wound type, size, and depth during the initial assessment and reassessment, failing to reassess the wounds on March 16 and 23, 2014, and failing to provide treatments as ordered by the physician on Patient 14□s left food pressure ulcer from March 7 to March 20, 2014 (a total of 11 days). This deficient practice had the potential to result in delay of the healing of the pressure ulcer (Refer to A 395). 4. Provide oral care to Patient 16 who was dependent on staff in his activities of daily living and was observed with dry lips and mouth odor. This deficient practice did not maintain the patient□s oral hygiene and had the potential to result in undetected problems in the patient□s oral	A 385	(Continued from page 20) **2).Corrective Actions**: Re-Educate all nursing staff on patient□s right to personal privacy and our responsibility to ensure patient privacy. Nursing staff will provide hourly round using the 5 □Ps□ focuses on PAIN, POTTY, POSSISON /PRIVACY and POSSESSIONS. All Nursing staff will complete Patient focused Sensitivity including non-R□ comfort measures Patient Liaison will conduct daily rounds to ensure patient□s privacy rights are upheld. **Date of implementation:** Start education on 4/30/2014 with full implementation within 30 days. **Monitoring Process:** Patient liaison will conduct 30 patient round observations per month to ensure 5 P□s, sensitivity, and privacy is done on each unit. Findings of the rounds will be reported to the specific nursing director for corrective action. A monthly report will be reported to the Quality Department monthly. Super users are collecting data on pain scale prior and after receiving pain medication this information is also sent to the quality department monthly **Person Responsible**: Nursing Leadership from each department **3).Corrective Actions:** (Patient □24) Re-education of nursing staff related to proper securing and storage of medications utilizing self-study module & policy □Mediation Storage PHA.045. **Date of Implementation:** 06/13/2014 **Monitoring Process**: Education will be monitored by certification upon completion of online self-study module. Wound Management Team Member to perform thirty Patient room audits, per month including location and securing of medications and products each month. Any issue of non-adherence will be addressed to the individual staff and referred to Quality department for further intervention as necessary including education and progressive disciplinary action. **Person Responsible:** Wound Management Team. **4).Corrective Actions:** Re-education of nursing staff related to wound characteristics as shown in wound photographs; to include size (LxWxD), shape, drainage, color, odor. (See Wound Record Attachment and Policy revision WOU.001. Educate nursing staff with regard to documentation of wound care treatment in McKesson under □integumentary tab.□ **Date of Implementation:** 6/13/2014 **Monitoring Process**: Wound Management Team Member to audit photo documentation on 30 wound record during patient rounds.Any issue of non-adherence will be addressed to the individual staff and referred to Quality department for further intervention as necessary including education and progressive disciplinary action. In addition, Wound Management Team Member to perform thirty audits, per month including documentation of treatments. **Person Responsible:** Wound Management Team. **4a). Corrective Actions:** Re - Educate all Registered nurses on supervising and evaluating the care for each patient. Nursing staff will provide hourly rounds using the 5 □Ps□focuses on PAIN, POTTY, POSITION /PRIVACY and POSSESSIONS. All Nursing staff will complete Patient focused Sensitivity Training including the importance of patient hygiene. **Date of implementation:** start education on 6/16/2014 full implementation within 30 days. **Monitoring Process:** On-line self-study module: Certification upon completion. . **Person Responsible**: Nursing Leadership from each department	4/30/2014 6/13/2014 6/13/2014 6/16/2014

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	050135	A. BUILDING **01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD** B. WING _____	**04/01/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, □IP CODE
SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	**6245 DE LONGPRE AVE** **HOLLYWOOD, CA 90028**

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A 385	Continued From page 21 cavity. (Refer to A 395). 5. Ensure Patient 17 admitted to the psychiatric unit as ordered by the physician when there was bed available in accordance with the facility□s census report for the psychiatric unit. This deficient practice had the potential for not meeting the psycho-social needs of the patient (Refer to A 395). 6. Ensure Patient 18 was administered Lisinopril medication (treat elevated blood pressure) as ordered by the physician. This deficient practice failed to ensure the physician□s order for Lisinopril medication was implemented for Patient 18 (Refer to A 395). 7. Ensure Patient 15 was administered Risperdal medication (psychoactive medication) as ordered by the physician. This deficient practice did not ensure the physician□s order for Risperdal medication was implemented for Patient 18 and had the potential for not meeting the psycho-social needs of the patient (Refer to A 395). 8. Evaluate Patient 45 after she had attempted to hang herself in the bathroom. This deficient practice had the potential for not identifying any physical condition related to her attempt to hang herself which may required interventions (Refer to A 395). 9. Ensure the nursing staff developed and kept current a nursing care plan for 8 of 52 sample patients (Patient 14, 25, 26, 29, 31, 32, 45 and 46). This deficient practice had the potential for not providing appropriate interventions to meet the needs of each patient (Refer to A 396).	A 385	(Continued from page 21) **5).Corrective Actions**: Policy Scope of Service- Emergency Department/urgent care □SOS.013 When it is anticipated that psychiatric patients will wait greater than 23 hours for a bed placement, calls are made to psychiatric facilities in other areas to determine if an appropriate bed is available and an evaluation shall be done for possible transfer and placement**.** Total census for BHU was 70 on March 23 & 24. On March 25, 2014, beds 624A & 624B were out of service because of plumbing concerns resulting in the flooding of the room. Bed 603A & 603B were also out of service due to bed bug infestation. All 4 beds were not in service House supervisors will monitor and track bed availability to decrease ER wait times. During the time bed placement is pending, patients are monitored under close observation. ER Staff will follow BHU.006 Close Observation Policy**.** **Date of Implementation:** 4/30/2014 **Monitoring Process:** House Supervisors monitor bed availability throughout the day utilizing the bed tracker system. At 6am, 3pm, 6pm, & 9pm, the house supervisor records the hospital census on the Supervisor ANS report**.** **Person Responsible:** House Supervisor /Nursing leadership **CULVER CITY** **6&7). Corrective Actions**: All nursing staff re-educated with self-study module to validate that physician orders have been noted, examined, and verified. Caregivers must use SBAR and provide the opportunity to use read-back techniques and medications orders received must be read back by the receiver. 24 hour order/chart check policy & procedure PAT.059 implemented that mandates documentation of chart review before 7am each day. **Date of Implementation:** 5/18/2014 **Monitoring Process**: Random audit of 30 charts will be done per nursing unit aggregated data will be sent to the Quality Dept., non-compliance will result in progressive discipline actions. **Person Responsible**: Nursing Leadership **8) Corrective Actions:** Re-educate all Registered Nurses on the importance of Head to Toe Assessment immediately after any patient placed on 1:1 with staff. In-service staff and provide the □Suicide Precaution Documentation Monitoring Checklist□tool which includes a □head to toe assessment□section for check off. **Date of Implementation:** 6/16/14 **Monitoring Process:** Director of Nursing and/or designee will conduct monitoring activity on the checklist tool submitted by staff the same day the incident occurs to ensure that the requirements and documentation monitoring tool has been completed to include the (head to toe)physical assessment. **Person Responsible:** Nursing Director, Nurse Manager, and Supervisors **9) Corrective Actions:** Re-educate/in-service the night shift staff on the existing □Nightly Chart Audit□ This audit includes a check off section for □Nursing Care Plan/Pain. Re-educate the supervisors who perform the already existing audit □Pain Management Audit Monitoring Tool□ Re-educate supervisors to complete the treatment plan for pain as needed while auditing. Policy PAT.001 Admission Assessment/Interdisciplinary Plan of Care strengthened the development of care plans and maintaining current nursing care plan for each patient. Enhancement/ development of electronic care plans for pressure ulcers, contact isolation, suicidal risk, hemodialysis treatments, seizure disorders and chronic pain. **Date of Implementation:** 6/16/14 **Monitoring Process:** The Nursing Director and/or designee will implement monitoring by auditing of pain medication orders every (24) hours. Auditing will begin with (10) random charts per day with target compliance set at 100%. Super Users will assist by auditing a minimum of 30 charts a month and report findings to quality department. **Person Responsible:** Nursing Director	4/30/2014 5/18/2014 6/16/2014 6/16/2014

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A 385	Continued From page 22 10. Ensure the patient would only receive medications or supplement that were prescribed by the physician for 1 of 52 sample patients (Patient 7). This deficient practice resulted in Patient 7 receiving a dietary supplement that was not ordered by the physician (Refer to A 405). The cumulative effect of these systemic issues resulted in the facility□s inability to ensure and provide a safe patient care environment.	A 385	(Continued from page 22) **10).Corrective Actions:** Development of PAT.059 24 hour Order/Chart Check policy to ensure patient records are consistently reviewed to validate orders and ensure they are carried out as well as to identify any discrepancies or inaccuracies between orders and actual patient care. Will also ensure documentation has occurred for any medications, treatments, or tests not performed and the explanation as to why. **Date of Implementation:** June 23, 2013 **Monitoring Process:** Monitoring of compliance with random review of 30 patient medical records a month for clinical areas with reporting to the Quality Council. **Person Responsible:** Nursing Director	6/23/2014
A 392	482.23(b) STAFFING AND DELIVERY OF CARE The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to have a monitor technician to provide continuous electrocardiographic (ECG) monitoring for 10 patients that required ECG telemetry monitoring (continuous monitoring of a patient□s heart rate and rhythm at a remote location) in the Critical Care Unit (CCU) and Surgical Intensive Care Unit (SICU). This deficient practice had the potential for not detecting abnormal heart rhythm timely which could result to life threatening heart condition that required immediate intervention. Findings:	A 392	**CULVER CITY** **Corrective Actions:** Effective immediately (6-12-14) ICU, CCU & SDU are consistently staffed with a Monitor Tech 24 hours a day/7 days a week for all units with cardiac monitors or Telemetry systems. The Monitor Tech for each unit is reflected on the Staffing Assignment record for each shift. The Staffing Matrix guiding staffing levels has been adjusted to ensure monitor tech for ICU, CCU & SDU for each shift **Date of Implementation:** 6-12-2014 **Monitoring Process:** Daily review of staffing to ensure Monitor Tech for each functioning ICU & CCU each shift. **Person Responsible:** Nursing Director of Critical Care Units & House Supervisors.	6/12/2014

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A 392	Continued From page 23 During the tour in the SICU of the facility□s Culver City campus on March 26, 2014, between 10 a.m. and 10;25 a.m., Registered Nurse (RN) 4 sat in front of the central EKG monitor station. During the concurrent interview, RN 4 stated she monitors the central EKG and there was no technician to monitor the central EKG at the station. According to RN 4, she and other ICU staff had to take turns to monitor the central EKG in the SICU. During the tour in the CCU on March 26, 2014, between 10:25 a.m. and 11:30 a.m., RN 4 sat in front of the central EKG monitor. During the concurrent interview, RN 4 stated there was no technician to monitor the central EKG at the station. According to RN 4, she and other ICU staff had to take turns to monitor the central EKG in the CCU. According to Staff G (assistant chief nursing officer), RN 4 was assigned to be the EKG Technician. However, according to RN 4, she had to relieve the ten (10) staff from the SICU, CCU, and SDU (Step-Down Unit) for their lunch breaks. The SICU Patient Assignment on March 26, 2014, for the day shift (7 a.m. to 7 p.m.) disclosed RN 4 was assigned as the charge nurse. There were 3 SICU nurses to take care of 5 patients. A review of the CCU Patient Assignment on March 26, 2014, for the day shift (7 a.m. to 7 p.m.) disclosed RN 4 was assigned as the charge nurse. There were 3 CCU nurses to take care of 5 patients. The SDU Patient Assignment on March 26, 2014, for the day shift (7 a.m. to 7 p.m.) disclosed RN 4 was assigned as the charge nurse. There were 2	A 392		

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A 392	Continued From page 24 SDU nurses to take care of 6 patients. There was no documentation in the assignment sheets that an EKG technician was assigned to monitor the central EKG station for the patients in the SICU, CCU and SDU.	A 392		
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on record review, observation and interview, the facility failed to supervise and evaluate the nursing care for 8 of 52 sampled patients (Patients 14, 15, 16, 17, 18, 22, 24 and 45) by failing to: 1. Provide non-pharmacological interventions for managing Patient 22□s pain (Refer to A 395). This deficient practice had the potential for not meeting the physical and mental needs of the patient. 2. Ensure Patient 24□s bedside did not have cleanser and supplies for a wound treatment left unattended. This deficient practice had the potential for administering the cleanser and supplies for the treatment of Patient 24□s wound which may not be inaccordance with the physician□s order. 3. Document the wound type, size, and depth during the initial assessment and reassessment. Failing to reassess the wound on March 16 and 23, 2014, and failing to provide treatments as ordered by the physician on Patient 14□s left foot pressure ulcer (localized injuries to the skin	A 395	**HOLLYWOOD** **1). Corrective Actions**: Review Scope of Practice to clearly delineate expected standards for nursing care Education/in-service provided to include patient rights, general care guidelines, general assessment, reassessment and intervention, patient evaluation, care plans, accurate and complete documentation. Re-education started June 18, 2014 will be completed June 30, 2014 **Date of Implementation:** April 19, 22, 2014; re-education June 18, 2014 to be completed June 30, 2014 **Monitoring Process:** Monitoring will be managed through Nursing rounds and monthly audits; data will be reported to PI, Quality Council and MEC **Person Responsible:** Nursing leadership on each department and senior leadership **2). Corrective Actions:** April 21-23, 2014 education/in-service provided to include general care guidelines, review of policy PHA.052 Preparing and Administration of Medications, and any unlabeled medication must not be used. Pharmacy will label all medications. **Date of Implementation:** May 1, 2014 **Monitoring Process:** Monitoring will be managed through nursing rounds and pharmacy rounds **Person Responsible:** Nursing leadership in each department and pharmacy **Culver City** **3) Corrective Actions:** Re-education of nursing staff related to wound characteristics as shown in wound photographs; to include size (LxWxD), shape, drainage, color, odor. (See Wound Record Attachment and Policy revision WOU.001). Re- educate nursing staff with regard to documentation of wound care treatment in McKesson under □integumentary tab.□ **Date of Implementation:** 6/13/2014 **Monitoring Process:** Wound Management Team Member to audit photo documentation on 30 wound record during patient rounds. Any issue of non-adherence will be addressed to the individual staff and referred to Quality department for further intervention as necessary including education and progressive disciplinary action. In addition, Wound Management Team Member to perform thirty audits, per month including documentation of treatments. **Person Responsible:** Wound Management Team.	4/19/2014 5/1/2014 6/13/2014

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A 395	Continued From page 25 and/or underlying tissue that usually occur over a bony prominence as a result of pressure, or pressure in combination) from March 7 to March 20, 2014 (a total of 11 days). This deficient practice had the potential to result in delay of the healing of the pressure ulcer (Refer to A 395). 4. Provide oral care to Patient 16 who was dependent on staff in his activities of daily living and was observed with dry lips and having mouth odor This deficient practice resulted in poor oral care for Patient 16. (Refer to A 395). 5. Ensure Patient 17 admitted to the psychiatric unit as ordered by the physician when there was bed available in accordance with the facility□s census report for the psychiatric unit. This deficient practice had the potential for not meeting the safety of the patient and others (Refer to A 395). 6. Ensure Patient 18 was administered Lisinopril medication (treat elevated blood pressure) as ordered by the physician. This deficient practice had the potential to result in an elevated blood pressure for Patient 18. (Refer to 395). 7. Ensure Patient 15 was administered Risperdal medication (psychoactive medication) as ordered by the physician. This deficient practice did not ensure the physician□s order for Risperdal medication was implemented for Patient 18 and had the potential for not meeting the psycho-social needs of the patient (Refer to A 395). 8. Evaluate Patient 45 after she had attempted to hang herself in the bathroom. This deficient	A 395	(Continued from page 25) **4) Corrective Actions:** Re - Educate all Registered nurses on supervising and evaluating the care for each patient. Nursing staff will provide hourly rounds using the 5 □Ps□focuses on PAIN, POTTY, POSITION /PRIVACY and POSSESSIONS. All Nursing staff will complete Patient focused Sensitivity Training including the importance of patient hygiene. **Date of implementation:** start re-education on 6/16/2014 full implementation within 30 days. **Monitoring Process:** Patient liaison will conduct 30 patient round observations per month to ensure 5 P□s, sensitivity, and privacy is done on each unit. Findings of the rounds will be reported to the specific nursing director for corrective action. A monthly report will be reported to the Quality Department monthly. Super users are collecting data on pain scale prior and after receiving pain medication this information is also sent to the quality department monthly. **Person Responsible:** Nursing Leadership from each department **5) Corrective Actions**: Policy Scope of Service- Emergency Department/urgent care □SOS.013 When it is anticipated that psychiatric patients will wait greater than 23 hours for a bed placement, calls shall be made to psychiatric facilities in other areas to determine if an appropriate bed is available and an evaluation shall be done for possible transfer and placement . Total census for BHU was 70 there was no bed availability for March 23, 24,of 2014. On March 25, the BHU had to take 4 beds out of service, beds A and B from 624 due to sink overflowing and flooding room and 603A and 603B closed due to bed bug infestation For care safety and welfare of our patients the beds could not be used until the bed bug situation Addendum could be ratified o improve transparency of bed availability the house supervisors have use of electronic bed tracking system that allows for transparency of bed availability and bed status: occupied □dirty-clean House supervisors will monitor and track bed availability to decrease ER wait times. During the time bed placement is pending patients are monitored under close observation. Staff will follow BHU .006 Close Observation Policy **Date of Implementation**: 4/30/2014 **Monitoring Process**: House Supervisors monitor bed availability throughout the day by bed tracker. At 6am 3pm 6pm 9pm the house supervisors record the hospital census **Person Responsible:** House Supervisor /Nursing leadership **6) Corrective Actions:** The pharmacy program will add standardized blood pressure parameters of when to hold a blood pressure medication. These will appear on the E-MAR for every blood pressure medication. **Date of Implementation:** 7/1/2014 **Monitoring Process**: N/A **Person Responsible**: VP of Pharmacy Operations or designee **7) Corrective Actions:** Re-educate/in-service the night shift staff on the existing □Nightly Chart Audit□ **Date of Implementation:** 6/16/14 **Monitoring Process:** The Nursing Director and/or designee will implement monitoring by auditing of medication orders every (24) hours. Auditing will begin with (10) random charts per day with target compliance set at 100%. Report findings to Quality Department on a quarterly basis. **Person Responsible:** Nursing Director **VAN NUYS** **8) Corrective Actions:** Re-educate all Registered Nurses on the importance of Head to Toe Assessment immediately after any patient placed on 1:1 with staff. In-service staff and provide the □Suicide Precaution Documentation Monitoring Checklist□tool which includes a □head to toe assessment□section for check off. **Date of Implementation:** 6/16/14	6/16/2014 4/30/2014 7/1/2014 6/16/2014 6/16/2014

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	050135	C. BUILDING **01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD** D. WING _____	**04/01/2014**

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A 395	Continued From page 26 practice had the potential of not identifying any physical condition related to her attempt to hand herself, which may required interventions (Refer to A 395). Findings: 1. In the facility□s Hollywood campus, a review of the open medical record of Patient 22 indicated the patient was admitted to the facility□s urgent care on March 24, 2014, at 9:27 a.m., for complaint of pain in bilateral legs and verbalizing of suicidal ideation□s with a plan to run into traffic. At 9:50 a.m., the medical record documented Patient 22 was assessed for pain with a pain level of 9 and 10 being the worst. A review of the facility□s Urgent Care Physician Report Order, dated March 24, 2014, indicated there was no order for pain medication. There was also no documentation the licensed nurse had provided non-pharmacological interventions for managing the patient□s pain. During a concurrent interview, Staff E reviewed the clinical record and stated there was no documentation of an order for pain medication and that the staff provided nay non-pharmacological interventions for managing the patient□s pain. 2. On March 24, 2014, at 11 a.m., during the tour, an observation in Patient 24□s room, Hollywood campus, there was a plastic container with two	A 395	(Continued from page 26) **Monitoring Process:** Director of Nursing and/or designee will conduct monitoring activity on the checklist tool submitted by staff the same day the incident occurs to ensure that the requirements and documentation monitoring tool has been completed to include the (head to toe)physical assessment. **Person Responsible:** Nursing Director, Nurse Manager, and Supervisors	

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A 395	Continued From page 27 bottles of Sure Prep skin barrier spray, a container of hydrogel skin integrity, a plastic cup of pink colored cream and wound cleanser on the patient□s bedside stand. During a concurrent interview, RN 20 stated the topical medications were used for wound treatment. RN 30 stated the plastic cup that contained pink colored cream was Calazime cream, which should not be left at the bedside and should be discarded after it was used. A review of Patient 24□s medical record indicated there was no physician□s order for the hydrogel. 3. On March 25, 2014, at 10 a.m., during an observation tour in the unit of the facility□s Culver City campus, Patient 14 was resting in bed, awake, alert, oriented, and was watching television. During a concurrent interview, Patient 14 stated she had a recent fall prior to admission and sustained open wounds. A review of the Admission Face Sheet indicated Patient 14 was admitted to the facility on March 4, 2014, with diagnoses that included bilateral lower leg pain with swelling, anemia, edema (swelling) and hypotension (low blood pressure). A review of the facility□s policy on Wound Report Procedure SAA.092 stipulated the following: a. Initiate the Wound Report Immediately and place in the medical record. b. Document on the Wound Report Form, at least	A 395		

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A 395	Continued From page 28 weekly, the wound location, size, depth, drainage, appearance, odor and progress. The Initial Nursing Admission Assessment indicated the patient had two (2) Stage II pressure ulcers on the mid back and left leg. The Impaired Skin Integrity Record on admission (March 4, 2014) indicated there were photographs of the patient□s wounds on the the left heel, right knee, left foot, right heel, right buttocks, and left back. The record did not specify the type of wound (pressure, arterial/venous ulcer, etc), size, stage and other wound characteristics. Additionally, a review of the physician□s orders for March 4, 2014, indicated there was no treatment orders for the wound on the right knee and pressure ulcer on the mid-back. The medical record also failed to indicated documentation the wounds were reassessed weekly for the week of March 16 and 23, 2014. A review of the Impaired Skin Integrity Record dated March 9, 2014, indicate a reassessment of the wounds that indicated the following: a. The photograph showed the patient□s right buttocks pressure ulcer Stage II, pink/red in color, intact surrounding skin and had no necrotic tissue, odor, or drainage. There was no documentation of the size and shape of the pressure ulcer as indicated on the Impaired Skin Integrity Record.	A 395		

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	050135	C. BUILDING **01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD** D. WING _____	**04/01/2014**

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A 395	Continued From page 29 b. The photograph showed the left knee skin tear/abrasion, pink/red in color, intact on the surrounding skin and had no necrotic tissue, odor, or drainage. There was no documentation of the size and shape of the wound as indicated on the Impaired Skin Integrity Record. c. The photograph showed the mid-back pressure ulcer, Stage II to III, intact surrounding skin, pink/red in color and had no necrotic tissue, odor, or drainage. The pressure ulcer was cleansed with wound spray, hydrogel was applied and covered with dressing. There was no documentation of the size of the pressure ulcer. d. The photograph showed a right heel wound. There was no documentation of the type of wound, stage, size, and other wound characteristics. e. The photograph showed a left foot wound. There was no documentation of the type of wound, stage, size, and other wound characteristics. f. The photograph showed a left heel wound. There was no documentation of the type of wound, stage, size, and other wound characteristics. a further review of Patient 14□s medical record indicated the treatments as ordered by the physician on the pressure ulcers were not done on the following days: March 7 8, 9, 10, 12, 14, 15, 16, 17, 19 and 20, 2014.	A 395		

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A 395	Continued From page 30 4. On March 25, 2014, at 10:30 a.m., during a tour of the unit with Staff G, Patient 16 was observed lying bed with bilateral rails up and there was a sign posted on the wall that indicated nothing by mouth (NPO). There was a foul odor emanating from the patient□s mouth. The patient□s lips were dry and the patient was receiving oxygen via nasal cannula. During a concurrent interview, Licensed Vocational Nurse (LVN) 4, stated she was in Patient 16□s room 10 minutes ago and was not aware the patient needed oral care. A review of Patient 16□s clinical record indicated the patient was admitted to the facility on March 24, 2014 for abdominal pain, seizure disorder, encephalopathy and constipation. The Admission Assessment Inquiry indicated the patient was dependent in his activities of daily living such a bathing, grooming and oral care, however, the patient□s level of consciousness is confused. 5. On March 26, 2014, at 9:15 a.m., during the tour of the emergency department (ER) with Staff N, Patient 17 was observed in bed, awake, alert, oriented, wearing hat and sunglasses. During a concurrent interview Patient 17, stated she lived in a skilled nursing facility, and went to the emergency room (ER) because of a pain in	A 395		

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A 395	Continued From page 31 the right side of her body. Patient 17 stated she had been in the emergency room for a couple of days. A review of Patient 17□s clinical record indicated she was admitted to the emergency room (ER) on March 23, 2014, with diagnosis of aggressive psychiatric evaluation for aggressiveness. The patient had been in ER for 3 days. During a concurrent interview, RN 14 stated the patient had been in the ER for three days because they were waiting for an available inpatient bed in the psychiatric unit. On March 3, 2014, the physician ordered the patient be admitted to Psychiatric 6 unit. According to the facility□s policy and procedure on the Scope of Service □Emergency Department/Urgent Care dated June 26, 2013, indicated mechanism for identifying patient care needs, included psychiatric patients with admission orders that are awaiting an available bed will be held in either the main ER or in the ER Overflow area pending bed availability. The Census Report for the facility□s Psychiatric Unit was reviewed with Staff B and indicated on March 23, 2014, there were three available Psychiatric beds in the seclusion unit. On March 24, 25, 2014, there were three available Psychiatric beds in the seclusion unit. On March 24 and 25, 2014, there were three available beds in the seclusion unit. On March 25, 2014, there were four beds available in the locked unit. Staff B stated the patient could have been transferred and/or admitted to the inpatient unit when there	A 395		

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A 395	Continued From page 32 was an available bed. Staff B stated the goal for the patient was to get her out of the ER and admitted to the unit. Further review of Patient 17□s clinical record indicated on March 25, 2014, at 4:32 p.m., there was a room available for the patient in the Psych 6 unit, and will call for report. At 5:29 p.m., the documentation in the clinical record indicated the transfer for Patient 17 was changed per the charge nurse due to no bed availability that day. 6. On March 26, 2014, at 2:15 p.m., during the tour of the unit, Patient 18 was observed in bed with an intravenous line □IV□ into the vein by a heplock (tube inserted into a vein, but capped) on the right hand. The Admission Facesheet indicated the patient was admitted to the facility on March 14, 2014, with diagnosis of chest pain. The physician□s order, dated March 14, 2014, indicated Lisinopril 20 milligram (mg) tablet to administer 40 mg, once a day orally for hypertension (High blood pressure). The physician order did not indicate an order to obtain a blood pressure reading and to hold the medication when the blood pressure was too low. A review of the Medication Administration Record (MAR), dated March 15, 2014, indicated Lisinopril medication was not given to the patient. During a concurrent interview, RN 15 stated she did not give the Lisinopril to the patient at that time because her blood pressure was 109/69. The RN was not able to show documentation the	A 395		

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A 395	Continued From page 33 physician was notified of the patient□s blood pressure. 7. The clinical record indicated Patient 15 was admitted to the facility on March 19, 2014, with the chief complaint of urinary tract infection and a psych evaluation for agitation. On March 20, 2014, the physician□s order indicated Risperdal (antipsychotic medication) 1 mg via gastrostomy tube (GT) every morning and 2 mg via GT in the afternoon. A review of the medication administration record (MAR) dated from March 21 through March 25, 2014, there was no documented evidence Risperdal was administered to the patient. On March 27, 2014, a review of the clinical record and an interview with the pharmacist failed to show documentation the order for Risperdal was carried out. 8. A review of the facility□s report disclosed an incident occurred on March 21, 2014, at 8:15 p.m., in Unit 1 (open unit) in Patient 45□s bathroom. MHW 2 was conducting a visual inspection and Patient 45 was not in the room. Patient 45 was in the bathroom and the door was locked. MHW 2 observed part of Patient 45□s gown was hanging at the top of the door. As MHW 2 approached the bathroom door, he called out Patient 45□s name. The door was completely locked and he (MHW 2) was unable to open the door MHW 2 heard a loud thump sound coming from the bathroom and heard gurgling sounds coming from Patient 45. MHW 2 yelled, □Code	A 395		

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A 395	Continued From page 34 Blue, Nurse□as he banged on the bathroom door. The bathroom door opened and Patient 45 □landed on the floor.□A nurse came in the room and assessed Patient 45. On March 24, 2014, at 12:15 p.m., an interview was conducted with Staff H regarding the registered nurse (RN) assessment after the incident. Staff H reviewed the report and stated the RN did not conduct a physical assessment of Patient 45 after the incident. Staff H stated the RN should have documented an assessment of Patient 45. He further stated Patient 45 was place on 1:1 for safety after the incident.	A 395		
A 396	482.23(b)(4) NURSING CARE PLAN The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure nursing staff developed and kept current nursing care plans for 8 of 52 sampled patients (Patient 14, 25, 26, 29, 31, 32, 45 and 46). 1. Patient 14, who had pressure ulcers, there was no care plan interventions to address the actual wounds/pressure ulcers to ensure the plan of care was effective for wound healing. 2. Patient 25, there were no care plans developed to manage the patient□s care while in contact isolation and required hemodialysis treatments.	A 396	**Culver City** **1-6) Corrective Actions:** Policy PAT.001 Admission Assessment/Interdisciplinary Plan of Care strengthened the development of care plans and maintaining current nursing care plan for each patient. Enhancement/development of electronic care plans for pressure ulcers, contact isolation, suicidal risk, hemodialysis treatments, seizure disorders and chronic pain. Educate nursing staff to create a care plan in EMR specific to skin integrity, during time of admission, evaluation, and updates on a daily basis. Policy revision WOU.001 **Date of Implementation**: 6/13/2014 with completion in 30 days. **Monitoring Process:** Auditing audit a minimum of 30 charts a month by Super Users with a report to the Quality Department on a quarterly basis. **Person Responsible:** Nursing Directors	6/13/2014

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A 396	Continued From page 25 3. Patient 26, there was no care plan developed for managing Patient 26 who had seizure disorder. 4. Patient 29, there was no care plan for the patient□s care while in contact isolation. 5. Patient 31, there was no care plan developed for the care while the patient was in contact isolation and receiving hemodialysis treatments. 6. Patient 32, there was no care plan developed for the care while the for contact isolation. 7. Patient 45, who was assessed as a suicidal risk, the care plan was no revised or updated to address the patient□s current status requiring 1:1 observation. 8. Patient 46, who had chronic pain, the care plan was not developed or initiated upon admission, but six days after admission. These deficient practices had the potential for not meeting the physical and mental needs of each patient. Findings: 1. A review of the Admission Face Sheet indicated Patient 14 was admitted to the facility on March 4, 2014, with diagnoses that included bilateral lower leg pain with swelling, anemia, edema (swelling) and hypotension (low blood pressure). A review of the care plan dated March 4, 2014,	A 396	(Continued from page 35) **HOLLYWOOD** **1,2,3) Corrective Actions:** Policy PAT.001 Admission Assessment/Interdisciplinary Plan of Care strengthened the development of care plans and maintaining current nursing care plan for each patient. Enhancement and development of electronic care plans for pressure ulcers, contact isolation, suicidal risk, hemodialysis treatments, seizure disorders and chronic pain. EMR Education/re-training provided beginning April 16, 2014 thru May 5, 2014 to include accurate and complete documentation of initial, care plan updates, and upon discharge utilizing the existing care plan modules **Date of Implementation:** Daily concurrent review of care plans on all patients performed beginning April 1, 2014, beginning May 1, 2014 review 30 random charts; re-training beginning June 18, 2014 thru June 30, 2014. **Monitoring Process:** Monitoring will be managed by review of 30 random charts by nursing; data will be reported through Quality Department. **Person Responsible:** Nursing Leadership **Van Nuys** **7) Corrective Actions:** Re-educate all Registered Nurses on the importance of creating a plan of care and updating the treatment plan immediately after placing a patient on a 1:1 with staff. In-service staff and provide the □Suicide Precaution Documentation Monitoring Checklist□tool which includes a check off section for □Patient Treatment Plan□ updated/revised to address the change of patient acuity. **Date of Implementation:** 6/16/14 **Monitoring Process:** Director of Nursing and/or designee will conduct monitoring activity on the checklist tool submitted by staff the same day the incident occurs to ensure that the requirements and documentation monitoring tool has been completed to include updating/revising of the patient treatment plan. **Person Responsible:** Nursing Director, Nurse Manager, and Supervisors **8) Corrective Actions:** Re-educate/inservice the night shift staff on the existing □Nightly Chart Audit□ This audit includes a check off section for □Nursing Care Plan/Pain□ Re-educate the supervisors who perform the already existing audit □Pain Management Audit Monitoring Tool□ Re-educate supervisors to complete the treatment plan for pain as needed while auditing. **Date of Implementation**: 6/16/14 **Monitoring Process:** The Nursing Director and/or designee will implement monitoring by auditing of pain medication orders every (24) hours. Auditing will begin with (10) random charts per day with target compliance set at 100%. **Person Responsible:** Nursing Director	4/1/2014 6/16/2014 6/16/2014

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A 396	Continued From page 36 indicated impairment of skin integrity. The care plan did not address specific interventions for Patient 14□s actual wounds/pressure ulcers to ensure the plan of care was effective. On March 27, 2014, at 8 a.m., a review of the electronic record was conducted with Registered Nurse (RN) 12. During a concurrent interview, RN 12 stated the plan of care was initiated but failed to indicate the interventions to be undertaken to heal and prevent the wounds/pressure ulcers from getting worst. 2. During the initial tour with RN 1 and 2, in the mixed unit of Definitive Observation Unit (DOU) and the Medical-Surgical unit of the Hollywood campus on March 24, 2014 between the time of 11:15 a.m. and 11:45 a.m., Patient 25 was observed resting on the bed and there was a sign that indicated □Contact Isolation□posted by the door. According to RN 2, Patient 25 was placed in the room for MRSA (methicillin resistant staphylococcus aureus is a bacteria that causes infection that are resistant to some antibiotics) contact isolation. RN 2 also stated Patient 26 had an AV fistula (dialysis access site) on her left arm for hemodialysis treatment. A review of the electronic clinical record was conducted with Licensed Vocational Nurse (LVN) 1 disclosed there were no care plans developed for managing Patient 25 who was on contact isolation and who required hemodialysis treatment. During an interview with LVN 1 on March 24, 2014 at 12:20 p.m., she stated the nursing staff failed to develop the care plans for contact	A 396		

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A 396	Continued From page 37 isolation and hemodialysis. 3. A review of the clinical record indicated Patient 26 was admitted on March 15, 2014, with a diagnosis of seizure disorder. A review of the electronic clinical record was conducted with LVN 1 disclosed there was no care plan developed for managing Patient 26 who had seizure disorder. During an interview with LVN 1 on March 24, 2014 at 12:20 p.m., she stated the nursing staffs failed to develop the care plan for the patient□s seizure disorder. 4. During the initial tour with RN 3 in the Medical-Surgical Unit of the Culver City campus on March 25, 2014 between the hours of 10:55 a.m. and 11:35 a.m., Patient 29 was observed resting on the bed with a sign that indicated □Contact isolation□posted by the door. According to RN 3, Patient 29 was placed in the room for MRSA contact isolation. However, the electronic clinical record was reviewed with RN 2 and indicated there was no care plan for contact isolation. 5. During the initial tour with RN 4 in the Surgical Intensive Care Unit (SICU) of the Culver City campus on March 26, 2014, between 10 a.m. and 10:25 a.m., Patient 31 was observed resting on the bed with a sign that indicated □Contact	A 396		

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A 396	Continued From page 38 Isolation□posted by the door. RN 4 also stated Patient 31 underwent the hemodialysis treatment. According to RN 4, Patient 31 was placed in the room for MRSA contact isolation. However, the electronic clinical record was reviewed with RN 4 and indicated there was no care plan for contact isolation and hemodialysis. During the concurrent interview with RN 4 on March 26, 2014 at 10:25 a.m., she stated the nursing staff failed to develop the care plans for contact isolation and hemodialysis. 6. During the initial tour with RN 4 in the Critical Care Unit (CCU) of the Culver City campus on March 26, 2014 between the time of 10:25 a.m. and 11:35 a.m., Patient 32 was observed resting on the bed with a sign that indicated □Contact Isolation□by the door. According to RN 4, Patient 32 was placed in the room for MRSA contact isolation. However, the electronic clinical record was reviewed with RN 4 and disclosed there was no care plan for contact isolation for Patient 32. During an interview with RN 4 on March 26, 2014 at 10:25 a.m., she stated the nursing staff failed to develop the care plans for contact isolation and hemodialysis. 7. A review of the facility□s report indicated an incident occurred on March 21, 2014, at 8:15 p.m., in Unit 1 (open unit) bathroom. Mental Health Worker (MHW) 2 was conducting a visual inspection in the room and Patient 45 was not in the room. Patient 45 was in the bathroom and the	A 396		

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A 396	Continued From page 39 door was locked. MHW 2 observed part of Patient 45□s gown was hanging at the top of the door. As MHW 2 approached the bathroom door, he called out Patient 45□s name. The door was completely locked and he (MHW 2) was unable to open the door. MHW 2 heard a loud thump sound coming from the bathroom and heard gurgling sounds coming from Patient 45. MHW 2 yelled, □Code Blue, Nurse□as he banged on the bathroom door. The bathroom door opened and Patient 45 □landed on the floor.□ On March 24, 2014, at 8:15 a.m., a review of the patient□s medical record was conducted with Staff I. During a concurrent interview, Staff I stated there was care plan, dated March 20, 2014, titled, □Potential for Self Harm as evidenced by Suicidal Ideation, with a Plan to Overdose.□The short term goal was that the patient will report □urge to harm self.□The long term goal was the patient will not harm self during hospitalization. The nursing interventions included encourage verbalizing thoughts and needs. Monitor for safety. However, the care plan was not revised to address Patient 45□s current status of level of observation which was a 1 to 1 observation. 8. During an interview with RN 8 on March 25, 2014, at 9 a.m., she reviewed Patient 46□s clinical record and stated she was unable to find a care plan for the pain management. A review of the Admission Face Sheet indicated Patient 46 was admitted to the facility on March 18, 2014. The History and Physical dated March 19, 2014 disclose Patient 46 had chronic back pain. The physician□s orders dated March 21, 2014 indicated the patient was receiving Robaxin (muscle relaxant) 750 milligrams (mg) one by	A 396		

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A 396	Continued From page 40 mouth twice a day and Flexeril (muscle relaxant) 10 mg one by mouth twice a day. The care plan titled, □Alteration in comfort due to Pain □ Chronic; dated March 24, 2014, indicated the pain was described as chronic low back pain. However, the care plan was not developed or initiated upon the patient□s admission on March 18, 2014, until six days after admission. According to a facility□s policy titled Interdisciplinary Treatment Plan and Update Scheduling dated November 2012 disclose dot ensure each client admitted to the facility has a written, individualized treatment plan based on assessments of clinical needs. All medical problems requiring interventions shall be entered on the Interdisciplinary Treatment Plan (IDT) Problem List and a care plan for the identified plan shall be initiated by the RN. Furthermore, within the first 72 hours the IDT Team shall meet to discuss the patient□s needs.	A 396		
A 405	482.23(c)(1), (c)(1)(i) & □ (2) ADMINISTRATION OF DRUGS (1) Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient□s care as specified under □482.12(c), and accepted standards of practice. (i) Drugs and biologicals may be prepared and administered on the orders of other practitioners not specified under □482.12(c) only if such practitioners are acting in accordance with State law, including scope of practice laws, hospital policies, and medical staff bylaws, rules, and regulations.	A 405	**Culver City** **Corrective Actions:** All nursing staff re-educated with self-study module to validate that physician orders have been noted, examined, and verified. Caregivers must use SBAR and provide the opportunity to use read-back techniques and medications orders received must be read back by the receiver. 24 hour order/chart check policy & procedure PAT.059 implemented that mandates documentation of chart review before 7am each day. **Date of Implementation**: 5/18/2014 **Monitoring Process:** Random audit of 30 charts for each nursing unit with report to Quality Department on a quarterly basis. **Person Responsible**: Nursing Leadership	5/18/2014

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A 405	Continued From page 41 (2) All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure patient would only receive medications or supplement that were prescribed by the physician for 1 of 52 sample patients (Patient 7). This deficient practice resulted in Patient 7 receiving a dietary supplement that was not ordered by the physician. Findings: On March 26, 2014 at 9:30 a.m., in the Telemetry Unit of the Culver City campus, during a medication pass for Patient 7, the patient received one tablet of the dietary supplement □inc Sulfate 220 milligrams (mg) but could not locate the physician□s order for the zinc sulfate in the patient□s chart. On March 26, 2014 at 10:45 a.m., the director of pharmacy (Pharmacist 2) confirmed he was unable to find the □inc Sulfate order in Patient 7□s chart. On March 26, 2014 at 11 a.m., the vice president pharmacy operations (Pharmacist 1) could not find the □inc Sulfate order in the Patient 7□s chart. A review of the Nutrition Recommendation Form	A 405		

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	050135	E. BUILDING **01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD** F. WING _____	**04/01/2014**

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A 405	Continued From page 42 for Patient 7, dated March 25, 2014 at 8:16 a.m., indicated a handwritten check mark in the check box for □Vitamins and Minerals□and another handwritten check mark in the check box for □Multivitamin mineral one table PO (orally) daily.□However, there was no marking by the check box for □□inc Sulfate 220 mg.□ A review of the fax copy of the □Nutrition Recommendation Form□dated March 24, 2014 at 1:05 p.m. indicated the pharmacy received the order on March 25, 2014 at 8:16 a.m. A review of the electronic Medication Administration Record (eMAR) for March 25, 2014, indicated Patient 7 received one □inc Sulfate 220 mg tablet on March 25, 2014 at 9 a.m. As of the medication pass observed on March 26, 2014 at 9:30 a.m., a total of two doses of □inc Sulfate 220 mg tablets were given to Patient 7. On March 26, 2014 at 11:23 a.m., an interview with Pharmacist 1 indicated a staff pharmacist misread the Nutrition Recommendation form as □inc Sulfate being included because of the long handwritten check mark for the multivitamin with mineral, which was located directly above it on the pre-printed Nutrition Recommendation Form. At 1:42 p.m., on March 26, 2014, Pharmacist 1 stated there was no policy and procedure for the chart check process performed by the nursing staff that would verify eMAR with actual physician orders. At 1:49 p.m. on March 26, 2014, during an interview, RN 10 described the process for the 12	A 405		

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A 405	Continued From page 43 hour chart check performed at shift change. The nurses performing the chart check would receive a report from a □supervising nurse,□ they would then confirm physician orders the chart with eMAR and verify in computer program. She stated □This is a routine protocol.□ She also described the 12 hour nursing shifts as 7 a.m. to 7 p.m. and 7 p.m. to 7 a.m. On March 28, 2014 at 11:53 a.m., during a follow-up interview, RN 10 stated the nurses responsible for their patients should have caught the medication entry error during the chart check process. A review of the policy and procedure dated 10/2013, titled, □Drug Distribution and Control□ Number: PHA.025 dated □10/2012,□ indicated □The Pharmacy department shall distribute medication and control the use of medication as follows: Review all medications orders for appropriateness and safety with respect to the current medication profile.□ A review of the policy and procedure dated 11/2012, titled, □Hand Off Communications,□ Number: PAT.043, □indicated□□ A □hand off□ communication is an interactive process of passing patient-specific information from one caregiver to another or from one team of caregivers to another for the purpose of ensuring the continuity and safety of the patient□s care □ This provides the caregivers an opportunity to verify information by using read-back techniques. Critical test results and medication orders received shall be read back by the receiver. The occurrence of the read back shall be documented in the medical record.□	A 405		

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A 432 A 432	Continued From page 44 482.24(a) ORGANI□ATION AND STAFFING The organization of the medical record service must be appropriate to the scope and complexity of the services performed. The hospital must employ adequate personnel to ensure prompt completion, filing, and retrieval of records. This STANDARD is not met as evidence by: Based on medical record review and medical records staff interview, the facility failed to ensure that physician orders were authenticated and that medical records were completed in a timely manner as evidenced by lack of an effective system to ensure authentication and medical records completion of telephone orders at the Van Nuys campus. This deficient practice had the potential to result in delays of pertinent information being available for continuing patient care. Findings: Patient 13 was admitted to the Van Nuys campus on March 25, 2014 with diagnosis including exacerbation of depression (a mood disorder in which feelings of sadness, loss, anger or frustration interfere with everyday life for weeks or longer). The physicians□admission diet order dated March 25, 2014, was a no added salt diet. In an interview on March 27, 2014 beginning at 3 p.m., (Administrative Staff) Staff 7 stated if there is no physician on site when patients are admitted both the medical doctor and the psychiatrist are contacted for telephone admitting orders, including diet orders. Staff 7 stated the orders were then put into the electronic medical record. Upon completion of order entry the medication	A 432 A 432	**Van Nuys** **FINDING 1:** ***Patient 13 Dietary Orders*** **Corrective Actions:** An internal review of dietary processes identified handwritten dietary recommendations were placed into the patient□s medical record and not reviewed in a timely manner. The following improvements have been implemented: • All physicians are required to input orders via the Computerized Physician Order Entry System (CPOE). • All dietary recommendations are required to be input into the electronic medical record (EMR). Input of a dietary recommendation into the EMR triggers a □flag□of a pending diet recommendation and prompts appropriate follow-up for a physician□s order to finalize said dietary recommendation. • The Dietary Department will monitor all diet orders, executed as a result of a diet recommendation, to ensure all diet orders are appropriately fulfilled. Audit results will be reported to the hospital□s Pharmacy and Therapeutics Committee, Quality Council, Medical Executive Committee, and Governing Board. **Date of Implementation** • Internal review of the dietary processes was conducted April through June 2014. — 4/15/2014 • Mandatory input of dietary recommendations into the EMR completed July 22, 2014 for the Culver City campus and August 1, 2014 for the Van Nuys and Hollywood campuses. — 7/22/2014 8/1/2014 • Physicians mandated to input orders via CPOE by July 15, 2014 for the Hollywood and Van Nuys campuses and by August 18, 2014 for the Culver City campus. — 7/15/2014 8/18/2014 • Super-users have been hired and trained to support physician adoption and training. Physician CPOE training commenced June 25, 2014. — 6/25/2014 **Monitoring Process:** • The Dietary Department will monitor all diet orders, executed as a result of a diet recommendation, to ensure diet orders are appropriately fulfilled. Audit results will be reported to the hospital□s Pharmacy and Therapeutics Committee, Quality Council, Medical Executive Committee, and Governing Board. • Compliance will be gauged by reviewing the number of diet recommendations generated (denominator), and of those, the number of orders written and executed (numerator) • Targeted compliance is 90% • Monitoring activity will commence for a period not to exceed 4 months or until optimal compliance is achieved and sustained. • Random audits will be performed thereafter. • Results of the audits will be reported to the hospital□s Pharmacy and Therapeutics Committee, Quality Council, Medical Executive Committee, and Governing Board. **Person Responsible:** Director of Dietary/Food Services or designee. **Finding 2, 3 and 4 –** ***Interview with (Administrative Staff) Staff 7, Staff 8, and Staff 9 (Health Information Manager)*** **Corrective Actions:** An internal assessment identified that incomplete (signed, dated, and timed) physician□s orders in the system existed primarily due to the slow rate of physician adoption to the EMR. Physicians not logging into the EMR system did not receive a prompt of incomplete orders in the system. Once a physician logs into the EMR a system generated prompt requires the physician to appropriately disposition (sign or refuse with reason) each unsigned order. When the physician authenticates an order, the system automatically dates and times the order.	

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A 432	Continued From page 45 order were printed and faxed to the pharmacy for implementation and eventual physician signature. All remaining orders and patient care documentation was maintained in the electronic medical record. She further stated that the intent would be for physicians to electronically authenticate all telephone orders and that each time a physician logged there was a reminder screen that depicted the number of orders that required reviewing. She also acknowledged that physicians did not routinely authenticate orders that were in the electronic medical record. In an interview on March 27, 2014 beginning at 3:40 p.m., Staff 8 was asked to describe the medical record auditing process. She stated the current electronic record was implemented in June 2013 and she routinely requests physicians□sign their orders. Staff 8 stated the orders were reviewed and those that were in the paper format, which were primarily medication orders were reviewed. Staff 8 determine the number of electronic telephone orders that were not authenticated within the last 30 days. In a follow up observation on March 27, 2014 at 4:14 p.m., Staff 7 as able to demonstrate the number of orders that were not authenticated for a random physician. It was noted on the screen shot being viewed the physician had 199 orders that required authentication. In an interview on March 28, 2014 at 9:15 a.m., Staff 9 (Health Information Manager) (HIM) stated the department audited elements such as history and physicals; operative reports and authentication of physicians□orders. Staff 9 stated the authentication of orders was limited to those that were printed; there was no audit of orders that may have been directly entered into	A 432	(Continued from page 45) The following improvements have been implemented: • Physicians mandated to input orders via CPOE by July 15, 2014 for the Hollywood and Van Nuys campuses and by August 18, 2014 for the Culver City campus. • Additional CPOE physician training commenced at the Hollywood, Van Nuys, and Culver City campuses on June 25, 2014. • Previous to the CPOE mandate, the Chief of Staff issued a memo, dated June 13, 2014, to All Medical and Allied Staff Members to serve as a reminder notice that pursuant to the Medical Staff Rules and Regulations that all orders and progress notes must be signed, dated, and timed. • Non-compliance discussed and corrective actions addressed at medical department meetings and the Medical Executive Committee (MEC). • Medical Staff leadership will continue to monitor progress and work with Administration to improve compliance with documentation standards. • Audit results will be reported to the hospital□s Quality Council, Medical Executive Committee, and Governing Board. **Date of Implementation** • Super-users have been hired and trained to support physician adoption and training. Physician CPOE training commenced June 25, 2014. • Physicians mandated to input orders via CPOE by July 15, 2014 for the Hollywood and Van Nuys campuses and by August 18, 2014 for the Culver City campus. • Previous to the CPOE mandate, the Chief of Staff issued a memo, dated June 13, 2014, to All Medical and Allied Staff Members to serve as a reminder notice that pursuant to the Medical Staff Rules and Regulations that all orders and progress notes must be signed, dated, and timed. • Non-compliance discussed and corrective actions addressed at medical department meetings and the Medical Executive Committee (MEC). • Medical Staff leadership will continue to monitor progress and work with Administration to improve compliance with documentation standards. • Audit results will be reported to the hospital□s Quality Council, Medical Executive Committee, and Governing Board. **Monitoring Process:** • The HIM Manager and/or designee will conduct monthly audits of patient charts to review for the completion of all physician orders (timed, dated, and signed). • Numerator = Number of complete physician orders (timed, dated, and signed) / Denominator □ Number of total physician orders reviewed. • The sample size will be based on monthly discharges, per the following guidelines: o Sample all cases for a population size of fewer than 30 cases o Sample 30 cases for a population size of 30□100 cases o Sample 50 cases for a population size of 101□500 cases o Sample 70 cases for a population size of more than 500 cases • Targeted compliance is 90% • Monitoring activity will commence for a period not to exceed 4 months or until optimal compliance is achieved and sustained. • Random audits will be performed thereafter. • Results of the audits will be reported to the hospital□s Quality Council, Medical Executive Committee, and Governing Board. **Person Responsible:** HIM Administrator and/or designee	6/25/2014 7/15/2014 8/18/2014 6/13/2014

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A 432	Continued From page 46 the electronic medical record. He also acknowledged that in the Culver City campus and Hollywood campus staff was instructed to print out all physicians□orders. He was unaware that the Van Nuys campus was not printing orders. Hospital document titled □General Medical Staff Rules and Regulations□dated 12/4/13 noted that it was the responsibility of the attending physician for the clinical accuracy and timely completion of the medical record. The rules also noted □The medical record shall be completed promptly and authenticated by signature by a physician□ □	A 432		
A 454	482.24(c)(1) CONTENT OF RECORD: ORDERS DATED & SIGNED All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner who is responsible for the care of the patient only if such a practitioner is acting in accordance with State law, including scope-of-practice bylaws, rules, and regulations. This STANDARD is not met as evidenced by; Based on record review and interview, the facility failed to ensure the verbal orders of the physicians were dated, timed, and authenticated promptly by the ordering practitioner, as in accordance with the facility□s Medical Staff Rules & Regulations for 6 of 52 sampled patients (Patient 15, 18, 25, 26, 29, and 32). This deficient practice had the potential for the physician orders not to be complete and accurate. Findings:	A 454	**ALL THREE CAMPUSES** **Findings 1-5 Corrective Actions:** An internal assessment identified that incomplete (signed, dated, and timed) physician□s orders in the system existed primarily due to the slow rate of physician adoption to the EMR. Physicians not logging into the EMR system did not receive a prompt of incomplete orders in the system. Once a physician logs into the EMR a system generated prompt requires the physician to appropriately disposition (sign or refuse with reason) each unsigned order. When the physician authenticates an order, the system automatically dates and times the order. The following improvements have been implemented: • Physicians mandated to input orders via CPOE by July 15, 2014 for the Hollywood and Van Nuys campuses and by August 18, 2014 for the Culver City campus. • Previous to the CPOE mandate, the Chief of Staff issued a memo, dated June 13, 2014, to All Medical and Allied Staff Members to serve as a reminder notice that pursuant to the Medical Staff Rules and Regulations that all orders and progress notes must be signed, dated, and timed. • Non-compliance discussed and corrective actions addressed at medical department meetings and the Medical Executive Committee (MEC). • Medical Staff leadership will continue to monitor progress and work with Administration to improve compliance with documentation standards. • Audit results will be reported to the hospital□s Quality Council, Medical Executive Committee, and Governing Board. **Date of Implementation:** • Super-users have been hired and trained to support physician adoption and training. Physician CPOE training commenced June 25, 2014. • Physicians mandated to input orders via CPOE by July 15, 2014 for the Hollywood and Van Nuys campuses and by August 18, 2014 for the Culver City campus. • Previous to the CPOE mandate, the Chief of Staff issued a memo, dated June 13, 2014, to All Medical and Allied Staff Members to serve as a reminder notice that pursuant to the Medical Staff Rules and Regulations that all orders and progress notes must be signed, dated, and timed.	6/25/2014 7/15/2014 8/18/2014 6/13/2014

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A 454	Continued From page 47 1. In the DOU (Definitive Observation Unit) of the Hollywood campus on March 24, 2014, a review of the physician□s order sheet for Patient 25 disclosed one telephone order received on March 15, 2014 at 4:15 p.m. was not dated, timed, and authenticated by the ordering practitioner. Two telephone orders dated March 22, 2014 were not timed and authenticated by the ordering practitioner. A review of the physician□s order sheet for Patient 26 disclosed one telephone order dated March 21, 2014 at 12:25 p.m. was not dated, timed, and authenticated by the ordering practitioner. During the concurrent interview with Registered Nurse 9RN) 1, she stated the physicians failed to date, time and authenticated the telephone orders for Patient 25 and 26. 2. During the initial tour with Staff C and RN 3 in the Medical/Surgical Unit of the Culver City campus on March 25, 2014 between 10:55 a.m. and 11:35 a.m., a review of the physician□s order sheet for Patient 29 disclosed the telephone order received on March 19, 2014 at 8:45 a.m. and 10 p.m., March 2014 at 9:30 a.m., March 21, 2014 at 10 a.m. and March 24, 2014 at 7 a.m., were not dated, timed, and authenticated by the ordering practitioner. During the concurrent interview with Staff C, she stated the physicians failed to date, time and authenticated the telephone orders for Patient 29. 3. During the initial tour with Staff C and RN 4 in the CCU (Critical Care Unit) of the Culver City campus on March 26, 2014 between 10 a.m. and 10:30 a.m., the physician□s order sheet for Patient	A 454	(continued from page 47) • Non-compliance discussed and corrective actions addressed at medical department meetings and the Medical Executive Committee (MEC). • Medical Staff leadership will continue to monitor progress and work with Administration to improve compliance with documentation standards. Audit results will be reported to the hospital□s Quality Council, Medical Executive Committee, and Governing Board. **Monitoring Process:** • The HIM Manager and/or designee will conduct monthly audits of patient charts to review for the completion of all physician orders (timed, dated, and signed). • Numerator = Number of complete physician orders (timed, dated, and signed) / Denominator □ Number of total physician orders reviewed. • The sample size will be based on monthly discharges, per the following guidelines: o Sample all cases for a population size of fewer than 30 cases o Sample 30 cases for a population size of 30□100 cases o Sample 50 cases for a population size of 101□500 cases o Sample 70 cases for a population size of more than 500 cases • Targeted compliance is 90% • Monitoring activity will commence for a period not to exceed 4 months or until optimal compliance is achieved and sustained. • Random audits will be performed thereafter. • Audit results will be reported to the hospital□s Quality Council, Medical Executive Committee, and Governing Board. **Person Responsible**: HIM Administrator and/or designee.	

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A 454	Continued From page 48 32 was reviewed and disclosed the telephone order received on February 29, 2014 was not dated, timed, and authenticated by the ordering practitioner. During the concurrent interview with Staff C ,she stated the physicians failed to date, time and authenticated the telephone orders for Patient 32. 4. During the initial tour with Staff C and RN 6 in the Telemetry Unit of the Culver City campus on March 26, 2014 between 2:12 p.m. and 3:30 p.m., the physician□s order sheet for Patient 32 was reviewed and disclosed the telephone order for admission medications was not dated, timed, and authenticated by the ordering practitioner. During the concurrent interview with Staff C, she stated the physicians failed to date, time and authenticated the telephone orders for Patient 34. According to the Medical Staff Rules & Regulations approved by the Governing Board on December 4, 2013, page 29, number 13: ORDERS, 13.2 □All medication order shall be signed within 48 hours.□ 5.On March 27, 2014, at 2:45 p.m., in the Culver City campus, during a review of the following patient medical records with RN 16 revealed the following: a. Patient 18□s Progress Notes dated March 22 through 25, 2014, were signed, dated but not timed by the physician.	A 454		

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A 454	Continued From page 49 b. Patient 15□s physician telephone orders dated March 22-25, 2014 were not signed, dated and timed by the physician. The telephone orders were Haldol 5 mg IM, Ativan 2 mg IM every 6 hours as needed for agitation and Benadryl 50 mg During a concurrent interview, RN 16 stated there was no time, date and signature by the physician.	A 454		
A 458	482.24(c)(4)(i)(A) CONTENT OF RECORD: HISTORY & PHYSICAL All records must document the following, as appropriate: (i) Evidence of□ (A) A medical history and physical examination completed and documented no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be placed in the patient□s medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the medical history and physical examination were completed within 24 hours after admission for 4 of 52 sampled patients (Patient 12, 29, 33 and 34). This deficient practice had the potential to affect the patient□s course of treatments. Findings:	A 458	**All Three Campuses** **1-3 Corrective Actions:** • Non-compliance discussed and corrective actions addressed at the Medical Executive Committee (MEC). • The Chief of Staff issued a memo, dated June 19, 2014, to All Medical and Allied Staff Members to serve as a reminder notice that pursuant to the Medical Staff Rules and Regulations that a medical history and physical examination must be completed and documented no more than 30 days before or 24 hours after admission or registration, but prior to surgery or procedure requiring anesthesia services. The medical history and physical examination must be placed in the patient□s medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. • Medical Staff leadership will continue to monitor progress and work with Administration to improve compliance with documentation standards. • Audit results reported to the hospital□s Quality and Medical Record Committee and Medical Executive Committee. **Date of Implementation:** • Non-compliance discussed and corrective actions addressed at the Medical Executive Committee meeting on June 17, 2014.	6/17/2014

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A 458	Continued From page 50 1. During the initial tour with Staff C and Registered Nurse (RN) 3 in the Medical-Surgical Unit of the Culver City campus n March 25, 2014 between 10:55 a.m. and 11;35 a.m., the clinical record for Patient 29 was reviewed and disclosed there was no medical history and physical examination since the patient was admitted on March 18, 2014. 2. During the initial tour with Staff C and RN 4 in the SDU (Step-Down Unit) of the Culver City campus on March 26, 2014 between 11:35 a.m. and 12:20 p.m., the clinical record for Patient 12 was reviewed and disclosed the medical history and physical examination had been transcribed on March 18, 2014 but not authenticated by the physician since admission on March 13, 2014. During the concurrent interview with Staff C, she stated the physicians failed to complete the medical history and physical examination within 24-hours of admission for Patient 12. According to Staff B, the medical history and physical examination for Patient 12 should have been authenticated by the physician for completion. 3. During the initial tour with Staff C and RN 6 in the Telemetry Unit of the Culver City campus on March 26, 2014 between the time of 2:12 p.m. and 3:30 p.m., the clinical record for Patient 33 was reviewed and disclosed there was no medical history and physical examination since the patient was admitted on March 18, 2014. Additionally, the clinical record for Patient 34 was reviewed and disclosed the medical history and physical examination was transcribed on March 5, 2014, but not authenticated by the physician since the patient was admitted on March 5, 2014.	A 458	(Continued from page 50) • Chief of Staff communication dated June 19, 2014. • Monitoring of H&P□s □ongoing • Audit results reported to the hospital□s Quality and Medical Record Committee and Medical Executive Committee □ June 2014 and quarterly as required. **Monitoring Process:** • The HIM Manager and/or designee will conduct monthly audits of patient charts to review for the timely completion of history and physical examinations. • Numerator = Number of history and physical present no more than 30 days prior to admission or 24 hours after admission or registration but prior to surgery / Denominator □ Number of total charts reviewed. • The sample size will be based on monthly discharges, per the following guidelines: o Sample all cases for a population size of fewer than 30 cases o Sample 30 cases for a population size of 30□100 cases o Sample 50 cases for a population size of 101□500 cases o Sample 70 cases for a population size of more than 500 cases • Targeted compliance is 90% • Monitoring activity will commence for a period not to exceed 4 months to ensure that compliance is achieved and sustained. • Random audits will be performed thereafter. • Results of the audits will be reported to the hospital□s Quality and Medical Record Committee and Medical Executive Committee. **Person Responsible:** HIM Administrator and/or designee.	6/19/2014 6/2014

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	050135	G. BUILDING **01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD** H. WING _____	**04/01/2014**

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A 458	Continued From page 51 During the concurrent interview with Staff C, stated the medical history and physical examination for Patient 33 should have been authenticated by the physician for completion. According to the Medical Staff Rules & Regulations approved by the Governing Board on December 4, 2013, Page 32, □14.3 A complete history and physical examination, performed by a qualified physician or by another individual approved for such privilege based on demonstrated competence, within the scope of his/her license, shall be recorded on all patients within 24-hours of admission.□	A 458		
A 467	482.24(c)(2)(vi) CONTENT OF RECORD: ORDERS, NOTES, REPORTS □All records must document the following, as appropriate:□ All practitioner□s orders, nursing notes, reports of treatment, medication records, radiology and laboratory reports, and vital signs and other information necessary to monitor the patient□s condition. This STANDARD is not met as evidenced by: Based on review of electronic and paper clinical record review, staff interviews and review of hospital policies and procedures, the facility failed to ensure that the records of 6 out of 52 sampled patients and one (1) randomly selected patient reviewed contained the appropriate information to monitor the progress and condition of the patients (Patients 8, 9, 10, 11, 12 and 14). This deficient practice had the potential for the patients not able to receive appropriate care.	A 467		

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A 467	Continued From page 52 Findings: 1. Patient 11 was admitted on March 9, 2014 with diagnoses including congestive heart failure, hypertension (high blood pressure), diabetes (a condition in which a person has high blood sugar) and chronic kidney disease (a gradual loss of kidney function). The physician ordered a 1500 to 1800 calorie diet on admission. The physician also ordered a fluid restriction of less than 1500 cubic centiliters (cc) on admission. This order was no transcribed as part of the diet order and so the fluid restriction was not implemented as part of the order until three days after admission on March 12, 2014, when the registered dietitian (RD 1) noticed it as an incomplete order while conducting a nutritional assessment on Patient 11. In between the three days the fluid restriction was no implemented, Patient 11 was ordered Boost, a nutritional supplement, three times a day with meals. He received this in addition to the 2000 cc of fluid which is part of his diet, an additional 7320 cc from three boxes of Boost. Clinical record review showed that Patient 11 was refusing dialysis (treatment that does some of the things healthy kidney does) which would have alleviated the fluid his body was retaining. Laboratory values on March 26, 2014 showed that his kidneys were working well and cleaning out toxins in his body. His blood urea nitrogen was 65 (normal 7 to 20) and creatinine was 5.0 (normal 0.6 □ 1.3). The physician had ordered daily weights also as part of the admission orders but nursing staff	A 467	**CULVER CITY** **1).Corrective Actions:** All nursing staff will be re-educated on proper I & O documentation, obtaining weights and documentation of weights. Super users will notify RNs of any discrepancies. RNs will correct discrepancies. SuperUsers are qualified clinical staff with extensive competencies in electronic clinical documentation. They are available on site 24 hrs. a day/ 7 days a week. **Date of Implementation**: 6-19-2014 with full implementation in 30 days. **Monitoring Process**: Super Users will monitor and collect data on a minimum of 200 charts a month and outcomes will be reported up to the Quality Council on a monthly basis. Any level of non-compliance will be reported to the Nursing Director for immediate corrective action. **Person Responsible:** Clinical Education Coordinator/Informatics	6/19/2014

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A 467	Continued From page 53 failed to weigh the patient. As of March 26, 2014, daily weights had not been completed on Patient 11, seventeen days after the order had been placed. Monitoring the weight is one of the ways a physician could monitor how much fluid the body is retaining. This is of significance because Patient 11 suffered from both congestive heart failure and kidney failure, two conditions in which excessive fluid retention is detrimental. 2. Patient 10 was admitted with diagnoses including decubitus ulcer, sacral and bottom. There were several pictures of the different wounds Patient 10 had but there was no description. There had been orders for a wound consult by the physician however, there was no description of the wounds y the wound consultant. Documentation in the RD notes describes these wounds as Stage III, Stage IV and unstageable wounds. In an interview with Staff 13 (Wound Consultant) on March 26, 2014 via telephone, he stated that the hospital policy was by photographic documentation and the present time no other documentation was being done. Review of the hospital policy titled □Management of Skin Integrity- Care of the Patient□dated August 2010 of which the Wound Consultant was the contributor, did not support his assertions. This policy required under the section □Documentation□specific information to be included. These included location, depth, Stage, drainage, presence of necrotic or non-viable tissue among other documentation. In an interview with a charge nurse on one of the Medical-Surgical floors on March 26, 2014 at approximately 3:00 p.m., she provided a poster	A 467	(Continued from page 53) **2).Corrective Actions:** Documentation by Wound Management team is entered in Physician Progress note section of medical record. This documentation will include stage, location, depth, drainage, presence of necrotic or non-viable tissue, and other descriptors as relevant to the specific wounds and follow up notes will be done as needed. Treatment recommendations entered in CPOE are also described in progress note. **Date of Implementation:** 6/13/2014 **Monitoring Process**: Wound Management Team Member to audit wound care progress note on 30 wound records. Any issue of non-adherence will be addressed to the individual staff and referred to Quality department for further intervention as necessary including education and progressive disciplinary action**.** **Person Responsible**: Wound Care Management team	6/13/2014

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A 467	Continued From page 54 titled □Documentation of Pressure Ulcer Care□ that outlined in detail what documentation was required for pressure ulcer care. The information contradicted the information provided the Wound Consultant. The hospital failed to ensure that all information necessary to assess the care of a patient with pressure ulcer was properly documented. 3. Patient 12 was admitted with diagnosis including pneumonia (an infection in the lungs) and hypoxia (a low level of oxygen in tissues and blood). Electronic medical record review was conducted on March 26, 2014 beginning at 2 p.m. Admission diet order dated March 13, 2014 was a cardiac diet. A physician□s order dated March 24, 2012 was for tube feeding through a nasogastric tube (tube through the nose inserted in the stomach for feeding) with Diabetasource (a supplement for patients with diabetes) at a rate of 20 cc (cubic centiliter)/hour. A follow up order dated March 26, 2014 requested water via the NG tube, 150 cc (a metric unit of measure) every 6 hours. The tube feeding was ordered on March 24, 2014, at 3 p.m. An observation of the tube feeding was conducted on March 26, 2014 at 3:00 p.m. It was noted that the tube feeding pump was off. It was also noted that the feeding bad or the tubing was not dated and/or labeled; the volume in the bag at the time of hanging was 1,000 cc and there was approximately 300 cc left. It was also noted that a new bag of Diabetasource was lying on the patient□s bedside table. In a concurrent interview with the director of food services (Staff 3), she stated that the dietary department sent up tube feedings every day at lunch that included labels which were intended to be placed on the tube	A 467	(Continued from page 54) **3).Corrective Actions:** Policy VAS.005 and Policy PAT.057. Re-educate nursing staff: All Feeding bags, IV bags and all tubing must be labeled date and timed and initialed. Hands on competencies for clinical areas that have feeding pump utilization to include pump set up, settings, steps to clearing pump, documentation of amounts provided to patient. Return demonstration will be required to demonstrate competency. **Date of implementation:** 8/16/2014 full implementation **Monitoring Process:** Nursing Leadership from each department will monitor proper labeling of IV bags, Feeding bags and all tubing. Audit of feeding pump settings. Data will be collected on a 30 random patients a month and reported to the Quality Council on a monthly basis. Any level of non-compliance will be reported to the Nursing Director for immediate corrective action. **Person Responsible:** Unit Nursing Director	8/16/2014

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A 467	Continued From page 55 feeding when it was hung. In an interview with RN 17, she stated that she reset the pump at 12 p.m. (3 hours prior). She also stated that she cleared the pump at 12 p.m. and turned the pump off shortly before 3 p.m. to provide personal care and probably forgot to turn it back on. Review of medical record document titled □Daily Assessment Inquiry□dated March 24, 2014 at 8 p.m. was the first time that the tube feeding was noted; however there was no documentation in the electronic medical record when the feeding was actually hung. It was also noted that the actual amount of feeding that was being delivered was not accurately recorded and/or the documentation noted the physician□s order of 20cc/hour. For example on March 26, 2014 at 6 a.m. the amount of tube feeding delivered was recorded as 240cc. Follow up documentation dated March 26, 2014 at 12 p.m., noted an entry of 200 cc. If the feeding was running per the physician□s order, the pump should have read either 360 cc (if the pump was not cleared at the 6am entry) or 120 cc for the 12 p.m. entry rather than the documented 200 cc. In an interview on March 24, 2014 at 2:15 p.m., RN 17 was unable to explain the discrepancy. In a concurrent interview with Staff 3, she acknowledged that the feeding was not likely delivered per the physician□s order. 4. Patient 9 was admitted with diagnoses including anemia (low blood iron), insulin dependent diabetes, sacral decubitus, (open sore on the top of the upper buttocks), end stage renal disease (the kidneys are not able to work at a	A 467	(continued from page 55) **4).Corrective Actions:** (Patient □9) Documentation by Wound Management team is entered in Physician Progress note section of medical record. This documentation will include stage, location, depth, drainage, presence of necrotic or non-viable tissue, and other descriptors as relevant to the specific wounds and follow up notes will be done as needed. Treatment recommendations entered in CPOE are also described in progress note.	

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A 467	Continued From page 56 level for day □ to day life) with dialysis. Electronic record review showed on March 24, 2014 at 12:25 a.m., there was an order for Novasource Renal, (a specialized feeding for patients with kidney disease) Give 20 milliliters (ml)/hour via PEG (percutaneous endoscopic gastrostomy tube). There were additional instructions □every evening hours.□ RN 18 stated in an interview at approximately 5:45 p.m. on March 24, 2014, on the definition of □evening hours□was 7 p.m. to 7 a.m. The hospital staff was not able to provide evidence as to the definition of evening hours. Inspection of the tube feeding at approximately 5:50 p.m. showed a feeding bag hung in the patient□s room with approximately 150 ml of a light brown colored liquid left in the bag. The tube feeding bag had a blue colored cap which indicated that the tube feeding was poured into the bag. The bag was dated □March 24, 2014□, it was not timed. It could not be determined how long the bag had been hung and how much Patient 9 had received. Review of electronic record flow sheets for March 23, 2014 at 6:30 a.m. showed 120 cc was given to the patient. There was additional documentation for 0700 shift, 120 cc was entered as total. Based on the time the order was written on March 23, 2014 and the definition of evening hours by the RN, Patient 9 should have received a total of between 120 and 140 cc on March 23, 2014 by 6:30 a.m. and no feeding for the 0700 shift. Nursing staff failed to accurately document what care it had provided.	A 467	(Continued from page 56) **Date of Implementation:** 6/13/2014 **Monitoring Process:** Wound Management Team Member to audit wound care progress note on 30 wound records. Any issue of non-adherence will be addressed to the individual staff and referred to Quality department for further intervention as necessary including education and progressive disciplinary action. **Person Responsible:** Wound Care Management team	6/13/2014

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A 467	Continued From page 57 There was no description for the wound on Patient 9. There were pictures but no other information on size, staging, depth and other pertinent information that would be valuable to other professionals providing care to this Patient. According to the hospital policy titled, □Management of Skin Integrity □ Care of the Patient□dated August 2010 □skin integrity, assessment and treatment is an interdisciplinary responsibility.□The physician, registered nurse, physical therapist, food and nutrition, case managers and home health staff were listed as responsible for the care of the patient with pressure ulcer. The lack of adequate documentation would prevent these other professionals from providing adequate care for the patient. 5. Patient 8 was admitted with diagnoses including diabetes mellitus, hypertension (high blood pressure) and asthma. Review of admitting orders revealed that there was no order for his diet. Electronic record review on March 27, 2014 revealed that an order was entered for a No Added Salt later than evening by one of the nurses. RN 20 stated that she received an order but was not sure if the verbal order had been faxed to the physician for authentication as it is customary to do with medical orders. There was no documented evidence that the nurse had called the physician to receive a diet order. Comments made by other unidentified nurses on the unit revealed that they use information on diet orders from previous admission to determine diet orders when physicians do not add diet orders. There was no telephone order authentication by the admitting physician either in the electronic	A 467	(Continued from page 57) **5).Corrective Actions**: All nursing staff re-educated with self-study module to validate that physician orders have been noted, examined, and verified. Caregivers must use SBAR and provide the opportunity to use read-back techniques and medications orders received must be read back by the receiver. 24 hour order/chart check policy & procedure PAT.059 implemented that mandates documentation of chart review before 7am each day. **Date of Implementation:** 5/18/2014 **Monitoring Process**: Random audit of 30 charts will be done per nursing unit. **Person Responsible:** Nursing Leadership	5/18/2014

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A 467	Continued From page 58 paper record. According to the Hospital policy titled □telephone and verbal orders□dated July 2004, states □Telephone orders are to be written and read back too physicians to clarify.□ 6. Review of the hospital Diet report for March 26, 2014, showed height and weight information on several patients (sampled and randomly selected) that were inaccurate and unrealistic. For example, Patient 10□s weight was entered as 2615 pounds, Patient 9□s height was documented as 66 centimeters (cm) or 2 feet 2 inches. A randomly selected patient□s height was similarly entered as 67 cm or 2 feet 6 inches. All of these patients were adults with no history of amputation. Information on height and weight is valuable to examine response to therapy and administration of medication. The facility failed to ensure that documented information was accurate. 7. On March 27, 2014, at 9 a.m., Patient 14□s medical record was reviewed. The verbal physician order dated March 7, 2014, indicated to transfuse one unit of packed red blood cells. The consent form dated March 7, 2014, indicated the patient had signed the consent. On the same day, the patient received the blood transfusion. Further review of the transfusion record failed to indicate documentation that the section on the suspected transfusion reaction was checked. During a concurrent interview RN 12 stated the section on suspected transfusion reaction of the	A 467	(Continued from page 58) **6).Corrective Actions:** Re-education of all nursing staff on timely and accurate collection and documentation of patient height and weights in accordance to hospital policies and physician orders. Evaluation performed regarding ability to implement critical value settings in electronic medical record for Heights and Weights. This feature is currently NOT available but this will be reviewed during system upgrades. **Date of Implementation:** 6/20/2014 with completion over next 30 days. **Monitoring Process:** Data will be collected on a 30 random patients a month and reported to the Quality Council on a monthly basis. Any level of non-compliance will be reported to the Nursing Director for immediate corrective action. **Person Responsible**: Nursing Leadership **7). Corrective Actions:** The blood bank section implemented a new process in which all blood transfusion form are to be returned to Blood bank within 4 hours of completion of transfusion. The forms are to be delivered and brought down to the Blood bank department by the charge nurse for the patient that had been transfused. This is to be presented to the CLS on duty in Blood bank and is to be inspected on the spot by both lab and nursing. **Date of Implementation:** 5/16/2014 **Monitoring Process:** Weekly **Person Responsible:** Lab supervisor; Lab Director	6/20/2014 5/16/2014

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A 467	Continued From page 59 transfusion record should have been filled out.	A 467		
A 468	482.24(c)(2)(vii) CONTENT OF RECORD: DISCHARGE SUMMARY □All records must document the following, as appropriate:□ Discharge summary with outcome of hospitalization, disposition of care and provisions for follow-up care. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the discharge summary with outcome of hospitalization, disposition of case, and provision for follow-up care, was completed for 1 of 52 sampled patients (Patient 43). This deficient practice had the potential for not assuring proper continuity of care. Findings: A review of the closed record on March 27, 2014 with Staff B indicate Patient 43 was admitted to the facility on November 19, 2013, and discharged on December 3, 203. A review of the closed record revealed there was no documentation the discharge summary with outcome of hospitalization, disposition of the case, and provision for follow-up care was completed by the physician as of March 28, 2014. During the interview with Staff B on March 28, 2014 at 9:15 a.m., she stated the discharge summary with outcome of hospitalization, disposition of the case, and provision for follow-up care, had not been complete by the	A 468	**All Three Campuses** **1-3 Corrective Actions:** • Non-compliance discussed and corrective actions addressed at the Medical Executive Committee (MEC). • The Chief of Staff issued a memo, dated June 19, 2014, to All Medical and Allied Staff Members to serve as a reminder notice that pursuant to the Medical Staff Rules and Regulations that a Discharge Summary with outcome of hospitalization, disposition or care and provisions for follow-up care shall be provided by the responsible practitioner and completed within fourteen (14) days after the patient□s discharge. The memo further stated that Medical Staff will be uncompromising in enforcing suspension that result from incomplete and/or delinquent medical records • Medical Staff leadership will continue to monitor progress and work with Administration to improve compliance with documentation standards. • Audit results reported to the hospital□s Quality and Medical Record Committee and Medical Executive Committee. **Date of Implementation:** • Non-compliance discussed and corrective actions addressed at the Medical Executive Committee meeting on June 17, 2014. • Chief of Staff communication dated June 19, 2014. • Monitoring of completion of Discharge Summaries □ ongoing • Audit results reported to the hospital□s Quality and Medical Record Committee and Medical Executive Committee □ June 2014 and quarterly as required. **Monitoring Process:** • The HIM Manager and/or designee will conduct monthly audits of patient charts to review for the timely completion of Discharge Summaries. • Numerator = Number of discharge summaries completed within 14 days / Denominator □ Total number of discharged charts reviewed. • The sample size will be based on monthly discharges, per the following guidelines: o Sample all cases for a population size of fewer than 30 cases	6/17/2014 6/19/2014 6/2014

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(□4) ID PREFI□ TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFI□ TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(□5) COMPLETION DATE
A 468	Continued From page 60 physician. According to the Medical Staff Rules & Regulations approved by the Governing Board on December 4, 2013, page 34, 14.18 Completion of the Record, 14.18.1 □In accordance with regulatory standards, medical records shall be completed within two (2) weeks following the patient□s discharge.---□	A 468	(Continued from page 60) o Sample 30 cases for a population size of 30□100 cases o Sample 50 cases for a population size of 101□500 cases o Sample 70 cases for a population size of more than 500 cases • Targeted compliance is 90% • Monitoring activity will commence for a period not to exceed 4 months to ensure that compliance is achieved and sustained. • Random audits will be performed thereafter. • Results of the audits will be reported to the hospital□s Quality and Medical Record Committee and Medical Executive Committee. **Person Responsible:** HIM Administrator and/or designee	
A 490	482.25 PHARMACEUTICAL SERVICES The hospital must have pharmaceutical services that meet the needs of the patients. The institution must have a pharmacy directed by a registered pharmacist or a drug storage area under competent supervision. The medical staff is responsible for developing policies and procedures that minimize drug errors. This function may be delegated to the hospital□s organized pharmaceutical service. This CONDITION is not met as evidenced by: Based on observations, interviews, and records review, the facility failed to ensure and provide services that meet the needs of its patients. The facility failed to meet Condition of Participation for Pharmaceutical Services by failing: 1. Properly label the drawers of the CCU and ICU crash carts. (Hollywood campus) (Refer to A 0500). 2. Properly label three tubes of external ointment found in an open tray of the crash carts (Hollywood campus) (Refer to A 0500). 3. Ensure the ICU Crash Cart Contents Log was readily available. (Hollywood campus) (Refer to A	A 490	**HOLLYWOOD** **1). Corrective Actions:** Standardize all crash carts to include appropriate labels on each drawer with corresponding items and to include list of medications on the drawer. **Date of Implementation:** Will be completed in 30 days, expected date July 17, 2014 **Monitoring Process:** Monitoring will be managed by daily crash cart checks, monthly review by pharmacy and as needed during crash cart exchange **Person Responsible**: Pharmacy and Nursing Leadership in each department **2). Corrective Actions:** Standardize all crash carts, place lubricating jelly inside the drawer with the appropriate labels on each drawer and with all corresponding items. April 21-23, 2014 Education provided included review of policy PHA.052 Preparing and Administration of Medications; any unlabeled medication must not be used. Pharmacy will label all medications. **Date of Implementation:** Target date of completion in 30 days July 17, 2014. **Monitoring Process:** Monitoring will be managed by daily crash cart checks, monthly review by pharmacy and as needed during crash cart exchange. **Person Responsible:** Pharmacy and Nursing Leadership in each department. **3). Corrective Actions:** Standardize all crash carts to include appropriate labels on each drawer with corresponding items and to include list of medications on the drawer. April 21-23, 2014 education provided included review of policy PAT.058 Crash cart and crash cart checks to include presence of crash cart logs on corresponding cart **Date of Implementation:** Target date of completion will be in 30 days July 17, 2014 **Monitoring Process:** Monitoring will be managed by daily crash cart checks, monthly review by pharmacy and as needed during crash cart exchange **Person Responsible:** Pharmacy Department and Nursing Leadership in each department	7/17/2014 7/17/2014 4/21/2014 7/17/2014

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	050135	I. BUILDING **01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD** J. WING _____	**04/01/2014**

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A 490	Continued From page 61 0500). 4. Ensure all components of a specialized emergency supply for the treatment of malignant hyperthermia are immediately accessible. (Culver City campus) (Refer to A 0500). 5. Ensure its patient would not receive medication or supplement that was not prescribed by the physician (Culver City) (Refer to A 0500). 6. Implement its policy and procedures for the use of a single-dose single-use ampule/vial (Culver City campus) (Refer to A 0500). 7. Ensure all medication orders in the Emergency Department be reviewed or verified by a pharmacist for therapeutic appropriateness prior to administration or at least retrospectively in cases of life-threatening emergency (Culver City campus) (Refer to A 0500). 8. Implement its policy and procedure on the safeguard of lock codes to a medication room (Hollywood campus) (Refer to A 0502). 9. Ensure drug storage areas are accessible only to authorized facility staff (Hollywood campus) (Refer to A 0502). 10. Ensure outdated medication in the refrigerator was not available for patient use (Van Nuy campus) (Refer to A 0505). The cumulative effect of these systemic issues resulted in the facility□s inability ensure and provide a safe patient care environment.	A 490	(Continued from page 61) **CULVER CITY** **4.) Corrective Actions:** Ensure all components of a specialized emergency supply for the treatment of malignant hyperthermia are immediately accessible. Malignant hyperthermia kit contents will be added to the monthly Pharmacist Unit Inspection. The malignant hyperthermia items that are refrigerated will be packaged in a kit labeled □Malignant Hyperthermia□and stored in the appropriate refrigerator. **Date of Implementation**: Completed 6/17/14 **Monitoring Process:** Malignant hyperthermia kit will be checked during monthly unit inspections per P&Ps **Person Responsible:** VP of Pharmacy or designee **5).Corrective Actions**: All nursing staff re-educated to validate that physician orders have been noted, examined, and verified. Caregivers must use SBAR and provide the opportunity to use read-back techniques and medications orders received must be read back by the receiver. **Date of Implementation:** 5/18/2014 **Monitoring Process:** Random audit of 30 charts will be done per nursing unit aggregated data will be sent to the Quality Dept, non-compliance will result in progressive discipline actions. **Person Responsible**: Nursing Leadership **6).Corrective Actions:** Implement its policy and procedure □Medication: Care & Handling□SAN.019 for use of single dose vials. Policy revised to be clear on the use of single dose vials. Policy will be sent to medical staff. **Date of Implementation:** July 1st 2014 **Monitoring Process:** DOP or designee will review anesthesia cart sheets, and will check that the SDVs are being used one time only. Any violations will be reported the Quality Counsel. **Person Responsible:** VP of Pharmacy or designee **7).Corrective Actions:** Ensure all medication orders in the Emergency Department be reviewed or verified by the pharmacist for therapeutic appropriateness prior to administration or at least retrospectively in case of life threatening emergency. All ED medication orders will be reviewed by a pharmacist prior to administration, with the exception of emergency medications, in which the orders will be reviewed retrospectively. Emergency medications will be defined as those that are time critical according to hospital P&Ps. These include antibiotics, IV seizure medications, pain medications and other emergency stat medications. Drugs not deemed as non-emergency medication will not be overridable in the automated drug dispensing machine. (ADM) **Date of Implementation:** July 1st 2014 **Monitoring Process:** DOP or designee will review the overridden medications retrospectively for appropriateness. Results will be reported to Quality Counsel. **Person Responsible**: VP of Pharmacy or designee **HOLLYWOOD** **8-9). Corrective Actions**: Inspected all medication rooms to ensure no codes are written on walls, doors and no signs posted indicating the code number for entry. 3rd floor medication room door entry re-painted and signs removed. Plans to change medication room access with ID badge reader to ensure only authorized personnel will have access to med room. Education provided to include review of policy, medication room access by authorized personnel and room to remain closed at all times **Date of Implementation:** April 21- 23, 2014 **Monitoring Process:** Monitoring will be managed through daily nursing rounds and to include in EOC rounds **Person Responsible:** Nursing Leadership in each department, EOC members, ENG, HR, pharmacy **VAN NUYS** **10).Corrective Actions:** Ensure outdated medication in the refrigerator was not available for patient use. All multiple dose vials will be checked in the Pharmacist Monthly Unit Inspection. At the end of the month all MDVs will be replaced. **Date of Implementation:** 7/1/2014 **Monitoring Process:** MDVs will be checked upon Pharmacist Monthly unit inspection. Any discrepancies will be reported to Quality Counsel. **Person Responsible:** VP of Pharmacy or designee	6/17/2014 5/18/2014 7/1/2014 7/1/2014 4/21/2014 7/1/2014
A 500	482.25(b) DELIVERY OF DRUGS	A 500		

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A 500	Continued From page 62 In order to provide patient safety, drugs and biologicals must be controlled and distributed in accordance with applicable standards of practice, consistent with Federal and State law. This STANDARD is not met as evidenced by: Based on observations, interviews and records review, the facility failed to: 1. Properly label the drawers of the CCU and ICU crash carts (Hollywood campus). This deficient practice had the potential for not easily accessing emergency drugs and equipment that are used to treat a person□s medical emergency. 2. Properly label three tubes of external ointment found in an open tray of the crash carts (Hollywood campus). This deficient practice had the potential for the staff to use unlabeled ointments to the patients. 3. Ensure the ICU Crash Cart Contents Log was readily available (Hollywood campus). This deficient practice had the potential for administering the cleaner and supplies for the treatment of Patient 24□s wound which may not be inaccordance with the physician□s order. 4. Ensure all components of a specialized emergency supply for the treatment of Malignant Hyperthermia are immediately accessible (Culver City campus). This deficient practice could result in not providing appropriate interventions for managing the patient with malignant hyperthermia, a deadly adverse outcome. 5. Ensure its patient would not receive medication or supplement that was not prescribed by the	A 500	**Hollywood** **1). Corrective Actions:** Standardize all crash carts, to ensure appropriate label outside the drawers with corresponding items listed **Date of Implementation:** Target date of completion in 30 days July 17, 2014 **Monitoring Process:** Monitoring will be managed through daily crash cart checks, monthly review by pharmacy and as needed during crash cart exchange **Person Responsible:** Pharmacy and Nursing Leadership in each department **2). Corrective Actions:** Standardize all crash carts, place lubricating jelly inside and all meds and all corresponding items in the drawer with the appropriate label outside the drawer. April 21-23, 2014 education provided included review of policy PHA.052 Preparing and Administration of Medications; any unlabeled medication must not be used and discarded. Pharmacy will label all medications **(see Addendum 30, 30a).** **Date of Implementation:** Label of meds implemented immediately by pharmacy, Target date of completion for crash cart standardization in 30 days July 17, 2014 Monitoring Process: Monitoring will be managed through daily crash cart checks, monthly review by pharmacy and as needed during crash cart exchange **Person Responsible:** Pharmacy and Nursing Leadership in each department **3). Corrective Actions:** Standardize all crash carts to include appropriate labels on each drawer with corresponding items and to include list of medications April 21-23, 2014 education provided included review of policy PAT.058 Crash cart and crash cart checks to include presence of crash cart logs on corresponding cart **(see Addendum 30, 30a).** **Date of Implementation:** Target date of completion will be in 30 days July 17, 2014 **Monitoring Process:** Monitoring will be managed through daily crash cart checks, monthly review by pharmacy and as needed during crash cart exchange	7/17/2014 7/17/2014 7/17/2014

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A 500	Continued From page 63 physician (Culver City campus). This deficient practice resulted in the patient receiving 2 doses of □inc Sulfate (dietary supplement) that not ordered by the physician and did not promote safety in the patient□s medication therapy. 6. Follow its policy and procedures for the use of a single-dose single-use ampule/vial (Culver City campus). 7. Ensure all medication orders in the Emergency Department be reviewed or verified by a pharmacist for therapeutic appropriateness prior to administration or at least retrospectively in cases of life-threatening emergency. This deficient practice had the potential to result in adverse drug events. Findings: 1. On March 27, 2014 at 12:53 p.m. on the third floor, the contents of drawers 2, 3, 4 and 6 of the CCU Crash Cart did not match the label affixed to the exterior of each drawer. A review of the facility□s policy and procedure, titled □Crash Cart,□Number: PAT.058, dated 11/2012, indicated □□ the pharmacist shall check the drug and IV contents □ and apply a label to the outside of the cart □ A list of the crash cart medications □ shall be kept on the outside of the cart □ □ 2. On March 27, 2014 at 12:59 p.m., on the third floor, the surveyor observed and identified two used, unlabeled 4-ounce tubes of lubricating jelly in the external open side tray of the CCU Crash Cart; one used, unlabeled 4-ounce tube of	A 500	(Continued from page 63) **Person Responsible:** Pharmacy and Nursing Leadership in each department **Culver City** **4) Corrective Actions:** Ensure all components of a specialized emergency supply for the treatment of malignant hyperthermia are immediately accessible. Malignant hyperthermia kit contents will be added to the monthly Pharmacist Unit Inspection. The malignant hyperthermia items that are refrigerated will be packaged in a kit labeled □Malignant Hyperthermia□ and stored in the appropriate refrigerator. (P&P attached). In addition, Policy SAN.018 has been revised to include the Malignant Hyperthermia cart monthly check will include checking the refrigerated medications for Malignant Hyperthermia**. (see Addendums 31, 31a, 31b)** A designated area in the OR refrigerator has been labeled □IV Normal saline for malignant hyperthermia. **Date of Implementation:** Completed 6/17/14, July 14, 2014 Revised Policy to be submitted to the Surgery and Anesthesia Committee Meeting for approval process. **Monitoring Process:** The Director of Perioperative Services and/or designee will conduct monthly monitoring activity to include the verification of the refrigerated IV Normal Saline as a part of the routine check of the Malignant Hyperthermia cart. Compliance data will be reported to the Medication Safety Committee and the Quality Council on a quarterly basis until optimal compliance is achieved. In addition, malignant hyperthermia kit will be checked during monthly unit inspections per P&Ps **(see Addendum 31, 31a)** **Person Responsible:** Director Perioperative Services, Director of Pharmacy **5).Corrective Actions:** All nursing staff re-educated to validate that physician orders have been noted, examined, and verified. Caregivers must use SBAR and provide the opportunity to use read-back techniques and medications orders received must be read back by the receiver **Date of Implementation:** 5/18/2014	7/14/2014 5/18/2014

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A 500	Continued From page 64 lubricating jelly in the external open side tray of the ICU Crash Cart. A review of the facility□s policy and procedure, titled, □Preparing and Administration of Medication□, Number; PHA.052, dated □02/2012□, indicated □□ An unlabeled medication must never be used □ □ 3. On March 27, 2014 at 12:59 p.m., on the third floor, Nurse 1 failed to located the ICU Crash Cart Contents Log that would disclose the contents of the crash cart. A review of the facility□s policy and procedure, titled □Crash Cart,□Number: PAT.058, dated 11/2012, indicated □□ A list of the crash cart medications□ shall be kept on the outside of the cart□ □ 4. Malignant hyperthermia (MH) is a rare but potentially lethal adverse effect of a commonly used general anesthetic gases and succinylcholine; succinylcholine is a muscle relaxant used by physicians during emergency procedure to insert artificial airways □intubation□ into patients with extreme difficulty in breathing. A defined list of supply has been published by the Malignant Hyperthermia Association of the United States (MHAUS) and the Association of Peri-Operative Registered Nurses (AORN), two nationally recognized organizations that set standards of care for this rare but deadly adverse medical outcome. On March 25, 2014, at 11 a.m., in the surgery department, both the director of peri-operative services (Staff J) and the chief nursing officer (Staff F) confirmed that there was no iced saline	A 500	(Continued from page 64) **Monitoring Process:** Random audit of 30 charts will be done per nursing unit **Person Responsible:** Nursing Leadership **6).Corrective Actions**: Implement its policy and procedure for use of single dose vials. Policy revised to be clear on the use of single dose vials. Policy will be sent to medical staff. **Date of Implementation:** July 1st 2014, Policy revised 5/5/2014, Revised Policy will be submitted through committee approval process. **Monitoring Process:** DOP or designee will review anesthesia cart sheets, and will check that the SDVs are being used one time only. Any violations will be reported the Quality Counsel. Anesthesiologists will be re-educated on the appropriate use of single use/dose vials. The hospital□s Anesthesia policy Medication, Care and Handling Number: SAN.019 policy will be revised to include the following statement: Medications labeled as □single dose□or □single use□is meant for use in a single patient for a single case/procedure/injection; because they typically lack antimicrobial preservative **(see Addendum 32).** **Person Responsible:** VP of Pharmacy or designee, Director Perioperative Services, Director of Anesthesia, and Director of Infection Prevention **7).Corrective Actions:** All ED medication orders will be reviewed by a pharmacist prior to administration, with the exception of emergency medications, in which the orders will be reviewed retrospectively. Emergency medications will be defined as those that are time critical according to hospital P&Ps. These include antibiotics, IV seizure medications, pain medications and other emergency stat medications. Drugs not deemed as non-emergency medication will not be overridable in the automated drug dispensing machine. **Date of Implementation:** July 1st 2014 **Monitoring Process:** DOP or designee will review the overridden medications retrospectively for appropriateness. Results will be reported to Quality Counsel.	7/1/2014 7/1/2014

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A 500	Continued From page 65 available as part of the emergency supply for the treatment of Malignant Hyperthermia. On March 25, 2014 at 2:45 p.m. in the Emergency Room, during an interview, the director of the emergency room and one emergency staff (Staff N) indicated that they did not have the required iced saline (sodium chloride 0.9%) bags for the Malignant Hyperthermia kit. On March 25, 2014 at 2:50 p.m. in the emergency room, the clinical pharmacist (Rx 4) stated that the saline for the Malignant Hyperthermia cart would be provided by the central supply. According to the facility policy, titled □Malignant Hyperthermia Cart,□Number: PHA.090; dated □10/2012,□the MH kit should include □Sodium Chloride 0.9% 2 liters (refrigerator).□The same policy also delineated the treatment regimen include initiate cooling with IV (intravenously administered) iced saline solution at a rate of 1000 ml (milliliter) per 10 min (minute) for 30 minutes, which indicates at least three bags of iced saline should be available. According to the facility policy, titled □Malignant Hyperthermia,□Number: SAN.018, dated □11/2012,□ the facility should have iced IV saline immediately available. Both policies listed MHAUS as reference. 5. On March 26, 2014 at 9:30 a.m. in the Telemetry Unit, a surveyor observed a medication pass for one patient, Patient 7. The surveyor observed that the Patient 7 received one tablet of the dietary supplement □inc Sulfate 220 mg but could not locate the physician□s order in the	A 500	(Continued from page 65) **Person Responsible:** VP of Pharmacy or designee	

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A 500	Continued From page 66 patient□s chart. On March 25, 2014 at 10:45 a.m., Rx 3 confirmed he did not find the □inc Sulfate order in the Patient 7□s chart. On March 26, 2014 at 11 a.m., Rx 1 could not find the □inc Sulfate order in the Patient 7□s chart. A review of the Nutrition Recommendation Form for Patient 7 dated March 25, 2014 at 8:16 a.m. indicated a handwritten check mark in the check box for □Vitamins and Minerals□and another handwritten check mark in the check box for □Multivitamin mineral 1 tablet PO (orally) daily.□However, there was no marking by the check box for □□inc Sulfate 220 mg.□ A review of the fax copy of the □Nutrition Recommendation Form□dated March 24, 2014 at 1:05 p.m., indicated the pharmacy received the order on March 25, 2014 at 8:16 a.m. when the pharmacy received the order. A review of the electronic Medication Administration Record (eMAR) for March 25, 2014, the day before, indicated that Patient 7 received one □inc Sulfate 220 mg tablet on March 25, 2014 at 9 a.m. As of the medication pass observed on March 26, 2014 at 9:30 a.m., a total of two doses of □inc Sulfate 220 mg tablets were given to Patient 7. On March 26, 2014 at 11:23 a.m., an interview with (Pharmacist 1) indicated that a staff pharmacist misread the Nutrition Recommendation form as that □inc Sulfate being included because of the long handwritten check	A 500		

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A 500	Continued From page 67 mark for the multivitamin with mineral, which was located directly above it on the pre-printed Nutrition Recommendation Form. At 1:42 p.m., Pharmacist 1 stated that there was no policy and procedure for the chart check process performed by the nursing staff that would verify eMAR with actual physician orders. At 1:49 p.m. during an interview, RN 10 described the process for the 12 hour chart check performed at shift change. The nruses performing the chart check would receive a report from a □supervising nurse,□they would then confirm physician orders the chart with eMAR and would verify in computer program. She stated □This is a routine protocol.□She also described the 12 hour nursing shifts as 7 a.m. to 7 p.m. and 7 p.m. to 7 a.m. On March 28, 2014 at 11:53 a.m., during a follow-up interview, RN 10 stated that the nurses responsible for their patients should have caught the medication entry error during the chart check process. A review of the policy and procedure titled, □Drug Distribution and Control□, Number: PHA.025 dated □10/2012□, indicated □□ The Pharmacy department shall distribute medication and control the use of medication as follow: □ Review all medications orders for appropriateness and safety with respect to the current medication profile □ □ A review of the policy and procedure titled, □Hand Off Communications,□Number: PAT.043, dated □11/2012□, indicated □□ A □hand off□ communication is an interactive process of	A 500		

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A 500	Continued From page 68 passing patient-specific information from one caregivers to another or from one team of caregivers to another for the purpose of ensuring the continuity and safety of the patient□s care□ This provides the caregivers an opportunity to verify information by using read-back techniques. Critical test results and medication orders received shall be read back by the receiver. The occurrence of the read back shall be documented in the medical record.□ 6. On March 24, 2014 at 11:29 a.m., a review of the Anesthesia Controlled Drug Record, dated □March 18, 19, 19 and 21, 2014□indicated that a Fentanyl 250 mg per 5 milliliter (ml) ampule was used for two different patients, that half of the content was used for Patient 3, marked as □0.5□and half the content was used for Patient 2, marked as □0.5.□The inventory count indicated the beginning count of 10 ampules and the ending balance of 9 ampules. The Anesthesia Record dated March 19, 2014 for Patient 3 showed that the Anesthesiologist administered Fentanyl 100 micrograms (mcg) at approximately 10:15 a.m. and 25 mcg at approximately 11:15 a.m., total 125 mcg. The Anesthesia Record dated March 19, 2014 for Patient 2 showed that the same Anesthesiologist administered Fentanyl 50 mcg at approximately 11:45 a.m. and 75 mcg at approximately 12:15 p.m., total 125 mcg. The manufacturer□s package insert indicated □Fentanyl Citrate Injection□ is preservative-free and available as □ 5 ml Single Dose ampules.	A 500		

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A 500	Continued From page 69 On March 25, 2014, at 11:36 a.m., the DOP confirmed those fentanyl ampules are single-use and should not be shared between patients. On March 28, 2014 at 11:20 a.m., during an interview, when the surveyor showed the Anesthesia Controlled Drug Record and the use of the single dose ampule on two different patients to the Director of Infection Prevention and Control, she responded □What does this have to do with me□□ On March 28, 2014 at 11:25 a.m. during an interview, the facility contracted Hospital Epidemiologist (Staff P) stated the single use ampule is not to be used for more than one patient. On March 28, 2014 at 12:45 p.m., a review of the facility policy and procedure titled □Medication, Care and Handling,□Number: SAN.019, dated □11/2012□, indicated □□ Each patient is medicated with either single dose or multiple dose vials. The remainder of each of the multi-dose vial is discarded after each patient.□When the surveyor asked Rx 1 (Pharmacist 1) to clarify this policy, she stated the policy should read □The remainder of each of the single dose vial is discarded after each patient.□ A review of the policy and procedure titled □Handling of Multidose/Single Dose Vials and IV Compounding (Low Risk Condition) Outside Laminar Flow Hood□, Number: PHA.090, dated □10/2012□indicated □□ Single Dose vials/ampoules should be discarded soon after opening and not stored□ Opened single dose ampoules hsall not be stored for any time period	A 500		

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A 500	Continued From page 70 □ □ 7. On March 25, 2014, at 10:15 a.m., during an discussion of the medication process, Rx 3 (Pharmacist 3) stated the pharmacy department does not review or reconcile medication removal report from the automated dispensing cabinet (ADC) located in the emergency department. At 3:15 p.m., Rx 3 also stated the pharmacy department does not regularly review the medication orders prescribed in the emergency room for therapeutic appropriateness. The department received an unknown percentage of those orders but not all. The pharmacy would receive orders for medications that were not stocked in the ADC located in the emergency room. On March 26, 2014, at 9:30 p.m., during another discussion, Rx 3 stated the current computer system does not have the capability to tally or report the physician orders prescribed in the emergency room. Rx 3 could not find out how many prescriptions had been sent to the pharmacy for verification. According to a nationally recognized professional association, American Society of Health-System Pharmacists (ASHP, which published numerous authoritative guidelines in pharmacy practice referred by the industry as the standard of practices), the guideline titled □Minimum Standard for Pharmacies in Hospitals□, dated 4/13/2012, indicated □All medication orders shall be prospectively reviewed by a pharmacist and assessed in relation to pertinent patient and clinical information before the first dose is administered or made available in an automated	A 500		

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A 500	Continued From page 71 dispensing device, except in emergent situation.. There shall be a procedure for retrospective review of these orders.□The guideline further suggested □use of □ADC□shall be structured so as to not hinder the pharmacist□s review of (and opportunity to intervene in) medication orders before the administration of first doses □ □ According to the facility policy, titled □Drug Distribution and Control,□Number: PHA.025, dated □10/2012□, □.The pharmacy department shall□ review all medications orders for appropriateness and safety with respect to the current medication profile.	A 500		
A 502	482.25(b)(2)(i) SECURE STORAGE All drugs and biologicals must be kept in a secure area, and locked when appropriate. This STANDARD is not met as evidenced by: Based on observations, interviews and documents review, the facility failed to: 1. Implement its policy and procedure on the safeguard of lock codes to a medication room (Hollywood campus). 2. Ensure drug storage areas are accessible only to authorized facility staff (Hollywood campus). These deficient practices had the potential for unauthorized persons access to drugs and intravenous solution in the facility□s medication room and drug storage room. Findings: 1. On March 27, 2014 at 1:05 p.m. on the third floor, the surveyors observed the Head nurse of the ICU punching in the lock code for the	A 502	**Hollywood** **1).Corrective Actions:** Inspected all medication rooms to ensure no codes are written on walls, doors and no signs posted indicating the code number for entry. 3rd floor medication room door entry re-painted and signs removed. Plans to change medication room access with ID badge reader to ensure only authorized personnel will have access to med room. Education provided April 21- 23, 2014 to include review of policy, medication room access by authorized personnel and room to remain closed at all times **(see Addendum 33, 33a)** **Date of Implementation**: March 27, 2014, full implementation of badge reader will be in 30 days July 17, 2014 **Monitoring Process**: Monitoring will be managed through daily nursing rounds and to include in EOC rounds **Person Responsible:** Nursing Leadership in each department, EOC members, ENG, HR, pharmacy **2).Corrective Actions:** Inspected all medication rooms to ensure no codes are written on walls, doors and no signs posted indicating the code number for entry. 3rd floor medication room door entry re-painted and signs removed.	3/27/2014

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A 502	Continued From page 72 medication room and simultaneously noticed the four-digit security code was handwritten on a sheet of paper taped to the exterior of the medication room door. Adjacent to this sheet of paper was a sign taped to the inside of the glass window of the secure medication room door that stated □Keep Doors Closed & Do Not Write the Lock Codes on Walls or Doors or This Sign.□The four numbers handwritten on the paper was the lock code. She then removed the sign and discarded it. 2. On March 27, 2014 at 1:55 p.m., on the sixth floor, the surveyor observed the double-door to the Purchasing/Central Supply Room was left wide open with a doorstop. For eight minutes, from 1:55 p.m. to 2:03 p.m., the pharmacy surveyors and Rx 1 (Pharmacist 1) visited the pharmacy across the hallway. Upon leaving the pharmacy at 2:03 p.m., the surveyor observed that the Purchasing/Central Supply Room door was still open. The surveyors and the VPPO entered the Purchasing/Central Supply Room and called out to see if anyone was present, but no one answered. The Purchasing/Central Supply Room was left unattended for approximately eight minutes if not longer. Rx 1 identified cases of I.V. bags (D51/2NS), syringes, and the drug lidocaine in the crash cart kits. A few minutes later, Staff Q walked in and stated he had gone for three to four minutes.□ On March 27, 2014 at 2:36 p.m., on the third floor, Rx 1 identified that the door of the secure medication room with a self-closing door mechanism did not completely close.	A 502	(Continued from page 72) Plans to change medication room access with ID badge reader to ensure only authorized personnel will have access to med room. Education provided April 21- 23, 2014 to include review of policy, medication room access by authorized personnel and room to remain closed at all times **(see Addendum 33, 33a).** **Date of Implementation:** March 27, 2014, full implementation of badge reader will be in 30 days July 17, 2014. **Monitoring Process:** Monitoring will be managed through daily nursing rounds and to include in EOC rounds. **Person Responsible:** Nursing Leadership in each department, EOC members, ENG, HR, pharmacy	3/27/2014

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A 502	Continued From page 73 On March 27, 2014 at 2:36 p.m., two surveyors noted that the access door from the nursing station leading to the secure medication room was not locked while another access door from the hallway was locked with a security code lock. On March 27, 2014 at 3:12 p.m., Rx 1 confirmed that the facility could not produce a policy and procedure for the security of the Purchasing/Central Supply Room. On March 27, 2014 at 3:37 p.m., on the third floor, the secure medication room door was ajar and not securely closed. The surveyor made three attempts within one minute but the door failed to close. Rx 1 also made three more attempts in the next minute and the door failed to close. According to the facility policy, titled □Security of Medications Outside the Main Pharmacy□, Number PHA.084, dated □10/2012□, □□ All drug storage areas are lockable. All drug storage areas are locked when not in use□ □	A 502		
A 505	482.25(b)(3 UNUSABLE DRUGS NOT USED Outdated, mislabeled or otherwise unusable drugs and biologicals must not be available for patient use. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure an outdated medication, such as Tuberculin purified protein derivative, PPD (skin test to determine if a person had been exposed to tuberculosis, a contagious lung infection) was not in the medication refrigerator, available for patient use. This deficient practice had the potential for	A 505	**Van Nuys** **Corrective Actions:** Ensure outdated medication in the refrigerator was not available for patient us. All multiple dose vials will be checked in the Pharmacist Monthly Unit Inspection. At the end of the month all MDVs will be replaced. **Date of Implementation**: 6/16/2014 **Monitoring Process:** MDVs will be checked upon Pharmacist Monthly unit inspection. Any discrepancies will be reported to Quality Counsel**. (see Addendum31a)** **Person Responsible:** Director of Pharmacy	6/16/2014

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A 505	Continued From page 74 administering an outdated Tuberculin PPD, to the patients Findings: On March 2, 2014, at 10:30 a.m., during a medication room inspection, in the Unit 2 of the facility□s psychiatric campus, the medication refrigerator had one Tuberculin (TB 5 units) ampule with an expiration date of November 23, 2013. Licensed Vocational Nurse (LVN) 3 stated the Tuberculin should have been discarded and should have reordered.	A 505		
A 592	482.27(b) POTENTIALLY INFECIOUS BLOOD/BLOOD PRODUCTS Standard: Potentially infectious blood and blood products. (1) Potentially human immunodeficiency virus (HIV) infectious blood and blood components. Potentially HIV infectious blood and blood components are prior to collections from a donor □ (i) Who tested negative at the time of donation but tests reactive for evidence of HIV infection on a later donation; (ii) Who tests positive on the supplemental (additional, more specific) test or other follow-up testing required by FDA; and (iii) For whom the timing of seroconversion cannot be precisely estimated. (2) Potentially hepatitis C virus (HCV) infectious blood and blood components. Potentially HCV infectious blood and blood components are the blood and blood components identified in 21 CFR 610.47.	A 592	**Culver City** **1-8) Corrective Actions:** Look Back Policy BBK.207 **(see Addendum 34)** has been amended to include the hospitals responsibility to the patient if the physician cannot be contacted or located as stated in Procedural notes number 1. **Date of Implementation:** This policy has been approved and implemented on April 2nd 2014. **Monitoring Process**: A monitoring process has been put in effect to address the number of recalled blood products and if there is any need for the clinicians□to be notified also being monitored is if there are any failed attempts to the clinicians. **Person Responsible:** Laboratory Supervisor, Laboratory Director	4/2/2014

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A 592	Continued From page 75 (3) Services furnished by an outside blood collecting establishment. If a hospital regularly uses the services of an outside blood collecting establishment, it must have an agreement with the blood collecting establishment that governs the procurement, transfer, and availability of blood and blood components. The agreement must require that the blood collecting establishment notify the hospital □ (i) Within 3 calendar days if the blood collecting establishment supplied blood and blood components collected from a donor who tested negative at the time of donation but tests reactive for evidence of HIV or HCV infection on a later donation or who is determined to be at increased risk for transmitting HIV or HCV infection; (ii) Within 45 days of the test, of the results of the supplemental (additional, more specific) test for HIV or HCV, as relevant, or other follow-up testing required by FDA; (iii) Within 3 calendar days after the blood collecting establishment supplied blood and blood components collected from an infectious donor, whenever records are available, as set forth at 21 CFR 610.48(b)(3). (4) Quarantine of blood and blood components pending completion of testing. If the blood collecting establishment (either internal or under an agreement) notifies the hospital of the reactive HIV or HCV screening test results, the hospital must determine the disposition of the blood or blood component and quarantine all blood and blood components from previous donations in inventory. (i) If the blood collecting establishment notifies the hospital that the result of the supplemental (additional, more specific) test or other follow-up			

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A 592	Continued From page 76 testing required by FDA is negative, absent other informative test results, the hospital may release the blood and blood components from quarantine. (ii) If the blood collecting establishment notifies the hospital that the result of the supplemental (additional, more specific) test or other follow-up testing required by FDA is positive, the hospital must □ (A) Dispose of the blood and blood components; and (B) Notify the transfusion recipients as set forth in paragraph (b)(6) of this section. (iii) If the blood collecting establishment notifies the hospital that the result of the supplemental (additional, more specific) test or other follow-up testing required by FDA is indeterminate, the hospital must destroy or label prior collections of blood or blood components held in quarantine as set fors at 21 CFR 610.46(b)(2), 610.47(b)(2), and 610.48(c)(2). (5) Recordkeeping by the hospital. The hospital must maintain □ (i) Records of the source and disposition of all units of blood and blood components for at least 10 years from the date of disposition in a manner that permits prompt retrieval; and (ii) A fully funded plan to transfer these records to another hospital or other entity if such hospital ceases operation for any reason. (6) Patient notification. If the hospital has administered potentially HIV or HCV infectious blood or blood components (either directly through its own blood collecting establishment or under an agreement) or released such blood or blood components to another entity or appropriate individual, the hospital must take the following	A 592		

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A 592	Continued From page 77 actions: (i) Make reasonable attempts to notify the patient, or to notify the attending physician who ordered the blood or blood component and ask the physician to notify the patient, or other individual as permitted under paragraph (b)(10) of this section, that potentially HIV or HCV infectious blood or blood components were transfused to the patient and that there may be a need for HIV or HCV testing and counseling. (ii) If the physician is unavailable or declines to make the notification, make reasonable attempts to give this notification to the patient, legal guardian or relative. (iii) Document in the patient□s medical record the notification or attempts to give the required notification. (7) Timeframe for notification. (i) For donors tested on or after February 20, 2008. For notifications resulting from donors tested on or after February 20, 2008 as set forth at 21 CFR 610.46 and 21 CFR 610.47 the notification effort begins when the blood collecting establishment notifies the hospital that is received potentially HIV or HCV infectious blood and blood components. The hospital must make reasonable attempts to give notification over a period of 12 weeks unless □ (A) The patient is located and notified; or (B) The hospital is unable to locate the patient and documents in the patient□s medical record the extenuating circumstances beyond the hospital□s control that caused the notification timeframe to exceed 12 weeks. (ii) For donors tested before February 20, 2008. For notifications from donors tested before February 20, 2008 as set forth at 21 CFR	A 592		

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A 592	Continued From 78 610.48(b) and (c), the notification effort begins when the blood collecting establishment notifies the hospital that it received potentially HCV infectious blood and blood components. The hospital must make reasonable attempts to give notification and must complete the actions within 1 year of the date on which the hospital received notification from the outside blood collecting establishment. (8) Content of notification. The notification must include the following information: (i) A basic explanation of the need for HIV or HCV testing and counseling. (ii) Enough oral or written information so that an informed decision can be made about whether to obtain HIV or HCV testing and counseling (iii) A list of programs or places where the person can obtain HIV or HCV testing and counseling, including any requirements or restrictions the program may impose. (9) Policies and procedures. The hospital must establish policies and procedures for notification and documentation that conform to Federal, State, and local laws, including requirements for the confidentiality of medical records and other patient information. (10) Notification to legal representative or relative. If the patient has been adjudged incompetent by a State court, the physician or hospital must notify a legal representative designated in accordance with State law. If the patient is competent, but State law permits a legal representative or relative to receive the information on the patient□s behalf, the physician or hospital must notify the patient or his or her legal representative or	A 592		

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A 592	Continued From page 79 relative. For possible HIV infectious transfusion recipients that are deceased, the physician or hospital must inform the deceased patient□s legal representative or relative. If the patient is a minor, the parents or legal guardian must be notified. (11) Applicability. HCV notification requirements resulting from donors tested before February 20, 2008 as set forth at 21 CFR 610.48 will expire on August 24, 2015. This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to have a written procedure for the hospital making reasonable attempts to notify a patient that was potentially administered HIV or HCV infectious blood or blood components if the patients physician was unavailable or declined to make the notification. This deficient practice had the potential for not informing the patient regarding the need for HIV or HCV testing and counseling. Finding: On March 31, 2014, between 10:54 a.m. and 11:55 a.m., accompanied by Staff 14 (director of laboratory and pathology) and Staff 15 (lab supervisor), a review of the hospital□s policies and procedures titled, Lookback Policy SOP □2324A (Number BB14) dated effective July 2002; Lookback Programs HIV, HTLV I/II, SOP 2325B (P&P 15) (Number BBK-203) dated effective October 2002; and Lookback Program Recall Notification (Number BBK0204) dated effective July 2002 revealed there was no procedure for the hospital to notify a patient that was potentially administered HIV or HCV infectious blood or	A 592		

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A 592	Continued From page 80 blood components if the patient□s physician was unavailable or declined to make the notification. At the same time, as the review, Staff 14 and Staff 15 were informed that the hospital□s Lookback Program Recall Notification policy and procedure did not indicate the hospital□s procedure to notify a patient that was potentially administered HIV or HCV infectious blood or blood components if the patients physician was unavailable or declined to make the notification. During concurrent interview, when asked what the hospital□s procedure was to notify the patient if the patient□s doctor was not available or if the patient□s doctor refused to notify the patient, the lab supervisor stated the procedure for the hospital was that the blood bank drafts a letter and the lab sends it to the pathologist to sign off on and the lab mails it to the clinician (patient□s doctor) and that the clinician will follow through. Neither the director of laboratory and pathology or the lab supervisor provided the hospital□s procedure for the hospital making reasonable attempts to notify a patient that was potentially administered HIV or HCV infectious blood or blood components if the patient□s physician was unavailable or decline to make the notification.	A 592		
A 618	482.28 FOOD AND DIETETIC SERVICES The hospital must have organized dietary services that are directed and staffed by adequate qualified personnel. However, a hospital that has a contract with an outside food management company may be found to meet this Condition of Participation if the company has a	A 618	**Hollywood** **1) Corrective Actions:** Prior director was replaced with a new Director of Dietary at both locations, Hollywood and Van Nuys. **Hollywood:** A full-time consulting Director of Dietary Department, RD was appointed to provide oversight of the dietary department. A full-time Food Services Supervisor was appointed to oversee the day to day operations of dietary department. A clinical dietitian and a per diem Registered Dietitian provide clinical support. **Date of implementation:** July 31, 2014	7/31/2014

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A 618	Continued From page 81 dietitian who serves the hospital on a full-time, part-time, or consultant basis, and if the company maintains at least the minimum standards specified in this section and provides for constant liaison with the hospital medical staff for recommendations on dietetic policies affecting patient treatment. This CONDITION is not met as evidenced by: Based on observation, review of facility documents and staff interview, the facility failed to meet the Condition of Participation in Food and Dietetic Services by failing to: 1. Provide organized dietetic services as evidenced by findings of unsafe food handling practices and inadequate supervision of the dietary department (Refer to A 619, A 620, A 621, A 628). 2. Ensure accurate nutritional analysis of regular and therapeutic menus, menus that were in compliance with nationally recognized practices (Refer to A 630). 3. Have menus for all physician ordered diets (Refer A to 628). 4. Have effective system to ensure that physician ordered diets were followed (Refer A to 629). 5. Ensure safe and effective food storage/production practices (Refer to A 620). 6. Ensure adequate food and water were on hand for use in an emergency (Refer to A 703). 7. Have policies and procedures, spreadsheets for the distribution of food.	A 618	(Continued from page 81) **Van Nuys:** A full time Director of Dietary Department, RD was placed to provide oversight of dietary department. A full time Food Services supervisor continues to oversee the day to day operations of dietary department. A per diem clinical dietitian is available for clinical support as needed. **Date of implementation:** July 31, 2014 **Both Hollywood and Van Nuys:** Additionally, a contract is in process to retain a Food Service Management company to permanently operate the Food & Nutrition Services Department at both the Hollywood and Van Nuys campuses. This contract will include safe food handling and sanitation compliance requirements to meet all State, Federal, and DNV regulatory requirements. A General Consultant and Chef Consultant are also working between both institutions. A contract is in process with a letter of intent given to retain a Food Service Management company to permanently operate the Food & Nutrition Services Department at both Hollywood and Van Nuys. This contract will include food safe handling and sanitation compliance requirement to meet all State, Federal and DNV regulatory requirements. **Date of Implementation:** Initial correction from May 19, 2014-June 16, 2014. Additional staff of Consulting RD Director and Consulting Staff to meet Organizational needs implemented July 31, 2014. Contract Company Agreement scheduled to start October 1, 2014. **Monitoring Process:** The hospital's leadership will ensure that the Dietary Department is staffed with competent and appropriately credentialed supervisory coverage at all times. The Food & Nutrition Services Contract will be reviewed for service level compliance and regulatory standards on an annual basis by Hospital Administration and the Quality Council for recommendation for continuation. **Person Responsible:** Administrators at both Southern California Hospital at Hollywood and Van Nuys. **2) Corrective Actions:** Menus have been analyzed to meet at least 90% of DRI for all diets with the exception of those noted in the diet manual or addendums as being unable to reach such levels due to their dietary restrictions. An alternate menu or meal substitution with nutritionally equivalent options are available **Date of Implementation:** September 10, 2014 **Monitoring Process:** The nutritional analysis of menus as served are approved by the Med Executive Committee and Governing Board. Patient satisfaction is monitored to determine patient acceptance of menus provided. . **Person Responsible**: RD, Director of Dietary Department and Clinical Dietitian RD **3) Corrective Actions:** Menus are available for all standard physician ordered diets. Diets other than those on the standard list of diets will be calculated as needed by a Registered Dietitian. **Date of Implementation:** September 10, 2014 **Monitoring Process:** Review of nutritional analysis of menus as served are approved by the Med Executive Committee and Governing Board. **Person Responsible:** RD, Director of Dietary Department and Clinical Dietitian RD	7/31/2014 5/19/2014 7/31/2014 10/1/2014 9/10/2014 9/10/2014

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A 618	Continued From page 82 8. Development of menus that were consistent with nutrient parameters as approved by the hospitals' Medical Executive Committee. (Refer to A 631). The cumulative effect of these systemic issues resulted in the facility's inability to ensure and provide a safe patient care environment.	A 618	(Continued from page 81) **4) Corrective Actions:** Implementation of Mandatory CPOE diet order entry and standardization of diet orders available in the system to be in compliance with the facility diet manuals. Dietitians write diet order clarification/recommendations when discrepancies are identified. **Date of Implementation:** September 10, 2014 Continued on Page 83a.	9/10/2014
A 619	482.28(a) ORGANI□ATION Organization This STANDARD is not met as evidenced by: Based on observation, review of hospital documents and staff interviews, the hospital failed to ensure that the food and dietetic services department was properly organized. The person in the position of leadership in two of the three campuses had too many responsibilities, lacked the proper education and training appropriate to the scope and complexity of the food service operations. These failures resulted in deficient practices that affected the quality of care being provided due to failure to meet the nutritional needs of patients, lack of policies and procedures and poor food safety practices. Findings: During an interview on March 24, 2014 with (food service director), Staff 2 revealed that he had responsibilities for four of five hospitals owned by the licensee. His office was not based in any of the hospitals being inspected. The name badge on his shirt did not reflect the name of the hospitals being surveyed but the other two	A 619	**Hollywood & Van Nuys** A Registered Dietitian Director of Food and Nutrition Services was recruited, interviewed, hired or promoted to ensure qualified and competent staff was in place. Responsibilities include: • Provides adequate overall supervision, • Oversight of patient services and menu, • Develops and ensures provision of ongoing training and development of department staff, • Maintains equipment in working order by notifying maintenance of needed repairs and administration for capital replacement, • Demonstrates knowledge of infection control, sanitation and HACCP guidelines related to safe food handling practices to ensure quality and safety of food services. **Corrective Actions:** Prior director was replaced with a new Director of Dietary at both locations, Hollywood and Van Nuys. **Hollywood:** A full-time consulting Director of Dietary Department, RD was appointed to provide oversight of the dietary department. A full-time Food Services Supervisor was appointed to oversee the day to day operations of dietary department. A clinical dietitian and a per diem Registered Dietitian provide clinical support. **Date of implementation**: July 31, 2014 **Van Nuys:** A full time Director of Dietary Department, RD was placed to provide oversight of dietary department. A full time Food Services supervisor continues to oversee the day to day operations of dietary department. A per diem clinical dietitian is available for clinical support as needed. **Date of implementation:** July 31, 2014 **Both Hollywood and Van Nuys:** Additionally, a contract is in process to retain a Food Service Management company to permanently operate the Food & Nutrition Services Department at both the Hollywood and Van Nuys campuses. This contract will include safe food handling and sanitation compliance requirements to meet all State, Federal, and DNV regulatory requirements. A General Consultant and Chef Consultant are also working between both institutions. A contract is in process with a letter of intent given to retain a Food Service Management company to permanently operate the Food & Nutrition Services Department at both Hollywood and Van Nuys. This contract will include food safe handling and sanitation compliance requirement to meet all State, Federal and DNV regulatory requirements.	7/31/2014 7/31/2014

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A 619	Continued From page 83 hospitals that was owned by the licensee. The hospital being surveyed had three campuses of which he had responsibilities for two. He explained that he visits all the hospitals and is helped by the food service supervisors in some of the hospitals. Of the two hospitals he was responsible for only one had a supervisor, who had started three weeks earlier, when he was not visiting the campus. Observations and review of hospital documents revealed that he was not responsible for the day to day management of either of the campuses. The lack of leadership and supervision of dietary staff was evident in the identified concerns about food ordering, failure to follow menu, improperly maintained food service equipment, lack of policies and procedures, poor food safety practices, Food Ordering At the Hollywood campus, there was inadequate food on hand to meet state requirements of seven days of staples and two days of perishable foods. There was inadequate food on hand to meet patient□s need in an emergency. Staff 2 stated in an interview at approximately 3:00p.m. on March 24, 2014 that food he ordered food once per week. This ordering procedure results in food supplies being low and running the risk of inadequate food if the delivery were delayed or interrupted due to catastrophic reasons. DS (dietary staff) 4 was unable to provide information on a product he had prepared when there were concerns about appropriateness for patients on renal diet. (Cross reference A 0622). There was about half box (50 lbs.) of sprouting potatoes. Review of the shipping order showed that the item had been ordered two weeks earlier and had	A 619	(Continued from page 83) **Date of Implementation:** Initial correction from May 19, 2014-June 16, 2014. Additional staff of Consulting RD Director and Consulting Staff to meet Organizational needs implemented July 31, 2014. Contract Company Agreement scheduled to start October 1, 2014. **Monitoring Process:** The hospital□s leadership will ensure that the Dietary Department is staffed with competent and appropriately credentialed supervisory coverage at all times. The Food & Nutrition Services Contract will be reviewed for service level compliance and regulatory standards on an annual basis by Hospital Administration and the Quality Council for recommendation for continuation. **Person Responsible:** Administrators at both Southern California Hospital at Hollywood and Van Nuys. **2a) Food Ordering** **Corrective Actions:** **Hollywood:** Food Delivery frequency has been increased to 3 days per week. Sufficient items are on hand to meet the needs of the menu as served for 7 days of staples and 2 days of perishables. Frequency of Deliveries will continue to be adjusted as needed to ensure minimum food requirements are met. **Van Nuys:** Food delivery frequency has been revised to meet 7 days of staples and 2 days of perishables. Frequency of perishable food deliveries was reviewed and adjusted. Additional adjustments will be made after equipment is repaired and/or replaced allowing for less frequent deliveries A disaster menu and supplies for patients were adjusted to meet the needs of the facility. Disaster food and supplies for patients have been received. A disaster plan to include staff and others is being developed and food products ordered accordingly. Once the plan is finalized, staff will be trained on its use. **Date of implementation**: August 4, 2014, with a completion date of August 29, 2014 **2b) Renal diets:** Food items for Renal and other therapeutic diets are maintained to ensure compliance with 7 days of staples and 2 days of perishables. **Date of implementation:** August 4, 2014	5/19/2014 7/31/2014 10/1/2014 8/4/2014 8/4/2014

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A 619	Continued From page 84 not been used and /or stored properly. There were no pasteurized eggs on hand, but there was fried eggs on the menu, improper cooking of the eggs could result in the exposure of patients who may be already immune-compromised be exposed to bacteria that could cause food borne illness. According to the hospital policy on food supplies dated 11/2012, there should be no less than a one week supply of staple food and less than two days□supply of perishable foods. In addition, the policy states that food is purchased in accordance to the needs of the menu and any items requested for special needs or nourishment of the patient in quantity and quality to ensure sufficient amounts for the number of patients or guests to be served. Menu The cooks had not been following the menu. On March 24, 2014, the lunch menu for patients on regular diet, had the following items: Tossed green salad with dressing, Roast beef or Chef salad, Baked Potato with sour cream, green beans, dinner roll, margarine, tapioca pudding and milk. Items prepared were roast beef, confetti rice, mixed vegetables with broccoli, noodles, macaroni salad and milk. It was not clear why the menu was not followed. Other items served were not identified in the therapeutic spreadsheet. There were no scoop sizes being used to serve vegetables, noodles to ensure that patients were served the correct amount. Review of the hospital policy and procedure titled □General Requirements for Food□ dated 11/12 states □The Clinical Dietitian shall be responsible for substituting food so that the patient has adequate quality and quantity.□The Clinical Dietitian was	A 619	(Continued from page 84) **2c) Food storage:** Spoiled food products were immediately discarded and proper storage of food items according to FDA Food Code 2013 has been implemented. Produce is ordered, stored and utilized in a timely manner to avoid spoilage. **Date of implementation:** August 4, 2014 **2 d) Pasteurized eggs:** Non-pasteurized eggs were discontinued. Only pasteurized Eggs are now ordered in place of non-pasteurized shell eggs. No non-pasteurized eggs are to be purchased or used in the future. **Date of Implementation**: Pasteurized eggs in use as of 7/21/14 **Training for food ordering 2 a, b, c and d:** Staff was trained and competency tested on proper storage of food. **Date of Implementation:** July 31, 2014 **Monitoring Process: Food ordering for a, b, c and d:** Weekly ordering inventory to ensure adequate menu supplies are on hand and only pasteurized eggs are ordered. . Monthly inventory for adequate emergency supplies will be compared to the □Disaster Inventory Sheet□ Results of disaster supply inventory levels will be reported to the hospital□s EOC Committee, Quality Council, and Governing Board on a quarterly basis. **Person Responsible:** RD, Director of Dietary Department **Hollywood & Van Nuys** **3) Menu:** **a) Menu spread not available and portion sizes not followed:** **Corrective Actions:** Copy of the current menu spread was immediately posted on tray line and reviewed with staff. Dietary Staff was in-serviced on menu comprehension, serving sizes, portions and following therapeutic requirements as shown on menu. Menu books have been provided to the Dietary staff for referencing menu items for each type of diet and portions sizes required. **b) Menu substitution:** **Corrective Actions:** The Food Service staff and Supervisor were in-serviced to consult Registered Dietitians for proper food substitution. Dietary staff was provided a routine substitution list on proper food substitution. **c) Policy for double portions, small portions and consistency of pureed foods:** **Corrective Actions:** A procedure was developed and implemented for double and small portion meals and staff was in-serviced. Staff was instructed on the proper preparation and service of puree food items. **Date of Implementation:** Training initiated June 17 and completed July 31, 2014. **Monitoring Process:** Return Demonstration/Comprehension competencies completed by July 31, 2014 and on a bi-annual basis. If staff is found to be incompetent, additional training will be provided and competency reassessed. Competency records will be maintained in employee files. Tray audits will be performed 3-5 times per week to ensure diet tray accuracy and compliance with the menu in relation to portion sizes and food items, appropriate food substitutions and food preparation procedures including pureed diets. Results of audit activity will be reported to the hospital□s Quality Council, MEC, and Governing Board on a quarterly basis. Additional training will be provided based on the results of the audits. **Person Responsible:** RD, Director of Dietary Department	8/4/2014 7/21/2014 7/31/2014 6/17/2014

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A 619	Continued From page 85 not consulted in the determination of substitutes being made. Dietary Staff did not provide diet as planned. Portion sizes were incorrect, items were missing. The therapeutic spreadsheet did not match the menu. There were no policies in place to validate that correct procedures were being followed. There was no policy for small portions. Incorrect consistency of pureed food was prepared was too watery. Policies and Procedures Dietary staff did not follow safe food practices. The roast that had been prepared the day before was not properly monitored to ensure that it was cooled to prevent the growth on bacteria that could cause food borne illness. The kitchen had never used cooling logs to monitor the temperature of leftovers and previously cooked large cuts of meat. There was no written policy on proper cooling. Staff Training OS (Dietary Staff) 3 was observed at approximately 11:20 a.m., on March 24, 2014, returning to the kitchen after emptying the garbage still wearing his apron. The correct procedure is to remove the apron prior to emptying the garbage to prevent cross contamination of his apron. There were food items in the refrigerator that had not been dated. Frozen items in the freezer were not stored in a manner to prevent cross contamination, fresh or ready to eat products were stored below raw meats. Dietary staff was not able to correctly calibrate	A 619	(Continued from page 85) **4) Policies and Procedures cooling:** **Corrective Actions:** A Food Cooling Procedure and Log were created and implemented to ensure the appropriate cooling of food products to prevent bacteria growth according FDA Food Code 2013. The need for Hot food cooling has been limited by preparing all food items on the day of service. All leftover food items are discarded after each meal. Ongoing training is provided to staff on food safety and food cooling procedures with emphasis on time and temperature, food temperature danger zones, food cooling process and corrective action to take when time and temperature are not within acceptable range as per FDA Food Code 2013. Food Cooling Log with acceptable HACCP procedures and standards was implemented and appropriate corrective actions are taken when temperatures are not within acceptable range and recorded on food cooling log. A policy regarding Food Cooling has been written and reviewed and is being approved by MEC and Governing Board. **Date of Implementation:** April 28,2014 training, September 10, 2014 Policy approval **Monitoring Process:** An audit of the Cooling Logs will be conducted on a weekly basis to ensure that leftover and previously cooked foods are not being cooled. . Results of audit activity will be reported to the hospital□s Quality Council, MEC, and Governing Board on a quarterly basis. **Person Responsible:** RD, Director of Dietary Department. **HOLLYWOOD:** **5) Staff training:** **a) Garbage removal:** **Corrective Actions:** Dietary Staff was in-serviced on the hospital□s policy requiring the removal of aprons prior to discarding waste. **b) Labeling and dating:** **Corrective Actions:** Products were immediately labeled and dated or discarded. Staff was in-serviced on proper labeling and dating of food items. **c) Storage of food resulting in cross-contamination:** **Corrective Actions:** Raw foods were immediately stored on bottom shelves. Staff was in-serviced on proper storage of food according FDA Food Code 2013 including raw meats must be stored at the bottom and ready to eat food items on top to prevent cross contamination. Organized training program was developed to prevent cross contamination. Staff was trained regarding preventing cross-contamination and ensuring food safety. All Food Service staff is required to have a food handler□s card. **Date of Implementation:** In-service provided on April 28, 2014 through May 31. Additional training on policy revisions to be completed for all staff by September 10 , 2014 **Monitoring:** All Food Service staff is required to obtain a Food Handlers Card. Food safety and sanitation training with competency testing was implemented. In addition, initial staff competencies of all staff to be completed by July 31, 2014. Bi-annual validation of staff competency will be completed twice yearly and placed in employee files.	4/28/2014 4/28/2014

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A 619	Continued From page 86 thermometers. The posted log did not have clear instructions on thermometer calibration. Food equipment stored away as clean was no properly cleaned. Yellow colored cutting board was badly stained with black colored substance in the grooves of the cut marks was observed being used for meal preparation. The interior components of the ice machine had not been cleaned as recommended by the manufacturer. There were several equipment including the dish machine and plate warmer that was not working resulting in the use of paper plates for patients in the hospitals. The plate warmer had not been working for over week according to OS 4. The dish machine that had been identified as being broken was used by OS 3 to wash cooking utensils. At the Van Nuys Campus, there were similar concerns with food ordering and inadequate supplies for use during emergency, menu/ therapeutic spreadsheets not available, poor food safety practices, Staff Training During initial tour on March 27, 2014 beginning at 8 a.m., it was noted that there were four cases of 4-ounce juices with the manufacturers□ guidance to □keep frozen□ printed on the outside of cartons. It was noted there was an undated, opened case, containing thawed juice. In a concurrent interview with Staff 3, she stated she had just started her position as supervisor and was unsure of the operational processes in the department. She also stated that she was unsure of the expiration date of the juices as it was not printed on the carton. Further review of the manufacturers guidance printed on the carton	A 619	(Continued from page 86) **d) Thermometer calibration:** **Corrective Actions:** Staff was in-serviced on how to calibrate thermometers and record on log to ensure food temperatures are recorded accurately for compliance with food safety. **e) Cleaning of small equipment:** **Corrective Actions:** Blender was immediately re-cleaned. Staff was in-serviced on proper ware washing. **f) Cutting board:** **Corrective Actions:** Yellow cutting board with black stain was immediately discarded. Staff was in-serviced on when to notify management for replacement of cutting boards that are stained or have deep grooves. **g) Ice-machine: Refer to A749** **Corrective Actions:** Cleaning of the ice machine will be monitored to ensure timely completion. Preventative maintenance was set up twice a year by facilities per manufacturer guidelines. Unit is disassembled and internal components (water curtain, water trough, water level probe, ice thickness probe, water distribution tube) are cleaned and sanitized before reassembly. **Date of Implementation:** Service scheduled for August 2014; to re-occur every six months. **Monitoring Process:** Cleaning/sanitizing of ice machine (twice yearly) is documented on log sheet attached to unit. Bi-monthly audits of kitchen and food storage practices with immediate correction and on the job training of staff. **Person Responsible:** Director of Facilities & Director of Food & Nutrition **h) Equipment not working:** **Dish-machine** Corrective Actions: Dish-machine was repaired. Staff was trained regarding the proper wash and final rinse temperatures for the dish-machine and the proper reporting procedures when equipment is not working. When dish-machine is not working, all ware washing will be processed using 3 compartment sinks. **Plate warmer: Refer to A724** **Corrective Actions:** The plate warmer has been determined to be un-repairable and has been removed from the department. Equipment is being specified via meetings with vendors and bids are in the process of being obtained for replacement equipment and an order will be placed. Food temperatures are being monitored to ensure food safety compliance. **Date of Implementation:** Policy and Procedures for all departmental processes will be completed by September 10, 2014. In service dates on manual ware washing will be completed by August 15, 2014. A new plate warmer for the Hollywood campus will be ordered prior to 9/10/14. The Dish machine was repaired on 3/27/14. **Monitoring Process:** Monthly monitoring using Food Service bi-monthly kitchen audits including observations for equipment functionality. **Person Responsible:** RD, Director of Dietary Department **<u>Van Nuys</u>** **6). Staff training:** **Corrective Actions:** Frozen juices kept after 10 days were immediately discarded. Staff was retrained on food handling and storage procedures. The procedure for dating food items was implemented to ensure expired food products were discarded in a timely manner. **Date of Implementation:** In-service began April 28, 2014; Initial staff competency validation completed by July 31, 2012 for all Food Service Staff. Training on revised Food Handling and Storage procedures will be completed by September 10, 2014	8/10/2014 3/27/2014 8/15/2014 9/10/2014 4/28/2014 7/31/2014 9/10/2014

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A 619	Continued From page 87 revealed that the juices expired 10 days after they were thawed. The hospital did not have a dating system to ensure that expired juices were not served to patients. Menu The posted menu in the kitchen was for a Renal CCHO (consistent carbohydrate diet) and not a regular diet as is the standard of practice. The hospital did not have any patients on Renal CCHO diet. The therapeutic spreadsheet for that day's meal was not available to validate that the patients were being served the proper diets. Patients were served scrambled eggs, hash browns, bagel or English muffin, sausage, milk, juice. Several food trays were observed with an usually large amount of food. Staff 1 stated on March 27, 2014 at approximately 9:50a.m. that those patients had orders for double portions. She stated there was no policy on double portions and that patients are given just what the patients want. They provide them every item times two. She stated patients □want double meats not salads□. There was no policy provided on double portions. Staff 2 stated in an interview on March 27, 2014 at approximately 10:00 a.m., that keeping the menus, spreadsheets and policies and procedure was a challenge because former employees who were disciplined would remove them from the department as retaliation. Items served to the patients did not match what was on the □menu.□On March 27, 2014, according to the menu, bread pudding was to be offered for lunch. DS 5 was observed dishing out	A 619	(Continued from page 87) **Monitoring Process:** Monitoring will be conducted through bi-monthly kitchen audits to ensure food storage and handling procedures are being implemented. **Person Responsible:** RD, Director of Dietary Department **7) Menu:** **a) Menu posted** **Corrective Actions:** Copy of the current menu spread was immediately posted on tray line and reviewed with staff. Food Service Staff was in-serviced on menu comprehension, serving sizes, portions and following therapeutic requirements as shown on menu. Menu books have been provided to the Dietary staff for referencing menu items for each type of diet and portions sizes required. Staff was also instructed not to remove any menus posted and to immediately report to management if any menus were missing. **b) Policy for double portions, small portions and consistency of pureed food:** **Corrective Actions:** A procedure was developed and implemented for double and small portion meals and staff was in-serviced. Staff was instructed on the proper preparation and service of puree food items. **c) Menu substitution:** **Corrective Actions:** The Food Service staff and Supervisor were in-serviced to consult Registered Dietitians for proper food substitution. Dietary staff was provided a routine substitution list on proper food substitution. **Date of Implementation:** Training initiated June 17 and completed July 31, 2014. **Monitoring Process:** Return Demonstration/Comprehension competencies completed by July 31, 2014 and on a bi-annual basis. If staff is found to be incompetent, additional training will be provided and competency reassessed. Competency records will be maintained in employee files. Tray audits will be performed 3-5 times per week to ensure diet tray accuracy and compliance with the menu in relation to portion sizes and food items, appropriate food substitutions and food preparation procedures including pureed diets. Results of audit activity will be reported to the hospital□s Quality Council, MEC, and Governing Board on a quarterly basis. Additional training will be provided based on the results of the audits. **Person Responsible:** RD, Director of Dietary Department	6/17/2014

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SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	**6245 DE LONGPRE AVE HOLLYWOOD, CA 90028**

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A 619	Continued From page 88 vanilla pudding. In an interview at approximately 10:30 a.m., OS 5 stated she had checked the refrigerator and there was no bread pudding and Staff 2 had asked her to substitute vanilla pudding for the bread pudding. Hospital policy titled "General Requirements for Food" dated 11/12 states, "The Clinical Dietitian shall be responsible for substituting food so that the patient has adequate quality and quantity." The Clinical Dietitian was not consulted in the determination of substitutes being made (Cross refer A 0701). There was no documented evidence presented to show that the dietary staff received adequate training. Review of the personnel record for Staff 2 revealed there were educational requirements for the position based on the job description. The person currently in the position does not currently meet any of the requirements. In an interview with Staff 12 (Director of Human Resources) on March 27, 2014 at approximately 2:30 p.m., she acknowledged that based on the documents in the file, it appeared Staff 2 did not meet the minimum educational qualifications. She stated that she was unable to provide an explanation as she was not the Human resources Director when the decision was made. The hospital hired and gave responsibilities to the DFS (Director of Food Service) that was not appropriate to the scope and complexity of the food service operations.	A 619	(continued from page 88) **8. Staff received adequate training:** **Corrective Actions:** The unqualified food service director was removed from his position at both the Van Nuys and Hollywood campuses and replaced with qualified individuals. Training records, indicating the date and time and duration of the training and subject matter covered, are being retained in personnel files. The department is in the process of reviewing and revising all food service job descriptions as necessary ensuring individuals in positions meet the minimum requirements for the position. **Date of Implementation**: In-services began April 28, 2014 and training records are maintained in personnel files. Qualified directors were in place July 31, 2014. Job description revisions will be completed by September 10, 2104. **Monitoring Process**: The process for ensuring the appointment of qualified personnel will be monitored by the department directors and HR review on an annual basis to ensure that the staff meet the minimum qualification for the positions held. **Person Responsible:** Directors of Dietary Departments and HR Department	4/28/2014 7/31/2014 9/10/2014
A 621	482.28(a)(2) QUALIFIED DIETITIAN There must be a qualified dietitian, full-time,	A 621		

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A 621	Continued From page 89 part-time, or on a consultant basis. This STANDARD is not met as evidenced by: Based on observation, review of hospital documents and staff interviews, the facility failed to ensure that adequate provisions were made to ensure that the hours of the registered dietitian (RD) was adequate to meet the needs of the patients on two of three campuses. These failures resulted in the RD□s inability to supervise the nutritional aspects of patient care. Finding: Review of the documents in the personnel record for the registered dietitian job description revealed that she was hired in 2005 as a clinical dietitian to cover two hospitals. A review of a position description/Performance Appraisal for the Position of Clinical Dietitian dated 04/2006 indicated that development, evaluation and approval of menus were included in the responsibilities. Observation and implementation of proper food handling and storage to assure safe quality nutrition; evaluate food served for conformance to dietary prescription was also listed as responsibilities. However, there was an Employee Status change, approved in 1/2014 by the administrator, for the position to change from Clinical Dietitian to Dietitian. This Status change did not include a job description for the position of Dietitian. Review of the menus for both the Hollywood and Van Nuys campuses showed the name another registered dietitian (RD), who was not an employee of either hospital, indicating approval of the menu. The menus had not been approved by the hospital RD. The therapeutic spreadsheet	A 621	**Hollywood & Van Nuys** **1. Qualified staff :** Corrective Actions: The organizational structure of Food and Nutrition Services department was reviewed and revised to ensure competent leadership and staff compliance to safe food handling and sanitation practices. □A Registered Dietitian Director of Food and Nutrition Services was recruited, interviewed, hired or promoted to ensure qualified and competent staff was in place. Pertinent responsibilities include: • Provides adequate overall supervision, • Oversight of patient services and menu, • Develops and ensures provision of ongoing training and development of department staff, • Maintains equipment in working order by notifying maintenance of needed repairs and administration for capital replacement, • Demonstrates knowledge of infection control, sanitation and HACCP guidelines related to safe food handling practices to ensure quality and safety of food services. Organization chart was revised to reflect supervisors and clinical dietitians (RD) reporting to the RD Food Service director who in turn reports to hospital administrator. Job descriptions for all positions are in place. **Hollywood:** A full-time consulting Director of Dietary Department, RD was appointed to provide oversight of the dietary department. A full-time Food Services Supervisor was appointed to oversee the day to day operations of dietary department. A clinical Registered dietitian and per diem Registered Dietitian are in place to provide clinical support. **Date of implementation**: July 31, 2014 **Van Nuys:** A full time Director of Dietary Department, RD was placed to provide oversight of dietary department as well as clinical support. A full time Food Services supervisor continues to oversee the day to day operations of dietary department. A per diem clinical Registered Dietitian is available on an as needed basis. **Date of implementation:** July 31, 2014 **Both Hollywood and Van Nuys:** Additionally, a contract is in process to retain a Food Service Management company to permanently operate the Food & Nutrition Services Department at both the Hollywood and Van Nuys campuses. This contract will include safe food handling and sanitation compliance requirements to meet all State, Federal, and DNV regulatory requirements. **Date of Implementation:** July 31, 2014 **Monitoring Process:** The hospital□s leadership will ensure that the Dietary Department is staffed with competent and appropriately credentialed supervisory coverage at all times. The Food & Nutrition Services Contract will be reviewed for service level compliance and regulatory standards on an annual basis by Hospital Administration and the Quality Council for recommendation for continuation. **Person Responsible:** Administrators of Southern California Hospital at Hollywood and Van Nuys. **2) Menu:** **a) Menus approved:** **Corrective Actions:** RD Clinical Dietitian approved and signed the menus for use in the facility. Menus were posted on tray line and reviewed with staff. Food Service Staff was in-serviced on menu comprehension, serving sizes, portions and following therapeutic requirements as shown on menu. Additionally, newly appointed RD Food Service Directors have reviewed and signed the facilities□menus.	7/31/2014 7/31/2014 7/31/2014

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A 621	Continued From page 90 A 621 was not complete and/or available for use during tray line operation, thereby leaving dietary staff (cooks and aides) to determine food choices. The menus were not in compliance with hospital policy and state regulations which require use of select menus. According to the hospital policy titled, □menu,□□The regular diet consists of a selective one -week cycle. Select menus are menus with food options which allows patients to select menu items that they would like to eat." Copies of select menus were stored on a shelf in the kitchen and not offered to patients. The menus lacked variety and color. There were mashed potatoes on the menu every day for lunch and dinner. White rice is on the menu four of seven days per week for lunch; white or Spanish rice seven of seven days at dinner. For example, one of the meals had 'Veil pamejon□(veal parmesan) Chicken Chinese salad, mashed potatoes, white rice, veggies, chicken rice soup, pound cake, pears. These items were white to off-white. The menu was not followed either at Hollywood or Van Nuys campuses. Substitutions and changes were made by staff with limited knowledge and training on appropriate substitution. Items that may not be appropriate on a diet were served. Hospital policy titled Menu states " ... All diet changes must be approved by a registered dietitian. Another policy states □The Clinical Dietitian shall be responsible for substituting food so that the patient has adequate quality and quantity.□ The Clinical Dietitian was not consulted in the determination of substitutes being made. In an interview with AD 1 (Registered Dietitian) on March 24 and March 27, 2014, she stated that	A 621	(Continued from page 90) **Date of implementation:** April 10, 2014, 8/2014 **b) Non-select menus:** **Corrective Actions:** In addition to the current non-select menu, an alternate choice menu was developed by a registered dietitian and implemented. Food service staff was trained on the execution of the alternate choice menu. **Date of implementation**: April 10, 2014 **c) Lack of variety and color:** **Corrective Actions:** Current menus are under revision to ensure variety and color and patient acceptance. Patient satisfaction tool is currently in place to monitor patients meal acceptance. Results of current Patient Satisfaction data concerning food service are exceeding benchmarks. **Date of implementation:** September 10, 2014 **d) Menu substitution clarification:** **Corrective Actions:** The Food Service staff and Supervisor were in-serviced to consult Registered Dietitians for proper food substitution. Dietary staff was provided a routine substitution list on proper food substitution. **Date of implementation:** July 31, 2014 **e) Food Service Director responsibilities:** **Corrective Actions:** The organizational structure of Food and Nutrition Services department was reviewed and revised to ensure competent leadership and staff compliance to safe food handling and sanitation practices. Job duties are defined in the job descriptions/performance appraisals.	4/10/2014 9/10/2014 7/31/2014

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A 621	Continued From page 91 she was not involved in the day to day operation or oversight of the food service operation because she believed it was not in her scope of work. Regarding the menu, nutrient analysis and therapeutic spreadsheet, she stated that the menu had been written by the registered dietitian from the other hospitals owned by the licensee and so she had not participated in the menu development. She stated she had no prior knowledge of the issues that had been identified during the survey because she had concentrated on clinical nutrition responsibilities for two hospitals. She further stated it was not possible to complete some of the responsibilities outlined in the position description/Performance Appraisal because she shuttled daily between the two hospitals completing nutrition assessments. Review of the personnel record of the registered dietitian revealed that her last job evaluation was conducted by the director of food services. It was assessed as satisfactory. According to the hospital organizational structure she reported to the hospital administrator and not the director of food service. In an interview with the Staff 12 (Human Resources Manager) on March 27, 2014 at approximately 2:00 p.m., she was unable to provide an explanation of why the Director of Food Services without a formal education and education in food and nutrition was allowed to evaluate the competency of the registered dietitian with an advanced degree (cross reference A 0622, A 0628, A 0619).	A 621	(Continued from page 91) A Registered Dietitian Director of Food and Nutrition Services was recruited, interviewed, hired or promoted to ensure qualified and competent staff was in place. Pertinent responsibilities include: • Provides adequate overall supervision, • Oversight of patient services and menu, • Develops and ensures provision of ongoing training and development of department staff, • Maintains equipment in working order by notifying maintenance of needed repairs and administration for capital replacement, • Demonstrates knowledge of infection control, sanitation and HACCP guidelines related to safe food handling practices to ensure quality and safety of food services. Organization chart was revised to reflect supervisors and clinical dietitians (RD) reporting to the RD Food Service director who in turn reports to hospital administrator. Job descriptions for all positions are in place. The Food Service Director who is an RD will be responsible for reviewing the job performance of the clinical RDs. HR will be responsible for ensuring the Food Service Director RD□s job performance is evaluated by consulting RD or RD peer review. **Date of implementation:** July 31, 2014 **Monitoring Process:** The hospital□s leadership will ensure that the Dietary Department is staffed with competent and appropriately credentialed supervisory coverage.. **Person Responsible:** Human Resources Director Staff training for menus and menu substitution process with Return Demonstration/Comprehension competencies completed by July 31, 2014. Tray audits will be performed 3-5 times per week to ensure diet tray accuracy and compliance with the menu in relation to portion sizes and food items, appropriate food substitutions and food preparation procedures including pureed diets. Results of audit activity will be reported to the hospital□s Quality Council, MEC, and Governing Board on a quarterly basis. Additional training will be provided based on the results of the audits. **Person Responsible:** Food Service Directors	7/31/2014
A 622	482.28(a)(3) COMPETENT DIETARY STAFF There must be administrative and technical personnel competent in their respective duties. This STANDARD is not met as evidenced by:	A 622	**Hollywood & Van Nuys :** **Corrective Actions:** The organizational structure of Food and Nutrition Services department was reviewed and revised to ensure competent leadership and staff compliance to providing physician diet order administration, safe food handling and sanitation practices.	

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A 622	Continued From page 92 Based on observation, review of facility documents and staff interviews, the hospital failed to ensure that its dietary staff was competent in their duties in the dietetic service area when they were unable to properly calibrate food thermometers, prepare pureed diet to the correct consistency, serve patients correct diets. These failures resulted in improper sanitation and food handling practices that could cause food borne illness. It also resulted in patients receiving incorrect diets and less nutrition than was ordered by their physicians and planned by the dietitian. Findings: Hollywood campus At approximately 11:20 a.m., on March 24, 2014, there was a discrepancy of approximately 60 degrees between the recorded food temperatures of the hospital staff and that of the surveyor. The pasta was 122 degrees Fahrenheit (F), but recorded as 162 degrees in the hospital log. Rice was 182 degrees F and recorded as 172 degrees F. As a result of these discrepancies, hospital staff was asked to recalibrate its thermometer. A review of the posted □Thermometer Calibration Daily Log Sheet□ for March 2014 showed the thermometer had been calibrated earlier that morning at 8:10 a.m. and it read 32 degrees F. The correct procedure to calibrate a bi-metallic thermometer in ice is to immerse thermometer in a 50/50 ice to water ratio. After approximately, three minutes, read thermometer. If thermometer temperature is not 32 (+/- 2) degrees F the thermometer is recalibrated in ice by turning the dial to 32 degrees. During observation of the calibration process,	A 622	(Continued from page 92) A Registered Dietitian Director of Food and Nutrition Services was recruited, interviewed, hired or promoted to ensure qualified and competent staff was in place. Pertinent responsibilities include: • Provides adequate overall supervision, • Oversight of patient services and menu, • Develops and ensures provision of ongoing training and development of department staff, • Maintains equipment in working order by notifying maintenance of needed repairs and administration for capital replacement, • Demonstrates knowledge of infection control, sanitation and HACCP guidelines related to safe food handling practices to ensure quality and safety of food services. Organization chart was revised to reflect supervisors and clinical dietitians (RD) reporting to the RD Food Service director who in turn reports to hospital administrator. Job descriptions for all positions are in place. **Hollywood:** A full-time consulting Director of Dietary Department, RD was appointed to provide oversight of the dietary department. A full-time Food Services Supervisor was appointed to oversee the day to day operations of dietary department. A clinical Registered dietitian and per diem Registered Dietitian are in place to provide clinical support. **Van Nuys:** A full time Director of Dietary Department, RD was placed to provide oversight of dietary department as well as clinical support. A full time Food Services supervisor continues to oversee the day to day operations of dietary department. A per diem clinical Registered Dietitian is available on an as needed basis. **Date of Implementation**: July 31, 2014 Current Food Service staff competency levels were assessed and thereafter will be assessed on a bi-annual basis including skills found lacking during this survey process. After appropriate training and retraining, those staff found to not reach minimum competency requirements, will either be placed in positions that they meet competency levels or if not trainable, will be replaced. **Date of Implementation:** July 31, 2014 **Both Hollywood and Van Nuys:** Additionally, a contract is in process to retain a Food Service Management company to permanently operate the Food & Nutrition Services Department at both the Hollywood and Van Nuys campuses. This contract will include safe food handling and sanitation compliance requirements to meet all State, Federal, and DNV regulatory requirements. Current Management & Supervisory staff probationary competency levels will be assessed. Appropriate actions will be taken as a result of those initial competency assessments. **Date of Implementation:** September 10, 2014.	7/31/2014 7/31/2014 9/10/2014

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A 622	Continued From page 93 Staff 2 (Food Service Director) who was present read the temperature of the thermometer out loud as □32 degrees□ when it was 24 degrees F. When the error was pointed out to him, he then proceeded to recalibrate the thermometer out of the ice water mixture by turning the dial to 32 degrees F. The Calibration procedure on the log directs staff to adjust the dial of the bi-metallic thermometer if the dial does not read 32 degrees F. However, the instructions on the □Thermometer Calibration Daily Log Sheet□did not explain that it needs to remain in the ice and water mixture. During the meal service at approximately 12:15 p.m. on March 24, 2014, a tray for a patient on pureed diet was observed placed on the cart for distribution to the floor. The plate of the unsampled patient contained three small plastic souffle cups. In each cup was pureed meat, pureed vegetable and mashed potatoes. The amounts served appeared smaller than would be expected for an adult. Measurement of the food revealed the meat and vegetables were each 2 oz. The mashed potato was 2/5 c. The consistency of the meat and vegetables was that of soup or liquefied pureed. The correct consistency of pureed food is that of mashed potatoes. In addition, based on the review of the therapeutic spreadsheet presented by hospital staff for that meal, it showed for the pureed diet, the patient did not receive adequate amounts of food. The pureed tray should have received 3 ounces pureed meat (not 2 ounces), 4 ounces vegetables (not 2ounces), 6 ounces soup, amount of mashed potato was not stated, pureed dinner roll, □ c	A 622	(Continued from page 93) **Monitoring Process:** The hospital□s leadership and Human Resources Department will ensure that the Dietary Department is staffed with appropriately credentialed and competent registered dietitians, Certified Dietary Managers, supervisors, cooks, diet aides and food service workers through the initial hiring, orientation and performance evaluation processes. The new Food & Nutrition Services Contract will be reviewed for service level compliance and regulatory standards on an annual basis by Hospital Administration and the Quality Council for recommendation for continuation. **Person Responsible:** Administrators and Human Resource professionals of Southern California Hospital at Hollywood and Van Nuys and Director of Dietary Departments.	

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A 622	Continued From page 94 tapioca pudding and 8 ounces lowfat milk. Another random observation at approximately 12:45 p.m. showed a tray served with food for a patient on a renal diet. The following items were served: Macaroni salad, mandarin oranges in light syrup, confetti rice, chicken, mixed vegetables with broccoli, 1 pat margarine, tapioca pudding and cater blend. The items on the tray were different than was on the spreadsheet approved by the registered dietitian. According to the spreadsheet, a patient on a renal 2 gram sodium, 2 gram potassium diet should have received tossed green salad with dressing (no tomato) 3 ounces meat,% cup green beans, 1dinner roll, 2 pats margarine. The concern is that these items as served such as oranges and broccoli which could be high in potassium and may not be appropriate on the diet. Earlier, the kitchen staff has placed a bowl of cream of chicken soup on the tray for a patient on renal diet. The soup was not observed on the tray for this random patient when the recipe for the soup was requested. The recipe or nutritional information was never provided because the cook stated he no longer had any cans of the product that was used. The concern with the product was that it may contain milk or milk products. Milk contains phosphorus, a mineral that could cause softening of the bones in a patient with impaired kidney function. An interview was conducted at approximately 1:00 p.m. with DS 6 In response to her abilities and knowledge to accurately serve the renal diet in the absence of the spreadsheet (the spreadsheet was not available on the tray line for use to serve the patients during tray line	A 622		

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A 622	Continued From page 95 operation), she indicated that she knew the diets well because she □knows her job□ The hospital did not provide documentation that the dietary staff had been properly trained to correctly serve the diets as planned. DS 7 was observed dishing out applesauce at approximately 12:30 p.m. on March 24, 2014, she was observed to use a □12 scoop or 1/3 cup. The usual serving size for applesauce or most fruits is □ cup. There was no guide to determine the proper size for the applesauce. There was no applesauce on the menu for that day. Review of personnel records for all the Dietary staff showed that all were evaluated in the past year for job related competencies. All were evaluated as a satisfactory based on returned demonstration and verbalization of procedure.	A 622		
A 628	482.28(b) DIETS Menus must meet the needs of the patients. This STANDARD is not met as evidenced by: Based on observation, review of hospital menu, policies and procedures and staff interviews, the hospital failed to ensure that its menus met the nutritional needs of its patients. Portion sizes and correct consistency were not provided to patients. There was no menu written for patients on double portions, substitutions were left to the discretion of the cooks during meal service. There were unsampled patients that did not receive diets as ordered by their physicians or according to recognized professional practices. The deficient practice had the potential for compromising patients□nutritional status.	A 628		

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A 628	Continued From page 96 Hollywood campus 1. During meal service at approximately 12:15 p.m., on March 24, 2014, a tray for a patient on pureed diet was observed placed on the cart for distribution to the floor. The plate of the unsampled patient contained three small plastic souffle cups. In each cup was pureed meat, pureed vegetable and mashed potatoes. The amounts served appeared smaller than would be expected for an adult. Measurement of the food revealed the meat and vegetables were each 2 oz. The mashed potato was 2/5 c. The consistency of the meat and vegetables was that of soup or liquefied pureed. The correct consistency of pureed food is that of mashed potatoes. In addition, based on the review of the therapeutic spreadsheet presented by hospital staff for that meal, it showed for the pureed diet, the patient did not receive adequate amounts of food. The pureed tray should have received 3 ounces pureed meat (not 2 ounces), 4 ounces vegetables (not 2ounces), 6 ounces soup, amount of mashed potato was not stated, pureed dinner roll, □ c tapioca pudding and 8 ounces lowfat milk. 2. Another random observation at approximately 12:45 p.m. showed a tray served with food for a patient on a renal diet. The following items were served: Macaroni salad, mandarin oranges in light syrup, confetti rice, chicken, mixed vegetables with broccoli, 1 pat margarine, tapioca pudding and cater blend. The items on the tray were different than was on the spreadsheet approved by the registered dietitian. According to the spreadsheet, a patient on a renal 2 gram sodium, 2 gram potassium diet should have	A 628	(Continued from page 96) **Hollywood** **1) Pureed food:** **Corrective Actions:** Food service staff was educated on proper preparation of pureed food using food thickener and portioning of pureed food items. **Date of Implementation:** May 19, 2014 **2) Renal diet:** **Corrective Actions:** Incorrect food items on the Renal Diet patient trays were replaced with appropriate food items.	5/19/2014

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(□4) ID PREFI□ TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFI□ TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(□5) COMPLETION DATE
A 628	Continued From page 97 received tossed green salad with dressing (no tomato)□3 ounces meat, %cup green beans, 1 dinner roll, 2 pats margarine. The concern is that these items as served such as oranges and broccoli which could be high in potassium and may not be appropriate on the diet. 3. Earlier, the kitchen staff has placed a bowl of cream of chicken soup on the tray for a patient on renal diet. The soup was not observed on the tray for this random patient when the recipe for the soup was requested. The recipe or nutritional information was never provided because the cook stated he no longer had any cans of the product that was used. The concern with the product was that it may contain milk or milk products. Milk contains phosphorus, a mineral that could cause softening of the bones in a patient with impaired kidney function. Culver City campus During tray line observation on March 25, 2014 at approximately 11:45 a.m., several patient trays had pieces of the main entree, pork loin. The portion size of the slices fluctuated from tray to tray with some tray receiving about half of what other trays received. Review of the therapeutic spreadsheet revealed that the portion size for the entree was 3 ounces. One of the trays with a small piece of meat was examined and weighed. The pork loin weighed 1-1/2 ounces, half of what the menu had called for. During the same trayline observation, the tray card of an unsampled patient was examined. The items doubled on the tray were pork loin and mashed potatoes. Review of the spreadsheet did	A 628	(Continued from page 97) **3) Renal diet appropriate food item:** **Corrective Actions**: Food service staff was trained on following the menu spread including therapeutic diets and any substitutions must be approved by RD dietitian. Dietary staff was in-serviced on appropriate portion sizes, correct consistency, menu reading and following therapeutic diet requirements including small and double portions. Menu books were provided to the dietary staff for reference to ensure accurate patient tray preparation. In addition a simplified □snap shot□of items to be used in the prep area was created and posted. Additional changes to these processes will be implemented and staff trained based on audit results. **Date of Implementation:** May 19, 2014 and April 30, 2014 to June 5, 2014. Initial Competency completed by 7/31/14.Additional process training to be completed and competency assessed by September 10-, 2014 **Monitoring Process:** Biannual return Demonstration/Comprehension competencies will be conducted on all food service staff at Hollywood and maintained in employee files. Tray audits will be performed 3-5 times per week to ensure diet tray accuracy and compliance with prescribed menu. Results of audit activity will be reported to the hospital□s Quality Council, MEC, and Governing Board on a quarterly basis. **Person Responsible:** RD, Director of Dietary Department **Culver City** **1. Menu portion sizes:** **Corrective Actions:** The inaccurate portion of pork loin was immediately corrected and patient received the correct portions as reflected on the menu. Verbal Counseling and re-training with cooks on preparing portions, Written Training with supervisors on daily monitoring of portioning for patients. **Date of Implementation**: 4/11/14 **Monitoring Process**: Daily data collection by supervisors and monthly data analysis by Clinical Nutrition Manager on portion accuracy with Semi-annual reporting to Quality Council. **Person Responsible**: R.D. Clinical Nutrition Manager **2. Double portion:** **Corrective Actions:** Policy for Double Portions was added to our current Policy on Special Patient Meals and Services. The policy includes serving double portions of meat, starch and vegetables. Procedure was added to daily menu spreadsheets. **Date of Implementation**: 6/20/2014 **Monitoring Process:** Random monitoring of double portions as part of Quarterly Tray Accuracy. **Person Responsible**: R.D. Clinical Nutrition Manager	5/19/2014 7/31/2014 4/11/2014 6/20/2014

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A 628	Continued From page 98 not include instructions on a Double Portions. Review of the policy titled Double Portions did not specify what food needed to be doubled per meal. It is unclear whether this tray was accurate as there was no formal checking of trays for accuracy except for those on □complicated diets.□ Van Nuys campus Dietary Staff (DS) 1 was observed not using scoops when dishing out patients□food. The assurance that the diet meets the need of the patients cannot be guaranteed when the correct portion size is not used in serving. There were several patient food trays observed with large amounts of food. Each of the trays had 2 large hash browns, two eggs, 2 slices of bagel, 2 sausages, a bowl of cream of wheat and a carton of 2 % milk. Staff 1 stated on March 27, 2014 at approximately 9:50a.m. that those patients had orders for double portions. She stated there was no policy on double portions and that patients are given just what the patients want. They provide them every item times two. She stated patients ..want double meats not salads... There was no policy provided on double portions. Staff 2 stated in an interview on March 27, 2014 at approximately 10:00 a.m. that keeping the menus, spreadsheets and policies and procedure was a challenge because former employees who were disciplined would remove them from the department as retaliation. Items served to the patients did not match what was on the □menu.□ On March 27, 2014	A 628	(Continued from page 98) **3. Tray accuracy:** **Corrective Actions:** To address the lack of formal checking of all patient food trays, the sample size of Tray Accuracy monitoring was increased to 10% to reduce inaccuracies through observation and training. .**Date of Implementation:** April 2014 **Monitoring Process:** Monitor 10% of patient trays on a quarterly basis for accuracy of patient trays against the tray ticket. Analyze data and report to Quality Council on a Semi-Annual Basis. **Person Responsible**: RD, Clinical Nutrition Manager **Van Nuys** **1) Portioning devices:** **Corrective Actions:** Portioning devices were purchased. Staff was in-serviced on using correct portioning devices to match the portions on the menu spreads. **2) Double portion:** **Corrective Actions**: A procedure was developed and implemented for double portions and staff was in-serviced. **3) Tray accuracy, portion sizes and food substitution:** **Corrective Actions**: The Food Service staff and Supervisor were trained to provide portion sizes to match the menu spread. Staff was in-serviced to consult Registered Dietitians for proper food substitution. Dietary staff was provided a routine substitution list on proper food substitution. Dietary staff was in-serviced on appropriate portion sizes, correct consistency, menu reading, menu substitutions procedures and following therapeutic diet requirements including double portions	4/30/2014

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A 628	Continued From page 99 according to the menu, bread pudding was to be offered for lunch. DS 5 was observed dishing out vanilla pudding. In an interview at approximately 10:30 a.m., DS 5 stated she had checked the refrigerator and there was no bread pudding and Director of Food Services A had asked her to substitute vanilla pudding for the bread pudding. She was observed using a □12 scoop (or approximately 3 ounces) to dish the vanilla pudding into containers. The usual portion size for food like vanilla pudding is% cup. The RD who was present during the observation could not validate the correct amount. Hospital policy titled □General Requirements for Food□dated 11/12 states □The Clinical Dietitian shall be responsible for substituting food so that the patient has adequate quality and quantity□The Clinical Dietitian was not consulted in the determination of substitutes being made.	A 628	(Continued from page 99) Menu books were provided to the dietary staff for reference to ensure accurate patient tray preparation. In addition a simplified □snap shot□of items to be used in the prep area was created and posted. Additional changes to these processes will be implemented and staff trained based on audit results. **Date of Implementation:** April 30, 2014 □ June 5, 2014 Initial competency assessed by 7/31/14 **Monitoring Process:** Biannual return Demonstration/Comprehension competencies will be conducted on all food service staff at Van Nuys and maintained in employee files. Tray audits will be performed 3-5 times per week to ensure diet tray accuracy and compliance with prescribed menu. Results of audit activity will be reported to the hospital□s Quality Council, MEC, and Governing Board on a quarterly basis. **Person Responsible:** RD, Director of Dietary Department and Food Services Supervisor	4/30/2014 7/31/2014
A 629	482.28(b)(1) THERAPEUTIC DIETS Therapeutic diets must be prescribed by the practitioner or practitioners responsible for the care of the patients. This STANDARD is not met as evidenced by: Based on food distribution observations, dietary and administrative staff interview and departmental document review, the facility failed to ensure that diets were ordered by the physician as evidenced by inaccurate interpretation of diet orders by dietary and nursing staff. Failure to ensure that physician diet orders are followed may result in the further compromising of patients□medical status. Findings:	A 629	**Corrective Actions:** Only diets ordered by physicians are to be transcribed. Dietitians have compared Diet orders as written by physicians are compared to those transcribed by others i.e. Computerized Physician Order Entry not used. Assessed current status of diet orders to identify potential opportunities for order to not reach food service as ordered by physicians. Errors included- transcription error or lack of deletion of previous diet order, verbal orders or other orders not authenticated by a physician or diets not sent as doctors ordered due to diet ticket errors in the food service department. Memos sent to physicians to use approved diet orders only to be entered in Electronic Medical Record by physicians. List of approved diet orders were streamlined to only include approved diet orders. Require the use of mandatory physician computer ordering to minimize errors. Nursing personnel completed training including procedures related to verbal order and order verification. Training provided to food service staff on properly full filling doctors□ orders or the requirement to contact a registered dietitian to calculate order and obtain clarification from physicians for orders not written according to standard. Dietitian to document requests in medical record for diet clarifications or inform physicians of recommended diet orders. **Date of Implementation:** April 30, 2014 to September 10, 2014 **Monitoring Process:** Diet accuracy of manual orders is monitored by clinical dietitians. These items are monitored including, accuracy of manual diet list completion at Hollywood and Van Nuys and monitoring of diet clerk tray tickets against diet lists. . Results of audit activity will be reported to the hospital□s Quality Council, MEC, and Governing Board on a semi-annual basis. **Person Responsible:** Clinical Dietitian, Clinical Manager or Food Service Director who is a Registered Dietitian	4/30/2014

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A 629	Continued From page 100 1. Patient 8 was admitted with diagnoses including diabetes mellitus (high blood sugar), hypertension (high blood pressure) and asthma. Review of admitting orders revealed that there was no order for diet. Electronic record review on March 27, 2014 revealed that an order was entered for a No Added Salt later than evening by one of the nurses. Registered Nurse (RN) 20 stated that she received an order but was not sure she faxed an authentication of the diet order to the physician was faxed as it is customary to do with medical orders. She stated that another nurse was helping her with the admission and that she assumed the other nurse faxed the diet order. There was no documented evidence that either nurse had called the physician to receive a diet order or authenticate a verbal order. Comments made by other unidentified nurses on the unit revealed that they use information on diet orders from previous admission to determine diet orders when physicians do not add diet orders. There was no telephone order authentication by the admitting physician either in the electronic or paper record. According to the Hospital policy titled 11telephone and verbal orders dated 07/2004, states Telephone orders are too be written and read back to physicians to clarify. 2. Patient 13 was admitted to the Van Nuys campus on March 25, 2014 with diagnosis including exacerbation of depression. Physicians' admission diet order dated March 25, 2014 was a no added salt diet. Review of Patient 13's meal tray ticket on March 27,2014 at 10:30 a.m., revealed that the diet	A 629	(Continued from page 100) **1.) Corrective Actions**: All nursing staff re-educated with self-study module to validate that physician orders have been noted, examined, and verified. Caregivers must use SBAR and provide the opportunity to use read-back techniques and medications orders received must be read back by the receiver. 24 hour order/chart check policy & procedure PAT.059 implemented that mandates documentation of chart review before 7am each day. **Date of Implementation:** 5/18/2014 **Monitoring Process**: Random audit of 30 charts will be done per nursing unit. **Person Responsible:** Nursing Leadership	

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A 629	Continued From page 101 delivered was a 2 grams sodium restriction. In an interview with Staff 1 she stated that on a daily basis she received a diet list from nursing staff. Review of the diet list dated March 27, 2014 noted that nursing staff indicated that Patient 13 was to receive a no added salt diet. A no added salt diet is typically a 4 gram sodium diet. Therefore, Patient 13 was served a more restrictive diet than his physician had ordered. In an interview on March 27, 2014 beginning at 11 a.m., with the Registered Dietitian (RD 1) she stated that it appeared that Staff 1 was transcribing the order from a no added salt to a 2 gram diet. In addition, RN 20 and RN 21 stated in concurrent interviews on March 27, 2014 at approximately 3:15 p.m. that when they receive orders for diabetic diet, they translate that as Non Concentrated Sweets Diet. A non-concentrated sweets diet is one in which desserts, and sugars are avoided. According to the American Diabetes Association, this diet incorrectly teaches patients that sugar intake is the cause of diabetes.	A 629	(continued from page 101) **Corrective Actions:** Non-concentrated sweets diet order is being eliminated from the list of approved diets in CPOE. Physicians who have a justified need for this particular diet order, can order it through other diet options. **Date of Implementation:** August 18, 2014, elimination of non-concentrated sweets, at the Culver City Campus, was put into effect. Elimination of the non-concentrated sweets diet will be put into effect at the Hollywood and Van Nuys Campuses on September 10, 2014. **Person Responsible:** RD, Food Service Director, Clinical Dietitian RD	8/18/2014 9/10/2014
A 630	482.28(b)(2) DIETS Nutritional needs must be met in accordance with recognized dietary practices and in accordance with orders of the practitioner or practitioners responsible for the care of the patients. This STANDARD is not met as evidenced by: Based on patient observations, nursing and dietary department interview and medical record and departmental policy review, the facility failed to ensure the physician diet orders were implemented as ordered for 3 of 7 patients, in a sample of 51, reviewed for clinical nutrition care as evidenced by 1) Patient 12□s tube feeding was	A 630		

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A 630	Continued From page 102 not delivered per physicians orders; 2) Patient 40's diet was implemented with greater restrictions than the physicians' orde; 3) patients with calorie defined diabetic diets were not implemented as ordered; 4) Patient 11's nutritional intervention delayed for five days before implementation. The deficient practice had the potential for compromising patients' nutritional status. Findings: Hollywood campus 1. During meal service at approximately 12:15 p.m. on March 24, 2014, a tray for a patient on pureed diet was observed placed on the cart for. distribution to the floor. The plate of the unsampled patient contained three small plastic souffle cups. In each cup was pureed meat, pureed vegetable and mashed potatoes. The amounts served appeared smaller than would be expected for an adult. Measurement of the food revealed the meat and vegetables were each 2 oz. The mashed potato was 2/5 c or 3.2 ounces. The correct portion for purred meat should have been 3 ounces, 4 ounces for the vegetables and mashed potatoes based on the serving size of the patients on the regular diets. The consistency of the meat and vegetables in each of the cups was that of soup or liquefied pureed. The correct consistency of pureed food is that of mashed potatoes. Incorrect consistency could result in aspiration of food into the lungs resulting in aspiration pneumonia. Aspiration pneumonia is an inflammation of the lungs or bronchial tubes resulting from food, saliva, liquids or vomit breathed into the lungs.	A 630	**Hollywood & Van Nuys** **1.) Pureed food :** **Corrective Actions:** Food service staff was educated on proper preparation of pureed food using food thickener and portioning of pureed food items. Dietary staff was in-serviced on appropriate portion sizes, correct consistency, menu reading and following therapeutic diet requirements. Menu books were provided to the dietary staff for reference to ensure accurate patient tray preparation. In addition a simplified □snap shot□of items to be used in the prep area was created and posted. Additional changes to these processes will be implemented and staff trained based on audit results. **Date of Implementation:** May 19, 2014 and April 30, 2014 to June 5, 2015. Initial Competency will be completed 7/31/14. **Monitoring Process:** Biannual return Demonstration/Comprehension competencies will be conducted on all food service staff at Hollywood and maintained in employee files. Tray audits will be performed 3-5 times per week to ensure diet tray accuracy and compliance with prescribed menu. Results of audit activity will be reported to the hospital□s Quality Council, MEC, and Governing Board on a quarterly basis. **Person Responsible:** RD, Director of Dietary Department	5/19/2014 7/31/2014

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A 630	Continued From page 103 Culver City campus 2. Patient 12 was admitted with diagnosis including pneumonia (an infection in the lungs) and hypoxia (a low level of oxygen in tissues and blood). Electronic medical record review was conducted on March 26, 2014 beginning at 2 p.m. Admission diet order dated March 13, 2014 was a cardiac diet. A physicians' order dated March 24, 2014 was for tube feeding through a nasogastric tube (tube through the nose inserted in the stomach for feeding) with Diabetasource (tube feeding formula for diabetics) at a rate of 20 cc (cubic centiliters)/hour. A follow up order dated March 26, 2014 requested water via the NG tube, 150 cc (a metric unit of measure) every 6 hours. The tube feeding was ordered on March 24, 2014 at 3 p.m. An observation of the tube feeding was conducted on March 26, 2014 at 3:00 p.m. It was noted that the tube feeding pump was off. It was also noted that the feeding bag or the tubing was not dated and/or labeled; the volume in the bag at the time of hanging was 1,000 cc and that there was approximately 300 cc left. It was also noted that a new bag of Diabetasource was lying on the residents' bedside table. In a concurrent interview with Staff 3, she stated that the dietary department sent up tube feedings every day at lunch that included labels which were intended to be placed on the tube feeding when it was hung. In an interview with RN 17, she stated that she reset the pump as 12 p.m. (3 hours prior). She also stated that she cleared the pump at 12 p.m. and turned the pump off shortly before 3 p.m. to provide personal care and probably forgot to turn it back on.	A 630	(Continued from page 103) **Culver City** **Corrective Action:** Policy VAS.005 □Intravenous Therapy □ Initiation and Management of Peripheral Intravenous Lines□and Policy PAT.057 □Enteral Nutrition Support□were used, along with the mandatory online self-study module, to re-educate nursing staff. All feeding bags, IV bags and all tubing must be labeled, dated, timed and initialed. Documentation of tube feeding will be accurate. **Date of Implementation:** 6/16/2014 **Monitoring Process:** Nursing Leadership from each department will monitor proper labeling of IV bags, feeding bags and all tubing using the newly created □IV Fluid P.I.□and □Feeding Formula P.I.□ audit tools. Date will be collected on 30 random patients and then results will be reported to the Quality Council on a monthly basis. **Person Responsible:** Nursing Leadership in each unit.	06/16/2014

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A 630	Continued From page 104 A review of medical record document titled □Daily Assessment Inquiry□dated March 24, 2014 at 8 p.m. was the first time that the tube feeding was noted; however there was no documentation in the electronic medical record when the feeding was actually hung. It was also noted that the actual amount of feeding that was being delivered was not accurately recorded and/or the documentation noted the physician□s order of 20 cc/hour. For example, on March 26, 2014 at 6 a.m. the amount of tube feeding delivered was recorded as 240 cc. Follow up documentation dated March 26, 2014 at 12 p.m., noted an entry of 240 cc. If the feeding was running per the physicians order the pump should have read either 360 cc (if the pump was not cleared at the 6 a.m. entry) or 120 cc for the 12 p.m. entry rather than the documented 200 cc. In an interview on March 24, 2014 at 3:15p.m., RN 17 was unable to explain the discrepancy. In a concurrent interview with Staff 3 she acknowledged that the feeding was not likely delivered per the physicians□order. A review of training dated 10/13 noted that Staff 4 completed a handout at the annual nursing skills fair that reminded staff to □always put a date and hang time on each tube feeding bag even if you do not get a pharmacy label ...□ 3. During a review of physician ordered diets on March 26, 2014 at 9 a.m., it was noted that Patient 49 had a physician ordered 3 gram potassium diet. It was also noted that the physicians□diet was transcribed as a low potassium diet. In an interview on March 26, 2014 at 3:30p.m., with DS 2 she was asked to	A 630	(Continued from page 104) **3)Culver City** **Physician orders not implemented:** **Corrective Actions:** The diet pattern was calculated by the RD dietitian and implemented immediately. Food & Nutrition Services Diet office personnel were retrained on Diet Modifications for K diets and on the requirement to contact a dietitian for diets not found in the diet manual or for diet clarifications. **Date of Implementation:** 4/22/14 **Monitoring Process:** Diet Modification accuracy is monitored quarterly with a sample size of 30 menus per clerk. . Results of audit activity will be reported to the hospital□s Quality Council, MEC, and Governing Board on a semi-annual basis. **Person Responsible:** R.D. Clinical Nutrition Manager	4/22/2014

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A 630	Continued From page 105 describe how this diet was implemented. She stated that she had not yet completed the tray cards for the ensuing day; however she would use the pre-printed menu for renal diets, which limited the potassium to 2 grams/day. She also stated that if the renal diet did not meet the physicians' specific parameters she would decrease the amount of protein in each of the meals to meet the parameters. The example she described was to decrease the noon meal to 1-ounce of protein and the dinner entree selection to 3 ounces. She also stated that once the meal was delivered she would not be able to recount what was actually delivered as there was no system to know what was delivered to patients after the fact. In a concurrent interview with Staff 4; she was asked if there was guidance for dietary staff to follow when referring specialized diets to a registered dietitian (RD) 1 for review. She replied that while there was no guidance this was one that should have been reviewed by an RD 1. Review of the hospitals diet manual on March 26, 2014 at 4 p.m., revealed that a renal diet would restrict protein, sodium and the potassium was limited to 2 grams, a more severe restriction than was ordered by the physician. Sources of potassium include meats, vegetables, and dairy (National Institute of Medicine), a 3 gram potassium diet would have included additional sources of potassium rather than restricting them. On March 28, 2014, the hospital presented a blank document titled □Diet Clerk Competency Test□ which included guidance to contact the RD for modification of complicated diet orders. 4. Patient 11 was admitted on March 9, 2014, with diagnoses including congestive heart failure (a	A 630	(continued from page 105) **Culver City (page 104)** **4) RD recommendation:** **Corrective Actions:** RD recommendations to physicians are a current performance indicator. A letter has been drafted by Food & Nutrition and was sent by Medical Administration reinforcing the importance of the timely acknowledgement and/or ordering of dietitian recommendations. **Date of Implementation:** 6/16/2014	6/16/2014

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SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	**6245 DE LONGPRE AVE HOLLYWOOD, CA 90028**

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A 630	Continued From page 106 condition in which the heart's function as a pump is inadequate to deliver oxygen rich blood to the body), hypertension (high blood pressure), diabetes (a condition in which a person has high blood sugar) and chronic kidney disease (a gradual loss of kidney function). His physician ordered a 1500 to 1800 calorie diet on admission. After a nutritional assessment on March 12, 2014, the registered dietitian recommended a diet change to a 2000 calorie ADA cardiac renal diet. This recommendation was written on a bright colored pink paper placed in the physician's order section of the clinical record for physician acknowledgement and/ or approval of recommendation. The physician did not acknowledge/approve the recommendation until March 16, 2014, four days after the recommendation was made. The diet was not ordered until the next day. Nutrition intervention was delayed for about five days due to physician's delay in acknowledging the RD's recommendation. In addition, the physician ordered a fluid restriction of less than 1500 cc on admission. This order was not transcribed as part of the diet order and so the fluid restriction was not implemented as part of the order until three days later on March 12, 2014 when the RD noticed it while conducting the nutritional assessment. In between the three days that the fluid restriction was not implemented, Patient 11 was ordered Boost, a nutritional supplement three times a day with meals. He received this in addition to the 2000 cc of fluid which is part of his diet, an additional 720 cc from three boxes of Boost. Laboratory values on March 26, 2014 showed	A 630	(Continued from page 106) **Monitoring Process:** Continued tracking of % of dietitian recommended√ acknowledged or ordered for all recommendations made. Results of audit activity will be reported to the hospital□s Quality Council, MEC, and Governing Board on a quarterly basis. **Person Responsible:** R.D. Clinical Nutrition Manager at Culver City **FINDING: PATIENT 11 *Dietary Orders*** **Corrective Actions:** An internal review of dietary processes identified handwritten dietary recommendations were placed into the patient□s medical record and not reviewed in a timely manner. The following improvements have been implemented: • All physicians are required to input orders via the Computerized Physician Order Entry System (CPOE). • All dietary recommendations are required to be input into the electronic medical record (EMR). Input of a dietary recommendation into the EMR triggers a □flag□of a pending diet recommendation and prompts appropriate follow-up for a physician□s order to finalize said dietary recommendation. • The Dietary Department will monitor all diet orders, executed as a result of a diet recommendation, to ensure all diet orders are appropriately fulfilled. Audit results will be reported to the hospital□s Pharmacy and Therapeutics Committee, Quality Council, Medical Executive Committee, and Governing Board. **Date of Implementation** • Internal review of the dietary processes was conducted April through June 2014. • Mandatory input of dietary recommendations into the EMR completed July 22, 2014 for the Culver City campus and August 1, 2014 for the Van Nuys and Hollywood campuses. • Physicians mandated to input orders via CPOE by July 15, 2014 for the Hollywood and Van Nuys campuses and by August 18, 2014 for the Culver City campus. • Super-users have been hired and trained to support physician adoption and training. Physician CPOE training commenced June 25, 2014. **Monitoring Process:** • The Dietary Department will monitor all diet orders, executed as a result of a diet recommendation, to ensure diet orders are appropriately fulfilled. Audit results will be reported to the hospital□s Pharmacy and Therapeutics Committee, Quality Council, Medical Executive Committee, and Governing Board. • Compliance will be gauged by reviewing the number of diet recommendations generated (denominator), and of those, the number of orders written and executed (numerator) • Targeted compliance is 90% • Monitoring activity will commence for a period not to exceed 4 months or until optimal compliance is achieved and sustained. • Random audits will be performed thereafter. • Results of the audits will be reported to the hospital□s Pharmacy and Therapeutics Committee, Quality Council, Medical Executive Committee, and Governing Board. **Person Responsible:** Director of Dietary/Food Services or designee.	4/15/2014 7/22/2014 8/1/2014 7/15/2014 8/18/2014 6/25/2014

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A 630	Continued From page 107 that his kidneys were working well and cleaning out toxins in his body. His blood urea nitrogen (measurement of nitrogen in the blood that comes from waste product urea) was 65 (normal 7-20) and creatinine a byproduct of normal muscle contractions that is cleared by the kidneys) was 5.0 (Normal 0.6 -1.3) Clinical record review showed that Patient 11 was refusing dialysis (treatment that removes wastes in the blood done by healthy kidneys) which would have alleviated the fluid his body was retaining. The physician had ordered daily weights also as part of the admission orders but this was not done. Monitoring weight is one of the ways a physician could monitor how much fluid the body is retaining. This is of significance because Patient 11 suffered from both congestive heart failure and kidney failure, two conditions in which excessive fluid retention is detrimental. 5. During review of physician ordered diets on March 26, 2014 at 9 a.m., it was noted that the diets for patients with diabetes were not consistent with what was transcribed to the electronic diet entry order system. The hospital utilized consistent carbohydrate diets which utilize meal plans without specific calorie levels, rather incorporates consistent levels of carbohydrate from day to day at breakfast, lunch and dinner (American Diabetes Association, 1997); however the physician ordered diets depicted specific calorie levels. For example, if a physician ordered a 2000 calorie American Diabetes Association (ADA) diet it would get transcribed to a 1900-2200 carbohydrate consistent diet. Review of the hospital diet list dated March 28, 2014 for the	A 630	(continued from page 107) **Corrective Actions:** All nursing staff will be re-educated on proper I & O documentation, obtaining weights and documentation of weights. Super users will notify RNs of any discrepancies. RNs will correct discrepancies. SuperUsers are qualified clinical staff with extensive competencies in electronic clinical documentation. They are available on site 24 hrs. a day/ 7 days a week. **Date of Implementation**: 6-19-2014 with full implementation in 30 days **Monitoring Process**: Super Users will monitor and collect data on a minimum of 200 charts a month and outcomes will be reported up to the Quality Council on a monthly basis. Any level of non-compliance will be reported to the Nursing Director for immediate corrective action. **Person Responsible:** Clinical Education Coordinator/Informatics	6/19/2014

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A 630	Continued From page 108 medical/surgical unit (5 east) revealed that 11 of 11 diets were transcribed in this manner. It was also noted that the method of transcription was not consistent within the hospital. For example, the diet list dated March 26, 2014 noted that the physician ordered an 1800 calorie ADA diet (Patient 18) which was transcribed to a 1500-1800 calorie consistent carbohydrate diet. In contrast Patient 50, who was on the medical surgical unit had an 1800 ADA diet order which was transcribed to a diabetic diet/consistent carbohydrate. Additionally, Patient 43 had a 2500 calorie ADA diet which was transcribed to a 1900-2200 calorie diet. On March 26, 2014 beginning at 9:30a.m., the analysis of the hospitals non-select, standard carbohydrate consistent diet which was designed to provide 4-5 carbohydrates/meal (60-75 grams/meal) was reviewed. It was noted that for 6 of 21 meals the carbohydrate level did not meet the hospitals upper limit parameter, ranging from 82-95 grams/meal. It was also noted that only 10 of 21 meals fell within the documented parameters of 60-75 grams/meal. In an interview on March 26, 2014 at 4 p.m., with Staff 4, she stated that the hospital was attempting to eliminate physicians ordering diabetic diets, rather transition to the carbohydrate consistent terminology. She also stated that while there was discussion with medical staff, physicians continued to prefer to use the concept of calorie restriction. On March 28, 2014 at 9 a.m., Staff 4 the hospitals' pharmacy and therapeutics committee approved the translation of the diet orders by the department. Review of hospital document titled "	A 630	(continued from page 108) **b) Consistent Carbohydrate diet:** **Corrective Actions:** Consistent Carbohydrate diets have been modified to fit within the description in the diet manual with appropriate changes noted on the diet spreadsheet. **Date of Implementation**: 6/19/14	6/19/2014

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A 630	Continued From page 109 Medical Staff Bylaws□dated 12/4/13, Section 12.7.2 which described the duties related to the Pharmacy and Therapeutics (P&T) Committee noted that the purpose of the committee was to □Objectively review the clinical use of all drugs□ □and to advise the Medical Executive Committee and Medical Staff on issues related to pharmacy services. There was no indication that the P&T was assigned the duty of reviewing nutrition practices that were not related to medication administration. On March 25, 2014 at 4 p.m., the hospital provided a screen shot of the available diet orders in the electronic medical record. It was noted that there were five different types of consistent carbohydrate diets: 1900-2200 calories (5-6 carbohydrates □CHO□/meal); 1500-1800 (4-5 CHO/meal); 1200-1400 (3-4 CHO/meal); 2300-2500 (6-7 CHO/meal) and a diabetic/consistent carbohydrate diet. Hospital policy titled □Diet Manual□dated 11/12 guided staff that the □diet order should be specified in terms of exact amount of restriction: 1500 calorie □ □ It also noted that if the physician □is unsure of the terminology necessary for desire diet order, he/she should consult the Clinical Diet Manual ...□ It was noted that the policy did not reflect the practice within the department, as the physicians ordered diets in accordance with the policy. Review of the hospitals□diet manual under the section titled 11 □Dietary Management of Diabetes Mellitus□ revealed that this section provided clinical practice recommendations; rather than the elements of a diet manual. Additionally it was noted that referring to the diet manual would not	A 630	(Continued from page 109) **c) Corrective Actions:** A separate document for Alta Hollywood Hospitals Medical Staff Bylaws was found which specifies the responsibilities to assess and make recommendations to the Medical Executive Committee regarding the nutritional products and services provided to the patients in the hospital. **d) Corrective Actions:** A diet manual addendum was added to include 5 different types of Consistent Carbohydrate diets. Diabetic/Consistent Carbohydrate diet was eliminated from the diet order list. **Date of Implementation:** 6/30/14 **e) Corrective Actions:** Dietitians reviewed the physicians□diet orders and requested clarifications from physician when orders were not written according to diet manual. Facility to enforce mandatory use of physician computer order entry which will restrict the possibility of ordering diets that are not present in the diet manual removing the potential for improper transcription or the need to interpret diet orders. Memo sent to physicians concerning the upcoming conversion to all computerized order entry and the diet types that will be present. Until conversion dietitians will monitor order transcription and make recommendations for diet order changes to currently accepted diets Interim plan to provide ADA diets as ordered by physicians until required use of Computerized Physician Order Entry (CPOE) is totally implemented. Diet Spread in the process of being modified to include ADA exchange diet patterns and complete nutritional analysis of these diets. **Date of Implementation:** 8/18/14 **f) Corrective Actions:** A diet manual addendum will be added for Van Nuys and Hollywood to include all required components for diets in the diet manual to ensure physicians can accurately order diets. A list of diets available within the CPOE will be created and distributed to the doctors to improve the ease of ordering. Diets not specifically on the list that are required for physician order will be available through an □other diet□entry system. **Date of Implementation: 9/10/14**	6/30/2014 8/18/2014

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A 630	Continued From page 110 have provided physicians additional guidance for ordering diabetic diets as the document provided clinical practice recommendations rather than guidance for ordering diabetic diets within the hospital. Hospital documents showed that on March 28, 2014 at 9 a.m., the hospital provided education provided to nursing leadership on entering diets into the system. It guided nurses to □transcribe the physician□s diet order correctly from the diets available in the system;□ however, it would not be possible for nursing staff to follow this guideline as ordering calorie specific diets was not an option in the electronic medical record.	A 630	(Continued from page 110) **Monitoring Process:** The Manual of Clinical Nutrition Management (diet manual) is reviewed and approved annually by the medical staff and Registered Dietitians. Audit to monitor physicians ordering approved diets and accurate diet order transcriptions. Clinical nutrition team audits 10% of patients admitted on a weekly basis. Report finding of diet order errors after CPOE mandatory implemented to Quality Council, Med Exec and Governing Board as part of PI program. **Person Responsible:** R.D. Clinical Dietitian or Culver City Clinical Nutrition Manager	
A 631	482.28(b)(3) THERAPEUTIC DIET MANUAL A current therapeutic diet manual approved by the dietitian and medical staff must be readily available to all medical, nursing, and food service personnel. This STANDARD is not met as evidenced by: Based on departmental document review, the facility failed to ensure that the approved hospital diet manual was used as the basis of ordering diets when it used on the Culver City campus, a non-select diet for a low fiber diet. According to the diet manual, a low fiber diet would provide less fiber than its regular diet. Failure to offer diets with as approved by the medical staff may result in further compromising patients□medical status. Findings: 1. On March 26, 2014 beginning at 11 a.m., the hospitals diet manual and nutritional analysis was	A 631		

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A 631	Continued From page 111 reviewed. It was noted that in the diet manual, a low fiber diet was described as less than 15 grams of fiber/day. Review of the nutritional analysis of the low-fiber menu revealed that for 3 of 7 days the fiber content exceeded the diet manuals specifications ranging from 16.4-18.7 grams of fiber/day. Hospital failed to use the low fiber diet parameters approved by medical staff to develop the menu for patients on low fiber diets. 2. Review of the hospitals' diet manual under the section titled □Dietary Management of Diabetes Mellitus□ revealed that this section provided clinical practice recommendations; rather than the elements of a diet manual. Diet manuals establish a common language based on hospital practices. A diet manual would reflect the purpose and principles of each diet, a meal pattern based on the hospitals menu, foods allowed and not allowed and the inadequacies of each diet. The facility's diet manual should mirror the diets ordered by physicians and the nutritional care provided by the facility. Hospital policy titled □Diet Manual□dated 11/12 guided staff that the □diet order should be specified in terms of exact amount of restriction: 1500 calorie ....□ However, when these diets were ordered with specific caloric restrictions they were changed and interpreted as consistent carbohydrate levels (CCHO). The policy also noted that if the physician □is unsure of the terminology necessary for desire diet order, he/she should consult the Clinical Diet Manual ... □It was noted that referring to the diet manual would not have provided physicians additional guidance for	A 631	(Continued from page 111) **Culver City** **1) Corrective Actions:** Low Fiber diet has been revised so that nutrition analysis is consistent with the Manual of Clinical Nutrition Management, diet manual used at Culver City. Diet spread sheets have been revised. **(see Addendum 55)** **Date of Implementation:** April 5, 2014 **Monitoring Process**: The Manual of Clinical Nutrition Management (diet manual) is reviewed and approved annually by the medical staff and Registered Dietitians. **Person Responsible:** R.D. Clinical Nutrition Manager. **2) Corrective Actions:** The Medical Nutrition Therapy for Diabetes Mellitus addendum to the Manual of Clinical Nutrition Management (Diet Manual) has been modified to reflect the missing components. Policies, Diet Manual and Electronic Medical Record System will be in sync with the requirement of computerized physician ordering in July 2014. The Diet Manual policy referred to is for Hollywood/Van Nuys. Culver City does not require that □diet orders should be specified in terms of exact amount of restriction□pertaining to 1500 calorie diets **(see Addendum 56)** **Date of Implementation:** 6/1/14 **Monitoring Process:** Monitoring of the accuracy of Diet orders in CPOE will be implemented in 8/2014 following implementation. **Person Responsible:** R.D. Clinical Nutrition Manager	4/5/2014 6/1/2014

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A 631	Continued From page 112 ordering diabetic diets as the document provided clinical practice recommendations rather than guidance for ordering diabetic diets within the hospital. The current standard of practice for the nutritional management of diabetes is the consistent carbohydrate meal plan with has the support of the American Diabetes Association. In an interview with Staff 4 on March 28, 2014 at approximately 10:45 a.m., she stated that the desire has been to have physician order the CCHO diets. If the hospital wanted to meet current standards of practice, its policies, diet manual and electronic medical record system were not in sync and did not reflect the requirements of a diet manual (cross reference A0630).	A 631		
A 700	482.41 PHYSICAL ENVIRONMENT The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community. This CONDITION is not met as evidenced by: Based on observation, review of facility documents and staff interview, the facility failed to meet the Condition of Participation in Physical Environment by failing to: 1. Develop and maintain the physical plant in a manner that assured the safety and well-being of patients (Refer A 701). 2. Ensure the safety of patients and staff when it	A 700	Item 1-6. Captured in A-701 Corrective Action Plans.	

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A 700	Continued From page 113 failed to ensure an adequate food supply to be implemented in a widespread disaster; and hand washing sink that did not have an adequate hot water supply. Failure to ensure maintenance of the physical environment may compromise the medical status of patients and the ability for staff to care for patients (Refer to A 701). 3. Ensure an effective water management plan and supplies to be implemented in a widespread disaster (Refer to A 703). 4. Properly store and dispose of trash by having overfilled and uncovered dumpster□s creating conditions conducive to fly breeding and offensive odors (Refer to A 713). 5. Ensure the plumbing in food production areas were designed and maintained in a manner to prevent potential cross contamination of foods (Refer to A 722). 6. Maintain facilities that mitigate cross contamination may result in exposing patients to a foodborne illness (Refer to A 722). The cumulative effect of these systemic issues resulted in the facility□s inability to ensure and provide a safe patient care environment.	A 700		
A 701	482.41(a) MAINTENANCE OF PHYSICAL A PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured.	A 701	**Van Nuys** **1) Corrective Actions** Patient room bathrooms, 101, 102, 103, 104, 105, 106, 107, 108, 109 and 110 grab bars were removed. Only the grab bar in room 110, an ADA accessible room, was replaced with an anti-ligature grab bar. Grab bars in other patient bathrooms will not be replaced. The exposed plumbing pipes in patient room bathrooms, 101- 110 will be covered with stainless steel flush valve vandal resistant covers and p-trap covers. The standard faucets in patient room bathrooms, 101- 110 were replaced with anti-ligature faucets. All accessible mortise hinges that could be used as anchors by patients will be replaced with anti-ligature continuous hinges. **Date of Implementation:** Patient room bathrooms, 101, 102, 103, 104, 105, 106, 107, 108, 109 and 110 grab bars were removed on 4/21/2014. Planned replacement of anti-ligature grab bars for room 110, an ADA accessible room, was completed on 8/16/2014. The exposed plumbing pipes in patient room bathrooms, 101- 110	4/21/2014 8/16/2014

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A 701	Continued From page 114 This STANDARD is not met as evidenced by: Based on observation and interview the acute psychiatric staffs, the facility failed to develop and maintain the physical plant in a manner that assured the safety and well-being of patients by not reducing opportunities for self-harm and eliminating as many risk factors as possible in the patient's environment including fixtures that could be used as anchor points to tie to that can hold a person's weight and other conditions that could be used as opportunities for self-harm. Additionally, the facility failed to ensure the safety of patients and staff when it failed to ensure an adequate food supply to be implemented in a widespread disaster; and hand washing sink that did not have an adequate hot water supply. Failure to ensure maintenance of the physical environment may compromise the medical status of patients and the ability for staff to care for patients. Findings: On March 24, 2014 between 10:05 a.m. and 3:20 p.m. the following conditions existed in the Van Nuys psychiatric campus. Station 1 (Van Nuys campus) There were fixtures throughout that could be used as anchor points to tie to that can hold a person's weight throughout the unit; including pendant sprinkler heads, grab bars, shower handles, soap dishes, exposed plumbing pipes (water supply to toilet and sink drain line), standard faucets, vents, mortise hinges and self-closing door arms. 1. Patient room bathrooms, including those in	A 701	(Continued from page 114) will be covered by stainless steel flush valve vandal resistant covers to be installed by September 26, 2014; P-trap covers will be installed by September 12, 2014. The standard faucets in patient room bathrooms, 101- 110 were replaced with anti-ligature faucets on August 19, 2014.All accessible mortise hinges that could be used as anchors by patients will be replaced with anti-ligature continuous hinges by September 26, 2014. **Monitoring Process:** Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted to ensure patient safety. Once anti-ligature safety features are complete, engineering will monitor via weekly EOC rounds to ensure a safe environment is maintained. **Person Responsible:** Director of Engineering, ACNO **2) Corrective Actions:** The mechanical fan cover that was exposing the spinning blades of the exhaust fan in Room 101 was secured to the ceiling with new securing screws. A hospital-wide review and facility tour made to ensure all covers are secured for all exhaust fans. **(See Addendum 58)** **Date of Implementation:** 3/24/14 **Monitoring Process:** Monitoring of all exhaust fans scheduled through EOC rounds daily by nursing staff. **(see Addendum 57)** **Person Responsible:** ACNO & Director of Engineering **3) Corrective Actions:** The atmospheric ventilation cover was replaced in Room 101. A hospital-wide review and facility tour made to ensure all atmospheric covers are secure and will be monitored in the EOC rounds daily by nursing staff. **(see Addendum 59)** **Date of Implementation**: 3/24/14 **Monitoring Process:** The monitoring of all atmospheric covers will be monitored in the EOC rounds daily by nursing staff. **(see Addendum 57)** **Person Responsible:** ACNO & Director of Engineering **4) Corrective Actions:** Shower room 4 grab bar was removed. New Anti-Ligature grab bar was installed. The mortise hinges that could be used as anchors by patients will be replaced with anti-ligature continuous hinges. The self-closer arm was reversed to the outside. **Date of Implementation:** Shower room 4 grab bar was removed and replaced with a new anti-Ligature grab bar on April 15, 2014. The mortise hinges that could be used as anchors by patients will be replaced with anti-ligature continuous hinges by September 26, 2014.The self-closer arm was reversed to the outside on 8/16/2014. **Monitoring Process:** Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted to ensure patient safety. Once anti-ligature safety features are complete, engineering will monitor via weekly EOC rounds to ensure a safe environment is maintained. **Person Responsible:** Director of Engineering, ACNO **5) Corrective Actions:** Shower room 5 grab bar was removed. New Anti-Ligature grab bar has been installed in shower room 5. The soap dish was removed. Liquid soap is provided upon request form nurses. The mortise hinges that could be used as anchors by patients will be replaced with anti-ligature continuous hinges. The self-closer arms have been reversed to the outside. **Date of Implementation:** New Anti-Ligature grab bar was installed in shower 5 on April 15, 2014. The soap dish was removed on March 30, 2014.The mortise hinges that could be used as anchors by patients was replaced with anti-ligature continuous hinges by September 26, 2014.The self-closer arms was reversed to outside on April 15, 2014.	8/16/2014 9/12/2014 9/26/2014 3/24/2014 3/24/2014 4/15/2014 8/16/2014 9/26/2014 3/30/2014 4/15/2014 9/26/2014

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	050135	S. BUILDING **01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD** T. WING _____	**04/01/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, □IP CODE
SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	**6245 DE LONGPRE AVE HOLLYWOOD, CA 90028**

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A 701	Continued From page 115 rooms 101, 102, 103, 104, 105, 106, 107, 108, 109, and 110 had grab bars, exposed plumbing pipes, standard faucets and mortise hinges that could be used as anchors. 2. Room 101 had the mechanical fan *cover* moved one inch exposing the spinning blades of the exhaust fan. 3. Room 101 had the atmospheric ventilation cover missing, exposing the ventilation duct and a damper and its components. 4. Shower room 4 had a grab bar, mortise hinges and self-closer arm at the door that could be used as anchors. 5. Shower room 5 had a grab bar, shower handles, soap dish mortise hinges and self-closer arm at the door that could be used as anchors. During an interview at the same time as the observation, Staff 6 (director of facilities) stated, □We should have the type of (grab) bar that has the safety plate, they can tie something here and lay down on the floor.□ 6. The dining/activity room had pendent sprinkler heads at the ceiling, a standard sink faucet, and exposed sink drain pipe that could be used as anchors. 7. The bathroom of the dining/activity room had grab bars, exposed plumbing pipes, a standard faucet and mortise hinges that could be used as anchors. At the time of the observation a patient had come non-escorted out of the rest room. 8. The women's common bathroom had grab bars, exposed plumbing pipes, and a standard	A 701	(Continued from page 115) **Monitoring Process:** Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted to ensure patient safety. Once anti-ligature safety features are complete, engineering will monitor via weekly EOC rounds to ensure a safe environment is maintained. **Person Responsible:** ACNO & Director of Engineering **6) Corrective Actions:** The dining/activity room pendent sprinkler heads have been changed to a Recessed Sprinkler head by Mid-Valley Automatic Fire System, Inc. Safety, anti-ligature faucets have replaced the standard faucets. P-trap covers have been ordered to cover exposed sink drain pipe in dining/activity room. **Date of Implementation:** The dining/activity room pendent sprinkler heads have been changed to Recessed Sprinkler heads by Mid-Valley Automatic Fire System, Inc. completed July 11, 2014. The replacement of standard faucets to safe, anti-ligature faucets was completed on August 19, 2014. Installation of p-trap covers will be completed by September 12, 2014. **Monitoring Process:** Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted to ensure patient safety. Once anti-ligature safety features are complete, engineering will monitor via weekly EOC rounds to ensure a safe environment is maintained. **Person Responsible:** Director of Engineering & ACNO **7) Corrective Actions**: The grab bar in the bathroom located in the dining/activity room was removed and will not be replaced. The exposed plumbing pipes will be covered by stainless steel flush valve vandal resistant covers and P-trap covers. Safety, anti-ligature faucets have replaced the standard faucet. The mortise hinges that could be used as anchors by patients will be replaced with anti-ligature continuous hinges door hinges have been ordered to replace the standard hinges. **Date of Implementation:** The grab bar was removed on April 21, 2014 and will not be replaced. The exposed plumbing pipes will be covered by stainless steel flush valve vandal resistant covers to be installed by September 26, 2014; P-trap covers will be installed by September 12, 2014.Safety, anti-ligature faucets replaced the standard faucet on August 19, 2014. The mortise hinges that could be used as anchors by patients was replaced with anti-ligature continuous hinges by September 26, 2014. **Monitoring Process:** Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted to ensure patient safety. Once anti-ligature safety features are complete, engineering will monitor via weekly EOC rounds to ensure a safe environment is maintained. **Person Responsible:** Director of Engineering & ACNO **8) Corrective Actions:** The grab bar in the women□s common bathroom was removed and will not be replaced. The exposed plumbing pipes will be covered by stainless steel flush valve vandal resistant covers and P-trap covers. Safety, anti-ligature faucets have replaced the standard faucet. **Date of Implementation:** The grab bar was removed on April 21, 2014 and will not be replaced. The exposed plumbing pipes will be covered by stainless steel flush valve vandal resistant covers to be installed by September 26, 2014; P-trap covers will be installed by September 12, 2014. Safety, anti-ligature faucets replaced the standard faucet on August 19, 2014. **Monitoring Process:** Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted to ensure patient safety. Once anti-ligature safety features are complete, engineering will monitor via weekly EOC rounds to ensure a safe environment is maintained. **Person Responsible:** Director of Engineering & ACNO	7/11/2014 8/19/2014 9/12/2014 8/19/2014 9/12/2014 9/26/2014 4/21/2014 8/19/2014 9/12/2014 9/26/2014

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A 701	Continued From page 116 faucet that could be used as anchors. During an interview, Staff *6* stated the patients are escorted to the bathroom and a staff member needs to unlock the bathroom, but the patient remains in the bathroom by themselves. 9. The men□s common bathroom had grab bars, exposed plumbing pipes, and a standard faucet that could be used as anchors. 10. There were pendent type sprinkler heads throughout the corridor. 11. There was unimpeded access from Unit 1 into an interior stairwell connecting the first floor to the basement. There were hand rails and sprinkler pipes in the stairwell that could be used as anchors. There was also a fourteen foot drop from the top first floor landing rail to the bottom of the stairwell. During an interview at the same time as the observation, Staff 6 stated that on a weekend morning years ago they found a patient hanging around at the top stairwell landing and that when they took the patient to his room they found a sheet in the patients room. Outpatient (Van Nuys campus) 12. Common bathroom by group meeting room had a ceiling pendent sprinkler, grab bars, exposed plumbing pipes, standard faucets, mortise hinges and arm of a self-closing device at the door that could be used as anchors. The bathroom also had a standard porcelain water tank and cover with accessible flush mechanism parts within. 13. Common bathroom by the group meeting	A 701	(Continued from page 116) **9) Corrective Actions**: The grab bar in the men□s common bathroom was removed and will not be replaced. The exposed plumbing pipes will be covered by stainless steel flush valve vandal resistant covers and P-trap covers. Safety, anti-ligature faucets have replaced the standard faucet. **Date of Implementation:** The grab bar was removed on April 21, 2014 and will not be replaced. The exposed plumbing pipes will be covered by stainless steel flush valve vandal resistant covers to be installed by September 26, 2014; P-trap covers will be installed by September 12, 2014. Safety, anti-ligature faucets replaced the standard faucet on August 19, 2014. **Monitoring Process:** Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted to ensure patient safety. Once anti-ligature safety features are complete, engineering will monitor via weekly EOC rounds to ensure a safe environment is maintained. **Person Responsible:** Director of Engineering & ACNO **10) Corrective Actions:** All pendent type sprinkler heads located throughout all corridors have been removed and replaced with Recessed Sprinkler heads by Mid-Valley Automatic Fire System, Inc. **Date of Implementation:** The pendent type sprinkler heads throughout all corridors have been replaced with Recessed Sprinkler heads by Mid-Valley Automatic Fire System, Inc. Completed July 11, 2014. **Monitoring Process:** Engineering will monitor integrity of the recessed sprinkler heads via weekly EOC rounds. EOC rounds are planned to be ongoing to ensure a safe environment is maintained. Monitoring of fire sprinklers will also be part of the Annual Sprinkler Testing Evaluation. **Person Responsible:** Director of Engineering **11) Corrective Actions:** Access from Unit 1 into the interior stairwell, exposing handrails and pipes, leading to the basement was secured with the installation of a lock and alarm. Patients are unable to access the interior stairwell; only authorized personnel can access stairway. **Date of Implementation:** Access from Unit 1 into the interior stairwell, with exposed handrails and pipes, was secured with the installation of a lock and alarm on March 25, 2014. **Monitoring Process**: All doors & locks throughout the hospital are checked 3 times a day by security. **Person Responsible:** Director of Engineering **12) Corrective Actions:** The pendent type sprinkler heads have been replaced with Recessed Sprinkler heads by Mid-Valley Automatic Fire System, Inc. The grab bar in the common bathroom by the group meeting room was removed and will not be replaced. The exposed plumbing pipes will be covered by stainless steel flush valve vandal resistant covers and P-trap covers. Safety, anti-ligature faucet has replaced the standard faucet. The mortise hinges that could be used as anchors by patients will be replaced with anti-ligature continuous hinges. The self-closer arm was reversed to outside. The toilet will be removed and replaced with a commercial vandal resistant toilet. **Date of Implementation**: The pendent type sprinkler heads have been replaced with Recessed Sprinkler heads by Mid-Valley Automatic Fire System, Inc. Completed July 11, 2014. The grab bar was removed on April 21, 2014 and will not be replaced. The exposed plumbing pipes will be covered by stainless steel flush valve vandal resistant covers to be installed by September 26, 2014; P-trap covers will be installed by September 12, 2014. Safety, anti-ligature faucets replaced the standard faucet on August 19, 2014. All accessible mortise hinges that could be used as anchors by patients will be replaced with anti-ligature continuous hinges by September 26, 2014.The self-closer arms was reversed to outside on April 15, 2014. The toilet will be removed and replaced with a commercial vandal resistant toilet by September 26, 2014. **Monitoring Process:** Engineering will monitor integrity of the recessed sprinkler heads via weekly EOC rounds. EOC rounds are planned to be ongoing to ensure a safe environment is maintained. Monitoring of fire sprinklers will also be part of the Annual Sprinkler Testing Evaluation. Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted to ensure patient safety.	4/21/2014 8/19/2014 9/12/2014 9/26/2014 7/11/2014 3/25/2014 4/15/2014 4/21/2014 7/11/2014 8/19/2014 9/12/2014 9/26/2014

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A 701	Continued From page 117 room had a loose toilet. Closer observation revealed the anchor bolt was missing. 14. Common bathroom by the outpatient lounge had grab bars, exposed plumbing pipes, standard faucets and mortise hinges that could be used as anchors. Basement (Van Nuys campus) 15. There was an 8 inch by 5 inch dark brown water stain at the ceiling of the intake department. 16. There was a 10 inch by 10 inch dark brown water stain with a 4 inch by 4 inch black stain at its center at the ceiling of the medical records storage room. 17. There was an exposed plumbing (P-trap) that could be used as an anchor at the corridor near the medical records room. There was unimpeded access from Unit 1 to the basement by use of an interior stairwell or elevator. 18. There was an unlocked laundry room that had a pendent ceiling sprinkler and self-closing device arm at the door that could be used as anchors. There was unimpeded access from Unit 1 to the unlocked laundry in the basement by use of an interior stairwell or elevator. Exterior (Nan Nuys campus) 18. There was overgrown live vegetation and accumulation of dry vegetation conducive to the possible harborage of rodents and other pests at and next to Unit 2 patio. The vegetation was next	A 701	(Continued from page 117) Once anti-ligature safety features are complete, engineering will monitor via weekly EOC rounds to ensure a safe environment is maintained. **Person Responsible:** Director of Engineering & ACNO **13) Corrective Actions:** The common bathroom toilet by the group meeting room was secured with new screws on March 25, 2014. A hospital-wide review and facility tour made to ensure all toilets are secured and will be monitored in the EOC rounds weekly by IOP staff**.** **Date of Implementation:** Bathroom toilet was secured with new screws on March 25, 2014. 3/25/2014 **Monitoring Process:** Monitoring that all toilets are secured in the EOC rounds weekly by IOP Staff**.** **Person Responsible:** Director of IOP & Director of Engineering **14) Corrective Actions:** The grab bars located in the common bathroom by the outpatient lounge was removed and will not be replaced. The exposed plumbing pipes will be covered by stainless steel flush valve vandal resistant covers and P-trap covers. Safety, anti-ligature faucets have replaced the standard faucet. All accessible mortise hinges that could be used as anchors by patients will be replaced with anti-ligature continuous hinges. **Date of Implementation:** The grab bars located in the common bathroom by the outpatient lounge was removed on April 21, 2014 and will not be replaced. 4/21/2014 The exposed plumbing pipes will be covered by stainless steel flush valve vandal resistant covers to be installed by September 26, 2014; 9/12/2014 P-trap covers will be installed by September 12, 2014. 9/26/2014 Replacement of standard faucets to safe, anti-ligature faucets will be completed on September 30, 2014. 9/30/2014 All accessible mortise hinges that could be used as anchors by patients will be replaced with anti-ligature continuous hinges by September 26, 2014. **Monitoring Process:** Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted to ensure patient safety. Once anti-ligature safety features are complete, engineering will monitor via weekly EOC rounds to ensure a safe environment is maintained. **Person Responsible:** Director of Engineering & ACNO **15) Corrective Actions:** The 8 inch by 5 inch dark brown water stain on the ceiling of the intake department was replace and re-tape the A/C lines with rubber tubes on March 27, 2014. A hospital-wide review and facility tour made to ensure all ceilings are clear of stains and will be monitored in the EOC rounds monthly. 3/27/2014 **Date of Implementation:** 3/27/14 **Monitoring Process:** All ceilings in intake departments are to be monitored for any stains in the EOC rounds. **Person Responsible:** Director of Engineering **16) Corrective Actions:** The 10 inch by 10 inch dark brown water stain with a 4 inch by 4 inch black stain at its center of the ceiling tile in medical records storage room was tile replaced on March 27, 2014. **See Addendum 71, 71a)** A hospital-wide review and facility tour made to ensure all ceilings are clear of stains and will be monitored in the EOC rounds monthly. **Date of Implementation:** 3/27/14 3/27/2014 **Monitoring Process:** All ceilings in medical records are to be monitored for any stains in the EOC rounds monthly. **Person Responsible:** Director of Engineering **17) Corrective Actions:** The exposed plumbing (p-trap) that could be used as an anchor at the corridor near the medical records room was removed. The access from Unit 1 to the basement by the use of the interior stairwell door was replaced with a locked handle to ensure only authorized personnel can access stairways. No impact on egress. **Date of Implementation:** In process, expected implementation date July 1, 2014. **Monitoring Process:** All doors & locks throughout the hospital are checked 3 times a day by security. **Person Responsible:** Director of Engineering **18) Corrective Actions:** The laundry room door is now locked and only authorized personnel have access. The access from Unit 1 to the basement by the use of the interior stairwell door was replaced with a locked handle to ensure only authorized personnel can access stairways	

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A 701	Continued From page 118 to, over, and on top of the smoking area canopy, and next to building structure. The vegetation (avocado tree) also created a food source, shelter and natural bridge onto the facility roof for possible rodents. On March 25, 2014 between the hours of 8:30 a.m. and 11:00 a.m. the following conditions existed in the Van Nuys psychiatric facility. Station 2 (Van Nuys campus) There were fixtures throughout that could be used as anchor points to tie to that can hold a person□s weight throughout the unit; including pendant sprinkler heads, grab bars, shower handles, soap dishes, exposed plumbing pipes (water supply to toilet, sink drain line and condensation line), standard faucets, vents, mortise hinges and self-closing door arms. 20. Patient Room bathrooms, including those in Rooms 203, 205, 207, 209, 210, 211, 212, 213, 214,215,216,217,218,219,220,222,226, had fixtures that could be used as anchors including grab bars, exposed plumbing pipes, standard faucets and mortise hinges. 21. Patient Room bathrooms, including those in Rooms 203, 205, 207, 209, 210, 211, 212, 213, 214,215,216,217,218,219,220,222,226,had locksets on the bathroom doors that were lockable from the inside and required an emergency key to unlock from the outside. During a interviews of two registered nurses (RN) at Unit 2 nurses Station, RN 23 stated we don□t have the pin (emergency key) and RN 24 stated I	A 701	(Continued from page 118) **Date of Implementation:** 3/14/2014 **Monitoring Process:** All doors & locks throughout the hospital are checked 3 times a day by security. **Person Responsible**: Director of Engineering **18) Corrective Actions:** The overgrown live vegetation and accumulation of dry vegetation next to Unit 2 patio was cleaned up and trimmed by gardener in March 27, 2014. It will be monitored and maintained by the gardener during routine weekly service as well as during EOC rounds monthly. **Date of Implementation:** 3/27/2014 **Monitoring Process:** The live and dry vegetation will be monitored and maintained by the gardener during routine weekly service as well as during EOC rounds monthly. **Person Responsible:** Director of Engineering **20) Corrective Actions:** Patient room bathrooms, 203, 205, 207, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 222, and 226 grab bars were removed. Only the grab bar in room 226, an ADA accessible room, was replaced with an anti-ligature grab bar. Grab bars in other patient bathrooms will not be replaced. The exposed plumbing pipes in patient room bathrooms, 203, 205, 207, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 222, and 226 will be covered with stainless steel flush valve vandal resistant covers and p-trap covers. The standard faucets in patient room bathrooms, 203, 205, 207, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 222, and 226 were replaced with anti-ligature faucets. All accessible mortise hinges that could be used as anchors by patients will be replaced with anti-ligature continuous hinges. **Date of Implementation:** Patient room bathrooms, 203, 205, 207, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 222, and 226 grab bars were removed on 4/21/2014. Planned replacement of anti-ligature grab bar for room 226, an ADA accessible room, was completed on 8/16/2014. The exposed plumbing pipes in patient room bathrooms, 203, 205, 207, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 222, and 226 will be covered by stainless steel flush valve vandal resistant covers to be installed by September 26, 2014; P-trap covers will be installed by September 12, 2014. The standard faucets in patient room bathrooms, 203, 205, 207, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 222, and 226 were replaced with anti-ligature faucets on August 19, 2014. All accessible mortise hinges that could be used as anchors by patients will be replaced with anti-ligature continuous hinges by September 26, 2014. **Monitoring Process**: Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted to ensure patient safety. Once anti-ligature safety features are complete, engineering will monitor via weekly EOC rounds to ensure a safe environment is maintained. **Person Responsible:** Director of Engineering **21)Corrective Actions:** New Push and Pull latch (GYLNN□Johnson) door handles will be installed for patient bathrooms 203, 205, 207, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 222, and 226. **Date of Implementation:** New Push and Pull latch (GYLNN□Johnson) door handles will be installed for patient bathrooms 203, 205, 207, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 222, and 226 by September 14, 2014. **Monitoring Process:** Engineering will monitor via weekly EOC rounds to ensure proper operation of door handles. **Person Responsible:** Director of Engineering	3/14/2014 3/27/2014 8/16/2014 8/19/2014 9/26/2014 9/14/2014

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A 701	Continued From page 119 don□t know where the pin is. 22. Retention clips were missing from the anti-ligature type ceiling sprinkler heads in Rooms 203,207 209,211,213,222,226 and in the medication room. The missing retaining clips caused the escutcheons to drop one inch from the ceiling exposing the sprinkler pipes that could be used as anchors. The anti-ligature type ceiling sprinkler head in Room 211 had expanding foam between the top of the escutcheon and the ceiling. During an interview the Director of Facilities stated "that's the wrong way to fix it, should have a ring (retention clip)". 23. Room 211 had a loose sink with dislodged caulking and a half inch space between the sink and the wall. 24. Room 213 had a loose toilet. 25. Room 215 had a loose toilet and a 4 foot by 2 foot area of corroded and water damaged ceiling above the doorway. 26. Room 216 had the door handle rosette pulled away from the bathroom side of the bathroom door creating a space between the rosette and the door that could be used as an anchor. 27. Room 205 had a loose exhaust fan cover with a half in gap between the cover and the ceiling. 28. Room 222 had a missing handle at the bathroom sink faucet exposing the valve stem and had a missing anchor bolt cap at the toilet. 29. The shaving room had standard faucet that could be used as an anchor.	A 701	(Continued from page 119) **22) Corrective Actions:** The retention clips missing from the anti-ligature type sprinkler in room 203, 207, 209, 211, 213, 222, 226, and medication room were replaced on April 20, 2014 by Engineering. A hospital-wide review and facility tour of all sprinklers in patient rooms and will be monitored during routine cleaning of sprinkler heads. In room 211 the anti-ligature type ceiling that had expanded foam between the top of the escutcheon and the ceiling was cleaned on March 27, 2014 by Engineering. **Date of Implementation:** 4/20/14 **Monitoring Process:** All sprinklers in patient rooms and will be monitored during routine cleaning of sprinkler heads. **Person Responsible:** Director of Engineering **23) Corrective Actions:** The sink in room 211 was removed and re-installed on the wall, secured, patched and sealed with white caulking by engineering on March 24, 2014. A hospital-wide review and facility tour made to ensure all sinks are secured and will be monitored in the EOC rounds daily by nursing staff. **Date of Implementation**: 3/24/14 **Monitoring Process:** All patient sinks will be monitored in the EOC rounds daily by nursing staff**.** **Person Responsible:** ACNO & Director of Engineering **24) Corrective Actions:** The toilet in room 213 secured with new screws on March 27, 2014. A hospital-wide review and facility tour made to ensure all toilets are secured and will be monitored in the EOC rounds daily by nursing staff. **Date of Implementation:** 3/24/14 **Monitoring Process**: All patient toilets are secured and will be monitored in the EOC rounds daily by nursing staff**.** **Person Responsible:** ACNO & Director of Engineering **25) Corrective Actions**: The toilet in room 213 secured with new screws on March 24, 2014 by Engineering. A hospital-wide review and facility tour made to ensure all toilets are secured and will be monitored in the EOC rounds daily by nursing staff. The 4 foot by 2 foot area of corroded and water damaged ceiling above the doorway was repaired on March 28, 2014. A hospital-wide review and facility tour made to ensure all toilets are secured and will be monitored in the EOC rounds daily by nursing staff. **Date of Implementation:** 3/24/14 **Monitoring Process:** All patient toilets will be monitored in the EOC rounds daily by nursing staff. All ceilings in patient rooms are to be monitored for any stains in the EOC rounds by nursing staff**.** **Person Responsible:** ACNO & Director of Engineering **26) Corrective Actions**: The door handle rosette from the bathroom side in room 216 that created a space between the rosette and door was repaired and the lock was replaced on March 28, 2014. **Date of Implementation:** 3/28/14 **Monitoring Process:** All patient doors to be monitored in the EOC rounds daily by nursing. **Person Responsible:** ACNO & Director of Engineering **27) Corrective Actions:** The loose exhaust fan cover gap between the cover and the ceiling in Room 205 was replaced and that corrected the problem. A hospital-wide review and facility tour made to ensure all fan covers are secured and will be monitored in the EOC rounds daily by nursing staff. **Date of Implementation:** 3/24/14 **Monitoring Process:** All fan covers are secured and will be monitored in the EOC rounds daily by nursing. **Person Responsible:** ACNO & Director of Engineering **28) Corrective Actions:** The missing handle on the bathroom room 222 exposing the valve stem and sink were replaced on March 25, 2014 by maintenance. The anchor bold cap was replaced on the toilet in room 222 on March 25, 2014. A hospital-wide review and facility tour made to ensure all toilet caps are secured on all toilets and will be monitored in the EOC rounds daily by nursing staff. **Date of Implementation:** 3/25/14 **Monitoring Process:** All patient room doors and toilets will be monitored through the EOC rounds daily by nursing**.** **Person Responsible:** ACNO & Director of Engineering	4/20/2014 3/24/14 3/24/2014 3/24/2014 3/28/2014 3/24/2014 3/25/2014

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	050135	S. BUILDING **01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD** T. WING _____	**04/01/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, □IP CODE
SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	**6245 DE LONGPRE AVE HOLLYWOOD, CA 90028**

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A 701	Continued From page 120 30. The observation room had a metal bed frame with a painted plywood board in it used as a mattress support. The plywood board could be removed from the bedframe without the need of tools which would leave the metal frame that could be used as an anchor. Also plywood is an absorbent material that is not easily cleaned and disinfected. 31. Shower Rooms 1, 2 and 3 had a grab bars that could be used as an anchors. 32. The hose for use in Shower Room 2 could not be found. Shower room 2 had a quick connect bib at the shower stall. During an interview, Staff 6 (director of facilities) stated the bib was used to connect a hose that is used by nursing in the shower when a patient is very dirty. Staff 6 stated that he did not know where the hose was but would ask the nursing staff. By the end of the survey the Staff 6 stated that the nursing staff did not know where the hose was. The shower hose could be used to tie onto an anchor point. 33. There were pendent type sprinkler heads throughout the corridor and in the recreation room. 34. There was an accumulation of dirt on the agitator and tub of the laundry room washing machine. Culver City Campus 6th floor Pavilion There were anchor points within the patient's	A 701	(Continued from page 120) **29) Corrective Actions:** The standard faucet in the shaving room was replaced with an anti-ligature faucet. **Date of Implementation:** The standard faucet in the shaving room was replaced with an anti-ligature faucet on August 19, 2014. **Monitoring Process:** Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted to ensure patient safety. Once anti-ligature safety features are complete, engineering will monitor via weekly EOC rounds to ensure a safe environment is maintained. **Person Responsible:** Director of Engineering & ACNO **30) Corrective Actions**: The observation room metal bed frame was replaced with plastic bed on April 21, 2014. The plastic bed is cleaned and disinfected daily. **Date of Implementation:** 4/21/14 **Monitoring Process:** Cleanliness will be monitored during routine cleaning of beds done daily by nursing staff and EVS. **Person Responsible:** ACNO & Director of Engineering **31) Corrective Actions:** The grab bars from shower room numbers 1, 2 and 3 were removed and replaced with anti-ligature grab bars. **Date of Implementation**: The grab bars from shower room numbers 1, 2 and 3 were removed and replaced with anti-ligature grab bars on March 30, 2014. **Monitoring Process:** Engineering will monitor via weekly EOC rounds to ensure a safe environment is maintained. **Person Responsible:** Director of Engineering & ACNO **32) Corrective Actions**: The hose from shower room 2 was located in the engineering shop awaiting repair. The shower hose will be kept and locked in the nursing office when not in use. The nurse will check the hose out for use. No hose will be left in the shower room unattended. An in-service will be provided to staff to reiterate proper safety precautions. **Date of Implementation:** The replacement hose will arrive August 21, 2014. The process of checking the hose out for use will be implemented on August 21, 2014. An in-service will be scheduled on August 21, 2014. **Monitoring Process:** A sign-out sheet will be used to monitor the hose usage and a □check for loose equipment□item will be added to the daily nursing checklists used for monitoring patient care areas. **Person Responsible:** ACNO, Nursing Supervisor and Charge Nurse **33) Corrective Actions** All pendent type sprinkler heads located throughout all corridors and the recreation room have been removed and replaced with Recessed Sprinkler heads by Mid-Valley Automatic Fire System, Inc. **Date of Implementation:** All pendent type sprinkler heads located throughout all corridors and the recreation room have been removed and replaced with Recessed Sprinkler heads by Mid-Valley Automatic Fire System, Inc. completed July 11, 2014. **Monitoring Process:** Engineering will monitor integrity of the recessed sprinkler heads via weekly EOC rounds. EOC rounds are planned to be ongoing to ensure a safe environment is maintained. Monitoring of fire sprinklers will also be part of the Annual Sprinkler Testing Evaluation. **Person Responsible:** Director of Engineering **34) Corrective Actions:** The accumulation of dirt on the agitator and tub of the laundry room washing machine was cleaned and disinfected on 3/24/14 by EVS. New washing machine delivered 6/19/14. Routine daily cleanliness to be monitored by mental health workers and EVS. **Date of Implementation:** 6/19/14 New washing machine delivered **Monitoring Process:** Routine daily cleaning by mental health worker and EVS. **Person Responsible:** ACNO & Director of Engineering	8/19/2014 4/21/2014 3/30/2014 8/21/2014 7/11/2014 6/19/2014

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A 701	Continued From page 121 environment and areas accessible to the patient that could be used to tie to that could hold a person□s weight, including mortise hinges & standard faucets throughout. 6th floor Unit A Psychiatric On March 26, 2014 between the time of 10:00 a.m. and 11:15 a.m. the following conditions existed in 6th floor Psychiatric Unit A. 35. Room 602 had burn (arching) marks at the electrical receptacle by the sink, there was damaged plaster the length of one foot at the corner by the bathroom, and there was blistering at the wall along the wall coving by the sink. 36. Room 604 had the door of the night stand hanging loose, and there was an accumulation of dust on the ceiling curtain rails. 37. Room 605 had a 4 inch by 4 inch area of water damage at the bathroom ceiling that included blistering of the paint. 38. Room 606 water damage around the window and at the ceiling that included blistering of the paint, had a broken soap dispenser, and had a loose air conditioning control that was pulled away from the wall by bed C. 39. Room 607 had an accumulation of dust below the air supply, above and on the side of the bathroom door, above the wall mounted light fixture, and had blistering at the corner of a wall by bed B. 40. Room 608 a 2 foot by 4 foot area of water damage at the ceiling above bed B and 2 feet	A 701	(Continued from page 121) **CULVER CITY CAMPUS (6th Floor Pavilion – Unit A)** **35) Corrective Actions:** The electrical receptacle by the sink in Room 602 in the Psych unit was replaced by Engineering on April 4, 2014. The damaged wall was repaired also on April 4, 2014. **Date of Implementation:** Electrical receptacle replaced on April 4, 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas including psych. **Person Responsible:** Director of Engineering **36) Corrective Actions:** The night stand was replaced with a new night stand by Engineering. Upon review of P&P, staff was in-serviced and high dusting was performed on the ceiling curtain rails. **Date of Implementation:** The night stand was replaced on June 19, 2014. High dusting was performed on March 26, 2014, when the room became available. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering & Director of EVS. **37) Corrective Actions:** The water damage at the bathroom ceiling, including blistering of paint, was repaired by Engineering on April 4, 2014. **Date of Implementation:** The water damage at the bathroom ceiling, including blistering of paint, was repaired on April 4, 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas including psych. **Person Responsible:** Director of Engineering **38) Corrective Actions:** The water damage around the window and the AC control switch in room 606 were repaired by Engineering on April 4, 2014. The hand soap dispenser will be replaced in June 2014. **Date of Implementation:** The water damage around the window and the AC control switch in room 606 were repaired by on April 4, 2014. The hand soap dispenser will be replaced in June 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas including psych. **Person Responsible:** Director of Engineering. **39) Corrective Actions:** The water damage along wall near window was repaired by Engineering on April 4, 2014. Dust accumulation in patient rooms was addressed by EVS. Daily rounding is conducted to monitor cleanliness. Deep cleaning is done in patient rooms in the Psych Unit bimonthly. **Date of Implementation:** The water damage along wall near window was repaired on April 4, 2014. Dust accumulation in patient rooms was addressed by EVS immediately on March 26, 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas including psych. Daily rounding is conducted by EVS to monitor cleanliness. Deep cleaning is done in patient rooms in the Psych Unit bimonthly. **Person Responsible:** Director of Engineering & Director of EVS **40) Corrective Actions:** The water damage at the ceiling area Room 608 above bed B and at the area 2 feet along the wall by window of bed B was repaired by Engineering on April 4, 2014. **Date of Implementation**: The water damage at the ceiling area above bed B and at the area 2 feet along the wall by window of bed B was repaired on April 4, 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas including psych. **Person Responsible:** Director of Engineering.	4/4/2014 3/26/2014 6/19/2014 4/4/2014 4/4/2014 6/30/2014 3/26/2014 4/4/2014 4/4/2014

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A 701	Continued From page 122 along the wall by window of bed B. 41. Room 609 had an exposed drain pipe (P-trap) under the sink that could be used as an anchor, and the wall was cracked near the bottom edge of the window by bed B. 42. Shower room 1 had a make-shift safety grab bar. The grab bar had two 2 inch by 1/4 inch spaces between the bar & plate that could be used to tie to. The shower room also had a blistered wall and a missing wall tile. 43. Shower Room 4 had a shower head with a 5 foot hose in it. During an interview at the same time as the observation Staff S (director of the psychiatric unit) stated the hand shower was suppose to remain in the shower because patients can only come in with staff and staff remain during the shower. Review of the hospital's policy titled Standards of Care (Number BHU.064) with an effective date of July 1998 indicated the handheld shower is available for patients who need assistance, the showerheads are held in the medication room on the open unit and are monitored by means of a sign in/out sheet. Staff S was asked to provide a copy of the sign in/out sheet for that included the hand held shower sign out for March 26, 2014. By the end of the survey a copy of or any evidence of the sign in/out sheet was not provided. 44. Shower Room 5 had an accumulation of mold on two of the walls.	A 701	(Continued from page 122) **41) Corrective Actions:** The exposed drain pipe will be covered with a p trap cover. The crack on the wall was repaired by Engineering. **Date of Implementation:** The exposed drain pipe will be covered with a p trap cover by September 19, 2014. The crack on the wall was repaired on April 4, 2014. **Monitoring Process:** Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted at 30-minute intervals to ensure patient safety. Criteria to monitor that integrity of p-trap covers are in place will be added to the Behavioral Safety Rounds sheets, and will be surveyed on a weekly basis. be added to the Behavioral Safety Rounds sheets, and will be surveyed on a weekly basis. Engineering to conduct weekly rounding for routine maintenance repairs in the Psych Unit. **Person Responsible:** Director of Engineering, Director of Behavioral Health **42) Corrective Actions:** Hang-proof grab bars will be purchased and installed in Shower Room □1 and wall damage will be repaired by Engineering scheduled for completion in June 2014. **Date of Implementation:** Hang-proof grab bars will be purchased and installed in Shower Room □1 and wall damage will be repaired in June 2014 or immediately upon receiving. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas including psych. **Person Responsible:** Director of Engineering. **43) Corrective Actions:** The removable shower head has been taken out and kept in the Nurse□s Station and is only re-installed by staff when or as needed. Re-educate of BHU nursing staff regarding monitoring the location (charge nurse office) and use of the hand held showerhead and the required signed in and out and must be visually monitored at all times to ensure patient safety. **Date of Implementation:** Completion of staff education 4/30/2014. **Monitoring Process:** The sign out /in sheet will be monitored by the charge nurse. The showers are monitored every shift by RN rounds. **Person Responsible:** BHU Nursing Leadership on BHU & Director of Engineering. **44) Corrective Actions**: Mold along back wall had been removed and water damage had been repaired in shower room □5 by Engineering on March 31, 2014. **Date of Implementation:** Mold along back wall had been removed and water damage had been repaired in shower room □5 on March 31, 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas including psych. Person Responsible: Director of Engineering.	4/4/2014 9/19/2014 6/30/2014 4/30/2014 3/31/2014

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A 701	Continued From page 123 45. There was a damaged phone cubicle exposing two 2 inch by 1 inch spaces between the metal frame & the metal shelve of the cubicle that could be used as an anchor. 46. There were three loose hand rails at corridor under pay phone by supply room, by secretary office, and by the laundry room. 47. There was a chair with torn upholstery exposing the padding underneath at the pay phone area. 48. There was a broken light diffuser at station kitchen. 49. There was a water damaged ceiling tile at the corridor of the doctors consultation area. 50. There was a sign of water damage at the ceiling of the 6th floor southwest stairway landing. 6th floor Unit B Psychiatric On March 26, 2014 between the time of 11:15 a.m. and 12:12 p.m. the following conditions existed in 6th floor Psychiatric Unit B. 51. Room 622 had a urine stained wall next to toilet, and burn (arching) marks at the electrical receptacle next to the sink. 52. Room 625 had an accumulation of dust at the ceiling light fixture. 53. Room 624 had a small flying insect in it.	A 701	(Continued from page 123) **45) Corrective Actions:** The phone booth shelf on Pavilion 6 was removed by Engineering on April 7, 2014. **Date of Implementation:** The phone booth shelf on Pavilion 6 was removed on April 7, 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas including psych. **Person Responsible**: Director of Engineering. **46) Corrective Actions:** The hand rails were re-secured at corridor by Engineering on April 4, 2014. **Date of Implementation:** The hand rails were re-secured at corridor on April 4, 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas including psych. **Person Responsible:** Director of Engineering. **47) Corrective Actions:** The torn chair was removed by Engineering immediately on March 26, 2014. **Date of Implementation:** The torn chair was removed immediately on March 26, 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas including psych. **Person Responsible:** Director of Engineering. **48) Corrective Actions:** The broken light diffuser at the station kitchen was replaced on June 18, 2014. **Date of Implementation:** The broken light diffuser at the station kitchen will be replaced in June 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas including psych. **Person Responsible:** Director of Engineering. **49) Corrective Actions:** The ceiling tile at the corridor of the doctor□s consultation area was replaced by Engineering on April 4, 2014. **Date of Implementation:** The ceiling tile at the corridor of the doctor□s consultation area was replaced on April 4, 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas including psych. **Person Responsible:** Director of Engineering. **50) Corrective Actions:** The sign of water damage at the ceiling of the southwest stairway landing was investigated by the Director of Engineering. Minor repairs were conducted on June 18, 2014 although no leaks were noted or identified. **Date of Implementation:** Minor repairs were conducted on June 18, 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas including psych. **Person Responsible:** Director of Engineering **51). Corrective Actions:** Urine stain on the wall in room 622 was cleaned by EVS then repainted. The electrical receptacle next to the sink was replaced by Engineering on April 15, 2014. **Date of Implementation:** April 15, 2014 **Monitoring Process:** Daily rounding is conducted by EVS to monitor cleanliness. Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible**: Director of EVS and Director of Engineering **52). Corrective Actions:** Dust accumulation was addressed immediately by EVS. Daily rounding is conducted to monitor cleanliness. Deep cleaning is done in Psych Unit patient rooms bimonthly. **Date of Implementation:** March 26, 2014 **Monitoring Process:** Daily rounding is conducted by EVS to monitor for cleanliness. **Person Responsible:** Director of EVS	4/7/2014 4/4/2014 3/26/2014 6/30/2014 4/4/2014 6/18/2014 4/15/2014 3/26/2014

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A 701	Continued From page 124 54. Room 627 had exposed plumbing pipe (P-trap) under the sink that could be used as an anchor, a blistered water damaged wall under the sink, and laminate pulled away from the base of the closet. 55. Room 628 had burn (arching) marks and a metal bolt in the ground slot of the electrical receptacle next to the sink, had a plastic tube in the ground slot of an emergency power receptacle and the tooth of a comb in another slot of the same receptacle, and was missing soap dispenser. 56. Room 629 had a strong urine odor and urine on the floor in the bathroom, and had wall caving pulled away from the wall next to the bathroom. 57. The men's common bathroom by day room had a standard faucet and an exposed plumbing pipe (P-trap) under the sink that could be used as an anchor. The bathroom also had strong urine odor. 58. The day room had an accumulation of dust around the air supply registers and at 8 foot by 3 foot ceiling areas on both sides of the room. There was also 2 inch by inch area of damage at the wall by the entrance to the room. 59. There were two loose hand rails at the wall by the water fountain and by the phone near the day room. 60. There a piece of broken wall caving with a sharp edge at the corridor between Rooms 622 and 623. 6th floor Unit C	A 701	(Continued from page 124) **53). Corrective Actions:** Steritech, a Pest control company, came on April 7 & 11, 2014 to address small flying insects in room 624. The pest control company also did visual inspection of the whole unit. **Date of Implementation:** April 7 (inspection) and April 11 (work performed) — 4/7/2014 **Monitoring Process:** Daily rounding is conducted by EVS to monitor cleanliness. **Person Responsible:** Director of EVS **54). Corrective Actions:** The water damage in room 627 will be repaired by Engineering in June 2014. The p-trap cover (under sink enclosure) will be purchased and installed in June 2014 or immediately upon receiving them. — 6/30/2014 **Date of Implementation**: June 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **55). Corrective Actions:** The electrical receptacle next to the sink in room 628 was replaced by Engineering on April 15, 2014. The hand soap dispenser was replaced by Engineering on June 18, 2014. **Date of Implementation:** April 15 and June 18, 2014, respectively — 4/15/2014 6/18/2014 **Monitoring Process**: Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible**: Director of Engineering **56). Corrective Actions:** Deep cleaning was performed in Room 629 to address the strong urine odor. The wall coving was replaced on April 7, 2014. **Date of Implementation**: April 7, 2014 — 4/7/2014 **Monitoring Process:** Daily rounding is conducted by EVS to monitor cleanliness. Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of EVS and Director of Engineering **57). Corrective Actions:** Ligature-proof faucets and p-trap cover will be purchased and installed in June 2014 or immediately upon receiving them. Deep cleaning was performed in the men□s common bathroom by EVS to address the strong urine odor. **Date of Implementation:** June 2014 or immediately upon receiving parts. — 6/30/2014 **Monitoring Process:** Daily rounding is conducted by EVS to monitor cleanliness. Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of EVS and Director of Engineering **58). Corrective Actions:** The wall damage at the entrance in the day room was repaired by Engineering. Upon review of P&P, staff was in-serviced and high dusting was performed in the day room around the air supply registers and ceiling area. **Date of Implementation:** The wall damage was repaired on April 30, 2014. High dusting was performed on March 26, 2014, when the room became available. — 3/26/2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. Daily rounding is conducted by EVS in the Psych Unit. Deep cleaning is done in the Psych Unit bimonthly. A dusting calendar is kept to ensure every patient room is dusted, starting in the Psych Unit then house-wide. In addition, EOC Rounding is conducted routinely, covering patient care areas, twice a year and as needed. **Person Responsible**: Director of Engineering & Director of EVS **59). Corrective Actions:** The loose hand rails at the wall by the water fountain and phone were repaired by Engineering on April 4, 2014. **Date of Implementation**: April 4, 2014 — 4/4/2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **60). Corrective Actions:** The broken wall coving at the corridor between rooms 622 and 623 will be repaired in June 2014. — 6/30/2014 **Date of Implementation:** June 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014.	

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A 701	Continued From page 125 On March 26, 2014 between the time of 12:12 p.m. and 12:40 p.m. the following conditions existed in 6th floor psychiatric unit C. 61. Room 630 had a standard faucet that could be used as an anchor, and there was a piece of wall caving missing from behind the bed. During an interview at the same time of the observation the director of engineering stated that all the rooms had standard faucets. 62. Room 631 had burn (arching) marks at the electrical receptacle next to the sink, and there were pieces of porcelain missing from the sink. 63. Room 632 had worn flooring exposing the sub-flooring. 64. Room 634 had had a standard faucet and exposed plumbing (P-trap) that could be used as an anchor, and had a strong urine odor. 65. Room 635 had had a standard faucet and exposed plumbing (P-trap) that could be used as an anchor. 66. Room 636 (seclusion room) had an accumulation of dirt around foot of the bed. 67. Room 639 had had a standard faucet and exposed plumbing (P-trap) that could be used as an anchor, and had a strong urine odor. 68. The recreation room had a standard faucet and exposed plumbing (P-trap) that could be used as an anchor, and had an accumulation of dust at the wall mounted light fixture.	A 701	(Continued from page 125) **Person Responsible**: Director of Engineering **CULVER CITY CAMPUS (6th Floor Pavilion – Unit C)** **61). Corrective Actions:** The ligature-proof faucet will be purchased and installed in June 2014 or immediately upon arrival. The wall coving in room 630 was replaced by Engineering on June 18, 2014. **Date of Implementation:** June 18, 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **62). Corrective Actions:** In room 631, the electrical receptacle was replaced on April 14, 2014 and porcelain sink was replaced by Engineering on June 18 2014. **Date of Implementation:** April 14, 2014 and June 18, 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible**: Director of Engineering **63). Corrective Actions:** The flooring in room 632 will be repaired by Engineering in June 2014. **Date of Implementation:** June 2014 **Monitoring Process**: Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible**: Director of Engineering **64). Corrective Actions**: The standard faucet in the patient bathroom will be replaced with anti-ligature faucet. The exposed drain pipe will be covered with a p trap covers. Room cleaning was performed in Room 634 immediately on March 26, 2014 by EVS to address the strong urine odor. **Date of Implementation:** The standard faucet in the patient bathroom will be replaced with anti-ligature faucet by September 19, 2014. The exposed drain pipe will be covered with a p trap cover by September 19, 2014. Deep cleaning was performed on March 26, 2014. **Monitoring Process:** Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted at 30-minute intervals to ensure patient safety. Criteria to monitor that integrity of anti-ligature faucets and p-trap covers are in place will be added to the Behavioral Safety Rounds sheets, and will be surveyed on a weekly basis. EVS to conduct daily routine at high-touched areas and restrooms. EVS also conducts discharge cleaning by performing daily cleaning routine and thorough cleaning of beds and mattresses, including high dusting. **Person Responsible**: Director of EVS, Director of Behavioral Health, Director of Engineering **65). Corrective Actions:** The standard faucet in the patient bathroom will be replaced with anti-ligature faucet. The exposed drain pipe will be covered with a p trap cover. **Date of Implementation:** The standard faucet in the patient bathroom will be replaced with anti-ligature faucet by September 19, 2014. The exposed drain pipe will be covered with a p trap cover by September 19, 2014. **Monitoring Process:** Engineering to conduct weekly rounding. Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted at 30-minute intervals to ensure patient safety. Criteria to monitor that integrity of anti-ligature faucets and p-trap covers are in place will be added to the Behavioral Safety Rounds sheets, and will be surveyed on a weekly basis. **Person Responsible:** Director of Engineering, Director of Behavioral Health **66). Corrective Actions:** EVS addressed the dirt accumulation in room 636 on March 29, 2014. Daily rounding is conducted to monitor cleanliness. Deep cleaning is done in patient rooms in the Psych Unit bimonthly. **Date of Implementation:** March 29, 2014 **Monitoring Process:** Daily rounding is conducted by EVS to monitor cleanliness. **Person Responsible**: Director of EVS **67). Corrective Actions:** The standard faucet in the patient bathroom will be replaced with anti-ligature faucet. The exposed drain pipe will be covered with a p trap cover. Deep cleaning was performed in Room 639 immediately on March 26, 2014 by EVS to address the strong urine odor. **Date of Implementation** The standard faucet in the patient bathroom will be replaced with anti-ligature faucet by September 19, 2014. The exposed drain pipe will be covered with a p trap cover by September 19, 2014. Deep cleaning was performed on March 26, 2014. **Monitoring Process:** Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted at 30-minute intervals to ensure patient safety. Criteria to monitor that integrity of anti-ligature faucets and p-trap covers are in place will be added to the Behavioral Safety Rounds sheets, and will be surveyed on a weekly basis.	6/18/2014 4/14/2014 6/18/2014 6/30/2014 3/26/2014 9/19/2014 9/19/2014 3/29/2014 3/26/2014 9/19/2014

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	050135	U. BUILDING **01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD** V. WING _____	**04/01/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, □IP CODE
SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	**6245 DE LONGPRE AVE HOLLYWOOD, CA 90028**

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A 701	Continued From page 126 69. The light missing in the patient food refrigerator at the nurses station. 6th floor Unit D 70. On March 26, 2014 between the times of 12:40 p.m. and 2:25 p.m. the following conditions existed in 6th floor psychiatric unit D. 71. Room 612 had a water damaged blistered wall under the sink, and had a small flying insect in the room. 72. Room 614 had had a standard faucet and exposed plumbing (P-trap) that could be used as an anchor. 73. Room 615 had had a standard faucet that could be used as an anchor, and had a small flying insect the room. 74. Room 616 had had a standard faucet and exposed plumbing (P-trap) that could be used as an anchor. There was also missing wall caving by the bathroom. 75. Room 617 had a standard faucet and exposed plumbing (P-trap) that could be used as an anchor, and a also had a broken soap dispenser. 76. Room 619 had a standard faucet and exposed plumbing (P-trap) that could be used as an anchor, and also had two drawers missing from a night stand. 77. Room 620 had a standard faucet and	A 701	(Continued from page 126) EVS to conduct daily routine at high-touched areas and restrooms. EVS also conducts discharge cleaning by performing daily cleaning routine and thorough cleaning of beds and mattresses, including high dusting. **Person Responsible:** Director of EVS, Director of Behavioral Health, Director of Engineering **68). Corrective Actions:** The standard faucet in the bathroom will be replaced with anti-ligature faucet. The exposed drain pipe will be covered with a p trap cover. Deep cleaning was performed by EVS in the recreation room to remove dust. **Date of Implementation:** The standard faucet in the patient bathroom will be replaced with anti-ligature faucet by September 19, 2014. The exposed drain pipe will be covered with a p trap cover by September 19, 2014. Deep cleaning was performed on March 26, 2014. **Monitoring Process:** Engineering to conduct weekly rounding for routine maintenance repairs in the Psych Unit. Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted at 30-minute intervals to ensure patient safety. Criteria to monitor that integrity of anti-ligature faucets and p-trap covers are in place will be added to the Behavioral Safety Rounds sheets, and will be surveyed on a weekly basis. Daily rounding is conducted by EVS in the Psych Unit. Deep cleaning is done in patient rooms in the Psych Unit bimonthly. In addition, EOC Rounding is conducted weekly covering patient areas twice a year. **Person Responsible**: Director of EVS, Director of Behavioral Health, Director of Engineering **69). Corrective Actions:** The light bulb in the patient food refrigerator at the nurse's station was replaced by Engineering on April 10, 2014. **Date of Implementation:** April 10, 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **CULVER CITY CAMPUS (6th Floor Pavilion – Unit D** **71). Corrective Actions:** Steritech, pest control, came on April 7 and 11, 2014 to address small flying insects in room 612. The pest control company also did visual inspection of entire unit. Water damage will be repaired in June 2014 by Engineering. Infection Control was notified of the insects in room 612. (A copy of the service report is attached) **Date of Implementation:** April 11, 2014 (pest control) / June 2014 (water damage) **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. Daily rounding is conducted by EVS to monitor cleanliness. **Person Responsible:** Director of EVS and Director of Engineering **72). Corrective Actions:** The standard faucet in the patient bathroom was replaced with anti-ligature faucet. The exposed drain pipe will be covered with a p trap cover. **Date of Implementation:** The standard faucet in the patient bathroom was replaced with anti-ligature faucet on August 19, 2014. The exposed drain pipe will be covered with a p trap cover by September 19, 2014. **Monitoring Process**: Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted at 30-minute intervals to ensure patient safety. Criteria to monitor that integrity of anti-ligature faucets and p-trap covers are in place will be added to the Behavioral Safety Rounds sheets, and will be surveyed on a weekly basis. **Person Responsible:** Director of Engineering, Director of Behavioral Health **73). Corrective Actions:** The standard faucet in the patient bathroom was replaced with anti-ligature faucet. Source of insects, e.g. food tray, was removed from the room by Nursing staff. Steritech, pest control, came on April 7 and 11, 2014 and got rid of small flying insects in room 615. The pest control company also did visual inspection of the entire unit. **Date of Implementation:** The standard faucet in the patient bathroom was replaced with anti-ligature faucet on August 19, 2014. Steritech completed work on April 11, 2014 (pest control). **Monitoring Process:** Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted at 30-minute intervals to ensure patient safety. Criteria to monitor that integrity of anti-ligature faucets and p-trap covers are in place will be added to the Behavioral Safety Rounds sheets, and will be surveyed on a weekly basis. Food trays are brought by staff inside the rooms of Geropsych patients and any patient who is unable to get out of bed. Leftover food is removed by staff immediately after meal time. All the other patients are allowed to dine only in the activity/dining room. Pest control provider comes monthly for routine service at high-risk areas for insects/pests and is on call to areas requiring their service. **Person Responsible:** Director of EVS and Director of Engineering	3/26/2014 9/19/2014 4/10/2014 4/11/2014 6/30/2014 8/19/2014 9/19/2014 4/7/2014 8/19/2014

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A 701	Continued From page 127 exposed plumbing (P-trap) that could be used as an anchor, and also had a broken soap dispenser 78. Room 621 had a standard faucet and exposed plumbing (P-trap) that could be used as an anchor, and also had wall caving that was pulled away from the wall. 79. There were water stains at the ceiling tile of the corridor by Room 610. 80. There was an electric insence burner stuck to the floor between a file cabinet and a wall cabinet in the utility review office. Detox Unit 6th Floor Tower 81. On March 26, 2014 between 3:20 p.m. and 3:35a.m. the following conditions existed in the Detox unit. 82. There were braided nurse call cords that could not be easily cleaned throughout the unit including dirty call bell cords in Rooms 679, 680, and 681. 83. Room 679 had a loose flange at a grab bar. 84. Room 680 was missing a grab bar next to toilet. There were three % inch holes in the bathroom wall where the grab bar use to be. 85. At the east stairway there was plaster missing at the wall around a wet stand by pipe. 4th floor Pavilion	A 701	(Continued from page 127) **74). Corrective Actions:** Safety, anti-ligature faucets and p-trap covers have been ordered to replace all standard faucets and cover exposed plumbing, respectively. The missing wall coving was replaced. **Date of Implementation:** The replacement of standard faucets to safe, anti-ligature faucets is expected to be completed by November 28, 2014 and installation of p-trap covers is expected to be completed by October 31, 2014.The missing wall coving was replaced on June 30, 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **75). Corrective Actions**: The standard faucet in the patient bathroom was replaced with anti-ligature faucet. The exposed drain pipe will be covered with a p trap cover. The hand soap dispenser was replaced by Engineering. **Date of Implementation:** The standard faucet in the patient bathroom was replaced with anti-ligature faucet on August 19, 2014. The exposed drain pipe will be covered with a p trap cover by September 19, 2014. The hand soap dispenser was replaced on June 18, 2014. **Monitoring Process:** Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted at 30-minute intervals to ensure patient safety. Criteria to monitor that integrity of anti-ligature faucets and p-trap covers are in place will be added to the Behavioral Safety Rounds sheets, and will be surveyed on a weekly basis. Daily rounding is conducted by EVS in the Psych Unit. Deep cleaning is done in patient rooms in the Psych Unit bimonthly. In addition, EOC Rounding is conducted weekly covering patient areas twice a year. **Person Responsible:** Director of Engineering, Director of Behavioral Health, Director of EVS. **76). Corrective Actions:** The standard faucet in the patient bathroom was replaced with anti-ligature faucet. The exposed drain pipe will be covered with a p trap cover. The night stand was replaced with a new night stand by Engineering. **Date of Implementation:** The standard faucet in the patient bathroom was replaced with anti-ligature faucet on August 19, 2014. The exposed drain pipe will be covered with a p trap cover by September 19, 2014. The night stand was replaced on June 18, 2014. **Monitoring Process**: Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted at 30-minute intervals to ensure patient safety. Criteria to monitor that integrity of anti-ligature faucets and p-trap covers are in place will be added to the Behavioral Safety Rounds sheets, and will be surveyed on a weekly basis. **Person Responsible**: Director of Engineering, Director of Behavioral Health **77). Corrective Actions:** The standard faucet in the patient bathroom will be replaced with anti-ligature faucet. The exposed drain pipe will be covered with a p trap cover. The broken soap dispenser was replaced with a new soap dispenser by Engineering. **Date of Implementation:** The standard faucet in the patient bathroom will be replaced with anti-ligature faucet by September 19, 2014. The exposed drain pipe will be covered with a p trap cover by September 19, 2014. The broken soap dispenser was replaced on June 18, 2014. **Monitoring Process:** Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted at 30-minute intervals to ensure patient safety. Criteria to monitor that integrity of anti-ligature faucets and p-trap covers are in place will be added to the Behavioral Safety Rounds sheets, and will be surveyed on a weekly basis. **Person Responsible:** Director of Engineering, Director of Behavioral Health **78). Corrective Actions:** The standard faucet in the patient bathroom will be replaced with anti-ligature faucet. The exposed drain pipe will be covered with a p trap cover. The wall coving was repaired by Engineering. **Date of Implementation:** The standard faucet in the patient bathroom will be replaced with anti-ligature faucet by September 19, 2014. Exposed drain pipe will be covered with a p trap cover by September 19, 2014. The wall coving was repaired on June 21, 2014 by Engineering. **Monitoring Process:** Engineering to conduct weekly rounding for routine maintenance repairs in the Psych Unit. Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted at 30-minute intervals to ensure patient safety. Criteria to monitor that integrity of anti-ligature faucets and p-trap covers are in place will be added to the Behavioral Safety Rounds sheets, and will be surveyed on a weekly basis. Daily rounding is conducted by EVS in the Psych Unit. Deep cleaning is done in patient rooms in the Psych Unit bimonthly. In addition, EOC Rounding is conducted weekly covering patient areas twice a year. **Person Responsible:** Director of Engineering	6/30/2014 10/31/2014 11/28/2014 6/18/2014 8/19/2014 9/19/2014 6/18/2014 8/19/2014 9/19/2014 6/18/2014 8/19/2014 9/19/2014 6/21/2014 9/19/2014 6/18/2014

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A 701	Continued From page 128 4th floor Rehabilitation Unit On March 28, 2014 between 9:30a.m. and 10:45 a.m. the following conditions existed in 4th floor rehabilitation unit. 86. Room 401 had a sharps container that was filled above the fill line. 87. Room 406 had a broken & loose soap dispenser next to the sink. 88. Room 409 had a dirty braided nurse call cord next to the shower. 89. Room 423 had a broken diffuser at the wall mounted light fixture by the door. 90. In the physical therapy room there four oxygen cylinders with gauges on them. The needles of the gauges of three of the oxygen cylinders were in the red area that indicated □0□. During an interview at the same time as the observation, Registered Nurse (RN) 25 (charge nurse) stated the cylinders were for patient emergency use. 91. The common tub room had a torn shower curtain missing a 2 ft by 3 ft piece of the curtain. 92. In the clean supply room, there was a clean supplies cart that was not covered and a clean supplies cabinet with the doors fully open. During the observation a nurse walked in to the supply room obtained supplies and left without covering the cart or closing the cabinet doors. Supplies in the cart included tape, gauze, mouth swabs and Band-Aid.	A 701	(Continued from page 128) **79). Corrective Actions:** The ceiling tile within the corridor outside of Room 610 was replaced June 18, 2014 by Engineering. **Date of Implementation:** June 18, 2014 **Monitoring Process**: Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **80). Corrective Actions:** The electric incense burner was removed and staff was in-serviced on June 18, 2014. The sign-in sheet is attached herewith. **Date of Implementation:** June 18, 2014 **Monitoring Process:** Monitoring during Engineering daily rounding. **Person Responsible:** Director of Engineering **CULVER CITY CAMPUS (Tower 6 – Detox Unit)** **82) Corrective Actions:** A All braided nurse call cords in the Detox Unit were replaced with cleanable plastic cords by Engineering. **Date of Implementation:** All braided nurse call cords were replaced on April 22, 2014. **Monitoring Process:** Nurse call cords have been replaced with cleanable plastic cords house-wide. Criteria to monitor that the integrity of the cleanable, plastic cords are in place, will be added to the EOC Rounds sheets, and will be surveyed on a semi-annual basis. **Person Responsible**: Director of Engineering **83) Corrective Actions**: The loose flange of the grab bar in room 679 was re-secured by tightening the screws. **Date of Implementation:** The loose flange of the grab bar in room 679 was secured on June 18, 2014. **Monitoring Process:** Engineering to conduct weekly rounding for routine maintenance repairs in the Psych Unit. **Person Responsible:** Director of Engineering **84) Corrective Actions:** The grab bar in room 680 was re-installed thereby covering holes on April 22, 2014 by Engineering. **Date of Implementation:** The grab bar in room 680 was re-installed thereby covering holes on April 22, 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas. **Person Responsible:** Director of Engineering **85) Corrective Actions**: The wall in East Stairway will be patched and repainted in June 2014 by Engineering. **Date of Implementation:** The wall in East Stairway will be patched and repainted in June 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas. **Person Responsible:** Director of Engineering **CULVER CITY CAMPUS (Pavilion 4 Rehabilitation Unit)** **86) Corrective Actions:** The sharps container in room 401 was removed and replaced on March 28, 2014 by EVS. EVS supervisor will in service staff to monitor sharps daily. **Date of Implementation:** The sharps container in room 401 was removed and replaced on March 28, 2014. **Monitoring Process:** Daily rounding is conducted by EVS to monitor cleanliness, including sharps container fill lines. **Person Responsible:** Director of EVS **87) Corrective Actions:** The hand soap dispenser in room 406 was replaced on April 4, 2014 by Engineering. **Date of Implementation:** The hand soap dispenser in room 406 was replaced on April 4, 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas. **Person Responsible**: Director of Engineering **88) Corrective Actions:** The nurse call pull cords have been replaced hospital-wide, including room 409, on April 2014 by Engineering. **Date of Implementation:** The nurse call pull cords have been replaced hospital-wide, including room 409, on April 4, 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas. **Person Responsible:** Director of Engineering **89) Corrective Actions**: The light diffuser in room 423 was replaced by Engineering. **Date of Implementation:** April 3, 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas. **Person Responsible:** Director of Engineering	6/18/2014 6/18/2014 4/22/2014 6/18/2014 4/22/2014 6/30/2014 3/28/2014 4/4/2014 4/4/2014 4/3/2014

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A 701	Continued From page 129 During an interview at the same time as the observation, AN 25 stated the cart was supposed to be covered and the cabinet doors were suppose to be closed. 93. The ice storage of ice machine in unit kitchen had a direct drain instead of an indirect drain (air gap). 94. At the construction separation between the back of the 4th floor and the rehabilitation unit at the front of the 4th floor, the plastic barrier in front of a gypsum board barrier was loose and separating from the drop down ceiling. Closer observation revealed there were also eight unsealed penetrations through the gypsum board barrier at the separation. During an interview Staff 5 (director of engineering) stated that besides being a dust barrier the gypsum board barrier is also suppose to be a fire barrier. 3rd floor Pavilion 3rd floor SICU On March 28, 2014 between the times of 10:45 a.m. and 11:20 a.m. the following conditions existed in 3rd floor SICU (surgical intensive care unit). 95. Room 332A had adhesive paper peeling off of the head wall mounted light fixture. 96. Room 332D had a towel taped onto a camera in the room. Further observation revealed that at the nurses station monitor the patients in the rest	A 701	(Continued from page 129) **90) Corrective Actions:** The oxygen tanks were immediately exchanged for full tanks. Charge nurses educated on use of Environment of Care Log to be completed every shift. This put in place to prevent oxygen tanks from being left empty in the Physical Therapy Room. Initial education completed to charge nurses on 6/19/2014 at 12:00pm. Education will be ongoing to ensure that all charge nurses will be aware. EOC charge nurse log will be kept on unit in separate binder at all times. **Date of Implementation:** 6/19/2014 **Monitoring Process:** Logs to reviewed weekly by Unit Director **Person Responsible:** Nursing Director **91) Corrective Actions:** The shower curtain in the common tub room was replaced by EVS. **Date of Implementation**: March 28, 2014. **Monitoring Process:** Daily rounding is conducted by EVS to monitor for cleanliness. **Person Responsible:** Director of EVS **92) Corrective Actions:** Linen cart cover was present but was not pulled down to provide coverage for the linen. The cover was pulled down and secured. Nursing education developed regarding ensuring cart covers are used and/or cabinet doors closed. **Date of Implementation**: Education started on June 19, 2014 with full implementation in 30 days. **Monitoring Process:** Infection Control Rounds **Person Responsible**: Nursing Director & Infection Control. **93) Corrective Actions**: Drain was redirected to an indirect drain line to provide air gap. **Date of Implementation:** Repairs will be completed by June 30, 2014. **Monitoring Process:** Engineering to conduct quarterly rounding, during performance of the Ice Machine Preventive Maintenance, to ensure integrity of the indirect drain line (air gap) is in place. **Person Responsible:** Director of Engineering **94) Corrective Actions:** Penetrations were sealed around pipes and joints using fire caulk, 3M-CP 25WB+, on the gypsum board barrier (dust barrier), at the construction separation between back of 4th floor and the Rehabilitation Unit on March 29, 2014 by Engineering. Below protocol will be complied: a) Contractors must train their employees in ILSM and provide documentation to the Director of Plant Operations/Safety Officer that this training has been accomplished. Documentation should include the subject matter covered, names of employees receiving the training, and the date the training was provided. In turn, the Director of Plant Operations will provide this documentation to the Chair of EOC. **Date of Implementation:** Penetrations were caulked on March 29, 2014. Protocol will be on going. **Monitoring Process:** During pre-construction meetings, the Director of Engineering will discuss the ILSM with the Contractor. Contractor is to sign on the copy of the ILSM for acknowledgment and agreement in compliance of fire penetrations **Person Responsible:** Director of Engineering **CULVER CITY CAMPUS (Pavilion 3 SICU)** **95).Corrective Actions:** The wall mounted light fixture in room 332A will be repaired in June 2014 by Engineering. **Date of Implementation:** June 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **96. Corrective Action:** Cameras placed on Charge RN daily environmental rounds to ensure their integrity. **Date of Implementation:** June 20, 2014 **Monitoring Process:** Charge RN Environmental Rounds Record**.** Data to be reviewed and aggregated by Nursing Director with report to Quality Dept. **Person Responsible:** Director of Engineering	6/19/2014 3/28/2014 6/19/2014 6/30/2014 3/29/2014 6/30/2014 6/20/2014

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A 701	Continued From page 130 of the unit□s rooms could be observed by the cameras except for Room 333D which had the view obstructed by the towel. During an interview, RN 26 (charge nurse) stated the the purpose of the cameras was to observe the patients for patient safety, she further stated that the patient did not request the towel to be placed over the camera and that she did not know why the towel was taped onto the camera or who taped onto the camera. 97. In Room 332G, there was a loose front panel of head wall mounted light fixture. 98. In the clean supply room, there was a clean supplies cart that was not covered and a clean supplies cabinet with the doors fully open. Supplies in the cart included suction tubing, yankawers, cath plugs, trach holders, suction cather kits, ball and trach care suction systems, tongue depressors and swab sticks. 3rd floor CCU On March 28, 2014 between the time of 11:20 a.m. and 11:50 a.m., the following conditions existed in 3rd floor CCU (critical care unit). 99. There was an accumulation of dust and a gray substance at ceiling of Rooms 333A, 333D, and 333E. 100. Room 333 F/G had six 1/2 inch diameter holes through the wall. 101. During an interview at the time of the observation, Staff 5 stated the holes were from a	A 701	(Continued from page 130) **97. Corrective Actions:** The wall mounted light fixture in room 332G will be repaired in June 2014 by Engineering. **Date of Implementation:** June 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **98. Corrective Actions:** Linen cart cover was present but was not pulled down to provide coverage for the linen. The cover was pulled down and secured. Nursing education developed regarding ensuring cart covers are used and/or cabinet doors closed. **Date of Implementation**: Education started on June 19, 2014 with full implementation in 30 days. **Monitoring Process:** Infection Control Rounds **Person Responsible:** Nursing Director & Infection Control. **CULVER CITY CAMPUS (Pavilion 3 CCU)** **99) Corrective Actions:** Upon review of P&P, staff was in-serviced and high dusting was performed in room nos. 333A, 333D and 333E by EVS. **Date of Implementation:** Dust in rooms 333A, 333D and 333E was removed on March 28, 2014, when the rooms became available. **Monitoring Process:** A dusting calendar is kept by EVS to ensure every patient room is dusted, commencing in the Psych unit and then house-wide. In addition, EOC Rounding is conducted routinely, covering patient areas, twice a year and as needed. **Person Responsible:** Director of Engineering **100-101) Corrective Actions:** Holes on wall were patched and painted in room 333, beds F&G, on April 7, 2014 by Engineering. **Date of Implementation:** Holes in the wall were patched and painted in room 333, beds F&G, on April 7, 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas. **Person Responsible:** Director of Engineering	6/30/2014 6/19/2014 3/28/2014 4/7/2014

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A 701	Continued From page 131 sharps container that use to be mounted on the wall and that the holes need to be sealed. 102. The patient rooms safety monitor was off at the at the nurses. 103. There was a missing cover plate at communication line at corridor wall between Rooms 3338 and 333C. 3rd floor ACU On March 28, 2014, between the time of 11:50 a.m. and 12:10 p.m,. the following conditions existed in 3rd floor ACU (ambulatory care unit). 104. There was no thermometer in the patient food refrigerator holding 8 cold cut sandwiches. 105. The □-Ray room had a two inch diameter hole in wall, and was missing wall caving. 106. There was a one foot crack at floor of common bathroom next to the waiting room. 3rd floor SOU On March 28, 2014 between the time of 12:10 p.m. and 2:00 p.m., the following conditions existed in 3rd floor SOU (step down unit). 107. Room 312 had a missing light shield at wall mounted light fixture exposing four fluorescent glass tubes, and had four 1/2 inch holes through the head wall exposing the wall cavity and particle board around the holes. 108. Room 314A had a loose nurse call at the	A 701	(Continued from page 131) **102) Corrective Actions:** Re-educate RN□s and Monitor Techs to keep safety monitor alarms on. Revised Patient Rhythm Documentation Form to include Alarm monitoring. **Date of Implementation:** Revised form will be implemented June 20, 2014. **Monitoring Process:** Registered Nurses (RN□s) and Monitor Techs (MT□s) will monitor for alarms and document on Patient Rhythm/Alarm Documentation Form. Nursing Director will monitor form for 100% compliance and report compliance to the Quality Department. Non-compliance will be addressed with progressive discipline; will monitor for 30 days. **Person Responsible**: Director of Nursing and/or Designee.	6/20/2014
			103) Corrective Actions: The cover plate in rooms 333B and 333B will be replaced in June 2014 by Engineering. Date of Implementation: The cover plate in rooms 333B and 333B will be replaced in June 2014. **Date of Implementation**: The cover plate in rooms 333B and 333B will be replaced in June 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas. **Person Responsible:** Director of Engineering	6/30/2014
			CULVER CITY CAMPUS (Pavilion 3 ACU) **104) Corrective Actions:** A thermometer was placed in the patient food refrigerator holding sandwiches on June 18, 2014 by Dietary. A log to ensure thermometers are checked daily has been created and is attached herewith. **Date of Implementation**: A thermometer was placed in the patient food refrigerator on June 18, 2014 by Dietary **Monitoring Process**: Dietary will conduct daily monitoring to ensure all patient food refrigerators have thermometers. **Person Responsible:** Director of Food Services.	6/18/2014
			105) Corrective Actions: The hole in the wall and the missing wall coving in the x-ray room will be addressed in June 2014 by Engineering. **Date of Implementation**: The hole in the wall and the missing wall coving in the x-ray room will be addressed in June 2014. **Monitoring Process**: Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas. **Person Responsible:** Director of Engineering.	6/30/2014
			106) Corrective Actions: The crack on the bathroom floor next to Pavilion 4 waiting room was repaired on April 10, 2014 by Engineering. **Date of Implementation:** The crack on the bathroom floor next to Pavilion 4 waiting room was repaired on April 10, 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas **Person Responsible:** Director of Engineering.	4/10/2014
			CULVER CITY CAMPUS (Pavilion 3 SDU) **107). Corrective Actions:** The light shield at light fixture in room 312 was replaced and the holes in the wall were patched and painted on April 11, 2014 by Engineering. **Date of Implementation**: April 11, 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering	4/11/2014
			108). Corrective Actions: The nurse call was re-secured to the wall in room 314A in March 2014 by Engineering. **Date of Implementation:** March 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering	3/30/2014

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A 701	Continued From page 132 head wall. 109. Room 318 had a three inch by one inch hole at the wall behind the door, and a loose nurse call bell light outside of the room. 110. There was a worn cover with tears and flaking pieces covering the clean linen cart in the corridor. 111. There was missing laminate at corners of nurses station exposing the wood beneath. 112. The common shower/tub room next to SOU had one foot by six inch area of damage at a wall, and three inch by two inch area of damage at a corner of the wall. 2nd floor Pavilion 113. There were braided nurse call cords throughout the southwest and southeast telemetry units. 114. The handrail across from room 244 had a broken corner with two inch wide sharp corner where a piece of the rail was missing. 2nd floor Southwest Telemetry On March 28, 2014 between 2:00 p.m. and 2:20 p.m. the following conditions existed in 2nd floor Telemetry Southwest Unit. 115. Room 203 had peeling paint at the shower stall. 116. Room 204 had a 1/2 inch diameter hole	A 701	(Continued from page 132) **109). Corrective Actions:** The nurse call bell light was re-secured to the wall in room 318 in March 2014 by Engineering. The holes were patched and painted on April 11, 2014 by Engineering. **Date of Implementation:** March 2014 and April 11, 2014, respectively **Monitoring Process**: Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible**: Director of Engineering **110) Corrective Actions**: A representative from Medline came on June 19, 2014 to assess replacement of worn and missing clean linen cart covers. An order has been placed for cart covers and ETA is July 3, 2014. **Date of Implementation:** July 3, 2014 **Monitoring Process**: Daily rounding is conducted by EVS to monitor cleanliness and ensure linen carts are covered at all times. Deficiencies will be addressed immediately. **Person Responsible**: Director of EVS **111). Corrective Actions:** The exposed wood at the corner of the nurse□s station was covered using new laminate sheet. **Date of Implementation:** Repairs will be completed on August 19, 2014. **Monitoring Process:** Engineering to conduct quarterly rounding to monitor work stations to ensure they are in good and safe working condition i.e., free of wood exposure or chipped surface. **Person Responsible**: Director of Engineering **112). Corrective Actions**: Wall damage in shower/tub room next to SDU was repaired on April 9, 2014 by Engineering. **Date of Implementation**: April 9, 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **CULVER CITY CAMPUS (2nd Floor Pavilion/2nd Floor Southwest Telemetry/2nd Floor Southeast Telemetry)** **113). Corrective Actions:** All nurse call pull cords have been replaced in April 2014 hospital-wide by Engineering. **(See Addendum 96)** **Date of Implementation:** April 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **114). Corrective Actions:** The handrail across from room 244 will be repaired in June 2014 by Engineering. **Date of Implementation:** June 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible**: Director of Engineering **115). Corrective Actions:** The shower stall in room 203 was repainted on May 5, 2014 by Engineering. **Date of Implementation**: May 5, 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **116). Corrective Actions:** The hole through the bathroom door in room 204 was patched and painted on April 10, 2014 by Engineering. **Date of Implementation:** April 10, 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in	3/30/2014 4/11/2014 7/3/2014 8/19/2014 4/9/2014 4/30/2014 6/30/2014 5/5/2014 4/10/2014

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A 701	Continued From page 133 through the bathroom door. 117. Room 207 had eight *V4* inch holes at a bathroom wall. Closer observation revealed the toilet paper dispenser was missing and the toilet paper roll was sitting on the bathroom sink counter. 118. Missing cover at two clean supply carts in supply room. 119. In the supply room there were two clean supplies carts that were not covered. During an interview at the same time as the observation, AN 27 (charge nurse) stated that the carts were clean supplies carts and should have been covered, that they were covered before and did not know why they were no longer covered. 2nd floor Southeast Telemetry On March 28, 2014, between the time of 2:23 p.m. and 2:45 p.m., the following conditions existed in 2nd floor Telemetry Southeast Unit. 120. Room 211 had a night stand table with a broken drawer. 121. Room 214 had a grab bar that was off the shower stall wall and laying against bottom of the stall wall. 121. Room 218 was missing the towel bar from the bathroom, and there was also damaged at the corner of a wall. 123. Room 220 had a water leak at the nut of the sink drain pipe (P-trap), and had a loose lockset	A 701	(Continued from page 133) **117) Corrective Actions:** holes at a bathroom wall in room 207 will be patched and painted and the toilet paper dispenser will be installed in June 2014 by Engineering. **Date of Implementation**: June 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible**: Director of Engineering **118) Corrective Actions:** A representative from Medline came on June 19, 2014 to assess replacement of worn and missing clean supply cart covers. An order has been placed for cart covers and ETA is July 3, 2014. **Date of Implementation:** July 3, 2014 **Monitoring Process:** Nursing will be in-serviced to ensure that clean supply carts are covered at all times. Daily rounding is conducted by Nursing and EVS to monitor cleanliness and ensure clean supply carts are covered at all times. Deficiencies will be addressed immediately. **Person Responsible:** Nursing Personnel, Charge Nurses and Nursing Directors on each unit. **119). Corrective Actions:** Nursing education developed, ensuring cart covers are used and cabinet doors closed. **Date of Implementation:** Education started on June 19, 2014 with full implementation in 30 days. **Monitoring Process:** Infection Control Rounds **Person Responsible:** Nursing Director & Infection Control. **120). Corrective Actions:** The night stand table in room 211 will be replaced in June 2014 by Engineering. **Date of Implementation:** June 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible**: Director of Engineering **121). Corrective Actions:** The grab bar in the shower stall in room 214 was remounted on April 29, 2014 by Engineering. **Date of Implementation**: April 29, 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **121). Corrective Actions:** The missing towel bar from the bathroom was replaced on April 22, 2014 and the wall damage was repaired on April 10, 2014 by Engineering. **Date of Implementation**: April 22 and April 10 accordingly **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **123). Corrective Actions**: The water leak in room 220 was repaired on April 22, 2014 and the lockset as re-secured on April 10, 2014 by Engineering. **Date of Implementation:** April 22 and April 10, 2014 accordingly **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering	6/30/2014 7/3/2014 6/19/2014 6/30/2014 4/29/2014 4/10/2014 4/22/2014 4/10/2014 4/22/2014

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A 701	Continued From page 134 handle at the bathroom door. 124. Room 221 had a missing grab bar at shower stall wall, and a three foot crack at shower stall wall. 1st floor Pavilion On March 31, 2014 between the time of 9:04a.m. and 10:20 a.m., the following conditions existed on 1st floor Pavilion. 125. The main laboratory had a missing light shield at a light fixture above the center work station where immunoassay procedures are done. 126. The pharmacy storage room was missing a light diffuser shield exposing four glass fluorescent tubes at at one of three ceiling lights over a rack of clean supplies. 127. The pharmacy had a pharmacy waste incineration container that was filled above the fill line and beginning to overflow out from the top of the container. There was also a missing cover plate at a wall exposing a three inch by two inch hole in the wall. 128. On March 25, 2014, the following conditions were observed in the the Hollywood campus: 4th Floor a. The toilet base was dirty and caulking; the sealant was in disrepair at the Nurse Station.	A 701	(Continued from page 134) **124). Corrective Actions:** The grab bar at the shower stall wall and the crack on the wall will be repaired in June 2014 by Engineering. **Date of Implementation**: June 2014 **Monitoring Process**: Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **CULVER CITY CAMPUS (Pavilion 1)** **125). Corrective Actions:** The missing light shield in the main laboratory above the center work station was replaced on April 11, 2014 by Engineering. **Date of Implementation:** April 11, 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **126). Corrective Actions:** The missing light diffuser shield in the Pharmacy storage room will be replaced in June 2014 by Engineering. **(see Addendum 98)** **Date of Implementation**: June 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **127). Corrective Actions:** The pharmacy waste incinerator container was replaced by EVS. The missing cover plate at a wall will be replaced in June 2014 by Engineering. **Date of Implementation**: Incinerator replaced on March 31, 2014 **Monitoring Process**: Daily rounding is conducted by EVS to monitor cleanliness. **Person Responsible:** Director of EVS **HOLLYWOOD** **Fourth Floor: 128 a-d** **128a). Corrective Actions:** Remove, clean and reset the toilet bowl and reseal with white caulking at the base. **Date of Implementation:** April 2, 2014 cleaning and repairs completed. **Monitoring Process:** Inspection of the toilet rooms will be performed quarterly. **Person Responsible:** Chief Engineer	6/30/2014 4/11/2014 6/30/2014 3/31/2014 4/2/2014

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A 701	Continued From page 135 b. There was leaking water/intrusion in the base cabinet of the Urgent Care base cabinet. c. The plumbing faucet was covered in calcium deposits in the Medication Room and the nurse station shower head. d. The shower/bathroom was in disrepair and the floor nurse station restroom shower enclosure had missing wall tiles. 3rd Floor a. Handwash sink had an unsealed hole measuring 3 inches (in) by 4 in. b. In the Nurse Station, the rest room had unclean shower base, missing shower door handle, missing threshold hardware, and missing facing in the dictation area. c. In Room 316, the wallpaper was torn and damage behind bed 3. d. Room 307, an over the bed table was damaged at a corner and revealed uncleanable particle board. e. In Room 308, the patient had no privacy curtain and a staff stated' 11She is the only one in the room□n 5th Floor a. The toilet base was dirty and caulking; the sealant was in disrepair in Room 507 and Room 508. b. The handwash sink faucets had aerators located in the following areas: respiratory,	A 701	(Continued from page 135) **128 b). Corrective Actions:** Replace defective angle stop to in the base cabinet of the Urgent Care cabinet base. **Date of Implementation**: April 7, 2014 angle stop replaced by Engineering and no more leaks noted. **Monitoring Process:** Continue to monitor sinks for water leaks during EOC rounds. **Responsible Person**: Chief Engineer **128 c). Corrective Actions:** Clean the calcium deposits on the plumbing faucet in the Medication Room and replace the shower head in the Nurse Station shower. **Date of Implementation:** April 5, 2014 faucet cleaned and shower head replaced. **Monitoring Process:** Continue to monitor sink faucets and shower heads for leaks during EOC rounds. **Responsible Person:** Chief Engineer **128 d) Corrective Actions:** Replace and re-caulk the missing wall tiles in the floor nurse station restroom shower enclosure. **Date of Implementation:** June 18, 2014 repairs completed. **Monitoring Process:** Continue to monitor shower/bathroom tiles during EOC rounds. **Responsible Person:** Maintenance Engineer **Third Floor: a-e** **128 a). Corrective Actions:** Seal the Hand wash sink hole (3 in. by 4 in) with 3M fire caulk. **Date of Implementation:** April 10, 2014 repairs completed. **Monitoring Process:** Quarterly Hospital-wide checks for penetrations will be performed. **Department Responsible:** Chief Engineer **128 b. Corrective Actions:** Clean shower base, replace the shower arm and shower head and shower door handle at the Nurse Station Lounge including the missing facing in the dictation area. **Date of Implementation:** June 20, 2014 cleaning and repairs completed. **Monitoring Process:** Continue to monitor during EOC rounds. **Department Responsible:** Chief Engineer **128 c). Corrective Actions:** Repair the torn and damaged wallpaper in ICU Room 316. **Date of Implementation:** June 16, 2014 repairs completed. **Monitoring Process:** Continue to monitor during EOC rounds. **Department Responsible:** Chief Engineer **128 d). Corrective Actions:** Remove and replace damaged over the bed table in room 307. **Date of Implementation**: March 25, 2014 replaced immediately. **Monitoring Process:** Continue to monitor during EOC rounds. **Department Responsible:** Chief Engineer **128 e) Corrective Actions:** Install a patient privacy curtain in Room 308. **Date of Implementation:** March 31, 2014 installation of curtain completed. **Monitoring Process;** Privacy curtains checks will continue to be performed during EVS Daily Rounds. **Department Responsible:** Environmental Services Lead Person **Fifth Floor: a-f** **128 a. Corrective Actions:** Clean toilet bases and reseal with new caulking in Rooms 507 and 508. **Date of Implementation:** March 31, 2014 cleaning and repairs completed. **Monitoring Process:** Continue to monitor during EOC rounds. **Department Responsible:** Engineering/Infection Control/EVS **128 b). Corrective Actions**: Remove all faucet aerators in Respiratory, Medical Supply floor, Basement sink, Recovery Room and Pharmacy hand wash sink. **Date of Implementation:** March 27, 2014 faucet aerators removed. **Monitoring Process;** Continue to monitor thru EOC rounds every six months. **Department Responsible:** Chief Engineer	4/7/2014 4/5/2014 6/18/2014 4/10/2014 6/20/2014 6/16/2014 3/25/2014 3/31/2014 3/27/2014

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A 701	Continued From page 136 medical supply floor, a basement sink, recovery area, and pharmacy handwash sink. c. There was ceiling damage and hole in the boiler room (3 in by 4 in hole). d. There was trash stored in the patient sleeping room 509. e. The ice maker had a direct connection to sewer system. f. In the Medical Supply room, the threshold floor was missing in the shower room and in the janitor room. 6th Floor a. There was missing threshold hardware in the IV (intravenous) Stockroom and one stained ceiling tile. b. The handwash sink faucets had aerators in the respiratory room. c. There were 4 suction containers that were rusted. d. In the Operating Room, the □-ray viewing frame was dirty/marred and the anesthesia cart had discolored white tape on the contact surface. e. The 6th floor pharmacy under the hood and the floor finish pieced together with open and dirty seams. f. The wall finish was damaged on the respiratory room. g. The 6th floor water heater room with a fifteen	A 701	(Continued from page 136) **128 c). Corrective Actions:** Repair the ceiling damage and hole in the boiler room. **Date of Implementation**: April 2, 2014 repair completed **Monitoring Process;** Monthly inspection rounds to be performed for penetrations, ceiling or wall damages. **Department Responsible**: Chief Engineer **128 d). Corrective Actions:** Remove all trash stored in the patient sleeping Room 509. **Date of Implementation:** March 25, 2014 trash immediately removed. **Monitoring Process;** Continue to monitor during EOC rounds. **Department Responsible:** Chief Engineer **128 e). Corrective Actions**: Adjusted Ice maker drain pipe tip/end to maintain (1) one inch clearance from sewer system/line. **Date of Implementation:** April 1, 2014 completed. **Monitoring Process;** Semi-annual inspection during EOC rounds. **Department Responsible:** Chief Engineer **128 f). Corrective Actions:** Reinstall missing threshold floors in the Medical Supply room, Shower Room and Janitors Rooms. **Date of Implementation:** June 16, 2014 started and will be completed June 20, 2014. **Monitoring Process;** Continue to monitor during EOC rounds. **Department Responsible:** Chief Engineer **Sixth Floor: a-i** **128 a). Corrective Actions:** Replace the missing threshold hardware in the IV Stockroom and replace the stained ceiling tile. **Date of Implementation:** April 15, 2014 repairs completed. **Monitoring Process;** Continue to monitor during the EOC rounds. **Department Responsible:** Chief Engineer **128 b). Corrective Actions:** Remove the aerators in the sink faucet located in Respiratory room. **Date of Implementation:** March 25, 2014 faucet aerator removed. **Monitoring Process:** Continue to monitor during the EOC rounds on a semi-annual inspection. **Department Responsible**: Chief Engineer **128 c). Corrective Actions:** Remove from service the 4 suction containers that were rusted and replaced with 4 new suction containers. **Date of Implementation:** April 23, 2014 completed. **Monitoring Process;** Continue to monitor during the EOC rounds. **Department Responsible:** EOC committee **128 d). Corrective Actions:** Replace the dirty/marred □-ray viewing frame and remove the discolored white tape on the contact surface of the anesthesia cart in the Operating Room. **Date of Implementation**: April 23, 2014 repairs completed **Monitoring Process;** Continue to monitor in the EOC rounds. **Department Responsible:** EOC Committee /Surgery Staff **128 e). Corrective Actions:** Remove and replace defective floor finish and clean the seams at the foot of Pharmacy hood. **Date of Implementation:** April 23, 2014 completed. **Monitoring Process;** Continue to monitor during EOC rounds. **Department Responsible:** Chief Engineer **128 f). Corrective Actions:** Remove the damaged wall finish and paint the walls in Respiratory. **Date of Implementation:** April 24, 2014 repairs completed. **Monitoring Process:** Continue to monitor during the EOC rounds. **Department Responsible:** Chief Engineer/Infection Control **128 g). Corrective Actions:** Anchor the copper pipe on the wall with metal clips in the hot water storage room of the 6th Floor.	4/2/2014 3/25/20144 6/16/2014 4/15/2014 3/25/2014 4/23/2014 4/23/2014 4/24/2014

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SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	**6245 DE LONGPRE AVE** **HOLLYWOOD, CA 90028**

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A 701	Continued From page 137 feet line without support brackets and held up at the ceiling with a mop stick. h. In the Medical File Room, there was one small two drawer file cabinet with missing facing exposing unfinish wood and dirty. i. In the Urgent Care Room, the door was not labeled and there was water intrusion under the handwash sink and inside the base cabinet. Basement a. There was an unfinished wall/plaster in the contaminate room ceiling puffy and damaged 3 in. by 6 in. b. In the □-ray room, the toilet base needed to be serviced/caulk. c. In the Pre-Op room, the floor finish had an one inch adhesive strip which was not cleanable. d. In Operating Room 3, two cabinets had missing facing and a section of the floor had left over adhesive/uncleanable. Culver City campus a. In the emergency room entryway rug runner, in the 1st floor Nurse Station, the floor was very dirty and the carpet was stained; In the 1st floor Transportation Dispatch Office, the rug and base flooring was elevated about 3/4 inch above the adjoining room and the threshold had no hardware. In the 1st floor □-ray room □3, the handwash sink counter top had missing facing and there was no handwash soap available; In the Nuclear Medicine disposal area, the entry door to the area was not labeled and the disposal	A 701	(Continued from page 137) **Date of Implementation:** April 23, 2014 completed. **Monitoring Process:** Continue to monitor by Engineers during rounds. **Department Responsible:** Engineering **128 h). Corrective Actions:** Clean and laminate the two drawer file cabinet in the Medical File Room. **Date of Implementation:** April 19, 2014 cleaning and repair completed. **Monitoring Process;** Continue to monitor during EOC rounds. **Department Responsible:** Chief Engineer **128 i). Corrective Actions:** Install label on the door and replace the angle stop in Urgent care under the sink cabinet. **Date of Implementation:** April 7, 2014 Installed door label and replaced angle stop and no leak noted. **Monitoring Process**: Continue to monitor sinks during the EOC rounds for leaks. **Person Responsible:** Chief Engineer **Basement: a-d** **128 a). Corrective Actions**: Repair and paint the puffy and damaged (3 in x 6 in) area on the ceiling in the contaminate room. **Date of Implementation:** April 9, 2014 started and completed on April 11, 2014. **Monitoring Process:** Continue to monitor during the EOC rounds. **Responsible Person:** Chief Engineer **128 b). Corrective Actions:** Re-caulk the toilet base in the □-ray room with polyurethane high performance sealer. **Date of Implementation:** April 9, 2014 repair completed. **Monitoring Process:** Continue to monitor during the EOC rounds. **Responsible Person**: Chief Engineer **128 c). Corrective Actions:** Remove the one inch adhesive strip on the floor in the Pre-op room. **Date of Implementation:** April 9, 2014 date completed. **Monitoring Process:** Continue to monitor during the EOC rounds. **Department Responsible:** Chief Engineer **128 d). Corrective Actions:** Repair the two cabinets in Operating Room 3 and remove the leftover adhesive from the floor. **Date of Implementation**: April 22, 2014 date completed. **Monitoring Process:** Continue to monitor during the EOC rounds. **Responsible Person:** Chief Engineer **CULVER CITY** **a). Corrective Actions:** The entryway rug runner was removed and the floor stripped and waxed by EVS. **Date of Implementation**: April 2014. **Monitoring Process:** Daily rounding is conducted by EVS to monitor cleanliness. **Person Responsible:** Director of EVS **Corrective Actions:** The transportation dispatch office flooring will be replaced in June 2014 by Starfloors, a flooring vendor. **Date of Implementation**: June 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering & Director of EVS **Corrective Actions:** The sink countertop in x-ray room □3 will be replaced with Formica and hand soap dispenser will be installed by Engineering. **Date of Implementation:** June 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering	4/23/2014 4/19/2014 4/7/2014 4/9/2014 4/9/2014 4/9/2014 4/22/2014 4/30/2014 6/30/2014 6/30/2014

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A 701	Continued From page 138 containers were not maintained; In the Radioactive Laboratory area, the dark room floor sink was very dirty and the floor tile was very dirty, separating, and lifting; In the Nuclear Medicine Imaging, the bathroom floor tiles was lifting. b. In the 1st floor emergency employee lounge, there were twenty plus American Cockroaches desiccate and stuck to 3-glue boards located underneath the employee lounge kitchenette base cabinet. c. In the Radioactive Laboratory, the exam table had missing screw and on screw missing, there was a sleeve to protect patients from the exposed screws. d. In the Emergency Room/ISO, the toilet base needs recaulking at the toilet base. e. In the Emergency Room, the patient bathroom had cracked doorjam; In the 2nd floor staff bathroom, the soap dispenser was relocated and wall not repaired; In the 2nd floor, the Janitor Closet had wall caving separating from the wall; In the 2nd floor kitchenette, the floor tiles was lifting. Basement a. In the dumb waiter, the storage area was unsanitary and dirty. b. In the Central Supply Room, the 5-shelf rack was dirty with dust and dirt, eyewash sink counter top damaged, rusty paper dispenser located over the sink; the sink's caving detached from the sides/wall; the door panel detached.	A 701	(Continued from page 138) **Corrective Actions:** Missing door signs, including the door in Nuclear Medicine, will be addressed by Sign Centrix, who is currently providing a master plan for all interior signage upgrades. Nuclear Medicine created a weekly log and scheduled weekly disposal of radioactive contaminated trash with EVS. (A copy of the log is as attached.) **Date of Implementation:** Weekly monitoring commenced on June17, 2014 **Monitoring Process:** Weekly disposal of radioactive contaminated trash. **Person Responsible**: Director of Engineering & Director of EVS **Corrective Actions:** The flooring in Radioactive Lab area dark room, Nuclear Medicine Imaging bathroom will be addressed by Starfloors, a flooring vendor, in June 2014. **Date of Implementation**: June 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. Daily rounding is conducted by EVS to monitor cleanliness. **Person Responsible:** Director of Engineering & Director of EVS **b) Corrective Actions:** Dead bugs were removed and the cabinet cleaned on March 25, 2014 while EVS staff is tasked to monitor cabinets in the ER Employee Lounge weekly. **Date of Implementation**: March 25, 2014 **Monitoring Process:** Daily rounding is conducted by EVS to monitor cleanliness. **Person Responsible:** Director of EVS **c) Corrective Actions:** The missing screws have been replaced on table of the gamma camera (exam table in the Radioactive Lab) by Bio Med. **Date of Implementation:** June 16, 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **d) Corrective Actions:** The toilet base in the restroom inside the Isolation Room in the ER was cleaned and recaulked by Engineering. **Date of Implementation:** April 11, 2014 Monitoring Process: Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. Person Responsible: Director of Engineering **e) Corrective Actions:** The cracked door jam in the patient bathroom in the Emergency Room will be repaired by Engineering. **Date of Implementation:** June 2014 **Corrective Actions:** The holes on wall in staff bathroom in Pavilion 2 will be patched and repainted by Engineering. **Date of Implementation**: June 2014 **Corrective Actions:** The wall coving in the Janitor Closet was repaired by Engineering. **Date of Implementation**: April 3, 2014 **Corrective Actions:** The floor tiles on the 2nd floor kitchenette will be repaired by Engineering. **Date of Implementation**: June 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **BASEMENT** **a).Corrective Actions:** EVS is scheduled to clean the dumb waiter and will monitor and log weekly. **Date of Implementation**: June 2014 **Monitoring Process**: Daily rounding is conducted by EVS to monitor cleanliness. **Person Responsible**: Director of EVS **b). Corrective Actions:** EVS dusted off the shelf rack in Central Supply on June 17, 2014 and will continue to monitor and log dustings bi-weekly. **Corrective Actions:** The eyewash sink will be repaired in June 2014. **Corrective Actions:** The rusty paper dispenser will be replaced in June 2014 **Corrective Actions:** The door panel will be repaired in June 2014. **Date of Implementation:** Repairs and replacements to be completed by the end of June 2014	6/17/2014 6/30/2014 3/25/2014 6/16/2014 4/11/2014 6/30/2014 6/30/2014 4/3/2014 6/30/2014 6/17/2014 6/30/2014

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A 701	Continued From page 139 c. In the Operating Room area, the floor finish/buckling with open floor seams; the dirty floor finish and caving were discolored and not clean; the corridor metal wall strip had exposed screw holes. d. In the Recovery area, the Nurse Station had damaged counter top with the facing detached or missing; handwash sink had an aerator; soap dispenser was dirty and blacken. e. In the Microbiology Room, the floor finish was removed; air hood with worn down finish and rusted. Van Nuys campus 129. On March 24, 2014, at 10:30 a.m., during an initial tour of locked unit 2 , the housekeeping staff was spraying air freshener in the hallways and walked toward the utility cart. The housekeeping staff opened the cabinet and placed the air fresher can inside. During a concurrent interview, when asked about the utility cart should be closed. She stated, □Yes, the utility cart is in use it should be locked at all times.□ She reached in the drawer and got the	A 701	(Continued from page 139) **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. Daily rounding is conducted by EVS to monitor cleanliness. **Person Responsible:** Director of Engineering & Director of EVS **c).Corrective Actions:** Operating Room • Minor repairs for heat welding seams have been made to the OR flooring while proposals are being obtained to replace the entire OR flooring. • The holes on the corridor metal wall strip were patched with Epoxy on April 7, 2014 by Engineering. **Date of Implementation**: April 7, 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **d).Corrective Actions & Date of Implementation**: Recovery Area • The damaged counter top in the Nurse Station will be assessed and repaired by Engineering. • The aerator in the Recovery Area hand wash sink was removed immediately on March 25, 2014. In addition, all aerators have been removed hospital-wide on April 4, 2014 by Engineering. • The soap dispenser was replaced on April 3, 2014 by Engineering. **Date of Implementation:** June 2014 for the countertop. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible**: Director of Engineering **e).Corrective Actions:** Microbiology Room • New flooring will be installed in Microbiology Room in July 2014. • The rusted portion of the air hood in Microbiology was refinished on April 11, 2014 by Engineering. **Date of Implementation:** July 2014 for the flooring. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **VAN NUYS** **129). Corrective Actions:** All utility carts in use should be locked at all times, except when removing or replacing cleaning items per policy item number 4.2.20. **Date of Implementation:** 3/24/14 **Monitoring Process:** JIT Training provided to EVS on March 25, 2014 for proper locking of utility carts. **Person Responsible:** Director of Engineering	4/7/2014 3/25/2014 4/3/2014 4/4/2014 4/11/2014 7/30/2014 3/24/2014

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A 701	Continued From page 140 keys to lock the utility cart. According to the facility's policy titled, All Cleaning Supply dated EVS 2011, when the utility cart was in use on the units it should be locked at all times, except when removing or replacing cleaning items. 130. On March 24,2014, at 11:10 a.m., in the patio area of the locked unit, there was an umbrella base turned upside down. There was no umbrella. The inside where the umbrella pole holder had cigarette butts. The patio area of open unit 1 had cigarette butts in the flower beds and smelled of cigarettes. During a concurrent interview with Staff I, she stated the facility was "2 weeks nonsmoking facility... She further stated the patients were informed they were to smoke off the facility grounds. Hollywood campus 131. Staff 2 was interviewed on March 24, 2014 at approximately 3:05 p.m. on the emergency food and water for Hollywood campus. He did not present a plan but stated that there was some food including pasta on hand. The dry storage room where the food would have been stored had just received a delivery of food that completely blocked access to the room. No other supporting information about adequacy of food and water for use during emergency was provided during the survey. Van Nuys campus 132. On March 27,2014 beginning at 10:10 a.m., the hospitals' disaster meal plan was reviewed	A 701	(Continued from page 140) **130). Corrective Actions:** The umbrella base in the patio area of the locked unit was cleaned and removed. (See attached). The inside of the holder is now free of cigarette butts. The patio area of Unit 1 flower beds is free of cigarette butts. Routine monitoring through daily rounds for monitoring patio area by EVS. **Date of Implementation:** 3/24/14 **Monitoring Process:** Routine monitoring through daily rounds for monitoring patio area by EVS. **Person Responsible:** Director of Engineering **HOLLYWOOD** **131) Corrective Actions:** The Disaster menu and supplies for patients were adjusted to meet the needs of the facility. Disaster food and supplies for patients have been received. A disaster plan for staff is in process of being developed and food products will be ordered accordingly. Once the plan is finalized, staff will be trained on its use. **Date of Implementation:** July 31, 2014 Written plan completion, staff training and monthly inventory of disaster supplies will be completed by September 10, 2014 Weekly inventory of all food products to ensure adequate availability will take place starting September 10, 2014 **Monitoring process:** Weekly inventory to ensure adequate menu supplies are on hand. Monthly inventory for adequate emergency supplies will be compared to the □Disaster Inventory Sheet□ Results of disaster supply monitoring activity will be reported to the hospital□s EOC Committee. **Person Responsible:** RD, Director of Dietary Department **Corrective Action:** Just in time training provided to the delivery drivers and dietary staff regarding clearance of E□IT doors at all times **Date of Implementation:** June 19, 2014 **Monitoring process:** Monitoring will be managed through EOC rounds and daily operational rounds **Person Responsible:** Dietary staff, Safety officer **VAN NUYS** **132) Corrective Actions:** The Disaster freeze dried food menu and supplies for patients were adjusted to meet the needs of the facility. Disaster food and supplies for patients have been received. A disaster plan for staff is in process of being developed and food products will be ordered accordingly. Once the plan is finalized, staff will be trained on its use.	3/24/2014 7/31/2014 9/10/2014 6/19/2014

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A 701	Continued From page 141 with Staff 2. She stated that the hospital was preparing to serve 160 patients and staff for a period of 5-7 days. Concurrent review of the hospital document titled □Disaster Plan□ dated 11/12 revealed that the menu was limited to 3 days, despite the hospitals' intent to be self-sufficient for 5-7 days. It was also noted that the food supply was inadequate, with insufficient quantity for some items for 1 meal. As an example the plan called for a tuna sandwich for 2 required 360 servings. It was also noted that the plan was to serve milk; however the hospital did not have any powdered milk and the current milk on hand would also be less than a 1-day supply. Similarly there were either inadequate or non-existent supplies of ravioli, soup, chicken or chili. Staff 1 acknowledged that the supply was not adequate. It was also noted that the menu/food supply consisted of items such as hot cereal, soups, and Sloppy Joes that required cooking. In an interview with the Facilities Director on March 27, 2014 at 10:30 a.m., he stated that he had a large barbeque in the basement that could be utilized. While the hospital had a barbeque, the fuel supply was limited to two 5-gallon tanks of propane. He stated he did not know how long these tanks would last and acknowledged that the use of the barbeque would not likely be practical in a mass disaster due to the unavailability of fuel. 133. During an initial kitchen tour on March 27, 2014 beginning at 8:20a.m., it was noted that the water at the employee hand washing sink was tepid. On March 27, 2014 at 9 a.m., Staff 2 was asked to take the water temperature. It was noted to be 70□F. It would be the standard of practice to ensure that the water temperature of	A 701	(Continued from page 141) **Date of Implementation:** July 31, 2014 Written plan completion, staff training and monthly inventory of disaster supplies will be completed by September 10, 2014 Weekly inventory of all food products to ensure adequate availability will take place starting September 10, 2014 **Monitoring Process:** Weekly inventory to ensure adequate menu supplies are on hand and no non pasteurized eggs are present. Monthly inventory for adequate emergency supplies will be compared to the □Disaster Inventory Sheet□ Results of disaster supply monitoring activity will be reported to the hospital□s EOC Committee. **Person Responsible:** RD, Director of Dietary Department **133) Corrective Action:** Kitchen sink has been fixed and calibrated **Date of Implementation:** March 26, 2014 **Monitoring Process**: Per dietary staff report **Person Responsible:** RD, Director of Dietary Department and Food Services Supervisor	7/31/2014 9/10/2014 3/26/2014

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A 701	Continued From page 142 the hand washing sink was a minimum of 100□F through the use of a hot water mixing valve (USDA Food Code 2013). In a concurrent interview with Foodservices Director 1 he stated he was unaware of the water temperature requirement.	A 701	(Continued from page 142)	
A 703	482.41 (a)(2) EMERGENCY GAS AND WATER There must be facilities for emergency gas and water supply. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to have documented evidence of a system to provide emergency water and failed to ensure an effective water management plan and supplies to be implemented in a widespread disaster as evidenced by a plan that did not effectively meet the hydration and personal care needs of patients and staff.. This deficient practice had the potential to result in inadequate supply of drinking water and water for other purposes to all patients and staff during a disaster affecting the hospital and effectively meet the hydration and personal care needs of patients. Finding: Van Nuys Campus 1. On March 24, 2014 between 2:45p.m. and 3:15p.m., accompanied by Staff 6 (Director of Facilities), a review of the facility□s safety and disaster manual revealed there was no written plan to provide emergency water as needed to provide care to inpatients and other persons who may come to the hospital in need of care.	A 703	**VAN NUYS** **1). Corrective Action:** Water needs for each campus have been calculated and the water is securely stored at each facility in the levels calculated. A system wide policy, EMP.018 Loss of Water Policy and Procedure has been revised to include each hospitals calculated needs, location of the water, prioritized use of water and indicates arrangements made for the provision of emergency sources of water and security for emergency water stored on hospital grounds. The policy is anticipated to be approved by appropriate committees in September 2014. **Date of Implementation:** August 1, 2014 **Monitoring:** Monthly inventory of disaster water supplies with physical inspection of condition of water being stored. Results of audit activity will be reported to the hospital□s Quality Council, MEC, and Governing Board on a quarterly basis. **Person Responsible:** Director of Facilities, each campus.	8/1/2014

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A 703	Continued From page 143 A policy titled, Dietary Responsibilities (Number D-021) dated effective November of 2001 indicated that in the event of water failure, potable water shall be obtained by engineering on a priority needs basis. The policy did not determine the hospital's emergency needs for water, calculations to determine the amount of water needed, location of the water, prioritize the use of the water, indicate if arrangements were made with the local utility company and others for the provision of emergency sources of water, nor indicated how to protect the emergency water. During an interview at the same time as the review, Staff 6 stated that there was no emergency water plan but that he thought the facility was going implement something with a bottled water vendor. On March 26, 2014, the facility provided the evaluator with a policy titled Loss of Water Policy and Procedure (Number EMP.018). The cover page of the policy had no effective date and had no date or other indication that it had been reviewed by the EOC committee, Quality council, medical executive committee, and governing board. Culver City Campus 2. On March 31, 2014, between 10:30 a.m. and 10:54 a.m., there were boxes of emergency drinking water stored in an exterior gated area at the Legion building. The boxes contained six one	A 703	(Continued from page 143) **CULVER CITY** **2).Corrective Actions:** Damaged boxes were disposed of, the bottled water inside the damaged boxes was restacked in clean boxes and the collapsing boxes were re-stacked. The disaster water supply stored in an exterior gated area at the Legion Building will all be replaced in July 2014 prior to its expiration date on July 31, 2014. • The Loss of Water Policy and Procedure went to the Combined EOC Committee meeting in April but was revised to include SCH at Hollywood and SCH at Van Nuys. The policy will be presented to the combined EOC Committee meeting in July and to the executive committees (Quality Council, MEC and the Governing Board) thereafter.	

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A 703	Continued From page 144 gallon bottles of water each and were stack on top of each other. Four of the boxes at the bottom of one side of the stacks had signs of water leakage (wet boxes). At the other side of the stacks six of the boxes at the top of the stacks were collapsing onto the fencing and two of the boxes were crushed at the bottom of the collapsing stack. Between 2:14 p.m. and 3:30 p.m. accompanied by Staff 5 the hospital provided a policy titled Loss of Water Policy and Procedure (Number EMP.018) as documented evidence of a system to provide emergency water. The cover page of the policy had no effective date and had no date or other indication that it had been reviewed by the EOC committee, quality council, medical executive committee, and governing board. The hospital also provided a policy titled, Failure of water supply (Number FSN-007) dated effective July of 2009 indicated that in the event of water failure to obtain water from Water Disaster stores through the disaster command center, to contact the bottle water providers, military organizations or Red Cross to have water trucked in. The policy did not determine the hospital's emergency needs for water, calculations to determine the amount of water needed, location of potable and non-potable water on site, prioritize the use of the water, indicate if arrangements were made with the local utility company and others for the provision of emergency sources of water, nor indicated how to protect the emergency water.	A 703	(Continued from page 144) • The same Loss of Water Policy and Procedure addresses calculations to determine the amount of water needed, location of potable and non-potable water on site, prioritization of the use of water and the hospital has MOUs with on file with appropriate vendors to receive additional emergency water sources. **Date of Implementation:** June 19, 2014. **Monitoring Process:** The Groundskeeper will conduct a visual inspection of the disaster water supply on a weekly basis while performing routine grounds keeping tasks in the area. **Person Responsible:** Director of Engineering	6/19/2014

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A 703	Continued From page 145 During an interview at the same time as the review, Staff 5 stated that the disaster coordinator not available and that the Loss of Water Policy and Procedure (Number EMP.018) is scheduled to go through committee in April. 3. On March 27, 2014 beginning at 10:30 a.m., an evaluation of the hospital disaster water storage was reviewed with the Facility Director (FD), Staff 6. It was noted that the hospital plan was to provide .5 gallons/person/day of potable water with an additional .5 gallons for non-potable water. It was also noted that in the basement the hospital was storing 240 gallons of bottled water. Staff 6 also stated that additional water would be obtained from the facility water heaters. Concurrent observation of the water heaters revealed that there was a discharge valve at the bottom of the water heater that was approximately 3 inches off the ground. Staff 6 director stated that he would use a garden hose to get the water out of the tank. He also stated the hospital did not have a hose specifically intended for the use of transferring potable water. Review on March 28, 2014 at 1 p.m., of an undated draft policy presented by the hospital titled 11 Loss of Water Policy and Procedure revealed that the hospital planned on using the boiler room water as a non-potable source of water, rather than a potable source which would limit the potable source to 240 gallons. It was also noted that the plan did not include any potable water required to implement the disaster menu or direct patient care needs. Additional review of the plan revealed that the hospital utilized a reference document developed by the Centers of Disease Control and the American Water Works Association (2012) that	A 703		

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A 703	Continued From page 146 was specific to water supply planning for health care facilities. Review of the reference document revealed that the amount of water, .5 gallon/person/day, was specific to healthy individuals. The referenced document suggested that individual needs vary, depending on age, physical condition, activity level, diet, climate and that ill people need more water. While the hospital utilized healthcare associated references there was no indication that a comprehensive evaluation of the anticipated water needs based on the hospital□s population was conducted. In a concurrent interview with Staff 5 he stated that the presented plan was a draft copy and was not fully reviewed.	A 703		
A 713	482.41(b)(6) DISPOSAL OF TRASH The hospital must have procedures for the proper routine storage and prompt disposal of trash. This STANDARD is not met as evidenced by: Based on observation, the facility failed to properly store and dispose of trash by having overfilled and uncovered dumpsters creating conditions conducive to fly breeding and offensive odors. Finding: On March 24, 2014 at 11:55 a.m. two of four dumpsters were overfilled with trash. One of the dumpsters had its lids propped open by the overfilled trash. The second dumpster had its lids left fully open behind the dumpster. The two remaining dumpsters were less than half full.	A 713	**CULVER CITY: Corrective Actions:** EVS will monitor the dumpsters in the back alley of the Pavilion Building every 2 hours starting from 7:00 a.m. to 10:00 p.m. to ensure that dumpsters are not overflowing with trash and the lids remain closed. **Date of Implementation:** EVS will commence monitoring log on June 19, 2014. **Monitoring Process:** Monitor log. **(See Addendum 131).** **Person Responsible:** Director of EVS **Corrective Actions:** There is a clear hose placed next to water storage used to transfer potable water on March 28, 2014. **Date of Implementation:** 3/28/14 **Monitoring Process:** EOC rounds done semi-annually. **Person Responsible:** Director of Engineering . **VAN NUYS : Corrective Actions:** On March 24, 2014, the two of four dumpsters that were propped open were emptied to the other less than full dumpsters and all lids were closed**. (see Addendum 131, 132, 132a, 132b, 132c)** JIT In-service for all staff on P&P. EVS to monitor daily when dumping trash. **Date of Implementation:** March 24, 2014 **Monitoring Process**: EVS & Dietary staff to will be monitoring daily. **Person Responsible:** Dietary Supervisor & Director of EVS	6/19/2014 3/28/2014 3/24/2014
A 722	482.41(c) FACILITIES The hospital must maintain adequate facilities for	A 722		

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A 722	Continued From page 147 its services. This STANDARD is not met as evidenced by: Based on kitchen observations and dietary staff interview, the facility failed to ensure the plumbing in food production areas were designed and maintained in a manner to prevent potential cross contamination of foods. Failure to maintain facilities that mitigate cross contamination may result in exposing patients to a foodborne illness. Findings: Culver City campus 1. During kitchen tour on March 25, 2014 beginning at 2:45 p.m., at the Culver City campus it was noted that there were three sinks that were directly plumbed into the waste water system. In a concurrent interview with Staff 3 (Food services Director) she confirmed that each of the sinks was utilized for food production activities. In an observation on March 27, 2014 at 8:20am, at the Van Nuys campus it was also noted that the food production sink was directly plumbed into the waste water system. In a concurrent interview with she confirmed that the identified sink was utilized for food production activities. The standard of practice would be to ensure that plumbing was installed in a manner to ensure the presence of an air gap between the water supply inlet and the flood level rim of the plumbing fixture, equipment, or nonfood equipment and shall be at least twice the diameter of the water supply inlet and may not be less than 1 inch (USDA Food Code 2013). Van Nuys campus 2. During initial kitchen tour on March 27, 2014	A 722	**Culver City** **1). Corrective Actions:** Drains to each of the three sinks in the kitchen were re-plumbed to ensure the presence of air gap between water supply inlet and the flood level rim of the plumbing fixture in June 2014 by Engineering. **(see Addendum 133, 133a)** **Date of Implementation:** The re-plumbing was completed in June 2014. **Monitoring Process:** This is a one -time repair to resolve the issue. **Person Responsible**: Director of Facilities & Director of Food & Nutrition **Van Nuys** **2). Corrective Actions:** On March 27, the racks and refrigerator in the dry storage area were cleaned and found that there was rust. 10 racks were replaced. **Date of Implementation:** Completion of rack replacement by September 10, 2014. **Monitoring Process:** Replacements monitored for any repairs / replacements during EOC Rounds. **Person Responsible:** Dietary Supervisor	6//2014 9/10/2014

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A 722	Continued From page 148 beginning at 8 a.m., it was noted that the racks of the refrigerator located adjacent to the food production sink and the refrigerator in the dry storage area were covered in a brown colored matter, resembling rust, which was able to be removed with a paper towel. It would be the standard of practice to ensure that nonfood-contact surfaces of equipment are kept free of an accumulation of dust, dirt, food residue, and other debris (Food Code, 2013).	A 722		
A 724	482.41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE This STANDARD is not met as evidenced by: Based on observation, review of hospital and staff interviews, the facility failed to maintain the food service equipment to ensure acceptable level of safety and quality. The dish machine, plate warmers, five refrigerators and freezer were not properly maintained. These failures had the potential food safety concern for patients and safety (fall risk) concerns for employees when its equipment were not in good working order, had the potential to result in unclean and unsanitized utensils, to result in cross contamination and growth of microorganisms that could cause food borne illness, and the build-up of ice on the floor from the outside freezer was a potential fall for the hospital employees. Finding: 1. During meal service on March 24, 2014, Dietary Staff (OS) 4 was observed serving all the	A 724	**1) Corrective Actions:** Plate warmer will be sent for further inspection and repair. Staff will be in-serviced on initiating work order process for broken equipment and will educate on policy UTM.015 Preventive maintenance. Will create a list of all kitchen items/equipment to include if internal or external service performance required and will include instructions on notification of broken equipment **Date of Implementation:** Target date of completion for plate warmer inspection/repair June 27, 2014. Target date of completion for education July 1, 2014; target date of completion for inventory list August 1, 2014 **Monitoring Process:** Will be managed through daily operations and to include in EOC rounds **Person Responsible:** RD, Director of Dietary Department and Food Services Supervisor, dietary staff and ENG **2). Corrective Actions:** Dishwashing machine has been repaired and in working condition. Staff will be in-serviced on initiating work order process for broken equipment and will educate on policy UTM.015 Preventive maintenance . Will create a list of all kitchen items/equipment to include if internal or external service performance required and will include instructions on notification of broken equipment **Date of Implementation:** Repair completed March 27, 2014; Target date of completion for education July 1, 2014; target date of completion for inventory list August 1, 2014 **Monitoring Process:** Will be managed through daily operations and to include in EOC rounds **Person Responsible:** RD, Director of Dietary Department and Food Services Supervisor	6/27/2014 3/27/2014

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A 724	Continued From page 149 patients with disposable plastic plates. In an interview at approximately 11:45 a.m., OS 4 stated that he had to use the disposable plates because the plate warmer was broken. He further stated the disposable plates were better than using unheated plates, because the plates were cold and would cause the hot foods to become cold and unpalatable. 2. At approximately 3:30 p.m. on March 24, 2014, it was determined that the water temperature of the high temperature was not hot enough to properly sanitize dishes and other cooking utensils. The water temperature was 119.5 degrees F. The required minimum temperature for a high temperature is of 180 degrees F. There was a discrepancy between OS 3 and Staff 10 (Chief Engineer) on when hospital staff became aware that the temperature of the machine was not adequate and should not be used to dish washing. Staff 10 stated at approximately 3:35 p.m. that a part in the machine needed to be replaced and that he had informed DS 3. Inside the dish room there were cooking utensils, pots and pans that had been washed in machine. Improper water temperatures could result in unclean and unsanitized utensils. 3. At approximately 3:40p.m. on March 24, 2014, the preventive maintenance for the ice machine was reviewed. It was noted there was a buildup of black particles on both sides of the ice shield (a plastic cover over the ice production area). In an interview with Staff 10 he stated that the machine interior should be cleaned every two months. There was no documented evidence that this was done. 4. Over twelve Patient trays on the van Nuys	A 724	(Continued from page 149) **3). Corrective Actions**: Will provide staff education to include review of policy Infection Control FNS.042; Cleaning, sanitizing of ice machine will be performed twice yearly and will be documented on log sheet attached to unit. **Date of Implementation:** Target date of implementation for education July 1, 2014; target date for cleaning and sanitizing July 31, 2014 **Monitoring Process:** Monitoring will be managed through weekly and monthly cleaning logs **Person Responsible:** RD, Director and Food Services supervisors **4) Corrective Actions:** Will purchase additional trays to ensure patient and staff safety; Will provide education to staff on work order process for broken equipment and reporting process to supervisor **Date of Implementation:** Target date of completion in 30 days July 15, 2014 **Monitoring Process:** Monitoring process will be managed through daily operations by dietary staff and to include in EOC rounds **Person Responsible:** RD, Director of Dietary Department and Food Services Supervisor, dietary staff **Culver City** **4) Corrective Actions**: Twice yearly cleaning/sanitizing of internal components to be performed by outside vendor (Redline Air) **(see Addendum 134, 134a)** **Date of Implementation:** Serviced June 2014; to re-occur every six months. **Monitoring Process:** Cleaning/sanitizing of ice machine (twice yearly) is documented on log sheet attached to unit. **Person Responsible:** Director of Facilities & Director of Food & Nutrition **5) Corrective Actions:** Capital Expenditure Request (CER) has been approved for two roll-in coolers to replace □out of order□units. **Date of Implementation**: units to arrive and be installed July 2014	7/1/2014 7/15/2014 6/30/2014 7/30/2014

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A 724	Continued From page 150 Campus had chipped, broken jagged edges exposing a metal interior. The state of the trays presented a risk of cuts to patients. Staff 1 stated that they had recently purchased 36 trays. She provided no other information on when the other trays will be replaced. On March 25, 2014 beginning at 3 p.m., at the Culver City campus the preventive maintenance of the ice machine was reviewed. In a concurrent interview with Staff 5 he described he process. He stated that a) the hospital installed an automatic cleaning system for the unit; b) that with the installation of this unit required no additional maintenance and c) that the hospital contracted with a vendor to complete manufacturers' required maintenance. The bottle of chemical in the unit was labeled as an ice machine cleaner. In an interview on March 26, 2014 beginning at 9:35a.m., with REP 1 from the contracted vendor described how the automatic cleaning system worked. He described a process whereby the chemical would circulate through the ice producing mechanism two times/month. He also stated that the ice machine cleaner was the only chemical circulated. Posted on the interior panel of the ice machine was manufacturers' guidance for both a cleaning and sanitizing process. There was no evidence that the ice machines were sanitized This could result in cross contamination and growth of microorganisms that could cause food borne illness. 5. During the initial tour of the kitchen on the Culver City campus on March 25, 2014 at approximately 10:30 a.m., approximately five built-in refrigerators and/or freezers was labeled	A 724	(Continued from page 150) **Monitoring Process:** Routine inspection for □out of order□ equipment included on quarterly safety audit. (□All equipment and tools in good working order□). **Person Responsible:** Joseph Pipes (Foodservice), Juanita Jones (Materials Mgmt) **6) Corrective Actions:** Work order (□209410) placed to provide insulation to close □gap□between freezer pipe and wall. **Date of Implementation**: date of service or installation of new unit, expected to be completed by the end of July 2014. **Monitoring Process:** Routine inspection for ice build-up in freezer included on quarterly safety audit. **(see Addendum 135)** **Person Responsible:** Ray La fond (Facilities), Joseph Pipes (Food & Nutrition)	7/30/2014

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A 724	Continued From page 151 as □out of order.□It was not clear how long these equipment had broken down and not repaired or replaced. There were several smaller mobile refrigerators around the kitchen resulting in a cluttered, cramped space. Dietary employees were often overheard warning other employees "I□m behind you." Staff 2 who was present during the tour stated that the equipment have been broken for a while and was not sure how long. She further stated that it was part of the capital expenditure that had been presented to the hospital administration. Staff 11 who was present during the tour acknowledged that it was part of the capital expenditure for this fiscal year. The outside freezer had a build-up of ice on the floor a result of water drips from the condenser. There was a stainless steel pan also observed under the condenser. Dietary Staff 10 stated the pan had been placed under the condenser to "catch the drips... The ice build-up on the floor is a fall risk for the hospital employees. While in the freezer, sunlight was observed through the freezer wall from around the pipes. Inspection of the pipe on the outside revealed a gap around the pipe that fed into the freezer. The gap could have contributed to the condensation and water drips experienced in the freezer as it introduced warm outside temperature into the freezer. The gap could also allow the introduction of other substances and contaminants into the freezer. Review of the work orders from Dietary from the previous six months was done. It did not include request for the built in refrigerators and freezer.	A 724		

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A 724	Continued From page 152 There was an order on 11/13/2013 for water leaking under fan inside walk-in freezer. It showed it was completed on the same day. AA provided a copy of the approval of two refrigerators. Closer review showed that the approvals did not include copies original signatures but copies of signatures cut out and taped on the signature lines. It is not clear whether these equipment were indeed approved for replacement. The hospital failed to ensure that its equipment were in good working order. These failures related in food safety concern for patients and safety (fall risk) concerns for employees.	A 724		
A 747	482.421NFECTION CONTROL The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases. This CONDITION is not met as evidenced by: Based on observation, review of facility documents and staff interview, the facility failed to meet the Condition of Participation in Infection Control by failing to: 1. Ensure the single use ampule/vial was used for one patient. This deficient practice had the potential for transmission of bloodborne viruses (Culver City) (Refer to A748). 2. Reprocess the endoscopes in the reprocessing area which minimize the opportunity	A 747	**Culver City** **1).Corrective Actions:** Director of Infection Prevention and Control will receive & review anesthesia log audits weekly from Pharmacy for appropriate use on single use vial and report monthly to Quality Council. Targeted compliance is 100%. Aggregated data will be reported to Infection Control Committee on a quarterly basis. **Monitoring Process:** Pharmacy/Surgery **Date of Implementation:** June 18, 2014 **Person Responsible:** Director of Infection Prevention and Control, Director of Pharmacy, Director of Peri-Operative Services **Hollywood** **2).Corrective Actions:** OR team re-educated to Policy SGI.006 Cleaning and Disinfection of Endoscopes to ensure policy compliance with procedure to re-process scopes only in the designated re-processing room and not in the procedure room. Policy reviewed for compliance to SGNA Society for Gastrointestinal Nurses and Associates guidelines **(see Addendum 136, 136a, 136b, 136c, 136d)**. Completing competencies on ORT□s on proper steps for cleaning/reprocessing of endoscopes in the proper locations target date for completion by July 31, 2014. **Date of Implementation:** Education provided 6-19-2014; target date of completion for competency tool 7-31-2014 **Monitoring Process**: Monitoring will be 100 % audit of all scope procedures until 100% compliance goal achieved consistently. Data will be reported monthly to PI, Quality and MEC **Person Responsible:** OR team, Infection Control	6/18/2014 6/19/2014

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A 747	Continued From page 153 for cross-contamination (Refer to A 749). 3. Change gloves and wash hands after removal of gloves which minimize the opportunity for cross contamination (Refer to A 749). 4. Develop a written policy and procedure for managing bed bugs to ensure an effective system was identified and developing practices and procedures were followed to prevent the spread of bed bugs. This deficient practice of not ensuring the infection prevention and control strategies for the bed bugs were implemented placed the patients, staff, and visitors at risk for infection and re-infestation (Refer to A 749). 5. Develop an effective systems for identifying, reporting and controlling infections when it failed to ensure safe food handling practices in the dietetic service areas on all three campuses and develop a policy to ensure tube feeding was handled in an effective manner to prevent growth of microorganisms. These failures are evidenced by: a. lack of system to ensure that meats and other leftover food items were monitored and cooled to prevent the growth of microorganisms that could result in food borne illness; b. lack of effective cleaning and sanitation of ice machines at the Hollywood, Culver City and Van Nuys campuses; c. lack of effective sanitation of soda syrup line connectors; d. lack of monitoring system for a cool down of potentially hazardous foods; e. lack of hand washing after handling soiled dishes; f. lack of an effective system to ensure food safety during thawing process of raw meat and	A 747	(Continued from page 153) **Culver City** **3).Corrective Actions**: All nursing staff re-educated starting 06/18/2014 on the hospital's policy titled Hand Hygiene with a focus on the expectation that hand hygiene must be practiced to decontaminate hands when moving from dirty to clean tasks and before donning and after removing gloves. Hand hygiene includes washing hands with soap and water &/or applying alcohol-hand rub. **Date of Implementation:** June 18, 2014 **Monitoring Process:** Director of Infection Control will conduct 30 random observations monthly among nursing staff to observe appropriate hand hygiene practices when moving from dirty to clean sites. Any episodes of non-compliance will immediately be corrected and nurses re-educated on the hand hygiene policy. Data will be aggregated monthly and reported quarterly to the Infection Control Committee and Quality Council. **Person Responsible:** Director of Infection Prevention and Control, Director of Nursing **Hollywood** **3).Corrective Actions**: In-services were conducted on hand hygiene practices and glove use for nursing staff. Hand hygiene audits are on-going. Hand Hygiene task force was initiated to discuss results and to work on ways to improve hand hygiene compliance. **[see Addendum 139, 141, 141a, 141b, 141c, 141d, 141e, 141f, 14 g, 141h]** **Date of Implementation:** 4/10/14; 4/30/14 **Monitoring Process:** On-going hand hygiene audits reported monthly to Hand Hygiene Task force and to Quality committee. **Person Responsible:** Infection Control Coordinator of Hollywood Campus **4).Corrective Actions:** A written policy and procedure **(see Addendum 144)** titled Control and Prevention of Bed Bug Infestation for managing bed bugs was developed and approved by Director of Infection Control on June 16, 2014 and has been sent to the Medical Executive Committee for approval (meeting taking place July 15, 2014). Re-education of all nursing staff will commence June 16th with a targeted and date of 31 days thereafter. **Date of Implementation:** June 18, 2014 **Monitoring Process:** EVS will determine a schedule for the routine assessment of bed bugs by the Pest Control Agency and report any findings to Director of Infection Prevention and Control for tracking and trending. Findings will be reported to Quality Council monthly and to the Infection Control Committee and Environment of Care Committee quarterly. **Person Responsible:** Director of Infection Prevention and Control, Director of Nursing	6/18/2014 4/10/2014 6/18/2014

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	050135	A. BUILDING **01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD** B. WING _____	**04/01/2014**

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A 747	Continued From page 154 the use of wiping cloths to dry food production equipment; g. lack of removal of aprons prior to throwing out the garbage; h. lack of washing and sanitizing dishes manually when the dish machine temperatures would not properly clean and sanitize dishes and develop policies to ensure that hang-times on tube feeding systems are monitored to prevent growth of microorganisms. Failure to ensure operational processes that support safe food handling practices may result in exposure of patients to bacteria associated with foodborne illness. Foodborne illness may result in further compromising patients' medical status and in severe instances may result in death (Refer to A 749). The cumulative effect of these systemic issues resulted in the facility's inability to ensure and provide a safe patient care environment.	A 747	(Continued from page 154) **All Three Campuses** **5a-h). Corrective Actions:** Dietary department instituted several new logs, including cool-down process for foods and audit of enteral feeding bags.**(see Addendum 46, 46a)** Thawing process was revised and staff was in-serviced **(see Addendum 140, 140a)**. Ice machine cleaning was initiated and log was created by dietary. In addition, dietary conducted in-services on proper apron use and sanitizing of work areas. In-service on manual washing and sanitizing of dishes will be conducted by dietary. Infection Control to in-service dietary staff on hand hygiene and general infection control. Infection control reviewed these in-services, logs and processes and will conduct audits on the log sheets during bimonthly dietary infection control rounds for a minimum of 3 months. Dietary supervisor will notify infection control coordinator of any equipment malfunction or needed repairs so that the Infection Control Coordinator will monitor any necessary interventions until repairs are made and assure adherence to proper infection control practices. In addition, dietary conducted in-services on proper apron use and sanitizing of work areas. □see tag A 619 for dietary supporting documents; attached is Infection Control Rounding sheet **(see Addendum 91)**, and IC dietary policy **(see Addendum 137, 137a)** addressing hand hygiene and enteral feeding, among other things□ **Date of Implementation**: 7/1/14 **Monitoring Process:** Infection Control bimonthly rounding and review of logs. **Person Responsible:** Infection Control Coordinator; Dietary Supervisor; Lead Dietician A 747 Continued on page 155a.	7/1/2014
A 748	482.42(a) INFECTION CONTROL OFFICER(S) A person or persons must be designated as infection control officer or officers to develop and implement policies governing control of infections and communicable diseases. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to implement its policy and procedures for the use of a single dose ampule/vial in the facility's Culver City campus by failing to ensure the single use ampule/vial was used for one patient. This deficient practice had	A 748	**Culver City** **Corrective Actions:** Director of Infection Prevention and Control will receive anesthesia log audits weekly from Pharmacy and report monthly to Quality Council. Targeted compliance is 100%. Aggregated data will be reported to Infection Control Committee on a quarterly basis. **Date of Implementation:** June 18, 2014 **Monitoring Process:** Pharmacy/Surgery **Person Responsible:** Director of Infection Prevention and Control, Director of Pharmacy, Director of Peri-Operative Services	6/18/2014

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A 748	Continue From page 155 the potential for transmission of bloodborne viruses. Findings: On March 24, 2014 at 11:29 a.m., a review of the Anesthesia Controlled Drug Record indicated that entries were done in a manual, paper-based process. The Anesthesia Controlled Drug Record, dated ..March 18, 19, and 21, 2014," indicated that a Fentanyl250 mg per 5 milliliter (ml) ampule was used for two different patients, that half of the content was used for Patient 3, marked as "0.5" and half the content was used for Patient 2, marked as "0.5." The inventory count indicated the beginning count of 10 ampules and the ending balance of 9 ampules. The Anesthesia Record dated March 19, 2014 for Patient 3 showed that the Anesthesiologist administered Fentanyl 100 micrograms (meg) at approximately 10:15 a.m. and 25 meg at approximately 11:15 a.m., total125 meg. The Anesthesia Record dated March 19, 2014 for Patient 2 showed that the same Anesthesiologist administered Fentanyl 50 meg at approximately 11:45 a.m. and 75 meg at approximately 12:15 p.m., total125 meg. The manufacturer□s package insert indicated "Fentanyl Citrate Injection ...is preservative-free and available as ...5 ml Single Dose ampules. On March 28, 2014 at 11:20 a.m., during an interview, when the surveyor showed the Anesthesia Controlled Drug Record and the use of the single dose ampule on two different patients to the director of infection prevention and	A 748	**Culver City** **Corrective Action:** Policy revised to be clear on the use of single dose vials. Policy will be sent to medical staff. **Date of Implementation:** July 1, 2014 **Monitoring Process:** DOP or designee will review anesthesia cart sheets, and will check that the SDVs are being used one time only. Any violations will be reported to the Quality Counsel. **Person Responsible:** VP of Pharmacy or designee	7/1/2014

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A 748	Continued From page 156 control, she responded □What does this have to do with me□ □ On March 28, 2014 at 11:25 a.m., during an interview, Staff P stated the single use ampule is not to be used for more than one patient. On March 28, 2014 at 12:45 p.m., a review of the facility policy and procedure titled □Medication, Care and Handling,□ Number: SAN.019, dated □11/2012,□ indicated □.. Each patient is medicated with either single dose or multiple dose vials. The remainder of each of the multi-dose vial is discarded after each patient. □When the surveyor asked Rx 1 to clarify this policy, she stated the policy should read □The remainder of each of the single dose vial is discarded after each patient.□ A review of the policy and procedure titled □Handling of Multidose/Single Dose Vials and IV Compounding (Low Risk Condition) Outside Laminar Flow Hood,□Number: PHA.090, dated □10/2012 □ indicated □□ Single Dose vials / ampoules should be discarded soon after opening and not stored ... Opened single dose ampules shall not be stored for any time period According to Centers for Disease Control and Prevention on Injection Safety, single dose vial should be used for a single patient and single case/procedure/injection. There have been multiple outbreaks resulting from healthcare personnel using single dose or single use vials for multiple patients. The safest practice was to enter a single dose vial once to prevent inadvertent contamination and vial and infection of transmission.	A 748		

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A 749	482.42(a)(1) INFECTION CONTROL PROGRAM The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a system was developed for controlling infections and communicable disease for 4 of 52 Sampled patients (Patient 14, 15, 23, and 25) and 7 randomly selected patients (Patients 53, 54, 55, 56, 57, 58, and 59) by failing to: 1. Reprocess the endoscopes in the reprocessing area which minimize the opportunity for cross-contamination. 2. Apply alcohol-based hand rub for decontaminating hands when moving from a contaminated-body site to a clean-body site and before donning and after removing gloves. This deficient practice had the potential to transmission of infectious agents to the patients. 3. Label the peripheral intravenous (IV) sites with the date, gauge of needle and initials and label the IV tubing with a date. This deficient practice had the potential for not monitoring when the IV sites needed to be changed to ensure patient safety of intravenous therapy. 4. Ensure that in a closed system enteral feeding bottle should be dated, timed and initialed when the formula bottle is spiked. This deficient	A 749	**Hollywood** **1) Corrective Actions:** OR team re-educated to Policy SGI.006 Cleaning and Disinfection of Endoscopes to ensure policy compliance with procedure to re-process scopes only in the designated re-processing room and not in the procedure room. Policy reviewed for compliance to SGNA Society for Gastrointestinal Nurses and Associates guidelines **(see Addendum 136, 136a, 136b, 136c, 136d)**. Completing competencies on ORTs on proper steps for cleaning/reprocessing of endoscopes in the proper locations target date for completion by July 31, 2014. **Date of Implementation**: Education provided 6-19-2014; target date of completion for competency tool July 31, 2014 **Monitoring Process:** Monitoring will be managed by 100 % audit of all scope procedures until 100% goal achieved. Data will be reported monthly to PI, Quality and MEC **Person Responsible:** OR team, Infection Control **2)Corrective Actions:** **(HOLLYWOOD):** Hand hygiene and PPE usage in-services were conducted for nursing staff. Hand Hygiene task force was initiated to discuss results and to work on ways to improve hand hygiene compliance. **(See Addendum 141, 141a, 141b, 141c, 141d, 141e, 141f, 14 g, 141h).** **Date of Implementation:**4/10/14; 4/30/14 **Monitoring Process:** Hand Hygiene audits with results reported to Hand Hygiene Task Force and Quality Committee **Person Responsible:** Infection Control Coordinator **2).Corrective Actions:** **(CULVER CITY):** Director of Infection Prevention and Control has implemented a monthly plan to conduct 30 random observations among nurses to ensure appropriate hand hygiene practice when moving between dirty to clean tasks and/or body sites. **Date of Implementation:** June 18, 2014 **Monitoring Process:** Director of Infection Control will conduct 30 random observations monthly among nursing staff to observe appropriate hand hygiene practices when moving from dirty to clean tasks and/or body sites.	6/19/2014 4/10/2014 6/18/2014

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A 749	Continued From page 158 practice had the potential to not being able to determine when the feeding bottle was hang and had the potential for growth of microorganisms. 5. Develop a written policy and procedure for managing bed bugs to ensure an effective system was identified and developing practices and procedures were followed to prevent the spread of bed bugs. This deficient practice of not ensuring the infection prevention and control strategies for the bed bugs were implemented placed the patients, staff, and visitors at risk for infection and re-infestation. 6. Develop an effective systems for identifying, reporting and controlling infections when it failed to ensure safe food handling practices in the dietetic service areas on all three campuses and develop a policy to ensure tube feeding was handled in an effective manner to prevent growth of microorganisms. These failures are evidenced by: a. lack of system to ensure that meats and other leftover food items were monitored and cooled to prevent the growth of microorganisms that could result in food borne illness; b. lack of effective cleaning and sanitation of ice machines at the Hollywood, Culver City and Van Nuys campuses; c. lack of effective sanitation of soda syrup line connectors; d. lack of monitoring system for a cool down of potentially hazardous foods; e. lack of hand washing after handling soiled dishes; f. lack of an effective system to ensure food safety during thawing process of raw meat and the use of wiping cloths to dry food production equipment;	A 749	(Continued from page 158) Any episodes of non-compliance will immediately be corrected and nurses re-educated on the hand hygiene policy using just-in-time training. Data will be aggregated and reported monthly to Quality Council and quarterly to the Infection Control Committee. **Person Responsible:** Director of Infection Prevention and Control, Director of Nursing **3) Corrective Actions:** Education provided include review of policy and procedure on Intravenous Therapy-Initiation and Management of Peripheral Intravenous Lines, label IV sites with date, gauge of needles and initials, IV tubing changes, accurate and complete documentation **(See Addendum 142).** policy VAS.005) **Date of Implementation:** May 1, 2014 **Monitoring Process:** Daily rounds by Nurse Leadership on each department on all patients with IV, weekly audit will be performed by Infection control/Nurse Educator, data will be reported monthly to PI and Quality until 95 % goal has been achieved. **Person Responsible:** Nursing Leadership in each department and infection control practitioner, nursing staff **4) Corrective Actions:** Nursing in-service conducted on proper hanging of feeding bottle. Dietician to do daily audits on enteral feeding bottles in use. **(See 143)**. **Date of Implementation**: 6/2014 **Monitoring Process:** Dietician to audit feeding bags monthly. **Person Responsible:** Dietician **5) Corrective Actions**: **(CULVER CITY):** A written policy and procedure titled Control and Prevention of Bed Bug Infestation **(see Addendum 144)** for managing bed bugs was developed and approved by Director of Infection Control on June 16, 2014 and has been sent to the Medical Executive Committee for approval (meeting taking place July 15, 2014). Re-education of all nursing staff will commence June 16th with a targeted and date of 31 days thereafter.	5/1/2014 6/30/2014

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A 749	Continued From page 159 g. lack of removal of aprons prior to throwing out the garbage; h. lack of washing and sanitizing dishes manually when the dish machine temperatures would not properly clean and sanitize dishes and develop policies to ensure that hang-times on tube feeding systems are monitored to prevent growth of microorganisms. Failure to ensure operational processes that support safe food handling practices may result in exposure of patients to bacteria associated with foodborne illness. Foodborne illness may result in further compromising patients□medical status and in severe instances may result in death. Findings: 1. During the initial tour with Registered Nurse (RN) 7 in the operating rooms of the Hollywood campus on March 24, 2014 between 9:58a.m. and 11 a.m., AN 7 stated all endoscopes had been reprocessed in Operating Room (OR) □3 (GI) room. According to RN 7, those endoscopes then were transported to a room for high-level disinfection. According to APIC, Chapter 47-Endoscopy, □PREVENTION AND CONTROL OF INFECTIONS ASSOCIATED WITH ENDOSCOPY,□in the Reprocessing Area or Room, reprocessing of contaminated equipment should be performed in a separate area or room, not in the endoscopy procedure room. The area must have adequate space for reprocessing, appropriate airflow and ventilation for the selection and method of disinfection/sterilization, appropriate work flow pattern (movement from dirty to clean minimizing the opportunity for	A 749	(Continued from page 159) **Date of Implementation:** June 18, 2014 **Monitoring Process:** EVS will determine a schedule for the routine assessment of bed bugs by the Pest Control Agency and report any findings to Director of Infection Prevention and Control for tracking and trending. Findings will be reported to Quality Council monthly and to the Infection Control Committee and Environment of Care Committee quarterly. **Person Responsible:** Director of Infection Prevention and Control, Director of Nursing **5). Culver City. Corrective Actions**: Infection Control in-service with Pharmacy staff regarding transportation and handling of Pharmacy items such as cassettes and contamination. **Monitoring Process:** Director of Pharmacy will randomly monitor Pharmacy Techs as they are doing their rounds on the floor. Any violations will be reported to the VP of Pharmacy. **Implementation Date:** 7/1/2014 **Person Responsible:** Director of Pharmacy. **a, c, d, e&f – Hollywood ; b- Culver City, Hollywood, Van Nuys** **Corrective Actions:** Created Policy on □Cool off log□and dietary staff in-serviced for the process; Policy created for Cool off method, staff in-serviced **(see Addendum 46, 46a)** . **Date of Implementation:** Education started April 23, 2014 and April 28, 2014; Policy created and will send for approval June 20, 2014 target approval date August 31, 2014 **Monitoring Process:** Will be managed through Staff competency Validation □Return Demonstration/Comprehension□will be done on a biannual basis and will be maintained in employee file. **Person Responsible:** RD, Director of Dietary Department and Food Services Supervisor **(e) Corrective Actions:** Will educate staff on proper hand hygiene practice, review of policy FNS.042 and will include in staff competency validation twice yearly **(see Addendum 145)**.	6/18/2014 7/1/2014 4/23/2014

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A 749	Continued From page 160 cross-contamination), and appropriate storage facilities. 2. During the initial tour with RN 1 in the mixed unit for DOU (Definitive Observation Unit) & Medical/surgical patients of the Hollywood campus on March 24, 2014 between 11:15 a.m. and 11:45 a.m., Patient 25 was observed resting on the bed with a sign of □Contact Isolation□posted by the door. According to RN 2, Patient 25 was placed in the room for Methicillin Resistant Staphyloccocus Aereus (MRSA) contact isolation. Licensed Vocational Nurse (LVN) 2 was standing by the patient□s right side-rails without any PPE (Personal Protection equipment) including mask, gown and gloves. During the concurrent interview with LVN 2 on March 24, 2014 at 11:35 a.m., he stated he was not required to wear any PPE because he did not touch the patient. An interview with Staff E was conducted on March 2414 at 12:20 p.m. Staff E stated the staff should wear PPE if they anticipated to contact the patient or patient□s environment. According to the facility□s policy for □Contact Precautions□ (Number INF.065) dated 11/2012: 4.2 PROCEDURE 4.1.26 GLOVES: 4.1.27 Wear gloves when hands will be in contact with body fluids (blood, urine, feces, wound drainage, oral secretions, sputum, vomitus, amniotic fluid, mucous membranes or non-intact skin of ALL patients.---. 4.1.28 MASK/GOGGLES: 4.1.31 Gowns are required when entering the room, when having contact with the environment,	A 749	(Continued from page 160) **Date of Implementation:** Will begin July 15-31, 2014 **Monitoring Process:** Will be managed through Staff competency Validation □Return Demonstration/Comprehension□will be done on a biannual basis and will be maintained in employee file. **Person Responsible:** RD, Director of Dietary Department and Food Services Supervisor **(f) Corrective Actions:** Staff education include review of policy Defrosting Meat FNS.010 and a new process □meat pull sheet□has been created and dietary staff have been trained on how to properly defrost meat (see attachment sign in sheet, log, pull sheet sample and policy) **Date of Implementation**: 4/23/2014; Staff validation competency will begin July 15-31, 2014 **Monitoring Process:** Will be managed through Staff Validation Competency □Return Demonstration/Comprehension log□will be done twice yearly and will be maintained in employee file **Responsible person:** RD, Director Dietary Department and Food Services Supervisor **Hollywood** **11). Corrective Actions:** □Cool off log□created and dietary staff in-serviced for the process; Policy created for Cool off method, staff in-serviced **(See Addendum 46, 46a).** **Date of Implementation:** Education started April 23, 2014 and April 28, 2014; Policy created and will send for approval June 20, 2014 target approval date August 31, 2014 **Monitoring Process:** □Return Demonstration/Comprehension□done on at least biannual basis and maintained in employee file. **Person Responsible:** RD, Director of Dietary Department and Food Services Supervisor **12) .Corrective Actions**: Water temp for dishwashing: Dishwasher has been fixed **(See Addendum 146)**. **Date of Implementation:** March 2014 **Monitoring Process:** Dish washer temperature check log implemented and water temperatures will be checked daily and reported. Aggregated data will be provided to the Quality Council.	7/15/2014 4/23/2014 4/23/2014 3/30/2014

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A 749	Continued From page 161 and/or when having contact with the patient. □ Culver City campus 2. On March 25,2014 at 10 a.m., a wound treatment observation for Patient 14 was conducted. Registered Nurse (RN) 11 was wearing gloves and removed the soiled dressing on the left knee and disposed the soiled dressing in the plastic bag. With the same gloves, RN 11 applied wound cleanser to the open wound and wiped with a gauze. RN 11 applied a xerofoam dressing, covered the wound with dry dressing and wrapped with Kerlix. The RN then took off the gloves and applied hand sanitizer. RN 11 donned a new pair of gloves and removed the soiled dressing on the patient□s mid-back wound and discarded the dressing in the plastic bag. With same gloves, RN 11 prepared the xerofoam dressing and started to cleanse the wound with wound cleanser. RN 11 applied the xerofoam dressing on the wound and cover it with optifoam dressing. RN 11 then gathered her residual supplies such as the xerofoam, gauzes and placed them back in the plastic basin container by the bedside table. During a concurrent interview, RN 11 stated hand hygiene/change of glove is performed when moving from dirty task to clean task such as removing soiled dressing, cleaning the wound then to applying new dressing. According to the facility□s policy and procedure on Hand Hygiene dated November 2012, apply alcohol-based hand rub for decontaminating hands if moving from a contaminated-body site to a clean-body site and before donning and after removing gloves. Hand Hygiene included	A 749	(Continued from page 161) **Person Responsible:** RD, Director of Dietary Department and Food Services Supervisor **13) Corrective Actions:** Blender Storage/ Cleanliness; Review of policy □FNS.042 and educated staff. **(See Addendum 147)**. Implementation of a daily cleaning schedule. **(see Addendum 147a)** **Date of Implementation:** June 2014 **Monitoring Process**: Will be monitored through daily □cleaning schedule□ **Person Responsible:** Food Service Supervisor, Dietary Staff **14). Corrective Actions :** Current process is already in place; cleaning and sanitizing of internal components are performed twice yearly **(See Addendum 148, 148a).** **Date of Implementation:** April 29, 2014 Monitoring Process: Monitor quarterly and/or as needed **Person Responsible:** Director of Facilities & Director of Dietary Department and Food Services Supervisor **15) Corrective Actions:** Tube Feedings & Evening hours: Reviewed and revised policy FNS.025 Dispensing Nutritional Products **(see Addendum 143)** and FNS.040 Guidelines for the Use of Parenteral Nutrition Therapy and will send for motions of approval **(See Addendum 149).** **Date of Implementation:** Education started 6/14/2014; target completion of policy August 31, 2014 **Monitoring Process:** On initial dietary assessments and on weekly basis through □Clinical Tube Feeding Audit□form conducted by the dietician. **Person Responsible:** Dietician **Culver City** **16. Corrective Actions:** Completed □Small Equipment Cleaning□in-service with production staff; included roster to document attendance/participation **(See Addendum 150).** **Date of Implementation**: 4/29/14	6/30/2014 4/29/2014 6/14/2014 4/29/2014

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A 749	Continued From page 162 washing hands with soap and water or applying alcohol-hand rub. Hand Hygiene is important prevention strategy for avoiding Healthcare Acquired Infections. The hands of personnel serve as a critical reservoir of infectious agents. 3. On March 25, 2014, at 10:20 a.m., during an observation tour with Staff E, a contact isolation sign was posted on the door of randomly selected patient (Patient 54). Staff E was wearing gown and gloves and checked the patient□s heplock/intravenous line, the oxygen tubing, and the indwelling catheter bag. With the same gloved hands, Staff E touched the gastrostomy tube feeding bag to check the label. During a concurrent interview, Staff E stated she was unaware that she did not wash her hands or apply hand sanitizer after removing the gloves. 4. On March 24, 2014, at 10:20 a.m., during provision of care observation of Patient 23, RN 5 with gloved hands started to check the patient□s indwelling catheter bag to see the amount of urine. The RN proceeded to touching the G-Tube feeding bag to check the label, the wrist restraint and the patient. The RN failed to change gloves and performed hand hygiene when performing dirty task to clean task. During a concurrent interview, RN 5 stated she failed to change gloves in when performing dirty task to clean task. 5. On March 24, 2014 at 10:05 a.m., during observation tour of the intensive care (ICU) unit, the PT (pharmacist technician) was noted to to pull out the medication cassette from the	A 749	(Continued from page 162) **Monitoring Process:** Random audits conducted by executive chef to ensure compliance. **Person Responsible:** Executive Chef **17. Corrective Actions**: Immediate removal/replacement of identified cutting boards was completed. **Date of Implementation:** 3/25/14 **Monitoring Process:** Random audits conducted by executive chef to assess condition of cutting boards and purchase/replace when needed. **Person Responsible:** Executive Chef **18. Corrective Actions:** Twice yearly cleaning/sanitizing of internal components to be performed by outside vendor (Redline Air) **(134, 134a).** **Date of Implementation:** Serviced June 2014; to re-occur every six months. **Monitoring Process:** Cleaning/sanitizing of ice machine (twice yearly) is documented on log sheet attached to unit **(see Addendum 135)**. **Person Responsible**: Director of Facilities & Director of Food & Nutrition **19. Corrective Actions**: Conducted □Soda Fountain Sanitizer□training with retail staff. Daily/Weekly/Monthly sanitizing requirements are documented as completed on log sheet posted on back of dispenser. **(see Addendum 138, 138a)**. **Date of Implementation:** 4/17/14 **Monitoring Process**: Completion documented on □Fountain Beverage Dispenser Cleaning/Sanitizing Log□ and reviewed weekly by executive chef. **Person Responsible**: Executive Chef **Van Nuys** **20) Corrective Actions:** Will provide staff education to include review of policy Infection Control FNS.042; Cleaning, sanitizing of ice machine will be performed twice yearly and will be documented on log sheet attached to unit **(see Addendum 148, 148a).**	3/25/2014 6/30/2014 4/17/2014

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A 749	Continued From page 163 medication refrigerator and put it on the floor. The PT took out a vial of medication, then placed back the insulin cassette to the refrigerator without disinfecting it. During a concurrent interview, PT stated that she should have not placed on the floor and if she did she should have disinfected the medication cassette. Before putting it back together with other cassettes in the medication refrigerator. Hollywood campus 6. On March 24, 2014, at 8:30 a.m., during a provision of care observation with RN 3 the following was noted: a. The randomly selected patient (Patient 56) had a peripheral intravenous (IV) line on the left arm which was not labeled with date, time and initial when it was initially placed. b. Patient 23 had a peripheral intravenous (IV) line on the right hand which was not labeled with date, time and initial when it was initially placed. c. Randomly selected patient (Patient 57) had a peripheral intravenous (IV) line on the right forearm which was not labeled with date, time and initial when it was initially placed. d. Randomly selected patient (Patient 58) had a peripheral intravenous (IV) line on the left forearm which was not labeled with date, time and initial when it was initially placed.	A 749	(Continued from page 163) **Date of Implementation:** Target date of implementation for education July 1, 2014; target date for cleaning and sanitizing July 31, 2014 **Monitoring Process:** Monitoring will be managed through weekly and monthly cleaning logs **Person Responsible:** RD, Director and Food Services supervisors **21) Corrective Action:** The new dietary policy for infection control includes a section on hand hygiene practice and technique for dietary workers **(see Addendum 137).** In-service on proper hand hygiene by the dietary staff will be given by infection control. Hand hygiene will be monitored during the bimonthly Infection Control rounds (see rounds worksheet attached). **Date of Implementation:** Policy (7/2014); In-service (7/15/14); Rounds (7/1/14) **Monitoring:** Rounds to be done bimonthly by infection control with hand hygiene audits during rounds. **Responsible Person**: Infection Control Coordinator **22) Corrective Actions:** Dietary department instituted a new log for the cool-down process for food and staff has been in-serviced. Thawing process was revised and staff was in-serviced. Ice machine cleaning was initiated and log was created by dietary. In addition, dietary conducted in-services on proper apron use and sanitizing of work areas. In-service on manual washing and sanitizing of dishes will be conducted by dietary. Infection Control to in-service dietary staff on hand hygiene and general infection control. Infection control reviewed these in-services, logs and processes and will conduct audits on the log sheets during bimonthly dietary infection control rounds for a minimum of 3 months; attached is Infection Control Rounding sheet, and IC dietary policy addressing hand hygiene, among other things **(see Addendum 91, 46, 46a 137).** **Date of Implementation:** 7/1/14 **Monitoring Process**: Infection Control rounding and review of logs. **Person Responsible**: Infection Control Coordinator; Dietary Supervisor; Lead Dietician	7/1/2014 7/1/2014 7/1/2014

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A 749	Continued From page 164 According to the facility's policy and procedure on Intravenous Therapy-Initiation and Management of Peripheral Intravenous Lines dated November 20, 2012, label the IV sites with the date, gauge of needle and initials. The IV sites may remain in place for up to 96 hours unless there are signs and symptoms of infection. The IV tubing set changes are every 96 hours and label the IV tubing with a date. 7. On March 24, 2014, at 11:30 a.m., during a tour with RN 3, the randomly selected patient (Patient 55) was receiving 2 liters of oxygen via nasal cannula, on a indwelling catheter and was on telemetry monitor. The AN after touching the indwelling catheter bag and tubing proceeded to pick up the telemetry box from the side of the bed and placed it on the patient's chest without performing hand washing or applying hand sanitizer. 8. On March 24, 2014, at 11:30 a.m., the randomly selected patient (Patient 53) had the G-Tube feeding bag label did not have the time when the feeding bag was initially hung. Culver City Campus 9. On March 25, 2014 at 10:20 a.m., during the observation tour of the unit the following was noted:	A 749	(Continued from page 164) **23) Corrective Actions:** Staff re-education to include review of policy Defrosting Meat FNS.010 and a new process □meat pull sheet□has been created and dietary staff have been trained on how to properly defrost meat **(see Addendum 140, 140a).** **Date of Implementation:** 4/23/2014; Staff validation competency will begin July 15-31, 2014 **Monitoring Process:** Will be managed through Staff Validation Competency □Return Demonstration/Comprehension log□will be done twice yearly and will be maintained in employee file **Responsible person:** RD, Director Dietary Department and Food Services Supervisor	4/23/2014

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A 749	Continued From page 165 a. There was a gastrostomy tube (GT) feeding bag of Diabetic Source formula hanging on the feeding pump pole and labeled the bag was hang on March 25, 2014 at 60 milliliters □ml)/hour (hr) for the randomly selected patient (Patient 54). However there was no time when the bag was initially hung. b. The randomly selected patient (Patient 59) had a peripheral intravenous (IV) line on the left forearm which was not labeled with a date, time and initial when it was placed. The patient was also observed receiving Ferlicit (iron medication) by IV and the IV tubing was not labeled with date, time and initial. c. Patient 15 had a midline peripheral IV line located in the right antecubital arm which was not labeled with date, time and intial when it was placed. d. There was a G-Tube feeding bag Fibersource HN running at 50 cc/hr with no date and time it was hung for the Patient 15. There was a 0.9% normal saline IV bag running at 75 cc/hr which did not have a label as to patient name, when it was hung and who hung it. According to the facility□s policy and procedure on Enteral Nutrition Support dated January 2014, closed system enteral feeding bag should be dated, timed and initialed when the formula bottle is spiked. 10. On March 26, 2014, at 10:30 a.m., during an	A 749		

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A 749	Continued From page 166 initial tour, of the open behavior health unit, room 603 had a sign which read □Closed this AM.□There was a man with white coveralls and a disinfectant canister going into the room. Staff S stated the room was closed due to bed bugs. A review of the Census Log dated March 21, 2014, disclosed two patients were in room 603. Shower Room 3, directly across the nurses' station, in the locked unit had a sign which read □Closed Needs to be Sanitized.□ Reviews of Pest Prevention Service Reports revealed the following dated: a. On January 8, 2014, a serviced was done for bed bugs in Room 509. b. On January 15, 2014, a serviced was done for bed bugs in Room 632. c. On March 7, 2014, a serviced was done for bed bugs in Room 603. d. On March 18, 2014, a serviced was done for bed bugs in Room 540. e. On March 21, 2014, a serviced was done for bed bugs in Room 603. An email communication dated April 9, 2014, at 4:22p.m., from Staff B (corporate vice president/quality risk management) disclosed the facility had no policy regarding how to identify, report, investigate and control of infections for bed bugs. The email communication indicated □the bed bug issue was confined to one room 603, on the behavioral health unit. There were three (3) documented incidents of which a service request was put in for pest control company. According to a facility's policy titled Pest Control dated May 2012 disclosed the purpose was to provide a sanitary, rodent, and pest free	A 749		

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A 749	Continued From page 167 environment. The procedure included housekeeping supervisor would log all pest control complaints. The housekeeping supervisor would accompany the pest control technician on treatment rounds within the department1S area responsibility. Hollywood campus 11. On March 241 2014 at approximately 10:40 a.m., a large stainless steel pan containing slices of meat was observed in the refrigerator. Dietary Staff (DS) 4 stated the pan contained the Roast Beef for the lunch meal. A temperature check revealed the roast was 74. 8 degrees Fahrenheit (F). DS 4 stated the roast was approximately 40 pounds and that he had sliced it that morning at approximately 9 a.m. He stated that he had not checked the temperature before slicing and added water after slicing. Staff 2, who was present during the concurrent interview, stated there was no cooling log to show how the roast was monitored during the cooling the period. He stated that cooks cools the roast, leaves it at room temperature for 2 hours till it reaches 160 degrees F. The roast is then put in the refrigerator and the morning cook comes in the next morning and slices it. Improper cooling is a major factor causing food borne illness. Foods that have been cooked and held at improper temperatures promote the growth of disease causing microorganisms that may have survived the cooking process. Large or	A 749		

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A 749	Continued From page 168 dense items such as roasts may require interventions (e.g. placing foods in shallow pans, cutting roasts into smaller portions, utilizing water baths and stirring periodically) in order to be chilled safely within an allowed time period. Cooked foods subject to time and temperature control safety foods are best cooled rapidly within 2 hours from 135 degrees to 70 degrees F and within 4 more hours to the temperature of 41 degrees F. The total time for cooling from 135 degrees to 41 degrees should not exceed *6* hours (Centers for Medicare and Medicaid, Appendix P, State Operations Manual.) 12. At approximately 3:30 p.m. on March 24, 2014, it was determined that the water temperature of the high temperature was not hot enough to properly sanitize dishes and other cooking utensils. The water temperature was 119.5 degrees F. The required minimum temperature for a high temperature is of 180 degrees F. There was a discrepancy between DS 3 and Staff 10 on when hospital staff became aware that the temperature of the machine was not adequate and should not be used to dish washing. Staff 10 stated at approximately 3:35 pm that a part in the machine needed to be replaced and that he had informed DS 3. Inside the dish room were cleaned cooking utensils, pots and pans that had been washed in machine within the time frame after CE stated he had informed Dietary Staff *6* that the dish machine needed a part and should not be used. Staff 2, who was present during the interview, instructed OS 3 to rewash the items and sanitize manually in the sink. 13. At approximately 11:10 a.m. on March 24,	A 749		

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A 749	Continued From page 169 2014, a food blender stored away as clean was observed on the counter. There was a light brown and cream colored substance on the rubber gasket and the base of the plastic food container of the blender. DS 4 stated it had been used earlier that morning to blend oatmeal. The standard of practice is that all removal parts of food service equipment are washed and sanitized. Improperly sanitized food contact surfaces could support the growth of microorganisms that could cause food borne illness resulting in cross-contamination of food prepared in/on the equipment. 14. At approximately 3:40 p.m. on March 24, 2014, the preventive maintenance for the ice machine was reviewed. It was noted there was a build-up of black particles on both sides of the ice shield (a plastic cover over the ice production area). In an interview with Staff 10, he stated that the machine interior should be cleaned every two months. There was no documented evidence that this was done. 15. Patient 9 was admitted with diagnoses including anemia (low blood iron), insulin dependent diabetes (high blood sugar), sacral decubitus (open sore on the top of the upper buttocks), end stage renal disease (when the kidneys are not able to work at a level for day - to day life) with dialysis (treatment that removes wastes in the blood done by healthy kidneys). Electronic record review showed on March 23, 2014 at 12: 25 a.m., there was an order for Novasource Renal, (a specialized tube feeding for patients with kidney disease) Give 20 milliliters □ml)/hour (hr) via PEG (percutaneous endoscopic gastrostomy tube). A medical procedure where a tube is passed into the stomach through the	A 749		

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A 749	Continued From page 170 abdominal wall. There were additional instructions □every evening hours.□ RN 18 stated in an interview at approximately 5:45p.m. on March 24, 2014 on the definition of □evening hours□ was 7 p.m. to 7 a.m. Inspection of the tube at approximately 5:50p.m. showed a feeding bag hung in the patient□s room with approximately 150 ml of a light brown colored liquid left in the bag. The tube feeding bag had a blue colored cap which indicated that the tube feeding was poured into the bag. The bag was dated March 24, 2014 was not timed. It could not be determined how long the bag had been hung and how much Patient 9 received. This kind of tube feeding where hospital nursing staff has to pour the feeding into a bag is called an □open□system. The system where the tube feeding is pre-filled and sealed from the factory is called a closed system. The recommended time that tube feeding in an □open system□ can be left hanging is 4 hours to prevent growth of microorganisms. RN 19 stated that at 7 p.m. the pump is turned on and whatever feeding that is left in the bag is allowed to infuse into the patient. He stated that at midnight all the bags are changed and new bags hung. RN 19 also stated that a new bag is hung at the beginning of each shift while RN 18 stated it was changed at 12 midnight. Neither RN 18 nor RN 19 was able to state how much feeding was poured into the bag, when it was hung. Review of hospital policy titled, □Enteral and Total Parenteral Nutrition□ dated November 2012 did not include information on hang times and how to	A 749		

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A 749	Continued From page 171 prevent microbial growth. The hospital lacked an effective system to ensure that tube feeding in an open system was hung in a manner that would not support the growth of microorganisms that could cause food borne illness. Culver City campus 16. At approximately 11:24 a.m. on March 25, 2014, a food blender stored away as clean was observed on the counter. There was a light brown and cream colored substance on the rubber gasket and the base of the plastic food container of the blender. Next to the blender was a Robot Coupe (food processor) also stored away as clean. There was an unidentifiable light brown colored substance on the lid. Staff 3 who was present during the observation stated that the hospital policy was to remove all the removable parts. She instructed on the dietary staff to remove the two pieces of equipment and rewash. At approximately 3:00p.m. on March 25, 2014, the robot coupe was observed in the same area stored away as clean. There was once again a dried on substance on the lid. Staff 3 who was present during the observation could not provide any explanation as to why the piece of equipment had not been properly cleaned. The standard of practice is that all removal parts of food service equipment are washed and sanitized. Improperly sanitized food contact surfaces could support the growth of microorganisms that could cause food borne illness resulting in cross-contamination of food prepared in/on the equipment. 17. At approximately 3:10p.m. on March 25, 2014, two cutting boards stored away were	A 749		

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A 749	Continued From page 172 observed with dark colored substances in the cut groove marks. Staff 3 acknowledged the presence of the unidentifiable black colored substances and stated the boards will be replaced. Improperly sanitized food contact surfaces could support the growth of microorganisms that could cause food borne illness resulting in cross-contamination of food prepared in/on the equipment. 18. On March 25, 2014 beginning at 3 p.m., at the Culver City campus the preventive maintenance of the ice machine was reviewed. In a concurrent interview with Staff 5 he described he process. He stated that a) the hospital installed an automatic cleaning system for the unit; b) that with the installation of this unit required no additional maintenance and c) that the hospital contracted with a vendor to complete manufacturers' required maintenance. The bottle of chemical in the unit was labeled as an ice machine cleaner. In an interview on March 26, 2014 beginning at 9:35a.m., with REP 1 from the contracted vendor described how the automatic cleaning system worked. He described a process whereby the chemical would circulate through the ice producing mechanism two times/month. He also stated that the ice machine cleaner was the only chemical circulated. Posted on the interior panel of the ice machine was manufacturers' guidance for both a cleaning and sanitizing process. 19. In an interview March 26, 2014 beginning at 9 am, with Dietary Staff (DS) 1 the maintenance of the coke machine syrup connectors was reviewed. DS 1 stated that when she changed the syrup boxes the connectors were rinsed in a	A 749		

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	050135	A. BUILDING **01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD** B. WING _____	**04/01/2014**

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A 749	Continued From page 173 bucket of hot water. On March 26, 2014 at 1:30 p.m., Staff 2 stated that she has previously attempted to obtain manufacturers□instructions for the dispensing unit; however was told by the purchasing group that it was a closed system and did not require any additional maintenance. She also stated that the vendor was trying to contact the manufacturer for guidance. As of April 1, 2014 at 5 p.m., the hospital was unable to provide manufacturers□guidance. On April 2, 2014 at 9 a.m., the surveyor reviewed of the soft drink vendors□web page and noted that it provided comprehensive guidance for daily, weekly and monthly cleaning of the syrup connectors and unit, which included a cleaning and sanitizing procedure. Van Nuys campus 20. In an interview on March 27, 2014 beginning at 10:30 a.m., with Staff 6 at the Van Nuys campus the preventive maintenance for the ice machine was reviewed. It was noted there was a buildup of black particles on both sides of the ice shield (a plastic cover over the ice production area) as well as the water supply tube. He stated he was unsure of the substance but thought it may be a disintegration of the foam on the interior of the shield. It was also noted that in the interior of the machine there was a white calcified substance, identified by Staff 6 as a mineral build up. Staff 6 described a preventive maintenance process that was limited to cleaning the filters, checking the pump and vacuuming dust on the interior of the machine. Review on March 27, 2014 at 4:15p.m., the manufacturers□guidance for cleaning and sanitizing of the ice machine was reviewed with Staff 6. He acknowledged that this process was not being followed.	A 749		

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A 749	Continued From page 174 21. On March 27, 2014 beginning at 8:20 a.m., DS 1 was observed in the dish room of the Van Nuys campus. It was noted that placed dirty Dishes in the dishwasher, wiped his hands dry with a paper towel and returned to food production activities. It was also noted that after the food production activities he placed gloves on his hands and began removing cleaned and Sanitized dishes. Review of hospital policy titled □Hand Hygiene □dated 11/12 guided staff that □ 4.2.1 Soap and water is required: 4.2.1.1Any Time hands are visibly dirty □ □ It was also noted That the hand washing procedure was intended to be used by healthcare workers in a patient Care setting □ □ Additionally it was noted that the procedure included alcohol based hand rub to be used in clinical situations. The policy did not include any specific guidance for food service workers. In an interview on March 28, 2014 at 1:30 pm, with the Vice President of Quality she stated that this was the only policy that the hospital had. 22. Potentially hazardous foods (PHF) are those are capable of supporting bacterial growth associated with foodborne illness. PHF□s require time/temperature control for food safety during all stages of receiving, storage, production and distribution. PHF□s that are cooked and held for use at a later time must be monitored for time/temperature control within specified time/frames (Food Code, 2013). During initial kitchen tour on March 27, 2014 beginning at 8 a.m., it was noted that there were leftover cooked egg rolls and tofu stir fry in the refrigerator adjacent to the trayline. In an interview on March 27, 2014 at 8:55 a.m., with Staff 2 she stated that if leftovers were saved	A 749		

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A 749	Continued From page 175 they would be taken off the steam table, put into Another container, covered, labeled, dated and put in the refrigerator. She also stated that to ensure food safety when the leftovers were served they would be heated to an internal temperature of 165□ She further stated there was not temperature monitoring of these leftovers once they were refrigerated. Additional observation on March 27, 2014 at 9:30 a.m. noted there were 15 packages of five pound rolls of raw, fully thawed ground beef. In a concurrent interview with Staff 1 she stated that the meat was thawed on March 24, 2014 to be used on 3/29/14 for spaghetti. She further stated that the item would be cooked for the cafeteria at lunch time and the leftovers would be used for the patient dinner meal. She also stated that after lunch meal the leftovers would be put in the refrigerator and reheated for dinner and that there would be no temperature monitoring between lunch and dinner. In an interview with Registered Dietitian (RD 1) 3 she stated that she did not do any routine foodservice oversight; however would provide training and guidance if asked to do so. Review of position description titled □Clinical Dietitian□ effective 4/1/06 noted that under the general responsibilities section this position was responsible to □observe and implement proper food handling and storage to assure safe quality nutrition.□ On March 28, 2014 beginning at 10:25 a.m., interviews were held with Staff K. The surveyor requested a description of the environment of care rounds. She stated that 2-3 times a year the department was reviewed for refrigerator/freezer	A 749		

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A 749	Continued From page 176 temperature and dishwasher logs, the physical Environment of the department; dating of food; cleanliness of equipment and the ice machine. She also stated the rounds were usually conducted with a hospital engineer and the department manager. She was also stated that The departmental policies did not go to the Infection control committee for review prior for implementation. Staff K also stated that the Health system recently acquired the Van Nuys campus and that all hospital policies/procedures were combined. Review of a copy of the Van Nuys campus environment of care rounds dated 1/23/14 noted that the evaluation included the cafeteria, kitchen, dishwasher, freezer, dry storage and office areas. It was also noted that cleanliness, labeling of food storage issues were identified. There was no evaluation or identification of the operational processes within the department related to food handling practices, specifically practices related to time/temperature control of potentially hazardous foods (PHF). PHF□s are those foods capable of supporting bacterial growth associated with foodborne illness (USDA Food Code, 2013) and require effective monitoring systems for food safety. Review of departmental document titled □Storage And Use of Leftovers□dated 11/12 noted that while a procedure was developed for handling of leftover foods, it did not meet safe food handling standards, rather was limited to labeling and dating of foods. It did not include monitoring cooling of leftovers. In addition, some of the temperatures identified as requirements were outdated and did not meet current temperatures outlined in the 2013 Food Code.	A 749		

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A 749	Continued From page 177 23. During initial tour on March 27, 2014 beginning at 8 a.m., it was noted there were 15 packages of five pound rolls of raw, fully thawed ground beef. In a concurrent interview with Staff 1 she stated that the meat was thawed on March 24, 2014 to be used on 3/29/14 (5 days after removal from the freezer) for spaghetti. She also stated she was unsure if there was a policy regarding the procedure for thawing meats. Hospital policy titled □Defrosting Meats □dated 11/12 guided staff to remove frozen meats two days in advance. The United States Department of Agriculture, Food Safety and Inspection Service (8/6/13) noted that ground beef may contain multiple bacterial strains. Extensive Holding of thawed meats provide an environment for increased bacterial growth. 16. During food production observation on March 27, 2014 beginning at 10:30 a.m., DS 1 Was observed preparing to transfer food into a Baking pan. He was observed taking a towel from a clean linen bin and wiping excess water from the pan. It would be the standard of practice to ensure that all dishware was dry before storage. Review undated of departmental policy and procedure manual revealed that there was no comprehensive ware washing procedure. In an interview with the RD 1 she stated that she did a cursory review of the policy/procedure manual; however she did not complete routine oversight of dietetic services. The standard of practice for storage of all equipment and utensils would be to ensure that after cleaning and sanitizing they were air-dried. Equipment and utensils may not be cloth dried except utensils that have been air-dried may be polished with cloths that are maintained clean	A 749		

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A 749	Continued From page 178 and dry.	A 749		
A 940	482.51 SURGICAL SERVICES If the hospital provides surgical services, the services must be well organized and provided in Accordance with acceptable standards Practice. If outpatient surgical services are Offered the services must be consistent in quality With inpatient care in accordance with the Complexity of services offered. This CONDITION is not met as evidenced by: Based on observation, review of facility documents and staff interview, the facility failed to meet the Condition of Participation in Surgical Services by failing to: 1. Ensure the surgical instruments and sterilized gowns that were opened on the back table prior to the surgery were constantly monitored and not Be left unattended in accordance with the recommendation from the Association of Operative Room Nursing (AORN). This deficient practice had the potential for contamination of the Surgical room with microorganisms which may affect the health and safety of the patients Receiving surgical services in the hospital (Refer To A 951). 2. Ensure the temperature and humidity were monitored in the autoclave room in accordance with recommendation from AAMI (Association for Advanced Medical Instrument). This defiant practice promote microbial growth and can result in contamination of sterile items (Refer to A 951). 3. To ensure a medical history and physical (H&P) examination completed and documented	A 940	**Culver City** **1) Corrective Actions:** Surgical Staff will be re- in serviced on the hospital□s policy Aseptic Technique SUR.002 with a focus on the expectation that the sterile field should be constantly monitored and maintained. Unguarded sterile fields should be considered contaminated. Without direct observation, there is no way to ensure sterility. The sterile field should be prepared as close as possible to the time of use. The sterility of an opened sterile field is event related. There is no specified amount of time that opened sterile supplies in an unused room can remain sterile. **(See Addendum 151, 151a, 151b).** **Date of Implementation:** Staff in-service completed on April 17, 2014. **Monitoring Process:** The Director of Perioperative Services and/ or designee will conduct monitoring activity to include monthly audits of a minimum of 20 OR cases to ensure rooms are not being left unattended after supplies are opened. Targeted compliance is 100%. Compliance data will be reported to the Surgery Committee and the Quality Council and the Governing Board on a quarterly basis until optimal compliance is achieved. **Person Responsible:** Director Perioperative Services **2).Corrective Actions:** Red Line Air Conditioning Service to assess decontamination area for proper exhaust. A temperature and Humidity gauge will be installed in the Decontamination Room in Central Processing. Room temperature and humidity will be monitored and recorded on a daily basis by Plant Operations and Central Processing Staff**. (see Addendum 152, 152a)** Corrective actions will be taken and documented when minimum parameters are not met. . ASHE, AORN, and AAMI, guideline parameters for Soiled/ decontaminated areas are temperature 60-65 degrees and 20-60% humidity. Digital gauges will replace the Analog gauges in those areas where the monitoring of temperature and humidity is required on June 18, 2014. **Date of Implementation:** June 17,2014 Red Line Air Conditioning to assess decontamination area for proper exhaust.; June 18,2014 installation of digital gauges in areas requiring monitoring of temperature and humidity; June 18,2014. Daily Monitoring of Temperature and Humidity in Central Processing **Monitoring Process:** Monitoring activity will include a verification of the Decontamination Room daily temperature and humidity log by the Director of Perioperative Services. Compliance data will be reported to the Infection Prevention Committee and the Quality Council on a quarterly basis until optimal compliance is achieved. **Person(s) Responsible:** Director Perioperative Services & Director Plant Operations **3).Corrective Actions**: The hospital□s leadership will ensure that its medical staff is re-educated on required documentation in the medical record to include the necessity for the signature, date and time of all entries in the medical record.	4/17/2014 6/17/2014

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A 940	Continued From page 179 24 hours after admission prior to the surgery Requiring anesthesia services for Patient 28 (Refer to A 952). 4. Ensure a tracheostomy set was available in the operating room suites in Hollywood campus. This deficient practice created the risk of poor health outcome in the event that a patient required a tracheostomy tray (Refer to A 959). The cumulative effect of these systemic practices Resulted in the hospital□s inability to provide safe and effective surgical services.	A 940	(Continued from page 179) **(see Addendum 153)** **3).Corrective Actions**: The hospital□s leadership will ensure that its medical staff is re-educated on required documentation in the medical record to include the necessity for the signature, date and time of all entries in the medical record. **(see Addendum 153).** Pre-op H & P Update form has been revised to include a designated place for physician signature, date and time**. (see Addendum 153a, 153b)** **Date of Implementation:** Pre-op H & P Update form presented at the Anesthesia and Surgery Committee Meeting of June 9, 2014. **Monitoring Process:** The Director of Perioperative Services will conduct a review of a minimum of 30 Pre-op H& P Update Progress Records per month. Compliance data will be reported through Surgery Committee Meeting, the Quality Council, and the Governing Board on a quarterly basis until compliance is achieved. **Person Responsible**: Director Perioperative Services & Director Medical Staff Office A 940 Continued on page 180a.	6/9/2014
A 951	482.51 (b) OPERATING ROOM POLICIES Surgical services must be consistent with needs and resources. Policies governing surgical care must be designed to assure the achievement and maintenance of high standards of medical practice and patient care. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide a safe environment and maintain high standards of care for patients receiving surgical services by failing to; 1. Ensure the surgical instruments and sterilized gowns that were opened on the back table prior to the surgery were constantly monitored and not be left unattended in accordance with recommendation from the Association of Perioperative room Nursing (AORN). This Deficient practice had the potential for contamination of the surgical room with microorganisms which may affect the health and safety of the patients receiving surgical services	A 951	**Culver City** **1) Corrective Actions:** Surgical Staff will be re- in-serviced on the hospital□s policy Aseptic Technique SUR.002 **(see Addendum 155, 155a, 155b, 155c)** with a focus on the expectation that the sterile field should be constantly monitored and maintained. Unguarded sterile fields should be considered contaminated. Without direct observation, there is no way to ensure sterility. The sterile field should be prepared as close as possible to the time of use. The sterility of an opened sterile field is event related. There is no specified amount of time that opened sterile supplies in an unused room can remain sterile. **Date of Implementation:** Staff in-service completed April 17, 2014. **Monitoring Process:** The Director of Perioperative Services and/ or designee will conduct monitoring activity to include monthly audits of a minimum of 30 OR cases to ensure rooms are not being left unattended after supplies are opened. Targeted compliance is 100%. Compliance data will be reported to the Surgery Committee and the Quality Council and the Governing Board on a quarterly basis until optimal compliance is achieved. **Person Responsible:** Director Perioperative Services	4/17/2014

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A 951	Continued From page 180 in the hospital. 1. Ensure the temperature and humidity were Monitored in the autoclave room in accordance with recommendation from AAMI (Association for Advanced Medical Instrument). This deficient practice promote microbial growth and result in contamination of sterile items. Findings: During the initial tour with Staff D in the operating Room (OR) suites and Autoclave Room of the Culver city campus on March 25, 2014 between 9:03 a.m. and 10 a.m., the following was observed: 1. In OR □2, the surgical instruments and sterilized gowns on the back table were opened to the air at 9:38 a.m. Scrub technician (ST) 1 Was about to go out of the room to scrub his Hands without constantly monitoring the sterile field until the surveyor intervened. During the concurrent interview, ST 1 stated he had to prepare the surgical instruments to be ready for surgical procedures. The patient was brought into the room at 10:15 a.m., which was 37 minutes after the surgical instruments were opened on the back table. According to Perioperative Standards and Recommended Practices for 2013 of the AORN Recommendation VII Sterile fields should be constantly monitored. VII.a. Once created, a sterile field should not be left unattended until the operative or other invasive procedure is completed. 2. There was no thermometer and humidity	A 951	(Continued from page 180) **2) Corrective Actions**: Red Line Air Conditioning Service to assess decontamination area for proper exhaust. A temperature and Humidity gauge will be installed in the Decontamination Room in Central Processing. Room temperature and humidity will be monitored and recorded on a daily basis by Plant Operations and Central Processing Staff **(see Addendum 156, 156a).** Corrective actions will be taken and documented when minimum parameters are not met. . ASHE, AORN, and AAMI, guideline parameters for Soiled/ decontaminated areas are temperature 60-65 degrees and 20-60% humidity. Digital gauges will replace the Analog gauges in those areas where the monitoring of temperature and humidity is required on June 18, 2014. **Date of Implementation**: June 17, 2014 Red Line Air Conditioning to assess decontamination area for proper exhaust. June 18, 2014 installation of digital gauges in areas requiring monitoring of temperature and humidity. June 18, 2014 Daily Monitoring of Temperature and Humidity in Central Processing **Monitoring Process:** Monitoring activity will include a verification of the Decontamination Room daily temperature and humidity log by the Director of Perioperative Services. Compliance data will be reported to the Infection Prevention Committee and the Quality Council on a quarterly basis until optimal compliance is achieved. **Person(s) Responsible:** Director Perioperative Services & Director Plant Operations	6/17/2014

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A 951	Continued From page 181 display in the Autoclave Room, where all surgical instruments trays were wrapped and sterilized in the steam autoclaves. According to Staff D, the temperature and humidity were centrally monitored by the maintenance services. A review of the □Third Shift Surgery Check List □dated March 25. 2-14 disclosed the temperature and Humidity for all operating rooms and recovery room had been monitored and recorded. However, there was no documentation that the temperature and humidity to the Autoclave Room had been monitored and recorded. During an interview with Staff B on March 25, 2014, 2014 at 4 p.m., she stated that the temperature and humidity to the Autoclave Room had not been monitored and recorded. According to AAMI (Association for Advanced Medical Instrument) (2014) Chapter 3: Design Consideration 3.3.6.5 Temperature General work areas should have a temperature controlled between 20˚C and 23˚C (68◦F and 73◦F). The decontamination area should have a temperature controlled between 16˚C and 18˚C (60˚F and 65˚F). The temperature in sterilization equipment access rooms should be controlled between 24˚C and 29˚C (75˚ F and85˚ F) or as recommended by the equipment manufacturer. The temperature in sterile storage and personnel support areas (e.g., toilets, showers, locker room) may be as high as 24 ˚C (75˚ F). Independent monitors should be located in each of the areas where temperature should be controlled; temperature should be recorded daily. Processing personnel in each work area are responsible for monitoring and recording the	A 951		

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A 951	Continued From page 182 temperature to ensure that the correct temperature is being achieved. Rationale: Work areas should be comfortable for properly attired personnel. Comfort is a particular consideration in the decontamination area, where PPE is worn for long periods of time and where temperatures suitable for general work areas might be uncomfortably hot. Also, bacteria thrive at high temperatures; cool temperatures in the Decontamination area might help minimize Bioburden. Although AIA (2006) allows the temperature in clean work areas to be as high as 24° C (75° F), the consensus of the AAMI Committee was to recommend consistent temperature ranges for all general work areas. Controlling the temperature in sterilization equipment access rooms promotes higher efficiency of the equipment contained within the enclosures. For additional information on temperature control, see AIA (2006). 3.3.6.6 Relative humidity Relative humidity should be controlled between 30% and 60% in all work areas except the sterile storage area, where the relative humidity should not exceed 70%. An independent humidity monitor should be located in each area that requires controlled relative humidity. Relative humidity should be recorded daily. Processing personnel in each work area are responsible for monitoring and recording the relative humidity to ensure that the correct relative humidity is being achieved. NOTE-Ideal relative humidity in the preparation And packaging area is 50% and should not be less than 35% for best results in achieving sterilization. In the decontamination area, the recommended range of relative humidity should	A 951		

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(□4) ID PREFI□ TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFI□ TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(□5) COMPLETION DATE
A 951	Continued From page 183 be maintained to the extent possible, but temporary elevations might occur because of the type and quantity of cleaning and decontamination equipment. Humidifiers may be installed to maintain the recommended humidity level seasonally (e.g., during the winter months, when the heating system is functioning). If duct humidifiers are located upstream of the final filters, they should be placed at least 15 feet (4.57 meters) upstream of the final filters. For ductwork with duct mounted humidifiers, there should be a means of water removal. An adjustable high-limit humidistat should be locteddownstream of the humidifier to reduce the potential for condensation inside the duct. All duct takeoffs should be sufficiently downstream of the humidifier to ensure complete moisture absorption. Steam humidifiers should be used. Reservoir-type water spray or evaporative pan humidifiers should not be used. Rationale: Relative humidities higher than those recommended can promote microbial growth and thus increase bioburden. Relative humidity lower than 30% will permit absorbent materials to become excessively dry, which can adversely affect certain sterilization parameters (such as steam penetration) and the performance of some products (such as BIs and CIs). Thus, for best results, the committee recommends an ideal relative humidity level of 50% and a minimum level of 35%. The recommended range for relative humidity was largely based on AIA (2006).	A 951		
A 952	482.51 (b) (1) HISTORY AND PHYSICAL Prior to surgery or a procedure requiring	A 952	**Culver City and Hollywood Campuses** **1-3 Corrective Actions:** • Non-compliance discussed and corrective actions addressed at the Medical Executive Committee (MEC).	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(□1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(□2) MULTIPLE CONSTRUCTION	(□3) DATE SURVEY COMPLETED
	050135	A. BUILDING **01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD** B. WING _____	**04/01/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, □IP CODE
SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	**6245 DE LONGPRE AVE** **HOLLYWOOD, CA 90028**

(□4) ID PREFI□ TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFI□ TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(□5) COMPLETION DATE
A 952	Continued From page 184 Anesthesia services and except in the case of Emergencies: (i) A medical history and physical examination must be completed and documented no more than 30 days before or 24 hours after admission or registration. (ii) An updated examination of the patient, including any changes in the patient□s condition, must be completed and documented within 24 hours after admission or registration when the medical history and physical examination are completed within 30 days before admission or registration. This STANDARD is not met as evidenced by: Based on record review and interview, the facility Failed to ensure a medical history and physical (H&P) examination completed and documented 24 hours after admission prior to the surgery Requiring anesthesia services for Patient 28. This deficient practice placed the patient at risk of Unrecognized medical conditions and substandard health outcome for that patient. Findings: A review of the Operative/Invasive Procedure Report disclosed Patient 28 had undergone a surgical procedure-retropubic uretheral suspension (used to treat urinary incontinence by lifting the sagging bladder neck and urethra that may have dropped abnormally low in the pelvic area) on March 15, 2014. The clinical record was reviewed and disclosed a History and Physical was completed on March 20, 2014. Another Short Form History and Physical was completed on March 21, 2014. The PRE-OP	A 952	• The Chief of Staff issued a memo, dated June 19, 2014, to All Medical and Allied Staff Members to serve as a reminder notice that pursuant to the Medical Staff Rules and Regulations that a medical history and physical examination must be completed and documented no more than 30 days before or 24 hours after admission or registration, but prior to surgery or procedure requiring anesthesia services. The medical history and physical examination must be placed in the patient□s medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. • Medical Staff leadership will continue to monitor progress and work with Administration to improve compliance with documentation standards. • Audit results reported to the hospital□s Quality and Medical Record Committee and Medical Executive Committee. **Date of Implementation:** • Non-compliance discussed and corrective actions addressed at the Medical Executive Committee meeting on June 17, 2014. • Chief of Staff communication dated June 19, 2014. • Monitoring of H&P□s prior to surgery □ ongoing • Audit results reported to the hospital□s Quality and Medical Record Committee and Medical Executive Committee □ June 2014 and quarterly as required. **Monitoring Process:** • The HIM Manager and/or designee will conduct monthly audits of patient charts to review for the timely completion of history and physical examinations prior to surgery. • Numerator = Number of history and physical present no more than 30 days prior to admission or 24 hours after admission or registration but prior to surgery / Denominator □ Number of total charts reviewed. • The sample size will be based on monthly discharges, per the following guidelines: o Sample all cases for a population size of fewer than 30 cases o Sample 30 cases for a population size of 30□100 cases o Sample 50 cases for a population size of 101□500 cases o Sample 70 cases for a population size of more than 500 cases	6/17/2014 6/19/2014 6/19/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(□1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(□2) MULTIPLE CONSTRUCTION	(□3) DATE SURVEY COMPLETED
	050135	A. BUILDING **01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD** B. WING _____	**04/01/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, □IP CODE
SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	**6245 DE LONGPRE AVE** **HOLLYWOOD, CA 90028**

(□4) ID PREFI□ TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFI□ TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(□5) COMPLETION DATE
A 952	Continued From page 185 H& P Update was reviewed and disclosed there was no change in H&P. However, there was no documentation when the PRE-OP H& P Update had been completed. During the concurrent interview with Staff J on March 25,2014 at 10:05 a.m., she stated the PRE-OP H& P Update had not been completed.	A 952	(Continued from page 185) • Targeted compliance is 90% • Monitoring activity will commence for a period not to exceed 4 months to ensure that compliance is achieved and sustained. • Random audits will be performed thereafter. • Results of the audits will be reported to the hospital□s Quality and Medical Record Committee and Medical Executive Committee. **Person Responsible:** HIM Administrator and/or designee	
A 956	482.51(b)(3) REQUIRED OPERATING ROOM EQUIPMENT The following equipment must be available to the operating room suites: call-in system, cardiac monitor, resuscitator, defibrillator, aspirator, and tracheotomy set. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a tracheostomy set was available in the operating room suites in Hollywood campus. This deficient practice created the risk of poor health outcome in the event that a patient required a tracheostomy tray. Findings: During the initial tour with RN 7 in the operating room suites of the Hollywood Campus on March 24, 2014 between 9:58a.m. and 11 a.m., there was no tracheostomy set available. According to RN 7, there was no a tracheostomy set available in the operating room suites. According to the facility's policy and procedure for "Required Emergency Equipment:□ 4.1 Policy C. The following equipment will be maintained in the Surgical Services Department: 7. tracheostomy set.□	A 956	**Hollywood** **Corrective Actions:** Emergency tracheostomy tray prepared and are now available in the OR suites Staff meeting with ORT was held immediately on March 25, 2014 include review of Policy Required Emergency Equipment and the need to ensure a tracheostomy tray is prepared and available in OR suites**(157, 157a)** **Date of Implementation:** March 27, 2014 **Monitoring Process:** Monitoring will be managed through daily rounds by OR lead tech to ensure all supplies are accounted for and readily available and to include in EOC rounds **Person Responsible:** ORT, Nursing leadership & EOC members	3/25/2014 3/27/2014

RESPONSE TO DEFICIENCIES
EXHIBIT P CMS Statements of Deficiency

Nix Health System

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

1100 West 49th Street • Austin, Texas 78756
P.O. Box 149347 • Austin, Texas 78714-9347
1-888-963-7111 • www tiqlts.state.tx.us

KIRK COLE
INTERIM COMMISSIONER

2303 SE Military Dr. Bldg. 514
San Antonio, Texas 78223

November 13, 2015

Administrator
Nix Health Care System
414 Navarro, Suite 600
San Antonio, TX 78205

Dear Administrator:

Enclosed is the CMS-2567 Statement of Deficiencies and Plan of Correction Forms for federal deficiencies and the State forms for State deficiencies cited during a Health Survey conducted at your facility on October 29, 2015. Please type your plans of correction and proposed completion dates on the enclosed forms. Your signature is required on page one of each set of deficiencies. The enclosed forms need to be returned to this office within ten days from the date of receipt. Please keep a copy of the forms for your files.

On the enclosed list of deficiencies, please follow these instructions:

1. Enter on the form provided a plan of correction for each deficiency cited; please assure that each plan of correction clearly indicates the corrective action to be taken; rebuttals to or explanations for the deifciencies cannot be construed as acceptable plans of correction; proper names cannot be used. Please include the mechanism for monitoring to assure compliance.
2. The plan should address improving the processes that led to the deficiency cited.
3. The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited.
4. A completion date of correction for each deifciency cited must be included.
5. The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

6. The plan must include the title of the person responsible for implementing the acceptable plan of correction. DO NOT use proper names.
7. Enter a date of completion for each deifciency.
5. Return the completed plans of correction to this office by email, fax or mail.

Please note acceptance of a plan of correction to any alleged noncompliance does not preclude a proposal to assess administrative penalties and/or to otherwise take disciplinary action for that or any alleged noncompliance.

Should you have any questions, please call me at 210-531-4532. Thank you for your cooperation.

Sincerely,

Mr. Larrie Collier, Program Administrator
Health Facility Compliance Division

Enclosure

CMS-2567 Forms

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ B. WING _____	10/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	44 14 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY R LSC IDENTIFYING INFORMATION)	ID PREFIX 1 TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS	A 0001		

Note: The CMS-2567 (Statement of Deficiencies) , is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation (s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (01G) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately.

An unannounced full survey was conducted on site. An entrance conference was held with the hospital delegated-representatives the morning of ! 10/26/15. The hospital delegated-representatives were informed this survey would be conducted according to the survey protocol in the State Operations Manual, Chapter 5, section 5100 and Appendix A, and according to 42 CFR 482 the Conditions of Participation for Hospitals.

Survey findings were presented at an exit conference on the afternoon of 10/29/15 with hospital delegated-representatives. The preliminary survey findings were presented and facility staff were given the opportunity to ask questions and provide additional information.

A 454	482.24(c)(2) CONTENT OF RECORD: ORDERS DATED & SIGNED All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner who is responsible for the care of the patient only if such a practitioner is acting in accordance with State	A 454	1. Policy will be updated to reflect 96 hours as time frame for authentication 2. Flags for the charts will be placed in all nursing units for nurses to use during the 12 and 24 hour chart check	11/27/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | ((6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufifcient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDERSUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 454	Continued From page 1 law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure all orders, including verbal and telephone orders were authenticated promptly by the ordering practitioner or by another practitioner who was responsible for the care of the Patient in accordance with State law, Hospital policies, and medical staff by laws, rules, and regulations for 5 of 21 patient records reviewed (#1, #2, #3, #9, and #12). This deficient practice could affect the authenticity and accuracy of Patients verbal and telephone orders taken and transcribed by others that require authentication by physician signature. Findings included: Review of the facility's Medical Staff By Laws approved 05/31/13, and Medical Staff Rules and Regulations revealed the following: , 'Telephone/Verbal ord rs must be authenticated within 48 hours" from the time of order. Patient #1 Record review on 10/28/15 of Patient #1's records revealed he had Telephone/Verbal Physician Orders for medications, g-tube feedings, and discharge orders, during his admission of 09/17/15 to 09/20/15, that were not signed or authenticated by a physician until 10/23/15.	A 454:	3. Education will be conducted with physicians and nursing staff regarding 96 hour compliance 4. Nurses will be instructed on using the flags in the charts during chart checks 5. Directors will conduct weekly audits with the goal of 90% compliance for 96 hour authentication. 6. Results of audits will be reported to PI /Quality, MEC and Governing Board until a sustained compliance of 90% is met for 3 consecutive months. Responsible Person: CNO Quality Director Unit Directors	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ B. WING _____	10/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

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A 464	Continued From page 2 Patient #2 Record review on 10/28/15 of Patient #2's records revealed he had Telephone/Verbal Physician Orders for admission to the facility, a bedside swallow test, a cardiac diet, case management consult, occupational therapy and physical therapy evaluations, and medications, during his admission of 08/07/15 to 08/09/15, that were not signed or authenticated by a physician until 08/27/15. Patient #3 Record review on 10/28/15 of Patient #3's records revealed she had Telephoneverbal Physician Orders for medications and emergency medications for agitation, during her admisson of 08/03/15 to 08/19/15, that were not signed or authenticated by a physician until 09/14/15. Patient #9 Record review on 10/28/15 of Patient #9's records revealed he had TelephoneVerbal Physician Orders for Restraints, Emergency Medications, and Seclusion that had not been signed or authenticated by a physician as of 10/28/15. The following Restraint/Seclusion records were reviewed: 1.) On 10/10/15 at 20:40 Physician A was notified and a Verbal/Telephone Order was obtained for a Physical Restraint for Patient #9 at 20:40. The Restraint/Seclusion Verbal/Telephone Order had not been signed in the area for Physician's Signature to include authentication. 2.) On 10/21/15 at 20:10 Physician B was notified	A 454;		

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	450130	A. BUILDING _____ B. WING _____	10/2912015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 454	Continued From page 3	A 454		

and Verbal/Telephone Order was obtained for a Mechanical Restraint (Restraint Chair) and Emergency Medications; Ativan and Benadryl to be administered to Patient #9. The Restraint/Seclusion Verbal/Telephone Order had not been signed in the area for Physician's Signature to include authentication.

3.) On 10/22/15 at 1500 Physician C was notified and a Verbal/Telephone Order was obtained for a Physical Hold, Mechanical Restraint (Restraint Chair), and Emergency Medication of Benadryl to be administered to Patient #9. The Restraint/Seclusion Verbal/Telephone Order had not been signed in the area for Physician's Signature to include authentication.

4.) On 10/23/15 at 15:00 Physician C was notified and a Verbal/Telephone Order was obtained for a Physical Hold, Mechanical Restraint (Restraint Chair), Seclusion, and Emergency Medication of Benadryl to be administered to Patient #9. The Restraint/Seclusion Verbal/Telephone Order had not been signed in the area for Physician's Signature to include authentication.

5.) On 10/23/15 at 21:42 Physician C was notified and a Verbal/Telephone Order was obtained for a Physical Hold and Emergency Medication of Benadryl to be administered to Patient #9. The Restraint/Seclusion Verbal/Telephone Order had not been signed in the area for Physician's Signature to include authentication.

6.) On 10/26/15 at 14:50 Physician B was notified and a Verbal/Telephone Order was obtained for a Physical Hold and Emergency Medication of Zyprexa to be administered to Patient #9. The Restraint/Seclusion Verbal/Telephone Order had

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	450130	A. BUILDING _____ B. WING _____	10/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 454	Continued From page 4	A 454		

not been signed in the area for Physician's Signature to include authentication.

Patient #12

Record review on 10/28/15 of Patient #12's records revealed he was admitted to the facility on 10/22/15. Patient #12's Admission Orders, Medication Orders, and Physician Certification dated 10/22/15 at 00:45 had not been signed or authenticated by a physician as of 10/28/15 (6 days past/144 hours).

Further review of Patient #12's Physician Orders revealed the following Telephone Order (TO) that : had not been signed or authenticated by a physician as of 10/28/15:
10/22/15 at 00:45 TO for the following medications: Tylenol 325 milligrams (mg), Hydroxyzine HCL 25 mg, Loperamide 2mg, Lorazepam (Ativan)1 mg, and milk of magnesium 400 mg.

During an interview on 10/29/15 at 10:40 AM with the facility's Chief Nursing Officer (CNO) and Director of Risk Management confirmed the following Patient records (# **1,** #2 #9, and #12) had Verbal/Telephone Orders that had not been signed or authenticated. The CNO stated that Verbal/Telephone Orders had to be signed within the facility's Policy; By Laws; which was 48 hours from the time of the order. The Director of Risk Management stated that the Psychiatrist would sign their own Restraint/Seclusion Verbal/Telephone Orders when doing rounds and reviewing charts. The Director of Risk Management confirmed that Patient #9 had 6 Restraint/Seclusion Verbal/Telephone Orders that had not been signed or authenticated. The

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A454	Continued From page 5 Director of Risk Management stated there were 3 different Doctors with outstanding Verbal/Telephone Orders and confirmed there was no other method to authenticate other than their signatures.	A 4541		
A 503	482.25(b)(2)(ii) CONTROLLED DRUGS KEPT (LOCKED Drugs listed in Schedules II, Ill, IV, and V of the Comprehensive Drug Abuse Prevention and Control Act of 1970 must be kept locked within a ; secure area. This STANDARD is not met as evidenced by: Based on observation, interviews and record reviews the facility failed to ensure drugs listed in schedules II, Ill, and V of the Comprehensive Drug Abuse Prevention and Control Act were kept locked within a secure area. Findings include: Observations conducted on 10/27/15 from 9:30 a.m. to 12:00 p.m. at the facility's specialty psychiatric hospital revealed the following: An open top red container which was approximately 2 to 3 feet tall was observed in the medication preparation area next to the door leading out to the nurse's station. The medication room door was open/ unlocked. The container was 213 full of various sharps (needles, syringes with liquid in them, suture removal kits, ect ...) and unidentified medications (pills). On the wall behind the container was a hand written note which stated "Not a waste can" In an interview conducted on 10/27/15 at 10:30 a.m., LVN-A stated that she (LVN-A) has voiced concern about the open top container with her	A 503'	1. Process to improve controlled substances involves education of staff regarding securement of Class II, III, IV and V medications and how to return/waste narcotics appropriately. All remaining liquid narcotics will be drawn up and wasted in the sink with running water and two nurses observing/signing off on the waste. 2. Staff will be tested and must pass written test after education with a grade of at least 95%. Staff who do not meet the 95% threshold will have remedial education and retake the test until a satisfactory grade is achieved. 3. 90% of nursing staff will complete the test by Nov 27th with a passing grade. 4. Directors will do observations in the med rooms to ensure compliance with narcotic wasting. Results of audits will be reported to PI /Quality, MEC and Governing Board until a sustained compliance of 90% is met for 3 consecutive months.	

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A 503	A 503 Continued From page 6 manager, because she "got tired of people throwing trash in there (container)." During further i interview, LVN-A further revealed that nursing staff were also disposing of unused narcotic medications in the same open top container. In an interview conducted on 10/27/15 at 10:40 a.m., the Executive Director of the specialty psychiatric hospital confirmed the above findings. Record review of the facility policy entitled Pyxis Drug Administration, Returning, & Wasting, dated November 2003 revealed in part the following: Controlled substances not used must be placed in locked return bin in medstation. If the package is opened, it should be wasted. If the contents of a controlled drug vial or mpule are drawn up and not administered, or partially administered, the contents must be wasted at the pyxis unit and witnessed by another licensed nurse or pharmacist. Wasted controlled medications will be documented via the medstation, flushed in a sink or drain and witnessed by a licensed nurse or pharmacist. Record review of the facility policy entitled Controlled Drugs- Disposition/ Destruction revealed in part the following: * When controlled drugs must be returned, a licensed contract service shall be utilized for the return of products. When controlled drugs cannot be returned to the manufacturer, distributor, or other source of supply, the Director of Pharmacy or designee shall destroy or dispose of these drugs in accordance with current destruction or disposition procedure of the DEA and this state.	A 503	1. Process to improve controlled substances involves education of staff regarding securement of Class II, III, IV and V medications and how to return/waste narcotics appropriately. All remaining liquid narcotics will be drawn up and wasted in the sink with running water and two nurses observing/signing off on the waste. 2. Staff will be tested and must pass written test after education with a grade of at least 95%. Staff who do not meet the 95% threshold will have remedial education and retake the test until a satisfactory grade is achieved. 3. 90% of nursing staff will complete the test by Nov 27th with a passing grade. 4. Directors will do observations in the med rooms to ensure compliance with narcotic wasting. Results of audits will be reported to PI /Quality, MEC and Governing Board until a sustained compliance of 90% is met for 3 consecutive months. Responsible Person: CNO Quality Director Unit Directors	11/27/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDERJSUPPLIER/CLIA I ENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A, BUILDING _____ B. WING _____	10/29/2015

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NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 701	! Continued From page 7 482.41(a) MAINTENANCE OF PHYSICAL PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the condition of the overall hospital environment was maintained for the safety and well-being of the patients. The findings include: Observations conducted on 10/27/15 from 9:30 a.m. to 12:00 p.m., at the facility' s Specialty Psychiatric Hospital revealed that the patient bathrooms contained sink faucets with long metal handles. In an interview conducted on 10/27/15 at the time of discovery, the Executive Director of Psychiatric Services revealed that the sink faucets in the facility were not breakaway faucets. On 10/28/15 at 11:15 a.m., observations in the pharmacy revealed: -The pharmacy work counter had chipped paint and exposed plywood, ensuring the counter was no longer a wipe able surface. The face of one cabinet drawer was held together by clear tape. Several of the drawer handles were either missing or loose. -What was described to the surveyor as a portable air conditioning " unit, when the unit is turned on, pools water on the lfoor. - The medication refrigerator had a thick accumulation of dust and debris underneath, with mold observed in the condensation drainage	A 701	1. All sinks in behavioral health units will be retrofitted with appropriate faucet handles to assure a safe environment for this patient population. 2. The pharmacy will have counter tops repaired, air conditioning unit repaired or replaced, and a tiles will be replaced under the refrigerator. Project Authorization will be submitted for approval by 11/30/15. Estimated date for approval and completion of project is 90 days. Counter tops will be refinished by 12/31/15. AC unit was fixed on 11/ 23/15. Work orders for the pharmacy have been placed through maintained to replace floor tile on 11/20/15. 3. Sinks for the behavior health unit will be ordered and changed out by a contractor. Quality Director will round on units to ensure project completion by said date Responsible Person: VP Facilities Management	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ B. WING _____	10129/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	**414 NAVARRO, SUITE 600** SAN ANTONIO, TX 78205

(X ID PREFIX TAG)	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
A 701	Continued From page 8 area. Interview with the Director of Pharmacy (DOP) on 10/28/15 at 11:25 a.m. revealed the pharmacy needs a new work counter. The DOP also revealed the water pooling on the floor from the portable air conditioning unit is a problem as it causes mold and a slipping hazard.	A 701		
A 749	482.42(a)(1) INFECTION CONTROL PROGRAM The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop, and implement a system for identifying and controlling infections and communicable diseases within the hospital. The facility failed to: 1.) Ensure staffs were knowledgeable in the use of disinfectant wipes used to disinfect equipment being removed from isolation rooms and 2.) Ensure staffs at the specialty psychiatric hospital disposed of sharps in approved closed top sharps containers for disposal and 3,) Ensure staffs consumed food and/or drinks in approved areas outside the patient care area. Findings included: 1.) Observations conducted on 10/27/15 from 12:30 p.m. to 5:30 p.m. of the medical/ surgical floors revealed the following: Clorox germicidal disinfectant wipes (used for C- Difficille toxin) were not available on the patient care lfoors for staff use.	A 749:	1. ICP produced educational material that address use of disinfectant wipes and dwell time 2. All open sharps containers were removed and replaced with closed top containers on 10/27/15 3. Staff involved were counseled the day of the survey and in-services were conducted with all supervisors. Additionally all staff at the Babcock location will complete a read and sign of the Standard and Transmission Based Precautions by Dec 4, 2015. 1. Instructions for disinfectant wipes were places on all isolation carts on 10/27. Education was conducted at the skills fairs dated 11/3, 11/4, and 11/10. 2. Sharps Containers were replaced on 10/27/15 3. Read and sign with all staff members at Babcock location	1. 2/28/16 2. 10/27/15 3. 12/4/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDE R/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ B. WING _____	10129/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	44 14 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETION DATE
A 749	Continued From page 9 In an interview conducted on 10/27/15 at 4:15 p.m., Registered Nurse (RN)-A stated that if they (staff) receive a patient with C- Difficille (C-Diff) , they have to contact housekeeping services to obtain Clorox germicidal disinfectant wipes, as they are not kept on the floor for use. When asked how long staff waited to remove equipment, which was disinfected with the Clorox wipes, from isolation rooms RN-A stated " Im not sure. " In an interview conducted on 10/27/15 at 4:30 p.m., the facility Chief Nursing Officer (CNO) stated that facility staff should be using Virex wipes to disinfect equipment used in C-Diff isolation rooms. In an interview conducted on 10/27/15 at 4:45 p.m., the facility Infection Control Practitioner revealed that staffs were supposed to be using germicidal Clorox wipes to disinfect C-Diff isolation rooms, with a wait time of **10** minutes before removing any disinfected equipment from isolation rooms. In an interview conducted on 10/27/15 at 5:00 p.m., Certified Nurse' s Aide- A (CNA) stated he routinely disinfects isolation equipment with bleach, but he was not sure how long to wait before removing equipment from the isolation rooms. He further revealed that Clorox wipes were not kept on the patient care lfoors, and that they (Clorox Wipes) must be brought to the floor by housekeeping. In an interview conducted on 10/27/15 at 5:20 p.m. Licensed Vocational Nurse (LVN)-B stated I that he was unsure how long to wait removing equipment from isolation rooms that	A 749	1. ICP will do monthly observation audits to ensure staff are compliant with process for disinfecting equipment. Results of audits will be sent to PI, MEC, and the Board until a sustained compliance of >90% is met for 3 consecutive months. 2. Director of Environment Services doing weekly audits to ensure compliance. Results of audits will be sent to PI, MEC, and the Board until a sustained compliance of >90% is met for 3 consecutive months. 3. Completed read and sign will be sent to Director of Quality and presented at PI/MEC and the Board in December. Responsible person: ICP Environmental Services Director VP BH Services	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NIX HEALTH CARE SYSTEM	4414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

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A 7491	Continued From page 10	A 7491		

had been disinfected with the Clorox germicidal wipes. He further stated, " I know it' s less than an hour. "

Record reviews of the facility' s Infection Control Program Plan, dated 2015, revealed in part the following:

VI- Education and Training: Education and training of healthcare workers in infection control interventions that interrupt disease transmission and reduce healthcare associated infection rates.

All new employees received education and training in infection control during general hospital orientation.

Current employees will receive education and training in infection control annually.

The responsibility for staff education falls on the Department Director in close collaboration with the Infection Control Preventionist.

2.) Observations conducted on 10/27/15 from 9:30 a.m. to 12:00 p.m. at the facility's specialty psychiatric hospital revealed the following:

An open top red container which was approximately 2 to 3 feet tall was observed in the medication preparation area next to the door leading out to the nurse ' s station. The medication room door was open/ unlocked. The container was 2/3 full of various sharps (needles, syringes with liquid in them, suture removal kits, ect ...) and unidentified medications (pills). On the wall behind the container was a hand written note which stated " Not a waste can "

In an interview conducted on 10/27/15 at 10:30 a.m., LVN-A stated that she (LVN-A) has voiced I concern about the open top container with her manager, because she " got tired of people

further interview, LVN-A further revealed that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CM IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ EL WING _____	10/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	**44 14 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205**

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A 749	Continued From page 11 nursing staff were also disposing of unused narcotic medications in the same open top container. In an interview conducted on 10/27/15 at 10:40 a.m., the Executive Director of the specialty psychiatric hospital confirmed the above findings. 3.) On 10/27/15 at 10:40 am. during a tour of the facility's specialty psychiatric hospital , a facility staff member was observed "squatting" in the work area hallway eating what was observed to be a candy bar. Several patients were walking ! around the staff member. Interview on 10/27/15 at 11:30 am. with the facility Vice President of Clinical Services of Behavioral Services confirmed the facility staff member was employed by the facility. The staff revealed to her "he was eating a breakfast bar, not a candy bar." Further interview confirmed the staff should not have been eating in the hallway. When asked if the facility had a policy in regards to staff not eating or drinking at their work , stations, the facility stated they did not have a policy. But handed the surveyor the following print out from Occupational Safety and Health Administration (OSHA) regulations: " OSHA/Blood Borne Pathogen Regulations Policy 1910.1030" stated in part "OSHA's blood borne pathogens standard prohibits the consumption of food and drink in areas in which work involving exposure or potential exposure to blood or other potentially infectious material place, or where the potential for contamination of work surfaces exist."	A 749		

SODState Forms

Texas Department of State Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	**414 NAVARRO, SUITE** 600 **SAN ANTONIO, TX** 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
X 000	**INITIAL COMMENTS** Note: The State Form is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be referred to the Office of the Texas Attorney General (OAG) for possible fraud. If information is inadvertently changed by the provider/supplier the State Survey Agency (SA) should be notified immediately. An unannounced licensure inspection was conducted on site. An entrance conference was held with the hospital delegated-representatives the morning of 10/26/15. The hospital delegated-representatives were informed this survey would be conducted according to the Texas Administrative Code (TAC), Chapter 133. Survey findings were presented at an exit conference on the afternoon of 10/29/15 with hospital delegated-representatives. The preliminary survey findings were presented and facility staff were given the opportunity to ask questions and provide additional information.	**X** 000		
X 241	133.41(g) infection Control Infection control. There shall be an active program for the prevention, control, and surveillance of infections and communicable diseases.	X 241	1. ICP produced educational material that address use of disinfectant wipes and dwell time 2. All open sharps containers were removed and replaced with closed top containers on 10/27/15 3. Staff involved were counseled the day of the survey and in-services were conducted with all supervisors. Additionally all staff at the Babcock location will complete a read and sign of the Standard and Transmission Based Precautions by Dec 4, 2015.	1. 2/28/16 2. 10/27/15 3. 12/4/15

SOD - State Form
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Texas Department of State Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	4 14 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX i TAG 1	SUMMARY STATEMENT OF EFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
X 2414	Continued From page 1 ThisRequirement isnot metasevidencedby: easedonobservationinterviewsandrecord reviews the facility failed to ensure drugs listed in schedules II, III, and V of the Comprehensive Drug Abuse Prevention and Control Act were kept locked within a secure area. Findings include: Observations conducted on 10/27/15 from 9:30 a.m. to 12:00 p.m. at the facility' s specialty psychiatric hospital revealed the following: An open top red container which was approximately 2 to 3 feet tall was observed in the medication preparation area next to the door leading out to the nurse's station. The medication room door was open/ unlocked. The container was 2/3 full of various sharps (needles, syringes with liquid in them, suture removal kits, ect ...) and unidentified medications (pills). On the wall behind the container was a hand written note which stated "Not a waste can" In an interview conducted on 10/27/15 at 10:30 a.m., LVN-A stated that she (LVN-A) has voiced concern about the open top container with her manager, because she "got tired of people throwing trash in there (container)." During further interview, LVN-A further revealed that nursing staff were also disposing of unused narcotic medications in the same open top container. In an interview conducted on 10/27/15 at 10:40 a.m., the Executive Director of the specialty psychiatric hospital confirmed the above findings. Record review of the facility policy entitled Pyxis Drug Administration, Returning, & Wasting, dated November 2003 revealed in part the following: Controlled substances not used must be	X241	1. Instructions for disinfectant wipes were places on all isolation carts on 10/27. Education was conducted at the skills fairs dated 11/3, 11/4, and 11/10. 2. Sharps Containers were replaced on 10/27/15 3. Read and sign with all staff members at Babcock. 1. ICP will do monthly observation audits to ensure staff are compliant with process for disinfecting equipment. Results of audits will be sent to PI, MEC, and the Board until a sustained compliance of >90% is met for 3 consecutive months. 2. Director of Environment Services doing weekly audits to ensure compliance. Results of audits will be sent to PI, MEC, and the Board until a sustained compliance of >90% is met for 3 consecutive months. 3.Completed read and sign will be sent to Director of Quality and presented at PI/MEC and the Board in December. Location. Responsible Person: ICP Environmental Services Director VP BH Services	

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X241	Continued From page 2 placed in locked return bin in medstation. If the package is opened, it should be wasted. If the contents of a controlled drug vial or ampule are drawn up and not administered, or partially administered, the contents must be wasted at the Pyxis unit and witnessed by another licensed nurse or pharmacist. Wasted controlled medications will be documented via the medstation, flushed in a sink or drain and witnessed by a licensed nurse or pharmacist. Record review of the facility policy entitled Controlled Drugs- Disposition/ Destruction revealed in part the following: When controlled drugs must be returned, a licensed contract service shall be utilized for the return of products. When controlled drugs cannot be returned to the manufacturer, distributor, or other source of supply, the Director of Pharmacy or designee shall destroy or dispose of these drugs in accordance with current destruction or disposition procedure of the DEA and this state. Based on observation, interview and record review, the facility failed to develop, and implement a system for identifying and controlling infections and communicable diseases within the hospital. The facility failed to: 1.) Ensure staffs were knowledgeable in the use of disinfectant wipes used to disinfect equipment 1 being removed from isolation rooms and 2.) Ensure staffs at the specialty psychiatric hospital disposed of sharps in approved closed	X241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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X 241	Continued From page 3 top sharps containers for disposal and 3,) Ensure staffs consumed food and/or drinks in approved areas outside the patient care area. Findings included: 1.) Observations conducted on 10/27/15 from 12:30 p.m. to 5:30 p.m. of the medical/ surgical floors revealed the following: Clorox germicidal disinfectant wipes (used for C- Difficille toxin) were not available on the patient care floors for staff use. In an interview conducted on 10/27/15 at 4:15 p.m., Registered Nurse (RN)-A stated that if they (staff) receive a patient with C- Difficille (C-Diff) they have to contact housekeeping services to obtain Clorox germicidal disinfectant wipes, as they are not kept on the floor for use. When asked how long staff waited to remove equipment, which was disinfected with the Clorox wipes, from isolation rooms RN-A stated " Im not sure. " In an interview conducted on 10/27/15 at 4:30 p.m., the facility Chief Nursing Officer (CNO) stated that facility staff should be using Virex wipes to disinfect equipment used in C-Diff isolation rooms. In an interview conducted on 10/27/15 at 4:45 p.m., the facility Infection Control Practitioner revealed that staffs were supposed to be using germicidal Clorox wipes to disinfect C-Diff isolation rooms, with a wait time of 10 minutes before removing any disinfected equipment from isolation rooms. In an interview conducted on 10/27/15 at 5:00 p.m., Certified Nurse ' s Aide- A (CNA) stated he routinely disinfects isolation equipment with bleach, but he was not sure how long to wait	X 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000415	A. BUILDING; _____ B WING _____	10/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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X 241	Continued From page 4	X 241		

before removing equipment from the isolation rooms, He further revealed that Clorox wipes were not kept on the patient care floors, and that they (Clorox Wipes) must be brought to the floor by housekeeping.

In an interview conducted on 10/27/15 at 5:20 p.m. Licensed Vocational Nurse (LVN)-B stated that he was unsure how long to wait before removing equipment from isolation rooms that had been disinfected with the Clorox germicidal wipes. He further stated, " I know it' s less than an hour. "

Record reviews of the facility' s Infection Control Program Plan, dated 2015, revealed in part the following:

VI- Education and Training: Education and training of healthcare workers in infection control interventions that interrupt disease transmission and reduce healthcare associated infection rates.

All new employees received education and training in infection control during general hospital orientation.

Current employees will receive education and training in infection control annually.

The responsibility for staff education falls on the Department Director in close collaboration with the Infection Control Preventionist.

2.) Observations conducted on **10/27/15** from 9:30 a.m. to 12:00 p.m. at the facility's specialty psychiatric hospital revealed the following:

An open top red container which was approximately 2 to 3 feet tall was observed in the medication preparation area next to the door leading out to the nurse ' s station. The medication room door was open/ unlocked. The container was 2/3 full of various sharps (needles, syringes with liquid in them, suture removal kits,

Texas Department of State Health Services

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X 241	Continued From page 5	X 241		

ect ...) and unidentified medications (pills). On the wall behind the container was a hand written note which stated " Not a waste can "
In an interview conducted on 10/27/15 at 10:30 a.m., LVN-A stated that she (LVN-A) has voiced concern about the open top container with her manager, because she " got tired of people throwing trash in there (container). " During further interview, LVN-A further revealed that nursing staff were also disposing of unused narcotic medications in the same open top container.

In an interview conducted on 10/27/15 at 10:40 a.m., the Executive Director of the specialty psychiatric hospital confirmed the above findings.

3.) On 10/27/15 at 10:40 a.m. during a tour of the facility's specialty psychiatric hospital , a facility staff member was observed "squatting" in the work area hallway eating what was observed to be a candy bar. Several patients were walking around the staff member.

Interview on 10/27/15 at 11:30 a.m. with the facility Vice President of Clinical Services of Behavioral Services confirmed the facility staff member was employed by the facility. The staff revealed to her "he was eating a breakfast bar, not a candy bar." Further interview confirmed the staff should not have been eating in the hallway.

When asked if the facility had a policy in regards to staff not eating or drinking at their work stations, the facility stated they did not have a policy. But handed the surveyor the following print out from Occupational Safety and Health Administration (OSHA) regulations:

" OSHA/Blood Borne Pathogen Regulations

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X 241	Continued From page 6 Policy 1910.1030" stated in part "OSHA's blood borne pathogens standard prohibits the consumption of food and drink in areas in which work involving exposure or potential exposure to blood or other potentially infectious material place, or where the potential for contamination of work surfaces exist."	X 241		
X 288	133.41(j)(7) Authentication of entries ; Medical record services. The hospital shall have a medical record service that has administrative responsibility for medical records. A medical record shall be maintained for every individual who presents to the hospital for evaluation or treatment. All verbal orders must be dated, timed, and authenticated within 96 hours by the prescriber or another practitioner who is responsible for the care of the patient and has been credentialed by the medical staff and granted privileges which are consistent with the written orders.	X 288	1. Policy will be updated to reflect 96 hours as time frame for authentication 2. Flags for the charts will be placed in all nursing units for nurses to use during the 12 and 24 hour chart check 1.Education will be conducted with physicians and nursing staff regarding 96 hour compliance 2. Nurses will be instructed on using the flags in the charts during chart check. Directors will conduct weekly audits with the goal of 90% compliance with 96 hour authentication. Results of audits will be reported to PI /Quality, MEC and Governing Board until a sustained compliance of 90% is met for 3 consecutive months. Responsible Person: CNO Quality Director Unit Directors	11/27/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDERISUPPLIERICLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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X 288	Continued From page 7	X 288		

This Requirement is not met as evidenced by:
Based on record review and interview, the facility failed to ensure all orders, including verbal and telephone orders were authenticated promptly by the ordering practitioner or by another practitioner who was responsible for the care of the Patient in accordance with State law, Hospital policies, and medical staff by laws, rules, and regulations for 5 of 21 patient records reviewed (#1, #2, #3, #9, and #12).

This deficient practice could affect the authenticity and accuracy of Patients verbal and telephone orders taken and transcribed by others that require authentication by physician signature.

Findings included:

Review of the facility's Medical Staff By Laws approved 05/31/13, and Medical Staff Rules and Regulations revealed the following: , "TelephoneNerbal orders must be authenticated within 48 hours" from the time of order.

Patient #1

Record review on 10/28/15 of Patient #1's records revealed he had TelephoneNerbal

Texas Departmento f State Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA I ENTIFICATION NUMBER:	(X2) MULTIPLE C NSTRUCTION	(X3) DATE SURVEY COMPLETED
	000415	A. BUILDING: _____ B. WING _____	10/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(x5) COMPLETE DATE
X 288	Continued From page 8 Physician Orders for medications, g-tube feedings, and discharge orders, during his admission of 09/17/15 to 09/20/15, that were not signed or authenticated by a physician until 10/23/15. Patient #2 Record review on 10/28/15 of Patient #2's records revealed he had Telephone/Verbal Physician Orders for admission to the facility, a beside swallow test, a cardiac diet, case management consult, occupational therapy and physical therapy evaluations, and medications, during his admission of 08/07/15 to 08/09/15, that were not signed or authenticated by a physician until 08/27/15. Patient #3 Record review on 10/28/15 of Patient #3's records revealed she had TelephoneNerbal Physician Orders for medications and emergency medications for agitation, during her admisson of 08/03/15 to 08/19/15, that were not signed or authenticated by a physician until Patient #9 Record review on 10/28/15 of Patient #9's records revealed he had TelephoneNerbal Physician Orders for Restraints, Emergency Medications, and Seclusion that had not been signed or authenticated by a physician as of 10/28/15. The following Restraint/Seclusion records were reviewed: 1.) On 10/10/15 at 20:40 Physician A was notified and a Verbal/Telephone Order was obtained for a Physical Restraint for Patient #9 at 20:40. The	X 288		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDERISUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000415	A. BUILDING: _____ B. WING _____	10/29/2015

NAME OF PROVIDER R SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CO E
NIX HEALTH CARE SYSTEM	4 14 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
X 288	Continued From page 9 Restraint/Seclusion Verbal/Telephone Order had not been signed in the area for Physician's Signature to include authentication. 2.) On 10/21/15 at 20:10 Physician B was notified and a Verbal/Telephone Order was obtained for a Mechanical Restraint (Restraint Chair) and Emergency Medications; Ativan and Benadryl to be administered to Patient #9. The Restraint/Seclusion Verbal/Telephone Order had not been signed in the area for Physician's Signature to include authentication. 3.) On 10/22/15 at 1500 Physician C was notified and a Verbal/Telephone Order was obtained for a Physical Hold, Mechanical Restraint (Restraint Chair), and Emergency Medication of Benadryl to be administered to Patient #9. The Restraint/Seclusion Verbal/Telephone Order had not been signed in the area for Physician's Signature to include authentication. 4.) On 10/23/15 at 15:00 Physician C was notified and a Verbal/Telephone Order was obtained for a Physical Hold, Mechanical Restraint (Restraint Chair), Seclusion, and Emergency Medication of Benadryl to be administered to Patient #9. The Restraint/Seclusion Verbal Telephone Order had not been signed in the area for Physician's Signature to include authentication. 5.) On 10/23/15 at 21:42 Physician C was notified and a Verbal Telephone Order was obtained for a Physical Hold and Emergency Medication of Benadryl to be administered to Patient #9. The Restraint/Seclusion Verbal/Telephone Order had not been signed in the area for Physician's Signature to include authentication. 6.) On 10/26/15 at 14:50 Physician B was notified	1 X 288		

Texas Department of State Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000415	A. BUILDING: _____ B. WING _____	1012912015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	4 14 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
X 288	Continued From page 10	X 288		

and a Verbal/Telephone Order was obtained for a Physical Hold and Emergency Medication of Zyprexa to be administered to Patient #9. The Restraint/Seclusion Verbal/Telephone Order had not been signed in the area for Physician's Signature to include authentication.

Patient #12

Record review on 10/28/15 of Patient #12's records revealed he was admitted to the facility on 10/22/15. Patient #12's Admission Orders, Medication Orders, and Physician Certification dated 10/22/15 at 00:45 had not been signed or authenticated by a physician as of 10/28/15 (6 days past/144 hours).

Further review of Patient #12's Physician Orders revealed the following Telephone Order (TO) that had not been signed or authenticated by a physician as of 10/28/15:
10/22/15 at 00:45 TO for the following medications: Tylenol 325 milligrams (mg), Hydroxyzine HCL 25 mg, Loperamide 2mg, Lorazepam (Ativan)1 mg, and milk of magnesium 400 mg.

During an interview on 10/29/15 at 10:40 AM with the facility's Chief Nursing Officer (CNO) and Director of Risk Management confirmed the following Patient records (# 1, #2 #9, and #12) had Verbal/Telephone Orders that had not been signed or authenticated. The CNO stated that Verbal/Telephone Orders had to be signed within the facility's Policy; By Laws; which was 48 hours from the time of the order, The Director of Risk Management stated that the Psychiatrist would sign their own Restraint/Seclusion Verbal/Telephone Orders when doing rounds and reviewing charts. The Director of Risk

Texas Department of State Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000415	A. BUILDING: _____ B. WING _____	10129/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC I ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
X 288	Continued From page 11 Management confirmed that Patient #9 had 6 Restraint/Seclusion Verbal/Telephone Orders that had not been signed or authenticated. The Director of Risk Management stated there were 3 different Doctors with outstanding VerbaliTelephone Orders and confirmed there was no other method to authenticate other than their signatures.	X 288		
X 466	133.41(05) Control and distribution Pharmacy Services. Delivery of Services. In order to provide patient safety, drugs and biologicals shall be controlled and distributed in accordance with applicable standards of practice, consistent with federal and state laws. This Requirement is not met as evidenced by: Based on observation, interviews and record reviews the facility failed to ensure drugs listed in schedules II, Ill, and V of the Comprehensive Drug Abuse Prevention and Control Act were kept locked within a secure area. Findings include: Observations conducted on 10/27/15 from 9:30 a.m. to 12:00 p.m. at the facility' s specialty psychiatric hospital revealed the following: An open top red container which was approximately 2 to 3 feet tall was observed in the 1 medication preparation area next to the door	X 466	1. Process to improve controlled substances involves education of staff regarding securement of Class II, III, IV and V medications and how to return/waste narcotics appropriately. All remaining liquid narcotics will be drawn up and wasted in the sink with running water and two nurses observing/signing off on the waste. 1. Staff will be tested and must pass written test after education with a grade of at least 95%. Staff who do not meet the 95% threshold will have remedial education and retake the test until a satisfactory grade is achieved. 1. 90% of nursing staff will complete the test by Nov 27th with a passing grade. 2. Directors will do observations in the med rooms to ensure compliance with narcotic wasting. Results of audits will be reported to PI /Quality, MEC and Governing Board until a sustained compliance of 90% is met for 3 consecutive months. Responsible person: CNO Quality Director Unit Directors	11/27/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000415	A. BUILDING: _____ B. WING _____	10/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	4 14 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
X 466	Continued From page 12	X 465		

leading out to the nurse's station. The medication room door was open/ unlocked. The container was 2/3 full of various sharps (needles, syringes with liquid in them, suture removal kits, eet ...) and unidentified medications (pills). On the wall behind the container was a hand written note which stated "Not a waste can"

in an interview conducted on 10/27/15 at 10:30 a.m., LVN-A stated that she (LVN-A) has voiced concern about the open top container with her manager, because she "got tired of people throwing trash in there (container)." During further interview, LVN-A further revealed that nursing staff were also disposing of unused narcotic medications in the same open top container.

In an interview conducted on 10/27/15 at 10:40 a.m., the Executive Director of the specialty psychiatric hospital confirmed the above findings.

Record review of the facility policy entitled Pyxis Drug Administration, Returning, & Wasting, dated November 2003 revealed in part the following:

Controlled substances not used must be placed in locked return bin in medstation. If the package is opened, it should be wasted.

If the contents of a controlled drug vial or ampule are drawn up and not administered, or partially administered, the contents must be wasted at the pyxis unit and witnessed by another licensed nurse or pharmacist.

Wasted controlled medications will be documented via the medstation, flushed in a sink or drain and witnessed by a licensed nurse or pharmacist.

Record review of the facility policy entitled Controlled Drugs- Disposition/ Destruction revealed in part the following:

When controlled drugs must be returned, a

Texas Department of State Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(Xi) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000415	A. BUILDING: _____ B. WING _____	10/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 70205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
X 466	Continued From page 13 licensed contract service shall be utilized for the return of products. When controlled drugs cannot be returned to the manufacturer, distributor, or other source of supply, the Director of Pharmacy or designee shall destroy or dispose of these drugs in accordance with current destruction or disposition procedure of the DEA and this state.	X 466		
X1036	133.47(c)(2) Posting requirements Abuse And Neglect Issues. Abuse and neglect of individuals with mental illness, and illegal, unethical, and unprofessional conduct. The requirements of this subsection are in addition to the requirements of subsection (b) of this section. Posting requirements. A facility shall prominently and conspicuously post for display in a public area that is readily visible to patients, residents, volunteers, employees, and visitors a statement of the duty to report abuse and neglect, or illegal, unethical or unprofessional conduct in accordance with HSC, §161.132(e). The statement shall be in English and in a second language appropriate to the demographic makeup of the community served and contain the number of the department's patient information and complaint line at (888) 973-0022. This Requirement is not met as evidenced by: Based on observation and interview, the facility	X1036	1. Temporary signage with required elements regarding the duty to report abuse and neglect, or illegal, unethical or unprofessional conduct with the TDSHS patient information and complaint phone number was placed throughout the system 10/25 - 10/27. 2. Formal permanent signs will replace temporary signs in all waiting areas, elevator landings and admitting by December 4, 2015. Formal permanent signs will be ordered by VP of Plant Operations and replace temporary signs in all waiting areas, all waiting areas, elevator landings and admitting by December 4, 2015. Director of Quality will do walking rounds to ensure all new signs are in place by required date. Responsible Person: VP Facilities Management	12/4/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000415	A. BUILDING: _____ B. WING _____	10/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	4 14 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
X1036	Continued From page 14 failed to prominently and conspicuously post for display in a public area that is readily visible to patients, residents, volunteers, employees, and visitors; a statement of the duty to report abuse and neglect, or illegal,unethical or unprofessional conduct in accordance with the Texas Health and Safety Code (HSC), and ensure the statement contains the number of the department's patient information and complaint line at (888) 973-0022. This deficient practice affected the rights of Patients Findings included: Observation conducted on 10/26/15 at 2:25 PM in the facility's emergency room of the facility's lobby/waiting area revealed a poster of Patient's Rights dated 09/01/2013. The posting failed to contain a statement of the duty to report abuse and neglect, or illegal, unethical or unprofessional conduct in accordance with the HSC §161.132(e); and failed to ensure it contained the number of the Texas Department of State Health Services patient information and complaint line at (888) 973-0022. Further observation conducted on 10/26/15 at 3:00 PM in the facility admission area did not reveal a posting of the department's (DSHS) patient information and complaint line phone number, or a statement of the duty to report abuse and neglect, or illegal, unethical or unprofessional conduct in accordance with the HSC §161.132(e). Continued observation conducted on 10/27/15 at 10:30 AM in the facility outpatient clinic and outpatient rehabilitation area did not reveal a	X1036		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDERSUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000415	A. BUILDING: _____ B. WING _____	10129/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	4 14 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

	SUMMARY STATEMENT OF DEFICIENCIES	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
X1036	Continued From page 15 posting of the department's (DSHS) patient information and complaint line phone number, or a statement of the duty to report abuse and neglect, or illegal, unethical or unprofessional conduct in accordance with the HSC §161.132(e). During an interview on 10/27/15 at 12:30 PM with the facility's Director of Performance Improvement confirmed the department's (DSHS) patient information and complaint line phone number (888-973-0022) were not posted in the facility or a statement of the duty to report abuse and neglect, or illegal, unethical or unprofessional i conduct in accordance with the HSC §161.132(e).	X1036

November 16, 2015

Jeanette Salinas
Patient Quality Care Unit
Health Care Quality Section
Texas Department of State Health Services
2303 SE Military Dr. Bldg. 514
San Antonio, TX 78223

Re: Provider Number 450130
Complaint Number TX00223777

Dear Ms. Salinas:

We acknowledge receipt of your letter in regards to the result of a survey conducted by Texas Department of State Health Services on October 28, 2015 at Nix Health Care System.

We look forward to continuing to work with you in the administration of the Medicare Program.

Sincerely,

Joseph W. Rafferty, Interim CEO

cc: Larrie Collier, Program Administrator

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

DAVID L. LAKEY, M.D.
COMMISSIONER

1100 West 49th Street • Austin, Texas 78756
P.O. Box 149347 • Austin, Texas 78714-9347
1-888-963-7111 • www.dshs.state.tx.us

2303 SE Military Dr. Bldg. 514
San Antonio, Texas 78223

November 13, 2015

Administrator
Nix Health Care System
414 Navarro, Suite 600
San Antonio, TX 78205

Re: Provider Number 450130
Complaint Number TX00223777

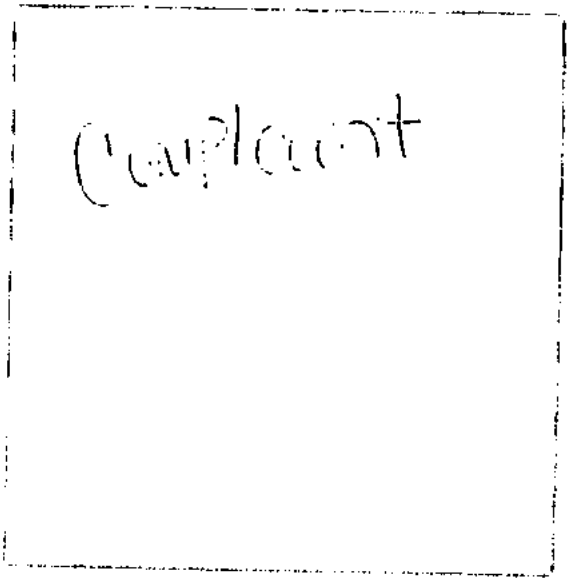
Dear Administrator:

I am pleased to inform you that as a result of the Texas Department of State Health Services substantial allegation survey conducted on **October 28, 2015, Nix Health Care System** was found in compliance with the applicable Medicare Conditions of Participation. We thank you for your cooperation and look forward to working with you on a continuing basis in the administration of the Medicare program. If you have any questions please contact Mr. Larrie Collier, Program Administrator, at 210-531-4532.

Sincerely,

Jeanette Salinas
Patient Quality Care Unit
Health Care Quality Section
Texas Department of State Health Services

CMS-2567 Forms



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ B. WING _____	C 10/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation (s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. An unannounced complaint survey (TX 00223777) was conducted on site. An entrance conference was held with the hospital delegated-representatives the morning of 10/26/15. The hospital delegated-representatives were informed of the purpose and process of the complaint survey with an opportunity for questions was provided. Complaint TX 00223777 was unsubstantiated. Complaint survey findings were presented at an exit conference on the afternoon of 10/29/15 with hospital delegated-representatives. The preliminary survey findings were presented and facility staff were given the opportunity to ask questions and provide additional information.	A 000		

Joseph W. Rafferty — Interim CEO — 11/17/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

SOD-State Forms

Texas Department of State Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000415	A. BUILDING: _____ B. WING _____	C 10/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
X 000	INITIAL COMMENTS Note: The State Form is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be referred to the Office of the Texas Attorney General (OAG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. An unannounced complaint survey (TX 00223777) was conducted on site. An entrance conference was held with the hospital delegated-representatives the morning of 10/26/15. The hospital delegated-representatives were informed of the purpose and process of the complaint survey with an opportunity for questions was provided. Complaint TX 00223777 was unsubstantiated. Complaint survey findings were presented at an exit conference on the afternoon of 10/29/15 with hospital delegated-representatives. The preliminary survey findings were presented and facility staff were given the opportunity to ask questions and provide additional information.	X 000		

Joseph W. Rafferty — Interim CEO — 11/17/15

SOD - State Form
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

November 16, 2015

Mr. Larrie Collier
Program Administrator
Health Facility Compliance Division
Texas Department of State Health Services
2303 SE Military Dr. Bldg. 514
San Antonio, TX 78223

Re: CMS-2567

Dear Mr. Collier:

We acknowledge receipt of your letter in regards to the result of a health survey conducted by Texas Department of State Health Services on October 27, 2015 at Nix Health Care System. We are submitting the signature page as requested.

We look forward to continuing to work with you in the administration of the Medicare Program.

Sincerely,

Joseph W. Rafferty, Interim CEO

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

KIRK COLE
INTERIM COMMISSIONER

1100 W. 49th Street • Austin, Texas 78756
1-888-963-7111 • http://www.dshs.state.tx.us

Health Facility Licensing and Compliance Division
2303 SE Military Dr. Bldg. 514
San Antonio, Texas 78223

11/13/2015

Administrator
Nix Health Care System
, 414 Navarro, Suite 600
San Antonio, TX 78205

Dear Administrator:

Enclosed is the CMS-2567 Statement of Deficiencies Plan of Correction form indicating no deficiencies were cited as a result of a Health Survey conducted at your facility on October 27, 2015. Your signature is required on page one. The enclosed form needs to be returned to this office within ten (10) days of receipt of this letter. You may keep a copy for your files.

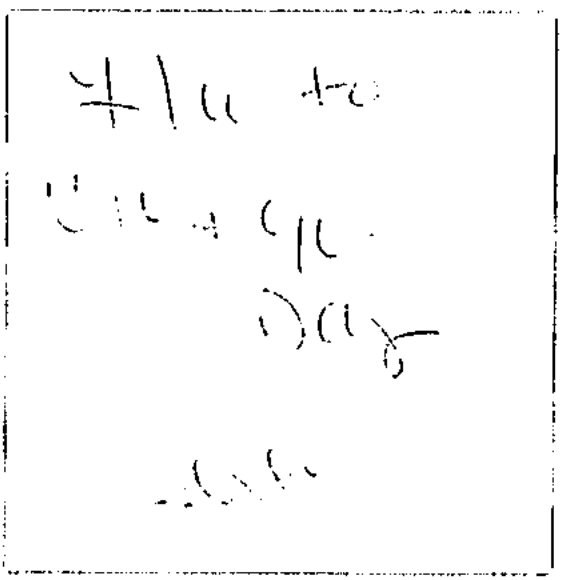
Should you have any questions, please contact me at 210-531-4532. Thank you for your cooperation.

Sincerely,

Mr. Larrie Collier, Program Administrator
Health Facility Compliance Division

Enclosure

CMS-2567 Forms



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ B. WING _____	R-C 10/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 000}	INITIAL COMMENTS The CMS - 2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates and the signature space. Any discrepancy in the original deficiency citation (s) will be reported to Dallas Regional Office (RO) for referral to the Office of Inspector General (OIG) for possible fraud if information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. An unannounced follow up survey visit was conducted from 10/26/15 to 10/27/15 to conduct the follow-up survey for complaint investigation (TX 00218998). An entrance conference was conducted on 10/26/15 in the conference room of the facility with the hospital delegated administrative staff. The purpose and process of the follow-up survey were discussed and an opportunity for questions was provided. An exit conference was conducted on 10/29/15 in the conference room. The hospital delegated administrative staff were in attendance. Preliminary findings of this survey were discussed and an opportunity for questions was provided.	{A 000}		

Joseph W. Rafferty — Interim CED — 11/17/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
450130	A. Building B. Wing	10/27/2015

Name of Facility	Street Address, City, State, Zip Code
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix A0115 Reg. # 482.13 LSC	Correction Completed 10/27/2015	ID Prefix A0145 Reg. # 482.13(c)(3) LSC	Correction Completed 10/27/2015	ID Prefix A0392 Reg. # 482.23(b) LSC	Correction Completed 10/27/2015
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date: 10/27/15
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 8/10/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

SOD-State Forms

Texas Department of State Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000415	A. BUILDING: _____ B. WING _____	R-C 10/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{X 000}	INITIAL COMMENTS Note: The State Form is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be referred to the Office of the Texas Attorney General (OAG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. An unannounced follow up survey visit was conducted from 10/26/15 to 10/27/15 to conduct the follow-up survey for complaint investigation (TX 00218998). An entrance conference was conducted on 10/26/15 in the conference room of the facility with the hospital delegated administrative staff. The purpose and process of the follow-up survey were discussed and an opportunity for questions was provided. An exit conference was conducted on 10/29/15 in the conference room. The hospital delegated administrative staff were in attendance. Preliminary findings of this survey were discussed and an opportunity for questions was provided.	{X 000}		

Joseph W. Rafferty — Interim CEO — 11/17/15

SOD - State Form
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Texas Department of State Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000415	A. BUILDING: _____ B. WING _____	R-C 10/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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SOD - State Form

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
000415	A. Building B. Wing	10/27/2015

Name of Facility	Street Address, City, State, Zip Code
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(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Y0313 Reg. # 134.46(c)(3)(A) LSC	Correction Completed 10/27/2015	ID Prefix Y0523 Reg. # 404.154(24) LSC	Correction Completed 10/27/2015	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor: Laura Longoria	Date: 10/27/15
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 8/10/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
000415	A. Building B. Wing	10/27/2015

Name of Facility	Street Address, City, State, Zip Code
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

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ID Prefix X0365 Reg. # 133.41(o)(2)(B) LSC	Correction Completed 10/27/2015	ID Prefix X0794 Reg. # 133.42(a)(1) LSC	Correction Completed 10/27/2015	ID Prefix X1037 Reg. # 133.47(c)(3)(A) LSC	Correction Completed 10/27/2015
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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Reviewed By _____ State Agency	Reviewed By	Date:	Signature of Surveyor: Laura Longoria	Date: 10/27/15
Reviewed By _____ CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 8/10/2015

_____ Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

nix

Terry J. Fontenot, FACHE
Chief Executive Officer
Nix Health Care System

October 1, 2015

Larrie Collier, MPA
HFC Manager-San Antonio Zone
Patient Quality Care Unit
Texas Department of State Health Services

via email: larrie.collier@dshs.state.tx.us

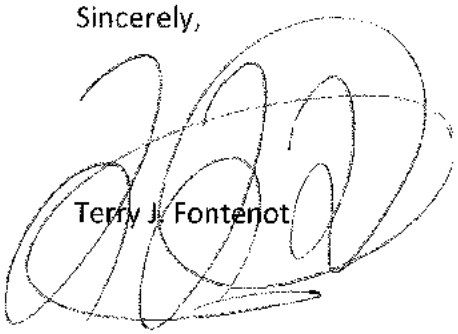
Re: CCN 450130, Intake #TX00218998

Dear Mr. Collier:

Please accept the following pages as the Nix Health Care System plan of correction for deficiencies cited during our August 10, 2015 complaint survey conducted by Texas Department of State Health Services, sent by email to: larrie.collier@dshs.state.tx.us.

Please confirm receipt by return email to: terryjfontenot@nixhealth.com, when you have received these items so we may preserve for our records.

Sincerely,



Terry J. Fontenot

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	460130	A. BUILDING _____ B. WING _____	8/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
A 000	INITIAL COMMENTS The CMS - 2567 (Statement of Deficiencies) is an official, legal document. AU information must remain unchanged except for entering the plan of correction, correction dates and the signature space. Any discrepancy in the original deficiency citation (s) will be reported to Dallas Regional Office (RO) for referral to the Office of Inspector General (010) for possible fraud if information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. An unannounced visit was conducted from 08/06/15 to 08/10/15 to conduct a survey for complaint investigation (TX 00218998). An entrance conference was conducted on 08/06/15 In the conference room of the facility with the Director of Risk Management. The purpose *and* process of the complaint survey were discussed and an opportunity for questions was provided. Complaint, TX 00218998, was substantiated with federal deficiencies cited. An exit conference was conducted on 08/10/15 in the conference room. The Director of Risk Management, the Vice President of clinical Services, the Nursing Clinical Director, and Interim Behavioral Health Administrator were in attendance. Preliminary findings of the survey were discussed and an opportunity for questions was provided.	A 000		

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE CEO | (xe) DATE 10-1-15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the Institution may be excused from correcting providing It Is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction Is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction Is requisite to continued

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIEFUOLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ a.WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	4414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(xs) COMPLETION OATE
A 115	Continuation from page 1 482.13 PATIENT RIGHTS A hospital must protect and promote each patient's rights. This CONDITION Is not met as evidenced by: Based on record review and interview, the facility failed to ensure specific patient rights were protected and promoted, and implement their written policy and procedures that protect and promote each patient's rights for 1 of 1 patients (Patient #1) reviewed with a rights violation complaint. Specifically, the facility failed to ensure Patient #1's rights to be free from all forms of abuse or harassment by failing to prevent, protect, investigate, and report/respond to a sexual assault allegation made by Patient #1 against another Patient (#2); as a result of facility neglect. On 04/27/15, Patient #1 reported to the unit's Registered Nurse (RN) an allegation of sexual assault from another Patient, (#2); who had a history of inappropriate sexual behaviors. The allegation was reported to the Medical Doctor, the Nursing Manager, and local Police Department (PD). However, this allegation was not reported to the state health care regulatory agency by any facility employees, in accordance with their policy. In addition, this allegation was not thoroughly investigated by the facility for the identification of neglect and/or a corrective action plan to prevent repeat incidence in accordance with the facility's policy. Refer to A 0145 for evidence of specific findings. The effect of these deficient practices resulted in the facility's inability to meet the Condition of	A 115	**Plan for Correction, Improving Processes, and Procedure Implementation:** The facility has implemented a policy titled "Managing Inappropriate Sexual Behaviors for Inpatient Hospitalization' which describes the process for identifying and managing patients who display such behaviors and the protective measures that will be taken to ensure that patients and staff are protected from potential sexual abuse. Clinical staff will be educated on the hospital's policy titled "Managing Inappropriate Sexual Behaviors for Inpatient Hospitalization" and moving forward, staff competence will be assessed upon hire and during annual competence assessment. All Behavioral Health Hospital staff members will be re-inserviced on the hospital's policy titled "Assessment and Reporting of Abuse and Neglect" to ensure their full understanding of the hospital's policy and their responsibility for ensuring that all patients are protected from abuse, neglect, or exploitation while under the care of the hospital. **Monitoring and Tracking procedures Monitoring/Tracking Procedures:** A monitoring process has been implemented in which all cases of potential or actual inappropriate sexual behaviors are identified will be escalated up to the VP of Clinical Services to ensure that the hospital's policy for managing such behaviors is implemented to mitigate threats to surrounding patient population and staff. The medical records for such cases will be reviewed to ensure that the documentation reflects adherence to the hospital's policy to include assessment, ongoing reassessment, and treatment planning. Any observations of non-compliance with the hospital's policy will be remediated immediately. The monitoring process will commence for a minimum of 90 days to ensure that the hospital's policy and processes are hardwired. Formal reports of compliance will be reported up to the hospital's Quality Council, MEC, and Governing Body for review and immediate action, if necessary. **Responsible Person**: VP of Clinical Services or designee	October, 6, 2015 September 30, 2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION
	Continued From page 2			
A 145	482.13(c) (3) PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT The patient has the right to be free from all forms of abuse or harassment. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the patient's rights tr be free from all forms of abuse or harassment by failing to prevent, protect, investigate, and report/respond to an allegation of neglect In accordance with their policy, for 1 of 1 patients reviewed (Patient #1) with a complaint allegation of sexual assault against another patient (Patient #2). On 04/27/15, Patient #1 reported to the unit's Registered Nurse (RN) an allegation of sexual assault from another Patient, (#2); who had a history of Inappropriate sexual behaviors. The allegation was reported to the Medical Doctor, the Nursing Manager, and local Police Department (PD). However, this allegation was not reported to the state health care regulatory agency by any facility employees in accordance with their policy. In addition, this allegation was not thoroughly investigated by the facility for the identification of neglect and/or a corrective action plan to prevent repeat Incidence; in accordance with the facility's policy. This deficient practice could affect the prevention of possible unidentified abuse, neglect, or mistreatment for all patients in the facility; by compromising their safety. Findings Included:	A145	**Plan for Correction, Improving Processes, and Procedure Implementation:** The facility has implemented a policy titled "Managing Inappropriate Sexual Behaviors for Inpatient Hospitalization' which describes the process for identifying and managing patients who display such behaviors and the protective measures that will be taken to ensure that patients and staff are protected from potential sexual abuse. Clinical staff will be educated on the hospital's policy titled "Managing Inappropriate Sexual Behaviors for Inpatient Hospitalization" and moving forward, staff competence will be assessed upon hire and during annual competence assessment. All Behavioral Health Hospital staff members will be re-inserviced on the hospital's policy titled "Assessment and Reporting of Abuse and Neglect" to ensure their full understanding of the hospital's policy and their responsibility for ensuring that all patients are protected from abuse, neglect, or exploitation while under the care of the hospital. **Monitoring and Tracking procedures Monitoring/Tracking Procedures:** A monitoring process has been implemented in which all cases of potential or actual inappropriate sexual behaviors are identified will be escalated up to the VP of Clinical Services to ensure that the hospital's policy for managing such behaviors is implemented to mitigate threats to surrounding patient population and staff. The medical records for such cases will be reviewed to ensure that the documentation reflects adherence to the hospital's policy to include assessment, ongoing reassessment, and treatment planning. Any observations of non-compliance with the hospital's policy will be remediated immediately. The monitoring process will commence for a minimum of 90 days to ensure that the hospital's policy and processes are hardwired. Formal reports of compliance will be reported up to the hospital's Quality Council, MEC, and Governing Body for review and immediate action, if necessary. **Responsible Person**: VP of Clinical Services or designee	October 6, 2015 September 30, 2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ B. WING _____	C 08110/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	4414 NAVARRO, SUITE 800 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 145	Continued From page 3 Review of Patient #1's Complaint Form dated 05/15/15, indicated the following in part: On 04/27/15 at approximately 11:30 AM, Patient #1 was admitted to the facility's "Psychiatric Emergency Services (PES) unit and received medication to help her sleep and calm down. Patient #1 reported shortly after she received the medications; she was asleep in her bed when she "felt someone touching my vagina and butt. I felt a hard pressure. I jumped up and another male patient (#2j jumped out from under my covers." Patient #1 stated she went to find a staff member (Mental Health Worker-A), to report what had happened. Patient #1 indicated she noticed her entire "crotch area [paper gown] was torn exposing her "vagina and butt." Patient #1 indicated the facility staff called the Police Department (PD) for Patient #1 to make a report. Patient #1 reported the staff apologized to her for the incident; "but they had an emergency on another floor and they were short staffed, so every staff member had left." Patient #1 indicated she was "so upset and scared; so they gave me more coeds to put me to sleep." Patient #1 stated the facility had done nothing more to help her; there were no witnesses but she believed there were cameras in the hall. Patient #1 stated she found out that Patient #2 had done this before and the Police Officer who responded stated that "he (Patient #21 has a history of doing this, why was he unsupervised?" Review of the facility's Policy titled, Abuse Reporting-External and Internal, last reviewed January 2012 revealed the following definitions: Psychological Abuse Included; humiliation and harassment.	A 145		

STATEMENT OF DEFICIENCIES AN PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A, WADING _____ B. WING _____	C 0811012015

NAME OF PROVIDER OR SUPPLIER	STREETADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 70205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTI N SH ULD BE CROSS•REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION
A 145	Continued From page 4 Sexual Abuse included: sexual harassment, sexual coercion, and sexual assault. Review of the facility's Policy titled, Assessment and Reporting of Abuse and Neglect, last reviewed February 2013 revealed Neglect included the failure to provide for one's self the goods or services including medical services, which are necessary to avoid physical or emotional harm or pain or the failure of a caretaker to provide the goods or services. The policy Indicated the facility "prohibits neglect, mental or physical abuse or misappropriation of property, of patients by staff, visitors, or other patients." The facility "will report alldgations and release information to the proper authorities, according to federal regulations, state speciifc rules and regulation and (facility] practice guidelines." Further review of the policy indicated, in part 1. Reporting allegations of abuse and/or neglect occurring while the patient is under the care in the facility: All alleged violations concerning abuse and neglect while the patient is under the care of the facility will be reported to the Compliance Officer or designee, who will advise the on-call administrator/designee. As appropriate, the facility will report the incident to appropriate state, federal and protective/regulatory agencies, and/or law enforcement agencies and conduct an internal investigation within a maximum of five working days of the incident The Texas Department of state Health Services (DSHS) is the regulatory body for reporting concerns of hospitals, psychiatric hospitals (Including private psychiatric facilities), and various other medical facilities.	A 145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 145	Continued From page 5 2. Investigations are always prompt comprehensive and responsive to the situation, well conducted, and contain founded conclusions. The investigation may include, but are not limited to the following: -Interviews conducted with Individuals having first-hand knowledge of the incident -Follow-up resolution -Corrective action plan to prevent repeat incidence. -Reports made to appropriate state health care regulatory agency. Review of the facility's Original Event report dated **04/27/15** at 12:15 PM completed by the unit RN revealed Patient #1 reported, "She was lying in bed asleep, when she felt Patient [#2] putting pressure around *her* buttocks area, and then touching her perineal area. Patient [#1] reported sitting up in bed shock and scared, and found Patient [#2] was up In her face with his finger to his mouth telling her to be quiet not to tell. She found her paper scrub button Corned on the outer left side. MD [Medical Doctor], Nurse Manager notified, Patient made a police comrlième'nt. PD interviewed Patient #1 and accused, Patient #2. "Patient visible distraught, but no other physical problems noted at this time." Further review of the Original Event Indicated the Event was documented as "Attempted Rape/Rape/Sexual Assault." Factors included; "Unit busy code greens called on other unit, and high acute of unit" The Original Event report did not include any documentation that this allegation was reported to the state health care regulatory agency by any facility employees, in accordance with the facility's policy. The Original Event report	A 145		

STATEMENT OF DEFICIENCIES AND PI AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A BUILDING _____ B. WING _____	C 0811012015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY. STATE, ZIP CODE
NIX **HEALTH CARE SYSTEM**	**414** NAVARRO, SUITE GOO **SAN ANTONIO, TX 18205**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVEACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	CoP COMPLETION DATE
A 145	Continued From page 8 did not Include documentation that this allegation was thoroughly investigated by the facility for the Identification of neglect and/or a corrective action plan to prevent repeat incidence; in accordance with the facility's policy. The Compliance Ofifcer/Director of Risk Management (RM) acknowledged receipt of the Original Event report dated 04/27/15 at 12:15 PM electronically on 05/06/15 documenting Patient #1 made a Police Report. Review of the local PD report dated 04/27/15 at 12:45PM revealed Patient #1 wanted to report that, "she was a sleep In her room, when she awaken and felt pressure around her buttock and vaginal area. When she fully awaken, she observed [Patient #2] in bed with her." Patient #1 further stated that Patient #2 told her "Don't teil anyone," before he left her room. Patient #1 did not feel Patient #2 penetrate her at any time, but the hospital [paper gown] pajama that she was wearing had a tear between the leg area. Patient #2 denied being in bed with Patient #1, or touching her. The report was deemed as "Disorderly Conduct" and Patient #1 was advised to contact the special victim's unit to4ile charges against Patient #2. "The Hospital staff was advised to monitor [Patient #2's] movement more closely." Record review of the medical record of Patient #1 revealed she was a 37 year-old female admitted to the psychiatric facility on 04/27/18 at 0830 under Emergency Detention (ED) when she cut her wrist and called a friend to call Police. Patient #1 has a history of Depression with Anxiety. Further review of Patient #1's permanent records revealed no documentation following the sexual	A 145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(xi) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ a WING _____	C 00/1012015

NAME OF PROVIDER OR SUPPLIER	STREETADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC1 EN11FYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X1 compLETIoN DATE
A 145	Continued From page 7	A 145		

assault allegation that she made on 04/27/15 against Patient #2. There was no documentation In her record that she received a physical and/or psychological assessment following her allegation on 04/27/15. There was a Telephone Physician Order (PO) on 04/27/15 at 12:30 PM (following the allegation) for Ativan (an anti-anxiety) 2 milligrams by mouth "now" without documentation of the reason for the emergency medication. The only documentation in Patient #1's record regarding her allegation against Patient #2 was a Behavioral Team Progress Note dated 05/01/15 at 12:25 completed by Licensed Social Worker- A that indicated "Patient discussed being sexually assaulted by Patient [#2] in the [facility's] PES unit.

Review of Patient #1's Daily Observation Notes for 04/27/15 revealed the following:
At 11:30-MHW-A documented 10 (1=On unit, and 0=Quiet/Calm).
At 11:45-MHW-A documented 1B (On unit, and B=Irt Bed Awake).
At 12:00-MHW-A documented 1BA On unit, In Bed Awake, and A=agitated/restlesg).
At 12:15 MHW-A documented 1BA.
At 12:30, 12:45, 13:00, 13:15, 13:30, and 13:45-MHW-A documented 1A (On Unit and agitated/restless).

Record review of Patient #2's medical records revealed the following:

Patient #2's Psychiatric Evaluation dated 04/24/15 revealed he was a 30 year old male admitted to the PES unit on 04/24/15 with a history of schizoaffective disorder and traumatic brain injury (TBI). Patient #2 was admitted on an ED basis with a history of aggressive behaviors

STATEMENT OF DEFICIENCIES AN PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ B. WING _____	C 0ED1012015

NAME OF PROVIDER OR SUPPLIER	STREETADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 500 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE EFICIENCY)	ots) COMPLETION DATE
A 145	Continued From page 8	A 145		

requiring emergency medications to calm him. Patient #2 had recently been discharged from this facility 4-5 weeks prior and has had multiple inpatient treatment episodes over the years (7 inpatient admissions in the previous 5 months). Patient #2 was documented with a known history of aggression and a "history of inappropriate sexual behavior on the unit (masturbating)."

Patient #2 had documented borderline intellectual functioning with poor insight, poor judgment, and poor impulse control.

A Behavioral Nursing Shift Assessment completed by the unit RN on 04/27/15 at 18:08 that Patient #2 was found by a female patient touching on her body while she was asleep in bed. MD, and Nurse Manager notified.

A Telephone PO dated 04/27/15 at 2015 for Patient #2 to be transferred to a higher acuity; sister facility.

A Behavior Team Progress noted dated 04/27/15 at 1855 revealed Patient #2 was transferred to a sister facility by the Sheriff's Department.

Review of the facility's Incident Event dated 04/27/15 at 11:37 AM confirmed a Code Green was called for another Patient (#3] in the Child/Adolescent Unit requiring Restraints/Seclusion. Patient #3 required physical restraint at 11:36 AM, and emergency medications at 11:96 AM. Patient #3 was released from restraint at 12:26 PM. This Code Green occurred during the same time frames of Patient #1's allegation on 04/27/15.

Review of the facility's Policy titled, Psychiatric

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	BUILDING _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 76205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVEACTIDN SHOUL BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 145	Continued From page 9 Emergencies-Code Green, last reviewed January 2012 revealed a Code Green was a Psychiatric Emergency. Code Green will be implemented by any unit personnel in the event of unmanageable behavior of an individual to prevent harm to that individual, patients, hospital personnel and/or others the general hospital area. D. Individuals responding to Code Green will meet in announced area. Available personnel is necessary to control atmosphere through a show of strength and caring or to assist in physical management. Interview on 08/06/15 at 12:35 PM with the PES unit RN revealed she completed Patient #1's admission assessment to the PES unit on 04/27/15, The unit RN indicated Patients were provided with paper scrubs to wear without other undergarments. The unit RN stated that on 04/27/15 at approximately 11:30 AM to 12:00 PM, "Code Greens" were going on; and "staff were busy". The unit RN stated there was a Code Green on another unit (child/adoles,n0 and a Code Green was called in the lobby; due to a patient needing to be "put in a [restraint] chair' because they were tearing up the lobby. The unit RN stated she left the unit to respond to the Code Green in the other unit (child/adolescent) and when she arrived; there was another RN responding, so she went to the Code Green in the lobby because they needed an RN to assist with "putting the patient in the [restraint] chair." The unit RN stated she returned to the PES unit following the Code Greens to "something else going on at the end of the unit" that she responded to. The unit RN stated she could not remember if it was LVN-A or LVN-B working on 04/27/15; but that she thought the LVN stayed back in the PES unit when she left *and*	A 145		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH EFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE EFICIENCY)	(55) comp:xl:0N DATE
A 145	Continued From page 10	A 145		

responded to the two Code Greens. The unit RN stated she was notified that during the Code Greens Patient #2 went into Patient #1's bedroom; and Patient #1 made an allegation of sexual assault. The unit RN stated she spoke with Patient #1 who reported that she was asleep in her bedroom and "she felt pressure" causing her to awake to Patient #2 touching her In the buttock and perinea' area. The unit RN stated that Patient #1's paper pants were "torn on the side." The unit RN stated the local PD was called. The unit RN stated she spoke to Patient #2 and he said, "1 touched her, but didn't do anything else." The unit RN stated he admitted that he "touched her and ripped her paper pants." The unit RN stated that Patient **#2** knew that the unit was "chaotic" and knew what Code Green meant; and that is when he "took advantage" of the situation. The unit RN stated she believed that Patient #2 sexually assaulted Patient #1 given the facts, and his own admission. The unit RN stated she notiifed the MD, Social Worker, and Nursing Manager of the allegation. The unit RN Indicated she documented the sexual assault 61legation made by Patient #1 on the Facility's Event Report; however, confirmed she did not document the sexual assault allegation in Patient #1's record following the Incident. The unit RN stated she offered for Patient #1 to have a Sexual Assault Nurse Examination (SANE) completed at another facility If she wanted; but Patient #1 declined, stating she did not believe Patient #2 actually raped her.

Interview on 08/06/15 at 04:45 PM with MHW-A revealed she was the only MHW working on 04/27/15 in the PES unit; along with the unit RN and a Licensed Vocational Nurse (LVN). MHW-A

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	4414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4)ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE EFICIENGY)	(x5) COMPLETION DATE
A 145	Continued From page 11 stated she was pulled to the PES unit at 9:15 AM and was unfamiliar to the PES unit; but was told by the leaving MHW to "watch it" for Patient #2, however, she did not know the specific reason why. MHW-A stated the females were assigned rooms on one side, and males on the other side. MHW-A stated during the morning on 04/27/15 at approximately 11:30 AM-12:00 PM it was a "hectic/busy" day with "Code Green's being called." MHW-A stated that security was usually on the PES unit; but on 04/27/15 at the time of the allegation; "security could not be found." MHW-A stated on 04/27/15 at around 11:30-12:00 PM she stayed in the unit when the Code Greens were called and was "getting something out of the supply closet." MHW-A indicated the unit RN "responded to the Code Green" leaving the unit; telling her she [unit RN] would be back. IVIHIN-A did not remember if LVN-A or LVN-B was working on 04/27/15; but further staled she did not remember any LVN being in the unit during the time of the allegation made by Patient #1. MHVV-A stated shortly after this Patient #1 "lfagged her (MHW-Al down" to her bedroom, and into the restroom of the bedroom where she reported that Patient #2 came into her room and touched her buttocks and vaginal area while she was sleeping in her bed. MHW-A stated that Patient #1's gown was torn around the buttock area and she offered to call the local PD for Patient #1 to make a report. MHW-A stated she then reported the incidenVailegation to the unit RN. MHW-A stated she was later told that Patient #2 had been an inpatient to the facility many times before, and he "knows the system; knows what Code Green means." MHW-A stated she had seen Patient #2 "walking out of her [Patient #1] room a few times" and further stated "right before she lfagged me down, he had	A 145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 500 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 145	Continued From page 12 walked out of her room". MHW-A indicated she told Patient #2 "not to go in to other people's rooms." MHW-A confirmed she had not documented the allegation reported by Patient #1 against Patient #2; but that she "told (unit RN]." interview on 08/10115at 1:20 PM with Patient #1 revealed on 04/27/15 at approximatyy 11:30-11:45 AM she was in her assiOned bedroom sleeping after she received multiple medications following her admission. Patient #1 stated she awoke after she "felt pressur'ein her buttock and vaginal area. Patient #1 stated that Patient #2 was present telling her not to tell anyone. Patient #1 stated that she noticed her paper pants were ripped and she was not actually aware what all Patient #2 actually did because she "was conked out" after taking multiple medications. Patient #1 stated she knows he touched her because that was what woke her up. Patient #1 stated she was very upset, "freaked out," and asked the MD for an "AIDS" test. Patient #1 stated the unit RN indicated to the nursing staff (LVN) to "give her more meds" because she was "upset, crying, and freaking out." Patient #1 stated she then received the Ativan for her anxiety, to "help me calm down." Patient #1 stated the local PD came and she made a report. Patient #1 stated she was told by the unit RN that "Code Green's" were called and "everyone had to leave the unit" which allowed the opportunity for Patient #2 to go into her room unsupervised. Interview on 08/10/15 at 2:20 PM with Security Guard-A revealed he was employed by the facility to maintain security and the safety of patients. The Security Guard-A stated Patient #2 had a	A 145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X0) PROVIDERISUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP C DE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

04) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEbED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVEACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETlON DATE
A 145	Continued From page 13 history of inappropriate sexual behavior of "masturbating in front of females." The Security Guard-A stated he assisted with "viewing the video" footage for evidence following the allegation on 04/27/15 made be Patient #1 against Patient #2. The Security Guard stated the video footage from 04/27/15 showed a total of "four times" that Patient #2 went Into Patient #1's room; and the last time Patient #2 came out of Patient #1's room; she was observed to come out of the room a few minutes later. The Security Guard stated that Patient #2 had already been assigned to the front "seclusion room" of the PES unit as his bedroom due to his history of masturbating. The Security Guard stated on the video footage Patient #2 could be seen coming from his room; "looking side to side" down the hallway, and then going into Patient #1's room. The Security Guard stated that female and male patient rooms were separated and that Patient #2 was not supposed to be going into Fiatient #1's room for any reason. Interview on 08/10/15 at 2:50 PM with MD-A revealed ***he*** was notified of Patient #1's sexual assault allegation against Patient #2 on 04/27/15. MD-A stated he discussed with Patient #1 the option of a "Rape Kit" but she "declined." MD-A stated he understood the allegation made by Patient #1 to be "only touching with no penetration." MD-A stated that Patient #1 was "distressed" about the incident and he ordered Ativan for Patient #1's anxiety following the incident. MD-A stated Patient #1 had already been distressed emotionally because of her ED inpatient admission; and really did not even want to take the Ativan. MD-A stated he recalled there was a Code Green called where staff left the unit In response to the Code Green; which letf less	A 145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTI N	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ B. WING _____	C 88/1012015

NAME OF PROVIDER OR SUPPLIER	STREETADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 500 SAN ANTONIO, TX 78206

(X4) to PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION GATE
A 145	Continued From page 14 staffing in the unit. MD-A confirmed that he did not document In Patient #1's records his contact or discussion with Patient #1 following her allegation. Interview on 08/10/15 at 3:00 PM with the facility's Risk Manager (RM) Indicated that she was aware of the alleged sexual assault allegation made by Patient #1 on 04/27/15 against Patient #2[1]; however, she had not been notified until 05/06/15 via the facility's Incident/Event electronic system because there had not been any harm documented in order to elevate the notification. The RM stated the staffing ratio on the PES unit was 1 staff to 4 patients. The RM indicated on 04/27/15 the patient census in the PES unit was 11; requiring 3 staff. The RM stated the first required staff is an RN, and then second could be a LVN, and/or MHW. The RM confirmed for 11 patients the required staffing would be 3. The RM stated the PES unit was to always have a licensed nurse present and available in the unit. The RM confirmed that she had not reported the sexual assault allegation made by Patient #1 on 04/27/15 against Patient #2 to the state health care regulatory agency, Department of State Health Services (DSHS); which was determined to have occurred as a result of Insufficient staffing in the PES unit during episodes of Code Green's. The RM further confirmed the facility had not completed a thorough investigation with documented findings specific to this allegation for the determination of Neglect and/or a corrective action plan to prevent repeat incidence; in accordance with the facility's policy. The RM stated she had not seen or viewed the video footage following this allegation due to the video being unavailable after 05/06/15; following her	A 145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIEFUCLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ B. WING _____	C 08110/2015

NAME OF PROVIDER OR SUPPLIER	STREETAI)DRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE SOO SAN ANTONIO, TX MOE

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	4X5) COMPLETION DATE
A 145	Continued From page 15 electronic notification. Interview on 08/10/15 at 3:15 PM with Licensed Social Worker (LSW)-A stated she assisted Security Guard-A in viewing the video footage on 04/27/15 after Patient #1 made a sexual assault allegation against Patient #2. LSW-A stated that during the allegation on 04/27/15; Patient #2 could be seen on the camera "looking both ways" and then would go into Patient #1's bedroom. LSW-A st ted they were able to count this event occurring a "couple of limes" where Patient #2 would go into Patient #1's bedroom and remain there "a couple of minutes" each time. LSW-A stated she saw on the video where MHW-A had been in the "Patient evaluation room" during these time periods; where a supply closet *was* located. LSW-A stated Patient #2 had a history of "exposing his self, public masturbatiOn, and talks sexually to other women." LSW-A stated that Patient #2 has publically masturbated in front of her during an assessment interview. Interview on 08/10/15 at 4:15 PM with LVN-A stated he was present and worked the PES unit on 04/27/15. LVN-A stated that on 04/27/15 there were Code Greens called on another unit, and in the facility's lobby about the same time. LVN-A stated he responded to the Code Green in the lobby to assist due to a "fight." LVN-A indicated he had left the unit for approximately 15 minutes. Interview on 08/10/15 at 4:30 PM with the Vice President (VP) of Clinical Services confirmed that she was notified of the sexual allegation made by Patient #1 against Patient #2 on 04127/15;	A 145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

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A 145	Continued From page 16 however, she had not been notified until 05/06/15 via the facility's Incident/Event electronic system because there ***had*** not been any harm documented in order to elevate the notification. The VP of Clinical Services indicated that an 04/27/15 the Nursing Clinical Directii'r (Nurse Manager) had been notified immediately following Patient #1's allegation and she had not obtained information that indicated Patient #1's allegation had occurred due to insufifcient staffing in the PES unit when Code Green's had been called; leaving the unit without a RN available. The VP of Clinical Services stated that the unit RN was not supposed to leave the unit and there should always be a Licensed Nurse in the unit during a Code Green; that "it is a judgement call." The VP of Clinical Services stated she had not ***seen*** or viewed the video footage following this allegation due to the video being unavallable after 05/06/15; following her electronic notification. Interview on 08/10/15 at 4:40 PM with the Nursing Clinical Director (Nurse Manager) stated she was immediately notified by the PES unit RN on 04/27/15 of Patient #1's sexual allegation against Patient #2. The Nursing Clinical Director Indicated she "separated" the Patients, talked to both of them, and Patient #1 saw the Doctor. The Nursing Clinical Director stated she spoke to the unit RN about the allegation but pad not been notified or received information that the RN and LVN had left the PES unit to respond to Code Greens which letf the unit without a RN and/or licensed nurse available. The Nursing Clinical Director stated she had not seen or viewed the video footage following this allegation.	A 145		
A 392	482.23(b) STAFFING AND DELIVERY OF CARE	A 392		

DEPARTMENT OF
HEALTH AND HUMAN SERVICES

PRINTED: 09/10/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ B. WING _____	C 08110/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM I	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

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A 392	Continued From page 17 The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure there were sufficient numbers of licensed registered nurses (RN), licensed vocational nurses (LVN), and other personnel immediately available at all times in the unit to ensure the provision of care and supervision for patients (Patient #1 and #2) as required resulting in an allegation of neglect. Specifically, on 04/27/15, Patient #1 reported to the unit's Registered Nurse (RN) an allegation of sexual assault from another Patient (#2), who had a history of inappropriate sexual behaviors, after the unit RN and LVN left their assigned unit to respond to "Code Green's" (psychiatric emergencies) in other units/areas of the facility. This deficient practice affected Patient #1's provision of care and compromised her safety resulting In allegation of Neglect due to insufficient staffing in the unit. Findings Included: Review of Patient #1's Complaint Form dated 05/15/15 indicated the following in part: On 04/27/15 at approximately 11:30 AM Patient #1 was admitted to the facility's "Psychiatric	A 392	**Plan for Correction, Improving Processes, and Procedure Implementation:** To mitigate the depletion of hospital staff on the BHU due to Code Green responses in the hospital and to ensure the protection of all patients on the unit, a staff member will be posted in each patient care area of the Behavioral Health Hospital until the Code Green incident is resolved. Hospital Staff will be in-serviced on their roles during Code Green incidents with a specific emphasis on the expectation that all patient care areas be manned throughout the entirety of the incident. Staff competence will be assessed upon hire and annually thereafter. **Monitoring/Tracking Procedures:** Observations of non-compliance will be remediated immediately. Formal reports of compliance will be reported up to the hospital's Quality Council, MEC, and Governing Body for review and immediate action, if necessary. **Responsible Person:** VP of Clinical Services or designee	September 30, 2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ B. WING _____	C 08/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	4414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 392	Continued From page 18	A 392		

Emergency Services (PES) unit and received medication to help her sleep and calm down. Patient #1 reported shortly after she received the medications; she was asleep in her bed when she "felt someone touching my vagina and butt I felt a hard pressure. I jumped up and another male patient (#2) jumped out from under my covers." Patient #1 stated she went to find a staff member (Mental Health Worker-A), to report what had happened. Patient #1 indicated she noticed her entire "crotch area [paper gown] was torn exposing her "vagina and butt." Patient #1 indicated the facility staff called the Police Department (PD) for Patient #1 to make a report. Patient #1 reported the staff apologized to her for the incident; "but they had an emergency on another floor and they were short staffed, so every staff member had left Patient #1 indicated she was upset and scared; so they gave me more meds to put me to sleep." Patient #1 stated the facility had done nothing more to help her; there were no witnesses but she believed there were cameras in the hall. Patient #1 stated she found out that Patient #2 had done this before and the Police Officer who responded stated that; "he [Patient #2] has a history of doing this; why was he unsupervised?"

Review of the facility's Policy titled, Abuse Reporting-External and internal, last reviewed January 2012 revealed the following definitions:
Psychological Abuse included; humiliation and harassment.
Sexual Abuse included; sexual harassment, sexual coercion, and sexual assault.

Review of the facility's Policy titled, Assessment and Reporting of Abuse and Neglect, last reviewed February 2013 revealed Neglect

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ B. WING _____	C 0811012016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY).	(X5) COMPLETION DATE
A 392	Continued From page 19 included the failure to provide for one's self the goods or services including medical services, which are necessary to avoid physical or emotional harm or pain or the failure of a caretaker to provide the goods or services. The policy indicated the facility "prohibits neglect, mental or physical abuse or misappropriation of property, of patients by staff, visitors, or other patients." The facility "will report allegations and release information to the proper authorities, according to federal regulations, state specific rules and regulation and [facility] practice guidelines." Review of the facility's Original Event report dated 04/27/15 at 12:15 PM completed by the unit RN revealed Patient #1 reported, "She was lying in bed asleep, when she felt Patient [#2] putting pressure around her buttocks area, and then touching her perineal area. Patient] #1] reported sitting up in bed shock and scared, and found Patient (#21 was up in her face with his finger to his mouth telling her to be quiet not to tell. She found **her paper** scrub button tomel on the outer left side. MD [Medical Doctor], Nurge Manager notified, Patient made a police complaint." PD interviewed Patient #1 and accused, Patient #2. "Patient visible distraught, but no other physical problems noted at this time." Further review of the Original Event indicated the Event was documented as "Attempted Rape/Rape/Sexual Assault." Factors included; "Unit busy code greens called on other unit, and high acute of unit." Record review of the medical record of Patient #1 revealed she was a 37 year-old female admitted to the psychiatric facility on 04/27/15 at 0830	A 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER1SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETION DATE
A 392	Continued From page 20 under Emergency Detention (ED) when she cut her wrist and called a friend to call Police. Patient #1 has a history of Depression with Anxiety. Further review of Patient #1's permanent records revealed no documentation following the sexual assault allegation that she made on 04/27/15 against Patient #2. There was no documentation in her record that she received a physical and/or psychological assessment following her allegation an 04/27/15. There was a Telephone Physician Order (PO) on 04/27/15 at 12:30 PM (following the allegation) for Ativan (an anti-anxiety) 2 milligrams by mouth "now" without documentation of the reason for the emergency medication. The only documentation in Patient #1's record regarding her allegation against Patient #2 was a Behavioral Team Progress Note dated 05/01/15 at 12:28 completed by Licensed Social Worker- A that Indicated "Patient discussed being sexually assaulted by Patient [#2] In the [facility's) PES unit. Review of Patient #1's Daily Observation Notes for 04/27/15 revealed the following: At 11:30-MHW-A documented 14 (1=On unit, and OrQuiet/Calm). At 11:45-MHW-A documented 1B (On unit, and B=In Bed Awake). At 12:00-MHW-A documented IBA (On unit, In Bed Awake, and A=agitated/restless). At 12:15 MHW-A documented 1 BA. At 12:30, 12:45, 13:00, 13:15, 13:30, and 13:45-MHW-A documented IA (On Unit and agitated/restless). Record review of Patient #2's medical records revealed the following:	A 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(Xi) PROVIDER/SUPPLIERICLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY. STATE. ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUM 600 SAN ANTONIO, TX 78205

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A 392	Continued From page 21' Patient #2's Psychiatric Evaluation dated 04/24/15 revealed he was a 30 year old male admitted to the PES unit on 04/24/15 with a history of schizoaffective disorder and traumatic brain injury (TBI). Patient #2 was admitted on an ED basis with a history of aggressive behaviors requiring emergency medications to calm him. Patient #2 had recently been discharged from this facility 4-5 weeks prior and has had multiple inpatient treatment episodes over the years (7 inpatient admissions in the previous,5 months). Patient #2 was documented with a known history of aggression and a "history of Inappropriate sexual behavior on the unit (masturbating)." Patient #2 had documented borderline intellectual functioning with poor insight, poor Judgment, and poor impulse control. A Behavioral Nursing Shift Assessment completed by the unit RN on 04/27/15 at 18:08 that Patient #2 was found by a female patient touching on her body while she was asleep in bed. MD, and Nurse Manager notified. A Telephone PO dated 04/27/15 at 2015 for Patient #2 to be transferred to a higher acuity; sister facility. A Behavior Team Progress noted dgted 04/27/15 at 1855 revealed Patient #2 was transferred to a sister facility by the Sheriff's Department. Review of the facility's Incident Event dated 04/27/15 at 11:37 AM confirmed a Code Green was called for another Patient [#3] in the Child/Adolescent Unit requiring Restraints/Seclusion. Patient #3 required physical restraint at 11:36 AM, and emergency medications at 11:46 AM. Patient #3 was	A 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 000 SAN ANTONIO, TX 70205

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A 392	Continued From page 22 released from restraint at 12:26 PM. This Code Green occurred during the same time frames of Patient #1's allegation on 04/27/15. Review of the facility's Policy titled, Psychiatric Emergencies-Code Green, last reviewed January 2012 revealed a Code Green was a Psychiatric Emergency. Code Green will be implemented by any unit personnel in the event of unmanageable behavior of an individual to prevent harm to that individual, patients, hospital personnel and/or others the general hospital area. D. Individuals responding to Code Green will meet In announced area. Available personnel is necessary to control atmosphere through a show of strength and caring or to assist in physical management. Interview on 08/08/15 at 12:35 PM with the PES unit RN revealed she completed Patient #1's admission assessment to the PES unit on 04/27/15. The unit RN indicated Patients were provided with paper scrubs to wear without other undergarments. The unit RN on 04/27/15 at approximately 11:30 AM to 12:00 PM, "Code Greens" were going on; and "staff were busy". The unit RN stated there was a Code Green on another unit (child/adolescent) and a Code Green was called In the lobby; due to a patient needing to be "put in a [restraint] chair" because they were tearing up the lobby. The unit RN stated she left the unit to respond to the Code Green in the other unit (child/adolescent) and when she arrived; there was another RN responding, so she went to the Code Green in the lobby because they needed an RN to assist with putting the patient in the [restraint] chair." The unit RN stated she returned to the PES unit following the Code Greens to "something else	A 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PR VIDEFU3UPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE. ZIP CO E
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 500 SAN ANTONIO, TX 78205

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A 392	Continued From page 23 going on at the end of the unit" that she responded to. The unit RN stated she could not remember if it was LVN-A or LVN-B working on 04/27/15; but that she thought the LVN stayed back in the PES unit when she left and responded to the two Code Greens. The unit RN stated she was notified that during the Code Greens Patient #2 went into Patient #1's bedroom; and Patient #1 made an allegation of sexual assault. The unit RN stated she spoke with Patient #1 who reported that she was asleep in her bedroom and "she felt pressure" causing *her* to awake to Patient #2 touching ter in the buttock and perinea! area. The unit RN stated that Patient #1's paper pants were "torn on the side." The unit RN stated the local PD was called. The unit RN stated she spoke to Patient #2 and he said, "I touched her, but didn't do anything else." The unit RN slated he admitted that he "touched her and ripped her paper pants." The unit RN stated that Patient #2 knew that the unit was chaotic" and knew what Code Green meant; and that is when he "took advantage" of the situation. The unit RN slated she believed that Patient #2 sexually assaulted Patient #1 given the facts, and his own admission, The unit RN stated she notified the MD, Social Worker, and Nursing Manager of the allegation. The unit RN indicated she documented the sexual assault allegation made by Patient #1 on the facility's Event Report; however, confirmed she did not document the sexual assault allegation in Patient #1's record following the Incident. The unit RN stated she offered for Patient #1 to have a Sexual Assault Nurse Examination (SANE) completed at another facility if she wanted; but Patient #1 declined, stating she did not believe Patient #2 actually raped her. I	A 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE GOO SAN ANTONIO, TX 78205

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A 392	Continued From page 24 Interview on 08/06/15 at 04:45 PM with MHW-A revealed she was the only MHW w9'king on 04/27/15 in the PES unit; along with the unit RN and a Licensed Vocational Nurse (LVN). MHW-A stated she was pulled to the PES unit at 9:15 AM and was unfamiliar to the PES unit; but was told by the leaving MHW to "watch it" for Patient #2, however, she did not know the specific reason why. MHW-A stated the females were assigned rooms on one side, and males on the other side. MHW-A stated during the morning on 04/27/15 at approximately 11:30 AM-12:00 PM it was a "hectic/busy" day with "Code Green's being called." MHW-A stated that security was usually on the PES unit; but on 04/27/15 at the time of the allegation; "security could not be found." MHW-A stated on 04/27/15 at around 11:30-12:00 PM she stayed In the unit when the Code Greens were called and was "getting something out of the supply closet." MHW-A indicated the unit RN "responded to the Code Green" leaving the unit; telling her she [unit RNJ would be back. MHW-A did not remember if LVN-A or LVN-B was working on 04/27/15; but further stated she did not remember any LVN being in the unit during the time of the allegation made by Patient #1. MHW-A stated shortly after this Patient #1 "flagged her [MHW-A] down" to her bedroom, and into the restroom of the bedroom where she reported that Patient #2 came into her room and touched her buttocks and vaginal area while she was sleeping in her bed. MHW-A stated that Patient #1's gown was torn around the buttock area and she offered to call the local PD for Patient #1 to make a report. MHW-A stated she then reported the incident/allegation to the unit RN. MHW-A stated she was later told that Patient #2 had been an inpatient to the facility many times before, and he "knows the system;	A 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDETUSUPPLIERCUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREETADDRESS, CITY. STATE, MP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSO IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVEACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(xi) COMPLETION OMM
A 392	Continued From page 25 knows what Code Green means." MHW-A stated she had seen Patient #2 "walking out of her [Patient #1] room a few times" and further stated "right before she flagged me down, he had walked out of her room". MHW-A indicated she told Patient #2 "not to go in to other people's rooms." MHW-A confirmed she had not documented the allegation reported by Patient #1 against Patient #2; but that she "told [unit RN]." Interview on 08/10115at 1:20 PM with Patient #1 revealed on 04/27/15 at approximately 11:30-11:45 AM she was in her assigned bedroom sleeping after she received multiple medications following her admission, Patient #1 stated she awoke after she "felt pressure on her buttock and vaginal area. Patient #1 stated that Patient #2 was present telling her not to tell anyone. Patient #1 stated that she noticed her paper pants were ripped ***and*** she was not actually aware what all Patient #2 actually did because she "was conked out" after taking multiple medications. Patient #1 stated she knows he touched her because that was what woke her up. Patient #1 stated she was very upset, "freaked out," and asked the MD for an "AIDS" test. Patient #1 stated the unit RN indicated to the nursing staff (LVN) to "give her more meds" because she was "upset, crying, and freaking out." Patient #1 stated she then received the Ativan for her anxiety, to "help me calm down." Patient #1 stated the local PD came and she made a report. Patient #1 stated she was told by the unit RN that "Code Green's" were called and "everyone had to leave the unit" which allowed the opportunity for Patient #2 to go into her room unsupervised.	A 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/ELIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREETADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 **SAN ANTONIO, TX 78205**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST SE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE EROSS•REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
A 392	Continued From page 26 interview on 08/10/15 at 2:20 PM with Security Guard-A revealed he was employed by the facility to maintain security and the safety of patients. The Security Guard-A stated Patient #2 had a history of inappropriate sexual behavior of "masturbating in front of females." The Security Guard-A stated he assisted with "viewing the video" footage for evidence following the allegation on 04/27/15 made be Patent #1 against Patient #2. The Security Guard stated the video footage from 04/27/15 showed a total of "four times" that Patient #2 went into Patient #1's room; and the last time Patient #2 came out of Patient #1's room; she was observed to come out of the room a few minutes later. The Security Guard stated that Patient #2 had already been assigned to the front "seclusion room" of the PES unit as his bedroom due to his history of masturbating. The Security Guard stated on the video footage Patient #2 could be seen coming from his room; "looking side to side" down the hallway, and then going into Patient #1's room. The Security Guard stated that female and male patient rooms were separated and that Patient #2 was not supposed to be going into Patient #1's room for any reason. Interview on 08/10/15 at 2:50 PM with MD-A revealed he was notified of Patient #1's sexual assault allegation against Patient #2 on 04/27/15. MD-A stated he discussed with Patient #1 the option of a "Rape Kit" but she "declined." MD-A stated he understood the allegation made by Patient #1 to be "only touching with tIO penetration." MD-A stated that Patient #1 was "distressed" about the incident and he ordered Ativan for Patient #1's anxiety following the incident. MD-A slated Patient #1 had already been distressed emotionally because of her ED	A 392		

STATEMENT OF EFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDERISUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREETADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING IIFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-EFERENCED TO THE APPROPRIATE DEFICIENCY)	vs) COMPLETION DATE
A 392	Continued From page 27 Inpatient admission; and really did not even want to take the Ativan. MD-A stated he recalled there was a Code Green called where staff left the unit In response to the Code Green; which left less staffing in the unit. Interview on 08/10/15 at 3:00 PM with the facility's Risk Manager (RM) indicated that she was aware of the alleged sexual assault allegation made by Patient #1 on 04/27/15 against Patient #2; however, she had not been notified until 05/06/15 via the facility's Incident/Event electronic system because there had not been any harm documented In order to elevate the notification. The RM stated the stafifng ratio on the PES unit was 1 staff to 4 patients, The RM indicated on 04/27/15 the patient census in the PES unit was 11; requiring 3 staff. The RM stated the first required staff is an RN, and then second could be a LVN, and/or MHW. The RM confirmed for 11 patients the required staffing would ire 3. The RM stated the PES unit was to always have a licensed nurse present and available in the unit. The RM stated she had not seen or viewed the video footage following this allegation due to the video being unavailable after 05/06/15; following her electronic notification. The RM stated there would not be documentation of the Code Green that may have occurred on 04/27/15 in the facility's lobby waiting area; if the patient had not yet been assessed for care. interview on 08/10/15 at 3:15 PM with Licensed Social Worker (LSW)-A stated she assisted Security Guard-A in viewing the video footage on 04/27/15 after Patient #1 made a sexual assault allegation against Patient #2. LSW-A stated that	A 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDEFUSUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	**414 NAVARRO, SUITE** 800 SAN ANTONIO, TX 70205

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A 392	Continued From page 28 during the allegation on 04127/15; Patient #2 could be seen on the camera "looking both ways" and then would go into Patient #1's bedroom. LSW-A stated they were able to count this event occurring a "couple of times" where Patient #2 would go into Patient #1's bedroom and remain there "a couple of minutes" each time. LSW-A stated she saw on the video where MHW-A had been in the "Patient evaluation room " during these time periods; where a supply ?Inset was located. LSW-A stated Patient #2 hpd a history of "exposing his self, public masturbation, and talks sexually to other women." LSW-A stated that Patient #2 has publically masturbated in front of her during an assessment interview. Interview on 08/10/15 at 415 PM with LVN-A stated he was present and worked the PES unit on 04/27/15. LVN-A staled that on 04/27/15 there were Code Greens called on another unit, and In the facility's lobby about the same time. LVN-A stated he responded to the Code Green in the lobby to assist due to a "fight." LVN-A indicated he had left the unit for approximately 15 minutes. Interview on 08/10/15 at 4:30 PM with the Vice President (VP) of Clinical Services confirmed that she was notified of the sexual allegation made by Patient #1 against Patient #2 on 04/27/15; however, she had not been notified until 05/06/15 via the facility's Incident/Event electronic system because there had not been any harm documented in order to elevate the notification. The VP of Clinical Services I that on 04/27/16 the Nursing Clinica I Direct& (Nurse Manager) had been notified immediately following Patient #1's allegation and she had not obtained	A 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIENCLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50130	A. BUILDING _____ B. WING _____	C 08/10/2015

NAME OF PROVI ER OR SUPPLIER	STREETADORESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	**414 NAVARRO, SUITE** Bob SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(x5) COMPLETIGN DATE
A 392	Continued From page 29 Information that Indicated Patient #1's allegation had occurred due to Insufficient staffing in the PES unit when Code Green's had been called; leaving the unit without a RN available. The VP of Clinical Services stated that the unit RN was not supposed to leave the unit and there should always be a Licensed Nurse In the unit during a Code Green; that it's a judgement call." The VP of Clinical Services stated she had not seen or viewed the video footage following this allegation due to the video being unavailable after 05/06/15; following her electronic notification. Interview on 08/10/15 at 4:40 PM with the Nursing Clinical Director (Nurse Manager) she was immediately notified by the PES un it RN on 04/27d/15 of Patient #1's sexual allegation against Patient #2. The Nursing Clinical Director indicated she "separated" the Patients, talked to both of them, and Patient #1 saw the Doctor. The Nursing Clinical Director stated she spoke to the unit RN about the allegation but,had.not been notified or received information that the RN and LVN had left the PES unit to respond to Code Greens which letf the unit without a RN and/or licensed nurse available. The Nursing Clinical Director stated she had not seen or viewed the video footage following thls allegation.	A 392		

SOD-State Forms

Texas Department of State Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000415	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	25 TAC 134 INITIAL COMMENTS Note: The State Form is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be referred to the Office of the Texas Attorney General (OAG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. An unannounced visit was conducted from 08/06/15 to 08/10/15 to conduct a survey for complaint investigation (TX 00218998). An entrance conference was conducted on 08/06/15 in the conference room of the facility with the Director of Risk Management. The purpose and process of the complaint survey were discussed and an opportunity for questions was provided. Complaint, TX 00218998, was substantiated with state violations cited. An exit conference was conducted on 08/10/15 in the conference room. The Director of Risk Management, the Vice President of Clinical Services, the Nursing Clinical Director, and Interim Behavioral Health Administrator were in attendance. Preliminary findings of the survey were discussed and an opportunity for questions was provided.	Y 000		
Y 313	134.46(c)(3)(A) Abuse & Neglect: Reporting responsibility Reporting abuse and neglect. A person, including an employee, volunteer, or other person	Y 313	**Plan of Correction** **Y313** Mandatory read and sign in-service for all front-line behavioral health staff to include nursing, MHT, NP, social workers, intake/assessment, security and admitting to be completed by 9/14/15.	**9/14/15**

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Y 313	Continued From page 1 associated with the facility who reasonably believes or who knows of information that would reasonably cause a person to believe that the physical or mental health or welfare of a patient of the facility who is receiving mental health or chemical dependency services has been, is, or will be adversely affected by abuse or neglect (as those terms are defined in this subsection) by any person shall as soon as possible report the information supporting the belief to the department or to the appropriate state health care regulatory agency in accordance with HSC, §161.132(a). This REQUIREMENT is not met as evidenced by: Based on interview and record review, facility employees failed to report an allegation of neglect to the state health care regulatory agency, the Department of State Health Services (DSHS); and in accordance with their policy, for 1 of 1 patients reviewed (Patient #1) with a complaint allegation of sexual assault against another patient (Patient #2). Specifically, on 04/27/15, Patient #1 reported to the unit's Registered Nurse (RN) an allegation of sexual assault from another Patient, (#2); who had a history of inappropriate sexual behaviors. The allegation was reported to the Medical Doctor, the Nursing Manager, and local Police Department (PD); however, this allegation was not reported to the state health care regulatory agency by any facility employees, in accordance with their policy. This deficient practice could affect the prevention of possible unidentified abuse, neglect, or mistreatment for all patients in the facility; by	Y 313	Mandatory In-services to be conducted on 9/14, 9/16, and 9/18 for all behavioral health staff with multiple offerings in order to ensure all staff are able to attend one of these educational events. The mandatory in-service will reinforce the hospital policy regarding Assessment and Reporting of Abuse and Neglect, reinforce the need to document outlier events affecting patients, and roll out the Code Green Response Protocol. The Code Green Response Protocol includes the following: 1.) reinforces assigning a specific Code Green response team to include back up for breaks as appropriate as well as for census level and unit acuity to ensure appropriate staffing is left on inpatient units, 2.) provides instruction for responding in the event multiple codes are called at the same time. to insure patient and staff safety, 3.) Psychiatric Emergency Service Unit (PES) staff will not respond to Code Greens unless the unit is overstaffed for its current population, 4.) reinforces that all supervisors will respond to Code Green, 5.) reinforces what should happen to maintain safety on the units when the Code Green team responds which includes: a.) suspension of non-essential tasks, b.) cohort the patients as much as possible to control the situation and monitor for safety,	

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Y 313	Continued From page 2 compromising their safety. Findings Included: Review of Patient #1's Complaint Form dated 05/15/15 indicated the following in part: On 04/27/15 at approximately 11:30 AM Patient #1 was admitted to the facility's "Psychiatric Emergency Services (PES) unit and received medication to help her sleep and calm down. Patient #1 reported shortly after she received the medications; she was asleep in her bed when she "felt someone touching my vagina and butt. I felt a hard pressure. I jumped up and another male patient [#2] jumped out from under my covers." Patient #1 stated she went to find a staff member (Mental Health Worker-A), to report what had happened. Patient #1 indicated she noticed her entire "crotch area [paper gown] was torn exposing her "vagina and butt." Patient #1 indicated the facility staff called the Police Department (PD) for Patient #1 to make a report. Patient #1 reported the staff apologized to her for the incident; "but they had an emergency on another floor and they were short staffed, so every staff member had left." Patient #1 indicated she was "so upset and scared; so they gave me more meds to put me to sleep." Patient #1 stated the facility had done nothing more to help her; there were no witnesses but she believed there were cameras in the hall. Patient #1 stated she found out that Patient #2 had done this before and the Police Officer who responded stated that; "he [Patient #2] has a history of doing this; why was he unsupervised?" Review of the facility's Policy titled, Abuse Reporting-External and Internal, last reviewed January 2012 revealed the following definitions: Psychological Abuse included; humiliation and	Y 313	c.) response team clearly communicates to their charge when they leave from and return to the unit. Additional topics for the mandatory in-service include: a decision tree to reinforce the policy on reporting and follow-up of suspected/reported allegations of abuse/neglect of a patient during hospitalization and in treating patients identified as having ordered sexual precautions. Follow up in-servicing is planned for February 2016 to include participation by same staff members to continue reinforcement of policies.	

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Y 313	Continued From page 3 harassment. Sexual Abuse included; sexual harassment, sexual coercion, and sexual assault. Review of the facility's Policy titled, Assessment and Reporting of Abuse and Neglect, last reviewed February 2013 revealed Neglect included the failure to provide for one's self the goods or services including medical services, which are necessary to avoid physical or emotional harm or pain or the failure of a caretaker to provide the goods or services. The policy indicated the facility "prohibits neglect, mental or physical abuse or misappropriation of property, of patients by staff, visitors, or other patients." The facility "will report allegations and release information to the proper authorities, according to federal regulations, state specific rules and regulation and [facility] practice guidelines." Further review of the policy indicated, in part: 1. Reporting allegations of abuse and/or neglect occurring while the patient is under the care in the facility: All alleged violations concerning abuse and neglect while the patient is under the care of the facility will be reported to the Compliance Officer or designee, who will advise the on-call administrator/designee. As appropriate, the facility will report the incident to appropriate state, federal and protective/regulatory agencies, and/or law enforcement agencies and conduct an internal investigation within a maximum of five working days of the incident. The Texas Department of state Health Services (DSHS) is the regulatory body for reporting concerns of hospitals, psychiatric hospitals (including private psychiatric facilities), and various other medical facilities.	Y 313		

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Y 313	Continued From page 4 Review of the facility's Original Event report dated 04/27/15 at 12:15 PM completed by the unit RN revealed Patient #1 reported, "She was lying in bed asleep, when she felt Patient [#2] putting pressure around her buttocks area, and then touching her perineal area. Patient[#1] reported sitting up in bed shock and scared, and found Patient [#2] was up in her face with his finger to his mouth telling her to be quiet not to tell. She found her paper scrub button torned on the outer left side. MD [Medical Doctor], Nurse Manager notified, Patient made a police complaint." PD interviewed Patient #1 and accused, Patient #2. "Patient visible distraught, but no other physical problems noted at this time." Further review of the Original Event indicated the Event was documented as "Attempted Rape/Rape/Sexual Assault." Factors included; "Unit busy code greens called on other unit, and high acute of unit." The Original Event report did not include any documentation that this allegation was reported to the state health care regulatory agency by any facility employees, in accordance with the facility's policy. The Original Event report did not include documentation that this allegation was thoroughly investigated by the facility for the identification of neglect and/or a corrective action plan to prevent repeat incidence; in accordance with the facility's policy. The Compliance Officer/Director of Risk Management (RM) acknowledged receipt of the Original Event report dated 04/27/15 at 12:15 PM electronically on 05/06/15 documenting Patient #1 made a Police Report. Review of the local PD report dated 04/27/15 at 12:45PM revealed Patient #1 wanted to report that, "she was a sleep in her room, when she awaken and felt pressure around her buttock and	Y 313		

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Y 313	Continued From page 5 vaginal area. When she fully awaken, she observed [Patient #2] in bed with her." Patient #1 further stated that Patient #2 told her "Don't tell anyone," before he left her room. Patient #1 did not feel Patient #2 penetrate her at any time, but the hospital [paper gown] pajama that she was wearing had a tear between the leg area. Patient #2 denied being in bed with Patient #1, or touching her. The report was deemed as "Disorderly Conduct" and Patient #1 was advised to contact the special victim's unit to file charges against Patient #2. "The Hospital staff was advised to monitor [Patient #2's] movement more closely." Record review of the medical record of Patient #1 revealed she was a 37 year-old female admitted to the psychiatric facility on 04/27/15 at 0830 under Emergency Detention (ED) when she cut her wrist and called a friend to call Police. Patient #1 has a history of Depression with Anxiety. Further review of Patient #1's permanent records revealed no documentation following the sexual assault allegation that she made on 04/27/15 against Patient #2. There was no documentation in her record that she received a physical and/or psychological assessment following her allegation on 04/27/15. There was a Telephone Physician Order (PO) on 04/27/15 at 12:30 PM (following the allegation) for Ativan (an anti-anxiety) 2 milligrams by mouth "now" without documentation of the reason for the emergency medication. The only documentation in Patient #1's record regarding her allegation against Patient #2 was a Behavioral Team Progress Note dated 05/01/15 at 12:28 completed by Licensed Social Worker- A that indicated "Patient discussed being sexually assaulted by Patient [#2] in the [facility's] PES	Y 313		

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Y 313	Continued From page 6 unit. Review of Patient #1's Daily Observation Notes for 04/27/15 revealed the following: At 11:30-MHW-A documented 1Q (1=On unit, and Q=Quiet/Calm). At 11:45-MHW-A documented 1B (On unit, and B=In Bed Awake). At 12:00-MHW-A documented 1BA (On unit, In Bed Awake, and A=agitated/restless). At 12:15 MHW-A documented 1BA. At 12:30, 12:45, 13:00, 13:15, 13:30, and 13:45-MHW-A documented 1A (On Unit and agitated/restless). Record review of Patient #2's medical records revealed the following: Patient #2's Psychiatric Evaluation dated 04/24/15 revealed he was a 30 year old male admitted to the PES unit on 04/24/15 with a history of schizoaffective disorder and traumatic brain injury (TBI). Patient #2 was admitted on an ED basis with a history of aggressive behaviors requiring emergency medications to calm him. Patient #2 had recently been discharged from this facility 4-5 weeks prior and has had multiple inpatient treatment episodes over the years (7 inpatient admissions in the previous 5 months). Patient #2 was documented with a known history of aggression and a "history of inappropriate sexual behavior on the unit (masturbating)." Patient #2 had documented borderline intellectual functioning with poor insight, poor judgment, and poor impulse control. A Behavioral Nursing Shift Assessment completed by the unit RN on 04/27/15 at 18:08 that Patient #2 was found by a female patient touching on her body while she was asleep in	Y 313		

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Y 313	Continued From page 7 bed. MD, and Nurse Manager notified. A Telephone PO dated 04/27/15 at 2015 for Patient #2 to be transferred to a higher acuity; sister facility. A Behavior Team Progress noted dated 04/27/15 at 1855 revealed Patient #2 was transferred to a sister facility by the Sheriff's Department. Review of the facility's Incident Event dated 04/27/15 at 11:37 AM confirmed a Code Green was called for another Patient [#3] in the Child/Adolescent Unit requiring Restraints/Seclusion. Patient #3 required physical restraint at 11:36 AM, and emergency medications at 11:46 AM. Patient #3 was released from restraint at 12:26 PM. This Code Green occurred during the same time frames of Patient #1's allegation on 04/27/15. Review of the facility's Policy titled, Psychiatric Emergencies-Code Green, last reviewed January 2012 revealed a Code Green was a Psychiatric Emergency. Code Green will be implemented by any unit personnel in the event of unmanageable behavior of an individual to prevent harm to that individual, patients, hospital personnel and/or others the general hospital area. D. Individuals responding to Code Green will meet in announced area. Available personnel is necessary to control atmosphere through a show of strength and caring or to assist in physical management. Interview on 08/06/15 at 12:35 PM with the PES unit RN revealed she completed Patient #1's admission assessment to the PES unit on 04/27/15. The unit RN indicated Patients were provided with paper scrubs to wear without other	Y 313		

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Y 313	Continued From page 8 undergarments. The unit RN stated that on 04/27/15 at approximately 11:30 AM to 12:00 PM, "Code Greens" were going on; and "staff were busy". The unit RN stated there was a Code Green on another unit (child/adolescent) and a Code Green was called in the lobby; due to a patient needing to be "put in a [restraint] chair" because they were tearing up the lobby. The unit RN stated she left the unit to respond to the Code Green in the other unit (child/adolescent) and when she arrived; there was another RN responding, so she went to the Code Green in the lobby because they needed an RN to assist with "putting the patient in the [restraint] chair." The unit RN stated she returned to the PES unit following the Code Greens to "something else going on at the end of the unit" that she responded to. The unit RN stated she could not remember if it was LVN-A or LVN-B working on 04/27/15; but that she thought the LVN stayed back in the PES unit when she left and responded to the two Code Greens. The unit RN stated she was notified that during the Code Greens Patient #2 went into Patient #1's bedroom; and Patient #1 made an allegation of sexual assault. The unit RN stated she spoke with Patient #1 who reported that she was asleep in her bedroom and "she felt pressure" causing her to awake to Patient #2 touching her in the buttock and perineal area. The unit RN stated that Patient #1's paper pants were "torn on the side." The unit RN stated the local PD was called. The unit RN stated she spoke to Patient #2 and he said, "I touched her, but didn't do anything else." The unit RN stated he admitted that he "touched her and ripped her paper pants." The unit RN stated that Patient #2 knew that the unit was "chaotic" and knew what Code Green meant; and that is when he "took advantage" of the situation. The unit RN stated she believed that	Y 313		

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Y 313	Continued From page 9 Patient #2 sexually assaulted Patient #1 given the facts, and his own admission. The unit RN stated she notified the MD, Social Worker, and Nursing Manager of the allegation. The unit RN indicated she documented the sexual assault allegation made by Patient #1 on the facility's Event Report; however, confirmed she did not document the sexual assault allegation in Patient #1's record following the incident. The unit RN stated she offered for Patient #1 to have a Sexual Assault Nurse Examination (SANE) completed at another facility if she wanted; but Patient #1 declined, stating she did not believe Patient #2 actually raped her. The unit RN confirmed she had not reported this allegation to the state health care regulatory agency (DSHS). Interview on 08/06/15 at 04:45 PM with MHW-A revealed she was the only MHW working on 04/27/15 in the PES unit; along with the unit RN and a Licensed Vocational Nurse (LVN). MHW-A stated she was pulled to the PES unit at 9:15 AM and was unfamiliar to the PES unit; but was told by the leaving MHW to "watch it" for Patient #2, however, she did not know the specific reason why. MHW-A stated the females were assigned rooms on one side, and males on the other side. MHW-A stated during the morning on 04/27/15 at approximately 11:30 AM-12:00 PM it was a "hectic/busy" day with "Code Green's being called." MHW-A stated that security was usually on the PES unit; but on 04/27/15 at the time of the allegation; "security could not be found." MHW-A stated on 04/27/15 at around 11:30-12:00 PM she stayed in the unit when the Code Greens were called and was "getting something out of the supply closet." MHW-A indicated the unit RN "responded to the Code Green" leaving the unit; telling her she [unit RN] would be back. MHW-A	Y 313		

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Y 313	Continued From page 10 did not remember if LVN-A or LVN-B was working on 04/27/15; but further stated she did not remember any LVN being in the unit during the time of the allegation made by Patient #1. MHW-A stated shortly after this Patient #1 "flagged her [MHW-A] down" to her bedroom, and into the restroom of the bedroom where she reported that Patient #2 came into her room and touched her buttocks and vaginal area while she was sleeping in her bed. MHW-A stated that Patient #1's gown was torn around the buttock area and she offered to call the local PD for Patient #1 to make a report. MHW-A stated she then reported the incident/allegation to the unit RN. MHW-A stated she was later told that Patient #2 had been an inpatient to the facility many times before, and he "knows the system; knows what Code Green means." MHW-A stated she had seen Patient #2 "walking out of her [Patient #1] room a few times" and further stated "right before she flagged me down, he had walked out of her room". MHW-A indicated she told Patient #2 "not to go in to other people's rooms." MHW-A confirmed she had not documented the allegation reported by Patient #1 against Patient #2; but that she "told [unit RN]." Interview on 08/10/15at 1:20 PM with Patient #1 revealed on 04/27/15 at approximately 11:30-11:45 AM she was in her assigned bedroom sleeping after she received multiple medications following her admission. Patient #1 stated she awoke after she "felt pressure" in her buttock and vaginal area. Patient #1 stated that Patient #2 was present telling her not to tell anyone. Patient #1 stated that she noticed her paper pants were ripped and she was not actually aware what all Patient #2 actually did because she "was conked out" after taking multiple medications. Patient #1 stated she knows he	Y 313		

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Y 313	Continued From page 11 touched her because that was what woke her up. Patient #1 stated she was very upset, "freaked out," and asked the MD for an "AIDS" test. Patient #1 stated the unit RN indicated to the nursing staff (LVN) to "give her more meds" because she was "upset, crying, and freaking out." Patient #1 stated she then received the Ativan for her anxiety, to "help me calm down." Patient #1 stated the local PD came and she made a report. Patient #1 stated she was told by the unit RN that "Code Green's" were called and "everyone had to leave the unit" which allowed the opportunity for Patient #2 to go into her room unsupervised. Interview on 08/10/15 at 2:20 PM with Security Guard-A revealed he was employed by the facility to maintain security and the safety of patients. The Security Guard-A stated Patient #2 had a history of inappropriate sexual behavior of "masturbating in front of females." The Security Guard-A stated he assisted with "viewing the video" footage for evidence following the allegation on 04/27/15 made be Patient #1 against Patient #2. The Security Guard stated the video footage from 04/27/15 showed a total of "four times" that Patient #2 went into Patient #1's room; and the last time Patient #2 came out of Patient #1's room; she was observed to come out of the room a few minutes later. The Security Guard stated that Patient #2 had already been assigned to the front "seclusion room" of the PES unit as his bedroom due to his history of masturbating. The Security Guard stated on the video footage Patient #2 could be seen coming from his room; "looking side to side" down the hallway, and then going into Patient #1's room. The Security Guard stated that female and male patient rooms were separated and that Patient #2	Y 313		

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Y 313	Continued From page 12 was not supposed to be going into Patient #1's room for any reason. Interview on 08/10/15 at 2:50 PM with MD-A revealed he was notified of Patient #1's sexual assault allegation against Patient #2 on 04/27/15. MD-A stated he discussed with Patient #1 the option of a "Rape Kit" but she "declined." MD-A stated he understood the allegation made by Patient #1 to be "only touching with no penetration." MD-A stated that Patient #1 was "distressed" about the incident and he ordered Ativan for Patient #1's anxiety following the incident. MD-A stated Patient #1 had already been distressed emotionally because of her ED inpatient admission; and really did not even want to take the Ativan. MD-A stated he recalled there was a Code Green called where staff left the unit in response to the Code Green; which left less staffing in the unit. MD-A confirmed that he did not document in Patient #1's records his contact or discussion with Patient #1 following her allegation. Interview on 08/10/15 at 3:00 PM with the facility's Risk Manager (RM) indicated that she was aware of the alleged sexual assault allegation made by Patient #1 on 04/27/15 against Patient #2'; however, she had not been notified until 05/06/15 via the facility's Incident/Event electronic system because there had not been any harm documented in order to elevate the notification. The RM stated the staffing ratio on the PES unit was 1 staff to 4 patients. The RM indicated on 04/27/15 the patient census in the PES unit was 11; requiring 3 staff. The RM stated the first required staff is an RN, and then second could be a LVN, and/or MHW. The RM confirmed for 11 patients the required staffing would be 3. The RM	Y 313		

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Y 313	Continued From page 13 stated the PES unit was to always have a licensed nurse present and available in the unit. The RM confirmed that she had not reported the sexual assault allegation made by Patient #1 on 04/27/15 against Patient #2 to the state health care regulatory agency, Department of State Health Services (DSHS); which was determined to have occurred as a result of insufficient staffing in the PES unit during episodes of Code Green's. The RM further confirmed the facility had not completed a thorough investigation with documented findings specific to this allegation for the determination of Neglect and/or a corrective action plan to prevent repeat incidence; in accordance with the facility's policy. The RM stated she had not seen or viewed the video footage following this allegation due to the video being unavailable after 05/06/15; following her electronic notification. Interview on 08/10/15 at 3:15 PM with Licensed Social Worker (LSW)-A stated she assisted Security Guard-A in viewing the video footage on 04/27/15 after Patient #1 made a sexual assault allegation against Patient #2. LSW-A stated that during the allegation on 04/27/15; Patient #2 could be seen on the camera "looking both ways" and then would go into Patient #1's bedroom. LSW-A stated they were able to count this event occurring a "couple of times" where Patient #2 would go into Patient #1's bedroom and remain there "a couple of minutes" each time. LSW-A stated she saw on the video where MHW-A had been in the "Patient evaluation room" during these time periods; where a supply closet was located. LSW-A stated Patient #2 had a history of "exposing his self, public masturbation, and talks sexually to other women." LSW-A stated that Patient #2 has publically masturbated in front of	Y 313		

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Y 313	Continued From page 14 her during an assessment interview. Interview on 08/10/15 at 4:15 PM with LVN-A stated he was present and worked the PES unit on 04/27/15. LVN-A stated that on 04/27/15 there were Code Greens called on another unit, and in the facility's lobby about the same time. LVN-A stated he responded to the Code Green in the lobby to assist due to a "fight." LVN-A indicated he had left the unit for approximately 15 minutes. Interview on 08/10/15 at 4:30 PM with the Vice President (VP) of Clinical Services confirmed that she was notified of the sexual allegation made by Patient #1 against Patient #2 on 04/27/15; however, she had not been notified until 05/06/15 via the facility's Incident/Event electronic system because there had not been any harm documented in order to elevate the notification. The VP of Clinical Services indicated that on 04/27/15 the Nursing Clinical Director (Nurse Manager) had been notified immediately following Patient #1's allegation and she had not obtained information that indicated Patient #1's allegation had occurred due to insufficient staffing in the PES unit when Code Green's had been called; leaving the unit without a RN available. The VP of Clinical Services stated that the unit RN was not supposed to leave the unit and there should always be a Licensed Nurse in the unit during a Code Green; that "it is a judgement call." The VP of Clinical Services stated she had not seen or viewed the video footage following this allegation due to the video being unavailable after 05/06/15; following her electronic notification. The VP of Clinical Services confirmed she had not reported this allegation to the state health care regulatory agency (DSHS).	Y 313		

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Y 313	Continued From page 15 Interview on 08/10/15 at 4:40 PM with the Nursing Clinical Director (Nurse Manager) stated she was immediately notified by the PES unit RN on 04/27d/15 of Patient #1's sexual allegation against Patient #2. The Nursing Clinical Director indicated she "separated" the Patients, talked to both of them, and Patient #1 saw the Doctor. The Nursing Clinical Director stated she spoke to the unit RN about the allegation but had not been notified or received information that the RN and LVN had left the PES unit to respond to Code Greens which left the unit without a RN and/or licensed nurse available. The Nursing Clinical Director stated she had not seen or viewed the video footage following this allegation. The Nursing Clinical Director confirmed she had not reported this allegation to the state health care regulatory agency (DSHS).	Y 313		
Y 523	404.154(24) Rights: Persons Receiving Mental Health Srvs The right to be free from mistreatment, abuse, neglect, and exploitation. See 40 TAC Chapter 710, Subchapter A (concerning Abuse and Neglect of Persons Served by TXMHMR Facilities), 40 TAC Chapter 710, Subchapter B (concerning Client Abuse and Neglect in Community Mental Health and Mental Retardation Centers), and 40 TAC Chapter 710, Subchapter C (concerning Patient Abuse in Private Psychiatric Facilities). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the patient's rights to be free from	Y 523	**Plan of Correction** **Y523** Mandatory read and sign in-service for all front-line behavioral health staff to include nursing, MHT, NP, social workers, intake/assessment, security and admitting to be completed by 9/14/15. Mandatory In-services to be conducted on 9/14, 9/16, and 9/18 for all behavioral health staff with multiple offerings in order to ensure all staff are able to attend one of these educational events. The mandatory in-service will reinforce the hospital policy regarding Assessment and Reporting of Abuse and Neglect, reinforce the need to document outlier events affecting patients, and roll out the	9/14/15

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Y 523	Continued From page 16 all forms of abuse or harassment by failing to prevent, protect, investigate, and report/respond to an allegation of neglect in accordance with their policy, for 1 of 1 patients reviewed (Patient #1) with a complaint allegation of sexual assault against another patient (Patient #2). On 04/27/15, Patient #1 reported to the unit's Registered Nurse (RN) an allegation of sexual assault from another Patient, (#2); who had a history of inappropriate sexual behaviors. The allegation was reported to the Medical Doctor, the Nursing Manager, and local Police Department (PD); however, this allegation was not reported to the state health care regulatory agency by any facility employees, in accordance with their policy. In addition, this allegation was not thoroughly investigated by the facility for the identification of neglect and/or a corrective action plan to prevent repeat incidence; in accordance with the facility's policy. This deficient practice could affect the prevention of possible unidentified abuse, neglect, or mistreatment for all patients in the facility; by compromising their safety. Findings Included: Review of Patient #1's Complaint Form dated 05/15/15 indicated the following in part: On 04/27/15 at approximately 11:30 AM Patient #1 was admitted to the facility's "Psychiatric Emergency Services (PES) unit and received medication to help her sleep and calm down. Patient #1 reported shortly after she received the medications; she was asleep in her bed when she "felt someone touching my vagina and butt. I felt a hard pressure. I jumped up and another male patient [#2] jumped out from under my covers."	Y 523	Code Green Response Protocol. The Code Green Response Protocol includes the following: 1.) reinforces assigning a specific Code Green response team to include back up for breaks as appropriate as well as for census level and unit acuity to ensure appropriate staffing is left on inpatient units, 2.) provides instruction for responding in the event multiple codes are called at the same time. to insure patient and staff safety, 3.) Psychiatric Emergency Service Unit (PES) staff will not respond to Code Greens unless the unit is overstaffed for its current population, 4.) reinforces that all supervisors will respond to Code Green, 5.) reinforces what should happen to maintain safety on the units when the Code Green team responds which includes: a.) suspension of non-essential tasks, b.) cohort the patients as much as possible to control the situation and monitor for safety, c.) response team clearly communicates to their charge when they leave from and return to the unit. Additional topics for the mandatory in-service include: a decision tree to reinforce the policy on reporting and follow-up of suspected/reported allegations of abuse/neglect of a patient during hospitalization and in treating patients identified as having ordered	

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Y 523	Continued From page 17 Patient #1 stated she went to find a staff member (Mental Health Worker-A), to report what had happened. Patient #1 indicated she noticed her entire "crotch area [paper gown] was torn exposing her "vagina and butt." Patient #1 indicated the facility staff called the Police Department (PD) for Patient #1 to make a report. Patient #1 reported the staff apologized to her for the incident; "but they had an emergency on another floor and they were short staffed, so every staff member had left." Patient #1 indicated she was "so upset and scared; so they gave me more meds to put me to sleep." Patient #1 stated the facility had done nothing more to help her; there were no witnesses but she believed there were cameras in the hall. Patient #1 stated she found out that Patient #2 had done this before and the Police Officer who responded stated that; "he [Patient #2] has a history of doing this; why was he unsupervised?" Review of the facility's Policy titled, Abuse Reporting-External and Internal, last reviewed January 2012 revealed the following definitions: Psychological Abuse included; humiliation and harassment. Sexual Abuse included; sexual harassment, sexual coercion, and sexual assault. Review of the facility's Policy titled, Assessment and Reporting of Abuse and Neglect, last reviewed February 2013 revealed Neglect included the failure to provide for one's self the goods or services including medical services, which are necessary to avoid physical or emotional harm or pain or the failure of a caretaker to provide the goods or services. The policy indicated the facility "prohibits neglect, mental or physical abuse or misappropriation of property, of patients by staff, visitors, or other	Y 523	sexual precautions. Follow up in-servicing is planned for February 2016 to include participation by same staff members to continue reinforcement of policies.	

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Y 523	Continued From page 18 patients." The facility "will report allegations and release information to the proper authorities, according to federal regulations, state specific rules and regulation and [facility] practice guidelines." Further review of the policy indicated, in part: 1. Reporting allegations of abuse and/or neglect occurring while the patient is under the care in the facility: All alleged violations concerning abuse and neglect while the patient is under the care of the facility will be reported to the Compliance Officer or designee, who will advise the on-call administrator/designee. As appropriate, the facility will report the incident to appropriate state, federal and protective/regulatory agencies, and/or law enforcement agencies and conduct an internal investigation within a maximum of five working days of the incident. The Texas Department of state Health Services (DSHS) is the regulatory body for reporting concerns of hospitals, psychiatric hospitals (including private psychiatric facilities), and various other medical facilities. 2. Investigations are always prompt, comprehensive and responsive to the situation, well conducted, and contain founded conclusions. The investigation may include, but are not limited to the following: -interviews conducted with individuals having first-hand knowledge of the incident. -Follow-up resolution -Corrective action plan to prevent repeat incidence. -Reports made to appropriate state health care regulatory agency. Review of the facility's Original Event report dated	Y 523		

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Y 523	Continued From page 19 04/27/15 at 12:15 PM completed by the unit RN revealed Patient #1 reported, "She was lying in bed asleep, when she felt Patient [#2] putting pressure around her buttocks area, and then touching her perineal area. Patient[#1] reported sitting up in bed shock and scared, and found Patient [#2] was up in her face with his finger to his mouth telling her to be quiet not to tell. She found her paper scrub button turned on the outer left side. MD [Medical Doctor], Nurse Manager notified, Patient made a police complaint." PD interviewed Patient #1 and accused, Patient #2. "Patient visible distraught, but no other physical problems noted at this time." Further review of the Original Event indicated the Event was documented as "Attempted Rape/Rape/Sexual Assault." Factors included; "Unit busy code greens called on other unit, and high acute of unit." The Original Event report did not include any documentation that this allegation was reported to the state health care regulatory agency by any facility employees, in accordance with the facility's policy. The Original Event report did not include documentation that this allegation was thoroughly investigated by the facility for the identification of neglect and/or a corrective action plan to prevent repeat incidence; in accordance with the facility's policy. The Compliance Officer/Director of Risk Management (RM) acknowledged receipt of the Original Event report dated 04/27/15 at 12:15 PM electronically on 05/06/15 documenting Patient #1 made a Police Report. Record review of the medical record of Patient #1 revealed she was a 37 year-old female admitted to the psychiatric facility on 04/27/15 at 0830 under Emergency Detention (ED) when she cut her wrist and called a friend to call Police. Patient #1 has a history of Depression with Anxiety.	Y 523		

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Y 523	Continued From page 20 Further review of Patient #1's permanent records revealed no documentation following the sexual assault allegation that she made on 04/27/15 against Patient #2. There was no documentation in her record that she received a physical and/or psychological assessment following her allegation on 04/27/15. There was a Telephone Physician Order (PO) on 04/27/15 at 12:30 PM (following the allegation) for Ativan (an anti-anxiety) 2 milligrams by mouth "now" without documentation of the reason for the emergency medication. The only documentation in Patient #1's record regarding her allegation against Patient #2 was a Behavioral Team Progress Note dated 05/01/15 at 12:28 completed by Licensed Social Worker- A that indicated "Patient discussed being sexually assaulted by Patient [#2] in the [facility's] PES unit. Review of Patient #1's Daily Observation Notes for 04/27/15 revealed the following: At 11:30-MHW-A documented 1Q (1=On unit, and Q=Quiet/Calm). At 11:45-MHW-A documented 1B (On unit, and B=In Bed Awake). At 12:00-MHW-A documented 1BA (On unit, In Bed Awake, and A=agitated/restless). At 12:15 MHW-A documented 1BA. At 12:30, 12:45, 13:00, 13:15, 13:30, and 13:45-MHW-A documented 1A (On Unit and agitated/restless). Record review of Patient #2's medical records revealed the following: Patient #2's Psychiatric Evaluation dated 04/24/15 revealed he was a 30 year old male admitted to the PES unit on 04/24/15 with a history of schizoaffective disorder and traumatic	Y 523		

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Y 523	Continued From page 21 brain injury (TBI). Patient #2 was admitted on an ED basis with a history of aggressive behaviors requiring emergency medications to calm him. Patient #2 had recently been discharged from this facility 4-5 weeks prior and has had multiple inpatient treatment episodes over the years (7 inpatient admissions in the previous 5 months). Patient #2 was documented with a known history of aggression and a "history of inappropriate sexual behavior on the unit (masturbating)." Patient #2 had documented borderline intellectual functioning with poor insight, poor judgment, and poor impulse control. A Behavioral Nursing Shift Assessment completed by the unit RN on 04/27/15 at 18:08 that Patient #2 was found by a female patient touching on her body while she was asleep in bed. MD, and Nurse Manager notified. A Telephone PO dated 04/27/15 at 2015 for Patient #2 to be transferred to a higher acuity; sister facility. A Behavior Team Progress noted dated 04/27/15 at 1855 revealed Patient #2 was transferred to a sister facility by the Sheriff's Department. Review of the facility's Incident Event dated 04/27/15 at 11:37 AM confirmed a Code Green was called for another Patient [#3] in the Child/Adolescent Unit requiring Restraints/Seclusion. Patient #3 required physical restraint at 11:36 AM, and emergency medications at 11:46 AM. Patient #3 was released from restraint at 12:26 PM. This Code Green occurred during the same time frames of Patient #1's allegation on 04/27/15. Review of the facility's Policy titled, Psychiatric	Y 523		

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Y 523	Continued From page 22 Emergencies-Code Green, last reviewed January 2012 revealed a Code Green was a Psychiatric Emergency. Code Green will be implemented by any unit personnel in the event of unmanageable behavior of an individual to prevent harm to that individual, patients, hospital personnel and/or others the general hospital area. D. Individuals responding to Code Green will meet in announced area. Available personnel is necessary to control atmosphere through a show of strength and caring or to assist in physical management. Interview on 08/06/15 at 12:35 PM with the PES unit RN revealed she completed Patient #1's admission assessment to the PES unit on 04/27/15. The unit RN indicated Patients were provided with paper scrubs to wear without other undergarments. The unit RN stated that on 04/27/15 at approximately 11:30 AM to 12:00 PM, "Code Greens" were going on; and "staff were busy". The unit RN stated there was a Code Green on another unit (child/adolescent) and a Code Green was called in the lobby; due to a patient needing to be "put in a [restraint] chair" because they were tearing up the lobby. The unit RN stated she left the unit to respond to the Code Green in the other unit (child/adolescent) and when she arrived; there was another RN responding, so she went to the Code Green in the lobby because they needed an RN to assist with "putting the patient in the [restraint] chair." The unit RN stated she returned to the PES unit following the Code Greens to "something else going on at the end of the unit" that she responded to. The unit RN stated she could not remember if it was LVN-A or LVN-B working on 04/27/15; but that she thought the LVN stayed back in the PES unit when she left and responded to the two Code Greens. The unit RN	Y 523		

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Y 523	Continued From page 23 stated she was notified that during the Code Greens Patient #2 went into Patient #1's bedroom; and Patient #1 made an allegation of sexual assault. The unit RN stated she spoke with Patient #1 who reported that she was asleep in her bedroom and "she felt pressure" causing her to awake to Patient #2 touching her in the buttock and perineal area. The unit RN stated that Patient #1's paper pants were "torn on the side." The unit RN stated the local PD was called. The unit RN stated she spoke to Patient #2 and he said, "I touched her, but didn't do anything else." The unit RN stated he admitted that he "touched her and ripped her paper pants." The unit RN stated that Patient #2 knew that the unit was "chaotic" and knew what Code Green meant; and that is when he "took advantage" of the situation. The unit RN stated she believed that Patient #2 sexually assaulted Patient #1 given the facts, and his own admission. The unit RN stated she notified the MD, Social Worker, and Nursing Manager of the allegation. The unit RN indicated she documented the sexual assault allegation made by Patient #1 on the facility's Event Report; however, confirmed she did not document the sexual assault allegation in Patient #1's record following the incident. The unit RN stated she offered for Patient #1 to have a Sexual Assault Nurse Examination (SANE) completed at another facility if she wanted; but Patient #1 declined, stating she did not believe Patient #2 actually raped her. Interview on 08/06/15 at 04:45 PM with MHW-A revealed she was the only MHW working on 04/27/15 in the PES unit; along with the unit RN and a Licensed Vocational Nurse (LVN). MHW-A stated she was pulled to the PES unit at 9:15 AM and was unfamiliar to the PES unit; but was told	Y 523		

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Y 523	Continued From page 24 by the leaving MHW to "watch it" for Patient #2, however, she did not know the specific reason why. MHW-A stated the females were assigned rooms on one side, and males on the other side. MHW-A stated during the morning on 04/27/15 at approximately 11:30 AM-12:00 PM it was a "hectic/busy" day with "Code Green's being called." MHW-A stated that security was usually on the PES unit; but on 04/27/15 at the time of the allegation; "security could not be found." MHW-A stated on 04/27/15 at around 11:30-12:00 PM she stayed in the unit when the Code Greens were called and was "getting something out of the supply closet." MHW-A indicated the unit RN "responded to the Code Green" leaving the unit; telling her she [unit RN] would be back. MHW-A did not remember if LVN-A or LVN-B was working on 04/27/15; but further stated she did not remember any LVN being in the unit during the time of the allegation made by Patient #1. MHW-A stated shortly after this Patient #1 "flagged her [MHW-A] down" to her bedroom, and into the restroom of the bedroom where she reported that Patient #2 came into her room and touched her buttocks and vaginal area while she was sleeping in her bed. MHW-A stated that Patient #1's gown was torn around the buttock area and she offered to call the local PD for Patient #1 to make a report. MHW-A stated she then reported the incident/allegation to the unit RN. MHW-A stated she was later told that Patient #2 had been an inpatient to the facility many times before, and he "knows the system; knows what Code Green means." MHW-A stated she had seen Patient #2 "walking out of her [Patient #1] room a few times" and further stated "right before she flagged me down, he had walked out of her room". MHW-A indicated she told Patient #2 "not to go in to other people's rooms." MHW-A confirmed she had not	Y 523		

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	000415	A. BUILDING: _____ B. WING _____	C 08/10/2015

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Y 523	Continued From page 25 documented the allegation reported by Patient #1 against Patient #2; but that she "told [unit RN]." Interview on 08/10/15at 1:20 PM with Patient #1 revealed on 04/27/15 at approximately 11:30-11:45 AM she was in her assigned bedroom sleeping after she received multiple medications following her admission. Patient #1 stated she awoke after she "felt pressure" in her buttock and vaginal area. Patient #1 stated that Patient #2 was present telling her not to tell anyone. Patient #1 stated that she noticed her paper pants were ripped and she was not actually aware what all Patient #2 actually did because she "was conked out" after taking multiple medications. Patient #1 stated she knows he touched her because that was what woke her up. Patient #1 stated she was very upset, "freaked out," and asked the MD for an "AIDS" test. Patient #1 stated the unit RN indicated to the nursing staff (LVN) to "give her more meds" because she was "upset, crying, and freaking out." Patient #1 stated she then received the Ativan for her anxiety, to "help me calm down." Patient #1 stated the local PD came and she made a report. Patient #1 stated she was told by the unit RN that "Code Green's" were called and "everyone had to leave the unit" which allowed the opportunity for Patient #2 to go into her room unsupervised. Interview on 08/10/15 at 2:20 PM with Security Guard-A revealed he was employed by the facility to maintain security and the safety of patients. The Security Guard-A stated Patient #2 had a history of inappropriate sexual behavior of "masturbating in front of females." The Security Guard-A stated he assisted with "viewing the video" footage for evidence following the	Y 523		

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Y 523	Continued From page 26 allegation on 04/27/15 made be Patient #1 against Patient #2. The Security Guard stated the video footage from 04/27/15 showed a total of "four times" that Patient #2 went into Patient #1's room; and the last time Patient #2 came out of Patient #1's room; she was observed to come out of the room a few minutes later. The Security Guard stated that Patient #2 had already been assigned to the front "seclusion room" of the PES unit as his bedroom due to his history of masturbating. The Security Guard stated on the video footage Patient #2 could be seen coming from his room; "looking side to side" down the hallway, and then going into Patient #1's room. The Security Guard stated that female and male patient rooms were separated and that Patient #2 was not supposed to be going into Patient #1's room for any reason. Interview on 08/10/15 at 2:50 PM with MD-A revealed he was notified of Patient #1's sexual assault allegation against Patient #2 on 04/27/15. MD-A stated he discussed with Patient #1 the option of a "Rape Kit" but she "declined." MD-A stated he understood the allegation made by Patient #1 to be "only touching with no penetration." MD-A stated that Patient #1 was "distressed" about the incident and he ordered Ativan for Patient #1's anxiety following the incident. MD-A stated Patient #1 had already been distressed emotionally because of her ED inpatient admission; and really did not even want to take the Ativan. MD-A stated he recalled there was a Code Green called where staff left the unit in response to the Code Green; which left less staffing in the unit. MD-A confirmed that he did not document in Patient #1's records his contact or discussion with Patient #1 following her allegation.	Y 523		

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Y 523	Continued From page 27 Interview on 08/10/15 at 3:00 PM with the facility's Risk Manager (RM) indicated that she was aware of the alleged sexual assault allegation made by Patient #1 on 04/27/15 against Patient #2'; however, she had not been notified until 05/06/15 via the facility's Incident/Event electronic system because there had not been any harm documented in order to elevate the notification. The RM stated the staffing ratio on the PES unit was 1 staff to 4 patients. The RM indicated on 04/27/15 the patient census in the PES unit was 11; requiring 3 staff. The RM stated the first required staff is an RN, and then second could be a LVN, and/or MHW. The RM confirmed for 11 patients the required staffing would be 3. The RM stated the PES unit was to always have a licensed nurse present and available in the unit. The RM confirmed that she had not reported the sexual assault allegation made by Patient #1 on 04/27/15 against Patient #2 to the state health care regulatory agency, Department of State Health Services (DSHS); which was determined to have occurred as a result of insufficient staffing in the PES unit during episodes of Code Green's. The RM further confirmed the facility had not completed a thorough investigation with documented findings specific to this allegation for the determination of Neglect and/or a corrective action plan to prevent repeat incidence; in accordance with the facility's policy. The RM stated she had not seen or viewed the video footage following this allegation due to the video being unavailable after 05/06/15; following her electronic notification. Interview on 08/10/15 at 3:15 PM with Licensed Social Worker (LSW)-A stated she assisted Security Guard-A in viewing the video footage on	Y 523		

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Y 523	Continued From page 28 04/27/15 after Patient #1 made a sexual assault allegation against Patient #2. LSW-A stated that during the allegation on 04/27/15; Patient #2 could be seen on the camera "looking both ways" and then would go into Patient #1's bedroom. LSW-A stated they were able to count this event occurring a "couple of times" where Patient #2 would go into Patient #1's bedroom and remain there "a couple of minutes" each time. LSW-A stated she saw on the video where MHW-A had been in the "Patient evaluation room" during these time periods; where a supply closet was located. LSW-A stated Patient #2 had a history of "exposing his self, public masturbation, and talks sexually to other women." LSW-A stated that Patient #2 has publically masturbated in front of her during an assessment interview. Interview on 08/10/15 at 4:15 PM with LVN-A stated he was present and worked the PES unit on 04/27/15. LVN-A stated that on 04/27/15 there were Code Greens called on another unit, and in the facility's lobby about the same time. LVN-A stated he responded to the Code Green in the lobby to assist due to a "fight." LVN-A indicated he had left the unit for approximately 15 minutes. Interview on 08/10/15 at 4:30 PM with the Vice President (VP) of Clinical Services confirmed that she was notified of the sexual allegation made by Patient #1 against Patient #2 on 04/27/15; however, she had not been notified until 05/06/15 via the facility's Incident/Event electronic system because there had not been any harm documented in order to elevate the notification. The VP of Clinical Services indicated that on 04/27/15 the Nursing Clinical Director (Nurse Manager) had been notified immediately following	Y 523		

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Y 523	Continued From page 29 Patient #1's allegation and she had not obtained information that indicated Patient #1's allegation had occurred due to insufficient staffing in the PES unit when Code Green's had been called; leaving the unit without a RN available. The VP of Clinical Services stated that the unit RN was not supposed to leave the unit and there should always be a Licensed Nurse in the unit during a Code Green; that "it is a judgement call." The VP of Clinical Services stated she had not seen or viewed the video footage following this allegation due to the video being unavailable after 05/06/15; following her electronic notification. Interview on 08/10/15 at 4:40 PM with the Nursing Clinical Director (Nurse Manager) stated she was immediately notified by the PES unit RN on 04/27d/15 of Patient #1's sexual allegation against Patient #2. The Nursing Clinical Director indicated she "separated" the Patients, talked to both of them, and Patient #1 saw the Doctor. The Nursing Clinical Director stated she spoke to the unit RN about the allegation but had not been notified or received information that the RN and LVN had left the PES unit to respond to Code Greens which left the unit without a RN and/or licensed nurse available. The Nursing Clinical Director stated she had not seen or viewed the video footage following this allegation.	Y 523		

SOD-State Forms

Texas Department of State Health Services

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X 000	INITIAL COMMENTS Note: The State Form is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be referred to the Office of the Texas Attorney General (OAG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. An unannounced visit was conducted from 08/06/15 to 08/10/15 to conduct a survey for complaint investigation (TX 00218998). An entrance conference was conducted on 08/06/15 in the conference room of the facility with the Director of Risk Management. The purpose and process of the complaint survey were discussed and an opportunity for questions was provided. Complaint, TX 00218998, was substantiated with state violations cited. An exit conference was conducted on 08/10/15 in the conference room. The Director of Risk Management, the Vice President of Clinical Services, the Nursing Clinical Director, and Interim Behavioral Health Administrator were in attendance. Preliminary findings of the survey were discussed and an opportunity for questions was provided.	X 000		
X 365	133.41(o)(2)(B) Staffing: adequate personnel Nursing Services. Staffing and delivery of care.	X 365	**Plan of Correction** **X365** Mandatory In-services to be conducted on 9/14, 9/16, and 9/18 for all behavioral health staff with multiple offerings in	9/18/15

SOD - State Form

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Angela Dreal — TITLE: VP, Behavioral Health Svcs — (X6) DATE: 9/11/15

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X 365	Continued From page 1 (B) There shall be adequate numbers of RNs, licensed vocational nurses (LVNs), and other personnel to provide nursing care to all patients as needed. This Requirement is not met as evidenced by: Based on record review and interview, the facility failed to ensure there were sufficient numbers of licensed registered nurses (RN), licensed vocational nurses (LVN), and other personnel immediately available at all times in the unit to ensure the provision of care and supervision for patients (Patient #1 and #2) as required; resulting in an allegation of Neglect. Specifically, on 04/27/15, Patient #1 reported to the unit's Registered Nurse (RN) an allegation of sexual assault from another Patient (#2), who had a history of inappropriate sexual behaviors, after the unit RN and LVN left their assigned unit to respond to "Code Green's" (psychiatric emergencies) in other units/areas of the facility. This deficient practice affected Patient #1's provision of care and compromised her safety resulting in allegation of Neglect due to insufficient staffing in the unit.	X 365	order to ensure all staff are able to attend one of these educational events. The mandatory in-service will reinforce the hospital policy regarding Assessment and Reporting of Abuse and Neglect, reinforce the need to document outlier events affecting patients, and roll out the Code Green Response Protocol. The Code Green Response Protocol includes the following: 1.) reinforces assigning a specific Code Green response team to include back up for breaks as appropriate as well as for census level and unit acuity to ensure appropriate staffing is left on inpatient units, 2.) provides instruction for responding in the event multiple codes are called at the same time. to insure patient and staff safety, 3.) Psychiatric Emergency Service Unit (PES) staff will not respond to Code Greens unless the unit is overstaffed for its current population, 4.) reinforces that all supervisors will respond to Code Green, 5.) reinforces what should happen to maintain safety on the units when the Code Green team responds which includes: a.) suspension of non-essential tasks, b.) cohort the patients as much as possible to control the situation and monitor for safety, c.) response team clearly communicates to their charge when they leave from and return to the unit. Follow up in-servicing is planned for February 2016 to include participation by same staff members to continue reinforcement of policies.	

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X 365	Continued From page 2 Findings Included: Review of Patient #1's Complaint Form dated 05/15/15 indicated the following in part: On 04/27/15 at approximately 11:30 AM Patient #1 was admitted to the facility's "Psychiatric Emergency Services (PES) unit and received medication to help her sleep and calm down. Patient #1 reported shortly after she received the medications; she was asleep in her bed when she "felt someone touching my vagina and butt. I felt a hard pressure. I jumped up and another male patient [#2] jumped out from under my covers." Patient #1 stated she went to find a staff member (Mental Health Worker-A), to report what had happened. Patient #1 indicated she noticed her entire "crotch area [paper gown] was torn exposing her "vagina and butt." Patient #1 indicated the facility staff called the Police Department (PD) for Patient #1 to make a report. Patient #1 reported the staff apologized to her for the incident; "but they had an emergency on another floor and they were short staffed, so every staff member had left." Patient #1 indicated she was "so upset and scared; so they gave me more meds to put me to sleep." Patient #1 stated the facility had done nothing more to help her; there were no witnesses but she believed there were cameras in the hall. Patient #1 stated she found out that Patient #2 had done this before and the Police Officer who responded stated that; "he [Patient #2] has a history of doing this; why was he unsupervised?" Review of the facility's Policy titled, Abuse Reporting-External and Internal, last reviewed January 2012 revealed the following definitions: Psychological Abuse included; humiliation and harassment.	X 365		

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X 365	Continued From page 3 Sexual Abuse included; sexual harassment, sexual coercion, and sexual assault. Review of the facility's Policy titled, Assessment and Reporting of Abuse and Neglect, last reviewed February 2013 revealed Neglect included the failure to provide for one's self the goods or services including medical services, which are necessary to avoid physical or emotional harm or pain or the failure of a caretaker to provide the goods or services. The policy indicated the facility "prohibits neglect, mental or physical abuse or misappropriation of property, of patients by staff, visitors, or other patients." The facility "will report allegations and release information to the proper authorities, according to federal regulations, state specific rules and regulation and [facility] practice guidelines." Review of the facility's Original Event report dated 04/27/15 at 12:15 PM completed by the unit RN revealed Patient #1 reported, "She was lying in bed asleep, when she felt Patient [#2] putting pressure around her buttocks area, and then touching her perineal area. Patient[#1] reported sitting up in bed shock and scared, and found Patient [#2] was up in her face with his finger to his mouth telling her to be quiet not to tell. She found her paper scrub button turned on the outer left side. MD [Medical Doctor], Nurse Manager notified, Patient made a police complaint." PD interviewed Patient #1 and accused, Patient #2. "Patient visible distraught, but no other physical problems noted at this time." Further review of the Original Event indicated the Event was documented as "Attempted Rape/Rape/Sexual Assault." Factors included; "Unit busy code greens called on other unit, and high acute of unit."	X 365		

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X 365	Continued From page 4 Record review of the medical record of Patient #1 revealed she was a 37 year-old female admitted to the psychiatric facility on 04/27/15 at 0830 under Emergency Detention (ED) when she cut her wrist and called a friend to call Police. Patient #1 has a history of Depression with Anxiety. Further review of Patient #1's permanent records revealed no documentation following the sexual assault allegation that she made on 04/27/15 against Patient #2. There was no documentation in her record that she received a physical and/or psychological assessment following her allegation on 04/27/15. There was a Telephone Physician Order (PO) on 04/27/15 at 12:30 PM (following the allegation) for Ativan (an anti-anxiety) 2 milligrams by mouth "now" without documentation of the reason for the emergency medication. The only documentation in Patient #1's record regarding her allegation against Patient #2 was a Behavioral Team Progress Note dated 05/01/15 at 12:28 completed by Licensed Social Worker- A that indicated "Patient discussed being sexually assaulted by Patient [#2] in the [facility's] PES unit. Review of Patient #1's Daily Observation Notes for 04/27/15 revealed the following: At 11:30-MHW-A documented 1Q (1=On unit, and Q=Quiet/Calm). At 11:45-MHW-A documented 1B (On unit, and B=In Bed Awake). At 12:00-MHW-A documented 1BA (On unit, In Bed Awake, and A=agitated/restless). At 12:15 MHW-A documented 1BA. At 12:30, 12:45, 13:00, 13:15, 13:30, and 13:45-MHW-A documented 1A (On Unit and agitated/restless).	X 365		

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X 365	Continued From page 5 Record review of Patient #2's medical records revealed the following: Patient #2's Psychiatric Evaluation dated 04/24/15 revealed he was a 30 year old male admitted to the PES unit on 04/24/15 with a history of schizoaffective disorder and traumatic brain injury (TBI). Patient #2 was admitted on an ED basis with a history of aggressive behaviors requiring emergency medications to calm him. Patient #2 had recently been discharged from this facility 4-5 weeks prior and has had multiple inpatient treatment episodes over the years (7 inpatient admissions in the previous 5 months). Patient #2 was documented with a known history of aggression and a "history of inappropriate sexual behavior on the unit (masturbating)." Patient #2 had documented borderline intellectual functioning with poor insight, poor judgment, and poor impulse control. A Behavioral Nursing Shift Assessment completed by the unit RN on 04/27/15 at 18:08 that Patient #2 was found by a female patient touching on her body while she was asleep in bed. MD, and Nurse Manager notified. A Telephone PO dated 04/27/15 at 2015 for Patient #2 to be transferred to a higher acuity; sister facility. A Behavior Team Progress noted dated 04/27/15 at 1855 revealed Patient #2 was transferred to a sister facility by the Sheriff's Department. Review of the facility's Incident Event dated 04/27/15 at 11:37 AM confirmed a Code Green was called for another Patient [#3] in the Child/Adolescent Unit requiring	X 365		

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X 365	Continued From page 6 Restraints/Seclusion. Patient #3 required physical restraint at 11:36 AM, and emergency medications at 11:46 AM. Patient #3 was released from restraint at 12:26 PM. This Code Green occurred during the same time frames of Patient #1's allegation on 04/27/15. Review of the facility's Policy titled, Psychiatric Emergencies-Code Green, last reviewed January 2012 revealed a Code Green was a Psychiatric Emergency. Code Green will be implemented by any unit personnel in the event of unmanageable behavior of an individual to prevent harm to that individual, patients, hospital personnel and/or others the general hospital area. D. Individuals responding to Code Green will meet in announced area. Available personnel is necessary to control atmosphere through a show of strength and caring or to assist in physical management. Interview on 08/06/15 at 12:35 PM with the PES unit RN revealed she completed Patient #1's admission assessment to the PES unit on 04/27/15. The unit RN indicated Patients were provided with paper scrubs to wear without other undergarments. The unit RN stated that on 04/27/15 at approximately 11:30 AM to 12:00 PM, "Code Greens" were going on; and "staff were busy". The unit RN stated there was a Code Green on another unit (child/adolescent) and a Code Green was called in the lobby; due to a patient needing to be "put in a [restraint] chair" because they were tearing up the lobby. The unit RN stated she left the unit to respond to the Code Green in the other unit (child/adolescent) and when she arrived; there was another RN responding, so she went to the Code Green in the lobby because they needed an RN to assist with "putting the patient in the [restraint] chair." The	X 365		

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X 365	Continued From page 7 unit RN stated she returned to the PES unit following the Code Greens to "something else going on at the end of the unit" that she responded to. The unit RN stated she could not remember if it was LVN-A or LVN-B working on 04/27/15; but that she thought the LVN stayed back in the PES unit when she left and responded to the two Code Greens. The unit RN stated she was notified that during the Code Greens Patient #2 went into Patient #1's bedroom; and Patient #1 made an allegation of sexual assault. The unit RN stated she spoke with Patient #1 who reported that she was asleep in her bedroom and "she felt pressure" causing her to awake to Patient #2 touching her in the buttock and perineal area. The unit RN stated that Patient #1's paper pants were "torn on the side." The unit RN stated the local PD was called. The unit RN stated she spoke to Patient #2 and he said, "I touched her, but didn't do anything else." The unit RN stated he admitted that he "touched her and ripped her paper pants." The unit RN stated that Patient #2 knew that the unit was "chaotic" and knew what Code Green meant; and that is when he "took advantage" of the situation. The unit RN stated she believed that Patient #2 sexually assaulted Patient #1 given the facts, and his own admission. The unit RN stated she notified the MD, Social Worker, and Nursing Manager of the allegation. The unit RN indicated she documented the sexual assault allegation made by Patient #1 on the facility's Event Report; however, confirmed she did not document the sexual assault allegation in Patient #1's record following the incident. The unit RN stated she offered for Patient #1 to have a Sexual Assault Nurse Examination (SANE) completed at another facility if she wanted; but Patient #1 declined, stating she did not believe Patient #2 actually raped her.	X 365		

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X 365	Continued From page 8 Interview on 08/06/15 at 04:45 PM with MHW-A revealed she was the only MHW working on 04/27/15 in the PES unit; along with the unit RN and a Licensed Vocational Nurse (LVN). MHW-A stated she was pulled to the PES unit at 9:15 AM and was unfamiliar to the PES unit; but was told by the leaving MHW to "watch it" for Patient #2, however, she did not know the specific reason why. MHW-A stated the females were assigned rooms on one side, and males on the other side. MHW-A stated during the morning on 04/27/15 at approximately 11:30 AM-12:00 PM it was a "hectic/busy" day with "Code Green's being called." MHW-A stated that security was usually on the PES unit; but on 04/27/15 at the time of the allegation; "security could not be found." MHW-A stated on 04/27/15 at around 11:30-12:00 PM she stayed in the unit when the Code Greens were called and was "getting something out of the supply closet." MHW-A indicated the unit RN "responded to the Code Green" leaving the unit; telling her she [unit RN] would be back. MHW-A did not remember if LVN-A or LVN-B was working on 04/27/15; but further stated she did not remember any LVN being in the unit during the time of the allegation made by Patient #1. MHW-A stated shortly after this Patient #1 "flagged her [MHW-A] down" to her bedroom, and into the restroom of the bedroom where she reported that Patient #2 came into her room and touched her buttocks and vaginal area while she was sleeping in her bed. MHW-A stated that Patient #1's gown was torn around the buttock area and she offered to call the local PD for Patient #1 to make a report. MHW-A stated she then reported the incident/allegation to the unit RN. MHW-A stated she was later told that Patient #2 had been an inpatient to the facility many times before, and he "knows the system;	X 365		

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X 365	Continued From page 9 knows what Code Green means." MHW-A stated she had seen Patient #2 "walking out of her [Patient #1] room a few times" and further stated "right before she flagged me down, he had walked out of her room". MHW-A indicated she told Patient #2 "not to go in to other people's rooms." MHW-A confirmed she had not documented the allegation reported by Patient #1 against Patient #2; but that she "told [unit RN]." Interview on 08/10/15at 1:20 PM with Patient #1 revealed on 04/27/15 at approximately 11:30-11:45 AM she was in her assigned bedroom sleeping after she received multiple medications following her admission. Patient #1 stated she awoke after she "felt pressure" in her buttock and vaginal area. Patient #1 stated that Patient #2 was present telling her not to tell anyone. Patient #1 stated that she noticed her paper pants were ripped and she was not actually aware what all Patient #2 actually did because she "was conked out" after taking multiple medications. Patient #1 stated she knows he touched her because that was what woke her up. Patient #1 stated she was very upset, "freaked out," and asked the MD for an "AIDS" test. Patient #1 stated the unit RN indicated to the nursing staff (LVN) to "give her more meds" because she was "upset, crying, and freaking out." Patient #1 stated she then received the Ativan for her anxiety, to "help me calm down." Patient #1 stated the local PD came and she made a report. Patient #1 stated she was told by the unit RN that "Code Green's" were called and "everyone had to leave the unit" which allowed the opportunity for Patient #2 to go into her room unsupervised. Interview on 08/10/15 at 2:20 PM with Security	X 365		

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X 365	Continued From page 10 Guard-A revealed he was employed by the facility to maintain security and the safety of patients. The Security Guard-A stated Patient #2 had a history of inappropriate sexual behavior of "masturbating in front of females." The Security Guard-A stated he assisted with "viewing the video" footage for evidence following the allegation on 04/27/15 made be Patient #1 against Patient #2. The Security Guard stated the video footage from 04/27/15 showed a total of "four times" that Patient #2 went into Patient #1's room; and the last time Patient #2 came out of Patient #1's room; she was observed to come out of the room a few minutes later. The Security Guard stated that Patient #2 had already been assigned to the front "seclusion room" of the PES unit as his bedroom due to his history of masturbating. The Security Guard stated on the video footage Patient #2 could be seen coming from his room; "looking side to side" down the hallway, and then going into Patient #1's room. The Security Guard stated that female and male patient rooms were separated and that Patient #2 was not supposed to be going into Patient #1's room for any reason. Interview on 08/10/15 at 2:50 PM with MD-A revealed he was notified of Patient #1's sexual assault allegation against Patient #2 on 04/27/15. MD-A stated he discussed with Patient #1 the option of a "Rape Kit" but she "declined." MD-A stated he understood the allegation made by Patient #1 to be "only touching with no penetration." MD-A stated that Patient #1 was "distressed" about the incident and he ordered Ativan for Patient #1's anxiety following the incident. MD-A stated Patient #1 had already been distressed emotionally because of her ED inpatient admission; and really did not even want to take the Ativan. MD-A stated he recalled there	X 365		

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X 365	Continued From page 11 was a Code Green called where staff left the unit in response to the Code Green; which left less staffing in the unit. Interview on 08/10/15 at 3:00 PM with the facility's Risk Manager (RM) indicated that she was aware of the alleged sexual assault allegation made by Patient #1 on 04/27/15 against Patient #2'; however, she had not been notified until 05/06/15 via the facility's Incident/Event electronic system because there had not been any harm documented in order to elevate the notification. The RM stated the staffing ratio on the PES unit was 1 staff to 4 patients. The RM indicated on 04/27/15 the patient census in the PES unit was 11; requiring 3 staff. The RM stated the first required staff is an RN, and then second could be a LVN, and/or MHW. The RM confirmed for 11 patients the required staffing would be 3. The RM stated the PES unit was to always have a licensed nurse present and available in the unit. The RM stated she had not seen or viewed the video footage following this allegation due to the video being unavailable after 05/06/15; following her electronic notification. The RM stated there would not be documentation of the Code Green that may have occurred on 04/27/15 in the facility's lobby waiting area; if the patient had not yet been assessed for care. Interview on 08/10/15 at 3:15 PM with Licensed Social Worker (LSW)-A stated she assisted Security Guard-A in viewing the video footage on 04/27/15 after Patient #1 made a sexual assault allegation against Patient #2. LSW-A stated that during the allegation on 04/27/15; Patient #2 could be seen on the camera "looking both ways" and then would go into Patient #1's bedroom.	X 365		

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X 365	Continued From page 12 LSW-A stated they were able to count this event occurring a "couple of times" where Patient #2 would go into Patient #1's bedroom and remain there "a couple of minutes" each time. LSW-A stated she saw on the video where MHW-A had been in the "Patient evaluation room" during these time periods; where a supply closet was located. LSW-A stated Patient #2 had a history of "exposing his self, public masturbation, and talks sexually to other women." LSW-A stated that Patient #2 has publically masturbated in front of her during an assessment interview. Interview on 08/10/15 at 4:15 PM with LVN-A stated he was present and worked the PES unit on 04/27/15. LVN-A stated that on 04/27/15 there were Code Greens called on another unit, and in the facility's lobby about the same time. LVN-A stated he responded to the Code Green in the lobby to assist due to a "fight." LVN-A indicated he had left the unit for approximately 15 minutes. Interview on 08/10/15 at 4:30 PM with the Vice President (VP) of Clinical Services confirmed that she was notified of the sexual allegation made by Patient #1 against Patient #2 on 04/27/15; however, she had not been notified until 05/06/15 via the facility's Incident/Event electronic system because there had not been any harm documented in order to elevate the notification. The VP of Clinical Services indicated that on 04/27/15 the Nursing Clinical Director (Nurse Manager) had been notified immediately following Patient #1's allegation and she had not obtained information that indicated Patient #1's allegation had occurred due to insufficient staffing in the PES unit when Code Green's had been called; leaving the unit without a RN available. The VP	X 365		

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X 365	Continued From page 13 of Clinical Services stated that the unit RN was not supposed to leave the unit and there should always be a Licensed Nurse in the unit during a Code Green; that "it is a judgement call." The VP of Clinical Services stated she had not seen or viewed the video footage following this allegation due to the video being unavailable after 05/06/15; following her electronic notification. Interview on 08/10/15 at 4:40 PM with the Nursing Clinical Director (Nurse Manager) stated she was immediately notified by the PES unit RN on 04/27d/15 of Patient #1's sexual allegation against Patient #2. The Nursing Clinical Director indicated she "separated" the Patients, talked to both of them, and Patient #1 saw the Doctor. The Nursing Clinical Director stated she spoke to the unit RN about the allegation but had not been notified or received information that the RN and LVN had left the PES unit to respond to Code Greens which left the unit without a RN and/or licensed nurse available. The Nursing Clinical Director stated she had not seen or viewed the video footage following this allegation.	X 365		
X 794	133.42(a)(1) Patient rights requirements: all hospitals Patient Rights. Patient rights requirements for all hospitals. A hospital shall adopt, implement, and enforce a policy to ensure patients' rights.	X 794	**Plan of Correction** **X 794** Mandatory read and sign in-service for all front-line behavioral health staff to include nursing, MHT, NP, social workers, intake/assessment, security and admitting to be completed by 9/14/15. Mandatory In-services to be conducted on 9/14, 9/16, and 9/18 for all behavioral health staff with multiple offerings in order to ensure all staff are able to attend one of these educational events. The mandatory in-service will reinforce the	9/14/15

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X 794	Continued From page 14 This Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure the patient's rights to be free from all forms of abuse or harassment by failing to prevent, protect, investigate, and report/respond to an allegation of neglect in accordance with their policy, for 1 of 1 patients reviewed (Patient #1) with a complaint allegation of sexual assault against another patient (Patient #2). On 04/27/15, Patient #1 reported to the unit's Registered Nurse (RN) an allegation of sexual assault from another Patient, (#2); who had a history of inappropriate sexual behaviors. The allegation was reported to the Medical Doctor, the Nursing Manager, and local Police Department (PD); however, this allegation was not reported to the state health care regulatory agency by any facility employees, in accordance with their policy. In addition, this allegation was not thoroughly investigated by the facility for the identification of	X 794	hospital policy regarding Assessment and Reporting of Abuse and Neglect, reinforce the need to document outlier events affecting patients, and roll out the Code Green Response Protocol. The Code Green Response Protocol includes the following: 1.) reinforces assigning a specific Code Green response team to include back up for breaks as appropriate as well as for census level and unit acuity to ensure appropriate staffing is left on inpatient units, 2.) provides instruction for responding in the event multiple codes are called at the same time. to insure patient and staff safety, 3.) Psychiatric Emergency Service Unit (PES) staff will not respond to Code Greens unless the unit is overstaffed for its current population, 4.) reinforces that all supervisors will respond to Code Green, 5.) reinforces what should happen to maintain safety on the units when the Code Green team responds which includes: a.) suspension of non-essential tasks, b.) cohort the patients as much as possible to control the situation and monitor for safety, c.) response team clearly communicates to their charge when they leave from and return to the unit. Additional topics for the mandatory in-service include: a decision tree to reinforce the policy on reporting and follow-up of suspected/reported	

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X 794	Continued From page 15 neglect and/or a corrective action plan to prevent repeat incidence; in accordance with the facility's policy. This deficient practice could affect the prevention of possible unidentified abuse, neglect, or mistreatment for all patients in the facility; by compromising their safety. Findings Included: Review of Patient #1's Complaint Form dated 05/15/15 indicated the following in part: On 04/27/15 at approximately 11:30 AM Patient #1 was admitted to the facility's "Psychiatric Emergency Services (PES) unit and received medication to help her sleep and calm down. Patient #1 reported shortly after she received the medications; she was asleep in her bed when she "felt someone touching my vagina and butt. I felt a hard pressure. I jumped up and another male patient [#2] jumped out from under my covers." Patient #1 stated she went to find a staff member (Mental Health Worker-A), to report what had happened. Patient #1 indicated she noticed her entire "crotch area [paper gown] was torn exposing her "vagina and butt." Patient #1 indicated the facility staff called the Police Department (PD) for Patient #1 to make a report. Patient #1 reported the staff apologized to her for the incident; "but they had an emergency on another floor and they were short staffed, so every staff member had left." Patient #1 indicated she was "so upset and scared; so they gave me more meds to put me to sleep." Patient #1 stated the facility had done nothing more to help her; there were no witnesses but she believed there were cameras in the hall. Patient #1 stated she found out that Patient #2 had done this before and the Police Officer who responded stated that;	X 794	allegations of abuse/neglect of a patient during hospitalization and in treating patients identified as having ordered sexual precautions. Follow up in-servicing is planned for February 2016 to include participation by same staff members to continue reinforcement of policies.	

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X 794	Continued From page 16 "he [Patient #2] has a history of doing this; why was he unsupervised?" Review of the facility's Policy titled, Abuse Reporting-External and Internal, last reviewed January 2012 revealed the following definitions: Psychological Abuse included; humiliation and harassment. Sexual Abuse included; sexual harassment, sexual coercion, and sexual assault. Review of the facility's Policy titled, Assessment and Reporting of Abuse and Neglect, last reviewed February 2013 revealed Neglect included the failure to provide for one's self the goods or services including medical services, which are necessary to avoid physical or emotional harm or pain or the failure of a caretaker to provide the goods or services. The policy indicated the facility "prohibits neglect, mental or physical abuse or misappropriation of property, of patients by staff, visitors, or other patients." The facility "will report allegations and release information to the proper authorities, according to federal regulations, state specific rules and regulation and [facility] practice guidelines." Further review of the policy indicated, in part: 1. Reporting allegations of abuse and/or neglect occurring while the patient is under the care in the facility: All alleged violations concerning abuse and neglect while the patient is under the care of the facility will be reported to the Compliance Officer or designee, who will advise the on-call administrator/designee. As appropriate, the facility will report the incident to appropriate state, federal and protective/regulatory agencies, and/or law enforcement agencies and conduct an internal investigation within a maximum of five	X 794		

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X 794	Continued From page 17 working days of the incident. The Texas Department of state Health Services (DSHS) is the regulatory body for reporting concerns of hospitals, psychiatric hospitals (including private psychiatric facilities), and various other medical facilities. 2. Investigations are always prompt, comprehensive and responsive to the situation, well conducted, and contain founded conclusions. The investigation may include, but are not limited to the following: -Interviews conducted with individuals having first-hand knowledge of the incident. -Follow-up resolution -Corrective action plan to prevent repeat incidence. -Reports made to appropriate state health care regulatory agency. Review of the facility's Original Event report dated 04/27/15 at 12:15 PM completed by the unit RN revealed Patient #1 reported, "She was lying in bed asleep, when she felt Patient [#2] putting pressure around her buttocks area, and then touching her perineal area. Patient[#1] reported sitting up in bed shock and scared, and found Patient [#2] was up in her face with his finger to his mouth telling her to be quiet not to tell. She found her paper scrub button torned on the outer left side. MD [Medical Doctor], Nurse Manager notified, Patient made a police complaint." PD interviewed Patient #1 and accused, Patient #2. "Patient visible distraught, but no other physical problems noted at this time." Further review of the Original Event indicated the Event was documented as "Attempted Rape/Rape/Sexual Assault." Factors included; "Unit busy code greens called on other unit, and high acute of	X 794		

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X 794	Continued From page 18 unit." The Original Event report did not include any documentation that this allegation was reported to the state health care regulatory agency by any facility employees, in accordance with the facility's policy. The Original Event report did not include documentation that this allegation was thoroughly investigated by the facility for the identification of neglect and/or a corrective action plan to prevent repeat incidence; in accordance with the facility's policy. The Compliance Officer/Director of Risk Management (RM) acknowledged receipt of the Original Event report dated 04/27/15 at 12:15 PM electronically on 05/06/15 documenting Patient #1 made a Police Report. Review of the local PD report dated 04/27/15 at 12:45PM revealed Patient #1 wanted to report that, "she was a sleep in her room, when she awaken and felt pressure around her buttock and vaginal area. When she fully awaken, she observed [Patient #2] in bed with her." Patient #1 further stated that Patient #2 told her "Don't tell anyone," before he left.her room. Patient #1 did not feel Patient #2 penetrate her at any time, but the hospital [paper gown] pajama that she was wearing had a tear between the leg area. Patient #2 denied being in bed with Patient #1, or touching her. The report was deemed as "Disorderly Conduct" and Patient #1 was advised to contact the special victim's unit to file charges against Patient #2. "The Hospital staff was advised to monitor [Patient #2's] movement more closely." Record review of the medical record of Patient #1 revealed she was a 37 year-old female admitted to the psychiatric facility on 04/27/15 at 0830 under Emergency Detention (ED) when she cut	X 794		

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X 794	Continued From page 19 her wrist and called a friend to call Police. Patient #1 has a history of Depression with Anxiety. Further review of Patient #1's permanent records revealed no documentation following the sexual assault allegation that she made on 04/27/15 against Patient #2. There was no documentation in her record that she received a physical and/or psychological assessment following her allegation on 04/27/15. There was a Telephone Physician Order (PO) on 04/27/15 at 12:30 PM (following the allegation) for Ativan (an anti-anxiety) 2 milligrams by mouth "now" without documentation of the reason for the emergency medication. The only documentation in Patient #1's record regarding her allegation against Patient #2 was a Behavioral Team Progress Note dated 05/01/15 at 12:28 completed by Licensed Social Worker- A that indicated "Patient discussed being sexually assaulted by Patient [#2] in the [facility's] PES unit. Review of Patient #1's Daily Observation Notes for 04/27/15 revealed the following: At 11:30-MHW-A documented 1Q (1=On unit, and Q=Quiet/Calm). At 11:45-MHW-A documented 1B (On unit, and B=In Bed Awake). At 12:00-MHW-A documented 1BA (On unit, In Bed Awake, and A=agitated/restless). At 12:15 MHW-A documented 1BA. At 12:30, 12:45, 13:00, 13:15, 13:30, and 13:45-MHW-A documented 1A (On Unit and agitated/restless). Record review of Patient #2's medical records revealed the following: Patient #2's Psychiatric Evaluation dated 04/24/15 revealed he was a 30 year old male	X 794		

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X 794	Continued From page 20 admitted to the PES unit on 04/24/15 with a history of schizoaffective disorder and traumatic brain injury (TBI). Patient #2 was admitted on an ED basis with a history of aggressive behaviors requiring emergency medications to calm him. Patient #2 had recently been discharged from this facility 4-5 weeks prior and has had multiple inpatient treatment episodes over the years (7 inpatient admissions in the previous 5 months). Patient #2 was documented with a known history of aggression and a "history of inappropriate sexual behavior on the unit (masturbating)." Patient #2 had documented borderline intellectual functioning with poor insight, poor judgment, and poor impulse control. A Behavioral Nursing Shift Assessment completed by the unit RN on 04/27/15 at 18:08 that Patient #2 was found by a female patient touching on her body while she was asleep in bed. MD, and Nurse Manager notified. A Telephone PO dated 04/27/15 at 2015 for Patient #2 to be transferred to a higher acuity; sister facility. A Behavior Team Progress noted dated 04/27/15 at 1855 revealed Patient #2 was transferred to a sister facility by the Sheriff's Department. Review of the facility's Incident Event dated 04/27/15 at 11:37 AM confirmed a Code Green was called for another Patient [#3] in the Child/Adolescent Unit requiring Restraints/Seclusion. Patient #3 required physical restraint at 11:36 AM, and emergency medications at 11:46 AM. Patient #3 was released from restraint at 12:26 PM. This Code Green occurred during the same time frames of Patient #1's allegation on 04/27/15.	X 794		

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X 794	Continued From page 21 Review of the facility's Policy titled, Psychiatric Emergencies-Code Green, last reviewed January 2012 revealed a Code Green was a Psychiatric Emergency. Code Green will be implemented by any unit personnel in the event of unmanageable behavior of an individual to prevent harm to that individual, patients, hospital personnel and/or others the general hospital area. D. Individuals responding to Code Green will meet in announced area. Available personnel is necessary to control atmosphere through a show of strength and caring or to assist in physical management. Interview on 08/06/15 at 12:35 PM with the PES unit RN revealed she completed Patient #1's admission assessment to the PES unit on 04/27/15. The unit RN indicated Patients were provided with paper scrubs to wear without other undergarments. The unit RN stated that on 04/27/15 at approximately 11:30 AM to 12:00 PM, "Code Greens" were going on; and "staff were busy". The unit RN stated there was a Code Green on another unit (child/adolescent) and a Code Green was called in the lobby; due to a patient needing to be "put in a [restraint] chair" because they were tearing up the lobby. The unit RN stated she left the unit to respond to the Code Green in the other unit (child/adolescent) and when she arrived; there was another RN responding, so she went to the Code Green in the lobby because they needed an RN to assist with "putting the patient in the [restraint] chair." The unit RN stated she returned to the PES unit following the Code Greens to "something else going on at the end of the unit" that she responded to. The unit RN stated she could not remember if it was LVN-A or LVN-B working on 04/27/15; but that she thought the LVN stayed	X 794		

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X 794	Continued From page 22 back in the PES unit when she left and responded to the two Code Greens. The unit RN stated she was notified that during the Code Greens Patient #2 went into Patient #1's bedroom; and Patient #1 made an allegation of sexual assault. The unit RN stated she spoke with Patient #1 who reported that she was asleep in her bedroom and "she felt pressure" causing her to awake to Patient #2 touching her in the buttock and perineal area. The unit RN stated that Patient #1's paper pants were "torn on the side." The unit RN stated the local PD was called. The unit RN stated she spoke to Patient #2 and he said, "I touched her, but didn't do anything else." The unit RN stated he admitted that he "touched her and ripped her paper pants." The unit RN stated that Patient #2 knew that the unit was "chaotic" and knew what Code Green meant; and that is when he "took advantage" of the situation. The unit RN stated she believed that Patient #2 sexually assaulted Patient #1 given the facts, and his own admission. The unit RN stated she notified the MD, Social Worker, and Nursing Manager of the allegation. The unit RN indicated she documented the sexual assault allegation made by Patient #1 on the facility's Event Report; however, confirmed she did not document the sexual assault allegation in Patient #1's record following the incident. The unit RN stated she offered for Patient #1 to have a Sexual Assault Nurse Examination (SANE) completed at another facility if she wanted; but Patient #1 declined, stating she did not believe Patient #2 actually raped her. Interview on 08/06/15 at 04:45 PM with MHW-A revealed she was the only MHW working on 04/27/15 in the PES unit; along with the unit RN and a Licensed Vocational Nurse (LVN). MHW-A	X 794		

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X 794	Continued From page 23 stated she was pulled to the PES unit at 9:15 AM and was unfamiliar to the PES unit; but was told by the leaving MHW to "watch it" for Patient #2, however, she did not know the specific reason why. MHW-A stated the females were assigned rooms on one side, and males on the other side. MHW-A stated during the morning on 04/27/15 at approximately 11:30 AM-12:00 PM it was a "hectic/busy" day with "Code Green's being called." MHW-A stated that security was usually on the PES unit; but on 04/27/15 at the time of the allegation; "security could not be found." MHW-A stated on 04/27/15 at around 11:30-12:00 PM she stayed in the unit when the Code Greens were called and was "getting something out of the supply closet." MHW-A indicated the unit RN "responded to the Code Green" leaving the unit; telling her she [unit RN] would be back. MHW-A did not remember if LVN-A or LVN-B was working on 04/27/15; but further stated she did not remember any LVN being in the unit during the time of the allegation made by Patient #1. MHW-A stated shortly after this Patient #1 "flagged her [MHW-A] down" to her bedroom, and into the restroom of the bedroom where she reported that Patient #2 came into her room and touched her buttocks and vaginal area while she was sleeping in her bed. MHW-A stated that Patient #1's gown was torn around the buttock area and she offered to call the local PD for Patient #1 to make a report. MHW-A stated she then reported the incident/allegation to the unit RN. MHW-A stated she was later told that Patient #2 had been an inpatient to the facility many times before, and he "knows the system; knows what Code Green means." MHW-A stated she had seen Patient #2 "walking out of her [Patient #1] room a few times" and further stated "right before she flagged me down, he had walked out of her room". MHW-A indicated she	X 794		

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X 794	Continued From page 24 told Patient #2 "not to go in to other people's rooms." MHW-A confirmed she had not documented the allegation reported by Patient #1 against Patient #2; but that she "told [unit RN]." Interview on 08/10/15at 1:20 PM with Patient #1 revealed on 04/27/15 at approximately 11:30-11:45 AM she was in her assigned bedroom sleeping after she received multiple medications following her admission. Patient #1 stated she awoke after she "felt pressure" in her buttock and vaginal area. Patient #1 stated that Patient #2 was present telling her not to tell anyone. Patient #1 stated that she noticed her paper pants were ripped and she was not actually aware what all Patient #2 actually did because she "was conked out" after taking multiple medications. Patient #1 stated she knows he touched her because that was what woke her up. Patient #1 stated she was very upset, "freaked out," and asked the MD for an "AIDS" test. Patient #1 stated the unit RN indicated to the nursing staff (LVN) to "give her more meds" because she was "upset, crying, and freaking out." Patient #1 stated she then received the Ativan for her anxiety, to "help me calm down." Patient #1 stated the local PD came and she made a report. Patient #1 stated she was told by the unit RN that "Code Green's" were called and "everyone had to leave the unit" which allowed the opportunity for Patient #2 to go into her room unsupervised. Interview on 08/10/15 at 2:20 PM with Security Guard-A revealed he was employed by the facility to maintain security and the safety of patients. The Security Guard-A stated Patient #2 had a history of inappropriate sexual behavior of "masturbating in front of females." The Security	X 794		

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X 794	Continued From page 25 Guard-A stated he assisted with "viewing the video" footage for evidence following the allegation on 04/27/15 made be Patient #1 against Patient #2. The Security Guard stated the video footage from 04/27/15 showed a total of "four times" that Patient #2 went into Patient #1's room; and the last time Patient #2 came out of Patient #1's room; she was observed to come out of the room a few minutes later. The Security Guard stated that Patient #2 had already been assigned to the front "seclusion room" of the PES unit as his bedroom due to his history of masturbating. The Security Guard stated on the video footage Patient #2 could be seen coming from his room; "looking side to side" down the hallway, and then going into Patient #1's room. The Security Guard stated that female and male patient rooms were separated and that Patient #2 was not supposed to be going into Patient #1's room for any reason. Interview on 08/10/15 at 2:50 PM with MD-A revealed he was notified of Patient #1's sexual assault allegation against Patient #2 on 04/27/15. MD-A stated he discussed with Patient #1 the option of a "Rape Kit" but she "declined." MD-A stated he understood the allegation made by Patient #1 to be "only touching with no penetration." MD-A stated that Patient #1 was "distressed" about the incident and he ordered Ativan for Patient #1's anxiety following the incident. MD-A stated Patient #1 had already been distressed emotionally because of her ED inpatient admission; and really did not even want to take the Ativan. MD-A stated he recalled there was a Code Green called where staff left the unit in response to the Code Green; which left less staffing in the unit. MD-A confirmed that he did not document in Patient #1's records his contact or discussion with Patient #1 following her	X 794		

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X 794	Continued From page 26 allegation. Interview on 08/10/15 at 3:00 PM with the facility's Risk Manager (RM) indicated that she was aware of the alleged sexual assault allegation made by Patient #1 on 04/27/15 against Patient #2'; however, she had not been notified until 05/06/15 via the facility's Incident/Event electronic system because there had not been any harm documented in order to elevate the notification. The RM stated the staffing ratio on the PES unit was 1 staff to 4 patients. The RM indicated on 04/27/15 the patient census in the PES unit was 11; requiring 3 staff. The RM stated the first required staff is an RN, and then second could be a LVN, and/or MHW. The RM confirmed for 11 patients the required staffing would be 3. The RM stated the PES unit was to always have a licensed nurse present and available in the unit. The RM confirmed that she had not reported the sexual assault allegation made by Patient #1 on 04/27/15 against Patient #2 to the state health care regulatory agency, Department of State Health Services (DSHS); which was determined to have occurred as a result of insufficient staffing in the PES unit during episodes of Code Green's. The RM further confirmed the facility had not completed a thorough investigation with documented findings specific to this allegation for the determination of Neglect and/or a corrective action plan to prevent repeat incidence; in accordance with the facility's policy. The RM stated she had not seen or viewed the video footage following this allegation due to the video being unavailable after 05/06/15; following her electronic notification. Interview on 08/10/15 at 3:15 PM with Licensed	X 794		

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X 794	Continued From page 27 Social Worker (LSW)-A stated she assisted Security Guard-A in viewing the video footage on 04/27/15 after Patient #1 made a sexual assault allegation against Patient #2. LSW-A stated that during the allegation on 04/27/15; Patient #2 could be seen on the camera "looking both ways" and then would go into Patient #1's bedroom. LSW-A stated they were able to count this event occurring a "couple of times" where Patient #2 would go into Patient #1's bedroom and remain there "a couple of minutes" each time. LSW-A stated she saw on the video where MHW-A had been in the "Patient evaluation room" during these time periods; where a supply closet was located. LSW-A stated Patient #2 had a history of "exposing his self, public masturbation, and talks sexually to other women." LSW-A stated that Patient #2 has publically masturbated in front of her during an assessment interview. Interview on 08/10/15 at 4:15 PM with LVN-A stated he was present and worked the PES unit on 04/27/15. LVN-A stated that on 04/27/15 there were Code Greens called on another unit, and in the facility's lobby about the same time. LVN-A stated he responded to the Code Green in the lobby to assist due to a "fight." LVN-A indicated he had left the unit for approximately 15 minutes. Interview on 08/10/15 at 4:30 PM with the Vice President (VP) of Clinical Services confirmed that she was notified of the sexual allegation made by Patient #1 against Patient #2 on 04/27/15; however, she had not been notified until 05/06/15 via the facility's Incident/Event electronic system because there had not been any harm documented in order to elevate the notification. The VP of Clinical Services indicated that on	X 794		

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X 794	Continued From page 28 04/27/15 the Nursing Clinical Director (Nurse Manager) had been notified immediately following Patient #1's allegation and she had not obtained information that indicated Patient #1's allegation had occurred due to insufficient staffing in the PES unit when Code Green's had been called; leaving the unit without a RN available. The VP of Clinical Services stated that the unit RN was not supposed to leave the unit and there should always be a Licensed Nurse in the unit during a Code Green; that "it is a judgement call." The VP of Clinical Services stated she had not seen or viewed the video footage following this allegation due to the video being unavailable after 05/06/15; following her electronic notification. Interview on 08/10/15 at 4:40 PM with the Nursing Clinical Director (Nurse Manager) stated she was immediately notified by the PES unit RN on 04/27d/15 of Patient #1's sexual allegation against Patient #2. The Nursing Clinical Director indicated she "separated" the Patients, talked to both of them, and Patient #1 saw the Doctor. The Nursing Clinical Director stated she spoke to the unit RN about the allegation but had not been notified or received information that the RN and LVN had left the PES unit to respond to Code Greens which left the unit without a RN and/or licensed nurse available. The Nursing Clinical Director stated she had not seen or viewed the video footage following this allegation.	X 794		
X1037	133.47(c)(3)(A) Reporting responsibility: reporting abuse & n Abuse And Neglect Issues. Abuse and neglect of individuals with mental illness, and illegal, unethical, and unprofessional	X1037	**Plan of Correction** **X 1037** Mandatory read and sign in-service for all front-line behavioral health staff to include nursing, MHT, NP, social workers, intake/assessment, security and	9/14/15

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X1037	Continued From page 29 conduct. Reporting responsibility. Reporting abuse and neglect. A person, including an employee, volunteer, or other person associated with the facility who reasonably believes or who knows of information that would reasonably cause a person to believe that the physical or mental health or welfare of a patient of the facility who is receiving mental health or chemical dependency services has been, is, or will be adversely affected by abuse or neglect (as those terms are defined in this subsection) by any person shall as soon as possible report the information supporting the belief to the department or to the appropriate state health care regulatory agency in accordance with HSC, §161.132(a). This Requirement is not met as evidenced by: Based on interview and record review, facility employees failed to report an allegation of neglect to the state health care regulatory agency, the Department of State Health Services (DSHS); and in accordance with their policy, for 1 of 1 patients reviewed (Patient #1) with a complaint allegation of sexual assault against another patient (Patient #2). Specifically, on 04/27/15, Patient #1 reported to the unit's Registered Nurse (RN) an allegation of sexual assault from another Patient, (#2); who had a history of inappropriate sexual behaviors. The allegation was reported to the Medical Doctor, the Nursing Manager, and local Police	X1037	admitting to be completed by 9/14/15. Mandatory In-services to be conducted on 9/14, 9/16, and 9/18 for all behavioral health staff with multiple offerings in order to ensure all staff are able to attend one of these educational events. The mandatory in-service will reinforce the hospital policy regarding Assessment and Reporting of Abuse and Neglect, reinforce the need to document outlier events affecting patients, and roll out the Code Green Response Protocol. Additional topics for the mandatory in-service include: a decision tree to reinforce the policy on reporting and follow-up of suspected/reported allegations of abuse/neglect of a patient during hospitalization and in treating patients identified as having ordered sexual precautions. Follow up in-servicing is planned for February 2016 to include participation by same staff members to continue reinforcement of policies.	

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X1037	Continued From page 30 Department (PD); however, this allegation was not reported to the state health care regulatory agency by any facility employees, in accordance with their policy. This deficient practice could affect the prevention of possible unidentified abuse, neglect, or mistreatment for all patients in the facility; by compromising their safety. Findings included: Review of Patient #1's Complaint Form dated 05/15/15 indicated the following in part: On 04/27/15 at approximately 11:30 AM Patient #1 was admitted to the facility's "Psychiatric Emergency Services (PES) unit and received medication to help her sleep and calm down. Patient #1 reported shortly after she received the medications; she was asleep in her bed when she "felt someone touching my vagina and butt. I felt a hard pressure. I jumped up and another male patient [#2] jumped out from under my covers." Patient #1 stated she went to find a staff member (Mental Health Worker-A), to report what had happened. Patient #1 indicated she noticed her entire "crotch area [paper gown] was torn exposing her "vagina and butt." Patient #1 indicated the facility staff called the Police Department (PD) for Patient #1 to make a report. Patient #1 reported the staff apologized to her for the incident; "but they had an emergency on another floor and they were short staffed, so every staff member had left." Patient #1 indicated she was "so upset and scared; so they gave me more meds to put me to sleep." Patient #1 stated the facility had done nothing more to help her; there were no witnesses but she believed there were cameras in the hall. Patient #1 stated she found out that Patient #2 had done this before	X1037		

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X1037	Continued From page 31 and the Police Officer who responded stated that; "he [Patient #2] has a history of doing this; why was he unsupervised?" Review of the facility's Policy titled, Abuse Reporting-External and Internal, last reviewed January 2012 revealed the following definitions: Psychological Abuse included; humiliation and harassment. Sexual Abuse included; sexual harassment, sexual coercion, and sexual assault. Review of the facility's Policy titled, Assessment and Reporting of Abuse and Neglect, last reviewed February 2013 revealed Neglect included the failure to provide for one's self the goods or services including medical services, which are necessary to avoid physical or emotional harm or pain or the failure of a caretaker to provide the goods or services. The policy indicated the facility "prohibits neglect, mental or physical abuse or misappropriation of property, of patients by staff, visitors, or other patients." The facility "will report allegations and release information to the proper authorities, according to federal regulations, state specific rules and regulation and [facility] practice guidelines." Further review of the policy indicated, in part: 1. Reporting allegations of abuse and/or neglect occurring while the patient is under the care in the facility: All alleged violations concerning abuse and neglect while the patient is under the care of the facility will be reported to the Compliance Officer or designee, who will advise the on-call administrator/designee. As appropriate, the facility will report the incident to appropriate state, federal and protective/regulatory agencies, and/or law enforcement agencies and conduct an	X1037		

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X1037	Continued From page 32 internal investigation within a maximum of five working days of the incident. The Texas Department of state Health Services (DSHS) is the regulatory body for reporting concerns of hospitals, psychiatric hospitals (including private psychiatric facilities), and various other medical facilities. Review of the facility's Original Event report dated 04/27/15 at 12:15 PM completed by the unit RN revealed Patient #1 reported, "She was lying in bed asleep, when she felt Patient [#2] putting pressure around her buttocks area, and then touching her perineal area. Patient[#1] reported sitting up in bed shock and scared, and found Patient [#2] was up in her face with his finger to his mouth telling her to be quiet not to tell. She found her paper scrub button torned on the outer left side. MD [Medical Doctor], Nurse Manager notified, Patient made a police complaint." PD interviewed Patient #1 and accused, Patient #2. "Patient visible distraught, but no other physical problems noted at this time." Further review of the Original Event indicated the Event was documented as "Attempted Rape/Rape/Sexual Assault." Factors included; "Unit busy code greens called on other unit, and high acute of unit." The Original Event report did not include any documentation that this allegation was reported to the state health care regulatory agency by any facility employees, in accordance with the facility's policy. The Original Event report did not include documentation that this allegation was thoroughly investigated by the facility for the identification of neglect and/or a corrective action plan to prevent repeat incidence; in accordance with the facility's policy. The Compliance Officer/Director of Risk Management (RM) acknowledged receipt of the Original Event report	X1037		

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X1037	Continued From page 33 dated 04/27/15 at 12:15 PM electronically on 05/06/15 documenting Patient #1 made a Police Report. Review of the local PD report dated 04/27/15 at 12:45PM revealed Patient #1 wanted to report that, "she was a sleep in her room, when she awaken and felt pressure around her buttock and vaginal area. When she fully awaken, she observed [Patient #2] in bed with her." Patient #1 further stated that Patient #2 told her "Don't tell anyone," before he left her room. Patient #1 did not feel Patient #2 penetrate her at any time, but the hospital [paper gown] pajama that she was wearing had a tear between the leg area. Patient #2 denied being in bed with Patient #1, or touching her. The report was deemed as "Disorderly Conduct" and Patient #1 was advised to contact the special victim's unit to file charges against Patient #2. "The Hospital staff was advised to monitor [Patient #2's] movement more closely." Record review of the medical record of Patient #1 revealed she was a 37 year-old female admitted to the psychiatric facility on 04/27/15 at 0830 under Emergency Detention (ED) when she cut her wrist and called a friend to call Police. Patient #1 has a history of Depression with Anxiety. Further review of Patient #1's permanent records revealed no documentation following the sexual assault allegation that she made on 04/27/15 against Patient #2. There was no documentation in her record that she received a physical and/or psychological assessment following her allegation on 04/27/15. There was a Telephone Physician Order (PO) on 04/27/15 at 12:30 PM (following the allegation) for Ativan (an anti-anxiety) 2	X1037		

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X1037	Continued From page 34 milligrams by mouth "now" without documentation of the reason for the emergency medication. The only documentation in Patient #1's record regarding her allegation against Patient #2 was a Behavioral Team Progress Note dated 05/01/15 at 12:28 completed by Licensed Social Worker- A that indicated "Patient discussed being sexually assaulted by Patient [#2] in the [facility's] PES unit. Review of Patient #1's Daily Observation Notes for 04/27/15 revealed the following: At 11:30-MHW-A documented 1Q (1=On unit, and Q=Quiet/Calm). At 11:45-MHW-A documented 1B (On unit, and B=In Bed Awake). At 12:00-MHW-A documented 1BA (On unit, In Bed Awake, and A=agitated/restless). At 12:15 MHW-A documented 1BA. At 12:30, 12:45, 13:00, 13:15, 13:30, and 13:45-MHW-A documented 1A (On Unit and agitated/restless). Record review of Patient #2's medical records revealed the following: Patient #2's Psychiatric Evaluation dated 04/24/15 revealed he was a 30 year old male admitted to the PES unit on 04/24/15 with a history of schizoaffective disorder and traumatic brain injury (TBI). Patient #2 was admitted on an ED basis with a history of aggressive behaviors requiring emergency medications to calm him. Patient #2 had recently been discharged from this facility 4-5 weeks prior and has had multiple inpatient treatment episodes over the years (7 inpatient admissions in the previous 5 months). Patient #2 was documented with a known history of aggression and a "history of inappropriate sexual behavior on the unit (masturbating)."	X1037		

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X1037	Continued From page 35 Patient #2 had documented borderline intellectual functioning with poor insight, poor judgment, and poor impulse control. A Behavioral Nursing Shift Assessment completed by the unit RN on 04/27/15 at 18:08 that Patient #2 was found by a female patient touching on her body while she was asleep in bed. MD, and Nurse Manager notified. A Telephone PO dated 04/27/15 at 2015 for Patient #2 to be transferred to a higher acuity; sister facility. A Behavior Team Progress noted dated 04/27/15 at 1855 revealed Patient #2 was transferred to a sister facility by the Sheriff's Department. Review of the facility's Incident Event dated 04/27/15 at 11:37 AM confirmed a Code Green was called for another Patient [#3] in the Child/Adolescent Unit requiring Restraints/Seclusion. Patient #3 required physical restraint at 11:36 AM, and emergency medications at 11:46 AM. Patient #3 was released from restraint at 12:26 PM. This Code Green occurred during the same time frames of Patient #1's allegation on 04/27/15. Review of the facility's Policy titled, Psychiatric Emergencies-Code Green, last reviewed January 2012 revealed a Code Green was a Psychiatric Emergency. Code Green will be implemented by any unit personnel in the event of unmanageable behavior of an individual to prevent harm to that individual, patients, hospital personnel and/or others the general hospital area. D. Individuals responding to Code Green will meet in announced area. Available personnel is necessary to control atmosphere through a show	X1037		

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X1037	Continued From page 36 of strength and caring or to assist in physical management. Interview on 08/06/15 at 12:35 PM with the PES unit RN revealed she completed Patient #1's admission assessment to the PES unit on 04/27/15. The unit RN indicated Patients were provided with paper scrubs to wear without other undergarments. The unit RN stated that on 04/27/15 at approximately 11:30 AM to 12:00 PM, "Code Greens" were going on; and "staff were busy". The unit RN stated there was a Code Green on another unit (child/adolescent) and a Code Green was called in the lobby; due to a patient needing to be "put in a [restraint] chair" because they were tearing up the lobby. The unit RN stated she left the unit to respond to the Code Green in the other unit (child/adolescent) and when she arrived; there was another RN responding, so she went to the Code Green in the lobby because they needed an RN to assist with "putting the patient in the [restraint] chair." The unit RN stated she returned to the PES unit following the Code Greens to "something else going on at the end of the unit" that she responded to. The unit RN stated she could not remember if it was LVN-A or LVN-B working on 04/27/15; but that she thought the LVN stayed back in the PES unit when she left and responded to the two Code Greens. The unit RN stated she was notified that during the Code Greens Patient #2 went into Patient #1's bedroom; and Patient #1 made an allegation of sexual assault. The unit RN stated she spoke with Patient #1 who reported that she was asleep in her bedroom and "she felt pressure" causing her to awake to Patient #2 touching her in the buttock and perineal area. The unit RN stated that Patient #1's paper pants were "torn on the side." The unit RN stated the local PD was called.	X1037		

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X1037	Continued From page 37 The unit RN stated she spoke to Patient #2 and he said, "I touched her, but didn't do anything else." The unit RN stated he admitted that he "touched her and ripped her paper pants." The unit RN stated that Patient #2 knew that the unit was "chaotic" and knew what Code Green meant; and that is when he "took advantage" of the situation. The unit RN stated she believed that Patient #2 sexually assaulted Patient #1 given the facts, and his own admission. The unit RN stated she notified the MD, Social Worker, and Nursing Manager of the allegation. The unit RN indicated she documented the sexual assault allegation made by Patient #1 on the facility's Event Report; however, confirmed she did not document the sexual assault allegation in Patient #1's record following the incident. The unit RN stated she offered for Patient #1 to have a Sexual Assault Nurse Examination (SANE) completed at another facility if she wanted; but Patient #1 declined, stating she did not believe Patient #2 actually raped her. The unit RN confirmed she had not reported this allegation to the state health care regulatory agency (DSHS). Interview on 08/06/15 at 04:45 PM with MHW-A revealed she was the only MHW working on 04/27/15 in the PES unit; along with the unit RN and a Licensed Vocational Nurse (LVN). MHW-A stated she was pulled to the PES unit at 9:15 AM and was unfamiliar to the PES unit; but was told by the leaving MHW to "watch it" for Patient #2, however, she did not know the specific reason why. MHW-A stated the females were assigned rooms on one side, and males on the other side. MHW-A stated during the morning on 04/27/15 at approximately 11:30 AM-12:00 PM it was a "hectic/busy" day with "Code Green's being called." MHW-A stated that security was usually	X1037		

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X1037	Continued From page 38 on the PES unit; but on 04/27/15 at the time of the allegation; "security could not be found." MHW-A stated on 04/27/15 at around 11:30-12:00 PM she stayed in the unit when the Code Greens were called and was "getting something out of the supply closet." MHW-A indicated the unit RN "responded to the Code Green" leaving the unit; telling her she [unit RN] would be back. MHW-A did not remember if LVN-A or LVN-B was working on 04/27/15; but further stated she did not remember any LVN being in the unit during the time of the allegation made by Patient #1. MHW-A stated shortly after this Patient #1 "flagged her [MHW-A] down" to her bedroom, and into the restroom of the bedroom where she reported that Patient #2 came into her room and touched her buttocks and vaginal area while she was sleeping in her bed. MHW-A stated that Patient #1's gown was torn around the buttock area and she offered to call the local PD for Patient #1 to make a report. MHW-A stated she then reported the incident/allegation to the unit RN. MHW-A stated she was later told that Patient #2 had been an inpatient to the facility many times before, and he "knows the system; knows what Code Green means." MHW-A stated she had seen Patient #2 "walking out of her [Patient #1] room a few times" and further stated "right before she flagged me down, he had walked out of her room". MHW-A indicated she told Patient #2 "not to go in to other people's rooms." MHW-A confirmed she had not documented the allegation reported by Patient #1 against Patient #2; but that she "told [unit RN]." Interview on 08/10/15at 1:20 PM with Patient #1 revealed on 04/27/15 at approximately 11:30-11:45 AM she was in her assigned bedroom sleeping after she received multiple medications following her admission. Patient #1	X1037		

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X1037	Continued From page 39 stated she awoke after she "felt pressure" in her buttock and vaginal area. Patient #1 stated that Patient #2 was present telling her not to tell anyone. Patient #1 stated that she noticed her paper pants were ripped and she was not actually aware what all Patient #2 actually did because she "was conked out" after taking multiple medications. Patient #1 stated she knows he touched her because that was what woke her up. Patient #1 stated she was very upset, "freaked out," and asked the MD for an "AIDS" test. Patient #1 stated the unit RN indicated to the nursing staff (LVN) to "give her more meds" because she was "upset, crying, and freaking out." Patient #1 stated she then received the Ativan for her anxiety, to "help me calm down." Patient #1 stated the local PD came and she made a report. Patient #1 stated she was told by the unit RN that "Code Green's" were called and "everyone had to leave the unit" which allowed the opportunity for Patient #2 to go into her room unsupervised. Interview on 08/10/15 at 2:20 PM with Security Guard-A revealed he was employed by the facility to maintain security and the safety of patients. The Security Guard-A stated Patient #2 had a history of inappropriate sexual behavior of "masturbating in front of females." The Security Guard-A stated he assisted with "viewing the video" footage for evidence following the allegation on 04/27/15 made be Patient #1 against Patient #2. The Security Guard stated the video footage from 04/27/15 showed a total of "four times" that Patient #2 went into Patient #1's room; and the last time Patient #2 came out of Patient #1's room; she was observed to come out of the room a few minutes later. The Security Guard stated that Patient #2 had already been	X1037		

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X1037	Continued From page 40 assigned to the front "seclusion room" of the PES unit as his bedroom due to his history of masturbating. The Security Guard stated on the video footage Patient #2 could be seen coming from his room; "looking side to side" down the hallway, and then going into Patient #1's room. The Security Guard stated that female and male patient rooms were separated and that Patient #2 was not supposed to be going into Patient #1's room for any reason. Interview on 08/10/15 at 2:50 PM with MD-A revealed he was notified of Patient #1's sexual assault allegation against Patient #2 on 04/27/15. MD-A stated he discussed with Patient #1 the option of a "Rape Kit" but she "declined." MD-A stated he understood the allegation made by Patient #1 to be "only touching with no penetration." MD-A stated that Patient #1 was "distressed" about the incident and he ordered Ativan for Patient #1's anxiety following the incident. MD-A stated Patient #1 had already been distressed emotionally because of her ED inpatient admission; and really did not even want to take the Ativan. MD-A stated he recalled there was a Code Green called where staff left the unit in response to the Code Green; which left less staffing in the unit. MD-A confirmed that he did not document in Patient #1's records his contact or discussion with Patient #1 following her allegation. Interview on 08/10/15 at 3:00 PM with the facility's Risk Manager (RM) indicated that she was aware of the alleged sexual assault allegation made by Patient #1 on 04/27/15 against Patient #2'; however, she had not been notified until 05/06/15 via the facility's Incident/Event electronic system because there had not been any harm	X1037		

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X1037	Continued From page 41 documented in order to elevate the notification. The RM stated the staffing ratio on the PES unit was 1 staff to 4 patients. The RM indicated on 04/27/15 the patient census in the PES unit was 11; requiring 3 staff. The RM stated the first required staff is an RN, and then second could be a LVN, and/or MHW. The RM confirmed for 11 patients the required staffing would be 3. The RM stated the PES unit was to always have a licensed nurse present and available in the unit. The RM confirmed that she had not reported the sexual assault allegation made by Patient #1 on 04/27/15 against Patient #2 to the state health care regulatory agency, Department of State Health Services (DSHS); which was determined to have occurred as a result of insufficient staffing in the PES unit during episodes of Code Green's. The RM further confirmed the facility had not completed a thorough investigation with documented findings specific to this allegation for the determination of Neglect and/or a corrective action plan to prevent repeat incidence; in accordance with the facility's policy. The RM stated she had not seen or viewed the video footage following this allegation due to the video being unavailable after 05/06/15; following her electronic notification. Interview on 08/10/15 at 3:15 PM with Licensed Social Worker (LSW)-A stated she assisted Security Guard-A in viewing the video footage on 04/27/15 after Patient #1 made a sexual assault allegation against Patient #2. LSW-A stated that during the allegation on 04/27/15; Patient #2 could be seen on the camera "looking both ways" and then would go into Patient #1's bedroom. LSW-A stated they were able to count this event occurring a "couple of times" where Patient #2 would go into Patient #1's bedroom and remain	X1037		

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X1037	Continued From page 42 there "a couple of minutes" each time. LSW-A stated she saw on the video where MHW-A had been in the "Patient evaluation room" during these time periods; where a supply closet was located. LSW-A stated Patient #2 had a history of "exposing his self, public masturbation, and talks sexually to other women." LSW-A stated that Patient #2 has publically masturbated in front of her during an assessment interview. Interview on 08/10/15 at 4:15 PM with LVN-A stated he was present and worked the PES unit on 04/27/15. LVN-A stated that on 04/27/15 there were Code Greens called on another unit, and in the facility's lobby about the same time. LVN-A stated he responded to the Code Green in the lobby to assist due to a "fight." LVN-A indicated he had left the unit for approximately 15 minutes. Interview on 08/10/15 at 4:30 PM with the Vice President (VP) of Clinical Services confirmed that she was notified of the sexual allegation made by Patient #1 against Patient #2 on 04/27/15; however, she had not been notified until 05/06/15 via the facility's Incident/Event electronic system because there had not been any harm documented in order to elevate the notification. The VP of Clinical Services indicated that on 04/27/15 the Nursing Clinical Director (Nurse Manager) had been notified immediately following Patient #1's allegation and she had not obtained information that indicated Patient #1's allegation had occurred due to insufficient staffing in the PES unit when Code Green's had been called; leaving the unit without a RN available. The VP of Clinical Services stated that the unit RN was not supposed to leave the unit and there should always be a Licensed Nurse in the unit during a	X1037		

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X1037	Continued From page 43 Code Green; that "it is a judgement call." The VP of Clinical Services stated she had not seen or viewed the video footage following this allegation due to the video being unavailable after 05/06/15; following her electronic notification. The VP of Clinical Services confirmed she had not reported this allegation to the state health care regulatory agency (DSHS). Interview on 08/10/15 at 4:40 PM with the Nursing Clinical Director (Nurse Manager) stated she was immediately notified by the PES unit RN on 04/27d/15 of Patient #1's sexual allegation against Patient #2. The Nursing Clinical Director indicated she "separated" the Patients, talked to both of them, and Patient #1 saw the Doctor. The Nursing Clinical Director stated she spoke to the unit RN about the allegation but had not been notified or received information that the RN and LVN had left the PES unit to respond to Code Greens which left the unit without a RN and/or licensed nurse available. The Nursing Clinical Director stated she had not seen or viewed the video footage following this allegation. The Nursing Clinical Director confirmed she had not reported this allegation to the state health care regulatory agency (DSHS).	X1037		

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X 000	INITIAL COMMENTS Note: The State Form is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be referred to the Office of the Texas Attorney General (OAG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. An unannounced visit was completed from 04/08/15 to 04/09/15 to conduct a complaint investigation survey (TX 00212197). An entrance conference was conducted in the conference room of the facility. In attendance were the Director of Social Services, and the Vice President of Clinical Services. The purpose and process of the complaint survey were discussed and an opportunity for questions was provided. Complaint TX 00212197 was substantiated with violations cited. An exit conference was conducted in the afternoon of 04/09/15 in the facility conference room. The Director of Risk Management was in attendance. Preliminary findings of the survey were discussed and an opportunity for questions was provided.	X 000		
X 123	133.41(c)(8)(A) Discharge and continuing care plan Comprehensive Medical Rehabilitation Services. Discharge and continuing care plan. The patient's interdisciplinary team shall prepare a written continuing care plan that addresses the	X 123	1) 133.41 c 8 A Discharge and Continuing Care Plan Corrective Action : For all new medical diagnoses the APN will immediately consult with attending psychiatrist and pending approval will be added by the APN immediately in axis as part of the discharge summary. At discharge nursing staff will document	5/15/15

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X 123	Continued From page 1 patient's needs for care after discharge. (A) The continuing care plan for the patient shall include recommendations for treatment and care and information about the availability of resources for treatment or care. This Requirement is not met as evidenced by: Based on a record review and interview, the hospital failed to ensure that discharge instructions included the written referral for follow-up/continuing care as ordered by the Advanced Nurse Practitioner (ANP). Patient #1's discharge summary completed by the Psychiatrist did not include her newly diagnosed Diabetes made by the ANP on 01/17/15; or the follow-up care recommended for her Primary Care Physician (PCP) by the ANP. This deficient practice could affect Patient #1's overall health by failure to follow-up and seek treatment of her health conditions. Findings included: Record review of Patient #1's medical record revealed she was admitted on 01/13/15 and discharged 01/20/15 at 18:40. On 01/17/15 the facility's ANP assessed Patient #1's laboratory results for a Hemoglobin, A1C at 7.24 (normal results less than 6.5) and indicated that she had "[Diabetes Mellitus] (DM)". ANP documented that she would place Patient #1 on a 2000 American Diabetes Association (ADA) diet, have the	X 123	education to patient and or guardian (as appropriate) for need and recommended follow-up with PCP. Ongoing compliance will be checked daily via nursing 12 and 24 hr chart checks. All nursing staff will be in-serviced by Behavioral Health Nursing Administration by 5/15/15.	

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X 123	Continued From page 2 dietician see patient before discharge, and documented that Patient #1 needed to follow up with her PCP. Record review of the Discharge Instructions dated 01/20/15 presented and signed by Patient #1's mother/guardian revealed only "Follow-up appointments" were for the Psychiatrist and Individual Therapist appointments. The area of Follow-up appointments for Primary Care Physician was documented "Deferred." Further review revealed discharge diagnosis for AXIS III: Medical problems were- "Asthma, gastro esophageal reflux disease (GERD)." The Discharge Summary diagnosis did not include Diabetes Mellitus as diagnosed by the ANP on 01/17/15. Record review of Patient #1's written complaint completed by her mother/guardian, undated, revealed when her daughter was discharged on 01/20/15; "they did blood work on her [Patient #1] and never told me she has Diabetes. My daughter told me, I confronted the nurses, they said they don't tell me; papers are sent home when she leaves; and that it's not that bad." Record review of the facility's Medical Staff Bylaws; Rules and Regulations approved by the Board of Control May 31, 2013, revealed the following; Where there is need of a discharge summary, a clinical resume covering the necessary five (5) points including the final diagnosis and authenticated by the attending Practitioner is sufficient to exclude the completion of the face sheet. Necessary five (5) points: (1) Why was the patient admitted?	X 123		

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X 123	Continued From page 3 (2) Pertinent findings. (3) What was done? Procedures performed and treatment rendered (4) Condition on discharge. (5) Instructions, including medications, diet, physical activity, if any, and follow-up. During an interview on 04/08/15 at 4:45 PM with the ANP, she stated that she diagnosed Patient #1 with DM on 01/17/15 following her laboratory test results, Hemoglobin A1C; positive for Diabetes. ANP stated she wanted Patient #1 to follow-up with her PCP following discharge because she did not want to initiate medication therapy that she was not able to monitor. ANP confirmed Patient #1's Discharge Summary and Instructions dated 01/20/15 failed to document her new diagnosis of Diabetes Mellitus and the recommended follow-up with her PCP. ANP stated that the nurse completing the Discharge Instructions did not pick that up from her record and the Psychiatrist did not add it to her final diagnosis upon discharge. During an interview on 04/09/15 at 8:55 AM with Patient #1's mother/guardian revealed she was not told when her daughter was discharged on 01/20/15 that she had Diabetes; or that she needed to follow-up with her PCP.	X 123		
X 795	133.42(a)(1)(A) Patient rights requirements: all hospitals Patient Rights. Patient rights requirements for all hospitals. A hospital shall adopt, implement, and enforce a policy to ensure patients' rights. The written policy shall include:	X 795	2) 133.42 a 1 A Patient Rights Requirements a. Corrective Action - Updated signage in the NMC mailroom and statement with address included in the patient handbooks. Signage in NMC mailroom will be installed and BH patient handbooks will be updated by and completed by the Director of Risk Management.	5/15/15

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X 795	Continued From page 4 (A) the right of the patient to the hospital's reasonable response to his or her requests and needs for treatment or service, within the hospital's capacity, its stated mission, and applicable law and regulation; This Requirement is not met as evidenced by: Based on record review and interview, the facility failed to implement and ensure the rights for 1 of 1 Patient (# 1) reviewed for rights. Specifically, the facility failed to: 1.) Ensure prompt resolution of grievances within 30 days; as indicated by the facility's Complaints and Grievances policy and; 2.) Ensure reasonable access to care and services upon request of Patient #1's mother/guardian regarding the need for assessment and treatment. This deficient practice affected Patient #1's rights when the facility failed to address concerns, complaints, and grievances related to the patient	X 795	b. Corrective Action - For medical complaints lasting 24 hours and requiring PRN medication the patient will receive a medical consult within 24 hours. If symptoms persist after the medical consult and any ordered follow-up has been satisfied the APN will address the patient's complaints with the attending psychiatrist for further recommendations. Ongoing compliance will be checked daily via nursing 12 and 24 hr chart checks. All nursing staff will be in-serviced by Behavioral Health Nursing Administration by 5/15/15.	5/15/15

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X 795	Continued From page 5 rights, safety, and satisfaction. Findings included: 1.) Record review of the facility's Patient Complaints and Grievances Policy, last reviewed 11/2013 revealed the following: Grievances: 1.) Upon receipt of a grievance, the receiving department will indicate the date of receipt and sent the grievance to Quality/Risk Department. 2.) The Director of Risk Management or designee will investigate all grievances. 3.) A written response for the initial acknowledgment of the grievance is sent within 7 to 10 days of the person filing the grievance. 4.) A written resolution is sent within a stated number of days, but will not exceed 30 days unless notification is sent to the complainant prior to the expiration of the above stated period. The Director of Risk Management or designee will develop a written response to the patient. 5.) A copy of the completed Grievance From Written Complaint and response letter will be sent to the Chief Compliance Officer or the hospital's General Counsel for review before being mailed to the person filing the grievance. Record review of the Department of State Health Services (DSHS) Complainant Investigative Report (CIR) TX 00212197 revealed that Patient #1's mother/guardian alleged complaints towards the facility which included a substantive quality of care issues, and a perceived violation of her daughter/patient's (#1) rights when she received services on 01/13/2015 to 01/20/2015. Record review of the facility's Complaints and Grievances specific for Patient #1 revealed the facility had received the same alleged complaints	X 795		

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X 795	Continued From page 6	X 795		

and grievance letter (TX 00212197) towards the facility regarding her daughter's/Patient #1's care while an inpatient at the facility from 01/13/2015 to 01/20/2015. Further review revealed this letter was sent and postmarked from the sender/complainant on 02/02/2015 (over 60 days ago) to the Patient Advocate at the address of the facility that provided the services and care to Patient #1 from 01/13/2015 to 01/20/2015.

Record review of the letter provided to this surveyor from Patient #1's mother/guardian/complainant revealed a letter of acknowledgment by the facility's Director of Risk Management, dated 03/08/2015 (over 30 days from the post mark of 02/02/2015); acknowledging receipt of Patient #1's/complainants concerns. Further review revealed the concerns were received by the Quality Review Department, and the complainant could expect a written response within 30 days.

Further review of the facility's Complaints and Grievances specifically for Patient #1 revealed the facility's Risk Manager sent an acknowledgment letter to the complainant that was dated 03/11/15 (over 30 days from the post mark of 02/02/2015) that stated the facility would send a written response within 30 days. Review on 04/09/15, over 30 days from the letter sent to the complainant dated 03/08/15, revealed there was no documentation that a written resolution was sent to the complainant or a completed investigation regarding her complaints and grievances towards the facility.

During an interview on 04/08/15 at 3:50 PM with Director of Risk Management indicated she did not know exactly what day she received the

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X 795	Continued From page 7 complaints and grievance from Patient #1's mother/guardian regarding her daughters services from 01/13/15 to 01/20/15 but stated that Patient #1 was readmitted a second time I February (02/10/15) and, "by that time had the letter." The Director of Risk Management indicated she sent an acknowledgment letter in March 2015 and was still investigating the mother's allegations in the letter. Further interview on 04/09/15 at 1:30 PM with the Director of Risk Management confirmed she was over the 30 days to send a written response to Patient #1's mother/guardian/complainant; in accordance with the facility's Complaint and Grievances Policy stating she missed it. The Director of Risk Management indicated she was responsible to ensure the completion and investigation of the Grievance process; and she had delegated this grievance investigation (TX 00212197) to the facility's Patient Advocate, who no longer was employed at the facility and had not completed this grievance resolution. During a phone interview on 04/09/15 at 8:55 AM with Patient #1's guardian/mother/complainant stated she received a letter dated 03/08/2015 from the Director or Risk Management acknowledging receipt of her concerns/complaints. The complainant stated the letter indicated she would receive a written response within 30 days. Further interview revealed that the complainant had not yet received a written response regarding her alleged allegations regarding her daughter's care and services from her visit dated 01/13/2015 to 01/20/2015.	X 795		

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X 795	Continued From page 8 2.) Record review of the DSHS CIR TX 00212197 revealed that Patient #1's mother/guardian alleged written complaints towards the facility, undated, that indicated on January 17th 2015; Patient #1 "had a sore throat. I told the nurse she said she would tell the Doctor. The next day (01/08/15) I visited; she could hardly talk or swallow. Told [Nurse A] the nurse, he said did I want a medical Doctor to see her; I said yes. They said the Doctor ordered her Lozenges and they're giving her them. I said I want the Doctor to check her for strep throat. [Nurse A] said okay, he'd put the request in. When I visited on Monday [01/19/15] no one had seen her [Patient #1]. Complained again the nurse said, Oh they didn't come in today yet. So on Tuesday [01/20/15] she was checked out [discharged] with No Doctor seeing her. That night I had to take her to [a local hospital] and they said she has strep throat." Record review of Patient #1's medical record revealed the following Physician Orders: 01/17/15: Telephone Order (TO) for Cepacol lozenges every 2 hours for sore throat. 01/19/15 at 0700 TO from Psychiatrist A for a "med [medical] consult for sore throat to [rule out] r/o infection." Record review of Patient #1's medication administration records revealed she was administered Acetaminophen 325 milligrams as follows for sore throat pain: 01/17/15 at 1009 with a pain scale of 7, 01/17/15 at 1754 with a pain scale of 0, 01/19/15 at 0824 with a pain scale of 2, and 01/20/16 at 0752 with a pain scale of 8.	X 795		

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X 795	Continued From page 9 Record review of Patient #1's Psychiatrist Progress notes revealed Patient #1 complained to him during assessment of a sore throat on 01/18/15 and 01/19/15. Review of Patient #1's medical record revealed she was discharged on 01/20/15 at 1840; had not been seen for a medical consult for sore throat to r/o infection prior to her discharge and had not been physically assessed. During an interview on 04/08/15 at 4:45 PM with the Advanced Nurse Practitioner (ANP) stated that Patient #1 should have had a med consult before she was discharged on 01/20/15 or within 24 hours of the TO written on 01/19/15 at 0700. ANP stated that she has experienced communication issues from the weekend nurses to notify her when a med consult was needed. During a phone interview on 04/09/15 at 8:55 AM with the complainant, Patient #1's mother/guardian, indicated that her daughter was never seen for assessment or treatment prior to her discharge on 01/20/15 despite repeated requests for assessment by a Doctor. The complainant stated she took her daughter to the hospital on 01/20/15 following discharge from the facility where her daughter was diagnosed with "Strep throat" and prescribed antibiotics for 10 days.	X 795		
X1036	133.47(c)(2) Posting requirements Abuse And Neglect Issues. Abuse and neglect of individuals with mental illness, and illegal, unethical, and unprofessional conduct.	X1036	3) 133.47 c Posting Requirements Corrective Action: Signage with TxDSHS complaint line will be posted in the lobby at both BH campuses and on each patient unit. Temporary signs will be up in these locations no later than 5/15/15 and	7/1/15

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X1036	Continued From page 10 The requirements of this subsection are in addition to the requirements of subsection (b) of this section. Posting requirements. A facility shall prominently and conspicuously post for display in a public area that is readily visible to patients, residents, volunteers, employees, and visitors a statement of the duty to report abuse and neglect, or illegal, unethical or unprofessional conduct in accordance with HSC, §161.132(e). The statement shall be in English and in a second language appropriate to the demographic makeup of the community served and contain the number of the department's patient information and complaint line at (888) 973-0022. This Requirement is not met as evidenced by: Based on observation and interview, the facility failed to prominently and conspicuously post for display in a public area that is readily visible to patients, residents, volunteers, employees, and visitors; a statement of the duty to report abuse and neglect, or illegal, unethical or unprofessional conduct in accordance with the Texas Health and Safety Code (HSC), and ensure the statement contains the number of the department's patient information and complaint line at (888) 973-0022. This deficient practice affected the rights of Patients. Findings included: Observation conducted on 04/08/15 at 12:15 PM of the facility's lobby/waiting area revealed a	X1036	permanent signs will be up by 7/1/15. This will be completed by the Director of Risk Management.	

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X1036	Continued From page 11 poster of Patient's Rights dated 09/01/2013. The posting failed to contain a statement of the duty to report abuse and neglect, or illegal, unethical or unprofessional conduct in accordance with the HSC §161.132(e); and failed to ensure it contained the number of the Texas Department of State Health Services patient information and complaint line at (888) 973-0022. Further observation conducted on 04/08/15 at 3:40 PM throughout the facility did not reveal a posting of the department's (DSHS) patient information and complaint line phone number, or a statement of the duty to report abuse and neglect, or illegal, unethical or unprofessional conduct in accordance with the HSC §161.132(e). During an interview on 04/09/15 at 1:45 PM with the facility's Risk Manager confirmed the department's (DSHS) patient information and complaint line phone number (888-973-0022) were not posted in the facility or a statement of the duty to report abuse and neglect, or illegal, unethical or unprofessional conduct in accordance with the HSC §161.132(e).	X1036		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ B. WING _____	C 04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 000	INITIAL COMMENTS The CMS - 2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates and the signature space. Any discrepancy in the original deficiency citation (s) will be reported to Dallas Regional Office (RO) for referral to the Office of Inspector General (OIG) for possible fraud if information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. An unannounced visit was completed from 04/08/15 to 04/09/15 to conduct a complaint investigation survey (TX 00212197). An entrance conference was conducted in the conference room of the facility. In attendance were the Director of Social Services, and the Vice President of Clinical Services. The purpose and process of the complaint survey were discussed and an opportunity for questions was provided. Complaint TX 00212197 was substantiated with deficiencies cited. An exit conference was conducted in the afternoon of 04/09/15 in the facility conference room. The Director of Risk Management was in attendance. Preliminary findings of the survey were discussed and an opportunity for questions was provided.	A 000		
A 119	482.13(a)(2) PATIENT RIGHTS: REVIEW OF GRIEVANCES [The hospital must establish a process for prompt	A 119	1) 482.3 a 2 Patient Rights: Review of Grievances: Corrective Action: Updated signage in the NMC mailroom and statement with address included in the patient handbooks. Signage in NMC mailroom will be installed and BH	5/15/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: SUP COO — (X6) DATE: 5/1/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 118	Continued From page 1 resolution of patient grievances and must inform each patient whom to contact to file a grievance.) The hospital's governing body must approve and be responsible for the effective operation of the grievance process, and must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure prompt resolution of grievances, and the governing body failed to ensure the effective operation of the grievance process to review and notify complainants of the resolution within 30 days; as indicated by the facility's Complaints and Grievances policy for 1 of 1 patient (#1) reviewed for grievances. Specifically, Patient #1's mother/guardian/ complainant had written a grievance post marked to the facility 02/02/15. The facility's Risk Manager sent an acknowledgment letter to the complainant dated 03/08/15 (over 30 days) stating the facility would send a written response within 30 days. On 04/09/15 (over 30 days) there was no documentation that a written resolution was sent to the complainant or a completed investigation regarding her complaints and grievances. This deficient practice affected Patient #1's rights when the facility failed to address concerns, complaints, and grievances related to the patient rights, safety, and satisfaction. Findings included: Record review of the facility's Patient Complaints and Grievances Policy, last reviewed 11/2013	A 119	patient handbooks will be updated by 5/15/15 and completed by the Director of Risk Management.	

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A 119	Continued From page 2 revealed the following: Grievances: 1.) Upon receipt of a grievance, the receiving department will indicate the date of receipt and sent the grievance to Quality/Risk Department. 2.) The Director of Risk Management or designee will investigate all grievances. 3.) A written response for the initial acknowledgment of the grievance is sent within 7 to 10 days of the person filing the grievance. 4.) A written resolution is sent within a stated number of days, but will not exceed 30 days unless notification is sent to the complainant prior to the expiration of the above stated period. The Director of Risk Management or designee will develop a written response to the patient. 5.) A copy of the completed Grievance From Written Complaint and response letter will be sent to the Chief Compliance Officer or the hospital's General Counsel for review before being mailed to the person filing the grievance. Record review of the Department of State Health Services (DSHS) Complainant Investigative Report (TX 00212197) revealed that Patient #1's mother/guardian alleged complaints towards the facility which included a substantive quality of care issues, and a perceived violation of her daughter/patient's (#1) rights when she received services on 01/13/2015 to 01/20/2015. Record review of the facility's Complaints and Grievances specific for Patient #1 revealed the facility had received the same alleged complaints and grievance letter (TX 00212197) towards the facility regarding her daughter's/Patient #1's care while an inpatient at the facility from 01/13/2015 to 01/20/2015. Further review revealed this letter was sent and postmarked from the	A 119		

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A 119	Continued From page 3 sender/complainant on 02/02/2015 (over 60 days ago) to the Patient Advocate at the address of the facility that provided the services and care to Patient #1 from 01/13/2015 to 01/20/2015. Record review of the letter provided to this surveyor from Patient #1's mother/guardian/complainant revealed a letter of acknowledgment by the facility's Director of Risk Management, dated 03/08/2015 (over 30 days from the post mark of 02/02/2015); acknowledging receipt of Patient #1's/complainants concerns. Further review revealed the concerns were received by the Quality Review Department, and the complainant could expect a written response within 30 days. Further review of the facility's Complaints and Grievances specifically for Patient #1 revealed the facility's Risk Manager sent an acknowledgment letter to the complainant that was dated 03/11/15 (over 30 days from the post mark of 02/02/2015) that stated the facility would send a written response within 30 days. Review on 04/09/15, over 30 days from the letter sent to the complainant dated 03/08/15, revealed there was no documentation that a written resolution was sent to the complainant or a completed investigation regarding her complaints and grievances towards the facility. During an interview on 04/08/15 at 3:50 PM with Director of Risk Management indicated she did not know exactly what day she received the complaints and grievance from Patient #1's mother/guardian regarding her daughters services from 01/13/15 to 01/20/15 but stated that Patient #1 was readmitted a second time f	A 119		

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A 119	Continued From page 4 February (02/10/15) and, "by that time had the letter." The Director of Risk Management indicated she sent an acknowledgment letter in March 2015 and was still investigating the mother's allegations in the letter. Further interview on 04/09/15 at 1:30 PM with the Director of Risk Management confirmed she was over the 30 days to send a written response to Patient #1's mother/guardian/complainant; in accordance with the facility's Complaint and Grievances Policy stating she missed it. The Director of Risk Management indicated she was responsible to ensure the completion and investigation of the Grievance process; and she had delegated this grievance investigation (TX 00212197) to the facility's Patient Advocate, who no longer was employed at the facility and had not completed this grievance resolution. During a phone interview on 04/09/15 at 8:55 AM with Patient #1's guardian/mother/complainant stated she received a letter dated 03/08/2015 from the Director or Risk Management acknowledging receipt of her concerns/complaints. The complainant stated the letter indicated she would receive a written response within 30 days. Further interview revealed that the complainant had not yet received a written response regarding her alleged allegations regarding her daughter's care and services from her visit dated 01/13/2015 to 01/20/2015.	A 119		
A 468	482.24(c)(2)(vii) CONTENT OF RECORD: DISCHARGE SUMMARY	A 468	2) 482.24 c 2 vii Content of Record: Discharge Summary Corrective Action: For all new medical diagnoses the APN will immediately consult with attending psychiatrist and pending approval will be added by the APN immediately in axis as part of the	5/15/15

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A 468	Continued From page 6 [All records must document the following, as appropriate:] Discharge summary with outcome of hospitalization, disposition of care and provisions for follow-up care. This STANDARD is not met as evidenced by: Based on record review and interview, the hospital failed to include a discharge summary with an outcome of hospitalization, a disposition of care, and provisions for follow-up care for 1 of 1 Patient (#1) reviewed. Patient #1's discharge summary completed by the Psychiatrist did not include her newly diagnosed Diabetes Mellitus (DM) made by the Advanced Nurse Practitioner (ANP); or the follow-up care recommended for her Primary Care Physician (PCP) by the ANP. This deficient practice could affect Patient #1's overall health by failure to follow-up and seek treatment of her health conditions. Findings Included: Record review of Patient #1's medical record revealed she was admitted on 01/13/15 and discharged 01/20/15 at 18:40. On 01/17/15 the facility's ANP assessed Patient #1's laboratory results for a Hemoglobin, A1C at 7.24 (normal results less than 6.5) and indicated that she had "DM". ANP documented that she would place Patient #1 on a 2000 American Diabetes Association (ADA) diet, have the dietician see patient before discharge, and documented that Patient #1 needed to follow up with her PCP.	A 468	discharge summary. Ongoing compliance will be checked daily via nursing 12 and 24 hr chart checks. All nursing staff will be in-serviced by Behavioral Health Nursing Administration by 5/15/15	

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A 468	Continued From page 6 Record review of Patient #1's Interdisciplinary Education completed by the Dietician dated 01/19/15 revealed in part; Patient #1 "is newly diagnosed with diabetes, HA1C 7.24, [Registered Dietician] RD discussed principles of a diabetic diet. Also revealed meal plan for 2000 ADA. [Patient] Pt. was responsive to information given. Provided written educational materials in chart for child/parent review upon discharge." Record review of Patient #1's Discharge Summary dated 01/20/15 completed by the Psychiatrist revealed discharge diagnosis for AXIS III: Medical problems were- "Asthma, gastro esophageal reflux disease (GERD)." The Discharge Summary diagnosis did not include Diabetes Mellitus as diagnosed by the ANP on 01/17/15. Record review of the Discharge Instructions dated 01/20/15 presented and signed by Patient #1's mother/guardian revealed only "Follow-up appointments" were for the Psychiatrist and Individual Therapist appointments. Further review for the area of Follow-up appointments for Primary Care Physician was documented "Deferred." Record review of Patient #1's written complaint completed by her mother/guardian, undated, revealed when her daughter was discharged on 01/20/15; "they did blood work on her [Patient #1] and never told me she has Diabetes. My daughter told me, I confronted the nurses, they said they don't tell me; papers are sent home when she leaves; and that it's not that bad." Record review of the facility's Medical Staff Bylaws; Rules and Regulations approved by the	A 468		

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A 468	Continued From page 7 Board of Control May 31, 2013, revealed the following; Where there is need of a discharge summary, a clinical resume covering the necessary five (5) points including the final diagnosis and authenticated by the attending Practitioner is sufficient to exclude the completion of the face sheet. Necessary five (5) points: (1) Why was the patient admitted? (2) Pertinent findings. (3) What was done? Procedures performed and treatment rendered (4) Condition on discharge. (5) Instructions, including medications, diet, physical activity, if any, and follow-up. During an interview on 04/08/15 at 4:45 PM with the ANP, she stated that she diagnosed Patient #1 with DM on 01/17/15 following her laboratory test results, Hemoglobin A1C; positive for Diabetes. ANP stated she wanted Patient #1 to follow-up with her PCP following discharge because she did not want to initiate medication therapy that she was not able to monitor. ANP confirmed Patient #1's Discharge Summary and Instructions dated 01/20/15 failed to document her new diagnosis of Diabetes Mellitus and the recommended follow-up with her PCP. ANP stated that the nurse completing the Discharge Instructions did not pick that up from her record and the Psychiatrist did not add it to her final diagnosis upon discharge. During an interview on 04/09/15 at 8:55 AM with Patient #1's mother/guardian revealed she was not told when her daughter was discharged on 01/20/15 that she had Diabetes; or that she	A 468		

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A 468	Continued From page 8 needed to follow-up with her PCP.	A 468	3) 782.43 d Transfer or Referral Corrective Action:	
A 837	482.43(d) TRANSFER OR REFERRAL The hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care. This STANDARD is not met as evidenced by: Based on a record review and interview, the hospital failed to ensure that discharge instructions included the referral for follow-up care as ordered by the Advanced Nurse Practitioner (ANP) along with the necessary medical information. Patient #1's discharge summary completed by the Psychiatrist did not include her newly diagnosed Diabetes Mellitus (DM) made by the ANP on 01/17/15; or the follow-up care recommended for her Primary Care Physician (PCP) by the ANP. This deficient practice could affect Patient #1's overall health by failure to follow-up and seek treatment of her health conditions. Findings Included: Record review of Patient #1's medical record revealed she was admitted on 01/13/15 and discharged 01/20/15 at 18:40. On 01/17/15 the facility's ANP assessed Patient #1's laboratory results for a Hemoglobin, A1C at 7.24 (normal results less than 6.5) and indicated that she had "DM". ANP documented that she would place Patient #1 on a 2000 American Diabetes Association (ADA) diet, have the dietician see	A 837	For all new medical diagnoses the APN will immediately consult with attending psychiatrist and pending approval will be added by the APN immediately in axis as part of the discharge summary. At discharge nursing staff will document education to patient and or guardian (as appropriate) for need and recommended follow-up with PCP. Ongoing compliance will be checked daily via nursing 12 and 24 hr chart checks. All nursing staff will be in-serviced by Behavioral Health Nursing Administration by 5/15/15.	5/15/15

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A 837	Continued From page 9 patient before discharge, and documented that Patient #1 needed to follow up with her PCP. Record review of the Discharge Instructions dated 01/20/15 presented and signed by Patient #1's mother/guardian revealed only "Follow-up appointments" were for the Psychiatrist and Individual Therapist appointments. The area of Follow-up appointments for Primary Care Physician was documented "Deferred." Further review revealed discharge diagnosis for AXIS III: Medical problems were- "Asthma, gastro esophageal reflux disease (GERD)." The Discharge Summary diagnosis did not include Diabetes Mellitus as diagnosed by the ANP on 01/17/15. Record review of Patient #1's written complaint completed by her mother/guardian, undated, revealed when her daughter was discharged on 01/20/15; "they did blood work on her [Patient #1] and never told me she has Diabetes. My daughter told me, I confronted the nurses, they said they don't tell me; papers are sent home when she leaves; and that it's not that bad." Record review of the facility's Medical Staff Bylaws; Rules and Regulations approved by the Board of Control May 31, 2013, revealed the following; Where there is need of a discharge summary, a clinical resume covering the necessary five (5) points including the final diagnosis and authenticated by the attending Practitioner is sufficient to exclude the completion of the face sheet. Necessary five (5) points: (1) Why was the patient admitted?	A 837		

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A 837	Continued From page 10 (2) Pertinent findings. (3) What was done? Procedures performed and treatment rendered (4) Condition on discharge. (5) Instructions, including medications, diet, physical activity, if any, and follow-up. During an interview on 04/08/15 at 4:45 PM with the ANP, she stated that she diagnosed Patient #1 with DM on 01/17/15 following her laboratory test results, Hemoglobin A1C; positive for Diabetes. ANP stated she wanted Patient #1 to follow-up with her PCP following discharge because she did not want to initiate medication therapy that she was not able to monitor. ANP confirmed Patient #1's Discharge Summary and Instructions dated 01/20/15 failed to document her new diagnosis of Diabetes Mellitus and the recommended follow-up with her PCP. ANP stated that the nurse completing the Discharge Instructions did not pick that up from her record and the Psychiatrist did not add it to her final diagnosis upon discharge. During an interview on 04/09/15 at 8:55 AM with Patient #1's mother/guardian revealed she was not told when her daughter was discharged on 01/20/15 that she had Diabetes; or that she needed to follow-up with her PCP.	A 837		

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

P.O. Box 149347
Austin, Texas 78714-9347
1-888-963-7111

DAVID L. LAKEY, M.D.
COMMISSIONER

TTY: 1-800-735-2989
www.dshs.state.tx.us

Texas Department of State Health Services
Health Facility Compliance Group-San Antonio
2303 SE Military Drive, Bldg 514
San Antonio, TX 78223
Mail Code: 1979

December 16, 2014

NIX Health Care System
414 Navarro, Suite 600
San Antonio Texas 78205

Dear Administrator:

Enclosed are the CMS 2567 and the Statement of Deficiencies forms listing those deficiencies found at your facility on 11-19-14. Please develop a plan of correction for each deficiency cited and return to this office (within ten (10) calendar days from receipt of this letter).

In the space provided on the forms, please provide a plan of correction and completion date for each deficiency. After completing the forms, sign and date at the bottom of page one of each form and return to the address above. It will be necessary to make copies for your records, please make a copy of the Statement of Deficiencies for your records prior to completing the Plan of Correction on that form.

The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should by the provider/supplier; the State Survey Agency (SA) should be notified immediately.

PLEASE DO NOT PUNCH HOLES

An approved plan of correction is requisite to continued program participation. You will be notified only if your plan of correction is unacceptable. Certification of your facility cannot be recommended to the Centers for Medicare/Medicaid Services until I have received the completed forms. Therefore, I am requesting that you give this matter priority and that you return the forms to the address above within ten (10) calendar days from receipt of this letter. If you have any questions, do not hesitate to contact my office.

Sincerely,

/S/

Larrie Collier, HFC Manager
Health Facility Compliance Group-San Antonio
(210)531-4946
larrie.collier@dshs.state.tx.us

LC/js
Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ B. WING _____	C 11/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS The CMS - 2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates and the signature space. Any discrepancy in the original deficiency citation (s) will be reported to Dallas Regional Office (RO) for referral to the Office of Inspector General (OIG) for possible fraud if information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. An unannounced visit was conducted on 11/10/14 to conduct a complaint investigation survey. An entrance conference was conducted in the conference room of the facility. In attendance was the Vice President of Behavioral Health Care and the Patient Advocate. The purpose and process of the complaint survey were discussed and an opportunity for questions was provided. Complaint TX 00203333 was substantiated in the area of patient rights with related standard level deficiencies cited. An exit conference was conducted in the afternoon of 11/19/14 in the facility conference room. The Director of Risk Management was in attendance. Preliminary findings of the survey were discussed and an opportunity for questions was provided.	A 000	Plan of Correction: All Admission, Assessment, Social Work and Nursing Staff will receive formal inservice training to include an attestation to the effect that they have been educated on the legal specifics related to patients with guardians. Staff will demonstrate an understanding of Proper notifications and consents which must be provided to and received from the patient's guardian related to patient's admission, inpatient care and receipt of psychotropic and other medications. The staff member who discovers that a patient has a guardian, regardless of their position, will immediately: 1. Notify the Nursing Supervisor as well as their immediate supervisor upon discovery that the patient has a guardian 2. Contact the Admissions office to inform that patient's guardian must be notified to sign all forms pertaining to the patient's admission and subsequent treatment modalities 3. Work with Supervisor and Admissions staff to ensure that admission, medication and all other consents are reviewed with and signed by the patient's guardian 4. Attempt to acquire copies of legal documents that name the patient's guardian and place such documents in the patient's medical record	
A 131	482.13(b)(2) PATIENT RIGHTS: INFORMED CONSENT The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care	A 131		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Chief Quality & Compliance Officer 12/23/2014

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 131	Continued From page 1 planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate. This STANDARD is not met as evidenced by: Based on record reviews and interviews, it was determined the facility failed to follow their Informed Consent Policy and Procedure that would ensure one of one patient's (patient #1) guardian was given the right to make informed decisions regarding consent to the use of psychotropic medications. This had the potential to affect any patient who had a guardian and was placed on psychotropic medications. Findings included: Record review on 11/10/14 of Informed Consent Policy and Procedure, last reviewed by facility in February 2011, revealed but was not limited to the following: "Written Consent: A written consent form is to be used to obtain authorization prior to the procedure or treatment. When completed, the form serves as a record and evidence that the patient authorized the procedure and accepted the associated risks as disclosed by the physician. Persons under Guardianship (adults or minors): All persons under legal custody of a guardian or conservator shall have permits signed by their legal guardian (as guardian) and a certified copy of his/her official letters of guardianship shall be obtained and placed in and become part of the patients' permanent medical record, prior to receiving treatment."	A 131	5. Ensure that all signed consents received from the patient's guardian are placed in patient's medical record as soon as they are completed Additionally, a form will be developed and approved by forms committee and implemented to ensure that every effort is made to determine whether any patient requiring admission to our services has a guardian, so that appropriate consents will be received prior to a patient's admission. Completion date for the training and implementation of this process: January 15, 2015	

12-23-2014

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A 131	Continued From page 2 Record review on 11/10/14 of Patient #1's medical record revealed but was not limited to the following: "Annual Report On Condition and Well-Being of Ward and Oath of Guardian signed by Patient's guardian [mother] on 05/07/2014." Patient #1 was documented to have "Mental Retardation" and deemed an Incapacitated person. Record review on 11/10/14 of Patient #1's medical record revealed Consents for Treatment with Psychotropic Medication for Risperdal, dated 08/09/14, for Depakote Extended Release (ER), dated 08/09/14, and Valium, dated 08/11/14. The consents for Risperdal and Depakote ER documented Patient #1 gave verbal consent. The consent for Valium had Patient #1 signing his first name. The guardian did not sign Consents to Treatment with Psychotropic Medication forms. Interview on 11/19/14 at 1:30 PM with Social Worker #1 confirmed she was aware that Patient #1 had a guardian. She stated that information is given to the nursing staff by the social work staff and then it is up to the nursing staff to obtain consents from the guardian.	A 131		

12-23-2014

TRANSMISSION VERIFICATION REPORT

TIME : 05/21/2014 15:21
NAME : NIX HEALTH
FAX : 2102712023
TEL : 2102712188
SER.# : BROJ1J311189

DATE,TIME	05/21 15:19
FAX NO./NAME	9-15128346620
DURATION	00:01:29
PAGE(S)	06
RESULT	OK
MODE	STANDARD ECM

nix HEALTH

FAX:

To:	Glenn Crow/Ginger Smith Texas Department of State Health Services
Fax number:	512-834-6620

From:	Blake Hubbard
Fax number:	210-271-2023
Phone number:	210-579-3133

Date:	May 21, 2014
Number of pages: (including cover)	6

Comments: Please see the attached Plan of Correction

The information contained in the FAX may be confidential and/or privileged. This FAX is intended to be reviewed initially

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

DAVID L. LAKEY, M.D.
COMMISSIONER

P.O. Box 149347
Austin, Texas 78714-9347
1-888-963-7111
TTY: 1-800-735-2989
www.dshs.state.tx.us

May 19, 2014

John Striby, Administrator
Nix Behavioral Health Center
1975 Babcock Rd.
San Antonio, TX 78229

Re: Nix Behavioral Health Center 45-0130

Dear Mr. Striby:

Enclosed are the CMS 2567 form listing deficiencies found at your facility on May 14, 2014, and the guidance sheet on How To Write An Acceptable Plan of Correction. Please develop a plan of correction for each deficiency cited and return to this office within (ten) 10 calendar days from receipt of this letter. **In the space provided on the forms, provide a plan of correction and completion date for each deficiency. After completing the forms, sign and date at the bottom of page one of each form and return the original to the address above.** It will be necessary to make copies for your records. **An approved plan of correction is requisite to continued program participation. You will be notified only if your plan of correction is unacceptable.** It will be necessary to make copies for your records. Certification of your facility cannot be recommended to the Centers for Medicare/Medicaid Services until I have received the completed forms. Therefore, I am requesting that you give this matter priority and that you return the forms to the address above within ten (10) calendar days from receipt of this letter. *Please include the above mail code in addressing your correspondence to this office to ensure prompt delivery.* If you have any questions, do not hesitate to contact my office.

To expedite approval, please forward a copy of your plan of correction to this office by fax. Our fax number is (512) 834-6620. If we can be of further assistance, please contact this office at (512) 834-6649.

Sincerely,

Glenn Crow, Architect
Architectural Review Group
Regulatory Licensing Unit

GC/gns

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING 01 - NIX BEHAVIORAL HEALTH CENTER B. WING _____	05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A life safety code (LSC) investigation survey was conducted on site on 5/14/2014. An entrance conference was held for the Vice President of Facility Operations on 5/14/2014 to discuss the purpose of the LSC survey, and the survey process was explained. Instructions were provided on writing plans of correction. An opportunity was provided for questions and discussion. The LSC survey was conducted under the authority of Chapter 2 of the State Operations Manual, Appendix A, Acute Care Hospitals, 42CFR482 to determine the Hospital ' s compliance. An LSC exit conference was conducted on 5/14/2014 in the hospital. In attendance were the Vice President of Facility Operations and the Security Officer. The preliminary findings of the survey and the next steps in the survey process were explained. An opportunity was provided for questions and discussion.	K 000		
K 029	NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 This STANDARD is not met as evidenced by: Based on observation the facility failed to provide adequate hazardous area separation. The inspector observed, while accompanied by	K 029	This item has been corrected. The door closing and latching mechanism was adjusted and repaired such that automatic closing and latching was achieved. Completed May 20, 2014. Ongoing monitoring of door function is accomplished through environmental rounds and inspections. These rounds are performed by a multi-disciplinary group, including facilities, security and nursing personnel. The individual responsible for assuring ongoing compliance will be our Senior Vice President and Chief Operating Officer.	05/20/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X8) DATE
Blake W. Hubbard, FACHE	Senior Vice President & COO	05/21/2014

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

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K 029	Continued From page 1 the Vice President of Facility Operations and the Security Officer during the hours of the inspection from 10:00 am to 12:15 pm on 5/14/2014 that there was the following issue. The soiled utility door at the " A " wing on the second floor did not close and latch properly.	K 029		
K 034	NFPA 101 LIFE SAFETY CODE STANDARD Stairways and smokeproof towers used as exits are in accordance with 7.2. 18.2.2.4 This STANDARD is not met as evidenced by: Based on observation the facility failed to provide adequate stair enclosures. The inspector observed, while accompanied by the Vice President of Facility Operations and the Security Officer during the hours of the inspection from 10:00 am to 12:15 pm on 5/14/2014 that the stairs were being used for storage of construction materials. The following stairs had storage inside of the enclosure, Stair " B " and " D ". " There shall be no enclosed, usable space within an exit enclosure, including under stairs, nor shall any open space within the enclosure be used for any purpose that has the potential to interfere with egress. " NFPA 101, 2000, 7.2.2.5.3.	K 034	This item has been corrected. Items found in the stairwell were related to ongoing renovation project. Items have been removed. Contractors educated as to requirements for egress routes to be clear of obstructions and storage. Nix Health Security to monitor daily to assure clear egress is maintained. Item corrected as of May 20, 2104. The individual responsible for assuring ongoing compliance will be our Senior Vice President and Chief Operating Officer.	05/20/2014
K 211	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers shall have a minimum spacing	K 211	This item has been corrected. The alcohol based hand rub dispensers have been removed and relocated to an appropriate location. Facilities staff educated as to the appropriate installation of such dispensers. Item corrected as of May 20, 2014. The individual responsible for assuring ongoing compliance will be our Senior Vice President and Chief Operating Officer.	05/20/2014

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K 211	Continued From page 2 of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 18.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 This STANDARD is not met as evidenced by: Based on observation the facility failed to provide an acceptable location for alcohol based hand rub dispensers. The inspector observed, while accompanied by the Vice President of Facility Operations and the Security Officer during the hours of the inspection from 10:00 am to 12:15 pm on 5/14/2014 that there were alcohol based hand rubs above or immediately adjacent to electrical switches in the nurse station on the first floor.	K 211		
K9999	FINAL OBSERVATIONS Staff Did Not Have Keys to Locked Fire Extinguisher Cabinets " Physical environment. A physical environment that protects the health and safety of patients, personnel, and the public shall be provided in each facility. The physical premises of the facility and those areas of the facility's physical structure that are used by the patients (including all stairwells, corridors, and passageways) shall meet the local building and fire safety codes and subchapters F and G of this chapter. " - 2004, §134.122 (d)(1)(C). Based on observation the facility failed to provide	K9999	This item has been corrected. All staff were surveyed to ascertain their possession/access to keys necessary to perform their roles within their assigned unit. Any employee found not to have the appropriate keys were immediately issued keys and in-serviced on the associated use and responsibilities. This action was completed on May 20, 2014. Further a multi-disciplinary team, including Administration, Security, Facilities and Nursing has been formed to review the processes surrounding the issuance and use of keys within the facility and units. This team has been charged with a process redesign to assure that all staff have access to necessary keys while on duty. The team will also address unit safety and security and key control.	06/13/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K9999	Continued From page 3 adequate keys to the staff for the locked fire extinguisher cabinets. The inspector observed, while accompanied by the Vice President of Facility Operations and the Security Officer during the hours of the inspection from 10:00 am to 12:15 pm on 5/14/2014 that there was the following issue. The inspector asked a nurse on the staff if she could open up one of the locked fire extinguisher cabinets. She was not able to open up the cabinet because she had not been issued a key. The Security Officer stated that the locks had been changed and new keys had not been issued.	K9999	The team has been given until June 13, 2014 to implement new and improved processes. The individual responsible for assuring ongoing compliance will be our Senior Vice President and Chief Operating Officer.	
	Window Screens " In building housing for certain types of patients, detention rooms, or a security section, the facility shall provide detention screens to confine or protect building inhabitants, when necessary. " - 2004, §134.122 (n)(3)(A)(viii)(II) Based on observation the facility failed to provide adequate window screens. The inspector observed, while accompanied by the Vice President of Facility Operations and the Security Officer during the hours of the inspection from 10:00 am to 12:15 pm on 5/14/2014 that there were no window screens on the second floor windows that were directly above the Adolescent Recreation Area. One of the windows had been broken out by a patient throwing a football when within the Recreation Area.		This item in in process. The window screens had been ordered on April 30, 2014. These screens are currently in the manufacturing process. The screens will be delivered and installed by June 6, 2014. The individual responsible for assuring ongoing compliance will be our Senior Vice President and Chief Operating Officer.	06/06/2014

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

DAVID L. LAKEY, M.D.
COMMISSIONER

P.O. Box 149347
Austin, Texas 78714-9347
1-888-963-7111
TTY: 1-800-735-2989
www.dshs.state.tx.us

HOW TO WRITE AN ACCEPTABLE PLAN OF CORRECTION

The content of the plan of correction should include the following information:

Who, by title, will be responsible for the plan? DO NOT USE PROPER NAME
What is the plan going to be?
How is the plan going to be implemented?
How is ongoing compliance going to be monitored?

Once you have the answer to the questions listed above, you are ready to document that information on the statement of deficiencies:

* **Begin each plan of correction in the second column of the statement of deficiencies and plan of correction form next to the tag number (i.e. G224).**

* **Type or write legibly the plan that you have developed.**

* **List the date the deficiencies will be corrected in the far right column:**

  If there are no condition-level deficiencies, the date listed must be within 60 days of the survey date listed on top of the form.

  If there are conditions-level deficiencies, the correction date for deficiencies should be within 30 days or less of the survey date. This will allow sufficient evidence for review by surveyors when a follow-up visit is conducted after the 45th day.

* **Each deficiency must have a plan of correction.**

The administrator or responsible person must sign the first page of the statement of deficiencies and plan of correction form, including their title and the date. Return deficiencies with plans of corrections to:

Texas Department of State Health Services
Architectural Review Group – Austin – Mail Code 2835
Attention: Ginger Smith
PO Box 149347
Austin, TX 78714-9347

An Equal Employment Opportunity Employer and Provider

PRIVACY NOTIFICATION/NOTIFICACION SOBRE PRIVACIDAD

With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 522.021, 522.023, 559.003 and 559.004)

Tan solo por unas cuantas excepciones, usted tiene el derecho de solicitar y de ser informado sobre la informacion que el Estado de Texas reune sobre usted. A usted se le debe conceder el derecho de recibir y revisar la informacion al requerirla. Usted tambien tiene el derecho de pedir que la agencia estatal corrija cualquier informacion que se ha determinado sea incorrecta. Dirijase a http://www.dshs.state.tx.us para mas informacion sobre la Notification sobre privacidad. (Referencia: *Government Code*, seccion 522.021, 522.023, 559.003 y 559.004)

* * * Communication Result Report (Jan. 3. 2014 4:38PM) * * *

Fax Header) NIX Hospital

Date/Time: Jan. 3. 2014 4:37PM

File No.	Mode	Destination	Pg(s)	Result	Page Not Sent
1101	Memory TX	95314533	P. 5	OK	

Reason for error
E. 1) Hang up or line fail
E. 2) Busy
E. 3) No answer
E. 4) No facsimile connection
E. 5) Exceeded max. E-mail size

nix HEALTH

FAX:

To:	Ms Pamela Justice via Sarah Clair
Fax number:	210 531-4533

From:	Adele Giles, SVP, Quality & Compliance
Fax number:	210 587-8141
Phone number:	210 579-3200

Date:	1/3/2014
Number of pages: (including cover)	5

Corrective action plan attached -

Thank you

Adele Giles

The information contained in the FAX may be confidential and/or privileged. This FAX is intended to be reviewed initially by only the individual named above. If the reader of this TRANSMITTAL PAGE is not the intended recipient or a representative of the intended recipient, you are hereby notified that any review, dissemination or copying of this FAX or the information contained herein is prohibited. If you have received this FAX in error, please immediately notify the sender by telephone and return this FAX to the sender at the address below.

Nix Medical Center ■ 414 Navarro, San Antonio, TX 78205 ■ 210.271.1800
Nix Specialty Health Center ■ 4330 Vance Jackson, San Antonio, TX 78230 ■ 210.579.3600
Nix Alamo Heights ■ 5907 Broadway, San Antonio, TX 78209 ■ 210.824.5130
Nix Primary Care Center ■ 700 S. Zarzamora, San Antonio, TX 78207 ■ 210.569.3090
Nix North Orthopaedics Center ■ 9150 Huebner Road, San Antonio, TX 78240 ■ 210.351.6500
Nix Home Care ■ 4402 Vance Jackson, Suite 140, San Antonio, TX 78230 ■ 210.341.0505

nixhealth.com

nix HEALTH

FAX:

To:	Ms Pamela Shelton / Ms Sarai Collier
Fax number:	210 531-4533

From:	Adele Giles, SVP, Quality & Compliance
Fax number:	210 587-8141
Phone number:	210 579-3200

Date:	1/3/2014
Number of pages: (including cover)	5

Corrective action plan attached -

Thank you

Adele Giles

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Nix Medical Center ■ 414 Navarro, San Antonio, TX 78205 ■ 210.271.1800
Nix Specialty Health Center ■ 4330 Vance Jackson, San Antonio, TX 78230 ■ 210.579.3800
~~**Nix Alamo Heights** ■ 5307 Broadway, San Antonio, TX 78209 ■ 210.824.3130~~
Nix Primary Care Center ■ 700 S. Zarzamora, San Antonio, TX 78207 ■ 210.569.7090
Nix North Orthopaedics Center ■ 9150 Huebner Road, San Antonio, TX 78240 ■ 210.351.6500
Nix Home Care ■ 4402 Vance Jackson, Suite 140, San Antonio, TX 78230 ■ 210.341.0505

nixhealth.com

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

DAVID L. LAKEY, M.D.
COMMISSIONER

1100 W. 49th Street • Austin, Texas 78756
1-888-963-7111 • http://www.dshs.state.tx.us
TDD: 512-458-7708

December 20, 2013

Administrator of:
Nix Health Care
414 Navarro, Suite 600
San Antonio, TX. 78205

Dear Administrator:

In reference to the complaint survey conducted at your facility on December 17, 2013, enclosed is the Statement of Deficiencies, for state licensure, which lists the deficiencies cited. **In the space provided on the forms, please provide a plan of correction and completion date for each deficiency. After completing the forms, sign and date at the bottom of page one of each form and return to the address below.** It will be necessary to make copies for your records. **An approved plan of correction is requisite to continued program participation.** Certification of your facility cannot be recommended to the Centers for Medicare and Medicaid Services (CMS) until I have received the completed forms. Therefore, I am requesting that you give this matter priority and that you return the forms to the address below within 10 calendar days from receipt of this letter. If you have any questions, do not hesitate to contact my office.

Sincerely,

/s/ Pam Shelton for
Larrie Collier
Program Administrator
2303 SE Military Drive Bldg. 514
San Antonio, TX. 78223

CJ/PS
Enclosure

Texas Department of State Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000415	A. BUILDING: _____ B. WING _____	C 12/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
X 000	INITIAL COMMENTS Note: The State Form is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be referred to the Office of the Texas Attorney General (OAG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. An unannounced visit was conducted on 12/09/13 to conduct a complaint investigation. An entrance conference was conducted in the conference room of the facility . In attendance was the Vice President of Behavioral Health. The purpose and process of the complaint survey were discussed and an opportunity for questions was provided. Complaint TX 00185836 was unsubstantiated with unrelated state licensure violations cited. An exit conference was conducted in the afternoon of 12/17/13 in the facility conference room. The Vice President of Behavioral Health, The Director of Risk Manager, and The Nurse Manager was in attendance. Preliminary findings of the survey were discussed and an opportunity for questions was provided.	X 000		
X 286	133.41(j)(5) Legible, complete entries Medical record services. The hospital shall have a medical record service that has administrative responsibility for medical records. A medical record shall be maintained for every individual who presents to the hospital for evaluation or treatment. Medical record entries must be legible, complete, dated, timed, and authenticated in written or	X 286		

Texas Department of State Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000415	A. BUILDING: _____ B. WING _____	C 12/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
X 286	Continued From page 1 electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures. . This Requirement is not met as evidenced by: Based on record review and interview, the facility failed to ensure that for one of one patient (Patient #1) clinical records reviewed, all entries were signed, dated and times in accordance with facility policy. Findings included: Record review on 12/09/13 of Patient #1's clinical record revealed the following: Patient #1 was admitted to the facility on 09/13/13 and discharged from the facility on 09/ 20/13. A Pre-Admission Comprehensive Assessment Tool was signed by Physician #1 but was not dated or timed. This Pre-Admission Comprehensive Assessment Tool had a space for a facility social worker to sign and date but was left blank. The Admission Orders and Physician Certification was signed by Physician #1 but was not dated or timed. A Psychiatrist's Progress Note was signed and dated by the physician but no time for the note was noted. Record review on 12/09/13 of three Consents for Psychoactive Medication (Ativan, Risperdal, and Ambien) revealed they were signed by Patient #1 but not dated or timed.	X 286	1. On 1-2-2014, Admission orders policy and procedure was revised: "If the order is a verbal or telephone order, the order is authenticated by the Physician within 48 hours." 2. All physicians in department of psychiatry were re-educated on timing requirements for authentication of telephone/verbal orders. This education was completed on 1-2-2014. 3. Signage reminding physicians and staff to date and time all entries were posted on units 1-2-2014. 4. Date and time "flags" were ordered on 1-2-2014. The flags will be in place and implemented by 1-10-2014. 5. Facility Director of Social Work will re-educate social work staff on requirements for signing, dating, and timing the pre-admission comprehensive assessment tool. This was completed by 1-3-2014. 6. Nursing staff was in-serviced on the requirement to obtain both date and time in addition to patient signature on	

Texas Department of State Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000415	A. BUILDING: _____ B. WING _____	C 12/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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X 286	Continued From page 2 Record review on 12/17/13 of Admission Orders Policy and Procedure, last reviewed January 2012, revealed the following: If the order is a verbal or telephone order, the co-signature by the physician occurs within 24 hours. Orders are always signed with name, credential, date, and time. Record review on 12/17/13 of Inquiry and Preadmission Assessment Policy and Procedure, last reviewed January 2012, revealed the following: Upon admission, assessments, when appropriate and feasible while the family is available, a licensed, masters level therapist and/or social worker meets with the family so they can contribute data concerning the patient's psychosocial history and also receive information about the program. If this is not feasible, the psychosocial history is scheduled within 72 hours of admission. An LMSW or LCSW reviews and completes all psychosocial histories. Interview on 12/17/13 at 10:50 AM with the facility Director of Medical Records confirmed that all entries in Patient #1's clinical record described above should have been signed, dated and timed per facility policy.	X 286	the consent of treatment with psychoactive medication. This was completed by 1-3-2014. Medical staff was in-serviced on this requirement at the Department of Psychiatry Meeting on 1-2-2014. The "consent to treatment with psychoactive medication" form will be revised to include a line for "time." Currently the form only has a line for date. This will be completed and implemented by 1-7-2014. To demonstrate sustained compliance, a minimum of 30 charts will be reviewed in a 4 month period with goal of 90% compliance for all entries to be dated and timed. - # of dated & timed entries / # of entries.	

CERTIFICATE OF NEED

RESPONSE TO DEFICIENCIES DATED OCTOBER 30, 2015 AND NOVEMBER 12, 2015

Eastern Connecticut Health Network, Inc.
Proposed Asset Purchase by
Prospect Medical Holdings, Inc.

OHCA Docket Number: 15-31216-486
Attorney General Docket Number: 15-486-01

November 23, 2015

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Office of
HEALTHCARE ACCESS

November 23, 2015

VIA HAND-DELIVERY

Office of the Attorney General
55 Elm Street
P.O. Box 120
Hartford, Connecticut 06141-0120
Attn: Gary W. Hawes, Assistant Attorney General

Office of Health Care Access
Department of Public Health
410 Capitol Avenue
Hartford, Connecticut 06134
Attn: Steven W. Lazarus, Health Care Analyst

Re: Eastern Connecticut Health Network, Inc.
Proposed Asset Purchase by Prospect Medical Holdings, Inc.
OHCA Docket Number: 15-31216-486
Attorney General Docket Number: 15-486-01

Dear Mr. Hawes and Mr. Lazarus:

Eastern Connecticut Health Network, Inc. and Prospect Medical Holdings, Inc. (the "Applicants") hereby submit the enclosed responses to the completeness questions issued by the Office of the Attorney General and the Office of Health Care Access in two separate letters to the Applicants: the first dated October 30, 2015 and the second dated November 12, 2015.

At your request, one (1) hard copy and one (1) electronic copy have been provided to each Office. Per the instructions in the letter dated October 30, 2015, the information requested in Question 39 of that letter has been provided only in electronic form.

If you have any questions or need anything further, please feel free to contact Rebecca Matthews at (203) 498-4502 or Melinda Agsten at (203) 498-4326. Thank you for your assistance in this matter.

Sincerely,

Wiggin and Dana LLP

By _____
Rebecca A. Matthews
Its Partner

By _____
Melinda A. Agsten
Its Partner

cc: Kevin Hansted, Staff Attorney, Department of Public Health Division of Office of Health Care Access
Kimberly Martone, Director of Operations, Department of Public Health Division of Office of Health Care Access
Perry Zinn Rowthorn, Deputy Attorney General, Office of the Attorney General
Dennis P. McConville, Senior Vice President and Chief Strategy Officer, Eastern Connecticut Health Network, Inc.
Thomas M. Reardon, President, Prospect Medical Holdings-East, Inc.
Frank Saidara, Vice President, Corporate Development, Prospect Medical Holdings, Inc.
Jonathan Spees, Senior Vice President, Corporate Development, Prospect Medical Holdings, Inc.
Joyce Tichy, Senior Vice President and General Counsel, Eastern Connecticut Health Network, Inc.
Michele M. Volpe, Esq., Bershtein, Volpe & McKeon, P.C

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On October 30, 2015 and November 12, 2015, Eastern Connecticut Health Network (□ECHN□) and Prospect Medical Holdings (□PMH□ and, together with ECHN, the □Applicants□) received correspondence from the Office of the Attorney General (□OAG□) and the Office of Health Care Access (□OHCA□) re□uesting additional clarification for certain deficiencies identified in the Application submitted on October 13, 2015. The Applicants□ response to the deficiencies identified on October 30, 2015 has been provided below; the Applicants□ response to the deficiencies identified on November 12, 2015 begins on page 2204:

1. Page 23 of the Application and Section 2.05(b) of the proposed Asset Purchase Agreement (□APA□) state that if ECHN obtains, prior to the Closing Date, an assumable loan in an amount not to exceed □45 million to refinance certain of its outstanding bond liabilities (the □Refinancing Loan□), PMH will pay □115 million instead of □105 million for the assets of ECHN, subject to certain adjustments. The same section of the APA states that if ECHN obtains the Refinancing Loan and spends less than □10M on capital projects that could be counted toward the □75 million Commitment Amount under Section 5.18 of the APA, the purchase price of □115 million would be reduced by the difference between □10 million and the amount spent on such capital projects. With respect to these provisions, please answer the following:

   a) Has ECHN obtained the Refinancing Loan and, if not, what is the status of its efforts in this regard and how likely is it that the Refinancing Loan will be obtained before the Closing Date□

      Response:

      ECHN has not obtained the Refinancing Loan. There are no plans to obtain the Refinancing Loan at this time, however ECHN reserves the right to pursue obtaining the proposed Refinancing Loan should the need arise prior to the Closing Date.

   b) If ECHN has obtained the Refinancing Loan, what is the loan amount, how much of the loan amount has been expended on capital projects as of the date of ECHN□s response and what is the likelihood that □10 million of the new capital will be expended before the Closing Date□

      Response:

      As stated in the response to Question 1a above, ECHN has not obtained the Refinancing Loan. ECHN is, however, seeking to secure a bank loan of □5 million to cover the cost of planned capital projects and, if received, expects to expend the full amount prior to the Closing Date. If the bank loan is secured, and the planned projects are completed prior to the closing, the purchase price will be

increased by $5 million to reflect the increased value of ECHN that will result from the investment in these planned capital projects and the Commitment Amount would be reduced by $5 Million. If the planned projects have not been completed by the time of the closing of the transaction, then an amount equal to $5 million minus the amount spent on such planned capital projects shall be transferred to PMH. In essence, PMH has agreed to pre-fund a portion of its Commitment Amount.

c) Please provide detail on the improvements to ECHN's OB and Behavioral Health facilities that the $10 million is intended to be expended on.

Response:

In February 2015, four physicians from Mansfield OB/GYN Associates joined the ECHN Medical staff and began performing deliveries at Manchester Memorial Hospital ("MMH"). The added demand for OB services increases the number of annual deliveries expected at MMH to 1,500 per year which has resulted in a need to add capacity to MMH's birthing center. To address this need, MMH has discussed a plan to add three labor delivery recovery and postpartum (LDRP) beds to the fifteen beds currently available. The addition of these LDRP beds will require the coordination of various relocations, including (i) the relocation of existing physician sleep rooms on the birthing unit to an adjacent area that will still provide the physicians with easy accessibility to the birthing center; and (ii) relocation of MMH's Health Information Management staff. The cost for the project has been estimated at $1.7 million. Although ECHN had initially planned to begin the project in the short term and to fund the project with proceeds from the planned Refinancing Loan, a decision has been made to further discuss the plans as part of the overall capital budget to be developed with PMH post-closing. In the meantime, ECHN will continue to utilize the Third West nursing unit as an obstetrics overflow to accommodate postpartum patients when demand for labor and delivery beds on the maternity unit is at or near the unit's capacity.

At Rockville General Hospital ("RGH"), designs have been developed to renovate the former maternity unit to accommodate up to 30 patients with behavioral health conditions. The cost of that project has been estimated to be $5 million. The Department of Public Health was consulted on the design in order to ensure that the unit would be compliant with current building codes to ensure the safety of this patient population. The unit will incorporate the finishes, hardware and security equipment recommended by the Department of Public Health. The renovations will begin in December and are expected to be completed by September 2016.

2. Section 4 of the Letter of Intent ("LOI") states that the joint venture interests of ECHN subject to transfer to PMH, except for Metro Wheelchair Services, Inc., have been valued at a six (6) times multiple of FY2014 EBITDA.

   a) Please explain how and why the parties determined the 6X multiple to be appropriate.

   Response:

   The parties determined the 6X multiple based on their substantial mergers and acquisitions industry experience, independent valuations of similar facilities at other PMH locations, and independent fair market valuations of the joint ventures which were completed by ECHN in 2014.

   b) Please provide the aggregate value of the joint venture assets using this valuation method and the value ascribed to each individual joint venture asset under this methodology.

   Response:

   Please refer to **Exhibit A** for a schedule showing the joint venture valuations as of September 30, 2014.

   c) Please provide an update on the status of the transfer of these interests (e.g., for which joint ventures have the JV partners of ECHN agreed to a transfer if the asset purchase is consummated).

   Response:

   The effort to obtain consents from joint venture partners to sell the joint venture interests of ECHN and its affiliates is ongoing. To date, consents have been obtained from Harford Hospital to permit the transfer of MMH's ownership interests in Ambulance Service of Manchester, LLC, Aetna Ambulance Service, Inc., and Metro Wheelchair Service, Inc.

   For the following joint ventures, meetings are being scheduled to formalize the consents requested by ECHN. Walden Behavioral Care has indicated its consent to the transfer of ECHN's membership in WBC East, LLC and this consent is in the process of being documented. The operating agreement for Evergreen

Endoscopy Center, LLC allows for ECHN to sell its membership in that company. The real estate joint venture members have consented to allow ECHN to sell its memberships in Haynes Street Medical Associates, LLC, Haynes Street Medical Associates II, LLC, Evergreen Medical Associates, LLC and Haynes Street Medical Associates II, LLC. The re□uest for consent to sell ECHN□s membership in Connecticut Occupational Partners, LLC (COMP) was raised at its recent Board Meeting and action will be taken at its next meeting.

Meetings for the member representatives of Northeast Regional Radiation Oncology Network, Inc. and the member representatives of Tolland Imaging Center, LLC have been scheduled to decide on the transfer of ownership interests of MMH and RGH in those companies.

3. The LOI at Section 5 and the APA at Section 2.05(d) provide that if, on the Closing Date, ECHN has more than □77 million of liabilities under Scenario A (purchase price of □105 million) or □122 million of liabilities under Scenario B (purchase price of □115 million) other than long-term debt, PMH shall assume such excess liabilities provided it is reimbursed dollar-for-dollar by ECHN from its Available Cash (to the extent the Available Cash exceeds □1 million) and the □4.5 million Indemnity Reserve established under Section 9.8 of the APA. If the Indemnity Reserve is exhausted and there are still additional liabilities to assume, PMH will assume up to an additional □10 million of such liabilities and reduce its □75 million Commitment Amount by that amount. PMH also has the option to assume more than □10 million of ECHN□s remaining debt and offset those additional amounts from the Commitment Amount. Please respond to the following □uestions regarding that option:

   a) Do the figures in Table 8 of the Application (p. 88) reflect all liabilities of ECHN□

      Response:

      The figures presented in Table 8 of the Application reflect both the liabilities to be assumed by PMH and the long-term debt liabilities to be paid off by ECHN at closing. ECHN may be left with some additional liabilities that are not paid at closing, including, for example, liabilities from prior Medicare and Medicaid cost reports. Because these liabilities are not known and are not being assumed by PMH, they are not reflected in the figures in Table 8.

   b) Did the parties consider a cap on reductions to the Commitment Amount□

Response:

It should be noted that if ECHN does not have sufficient cash to discharge all of its liabilities, ECHN will not be in a position to close the transaction. The parties conducted a forecast of cash at closing. Although the parties anticipate sufficient cash to enable ECHN to close, there is a possibility that ECHN will not have sufficient cash at time of the closing if there is a deterioration of ECHN's financial performance during the Certificate of Need and for-profit conversion process. As such the parties discussed and negotiated various alternatives to enable ECHN to close in the event that it did not have sufficient cash. A cap on the reductions to the Commitment Amount was discussed.

c) If the answer to the above question is no, why was no such cap considered? If the answer is yes, why was no cap instituted?

Response:

The Commitment Amount is part of the consideration and the purchase price for the assets of ECHN as described in the APA. Furthermore, any increase in the amount of liabilities assumed by PMH is considered an increase in the consideration and the purchase price for ECHN's assets.

After good faith negotiations between the parties, PMH agreed to increase the purchase price for the assets by $10 million in the event that ECHN does not have sufficient cash to close the transaction, which increase would be offset by a corresponding reduction in the Commitment Amount. This concession by PMH is significant because PMH essentially agreed to pay more for the assets of ECHN in the event that ECHN underperforms on its operations. In essence, PMH has agreed to potentially pay more for assets that would be worth less because of a deteriorating financial condition of ECHN. From an enterprise value perspective, and without taking the Commitment Amount into account, the purchase price offered by PMH exceeds the high value determined by Duff & Phelps by $32 million. If the Commitment Amount is taken into account, the total consideration exceeds the high enterprise value by $107 million. In the event that ECHN's operations deteriorate and, assuming that the enterprise value of ECHN does not change, PMH may potentially pay $42 million above ECHN's value (without taking the Commitment Amount into account). It is only due to an increase in purchase price and the exhaustion of all other sources of cash that the Commitment Amount may be reduced.

It should be noted that PMH views the Commitment Amount as the minimum that it would spend for capital expenditures at ECHN. If there is a need to spend more

on such projects that will contribute to ECHN's growth, PMH plans to make such additional capital investments.

4. Table 8 of the Application provides a net proceeds analysis of the funds payable to ECHN from the asset purchase. Please update the Assumed Liabilities and other line items of the table to reflect the net proceeds analysis under Scenarios A and B as of the date of your response to this Completeness Letter and confirm whether or not the line item for the underfunding of ECHN's pension plan will change between the date of your response and September 30, 2016. Please also:

Response:

An update of the Net Proceeds Analysis (Table 8), including the Assumed Liabilities and other line items, has been provided as **Exhibit B**.

With regard to the pension plan, the Applicants cannot determine at this time if the amount underfunded will increase or decrease between the date of the Applicants' response and September 30, 2016. This is primarily driven by the interest rate market which the Applicants are not able to predict.

a) Describe the cause and estimated amount of any other changes to the Assumed Liabilities line item amounts that may occur between the date of your response and the Closing Date.

Response:

The line items that ECHN expects to change between now and the Closing Date are Capital Leases and Long Term Debt. The budget for fiscal year 2016 has no provision for new debt (although the $5 million loan discussed in the response to Question 1 has been included in the estimates in Table 8 "Scenario B" already) nor does ECHN plan to incur new Capital Lease Obligations over the next fiscal year. ECHN plans to pay down the existing Capital Lease Obligations and Long Term Debt, so the expectation is to have the Capital Leases and Long Term Debt line items decrease between now and the Closing as outstanding principal payments are applied. The other line items to track are the net working capital "true-up" and cash and investments. When one increases the other is expected to decrease and vice versa, however the net of two should remain fairly consistent through the next year as ECHN manages to cash flow neutral. A reliable estimate of any changes to the captive and workers compensation programs is not feasible at this time, but the Applicants do not expect any material change in the amounts projected for these line items.

b) Comment on the likelihood of the $75 million Commitment Amount being substantially reduced under the terms of the APA given ECHN's unfunded pension liabilities, level of debt and declines in cash and cash equivalents as set forth in its FY 2014 financial statements and Table 8 of the Application.

Response:

It is difficult to forecast whether the pension underfunding amount will increase or decrease, but ECHN estimates that the amount of variation from what has been presented in Table 8 is not expected to change materially. In addition, ECHN FY 2016 budget does not include new debt and thus debt (both assumed and paid down at closing) will decrease. If any new debt is incurred, it will be debt that PMH is assuming and also adjusting the price accordingly. Finally, cash flow is budgeted to be neutral in FY 2016. Based on each of these different assumptions and projections, there would be no reduction to the capital commitment as there would be sufficient cash to pay down the outstanding debt not assumed.

c) If the $75 million Commitment Amount is substantially reduced by what means and under what timetable would the proposed capital projects described at page 31 of the Application be funded by PMH?

Response:

The capital projects described on page 31 of the Application are examples of capital projects that may be funded by PMH. After closing, PMH will develop a specific capital plan in consultation with the Local Boards and medical staff. This plan will prioritize capital projects and service improvements given the capital funding available. The goal will be to establish priorities based on maintaining or providing access to needed services that allow for the optimum care and coordination of care within and across the community. The plan and priorities will be evaluated periodically by PMH, and adjustments made based on changes in funding available and capital needs, with input from the Local Board and medical staff.

5. Please provide a copy of PMH's written response to the February 19, 2015 Request For Proposal set forth at Exhibit Q5 to the Application, including, without limitation, the responses to the questions and other items listed at pages 229 to 232 thereof from the Visions

and Operations section to the section entitled Additional Information Due Diligence Required.

Response:

Please refer **Exhibit C** for a copy of PMH's written response to the February 19, 2015 Request for Proposal.

6. The LOI provides in Section 9 that the parties agree to enter into a Consulting Agreement, to be effective 30 days after the parties have made any required Hart-Scott-Rodino Act filing, pursuant to which PMH "would provide operational support to ECHN's leadership." The parties also state that "ECHN agrees to reasonably consent to make recommended operational changes" pursuant to the Consulting Agreement. Please elaborate on the content and purpose of the Consulting Agreement by providing specific examples of the type of operational support that would be offered, the operational changes PMH is likely to make and provide a copy of the Consulting Agreement if one is available.

Response:

Attached as **Exhibit D** is a draft copy of the proposed Consulting Agreement. The purpose of the Consulting Agreement is to provide additional support to ECHN's management team to improve its operations and to prepare ECHN to implement PMH's Coordinated Regional Care strategy ("CRC"). For a complete description of support services, please refer to the Consulting Agreement. Please note that the Consulting Agreement has not yet commenced.

Under the terms of the Consulting Agreement, ECHN's Board and management will retain full authority over the operations of ECHN prior to Closing, and PMH will not have authority to make any operational changes during that time. PMH may make recommendations to ECHN, and if ECHN believes that the recommendations are reasonable, in the best interests of ECHN, and improve the operations of ECHN, then ECHN may implement such recommendations.

One key area that the parties intend to focus on during the consulting engagement is the foundational work required to implement CRC. CRC is the clinical integration among hospitals, physicians and other medical, social and community providers working closely with strategic partner health plans and other payers under a value-based, global risk reimbursement payment system to achieve the triple aim of improved patient care and experience, better patient health, and lower costs.

In anticipation of implementing CRC in Connecticut, PMH, has established a risk-taking entity called Prospect Health Service CT, Inc. and received licensure for the entity from the Connecticut Department of Insurance as a Preferred Provider Network.

7. The Application at page 97 states that PMH will be seeking property and sales tax abatements post-closing for a transition period and that "such abatement is deemed critical to the overall success of the proposed transaction." In connection with these statements:

   a) Please describe the length of the proposed transition period and the particulars of the abatement that will be sought.

   Response:

   As a for-profit health system, PMH will be expected to pay property taxes, sales taxes and income taxes post-closing. Even though PMH does not have the benefits of tax-exemption, PMH has committed to maintain and adhere to ECHN's current policies regarding charity care, indigent care, community volunteer services and community benefits or to adopt other policies that are at least as favorable to the community as ECHN's policies. In essence, PMH is not only required to provide the benefits generally expected from non-profit hospital operators, but is also required to pay the taxes described above even though similarly situated hospital operators would not be responsible for such taxes.

   Although PMH expects that implementation of the CRC model will result in an improved financial outlook for the current ECHN operations, these benefits will take time to realize. If taxes are imposed on PMH before any of these benefits can be obtained, there is a risk that the new tax burden could negatively affect the community in terms of jobs, local vendor payments and other factors which could outweigh the benefits from tax collections. Accordingly, PMH plans to work with the State and local communities to seek temporary relief from the new tax burden. This temporary relief has been deemed appropriate in other states in order to allow a hospital to re-gain its strength for the benefit of its employees and the communities that it serves before taking on the full tax burden.

   Seeking temporary tax relief is a process that necessarily involves the participation of all constituents. PMH is aware of pilot programs where cities receive funds from the State because they host non-profit entities. PMH is in the process of gathering facts that are necessary to formulate a fair proposal for all parties. As such, PMH, at this time, does not have any specific proposals that it can share. PMH will update this response once it has formulated a fair proposal.

   b) Explain why the abatement is deemed critical to the overall success of the proposed transaction.

Response:

Please refer to the response to Question 7a above for the Applicants explanation regarding the need for the abatements post-closing.

c) If PMH is unsuccessful in its negotiations for such an abatement, will there be any changes to the Commitment Amount or PMH s commitment, as noted on page 75, to ensure that MMH and RGH each maintains and adheres to ECHN s current policies regarding charity care, indigent care, community volunteer services and community benefits or adopts other policies that are at least as favorable to the community as ECHN s policies

Response:

PMH is proud of its history of providing health care services to underserved communities. PMH hopes that it will be able to negotiate a fair tax abatement plan that will place all healthcare providers on e ual competitive grounds. However, in the event that PMH is not successful in those negotiations, PMH will continue to honor all of its obligations under the APA (including but not limited to the Commitment Amount), to maintain ECHN s current policies regarding charity care and indigent care and will adopt policies that are at least as favorable to the community as ECHN s policies.

8. The LOI provides in Section 10 that Eastern Connecticut Physician Hospital Organi ation (ECPHO) and Clinically Integrated Network of Eastern Connecticut (CINECT) will enter into a 5-year management agreement with Coordinated Regional Care Group, Inc., a subsidiary of PMH, to implement PMH s Coordinated Regional Care (CRC) strategy. Please provide the number of physicians currently participating in ECPHO and CINECT, respectively, describe any physician participation overlap between these two entities and detail the nature of the management services to be provided by the PMH subsidiary under the agreement. Also, provide a copy of the management agreement if available.

Response:

ECPHO is a nonstock corporation with two members: ECHN and the Eastern Connecticut Individual Provider Group, Inc. (ECIPG). ECIPG is a separately incorporated nonstock corporation that represents two hundred and two (202) physicians in the communities served by ECHN. ECPHO provides administrative, purchasing and other services to its members, including contracting with insurers.

CINECT is a limited liability company, the sole member of which is ECHN. CINECT was formed in 2014 to address changes in the healthcare environment as a result of healthcare reform. The purpose of CINECT is to implement protocols and programs for healthcare providers that promote quality, coordination and efficiency in the delivery of healthcare and to provide management, purchasing and administrative and other services to subscribing providers. There are currently no physician members of CINECT and no contractual relationship between CINECT and ECIPG, so there is no overlap of any physician participation between ECPHO and CINECT. ECPHO continues to provide the management, administrative and other services to ECIPG and its physician members. ECHN and ECIPG had planned to transition these activities to CINECT to better address changes in the healthcare environment due to healthcare reform, but have put these plans on hold, pending the acquisition of ECHN by PMH.

Although a five-year management agreement among ECPHO, CINECT and the PMH Coordinated Regional Care Group was anticipated at the time the LOI was originally signed, the Applicants have since determined not to proceed with such an arrangement. Instead, PMH has established its own Independent Practice Association entity in Connecticut (Prospect Provider Group CT-ECHN, LLC, "PPGCTE") and a Preferred Provider Network/Health System Risk Taking entity (Prospect Health Services, CT, Inc.). These two organizations, through management services agreements with Prospect Medical Systems, Inc., will manage physician participation, risk contracting and care management activities for participating members. Physicians currently represented by ECIPG will make individual and independent decisions regarding their participation in PPGCTE.

The Risk Taking Entity and the Independent Practice Association Management Services Agreements have not been drafted at this time.

9. On page 26 of the Application, Applicants describe the CRC model as being "highly successful in aligning physicians with PMH hospitals and improving quality, efficiency and financial performance in California, and local versions of the model have been implemented in Texas and Rhode Island with similar success." The Application also states that the size of PMH's physician network in these three states encompasses approximately 8,900 physicians. With respect to these statements, please provide the following:

   a) How many physicians participate in PMH's physician networks in California, Texas and Rhode Island, respectively?

      Response:

      Please refer to **Exhibit E** for the number of physicians participating in PMH's physician networks in California, Texas and Rhode Island from 2012 to present.

Please note that the number of physicians reflected in this exhibit includes both fully contracted physicians and physicians who have entered into a Memorandum of Understanding ("MOU") with PMH. The MOUs are generally related to limited services by a physician, provide for a limited period of time for the provision of services and/or are limited to a particular patient for physicians who do not wish to be fully contracted with PMH.

PMH's contracting system is not able to distinguish between MOU physicians and fully contracted physicians. In order to determine how many physicians are fully contracted and how many are part of an MOU requires physical inspection of each agreement. Within the past year, such an exercise was performed to determine the approximate number of fully contracted physicians (8,900).

b) Do the physician networks in each of these states operate as independent practice associations ("IPAs") that contract with a management services organization ("MSO") controlled by PMH or, if there are other models used, please describe the models and the states in which they are used.

Response:

The physician networks for risk taking are all IPAs comprised of employed and independent physicians. The IPAs are managed by PMH-owned MSOs.

c) How will the physician network that PMH seeks to establish in Connecticut differ from those developed in these other states?

Response:

PMH will seek to replicate the same model in Connecticut.

d) For the CRC model developed for the Alta Los Angeles Hospitals in California, provide the number of physicians participating in PMH's physician network for each year from 2007 to present;

Response:

PMH manages its physician networks regionally and not by specific hospital. As such, PMH does not have separate networks for Alta Los Angeles Hospitals and Southern California Healthcare System. Please refer to **Exhibit E** for the number

of physicians participating in PMH's physician network in California for each year from 2012 to present.

Please be advised, PMH changed information technology data systems and data for years prior to 2012 are on legacy systems that are not readily available.

e) For the CRC model developed for the Southern California Healthcare System in California, provide the number of physicians participating in PMH's physician network for each year from 2009 to present;

Response:

Please see the Applicants' response to Question 9d above.

f) For the CRC model developed for the Nix Health System in Texas, provide the number of physicians participating in PMH's physician network for each year from 2012 to present; and

Response:

PMH received and implemented a risk-based contract in Texas approximately one year ago. PMH's network in Texas currently consists of 23 primary care practitioners and 594 specialists. The network remained stable and consistent over the past year.

g) For the CRC model developed for the Prospect CharterCare Hospitals in Rhode Island, where applicants state in Exhibit Q58-1 that PMH developed an IPA and recruited 105 primary care physicians and 270 specialists, please state the number of physicians that were affiliated with these hospitals through IPAs or other physician organizations at the inception of the joint venture.

Response:

There was no IPA at the CharterCARE Hospitals at the inception of the joint venture. Of the 375 physicians recruited to the IPA only 18 were employed by the CharterCARE Hospitals at the inception of the joint venture.

10. Elaborate on whether there is a standard CRC business plan that is used by PMH in the development of IPAs and what specific CRC policies, procedures and processes are implemented for recruiting purposes to reach target amounts of affiliated medical professionals.

Response:

PMH does have a standard business plan by which it approaches each new market. The initial plan entails three work streams that PMH begins working on simultaneously and soon after an acquisition Letter of Intent has been agreed upon with a health system such as EHCN. The three work streams are:

- Regulatory Infrastructure
- Provider Network Development
- Health Plan Engagement

The first two work streams are relevant to answering the question posed.

The first work stream addresses investigating and developing the Regulatory Infrastructure necessary in order for providers to assume and manage value-based risk contracts with health plans under our CRC model. In Connecticut that requires a license as a Preferred Provider Network ("PPN"). Prospect Health Services CT, Inc. received its license to transact business as a Preferred Provider Network from the Connecticut Insurance Commissioner on October 21, 2015.

The second work stream is Provider Network Development which entails identifying and beginning to contract with the provider network described in the PPN application and required by health plans in the market for our PPN to enter into value-based risk contracts. A critical component of this work stream is the development of the IPA affiliated with the health system, in this case ECHN. PMH has formed an IPA called Prospect Provider Group CT-ECHN, LLC. (PPCTE), which will be the ECHN-affiliated IPA. PMH is currently developing the participating agreements for the ECHN-affiliated physicians and will begin contracting the physicians into the IPA in the near future.

The PPN application requires that Prospect Health Service CT, Inc. comply with National Committee for Quality Assurance ("NCQA") network adequacy standards, so those are the standards that PMH will use to gauge the number and type of providers needed to contract in the IPA. PMH has identified the physicians affiliated with ECHN, many of whom already participate in another ECHN-affiliated physician organization. When the contracts are approved for use, PMH will begin contracting those physicians into the IPA. PMH will then recruit any additional providers necessary to meet the requirements of the value-based contracts negotiated with the health plans in Connecticut.

11. PMH's prior hospital acquisitions in California, Texas and Rhode Island have been concentrated in high density urban markets. ECHN's service area population for 2020 is projected to be 356,046 residents. Explain how PMH's experience with the CRC model in high density urban markets will be adapted to a more rural market.

Response:

It is important to note that PMH's operations in California are in four separate and distinct markets. The markets are as follows: (a) South Orange County; (b) Central Orange County; (c) Inland Empire; and (d) Los Angeles. While these counties are populous, the population is spread over a very large geographic area. For example, Orange County is over 948 square miles, the Inland Empire covers over 27,000 square miles, and Los Angeles is over 4,000 square miles. PMH provides services to distinct areas within each county and manages approximately 260,000 lives. PMH does not consider a market service area of 356,046 residents to be rural. PMH believes ECHN's service area is a good size and appropriate for implementation of CRC.

12. On page 76 of the Application and in Figure 3, Applicants indicate that from 2012 to 2014, in Texas and California, PMH reduced hospital bed days per thousand from 1,260 to 720, reduced length of stay from 5.1 days to 3.9 days, dropped admissions per thousand from 245 to 182 and reduced hospital readmissions within thirty days from 19% to 13% for Medicare Advantage participants. This data is provided as evidence of PMH's ability to operate its hospitals efficiently through the CRC model while avoiding unnecessary, inefficient and duplicative services and reducing medical errors. Using these same benchmarks (hospital bed days, length of stay, patient admissions and readmissions) please update Figure 3 to show whether similar reductions have been achieved across all patient populations for each of the healthcare systems owned by PMH in California and Texas over the past 3 years and for Prospect CharterCare Hospitals since 2014. Provide data and detailed explanations on the specific programs, policies and procedures under the CRC model that have been implemented in the PMH member hospitals to reduce hospital stays, admissions and medical errors.

Response:

The referenced data above is largely based on PMH's California experience.

In Texas, PMH's risk-based contract under the CRC model was implemented approximately one year ago. Trends are both encouraging and positive, but show room for improvement. CRC development requires education and training of physicians, patients and other providers across the healthcare continuum and takes several years to implement. PMH expects to achieve similar results in Texas to what has been accomplished in California over time.

Please note that results in California were achieved over two to three years. A summary of performance metrics for Texas can be found in the **Exhibit F.**

Please note that in Rhode Island, PMH began medical management under a risk-based contract in September 2015. As such, there is no data to report at this time. However, because of the programs and systems used, PMH is confident it can produce the same results in Rhode Island and Connecticut.

For an overview of PMH's programs and procedures, please see **Exhibit G**.

13. On page 56 of the Application, Applicants state that "the transaction will allow ECHN the ability to adjust to a rapidly changing healthcare delivery environment and reinvest in itself to continuously improve care coordination, address continued improvement in quality and safety, expand and add needed services, recruit and retain physicians, and improve access to services across its service area." Please explain how implementation of the CRC model will facilitate the expansion and addition of needed services and improve access to services. Specifically focus on examples where PMH opened new outpatient facilities and developed new service lines for the hospitals it acquired in California, Rhode Island and Texas.

Response:

Implementation of the CRC model necessarily requires that a full continuum of care be accessible and available to patients. As part of the implementation process, PMH reviews the services offered by its systems and seeks to enhance or expand services over time. To the extent that a PMH-affiliated system does not provide the full range of services, PMH seeks to add such services or to affiliate with other service providers for the provision of such services, as appropriate. PMH's focus initially will be to:

- Invest in Primary Care/Specialty practices through
  - Attractive physician models that reward quality and service
  - Participation in academic-affiliated residency programs

- Expand Ambulatory Offerings, such as
  - Urgent care facilities
  - Out-patient services/service lines
  - Primary care clinics

Examples of development activities in Texas include:

- Formation of an IPA
- Formation of a Multi-Specialty IPA – Including Integration with Behavioral Health doubling the Behavioral Health service capacity

- Expansion of Hospital-Based Outpatient Clinics
- Purchase of a rural hospital resulting in increased access to care
- Establishment of an Emergency Room; and
- Leasing and converting additional space for expansion of services

In Rhode Island PMH has accomplished the following:

- Purchased 28 primary care clinics, expanding access to care;
- Joint ventured on a radiation-oncology center;
- Expanded cardiac catheteri□ation services

California is a mature market for PMH. Efforts to improve access to services that have been recently accomplished (or are about to be accomplished) include the following:

- Purchased a closed hospital in South Orange County (which PMH reopened in September 2015) to better serve patients who are members of our owned or managed IPAs; and
- Will purchase primary care and multi-specialty clinics to increase access to care

All of the above are examples of service line expansions and improving access to care.

14. In reference to the □Local Board□as described on page 30 of the Application, please provide the following:

    a) Elaborate on recommending authority of the respective Local Boards as described in Sections 5.18 (strategic capital plan), 5.21 (clinical □uality matters), and 5.26 (strategic business plan) of the APA.

    Response:

    PMH and the management of the Hospitals will provide the respective Local Boards with the necessary information to make informed recommendations to PMH with respect to (i) a strategic capital plan (APA Section 5.18), (ii) clinical □uality matters (APA Section 5.21) and (iii) the Strategic Business Plan (APA Section 5.26). PMH will carefully consider the recommendations of the respective Local Boards in its deliberations on those matters, and will collaborate with the Local Boards to ensure that such recommendations are in the best interests of the Hospitals and the System. PMH and the local management of the Hospitals and the System will then seek to implement the recommendations and will provide timely updates to the Local Boards regarding such implementation. The role of the Local Boards will include oversight and responsibility for medical staff credentialing as well as □uality matters.

b) Please clarify how each respective Local Boards of MMH and RGH will function collaboratively in providing recommendations to PMH.

Response:

The Local Boards will be appointed upon the closing of the transaction, and it is anticipated that they will begin operations shortly thereafter. Since the time ECHN was formed, the hospital boards of MMH and RGH have met concurrently with the ECHN parent board. This arrangement ensures common focus for the system while also providing the mechanism for each hospital to handle formal governance business individually as necessary. PMH plans to continue this approach for the two Local Boards by appointing the same individuals to each and having them meet concurrently. As is currently the case with the ECHN Board, tenures on the Local Boards will be predetermined and limited in order to ensure that fresh perspectives are continuously present. PMH expects that the Local Boards will be comprised of community physicians who are active parts of the ECHN Medical staff along with other community members who have demonstrated an active commitment to ECHN s mission to enhance the health of its community. PMH will schedule regular standing meetings to update the Local Boards on clinical uality and strategic matters, to allow the Local Boards to provide feedback on health issues of concern to the community, and to provide a forum for the Local Boards to deliberate and formulate recommendations to PMH. Educational sessions will also be scheduled as appropriate and desired by the Local Boards. In order to ensure that the perspectives of the Local Boards are heard, representatives of PMH and the senior local managers of the System will either sit on both of the Local Boards or attend the meetings of both of the Local Boards. In this way the representatives will be able to facilitate coordination and collaboration among the members of the Local Boards with respect to making recommendations to PMH.

15. On page 66 of the Application, Applicants state that PMH has already begun implementation efforts with respect to its CRC model for ECHN, including formation of an IPA and Board, review of regulatory re uirements, discussions with payers and evaluation of the care delivery network. Please provide the following:

a) the status on the formation of the IPA and the Board;

Response:

The IPA legal entity has been formed as a limited liability company called Prospect Provider Group CT-ECHN, LLC. (PPGCTE). The Chair and the Board of the newly formed IPA are being selected currently and the Board will likely begin to meet in

December. Physician contracting will begin as soon as the Board has approved the participating physician agreements.

b) the opportunities and impediments for utili□ing the CRC model in Connecticut based on regulatory re□uirements;

Response:

The primary CRC regulatory re□uirement for providers assuming and managing value-based risk contracts in Connecticut is licensure as a Preferred Provider Network by the Connecticut Insurance Department. Prospect Health Services CT, Inc. received its license to transact business as a Preferred Provider Network from the Connecticut Insurance Commissioner on October 21, 2015. As such, PMH has already satisfied the main regulatory re□uirement necessary for implementing the CRC model in Connecticut.

That said, one potential impediment to fully implementing the CRC model across geographies is the restriction on the number of medical foundation entities per health system that exists under Connecticut law. Specifically, pursuant to □33-182bb(f) of the Connecticut medical foundation statute, □a hospital, health system or medical school may organi□e and be a member of no more than one medical foundation.□ This statutory restriction does not permit for the formation of separate medical foundation entities by a hospital system that owns multiple hospitals in wholly separate service areas. This restriction is a significant issue for hospital systems that operate in more than one market in that third party payers typically set contract rates, adjudicate claims or limit participation in certain risk sharing arrangements or incentives based on service area. PMH is seeking approval to own three hospitals in two different markets but will have to utili□e a single medical foundation even though the professionals employed in the medical foundation will be in two distinct markets. In order to participate in regionali□ed payer contracts or programs, a medical foundation formed by PMH will need to work with payers to allocate providers under different risk arrangements while maintaining a single tax identification number. Many payors do not have ready systems that can allocate providers to divisions within a single tax identification number, making population health management and risk-based contracting more difficult. There is no easy immediate solution to this problem and PMH□s plan is to try to work closely with payers to develop internal tracking mechanisms by the payer and PMH. However these unnecessary added administrative costs may defeat some of the healthcare savings of the risk model.

c) the substance of discussions with payers; and

Response:

PMH has had preliminary discussions with most of the major payers in Connecticut to introduce PMH's CRC model to them. They have all expressed the desire to work with PMH on value-based contracts such as those preferred in PMH's CRC model. To date, the discussions with payers have been introductory, rather than substantive. However, PMH is optimistic that the discussions will result in most payers embracing the skills and expertise that PMH brings to the Connecticut market in its CRC model.

d) any reports on PMH's evaluation of the care delivery network.

Response:

PMH does not have any written evaluations of the care delivery network. However, PMH filed an application for the Preferred Provider Network as a substantial component of the delivery network and PMH received its PPN license last month. PMH is pleased with ECHN's care delivery network and believes it will provide a substantial foundation for PMH's CRC model in Connecticut.

16. On page 75 of the Application, Applicants disclose that "PMH and ECHN representatives have already met with leadership for Connecticut's Medicaid Program and expressed their desire to work under a risk-based arrangement to provide care to Medicaid recipients." Please provide an update on the status of these discussions. What impact, if any, would there be on the proposed asset purchase if Connecticut's Department of Social Services were to decide not to enter into risk-based arrangements with PMH?

Response:

Since the initial meeting with the Department of Social Services, PMH has not met with representatives of that Department. PMH expects to meet with the Department in the near future. The Applicants would be disappointed if the Department of Social Services decided not to enter into a risk-based arrangement with PMH, but it would not have an impact on the proposed asset purchase.

17. In table format, provide historical volumes (three full fiscal years (FY) and the current year-to-date) for the number of discharges and patient days, by service for MMH and RGH, respectively.

TABLE A
HISTORICAL AND CURRENT DISCHARGES

Manchester Memorial Hospital	**Actual Volume** *(Last 3 Completed FYs)**			
	FY 2013	**FY 2014**	**FY 2015**	**CFY 2016 (October)**
Medical Surgical	5,433	5,223	4,685	407
Maternity	1,233	1,259	1,406	139
Psychiatric	1,444	1,372	1,313	123
Pediatric	1,232	1,256	1,402	135
Total	**9,342**	**9,110**	**8,806**	**804**

** Fiscal Year period runs from October 1 to September 30*
***Only reflects patients categorized as "Newborn" in ECHN's internal Daily Census Report*

Rockville General Hospital	**Actual Volume** *(Last 3 Completed FYs)**			
	FY 2013	**FY 2014**	**FY 2015**	**CFY 2016 (October)**
Medical Surgical	2,567	2,341	2,112	172
Maternity	0	0	0	0
Psychiatric	0	0	0	0
Pediatric	0	0	0	0
Total	**2,567**	**2,341**	**2,112**	**172**

** Fiscal Year period runs from October 1 to September 30*

TABLE B
HISTORICAL AND CURRENT PATIENT DAYS

Manchester Memorial Hospital	**Actual Volume** *(Last 3 Completed FYs)**			
	FY 2013	**FY 2014**	**FY 2015**	**CFY 2016 (October)**
Medical Surgical	29,363	26,169	22,040	1,799
Maternity	3,369	3,412	3,760	355
Psychiatric	10,277	10,866	10,745	890
Pediatric	3,657	3,653	4,147	438
Total	**46,666**	**44,100**	**40,692**	**3,482**

** Fiscal Year period runs from October 1 to September 30*
***Only reflects patients categorized as "Newborn" in ECHN's internal Daily Census Report*

Rockville General Hospital	**Actual Volume** *(Last 3 Completed FYs)**			
	FY 2013	**FY 2014**	**FY 2015**	**CFY 2016 (October)**
Medical Surgical	12,363	11,155	9,873	682
Maternity	0	0	0	0
Psychiatric	0	0	0	0
Pediatric	0	0	0	0
Total	**12,363**	**11,155**	**9,873**	**682**

** Fiscal Year period runs from October 1 to September 30*

18. Complete the following tables for MMH and RGH, respectively, for the first three (full) fiscal years following the proposed asset purchase, if the first year is a partial year, include that as well.

TABLE C
PROJECTED DISCHARGES BY SERVICE

Manchester Memorial Hospital	**Projected Volume with Proposed Asset Purchase***			
	FY 2016	**FY 2017**	**FY 2018**	**FY 2019**
Medical Surgical	4,665	4,846	4,936	5,027
Maternity	1,538	1,538	1,538	1,538
Psychiatric	1,370	1,370	1,370	1,370
Pediatric	1,533	1,533	1,533	1,533
Total	**9,043**	**9,224**	**9,314**	**9,405**

** Fiscal Year period runs from October 1 to September 30*
***Only reflects patients categorized as "Newborn" in ECHN's internal Daily Census Report*

Rockville General Hospital	**Projected Volume with Proposed Asset Purchase***			
	FY 2016	**FY 2017**	**FY 2018**	**FY 2019**
Medical Surgical	2,159	2,191	2,213	2,235
Maternity	0	0	0	0
Psychiatric	0	0	0	0
Pediatric	0	0	0	0
Total	**2,159**	**2,191**	**2,213**	**2,235**

** Fiscal Year period runs from October 1 to September 30*

TABLE D
PROJECTED PATIENT DAYS BY SERVICE

Manchester Memorial Hospital	**Projected Volume with Proposed Asset Purchase***			
	FY 2016	**FY 2017**	**FY 2018**	**FY 2019**
Medical Surgical	22,040	22,040	22,040	22,040
Maternity	3,760	3,760	3,760	3,670
Psychiatric	10,745	10,745	10,745	10,745
Pediatric	4,147	4,147	4,147	4,147
Total	**40,692**	**40,692**	**40,692**	**40,692**

** Fiscal Year period runs from October 1 to September 30*
***Only reflects patients categorized as "Newborn" in ECHN's internal Daily Census Report*

Rockville General Hospital	**Projected Volume with Proposed Asset Purchase***			
	FY 2016	**FY 2017**	**FY 2018**	**FY 2019**
Medical Surgical	9,873	9,873	9,873	9,873
Maternity	0	0	0	0
Psychiatric	0	0	0	0
Pediatric	0	0	0	0
Total	**9,873**	**9,873**	**9,873**	**9,873**

** Fiscal Year period runs from October 1 to September 30*

a) Explain any increases and/or decreases in historical volumes reported in the tables above.

Response:

The decreasing trend in total discharge volume experienced by MMH and RGH from FY 2013 through FY 2015 is, in part, due to an industry-wide trend to shift inpatient care to the outpatient setting.[1] ECHN's struggle to recruit and retain primary care physicians in the communities served by the Hospitals has also contributed to the decline in patient discharges at both facilities. MMH did experience an increase in maternity and pediatric (newborn) discharges and patient days beginning in FY 2015 when an established OB/GYN practice in the region joined ECHN's active medical staff.

Total patient days declined along with the decrease in discharges, but the Hospitals also experienced a decrease in the average length of stay ("LOS") during the same time period which further contributed to the decline in the patient day volume. Ongoing efforts to reduce patient lengths of stay and an industry-wide increase in observation status utilization are primary drivers behind the reduction in the average LOS.[2]

b) Provide a detailed explanation of all assumptions used in the derivation/calculation of the projected volume.

Response:

Inpatient discharges for FY 2016 were based on ECHN's internal budget for the current fiscal year and assumes that inpatient discharges will increase 2.5% from FY 2015 to FY 2016 (3% at MMH and 0% at RGH). The increase in discharges at MMH is directly related to the additional maternity and newborn volume that is expected with the addition of deliveries from the physicians from Mansfield OB/GYN Associates, who joined ECHN's Medical staff midway through FY 2015.

[1] The New Normal: Shift to Outpatient Care, Payer Pressure Hit Hospitals. Modern Healthcare, August 10, 2013. http://www.modernhealthcare.com/article/20130810/MAGAZINE/308109974

[2] Study: Hospital Observation Stays Increase 25 Percent in 3 Years. Kaiser Health News, June 4 2012. http://khn.org/news/study-hospital-observation-stays-increase-25-percent-in-3-years/

As presented in Exhibit Q38-1 (page 1851), with CON approval, total inpatient discharges are anticipated to increase after FY 2016 by the percentages listed below as a result of implementing PMH's CRC model of care delivery:

Entity	Volume Statistics	Projected Growth with CON Authorization		
		FY 2017	FY 2018	FY 2019
PMH ECHN	Inpatient Discharges	1.9%	2.9%	3.9%
	Outpatient Visits	0.1%	0.2%	0.3%
Prospect MMH	Inpatient Discharges	2.0%	3.0%	4.0%
	Outpatient Visits	0.1%	0.2%	0.3%
Prospect RGH	Inpatient Discharges	1.5%	2.5%	3.5%
	Outpatient Visits	0.1%	0.2%	0.4%

The model assumed that increased Medical/Surgical discharges at both facilities will be the primary driver of discharge growth, as both the maternity unit and behavioral health unit are operating at capacity and RGH does not provide either of these services at the present time. Based on this assumption, discharge volume for maternity, pediatric (newborn) and psychiatric services will remain constant at the levels projected for FY 2016 through FY 2019. Medical/Surgical discharges will increase each year, resulting in the overall growth presented in the table above. Efforts currently underway at ECHN, which have historically reduced Medical/Surgical LOS, will continue to reduce patient days through FY 2019 despite the increase in discharges. Based on the continuation of these efforts, it was assumed that patient days would remain at FY 2015 levels throughout the projection period.

19. Please complete the following tables setting forth the number of physicians comprising Active and total members of the medical staffs (Active plus all other staff categories) for both MMH and RGH for the years listed below:

TABLE E
MMH

	2013	**2014**	**2015***
Active Staff	297	308	303
Consulting	13	15	13
Courtesy	49	41	41
Part Time	34	29	36
Allied Health**	**83**	**80**	**93**
Total Physician Staff	**476**	**473**	**486**

** Medical staff totals as of October 31, 2015*

*** Non-physician medical staff personnel (i.e. APRN, Physician Assistant, etc.)*

TABLE F
RGH

	2013	**2014**	**2015***
Active Staff	297	308	303
Consulting	13	15	13
Courtesy	49	41	41
Part Time	34	29	36
Allied Health**	**83**	**80**	**93**
Total Physician Staff	**476**	**473**	**486**

** Medical staff totals as of October 31, 2015*

*** Non-physician medical staff personnel (i.e. APRN, Physician Assistant, etc.)*

Response:

Table E and Table F have been completed to show the number of physicians comprising each medical staff category for ECHN. MMH and RGH have utilized a single medical staff since 1997.

While the overall Medical staff participation total has remained relatively constant year to year, ECHN has struggled to retain individual providers, particularly primary care providers (family medicine and internal medicine):

Specialty	2013		2014		2015*	
	Add	Delete	Add	Delete	Add	Delete
Anesthesiology	4	12	6	5	11	5
Emergency Medicine	5	3	2	4	5	8
Family Medicine	**5**	**6**	**5**	**1**	**2**	**4**
Internal Medicine	**9**	**32**	**14**	**17**	**20**	**18**
Medical Imaging	1	11	3	2	0	1
Obstetrics & Gynecology	2	2	3	7	12	5
Pathology	0	0	0	0	0	0
Pediatrics	2	1	5	3	3	2
Psychiatry	4	4	5	7	2	1
Surgery	6	13	9	12	8	9
TOTAL	**38**	**84**	**52**	**58**	**63**	**53**

20. With respect to ECHN's Medical Foundation, please provide the number of physicians and other allied health professional participants for each year since the inception of the Foundation to the current year to date.

Response:

Table G below provides the number of physicians and other allied health professional participants for ECHN's Medical Foundation since its inception on November 17, 2011. It reflects the number of participants (individuals, not full-time equivalents) as of the calendar-year end-date (December 31) for each year requested.

The decline in the number of participants from 2013 to 2014 is primarily related to ECHN's decision to contract with a third party to provide hospitalist services at the Hospitals.

TABLE G
ECHN's Medical Foundation

	2011	2012	2013	2014	2015
Physicians	60	62	56	40	36
Allied Health Professionals	32	31	36	39	42
Medical Foundation Total	**92**	**93**	**92**	**79**	**78**

** Participant totals as of December 31 of each year except 2015 (totals as of 10/31/2015).*

21. In accordance with the provisions of the Section 5.18 of the APA, PMH may direct some portion of the Commitment Amount to expenditures in support of the recruitment of the Hospitals' medical staff located in the Hospitals' Service Area. Please elaborate on the extent to which ECHN has had difficulty recruiting and/or maintaining medical staff in recent years and how and PMH's experience with the development of its CRC models of care in California, Texas and Rhode Island would demonstrate PMH's ability to effectively grow ECHN's physician network from the 39 community-based physicians and 16 allied health professionals reported to be currently employed by its medical foundation.

Response:

ECHN works continuously to recruit physicians to its medical staff as physicians retire, move away or as needs for physician specialists are identified. The competition among healthcare systems to attract and employ physicians has been intensifying. It is well known that ECHN has been pursuing a transaction to join a larger health care organization. Current medical staff and potential recruits to the medical staff want to know ECHN's future. They want to know that ECHN will be joining an organization that will support their practices. The uncertainty caused by Tenet Healthcare's withdrawal from Connecticut and its planned venture with Yale New Haven Health System to acquire ECHN made an already uncertain healthcare landscape more uncertain. This has made the process of recruiting needed medical staff even more challenging.

Capital investments to support medical staff development are essential to the success of a health system like ECHN. ECHN has been strategic with its deployment of capital to develop medical offices in its communities which help to attract and retain primary and specialty care physicians. Future investments will be needed to develop additional ambulatory sites to house physician practices in the communities served by ECHN. Capital investments in equipment and technology are also important to recruit and support physicians on the medical staff. An example would be ECHN's purchase of robotic technology to assist with surgical procedures, technology that has become expected by today's surgeons.

ECHN has also been creative in establishing programs to recruit physicians. In 2013, ECHN established a Family Practice Graduate Medical Education (GME) Program to help train

primary care physicians with a goal of attracting medical residents to train with the medical staff, become familiar with the communities and practice opportunities at ECHN and encourage them join the medical staff following their post graduate studies. Having sufficient primary care physicians located throughout the service area is critical to effectively addressing the health of the patients served by the network.

For 2013-2014, the ECHN GME program included a total of eleven first year and second year family medicine residents. For 2014-2015, the program included a total of nineteen first year, second year and third year family medicine residents. One of four 2015 graduates joined the ECHN Medical staff. The current 2015-2016 class has a total of twenty-two family medicine residents. It is our hope that some of the six eligible graduates from the current third year class will join the medical staff. It is important to note that PMH supports the continuation of the GME program which will grow in its importance as a resource for primary care providers.

ECHN believes that PMH, through the development of its CRC model, will bring success in meeting the challenges of retaining and recruiting physicians needed for our communities. ECHN considers its physician staff to include all physician and allied health members of the ECHN Medical staff, both employed and independent physicians and allied health professionals, not just those community-based providers currently employed by the Eastern Connecticut Medical Professionals Foundation. The CRC Model will attract and align both employed and independent physicians with the health system and the payer community to the benefit of our patients. CRC is a patient and physician focused model. It is organi□ed to allow for strong physician governance of the Prospect Provider Group CT-ECHN, LLC (PPGCTE) that will result in the physician community having a central role in determining what health services are needed and developed by the health system for patients, as well as overseeing the service and □uality of care of delivered to patients by the PPGCTE. In addition to stronger leadership and governance opportunities, physicians will be supported with care management programs to effectively manage their patients with challenging chronic medical conditions, and to keep their patients well in the appropriate care settings. Finally, PMH brings significant value to physicians with its experience and success with risk-based payment arrangements which will continue to expand and replace the fee-for-service payment system healthcare services.

The value that PMH brings to physicians in the form of experience and competencies under risk-based payment arrangements; capital to invest in facilities, e□uipment, programs and technology; leadership and governance opportunities; and programs to assist in the management of patients will support and grow the ECHN Medical staff.

PMH is a physician friendly company that tries to accommodate physicians□ preferences for practicing medicine. Some physicians prefer to be employed, while others wish to remain independent but would like to work in a hospital environment where they know that independent physicians are valued. There is another subset of physicians who would like to remain independent but work in hospital-based clinics. PMH provides the full menu of

options to physicians. Furthermore, as described in the response to Question 10 above, PMH has been very successful at recruiting physicians, including the most recent success in establishing an IPA in Rhode Island with 105 primary care practitioners and 270 specialist physicians. Of the 105 primary care practitioners in Rhode Island, only 18 were previously employed by the CharterCare System.

22. On page 70 of the Application, PMH and its affiliates commit to "continue support the CHNA [Community Health Needs Assessment] implementation plans [of ECHN] as they are rolled out through 2016." With respect to this statement, please respond to the following:

    a) Please address whether PMH intends to conduct CHNAs after the closing and, if so, whether it intends to conduct them in a manner that meets the requirements of IRS Code Section 501(r), including conducting a CHNA at least once every three years and adopting an implementation strategy to address those identified needs.

       Response:

       PMH will support and implement ECHN's CHNA plans through 2016. For subsequent years, PMH will work closely with ECHN's Local Advisory Boards (comprised of local leaders and physicians) to help assess local community needs and develop effective plans to address such needs.

    b) Describe PMH's experience in conducting CHNAs subsequent to acquiring non-profit, tax-exempt hospitals, specifically, those hospitals located in California and Texas;

       Response:

       PMH has not been required by any state to conduct CHNAs. However, PMH works closely with its Local community advisory Boards (comprised of local physicians and community leaders) to help assess local community needs and develop effective plans to address such needs.

    c) In 2013, MMH and RGH jointly conducted a CHNA. The CHNA identified four priority health needs including heart disease incidence, cancer incidence, diabetes incidence and arthritis incidence. Please provide, for years 2013 to present, the dates, locations, and number of free screenings ECHN conducted for the following:

       i. Blood pressure screenings
       ii. Cholesterol and/or body fat screenings
       iii. Cancer screenings

iv. Diabetes glucose testing

Response:

A list of screenings and educational programs conducted by ECHN for each of the four priority health needs identified in the CHNA has been provided in **Exhibit H**.

d) On page 1783 of the Application, ECHN's CHNA identified additional priority needs, including addressing Alzheimer's, Multiple Sclerosis, substance abuse and childhood lead screening, that ECHN was not able to address due to limited resources. Please elaborate how PMH plans to address these additional identified areas of need.

Response:

PMH will reevaluate the healthcare needs of the community with input from the Local Boards as part of its overall planning process post-closing and expects to prioritize capital projects and service improvements based on hospital and community needs. The goal will be to establish priorities based on maintaining or providing access to needed services that allow for the optimum care and coordination of care within and across the community. Plans to address the priority needs in ECHN's service area will be developed post-closing once the priority needs have been confirmed or identified.

23. Reference is made to the chart below concerning the amount of charity care provided by MMH and RGH from FY 2012 to FY 2014:

	FY 2012	**FY 2013**	**FY 2014**
MMH	$4,953,633	$3,908,882	$2,411,263
RGH	$2,192,753	$1,271,767	$1,188,543

** Source: OHCA Annual Report on the Financial Status of Connecticut's Short Term Acute Care Hospitals (Sept. 2015)*

a) Please explain the reasons for the year over year declines in charity care provided by MMH and RGH.

Response:

Charity care amounts reported by hospitals in OHCA's annual filings report the financial assistance provided to a subset of uninsured patients that apply for charity care and qualify per the hospital financial assistance guidelines. With the implementation of the Affordable Care Act ("ACA") and the expansion of Medicaid eligibility, the number of uninsured patients seen by ECHN has decreased. In addition, following implementation of the ACA, ECHN contracted with an outside vendor to improve the identification of Medicaid eligible patients and to assist those patients with the application process. As a result of these factors, the number of patients who were uninsured and qualified for charity care decreased, which contributed to the reduction in charity care amounts reported to OHCA. More than 60% of the hospitals in Connecticut (including MMH and RGH) also reported a decrease in charity care.[3]

It is important to note that the charity care amounts referenced above only reflect gross revenue (charges) for the uninsured patient population treated by the Hospitals. It is also important to note that with more patients covered by the Medicaid Program, the community benefit reported to the IRS for MMH and RGH has increased, reflecting the uncovered costs for providing services to Medicaid beneficiaries. The level of community benefit provided by a nonprofit hospital is based on the expenses associated with financial assistance provided at cost, the unreimbursed Medicaid services, other community benefit and community building activities of the hospital.

The total community benefit amounts reported for FY 2014 increased 30% at MMH and 10% at RGH compared to FY 2012 levels, despite the impact of the ACA. While the amount of total community benefit reported by MMH in FY2014 was less than the totals reported in FY 2013 (a 4% decline), this was due to a change in IRS instructions effective for FY 2014 that required grant revenue to offset grant program costs. Without this change, the MMH Community Building Activities would have been $1,841,362 and the total community benefit amount would have been $17,221,538 (a 5% increase over FY 2013 amounts). Despite this IRS reporting change the community benefit amount reported for the two ECHN hospitals combined shows an increase in the community benefit totals from FY 2013 to FY 2014:

[3] OHCA Annual Report on the Financial Status of Connecticut's Short Term Acute Care Hospitals (Sept 2015), Table 3, page 10.

Total Community Benefit - MMH	**FY 2012**	**FY 2013**	**FY 2014**
Financial Assistance at Cost *IRS 990 Schedule H Part I, 7a*	□1,602,647	□1,162,736	□577,404
Unreimbursed Medicaid Services *IRS 990 Schedule H Part I, 7b*	□6,221,594	□8,753,602	□8,167,609
Other Community Benefits *IRS 990 Schedule H Part I, 7j*	□2,937,827	□4,670,039	□6,635,163
Community Building Activities *IRS 990 Schedule H Part II, 10*	□1,335,251	□1,760,601	□293,406
Total	**$12,097,319**	**$16,336,978**	**$15,673,582**

Total Community Benefit - RGH	**FY 2012**	**FY 2013**	**FY 2014**
Financial Assistance at Cost *IRS 990 Schedule H Part I, 7a*	□742,084	□367,583	□333,537
Unreimbursed Medicaid Services *IRS 990 Schedule H Part I, 7b*	□3,631,357	□3,505,315	□4,675,911
Other Community Benefits *IRS 990 Schedule H Part I, 7j*	□1,500,538	□1,747,298	□1,414,904
Community Building Activities *IRS 990 Schedule H Part II, 10*	□3,244	□2,901	□19,070
Total	**$5,877,223**	**$5,622,997**	**$6,443,422**

Total Community Benefit – ECHN	**$17,974,542**	**$21,959,975**	**$22,117,004**

ECHN treats patients regardless of their ability to pay for services and hospital policies regarding charity care have not changed. The hospitals continue to provide the same level of financial assistance to patients that □ualify based on need. PMH has committed to continue these ECHN policies. Medicaid expansion and the availability of low-cost insurance plans through the Health Insurance Exchange (created as a result of the ACA) have reduced the number of patients who □ualify for financial assistance at hospitals across Connecticut, including MMH and RGH. Despite this, ECHN has continued to increase the total amount of community benefit that it provides to patients in its service area.

b) Please provide the amount of charity care provided by each hospital for FY 2015.

Response:

In FY 2015, as projected for FY 2015 in Financial Worksheet C, MMH provided charity care in the amount of $2,382,698 and RGH provided charity care in the amount of $1,195,377.

c) Please describe how the proposed asset purchase with PMH can result in an increase in charity care provided by MMH and RGH, respectively, and cite to any examples from PMH's prior non-profit acute care hospital acquisitions where the amount of charity care (not total uncompensated care inclusive of bad debt) has increased from year to year post acquisition.

Response:

With the passage and implementation of the ACA, the amount of charity care for the industry as whole has been declining. As more people are insured, the need for charity care has decreased. PMH remains committed to providing charity care and to maintaining the charity care policies of MMH and RGH.

24. In reference to Table 9 at page 96 of the Application, Applicants identify $27,678 in community based clinical services and $412,862 in health care support services provided by MMH in FY 2014; in reference to Table 10 at page 97, Applicants identify $47,369 in health care support services provided by RGH in FY 2014; and, in reference to Table 11 at page 100, Applicants identify $140,797 and $124,710 in community support and workforce development expenditures by MMH in FY 2014. Please provide the following:

a) A breakout of the services and community building activities associated with each of these amounts;

Response:

A breakout of the services and community building activities associated with the referenced amounts is presented below:

Manchester Memorial Hospital

Community Based Clinical Services

Breast health information and screening events, oversight of the Early Detection Program [4]	□	26,546
Blood pressure and cardiac health screenings	□	204
Diabetic foot screenings	□	928
Total Community Based Clinical Services:	**$**	**27,678**

Health Care Support Services

Expenses associated with transportation for patients to outpatient behavioral health services provided at 150 North Main Street:		
Costs of bus passes and taxi service	□	24,006
Time spent for referrals to other programs for patients residing outside of ECHN service area	□	3,214
2014 Medicaid Referral Calls (70□ of expense allocated to MMH)	□	2,305
Lifeline □Free replacement buttons provided to clients	□	148
Nurse and survivorship navigator programs	□	334,474
Staff to assist patients in enrolling in Medicaid and other public assistance programs	□	48,715
Total Health Care Support Services:	**$**	**412,862**

[4] Grant funded program managed by ECHN□s Breast Care Collaborative which provides breast screenings and colonoscopies for the uninsured and underinsured.

Community Support

Expenses associated with hosting the Veteran□s Day dinner and Veteran□s Day ceremony at MMH	□	1,778
Emergency management and disaster preparedness meetings and drills (including simulated situations involving hurricane, bed triage□patient overflow, active shooter, emergency supply, etc.)	□	5,330
Family Development Center Programs *(see the response to Question 24b below for more information on these programs)*	□	133,104
Staff participation in Manchester Chamber of Commerce events and South Windsor Chamber of Commerce board meetings	□	585
Total Community Support:	**$**	**140,797**

Workforce Development

Workforce training, vocational services to residents to obtain integrated competitive employment	□	115,766
Legal department mentoring of interns and volunteers	□	272
Capital Community College Advisory Board Annual Meeting, Rockville High School student and paramedic mock interviews	□	1,738
Career Advancement Program for Manchester High School seniors	□	4,724
Sleep Lab presentations to students and intern rotations	□	1,157
Rockville High School to Business Partnership meeting; orientation for parents of Allied Health Students; interviewing students and parent for Junior Volunteer summer program	□	1,053
Total Workforce Development:	**$**	**124,710**

Please see the response to Question 24c below for more information on the workforce development activities at MMH.

Rockville General Hospital

Health Care Support Services

2014 Medicaid Referral Calls (30 of expense allocated to RGH)		988
Lifeline Free replacement buttons provided to clients		183
Staff to assist patients in enrolling in Medicaid and other public assistance programs		46,198
Total Health Care Support Services:	**$**	**47,369**

b) Details on the Early Head Start, Family Enrichment Services, Nurturing Families Network programs and the School-based Family Resources Centers services provided by MMH s Family Development Center; and

Response:

As discussed previously in the Applicants response to Question 52 of the CON application, MMH s Family Development Center operates programs for families needing support with parenting and other family issues. These programs are funded by state and federal grants. The 133,104 represents the in-kind contributions to the programs made by MMH.[5]

Additional information related to the specific programs has been provided below:

Early Head Start Program

The Early Head Start (EHS) program serves low-income children (birth to age three), pregnant women and their families residing in Manchester and or Vernon. A Family Development Educator (FDE) provides parent education, child development information and learning activities.

EHS provides families with opportunities to get involved in their child s education.

[5] In-kind contributions refer to the expenses incurred by MMH in support of the program including, but not limited to, rent, administrative overhead (human resources, payroll, accounting, legal, information technology, etc.), insurance and overall program administration.

Positive Parenting Program[6]

Positive Parenting Program (Triple P) is a Connecticut State Department of Children and Families funded grant program. Triple P is suitable for parents with concerns about a child's behavior or who wish to learn a variety of parenting skills that will promote the development and potential of their child or teenager.

Nurturing Families Network Programs

The Nurturing Families Network (NFN) is designed to help new parents and consists of: (i) home visitation which helps first-time parents get off to a great start with a new baby and provides infant development and care information; (ii) Nurturing Connections provides phone support to help first-time parents adjust to their first few weeks home with a new baby; and (iii) organizing parenting groups.

School-based Family Resource Center Services

The ECHN Family Resource Centers (FRC) offer education and support services for the entire family Services included child care, school-age care, parent-child playgroups, parent education, home visits, support for child care providers, positive youth development, adult education, resources and referrals to community services.

c) Details on the Workforce Development activities of MMH.

Response:

The majority of activities related to the Workforce Development activities of MMH are related to the organization's Work Source program. Work Source is a program designed to help people with mental illness and substance abuse achieve vocational success and social and economic independence. The program provides assistance in securing and maintaining competitive employment and educational opportunities.

25. Applicants state that ECHN's present teaching arrangements with the University Of New England College of Medicine for third year medical students, residents, and interns will be maintained. Please explain how these students, residents and interns are deployed within MMH, RGH and the towns served by ECHN to provide healthcare services and whether PMH plans any changes to how such medical students, residents, and interns are utilized.

[6] Family Enrichment Services was renamed Positive Parenting Program by the Department of Children and Families to reflect changes in the program curriculum.

Response:

PMH has committed to maintaining key clinical operations and community support including ECHN's University of New England College of Osteopathic Medicine ("UNECOM") medical student and other health professions teaching programs, and ECHN's graduate medical education programs. PMH does not have any plans to change how the medical students, residents and interns are utilized. Students, residents and interns will continue to be deployed to the Hospitals and communities served by ECHN utilizing a rotation structure that has been developed for each program:

Medical Students - In 2010, ECHN partnered with UNECOM to provide medical education and clinical opportunities at ECHN for sixteen of UNECOM's third year medical students. Students spend their entire third year of medical school in Connecticut and participate in the following clinical rotations:

- Family medicine
- Internal medicine (Hospitalist Service and Critical Care)
- Obstetrics and gynecology
- Pediatrics
- Psychiatry
- Surgery

Medical students also select rotations in the following areas to complete the third-year requirements for their program:

- Emergency medicine (hospital-based)
- Gastroenterology (inpatient and outpatient settings)
- Osteopathic manipulative medicine (outpatient setting)
- Otolaryngology (inpatient and outpatient settings)
- Pathology (inpatient setting)
- Radiology (inpatient setting)

Residents and Interns - In 2013, in response to the growing need for primary care providers, ECHN launched its own graduate medical education (GME) program that includes a family medicine residency program (twenty-four positions) and a rotating internship program (six positions). Residents and interns participate in the following clinical rotations:

- Hospital-based rotations
    - Hospitalist service (Family Medicine Inpatient Service)
    - Critical care
    - Emergency medicine
    - Geriatrics (completed at ECHN's Woodlake at Tolland)
    - Obstetrics

  - Pediatrics - completed at Connecticut Children's Medical Center ("CCMC")
  - Pediatric emergency medicine - completed at CCMC
  - Psychiatry
  - Surgery

- Community-based (outpatient) rotations
  - Cardiology
  - Dermatology
  - Family medicine
  - Gynecology
  - Nephrology
  - Ophthalmology
  - Orthopedics
  - Osteopathic manipulative medicine
  - Otolaryngology
  - Podiatry
  - Rheumatology
  - Sports medicine
  - Surgery

26. On page 63 of the Application, Applicants cite that the "Rockville section of Vernon, where RGH is located, has been designated by the Health Resources and Services Administration as a Medically Underserved Population and the northwestern part of Mansfield has been designated as a Health Professional Shortage Area for Primary Medical Care. RGH, MMH and their System affiliates provide safety net services to this region of the State." Please explain specifically how the proposed transaction with PMH will continue to address the needs of these underserved areas by identifying those programs, services and collaborations with other community organizations that will continue post-closing and provide information on any plans for new programs, services and collaborations that will expand access to health care in these underserved areas.

Response:

Services currently provided by ECHN at RGH and in the surrounding communities address the needs of Rockville's medically underserved population. RGH's emergency department has over 20,000 patient visits annually and nearly half of those patients come from the town of Vernon. The Maternity Care Center, located on the RGH campus, provides free maternity services to uninsured and underinsured women from Vernon and surrounding towns, including Manchester, Ellington, East Hartford and Mansfield. ECHN has established, through its medical foundation, a family medicine practice in Rockville within close proximity to RGH and another practice in Vernon, just a few miles from the Rockville section, to support the primary care needs of the area.

In Tolland, which is only a few miles from the northwestern border of Mansfield, ECHN offers laboratory services and has a number of specialists that see patients in a shared specialty suite at Fieldstone Commons. Also at this location is ECHN's joint venture imaging center Tolland Imaging Center which makes MRI, CT and other medical imaging services available to patients in a convenient outpatient setting. Several independent primary care physicians on the ECHN Medical staff practice at locations in Vernon, Tolland and Coventry, all of which offer a convenient source of primary care services for residents of northwestern Mansfield.

PMH has committed to keeping the Hospitals open for three years and has no plans to eliminate any services. No service line or service location changes are currently planned in connection with the proposed transaction, although it is expected that the ECHN ambulatory network will be expanded and services configured to promote the most efficient delivery of coordinated care following the closing. Through PMH's CRC model, PMH works closely with hospitals and affiliated medical groups for the benefit of every person who comes to them for care, building comprehensive networks of quality healthcare services that are designed to offer patients highly coordinated, personalized care and help them live healthier lives.

PMH will look to work with current service area providers such as Federally Qualified Health Centers in such underserved and health professional shortage areas to support their health care delivery efforts. PMH will also aggressively recruit physicians for these areas. PMH will also seek to expand services in these areas by establishing clinics urgent care centers and staffing such centers with either independent or employed physicians. There are no definitive plans at this time to add service locations for MMH or RGH. PMH will conduct a planning effort with the Local Boards post-closing to determine where there are opportunities to improve access, enhance services and introduce new programs that address identified health needs.

27. With respect to Exhibits Q42-1, Q42-2 and Q44-1, please address the following:

a) Applicants project no change in Nurse Staff to Patient Ratios or the Average Weekly Hours for Ancillary Caregivers for three years following approval of the asset purchase. Reconcile how the asset purchase will achieve efficiencies and improve quality of care without corresponding adjustments to nurse to patient ratios and the hours of ancillary caregivers.

Response:

PMH expects to implement cost and clinical efficiencies over time utilizing a planned and coordinated approach. Specific plans to address potential areas of opportunity that would impact patient census, patient acuity, staff experience levels and

technology utilized by caregivers have not been developed at this time, so staffing changes that would result related to these factors cannot be reasonably predicted. Furthermore, the parties have been careful to wait for the required antitrust approvals before making any post-closing plans, including any operational or capital plans.

Given these limitations, the projections presented in Exhibit Q42-2 (Staffing Attachment II) and Exhibit Q44-1 (Ancillary Caregiver Staffing Attachment) assumes volume demands (which would impact unit configuration and size), patient acuity, staff experience levels, and technology will remain constant during the projection period. During the first three full fiscal years following approval of the Asset Purchase (FY 2017, FY 2018, and FY 2019) staffing levels may begin to shift as PMH introduces best practices from its other hospitals and implements its CRC model, which is expected eventually to result in changes in patient acuity caused by improving population health and a shift in relative volumes of inpatient and outpatient services. PMH is committed to staffing levels that comply with ratios mandated by Connecticut state law, which implement best industry practices, and which take into account patient safety and acuity, employee safety and facility census.

b) ECHN failed to meet budgeted targets for Average Nursing Hours per Patient Day in several categories yet no changes in Nursing Staff ratios for the first three years following approval of the asset purchase are projected. Explain why this is the case.

Response:

The Nursing Hours per Patient Day (NHPPD) target is a metric used by nursing unit leaders to manage staffing levels and help them to respond to fluctuations in unit census. Unit census changes constantly and can vary significantly from day-to-day and hour-to-hour, making the decision of when to adjust staffing levels (and for how long) challenging. Factors including, but not limited to, the number of patients being admitted to or discharged from a unit, the acuity of patients on the unit and staff experience all influence decisions regarding staffing levels. Whether or not a unit has historically met NHPPD targets does not affect the Nursing Staff ratio guidelines for future years because the ratios are determined by the projected unit census and the Nursing Staff requirements at that census level.

PMH expects to implement cost and clinical efficiencies over time utilizing a planned and coordinated approach. Specific plans to address potential areas of opportunity that would impact patient census, patient acuity, staff experience levels and technology utilized by caregivers have not been developed at this time, so staffing changes that would result related to these factors cannot be reasonably predicted. Furthermore, the parties have been careful to wait for the required antitrust approvals before making any post-closing plans, including any operational or capital plans.

Given these limitations, comparable Staffing ratios were maintained until specific plans are developed

28. Please elaborate on the expected revenue growth for MMH and RGH associated with the use of the CRC model of care and provide specific examples from hospitals currently owned by PMH of actual savings realized post-acquisition in the various operating expense categories set forth in Financial Worksheet (C).

Response:

The implementation of CRC is not expected to cause a reduction in operating expense categories. The goal of CRC is reduce the overall cost of healthcare by increasing preventative care and early interventions, reducing re-admissions, reducing inpatient utilization and reducing emergency room visits. CRC achieves these objectives by incentivizing physicians and patients to appropriately use urgent cares centers and to keep patients compliant with various homebound and other wellness programs, and by keeping patients healthier so as to reduce the overall over-utilization of healthcare services. By achieving these objectives, the cost of healthcare will be reduced, including for such programs as Medicaid and Medicare.

In the state of Rhode Island, PMH projects to reduce the cost of care for a segment of the Medicaid population by 5%.

29. On page 78 of the Application, the Applicants indicate that "PMH has access to an existing corporate level credit facility in addition to its cash on hand." Name the credit facility, provide PMH's current credit rating and elaborate on the process associated with borrowing funds from this credit facility to fund any portion of the $75 million Commitment Amount in lieu of cash from MMH and RGH operations.

Response:

PMH has received credit upgrades by both Moody's and S&P in 2015. Moody's rates PMH's bonds as B1, while S&P rates PMH's bonds as B.

PMH has access to a revolving line of credit with Morgan Stanley that has been pre-approved. In order to draw on this line, PMH simply provides a 24 hour advance verbal notice to the lenders. The line of credit is available to fund the Commitment Amount if necessary.

30. Elaborate on the financial feasibility to fund the $105 million (or $115 million) purchase price given PMH's declines in cash and cash equivalents, operating income, net income, and realized deficits in Stockholder's equity from FY 2012 to 2014 reported in its FY 2014 audited financial statements as set forth at Exhibit Q8-1.

Response:

PMH's financial performance has demonstrated significant growth from 2012 to present:

PMH Financial Performance	2012	9 Months Ending 06/30/2015
Operating Income:	$80 Million	$82.3 Million
Net Income	$26 Million	$32 Million
Stockholders' Equity	$31 Million	$34 Million

The growth in Stockholders' Equity is net of a $100 million dividend paid in November 2012. Please refer to Exhibit Q8-2 of the CON application for more information pertaining PMH's stockholder equity.

Impacting 2014 reported financial and cash flow was the delay in revenue recognition of the California Quality Assurance Fee (SB 239) program. The associated revenue, EBITA and cash receipts could not be recognized until formal Federal approval of the program was received which occurred after the fiscal year-end.

Cash balances from 2012 to 2014 were impacted by the completion of multiple acquisitions paid with existing cash on the balance sheets. The cash consideration for these acquistions totaled in excess of $81 million. Additionally, during this time, the Due from Government payor receivable increased by more than $28 million, primarily due to the delay in funding the California Quality Assurance Fee program for the period of January 2014 to September 2014. Payments related to this program were subsequently received in 2015.

PMH has significant cash on hand to complete the transaction. As of September 30, 2015, PMH on consolidated basis had in excess of $110 million in funds available. Furthermore, PMH generates over $7.5 million in free cash flow per month. The amount of cash necessary to close the ECHN transaction is currently estimated to be approximately $28 million.

31. On page 907 of the Application, in PMH's Condensed Consolidated Statements of Operations, Applicants report significant growth in both Total Net Revenues and Total Operating Expenses for the nine months ending June 30, 2015 as compared to the same reporting period in 2014. Please explain the factors impacting these changes.

Response:

Revenue and expense growth for the nine months ended on June 30, 2015 as compared to the same reporting period in 2014 is due to the acquisition of CharterCARE in the state of Rhode Island and the recognition of payments from the California Quality Assurance Fee (SB 239) program.

32. In reference to the priority capital projects identified by ECHN management on page 82 of the Application, provide their current estimated cost and, as applicable, the years beyond useful life for these assets.

Response:

The following table contains cost estimates for the capital list identified by ECHN management. The years beyond useful life for the assets being replaced indicate the time since the asset was last being depreciated for accounting purposes and does not suggest that the assets are not in good working order.

	Estimated Cost	Estimated Years beyond useful financial life
Upgrades to emergency department for behavioral health patients (MMH)	$1.1M	N/A
Electronic medical record system (MMH & RGH)	$20M	N/A
Upgrades to nursing units (RGH)	$6.6M	N/A
Upgrades to nursing units (MMH)	$11M	N/A
Vessel sealing systems (MMH & RGH)	$0.6M	N/A
MRI replacement (MMH)	$1.6M	4
SPECT scanner replacement (MMH)	$0.4M	10

33. With the understanding that the $75 million Commitment Amount has not been apportioned by hospital or other affiliates, please submit a preliminary capital investment plan that provides an approach on how PMH might distribute the $75 million by capital projects.

Response:

The parties have not yet prepared a capital investment plan. ECHN and PMH have agreed to seek the input of the Local Boards and medical staff to produce a capital plan post-closing that will ultimately determine the capital projects and priorities. The parties have been careful to wait for the required antitrust approvals before making any post-closing plans, including any operational or capital plans.

In order to better position ECHN as a premier choice for healthcare in its community, PMH believes that it will need to continually evaluate the facilities and markets for future capital projects. Immediately post-closing, as a part of the strategic planning process, PMH would consider and evaluate market data and projections, current and proposed regulatory environments, operational and financial requirements, and capital expenditures models in the markets in which ECHN operates. This strategic planning process would be led by the local management team; however the resources of PMH would provide the necessary capital and expertise to enhance existing services and add new service lines.

Working with the local leadership, PMH will identify and prioritize the identified capital projects. PMH's objective is to implement growth initiatives for the benefit of the surrounding communities served by ECHN so long as that care can be delivered in a high quality and financially responsible manner.

34. Provide an updated Exhibit Q8-2, providing PMH's FY 2015 unaudited financial statements to reflect twelve months of financial activity.

Response:

PMH's FY 2015 unaudited financial statements reflecting twelve months of financial activity are not yet available as PMH's year-end financials cannot be disclosed publicly in draft form, particularly in light of the potential investment transaction at PMH corporate level, described more fully below (see response to the deficiencies identified by OAG and OHCA on November 12, 2015, beginning on page 2204, for more information on this investment transaction). The Applicants will provide a copy of the financial statements once the audited financials have been received and they have been publicly disclosed.

35. In reference to Financial Worksheet (C), Exhibit Q37, and the related Assumptions, at Exhibit Q38, for MMH, RGH and ECHN address the following:

a) Provide a revised Financial Worksheet (C) that will include projections of total revenue, expense and volume statistics without, incremental to and with the CON proposal for FYs 2015 and 2016. Provide the assumptions utilized in developing the projections and explain any projected losses from operations;

Response:

Financial Worksheet (C) has been revised to include projections of total revenue, expense and volume statistics without, incremental to and with the CON proposal for FY 2015 and FY 2016.

The FY 2015 projections are annualized statistics based on actual FY 2015 year-to-date amounts through July and were originally provided on pages 1846 and 1847 of the CON application submitted on October 13, 2015. Assumptions utilized in developing the FY 2016 projections can be found on pages 1852 and 1853 of the CON application.

Additionally, after reviewing the detail assembled for other operating revenue (requested in Question 35b below), it was brought to the Applicants' attention that the amounts for Public Support were not removed in the "with CON" scenario. This oversight has been corrected and the revised incremental amounts for other operating revenue are now reflected in the projections with CON approval presented on Financial Worksheet (C).

Please refer to **Exhibit I** for the revised version of Financial Worksheet (C) reflecting the changes described above.

ECHN is projecting declines in net patient revenues in FY 2015 and FY 2016 as a result of payer mix shifts to the exchanges and Medicaid. As discussed on page 36 of the CON application in the Applicants' response to Question 5, increases to the state hospital tax, Medicare wage index changes, and the continued evolution of the health spending accounts are additional factors behind ECHN's projected operating losses.

b) The Assumptions, listed under the other operating revenue section, indicate that joint venture income will increase 2% each year after FY 2016. Provide an itemized schedule of the other operating revenue amounts reported for FYs 2017, 2018 and 2019 without, incremental to and with the CON proposal, inclusive of joint venture income for all three entities; and

Response:

An itemized schedule of the other operating revenue amounts reported for FY 2015 through FY 2019 without, incremental to, and with the CON proposal, inclusive of joint venture income for all three entities has been provided in **Exhibit J**.

c) The Assumptions indicate that the asset purchase by PMH will allow MMH and RGH and their provider affiliates to benefit from economies of scale inherent of a large organization when purchasing supplies and services. In reference to this statement, explain the projected incremental increases in fringe benefits, supplies and drugs, and other expenses reported between FYs 2017 and 2019.

Response:

PMH believes that the costs to provide fringe benefits will decrease in the first full year of operation, because PMH is essentially self-insured for providing benefits and will therefore save on the profit portion of the premium generally paid to third parties in order to provide fringe benefits to employees. PMH estimates, however, that cost of providing fringe benefits will increase over time, as salaries and costs of providing benefits increase each year.

From a supplies perspective, PMH believes that through the economies of scale, the Hospitals will enjoy higher discounts for supplies and drugs as part of a larger organization in the first year. Subsequently, the Hospitals should be entitled to better discounts and pricing through better compliance with purchasing protocols. It should be noted, that if PMH is successful in future hospital acquisitions (whether within the state of Connecticut or outside), the Hospitals should receive better pricing as PMH's purchasing power increases.

36. Please provide updated Financial Measurements Indicators, Exhibit Q50-1, for the months of July, August and September 2015 and comparable months from the previous fiscal year for MMH and RGH, ECHN and PMH. Provide the methodology utilized to calculate the financial ratios on Sections A through C and an explanation for any decreases or increases that apply to any of the items listed on Section D between YTD FYs 2014 and 2015.

Response:

Please refer to **Exhibit K** for Financial Measurement Indicators for July, August and September 2015[7] and comparable months from the previous fiscal year for MMH, RGH and ECHN. Financial statistics for the entity which will acquire ECHN (Prospect ECHN, Inc.) are not available as the entity does not currently exist and will not be formed unless the proposed asset purchase is approved.

For the financial ratios on Sections A through C, the Applicants utilized the formulas provided by OHCA in the Twelve-month filing Report 185 to calculate all of the statistics with the exception of the following:

Statistic	Calculation Methodology Used
ECHN's Days Cash on Hand	(Cash + Board Designated Investments + Investments) ÷ (Operating Expenses - Depreciation) x 365 days
ECHN's Average Payment Period	Current Liabilities x 365 days ÷ (Operating Expenses - Depreciation)
ECHN's Long-term Debt to Capitalization	Long-term debt ÷ (Long-term debt + Unrestricted Net Assets)
ECHN's Debt Service Coverage Ratio	(Net Income + Depreciation + Interest Expense + Change in Swap value) ÷ Maximum Annual Debt Service

ECHN saw a deterioration in all of the financial indicators in Section D due mainly to lower government reimbursements, most notably from the State. In addition, ECHN saw a decrease in volume across many of the key inpatient and outpatient services provided by the hospitals which also contributed to the declines observed in these financial indicators.

37. For each of PMH's five most recent acute care hospital acquisitions identified in Exhibit Q58-1 of the Application address the following:

    a) Complete the following table:

[7] Financial statistics provided for September 2015 are based on the unaudited financials for MMH, RGH and ECHN available at the time of this submission. The Applicants will plan to submit an updated version of the September 2015 financials once the year-end audit has been completed and the final audited financial statements for FY 2015 are available.

Name	Total Capital Investments	Describe Improvements in Financial Performance			Total Cost Savings
		Profits	Liquidity	Solvency	

Response:

Please see **Exhibit L** for the completed Table.

b) Describe particular initiatives utilized to achieve the results described above;

Response:

With respect to Los Angeles Community Hospital at Bellflower and Foothill Regional Medical Center, the capital investments were for improvement to the plant and equipment to open the hospitals.

With respect to Nix, PMH made investments in creating an IPA, expanding outpatient clinics, opening an emergency room, expanding behavioral health capacity, and upgrading plant and equipment.

With respect to the CharterCARE, in only its first year of ownership, PMH has made investments in forming an IPA, forming a risk bearing entity, acquiring primary care clinics, and making upgrades to plant and equipment. PMH has committed to spending an additional $20 million on a cancer center, Digestive Diseases Center, expansion and upgrade to the emergency department and additional physician practice acquisitions.

c) Indicate how the financial performance improvements translated into lower health care costs; and

Response:

Initiatives implemented through the development of the CRC model of care will facilitate a more efficient care delivery model. CRC encourages providers to be more clinically integrated with other care givers and enables patients to receive the right care, with the highest levels of quality, in the most appropriate care setting. Through the development of the CRC and the attainment of these objectives, PMH will be successful reducing unnecessary re-admissions, inpatient

utilization, and emergency room visits which will translate into improved outcomes and lower health care costs for patients in the region.

d) Indicate how the cost savings were due to economies of scale inherent of a larger organization; and

Response:

As discussed in response to Question 28 above, the implementation of PMH's CRC will not cause a reduction in operating expense categories at a hospital. The goal of CRC is reduce the overall cost of healthcare by reducing re-admissions, reducing inpatient utilization and reducing emergency room visits. By achieving these objectives, PMH will reduce the cost of healthcare for such government programs as Medicaid and Medicare, but also to commercial insurers who elect to participate in risk-based contracts.

It should be noted that by affiliating with a larger organization, ECHN will benefit from economies of scale due to PMH's overall purchasing power. Post-acquisition, ECHN should realize benefits in lower supply costs, drug costs and costs related to consultants. By having ECHN participate in PMH's Group Purchasing Organization, ECHN will realize lower supply and drug costs. Furthermore, the resources of PMH will be made available to ECHN to assist ECHN in developing and implementing its strategic plans, whereas in the past, ECHN may have employed consultants to aid in such efforts.

e) Since Exhibit Q58-1 contains no discussion of how these acquisitions improved the quality of health care for the hospital's service area, comment on each hospital's performance under the following CMS quality improvement programs since PMH first acquired the hospital (comparison to national, state and local performance standards as well as ECHN's current performance statistics is invited):

i. Hospital Inpatient Quality Reporting Program;
ii. Hospital Outpatient Quality Reporting Program;
iii. Hospital Value-Based Purchasing Program; and
iv. Hospital Readmissions Reduction Program.

Response:

Please see **Exhibit M** for the quality report generated by the State of Rhode Island with respect to the CharterCare CON and conversion process. The report includes the historical quality metrics at the now current PMH hospitals.

Attached in the **Exhibit N** is an update of the quality metrics for 2014. Metrics for MMH and RGH are included in the exhibit. Additionally, please note that 2015 risk adjusted quality metrics have not been published.

Delivering quality care is of utmost importance in operating a hospital as well as the CRC model. As physicians are such an integral part of delivery of care, PMH believes that quality issues should be handled at a local level. The goals of the PMH Quality Program consist of achieving results in each of measures that are better than the national average, with the expectation of continuous improvement. The PMH Quality program is the accomplished through a joint process between the Medical staff leadership and Hospital leadership within each entity with oversight by the Local Governing Board. PMH provides overall leadership, coordination of best practice, and Policy and Procedures for Standardization of protocols.

38. On page 865 of the Application, PMH's FY 2014 audited financial statements, indicate that "*Patients without insurance are offered assistance in applying for Medicaid and other programs they may be eligible for, such as state disability. Patient advocates from the Company's Medical Eligibility Program ("MEP") screen patients in the Hospital and determine potential linkage to financial assistance programs. They also expedite the process of applying for these government programs.*" Elaborate on the MEP process and success record. Indicate whether this program will be available at MMH and RGH if the asset purchase is approved and consummated.

Response:

Uninsured patients who receive services at PMH-affiliated hospitals are interviewed by either employees or third party contractors to determine if such patients are entitled to benefits from a variety of financial assistance programs, most notably state Medicaid. With the expansion of Medicaid under the ACA, many patients who present as uninsured are not aware that they could potentially qualify for Medicaid. Through the interview process, PMH hospitals determine if such patients qualify for Medicaid and assist such patients with submitting the appropriate forms to the relevant state agencies. In California, PMH estimates the success rate on assisting patients to qualify for financial assistance programs to be approximately 60%. In Texas, this success rate is approximately 15%. The success rate is lower in Texas because Texas did not opt for Medicaid expansion as part of the ACA. PMH has just

recently instituted our MEP program in Rhode Island. As such, PMH has not had a chance to assess its success in Rhode Island.

39. On page 92, Applicants were asked provide copies of the most recent CMS Statements of Deficiencies and Plans of Correction (CMS Form 2567) for all hospitals owned by PMH. Applicants provided only those statements pertaining to its Rhode Island hospitals. Please provide the requested information for PMH owned hospitals in Texas and California. Provide these documents in an electronic format only. PDF file on a CD to accompany the responses.

Response:

Please see **Exhibit P** for the requested CMS Statements of Deficiencies. Documents have been provided in electronic format only as requested.

40. With respect to the proposed Asset Purchase Agreement, please provide the information contained in the following schedules: Schedule 2.01 (a) Owned Real Property; Schedule 2.01(b) Leased real property; Schedule 3.12 (c) Building Maintenance and Repairs; Schedule 3.12(g) Rent Roll; Schedule 3.12 Tenant Lease Encumbrances; Schedule 3.13(a) Environmental claims; Schedule 3.13 (b) Underground storage tanks and waste disposal; and Schedule 3.18 People in possession of owned property.

Response:

The APA schedules referenced above are documents that will be produced for Closing. Please see **Exhibit O** for responsive information describing ECHN owned real property, leased real property, building maintenance and repairs, rent rolls, tenant lease encumbrances, environmental claims, underground tanks and waste disposal. Schedule 3.18 to the APA (Exhibit Q3-2 of the CON submission, page 127) does not concern owned property; however, responsive information regarding this topic is being made available in **Exhibit O** under the title Owned Real Property. The information in **Exhibit O** is subject to change in the ordinary course of business prior to Closing.

41. Please provide a full and complete listing of both owned and leased real property, including any real estate related to joint ventures.

Response:

Please refer to the responsive information included in **Exhibit O** under the titles Owned Real Property and Leased Real Property for a listing of ECHN's owned and leased property.

The real property leased by the joint ventures is listed in the following table:

Joint Venture	Real Property
Ambulance Service of Manchester, LLC	275 New State Road, Manchester, CT 06042
Aetna Ambulance Service, Inc.	140 Van Block Avenue, Hartford, CT 06114
Connecticut Occupational Medicine Partners, LLC*	2800 Tamarack Avenue, South Windsor, CT 06074
Eastern Connecticut Physician Hospital Organization, Inc.	26 Haynes Street, Manchester, CT 06040
Evergreen Endoscopy Center, LLC	2400 Tamarack Avenue, South Windsor, CT 06074
Evergreen Medical Associates, LLC	2800 Tamarack Avenue, South Windsor, CT 06074
Evergreen Medical Associates II, LLC	2400 Tamarack Avenue, South Windsor, CT 06074 2600 Tamarack Avenue, South Windsor, CT 06074
Haynes Street Medical Associates, LLC	29 Haynes Street, Manchester, CT 06040
Haynes Street Medical Associates II, LLC	100 Haynes Street Manchester, CT 06040
Metro Wheelchair Service, Inc.	275 New State Road, Manchester, CT 06042
Northeast Regional Radiation Oncology Network, Inc.	100 Haynes Street, Manchester, CT 06040 142 Hazard Avenue, Enfield, CT 06082
Tolland Imaging Center, LLC	6 Fieldstone Commons, Tolland, CT 06084
WBC Connecticut East, LLC	2400 Tamarack Avenue, South Windsor, CT 06074

** Connecticut Occupational Medicine Partners, LLC provides management services for Manchester Memorial Hospital's CorpCare Program at this address.*

42. With respect to Question 5, please provide any information and documents that are not attorney-client privileged or are protected by confidentiality agreements relating to any other offers to transfer assets or operations or change control of operations received by ECHN.

Response:

As referenced in response to Question 5 of the Application, ECHN received three responses to its February 19, 2015 Request for Proposal (RFP). One was from a nonprofit system that proposed making a minority investment in ECHN, purchasing its home care agency and providing a management agreement for ECHN. A second was from a national nonprofit organization that was merging with a Connecticut nonprofit system and that proposed a member substitution pursuant to which it would become ECHN's corporate parent. The third proposal was from PMH to acquire all or substantially all of the assets of ECHN. As part of the RFP process, ECHN entered into confidentiality agreements with each of the respondents. As such, ECHN has committed to the respondents (other than PMH who has consented to disclose information about its response in connection with obtaining necessary regulatory approvals) to keep the details of those offers confidential. ECHN is not, therefore, permitted to provide any additional information or documentation on the offers received, other than the offer received from PMH (see response to Question 5 for the complete response received from PMH).

On November 12, 2015, ECHN and PMH received additional correspondence from the OAG and the OHCA requesting additional information regarding reports of a potential sale of PMH. The Applicants response to the deficiencies received on November 12, 2015 has been provided below:

1. Please confirm or deny the reports identified above and specifically explain the basis for the report.

   Response:

   Neither PMH nor any of its subsidiaries are affiliated with the Deal Pipeline s website or the LBO Wire. Therefore, we cannot explain how or why those particular reports were generated.

   We can confirm, however, that PMH has retained Morgan Stanley to review and assess additional sources of investment to support its overall growth strategy, and that PMH has been in discussions with additional investment groups to evaluate opportunities to partner during this next phase of the company s growth.

   PMH is a growing company that is performing very well and receives inquiries from interested investors. The company is not for sale to a strategic buyer such as another healthcare provider, health plan or health system. PMH is only considering its financial investment and investor options to support its plans for future growth.

2. Please describe Leonard Green & Partners and its present ownership stake and control of PMH.

   Response:

   About Leonard Green & Partners, L.P. (Leonard Green) - Source: www.leonardgreen.com

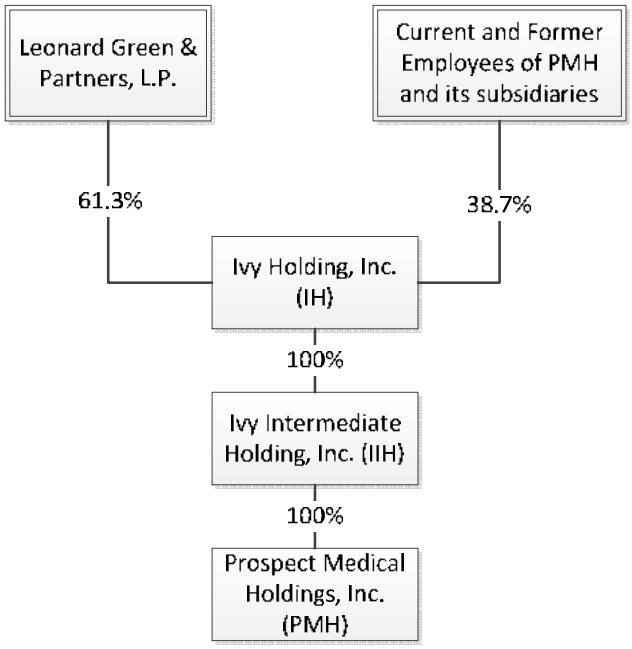
   Leonard Green is one of the nation s preeminent private equity firms with over 15 billion of private equity capital raised since its inception. Founded in 1989, the firm has invested in 76 companies in the form of traditional buyouts, going-private transactions, recapitalizations, growth capital investments, corporate carve-outs and selective public equity and debt positions. Based in Los Angeles, CA, Leonard Green invests in established companies that are leaders in their markets. [8]

   The affiliated investment funds of Leonard Green own approximately 61.3 of the common stock of Ivy Holding, Inc. (IH), a Delaware corporation which owns 100 of the stock in Ivy Intermediate Holding, Inc. (IIH). IIH is a Delaware corporation which owns 100 of the stock of PMH. IIH is a holding company for such stock ownership. It has no other assets,

[8] http: www.leonardgreen.com news 081415-Ellucian-n.pdf

liabilities or operations. Current and former employees of PMH and its subsidiaries own the remaining shares of IH stock.

Figure 1 Relationship of Leonard Green to PMH



Other healthcare related investments held by Leonard Green include CHG Healthcare Services, RestorixHealth and US Renal Care.

3. If PMH is contemplating a sale, whether for a controlling or non-controlling interest in PMH, please explain the motivation and rationale for the sale.

Response:

PMH is not for sale to a strategic buyer such as another healthcare provider, health plan or health system. PMH is only considering its financial investment and investor options to support its plans for future growth. The rationale for pursuing these potential partnerships is to secure a means of raising additional capital to support its existing operations and for further acquisitions in new and existing markets.

4. If PMH is contemplating a sale, whether for a controlling or non-controlling interest in PMH, please explain the planned timeline for the sale.

Response:

The engagement with Morgan Stanley to review and assess additional sources of investment for PMH will likely conclude within the next year. PMH will only proceed further with any additional investors if we find a partner that supports our current growth strategy. The engagement with Morgan Stanley may not yield any additional investment into the Company. This is an evaluation at this point in time.

5. If PMH is contemplating a sale, whether for a controlling or non-controlling interest in PMH, please explain the anticipated key terms and conditions of the sale.

Response:

At of the date of this response, there is no pending sale of PMH, and as a result, no terms and conditions.

6. If PMH is contemplating a sale, whether for a controlling or non-controlling interest in PMH, please explain how a sale would affect the planned acquisition of ECHN.

Response:

PMH's pursuit of additional investment partners will not affect the planned acquisition of ECHN. Capital funding associated with PMH's acquisition of ECHN is currently available. The rationale for pursuing additional investment partners at this time is to prepare the organization for future growth and to support PMH's overall growth strategy.

7. If PMH is contemplating a sale, whether for a controlling or non-controlling interest in PMH, please explain how the sale would affect the future operations of ECHN.

Response:

PMH's pursuit of additional investment partners will not affect the future operations of ECHN other than to support the overall growth of PMH which could also benefit ECHN as part of a growing system. PMH's short and long term strategy and focus on transforming the healthcare delivery model will not change. PMH will continue to focus on its current operations and will continue to invest in its hospitals, medical groups, CRC network and related business. The management of PMH will remain unchanged.

RESPONSE TO DEFICIENCIES
EXHIBIT A – Joint Venture Valuations

Joint Venture Valuations

	Ownership/ Membership	ECHN Net Income/(Loss) 9/30/2014	Joint Venture EBITDA 9/30/2014	EBITDA @6X
Metro Wheelchair Service, Inc.	50%	(54,225)	(54,462)	(326,772)
Aetna Ambulance Service, Inc.	50%	188,996	495,936	2,975,616
Ambulance Service of Manchester, LLC	50%	1,026,411	1,355,963	8,135,775
WBC Connecticut East, LLC	16%	(1,455)	10,366	62,195
Evergreen Endoscopy Center, LLC	50%	491,891	565,547	3,393,279
Tolland Imaging Center, LLC	70%	179,810	238,046	1,428,277
Northeast Regional Radiation Oncology Network, Inc.	50%	381,743	506,689	3,040,131
Haynes Street Medical Associates, LLC	23%	20,243	46,896	281,374
Haynes Street Medical Associates II, LLC	15%	65,410	186,919	1,121,513
Evergreen Medical Associates, LLC	20%	108,866	130,389	782,333
Evergreen Medical Associates II, LLC	20%	70,834	205,715	1,234,292
Total		**2,478,524**	**3,688,002**	**22,128,012**

RESPONSE TO DEFICIENCIES

EXHIBIT B - Table 8: Net Proceeds Analysis (Revised 11/4/2015)

Response to Deficiencies Question 4

Table 8: Net Proceeds Analysis

Assumes transaction will close on 09/30/2015

			Scenario B 9/30/2015	Scenario A 9/30/2015
ACQUISITION PRICE (EV)	A		$115,000,000	$105,000,000
ASSUMED LIABILITIES:				
Pension & Retiree Medical			($62,598,000)	($62,598,000)
Captive & Workers Comp.			($1,705,000)	($1,705,000)
Net Working Capital True-up			($9,107,000)	($9,107,000)
"Taxable" Long Term Debt			($45,000,000)	0
Capital Leases, Misc (FIN47)			($8,045,000)	($8,045,000)
TOTAL ACQ LIABILITIES	B		($126,455,000)	($81,455,000)
NET PROCEEDS (CASH to ECHN)	C	A+B	($11,455,000)	$23,545,000
CASH & INVESTMENTS (ECHN)	D		$58,214,000	$58,214,000
TOTAL CASH for DEBT PAYOFF	E	C+D	$46,759,000	$81,759,000
LONG TERM DEBT (Net AWUIL)	F		($42,696,000)	($77,696,000)
SURPLUS after DEBT DEFEASANCE	G	E+F	$4,063,000	$4,063,000
INDEMNITY RESERVE	H		($3,063,000)	($3,063,000)
SURPLUS for COMM. FOUNDATION	I	G+H	$1,000,000	$1,000,000

Updated November 4, 2015

RESPONSE TO DEFICIENCIES
EXHIBIT C - Request for Proposal Response (PMH)

PROSPECT MEDICAL HOLDINGS, INC.

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

VIA EMAIL ONLY

March 16, 2015

Mr. Dennis P. McConville
Senior Vice President and Chief Strategy Officer
Eastern Connecticut Health Network, Inc.
71 Haynes Street
Manchester, CT 06040

Dear Mr. McConville:

This letter sets forth the non-binding intent of Prospect Medical Holdings, Inc. ("Prospect") with respect to a proposed transaction in which Prospect, or a designated subsidiary, would acquire the assets of Eastern Connecticut Health Network (collectively "ECHN"). The following represents the basic framework of our proposal and, if acceptable to ECHN shall serve as a basis for a more formal Asset Purchase Agreement ("APA").

Pursuant to your request we have attached a revised draft APA and side letter. Please note that the revised draft APA, as well as the side letter, are subject to further diligence, which will require exchange of additional information. Furthermore, should you have any questions or wish to discuss any of the revisions, please do not hesitate to contact us.

Prior to responding to the requested proposal elements, we believe a brief background on Prospect would be helpful.

Prospect is an innovative healthcare services delivery company that is responding to the evolving healthcare environment through meaningful collaboration between physicians and hospitals. Prospect's proven track-record with hospital integration and growth is directly related to its collaborative and cooperative relationships with physicians on a hospital's medical staff to promote the quality and efficiency of patient care. Prospect believes that it will meet ECHN's transaction objectives due to its financial strength, proven population management expertise, and its strong management team of seasoned operating, marketing, contracting, financial and administrative executives that maintain a dedicated "*hands-on*" commitment to the delivery of quality, cost effective healthcare services.

Prospect provides quality, cost-efficient and coordinated healthcare services through our hospitals, clinics and physician networks in Southern California, Texas, and Rhode Island. We are also purchasing an additional hospital in New Jersey.

We conduct our business operations through two complementary segments: the hospital segment and the medical group segment. Through our hospital segment, we own and operate 13 acute care and behavioral hospitals, with a total of approximately 2,258 licensed beds, and a network of 32 specialty and primary care clinics. Our hospitals are located in diverse population areas within Southern California, Texas and Rhode Island and maintain significant market positions in the areas they serve. All of our facilities provide a comprehensive range of services tailored to their specific communities, including other area hospitals, physicians and health plans. We believe that our proven model has a number of competitive advantages, including a data-driven and cost-efficient platform that has enabled us to provide quality care to patients.

Through our medical group segment and hospitals, we manage the provision of healthcare services to approximately 260,000 enrollees of Health Maintenance Organizations ("HMOs") and other payers in Southern California through a network of approximately 8,900 primary care and specialty physicians. Based on our enrollment, our medical groups have a significant presence in Southern California and have long-term capitated contracts with nearly all major HMOs operating in the region. In addition to the medical group capitated enrollment, we also have contracts with affiliated medical groups and health plans which capitate our hospitals in Southern California for more than 30,000 members bringing our total lives under risk management to more than 300,000.

We align our hospitals and physicians under what we call coordinated regional care ("CRC"). CRC is the clinical integration among hospitals, physicians and other medical, social and community providers working closely with strategic partner health plans and other payers under a value-based, global risk reimbursement payment system to achieve the triple aim of improved patient care and experience, better patient health and lower costs. This has been a highly successful strategy for aligning physicians with our hospitals and improving the volume, quality, efficiency and financial performance of our system in California. We have implemented a similar, local version of the CRC strategy in our Texas and Rhode Island markets and have seen similar success.

We operate both our facilities and medical groups by applying highly disciplined, data-driven management to the provision of quality care to our patients. Through the in-depth analysis and application of various operational and financial metrics, we have been able to achieve a highly efficient cost structure across a diverse mix of payers and have been able to adapt to economic and regulatory changes. We believe the most cost-efficient and quality driven providers will succeed in this rapidly changing economic and regulatory environment. Furthermore, we believe the coordination of our facilities and medical groups creates an efficient healthcare delivery system that positions us well for the future of healthcare delivery.

Prospect currently owns the following hospitals:

- Los Angeles Community Hospital;
- Los Angeles Community Hospital at Bellflower;
- Norwalk Community Hospital;
- Southern California Hospital at Hollywood;
- Southern California Hospital at Van Nuys;
- Southern California Hospital at Culver City;
- Newport Specialty Hospital;
- Roger Williams Medical Center
- Our Lady of Fatima Hospital; and
- Nix Health (four campuses)

Furthermore, we believe that ECHN's vision for the future is compatible with Prospect's objectives in expanding into the Connecticut market. Prospect seeks to establish a quality healthcare delivery system in Connecticut with a continuum of services that would provide access to quality healthcare services to ECHN's surrounding communities on a cost efficient basis. We plan to employ a number of physician alignment strategies that will help ECHN to not only maintain its current market position but to grow its patient care services and enhance its market position. We also believe that Prospect's long and deep experience in population health management and coordinated regional care will make ECHN a leading healthcare provider in the state of Connecticut. Obviously, there is an enormous advantage to early adopters, which we believe we will be in the state of Connecticut.

Our interest in ECHN is based on its location in a very attractive market, its strong presence and commitment to its local community, its reputation for quality and service, and its significant potential for growth. We believe that this is the right opportunity for Prospect and plan to build upon ECHN's significant achievements as an essential community system.

Proposed Transaction

We propose to form one or more new entities to purchase all tangible and intangible assets owned or used by ECHN in the operation of the hospital and health delivery system. We contemplate that the assets would be conveyed and assigned free and clear of all liens, claims, charges or encumbrances. As a part of the transaction, Prospect expects to assume ECHN's pension liabilities.

Assuming that ECHN's consolidated balance sheet at closing would be free of all debt (including pension liabilities) and cash, Prospect is prepared to offer a total consideration of $180 million (based on ECHNS's financial statements as presented to date) for the assets of ECHN as described above. The consideration is broken down as follows:

Consideration for Assets	$105 million
Capital Commitment	$ 75 million
Total	$180 million

Please note that Prospect is amenable to and welcomes other potential transaction structures to be suggested by ECHN. Aside from acquisitions, Prospect has experience, and has had success, in structuring partnerships and joint ventures.

Vision and Operations

1. *How will affiliation with our organization help ECHN achieve its vision and goals?*

In order to better position ECHN as a premier choice for healthcare services in its community, we believe that we must continually evaluate the facilities and markets for future capital projects. Immediately upon the execution of the APA, as a part of our strategic planning process we would consider and evaluate market data and projections, current and proposed regulatory environments, operational and financial requirements, and capital expenditures models in the markets in which ECHN operates. Our strategic planning process would be led by the local management team; however the resources of Prospect would provide the necessary capital and expertise to enhance existing services and to add new service lines. Although we have not yet had an opportunity to review ECHN's strategic plan, we believe that we will build upon ECHN's plans.

We will form an integrated healthcare delivery system through the CRC model which will necessarily involve a physician engagement strategy with the goal of providing high quality care in an efficient manner. We plan to implement, as necessary and appropriate, value-based payments, bundled payments, accountable care, and clinical integration with physicians and other providers. This is a model we have successfully implemented in Southern California for many years and are in process of exporting to other markets such as Texas, Rhode Island and New Jersey. It is a model we would seek to establish in Connecticut.

2. *Based on your vision of the market, how can you help us improve the range of healthcare services available within the communities ECHN serves and access to those services?*

We recognize that meeting the long-term needs of ECHN's service area would require constant evaluation of the market to identify needed services to enhance growth. Growth strategies begin with a detailed assessment of the market to identify opportunities to add or expand healthcare services. ECHN's service lines would be identified and evaluated. Working with the local management team, and in consultation with local advisory boards, we will identify and prioritize the growth initiatives that make the most sense. It would be our objective to initiate growth initiatives for the benefit of the surrounding communities of the hospitals operated by ECHN so long as that care can be delivered in a high quality and financially responsible manner.

One of the key components of the CRC model is to build a coordinated network of providers that deliver the full range of services to a population for a value based payment. Of course it is preferable to have as many services delivered by owned and operated facilities as possible. However, it generally isn't possible or feasible to provide all services for such a population. We would use the CRC network development process to assist in the evaluation of those existing and new services best provided by ECHN and those that could be provided more advantageously by others.

As an example, since the closing of our transaction in Rhode Island on June 20, 2014, we have achieved the following in building our CRC model:

a. Formed a multi-specialty IPA with over 100 primary care providers;
b. Recruited a highly skilled team of vascular surgeons and bariatric surgeons;
c. Expanded the base of employed physicians;
d. Entered into a joint venture for outpatient radiation oncology;
e. Expanded out-patient clinics to outside our service area; and
f. Re-opened a closed Cath Lab.

In addition to the above, we are in the process of developing a digestive disease center, exploring the establishment of a hospital based surgical center, and developing a neurosciences center.

Prospect commits to spend $75 million in capital expenditures over 5 years to expand and enhance ECHN's market presence and growth. Such capital expenditures will be consistent with the strategic plan described in Question #1 above. We plan to commit sufficient funds in order to maintain and improve the physical plant and equipment at ECHN. Finally, we plan to commit sufficient capital to implement physician engagement strategies to align the incentives of physicians and ECHN.

As Prospect's first hospitals in Connecticut, our incentives are perfectly aligned to make ECHN the provider of choice in its service areas. As healthcare reform focuses on quality care delivered efficiently, ECHN is well positioned; and with Prospect's capital and resource commitments, ECHN will have the ability to expand on the quality healthcare services it provides to its surrounding communities.

3. *If you have facilities in ECHN's primary and secondary services areas or within the city of Hartford, how do you envision ECHN working with these facilities? What services, if any would you anticipated growing, adding, or eliminating at the local community level?*

As stated above, ECHN will be Prospect's first hospitals in the state of Connecticut. As such, we do not anticipate eliminating any services. In fact, our goal would be enhance and grow ECHN's service lines and market position within its communities.

4. *What governance or other changes would you propose to make to our medical staffs?*

Prospect would work with local advisory boards and ECHN's medical staff members to preserve the existing staff membership and the current privileges of each physician as well as the medical staff leadership. Furthermore, we believe that the delivery of quality healthcare services depends on quality physicians. It is our intention to attract and recruit quality physicians (both primary and specialty) in order to form a CRC network.

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

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

5. *What governance or other changes would you make to the medical foundation? What level of local governance or other changes would you make to the medical foundation? What level of local governance or influence would ECHN based providers or ECHN management has in the medical foundation*?

We believe that the delivery of healthcare is local in nature. As such we plan to organize and empower local governance boards comprised of local leaders and physicians to assist ECHN post transaction in the delivery of health care services. We anticipate that the local advisory boards would have oversight over the strategic direction and quality of health care services provided at ECHN facilities including the services provided by the physicians employed by the medical foundation. In addition, we will use our experience in working with physicians to improve the performance of the medical foundation. Finally, we will use the foundation as a cornerstone of our CRC strategy to improve the financial performance of the Foundation. Also see generally the response to question #4, above.

6. *How would a strategic transaction with your organization enhance ECHN's ability to attract and retain high quality physicians to the medical staff in ECHN's service area? Please discuss:*
    - *Your organization's processes and capabilities regarding physician recruitment and retention,*

- *Your organization's strategy for fostering clinical integration and alignment with employed and independent medical staff.*

Prospect does not have a standardized approach to physician recruitment and retention. We consider Prospect to be a physician friendly service operator. As such, we listen to our physicians and accommodate them to the extent reasonable. For example, certain physicians prefer to be employed. As such we will use the Medical Foundation for their employment. Some physicians prefer to remain independent in their practices, but would like to be free of the non-clinical aspects of running a practice. For such physicians, in our other markets have established hospital-based clinics to accommodate such physicians. We also form Independent Physician Associations ("IPAs"). Through our IPAs, both employed and independent physicians join together with the health system to contract with payers and participate in capitation, bundled payments and other value-based payment methodologies to improve their practice environment, performance and financial results. We use the health system aligned IPA as the vehicle for clinical and financial integration. Through value-based and risk contracting, we achieve financial integration between the health system and its aligned physicians. Through utilization review, quality improvement, clinical guideline development, pay for performance and data sharing and integration, we achieve clinic integration between the health system and its aligned physicians.

Clinical excellence and quality of care are the cornerstone of Prospect's philosophy with respect to the delivery of healthcare services. Prospect believes that quality healthcare services must be provided in a cost efficient manner. We believe that such model of a healthcare delivery system necessarily requires the input and participation of quality physicians who practice evidence-based medicine. Therefore, regardless of the physician engagement model, we incentivize physicians to provide high quality services through "pay-for-performance" standards that stress clinical integration and quality of services. We would employ the same approach at ECHN.

7. *How would the proposed affiliation enhance clinical quality, safety, service and patient satisfaction? Please describe the ways in which you measure quality and safety. Discuss how your hospitals perform in terms of CMS quality indicators and patient satisfaction.*

As stated above, quality of care is of paramount importance to Prospect. Attached for your convenience, is a list of quality awards that our hospitals and medical groups have recently received.

We intend to foster an environment that not only encourages quality of care but also rewards it.

Furthermore, as stated above, Prospect would work with local advisory boards to support any existing initiatives, develop new strategies and provide additional quality and safety expertise and protocols, as necessary, to enhance the quality of services at ECHN. The delivery of quality healthcare services requires constant and unwavering focus from all constituents. Through the

leadership of the local advisory boards and the local management team, we expect a tenacious focus on quality at ECHN post transaction.

As an example of our commitment to quality, we have attached a recent article regarding our cancer center in Rhode Island. The Cancer Center at Roger Williams Medical Center was recently classified by the Commission on Cancer as an Academic Comprehensive Cancer Care Program. Only 13% of the cancer programs accredited by the Commission on Cancer receive such designation.

The local advisory board, management and physician leaders at Roger Williams Medical Center thought that it was important for Roger Williams to earn such distinction. Prospect not only encouraged the pursuit of the designation, but also facilitated and provided all resources necessary to achieve such designation.

Finally, implementing the coordinated regional care model aligns physicians with the health system and measures the improvement in population health management as a result of the implementing value-based, risk contracts with payers. We integrate processes between the hospitals and its aligned physicians under those value-based contracts with payers that measure, manage and improve quality, utilization and efficiency metrics.

8. *Please describe your anticipated operational approach to ECHN, including anticipated operating efficiencies and cost avoidance, if any, resulting from the proposed transaction and any savings associated with such efficiencies/avoidance.*

We anticipate that by joining with Prospect, we can use our increased size in order to reduce costs related to supplies, pharmaceuticals and purchased services at ECHN. However, this transaction is not about the reduction of such costs or the elimination of duplicate services in order to avoid costs. We believe the true opportunity in this proposed business combination, aside from reductions in expenses, to be in the shared vision of the parties and the combined capabilities and expertise to execute on that vision and in particular growth opportunities.

As described above, Prospect has a well-developed integrated healthcare delivery network with a successful track record in population health management and accepting risk-based contracts, while delivering quality healthcare service. ECHN is a healthcare delivery network with all the necessary pieces to take the next steps in its evolution to accept more risk contracts and to immerse itself more in population health management. We believe that the synergies between the parties and the potential to implement best practices of each party across the Prospect-ECHN system will present far greater market growth opportunities.

As such, we intend to invest in ECHN's infrastructure and to develop scalable tools and technology to effectively manage the health of the population served by ECHN. It is our goal that ECHN to not only remain viable but be a leader in providing high safety and quality healthcare services at low cost to the community for the long-term. We will endeavor to form an integrated healthcare delivery model which will necessarily involve a physician engagement

strategy with the goal of providing high quality care in an efficient manner. We plan to implement, as necessary and appropriate, health reform required changes including, but not limited to: value-based payment, bundled payment, accountable care, and clinical integration with physicians and other providers.

9. *Please discuss the governance structure and continuing role of ECHN and/or the ECHN Board in the governance of the Health System, and if applicable, at your health system corporate level. Please describe your willingness to commit to the following roles as part of an affiliation agreement. Examples of comparable transactions where you have employed the proposed structure would be helpful.*

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

(A) Board Representation. Post-transaction, Prospect will appoint a local community advisory board. A significant and pre-determined number of the local advisory board shall be members of the local community and practicing physicians. Prospect would prefer that at least some members of the Board of Directors of ECHN agree to serve on such advisory boards at the local hospitals. A member of the board of directors of ECHN post transaction shall be a member of the local community governing advisory board. That way there is a direct communication between the advisory boards and the board of directors.

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

(i) make recommendations and suggestions with respect to medical staff credentialing;

(ii) provide input on policies and clinical programs;

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

(iv) provide input on operating and capital budgets;

(v) provide input and support physician recruitment efforts;

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

(vii) promote community health initiatives; and

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

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

In our most recent transaction in Rhode Island, each of the hospitals that were part of the transaction has local advisory boards. The compositions of the local advisory boards are local physicians and local community leaders. The local advisory boards have been indispensable in our efforts in Rhode Island. We welcome ECHN's input on this matter.

10. *Please indicate the senior management positions you would anticipate having at ECHN, as well as the roles and positions these individuals would have in the organization post-affiliation.*

We do not foresee any changes in the management of ECHN. It has been our practice and preference to rely on the existing strong management in place at the time of the transaction. In addition, Prospect will make all of its resources (both financial and human capital) available to ECHN management team in order to execute on the strategic plan and develop a healthcare delivery system with population health management and accountable care capabilities.

11. *Please describe your willingness, if requested, to commit to the following service enhancements and capital investments as part of an affiliation agreement. To the extent that some of these commitments are in the future and subject to changes in the market/context, please describe the requirements these initiatives have to meet in order to be implemented (e.g., an ROI within a period of time requirement, system Board approval, etc.). Additionally, to the extent there are capital investments required, please describe the structure of the capital pool(s) that these programs would be accessing and the mechanism for accessing them (e.g., would you segregate a certain capital pool for these programs over a period of time, would these programs be competing for capital with other facilities in your system, etc.).*

- ***Service Enhancements***

i. In addition to maintaining the services outlined in its template Agreement, ECHN anticipates developing, expanding or enhancing service in the following clinical areas. Please comment on how affiliation with your organization would support and enable clinical program development and/or

expansion, how you approach medical staffing, and/or facility and equipment enhancements for the following services:

1. *Enhancing and expanding Primary Care capabilities, in existing and new markets*
2. *Cardiovascular Services, including diagnostic and interventional catheterization, electrophysiology and pacemaker programs*
3. *Cancer Care, including medical oncology and specialty oncologic surgery*
4. *Bariatric Surgery*
5. *Orthopedics, with an emphasis on spine surgery and joint replacement surgery*
6. *Pain Management Service/Program*

ii. Maintaining joint ventures such as Tolland Imaging Center, Evergreen Endoscopy Center, Community Cancer Care and others.

- ***Capital Investments***
  - *i. Electronic Medical Record system replacement and implementation*
  - *ii. New care management capabilities and systems*
  - *iii. Building an ambulatory surgery center*
  - *iv. Transitioning capacity to private rooms*
  - *v. Upgrading and expanding OB and neonatal nursery*
  - *vi. Upgrading and expanding the inpatient operating rooms*
  - *vii. Renovating and expanding the radiology suite*
  - viii. *Investing in medical equipment*

It should be noted at the outset that hospitals and regional networks within the Prospect system do not compete against each other for capital. It is Prospect's practice to fund capital expenditures as are reasonable and necessary to foster an environment of growth and provision of quality healthcare services in each region. Therefore, how much Prospect spends on capital expenditures in its other regions will never have an impact on ECHN.

Furthermore, there is no set formula for approving of capital expenditures. We recognize a healthcare company's need to continually re-invest in its property, plant, equipment, and information systems. As stated above, immediately after the closing, we would embark on a strategic planning process involving the local management team and the local board. We understand that all of the items noted above are part of ECHN's strategic plan. We have not as of yet has the opportunity to review the plan. However, we intend to collaborate with the local management to prioritize ECHN's growth plans and capital expenditure needs and will use at a minimum the funds committed ($75 million) to fund such programs and improvements to

ECHN's infrastructure. If there's a need to spend more on such projects that will contribute to ECHN's growth, Prospect will make such an investment.

In addition please see our response to question #2 above illustrating the initiatives underway in Rhode Island for a transaction that closed on June 20, 2014 (less than one year ago)

12. *Please provide a detailed list of additional information required if selected to proceed with further due diligence.*

Attached please find a copy of due diligence request list.

13. *Please indicate the names of the financial, legal or other advisors who will be engaged in connection with the transaction.*

We have not yet hired any financial or legal advisors with respect to this transaction. We are in process of interviewing appropriate firms to assist us in this transaction. We will inform you of the firms that we ultimately hire as we move forward in this process.

14. *Upon the selection of a preferred acquirer/partner, ECHN intends to promptly negotiate a Definitive Agreement and consummate the transaction. Please discuss any corporate approvals required to complete the transaction, the time required for those approvals and any potential risks that could increase the time required or stop the process.*

Typically, we are able to complete our due diligence process within 30-45 days of receipt of all items requested in our due diligence list. Our process involves an in depth review of material documents, interviews with management and site visits by key personnel at Prospect.

This indication of interest has been approved by Prospect's senior management. Execution of a definitive agreement and completion of a transaction will require approval by the Prospect Board of Directors. Furthermore, the execution of the APA is subject to satisfactory completion of due diligence at Prospect's sole discretion and the closing of the proposed transaction is subject to any necessary and customary regulatory approvals.

15. *Please indicate any financing or other contingencies or material conditions to the consummation of the transaction, including any key assumptions in your valuation of ECHN that, if revised, could have a significant impact on the financial terms.*

Our proposal is not subject to any financing contingency. Prospect has the funds to consummate the proposed transaction.

16. *Describe the religious or ethical restrictions in detail.*

None

17. *Explain how ECHN would continue to meet the needs of its community in the event the restrictions apply.*

Does not apply.

We recognize that choosing a transaction partners involves more than financial considerations and legal structures. Our proposal is about preserving and enhancing a community resource in a way that honors ECHN's stated mission and vision.

Prospect is unique in the market place and is uniquely positioned to meet the challenges of the ever changing healthcare environment and thrive under healthcare reform. Although noted above, we believe it is important to reiterate that what distinguishes Prospect in the marketplace is its CRC model with the proven ability to effectively and profitably manage risk and value-based reimbursement, and bundled payments on behalf of our hospitals and medical groups while at the same time delivering a high quality of care. This unique structure allows managed care plans to focus on marketing; physicians to focus on patient care; and Prospect to coordinate population health management that ensures quality and efficiency.

This indication of interest is confidential and subject to the terms and conditions of our Confidentiality Agreement dated February 20, 2015.

The contacts for questions regarding our indication of interest are as follows:

Steve Aleman, Chief Financial Officer (steve.aleman@prospectmedical.com)
Frank Saidara Vice President (frank.saidara@prospectmedical.com)

Mr. Aleman and Mr. Saidara can be reached at 310.943.4500.

If you have any questions, please feel free to contact Messrs. Saidara or Aleman, or me.

We look forward to working with you.

Very truly yours,
PROSPECT MEDICAL HOLDINGS, INC.

Samuel S. Lee
Chief Executive Officer

Quality Awards

PROSPECT MEDICAL HOLDINGS, INC.
HOSPITAL QUALITY AWARDS
Wednesday, March 4, 2015
PROSPECT MEDICAL
California Association of Physician Groups – Standards of Excellence Program – Elite Status (2012-2014)
Citizens Choice Healthplan, HMO, Shooting Star Award Top Performer (2012)
Circle of Care Award from CalOptima (Health Plan), Health Educator, Paul Montanchez (2012)
Certificate of Outstanding Performance from Integrated Healthcare Association: 1. IT Enabled Systemness for groups Genesis, Prospect Medical Group, NWOC, Gateway Medical Group (2010) 2. Diabetes Registry and related activities for groups Genesis, Professional Care, NWOC, Gateway Medical Group (2010) 3.Meaningful Use of Health IT for groups – Genesis, Professional Care, NWOC, Gateway Medical Group (2011)
City of Anaheim recognized Prospect Medical for Community Service (2011)
Integrated Healthcare Association AMVI Medical Group - Pay for Performance (P4P) "Most Improved" award winner (2012)
Integrated Healthcare Association AMVI Medical Group - Certificate of Outstanding Performance - Meaningful Use of Health IT (2012)
DHMC - AMVI Medical Group, awarded a Certificate of Excellent HEDIS scores related to cardiovascular disease and diabetes (2012)
PROMED HEALTHCARE ADMINISTRATORS
California Association of Physician Groups – Standards of Excellence Program – Elite (2012)
Integrated Healthcare Association Pomona Valley Medical Group - Certificate of Outstanding Performance - Patient Assessment Survey (2012)
Dr. Prasad
Corporate Honorary Chair of the Arthritis Foundation I.E. Walk (June 2013)
LA Business Journal Healthcare Leadership Awards (Healthcare Advocate Award, Dr. Prasad was a finalist in the Healthcare Executive category). (April 2013)
LOS ANGELES Community Hospital/NORWALK Community Hospital (combined licensure)
Healthgrades Awards
America's Best 100 Hospitals
One of Healthgrades America's 100 Best Hospitals for Pulmonary Care (2013)
One of Healthgrades America's 100 Best Hospitals for Gastrointestinal Care (2013)
One of Healthgrades America's 100 Best Hospitals for Stroke Care (2014)
One of Healthgrades America's 100 Best Hospitals for General Surgery (2014)
Cardiac
Five-Star Recipient for Treatment of Heart Failure for 5 Years in a Row (2010 – 2014)
Neurosciences
Stroke Care Excellence Award for 7 Years in a Row (2008 – 2014)

Top 5% in the Nation for Treatment of Stroke for 5 Years in a Row (2010 – 2014)	
Five-Star Recipient for Treatment of Stroke for 7 Years in a Row (2008 – 2014)	
Orthopedic	
Five-Star Recipient for Hip Fracture Treatment (2014)	
Pulmonary	
Pulmonary Care Excellence Award for 2 Years in a Row (2013-2014)	
Top 5% in the Nation for Overall Pulmonary Care Services for 2 Years in a Row (2013-2014)	
Ranked #6 in California for Overall Pulmonary Services (2013)	
Top 10 in California for Overall Pulmonary Services (Ranked 6 in 2013)	
Five-Star Recipient for Overall Pulmonary Services (2013)	
Five-Star Recipient for Treatment of COPD for 10 Years in a Row (2005 – 2014)	
Five-Star Recipient for Treatment of Pneumonia for 2 Years in a Row (2013-2014)	
Gastrointestinal	
Gastrointestinal Care Excellence Award (2013)	
Top 5% in the Nation for Overall GI Services (2013)	
Ranked #6 in California for GI Services (2013)	
Top 10 in California for GI Services in 2013 (Ranked 6 in 2013)	
Five-Star Recipient for Treatment of GI Bleed for 2 Years in a Row (2013-2014)	
Five-Star Recipient for Treatment of Pancreatitis for 5 Years in a Row (2009 – 2013)	
Five-Star Recipient for Cholecystectomy (2013)	
General Surgery Excellence Award (2014)	
Top 5% in the Nation for General Surgery (2014)	
Five-Star Recipient for Esophageal/Stomach Surgeries (2014)	
Appendectomy	
Five-Star Recipient for Appendectomy for 2 Years in a Row (2013-2014)	
Critical Care	
Five-Star Recipient for Treatment of Sepsis for 9 Years in a Row (2006 – 2014)	
Five-Star Recipient for Treatment of Diabetic Acidosis and Coma (2013)	
Five-Star Recipient for Treatment of Respiratory Failure (2014)	
Maternity Care	
Five-Star Recipient for Maternity Care for 2 Years in a Row (2011 – 2012)	
GYN Surgery	
Five-Star Recipient for Gynecological Surgery (2012)	

CareChex Awards
Stroke Care - Top 10% Nationwide (2012)
Women's Health - Top 15% Nationwide (2012)
Gastrointestinal Care - Top 15% Nationwide (2012)
Bruce Grimshaw
2010 ACHE Regents Leadership Award
2013 ACHE Service Award
SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD
Healthgrades Awards
Pulmonary
Pulmonary Care Excellence Award for 10 Years in a Row (2005 – 2014)
Top 5% in the Nation for Overall Pulmonary Services for 2 Years in a Row (2013-2014)
Five-Star Recipient for Overall Pulmonary Services for 11 Years in a Row (2003 – 2013)
Five-Star Recipient for Treatment of COPD for 12 Years in a Row (2003 – 2014)
Five-Star Recipient for Treatment of Pneumonia (2013)
Gastrointestinal
Five-Star Recipient for Esophageal/Stomach Surgeries (2014)
Critical Care
Five-Star Recipient for Treatment of Sepsis for 9 Years in a Row (2006 – 2014)
CareChex Awards
Stroke Care - Top 15% Nationwide (2012)
Vascular Surgery - Top 10% Nationwide (2014)
SOUTHERN CALIFORNIA HOSPITAL AT CULVER CITY
Healthgrades Awards
Cardiac
Five-Star Recipient for Treatment of Heart Failure (2013)
Gastrointestinal
Five-Star Recipient for Treatment of Pancreatitis for 2 Years in a Row (2013-2014)
Critical Care
Five-Star Recipient for Treatment of Sepsis for 6 Years in a Row (2008 – 2013)

GYN Surgery
Five-Star Recipient for Gynecological Surgery for 2 Years in a Row (2011 – 2012)
Orthopedic
Five-Star Recipient for Hip Fracture Treatment (2014)
CareChex Awards
Women's Health - Top 10% Nationwide (2012)
NIX HEALTH
Healthgrades Awards
Hospital-Wide
Outstanding Patient Experience Award (2012)
Top 10% in the Nation for Outstanding Patient Experience (2012)
Appendectomy
Five-Star Recipient for Appendectomy for 4 Years in a Row (2010 – 2013)
Cardiac
Five-Star Recipient for Treatment of Heart Attack for 5 Years in a Row (2010 – 2014)
Critical Care
Five-Star Recipient for Treatment of Sepsis for 5 Years in a Row (2009 – 2013)
Gastrointestinal
Gastrointestinal Care Excellence Award (2015)
Gastrointestinal Care Excellence Award (2014)
Top 5% in the Nation for GI Medical Treatment (2014)
Top 10% in the Nation for Overall GI Services (2014)
Five-Star Recipient for Treatment of Bowel Obstruction (2014)
Five-Star Recipient for Gallbladder Removal Surgery for 4 Years in a Row (2011-2014)
Five-Star Recipient for Cholecystectomy for 3 Years in a Row (2011 – 2013)
Neurosciences
Five-Star Recipient for Treatment of Stroke for 4 Years in a Row (2011 – 2014)
Pulmonary
Five-Star Recipient for Treatment of COPD for 2 Years in a Row (2012 – 2013)
Joint Commission's Top Performers on Key Quality Measures™ (2012)

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Bariatric
Bariatric Surgery Center of Excellence by The American Society for Bariatric Surgery's (2011-2014)
OptumHealth Center of Excellence Designation for Bariatric Centers of Excellence Network (2011)
Five-Star for Bariatric Surgery (2010/2011, 2009/2010, 2008/2009, 2007/2008)
Five-Star Recipient for Overall Bariatric Surgery by Healthgrades (2013)
Bariatric Quality Program Accredited by The Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) 2014
Cardiovascular
Get with the Guidelines Gold Achievement Award by the American Heart Association (2010-2013)
CareChex Awards
Overall Hospital Care - Top 15% Nationwide (2012)
Overall Medical Care - Top 15% Nationwide (2012)
General Surgery - Top 10% San Antonio (2014)
Emergency Medicine
Dr. Gregory Roth, MD, CPE became a Certified Physician Executive (2014)
Executive Women's International San Antonio
Firm of the Year Award (2013)
Hospital-Wide
Top Improver Award Winner by Press Ganey Associates, Inc. (2011)
Bronze Award by Texas Hospital Quality Improvement Award (2014)
General Surgery Excellence Award (2015)
General Surgery Excellence Award (2014)
Texas Medical Foundation Health Quality Institute - Hospital Quality Improvement Award (2014)
Above and Beyond Award - Employer Support of the Guard and Reserve (2014)
Hyperbaric Medicine
Accreditation with Distinction from the Undersea and Hyperbaric Medical Society (2009-2014)
John Strieby
Graduate of the Masters in Leadership Program (2008)
Orthopedics
Blue Distinction Center for Knee and Hip Replacement® by Blue Cross and Blue Shield of Texas (2009-2013)

Institute of Quality Orthopedic Care for Total Joint Replacement by Aetna (2012-2013)
San Antonio Business Journal - Health Care Heroes
Elizabeth Llanas, RN, Health Care Heroes Health Care Provider (2013)
Peggy Perry, Health Care Heroes Volunteer (2012)
Adele Giles, Health Care Heroes Administrative Excellence (2011)
Sr. Stephanie Morales, Health Care Heroes Health Care Advocate (2011)
Dr. Robert Jimenez, Health Care Heroes Lifetime Achievement Award (2010)
Senior Health Center
Patient-Centered Medical Home, National Committee for Quality Assurance (2014)
Surgical Care
Joint Commission's Top Performers on Key Quality Measures™ (2012)
FATIMA/ST. JOSEPH
Patient Care Services
Director of Permformance Improvement is one of 21 contributors from across the country to the Nursing 2015 Drug Handbook
Joint Commission Accredited Hospital, (2015)
Joint Commission Accredited Hospital, 3 years (9/2011)
Joint Commission Certified for Advanced Primary Stroke Center, 2 years (9/2013)
Joint Commission Certified for Advanced Diabetes Center, 2 years (9/2013)
Joint Commission Disease Specific Certification for Diabetes (2014)
Joint Commission Certified for Joint Replacement-Hip, 2 years (9/2013)
Joint Commission Certified for Joint Replacement-Knee, 2 years (9/2013)
NDNQI (National Database of Nursing Quality Indicators from the American Nurses Association) for outstanding commitment to quality patient care (2014)
Designated a NICHE hospital, Nursing Improving the Care of Hospitalized Elders (2014)
Joint Commission Certified for Advanced Diabetes Center, 2 years (2014)
Pathway to Excellence Certification by the American Nurses Association (1/2015)
NICHE "Exemplar" status (2015)
Emergency Department
First senior-friendly emergency department opened (3/2013)
Rehabilitation
Comprehensive Integrated Inpatient Rehabilitation awarded January, 2012; expires January 2015
Stroke Specialty Program awarded January, 2012; expires January, 2015

Commission on the Accreditation of Rehabilitation Facilities (CARF) (recertified 2014)
Commission on the Accreditation of Rehabilitation Facilities (CARF) Stroke designation (2014)
Cancer Services
Cancer Services is STAR (Survivorship Training and Rehab) certified by Oncology Rehab Partners (3/2014)
Cancer Services – American College of Surgeons, Commission on Cancer Accredited (level to be determined) from March 2014 – March 2017
Infusion Therapy – All nurses certified by the Oncology Nursing Society for chemotherapy infusion, (4/2014)
Blood Bank
Certified by American Association of Blood Banks, AABB 4/1/14 – 3/31/16
College of American Pathologists (CAP), 2 years (9/13)
Infection Protection and Control Department
Marlene Fishman honored as a Knowledge Bar Expert at 41st APIC Annual Conference (6/2014)
Certificate of Improvement presented by Healthcentric Advisors to Our Lady of Fatima Hospital for 25% or Greater Relative Improvement Rate for *Clostridium difficile* Infection (CDI) LabID (June 2014)
Certificate of Participation presented by Healthcentric Advisors to Our Lady of Fatima Hospital for Participation in the CMS 10th Statement of Work (June 2014)
Rhode Island Department of Health recognition for supporting and contributing to the Department Quality Improvement efforts – to Marlene Fishman (2014)
Patient Safety Champion Award for joint efforts to decrease harm and improve the care delivered within St. Joseph Health Services of Rhode Island – to Marlene Fishman (2014)
Rhode Island Department of Health Certificates of Appreciation for participation in the Influenza Hospitalization Surveillance Network – to Our Lady of Fatima Infection Control Practitioners (2012 – 2013)
APIC Heroes of Infection Prevention Award for having successfully reduced infection, raised awareness, and improved the health and well-being of patients, healthcare workers, and the public - to Marlene Fishman Wolpert (2012)
ROGER WILLIAMS MEDICAL CENTER
Patient Care Services
Joint Commission Accredited Hospital, 3 years (9/2011)
Joint Commission Certified as Advanced Primary Stroke Center, 2 years (9/2013)
American Heart/Stroke Association's Silver Award for Advanced Primary Stroke Center's composite performance (3/2013)
Stroke and US News and World Report, "Best Hospitals" issue. (3/2013)
NDNQI (National Database of Nursing Quality Indicators) for outstanding commitment to Quality Patient Care (10/2013)
Palliative Care Program survey scheduled for June 13, 2014 to be first in state for certification by the Joint Commission (9/2013)

Emergency Department
Emergency Department, the states first senior-friendly emergency department (3/2013)
Bariatrics
Bariatric Surgery Center of Excellence by ASMBS (American Society for Metabolic and Bariatric Surgery) and SRC (Surgical Review Corporation) (12/2013)
Endoscopy
First hospital in RI to perform Endobronchial Ultrasound (EBUS) (8/2013)
Third hospital in the nation to offer Sedationless Colonoscopy (9/2013)
Orthopaedics
The Joint Commissions Gold Seal of Approval, total hip and knee replacement programs (2/2014)
Blue Cross/Blue Shield Blue Distinction Total Value Center for Spine Surgery and Hip & Knee Surgery (1/2014)
First hospital in RI to launch the American Orthopaedic Association's "Own the Bone program" (1/2014)
Cancer Center
18 Surg/Onc fellowship training programs, one of only two in New England (7/2013)
Cancer Program accreditation with commendation by the Commission on Cancer of the American College of Surgeons (10/2012)
National Marrow Donor Program approved Transplant Center (1/2014)
Foundation for the Accreditation of Cellular Therapy Accreditation for the Bone Marrow Unit
Commission on Cancer CCP Community Cancer program (October 2012 - October 2015)
National Accreditation Program for Breast Centers April 2013 – April 2016
Quality Oncology Practice Initiative Certification, American Society of Clinical Oncology October 2013 – October 2016
STAR Program Certification from Oncology Rehab Partners (2014)
Designated as a Academic Comprehensive Cancer Center (2/2015)
Behavioral Medicine
Optum Health recognition for ACE (Achievements in Clinical Excellence) program Behavioral Health (7/2013)
Optum Health - 2013 Achievements in Clinical Excellence in Behavioral Health Silver Level (7/2013)
Addiction Medicine
States only level 4 inpatient detox
American Hospital Association recognition for hosting Rally 4 Recovery Program (1/2014)
Geriatrics
Successfully pass annual FDA-MQSA (Mammography Quality Standards Act) facility inspection (8/2013)
Re-established Cardiac Catheterization Services (8/2013)
Redesignated as a NICHE (Nurses Improving Care for Healthsystem Elders) Hospital (9/2013)

OR
First hospital in state to conduct a Fire safety training with evacuation in the Operating Room, a training video has been developed from this session (10/2013)
Diagnostic Wing
ACR accreditation for CT Scanner (2/2014)
Certified as a Radiation Injury Treatment Network (8/2013)
Breast Health Clinic received American College of Radiology 3-year re-accreditation (8/2013)
Successfully pass annual FDA-MQSA (Mammography Quality Standards Act)
Re-established Cardiac Catheterization Services.
Pharmacy
Phaseal Safety Award: Pharmacy recognition of Chemotherapy Compounding Safety in the Northeast (10/2012)
Laboratory
CAP (College of American Pathologists) Certified, 2 years (12/2014)
AABB (American Association of Blood Bank), 3 years (10/2012)
Radiology
Accredited in Computed Tomography (CT) by the American College of Radiology (ACR) 3 years (2014)
ELMHURST
Joint Commission Accredited Hospital, 3 years (9/2014)

Article re Quality

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HEALTH CARE

Cancer Center at Roger Williams Medical Center receives new designation

ROGER WILLIAMS Medical Center's Cancer Center has been classified by the Commission on Cancer as an Academic Comprehensive Cancer Center Program.

By PBN Staff
Twitter: @ProvBusNews (http://twitter.com/ProvBusNews)

2/27/15

PROVIDENCE – The Cancer Center at Roger Williams Medical Center has been classified by the Commission on Cancer as an Academic Comprehensive Cancer Center Program, placing it among a select group of cancer centers in New England to hold the designation.

According to information from CharterCare Health Partners, of which Roger Williams Medical Center is an affiliate, 13 percent of the more than 1,500 Commission on Cancer-accredited cancer programs nationwide hold this designation.

Roger Williams met the following criteria from the Commission on Cancer to achieve the new classification:

- Provides postgraduate medical education in at least four program areas, including internal medicine and general surgery
- Records more than 500 newly diagnosed cancer cases each year
- Full range of diagnostic and treatment services either on-site or by referral
- Participates in cancer-related clinical research either by enrolling patients in cancer-related clinical trials or by referring patients for enrollment at another facility or through a physician's office.

"This designation is a reflection of both our academic and clinical efforts to provide better treatment for cancer patients in our region," Dr. N. Joseph Espat, director of the Cancer Center at Roger Williams, said in a statement. "More patients are coming to our cancer program, our residency and fellowship programs continue to provide excellent training for the next generation of physicians and our clinical trials are advancing research into diagnosis and treatment of cancer."

Kimberly O'Connell, president of Roger Williams, said the entire oncology team - including those involved with cancer teaching and research programs - has been involved is reaching this designation.

Dr. Steven Katz, chairman of the Roger Williams' Cancer Committee, said "innovative research programs" played a role in enabling the recognition.

"Our immunotherapy platforms promise to bring novel treatments to patients with limited options. We look forward to launching several new T cell trials for liver tumors in the coming year," Katz said.

The Commission on Cancer, a program of the American College of Surgeons, recognizes cancer care programs for their commitment to providing comprehensive patient-centered care. In Rhode Island, The Miriam Hospital and Rhode Island Hospital are also designated Academic Comprehensive Cancer Centers by the Commission on Cancer.

Due Diligence Document Checklist

Entity: ECHN & Affiliates (including JVs)

		GENERAL CORPORATE
A		**Minutes**
	1	Stockholders'/partnership meetings
	2	Board of Directors
	3	Board committees
B		**Charter Documents**
	1	Certificate of Incorporation/Partnership, as amended
	2	By-laws, as amended
C		**Corporate Organization**
	1	Officer & director lists
	2	Management structure organization chart
	3	Organization chart showing the Group, each subsidiary and affiliated partnership
	4	Stockholder or partnership list, including number of shares or units held
	5	Information regarding any subsidiaries of affiliated entities, i.e., ownership; management arrangement; acquisition documents
	6	Information regarding joint ventures or partnerships
	7	Agreements related to earnouts and contingency payments
	8	Material covenants against competition or exclusivity arrangements
	9	Shareholder agreements
D		**Capital Stock/Partnership Units**
	1	Stock records, stock ledgers
	2	Agreements relating to the purchase, repurchase, sale or issuance of securities/partnership units, including oral commitments to sell or issue securities/partnership units
	3	Agreements relating to voting of securities/partnership units and restrictive transfers
	4	Agreements relating to preemptive or other preferential rights to acquire securities/partnership units and any waivers thereof
	5	Documents relating to any conversion, recapitalization, reorganization or significant restructuring of the Group
E		**Business**
	1	Marketing or strategic plans
	2	Marketing brochures
	3	Policies and procedures
	4	List of any trademarks, trade names, copyrights, patents, service marks or other intellectual property rights, owned by or used in the business

Due Diligence Document Checklist

		Entity: ECHN & Affiliates (including JVs)
	5	Description of IT Systems
	6	List of physicians/providers by site& specialty
	7	Health plan audits & CAPs for last 12 months
F		**PHYSICIAN INFORMATION**
	1	Physician and physician extender census including name, hire date, status (full or part time), specialty
	2	Curriculum vitae (must include SSN, DOB, Medical School & year graduated)
	3	Copy of license & DEA for each physician
	4	Shareholder/Partner/Employed physician contracts
	5	Current IPA physician compensation arranagement and contracts
	6	Physician productivity reports for last fiscal year and current year: Gross charges & visits
	7	Physician and physician extender W-2s for last completed calendar year
	8	IPA physician contracts
	9	Encounter data by physician - Last two full calendar years
G		**MANAGEMENT & EMPLOYEES**
	1	Employment agreements and all other agreements with employees
	2	Consulting contracts
	3	Confidentiality or non-competition agreements
	4	List of all employees, headcount by function, describe current salary and wage program, including pay scales and forthcoming increases
	5	All employee compensation, bonus, profit-sharing plans, including deferred compensation, incentive, retirement, benefit or similar plans
	6	Description of all perquisites
	7	Employee manuals, handbooks, and other personnel policies
	8	Documents relating to any receivables from or payables to any employees/partners of the the Group
	9	Contracts with unions and other labor agreements
	10	Correspondence with any federal, state or local agencies regarding compliance with the U.S. Occupational Safety and Health Act or similar
H		**FINANCIAL & STATISTICAL**
	1	**Financial Statements**
	a	Audited statements, most recent three years

Due Diligence Document Checklist

	Entity: ECHN & Affiliates (including JVs)
b	Most recent unaudited interim financial statements (and the statements for the corresonding period of the previous fiscal year)
c	Last fiscal year and YTD detailed financial statements (income statement, balance sheet)
d	Detailed revenue breakdown for last fiscal year and current YTD, if not included above
e	Current year budget, including capital expenditure budget
f	Long range strategic/financial plan
g	Any reports, studies, and projections prepared internal or externally on the Group's finanical condition or planned operations
h	Significant correspondence with independent public accountants, including management letters in the last three years
i	Shared risk reconciliation reports and accrual schedules by HMO
j	IBNR analysis/lag study
k	Claims run: Dates of service 1/1/05 to 12/31/05 paid to date
l	Depreciation and amortization schedule
m	Aged accounts receivable schedule by payor
n	Aged accounts payable schedule
o	Accrued vacation and sick leave schedule
p	Complete inventory/asset listing
2	**Debt Financing**
a	All debt instruments, credit agreements and guarantees entered into by the Group and any of its affiliates, including lease financing, which are currently in effect
b	All material correspondence with lenders, including all compliance reports submitted by the Group or its designees
c	Any loans and guarantees of third party obligations
3	**Tax Matters**
a	Tax returns, most recent three years
b	Correspondence or notice from any foreign, federal, state or local taxing authority regarding any filed tax return (or any failure to file) including copies of all audit reports and descriptions of any pending tax audits by the IRS or other
c	Rulings, concessions, or the like which have been obtained from any federal or state taxing authority and which may apply to the Group's current or future operations
4	**Statistical & Other**
a	Last fiscal year and current YTD monthly HMO enrollment and capitation by plan
b	Last calendar year and current YTD inpatient days/1000 and SNF days/1000 for commercial, senior, and MediCal

Due Diligence Document Checklist

	Entity: ECHN & Affiliates (including JVs)
c	RAF Scores - Last two full calendar years
d	Encounter data submission
e	Pended claims report
f	Denials
g	Open auths report
h	P4P Reports
I	**CONTRACTS AND OTHER DOCUMENTS**
1	HMO, PPO or other third-party payor agreements, all other managed care agreements, and all proposals to enter into such agreements
2	Status/description of pending contractual changes related to the above
3	Hospital contracts- Include description of risk sharing agreements
4	Significant ancillary provider or professional services contracts
5	List of outside provider contracts with rates
6	Significant vendor contracts requiring more than $10,000 annual payments
7	Maintenance contracts for equipment, as well as all supply or service contracts and purchasing agreements
8	Outstanding guarantees, indemnities, or other similar agreements
J	**REAL PROPERTY**
1	Deeds
2	Leases of real property
3	Completed environmental surveys and assessments for all real property owned, leased or operated by the Group
4	Equipment financing documents, including leases
K	**RISK MANAGEMENT**
1	All insurance policies
2	List of all current or pending professional liability claims
3	List of closed claims for the past five years
4	Loss run reports from all insurance carriers for the past five years--Indicate closed claims
5	List of all current or pending workers' compensation claims
6	List of all current or pending litigation or investigation
7	Consent decrees, judgments, orders or settlement agreements which provided for ongoing covenants
8	Description of any outstanding judgments against the Group

Due Diligence Document Checklist

	Entity: ECHN & Affiliates (including JVs)
9	Actual and/or pending accusations, investigations and/or records of disciplinary action(s) by the Medical Board of California
10	Actual or pending hospital medical staff action
11	Information on any investigations, pending or threatened by any federal, state or local authority
12	Counsel's evaluation of pending litigation and any current litigation
13	Attorneys' letters to auditors
L	**REGULATORY INFORMATION**
1	All governmental (federal, state or local) licenses, titles, certificates, franchises, and permits necessary for the Group to conduct its business in compliance with applicable law, with expirations and renewal dates
2	List of all accreditations received by the Group and all professional or trade association memberships
3	Correspondence with any governmental agency requiring action by the Group which has not been taken or completed

RESPONSE TO DEFICIENCIES
EXHIBIT D - Interim Consulting Agreement (DRAFT)

INTERIM CONSULTING AGREEMENT

THIS INTERIM CONSULTING AGREEMENT (this "Agreement") is made and entered into as of the ___ day of October, 2015 (the "Effective Date") by and between Prospect Medical Holdings, Inc., a Delaware corporation ("Prospect," and collectively with its Affiliates (as defined below), "Advisor"), and Eastern Connecticut Health Network, Inc. a Connecticut non-stock corporation ("ECHN").

RECITALS

A. ECHN, together with its Affiliates (collectively, the "Company"), operate The Manchester Memorial Hospital and The Rockville General Hospital (the "Hospitals") which serve the needs of residents of the greater Manchester, Connecticut area.

B. On June 25, 2015, Advisor entered into a Letter of Intent with the Company, as amended by that certain Amendment No. 1 to Letter of Intent dated October ___, 2015 (as so amended, the "Letter of Intent"), which sets forth certain terms and conditions pursuant to which Advisor, or an Affiliate of Advisor, would acquire the businesses of the Company pursuant to the terms of a definitive Asset Purchase Agreement to be negotiated and entered into by ECHN and Advisor, the form of which is being filed in connection with the parties' application for a CON (as defined below) (the "Purchase Agreement"). Defined terms used but not defined herein shall have the meanings set forth in the Letter of Intent. References contained herein to Sections and Section numbers of the Purchase Agreement shall be deemed to refer to any successor provisions thereto, as the case may be.

C. The Letter of Intent provides, among other things, that the term of the Letter of Intent shall continue in effect until the earlier of (w) the execution by both parties of a definitive purchase agreement with respect to the matters set forth in the LOI, (x) thirty (30) days following the receipt by the parties of the proposed conditions or proposed settlement for certificate of need approval for the Hospitals by the Office of Healthcare Access of the Connecticut Department of Public Health ("OHCA"), (y) either the application for approval of the certificate of need by OHCA or the application for approval of the conversion of the Hospitals to a for-profit entity by the Attorney General of the State of Connecticut is withdrawn, and (z) June 30, 2016 (the "Expiration Date"). The Letter of Intent further provides that notwithstanding the foregoing, Prospect shall have the right (an "Extension Right"), exercisable upon prior written notice to ECHN and with the consent of ECHN, such consent to not be unreasonably withheld, to extend the Expiration Date by up to an additional thirty (30) days, if the foregoing regulatory approvals have not been received on or prior to thirty (30) days prior to the Expiration Date, in a form that Prospect has determined in good faith is on terms reasonably satisfactory to Prospect, and such failure to receive such approvals in satisfactory form is for reasons beyond the reasonable control of Prospect and without any fault on the part of Prospect. In addition, the Letter of Intent provides Prospect the right to exercise up to an aggregate of three (3) Extension Rights if the foregoing conditions to such exercise (including such consent of ECHN) are satisfied, and the Letter of Intent further states that the ECHN Board of Trustees shall be entitled to deny (i.e. withhold the required consent of ECHN) an Extension Right if it makes a good faith determination that the transaction is unlikely to close in the 90-Day period following June 30, 2016.

D. The Purchase Agreement is expected to set forth various conditions to Closing (including regulatory approvals), but pursuant to Connecticut law, the Purchase Agreement cannot be executed by the parties until receipt by the parties of the certificate of need approval for the Hospitals by OHCA and approval for the conversion of the Hospitals to a for-profit entity by the Office of the Attorney General of the State of Connecticut (the "CON Approvals").

E. Given the contracting restrictions imposed upon the parties by the State of Connecticut, the parties seek to confirm in writing that this Agreement is intended to continue until the closing of the transactions contemplated in the Letter of Intent (and, more specifically, in the Purchase Agreement) and that should this Agreement terminate, Advisor shall be entitled to be paid its Consulting Service Fees (as defined below) in accordance with, and to the extent provided by, Section 6.5 hereof.

F. Advisor, through its executives and other personnel, has certain experience and expertise in the management, operations, financial and administrative aspects of businesses like that of the Company.

G. Advisor is willing to provide certain consulting services, as described on Exhibit A hereto (the "Consulting Services"), with the objective of improving and otherwise benefitting the operations of the Company and the Hospitals during the time period from the Effective Date through the Closing of the Purchase Agreement, pursuant to the terms and conditions contained in this Agreement.

H. The Company seeks to confirm in writing Advisor's agreement to provide the Company with the Consulting Services between the Effective Date and the Closing Date (unless this Agreement is sooner terminated in accordance with the provisions of ARTICLE VI below).

NOW, THEREFORE, in consideration of the premises and mutual covenants set forth herein and other valuable consideration, the receipt and sufficiency of which are hereby acknowledged, and for their mutual reliance, the parties agree as follows:

ARTICLE I
RECITALS; AFFILIATES

1.1 Recitals. The recitals set forth above are hereby incorporated into this Agreement as if fully set forth in this ARTICLE I.

1.2 Affiliate. As used herein, "Affiliate" means, as to ECHN or Prospect, any person or entity that directly or indirectly controls, is controlled by, or is under common control with, as applicable, ECHN or Prospect and any successors or assigns of such person or entity; and the term "control" means possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of, as applicable, ECHN or Prospect whether through ownership of voting securities, by appointment of trustees, directors, and/or officers, by contract or otherwise.

ARTICLE II
OFFER OF CONSULTING SERVICES

2.1 Appointment; Provision of Services. For and during the Term (as defined in ARTICLE V below), the Company retains Advisor to provide the Consulting Services, and Advisor shall provide to the Company, with respect to the operation of the Hospitals and other programs and services carried on by the Company (collectively, the "Business"), those Consulting Services described on Exhibit A, as it may be amended from time to time, upon the terms and conditions as set forth herein.

2.2 Acceptance. Advisor hereby accepts such appointment by the Company and agrees that it will faithfully perform its duties and responsibilities hereunder.

2.3 Maintenance of Control. The Consulting Services entail recommendations to the Company regarding how to improve the operations and financial condition of the Company's Business. The Company agrees to reasonably consent to make operational changes recommended by Advisor. Nothing in this Agreement is intended to alter, weaken, displace or modify the authority of either (i) the Board of Trustees of the Company with respect to the ultimate oversight and governance of the Company, or (ii) the executive leadership of the Company with respect to day-to-day management of the Business and the assets and affairs of the Company. During the Term, the Board of Trustees of the Company shall exercise ultimate authority, supervision, direction and control over the business, policies, operation and assets of the Company, and shall retain the ultimate authority and responsibility regarding the powers, duties and responsibilities vested in the Board of Trustees of the Company by any and all applicable laws and regulations. The parties mutually acknowledge and agree that any Consulting Services provided pursuant to this Agreement are intended to constitute assistance and support to the Company's Board of Trustees and executive leadership, and are not intended and shall not be construed to grant Advisor any rights or interests in, nor decision-making authority with respect to, the Company or the Business, and the rights and interests of Advisor shall be limited to those expressly set forth herein or in the Purchase Agreement.

2.4 Input Into Company's Strategic Business Decisions. The Company, through its Chief Executive Officer, shall make Advisor aware of key strategic business decisions facing the Company that could compromise the Company's economic viability, marketability or competitive potential and shall elicit input from Advisor on said decisions.

2.5 Consulting Services Fee. During the Term, Fees payable to Advisor for the Consulting Services furnished hereunder shall accrue in an amount equal to two (2) percent of the Company's net patient revenue per month (cumulatively, the "Consulting Services Fee"). The Consulting Services Fee shall be deferred and payable to Consultant if and only if the Closing under the Purchase Agreement fails to occur as a result of a breach of the Purchase Agreement or Letter of Intent by the Company where such breach is willful and intentional by the Company and based on factors within the Company's control, in which such case the Consulting Services Fee shall be paid to Advisor pursuant to Section 6.5 hereunder. Notwithstanding anything to the contrary in this Agreement, the Consulting Services Fee shall be forgiven in its entirety and shall not be payable in any circumstance other than as set forth in the

immediately preceding sentence. If the Closing under the Purchase Agreement takes place, payment of the Consulting Services Fee shall be waived.

2.6 Company's Commitments. The Company shall provide Advisor with sufficient working space and other reasonable physical accommodations at the Facilities as appropriate to the Consulting Services, including access to telephones, facsimile machines, internet connections and copiers, to enable Advisor to fulfill its duties and responsibilities hereunder. The Company and its management staff shall provide timely responses to Advisor's requests for information (and other inquiries) to enable Advisor to perform the Consulting Services hereunder, and shall fully cooperate with Advisor in the fulfillment of Advisor's duties hereunder, including, without limitation, attending meetings and providing information, feedback and input to Advisor.

2.7 Liaisons. Advisor shall direct all inquiries regarding the Consulting Services, and provide all recommendations, reports and other matters relating to the Consulting Services, to Peter J. Carl, the Company's Chief Executive Officer, and/or such person(s) as he may from time to time designate. The Company shall direct all inquiries regarding the Consulting Services to Von Crockett at Prospect, and/or such person(s) as he may from time to time designate.

2.8 Access of Advisor; Patient Records.

(a) During the Term, Advisor shall be given complete access to the Company's records (including Patient Records as defined below), offices and Facilities, in order that it may carry out its obligations hereunder, subject to the confidentiality requirements relating to Patient Records and Confidential Information (as defined below).

(b) The Company shall maintain, to the fullest extent of the law, sole and exclusive responsibility for the preparation, storage and destruction of all patient medical records, clinical treatment plans, charts and similar documents generated in connection with the operation of the Business (collectively, the "Patient Records"). The Company shall assure that the Patient Records are prepared in compliance with all applicable federal, state and local laws and regulations. All Patient Records will be maintained by the Company and shall remain the property of the Company.

(c) To the extent permitted by law including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the standards or regulations promulgated thereunder, including the Privacy Standards and the Security Standards, as well as the federal Health Information Technology for Economic and Clinical Health Act (including any and all standards and regulations promulgated thereunder) and professional ethics regarding confidentiality and disclosure of medical information, the Company shall make such information available to Advisor to enable Advisor to perform its duties hereunder and for any and all other reasonable purposes. For the purposes of this Section 2.8, Advisor shall be referred to as the Company's Business Associate ("Business Associate"). As a Business Associate, Advisor agrees to enter into the Business Associate Agreement with the Company, attached hereto as Exhibit B.

ARTICLE III
[RESERVED]

ARTICLE IV
CONFIDENTIALITY; PROPRIETARY RIGHTS

4.1 Due to the highly competitive nature of the health care industry, disclosure of certain nonpublic, confidential or proprietary information including but not limited to Advisor s Proprietary Rights (as defined below), the Company s Proprietary Rights (as defined below), analyses, compilations, summaries, memoranda, studies, policy and procedure documentation information, uality assurance materials or other documents prepared by the Company or Advisor in connection with this Agreement or the Consulting Services provided hereunder (collectively, the Confidential Information) would be extremely damaging to the party that owns or has the right to such Confidential Information. The parties therefore agree to maintain the confidentiality of the other party s Confidential Information and to protect as a trade secret any portion of the other party s Confidential Information by using reasonable efforts to prevent any unauthori ed disclosure, copying, use, distribution, or transfer of possession of such Confidential Information. Each party agrees to maintain at least the same procedures regarding the other party s Confidential Information that it maintains with respect to its own Confidential Information, but in no event less than a reasonable standard of care. For purposes of this Agreement, Confidential Information shall not be deemed to include information and data: (a) rightfully previously known or ac uired by either party from a third party without a continuing restriction on use; (b) that is or becomes a part of the public domain through no breach of this Agreement by either party; (c) approved for release by written authori ation by the party who owns or has rights to the Confidential Information; (d) that is re uired to be disclosed by law; or (e) independently developed by either party.

4.2 The manuals, software, systems, methods, procedures, policies, controls, documents and pricing and the information relating thereto (including, without limitation, purchase orders and all form documents) and all information relating to Advisor and its Affiliates learned, ac uired or obtained by the Company and its Affiliates pursuant to this Agreement, including without limitation the financial condition, marketing plans, regulatory affairs and business strategies of Advisor or its Affiliates, employed or obtained by Advisor or its Affiliates, and all trademarks, service marks, trade names, copyrights and other proprietary rights in which Advisor or any of its Affiliates has any interest (collectively, Advisor s Proprietary Rights) are proprietary to Advisor and shall remain the property of Advisor or its Affiliates and are not, at any time during the Term or thereafter, to be utili ed, distributed, disseminated, copied or otherwise employed or ac uired by the Company, any of the Company s Affiliates, or their respective officers, directors, trustees, consultants, members, employees, shareholders, and agents, except as authori ed by Advisor in writing.

4.3 The manuals, software, systems, methods, procedures, policies, controls, documents and pricing and the information relating thereto (including, without limitation, purchase orders and all form documents) and all information relating to the Company and its

Affiliates learned, acquired or obtained by Advisor and its Affiliates pursuant to this Agreement, including without limitation the financial condition, marketing plans, regulatory affairs and business strategies of the Company or its Affiliates, employed or obtained by the Company or its Affiliates, and all trademarks, service marks, trade names, copyrights and other proprietary rights in which the Company or any of its Affiliates has any interest (collectively, "Company's Proprietary Rights") are proprietary to the Company and shall remain the property of the Company or its Affiliates and are not, at any time during the Term or thereafter, to be utilized, distributed, disseminated, copied or otherwise employed or acquired by Advisor, any of Advisor's Affiliates, or their respective officers, directors, trustees, contractors, members, employees, shareholders, and agents, except as authorized by the Company in writing.

4.4 Each party acknowledges that the breach of the provisions of this ARTICLE IV would cause irreparable injury to the non-breaching party that could not be adequately compensated by money damages. Accordingly, the non-breaching party may obtain a restraining order, injunction or other equitable relief prohibiting a breach or threatened breach of the provisions of this ARTICLE IV without the necessity of posting any bond or security whatsoever, in addition to any other legal or equitable remedies that may be available. In the event of a breach or threatened breach by either party of any of its obligations under this ARTICLE IV, the other party shall have the right, in addition to any other remedies that may be available to it, to obtain specific performance of the terms of this Agreement without posting any security or bond whatsoever.

4.5 If requested by court order or other legal process to disclose any information constituting Confidential Information, Advisor's Proprietary Rights or Company's Proprietary Rights, the party so requested shall promptly give notice of such request or requirement to the other party so that such party may, at its own cost and expense, seek an appropriate protective order or, in the alternative, waive compliance to the extent necessary to comply with such request if a protective order is not obtained. If a protective order or waiver is granted, the party to whom the request was made may disclose such information only to the extent required by such court order or other legal process or to the extent permitted by such waiver.

4.6 The provisions of this ARTICLE IV shall survive the termination of this Agreement, provided, however, this provision shall terminate upon the Closing of the Purchase Agreement. In that event, however, the parties shall continue to be subject to the terms and conditions of that certain Confidentiality and Non-Disclosure Agreement dated as of February 19, 2015, which shall remain in full force and effect in accordance with its terms.

ARTICLE V
TERM

The term of this Agreement shall commence on the Effective Date and shall continue until the Closing of the Purchase Agreement (the "Term"), unless sooner terminated in accordance with the provisions of ARTICLE VI below.

ARTICLE VI
TERMINATION

6.1 Termination by Either Party for Cause. If either party materially defaults in the performance of any material covenant, agreement, term or provision of this Agreement or the Letter of Intent to be performed by it and such material default continues for a period of thirty (30) days after written notice is delivered to the breaching party from the other party stating the specific default, then the non-breaching party may terminate this Agreement by giving written notice thereof to the breaching party; provided, however, that the non-breaching party shall not have the right to terminate under this Section 6.1 at the end of such thirty (30) day period so long as the breaching party has commenced a cure within such thirty (30) day period and thereafter diligently pursues such cure to completion, which shall be no later than sixty (60) days after the initial written notice.

6.2 Termination Upon Bankruptcy, Etc. If either party shall apply for or consent to the appointment of a receiver, trustee or li□uidator for it or for all or substantially all of its assets, file a voluntary petition in bankruptcy or admit in writing its inability to pay its debts as they become due, make a general assignment for the benefit of creditors, file a petition or any answer seeking reorgani□ation or arrangement with creditors or to take advantage of any insolvency law, or if an order, judgment or decree shall be entered by a court of competent jurisdiction, on the application of a creditor, adjudicating either party to be bankrupt or appointing a receiver, trustee or li□uidator of either party with respect to all or substantially all of the assets of either party, and such order, judgment or decree shall continue unstayed and in effect for any period of ninety (90) consecutive days, then this Agreement shall automatically terminate.

6.3 Termination Upon Dissolution of the Company, Termination of Letter of Intent or Termination of Purchase Agreement. This Agreement shall terminate immediately and automatically upon the first to occur of the following events:

(a) the Company files for voluntary dissolution;

(b) the Letter of Intent expires by it terms or is otherwise terminated; and

(c) the Purchase Agreement is terminated (in accordance with the provisions thereof) prior to a Closing of the transactions contemplated therein.

6.4 Regulatory Matters. If the performance by either party of any material covenant, agreement, term or provision of this Agreement would (a) result in the de-certification of a Hospital under any federal or state government program or by any other regulatory agency that would have a material adverse effect on the operation of the Business, (b) result in the loss of a Hospital□s accreditation, or (c) be in violation of any statute or regulation, or for any other reason be or become illegal and such violation or illegality would have a material adverse effect on the operation of the Business, and in any such event, the reason therefore cannot be corrected by good faith negotiations and effort of the parties hereto within sixty (60) days after written notice thereof (with the objective of keeping the financial intent of the parties hereunder materially the same), then either party may at its option terminate this Agreement.

6.5 Certain Rights Upon Termination.

(a) In the event of any of the following:

(i) upon the receipt of the CON Approvals, if (x) Advisor has executed a purchase agreement in the form of the Purchase Agreement and (y) ECHN willfully and intentionally fails to execute such purchase agreement within ten (10) days after Advisor's execution thereof; or

(ii) the parties having both executed a purchase agreement in substantially the form of the Purchase Agreement, if (x) all conditions to Closing (other than those that by their terms are to be satisfied by the actions to be taken at the Closing) have been satisfied by Advisor, but ECHN willfully and intentionally fails to close the transactions pursuant to Section 8.01 of the Purchase Agreement where such failure is based on factors within ECHN's control, or (y) ECHN willfully and intentionally breaches its obligations under Section 5.23 of the Purchase Agreement;

then, Advisor shall be paid by ECHN, within sixty (60) days after such termination and receipt of an invoice therefor, any accrued and unpaid Consulting Service Fees. For the avoidance of doubt, in all other event, including in the event a Closing occurs under the Purchase Agreement, Advisor shall not be entitled to receive any Consulting Service Fee hereunder.

(b) Subject always to the provision of Section 6.5(a), the termination of this Agreement for any reason shall be without prejudice to any payments or obligations that may have accrued or become due hereunder prior to the effective date of termination or that may become due after such termination.

6.6 Cessation of Use of Proprietary Rights Upon Termination. Upon termination of this Agreement, each party shall immediately discontinue the use of, and shall promptly return to the other party, as applicable, all Confidential Information (to the extent in tangible format) that was made available to such party by reason of its participation in this Agreement, including any copies that it may have in its possession or control.

6.7 Failure to Terminate. Failure to terminate this Agreement shall not waive any breach of this Agreement.

6.8 Survival. To the extent expressly set forth or contemplated in this Agreement, provisions of this Agreement shall survive the termination of this Agreement.

ARTICLE VII
LIABILITY, INDEMNIFICATION, PROFITABILITY AND INDEPENDENT CONTRACTOR

7.1 Limitation of Liability. Except for Advisor's gross negligence or willful misconduct, Advisor shall not by reason of this Agreement or any Consulting Services rendered pursuant to this Agreement have any liability in connection with the operation of the Business or

be deemed to have assumed any liabilities associated with or incident to the operation of the Business. All such liabilities shall remain with the Company. Without limiting the generality of the foregoing, Advisor shall have no liability for any breach of any obligation under this Agreement unless such breach shall constitute gross negligence or willful misconduct; it being understood that in such case of a breach of an obligation that does not constitute gross negligence or willful misconduct, the Company's sole remedies shall be to obtain damages pursuant to Section 15.1 below and/or to terminate this Agreement as provided herein.

7.2 Indemnification.

(a) The Company hereby agrees to defend, indemnify and hold harmless Advisor and its Affiliates, and their respective officers, directors, contractors, members, employees, shareholders, agents, successors and assigns (each, an "Advisor Indemnified Party"), from and against any and all liabilities, causes of action, damages, losses, demands, claims, penalties, judgments, costs and expenses (including, without limitation, reasonable attorneys' fees and related costs) of any kind or nature whatsoever that may be sustained or suffered by any Advisor Indemnified Party arising out of or resulting from (i) any breach by the Company of any of its representations, warranties, covenants, obligations or duties under this Agreement or (ii) the Company's gross negligence or willful misconduct.

(b) Advisor hereby agrees to defend, indemnify and hold harmless the Company, and its Affiliates, and their respective officers, directors, trustees, contractors, members, employees, shareholders, agents, successors and assigns (each a "Company Indemnified Party"), from and against any and all liabilities, causes of action, damages, losses, demands, claims, penalties, judgments, costs and expenses (including, without limitation, reasonable attorneys' fees and related costs) of any kind or nature whatsoever that may be sustained or suffered by any Company Indemnified Party arising out of or resulting from (i) the violation of state, federal, or local law, rules or regulations by Advisor, its directors, officers, agents, independent contractors and employees, which results in bodily injury or physical or actual and material damages or the imposition of a fine, penalty or other charge; or (ii) any breach by the Advisor, its directors, officers, agents, independent contractors or employees of any of its representations, warranties, covenants, obligations or duties under this Agreement; or (iii) the gross negligence or willful misconduct of Advisor, its directors, officers, agents, independent contractors or employees.

(c) The provisions of this Section 7.2 shall survive the termination of this Agreement.

7.3 No Representation of Profitability, Etc. Advisor does not guarantee or represent that operation of the Business will be profitable, or have a certain amount of revenues or cash flow. Except as otherwise expressly provided herein, Advisor shall not be liable for the Company's losses, whether from operation of the Business or otherwise.

7.4 Independent Contractor Status. Advisor does not under this Agreement act in any capacity other than as an independent contractor and does not, under this Agreement, act as principal in the operation of the Business, the Hospitals or any other facilities of the Company.

ARTICLE VIII
NON-SOLICITATION

8.1 Covenant Not To Solicit. During the Term and for a period of two (2) years after the Term (the "Non-Solicit Period"), each party shall not, and shall cause its Affiliates not to, directly or indirectly, (a) take any action that may induce any customer, employee, agent, contractor, or vendor of the other party (either individually or in the aggregate) to discontinue his, her or its affiliation with such other party, or (b) solicit or hire the employees or independent contractors of the other party or any Affiliate thereof without the prior written consent of such other party.

8.2 Equitable Relief. In the event of a breach or threatened breach by a party or any of its Affiliates of any of the obligations under this ARTICLE VIII, the other party shall be entitled, upon application to any court of proper jurisdiction, to a temporary restraining order or preliminary injunction to restrain and enjoin the breaching party and/or its Affiliates from such violation without prejudice as to any other remedies the non-breaching party may have at law or in equity. Each party agrees that, in the event of a violation by such party or an Affiliate thereof, it would be virtually impossible for the other party to calculate its monetary damages and that such other party would be irreparably harmed. If the non-breaching party seeks a temporary restraining order or preliminary injunction, such non-breaching party shall not be required to post any bond or other security with respect thereto, or, if, nonetheless, a bond is required, it may be posted without surety thereon. If any restriction contained in this ARTICLE VIII is held by any court to be unenforceable, or unreasonable, as to time, geographic area or business limitation, the parties agree that such provisions shall be and are hereby reformed to the maximum time, geographic area or business limitation permitted by applicable laws. The parties further agree that the remaining restrictions contained in this ARTICLE VIII shall be severable and shall remain in effect and shall be enforceable independently of each other. Each party specifically acknowledges, represents and warrants that the covenants set forth in this ARTICLE VIII are reasonable, necessary, and enforceable to protect the legitimate interests of the other party, and that such other party would not have entered into this Agreement in the absence of such covenants.

ARTICLE IX
REPRESENTATIONS AND WARRANTIES

9.1 Of Advisor. Advisor represents and warrants to the Company as follows:

(a) Advisor has been duly organized and validly exists as a corporation in good standing under the laws of the State of Delaware, with full corporate power to own its properties and to conduct its business under such laws.

(b) Advisor has the full corporate power and authority to execute and deliver this Agreement and to perform its obligations hereunder, and all necessary actions for the due authorization, execution, delivery and performance of this Agreement by Advisor have been duly taken. The individual executing this Agreement on behalf of Advisor is duly authorized and has the requisite power and authority to execute this Agreement.

(c) Neither the execution of this Agreement, the performance by Advisor under this Agreement, nor compliance by Advisor with any provision of this Agreement will conflict with or violate Advisor's articles of incorporation or bylaws, any agreements to which Advisor is a party, or any material provision of applicable federal, state and local laws, rules and regulations.

(d) Upon Advisor's execution of this Agreement, this Agreement shall constitute a valid and binding obligation of Advisor, enforceable in accordance with its terms.

(e) Neither Advisor, nor its Affiliates, employees, and agents (i) is currently excluded, debarred or otherwise ineligible to participate in any federal or state health care program, (ii) has been convicted of a criminal offense related to the provision of healthcare items and services, (iii) is under investigation or otherwise aware of any circumstances which may result in Advisor or any of its Affiliates, employees, or agents being excluded from participation in any federal or state health care program, (iv) is listed in the HHS/OIG List of Excluded Individuals (http://www.oig.hhs.gov/exclusions) ("LIEE"), the General Services Administration's List of Parties Excluded from Federal Programs (http://www.epls.gov), the National Practitioner Data Bank, or any similar federal or state database indicating that such individual is ineligible to perform the Consulting Services under this Agreement, or (v) is a Specially Designated National or a Blocked Person by the Office of the Foreign Asset Control of the U.S. Department of Treasury.

(f) Advisor will not employ or otherwise obtain the services of any individual to perform Consulting Services under this Agreement who is not legally authorized to work in the United States in the capacity indicated. In furtherance thereof, Advisor certifies that all persons assigned to work under this Agreement are legally authorized to work in the United States in the capacity they are serving under this Agreement and will provide any and all written documentation to support such certification. Advisor agrees that if the status of any such person changes during the term of the Agreement, it shall remove such person from performing Consulting Services under this Agreement. On no less than a monthly basis, Advisor shall screen each individual performing the Consulting Services under this Agreement in the manner recommended by the HHS/OIG May 8, 2013 Special Advisory Bulletin on the Effect of Exclusion from Participation in Federal Health Care Programs, and shall maintain a record of each such screening.

(g) Advisor will abide by any and all applicable federal and/or state employment statutes, rules and regulations including, without limitation, Title VII of the Civil Rights Act of 1964, the Equal Opportunity Act of 1972, the Age Discrimination in Employment Act of 1967, the Equal Pay Act of 1963, the National Labor Relations Act, the Fair Labor Standards Act, the Rehabilitation Act of 1973, and the Occupational Safety and Health Act of 1970, all as may be from time to time modified or amended.

(h) Advisor shall cooperate with the Company corporate compliance audits, reviews and investigations that relate to the services provided by Advisor under this Agreement. Advisor acknowledges that the Company has established a Corporate Compliance Plan ("CCP") and promotes a culture that fosters prevention, detection and resolution of instances of misconduct. Advisor shall cause all Advisor personnel performing the Consulting Services for the Company

to participate in the Company's initial corporate compliance and privacy training no later than thirty (30) days from the date such individual commences performing Services under this Agreement, and additionally in the Company's annual compliance and privacy training thereafter. The failure to complete such training within the designated time frame shall be cause for removal under this Agreement. Advisor shall additionally require all Advisor personnel furnishing the Consulting Services to sign and furnish to the Company the Certification and Acknowledgement attached to the ECHN Code of Conduct stating that such individual has read the ECHN Code of Conduct (available on the ECHN website at www.ECHN.org, About ECHN) and agrees to comply with all of its provisions.

(i) Advisor shall immediately notify ECHN's Compliance Officer of any violation of any applicable law, regulation, third party payor requirements or breach of ECHN's CCP of which Advisor or any of its employees or agents become aware of during the term hereof. Advisor shall instruct its employees and agents of this requirement.

(j) Advisor shall maintain and actively support, at all times during the term of this Agreement, a corporate compliance program that has been reasonably designed, implemented and enforced so that it generally will be effective in preventing and detecting criminal conduct and ethical lapses by Advisor, its agents and employees.

(k) Advisor shall cooperate with the Company in responding to or resolving any complaint, investigation, inquiry, or review initiated by a governmental agency or otherwise. Advisor shall cooperate with any insurance company providing protection to the Company in connection with the foregoing and shall, consistent with applicable law, fully follow the directions of the Company.

(l) Advisor has all rights, authorizations, and licenses necessary to provide any material furnished by Advisor to the Company, and that the material and the Company's use thereof, as authorized by this Agreement, shall not infringe, misappropriate, or otherwise violate the rights of any third party.

(m) Each of Advisor's employees, agents, or representatives assigned to perform under the Agreement shall have the proper skill, training, and background so as to be able to perform in a professional and workmanlike manner and that all work will be so performed in a manner compatible with Advisor's business operations at its premises.

(n) Advisor will not introduce into Advisor software, computer hardware or data any software that contains any "time-bombs," "usage authorization codes," or other codes or programming devices that might or might be used to access, modify, delete, damage, deactivate, or disable any of the Company's software, computer hardware, or data; nor will Advisor cause any of the Company's software, computer hardware or data to be infected with any "worms", "viruses", "Trojan horses" or other programs or programming devices that might be used to modify, delete, damage, deactivate or disable any of the Company's software, computer hardware or data.

9.2 Of the Company. The Company represents and warrants to Advisor as follows:

(a) The Company has been duly organi□ed and validly exists as a not-for-profit corporation in good standing under the laws of the State of Connecticut, with full limited power to own its properties and to conduct its business under such laws.

(b) The Company has the full corporate power and authority as a company to execute and deliver this Agreement and to perform its obligations hereunder, and all necessary actions for the due authori□ation, execution, delivery and performance of this Agreement by the Company have been duly taken. The individual executing this Agreement on behalf of the Company is duly authori□ed and has the re□uisite power and authority to execute this Agreement.

(c) Neither the execution of this Agreement, the performance by the Company under this Agreement, nor compliance by the Company with any provision of this Agreement will conflict with or violate the Company□s articles of incorporation, bylaws, any agreements to which the Company is a party, or any material provision of applicable federal, state and local laws, rules and regulations.

(d) Upon the Company□s execution of this Agreement, this Agreement shall constitute a valid and binding obligation of the Company, enforceable in accordance with its terms.

(e) Neither the Company, nor its Affiliates, employees, and agents (i) is currently excluded, debarred or otherwise ineligible to participate in any federal or state health care program, (ii) has been convicted of a criminal offense related to the provision of healthcare items and services, or (iii) is a Specially Designated National or a Blocked Person by the Office of the Foreign Asset Control of the U.S. Department of Treasury.

ARTICLE X
INSURANCE

10.1 Advisor□s Re□uired Coverage. During the Term hereof, Advisor shall maintain, at its own expense, workers□compensation coverage in accordance with statutory re□uirements for Advisor□s employees who provide services under this Agreement, and commercial general liability insurance and commercial auto insurance in an amount not less than One Million Dollars (□1,000,000) per occurrence and Three Million Dollars (□3,000,000) in the annual aggregate with insurance carriers duly licensed to conduct business in the State of Connecticut. In addition, Advisor shall maintain professional liability insurance and cyber liability insurance, each in an amount not less than One Million Dollars (□1,000,000) per occurrence and Three Million Dollars (□3,000,000) in the annual aggregate with insurance carriers duly licensed to conduct business in the State of Connecticut. The limits above may be satisfied by any combination of self insurance or umbrella policies, and Advisor may carry any insurance re□uired by this Agreement under a blanket policy.

10.2 The Company□s Re□uired Coverage. The Company shall maintain, at the Company□s expense, at all times during the Term: (a) workers□compensation coverage in accordance with statutory re□uirements for the Company□s employees; (b) commercial property

damage and fire hazard insurance written on full replacement value basis for all of the Company's assets and real property; (c) professional liability insurance covering the Company's employees who perform any work, duties, or obligations against claims for bodily injury, death, malpractice and property damage, which insurance shall provide coverage on a claims-made or occurrence basis with a per occurrence limit of not less than One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) in the annual aggregate; and (d) comprehensive commercial general liability insurance in an amount not less than One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) in the annual aggregate. The above limits may be satisfied by any combination of primary and excess or umbrella policies. The Company may carry any insurance required by this Agreement under a blanket policy. Advisor shall be an additional named insured under the Company's general liability insurance policy.

10.3 Certificates of Insurance. On the Effective Date and at any time upon request, each party shall provide the other party certificates of insurance evidencing the coverages required hereby, and shall notify the other party immediately of the cancellation, termination, or non-renewal of, or material change in, such insurance coverage.

ARTICLE XI
ARMS-LENGTH BARGAINING

The parties agree that the compensation provided herein has been determined in arm's-length bargaining and is consistent with fair market value in arm's length transactions and is not and has not been determined in a manner that takes into account the volume or value of any referrals or business otherwise generated for or with respect to the Hospitals or other facilities of the Company or between the parties or any of the undersigned persons or equity holders thereof for which payment may be made in whole or in part under Medicare or any state health care program or under any other payor program.

ARTICLE XII
ASSIGNMENT

Neither party shall, directly or indirectly, assign or otherwise transfer this Agreement, or any interest herein or obligation hereunder, without the prior written consent of the other party, which may be withheld in such other party's sole discretion. In no event may a party assign this Agreement unless the assignee shall have executed and delivered to the other party a written assumption of this Agreement in form and substance satisfactory to such other party in its sole discretion. Notwithstanding the foregoing, Advisor shall be permitted, without the consent of the Company, to assign this Agreement to any Affiliate of Advisor, but Advisor shall remain liable to the Company for the performance and satisfaction of all undertakings and commitments set forth herein.

ARTICLE XIII
NOTICES

All notices required or permitted hereunder shall be given in writing by actual delivery or by certified mail, postage prepaid or by nationally recognized overnight courier service. Notice shall be deemed given upon delivery, or if given by mail, upon receipt or if sent by next day delivery by a nationally recognized overnight courier service, on the next business day. Notice shall be delivered or mailed to the parties at the following addresses or at such other places as a party shall designate in writing:

If to the Company:	Eastern Connecticut Health Network, Inc. 71 Haynes Street Manchester, CT 06040 Attn: Peter J. Karl, President and Chief Executive Officer phone: e-mail:
with a copy (which shall not constitute notice) to:	Ropes & Gray LLP Prudential Tower 800 Boylston Street Boston, MA 02199-3600 Attn: Anne Ogilby Fax: 617-235-0234 Email: anne.ogilby@ropesgray.com
If to Advisor:	Prospect Medical Holdings, Inc. 10780 Santa Monica Boulevard, Suite 400 Los Angeles, CA 90025 Attention: Legal Department
with a copy (which shall not constitute	Epstein Becker & Green, P.C. One Gateway Center

notice) to: Newark, NJ 07102
Attention: Gary W. Herschman, Es□
phone: (973) 642-1900
email: gherschman@ebglaw.com
Attention: David E. Weiss, Es□
phone: (212) 351-4500
email: dweiss@ebglaw.com

ARTICLE XIV
RECORD ACCESS AND RETENTION

14.1 Access to Records. Each party hereto shall permit, and shall ensure that any subcontractor retained by it permits, the United States Department of Health and Human Services and General Accounting Office, or their authori□ed representatives, to review appropriate books and records relating to the performance hereunder to the extent re□uired under Section 1861(v)(1) of the Social Security Act, 42 U.S.C. Section 1395x(v)(1)(I), or any successor law or regulation for a period of four (4) years following the last day Advisor provided services hereunder. The access shall be provided in accordance with the provisions of Title 42, Code of Federal Regulations, Part 420, Subpart D.

14.2 Notification. Each party shall notify the other party immediately of the nature and scope of any re□uest for access to books and records described above and shall provide copies of any books, records or documents to the other party prior to the provision of same to any governmental agent to give such other party an opportunity to lawfully oppose such production of documents. Nothing herein shall be deemed to be a waiver of any applicable privilege (such as the attorney-client privilege) by either party.

ARTICLE XV
MISCELLANEOUS

15.1 Choice of Law; Dispute Resolution; Venue.

(a) Choice of Law. The parties agree that this Agreement shall be governed by and construed in accordance with the Laws of the State of Connecticut, without giving effect to any choice or conflict of law provision or rule thereof that would re□uire the application of any other law.

(b) Dispute Resolution. Except as provided in Section 15.2 below, in the event that any dispute, controversy or claim arises among the parties with respect to this Agreement, including as to the breach, termination or invalidity hereof (a □Dispute□), the parties shall attempt in good faith to resolve such Dispute promptly by negotiation (including at least one in-person meeting) over a period of not less than thirty (30) days, commencing upon one party□s delivery of a written notice of Dispute to the other party.

(c) Venue. In the event that any Dispute is not resolved through good faith negotiations as provided in Section 15.1(b) above, either party may submit the matter to a court

of law or equity through the filing of a claim. The Parties agree that, except as otherwise expressly provided in Section 15.2 below, venue for any and all claims associated with a Dispute between the Parties shall rest with the state courts of the State of Connecticut.

(d) Waiver of Jury Trial. EXCEPT AS PROVIDED IN SECTION 15.2 BELOW, EACH PARTY HEREBY IRREVOCABLY WAIVES ALL RIGHT TO TRIAL BY JURY IN ANY ACTION, PROCEEDING OR COUNTERCLAIM (WHETHER BASED ON CONTRACT, TORT OR OTHERWISE) ARISING OUT OF OR RELATING TO THIS AGREEMENT OR THE TRANSACTIONS CONTEMPLATED HEREBY OR THEREBY.

15.2 Injunctive Relief. Notwithstanding anything to the contrary contained herein, each party acknowledges and agrees that a party may seek, from a court of competent jurisdiction in the State of Connecticut, injunctive relief against a breaching party pursuant to Sections 4.4 and 8.2 above, without posting any bond or other undertaking.

15.3 Severability. Should any provision of this Agreement be found void or unenforceable, the remainder hereof nevertheless shall continue in full force and effect. A new provision shall be amended to this Agreement that is similar to the provision found unenforceable but which is enforceable.

15.4 Approval or Consent. Except as otherwise provided herein, whenever under any provisions of this Agreement, the approval or consent of either party is required, such approval or consent shall not be unreasonably withheld, conditioned or delayed.

15.5 Entire Agreement. This Agreement contains the entire agreement between the parties with respect to the subject matter hereof, and the parties expressly agree that this Agreement supersedes and rescinds any prior agreement between them (verbal or written) pertaining to the subject matter hereof.

15.6 No Third Party Beneficiary. Except as expressly provided in this Agreement, no person or entity that is not a party to this Agreement shall be a third party beneficiary of any rights or obligations hereunder or be entitled to enforce any of said rights or obligations.

15.7 Interpretation. The article and paragraph headings contained herein are for convenience of reference only, do not constitute part of this Agreement, and are not intended to define, limit or describe the scope of intent of any provision of this Agreement. All gender references used in this Agreement shall include all genders, and the singular shall include the plural and the plural shall include the singular whenever and as often as may be appropriate.

15.8 Force Majeure. Advisor shall not be deemed to be in violation of this Agreement, and shall not be liable for any resulting claims, losses, damages, expenses and liabilities if it is prevented, hindered or delayed, either directly or indirectly, from performing any of its obligations hereunder for any reason beyond its reasonable control, including without limitation labor disputes, fires, storms, earthquakes, acts of God, or any statute, regulation or rule of the federal government, any state or local government or any agency thereof.

15.9 Amendments; Course of Dealing. This Agreement may be amended or supplemented only in a writing signed by both parties. The failure of any party to enforce at any time any of the provisions of this Agreement shall in no way be construed to be a waiver of any such provision, nor in any way to affect the validity of this Agreement or any part hereof or the right of any party thereafter to enforce each and every such provision. No waiver of any breach of this Agreement shall be held to be a waiver of any other or subse□uent breach.

15.10 Cooperation; Further Assistance. From time to time, as and when reasonably re□uested by either party hereto, the other party will (at the expense of the re□uesting party) execute and deliver, or cause to be executed or delivered, all such documents, instruments and consents and will use reasonable efforts to take all such action as may be reasonably re□uested or necessary to carry out the intent and purpose of this Agreement.

15.11 Execution of this Agreement. The parties may execute this Agreement in counterparts, each of which shall be deemed an original and both of which together shall constitute but one and the same instrument. A signature delivered by facsimile or PDF shall be sufficient for all purposes between the parties.

[*signature page follows*]

IN WITNESS WHEREOF, the parties have executed this Agreement, through their duly authorized representatives, effective as of the date first above written.

ADVISOR:

PROSPECT MEDICAL HOLDINGS, INC., a Delaware corporation

By:_____
Name:
Title:

THE COMPANY:

EASTERN CONNECTICUT HEALTH NETWORK, INC., a Connecticut non-stock corporation

By:_____
Name:
Title:

EXHIBIT A
LIST OF CONSULTING SERVICES

In consideration of the payments to be made hereunder, Advisor shall from time to time and as appropriate provide, either directly or indirectly through one or more of its Affiliates, the following services to the Company:

1. Advise the Company regarding trends in the industry, make recommendations regarding new and/or expanded services and programs, physician alignment & recruitment, IT/EMR capabilities and improvements, technology implementation, ACOs and other reform-driven approaches, and managed care approaches.

2. Review, assess and provide recommendations regarding potential service consolidation and restructurings to achieve efficiencies.

3. Review, assess and provide recommendations regarding new clinical service lines, programs and locations.

4. Review, assess and provide recommendations regarding physician-alignment strategies, joint ventures and other strategic initiatives.

5. Advise the Company regarding expenditure and spending patterns, evaluate standard procurement lifecycle methodologies including working cash vs. discount modeling, invoice synchronization and vendor payment management. Such expenditures and contracts would include without limitation:

    - Third party service providers
    - Supply contracts
    - Contracts with outside contractors or consultants
    - Preventive maintenance with respect to equipment and building
    - Upkeep and maintenance of the physical facilities

6. Advise the Company regarding third-party reimbursement issues and consultation on such issues and compliance with all applicable reimbursement rules.

7. Assist the Company to develop, implement and maintain a compliance program that is committed to promoting, preventing, detecting and resolving instances of conduct that do not conform to federal or state laws.

8. Assist the Company to develop plans with respect to labor relations matters.

9. Review, assess and provide recommendations regarding a physician-led and focused clinical documentation program.

10. Review, assess and provide recommendations regarding the Company s case management program and length of stay initiatives.

11. Assist the Company to develop strategies with respect to cost accounting processes.

12. Provide other Consulting Services as mutually agreed upon in writing by the parties from time to time.

EXHIBIT B
BUSINESS ASSOCIATE AGREEMENT

THIS BUSINESS ASSOCIATE AGREEMENT (the "Business Associate Agreement") is made and entered into as of _____, 20____ (the "Effective Date"), by and between ("Business Associate"), and Eastern Connecticut Health Network, Inc. by and on behalf of its covered entity subsidiaries, affiliates and related organizations (collectively, the "Covered Entity").

RECITALS

WHEREAS, the Business Associate and Covered Entity have entered into and may enter into one or more agreements (the "Agreement(s)") under which the Business Associate performs or assists the Covered Entity with a function or activity involving the Use or Disclosure of Individually Identifiable Health Information;

WHEREAS, the Covered Entity and the Business Associate desire to comply with the requirements of regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

WHEREAS, the HIPAA Standards require that the Covered Entity obtain satisfactory assurances that the Business Associate will appropriately safeguard the Individually Identifiable Health Information Used or Disclosed by the Business Associate in the course of performing services pursuant to the Agreement(s).

NOW, THEREFORE, in consideration of the foregoing and the mutual promises and covenants herein contained, the parties agree as follows:

1. Definitions

a) HIPAA Rules shall mean the Privacy, Security, Breach Notification and Enforcement Rules at 45 C.F.R. Part 160 and Part 164.

b) The following terms Used in this business Associate Agreement shall have the same meaning as those terms defined in the HIPAA Standards: Business Associate, Covered Entity, Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required By Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

c) The Covered Entity and the Business Associate acknowledge and agree that capitalized terms Used, but not otherwise defined, herein are as defined in the HIPAA Standards;

2. Obligations and Activities of Business Associate

a) Business Associate shall not Use or further Disclose Protected Health Information other than as permitted or re□uired by this Business Associate Agreement or as re□uired by law.

b) Business Associate shall Use appropriate safeguards and comply with Subpart C of 45 C.F.R. Part 164 with respect to electronic protected health information, to prevent Use or Disclosure of the Protected Health Information not provided for by this Business Associate Agreement.

c) Business Associate shall immediately report to Covered Entity any Use or Disclosure of Protected Health Information or individually identifiable information not provided for by this Business Associate Agreement, including without limitation any Breach of Protected Health Information or Unsecured Protected Health Information as re□uired and any Security Incident of which the Business Associate becomes aware. Business Associate shall take any reasonable action necessary or re□uested by the Covered Entity to mitigate, to the extent practicable, any harmful effect that is known to Business Associate.

d) In the event of a Breach of Protected Health Information or Unsecured Protected Health Information, Business Associate□s notice to Covered Entity of such Breach shall include, to the extent possible, the identification of each Individual whose Protected Health Information has been, or is reasonably believed to have been, accessed, ac□uired, or disclosed. Business Associate shall also provide Covered Entity any other available information that the Covered Entity is re□uired to include in the notification to the Individual, even if such information becomes available after notification to the Individual, or take any reasonable action necessary as re□uested by the Covered Entity to assist Covered Entity in complying with any applicable Breach notification re□uirements.

e) Business Associate shall ensure that any agent of the Business Associate, including a subcontractor that creates, maintains transmits, or receives Protected Health Information on behalf of Covered Entity agrees to the same restrictions, conditions and re□uirements that apply through to Business Associate with respect to such information.

f) If the Business Associate maintains Protected Health Information in a Designated Record Set, the Business Associate shall:

(i) provide access or make available to Covered Entity Protected Health Information in a Designated Record Set, to Covered Entity or to an Individual, per Covered Entity□s direction in order to meet the re□uirements under 45 C.F.R. □164.524; and

(ii) make any amendment(s) to Protected Health Information in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 C.F.R. □164.526 at the re□uest of Covered Entity or an Individual in the time and manner designated by Covered Entity, or take other measures as necessary to satisfy Covered Entity□s obligations under 45 C.F.R. 164.526.

g) Business Associate shall maintain and make available to Covered Entity information pertaining to Disclosures of Protected Health Information by Business Associate to permit Covered Entity to respond to a request by an Individual for an accounting of Disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528. In the event that Business Associate receives a direct request from an Individual for an accounting of Disclosures of Protected Health Information made by Business Associate, Business Associate agrees to provide the Individual with such an accounting in accordance with 45 C.F.R. § 164.528.

h) To the extent Business Associate is to carry out one or more of Covered Entity's obligation(s) under Subpart E of 45 C.F.R. Part 164, Business Associate shall comply with the requirements of Subpart E that apply to Covered Entity in the performance of such obligation(s); and

i) Business Associate shall make internal practices, books, and records relating to the Use and Disclosure of Protected Health Information received from, or created, maintained or received by Business Associate on behalf of Covered Entity available to the Covered Entity or the Secretary, in a time and manner designated by the Covered Entity or the Secretary, for purposes of the Secretary determining Covered Entity's or Business Associate's compliance with the HIPAA Rules.

j) Business Associate shall implement and maintain safeguards as necessary to ensure that all Protected Health Information is Used or Disclosed only as authorized under the HIPAA Rules and this Business Associate Agreement. Business Associate agrees to assess potential risks and vulnerabilities to Protected Health Information in its possession and develop, implement and maintain the administrative, physical and technical safeguards required by the HIPAA Rules that protect the confidentiality, availability and integrity of the Protected Health Information that Business Associate creates, receives, maintains or transmits on behalf of the Covered Entity. These measures must be documented and kept current, and must include, at a minimum, those measures that fulfill the requirements outlined in the HIPAA Rules. Business Associate also agrees to implement policies and procedures that address Business Associate's compliance with applicable HIPAA Rules and its efforts to detect, prevent and mitigate the risks of identity theft resulting from the improper Use and/or Disclosure of an Individual's information.

k) In the event that Business Associate has knowledge of Covered Entity's breach of the HIPAA Rules, Business Associate agrees to notify Covered Entity and take reasonable steps to cure such breach.

l) Business Associate acknowledges that if it violates any of the requirements provided under this Business Associate Agreement, Business Associate will be subject to the same civil and criminal penalties that a Covered Entity would be subject to if such Covered Entity violated the same requirements.

3. Permitted Uses and Disclosures by Business Associate

a) Business Associate may Use or Disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Agreement(s), provided that such Use or Disclosure would not violate the HIPAA Rules if done by Covered Entity.

b) Business Associate may Use Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

c) Business Associate may Disclose Protected Health Information for the proper management and administration of the Business Associate, provided that Disclosures are Required by Law, or Business Associate obtains reasonable assurances from the person to whom the information is Disclosed that it will remain confidential and will be Used or further Disclosed only as Required by Law or for the purpose for which it was initially Disclosed to the recipient, and the recipient notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

d) Except as otherwise permitted by the HIPAA Rules, when using or disclosing Protected Health Information or responding to a request for Protected Health Information, Business Associate must limit such Protected Health Information, to the extent practicable, to a Limited Data Set, or if more information than a Limited Data Set is required, Business Associate agrees to make Uses and Disclosures and requests for protected health information consistent with the Minimum Necessary to accomplish the intended purpose of such Use, Disclosure, or request.

e) Except as otherwise permitted by the HIPAA Rules, Business Associate agrees that it will not directly or indirectly receive remuneration in exchange for any Protected Health Information unless Covered Entity has obtained from an Individual a valid authorization that includes a specification of whether the Protected Health Information can be further exchanged for remuneration by the entity receiving the Individual's Protected Health Information. When the Secretary issues the regulations that address the requirements of this Section and such regulations become effective, Business Associate shall comply with such regulations with respect to receiving remuneration in exchange for any Protected Health Information.

f) If an Individual requests that Business Associate restrict the Disclosure of the Individual's Protected Health Information to carry out treatment, payment, or health care operations, Business Associate agrees that it will comply with the requested restriction if, except as otherwise required by law, the Disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment), and the Protected Health Information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full.

g) Except as otherwise limited in this Business Associate Agreement, Business Associate may Use and Disclose Protected Health Information to provide Data Aggregation services to Covered Entity as permitted by 42 C.F.R. 164.504(e)(2)(i)(B).

4. Obligations of Covered Entity

a) Covered Entity shall provide Business Associate with the Notice of Privacy Practices that Covered Entity produces in accordance with 45 C.F.R. 164.520, as well as provide any changes to such Notice and the Business Associate shall comply with such Notice of Privacy Practices.

b) Covered Entity shall provide Business Associate with any changes in, or revocation of, permission by Individual to Use or Disclose Protected Health Information, if such changes affect Business Associate's permitted or required Uses and Disclosures.

c) Covered Entity shall notify Business Associate of any restriction to the Use or Disclosure of Protected Health Information that Covered Entity has agreed to in accordance with 45 C.F.R. 164.522.

d) Covered Entity shall not request Business Associate to Use or Disclose Protected Health Information in any manner that would not be permissible under the HIPAA Rules if done by Covered Entity.

5. Term and Termination

a) Term. The Term of this Business Associate Agreement shall be effective as of the Effective Date and shall terminate when all of the Protected Health Information provided by Covered Entity to Business Associate, or created, maintained, or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this Section.

b) Termination for Cause. Upon Covered Entity's knowledge of a material breach of this Business Associate Agreement by Business Associate, Covered Entity shall provide an opportunity for Business Associate to cure the breach or end the violation. Covered Entity shall terminate the Business Associate Agreement if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity. Covered Entity may immediately terminate the Business Associate Agreement if Business Associate has breached a material term of this Business Associate Agreement and cure is not possible, as determined by the Covered Entity in its reasonable discretion.

c) Effect of Termination.

(i) Except as provided in this subsection, upon termination of the Agreement(s) or this Business Associate Agreement, for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Entity, or created, maintained or received by Business Associate on behalf of Covered Entity that the Business Associate still maintains in any form. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.

(ii) In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon mutual agreement of the parties that return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this Business Associate Agreement to such Protected Health Information and limit further Uses and Disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

(iii) The parties hereto understand and agree that the terms of this Business Associate Agreement are reasonable and necessary to protect the interests of the Covered Entity and the Business Associate. The parties further agree that the Covered Entity would suffer irreparable harm if the Business Associate breached this Business Associate Agreement. Thus, in addition to any other rights or remedies, all of which shall be deemed cumulative, the Covered Entity shall be entitled to obtain injunctive relief to enforce the terms of this Business Associate Agreement.

(iv) Survival. The obligations of Business Associate under this Section shall survive the termination of this Business Associate Agreement.

6. Miscellaneous

a) Interpretation. Any ambiguity in this Business Associate Agreement shall be interpreted in a manner that permits the parties to comply with the HIPAA Rules.

b) No Private Cause of Action. This Business Associate Agreement is not intended to and does not create a private cause of action by any individual, other than the parties to this Business Associate Agreement, as a result of any claim arising out of the breach of this Business Associate Agreement, the HIPAA Standards or other state or federal law or regulation relating to privacy or confidentiality.

c) Amendment. Either party shall have the right to amend this Business Associate Agreement by providing written notice to the other party in order to bring it into compliance with any law or regulation enacted or promulgated regarding the protection of health information that is any way inconsistent with the terms of this Business Associate Agreement or interferes with either parties obligations with respect to the protection of health information.

d) Application of State Law. Where any applicable provision of Connecticut State law relates to the privacy of health information and is not preempted by HIPAA, as determined by application of the HIPAA Rules, the parties shall comply with the applicable provisions of Connecticut State law.

e) Severability. If any provision of this Business Associate Agreement shall be declared invalid or illegal for any reason whatsoever, then notwithstanding such invalidity or illegality, the remaining terms and provisions of this Business Associate Agreement shall remain in full force and effect in the same manner as if the invalid or illegal provision had not been contained herein, and such invalid, unenforceable or illegal provision shall be valid, enforceable and legal to the maximum extent permitted by law.

f) Governing Law. This Business Associate Agreement shall be interpreted, construed and governed according to the laws of the State of Connecticut. The parties agree that venue shall lie in Federal and State courts in the State in which the Covered Entity maintains its principal place of business, without regard to its conflicts of law principles, regarding any and all disputes arising from this Business Associate Agreement.

g) Notices. Any notice or other communication given pursuant to this Business Associate Agreement must be in writing and (i) delivered personally, (ii) delivered by overnight express, or (iii) sent by registered or certified mail, postage prepaid, to the address set forth below and shall be considered given upon delivery.

Chief Compliance and Privacy Officer

Eastern Connecticut Health Network

71 Haynes Street

Manchester, CT 06040

h) Indemnification. Without limitation to any indemnification obligation that Business Associate may have under the Agreement(s), Business Associate shall indemnify, hold harmless and defend Covered Entity from and against any and all claims, losses, liabilities, costs and other expenses resulting from, or relating to, the acts or omissions of Business Associate, its employees, agents, and subcontractors, in connection with any Use or Disclosure of Protected Health Information, Unsecured Protected Health Information, or an Individual's information not provided for by this Business Associate Agreement, including without limitation any Breach of Protected Health Information, Unsecured Protected Health Information, or an Individual's information or any expenses incurred by Covered Entity in providing required breach notifications.

IN WITNESS WHEREOF, the parties hereto have caused this Business Associate Agreement to be executed and delivered as of the day and year first above written.

COVERED ENTITY:	BUSINESS ASSOCIATE:
EASTERN CONNECTICUT HEALTH NETWOR□, INC.	PROSPECT MEDICAL HOLDINGS, INC.
BY: _____	BY: _____
NAME: _____	NAME: _____
ITS: _____	ITS: _____
DATE_____	DATE: _____

RESPONSE TO DEFICIENCIES
EXHIBIT E - Number of Physicians in PMH Network

Number of Physicians Participating in PMH's Physician Network by State

	Owned			
	2012	2013	2014	2015
Total PCP's (Contracted Only) - California	852	903	913	882
Total SP's (Contracted Only) - California	8,264	9,273	10,607	12,402
Total PCP's (Contracted Only) - Rhode Island				105
Total SP's (Contracted Only) - Rhode Island				270
Total PCP's (Contracted Only) - Texas				23
Total SP's (Contracted Only) - Texas				594
TOTAL PCP'S AND SP'S	**9,116**	**10,176**	**11,520**	**14,276**

Please note that the above data includes all fully contracted physicians and physicians who Prospect has Memorandum of Understandings for limited services and/or for a limited period of time and/or

PCP = Primary Care Physician

SP = Specialist

RESPONSE TO DEFICIENCIES
EXHIBIT F - PMH Performance Metrics (Texas)

Prospect Medical

12 Month Bed-Day Report - HMO Product Summary

Health Plan : ALL HEALTH PLANS

Location : PROSPECT HEALTH SERVICES-TEXAS

GOAL:

Senior: (900 / K)
Commercial: (125 / K)
Medi-Cal: (250 / K)
SPD: (400 / K)

PROSPECT HEALTH SERVICES-TEXAS

HMO Product		2015-01	2015-02	2015-03	2015-04	2015-05	2015-06	2015-07	2015-08	2015-09	2015-10	2015-11	2015-12	Total
SENIOR														
ACUTE	**Membership:**	1,617	1,611	1,626	1,465	1,439	1,430	1,378	1,320	1,317	1,339	0	0	14,542
	Admits:	31	28	32	20	24	22	23	17	18	14	0	0	229
	Days:	172	149	179	148	143	143	194	104	154	91	0	0	1,477
	Admits / 1000:	226	227	232	166	196	187	197	152	166	123	0	0	189
	Days / 1000:	1,252	1,206	1,296	1,229	1,170	1,217	1,658	928	1,423	800	0	0	1,218
	ALOS:	5.5	5.3	5.6	7.4	6.0	6.5	8.4	6.1	8.6	6.5	0	0	6.4
NON-ACUTE	**Membership:**	1,617	1,611	1,626	1,465	1,439	1,430	1,378	1,320	1,317	1,339	0	0	14,542
	Admits:	8	5	1	4	4	6	7	6	2	3	0	0	46
	Days:	219	200	137	103	120	93	181	173	54	50	0	0	1,330
	Admits / 1000:	58	40	7	33	33	51	60	54	18	26	0	0	38
	Days / 1000:	1,595	1,618	992	855	982	791	1,547	1,543	499	440	0	0	1,096
	ALOS:	27.4	40.0	137.0	25.8	30.0	15.5	25.9	28.8	27.0	16.7	0	0	28.9

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RESPONSE TO DEFICIENCIES
EXHIBIT G - PMH Programs and Procedures

PROSPECT MEDICAL
Quality Service ~ Quality Care



The Next Generation Healthcare System

THE PROSPECT MEDICAL DIFFERENCE: CARE PLUS

Care Management– Care Plus

What is Quality

- Simply put, health care quality is: getting the right care to the right patient at the right time every time.

Statement by: Carolyn Clancy MD, Director Agency for Health care Research and Quality, US Department of HHS.

Before: Committee on Finance, Subcommittee on Health Care; US Senate. Wednesday March 18, 2009.

http://www.hhs.gov/asl/testify/2009/03/t20090318b.html

Care Management– Care Plus

- What we do:
  - We improve patient outcomes & save lives with our innovative Care Plus Model for care coordination.
  - We embed specialized care teams into PCP practices & into the communities where our high-risk patients live.
  - Our medical-behavioral-social care model is executed across the care-continuum: any place of service, any time.
  - Seamless optimal care coordination & care transitions.
  - Leverage Complex Case Management, Palliative Care, Medication Therapy Management, & Home-based Care.
  - High-touch, high-service patient-centered approach.
  - Single operating platform with NCQA certified workflow.
  - Full Implementation with measurable results in 120 days.

Care Management– Care Plus

- What makes us special:
  - Our Care Model approach is Innovative & Effective.
  - Our Care Model drives Value.
  - Our Leaders are national experts in Care Coordination.
  - We are able to do this with all types of patients.
  - We specialize in highest-risk patients: chronic conditions, frail, disabled, homebound, severe mental illness, & end-of-life.
  - We also do this in all locations, geographies, & states.
  - We do this quickly, with minimum up-front investment.
  - We can reproduce, scale, & sustain.
  - Our results are compelling for all of our stakeholders.
  - Others are unable to replicate.

Care Management– Care Plus



- What this provides:

BETTER OUTCOMES

- Improved patient safety.
- Improved clinical quality of care.
- Saves lives due to care coordination.
- Better patient experience with improved satisfaction & retention.
- Better physician experience with improved satisfaction & retention.
- Dramatic reductions in avoidable hospital admissions.
- Dramatic reductions in hospital re-admissions.
- Dramatic reductions in population cost.
- Decrease in medical loss ratio (MLR): 70% - 85%.
- Increased savings from institutional & professional risk pools.

Care Management– Care Plus



- What this provides:

PATIENT VIEW

- VIP Concierge patient experience.
- I am healthier, safer, & living longer.
- Available caring PCP on any day that I need him/ her.
- Dedicated caring nurse to assist me whenever I need.
- Assistance in my home with medications, treatments, questions, or concerns; day or night or weekend or holiday.
- Transportation, appointments, community support, when I need.
- My care team knows me, & communicate with each other about my care needs and preferences.
- I will always get my care here.
- I will recommend Prospect to all of my family & friends.

Care Management– Care Plus



- What this provides:

PCP VIEW

- Improved clinical quality of care due to care coordination.
- Easier to care for complex patients.
- PCP is leader of care coordination team.
- Always available CM nurse, NP, social worker, pharmacist, or behavioral health (BH) specialist.
- Programs: Complex CM, Integrated BH, Inpatient CM (Hospital & SNF), Palliative Care, Homebound, Institutionalized (Long-term care).
- Transportation, medication delivery, care givers, community support
- Better care transitions to & from PCP.
- Better PCP experience with improved satisfaction & retention.
- Dramatic reduction in avoidable hospital admissions & re-admissions.
- Increased bonus & capitation payments to PCP.

Care Management– Care Plus



- What this provides:

HOSPITAL VIEW

- Improved patient safety.
- Improved clinical quality of care due to care coordination.
- Improved hospital throughput due to care coordination.
- Partners in moving from fee-for-service to value-based payment.
- Better alignment of physicians & health plans.
- Increased admissions from aligned physician referrals.
- Increased admissions from out-of-network hospital transfers.
- Better patient experience with improved satisfaction.
- Dramatic reductions in hospital re-admissions.
- Increased shared savings from institutional risk pools.

Care Management– Care Plus

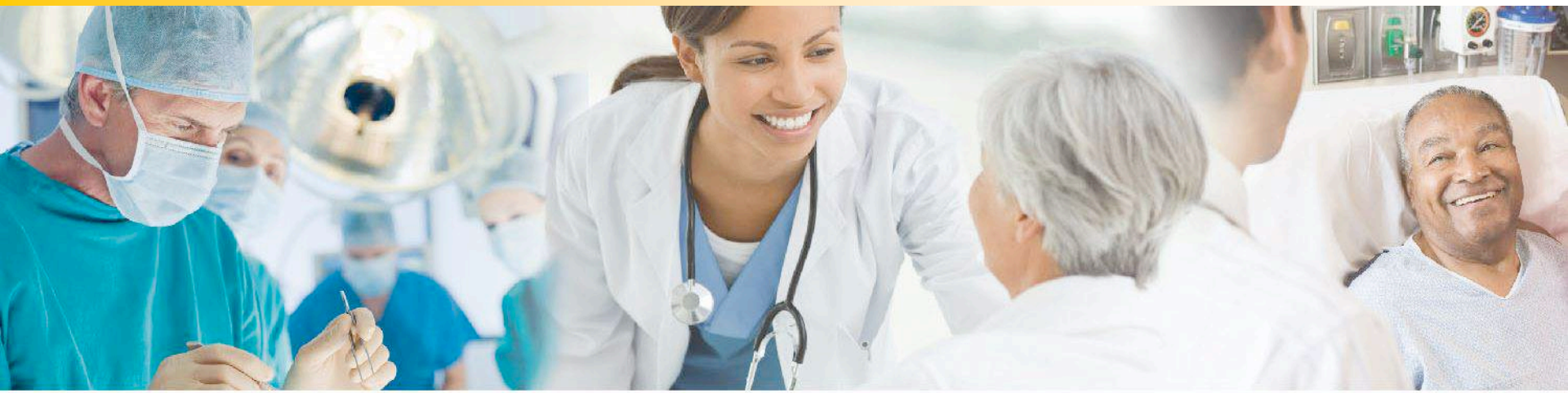


- What this provides:

HEALTHPLAN VIEW

- Improved clinical quality of care due to care coordination.
- Partners in population health management.
- Better alignment of physicians & hospitals.
- Delegate care coordination to Prospect, reduce G&A costs.
- Dramatic reductions in population cost.
- Reduced patient appeals & grievances.
- Decrease in medical loss ratio (MLR): 85%.
- Fixed budget & costs.
- Shift financial risk to Prospect

PROSPECT MEDICAL
Quality Service ~ Quality Care



Prospect Medical Group

Integrated Care Coordination Program

Care *Plus*-
High Intensity Care Management

- 24/7 Direct Telephonic Access
- Identification of patient admission drivers with development of specific actions plans
- Patient and Family Engagement of Care Plans
- Integrated Social Service coordination for members with psychosocial issues and placement issues
- Integrated Behavioral Health Management
- Disease Specific Action Plans and Self-Management
- Advance Care Planning
- Coordination of Ancillary Services/Physician Referrals

Care *Plus*- Palliative Care

- Outpatient Palliative Care Program
- Multidisciplinary team of physicians, RN, SW, chaplain, & pharmacist available 24/7
- Objectives are symptom management & reduce readmits
- Integrated with Prospect Care*Plus* Programs
- Goal to maximize care in home, then transition to hospice
- Screening LTC patients for palliative care & hospice

Care *Plus*-
Hospital Case Management

- Aggressive patient management & oversight
- Expectation of close monitoring of patients by rounding 2x per day until patient is discharged
- Medical Director rounds with CM & Hospitalist 2x per day
- Ability to direct patients from acute to preferred SNFs
- Ability to direct patients from acute to early Post DC Visit
- Close collaboration between Inpatient CM, SNF CM, Pharmacy, NP & PCP

Care *Plus*-
SNF Case Management

- Aggressive patient management
- Monitoring of patients by rounding 3-5x per week until patient is stable, then 2-3x per week
- Physician rounds supplemented by Prospect NPs
- Medical Director rounds with CM & SNFist 2x per week
- If patient's status deteriorates, transfer to network hospital
- Ability to direct patients from acute setting to preferred SNFs
- Direct patients from home or ED to preferred SNF for Therapy
- Close collaboration between Inpatient CM, SNF CM, Pharmacy, NP & PCP

Care *Plus*- Institutional (Long-Term Care)

- Patients to be seen weekly by Prospect SNFist/ NP
- Each facility assigned a dedicated SNFist & NP
- Each facility assigned a dedicated CM to assist in coordination of care
- Proactively manage ambulatory care sensitive conditions
  - Treat at SNF by converting patients from custodial to skilled LOC
  - Discontinue the practice of sending otherwise stable patients to hospital (IV Hydration, IV Antibiotics, Wound Care, etc.)
  - Advance Care Planning (DNR, DNH)

Care *Plus*- Utilization Management/ Referrals

- UM Program, Annual UM Plan, & UM Committee
- Utilization Measures, and related financial measures
  - Hospital Bed-days, Admits, ALOS
  - SNF Bed-days, Admits, ALOS
  - ER Visits
  - Specialty Referrals
  - Ambulatory Surgery Center Referrals
  - CT, MRI, PET Referrals
- Aggregate all data from provider referrals and claims, then analyze for improvement opportunities
- Detailed metric reporting for utilization & cost improvement
- Stream-lined, Effective process for provider requests for services, Referral review, Authorization, and Claims payment

Care *Plus*- Performance Programs/ QM

- Health Plan and Government based Quality Measures, and associated incentive payments
  - HEDIS
  - STARS
  - CMS ACO
  - CAHPS/ HOS
  - HCC/ RAF
- Collect data from health plans, labs, pharmacies, radiology, provider EHRs, and hospitals EHRs
- Aggregate all data, then analyze for improvement opportunities
- Detailed metric reporting for quality & RAF improvement
- Quality Program, Annual Quality Plan, & QM Committee

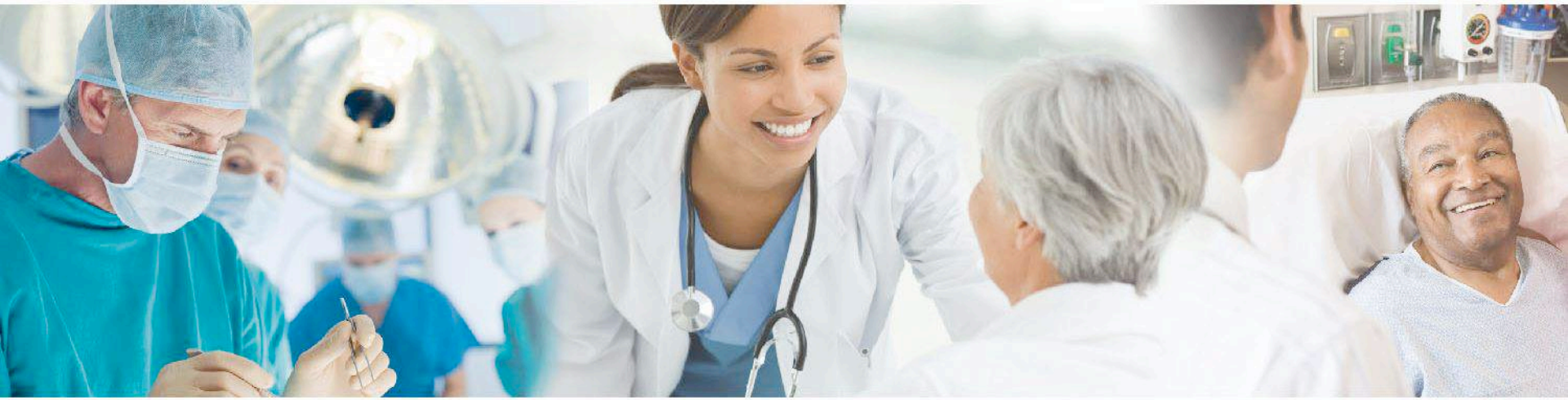
Care *Plus*- Homebound Program

- Mid-level providers NPs) with patient panels
- 24/7 direct telephonic access
- Expedited interventions for Pneumonia, COPD, CHF, Dehydration, & Cellulitis
- Hospital post-DC follow-up visits within 24 hr
- Same day urgent visits
- HCC risk assessment and STAR quality assessment
- NP Visit Notes to PCP
- Phone Communication with PCP & SCP for intervention

Care *Plus*- Pharmacy Program

- 24/7 Direct Telephonic Access with Pharmacist
- Telephonic Medication Therapy Management
- Disease Management Programs (DM & Anticoagulation)
- Post DC In-Home Medication Therapy Management
- LTC Medication Therapy Management
- Integrated with Inpatient & Outpatient Clinical Teams
- Patient Education and Assessment of Non Adherence

PROSPECT MEDICAL
Quality Service ~ Quality Care



Coordinated-Regional-Care: The Next Generation Healthcare System

Prospect Medical Directors

Care *Plus*-
High Intensity Case Management

PROSPECT MEDICAL DIRECTOR'S RESPONSIBILITIES

- High Intensity CM Case Rounds 2x weekly
- Target high risk patients: readmits, multiple co morbid conditions, functional impairment, cognitive decline, psychosocial issue
- Identify admission drivers, barriers and develop care plans with multidisciplinary team
- Use Care Plus programs: palliative or hospice team, pharmacy, high risk clinic, home visits or LTC visits by NP
- Focus on avoidance of ER visits or Hospital Admits
- Provide Strategic input to CM program

Care *Plus*- Palliative Care

PROSPECT MEDICAL DIRECTOR'S RESPONSIBILITIES

- Palliative Care Team Rounds 1x Weekly
- Palliative Care Physician consults, as needed
- Discuss Admits, Discharges, Change of Condition cases
- Recognize barriers, then develop home-based care plans
- Focus on Advance Care Planning & Hospice Conversions
- Focus on Symptom management
- Focus on avoidance of ER visits or Hospital Admits
- Provide Strategic input to Palliative Care programs

Care *Plus*- Hospital Case Management

PROSPECT MEDICAL DIRECTOR'S RESPONSIBILITIES

- Rounds AM and PM with Prospect concurrent review nurse
- Rounds daily with Hospitalists. Monthly Hospitalist JOCs.
- Focus on appropriateness of
  - Level of Care. Need for Inpatient Stay (OBS, IP, SNF, etc.).
  - Preferred Hospital (Low or high DRG, Per Diem, etc.)
  - Identify DC barriers. **Use Care Plus programs**.
  - Identify service delays: facility with payment denials vs provider
- Participate in Core Hospital JOCs
- Approve Tertiary Hospital transfers; then daily oversight
- Out-of-Network Hospital Rounds daily; Repatriation if able
- Provide Strategic input to Hospitalist & CM programs

Care *Plus*-
SNF Case Management

PROSPECT MEDICAL DIRECTOR'S RESPONSIBILITIES

- Biweekly SNF Rounds with Case Managers, NPs, & SNFists
- Quarterly JOC with Core SNFs. Develop higher standards for level of care & service in SNFs.
- Monthly SNFist Meetings
- DC planning for care transitions; Use of Care Plus programs
- Advance Care planning (ACP)
- Long Term Care planning (LTC)
- Provide Strategic input to SNF & LTC programs

Care *Plus*- UM & QI

PROSPECT MEDICAL DIRECTOR'S RESPONSIBILITIES

- Phone call discussions with physicians on specific requests
  - PCPs
  - Specialists
- Educational support to providers on EBM Standards & Goals
- Participate or Chair UM Committee
- Claims Review for key questions re: payment authorization
- Review Appeals & Grievances for authorization denials
- Provide Strategic input to Utilization Management program

Care *Plus*- Performance Programs & QM

PROSPECT MEDICAL DIRECTOR'S RESPONSIBILITIES

- Referral Review for a targeted complex service requests
- Office Meetings & Phone call discussions with physicians on Performance Programs
  - PCPs
  - Specialists
- Educational support to providers on Standards & Goals
  - Quality Measures (Pay4Performance, HEDIS, STARS, ACO)
  - Clinical Documentation for HCC/ RAF Scores
  - Tools for providers (Ascender, Reports, Training materials, Contacts)
  - Specific opportunities for Performance Improvement
- Participate or Chair QM Committee
- Provide Strategic input to Performance Programs

RESPONSE TO DEFICIENCIES
EXHIBIT H - ECHN Screenings and Educational Programs

Identified Community Health Need: Heart Disease Incidence

Fiscal Year 2013

Date	Screening/Education	Location	Number of People Served
Oct/Nov 2012	**Free blood pressure and cholesterol screenings** to employees	Manchester/Vernon	751
11/5/12	Free education program: "Keep the Beat: Lifestyle & Heart Health"	Manchester	16
11/29/12	Free education program: "Sodium Savvy: Making Health Choices	Manchester	13
2/1/13	**Free blood pressure/risk factor screening**	Manchester	30
2/1/13	**Free blood pressure/risk factor screening**	Vernon	20
2/27/13	Free education program: "Heart Health for Women"	Manchester	23
4/27/13	**Free blood pressure/risk factor screening**	South Windsor	25

Fiscal Year 2014

Date	Screening/Education	Location	Number of People Served
10/18/13	**Free blood pressure screenings at AHA Heart Walk**		undetermined
Oct/Nov 2013	**Free blood pressure and cholesterol screenings** to employees	Manchester/Vernon	691
2/7/14	**Free blood pressure/risk factor screening**	Vernon	30
2/10/14	Free education program: "Let's Talk About Your Ticker!"	Manchester	28
2/19/14	Free education program: "Understanding Hypertension: Break the Silence"	South Windsor	14
2/24/14	Free education program: "Heart Healthy Living in Children"	Manchester	60
6/1/14	**Free blood pressure screenings at health fair**	Manchester	55

Fiscal Year 2015

Date	Screening/Education	Location	Number of People Served
Oct/Nov 2014	**Free blood pressure and cholesterol screenings** to employees	Manchester/Vernon	850
11/15/14	**Free blood pressure, cholesterol & body mass screening**	Manchester	undetermined
11/18/14	**Free blood pressure, cholesterol & body mass screening**	East Hartford	undetermined
FY 2015	Heart Talk Support Group (meets monthly)	Vernon	

Identified Community Health Need: Cancer Incidence

Fiscal Year 2013

Date	Screening/Education	Location	Number of People Served
10/12/12	Free education program: "Nothing to Fear: The Truth About Colonoscopy Prep & Procedure"	Manchester	9
10/9/12	**Free mammogram screening to uninsured & underinsured women**	Vernon	51
10/9/12	**Free prostate screening**	Vernon	42
10/21/12	**Free mammogram event with Tolland Imaging Center & Big Y**	Tolland	10
10/24/12	Free education program: "Hereditary Cancer Genetics"	Manchester	19
2/19/13	Free education program: "Head & Neck Cancer: Early Detection is Key"	Manchester	9
3/4/13	Free education program: "Women & Colon Cancer"	Manchester	20
3/6/13	Free education program: "Prostate Screening: New Recommendation"	Manchester	19
4/27/13	**Free mammogram screenings to uninsured & underinsured woman**		53
5/6/13	**Free skin cancer screening**		48
5/17/13	Free program: Cancer Survivors Day Celebration	South Windsor	308
FY 2013	**Free breast and cervical screenings** (through Early Detection grant)		80
FY 2013	Free Smoking Prevention Outreach to middle schools	Vernon, Manchester, Tolland and Ellington	1,351

Fiscal Year 2014

Date	Screening/Education	Location	Number of People Served
Fall	Smoking cessation program: "Freedom From Smoking"	Manchester	11
10/1/2013	Free education program: "HPV & Oral Cancer: What's the Connection?"	South Windsor	10
10/19/13	**Free mammogram event with Tolland Imaging Center & Big Y**	Tolland	15
10/26/13	**Free mammogram screening**	South Windsor	17
11/18/13	Free education program: "I Have Dense Breasts: Now What?" (screening education)	South Windsor	27
Winter	Smoking cessation program: "Freedom From Smoking"	Manchester	3
3/12/14	Free education program: "Colon-ary Fun for Colon Cancer Awareness" (cooking demonstration)	Manchester	43

Date	Screening/Education	Location	Number of People Served
4/22/14	**Free mammogram screening event**	Glastonbury	1
5/7/14	**Free mammogram screening event**	South Windsor	1
5/21/14	**Free mammogram screening event**	Manchester	2
6/1/14	Free program: Cancer Survivors Day Celebration	Windsor	127
6/5/14	**Free mammogram screening event**	Vernon	1
FY 2014	**Free breast and cervical screenings** (through Early Detection grant)		234
FY 2014	Free Smoking Prevention Outreach to middle schools	Vernon, Manchester, Tolland and Ellington	478

Fiscal Year 2015

Date	Screening/Education	Location	Number of People Served
Fall	Smoking cessation program: "Freedom From Smoking"	Manchester/South Windsor	8
10/9/14	Free education program: "Emotional & Spiritual Self-Care	Manchester	25
10/23/14	Free education program: "Spirituality"	Manchester	21
Winter	Smoking cessation program: "Freedom From Smoking"	Manchester	6
4/1/15	Free education program: "Feeding the Body, Feeding the Soul"	Manchester	9
5/28/15	**Free mammography screening**	South Windsor	21
6/3/15	Free education program: "The Nuts and Bolts of Cancer Caregiving"	Manchester	3
6/7/15	Free program: Cancer Survivors Day Celebration	Windsor	372
6/17/15	Free education program: "When Cancer Can't Be Cured"	Manchester	9
8/6/15	Free education program: "Skin Lesions: Identification & Treatment Options"	South Windsor	35
FY 2015	**Free breast and cervical screenings** (through Early Detection grant)		143
FY 2015	Prostate Cancer Support Group (meets monthly)	Manchester	undertermined

Fiscal Year 2016

Date	Screening/Education	Location	Number of People Served
10/5/15	Free education program: "Encouraging Wellness in the Midst of Cancer"	Manchester	13
10/15/15	**Free Mammography screening**	South Windsor	55
Fall	Smoking cessation program: "Freedom From Smoking"	Manchester	3
10/26/15	Free education program: "Painting From the Heart" (for cancer patients and caregivers)	Manchester	12
11/2/15	Free education program: "Journaling Through the Cancer Journey"	Manchester	11
11/9/15	Free education program: "Creating Sacred Spaces" (for cancer patients and caregivers)	Manchester	
11/16/15	Free education program: "Skin Cancer: Detection, Prevention & Treatment Options"	South Windsor	
11/16/15	Free education program: "Palliative Cancer Care"	Manchester	

Identified Community Health Need: Diabetes Incidence

Fiscal Year 2013

Date	Screening/Education	Location	Number of People Served
10/17/12	Free education program: "Pre-diabetes: Making Changes That Will Last a Lifetime"	Manchester	64
Oct/Nov 2012	**Free glucose testing** for employees	Manchester/Vernon	751
11/4/12	**Free diabetic foot screening**	Manchester	16
11/8/12	Free education program: "Diabetes and the Eye"	South Windsor	11
2/18/13	**Free diabetic foot screening**	Manchester	15
4/9/13	Free education program at Manchester Senior Center	Manchester	75
5/6/13	**Free diabetic foot screening**	Manchester	18
8/5/13	**Free diabetic foot screening**	Manchester	15
FY 2013	Diabetes support group "Sweet Talk" - meets monthly	Manchester	undetermined

Fiscal Year 2014

Date	Screening/Education	Location	Number of People Served
10/9/13	Free education program: "Pre-Diabetes: Making Changes That Last a Lifetime"	Manchester	48
Oct/Nov 2013	**Free glucose testing** for employees	Manchester/Vernon	691
11/4/13	**Free diabetic foot screening**	Manchester	5
1/29/14	Free education program: "Pre-Diabetes: Making Changes That Last a Lifetime"	Manchester	42
3/8/14	**Free diabetic screening**	Manchester	13
6/9/14	**Free diabetic screening**	Manchester	20
8/6/2014	Free education program: "Pre-Diabetes: Making Changes That Last a Lifetime"	Manchester	38
9/15/14	**Free diabetic foot screening**	Manchester	18
FY 2014	Diabetes support group "Sweet Talk" - meets monthly	Manchester	undetermined

Fiscal Year 2015

Date	Screening/Education	Location	Number of People Served
10/14/14	Free education program: "Diabetes & Eye Health"	South Windsor	19
Oct/Nov 2014	**Free glucose testing** for employees	Manchester/Vernon	850
11/15/14	**Free glucose screening**	Manchester	undetermined
11/18/14	**Free glucose screening**	East Hartford	undetermined
12/3/14	Free education program: "Pre-Diabetes: Let's Take Action!"	South Windsor	53
12/8/14	**Free diabetic foot screening**	Manchester	13
3/3/15	Free education program: "Diabetes Made Simple!"	South Windsor	39
3/16/15	**Free diabetic foot screening**	Manchester	14
4/1/15	Free education program: "Pre-Diabetes: Let's Take Action!"	South Windsor	40
6/22/15	**Free diabetic foot screening**	Manchester	18
FY 2015	Diabetes support group "Sweet Talk" - meets monthly	Manchester	undetermined

Fiscal Year 2016

Date	Screening/Education	Location	Number of People Served
10/5/15	**Free diabetic foot screening**	Manchester	15
11/12/15	Free education program: "Just Keep Swimming: Dive In and Find Success Managing Your Diabetes"	Manchester	
12/9/15	Free education program: "Pre-Diabetes: Let's Take Action!"	South Windsor	

Identified Community Health Need: Arthritis Incidence

Fiscal Year 2013

Date	Screening/Education	Location	Number of People Served
5/22/13	Free education program: "Water Exercises for Arthritic Conditions"	Ellington	17
6/5/2013	Free education program: "Hip & Knee Arthritis: New Trends & Current Concepts"	Manchester	25

Fiscal Year 2014

Date	Screening/Education	Location	Number of People Served
10/30/13	Free education program: "Hip & Knee Arthritis: New Trends & Current Concepts"	Manchester	25
5/21/14	Free education program: "Understanding Rheumatoid Arthritis"	Manchester	30
6/19/14	Free education program: "Massage and Reiki for Arthritis Sufferers"	South Windsor	63

RESPONSE TO DEFICIENCIES
EXHIBIT I - Financial Worksheet C (Revised)

Sale of Non-Profit Hosptal to For-Profit Entity - REVISED

Name Entity: ECHN

Financial Worsheet (C):

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

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)
LINE	**Total Entity:**	**FY 2014 Actual**	**FY 2015 Projected**	**FY 2015 Projected**	**FY 2015 Projected**	**FY 2016 Projected**	**FY 2016 Projected**	**FY 2016 Projected**	**FY 2017 Projected**	**FY 2017 Projected**	**FY 2017 Projected**	**FY 2018 Projected**	**FY 2018 Projected**	**FY 2018 Projected**	**FY 2019 Projected**	**FY 2019 Projected**	**FY 2019 Projected**
	Description	**Results**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**
A.	**OPERATING REVENUE**																
1	Total Gross Patient Revenue	$929,318,695	$919,861,607	$0	$919,861,607	$911,417,931	$0	$911,417,931	$927,844,907	$17,635,006	$945,479,913	$945,508,033	$28,243,993	$973,752,026	$964,300,815	$38,852,980	$1,003,153,795
2	Less: Allowances	$613,774,825	$605,465,288	$0	$605,465,288	$599,410,635	$0	$599,410,635	$611,398,847	$12,229,890	$623,628,737	$623,626,824	$19,589,415	$643,216,239	$636,099,361	$26,948,940	$663,048,301
3	Less: Charity Care	$4,833,207	$4,778,075	$0	$4,778,075	$4,730,294	$0	$4,730,294	$4,824,900	$75,815	$4,900,715	$4,921,398	$122,094	$5,043,492	$5,019,826	$168,374	$5,188,200
4	Less: Other Deductions	$739,349	$689,936	$0	$689,936	$683,037	$0	$683,037	$696,698	$0	$696,698	$710,632	$0	$710,632	$724,844	$0	$724,844
	Net Patient Service Revenue	**$309,971,314**	**$308,928,308**	**$0**	**$308,928,308**	**$306,593,965**	**$0**	**$306,593,965**	**$310,924,462**	**$5,329,301**	**$316,253,763**	**$316,249,179**	**$8,532,484**	**$324,781,663**	**$322,456,784**	**$11,735,666**	**$334,192,450**
5	Medicare	$112,234,172	$115,287,873	$0	$115,287,873	$114,416,727	$0	$114,416,727	$116,032,810	$1,955,888	$117,988,698	$118,019,923	$3,134,443	$121,154,366	$120,336,517	$4,313,000	$124,649,517
6	Medicaid	$48,469,631	$49,459,392	$0	$49,459,392	$49,085,664	$0	$49,085,664	$49,778,976	$776,499	$50,555,475	$50,631,462	$1,234,950	$51,866,412	$51,625,299	$1,693,402	$53,318,701
7	CHAMPUS & TriCare	$1,895,490	$1,860,705	$0	$1,860,705	$1,846,645	$0	$1,846,645	$1,872,728	$19,948	$1,892,676	$1,904,799	$31,962	$1,936,761	$1,942,188	$43,975	$1,986,163
8	Other	$0	$0	$0	$0	$0	$0	$0		$0	$0		$0	$0		$0	$0
	Total Government	**$162,599,293**	**$166,607,970**	**$0**	**$166,607,970**	**$165,349,036**	**$0**	**$165,349,036**	**$167,684,514**	**$2,752,335**	**$170,436,849**	**$170,556,184**	**$4,401,355**	**$174,957,539**	**$173,904,004**	**$6,050,377**	**$179,954,381**
9	Commercial Insurers	$137,108,151	$133,386,403	$0	$133,386,403	$132,378,500	$0	$132,378,500	$134,248,284	$2,485,974	$136,734,258	$136,547,345	$3,984,510	$140,531,855	$139,227,611	$5,483,046	$144,710,657
10	Uninsured	$666,816	$526,077	$0	$526,077	$522,102	$0	$522,102	$529,477	$11,120	$540,597	$538,544	$17,931	$556,475	$549,115	$24,741	$573,856
11	Self Pay	$4,893,477	$4,051,067	$0	$4,051,067	$4,020,456	$0	$4,020,456	$4,077,244	$0	$4,077,244	$4,147,068	$0	$4,147,068	$4,228,470	$0	$4,228,470
12	Workers Compensation	$4,507,382	$4,058,179	$0	$4,058,179	$4,027,514	$0	$4,027,514	$4,084,401	$79,872	$4,164,273	$4,154,348	$128,687	$4,283,035	$4,235,893	$177,502	$4,413,395
13	Other	$196,195	$298,613	$0	$298,613	$296,357	$0	$296,357	$300,543	$0	$300,543	$305,689	$0	$305,689	$311,690	$0	$311,690
	Total Non-Government	**$147,372,021**	**$142,320,339**	**$0**	**$142,320,339**	**$141,244,929**	**$0**	**$141,244,929**	**$143,239,949**	**$2,576,966**	**$145,816,915**	**$145,692,994**	**$4,131,128**	**$149,824,122**	**$148,552,779**	**$5,685,289**	**$154,238,068**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$309,971,314**	**$308,928,309**	**$0**	**$308,928,309**	**$306,593,965**	**$0**	**$306,593,965**	**$310,924,463**	**$5,329,301**	**$316,253,764**	**$316,249,178**	**$8,532,483**	**$324,781,661**	**$322,456,783**	**$11,735,666**	**$334,192,449**
14	Less: Provision for Bad Debts	$10,216,094	$6,060,538	$0	**$6,060,538**	$5,999,933	$0	**$5,999,933**	$6,059,932	$112,360	**$6,172,292**	$6,181,131	$180,494	**$6,361,625**	$6,304,753	$248,637	**$6,553,390**
	Net Patient Service Revenue less provision for bad debts	**$299,755,220**	**$302,867,770**	**$0**	**$302,867,770**	**$300,594,032**	**$0**	**$300,594,032**	**$304,864,530**	**$5,216,941**	**$310,081,471**	**$310,068,048**	**$8,351,990**	**$318,420,038**	**$316,152,031**	**$11,487,029**	**$327,639,060**
15	Other Operating Revenue	$28,166,459	$16,802,913	$0	**$16,802,913**	$15,925,913	$0	**$15,925,913**	$15,972,139	($1,417,903)	**$14,554,236**	$16,019,290	($1,417,903)	**$14,601,387**	$16,067,383	($1,417,903)	**$14,649,480**
17	Net Assets Released from Restrictions	$833,650	$913,370	$0	**$913,370**	$913,370	$0	**$913,370**	$913,370	($913,370)	**$0**	$913,370	($913,370)	**$0**	$913,370	($913,370)	**$0**
	TOTAL OPERATING REVENUE	**$328,755,329**	**$320,584,053**	**$0**	**$320,584,053**	**$317,433,315**	**$0**	**$317,433,315**	**$321,750,039**	**$2,885,668**	**$324,635,707**	**$327,000,708**	**$6,020,717**	**$333,021,425**	**$333,132,784**	**$9,155,756**	**$342,288,540**
B.	**OPERATING EXPENSES**																
1	Salaries and Wages	$162,727,445	$156,292,474	$0	$156,292,474	$150,021,693	$0	$150,021,693	$150,778,127	$1,410,518	$152,188,645	$153,793,689	$2,257,113	$156,050,802	$156,869,563	$3,103,708	$159,973,271
2	Fringe Benefits	$43,859,398	$47,762,750	$0	$47,762,750	$50,610,250	$0	$50,610,250	$49,260,250	($284,122)	$48,976,128	$49,710,250	$324,373	$50,034,623	$50,160,250	$639,204	$50,799,454
3	Physicians Fees	$14,478,331	$14,605,651	$0	$14,605,651	$14,605,651	$0	$14,605,651	$15,043,821	$0	$15,043,821	$15,495,135	$0	$15,495,135	$15,959,989	$0	$15,959,989
4	Supplies and Drugs	$34,194,649	$34,974,486	$0	$34,974,486	$35,324,231	$0	$35,324,231	$35,677,473	($913,733)	$34,763,740	$36,034,248	($474,183)	$35,560,065	$36,394,590	($34,635)	$36,359,955
5	Depreciation and Amortization	$12,196,877	$11,958,956	$0	$11,958,956	$11,958,956	$0	$11,958,956	$11,958,956	$714,285	$12,673,241	$11,958,956	$1,428,571	$13,387,527	$11,958,956	$2,142,857	$14,101,813
6	Provision for Bad Debts-Other[b]	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
7	Interest Expense	$3,764,488	$3,570,511	$0	$3,570,511	$3,570,511	$0	$3,570,511	$3,570,511	($2,847,514)	$722,997	$3,570,511	($2,925,174)	$645,337	$3,570,511	($2,978,049)	$592,462
8	Malpractice Insurance Cost	$3,807,147	$3,845,218	$0	$3,845,218	$3,883,671	$0	$3,883,671	$3,922,507	$0	$3,922,507	$3,961,732	$0	$3,961,732	$4,001,350	$0	$4,001,350
9	Lease Expense	$6,622,257	$6,245,578	$0	$6,245,578	$6,308,033	$0	$6,308,033	$6,371,114	$0	$6,371,114	$6,434,825	$0	$6,434,825	$6,499,173	$0	$6,499,173
10	Other Operating Expenses	$44,932,012	$44,334,273	$0	$44,334,273	$44,883,620	$0	$44,883,620	$45,412,457	($451,595)	$44,960,862	$45,946,581	($3,616)	$45,942,965	$46,486,047	$444,362	$46,930,409
	TOTAL OPERATING EXPENSES	**$326,582,604**	**$323,589,897**	**$0**	**$323,589,897**	**$321,166,616**	**$0**	**$321,166,616**	**$321,995,216**	**($2,372,161)**	**$319,623,055**	**$326,905,927**	**$607,084**	**$327,513,011**	**$331,900,429**	**$3,317,447**	**$335,217,876**
	Provision for Income Taxes[c]		$0	$0	**$0**	$0	$0	**$0**	$0	$2,426,950	**$2,426,950**	$0	$2,635,170	**$2,635,170**		$3,344,235	**$3,344,235**
	Earnings Before Interest, Taxes, Depreciation & Amortization **(EBITDA)**	**$18,134,090**	**$12,523,623**	**$0**	**$12,523,623**	**$11,796,166**	**$0**	**$11,796,166**	**$15,284,290**	**$3,124,600**	**$18,408,890**	**$15,624,248**	**$3,917,030**	**$19,541,278**	**$16,761,822**	**$5,003,117**	**$21,764,939**
	INCOME / (LOSS) FROM OPERATIONS	**$2,172,725**	**($3,005,844)**	**$0**	**($3,005,844)**	**($3,733,301)**	**$0**	**($3,733,301)**	**($245,177)**	**$2,830,879**	**$2,585,702**	**$94,781**	**$2,778,463**	**$2,873,244**	**$1,232,355**	**$2,494,074**	**$3,726,429**
	NON-OPERATING INCOME / REVENUE	($2,125,751)	($2,394,868)	$0	**($2,394,868)**	($1,500,000)	$0	**($1,500,000)**	($500,000)	$0	**($500,000)**	($500,000)	$0	**($500,000)**	($500,000)	$0	**($500,000)**
	NET INCOME / EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSES	**$46,974**	**($5,400,712)**	**$0**	**($5,400,712)**	**($5,233,301)**	**$0**	**($5,233,301)**	**($745,177)**	**$2,830,879**	**$2,085,702**	**($405,219)**	**$2,778,463**	**$2,373,244**	**$732,355**	**$2,494,074**	**$3,226,429**

Sale of Non-Profit Hosptal to For-Profit Entity - REVISED

Name Entity: ECHN

Financial Worsheet (C):

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

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)
LINE	Total Entity:	FY 2014 Actual	FY 2015 Projected	FY 2015 Projected	FY 2015 Projected	FY 2016 Projected	FY 2016 Projected	FY 2016 Projected	FY 2017 Projected	FY 2017 Projected	FY 2017 Projected	FY 2018 Projected	FY 2018 Projected	FY 2018 Projected	FY 2019 Projected	FY 2019 Projected	FY 2019 Projected
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
C.	**Retained Earnings/ Net Assets, beginning of year**	**$85,849,149**	$77,693,789	**$0**	**$77,693,789**	$72,293,077	**$0**	**$72,293,077**	**$67,059,776**	**$0**	**$67,059,776**	**$66,314,599**	**$2,830,879**	**$69,145,478**	**$65,909,381**	**$5,609,341**	**$71,518,722**
	Retained Earnings / Net Assets, end of year	**$77,693,789**	$72,293,077	**$0**	**$72,293,077**	$67,059,776	**$0**	**$67,059,776**	**$66,314,599**	**$2,830,879**	**$69,145,478**	**$65,909,381**	**$5,609,341**	**$71,518,722**	**$66,641,736**	**$8,103,415**	**$74,745,151**
	Principal Payments	$7,235,595	$7,086,082	$0	**$7,086,082**	$7,163,415	$0	**$7,163,415**	$6,382,582	($6,382,582)	**$0**	$6,771,353	($6,771,353)	**$0**	$6,058,092	($6,058,092)	**$0**
D.	**PROFITABILITY SUMMARY**																
1	Hospital Operating Margin	**0.7%**	**-0.9%**	**0.0%**	**-0.9%**	**-1.2%**	**0.0%**	**-1.2%**	**-0.1%**	**98.1%**	**0.8%**	**0.0%**	**46.1%**	**0.9%**	**0.4%**	**27.2%**	**1.1%**
2	Hospital Non Operating Margin	**-0.7%**	**-0.8%**	**0.0%**	**-0.8%**	**-0.5%**	**0.0%**	**-0.5%**	**-0.2%**	**0.0%**	**-0.2%**	**-0.2%**	**0.0%**	**-0.2%**	**-0.2%**	**0.0%**	**-0.1%**
3	Hospital Total Margin	**0.0%**	**-1.7%**	**0.0%**	**-1.7%**	**-1.7%**	**0.0%**	**-1.7%**	**-0.2%**	**98.1%**	**0.6%**	**-0.1%**	**46.1%**	**0.7%**	**0.2%**	**27.2%**	**0.9%**
E.	**FTEs**	**2,298**	**2,240**	**-**	**2,240**	**2,117**	**-**	**2,117**	**2,117**	**21**	**2,138**	**2,117**	**32**	**2,149**	**2,117**	**44**	**2,161**
F.	**VOLUME STATISTICS**[d]																
1	Inpatient Discharges	11,451	10,927	-	**10,927**	11,202	-	**11,202**	11,202	213	**11,415**	11,202	325	**11,527**	11,202	438	**11,640**
2	Outpatient Visits	2,052,425	2,085,348	-	**2,085,348**	2,085,348	-	**2,085,348**	2,085,348	2,170	**2,087,518**	2,085,348	4,340	**2,089,688**	2,085,348	6,510	**2,091,858**
	TOTAL VOLUME	**2,063,876**	**2,096,275**	**0**	**2,096,275**	**2,096,550**	**0**	**2,096,550**	**2,096,550**	**2,383**	**2,098,933**	**2,096,550**	**4,665**	**2,101,215**	**2,096,550**	**6,948**	**2,103,498**

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

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c]Provide the amount of income taxes as defined by the Internal Revenue Services for for-profit entities.

[d]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

Sale of Non-Profit Hosptal to For-Profit Entity - REVISED

Name Entity: MMH

Financial Worsheet (C):

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

LINE	Total Entity:	(1) FY 2014 Actual	(2) FY 2015 Projected	(3) FY 2015 Projected	(4) FY 2015 Projected	(5) FY 2016 Projected	(6) FY 2016 Projected	(7) FY 2016 Projected	(8) FY 2017 Projected	(9) FY 2017 Projected	(10) FY 2017 Projected	(11) FY 2018 Projected	(12) FY 2018 Projected	(13) FY 2018 Projected	(14) FY 2019 Projected	(15) FY 2019 Projected	(16) FY 2019 Projected
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
A.	**OPERATING REVENUE**																
1	Total Gross Patient Revenue	$601,959,668	$594,394,400	$0	$594,394,400	$588,450,456	$0	$588,450,456	$596,688,762	$13,369,792	$610,058,554	$606,832,471	$20,855,080	$627,687,551	$618,362,288	$28,340,367	$646,702,655
2	Less: Allowances	$421,521,668	$411,650,321	$0	$411,650,321	$407,533,818	$0	$407,533,818	$413,239,291	$9,259,305	$422,498,596	$420,264,359	$14,443,273	$434,707,632	$428,249,382	$19,627,240	$447,876,622
3	Less: Charity Care	$2,411,263	$2,382,698	$0	$2,382,698	$2,358,871	$0	$2,358,871	$2,391,895	$53,594	$2,445,489	$2,432,557	$83,600	$2,516,157	$2,478,776	$113,606	$2,592,382
4	Less: Other Deductions	$0	$0	$0	$0	$0	$0	$0	$0		$0	$0	$0	$0	$0	$0	$0
	Net Patient Service Revenue	**$178,026,737**	**$180,361,381**	**$0**	**$180,361,381**	**$178,557,767**	**$0**	**$178,557,767**	**$181,057,576**	**$4,056,893**	**$185,114,469**	**$184,135,555**	**$6,328,207**	**$190,463,762**	**$187,634,130**	**$8,599,521**	**$196,233,651**
5	Medicare	$63,378,038	$65,429,033	$0	$65,429,033	$64,774,743	$0	$64,774,743	$65,681,589	$1,471,704	$67,153,293	$66,798,176	$2,295,660	$69,093,836	$68,067,341	$3,119,617	$71,186,958
6	Medicaid	$27,585,570	$28,409,212	$0	$28,409,212	$28,125,120	$0	$28,125,120	$28,518,872	$639,012	$29,157,884	$29,003,692	$996,773	$30,000,465	$29,554,763	$1,354,534	$30,909,297
7	CHAMPUS & TriCare	$664,283	$668,944	$0	$668,944	$662,255	$0	$662,255	$671,526	$15,047	$686,573	$682,942	$23,471	$706,413	$695,918	$31,895	$727,813
8	Other	$0	$0	$0	$0	$0	$0	$0	$0		$0	$0	$0	$0	$0	$0	$0
	Total Government	**$91,627,891**	**$94,507,189**	**$0**	**$94,507,189**	**$93,562,117**	**$0**	**$93,562,117**	**$94,871,987**	**$2,125,763**	**$96,997,750**	**$96,484,811**	**$3,315,904**	**$99,800,715**	**$98,318,022**	**$4,506,046**	**$102,824,068**
9	Commercial Insurers	$83,212,124	$83,015,701	$0	$83,015,701	$82,185,544	$0	$82,185,544	$83,336,142	$1,867,283	$85,203,425	$84,752,856	$2,912,711	$87,665,567	$86,363,160	$3,958,139	$90,321,299
10	Uninsured	$413,470	$343,512	$0	$343,512	$340,077	$0	$340,077	$344,838	$7,727	$352,565	$350,700	$12,053	$362,753	$357,364	$16,378	$373,742
11	Self Pay	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
12	Workers Compensation	$2,773,252	$2,494,979	$0	$2,494,979	$2,470,029	$0	$2,470,029	$2,504,610	$56,120	$2,560,730	$2,547,188	$87,539	$2,634,727	$2,595,585	$118,959	$2,714,544
13	Other	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Total Non-Government	**$86,398,846**	**$85,854,192**	**$0**	**$85,854,192**	**$84,995,650**	**$0**	**$84,995,650**	**$86,185,589**	**$1,931,130**	**$88,116,719**	**$87,650,744**	**$3,012,303**	**$90,663,047**	**$89,316,108**	**$4,093,476**	**$93,409,584**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$178,026,737**	**$180,361,381**	**$0**	**$180,361,381**	**$178,557,767**	**$0**	**$178,557,767**	**$181,057,576**	**$4,056,893**	**$185,114,469**	**$184,135,555**	**$6,328,207**	**$190,463,762**	**$187,634,130**	**$8,599,522**	**$196,233,652**
14	Less: Provision for Bad Debts	$5,822,470	$3,643,728	$0	**$3,643,728**	$3,607,291	$0	**$3,607,291**	$3,657,793	$81,969	**$3,739,762**	$3,719,975	$127,845	**$3,847,820**	$3,790,655	$173,731	**$3,964,386**
	Net Patient Service Revenue less provision for bad debts	**$172,204,267**	**$176,717,653**	**$0**	**$176,717,653**	**$174,950,476**	**$0**	**$174,950,476**	**$177,399,783**	**$3,974,924**	**$181,374,707**	**$180,415,579**	**$6,200,362**	**$186,615,941**	**$183,843,475**	**$8,425,790**	**$192,269,265**
15	Other Operating Revenue	$16,853,888	$11,023,919	$0	**$11,023,919**	$10,633,672	$0	**$10,633,672**	$10,846,346	($735,367)	**$10,110,979**	$11,063,272	($735,367)	**$10,327,905**	$11,284,538	($735,367)	**$10,549,171**
17	Net Assets Released from Restrictions	$486,908	$646,366	$0	**$646,366**	$776,365	$0	**$776,365**	$776,365	($776,365)	**$0**	$776,365	($776,365)	**$0**	$776,365	($776,365)	**$0**
	TOTAL OPERATING REVENUE	**$189,545,063**	**$188,387,937**	**$0**	**$188,387,937**	**$186,360,513**	**$0**	**$186,360,513**	**$189,022,494**	**$2,463,192**	**$191,485,686**	**$192,255,217**	**$4,688,630**	**$196,943,847**	**$195,904,378**	**$6,914,058**	**$202,818,436**
B.	**OPERATING EXPENSES**																
1	Salaries and Wages	$83,606,297	$82,578,386	$0	$82,578,386	$79,275,251	$0	$79,275,251	$80,068,003	$1,080,696	$81,148,699	$81,669,364	$1,685,741	$83,355,105	$83,302,751	$2,290,786	$85,593,537
2	Fringe Benefits	$25,720,253	$27,704,116	$0	$27,704,116	$29,366,363	$0	$29,366,363	$28,485,372	($186,999)	$28,298,373	$28,770,225	$330,795	$29,101,020	$29,057,928	$554,925	$29,612,853
3	Physicians Fees	$9,813,958	$10,038,473	$0	$10,038,473	$10,038,473	$0	$10,038,473	$10,339,627	$0	$10,339,627	$10,649,816	$0	$10,649,816	$10,969,310	$0	$10,969,310
4	Supplies and Drugs	$25,775,974	$23,929,618	$0	$23,929,618	$24,168,914	$0	$24,168,914	$24,410,603	($901,009)	$23,509,594	$24,654,709	($593,572)	$24,061,137	$24,901,256	($286,136)	$24,615,120
5	Depreciation and Amortization	$7,116,905	$7,114,038	$0	$7,114,038	$7,114,038	$0	$7,114,038	$7,114,038	$488,896	$7,602,934	$7,114,038	$977,792	$8,091,830	$7,114,038	$1,466,689	$8,580,727
6	Provision for Bad Debts-Other[b]	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
7	Interest Expense	$2,589,201	$2,451,251	$0	$2,451,251	$2,353,201	$0	$2,353,201	$2,353,201	($2,175,156)	$178,045	$2,353,201	($2,252,816)	$100,385	$2,353,201	($2,305,691)	$47,510
8	Malpractice Insurance Cost	$2,774,065	$2,801,806	$0	$2,801,806	$2,829,824	$0	$2,829,824	$2,858,122	$0	$2,858,122	$2,886,703	$0	$2,886,703	$2,915,570	$0	$2,915,570
9	Lease Expense	$2,328,809	$2,207,010	$0	$2,207,010	$2,229,080	$0	$2,229,080	$2,251,371	$0	$2,251,371	$2,273,885	$0	$2,273,885	$2,296,623	$0	$2,296,623
10	Other Operating Expenses	$25,584,097	$25,294,474	$0	$25,294,474	$25,547,418	$0	$25,547,418	$25,802,892	($419,554)	$25,383,338	$26,060,921	($94,582)	$25,966,339	$26,321,531	$230,389	$26,551,920
	TOTAL OPERATING EXPENSES	**$185,309,559**	**$184,119,170**	**$0**	**$184,119,170**	**$182,922,561**	**$0**	**$182,922,561**	**$183,683,229**	**($2,113,126)**	**$181,570,103**	**$186,432,862**	**$53,358**	**$186,486,220**	**$189,232,208**	**$1,950,962**	**$191,183,170**
	Provision for Income Taxes[c]		$0	$0	**$0**	$0	$0	**$0**		$4,254,950	**$4,254,950**		$4,482,606	**$4,482,606**		$5,030,134	**$5,030,134**
	Earnings Before Interest, Taxes, Depreciation & Amortization **(EBITDA)**	**$13,941,610**	**$13,834,056**	**$0**	**$13,834,056**	**$12,905,191**	**$0**	**$12,905,191**	**$14,806,503**	**$2,890,058**	**$17,696,561**	**$15,289,594**	**$3,360,248**	**$18,649,842**	**$16,139,409**	**$4,124,094**	**$20,263,503**
	INCOME / (LOSS) FROM OPERATIONS	**$4,235,504**	**$4,268,767**	**$0**	**$4,268,767**	**$3,437,952**	**$0**	**$3,437,952**	**$5,339,265**	**$321,368**	**$5,660,633**	**$5,822,355**	**$152,666**	**$5,975,021**	**$6,672,171**	**($67,038)**	**$6,605,133**
	NON-OPERATING INCOME / REVENUE	($1,743,322)	($1,672,972)	$0	**($1,672,972)**	($1,140,000)	$0	**($1,140,000)**	($380,000)		**($380,000)**	($380,000)		**($380,000)**	($380,000)		**($380,000)**
	NET INCOME / EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSES	**$2,492,182**	**$2,595,795**	**$0**	**$2,595,795**	**$2,297,952**	**$0**	**$2,297,952**	**$4,959,265**	**$321,368**	**$5,280,633**	**$5,442,355**	**$152,666**	**$5,595,021**	**$6,292,171**	**($67,038)**	**$6,225,133**

Sale of Non-Profit Hosptal to For-Profit Entity - REVISED

Name Entity: MMH
Financial Worsheet (C):

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

LINE	Total Entity:	(1) FY 2014 Actual Results	(2) FY 2015 Projected W/out CON	(3) FY 2015 Projected Incremental	(4) FY 2015 Projected With CON	(5) FY 2016 Projected W/out CON	(6) FY 2016 Projected Incremental	(7) FY 2016 Projected With CON	(8) FY 2017 Projected W/out CON	(9) FY 2017 Projected Incremental	(10) FY 2017 Projected With CON	(11) FY 2018 Projected W/out CON	(12) FY 2018 Projected Incremental	(13) FY 2018 Projected With CON	(14) FY 2019 Projected W/out CON	(15) FY 2019 Projected Incremental	(16) FY 2019 Projected With CON
	Description																
C.	**Retained Earnings/ Net Assets, beginning of year**	$37,731,740	$24,798,417	$0	$24,798,417	$27,394,212	$0	$27,394,212	$29,692,165	$0	$29,692,165	$34,651,429	$321,368	$34,972,797	$40,093,784	$474,034	$40,567,818
	Retained Earnings / Net Assets, end of year	$24,798,417	$27,394,212	$0	$27,394,212	$29,692,165	$0	$29,692,165	$34,651,429	$321,368	$34,972,797	$40,093,784	$474,034	$40,567,818	$46,385,955	$406,996	$46,792,951
	Principal Payments	$4,145,905	$4,883,195	$0	$4,883,195	$4,924,258	$0	**$4,924,258**	$4,234,565	($4,234,565)	**$0**	$4,781,812	($4,781,812)	**$0**	$4,061,758	($4,061,758)	**$0**
D.	**PROFITABILITY SUMMARY**																
1	Hospital Operating Margin	**2.3%**	**2.3%**	**0.0%**	**2.3%**	**1.9%**	**0.0%**	**1.9%**	**2.8%**	**13.0%**	**3.0%**	**3.0%**	**3.3%**	**3.0%**	**3.4%**	**-1.0%**	**3.3%**
2	Hospital Non Operating Margin	**-0.9%**	**-0.9%**	**0.0%**	**-0.9%**	**-0.6%**	**0.0%**	**-0.6%**	**-0.2%**	**0.0%**	**-0.2%**	**-0.2%**	**0.0%**	**-0.2%**	**-0.2%**	**0.0%**	**-0.2%**
3	Hospital Total Margin	**1.3%**	**1.4%**	**0.0%**	**1.4%**	**1.2%**	**0.0%**	**1.2%**	**2.6%**	**13.0%**	**2.8%**	**2.8%**	**3.3%**	**2.8%**	**3.2%**	**-1.0%**	**3.1%**
E.	**FTEs**	**1,177**	**1,140**	**0**	**1,140**	**1,052**	**0**	**1,052**	**1,052**	**16**	**1,068**	**1,052**	**24**	**1,076**	**1,052**	**33**	**1,085**
F.	**VOLUME STATISTICS**[d]																
1	Inpatient Discharges	9,110	8,768	0	**8,768**	9,043	0	**9,043**	9,043	181	**9,224**	9,043	271	**9,314**	9,043	362	**9,405**
2	Outpatient Visits	1,631,301	1,651,094	0	**1,651,094**	1,651,094	0	**1,651,094**	1,651,094	1,640	**1,652,734**	1,651,094	3,280	**1,654,374**	1,651,094	4,920	**1,656,014**
	TOTAL VOLUME	**1,640,411**	**1,659,862**	**0**	**1,659,862**	**1,660,137**	**0**	**1,660,137**	**1,660,137**	**1,821**	**1,661,958**	**1,660,137**	**3,551**	**1,663,688**	**1,660,137**	**5,282**	**1,665,419**

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.
[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.
[c]Provide the amount of income taxes as defined by the Internal Revenue Services for for-profit entities.
[d]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

Sale of Non-Profit Hosptal to For-Profit Entity - REVISED

Name Entity: RGH
Financial Worsheet (C):

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

LINE	Total Entity:	(1) FY 2014 Actual Results	(2) FY 2015 Projected W/out CON	(3) FY 2015 Projected Incremental	(4) FY 2015 Projected With CON	(5) FY 2016 Projected W/out CON	(6) FY 2016 Projected Incremental	(7) FY 2016 Projected With CON	(8) FY 2017 Projected W/out CON	(9) FY 2017 Projected Incremental	(10) FY 2017 Projected With CON	(11) FY 2018 Projected W/out CON	(12) FY 2018 Projected Incremental	(13) FY 2018 Projected With CON	(14) FY 2019 Projected W/out CON	(15) FY 2019 Projected Incremental	(16) FY 2019 Projected With CON
	Description																
A.	**OPERATING REVENUE**																
1	Total Gross Patient Revenue	$227,300,072	$229,450,128	$0	$229,450,128	$228,302,877	$0	$228,302,877	$231,499,118	$4,265,214	$235,764,332	$235,434,603	$7,388,913	$242,823,516	$239,907,860	$10,512,613	$250,420,473
2	Less: Allowances	$154,781,564	$159,804,700	$0	$159,804,700	$159,005,677	$0	$159,005,677	$161,231,756	$2,970,585	$164,202,341	$163,972,696	$5,146,142	$169,118,838	$167,088,177	$7,321,700	$174,409,877
3	Less: Charity Care	$1,188,543	$1,195,377	$0	$1,195,377	$1,189,400	$0	$1,189,400	$1,206,052	$22,221	$1,228,273	$1,226,555	$38,494	$1,265,049	$1,249,859	$54,768	$1,304,627
4	Less: Other Deductions	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Net Patient Service Revenue	**$71,329,965**	**$68,450,051**	**$0**	**$68,450,051**	**$68,107,801**	**$0**	**$68,107,801**	**$69,061,310**	**$1,272,408**	**$70,333,718**	**$70,235,352**	**$2,204,277**	**$72,439,629**	**$71,569,824**	**$3,136,145**	**$74,705,969**
5	Medicare	$25,494,325	$26,046,989	$0	$26,046,989	$25,916,754	$0	$25,916,754	$26,279,589	$484,184	$26,763,773	$26,726,342	$838,783	$27,565,125	$27,234,142	$1,193,383	$28,427,525
6	Medicaid	$7,614,784	$7,396,197	$0	$7,396,197	$7,359,216	$0	$7,359,216	$7,462,245	$137,487	$7,599,732	$7,589,103	$238,177	$7,827,280	$7,733,296	$338,868	$8,072,164
7	CHAMPUS & TriCare	$300,295	$263,667	$0	$263,667	$262,349	$0	$262,349	$266,022	$4,901	$270,923	$270,544	$8,491	$279,035	$275,684	$12,080	$287,764
8	Other	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Total Government	**$33,409,404**	**$33,706,853**	**$0**	**$33,706,853**	**$33,538,319**	**$0**	**$33,538,319**	**$34,007,855**	**$626,572**	**$34,634,427**	**$34,585,989**	**$1,085,451**	**$35,671,440**	**$35,243,123**	**$1,544,331**	**$36,787,454**
9	Commercial Insurers	$36,237,003	$33,282,888	$0	$33,282,888	$33,116,474	$0	$33,116,474	$33,580,104	$618,691	$34,198,795	$34,150,966	$1,071,799	$35,222,765	$34,799,834	$1,524,907	$36,324,741
10	Uninsured	$252,693	$182,539	$0	$182,539	$181,626	$0	$181,626	$184,169	$3,393	$187,562	$187,300	$5,878	$193,178	$190,859	$8,363	$199,222
11	Self Pay	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
12	Workers Compensation	$1,430,865	$1,277,771	$0	$1,277,771	$1,271,382	$0	$1,271,382	$1,289,181	$23,752	$1,312,933	$1,311,098	$41,148	$1,352,246	$1,336,008	$58,543	$1,394,551
13	Other	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Total Non-Government	**$37,920,561**	**$34,743,198**	**$0**	**$34,743,198**	**$34,569,482**	**$0**	**$34,569,482**	**$35,053,455**	**$645,836**	**$35,699,291**	**$35,649,363**	**$1,118,825**	**$36,768,188**	**$36,326,701**	**$1,591,813**	**$37,918,514**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$71,329,965**	**$68,450,051**	**$0**	**$68,450,051**	**$68,107,801**	**$0**	**$68,107,801**	**$69,061,310**	**$1,272,408**	**$70,333,718**	**$70,235,352**	**$2,204,276**	**$72,439,628**	**$71,569,824**	**$3,136,144**	**$74,705,968**
14	Less: Provision for Bad Debts	$2,801,283	$1,643,173	$0	**$1,643,173**	$1,626,741	$0	**$1,626,741**	$1,649,516	$30,391	**$1,679,907**	$1,677,558	$52,649	**$1,730,207**	$1,709,431	$74,906	**$1,784,337**
	Net Patient Service Revenue less provision for bad debts	**$68,528,682**	**$66,806,878**	**$0**	**$66,806,878**	**$66,481,059**	**$0**	**$66,481,059**	**$67,411,794**	**$1,242,017**	**$68,653,811**	**$68,557,795**	**$2,151,628**	**$70,709,423**	**$69,860,393**	**$3,061,239**	**$72,921,632**
15	Other Operating Revenue	$6,342,519	$2,128,076	$0	**$2,128,076**	$2,052,742	$0	**$2,052,742**	$2,093,797	($112,743)	**$1,981,054**	$2,135,673	($112,743)	**$2,022,930**	$2,178,387	($112,743)	**$2,065,644**
17	Net Assets Released from Restrictions	$49,147	$78,358	$0	**$78,358**	$91,337	$0	**$91,337**	$77,636	($77,636)	**$0**	$77,636	($77,636)	**$0**	$77,636	($77,636)	**$0**
	TOTAL OPERATING REVENUE	**$74,920,348**	**$69,013,312**	**$0**	**$69,013,312**	**$68,625,139**	**$0**	**$68,625,139**	**$69,583,227**	**$1,051,638**	**$70,634,865**	**$70,771,104**	**$1,961,249**	**$72,732,353**	**$72,116,415**	**$2,870,860**	**$74,987,275**
B.	**OPERATING EXPENSES**																
1	Salaries and Wages	$32,460,253	$30,649,768	$0	$30,649,768	$29,423,777	$0	$29,423,777	$29,718,015	$329,822	$30,047,837	$30,312,375	$571,372	$30,883,747	$30,918,622	$812,922	$31,731,544
2	Fringe Benefits	$9,360,797	$10,423,090	$0	$10,423,090	$11,048,475	$0	$11,048,475	$10,717,021	($97,123)	$10,619,898	$10,824,191	($6,422)	$10,817,769	$10,932,433	$84,279	$11,016,712
3	Physicians Fees	$3,728,005	$4,310,255	$0	$4,310,255	$4,310,255	$0	$4,310,255	$4,439,562	$0	$4,439,562	$4,572,749	$0	$4,572,749	$4,709,932	$0	$4,709,932
4	Supplies and Drugs	$9,776,421	$9,560,149	$0	$9,560,149	$9,655,751	$0	$9,655,751	$9,752,308	($12,724)	$9,739,584	$9,849,831	$119,389	$9,969,220	$9,948,330	$251,501	$10,199,831
5	Depreciation and Amortization	$3,281,014	$3,234,649	$0	$3,234,649	$3,234,649	$0	$3,234,649	$3,234,649	$225,389	$3,460,038	$3,234,649	$450,779	$3,685,428	$3,234,649	$676,168	$3,910,817
6	Provision for Bad Debts-Other[b]	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
7	Interest Expense	$689,882	$700,373	$0	$700,373	$672,358	$0	$672,358	$672,358	($672,358)	($0)	$672,358	($672,358)	($0)	$672,357.89	($672,358)	($0)
8	Malpractice Insurance Cost	$1,033,082	$1,043,413	$0	$1,043,413	$1,053,847	$0	$1,053,847	$1,064,385	$0	$1,064,385	$1,075,029	$0	$1,075,029	$1,085,780	$0	$1,085,780
9	Lease Expense	$1,013,626	$1,188,827	$0	$1,188,827	$1,200,715	$0	$1,200,715	$1,212,722	$0	$1,212,722	$1,224,849	$0	$1,224,849	$1,237,098	$0	$1,237,098
10	Other Operating Expenses	$10,816,575	$8,901,262	$0	$8,901,262	$8,990,275	$0	$8,990,275	$9,080,177	($32,041)	$9,048,136	$9,170,979	$90,966	$9,261,945	$9,262,689	$213,973	$9,476,662
	TOTAL OPERATING EXPENSES	**$72,159,655**	**$70,011,785**	**$0**	**$70,011,785**	**$69,590,101**	**$0**	**$69,590,101**	**$69,891,198**	**($259,035)**	**$69,632,163**	**$70,937,011**	**$553,726**	**$71,490,737**	**$72,001,890**	**$1,366,485**	**$73,368,375**
	Provision for Income Taxes[c]		$0	$0	**$0**	$0	$0	**$0**		$419,357	**$419,357**		$607,900	**$607,900**		$766,359	**$766,359**
	Earnings Before Interest, Taxes, Depreciation & Amortization **(EBITDA)**	**$6,731,589**	**$2,936,549**	**$0**	**$2,936,549**	**$2,942,045**	**$0**	**$2,942,045**	**$3,599,036**	**$863,704**	**$4,462,740**	**$3,741,100**	**$1,185,944**	**$4,927,044**	**$4,021,532**	**$1,508,185**	**$5,529,717**
	INCOME / (LOSS) FROM OPERATIONS	**$2,760,693**	**($998,473)**	**$0**	**($998,473)**	**($964,962)**	**$0**	**($964,962)**	**($307,971)**	**$891,316**	**$583,345**	**($165,908)**	**$799,623**	**$633,715**	**$114,525**	**$738,016**	**$852,541**
	NON-OPERATING INCOME / REVENUE	($378,564)	($468,022)	$0	**($468,022)**	($315,000)	$0	**($315,000)**	($105,000)		**($105,000)**	$105,000		**$105,000**	$105,000		**$105,000**
	NET INCOME / EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSES	**$2,382,129**	**($1,466,495)**	**$0**	**($1,466,495)**	**($1,279,962)**	**$0**	**($1,279,962)**	**($412,971)**	**$891,316**	**$478,345**	**($60,908)**	**$799,623**	**$738,715**	**$219,525**	**$738,016**	**$957,541**

Sale of Non-Profit Hosptal to For-Profit Entity - REVISED

Name Entity: RGH
Financial Worsheet (C):

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

LINE	Total Entity:	(1) FY 2014 Actual Results	(2) FY 2015 Projected W/out CON	(3) FY 2015 Projected Incremental	(4) FY 2015 Projected With CON	(5) FY 2016 Projected W/out CON	(6) FY 2016 Projected Incremental	(7) FY 2016 Projected With CON	(8) FY 2017 Projected W/out CON	(9) FY 2017 Projected Incremental	(10) FY 2017 Projected With CON	(11) FY 2018 Projected W/out CON	(12) FY 2018 Projected Incremental	(13) FY 2018 Projected With CON	(14) FY 2019 Projected W/out CON	(15) FY 2019 Projected Incremental	(16) FY 2019 Projected With CON
	Description																
C.	**Retained Earnings/ Net Assets, beginning of year**	**$31,052,463**	**$28,334,302**	**$0**	**$28,334,302**	**$26,867,807**	**$0**	**$26,867,807**	**$25,587,845**	**$0**	**$25,587,845**	**$25,174,874**	**$891,316**	**$26,066,190**	**$25,113,967**	**$1,690,939**	**$26,804,906**
	Retained Earnings / Net Assets, end of year	**$28,334,302**	**$26,867,807**	**$0**	**$26,867,807**	**$25,587,845**	**$0**	**$25,587,845**	**$25,174,874**	**$891,316**	**$26,066,190**	**$25,113,967**	**$1,690,939**	**$26,804,906**	**$25,333,492**	**$2,428,955**	**$27,762,447**
	Principal Payments	$874,828	$881,957	$0	**$881,957**	$926,631	$0	**$926,631**	$984,173	($984,173)	**$0**	$1,110,055	($1,110,055)	**$0**	$1,132,025		**$1,132,025**
D.	**PROFITABILITY SUMMARY**																
1	Hospital Operating Margin	**3.7%**	**-1.5%**	**0.0%**	**-1.5%**	**-1.4%**	**0.0%**	**-1.4%**	**-0.4%**	**84.8%**	**0.8%**	**-0.2%**	**40.8%**	**0.9%**	**0.2%**	**25.7%**	**1.1%**
2	Hospital Non Operating Margin	**-0.5%**	**-0.7%**	**0.0%**	**-0.7%**	**-0.5%**	**0.0%**	**-0.5%**	**-0.2%**	**0.0%**	**-0.1%**	**0.1%**	**0.0%**	**0.1%**	**0.1%**	**0.0%**	**0.1%**
3	Hospital Total Margin	**3.2%**	**-2.1%**	**0.0%**	**-2.1%**	**-1.9%**	**0.0%**	**-1.9%**	**-0.6%**	**84.8%**	**0.7%**	**-0.1%**	**40.8%**	**1.0%**	**0.3%**	**25.7%**	**1.3%**
E.	**FTEs**	**405**	**377**	**0**	**377**	**348**	**0**	**348**	**348**	**5**	**353**	**348**	**8**	**356**	**348**	**11**	**359**
F.	**VOLUME STATISTICS[d]**																
1	Inpatient Discharges	2,341	2,159	0	**2,159**	2,159	0	**2,159**	2,159	32	**2,191**	2,159	54	**2,213**	2,159	76	**2,235**
2	Outpatient Visits	421,124	434,254	0	**434,254**	434,254	0	**434,254**	434,254	530	**434,784**	434,254	1,060	**435,314**	434,254	1,590	**435,844**
	TOTAL VOLUME	**423,465**	**436,413**	**0**	**436,413**	**436,413**	**0**	**436,413**	**436,413**	**562**	**436,975**	**436,413**	**1,114**	**437,527**	**436,413**	**1,666**	**438,079**

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.
[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.
[c]Provide the amount of income taxes as defined by the Internal Revenue Services for for-profit entities.
[d]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

RESPONSE TO DEFICIENCIES
EXHIBIT J - Other Operating Revenue Detail

Other Operating Revenue Detail

Entity Name: ECHN

	FY 2015 Projected W/out CON	FY 2015 Projected Incremental	FY 2015 Projected With CON	FY 2016 Projected W/out CON	FY 2016 Projected Incremental	FY 2016 Projected With CON	FY 2017 Projected W/out CON	FY 2017 Projected Incremental	FY 2017 Projected With CON	FY 2018 Projected W/out CON	FY 2018 Projected Incremental	FY 2018 Projected With CON	FY 2019 Projected W/out CON	FY 2019 Projected Incremental	FY 2019 Projected With CON
Adolescent Education	$1,990,410	$0	$1,990,410	$1,990,410	$0	$1,990,410	$1,990,410	$0	$1,990,410	$1,990,410	$0	$1,990,410	$1,990,410	$0	$1,990,410
Behavioral Health	$408,035	$0	$408,035	$408,035	$0	$408,035	$408,035	$0	$408,035	$408,035	$0	$408,035	$408,035	$0	$408,035
Biomed Service Contract w/ Tolland Imaging (JV)	$140,667	$0	$140,667	$140,667	$0	$140,667	$140,667	$0	$140,667	$140,667	$0	$140,667	$140,667	$0	$140,667
Cafeteria Income	$965,455	$0	$965,455	$965,455	$0	$965,455	$965,455	$0	$965,455	$965,455	$0	$965,455	$965,455	$0	$965,455
Cancer Services - Salary Recovery from NRRON (JV)	$195,500	$0	$195,500	$195,500	$0	$195,500	$195,500	$0	$195,500	$195,500	$0	$195,500	$195,500	$0	$195,500
ECHN Allocation	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
ECMPF Revenue	$371,634	$0	$371,634	$371,634	$0	$371,634	$371,634	$0	$371,634	$371,634	$0	$371,634	$371,634	$0	$371,634
ECMPF Sound Revenue	$338,800	$0	$338,800	$338,800	$0	$338,800	$338,800	$0	$338,800	$338,800	$0	$338,800	$338,800	$0	$338,800
EHR Initiative Program	$868,039	$0	$868,039	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Gift Shop	$647,433	$0	$647,433	$647,433	$0	$647,433	$647,433	$0	$647,433	$647,433	$0	$647,433	$647,433	$0	$647,433
Grant Income	$1,741,542	$0	$1,741,542	$1,741,542	$0	$1,741,542	$1,741,542	$0	$1,741,542	$1,741,542	$0	$1,741,542	$1,741,542	$0	$1,741,542
HR - Wellness Program & Medicare Part D Subsidy	$468,715	$0	$468,715	$468,715	$0	$468,715	$468,715	$0	$468,715	$468,715	$0	$468,715	$468,715	$0	$468,715
Lab Services - Eastern CT Pathology	$1,313,440	$0	$1,313,440	$1,313,440	$0	$1,313,440	$1,313,440	$0	$1,313,440	$1,313,440	$0	$1,313,440	$1,313,440	$0	$1,313,440
Maintanance Cost Recovery Woodlake	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Miscellaneous Income	$95,627	$0	$95,627	$86,666	$0	$86,666	$86,666	$0	$86,666	$86,666	$0	$86,666	$86,666	$0	$86,666
MPP Billing Revenue	$2,305,526	$0	$2,305,526	$2,305,526	$0	$2,305,526	$2,305,526	$0	$2,305,526	$2,305,526	$0	$2,305,526	$2,305,526	$0	$2,305,526
Nursing/Perinatal Education	$69,584	$0	$69,584	$69,584	$0	$69,584	$69,584	$0	$69,584	$69,584	$0	$69,584	$69,584	$0	$69,584
Physician Hospital Organization	$331,559	$0	$331,559	$331,559	$0	$331,559	$331,559	$0	$331,559	$331,559	$0	$331,559	$331,559	$0	$331,559
Radiology Directorship - Tolland Imaging (JV)	$89,645	$0	$89,645	$89,645	$0	$89,645	$89,645	$0	$89,645	$89,645	$0	$89,645	$89,645	$0	$89,645
Rental Income	$350,197	$0	$350,197	$350,197	$0	$350,197	$350,197	$0	$350,197	$350,197	$0	$350,197	$350,197	$0	$350,197
UNECOM - Medical Education	$237,480	$0	$237,480	$237,480	$0	$237,480	$237,480	$0	$237,480	$237,480	$0	$237,480	$237,480	$0	$237,480
VNHSC (Flu Clinic/Health Promotions)	$66,508	$0	$66,508	$66,508	$0	$66,508	$66,508	$0	$66,508	$66,508	$0	$66,508	$66,508	$0	$66,508
Joint Venture Income	$2,311,296	$0	$2,311,296	$2,311,296	$0	$2,311,296	$2,357,522	$0	$2,357,522	$2,404,672	$0	$2,404,672	$2,452,766	$0	$2,452,766
Public Support	$1,265,801	$0	$1,265,801	$1,265,801	$0	$1,265,801	$1,265,801	($1,265,801)	$0	$1,265,801	($1,265,801)	$0	$1,265,801	($1,265,801)	$0
Realized Gains	$0	$0	$0	$0	$0	$0	$36,261	$0	$36,261	$36,261	$0	$36,261	$36,261	$0	$36,261
Interest Income	$230,020	$0	$230,020	$230,020	$0	$230,020	$193,759	($152,102)	$41,657	$193,759	($152,102)	$41,657	$193,759	($152,102)	$41,657
Total Other Operating Revenue	**$16,802,913**	**$0**	**$16,802,913**	**$15,925,913**	**$0**	**$15,925,913**	**$15,972,139**	**($1,417,903)**	**$14,554,236**	**$16,019,290**	**($1,417,903)**	**$14,601,387**	**$16,067,383**	**($1,417,903)**	**$14,649,480**

Other Operating Revenue Detail

Entity Name: MMH

	FY 2015 Projected W/out CON	FY 2015 Projected Incremental	FY 2015 Projected With CON	FY 2016 Projected W/out CON	FY 2016 Projected Incremental	FY 2016 Projected With CON	FY 2017 Projected W/out CON	FY 2017 Projected Incremental	FY 2017 Projected With CON	FY 2018 Projected W/out CON	FY 2018 Projected Incremental	FY 2018 Projected With CON	FY 2019 Projected W/out CON	FY 2019 Projected Incremental	FY 2019 Projected With CON
Adolescent Education	$1,790,410	$0	$1,790,410	$1,790,410	$0	$1,790,410	$1,826,218	$0	$1,826,218	$1,862,743	$0	$1,862,743	$1,899,997	$0	$1,899,997
Behavioral Health	$376,535	$0	$376,535	$376,535	$0	$376,535	$384,066	$0	$384,066	$391,747	$0	$391,747	$399,582	$0	$399,582
Biomed Service Contract w/ Tolland Imaging (JV)	$140,667	$0	$140,667	$140,667	$0	$140,667	$143,480	$0	$143,480	$146,350	$0	$146,350	$149,277	$0	$149,277
Cafeteria Income	$873,648	$0	$873,648	$873,648	$0	$873,648	$891,121	$0	$891,121	$908,943	$0	$908,943	$927,122	$0	$927,122
Cancer Services - Salary Recovery from NRRON (JV)	$195,500	$0	$195,500	$195,500	$0	$195,500	$199,410	$0	$199,410	$203,398	$0	$203,398	$207,466	$0	$207,466
ECHN Allocation	$901,129	$0	$901,129	$901,129	$0	$901,129	$919,152	$0	$919,152	$937,535	$0	$937,535	$956,285	$0	$956,285
ECMPF Revenue	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
ECMPF Sound Revenue	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
EHR Initiative Program	$429,536	$0	$429,536	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Gift Shop	$613,616	$0	$613,616	$613,616	$0	$613,616	$625,888	$0	$625,888	$638,406	$0	$638,406	$651,174	$0	$651,174
Grant Income	$1,529,803	$0	$1,529,803	$1,529,803	$0	$1,529,803	$1,560,399	$0	$1,560,399	$1,591,607	$0	$1,591,607	$1,623,439	$0	$1,623,439
HR - Wellness Program & Medicare Part D Subsidy	$468,715	$0	$468,715	$468,715	$0	$468,715	$478,089	$0	$478,089	$487,651	$0	$487,651	$497,404	$0	$497,404
Lab Services - Eastern CT Pathology	$1,313,441	$0	$1,313,441	$1,313,441	$0	$1,313,441	$1,339,711	$0	$1,339,711	$1,366,504	$0	$1,366,504	$1,393,834	$0	$1,393,834
Maintanance Cost Recovery Woodlake	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Miscellaneous Income	$29,342	$0	$29,342	$68,631	$0	$68,631	$85,706	$0	$85,706	$103,123	$0	$103,123	$120,888	$0	$120,888
MPP Billing Revenue	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Nursing/Perinatal Education	$69,584	$0	$69,584	$69,584	$0	$69,584	$70,976	$0	$70,976	$72,395	$0	$72,395	$73,843	$0	$73,843
Physician Hospital Organization	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Radiology Directorship - Tolland Imaging (JV)	$89,645	$0	$89,645	$89,645	$0	$89,645	$91,438	$0	$91,438	$93,267	$0	$93,267	$95,132	$0	$95,132
Rental Income	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
UNECOM - Medical Education	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
VNHSC (Flu Clinic/Health Promotions)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Joint Venture Income	$1,417,219	$0	$1,417,219	$1,417,219	$0	$1,417,219	$1,445,563	$0	$1,445,563	$1,474,475	$0	$1,474,475	$1,503,964	$0	$1,503,964
Public Support	$595,242	$0	$595,242	$595,242	$0	$595,242	$595,242	($595,242)	$0	$595,242	($595,242)	$0	$595,242	($595,242)	$0
Realized Gains	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Interest Income	$189,887	$0	$189,887	$189,887	$0	$189,887	$189,887	($140,125)	$49,762	$189,887	($140,125)	$49,762	$189,887	($140,125)	$49,762
Total Other Operating Revenue	**$11,023,919**	**$0**	**$11,023,919**	**$10,633,672**	**$0**	**$10,633,672**	**$10,846,346**	**($735,367)**	**$10,110,979**	**$11,063,272**	**($735,367)**	**$10,327,905**	**$11,284,538**	**($735,367)**	**$10,549,171**

Other Operating Revenue Detail

Entity Name: RGH

	FY 2015 Projected W/out CON	FY 2015 Projected Incremental	FY 2015 Projected With CON	FY 2016 Projected W/out CON	FY 2016 Projected Incremental	FY 2016 Projected With CON	FY 2017 Projected W/out CON	FY 2017 Projected Incremental	FY 2017 Projected With CON	FY 2018 Projected W/out CON	FY 2018 Projected Incremental	FY 2018 Projected With CON	FY 2019 Projected W/out CON	FY 2019 Projected Incremental	FY 2019 Projected With CON
Adolescent Education	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Behavioral Health	$31,500	$0	$31,500	$31,500	$0	$31,500	$32,130	$0	$32,130	$32,773	$0	$32,773	$33,428	$0	$33,428
Biomed Service Contract w/ Tolland Imaging (JV)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Cafeteria Income	$208,628	$0	$208,628	$208,628	$0	$208,628	$212,801	$0	$212,801	$217,057	$0	$217,057	$221,398	$0	$221,398
Cancer Services - Salary Recovery from NRRON (JV)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
ECHN Allocation	$355,646	$0	$355,646	$355,646	$0	$355,646	$362,759	$0	$362,759	$370,014	$0	$370,014	$377,414	$0	$377,414
ECMPF Revenue	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
ECMPF Sound Revenue	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
EHR Initiative Program	$438,503	$0	$438,503	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Gift Shop	$33,817	$0	$33,817	$33,817	$0	$33,817	$34,493	$0	$34,493	$35,183	$0	$35,183	$35,887	$0	$35,887
Grant Income	$193,670	$0	$193,670	$193,670	$0	$193,670	$197,543	$0	$197,543	$201,494	$0	$201,494	$205,524	$0	$205,524
HR - Wellness Program & Medicare Part D Subsidy	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Lab Services - Eastern CT Pathology	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Maintanance Cost Recovery Woodlake	$139,548	$0	$139,548	$139,548	$0	$139,548	$142,339	$0	$142,339	$145,186	$0	$145,186	$148,089	$0	$148,089
Miscellaneous Income	$13,964	$0	$13,964	$377,134	$0	$377,134	$387,184	$0	$387,184	$397,435	$0	$397,435	$407,892	$0	$407,892
MPP Billing Revenue	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Nursing/Perinatal Education	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Physician Hospital Organization	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Radiology Directorship - Tolland Imaging (JV)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Rental Income	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
UNECOM - Medical Education	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
VNHSC (Flu Clinic/Health Promotions)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Joint Venture Income	$587,431	$0	$587,431	$587,431	$0	$587,431	$599,180	$0	$599,180	$611,163	$0	$611,163	$623,386	$0	$623,386
Public Support	$100,766	$0	$100,766	$100,766	$0	$100,766	$100,766	($100,766)	$0	$100,766	($100,766)	$0	$100,766	($100,766)	$0
Realized Gains	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Interest Income	$24,602	$0	$24,602	$24,602	$0	$24,602	$24,602	($11,977)	$12,625	$24,602	($11,977)	$12,625	$24,602	($11,977)	$12,625
Total Other Operating Revenue	**$2,128,076**	**$0**	**$2,128,076**	**$2,052,742**	**$0**	**$2,052,742**	**$2,093,797**	**($112,743)**	**$1,981,054**	**$2,135,673**	**($112,743)**	**$2,022,930**	**$2,178,387**	**($112,743)**	**$2,065,644**

RESPONSE TO DEFICIENCIES
EXHIBIT K - OHCA Financial Statistics Report
(ECHN – July, August, September)

OHCA Financial Statistics Report (July FY 2015 and July FY 2014)

	Manchester Memorial Hospital				Rockville General Hospital				Eastern CT Health Network			
	MTD		YTD		MTD		YTD		MTD		YTD	
	July FY 2015	July FY 2014	July FY 2015	July FY 2014	July FY 2015	July FY 2014	July FY 2015	July FY 2014	July FY 2015	July FY 2014	July FY 2015	July FY 2014
A. Operating Performance												
Operating Margin	4.12%	3.32%	2.51%	3.23%	-3.13%	0.81%	-2.72%	1.05%	3.71%	0.89%	-0.98%	0.34%
Non-Operating Margin	-1.21%	-1.76%	-0.89%	-0.88%	-1.20%	-1.71%	-0.69%	-0.45%	-0.92%	-1.36%	-0.67%	-0.59%
Total Margin	2.91%	1.56%	1.62%	2.35%	-4.32%	-0.90%	-3.41%	0.60%	2.80%	-0.47%	-1.65%	-0.25%
Bad Debt as % of Gross Revenue	0.58%	0.38%	-0.61%	-0.66%	0.99%	0.35%	-0.72%	-0.63%	-0.76%	0.48%	-0.65%	-0.75%
B. Liquidity												
Current Ratio	1.16	1.31	1.16	1.31	1.54	1.50	1.54	1.50	1.38	1.40	1.38	1.40
Days Cash on Hand	19	28	13	20	66	61	45	45	65	70	65	70
Days in Net Accounts Receivable	53	59	38	43	62	55	42	41	52	55	38	40
Average Payment Period	62	54	43	39	48	47	32	34	64	70	64	70
C. Leverage and Capital Structure												
Long-term Debt to Equity	2.07	1.64	2.07	1.64	0.91	0.74	0.91	0.74	1.11	0.93	1.11	0.93
Long-term Debt to Capitalization	67	62	67	62	48	42	48	42	67	59	67	59
Unrestricted Cash to Debt	1.30	0.90	10.83	12.60	0.08	0.43	2.49	9.86	1.37	0.49	4.36	7.21
Times Interest Earned Ratio	6.75	5.72	5.82	6.03	2.44	4.94	2.99	6.96	7.70	4.40	3.49	4.46
Debt Service Coverage Ratio	N/A	N/A	1.42	1.83	N/A	N/A	0.92	2.66	N/A	N/A	1.40	1.16
Equity Financing Ratio	16.17	21.64	16.17	21.64	35.23	41.31	35.23	41.31	28.11	32.92	28.11	32.92
D. Additional Statistics												
Income from Operations	$633,053	$520,994	$3,919,130	$5,079,849	($166,895)	$49,602	($1,534,668)	$637,755	$1,033,957	$251,617	($2,648,012)	$961,199
Revenue Over/(Under) Expense	$446,906	$244,365	$2,524,988	$3,695,991	($230,700)	($55,083)	($1,924,686)	$362,997	$778,733	($133,319)	($4,472,987)	($691,635)
EBITDA	$1,413,261	$1,163,486	$11,890,204	$13,184,731	$149,301	$305,483	$1,744,517	$4,002,648	$2,291,661	$1,335,849	$10,337,145	$14,344,707
Cash from Operations	$14,290,215	$15,719,667	$144,426,487	$146,614,120	$5,527,405	$6,707,356	$57,671,830	$58,437,110	$24,789,135	$27,474,495	$250,965,459	$255,093,461
Cash and Cash Equivalents	$9,163,954	$13,849,738	$9,163,954	$13,849,738	$11,726,452	$12,105,457	$11,726,452	$12,105,457	$46,307,239	$51,231,181	$46,307,239	$51,231,181
Net Working Capital	$4,709,127	$8,495,203	$4,709,127	$8,495,203	$4,519,871	$4,689,471	$4,519,871	$4,689,471	$18,060,122	$20,490,665	$18,060,122	$20,490,665
Unrestricted Assets	$10,376,011	$19,815,466	$10,376,011	$19,815,466	$20,665,705	$26,324,679	$20,665,705	$26,324,679	$54,034,965	$71,217,658	$54,034,965	$71,217,658
Credit Ratings (S&P, FITCH, and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

OHCA Financial Statistics Report (August FY 2015 and August FY 2014)

	Manchester Memorial Hospital				Rockville General Hospital				Eastern CT Health Network			
	MTD		YTD		MTD		YTD		MTD		YTD	
	August FY 2015	August FY 2014	August FY 2015	August FY 2014	August FY 2015	August FY 2014	August FY 2015	August FY 2014	August FY 2015	August FY 2014	August FY 2015	August FY 2014
A. Operating Performance												
Operating Margin	4.05%	-3.59%	2.65%	2.64%	-2.38%	-0.70%	-2.69%	0.90%	-0.94%	-4.14%	-0.97%	-0.05%
Non-Operating Margin	-1.66%	-0.44%	-0.96%	-0.84%	-1.58%	-0.17%	-0.76%	-0.43%	-1.29%	-0.29%	-0.73%	-0.56%
Total Margin	2.39%	-4.03%	1.69%	1.80%	-3.96%	-0.87%	-3.46%	0.47%	-2.23%	-4.43%	-1.70%	-0.61%
Bad Debt as % of Gross Revenue	1.22%	-0.66%	-0.44%	-0.66%	1.21%	-0.84%	-0.55%	-0.65%	0.96%	-0.79%	-0.51%	-0.75%
B. Liquidity												
Current Ratio	1.19	1.19	1.19	1.19	1.48	1.69	1.48	1.69	1.36	1.39	1.36	1.39
Days Cash on Hand	23	27	15	19	72	62	46	43	66	67	66	67
Days in Net Accounts Receivable	56	64	39	44	64	63	42	44	57	60	39	41
Average Payment Period	67	61	45	44	52	44	34	30	65	67	65	67
C. Leverage and Capital Structure												
Long-term Debt to Equity	2.14	1.74	2.14	1.74	0.92	0.77	0.92	0.77	1.14	0.97	1.14	0.97
Long-term Debt to Capitalization	68	64	68	64	48	44	48	44	67	61	67	61
Unrestricted Cash to Debt	1.20	0.06	11.86	12.11	0.06	0.77	2.55	10.84	0.30	(0.08)	4.60	7.04
Times Interest Earned Ratio	6.91	1.53	6.41	5.64	2.68	5.33	2.96	6.81	3.45	0.91	3.49	4.16
Debt Service Coverage Ratio	N/A	N/A	1.50	1.68	N/A	N/A	0.91	2.72	N/A	N/A	1.41	1.06
Equity Financing Ratio	15.99	20.58	15.99	20.58	34.93	41.46	34.93	41.46	27.76	32.38	27.76	32.38
D. Additional Statistics												
Income from Operations	$597,835	($531,932)	$4,516,964	$4,547,917	($119,527)	($40,468)	($1,654,194)	$597,288	($240,325)	($1,110,535)	($2,888,337)	($149,336)
Revenue Over/(Under) Expense	$353,116	($597,128)	$2,878,103	$3,098,864	($198,666)	($50,522)	($2,123,350)	$312,476	($570,339)	($1,188,772)	($5,043,326)	($1,880,407)
EBITDA	$1,400,713	$316,488	$13,088,122	$13,501,219	$156,631	$307,715	$1,901,150	$4,310,364	$1,003,678	$275,706	$11,340,823	$14,620,413
Cash from Operations	$13,850,383	$14,385,361	$158,276,870	$160,999,481	$5,606,279	$5,677,456	$63,278,109	$64,114,566	$24,438,646	$24,966,839	$275,404,105	$280,060,300
Cash and Cash Equivalents	$10,094,581	$12,933,064	$10,094,581	$12,933,064	$11,578,760	$11,103,202	$11,578,760	$11,103,202	$47,023,731	$49,069,770	$47,023,731	$49,069,770
Net Working Capital	$5,603,489	$5,450,496	$5,603,489	$5,450,496	$4,023,147	$5,397,747	$4,023,147	$5,397,747	$17,639,012	$19,611,711	$17,639,012	$19,611,711
Unrestricted Assets	$10,308,640	$18,971,156	$10,308,640	$18,971,156	$20,279,098	$26,051,748	$20,279,098	$26,051,748	$53,344,364	$70,108,676	$53,344,364	$70,108,676
Credit Ratings (S&P, FITCH, and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

OHCA Financial Statistics Report (September FY 2015 and September FY 2014)

DRAFT BASED ON UNAUDITED RESULTS

	Manchester Memorial Hospital				Rockville General Hospital				Eastern CT Health Network			
	MTD		YTD		MTD		YTD		MTD		YTD	
	September FY 2015	September FY 2014	September FY 2015	September FY 2014	September FY 2015	September FY 2014	September FY 2015	September FY 2014	September FY 2015	September FY 2014	September FY 2015	September FY 2014
A. Operating Performance												
Operating Margin	17.81%	-1.98%	4.00%	2.26%	-0.66%	26.83%	-2.53%	3.70%	9.21%	2.28%	-0.13%	0.15%
Non-Operating Margin	0.00%	-1.87%	-0.87%	-0.93%	-1.44%	-1.16%	-0.82%	-0.51%	-0.30%	-1.37%	-0.69%	-0.63%
Total Margin	17.82%	-3.85%	3.13%	1.33%	-2.11%	25.67%	-3.35%	3.20%	8.91%	0.91%	-0.82%	-0.48%
Bad Debt as % of Gross Revenue	0.75%	-4.49%	-0.34%	-0.97%	0.50%	-7.75%	-0.46%	-1.23%	0.85%	0.66%	-0.39%	-0.64%
B. Liquidity												
Current Ratio	1.12	1.17	1.12	1.17	1.94	1.59	1.94	1.59	1.37	1.37	1.37	1.37
Days Cash on Hand	30	36	21	29	75	66	54	50	73	78	73	78
Days in Net Accounts Receivable	48	64	39	40	58	73	42	47	55	64	41	39
Average Payment Period	78	67	54	54	41	47	30	36	69	71	69	71
					0							
C. Leverage and Capital Structure												
Long-term Debt to Equity	3.72	2.03	3.72	2.03	1.08	0.83	1.08	0.83	1.37	1.06	1.37	1.06
Long-term Debt to Capitalization	79	67	79	67	52	45	52	45	76	65	76	65
Unrestricted Cash to Debt	4.26	(0.06)	15.48	11.20	0.38	6.98	3.05	17.41	2.43	0.88	6.76	7.68
Times Interest Earned Ratio	21.38	2.24	7.04	5.38	4.14	42.56	3.06	9.24	14.05	7.45	4.27	4.38
Debt Service Coverage Ratio	N/A	N/A	1.79	1.60	N/A	N/A	0.97	3.99	N/A	N/A	1.27	1.36
Equity Financing Ratio	8.83	16.28	8.83	16.28	30.95	37.96	30.95	37.96	22.08	28.81	22.08	28.81
D. Additional Statistics												
Income from Operations	$2,980,224	($312,411)	$7,497,189	$4,235,507	($35,560)	$2,163,409	($1,689,753)	$2,760,694	$2,461,753	$658,388	($426,584)	$509,052
Revenue Over/(Under) Expense	$2,980,415	($606,680)	$5,858,519	$2,492,184	($113,096)	$2,069,656	($2,236,445)	$2,382,130	$2,381,332	$263,708	($2,661,994)	($1,616,699)
EBITDA	$3,743,274	$440,393	$17,034,191	$13,941,613	$250,620	$2,421,228	$2,151,771	$6,774,667	$3,666,884	$1,850,004	$15,007,707	$16,470,417
Cash from Operations	$14,563,917	$14,901,325	$172,840,787	$175,900,806	$5,514,418	$5,768,359	$68,792,527	$69,882,925	$24,854,112	$25,589,485	$300,258,217	$305,649,785
Cash and Cash Equivalents	$13,188,728	$18,856,818	$13,188,728	$18,856,818	$13,081,652	$12,735,604	$13,081,652	$12,735,604	$53,111,506	$58,713,876	$53,111,506	$58,713,876
Net Working Capital	$4,127,089	$5,986,254	$4,127,089	$5,986,254	$6,725,388	$5,392,746	$6,725,388	$5,392,746	$21,095,237	$20,280,901	$21,095,237	$20,280,901
Unrestricted Assets	$1,126,292	$11,344,473	$1,126,292	$11,344,473	$16,813,993	$24,211,838	$16,813,993	$24,211,838	$42,021,427	$59,544,869	$42,021,427	$59,544,869
Credit Ratings (S&P, FITCH, and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

RESPONSE TO DEFICIENCIES
EXHIBIT L - PMH Capital Investments and Cost Savings Table

Table from Question 37a - Capital Investments and Cost Savings Table

Hospital	Describe Improvements in Financial Performance									
	Investments since Acquistion		Profitability		Liquidity		Solvency		Cost Savings	
Los Angeles Community Hospital at Bellflower	$ 3,646,633		N//A	(a)	N/A	(a)	N/A	(a)	N/A	(a)
Foothill Regional Medical Center	$ 7,912,807		N/A	(a)	N/A	(a)	N/A	(a)	N/A	(a)
Our Lady of Fatima Hospital	$ 11,321,376	(f)	$ 15,184,000	(g)	$ 4,976,828	(c)	$ 67,475,613	(c)	Marginal Cost per day reduced to $1,493 from $1,542	(d)
Roger Williams Medical Center	$ 11,321,376	(f)	$ 15,184,000	(g)	$ 4,976,828	(c)	$ 67,475,613	(c)	Marginal Cost per day reduced to $2,271 from $2,263	(d)
Nix Health System	$ 33,350,077		$ 20,867,000	(h)	$ 15,882,118		$ 63,789,134		Total Costs per day decreased to $1,444 from $1,584	(e)

(a) Both Los Angeles Community Hospital at Bellflower (Bellflower) and Foothill Regional Medical Center (Foothill) were closed prior to PMH acquisition
Bellflower re-opened in July 2015 and Foohill re-opened in September 2015. Both facilities were purchased in May 2014.

(b) Los Angeles Community Hospital at Bellflower is under common corporate ownership structure and license as Los Angeles Community Hospital and
Los Angeles Community Hospital at Norwalk. As such, liquidity and solvency for this campus includes financial information for all three campuses combined

(c) The profitability, liquidity and solvency of Our Lady of Fatima and Roger Williams Medical Center are reported on a consoldiated basis for the CharterCARE system
Prior to the acquisition, the liquidity of CharterCARE system was approximately a negative $2.5 million
Profitability is measured on an EBITDA basis and reported on a consolidated basis for the CharterCARE system

(d) Measured from June 2014 to May 2015

(e) Measured from Dember 2011 to September 2015. Prior to acquisition Nix did not compute Marginal cost per day.

(f) Total capital investment in Our Lay of Fatima and Roger Williams Medical Center (which comprise CharterCARE) is reported on a combined basis.
In addition to the amount already spent, we have committed to spend $20 million in addtion to what has already been spent
on (i) cancer center; (ii) Digestive Diseases Center; (iii) Emergency Department and (iv) physician practice acquisitions.

RESPONSE TO DEFICIENCIES
EXHIBIT M - PMH Quality Report from Rhode Island CON

CharterCare and Prospect Holdings Quality Review

Health Services Council

April 8, 2014

Mary Reich Cooper MD JD

No Conflicts of Interest

Statutory Authority and Background

RIGL 23-17-14.3 "Licensing of Health Care Facilities"

- The character, commitment, competence, and standing in the community of the proposed owners, operators, or directors of the health care facility;
- In cases of initial licensure or of proposed change in owner, operator, or lessee, the extent to which the facility will provide or will continue to provide, without material effect on its viability at the time of initial licensure or of change of owner, operator, or lessee, safe and adequate treatment for individuals receiving the health care facility's services;
- The extent to which the facility will provide or will continue to provide safe and adequate treatment for individuals receiving the health care facility's services; and
- The extent to which the facility will provide or will continue to provide appropriate access with respect to traditionally underserved populations and in consideration of the proposed continuation or termination of health care services by the health care facility.

Hospital Conversion Act 23-17.14-3 and 23-17.14-4

- Assure the viability of a safe, accessible, and affordable healthcare system that is available to all of the citizens of the state.
- Establish a process to review whether for-profit hospitals will maintain, enhance or disrupt the delivery of healthcare in the state and to monitor hospital performance to assure that standards for community benefit continue to be met.

Hospital Conversion Act 23-17.14-8

- Whether the character, commitment, competence, and standing in the community or any other proposed communities served by the proposed transacting parties is satisfactory.
- Whether sufficient safeguards are included to assure the affected community continued access to affordable care.

Hospital Conversion Act 23-17.14-8

- Whether the transacting parties have provided clear and convincing evidence that the new hospital will provide health care and appropriate access with respect to traditionally underserved populations in the affected community.
- Whether the conversion demonstrates that the public interest will be served considering the essential medical services needed to provide safe and adequate treatment, appropriate access and balanced health care delivery to the residents of the state.

Scope of Review

- Review of CEC Application
- Review of HCA Filing
- Internet Research and Review of Findings
  - WhyNotTheBest.org (aggregating medicare.gov/hospitalcompare)
  - Kaiser Family Foundation (kff.org)
  - Qualitycheck.org (Joint Commission), DNV.org, NursingHomeCompare, homehealthcompare
  - Other public documents
- Interviews with Leadership

Roger Williams

Roger Williams Medical Center is a general medical and surgical hospital in Providence, RI, with 177 beds. It is also a teaching hospital. Survey data for the latest year available shows 165,058 outpatient visits. The hospital had a total of 7,233 admissions. Its physicians performed 2,133 inpatient and 3,082 outpatient surgeries.

http://health.usnews.com/best-hospitals/area/ri/roger-williams-medical-center-6150160 accessed April 2, 2014 and file:///C:/Users/Mary/Downloads/Free_Hospital_Look_up___Roger_Williams_Medical_Center%20(1).pdf accessed April 6 2014

St. Joseph's

St. Joseph Health Services is a general medical and surgical hospital in North Providence, RI, with 231 beds. Survey data for the latest year available shows 229,153 outpatient visits. The hospital had a total of 7,924 admissions. Its physicians performed 1,694 inpatient and 5,426 outpatient surgeries.

http://health.usnews.com/best-hospitals/area/ri/st-joseph-health-services-6150091 accessed April 2, 2014 and file:///C:/Users/Mary/Downloads/Free_Hospital_Look_up__St_Joseph_Health_Services_of_Rhode_Island.pdf accessed April 6, 2014

Nix Health System

Nix Medical Center is a general medical and surgical hospital in San Antonio, TX, with 173 beds. Survey data for the latest year available shows that the hospital had a total of 7,751 admissions. Outpatient visits totaled 131, 709 Its physicians performed 1,775 inpatient and 3,546 outpatient surgeries.

http://health.usnews.com/best-hospitals/area/tx/nix-medical-center-6743070 accessed April 2, 2014 and file:///C:/Users/Mary/Downloads/Free_Hospital_Look_up__Nix_Health_Care_System.pdf accessed April 6, 2014

Nix Community Hospital

Community General Hospital is a general medical and surgical hospital in Dilley, TX, with 18 beds. Survey data for the latest year available shows that 5,383 outpatient visits. The hospital had a total of 647 admissions.

http://health.usnews.com/best-hospitals/area/tx/community-general-hospital-6740286 and file:///C:/Users/Mary/Downloads/Free_Hospital_Look_up___Nix_Community_General_Hospital.pdf accessed April 6, 2014

SoCal Culver City

(Brotman) is a general medical and surgical hospital in Culver City, CA, with 239 beds. Survey data for the latest year available shows 30,622 outpatients. The hospital had a total of 9,255 admissions. Its physicians performed 788 inpatient and 1,189 outpatient surgeries.

http://health.usnews.com/best-hospitals/area/ca/brotman-medical-center-6930540/details accessed March 30, 2014 and file:///C:/Users/Mary/Downloads/Free_Hospital_Look_up__Southern_California_Hospital_at_Culver_City.pdf accessed April 6, 2014

SoCal Hollywood

Hollywood Community Hospital (SoCal Hollywood) is a general medical and surgical hospital in Los Angeles, CA, with 45 beds, 3,081 admissions, and 5,668 outpatient visits.

http://health.usnews.com/best-hospitals/area/ca/hollywood-community-hospital-6930072 accessed April 2, 2014 and file:///C:/Users/Mary/Downloads/Free_Hospital_Look_up___Southern_California_Hospital_at_Hollywood.pdf accessed April 6 2014

SoCal Van Nuys

"SoCal Van Nuys located in Van Nuys, California is a 60-bed psychiatric hospital that provides acute inpatient and outpatient psychiatric services on a voluntary basis."

http://www.altacorp.com/altacorp/ accessed April 3, 2014

LA Community

LA Community is a general medical and surgical hospital in Los Angeles, CA, with 180 beds. Survey data for the latest year available shows that there were 23,337 outpatient visits. The hospital had a total of 8,393 admissions and 1586 births.

http://health.usnews.com/best-hospitals/area/ca/los-angeles-community-hospital-6930060 accessed April 2, 2014 and file:///C:/Users/Mary/Downloads/Free_Hospital_Look_up___Los_Angeles_Community_Hospital_at_Los_Angeles.pdf accessed April 6 2014

Norwalk Community

"Our hospital located in Norwalk, California is a 50-bed community hospital that offers a comprehensive range of medical and surgical services, including general acute care hospital services, inpatient and outpatient surgery, emergency room and general medical/surgical care and intensive care."

http://www.altacorp.com/altacorp/
accessed April 3, 2014

Framework: Institute of Medicine

- Safety
- Access
- Patient Centered Care
- Effectiveness
- Timeliness
- Efficiency

Crossing the Quality Chasm 2001

Accreditation

Review accreditation decisions for hospitals held by the transacting parties and determine if any adverse accreditation reviews have been identified and corrected.

Accreditation Decisions

- CharterCare
  - **St. Josephs: Joint Commission**
    - Hospital accredited 12/17/2011
    - Advanced Inpatient Diabetes 12/08/2012 1/75
    - Advanced Primary Stroke 12/04/2012 1/1024
    - Hip Replacement 12/12/2012 1/376
    - Knee Replacement 12/12/2012 1/379

http://www.qualitycheck.org/qualityreport.aspx?hcoid=5647 accessed 3/29/2014

Accreditation Decisions

- CharterCare
  - **Roger Williams: Joint Commission**
    - Hospital accredited 09/24/2011
    - Home Care 09/21/2011
    - Nursing Care Center 09/23/2011
    - Advanced Primary Stroke 03/21/2014 1/1024
    - Hip Replacement 02/11/2014 1/376
    - Knee Replacement 02/11/2014 1/379

    - Special Quality Awards
      - 2013 AHCA/NCAL Bronze - Commitment to Quality
      - 2013 Silver Get With The Guidelines - Stroke

http://www.qualitycheck.org/qualityreport.aspx?hcoid=5652# accessed 3/29/2014

Accreditation Decisions

- Prospect Medical Holdings
  - **Nix Health Care System: DNV**
    - Health System accredited 11/25/2013
  - **TX DSHS**
    - Behavioral Health through 12/31/2015
    - Health Care System through 12/31/2015
    - Specialty Health Center through 12/31/2015

http://dnvglhealthcare.com/hospitals?q=&c=&c=19211&prSubmit=Search&page=4 accessed April 2, 2014

http://www.dshs.state.tx.us/HFP/apps.shtm#hosp_gen_spec accessed March 30, 2014

Accreditation Decisions

- Prospect Medical Holdings
  - **Nix Community Hospital: Joint Commission (TJC)**
    - Hospital accredited 08/08/2013
  - **TX DSHS**
    - Community Hospital through 4/30/2015

http://www.qualitycheck.org/qualityreport.aspx?hcoid=546980 accessed March 30, 2014

http://www.dshs.state.tx.us/HFP/apps.shtm#hosp_gen_spec accessed March 30, 2014

Accreditation Decisions

- Prospect Medical Holdings
  - **SoCal Hollywood: DNV**
    - Hospital accredited 1/12/2014
  - **TJC**
    - Laboratory program accredited 9/13/2013
  - **CA DPH**: licensed through 2/24/2015

https://hfcis.cdph.ca.gov/LongTermCare/Facility.aspx?fac=930000064 accessed March 30 2014

http://dnvglhealthcare.com/hospitals?q=&c=&c=19173&prSubmit=Search&page=2 accessed April 2, 2014

http://www.qualitycheck.org/Consumer/searchResults.aspx?zip=90028&Select1=-1&dist=-1&provId=2&provIdtracker=2 accessed March 30, 2014

Accreditation Decisions

- Prospect Medical Holdings
  - **Los Angeles Community/Norwalk Community: DNV**
    - Hospital accredited 1/7/2014
  - **TJC** Laboratory accreditation 7/12/2013
  - **CA DPH** licensed through 3/14/2015

https://hfcis.cdph.ca.gov/LongTermCare/Facility.aspx?fac=930000085 accessed March 30, 2014

http://dnvglhealthcare.com/hospitals?q=&c=&c=19173&prSubmit=Search&page=2 accessed March 30, 2014

http://www.qualitycheck.org/qualityreport.aspx?hcoid=9923 accessed March 30 2014

Accreditation Decisions

- Prospect Medical Holdings
  - **SoCal Culver City: DNV**
    - Hospital accredited 1/12/2014
  - **TJC** No accreditations found; none necessary
  - **CA DPH** licensed through 2/24/2015

https://hfcis.cdph.ca.gov/LongTermCare/Facility.aspx?fac=930000015 accessed April 3, 2014

http://dnvglhealthcare.com/hospitals?q=&c=&c=19173&prSubmit=Search accessed March 30, 2014

http://www.qualitycheck.org/Consumer/searchPage2.aspx?zip=90232&Select1=-1&dist=-1 accessed March 30, 2014

Accreditation Decisions

- Prospect Medical Holdings
  - **Van Nuys: DNV**
    - Effective Date of Accreditation 1/12/2014
  - **TJC**: Laboratory Accreditation 9/13/2013
  - **CA DPH** licensed through 2/24/2015

https://hfcis.cdph.ca.gov/LongTermCare/Facility.aspx?fac=930000492 accessed April 3, 2014

http://dnvglhealthcare.com/hospitals?q=&c=&c=19173&prSubmit=Search&page=2 accessed March 30, 2014

http://www.qualitycheck.org/Consumer/searchResults.aspx?zip=91401&Select1=-1&dist=-1&provGrpId=2&provGrpIdtracker=2 accessed March 30, 2014

Quality Metrics

Review HospitalCompare Reports including federal measures of outcomes, patient satisfaction, efficiency, and safety, and benchmark using the Commonwealth Fund's benchmarking information, Why Not the Best®?

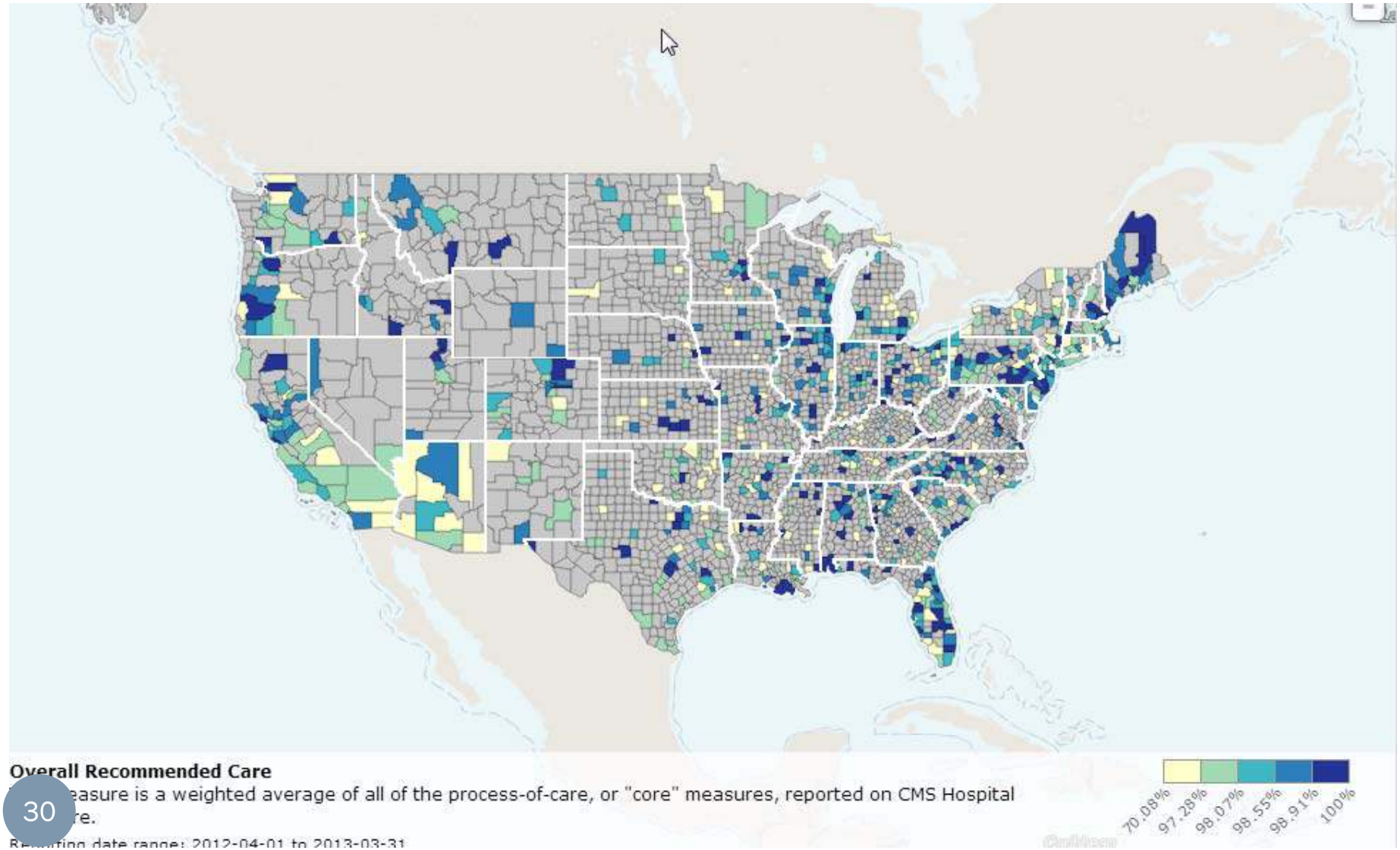
Data and Benchmarks
Overall Quality

WhyNotTheBest.org, accessed March 17, 2014, and April 2, 2014 based on data from hospitalcompare.medicare.gov through March 2013



THE COMMONWEALTH FUND
A Private Foundation Working Toward a High Performance Health System

Overall quality: national

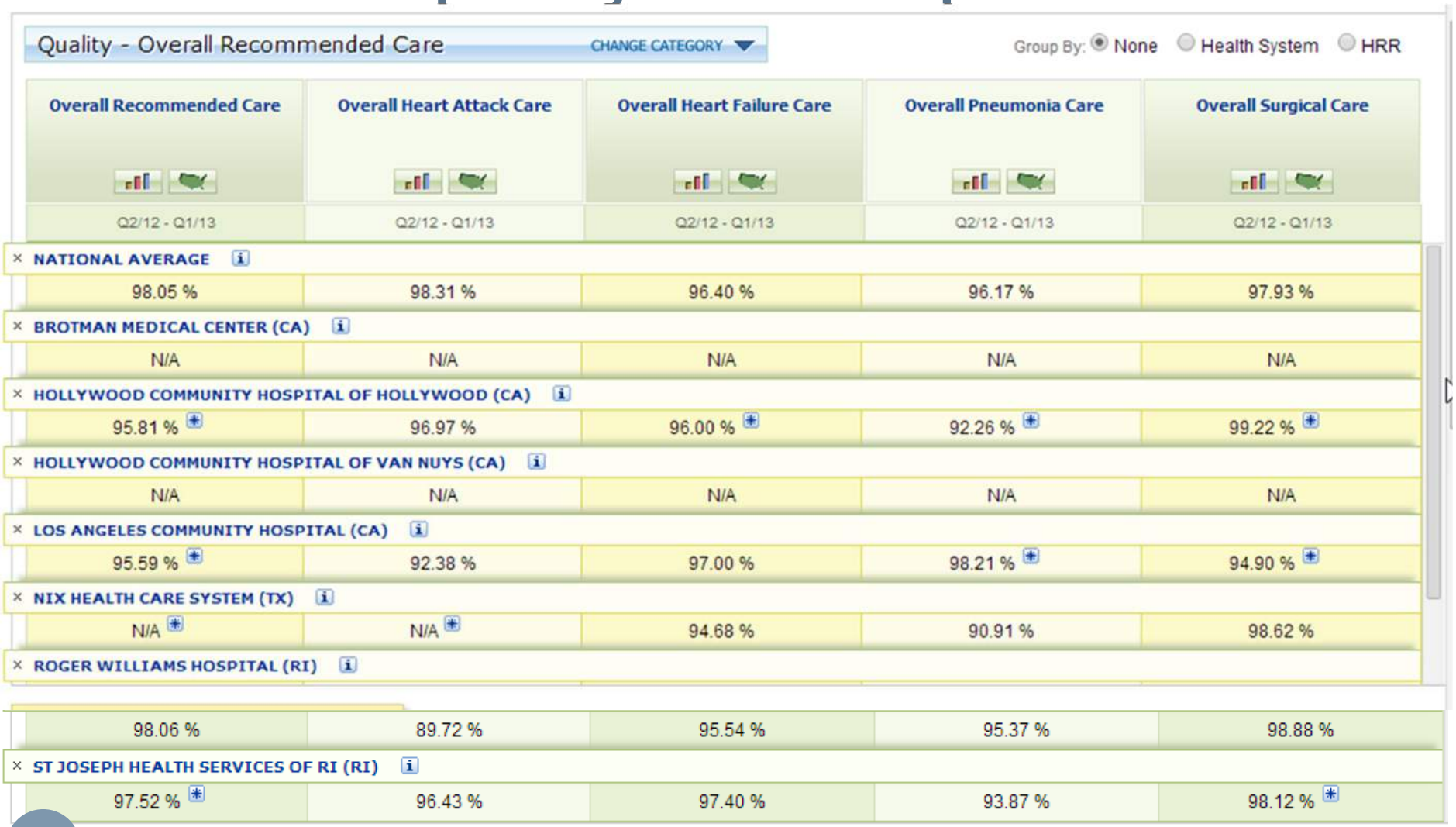


Overall quality: RI, CA, TX

Quality - Overall Recommended Care CHANGE CATEGORY

	Overall Recommended Care	Overall Heart Attack Care	Overall Heart Failure Care	Overall Pneumonia Care	Overall Surgical Care
	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13
NATIONAL AVERAGE	98.05 %	98.31 %	96.40 %	96.17 %	97.93 %
NATIONAL TOP 10%	99.55 %	100.00 %	100.00 %	99.58 %	99.63 %
CALIFORNIA (CA)	97.91 %	98.29 %	96.80 %	96.58 %	97.74 %
RHODE ISLAND (RI)	97.62 %	96.24 %	96.32 %	96.02 %	98.28 %
TEXAS (TX)	98.21 %	97.99 %	96.39 %	96.24 %	98.01 %

Overall quality: All Hospitals



Quality - Overall Recommended Care CHANGE CATEGORY

Group By: None Health System HRR

	Overall Recommended Care	Overall Heart Attack Care	Overall Heart Failure Care	Overall Pneumonia Care	Overall Surgical Care
	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13
NATIONAL AVERAGE	98.05 %	98.31 %	96.40 %	96.17 %	97.93 %
BROTMAN MEDICAL CENTER (CA)	N/A	N/A	N/A	N/A	N/A
HOLLYWOOD COMMUNITY HOSPITAL OF HOLLYWOOD (CA)	95.81 %	96.97 %	96.00 %	92.26 %	99.22 %
HOLLYWOOD COMMUNITY HOSPITAL OF VAN NUYS (CA)	N/A	N/A	N/A	N/A	N/A
LOS ANGELES COMMUNITY HOSPITAL (CA)	95.59 %	92.38 %	97.00 %	98.21 %	94.90 %
NIX HEALTH CARE SYSTEM (TX)	N/A	N/A	94.68 %	90.91 %	98.62 %
ROGER WILLIAMS HOSPITAL (RI)	98.06 %	89.72 %	95.54 %	95.37 %	98.88 %
ST JOSEPH HEALTH SERVICES OF RI (RI)	97.52 %	96.43 %	97.40 %	93.87 %	98.12 %

Overall quality: Roger Williams

Roger Williams Hospital
825 CHALKSTONE AVENUE
Providence, RI 02908

Quality - Overall Recommended Care CHANGE CATEGORY

	Q2/12-Q1/13	Q4/11-Q3/12	Q3/11-Q2/12	Q2/11-Q1/12	Q1/11-Q4/11	Q4/10-Q3/11	Q3/10-Q2/11	Q2/10-Q1/11
OVERALL RECOMMENDED CARE	98.06 %	97.39 %	96.34 % *	96.01 % *	95.19 % *	94.55 % *	94.59 % *	94.67 % *
OVERALL HEART ATTACK CARE	89.72 %	89.22 %	89.42 %	87.37 %	91.07 %	93.29 %	93.11 %	94.94 %
OVERALL HEART FAILURE CAR...	95.54 %	90.55 %	88.80 %	88.52 %	89.42 %	88.89 %	89.90 %	92.07 %
OVERALL PNEUMONIA CARE	95.37 %	95.38 %	96.15 %	97.35 %	90.74 % *	90.05 % *	90.40 % *	88.34 % *
OVERALL SURGICAL CARE	98.88 %	98.30 %	97.25 % *	97.02 % *	97.15 % *	96.54 % *	96.39 % *	96.42 % *

2361

Overall quality: St. Joseph

St Joseph Health Services Of Ri
200 HIGH SERVICE AVENUE
North Providence, RI 02904

Quality - Overall Recommended Care CHANGE CATEGORY

	Q2/12-Q1/13	Q4/11-Q3/12	Q3/11-Q2/12	Q2/11-Q1/12	Q1/11-Q4/11	Q4/10-Q3/11	Q3/10-Q2/11	Q2/10-Q1/11
OVERALL RECOMMENDED CARE	97.52 %	N/A	N/A	95.44 %	95.01 %	93.48 %	93.27 %	93.09 %
OVERALL HEART ATTACK CARE	96.43 %	N/A	N/A	93.44 %	97.31 %	97.80 %	98.52 %	99.42 %
OVERALL HEART FAILURE CAR...	97.40 %	94.42 %	91.27 %	89.09 %	89.02 %	89.62 %	89.88 %	90.64 %
OVERALL PNEUMONIA CARE	93.87 %	94.86 %	95.54 %	93.46 %	91.32 %	87.54 %	88.08 %	88.93 %
OVERALL SURGICAL CARE	98.12 %	97.79 %	97.96 %	96.97 %	97.15 %	96.22 %	95.50 %	94.75 %

Overall quality: Nix

Nix Health Care System
414 NAVARRO
San Antonio, TX 78205

Quality - Overall Recommended Care CHANGE CATEGORY

	Q2/12-Q1/13	Q4/11-Q3/12	Q3/11-Q2/12	Q2/11-Q1/12	Q1/11-Q4/11	Q4/10-Q3/11	Q3/10-Q2/11	Q2/10-Q1/11
OVERALL RECOMMENDED CARE	N/A*	N/A*	N/A*	N/A*	98.10 %*	97.66 %*	96.74 %*	N/A*
OVERALL HEART ATTACK CARE	N/A*	N/A*	N/A*	N/A*	96.75 %	97.41 %*	97.37 %*	N/A*
OVERALL HEART FAILURE CAR...	94.68 %	95.43 %	96.47 %	95.98 %	96.25 %	96.75 %*	96.50 %*	92.90 %*
OVERALL PNEUMONIA CARE	90.91 %	93.33 %	N/A*	93.75 %	96.30 %	94.77 %*	94.08 %*	93.83 %*
OVERALL SURGICAL CARE	98.62 %	98.72 %	99.03 %	98.40 %	98.35 %*	97.96 %*	96.97 %*	96.36 %*

2363

Overall quality: SoCal Hollywood

Hollywood Community Hospital Of Hollywood
6245 DE LONGPRE AVE
Hollywood, CA 90028

Quality - Overall Recommended Care CHANGE CATEGORY

	Q2/12-Q1/13	Q4/11-Q3/12	Q3/11-Q2/12	Q2/11-Q1/12	Q1/11-Q4/11	Q4/10-Q3/11	Q3/10-Q2/11	Q2/10-Q1/11
OVERALL RECOMMENDED CARE	95.81 %	N/A	N/A	N/A	N/A	N/A	N/A	N/A
OVERALL HEART ATTACK CARE	96.97 %	N/A	N/A	N/A	N/A	N/A	N/A	N/A
OVERALL HEART FAILURE CAR...	96.00 %	87.65 %	80.95 %	77.66 %	81.75 %	86.51 %	87.07 %	87.07 %
OVERALL PNEUMONIA CARE	92.26 %	85.42 %	87.88 %	N/A	67.28 %	62.23 %	59.53 %	60.00 %
OVERALL SURGICAL CARE	99.22 %	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Overall quality: LA Community

Los Angeles Community Hospital
4081 E OLYMPIC BLVD
Los Angeles, CA 90023

Quality - Overall Recommended Care CHANGE CATEGORY

	Q2/12-Q1/13	Q4/11-Q3/12	Q3/11-Q2/12	Q2/11-Q1/12	Q1/11-Q4/11	Q4/10-Q3/11	Q3/10-Q2/11	Q2/10-Q1/11
OVERALL RECOMMENDED CARE	95.59 %	94.68 %	85.62 %	75.97 %	71.44 %	65.69 %	65.32 %	66.28 %
OVERALL HEART ATTACK CARE	92.38 %	94.49 %	80.95 %	67.19 %	53.28 %	52.47 %	52.60 %	51.66 %
OVERALL HEART FAILURE CAR...	97.00 %	96.32 %	86.63 %	76.31 %	73.47 %	70.15 %	71.78 %	74.62 %
OVERALL PNEUMONIA CARE	98.21 %	94.12 %	91.00 %	90.32 %	76.70 %	63.08 %	60.00 %	56.25 %
OVERALL SURGICAL CARE	94.90 %	92.63 %	83.26 %	71.12 %	71.53 %	67.83 %	65.42 %	69.35 %

2365

Overall quality: SoCal Culver City

Brotman Medical Center
3828 DELMAS TERRACE
Culver City, CA 90232

Quality - Overall Recommended Care — CHANGE CATEGORY

	Q4/11-Q3/12	Q3/11-Q2/12	Q2/11-Q1/12	Q1/11-Q4/11	Q4/10-Q3/11	Q3/10-Q2/11	Q2/10-Q1/11	Q1/10-Q4/10
OVERALL RECOMMENDED CARE	98.29 %	96.24 %	92.35 %	89.36 %	82.05 %	80.25 %	79.36 %	78.98 %
OVERALL HEART ATTACK CARE	100.00 %	98.94 %	96.15 %	95.67 %	91.35 %	90.23 %	91.82 %	92.55 %
OVERALL HEART FAILURE CAR...	100.00 %	97.89 %	95.41 %	87.44 %	81.02 %	80.33 %	81.04 %	82.08 %
OVERALL PNEUMONIA CARE	100.00 %	98.88 %	94.27 %	89.59 %	77.22 %	76.69 %	77.35 %	78.14 %
OVERALL SURGICAL CARE	96.55 %	94.33 %	89.81 %	88.48 %	84.73 %	81.72 %	78.29 %	74.61 %

Overall quality: SoCal Van Nuys

No Data Available: Psychiatric Hospital Does Not Require Reporting

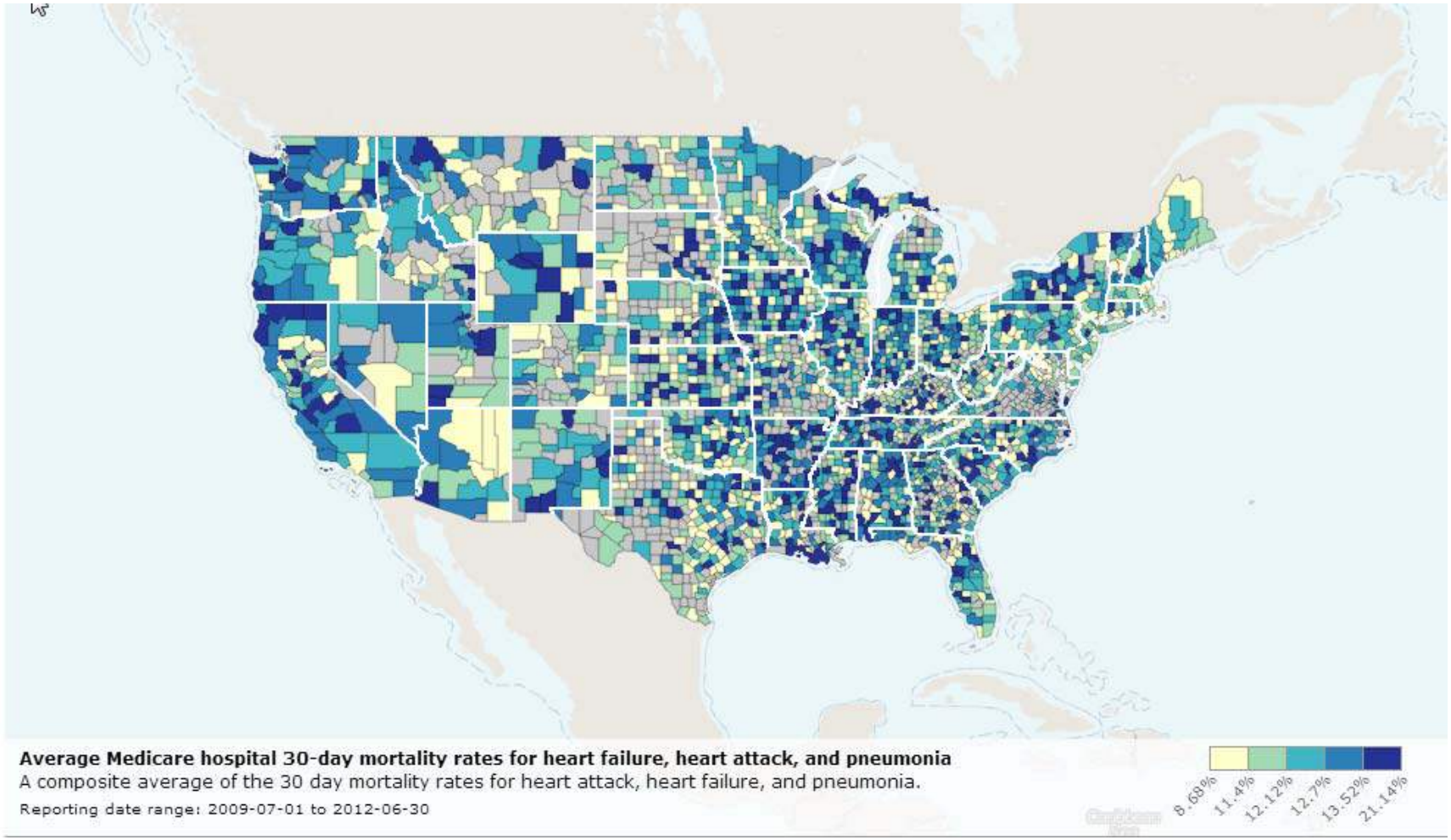
Data and Benchmarks
Mortality

WhyNotTheBest.org, accessed March 17, 2014 and April 2, 2014 based on data from hospitalcompare.medicare.gov through June 2012



THE COMMONWEALTH FUND
A Private Foundation Working Toward a High Performance Health System

Mortality: national



Mortality: RI, CA, TX

Mortality Rates — CHANGE CATEGORY

	Average Medicare hospital 30-day mortality rates for heart fail...	Heart Attack 30-Day Mortality Rate	Heart Failure 30-Day Mortality Rate	Pneumonia 30-Day Mortality Rate
	Q3/09 - Q2/12	Q3/09 - Q2/12	Q3/09 - Q2/12	Q3/09 - Q2/12
NATIONAL AVERAGE	12.31 %	15.20 %	11.70 %	11.90 %
NATIONAL TOP 10%	10.61 %	13.30 %	9.90 %	9.90 %
CALIFORNIA (CA)	12.01 %	14.89 %	11.23 %	11.68 %
RHODE ISLAND (RI)	12.38 %	14.48 %	12.12 %	11.85 %
TEXAS (TX)	12.09 %	15.39 %	11.61 %	11.69 %

*Value is a simple average of all the risk-adjusted rates for entities reporting within this region

Mortality: All Hospitals



Mortality Rates — CHANGE CATEGORY

Group By: None | Health System | HRR

Average Medicare hospital 30-day mortality rates for heart fail...	Heart Attack 30-Day Mortality Rate	Heart Failure 30-Day Mortality Rate	Pneumonia 30-Day Mortality Rate
Q3/09 - Q2/12	Q3/09 - Q2/12	Q3/09 - Q2/12	Q3/09 - Q2/12
NATIONAL AVERAGE			
12.31 % *	15.20 %	11.70 %	11.90 %
BROTMAN MEDICAL CENTER (CA)			
10.63 %	15.00 %	10.30 %	9.60 %
HOLLYWOOD COMMUNITY HOSPITAL OF HOLLYWOOD (CA)			
9.47 %	N/A *	10.10 %	9.20 %
HOLLYWOOD COMMUNITY HOSPITAL OF VAN NUYS (CA)			
N/A	N/A	N/A	N/A
LOS ANGELES COMMUNITY HOSPITAL (CA)			
9.30 %	14.40 %	9.50 %	7.40 % *
NIX HEALTH CARE SYSTEM (TX)			
10.54 %	13.90 %	10.00 %	9.70 %
ROGER WILLIAMS HOSPITAL (RI)			
12.06 %	16.10 %	10.90 %	10.90 %
ST JOSEPH HEALTH SERVICES OF RI (RI)			
12.88 %	15.50 %	11.90 %	13.00 %

Mortality: Roger Williams

Roger Williams Hospital
825 CHALKSTONE AVENUE
Providence, RI 02908

Mortality Rates CHANGE CATEGORY

	Q3/09-Q2/12	Q3/08-Q2/11	Q3/07-Q2/10	Q3/06-Q2/09
AVERAGE MEDICARE HOSPITAL...	12.06 %	12.21 %	12.37 %	N/A
HEART ATTACK 30-DAY MORTA...	16.10 %	16.30 %	17.50 %	16.00 %
HEART FAILURE 30-DAY MORT...	10.90 %	10.80 %	10.50 %	10.10 %
PNEUMONIA 30-DAY MORTALIT...	10.90 %	11.60 %	11.80 %	13.60 %

Mortality: St Joseph

St Joseph Health Services Of Ri
200 HIGH SERVICE AVENUE
North Providence, RI 02904

Mortality Rates — CHANGE CATEGORY

	Q3/09-Q2/12	Q3/08-Q2/11	Q3/07-Q2/10	Q3/06-Q2/09
AVERAGE MEDICARE HOSPITAL...	12.88 %	13.49 %	12.65 %	N/A
HEART ATTACK 30-DAY MORTA...	15.50 %	15.50 %	14.70 %	17.20 %
HEART FAILURE 30-DAY MORT...	11.90 %	11.90 %	12.10 %	12.30 %
PNEUMONIA 30-DAY MORTALIT...	13.00 %	14.60 %	12.50 %	11.90 %

Mortality: Nix

Nix Health Care System
414 NAVARRO
San Antonio, TX 78205

Mortality Rates CHANGE CATEGORY

	Q3/09-Q2/12	Q3/08-Q2/11	Q3/07-Q2/10	Q3/06-Q2/09
AVERAGE MEDICARE HOSPITAL...	10.54 %	10.65 %	11.08 %	N/A
HEART ATTACK 30-DAY MORTA...	13.90 %	14.00 %	14.30 %	13.90 %
HEART FAILURE 30-DAY MORT...	10.00 %	9.90 %	9.70 %	9.80 %
PNEUMONIA 30-DAY MORTALIT...	9.70 %	9.90 %	11.10 %	9.90 %

Mortality: SoCal Hollywood

Hollywood Community Hospital Of Hollywood

6245 DE LONGPRE AVE
Hollywood, CA 90028

Mortality Rates — CHANGE CATEGORY

	Q3/09-Q2/12	Q3/08-Q2/11	Q3/07-Q2/10	Q3/06-Q2/09
AVERAGE MEDICARE HOSPITAL...	9.47 %	10.50 %	10.41 %	N/A
HEART ATTACK 30-DAY MORTA...	N/A *	N/A *	N/A *	N/A
HEART FAILURE 30-DAY MORT...	10.10 %	N/A *	10.20 %	10.20 %
PNEUMONIA 30-DAY MORTALIT...	9.20 %	10.50 %	10.50 %	11.00 %

Mortality: LA Community

Los Angeles Community Hospital
4081 E OLYMPIC BLVD
Los Angeles, CA 90023

Mortality Rates — CHANGE CATEGORY

	Q3/09-Q2/12	Q3/08-Q2/11	Q3/07-Q2/10	Q3/06-Q2/09
AVERAGE MEDICARE HOSPITAL...	9.30 %	9.77 %	9.56 %	N/A
HEART ATTACK 30-DAY MORTA...	14.40 %	N/A *	N/A *	N/A
HEART FAILURE 30-DAY MORT...	9.50 %	8.90 %	9.00 %	10.00 %
PNEUMONIA 30-DAY MORTALIT...	7.40 % *	9.10 %	10.10 %	10.30 %

2376

Mortality: SoCal Culver City

Brotman Medical Center
3828 DELMAS TERRACE
Culver City, CA 90232

Mortality Rates — CHANGE CATEGORY

	Q3/09-Q2/12	Q3/08-Q2/11	Q3/07-Q2/10	Q3/06-Q2/09
AVERAGE MEDICARE HOSPITAL...	10.63 %	10.40 %	11.47 %	N/A
HEART ATTACK 30-DAY MORTA...	15.00 %	14.80 %	16.20 %	16.30 %
HEART FAILURE 30-DAY MORT...	10.30 %	9.50 %	11.00 %	10.30 %
PNEUMONIA 30-DAY MORTALIT...	9.60 %	9.70 %	10.00 %	9.90 %

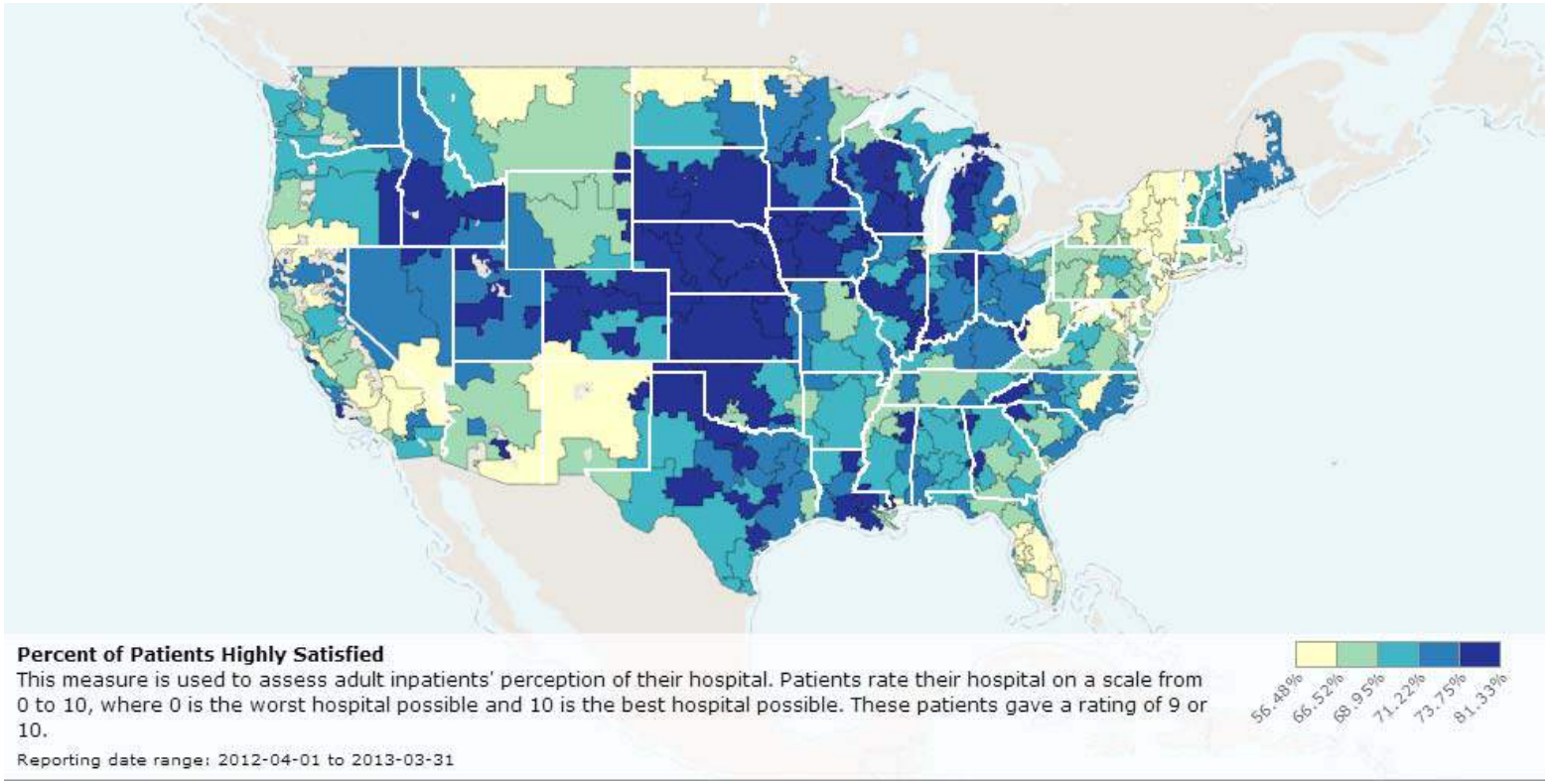
Data and Benchmarks
Patient Experience

WhyNotTheBest.org, accessed March 17, 2014 and April 2, 2014 based on data from hospitalcompare.medicare.gov through March 2013



THE COMMONWEALTH FUND
A Private Foundation Working Toward a High Performance Health System

Patient Experience: national



Percent of Patients Highly Satisfied
This measure is used to assess adult inpatients' perception of their hospital. Patients rate their hospital on a scale from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible. These patients gave a rating of 9 or 10.

Reporting date range: 2012-04-01 to 2013-03-31

Patient Experience: RI, CA, TX

Patient Experience (HCAHPS) CHANGE CATEGORY

	Percent of Patients Highl...	Doctors Always Communicat...	Nurses Always Communicate...	Patients Always Received ...	Staff Always Explained Ab...	Pain Was Always Well Cont...	Patient's Room Always Kep...	Patient's Room and Bathro...	Patients Given Informatio...	Patients Would Definitely...
	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13
× NATIONAL AVERAGE	70.06 %	81.37 %	78.42 %	67.03 %	63.80 %	70.56 %	60.59 %	72.87 %	84.82 %	70.78 %
× NATIONAL TOP 10%	81.00 %	88.00 %	85.00 %	79.00 %	72.00 %	77.00 %	73.00 %	83.00 %	90.00 %	82.00 %
× CALIFORNIA (CA)	67.31 %	77.65 %	73.95 %	61.21 %	60.85 %	68.41 %	50.87 %	70.33 %	82.89 %	69.53 %
× RHODE ISLAND (RI)	68.64 %	80.09 %	79.09 %	65.91 %	60.82 %	71.18 %	54.00 %	73.45 %	85.18 %	71.64 %
× TEXAS (TX)	72.60 %	83.28 %	79.23 %	68.93 %	65.67 %	72.54 %	67.98 %	74.25 %	84.58 %	72.93 %

Patient Experience: All Hospitals

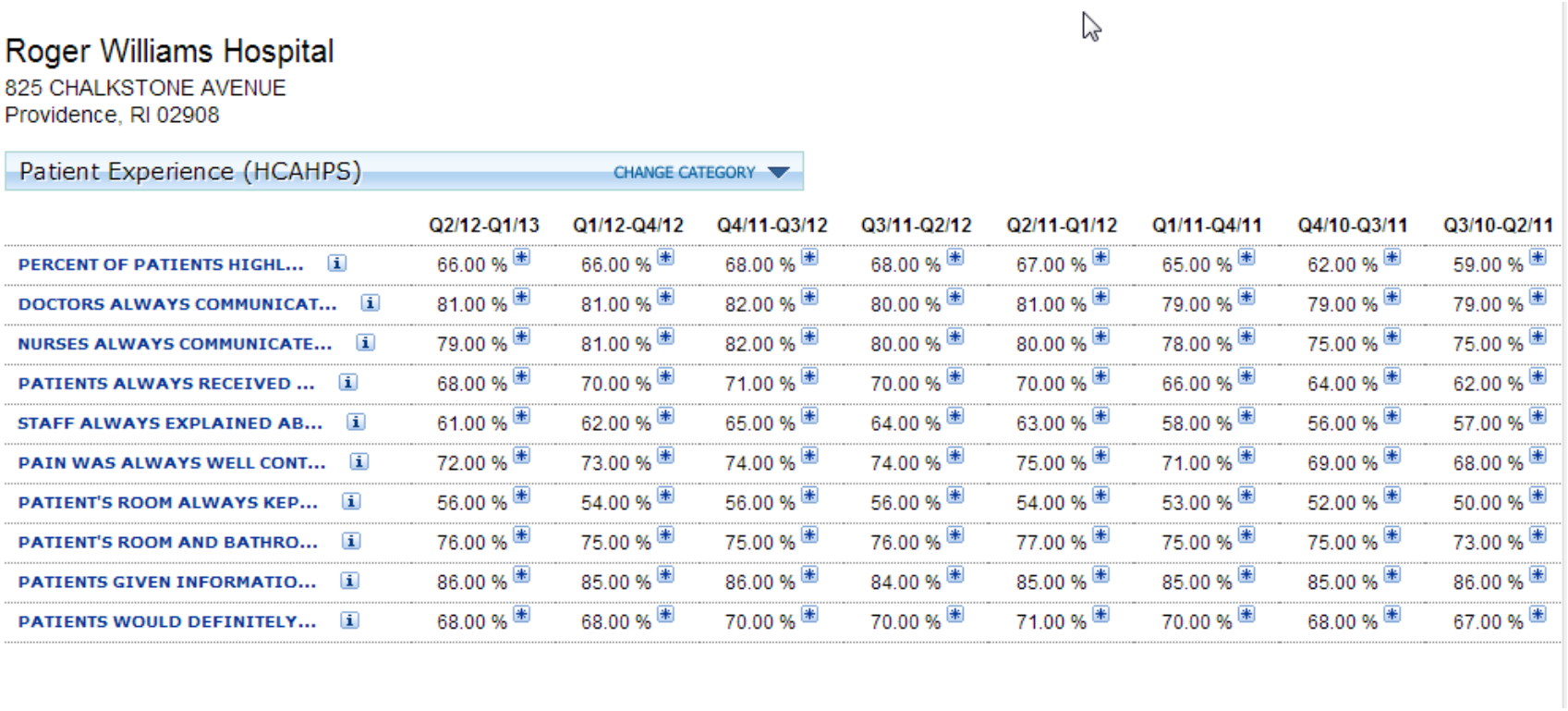


Patient Experience (HCAHPS) CHANGE CATEGORY

Group By: None Health System HRR

	Percent of Patients Highl...	Doctors Always Communicat...	Nurses Always Communicate...	Patients Always Received ...	Staff Always Explained Ab...	Pain Was Always Well Cont...	Patient's Room Always Kep...	Patient's Room and Bathro...	Patients Given Informatio...	Patients Would Definitely...
	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13	Q2/12 - Q1/13
NATIONAL AVERAGE	70.06 %	81.37 %	78.42 %	67.03 %	63.80 %	70.56 %	60.59 %	72.87 %	84.82 %	70.78 %
BROTMAN MEDICAL CENTER (CA)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
HOLLYWOOD COMMUNITY HOSPITAL OF HOLLYWOOD (CA)	44.00 %	55.00 %	54.00 %	42.00 %	35.00 %	50.00 %	44.00 %	59.00 %	72.00 %	48.00 %
HOLLYWOOD COMMUNITY HOSPITAL OF VAN NUYS (CA)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
LOS ANGELES COMMUNITY HOSPITAL (CA)	47.00 %	64.00 %	61.00 %	45.00 %	47.00 %	58.00 %	40.00 %	56.00 %	70.00 %	43.00 %
NIX HEALTH CARE SYSTEM (TX)	75.00 %	84.00 %	79.00 %	58.00 %	67.00 %	72.00 %	65.00 %	78.00 %	82.00 %	75.00 %
ROGER WILLIAMS HOSPITAL (RI)	66.00 %	81.00 %	79.00 %	68.00 %	61.00 %	72.00 %	56.00 %	76.00 %	86.00 %	68.00 %
ST JOSEPH HEALTH SERVICES OF RI (RI)	66.00 %	80.00 %	82.00 %	68.00 %	63.00 %	73.00 %	60.00 %	68.00 %	89.00 %	65.00 %

Patient Experience: Roger Williams



Roger Williams Hospital
825 CHALKSTONE AVENUE
Providence, RI 02908

Patient Experience (HCAHPS) CHANGE CATEGORY

	Q2/12-Q1/13	Q1/12-Q4/12	Q4/11-Q3/12	Q3/11-Q2/12	Q2/11-Q1/12	Q1/11-Q4/11	Q4/10-Q3/11	Q3/10-Q2/11
PERCENT OF PATIENTS HIGHL...	66.00 %	66.00 %	68.00 %	68.00 %	67.00 %	65.00 %	62.00 %	59.00 %
DOCTORS ALWAYS COMMUNICAT...	81.00 %	81.00 %	82.00 %	80.00 %	81.00 %	79.00 %	79.00 %	79.00 %
NURSES ALWAYS COMMUNICATE...	79.00 %	81.00 %	82.00 %	80.00 %	80.00 %	78.00 %	75.00 %	75.00 %
PATIENTS ALWAYS RECEIVED ...	68.00 %	70.00 %	71.00 %	70.00 %	70.00 %	66.00 %	64.00 %	62.00 %
STAFF ALWAYS EXPLAINED AB...	61.00 %	62.00 %	65.00 %	64.00 %	63.00 %	58.00 %	56.00 %	57.00 %
PAIN WAS ALWAYS WELL CONT...	72.00 %	73.00 %	74.00 %	74.00 %	75.00 %	71.00 %	69.00 %	68.00 %
PATIENT'S ROOM ALWAYS KEP...	56.00 %	54.00 %	56.00 %	56.00 %	54.00 %	53.00 %	52.00 %	50.00 %
PATIENT'S ROOM AND BATHRO...	76.00 %	75.00 %	75.00 %	76.00 %	77.00 %	75.00 %	75.00 %	73.00 %
PATIENTS GIVEN INFORMATIO...	86.00 %	85.00 %	86.00 %	84.00 %	85.00 %	85.00 %	85.00 %	86.00 %
PATIENTS WOULD DEFINITELY...	68.00 %	68.00 %	70.00 %	70.00 %	71.00 %	70.00 %	68.00 %	67.00 %

Patient Experience: St Joseph

St Joseph Health Services Of Ri
200 HIGH SERVICE AVENUE
North Providence, RI 02904

Patient Experience (HCAHPS) CHANGE CATEGORY

	Q2/12-Q1/13	Q1/12-Q4/12	Q4/11-Q3/12	Q3/11-Q2/12	Q2/11-Q1/12	Q1/11-Q4/11	Q4/10-Q3/11
PERCENT OF PATIENTS HIGHL...	66.00 %	64.00 %	61.00 %	60.00 %	56.00 %	57.00 %	58.00 %
DOCTORS ALWAYS COMMUNICAT...	80.00 %	81.00 %	81.00 %	81.00 %	81.00 %	78.00 %	78.00 %
NURSES ALWAYS COMMUNICATE...	82.00 %	81.00 %	79.00 %	78.00 %	78.00 %	76.00 %	74.00 %
PATIENTS ALWAYS RECEIVED ...	68.00 %	68.00 %	64.00 %	63.00 %	63.00 %	61.00 %	59.00 %
STAFF ALWAYS EXPLAINED AB...	63.00 %	64.00 %	65.00 %	62.00 %	62.00 %	57.00 %	56.00 %
PAIN WAS ALWAYS WELL CONT...	73.00 %	72.00 %	72.00 %	71.00 %	72.00 %	71.00 %	68.00 %
PATIENT'S ROOM ALWAYS KEP...	60.00 %	61.00 %	58.00 %	56.00 %	55.00 %	52.00 %	51.00 %
PATIENT'S ROOM AND BATHRO...	68.00 %	70.00 %	71.00 %	71.00 %	75.00 %	70.00 %	67.00 %

Patient Experience: Nix

Nix Health Care System
414 NAVARRO
San Antonio, TX 78205

Patient Experience (HCAHPS) CHANGE CATEGORY

	Q2/12-Q1/13	Q1/12-Q4/12	Q4/11-Q3/12	Q3/11-Q2/12	Q2/11-Q1/12	Q1/11-Q4/11	Q4/10-Q3/11	Q3/10-Q2/11
PERCENT OF PATIENTS HIGHL...	75.00 %	75.00 %	74.00 %	75.00 %	74.00 %	72.00 %	72.00 %	72.00 %
DOCTORS ALWAYS COMMUNICAT...	84.00 %	84.00 %	82.00 %	82.00 %	81.00 %	81.00 %	83.00 %	84.00 %
NURSES ALWAYS COMMUNICATE...	79.00 %	80.00 %	78.00 %	78.00 %	76.00 %	77.00 %	78.00 %	80.00 %
PATIENTS ALWAYS RECEIVED ...	58.00 %	59.00 %	60.00 %	63.00 %	62.00 %	64.00 %	66.00 %	66.00 %
STAFF ALWAYS EXPLAINED AB...	67.00 %	67.00 %	66.00 %	66.00 %	64.00 %	64.00 %	62.00 %	64.00 %
PAIN WAS ALWAYS WELL CONT...	72.00 %	72.00 %	70.00 %	71.00 %	70.00 %	72.00 %	73.00 %	74.00 %
PATIENT'S ROOM ALWAYS KEP...	65.00 %	65.00 %	65.00 %	66.00 %	67.00 %	68.00 %	68.00 %	69.00 %
PATIENT'S ROOM AND BATHRO...	78.00 %	79.00 %	78.00 %	82.00 %	81.00 %	81.00 %	80.00 %	79.00 %
PATIENTS GIVEN INFORMATIO...	82.00 %	83.00 %	85.00 %	85.00 %	85.00 %	85.00 %	84.00 %	83.00 %
PATIENTS WOULD DEFINITELY...	75.00 %	74.00 %	73.00 %	74.00 %	73.00 %	73.00 %	74.00 %	74.00 %

Patient Experience: SoCal Hollywood

Hollywood Community Hospital Of Hollywood

6245 DE LONGPRE AVE
Hollywood, CA 90028

Patient Experience (HCAHPS) CHANGE CATEGORY

	Q2/12-Q1/13	Q1/12-Q4/12	Q4/11-Q3/12	Q3/11-Q2/12	Q2/11-Q1/12	Q1/11-Q4/11	Q4/10-Q3/11	Q3/10-Q2/11
PERCENT OF PATIENTS HIGHL...	44.00 %	42.00 %	39.00 %	42.00 %	36.00 %	38.00 %	42.00 %	40.00 %
DOCTORS ALWAYS COMMUNICAT...	55.00 %	57.00 %	56.00 %	60.00 %	64.00 %	57.00 %	61.00 %	60.00 %
NURSES ALWAYS COMMUNICATE...	54.00 %	54.00 %	53.00 %	59.00 %	55.00 %	50.00 %	54.00 %	53.00 %
PATIENTS ALWAYS RECEIVED ...	42.00 %	42.00 %	42.00 %	35.00 %	28.00 %	30.00 %	31.00 %	31.00 %
STAFF ALWAYS EXPLAINED AB...	35.00 %	35.00 %	30.00 %	41.00 %	45.00 %	29.00 %	33.00 %	34.00 %
PAIN WAS ALWAYS WELL CONT...	50.00 %	52.00 %	49.00 %	45.00 %	44.00 %	42.00 %	45.00 %	46.00 %
PATIENT'S ROOM ALWAYS KEP...	44.00 %	44.00 %	51.00 %	53.00 %	51.00 %	50.00 %	48.00 %	44.00 %
PATIENT'S ROOM AND BATHRO...	59.00 %	59.00 %	61.00 %	60.00 %	58.00 %	57.00 %	59.00 %	59.00 %
PATIENTS GIVEN INFORMATIO...	72.00 %	71.00 %	66.00 %	69.00 %	65.00 %	62.00 %	65.00 %	67.00 %
PATIENTS WOULD DEFINITELY...	48.00 %	48.00 %	47.00 %	47.00 %	45.00 %	43.00 %	49.00 %	49.00 %

Patient Experience: LA Community

Los Angeles Community Hospital
4081 E OLYMPIC BLVD
Los Angeles, CA 90023

Patient Experience (HCAHPS) CHANGE CATEGORY

	Q2/12-Q1/13	Q1/12-Q4/12	Q4/11-Q3/12	Q3/11-Q2/12	Q2/11-Q1/12	Q1/11-Q4/11	Q4/10-Q3/11	Q3/10-Q2/11
PERCENT OF PATIENTS HIGHL...	47.00 %	44.00 %	43.00 %	42.00 %	43.00 %	41.00 %	43.00 %	42.00 %
DOCTORS ALWAYS COMMUNICAT...	64.00 %	65.00 %	61.00 %	60.00 %	58.00 %	56.00 %	58.00 %	56.00 %
NURSES ALWAYS COMMUNICATE...	61.00 %	57.00 %	53.00 %	52.00 %	53.00 %	48.00 %	48.00 %	46.00 %
PATIENTS ALWAYS RECEIVED ...	45.00 %	45.00 %	49.00 %	50.00 %	42.00 %	40.00 %	42.00 %	40.00 %
STAFF ALWAYS EXPLAINED AB...	47.00 %	47.00 %	44.00 %	44.00 %	37.00 %	37.00 %	43.00 %	39.00 %
PAIN WAS ALWAYS WELL CONT...	58.00 %	55.00 %	48.00 %	47.00 %	47.00 %	45.00 %	48.00 %	45.00 %
PATIENT'S ROOM ALWAYS KEP...	40.00 %	42.00 %	50.00 %	54.00 %	52.00 %	47.00 %	47.00 %	42.00 %
PATIENT'S ROOM AND BATHRO...	56.00 %	59.00 %	67.00 %	69.00 %	64.00 %	61.00 %	62.00 %	64.00 %
PATIENTS GIVEN INFORMATIO...	70.00 %	68.00 %	66.00 %	64.00 %	66.00 %	69.00 %	69.00 %	66.00 %
PATIENTS WOULD DEFINITELY...	43.00 %	41.00 %	44.00 %	46.00 %	46.00 %	43.00 %	43.00 %	44.00 %

Patient Experience: SoCal Culver City

Brotman Medical Center
3828 DELMAS TERRACE
Culver City, CA 90232

Patient Experience (HCAHPS) CHANGE CATEGORY

	Q4/11-Q3/12	Q3/11-Q2/12	Q2/11-Q1/12	Q1/11-Q4/11	Q4/10-Q3/11	Q3/10-Q2/11	Q2/10-Q1/11	Q1/10-Q4/10
PERCENT OF PATIENTS HIGHL...	48.00 %	46.00 %	44.00 %	43.00 %	42.00 %	44.00 %	45.00 %	48.00 %
DOCTORS ALWAYS COMMUNICAT...	68.00 %	67.00 %	67.00 %	69.00 %	67.00 %	68.00 %	69.00 %	67.00 %
NURSES ALWAYS COMMUNICATE...	62.00 %	59.00 %	58.00 %	59.00 %	57.00 %	56.00 %	57.00 %	55.00 %
PATIENTS ALWAYS RECEIVED ...	45.00 %	43.00 %	39.00 %	39.00 %	36.00 %	35.00 %	38.00 %	39.00 %
STAFF ALWAYS EXPLAINED AB...	47.00 %	44.00 %	42.00 %	41.00 %	38.00 %	39.00 %	40.00 %	42.00 %
PAIN WAS ALWAYS WELL CONT...	59.00 %	56.00 %	56.00 %	56.00 %	57.00 %	59.00 %	59.00 %	56.00 %
PATIENT'S ROOM ALWAYS KEP...	47.00 %	44.00 %	43.00 %	46.00 %	43.00 %	45.00 %	46.00 %	44.00 %
PATIENT'S ROOM AND BATHRO...	58.00 %	56.00 %	55.00 %	56.00 %	56.00 %	57.00 %	59.00 %	58.00 %
PATIENTS GIVEN INFORMATIO...	68.00 %	66.00 %	65.00 %	64.00 %	62.00 %	63.00 %	64.00 %	67.00 %
PATIENTS WOULD DEFINITELY...	48.00 %	45.00 %	45.00 %	44.00 %	42.00 %	43.00 %	45.00 %	48.00 %

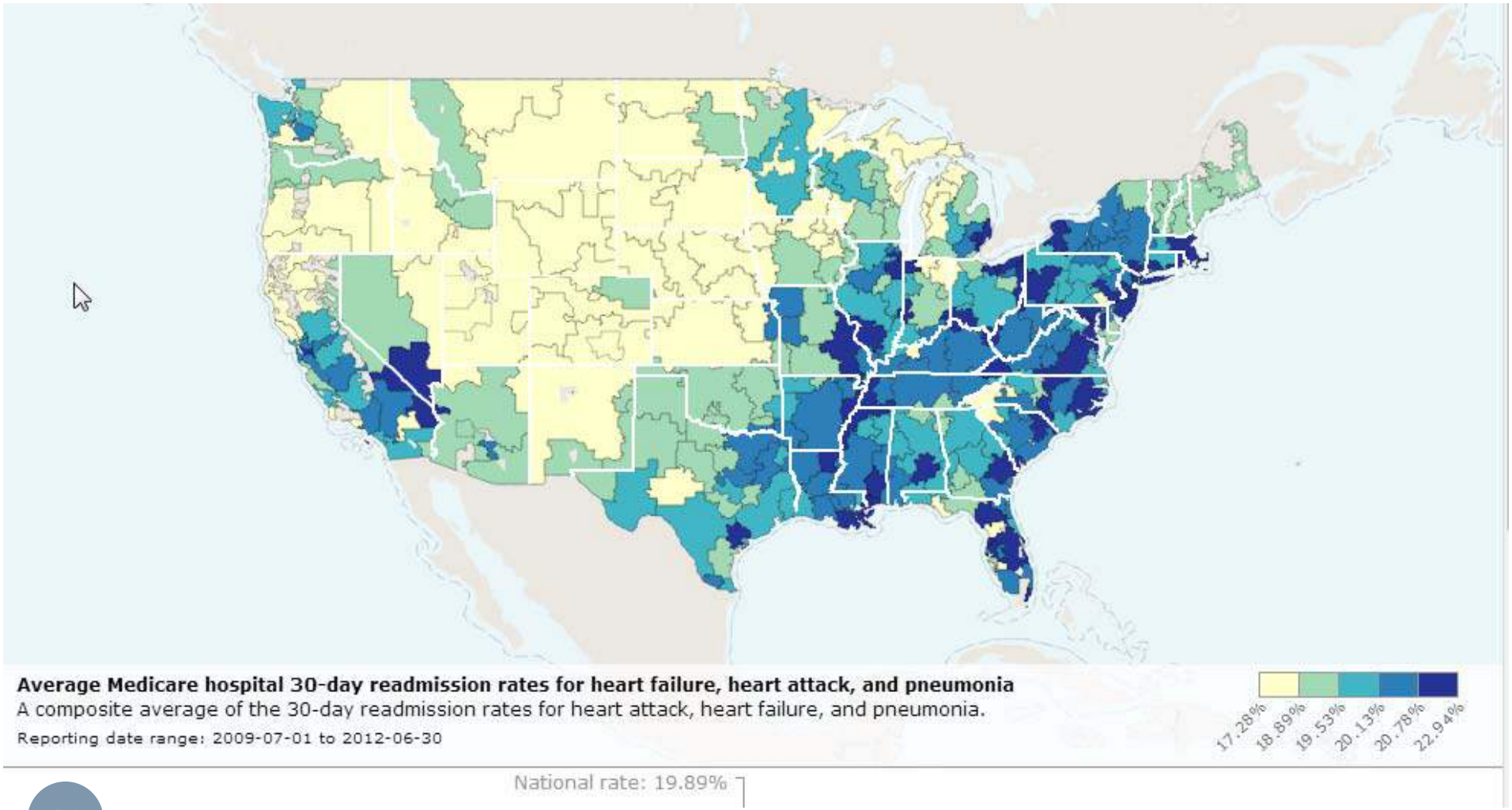
Data and Benchmarks
Readmissions

WhyNotTheBest.org, accessed March 17, 2014 and April 2, 2014 based on data from hospitalcompare.medicare.gov through March 2013



THE COMMONWEALTH FUND
A Private Foundation Working Toward a High Performance Health System

Readmissions: national



Readmissions: RI, CA, TX

Readmission Rates — CHANGE CATEGORY

	Average Medicare hospital 30-day readmission rates for heart fa...	Heart Attack Patients Readmitted to Hospital Within 30 Days	Heart Failure Patients Readmitted to Hospital Within 30 Days	Pneumonia Patients Readmitted to Hospital Within 30 Days
	Q3/09 - Q2/12	Q3/09 - Q2/12	Q3/09 - Q2/12	Q3/09 - Q2/12
NATIONAL AVERAGE	19.89 %	18.30 %	23.00 %	17.60 %
NATIONAL TOP 10%	17.80 %	16.90 %	20.90 %	15.90 %
CALIFORNIA (CA)	19.94 %	18.25 %	22.85 %	17.47 %
RHODE ISLAND (RI)	21.11 %	18.46 %	24.30 %	18.17 %
TEXAS (TX)	19.73 %	18.17 %	22.83 %	17.32 %

Readmissions: All Hospitals



Readmission Rates — CHANGE CATEGORY

Group By: None | Health System | HRR

Average Medicare hospital 30-day readmission rates for heart fa...	Heart Attack Patients Readmitted to Hospital Within 30 Days	Heart Failure Patients Readmitted to Hospital Within 30 Days	Pneumonia Patients Readmitted to Hospital Within 30 Days
Q3/09 - Q2/12	Q3/09 - Q2/12	Q3/09 - Q2/12	Q3/09 - Q2/12
NATIONAL AVERAGE			
19.89 % *	18.30 %	23.00 %	17.60 %
BROTMAN MEDICAL CENTER (CA)			
N/A	N/A	N/A	N/A
HOLLYWOOD COMMUNITY HOSPITAL OF HOLLYWOOD (CA)			
18.60 %	18.80 %	22.40 %	16.90 %
HOLLYWOOD COMMUNITY HOSPITAL OF VAN NUYS (CA)			
N/A	N/A	N/A	N/A
LOS ANGELES COMMUNITY HOSPITAL (CA)			
21.71 %	18.40 %	25.80 %	19.20 %
NIX HEALTH CARE SYSTEM (TX)			
20.29 %	18.00 %	22.90 %	17.00 %
ROGER WILLIAMS HOSPITAL (RI)			
19.66 %	18.00 %	23.50 %	16.90 %
ST JOSEPH HEALTH SERVICES OF RI (RI)			
22.54 %	19.30 %	25.20 %	20.30 %

Readmissions: Roger Williams

Roger Williams Hospital
825 CHALKSTONE AVENUE
Providence, RI 02908

Readmission Rates CHANGE CATEGORY

	Q3/09-Q2/12	Q3/08-Q2/11	Q3/07-Q2/10	Q3/06-Q2/09
AVERAGE MEDICARE HOSPITAL...	19.66 %	20.80 %	21.30 %	N/A
HEART ATTACK PATIENTS REA...	18.00 %	19.00 %	19.60 %	18.80 %
HEART FAILURE PATIENTS RE...	23.50 %	26.10 %	25.10 %	27.60 %
PNEUMONIA PATIENTS READMI...	16.90 %	16.90 %	18.20 %	18.70 %

Readmissions: St Joseph

St Joseph Health Services Of Ri
200 HIGH SERVICE AVENUE
North Providence, RI 02904

Readmission Rates CHANGE CATEGORY

	Q3/09-Q2/12	Q3/08-Q2/11	Q3/07-Q2/10	Q3/06-Q2/09
AVERAGE MEDICARE HOSPITAL...	22.54 %	23.56 %	22.89 %	N/A
HEART ATTACK PATIENTS REA...	19.30 %	20.10 %	21.00 %	22.00 %
HEART FAILURE PATIENTS RE...	25.20 %	26.70 %	25.90 %	25.80 %
PNEUMONIA PATIENTS READMI...	20.30 %	20.30 %	19.30 %	19.40 %

Readmissions: Nix

Nix Health Care System
414 NAVARRO
San Antonio, TX 78205

Readmission Rates — CHANGE CATEGORY

	Q3/09-Q2/12	Q3/08-Q2/11	Q3/07-Q2/10	Q3/06-Q2/09
AVERAGE MEDICARE HOSPITAL...	20.29 %	21.13 %	19.66 %	N/A
HEART ATTACK PATIENTS REA...	18.00 %	19.70 %	18.50 %	19.60 %
HEART FAILURE PATIENTS RE...	22.90 %	24.00 %	21.70 %	23.80 %
PNEUMONIA PATIENTS READMI...	17.00 %	18.10 %	17.90 %	17.60 %

Readmissions: SoCal Hollywood

Hollywood Community Hospital Of Hollywood

6245 DE LONGPRE AVE
Hollywood, CA 90028

Readmission Rates — CHANGE CATEGORY

	Q3/09-Q2/12	Q3/08-Q2/11	Q3/07-Q2/10	Q3/06-Q2/09
AVERAGE MEDICARE HOSPITAL...	18.60 %	19.72 %	21.10 %	N/A
HEART ATTACK PATIENTS REA...	N/A	N/A *	N/A *	N/A
HEART FAILURE PATIENTS RE...	22.40 %	25.70 %	26.10 %	26.20 %
PNEUMONIA PATIENTS READMI...	16.90 %	17.50 %	18.90 %	18.70 %

Readmissions: LA Community

Los Angeles Community Hospital
4081 E OLYMPIC BLVD
Los Angeles, CA 90023

Readmission Rates CHANGE CATEGORY

	Q3/09-Q2/12	Q3/08-Q2/11	Q3/07-Q2/10	Q3/06-Q2/09
AVERAGE MEDICARE HOSPITAL...	21.71 %	24.63 %	25.20 %	N/A
HEART ATTACK PATIENTS REA...	18.40 %	N/A *	N/A *	N/A
HEART FAILURE PATIENTS RE...	25.80 %	28.10 %	28.30 %	25.60 %
PNEUMONIA PATIENTS READMI...	19.20 %	21.30 %	21.90 %	20.30 %

Readmissions: SoCal Culver City

Brotman Medical Center
3828 DELMAS TERRACE
Culver City, CA 90232

Readmission Rates — CHANGE CATEGORY

	Q3/08-Q2/11	Q3/07-Q2/10	Q3/06-Q2/09
AVERAGE MEDICARE HOSPITAL...	22.49 %	22.75 %	N/A
HEART ATTACK PATIENTS REA...	19.80 %	19.10 %	20.20 %
HEART FAILURE PATIENTS RE...	24.40 %	26.30 %	28.50 %
PNEUMONIA PATIENTS READMI...	21.50 %	20.60 %	19.10 %

Additional Quality Areas

2398

Assessment and Findings

Review the service lines and clinical services delivered by the hospital to ascertain whether adequate resources will continue to be available for those services.

Assessment and Findings

Review bed availability, staffing, occupancy and maintenance of adequate resources to provide care.

Assessment and Findings

- Review Information Technology, including
  - Electronic Health Records' Platforms and Investments
  - Access to Health Information Exchanges
  - Meaningful Use Cert.
  - HIMSS Analytics

US EMR Adoption Model℠

Stage	Cumulative Capabilities	2008 Year End	2013 Q3
Stage 7	Complete EMR, CCD transactions to share data; Data warehousing; Data continuity with ED, ambulatory, OP	0.0%	2.2%
Stage 6	Physician documentation (structured templates), full CDSS (variance & compliance), full R-PACS	0.1%	11.1%
Stage 5	Closed loop medication administration	0.5%	20.9%
Stage 4	CPOE, Clinical Decision Support (clinical protocols)	3.1%	15.1%
Stage 3	Nursing/clinical documentation (flow sheets), CDSS (error checking), PACS available outside Radiology	18.7%	31.9%
Stage 2	CDR, Controlled Medical Vocabulary, CDS, may have Document Imaging; HIE capable	40.0%	8.4%
Stage 1	Ancillaries - Lab, Rad, Pharmacy - All Installed	17.4%	3.5%
Stage 0	All Three Ancillaries Not Installed	20.4%	6.9%

Data from HIMSS Analytics® Database © 2013 HIMSS Analytics N = 4237 N = 5437

HIMSS Analytics

Assessment and Findings

Review Public Health Indicators for the population served, including Kaiser Family Foundation, California Health Care Foundation, and other public data.

Assessment and Findings

Review additional external certifications such as Magnet, Baby Friendly, CARF, and Disease Management Certifications such as stroke, diabetes, et al.

Assessment and Findings

Review any available public citations for fraud and abuse as they pertain to provision of care.

Assessment and Findings

Review external grading agency reports as available, including but not limited to US News, Healthgrades, Leapfrog, and Consumer Reports.

Assessment and Findings

Review PSO participation and any public or submitted information about adverse events.

Assessment and Findings

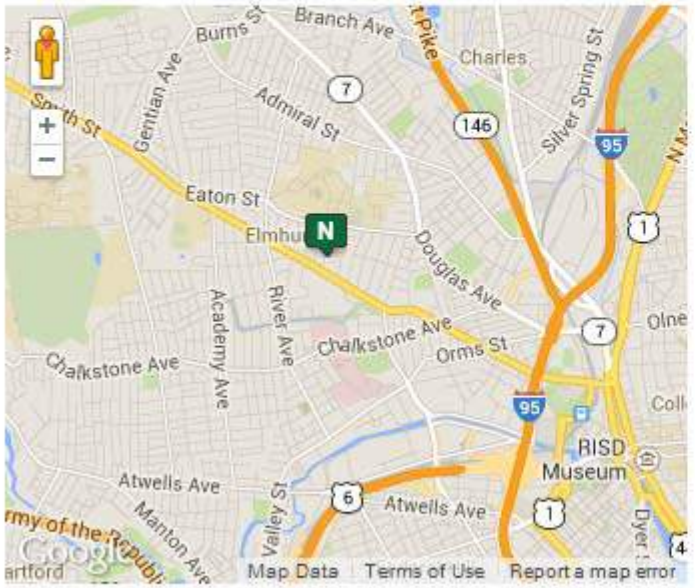
For any wholly-owned or affiliated nursing homes and other post-acute hospital care organizations, review nursing home compare, homecare compare and any submitted information.

Elmhurst Extended Care Facility

ELMHURST EXTENDED CARE FACILITY

50 MAUDE STREET
PROVIDENCE, RI 02908
(401) 456-2600

Add to my Favorites
Map and Directions



Nursing home information

- 206 Certified Beds
- Participates in ℹ: Medicare and Medicaid
- Ownership ℹ: Non profit - Corporation
- Automatic Sprinkler Systems ℹ in All Required Areas: Yes
- Not in a Continuing Care Retirement Community ℹ (CCRC)
- Not in a Hospital
- Resident Council Only ℹ

Star Rating Summary

Overall Rating ℹ	★★★★★ Above Average
Health Inspection ℹ	★★★★★ Below Average
Staffing ℹ	★★★★★ Above Average
Quality Measures ℹ	★★★★★ Much Above Average

http://www.medicare.gov/nursinghomecompare/results.html#s
xlat=0&lng=0&AspxAutoDetectCookieSupport=1
accessed April 3 2014

CharterCare Home Health Services

- **CharterCare Home Health Services performed at or above the national average for Home Health Care Agencies in all categories.**

http://www.medicare.gov/homehealthcompare/profile.html#profTab=2&ID=417029&state=RI&lat=0&lng=0&name=CharterCare accessed April 6 2014

Assessment and Findings

Review status of ACGME or AOA oversight and accreditation or citations of any training programs that exist.

Assessment and Findings

Review Quality Improvement activities.

Conclusion

Based on my review of all available material, my role and experience as an expert consultant in the six domains of Quality, and my review of the statutory requirements for a Change in Effective Control and Hospital Conversion, my opinion is that the transacting parties satisfy all the requirements identified in RIGL 23-17-14.3 "Licensing of Health Care Facilities" and HCA 23-17.14-3, 23-17.14-4 and 23-17.14-8 that pertain to a quality review.

RESPONSE TO DEFICIENCIES
EXHIBIT N - Quality Metrics for 2014

Prospect Medical Holdings

Outcome Measures

For the period of 1/1/14 - 12/31/14
Source: www.medicare.gov/hospitalcompare

Readmissions & Deaths Tab

Readmissions Reduction Program Measures: (Risk Adjusted)

	Rate of Unplanned Readmission by Medical Condition					
	COPD	**AMI**	**CHF**	**Pneumonia**	**Stroke**	**Hospital Wide**
LACH	No Diff	No Diff	No Diff	No Diff	No Diff	No Diff
SCH	No Diff	No Diff	No Diff	No Diff	No Diff	No Diff
Nix	No Diff	No Diff	No Diff	No Diff	No Diff	No Diff
RW	No Diff	No Diff	No Diff	No Diff	No Diff	No Diff
OLF	No Diff	No Diff	No Diff	No Diff	No Diff	No Diff
National Avg	20.2%	17.0%	22.0%	16.9%	12.7%	15.2%
MGH	No Diff	No Diff	No Diff	No Diff	No Diff	No Diff
RGH	No Diff	N/A(3)	No Diff	No Diff	No Diff	No Diff

30-Day Mortality: (Risk Adjusted)

	Death Rate by Medical Condition				
	COPD	**AMI**	**CHF**	**Pneumonia**	**Stroke**
LACH	No Diff	No Diff	No Diff	Better (2)	No Diff
SCH	Better (1)	No Diff	No Diff	Better (2)	No Diff
Nix	No Diff	No Diff	No Diff	No Diff	No Diff
RW	No Diff	No Diff	No Diff	No Diff	No Diff
OLF	No Diff	No Diff	No Diff	No Diff	No Diff
National Avg	7.7%	14.2%	11.6%	11.5%	14.8%
MGH	No Diff	No Diff	No Diff	No Diff	No Diff
RGH	No Diff	No Diff	No Diff	No Diff	No Diff

Complications Tab

Complications: (Risk Adjusted)

	Hip/Knee Surgery	Serious Complication	Deaths/Treat Comp.
LACH	N/A(3)	No Diff	No Diff
SCH	N/A(3)	No Diff	No Diff
Nix	No Diff	No Diff	No Diff
RW	No Diff	No Diff	No Diff
OLF	No Diff	No Diff	Worse
National Avg	3.1%	0.8%	11.8%
MGH	No Diff	No Diff	No Diff
RGH	No Diff	No Diff	N/A(3)

Healthcare-associated Infections: (Risk Adjusted)

	Central Line	Catherter	Surgical Site:Colon	MRSA	Intestinal
LACH	No Diff	Better	N/A	Worse	Better
SCH	No Diff	No Diff	No Diff	No Diff	No Diff
Nix	No Diff	Worse	No Diff	No Diff	Better
RW	No Diff	Worse	No Diff	No Diff	No Diff
OLF	No Diff	No Diff	No Diff	No Diff	No Diff
MGH	No Diff	No Diff	No Diff	No Diff	Better
RGH	No Diff	No Diff	N/A(4)	N/A(4)	No Diff

Key:

LAC - Los Angeles Community Hospital, and Norwalk Campus, CA
SCH - Southern California Hospital, Culver City, Hollywood and Van Nuys Campuses, CA
NIX - Nix Health System, TX
RW - Roger Williams Medical Center, RI
OLF - Our Lady of Fatima, RI
MGH - Manchester General Hospital, CT
RGH - Rockville General Hospital, CT

Prospect Medical Holdings

Timely and Effective Care Measures

For the period of 1/1/14 - 12/31/14

Source: www.medicare.gov/hospitalcompare

Timely and Effective Care Tab

Timely and Effective Care - Heart Attack and Pneumonia Care

	Asprin at Discharge - AMI	Statin At Discharge - AMI	Appr. Antibiotics - Pnem
LACH	100%	91%	73%
SCH	100%	100%	N/A(4)
Nix	100%	98%	92%
RW	98%	86%	100%
OLF	100%	85%	97%
National Avg	99.0%	99.0%	96.0%
MGH	100%	94%	95%
RGH	N/A(4)	N/A(4)	97%

Timely and Effective Care - Surgical Care

	O/P Antibiotic w/hour	I/P Antibiotic w/hour	Antibiotics stopped w/24 post	Trt to Prevent Blood Clots	Continue Beta Blockers	Removal of Urinary Cath
LACH	N/A(4)	71%	97%	76%	95%	100%
SCH	98%	96%	81%	98%	98%	96%
Nix	100%	99%	97%	100%	97%	95%
RW	95%	100%	98%	99%	97%	96%
OLF	98%	100%	99%	100%	99%	99%
National Avg	98.0%	99.0%	98.0%	100.0%	98.0%	98.0%
MGH	98%	99%	99%	100%	98%	100%
RGH	97%	100%	100%	100%	100%	100%

Timely and Effective Care - Emergency Department Care

	Avg wait time/Broken Bone	Left before being seen
LACH	56 minutes	1%
SCH	68 minutes	4%
Nix	41 minutes	4%
RW	69 minutes	3%
OLF	75 minutes	1%
National Avg	54 minutes	2%
MGH	60	3%
RGH	50	1%

Timely and Effective Care - Preventive Care

	Patients given Flue Shot	Health Workers Flue Shot
LACH	76%	74%
SCH	92%	64%
Nix	98%	95%
RW	80%	90%
OLF	92%	90%
National Avg	93.0%	84.0%
MGH	95%	94%
RGH	94%	97%

Timely and Effective Care - Stroke Care

	Preventive Anti-Clot/2 days	Anti-clot/2 days	Anti-Clot prior/discharge	Medicine to Lower CHL	Eval for Rehab
LACH	88%	87%	96%	86%	93%
SCH	100%	100%	100%	99%	100%
Nix	98%	91%	100%	88%	100%
RW	100%	91%	100%	95%	95%
OLF	98%	91%	98%	92%	95%

National Avg	98.0%	97.0%	99.0%	96.0%	98.0%
MGH	98%	91%	100%	97%	94%
RGH	100%	93%	100%	100%	100%

Timely and Effective Care - Blood Clot Prevention & Treatment

	Trx on same day	Trx on Day +1 ICU	Pat who did not receive Trx	Trx X2 Thinners	Written Edu. Materials
LACH	82%	93%	17%	93%	100%
SCH	91%	97%	0%	100%	100%
Nix	80%	81%	20%	97%	100%
RW	84%	93%	N/A(4)	94%	N/A(4)
OLF	86%	98%	8%	98%	100%
National Avg	92.0%	96.0%	6.0%	95.0%	89.0%
MGH	97%	98%	N/A(4)	98%	76%
RGH	94%	99%	N/A(4)	100%	88%

Use of Medical Imaging Tab

Timely and Effective Care - O/P

	O/P Breast Screening - Rad	O/P CT Chest Combo Scan	O/P CT Scans Abd Combo
LACH	N/A(4)	N/A(4)	N/A(4)
SCH	N/A(4)	0.0%	2.8%
Nix	8.7%	2.2%	11.2%
RW	2.1%	0.3%	14.9%
OLF	24.5%	0.0%	7.1%
National Avg	8.9%	2.4%	9.4%
MGH	14.7%	0.0%	3.1%
RGH	12.3%	0.6%	4.6%

Key:
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RW - Roger Williams Medical Center, RI
OLF - Our Lady of Fatima, RI
MGH - Manchester General Hospital, CT
RGH - Rockville General Hospital, CT

RESPONSE TO DEFICIENCIES
EXHIBIT O Information Contained in Requested APA Schedules

Owned Real Property DRAFT

Last Updated: 10 16 2015

Owned Real Property Address	City	State	Zipcode	Property Description
17 Armory Street	Manchester	CT	06040	Residential
19 Armory Street	Manchester	CT	06040	Residential
319 Broad Street	Manchester	CT	06040	Thrift Shop/Commercial
460 Hartford Turnpike	Vernon	CT	06066	Commercial
18 Haynes Street	Manchester	CT	06040	Office Building/Commercial
26 Haynes Street	Manchester	CT	06040	Office Building/Commercial
36 Haynes Street	Manchester	CT	06040	Office Building/Commercial
44 Haynes Street	Manchester	CT	06040	Office Building/Commercial
56 Haynes Street	Manchester	CT	06040	Vacant lot
71-80 Haynes Street	Manchester	CT	06040	Hospital
37-97 Hemlock Street	Manchester	CT	06040	vacant land
314 Main Street	Manchester	CT	06040	Parking lot
320 Main Street	Manchester	CT	06040	Office Building/Commercial
353 Main Street	Manchester	CT	06040	Office Building/Commercial
945 Main Street	Manchester	CT	06040	Office Condominium
310-312 Main Street	Manchester	CT	06040	Mixed Use
190 Meadow Street	Lee	MA	01260	Time Share
150 North Main Street	Manchester	CT	06040	Office Building
72 Russell Street	Manchester	CT	06040	Residential
110 Russell Street	Manchester	CT	06040	Residential
26 Shenipsit Lake Road	Tolland	CT	06084	Elder Care/Commercial
62 So. Hawthorne Street	Manchester	CT	06040	vacant land
66 So. Hawthorne Street	Manchester	CT	06040	vacant land
11 South Alton Street	Manchester	CT	06040	Residential
77 South Alton Street	Manchester	CT	06040	vacant land
31 Union Street	Vernon	CT	06066	Hospital
35 Village Street	Vernon	CT	06066	vacant land
22-25-26 Village Street	Vernon	CT	06066	Vacant Building
8-11-12 Ward Street	Vernon	CT	06066	Vacant Land
70 West Middle Turnpike	Manchester	CT	06040	Residential
74 West Middle Turnpike	Manchester	CT	06040	Residential
88 West Main Street	Vernon	CT	06066	Parking lot
94 West Middle Turnpike	Manchester	CT	06040	Residential
98 West Middle Turnpike	Manchester	CT	06040	Residential
104 West Middle Turnpike	Manchester	CT	06040	Residential
108 West Middle Turnpike	Manchester	CT	06040	Residential
114 West Middle Turnpike	Manchester	CT	06040	Residential
28-34-40-46-50 West Middle Turnpike	Manchester	CT	06040	Parking lot

Leased Real Property DRAFT

Last Updated: 10 16 2015

Leased Real Property Address	City	State	Zipcode	Property Description
1707 Boston Turnpike	Coventry	CT	06238	Commercial
47 Hartford Turnpike	Vernon	CT	06066	Commercial
57 Hartford Turnpike	Vernon	CT	06066	Commercial
130 Hartford Road	Manchester	CT	06040	Commercial
428 Hartford Turnpike	Vernon	CT	06066	Commercial
428 Hartford Turnpike	Vernon	CT	06066	Commercial
29 Haynes Street	Manchester	CT	06040	Commercial
100 Haynes Street	Manchester	CT	06040	Commercial
100 Haynes Street	Manchester	CT	06040	Commercial
100 Haynes Street	Manchester	CT	06040	Commercial
622 Hebron Avenue	Glastonbury	CT	06033	Commercial
622 Hebron Avenue	Glastonbury	CT	06033	Commercial
28 Main Street	East hartford	CT	06118	Commercial
146 Merrow Road	Tolland	CT	06084	Commercial
11 Pinney Street	Ellington	CT	06029	Commercial
95 Somers Road/Somers Crossing	Somers	CT	06071	Commercial
2400 Tamarack Avenue	South Windsor	CT	06074	Commercial
2400 Tamarack Avenue	South Windsor	CT	06074	Commercial
2400 Tamarack Avenue	South Windsor	CT	06074	Commercial
2600 Tamarack Avenue	South Windsor	CT	06074	Commercial
2600 Tamarack Avenue	South Windsor	CT	06074	Commercial
2600 Tamarack Avenue	South Windsor	CT	06074	Commercial
2800 Tamarack Avenue	South Windsor	CT	06074	Commercial
2800 Tamarack Avenue	South Windsor	CT	06074	Commercial
2800 Tamarack Avenue	South Windsor	CT	06074	Commercial
2800 Tamarack Avenue	South Windsor	CT	06074	Commercial
2800 Tamarack Avenue	South Windsor	CT	06074	Commercial
2800 Tamarack Avenue	South Windsor	CT	06074	Commercial
2800 Tamarack Avenue	South Windsor	CT	06074	Commercial
2800 Tamarack Avenue	South Windsor	CT	06074	Commercial
2800 Tamarack Avenue	South Windsor	CT	06074	Commercial
2800 Tamarack Avenue	South Windsor	CT	06074	Commercial
2800 Tamarack Avenue	South Windsor	CT	06074	Commercial
2800 Tamarack Avenue	South Windsor	CT	06074	Commercial
2800 Tamarack Avenue	South Windsor	CT	06074	Commercial
2800 Tamarack Avenue	South Windsor	CT	06074	Commercial
2800 Tamarack Avenue	South Windsor	CT	06074	Commercial
360 Tolland Turnpike, Suite 3E	Manchester	CT	06040	Commercial
145 Union Street	Vernon	CT	06066	Commercial
43 West Main Street	Vernon	CT	06066	Parking Lot
175 West Road	Ellington	CT	06029	Commercial
43 Woodland Street, Suite 280	Hartford	CT	06105	Commercial

Building Maintenance and Repairs

DRAFT

Last Updated: 11 6 2015

Property Address	City	State	Zipcode	Property Description	Property Description
22-25-26 Village Street	Vernon	CT	06066	Vacant Historical Building	Polish American Club Building Fire Damage, No Working Building systems or Utilities, Not in Working Order

Rent Roll

DRAFT

Last Updated: 10/16/2015

Lease Address (Street, City, Zip)	Current Month Rental Payment	Outstanding Concessions	Tenant Deposits	Lease Commencement Date	Space Lease Expiration Date	Square Footage of Space Leased	Renewal Options Available to Tenant
17 Armory Street, manchester, CT 06040	$875.00	None	$975.00 - Security Dep.	2/1/2012	1/31/2016	1,532	yearly
19 Armory Street, Manchester, CT 06040	$950.00	None	$1050.00 - Security Dep.	6/1/2015	5/31/2016	1,920	yearly
1707 Boston Tpke., Coventry, CT 06238	$1,829.50	None	0	2/1/2006	1/31/2018	1,280	yearly
460 Hartford Tpke., Vernon, CT 06066	$26,100.88	Before 8/31/2016 install new carpet	$20789.66 - Security Dep.	9/1/2006	8/31/2021	10,616	yearly
460 Hartford Tpke., Vernon, CT 06066	$7,267.00	None	$6828.77 - Security Dep.	11/1/2009	10/31/2015	3,785	yearly
460 Hartford Tpke., Vernon, CT 06066	$5,259.77	None	0	9/1/2007	8/31/2016	2,980	yearly
18 Haynes Street, Manchester, CT 06040	$5,400.50	None	0	12/1/2012	11/30/2017	3,066	5 years
18 Haynes Street, Manchester, CT 06040	$1,950.00	None	0	4/1/2015	3/31/2016	1,075	yearly
18 Haynes Street, Manchester, CT 06040	$310.00	None	0	10/1/2014	9/30/2016	session	yearly
26 Haynes Street, Manchester, CT 06040	$1,334.02	None	0	12/1/2010	11/30/2015	750	yearly
36 Haynes Street, Manchester, CT 06040	$6,698.33	None	0	4/11/2013	3/31/2018	3,719	5 years
44 Haynes Street, Manchester, CT 06040	$3,091.75	None	0	2/1/2007	1/31/2016	1,523	yearly
71 Haynes Street, Manchester, CT 06040	$453.57	None	0	7/1/2006	1/29/2017	190	yearly
622 Hebron Ave., Suite 104B, Glastonbury, CT 06033	$5,000.82	None	$2617.71 - Security Dep.	2/1/2012	1/31/2022	1,997	yearly
622 Hebron Ave., Suite 104C, Glastonbury, CT 06033	$546.36	None	$325.00 - Security Dep.	2/1/2012	1/31/2017	1,215	yearly
622 Hebron Ave., Suite 201, Glastonbury, CT 06033	$9,480.78	None	$3720.21 - Security Dep.	2/1/2012	1/31/2022	2,588	yearly
28 Main Street, East Hartford, CT 06118	$5,578.10	None	0	8/1/2008	7/31/2017	3,672	yearly
310 Main Street, Manchester, CT 06040	$900.00	None	850.00 - Security Dep.	1/4/2010	12/31/2015	1,018	yearly
312 Main Street, Manchester, CT 06040	$450.00	None	0	2/28/2005	month to month		yearly
353 Main Street, Manchester, CT 06040	$10,250.33	None	0	5/9/2014	4/30/2017	5,348	yearly
353 Main Street, Manchester, CT 06040	$300.00	None	0	12/1/2014	11/30/2015	session	yearly
353 Main Street, Manchester, CT 06040	$1,487.33	None	0	10/1/2015	9/30/2016	776	yearly
945 Main Street, Manchester, CT 06040	$3,776.26	None	0	7/1/2012	6/30/2016	2,330	yearly
146 Merrow Road, Tolland, CT 06084	$11,802.15	None	0	9/1/2008	6/30/2016	5,163	yearly
146 Merrow Road, Tolland, CT 06084	$8,102.43	None	$7719.75 - Security Dep.	10/1/2006	6/30/2016	3,431	5 years
146 Merrow Road, Tolland, CT 06084	$4,966.66	None	$4608.00 - Security Dep.	9/1/2006	6/30/2016	2,048	5 years
146 Merrow Road, Tolland, CT 06084	$2,275.00	None	$2600.00 - Security Dep.	4/30/2007	8/31/2016	1,340	5 years
150 North Main Street, Manchester, CT 06040	$6,947.46	None	$2925.00 - Security Dep.	6/1/2005	4/30/2016	4,672	yearly
72 Russell Street, Manchester, CT 06040	$800.00	None	0	12/1/2014	11/30/2016	1,150	yearly
110 Russell Street, Manchester, CT 06040	$1,500.00	None	$1500.00 - Security Dep.	2/1/2007	11/30/2015	1,976	yearly
11 South Alton Street, Manchester, CT 06040	$925.00	None	$1025.00 - Security Dep.	9/1/2003	8/31/2016	1,080	yearly
145 Union Street, Vernon, CT 06066	$4,109.38	None	0	3/15/2012	3/31/2016	1,968	yearly
145 Union Street, Vernon, CT 06066	$1,561.15	None	0	4/1/2009	3/31/2016	532	yearly
70 West Middle Tpke., Manchester, CT 06040	$900.00	None	$900.00 - Security Dep.	9/1/2002	10/31/2016	1,080	yearly
74 West Middle Tpke., Manchester, CT 06040	$900.00	None	$1000.00 - Security Dep.	1/15/2006	1/31/2016	1,320	yearly
94 West Middle Tpke., Manchester, CT 06040	$900.00	None	$1000.00 - Security Dep.	6/1/2010	5/31/2016	1,080	yearly
98 West Middle Tpke., Manchester, CT 06040	$975.00	None	$1075.00 - Security Dep.	8/1/2012	7/31/2016	1,270	yearly
104 West Middle Tpke., Manchester, CT 06040	$925.00	None	$1025.00 - Security Dep.	6/1/2012	6/30/2016	1,080	yearly
108 West Middle Tpke., Manchester, CT 06040	$925.00	None	$1025.00 - Security Dep.	6/1/2009	5/31/2016	1,200	yearly
175 West Road, Ellington, CT 06029	$579.25	None	0	4/12/2010	4/30/2016	252	yearly

Tenant Lease Encumbrances

DRAFT

Last Updated: 10 16 2015

None.

Environmental Claims DRAFT

Last Updated: 10 16 2015

On April 28, 2011 an Emergency Incident Report was made to the State of Connecticut, Department of Environmental Protection as to an in-ground tank failure resulting in the release of #6 Fuel Oil (Petroleum) at Manchester Memorial Hospital, 71 Haynes Street, Manchester, Connecticut. All corrective action items completed with the installation of four monitoring wells. Water samples will be regularly monitored. First report after installation had no issues.

On February 13, 2014 the Department of Energy and Environmental Protection (DEEP) was contacted as to a possible break in an oil line resulting in the release of hydraulic fuel oil at 36 Haynes Street, Manchester, CT. The area of concern was excavated and no break in the pipe was found. DEEP determined that the leak occurred under the building and was un-recoverable as digging under the foundation would jeopardize the building structure. The excavated area was restored. There are no follow-up action items.

Underground Storage Tanks and Waste Disposal

DRAFT

Last Updated: 10/22/2015

Underground Storage Tank Inventory							
Address	**City**	**State**	**Zipcode**	**Location**	**Tank #**	**Capacity (Gallons)**	**Contents**
71 Haynes Street	Manchester	CT	06040	MMH	D1R1	20,000	Heating Oil (#2)
71 Haynes Street	Manchester	CT	06041	MMH	C1R1	4,000	Diesel Fuel
71 Haynes Street	Manchester	CT	06042	MMH	B1R1	6,000	Diesel Fuel
31 Union Street	Vernon	CT	06066	RGH	O1R1	20,000	Fuel Oil
31 Union Street	Vernon	CT	06066	RGH	D1R1	5,000	Diesel Fuel

Waste Disposal Location					
Address	**City**	**State**	**Zipcode**	**Property Description**	**Prpperty Type**
1707 Boston Turnpike	Coventry	CT	06238	Commercial	Leased Real Property
130 Hartford Road	Manchester	CT	06040	Commercial	Leased Real Property
47 Hartford Turnpike	Vernon	CT	06066	Commercial	Leased Real Property
57 Hartford Turnpike	Vernon	CT	06066	Commercial	Leased Real Property
428 Hartford Turnpike	Vernon	CT	06066	Commercial	Leased Real Property
460 Hartford Turnpike	Vernon	CT	06066	Commercial	Owned Real Property
29 Haynes Street	Manchester	CT	06040	Commercial	Leased Real Property
100 Haynes Street	Manchester	CT	06040	Commercial	Leased Real Property
18 Haynes Street	Manchester	CT	06040	Office Building/Commercial	Owned Real Property
36 Haynes Street	Manchester	CT	06040	Office Building/Commercial	Owned Real Property
71-80 Haynes Street	Manchester	CT	06040	Hospital	Owned Real Property
622 Hebron Avenue	Glastonbury	CT	06033	Commercial	Leased Real Property
28 Main Street	East hartford	CT	06118	Commercial	Leased Real Property
353 Main Street	Manchester	CT	06040	Office Building/Commerical	Owned Real Property
945 Main Street	Manchester	CT	06040	Office Condominium	Owned Real Property
146 Merrow Road	Tolland	CT	06084	Commercial	Leased Real Property
150 North Main Street	Manchester	CT	06040	Office Building	Owned Real Property
25 Oakland Road	South Windsor	CT	06074	Commercial	Leased Real Property
11 Pinney Street	Ellington	CT	06029	Commercial	Leased Real Property
26 Shenipsit Lake Road	Tolland	CT	06084	Elder Care/Commercial	Owned Real Property
95 Somers Road/Somers Crossing	Somers	CT	06071	Commercial	Leased Real Property
2400 Tamarack Avenue	South Windsor	CT	06074	Commercial	Leased Real Property
2600 Tamarack Avenue	South Windsor	CT	06074	Commercial	Leased Real Property
2800 Tamarack Avenue	South Windsor	CT	06074	Commercial	Leased Real Property
360 Tolland Turnpike, Suite 3E	Manchester	CT	06040	Commercial	Leased Real Property
145 Union Street	Vernon	CT	06066	Commercial	Leased Real Property
31 Union Street	Vernon	CT	06066	Hospital	Owned Real Property
175 West Road	Ellington	CT	06029	Commercial	Leased Real Property
43 Woodland Street, Suite 280	Hartford	CT	06105	Commercial	Leased Real Property

RESPONSE TO DEFICIENCIES
EXHIBIT P CMS Statements of Deficiency

RESPONSE TO DEFICIENCIES
EXHIBIT P CMS Statements of Deficiency

Los Angeles Community Hospital

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA930000085	A. BUILDING: _____ B. WING _____	C 07/09/2015

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LOS ANGELES COMMUNITY HOSPITAL	4081 E OLYMPIC BLVD LOS ANGELES, CA 90023

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E 292	Continued From page 1 Findings: 1. Patient 1 was admitted to the facility on 4/29/15 with diagnoses that included high blood sugar levels, anemia (low concentration of red blood cells), and acute respiratory failure. Patient 2 was admitted to the facility on 6/15/15 with diagnoses that included seizure disorder. During an interview with the Director of Quality Management on 7/8/15 at 10:35 AM, she stated Patient 2 had been physically assaultive to two staff nurses when Patient 2 pulled the two nurse's hair on 6/20/15 while they were inside Patient 2's room, and also had tried to kick the social worker on 6/20/15. During this interview with the Director of Quality Management, she further stated that on 6/21/15, Patient 2 hit Patient 1 in the face and Patient 1 sustained a jaw fracture. During an interview with the Lead Social Worker on 7/8/15 at 10:40 AM, she stated on 6/20/15, she was working with Patient 2 in Patient 2's room, when the patient became agitated and upset, and kicked out at her. She stated Patient 2's foot grazed her breast area and stomach. During this interview, the social worker further stated that Patient 2 had a "sitter" for one-to-one supervision that day because of the patient's risk of leaving the facility against physician order. During an interview with RN 1 (Registered Nurse) on 7/8/15 at 10:55 AM, she stated on 6/20/15 around lunchtime, she took over one-to-one supervision of Patients 1 and 2. She stated she and another nurse were looking down at paperwork and Patient 2 grabbed both of their	E 292	***Monitoring*** Nursing Supervisors will monitor nursing units daily for appropriate ratio of sitters to patients as ordered by physicians. Any non-conformity will immediately be corrected and reported to the CNO. ***Responsible Persons*** Chief Nursing Officer	7/21/15

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E2145	Continued From page 6 safety or health of patients, personnel or visitors would be reported as soon as reasonably practical, whether by telephone or by telegraph, to the CDPH (California Department of Public Health). The policy indicated the reporting timeframe would be no later than five days after the adverse event had been detected. The P&P further indicated the facility's Quality Management Department would e-mail the regulatory supervisor at the CDPH as well as e-mailing the sender to validate the delivery. In addition, the hospital Quality Management Department would fax the report to CDPH and secure the fax confirmation sheet to be kept on file for validation purposes.	E2145		
E2243	T22 DIV5 CH1 ART7-70751(g) Medical Record Availability (g) Medical records shall be completed promptly and authenticated or signed by a physician, dentist or podiatrist within two weeks following the patient's discharge. Medical records may be authenticated by a signature stamp or computer key, in lieu of a physician's signature, only when that physician has placed a signed statement in the hospital administrative offices to the effect that he is the only person who: This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure Patient 2's EHR (electronic health record) was complete and contained a discharge summary within two weeks after Patient 2 was discharged. Findings:	E2243	E2243 Medical Record Availability ***Corrective Action*** The discharge summary for Patient 2 was completed on 07/08/15 and added to the patient's record immediately. To assure other patients' discharge summaries are completed within two weeks following discharge, the Director of Health Information Management is tracking completion of discharge summaries on a daily basis and notifying physicians when they have not been completed timely. ***Monitoring*** Rates of completion of discharge summaries within 2 weeks is monitored and reported at monthly Quality Council meetings. ***Responsible Persons*** Director of Health Information Management	7/31/15

Alta Los Angeles Hospitals, Inc.

Los Angeles Community Hospital
4081 East Olympic Blvd.
Los Angeles, CA 90023
(323) 267-0477
(323) 881-2611 Fax

Los Angeles Community Hospital
at Norwalk
13222 Bloomfield Avenue
Norwalk, CA 90650
(562) 863-4763
(562) 207-9721 Fax

Los Angeles Community Hospital
at Bellflower
9542 Artesia Blvd.
Bellflower, CA 90706
(562) 273-1800
(562) 273-1818 Fax

July 29, 2015

Ms. Renee Buell, Health Facilities Evaluator Nurse
State of California Department of Public Health
Licensing and Certification Program
State Facilities Section
625 E. Carnegie Dr., Suite 280
San Bernardino, CA 92408

Dear Ms. Buell:

Attached you will find our Plan of Correction related to your visit of July 9, 2015, during which you investigated an incident involving a patient who assaulted another patient.

We feel we have adequately addressed your findings in this Plan of Correction. However, please feel free to contact us if further information is needed.

Sincerely,

Barbara Studer, RN, MAOM, CPHQ
Corporate Director of Quality & Risk Management

ENC: Plan of Correction (2567)

California Department of Public Health

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E 000	Initial Comments The following reflects the findings of the California Department of Public Health during the investigation of an entity reported incident. Entity Reported Incident: CA00449364 Representing the Department: 2091, HFEN The investigation is limited to the specific entity reported incident investigated and does not represent the findings of a full inspection of the facility. Three deficiencies were written for entity reported incident CA00449364	E 000		
E 292	T22 DIV5 CH1 ART3-70215(a)(2) Planning and Implementing Patient Care (a) A registered nurse shall directly provide: (2) The planning, supervision, implementation, and evaluation of the nursing care provided to each patient. The implementation of nursing care may be delegated by the registered nurse responsible for the patient to other licensed nursing staff, or may be assigned to unlicensed staff, subject to any limitations of their licensure, certification, level of validated competency, and/or regulation. This Statute is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide one-to-one supervision as ordered by the physician for three of three sampled patients (Patient 1, Patient 2, and Patient 3). This failure resulted in Patient 1 sustaining a jaw fracture after being hit in the face by Patient 2.	E 292	E 292 Planning & Implementing Patient Care – One-to-One Supervision ***Corrective Action*** Patient 1 was immediately placed in a room separate from Patient 2 after being hit by Patient 2. Patient 2's discharge to a mental health unit was expedited. Regarding one-to-one observation of Patient 3, the ordering physician was contacted to clarify whether 1:2 or 1:3 observation would be acceptable. The physician indicated that 1:3 observation would be acceptable. Computerized order entry now offers a "SITTER" option, where prior to this, "1:1 Observation" was the only available choice when a physician ordered observation of a patient. This became effective 7/21/15. To assure other patients are appropriately observed when sitters are ordered, the policy, "Sitter Usage, Assessment and implementation," was revised to include criteria for observation by sitters, to include 1:1, 1:2, 1:3, and 1:4 sitter-to-patient ratios. Nursing Supervisors were in-serviced on the revised policy on 7/21/15.	

Licensing and Certification Division
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: COO (X6) DATE: 7-29-15

California Department of Public Health

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E 292	Continued From page 1 Findings: 1. Patient 1 was admitted to the facility on 4/29/15 with diagnoses that included high blood sugar levels, anemia (low concentration of red blood cells), and acute respiratory failure. Patient 2 was admitted to the facility on 6/15/15 with diagnoses that included seizure disorder. During an interview with the Director of Quality Management on 7/8/15 at 10:35 AM, she stated Patient 2 had been physically assaultive to two staff nurses when Patient 2 pulled the two nurse's hair on 6/20/15 while they were inside Patient 2's room, and also had tried to kick the social worker on 6/20/15. During this interview with the Director of Quality Management, she further stated that on 6/21/15, Patient 2 hit Patient 1 in the face and Patient 1 sustained a jaw fracture. During an interview with the Lead Social Worker on 7/8/15 at 10:40 AM, she stated on 6/20/15, she was working with Patient 2 in Patient 2's room, when the patient became agitated and upset, and kicked out at her. She stated Patient 2's foot grazed her breast area and stomach. During this interview, the social worker further stated that Patient 2 had a "sitter" for one-to-one supervision that day because of the patient's risk of leaving the facility against physician order. During an interview with RN 1 (Registered Nurse) on 7/8/15 at 10:55 AM, she stated on 6/20/15 around lunchtime, she took over one-to-one supervision of Patients 1 and 2. She stated she and another nurse were looking down at paperwork and Patient 2 grabbed both of their	E 292	***Monitoring*** Nursing Supervisors will monitor nursing units daily for appropriate ratio of sitters to patients as ordered by physicians. Any non-conformity will immediately be corrected and reported to the CNO. ***Responsible Persons*** Chief Nursing Officer	

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E 292	Continued From page 2 hair. RN 1 stated Patient 2 had a one-to-one "sitter" for high risk of leaving the facility without physician order, and because the patient "gets aggressive." During this interview, RN 1 stated, "The next day was the fight between the patients. ... (Patient 2) hit ... (Patient 1) in the face." During an interview with CNA 1 (Certified Nurse Assistant) on 7/8/15 at 11:25 AM, stated that on 6/21/15, she was assigned to "sitter" duties for Patient 1 and Patient 2 who shared the same room. CNA 1 stated Patient 1 was coming out of the restroom inside the patient room when Patient 2 "went and hit ... (Patient 1)." During this interview, CNA 1 stated that she was aware of Patient 2 pulling the nurses hair the day before and was afraid of Patient 2, so she sat in a chair by the doorway to supervise Patients 1 and 2. During a review of the EHR (electronic health record) for Patient 1, Physician Orders dated 6/20/15 at 6:53 AM, indicated an order for "1:1 Observation". During a review of the EHR for Patient 1, Physician Orders dated 6/21/15 at 7:38 AM, indicated an order for "1:1 Observation". During a review of the EHR for Patient 1, Assessment and Care Note dated 6/21/15 at 1:45 PM, indicated Patient 1 "was found with blood and several cuts on lips due to trauma caused by patient next to her." During a review of the EHR for Patient 1, an X-ray result dated 6/21/15, indicated Patient 1 had a fracture of the left lower jaw. During a review of the EHR for Patient 2, Physician Orders dated 6/19/15 at 7:05 PM, and	E 292		

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E 292	Continued From page 3 6/20/15 at 3:41 PM, indicated order for "1:1 Observation". During a review of Patient 2's EHR, Assessment and Cares documentation by nursing staff, dated 6/20/15 at 10:14 AM, indicated Patient 2 had a "1:1 sitter." During a review of Patient 2's EHR, Assessment and Cares documentation by nursing staff, dated 6/20/15 at 4:00 PM, indicated "received pt (Patient 2) very aggressive Ativan given pt with 1:1 sitter monitoring pt." During a review of Patient 2's EHR, Assessment and Cares documentation by nursing staff, dated 6/21/15 at 3:20 PM, indicated "pt with 1:1 sitter became very aggressive starting punching another pt in the face, separated pts...working on transferring pt to a psych facility. Pt place on 5150 (a 72 hour hold for danger to others or danger to self)." 2. Patient 3 was admitted to the facility on 6/23/15 with diagnoses that included unsteady gait. During a random observation of unit 3, room 207, a medical/surgical unit, on 7/9/15 at 9:05 AM, a four-patient room was occupied by four male patients. A staff member was located inside the room and identified himself as a hospital "sitter. During an interview with this hospital "sitter" on 7/9/15 at 9:05 AM, he stated he was assigned to watch three of the four patients inside the room for the duration of his shift on 7/9/15. He stated he "occasionally is assigned one-to-one observation, but not today." He further stated he sits on a chair by the doorway unless one of the patients needs help. During this interview, the	E 292		

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E 292	Continued From page 4 "sitter" stated Patient 3 is being observed because of an unsteady gait and has a history of falling. During an interview with a RN supervisor on 7/9/15 at 9:25 AM, he reviewed Patient 3's EHR and located a physician order dated 7/9/15 for "1:1 Observation." During this interview, the RN supervisor stated the "sitter" for this date was assigned to Patient 3 and two other patients in the same room. He further stated that a 1:1 supervision order means one staff supervises one patient, but further stated implementation depends on the patient mobility in bed, and the staff member assigned to watch the patient may also be assigned more than one patient to observe. During a review of Patient 3's EHR, physician order dated 7/9/15 indicated, "1:1 Supervision" for history of falls and unsteady gait.	E 292		
E2145	T22 DIV5 CH1 ART7-70737(a) Reporting (a) Reportable Disease or Unusual Occurrences. All cases of reportable diseases shall be reported to the local health officer in accordance with Section 2500, Article 1, Subchapter 4, Chapter 4, Title 17, California Administrative Code. Any occurrence such as epidemic outbreak, poisoning, fire, major accident, disaster, other catastrophe or unusual occurrence which threatens the welfare, safety or health of patients, personnel or visitors shall be reported as soon as reasonably practical, either by telephone or by telegraph, to the local health officer and to the Department. The hospital shall furnish such other pertinent information related to such occurrences as the local health officer or the Department may	E2145	E 2145 Reporting ***Corrective Action*** At a staff meeting on 7/22/15, all Quality Management Department staff reviewed CDPH reporting requirements and the hospital's policy on unusual occurrence reporting, emphasizing the importance of immediately faxing a report and not relying on the U. S. mail to deliver a report within the 5-day reporting period. ***Monitoring*** Quality Management will report a minimum of quarterly to the Quality Council regarding the length of time from recognition of an unusual occurrence to the reporting to CDPH of an unusual occurrence. ***Responsible Persons*** Director of Quality & Risk Management	7/22/15

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E2145	Continued From page 5 require. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to report an unusual occurrence of a patient to patient altercation within 5 days to the California Department of Public Health according to the facility Policy and Procedure titled, "Reporting Unusual Occurrences to the California Department of Public Health." This failure had the potential to compromise and threaten the welfare, safety or health of patients. Findings: During an interview with the Director of Quality Management on 7/8/15 at 1:45 PM, she stated unusual incidents should be reported to CDPH (California Department of Public Health) within 5 days. During an interview with the Director of Quality Management on 7/9/15 9:00 AM, she stated the incident was not telephoned in or faxed to CDPH, but was only mailed to CDPH via United States Postal Service on 6/23/15 and "thought it would get to CDPH on time." During this interview, she reviewed the stamped date and time of July 2, 2015 at 3:20 PM that indicated when the facility report of unusual occurrence was received by CDPH. The facility P&P (Policy and Procedure) titled "Reporting Unusual Occurrences to the California Department of Public Health" dated August, 2007, indicated it was the policy of the facility to report unusual occurrences which threaten the welfare,	E2145		

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E2145	Continued From page 6 safety or health of patients, personnel or visitors would be reported as soon as reasonably practical, whether by telephone or by telegraph, to the CDPH (California Department of Public Health). The policy indicated the reporting timeframe would be no later than five days after the adverse event had been detected. The P&P further indicated the facility's Quality Management Department would e-mail the regulatory supervisor at the CDPH as well as e-mailing the sender to validate the delivery. In addition, the hospital Quality Management Department would fax the report to CDPH and secure the fax confirmation sheet to be kept on file for validation purposes.	E2145		
E2243	T22 DIV5 CH1 ART7-70751(g) Medical Record Availability (g) Medical records shall be completed promptly and authenticated or signed by a physician, dentist or podiatrist within two weeks following the patient's discharge. Medical records may be authenticated by a signature stamp or computer key, in lieu of a physician's signature, only when that physician has placed a signed statement in the hospital administrative offices to the effect that he is the only person who: This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure Patient 2's EHR (electronic health record) was complete and contained a discharge summary within two weeks after Patient 2 was discharged. Findings:	E2243	E2243 Medical Record Availability ***Corrective Action*** The discharge summary for Patient 2 was completed on 07/08/15 and added to the patient's record immediately. To assure other patients' discharge summaries are completed within two weeks following discharge, the Director of Health Information Management is tracking completion of discharge summaries on a daily basis and notifying physicians when they have not been completed timely. ***Monitoring*** Rates of completion of discharge summaries within 2 weeks is monitored and reported at monthly Quality Council meetings. ***Responsible Persons*** Director of Health Information Management	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA930000085	A. BUILDING: _____	C 07/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOS ANGELES COMMUNITY HOSPITAL	4081 E OLYMPIC BLVD LOS ANGELES, CA 90023

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E2243	Continued From page 7 During a review of Patient 2's EHR on 7/8/15, the face sheet indicated Patient 2 was discharged from the facility on 6/21/15. During an interview with the Director of Health Information Management on 7/8/15 at 2:00 PM, 17 days after Patient 2 was discharged, he reviewed the EHR for Patient 2 and was unable to locate a discharge summary. He stated the discharge summary had not been dictated by the physician yet. He stated the summary should have been dictated and in the patient's EHR by this date. He further stated that staffing had been low for the department that handles the dictations. During an interview with the Director of Health Information Management on 7/8/15 at 2:55 PM, he stated he was aware the clinical record for Patient 2 was "delinquent and had been flagged." He stated the discharge summary for Patient 2 was being typed at the time of this interview. The facility policy and procedure titled "Discharge and Death Summaries" dated April, 2008, indicated the physician must dictate a concise discharge summary which recapitulated the significant findings and events of the patient's hospitalization and condition on discharge. The policy indicated it was the responsibility of the Health Information Services department to monitor medical records to ensure the proper documentation was present.	E2243		

DEPARTMENTOF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555638	A. BUILDING 01 – **MAIN BUILDING 01** B. WING_____	01/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOS ANGELES COMM HOSPITAL	4081 EAST OLYMPIC BLVD. LOS ANGELES, CA 90023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS This facility was surveyed under the Life Safety Code NFPA 101, 2000 Edition, Chapter 19, Existing Health Care Occupancies, and other applicable codes. The following represents the findings of the California Department of Public Health during a Life Safety Code Survey. Representing the California Department of Public Health: Evaluator 14041, REHS, HFE I	K 000		
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: NFPA 72, 1999 Edition, 208.2.1 Manual fire alarm boxes shall be located throughout the protected area so that they are unobstructed and accessible. Based on observation and interview, the facility failed to ensure that the only manual pull fire alarm device located in the hospital's licensed area was immediately available and visible at all times.	K 050	**Corrective Action** 1. Fire drill conducted in SubAcute. (See Attachment C-1 through C-9.) 2. Inservice was given during the drill in regards to the location of the pull stations in the nurse's area free of any obstacles. (See Attachment C-1 through C-9.) 3. Signage was placed above the nurse station pull device for activating fire alarm. (See Attachments A&B). **Date of Implementation** Fire Drill & Education conducted 1/31/14. **Monitoring Process** All fire drills are reviewed in the EOC/Safety Committee that meets 4 times a year. **Responsible Person** Director of Facilities	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 2/17/14

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K 050	Continued From page 1 Finding: On January 11, 2014, at 1:20 p.m., the evaluator conducted an inspection and observation of the life safety code system fire alarm devices. The evaluator held an interview with Staff 2 regarding the Life Safety Code System. The evaluator asked Staff 2 how she would activate the fire alarm. She stated that there were no manual pull fire alarms in the area and the closest fire alarm box was located near the exit doors outside the licensed area of the hospital. The evaluator held an interview with the building supervisor and he stated, "There is a manual pull alarm located in the nurse station." The evaluator had previously inspected the nurse station and she did not see a manual pull fire alarm. The building supervisor directed the evaluator to a section of nurse station used for the patient monitors and the communication system. A licensed nurse relocated one of the monitors and the evaluator saw a manual pull fire alarm. The computer monitor hid the manual pull fire alarm from view or access and there was no signage or information that manual pull alarm was available in the licensed area of the hospital in case of fire emergency. A review of the fire drills revealed that no one had activated the manual pull alarm at any time. NFPA 101 LIFE SAFETY CODE STANDARD	K 050	**Corrective Action** 1. Fire drill conducted in SubAcute. (See Attachment C-1 through C-9.) 2. Inservice was given during the drill in regards to the location of the pull stations in the nurse's area free of any obstacles. (See Attachment C-1 through C-9.) 3. Signage was placed above the nurse station pull device for activating fire alarm. (See Attachments A&B). **Date of Implementation** Fire Drill & Education conducted 1/31/14. **Monitoring Process** All fire drills are reviewed in the EOC/Safety Committee that meets 4 times a year. **Responsible Person** Director of Facilities	
K 051 SS=D	A fire alarm system with approved components,	K 051		

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K 051	Continued From page 2 devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that all activated smoke detector locations were correctly identified on the main fire alarm panel, in case of a fire emergency. Finding: On January 11, 2014, at 11:11 a.m., the evaluator conducted an inspection and observed a test of the fire alarm system devices. The Building Supervisor activated the patients'	K 051	**Corrective Action** 1. Vendor was called for service. 2. Vendor found a smoke detector that was faulty and replaced. System was tested and all signals were good. (See Attachment D). **Date of Implementation** 1/24/14 **Monitoring Process** Fire alarm systems are tested periodically with reporting to the EOC/Safety Committee that meets 4 times/year. **Responsible Person** Director of Facilities	

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K 051	Continued From page 3 sleeping room smoke detectors. The smoke detector located in room 102 activated and the alarm sounded. The evaluator checked the fire alarm panel and the panel incorrectly identified sleeping room 107 vs. room 102. The evaluator held an interview with the Building Supervisor and he stated that he would have the fire alarm panel serviced as soon as possible. NFPA 101 LIFE SAFETY CODE STANDARD	K 051		
K 061 SS=D	Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the fire sprinkler alarm system was monitored and maintained. Finding: On January 11, 2014, at 11:45 a.m., the evaluator conducted an inspection of the fire sprinkler supervised system. An interview was held with the facility building employee and he stated that the fire sprinkler alarm only sounds when a fire sprinkler is activated or if the fire sprinkler system is drained. The evaluator requested and observed a test of the fire sprinkler system tamper switch. The employee turned off the system control valve that	K 061	**Corrective Action** 1. Vendor was called for service. 2. Vendor replaced tamper switch. Later tested and all signals were good. (See Attachment E-1.) **Date of Implementation** 2/10/14 **Monitoring Process** The sprinkler system is periodically tested and reports of such are shared with the EOC/Safety Committee that meets 4 times/year. **Responsible Person** Director of Facilities	

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K 061	Continued From page 4 is connected to the tamper switch, and no local alarm sounded. The fire sprinkler system tamper switch is designed to alert the facility staff when the fire sprinkler system water is shut off for repairs, inadvertently, or maliciously. The fire sprinkler system shall be electronically supervised to locally alert the facility staff regarding a fire sprinkler flow, tamper, or trouble at all times. An interview was held with the Building Supervisor and he stated that he would have the tamper switch serviced as soon as possible. NFPA 101 MISCELLANEOUS	K 061		
K 130 SS=D	OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: NFPA 72, 1999 Edition, 2-8.2.1 Manual fire alarm boxes shall be located throughout the protected area so that they are unobstructed and accessible. Based on observation and interview, the facility fail to ensure that the only manual pull fire alarm device located in the hospital's licensed area was immediately available at all times. Finding: The evaluator conducted an inspection of the facility's licensed area with one central nurse	K 130		

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K 130	Continued From page 5 station, three smoke compartments, and one manual pull alarm. An interview was held with Staff 2 and she stated that there was no manual pull alarm located in the licensed area and she guided the evaluator outside the smoke compartments to the nearest exit door. The door lead directly outside and the evaluator observed a manual pull fire alarm device located adjacent to the floor. An interview was held with the building engineer and he stated that there was a manual pull fire alarm within the licensed area located in the nurse station. The building engineer led the evaluator to the nurse station and pointed to a patient monitor on a counter top. A licensed nurse sitting nearby pushed aside the monitor to reveal a manual pull alarm that was hidden from view. The evaluator did not observe any signage or indication that a manual pull fire alarm was available in the nurse station in case of a fire emergency.	K 130	**Corrective Action** 1. Fire drill conducted in SubAcute. (See Attachment C-1 through C-9.) 2. Inservice was given during the drill in regards to the location of the pull stations in the nurse's area free of any obstacles. (See Attachment C-1 through C-9.) 3. Signage was placed above the nurse station pull device for activating fire alarm. (See Attachments A&B). **Date of Implementation** Fire Drill & Education conducted 1/31/14. **Monitoring Process** All fire drills are reviewed in the EOC/Safety Committee that meets 4 times a year. **Responsible Person** Director of Facilities	
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		

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K 144	Continued From page 6 This STANDARD is not met as evidenced by: NFPA 110 Standard for Emergency and Standby Power Systems 1999 Edition 6-4.1 Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly. 6-4.1 Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (a) under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating (b) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. NFPA 110 Standard for Emergency and Standby Power Systems 99 Ed 6-2.1, At least two sets of instruction manuals for all major generator components of the EPSS shall be supplied by the manufacturer(s) of the EPSS and shall contain the following: (a) A detailed explanation of the operation of the system (b) Instructions for routine maintenance (c) Detailed repair instructions for the EPS and other major components of the EPSS (d) An illustrated parts list and part numbers (e) Illustrated and schematic drawings of electrical wiring systems, including operating and safety devices, control panels, instrumentation and annunciators NFPA 99, Chapter 3, Electrical System, 3-4.4.1.1, Maintenance and Testing of Alternate Power Source and Transfer Switches (b) 3 Test	K 144	**Corrective Action** Inservice was performed to all plant operations staff in regards to understanding proper testing of the emergency generator and proper documentation. (See Attachments E-2 and E-3.) **Date of Implementation** 2/11/14 **Monitoring Process** Generator testing is reported to the EOC/Safety Committee that meets 4 times/year. **Responsible Person** Director of Facilities	

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K 144	Continued From page 7 Personnel. The scheduled tests shall be conducted by competent personnel. The tests are need to keep the machines ready to function and, in addition, serve to detect causes of malfunction and to train personnel in operating procedures….. The Occupational Safety and Health Administration (OSHA) mandates training in such areas as electrical safety, personal protective equipment, and hazard communication. Relevance to emergency generators should be determined. Based on observation, interview, and record review, the facility failed to ensure that the back up source of power, the generator, was tested and maintained in accordance with the operator manual and by a staff that was trained. The facility failed to ensure that the monthly generator test documentation was fully documented with all the pertinent information regarding the status of the generator. Finding: On January 11, 2014, at 10:30, the evaluator conducted an inspection of the facility's Life Safety Code System. A review of the emergency generator monthly test and maintenance records revealed no information regarding the condition or status of the generator other than check marks, and there was no generator operating manual available at the time of the survey. An interview was held with the Building Supervisor and he stated that there was no documentation regarding the training of the staff in charge of the generator monthly test available	K 144		

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K 144	Continued From page 8 at the time of the survey. In case of a loss of normal power, the emergency back up generator shall be tested and maintained based on the manufacturer's recommendation, all information shall be documented on the generator's monthly test record, and the staff in charge of the monthly test shall be trained and competent.	K 144		

Attachment A



Attachment B



Attachment C-1

ALTA Healthcare

Los Angeles Community Hospital

4081 East Olympic Blvd., Los Angeles Ca 90023

EDUCATION
Training Records

DEPARTMENT: DATE:

TOPIC: Fire Drill / Practice Pull station Activation

SHIFT: LOCATION:

Reason For Class / In Service:

- [x] Mandatory
- [x] Hospital Wide
- [x] Department
- [x] Staff Needs / Request
- [x] Safety
- [x] Risk Management
- [ ] New Product / Procedure
- [ ] Patient Population /
- [ ] Infection Control
- [x] Performanace Improvement
- [x] Annual Update
- [x] Competency
- [ ] Equipment
- [ ] **Other:**

Teaching Methods:

- [ ] Video
- [ ] Slide Presentation
- [x] Lectures
- [ ] Demonstration
- [ ] **Other:**

Instructor: (i.e., Sales Rep., Person with Expertise On Subject):

Jose A. Barahona

Objective (By the Completion of the Class/In-Service the learner will be able to):

EMPLOYEES WILL KNOW LOCATION, AND HOW TO ALARM PULL STATION PREVENT FIRE FROM SPREADING

TRAINING OUTLINE: INFORMED STAFF ABOUT LOCATION OF OXYGEN SHUT OFF VALVE / LOCATION OF NEAREST FIRE

RESPOND TO REAL FIRE & / EVACUATION ROUTE / LOCATION OF AIR CONDITIONING THERMOSTAT / TYPES OF

FIRE EXTINGUISHERS / HOW TO REPORT FIRE / HOW TO USE FIRE EXTINGUISHER / HOW TO EVACUATE

Class Outline: (May attach outline if there is one available): *SCHEDULE AND TRAINING ADJUSTED TO COMPLY WITH CDPH FINDING REQUEST***

SEE ATTACHED: PAGE 3 TO 5

Evaluation:

- [ ] Quiz
- [ ] Written Evaluation
- [ ] Return Demonstration
- [x] Discussion
- [ ] **Other:**

INSTRUCTOR: Jose A. Barahona.

SIGNATURE: Jose A. Barahona. TIME 2:45 DATE: 1.31.14

ALTA Healthcare

Los Angeles Community Hospital
4081 East Olympic Blvd., Los Angeles Ca 90023

EDUCATION
Training Records

FIRE / LIFE SAFETY

The mission of Fire and Life Safety management is to support the hospital in maintaining a safe environment for our patient, Visitors, and employees.
In the entire field of fire life safety, nothing is more important than prevention!

Prepare For The Fire:

- Keep fire alarm pull boxes, fire extinguishers, sprinkler heads, and smoke detectors free from obstruction.
- Keep corridors, passageways and exits clear at all times.
- Know the locations of the nearest fire alarm pull boxes and fire extinguishers in your area.
- Know the location of the closest exits, evacuation routes and what to do in response to the fire alarm
- Keep work areas and storage rooms free from combustible clutter and debris.
- Report defective electrical equipment, blocked exits, stairways, and fire doors to your Supervisor.
- DO NOT BLOCK EXITS.

Possible causes of fires include:

- Electrical equipment and small appliances;
- combustible materials-such as paper, cardboard boxes, dirty linen – pile up;
- Carelessness with oxygen;
- Arson.
- Keep an eye out for all these problems, and report them as appropriate.

Types of Fire:

CLASS "A"
fires occur in combustible solids, like paper, linen, and clothing. Can be extinguish by water.

CLASS "B"
Fires involving flammable liquids, such as gasoline, oil, alcohol, benzine, etc., which are best extinguished by smothering. (This includes food on the stove fires.)

CLASS "C"
Fires involving electrical equipment, appliances and wiring in which the use of non-conductive extinguishing agent prevents injury.

THE MAJORITY OF LACH & NCH FIRE EXTINGUISHERS ARE: **ABC TYPE**

The Fire Response Plan – RACE

- **RESCUE / The highest priority are saving people's Lives**, the first step is to get everyone out of the room or area where the fire is. We are especially concerned about patients who can't take care of themselves. Employees and visitors with disabilities will also need special attention.
  When leaving the room be sure to shut the doors behind you. They should latch, but not lock, so the fire fighters can get in when they arrive.

- **ALARM / Activate alarm.** (Know Location of Nearest Pull Station) Activating alarm ensures that the building occupants are alerted to the emergency and fire department is notified. call the PBX operator to report the fire. Be sure to take this step immediately after rescuing, so that the appropriate emergency response personnel are notified and can start to the scene of the fire.

  In addition to the alarm, call the emergency number- 911

  DIRECT OPERATOR HOTLINE:
  LACH Ext. 555 NCH Ext. 77

- CONTAIN / The third step is to keep the fire – and smoke – from spreading. Close each door and window in the area.
  If fire threatens your area, initiate the following procedures:

  a. Turn off all fans, air-conditioning, exhaust fans, etc.
  b. Turn off all electrically operated equipment, however leave the lights on.
  c. In case of an electrical fire, power is to be turned off at the main switch.
  d. Keep telephone lines clear.
  e. Close all doors and windows.
  f. Use the fire extinguisher to suppress the fire only if you have been trained and it is safe to do so.
  g. Notify the Control Center when you are in readiness for evacuation.
  h. Standby for orders.

  If the fire is not in your area, be alert, be guided by the instructions of your area supervisor, or Director of Plant Operations.

  a. Area supervisors will direct activities of staff members within their units by:
     - Assigning personnel to take fire extinguishers and reporting to the scene of the fire.
     - Turning off all fans, air-conditioning, exhaust fans.
     - Turning off utilities as required.
     - Turning off oxygen shut-off valves as required.
     - Closing all doors and windows.
     - Standing by for further orders.

- EXTINGUISH / When you reach the fourth step, it is time to attempt to extinguish the fire, by using a fire extinguisher.

The steps to Putting Out a Fire – PASS

- PULL the pin. / Break the plastic tie by turning the pin like a key in a lock, and then pull the pin out. Don't squeeze the handle while doing this.

- AIM the hose, horn at the base of the fire. Water extinguisher will shoot 30-40 feet when fully charged. The other kinds require you to get up to 8-10 feet away, or even closer.

- SQUEEZE the handle.

- SWEEP the stream from side to side, covering the material that is burning.

Evacuation

It is important for each employee to know their department's specific evacuation procedures. If evacuation is required, give special attention to children and person with disabilities. Go to your appropriate relocation point and verify that everyone from your area is accounted for. If someone is missing, notify fire department personnel on scene.

C-4

Los Angeles Community Hospital

SHIFT:	DAY	✓
	SWING	
	NIGHT	

FIRE OBSERVATION REPORT

DATE: 1-31-14

OBSERVERS LOCATION: Sub Acute

☑ Simulated Situation ☐ Fire ☐ Smoke ☐ Other _____

CAUSE & SOURCE OF FIRE:

☐ Bed ☑ Wastebasket ☐ Electrical ☐ Laundry ☐ Medical Gas
☐ Explosion ☐ Paper ☐ Wood ☐ Other _____

EXTENT OF FIRE:

☐ Large ☑ Small

INSTRUCTIONS:
Place "yes" in the blank space if conditions are satisfactory and "no" in space if unsatisfactory.

SAFETY OF LIFE

Yes ☐ No ☑ Occupant removed from the room. Simulated
Yes ☑ No ☐ closed to fire room.

NOTIFICATION / COMMUNICATION

Yes ☑ No ☐ Did Staff sound the alarm when the fire was recognized?
Yes ☑ No ☐ Did Staff sound the alarm by pulling down on the alarm box?
Yes ☑ No ☐ Notification from fire area to the PBX
Yes ☐ No ☑ Was the Fire department called? By who? Simulated
Yes ☑ No ☐ Administrator Paged? By who? PBX
Yes ☑ No ☐ Was fire alarm audible?
Yes ☑ No ☐ Was the page audible? Was the location clear?
Yes ☑ No ☐ "All Clear" sounded to all departments?

ORDERS

Yes ☑ No ☐ Was on duty personnel reported to assigned area and remained for orders?
Yes ☑ No ☐ Was personnel stationed at the telephone for further orders?
Yes ☐ No ☑ Was personnel sent to meet and direct the Fire Department? Sim
Yes ☐ No ☑ Were elevators brought down and held on the main floor? Sim.

RETURN/REPORT TO FIRE LOCATION

Yes ☑ No ☐ Were all doors closed?
Yes ☑ No ☐ Were Fire Extinguishers taken to the to the fire area?
Yes ☑ No ☐ Did Staff simulate fire extinguishment?
Yes ☑ No ☐ Did Staff know their specific fire response duties?

EVACUATION

C.5

_____ Horizontal (at least one set of fire doors)
_____ Vertical
_____ Total
Yes ☑ No ☐ Was Staff prepared to evacuate the building?

PATIENT AND VISITOR SAFETY

Yes ☑ No ☐ Were all exits and passageways leading to exits kept clear?
Yes ☑ No ☐ Were Patients and visitors escorted to a safe area?
Yes ☑ No ☐ Did personnel assisted in calming Patients and visitors?

EQUIPMENT AND APPLIANCES

Yes ☐ No ☑ Were gas appliances turned off
Yes ☐ No ☑ Were electrical equipment shut down? (Not lights) Sin dato
Yes ☐ No ☑ was it necessary to shut off oxygen?
Yes ☐ No ☑ Were HVAC systems shut off

PROTECTION OF HOSPITAL SUPPLIES AND RECORDS

Yes ☑ No ☐ Were the narcotics cabinets locked?
Yes ☐ No ☐ Were all cash, books, ledgers, charts & files prepared for removal?

INTERIM LIFE SAFETY MEASURES (ILSMS) (Los Angeles Community Hospital)

Before actual fire or Fire Drill:

Yes ☐ No ☑ Did Engineering, Security, or Housekeeping personnel SHUT OFF the air conditioning unit switches in the corridor adjacent to room 105 and 106. Sin

After actual fire or Fire Drill:

Yes ☐ No ☑ Did Engineering, Security, or Housekeeping personnel TURNED the air conditioning unit switches in the corridor adjacent to room 105 and 106. Sin

REMARKS AND RECOMMENDATIONS

Note: Reports to be made out immediately after each drill by the unit/department supervisor
Reports shall be sent to the Director of Plant Operations

Comments: No issues to Report.

1.31.14 / 2:45
Date / Time

Jose A. Barahona / Engineer. / Jose A. Barahona
Name / Position /Title / Signature

C-6

ALTA Healthcare

Los Angeles Community Hospital

4081 East Olympic Blvd., Los Angeles Ca 90023

Fire Drill Critique

Date: 1-31-14		Shift: day		
Location	Sub Acute	Fire Dept. Notified	☐ YES	☑ NO
Coordinator	Mohammad Davani	Drill Started	2:15 pm	
Engineer	Jose Barahona	Drill Ended	2:45 pm	
Safety Officer	Jim Ruiz			

✓	TYPE of Fire	✓	In-service Training
X	A- Wood, Paper, Rubbish	X	Verbal Critique
	B- Flammable, Oil, Gas	√	Hand0ut Training Memos
	C- Electrical		
	D-		

✓	Initiator Response	✓	Department Response
	Called Fire Department (911) NO	√	Administration
√	Called Operator (Ex. ~~555~~) ~~777~~	√	Admitting
	Called Emergency (911) NO	√	Security
√	Pulled Fire Alarm Pull Station	√	Engineering / Safety Officer

✓	PBX Operator Response	✓	Equipment Response
√	Time Before Announcement	√	First Bells Sounded
√	3 Time "Code Red (Location)"	√	Door Closed and Latched
√	Notified Appropriate Personnel		Oxygen was Shut Off Simulated
√	3 Time "Code Red All Clear"	√	Alarm System Was Reset

GENERAL RESPONSE			
✓	PBX Operator Response	✓	Equipment Response
	Excellent		Slow
√	Good	√	Calm
	Fair		Exited
	Poor		Panic

OBSERVATION MADE FROM: Unit 3

SIGNATURE: Brian Mulloy TIME 2:45 DATE: 1-31-14

C-7

ALTA Healthcare

Los Angeles Community Hospital

4081 East Olympic Blvd., Los Angeles Ca 90023

EDUCATION
Training Records

ATTENDANCE RECORD:

Date: 1.31.14

No.	NAME (PLEASE PRINT)	TITLE / DEPARTMENT	SIGNATURE
1	SILVIA ARBOLEDA	HIS	[signature]
2	Remy Miranda	HIS	[signature]
3	Martha Marquez	S/A	Martha Marquez
4	M GONZALEZ	ICU	[signature]
5	HECTOR CASTILLO	CNA/SKA	[signature]
6	Uracha Pinto	S/A	[signature]
7	Ana Capristo	CNA	[signature]
8	W. GIMETE	RN / Unit IV	[signature]
9	RICHARD GONSALVES	LAB	[signature]
10	Christine Joh	Pharmacy	[signature]
11	Claudia Rivera	CNA	[signature]
12	OCTAVIO LUNA	C.S.	[signature]
13	[illegible]	[illegible]	[signature]
14	NELSON TOGA	LVN/S/A	[signature]
15	MEALY MIN	S/A	[signature]
16	Arnold Sanchez	LVN	[signature]
17	[illegible]	RN	[signature]
18	Victor Paz	RN	[signature]
19	PINKY LITUANAS	PT	[signature]
20	Cesar Lopez	S/A	[signature]
21	Cegan	PT-WC	[signature]
22	Brian Gutierrez	ENG	Brian Gutierrez
23			

C-8

Los Angeles Community Hospital

4081 East Olympic Blvd., Los Angeles Ca 90023

SHIFT:	DAY	✓
	SWING	
	NIGHT	

Fire Drill Attendance Sign Sheet

Date: 1.31.14	Time: 2:15	Location: Sub Acute.

No.	Name:	Department:	Fire Ext.
1	[illegible]	LAB	
2	Christine Joh	Pharmacy	
3	[illegible]	U-4	
4	[illegible]	M/S	
5	Antonio Salazar	Resp.	
6	Claudia Rivera	M/S	
7	OCTAVIO LUNA	C.S.	
8	[illegible]	Icy	
9	NELSON TOBAR	S/A	
10	Arnold Sanchez	LVN	
11	MEALY MIN	SA	
12	SHENAN MERZA	SA	
13	Melissa Acero	SA	
14	ANNA PASTORES	SA	
15	DANIELLE JAMES	SA	
16	PINKY LITUANAS	PT	
17	[illegible] SHIRTICK	ACC-SB	
18	Catherine [illegible]	PT-WC	

FIRE DRILL TOPIC:

C-9

Los Angeles Community Hospital

4081 East Olympic Blvd., Los Angeles Ca 90023

SHIFT:	DAY	✓
	SWING	
	NIGHT	

Fire Drill Attendance Sign Sheet

Date: 1.31.14	Time: 2:15	Location: Sub Acute

No.	Name:	Department:	Fire Ext.
1	BOCFERIA	PEDS	
2	Isabel Vindel	S/A	
3	[illegible]	[illegible]	
4	[illegible]	[illegible] S/A	
5	FLORENCIO CRUZ	S/A	yes
6	SILVIA ARBOLEDA	HIS	
7	Remy Miranda	HIS	yes
8	M Gonzalez	ICU	yes
9	Martha Marquez	S/A	yes
10	Ana Capristo	S/A	
11	Hector Castillo	S/A	
12	W. GIMETE	OB UNIT IV	[illegible]
13	David Gale	[illegible] S/A	[illegible]
14	MARIANO RESTO	[illegible]	
15	Eric Abarca	E.R.	
16	Caroline Henderson SKN	Tele	
17	[illegible]	ER	
18	Victor Paz [illegible]	[illegible]	

FIRE DRILL TOPIC:

Attachment D

MID VALLEY AUTOMATIC FIRE PROTECTION SYSTEMS, INC.

347 Paseo Sonrisa
Walnut, CA 91789
(909) 594-4060 FAX: No. (909) 595-9828
www.midvalleyfire.com

WORK ORDER

№ A14102

DATE: 1/24/14

CUSTOMER NAME: Los Angeles Community Hospital

ADDRESS: _____

CITY: Los Angeles STATE: CA ZIP: _____

JOB LOCATION: _____

WORK DONE BY: Mary + Jon

PO#: _____

Smoke detector trouble

QUANTITY	ITEM	DESCRIPTION	PRICE	TOTAL
		Need to replace smoke detector on 1st fl. Patient Rm. #5.		
		Replaced smoke detector and fire alarm is now Normal, System Normal,		
		Mary		
		Trouble shoot 2 HRS.		190.00
		Replace w/ new 2 HR. minimum		190.00
				380.00

SUMMARY OF INSPECTION: _____

X Josh A. Berkhoan
CUSTOMERS SIGNATURE

Attachment E-1

MID VALLEY AUTOMATIC FIRE PROTECTION SYSTEMS, INC.

347 Paseo Sonrisa
Walnut, CA 91789
(909) 594-4060 FAX: No. (909) 595-9828
www.midvalleyfire.com

WORK ORDER

№

Alta Hospitals

DATE: 2/10/14

CUSTOMER NAME: Fox - Los Angeles Community Hospital

ADDRESS: 4081 Olympic Bl.

CITY: Los Angeles STATE: Ca ZIP: 90023

Acct # WK50131

JOB LOCATION:

WORK DONE BY: Harry

PO#:

* Check Tamper *

QUANTITY	ITEM	DESCRIPTION	PRICE	TOTAL
1	OS+Y	* Checked existing tamper and it was not operational. I showed George Martinez and he agreed that existing tamper was not operational. I replaced with a new potter OS+Y tamper and tested zone 1. operational and normal. (Alter Tamper) → * I was also instructed that system was not monitored anymore by Simplex so I got acct. Info from John Martinez at our office and I reprogrammed silent knight dialer to our central station and tested. System normal. Acct # is WK50131 Harry		

SUMMARY OF INSPECTION:

CUSTOMERS SIGNATURE

E-2

ALTA Healthcare

Los Angeles Community Hospital
4081 East Olympic Blvd., Los Angeles Ca 90023

EDUCATION
Training Records

DEPARTMENT: **Engineering** DATE: **2-11-14**

TOPIC: Testing and documenting of Emergency Generator

SHIFT: **1st Shift (Day)** LOCATION: **Generator Area**

Reason For Class / In Service:

- [x] Mandatory
- [x] Hospital Wide
- [ ] Department
- [ ] Staff Needs / Request
- [ ] Safety
- [ ] Risk Management
- [ ] New Product / Procedure
- [ ] Patient Population /
- [ ] Infection Control
- [ ] Performanace Improvement
- [ ] Annual Update
- [ ] Competency
- [x] Equipment
- [ ] **Other:**

Teaching Methods:

- [ ] Video
- [ ] Slide Presentation
- [ ] Lectures
- [ ] Demonstration
- [ ] **Other:**

Instructor: (notified Engineering staff of location of Manuals):
A COPY OF GENERATOR MANUAL IS LOCATED AT THE ENGINEERING OFFICE AND INSIDE THE GENERATOR ENCLOSURE.

Objective (By the Completion of the Class/In-Service the learner will be able to):
1.UNDERSTANDING THE EMERGENCY GENERATOR TESTING PROCESS AND THE PROPER DOCUMENTATION OF THE RESULTS. WE MUST INDICATE PROPER LEVELS AND OR RESPONSES NOT ONLY CHECK MARKS.

Class Outline: (May attach outline if there is one available):
*******THIS IS TRAINING IS TO COMPLY WITH CDPH FINDING *******

Evaluation:

- [ ] Quiz
- [ ] Written Evaluation
- [ ] Return Demonstration
- [x] Discussion
- [ ] **Other:**

INSTRUCTOR: MARTIN RODRIGUEZ / JIM RUIZ /GEORGE MARTINEZ

E-3

ALTA Healthcare

Los Angeles Community Hospital

4081 East Olympic Blvd., Los Angeles Ca 90023

EDUCATION
Training Records

ATTENDANCE RECORD:

Date: February 11 2014

No.	NAME (PLEASE PRINT)	TITLE / DEPARTMENT	SIGNATURE
1	BENNY ANAYA	HVAC MECHANIC/ENG.	
2	Brian Gutierrez	ENG	Brian Gutierrez
3	HIPOLITO. ORTEGA	ENG	Hipolito Ortega
4	Jose A. Barchona	Eng.	Jose A Barchona
5	Jose Romero	Eng. Dept.	
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RESPONSE TO DEFICIENCIES
EXHIBIT P CMS Statements of Deficiency

Newport Specialty Hospital
(Now called Foothill Regional Medical Center)

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555710	A. BUILDING _____ B. WING _____	04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWPORT SPECIALTY HOSPITAL D/P SNF	14662 Newport Ave, Tustin, CA 92780-6064 ORANGE COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	The following reflects the findings of the Department of Public Health during a Comp'aint Investigation visit: CLASS B CITATION – PATIENT CARE 06-2207-0011387-F Complaint(s): CA00434111 Representing the Department of Public Health: Surveyor ID # 27007, HFEN The inspection was limited to the specific facility event investigated and does not represent the find ngs of a full inspection of the facility. Accidents and Supervision F323 G. The facility must ensure that the resident environment remains as free of accident hazards as is possible, and each resident receives adequate supervision and assistance devices to prevent accidents The facility failed to ensure Resident 1 was as free from accident hazards as possible Resident 1 was nonverbal, had contractures to her arms and hands, and was unable to move her extremities On 1/18/15, while attempting to dry Resident 1's hair, LVN 1 left a hairdryer on and placed in close proximity to Resident 1's left hand A few hours later, a staff member noticed Resident 1 had sustained blisters from a second degree burn to her left hand and left shoulder. Review of an article titled Hair Dryer Burns in Children published in 1990, by the Official Journal of the American Academy of Pediatrics showed	F323 G	Corrective actions for the affected resident: • Upon discovery of Resident's skin impairment, the physician was called, orders obtained and treatment was immediately initiated. • Consults obtained from wound care nurse and Infectious Disease physician. • Facility conducted a thorough investigation, including interviews with all staff. • Family was immediately notified upon discovery, and kept apprised of the resident's condition, plan of care, and told of the facilities plans to conduct a formal investigation. • Hairdryer was immediately removed from patient room. Hairdryers to be kept at nurses' station and checked out for use with patients, January 2015. • Safety check of hairdryer was done by engineering, January 2015. • Treatment was successful, and no longer required as of 3/12/2015. Wound healed completely, and without any scaring. The Director of Nurses was responsible to ensure the above mentioned actions were taken.	1/18/2015 1/24/2015 2/3/2015 1/18/2015 1/19/2015 1/24/15 3/12/2015

Event ID 5OLP11 4/14/2015 9:01:57AM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

CSO 4/14/15

By signing this document, I am acknowledging receipt of the entire citation packet. Page(s) 1 thru 7

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

State-2567

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555730	A. BUILDING _____ B. WING _____	04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWPORT SPECIALTY HOSPITAL DIP SNF	14662 Newport Ave, Tustin, CA 92780-6064 ORANGE COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	testing of home hairdryers was done to determine their heat output. At the highest heat settings, the hairdryers rapidly generated temperatures in excess of 110°C (230 degrees F). After the hairdryers were turned off, the protective grills maintained sufficient temperatures to cause full-thickness burns for up to 2 minutes. These cases and the results of testing demonstrate that hairdryers must be added to the list of known causes of accidental and non-accidental burns in children. www.medicinenet.com showed a first degree burn is superficial and causes local inflammation of the skin. Sunburns often are categorized as first degree burns. The inflammation is characterized by pain, redness, and a mild amount of swelling. The skin may be very tender to touch. A second degree burn is deeper than a first degree burn and in addition to the pain, redness and inflammation, there is also blistering of the skin. Clinical record review for Resident 1 was initiated on 3/16/15. Resident 1, a pediatric, was admitted to the facility on 11/29/08, with diagnoses including severe encephalopathy, quadriplegia, and near vegetative state. Review of the computerized note (untitled) dated 1/18/15, showed Resident 1 was identified to have blisters to her left hand. The "primary nurse and CNA are unaware of how it may have happened." Review of the Nursing Progress/Summary Notes dated 1/18/15 at 1500 hours, identified Resident 1	F323 G	How the facility will identify other residents having the potential to be affected by the same deficit practice and what corrective action will be taken: ▪ Routine daily skin assessments of all residents are performed by the primary nurse each shift. ▪ Weekly comprehensive skin assessments will be performed by charge nurse and monitored daily for any identified skin issue. ▪ Ongoing spot checks of Hair Dryer usage to ensure that proper usage techniques are followed. The Director of Nurses is ultimately responsible to ensure the above actions are taken. All resident skin assessments completed. NO other residents affected.	1/18/2015 1/18/2015 4/22/15 LM ~~4/15/15~~ Ongoing 1/18/15 LM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555730	A. BUILDING _____ B. WING _____	04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWPORT SPECIALTY HOSPITAL D/P SNF	14662 Newport Ave, Tustin, CA 92780-6064 ORANGE COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	had blisters to her left hand. At 2000 hours, staff documented there were multiple open, weeping fluid blisters to her left hand. On 1/19/15 at 1030 hours, staff documented Resident 1 also had a small blister to her left shoulder. Review of Resident 1's physician's order dated 1/20/15 at 1015 hours showed to administer Motrin and Tylenol (alternate) every four hours for 48 hours for pain prophylaxis. On 1/22/15 at 1315 hours, a physician's order was received to administer Motrin 220 mg via GT every eight hours for four days for pain. Review of Resident 1's Comprehensive Skin Assessments showed the following: * On 1/18/15 at 1600 hours, showed blisters and redness to the dorsal aspect (back) of Resident 1's left hand. The photograph showed multiple raised, fluid filled blisters. Staff documented if the blister was to open to apply Bacitracin (antibiotic) ointment four times a day for 10 days. * On 1/20/15 at 1100 hours, Resident 1's left hand blisters opened and draining serous fluid. The affected area measured 6 cm (length) x 4 cm (width). Staff documented Bacitracin ointment was to be started after the C&S of the left hand blister drainage was obtained. The photograph showed some of the blisters had popped and others remained filled with fluid. * On 1/23/15 at 0900 hours, the left hand blisters and redness were present and continued to be	F323G	What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: • New Equipment Usage policy, effective January 2015. Emphasized using all unit equipment only for the manufacturer's intended purpose, and included mandatory education of patient families wishing to use facility equipment to participate in the care of their family member. • New Treatment of Hypothermia policy, effective January 2015. Outlines appropriate use of Bair Hugger for patient warming, appropriate heat settings, and guidelines for monitoring patient while Bair Hugger is in use. • Hairdryers were immediately removed from patient rooms. • New lower wattage, short shaft hairdryers were ordered for the unit, 4/15/2015. • Hair dryer competency to be completed by all nursing staff, applicable to their patient care role. (DSO) • All staff educated by DON and Quality & Risk Director about the use of equipment, treating hypothermia, as well as informed about hairdryer usage and the need to monitor families use of such equipment. Staff also encouraged to actively participate in ongoing investigation and unit improvement activities The Director of Nurses will be ultimately responsible to ensure the above written action plan is followed.	1/27/2015 1/27/2015 1/18/2015 4/22/15 LH ~~4/15/2015~~ 4/22/15 LH ~~4/16/2015~~ 2/3/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIF CATION NUMBER	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555730	A BUILDING _____ B WING _____	04/13/2015

NAME OF PROVIDER OR SUPPL ER	STREET ADDRESS CITY STATE ZIP CODE
NEWPORT SPECIALTY HOSPITAL D/P SNF	14662 Newport Ave, Tustin, CA 92780-6064 ORANGE COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	treated with Bacitracin ointment. * On 1/26/15 at 1800 hours, Resident 1's left hand blisters were assessed to be a second degree burn * On 1/29/15 at 2000 hours, staff documented all of Resident 1's blisters had popped The treatment was changed to Silvadene cream (medication used to treat burns) daily and to cover with a non-stick dressing for seven days On 3/10/15 at 1000 hours, staff documented Resident 1's left hand wound had completely healed Review of Resident 1's Doctors' Progress Note dated 1/24/15, showed an evaluation was completed by an Infectious Disease Consultant The doctor documented Resident 1 had a recent appearance of blisters over the left dorsal hand and fingers, and to treat the blisters as a "second degree burn" injury. Review of a (untitled) document dated 3/11/15 at 1616 hours, showed on 2/5/15 the left hand (blisters) healing well and appeared to be in much less pain. Review of the Restorative Administration Record for January 2015 showed Resident 1 was to have PROM to her upper extremities and the application of bilateral elbow extensor splints for 12 hours a day five days per week However, the RNA documented on the reverse side of the sheet from 1/20/15 to 1/30/15, the PROM and left hand splint were not provided due to the resident's left hand	F323G	How the facility plans to monitor its performance to make sure that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for effectiveness: • Daily routine daily skin assessments will be performed by the primary nurse and documented in the resident's medical record. • Weekly comprehensive skin assessments will be performed by charge nurse and monitored daily for any identified skin issue. • Quarterly reports of the results of skin assessment and reassessments will be submitted to Peds Committee, Quality Patient Safety Committee, Medical Executive Committee, and Governing Board To continue through 2015 and evaluated during annual evaluation. • Hair dryer competency to be completed by all new hires, and annually. This will be performed by the DSD. A competency report of findings will be submitted to the Pediatric Medical Staff Committee, Medical Executive Committee, and Governing Board. • Weekly spot checks of hairdryer usage to be done by charge nurses and data collected for at least 6 months with reevaluation to determine the need to continue. Results to be reported to DON and Director of Quality/Risk Management on a monthly basis. The Director of Nurses will be ultimately responsible to ensure the above written action plan is followed.	Ongoing since 9/2014 Ongoing since 9/2014 4/22/15 LM ~~4/16/15~~ 4/22/15 LM ~~4/16/15~~ 4/22/15 LM ~~4/16/15~~

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555730	A. BUILDING _____ B. WING _____	04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWPORT SPECIALTY HOSPITAL D/P SNF	14662 Newport Ave, Tustin, CA 92780-6064 ORANGE COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE

wound.

On 3/16/15 at 1405 hours, Resident 1 was observed sitting in her wheelchair next to her bed. She was unable to respond to verbal commands. Her arms and hands were contracted and the top of her left hand had multiple skin (pigment) discolorations as a result of the burn.

On 3/16/15 at 1455 hours, Resident 1's attending physician was interviewed. The physician stated Resident 1 had limited movement in her extremities and required total assistance from the staff for all ADL care. When asked how Resident 1 sustained the burn to her left hand, the physician stated he could not think of anything "hot enough" to cause a burn, but the item would have to be very close (to the left hand).

An interview with RN 1 was conducted on 3/16/15 at 1540 hours. RN 1 stated Resident 1 was showered every day on the day shift. She stated the resident's hair was washed during the showers.

On 3/16/15 at 1550 hours, an interview was conducted with CNA 1. CNA 1 stated before the burn to the resident's left hand, the resident's family and staff used a hairdryer to dry the resident's hair. CNA 1 stated the hairdryer was stored in Resident 1's room but had been removed after the 1/18/15 incident.

On 3/16/15 at 1605 hours, an interview was conducted with LVN 1. LVN 1 stated she was assigned to work as a caregiver for Resident 1 on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555730	A. BUILDING _____ B. WING _____	04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWPORT SPECIALTY HOSPITAL D/P SNF	14662 Newport Ave, Tustin, CA 92780-6064 ORANGE COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	1/18/15. LVN 1 stated on the morning of 1/18/15, she gave Resident 1 a shower and washed her hair. She stated while Resident 1 was still lying on the shower gurney, she took the hairdryer from Resident 1's bedside to dry the resident's hair. LVN 1 stated when she was going to dry the back of her hair, she took the hairdryer from her left hand and placed it down near the top of the gurney, on the left side, so she could raise Resident 1's head. She stated the hairdryer was remained on while she was repositioning the resident's head. LVN 1 stated Resident 1's arms/hands were contracted (when lying down the resident's hands were up by her head) and the heat from of the hairdryer was blowing in the direction toward the resident's left hand. When LVN 1 was asked if she thought the burn could have been caused by the hairdryer being left on and placed at the head of the shower gurney, she stated the hairdryer was "the only thing it could have been." When LVN 1 was asked if the burn to Resident 1's hand could have been prevented, she stated "yes." She stated she could have placed Resident 1 in a wheelchair before she dried her hair, like she had seen other CNAs do. When LVN 1 was asked if she was aware of Resident 1's left shoulder blister that was observed on 1/19/15, she stated "no." During an interview on 3/16/15 at 1635 hours, the DON stated Resident 1 required total care from the staff for all her ADL care. When asked how Resident 1 sustained the burn to her left hand, the DON stated she was unable to determine the cause. The DON stated since the incident to Resident 1's left hand, all hairdryers had been			

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removed from all residents' rooms and were to have a safety check by the Maintenance Director

The facility's failure had a direct or immediate relationship to the health safety or security of long-term health care facility residents

State of California--Health and Human Services Agency
Department of Public Health

KAREN L. SMITH, MD, MPH
Director and State Health Officer

EDMUND G. BROWN JR.
Governor

April 8, 2015

Barbara Schneider, Administrator
Newport Specialty Hospital
14662 Newport Avenue
Tustin, CA 92780

Dear Ms. Schneider:

FACILITY: Newport Specialty Hospital
ENTITY REPORTED INCIDENT NUMBER'S: CA00325828 and CA00329252

The purpose of this letter is to inform you of the results of our entity reported incident investigation's completed on March 24, 2015.

Attached you will find a Statement of Deficiencies and Plan of Correction (CMS 2567), indicating that no deficiencies were found during this investigation. Please sign and date this document and return it to the department. Please make a copy for your facility.

Sincerely,

Hang Nguyen

Hang Nguyen, RN, MSN
District Manager
Orange County District Office

HN/sd

Enclosure *(CMS 2567)*

Licensing and Certification Program, 681 S. Parker Street, Suite 200, Orange, CA 92868
Telephone: (714) 567-2906 / Fax: (714) 567-2815
Internet Address: www.cdph.ca.gov

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA06000013	A. BUILDING: _____ B. WING _____	C 03/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWPORT SPECIALTY HOSPITAL	14662 NEWPORT AVENUE TUSTIN, CA 92780

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A 000	Initial Comments The following reflects the findings of the California Department of Public Health during the investigation of Entity Reported Incident No. CA00325828 and CA00329252. Inspection was limited to the specific Entity Reported Incident(s) investigated and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: Surveyor 2097, HFES. THE DEPARTMENT SUBSTANTIATED THE ENTITY REPORTED INCIDENTS THAT DID NOT CONSTITUTE A VIOLATION OF THE REGULATIONS.	A 000		
A 001	Informed Adverse Event Notification Health and Safety Code Section 1279.1 (c), "The facility shall inform the patient or the party responsible for the patient of the adverse event by the time the report is made." The CDPH verified that the facility informed the patient or the party responsible for the patient of the adverse event by the time the report was made.	A 001		
A 010	1279.1(b) HSC Section 1279 (b) For purposes of this section, "adverse event" includes any of the following: This Statute is not met as evidenced by:	A 010		

California Department of Public Health

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A 010	Continued From page 1	A 010		
A 031	1279.1(b)(4)(F) Stage 3 or 4 ulcer acquired after admission (b) For purposes of this section, "adverse event" includes any of the following: (4) Care management events, including the following: (F) A Stage 3 or 4 ulcer, acquired after admission to a health facility, excluding progression from Stage 2 to Stage 3 if Stage 2 was recognized upon admission. This Statute is not met as evidenced by:	A 031		

State of California-Health and Human Services Agency
California Department of Public Health

Ron Chapman, MD, MPH
Director & State Health Officer

EDMUND G. BROWN JR.
Governor

January 26, 2015

Letter 1

IMPORTANT NOTICE – PLEASE READ CAREFULLY

Lawrence Bottorff, Administrator
Newport Specialty Hospital
14662 Newport Avenue
Tustin, CA 92780

Dear Mr. Bottorff:

On January 15, 2015, an abbreviated survey for complaint no. 426078 was conducted at your facility by the California Department of Public Health, Licensing and Certification Program (State Agency), to determine if your facility was in compliance with federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs.

The enclosed Centers for Medicare and Medicaid Services (CMS) form, entitled "Statement of Deficiencies and Plan of Correction" (CMS-2567), documents that no deficiencies of participation requirements were identified during this visit. Please sign, date, and return this form to our office (see address below) by February 6, 2015.

If you have questions concerning the instructions contained in this letter, please contact Kathleen Davidson, District Administrator at 714-567-2906.

Sincerely,

Hang Nguyen

Hang Nguyen, RN
Orange County District Office

Enclosure: CMS-2567

HN/ap

Licensing and Certification, 681 S. Parker Street, Suite 200, Orange, CA 92868
Telephone: (714) 567-2906 / Fax: (714) 567-2815
Internet Address: www.cdph.ca.gov

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an ABBREVIATED SURVEY for investigation of COMPLAINT No: CA00426078. Inspection was limited to the specific complaints investigated and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: Surveyor 27007, HFEN. THE DEPARTMENT WAS ABLE TO PARTIALLY SUBSTANTIATE THE COMPLAINT ALLEGATION(S) AND FOUND NO VIOLATION OF THE REGULATIONS.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Barbara Dell | CEO | 1/21/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

EMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555730	A. BUILDING _____ B. WING _____	09/30/2014

E OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NPORT SPECIALTY HOSPITAL	14662 NEWPORT AVENUE TUSTIN, CA 92780

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000	INITIAL COMMENTS	F 000		

The following reflects the findings of the California Department of Public Health during a RECERTIFICATION survey.

Representing the California Department of Public Health: Surveyor 28950, HFEN; Surveyor 29767, HFEN; and Surveyor 34325, HFEN.

The surveyors entered the facility on 9/3/14 at 0730 hours. The census was 21.

This Plan of Correction constitutes my written credible allegation of compliance to the deficiencies noted.

GLOSSARY OF ABBREVIATIONS
BM - bowel movement
CDC - Centers for Disease Control and Prevention
C-diff - Clostridium difficile
cm - centimeter(s)
CNA - Certified Nurses Aide
CNO - Chief Nursing Officer
CPR - cardiopulmonary resuscitation
DSS - Dietary Service Supervisor
ESBL - Extended Spectrum Beta Lactamase
EMT - Emergency Medical Technician
GT - gastrostomy tube
H2O - water
H&P - History and Physical
IDT - Interdisciplinary Team
kg - kilogram(s)
LVN - Licensed Vocational Nurse
MAR - Medication Administration Record
mg - milligram(s)
MLT - Minimal Leak Test
MRSA - Methicillin Resistant Staphylococcus Aureus
P&P - Policy and Procedure
PEEP - Positive End Expiratory Pressure
PIP - Peak Inpiratory Pressure (the pressure

CS 1 LU 01 10 H02

ATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

CEO 10/16/14

eficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that afeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ng the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 llowing the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued m participation.

POC Accepted 10-20-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	Continued From page 1 needed to provide each breath from the ventilator) RD - Registered Dietician RN - Registered Nurse RT - Respiratory Therapist/Respiratory Therapy UTI - Urinary Tract Infection VRE - Vancomycin Resistant Enterococcus	F 000	Resident 7 → Crib Resident E → Crib Resident H → Lo Boy	
F 221 SS=E	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, interview, review of the facility's P&P, and review of the manufacturer's specifications, the facility failed to ensure one of 10 sampled residents (Resident 7) and two non-sampled residents (Residents E and H) were free from a physical restraint. The facility failed to obtain the informed consents from the responsible parties regarding the risks and benefits of the Posey bed (an A-framed canopy system enclosure which when attached to a hospital bed, restricts the resident from exiting the bed. The sides of the canopy have zippered panels which can only be accessed from the outside). Failure to provide the information regarding the risks and benefits of the Posey bed restraint as well as any other alternative interventions posed the risk of the residents' responsible parties not having the necessary	F 221	**482.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS** **F221** Corrective Actions Taken for Affected Residents: *All residents in the Posey bed not meeting the manufactures height and weight recommendations were immediately removed from the Posey beds. 9/30/14 *Appropriate alternative measures have been deployed and others are being explored for residents not meeting the requirements for the Posey bed, including low boy beds, cribs, hospital beds and alternative enclosed beds. 9/4/14 ongoing *All physician orders for specialty beds have been reviewed with the Medical Director and revised as appropriate. 10/3/14	

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F 221	Continued From page 2 ~~information to make an informed decision~~ regarding the use of the Posey bed. The facility failed to follow the manufacturer's specifications for the use of the Posey bed. According to the manufacturer, the Posey bed is a restraint and improper use of the Posey bed could lead to serious injury or death. The Posey bed is "not intended for use with patients who weigh less than 46 pounds, or are shorter than 46 inches." Resident 7, E, and H did not meet the manufacturer's minimum height and weight requirements for the use of the Posey bed. This posed the risk of serious injury to the residents. The facility failed to attempt alternative measures prior to the implementation of the Posey bed restraint. This placed the residents at risk for an unnecessary restraint. The facility failed to develop a comprehensive plan of care to address the use of the Posey bed, including restraint free periods, therapeutic interventions to minimize decline in function, and a process for restraint reduction. This posed the risk for not receiving the appropriate care. The facility failed to ensure documentation in the weekly progress notes addressing the alternatives attempted other than the use of a Posey bed restraint as described in their P&P. This had the potential for unnecessary restraint for the residents. The facility failed to follow the physician's order regarding observing the restraint every 15 minutes. This had the potential for a serious injury not to be detected in a timely manner	F 221	* The remaining resident in a Posey bed had a signed inform consent in their record. for the use of the enclosed bed. 9/6/13 *The care plan for the remaining resident in a Posey Beds was updated and appears in the resident record. including discussion of restraint free periods and monthly assessment of ROM by Physical therapy. 10/5/14 *Monthly reviews in IDT will be done to re-evaluate the appropriateness of enclosed beds and less restrictive options will be explored for each resident. 10/16/14 *A new enclosed bed policy has been drafted and approved to address the specific handling and documentation of enclosed bed usage specific to the pediatric population. Evaluation of patient need for bed monthly and IDT review of less restrictive options. 10/14/14 *Pediatric staff was re-educated on the use of enclosed beds and the special charting requirements. (10/16/14) 10/16/14	

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F 221	Continued From page 3	F 221	Corrective Actions for Other Residents:	

Findings:

According to the facility's P&P titled Restraints - Physical dated 5/2014, a physical restraint is any device attached or adjacent to the resident's body which restricts the resident's freedom of movement. A physician's order must be obtained prior to the use of a restraint. Possible alternative measures other than the use of the restraint should be discussed with the resident or responsible party. If a restraint is needed, the nurse should contact the physician and initiate verification of informed consent. The care plan should be updated to reflect the needs of the resident. The weekly progress note shall address the need for the restraint, any alternatives to the restraint, any least restrictive measures other than the restraint, address the possibility of a restraint reduction and address how the resident can maintain his highest functional level.

1. On 9/3/14 at 1500 hours, Resident E was observed sitting up in bed. The resident's bed was enclosed with a mesh covering on top of the bed and around all sides. The mesh covering had a zippered area to allow the staff to provide the resident's care as needed while the resident was in the bed. The zipper was closed.

Clinical record review for Resident E was initiated on 9/10/14. Resident E was admitted to the facility on 11/5/13.

On 9/4/14, Resident E's height was 113.5 cm (44.7 inches) and weight was 21.3 kg (44.86 pounds).

Review of the physician's orders showed an order dated 5/16/14, for the use of a Posey bed to

*Residents will be reviewed monthly during the Interdisciplinary Team meeting. Discussion will include the appropriateness of beds, and to explore less restrictive bedding options. as long as Posey bed is in use. 10/16/14

*The records of all residents using enclosed beds will be audited monthly to ensure proper documentation is being followed. 10/10/14

*Quarterly fall risk assessment will be reviewed at the Interdisciplinary Team monthly meeting. 10/16/14

*All new orders for enclosed beds will be audited to ensure that all required elements are in place, including MD order, trial of less restrictive measures, signed consent and parent request for enclosed bed when appropriate. while Posey bed is in use. 10/5/14

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F 221	Continued From page 5	F 221		

Review of the clinical record failed to show documentation an informed consent was obtained from Resident E's responsible party regarding the risks and benefits of the use of the Posey bed.

Documentation in the clinical record failed to show Resident E was thoroughly assessed for the need of the restraint and which alternative therapies had been implemented prior to the use of the Posey bed.

An interview and concurrent clinical record review with RN 1 was initiated on 9/10/14 at 1500 hours. When asked why Resident E was using the Posey bed, RN 1 stated Resident E could stand up and was in danger of falling out of bed. When asked if the resident had ever fallen out of bed since his admission to the facility, RN 1 stated no, but he was at risk of falling. When asked for documentation to show the informed consent was obtained to address the use of Resident E's Posey bed, RN 1 stated she would check the overflow files to find the consent. However, no documentation to show the informed consent was obtained was provided. RN 1 was unable to provide documentation showing alternative interventions had been attempted prior to the implementation of the Posey bed. RN 1 was unable to provide documentation to show Resident E was thoroughly assessed regarding the need for the Posey bed.

2. Clinical record review for Resident 7 was initiated on 9/3/14. Resident 7 was admitted to the facility on 3/28/14.

On 9/4/14, Resident 7's height was 106.5 cm (41.93 inches) and weight was 17.6 kg (38.72

*Findings will be included in quarterly PI reports and reported to Organization-Wide Quality Council for further actions as needed.

Person(s) Responsible:

Pediatric Director of Nursing (DON), Quality and Compliance Coordinator and DSD

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F 221	Continued From page 4 ~~replace the crib for safety purposes. Further~~ review of the clinical record showed a "Physician Order: Pediatric Sub-Acute Restraints" form dated 9/4/14. The documentation on the form showed the use of the Posey bed as a restraint for up to seven days. The form showed the definition of behavioral modification restraints included: "the use of physical or mechanical devices to involuntarily retain movement of the whole or a portion of the patient's body as a means for controlling his/her physical activity in order to protect him/her or others from injury. Patient restraints will be observed every 15 minutes." The area to document the status of the resident showed "fall risk." The area to document the reason for the implementation of the restraint order showed a check mark in the box indicating to "prevent the patient from climbing out of the bed/chair and injuring himself" and a check mark in the box indicating to "protect the patient from self-harm." Review of the care plan showed a care plan problem to address Resident E's need for a restraint. An entry dated 5/16/14, showed to replace the crib with a Posey bed for safety. The interventions included to monitor for ongoing need of environmental restraints and discontinue as change of condition warranted and as ordered, monitor the resident on the restraint, assess every two hours, and document on the restraint flow sheet. However, the plan of care failed to show the approaches to include observing the resident every 15 minutes for the use of the restraint as ordered, specific measures to address Resident E's climbing out of bed, and prior interventions to be attempted prior to the implementation of the Posey bed.	F 221	Measures/Systemic Changes: *Re-education was provided to the licensed nursing staff about the use of restraints and informed consent. 10/25/14 *Charge nurses and RNs have been re-educated on the charting requirements for Posey beds, including restraint documentation, signed consents, MD progress notes, care plans, and the re-evaluation of resident condition and options for less restrictive measures. 10/25/14 Monitoring: *Monthly audits are being conducted by the Quality and Compliance Coordinator of nursing documentation and includes charting requirements for Posey beds, including restraint documentation, signed consents MD progress notes, care plans, and the re-evaluation of resident condition and options for less restrictive measures *Audit results to be presented in monthly Interdisciplinary Team meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 221	Continued From page 6	F 221		

pounds).

Review of the September 2014 recapitulated physician's orders failed to show an order for the use of the Posey bed. Further review of the clinical record showed a "Physician Order: Pediatric Sub-Acute Restraints" form dated 7/21/14. The type of restraint was documented as a Posey bed. The area to document the status of Resident 7 showed "over actively moves bilateral lower extremities out of the bed, kicking rails and constantly moves in bed." The instructions on the form showed restraints "will be observed every 15 minutes." Further review showed a "Physician Order : Pediatric Sub-Acute Restraints" form dated 9/4/14, showing the use of the Posey bed with the status of the Resident 7 documented as a "Fall Risk"

Review of the Doctors Progress Notes dated 7/21/14, showed an IDT conference was held and Resident 7 was doing well with no major issues over the month. The documentation failed to show the need for the Posey bed.

Review of the care plan failed to show a care plan problem to address the use of the Posey bed or a care plan problem to address Resident 7's behavior of "over actively moving of his lower extremities out of the bed, kicking the side rails, constantly moving in bed" or his risk for a fall.

Review of the Weekly Nursing Summary reports dated 8/25 and 8/18/14, failed to address any alternatives or least restrictive measures to be attempted prior to using the Posey bed for Resident 7.

On 9/4/14 at 0750, a Posey bed was observed in

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Room B which was designated for Resident 7. Resident 7 was out of the facility at the time.

An interview and concurrent clinical record review was conducted with RN 1 on 9/4/14 at 0800 hours. RN 1 verified the Posey bed was considered a restraint. RN 1 was unable to find an informed consent regarding the use of Resident 7's Posey bed. Furthermore, RN 1 was unable to find documentation showing Resident 7's responsible party had been informed of the risks and benefits of using a Posey bed as a restraint and had been provided information regarding alternative therapies.

A telephone interview was conducted with RN 1 on 9/9/14 at 1100 hours. When asked if ongoing assessments to address Resident 7's need for the Posey bed had been completed, RN 1 stated she was unable to find an assessment to address Resident 7's need for the Posey bed restraint. RN 1 stated the physician rewrote the order every 7 days and documented the status of the resident on the form. RN 1 further verified the Weekly Nursing Summary reports dated 8/25 and 8/18/14, failed to address the use of any alternative interventions or least restrictive measures to be attempted prior to using the Posey bed for Resident 7. RN 1 verified the physician's order form showed restraints to be observed every 15 minutes and stated the facility did not check the resident every 15 minutes when a restraint was ordered. The facility's P&P is to check the resident every two hours and document on the Restraint Flow sheet.

3. On 9/10/14 at 1430 hours, Resident H was observed in a Posey bed restraint with all the mesh covering zippered closed. Resident H was

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resting quietly with arms moving.

On 9/10/14, clinical record review was initiated for Resident H. Resident H was admitted to the facility on 5/6/14.

On 9/4/14, Resident H's height was 89 cm (35.04 inches) and weight was 13.5 kg (29.7 pounds).

A care plan problem to address the use of the Posey bed was not found in the clinical record.

Review of the Physician Order, Pediatric Sub -Acute Restraints form dated 9/4/14, showed the Posey Crib as the type of the restraint for "Spastic Movements".

An interview and concurrent clinical record review was conducted with RN 1 on 9/10/14 at 1445 hours. RN 1 verified Resident H's use of the Posey bed as a restraint. RN 1 was unable to find an informed consent to address the use of Resident H's Posey bed. Furthermore, RN 1 was unable to find documentation showing Resident H's responsible party had been informed of the risks and benefits of using a Posey bed as a restraint. RN 1 was unable to find a care plan problem to address the approaches including the staff needed to take when caring for Resident H while using the Posey bed restraint. RN 1 was also unable to find documentation an assessment to address Resident H's need for the Posey bed restraint had been completed. RN 1 stated there was no documentation found in the IDT notes dated 8/14/14, or in the Weekly Nursing Summary dated 8/28/14.

An interview by phone was conducted with the

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F 221	Continued From page 9 Medical Director on 9/10/14 at 1700 hours. The Medical Director stated he did not obtain the informed consent or speak to the family regarding the risks and benefits of the Posey bed restraints. The Medical Director state the nursing staff obtained the informed consent for restraints, psychoactive medications, and pain medications from the residents' responsible parties. He further stated he would talk to the family if they were in the facility or if the nurse informed him the family would like to speak to him. On 9/30/14 at 0905 hours, an interview and concurrent clinical record review was conducted with the CNO. The CNO verified the facility utilized the Posey bed model number 8070 as means of restraint for Residents 7, E, and H. The CNO verified Resident 7, E, and H's heights and weights were last obtained on 9/4/14. When the manufacturer's specifications regarding the minimum height and weight requirements for the use of the Posey bed was discussed, the CNO verified Residents 7, E, and H did not meet the manufacturer's specifications. When asked how the facility verified the use of the Posey beds was appropriate for these residents, the CNO stated the facility had been using the Posey beds for some time, and he was not aware of the manufacturer's specifications. When asked if the facility had attempted any other interventions such as a low bed and floor mats as an intervention prior to the implementation of the Posey beds, the CNO stated he needed to research other alternatives than the Posey beds.	F 221		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment	F 279		

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F 279	Continued From page 10 to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and clinical record review, the facility failed to update the plan of care to reflect the resident's current care needs for one of 10 sampled residents (Resident 6). Resident 6 had bilateral myringotomy tympanostomy tubes (tubes inserted into the eardrums to prevent accumulation of fluid in the middle ear) inserted on 8/26/14. Seven days later Resident 6 was started on antibiotics due to an ear infection. The facility failed to update the plan of care for Resident 6 to address the placement of the ear tubes and the current ear infection. This had the potential of Resident 6 not to receive the appropriate care he required to minimize or prevent complications.	F 279	**483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS** **F279** Resident 6 - Care plan was immediately revised. Corrective Actions Taken for Affected Residents: 10/10/14 Care plans for all Pediatric Sub-Acute residents have been reviewed and updated as appropriate to include all new MD orders and changes in resident conditions. (10/10/2014) Corrective Actions for Other Residents: 10/10/14 RN staff were assigned monthly auditing responsibility to ensure that care plans reflect services that are to be furnished to attain or maintain the resident's highest attainable physical, mental and psychosocial well-being, to reflect any changes in resident condition, and to immediately update any care plan found to be incomplete. Findings will be reported at the monthly RN/Charge Nurse meeting. 10/21/14	

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F 279	Continued From page 11 Findings: Clinical record review for Resident 6 was initiated on 9/3/14. Resident 6 was admitted to the facility on 1/22/10 and readmitted to the facility on 5/6/14. Review of the physician's order dated 8/20/14, showed the bilateral myringotomy typmpanostomy tubes were to be surgically inserted on 8/26/14. Further review of the clinical record showed an order dated 9/3/14, to administer an antibiotic for a right ear infection for seven days. The order also showed specific instructions regarding use of the Otwick ear sponge (sponge is used to administer antibiotic drops deep into the ear canal). Review of the care plan problem dated 10/11/12, to address Resident 6's bilateral ear cerumen (ear wax) failed to include the insertion of the ear tubes or the current ear infection and approaches needed to provide the appropriate care. An interview and concurrent clinical record review with RN 1 was conducted on 9/4/14 at 0810 hours. RN 1 was unable to find a care plan problem addressing Resident 6's ear tubes or current ear infection. RN 1 verified the finding and stated the plan of care needed to address these issues.	F 279	Measures/Systemic Changes: Patient load has been equally distributed to RNs for *Quarterly audits of care plans will be performed by the charge nurses and presented at the monthly IDT meetings. 10/16/14 *All RN staff received re-education of care plan policies and procedures and nursing responsibilities. 9/25/14 *Re-education of care plan policies and procedures and nursing responsibilities was done with all RN staff. 9/25/14 Monitoring: *Quarterly reports of monthly audit findings will be reported to the Organization-Wide Quality Council. Person(s) Responsible: Pediatric DON, Quality and Compliance Coordinator and DSD	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in	F 309		

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Review of the physician's order order dated 11/26/10, showed Resident 6 "may only OOF (out of facility) if two people with completed educational packet and valid CPR cards" were present. A physician's order dated 12/31/11, showed Resident 6 might go out of facility for six hours up to two times per week.

Review of the care plan showed a care plan problem to address Resident 6's family dynamics dated 1/22/10; however, it failed to address the physician's order regarding the need for two persons with completed educational packets and valid CPR cards to accompany Resident 6 for out of the facility passes.

Further review of the clinical record showed two American Heart Association Healthcare Provider CPR cards for Resident 6's family members issued on 10/2010, which had expired on 10/2012. No further documentation of current CPR card verification was found in the clinical record.

Review of the facility's form titled Out of Facility Release showed the facility and the physician were free from all responsibility in regards to the resident's condition during the resident's absence from the facility. Review of Resident 6's Out of Facility Release form dated 9/7/14, showed Resident 6's family member signed him out at 1400 hours, and returned Resident 6 to the facility at 2000 hours. Resident 6's family member also signed him out on 8/3, 8/10, 8/17, 8/24, and 9/1/14, for a period of approximately six hours each time. Further review of the Out of Facility Release form failed to show documentation of a second person being present during Resident 6's

requirements continue to be met, including current family education. CPR cards and other requirements per the MD order.

Measures/Systemic Changes:

*All parents requesting OOF privileges will be required to complete all education and other requirements before being granted OOF pass. 9/5/14

*Monthly audits of all residents that are eligible for OOF passes to ensure that all eligibility requirements have been met, including CPR card, other requirements per MD order. Facility will offer assistance to family members in finding locations and times to obtain required certifications. 10/1/14

*Parents will receive monthly reminder notices about impending expiration dates of CPR cards. 10/1/14

Monitoring:

*Monthly audits of all eligibility requirements, including current 10/1/14

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F 309	Continued From page 12	F 309	**483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING**	

accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on interview and clinical record review, the facility failed to follow the physician's order regarding the necessary medical training and supervision needed to ensure one of 10 sampled residents (Resident 6) was safe when taken out of the facility by the family. Resident 6 has a tracheostomy (a tube going from the front of the neck to the trachea to provide an air passage to help with breathing when the usual route for breathing is obstructed or impaired) due to a history of respiratory distress (not enough oxygen passes from the lungs into blood) A physician's order showed two people with valid CPR cards were needed to take Resident 6 out of the facility. The facility failed to follow the physician's order to ensure two people with valid CPR cards were present when taking Resident 6 out of the facility. This posed the risk of compromising Resident 6's health and safety during out of the facility passes.

Findings:

Clinical record review initiated on 9/3/14, showed Resident 6 was admitted to the facility on 1/22/10 and readmitted to the facility on 5/6/14. Resident 6 had a tracheostomy tube and GT (a tube placed through a surgical opening in the abdomen to the stomach for the purpose of feeding and medication administration) Resident 6 had diagnoses including anoxic encephalopathy (brain damage due to lack of oxygen) and respiratory failure.

F309

Corrective Actions Taken for Affected Residents:

*The affected resident family has been notified that their Out of Facility (OOF) pass are suspended until evidence of current CPR cards is presented. 9/3/14

*New Out of Facility Policy has been drafted and approved by the Medical Director to include guidelines about OOF passes and family requirements. 10/14/14

Corrective Actions for Other Residents:

*Immediate audit of all resident records was done. No others were found to be deficient. 9/3/14

*Monthly audits will be done of all residents that are eligible for OOF passes to ensure that all eligibility 10/1/14
throughout the year The need to continue audits will be determined at the annual evaluation.

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release from the facility as specified in the physician's order.

An interview with RN 1 was conducted on 9/4/14 at 0930 hours. RN 1 verified due to family dynamics, two people with valid CPR cards were necessary to accompany Resident 6 when he left the facility. RN 1 was unable to find documentation showing proof of current CPR cards of Resident 6's family members who had been taking Resident 6 out of the facility. Furthermore, she was unable to find a care plan problem to address Resident 6's needs when leaving the facility.

F 322 SS=D 483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS

Based on the comprehensive assessment of a resident, the facility must ensure that --

(1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and

(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.

F 309

CPR cards and other requirements per the MD order, certification expiration and review of OOF requests will be done.

*Parents will receive monthly reminder notices about impending expiration dates of CPR cards.

*Findings will be included in quarterly PI reports, and reported to Organization-Wide Quality Council. and re evaluated at the end of the year for the need to continue reporting.

F 322

Person(s) Responsible:

Pediatric DON, DSD, Quality and Compliance Director

483.25(G)(2) NG TREATMENT/ SERVICES – RESTORE EATING SKILLS

F322

Resident 5: immediate re evaluation by medical director. New treatment to started.

Corrective Actions Taken for Affected Residents:

*All residents were re-assessed for skin integrity. Skin monitoring sheets have been started for residents showing any alteration in skin integrity. 9/5/14

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview, clinical record review, and review of the facility's P&P, the facility failed to accurately assess the GT (tube surgically inserted through the abdominal wall into the stomach to deliver nutrition and medication) site for one of 10 sampled residents (Resident 5). Resident 5 was receiving treatments for redness at the GT site. The nurses failed to assess the GT site daily as specified in their P&P. The wound area continued to deteriorate. The nurses failed to notify the physician and provide ongoing assessments of the wound condition. This posed the risk of Resident 5 not receiving the appropriate care and treatment.

Findings

Review of the facility's P&P titled Assessment of Skin Breakdown dated May 2014, showed the skin and/or wounds will be reassessed daily. Assessment will include centimeter measurements, characteristics of the wound bed, surrounding skin and exudates, and presence of pain associated with the wound.

Clinical record review for Resident 5 was initiated on 9/3/14. Resident 5 was admitted to the facility on 3/13/07 and readmitted on 6/17/14. Resident 5 had a G/JT tube (a combination gastric and jejeunostomy tube. Tubes surgically inserted through the abdominal wall into the stomach and intestine to deliver nutrition and medication) which was leaking and became dislodged on 9/3/14, and replaced with a temporary catheter.

Review of the physician's order dated 8/13/14,

Corrective Actions for Other Residents:

*Skin integrity is assessed daily - Incidents of skin breakdown will be documented in the resident record and comprehensive skin assessment tool and shift reassessment tool initiated and MD notified. 9/5/14

*Initial assessment will be completed, including photo and measurements of skin breakdown or redness and will be documented on the comprehensive skin assessment sheet. Re-assessment will occur every shift until the issue has resolved. 10/14/14
Initial / weekly assessment - charge nurse.
Daily monitoring - primary licensed nurse.

*New wound measurement tools, and upgraded camera and photo printer have been ordered to help in charting and monitoring the progress of identified skin problems. 10/14/14

Measures/Systemic Changes:

New skin monitoring tool is in place to directly address and facilitate the special skin assessment needs of the pediatric population. 10/14/14

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F 322	Continued From page 17 and 0400 hours, the GT was leaking. Documentation describing the skin redness or condition was not found. There was no documentation the physician had been notified of the change in the condition regarding the GT leaking. On 9/3/14 at 2000 hours, the LVN documented the GT site was very red and excoriated down the left side of the abdomen but failed to show the size of the excoriation, the condition of the surrounding skin, or the presence of any signs of pain. There was no documentation showing the physician had been notified of the change in the condition of the resident's skin. On 9/4/14 at 1145 hours, an interview was conducted with RN 1. She stated she was not aware of the open area surrounding Resident 5's GT site, LVN 1 had just reported the redness to her. RN 1 stated it was LVN 1's responsibility to perform daily treatments and monitor the GT site. She further stated the nurses did not have a form to document their findings. When asked how she would determine if the redness was getting worse, RN 1 stated there was no way to tell if the redness was getting larger or worse. On 9/4/14 at 1520 hours, an interview was conducted with LVN 1. He stated the open area surrounding Resident 5's GT was not reported to him at change of shift. He further stated the facility policy was to report any open areas on the resident's skin to the Charge Nurse. LVN 1 was unable to provide documentation showing centimeter measurements, characteristics of the wound bed, surrounding skin and exudates, and presence of pain associated with the wound were assessed daily. LVN 1 stated Resident 5's GT site had been reddened for a long time, and the	F 322	*New skin monitoring tools are in place to directly address the special needs of the pediatric population. Person(s) Responsible: Pediatric DON/ DSD/Director of Quality and Compliance	10/14/14

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F 322	Continued From page 16 showed an order to apply 1/2 Maalox (an antacid medication used topically to dry the area) mixed with 1/2 hydrophilic cream (topical skin cream) to GT site redness twice daily for 30 days. On 9/4/14 at 1115 hours, LVN 1 was observed performing treatment for Resident 5's GT. A red, excoriated (damage or superficial loss of the surface of the skin), open area was noted surrounding Resident 5's GT, measuring approximately 4 cm x 2 cm. An additional crescent shaped excoriated area was observed to the left of the GT site. There was a clear liquid leaking from the GT site, which dripped down Resident 5's left abdomen. Review of the care plan showed a care plan problem to address Resident 5's nutrition dated 6/17/14. The approaches included to provide GT site care every shift and as needed; however, there was no documentation to show the type of treatment to be provided for the GT site. Further review of the care plan for Resident 5's failed to show a specific care plan problem to address the resident's skin redness/excoriation around the GT and the indicated treatment to address the leaking of fluid from the GT site. The Nursing Progress/Summary Notes for 8/30/14 at 2000 hours, showed the GT site was still red with excoriation. Further review of the documentation failed to show measurements of the size and location of the excoriation or presence of signs of pain. There was no documentation the physician was notified of the change in the condition of the resident. The entry for 9/2/14, showed at 0800 hours, the GT was intact and patent; at 1200 hours and 1600 hours the GT site was clean and dry; and at 2400 hours	F 322	*Shift skin monitoring tool revised to reflect the unique needs of the pediatric population. 10/15/14 *Skin monitoring/pain assessment will be done on all residents every shift, and skin sheets started for all residents with redness, excoriation or any other skin issues. by primary licensed nurse. 10/15/14 Monitoring: Weekly audits of skin monitoring tool is being done by the licensed nursing staff. *Unit DON will review report and assign staff to follow up on findings. *Summary of findings will be reported to MD at weekly IDT meetings. *Findings will be included in quarterly PI reports, and reported to the Organization-Wide Quality Council.	

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F 322 Continued From page 18

only place to document this would be in the Nursing Progress/Summary Notes.

On 9/4/14 at 1530 hours, a follow-up interview and concurrent clinical record review was conducted with RN 1. When asked who was responsible for assessing the effectiveness of the skin treatments, RN 1 stated it was the RN's responsibility to assess and measure any open areas on the skin of the resident and document on the "skin sheet." She confirmed there was no "skin sheet" for Resident 5's treatments of the redness surrounding his GT. RN 1 further stated the RNs did not monitor redness even if there was a treatment. The RNs only monitored open areas on the skin.

F 328 SS=E 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS

The facility must ensure that residents receive proper treatment and care for the following special services:
Injections;
Parenteral and enteral fluids;
Colostomy, ureterostomy, or ileostomy care;
Tracheostomy care;
Tracheal suctioning;
Respiratory care;
Foot care; and
Prostheses.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and clinical record review, the facility failed to provide proper treatment and care for the residents requiring ventilator (a machine used to provide assisted

F 322

Resident 2, 3, 4 & 5: Were immediately re assessed with involvement of Medical director. Settings were adjusted according to policy.

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483.25(K) TREATMENT/CARE FOR SPECIAL NEEDS

F328

F 328

Corrective Actions Taken for Affected Residents:

*All resident records were reviewed with the Medical Director and MD orders were updated to comply with Policy & Procedures in regards to vent settings and cuff pressures. 9/4/14

*All Cardio-Pulmonary staff were re-educated on Ventilator Alarm Policy CPS 340. as well as proper documentation of tracheostomy cuff pressures where appropriate. 9/4/14

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F 328	Continued From page 19 breathing when they can not breathe effectively on their own) support. *Ventilator alarm settings for four of 10 sampled residents (Residents 2, 3, 4, and 5) and six nonsampled residents (Residents B, C, D, E, F, and G) were set too high. Alarm settings alert the staff to potential problems between the ventilator and the residents. When the alarm setting is too high, early detection and troubleshooting of ventilator problems does not occur. * Physician's orders to check the tracheostomy [a surgically created opening through the front of the neck into the airway (trachea) which provides an air passage when the usual route for breathing is obstructed or impaired or when long term use of a ventilator is required] cuff (a balloon at the end of the tracheostomy tube) pressure every shift were not followed for two of 10 sampled residents (Residents 3 and 5). The tracheostomy cuff seals the lower airway to prevent excessive air leakage and ensure the ventilator delivers the correct volume of air to the lungs. If the cuff pressure is too high, damage to the surrounding tissue may occur. These had the potential for serious complications to go undetected and resolved timely. Findings 1. Residents 2, 3, 4, 5, B, C, D, E, F, and G had medical conditions requiring ventilator support. During the initial tour on 9/3/14 at 0750 hours, RT 4 stated the RT set the normal ventilator high pressure alarm at 10 to 15 cm H2O above the residents' PIPs.	F 328	*Orders for all residents receiving ventilator support have been reviewed by Cardio Pulmonary leads, and limits updated to reflect current vent settings and trach cuff pressures. 9/10/14 Corrective Actions for Other Residents: *All residents receiving mechanical ventilation were audited for ventilator alarm settings to insure that all are set according to policy CPS 340 (10cm-15cm above/or below set pressure). 9/10/14 Measures/Systemic Changes: *Audits of MD orders and Cardio Pulmonary charts will be conducted daily and deficiencies will be addressed immediately. Audit overall results will be included in the Performance Improvement reports will be reported quarterly to the Organization-Wide Quality Council. for ~~at-lea~~ one year, then re evaluated for need to continue. 10/16/14 *Alarm settings will be reviewed by the interdisciplinary team at the 10/16/14	

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Review of the physician's orders for Residents 2, 4, 5, B, C, D, E, F, and G showed the orders for the ventilator settings to include:

* Mode (refers to the method of inspiratory or breathing support from the ventilator).

* Tidal volume (the volume of gas exchanged during each breathe from the ventilator).

* Rate (the number of times per minute the ventilator pushes air into the lungs).

* PEEP (this ventilator pressure is applied at the end of expiration to hold the lungs open and thereby increase oxygenation in the lungs).

* Amount of oxygen (room air contains 21% oxygen. The physician may order more oxygen depending on the resident's condition).

* Pressure control (provides a set pressure during inspiration).

* Pressure support (a spontaneous mode of ventilation when the resident initiates every breathe and the ventilator delivers a preset pressure).

The physician's orders did not contain the orders for the high pressure alarm settings (a ventilator alarm is triggered when there is something wrong with the ventilator pressure, volume, or the rate of air being delivered. The high pressure alarm occurs if two consecutive breaths are limited because they reach the high pressure setting. Triggering of high pressure alarm is usually caused by coughing but may indicate the airway

monthly scheduled IDT meeting and modifications to orders will be made by the MD based on recommendations as appropriate.

Monitoring:

Alarm

*Audits will be conducted daily and deficiencies will be addressed immediately. Audit overall results will be included in the Performance Improvement reports for the department.

*Audit findings will be reviewed with Cardio Pulmonary staff in monthly staff meetings and/or posted for all to review.

Person(s) Responsible:

Respiratory Leads and Chief of Ancillary Services.

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is blocked. The high pressure alarm will continue to be triggered if pressures do not decrease below the high pressure setting. If the high pressure alarm is set too high, a potentially serious complication may not be detected timely because the ventilator alarm will be delayed.

For Resident 3, the physician's order included the mode, rate, pressure control, pressure support, PEEP, amount of oxygen, and setting for a high pressure alarm at 45 cm H2O.

Review of the 24 Hour Continuous Mechanical Ventilator Records for Residents 2, 3, 4, B, C, D, E, F, and G for August and early September 2014, showed the high pressure alarms were continuously set at 45 cm H2O. The 24 Hour Continuous Mechanical Ventilator Records for Resident 5 for August and early September 2014 showed the high pressure alarm was continuously set at 50 cm H2O.

Further review of the 24 Hour Continuous Mechanical Ventilator Records for August and early September 2014, showed the following:

* The PIP for Resident 2 ranged from 15 to 25 cm H2O (20-30 cm H2O below the high pressure alarm setting). On 8/28/14 at 1530 hours, the PIP for Resident 2 was recorded at 31 cm H2O (14 cm H2O below the high pressure alarm setting).

* The PIP for Resident 3 ranged from 15 to 25 cm H2O (20-30 cm H2O below the high pressure alarm setting).

*The PIP for Resident 4 ranged from 20 to 25 cm H2O (15-20 cm H2O below the high pressure alarm setting).

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* The PIP for Resident 5 ranged from 24 to 48 cm H2O (2-26 cm below the high pressure alarm setting of 50 cm H20).

* The PIP for Resident B ranged from 14 to 20 cm H2O (25-31 cm H20 below the high pressure alarm setting).

* The PIP for Resident C ranged from 8 to 25 cm H2O (20-37 cm below the high pressure alarm setting).

* The PIP for Resident D ranged from 16 to 20 cm H2O (25-29 cm H2O below the high pressure alarm setting) . On 8/24, 8/27, and 8/29/14, the PIP for Resident D was recorded at 30 and 31 cm H2O (14-15 cm H2O below the high pressure alarms setting).

* The PIP for Resident E ranged from 14 to 27 cm H2O (18-31 cm below the high pressure alarm setting).

* The PIP for Resident F ranged from 18 to 26 cm H2O (19-27 cm H2O below the high pressure alarm setting). On 8/31/14 at 1900 hours, the PIP for Resident F was recorded at 32 cm H2O (13 cm H2O below the high pressure alarm setting).

* The PIP for Resident G ranged from 16 to 24 cm H2O (21-29 cm H2O below the high pressure alarm setting).

Review of the facility's P&P titled Mechanical Ventilator Set-Up dated May 2014, showed recommended setting for the ventilator high pressure alarm is 45 cm H2O.

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During an interview with the Medical Director on 9/8/14 at 1330 hours, when asked if he approved the facility's P&P, the Medical Director stated he had reviewed and approved the facility's clinical P&P. When the facility's P&P for Mechanical Ventilator Set-up dated May 2014, showing a recommended setting for the high pressure alarm at 45 cm H2O was discussed, the Medical Director stated this P&P needed to be reviewed.

When the Medical Director was informed the RT staff had stated during the initial tour, the high pressure alarms should be set at 10 to 15 cm H2O above the residents' PIPs, the Medical Director stated in most cases, this would be the correct setting.

After the Medical Director was informed of the 24 Hour Continuous Mechanical Ventilator Records for three sampled and six nonsampled residents showed all of the ventilator high pressure alarms were set at 45 cc H2O despite the residents' varying PIPs, the Medical Director agreed the high pressure alarm was set to high

During an interview with RT 1 and the Director for Ancillary Services on 9/8/14 at 1530 hours, the findings from the 24 Hour Continuous Mechanical Ventilator Records for three sampled and six nonsampled residents were reviewed and showed all of the ventilator high pressure alarms were set at 45 cm H2O even though the residents' PIPs varied from 8 to 32 cm H2O. RT 1 and the Director for Ancillary Services agreed the high pressure alarms should have been set at 10 to 15 cm H20 above the residents' PIPs.

Review of the facility's P&P for the Ventilator Flow Sheet showed the department/team's approval

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F 328	Continued From page 24 dated May 2014, and the approval by the Medical Executive Committee and the Board of Directors dated June 2014. The policy showed "...pressure alarms will be set by the RT at 10 cm - 15 cm above and/or below pressures ...unless specified by MD (medical doctor)." During an interview and review of the Ventilator Flow Sheet P&P with RT 1 and RT 2 on 9/10/14 at 1610 hours, the two RTs were asked why the Ventilator Flow Sheet P&P differed from the Mechanical Ventilator Set-Up P&P regarding the settings for the high pressure alarm. Neither RTs were able to answer. During a telephone interview with the Corporate RT on 9/10/14 at 1115 hours, the Corporate RT stated he was unaware of any P&P showing the recommended settings for the ventilator high pressure alarm at 45 cm H2O. When asked if the RT should be adjusting the high pressure alarm based on the resident's condition, the Corporate RT stated unless the physician had ordered the high pressure alarm to be set at a specific setting, the RT should be adjusting the high pressure alarm to be 10-20 cm H2O above the residents' PIPs. 2. According to Respiratory Board Review, tracheal tube cuffs seal off the lower airway which facilitates ventilator support without excessive gas leaks and minimizes aspiration into the lungs. The pressure used to inflate the cuff can cause damage to the surrounding tissues. If the cuff pressure is high enough to block off capillary blood flow it can cause ischemia, tissue ulceration, and necrosis. Capillary perfusion pressures range between 20-30 cm H2O. The goal is to keep the cuff pressure below these	F 328		

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levels.

According to the Respiratory Board Review, a MLT is used to measure cuff pressure and minimize the air leak around the tracheostomy cuff. The procedure outlined the technique to be used and recommended recording of the measured cuff pressure.

Review of the physician's orders for Resident 3 showed an order dated 1/22/14, to check the tracheostomy tube (cuff) pressure every shift and as needed and maintain the pressure at 18-20 cm H2O.

Review of the physician's orders for Resident 5 showed an order dated 6/17/14, to check the tracheostomy tube (cuff) pressure every shift and as needed and maintain the pressure at 18-20 cm H2O.

The Medical Director was the primary care physician for both Residents 3 and 5.

During an interview, concurrent clinical record review, and review of the facility's P&P with RT 1 and RT 2 on 9/10/14 at 1610 hours, the physician's orders and the 24 hour Mechanical Ventilator Record for Residents 3 and 5 were reviewed. The physician's orders showed to check the tracheostomy tube pressure every shift and as needed and maintain the pressure at 18-20 cm H2O. The designated area to document the cuff pressure on the 24 hour Mechanical Ventilator Record showed the MLT, however, the documentation failed to show the amount of pressure determined. RT 1 stated she had already spoken to the Medical Director about the order to check Residents 3's and 5's

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tracheostomy tube cuff pressures. RT 1 stated the Medical Director indicated the order needed to be clarified because the facility used the MLT to ensure the tracheostomy cuff was not overly inflated. RT 1 stated the RT was to record just "MLT" on the 24 hour Mechanical Ventilator Record, not the actual tracheostomy cuff pressure. Review of the facility's P&P titled Ventilator Flow Sheet dated May 2014, showed the various procedures for completing the data on the 24 hour Mechanical Ventilator Record. The section to document the cuff pressure showed "observed amount of pressure (cm of H2O/MLT/MOV minimal occluding volume) in ..tracheostomy tube cuff." RT 1 verified the RT's document of "MLT" under cuff pressure not the actual cuff pressure.

When the physician's order for checking the tracheostomy cuff pressure for Residents 3 and 5 were reviewed with RT 1, RT 1 agreed the order required documentation of the actual cuff pressure, not the "MLT."

RT 1 also agreed if the physician's orders needed to be clarified, the clarification should have been done at the time the order was written, not months later.

F 371 SS=E 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY

The facility must -
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities, and
(2) Store, prepare, distribute and serve food under sanitary conditions

F 328 **483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY**

F371

Corrective Actions Taken for Affected Residents:

*Immediate replacement of dented, discolored, pitted, bowed cookware was accomplished. 9/4/14

*Repair of the wall board, removal of the silver-colored tape and repair of the torn cove base was done. 10/6/14

("Cove base is a type of trim that is installed along the base of an interior wall where the wall meets the floor. It is primarily made of vinyl or rubber and is used to protect the base of a wall from damage and to provide a finished and more aesthetically pleasing look where it is installed.")

F 371

Corrective Actions for Other Residents:

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This REQUIREMENT is not met as evidenced by:
Based on observation and interview, the facility failed to complete preventive maintenance in the kitchen to decrease the likelihood of harborage sites for pest infestations. Additionally, multiple cooking pots had bowed bottoms and pitting on the inside of the pots. Bowed bottoms of the cooking pots had the potential for the pots to rock on the stove and spill hot contents onto the staff using them. Pots with pitting were more apt to leach aluminum into foods and gave food an off taste.

Findings:

During a tour of the kitchen on 9/8/14 at 1200 hours, with the RD and the DSS, the wall beneath the sinks near the puree station was tapped using a yardstick. The wall board was spongy and moveable when pressed with the yardstick. The moveable section was approximately four feet wide. Additionally, silver colored tape was observed on the linoleum coving next to the walk-in refrigerator. The RD and DSS agreed with these findings.

An observation was made of a pot on a stove burner which appeared to be leaning to one side. The pot contained approximately two inches of warm water. When the pot was touched it rocked from side to side. The bottom of the pot was bowed outward. The RD agreed with this finding.

During an inspection of all of the cooking

This deficiency has no direct impact on the Pediatric Sub Acute resident population; as the resident involved is the only one currently in residence that is able to take food PO (by mouth). All other residents of the Pediatric Sub Acute unit are NPO (nothing by mouth) and are fed exclusively by gastrostomy (GT) tube.

Measures/Systemic Changes:

*Nutrition Services will conduct daily inspections of the kitchen to identify problems, including cookware needing to be replaced, and to identify potential repairs needed for walls, coves, etc.. 9/5/14

Monitoring:

*Monthly Environment of Care rounds will be completed in the kitchen and include cookware needing to be replaced, and to identify potential repairs needed for walls, coves, etc..

*Kitchen checklist was revised to include cookware. 10/9/14

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equipment, eight large pots and three medium pots were observed having bowed bottoms. Two medium pots and one large pot were observed to have pitting in the bottom and sides. One large colander was dented and showed black discoloration on the outside bottom.

The RD agreed with these findings.

F 428 SS=D 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON

The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.

This REQUIREMENT is not met as evidenced by:
Based on interview and clinical record review, the facility failed to ensure the drug regimen review was completed and irregularities were reported for one of 10 sampled residents (Resident 8). Failure to review a medication ordered an excessive dose and make recommendations had the potential for this resident to have an adverse reaction or an overdose.

Findings:

Clinical record review for Resident 8 was initiated

F 371

Person(s) Responsible:

Director of Dietary and Director of Engineering

F 428

483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON

F428

Corrective Actions Taken for Affected Residents:

Resident 8:

*Physician's PRN (as needed) order for Ativan was changed to include a maximum 24 hours dose not to exceed 10 mg. 9/4/14

Corrective Actions for Other Residents:

*Review was completed of all residents with PRN Ativan orders, as well as other PRN orders, to ensure that maximum dose limits are included where needed. 9/5/14

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NEWPORT SPECIALTY HOSPITAL	14662 NEWPORT AVENUE TUSTIN, CA 92780

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on 9/4/14. Resident 8 was admitted to the facility on _____with diagnoses including tuberous sclerosis [a rare genetic incurable disease that causes noncancerous (benign) lesions to grow in many parts of the body. It may effect the brain, lungs, and kidneys. Lesions in the brain can be associated with seizures, intellectual disability, learning disabilities or developmental delays] and seizures.

Review of the physician's orders showed an order dated 8/14/13, to administer lorazepam (anti-anxiety medication) 2 mg every four hours as needed for agitation (a total 24 hour dose equaling 12 mg). Review of the MAR for July and August 2014, showed no as needed doses of lorazepam had been given.

Review of Lexi-comp, an online drug reference for healthcare professionals showed the total oral dose of lorazepam ordered for anxiety disorders is 1 mg to 10 mg daily in divided doses; the usual dose is 2-6 mg daily in divided doses.

During a telephone interview with the pharmacist on 9/4/14 at 1600, the pharmacist stated she did the drug regimen review for the facility in July and August 2014. When asked if she had made any recommendations for the lorazepam 2 mg every four hours as needed ordered for Resident 8, the pharmacist stated she did not make any recommendations because Resident 8 had not received any doses of lorazepam in July 2014 or August 2014. When asked if the 2 mg dose was of concern, the pharmacist stated she was not concerned because Resident 8 had not received any doses in July 2014 or August 2014. When asked what would happen if a nurse gave the lorazepam as ordered and Resident 8 received

Measures/Systemic Changes:

*Review of findings with Omnicare (contracted pharmacy) for educational purposes was done to insure that pharmacist is able to identify order issues specific to PRN daily dosing limits in the future. 10/16/14

*Monthly review of the appropriateness of anti-psychotic medication dosing will be done at monthly IDT meetings. 10/16/14

*Monthly pharmacist review of each resident's medication regiment is being done. The monthly review report is forwarded to the Pediatric Sub-Acute DON and CNO. All recommendations requiring modification will be followed up by DON or designee with the MD for modification or clarification as needed 10/16/14

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Monitoring:

Monthly drug review is completed by pharmacy and reviewed at IDT meetings 9/28/14

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12 mg of lorazepam in 24 hours, the pharmacist responded that would be a change of condition and the nurse would have called the physician before giving all 12 mg in 24 hours. When reminded the physician's order for lorazepam did not contain any specific instructions to call the physician after a certain number of doses, the pharmacist agreed. When asked if the nurse followed the physician's order as written and did not question the dosing of lorazepam, then Resident 8 could receive 12 mg of lorazepam in a 24 hour period. The pharmacist agreed and stated she would do a recommendation in September 2014, to discontinue the lorazepam if no doses had been given.

During an interview with the Medical Director on 9/8/14 at 1330 hours, the order for lorazepam 2 mg every four hours as needed for agitation for Resident 8 and the findings in Lexi-comp for a total daily dose of lorazepam was 1 to 10 mg was reviewed. The Medical Director agreed with the potential for Resident 8 to receive 12 mg in 24 hours seemed to be an excessive dose and needed to be reviewed.

F 441 SS=F 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections

F 428

Unit DON will review report and assign staff to follow up on findings. 10/9/14

Summary of findings will be reported to MD at weekly IDT meetings. 10/11/14

Findings will be included in quarterly PI reports, and reported to the Organization-Wide Quality Council.

Person(s) Responsible:

DON/pharmacist

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F 441

483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS

F441

Corrective Actions Taken for Affected Residents:

*At the time of the survey the CNO/CIC (Certification in Infection Control) was the acting infection

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F 441	Continued From page 31 in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and clinical record review, the facility failed to maintain an infection control program designed to provide a safe and sanitary environment and help prevent the development and transmission of infections * The monthly infection control surveillance data was not complete for 10 of 10 months reviewed. This had the potential to not recognize infection trends.	F 441	control nurse while the position was being filled. A qualified infection control nurse was subsequently recruited and hired. Columns were added to the infection control log to indicate which McGeers Criteria were met including the clinical signs and symptoms. A column for antibiotic usage and rationale was also added. *All resident isolation status was reviewed and it was decided, in collaboration with the Medical Director and unit leadership, to initiate enhanced standard precautions on all residents pursuant to AFL 10-27. The new policy and procedure includes procedures for identification of and isolation of actual or potential C. diff infections. *Infection Control refresher and procedures for enhanced precautions were reviewed with the teacher from the school district.	10/10/14 10/8/14 10/16/14 10/15/14

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F 441	Continued From page 32	F 441	Corrective Actions for Other Residents:	

* The facility failed to use the infection control surveillance data to monitor the use of unnecessary antibiotics for conditions not meeting McGeer's Criteria (a symptom based criteria to identify true infections in long-term nursing facilities). In addition, the facility did not document the symptoms associated with infections, which was an important part of the McGeer's criteria. This had the potential for unnecessary use of antibiotics, which could contribute to the development of antibiotic resistant bacteria and could cause a secondary infection such as C-diff (a bacterium causing severe diarrhea).

* The facility failed to document any infection control surveillance for the months of January and February 2014. This had the potential for an infection outbreak to go unrecognized.

* Resident 5 had signs and symptoms of a C-diff infection. However, the facility did not implement isolation precautions while waiting for Resident 5's culture (a laboratory test taking approximately 72 hours to determine if infectious bacteria is present) was being processed. This had the potential for other residents to be exposed to infection.

* Teacher 1 did not follow proper infection control practices to minimize the risk of spread of infections in the facility.

Findings:

According to the CDC, each year in the United States at least 2 million people become infected with bacteria that are resistant to antibiotics and

*All residents are being reviewed daily and new potential infections and/or antibiotic usage is entered into the infection control log for further investigation. 9/8/14

*Enhanced standard precautions were initiated for all residents. A new policy and procedure was introduced and contained procedures for identification and isolation of actual and/or suspected C diff infections. All staff who enters resident rooms received in-service education regarding the new enhanced procedures. All EMT and other unscheduled non-staff individuals who enter resident rooms receive instruction upon arrival, prior to their interaction with the resident. 10/15/14

*Any new teachers and other scheduled non-staff individuals who enter resident rooms receive infection control instruction upon arrival, prior to their interaction with the resident. 10/15/14

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facility did not have an infection control nurse on staff.

Review of the Subacute Infection Control Logs which included the facility's infection control surveillance showed the log had columns for staff to document resident name, room number, presumptive diagnosis such as a UTI, infectious organism, if the resident was placed in isolation, any pertinent laboratory results, the treatment given and the dates the infection started and resolved. However, the log did not have a column or an area for staff to identify the resident's signs or symptoms of the infection (i.e. fever, cough or changes in the color of sputum or urine) as specified in McGeer's criteria. In addition, there was no area to document if the infection met McGeer's criteria and considered a true infection, which would help identify unnecessary antibiotic usage.

a. Review of the Subacute Infection Control Log for November 2013, showed a total of three infections documented for the month. Two of the infections were UTIs and one infection was pneumonia. Both UTI were identified to have cultures done. A culture is a test to determine the amount and type of bacteria present in the specimen, in this case urine. According to McGeer's criteria, the amount of bacteria present must be greater than 100,000 to be considered a true infection.

Further review of the Subacute Infection Control Logs showed incomplete documentation. For example:

* The column entitled "Pertinent Lab (laboratory) or X-ray Findings" showed no documentation

Monitoring:

*The infection control practitioner will prepare monthly summaries of the infection control log including antibiotic usage, infections using McGeer's criteria, isolation, trends, etc. The report will be reviewed by the unit Medical Director and CNO for completeness. The report along with a summary of other infection control monitors will be reported to the Organization-Wide Infection Control Committee and Quality Council on a quarterly basis unless there are significant opportunities for improvement noted in the interim.

*Results of monitoring adherence to enhanced standard precautions are presented monthly to the Pediatric Unit Medical Director and other leadership. The results are reported to the Organization-Wide Quality Council on a quarterly basis unless there are significant opportunities for improvement noted in the interim.

*Results of monitoring adherence to infection control standards are

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F 441	Continued From page 35 related to the results of the lab or x-ray done. Staff only documented a culture or x-ray had been done. b. Review of the Subacute Infection Control Logs for December 2013, March, April, May, June, July and August 2014, showed the following: * Under the area for pertinent laboratory findings, staff documented all the infections had either a culture or x-rays done. However, no results were identified to show if the bacteria counts were positive for a true infection, or an x-ray revealed a positive findings such as pneumonia. * All of the seven months of log failed to have documentation of each of the resident's signs or symptoms which would help determine if the resident had a true infection, or if it was treated with antibiotics unnecessarily. * The treatment column for these logs failed to consistently identify what medication was used to treat the infections. Of the 16 entries, only four were identified. In the treatment column staff had been documenting the route the medication was given (i.e. by mouth or intravenously), not the actual medication. c. Review of the Subacute Infection Control Logs for January and February 2014, showed the logs were blank. The CNO confirmed the logs were blank. He stated he did not fill out the logs for these two months. On 9/4/14 at 1400 hours, an interview was conducted with the CNO. The CNO was asked about the Subacute Infection Control Logs. The CNO stated he entered the data based on the	F 441	presented monthly to the Pediatric Unit Medical Director and other leadership. The results are reported to the organization-wide quality council on a quarterly basis unless there are significant opportunities for improvement noted in the interim. Person(s) Responsible: Infection Control Practitioner and Pediatric Sub-Acute DON.	

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culture reports he received from the nursing staff. He was asked based on the information provided on the Subacute Infection Control Logs, whether he could determine if the residents had a true infection or were being treated with unnecessary antibiotics. He stated based on the Subacute Infection Control Logs he could not determine this information. The CNO was asked if the facility was monitoring for the use of unnecessary antibiotics. The CNO stated, "No not yet." He also stated he had just hired an infection control nurse. The CNO was asked about the missing information, such as the culture results, resident specific signs and symptoms of the infection, and the medication used to treat the infection. The CNO verified he had not been documenting this information on the logs. He stated he was not aware this information was needed. He stated the infection control committee had last met in April 2014, and he had reported the infection control rates at that time. He stated he was not aware the unnecessary antibiotic usage should be part of the surveillance.

2.a. On 9/3/14 at 0745 hours, Resident 5 was observed in bed. A sign posted on the wall outside the room showed Resident 5 was on contact isolation precautions (isolation requiring staff to wear gown, gloves, and mask if they may come in contact with any body secretions or fluids).

Clinical record review for Resident 5 was initiated on 9/3/14. Resident 5 was readmitted to the facility on 6/17/14, with diagnoses including history of partial small bowel obstruction and history of recurrent intermittent ileus (disruption of the muscle contractions of the intestines stopping

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the movement of food and fluid through the digestive system). Resident 5 was ventilator dependent.

Review of the H&P dated 6/23/14, showed Resident 5 was to be placed on isolation.

Review of a care plan problem dated 6/17/14, addressed the Resident 5's infections of VRE, MRSA, and ESBL (multi-drug resistant organisms where the bacteria is resistant to many antibiotics) and contact isolation precautions.

Review of the physician's orders for Resident 5 failed to find an order for contact isolation.

Review of the facility P&P titled Infection Control dated 11/2010, showed the physician had to write an order on what extra precautions were necessary.

On 9/4/14 at 1100 hours, an interview with LVN 4 was conducted. LVN 4 was unable to find an order for contact isolation for Resident 5.

b. Further review of the physician's orders for Resident 5 showed an order dated 7/6/14, for stool culture for C-diff.

Review of the nursing progress summary notes dated 7/4/14, showed Resident 5 had a total of 9 BMs for that day. On 7/5/14, the resident had a total of 6 BMs for that day. On 7/6/14 at 1130 hours, staff documented Resident 5 has loose yellow stool, with a total of 6 BMs for that day.

On 9/8/14 at 1010 hours, an interview with RN 2 was conducted regarding Resident 5. RN 2 stated the resident's C-diff culture was obtained

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due to the resident experiencing more than normal BMs. She stated if a resident had C-diff due to the symptoms of more than normal loose BMs, they would have placed the resident in a private room. When asked if Resident 5 was transferred to a private room when the symptoms were observed. RN 2 stated, "No, he remained in the same room with his current roommate." RN 2 stated the roommate did not have any symptoms of C-diff.

c. On 9/8/14 at 0840 hours, two EMTs entered Resident 5's room with a gurney. EMT 1 was wearing gloves and a mask and EMT 2 was only wearing gloves. Neither EMTs were wearing a gown. The EMTs were accompanied by an RT from the EMT company. This RT was wearing a mask and gloves. In addition, the facility's RT 5 was in Resident 5's room and was observed to be wearing a gown, a mask, and gloves.

The RT from the EMT company stood at Resident 5's bedside on the nonventilator side of the bed. He turned on the portable ventilator located on the gurney, checked the ventilator settings, and then removed Resident 5 from the facility's ventilator and attached the resident to the portable ventilator.

EMT 1 was observed to lift Resident 5 off of the bed and placed her onto the gurney. Neither EMTs removed or changed their gloves or attempted to sanitize or wash their hands before they exited the resident's room.

The RT from the EMT company removed the gloves and a mask while inside the resident's room and used a sanitizing hand gel on his hands as he exited the room.

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During this observation, RT 5 did not provide any directions to either EMT company staff regarding the contact isolation precautions for Resident 5.

3. On 9/4/14 at 1030 hours, an observation was made of a teacher (Teacher 1) walking down the hallway holding a tray containing small cut pieces of purple tissue paper and a bottle of tacky glue. As the teacher was walking down the hallway, three small pieces of the tissue paper flew off of the tray and landed on the floor. Teacher 1 bent down, retrieved the pieces of tissue paper, and replaced the pieces back onto the tray. Teacher 1 continued down the hallway to Room A, placed the tray down on the isolation cart, and opened one drawer to retrieve an isolation gown.

However, before Teacher 1 retrieved a gown she was asked about the above observation. The teacher agreed this was the sequence of events. When asked what procedure she should have followed when the papers fell off of the tray. The teacher stated she should have discarded the pieces of tissue and washed her hands before proceeding on to a resident's room.

F 518 SS=E 483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS

The facility must train all employees in emergency procedures when they begin to work in the facility, periodically review the procedures with existing staff, and carry out unannounced staff drills using those procedures.

This REQUIREMENT is not met as evidenced by:

F 441

483.75(M)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURE/DRILLS

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F518

Corrective Actions Taken for Affected Residents:

This issue does not directly address resident life.

*All staff were re-educated about the Environment of Care (EOC), including emergency food/water, location of emergency equipment, location of emergency shut off valves, etc. 9/5/14

F 518

Corrective Actions for Other Residents:
This issue does not directly address resident life.

*All staff were re-educated about the Environment of Care (EOC), including emergency food/water, 10/16/14

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at least 23,000 people die each year as a direct result of these infections. Many more people die from other conditions that were complicated by an antibiotic-resistant infection. Studies indicate that 30-50% of antibiotics prescribed in hospitals are unnecessary or inappropriate. "There is no doubt that overprescribing and misprescribing is contributing to the growing challenges posed by C-diff and antibiotic-resistant bacteria." Most deaths related to antibiotic resistance happen in healthcare settings, such as hospitals and nursing homes. Studies demonstrate that improving prescribing practices in hospitals can not only help reduce rates of C-diff infection and antibiotic resistance but can also improve individual patient outcomes, all while reducing healthcare costs. A CDC analysis of data regarding antibiotics prescribed in hospitalized patients, showed a 30% reduction in use of broad-spectrum antibiotics would result in a 26% reduction in C-diff infections. In addition, improvement of physician antibiotic prescribing habits from overuse and incorrect use would also help to reduce antibiotic resistance.

According to Medscape.com, C-diff colitis results from a disturbance of the normal bacterial flora of the colon and the release of toxins that cause mucosal inflammation and damage. Antibiotic therapy is the key factor that alters the colonic flora causing C-diff infections.

1 An interview and concurrent clinical record review of the Subacute Infection Control Logs was initiated with the CNO on 9/4/14 at 1345 hours. The CNO stated the facility was using McGeer's criteria to determine the facility's infection rates. The CNO stated he was completing the logs monthly. He stated the

Measures/Systemic Changes:

*A dedicated/qualified infection control practitioner has been recruited and hired to oversee the infection control process. The infection control log has been modified to include the necessary information needed to properly monitor infections on the unit and detect trends in infections and/or antibiotic usage. 10/10/14 9/8/14

*Direct observation of adherence to enhanced standard precautions is being accomplished. A monitoring tool has been developed and will be used to perform direct observation of compliance to the precautions. 10/15/14 Monthly for 6 months and then quarterly thereafter with annual evaluation for need to continue.

*Direct Observation of adherence to infection control practices is being accomplished. A monitoring tool has been developed and will be used to perform direct observation of compliance. 10/15/14

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F 518	Continued From page 41 emergency fire alarm pull was located. She pointed to an oxygen/gas turn off valve located on the wall near the conference/activity room. However, the fire alarm pull was located near the entrance to the nursing unit. 4. On 9/8/14 at 1130 hours, an interview was conducted with RT 3 regarding emergency preparedness. He was able to identify the main gas supply and stated the red lever was the emergency gas shut off valve. However, when asked what the wrench hanging by the main gas supply was for, he stated it could be used to turn off the gas if the red lever broke. 5. During an interview with CNA 2 on 9/4/14 at 0710 hours, CNA 2 was able to locate the facility's main gas supply. When asked how the gas would be shut off in the event of a disaster, CNA 2 stated she would use the large wrench attached with a chain to the main gas supply. When asked where she would place the wrench, CNA 2 stated she was not sure since there were two bolts that could be turned. The Maintenance Director happened to pass by and was asked how to turn off the main gas supply. The Maintenance Director pointed to the bolt located near the ground and stated that was the correct bolt to turn to shut off the gas.	F 518	at all times with identification badge. Person(s) Responsible: Pediatric DSD. DON	

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	555730	A. BUILDING _____ B. WING _____	09/30/2014

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NEWPORT SPECIALTY HOSPITAL	14662 NEWPORT AVENUE TUSTIN, CA 92780

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 518	Continued From page 40 Based on observation and interview, the facility failed to ensure five of six staff were knowledgeable about the facility's emergency procedures. This had the potential to place residents, staff, and visitors in danger in the event of an emergency. Findings: 1. On 9/8/14 at 1015 hours, an interview was conducted with the Activities Coordinator regarding emergency preparedness. When asked where the facility's emergency food and water supply were located. She stated she did not know. When asked where the emergency water shut off valve was located. The Activities Coordinator stated in the basement. She pointed to a green lever as the shut off valve. However, the emergency water shut off valve was located in an adjacent room and on a pipe near the ceiling. She was able to identify the main emergency gas shut off valve. However, when asked what the wrench hanging by the main gas supply was for, she stated she did not know. The wrench was needed to turn off the gas valve. 2. On 9/8/14 at 1030 hours, an interview was conducted with RN 2 regarding emergency preparedness. She was able to point out the main gas supply and stated the red lever was the emergency gas shut off valve. When asked what the wrench hanging by the main gas supply was for, she stated she did not know. 3. On 9/8/14 at 1100 hours, an interview was conducted with CNA 1 regarding emergency preparedness. When asked where the facility's emergency food supply was located. CNA 1 stated she did not know. When asked where the	F 518	location of emergency equipment, location of emergency shut off valves, etc. Measures/Systemic Changes: *Re-education of all staff on EOC, including facility tours. 10/16/14 *Signage was placed on the wall near the main gas shut off valve to instruct in conducting emergency shut off procedure. 10/16/14 *Staff provided with reference material outlining emergency procedures (badge buddies) to wear at all times with identification badge. 10/16/14 Monitoring: *Staff re-education of emergency procedure. 9/15/14 – ongoing *Monthly assessment of staff knowledge is done during EOC rounds and drills. evaluated by direct questions to and return answers by the staff. *Staff were provided with reference material outlining emergency procedures (badge buddies) to wear 10/14/15	

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K 000	INITIAL COMMENTS K3 BUILDING: 02 WING K6 PLAN APPROVAL 1998 K7 SURVEY UNDER: 2000 EXISTING STRUCTURE TYPE: ONE STORY, CONSTRUCTION TYPE (V) (111), FULLY SPRINKLERED The following reflects the find ngs of the California Department of Public Health, during an annual Life Safety Code recertification survey. The findings are in accordance with 42 CFR (Code of Federal Regulations) 483.70 (a) and NFPA (National Fire Protection Association) 101, Life Safety Code 2000 edition, Existing codes Representing the California Department of Public Health 26367 The facility is not in substantial compliance with 42 CFR 483.70 (a) for Long Term Care Facilities. Census = 22	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of res sting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping	K 018	**This Plan of Correction constitutes my written credible allegation of compliance to the deficiencies noted.** **NFP 101 Life Safety code Standard** **K018** Immediate Actions Taken: 9/9/2014 All brown rubber wedges were removed and discarded to allow proper un-impeded closure of the doors noted. All areas were reviewed and no other door hold open devices were found. Education was immediately provided to all staff present focusing on the need to maintain proper closure of all doors and the exclusion of hold open devices	

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are d sclosable 14 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

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K 018	Continued From page 1 the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain their corridor doors. This was evidenced by corridor doors that were impeded from closing. This could result in delay to contain smoke or fire to a room in the event of a fire. This affected 2 of 3 smoke compartments. NFPA 101, Life Safety Code, 2000 Edition 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1 3/4-in. (44-mm) thick, solid bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.	K 018	Systemic Changes: Education was provided to all staff 9/27/14 during a staff meeting to reinforce the proper function and of all doors in the hospital and that any hold open device that impedes the door from proper closure is forbidden. This will also be reinforced in the orientation of any new staff. Absence of hold open devices is included on the environment of care inspection tool and Charge nurse rounding tool. Monitoring: Absence of hold open devices is being monitored during monthly Safety Rounds as well as daily during charge nurse rounds. Results of the monitoring will be reported through the quality assurance reports at the Leadership Team meetings and the hospital Quality Assurance meeting at least quarterly in order to evaluate the POCs effectiveness. . Any deficiencies noted in the interim will be immediately corrected.	

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K 018	Continued From page 2	K 018		

Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.

NFPA 80, Standard for Fire Doors and Fire Windows, 1999 Edition
2-4.1.4. All closing mechanisms shall be adjusted to overcome the resistance of the latch mechanism so that positive latching is achieved on each door operation.

19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted

A 19.3.6.3.3 Doors should not be blocked open by furniture, door stops, chocks, tie backs, drop down or plunger type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches.

Findings:

During a tour of the facility with the Director of Plant Operations, and the Chief of Ancillary Services on 9/9/14, the doors in the facility were observed, and a staff person was interviewed

1. At 9:40 a.m., the self-closing corridor door to the Staff Break Room, was impeded from closing with a brown rubber wedge under the door.

2. At 10:59 a.m., the self-closing corridor door to Physical Therapy/Rehab, was impeded from

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K 018 Continued From page 3

closing with a brown rubber wedge under the door

3. At 11:00 a.m., the Director of Plant Operations said during an interview that he checked all of the doors yesterday and they were not wedged open.

K 025 NFPA 101 LIFE SAFETY CODE STANDARD
SS=E

Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4

This STANDARD is not met as evidenced by:
Based on observation, the facility failed to maintain the integrity of the fire resistance rated construction of its smoke barrier walls. This was evidenced by an unsealed penetration. This could result in the reduction in staff ability to protect in place due to smoke and fire. This affected 2 of 3 smoke compartments.

NFPA 101, Life Safety Code, 2000 Edition
19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour.

K 018

K 025

NFP 101 Life Safety code Standard

K025

Immediate Actions Taken:

The noted unsealed pipe penetration was sealed with the proper fire caulking. All other smoke barriers were inspected and no other unsealed penetrations were found. 9/9/14

Systemic Changes: 9/24/14

All work done above the ceiling by contractors and/or in-house personnel will be required to obtain an "above the ceiling work permit" that includes a final inspection of any work done to insure that any penetrations are properly sealed.

Monitoring:

All above the ceiling work will be monitored through the work permit process. Monthly life safety inspections will include observation of smoke barrier walls. Work permits and inspections will be reported through the quality assurance reports at the Leadership Team meetings and the

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K 025	Continued From page 4 Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor. Exception No. 2: * Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 has been provided for smoke compartments adjacent to the smoke barrier. 8.3.6.1 Pipes, conduits, ducts, cables, wires, air ducts, pneumatic tube and ducts, and similar building services equipment that pass through floors and smoke barriers shall be protected as follows: (1) The space between the penetrating item and the smoke barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed of the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (3) Where designs take transmission of vibration into consideration, any vibration isolation shall	K 025	hospital Quality Assurance meeting at least quarterly in order to evaluate the POCs effectiveness. Any deficiencies noted in the interim will be immediately corrected.	

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K 025	Continued From page 5 meet one of the following a. It shall be made on either side of the smoke barrier. b. It shall be made by an approved device that is designed for the specific purpose. Findings. During a tour of the facility with the Director of Plant Operations, and the Chief of Ancillary Services on 9/9/14, the smoke barrier walls were observed. At 12:49 p.m., there was an approximately 1/2 inch unsealed conduit pipe in the smoke barrier wall near Room 309. The Director of Plant Operations acknowledged the finding	K 025		
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by Based on observation and interview, the facility failed to maintain the smoke barrier doors. This was evidenced by a smoke barrier door that failed to latch. This could fail to contain smoke during a	K 027	**NFP 101 Life Safety code Standard** **K027** Immediate Actions Taken: 9/9/14 The door near room 307 was adjusted to insure proper latching. All other doors were checked and no others were found to be deficient. Systemic Changes: 9/22/14 All fire doors will be checked for proper latching with each fire drill (monthly) and each safety inspection (monthly). Any deficiencies will immediately be corrected.	

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K 027	Continued From page 6 fire. This affected 2 of 3 smoke compartments. NFPA 101, Life Safety Code, 2000 Edition 19.2.2.2.6* Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier, or hazardous area enclosure shall be permitted to be held open only by an automatic release device that complies with 7.2.1.8.2. The automatic sprinkler system, if provided, and the fire alarm system, and the systems required by 7.2.1.8.2 shall be arranged to initiate the closing action of all such doors throughout the smoke compartment or throughout the entire facility. 7.2.1.8.2 In any building of low or ordinary hazard contents, as defined in 6.2.2.2 and 6.2.2.3, or where approved by the authority having jurisdiction, doors shall be permitted to be automatic-closing, provided that the following criteria are met. (1) Upon release of the hold-open mechanism, the door becomes self-closing. (2) The release device is designed so that the door instantly releases manually and upon release becomes self-closing, or the door can be readily closed. (3) The automatic releasing mechanism or medium is activated by the operation of approved smoke detectors installed in accordance with the requirements for smoke detectors for door release service in NFPA 72, National Fire Alarm Code®. (4) Upon loss of power to the hold-open device, the hold-open mechanism is released and the door becomes self-closing. (5) The release by means of smoke detection of one door in a stair enclosure results in closing all doors serving that stair.	K 027	Monitoring: Results of the inspection and drills will be reported through the quality assurance reports at the Leadership Team meetings and the hospital Quality Assurance meeting at least quarterly in order to evaluate the POCs effectiveness.	

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K 027	Continued From page 7 Findings: During a tour of the facility with the Director of Plant Operations, and the Chief of Ancillary Services on 9/9/14, the facility smoke barrier doors were observed, and a staff person was interviewed. 1. At 11:07 a.m., the north smoke barrier door near Room 307 was not latching when tested. Two attempts were made without the door latching. 2. At 11:08 a.m., the Director of Plant Operations said during an interview that he checked all of the doors yesterday and they all worked.	K 027	**NFP 101 Life Safety code Standard** **K050**	
K 050 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on interview, the facility failed to prepare staff members to respond to emergency situations. This was evidenced by staff members that failed to know how to open a locked bathroom door and by not being aware of the facility protocols. This could result in facility staff	K 050	Immediate Actions Taken: 9/15/14 Remedial instruction was immediately provided to the staff members on the unit including the two that could not properly answer the questions. All other staff members present were given instruction as well. Systemic Changes: 9/15/14 Remedial instruction was given for all staff members. RACE, PASS, Code Red and unlocking of the bathroom doors is included in the annual competency assessment with return demonstration. Devices to open the bathroom doors are maintained in each Fire Extinguisher cabinet to facilitate.	

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K 050	Continued From page 8 not being prepared to respond to emergency evacuation with a person locked in a bathroom. This affected 3 of 3 smoke compartments. NFPA 101, Life Safety Code, 2000 Edition 19.7.1.3 Employees of health care occupancies shall be instructed in life safety procedures and devices. 19.7.2 Procedure in Case of Fire 19.7.2.1* For health care occupancies, the proper protection of patients shall require the prompt and effective response of health care personnel. The basic response required of staff shall include the removal of all occupants directly involved with the fire emergency, transmission of an appropriate fire alarm signal to warn other building occupants and summon staff, confinement of the effects of the fire by closing doors to isolate the fire area, and the relocation of patients as detailed in the health care occupancy's fire safety plan. 19.7.2.2 A written health care occupancy fire safety plan shall provide for the following (1) Use of alarms (2) Transmission of alarm to fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire 19.7.2.3 All health care occupancy personnel shall be instructed in the use of and response to fire alarms. In addition, they shall be instructed in the use of the code phrase to ensure transmission of an alarm under the following conditions (1) When the individual who discovers a fire must immediately go to the aid of an endangered	K 050	Monitoring: Staff knowledge of RACE, PASS, Code Red and unlocking of the bathroom doors is being monitored during monthly Safety Rounds and fire drills as well as periodically during leadership rounds. Results of the monitoring will be reported through the quality assurance reports at the Leadership Team meetings and the hospital Quality Assurance meeting at least quarterly in order to evaluate the POCs effectiveness. Any deficiencies noted in the interim will be immediately corrected.	

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K 050	Continued From page 9 person (2) During a malfunction of the building fire alarm system Personnel hearing the code announced shall first activate the building fire alarm using the nearest manual fire alarm box and then shall execute immediately their duties as outlined in the fire safety plan. Findings During a tour of the facility with the Director of Plant Operations, and the Chief of Ancillary Services on 9/9/14, staff members were interviewed. At 12:55 p.m., staff member 1 and staff member 2 were interviewed, and were asked to open a locked bathroom door to evacuate a person out of the room during a trash can fire. Two of two staff could not open the locked door and were unable to describe the facilities protocols RACE (Rescue, Alarm Confine, Extinguish), PASS (Pull, Aim, Squeeze, and Sweep), code word (Code RED). The door could be unlocked with a small key or a coin	K 050		
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by Based on document review and interview, the facility failed to maintain the fire sprinkler system.	K 062	**NFP 101 Life Safety code Standard** **K062** Immediate Actions Taken: 9/23/14 The fire sprinkler repairs listed were scheduled and completed on 9/23/2014	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	555730	A. BUILDING 01 B. WING	09/09/2014

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K 062	Continued From page 10 This was evidenced by documented failures of the sprinkler system during an inspect on by a licensed vendor and by the failure to conduct 1 of 4 quarterly test of the Inspector's Test Valve. This could resu l in the failure of the fire sprinkler system in the event of a fire. This affected 3 of 3 smoke compartments. NFPA 101, L fe Safety Code 2000 Edition 9 7 5 Maintenance and Testing. All automatic sprinkler and standp pe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based F re Protection Systems 4 6 12.1 Whenever or wherever any device, equ pment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by the authority having jurisdiction. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 1998 Edition 1-11.3 Corrective maintenance includes, but is not limited to, replacing loaded, corroded, or painted sprinklers; replacing missing or loose pipe hangers, cleaning clogged fire pump impellers, replacing valve seats and gaskets, restoring heat in areas subject to freezing temperatures where water-filled piping is installed, and replacing worn or missing fire hose or nozzles. 9-5.1.1 All valves shall be inspected quarterly	K 062	Systemic Changes: Annual fire sprinkler inspection and quarterly valve testing are scheduled on an ongoing basis by the Director of Plant Operations. A vendor was selected who will also calendar the required inspections and testing in their PM system.. Any corrective actions required as a result of the scheduled testing are performed as soon as possible following the testing. The testing schedule, results of the testing and any corrective actions required and performed are reported to and reviewed by hospital leadership and the Environment of Care Team by the Director of Plant Operations. Monitoring: The Annual fire sprinkler inspection and quarterly valve testing schedule, results of the testing and any corrective actions required and performed are monitored and reported through Leadership Team meetings and the hospital Quality Assurance and Environment of Care Team meetings at least quarterly in order to evaluate the POCs effectiveness. . Any deficiencies noted in the interim will be immediately corrected.	9/23/14

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K 062	Continued From page 11 The inspection shall verify that the valves are in the following condition: (a) In the open position (b) Not leaking (c) Maintaining downstream pressures in accordance with the design criteria (d) In good condition, with handwheels installed and unbroken 1-8.1 Records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. 2-2.1.1 Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint and physical damage and shall be installed in the proper orientation (e.g., upright, pendent, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, or in the improper orientation. Exception No. 1: Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown. 2-2.6 Alarm Devices. Alarm devices shall be inspected quarterly to verify that they are free of physical damage. Findings: During document review with the Director of Plant Operations and the Chief of Ancillary Services on 9/9/14, the sprinkler maintenance documents	K 062		

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K 062	Continued From page 12 were reviewed, repair documents were requested, and a staff member was interviewed. 1. At 9:57 a.m., there was no documented evidence of an Inspector's Test Valve test for the month of March 2014. The testing records provided the dates 6/17/14 and 1/13/14. 2. At 9:59 a.m., there was documented evidence that 29 sprinklers failed during an annual inspection on 6/6/14 by a licensed vendor. There was no evidence of repairs. The following items were identified as failed: a. 15 corroded sprinkler heads at the main entrance. b. 3 corroded sprinkler heads in the kitchen. c. 1 corroded sprinkler head in the basement. d. 2 corroded sprinkler heads at the south exit. e. 4 corroded sprinkler heads located at the west over hang. f. 2 corroded sprinkler heads at south exit (165 ssp 8 ft ceiling). g. 2 corroded sprinkler heads at west exit (165 ssp 8 ft ceiling). 3. At 10:02 a.m., the Director of Plant Operations said during an interview, that he has schedu'ed to have the sprinklers repaired tomorrow.	K 062		
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10	K 064	NFP 101 Life Safety code Standard K064 Immediate Actions Taken: 9/9/14 The dresser was removed and remedial instruction was immediately provided to all staff members on the unit in the proper clearance required to maintain access to all fire extinguishers.	

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K 064	Continued From page 13	K 064		

This STANDARD is not met as evidenced by:
Based on observation and interview, the facility failed to maintain its portable fire extinguishers. This was evidenced by a portable fire extinguisher that was obstructed from access. This could result in a delay of access to the fire extinguisher in the event of a fire. This affected 1 of 3 smoke compartments.

NFPA 101, Life Safety Code, 2000 Edition
9.7.4 Manual Extinguishing Equipment.
9.7.4.1* Where required by the provisions of another section of this Code, portable fire extinguishers shall be installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers.

NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition
1-6.3 Fire extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of fire. Preferably they shall be located along normal paths of travel, including exits from areas.

Findings:

During a tour of the facility with the Director of Plant Operations, and the Chief of Ancillary Services on 9/9/14, the portable fire extinguishers were observed, and staff was interviewed.

1. At 9:51 a.m. there was a fire extinguisher near the soiled utility Room/Bio-Hazard Room near shower B, that was impeded from access with a three drawer dresser in front of the device.

Systemic Changes: 9/25/14

Remedial instruction was given for all staff members in the proper clearance required to maintain access to all fire extinguishers. In addition, signage was placed on each fire extinguisher cabinet as a reminder.

Monitoring:

Proper clearance for all fire extinguishers is being monitored during monthly Safety Rounds as well as daily during charge nurse rounds. Results of the monitoring will be reported through the quality assurance reports at the Leadership Team meetings and the hospital Quality Assurance meeting at least quarterly in order to evaluate the POCs effectiveness. . Any deficiencies noted in the interim will be immediately corrected.

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K 064	Continued From page 14 2. At 9:52 a.m., the Director of Plant Operations said during an interview that the dresser should not be in front of the fire extinguisher. The Director of Plant Operations stated that it not there yesterday when he toured.	K 064		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9 1.2 This STANDARD is not met as evidenced by Based on observation and interview, the facility failed to maintain their electrical equipment and utilities. This was evidenced by a multi-plug power strip that was plugged into another multi-plug power strip, and by unidentified circuit breakers. This could result in an electrical fire and cause delay in locating a circuit breaker. This affected 1 of 3 smoke compartments. NFPA 101, Life Safety Code, 2000 Edition SECTION 9.1 UTILITIES 9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction. NFPA 70, National Electrical Code, 1999 Edition 240-4 Flexible cord, including tinsel cord and extension cords, and fixture wires shall be protected against overcurrent by either (a) or (b) (a) Ampacities. Flexible cord shall be protected by an overcurrent device in accordance with its ampacity as specified in Tables 400-5(A) and (B).	K 147	NFP 101 Life Safety code Standard K147 Immediate Actions Taken: 9/10/14 The improperly deployed multi-plug power strips were removed and all plugs and cords were re-done to insure that they were orderly and proper. Re Remedial instruction was immediately provided to the staff members on the unit. An Electrical contractor was hired to begin to work to trace electrical circuits 2, 5, 25 26, and 28 to label appropriately. Systemic Changes: 9/25/14 Remedial instruction was given for all staff members in the proper use when required of extension cords/multi-plug power strips. Whenever an extension cord or multi-plug power strip is needed, the plant operations department will inspect to insure proper usage. The electrical contractor will verify the hospital single line drawing and review each circuit to insure that they are all labeled correctly.	

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K 147	Continued From page 15 Fixture wire shall be protected against overcurrent in accordance with its ampacity as specified in Table 402-5. Supplementary overcurrent protection, as in Section 240-10, shall be permitted to be an acceptable means for providing this protection. 400-8 Unless specifically permitted in Section 400-7, flexible cord and cables shall not be used for the following. (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces (5) Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (6) Where installed in raceways, except as otherwise permitted in this Code 384-13. General. All panelboards shall have a rating not less than the minimum feeder capacity required for the load computed in accordance with Article 220. Panelboards shall be durably marked by the manufacturer with the voltage and the current rating and the number of phases for which they are designed and with the manufacturer's name or trademark in such a manner so as to be visible after installation, without disturbing the interior parts or wiring. All panelboard circuits and circuit modifications shall be legibly identified as to purpose or use on a circuit directory located on the face or board Findings:	K 147	Monitoring: The absence of improper usage of Multi-plug power strips and extension cords and the proper labeling of electrical circuits is being monitored during monthly Safety Rounds. Results of the monitoring will be reported through the quality assurance reports at the Leadership Team meetings and the hospital Quality Assurance meeting at least quarterly in order to evaluate the POCs effectiveness. . Any deficiencies noted in the interim will be immediately corrected.	

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K 147	Continued From page 16 During a tour of the facility with the Director of Plant Operations, and the Chief of Ancillary Services on 9/9/14, the electrical equipment and wiring were observed, and a staff person was interviewed. 1. At 9:47 a.m., there was a multi-plug power strip that was plugged into another multi-plug power strip under the desk of the nursing station 2. At 9:49 a.m., there were 6 of 42 circuit breakers that were not identified to their purpose. Circuits 2, 5, 6, 25, 26, and 28 were not labeled. 3. At 9:50 a.m., the Director of Plant Operations said during an interview, that he was working with Office of Statewide Health Planning and Development to correct the unmarked circuit breakers	K 147		

California Department of Public Health

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	CA060001166	A. BUILDING _____ B. WING _____	C 08/18/2014

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A 000	Initial Comments The following reflects the findings of the California Department of Public Health during the investigation of COMPLAINT NUMBER: CA00408741. Inspection was limited to the specific complaint(s) investigated and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: Surveyor 1835, HFEN. Findings for Complaint Number: CA00408741. The complaint allegation(s) were substantiated and regulatory violations written at A001 and A017.	A 000	**This Plan of Correction constitutes my written credible allegation of compliance to the deficiency noted.**	
A 001	Informed Medical Breach Health and Safety Code Section 1280.15 (b)(2), " A clinic, health facility, agency, or hospice shall also report any unlawful or unauthorized access to, or use or disclosure of, a patient's medical information to the affected patient or the patient's representative at the last known address, no later than five business days after the unlawful or unauthorized access, use, or disclosure has been detected by the clinic, health facility, agency, or hospice." The CDPH verified that the facility informed the affected patient(s) or the patient's representative(s) of the unlawful or unauthorized access, use or disclosure of the patient's medical information.	A 001	**Health and Safety Code Section 1280.15(b)(2),** **A001** Immediate Actions Taken: As soon as the potential breach was identified, the Activity Coordinator (AC) was interviewed and placed on administrative suspension until the investigation was complete. The AC was asked if she had posted PHI on any social media for any patient at any time other than this one incident. The AC stated that there were no other	8/4/2014

Licensing and Certification Division
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 017	Continued From page 1	A 017	postings. Additionally the Facebook page was reviewed at the time and this was confirmed. The posting with the photo was removed from the AC's Facebook account at this time. The hospital Compliance Officer was notified who then informed the patient's representatives of the disclosure.	8/7/14
A 017	1280.15(a) Health & Safety Code 1280 (a) A clinic, health facility, home health agency, or hospice licensed pursuant to Section 1204, 1250, 1725, or 1745 shall prevent unlawful or unauthorized access to, and use or disclosure of, patients' medical information, as defined in subdivision (g) of Section 56.05 of the Civil Code and consistent with Section 130203. The department, after investigation, may assess an administrative penalty for a violation of this section of up to twenty-five thousand dollars ($25,000) per patient whose medical information was unlawfully or without authorization accessed, used, or disclosed, and up to seventeen thousand five hundred dollars ($17,500) per subsequent occurrence of unlawful or unauthorized access, use, or disclosure of that patients' medical information. For purposes of the investigation, the department shall consider the clinic's, health facility's, agency's, or hospice's history of compliance with this section and other related state and federal statutes and regulations, the extent to which the facility detected violations and took preventative action to immediately correct and prevent past violations from recurring, and factors outside its control that restricted the facility's ability to comply with this section. The department shall have full discretion to consider all factors when determining the amount of an administrative penalty pursuant to this section. This Statute is not met as evidenced by: Findings: Review of hospital documentation showed a breach involving Patient A, an incapacitated	A 017	<u>Systemic Changes:</u> HIPAA in-services were performed by the Compliance Officer for all staff. The Compliance Officer met with the AC for a one on one session. The use of social media and its potential for privacy violations was emphasized. A pamphlet titled "A Nurse's Guide to the Use of Social Media" was ordered from the National Council of State Boards of Nursing and shared with all patient care staff. The content of the Compliance Officer's in-services as well as the pamphlet is included in new employee orientation for all new employees. <u>Monitoring:</u> The staff has been requested to notify the leadership/supervisory team about any potential social media (or other) HIPAA violations immediately, either ones they committed or other staff may have committed. The leadership and supervisory teams will be reminded by the CNO/COO during monthly management meetings to reinforce this reporting requirement with their staff and query the staff during unit staff	9/2/14 9/2/14 9/2/14 ongoing

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A 017	Continued From page 2 minor, occurred on 8/2/14. On 8/4/14, the hospital's investigation showed a photo of Patient A was posted onto the Activity Coordinator's (AC) Facebook (a social network) account. The Facebook post of Patient A's photo showed it had been viewed by unauthorized "friends" of the AC. There were also comments posted between the parents of Patient A and the AC. Further review of the hospital's investigation showed an interview with the AC occurred on 8/4/14. The AC stated, when asked, she was aware taking the picture and posting it on Facebook violated privacy laws as well as hospital policy, but did it anyway for the parents. Patient A's disclosed PHI included a full face and torso picture which showed the tracheostomy dressing at his neck and the use of stabilization cushions. The picture portrays Patient A as a patient of the hospital as evidenced by the electrical socket in the wall behind the patient and the privacy curtains at each side. On 8/18/14 at 1132 hours, an informal telephone conference with the Chief Compliance Officer confirmed the breach occurred as documented. Additionally, it was confirmed there was no documentation found permitting the AC to photograph the patient for posting on a social network.	A 017	meetings. Any reports about potential violations are reported to the Compliance Officer and investigated in accordance with the usual compliance investigations procedure. Results are reported by the Compliance Officer to the Compliance Committee on a quarterly basis. Periodically the process will be assessed by the Compliance Committee to determine whether additional or different measures might be considered.	

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F 000	INITIAL COMMENTS The following represents the findings of the California Department of Public Health during an ABBREVIATED survey for complaint No: CA00405575. The investigation was limited to the specific complaint investigated and does not represent the findings of a full investigation of the facility. Representing the California Department of Public Health: Pharmacist Consultant II, 32097 and Pharmacist Consultant II, 13095 The Pharmacist Consultants entered the facility on 7/22/14 at 1340 hours and reviewed three clinical records. THE DEPARTMENT WAS ABLE TO SUBSTANTIATE THE COMPLAINT ALLEGATIONS. Glossary: P&P: Policy and Procedure RPh: Facility Pharmacist RN: Registered Nurse MAR: Medication Administration Record	F 000	**This Plan of Correction constitutes my written credible allegation of compliance to the deficiencies noted.**	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 425	**483.60(1)(b) PHARMACEUTICAL SVC-ACCURATE PROCEDURES, RPH** **F425** Immediate Actions Taken: 1. Cephalexin was immediately administered to Resident 1 upon return from the outside appointment. Charge nurses will immediate notify the pharmacy upon receipt of any new medication order The charge nurse will call the pharmacy for any new order for anti-infectives, and drugs used for nausea, agitation, diarrhea or other	8/8/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

CEO | 8/22/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555730	A. BUILDING _____ B. WING _____	C 08/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWPORT SPECIALTY HOSPITAL	14662 NEWPORT AVENUE TUSTIN, CA 92780

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 1 A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility failed to implement their P&Ps to ensure resident safety as evidenced by: 1. Cephalexin (antibiotic used to treat infections) was not administered within four hours of the ordered time for Resident 1. This failure has the potential to result in a delay of treatment. 2. The pharmacy dispensed pediatric glycerin (laxative) suppositories instead of a dulcolax (laxative) suppository for Resident 2. This failure has the potential to result in a medication error. 3. A physician's medication order was not accurately transcribed for Resident 3. This failure has the potential to result in a medication error. 4. There was no accountability of the medications in the oral emergency kit (E-Kit) when it was left unlocked and there was no documentation of the	F 425	severe discomfort if not received within 2 hours to insure timely delivery. The medication will be administered immediately upon receipt. 2. All medications were reviewed to insure that there were no other errors in dispensing. All medications are verified with the MAR before administration. 3. The Transcription error was corrected before any incorrect doses were administered. All other new orders and recaps were reviewed to insure accurate transcription. No other errors were found. 4. The e-kit withdrawal form was immediately completed and the kit was locked with the appropriate lock and pharmacy notified for replacement. <u>Systemic Changes:</u> 1. E-kit contents were reviewed to insure that common anti-infectives, and drugs used for nausea, agitation, diarrhea or other severe discomfort are present and stocked. A meeting was held with the pharmacy to insure that any new stat or anti-infectives, and drugs used for nausea, agitation, diarrhea or other severe discomfort that are not present in the e-kit will be delivered by the pharmacy in a timely manner so that the medication can be administered	8/8/2014 8/8/2014 8/8/2014 8/19/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 425	Continued From page 2 medication removed from the kit found on the emergency medication log. This failure has a potential to result in a medication diversion or loss. Findings: 1. Review of the facility's P&P titled "Administration of Medication: General - Sub-Acute" dated 3/11, showed on page 4: anti-infectives and drugs used to treat severe pain, nausea, agitation, diarrhea, or other severe discomfort shall be available and administered within four hours of the time ordered. Clinical record review for Resident 1 was initiated on 8/4/14. Review of Resident 1's physician's orders showed cephalexin 250 mg was ordered on 8/2/14 at 1015 hours, for a possible infected ingrown hair on the left labia. Review of the facility's faxed confirmation showed the order was faxed to the pharmacy on 8/2/14 at 1025 hours, per the charge RN. Review of the Out of Facility Release form showed the resident was out of the facility on 8/2/14 between the 1500 and 2100 hours. Review of Resident 1's MAR showed cephalexin was administered at 2200 hours on 8/2/14, 11 hours and 45 minutes after the ordered time. During an interview on 8/4/14 at 1415 hours, RPh 1 stated the Pharmacy's documentation showed the order was received at 1115 hours. Cephalexin was delivered at 1800 hours. During an interview on 8/4/14 at 1220 hours, Charge RN 1 confirmed the cephalexin for Resident 1 was delivered from the pharmacy at	F 425	within the 4 hour time window. In-service education was conducted with the Charge Nurses. 2. It was noted that the two drugs in question were packaged very similarly. Glycerin suppositories and dulcolax suppositories were added to the look alike/sound alike alert list. A different brand of drug is being requested so that there is a greater contrast between the two packaging. 3. A new computer system is being deployed to reduce manual transcription of medication recaps and renewals. The 24 hour chart check policy and procedure was written and reviewed with the licensed nursing staff during a mandatory in-service education session. 4. In-service education was completed for all licensed nurses on the proper use of the e-kit. The e-kit review was added to the charge nurse checklist to insure that the proper procedures are being followed. <u>Monitoring:</u> 1. All orders for new stat or anti-infectives, and drugs used for nausea, agitation, diarrhea or other severe discomfort will be monitored for timely administration. The number of drugs administered within the 4 hour time frame divided by the number ordered will be	8/29/2014 8/29/2014 8/29/2014 8/29/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 425	Continued From page 3 1800 hours on 8/2/14 and administered at 2200 hours. 2. Inspection of medication cart 1 was initiated on 8/4/14 at 1205 hours. A clear medication bag labeled as containing a dulcolax suppository for Resident 2 was found in the medication cart. However, the content of the medication bag was identified as two pediatric glycerin suppositories. RN 1, RPh 1 and RPh 2 examined the bag labeled as dulcolax suppository for Resident 2 and acknowledged the bag contained pediatric glycerin suppositories. 3. Review of the facility's Administration P&P titled ADM-334 Transcription of Physician's Orders" dated 11/10, read: "Goal: To assure accuracy in transcription as well as coordination and implementation of therapeutic orders ....L. The physician must be notified of the inability to carry out an order if appropriate. A 24 hour chart check must be completed during the Night Shift to verify the accuracy and follow through of all orders written that day." Review of the facility's Nursing Services P&P titled NUR-232 Medication Administration, General Guidelines dated 11/10, read: "A. All medication orders must be ordered for a specific patient and include the name of drug, exact dosage ..." Review of the facility's Pharmacy P&P titled RX-173 Orders: Drugs dated 11/10, read: "All orders for drugs shall be written ....All orders for medications, procedures and devices shall be reviewed by a pharmacist." The clinical record for Resident 3 was reviewed	F 425	reported through the quality assurance reports at the Leadership Team meetings in order to evaluate the POCs effectiveness. Further changes will be implemented if necessary based on this evaluation. 2. All medications are verified by the licensed nurse to insure the proper medication is administered. Any discrepancies are immediately reported to the charge nurse and pharmacy. Each incidence will be reported through the quality assurance reports at the Leadership Team meetings in order to evaluate the POCs effectiveness. Further changes will be implemented if necessary based on this evaluation. 3. All Transcription errors found during the 24 hour chart check and/or pharmacist review will be immediately verified and corrected. Each incidence will be reported through the quality assurance reports at the Leadership Team meetings in order to evaluate the POCs effectiveness. Further changes will be implemented if necessary based on this evaluation. 4. Each entry into the e-kit will be monitored by the charge nurse. Each entry divided by the number of correctly processed entries will be reported through the quality assurance reports at the Leadership Team meetings in order	8/29/2014 8/29/2014 8/29/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 425	Continued From page 4 on 8/4/14 at 1500 hours. A hand-written physician's medication order for Baclofen (a muscle relaxant) dated on 8/3/14, showed an order for "Baclofen 10 milligram (mg) tab via gastrostomy tube (GT) every 6 hours for spasticity." Review of Resident 3's MAR on 8/4/14 at 1505 hours, showed the resident received a different amount of Baclofen than was ordered on 8/3/14. The medication order transcribed on Resident 3's MAR read: "Baclofen 10 mg tab take 2.5 tabs (25 mg) via G-Tube every 6 hours for spasticity." During an interview with Charge Nurse 2 on 8/4/14 at 1545 hours, Charge Nurse 2 confirmed the above order for Baclofen on Resident 3's MAR. In a concurrent interview with RN 1, the RN stated she transcribed the physician's medication order for the Baclofen in Resident 3's clinical record on 8/3/14. During the interview, RN 1 stated: "I gave this resident 25 mg of Baclofen this morning, but I must have been writing too fast when I wrote this order and I made this mistake." RN 1 further stated a second licensed nurse on the night shift of 8/3/14, reviewed the physician's medication order for Baclofen transcribed by RN 1. The second licensed nurse, who was responsible for reviewing all medication orders written during the day shift, did not catch the transcription error made by RN 1 earlier on 8/3/14, regarding Resident 3's Baclofen order. During an interview with Charge Nurse 2 and PIC on 8/4/14 at 1550 hours, they stated the physician's order, written by RN 1 for Resident 3's Baclofen, was not reviewed by the RPh. 4. Review of the facility's Pharmacy P&P titled	F 425	to evaluate the POCs effectiveness. Further changes will be implemented if necessary based on this evaluation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 425	Continued From page 5 Emergency Medication Supplies dated 01/01/13, showed the facility should complete the emergency box withdrawal form for documenting the resident and the medication used for the resident. On 8/7/14 at 1410 hours, the E-Kits were inspected in the medication room with the Charge Nurse, RPh 2 and the Nurse Manager. The oral E-kit was unlocked. Review of the Emergency Medication log inside the E-kit showed it was not completed. The Charge Nurse, RPh 2 and the Nurse Manager acknowledged the unlocked E-kit and that there was no documentation as to when the E-kit was opened, by whom and what medication was removed from the E-kit. The Charge Nurse stated the E-kit was opened during the night, and the night Charge Nurse notified the pharmacy that the E-Kit was opened per the change of shift report.	F 425		

RESPONSE TO DEFICIENCIES
EXHIBIT P CMS Statements of Deficiency

Southern California Hospital at Culver City

COUNTY OF LOS ANGELES
HEALTH FACILITIES DIVISION
3400 Aerojet Avenue, Suite 323
El Monte, CA 91731

FACSIMILE TRANSMISSION

ADDRESSEE:	ORIGINATOR:
NAME: Pamela Loo, RN Director of Quality **Attention:**	FROM: Rosario Grospe, RN, Senior HFEN Assistant Supervisor, Acute and Ancillary Unit
ORGANIZATION: Southern California Hosp at Culver City SNF DP	**Phone:** (626) 312-1129
CITY, STATE, & ZIP Culver City	FAX: (626) 927-9293
Telephone 310-836-7000 ext 1046	DATE 714/15
FAX #: 310-840-5426	PAGES INCLUDING COVER PAGE = 11

NOTES TO ADDRESSEE:

Attached is the ameded CMS 2567, Statement of Deficiencies and Plan of Correction for the Recertification Survey (LSC) completed 6/22/15. The hard copy will be mailed today. Please sign the Signature Requirement Notice and fax it back to our office as soon as possible.

Please submit the plan of correction on or before 7/24/15.

If you have any questions, please don't hesitate to call us.

Thank you, Rosario Grospe, Senior HFEN

Information contained in this facsimile message is privileged and confidential information intended for the use of the Addressee listed above.

If you are neither the intended recipient not the employee or agent responsible for delivering this information to the intended recipient, you are hereby notified that any disclosure, copying, distribution, or taking any action in reliance on the content of this facsimile information is strictly prohibited.

If you have received this FAX in error, please notify the sender immediately by telephone and destroy all documents received in error.

State of California—Health and Human Services Agency Department of Health Services

SIGNATURE REQUIREMENT NOTICE
(For Plan of Correction)

Notice to Licensee/Designee

The surveying state agency is required to obtain a signed plan of correction for deficiencies noted on the Statement of Deficiencies and Plan of Correction (Code of Federal Regulations, Title 42, Section 489.13; State Operations Manual, Section 2612; and California Health and Safety Code, Section 1280). By signing a plan of correction, a licensee or designee does not necessarily admit guilt of any alleged violation nor does this interfere with the right to contest or appeal any alleged violations on which the plan of correction is based or the same period for correction. It does acknowledge responsibility for compliance with licensing requirements, with appropriate requirements of the Medicare and Medi-Cal programs, that an exit conference was held during which the items listed were discussed, and that a copy of the deficiency/report and plan of correction was received.

Name of facility	City
Southern California Hosp at Culver City SNF/DP	Culver City

Copy of this notice received:

Licensee or designee signature	Date
Gerald B. Clute	7/20/15

Copy of this notice presented to licensee or designee:

Licensing Evaluator signature	Date
Rosario Grosse for Sin Lin Chang	7/13/15

Complaint Notice

If there should be disagreement between the Licensee or Designee and the Evaluator of the Survey Team on an interpretation of the regulations or a field decision, the Licensee of Designee may wish to call and discuss this with the District Licensing Supervisor.

Name of Licensing Supervisor	Telephone
Eric Stone, Program Manager	626-312-1142

Instructions

This notice is to be used with Plans of Correction for Skilled Nursing Facilities, Intermediate Care Facilities, Intermediate Care Facilities/Developmentally Disabled, Intermediate Care Facilities/Developmentally Disabled-Habilitative, Intermediate Care Facilities/Developmentally Disabled-Nursing, Congregate Living Health Facilities, Pediatric Day Health and Respite Care Facilities, and Hospitals with Distinct Part Skilled Nursing Facilities or Intermediate Care Facilities. It is to be signed by the licensee/designee and the licensing evaluator. A copy is left with the licensee/designee and the original is kept in the district office licensing file.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	555874		06/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during a re-certification survey. Representing the Department of Public Health: Surveyor 17030, RN, HFEN Surveyor 25524, RN, HFEN Surveyor 16281, REHS, HFE Total Resident Population 17 Total Resident Sample Size: 8 Highest Scope/Severity: E	F 000		
F 154 SS=E	483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the resident or the resident's representative had the right to be fully informed in advance of the risks and benefits of anti-antipsychotic and physical restraints to be administered to six (6) of eight (8) sampled residents (1, 2, 3, 4, 6, and 7). The facility failed	F 154	1. How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Corrective Action will be accomplished by the re-education of staff on the Restraints Policy and Procedure Application and monitoring SAA.049 and Consents PAT.037, completed on 7/19/2015. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. The SubAcute Unit at Southern California Hospital at Culver City (SCHCC) will identify other residents having the same potential for deficient practice by discussing restraint plan of care in interdisciplinary weekly rounds, and 100% monitoring of restraint documentation and informed consents, and will monitor them beginning August 1,2015 as process improvements and report it quarterly to quality council, medical executive committee and governing board.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Gerald [signature]	CEO	7/20/15

...y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ...her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555874	A. BUILDING 01 - BROTMAN MEDICAL CENTER DP SNF B. WING _____	06/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

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K 000	INITIAL COMMENTS This facility was surveyed under 42 CFR Part 483.70(a), Life Safety Code NFPA 101, 2000 Edition, Chapter 19, Existing Health Care Occupancies, and other applicable codes. Amended 7/14/15 Representing the Department of Public Health: Evaluator ID#16281 The following represents the findings of the Department of Public Health during a Life Safety Code Survey.	K 000		
K 050 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on record review, and interview, the facility failed to provide supporting documentation that the subacute staff participated in fire drills at least quarterly on each shift. The deficiency had the potential for staff to not be familiar with the facility's fire emergency plan, and not be prepared to put it in effect in the event of a	K 050	*Fire Drill reports* • No residents were affected by the deficient practice. • The Facility performs audits of all Fire Life Safety requirements on a monthly basis to ensure compliance. • An additional form has been added to the Fire Drill Critique package to document participation/attendance for all employees. The facilities Environment of Care committee meets regularly and fire drills are monitored and reviewed at these meetings. The hospital has also assigned the Vice President of Facilities to ensure that all Life safety & Environmental requirements are met. • Fire Drills are reported to the EOC Committee and any deficiencies will be corrected immediately. EOC reports quarterly to the Quality Council, Medical Executive Committee and the Governing Board. • Changes completed on 6/30/16	6/30/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

CEO | 7/20/15

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SIGNATURE REQUIREMENT NOTICE
(For Plan of Correction)

Notice to Licensee/Designee

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Name of facility	City
Southern California Hosp at Culver City SNF/DP	Culver City

Copy of this notice received:

Licensee or designee signature	Date

Copy of this notice presented to licensee or designee:

Licensing Evaluator signature	Date
Rosario Broyce for Sirlin Chang	7/13/15

Complaint Notice

If there should be disagreement between the Licensee or Designee and the Evaluator of the Survey Team on an interpretation of the regulations or a field decision, the Licensee of Designee may wish to call and discuss this with the District Licensing Supervisor.

Name of Licensing Supervisor	Telephone
Eric Stone, Program Manager	626-312-1142

Instructions

This notice is to be used with Plans of Correction for Skilled Nursing Facilities, Intermediate Care Facilities, Intermediate Care Facilities/Developmentally Disabled, Intermediate Care Facilities/Developmentally Disabled-Habilitative, Intermediate Care Facilities/Developmentally Disabled-Nursing, Congregate Living Health Facilities, Pediatric Day Health and Respite Care Facilities, and Hospitals with Distinct Part Skilled Nursing Facilities or Intermediate Care Facilities. It is to be signed by the licensee/designee and the licensing evaluator. A copy is left with the licensee/designee and the original is kept in the district office licensing file.

COUNTY OF LOS ANGELES
Public Health

CYNTHIA A. HARDING, M.P.H.
Interim Director

JEFFREY D. GUNZENHAUSER, M.D., M.P.H.
Interim Health Officer

ANGELO J. BELLOMO, REHS, QEP
Director of Environmental Health

TERRI S. WILLIAMS, REHS
Assistant Director of Environmental Health

5050 Commerce Drive
Baldwin Park, California 91706
TEL (626) 430-5100 · FAX (626) 813-3000

www.publichealth.lacounty.gov

BOARD OF SUPERVISORS

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Fifth District

Letter 4

IMPORTANT NOTICE - PLEASE READ CAREFULLY

July 13, 2015

Darrin Buckner, RN
Director of Subacute
Southern California Hosp At Culver City D/p Snf
3828 Delmas Terrace
Culver City, CA 90230

Dear Administrator:

On June 22, 2015, a standard annual Health and Life Safety Code survey was conducted at your facility by the California Department of Public Health, Licensing and Certification Program (Los Angeles Acute - South), to determine if your facility was in compliance with federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiency(ies) to be:

[ ] Isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the enclosed "Statement of Deficiencies and Plan of Correction" form, whereby corrections are required (D).

[x] A pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the enclosed "Statement of Deficiencies and Plan of Correction" form, whereby corrections are required (E).

The enclosed Centers for Medicare and Medicaid Services (CMS) form, entitled "Statement of Deficiencies and Plan of Correction" (CMS-2567), documents the deficiencies of participation requirements identified during this visit. All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations (CFR).

Plan of Correction (POC)

A POC for the deficiencies must be submitted within **ten (10) days from receipt of the CMS- 2567.** Failure to submit an acceptable POC by the due date will result in remedies being recommended for imposition by the CMS and/or the State Medicaid Agency effective as soon as notice requirements are met.

Your POC must be submitted on the enclosed CMS-2567 form and must contain the following:

- How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;
- How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system; and
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Agency.

Remedies will be recommended for imposition by the CMS Regional Office and/or the State Medicaid Agency if your facility has failed to achieve substantial compliance by .

Recommended Remedies

The remedies, which will be recommended if substantial compliance has not been achieved by July 23, 2015 , include the following:

[x] Civil money penalty of $ 150.00 , effective June 22, 2015 (§488.430).

We are also recommending to the CMS Regional Office and/or the State Medicaid Agency that your provider agreement be terminated on if substantial compliance is not achieved by that time.

Denial of Payment for New Admissions (DPNA)

Based on deficiencies cited during this survey and as authorized by CMS San Francisco Regional Office, we are giving formal notice of imposition of statutory DPNA effective September 22, 2015. This remedy will be effectuated on the stated date unless you demonstrate substantial compliance with an acceptable POC and subsequent revisit. This notice in no way limits the prerogative of CMS to impose discretionary DPNA at any appropriate time.

CMS Regional Office will notify your intermediary and the Medicaid Agency. If effectuated, denial of payment will continue until your facility achieves substantial Compliance or your provider agreement is terminated. Facilities are prohibited from billing those Medicare/Medicaid residents or their responsible parties during the denial period for services normally billed to Medicare or Medicaid.

Appeal Rights

If you disagree with the determination of noncompliance (and/or substandard quality of care, if applicable), you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in 42 CFR §498.40, et. seq. You may appeal the finding of noncompliance that led to an enforcement action, but not the enforcement action or remedy itself. A written request for hearing must be filed no later than 60 days from the date of receipt of this letter.

Such written request should be made directly to:

Attention: Ms. Karen Robinson
Departmental Appeals Board
Civil Remedies Division
Cohen Building, Room G-644
330 Independence Avenue S.W.
Washington, D.C. 20201

A request for hearing should identify specific issues, and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You may be represented at a hearing by counsel at your own expense.

Be sure to include a copy of this letter with your request to the Departmental Appeals Board. In addition, please forward a copy of your request to:

Attention: Paula Perse, Manager
Long Term Care Branch
Division of Survey and Certification
Centers for Medicare & Medicaid Services
90 7th Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

Alternatively, you can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at https://dab.efile.hhs.gov.

To file a new appeal using DAB E-File, you first need to register a new account by: (1) clicking **Register** on the DAB E-File home page; (2) entering the information requested on the "Register New Account" form; and (3) clicking **Register Account** at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he or she is a party or authorized representative. Once registered, you may file your appeal by:

-Clicking the **File New Appeal** link on the Manage Existing Appeals screen, then clicking Civil Remedies Division on the File New Appeal screen.
And,
-Entering and uploading the requested information and documents on the "File New Appeal-Civil Remedies Division" form.

At minimum, the Civil Remedies Division (CRD) requires a party to file a signed request for hearing and the underlying notice letter from CMS that sets forth the action taken and the party's appeal rights. All documents must be submitted in Portable Document Format ("PDF"). Any document, including a request for hearing, will be deemed to have been filed on a given day, if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day. A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the Administrative Law Judge, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service. More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E-File Procedures link on the File New Appeal Screen for CRD appeals.

If you choose to file your appeal electronically, please also send a copy of the hearing request to:

Attention: Paula Perse, Manager
Long Term Care Branch
Division of survey and Certification
Centers for Medicare & Medicaid Services
90 7th Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

Allegation of Compliance

If you believe these deficiencies have been corrected, you may submit your POC as your allegation of compliance to Eric Stone, Program Manager, California Department of Public Health, Licensing and Certification Program, Los Angeles Acute and Ancillary Unit - South, 3400 Aerojet Suite 323 El Monte, CA 91731. We may accept your POC as your allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy(ies) at that time.

If, upon a subsequent revisit or by other means it is determined your facility has not achieved substantial compliance, we will recommend the remedies previously mentioned in this letter be imposed by the CMS Regional Office beginning on June 22, 2105 and continue until substantial compliance is achieved. Additionally, the CMS Regional Office may impose a revised remedy(ies), based upon changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

Informal Dispute Resolution

In accordance with §488.331, you have one (1) opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and relevant information (evidence) as to why you are disputing those deficiencies to Suzette Leverett - Clark, RN Assistant Chief, California Department of Public Health, Licensing and Certification Division at 12440 East Imperial Highway Room 522, Norwalk, CA 90650.

This request must be sent during the same ten (10) days you have for submitting a POC for the cited deficiencies. An informal dispute resolution for the cited deficiencies will not delay the imposition of the recommended enforcement actions. A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

Should CMS determine that termination or any other remedy is warranted, they will provide you with a separate formal notification of that determination.

If you have questions concerning the instructions contained in this letter, please contact, Eric Stone, Program Manager, at (626) 312-1142.

Sincerely,

Nwamaka Oranusi, Acting Chief
Health Facilities Inspection Division

Rosario Quispe RN, Sr. HFEW for

Eric Stone, Program Manager
Acute and Ancillary Unit- South
3400 Aerojet Avenue Suite 323
Tel. (626) 312-1142 - Fax (626) 927-9293

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555674	A. BUILDING 01 - BROTMAN MEDICAL CENTER DP SNF B. WING _____	06/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147	Continued From page 9 (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (5) Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors. These Codes were not met as evidenced by: Based on observation and interview, the facility failed to ensure electrical wiring was in accordance with NFPA 70 National Electrical Code by having electrical cord run through a wall. The deficiency had the potential of not adhering to the provisions of NFPA 70 necessary for safety, and the practical safeguarding of persons, and property from hazards arising from the use of electricity. Findings: On 6/19/15 at 9:20 a.m., there was an electrical cord coming out of and entering a wall in the kitchen, above the dietary office room door. During an interview at the same time as the observation, the Dietician/Director of food & Nutrition stated that the electrical cord was connected to a video camera, but did not know why the wire was pulled out of, and back into the wall.	K 147	*Electrical Wiring* • No residents or staffs were affected by the said deficient practice. • The facility performs environmental rounds regularly and identifies deficiencies and reports the deficiencies to the Facilities Operations Center for repair. Environmental/Safety deficiencies are top priority and repairs are scheduled first. • The cable observed by the surveyor was identified as being video cable and is not high voltage and poses no electrical shock risk. The walls that the cable penetrates are not fire walls. • The facilities Environment of Care committee meets regularly and EOC audits are monitored and reviewed at these meetings. The hospital has also assigned the Vice President of Facilities to ensure that all Life safety & Environmental requirements are met. • Completed 6/24/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555874	A. BUILDING 01 - BROTMAN MEDICAL CENTER DP SNF B. WING _____	06/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

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K 140	Continued From page 8 log that included monitoring of the main and reserve liquid oxygen vessels' level and pressure readings. Earlier that morning at 9:10 a.m., the gauges at the main vessel had readings of 180 inches of water and 140 psi., and the gauges at the reserve vessel had readings of 108 inches of water and 135 psi. Both vessels were within their marked limits. Nine (9) of seventeen (17) residents were on nasal cannula or trach aerosol.	K 140		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: NFPA 70 National Electrical Code 1999 Edition 110-12. Mechanical Execution of Work. Electrical equipment shall be installed in a neat and workmanlike manner. 305-4.(h) Protection from Accidental Damage. Flexible cords and cables shall be protected from accidental damage. Sharp corners and projections shall be avoided. Where passing through doorways or other pinch points, protection shall be provided to avoid damage. 400-8. Uses not permitted. Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following:	K 147	*Electrical Wiring* • No residents or staffs were affected by the said deficient practice. • The facility performs environmental rounds regularly and identifies deficiencies and reports the deficiencies to the Facilities Operations Center for repair. Environmental/Safety deficiencies are top priority and repairs are scheduled first. • The cable observed by the surveyor was identified as being video cable and is not high voltage and poses no electrical shock risk. The walls that the cable penetrates are not fire walls. • The facilities Environment of Care committee meets regularly and EOC audits are monitored and reviewed at these meetings. The hospital has also assigned the Vice President of Facilities to ensure that all Life safety & Environmental requirements are met. • Completed 6/24/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555874	A. BUILDING 01 - BROTMAN MEDICAL CENTER DP SNF B. WING _____	06/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 140	Continued From page 7 Findings: 1. On 6/22/15 at 10:10 a.m., during document review, the Bulk Oxygen Source Evaluation Report Annual Inspection equipment checklist dated 12/30/14, indicated the following: The bulk primary system did not have a pressure switch for "Emergency Reserve in use". The signals were not wired to the master alarm panel(s). The source valve was not labeled. Source equipment was not free of leaks. The report also indicated a physical deficiency that reserve wires were cut at the pressure switch above the liquid gauge, and that the location of leakage was at the source valve. During an interview at the same time as the record review, the Director of Facilities stated that the physical deficiency listed on the report were wires that were cut because they use to be connected to the former fire alarm control panel (FACP), where it would activate an alarm if the oxygen was low at the bulk liquid oxygen vessels. That the new FACP does not activate an alarm when the oxygen is low at the vessels. That the there has never been an alarm system at the facility to monitor the operation and condition of the bulk oxygen source of supply and reserve. That the oxygen vessels did not send a signal to the liquid oxygen supplier/vendor when the vessels were low. That in lieu of the alarm, engineering staff conducted three rounds per day to monitor the oxygen tank and pressure levels at the gauges of the liquid oxygen vessels. Further document review revealed an engineering	K 140	*Source Valve labeled* • No residents were affected by the deficient practice. • The facility performs an annual medical gas deficiency audit annually and review by the Facilities Management staff. Any deficiencies found during the audit are prioritized and repaired in a timely manner. • The oxygen annual test is part of the quarterly EOC report and is reported to the EOC Committee, Quality Council, Medical Executive Committee and the Governing Board on a quarterly basis. • Completed 7/23/15 *Source equipment free of leaks* • No residents were affected by the deficient practice. • The facility performs an annual medical gas deficiency audit annually and review by the Facilities Management staff. Any deficiencies found during the audit are prioritized and repaired in a timely manner. • The oxygen annual test is part of the quarterly EOC report and is reported to the EOC Committee, Quality Council, Medical Executive Committee and the Governing Board on a quarterly basis. • The source leak was repaired 4/5/2015	

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	555874	A. BUILDING 01 - BROTMAN MEDICAL CENTER DP SNF B. WING _____	06/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

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K 140	Continued From page 6 for use only in an emergency. An actuating switch shall be connected to the master signal panels to indicate when, or just before, the reserve begins to supply the system. 4-3.1.2.2 Gas Warning Systems. (b) Master Alarms. 1. A master alarm system shall be provided to monitor the operation and condition of the source of supply, the reserve (if any), and the pressure of the main lines of all medical gas piping systems. 2. The master alarm system shall consist of two or more alarm panels located in two separate locations. One panel shall be located in the principal working area of the individual responsible for the maintenance of the medical gas piping systems and one or more panels shall be located to assure continuous surveillance during the working hours of the facility (e.g., the telephone switchboard, security office, or other continuously staffed location). This Standard was not met as evidenced by: Based on document review, interview, and observation, the facility staff failed to ensure the medical gas warning system was in accordance with NFPA 99 by not having medical gas master alarm panels with visible and audible alarms, and failed to ensure an emergency oxygen supply connection was present. The deficiency had the potential to not alarm the facility of a low oxygen tank level and pressure, and to not have a connection for emergency oxygen supply.	K 140	• No residents were affected by the deficient practice as the oxygen alarm is checked by the engineering staff three (3) per day and values are logged and reported to the Facilities Management staff. If oxygen levels are low, the oxygen supply company is called for service. • The facility performs environmental rounds regularly and identifies deficiencies and reports the deficiencies to the Facilities Operations Center for repair. Environmental/Safety deficiencies are top priority and repairs are scheduled first. • A master alarm system will be installed in two locations per NFPA 101 4.3.1.2.2. • The EOC committee meets at least (6) six times per year and environmental issues including oxygen systems and oxygen alarm systems are reported annually, which is then reported to the Quality Council, Medical Executive Committee and the Hospital Board. • The Master Alarm system will be an OSHPD project and require multiple disciplines for design. Estimated completion date 3/31/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555874	A. BUILDING 01 - BROTMAN MEDICAL CENTER D/P SNF B. WING _____	06/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

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K 130	Continued From page 5 Based on observation and interview, the facility failed to ensure a minimum of 6 spare sprinkler were maintained at the facility. The deficiency had the potential to not have spare sprinklers immediately available to help put the system back into service without delay, in the event a sprinkler was needed to be replaced because it has operated or has been damaged. Finding: On 6/22/15 at 3 p.m., there was one spare sprinkler in the spare sprinklers cabinet box in the sprinkler main riser room. At the time of the observation, during an interview, the Lead Man stated that the 5 missing spare sprinklers had been used during the installation of the sprinkler system.	K 130		
K 140 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Master alarm panels are in two separate locations and have audible and visible signals. There are high/low alarms for +/- 20% operating pressure. NFPA 99, 4.3.1.2.2 This STANDARD is not met as evidenced by: NFPA 99 Standard for Health Care Facilities 1999 Edition 4-3.1.1.7 Bulk Medical Gas Systems. (a) The bulk system shall consist of two sources of supply, one of which shall be a reserve supply	K 140	K 140 *Pressure Switch for "Emergency Reserve in Use"* • No residents were affected by the deficient practice. • The facility performs an annual medical gas deficiency audit annually and review by the Facilities Management staff. Any deficiencies found during the audit are prioritized and repaired in a timely manner. • The oxygen annual test is part of the quarterly EOC report and is reported to the EOC Committee, Quality Council, Medical Executive Committee and the Governing Board on a quarterly basis. • Installation of the emergency oxygen supply connection will be an OSHPD project and require design from a mechanical engineer for and OSHPD approval. Estimated completion date is 3/31/16.	3/31/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555874	A. BUILDING 01 - BROTMAN MEDICAL CENTER DP SNF B. WING _____	06/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

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K 130	Continued From page 4 3-2.9.3 The stock of spare sprinklers shall include all types and ratings installed and shall be as follows: (1) For systems having less than 300 sprinklers - not fewer than 6 sprinklers (2) For systems with 300 to 1000 sprinklers - not fewer than 12 sprinklers (3) For systems with over 1000 sprinklers - not fewer than 24 sprinklers NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems 1998 Edition 2-4.1.4 A supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. The cabinet shall be so located that it will not be exposed to moisture, dust, corrosion, or a temperature exceeding 100 degrees Fahrenheit (38 degrees Celsius). 2-4.1.5 The stock of spare sprinklers shall be as follows: (a) For protected facilities having under 300 sprinklers - no fewer than 6 sprinklers (b) For protected facilities having 300 to 1000 sprinklers - no fewer than 12 sprinklers (c) For protected facilities having over 1000 sprinklers - no fewer than 24 sprinklers These requirements were not met as evidenced by:	K 130	*Supply of spare sprinkler heads* • No residents were affected by the deficient practice. • The facility performs environmental rounds regularly and identifies deficiencies and reports the deficiencies to the Facilities Operations Center for repair. Environmental/Safety deficiencies are top priority and repairs are scheduled first. • Fire sprinkler spare head check has been added to the "Environmental Rounds" list and will be checked during audit time. Based upon the finding fire sprinkler heads have been ordered. The facilities Environment of Care committee meets regularly and EOC audits are monitored and reviewed at these meetings. The hospital has also assigned the Vice President of Facilities to ensure that all Life safety & Environmental requirements are met. • EOC Audits are reported to the EOC Committee, Quality Council and the Governing Board on a quarterly basis. • Changes completed on 7/23/15	7/23/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555874	A. BUILDING 01 - BROTMAN MEDICAL CENTER DP SNF B. WING _____	06/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

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K 077	Continued From page 3 Finding: On 6/22/15 at 10:10 a.m., during document review, the Bulk Oxygen Source Evaluation Report Annual Inspection equipment checklist dated 12/30/14, indicated that an emergency oxygen supply connection was not present. During an interview at the same time as the record review, the VP of Corporate Facilities Operations, stated that he had not seen an emergency oxygen supply connection for the facility's oxygen system. Nine (9) of seventeen (17) residents were on nasal cannula or trach aerosol.	K 077		
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: NFPA 13 Standard for the Installation of Sprinkler Systems 1999 Edition 3-2.9.1 A supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or have been damaged in any way can be promptly replaced. These sprinklers shall correspond to the types of temperature ratings of the sprinklers in the property. The sprinklers shall be kept in a cabinet located where the temperature to which they are subjected will at no time exceed 100 degrees Fahrenheit (38 degrees Celsius).	K 130	*Supply of spare sprinkler heads* • **No residents were affected by the deficient practice.** • **The facility performs environmental rounds regularly and identifies deficiencies and reports the deficiencies to the Facilities Operations Center for repair. Environmental/Safety deficiencies are top priority and repairs are scheduled first.** • **Fire sprinkler spare head check has been added to the "Environmental Rounds" list and will be checked during audit time. Based upon the finding fire sprinkler heads have been ordered. The facilities Environment of Care committee meets regularly and EOC audits are monitored and reviewed at these meetings. The hospital has also assigned the Vice President of Facilities to ensure that all Life safety & Environmental requirements are met.** • **EOC Audits are reported to the EOC Committee, Quality Council and the Governing Board on a quarterly basis.** • **Changes completed on 7/23/15**	7/23/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	556874	A. BUILDING 01 - BROTMAN MEDICAL CENTER DP SNF B. WING	06/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

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K 077	Continued From page 2 This STANDARD is not met as evidenced by: NFPA 99 Standard for Health Care Facilities 1999 Edition 4-3.1.1.8 (h) Emergency Oxygen Supply Connection. Where the cryogenic oxygen supply is located outside of the building served, there shall be incorporated in the piping system and inlet for connecting a temporary auxiliary source of supply for emergency or maintenance situations. The inlet shall be located on the exterior of the building served and shall be physically protected to prevent tampering and unauthorized access. It shall be labeled "EMERGENCY LOW PRESSURE GASEOUS OXYGEN INLET." This connection shall be installed downstream of the shutoff valve on the main supply line [see 4-3.1.2.3(b)] and be suitably controlled with the necessary valves to allow emergency supply of oxygen and isolation of the piping to the normal source of supply. It shall have one check valve in the main line between the main line shutoff valve and the tee'd connection and one check valve between the tee'd connection and the emergency supply shutoff valve. [See Figure 4-3.1.1.8(h) and Figure 4-3.1.2.] This Standard was not met as evidenced by: Based on document review, and interview, the facility staff failed to ensure an emergency oxygen supply connection was present. The deficiency had the potential to not have a connection for emergency oxygen supply.	K 077	*Emergency oxygen supply connection* • No residents were affected by the deficient practice. • The facility performs an annual medical gas deficiency audit annually and review by the Facilities Management staff. Any deficiencies found during the audit are prioritized and repaired in a timely manner. • The oxygen annual test is part of the quarterly EOC report and is reported to the EOC Committee, Quality Council and the Governing Board on a quarterly basis. • Installation of the emergency oxygen supply connection will be an OSHPD project and require design from a mechanical engineer for and OSHPD approval. Estimated completion date is 3/31/16.	3/31/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	556874	A. BUILDING 01 - BROTMAN MEDICAL CENTER DP SNF B. WING _____	06/22/2015

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SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

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K 050	Continued From page 1 fire emergency. Findings: On 6/22/15 at 10 a.m., during record review of the facility's fire drill reports for the period of April 2014 through June 2015, it revealed there were 3 fire drill reports missing, for the following shifts and quarters: Swing shift - 3rd quarter of 2014. Night shift - 2nd,and 4th quarter of 2014. Further review of the fire drill reports revealed there was no documented evidence, such as participant signatures in the fire observation report, identifying sub acute staff participation in 5 fire drills, for the following shifts and dates: Day shift - 7/12/14, 8/10/14, 11/8/14, 1/31/15. Swing shift - 5/28/15. During an interview at the same time as the observation, the Lead Man stated that the Fire Observation Report was the only document staff would sign as evidence of participation in a fire drill. During record review, and by the end of the survey, the facility failed to provide the missing fire drills reports or documentation to review that would show participation of the subacute staff in the 5 fire drills.	K 050	*Fire Drill reports* • No residents were affected by the deficient practice. • The Facility performs audits of all Fire Life Safety requirements on a monthly basis to ensure compliance. • An additional form has been added to the Fire Drill Critique package to document participation/attendance for all employees. The facilities Environment of Care committee meets regularly and fire drills are monitored and reviewed at these meetings. The hospital has also assigned the Vice President of Facilities to ensure that all Life safety & Environmental requirements are met. • Fire Drills are reported to the EOC Committee and any deficiencies will be corrected immediately. EOC reports quarterly to the Quality Council, Medical Executive Committee and the Governing Board. • Changes completed on 5/30/15	6/30/15
K 077 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Piped in medical gas systems comply with NFPA 99, Chapter 4.	K 077	*Emergency oxygen supply connection* • No residents were affected by the deficient practice. • The facility performs an annual medical gas deficiency audit annually and review by the Facilities Management staff. Any deficiencies found during the audit are prioritized and repaired in a timely manner.	3/31/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555874	A. BUILDING 01 - BROTMAN MEDICAL CENTER DP SNF B. WING _____	06/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS This facility was surveyed under 42 CFR Part 483.70(a), Life Safety Code NFPA 101, 2000 Edition, Chapter 19, Existing Health Care Occupancies, and other applicable codes. Amended 7/14/15 Representing the Department of Public Health: Evaluator ID#16261 The following represents the findings of the Department of Public Health during a Life Safety Code Survey.	K 000		
K 050 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on record review, and interview, the facility failed to provide supporting documentation that the subacute staff participated in fire drills at least quarterly on each shift. The deficiency had the potential for staff to not be familiar with the facility's fire emergency plan, and not be prepared to put it in effect in the event of a	K 050	*Fire Drill reports* • No residents were affected by the deficient practice. • The Facility performs audits of all Fire Life Safety requirements on a monthly basis to ensure compliance. • An additional form has been added to the Fire Drill Critique package to document participation/attendance for all employees. The facilities Environment of Care committee meets regularly and fire drills are monitored and reviewed at these meetings. The hospital has also assigned the Vice President of Facilities to ensure that all Life safety & Environmental requirements are met. • Fire Drills are reported to the EOC Committee and any deficiencies will be corrected immediately. EOC reports quarterly to the Quality Council, Medical Executive Committee and the Governing Board. • Changes completed on 6/30/15	6/30/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

SOUTHERN CALIFORNIA HEALTHCARE SYSTEM, INC.

Southern California Hospital at Culver City
3828 Delmas Terrace
Culver City, CA 90232
(310) 836-7000(310) 202-4141 Fax

July 21, 2015 **Via Fax 62 pages including this page**

Attention Rosario Grospe, RN Senior HFEN Assistant Supervisor, Acute and Ancillary Unit
California Department of Public Health
County of Los Angeles Health Facilities Division
3400 Aerojet Avenue, Suite 323
El Monte, CA 91731

Phone: 626-312-1129 **Fax 626-927-9293**

Re: 55874

POC Response to the 2567 from the Annual Health and Life Safety Code survey conducted on 6/22/15.

Sincerely,

Pamela Loo, Director of Quality
310-486-8911
Contact info: 310 836 7000 ext. 1046 cell: **310-486-8911**

Confidentiality Note: The documents accompanying this facsimile transmission may contain confidential information. The information is intended only for the use of the individuals or entity named above. If you are not the intended recipient or the person responsible for delivering it to the intended recipient, you are hereby notified that any disclosure, copying, distribution or use of the information contained in this transmission is strictly PROHIBITED. If you receive this transmission in error, please notify the sender immediately by telephone or by return fax and destroy this transmission, along with any attachments. Thank you.

State of California—Health and Human Services Agency

Department of Health Services

SIGNATURE REQUIREMENT NOTICE
(For Plan of Correction)

Notice to Licensee/Designee

The surveying state agency is required to obtain a signed plan of correction for deficiencies noted on the Statement of Deficiencies and Plan of Correction (Code of Federal Regulations, Title 42, Section 489.13; State Operations Manual, Section 2612; and California Health and Safety Code, Section 1280). By signing a plan of correction, a licensee or designee does not necessarily admit guilt of any alleged violation nor does this interfere with the right to contest or appeal any alleged violations on which the plan of correction is based or the same period for correction. It does acknowledge responsibility for compliance with licensing requirements, with appropriate requirements of the Medicare and Medi-Cal programs, that an exit conference was held during which the items listed were discussed, and that a copy of the deficiency/report and plan of correction was received.

Name of facility	City
Southern California Hosp at Culver City SNF/DP	Culver City

Copy of this notice received:

Licensee or designee signature	Date
Gerald B. Clute	7/20/15

Copy of this notice presented to licensee or designee:

Licensing Evaluator signature	Date
Rosario Grosse for Sin Lin Chang	7/13/15

Complaint Notice

If there should be disagreement between the Licensee or Designee and the Evaluator of the Survey Team on an interpretation of the regulations or a field decision, the Licensee of Designee may wish to call and discuss this with the District Licensing Supervisor.

Name of Licensing Supervisor	Telephone
Eric Stone, Program Manager	626-312-1142

Instructions

This notice is to be used with Plans of Correction for Skilled Nursing Facilities, Intermediate Care Facilities, Intermediate Care Facilities/Developmentally Disabled, Intermediate Care Facilities/Developmentally Disabled-Habilitative, Intermediate Care Facilities/Developmentally Disabled-Nursing, Congregate Living Health Facilities, Pediatric Day Health and Respite Care Facilities, and Hospitals with Distinct Part Skilled Nursing Facilities or Intermediate Care Facilities. It is to be signed by the licensee/designee and the licensing evaluator. A copy is left with the licensee/designee and the original is kept in the district office licensing file.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	555874		06/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during a re-certification survey. Representing the Department of Public Health: Surveyor 17030, RN, HFEN Surveyor 25524, RN, HFEN Surveyor 16281, REHS, HFE Total Resident Population 17 Total Resident Sample Size: 8 Highest Scope/Severity: E	F 000		
F 154 SS=E	483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the resident or the resident's representative had the right to be fully informed in advance of the risks and benefits of anti-antipsychotic and physical restraints to be administered to six (6) of eight (8) sampled residents (1, 2, 3, 4, 6, and 7). The facility failed	F 154	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* Corrective Action will be accomplished by the re-education of staff on the Restraints Policy and Procedure Application and monitoring SAA.049 and Consents PAT.037, completed on 7/19/2015. 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* The SubAcute Unit at Southern California Hospital at Culver City (SCHCC) will identify other residents having the same potential for deficient practice by discussing restraint plan of care in interdisciplinary weekly rounds, and 100% monitoring of restraint documentation and informed consents, and will monitor them beginning August 1,2015 as process improvements and report it quarterly to quality council, medical executive committee and governing board.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Gerald [signature]	CEO	7/20/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	INITIAL COMMENTS This facility was surveyed under 42 CFR Part 483.70(a), Life Safety Code NFPA 101, 2000 Edition, Chapter 19, Existing Health Care Occupancies, and other applicable codes. Amended 7/14/15 Representing the Department of Public Health: Evaluator ID#16281 The following represents the findings of the Department of Public Health during a Life Safety Code Survey.	K 000		
K 050 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on record review, and interview, the facility failed to provide supporting documentation that the subacute staff participated in fire drills at least quarterly on each shift. The deficiency had the potential for staff to not be familiar with the facility's fire emergency plan, and not be prepared to put it in effect in the event of a	K 050	*Fire Drill reports* • No residents were affected by the deficient practice. • The Facility performs audits of all Fire Life Safety requirements on a monthly basis to ensure compliance. • An additional form has been added to the Fire Drill Critique package to document participation/attendance for all employees. The facilities Environment of Care committee meets regularly and fire drills are monitored and reviewed at these meetings. The hospital has also assigned the Vice President of Facilities to ensure that all Life safety & Environmental requirements are met. • Fire Drills are reported to the EOC Committee and any deficiencies will be corrected immediately. EOC reports quarterly to the Quality Council, Medical Executive Committee and the Governing Board. • Changes completed on 6/30/15	6/30/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

CEO 7/20/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 050	Continued From page 1 fire emergency. Findings: On 6/22/15 at 10 a.m., during record review of the facility's fire drill reports for the period of April 2014 through June 2015, it revealed there were 3 fire drill reports missing, for the following shifts and quarters: Swing shift - 3rd quarter of 2014. Night shift - 2nd,and 4th quarter of 2014. Further review of the fire drill reports revealed there was no documented evidence, such as participant signatures in the fire observation report, identifying sub acute staff participation in 5 fire drills, for the following shifts and dates: Day shift - 7/12/14, 8/10/14, 11/8/14, 1/31/15. Swing shift - 5/28/15. During an interview at the same time as the observation, the Lead Man stated that the Fire Observation Report was the only document staff would sign as evidence of participation in a fire drill. During record review, and by the end of the survey, the facility failed to provide the missing fire drills reports or documentation to review that would show participation of the subacute staff in the 5 fire drills.	K 050	*Fire Drill reports* • No residents were affected by the deficient practice. • The Facility performs audits of all Fire Life Safety requirements on a monthly basis to ensure compliance. • An additional form has been added to the Fire Drill Critique package to document participation/attendance for all employees. The facilities Environment of Care committee meets regularly and fire drills are monitored and reviewed at these meetings. The hospital has also assigned the Vice President of Facilities to ensure that all Life safety & Environmental requirements are met. • Fire Drills are reported to the EOC Committee and any deficiencies will be corrected immediately. EOC reports quarterly to the Quality Council, Medical Executive Committee and the Governing Board. • Changes completed on 6/30/15	6/30/15
K 077 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Piped in medical gas systems comply with NFPA 99, Chapter 4.	K 077	*Emergency oxygen supply connection* • No residents were affected by the deficient practice. • The facility performs an annual medical gas deficiency audit annually and review by the Facilities Management staff. Any deficiencies found during the audit are prioritized and repaired in a timely manner.	3/31/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 077	Continued From page 2 This STANDARD is not met as evidenced by: NFPA 99 Standard for Health Care Facilities 1999 Edition 4-3.1.1.8 (h) Emergency Oxygen Supply Connection. Where the cryogenic oxygen supply is located outside of the building served, there shall be incorporated in the piping system and inlet for connecting a temporary auxiliary source of supply for emergency or maintenance situations. The inlet shall be located on the exterior of the building served and shall be physically protected to prevent tampering and unauthorized access. It shall be labeled "EMERGENCY LOW PRESSURE GASEOUS OXYGEN INLET." This connection shall be installed downstream of the shutoff valve on the main supply line [see 4-3.1.2.3(b)] and be suitably controlled with the necessary valves to allow emergency supply of oxygen and isolation of the piping to the normal source of supply. It shall have one check valve in the main line between the main line shutoff valve and the tee'd connection and one check valve between the tee'd connection and the emergency supply shutoff valve. [See Figure 4-3.1.1.8(h) and Figure 4-3.1.2.] This Standard was not met as evidenced by: Based on document review, and interview, the facility staff failed to ensure an emergency oxygen supply connection was present. The deficiency had the potential to not have a connection for emergency oxygen supply.	K 077	*Emergency oxygen supply connection* • No residents were affected by the deficient practice. • The facility performs an annual medical gas deficiency audit annually and review by the Facilities Management staff. Any deficiencies found during the audit are prioritized and repaired in a timely manner. • The oxygen annual test is part of the quarterly EOC report and is reported to the EOC Committee, Quality Council and the Governing Board on a quarterly basis. • Installation of the emergency oxygen supply connection will be an OSHPD project and require design from a mechanical engineer for and OSHPD approval. Estimated completion date is 3/31/16.	3/31/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 077	Continued From page 3 Finding: On 6/22/15 at 10:10 a.m., during document review, the Bulk Oxygen Source Evaluation Report Annual Inspection equipment checklist dated 12/30/14, indicated that an emergency oxygen supply connection was not present. During an interview at the same time as the record review, the VP of Corporate Facilities Operations, stated that he had not seen an emergency oxygen supply connection for the facility's oxygen system. Nine (9) of seventeen (17) residents were on nasal cannula or trach aerosol.	K 077		
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: NFPA 13 Standard for the Installation of Sprinkler Systems 1999 Edition 3-2.9.1 A supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or have been damaged in any way can be promptly replaced. These sprinklers shall correspond to the types of temperature ratings of the sprinklers in the property. The sprinklers shall be kept in a cabinet located where the temperature to which they are subjected will at no time exceed 100 degrees Fahrenheit (38 degrees Celsius).	K 130	*Supply of spare sprinkler heads* • No residents were affected by the deficient practice. • The facility performs environmental rounds regularly and identifies deficiencies and reports the deficiencies to the Facilities Operations Center for repair. Environmental/Safety deficiencies are top priority and repairs are scheduled first. • Fire sprinkler spare head check has been added to the "Environmental Rounds" list and will be checked during audit time. Based upon the finding fire sprinkler heads have been ordered. The facilities Environment of Care committee meets regularly and EOC audits are monitored and reviewed at these meetings. The hospital has also assigned the Vice President of Facilities to ensure that all Life safety & Environmental requirements are met. • EOC Audits are reported to the EOC Committee, Quality Council and the Governing Board on a quarterly basis. • Changes completed on 7/23/15	7/23/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 130	Continued From page 4 3-2.9.3 The stock of spare sprinklers shall include all types and ratings installed and shall be as follows: (1) For systems having less than 300 sprinklers - not fewer than 6 sprinklers (2) For systems with 300 to 1000 sprinklers - not fewer than 12 sprinklers (3) For systems with over 1000 sprinklers - not fewer than 24 sprinklers NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems 1998 Edition 2-4.1.4 A supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. The cabinet shall be so located that it will not be exposed to moisture, dust, corrosion, or a temperature exceeding 100 degrees Fahrenheit (38 degrees Celsius). 2-4.1.5 The stock of spare sprinklers shall be as follows: (a) For protected facilities having under 300 sprinklers - no fewer than 6 sprinklers (b) For protected facilities having 300 to 1000 sprinklers - no fewer than 12 sprinklers (c) For protected facilities having over 1000 sprinklers - no fewer than 24 sprinklers These requirements were not met as evidenced by:	K 130	*Supply of spare sprinkler heads* • No residents were affected by the deficient practice. • The facility performs environmental rounds regularly and identifies deficiencies and reports the deficiencies to the Facilities Operations Center for repair. Environmental/Safety deficiencies are top priority and repairs are scheduled first. • Fire sprinkler spare head check has been added to the "Environmental Rounds" list and will be checked during audit time. Based upon the finding fire sprinkler heads have been ordered. The facilities Environment of Care committee meets regularly and EOC audits are monitored and reviewed at these meetings. The hospital has also assigned the Vice President of Facilities to ensure that all Life safety & Environmental requirements are met. • EOC Audits are reported to the EOC Committee, Quality Council and the Governing Board on a quarterly basis. • Changes completed on 7/23/15	7/23/15

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K 130	Continued From page 5 Based on observation and interview, the facility failed to ensure a minimum of 6 spare sprinkler were maintained at the facility. The deficiency had the potential to not have spare sprinklers immediately available to help put the system back into service without delay, in the event a sprinkler was needed to be replaced because it has operated or has been damaged. Finding: On 6/22/15 at 3 p.m., there was one spare sprinkler in the spare sprinklers cabinet box in the sprinkler main riser room. At the time of the observation, during an interview, the Lead Man stated that the 5 missing spare sprinklers had been used during the installation of the sprinkler system.	K 130		
K 140 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Master alarm panels are in two separate locations and have audible and visible signals. There are high/low alarms for +/- 20% operating pressure. NFPA 99, 4.3.1.2.2 This STANDARD is not met as evidenced by: NFPA 99 Standard for Health Care Facilities 1999 Edition 4-3.1.1.7 Bulk Medical Gas Systems. (a) The bulk system shall consist of two sources of supply, one of which shall be a reserve supply	K 140	K 140 *Pressure Switch for "Emergency Reserve in Use"* • No residents were affected by the deficient practice. • The facility performs an annual medical gas deficiency audit annually and review by the Facilities Management staff. Any deficiencies found during the audit are prioritized and repaired in a timely manner. • The oxygen annual test is part of the quarterly EOC report and is reported to the EOC Committee, Quality Council, Medical Executive Committee and the Governing Board on a quarterly basis. • Installation of the emergency oxygen supply connection will be an OSHPD project and require design from a mechanical engineer for and OSHPD approval. Estimated completion date is 3/31/16.	3/31/16

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K 140	Continued From page 6 for use only in an emergency. An actuating switch shall be connected to the master signal panels to indicate when, or just before, the reserve begins to supply the system. 4-3.1.2.2 Gas Warning Systems. (b) Master Alarms. 1. A master alarm system shall be provided to monitor the operation and condition of the source of supply, the reserve (if any), and the pressure of the main lines of all medical gas piping systems. 2. The master alarm system shall consist of two or more alarm panels located in two separate locations. One panel shall be located in the principal working area of the individual responsible for the maintenance of the medical gas piping systems and one or more panels shall be located to assure continuous surveillance during the working hours of the facility (e.g., the telephone switchboard, security office, or other continuously staffed location). This Standard was not met as evidenced by: Based on document review, interview, and observation, the facility staff failed to ensure the medical gas warning system was in accordance with NFPA 99 by not having medical gas master alarm panels with visible and audible alarms, and failed to ensure an emergency oxygen supply connection was present. The deficiency had the potential to not alarm the facility of a low oxygen tank level and pressure, and to not have a connection for emergency oxygen supply.	K 140	• No residents were affected by the deficient practice as the oxygen alarm is checked by the engineering staff three (3) per day and values are logged and reported to the Facilities Management staff. If oxygen levels are low, the oxygen supply company is called for service. • The facility performs environmental rounds regularly and identifies deficiencies and reports the deficiencies to the Facilities Operations Center for repair. Environmental/Safety deficiencies are top priority and repairs are scheduled first. • A master alarm system will be installed in two locations per NFPA 101.4.3.1.2.2. • The EOC committee meets at least (6) six times per year and environmental issues including oxygen systems and oxygen alarm systems are reported annually, which is then reported to the Quality Council, Medical Executive Committee and the Hospital Board. • The Master Alarm system will be an OSHPD project and require multiple disciplines for design. Estimated completion date 3/31/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555874	A. BUILDING 01 - BROTMAN MEDICAL CENTER DP SNF B. WING _____	06/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

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K 140	Continued From page 7 Findings: 1. On 6/22/15 at 10:10 a.m., during document review, the Bulk Oxygen Source Evaluation Report Annual Inspection equipment checklist dated 12/30/14, indicated the following: The bulk primary system did not have a pressure switch for "Emergency Reserve in use". The signals were not wired to the master alarm panel(s). The source valve was not labeled. Source equipment was not free of leaks. The report also indicated a physical deficiency that reserve wires were cut at the pressure switch above the liquid gauge, and that the location of leakage was at the source valve. During an interview at the same time as the record review, the Director of Facilities stated that the physical deficiency listed on the report were wires that were cut because they use to be connected to the former fire alarm control panel (FACP), where it would activate an alarm if the oxygen was low at the bulk liquid oxygen vessels. That the new FACP does not activate an alarm when the oxygen is low at the vessels. That the there has never been an alarm system at the facility to monitor the operation and condition of the bulk oxygen source of supply and reserve. That the oxygen vessels did not send a signal to the liquid oxygen supplier/vendor when the vessels were low. That in lieu of the alarm, engineering staff conducted three rounds per day to monitor the oxygen tank and pressure levels at the gauges of the liquid oxygen vessels. Further document review revealed an engineering	K 140	*Source Valve labeled* • No residents were affected by the deficient practice. • The facility performs an annual medical gas deficiency audit annually and review by the Facilities Management staff. Any deficiencies found during the audit are prioritized and repaired in a timely manner. • The oxygen annual test is part of the quarterly EOC report and is reported to the EOC Committee, Quality Council, Medical Executive Committee and the Governing Board on a quarterly basis. • Completed 7/23/15 *Source equipment free of leaks* • No residents were affected by the deficient practice. • The facility performs an annual medical gas deficiency audit annually and review by the Facilities Management staff. Any deficiencies found during the audit are prioritized and repaired in a timely manner. • The oxygen annual test is part of the quarterly EOC report and is reported to the EOC Committee, Quality Council, Medical Executive Committee and the Governing Board on a quarterly basis. • The source leak was repaired 4/6/2015	

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K 140	Continued From page 8 log that included monitoring of the main and reserve liquid oxygen vessels' level and pressure readings. Earlier that morning at 9:10 a.m., the gauges at the main vessel had readings of 180 inches of water and 140 psi., and the gauges at the reserve vessel had readings of 108 inches of water and 135 psi. Both vessels were within their marked limits. Nine (9) of seventeen (17) residents were on nasal cannula or trach aerosol.	K 140		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: NFPA 70 National Electrical Code 1999 Edition 110-12. Mechanical Execution of Work. Electrical equipment shall be installed in a neat and workmanlike manner. 305-4.(h) Protection from Accidental Damage. Flexible cords and cables shall be protected from accidental damage. Sharp corners and projections shall be avoided. Where passing through doorways or other pinch points, protection shall be provided to avoid damage. 400-8. Uses not permitted. Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following:	K 147	*Electrical Wiring* • No residents or staffs were affected by the said deficient practice. • The facility performs environmental rounds regularly and identifies deficiencies and reports the deficiencies to the Facilities Operations Center for repair. Environmental/Safety deficiencies are top priority and repairs are scheduled first. • The cable observed by the surveyor was identified as being video cable and is not high voltage and poses no electrical shock risk. The walls that the cable penetrates are not fire walls. • The facilities Environment of Care committee meets regularly and EOC audits are monitored and reviewed at these meetings. The hospital has also assigned the Vice President of Facilities to ensure that all Life safety & Environmental requirements are met. • Completed 6/24/2015	

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K 147	Continued From page 9 (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (5) Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors. These Codes were not met as evidenced by: Based on observation and interview, the facility failed to ensure electrical wiring was in accordance with NFPA 70 National Electrical Code by having electrical cord run through a wall. The deficiency had the potential of not adhering to the provisions of NFPA 70 necessary for safety, and the practical safeguarding of persons, and property from hazards arising from the use of electricity. Findings: On 6/19/15 at 9:20 a.m., there was an electrical cord coming out of and entering a wall in the kitchen, above the dietary office room door. During an interview at the same time as the observation, the Dietician/Director of food & Nutrition stated that the electrical cord was connected to a video camera, but did not know why the wire was pulled out of, and back into the wall.	K 147	*Electrical Wiring* • No residents or staffs were affected by the said deficient practice. • The facility performs environmental rounds regularly and identifies deficiencies and reports the deficiencies to the Facilities Operations Center for repair. Environmental/Safety deficiencies are top priority and repairs are scheduled first. • The cable observed by the surveyor was identified as being video cable and is not high voltage and poses no electrical shock risk. The walls that the cable penetrates are not fire walls. • The facilities Environment of Care committee meets regularly and EOC audits are monitored and reviewed at these meetings. The hospital has also assigned the Vice President of Facilities to ensure that all Life safety & Environmental requirements are met. • Completed 6/24/2015	

COUNTY OF LOS ANGELES
Public Health

CYNTHIA A. HARDING, M.P.H.
Interim Director

JEFFREY D. GUNZENHAUSER, M.D., M.P.H.
Interim Health Officer

ANGELO J. BELLOMO, REHS, QEP
Director of Environmental Health

TERRI S. WILLIAMS, REHS
Assistant Director of Environmental Health

5050 Commerce Drive
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Letter 4

IMPORTANT NOTICE - PLEASE READ CAREFULLY

July 13, 2015

Darrin Buckner, RN
Director of Subacute
Southern California Hosp At Culver City D/p Snf
3828 Delmas Terrace
Culver City, CA 90230

Dear Administrator:

On June 22, 2015, a standard annual Health and Life Safety Code survey was conducted at your facility by the California Department of Public Health, Licensing and Certification Program (Los Angeles Acute - South), to determine if your facility was in compliance with federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiency(ies) to be:

[ ] Isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the enclosed "Statement of Deficiencies and Plan of Correction" form, whereby corrections are required (D).

[x] A pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the enclosed "Statement of Deficiencies and Plan of Correction" form, whereby corrections are required (E).

The enclosed Centers for Medicare and Medicaid Services (CMS) form, entitled "Statement of Deficiencies and Plan of Correction" (CMS–2567), documents the deficiencies of participation requirements identified during this visit. All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations (CFR).

Plan of Correction (POC)

A POC for the deficiencies must be submitted within **ten (10) days from receipt of the CMS- 2567.** Failure to submit an acceptable POC by the due date will result in remedies being recommended for imposition by the CMS and/or the State Medicaid Agency effective as soon as notice requirements are met.

Your POC must be submitted on the enclosed CMS-2567 form and must contain the following:

- How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;
- How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system; and
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Agency.

Remedies will be recommended for imposition by the CMS Regional Office and/or the State Medicaid Agency if your facility has failed to achieve substantial compliance by .

Recommended Remedies

The remedies, which will be recommended if substantial compliance has not been achieved by July 23, 2015 , include the following:

[x] Civil money penalty of $ 150.00 , effective June 22, 2015 (§488.430).

We are also recommending to the CMS Regional Office and/or the State Medicaid Agency that your provider agreement be terminated on if substantial compliance is not achieved by that time.

Denial of Payment for New Admissions (DPNA)

Based on deficiencies cited during this survey and as authorized by CMS San Francisco Regional Office, we are giving formal notice of imposition of statutory DPNA effective September 22, 2015. This remedy will be effectuated on the stated date unless you demonstrate substantial compliance with an acceptable POC and subsequent revisit. This notice in no way limits the prerogative of CMS to impose discretionary DPNA at any appropriate time.

CMS Regional Office will notify your intermediary and the Medicaid Agency. If effectuated, denial of payment will continue until your facility achieves substantial Compliance or your provider agreement is terminated. Facilities are prohibited from billing those Medicare/Medicaid residents or their responsible parties during the denial period for services normally billed to Medicare or Medicaid.

Appeal Rights

If you disagree with the **determination of noncompliance (and/or substandard quality of care, if applicable)**, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in 42 CFR §498.40, et. seq. You may appeal the finding of noncompliance that led to an enforcement action, but not the enforcement action or remedy itself. A written request for hearing must be filed no later than 60 days from the date of receipt of this letter.

Such written request should be made **directly** to:

Attention: Ms. Karen Robinson
Departmental Appeals Board
Civil Remedies Division
Cohen Building, Room G-644
330 Independence Avenue S.W.
Washington, D.C. 20201

A request for hearing should identify specific issues, and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You may be represented at a hearing by counsel at your own expense.

Be sure to include a copy of this letter with your request to the Departmental Appeals Board. In addition, please forward a copy of your request to:

Attention: Paula Perse, Manager
Long Term Care Branch
Division of Survey and Certification
Centers for Medicare & Medicaid Services
90 7th Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

Alternatively, you can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at https://dab.efile.hhs.gov.

To file a new appeal using DAB E-File, you first need to register a new account by: (1) clicking **Register** on the DAB E-File home page; (2) entering the information requested on the "Register New Account" form; and (3) clicking **Register Account** at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he or she is a party or authorized representative. Once registered, you may file your appeal by:

-Clicking the **File New Appeal** link on the Manage Existing Appeals screen, then clicking Civil Remedies Division on the File New Appeal screen.
And,
-Entering and uploading the requested information and documents on the "File New Appeal-Civil Remedies Division" form.

At minimum, the Civil Remedies Division (CRD) requires a party to file a signed request for hearing and the underlying notice letter from CMS that sets forth the action taken and the party's appeal rights. All documents must be submitted in Portable Document Format ("PDF"). Any document, including a request for hearing, will be deemed to have been filed on a given day, if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day. A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the Administrative Law Judge, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service. More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E-File Procedures link on the File New Appeal Screen for CRD appeals.

If you choose to file your appeal electronically, please also send a copy of the hearing request to:

Attention: Paula Perse, Manager
Long Term Care Branch
Division of survey and Certification
Centers for Medicare & Medicaid Services
90 7th Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

Allegation of Compliance

If you believe these deficiencies have been corrected, you may submit your POC as your allegation of compliance to Eric Stone, Program Manager, California Department of Public Health, Licensing and Certification Program, Los Angeles Acute and Ancillary Unit - South, 3400 Aerojet Suite 323 El Monte, CA 91731. We may accept your POC as your allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy(ies) at that time.

If, upon a subsequent revisit or by other means it is determined your facility has not achieved substantial compliance, we will recommend the remedies previously mentioned in this letter be imposed by the CMS Regional Office beginning on June 22, 2105 and continue until substantial compliance is achieved. Additionally, the CMS Regional Office may impose a revised remedy(ies), based upon changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

Informal Dispute Resolution

In accordance with §488.331, you have one (1) opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and relevant information (evidence) as to why you are disputing those deficiencies to Suzette Leverett - Clark, RN Assistant Chief, California Department of Public Health, Licensing and Certification Division at 12440 East Imperial Highway Room 522, Norwalk, CA 90650.

This request must be sent during the same ten (10) days you have for submitting a POC for the cited deficiencies. An informal dispute resolution for the cited deficiencies will not delay the imposition of the recommended enforcement actions. A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

Should CMS determine that termination or any other remedy is warranted, they will provide you with a separate formal notification of that determination.

If you have questions concerning the instructions contained in this letter, please contact, Eric Stone, Program Manager, at (626) 312-1142.

Sincerely,

Nwamaka Oranusi, Acting Chief
Health Facilities Inspection Division

Rosario Burgos RN, Sr. HFEW for

Eric Stone, Program Manager
Acute and Ancillary Unit- South
3400 Aerojet Avenue Suite 323
Tel. (626) 312-1142 - Fax (626) 927-9293

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555874	A. BUILDING _____ B. WING _____	06/20/2015

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F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during a re-certification survey. Representing the Department of Public Health: Surveyor 17030, RN, HFEN Surveyor 25524, RN, HFEN Surveyor 16281, REHS, HFE Total Resident Population 17 Total Resident Sample Size: 8 Highest Scope/Severity: E	F 000		
F 154 SS=E	483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the resident or the resident's representative had the right to be fully informed in advance of the risks and benefits of anti-antipsychotic and physical restraints to be administered to six (5) of eight (8) sampled residents (1, 2, 3, 4, 6, and 7). The facility failed	F 154	1. How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Corrective Action will be accomplished by the re-education of staff on the Restraints Policy and Procedure Application and monitoring SAA.049 and Consents PAT.037, completed on 7/19/2015. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken The SubAcute Unit at Southern California Hospital at Culver City (SCHCC) will identify other residents having the same potential for deficient practice by discussing restraint plan of care in interdisciplinary weekly rounds, and 100% monitoring of restraint documentation and informed consents, and will monitor them beginning August 1, 2015 as process improvements and report it quarterly to quality council, medical executive committee and governing board.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 7/20/15

...deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ...r safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 154	Continued From page 1 to develop a written policy and procedure for informing the resident or the resident's representative the risks and benefits of the physical restraints. For Resident 1 and 6, the physician failed to obtain an informed consent from the authorized representative for the use of anti-antipsychotic and anti-depressant medications. For Resident 1, 2 and 7, the physician failed to obtain an informed consent from the resident or resident's representative for the physical restraints. This deficient practice had the potential for violating the resident's right to be fully informed in advance about the care. For Resident 3's blood transfusion, the physician failed to obtain an informed consent from the resident or resident's representative. For Residents 4's Peripherally Inserted Central Line, (PICC) line insertion, the physician failed to obtain an informed consent from the resident or resident's representative. For Resident 6's PICC line insertion and psychotropic medication, the physician failed to obtain an informed consent from the resident or resident's representative. This deficient practice had the potential for violating the resident's right to be fully informed in advance about the care. Findings: 1. During the initial tour of the unit with Registered Nurse (RN) 1 on June 19, 2015 at 8:30 a.m., Resident 1 was observed lying in bed with a PEG	F 154	3. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* 100% monitoring of restraint documentation and informed consents, and will monitor them beginning August 1, 2015 as process improvements and report it quarterly to Quality Council, Medical Executive Committee and Governing Board. 4. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* Discussions of residents on restraints plan of care in interdisciplinary weekly rounds, and 100% monitoring of restraint documentation and informed consents, and will monitor them beginning August 1, 2015 as process improvements and report it quarterly to quality council, medical executive committee and governing board.	7/19/15

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F 154	Continued From page 2 (Percutaneous endoscopic gastrostomy) tube (a tube passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate) and tracheostomy tube (a tube to be inserted allows a person to breathe without the use of his or her nose or mouth). Resident 1 was observed with soft wrist restraints applied on his wrists. According to RN 1, the resident was confused and was on soft wrist restraints to prevent the resident from pulling out the tracheostomy tube and PEG tube. a. A review of clinical record indicated Resident 1 was admitted to the facility on April 20, 2015 with diagnosis of intracranial hemorrhage (bleeding within the skull). The Minimum Data Set (MDS- assessment tool) dated April 27, 2015, indicated the resident was on persistant vegetative state (A disorder of consciousness in which patients with severe brain damage are in a state of partial arousal rather than true awareness). A review of the safety restraint order indicated the physician had ordered bilateral soft wrist restraints on April 20, 2015. A review of the entire clinical record indicated there was no documentation the resident's surrogate had been informed of the risks and benefits for the use of physical restraints. b. A review of the medication administration record indicated the physician had prescribed haldol (antipsychotic medication) since May 2, 2015 for Resident 1. The "Consent to Receive psychotropic	F 154	1. *How corrective action( ) will be accomplished for those residents found to have been affected by the deficient practice* Corrective Action will be accomplished by the re-education of staff on the Restraints Policy and Procedure Application and monitoring SAA.049 and Consents PAT.037, completed on 7/19/2015. 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* The SubAcute Unit at Southern California Hospital at Culver City (SCHCC) will identify other residents having the same potential for deficient practice by discussing restraint plan of care in interdisciplinary weekly rounds, and 100% monitoring of restraint documentation and informed consents, and will monitor them beginning August 1,2015 as process improvements and report it quarterly to quality council, medical executive committee and governing board. 3. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* 100% monitoring of restraint documentation and informed consents, and will monitor them beginning August 1, 2015 as process improvements and report it quarterly to Quality Council, Medical Executive Committee and Governing Board. 4. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* Discussions of residents on restraints plan of care in interdisciplinary weekly rounds, and 100% monitoring of restraint documentation and informed consents, and will monitor them beginning August 1,2015 as process improvements and report it quarterly to quality council, medical executive committee and governing board.	7/19/15

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555874	A. BUILDING _____ B. WING _____	06/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 154	Continued From page 3 Medications" dated May 2, 2015 was reviewed and indicated the physician and the nurse signed but there was no documented evidence that the physician had informed the surrogate the risks and benefits of the medication. During an interview on June 20, 2015 at 4 p.m., RN 1 stated the physician had not informed the surrogate of the risks and benefits of the medication. 2. During the initial tour of the unit with RN 1 on June 19, 2015 at 8:37 a.m., Resident 2 was observed lying in bed with a PEG tube and tracheostomy tube. According to RN 1, the resident was confused and was on soft wrist restraints to prevent the resident from pulling out the tracheostomy tube and PEG tube. A review of clinical record indicated Resident 2 was admitted to the facility on June 17, 2015 with diagnosis of intracranial hemorrhage (bleeding within the skull). A review of the safety restraint order indicated the physician had ordered bilateral soft wrist restraints on June 19, 2015. A review of the entire clinical record indicated there was no documentation that the resident's surrogate was informed of the risks and benefits for the use of physical restraints. 3. During the initial tour of the unit with RN 1 on June 19, 2015 at 8:48 a.m., Resident 7 was observed lying in bed with a PEG tube and tracheostomy tube. According to RN 1, the resident was confused and was on soft wrist restraints to prevent the resident from pulling out the tracheostomy tube and PEG tube.	F 154	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* Corrective Action will be accomplished by the re-education of staff on the Restraints Policy and Procedure Application and monitoring SAA.049 and Consents PAT.037, completed on 7/19/2015. 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* The SubAcute Unit at Southern California Hospital at Culver City (SCHCC) will identify other residents having the same potential for deficient practice by discussing restraint plan of care in interdisciplinary weekly rounds, and 100% monitoring of restraint documentation and informed consents, and will monitor them beginning August 1, 2015 as process improvements and report it quarterly to quality council, medical executive committee and governing board. 3. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* 100% monitoring of restraint documentation and informed consents, and will monitor them beginning August 1, 2015 as process improvements and report it quarterly to Quality Council, Medical Executive Committee and Governing Board. 4. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* Discussions of residents on restraints plan of care in interdisciplinary weekly rounds, and 100% monitoring of restraint documentation and informed consents, and will monitor them beginning August 1, 2015 as process improvements and report it quarterly to quality council, medical executive committee and governing board.	7/19/15

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F 154	Continued From page 4 A review of clinical record indicated Resident 7 was admitted to the facility on April 2, 2015 with diagnosis of respiratory failure (a condition in which not enough oxygen passes from the lungs into the blood). A review of the safety restraint order indicated the physician had ordered bilateral soft wrist restraints on April 2, 2015. A review of the entire clinical record indicated there was no documentation that the resident's surrogate had been informed of the risks and benefits for the use of physical restraints. During an interview on June 19, 2015 at 4:45 p.m., Employee 2 stated the physician had not informed the surrogate the risks and benefits of physical restraints. According to Employee 2, there was no policy and procedure developed for informing the resident/surrogate the risks and benefits of the physical restraints. 4. A review of the Admission Face sheet indicated Resident 3 was admitted to the facility on March 27, 2015, with diagnoses that included respiratory failure (a condition which not enough oxygen passes from your lungs into your blood). The Blood Component Requisition and Transfusion Record was dated June 9, 2015. The Informed Consent to Blood Transfusion form was dated April 9, 2015, was done by telephone, Resident 3's family member gave a consent, and the witness signed. However, there was no physician signature, date and time. There was no	F 154	*1. How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* Corrective Action will be accomplished by the re-education of staff on the Restraints Policy and Procedure Application and monitoring SAA.049 and Consents PAT.037, completed on 7/19/2015. *2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* The Sub Acute Unit at Southern California Hospital at Culver City (SCHCC) will identify other residents having the same potential for deficient practice by discussing restraint plan of care in interdisciplinary weekly rounds, and 100% monitoring of restraint documentation and informed consents, and will monitor them beginning August 1,2015 as process improvements and report it quarterly to quality council, medical executive committee and governing board.	7/19/15

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F 154	Continued From page 6 other consent for the blood transfusion on April 2015. A review of two (2) facility's policies indicated the following: a. The policy titled, "Blood Component Administration Protocol" dated November 28, 2014, indicated verify the resident had signed the informed consent and the physician had explained the risks and benefits of blood transfusion, alternatives to transfusion, and the right of the resident to refuse transfusion. b. The policy titled, "Blood Transfusion Consent" dated November 2012 indicated all patients receiving blood or blood products must be informed of the risks of such transfusion and must sign the consent. The treating physician must provide information to the patient or the patient's surrogate decision marker. The physician is responsible for documenting that the conversation took place. 5. A review of the Admission Face Sheet indicated Resident 4 was admitted to the facility on March 3, 2015 with diagnoses that included respiratory failure. The Authorization and Informed Consent to Surgery or Special Diagnostic or Therapeutic Procedures (page 1 of 6) indicated Peripherally Inserted Central Line (PICC- line is a long, thin, hollow tube that a doctor or nurse puts into a vein above the bend of your elbow. It is used to give you chemotherapy and other medicines). The Signatures for Surgery or Procedure Informed Consent (page 3 of 6) dated June 5, 2015 indicated Resident 4's family member gave a	F 154	*3. What measures will be put into place* 100% monitoring of restraint documentation and informed consents, and will monitor them beginning August 1, 2015 as process improvements and report it quarterly to Quality Council, Medical Executive Committee and Governing Board. *4. How the facility plans to monitor* Discussions of residents on restraints plan of care in interdisciplinary weekly rounds, and 100% monitoring of restraint documentation and informed consents, and will monitor them beginning August 1,2015 as process improvements and report it quarterly to quality council, medical executive committee and governing board. *5. Include dates when corrective action will be completed.* 7/19/15	7/19/15

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F 154	Continued From page 6 telephone consent. However, there was no physician's verification of informed consent which included the signature to indicate the risks, benefits, and alternatives were discussed with the resident and/or family member. A review of a facility's policy titled, "Peripherally Inserted Central Catheter" dated November 20, 2012, indicated the resident has the right to receive information on all aspects of care. Explanation should include the benefits, potential risks, and expected outcomes. 6. A review of the Admission Face Sheet indicated Resident 6 was admitted to the facility on April 9, 2015, with diagnoses that included respiratory failure. Resident 6 was able to make her needs known. a. The Authorization and Informed Consent to Surgery or Special Diagnostic or Therapeutic Procedures (page 1 of 6) indicated Computed Tomography Scan of the Abdomen with/without Contrast (CT or CAT scan is a noninvasive diagnostic imaging procedure that uses a combination of X-rays and computer technology to produce horizontal, or axial, images (often called slices) of the body. A computerized tomography (CT scan combines a series of X-ray images taken from different angles and uses computer processing to create cross-sectional images, or shows detailed images of any part of the body, including the bones, muscles, fat, organs, and blood vessels). The Signatures for Surgery or Procedure Informed Consent page 3 of 6 dated June 6, 2015 indicated Resident 6 gave consent. However, there was no physician's verification of informed consent which included signature to indicate that the risks,	F 154	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **Corrective Action will be accomplished by the re-education of staff on the Restraints Policy and Procedure Application and monitoring SAA.049 and Consents PAT.037, completed on 7/19/2015.** 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **The SubAcute Unit at Southern California Hospitals at Culver City (SCHCC) will identify other residents having the same potential for deficient practice by discussing restraint plan of care in interdisciplinary weekly rounds, and 100% monitoring of restraint documentation and informed consents, and will monitor them beginning August 1,2015 as process improvements and report it quarterly to quality council, medical executive committee and governing board.** 3. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **100% monitoring of restraint documentation and informed consents, and will monitor them beginning August 1, 2015 as process improvements and report it quarterly to Quality Council, Medical Executive Committee and Governing Board.** 4. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness. The PQCI is integrated into the quality assurance system* **Discussions of residents on restraints plan of care in interdisciplinary weekly rounds, and 100% monitoring of restraint documentation and informed consents, and will monitor them beginning August 1,2015 as process improvements and report it quarterly to quality council, medical executive committee and governing board.**	

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F 154	Continued From page 7 benefits, and alternatives were discussed with the resident /or family member. b. The Consent to Receive Psychotropic Medications dated April 10, 2015 indicated Zoloft (antidepressant medication) 100 milligrams (mg) by mouth once a day and was signed by the resident and the licensed nurse. However, there was no physician signature on the consent.	F 154		
F 221 SS=E	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that three (3) of eight (8) sampled residents (1, 4 and 7) had the right to be free from any physical restraints and not required to treat the resident's medical symptoms. For Resident 1 and 7, the physician failed to authenticate the order for soft wrist restraint within 24 hours after the initiation of restraint. For Resident 4 and 7, the facility failed to attempt the less restrictive measures prior to the use of restraint. These deficient practices had the potential to violate the resident's right to be free from injury and had the potential for decreased mobility. Findings:	F 221	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **Corrective Action for F 221 will be accomplished by re-education of staff on policy SAA.049 Restraint Policy and Procedure and Monitoring on 7/19/2015. SCHCC will create a "Hard Stop in the EMR documentation" for nursing to document alternatives attempted before placing restraints, and use of least restrictive measures, by August 21, 2015. Medical Staff will receive re-education on Policy and Procedure regarding necessity of orders for restraint by a M.D. with date and time by 7/29/15.** 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **SCHCC will identify other residents having the potential to be affected by the same deficient practice after weekly Interdisciplinary Team (IDT) meetings. The Nursing Manager and MDS Coordinator will complete a 100% audit of "IDT" form for accuracy and completeness, starting July 21, 2015, and report any significant findings to Sub Acute Director.**	7/23/15

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F 221	Continued From page 8	F 221		

1. During the initial tour of the unit with Registered Nurse (RN) 1 on June 19, 2015 at 8:30 a.m., Resident 1 was observed lying in bed with a PEG (Percutaneous endoscopic gastrostomy) tube (a tube passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate) and tracheostomy tube (a tube to be inserted allows a person to breathe without the use of his or her nose or mouth). Resident 1 was observed with soft wrist restraints applied on his wrists. According to RN 1, the resident was confused and was on soft wrist restraints to prevent the resident from pulling out the tracheostomy tube and PEG tube.

A review of clinical record indicated Resident 1 was admitted to the facility on April 20, 2015, with diagnosis of intracranial hemorrhage (bleeding within the skull).

A review of the "Non-Behavioral restraint orders and flow sheet" dated April 20, 2015, indicated the physician had ordered bilateral soft wrist restraints to prevent the resident from pulling out tracheostomy tube and PEG tube. The order was countersigned by the physician. However, there was no documentation the physician had authenticated the order within 24 hours after the initiation of restraint for the following days: 5/29/15, 5/30/15, 6/3/15, 6/5/15, and 6/7/15 to 6/16/15. The less restrictive measures were attempted on 5/29/15 and 6/1/15.

2. During the initial tour of the unit with RN 1 on June 19, 2015 at 8:49 a.m., Resident 7 was observed lying in bed with a PEG tube and

3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur

SCHCC will identify other residents having the potential to be affected by the same deficient practice after weekly Interdisciplinary Team (IDT) meetings. The Nursing Manager and MDS Coordinator will complete a 100% audit of "IDT" form for accuracy and completeness, starting July 21, 2015, and report any significant findings to Sub Acute Director.

4. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system

The Nursing Manager and MDS Coordinator will complete a 100% audit of "IDT" form for accuracy and completeness, starting July 21, 2015, and report any significant findings to Sub Acute Director. Reports will be submitted quarterly to Quality Council, Medical Executive Committee and Governing Board.

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F 221	Continued From page 9 tracheostomy tube. According to RN 1, the resident was confused and was on soft wrist restraints to prevent the resident from pulling out the tracheostomy tube and PEG tube. A review of clinical record indicated Resident 7 was admitted to the facility on April 2, 2015, with diagnosis of respiratory failure (a condition in which not enough oxygen passes from the lungs into the blood). A review of the "Non-Behavioral restraint orders and flow sheet" dated April 20, 2015, indicated the physician had ordered bilateral soft wrist restraints to prevent the resident from pulling out tracheostomy tube and PEG tube. The order was countersigned by the physician. However, there was no documentation the physician had authenticated the order within 24 hours after the initiation of restraint from June 12, 2015 to June 16, 2015. According to the facility's policies and procedures dated May 2015, titled, "Non-Behavioral Restraints:" "PROCEDURES 4.7 Alternatives to Restraint use 4.7.1 Safe, effective and the least restrictive protective measures will be employed based on the patient's assessed needs and history of effective and ineffective. 4.7.2 Companionship/supervision 4.7.3 Continuous observation, i.e., sitter or family member; 4.7.4 Diversion/physical activities (music, television); 4.7.5 pain relief/comfort measures (warmth, noise	F 221	*1. How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* Corrective Action for F 221 will be accomplished by re-education of staff on policy SAA.049 Restraint Policy and Procedure and Monitoring on 7/19/2015. SCHCC will create a "Hard Stop in the EMR documentation" for nursing to document alternatives attempted before placing restraints, and use of least restrictive measures, by August 31, 2015. Medical Staff will receive re-education on Policy and Procedure regarding necessity of orders for restraint by a M.D. with date and time by 7/23/15. *2. Identify Residents and Corrective action taken* SCHCC will identify other residents having the potential to be affected by the same deficient practice after weekly Interdisciplinary Team (IDT) meetings. The Nursing Manager and MDS Coordinator will complete a 100% audit of "IDT" form for accuracy and completeness, starting July 21, 2015, and report any significant findings to Sub Acute Director.	7/23/15

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F 221	Continued From page 10 level, etc.); 4.7.6 patient placement in room close to nurses' station; 4.7.7 Reality orientation/mental stimulation (music, television, reading materials); 4.7.8 Scheduled toileting. 4.7.9 Documentation in the patient's medical record will be reflect those times when less restrictive protective measures are attempted. 4.7.10 When less restrictive protective measures 4.8 Assessment and the Decision to Use restraints have been unsuccessful, or have been determined to be appropriate, restraints may be used. 4.8.3 Restraint will be employed only after less restrictive measure have been attempted and have failed to produce a desire outcome or have been found to be contraindicated. 4.10 Restraint Application without an Order 4.10.1 If an LIP (Licensed Independent Practitioner) is not available to issue a restraint order, a registered Nurse may initiate restraint use based on his/her appropriate assessment of the patient. The LIP is notified within 1-hour of the initiation of restraint, and a telephone order is obtained from the LIP and entered into the patient's record. The telephone order must be authenticated within 24-hours of the initial order." 3. During an initial tour on June 19, 2015, at 9:05 a.m., Resident 4 was lying in bed, his eyes closed, had a foley (indwelling) catheter, and soft wrist restraints were applied to both wrists. Licensed Vocational Nurse (LVN) 2 stated Resident 4 had bilateral soft restraints due to pulling out the tubes.	F 221	*3. Measures put into place.* SCHCC will identify other residents having the potential to be affected by the same deficient practice after weekly Interdisciplinary Team (IDT) meetings. The Nursing Manager and MDS Coordinator will complete a 100% audit of "IDT" form for accuracy and completeness, starting July 21, 2015, and report any significant findings to Sub Acute Director. *4. Monitoring performance to make sure that solutions are sustained.* The Nursing Manager and MDS Coordinator will complete a 100% audit of "IDT" form for accuracy and completeness, starting July 21, 2015, and report any significant findings to Sub Acute Director. Reports will be submitted quarterly to Quality Council, Medical Executive Committee and Governing Board. *5. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Agency.* 7/23/15	7/23/15

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F 221	Continued From page 11 a. A review of the Admission Face Sheet indicated Resident 4 was admitted to the facility on March 3, 2015, with diagnoses that included respiratory failure. The Minimum Data Set (MDS an assessment and care plan tool) dated March 10, 2015, indicated Resident 4 was totally dependent on the staff for activities of daily living such as dressing bed mobility, toileting, and bathing. The MDS Sections: Section G0400 indicated Resident 4 had impairment on both sides of his lower extremity. Section P-Restraints of the MDS assessment indicated Resident 4 had "limb restraints and were used daily." The Care Area Assessment (CAA) Worksheet dated March 10, 2015, indicated Resident 4 had episodes of confusion due to medical condition and diagnosis of dementia. A care plan for dementia will be developed. The CAA #3 "Limb Restraint Used in Bed" indicated Resident 4 was confused and at times had attempted to pull the tubing. The Care Area Assessment (CAA) Worksheet dated March 10, 2015, indicated to refer to the license nurses notes and documentation during the look back dated March 4, 2015 through March 10, 2015. There was no current documentation of Resident 4's behavior for the use of the soft wrist restraints. There were only the pre-printed Non-Behavioral Restraint Order and Flow Sheets which indicated checks. There was no documentation the RN had assessed the behavior that Resident 4 exhibited. During an electronic record review on June 20, 2015, at 11:40 a.m., RN 1 stated Resident 4's plan of care indicated the staff had been applying the wrist restraints on the resident since March	F 221	1. *How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice* **Corrective Action for F 221 will be accomplished by re-education of staff on policy SAA.049 Restraint Policy and Procedure and Monitoring on 7/19/2015. SCHCC will create a "Hard Stop in the EMR documentation" for nursing to document alternatives attempted before placing restraints, and use of least restrictive measures, by August 31, 2015. Medical Staff will receive re-education on Policy and Procedure regarding necessity of orders for restraint by a M.D. with date and time by 7/29/15.** 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **SCHCC will identify other residents having the potential to be affected by the same deficient practice after weekly Interdisciplinary Team (IDT) meetings. The Nursing Manager and MDS Coordinator will complete a 100% audit of "IDT" form for accuracy and completeness, starting July 21, 2015, and report any significant findings to Sub Acute Director.**	

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F 221	Continued From page 12 10, 2015. There was no documented evidence from the RN regarding other alternative measures used prior to the use of soft wrist restraints. A care plan titled, "Physical Restraint Limb secondary to varies at times to pull on cords and tubing, and fall risk." The staff approaches included refer to the IDT members for evaluation and recommendation of appropriate use of correct restraints. Attempt to use less restrictive devices on an ongoing basis. Quarterly assessment review and follow up by the IDT to ensure appropriateness of restraints. During an interview on June 20, 2105, at 10:45 a.m., RN 1 stated she had witnessed Resident 4 scratched himself when the bilateral soft restraints were removed. However, there was no documentation provided by the RN. A review of the Weekly IDT Notes dated May 26 through June 9, 2015, indicated no documented evidence the use of soft restraints was discussed in the IDT meeting. The Interdisciplinary Team (IDT) Conference Record Quarterly Review dated May 5, 2015, indicated the pre-printed box was checked off for bilateral soft restraints use to indicate the restraint was appropriate and necessary to manage Resident 4's safety needs. The IDT Conference Record had a section which indicated a discussion with the physician regarding the treatment plan without any changes made with	F 221	*3. What measures will be put into place or what system changes the facility will make to ensure that the deficient practice does not recur* **SCHCC will identify other residents having the potential to be affected by the same deficient practice after weekly Interdisciplinary Team (IDT) meetings. The Nursing Manager and MDS Coordinator will complete a 100% audit of "IDT" form for accuracy and completeness, starting July 21, 2015, and report any significant findings to Sub Acute Director.** *4. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **The Nursing Manager and MDS Coordinator will complete a 100% audit of "IDT" form for accuracy and completeness, starting July 21, 2015, and report any significant findings to Sub Acute Director. Reports will be submitted quarterly to Quality Council, Medical Executive Committee and Governing Board.**	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	556874	A. BUILDING _____ B. WING _____	06/20/2015

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SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

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F 221	Continued From page 13 the plan of care and/or discussed with physician regarding plan of care with new changes made. There was no documented evidence that Resident 4's physician was made aware of the continued use of the restraint. b. Review of the Non-Behavioral Restraint Order and Flow Sheet dated June 14, 2015 through June 19, 2015 indicated that on June 19, 2015 Resident 4 had been in restraints for 92 days. The Nursing- Clinical Assessment did not indicate the alternative/least restrictive measures attempted prior to the use of restraints.	F 221		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on a review of activity calendar and interview, the facility failed to provide an ongoing program of activities, designed to meet the interests and the physical, mental, and psychosocial well-being of the residents. There was no staff member conducting activities during the weekend as indicated by the facility's policy and procedure. This deficient practice had the potential for not meeting the residents' activity needs.	F 248	*1. How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **Activity Coordinator Designee will be hired for weekend coverage to meet a seven day per week coverage.** *2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **Staffing schedule will identify the potential and a designee Activities Coordinator will be assigned to cover the weekend.** *3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **Daily monitoring to ensure an Activity Coordinator or Designee is scheduled every day.** *4. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **Monitor staffing schedule daily. Outliers will be tracked and trended, then reported quarterly to Quality Council, Medical Executive Committee and Governing Board.**	

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F 248	Continued From page 14 Findings: A review of the Activity Calendar for May and June of 2015 indicated all variety of activities were scheduled seven days per week. During an interview with the Activity Coordinator on June 20, 2015 at 10:55 a.m., she stated there was no staff member who could coordinate the activities while she was off during the weekend. During an interview with Employee 2 on June 20, 2015 at 4 p.m., he stated the Activity Coordinator usually works 5 days per week (Monday to Friday) to coordinate and provide activities to the residents. Employee 2 stated there was no staff member conducting activities during the weekend. According to the facility's policy and procedure dated November 20, 2012, titled, "Activity Program-General Description": "4.2 Procedure 4.2.6 Activities are offered at hours convenient to the patient (i.e. morning, afternoon, some evenings and weekends) and involve the community when appropriate (in and out of he facility)."	F 248		
F 272 SS=C	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.	F 272	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **MDS Coordinator had consulted the facilities MDS Software Company Point Click Care for information on how to add dates and location to the Summary of the Care Area Assessment. Adding Dates and location to the Care Area Assessment to begin by 7/22/2015 when next Care Area Assessment is due.** 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **SCHCC will identify other residents having the potential to be affected by reviewing the Care Area Assessment at IDT meetings. Once identified, Care Area Assessment will be completed.**	

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F 272	Continued From page 15 A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility's licensed nurse failed to use the State specified RAI (Resident Assessment Instrument) in its entirety, when conducting an assessment of	F 272	*3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **MDS Coordinator had consulted the facilities MDS Software Company Point Click Care for information on how to add dates and location to the Summary of the Care Area Assessment. Adding Dates and location to the Care Area Assessment to begin by 7/22/2015 when next Care Area Assessment is due.** *4. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **This will be monitored weekly at the Interdisciplinary Team Meeting. Outliers will be tracked and trended, then reported quarterly to Quality Council, Medical Executive Committee and Governing Board.**	

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F 272	Continued From page 16 the needs of three (3) of eight (8)sampled residents (1, 7, and 8). The facility failed to conduct an MDS (Minimum Data Set, a standardized assessment and care planning tool) assessment with a CAA (Care Area Assessment) Summary Report that indicated the date of the CAA documentation (where information related to the CAA can be found) to help provide additional information for the development of an individualized care plan for Resident 1, 7, and 8. These deficient practices had the potential to result in not developing an individualized care plan to meet the resident's needs. Findings: 1. A review of clinical record indicated Resident 1 was admitted to the facility on April 20, 2015 with diagnosis of intracranial hemorrhage (bleeding within the skull). The MDS dated April 27, 2015 indicated the resident required total assistance in performing activities of daily living (ADLs), was incontinent of bowel and bladder, received nutrition and hydration via GT (gastrostomy tube, a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications), and was at risk for pressure sore development. A review of the CAA (Care Area Assessment) Summary dated April 30, 2015, indicated seven triggered care areas from the MDS findings that were problematic for the resident. These triggered care areas were urinary incontinence, falls, nutritional status, feeding tube, dehydration, pressure ulcer, and physical restraints. For the CAA Summary, the "Location and Date of CAA	F 272	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **MDS Coordinator had consulted the facilities MDS Software Company Point Click Care for information on how to add dates and location to the Summary of the Care Area Assessment. Adding Dates and location to the Care Area Assessment to begin by 7/22/2015 when next Care Area Assessment is due.** 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **SCHCC will identify other residents having the potential to be affected by reviewing the Care Area Assessment at IDT meetings. Once identified, Care Area Assessment will be completed.** 3. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **MDS Coordinator had consulted the facilities MDS Software Company Point Click Care for information on how to add dates and location to the Summary of the Care Area Assessment. Adding Dates and location to the Care Area Assessment to begin by 7/22/2015 when next Care Area Assessment is due.** 4. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **This will be monitored weekly at the Interdisciplinary Team Meeting. Outliers will be tracked and trended, then reported quarterly to Quality Council, Medical Executive Committee and Governing Board.**	

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SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

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F 272	Continued From page 17 Documentation" referred to CAA WS (Worksheet) dated April 15, 2015. However, the CAA WS did not provide documentation of the date and location where the assessment information could be found for the seven triggered areas. 2. A review of clinical record indicated Resident 7 was admitted to the facility on April 2, 2015 with diagnosis of respiratory failure (a condition in which not enough oxygen passes from the lungs into the blood). The MDS dated April 9, 2015 indicated the resident required total assistance in performing activities of daily living (ADLs), was incontinent of bowel, received nutrition and hydration via GT tube, and was at risk for pressure sore development. A review of the CAA (Care Area Assessment) Summary dated April 16, 2015, indicated nine triggered care areas from the MDS findings that were problematic for the resident. These triggered care areas were cognitive loss, communication, urinary incontinence, falls, nutritional status, feeding tube, dehydration, pressure ulcer, and physical restraints. For the CAA Summary, the "Location and Date of CAA Documentation" referred to CAA WS (Worksheet) dated April 15, 2015. However, the CAA WS did not provide documentation of the date and location where the assessment information could be found for the seven triggered areas. 3. A review of clinical record indicated Resident 8 was admitted to the facility on March 23, 2015 with diagnosis of respiratory failure. The resident expired on May 12, 2015.	F 272	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **MDS Coordinator had consulted the facilities MDS Software Company Point Click Care for information on how to add dates and location to the Summary of the Care Area Assessment. Adding Dates and location to the Care Area Assessment to begin by 7/22/2015 when next Care Area Assessment is due.** 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **SCHCC will identify other residents having the potential to be affected by reviewing the Care Area Assessment at IDT meetings. Once identified, Care Area Assessment will be completed.** 3. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **MDS Coordinator had consulted the facilities MDS Software Company Point Click Care for information on how to add dates and location to the Summary of the Care Area Assessment. Adding Dates and location to the Care Area Assessment to begin by 7/22/2015 when next Care Area Assessment is due.** 4. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **This will be monitored weekly at the Interdisciplinary Team Meeting. Outliers will be tracked and trended, then reported quarterly to Quality Council, Medical Executive Committee and Governing Board.**	

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F 272	Continued From page 18 The MDS dated March 30, 2015 indicated the resident required total assistance in performing activities of daily living (ADLs), was incontinent of bowel, received nutrition and hydration via GT (gastrostomy tube, a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications), and developed pressure sore. A review of the CAA (Care Area Assessment) Summary dated April 11, 2015, indicated five triggered care areas from the MDS findings that were problematic for the resident. These triggered care areas were urinary incontinence, nutritional status, feeding tube, dehydration, and pressure ulcer. For the CAA Summary, the "Location and Date of CAA Documentation" referred to CAA WS (Worksheet) dated April 10, 2015. However, the CAA WS did not provide documentation of the date and location where the assessment information could be found for the five triggered areas. On June 20, 2015 at 11:30 a.m., during an interview, MDS 1 stated the location of the date and assessment information for all triggered problem areas should have been documented.	F 272		
F 273 SS=D	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.)	F 273	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* Timely completion of the MDS Assessment within 14 days by the MDS Coordinator, the RN nursing manager will be certified in MDS 3.0 and Review MDS Comprehensive Assessment for completion in the correct time frame.	

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F 273	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to conduct a comprehensive assessment within 14 days of admission for one (1) of eight sample residents (8). This deficient practice had the potential for an untimely assessment of the resident's needs. Findings: A review of the medical record indicated Resident 8 was admitted to the facility on March 23, 2015, with diagnosis of respiratory failure (a condition in which not enough oxygen passes from the lungs into the blood). A review of the admission Minimum Data Set (MDS) for Resident 8 indicated the assessment was completed on April 11, 2015, which was 19 days of admission to the facility. In an interview with MDS 1 on June 20, 2015 at 11:30 a.m., she stated the admission MDS for Resident 8 was not completed within 14 days.	F 273	2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **The certified RN nursing manager reviews the MDS Comprehensive Assessment for completion in the correct time frame.** 3. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* 4. **The certified RN nursing manager reviews the MDS Comprehensive Assessment for completion in the correct time frame.**	
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the	F 278	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **The facility RN nursing manager will become certified in MDS 3.0 and represent the MDS Coordinator.** 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **Identification of potential deficient practice will be made by reviewing MDS 3.0 certifications annually. HR will notify Director Sub Acute if Certification expires within 3 months.**	

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F 278	Continued From page 20 assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a registered nurse coordinated each assessment with the appropriate participation of health professionals for three (3) of eight (8) sampled residents (1, 7, and 8). This deficient practice had a potential for not providing appropriate assessment and interventions for residents. Findings: 1. A review of the clinical record indicated Resident 1 was admitted to the facility on April 20, 2015 with diagnosis of intracranial hemorrhage	F 278	*3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **The facility RN nursing manager will become certified in MDS 3.0 and represent the MDS Coordinator.** *4. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **Outliers will be tracked and trended, then reported quarterly to Quality Council, Medical Executive Committee and Governing Board.**	

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F 278	Continued From page 21 (bleeding within the skull). A review of the CAA (Care Area Assessment) Summary dated April 30, 2015, indicated it was completed by Licensed Vocational Nurse (LVN) 1 and coordinated by MDS (Minimum Data Set) Coordinator. 2. A review of the clinical record indicated Resident 7 was admitted to the facility on April 2, 2015 with diagnosis of respiratory failure (a condition in which not enough oxygen passes from the lungs into the blood). A review of the CAA (Care Area Assessment) Summary dated April 16, 2015, indicated it was completed by LVN 1 and coordinated by MDS Coordinator. 3. A review of the clinical record indicated Resident 8 was admitted to the facility on March 23, 2015 with diagnosis of respiratory failure. The resident expired on May 12, 2015. A review of the CAA (Care Area Assessment) Summary dated April 11, 2015, indicated it was completed by LVN 1 and coordinated by MDS Coordinator. During an interview with Employee 2 on June 20, 2015 at 4:40 p.m., he stated the MDS Coordinator is the Director of the ICU (Intensive Care Unit), who signed under the "Signature of RN Assessment Coordinator Verifying Assessment Completion" for each MDS assessment. According to Employee 2, the MDS Coordinator had no formal training in MDS assessment.	F 278	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **The facility RN nursing manager will become certified in MDS 3.0 and represent the MDS Coordinator.** 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **Identification of potential deficient practice will be made by reviewing MDS 3.0 certifications annually. HR will notify Director Sub Acute if Certification expires within 3 months.** 3. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **The facility RN nursing manager will become certified in MDS 3.0 and represent the MDS Coordinator.** 4. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **Outliers will be tracked and trended, then reported quarterly to Quality Council, Medical Executive Committee and Governing Board.**	

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F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility's staff failed to develop comprehensive care plans for two (2) of eight (8) sampled residents (8 and 9). There was no care plan developed to address the care area for Resident 8's "urinary incontinence/indwelling catheter," as indicated in the Care Area Assessment (CAA). For Resident 9, there was no care plan developed for the isolation precautions for clostridium difficile (a fatal health care bacterium that can cause symptoms ranging from diarrhea to life-threatening inflammation of the colon).	F 279	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **Re-education of staff on review of Policy and Procedure at IDT meetings and necessity of review of all Comprehensive Care Plan items weekly during interdisciplinary team meeting.** 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **Residents will be identified through medical record reviews at IDT meetings.** 3. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **Comprehensive Care Plan items are reviewed weekly during IDT meetings.** 4. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **Monitoring at IDT meetings. Outliers will be tracked and trended, then reported quarterly to Quality Council, Medical Executive Committee and Governing Board.**	

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	556874	A. BUILDING _____ B. WING _____	06/20/2015

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F 279	Continued From page 23 This deficient practice has the potential for not providing appropriate interventions when there was no comprehensive care plan developed for the resident. Findings: 1. A review of Resident 8's medical record indicated the resident was admitted to the facility on March 23, 2015 with diagnosis of respiratory failure (a condition in which not enough oxygen passes from the lungs into the blood). The resident expired on May 12, 2015. According to the Section V (Care Area Assessment) of the MDS, "urinary incontinence/indwelling catheter" was a triggered area and a care plan was necessary to address the problem. A review of the CAA Summary Report dated April 11, 2015, for Resident 8 indicated the care area for "urinary incontinence/indwelling catheter" was triggered. A review of the care plans indicated there was no documentation a care plan was developed for "urinary incontinence/indwelling catheter." During an interview with Licensed Vocational Nurse (LVN) 1 on June 20, 2015, at 11:30 a.m., she stated a care plan should have been developed for "urinary incontinence/indwelling catheter."	F 279	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **Re-education of staff on review of Policy and Procedure at IDT meetings and necessity of review of all Comprehensive Care Plan items weekly during interdisciplinary team meeting.** 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **Residents will be identified through medical record reviews at IDT meetings.** 3. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **Comprehensive Care Plan items are reviewed weekly during IDT meetings.** 4. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **Monitoring at IDT meetings. Outliers will be tracked and trended, then reported quarterly to Quality Council, Medical Executive Committee and Governing Board.**	

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F 279	Continued From page 24 2. Resident 9 was admitted to the facility on April 10, 2015, with diagnoses that included pulmonary embolism (Pulmonary embolism is the sudden blockage of a major blood vessel in the lung, usually by a blood clot). During an initial tour on June 19, 2015, at 8:30 a.m., LVN 2 stated that Resident 9 was on isolation precautions for clostridium difficile (C. diff) (a fatal health care bacterium that can cause symptoms ranging from diarrhea to life-threatening inflammation of the colon). A review of the medical record on June 19, 2015 , at 2:35 p.m., indicated there was a plan of care titled, "Contact Isolation" dated April 17, 2015, for Methicillin Resistant Staphylococcus Aureus, MRSA (a bacteria that resists antibiotics) of the nares and Vancomycin Resistant Enterococci (VRE -are a type of bacteria called enterococci that have developed resistance to many antibiotics especially vancomycin) in the urine. However, there was no documented evidence of a care plan for managing C-Diff. A review of a laboratory result for Resident 9 dated June 17, 2015, indicated C-Diff "positive. "	F 279		
F 283 SS=B	483.20(l)(1)&(2) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to	F 283	1. *How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice* Will enforce the 14 day turn around for completion of discharge summaries. Completion of discharge summaries over 14 days Targeted date 60 days.	

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F 283	Continued From page 25 authorized persons and agencies, with the consent of the resident or legal representative. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to have a discharge summary that included a recapitulation of the resident's stay and a final summary of the resident's status, authenticated or signed and dated by the physician for completion within 14 days following discharge as indicated in the facility's policy and procedure for one of eight sampled residents (8). Findings: 1. A review of Resident 8's medical record indicated the resident was admitted to the facility on March 23, 2015. The resident expired on May 12, 2015. A review of the Discharge Summary indicated the discharge summary was dictated by the physician on June 20, 2015, which was 58 days after the resident expired. In addition, the Discharge Summary was not authenticated or signed by a physician. On June 20, 2015 at 11:50 a.m., during an interview with Employee 3, she stated the discharge summary was signed by the physician as of June 20, 2015. According to Employee 3, the discharge summary should be completed promptly and authenticated or signed by a physician within two (2) weeks following a patient's discharge. According to the facility's policy and procedure	F 283	*2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.* ***Discharge censuses are reviewed daily to identify deficiencies.*** **Will enforce the 14 day turn around for completion of discharge summaries. Completion of discharge summaries over 14 days Targeted date 60 days.** *3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **Will enforce the 14 day turn around for completion of discharge summaries. Completion of discharge summaries over 14 days Targeted date 60 days.** *4. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **Outliers will be tracked and trended, then reported quarterly to Quality Council, Medical Executive Committee and Governing Board.**	

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F 283	Continued From page 26 dated 8/12, titled, "Completion Requirements for the Medical Record": "4.1 Policy 4.1.2 medical records shall be completed promptly and authenticated or signed by a physician, dentist or podiatrist within two (2) weeks following a patient's discharge."	F 283		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to assess and re-assess the rashes for one (1) of eight (8) sampled residents (3). Resident 3 was identified with rashes and was treated with Clotrimazole 1% cream (antifungal topical ointment) and Hydrocortisone 1% ointment (corticosteroid) for 30 days, then 20 days later treated with Elimite cream (a scabicide agent that kills the scabies mite). The facility did not assess and re-assess the effectiveness and/or ineffectiveness of the treatment and the resident's response to the treatment. This deficient practice had the potential to result in	F 309	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **Re-education of staff on review of Policy and Procedure SAA at IDT meetings and necessity of review of all Comprehensive Care Plan items weekly during interdisciplinary team meeting.** 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **Residents will be identified through medical record reviews at IDT meetings.** 3. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **Comprehensive Care Plan items are reviewed weekly during IDT meetings.** 4. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **Monitoring at IDT meetings. Outliers will be tracked and trended, then reported quarterly to quality council, medical executive committee and governing board.**	

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F 309	Continued From page 27 recurring skin problems. Findings: During an initial tour, on June 19, 2015, Licensed Vocational Nurse (LVN) 2 stated Resident 3 was positive for Scabies last month. A review of the Admission Face Sheet indicated Resident 3 was admitted to the facility on March 27, 2015 with diagnoses that included respiratory failure (a condition which not enough oxygen passes from your lungs into your blood). A review of a Consultation dated May 1, 2015, indicated Resident 3 had a 3 day history of a rash. The resident was transferred from a skilled nursing facility. Resident 3 had a rash that began on her upper chest and left shoulder and subsequently spread to the back. The Assessment and Plan indicated probable folliculitis (common skin condition in which hair follicles become inflamed) and candidiasis (fungal infection). Per the nurses, the resident has improved on Clindamycin (treatment of acne vulgaris) and clotrimazole (is an antifungal medication commonly used in the treatment of fungal infections) use. Recommendation to continue both medications be applied twice daily on affected skin. The follow-up Dermatology Consultation dated May 15, 2015, indicated scabietic infestation cannot be ruled out and a skin scrapping was done. During an interview and clinical record review on June 19, 2015, at 11:40 a.m., Registered Nurse (RN) 1 stated the documentation of skin rashes	F 309	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **Re-education of staff on review of Policy and Procedure SAA at IDT meetings and necessity of review of all Comprehensive Care Plan items weekly during interdisciplinary team meeting.** 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **Residents will be identified through medical record reviews at IDT meetings.** 3. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **Comprehensive Care Plan items are reviewed weekly during IDT meetings.** 4. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **Monitoring at IDT meetings. Outliers will be tracked and trended, then reported quarterly to quality council, medical executive committee and governing board.**	

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F 309	Continued From page 28 was on April 2, 2015. RN 1 stated the rash was not specific to location and was not descriptive. RN 1 stated from April 2 through June 19, 2015, there was a diagnosis of Scabies. RN 1 stated that on May 19, 2015, there was documentation of a rash but was not descriptive and location of the rash was not specified. When asked for the location and description, RN 1 replied, "Yes, there should be location and description." Resident 3 had rashes since April 2, 2015 with treatments. When asked for an assessment and reassessment, RN 1 stated, "Yes, there should be an assessment and reassessment of the resident." RN 1 stated there should be a weekly progress notes. A review of an order titled, "Miscellaneous Nursing Order" dated May 15, 2015, indicated "ask Id and Dermatologist consultants to see her about worsening of her rash." A review of the Pathology Consultation to Rule Out Scabies dated collected May 15, 2015, indicated Resident 3 was positive for Scabies and the plan was to recommend further treatment. A plan of care titled, "Resident had diagnoses of Scabies" indicated the staff approaches included to observe for effectiveness of medication. There was no description where the scabies were located on Resident 3's body. There was no assessment and re-assessment of the scabies and response to Elimite treatment. During an interview on June 19, 2015, at 11:30 a.m., Employee 4 stated the staff should monitor the resident's skin for any conditions.	F 309	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **Re-education of staff on review of Policy and Procedure SAA at IDT meetings and necessity of review of all Comprehensive Care Plan items weekly during interdisciplinary team meeting.** 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **Residents will be identified through medical record reviews at IDT meetings.** 3. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **Comprehensive Care Plan items are reviewed weekly during IDT meetings.** 4. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **Monitoring at IDT meetings. Outliers will be tracked and trended, then reported quarterly to quality council, medical executive committee and governing board.**	

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F 309	Continued From page 29 A review of the Weekly IDT Notes dated May 19, 2015 did not indicate documentation of scabies. The nursing section was not completed. According to the instructions, any progress, changes, additional information with current condition since review date should be documented. During a concurrent interview with Employee 1 and Employee 4 on June 20, 2015, between 9:55 a.m. and 10:20 a.m., Employee 1 reviewed the clinical record and stated there was a progress note dated May 1, 2015 which indicated Resident 3 had a 3 day rash and the dermatologist consultant came on May 15, 2015. Employee 4 stated Resident 4 had skin symptoms more than a few weeks ago. Employee 4 further stated Resident 3's physician did not feel Resident 3 had Scabies. A review of the Medication Administration Record indicated the following orders: 1. Clotriazole 1% Cream (Lotromin) dated April 7, 2015, to be applied twice a day, to the rash on back, chest, neck, ad arms. 2. Clindamycin Phosphate 1% lotion (Cleocin T) dated April 29, 2015, applied twice a day. There was no indication were to apply. A review of a facility's policy and procedure titled, "Comprehensive Care Plan" dated January 2014 indicated the care plan will be revised weekly as part of the Interdisciplinary Team process. It will be incorporated into team meeting or by having the nurse review the care plan during the team 's	F 309	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **Re-education of staff on review of Policy and Procedure SAA at IDT meetings and necessity of review of all Comprehensive Care Plan items weekly during interdisciplinary team meeting.** 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **Residents will be identified through medical record reviews at IDT meetings.** 3. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **Comprehensive Care Plan items are reviewed weekly during IDT meetings.** 4. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **Monitoring at IDT meetings. Outliers will be tracked and trended, then reported quarterly to quality council, medical executive committee and governing board.**	

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F 309	Continued From page 30 reports.	F 309		
F 315 68=E	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure there was documented medical justification in the physician orders for the use of an indwelling urinary catheter (a flexible plastic tube inserted into the bladder used to drain urine) for three (3) of eight (8) sampled residents (2, 3 and 7). This deficient practice had the potential to result in urinary tract infection. Findings: 1. During the initial tour with Registered Nurse (RN) 1 on June 19, 2015 at 8:37 a.m., Resident 2 was observed resting in bed, and had an indwelling urinary catheter. RN 1 stated the resident was non-verbal. RN 1 further stated the resident's indwelling urinary catheter was due to the physician's request. According to RN 1, the	F 315	1. *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **Change the CPOE order for Placement of Indwelling Catheters to include justification of Placement** 2. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **Residents will be identified through medical record reviews at IDT meetings.** 3. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **Change the CPOE order for Placement of Indwelling Catheters to include justification of Placement** 4. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **Review at IDT meetings. Outliers will be tracked and trended, then reported quarterly to Quality Council, Medical Executive Committee and Governing Board.**	

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F 315	Continued From page 31 resident had no urinary retention, neurogenic bladder, Stage III or VI pressure ulcers, or cancers. A review of clinical record indicated Resident 2 was admitted to the facility on June 17, 2015 with diagnosis of intracranial hemorrhage (bleeding within the skull). A review of the physician order indicated a Foley catheter had been prescribed for Resident 2 on 6/17/15. However, there was no medical justification in the physician order for the use of an indwelling catheter. During the interview with RN 1 on April 24, 2015 at 2:40 p.m., she stated there was no physician order for the indwelling catheter. 2. During the initial tour with RN 1 on June 19, 2015 at 8:49 a.m., Resident 7 was observed resting in bed, and had an indwelling urinary catheter. RN 1 stated the resident was confused. According to RN 1, the indwelling urinary catheter was used for Stage III ulcer on the sacral area. A review of clinical record indicated Resident 7 was admitted to the facility on April 2, 2015 with diagnosis of respiratory failure (a condition in which not enough oxygen passes from the lungs into the blood). A review of the physician order indicated a Foley catheter had been prescribed for Resident 7 on April 10, 2015. However, there was no medical justification in the physician order for the use of an indwelling catheter. There was no documentation the resident had been assessed	F 315	*1. How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **Change the CPOE order for Placement of Indwelling Catheters to include justification of Placement** *2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **Residents will be identified through medical record reviews at IDT meetings.** *3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **Change the CPOE order for Placement of Indwelling Catheters to include justification of Placement** *4. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **Review at IDT meetings. Outliers will be tracked and trended, then reported quarterly to Quality Council, Medical Executive Committee and Governing Board.**	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555874	A. BUILDING _____ B. WING _____	06/20/2015

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F 315	Continued From page 32 as having urinary retention, neurogenic bladder, Stage III or VI pressure ulcers, or cancers. During an interview with RN 1 on June 20, 2015 at 9:35 a.m., she stated the Foley catheter was not medically indicated for Resident 7. During an interview with RN 2 on June 20, 2015 at 3:30 p.m., she stated the resident was assessed as having unstageable ulcer on the sacral area. A review of the urine specimen for urinalysis dated April 11, 2015 indicated the resident's urine had many bacteria. The urine specimen for culture dated April 14, 2015 indicated the resident's urine had more than 100,000 Proteus mirabilis (a Gram-negative facultative anaerobic, rod-shaped bacterium) CFU/ml (colony-forming unit per milliliter) (a measure of viable bacterial or fungal cells). According to the facility's policy and procedure dated March 2012, titled, "Urinary Tract Infection" " 3.0 Objectives 3.2 Criteria for urinary catherization include: 3.2.1 To relieve urinary tract obstruction 3.2.2 To permit bladder drainage in patients with neurogenic bladder dysfunction or retention 3.2.6 To maintain quality of life for terminally ill patients." 3. During an initial tour, on June 19, 2015, at 8:40	F 315	1. *How corrective action() will be accomplished for those residents found to have been effected by the deficient practice* **Change the CPOE order for Placement of Indwelling Catheters to include justification of Placement** 2. *How the facility will identify other residents having the potential to be effected by the same deficient practice and what corrective action will be taken* **Residents will be identified through medical record reviews at IDT meetings.** 3. *What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **Change the CPOE order for Placement of Indwelling Catheters to include justification of Placement** 4. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **Review at IDT meetings. Outliers will be tracked and trended, then reported quarterly to Quality Council, Medical Executive Committee and Governing Board.**	

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F 315	Continued From page 33 a.m., Licensed Vocational Nurse (LVN) 2 stated Resident 3 was on strict intake and output and had an indwelling catheter. A review of the Admission Face Sheet indicated Resident 3 was admitted to the facility on March 27, 2015. A physician's order dated March 27, 2015, indicated strict intake and output. The laboratory culture dated May 15, 2015, was positive for bacteria and urine was cloudy. During an interview on June 20, 2015 at 11:40 a.m., RN 1 stated the initial order for Resident 3's indwelling catheter (a tube which is inserted into the bladder to drain urine from the bladder into a bag) was on March 27, 2015 for strict intake and output. RN 1 reviewed the laboratory results and stated Resident 3 was positive for bacteria in the urine and was cloudy. RN 1 further stated there was no indication why Resident 3 continued to have the indwelling catheter (Resident 3 had the indwelling catheter for 84 days).	F 315		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	*1. How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **On the day of audit, once parts per million (PPM) was identified not at the correct PPM; the buckets were changed out immediately. In-service/re-education was provided to associates regarding proper PPM for sanitizer, when it should be checked, and by whom.** *2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **Adherence to the policy and procedure related to sanitizer bucket will be monitored as part of Quality Control Program. Outliers will be tracked and trended, then reported quarterly to Quality Council, Medical Executive Committee and Governing Board.** *3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **Adherence to the policy and procedure related to sanitizer bucket will be monitored as part of Quality Control Program. Outliers will be tracked and trended, then reported quarterly to Quality Council, Medical Executive Committee and Governing Board.**	

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F 371	Continued From page 34 This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to store and serve food under sanitary conditions by failing to ensure the presence of sanitizer in 2 sanitizer buckets, missing a light shield, and having ice build-up in a freezer. These deficiencies had the potential for contamination and adulteration of food. Findings: 1. On 6/19/15 at 9:34 a.m., there were two sanitizer buckets at the cafeteria service line. Each bucket contained liquid and a towel. The Dietician/Director of Food & Nutrition tested the liquid in the bucket by dipping orange color Hydrion Papers QT-40 into the liquid, the papers remained orange. During an interview, at the same time as the observation, the Dietician/Director of Food & Nutrition stated there should have been a 200 to 300 ppm sanitizer concentration in the sanitizer buckets, that the papers should have turned from orange to green in the presence of 200 to 300 ppm sanitizer concentration, and that he did not know why there was not a 200 to 300 ppm sanitizer concentration in the sanitizer bucket. 2. Between 9:34 a.m. and 10:30 a.m., the exterior walk in freezer was missing 1 of 2 light shields. During an interview, at the same time as the observation, the Dietician/Director of Food & Nutrition stated he was not aware of the missing light shield.	F 371	*4. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **Adherence to the policy and procedure related to sanitizer bucket will be monitored as part of Quality Control Program. Outliers will be tracked and trended, then reported quarterly to Quality Council, Medical Executive Committee and Governing Board.** *1. How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **Light shield replace immediately upon discovery.** *2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **Potential deficiencies will be identified at EOC rounds.** *3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **Regular and frequent monitoring during EOC rounds.**	

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F 371	Continued From page 35 3. Between 9:34 a.m. and 10:30 a.m., the exterior walk-in freezer had ice build-up at the ceiling, fan/blower, and floor. During an interview, at the same time as the observation, the Dietician/Director of Food & Nutrition stated that at one point water got into the freezer and expanded parts of the freezer and that could be why there is ice build-up.	F 371	4. *How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **Will monitor as part of our safety rounds and EOC rounds. Outliers will be tracked and trended, then reported quarterly to EOC, Quality Council, Medical Executive Committee and Governing Board.**	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their	F 441	1 *How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **All cassettes with adhesive build up have been replaced. The new cassettes have label slots covered with clears. The patient labels with the backing will be inserted in the slots rather than affixed to the cassette. This process will prevent any use of adhesive.** 2 *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **Residents having the potential to be affected by the same deficient practice are identified when RN cleans the cassette before the next exchange. Cassettes with adhesive build up will be replaced. The new cassettes have label slots covered with clears. The patient labels with the backing will be inserted in the slots rather than affixed to the cassette.**	

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F 441	Continued From page 36 hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to implement its infection control policies and procedures. Two staff members were observed leaving the rooms with contact isolation residents with clostridium difficile (C. diff) (a bacterium that can cause symptoms ranging from diarrhea to life-threatening inflammation of the colon). The medication cassettes in the medication room were dirty with old adhesive markings of labels (old labels removed but the sticky part was not completely removed), brownish color dirt markings in/on the outside of the cassettes, and some names were faded. Resident 9, who was on isolation, had C-Diff. The registered nurse (RN) came out of the room without washing her hands with soap and water and used the key pad at the medication door and went in. Resident 3, who was on isolation, had C-Diff. The biomed technician went into the room with a cart and tool, to fix the television. Then as he was leaving the room used hand gel and he did not disinfect the equipment that he had brought into	F 441	*3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **Assessment has been made hospital wide. All old cassettes with adhesive buildup will be replaced with new cassettes. In addition, the cassettes are cleaned before the exchange take place daily.** *4 How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **The cleanliness of medication cassettes will be monitored as part of the monthly unit inspection conducted by a pharmacist. The result will be tracked and reported to the unit director and pharmacy director. Compliance reports will be submitted to Quality Council, Medical Executive Committee, and Governing Board.**	

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F 441	Continued From page 37 the room with proper disinfecting agents. This deficient practice had the potential to result in cross-contamination and spread of infection. Findings: During an initial tour, on June 19, 2015, at 8:35 a.m., Licensed Vocational Nurse (LVN) 2 stated that Resident 3 and 9 were on isolation precautions due to C-Diff. The following was observed: 1. Resident 9, was on isolation precautions for C-Diff. The RN was observed coming out of the room without washing her hands with soap and water. The RN 3 went to the keypad lock of the medication room, punch in the code, touched the door knob, and went into the medication room. The surveyor informed RN 3 that she did not wash her hands upon leaving Resident 9's room. RN 3 stated that she washed her hands in the medication room. 2. Resident 3, was on isolation precautions for C-Diff. The biomed technician went into the room with a cart and tool, to fix the television. Then as he was leaving the room, he used hand gel and he did not disinfect the equipment that he had brought into the room with proper disinfecting agents. The surveyor asked the biomed technician if he was informed to wash his hands with soap and water. He stated he was not informed he had to wash his hands with soap and water upon leaving the room. During an interview on, June 19, 2015, at 2:35 p.m., the Director of Laboratory and Patho stated	F 441	*1 How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **All cassettes with adhesive buildup have been replaced. The new cassettes have label slots covered with clears. The patient labels with the backing will be inserted in the slots rather than affixed to the cassette. This process will prevent any use of adhesive.** *2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **Residents having the potential to be affected by the same deficient practice are identified when RN cleans the cassette before the next exchange. Cassettes with adhesive build up will be replaced. The new cassettes have label slots covered with clears. The patient labels with the backing will be inserted in the slots rather than affixed to the cassette.** *3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **Assessment has been made hospital wide. All old cassettes with adhesive buildup will be replaced with new cassettes. In addition, the cassettes are cleaned before the exchange take place daily.** *4 How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **The cleanliness of medication cassettes will be monitored as part of the monthly unit inspection conducted by a pharmacist. The result will be tracked and reported to the unit director and pharmacy director. Compliance reports will be submitted to Quality Council, Medical Executive Committee, and Governing Board.**	

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F 441	Continued From page 38 Resident 3 and 9 were both positive for C-Diff. 3. During a medication room inspection, on June 20, 2015, at 9:15 a.m., with three (3) licensed nurses present they verified that the cassettes were dirty and had adhesive build up of bio-burden. The licensed nurses stated that everyday pharmacy comes to deliver new medications, the labels on the cassettes were removed by pharmacy when the resident was discharged, and replaced with a new label. The licensed nurses further stated that it was pharmacy's responsibility to clean the cassettes. According to the Centers for Disease Control and Prevention (CDC) website indicated C-Diff is shed in the feces. Any surface that becomes contaminated with feces may serve as a reservoir for C-Diff spores-Diff spores are transferred to patients mainly via hands of healthcare personnel who have touched a contaminated surface or item. The CDC recommends to prevent transmission in hospital and other healthcare settings "perform hand hygiene" use of soap and water is more effective than alcohol based hand rubs. According to the facility's policy titled, "Isolation Guidelines" dated May 2016 indicated the purpose was to provide a safe environment by preventing the spread/transmission of infectious diseases throughout the facility. 4.2.4 Contact Precautions included C-Diff the transmission can be hand or skin to skin contact, or indirect contact (touching) with environmental surfaces or patient care items in the patient's environment.	F 441	*1 How corrective action() will be accomplished for those residents found to have been affected by the deficient practice* **All cassettes with adhesive build up have been replaced. The new cassettes have label slots covered with clears. The patient labels with the backing will be inserted in the slots rather than affixed to the cassette. This process will prevent any use of adhesive.** *2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken* **Residents having the potential to be affected by the same deficient practice are identified when RN cleans the cassette before the next exchange. Cassettes with adhesive build up will be replaced. The new cassettes have label slots covered with clears. The patient labels with the backing will be inserted in the slots rather than affixed to the** *3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **Assessment has been made hospital wide. All old cassettes with adhesive buildup will be replaced with new cassettes. In addition, the cassettes are cleaned before the exchange take place daily.** *4 How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **The cleanliness of medication cassettes will be monitored as part of the monthly unit inspection conducted by a pharmacist. The result will be tracked and reported to the unit director and pharmacy director. Compliance reports will be submitted to Quality Council, Medical Executive Committee, and Governing Board.**	

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F 441	Continued From page 39 According to the facility's policy titled, "Dispensing of Medication" dated October 2010 indicated individual bins shall be labeled with the patient's name and/or room number. All bins will be checked by the pharmacist. Cassettes shall be exchanged daily. Furthermore, the policy did not mention who would be responsible to ensure the cassettes were cleaned daily and on a needed basis.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a safe, functional, and sanitary environment by not covering dumpsters, having stagnated water, closet doors not working, having peeling paint, broken cover plate, and not notifying the Office of Statewide Health Planning and Developing (OSHPD) of new equipment installation. OSHPD monitors the construction, renovation, and seismic safety of hospitals, and skilled nursing facilities. The OSPHD reviews and inspects health facility construction projects, and enforces building standards, per the California Building Standards Code, as they relate to health facilities construction. These deficiencies had the potential for vermin	F 465	*1. How corrective action() will be accomplished for those residents found to have been effected by the deficient practice* **Lid closed and replaced immediately upon discovery. Purchase new dumpster.** *2. How the facility will identify other residents having the potential to be effected by the same deficient practice and what corrective action will be taken* **Potential deficiencies will be identified at daily rounds.** *3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur* **Regular and frequent monitoring during EOC rounds.** *4. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system* **Will monitor as part of our safety rounds and EOC rounds. Outliers will be tracked and trended, then reported quarterly to EOC, Quality Council, Medical Executive Committee and Governing Board.**	

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F 485	Continued From page 40 breeding and harborage, un-usable closets, non-easily cleanable surface, electrical hazard, and un-safe equipment installation. Findings: 1. On 6/19/15 at 10:05 a.m., 2 of 3 dumpsters located behind the dietary department had 3 of 4 lids fully open. There was also an accumulation of trash, debris, and stagnated yellow/white water at the trash bin area. 2. Between 3:15 p.m. and 3:50 p.m., 3 resident rooms (372, 373, 375), had closets with sliding doors that were impeded from opening and closing freely. During an interview, at the same time as the observation, the Facilities Director stated that the closets' sliding doors were off their tracks, impeding the doors from opening and closing freely. 3. There was peeling paint at the wall behind bed A of room 375. 4. There was a broken electrical receptacle cover at a wall in the Hydrotherapy room. 5. At 10 a.m., there were 3 new 3 door reach in coolers installed at the kitchen without notifying the Office of Statewide Health Planning and Developing (OSHPD). During an interview, at the same time as the observation, the Dietician/Director of Food & Nutrition stated the coolers were installed last August (2014).	F 485	*Resident rooms closet doors...* • No residents were affected by the deficient practice. • The facility performs environmental rounds regularly and identifies deficiencies and reports the deficiencies to the Facilities Operations Center for repair. Environmental/Safety deficiencies are top priority and repairs are scheduled first. • Door hardware will be adjusted to ensure this will not reoccur. • Environmental rounds are performed regularly and reported to the Environment of Care committee, Quality Council Committee and the Hospital Board. *Peeling paint behind bed...* • No residents were affected by the deficient practice. • The facility performs environmental rounds regularly and identifies deficiencies and reports the deficiencies to the Facilities Operations Center for repair. Environmental/Safety deficiencies are top priority and repairs are scheduled first. • Facility damage happens and there is no way to ensure it does not reoccur. Additionally Sub-Acute staff has been informed to call Facilities and request repairs when damage occurs. • Environmental rounds are performed regularly and reported to the Environment of Care committee, Quality Council Committee and the Hospital Board. • Repairs completed by 7/23/15	

PRINTED: 07/13/2015
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	556574	A. BUILDING _____ B. WING _____	06/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

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F 465	Continued From page 41 During an interview, at 1:60 p.m., the VP Corporate Facilities Operations stated that he was not aware that there were new coolers in the kitchen, and that the facility probably did not have any OSHPD paperwork on their installation. Review of the 2013 OSHPD FREER manual, indicated that the installation of new kitchen equipment required a field visit.	F 465	*Broken electrical receptacle cover broken...* • No residents were affected by the deficient practice. • The facility performs environmental rounds regularly and identifies deficiencies and reports the deficiencies to the Facilities Operations Center for repair. Environmental/Safety deficiencies are top priority and repairs are scheduled first. • Facility damage happens and there is no way to ensure it does not reoccur. Sub-Acute staff has been informed to call Facilities and request repairs when damage occurs. • Environmental rounds are performed regularly and reported to the Environment of Care committee, Quality Council Committee and the Hospital Board. *Reach-in coolers install without OSHPD approval...* • No residents were affected by the deficient practice. • The facility performs environmental rounds regularly and identifies deficiencies and reports the deficiencies to the Facilities Operations Center for repair. • The Facilities Operations Department will contact the OSHPD ACO prior to installation of equipment based off of the OSHPD FREER manual. • Environmental rounds are performed regularly and reported to the Environment of Care committee, Quality Council Committee and the Hospital Board. • This is an OSHPD item and plans for installation require a structural engineer design an approved anchorage system for submittal to OSHPD. An evaluation of electrical loads will be performed to ensure electrical loads are in compliance with OSHPD/NEC requirements; if necessary an electrical engineer will also be engaged to provide plans to OSHPD. Estimated completion date is 12/31/15.	

COUNTY OF LOS ANGELES
HEALTH FACILITIES DIVISION
3400 Aerojet Avenue, Suite 323
El Monte, CA 91731

FACSIMILE TRANSMISSION

ADDRESSEE:	ORIGINATOR:
NAME: Pamela Loo, RN Director of Quality **Attention:**	FROM: Rosario Grospe, RN, Senior HFEN Assistant Supervisor, Acute and Ancillary Unit
ORGANIZATION: Southern California Hosp at Culver City SNF DP	**Phone:** (626) 312-1129
CITY, STATE, & ZIP Culver City	FAX: (626) 927-9293
Telephone 310-836-7000 ext 1046	DATE 714/15
FAX #: 310-840-5426	PAGES INCLUDING COVER PAGE = 11

NOTES TO ADDRESSEE:

Attached is the ameded CMS 2567, Statement of Deficiencies and Plan of Correction for the Recertification Survey (LSC) completed 6/22/15, The hard copy will be mailed today. Please sign the Signature Requirement Notice and fax it back to our office as soon as possible.

Please submit the plan of correction on or before 7/24/15.

If you have any questions, please don't hesitate to call us.

Thank you, Rosario Grospe, Senior HFEN

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	006874	A. BUILDING _____ B. WING _____	C 09/22/2014

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F 000	INITIAL COMMENTS The following reflects the finding of the Department of Public Health during a complaint investigation. Amended 10/22/14 Complaint Intake Number: CA00380633 Representing the Department of Public Health: Surveyor 16281, REHS, HFEI Surveyor 09452, RN, Sr. HFEN One Deficiency was issued for intake CA00380633.	F 000		
F 328 SSS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that 1 of 3 sample residents (Resident 1) received proper treatment and care in intravenous antibiotics therapy. Medical record review revealed there was no	F 328		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

M. [signature] | ADMINISTRATOR | 10/30/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

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	555874	A. BUILDING _____ B. WING _____	C 08/22/2014

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F 328	Continued From page 1 documented evidence that the intravenous (IV) line was removed from Resident 1's arm at or before the resident was discharged from the facility. This deficient practice had the potential to result in bleeding and/or infection at the IV line site. Findings: On January 2, 2014 at 2:00 p.m., an investigation was conducted at the facility regarding allegation that the resident was discharged and left the hospital's transitional care unit with an IV still in the resident's arm. On January 3, 2014, between 8:00 a.m. and 1:30 p.m., a review of Resident 1's medical record revealed that there was no documented evidence the IV line was removed from the resident's arm before discharge from the facility. A review of a face/cover sheet disclosed Resident 1 was admitted to the facility on November 27, 2013, with diagnoses which included ankle wound and cellulitis. Cellulitis is a spreading bacterial infection just below the skin surface. A review of IV Site and Fluid Report dated November 28, 2013 at 8:40 p.m., indicated an IV Line was started on the resident's right arm. The IV site was discontinued on December 1, 2013 at 8:30 a.m. The Daily Focus Assessment Report dated December 3, 2013 at 6:15 p.m., indicated a PICC (peripherheral inserted central catheter-a from of intravenous access that can be used prolonged period of time), single lumen, was inserted on the resident's right upper arm and secured with "statlock."	F 328	Action: Education will be provided to TCU nursing staff on the following: a. The Policy and Procedure on discharging of patients to include the need for a nursing assessment to be performed the day of discharge. b. The procedure on the completion of the Patient Discharge Instructions form. Implementation Education will commence immediately with completion of all staff by November 21, 2014. Monitoring: 1. The provision of Education will be monitored by review of sign-in sheets to ensure 100% compliance of all staff, excluding those on MLOA. 2. The compliance of nursing assessment and the completion of discharge instructions will be monitored by a sample of 30 discharge charts or 100% if less than 30 per month; charts will be retrospectively reviewed for compliance with nursing assessment performed on day of discharge and completion of the Patient Discharge Instructions form. Monitoring will continue until 3 concurrent months of 100% compliance is achieved. Findings will be reported to the Quality Council on a quarterly basis. Responsible Person: ACNO and Director of Rehab Services	11/21//2014

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F 328	Continued From page 2 A review of the Medication Administration Record, and the Medication Administration History Report indicated the resident was administered Nafcillin antibiotics 1 gram and infused over 30 minutes every four hours by IV route with a start date of November 27, 2013 and a stop date of December 4, 2013 with a new stop date of December 7, 2013, and that the last dose of Nafcillin by route was administered on December 6, 2013. A review of a Physician Order dated December 6, 2013, indicated to discontinue Nafcillin after the last dose on the same day as the order. There was no order found for the discontinuation and removal of the IV line. A review of the Discharge Assessment/Summary report indicated the patient was discharged on December 9, 2013. The report had no indication if the IV line in the resident's are had been removed. A review of the Patient Discharge Instructions did not have a Discharge Summary and that there was no indication if the IV line had been removed. The Patient Discharge Instructions also did not have dated signatures of the caregiver, physician, patient/significant other and discharge coordinator at the signature/date area provided. A review of the medical record by the director of TCU (registered nurse) and the Director of Quality/Risk Management (registered nurse) revealed there was no documented evidence the IV line was removed from the resident's arm before being discharged from the facility.	F 328	Action: Education will be provided to TCU nursing staff on the following: A. Policy and Procedure on Intravenous Therapy and Peripherally Inserted Central Catheter Care and Maintenance. To include assurance that any appliances or tubes are removed per doctor's order. Implementation: Education will commence immediately with completion of all staff by November 21, 2014 Monitoring: 1. The provision of Education will be monitored by review of sign-in sheets to ensure 100% compliance of all staff, excluding those on MLOA. 2. Compliance will be monitored by a sample of 30 discharge charts or 100% if less than 30 per month; charts will be retrospectively reviewed for compliance with policy and procedure on Peripherally Inserted Central Catheter Care and Maintenance. Monitoring will continue until 3 concurrent months of 100% compliance is achieved. Findings will be reported to the Quality Council on a quarterly basis. Responsible Person(s): ACNO and Director of Rehab Services.	11/21/2014

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F 328	Continued From page 3 During an interview at the same time as the Record review, the Director of Quality/Risk Management stated that if there was a Discontinuation of the IV line and removal of the IV line, there should have been documentation in the medical record. The Director of Quality/Risk Management stated there was no documentation of a discontinuation or removal of the IV line in the record. Although there was a physician order for the discontinuation of the medication (Nafcillin), the Director of Quality/Risk Management stated she could not find a physician order for the discontinuation of the IV line and there should have been a physician order for the discontinuation of the IV line. The Director of Quality/Risk Management stated there was no reason why the IV line should not have been discontinued after the discontinuation of the antibiotic (Nafcillin) and that she could not find anything in the record of why the IV line should not have been removed. A review of the facility policy titled, "Intravenous Therapy-Initiation and Management of Peripheral Intravenous Lines" last reviewed November 20, 2012 indicated that a physician order was required for the discontinuing of IV therapy.	F 328		

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F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during a recertification survey. Representing the Department of Public Health: Surveyor 14042 RN, HFEN Surveyor 25487, RN, HFEN Surveyor 14041, REHS, HFE I Total Population: 11 Total Sample Size: 8 Highest Scope and Severity: E	F 000		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the premises in a sanitary manner at all times. This deficient practice did not promote a sanitary and comfortable interior for the residents and had the potential to result in the spread of disease-causing organisms. Findings: On March 7 and 8, 2014 at 8:55 a.m., an inspection was conducted on the premises and the following were observed:	F 253		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (□6) DATE

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F 253	Continued From page 1 a. missing vertical blind panels in residents' sleeping rooms, Room 371 (10 blind panels), 372 (seven blind panels), 373 (six blind panels), 374 (one blind panel), and Room 370 (eight blind panels); b. in the nurse station located on the 3rd floor, the restroom linoleum floor had a section replaced and glued to the existing linoleum with open blacken seams and a small trash receptacle was filled with fecal and urine soiled toilet paper that were clearly visible; c. the toilet base sealant was cracked with gaps and blacken in the resident room, Room 376; and d. two stained and blacken ceiling tiles located in the corridor and near resident room 374. On March 7, 2014, an inspection was conducted on the 3-floor kitchenette and a small double sink base cabinet storage compartment which was not locked was observed. The area was inspected and the following were also observed: a. mold throughout the base cabinet storage area; b. a badly rusted and dirty water filter with no installation date; c. one (1) of two (2) sink drain sealant was totally disintegrated and the water filter valve was leaking water; and d. the automatic icemaker with the water dispenser spout was encased with layers of unsanitary mineral deposit.	F 253		

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F 253	Continued From page 2 An interview was held with the Building Engineer and he stated he does not know when the water filter was installed and the lower cabinet is usually locked. On March 8, 2014 at 10:23 a.m., an interview was held with the Environmental Services and the staff in charge stated the staff could clean the base cabinet storage area because it was usually locked. The evaluator conducted an inspection of the dietary department and observed a two compartment sink used for food preparation. The evaluator inspected the waste water pipes and observed no air gap available at the time of survey. In case of sub-surface sewer system back-up, the sewage can back up into the sink and contaminate the food product held in the sink. On March 8, 20014, at the time of the exit, an interview was held with the staff in charge and he stated he will inform the building supervisor or housekeeping regarding the concerns as soon as possible.	F 253		
F 365 SS=D	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that food was	F 365	**Dietary Reponse:** Re-trained Dietician Staff on proper assessment of dentition of patients and recommendation of altered texture diets, as well as record documentation. Method for Follow-Up: Audits and reporting on non-conformity to Quality Council. **Nursing Response:** • Review of oral and dietary assessment indicates that 100% of the residents who have dentures wear it daily in the duration of the admission in the TCU. • Review of the weight record of 100% of the residents revealed no significant weight loss of 3-5% in the duration of admission.	4/23/14 4/25/14 4/24/14

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F 365	Continued From page 3 prepared in a form designed to meet individual needs for one of eight sampled residents (4). Resident 4 was missing his dentures and was unable to bite/chew his food. Dietary and nursing services failed to identify/assess the resident's need for a mechanically altered diet. This deficient practice had the potential to result in weight loss and further medical complications for the resident. Findings: On March 7, 2014 at 6:30 p.m., during an observation, Resident 4 was awake and alert while lying in bed. The resident's dinner tray was still on his overbed table. The dinner tray contained a roast beef sandwich on a roll. One half of the sandwich appeared as if the resident had attempted to bite it, but had only broken the roll and did not go through the meat. During a concurrent interview, Resident 4 stated he did not have much of an appetite. The resident further stated he lost his dentures at the acute facility he was recently transferred from; therefore, he could not eat the sandwich. A review of the clinical record indicated Resident 4 was admitted to the facility on March 5, 2014 with diagnoses that included lung cancer and diabetes. The MDS (Minimum Data Set, a standardized assessment and care planning tool) was still in the process of being completed. A review of the physician's admission orders dated March 6, 2014 included a diet order for 1800 calories ADA (diet plan devised by the American Diabetes Association) and Boost (a nutritional supplement drink).	F 365	• The Director of Nursing re-educated the nursing staff on recognizing, evaluating, and addressing the needs of every resident including but not limited to, the resident at risk or already experiencing impaired nutrition. • The Dietician was re-educated on ensuring that resident's therapeutic diet takes into account the residents clinical condition, and preferences when there is nutritional indication. • The Director of Nursing re-educated the interdisciplinary committee (IDT) members about including the oral assessment/status and ensure that resident has the appropriate/therapeutic diet order in the IDT weekly meeting. • The Director of Nursing or Designee to monitor 100% compliance through the IDT notes. Any issues of non-compliance will be addressed to the appropriate staff who will be required to submit a plan of action	4/28/14 4/28/14 4/28/14 4/28/14 & Ongoing

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F 365	Continued From page 4 According to the Daily Assessment Inquiry dated March 7, 2014, an initial dietary/nutritional assessment was conducted and the resident was assessed as having a diagnosis of lung cancer, a weight of 47.27 kg (kilograms), an ideal body weight of 70 kg, and being underweight. The initial assessment indicated the resident had a diet order 1800 calories ADA, Boost with meals and his nutritional intake was poor (less than 50%). The resident's nutritional related history indicated he had poor intake, no appetite, no food preferences at this time, only drinks Boost, and he was not appropriate for diet education due to poor po (mouth) intake. One of the nutritional interventions indicated that if the resident's intake did not meet 50% or greater, he may need more aggressive nutrition support. There was no documented evidence the assessment identified the resident's missing dentures. On March 9, 2014 at 10:30 a.m., during an interview with the Registered Dietitian (RD), she stated information regarding missing dentures of a resident was usually provided by the resident during interviews with staff. A review of the Intake/Output Reports indicated the resident's meal intake percentage on March 8 was 35% for lunch and 40% for dinner. On March 9, the resident ate 30% of his breakfast. On March 9, 2014 at 11 p.m., during an interview, the Charge Nurse stated there were no other intake records available for the resident. According to the facility's policy and procedure titled "Dietician Responsibilities," revised November 12, 2012, the primary responsibility of	F 365		

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F 365	Continued From page 5 the dietician is the nutritional care of the patient/resident to include assessment, planning, application and monitoring of each patient's/resident's nutritional and hydration status. There was no documented evidence the RD assessed Resident 4's need for a mechanically altered diet due to his missing dentures to make the food easier to chew and safely swallow.	F 365		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure that food are prepared and held under optimal and safe condition at all times. This deficient practice had the potential to result in foodborne illnesses and outbreaks. Findings: On March 7, 2014 at 6:02 p.m., an inspection of the dietary department was conducted and 2 (two) Mobile Refrigerated Air Screen units were	F 371	Procedural changes were put into effect requiring the doors to the refrigerators to remain closed. Submitted a request for additional refrigeration for the department to replace inoperable refrigerators. Method for Follow-Up: Monitor at each meal period refrigerated cold food temperatures. Report non-conformity to Quality Council.	

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	555874	A. BUILDING _____ B. WING _____	03/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, □IP CODE
SOUTHERN CALIFORNIA HOSP AT CULVER CITY D/P SNF	3828 DELMAS TERRACE CULVER CITY, CA 90230

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F 371	Continued From page 6 observed. The staff were setting up the residents' food trays for dinner and the two equipment doors were in an open locked position. A concurrent interview was held with the dietary supervisor and she stated the units were designed to remain open for an maximum of 90 minutes under acceptable refrigerator temperature. When asked how long were the refrigerators' doors held open and where was the time log, the dietary supervisor looked around the kitchen and could not produce any time log documentation at the time of the survey. Upon inspection of the units' thermometers, their temperatures were both 42 degrees Fahrenheit. On March 8, 2014 at 1:35 p.m., an additional inspection of the dietary department was conducted and the two refrigerator unit doors were again observed held open during the end of the tray line operation. Upon inspection of the refrigerators' thermometers, the temperature was observed as 66 degrees Fahrenheit. The digital temperature display flashed "open" and there was no alarm that made a sound or alerted the staff at the time of observation. A concurrent interview was held with the dietary supervisor and she stated she would check when the two units' doors were first locked in an open position. The log indicated the tray line started at 11:30 and the dietary supervisor stated the doors should have been closed at 1:00 p.m. The dietary supervisor stated the staff should have monitored the time and the temperature of the refrigerator units at all times. According to the Mobile Refrigerated Air Screen operating literature, undated, "when operating	F 371		

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F 371	Continued From page 7 with door open, the display will show 'OPEn' and an internal count down timer will start. This unit will allow open door operation for a maximum of 90 minutes. If the door is open longer than the allowed 90 minutes, an open door alarm will be activated. Display will flash 'OPEn' and beep three times every ten seconds". The refrigerator units were observed to hold small plates of cakes, Boost Plus, glucose control milk, juices, and small containers of 3-bean salads. The refrigerator units open door log, temperature, and alarm were not being monitored as often as necessary to maintain safe food storage temperature.	F 371		
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in □483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	F 425	**Nursing Response:** • The Director of Nursing verified with the Director of Environment Services and the Director of Pharmacy that appropriate biohazard containers are available and emptied daily and as needed. • The Director of Nursing or designee will conduct Department Audit Round that includes Medication Room Inspection to ensure appropriate biohazard container is available and emptied as appropriate: • The Director of Nursing or designee to monitor 100% compliance to Medication Room inspection from the Department Audit Report Form until July 30, 2014. Any issue of non-compliance will be reported to the appropriate staff who will be required to submit an action plan.	4/25/14 4/29/14 & Ongoing Ongoing

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F 425	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to properly dispose the leftover or unused medications in accordance with the facility's policy and procedure for two randomly selected residents (9, 10). The medication nurse divided into half by using a pill-splitter the Prednisone tablet (a hormone to treat severe illness) for Resident 9 and the Rivaroxaban tablet (a medication used to prevent blood clots from forming after surgery) for Resident 10. The medication nurse improperly disposed the unused half of the medications in the sink and residents' trash cans. This deficient practice had the potential to result in unauthorized access of prescription medications that could be lethal. Findings: 1. On March 8, 2014 at 9:12 a.m., during a medication pass observation, Registered Nurse (RN) 1 prepared routine medications to be administered to Resident 9. RN 1 opened the pill-splitter and found an unidentifiable pill which she discarded in the medication room sink. She then obtained a tablet of five (5) milligrams of Prednisone (a hormone to treat severe illnesses), divided the tablet into half using the pill-splitter, and then discarded half of the tablet, which was equivalent to 2.5 milligrams, in the resident's trash can. At 10 a.m., during an interview, RN 1 stated she was not familiar with the facility's policy on documenting and properly discarding the leftover	F 425	• The Director of Nursing re-educated the licensed nurses about the policy on Return, Handling, and Disposal of Medication Waste. • Director of Nursing or designee will conduct random observation to licensed nurses on correct medication waste to ensure 100%. The findings of the observation will be used to educate the staff and identify issues for competency and educational needs of all licensed nurses. Progressive issues of non-compliance will be addressed by progressive disciplinary action.	4/28/14 4/29/14 & Ongoing

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F 425	Continued From page 9 or unused medications. A review of Resident 9's clinical record indicated the resident was admitted to the facility on January 20, 2014 with diagnoses which included polyneuropathy (damage to multiple nerves). A review of the physician's order dated March 7, 2014 indicated to administer Prednisone tablet 7.5 mg (milligrams) twice a day with meals. A review of the facility's policy and procedure titled "Return, Handling, and Disposal of Medication Waste," dated July 31, 2010, indicated the purpose of the policy is to ensure safe disposition of the medications and any opened unit dose or loose items shall be placed in the regular pharmaceutical waste containers. 2. On March 8, 2014 at 9:35 a.m., during a medication pass observation, Registered Nurse (RN) 1 prepared routine medications to be administered to Resident 10 which included two tablets of 10 mg (milligrams) of Rivaroxaban. RN 1 divided one of the two tablets into half by using the pill-splitter in order to administer 15 milligrams of the medication to the resident. RN 1 then discarded half of the tablet, which was equivalent to five (5) milligrams, in the resident's trash can. At 10 a.m., during an interview, RN 1 stated she was not familiar with the facility's policy on documenting and properly discarding the leftover or unused medications in the regular pharmaceutical waste containers. A review of Resident 10's clinical record indicated the resident was admitted to the facility on March	F 425		

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F 425	Continued From page 10 6, 2014 with diagnoses which included atrial fibrillation (abnormal heat beat) and deep vein thrombosis (DVT, a blood clot that forms in a vein deep in the body and when blood thickens it clumps together) requiring thromboprophylaxis (the prevention of blood clotting) medication. A review of the physician's order, dated March 8, 2014, indicated to administer Rivaroxaban 15 mg once a day as a thromboprophylaxis. A review of the facility's policy and procedure titled "Return, Handling, and Disposal of Medication Waste," dated July 31, 2010, indicated the purpose of the policy is to ensure safe disposition of the medications and any opened unit dose or loose items shall be placed in the regular pharmaceutical waste containers.	F 425		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection	F 441	**Nursing Response:** • Review of records of 100% of current residents revealed 0% nosocomial infection. • Review of the infection rate for the 1st quarter of 2014 revealed 0% nosocomial infection. • The Director of Nursing re-educated all staff about the policy on infection control through: Hand Hygiene Contact Precaution Use of Personal Protective Equipment	4/25/14 4/25/14 4/28/14

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F 441	Continued From page 11 (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement infection control practices for two of 10 sampled residents (1, 5). For Resident 1, the licenced nurse did not educate the family member to wash hands and wear personal protective equipment (PPE, protective items or garments worn to protect the body or clothing from hazards that can cause injury) before entering the contact precaution room, and to remove PPE and wash hands again before leaving the contact precaution room. For Resident 5, the licensed nurse did not wash hands after emptying a urinal filled with urine and before touching the resident's environment, such	F 441	• The Director of Nursing or designee will do 10 random observations to staff every month on the use of appropriate personal protective equipment to ensure 100% compliance. Any issues of non-compliance will be addressed to the individual staff and will be re-educated or given progressive disciplinary action • The Director of Nursing re-educated all licensed nurses about providing educational handout to patient and or family members and visitors on appropriate isolation precaution. • The Director of Nursing or designee to conduct chart review for the copy of the patient education handout until July 30, 2014 to ensure 100% compliance. Any issues of non-compliance will be addressed to the individual staff and will be re-educated or given progressive disciplinary action.	4/29/14 & Ongoing 4/28/14 4/28/14 & Ongoing

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F 441	Continued From page 12 as bedsheets and table. This failure increased the potential for spreading infections. Findings: 1. On March 7, 2014 at 5:15 p.m., during the initial tour of the facility in the presence of RN 2, a sign was observed posted outside Resident 1's room that indicated contact plus isolation (measures that are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or resident's environment) and for visitors to see the nurse before entering the room. A family member was in the resident's room and was not wearing any PPE while touching the resident's bedding and table with his bare hands. During the course of the observation, RN 2 saw the family member leave the room, but she did not stop him to give an instruction to wash his hands and wear PPE the next time he visited. The family member went to the activity room after leaving the resident's room and sat on a chair to make phone calls. The family member was still not instructed to wash his hands. At 6 p.m., during an interview, the family member stated he knew the resident had an infection in her stomach but he did not know he had to wash his hands before entering the resident's room, wear PPE while inside the room touching the resident and/or the resident's environment, remove his PPE before leaving the room, and wash his hands again before he touched anything else.	F 441	**Infection Control Response:** Surveillance of isolated patients is conducted daily and review of laboratory results are done daily. Positive laboratory results of critical organisms are reported by phone call to Director of Infection Control and to patient's nurse. In-services are scheduled for each unit to re-educate staff on appropriate standard and isolation precautions and appropriate PPE use. Education will include topics such as C.difficile and methods of transmission. Will retrain staff on hand hygiene techniques and launch a hand hygiene campaign to increase compliance. Staff will be reminded to inform and educate visitors on PPE use and hand hygiene. Appropriate reporting of incidences will be reviewed and employees observed breaching policies will be counseled and incident reports recorded. All clinical staff and EVS staff will be retrained on the appropriate handling, storage, processing, and transport of all linens. Method for Follow-Up: Infection control rounds and review of incident reports. Non-conformity will be reported to the Infection Control Committee and Quality Council.	4/25/14

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F 441	Continued From page 13 A review of the clinical record indicated Resident 1 was admitted to the facility on March 6, 2014 with diagnoses which included urosepsis (urinary infection that travels to the blood stream), Clostridium difficile infection (C. diff, an infection of the colon which may be transferred to residents through the hands of health care personnel who had contact with contaminated residents, their feces or environment), and anemia (a condition in which the body does not have enough healthy red blood cells to provide oxygen to body tissues). The MDS assessment was still in the process of being completed. According to the facility's policy and procedure titled "Isolation Guidelines," dated November 2012, transmission-based precaution, such as contact plus precautions, was to be used in conjunction with Standard Precautions which are measures to be used in all patients regardless of diagnosis when there is potential for contact with any body fluid, non-intact skin or mucous membranes. Contact plus precaution was to be used for patients known or suspected to have a disease spread by direct contact, such as Clostridium difficile. A review of the Contact Plus Isolation signage indicated to clean hands and then wear a gown and gloves when entering (the room), discard gown and gloves and then wash hands when exiting (the room), and wash hands with soap and water only. 2. On March 8, 2014 at 9:12 a.m., during the medication pass observation, Registered Nurse (RN) 1 entered Resident 5's room in order to	F 441		

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F 441	Continued From page 14	F 441		

administer the routine medications. After RN 1 administered all the oral (through the mouth) medications, she put on a pair of gloves, emptied the resident's urinal in the toilet, and without removing her gloves to wash her hands, she moved the overbed table to the side and uncovered the resident by pulling the linen sheet in order to administer Vancomycin (an antibiotic) enema (a procedure of introducing liquids into the rectum and colon via the anus through a tube).

During a concurrent interview, RN 1 stated she should have washed her hands after she emptied the urinal and before she touched the resident's environment.

A review of Resident 5's clinical record indicated the resident was admitted to the facility on February 28, 2014 with diagnoses which included methicillin-resistant staphylococcus aureus (MRSA, a bacteria responsible for several difficult-to-treat infections in humans) of the nares (nose) and Clostridium difficile (C. diff). The MDS assessment was still in the process of being completed.

A review of the physician's order, dated March 4, 2014, indicated the antibiotic was changed to Vancomycin enema 500 milligrams (mg) twice a day for seven (7) days and to place the resident on contact isolation for C. diff in the stool.

According to the facility's policy and procedure titled "Isolation Guidelines," dated November 2012, transmission-based precaution, such as contact plus precautions, was to be used in conjunction with Standard Precautions which are measures to be used in all patients regardless of diagnosis when there is potential for contact with

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F 441	Continued From page 15 any body fluid, non-intact skin or mucous membranes. Contact plus precaution was to be used for patients known or suspected to have a disease spread by direct contact, such as Clostridium difficile. Wearing gloves does not replace the need hand antisepsis and hand hygiene must be practiced after removing the gloves.	F 441		

RESPONSE TO DEFICIENCIES
EXHIBIT P CMS Statements of Deficiency

Southern California Hospital at Hollywood

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050135	A. BUILDING 01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD B. WING _____	02/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	6245 DE LONGPRE AVE HOLLYWOOD, CA 90028

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS This facility was surveyed under the Life Safety Code NFPA 101, 2000 Edition, Chapter 19, Existing Health Care Occupancies, and other applicable codes. The following represents the findings of the Department of Public Health during Life Safety Code Complaint Validation Survey at the Culver City Campus. Intake No: CA00429647 Representing the Department of Public Health: Surveyor 14041, REHS, CFI 1, HFE I Surveyor 16281, REHS, CFI 1, HFE I	K 000		
K 051	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4,9.6	K 051		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: INTERIM CEO — (X6) DATE: 5/29/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	050135	A. BUILDING **01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD** B. WING _____	**02/05/2015**

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SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	**6245 DE LONGPRE AVE HOLLYWOOD, CA 90028**

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K 051	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure that the 2 of 4 elevators Phase II firefighter operation were fully functional at all times. Finding: On February 3, 4, and 5, 2015, the evaluator conducted a complaint investigation into a fire / evacuation emergency. On February 5, 2015, the elevator requested the Pavilion elevator test and service documentation for all four elevators. The Building Engineer provided the service test documents and he explained that the State of California were slow in sending the current annual certificates. The evaluator reviewed the elevator documents and observed the following: North Elevator – the Phase II Operation failed from June 2014 through December 2014; the Staff Elevator – the Phase II Operation failed from August 2014 through December 2014; and the Service Elevator – the Phase II Operation failed from May 2, 2014 through July 16, 2014. The evaluator conducted a record review of the elevator's certificates posted and 2 of 2 elevators certificates were expired. One of the certificates expired on October 18, 2014 and the other	K 051	**Corrective Action:** Vendor, Liftech has corrected elevators to be. Phase II elevator testing has been inspected and permits have been renewed and obtained. **(Attachment #1 & #22)** **Date of Implementation:** 4/8/2015 **Monitoring Process:** Results of monitoring will be reported up to EOC and Quality Council on a quarterly basis. **Person Responsible:** Director of Facilities	04/08/2015

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K 051	Continued From page 2 expired on September 20, 2014. On February 13, 2014, at 11:30 a.m., the evaluator contacted the State of California, Department of Industrial Relations, Div of Occupational Safety & Health, and staff verified that the two elevators failed the Phase II annual test. The staff also stated that the facility was fined because the two elevators' Phase II were not repaired within the time period initially allowed, 5-weeks. The evaluator reviewed the fire incident report and it revealed that "Since the keys in the knox (security) box did not have the correct elevator recall key nor did security. Engineer T2 proceeded to recall elevators to the first floor and pull the "Emergency Stop" button in elevator panel." Under Phase I operation, elevators that are 25 feet or more above the main floor return either to a designated landing area or an alternate area. Phase I operation is activated either manually by a special key, or automatically by a fire alarm initiating device. The elevator Phase II operation is an override meant for firefighters after Phase I has been activated. Under the Phase II operation, firefighters can use a key-switch to operate the elevator, provided the hoistway is clear of smoke and the elevator has electricity.	K 051	**Corrective Action:** Upon review with the Culver City Fire Department Fire Inspector, Steve Poelstra, all necessary keys were in place inside knox box. Per request of the CCFD, an additional knox box has been ordered and approved; arrival pending **(Attachments #3 and #4).** **Date of Implementation:** April 7, 2015 **Monitoring Process:** Only CCFD has access to the knox boxes. Upon arrival of the additional knox box, CCFD will have to install and ensure all keys are in place. **Person Responsible:** Director of Facilities	4/27/2015
K 067	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2	K 067		

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K 067	Continued From page 3 This STANDARD is not met as evidenced by: NFPA 90A, Standard for the Installation of Air Conditioning and Ventilating Systems. 2-3.11.1 Egress Corridors in health care, detention and correctional and residential occupancies shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas. An air transfer opening(s) shall not be permitted in walls or in doors separating egress corridors from adjoining areas. Exception No. 1: Toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces opening directly onto the egress corridor. Exception No. 2: Where door clearances do not exceed those specified for fire doors in NFPA 80, Standard for Fire Doors and Fire Windows, air transfer caused by pressure differentials shall be permitted. Exception No. 3: Use of egress corridors as part of the engineered smoke control system. Exception No. 4: In detention and correctional occupancies with corridor separations of open construction (e.g. grating doors or grating partitions). 4-3.1 Smoke dampers shall be controlled by an automatic alarm initiating device. Smoke dampers shall be permitted to be positioned manually from a command station.	K 067		

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K 067	Continued From page 4 4-4.1 All automatic shutdown devices shall be tested annually. 4-4.3 Smoke detectors provided as required by 4-4.2 shall automatically stop their respective fan(s) on detecting the presence of smoke. NFPA 101 Code for Safety to Life from Fire in Buildings and Structures 2000 Edition 9.2.1 Air Conditioning, Heating, Ventilating Ductwork, and Related Equipment. Air conditioning, heating, ventilating ductwork, and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Warm Heating and Air-Conditioning Systems, as applicable, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction. 9.3.1* General. Smoke control systems, where required or permitted by Chapters 11 through 42, shall have an approved maintenance and testing program to ensure operational integrity. The purpose of such smoke control systems shall be to confine smoke to the general area of fire origin and maintain use of the means of egress system. 9.6.5.1 A fire alarm and control system, where required by another section of this Code, shall be arranged to actuate automatically the control functions necessary to make the protected premises safer for building occupants. 9.6.5.2 Where required by another section of this Code, the following functions shall be actuated by	K 067		

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K 067	Continued From page 5 the complete fire alarm system: (1) Release of hold-open devices for doors or other opening protectives (2) Stairwell or elevator shaft pressurization (3) Smoke management or smoke control systems (4) Emergency lighting control (5) Unlocking of doors 19.3.4.4 Emergency Control. Operation of any activating device in the required fire alarm system shall be arranged to accomplish automatically any control functions to be performed by that device. (See 9.6.5) 19.5.2.1 Heating, ventilating, and air conditioning shall comply with the provisions of Section 9.2 and shall be installed in accordance with the manufacturer's specifications. These codes and standards were not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an air handler automatically shut down with the presence of smoke. The facility failed to ensure that all automatic shutdown devices were tested annually. The facility used corridors as plenums. The deficiencies permitted, and had the potential to permit accelerated spread of smoke and gases during a fire. Findings: 1. On 2/3/15, a review of an OSHPD Fire and Life Safety Field Visit Report dated 2/2/15, indicated that on 1/29/15 a fire appeared to have damaged	K 067		

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K 067	Continued From page 6 the HVAC supply air-intake filter banks that apparently supply air to the 2nd, 4th, 5th, and 6th floor patient rooms. That the HVAC system did not automatically shut-down during the fire on 1/29/15 and the smoke from the fire was dispersed from the roof supply intake to other areas and floors of the building. On 2/3/15 at 12:05 p.m., during an interview the Project Manager stated that one of two air handlers (air handler 2) in the penthouse was affected by the fire, and that air handler 2 affected the 2nd, front 3rd SDU, 4th, 5th, and 6th floors that it served. At 2:10 p.m., Air handler 2 was observed to have fire, heat, and smoke damage. There was a duct detector located at the main supply duct coming form the air handler. The air handler was in the penthouse located at the 7th floor roof level. During an interview at the same time as the observation, the Project Manager and the Lead Man stated that the smoke from the fire should have activated the duct detectors to shut down both air handler 1 and 2. On 2/4/15 at at 11:05 a.m., during an interview, the Lead Man stated that every floor in the Pavilion had smoke dampers, and that there were two duct detectors in the main supply ducts located at the penthouse. That the way the system was suppose to function was that the duct detectors send a signal to the fire alarm control panel that activates the alarm and the panel sends a signal to the fire alarm air handler controls that shuts down the air handler motor. That on the day of the fire both air handler 1 and 2 had to be shut down manually at the air	K 067	**Corrective Action:** A new fire system is being installed **(Attachments #6 and #15)** which will immediately shut down air handlers, should the relays be pulled. Engineers have been instructed that relays are no longer to be pulled during fire alarm testing, as was common practice beforehand **(Attachment #7)**. New fire system is in final stages of testing. **Date of Implementation:** February 15, 2015 with an estimated completion date of May 30, 2015. **Monitoring Process:** Redesigned system will shut down air handlers should there be any attempt to pull or disable relays. **Person Responsible:** Vice President of Facilities Operations **Corrective Action** Air handler #1 is still in use, while air handler #2 has a temporary replacement. Air balancing for temporary unit not required per ACO Attachment #20 **(Attachment #8, 15, 16, 17, 18, 19, 20, 21, 23)**. **Date of Implementation:** Temporary air handler was installed on March 25, 2015. **Monitoring Process:** Testing will occur upon installation, with quarterly inspections thereafter. **(Attachment #2).** Results of monitoring will be reported up to EOC and Quality Council on a quarterly basis. **Person Responsible:** Director of Facilities **Corrective Action:** A new fire system is being installed **(Attachments #6 & #15)** which will immediately shut down air handlers, should the relays be pulled. Engineers have been instructed that relays are no longer to be pulled during fire alarm testing, as was common practice beforehand **(Attachment #7)**. New fire system is in final stages of testing. **Date of Implementation:** February 15, 2015 with an estimated completion date of June 15, 2015. **Monitoring Process:** Redesigned system will shut down air handlers should there be any attempt to pull or disable relays. **Person Responsible:** Vice President of Facilities	5/30/2015 3/25/2015 6/15/2015

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K 067	Continued From page 7 handlers, and that he did not know what part of the HVAC shut down system did not work. The Lead Man also stated that there were relays in the fire alarm air handlers control panel at the penthouse that could bi-pass the air handler shut down system so that the air handlers do no shut down when the fire alarm system was activated, and that only engineering knew about the relays. Between 11:05 a.m., and 12:40 p.m., the Corporate Vice President of Facilities Operations stated that the hospital engineers had not been asked about the relays. At 2:18 p.m., the Corporate Vice President of Facilities Operations stated that he had found out from the Engineer that the relays at the fire alarm air handlers control panel had been found pulled (unplugged). On 2/5/15 at 8:52 a.m., during an interview the Corporate Vice President of Facilities Operations stated that the 2nd shift Stationary Engineer had found the relays pulled. On 2/5/14 at 10:10 a.m., during an interview, the Lead Man stated that on the day of the fire (1/29/15) he heard a code red announced from the 3rd floor, that he went to the 3rd floor and saw smoke coming from the vents at the 3rd floor, that he went up to the penthouse and saw smoke coming from air handler 2, saw fire at the door of the air handler, and saw the air handler was still on, so he (manually) shut off the air handler. The Lead Man also stated that the engineers can pull the relays in the fire alarm air handlers control panel if a vendor is scheduled to conduct	K 067		

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K 067	Continued From page 8 a fire alarm test and then reconnect them after the test, that its was the practice when he came to the hospital, and its what they (engineering) have continued to do, that the relays have to be pulled otherwise air conditioning and heating is lost for the whole building and that there was no other reason to pull the relays. The Lead Man further stated that he asked the engineers to log whenever they pull and reconnect the relays, but did not know if the engineers log when they pull and reconnect the relays, that he did not know who the last person that pulled the relays was, that he asked the engineer who worked on the day of the fire, and the engineer told him he did not pull the relays. At 2:40 p.m., during an interview, the Lead Man stated that engineering was not logging when the relays in the fire alarm air handlers control panel were being pulled and reconnected. On 2/5/15, at 2:42 p.m., during an interview, the 2nd shift Stationary Engineer stated that on 1/29/15 he had arrived to the hospital at 1:30 p.m., after the fire, and discovered there had been a fire on the roof of the Pavilion. That around 5 p.m. the Lead Man asked him to go up to the penthouse to the fire alarm air handlers control panel to heck if the relays for air handlers 1 and 2 were installed in place. That upon opening the relay box he found both relays unplugged and laying at the bottom of the panel at which time he installed them in there place. The 2nd shift Stationary Engineer also sated he did not know who pulled the relays. 2. On 2/4/15 at 12:40 p.m., a review of fire alarm	K 067	**Corrective Action:** Engineering has been instructed that relays are never to be pulled, without exception. **(Attachment #7).** **Date of Implementation:** Staff meeting with education was held on February 5, 2015 **Monitoring Process:** The new fire system in place will automatically shut down air handlers should there be any attempt to pull or disable the relays. **Person Responsible:** Corporate VP of Facilities Operations	2/5/2015

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K 067	Continued From page 9 system inspection and test report dated 7/28/14, indicated there was no documented evidence that the duct detectors for air handlers 1 and 2 at the 7th floor penthouse were inspected and tested. During an interview, after reviewing the fire alarm system inspection and test report dated 7/28/14, the Corporate Vice President of Facilities Operations stated that he didn't see any evidence in the report that air handler one and two at the 7th floor penthouse were inspected and tested. During an interview, after reviewing the fire alarm system inspection and test reports dated 7/28/14, the Lead Man stated that the duct detectors on the air handlers were shut down devices that were tested annually, that per his review of the fire alarm inspection and test report dated 7/28/14, there was no evidence in the report that air handler 1 and 2 at the 7th floor penthouse were inspected and tested. The Lead Man also stated that when he received the fire alarm inspection and test report he review the deficiency sheet at the end of the report, but not review the rest of the report to check that all systems were tested, and that he should have reviewed the full report. A review of the facility's Fire Alarm and Inspection schedule for 2014 indicated that the smoke detection shut down devices for the HVAC system had an annual testing frequency and were supposed to be tested in July of 2014. On 2/5/15 at 1:15 p.m., review of the fire alarm system inspection and test report dated 4/24/13, indicated there was no documented evidence that the duct detectors for air handlers 1 and 2 at the 7th floor penthouse were inspected and tested.	K 067	**Corrective Action:** Vendor for testing is no longer being used; currently in the process of contracting a new vendor. Air handler #1 is still in use; air handler #2 has a temporary. Replacement. Air balancing for temporary unit not required per ACO Attachment #20 **(Attachment #8, 15, 16, 17, 18, 19, 20, 21, 23).** **Date of Implementation:** Implementation immediately upon installation of new fire system, an estimated date of June 15,2015 **Monitoring Process:** Testing will occur upon installation, with quarterly inspections thereafter **(Attachment #2).** Results of monitoring will be reported up to EOC and Quality Council on a quarterly basis. **Person Responsible:** Director of Facilities	6/15/2015

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K 067	Continued From page 10 During an interview, after reviewing the fire alarm system inspection and test report dated 4/24/13, the Lead Man stated that he he didn't see any evidence in the report that air handlers 1 and 2 at the 7th floor penthouse were inspected and tested. The last documented evidence of duct smoke detectors for air handler one and two being inspected was on 3/20/12. 3. On 2/5/15 between 10 a.m. and 12 a.m., the Lead Man stated that the tower building had plenums as part of the buildings air distribution system on some of the tower building floors , but that he would have to investigate to determine which floors had plenums. A review of the tower building's supply and exhaust conveyance document indicated that Tower floors 2, 4, 5, and 6 (T-2, T-4, T-5, and T-6) had plenums as part of the buildings air distribution system. On 2/17/15, between 2 p.m. and 4 p.m., the following condition existed in the Tower. At T-6, a Med-Detox unit, the air duct in the corridor was an open system with air blowing into the pen egress corridor space above the drop down suspended ceiling. There were no ducts branching out from the corridor air duct, and there were transfer openings in the egress corridor walls that separated patient rooms from the corridor. There were no ducts from the corridor duct to the patient rooms, and the egress corridor above the ceiling space was used as a portion of the supply air system serving the patient rooms.	K 067		

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K 067	Continued From page 11 During an interview at the same time as the observation, the Lead Man stated that there were no ducts between the corridor duct and the rooms. That the air duct in the corridor was an open system with air blowing into the open corridor space above the suspended ceiling, with that open space used as a plenum. That the air movement went from the open corridor duct, to the open space plenum above the corridor ceiling, to the transfer openings in the egress corridor walls, pulled through the transfer openings into the rooms by the direction of air flow of the the exhaust vents in the rooms taking the air out of the rooms. T-6 is a Med-Detox unit that had patients and staff at the time of the observation. At T-5, the corridor had hard lid ceilings. During an interview at the same time as the observation, the Lead Man stated that the air supply at T-5 had the same type of plenum system as T-6. During an interview at the same time as the observation, the Corporate Vice President of Facilities Operations stated that T-5 was used last week as turn around space to house patients while the cleaning was done at the Pavilion. At T-4, the corridor had hard lid ceilings. During an interview at the same time as the observation, the Lead Man stated that the air supply at T-4 had the same type of plenum system as T-6. At the same time as the observation, during an interview, the Risk Manager stated that T-4 is not on the facility's license and is not used for patients.	K 067		

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K 067	Continued From page 12 At T-2 the air duct in the corridor above the drop down suspended ceiling was a closed system with ducts branching from the corridor duct to the patient rooms. During an interview at the same time as the observation, the Lead Man stated that T-2 was completely ducted and did not have a plenum as part of the floors air distribution system. The egress (exit) corridors of T-4, T-5, and T-6 were the same corridors used as a portion of the air supply (plenums). T-2, T-4, T-5, and T-6 were not sprinklered. T-2, T-4, T-5, and T-6 had smoke detectors in the corridors including at the elevator lobby. T-2, -5, and T-6 had smoke detectors in the rooms. T-4 did not have smoke detectors in the rooms. Per an e-mail dated 2/9/15, from the Corporate Vice President of Facilities Operations, there was an automatic fan shut down for T-2, T-4, T-5, and T-6 upon detection of smoke and activation of the building fire alarm system. Per CMS S&C-06-18 letter dated 5/26/06, NFPA 90A, "Installation of Air Conditioning and Ventilating Systems" document, 1999 Edition prohibits egress (exit) corridors in health care occupancies from being used as a portion of the supply, return or exhaust air system serving adjoining areas (5-3.11.1, 1999 ed.). This prohibits the corridor from being used as a plenum.	K 067	**Corrective Action:** As per CMS S&C-06-18 criteria, a waiver has been requested, citing a review of the fire alarm system pertaining to the corridor protection. The existing system, as installed and tested, contains full corridor coverage, with smoke detectors, and is interconnected to the existing ventilation system. **(Attachments #8, #9, #10, #11, #12, #15 and #24)** **Date of Implementation:** Compliance confirmed May 4, 2015 **Monitoring Process:** Newly designed fire system will automatically shut down at any attempt to pull or disable relays. Anticipated completion of new fire alarm system 5/30/15 **Person Responsible:** Director of Facilities	5/4/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050135	A. BUILDING 01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD B. WING _____	02/05/2015

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K 147	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: NFPA 70 National Electrical Code 1999 edition 110-3. Examination, Identification, Installation, and Use of Equipment (a) Examination. In judging equipment, considerations such as the following shall be evaluated: (3) Wire-bending and connection space (4) Electrical insulation (8) Other factors that contribute to the practical safeguarding of persons using or likely to come in contact with the equipment 110-12(c) Internal parts of electrical equipment, including busbars, wiring terminals, insulators, and other surfaces, shall not be damaged or contaminated by foreign materials such as paint, plaster, cleaners, abrasives, or corrosive residues. There shall be no damaged parts that may adversely affect safe operation or mechanical strength of the equipment such as parts that are broken; bent; cut; or deteriorated by corrosion, chemical action, or overheating. 310-2. (a) Insulated. Conductors shall be insulated. These codes were not met as evidenced by: Based on observation and interview, the facility failed to ensure 2 electrical cords were not compromised.	K 147		

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K 147	Continued From page 14 The deficient practices bypassed the safe use and maintenance of electrical cords and their safeguards against fire and electric shock. Findings: On 2/3/15, between 4:20 p.m. and 4:55 p.m., there were two extension cords connected to air scrubbers on the 3rd and 5th floors of the pavilion. Closer observation revealed the extension cords had damaged that consisted of their electrical cord protective jacket being pulled away from the plug, thereby exposing the electrical wiring beneath. During an interview at the same time as the observations, the Corporate Vice President of Facilities Operations stated damaged extension cords would be removed.	K 147	**Corrective Action:** Third party vendor removed air scrubber, along with damaged electrical cord. **Date of Implementation:** Removed immediately on 2/3/15. **Monitoring Process:** No monitoring necessary. **Person Responsible:** Director of Facilities	2/3/2015

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K 067	Continued From page 12 At T-2 the air duct in the corridor above the drop down suspended ceiling was a closed system with ducts branching from the corridor duct to the patient rooms. During an interview at the same time as the observation, the Lead Man stated that T-2 was completely ducted and did not have a plenum as part of the floors air distribution system. The egress (exit) corridors of T-4, T-5, and T-6 were the same corridors used as a portion of the air supply (plenums). T-2, T-4, T-5, and T-6 were not sprinklered. T-2, T-4, T-5, and T-6 had smoke detectors in the corridors including at the elevator lobby. T-2, -5, and T-6 had smoke detectors in the rooms. T-4 did not have smoke detectors in the rooms. Per an e-mail dated 2/9/15, from the Corporate Vice President of Facilities Operations, there was an automatic fan shut down for T-2, T-4, T-5, and T-6 upon detection of smoke and activation of the building fire alarm system. Per CMS S&C-06-18 letter dated 5/26/06, NFPA 90A, "Installation of Air Conditioning and Ventilating Systems" document, 1999 Edition prohibits egress (exit) corridors in health care occupancies from being used as a portion of the supply, return or exhaust air system serving adjoining areas (5-3.11.1, 1999 ed.). This prohibits the corridor from being used as a plenum.	K 067	**Corrective Action:** As per CMS S&C-06-18 criteria, a waiver has been requested, citing a review of the fire alarm system pertaining to the corridor protection. The existing system, as installed and tested, contains full corridor coverage, with smoke detectors, and is interconnected to the existing ventilation system. **(Attachments #8, #9, #10, #11, #12, #15 and #24)** **Date of Implementation:** Compliance confirmed May 4, 2015 **Monitoring Process:** Newly designed fire system will automatically shut down at any attempt to pull or disable relays. Anticipated completion of new fire alarm system 5/30/15 **Person Responsible:** Director of Facilities	5/4/2015

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K 147	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: NFPA 70 National Electrical Code 1999 edition 110-3. Examination, Identification, Installation, and Use of Equipment (a) Examination. In judging equipment, considerations such as the following shall be evaluated: (3) Wire-bending and connection space (4) Electrical insulation (8) Other factors that contribute to the practical safeguarding of persons using or likely to come in contact with the equipment 110-12(c) Internal parts of electrical equipment, including busbars, wiring terminals, insulators, and other surfaces, shall not be damaged or contaminated by foreign materials such as paint, plaster, cleaners, abrasives, or corrosive residues. There shall be no damaged parts that may adversely affect safe operation or mechanical strength of the equipment such as parts that are broken; bent; cut; or deteriorated by corrosion, chemical action, or overheating. 310-2. (a) Insulated. Conductors shall be insulated. These codes were not met as evidenced by: Based on observation and interview, the facility failed to ensure 2 electrical cords were not compromised.	K 147		

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K 147	Continued From page 14 The deficient practices bypassed the safe use and maintenance of electrical cords and their safeguards against fire and electric shock. Findings: On 2/3/15, between 4:20 p.m. and 4:55 p.m., there were two extension cords connected to air scrubbers on the 3rd and 5th floors of the pavilion. Closer observation revealed the extension cords had damaged that consisted of their electrical cord protective jacket being pulled away from the plug, thereby exposing the electrical wiring beneath. During an interview at the same time as the observations, the Corporate Vice President of Facilities Operations stated damaged extension cords would be removed.	K 147	**Corrective Action:** Third party vendor removed air scrubber, along with damaged electrical cord. **Date of Implementation:** Removed immediately on 2/3/15. **Monitoring Process:** No monitoring necessary. **Person Responsible:** Director of Facilities	2/3/2015

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A 000	INITIAL COMMENTS The following represents the findings of the Department of Public Health during a Complaint Validation Survey at the Culver City Campus. Intake No.: CA00429647 Representing the Department of Public Health: Evaluator ID #14041, REHS, CFI 1, HFE I Evaluator ID #16281, REHS, CFI 1, HFE I	A 000	**A 700-1Corrective Action:** Hot work permit protocol has been revised **(Attachment # 1).** Project Manager no longer has authority to approve Hot Work permits. All permits must be approved by Facilities Director, or his designee. Contractor holds sole responsibility to notify IOR when presence is needed. Fire Watch has been conducted on 1/29/15, the day of the fire, albeit, incorrectly, by the contracting company MK Roofing. **(Attachment #2)** Contractor on site notice process has been implemented so that no contractor can have facility access without prior notification and approval by facilities director and project manager should IOR be required. Process includes description of work, area impacted with dates and times. See attachment 5 & 14. **Date of Implementation:** February 3, 2015 **Monitoring Process:** Fire Watch will be monitored and logged by SCHCC staff, rather than third party company. Fire Watch log sheet is attached to Hot Work policy and procedure. **Person Responsible:** Director of Facilities	2/3/2015
A 700	482.41 PHYSICAL ENVIRONMENT The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community. This CONDITION is not met as evidenced by: Based on observation, document review, and interview, the facility failed to meet the Condition of Participation in Physical Environment by failing to: 1. Maintain the physical plant in a manner that assured the safety and well-being of patients (Refer to A 701 and A 710). 2. Ensure the safety of patients and staff when the hospital failed to ensure the Inspector of Record was present during hot works construction (Refer to A 701). 3. Ensure the safety of patients and staff when the hospital failed to have an approved and effective Hot Work policy and procedure (Refer to A 701).	A 700	**A 710 Corrective Action:** A new fire system is being installed **(Attachment #6)** which will immediately shut down air handlers, should the relays be pulled. Engineers have been instructed that relays are no longer to be pulled during fire alarm testing, as was common practice beforehand **(Attachment #7)**. New fire system is in final stages of testing. **Date of Implementation:** February 15, 2015 with an estimated completion date of May 30, 2015. **Monitoring Process:** Redesigned system will shut down air handlers should there be any attempt to pull or disable relays. **Person Responsible:** Vice President of Facilities Operations	6/15/2015
			A 700-2 Corrective Action: Hot work permit protocol has been revised **(Attachment # 1).** Project Manager no longer has authority to approve Hot Work permits. All permits must be approved by Facilities Director, or his designee. Contractor holds sole responsibility to notify IOR when presence is needed. Fire Watch has been conducted on 1/29/15, the day of the fire, albeit, incorrectly, by the contracting company MK Roofing. **(Attachment #2)** Contractor on site notice process has been implemented so that no contractor can have facility access without prior notification and approval by facilities director and project manager should IOR be required. Process includes description of work, area impacted with dates and times. See attachment 5 & 14. **Date of Implementation:** February 3, 2015 **Monitoring Process:** Fire Watch will be monitored and logged by SCHCC staff, rather than third party company. Fire Watch log sheet is attached to Hot Work policy and procedure. **Person Responsible:** Director of Facilities	2/3/2015
			A 700-3 Corrective Action: Hot work permit protocol has been revised **(Attachment # 1).** Project Manager no longer has authority to approve Hot Work permits. All permits must be approved by Facilities Director, or his designee. Contractor holds sole responsibility to notify IOR when presence is needed. Fire Watch has been conducted on 1/29/15, the day of the fire, albeit, incorrectly, by the contracting company MK Roofing. **(Attachment #2)** Contractor on site notice process has been implemented so that no contractor can have facility access without prior notification and approval by facilities director and project manager should IOR be required. Process includes description of work, area impacted with dates and times. See attachment 5 & 14. **Date of Implementation:** February 3, 2015 **Monitoring Process:** Fire Watch will be monitored and logged by SCHCC staff, rather than third party company. Fire Watch log sheet is attached to Hot Work policy and procedure. **Person Responsible:** Director of Facilities	2/3/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Interim CEO — (X6) DATE: 5/29/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 700	Continued From page 1 4. Ensure the safety of patients and staff when the hospital failed to ensure relays at the fire alarm air handler shutoff control panel remained installed in place (Refer to A 701). 5. Ensure the safety of patients and staff when the hospital failed to ensure the air system operated continuously and provided balanced air-supply to patient rooms (Refer to A 701). 6. Ensure the safety of patients and staff when the hospital removed self-closing area separation fire doors from the fourth and fifth floors (Refer to A 701). 7. Ensure the safety of patients and staff when the hospital failed to ensure an air handler automatically shut down with the presence of smoke (Refer to A 710 and K 067). 8. Ensure the safety of patients and staff when the hospital failed to ensure that all automatic shutdown devices were tested annually (Refer to A 710 and K 067). 9. Ensure the safety of patients and staff when the hospital used egress corridors as plenums (Refer to A 710 and K 067). 10. Ensure the safety of patients and staff when the hospital failed to ensure electrical power cords were maintained intact (Refer to A 710 and K 147). 11. Ensure 2 of 4 elevators Phase II fire fighter operation were fully functional at all times (Refer to K 051).	A 700	**A 700-4 Corrective Action:** A new fire system is being installed **(Attachment #6 & 15)** which will immediately shut down air handlers, should the relays be pulled. Engineers have been instructed that relays are no longer to be pulled during fire alarm testing, as was common practice beforehand **(Attachment #7)**. New fire system is in final stages of testing. **Date of Implementation:** February 15, 2015 with an estimated completion date of June 15,, 2015. **Monitoring Process:** Redesigned system will shut down air handlers should there be any attempt to pull or disable relays. **Person Responsible:** Vice President of Facilities Operations **A700-5 Corrective Action:** A new fire system is being installed **(Attachment #6 & 15)** which will immediately shut down air handlers, should the relays be pulled. Engineers have been instructed that relays are no longer to be pulled during fire alarm testing, as was common practice beforehand **(Attachment #7)**. New fire system is in final stages of testing. **Date of Implementation:** February 15, 2015 with an estimated completion date of June 15,, 2015. **Monitoring Process:** Redesigned system will shut down air handlers should there be any attempt to pull or disable relays. **Person Responsible:** Vice President of Facilities Operations **A 700-6 Corrective Action:** Project for self-closing area separation fire doors has been opened with OSHPD and design has been approved **(Attachment #11).** Currently, the project is out for bids, with an anticipated award date of June 1, 2015 Anticipated completion date of July 15, 2015.. **Date of Implementation:** 1/30/2015 **Monitoring Process:** Fire Doors are inspected on a quarterly basis **(Attachment #12).** Results of monitoring will be reported up to EOC and Quality Council on a quarterly basis. **Person Responsible:** Corporate Vice President of Facilities Operations **A700-7 Corrective Action:** A new fire system is being installed **(Attachment #6 & 15)** which will immediately shut down air handlers, should the relays be pulled. Engineers have been instructed that relays are no longer to be pulled during fire alarm testing, as was common practice beforehand **(Attachment #7)**. New fire system is in final stages of testing. **Date of Implementation:** February 15, 2015 with an estimated completion date of June 15,, 2015. **Monitoring Process:** Redesigned system will shut down air handlers should there be any attempt to pull or disable relays. **Person Responsible:** Vice President of Facilities Operations **A700-8 Corrective Action:** A new fire system is being installed **(Attachment #6 & 15)** which will immediately shut down air handlers, should the relays be pulled. Engineers have been instructed that relays are no longer to be pulled during fire alarm testing, as was common practice beforehand **(Attachment #7)**. New fire system is in final stages of testing. **Date of Implementation:** February 15, 2015 with an estimated completion date of June 15,, 2015. **Monitoring Process:** Redesigned system will shut down air handlers should there be any attempt to pull or disable relays. **Person Responsible:** Vice President of Facilities Operations **A700-9 Corrective Action:** As per CMS S&C-06-18 criteria, a waiver has been requested, citing a review of the fire alarm system pertaining to the corridor protection. The existing system, as installed and tested, contains full corridor coverage, with smoke detectors, and is interconnected to the existing ventilation system. **(Attachments #9, #10, #11 and #12)** **Date of Implementation:** Compliance confirmed May 4, 2015 **Monitoring Process:** Newly designed fire system will automatically shut down at any attempt to pull or disable relays; receipt of waiver pending. **Person Responsible:** Director of Facilities	6/15/2015 6/15/2015 7/15/2015 6/15/2015 6/15/2015 5/4/2015

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A 700	Continued From page 2 The cumulative effect of the systemic issues resulted in the facility's inability to ensure and provide a safe patient care environment.	A 700	**A 700-10 Corrective Action:** Third party vendor removed air scrubber, along with damaged electrical cord. **Date of Implementation:** Removed immediately on 2/3/15. **Monitoring Process:** No monitoring necessary. **Person Responsible:** Director of Facilities **A 700-11Corrective Action:** Third party vendor removed air scrubber, along with damaged electrical cord. **Date of Implementation:** Removed immediately on 2/3/15. **Monitoring Process:** No monitoring necessary. **Person Responsible:** Director of Facilities	2/3/2015 4/8/2015
A 701	482.41(a) MAINTENANCE OF PHYSICAL PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained such a manner that the safety and well-being of patients are assured. This STANDARD is not met as evidence by: Based on interview and document review, the hospital failed to assure a safe environment for the patients by not ensuring the IOR (Inspector of Record) was present during hot works construction done on the roof, failing to ensure two relays at the fire alarm air handler shutoff control panel remained installed in place, failing to have an approved and effective Hot Work policy and procedure, failure to provide an air system to operate continuously and provide balanced air-supply to patient rooms for the 2nd, front of 3rd (SDU), 4th, 5th, and 6th floors, removing self-closing area separation fire doors, and failing to ensure privacy curtains were in place. These deficient practices had the potential to have hot work construction being conducted in an unsafe manner, permitted the accelerated spread of smoke and gases during a fire, discontinued the provision of balanced air-supply to patient rooms on the 2nd, front of 4rd, 4th, 5th, and 6th floors, and affected the patients well-being, dignity and comfort while in the hospital. Findings:	A 701		

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A 701	Continued From page 3 1. On 2/3/15, a review of an OSHPD (Office of Statewide Health Planning & Development) Fire and Life Safety Field Visit Report dated 2/2/15, indicated that on 1/29/15 a fire occurred as a direct result of the scope of work for the "parapet" reconstruction project. That work being performed when the fire occurred was being performed without the knowledge or the presence of the Inspector of Record (IOR), as well as without an appropriate "Fire Watch." Review of the Inspector's Daily Report dated 3/4/14 from the IOR for the parapet roof repair project indicated that there was a kick off meeting with the roofing company, Corporate Project Manager, and the Special Instructor for preconstruction meeting. The report indicated that a minimum 48 hours notice was required for inspections. Review of the hot works permit dated 1/26/15, indicated there would be a parapet roof replacement at the roof of the pavilion. Review of the roofing company's fire watch log sheet dated 1/29/15, at 12 p.m., indicated the torch was started at "top of wing." Review of the Notice of Non-Conformance dated 1/29/15 (revised 1/30/15), from the IOR for the parapet roof repair project indicated that the contractor failed to notify the IOR that their intent was to perform hot work in order for the IOR to verify that a hot work permit had been obtained and posed in the direct area of work, confirm times allowed for hot work, verify that the interim life safety measures were in place, which included, fire extinguishers and required	A 701	**Corrective Action:** Hot work permit protocol has been revised **(Attachment # 1).** Project Manager no longer has authority to approve Hot Work permits. All permits must be approved by Facilities Director, or his designee. Contractor holds sole responsibility to notify IOR when presence is needed. Fire Watch has been conducted on 1/29/15, the day of the fire, albeit, incorrectly, by the contracting company MK Roofing. **(Attachment #2)** Contractor on site notice process has been implemented so that no contractor can have facility access without prior notification and approval by facilities director and project manager should IOR be required. Process includes description of work, area impacted with dates and times. **(See attachment 5 & 14).** **Date of Implementation:** February 3, 2015 **Monitoring Process:** Fire Watch will be monitored and logged by SCHCC staff, rather than third party company. Fire Watch log sheet is attached to Hot Work policy and procedure. **Person Responsible:** Director of Facilities	2/3/2015

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 701	Continued From page 4 personnel available for fire watch for the entire duration of the work being performed. That without such notification, IOR was not scheduled to be onsite or aware of the work that needed to be observed. And that the contractor was in violation of CAC (California Administrative Code) Section 7-145. On 2/5/15 at 1:15 p.m., during an interview, the Director of Plant Operations stated the plant operations did not know the workers on the pavilion roof were going to use a torch. He further stated that when he knows there will be hot works he calls and ensures the IOR is present. Also, he would know if hot works are to be conducted because the vendors/contractors are suppose to notify him or the Lead Man before doing hot work, that usually the vendors/contractors notify the IOR first, and usually the IOR comes and stays the whole time the hot work is conducted. In addition, it was always the procedure for the vendors/contractors to notify plant operations before conducting hot work and that the vendors/contractors know they are suppose to report to plant operations first. 2. On 2/3/15, a review of an OSHPD Fire and Life Safety Field Visit Report dated 2/2/15, indicated that on 1/29/15 a fire appeared to have damaged the HVAC supply air-intake filter banks that apparently supply air to the 2nd , 4th, 5th , and 6th floor patient rooms. That the HVAC system did not automatically shut-down during the fire on 1/29/15 and the smoke from the fire was dispersed from the roof supply intake to other areas and floors of the building. On 2/4/15 at 11:05 a.m., during an interview, the	A 701	**Corrective Action:** All contractors must check in with Plant Engineering prior to starting any work, as well as signing out at the end of the work day. **(Attachment #3)**. A "Contractor on Site" notice must be sent out at least 24 hours in advance, preferably 48 hours when possible. **(Attachments #4 and #5).** **Date of Implementation:** February 3, 2015 **Monitoring Process:** Plant Engineering will establish and maintain a Contractor Sign IN/OUT Log for all contractors working on site. See Attachment #3. **Person Responsible:** Director of Facilities **Corrective Action:** A new fire system is being installed **(Attachment #6 & 15)** which will immediately shut down air handlers, should the relays be pulled. Engineers have been instructed that relays are no longer to be pulled during fire alarm testing, as was common practice beforehand **(Attachment #7)**. New fire system is in final stages of testing. **Date of Implementation:** February 15, 2015 with an estimated completion date of June 15, 2015. **Monitoring Process:** Redesigned system will shut down air handlers should there be any attempt to pull or disable relays. **Person Responsible:** Vice President of Facilities Operations	2/3/2015 6/15/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050135	A. BUILDING _____ B. WING _____	02/05/2015

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A 701	Continued From page 5 Lead Man stated that the automatic shut down of the air handlers could be bi-passed by pulling (removing) the relays in the fire alarm air handler shutoff control panel. On 2/5/15 at 10:10 a.m., during an interview, the Lead Man stated that on the day of the fire (1/29/15), he heard a code red announced from the 3rd floor, that he went to the 3rd floor and saw smoke coming from vents at the 3rd floor, that he went up to the penthouse and saw smoke coming from air handler 2, and saw fire at the door of the air handler, and that he saw the air handler was still on, so he (manually) shut off the air handler. The Lead Man also stated that the engineers can pull the relays in the fire alarm air handlers control panel if a vendor is scheduled to conduct a fire alarm test and then reconnect them after the test, that it was the practice when he came to the hospital, and its what they (engineering) have continued to do, that the relays have to be pulled, otherwise air conditioning and heating is lost for the whole building and that there was no other reason to pull the relays. On 2/5/15 at 2:42 p.m., during an interview, the 2nd shift Stationary Engineer stated that on 1/29/15 he had arrived to the hospital at 1:30 p.m., after the fire, and discovered there had been a fire on the roof of the Pavilion. That around 5 p.m. the Lead Man asked asked him to go up to the penthouse to the fire alarm air handlers control panel to check if the relays for air handlers 1 and 2 were installed in place. That upon opening the relay box, he found both relays unplugged and laying at the bottom of the panel at which time he installed them in their place.	A 701	**Corrective Action:** A new fire system is being installed **(Attachment #6 & #15)** which will immediately shut down air handlers, should the relays be pulled. Engineers have been instructed that relays are no longer to be pulled during fire alarm testing, as was common practice beforehand **(Attachment #7)**. New fire system is in final stages of testing. **Date of Implementation:** February 15, 2015 with an estimated completion date of June 15, 2015. **Monitoring Process:** Redesigned system will shut down air handlers should there be any attempt to pull or disable relays. **Person Responsible:** Vice President of Facilities Operations	6/15/2015

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A 701	Continued From page 6 The 2nd shift Stationary Engineer, also stated he did not know who pulled the relays, and did not tell anyone that on Thursday (1/29/15) he had found the relays laying in the panel until the Lead Man asked him about it on Wednesday (2/4/15). On 2/5/15 at 2:45 p.m., during an interview, the Lead Man stated he did not know the relays were unplugged until Wednesday (2/4/15), when he asked the Stationary Engineer. That the last communication he had with the Stationary Engineer was on the day of the fire (1/29/15) and did not try to call the Stationary Engineer between that Thursday (1/29/15) and Wednesday (2/4/15). 3. On 2/3/15, a review of an OSHPD Fire and Life Safety Field Visit Report, dated 2/2/15, indicated that on 1/29/15 a fire occurred as a direct result of the scope of work for the parapet reconstruction project. That work being performed when the fire occurred was being performed without the knowledge or the presence of the IOR (Inspector of Record), as well as without an appropriate "Fire Watch". Review of the hot works construction permit dated 1/26/15 indicated there would be parapet roof replacement at the roof of the pavilion. Review of the roofing company's fire watch log sheet dated 1/29/15, at 12 p.m. indicated the torch was started at "top of wing." Review of the Notice of Non-Conformance dated 1/29/15 (revised 1/30/15) from the IOR for the parapet roof repair project indicated that the contractor failed to notify the Inspector of Record (IOR) that their intent was to perform hot work, in	A 701	**Corrective Action:** Hot work permit protocol has been revised **(Attachment # 1).** Project Manager no longer has authority to approve Hot Work permits. All permits must be approved by Facilities Director, or his designee. Contractor holds sole responsibility to notify IOR when presence is needed. Fire Watch has been conducted on 1/29/15, the day of the fire, albeit, incorrectly, by the contracting company MK Roofing. **(Attachment #2)** **Date of Implementation:** February 3, 2015 **Monitoring Process:** Fire Watch will be monitored and logged by SCHCC staff, rather than third party company. Fire Watch log sheet is attached to Hot Work policy and procedure. Results of monitoring will be reported up to EOC and Quality Council on a quarterly basis. **Person Responsible:** Director of Facilities	2/3/2015

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A 701	Continued From page 7 order for the IOR to verify that a hot work permit had been obtained and posted in the direct area of work, confirm times allowed for hot work, verify that the interim life safety measures were in place, which included, fire extinguishers and required personnel available for fire watch for the entire duration of the work being performed. On 2/5/15 at 1:15 p.m., during an interview, the Corporate Vice President of Plant Operations stated that plant operations did not know the workers on the pavilion roof were using a torch to put down roofing material. Also, the vendor/contractor did not contact plant operations or the IOR. On 2/5/15 at 1:15 p.m., during an interview, the Director of Plant Operations stated that plant operations did not know the workers on the pavilion roof were going to use a torch. The he would know if hot works are to be conducted because the vendor/contractor are suppose to notify him or the Lead Man before doing hotworks. That it was always the procedure for the vendors to notify plant operations before conducting hot works and that the vendors/contractors know they are suppose to report to plant operations first. Review of a document provided by the facility as a policy titled Hot Works, indicated there was no date of submittal to the governing body of the document and there was no effective date of the document. The document indicated that the purpose of the document was to maintain current policies and guidelines for Hot Work. The document did not indicate the procedure notifying the IOR when hot work would be performed, and did not indicate the procedure to ensure the	A 701	**Corrective Action:** Hot work permit protocol has been revised **(Attachment # 1).** Project Manager no longer has authority to approve Hot Work permits. All permits must be approved by Facilities Director, or his designee. Contractor holds sole responsibility to notify IOR when presence is needed. Fire Watch has been conducted on 1/29/15, the day of the fire, albeit, incorrectly, by the contracting company MK Roofing. **(Attachment #2)** **Date of Implementation:** February 3, 2015 **Monitoring Process:** Fire Watch will be monitored and logged by SCHCC staff, rather than third party company. Fire Watch log sheet is attached to Hot Work policy and procedure. Results of monitoring will be reported up to EOC and Quality Council on a quarterly basis. **Person Responsible:** Director of Facilities	2/3/2015

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A 701	Continued From page 8 facility was aware of hot work being performed. 4. On 2/3/15, a review of an OSHPD Fire and Life Safety Field Visit Report dated 2/2/15, indicated that on 1/29/15 a fire appeared to have damaged the HVAC supply air-intake filter banks that apparently supply air to the 2nd, 4th, 5th, and 6th floor patient rooms. That the HVAC system serving these rooms had been shut down pending repairs to the damaged system. On 2/3/15 at 12:05 p.m., during an interview, the Project Manager stated that one of two air handlers (air handler 2) in the penthouse was affected by the fire, and that air handler 2 affected patient rooms of the 2nd , front 3rd SDU, 4th, 5th, and 6th floors that it served. On 2/3/15 at 12:35 p.m., the Corporate Vice President of Facilities Operations stated that patient room temperatures were not being monitored and there was no plan if there was a change in temperature due to inclement weather. At 1:10 p.m., the Corporate Vice President of Facilities Operations stated that plant operations would begin monitoring patient room temperatures immediately. At 2:10 p.m., the Project Manager stated that scrubbers were placed in the corridors of the affected floors to clean and circulate the air. Between 4:15 p.m. and 5:20 p.m., HEPA (High Efficiency Particulate Air) filtration systems (air scrubbers) were observed at the 2nd, 3rd, 4th, 5th, and 6th floors.	A 701	**Corrective Action:** Vendor for testing is no longer being used; currently in the process of contracting a new vendor. Air handler #1 is still in use, while air handler #2 has a temporary replacement. Air balancing for temporary unit not required per ACO Attachment #20 **(Attachment # 8, 15, 16, 17, 18, 19, 20 & 21).** **Date of Implementation:** Implementation immediately upon installation of new fire system, an estimated date of May 30, 2015. **Monitoring Process:** Testing will occur upon installation, with quarterly inspections thereafter. **(Attachment # 9).** Results of monitoring will be reported up to EOC and Quality Council on a quarterly basis. **Person Responsible:** Director of Facilities **Corrective Action:** Temperature monitoring was immediately implemented for all patient rooms impacted by the fire-damaged air hander. **Date of Implementation:** February 3, 2015 **Monitoring Process:** Temperatures were gauged for ranges between 73°-77°, every 4 hours. Temperatures were monitored until air handler #2 temporary replacement was installed on March 25, 2015. **(Attachment # 10)** **Person Responsible:** Director of Facilities	6/15/2015 3/26/2015

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A 701	Continued From page 9 A letter from the hospital dated 2/3/15 indicated that due to to the fire on 1/29/15, air handler #2 that provides supply air to patient rooms on P2, P3 SDU, P4, P6 and P6 was off line. That air scrubbers were installed on each of the floors to clean and circulate the air. That all patient rooms on the affected floors would be monitored for temperature every four hours, twenty four hours a day to insure ambient temperatures were between the range of 73 and 77 degrees Fahrenheit, and that because there was no temperature control, windows would be open for fresh air ensuring screens were in place and additional blankets were deployed to each affected floor should temperatures cool. 5. On 2/5/15 at 8:52 a.m., in response to a request of the incident report from the local fire department, the Corporate Vice President of Facilities Operations stated that the local fire department would not have the report until two weeks after the date of the incident. Review of the local fire department report undated Fire Investigation Report regarding the fire incident at the hospital on 1/29/15, indicated in its summary that it was noted at the time of the fire, that self-closing area separation fire doors had been removed from the fourth and fifth floors, and that an OTC (Order to Comply) for replacement of the doors had been issued. 6. On 2/3/15 at 5:07 p.m., 9 patient rooms (210, 211, 212, 214, 216 A, 217 B, 219 B, 220 A, and 221 A) in 2nd floor Telemetry, were observed to be without privacy curtains. There were patients in the beds of the 9 rooms at the time of the observation.	A 701	**Corrective Action:** Project for self-closing area separation fire doors has been opened with OSHPD and design has been approved **(Attachment #11).** Currently, the project is out for bids, with an anticipated award date of June 1, 2015 Anticipated completion date of July 15, 2015. **Date of Implementation:** 1/30/2015 **Monitoring Process:** Fire Doors are inspected on a quarterly basis **(Attachment #12).** Results of monitoring will be reported up to EOC and Quality Council on a quarterly basis. **Person Responsible:** Corporate Vice President of Facilities Operations	7/15/2015

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A 701	Continued From page 10 Between 5:07 p.m. and 5:10 p.m., the Director of Environmental Services (EVS) stated that the curtains had been taken down to be sent away to be washed. That the curtains had arrived at 4 p.m., that EVS had been downstairs checking that the replacement curtains were not stained, and that the curtains were being hung now. On 2/5/15 at 10:35 a.m., the Director of EVS stated that on Tuesday (2/3/15), the privacy curtains were taken down because the patients were complaining that the curtains were stained. That she had the Lead EVS take the curtains down and had EVS staff gather the replacement curtains.	A 701	**Corrective Action:** Privacy curtains have been installed in rooms 210, 211, 212, 214, 216 A, 217 B, 219 B, 220 A, and 221 A on the 2nd floor, Pavilion Building. Curtains are not to be removed, unless replacement curtains are readily available and are able to be hung immediately afterwards. A policy titled "Privacy Curtain Cleaning" has been drafted and is pending review by the EOC, Quality Council and Medical Executive Committees, as well as the Governing Board **(Attachment #13).** **Date of Implementation:** February 3, 2015 **Monitoring Process:** EVS will monitor during daily rounds. Results of monitoring will be reported up to EOC and Quality Council on a quarterly basis. **Person Responsible:** Director of EVS	2/3/2015
A 710	482.41 (b)(1)(2)(3) LIFE SAFETY FROM FIRE (1) Except as otherwise provided in this section – (i) The hospital must meet the applicable provisions of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR Part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html Copies may be obtained from the National Fire Protection Association, 1 Battermarch Park, Quincy, MA 02269. If any changes in this edition	A 710		

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A 710	Continued From page 11 of the Code are incorporated by reference, CMS will publish notice in the Feral Register to announce the changes. (ii) Chapter 19.3.6.3.2, exception number 2 of the adopted edition of the LSC does not apply to hospitals. (2) After consideration of State survey agency findings, CMS may waive specific provisions of the Life Safety Code which, if rigidly applied, would result in unreasonable hardship upon the facility, but only if the waiver does not adversely affect the health and safety of the patients. (3) The provisions of the Life Safety Code do not apply in a State where CMS finds that a fire and safety code imposed by State law adequately protects patients in hospitals. This STANDARD is not met as evidenced by: Based on observation, interview, and document review, the facility failed to meet the applicable provisions of the Life Safety Code of the National Fire Protection Association (NFPA) including NFPA 70 National Electrical Code 1999 edition, NPA 90A, Standard for the Installation of Air Condition and Ventilating Systems, and NFPA 101 Code for Safety to Life from Fire in Buildings and Structures 2000 Edition, as indicated in tags K067 and K 147 of the Statement of Deficiencies. These codes and standards were not met as evidenced by: Based on observation, interview and document review, the hospital failed to ensure an air handler automatically shut down with the presence of smoke. The hospital failed to ensure that all	A 710		

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A 710	Continued From page 12 automatic shutdown devices were tested annually. The hospital used corridors as plenums. The hospital failed to ensure electrical power cords were maintained in tact. The deficiencies permitted, and had the potential to permit accelerated spread of smoke and gases during a fire, and bypassed the safe use and maintenance of electrical power cords and their safeguards against fire and electric shock.	A 710	**Corrective Action:** A new fire system is being installed **(Attachment #6 & #15)** which will immediately shut down air handlers, should the relays be pulled. Engineers have been instructed that relays are no longer to be pulled during fire alarm testing, as was common practice beforehand **(Attachment #7)**. New fire system is in final stages of testing. **Date of Implementation:** February 15, 2015 with an estimated completion date of June 15, 2015. **Monitoring Process:** Redesigned system will shut down air handlers should there be any attempt to pull or disable relays. **Person Responsible:** Vice President of Facilities Operations	6/15/2015

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	050135	A. BUILDING _____ B. WING □__□□□__□□__□□□__□□__□□□__□__□□□	08/21/2014

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□A 000□	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during the Follow-Up Visit to a Sampled Validation Survey completed on April 1, 2014. Representing the Department of Public Health: Surveyor 17030, RN, HFEN Surveyor 16281, REHS, HFE I Surveyor 10933, Nutritional Consultant Surveyor 17065, Nutritional Consultant Surveyor 25049, MD, Medical Consultant Surveyor 29775, MD, Medical Consultant Surveyor 28851, Pharm D, Pharmacy Consultant Surveyor 29643, RN, Nurse Consultant, L & C Infection Control On August 20, 2014, at 1:30 p.m., the survey team declared an Immediate Jeopardy (IJ) situation, in the presence of the Chief Executive Officer (CEO) of Culver City Campus, director of risk management, as a result of the facility□s failure: 1. To ensure flexible endoscopes were stored in accordance with the Association of Peri-Operative Registered Nurse (AORN) Recommended Practices. AORN is the National Recognized Standards (NRS) the hospital identified as the standard they followed. 2. To ensure re-usable surgical instruments were packaged and stored in accordance with the AORN Standards. On August 21, 2014, at 3:45 p.m., the IJ was abated in the presence of the director of risk	□A 000□	**Culver City** **1.) Corrective Actions:** The following was implemented to ensure flexible endoscopes are stored in accordance to the AORN recommended practices: The facility purchased and installed new vented scope cabinet **(Attachment 1)** and placed in a storage area back side of surgery with adequate ventilation for proper storage of scopes; all scopes now have tip protectors to ensure tips do not touch the cabinet; all scopes are tagged after processing with indication of next date to re-process if not in use. Surgical services provided education & in-service to staff on the use of enzymatic cleaners and proper measurements **(Attachment 6);** for scope re-processing; high-level disinfection, and included competency validation and return demonstrations **(Attachment 2).** **Date of Implementation:** Scope Cabinet installed 9-15-14; Education completed on August 12, 2014 and August 21, 2014. **Monitoring Process:** Monitoring managed by daily inspection of the scopes for next date of re-processing; Daily scopes monitoring include before and after each use to ensure proper placement in scope cabinet. Weekly monitoring of all scope procedures are performed to ensure completeness and accuracy of recoding in the log **(Attachment 3)**. Log compliance will be submitted to the Regulatory Compliance Committee & Quality Council to ensure compliance with AORN standards. **Person Responsible:** OR Team/Infection Control. **Hollywood** **1.) Corrective Actions:** The following was implemented to ensure flexible endoscopes are stored in accordance to the AORN recommended practices: The facility purchased and installed new vented scope cabinet and placed in a storage area back side of surgery with adequate ventilation for proper storage of scopes **(Attachment 4)**; all scopes now have tip protectors to ensure tips do not touch the cabinet; all scopes are tagged after processing with indication of next date to re-process if not in use. Surgical services provided education & in-service to staff on the use of enzymatic cleaners and proper measurements; for scope re-processing; high-level disinfection, and included competency validation and return demonstrations **(Attachment 5).** **Date of Implementation:** Scope Cabinet installed 9-8-14; Education completed on August 11, 2014 and August 20, 2014; and repeated September 22, 2014. **Monitoring Process:** Monitoring managed by daily inspection of the scopes for next date of re-processing; Daily scopes monitoring include before and after each use to ensure proper placement in scope cabinet. Weekly monitoring of all scope procedures are performed to ensure completeness and accuracy of recoding in the log **(Attachment 7).** Log compliance will be submitted to the Regulatory Compliance Committee & Quality Council to ensure compliance with AORN standards. **Person Responsible:** OR Team/Infection Control.	8/12/2014 8/21/2014 9/15/2014 8/11/2014 8/20/2014 9/8/2014 9/22/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (□6) DATE

Any deficiency statement ending with an asterisk (□) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	6245 DE LONGPRE AVE HOLLYWOOD, CA 90028

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A 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during the Follow-Up Visit to a Sampled Validation Survey completed on April 1, 2014. Representing the Department of Public Health: Surveyor 17030, RN, HFEN Surveyor 16281, REHS, HFE I Surveyor 10933, Nutritional Consultant Surveyor 17065, Nutritional Consultant Surveyor 25049, MD, Medical Consultant Surveyor 29775, MD, Medical Consultant Surveyor 28851, Pharm D, Pharmacy Consultant Surveyor 29643, RN, Nurse Consultant, L & C Infection Control On August 20, 2014, at 1:30 p.m., the survey team declared an Immediate Jeopardy (IJ) situation, in the presence of the Chief Executive Officer (CEO) of Culver City Campus, director of risk management, as a result of the facility's failure: 1. To ensure flexible endoscopes were stored in accordance with the Association of Peri-Operative Registered Nurse (AORN) Recommended Practices. AORN is the National Recognized Standards (NRS) the hospital identified as the standard they followed. 2. To ensure re-usable surgical instruments were packaged and stored in accordance with the AORN Standards. On August 21, 2014, at 3:45 p.m., the IJ was abated in the presence of the director of risk	A 000	**Culver City** **2.) Corrective Actions:** The following was implemented to ensure re-usable surgical instruments (SI) are packed & stored in accordance with the AORN recommended practices: 1) All re-usable surgical instruments (SI) were re-processed, packaged, and stored in accordance to AORN standards; 2) bin dividers purchased to ensure packages are stored up-right on 9/5/2014 **(Attachment: 8)**. 3) 5 inch stringers were purchased to ensure SI are completely open for processing & implemented on 8/25/2014 **(Attachment: 9)**; 4). 3 M Comply cards purchased and placed into service to ensure tip and lock boxes in peel packs maintain an open position for sterilization on 8/26/14 **(Attachment: 10)**; 5). Purchased new biological incubator and indicator with corresponding supplies for sterilization on 10/10/14; 6). Provided education/in-service to staff on standards for processing, packaging and storing of SI, this includes competency validation and return demonstration **(Attachment 11)**. **Date of Implementation:** August 20, 2014 Immediate Staff Education SI re-processing completed **Monitoring Process:** Monitoring will be managed once bimonthly by Infection Control rounds with ORT or RN (**Attachment 12)** with compliance reported to the Regulatory Compliance Committee & Quality Council to ensure AORN standards are maintained. **Person Responsible:** Infection Control/OR Director **Hollywood** **2.) Corrective Actions:** The following was implemented to ensure re-usable surgical instruments (SI) are packed & stored in accordance with the AORN recommended practices: 1) All re-usable surgical instruments (SI) were re-processed, packaged, and stored in accordance to standards; 2) bin dividers purchased and installed to ensure packages are stored up-right 9/5/2014 (**Attachment 13)** . 3). new instrument trays to accommodate the 5-6 inch stringers that were purchased to ensure SI are completely open for processing 8/25/2014 **(Attachment 14**); 4) tip protectors purchased and placed to prevent tears and penetration of peel packs 9/9/2014; 5). Purchased new biological incubator and indicator with corresponding supplies for sterilization 9/8/2014; **(Attachment 15)** 6). Provided education/in-service to staff on standards for processing, packaging and storing of SI, this includes competency validation and return demonstration. **(Attachment 16)** **Date of Implementation**: August 20, 2014 Immediate Education SI re-processed; Education incubator/indicator September 24, 2014 and repeated October 8, 2014 with competency validation and return demonstration **(Attachment 17**) **Monitoring Process:** Monitoring will be managed during bi-weekly IC rounds with ORT **(Attachment 12)** with compliance reported to the Regulatory Compliance Committee & Quality Council to ensure AORN standards are maintained. **Person Responsible:** Infection Control/OR Team	8/20/2014 8/20/2014

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□A 000□	Continued From page 1 management and CEO of the facility's Culver City campus.	□A 000□	Continued on page 1a.	
□A 263□	482.21 QAPI The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by: Based on observation, record review, and interview, the hospital failed to develop, implement, and maintain an effective quality assurance performance improvement (QAPI) program as evidenced by: 1. Failure of the QAPI program to ensure the quality program assessed the effectiveness and processes of cleaning sterilizing and packaging surgical instruments, a deficiency found at the time of a validation survey three month earlier (Refer to A 283). 2. Failure of the QAPI to identify opportunities for improvement and change in the cleaning,	□A 263□	**1.) Corrective Actions (Surgical Instruments):** All re-usable surgical instruments (SI) were re-processed, packaged, and stored in accordance to AORN standards; bin dividers were purchased to ensure packages are stored up-right on 9/5/2014. 5 inch stringers were purchased to ensure SI tips and lock boxes are completely open for processing on 8/25/2014; 3M Comply cards purchased and placed into service to ensure tip and lock boxes in open position for sterilization of peel packs on 9/9/2014; Purchased new biological incubator and indicator with corresponding supplies for sterilization on 9/8/ 2014; Provided education/in-service to staff on standards for processing, packaging/storing of SI, the use of enzymatic cleaners/proper measurements for scope re-processing, and high-level disinfection to include competency validation and return demonstration **(Refer to A-000.1).** Revision to policy SCA.025 Selection and use of packing systems for sterilization with staff education (**Attachment 1)** **Date of Implementation:** Education completed August 11, 2014 and August 20, 2014 and repeated September 22, 2014 **Monitoring Process:** Monitoring will be conducted daily by the GI/OR Team and bi-weekly through IC rounds with RN or OR technician **(Refer to A-297 for attachment 1)** Compliance will be reported to the Regulatory Compliance Committee & Quality Council on a monthly basis for a minimum of 6 months or until target benchmarks of compliance is achieved to ensure the effectiveness of the processes for cleaning, sterilizing, packaging and storage of surgical instruments. Should variance from standard practice be identified, the hospital will take immediate action to improve performance, measure the success of the improvements, and monitor performance to ensure that the improvements are sustained. **Person Responsible**: Director of OR (or designee), Director of Infection Control (or designee), and Director of Quality **2).Corrective Actions (Colonoscopes):** Purchased and installed new ventilated scope cabinets and placed them in areas with adequate ventilation for proper storage of colonoscopes; all colonoscopes now have tip protectors to ensure tips do not touch the cabinets; all colonoscopes are tagged after processing to indicate the next date to re-process if not in use. Revision to policy SGI.006 Cleaning and disinfection of endoscopes with staff education (**Attachment 2)** **Date of Implementation:** Scope cabinet installed at Hollywood September 8, 2014; Scope cabinet installed at Culver City September 15, 2014	8/11/2014 8/20/2014 9/22/2014 9/8/2014 9/15/2014

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□A 263□	Continued From page 2 maintenance and storage of colonoscopes in order to reduce the risk of patient infections from an instrument contaminated by bacteria acquired from use on previous patients (Refer to A 283). 3. Failure to have an ongoing quality appraisal and performance improvement program that addressed the complexity and scope of Nutrition and Dietetic Services. This has resulted in failure to identify issues in safe food handling practices, food storage and sanitation all of which could result in foodborne illness. Additionally, departmental staff failed to recognize inadequacies in services that could lead to unmet patient nutritional needs (Refer to A 297). The cumulative effects of these systemic problems resulted in the facility inability to assure quality health care in a safe environment.	□A 263□	**Monitoring Process:** Monitoring utilizing daily inspection of colonoscopes for next date of re-processing and after each use to ensure proper placement in the scope cabinet. Weekly monitoring of all colonoscope procedures to ensure completeness and accuracy of log **(Refer to A-000.1).** Compliance will be reported to the Regulatory Compliance Committee & Quality Council on a monthly basis for a minimum period of 6 months or until targeted benchmarks of compliance is achieved and then periodically as indicated based on PI plan to ensure the effectiveness of the cleaning, maintenance, and storage of colonoscopes in an effort to mitigate potential infection risk. Should variance from standard practice be identified, the hospital will take immediate action to improve performance, measure the success of the improvements, and monitor performance to ensure that the improvements are sustained. **Person Responsible:** Director of OR (or designee), and Director of Infection Control (or designee), Director of Quality **3). Corrective Actions (Ongoing Quality Appraisal for Dietary Services):** The hospital has enhanced its QAPI program to reflect an on-going quality appraisal of the complexity and scope of Nutrition and Dietetic Services by calling for the daily and weekly monitoring of specific indicators that would detect concerns with food handling practices, food storage, sanitation, and unmet patient nutritional needs. Continued on page 3a.	
□A 283□	482.21(b)(2)(ii), (c)(1), (c)(3) QUALITY IMPROVEMENT ACTIVITIES (b) Program Data (2) □The hospital must use the data collected to - □ ..□ (ii) Identify opportunities for improvement and changes that will lead to improvement. (c) Program Activities (1) The hospital must set priorities for its performance improvement activities that-- (i) Focus on high-risk, high-volume, or problem-prone areas; (ii) Consider the incidence, prevalence, and severity of problems in those areas; and (iii) Affect health outcomes, patient safety, and quality of care.	□A 283□		

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{A 263}	Continued From page 2 maintenance and storage of colonoscopes in order to reduce the risk of patient infections from an instrument contaminated by bacteria acquired from use on previous patients (Refer to A 283). 3. Failure to have an ongoing quality appraisal and performance improvement program that addressed the complexity and scope of Nutrition and Dietetic Services. This has resulted in failure to identify issues in safe food handling practices, food storage and sanitation all of which could result in foodborne illness. Additionally, departmental staff failed to recognize inadequacies in services that could lead to unmet patient nutritional needs (Refer to A 297). The cumulative effects of these systemic problems resulted in the facility inability to assure quality health care in a safe environment.	{A 263}	Continued from page 3 The quality appraisal consists of monitoring activity outcomes data that is submitted to the hospital□s Regulatory Compliance Committee and to it Quality Council on a monthly basis. Monitoring activity consists of the following quality appraisals: (1) Correct consistency of pureed foods (pudding-like), (2) Food items evaluated for correct temperatures, (3) Food items evaluated for palatability, (4) Stock dishware/flatware used to serve patient meals, (5) Menu recipes followed verbatim, (6) Food items have a documented recipe, (7) Food recipes provide guidance on expected consistency of finished product, (8) Perishable food items dated w/opening and expiration dates, (9) Refrigerator storage space adequate (containers stored to allow ample air circulation), (10) Freezer storage temperature w/range (0 C or less), (11) Refrigerator storage temperature w/range (32F □41F), (12) Dry storage temperature w/range (50F □70F), (13) Menus have variety, (14) Planned menus available for special diets, (15) Menus meet the needs of the patients, (16) Recipe substitutions are evaluated for nutritional adequacy, (17) Food items are of proper portion sizes, (18) Enteral feeding administered per order, (19) Closed system used for Enteral feedings, (20) Feeding tubes are dated/timed, (21) Feeding tube □hang time□ w/policy, (22) Feeding tube records evidence actual volume delivered, (23) Diet orders administered per therapeutic spreadsheet, (24) Patients receive correct diet order, (25) Unclear diet orders are clarified, (26) Sanitation practices followed (gloves changed between tasks and hand hygiene), (27) Air gaps installed on sinks, (28) Proper protection used when disposing garbage, (29) Dry wiping cloths used to dry food production equipment. **Date of Implementation:** October 28, 2014 **Monitoring Process:** Monitoring activity outcomes data **(Attachment 3)** is submitted to the hospital□s Regulatory Compliance Committee on a weekly basis and to it Quality Council on a monthly basis. Further, monitoring activity outcomes data will be reported up to the hospital□s MEC and Governing Board on a quarterly basis. Should variance from standard practice be identified, the hospital will take immediate action to improve performance, measure the success of the improvements, and monitor performance to ensure that the improvements are sustained. **Person (s) Responsible:** Director of Quality; Director of Dietary Services; Director of Infection Prevention	10/28/2014

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□A 283□	Continued From page 3 (3) The hospital must take actions aimed at performance improvement and, after implementing those actions, the hospital must measure its success, and track performance to ensure that improvements are sustained. This STANDARD is not met as evidenced by: Based on interview and record review, the hospital failed to develop, implement, and maintain an effective quality assurance performance improvement (QAPI) program as evidenced by: 1. Failure of the QAPI to identify opportunities for improvement and change in the cleaning, maintenance and storage of colonoscopes in order to reduce the risk of patient infections from an instrument contaminated by bacteria acquired from use on previous patients. 2. Failure of the QAPI program to ensure the quality program assessed the effectiveness and processes of cleaning, sterilizing and packaging surgical instruments. Findings: 1. On August 20, 2014 at 2:00 p.m., an interview of Physician 1 and review of the facility's Quality Council Management Meeting Summary report dated July 17, 2014, in regards to the activities of the Performance Improvement Committee of the Quality Council failed to reveal evidence of activities to identify opportunities for improvement and change in the cleaning, maintenance, and	□A 283□	**1).Corrective Actions:** In an effort to mitigate the risk of patient infections from instruments (colonscopes) that may contain bacteria acquired from the use of a previous patient, the hospital has enhanced its QAPI program to reflect an on-going quality appraisal of the complexity and scope of its sterile processing activities that would identify opportunities for improvement in the change in the cleaning, maintenance, and storage of colonoscopes. The quality appraisal consists of monitoring activity outcomes data that is submitted to the hospital□s Regulatory Compliance Committee and to it Quality Council on a monthly basis. Monitoring activity consists of the following quality appraisals: (1) Flexible scopes hung in a secure vertical position housed in a ventilated cabinet, (2) Flexible scope tips contain protectors and do not touch cabinet wall, (3) Flexible scopes reprocessed before use if not used w/5 days. **Date of Implementation:** August 20, 2014 **Monitoring Process:** Monitoring activity outcomes data **(Attachment 1)** is submitted to the hospital□s Regulatory Compliance Committee and to it Quality Council on a monthly basis. Further, monitoring activity outcomes data will be reported up to the hospital□s MEC and Governing Board on a quarterly basis. Should variance from standard practice be identified, the hospital will take immediate action to improve performance, measure the success of the improvements, and monitor performance to ensure that the improvements are sustained. **Person (s) Responsible:** Director of Quality: Director of Operating Room; Director of Infection Prevention. **2). Corrective Actions:** In an effort to ensure the effectiveness of its processes for cleaning, sterilizing and packaging surgical instruments, the hospital has enhanced its QAPI program to reflect an on-going quality appraisal of the complexity and scope of its sterile processing activities that would identify opportunities for improvement in the management of re-usable surgical instruments to ensure that packing and storage is in accordance with AORN standards. The quality appraisal consists of monitoring activity outcomes data **(Attachment 2)** that is submitted to the hospital□s Regulatory Compliance Committee and to it Quality Council on a monthly basis. Monitoring activity consists of the following quality appraisals: (1) Surgical instrument pouches stored in vertical manner, (2) Forceps blades open; tips not touching; lock boxes open; instruments hung on proper stringer, (3) Supplies stored as per AORN guidelines (not stacked). **Date of Implementation:** August 20, 2014 **Monitoring Process:** Monitoring activity outcomes data is submitted to the hospital□s Regulatory Compliance Committee and to it Quality Council on a monthly basis. Further, monitoring activity outcomes data will be reported up to the hospital□s MEC and Governing Board on a quarterly basis. Should variance from standard practice be identified, the hospital will take immediate action to improve performance, measure the success of the improvements, and monitor performance to ensure that the improvements are sustained. **Person (s) Responsible:** Director of Quality; Director of Operating Room; Director of Infection Prevention.	8/20/2014 8/20/2014

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□A 283□	Continued From page 4 storage of colonoscopes in order to reduce the risk of patient infections from an instrument contaminated by bacteria acquired from use on previous patients. An interview of Physician 1 on the same date and time also failed to reveal evidence of the QAPI program to ensure the quality program assessed the effectiveness and processes of cleaning, sterilizing and packaging surgical instruments (Cross reference to A 749 and A 951).	□A 283□		
□A 297□	482.21(d) QAPI PERFORMANCE IMPROVEMENT PROJECTS As part of its quality assessment and performance improvement program, the hospital must conduct performance improvement projects. (1) The number and scope of-distinct improvement projects conducted annually must be proportional to the scope and complexity of the hospital's services and operations. (2) A hospital may, as one of its projects, develop and implement an information technology system explicitly designed to improve patient safety and quality of care. This project, in its initial stage of development, does not need to demonstrate measurable improvement in indicators related to health outcomes. □ (3) The hospital must document what quality improvement projects are being conducted, the reasons for conducting these projects, and the measurable progress achieved on these projects. (4) A hospital is not required to participate in a QIO cooperative project, but its own projects are required to be of comparable effort.	□A 297□	**Hollywood** **1.) Corrective Actions:** The hospital has enhanced its QAPI program to ensure that its Dietary performance improvement activities extend beyond patient satisfaction surveys and minimal clinical nutrition by calling for a more robust quality appraisal of those concerns which may expose patients to foodborne illnesses and malnutrition. The quality appraisal, designed to evaluate the full scope services, detect variance and identify on-going opportunities for improvement, consists of monitoring activity outcomes data that is submitted to the hospital□s Regulatory Compliance Committee and to it Quality Council on a monthly basis. Monitoring activity consists of the following quality appraisals. Dietary (1) Correct consistency of pureed foods (pudding-like), (2) Food items evaluated for correct temperatures, (3) Food items evaluated for palatability, (4) Stock dishware/flatware used to serve patient meals, (5) Menu recipes followed verbatim, (6) Food items have a documented recipe, (7) Food recipes provide guidance on expected consistency of finished product, (8) Perishable food items dated w/opening and expiration dates, (9) Refrigerator storage space adequate (containers stored to allow ample air circulation), (10) Freezer storage temperature w/range (0F or less), (11) Refrigerator storage temperature w/range (32F □ 41F), (12) Dry storage temperature w/range (50F □70F), (13) Menus have variety, (14) Planned menus available for special diets, (15) Menus meet the needs of the patients, (16) Recipe substitutions are evaluated for nutritional adequacy, (17) Food items are of proper portion sizes, (18) Enteral feeding administered per order, (19) Closed system used for Enteral feedings, (20) Feeding tubes are dated/timed, (21) Feeding tube □hang time□w/policy, (22) Feeding tube records evidence actual volume delivered, (23) Diet orders administered per therapeutic spreadsheet, (24) Patients receive correct diet order, (25) Unclear diet orders are clarified, (26) Sanitation practices followed (gloves changed between tasks and hand hygiene), (27) Air gaps installed on sinks, (28) Proper protection used when disposing garbage, (29) Dry wiping cloths used to dry food production equipment. **Date of Implementation:** October 24, 2014 **Monitoring Process:** Monitoring activity outcomes data is submitted to the hospital□s Regulatory Compliance Committee	10/24/2014

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□A 297□	Continued From page 5 This STANDARD is not met as evidenced by: Hollywood, Culver City and Van Nuys Campuses In an interview on 8/21/14 beginning at 9 a.m., with Staff A (Hospital Administrator), Staff L (Director .of Food Service), RD (Registered Dietitian) 1, 2, 3 and Staff W (Director, Quality) and concurrent review of performance indicators beginning January 2014 revealed the following improvement activities: 1. At the Hollywood campus, performance improvement activities were limited to data collected through patient satisfaction surveys that included the timeliness of meals served, food temperatures and overall rating of food. With respect to clinical nutrition, care data collection included the timeliness of Registered Dietitian (RD) assessment and accuracy of diet It was noted that for 2014 the hospital's goal was met for all elements; however, the follow up action was to continue to monitor, despite the lack of identification of opportunities for improvement No new activities were identified for improvement for the current year. RD 1 acknowledged that with the majority of these indicators the department was meeting or exceeding the departmental set thresholds. She also stated that within the last several years the department had not identified new issues that □ may warrant a performance improvement study. It was also noted, there was no evaluation of the effectiveness of food handling systems within the department There have been deficient practices in the areas of food service operation and clinical nutrition services identified by the survey team at the initial	□A 297□	and to it Quality Council on a monthly basis. Further, monitoring activity outcomes data will be reported up to the hospital□s MEC and Governing Board on a quarterly basis. Should variance from standard practice be identified, the hospital will take immediate action to improve performance, measure the success of the improvements, and monitor performance to ensure that the improvements are sustained. (**Attachment 1)** **Person (s) Responsible:** Director of Quality; Director of Dietary Services; Director of Infection Prevention. **Culver City** **2.) Corrective Actions:** The hospital has enhanced its QAPI program to ensure that it evaluates the full scope of Dietary services to ensure that **corrective action** is implemented when variance is detected and to ensure that an evaluation of the effectiveness of those **corrective action** interventions is performed. The hospital has implemented a quality appraisal that is designed to evaluate the full scope of services, detect variance and identify on-going opportunities for improvement. The quality appraisal is inclusive of on-going monitoring activity which consists of the reporting of outcomes to the hospital□s Regulatory Compliance Committee and to its Quality Council on a monthly basis. Monitoring activity consists of the following quality appraisals: (1) Correct consistency of pureed foods (pudding-like), (2) Food items evaluated for correct temperatures, (3) Food items evaluated for palatability, (4) Stock dishware/flatware used to serve patient meals, (5) Menu recipes followed verbatim, (6) Food items have a documented recipe, (7) Food recipes provide guidance on expected consistency of finished product, (8) Perishable food items dated w/opening and expiration dates, (9) Refrigerator storage space adequate (containers stored to allow ample air circulation), (10) Freezer storage temperature w/range (0F or less), (11) Refrigerator storage temperature w/range (32F □ 41F), (12) Dry storage temperature w/range (50F □ 70F), (13) Menus have variety, (14) Planned menus available for specia diets, (15) Menus meet the needs of the patients, (16) Recipe substitutions are evaluated for nutritional adequacy, (17) Food items are of proper portion sizes, (18) Enteral feeding administered per order, (19) Closed system used for Enteral feedings, (20) Feeding tubes are dated/timed, (21) Feeding tube □hang time□ w/policy, (22) Feeding tube records evidence actual volume delivered, (23) Diet orders administered per therapeutic spreadsheet, (24) Patients receive correct diet order, (25) Unclear diet orders are clarified, (26) Sanitation practices followed (gloves changed between tasks and hand hygiene), (27) Air gaps installed on sinks, (28) Proper protection used when disposing garbage, (29) Dry wiping cloths used to dry food production equipment. The hospital will continue to review its QAPI program for opportunities to further enhance it to target opportunities for improvement and mitigation of identified issues. **Date of Implementation**: October 24, 2014 **Monitoring Process:** Monitoring activity outcomes data is submitted to the hospital□s Regulatory Compliance Committee and to it Quality Council on a monthly basis. Further, monitoring activity outcomes data will be reported up to the hospital□s MEC and Governing Board on a quarterly basis.	10/24/2014

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□A 297□	Continued From page 6 and subsequent validation visits such as incorrec consistencies for pureed diet, equipment failures staff in competencies that could have been used to develop new performance improvement activities. 2. At the Culver City campus, review of the Performance Improvement document showed staff tracking the implementation of RD recommendations and timeliness of nutrition interventions. It was noted that while actions were put into effect in both of these instances, the effectiveness of the interventions were not fully evaluated, rather the follow up was to continue to monitor. The hospital failed to evaluate and implement **corrective actions** in areas where problems had been identified. It was also noted that since January 2014 the temperature of patient food at the time of service was reviewed and was found to be below the hospital goal. It was noted that proper refrigeration was the basis of the problem; however as of 8/21/14 the issue had not yet been fully resolved. 3. At the Van Nuys campus, the improvement activities included diet accuracy, overall rating of food, timely RD assessment, food temperatures and timeliness of meal service. It was noted that all the parameters with the exception of 1 month with respect to meal timeliness the facility met the goal for all elements. It was noted that overall the hospital failed to demonstrate a performance improvement program that fully represented the scope and nature of the departmental functions. While campus wide data was collected, the majority of the data did not demonstrate opportunities for improvement. It was also noted that in areas	□A 297□	Should variance from standard practice be identified, the hospital will take immediate action to improve performance, measure the success of the improvements, and monitor performance to ensure that the improvements are sustained. (**Attachment 1**) **Person (s) Responsible:** Director of Quality; Director of Dietary Services; Director of Infection Prevention. **Van Nuys** **3.) Corrective Actions:** The hospital has enhanced its QAPI program to ensure that it evaluates the full scope of Dietary services to ensure that **corrective action** is implemented when variance is detected and to ensure that an evaluation of the effectiveness of those **corrective action** interventions is performed. The hospital has implemented a quality appraisal that is designed to evaluate the full scope of services, detect variance and identify on-going opportunities for improvement. The quality appraisal is inclusive of on-going monitoring activity which consists of the reporting of outcomes to the hospital□s Regulatory Compliance Committee and to it Quality Council on a monthly basis. Monitoring activity consists of the following quality appraisals: (1) Correct consistency of pureed foods (pudding-like), (2) Food items evaluated for correct temperatures, (3) Food items evaluated for palatability, (4) Stock dishware/flatware used to serve patient meals, (5) Menu recipes followed verbatim, (6) Food items have a documented recipe, (7) Food recipes provide guidance on expected consistency of finished product, (8) Perishable food items dated w/opening and expiration dates, (9) Refrigerator storage space adequate (containers stored to allow ample air circulation), (10) Freezer storage temperature w/range (0F or less), (11) Refrigerator storage temperature w/range (32F □ 41F), (12) Dry storage temperature w/range (50F □ 70F), (13) Menus have variety, (14) Planned menus available for special diets, (15) Menus meet the needs of the patients, (16) Recipe substitutions are evaluated for nutritional adequacy, (17) Food items are of proper portion sizes, (18) Enteral feeding administered per order, (19) Closed system used for Enteral feedings, (20) Feeding tubes are dated/timed, (21) Feeding tube □hang time□ w/policy, (22) Feeding tube records evidence actual volume delivered, (23) Diet orders administered per therapeutic spreadsheet, (24) Patients receive correct diet order, (25) Unclear diet orders are clarified, (26) Sanitation practices followed (gloves changed between tasks and hand hygiene), (27) Air gaps installed on sinks, (28) Proper protection used when disposing garbage, (29) Dry wiping cloths used to dry food production equipment. The hospital will continue to review its QAPI program for opportunities to further enhance it to target opportunities for improvement and mitigation of identified issues. **Date of Implementation:** October 24, 2014 **Monitoring Process:** Monitoring activity outcomes data is submitted to the hospital□s Regulatory Compliance Committee and to it Quality Council on a monthly basis. Further, monitoring activity outcomes data will be reported up to the hospital□s MEC and Governing Board on a quarterly basis. Should variance from standard practice be identified, the hospital will take immediate action to improve performance, measure the success of the improvements, and monitor	10/24/2014

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□A 297□	Continued From page 7 where opportunities for improvement were identified, there were no timely interventions to mitigate the identified issue.	□A 297□	performance to ensure that the improvements are sustained. **(Attachment 1)** **Person (s) Responsible:** Director of Quality; Director of Dietary Services; Director of Infection Prevention.	
□A 500□	482.25(b) DELIVERY OF DRUGS In order to provide patient safety, drugs and biologicals must be controlled and distributed in accordance with applicable standards of practice, consistent with Federal and State law. This STANDARD is not met as evidenced by: Based on observations, interviews and records review, the facility failed to properly label the drawers of the fifth and fourth floors crash carts. This deficient practice had the potential to cause delay during an emergency situation that required the use of crash carts. Findings: Hollywood Campus On 8/18/14 at 10 a.m., on the fifth floor, during a crash cart inspection with Pharm 2 (director of pharmacy) , the contents of drawer □1 of the Crash Cart did not match the label affixed to the exterior of the drawer. Pharm 2 stated the nursing leadership was in the process of reorganizing the crash cart contents. At 10:20 a.m., during another crash cart inspection on the fourth floor with Pharm 2, Pharm 2 acknowledged that the label affixed to the exterior of the drawer□1 was also old and not accurate. A comparison of the crash cart content list and the label affixed to the drawers revealed that	□A 500□	**Hollywood** **1).Corrective Actions:** The fifth and fourth floor crash cart drawers have been labelled and updated with appropriate list of medications matching labels on medication drawers. Staff in servicing **(Attachment 1 & 2)** **Date of Implementation:** August 22, 2014 **Monitoring Process:** Monthly nursing unit inspection by pharmacy department to make sure medication list is in place and matches list of medications inside the crash cart. **(Attachment: 3)** **Person Responsible**: Pharmacy/ Nursing	8/22/2014

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□A 500□	Continued From page 8 three out of the thirty medications listed on the label were not on the content list. Also, one of out of the thirty medications was listed in a different strength. A review of the facility's policy and procedure, titled "Crash Cart," Number: PAT.058, dated 11/2012, indicated " ...the pharmacist shall check the drug and IV contents ... and apply a label to the outside of the cart ... A list of the crash cart medications□ shall be kept on the outside of the cart ... " This is a repeat deficiency from the sample validation survey completed on 4/1/14.	□A 500□		
□A 502□	482.25(b)(2)(i) SECURE STORAGE All drugs and biologicals must be kept in a secure area, and locked when appropriate. This STANDARD is not met as evidenced by: Based on observations, interviews and documents review, the facility failed to ensure medication storage areas are accessible only to the authorized facility staff. This deficient practice had the potential for unauthorized person to access medication storage areas. Findings: Hollywood Campus On 8/18/14 at 10:15 a.m. on the fifth floor, during an inspection of the medication room with Pharm 2 (director of pharmacy), the surveyor was able to push open the door to the medication room without deactivating the keypad lock on that door.	□A 502□	**Hollywood** **1).Corrective Actions:** Medication room locks were changed to card readers. Card readers were provided to authorized personnel only. **(Attachment 1)**. Policy (PHA0.24) for □Drug administration: Who may administer and have an access to medications□was updated in September 2014 **(Attachment 2)**. Staff in-service **(Attachment 3)** **Date of Implementation:** September 18, 2014 **Monitoring Process:** Monthly nursing unit inspection **(Attachment 4)** **Person Responsible:** Pharmacy/ Nursing	9/18/2014

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□A 502□	Continued From page 9 In addition, the access door from the nursing station leading to the medication room was not locked. According to the facility policy, titled, "Storage of Medications," Number: PHA.090, dated 10/2012, " ... Medications are to be stored in locked areas not accessible to unlicensed persons ... " In reference to the California Code of Regulations, Title 22, section 70263 (q) (8)," Drugs shall be accessible only to responsible personnel designated by the hospital ..." This is a repeat deficiency from the sample validation survey completed on 4/1/14.	□A 502□		
□A 504□	482.25(b)(2)(iii) ACCESS TO LOCKED AREAS Only authorized personnel may have access to locked areas. This STANDARD is not met as evidenced by: Based on observations, interviews and documents review, the facility failed to ensure the passcode to a locked area was kept secure. There was a passcode written on a limited access door that led to a medication storage area, which made the locked area no longer secured. Findings: On 8/18/14 at 10:40 a.m., on the third floor hallway, the surveyor noticed a door with a keypad lock and a sign "Clean utility." At the top right corner of the door, there was a group of four digits written on the surface. The surveyor	□A 504□	**Hollywood** **1).Corrective Actions**: Security code written on the third floor Clean Utility door was removed immediately. **(Attachment 1)** Third floor Clean Utility room locks were changed to card readers. Card readers were provided to authorized personnel only. **Date of Implementation**: August 18, 2014 **Monitoring Process:** Monthly nursing unit inspection **Person Responsible:** Nursing	8/18/2014

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□A 504□	Continued From page 10 pointed that out to the accompanying Pharm 2 (Director of Pharmacy), Pharm 2 said the four digits were the passcode to the keypad lock for that door. Pharm 2 then proceeded to punch in the code and opened the door. Behind the door, there was the Omnicell (an automated drug cabinet). Then, around the corner, there was the medication room that stored large volumes and other miscellaneous medications that were not stored inside the Omnicell. On 8/20/14, at 10:30 a.m., the Pharm 1 (Vice President Pharmacy Operations) confirmed that there was no policy and procedure on safeguarding the access codes to limited access areas.	□A 504□		
□A 618□	482.28 FOOD AND DIETETIC SERVICES The hospital must have organized dietary services that are directed and staffed by adequate qualified personnel. However, a hospital that has a contract with an outside food management company may be found to meet this Condition of Participation if the company has a dietitian who serves the hospital on a full-time, part-time, or consultant basis, and if the company maintains at least the minimum standards specified in this section and provides for constant liaison with the hospital medical staff for recommendations on dietetic policies affecting patient treatment. This CONDITION is not met as evidenced by: Based on observation, review of facility documents and staff interviews, the hospital failed to ensure that the food and dietetic department was organized in a manner appropriate to the scope and complexity of the food service	□A 618□		

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□A618□	Continued From page 11 operations. As a result of the deficient practices identified during August 18-21, 2014 inspection, the hospital failed to ensure that the department was organized in a manner to ensure that dietary services met the needs of all patients as evidenced by failure to: 1. Provide organized dietetic services as evidenced by findings of unsafe food handling practices (Refer to A 620, A628). 2. Ensure meal portions were accurate, menus and preparation methods were in compliance with nationally recognized practices (Refer to A 630). 3. Plan menus for all physician ordered diets (Refer to A 628). 4. Lack of an effective system to ensure that physician ordered diets were followed (Refer to A 628). 5. Ensure safe and effective food storage/production practices (Refer to A 620, A 749). 6. Ensure adequate food on hand for use in an emergency (Refer to A 701). 7. Failure to have an ongoing quality appraisal and performance improvement program that addressed the complexity and scope of Nutrition and Dietetic Services (Refer to A 267). 8. Ensure that there was adequate ventilation and proper temperature controls in the kitchen and dry food storage areas (Refer to A 726). 9. Failure to maintain refrigerators, freezers, plate warmer and supplies to an acceptable level of safety and quality (Refer to A724, A 726). The cumulative effects of these systemic problems resulted in the facility's inability of the	□A618□	**1). Corrective Actions:** unsafe food handling: As of 10-4-14, contracted food and dietetic services management company was secured to provide a consistent organized approach to services for FNS for all three campuses. This includes a consistent organized same policies, procedures and manuals used for all three campuses. In service was provided to staff in related to proper safe food handling per the 2013 Food Code. Competency of staff was assessed individually (1:1 competency assessment) **(Attachment 1 & 2)** Competency validation **(Attachment 3)** **Date of Implementation:** 6/20/2014 to 10/23/2014 **Monitoring Process:** Food handling practices are monitored monthly by Infection Control through kitchen inspection and observation of employee□s performance. **Person Responsible:** Directors of Food Service, RD, Infection Control. **2). Corrective Actions:** (Meal Portions accurate menus & preparation methods in compliance with nationally recognized standards) New menus have been implemented to include accurate portions and standardized recipes with preparation methods that meet nationally recognized standards. Food & Nutrition Policy FNS. B016 Standardized Recipes illustrating the requirement to use standardized recipes and the components of a recipe including preparation instructions has been adopted in all facilities under the license. The menus and nutritional analysis of menus were approved by the Pharmacy & Therapeutics committee, Med Executive Committee and Governing Board. Staff training included the reading of menu spreads, standardized recipes and portion control. (**Attachment 4)** **Date of Implementation**: August 22- September 16 2014 **Monitoring Process:** The meal portions and preparation methods were observed as part of the tray accuracy monitoring noting portion, taste and appearance. 100% of trays were monitored for accuracy during menu implementation until 90% or better accuracy was achieved **(Attachment 5)**. Ongoing monitoring of tray accuracy will continue to be monitored with a minimum of 100 trays per week as part of the department performance improvement program and appropriate action for compliance meets the standard of 97% trays meet accuracy standards. Results of monitoring and actions taken to improve compliance are reported monthly to the Facility Quality Council, Med Executive committee and Governing Board. **Person Responsible:** RD, Director of Dietary Department and Clinical Dietitian RD Continued on page 12a.	6/20/2014 8/22/2014

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A618	Continued From page 11 operations. As a result of the deficient practices identified during August 18-21, 2014 inspection, the hospital failed to ensure that the department was organized in a manner to ensure that dietary services met the needs of all patients as evidenced by failure to: 1. Provide organized dietetic services as evidenced by findings of unsafe food handling practices (Refer to A 620, A628). 2. Ensure meal portions were accurate, menus and preparation methods were in compliance with nationally recognized practices (Refer to A 630). 3. Plan menus for all physician ordered diets (Refer to A 628). 4. Lack of an effective system to ensure that physician ordered diets were followed (Refer to A 628). 5. Ensure safe and effective food storage/production practices (Refer to A 620, A 749). 6. Ensure adequate food on hand for use in an emergency (Refer to A 701). 7. Failure to have an ongoing quality appraisal and performance improvement program that addressed the complexity and scope of Nutrition and Dietetic Services (Refer to A 267). 8. Ensure that there was adequate ventilation and proper temperature controls in the kitchen and dry food storage areas (Refer to A 726). 9. Failure to maintain refrigerators, freezers, plate warmer and supplies to an acceptable level of safety and quality (Refer to A724, A 726). The cumulative effects of these systemic problems resulted in the facility's inability of the	A618	**3) Corrective Actions**: Menus are available for all standard physician ordered diets. New menus for all standard physician ordered diets have been revised and implemented and are available via R.D. approved menu spreadsheets. Diets other than those on the standard list of diets are calculated as needed by a Registered Dietitian. Staff educated on revised menus **(Attachment 4)** **Date of Implementation**: Van Nuys: 8-22-14; Hollywood 9-15-14; Culver City 8-22 -14 **Monitoring Process:** Physician ordered diets are being reviewed for menu availability and order accuracy. Any discrepancies are brought to the attention of a registered dietitian for diet order clarification or menu creation. Results of order accuracy are being reported on a monthly basis to the Quality Council, Medical Executive Committee and Governing Board. **Person Responsible:** RD, Director of Dietary Department and Clinical Dietitian RD	8/22/2014 9/15/2014

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	050135	A. BUILDING _____ B. WING _____	08/21/2014

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SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	6245 DE LONGPRE AVE HOLLYWOOD, CA 90028

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A618	Continued From page 11 operations. As a result of the deficient practices identified during August 18-21, 2014 inspection, the hospital failed to ensure that the department was organized in a manner to ensure that dietary services met the needs of all patients as evidenced by failure to: 1. Provide organized dietetic services as evidenced by findings of unsafe food handling practices (Refer to A 620, A628). 2. Ensure meal portions were accurate, menus and preparation methods were in compliance with nationally recognized practices (Refer to A 630). 3. Plan menus for all physician ordered diets (Refer to A 628). 4. Lack of an effective system to ensure that physician ordered diets were followed (Refer to A 628). 5. Ensure safe and effective food storage/production practices (Refer to A 620, A 749). 6. Ensure adequate food on hand for use in an emergency (Refer to A 701). 7. Failure to have an ongoing quality appraisal and performance improvement program that addressed the complexity and scope of Nutrition and Dietetic Services (Refer to A 267). 8. Ensure that there was adequate ventilation and proper temperature controls in the kitchen and dry food storage areas (Refer to A 726). 9. Failure to maintain refrigerators, freezers, plate warmer and supplies to an acceptable level of safety and quality (Refer to A724, A 726). The cumulative effects of these systemic problems resulted in the facility's inability of the	A618	**7) Corrective Actions:** A quality appraisal and performance improvement program has been revised to include measures to monitor: 1) RD timeliness of nutrition assessments, 2) Patient Tray Quality Factors- ie 3). Temperature, taste, appearance; 4). Patient tray accuracy of preparation; 5). MD order accuracy and 6). Food labeling and storage practices; and 7). RD Recommendations Acknowledgement by Physicians. **(Attachment 9)** **Date of Implementation**: September 20, 2014 Monitoring Process: Daily, weekly and monthly data collection with analysis of data and creation of action steps related to continuous improvement of items being monitored. **Person Responsible:** RD, Director of Dietary Department and RD, Clinical Dietitians	9/20/2014

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□A 618□	Continued From page 12 hospital's food and nutrition services to direct the staff in such a manner to ensure that the nutritional needs of the patients were met in accordance with the physician's orders and acceptable standard of practice.	□A618□		
□A 620□	482.28(a)(1) DIRECTOR OF DIETARY SERVICES The hospital must have a full-time employee who- (i) Serves as director of the food and dietetic services; (ii) Is responsible for daily management of the dietary services; and (iii) Is qualified by experience or training. This STANDARD is not met as evidenced by: Based on observations, review of hospital documents, and staff interviews, the facility failed to ensure that persons in the position of food service director demonstrated authority for the direction of the food and dietary service. There were deficient practices in all three campuses in the one or more of the following areas: safety practices for food handling, emergency food supplies, personnel performance, menu planning, purchasing of foods and supplies and quality assurance performance improvement (QAPI). Findings: Hollywood Campus 1. On 8/18/14 beginning at 11:45 a.m., Dietary Staff (DS) 2 was observed preparing pureed green beans. It was noted that he placed 4 cups of cooked green beans in the blender after which he added 16 ounces of fluid. He was then	□A 620□	**All Campuses** **Corrective Action:** For Culver City facility identified a Director of Food and Nutritional Services (RD); Hollywood facility identified a Director of Food and Nutritional Services (RD); Van Nuys facility identified a Director of Food and Nutritional Services (RD). All three directors have assumed the leadership role for dietary services. **Hollywood** **1). Corrective Action:** New menus have been implemented to include accurate portions and standardized recipes with preparation methods that meet nationally recognized standards. Staff has been in-serviced on proper preparation of menu items including purees and the use of thickeners and the importance of following standardized recipes. Competency testing and return demonstration has been conducted **(Attachment 1).** Food & Nutrition Policy FNS. B016 Standardized Recipes illustrating the requirement to use standardized recipes and the components of a recipe including preparation instructions has been implemented in all three facilities. The new menus and nutritional analysis of specified portions and standardized recipes with appropriate preparation methods were approved by the committees.	

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□A 620□	Continued From page 13 observed pouring the green beans into a steam pan. The resultant texture of the item was a grainy liquid resembling runny applesauce. Concurrent observation also noted that the pureed meat was of a similar consistency. OS 2 utilized a soup ladle to portion the pureed meat and vegetables into individual plastic cups. On 8/18/14 beginning at 11:30 a.m., meal production was observed. OS 2 was preparing green beans by draining them into a colander and placing them on the steam table. There was no observation for the addition of margarine or spices to the beans. At 12:15 p.m., meal distribution was observed. It was noted that the roast beef being served was surrounded by a clear broth-like fluid and the green beans appeared to have a dried exterior texture. Review of recipe titled, □Roast Beef□revealed that in addition to the meat the recipe called for 1 teaspoon of garlic powder and 1 teaspoon of black pepper for a 24 pound roast. While each of these spices could add flavor to the item, the quantity of 1 teaspoon each would have no discernable flavor once the item was cooked. Similarly the recipe titled, "Green Beans" called for 1 cup of margarine, 2-1/4 teaspoons of salt and % teaspoon of pepper for 75 servings. The amount of salt and pepper would have not have had any impact on the flavor of the food. On 8/18/14 at 1:05 p.m., as a result of these observations, a test tray for taste and temperature was completed. The temperatures of the items were as follows: roast beef 115□ (degrees) F (Fahrenheit), green beans - 110°F milk- 52□F and tapioca- 64°F. In addition to recording food temperatures each of the items was tasted. It was noted that the roast beef and	□A 620□	**Date of Implementation:** August 22- September 16 2014 **Monitoring Process:** The portions, appearance, taste and temperatures of menu items made using specified preparation methods are observed as part of the tray quality assessment monitoring **(Attachment: 2)**. Test tray quality assessments are performed at a minimum of 3-5 times per week and results are reported monthly to Quality. **Person Responsible:** RD, Director of Dietary Department and Clinical Dietitian RD	8/22/2014

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□A 620□	Continued From page 14 green beans were lukewarm. The roast beef was not tender and both the roast beef and green beans were bland. Similarly the items intended to be served cold such as the milk were warm. A test tray was also completed for the pureed items. It was noted that the items were grainy, watery (consistency of soup) with a bland flavor. In a follow up observation on 8/18/14 beginning at 5:15 p.m., the evening meal entree consisted of roasted chicken, garden rice and carrots. It was noted that the garden rice was substituted with plain white rice. It was also noted that the consistency of the pureed items was similar to the noon meal, a liquid consistenc y: A taste sampling was done on 8/18/14 at 5:45 p.m. It was noted that the carrots and pureed rice were watery and had no flavor. The pureed chicken had a gritty texture and was not flavorful either. In a concurrent interview Staff L (Director of Food Services) stated that she had substituted plain canned chicken for the roasted. The roasted chicken and canned pureed chicken were not similar in flavor. Pureeing the roasted chicken served to patients on a regular diet would have been more flavorful than the canned pureed chicken. Document review on 8/18/14 beginning at 5:45 p.m., of the pureed green bean recipe revealed that staff should have added a food thickener to the product. It was also noted that the recipe failed to provide any guidance on the expected consistency of the finished product. According to the Academy of Nutrition and Dietetics' Nutrition Care Manual titled, "Nutrition Therapy for Pureed Diet," "Food should be "pudding-like" ...Be sure that any pureed foods prepared in advance the consistency of pudding or moist mashed	□A 620□		

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□A 620□	Continued From page 15 potatoes." Under the heading Cooking Preparation Tips it states, "when pureeing or blenderizing foods, add as little fluid initially as possible." The issue with the preparation of incorrect consistency of pureed food was identified in the previous survey. Review of departmental document titled, "Garden Rice" dated 2/5/05 noted that the rice should have contained sauteed onions, bay leaves and chicken soup base. No explanation was provided as to why the recipe for "Garden Rice" was not followed. Review of departmental policy and procedure manual on 8/18/14 failed to reveal a policy for evaluation of temperature and palatability of food items. In a concurrent interview with Staff L at 5:35 p.m., she stated the expectation was that hot food was 140□F or greater when patients receive their trays and cold foods should be 41oF or below and acknowledged that the pureed items were not tasteful. She also stated that to her knowledge there was no departmental mechanism for evaluating the quality of patient meals□ She further stated she had identified the consistency of pureed items as an issue; however had not provided interventions or guidance to dietary staff on the proper preparation method and desired consistency for the pureed items. Disposable Plates During food distribution observations on 8/18/14 beginning at 3:35 p.m., all patient meals were plated using disposable plates, cups and flatware. In a concurrent interview with Staff L, she stated that staff told her the plate warmer was broken. The surveyor asked for an explanation of why a broken plate warmer would cause the hospital to	□A 620□	**Disposable Plates** **2). Corrective Action:** Available china ware in storage was put into service. Additional china plates and reusable meal tray service ware were purchased. The plate warmer was replaced **(Attachment 3).** Induction heated base unit and china plates, base and dome lids were replaced Additional stock is available to be used for increased patient census. **Date of Implementation:** 8/20/14 **Monitoring Process:** Observation of patient meal assembly to ensure that reusable service ware is used for all patients. Patient with restriction or safety concerns (exhibit aggressive behavior or isolation per policy) will be served in disposable dinnerware. **Person Responsible:** RD, Director of Dietary Department	8/20/2014

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□A 620□	Continued From page 16 utilize all disposable items. She was unable to explain the rationale in response to the use of plates in the absence of a plate warmer. She also acknowledged that during the past 2 weeks, when she took over the position, she had not observed a stock of any dishware or flatware. The use of the disposable plates does not enhance dignity and contributes to the inability to maintain food temperatures. Most food temperature maintenance systems usually includes the use of insulated container and plates that will either generate heat to keep food hot during delivery, or absorb heat to keep food cold during delivery. Disposable plates do not insulate or retain heat. Menu On 8/18/14 beginning at 5:30 p.m., it was noted that the dessert for the evening meal was listed as jello jewels. Concurrent trayline observation revealed patients received a cup portion of plain red jello. It was not clear what "jello jewels" meant on the menu and whether the menu was correctly served. In an interview with OS 3 and concurrent review of the departments' standardized recipes on 8/18/14 at 5:45 p.m., revealed that there was no recipe for this dessert item. Sanitation On 8/18/14 at 11:30 am, OS 2 was observed loading dirty trays with her gloved hands. She was also observed unloading clean trays with the same gloved hand. She was not observed to change gloves, wash her hands, and put on new gloves before proceeding to unload clean trays. A review of the hospital policy titled, "Disposable Glove Use" dated 4/25/12 indicated "Disposable gloves must be changed when dirty or ripped and	□A 620□	**Menu** **3). Corrective Action**: Menus have been implemented to include accurate portions and standardized recipes for all menu items that meet nationally recognized standards. **Date of Implementation:** September 4- September 16, 2014 **Monitoring Process:** 100% of trays are monitored for accuracy of menu implementation with 90% or better rate of compliance. Ongoing monitoring of tray will continue at a 100 trays per week as part of the department performance improvement program. The taste and temperature of patient meal trays is assessed through test tray quality assessment evaluations. Results of monitoring are reported to Quality. **Person Responsible:** RD, Director of Dietary Department and Clinical Dietitian RD **Sanitation** **4). Corrective Action:** Kitchen staff was trained on the policy of glove use and requirement to remove gloves and wash hands after handling dirty dishes and prior to handling clean dishes. Competency and return demonstration was conducted (**Attachment 4)**. Policy FNS F021 Disposable Glove Use. (**Attachment 5)** **Date of Implementation:** September 11, 2014 Oct 23, 2014 **Monitoring Process:** Competency and return demonstration on glove usage. Daily Management Food Service Rounds and the Monthly Infection Control rounding. **Person Responsible:** RD, Director of Dietary Department	9/4/2014 9/11/2014

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□A 620□	Continued From page 17 when moving from one task to another " . Culver City Campus Disposable Plates During food distribution observations on 8/19/14 beginning at 12 p.m., a large percentage of patient meals were delivered on disposable paper plates. In a concurrent interview with DS 7, he stated the patients on the behavioral health unit received paper products and as for the rest of the patients it would depend on the item. He also stated there was a limited number of non-disposable dishware. In an observation on 8/19/14 beginning at 2:45 p.m., there were less than 150 plates within the hospital. During the general dietetic observations on 8/20/14 beginning at 3:30p.m., there were greater than 10 cases of dishware in a chemical closet located in 'the loading dock area. In a concurrent interview with RD (Registered Dietitian) 3, he stated that the hospital planned to reopen the labor and delivery unit and planned to enhance the meal service for this unit. He was unable to verbalize why specifically this unit would receive non-disposable dishware, yet other inpatient units (with the exception of the behavioral health unit) would continue t6 receive disposable dishware. Hospital policy titled, "Patient Food Service" dated 5/14 noted that "Food shall be served ...with appropriate eating utensils ... " Hospital policy titled, "Objective for Patient- Resident Tray Service" dated 4/12 indicated " ...Equal emphasis will be placed on dining program regardless of the level of care." Food Storage During the food storage observation on 8/19/14 beginning at 2 p.m., there were issues	□A 620□	**Culver City** **1). Corrective Action:** Available china ware in storage was put into service. Additional china plates and reusable meal tray service ware were purchased (**Attachment1**). Additional stock is available to be used for increased patient census. **Date of Implementation:** 8/20/14 **Monitoring Process:** Observation of patient meal assembly to ensure that reusable service ware is used for all patients. Patient with restriction or safety concerns (exhibit aggressive behavior or isolation per policy) will be served in disposable dinnerware. **Person Responsible**: RD, Director of Dietary Department	8/20/2014

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□A 620□	Continued From page 18 surrounding storage and dating of perishable foods. In Refrigerator □1, there were vegetarian hot dogs opened, no date; liquid whole eggs that were thawed, undated; 3 cases of potatoes with manufacturers' guidance to keep frozen. It was also noted there were 2 cases of raw, thawed chicken that were pulled from the freezer on 8/12/14 with a use by date of 8/22/14 (10 days later). In a concurrent interview with RD 3, he was asked to describe the holding time for thawed, raw meat products. RD 3 stated he was unsure; however would refer to the food storage guidelines. He also stated that the expectation would be that all items are labeled and dated once opened. Concurrent review of departmental document titled, "Refrigerated Storage Life of Foods" dated 3/24/14 noted that thawed meats were not to be held for a period greater than 5 days. Department policy titled, "Food Supply and Storage" dated 11/12 noted that "Orange label must be used on all foods ...Items included on label: Date, ...Expiration Date, ... " Trays During the general kitchen observations on 8/19/14 beginning at 2:50 p.m., there were greater than 10 patient meal delivery trays that were cracked and had exposed metal edges. It would be the standard of practice to ensure that all patient meal delivery utensils be free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections (Food Code, 2013). Van Nuys Campus □ Food Storage During observation on 8/19/14 starting at 11:15 a.m., there were observed food storage concerns including inadequate refrigerator storage space,	□A 620□	**Food Storage** **2). Corrective Actions:** The open vegetarian hot dogs with no date were immediately discarded; liquid whole eggs that were thawed undated were discarded; 3 case of potatoes with manufacture guidance to keep frozen & 3 case of raw and thawed chicken that were pulled from freezer 8-12 to be used by 8-22-14 were discarded. All other food items in the kitchen were reviewed, labeled and dated per policy. Staff was in-serviced on labeling dating, food items and thawing with monitoring. **(Attachment-2 & 3)** **Date of Implementation:** August 19, 2014 **Monitoring Process:** Daily inspection by dietary management will be documented on the Supervisor Opening & Daily Check list **(Attachment 3)**. **Person Responsible:** RD, Director of Dietary Department and Executive Chef **Trays** **3). Corrective Actions:** Patient meal trays identified as being cracked with exposed metal edges were immediately removed from service. Replacement trays were removed from storage and put into service. Staff was in-serviced on identifying damaged trays and discarding them. **(Attachment 2)** **Date of Implementation:** October 23, 2014 **Monitoring Process:** The condition of trays will be observed as part of the Routine Infection Control (**Attachment 4**). **Person Responsible:** RD, Director of Dietary Department **Van Nuys** **1). Corrective Action:** Daily monitoring of all storage locations (refrigerators, freezers, and dry storage spaces) will be monitored by kitchen staff and recorded in a log. Rental of a refrigerator truck acting as a supplemental refrigerator storage space is replacing the out of order refrigerator on 9-5-14. **Date of Implementation:** August 22, 2014 **Monitoring Process:** Daily monitoring of refrigerated and frozen food storage locations and the dry food storage location. **Person Responsible:** RD, Director of Dietary Department	8/19/2014 10/23/2014 8/22/2014

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□A 620□	Continued From page 19 improper freezer storage temperatures, and improper dry food storage temperatures. Inadequate refrigerator space is evidenced by the stacking of food and plastic storage food containers on top of another in a manner that did not allow ample air circulation. There was another refrigerator that was labeled "Out of Order" dated 6/4/14. In an interview on 8/19/14 at 4:30p.m. with the Head of Plant Operations, he stated that two weeks earlier the hospital decided that repairing the refrigerator was not ideal because it was too expensive and replacement was more practical. One of the freezers (□5) was observed to read 23 degrees Fahrenheit. According to the hospital policy titled, "Food Storage" dated November 2012, " Frozen foods are stored in the freezer and the temperature is maintained at 0 degrees Fahrenheit or less. Produce is stored in the refrigerator and the temperature is maintained at 32 to 41 degrees Fahrenheit." Foods held at less than optimum temperatures could support the growth of microorganisms that promote spoilage and /or food borne illness. The impact of the inadequate refrigerated space was demonstrated when patients were served cottage cheese instead of milk for lunch on 8/19/14. According to the menu, the patients were to receive Tossed green salad, Baked Fish with lemon, parsley noodles, mixed vegetables, dinner roll, fresh fruit and milk for lunch. Trayline observation showed that patients were served all the items listed above and cottage cheese. In an interview with Staff L (Food Service Director), she explained that the substitution was due to refrigerator space issues. In addition, there were refrigerators/freezers stored in the dry storage	□A 620□	**Improper Freezer Storage Temperatures** **Corrective Action:** Interim measure included the attempted repair of existing freezers and the rental of a freezer truck. **(Attachment)** **Date of Implementation**: Freezer truck rented 8/21/2014 **Monitoring Process:** Daily monitoring of freezer food storage locations **Person Responsible:** RD, Director of Dietary Department, Director of Facilities Management **Corrective Action:** New Freezers were purchased and installed to replace the existing units. **Date of Implementation:** 8/29/2014 **Monitoring Process:** Daily monitoring of freezer food storage locations Monthly reporting of kitchen work order completion tracking to hospital administration. Observation of functionality via EOC rounding. Report of work order completion and Finding of EOC rounding on a monthly basis to Quality Council, Med Executive Committee and the Governing Board. **Person Responsible:** RD, Director of Dietary Department, Director of Facilities Management	8/21/2014 8/29/2014

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□A 620□	Continued From page 20 room emitting heat resulting in high room temperature. At 11:53 a.m. on 8/19/14, the temperature of the dry storage room was 88.6 degrees Fahrenheit. At 12:55 p.m., the temperature was 88 degrees Fahrenheit. The dry storage thermometer gauge had exceeded the graduated the 80 degree mark indicating that the room was warmer than 80 degrees. In a concurrent interview with Staff L, she stated that they do not monitor or keep logs of the dry storage room. According to the same policy described above, "All dry goods are stored in storeroom that is clean, dry and well ventilated ... " The dry storage room was not well-ventilated. The recommended temperature of dry storage by the Food and Drug Administration is between 50 to 70 degrees Fahrenheit. Improperly stored staple foods could result in poor quality such as deterioration of food products including rancidity and altered flavors. Menu Review of the menu for 8/18/14 through 8/19/14 for both Hollywood and Van Nuys Campuses showed continued lack of variety. Concerns with the menu were identified in the Statement of Deficiencies form the April 2014 survey. The patients continued to receive tossed salad every day at lunch. The patients on pureed diet continued to receive mashed potatoes every day for lunch and dinner. For example, at dinner on 8/19/14, the patients on pureed diet received double portions of the mashed potatoes to replace the dinner roll and steamed rice that patients on regular diets were served. In addition, green beans was offered to patients on renal diets for both lunch and dinner on 8/19/14.	□A 620□	**Improper Dry Food Storage Room Temperature** **Corrective Action:** Dry storage area temperatures are being monitored and recorded daily since August 20, 2014 **(Attachment: 1)**. To ensure FDA acceptable range of 50-70 degrees is maintained. **Date of Implementation:** 8/20/14 **Monitoring Process:** Daily monitoring of temperature of the dry food storage location. **Person Responsible:** RD, Director of Dietary Department, Director of Facilities Management **Van Nuys & Hollywood** **Menu** **Lack of Variety** **Corrective Actions**: Menus have been revised to include variety, color, and accurate portions per standardized recipes including purees per nationally recognized standards. Food & Nutrition Services Policy FNS C009 Patient Menu**.** Staff insserviced **(Attachment 2)** **Date of Implementation:** September 4- September 16, 2014 **Monitoring Process**: The revised menu is monitored by manager/supervisor during the tray quality assessment and the patient satisfaction rounds. **(Attachment 3)** **Person Responsible:** RD, Director of Dietary Department and Clinical Dietitian RD	8/20/2014 9/4/2014

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□A 620□	Continued From page 21 There was no written menu for patients on the vegetarian diet. Review of the Patient Diet Order List dated 8/19/14 showed there were two unsampled patients on vegetarian diets. Review of the menu showed that there was no planned menu for the vegetarian diet. Staff L stated in an interview on 8/19/14 that she had interviewed the patient and was "fine" with eggs and dairy. A lack of a planned menu could put the patient at risk of a diet that does not meet nutritional needs and the recommended daily allowance. Review of the hospital policy titled, "Patient Menus" dated 11/12 did not list the vegetarian diet as one of the diets on the patient menu but adds that "other diets as ordered by the physician will be provided for." The therapeutic spreadsheet which is used by dietary staff for the serving of food did not include the vegetarian diet.	□A 620□	**Lack of Vegetarian Options** **Corrective Actions:** A vegetarian menu was put into place with a variety of vegetarian options. The newly implemented menu and menu spread includes both Vegetarian and Vegan options. **Date of Implementation:** August 22, 2014 interim and permanent September 4- September 16 2014 **Monitoring Process:** The new vegetarian menu is monitored manager./supervisor during the tray quality assessment and the patient satisfaction rounds. **(Attachment 3)** **Person Responsible:** RD, Director of Dietary Department and Clinical Dietitian RD	8/22/2014 9/4/2014
□A 628□	482.28(b) DIETS Menus must meet the needs of the patients. This STANDARD is not met as evidenced by: Based on observation, review of hospital documents and staff interviews, the hospital failed to ensure that menus met the needs of two of eight patients (Patient 53 and 54) when substitutes prepared and offered were not of same nutritive value as the items that were originally planned. The hospital also failed to plan in advance menus for vegetarian and gluten-free diets; dietary staff failed to follow recipes to ensure that the nutritive value of the items were met. The lack of planning of menus in advance and failure to follow recipes put the patients at risk of receiving diets that may not be nutritionally balanced and lacking in variety.	□A 628□		

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□A 628□	Continued From page 22 Findings: Hollywood Campus During the trayline observation on 8/18/14 beginning at 11:30 a.m., there were two patients (Patient 53 and 54) one of whom had a physician ordered wheat free diet and the second with a physician ordered vegetarian diet. Wheat free diets are used to treat patients with gluten sensitivity (a protein found in grains). Gluten is found in a wide variety of foods and food additives (Mayo Clinic, 2014). It was noted that the patient with the wheat -free diet received a regular meal tray and the patient with the vegetarian diet received cottage cheese and fruit. In a concurrent interview with DS 2 (Dietary Staff), he stated that for wheat -free diets he would eliminate bread and vegetarian diets usually received items such as cottage cheese and fruit. He stated he did not have a menu spreadsheet for either of these items. In an interview on 8/18/14 at 2:30p.m., with Dietary Staff (DS) 5 she confirmed that the hospital did not have spreadsheets for gluten free or vegetarian diets. Culver City Campus During the food distribution observations on 8/19/14 beginning at 12 p.m., the substitute meal entree was a chicken enchilada. The enchilada contained chicken, corn tortilla, red sauce and a small amount of cheese melted on the top of the casserole. While there was visible chicken in the item, it did not appear that the amount of chicken was substantial in amount of protein for a main entree. It was also noted that the enchilada was cut into approximately 32 pieces and was served using a :□ cup serving.	□A628□	**Hollywood** **Corrective Action:** A vegetarian and wheat free menu was put into place with a variety of options. The newly implemented menu and menu spread includes both Vegetarian and Vegan as well as wheat free options. Food Service Staff have been inserviced on the menu spreadsheet **(refer to Attachment: A-620.1 attachment 1)**. **Date of Implementation:** August 22, 2014 - September 16, 2014 **Monitoring Process:** The new menus are monitored by manager/supervisor during the tray quality assessment and the patient satisfaction rounds. **Person Responsible:** RD, Director of Dietary Department and Clinical Dietitian RD **Culver City** **Corrective Actions:** Enchilada casserole recipe was reviewed and kitchen staff inservice to follow the standardized recipe without adjustments and proper portioning of the meal. **(Attachment 1)** **Date of Implementation:** October 23, 2014 **Monitoring Process:** Daily data collection on proper preparation and portioning of the recipes (**Attachment 2).** **Person Responsible:** RD, Director of Dietary Department and RD, Clinical Nutrition Manager	8/22/2014 10/23/2014

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□A 628□	Continued From page 23 Review of the standardized titled, "Chicken Enchilada" revealed that the recipe was intended for 24 servings. The recipe also called for greater than 2 pounds of cheese for 24 servings. While there was a light layer of melted cheese on top of the casserole there was no visible amount of cheese in the enchilada. In a concurrent interview with OS 3, she stated the chicken enchilada replaced a vegetarian entree on the menu. She also stated that likely the recipe substitution was not evaluated for nutritional adequacy rather was accepted primarily for patient acceptability. On 8/19/14 at 12:15 p.m., the edible protein was weighed and was noted to be 2 ounces. Review of departmental document showed the edible protein portion of the enchilada was 3 ounces. During an observation of food production activities on 8/19/14 beginning at 2:20 p.m., the dietary staff was preparing sandwiches for patient use. He was observed placing 3 slices of deli turkey with lettuce and 2 slices of bread. In a concurrent interview, OS 6 stated that the items would be used for a meal substitution on trayline as well as for patient snacks. On 8/20/14 at 3 p.m., OS 7 was asked to weight 3 slices of the deli turkey. It was noted the meat weighed 2 ounces. Review of the facility spreadsheet revealed that main entrees were to have 3 ounces of edible protein. Improper portion sizes would result in inadequate calories and protein which could impair wound healing resulting in longer hospital stays. The staff had failed to follow recipes and persons in position of authority had failed to ensure the recipes were followed to the menu met the	□A 628□	**Corrective Actions:** Staff was in-serviced on menu substitutions and the difference between nourishment items and meal items. **(Attachment 1 & 2)** **Date of Implementation:** October 23, 2014 **Monitoring Process**: Daily data collection on proper preparation and portioning by manager/supervisor (**Attachment 2**). **Person Responsible:** RD, Director of Dietary Department and RD, Clinical Nutrition Manager	10/23/2014

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A 628	Continued From page 24 nutritional needs of the patients. This is a repeat deficiency from the sampled validation survey on 4/1/14.	A628		
A 630	482.28(b)(2) DIETS Nutritional needs must be met in accordance with recognized dietary practices and in accordance with orders of the practitioner or practitioners responsible for the care of the patients. This STANDARD is not met as evidenced by: Based on observation, review of hospital documents and staff interviews, the hospital failed to ensure the nutritional needs of patients on pureed and diabetic diets (Patient 57, 58, 59, and 60) and two sample patients on tube feeding (Patient 55 and 56), in sample of eight, were in accordance with recognized practices and orders of the practitioner responsible for the care of patients. Tube feeding orders were not carried out correctly; recommended hang times for tube feeding orders were not followed, which could result in growth of microorganisms. The pureed diet was improperly prepared resulting in a watery consistency that could result in aspiration; improper preparation method also compromised the nutritive value of the food. Diabetic diets incorrectly translated to meet the caloric limits set by the physician in the diet order and unclear diet order was served without clarification with the physicians. This could result in patients receiving diets not in line with the therapy planned by the physician. Findings:	A630		

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□A 630□	Continued From page 25 Hollywood Campus 1. On 8/18/14 beginning at 6 p.m., Patient 55□s tube feeding was running at a rate of 40 cubic centimeters (cc- a metric unit of measure). Patient 55□s feeding was an open system feeding. An open system allows of addition of formula throughout the course of the day; whereas a closed system does not allow for the addition of formula (Critical Care Nutrition, 2011). It was also noted that the feeding was dated as 8/18/14; however the time the feeding was hung was not documented. It was also noted that 200 cc of formula remained in the feeding bag. In a concurrent interview and demonstration with RN 2 (Registered Nurse), she stated that she started the feeding at approximately 6 a.m., on 8/18/14. She also stated that she added 2 cans or the physician ordered supplement when the feeding was started. She further stated that when the feeding became depleted she would add additional cans of formula. In a concurrent observation of the enteral pump, the pump recorded of 112 cc□s of feeding delivered. RN 2 was unable to demonstrate the amount of feeding that was delivered since it was hung on 8/18/14 at 6 a.m. Review of patient intake/output records dated 8/18/14 noted that nursing staff documented that 40 cc□s of formula was delivered every hour. It was also noted that based on hospital documentation a total of 480 cc□s of formula was delivered. There was an inconsistency of 368 cc□s between the cumulative total of the enteral pump and the documentation in the electronic medical record. RN 33 was unable to describe the inconsistency. She also stated that she documented the physician□s order in the medical	□A 630□	**Hollywood** **1.) Corrective Actions**: All open-system tube feedings have been discontinued and switched to closed system feeding; education/in-service with return demonstration provided to staff to included: 1) new closed-system feeding, 2) tube feeding orders, 3) date and hang time of feeding, 4).water flushing and 5). Proper documentation in EMR to include accurate documentation of Intake and Output. Education inservice with return demonstration was provided to staff on August 23-Sept 17, 2014. (**Attachment 1**) **Date of Implementation:** Education for tube feeding occurred August 23, 2014- September 17, 2014; closed system implemented facility wide on September 16, 2014; RD education on diet list, entering diet orders, MD orders September 17- 29, 2014 **Monitoring process:** Nursing performs audits on tube feedings **Person Responsible:** Nursing department	8/23/2014 9/16/2014 9/17/2014

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□A 630□	Continued From page 26 record, rather than the actual amount of feeding delivered. There was also no documentation of water flushes that is necessary to clean out bags prior to the addition of new feeding. Failure to perform this function could result in feedings being hung for time periods that would support bacterial growth. 2. On 8/18/14 beginning at 6:30 p.m., Patient 56 had a physician ordered enteral feeding with a □rate of 40 cc's/hour. The enteral pump reading confirmed that the feeding was running at 40 cc's/hour. The feeding bag was dated 8/18/14 and timed at 6 a.m. The enteral pump revealed that 174 cc's of feeding were delivered□and there was 100 cc's left in the bag. Review of clinical record for Patient 56 showed documentation of 40 cc per hour not actual volume delivered. The documentation showed more feeding had been delivered, based on the amount shown on the pump. In a concurrent interview with RN 33 on 8/18/14 she was unable to explain the total amount of feeding that was delivered from the feeding bag since 6 a.m. when the bag was hung. It could not be determined whether or not the hospital was following physicians' orders. There was also no documentation of water flushes that is necessary to clean out bags prior to the addition of new feeding. Failure to perform this function could result in feedings being hung for time periods that would support bacterial	□A 630□		

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□A 630□	Continued From page 27 growth. The hospital failed to follow manufacturer's guidelines and standards of practice for the amount of time the open enteral formula could be hung at the patient's bedside (known as "hang time") by allowing hang times of up to 12 hours when manufacturer's guidelines were for no greater than 8 hours hang time. This failure had the likely potential to result in enteral formulas with unacceptable levels of bacteria delivered to the patients and result in infections in patients receiving enteral feedings. "The A.S.P.E.N. (American Society for Parenteral and Enteral Nutrition) Enteral Practice Recommendations provides the following hang time recommendations: For reconstituted powdered formula or a formula with additives, a 4-hour hang time is recommended; For a commercially sterile, liquid formulas decanted (poured) from a can or brik-pak (similar to a juice box), an 8-hour hang time is recommended. These hang time recommendations assume the formula is kept at room temperature and is subject to minimal handling and manipulation... This information also indicates that the bag and administration set (tubing) should be flushed with water before adding additional formula." 3. On 8/18/14 beginning at 11:45 a.m., OS 2 was observed preparing pureed green beans. OS 2 placed a cups of cooked green beans in the blender after which he added 16 ounces of fluid. He was then observed pouring the green beans into a steam pan. The resultant texture of the	□A 630□	**3.) Corrective Actions:** Education of kitchen staff provided on the use of thickeners in the preparation of puree diets. **(Attachment: 3 & 4)** **Date of Implementation:** August 22- September 16, 2014 **Monitoring Process:** The puree preparation methods are monitored by management observation during the preparation of the meal weekly. **Person Responsible:** RD, Director of Dietary Department and Clinical Dietitian RD	8/22/2014

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□A 630□	Continued From page 28 item was a grainy liquid resembling runny applesauce. Concurrent observation also noted that the pureed meat was of a similar consistency. During the trayline observation, OS 2 utilized a soup ladle to portion the pureed meat and vegetables into individual plastic cups. Excessive addition of food additives alters the nutritional value of the item. In a follow-up observation on 8/18/14 beginning at 5:15 p.m. of meal production activities, the consistency of the pureed items was similar to the noon meal, a liquid consistency. Review on 8/18/14 beginning at 5:45 p.m., of the pureed green bean recipe revealed there was no guidance to add additional liquid while preparing the items. The staff should have added a food thickener to the product. Additionally, the recipe failed to provide any guidance on the expected consistency of the finished product. According to the Academy of Nutrition and Dietetics' Nutrition Care Manual titled, "Nutrition Therapy for Pureed Diet," Food should be "pudding-like" ...Be sure that any pureed foods prepared in advance are the consistency of pudding or moist mashed potatoes." Under the heading , Cooking and Preparation Tips, "when pureeing or blenderizing foods, add as little fluid initially as possible." This is a repeat deficiency. Culver City Campus 4. During review of physician ordered diets on 8/19/14 beginning at 11:30 a.m., the diets for patients with diabetes was not consistent with what was transcribed to the electronic diet entry order system. The meals were plated as a carbohydrate consistent diet which utilized meal plans without specific calorie levels, but	□A 630□	**Culver City** **4). Corrective Actions:** Diet policy called C002 □Diet Orders□ was revised to provide more specific information on ordering diets including those used for diabetes reflecting consistent levels of carbohydrates throughout the day. **(Attachment 5)** **Date of Implementation:** Oct 15-17, 2014 **Monitoring Process:** Monitoring the accuracy of menu modifications including consistency of the carbohydrates meal plans using a sample of 30 menus per clerk is monitored quarterly. **(Attachment 6)** **Person Responsible:** RD, Director of Dietary Department & RD, Clinical Nutrition Manager	10/15/2014

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□A 630□	Continued From page 29 incorporated consistent levels of carbohydrate throughout the day. For example, if a physician ordered 1800 calorie American Diabetes Association (ADA) diet, the diet would get transcribed to a consistent carbohydrate meal pattern that offered 60 grams of carbohydrate (CHO) at breakfast and 75 grams of CHO at lunch and dinner. It was also noted that there was inconsistencies in how the physician ordered diabetic diets. For example, some of the 1800 calories diets were transcribed to a 4-5-5- meal pattern (indicating the number of carbohydrates per meal) and other 1800 calorie diets were transcribed as a "Diabetic Diet Consistent Carbohydrate" without an indication of the amount of carbohydrate at each meal. In an interview on 8/19/14 beginning at 3 p.m., with Registered Dietitian (RD) 2, she stated that she was aware that the diet orders were being translated and had developed a therapeutic spreadsheet for staff to follow; however she had not implemented it. On 8/21/14 at 5:45 p.m., the hospital provided a screenshot of the available electronic diet orders. The diabetic diet could only be ordered as a general "diabetic diet" and there was not the possibility to order it as a calorie specific or consistent carbohydrate diet. Hospital policy titled, "Diet Manual" dated 11/12 guided staff that the "diet order should be specified in terms of exact amount of restriction ... " It also noted that if the physician " is unsure of the terminology necessary for desired diet order, he/she should consult the Clinical Diet Manual ... " The policy did not reflect the practice within the department.	□A 630□		

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□A 630□	Continued From page 30 Additionally, referring to the diet manual would not have provided physicians additional guidance for ordering diabetic diets as the document provided clinical practice recommendations rather than guidance for ordering diabetic diets within the hospital. Review of hospital document titled, "Diet Report" dated 8/19/14 noted that there were greater than 20 patients who did not receive the correct diet order. 5. During trayline observation on 8/19/14 beginning at 12 p.m., the tray ticket for 3 random patients (Patients 57, 58 and 59) guided staff to plate 5 carbohydrate selections for the noon meal. It was noted that the meal plated on each of the trays consisted of 3.5 carbohydrate selections (pineapple salsa, sweet mashed potatoes, green beans and a garden salad) rather than the diet list designation of 5 carbohydrates. In an interview on 8/19/14 beginning at 3 p.m., with DS 8, whose position was responsible for diet accuracy, he stated that the departmental policy was that if patients did not select an adequate amount of carbohydrates additional food items should be marked to increase the carbohydrate content of the meal to hospital specified parameters. Review of the therapeutic spreadsheet for the noon meal on 8/19/14 revealed that if patients did not select menu items the maximum number of carbohydrates for the noon meal would be 4 carbohydrate choices. Hospital document titled, "Diet Report" dated 8/19/14 noted that a carbohydrate consistent pattern for an 1800 calorie diet was a meal pattern of 4-5-5 for breakfast, lunch and dinner respectively.	□A 630□	**5). Corrective Actions.** The Manual for Clinical Nutrition Management (Diet Manual) was revised to include the appropriate diet Addendums. This will ensure a practice related to menu creation, nutritional adequacy, and clinical nutrition practice. **(Attachment 7)** **Date of Implementation:** 9/10/2014 to 10/4/2014 **Monitoring Process:** The kitchen staff was inserviced on the use of diabetic diet ensuring consistency with levels of carbohydrates throughout the day. **(Attachment: 7)** **Person Responsible:** RD, Director of Dietary Department and RD, Clinical Nutrition Manager	9/10/2014

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A 630	Continued From page 31 Van Nuys 6. Clinical Record review showed when Patient 60 was admitted his physician ordered diet was a diabetic, No Added Salt: 2000 calories, Na (sodium) 2 gram. He was served according to the Diet order list dated 8/19/14 a 2000 calorie 2 gram Na diet. The diet as ordered has two levels of sodium restriction: NAS and 2 gram sodium. The NAS, or no-added-salt diet, involves restricting sodium intake to less than 4 grams, or 4,000 milligrams per day while the 2 gram sodium involves restricting sodium intake to 2000 milligrams. The standard of practice is to clarify conflicting or unclear orders. Clinical record review did not show any clarification in the diet order by either nursing staff or registered dietitian. DFS1 stated in an interview on 8/19/14 at 3:40 p.m. that the diet served was the diet that was ordered. 7. According to the menu on 8/19/14, the following items were served for lunch: Tossed salad, Lemon Fish, mixed vegetables, parsley noodles, fresh fruit and low fat milk. During a trayline observation, on 8/19/14 at 12:50 p.m., random observation showed a patient on double portions received 2 pieces of fish and same portion of noodles, vegetables and fruit. Staff K (Director of Food Service) who was	A 630	**Van Nuys** **6). Corrective Action:** Food & Nutrition Services policy FNS C002 Diet Orders was revised to include the approved diet orders. Training was provided to kitchen staff, nurses and physicians concerning the clarification of diet orders. **(Attachment 5)** **Date of Implementation:** 8/21/14 and on going **Monitoring Process:** Electronic MD diet orders are compared daily to the approved diet order for accuracy and monitored by manager/supervisor **(Attachment 10)** **Person Responsible:** R.D. Food Service Director, Clinical Dietitian, RD **7). Corrective Action:** A revised policy for double portion was implemented specifying the composition of a double portion diet as stated in Food & Nutrition Service Department P&P Manual FNS C013 Special Patient Meals and Services. Kitchen staff was inserviced on the policy on double portions. (**Addendum: 8)** **Date of Implementation:** 9/4/14 **Monitoring Process**: Supervisor/manager will monitor during tray preparation accuracy of the double diet portion. **(Attachment 9)** **Person Responsible:** R.D. Food Service Director, Clinical Dietitian, RD	8/21/2014 9/4/2014

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□A 630□	Continued From page 32 present during the observation confirmed the accuracy of the meal served. Staff M (Food Service Supervisor), in a concurrent interview, stated that the patient should have received double portions of the fish and starch. Review of the hospital policy titled, "Special Patient Meals and Services" dated 7/14 indicated "a patient on double will receive a double entree plate with all the components. Typically, a hot entree with starch, vegetable, dinner roll .... " Review of the Diet List dated 8/19/14 showed that there were eight patients who had double portion as part of their diet orders. The incorrect portion sizes would result in decrease calories and overall nutrient deficit. This is a repeat deficiency from the sample validation survey on 4/1/14.	□A 630□		
□A 700□	482.41 PHYSICAL ENVIRONMENT The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community. This CONDITION is not met as evidenced by: Based on observation, review of facility documents and staff interview, the facility failed to meet the Condition of Participation in Physical Environment by failing to: 1. Develop and maintain the physical plant in a manner that assured the safety and well-being of patients (Refer A 701).	□A 700□	**1). Corrective Actions:** The facilities have initiated a proactive system to conduct physical plant rounds covering all patient care and non-patient care areas to address maintenance issues. **Date of Implementation:** August 2014 **Monitoring Process:** Weekly monitoring physical plant rounds and Environment of Care rounds covering patient care and non-patient care areas. In addition, daily EVS environmental rounds and periodical terminal cleaning. **Person Responsible**: Director of Engineering	08/2014

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□A 700□	Continued From page 33 2. Ensure the safety of patients and staff when it failed to ensure there were appropriate plans in place to implement its emergency preparedness program and ensure that its emergency food was properly secured. Failure to ensure maintenance of the physical environment may compromise the medical status of patient and the ability for staff to care for patients (Refer to A 701). 3. Ensure that food service equipment was maintained to assure the safety and well-being of patients (Refer to A 701). 4. Ensure an effective approved water management plan to be implemented in a widespread disaster. Failure to ensure an effective approved water management plan may compromise the medical status of patients and the ability for staff to care for patients (Refer to A 703). The cumulative effect of these systemic issues resulted in the facility□s inability to ensure and provide a safe patient care environment.	□A 700□	**2). Corrective Actions:** The emergency policy and procedur was reinforced through education of dietary and physical plan staff. Education and inservice of the dietary and physical plan staff. **Date of Implementation:** October 23 2014 **Monitoring Process:** Monitor and Log Disaster food and water inventory quarterly. **Person Responsible:** Dietary and Engineering. **3). Corrective Actions**: Repairs will be done in a timely manner □same day or within 3 hours□and work orders will be processed by the Engineering Dept by priority. **Date of Implementation:** on-going. **Monitoring Process:** Work orders will be monitored daily by Engineering staff and repairs will be tracked through the work order system. **Person Responsible:** Dietary and Engineering **4). Corrective Actions:** The emergency preparedness policy and procedure on water management was reviewed and inserviced to the dietary staff and engineering. **Date of Implementation**: October 23, 2014 **Monitoring Process:** Water supplies will be monitored by dietary and engineering. **Person Responsible:** Director of Engineering, RD	10/23/2014 10/23/2014
□A 701□	482.41(a) MAINTENANCE OF PHYSICAL PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This STANDARD is not met as evidenced by: Based on observation, interview, and document review the hospital failed to ensure maintenance of the physical environment, and develop and maintain the physical plant in a manner that	□A 701□		

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□A 701□	Continued From page 34 reduced opportunities for self-harm and eliminating as many risk factors as possible in the patient's environment including fixtures that could be used as anchor points to tie to that can hold a person's weight and other conditions that could be used as opportunities for self-harm. The deficient practice had the potential to provide patients opportunities for self-harm, infection transmission, accident hazards, and rodent activity. Also, the hospital failed to ensure there were appropriate plans in place to implement its emergency preparedness program and ensure that its emergency food was properly secured. Improper storage of emergency food could result in misappropriation and loss of food items preventing use during a disaster. Findings: Hollywood campus On August 18, 2014 between 10:06 a.m. and 3:30 p.m., the following conditions existed at the Hollywood campus. 5th Floor 1. Room 509 had a 5 ft. by 4 ft. section of ceiling missing, and the room was being used for storage of Environmental Services (EVS) equipment and mattresses. During an interview at the same time as the observation, Staff D (Corporate Director of Facilities) stated the damage at the ceiling was	□A 701□	**Hollywood – 5th Floor** **1).Corrective Actions:** A permit was approved by OSHPD on September 19, 2014, Permit No. S141549-19-00 for the repair of the ceiling **(Attachment: 1)**. The OSHPD procedure of the repair is currently ongoing. **Date of Implementation**: Permit was granted on September 19, 2014. **Monitoring Process:** EOC rounds are conducted weekly on all patient care areas. **(Attachment: 2)** **Person Responsible:** Lead Engineer	9/19/2014

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□A 701□	Continued From page 35 caused by a water leak from the tube bundle of the boiler located above room 509. During an interview at the same time as the observation, Staff D stated the room was still on the license as a patient room. 2. The bathroom of room 509 had a loose toilet; missing toilet vertical flush pipe, the toilet bowl was stuffed passed the rim with paper, had a light fixture was falling off the wall, and the towel bar was missing. 1st floor □ 3. At Urgent Care there was an accumulation of dust and a bundled blood stained bandage with tape wedged at the top of the corridor door holding the door in the open position. Basement 4. In the Pre-Op room, a sink cabinet had missing laminate at a corner. During an interview at the same time as the observation, Staff N (Disaster Coordinator) stated he replaced the laminate at the edge of the cabinet's counter that the evaluator had pointed out on 4/1/14, and that laminate was being bought, and that the facility had a program to replace all the counters. 5. In the Pre Op room 3 of 3 gurneys had cracks in the upholstery, and 1 of 3 had a three inch tear	□A 701□	**2.).Corrective Actions:** The toilet bowl was replaced, the vertical flush valve pipe was installed, the room was cleaned, the light fixtures fixed, the towel bar replaced and the whole room repainted. **(Attachment: 3)** **Date of Implementation**: September 24, 2014 **Monitoring Process:** EOC rounds are conducted weekly in all patient care areas. **Person Responsible:** Lead Engineer **1st Floor** **3).Corrective Actions:** The tape wedge at the top of the corridor door was immediately removed and terminal cleaning was done in Urgent Care. Urgent Care staff was In-serviced on infection control and door propping **(Attachment 3)**. **Date of Implementation:** September 29, 2014 **Monitoring Process:** EOC rounds are conducted weekly in all patient care areas. **Person Responsible:** Lead Engineer **Basement** **4).Corrective Actions:** The Pre-Op room missing laminate was replaced **(Attachment 3)**. **Date of Implementation**: September 29, 2014 **Monitoring Process:** EOC rounds are conducted weekly in all patient care areas. **Person Responsible:** Lead Engineer **5).Corrective Actions:** The defective pads on the gurneys in Pre Op room 3 were replaced **(Attachment 3)**. **Date of Implementation:** October 7, 2014 **Monitoring Process:** EOC rounds are conducted weekly for all patient care areas. **Person Responsible**: Lead Engineer	9/24/2014 9/29/2014 9/29/2014 10/7/2014

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□A 701□	Continued From page 36 □through the upholstery visibly exposing the foam padding beneath. 6. In Operating Room (OR) 3, the □-ray box had missing paint and rust at the frame front of the box. During an interview at the same time as the observation, Staff C (CEO) stated that he could see the rust at the □-ray box. 7. In OR 3, a cabinet had missing laminate at the edge and doors. During an interview at the same time as the observation, Staff N stated the cabinet was part of the casement work to be replaced. 8. In OR 3, the ceiling surgical lamp arm had an accumulation of dust. During an interview at the same time as the observation, Staff C stated that the surgical lamp would be over the patient. 9. In OR 2, the □-ray box's front plexi glass was loose and had tape and adhesive on the glass and frame box. 10. In OR 2, there was tape placed across a thermostat. During an interview at the same time as the observation, Staff N stated that the thermostat was an old thermostat that was no longer in use, and that the thermostat and tape needed to be removed and replaced with a cover plate.	□A 701□	**6).Corrective Actions:** The □ ray box in OR 3 was refurbished. **(Attachment 3)** **Date of Implementation:** September 10, 2014 **Monitoring Process:** EOC rounds are conducted weekly on all patient care areas. **Person Responsible:** Lead Engineer	9/10/2014
			7).Corrective Actions: OR 3 the cabinet missing laminate a the edges and doors have been repaired(**Attachment 3 & 6** **Date of Implementation:** October 7, 2014 **Monitoring Process:** EOC rounds are conducted weekly for all patient care areas. **Person Responsible:** Lead Engineer	10/7/2014
			8).Corrective Actions: In OR 3 the ceiling surgical light arm and room had immediate terminal cleaning. **(Attachment 3 & 7)** **Date of Implementation:** September 10, 2014 **Monitoring Process**: EOC rounds are conducted weekly on all patient care areas. **Person Responsible**: Lead Engineer	9/10/2014
			9).Corrective Actions: In OR 2, the xray box plexi glass was replaced and fastened appropriately. **(Attachment 3)** **Date of Implementation**: September 24, 2014 **Monitoring Process**: EOC rounds is conducted weekly for all patient care areas. **Person Responsible:** Lead Engineer	9/24/2014
			10).Corrective Actions: In OR 2, Tape was removed from the thermostat and the thermostat in OR □2 was put back into service. **(Attachment 3)** **Date of Implementation:** September 11, 2014 **Monitoring Process:** EOC rounds are conducted weekly for all patient care areas. **Person Responsible:** Lead Engineer	9/11/2014

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□A 701□	Continued From page 37 11. In OR 1, the □-ray box□s front plexi glass was cracked, had tape and adhesive on the glass and frame box, and had a knotted electrical cord with accumulation of dust at the knotted area of the cord, and tape at the plug. During an interview at the same time as the observation, Staff N stated that the housekeeper was supposed to unknot the electrical cord to clean it. At the same time as the interview, Staff N unknotted the cord, which then fell into the biohazard bin, which was pointed out to the Disaster Coordinator. 12. The Decontamination Room had unpainted plaster at the wall under the announcement speaker. 13. The Sterilization Room had unpainted plaster at the wall next to the paper towel dispenser. During an interview at the same time as the observation, Staff N stated that they were in the process of painting, and that the problem of having unpainted wall with exposed plaster is that the wall cannot be cleaned. 14. In the Recovery Room, there was a cabinet with peeling paint. 15. In the Recovery Room, there was a dirty braided cord at the nurse call. During an interview at the same time as the observation, Staff N stated that the cord at the nurse call needed to be replaced because it was dirty.	□A 701□	**11).Corrective Actions:** In OR 1, the plexi glass on the □ ray box was replaced and the knotted electrical cord that fell in biohazardous bin was sanitized and secured to prevent tripping. **(Attachment 3)** **Date of Implementation:** September 12, 2014 **Monitoring Process:** EOC rounds are conducted weekly in all patient care areas. **Person Responsible:** Lead Engineer	9/12/2014
			12).Corrective Actions: The plaster on the wall in the Decontamination Room in Surgery Department was repainted. **(Attachment 3)** **Date of Implementation**: September 22, 2014 **Monitoring Process**: EOC rounds are conducted weekly for all patient care areas. **Person Responsible**: Lead Engineer	9/22/2014
			13).Corrective Actions: The plaster on the wall in the sterilization room, including the wall next to the paper towel dispenser, was repainted. **(Attachment 3)** **Date of Implementation**: September 22, 2014 **Monitoring Process**: EOC rounds are conducted weekly for all patient care areas. **Person Responsible**: Lead Engineer	9/22/2014
			14).Corrective Actions: The cabinets in the recovery room were repainted. **(Attachment 3 & 8)** **Date of Implementation**: September 25, 2014 **Monitoring Process**: EOC rounds are conducted weekly for all patient care areas. **Person Responsible**: Lead Engineer	9/25/2014
			15).Corrective Actions: The nurse call braided cord in the Recovery Room was replaced **(Attachment 3)**. **Date of Implementation**: Sept 5, 2014 **Monitoring Process**: EOC rounds are conducted weekly for all patient care areas. **Person Responsible**: Lead Engineer:	9/5/2014

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□A 701□	Continued From page 38 Van Nuys campus On August 19, 2014 between 8:30 a.m. and 3:30 p.m., the following conditions existed in the Van Nuys psychiatric campus. Station 1 There were fixtures throughout that could be used as anchor points to tie to that can hold a person's weight throughout the unit; including exposed plumbing pipes (water supply to toilet and sink drain line), standard faucets, and mortise hinges. 16. Patient rooms, including rooms 101, 102, 104, 105, 106, 107, 108, 109, and 110 had exposed plumbing pipes that could be used as anchors. Bathroom of room 103 was occupied during observation. Between 1:30 p.m. and 2:58 p.m., during an interview, the Lead Engineer stated that the anti-ligature plumbing covers for the P-traps would be installed no later than 3 weeks (9/12/14). At the same time during an interview, Staff B (Administrator) (Van Nuys campus) stated that the facility has two extra staff every day, in every unit monitoring the areas that could be used as anchors in every room, every 15 minutes, and that starting today (8/19/14) a monitoring form/log will be documented. 17. Patient rooms, including rooms 101, 102, 1d4, 105, 106, 107, 108, 109, and 110 had standard	□A 701□	**Van Nuys** **Station 1** **16).Corrective Actions**: P trap covers were installed in rooms 101, 102, 104, 105, 106, 107, 108, 109, 110 and including room 103 to cover the exposed plumbing pipes. **(Attachment)** **Date of Implementation**: completed September 12, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily.**(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing	9/12/2014

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□A 701□	Continued From page 39 mortise hinges that could be used as anchors. Between 1:30 p.m. and 2:58p.m., during an interview, Staff P (Lead Engineer) stated that the anti-ligature hinges would be installed no later than 5 weeks (9/26/14). At the same time during an interview, Staff B stated that the facility has two extra staff every day, in every unit monitoring the areas that could be used as anchors in every room, every 15 minutes, and that starting today (8/19/14) a monitoring form/log will be documented. 18. Room 101 had window blinds with an accessible cord. The cord could be used to tie onto an anchor point. 19. Shower room □4 and 5 standard mortise hinges that could be used as anchors. Between 1:30 p.m. and 2:58 p.m., during an interview, Staff P stated that the anti-ligature hinges would be installed no later than 5 weeks (9/26/14). At the same time during an interview, Staff B stated that the facility has two extra staff every day, in every unit monitoring the areas that could be used as anchors in every room, every 15 minutes, and that starting today (8/19/14) a monitoring form/log will be documented. 20. The dining room sink had a standard faucet and exposed plumbing that could be used as anchors.	□A 701□	**17). Corrective Actions**: A third party certified company was hired to replace mortise hinges with anti-ligature hinges in rooms 101, 102, 104, 105, 106, 107, 108, 109, 110. **(Attachment 17 -29)** Originally scheduled to be done by 9/26/14, the manufacturer needed additional time to complete the back order. **Date of Implementation**: Completed October 22, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. .**(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing **18). Corrective Actions**: Room 101 window blind accessible cord was shortened and the blinds were secured to the base of the window. **(Attachment 9a)** **Date of Implementation**: August 19, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly. .**(Attachment 2)** **Person Responsible**: Director of Engineering **19). Corrective Actions**: A third party certified company was hired to replace mortise hinges with anti-ligature hinges in Shower Room □4 & □5.(**Attachment 10).** Originally scheduled to be done by 9/26/14, the manufacturer needed additional time to complete the back order. **Date of Implementation**: October 22, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. **(Attachment 2)** **Person Responsible**: Director of Engineering & nursing **20). Corrective Actions**: The standard faucet on the dining room sink was replaced with anti-ligature faucet and the p-trap cover was installed. **(Attachment 11)** **Date of Implementation**: Faucet - August 19, 2014; P-Trap cover □ September 12, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. .**(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing	10/22/2014 8/19/2014 10/22/2014 8/19/2014 9/12/2014

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□A 701□	Continued From page 40 Between 1:30 p.m. and 2:58 p.m. during an interview Staff P stated that the anti-ligature plumbing covers for the P-traps would be installed no later than 3 weeks (9/12/14), and the anti-ligature faucets would be installed by the end of the day (8/19/14). At the same time during an interview, Staff B stated that the facility has two extra staff every day, in every unit monitoring the areas that could be used as anchors in every room, every 15 minutes, and that starting today (8/19/14) a monitoring form/log will be documented. 21. The dining room bathroom had a standard faucet, exposed plumbing, standard hinges, and a metal shelf that could be used as anchors. Between 1:30 p.m. and 2:58 p.m., during an interview, Staff P stated that the anti-ligature hinges would be installed no later than 5 weeks (9/26/14), the anti-ligature plumbing covers for the P-traps would be installed no later than 3 weeks (9/12/14), and the anti-ligature faucets would be installed by the end of the day (8/19/14). At the same time during an interview, Staff B stated that the facility has two extra staff every day, in every unit monitoring the areas that could be used as anchors in every room, every 15 minutes, and that starting today (8/19/14) a monitoring form/log will be documented. 22. The women's patient common bathroom had a standard faucet and exposed plumbing that could be used as anchors.	□A 701□	**21). Corrective Actions**: Dining room bathroom standard faucet was replaced with anti-ligature faucet, the p-trap cover was installed, the metal shelf was removed and a third party certified company was hired to replace mortise hinges with anti-ligature hinges **(Attachment 12)** **Date of Implementation**: Faucet □August 19, 2014; P-Trap cover □September 12, 2014 ; Metal Shelf removed □August 19, 2014; Anti-ligature hinges - September 26, 2014. **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. .**(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing **22).Corrective Actions**: Women□s patient common bathroom standard faucet was replaced with an anti-ligature faucet and the p □trap cover was installed to cover exposed plumbing. **Attachment 13)** **Date of Implementation**: Faucet □August 19, 2014; P-Trap cover □September 12, 2014. **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. .**(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing	8/19/2014 9/12/2014 9/26/2014 8/19/2014 9/12/2014

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□A 701□	Continued From page 41 Between 1:30 p.m. and 2:58p.m., during an interview, Staff P stated that the anti-ligature plumbing covers for the P-traps would be installed no later than 3 weeks (9/12/14), and the anti-ligature faucets would be installed by the end of the day (8/19/14). At the same time during an interview, Staff B stated that the□facility has two extra staff every day, in every unit monitoring the areas that could be used as anchors in every room, every 15 minutes, and that starting today (8/19/1.4) a monitoring form/log will be documented. 23. The men's patient common bathroom had standard faucet and exposed plumbing that could be used as anchors. Between 1:30 p.m. and 2:58p.m., during an interview, Staff P stated that the anti-ligature plumbing covers for the P-traps would be installed no later than 3 weeks (9/12/14), and the anti-ligature faucets would be installed by the end of the day (8/19/14). At the same time during an interview, Staff B stated that the facility has two extra staff every day, in every unit monitoring the areas that could be used as anchors in every room, every 15 minutes, and that starting today (8/19/14) a monitoring form/log will be documented. 24. Patient rooms, including rooms 101, 109, and 110 had loose toilets. 25. Patient rooms, rooms 108 and 109 loose sinks.	□A 701□	**. 23). Corrective Actions**: Men□s patient common bathroom standard faucet replaced with an anti-ligature faucet and the p □trap cover was installed to cover exposed plumbing. **Attachment 14)** **Date of Implementation**: Faucet □August 19, 2014; P-Trap cover □September 12, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. .**(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing **24). Corrective Actions**: Toilets in rooms 101, 109 & 110 were re-secured. **(Attachment 15)** **Date of Implementation**: August 19, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. .**(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing **25). Corrective Actions**: Sinks in room 108 & 109 were remounted and secured. **(Attachment 15a)** **Date of Implementation**: August 19, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. .**(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing	8/19/2014 9/12/2014 8/19/2014 8/19/2014

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□A 701□	Continued From page 42 26. Patient rooms, including rooms 101 and 107 had leaking plumbing at the toilet pipes. 27. Dining room bathroom had a water leak at the toilet plumbing. Station 2 There were fixtures throughout that could be used as anchor points to tie to that can hold a person's weight throughout the unit; including exposed plumbing pipes (water supply to toilet and sink drain line), standard faucets, and mortise hinges. 28. Patient rooms, including rooms 203, 205, 207, 209, 210,211,212, 213,214, 215, 217,218, 219,220, 222, and 226 had exposed plumbing pipes that could be used as anchors. Between 1:30 p.m. and 2:58 p.m. during an interview the Lead Engineer stated that the anti-ligature plumbing covers for the P-traps would be installed no later than 3 weeks (9/12/14). At the same time during an interview, Staff B stated that the facility has two extra staff every day, in every unit monitoring the areas that could be used as anchors in every room, every 15 minutes, and that starting today (8/19/14) a monitoring form/log will be documented. 29. Patient rooms, including rooms 215, 217, 219, 220, 222, and. 226 had standard faucets that could be used as anchors. Between 1:30p.m. and 2:58p.m. during an interview the Lead Engineer stated that	□A 701□	**26). Corrective Actions**: Toilet pipes in room 101 & 107 were replaced & repaired. **(Attachment 16)** **Date of Implementation**: August 19, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. .**(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing **27). Corrective Actions**: The dining room toilet plumbing pipes were repaired. **(Attachment 17)** **Date of Implementation**: August 19, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. .**(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing **Station 2** **28). Corrective Actions**: P trap covers were installed in rooms 203, 205, 207, 209, 210, 211, 212, 213, 214, 215, 217, 218, 219, 220, 222 and 226 to cover exposed plumbing. **(Attachment 18)** **Date of Implementation**: August 19, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. .**(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing **29). Corrective Actions**: The standard faucets were replaced with anti-ligature faucets in patient rooms 215, 217, 219, 220, 222, and 226. **(Attachment 19)** **Date of Implementation**: August 19, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. .**(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing	8/19/2014 8/19/2014 8/19/2014 8/19/2014

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□A 701	Continued From page 43 anti-ligature faucets would be installed by the end of the day (8/19/14). At the same time during an interview, Staff B stated that the facility has two extra staff every day, in every unit monitoring the areas that could be used as anchors in every room, every 15 minutes, and that starting today (8/19/14) a monitoring form/log will be documented. 30. The shaving room had a standard faucet that could be used as an anchor. 31. Patient rooms, including rooms 203, 205, 207, 209, 210, 211, 212,213,214,215,217,218, 219, 220, 222, and 226 had standard mortise hinges that could be used as anchors. Between 1:30 p.m. and 2:58 p.m., during an interview, Staff P stated that the anti-ligature hinges would be installed no later than 5 weeks (9/26/14). At the same time during an interview, Staff B stated that the facility has two extra staff every day, in every unit monitoring the areas that could be used as anchors in every room, every 15 minutes, and that starting today (8/19/14) a monitoring form/log will be documented. 32. Shower room □3 had mortise hinges that could be used as anchors. Between 1:30 p.m. and 2:58p.m., during an interview, Staff P stated that the anti-ligature hinges would be installed no later than 5 weeks (9/26/14). At the same time during an interview, Staff B	□A 701□	**30). Corrective Actions**: The standard faucet was replaced with an anti-ligature faucet in the shaving room. **(Attachment 20)** **Date of Implementation**: August 19, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. **(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing **31). Corrective Actions**: A third party certified company was hired to replace mortise hinges with anti-ligature hinges in rooms 203, 205, 207, 209, 210, 211, 212, 213, 214, 215, 217, 218, 219, 220, 222, and 226. **(Attachment 21).** Originally scheduled to be done by 9/26/14, the manufacturer needed additional time to complete the back order. **Date of Implementation**: October 22, 2014, **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. .**(Attachment 2) Person Responsible**: Director of Engineering & Nursing **32). Corrective Actions**: A third party certified company was hired to replace mortise hinges with anti-ligature hinges in Shower room □3. **(Attachment 22).** Originally scheduled to be done by 9/26/14, the manufacturer needed additional time to complete the back order. **Date of Implementation**: October 22, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. .**(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing	8/19/2014 10/22/2014 10/22/2014

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□A 701□	Continued From page 44 stated that the facility has two extra staff every day, in every unit monitoring the areas that could be used as anchors in every room, every 15 minutes, and that starting today (8/19/14) a monitoring form/log will be documented. 33. The observation room bathroom had exposed plumbing, and standard hinges at bathroom and room doors that could be used as anchors. Between 1:30 p.m. and 2:58p.m., during an interview, Staff P stated that the anti-ligature plumbing covers for the P-traps would be installed no later than 3 weeks (9/12/14), and that the anti-ligature hinges would be installed no later than 5 weeks (9/26/14). At the same time during an interview, Staff B stated that the facility has two extra staff every day, in every unit monitoring the areas that could be used as anchors in every room, every 15 minutes, and that starting today (8/19/14) a monitoring form/log will be documented. 34. Bathroom in patient room 212 had a loose toilet. 35. Bathroom in patient room 214 had a loose sink. 36. Station 2 Patient patio had an avocado tree with branches against and over the building roof line, creating access to the roof for potential rodent activity. Outpatient (Van Nuys campus)	□A 701□	**33). Corrective Actions**: A P trap cover was installed and a third party certified company was hired to replace mortise hinges with anti-ligature hinges in the observation room bathroom. **(Attachment 23).** Originally scheduled to be done by 9/26/14, the manufacturer needed additional time to complete the back order. **Date of Implementation**: October 22, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. .**(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing **34). Corrective Actions**: The toilet in room 212 was re-fastened and secured. **(Attachment 24)** **Date of Implementation**: August 19, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. .**(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing **35). Corrective Actions**: The sink in room 214 was re-fastened and secured. **(Attachment 24a)** **Date of Implementation**: August 19, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. **(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing **36). Corrective Actions**: The avocado tree branches at Station 2 patient patio were trimmed away from the building roof. **(Attachment 24b)** **Date of Implementation**: August 19, 2014 **Monitoring Process**: Security conducts daily monitoring of the grounds. **(Attachment 2)** **Person Responsible**: Security **Van Nuys** **Outpatient**	10/22/2014 8/19/2014 8/19/2014 8/19/2014

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□A 701□	Continued From page 45 37. Common Unisex bathroom by group meeting room II, had a standard faucet, exposed plumbing pipes and standard mortise hinges at the door that could be used as anchors. Between 1:30 p.m. and 2:58 p.m., during an interview, Staff P stated that the anti-ligature hinges would be installed no later than 5 weeks (9/26/14), the anti-ligature plumbing covers for the P-traps would be installed no later than 3 weeks (9/12/14), and the anti-ligature faucets would be installed by the end of the day (8/19/14). At the same time during an interview, Staff 8 stated that the facility has two extra staff every day, in every unit monitoring the areas that could be used as anchors in every room, every 15 minutes, and that starting today (8/19/14) a monitoring form/log will be documented. 38. Common Unisex bathroom by group meeting room II, had a water leak at the toilet's flush pipe. Culver City Campus Pavilion 6th floor Pavilion There were fixtures throughout that could be used as anchor- points to tie to that can hold a person's weight throughout the unit; including exposed plumbing pipes (water supply to toilet and sink drain line), standard faucets, and mortise hinges. 6th floor Unit A Psychiatric	□A 701□	**37). Corrective Actions**: The standard faucet was replaced with anti-ligature faucet and the p □trap cover was installed to cover exposed plumbing in the common unisex bathroom. A third party certified company was hired to replace mortise hinges with anti-ligature hinges also in the common unisex bathroom. **(Attachment 25)** **Date of Implementation**: Faucet □ August 19, 2014; P-Trap cover □ September 12, 2014; Anti-ligature hinges- October 22, 2014 **Monitoring Process**: EOC monitoring is conducted by Engineering weekly and by Nursing daily. **(Attachment 2)** **Person Responsible**: Director of Engineering & Nursing **38). Corrective Actions**: Loose toilets in common room bathroom by group room II loose toilet bolts were replaced & tightened. **(Attachment 25a)** **Date of Implementation**: Bolts replaced & tightened 8/19/14 **Monitoring Process**: EOC monitoring is to be done by Engineering weekly and weekly monitoring by IOP staff. **(Attachment 2)** **Person Responsible**: Director of Engineering & Director of IOP **Culver City** **6th Floor Pavilion – Unit A** **39).Corrective Actions**: P trap covers were installed in rooms 605, 606, 607, 608 and 609 to cover the exposed plumbing pipes. **(Attachment 26)** **Date of Implementation**: September 19, 2014 **Monitoring Process**: Behavioral health is conducting daily inspection of patient rooms including checking of p trap covers. In addition the monitoring of p trap covers was also added to the Bi-annual check list of the Environment of Care rounds for patient care areas. **(Attachment 27)** **Person Responsible**: Director of BHU & Director of Engineering	8/19/2014 9/12/2014 10/22/2014 8/19/2014 9/19/2014

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□A 701□	Continued From page 46 On 8/20/14 between 8:30a.m. and 9:04a.m. the following conditions existed in 6th floor Psychiatric Unit A. 39. Patient rooms, including rooms 605, 606, 607, 608, and 609 had exposed plumbing pipes that could be used as anchors. 40. Patient rooms, including rooms 602, 604, 605, 606, 607, 608, and 609 had one ligature resistant mortise hinge, and three standard mortise hinges that could be used as anchors on the doors. 41. Shower room 1 had a make-shift safety grab bar. The grab bar had two 2 inch by 1/4 inch spaces between the bar & plate that could be used as an anchor. The shower room also had standard mortise hinges. 42. Shower room 4 had a make-shift safety grab bar. The grab bar had two spaces between the bar & plate that could be used as an anchor. There were also pluming extensions at the shower head pipe that could be used as an anchor. The shower room also had standard mortise hinges. 6th floor Unit B Psychiatric On 8/20/14 between 9:04a.m. and 9:30a.m. the following conditions existed in 6th floor Psychiatric Unit B. 43. Patient rooms, including rooms 622, 624, 625, 627, 628 and 629 had exposed plumbing pipes that could be used as anchors. 44. Patient rooms, including rooms 622, 623, 624,	□A 701□	**40).Corrective Actions**: A third party certified company replaced mortise hinges with anti-ligature hinges in rooms 602, 604, 605, 606, 607, 608 and 609. **(Attachment 28)** **Date of Implementation**: Completed October 22, 2014 **Monitoring Process**: Behavioral health conducting daily inspection of patient rooms including checking of door hinges. **(Attachment 27)** **Person Responsible**: Director of Engineering & Director of BHU **41).Corrective Actions**: Shower room 1: The safety grab bar was repaired and a third party certified company replaced mortise hinges with anti-ligature hinges. **(Attachment 28)** **Date of Implementation**: September 15, 2014 and October 22, 2014, respectively. **Monitoring Process**: Behavioral health conducting daily inspection of patient rooms/shower rooms including checking of safety grab bars and door hinges. **(Attachment 27)** **Person Responsible**: Director of Engineering & Director of BHU **42).Corrective Actions**: Shower room 4: The safety grab bar was repaired and a third party certified company replaced the mortise hinges with anti-ligature hinges. **(Attachment 29)** The plumbing extension at the shower head pipe was removed. **Date of Implementation**: Grab bar repaired - September 15, 2014; Hinges replaced □ October 22, 2014; Plumbing extension removed □ August 22, 2014 **Monitoring Process**: Behavioral health conducting daily inspection of patient rooms/shower rooms including checking the safety grab bars, the anti-ligature hinges and the shower room in general. **(Attachment 27)** **Person Responsible**: Director of Engineering& Director of BHU **6th Floor – Unit B Psychiatric** **43).Corrective Action**s: P trap covers were installed in rooms 622, 624, 625, 627, 628 and 629 to cover the exposed plumbing pipes. **(Attachment 30)** **Date of Implementation**: September 19, 2014 **Monitoring Process**: Behavioral health conducting daily inspection of patient rooms including checking of p trap covers. **(Attachment 27)** In addition the monitoring of p trap covers was also added to the Bi-annual check list of the Environment of Care rounds for patient care areas. **(Attachment 2)** **Person Responsible**: Director of BHU & Director of Engineering **44). Corrective Action**s: A third party certified company replaced the mortise hinges with anti-ligature hinges in rooms 622, 623, 624, 625, 627, 628 and 629. **(Attachment 31)** **Date of Implementation**: October 22, 2014 **Monitoring Process**: Behavioral health conducting daily inspection of patient rooms including checking of door hinges. **(Attachment 27)** **Person Responsible**: Director of Engineering & Director of BHU	10/22/2014 9/15/2014 10/22/2014 8/22/2014 9/15/2014 10/22/2014 9/19/2014 10/22/2014

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□A 701□	Continued From page 47 625, 627, 628 and 629 had one ligature resistant mortise hinge, and three standard mortise hinges that could be used as anchors on the doors. 45. The men's common bathroom by day room had a standard faucet and an exposed plumbing pipe (P-trap) under the sink that could be used as an anchor. 6th floor Unit C Psychiatric On 8/20/14 between 9:30a.m. and 9:45a.m. the following conditions existed in 6th floor Psychiatric Unit C. 46. Patient rooms, including rooms 630, 631, 632, 634, 635, and 639/day room had exposed plumbing pipes that could be used as anchors. 47. Patient rooms, including rooms 630, 631, 632, 634, 635, 636, and 639/day room had one ligature resistant mortise hinge, and three standard mortise hinges that could be used as anchors on the doors. 48. Patient rooms, including rooms 634, 635, and 639/day room had standard faucets that could be used as anchors. 49. Patient rooms 632 and 636 had missing soap dispensers. 50. Patient room 634 had a missing soap dispenser cover. 51. Room 636 (seclusion room) had an	□A 701□	**45) Corrective Action**s: The standard faucet in the men□s common bathroom was replaced with anti-ligature faucet and a p trap cover was installed to cover the exposed plumbing pipe under the sink. **(Attachment 32)** **Date of Implementation**: September 19, 2014 **Monitoring Process**: Behavioral health conducting daily inspection of patient rooms/bathrooms including checking of faucets and the p trap covers in the men□s common bathroom. **(Attachment 27 & 2)**. In addition the monitoring of p trap covers and anti-ligature faucets was also added to the Bi-annual check list of the Environment of Care rounds for patient care areas. **Person Responsible**: Director of Engineering & Director of BHU. **6th Floor – Unit C Psychiatric** **46). Corrective Action**s: P trap covers were installed in rooms 630, 631, 632, 634, 635 and 639 to cover the exposed plumbing pipes. **(Attachment 33)** **Date of Implementation**: September 19, 2014 **Monitoring Process**: Behavioral health is conducting daily inspection of patient rooms which includes checking of p trap covers. **(Attachment 27)** In addition the monitoring of p trap covers was also added to the Bi-annual check list of the Environment of Care rounds for patient care areas. **(Attachment 2)** **Person Responsible**: Director of BHU & Director of Engineering **47).Corrective Action**s: A third party certified company replaced the mortise hinges with anti-ligature hinges in rooms 630, 631, 632, 634, 635, 636 and 639. **(Attachment 31)** **Date of Implementation**: October 22, 2014 **Monitoring Process**: Behavioral health is conducting daily inspection of patient rooms which includes checking of door hinges. **(Attachment 27)** **Person Responsible**: Director of Engineering & Director of BHU **48).Corrective Action**s: The standard faucet was replaced with anti-ligature faucet in rooms. 634, 635 and 639. **(Attachment 34)** **Date of Implementation**: September 15, 2014 **Monitoring Process**: Behavioral health is conducting daily inspection of patient rooms which includes checking of faucets. **(Attachment 27).** The criteria to monitor anti-ligature faucets was also added to the check list of the Environment of Care rounds which is conducted twice a year in patient care areas. **(Attachment 2)** **Person Responsible**: Director of Engineering & Director of BHU **49).Corrective Action**s: Soap dispensers were installed in rooms 632 and 636. **(Attachment 35)** **Date of Implementation**: August 20, 2014 **Monitoring Process**: Behavioral health is conducting daily inspection of patient rooms which includes checking of soap dispensers. **(Attachment 27)** **Person Responsible**: Director of Engineering & Director of BHU **50).Corrective Action**s: A soap dispenser was installed in room 634. **(Attachment 36)** **Date of Implementation**: August 20, 2014 **Monitoring Process**: Behavioral health is conducting daily inspection of patient rooms which includes checking of soap dispensers. **(Attachment 27)** **Person Responsible**: Director of Engineering & Director of BHU **51).Corrective Action**s: Room 636 (seclusion room) was stripped and waxed removing the dirt around the foot of the bed	9/19/2014 9/19/2014 10/22/2014 9/15/2014 8/20/2014 8/20/2014

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□A 701□	Continued From page 48 accumulation of dirt around foot of the bed. 6th floor Unit D Psychiatric On 8/20/14 between 9:45a.m. and 10:05 a.m., the following conditions existed in 6th floor Psychiatric Unit D. 52. Patient rooms, including rooms 612, 614, 615, 616, 617, 619, 620, and 621 had exposed plumbing pipes that could be used as anchors. 53. Patient rooms; including rooms 610, 612, 614, 615, 616, 617, 619, 620, and 621 had one ligature resistant mortise hinge, and three standard mortise hinges that could be used as anchors on the doors. 54. Patient rooms, including rooms 620 and 621, had standard faucets that could be used as anchors. 55. Patient room 612 had a missing soap dispenser. 56. Patient room 612 had a gap between the edge of the sink counter and the wall. 57. Patient room 617 had a loose sink and damaged plaster at the wall around the sink. 58. Patient room 621 had peeling paint at the wall of the bathroom. 4th floor Rehabilitation Unit	□A 701□	**Date of Implementation**: August 20, 2014 **Monitoring Process**: Daily cleaning and rounding are conducted by EVS in the Psych Unit. In addition, detail cleaning is done every weekend. **(Attachment 37 & 38)** **Person Responsible**: Director of EVS **6th Floor – Unit D Psychiatric** **52).Corrective Action**s: P trap covers were installed in rooms 612, 614, 615, 616, 617, 619, 620 and 621 to cover the exposed plumbing pipes. **(Attachment 39)** **Date of Implementation**: September 19, 2014 **Monitoring Process**: Behavioral health is conducting daily inspection of patient rooms which includes checking of p trap covers. **(Attachment 27)** The criteria to monitor p trap covers was also added to the check list of the Environment of Care rounds which is conducted twice a year in patient care areas. **(Attachment 2)** **Person Responsible**: Director of BHU & Director of Engineering **53).Corrective Action**s: A third party certified company replaced mortise hinges with anti-ligature hinges in rooms 610, 612, 614, 615, 616, 617, 619, 620 and 621. **(Attachment 31)** **Date of Implementation**: October 22, 2014 **Monitoring Process**: Behavioral health is conducting daily inspection of patient rooms which includes checking of door hinges. **(Attachment 27)** **Person Responsible**: Director of Engineering & Director of BHU **54).Corrective Action**s: The standard faucet was replaced with anti-ligature faucet in room nos. 620 and 621. **(Attachment 40)** **Date of Implementation**: September 15, 2014 **Monitoring Process**: Behavioral health is conducting daily inspection of patient rooms which includes checking of faucets. **(Attachment 27)** The criteria to monitor anti-ligature faucets was also added to the check list of the Environment of Care rounds which is conducted twice a year in patient care areas. **(Attachment 2)** **Person Responsible**: Director of Engineering & Director of BHU **55).Corrective Action**s: A soap dispenser was installed in room 612. **(Attachment 41)** **Date of Implementation**: August 20, 2014 **Monitoring Process**: Behavioral health is conducting daily inspection of patient rooms which includes checking of soap dispensers. **(Attachment 27)** **Person Responsible**: Director of Engineering & Director of BHU **56).Corrective Action**s: Sink was remounted in room 612 which eliminated the gap between the edge of sink counter and the wall. **(Attachment 42)** **Date of Implementation**: August 26, 2014 **Monitoring Process**: Engineering conducts daily rounds covering all patient rooms in a week. **(Attachment 43)** **Person Responsible**: Director of Engineering **57).Corrective Action**s: Sink was remounted in room 617 and wall was patched and painted. **(Attachment 44)** **Date of Implementation**: August 20, 2014 **Monitoring Process**: Engineering conducts daily rounds covering all patient rooms in a week. **(Attachment 43)** **Person Responsible**: Director of Engineering **58).Corrective Action**s: The peeling paint was removed and the wall of the bathroom in room 621 was painted. **(Attachment 45)** **Date of Implementation**: August 21, 2014 **Monitoring Process**: Engineering conducts daily rounds covering all patient rooms in a week. **(Attachment 43)** **Person Responsible**: Director of Engineering	8/20/2014 9/19/2014 10/22/2014 9/15/2014 8/20/2014 8/26/2014 8/20/2014 8/21/2014

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□A 701	Continued From page 49 59. On 8/20/14 between 10:05 a.m. and 10:23 a.m., Room 423 had a broken diffuser at the wall mounted light fixture by the door. 60. At the construction separation between the back of the 4th floor and the rehabilitation unit at the front of the 4th floor, there was a 3 foot by 5 foot section missing from the gypsum board barrier at the separation. During an interview at the same time as the observation, Staff D stated that the gypsum board barrier is supposed to go all the way up to the ceiling. 3rd floor SICU (surgical intensive care unit) 61. On 8/20/14 at 10:23 a.m., room 332Ahad adhesive paper peeling off of the head wall mounted light fixture. 3rd floor CCU (critical care unit) 62. On 8/20/14 between the time of 10:30 a.m. and 10:40 a.m., the patient rooms' safety monitor was off at the nurses' station. During an interview at the same time as the observation RN (Registered Nurse) 3 stated monitor at the nurses' station was to monitor patients in rooms 333 A through 333L, that the monitor was off because the monitor did not work, and had not worked for a few months.	□A 701	**4th Floor Rehabilitation Unit** **59).Corrective Action**s: The light diffuser in room 423 was replaced. **(Attachment 46)** **Date of Implementation**: August 21, 2014 **Monitoring Process**: Engineering conducts daily rounds covering all patient rooms in a week. **(Attachment 47)** **Person Responsible**: Director of Engineering **60).Corrective Action**s: The 3 foot by 5 foot section of missing gypsum board was extended all the way up to the ceiling by the contractor. Construction crew and Engineering staff were given in-service on ILSM and Above Ceiling process. **(Attachment 48)** **Date of Implementation**: September 1, 2014 **Monitoring Process**: Monitoring for hazards posed by construction (**Attachment 48)** **Person Responsible**: Director of Engineering **3RD Floor SICU (Surgical Intensive Care Unit)** **61).Corrective Action**s: The adhesive paper was removed from the mounted light fixture in room 332A. **(Attachment 49)** **Date of Implementation**: August 27, 2014 **Monitoring Process**: Engineering conducts daily rounds covering all patient rooms in a week. **(Attachment 50)** **Person Responsible**: Director of Engineering **3rd Floor CCU (Critical Care Unit)** **62).Corrective Action**s: The cameras were repaired and safety monitors are back on and working in CCU. **Date of Implementation**. September 8, 2014 **Monitoring Process**: Charge nurse conducts daily monitoring using the Charge RN shift report tool. **(Attachment 51)** **Person Responsible**: Director of Nursing □Critical Care	8/21/2014 9/1/2014 8/27/2014 9/8/2014

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□A 701□	Continued From page 50 3rd floor ACU (ambulatory care unit) On 8/20/14 between 10:44 a.m. and 10:50 a.m. the following conditions existed in 3rd floor ACU. 63. There was damaged upholstery of couches in waiting area outside the □-ray room. 64. There was a one foot crack at the edge between the floor and wall in a stall of the women's common bathroom next to the waiting area outside the □-ray room. 2nd floor 65. On 8/20/14 between 11:02 a.m. and 11:35 a.m., 1 of 4 clean supplies carts was not covered in the clean supply room located across from the nurses' station. 2nd floor Southwest Telemetry 66. On 8/20/14 between 11:02 a.m. and 11:35 a.m., there was a chair in room 202 with torn upholstery. □ 2nd floor Southeast Telemetry On 8/20/14 between 11:02 a.m. and 11:35 a.m. the following conditions existed on the 2nd floor Telemetry Southeast Unit. 67. Room 220 was missing a shower head at the shower stall. 68. Room 220's shower mixing valve was	□A 701□	**3rd Floor ACU (Ambulatory Care Unit)** **63).Corrective Action**s: The damaged couches in the waiting area outside the □-ray room were removed and discarded. **(Attachment 52** **Date of Implementation**: October 21, 2014 **Monitoring Process**: Furniture pieces are checked for damages and tears during the Environment of Care rounds **(Attachment 53)** **Person Responsible**: Director of Engineering **64).Corrective Action**s: The one foot crack between the edge and floor in the stall of the women□s common bathroom next to waiting area outside of □-ray room was repaired **(Attachment 54)** **Date of Implementation**: September 17, 2014 **Monitoring Process**: Engineering conducts daily rounds covering all patient rooms in a week. **(Attachment 43)** **Person Responsible**: Director of Engineering **2nd Floor** **65). Corrective Action**s: Education of staff regarding clean supplies carts in clean supply room must be covered at all times. Charge Nurses to monitor compliance on each shift **(Attachment 55**). **Date of Implementation**: August 22, 2014 **Monitoring Process**: Charge Nurse Rounding on clean supplies cart covers being down and covering supplies at all times (**Attachment 56)** **Person Responsible**: Telemetry Nursing Director **2nd Floor Southwest Telemetry** **66). Corrective Action**s: Chair in room 202 was immediately removed from service and discarded. **(Attachment 57)** **Date of Implementation**: 8-20-14 was discarded. **Monitoring Process**: Charge Nurse & Staff educated to notify Environmental services to remove broken furniture & /or defective upholstery (**Attachment 55).** **Person Responsible**: Telemetry Nurse Director **2nd Floor Southeast Telemetry** **67).Corrective Action**s: The missing shower head in room 220 was replaced. **(Attachment 58)** **Date of Implementation**: August 20, 2014 **Monitoring Process**: Engineering conducts daily rounds covering all patient rooms in a week. **(Attachment 59)** **Person Responsible**: Director of Engineering **68).Corrective Action**s: The shower mixing valve in room 220 was re-reversed to correct water temperature. **(Attachment 60)** **Date of Implementation**: August 21, 2014 **Monitoring Process**: Engineering conducts daily rounds covering all patient rooms in a week. **(Attachment 59)** **Person Responsible**: Director of Engineering	10/21/2014 9/17/2014 8/22/2014 8/20/2014 8/20/2014 8/21/2014

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□A 701□	Continued From page 51 reversed. The patient in room 220 complained that there was no hot water at the shower. Troubleshooting by Staff P at the same time as the complaint revealed that the shower's mixing valve was reversed. 69. Room 221 had a three foot crack at shower stall wall. During an interview, at the same time as the observation Staff R (Lead Man) (for engineering) stated that they (the facility) did not want to replace the shower stall, but instead wanted to repair it. That they were still looking for a vendor to repair the crack at the shower stall wall, that he had called the vendor they usually use for repairs but not received a response, and that he had not called any other vendors. 70. Room 221 was missing a floor drain grate at the shower stall. 71. Room 221 had water leak at the flush pipe of the toilet. 1st floor Laboratory 72. On 8/20/14 at 11:35 a.m., there was a 3ft. by 3 ft. sign water damage and unpainted plaster at the ceiling above Centar machine in the main laboratory. Pharmacy 73. On 8/20/14 at 11:50 a.m., there were signs of water damage at 3 pharmacy ceiling light fixtures	□A 701□	**69**).**Corrective Action**s: The crack in the shower stall wall in room 221 was repaired. **(Attachment 61)** **Date of Implementation**: September 23, 2014 **Monitoring Process**: Engineering conducts daily rounds covering all patient rooms in a week. **(Attachment 59)** **Person Responsible**: Director of Engineering	9/23/2014
			70).Corrective Actions: The floor drain grate at the shower stall in room 221 was replaced. **(Attachment 62)** **Date of Implementation**: August 21, 2014 **Monitoring Process**: Engineering conducts daily rounds covering all patient rooms in a week. **(Attachment 59)** **Person Responsible**: Director of Engineering	8/21/2014
			71).Corrective Actions: The leaky flush pipe of the toilet in room 221 was replaced. **(Attachment 63)** **Date of Implementation**: August 21, 2014 **Monitoring Process**: Engineering conducts daily rounds covering all patient rooms in a week. **(Attachment 59)** **Person Responsible**: Director of Engineering	8/21/2014
			1st Floor **Laboratory** **72).Corrective Action**s: The ceiling above the Centaur machine in the Laboratory was repaired and painted. The pipe causing condensation was insulated. **(Attachment 64)** **Date of Implementation**: August 25, 2014 **Monitoring Process**: Weekly rounds are conducted by Engineering in non-patient room areas **(Attachment 65)**. Environment of Care rounds are conducted weekly covering patient care areas twice a year and non-patient care areas once a year. **Person Responsible**: Director of Engineering & EOC. **Pharmacy** **73).Corrective Action**s: The three Pharmacy light fixtures had light diffusors removed and ceiling assessed for water damage with repair. Brown stains removed off of the light fixtures. **(Attachment 66)** **Date of Implementation**: August 25, 2014	8/25/2014 8/25/2014

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□A 701□	□Continued From page 52 that included brown stains at the light diffusers and frames. Basement Operating Room (OR) 3 74. On 8/20/14 between 11:50 a.m. and 12:20 p.m.., sections of laminate were missing from the door of OR 3. Recovery Area 75. On 8/20/14 between 11:50 a.m. and 12:20 p.m., sections of laminate were missing from the nurses' station. Central Processing 76. On 8/20/14 between 11:50 a.m. and 12:20 p.m.,1 of 2 autoclaves in central processing was out of order. On 8/21/14 at 2:25p.m., during an interview Staff S (Biomed) stated that the autoclave had been out of service since 11/1/13. That he tried to repair it on 11/1/13 but it was beyond his knowledge and called a vendor, but had trouble with the vendor coming to the hospital because of the hospital's address was attached to a bankruptcy. He also stated that on 11/4/13 he found out the autoclave needed a new separator. That the vendor did not visit the facility until11/31/14, and that the purchase requisition for the separator was done on 12/10/13. That he has had the separator for a month and a half, but has had	□A 701□	**Monitoring Process**: Weekly rounds are conducted by Engineering in non-patient room areas. **(Attachment 65)**. Environment of Care rounds are conducted weekly covering patient care areas twice a year and non-patient care areas once a year. **Person Responsible**: Director of Engineering & EOC **Basement** **Operating Room (OR) 3** **74).Corrective Action**s: The laminate section on the door of OR□3 was repaired. **(Attachment 67).** **Date of Implementation**: August 28, 2014 **Monitoring Process**: Weekly rounds are conducted by Engineering in non-patient room areas **(Attachment 65).** Environment of Care rounds are conducted weekly covering patient care areas twice a year and non-patient care areas once a year. **Person Responsible**: Director of Engineering **Recovery Area** **75).Corrective Action**s: Laminate sections from the nurses□ station was repaired. **(Attachment 69)** **Date of Implementation**: September 9, 2014 **Monitoring Process**: Weekly rounds are conducted by Engineering in non-patient room areas **(Attachment 68)**. Environment of Care rounds are conducted weekly covering patient care areas twice a year and non-patient care areas once a year. **Person Responsible**: Director of Engineering **Central Processing** **76).Corrective Action**s: A third party Biomed Company was hired and put autoclave □2 back into service. **(Attachment 70)** **Date of Implementation**: September 2, 2014 **Monitoring Process**: Biomed conducts semi-annual preventative maintenance on medical equipment. **(Attachment 71)** **Person Responsible**: Biomed Engineer and Director of Engineering	8/28/2014 9/9/2014 9/2/2014

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□A 701□	Continued From page 53 trouble getting the vendor to visit the hospital for repair of the autoclave because of scheduling problems. That the vendor had started working on the autoclave today (8/21/14) and would be completed with the repair in 45 minutes, and should be up and running by Monday (8/25/14). He further stated that the nine month delay in getting the autoclave repaired was in trying to find the correct separator, and that it took a while to get a purchase order. That another reason it took so long was because he had other issues to take care of and did not have a full crew. The Asset"10249 history report had entries dated 11/1/13 that indicated that the unit would not hold steam, entry dated 1/31/14 that indicated unit was checked and found to not hold steam and was informed by the vendor that the unit needed a steam separator, and were waiting on parts. The purchase requisition dated 12/10/13, had a description of steam separator as the part requisitioned. The justification noted was that autoclave II was down due to cold condensation and not holding steam, and that the separator would eliminate the problem. Per the Biomed the purchase requisition is the request for his company to give him a purchase order. The request to purchase dated 8/8/14, indicated a request to purchase a steam separator for autoclave in central supply. The justification noted was that it was for a repair/installation, that autoclave had condensation problem and needed a steam separator installed to resolve the issue. Tower	□A 701□		

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□A 701□	Continued From page 54 6th Floor Detox Unit 77. On August 21, 2014 at 8:43a.m., in room 680, there was a missing cover at the toilet paper dispenser, there was an unpainted plaster patch at the wall next to the toilet, and there was black and green slime at the bed pan washer joint. Single Story Building Exterior West Side 78. OnAugust21, 2014 between 9:10a.m. and 9:35a.m. there were seven bins at the exterior west side of the single storage building. The area was accessible through an interior door with a radiation caution sign. Three of the seven bins had cracked and broken lids on them, and contained trash in clear plastic bags that were visible through the cracked and broken areas of the lids. One of the bags was untied and open, and another bag had an accumulation of moisture in the bag. Four of the seven bins had no lids, and were empty. During an interview at the same time as the observation Staff U (Chief Nuclear Medical Technician) stated that the waste in the bins was nuclear waste from tracers and that the area was a secured area where the nuclear waste was allowed to decay. Radioactive Laboratory 79. On August 21, 2014 at 11 a.m., in the	□A 701□	**Tower** **6th Floor Detox Unit** **77).Corrective Action**s: The toilet paper dispenser was replaced, wall was painted and alkaline deposit on the bed pan washer joint was cleaned in the restroom in room 680. **(Attachment 72)** **Date of Implementation**: August 26, 2014 **Monitoring Process**: Engineering conducts daily rounds covering all patient rooms in a week. **(Attachment 73)** **Single Story Building** **Exterior West Side** **78).Corrective Action**s: The cracked containers with broken lids have been removed and discarded. New covered containers have been purchased and relocated to a secured non-public area. **(Attachment 79)** **Date of Implementation**: September 1, 2014 **Monitoring Process**: On-going. **Person Responsible**: Director of Ancillary Services & Chief Nuclear Medicine Technologist **Radioactive Laboratory** **79). Corrective Action**s: The □bolts□on the exam table in the Nuclear Medicine exam suite have been replaced. **(Attachment 80)** **Date of Implementation**: September 1, 2014 **Monitoring Process**: On-going. **Person Responsible**: Director of Ancillary Services & Chief Nuclear Medicine Technologist	8/26/2014 9/1/2014 9/1/2014

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□A 701□	Continued From page 55 Radioactive Laboratory, (Nuclear Medicine □1) the examination table had two missing nylon fasteners replaced with metal bolts and nuts, with the end of the bolts facing up to where the patient would lie on the table. The end of one of the bolt had a sharp edge, and the nut was loose. 80. Hollywood Campus Emergency Preparedness During observation on 8/18/14 beginning at 10:45 a.m., the hospital's disaster preparedness was reviewed in the presence of Staff L (Director of Food Service). In a concurrent interview, she stated that the hospital was planning for a total of 200 patients and staff for a period of 4 days. She also stated the plan was to utilize dehydrated meal products. Review of the inventory revealed that currently the hospital had 125 meals on hand for approximately two days; however had planned to augment that supply with additionally stocked dry goods such as canned tuna. Review of current stock revealed there were 9 cans each weighing 5 pounds which would equate to 200 servings, a quantity for 1 meal. It is unclear how the hospital would implement the plan when there was no menu, staff guidance, recipes or evaluation of inventory to ensure the development of a comprehensive feeding plan that would meet the nutritional needs and could be implemented in the event of a disaster. In addition, additional review of 8/18/14 at 2:45p.m. of available fluid revealed that the hospital had insufficient quantities of dry milk. The plan as discussed would be inadequate to meet the hospital needs for four days. It was also noted that the dehydrated meal	□A 701□	**Hollywood** **80).Corrective Action**s: A plan was enacted to have on hand a minimum of 4 days of water & 7 days of foods and related supplies on hand based on population of 200. (100 licensed beds and 100 staff and others) as indicated by the policy. **(Attachment 74).** Disaster preparedness meeting minutes **(Attachment 75)** **Date of Implementation**: August 28, 2014 **Monitoring Process**: Monthly inventory inspection will be conducted. **(Attachment 76)** **Person Responsible**: Dietary Manager & Facility Management	8/28/2014

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□A 701□	Continued From page 56 products were stored in a house adjacent to the hospital building which was used as an office for engineering. There were no defined security actions taken to ensure the security of the supply. In an interview on 8/18/14 beginning at 4:30 p.m., with Staff N (Disaster Coordinator), he stated that he followed guidelines set forth by a specialty grant awarded to hospitals for disaster preparedness. He described the grant requested hospitals be self-sufficient for 3 days. He also stated that meetings were held with local hospitals and clinics; however, Staff N was unsure of the involvement of federal and/or local agencies with this hospital committee. Staff N was also asked to demonstrate membership/sponsorship of this committee. As of 8/21/14 at 2 p.m., the hospital was unable to demonstrate coordinated involvement at the local, state or federal level. There were also inconsistencies between hospital departments with respect to timeframes for self-sufficiency. This is a repeat deficiency from the sampled validation survey on April 1, 2014.	□A 701□		
□A 703□	482.41(a)(2) EMERGENCY GAS AND WATER There must be facilities for emergency gas and water supply. This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to have documented evidence of an approved system to provide emergency water and ensure an effective water management plan and supplies to be implemented in a widespread disaster.	□A 703□		

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□A 703□	Continued From page 57 This deficient practice had the potential to result in inadequate supply of drinking water and water for other purposes to all patients and staff during a disaster affecting the hospital and effectively meet the hydration and personal care needs of patients. Finding: On August 19, 2014 at 2:58p.m., during document review there was no approved written plan to provide emergency water as needed to provide care to inpatients and other persons who may come to the hospital in need of care. The facility provided a document that had a policy titled, Loss of Water Policy and procedure, Number: EMP.018, as documented evidence of a system to provide emergency water and ensure an effective water management and supplies to be implemented in a widespread disaster to effectively meet the hydration and personal care needs of patients and staff. Review of the document indicated it was not a policy in effect as evidenced by the lack of an effective date. The document indicated it had not been reviewed or approved by the EOC Committee, Quality Council, Medical Executive Committee, and Governing Body, as evidenced by a lack of dated signatures on the front page and in the Approval section (section 10.0). The document also indicated a failure to assign responsibility as evidenced by no person, department or entity identified in the Responsibility section (section 5.0). During an interview at the same time as the review, Staff D (Corporate Director of Facilities)	□A 703□	**Corrective Action**s: The Loss of Water Policy and Procedure was approved by the EOC Committee, Quality Council Committee, Medical Executive Committee and the Governing Board. **(Attachment 1)** **Date of Implementation**: EOC Committee: July 2014; Quality Council: September 2014; MEC: September 2014; Governing Board: September 2014 **Monitoring Process**: The policy will be reviewed annually and will be presented back to the committees tri-annually. **Person Responsible**: Director of Engineering	07/2014 9/2014

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□A 703□	Continued From page 58 stated the document had not yet been approved as policy, that it had only been approved by the EOC committee, was currently going through the Medical Executive Committee, and then would go to the Governing Board. This is a repeat deficiency from the sampled validation survey on April 1, 2014.	□A 703□		
□A 724□	482.41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This STANDARD is not met as evidenced by: Based on observation, review of hospital documents and staff interviews, the hospital failed to maintain its refrigerators, freezers,. plate warmer and supplies to ensure an acceptable level of safety and quality. Failures resulted in storage of food at unsafe food temperature range. Safe food temperature range is 0 degrees Fahrenheit and below for frozen items and 41 degrees and below for refrigerated items. Storage of food outside of these temperature ranges could result in growth of food borne illness causing microorganisms thereby endangering the safety of patients, staff and visitors. In addition, the use of disposable ware resulted in poor maintenance of food temperatures and unpalatable food. Findings: Hollywood Campus 1. During the initial tour on 8/18/14 beginning at 10 a.m., there was a significant ice build-up within	□A 724□		

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□A 724□	Continued From page 59 the walk-in freezer. There was a large piece of ice, measuring approximately 6" (inches) x 6" x 4," adhered to the metal shelving directly below the blower. Additionally there were pieces of ice measuring from 1" to 4" adhered to the floor, mats on the floor, a buildup of ice on the blower within the unit and a frozen condensation buildup on the air curtain (plastic strips that are adhered to the interior door frame to mitigate the escaping of the cold air). It was noted that the internal thermometer read 10□F. In a concurrent interview with Dietary Staff (OS) 3, "She stated that during the past 2 weeks the unit had not been functioning properly. She also stated that the hospital had several service calls, each vendor indicated the unit was fixed; however the issues persisted with no recent attempts to further address the issue. It was also noted that this temperature depicted an unacceptable temperature (which was designated as a red color) on the thermometer. A follow up observation on 8/18/14 at 12:30 p.m., and 4 p.m., noted the freezer temperature was consistently 32□F. It would be the standard of practice to ensure equipment was maintained in a manner to keep frozen foods frozen (Food Code, 2013). In a follow up interview on 8/19/14 at 12:30 p.m., with OS 3, she stated the previous evening a different vendor evaluated the unit. She further stated she was told the unit had significant issues; however it would not be able to be accurately evaluated until the unit was empty and defrosted. Review of the service work orders dated 7/19/14 noted that the door sweep and door curtain strip required replacement and it was also noted there was an electrical issue with the door frame heater	□A 724□	**Hollywood** **1).Corrective Action**s: A third party vendor repaired the walk-in freezer to meet the temperature requirement and to eliminate ice build ups. **(Attachment 1)** **Date of Implementation**: August 18, 2014 **Monitoring Process**: Dietary staff is monitoring the freezer and refrigerator temperature twice daily. **Person Responsible**: Dietary Manager and Plant Operations	8/18/2014

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□A 724□	Continued From page 60 wire. Review of completed work order dated 7/22/14 noted that 2 out of the 3 items were repaired. There was no documentation that the heater wire repair was completed. It was also noted that the most recent work order was dated 1 month prior; however the issue continued to be unresolved. In an interview on 8/18/14 beginning at 3:30 p.m., with Staff 18, he stated he was told by the vendor that the issue was fixed; however was unable to demonstrate an effective system to ensure that identified maintenance issues were fully resolved. Review of hospital submitted document titled, □Freezer Temperature□dated 8/20/14 noted that despite repair interventions on the evening of 8/18, and early morning hours of 8/19 and 8/20 the facility document titled, □Freezer Temperature Log□dated 8/20/14 demonstrated that 6 of 8 recorded temperatures were greater than 0°F, ranging from 1-35°F. Departmental policy titled, □Temperatures of Refrigerators and Freezers□dated 12/12 noted that □Freezer temperatures shall be 0°F or less.□ Hospital policy titled, □Work Order Request Procedures□dated 11/12 revealed that the Director of Plant Operations was the position accountable and responsible for monitoring and enforcement of the work order request procedures. It was also noted that the work order request form was an electronic system that was accessible on all hospital computers. The policy also depicted that urgent requests would be those that a lack of action would jeopardize the operation of the medical center and procedures for resolution of urgent issues would be corrected by the fastest means possible. Staff N (Disaster Coordinator) was unable to demonstrate the implementation of the work order system for this	□A 724□		

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□A 724□	Continued From page 61 issue. Departmental policy titled, "Management of the Environment of Care" dated 11/12 noted it was the responsibility of the department director as the position responsible for maintaining safety standards. Culver City Campus 1. During general food storage observations on 8/19/14 beg.inning at 2:20p.m., in walk-in refrigerator □2, there was a circular hole of the flooring measuring approximately 6" (inches) x 6 " x 2 " exposing the wood underneath the flooring. It was also noted that at the joint where the wall and flooring met, there were multiple areas where the metal wall material was covered by a brown rust-like material, the wall material was disintegrating, exposing the wood behind the wall. Additionally it was also noted that at the plastic coating of the food storage shelves was disintegrating, exposing a brown, rust-like material that could be wiped off. In a concurrent interview with RD 3 (Registered Dietitian), he stated that he had put a repair work order for the floor; however had not noted the exposed wood on the walls. He also stated he had no response from facility operations regarding an evaluation or proposed solution to the maintenance issue. Dietary document titled "Work Order" dated 7/14/14 (1 month earlier) revealed that while the issue was identified there was no activity with respect to completion of the request. The work order also noted that the hole presented a safety risk to staff and was unsanitary. The standard of practice would be to ensure that equipment remained free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections and was finished to have smooth welds and joints (Food Code, 2013).	□A 724□	**Culver City** **1a).Corrective Actions**: Work order was re-submitted for the circular hole in the floor of refrigerator □2. Repair has been completed. **(Attachment 2)** **Date of Implementation**: 8/21/14 **Monitoring Process**: Weekly monitoring of Work orders process. **(Attachment 3)** **Person Responsible**: RD, Director of Dietary Services & Director of Plant Management **1b) Corrective Actions**: Work order was submitted for refrigerator □2 and the repair of the joint where the wall and floor meet **(Attachment 4)** **Date of Implementation**: Work order submitted 8/21/14; repair completed on 10/21/14 **Monitoring Process**: Work orders are tracked with the FNS department for completion **Person Responsible**: RD, Director of Dietary Services & Director of Plant Management **1c) Corrective Actions**: Wiped off the brown rust like material. Replacement shelving has been ordered; will be installed upon receipt. **(Attachment 5)** **Date of Implementation**: 11/7/14 expected completion **Monitoring Process**: Work orders are tracked with the FNS department for completion. **Person Responsible**: RD, Director of Dietary Services & Director of Plant Management	8/21/2014 10/21/2014 11/7/2014

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□A 724□	Continued From page 62 In an interview on 8/20/14 at 9:20a.m., with Staff C (CEO) and A (Administrator), they stated they were recently assigned to provide leadership to the hospital and acknowledged that they were notified during the survey the scope of maintenance issues in relationship to dietetic services. Departmental policy titled, "Repairs" dated 11/12 noted that once the department files a copy of written request in the department " 4.2.4 Maintenance Department initiates repairs within 24-48 hours ... " 2. During the food service observations on 8/19/14 beginning at 12:50 p.m., there was a patient refrigerator in the behavioral health unit. It was noted that in both the refrigerator and freezer there was a build-up of unidentifiable food products. It was also noted that the gaskets on the unit had a brown discoloration, resembling rust. Additionally the gaskets were partially torn and no longer fully adhered to the unit. 3. During general kitchen observations on 8/19/14 beginning at2:50 p.m., there were greater than 10 patient meal delivery trays that were cracked and had exposed metal edges. It would be the standard of practice to ensure that all patient meal delivery utensils be free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections (Food Code, 2013). Hospital policy titled, "Storage of Pots, Dishes, Flatware, Utensils" dated 11/12 noted that "All utensils ...equipment will be kept clean, maintained in good repair ..." 4. The plate warmer has been out of order prior to the first survey in April 2014. All patients are being served food on disposable Styrofoam	□A 724□	**2).Corrective Action**s: The Refrigerator in BHU was replaced. **(Attachment 6)** **Date of Implementation**: August 22, 2014 **Monitoring Process**: Behavioral Health conducts daily environmental rounds including inspection of refrigerators. **(Attachment 7)** **Person Responsible**: Director of BHU **3).Corrective Action**s: The meal delivery trays identified as being cracked with exposed metal edges were immediately removed from service and replaced with new ones from storage. **Date of Implementation**: August 19, 2014 **Monitoring Process**: The condition of patient meal service ware (including trays) will be observed as part of the Routine Infection Control and Food Safety Audit **(Attachment 8)**. **Person Responsible**: RD, Director of Dietary Department **4) Corrective Action**s: A new plate warmer was purchased, delivered and installed at Hollywood **(Attachment 9)** **Date of Implementation**: 9/17/2014 **Monitoring Process**: Equipment functionality is monitored via Plant Operation rounding and the work order process **Person Responsible**: RD, Director of Dietary Department and Director of Plant Management	8/22/2014 8/19/2014 9/17/2014

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□A 724□	Continued From page 63 plates. During food□distribution observations on 8/18/14 beginning at 3:35 p.m., all patient meals were plated using disposable plates, cups and flatware. In a concurrent interview with DS 3, she stated that staff told her the plate warmer was broken. The surveyor asked for an explanation of why a broken plate warmer would cause the hospital to utilize all disposable items. She was unable to explain the rationale. 5. In response to questions about the use of plates in the absence of a plate warmer, DS 3 also acknowledged that during the past 2 weeks (when she took over the position) she had not observed a stock of any dishware or flatware. Van Nuys 6. There was a refrigerator that was labeled "Out of Order" dated 6/4/14. In an interview on 8/19/14 at 4:30p.m. with the Head of Plant Operations, he stated that two weeks earlier the hospital decided that repairing the refrigerator was not ideal because it was too expensive and replacement was more practical. 7. One of the freezers (□5) was observed to read 23 degrees Fahrenheit. The recommended temperature for a freezer is 0 degrees Fahrenheit □ and below. During the survey, arrangements were being made to bring in a refrigerated truck to store the items. It was not clear how long this freezer had not been in good working order. This is a repeat deficiency from the sampled validation survey on 4/1/14.	□A 724□	**5) Corrective Action**s: Dishware and flatware stock implemented for use and purchases made for additional stock **(Attachment 10)** **Date of Implementation**: 9/5/14 **Monitoring Process**: A monthly inventory of china and reusable service ware is maintained at par levels required to meet the facility licensed bed capacity. **(Attachment 11)** **Person Responsible**: RD, Director of Dietary Department and Directors of Plant Management **Van Nuys** **6). Corrective Action**s: Upon further assessment, it was deemed that the refrigerator was repairable and was repaired by an outside vendor. **(Attachment 12)** **Date of Implementation**: October 14, 2014 **Monitoring Process**: Equipment monitoring is conducted by Dietary. **(Attachment 13a)** **Person Responsible**: Dietary **7). Corrective Action**s: A refrigerated truck was ordered to store the items when freezer □5 was observed to read 23 degrees Fahrenheit instead of 0 degrees Fahrenheit. **(Attachment 14)**. **Date of Implementation**: August 29, 2014 **Monitoring Process**: Equipment monitoring is conducted by Dietary **(Attachment 13)** **Person Responsible**: Dietary	9/5/2014 10/14/2014 8/29/2014
A 726	482.41(c)(4) VENTILATION, LIGHT,	A 726		

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A 726	Continued From page 64 TEMPERATURE CONTROLS There must be proper ventilation, light, and temperature controls in pharmaceutical, food preparation, and other appropriate areas. This STANDARD is not met as evidenced by: Based on observation, review of facility documents and staff interviews, the hospital faile to ensure that there was adequate ventilation an proper temperature controls in the kitchen and dry food storage areas. Findings: Hollywood campus 1. During the food production and distribution observations on 8/18/14 beginning at 11:40 a.m., Dietary Staff (OS) 2 was wiping perspiration from his forehead and continuing with food distribution activities without handwashing. It was also noted that the ambient room air temperature was 85□ (degrees) F (Fahrenheit). In a concurrent interview with OS 2, he stated that the room was always hot and that it was verbally mentioned to supervisory staff. He also stated that the only ventilation for the kitchen was an air vent located above the dishwasher. A follow up observation on 8/18/14 at 12:30 p.m., noted that the room temperature increased to 86.5□F. It was also noted that while there was air blowing from the vent, the air was not cool, rather was room temperature. In an interview on 8/18/14 beginning at 5:15 p.m., with Staff V (Engineering Staff), he stated that this was his second day with the campus as plant operations. He also stated that mid- afternoon an employee evaluated the unit and noted that the float which pumped water to the unit was broken. Staff V was unable to	A 726	**Hollywood** **1).Corrective Action**s: A third party vendor serviced the AC and swamp cooler that supplied the cafeteria and kitchen to meet an appropriate temperature. Staff inservices on hand hygiene **(Attachment 1 & 2)** **Date of Implementation**: 9/8/2014 **Monitoring Process**: Dietary conducts room temperature testing twice daily. **(Attachment 3)** **Person Responsible**: Dietary Manager	9/8/2014

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A 726	Continued From page 65 demonstrate that the ventilation in the kitchen was evaluated to ensure that it provided proper ventilation to dietetic services. A follow up observation on 8/18/14 at 5:35p.m., revealed an ambient air temperature in the kitchen of 86□F. 2. During the food storage observations on 8/18/14 beginning at 10:40 a.m., the ambient room temperature in the dry storage area was 74□F. It was noted that the dry storage area contained canned goods as well as dry goods such as crackers, cereals and bakery mixes. In a concurrent interview with Staff L (Director of Food Service), she stated that in accordance with the thermometer in the room the air temperature should be 70° F or below. She also acknowledged that the room thermometer gauge was in the "red" zone (for the thermometer) which depicted that the room was above the upper limit of 70□F. She also stated she was unsure of air supply to the dry storage area. It was also noted that while there was a vent in the room there was no air circulation. Van Nuys At 11:53 a.m. on 8/19/14, the ambient air temperature of the dry storage room was 88.6 degrees Fahrenheit (per surveyor thermometer). There was no visible thermometer hanging in the room. In response to the comment by the surveyor that the room seemed warm, Staff K placed a new room thermometer in the room. At 12:55 p.m., the temperature was 88 degrees Fahrenheit. The dry storage thermometer gauge had exceeded the graduated 80 degree mark indicating that the room was warmer than 80 degrees.	A 726	**2) Corrective Action**s: Storage area is now within standards of 50 to 70 degrees. Action taken to reach these temperatures includes hiring a third party certified vendor to adjust the dampers allowing the required air flow in the area. **(Attachment 1)** **Date of Implementation**: 8/25/14 **Monitoring Process**: Daily monitoring of Dry Food Storage temperatures to ensure compliance with Food Code 2013 of temperatures between 50-70 degrees. Department EOC Rounds and Monthly Infection Control and Food Safety Audits. **(Attachment 4 & 5)** **Person Responsible**: RD, Director of Dietary Department and Director of Plant Management **Van Nuys** **1) Corrective Action**s: The Dry Food storage area was moved to a location that did not contain a refrigerator/freezer unit. The Dry food storage area has been provided a thermometer with daily monitoring of temperatures to ensure compliance with Food Code 2013 temperatures range between 50-70 degrees **Date of Implementation**: 8/20/14 **Monitoring Process**: Daily monitoring of Dry Food Storage temperatures **(Attachment 6).** **Person Responsible**: RD, Director of Dietary Department and Directors of Plant Management	8/25/2014 8/20/2014

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A 726	Continued From page 66 Although there was an air vent in the room, there was a refrigerator/freezer in the room that generated heat possibly contributing to the high room temperature. In an interview with Staff K, she stated that they do not monitor or keep logs of the dry storage room. According to the same policy described above, "All dry goods are stored in storeroom that is clean, dry and well ventilated ... " The dry storage room was not well-ventilated. Improperly stored staple foods could result in poor quality such as deterioration of food products including rancidity and altered flavors. Foods held at less than optimum temperatures could support the growth of microorganisms that promote spoilage and /or food borne illness. Best practices guidelines would ensure dry food staples such as flour, crackers, cake mixes, seasonings, and canned goods should be stored in their original packages at an optimal range 50°F to 70□F. Higher temperatures speed up deterioration (Virginia, Clemson State and Ohio State Universities Cooperative Extension). While the hospital's policy titled, "Food Supply and Storage Procedures" dated 11/12 noted that dry storage areas may be maintained at temperatures ranging from 50-75□F, there were no standard of practice references to support the elevated temperature range. Departmental policy titled, "Surveillance, Prevention, and Control of Infection" dated 11/12 noted that "Adequate ventilation shall be provided in all storage areas ...Lighting, ventilation, and humidity shall be controlled to prevent the growth of microorganisms."	A 726		
□A 747□	482.42 INFECTION CONTROL	□A 747□		

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□A 747□	Continued From page 67 The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases. This CONDITION is not met as evidenced by: Based on observation, review of facility documents and staff interview, the facility failed to meet the Condition of Participation in Infection Control by failing to: 1. Provide a functional and sanitary environment for the provision of surgical services (Refer to A 749). 2. Ensure re-usable surgical instruments were sterilized and stored in accordance with the Association of Peri-Operative Registered Nurse (AORN) Standards. AORN is the National Recognized Standards (NRS) the hospital identified as the standard they followed (Refer to A 749). These deficient practices promote microbial growth and can result in contamination of sterile items. 3. Ensure effective systems for safe food handling to prevent food borne illness. This was evidenced by: a. the storing of food in refrigerators and freezers that were not maintaining temperatures by hospital policies and customary practices; b. not following tube feeding orders to prevent growth of microorganisms; c. failure to sanitize the ice machine as recommended by the	□A 747□	**1). Corrective Actions**□ Monitor sanitary environment of the surgical services; 1) areas free of clutter & non-essential storage, 2) monitor the function of terminal cleaning by EVS, 3) Operating room staff completed competencies on between case cleaning. **(Attachment 1 & 2)** **Date of Implementation**: 10/23/2014 **Monitoring Process**: Twice monthly infection control rounds to review cleanliness of Surgical Services Area **(Attachment 3).** **Person Responsible**: Surgery Department, Infection Control Department **2.) Culver City**: **Corrective Action**s; All re-usable surgical instruments (SI) were re-processed, packaged, and stored in accordance to AORN standards; bin dividers purchased to ensure packages are stored up-right on 9/5/2014. 5 inch stringers were purchased to ensure SI are completely open for processing & implemented on 8/25/2014; 3 M Comply cards purchased and placed into service to ensure tip and lock boxes in peel packs maintain an open position for sterilization on 8/26/14; Purchased new biological incubator and indicator with corresponding supplies for sterilization on 10/10/14 9/8/ 2014; Provided education/in-service to staff on standards for processing, packaging and storing of SI, this includes competency validation and return demonstration **(see Attachments-A-000.2)** **Date of Implementation**: Education SI re-processed August 20, 2014 **Monitoring Process**: Monitoring will be managed during bi-monthly Infection Control rounds with ORT or RN with compliance reported to the regulatory Compliance Committee. **Person Responsible**: Infection Control/OR Director; to be completed on the EOC log and will report results to the Regulatory Compliance Committee & Quality. **2.). Hollywood: Corrective Action**: (p.68)--Failure to ensure proper packaging and storage of re-usable surgical instruments: All surgical instruments were re-processed □during the time of the initial survey□and were packaged in a way that provided for adequate sterilant contact by adding fewer instruments in the trays, removing plastic peel pouches from the trays, adding larger stringers when needed, adding tip protectors and devices to keep instruments open during reprocessing. Storage practices were also changed to prevent overcrowding and storing peel pouches on edge. **(See Attachments-A-000.2 & Attachment 4)** **Date of Implementation**: August 21, 2014 **Monitoring Process**: Infection Control bi-monthly rounds in the Operating Room areas to review storage practices (implemented 9/18/14) **(Attachment 3)** **Person Responsible**: Infection Control Department, Surgical/Central Processing **3a). Culver City: Corrective Action**: In-services provided to staff on process for improperly functioning equipment. **(Attachment 5)** **Date of Implementation**: October 23, 2014.	10/23/2014 8/20/2014 8/21/2014 10/23/2014

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□A 747□	Continued From page 68 manufacturer; d. failure to install air gaps in all the sinks in the kitchen; e. use of wiping cloths to dry food production equipment; f. disposal of garbage without proper protection; g. the unloading of clean trays in the dish washing area with same gloves that had been used to load dirty trays. These deficient practices failed to promote operational processes that support safe food handling practices may result in exposure of patients to bacteria associated with foodborne illness. Foodborne illness may result in further compromising patients' medical status and in severe instances may result in death. The cumulative effects of these systemic issues resulted in the facility's inability to ensure and provide a safe patient care environment. This is a repeat deficiency from the sampled validation survey on April 1, 2014.	□A 747□	**Monitoring Process**: Monitored daily by dietary staff **(Attachment 5)** **Person Responsible**: Dietary Director/Supervisor **3a). Van Nuys: Corrective Action**: New refrigerators and freezers were ordered and have been installed. Repairs of existing refrigerators/freezers also being conducted. In-services provided to staff on process for improperly functioning equipment. Refrigerated truck was brought in during the interim to provide adequate refrigeration while repairs and installations are carried out **(Attachment 6)** **Date of Implementation**: August 20, 2014. **Monitoring Process**: Refrigerator & Freezer Temperatures monitored daily by dietary staff **Person Responsible**: RD Director Dietary Department **3a). Hollywood. Corrective Action**: Freezer and Refrigerators were repaired. Staff in-serviced on appropriate procedures to take when equipment malfunctions **(Attachment 6)** **Date of Implementation**: August 20, 2014. **Person Responsible**: RD Director Dietary Department **3b). Culver City** G-tube feeding orders not followed **Corrective Action**: Education and in-services provided to nursing staff. **(Attachment 7)** **Date of Implementation**: July 1, 2014 **Monitoring Process**: Monitored by nursing **(Attachment 8)** **Person Responsible**: Nursing Directors **3b). Hollywood**-G-tube feeding orders not followed **Corrective action** plan: all open feeding systems were eliminated and only the closed systems are being used to prevent the growth of microorganisms. Education and in-services provided to nursing staff **(Attachment 9)** **Date of Implementation**: 9/16/14 **Monitoring Process**: Monitored by nursing and dietitians **(Attachment 10)** **Person Responsible**: Nursing Services	8/20/2014 8/20/2014 07/01/2014 9/16/2014
□A 749□	482.42(a)(1) INFECTION CONTROL PROGRAM The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: On August 20, 2014, at 1:30p.m., the survey team declared an Immediate Jeopardy (IJ) situation, in the presence of the Chief Executive Officer (CEO) of the Culver City Campus, director	□A 749□	Continued on page 69a. **1). Culver City: Corrective Action**s: The following was implemented to ensure flexible endoscopes are stored in accordance with the AORN recommended practices: 1). Purchased and installed new vented scope cabinet and placed in area with adequate ventilation for proper storage of scopes; 2) all scopes now have tip protectors to ensure tips do not touch the cabinets; 3) all scopes are tagged after processing indicating next date to re-process if not in use.4). Provided education/in-service to staff for use of enzymatic cleaners and proper measurements; 5) for scope re-processing; high-level disinfection, this included competency validation and return demonstrations **(refer to Attachment A-000.1);** **Date of Implementation**: Scope Cabinet installed 9-15-14; Education completed on August 12, 2014 and August 21, 2014. **Monitoring Process**: Monitoring managed by daily inspection of the scopes for next date of re-processing; Daily scopes monitoring and after each use to ensure proper placement in scope cabinet; weekly monitoring of all scope procedure to ensure completeness and accuracy of log. Log compliance will be submitted to the Regulatory Compliance Committee & Quality Council to ensure compliance with AORN standards.	8/12/2014 8/21/2014 9/15/2014

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A 747	Continued From page 67 .. 3. Ensure effective systems for safe food handling to prevent food borne illness. This was evidenced by: a. the storing of food in refrigerators and freezers that were not maintaining temperatures by hospital policies and customary practices; b. not following tube feeding orders to prevent growth of microorganisms; c. failure to sanitize the ice machine as recommended by the . Continued From page 68 .. manufacturer; d. failure to install air gaps in all the sinks in the kitchen; e. use of wiping cloths to dry food production equipment; f. disposal of garbage without proper protection; g. the unloading of clean trays in the dish washing area with same gloves that had been used to load dirty trays. These deficient practices failed to promote operational processes that support safe food handling practices may result in exposure of patients to bacteria associated with foodborne illness. Foodborne illness may result in further compromising patients' medical status and in severe instances may result in death. The cumulative effects of these systemic issues resulted in the facility's inability to ensure and provide a safe patient care environment. This is a repeat deficiency from the sampled validation survey on April 1, 2014.	A 747	**3c).Culver City Corrective Action**: Ice machine at the Culver City campus was sanitized according to manufacturer's recommendations. **(Attachment 5)**. Staff in-services on ice machine maintenance. **Date of Implementation**: October 23, 2014 **Monitoring Process**: Will be monitored through preventative maintenance schedule and during Infection Control Rounds **Person Responsible**: Engineering, Infection Control Department, Dietary Department	10/23/2014
			3c) Van Nuys Corrective Action: Ice machine was sanitized and placed on the Engineering Preventative Maintenance list for a regular sanitizing schedule. **(Attachment 11)** **Date of Implementation**: 10/27/14 **Monitoring Process**: Will be monitored through preventative maintenance schedule and during Infection Control Rounds **(Attachment 12)** **Person Responsible**: Director of Engineering, Infection Control	10/27/2014
			3c).Hollywood: Corrective Action: Ice machine was sanitized and placed on the Engineering Preventative Maintenance list for a regular sanitizing schedule. **(Attachment 13)** **Date of Implementation**: August 20, 2014 **Monitoring Process**: Will be monitored through preventative maintenance schedule and during Infection Control Rounds **(Attachment 12)** **Person Responsible**: Director of Engineering, Infection Control	8/20/2014
			3d) Culver City Corrective Action: Air gaps were installed in all food preparation sinks. Staff in-serviced on the purpose of air gaps. **(Attachment 14)** **Date of Implementation**: October 23, 2014 **Monitoring Process**: Bimonthly rounds with Infection Control and Dietary. **(Attachment 5)** **Person Responsible**: Engineering Department	10/23/2014 10/20/2014
			3d). Van Nuys Corrective Action: Air gaps were installed in all food prep sinks **(Attachment 15)** **Date of Implementation**: 10/20/14 **Monitoring process**: Bimonthly rounds with Infection Control and Dietary. **(Attachment 12)** **Person Responsible**: Director of Engineering	8/22/2014
			3d). Hollywood Corrective Action: Air gaps were installed in all food prep sinks. **(Attachment 16)** **Date of Implementation**: August 22, 2014 **Monitoring process**: Bimonthly rounds with Infection Control and Dietary. **(Attachment 12)** **Person Responsible**: Director of Engineering	10/22/2014
			3. e) Culver City Corrective Action: Education given to by Dietary supervisors regarding air drying all food production equipment **(Attachment 5)** **Date of Implementation**: 10/22/14 **Monitoring process**: Daily rounding by Dietary Supervisor, Bimonthly rounding by Infection Control and Dietary department **(Attachment 5)** **Person Responsible**: Director of Dietary, Director of Infection Control	

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A 747	Continued From page 67 .. 3. Ensure effective systems for safe food handling to prevent food borne illness. This was evidenced by: a. the storing of food in refrigerators and freezers that were not maintaining temperatures by hospital policies and customary practices; b. not following tube feeding orders to prevent growth of microorganisms; c. failure to sanitize the ice machine as recommended by the . Continued From page 68 .. manufacturer; d. failure to install air gaps in all the sinks in the kitchen; e. use of wiping cloths to dry food production equipment; f. disposal of garbage without proper protection; g. the unloading of clean trays in the dish washing area with same gloves that had been used to load dirty trays. These deficient practices failed to promote operational processes that support safe food handling practices may result in exposure of patients to bacteria associated with foodborne illness. Foodborne illness may result in further compromising patients' medical status and in severe instances may result in death. The cumulative effects of these systemic issues resulted in the facility's inability to ensure and provide a safe patient care environment. This is a repeat deficiency from the sampled validation survey on April 1, 2014.	A 747	**3e). Van Nuys Corrective Action**: Additional drying racks purchased and installed. Education given to by Dietary supervisors regarding air drying all food production equipment **(Attachment 17)** **Date of Implementation**: 10/27/14 **Monitoring Process**: Daily rounding by dietary supervisor (**Attachment 18)** **Person Responsible**: RD, Director of Dietary **3e). Hollywood Corrective Action**: Additional drying racks purchased and installed. Education given to by Dietary supervisors regarding air drying all food production equipment **(Attachment 19)** **Date of Implementation**: 10/19/14 **Monitoring process**: Daily rounding by dietary supervisor **(Attachment 18)** **Person Responsible**: RD, Director of Dietary **3f). Culver City Corrective action** plan: Staff education on the proper process of garbage disposal. **(Attachment 5)** **Date of Implementation**: October 23, 2014 **Monitoring Process**: Observations during Dietary supervisor rounds and bimonthly Infection Control rounds **(Attachment 5)** **Person Responsible**: Dietary Department, Infection Control Department **3f). Van Nuys Corrective action** plan: Staff were educated on the proper process of garbage disposal. Plastic aprons for wear during removal of garbage were purchased and put in place at. **(Attachment 20)** **Date of Implementation**: October 27, 2014 **Monitoring Process**: Observations during Dietary supervisor rounds and Infection Control rounds **(Attachment 12)** **Person Responsible**: RD, Director of Dietary **3g). Culver City Corrective Action**: In-service given on the proper use of gloves and hand hygiene when handling dirty and clean dishes. **(Attachment 5)** **Date of Implementation**: 10/27/14 **Monitoring Process**: Observations during Dietary Supervisor rounds, bimonthly Infection Control Rounds **(Attachment 5)** **Person Responsible**: Director of Dietary **3g). Van Nuys Corrective Action**: In-service given on the proper use of gloves and hand hygiene when handling dirty and clean dishes. **(Attachment 21)** **Date of Implementation**: 10/21/14 **Monitoring Process**: Observations during Dietary Supervisor rounds **(Attachment 18)** **Person Responsible**: RD, Director of Dietary **3g). Hollywood Corrective Action**: In-service given on the proper use of gloves and hand hygiene when handling dirty and clean dishes. **(Attachment 22)** **Date of Implementation**: 10/19/14 **Monitoring Process**: Observations during Dietary Supervisor rounds **(Attachment 18)** **Person Responsible**: RD, Director of Dietary	10/27/2014 10/19/2014

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□A 749□	Continued From page 69 of risk management, as a result of the facility's failure: 1. To ensure flexible endoscopes were stored in accordance with the Association of Peri-Operative Registered Nurse (AORN) Recommended Practices. AORN is the National Recognized Standards (NRS) the hospital identified as the standard they followed. 2. To ensure re-usable surgical instruments were packaged and stored in accordance with the AORN Standards. On August 21, 2014, at 3:45p.m., the IJ was abated in the presence of the director of risk management and CEO of the facility's Culver City campus. Based on observation, interview and record review, the facility failed to: 1. Ensure flexible endoscopes were stored in accordance with the Association of Peri-Operative Registered Nurse (AORN) Recommended Practices . AORN is the National Recognized Standards (NRS) the hospital identified as the standard they followed. 2. Ensure re-usable surgical instruments were packaged and stored in accordance with the Association of Peri-Operative Registered Nurse (AORN) Recommended Practices. 3. Perform one GI (Gastroenterology) Technician's competency in the use, care, and processing of flexible endoscopes and related equipment, and two CST (Central Surgical Technician)'s competency in the use of sterilization packaging systems and accessories.	□A 749□	**Person Responsible**: OR Team/Infection Control will be responsible for monitoring; Daily monitoring by GI/OR Team and weekly monitoring by Infection Control. **1). Hollywood**: **Corrective Action**: Failure to ensure flexible endoscopes were stored appropriately The following was implemented to ensure flexible endoscopes are stored in accordance with the AORN recommended practices: 1) A new scope cabinet was purchased that allows for all scopes to be hung vertically without touching each other or the bottom of the cabinet in accordance to the AORN recommended practice, 2) scope tip protectors that are breathable were purchased to protect tips where it was possible that the tip may touch the back of the cabinet or another scope, 3) Competency for GI processing and storage was conducted by the scope manufacturer, 4). all scopes are tagged with the processing date to ensure that they are processed within 5 days. **(Attachment 1)** **Date of Implementation**: September 8, 2014 (scope cabinet); August 12 & 21, 2014 & September 22, 2014 (competency) **Monitoring Process**: Biweekly Infection control rounds to review appropriate storage of equipment. **(Attachment 2)** **Person Responsible**: GI team, Infection Control **2). Culver City Corrective Action**s; All re-usable surgical instruments (SI) were re-processed, packaged, and stored in accordance to AORN standards; bin dividers purchased to ensure packages are stored up-right on 9/5/2014. 5 inch stringers were purchased to ensure SI are completely open for processing & implemented on 8/25/2014; 3 M Comply cards purchased and placed into service to ensure tip and lock boxes in peel packs maintain an open position for sterilization on 8/26/14; Purchased new biological incubator and indicator with corresponding supplies for sterilization on 10/10/14; Provided education/in-service to staff on standards for processing, packaging and storing of SI, this includes competency validation and return demonstration **(see Attachment A-000.2)** **Date of Implementation**: Education SI re-processed August 20, 2014. **Monitoring Process**: Monitoring will be managed during weekly Infection Control rounds with ORT or RN with compliance reported to the regulatory Compliance Committee. **Person Responsible**: Infection Control/OR Director; to be completed on the EOC log and will report results to the Regulatory Compliance Committee & Quality. **2) Hollywood Corrective Action**s: Paper-plastic pouches now stored in a vertical manner in accordance to AORN recommended practice. Bin dividers purchased to further aid this process, plastic, autoclavable devices are in use to ensure instruments stay open during the sterilization process. Process of use of peel-pouches changed to indicate that items are placed to allow sterilant contact and typically only 1 item placed per pouch (no more than two small items). Surgical trays were divided into several trays to ensure appropriate sterilant penetration. Larger trays were purchased to accommodate larger instruments that are more fully propped open **(Attachment 3)** **Date of Implementation**: 9/9/14 **Monitoring Process**: Infection Control biweekly rounds to review appropriate placement and use of paper-plastic pouches. Infection Control to randomly check trays prior to sterilization to ensure appropriate tray placement. **(Attachment 4)** **Person Responsible**: OR/Central Service Team, Infection Control Continued on page 70a.	8/12/2014 8/21/2014 9/8/2014 9/22/2014 8/20/2014 9/9/2014

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A 749	Continued From page 69 of risk management, as a result of the facility's failure: 1. To ensure flexible endoscopes were stored in accordance with the Association of Peri-Operative Registered Nurse (AORN) Recommended Practices. AORN is the National Recognized Standards (NRS) the hospital identified as the standard they followed. 2. To ensure re-usable surgical instruments were packaged and stored in accordance with the AORN Standards. On August 21, 2014, at 3:45p.m., the IJ was abated in the presence of the director of risk management and CEO of the facility's Culver City campus. Based on observation, interview and record review, the facility failed to: 1. Ensure flexible endoscopes were stored in accordance with the Association of Peri-Operative Registered Nurse (AORN) Recommended Practices . AORN is the National Recognized Standards (NRS) the hospital identified as the standard they followed. 2. Ensure re-usable surgical instruments were packaged and stored in accordance with the Association of Peri-Operative Registered Nurse (AORN) Recommended Practices. 3. Perform one GI (Gastroenterology) Technician's competency in the use, care, and processing of flexible endoscopes and related equipment, and two CST (Central Surgical Technician)'s competency in the use of sterilization packaging systems and accessories.	A 749	**3). Culver City Corrective Action**: Competencies were completed by the scope manufacturer for the one GI tech on the use, care and processing of flexible endoscopes. In-services with return demonstration performed on the two central service technicians on sterilization and processing of sterile instruments **(Attachment 5)** **Date of Implementation**: GI Lab Scope processing in-services, Aug 12 and Aug 21, Central processing in-service Aug 20, 2014 **Monitoring Process**: Audit of scope processing log with reporting to PI committee; infection control bimonthly OR rounding with spot checks for instrument sterilization and processing practices. **(Attachment 6)** **Person Responsible**: Nursing Services, Infection Control, OR Team **3). Hollywood Corrective Action**: Competencies were completed by the scope manufacturer for the one GI techs on the use, care and processing of flexible endoscopes. In-services were performed on the two central service technicians on sterilization and processing of sterile instruments. **(Attachment 7)** **Date of Implementation**: 9/22/14 (Scopes); 10/8/14 (Central Processing); **Monitoring Process**: Audit of scope processing log with reporting to PI committee; infection control biweekly OR rounding with spot checks for instrument sterilization and processing practices. **(Attachment 4)** **Person Responsible**: Nursing Services, Infection Control, OR Team	8/12/2014 8/20/20/2014 8/21/2014 9/22/2014 10/8/2014

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□A 749□	Continued From page 70 4. Develop those policies referred to infection control that conformed to AORN recommended practice guidelines. These deficient practices promote microbial growth and can result in contamination of sterile items. 5. Ensure there was an effective system for safe food handling to prevent food borne illness. This was evidenced by: a. the storing of food in refrigerators and freezers that were not maintaining temperatures by hospital policies and customary practices; b. not following tube feeding orders to prevent growth of microorganisms; c. failure to sanitize the ice machine as recommended by the manufacturer; d. failure to install air gaps in- all the sinks in the kitchen; e. failing to use of wiping cloths to dry food production equipment; f. failing to disposal of garbage without proper protection; g. the unloading of clean trays in the dish washing area with same gloves that had been used to load dirty trays. These deficient practices failed to promote operationa processes that support safe food handling practices may result in exposure of patients to bacteria associated with foodborne illness. Foodborne illness may result in further compromising patients' medical status and in severe instances may result in death. Findings:	□A 749□	**4). Culver City Corrective Action:** Policies reviewed and amended as needed to be more facility specific and conform to AORN recommendations. **(Attachment 8)** **Date of Implementation**: November 1, 2014 **Monitoring Process**: Annual review with tri-annual committee approval **Person Responsible**: Surgery Committee, Surgical Services Director, Nursing Services, Infection Control Team **4). Hollywood Corrective Action**: Policies reviewed and amended as needed to ensure infection control processes conform to AORN recommended practice guidelines. **(Attachment 8)** **Date of Implementation**: November 1, 2014 **Monitoring Process**: Annual review with tri-annual committee approval **Person Responsible**: Surgery Committee, Surgical Services Director, Nursing Administration, Infection Control Team **5a). Culver City Corrective Action**: In-services provided to staff on process of logging temperatures and the reporting of temperatures not meeting expected ranges per policy. **(Attachment 9)** **Date of Implementation**: October 23, 2014. **Monitoring Process**: Monitored daily by dietary staff **Person Responsible**: Dietary Director/Supervisor **5a). Van Nuys Corrective Action**: New refrigerators and freezers were ordered and have been installed. Repairs of existing refrigerators/freezers have been conducted. In-services provided to staff on process for improperly functioning equipment. Refrigerated truck was brought in during the interim to provide adequate refrigeration while repairs and installations are carried out. **(Attachment: 10)** **Date of Implementation**: August 20, 2014. **Monitoring Process**: Monitored daily by dietary staff **Person Responsible**: RD, Director of Dietary **5a). Hollywood Corrective Action**: Refrigerators were repaired. In-services provided to staff on process of logging temperatures and the reporting of temperatures not meeting expected ranges per policy. **(Attachment: 10)** **Date of Implementation**: August 20, 2014. **Monitoring Process**: Monitored daily by dietary staff **Person Responsible**: RD, Director of Dietary **5b). Culver City Corrective** Action: Education and in-services provided to nursing staff. **(Attachment 11)** **Date of Implementation**: October 23, 2014 **Monitoring Process**: Monitored by nursing and dieticians and reported monthly to PI committee **Person Responsible**: Nursing Directors **5b). Hollywood Corrective Action**: all open feeding systems were eliminated and only the closed systems are being used to prevent the growth of microorganisms. Education and in-services provided to nursing staff **(Attachment: 12)** **Date of Implementation**: 9/16/14 **Monitoring Process**: Monitored by nursing and dietitian and reported monthly to PI committee **(Attachment 12)** **Person Responsible**: Nursing Administration Continued on page 71a.	10/1/2014 10/1/2014 10/23/2014 8/20/2014 8/20/2014 10/23/2014 9/16/2014

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A 749	Continued From page 70 4. Develop those policies referred to infection control that conformed to AORN recommended practice guidelines. These deficient practices promote microbial growth and can result in contamination of sterile items. 5. Ensure there was an effective system for safe food handling to prevent food borne illness. This was evidenced by: a. the storing of food in refrigerators and freezers that were not maintaining temperatures by hospital policies and customary practices; b. not following tube feeding orders to prevent growth of microorganisms; c. failure to sanitize the ice machine as recommended by the manufacturer; d. failure to install air gaps in- all the sinks in the kitchen; e. failing to use of wiping cloths to dry food production equipment; f. failing to disposal of garbage without proper protection; g. the unloading of clean trays in the dish washing area with same gloves that had been used to load dirty trays. These deficient practices failed to promote operational processes that support safe food handling practices may result in exposure of patients to bacteria associated with foodborne illness. Foodborne illness may result in further compromising patients' medical status and in severe instances may result in death. Findings:	A 749	**5c). Culver City Corrective Action**: Ice machine was sanitized according to manufacturer's recommendations. (**Attachment 9**). Staff in-services on ice machine maintenance. (**Attachment 9**). **Date of Implementation**: October 23, 2014 **Monitoring Process**: Will be monitored through daily sanitation log and preventative maintenance schedule. Sanitation will also be monitored during bimonthly Infection Control and Dietary Rounds (**Attachment 9**). **Person Responsible**: Engineering, Infection Control Department, Dietary Department **5c). Van Nuys Corrective Action**: Ice machine was sanitized and placed on the Engineering Preventative Maintenance list for a regular sanitizing schedule. **(Attachment: 13)** **Date of Implementation**: 10/27/14 **Monitoring Process**: Will be monitored through preventative maintenance schedule and during Infection Control Rounds (**Attachment 14**). **Person Responsible**: Director of Engineering, Infection Control **5c). Hollywood Corrective Action**: Ice machine was sanitized and placed on the Engineering Preventative Maintenance list for a regular sanitizing schedule. **(Attachment: 15)** **Date of Implementation:** August 20, 2014 **Monitoring Process:** will be monitored through preventative maintenance schedule and during Infection Control Rounds **5d). Culver City Corrective Action**: Air gaps were installed in all food preparation sinks. (**Attachment: 16**). Staff in-serviced on the purpose of air gaps. (**Attachment: 17**). **Date of Implementation**: October 23, 2014 **Monitoring Process**: Bimonthly rounds with Infection Control and Dietary. (**Attachment: 18**). **Person Responsible**: Engineering Department, Infection Control Department, Dietary Department **5d). Van Nuys Corrective Action**: Air gaps were installed in all food prep sinks (**Attachment: 19**). **Date of Implementation**: 10/20/14 **Monitoring Process**: Bimonthly rounds with Infection Control and Dietary. (**Attachment: 18**). **Person Responsible**: Director of Engineering **5d). Hollywood Corrective Action**: Air gaps were installed in all food prep sinks. (**Attachment: 20**). **Date of Implementation**: August 22, 2014 **Monitoring Process**: Bimonthly rounds with Infection Control and Dietary. (**Attachment: 18**). **Person Responsible**: Director of Engineering **5e). Culver City Corrective Action**: Education given to by Dietary supervisors regarding air drying all food production equipment **(Attachment: 9)** **Date of Implementation**: 10/23/14 **Monitoring process**: Daily rounding by Dietary Supervisor, Biweekly rounding by Infection Control and Dietary departments **(Attachment: 9)** **Person Responsible**: Director of Dietary, Director of Infection Control **5e). Van Nuys Corrective Action**: Additional drying racks purchased and installed. Education given to by Dietary supervisors regarding air drying all food production equipment **(Attachment: 21)** **Date of Implementation**: 10/27/14 **Monitoring Process**: Daily rounding by dietary supervisor **Person Responsible**: RD, Director of Dietary	10/23/2014 10/27/2014 08/20/2014 10/23/2014 10/20/2014 8/22/2014 10/23/2014 10/27/2014

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A 749	Continued From page 70 4. Develop those policies referred to infection control that conformed to AORN recommended practice guidelines. These deficient practices promote microbial growth and can result in contamination of sterile items. 5. Ensure there was an effective system for safe food handling to prevent food borne illness. This was evidenced by: a. the storing of food in refrigerators and freezers that were not maintaining temperatures by hospital policies and customary practices; b. not following tube feeding orders to prevent growth of microorganisms; c. failure to sanitize the ice machine as recommended by the manufacturer; d. failure to install air gaps in- all the sinks in the kitchen; e. failing to use of wiping cloths to dry food production equipment; f. failing to disposal of garbage without proper protection; g. the unloading of clean trays in the dish washing area with same gloves that had been used to load dirty trays. These deficient practices failed to promote operational processes that support safe food handling practices may result in exposure of patients to bacteria associated with foodborne illness. Foodborne illness may result in further compromising patients' medical status and in severe instances may result in death. Findings:	A 749	**5e). Hollywood Corrective Action**: Additional drying racks purchased and installed. Education given to by Dietary supervisors regarding air drying all food production equipment **(Attachment: 21)** **Date of Implementation**: 10/19/14 **Monitoring process**: Daily rounding by dietary supervisor **Person Responsible**: RD, Director of Dietary **5f). Culver City Corrective Action:** Staff education on the proper process of garbage disposal. **(Attachment: 9)** **Date of Implementation**: October 23, 2014 **Monitoring Process**: Observations during Dietary supervisor rounds and bimonthly Infection Control rounds **(Attachment: 9)** **Person Responsible**: Dietary Department, Infection Control Department **5f). Van Nuys Corrective Action:** Staff was educated on the proper process of garbage disposal. Plastic aprons for wear during removal of garbage were purchased and put in place at. **(Attachment: 22)** **Date of Implementation**: October 27, 2014 **Monitoring Process**: Observations during Dietary supervisor rounds and Infection Control rounds **Person Responsible**: RD, Director of Dietary **5g). Culver City Corrective Action**: In-service given on the proper use of gloves and hand hygiene when handling dirty and clean dishes. **(Attachment: 9)** **Date of Implementation**: 10/23/14 **Monitoring Process**: Observations during Dietary Supervisor rounds, bimonthly Infection Control Rounds **(Attachment: 9)** **Person Responsible**: Director of Dietary, Director of Infection Control **5g). Van Nuys Corrective Action**: In-service given on the proper use of gloves and hand hygiene when handling dirty and clean dishes. **(Attachment: 23)** **Date of Implementation**: 10/21/14 **Monitoring Process**: Observations during Dietary Supervisor rounds **Person Responsible**: RD, Director of Dietary **5g). Hollywood Corrective Action**: In-service given on the proper use of gloves and hand hygiene when handling dirty and clean dishes. **(Attachment: 23)** **Date of Implementation**: 10/19/14 **Monitoring Process**: Observations during Dietary Supervisor rounds **Person Responsible**: RD, Director of Dietary	10/19/2014 10/23/2014 10/272014 10/23/2014 10/21/2014 10/19/2014

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□A 749□	Continued From page 71 Hollywood campus 1. During the tour with Registered Nurse (RN) 1 in the Semi-Restricted and Restricted area on August 18, 2014 between 1:10 p.m. and 3 p.m., the following were observed: There were four endoscopes, stored and hung in a vertical position, in a closed cabinet, adjacent to Sterile Supply Room. There was no venting to allow air circulation around the flexible endoscopes. Two (2) of four (4) endoscopes tips were in contact with the cabinet wall with no scope protectors. During an interview with Gastroenterology Technician (GI T) 1, at the same time of the observation, she stated the flexible endoscopes should be stored in a closed cabinet with venting allows air circulation around flexible endoscopes. During an interview with RN 1 on August 18, 2014 at 2:55p.m., she stated the flexible endoscopes should be hanging in a secure vertical position without contacting with the cabinet wall. According to Perioperative Standards and Recommended Practices for 2013 of the AORN, "Recommended Practices for Cleaning and Processing Flexible Endoscopes and Endoscope Accessories:" "Recommendation I□ Flexible endoscopes should be stored in a manner that protects the device from damage and minimizes microbial contamination. I□.a. Flexible endoscopes should be stored in a closed cabinet with venting allows air	□A 749□	**Hollywood** **1). Corrective Action**: A new scope cabinet was purchased that allows for all scopes to be hung vertically without touching each other or the bottom of the cabinet. In addition, scope tip protectors that are breathable were purchased to protect tips where it was possible that the tip may touch the back of the cabinet or another scope. Competency for GI processing and storage was conducted by the scope manufacturer. All scopes are tagged with the processing date to ensure that they are processed within 5 days. **(refer to Attachment: A-000.1)** **Date of Implementation**: September 8, 2014 (scope cabinet); September 22, 2014 (competency) **Monitoring Process**: Biweekly Infection control rounds to review appropriate storage of equipment. **Person Responsible**: GI team, Infection Control	9/8/2014

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□A 749□	Continued From page 72 circulation around Flexible endoscopes; hanging in a secure vertical position; with scope protectors applied if the protector does not interfere with the flexible endoscopes hanging straight or restrict the air movement around channel opening; I□.b. Flexible endoscopes should be reprocessed before use if unused for more than 5 days." Recommendation □III Personnel should demonstrate competency in the use, care, and processing of flexible endoscopes □and related equipment periodically and before new endoscopic equipment and/or accessories are introduced into the practice setting. 2. During the tour with RN 1 in the Semi-Restricted area and Restricted area on August 18,2014 between 10:25.m. and 11:33 a.m., the followings were observed: In OR□2: A. There were multiple blue bins with multiple paper-plastic pouch package of surgical instruments in the cabinet. The packages were not stored in a vertical manner in each bin. The packages were compressed in each bin. All instruments blades closed and tips touching. B. In a paper-plastic pouch package of two (2□ babcock forceps (used for graping in surgical procedures), one babcock stacked on another. These two (2) babcock forceps blades closed and tips touching. C. A laminectomy tray (instruments used for surgery on the back) also known as a Major Tray was ready for use in the operating room. Assembled in the tray:	□A 749□	**2A) .Corrective Action**s: Paper-plastic pouches now stored in a vertical manner. Bin dividers purchased to further aid this process **(refer to Attachment: A-000.1)** **Date of Implementation**: 9/5/14 **Monitoring Process**: Infection Control bimonthly rounds to review appropriate placement and use of paper-plastic pouches **Person Responsible**: Central processing team; Infection Control **2B). Corrective Action**s: Plastic, autoclavable devices are in use to ensure instruments stay open during the sterilization process. Process of use of peel-pouches changed to indicate that items are placed to allow sterilant contact and typically only 1 item placed per pouch (no more than two small items). **(refer to Attachment: A-000.2)** **Date of Implementation** 9/9/14 **Monitoring Process**: Infection Control bimonthly rounds to review use of paper-plastic pouches **Person Responsible**: Infection control; Central processing team **2C). Corrective Action**s: Surgical trays were divided into several trays to ensure appropriate sterilant penetration. Larger trays were purchased to accommodate larger instruments that are more fully propped open utilizing the 5 in instrument stringers. **(Attachment: refer to Attachment A-000-2)** **Date of Implementation**: 8/22/14; 9/12/14 (purchase of larger trays) **Monitoring Process**: Infection Control bimonthly rounds to review appropriate placement and use of paper-plastic pouches. Infection Control to randomly check trays prior to sterilization to ensure appropriate tray placement. **Person Responsible**: Central processing team; Infection Control	9/5/2014 9/9/2014 8/22/2014 9/12/2014

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□A 749□	Continued From page 73 On the stringer (typically, approximately a foot long 3 rod type device to assist with the positioning of instruments for sterilizing), 10 hinged instruments blades closed and tips touching. During an interview with Certified Scrub Technician (CST) 1 on August 18, 2014 at 11:01 a.m., she stated the surgical instruments should not be stacked on each other to allow sterilant penetration and direct contact with the item and surfaces. A subsequent interview with Staff I and RN 1 at the same time, both stated they were following event related sterility □Concept that the sterility of an item does not change with passing of time but nay be affected by particular event (eg, amount of handling), or environmental conditions (eg, temperature, humidity)□when processing and storing of sterile surgical instruments. Both RN 1 and CST 1 stated the supplies are incorrectly stored according to the AORN Standards. According to Perioperative Standards and Recommended Practices for 2013 of the AORN, "Recommended Practices for Selection and Use of packaging Systems for Sterilization:" "Recommendation I 1. Packaging systems should be appropriate for items being sterilized. The packaging system should: maintain sterility of package contents until opened; allow sterilant penetration and direct contact with the item and surfaces, and removal of the sterilant" Culver City campus	□A 749□		

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A 749	Continued From page 74 3. During the tour with RN 1 in the Semi-Restricted Area on August 20, 2014 between 11 a.m. and 12 p.m., the followings were observed: A. In Central Processing Room One C (Caesarean)-Section (a surgical procedure in which one or more incisions are made through a mother's abdomen and uterus to deliver one or more babies, or, rarely, to remove a dead fetus) tray (instruments used for surgery to deliver baby) was ready for use in the operating room. Assembled in the tray: On the stringer (typically, approximately a foot long 3 rod type device to assist with the positioning of instruments for sterilizing), multiple hinged instruments blades closed and tips touching. During an interview with CST 2 and 3 on August 18, 2014 at 11:01 a.m., both stated the surgical instruments should not be stacked on each other to allow sterilant penetration and direct contact with the item and surfaces. In Sterile Supply Room There were multiple cartons (boxes) on the 3rd shelf of the cabinet with multiple sterile supplies and multiple non-sterile supplies. There was no thermometer and humidity display in the Central Sterilization. There were multiple blue bins with multiple paper-plastic pouch package of surgical instruments in the cabinet. The packages were	A 749	**Culver City** **Central Processing Room** **3A). Corrective Actions**: 3 Instruments stringers have been replaced with 5 stringers to hold hinged instrument blades open and tips not touching to allow sterilant penetration and direct contact with the items and surfaces. **Date of Implementation** Aug.25, 2014 receipt of 5 stringers **(refer to Attachment: A-000.2)** **Monitoring Process**: Monitoring will be managed during bi-monthly rounds with IC and OR RN or ST Compliance Data will be reported through Regulatory Compliance Committee, IC and Quality. **Person Responsible**: Surgery Director and Director of Infection Control: **Sterile Supply Room** **3A). Corrective Actions**: All cartons have been removed from the sterile supply room. Non sterile and sterile items have been separated. A temperature and humidity gauge was present in the sterile supply room areas and readings are being recorded. Plastic paper pouch packages have been decompressed and stored in a vertical position in the blue bins. 3M comply cards are now utilized to keep instrument blades open and prevent tips from touching. **Date of Implementation**: Aug 21, 2014 cartons removed and Aug 26, 2014 3M comply cards received, Temperature and Humidity Gauge was installed on July 26, 2014. **Monitoring Process**: Monitoring will be managed during bi-monthly rounds with IC and OR RN or ST. Compliance data will be reported through Regulatory Compliance Committee, IC and Quality. **Person Responsible**: Infection Prevention/OR/CS team	8/25/2014 7/26/2014 8/21/2014 8/26/2014

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□A 749□	Continued From page 75 not stored in a vertical manner in each bin. The packages were compressed in each bin. All instruments blades closed and tips touching. B. In Sterile Central Supply Room a. There was one paper-plastic pouch package of surgical instrument (a retractor) with discoloration on the paper-plastic pouch. There was one paper-plastic pouch package of surgical instrument dated 10/5/9. b. There were multiple blue bins with multiple paper-plastic pouch package of surgical instrument compressed in each bin. During an interview with Staff G on August 20, 2014 at 11:26 a.m., she stated there should not be any sterile supplies in this room. A subsequent interview with Staff G and J at the same time, both stated they were using event related sterility (Concept that the sterility of an item does not change with passing of time but nay be affected by particular event (eg, amount of handling), or environmental conditions (eg, temperature, humidity). Staff I stated the supplies are incorrectly stored according to the AORN Standards. According to Staff G, the temperature and humidity in the Central Sterilization Room were not monitored and recorded. According to the facility's policy and procedure dated 9/11, titled "Storage and Rotation of Sterile Supplies:" 4.1.3. Shipping cartons must never be allowed in either a clean storage area or a sterile storage area, and these containers should never be used as storage containers within these areas."	□A 749□	**Sterile Central Supply Room** **3Ba). Corrective Action**s: Peel packed instruments have been removed from the Sterile Central Supply Room **Date of Implementation** Aug 21, 2014 **Monitoring Process**: Monitoring will be managed during bi-monthly rounds with IC, OR RN and CS staff member. Compliance data will be reported through Regulatory Compliance Committee, IC and Quality. **Person Responsible**: Infection Prevention/OR/CS team: **3Bb). Corrective Action**s: Plastic □paper pouch packages have been decompressed and stored in a vertical position in the blue bins. 3M comply cards are now utilized to keep instrument blades open and prevent tips from touching **Date of Implementation**: August 26, 2014 **Monitoring Process**: Monitoring will be managed during bi-monthly IC rounds with OR RN and CS staff member. Compliance data will be reported through Regulatory Compliance Committee, IC and Quality. **Person Responsible**: Infection Prevention/OR/CS team	8/21/2014 8/26/2014

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□A 749□	Continued From page 76 According to Perioperative Standards and Recommended Practices for 2013 of the AORN, "Recommended Practices for Selection and Use of packaging Systems for Sterilization:" "Recommendation I 1. Packaging systems should be appropriate for items being sterilized. The packaging system should: maintain sterility of package contents until opened; allow sterilant penetration and direct contact with the item and surfaces, and removal of the sterilant. Recommendation V 1. Paper-plastic pouch packages should be used only for small, lightweight, low-profile items (e.g., one or two clamps, scissors). Heavy metal instruments (e.g. drills, retractors, weighted vaginal speculums) should not be sterilized in peel pouches because problems (e.g., wet packages following sterilization) and sterility maintenance problems (e.g., package seal break) may occur. Recommendation VIII Sterilized packages should be considered sterile until an event occurs to compromise the package barrier integrity. 1. Health care organizations should determine the best methods and materials for packaging sterile items, based upon the anticipated storage, handling, and environmental events that may be encountered. Loss of sterility of a package sterile item is event related. An event must occur to compromise package content sterility. Even that may affect the sterility of a package include, but not limited to, multiple handling that leads to seal breakage or loss of package integrity; compression during storage;	□A 749□		

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□A 749□	Continued From page 77 storage conditions (e.g., type of shelving, cleanliness, temperature, humidity, traffic control)" On August 20, 2014, at 1:30 p.m., the survey team declared an Immediate Jeopardy (IJ) situation, in the presence of the Chief Executive Officer (CEO) of Culver City Campus, director of risk management, as a result of the facility's failure to ensure flexible endoscopes and endoscope accessories were stored in accordance with the AORN and to ensure re-usable surgical instruments were packaged and stored in accordance with AORN Standards. On August 20, 2014, at 9:30a.m., the facility submitted a letter to respond to the immediate Jeopardy, dated August 20, 2104, disclosed all flexible endoscopes had been relocated to a properly storage area. The facility's letter indicated all re-usable surgical instruments were resterilized, repackaged and stored in accordance with the AORN Standards. On August 21, 2014, at 9:30a.m., during the tour of the facility at the Hollywood Campus with Staff E (Administrator) and RN 1, the surveyor observed all flexible endoscopes had been stored in a properly storage area and all re-usable surgical instruments were resterilized, repackaged and stored in accordance with the AORN Standards. On August 21, 2014, at 1:05 p.m., during the tour of the facility at the Culver City Campus with Staff G (Director, Perioperative) and CST 3, the surveyor observed all re-usable surgical instruments were repackaged and stored in accordance with the AORN Standards. On August 21, 2014, at 3:45p.m., the IJ was abated	□A 749□		

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□A 749□	Continued From page 78 in the presence of the director of risk management and CEO of the facility's Culver City campus. Hollywood campus 4. During the tour with Registered Nurse (RN) 1 in the Non-Restricted area on August 18, 2014 between 10:10.m. and 10:25 a.m., the followings were observed: In Pre-Op room: There were three gurneys, with multiple cracks on the mattress on □1 gurney, and multiple small size of holes on the mattress of □2 gurney, and with a approximately 3 inches long cracks and a 3 inches long plastic tap over the edge of the mattress on □3 gurney. According to Perioperative Standards and Recommended Practices for 2013 of the AORN, "Recommended Practices for Environmental Cleaning:" "Recommendation II II.b.2. Damaged or worn coverings should be replaced." 5. During the tour with RN 1 in the Semi-Restricted area and Restricted area on August 18,2014 between 10:25.m. and 11:33 a.m., the followings were observed: In OR □2, there were a C-Arm (encompasses the actual □-ray source and image intensifier) and multiple sterile supplies. According to RN 1 at that time, she stated OR □2 had been used as a storage room, instead of an operating room. Culver City campus 6. During the tour with RN 1 in the Semi-Restricted Area on August 20, 2014 between 11 a.m. and 12 p.m., the followings were	□A 749□	**Hollywood** **4). Corrective Action**: All torn and cracked gurneys were removed from unit and disposed of. New gurneys were purchased with additional purchases made to promptly replace torn gurney mattresses as needed. **(Attachment: 30)** **Date of Implementation**: 8/21/14 **Monitoring Process**: Gurneys mattresses checked for tears and cracks during biweekly infection control rounds. **Person Responsible**: Surgical staff, Infection Control **5). Corrective Action**: All stored items removed from OR □2 and room set up as a functioning OR. **(Attachment: 24)** **Date of Implementation**: August 21, 2014 **Monitoring Process**: Infection control biweekly, OR rounds **Person Responsible**: Surgery Staff, Infection Control	8/21/2014 8/21/2014

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□A 749□	Continued From page 79 observed: In Central Processing Room In the Sterile Central Supply Room, there were multiple cartons on the 3rd shelf of the cabinet with multiple sterile supplies and multiple non-sterile supplies. There was no thermometer and humidity display in the Sterile Central Supply Room. During an interview with CST 4 on August 20, 2014 at 11:48 a.m., she stated the shipping cartons should never be allowed in either a clean storage area or a sterile storage area, Staff G and H stated there should be no sterile supply in this room. According to Staff G, the temperature and humidity in the Sterile Central Supply Room were not monitored and recorded. According to the facility's policy and procedure dated 9/11, titled, "Storage and Rotation of Sterile Supplies:" 4.1.3. Shipping cartons must never be allowed in either a clean storage area or a sterile storage area, and these containers should never be used as storage containers within these areas." According to Perioperative Standards and Recommended Practices for 2013 of the AORN, "Recommended Practices for Selection and Use of packaging Systems for Sterilization:" "Recommendation VIII 2. Sterile packages should be stored under environmentally controlled conditions. Sterile storage area temperature should be controlled and not exceed 75 degree F. The humidity should not exceed 70%." "Recommendation □I	□A 749□	**Culver City** **6). Corrective Actions**: All cartons have been removed from the sterile supply room. Non sterile and sterile items have been separated. A temperature and humidity gauge was in place in the Central Processing area and readings are being recorded. Staff education on the Temperature and Humidity in Central sterilization. **(Attachment 25)** **Date of Implementation** Aug 21, 2014 cartons removed; Temperature and Humidity Gauge was installed on July 26, 2014. **Monitoring Process**: Monitoring will be managed during bi-monthly rounds with IC and OR RN or ST. Compliance data will be reported through Regulatory Compliance Committee, IC and Quality. **(Attachment 26)** **Person Responsible**: Infection Prevention/OR/CS team **2). Corrective Actions**: A temperature and humidity gauge was placed in the Central Processing area and readings are being recorded. Education provided to ensure staff competency in the use of sterilization packing systems and accessories. **Date of Implementation** Temperature and Humidity Gauge was installed on July 26, 2014. Education occurred: 8-20-14 **Monitoring Process**: Monitoring will be managed during bi-monthly rounds with IC and OR RN or ST. Compliance data will be reported through Regulatory Compliance Committee, IC and Quality. **Person Responsible**: Infection Prevention/OR/CS team.	8/21/2014 7/26/2014 8/20/2014

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□A 749□	Continued From page 80 Personnel should demonstrate competency in the use of sterilization packaging systems and □ accessories. 3. Administrative personnel should periodically assess and document the competency of personnel in the use of packaging systems, according to hospital and department policy." 7. On August 18, 2014, Staff E was requested by the evaluator to provide GIT 1's competency in the use, care, and processing of flexible endoscopes and related equipment. However, as of the exit day (8/21/14), the facility could not provide the evaluator with GIT 1's competency in the use, care, and processing of flexible endoscopes and related equipment. 8. On August 20, 2014, Staff G was requested by the evaluator to provide CST 2, 3 and 4's competency in the use of sterilization packaging systems and accessories at the same time. However, as of the exit day (8/21/14), the facility could not provide the evaluator with CST 2, 3, and 4's competency in the use of sterilization packaging systems and accessories. 9. On August 21, 2014, the facility was requested to provide policies and procedures, titled, "cleaning and processing flexible endoscopes, selection and use of packaging systems for sterilization, use and storage of paper-plastic pouch package, and use and storage of containment device (eg, rigid container, instrument cases/cassettes, organizing trays)."	□A 749□	**3).Corrective Action**s: In-service with return demonstration in the use of packaging systems and accessories was completed on Aug.20, 2014. Administrative personnel will assess and document the competency of personnel on a quarterly basis in the use of packaging systems and accessories **Date of Implementation** In-service with return demonstration Aug.20, 2014, Quarterly competency assessments will begin Nov.1, 2014 **Monitoring Process**: Competencies will be conducted and documented on a quarterly basis for the use of packaging systems and accessories. **Person Responsible**: Director of Perioperative Services **7).Corrective Action**s: Competencies in the use, care and processing of flexible endoscopes and related equipment was completed on Aug. 12 and re-inserviced with return demonstration on Aug.21, 2014. Competencies with return demonstrations were also completed on 3/10/2014 as a part of the annual evaluation process. **(Attachment 27)** **Date of Implementation**: March 3/2014 annual competency, Inservices with competencies Aug. 12 and re-inservice Aug 21 with return demonstration **Monitoring Process**: Competencies will be conducted and documented on a quarterly basis for use, care, processing and storage of flexible endoscopes **Person Responsible**: Director of Perioperative Services **8).Corrective Action**s: Competencies in the use of sterilization packaging systems and accessories were completed on Aug 20.2014 for Central Supply techs. **(refer to Attachments for A-000.2)** **Date of Implementation** Aug 20, 2014 **Monitoring Process**: Competencies will be conducted and documented on a quarterly basis for sterilization packaging systems and accessories. Compliance data will be reported through Regulatory Compliance Committee, IC and Quality. **Person Responsible**: Director Perioperative Services **9).Corrective Action**s: Policies SGI. 006 □Cleaning and Disinfection of Endoscopes□and SCS.025 □Selection and Use of Packaging Systems for Sterilization □were reviewed and amended as needed to ensure infection control processes conform to AORN recommended practice guidelines and are facility specific**. (Attachment 28)** **Date of Implementation** Nov 1, 2014 **Monitoring Process**: Policies will be reviewed and revised to reflect current standards on an annual basis. **Person Responsible**: Surgery Committee, Surgical Services Director, Nursing Administration, Infection Control Team	8/20/2014 3/2014 8/12/2014 8/21/2014 8/20/2014 11/1/2014

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□A 749□	Continued From page 81 When reviewed the policies and procedures, these were found to be generic in nature, and intended to be used by any given facility, subsequently, not to be specifically identified, modified and operationalized to a specific facility's infection control. The evidence indicated that this facility had failed to develop and provide those aforementioned requested and operationalize any of these requested policies, that referred to infection control that conformed to AORN recommended practice guidelines, an accepted national standards and guidelines. Hollywood Campus 10. On August 18, 2014 beginning at4:30 p.m., the hospitals' maintenance of the dietetic departments' ice machine was reviewed with Staff 18 and Staff L (Director of Food Service). In a concurrent interview with Staff 18, he stated that the engineering department changed the water filter and vacuumed the air filter every few months. He stated they did not complete any additional tasks and that the dietary department was responsible for cleaning/sanitation. Staff L stated the department cleaned only the ice holding bin and wiped down outside of the machine. Review of manufacturers' guidance for preventive maintenance of the ice machine called for the regular cleaning/sanitation of internal ice producing components utilizing manufacturer specified chemicals. 11. During general kitchen observations on	□A 749□	**Hollywood Campus** **10). Corrective Action**: The manufacturer□s instructions for care and use of ice machines were identified and the Engineering staff used these to develop a cleaning protocol and checklist for the ice machines. The machines will be sanitized on a biannual basis and placed on the engineering preventative maintenance list for future servicing/sanitizing. **(Attachment: 29)** **Date of Implementation**: August 22, 2014 **Monitoring Process**: Listing of Ice machine sanitizing on preventative maintenance list. Review of ice machine documentation during Infection Control/ Dietary rounds. **Person Responsible**: Engineering Department, Infection Control, RD, Director of Dietary	8/22/2014

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□A 749□	Continued From page 82 8/18/14 beginning at 10:30 a.m., it was noted that there was no air gap in the food production sink. The standard of practice would be to ensure the existence of an air gap which is an unobstructed vertical space between the water outlet of food service equipment and the flood level of a fixture (Food Code, 2013). In a concurrent interview with DS (Dietary Staff) 5 she stated that a work order was generated for installation of the air gap; however she was unsure of the status of the work order. Review of facility document titled " Work Order Notification " dated 8/13/14 noted the request to "install a 1" gap in prep sink, cook sink and ice machine ... " It was also noted that on 8/14/14 the staff member assigned to the task indicated that action was taken and there was the installation of a "piping gap." The staff member who documented the work order as complete was unavailable for interview. 12. During food distribution observations on 8/18/24 from 11:30 a.m.-12:30 p.m., DS 2 was regularly using a single terry towel to wipe off food stuff from patient plates as well as the food production counter. The standard of practice would be to ensure that dry wiping cloths used for food wiping food be maintained solely for wiping food, be free of visible food particles and not be used for wiping food production surfaces (Food Code, 2013). Review of undated departmental policy and procedure manual revealed there was no policy in relationship to the proper use of wiping cloths. Culver City Campus 13. During general kitchen observation on August 19, 2014 beginning at 11:30 a.m., there was no air gap in the food production sink in the bakery area. In an interview on August 21, 2014 Staff L	□A 749□	**11). Corrective Action**: Air gaps were installed on all food prep sinks **(Attachment: 20)** **Date of Implementation**: 8/20/14 **Monitoring process**: Bimonthly rounds with Infection Control and Dietary. **Person Responsible**: Director of Engineering **12). Corrective Action**: Revision of Food & Nutrition Policy F018 Sanitizing Food Contact Surfaces requiring the use of disposable towels to be used for the purpose of improving plated food presentation by wiping off edges of plated foods. Each towel cannot be used for any other purpose. In-services conducted on discontinuation of use of terry towels on patient plates and initiation of. single-use disposable cloths. **(refer to Attachment: A-749.5 e Attachment 21)** **Date of Implementation**: 10/28/14 **Monitoring Process**: Observations by dietary supervisor/Director during tray line audits **Person Responsible**: RD, Director of Dietary **Culver City** **13).Corrective Action**s: Air gaps in the kitchen were verified to have been placed in all three food preparation sinks **(Attachment: 16)** **Date of Implementation**: 8/21/14 **Monitoring Process**: Facilities monitors maintenance issues via EOC rounds which are reported to Quality Council. **Person Responsible**: RD, Director of Dietary Department & Director, Plant Management	8/20/2014 10/28/2014 8/21/2014

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□A 749□	Continued From page 83 stated a work order was generated for engineering staff to fix to ensure that all sinks had the required air gap. She stated that 1 air gap was installed in the cold production area but did not verify completion of the work. This is a repeat deficiency from the sampled validation survey on 4/1/14.	□A 749□		
□A 940□	482.51 SURGICAL SERVICES If the hospital provides surgical services, the services must be well organized and provided in accordance with acceptable standards of practice. If outpatient surgical services are offered the services must be consistent in quality with inpatient care in accordance with the complexity of services offered. This CONDITION is not met as evidenced by: Based on observation, review of facility documents and staff interview, the facility failed to meet the Condition of Participation in Surgical Services by failing to: 1. Ensure the temperature and humidity were monitored in the autoclave room in accordance with recommendation from AAMI (Association for Advanced Medical Instrument) (Hollywood campus) (Refer to A 951). 2. Establish functional workflow patterns in the following order from potentially high contamination areas to clean areas in accordance with recommendation from AORN (Association of Peri-Operative Registered Nurse Standards. AORN is the National Recognized Standards (NRS) the hospital identified as the standard they followed (Hollywood campus)	□A 940□	**1). Corrective Action**: Temperature and humidity monitor placed in Central Processing area and temperature monitored and recorded daily according to AAMI recommendations. **(Attachment 1)**Any deviation from AAMI recommendations will be immediately reported to engineering for action. Follow up will be documented. Staff education occurred **(Attachment 2)** **Date of Implementation**: Monitor placed: October 1, 2014; Staff education on 9/24/14. **Monitoring Process**: Temperature and humidity log with compliance reported to Regulatory Compliance Committee & Quality Council **Person Responsible**: Surgery/Central processing staff//Engineering **2). Corrective Action**: Workflow patterns re-defined from high contamination areas to clean areas based on AORN recommendation as follow: instruments are pre-cleaned at the point of use, sprayed with enzymatic foam, transported with closed container into the decontamination room where instruments are decontaminated and cleaned; cleaned instruments are placed in a clean instrument tray, closed and cover and transported via clean cart to central processing through the side door (□2) to complete sterilization process. After completion of sterilization process, instruments are transported and taken out through door (□1) for storage in sterile area. Door □1 from Central processing into the main OR hallway is being used to remove sterilized equipment from central processing to the Surgical areas. Staff has been educated on the process. Revision to policy SCS.010 Flow pattern sterile processing area with staff education. **(Attachment: 3**) Staff Inservicing **(Attachment 4)** **Date of Implementation**: September 4, 2014 **Monitoring Process**: Periodic random monitoring. **Person Responsible**: Central processing team, Infection Control.	9/24/2014 10/1/2014 9/4/2014

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□A 940□	Continued From page 84 (Refer to A 951). The cumulative effects of these systemic issues resulted in the facility's inability to ensure and provide safe patient care environment. This is a repeat deficiency from the sampled validation survey on April 1, 2014.	□A 940□		
□A 951□	482.51(b) OPERATING ROOM POLICIES Surgical services must be consistent with needs and resources. Policies governing surgical care must be designed to assure the achievement and maintenance of high standards of medical practice and patient care. This STANDARD is not met as evidenced by: □ Based on observation, interview and record review, the facility failed to 1. Ensure the temperature and humidity were monitored in the autoclave room in accordance with recommendation from AAMI (Association for Advanced Medical Instrument) (Hollywood campus). 2. Establish functional workflow patterns from potentially high contamination areas to clean areas in accordance with recommendation from AORN (Association of Peri-Operative Registered Nurse Standards. AORN is the National Recognized Standards (NRS) the hospital identified as the standard they followed. This deficient practice promote microbial growth and can result in contamination of sterile items. Findings:	□A 951□		

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□A 951□	Continued From page 85 Hollywood campus Central Processing Room During the tour with Registered Nurse (RN) 1 in the Semi-Restricted and Restricted areas on August 18, 2014 between 1:10 p.m. and 3 p.m., the following were observed: 1. There was no thermometer and humidity display in the Central processing Room, where all surgical instruments trays were wrapped and sterilized in the steam autoclaves. According to Certified Scrub Technician (CST) 1, the temperature and humidity had not been monitored and recorded. There was no documentation that the temperature and humidity to the Central Processing Room had been monitored and recorded. During an interview with CST 1 on August 18, 2014 at 3 p.m., she stated that the temperature and humidity to the Central Processing Room had not been monitored and recorded. According to AAMI (Association for Advanced Medical Instrument) (2014) Chapter 3: Design Considerations "3.3.6.5 Temperature General work areas should have a temperature controlled between 20oc and 23□C (68□F and 73□F). The decontamination area should have a temperature controlled between 16□C and 18□C (60□F and 65□F). The temperature in sterilization equipment access rooms should be controlled between 24□C and 29□C (75□F and 85□F) or as recommended by the equipment manufacturer. The temperature in sterile storage and personnel support areas (e.g., toilets, showers, locker rooms) may be as high as 24□C (75□F). Independent monitors should be located in each	□A 951□	**1). Corrective Action**: Temperature and humidity monitor wa placed in Central Processing area. Temperature and humidit is monitored and recorded daily. Any deviation from established normal range of temperatures will be immediately reported to engineering for action. Follow up will be documented. Staff has been educated to the process. **(Attachment 1)** Processing personnel in each work area are responsible for monitoring and recording the temperature to ensure that the correct temperature is being achieved. **Date of Implementation**: October 1, 2014 **Monitoring Process**: Temperature and humidity log **(refer to A-940.2 attachment 1)** **Person Responsible**: Surgery/Central processing staff/Engineering	10/1/2014

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□A 951□	Continued From page 86 of the areas where temperature should be controlled; temperature should be recorded daily. Processing personnel in each work area are responsible for monitoring and recording the temperature to ensure that the correct temperature is being achieved." 2. The dirty surgical instruments were decontaminated in other room and transported into the entrance of the Central Processing Room for preparation, packaging , and sterilization processing. The surgical instruments were transported through the same entrance, where the decontaminated surgical instruments were transported into, and were distributed to the OR □1 for surgical procedures after they were sterilized in the steam autoclave. During an interview with RN 1 on August 18, 2014 at 3 p.m., she stated the functional workflow patterns should be following the order from potentially high contamination areas to clean areas. According to Perioperative Standards and Recommended Practices for 2013 of the AORN, "Sterilization :" "Recommendation III III.b.2. Functional workflow patterns should be established in the following order from potentially high contamination areas to clean areas: 1. Decontamination area, 2. Preparation and packaging, 3. Sterilization processing, 4. Sterile storage, and	□A951□	**2). Corrective Action**: Workflow re-defined as follow: instruments are pre-cleaned at the point of use, sprayed with enzymatic foam, transported with closed container into the decontamination room where instruments are decontaminated and cleaned; cleaned instruments are placed in a clean instrument tray, closed and cover and transported via clean cart to central processing through the side door (□2) to complete sterilization process. After completion of sterilization process, instruments are transported and taken out through door (□1) for storage in sterile area. Door □1 from Central processing into the main OR hallway is being used to remove sterilized equipment from central processing to the Surgical areas. Staff has been educated on the process **Attachment 2) Date of Implementation**: September 4, 2014 **Monitoring Process**: Periodic random monitoring. **Person Responsible**: Central processing team, Infection Control	9/4/2014

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□A 951□	Continued From page 87 5. Clean distribution On August 21, 2014, the facility was requested to provide policies and procedures, titled, "Functional workflow patterns." When reviewed the policies and procedures titled, "Flow pattern-Sterile Processing Areas," these was found not to be specifically identified, modified and operationalized to a surgical service. The evidence indicated that this facility had failed to develop and provide those aforementioned requested and operationalize any of the requested policy, that referred to surgical services that conformed to AORN recommended practice guidelines, an accepted national standards and guidelines. This is a repeat deficiency from the sampled validation survey on 4/1/14.	□A 951□		

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□K 000□	INITIAL COMMENTS This facility was surveyed under the Life Safety Code NFPA 101, 2000 Edition, Chapter 19, Existing Health Care Occupancies, and other applicable codes. Representing the Department of Public Health: Evaluator ID □16281, REHS, HFE I, REHS, CFII The following represents the findings of the Department of Public Health during a Life Safety Code Survey Follow-Up Visit pursuant to a Full Sample Validation Survey completed on April 1, 2014.	□K 000□		
□K 018□	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1% inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	□K 018□		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (□6) DATE

Any deficiency statement ending with an asterisk (□) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	050135	A. BUILDING **01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD** B. WING _____	**08/21/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, □IP CODE
SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	**6245 DE LONGPRE AVE HOLLYWOOD, CA 90028**

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□K 018□	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and interview, the hospital failed to ensure two corridor doors could resist the passage of smoke, and that there was no impediment to the closing of a corridor door. The deficiency had the potential to permit the passage of smoke, flame, or gases during a fire. Findings: Hollywood Campus Basement 1.) On August 18, 2014 at 11:30 a.m., the doctors' break/locker room had a □ □diameter penetration through the solid wood corridor door of at a fire rated exit corridor. During an interview at the same time as the observation, the Disaster Coordinator stated that the corridor was a fire rated exit corridor. This is a repeat deficiency; on 4/1/14, during a Sample Validation survey, the facility received a deficiency for having a corridor door in a condition that could not resist the passage of smoke. First Floor 2.) At 12:25 p.m., the Urgent Care door at a fire exit corridor was held fully open by a bundled bandage with tape wedged between the top of the door and door frame. This is a repeat deficiency; on 4/1/14 during a	□K 018□	**Hollywood Campus** **Basement** **1. Corrective Actions:** The corridor door was repaired on August 26, 2014. The Engineering Department has added the basement doors to their quarterly door inspection, which will be tracked using the Fire Door Quarterly Inspection Log **(Attachment 1).** All engineers were in-serviced on the policy titled □Fire Door□ for proper visual inspection of the doors. **(Attachment 2 and 3).** **Date of Implementation:** August 26, 2014. **Monitoring Process:** The basement corridor doors were added to Engineering□s quarterly monitoring. After 100% compliance is achieved in two consecutive quarters, monitoring will be complete. **Person Responsible:** Director of Engineering & Lead Engineer **First Floor** **2. Corrective Actions:** The Engineering Department held an in-service with the Urgent Care, EVS and Security staff on the current Fire Life Safety policies that prohibit the doors from being held open. **(Attachment 4 & 5)** **Date of Implementation:** Staffing in-service was held on August 26, 2014. The door will be monitored daily, beginning September 1, 2014.	8/26/2014 8/26/2014 9/1/2014

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□K 018□	Continued From page 2 sampled validation survey the facility received a deficiency for having a corridor door that was impeded from closing. Culver City Campus Pavilion 6th floor Unit C Psychiatric 3.) On 8/20/14 between 9:30a.m. and 9:45a.m., the Dutch corridor door at nurses station C had an aluminum floor threshold with no indication of a fire rating at the meeting edges of the upper and lower leaves. The door was not equipped with an astragal, a rabbet, or a bevel with the same fire rating as the door at the meeting edges of the upper and lower leaves. Closer observation revealed the labels that indicate the fire rating had been removed from the door and door frame. During an interview at the same time as the observation, the Nursing director of P6 (Psychiatric 6) stated, the metal piece (threshold) was placed there yesterday (8/19/14). This is a repeat deficiency; on 4/1/14 during a Sampled Validation survey, the facility received a deficiency for having a corridor Dutch door with no astragal.	□K 018□	Continued from page 2 **Monitoring Process:** The door will be monitored daily, beginning September 1, 2014 **(Attachment 6)**. The door will be monitored for thirty (30) consecutive days. After achieving 100% compliance for sixty (60) days, monitoring will be discontinued. **Person Responsible:** Director of Engineering & Lead Engineer. **Culver City Campus** **6th Floor Unit C** **3. Corrective Actions:** The Engineering Department contacted a third party certification company to re-rate and label the Dutch doors. An astragal was placed on the Dutch doors to achieve the proper certification. **Date of Implementation:** The Dutch doors were re-certified on October 8, 2014. **Monitoring Process:** During the first quarter, the Dutch door will be monitored for tampering, astragal placement and labeling. When 100% is reached continuous monitoring will occur as a part of EOC weekly rounds, covering patient care areas twice a year. **(Attachment 7)** **Person Responsible:** Director of Engineering & Lead Engineer.	10/8/2014
□K 025□	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at□ least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each	□K 025□		

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□K 025□	Continued From page 3 floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, the hospital failed to ensure smoke barriers were maintained with a half hour fire resistance by having missing gypsum board at corridor smoke barrier wall, and a penetration through a construction□ separation wall. The deficiency had the potential to reduce the time the corridor smoke barrier wall had to withstand a fire exposure, and permit the passage of smoke, flame, or gases through the construction separation wall during a fire. Findings: Van Nuys Campus Station 2 1.) On 8/19/14, at Station 2 15ft. a gypsum board was missing from one side of a corridor smoke barrier wall exposing the wood framing members. The area missing the gypsum board was located above the drop down ceiling, above the observation and dictation room, both of which had 20 minute rated fire doors. At the same time as the interview, the Head Engineer stated that the wall was a 30 minute rated fire wall that needed to have dry wall on	□K 025□	**Van Nuys Campus** **Station 2** **1. Corrective Actions:** The Engineering Department attained help from a third party for remediation of fire penetrations throughout the facility. The Engineering staff was also in-serviced on the use of the approved above ceiling work permit and quarterly fire wall and smoke penetration Inspection Preventive Maintenance. **Date of Implementation:** The work of remediation was completed on October 22, 2014. The Engineering staff was in-serviced on above ceiling work permits on August 25, 2014. **(Attachment 8, 9, 10, 11)** **Monitoring Process:** The Engineers will monitor their smoke and fire walls for penetrations on a quarterly basis **(Attachment 12).**	8/22/2014 10/22/2014

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□K 025□	Continued From page 4 both sides of the wall. Culver City Campus Pavilion 4th floor Rehabilitation Unit 2.) On 8/20/14 between 10:05 a.m. and 10:23 a.m., at the construction separation between the back of the 4th floor and the rehabilitation unit at the front of the 4th floor, there was a 3 foot by 5 foot section missing from the gypsum board barrier at the separation. During an interview at the same time as the observation, the Corporate Director of Facilities stated that the gypsum board barrier was supposed to go all the way up to the ceiling. This is a repeat deficiency; on 4/1/14 during a Sampled Validation survey, the facility received a deficiency for having unsealed penetrations through the gypsum board barrier at the construction separation between the back of the 4th floor and the rehabilitation unit at the front of the 4th floor.	□K 025□	Continued from page 4 The above ceiling work permit will be used for all work done above ceiling to monitor and assure fire walls are always 100% compliant. **Person Responsible:** Director of Engineering & Lead Engineer **Culver City Campus** **4th Floor Rehabilitation Unit** **2. Corrective Actions:** The Engineering Department repaired the fire penetrations throughout the facility. The Engineering staff was also in-serviced on the use of the approved above ceiling work permit and quarterly fire wall and smoke penetration Inspection Preventive Maintenance. **Date of Implementation:** The work of remediation was completed on August 25, 2014. The Engineers were in-serviced on above ceiling work, as well as fire and smoke wall penetration inspection preventive maintenance on the same date **(Attachment 13)** **Monitoring Process:** The Engineers will monitor their smoke and fire walls for penetrations on a quarterly basis **(Attachment 14).** The above ceiling work permit will be used for all work done above ceiling to monitor and assure fire walls are always 100% compliant. **Person Responsible:** Director of Engineering & Lead Engineer.	8/25/2014
□K 027□	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6,	□K 027□		

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□K 027□	Continued From page 5 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation and interview, the hospital failed to ensure a cross corridor door automatically self closed when the fire alarm system was activated. The deficiency had the potential to permit the passage of smoke, flame, or gases during a fire, and permit drafts which could spread fire rapidly. Finding: Hollywood Campus First Floor On August 18, 2014 at 12:37 p.m., a cross corridor door located on the first floor, between Urgent Care and the kitchen, failed to close upon activation of the fire alarm system. Closer observation revealed the magnetically held door released upon activation of the fire alarm system, but failed to close. Further observation revealed the door was stuck to the floor. At the same time as the observation, the Corporate Director of Facilities stated that the door failed to close because of wax built up on the floor. At 1:20 p.m., after the wax build up was removed from the floor, the door was retested by again activating the fire alarm system. The door released from the magnetic holder and closed.	□K 027□	**Hollywood Campus** **First Floor** **1. Corrective Actions:** The Engineering Department in-serviced the EVS staff on the excessive use of wax and the need to pay extra attention to the cross corridor doors for assurance of proper closing. **Date of Implementation:** The EVS staff was in-serviced on August 18, 2014 **(Attachment 15).** **Monitoring Process:** The Engineering and EVS staff will monitor cross corridor doors for excessive wax. A floor cleaning schedule has been created for the monitoring of these doors. The floors will be monitored for two rounds of cleaning; monitoring will discontinue after two rounds of cleaning result in doors not sticking. **Person Responsible:** Director of Engineering & Lead Engineer	8/18/2014

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□K 027□	Continued From page 6 This is a repeat deficiency; on 4/1/14 during a Sampled Validation survey, the facility received a deficiency for the same cross corridor door not closing during a test of the fire alarm system.	□K 027□		
□K 052□	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: NFPA 72 National Fire Alarm Code, 1999 Edition 7-3.2 Testing. Testing shall be performed in accordance with the schedules in Chapter 7 or more often if required by the authority having jurisdiction. If automatic testing is performed at least weekly by a remotely monitored fire alarm control unit specifically listed for the application, the manual testing frequency shall be permitted to be extended to annual. Table 7-3.2 shall apply.	□K 052□		

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□K 052□	Continued From page 7 Exception: Devices or equipment that are inaccessible for safety considerations (for example, continuous process operations, energized electrical equipment, radiation, and excessive height) shall be tested during scheduled shutdowns if approved by the authority having jurisdiction but shall not be tested more than every 18 months. Table 7-3.2 Testing Frequencies 5. Batteries - Central Station Facilities c. Sealed Lead-Acid Type 1. Charger Test- Monthly, Quarterly 2. Discharge Test (30 minutes)- Monthly 3. Load Voltage Test - Monthly 6. Batteries - Fire Alarm System c. Sealed Lead-Acid Type 1. Charger Test - Annually 2. Discharge Test (30 minutes) -Annually 3. Load Voltage Test - Semiannually The Code was not met as evidenced by: Culver City Campus Based on document review, and interview, the hospital failed to ensure the batteries of the fire alarm system were tested at the frequencies indicated by NFPA 72. The deficiency had the potential to not supply backup power to the fire alarm system.	□K 052□		

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□K 052□	Continued From page 8 Finding: On August 21, 2014 at 10:30 a.m., during document review, there was no documented evidence the fire alarm system batteries were routinely tested. During an interview, at the same time as the document review, the Lead Man stated that the fire alarm system had sealed lead acid batteries, and that the load voltage tests of the batteries was not being conducted.	□K 052□	**Culver City Campus** **1. Corrective Actions:** The Engineering Department has revised their monthly preventive maintenance to include the monitoring and testing of the fire alarm batteries. The batteries will also be replaced after the second year of use. **Date of Implementation:** The policy and procedure was revised on August, 25, 2014. **Monitoring Process:** The Engineering staff will monitor the batteries on a monthly basis and replace every two years. **(Attachment 16).** **Person Responsible:** Director of Engineering & Lead Engineer	8/25/2014
□K 054□	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer□s specifications. 9.6.1.3 This STANDARD is not met as evidenced by: NFPA 72 National Fire Alarm Code 1999 Edition 2-1.3.2 In all cases, initiating devices shall be supported independently of their attachment to the circuit conductor. The Code was not met as evidenced by: Based on observation and interview, the hospital failed to ensure that a required smoke detector (initiating device) was maintained as required by having a dismounted smoke head suspended by its electrical wires. The deficiency had the potential to impair the operation of the initiating device circuit.	□K 054□		

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□K 054□	Continued From page 9 conceivably resulting in loss of life or property because of fire alarm failure. Copper used in wiring conductors is not formulated to serve as a mechanical support. Copper fatigues over time if placed under mechanical stress, resulting in increasing brittleness and increasing electrical resistance. Ultimately, the fatigued conductor either breaks or its resistance becomes too high to allow the initiating device to function properly. Finding: Culver City Campus Pavilion 6th floor Unit C Psychiatric On 8/20/14 between 9:30a.m. and 9:45a.m., in room 636, there was a smoke detector head that was detached from its base, supported only by its electrical wires. During an interview at the same time as the observation, the Director of Engineering acknowledged the smoke detector head was supported by its wires, and stated the head would be repaired to be supported by its base or it would be replaced. This is a repeat deficiency; on 4/1/14 during a Sampled Validation survey, the facility received a deficiency for having a smoke detector that was pulled of a wall.	□K 054□	**<u>Culver City Campus</u>** **<u>6th Floor Unit C Psychiatric</u>** **Corrective Actions:** The smoke detector in Room 636 was immediately remounted to its base. **Date of Implementation:** The smoke detector was remounted on August 20, 2014. **Monitoring Process:** The Engineering Department conducts weekly visual inspections to ensure secure mounting of smoke detectors. **(Attachment 17).** **Person Responsible:** Director of Engineering & Lead Engineer	8/20/2014
□K 130□	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY-NOT ON 2786	□K 130□		

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□K 130□	Continued From page 10 This STANDARD is not met as evidenced by: NFPA 99 Standard for Health Care Facilities 1999 Edition 4-3.1.1.1 Cylinder and Container Management. Cylinders in service and in storage shall be individually secured and located to prevent falling or being knocked over. 4-3.5.2.1(b)24. Even if they are considered empty, cylinders shall never be used as rollers, supports, or for any purpose other than that for which they are intended by the supplier. 4.3.5.2.2(b)2. If stored within the same enclosure, empty cylinders shall be segregated from full cylinders. Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed hurriedly. 8-3.1.11.2 Storage for nonflammable gases less than 3000 ft3 (85 m3). (h) Cylinder or container restraint shall meet 4-3.5.2.1(b)27. 4-3.5.2.1(b)27. Freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. These Standards was not met as evidenced by: Based on observation and interview, the hospital failed to ensure oxygen cylinders were properly chained or supported in proper cylinder stands or carts. The deficiency had the potential to create a	□K 130□		

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□K 130□	Continued From page 11 mechanical hazard. If a cylinder falls, the valve could snap off and/or if the cylinder is cracked open and the cylinder has a sudden, uncontrollable release of its contents, it could be propelled rapidly and/or violently. Findings: Culver City Campus Exterior Oxygen Cylinder Storage On August 21, 2014 at 9:10a.m. the following conditions existed at the exterior oxygen (02) cylinder storage area. 1.) Two 02 (a non-flammable gas) cylinders were lying on their sides on the ground with a metal hand truck on top of them. During an interview, at the same time as the observation, the Head Engineer stated that the cylinders should have been in racks, stands or secured by chains. 2.) One 02 cylinder was free standing and unsecured. During an interview, at the same time as the observation, the Head Engineer stated that the cylinder should have been in a rack, stand or secured by a chain. This is a repeat deficiency; on 4/1/14 during a Sample Validation survey, the facility received a deficiency for having free standing oxygen cylinders that were not supported or chained throughout the hospital, including the exterior oxygen storage area.	□K 130□	**Culver City Campus** **Exterior Cylinder Storage** **1. Corrective Actions:** The cylinders were immediately put back onto the appropriate rack. A daily surveillance procedure has been implemented to check for inappropriate or unsafe storage. Staff was in-serviced on O_2 tank safety, monitoring and surveillance. **(Attachment 18)** **Date of Implementation:** August 21, 2014. **Monitoring Process:** A twice daily check log has been implemented to ensure tanks are secured safely and in the appropriate locations. Monitoring log is effective starting October 1, 2014. **(Attachment 19)** **Person Responsible:** Respiratory Therapy Clinical Coordinator **2. Corrective Actions:** The cylinder was immediately put back onto the appropriate rack. Additional racks have been ordered to ensure O_2 cylinders throughout the facility will be properly secured. **Date of Implementation:** August 21, 2014. **Monitoring Process:** Cylinders are monitored during morning and afternoon daily rounds. **(Attachment 19)** **Person Responsible:** Respiratory Therapy Clinical Coordinator	8/21/2014 10/1/2014 8/21/2014

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	Continued From page 12		Continued from page 12	
□K 130□	3.) One Argon (a non-flammable gas) cylinder was free standing unsecured. During an interview, at the same time as the observation, the Head Engineer identified the cylinder as an argon cylinder and stated that the cylinder should have been in a rack, stand or secured by a chain. 4.) There were ten full 02 cylinders stored on the empty cylinder side of the cylinder storage area. A sign on the wall identified the section as the empty cylinder section of the 02 storage area. During an interview, at the same time as the observation, the Head Engineer identified the cylinders as full cylinders and stated that the should been stored on the full side.	□K 130□	**3. Corrective Actions:** The cylinder was immediately put back onto the appropriate rack. Additional racks have been ordered to ensure O_2 cylinders throughout the facility will be properly secured. **Date of Implementation:** August 21, 2014 **Monitoring Process:** Cylinders are monitored during morning and afternoon daily rounds. **(Attachment 19** **Person Responsible:** Respiratory Therapy Clinical Coordinator **4. Corrective Actions:** Areas for storage of full and empty tank in the tank storage cage have been clearly marked. Additional racks have been ordered to segregate full tanks from empty tanks. **Date of Implementation:** August 21, 2014 **Monitoring Process:** Cylinders are monitored during monitoring and afternoon daily rounds. **(Attachment 19)** **Person Responsible:** Respiratory Therapy Clinical Coordinator & Senior Transportation Coordinator	8/21/2014 8/21/2014
□K 147□	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: NFPA 70 National Electrical Code (NEC) 1999 Edition 400-8. Uses not permitted. Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure 400-9. Splices. Flexible cord shall be used only in continuous lengths without splice or tap where	□K 147□		

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□K 147□	Continued From page 13 initially installed in applications permitted by section 400-7(a). The repair of hard-service cord and junior hard-service cord (see Trade Name column in Table 400-4) No. 14 and larger shall permitted if conductors are spliced in accordance with Section 110-14-(b) and the completed splice retains the insulation, outer sheath properties, and usage characteristics of the cord being spliced. These requirements were not met as evidenced by: Based on observation and interview, the hospital had an extension cord in use as permanent wiring. The deficiency had the potential to present a fire safety hazard. The National Electrical Code (NEC) stipulates that temporary wiring is to be removed immediately upon completion of construction or other purpose (i.e. remodeling, maintenance, repair, and demolition) for which the wiring was installed. Finding: Culver City Campus Single Story Building On August 21, 2014, at 9:35a.m., there was an extension cord being used as permanent wiring at the exterior west side of the single story building. A mini drop amplifier was connected to the extension cord. During an interview, at the same time as the observation, the Lead Engineer stated that the	□K 147□	**Culver City Campus** **Single Story Building** **1. Corrective Actions:** The Engineering Department removed the extension cord and repaired the existing outlet at the location. The Engineering staff was in-serviced on the use of extension cords. **(Attachment 20)** **Date of Implementation:** Repairs to existing outlet were complete on August 21, 2014. Staff in-service was conducted on August 25, 2014. **Monitoring Process:** The receptacle will be monitored for the next two (2) months, after that, it will be monitored annually during EOC rounds. **Person Responsible:** Director of Engineering & Lead Engineer	8/21/2014 8/25/2014

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□K 147□	Continued From page 14 extension cord should not have been in use as permanent wiring. This is a repeat deficiency; on 4/1/14 during a Sampled Validation survey, the facility received a deficiency for using extension cords as permanent wiring.	□K 147□		

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E 000	Initial Comments The following reflects the findings of the Department of Public Health during a Complaint Investigation. Intake Number: CA00404848 Inspection was limited to the specific complaint investigation and does not represent the findings of a full inspection of the facility. Representing the Department of Public Health: Surveyor 16281 One deficiency was issued to intake CA00404848.	E 000		
E 2429	T22 DIV5 CH1 ART8-70855 Mechanical Systems Heating, air conditioning and ventilating systems shall be maintained in operating condition to provide a comfortable temperature and to meet the new construction requirements in effect at the time plans were approved for the facility. This Statute is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure the air conditioning equipment was maintained to provide a comfortable temperature, and failed to adhere to its Patient Room Temperature Control Policy by having temperatures in patient care areas that were outside the hospital's target temperature range. According to the Centers for Disease Control (CDC), Extreme Heat Prevention Guide – Part 1, last reviewed: May 31, 2012. Elderly people (65 years and older), infants and children and people	E 2429		

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E 2429	Continued From page 1 with chronic medical conditions are more prone to heat stress. Air-conditioning is the number one protective factor against heat-related illness and death. Finding: On July 17, 2012 at 2:30 p.m., a complaint visit was conducted at the hospital regarding a complaint allegation that the hospitals air conditioning system was not working. The hospital census was 64. At 2:45 p.m., the Disaster Coordinator stated that half the time he works as the hospital engineer. He stated that the facility had two chillers a 100 ton and a 15 ton. That the 100 ton chiller would sometimes shut off and turn on again, that it happened for three consecutive days and then it was decided to change the parts the air conditioning service vendor had recommended. That the parts were changed on the compressor yesterday (7/8/14) by the vendor. That it fixed the problems at first but that there were other problems such as holes in the water circulation pipe which were discovered in the process of servicing the chiller. He also stated that the whole hospital was affected by the problems with the 100 ton chiller except for the basement. That the last time the air conditioning was not working was Monday afternoon (7/7/14). Between a 3:15 p.m. and 4:07 p.m., on July 17, 2014, samples of room temperatures were taken by the Disaster Coordinator using a infrared temperature gun with a lowest temperature	E 2429	**Corrective Actions:** To assure prompt actions, the facility has hired a Lead Engineer to alleviate response time and management from the Disaster Coordinator. The facility has reached a maintenance agreement with a third party for monthly service to the chiller. In the event that the chiller goes down, the facility will call for portable units and also call the IOR to contact the CO for emergency approval process of an on-site temporary chiller as the repairs are completed. The facility has in-serviced the engineering department on the new policy, implemented in March 2014, and will be auditing findings on a bi-weekly basis. The facility has also implemented a preventive maintenance program, which will be performed on a quarterly basis. **Date of Implementation:** The Lead Engineer was hired on August 14, 2014. The third party agreement was implemented on September 19, 2014. In-services were conducted and audits began on August 25, 2014. Redline Air's quarterly preventive maintenance program will commence on September 18, 2014. **Monitoring Process:** Temperature Log is monitored bi-weekly. Engineering will be conducting mechanical rounds on a daily basis. Quarterly preventive maintenance program by Redline Air. **Person Responsible:** Lead Engineer and Engineering department.	8/14/2014 8/25/2014 9/18/2014 9/19/2014

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E2429	Continued From page 2 reading of 68.3 degrees Fahrenheit and the highest temperature reading of 80.0 degrees Fahrenheit as follows: 6th floor 1. The respiratory therapy room was 72.6 degrees Fahrenheit. 5th floor (Med Surge Unit) 2. Room 510 was 72.2 degrees Fahrenheit. 3. Room 505 was 70.9 degrees Fahrenheit. 4. Room 501 was 68.9 degrees Fahrenheit. 4th floor (Med Surge Unit) 5. Room 409 was 72.7 degrees Fahrenheit. 6. Room 406 was 71.0 degrees Fahrenheit. 7. Room 401 was 78.9 degrees Fahrenheit. 3rd floor 8. Room 307 part of the Med Surge Unit, was 70.9 degrees Fahrenheit. 9. The CCU was 80.0 degrees Fahrenheit. 10. The ICU was 68.3 degrees Fahrenheit. 11. Room 301 was 69.0 degrees Fahrenheit. 2nd floor (currently not occupied by patients) 12. Room 202 was 68.7 degrees Fahrenheit.	E 2429		

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E 2429	Continued From page 3 13. Room 201 was 72.4 degrees Fahrenheit. 1st floor 14. The Urgent Care room was 70.9 degrees Fahrenheit. 15. The kitchen was 73.2 degrees Fahrenheit. Basement 16. The corridor to surgery was 77.3 degrees Fahrenheit. Two of fourteen sampled rooms (401 and the CCU), and the surgery corridor were above the hospitals target temperature range. At the same time as the observation four of six patients interviewed (Patients 1, 2, 3 and 4) stated their rooms were hot or warm. Patient 1 stated, “It’s hot, it may be my because of my medication, but its better than the other day.” Patient 2 stated, “It’s warm in here.” Patient 3 stated, “Gets hot at night.” Patient 4 stated, “It’s hot in the room.” Also, at the same time as the observation, during an interview, the Disaster Coordinator stated that the temperature that was out of range in room 401 was a thermostat issue because the thermostat was set too high. Between 4:07 p.m. and 5:02 p.m., during document review, policy number UTL-086, titled,	E 2429		

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E 2429	Continued From page 4 "Patient Room Temperature Control," with an effective date of 3/20/2014 indicated that the heating, air conditioning, and ventilation systems shall be maintained in operating condition to provide a comfortable temperature based on Title 24 Mechanical Code (Ref. Table 325.0). The policy indicated that the target temperature range was 68 to 77 degrees (Fahrenheit) (Title 24, Table 325.0). The policy indicated that the objective was to establish an effective and compliant temperature control system that can be monitored in all general patient care areas of the facility, and indicated the procedure was that on the day determined readings would be taken and logged as part of the daily rounds on non-critical patient care areas. That the readings were to be taken from two points within the patient room, and at the bedside level for every HVAC unit service area, every two weeks, twice per day (7:00 a.m. and 2:00 p.m.) A review of the Daily Mechanical Inspections log from July 1 to 9, 2014, indicated that on July 2, 3, 5 and 6, 2014, the air conditioning was malfunctioning. A review of the Hospital wide Temperature Log for July 1, 2, 4, 5, 6, 7, 8 and 9, 2014, indicated that on July 2, 4, 5, 7, 6, 8, and 9 2014, the temperature in patient areas throughout the hospital were above the hospital's target temperature range of 68 to 77 degrees Fahrenheit. Per the log on July 2, 2014, at 9 a.m., the measured temperatures of 22 of 24 areas, including patient areas in the hospital were between 77.1 and 78.6 degrees Fahrenheit.	E 2429		

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E 2429	Continued From page 5 Per the log on July 4, 2014, at 11 a.m., the measured temperatures of 52 of 52 areas, including patient areas in the hospital were between 78.0 and 83.1 degrees Fahrenheit. Per the log on July 5, 2014, at 8 a.m., the measured temperatures of 59 of 59 areas, including patient areas in the hospital were between 79.0 and 83.1 degrees Fahrenheit. Per the log on July 6, 2014, at 11 a.m., the measured temperatures of 49 of 49 areas, patient areas in the hospital were between 79.0 and 85.1 degrees Fahrenheit. Per the log on July 7, 2014, time not indicated, the measured temperatures of 4 of 48 areas, including patient areas in the hospital were above the hospital's target temperature range. Room 305, and the third and fourth floor hallways, were 78 degrees Fahrenheit. Per a log on July 8, 2014, time not indicated, the measured temperatures of 3 of 51 areas, including patient areas in the hospital were above the hospital's target temperature range. Room 301, 410 and 506, were 78 degrees Fahrenheit. Per a second log on July 8, 2014, at 11:14 a.m., the measured temperatures of 60 of 63 areas, including patient areas in the hospital were between 78.1 and 88.8 degrees Fahrenheit. Per the log on July 9, 2014, time not indicated, the measured temperature of 2 of 51 areas, including patient areas in the hospital was above the hospital's target temperature range. Room 309 was 78 degrees Fahrenheit. The facility did not provide Hospital wide	E 2429		

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E 2429	Continued From page 6 Temperature Logs for July 3, 2014, or any other documented evidence temperature measurements of patient areas were taken, or that the hospital patient areas were within the hospital's target temperature range on July 3, 2014. At 2:50 p.m., during an interview, the Disaster Coordinator had stated that the temperature is usually monitored every day but that currently they were monitoring the temperature three times a day. There was no documented evidence provided the temperature was being monitored three times a day, evidence of daily monitoring twice a day was provided for 1 of 9 days, and evidence of daily monitoring once a day was provided for 7 of 9 days. The Disaster Coordinator was not aware that the hospital had a Patient Room Temperature Control policy. At 4:40 p.m., during an interview, the Chief Engineer stated that every morning he checks that the chiller is running at between 50 to 58 degrees Fahrenheit but that the patient rooms are only checked when the nurses call if there is a problem, and that the temperatures are not logged unless there is a problem. He also stated that the target temperature range he checks for is 60 to 72 degrees Fahrenheit. The Chief Engineer was not aware that the hospital had a Patient Room Temperature Control policy. A review of rental agreements dated July 2, 5, 6, and 7, 2014 indicated that twenty portable spot coolers (air conditioners) were rented by the hospital. During an interview, at the same time as the	A 2429		

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E 2429	Continued From page 7 document review, the Administrator stated that twenty nine portable spot coolers were rented and placed throughout the hospital, primarily in patient areas. A review of the description of work form from the air conditioning service vendor dated July 7, 2014, indicated the technician installed hot gas discharge thermostat and suction line freeze stat, rebuilt, reinstalled the compressor and aligned, evacuated, opened all valves, replaced liquid line driers, started system, set oil pressure safety at 25 psi and tested OK, system running good with 21 degree superheat – 6 degree subcooling and 60 psi net oil pressure, changed oil after one hour will return to change again. A review of the description of work form from the air conditioning service vendor dated July 8, 2014, indicated the technician ran flexible conduit and wiring from suction line freezes stat and discharge line T-stat at 180 degrees Fahrenheit and freeze stat at 40 degrees Fahrenheit, replaced bad condenser fan motor and fan blade, verified rotation and operations OK, monitored chiller operations, adjusted to unload at 59 psi, will return to change oil and driers.	E 2429		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 000}	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during a focused revisit following a Complaint Validation Survey (Intake Number CA00429647) completed on 2/5/15 with Condition of Participation (CoP) CFR 482.41 Physical Environment not met. The focused revisit was completed on 6/4/15. Representing the Department of Public Health: Surveyor 16281, REHS, CFI 1, HFE I	{A 000}		
{A 701}	482.41(a) MAINTENANCE OF PHYSICAL PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This STANDARD is not met as evidenced by: Based on observation, interview, and document review, the hospital failed to provide a permanent air system to operate continuously and provide balanced air-supply to patient rooms for the 2nd, front of 3rd (SDU), 4th, 5th, and 6th floors, provide a Construction Final (CF) for the new temporary air handler and fire alarm control panel, and provide self-closing area separation fire doors. The deficiencies had the potential to permit the spread of smoke and gases during a fire, and not provide a permanent provision of balanced air-supply to patient rooms on the 2nd, front of 3rd, 4th, 5th, and 6th floors. Findings:	{A 701}	1. Corrective Action: The ability to remove relays that would allow bypass of the air handlers has been permanently eliminated. With the installation of the new fire panel, the relays are now designed to fail safe. This means that should someone remove or tamper with the relays, the air handlers will automatically shut down, which will immediately stop air flow in the ventilation system. The fire system has been fully tested by Culver City Fire Dept and Inspector of Record, to insure that in the event of a fire or smoke alarm, both the permanent and temporary air handler will shut down. Attachment's •OSHPD CO 8/19/2015 Certificate of Occupancy for use of Temporary Air Handler •OSHPD FV 6/30/15 indicating we will be able to obtain Construction Final once the replacement air handler is installed and temporary air handler is removed. •OSHPD Notice of Start of Construction for New Permanent Air Handler •OSHPD VR 6/3/15 indicating all devices have been tested	06/22/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050135	A. BUILDING _____ B. WING _____	R 06/04/2015

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{A 701}	Continued From page 1 1. On 6/4/15 the evaluator conducted a follow up visit for a complaint validation survey dated 2/5/15, for a fire that occurred on the roof, and at air handler 2 of the pavilion building on 1/29/15, during roofing work. Relays at the air handler control panel had been disconnected, permitting air handlers 1 and 2 to not shut down with the presence of smoke, dispersing smoke from the roof and air handler 2 to other areas and floors of the pavilion. On 6/4/15 at 10 a.m., during an interview, the VP of Corporate Facilities Operations stated that with the new design of the fire alarm control panel (FACP), if the relays are disconnected, air handler 1, and the replacement for air handler 2, when installed, will shut down and activate an alarm at the FACP. At 10:38 a.m., there was a new temporary air handler, and new ducting on the roof of the pavilion building. There was a work crew on the roof, a hot works permit #5218589 dated 6/2/15 with an expiration date of 6/5/15 at 4 p.m., for roofing patch back was posted on the air duct frame, and a fire watch was being conducted at the work site. During an interview at the same time as the observation, the VP of Corporate Facilities Operations stated that the air handler was temporary and could not be used as the permanent because it did not meet the seismic requirements of a permanent air handler, but that the new air ducting the temporary air handler was connected to was the new permanent ducting. At 10:50 a.m., during an interview, the Fire Alarm	{A 701}	•OSHPD FV 6/22/15 indicating OSHPD Fire Marshall issuing Occupancy for use of the Fire Alarm System •OSHPD CO Fire panel Certificate of Occupancy 6/22/15 2.Plan for Improvement: By making the modifications described above, the deficiency has been permanently corrected. 3.Expected Completion date: This is complete, please see attached Certificate of Occupancy from OSHPD. Project # S142962-19-00 4. Demonstrated hospital Improvement Actions: Not only has this deficiency been eliminated, the air handlers will immediately shut down should the relays be removed or tampered with. The fire panel will also alarm indicating a problem with a relay. 5. Responsible Person: Dean Morford, Director of Facilities Operations.	

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{A 701}	Continued From page 2 System Vendor/Technician present on site, stated that both relays at the air handler control panel are now wired fail safe so that if the relays are disconnected, air handler 1, and the replacement for air handler 2, when installed, will shut down and activate a visual and audible alarm at the FACP and annunciator panels located at the basement and lobby of the pavilion building, and PBX of the tower building. The Fire Alarm System Vendor/Technician also stated that the temporary air handler does not shut down when the relays are disconnected because that air handler is not controlled by the relays, but that the temporary air handler will shut down with the activation of any smoke detector in the building, and that once installed the permanent air handler replacing air handler 2 will be controlled by the relays, and will also shut down when the relays are disconnected. During an observation at the same time as the interview, engineering staff demonstrated the shutting down of air handler 1 by disconnecting a relay from the air handler control panel. At 1:25 p.m., during document review, there was an Office of Statewide Health Planning and Development (OSHPD) permit, and Certificate of Occupancy (CO) from the OSHPD Fire Life Safety Officer (FLSO) dated 5/28/15, but there was no Construction Final (CF) for the new temporary air handler. There was no documented evidence of submitted architect drawings, OSHPD permit, contracts, and completion timeline for the installation of the permanent air handler replacing air handler 2. There was an OSHPD Verified Compliance Report (VR) dated 6/3/15 for the replacement of the FACP, but there was no acceptance test and CF for the new FACP.	{A 701}		

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{A 701}	Continued From page 3 During an interview at the same time as the document review, the VP of Corporate Facilities Operations stated that there was not a CF for the new FACP because the hospital is waiting for the OSHPD FLSO for the CF. On 6/9/15, a copy of an OSHPD FLSO Field Visit (FV) dated 6/8/15, was provided by the VP of Corporate Facilities Operations, that indicated the FACP project was 80% complete, that with the exception of minor "punch-list" items the scope of work had been inspected and accepted by the Inspector of Record (IOR) and is ready for the required acceptance testing with the Authority Having Jurisdiction (AHJ) or OSHPD. That the OSHPD Fire Marshall has agreed to accept any testing that has been witnessed and accepted by personnel from the Culver City Fire Department in lieu of testing with the OSHPD Fire Marshall. 2. On 6/4/15 the evaluator conducted a follow up visit for a complaint validation survey dated 2/5/15. As a result of the complaint validation survey dated 2/5/15 it was revealed through review of the local fire departments undated Fire Investigation Report regarding a fire incident at the hospital on 1/29/15, that self-closing area separation fire doors had been removed from the fourth and fifth floors, and that an OTC (Order to Comply) for replacement of the doors had been issued. On 6/4/15 at 11:29 a.m., on the 5th floor, the VP of Corporate Facilities Operations identified a cross corridor door frame near room 533 as one of the areas where the doors were missing. There were no cross corridor doors within the door frame.	{A 701}	1. Corrective Action: A project to replace/install new door was opened with OSHPD. This project has been completed. The testing of the doors was included with the new fire panel project, conducted by the Culver City Fire Dept and Inspector of Record.	07/01/2015

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{A 701}	Continued From page 4 During an interview at the same time as the observation, the VP of Corporate Facilities Operations stated that construction on the fire doors should start in 3 weeks (6/25/15) and be completed by 7/6/15. At 11:42 a.m., on the 5th floor, the VP of Corporate Facilities Operations identified a cross corridor door frame near room 523 as one of the areas where the doors were missing. There were no cross corridor doors within the door frame. Between 11:42 a.m. and 12:07 p.m., on the 4th floor, the VP of Corporate Facilities Operations identified a cross corridor door frame near room 423 as one of the areas where the doors were missing. There were no cross corridor doors within the door frame. During document review, there was an application to OSHPD for the installation of cross-corridor doors at the second, third, fourth and fifth floors. Review of a Gantt chart for the installation of the doors indicated the installation of the doors would start on 6/18/15 on the 2nd floor, 6/29/15 on the 4th floor, and 7/2/15 on the 5th floor, and would finish on 6/18/15 on the 2nd floor, 7/1/15 on the 4th floor, and 7/6/15 on the 5th floor, with OSHPD final approvals between 7/7/15 and 7/13/15. On 6/5/15, a copy of purchase order for 6 doors and 3 frames, dated 6/5/15, was provided by the VP of Corporate Facilities Operations.	{A 701}	•OSHPD Application for New Project 1/30/15 •OSHPD Notice of Construction 4/31/15 •Door Order 6/5/15 •OSHPD CO 7/1/15 Certificate of Occupancy •Quarterly Door Inspection (Not due until 10/15) 2.Plan for Improvement The doors will be added to the Quarterly Door Inspection Program. 1st inspection will be October 2015. 3.Expected completion Date: Project is complete, please Certificate Occupancy Project # S150397-19-00- SCH Door Installation 4.Demonstrated hospital Improvement Actions: The doors have been added to the Quarterly Door Inspection Program. 5. Responsible person: Mark Stultz, Director of Facilities Operations.	
A 724	482.41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE	A 724		

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A 724	Continued From page 5 Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This STANDARD is not met as evidenced by: Based on observation, and interview, the hospital staff failed to ensure the hospital was maintained to ensure an acceptable level of safety for patients, staff and visitors, by having a water leak at the ceiling of a nurses' station. The deficiency had the potential for the water with contaminants within it, from running through the area between the roof and the 6th floor ceiling, to act as a conductor of electricity, and the electrical wires and/or box touched by the water from the leak had the potential for electrical short, arcs and other failures. Findings: On 6/4/15 at 11:19 a.m., at the 6th floor nurses' station there was water leaking from above the drop down suspended ceiling into a receptacle below. Closer observation revealed the water was dripping from an electrical box containing wires that was connected to an electrical conduit. During an interview at the same time as the observation, the VP of Corporate Facilities Operations stated that the leak originated at the roof from a steam line for a boiler, and that it would be repaired in the afternoon. During another interview also at the same time as the observation, the Director of Facilities stated that the leak was discovered that morning.	A 724	1. Corrective Action: The temporary plan of correction was to place a pipe clamp on the leaking pipe and contain dripping water. The permanent solution involved obtaining a proposal from a vendor for repair of the 4" water line and faulty shutoff valve. Part of the process was to schedule a shutdown of the building heating system hot water. Attachments •Engineering work order 6/4/14 indicating work repair •RF MacDonald Proposal for repair 6/22/15 •Repair P.O. •RF MacDonald Work Ticket – indication repair completion 8/11. 2. Plan for improvement: Water leaks cannot be predicted, as leaks occur, the Facilities Operations Center is notified and a work order is generated to repair. 3. Expected Completion Date: Temporary repairs were completed on 6/4/2015. Permanent repairs were completed on 8/11/2015. Please see attached work orders, proposal for repair from R.F. MacDonald, Purchase Order to perform work and work order ticket form R.F. MacDonald. 4. Demonstrated Hospital Improvement Actions: Utility failures are reported to the EOC committee, EOC reports are reported to the Quality Council Committee. 5. Responsible Person(s): Dean Morford, Director of Facilities Operations, Mark Stultz, VP of Corporate Facilities Operations, and Toby Davis, Director of the Behavioral Health Unit.	06/04/2015

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{K 000}	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during a focused revisit following a Complaint Validation Life Safety Code Survey (Intake Number CA00429647) completed on 2/5/15 with Condition of Participation (CoP) CFR 482.41 Physical Environment not met. The focused revisit was completed on 6/4/15. Representing the Department of Public Health: Surveyor 16281, REHS, CFI 1, HFE I	{K 000}		
{K 067}	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: NFPA 90A, Standard for the Installation of Air Conditioning and Ventilating Systems. 2-3.11.1 Egress Corridors in health care, detention and correctional and residential occupancies shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas. An air transfer opening(s) shall not be permitted in walls or in doors separating egress corridors from adjoining areas. Exception No. 1: Toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary	{K 067}		

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{K 067}	Continued From page 1 spaces opening directly onto the egress corridor. Exception No. 2: Where door clearances do not exceed those specified for fire doors in NFPA 80, Standard for Fire Doors and Fire Windows, air transfer caused by pressure differentials shall be permitted. Exception No. 3: Use of egress corridors as part of the engineered smoke control system. Exception No. 4: In detention and correctional occupancies with corridor separations of open construction (e.g. grating doors or grating partitions). 4-3.1 Smoke dampers shall be controlled by an automatic alarm initiating device. Smoke dampers shall be permitted to be positioned manually from a command station. 4-4.1 All automatic shutdown devices shall be tested annually. 4-4.3 Smoke detectors provided as required by 4-4.2 shall automatically stop their respective fan(s) on detecting the presence of smoke. NFPA 101 Code for Safety to Life from Fire in Buildings and Structures 2000 Edition 9.2.1 Air Conditioning, Heating, Ventilating Ductwork, and Related Equipment. Air conditioning, heating, ventilating ductwork, and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems, or NFPA 90B, Standard for the Installation of Warm Air Heating and Air-Conditioning Systems, as	{K 067}		

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{K 067}	Continued From page 2 applicable, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction. 9.3.1* General. Smoke control systems, where required or permitted by Chapters 11 through 42, shall have an approved maintenance and testing program to ensure operational integrity. The purpose of such smoke control systems shall be to confine smoke to the general area of fire origin and maintain use of the means of egress system. 9.6.5.1 A fire alarm and control system, where required by another section of this Code, shall be arranged to actuate automatically the control functions necessary to make the protected premises safer for building occupants. 9.6.5.2 Where required by another section of this Code, the following functions shall be actuated by the complete fire alarm system: (1) Release of hold-open devices for doors or other opening protectives (2) Stairwell or elevator shaft pressurization (3) Smoke management or smoke control systems (4) Emergency lighting control (5) Unlocking of doors 19.3.4.4 Emergency Control. Operation of any activating device in the required fire alarm system shall be arranged to accomplish automatically any control functions to be performed by that device. (See 9.6.5.) 19.5.2.1 Heating, ventilating, and air conditioning shall comply with the provisions of Section 9.2 and shall be installed in accordance with the	{K 067}		

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{K 067}	Continued From page 3 manufacturer's specifications. These codes and standards were not met as evidenced by: Based on observation, interview and document review, the facility failed to failed to ensure that all automatic shutdown devices were tested annually. The facility used corridors as plenums. The deficiencies had the potential to permit accelerated spread of smoke and gases during a fire. Findings: 1. On 6/4/15 the evaluator conducted a follow up visit for a complaint validation survey dated 2/5/15, for a fire that occurred on the roof, and at air handler 2 of the pavilion building on 1/29/15. Relays at the air handler control panel were found to have been disconnected, permitting air handlers 1 and 2 to not shut down with the presence of smoke, dispersing smoke from the roof and air handler 2, to other areas and floors of the pavilion. During the complaint validation survey dated 2/5/15, review of fire alarm system inspection and test reports dated 7/28/14, and 4/24/13, indicated there was no documented evidence that the duct detectors for air handlers 1 and 2 at the 7th floor penthouse were inspected and tested. The last documented evidence of duct smoke detectors for air handler one and two being inspected was on 3/20/12. On 6/4/15 at 1:25 p.m., during document review, there was no documented evidence that the duct	{K 067}	1. Corrective Action: The ability to remove relays that would allow bypass of the air handlers has been permanently eliminated. With the installation of the new fire panel, the relays are now designed to fail safe. This means that s hould someone remove or tamper with the relays, the air handlers will automatically shut down, which will immediately stop air flow in the ventilation system. The fire system has been fully tested by Culver City Fire Dept and Inspector of Record, to insure that in the event of a fire or smoke alarm, both the permanent and temporary air handler will shut down. The new fire panel, smoke detectors, Fire dampers and smoke dampers were completely tested and signed off by the Culver City Fire Dept. Please see OSHPD Field Visit Report dated 6/22/15. Attachment's: •OSHPD CO 8/19/2015 Certificate of Occupancy for use of Temporary Air Handler •OSHPD FV 6/30/15 indicating we will be able to obtain Construction Final once the replacement air handler is installed and temporary air handler is removed.	06/22/2015

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{K 067}	Continued From page 4 detectors for air handlers at the 7th floor penthouse were inspected and tested. There was also no documented evidence of any inspection and testing of duct detectors for the new temporary air handler. During an interview, at the same time as the document review the VP of Corporate Facilities Operations stated that the Fire Alarm System Vendor/Technician has been testing the automatic shutdown devices continuously during the installation of the new fire alarm control panel and new temporary air handler, and that Fire Alarm System Vendor/Technician will retest the automatic shutdown devices again at the end of the project, and provide a written report. 2. On 6/4/15 the evaluator conducted a follow up visit for a complaint validation survey dated 2/5/15. As a result of the complaint validation survey dated 2/5/15 it was revealed through interview of the Lead Man, and review of the tower building's supply and exhaust conveyance document, that Tower floors 4, 5, and 6 (T-4, T-5, and T-6) had plenums as part of the buildings air distribution system. T-6, was a Med-Detox unit. T-5 had been used as turn around space to house patients while the cleaning from the fire incident was done at the Pavilion. T-4 was not on the facility's license and was not used for patients. T-2 was completely ducted and did not have a plenum as part of the floors air distribution system.	{K 067}	•OSHPD Notice of Start of Construction for New Permanent Air Handler. •OSHPD VR 6/3/15 indicating all devices have been tested •OSHPD FV 6/22/15 indicating OSHPD Fire Marshall issuing Occupancy for use of the Fire Alarm System. 2. Plan for Improvement: By making the modifications described above, the deficiency has been permanently corrected. 3. Expected Completion Date: This is complete, please see attached Certificate of Occupancy from OSHPD. Project # S142962-19-00 Issued by Fire Life Safety Officer. 4. Demonstrated Hospital Improvement Actions: Not only has this deficiency been eliminated, the air handlers will immediately shut down should the relays be removed or tampered with. The fire panel will also alarm indicating a problem with a relay. 5. Responsible Person(s): Dean Morford, Director of Facilities Operations, and Mark Stultz, VP of Corporate Facilities Operations.	

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	050135	A. BUILDING 01 - SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD B. WING	R 06/04/2015

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{K 067}	Continued From page 5 The egress (exit) corridors of T-4, T-5, and T-6 were the same corridors used as a portion of the air supply (plenums). T-2, T-4, T-5, and T-6 were not sprinklered. T-2, T-4, T-5, and T-6 had smoke detectors in the corridors including at the elevator lobby. T-2, T-5, and T-6 had smoke detectors in the rooms. T-4 did not have smoke detectors in the rooms. On 6/4/15 at 1:25 p.m., during document review, OSHPD Verification Compliance Report dated 2/24/14 indicated that the Inspector of Record (IOR) inspected and tested the new fire alarm control panel and system in the "Tower Building" to be in full operation. That every device in the system had been tested and inspected for alarm, trouble, supervisory, ground fault, end of line voltage drop, air handler shut down, damper activation/operation, and dialer verification. During an interview, the VP of Corporate Facilities Operations stated that nothing had changed in the Tower building since the complaint validation survey dated 2/5/15. Per CMS S&C-06-18 letter dated 5/26/06, NFPA 90A, "Installation of Air Conditioning and Ventilating Systems" document, 1999 Edition prohibits egress (exit) corridors in health care occupancies from being used as a portion of the supply, return or exhaust air system serving adjoining areas (2-3.11.1, 1999 ed.). This prohibits the corridor from being used as a plenum.	{K 067}	1. Corrective Action: The hospital is requesting a variance for this deficiency. As per CMS S&C-06-18 criteria, citing a review of the fire alarm system pertaining to the corridor protection. The existing system, as installed and tested, contains full corridor coverage, with smoke detectors, and is interconnected to the existing ventilation system. Attachment •Description of Tower Building HVAC – Gevork Consulting Engineering 4/30/15. •Description of fire and smoke alarm interaction with ventilation System. 2. Plan for Improvement: The hospital is requesting a variance for this deficiency. 3. Expected Completion Date: The hospital is requesting a variance for this deficiency. 4. Demonstrated Hospital Improvement Actions: The mechanical system will be part of the annual fire system testing. 5. Responsible Person: Dean Morford, Director of Facilities.	04/30/2015

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{K 067}	Continued From page 6 The CMS S&C-06-18 letter dated 5/26/06, also indicated that in the cases where it is determined that the corridor is being used as a plenum and the deficiency is cited at tag K-067, a waiver may be granted. The letter further indicated that one of the criteria that should be used when considering the waiver request is that for partially sprinklered or unsprinklered buildings. if the zone with the corridor plenum is protected by a complete corridor smoke detection system, and there is provision for automatic fan shut down upon detection of smoke and activation of the building fire alarm system, a waiver may be recommended.	{K 067}		

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A 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during a Full Sampled Validation Survey. Representing the Department of Public Health: Surveyor 17030, RN, HFEN Surveyor 11683, RN HFEN Surveyor 25524, RN, HFEN Surveyor 16281, REHS, HFE I Surveyor 14041, REHS, HFE I Surveyor 10933, Nutritional Consultant Surveyor 25049, Nutritional Consultant Surveyor 25049, MD, Medical Consultant Surveyor 29775, MD, Medical Consultant Surveyor 28851, Pharm D, Pharmacy Consultant Surveyor 32022, Pharm D, Pharmacy Consultant Total Population: 315 Total Sample Size: 52 On March 26, 2014, at 4:20 p.m., the survey team declared an Immediate Jeopardy (IJ) situation, in the presence of the chief nursing officer, director of risk management, and administrator of facility□s Van Nuys campus, as a result of the facility□s failure: To ensure the patients received care in an environment that assured the safety of the well-being of the patients in the facility□s Psychiatric Unit 1 and Unit 2. On March 26, 2014, at 6 p.m., the IJ was abated in the presence of the director of risk management and administrator of the facility□s Van Nuys campus.	A 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (□6) DATE

Any deficiency statement ending with an asterisk (□) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 043	482.12 GOVERNING BODY There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ... This CONDITION is not met as evidenced by: Based on observation, interview, and record review, the facility□s Governing Body failed to provide oversight for the operations of the hospital by failing to meet the following Condition of Participation: 1. For Patient Rights by the facility□s inability to ensure and provide patients□rights in a safe patient care environment. (Refer to A 0115) 2. For Nursing Services the facility□s failure to provide nursing services in safe patient care environment (refer to A 0385) 3. For Pharmaceutical Services, the facility□s inability to ensure and provide Pharmacy services in a safe patient care environment. (Refer to A 0490) 4. Food and Dietetic Services, the facility's failure to provide organized dietetic services as evidenced by findings of unsafe food handling practices and inadequate supervision of the dietary department menus that were in compliance with nationally recognized practices, effective system to ensure that physician ordered diets were followed, adequate food and water were on hand for use in an emergency and policies and procedures, spreadsheets for the distribution of food. (refer to A 0618) 5. Physical Environment, the facility failed to	A 043	**ALL THREE CAMPUSES** **1-7). Corrective Actions**: Development of a roll up report **(see Addendum 1)** reflecting operations of the three campuses to ensure oversight and monitoring of Patient Right□s, Nursing Services, Pharmaceutical Services, Food and Dietetic Services, Physical Environment, Infection Control & Surgical Services. **Date of Implementation:** First report to Governing Board will be July 1, 2014. **Monitoring Process:** All three campuses will monitor and report indicators for Patient Right□s, Nursing Services, Pharmaceutical Services, Food and Dietetic Services, Physical Environment, Infection Control & Surgical Services. This report will be a standing agenda item for the three campuses. Report will be presented to the Quality Council, the Medical Executive Committee and the Governing Board. **Person Responsible:** Data gathering will occur by the appropriate Directors and reported to ACNO of each facility with the Quality Director and Executive CNO to aggregation and analysis data for final report through the committee process.	7/1/2014

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A 043	Continued From page 2 develop and maintain the physical plant in a manner that assured the safety of well-being of patients (Refer to A 0700) 6. Infection Control, the facility failed to develop an effective system for identifying, reporting and controlling infections on all three campuses. (Refer to A 0747) 7.Surgical Services, the facility□s inability to provide safe and effective surgical services. (Refer to A 0940) The cumulative effects of these systemic failures resulted in the hospital□s governing body inability to maintain appropriate oversight to assure quality health care in safe environment.	A 043	(continued from page 2)	
A 115	482.13 PATIENT RIGHTS A hospital must protect and promote each patient□s rights. This CONDITION is not met as evidenced by: Based on observation, interview and document review, the facility failed to meet the Condition of Participation in Patient Right by failing to: 1. Ensure that 1 of 52 sampled patients (Patient 27) had the right to participate in the implementation of her care (Refer to A 130). 2. Ensure the patients were provided personal privacy while receiving care in the facility as well as patient□s personal information for 1 of 52 sample patients and 2 randomly selected patients (Patients 53 and 60). This deficient practice violated the patient□s right to personal privacy during care and to personal information (Refer to A 143).	A 115	**ALL THREE CAMPUSES:** **1).Corrective Actions:** Revision to policy PAT.001 Admission Assessment/Interdisciplinary Plan of Care to strengthen patient participation in care planning including management of patient pain levels. **Date of Implementation:** Staff in servicing beginning on June 19, 2014 with expected completion in 30 days. **Monitoring Process:** Monitoring of patient participation in their plan of care will be incorporated into the Patient Right□s/Safety Rounds for the clinical areas of the three campuses. **Person Responsible:** Data gathering will occur by the appropriate Directors and reported to the Quality Director and Executive CNO for aggregation and analysis. **2).Corrective Actions**: Monitoring clinical units for maintaining patient privacy and access to patient health information (PHI). Computer Auto-logoff function enhanced to activate at 2 mins of inactivity across all three campuses. Implemented at Culver City on 3-26-14 and at Hollywood & Van Nuys will be completed on July 1, 2014. Audits performed by IT Dept are to reflect 100% compliance with maintaining 2 min auto-log off feature. **Date of Implementation:** Culver City implementation on March 26, 2014 & will be completed on July 1, 2014 for Hollywood & Van Nuys. **Monitoring Process:** Quarterly, the Culver City Security Specialist or technician will perform a review of the user templates in the McKesson Paragon Security application**.** Using the Logon Maintenance screen, Application Time-out values will be verified that they are set to 2 minutes for all clinical personnel who access patient information in open areas that would possibly compromise the privacy of patient data. The McKesson Paragon Security application is only accessible by the Information Systems personnel. Quarterly, the Hollywood & Van Nuys Security Specialist or technician will perform a similar review of the user templates in All Scripts. **Person Responsible:** Information Systems Directors	6/19/2014 3/26/2014

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A 115	Continued From page 3 3. Ensure the patients received care in an environment that assured the safety of the well-being of the patients in the facility□s psychiatric Unit 1 and 2 by: a. Having locksets on the bathroom doors that were lockable from the inside and required an emergency key to unlock from the outside in the bathroom of Patient 45 in Unit 1 and 16 patient bathrooms in Unit 2 and placed the 34 patients residing in the 16 rooms at risk for harm/injury. b. Failing to provide a closer observation such as a 1:1 observation to Patient 45, who presented with acute suicidal ideation as per facility□s policies and procedures. Patient 45, who was identified as a suicide risk, was inside her bathroom and the door was locked. Patient 45 made two knots on both ends of a gown, placed it on top of the door sill and shut the door. Patient 45 locked the door when a staff member called out her name. The mental health worker tried to open the door, banged on the door and finally the door opened. The twisted gown and the patient slid to the floor. The patient was coughing and rubbing her neck. Patient 45 was transferred to a locked unit (Unit 2). (Refer to A 144) 4.Ensure that the staff protect each patient from any forms of abuse by ensuring the hospital staff had ongoing training program regarding abuse, neglect and related reporting requirements, including prevention, intervention, and detection. This deficient practice had the potential for not ensuring the patients are protected from all forms of abuse, neglect or harassment (Refer to A 145).	A 115	(Continued from page 3) **VAN NUYS** **3a) Corrective Actions:** All patients□bathroom locksets on both Unit 1 and Unit 2 were removed on 3/26/14 and new □pass through□door handle (non-lockable type) installed. Staff was in-serviced beginning 3/26/14 on the removal of □lockable type□door handles and replaced with the □non-lockable type □door handle on all patient bathroom doors to ensure patient safety. **Date of Implementation:** 3/26/14 **Monitoring Process:** On 4/16/14 we upgraded our visual inspection of the environment of care. We have implemented the □Licensed Staff EOC Safety Rounds□(coverage includes nurses station, contraband room, laundry room, etc.) and □Mental Health Worker EOC Safety Rounds□ (coverage includes all patients rooms and bathrooms). These rounds are done twice daily to ensure safety throughout the units. Electronic Service Requests are filled out and sent to Engineering Department for any repairs or concerns. **Person Responsible:** Director of Engineering and Director of Nursing **3b) Corrective Actions**: Revisions made to Policy BHU.053 Precautions (under □Van Nuys Facility Specific: Suicide Precaution□) to reflect the procedure (using the Suicide Potential Rating Scale) of which the Van Nuys facility had been following when assigning a level of suicide precautions during the patient□s admission process. **Date of Implementation**: 6/16/14 **Monitoring Process:** Staff will be in serviced on utilizing the □Suicide Precautions Documentation Monitoring Checklist□tool and the □Suicide Potential Rating Scale□ The checklist tool will be completed by the RN staff, given to the supervisor and/or nurse manager for monitoring when the need for a 1:1 with staff arises. This ensures that staff is utilizing both tools to take appropriate suicide precautions. **Person Responsible:** Nursing Director, Nurse Manager, and Supervisors **All Three Campuses** **4) Corrective Actions:** New hires will receive training regarding patient abuse, neglect, and reporting requirements as a part of their new hire onboarding process and at the New Hire Orientation (Initial Orientation Essentials 2014 and answer key. Existing employees at Culver City will receive the training as part of the Skills Fair which is held annually in the month of October; refer to the Culver City Skills Fair. For Hollywood and Van Nuys enhancement of the Annual Update Self-study guide, 2014 Annual update test, and Mandated abuse reporting training test. **Date of Implementation:** New hire training will begin with the next new hire orientation on Monday June 23, 2014 for Culver City. New hire training and test implemented on June 17, 2014. With Annual update sessions will commence in September, 2014 at Hollywood/Van Nuys locations. **Monitoring Process:** New hire orientation attendance is monitored through Human Resources and compliance with the Annual Skills Fair is monitored through the Education department. The Annual Skills fair will be held in October 2014. **Person Responsible:** Human Resources and Education departments.	3/26/2014 6/16/2014 6/17/2014 9/1/2014

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A 115	Continued From page 4 The cumulative effect of these systemic issues resulted in the facility□s inability to ensure and provide a safe patient care environment.	A 115		
A 130	482.13(B) (1) PATIENT RIGHTS PARTICIPATION IN CARE PLANNING The patient has the right to participate in the development and implementation of his or her plan of care. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure 1 of 52 sampled patients (Patient 27) had the right to participate in the implementation of her care. Patient 27 complained of back pain to Licensed Vocational Nurse (LVN) 2 and wanted a pain medication. According to Patient 27, LVN stated, □You have to wait. I was there to chart while you were sleeping.□Patient 27 stated LVN 2 refused to administer pain medication to her at that time of her request. This deficient practice failed to promote the right of the patient to participate in her care. Findings: During an interview with Patient 27 on March 24, 2014 at 5:20 p.m., she stated she complained of itching and back pain, pain scale was 10, (Pain scaled from 1 to 10 and 10 being the worst) to LVN 2 at 10:20 a.m. and wanted a pain medication. According to Patient 27, LVN stated, □You have to wait. I was there to chart while you were sleeping.□Patient 27 stated LVN 2 refused to administer pain medication to her at that time of her request.	A 130		

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A 130	Continued From page 5 The History and Physical report was reviewed and disclosed the patient was admitted on March 22, 2014, with left arm pain and history of end stage renal disease with hemodialysis treatment. According to the History and Physical report, the patient□s dialysis access was on her left upper arm. A review of the Physician□s Order Sheet disclosed □BenadryL 50 mg (milligram) IVP (intravenous PUSH) Q (every) 6 hour PRN (as needed) for itching□and □Dialudid 1 mg IVP Q 4 hours PRN for pain□were prescribed on March 22, 2014 at 6:30 a.m. The eMAR (electronic Medication Administration Record) was reviewed and disclosed that both Benadryl (for itching) and dialudid (for pain) were administered to Patient 27 at 11 a.m. During an interview with Staff R on March 24, 2014 at 5:45 p.m., he stated the facility would not tolerate LVN 2□s behavior for not allowing Patient 27 to participate in the implementation of her care.	A 130	(continued from page 5) **CULVER CITY** **Corrective Actions:** Policy PAT.001 Admission Assessment/Interdisciplinary Plan of Care strengthened to reflect the patient participation in their care planning. Re-Educate all nursing staff on patient□s to participate in the development and implementation of his/her pain management. Nursing staff to provide hourly rounds using the 5 □Ps□focuses on PAIN, POTTY, POSITION /PRIVACY and POSSESSIONS. All Nursing staff will complete Patient focused Sensitivity Training to include understanding of pain management. **Date of Implementation**: Policy to Medical Staff Dept. for Approval through Medicine Comm., Medical Exec Committee and Governing Board. Draft policy rolled out to staff June 18, 2014. Start education on 4/30/2014 full implementation within 30 days. **Monitoring Process:** Pt Liaison will conduct 30 random patient round observations per month to ensure 5 P□s, sensitivity, and privacy is done on each unit. Findings of the rounds will be reported to the specific nursing director for corrective action. A monthly report will be provided to the Quality Department monthly. **Person Responsible:** Nursing Leadership for each department.	4/30/2014 6/18/2014
A 143	482.13(c)(1) PATIENT RIGHTS: PERSNAL PRIVACY The patient has the right to personal privacy. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the patients were provided personal privacy while receiving care in the facility as well as patient□s personal information for 1 of 52 sample patients (Patient 22) and 2 randomly selected patients (Patients 53 and 60). This deficient practice violated the patient□s right to	A 143		

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A 143	Continued From page 6 personal privacy during care and to personal information. Findings: 1. On March 24, 2014, in the facility□s Hollywood campus, the following was observed: a. At 10 a.m., during the initial tour of the 3rd floor, a cart was left unattended. The cart contained a bottle labeled Lothalamate Meglumine Injections USPS Cysto-Conray IM II, a cardex with a patient name and date of birth, a marker, couple of alcohol pads and primary plumset. During an interview with the respiratory therapist (RT), he stated he should not have left the cart which contained medication, supplies and especially the cardex with the patient name and date of birth. He stated he left the cart and went to check on a patient prior to a procedure. b. At 11:35 a.m., during provision of care observation, Registered Nurse 9RN) 28 did not fully draw the privacy curtain when conducting a body check on the randomly selected patient (Patient 53). The patient was wearing a diaper and was exposed from the waist down. The patient was in view of staff members and people passing by and by the nurses station. During a concurrent interview, RN 28 stated the privacy curtain should have been drawn to provide the patient with privacy.	A 143	(Continued from page 6) **HOLLYWOOD** **1a). Corrective Actions**: Staff meeting and education held with Respiratory staff to include securing 02 tanks in proper and designated locations, ensure that no meds and patient identifiers are left on carts or EKG machines. **Date of Implementation:** March 25, 2014 **Monitoring Process:** Will be monitored by RT lead and RT staff daily and to be included in EOC rounds **Person Responsible:** Respiratory Department **1b). Corrective Actions**: Education provided to include Patient rights and privacy. EOC rounds on all nursing department, replaced any missing curtains and ensure appropriate size and length **Date of Implementation:** Education provided April 3-5, 2014; EOC/missing curtains replaced March 27, 2014 **Monitoring Process:** Monitoring will be managed through daily rounds and EOC rounds **Person Responsible:** Nursing leadership in each department and EOC members, ENG, EVS	3/25/2014 3/27/2014 4/3/2014

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SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	**6245 DE LONGPRE AVE** **HOLLYWOOD, CA 90028**

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A 143	Continued From page 7 c. At 2:30 p.m., during an initial tour of the Urgent Care Unit, there were five (5) patients awaiting for the disposition of their visits. Patient 22 was seen at 10:05 a.m. for pain on bilateral legs. The patient also manifested behavior such as talking out loud continuously with agitated features. During a concurrent interview, RN 29 stated the patient could have been provided a calmer and private environment at the time the patient was manifesting agitation and talking out loud to self. d. At 12:40 p.m., during an observation tour of the Medical/Surgical floor, the randomly selected patient (Patient 60) was lying in bed. The patient was exposed from the waist down, the patient was wearing a diaper, and was in full view of the facility staff members passing by the patient□s room. During a concurrent interview, RN 31, who was observed passing by patient□s room, stated she would be checking the patients for privacy issues as she was conducting her rounds. 2. In the facility□s Culver City campus, on March 25, 2014, at 9:50 a.m., during a tour of the unit, Patient 52 was observed in his room lying in bed. His hospital gown was raised up to his waist exposing his diapers, thighs and legs. RN 13 was observed seating by the hallway across from the patient□s room and working on	A 143	(Continued from page 7) **1c). Corrective Actions:** Waiting room created and triage room created in the urgent care to provide privacy and for those patients waiting for disposition and waiting to be seen. **Date of Implementation:** March 28, 2014 **Monitoring Process:** Monitoring will be managed by urgent care staff, nursing supervisor will perform hourly rounding in Urgent care **Person Responsible:** Nursing Leadership and EOC members, ENG **1d).Corrective Actions:** Education provided to include Patient rights and privacy. EOC rounds on all nursing department, replaced any missing curtains and ensure appropriate size and length. **Date of Implementation:** Education provided April 3-5, 2014; EOC/missing curtains replaced March 27, 2014 **Monitoring Process:** Monitoring will be managed through daily rounds and EOC rounds **Person Responsible:** Nursing leadership in each department, Environment of care, Engineering, & Environmental Services. **CULVER CITY** **2a) Corrective Actions**: Re-Educate all nursing staff on patient□s right to personal privacy and our responsibility to ensure patient privacy. Nursing staff will provide hourly round using the 5 □Ps□ focuses on PAIN, POTTY, POSITION /PRIVACY and POSSESSIONS. All Nursing staff will complete Patient focused Sensitivity Training and will receive a certificate upon completion. Patient Liaison will conduct daily rounds to ensure patient□s privacy rights are upheld. **Date of implementation**: Start education on 4/30/2014 full implementation on **Monitoring Process:** Pt liaison will conduct 30 patient round observations per month to ensure 5 P□s, sensitivity, and privacy is done on each unit. Findings of the rounds will be reported to the specific nursing director for corrective action. A monthly report will be reported to the Quality Department monthly. Super users are collecting data on pain scale prior and after receiving pain medication this information is also sent to the quality department monthly. **Person Responsible:** Nursing Leadership from each department **2b) Corrective Actions:** Policy PAT.025 Patient Rights and Responsibilities and Procedure strengthened to reflect the patient□s right to personal privacy. Computer Auto-logoff function enhanced to activate at 2 mins of inactivity. Implemented on 3-26-14. Audits performed by IT Dept. reflect 100% compliance with maintaining 2 min auto-log off feature. **Date of Implementation:** Revised policy to Medical Staff Dept. for Approval through Quality Council, Medicine Committee, Medical Exec Committee and Governing Board. Draft policy rolled out to staff June 18, 2014	3/28/2014 3/27/2014 4/3/2014 4/30/2014 6/18/2014

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A 143	Continued From page 8 the computer. The patient was in full view of the licensed nurse. The environmental staff and other facility staff members were observed passing by the hallway while patient lay exposed in view of them. RN 13 stood up and went to attend to a patient in another room and left the computer screen showing with a patient name, visit ID number and other information that relates to the patient. During a concurrent interview, RN 13 stated that she was not aware the patient was exposed. She further stated that she should have exited the computer screen with patient□s information before she went to another patient□s room.	A 143	(continued from page 8) **Monitoring Process**: On a quarterly basis, the Security Specialist or technician will perform a review of the user templates in the McKesson Paragon Security application. Through the Logon Maintenance screen, Application Time-out values will be verified that they are set to 2 minutes for all clinical personnel who must access patient information in open areas that would possibly compromise the privacy of patient data. The McKesson Paragon Security application is only accessible by the Information Systems personnel. **Person Responsible:** Nursing Leadership for each department; Information Systems Department Security Specialist or technician. **HOLLYWOOD** **Corrective Actions**: EMR Education/re-training provided to include utilizing □suspend□ function as manual log-off procedure. Computer Auto-logoff function will be enhanced to activate at 2 mins of inactivity, target date of completion in 30 days July 17, 2014. Re-education started June 18, 2014 will be completed June 30, 2014. **Date of Implementation**: Education provided April 16, 2014 full implementation May 6, 2014 and target date as of July 17, 2014 after upgrade; re-education started June 18, 2014 to be completed June 30, 2014 **Monitoring Process:** Audits by IT Dept. to reflect 100% compliance with maintaining 2 min auto-log off feature.	4/16/2014
A 144	482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: On March 26, 2014, at 4:20 p.m., the survey team declared an Immediate Jeopardy (IJ) situation, in the presence of the chief nursing officer, director of risk management, and administrator of facility□s Van Nuys campus, as a result of the facility□s failure: To ensure the patients received care in an environment that assured the safety of the well-being of the patient□s in the facility□s Psychiatric Unit 1 and 2. On March 26, 2014, at 6 p.m., the IJ was abated in the presence of the director of risk management and the administrator of the facility□s	A 144		

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A 144	Continued From page 9 Van Nuys campus. Based on observation, interview and record review, the facility failed to ensure the patients received care in an environment that assured the safety of the well-being of the patients in the facility□s psychiatric Unit 1 and 2 by: 1. Having locksets on the bathroom doors that were lockable from the inside and required an emergency key to unlock from the outside in the bathroom of Patient 45 in Unit 1 and 16 patient bathrooms in Unit 2 and laced the 34 patients residing in the 16 rooms at risk for harm/injury. 2. Failing to provide a closer observation such as a 1:1 observation to Patient 45, who presented with acute suicidal ideation as per facility□s policies and procedures. Patient 45, who was identified as a suicide risk, was inside her bathroom and the door was locked. Patient 45 made two knots on both ends of a gown, placed it on top of the door sill and shut the door Patient 45 locked the door when a staff member called out her name. The mental health worker tried to open to door, banged on the door and finally the door opened. The twisted gown and the patient slid to the floor. The patient was coughing and rubbing her neck. Patient 45 was transferred to a locked unit (Unit 2). Findings: 1. On March 24, 2014, at 11:20 a.m., during an initial tour of the activity room of the locked unit (Unit 2) in the facility□s psychiatric campus, Patient 45 was observed sitting in a chair and talking with another patient. During an	A 144	(Continued from page 9) **Van Nuys** **1).Corrective Actions:** All patients□bathroom locksets on both Unit 1 and Unit 2 were removed on 3/26/14 and new □pass through□door handle (non-lockable type) installed. Staff was in-serviced beginning 3/26/14 on the removal of □lockable type□door handles and replaced with the □non-lockable type □door handle on all patient bathroom doors to ensure patient safety. **Date of Implementation:** 3/26/14 **Monitoring Process:** Since 4/16/14 we upgraded our visual inspection of the environment of care. We have implemented the □Licensed Staff EOC Safety Rounds□(coverage includes nurses station, contraband room, laundry room, etc.) and □Mental Health Worker EOC Safety Rounds□(coverage includes all patients rooms and bathrooms). These rounds are done twice daily to ensure safety throughout the units. Electronic Service Requests are filled out and sent to Engineering Department for any repairs or concerns. **Person Responsible:** Director of Engineering and Director of Nursing **2).Corrective Actions:** Policy PAT.025 Patient Rights and Responsibilities and Procedure strengthened to reflect the patient□s right to receive care in a safe setting. Revision made to Policy BHU.053 Precautions (under □Van Nuys Facility Specific: Suicide Precaution□) to reflect the procedure (using the Suicide Potential Rating Scale) of which the Van Nuys facility will follow when assigning a level of suicide precautions during the patient□s admission process. **Date of Implementation**: 6/16/14 **Monitoring Process:** Staff will be in serviced on utilizing the □Suicide Precautions Documentation Monitoring Checklist□tool and the □Suicide Potential Rating Scale□The checklist tool will be completed by the RN staff, given to the supervisor and/or nurse manager for monitoring when the need for a 1:1 with staff arises. This ensures that staff is utilizing both tools to take appropriate suicide precautions. **Person Responsible:** Nursing Director, Nurse Manager, and Supervisors	3/26/2014 6/16/2014

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A 144	Continued From page 10 interview at the same time of the observation, Mental Health Worker (MHW) 1 stated Patient 45 was on a 1:1 (observed by one staff member at all times) observation because the patient had attempted to hang herself on Friday (March 21, 2014). On March 24, 2014, Patient 45□s medical record was reviewed. The Admission Psych Note Nursing dated March 20, 2014, at 4:52 p.m., disclosed Patient 45 was admitted from an acute care hospital via ambulance, on a voluntary status, and her chief complaint was depression with suicidal ideations and plan to overdose. Patient 45□s mental status included uncooperative, guarded, eye contact was inconsistent, hopeless/helpless, depressed, anxious, irritable, and with a flat affect. The Interdisciplinary Patient Progress Record dated March 21, 2014, at 5 a.m., disclosed □Patient appeared to sleep well through the night. Patient had no signs of distress. Continue to monitor for safety.□ The interdisciplinary Patient Progress Record dated March 21, 2014, at 11:05 a.m., disclosed □Patient had very poor visibility in the milieu.□Patient 45□s mood was blunt (failure of a person to display emotion affect) and depressed. Patient 45 ate breakfast then went to her room to sleep. Patient 45 refused group therapy despite the prompts, non-social with peers, guarded, and suspicious on approach. The interdisciplinary Patient Progress Record dated March 21, 2014, at 6 p.m., disclosed Patient 45 was noted with episodes of crying and anxious. Patient 45 required prompting with her	A 144		

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A 144	Continued From page 11 medications and to attend group therapy. Her appearance was unkempt and disheveled. Patient 45 had poor grooming. The staff indicated □will continue to monitor for safety.□ A review of the facility□s report disclosed an incident occurred on March 21, 2014, at 8:15 p.m., in Unit 1 (open unit) in Patient 45□s bathroom. MHW 2 was conducting visual inspection of Patient 45□s room and Patient 45 was not in the room. Patient 45 was in the bathroom and the door was locked. MHW 2 observed part of Patient 45□s gown was hanging at the top of the door. As MHW 2 approached the bathroom door, he called out Patient 45□s name. The door was completely locked and he (MHW 2) was unable to open the door. MHW 2 heard a loud thump sound coming from the bathroom and heard gurgling sounds coming from Patient 45. MHW 2 yelled, □Code Blue, Nurse□as he banged on the bathroom door. The bathroom door opened and Patient 45 □landed on the floor.□A nurse came in the room and assessed Patient 45. The Interdisciplinary Patient Progress Record documented by the Registered Nurse (RN) dated March 21, 2014, at 8:10 p.m., disclosed Patient 45 was inside her bathroom and the door was locked. Patient 45 made two (2) knots on both ends of a gown, placed it on top of the door sill and shut the door. As the MHW attempted to call her name, Patient 45 locked the door. Patient 45 made a loud thump sound and began making choking sounds. Code Blue (life threatening medical emergency) was called. The MHW continued to try to open the door, banged on the door and finally the door opened. The twisted gown and the patient slid to the floor. Patient 45	A 144		

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A 144	Continued From page 12 was coughing and rubbing her neck. Patient 45 was awake and responding that she was able to breathe. The physician was notified and Patient 45 was transferred to Unit 2 (locked unit). On March 24, 2014, at 12:25 p.m., during an interview with Staff H (assistant chief nursing officer), he stated Patient 45 was placed on 1:1 observation for safety and the action plan for the incident was pending. Staff H stated there were no changes to the lock of the bathroom door of Patient 45. An interview with Staff H and Staff M (maintenance supervisor) was conducted on March 25, 2014, between the hours of 8:45 a.m. and 11:20 a.m. When asked about how to prevent this incident from occurring, Staff H stated there was no action plan yet until the quality/risk department reviews the incident. At 11:20 a.m., Staff M stated he was aware of Patient 45□s incident. Staff M stated that there was a □pin□key at the nurses□station to unlock the patients□bathrooms. Staff M stated that after the renovation in this unit, there was no written policy regarding the use of pin key to the patients□bathrooms. Staff M further stated the nurses were aware and should have communicated to each other. Staff M stated, □I told the use of the pin key to one nurse and I assumed she would pass it on to other nurses.□ On March 25, 2014, between the hour or 8:45 a.m. and 9 a.m., an observation of Room 108□s bathroom door revealed a lockset on the bathroom door that was lockable from the inside. During a concurrent interview, RN 8 stated the □pin□key was kept in the Medication Room and at the nurses□station. When asked to show the □pin□	A 144		

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A 144	Continued From page 13 key, RN 8 did not present the key to the surveyor. On March 25, 2014, between the hours of 8:30 a.m. and 11:00 a.m., the patient room bathrooms in Unit 2 (locked unit), including those in Rooms 203, 205, 207, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 222, 226, had locksets on the bathroom doors that were lockable from the inside and required an emergency key to unlock them from the outside. On March 25, 2014, between the hour 10:15 a.m. and 11:00 a.m., during interviews of two RN at Unit 2 nurses station, RN 23 stated we don□t have the pin (emergency key) and RN 24 stated, □I don□t know where the pin is.□ A review of the facility□s census list for March 24, 2014 for Unit 2 (locked unit) disclosed there were 34 patients residing in the sixteen (16) patient rooms of Unit 2 (Rooms 203, 205, 207, 209, 210, 211, 212, 213, 214, 215, 217, 218, 219, 220, 222 and 226). Each patient room had a bathroom. The census lists indicated that for the census on March 24, 2014, there were 20 patients in Unit 1 and 35 patients in Unit 2. For the census on March 25, 2014, there were 16 patients in Unit 1 and 33 patients in Unit 2. For the census on March 26, 2014, there were 21 patients in Unit 1 and 35 patients in Unit 2. On March 26, 2014, at 4:20 p.m., the survey team declared an Immediate Jeopardy situation, in the	A 144		

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A 144	Continued From page 14 presence of the chief nursing officer director of risk management, and administrator of facility□s Van Nuys campus, as a result of the facility□s failure to ensure the patients received care in an environment that assured the safety of the well-being of the patients in the facility□s psychiatric campus by not having locksets on the bathroom doors that were lockable form the inside and required an emergency key to unlock from the outside. On March 26, 2014 at 5:35 p.m., the administrator provided photographs of room 108□s bathroom with the lock removed. On March 26, 2014, at 6 p.m., the IJ was abated in the presence of the director of risk management and the administrator of Van Nuys campus. A review of the facility□s letter to the Immediate Jeopardy, dated March 26, 2014, disclosed one (1) patient bathroom on Unit 1 (room 108) and sixteen (16) patient bathrooms on Unit 2 (locked unit), in which the door, when locked from the inside, could not easily be opened from the outside without a special key. The staff did not have access to the key and that they had to contact maintenance to open the door. The facility□s letter indicated the corrective actions included removing the door locks from 16 patient bathrooms on Unit 2 (locked unit). The staff would be inserviced on the short term plan beginning the evening of March 26 2014. On March 27, 2014, at 10:15 a.m., during a tour of the facility at the Van Nuys campus with the hospital administrator and the vice president of	A 144		

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A 144	Continued From page 15 pharmacy operations ,the surveyors observed that all bathroom door locks in the patient rooms of Unit 1 and 2 have been removed. The hospital administrator started new locks were ordered. 2. On March 24, 2014, Patient 45□s medical record was reviewed. The Admission Psych Note Nursing dated March 20, 2014, at 4:52 p.m., disclosed Patient 45 was admitted from an acute care hospital via ambulance, on a voluntary status, and her chief complaint was depression with suicidal ideations and plan to overdose. Patient 45□s mental status included uncooperative, guarded, eye contact was inconsistent, hopeless/helpless, depressed, anxious, irritable, and with a flat affect. The Interdisciplinary Patient Progress Record dated March 21, 2014, at 5 a.m., disclosed □Patient appeared to sleep well through the night. Patient had no signs of distress. Continue to monitor for safety.□ The Interdisciplinary Patient Progress Record dated March 21, 2014, at 11:05 a.m., disclosed □Patient had very poor visibility in the milieu□ Patient 45□s mood was blunt (failure of a person to display emotion affect) and depressed. Patient 45 ate breakfast then went to her room to sleep. Patient 45 refused group therapy despite the prompts, non-social with peers, guarded, and suspicious on approach. The Interdisciplinary Patient Progress Record dated March 21, 2014, at 6 p.m., indicated Patient 45 was noted with episodes of crying and anxious. Patient 45 required prompting with her	A 144		

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A 144	Continued From page 16 medications and to attend group therapy. Her appearance was unkempt and disheveled. Patient 45 had poor grooming. The staff indicated □will continue to monitor for safety.□ A review of the facility□s report disclosed an incident occurred on March 21, 2014, at 8:15 p.m., in Unit 1 (open unit) in Patient 45□s bathroom. MHW 2 was conducting visual inspection of Patient 45□s room and Patient 45 was not in the room. Patient 45 was in the bathroom and the door was locked. MHW 2 observed part of Patient 45□s gown was hanging at the top of the door. As MHW 2 approached the bathroom door, he called out Patient 45□s name. The door was completely locked and he (MHW 2) was unable to open the door. MHW 2 heard a loud thump sound coming from the bathroom and heard gurgling sounds coming from Patient 45. MHW 2 yelled, □Code Blue, Nurse□as he banged on the bathroom door. The bathroom door opened and Patient 45 □landed on the floor.□A nurse came in the room and assessed Patient 45. The Interdisciplinary Patient Progress Record documented by the Registered Nurse (RN) dated March 21, 2014, at 8:10 p.m., disclosed Patient 45 was inside her bathroom and the door was locked. Patient 45 made two (2) knots on both ends of a gown, placed it on top of the door sill and shut the door. As the MHW attempted to call her name, Patient 45 locked the door. Patient 45 made a loud thump sound and began making choking sounds. Code Blue (life threatening medical emergency) was called. The MHW continued to try to open the door, banged on the door and finally the door opened. The twisted gown and the patient slid to the floor.	A 144		

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A 144	Continued From page 17 Patient 45 was coughing and rubbing her neck. Patient 45 was awake and responding that she was able to breathe. The physician was notified and Patient 45 was transferred to Unit 2. According to the Admission Psych Note Nursing dated March 20, 2014, at 4:52 p.m., Patient 45 was screened for suicide risk. Patient 45□s suicide total score was 13. The Risk Screen section of the Admission Psych Note dated March 20, 2014, indicated the score from 10 to 19 is under □Suicide Precaution 1□which indicated the patient required every 15 minutes monitoring. A review of the Patient Close Observation Status dated March 21, 2014 from 12 a.m. to 11:45 a.m. to 8:15 p.m., revealed the staff conducted a visual inspection to Patient 45 every 15 minutes, instead of a 1 to 1 observation. Additionally, the Admission Psych Note Nursing dated March 20, 2014, at 4:52 p.m., indicated Patient 45 had recent (acute) previous attempts of suicide ideation within the past 36 hours, prior to admission. According to the facility□s policy and procedure titled, □Admission Criteria,□dated November 2012, under General Admission Procedures Section 4.2.57. disclosed any patient that presented with acute suicidal ideation and required a 1:1 based on the suicide potential rating scale, shall be admitted to a unit with a staff member present as 1:1 observation. A review of the facility□s policy and procedure titled, □Precautions□dated November 2012, stipulated the purpose of the policy was to assure heightened awareness of special identified	A 144		

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A 144	Continued From page 18 circumstances that could impact patient safety. The objectives of the policy included to assess each patient for suicide potential and to provide monitoring accordingly to the level of determined suicide risk. The procedure for Suicide Precaution (SP) 4.2.14 disclosed the patients who scored at an intermediate risk for Suicide Precaution with a score of 10 to 19 shall have closer observations initiated. The precaution will be noted as □Suicide Precaution 1.□ An email communication from Staff B (corporate vice president/quality risk management) dated April 9, 2014, at 4:22 p.m., disclosed closer observations meant that the patient would have 1 to 1 observation.	A 144		
A 145	482.13(c)(3) PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT The patient has the right to be free from all forms of abuse or harassment. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that the staff protect each patient from any forms of abuse by ensuring the hospital staff had ongoing training regarding abuse, neglect and related reporting requirements, including prevention, intervention, and detection. This deficient practice had the potential for not ensuring the patients are protected from all forms of abuse, neglect or harassment. Findings: On March 24, 2014, at 11:02 a.m., a review of the employee files indicated that 2 of 5 files did not	A 145	**ALL THREE CAMPUSES** **Corrective Actions:** New hires will receive training regarding patient abuse, neglect, and reporting requirements as a part of their new hire onboarding process and at the New Hire Orientation (Initial Orientation Essentials 2014 and answer key. Existing employees at Culver City will receive the training as part of the Skills Fair which is held annually in the month of October; refer to the Culver City Skills Fair.For Hollywood and Van Nuys enhancement of the Annual Update Self-study guide, 2014 Annual update test, and Mandated abuse reporting training test**.** **Date of Implementation**: New hire training will begin with the next new hire orientation on Monday June 23, 2014 for Culver City. New hire training and test implemented on June 17, 2014. Annual update sessions will commence in September, 2014 at Hollywood/Van Nuys locations. **Monitoring Process:** New hire orientation attendance is monitored through Human Resources and compliance with the Annual Skills Fair is monitored through the Education department. The Annual Skills fair will be held in October 2014. **Person Responsible:** Human Resources and Education departments.	6/17/2014

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A 145	Continued From page 19 have documentation that the employees received ongoing abuse training. During an interview with Human Resources Staff 1, she stated the employees had abuse training during their initial orientation. She further stated there was no ongoing training after orientation which provided all employees with information regarding abuse prevention. In addition, the employee files indicated some employees were hired in 2003 and 2008 and there was no ongoing training for abuse and neglect, and related reporting requirements. An email communication dated April 9, 2014, at 4:22 p.m., from Staff B (corporate vice president/quality risk management) provided two (2) POLICIES AND PROCEDURES ON Domestic Violence Assessment and Reporting dated April 2007 and Social Services dated November 2012. However, there was no documented evidence that addressed staff training on abuse prevention on an ongoing basis.	A 145	(Continued from page 19)	
A 385	482.23 NURSING SERVICES The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by: Based on observation, interview and document review, the facility failed to meet the Condition of Participation in Nursing Services by failing to: 1. Having a monitor technician to provide continuous electrocardiographic (ECG) monitoring for 10 patients that required ECG telemetry monitoring (continuous monitoring of a	A 385	**Culver City** **1).Corrective Actions:** Effective immediately (6-12-14) ICU, CCU & SDU are consistently staffed with a Monitor Tech 24 hours a day/7 days a week for all units with cardiac monitors or Telemetry systems. The Monitor Tech for each unit is reflected on the Staffing Assignment record for each shift **.**The Staffing Matrix guiding staffing levels has been adjusted to ensure monitor tech for ICU, CCU & SDU for each shift. **Date of Implementation:** June 12, 2014 **Monitoring Process:** Daily review of staffing to ensure Monitor Tech for each functioning ICU & CCU each shift. **Person Responsible:** Nursing Director of Critical Care Units & House Supervisors.	6/12/2014

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A 385	Continued From page 20 patient□s heart rate and rhythm at a remote location) in the Critical Care Unit (CCU) and Surgical Intensive Care Unit (ICU). This deficient practice had the potential for not detecting abnormal heart rhythm timely which could result to life threatening heart condition that required immediate intervention (Refer to A 392). 2. Provide non-pharmacological interventions for managing Patient 22□s pain (Refer to A 395). This deficient practice had the potential for not meeting the physical and mental needs of the patient. 3. Ensure Patient 24□s bedside did not have medications and supplies for a wound treatment. This deficient practice had the potential for administering the cleanser and supplies for the treatment of Patient 24□s wound which may not be concordance with the physician□s order (Refer to A 395). 4. Document the wound type, size, and depth during the initial assessment and reassessment, failing to reassess the wounds on March 16 and 23, 2014, and failing to provide treatments as ordered by the physician on Patient 14□s left food pressure ulcer from March 7 to March 20, 2014 (a total of 11 days). This deficient practice had the potential to result in delay of the healing of the pressure ulcer (Refer to A 395). 4. Provide oral care to Patient 16 who was dependent on staff in his activities of daily living and was observed with dry lips and mouth odor. This deficient practice did not maintain the patient□s oral hygiene and had the potential to result in undetected problems in the patient□s oral	A 385	(Continued from page 20) **2).Corrective Actions**: Re-Educate all nursing staff on patient□s right to personal privacy and our responsibility to ensure patient privacy. Nursing staff will provide hourly round using the 5 □Ps□ focuses on PAIN, POTTY, POSSISON /PRIVACY and POSSESSIONS. All Nursing staff will complete Patient focused Sensitivity including non-R□ comfort measures Patient Liaison will conduct daily rounds to ensure patient□s privacy rights are upheld. **Date of implementation:** Start education on 4/30/2014 with full implementation within 30 days. **Monitoring Process:** Patient liaison will conduct 30 patient round observations per month to ensure 5 P□s, sensitivity, and privacy is done on each unit. Findings of the rounds will be reported to the specific nursing director for corrective action. A monthly report will be reported to the Quality Department monthly. Super users are collecting data on pain scale prior and after receiving pain medication this information is also sent to the quality department monthly **Person Responsible**: Nursing Leadership from each department **3).Corrective Actions:** (Patient □24) Re-education of nursing staff related to proper securing and storage of medications utilizing self-study module & policy □Mediation Storage PHA.045. **Date of Implementation:** 06/13/2014 **Monitoring Process**: Education will be monitored by certification upon completion of online self-study module. Wound Management Team Member to perform thirty Patient room audits, per month including location and securing of medications and products each month. Any issue of non-adherence will be addressed to the individual staff and referred to Quality department for further intervention as necessary including education and progressive disciplinary action. **Person Responsible:** Wound Management Team. **4).Corrective Actions:** Re-education of nursing staff related to wound characteristics as shown in wound photographs; to include size (LxWxD), shape, drainage, color, odor. (See Wound Record Attachment and Policy revision WOU.001. Educate nursing staff with regard to documentation of wound care treatment in McKesson under □integumentary tab.□ **Date of Implementation:** 6/13/2014 **Monitoring Process**: Wound Management Team Member to audit photo documentation on 30 wound record during patient rounds.Any issue of non-adherence will be addressed to the individual staff and referred to Quality department for further intervention as necessary including education and progressive disciplinary action. In addition, Wound Management Team Member to perform thirty audits, per month including documentation of treatments. **Person Responsible:** Wound Management Team. **4a). Corrective Actions:** Re - Educate all Registered nurses on supervising and evaluating the care for each patient. Nursing staff will provide hourly rounds using the 5 □Ps□focuses on PAIN, POTTY, POSITION /PRIVACY and POSSESSIONS. All Nursing staff will complete Patient focused Sensitivity Training including the importance of patient hygiene. **Date of implementation:** start education on 6/16/2014 full implementation within 30 days. **Monitoring Process:** On-line self-study module: Certification upon completion. . **Person Responsible**: Nursing Leadership from each department	4/30/2014 6/13/2014 6/13/2014 6/16/2014

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A 385	Continued From page 21 cavity. (Refer to A 395). 5. Ensure Patient 17 admitted to the psychiatric unit as ordered by the physician when there was bed available in accordance with the facility□s census report for the psychiatric unit. This deficient practice had the potential for not meeting the psycho-social needs of the patient (Refer to A 395). 6. Ensure Patient 18 was administered Lisinopril medication (treat elevated blood pressure) as ordered by the physician. This deficient practice failed to ensure the physician□s order for Lisinopril medication was implemented for Patient 18 (Refer to A 395). 7. Ensure Patient 15 was administered Risperdal medication (psychoactive medication) as ordered by the physician. This deficient practice did not ensure the physician□s order for Risperdal medication was implemented for Patient 18 and had the potential for not meeting the psycho-social needs of the patient (Refer to A 395). 8. Evaluate Patient 45 after she had attempted to hang herself in the bathroom. This deficient practice had the potential for not identifying any physical condition related to her attempt to hang herself which may required interventions (Refer to A 395). 9. Ensure the nursing staff developed and kept current a nursing care plan for 8 of 52 sample patients (Patient 14, 25, 26, 29, 31, 32, 45 and 46). This deficient practice had the potential for not providing appropriate interventions to meet the needs of each patient (Refer to A 396).	A 385	(Continued from page 21) **5).Corrective Actions**: Policy Scope of Service- Emergency Department/urgent care □SOS.013 When it is anticipated that psychiatric patients will wait greater than 23 hours for a bed placement, calls are made to psychiatric facilities in other areas to determine if an appropriate bed is available and an evaluation shall be done for possible transfer and placement**.** Total census for BHU was 70 on March 23 & 24. On March 25, 2014, beds 624A & 624B were out of service because of plumbing concerns resulting in the flooding of the room. Bed 603A & 603B were also out of service due to bed bug infestation. All 4 beds were not in service House supervisors will monitor and track bed availability to decrease ER wait times. During the time bed placement is pending, patients are monitored under close observation. ER Staff will follow BHU.006 Close Observation Policy**.** **Date of Implementation:** 4/30/2014 **Monitoring Process:** House Supervisors monitor bed availability throughout the day utilizing the bed tracker system. At 6am, 3pm, 6pm, & 9pm, the house supervisor records the hospital census on the Supervisor ANS report**.** **Person Responsible:** House Supervisor /Nursing leadership **CULVER CITY** **6&7). Corrective Actions**: All nursing staff re-educated with self-study module to validate that physician orders have been noted, examined, and verified. Caregivers must use SBAR and provide the opportunity to use read-back techniques and medications orders received must be read back by the receiver. 24 hour order/chart check policy & procedure PAT.059 implemented that mandates documentation of chart review before 7am each day. **Date of Implementation:** 5/18/2014 **Monitoring Process**: Random audit of 30 charts will be done per nursing unit aggregated data will be sent to the Quality Dept., non-compliance will result in progressive discipline actions. **Person Responsible**: Nursing Leadership **8) Corrective Actions:** Re-educate all Registered Nurses on the importance of Head to Toe Assessment immediately after any patient placed on 1:1 with staff. In-service staff and provide the □Suicide Precaution Documentation Monitoring Checklist□tool which includes a □head to toe assessment□section for check off. **Date of Implementation:** 6/16/14 **Monitoring Process:** Director of Nursing and/or designee will conduct monitoring activity on the checklist tool submitted by staff the same day the incident occurs to ensure that the requirements and documentation monitoring tool has been completed to include the (head to toe)physical assessment. **Person Responsible:** Nursing Director, Nurse Manager, and Supervisors **9) Corrective Actions:** Re-educate/in-service the night shift staff on the existing □Nightly Chart Audit□ This audit includes a check off section for □Nursing Care Plan/Pain. Re-educate the supervisors who perform the already existing audit □Pain Management Audit Monitoring Tool□ Re-educate supervisors to complete the treatment plan for pain as needed while auditing. Policy PAT.001 Admission Assessment/Interdisciplinary Plan of Care strengthened the development of care plans and maintaining current nursing care plan for each patient. Enhancement/ development of electronic care plans for pressure ulcers, contact isolation, suicidal risk, hemodialysis treatments, seizure disorders and chronic pain. **Date of Implementation:** 6/16/14 **Monitoring Process:** The Nursing Director and/or designee will implement monitoring by auditing of pain medication orders every (24) hours. Auditing will begin with (10) random charts per day with target compliance set at 100%. Super Users will assist by auditing a minimum of 30 charts a month and report findings to quality department. **Person Responsible:** Nursing Director	4/30/2014 5/18/2014 6/16/2014 6/16/2014

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A 385	Continued From page 22 10. Ensure the patient would only receive medications or supplement that were prescribed by the physician for 1 of 52 sample patients (Patient 7). This deficient practice resulted in Patient 7 receiving a dietary supplement that was not ordered by the physician (Refer to A 405). The cumulative effect of these systemic issues resulted in the facility□s inability to ensure and provide a safe patient care environment.	A 385	(Continued from page 22) **10).Corrective Actions:** Development of PAT.059 24 hour Order/Chart Check policy to ensure patient records are consistently reviewed to validate orders and ensure they are carried out as well as to identify any discrepancies or inaccuracies between orders and actual patient care. Will also ensure documentation has occurred for any medications, treatments, or tests not performed and the explanation as to why. **Date of Implementation:** June 23, 2013 **Monitoring Process:** Monitoring of compliance with random review of 30 patient medical records a month for clinical areas with reporting to the Quality Council. **Person Responsible:** Nursing Director	6/23/2014
A 392	482.23(b) STAFFING AND DELIVERY OF CARE The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to have a monitor technician to provide continuous electrocardiographic (ECG) monitoring for 10 patients that required ECG telemetry monitoring (continuous monitoring of a patient□s heart rate and rhythm at a remote location) in the Critical Care Unit (CCU) and Surgical Intensive Care Unit (SICU). This deficient practice had the potential for not detecting abnormal heart rhythm timely which could result to life threatening heart condition that required immediate intervention. Findings:	A 392	**CULVER CITY** **Corrective Actions:** Effective immediately (6-12-14) ICU, CCU & SDU are consistently staffed with a Monitor Tech 24 hours a day/7 days a week for all units with cardiac monitors or Telemetry systems. The Monitor Tech for each unit is reflected on the Staffing Assignment record for each shift. The Staffing Matrix guiding staffing levels has been adjusted to ensure monitor tech for ICU, CCU & SDU for each shift **Date of Implementation:** 6-12-2014 **Monitoring Process:** Daily review of staffing to ensure Monitor Tech for each functioning ICU & CCU each shift. **Person Responsible:** Nursing Director of Critical Care Units & House Supervisors.	6/12/2014

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A 392	Continued From page 23 During the tour in the SICU of the facility□s Culver City campus on March 26, 2014, between 10 a.m. and 10;25 a.m., Registered Nurse (RN) 4 sat in front of the central EKG monitor station. During the concurrent interview, RN 4 stated she monitors the central EKG and there was no technician to monitor the central EKG at the station. According to RN 4, she and other ICU staff had to take turns to monitor the central EKG in the SICU. During the tour in the CCU on March 26, 2014, between 10:25 a.m. and 11:30 a.m., RN 4 sat in front of the central EKG monitor. During the concurrent interview, RN 4 stated there was no technician to monitor the central EKG at the station. According to RN 4, she and other ICU staff had to take turns to monitor the central EKG in the CCU. According to Staff G (assistant chief nursing officer), RN 4 was assigned to be the EKG Technician. However, according to RN 4, she had to relieve the ten (10) staff from the SICU, CCU, and SDU (Step-Down Unit) for their lunch breaks. The SICU Patient Assignment on March 26, 2014, for the day shift (7 a.m. to 7 p.m.) disclosed RN 4 was assigned as the charge nurse. There were 3 SICU nurses to take care of 5 patients. A review of the CCU Patient Assignment on March 26, 2014, for the day shift (7 a.m. to 7 p.m.) disclosed RN 4 was assigned as the charge nurse. There were 3 CCU nurses to take care of 5 patients. The SDU Patient Assignment on March 26, 2014, for the day shift (7 a.m. to 7 p.m.) disclosed RN 4 was assigned as the charge nurse. There were 2	A 392		

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A 392	Continued From page 24 SDU nurses to take care of 6 patients. There was no documentation in the assignment sheets that an EKG technician was assigned to monitor the central EKG station for the patients in the SICU, CCU and SDU.	A 392		
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on record review, observation and interview, the facility failed to supervise and evaluate the nursing care for 8 of 52 sampled patients (Patients 14, 15, 16, 17, 18, 22, 24 and 45) by failing to: 1. Provide non-pharmacological interventions for managing Patient 22□s pain (Refer to A 395). This deficient practice had the potential for not meeting the physical and mental needs of the patient. 2. Ensure Patient 24□s bedside did not have cleanser and supplies for a wound treatment left unattended. This deficient practice had the potential for administering the cleanser and supplies for the treatment of Patient 24□s wound which may not be inaccordance with the physician□s order. 3. Document the wound type, size, and depth during the initial assessment and reassessment. Failing to reassess the wound on March 16 and 23, 2014, and failing to provide treatments as ordered by the physician on Patient 14□s left foot pressure ulcer (localized injuries to the skin	A 395	**HOLLYWOOD** **1). Corrective Actions**: Review Scope of Practice to clearly delineate expected standards for nursing care Education/in-service provided to include patient rights, general care guidelines, general assessment, reassessment and intervention, patient evaluation, care plans, accurate and complete documentation. Re-education started June 18, 2014 will be completed June 30, 2014 **Date of Implementation:** April 19, 22, 2014; re-education June 18, 2014 to be completed June 30, 2014 **Monitoring Process:** Monitoring will be managed through Nursing rounds and monthly audits; data will be reported to PI, Quality Council and MEC **Person Responsible:** Nursing leadership on each department and senior leadership **2). Corrective Actions:** April 21-23, 2014 education/in-service provided to include general care guidelines, review of policy PHA.052 Preparing and Administration of Medications, and any unlabeled medication must not be used. Pharmacy will label all medications. **Date of Implementation:** May 1, 2014 **Monitoring Process:** Monitoring will be managed through nursing rounds and pharmacy rounds **Person Responsible:** Nursing leadership in each department and pharmacy **Culver City** **3) Corrective Actions:** Re-education of nursing staff related to wound characteristics as shown in wound photographs; to include size (LxWxD), shape, drainage, color, odor. (See Wound Record Attachment and Policy revision WOU.001). Re- educate nursing staff with regard to documentation of wound care treatment in McKesson under □integumentary tab.□ **Date of Implementation:** 6/13/2014 **Monitoring Process:** Wound Management Team Member to audit photo documentation on 30 wound record during patient rounds. Any issue of non-adherence will be addressed to the individual staff and referred to Quality department for further intervention as necessary including education and progressive disciplinary action. In addition, Wound Management Team Member to perform thirty audits, per month including documentation of treatments. **Person Responsible:** Wound Management Team.	4/19/2014 5/1/2014 6/13/2014

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	050135	A. BUILDING **01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD** B. WING _____	**04/01/2014**

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A 395	Continued From page 25 and/or underlying tissue that usually occur over a bony prominence as a result of pressure, or pressure in combination) from March 7 to March 20, 2014 (a total of 11 days). This deficient practice had the potential to result in delay of the healing of the pressure ulcer (Refer to A 395). 4. Provide oral care to Patient 16 who was dependent on staff in his activities of daily living and was observed with dry lips and having mouth odor This deficient practice resulted in poor oral care for Patient 16. (Refer to A 395). 5. Ensure Patient 17 admitted to the psychiatric unit as ordered by the physician when there was bed available in accordance with the facility□s census report for the psychiatric unit. This deficient practice had the potential for not meeting the safety of the patient and others (Refer to A 395). 6. Ensure Patient 18 was administered Lisinopril medication (treat elevated blood pressure) as ordered by the physician. This deficient practice had the potential to result in an elevated blood pressure for Patient 18. (Refer to 395). 7. Ensure Patient 15 was administered Risperdal medication (psychoactive medication) as ordered by the physician. This deficient practice did not ensure the physician□s order for Risperdal medication was implemented for Patient 18 and had the potential for not meeting the psycho-social needs of the patient (Refer to A 395). 8. Evaluate Patient 45 after she had attempted to hang herself in the bathroom. This deficient	A 395	(Continued from page 25) **4) Corrective Actions:** Re - Educate all Registered nurses on supervising and evaluating the care for each patient. Nursing staff will provide hourly rounds using the 5 □Ps□focuses on PAIN, POTTY, POSITION /PRIVACY and POSSESSIONS. All Nursing staff will complete Patient focused Sensitivity Training including the importance of patient hygiene. **Date of implementation:** start re-education on 6/16/2014 full implementation within 30 days. **Monitoring Process:** Patient liaison will conduct 30 patient round observations per month to ensure 5 P□s, sensitivity, and privacy is done on each unit. Findings of the rounds will be reported to the specific nursing director for corrective action. A monthly report will be reported to the Quality Department monthly. Super users are collecting data on pain scale prior and after receiving pain medication this information is also sent to the quality department monthly. **Person Responsible:** Nursing Leadership from each department **5) Corrective Actions**: Policy Scope of Service- Emergency Department/urgent care □SOS.013 When it is anticipated that psychiatric patients will wait greater than 23 hours for a bed placement, calls shall be made to psychiatric facilities in other areas to determine if an appropriate bed is available and an evaluation shall be done for possible transfer and placement . Total census for BHU was 70 there was no bed availability for March 23, 24,of 2014. On March 25, the BHU had to take 4 beds out of service, beds A and B from 624 due to sink overflowing and flooding room and 603A and 603B closed due to bed bug infestation For care safety and welfare of our patients the beds could not be used until the bed bug situation Addendum could be ratified o improve transparency of bed availability the house supervisors have use of electronic bed tracking system that allows for transparency of bed availability and bed status: occupied □dirty-clean House supervisors will monitor and track bed availability to decrease ER wait times. During the time bed placement is pending patients are monitored under close observation. Staff will follow BHU .006 Close Observation Policy **Date of Implementation**: 4/30/2014 **Monitoring Process**: House Supervisors monitor bed availability throughout the day by bed tracker. At 6am 3pm 6pm 9pm the house supervisors record the hospital census **Person Responsible:** House Supervisor /Nursing leadership **6) Corrective Actions:** The pharmacy program will add standardized blood pressure parameters of when to hold a blood pressure medication. These will appear on the E-MAR for every blood pressure medication. **Date of Implementation:** 7/1/2014 **Monitoring Process**: N/A **Person Responsible**: VP of Pharmacy Operations or designee **7) Corrective Actions:** Re-educate/in-service the night shift staff on the existing □Nightly Chart Audit□ **Date of Implementation:** 6/16/14 **Monitoring Process:** The Nursing Director and/or designee will implement monitoring by auditing of medication orders every (24) hours. Auditing will begin with (10) random charts per day with target compliance set at 100%. Report findings to Quality Department on a quarterly basis. **Person Responsible:** Nursing Director **VAN NUYS** **8) Corrective Actions:** Re-educate all Registered Nurses on the importance of Head to Toe Assessment immediately after any patient placed on 1:1 with staff. In-service staff and provide the □Suicide Precaution Documentation Monitoring Checklist□tool which includes a □head to toe assessment□section for check off. **Date of Implementation:** 6/16/14	6/16/2014 4/30/2014 7/1/2014 6/16/2014 6/16/2014

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A 395	Continued From page 26 practice had the potential of not identifying any physical condition related to her attempt to hand herself, which may required interventions (Refer to A 395). Findings: 1. In the facility□s Hollywood campus, a review of the open medical record of Patient 22 indicated the patient was admitted to the facility□s urgent care on March 24, 2014, at 9:27 a.m., for complaint of pain in bilateral legs and verbalizing of suicidal ideation□s with a plan to run into traffic. At 9:50 a.m., the medical record documented Patient 22 was assessed for pain with a pain level of 9 and 10 being the worst. A review of the facility□s Urgent Care Physician Report Order, dated March 24, 2014, indicated there was no order for pain medication. There was also no documentation the licensed nurse had provided non-pharmacological interventions for managing the patient□s pain. During a concurrent interview, Staff E reviewed the clinical record and stated there was no documentation of an order for pain medication and that the staff provided nay non-pharmacological interventions for managing the patient□s pain. 2. On March 24, 2014, at 11 a.m., during the tour, an observation in Patient 24□s room, Hollywood campus, there was a plastic container with two	A 395	(Continued from page 26) **Monitoring Process:** Director of Nursing and/or designee will conduct monitoring activity on the checklist tool submitted by staff the same day the incident occurs to ensure that the requirements and documentation monitoring tool has been completed to include the (head to toe)physical assessment. **Person Responsible:** Nursing Director, Nurse Manager, and Supervisors	

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A 395	Continued From page 27 bottles of Sure Prep skin barrier spray, a container of hydrogel skin integrity, a plastic cup of pink colored cream and wound cleanser on the patient□s bedside stand. During a concurrent interview, RN 20 stated the topical medications were used for wound treatment. RN 30 stated the plastic cup that contained pink colored cream was Calazime cream, which should not be left at the bedside and should be discarded after it was used. A review of Patient 24□s medical record indicated there was no physician□s order for the hydrogel. 3. On March 25, 2014, at 10 a.m., during an observation tour in the unit of the facility□s Culver City campus, Patient 14 was resting in bed, awake, alert, oriented, and was watching television. During a concurrent interview, Patient 14 stated she had a recent fall prior to admission and sustained open wounds. A review of the Admission Face Sheet indicated Patient 14 was admitted to the facility on March 4, 2014, with diagnoses that included bilateral lower leg pain with swelling, anemia, edema (swelling) and hypotension (low blood pressure). A review of the facility□s policy on Wound Report Procedure SAA.092 stipulated the following: a. Initiate the Wound Report Immediately and place in the medical record. b. Document on the Wound Report Form, at least	A 395		

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A 395	Continued From page 28 weekly, the wound location, size, depth, drainage, appearance, odor and progress. The Initial Nursing Admission Assessment indicated the patient had two (2) Stage II pressure ulcers on the mid back and left leg. The Impaired Skin Integrity Record on admission (March 4, 2014) indicated there were photographs of the patient□s wounds on the the left heel, right knee, left foot, right heel, right buttocks, and left back. The record did not specify the type of wound (pressure, arterial/venous ulcer, etc), size, stage and other wound characteristics. Additionally, a review of the physician□s orders for March 4, 2014, indicated there was no treatment orders for the wound on the right knee and pressure ulcer on the mid-back. The medical record also failed to indicated documentation the wounds were reassessed weekly for the week of March 16 and 23, 2014. A review of the Impaired Skin Integrity Record dated March 9, 2014, indicate a reassessment of the wounds that indicated the following: a. The photograph showed the patient□s right buttocks pressure ulcer Stage II, pink/red in color, intact surrounding skin and had no necrotic tissue, odor, or drainage. There was no documentation of the size and shape of the pressure ulcer as indicated on the Impaired Skin Integrity Record.	A 395		

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A 395	Continued From page 29 b. The photograph showed the left knee skin tear/abrasion, pink/red in color, intact on the surrounding skin and had no necrotic tissue, odor, or drainage. There was no documentation of the size and shape of the wound as indicated on the Impaired Skin Integrity Record. c. The photograph showed the mid-back pressure ulcer, Stage II to III, intact surrounding skin, pink/red in color and had no necrotic tissue, odor, or drainage. The pressure ulcer was cleansed with wound spray, hydrogel was applied and covered with dressing. There was no documentation of the size of the pressure ulcer. d. The photograph showed a right heel wound. There was no documentation of the type of wound, stage, size, and other wound characteristics. e. The photograph showed a left foot wound. There was no documentation of the type of wound, stage, size, and other wound characteristics. f. The photograph showed a left heel wound. There was no documentation of the type of wound, stage, size, and other wound characteristics. a further review of Patient 14□s medical record indicated the treatments as ordered by the physician on the pressure ulcers were not done on the following days: March 7 8, 9, 10, 12, 14, 15, 16, 17, 19 and 20, 2014.	A 395		

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A 395	Continued From page 30 4. On March 25, 2014, at 10:30 a.m., during a tour of the unit with Staff G, Patient 16 was observed lying bed with bilateral rails up and there was a sign posted on the wall that indicated nothing by mouth (NPO). There was a foul odor emanating from the patient□s mouth. The patient□s lips were dry and the patient was receiving oxygen via nasal cannula. During a concurrent interview, Licensed Vocational Nurse (LVN) 4, stated she was in Patient 16□s room 10 minutes ago and was not aware the patient needed oral care. A review of Patient 16□s clinical record indicated the patient was admitted to the facility on March 24, 2014 for abdominal pain, seizure disorder, encephalopathy and constipation. The Admission Assessment Inquiry indicated the patient was dependent in his activities of daily living such a bathing, grooming and oral care, however, the patient□s level of consciousness is confused. 5. On March 26, 2014, at 9:15 a.m., during the tour of the emergency department (ER) with Staff N, Patient 17 was observed in bed, awake, alert, oriented, wearing hat and sunglasses. During a concurrent interview Patient 17, stated she lived in a skilled nursing facility, and went to the emergency room (ER) because of a pain in	A 395		

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A 395	Continued From page 31 the right side of her body. Patient 17 stated she had been in the emergency room for a couple of days. A review of Patient 17□s clinical record indicated she was admitted to the emergency room (ER) on March 23, 2014, with diagnosis of aggressive psychiatric evaluation for aggressiveness. The patient had been in ER for 3 days. During a concurrent interview, RN 14 stated the patient had been in the ER for three days because they were waiting for an available inpatient bed in the psychiatric unit. On March 3, 2014, the physician ordered the patient be admitted to Psychiatric 6 unit. According to the facility□s policy and procedure on the Scope of Service □Emergency Department/Urgent Care dated June 26, 2013, indicated mechanism for identifying patient care needs, included psychiatric patients with admission orders that are awaiting an available bed will be held in either the main ER or in the ER Overflow area pending bed availability. The Census Report for the facility□s Psychiatric Unit was reviewed with Staff B and indicated on March 23, 2014, there were three available Psychiatric beds in the seclusion unit. On March 24, 25, 2014, there were three available Psychiatric beds in the seclusion unit. On March 24 and 25, 2014, there were three available beds in the seclusion unit. On March 25, 2014, there were four beds available in the locked unit. Staff B stated the patient could have been transferred and/or admitted to the inpatient unit when there	A 395		

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A 395	Continued From page 32 was an available bed. Staff B stated the goal for the patient was to get her out of the ER and admitted to the unit. Further review of Patient 17□s clinical record indicated on March 25, 2014, at 4:32 p.m., there was a room available for the patient in the Psych 6 unit, and will call for report. At 5:29 p.m., the documentation in the clinical record indicated the transfer for Patient 17 was changed per the charge nurse due to no bed availability that day. 6. On March 26, 2014, at 2:15 p.m., during the tour of the unit, Patient 18 was observed in bed with an intravenous line □IV□ into the vein by a heplock (tube inserted into a vein, but capped) on the right hand. The Admission Facesheet indicated the patient was admitted to the facility on March 14, 2014, with diagnosis of chest pain. The physician□s order, dated March 14, 2014, indicated Lisinopril 20 milligram (mg) tablet to administer 40 mg, once a day orally for hypertension (High blood pressure). The physician order did not indicate an order to obtain a blood pressure reading and to hold the medication when the blood pressure was too low. A review of the Medication Administration Record (MAR), dated March 15, 2014, indicated Lisinopril medication was not given to the patient. During a concurrent interview, RN 15 stated she did not give the Lisinopril to the patient at that time because her blood pressure was 109/69. The RN was not able to show documentation the	A 395		

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A 395	Continued From page 33 physician was notified of the patient□s blood pressure. 7. The clinical record indicated Patient 15 was admitted to the facility on March 19, 2014, with the chief complaint of urinary tract infection and a psych evaluation for agitation. On March 20, 2014, the physician□s order indicated Risperdal (antipsychotic medication) 1 mg via gastrostomy tube (GT) every morning and 2 mg via GT in the afternoon. A review of the medication administration record (MAR) dated from March 21 through March 25, 2014, there was no documented evidence Risperdal was administered to the patient. On March 27, 2014, a review of the clinical record and an interview with the pharmacist failed to show documentation the order for Risperdal was carried out. 8. A review of the facility□s report disclosed an incident occurred on March 21, 2014, at 8:15 p.m., in Unit 1 (open unit) in Patient 45□s bathroom. MHW 2 was conducting a visual inspection and Patient 45 was not in the room. Patient 45 was in the bathroom and the door was locked. MHW 2 observed part of Patient 45□s gown was hanging at the top of the door. As MHW 2 approached the bathroom door, he called out Patient 45□s name. The door was completely locked and he (MHW 2) was unable to open the door MHW 2 heard a loud thump sound coming from the bathroom and heard gurgling sounds coming from Patient 45. MHW 2 yelled, □Code	A 395		

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A 395	Continued From page 34 Blue, Nurse□as he banged on the bathroom door. The bathroom door opened and Patient 45 □landed on the floor.□A nurse came in the room and assessed Patient 45. On March 24, 2014, at 12:15 p.m., an interview was conducted with Staff H regarding the registered nurse (RN) assessment after the incident. Staff H reviewed the report and stated the RN did not conduct a physical assessment of Patient 45 after the incident. Staff H stated the RN should have documented an assessment of Patient 45. He further stated Patient 45 was place on 1:1 for safety after the incident.	A 395		
A 396	482.23(b)(4) NURSING CARE PLAN The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure nursing staff developed and kept current nursing care plans for 8 of 52 sampled patients (Patient 14, 25, 26, 29, 31, 32, 45 and 46). 1. Patient 14, who had pressure ulcers, there was no care plan interventions to address the actual wounds/pressure ulcers to ensure the plan of care was effective for wound healing. 2. Patient 25, there were no care plans developed to manage the patient□s care while in contact isolation and required hemodialysis treatments.	A 396	**Culver City** **1-6) Corrective Actions:** Policy PAT.001 Admission Assessment/Interdisciplinary Plan of Care strengthened the development of care plans and maintaining current nursing care plan for each patient. Enhancement/development of electronic care plans for pressure ulcers, contact isolation, suicidal risk, hemodialysis treatments, seizure disorders and chronic pain. Educate nursing staff to create a care plan in EMR specific to skin integrity, during time of admission, evaluation, and updates on a daily basis. Policy revision WOU.001 **Date of Implementation**: 6/13/2014 with completion in 30 days. **Monitoring Process:** Auditing audit a minimum of 30 charts a month by Super Users with a report to the Quality Department on a quarterly basis. **Person Responsible:** Nursing Directors	6/13/2014

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A 396	Continued From page 25 3. Patient 26, there was no care plan developed for managing Patient 26 who had seizure disorder. 4. Patient 29, there was no care plan for the patient□s care while in contact isolation. 5. Patient 31, there was no care plan developed for the care while the patient was in contact isolation and receiving hemodialysis treatments. 6. Patient 32, there was no care plan developed for the care while the for contact isolation. 7. Patient 45, who was assessed as a suicidal risk, the care plan was no revised or updated to address the patient□s current status requiring 1:1 observation. 8. Patient 46, who had chronic pain, the care plan was not developed or initiated upon admission, but six days after admission. These deficient practices had the potential for not meeting the physical and mental needs of each patient. Findings: 1. A review of the Admission Face Sheet indicated Patient 14 was admitted to the facility on March 4, 2014, with diagnoses that included bilateral lower leg pain with swelling, anemia, edema (swelling) and hypotension (low blood pressure). A review of the care plan dated March 4, 2014,	A 396	(Continued from page 35) **HOLLYWOOD** **1,2,3) Corrective Actions:** Policy PAT.001 Admission Assessment/Interdisciplinary Plan of Care strengthened the development of care plans and maintaining current nursing care plan for each patient. Enhancement and development of electronic care plans for pressure ulcers, contact isolation, suicidal risk, hemodialysis treatments, seizure disorders and chronic pain. EMR Education/re-training provided beginning April 16, 2014 thru May 5, 2014 to include accurate and complete documentation of initial, care plan updates, and upon discharge utilizing the existing care plan modules **Date of Implementation:** Daily concurrent review of care plans on all patients performed beginning April 1, 2014, beginning May 1, 2014 review 30 random charts; re-training beginning June 18, 2014 thru June 30, 2014. **Monitoring Process:** Monitoring will be managed by review of 30 random charts by nursing; data will be reported through Quality Department. **Person Responsible:** Nursing Leadership **Van Nuys** **7) Corrective Actions:** Re-educate all Registered Nurses on the importance of creating a plan of care and updating the treatment plan immediately after placing a patient on a 1:1 with staff. In-service staff and provide the □Suicide Precaution Documentation Monitoring Checklist□tool which includes a check off section for □Patient Treatment Plan□ updated/revised to address the change of patient acuity. **Date of Implementation:** 6/16/14 **Monitoring Process:** Director of Nursing and/or designee will conduct monitoring activity on the checklist tool submitted by staff the same day the incident occurs to ensure that the requirements and documentation monitoring tool has been completed to include updating/revising of the patient treatment plan. **Person Responsible:** Nursing Director, Nurse Manager, and Supervisors **8) Corrective Actions:** Re-educate/inservice the night shift staff on the existing □Nightly Chart Audit□ This audit includes a check off section for □Nursing Care Plan/Pain□ Re-educate the supervisors who perform the already existing audit □Pain Management Audit Monitoring Tool□ Re-educate supervisors to complete the treatment plan for pain as needed while auditing. **Date of Implementation**: 6/16/14 **Monitoring Process:** The Nursing Director and/or designee will implement monitoring by auditing of pain medication orders every (24) hours. Auditing will begin with (10) random charts per day with target compliance set at 100%. **Person Responsible:** Nursing Director	4/1/2014 6/16/2014 6/16/2014

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A 396	Continued From page 36 indicated impairment of skin integrity. The care plan did not address specific interventions for Patient 14□s actual wounds/pressure ulcers to ensure the plan of care was effective. On March 27, 2014, at 8 a.m., a review of the electronic record was conducted with Registered Nurse (RN) 12. During a concurrent interview, RN 12 stated the plan of care was initiated but failed to indicate the interventions to be undertaken to heal and prevent the wounds/pressure ulcers from getting worst. 2. During the initial tour with RN 1 and 2, in the mixed unit of Definitive Observation Unit (DOU) and the Medical-Surgical unit of the Hollywood campus on March 24, 2014 between the time of 11:15 a.m. and 11:45 a.m., Patient 25 was observed resting on the bed and there was a sign that indicated □Contact Isolation□posted by the door. According to RN 2, Patient 25 was placed in the room for MRSA (methicillin resistant staphylococcus aureus is a bacteria that causes infection that are resistant to some antibiotics) contact isolation. RN 2 also stated Patient 26 had an AV fistula (dialysis access site) on her left arm for hemodialysis treatment. A review of the electronic clinical record was conducted with Licensed Vocational Nurse (LVN) 1 disclosed there were no care plans developed for managing Patient 25 who was on contact isolation and who required hemodialysis treatment. During an interview with LVN 1 on March 24, 2014 at 12:20 p.m., she stated the nursing staff failed to develop the care plans for contact	A 396		

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A 396	Continued From page 37 isolation and hemodialysis. 3. A review of the clinical record indicated Patient 26 was admitted on March 15, 2014, with a diagnosis of seizure disorder. A review of the electronic clinical record was conducted with LVN 1 disclosed there was no care plan developed for managing Patient 26 who had seizure disorder. During an interview with LVN 1 on March 24, 2014 at 12:20 p.m., she stated the nursing staffs failed to develop the care plan for the patient□s seizure disorder. 4. During the initial tour with RN 3 in the Medical-Surgical Unit of the Culver City campus on March 25, 2014 between the hours of 10:55 a.m. and 11:35 a.m., Patient 29 was observed resting on the bed with a sign that indicated □Contact isolation□posted by the door. According to RN 3, Patient 29 was placed in the room for MRSA contact isolation. However, the electronic clinical record was reviewed with RN 2 and indicated there was no care plan for contact isolation. 5. During the initial tour with RN 4 in the Surgical Intensive Care Unit (SICU) of the Culver City campus on March 26, 2014, between 10 a.m. and 10:25 a.m., Patient 31 was observed resting on the bed with a sign that indicated □Contact	A 396		

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A 396	Continued From page 38 Isolation□posted by the door. RN 4 also stated Patient 31 underwent the hemodialysis treatment. According to RN 4, Patient 31 was placed in the room for MRSA contact isolation. However, the electronic clinical record was reviewed with RN 4 and indicated there was no care plan for contact isolation and hemodialysis. During the concurrent interview with RN 4 on March 26, 2014 at 10:25 a.m., she stated the nursing staff failed to develop the care plans for contact isolation and hemodialysis. 6. During the initial tour with RN 4 in the Critical Care Unit (CCU) of the Culver City campus on March 26, 2014 between the time of 10:25 a.m. and 11:35 a.m., Patient 32 was observed resting on the bed with a sign that indicated □Contact Isolation□by the door. According to RN 4, Patient 32 was placed in the room for MRSA contact isolation. However, the electronic clinical record was reviewed with RN 4 and disclosed there was no care plan for contact isolation for Patient 32. During an interview with RN 4 on March 26, 2014 at 10:25 a.m., she stated the nursing staff failed to develop the care plans for contact isolation and hemodialysis. 7. A review of the facility□s report indicated an incident occurred on March 21, 2014, at 8:15 p.m., in Unit 1 (open unit) bathroom. Mental Health Worker (MHW) 2 was conducting a visual inspection in the room and Patient 45 was not in the room. Patient 45 was in the bathroom and the	A 396		

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A 396	Continued From page 39 door was locked. MHW 2 observed part of Patient 45□s gown was hanging at the top of the door. As MHW 2 approached the bathroom door, he called out Patient 45□s name. The door was completely locked and he (MHW 2) was unable to open the door. MHW 2 heard a loud thump sound coming from the bathroom and heard gurgling sounds coming from Patient 45. MHW 2 yelled, □Code Blue, Nurse□as he banged on the bathroom door. The bathroom door opened and Patient 45 □landed on the floor.□ On March 24, 2014, at 8:15 a.m., a review of the patient□s medical record was conducted with Staff I. During a concurrent interview, Staff I stated there was care plan, dated March 20, 2014, titled, □Potential for Self Harm as evidenced by Suicidal Ideation, with a Plan to Overdose.□The short term goal was that the patient will report □urge to harm self.□The long term goal was the patient will not harm self during hospitalization. The nursing interventions included encourage verbalizing thoughts and needs. Monitor for safety. However, the care plan was not revised to address Patient 45□s current status of level of observation which was a 1 to 1 observation. 8. During an interview with RN 8 on March 25, 2014, at 9 a.m., she reviewed Patient 46□s clinical record and stated she was unable to find a care plan for the pain management. A review of the Admission Face Sheet indicated Patient 46 was admitted to the facility on March 18, 2014. The History and Physical dated March 19, 2014 disclose Patient 46 had chronic back pain. The physician□s orders dated March 21, 2014 indicated the patient was receiving Robaxin (muscle relaxant) 750 milligrams (mg) one by	A 396		

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A 396	Continued From page 40 mouth twice a day and Flexeril (muscle relaxant) 10 mg one by mouth twice a day. The care plan titled, □Alteration in comfort due to Pain □ Chronic; dated March 24, 2014, indicated the pain was described as chronic low back pain. However, the care plan was not developed or initiated upon the patient□s admission on March 18, 2014, until six days after admission. According to a facility□s policy titled Interdisciplinary Treatment Plan and Update Scheduling dated November 2012 disclose dot ensure each client admitted to the facility has a written, individualized treatment plan based on assessments of clinical needs. All medical problems requiring interventions shall be entered on the Interdisciplinary Treatment Plan (IDT) Problem List and a care plan for the identified plan shall be initiated by the RN. Furthermore, within the first 72 hours the IDT Team shall meet to discuss the patient□s needs.	A 396		
A 405	482.23(c)(1), (c)(1)(i) & □ (2) ADMINISTRATION OF DRUGS (1) Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient□s care as specified under □482.12(c), and accepted standards of practice. (i) Drugs and biologicals may be prepared and administered on the orders of other practitioners not specified under □482.12(c) only if such practitioners are acting in accordance with State law, including scope of practice laws, hospital policies, and medical staff bylaws, rules, and regulations.	A 405	**Culver City** **Corrective Actions:** All nursing staff re-educated with self-study module to validate that physician orders have been noted, examined, and verified. Caregivers must use SBAR and provide the opportunity to use read-back techniques and medications orders received must be read back by the receiver. 24 hour order/chart check policy & procedure PAT.059 implemented that mandates documentation of chart review before 7am each day. **Date of Implementation**: 5/18/2014 **Monitoring Process:** Random audit of 30 charts for each nursing unit with report to Quality Department on a quarterly basis. **Person Responsible**: Nursing Leadership	5/18/2014

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A 405	Continued From page 41 (2) All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure patient would only receive medications or supplement that were prescribed by the physician for 1 of 52 sample patients (Patient 7). This deficient practice resulted in Patient 7 receiving a dietary supplement that was not ordered by the physician. Findings: On March 26, 2014 at 9:30 a.m., in the Telemetry Unit of the Culver City campus, during a medication pass for Patient 7, the patient received one tablet of the dietary supplement □inc Sulfate 220 milligrams (mg) but could not locate the physician□s order for the zinc sulfate in the patient□s chart. On March 26, 2014 at 10:45 a.m., the director of pharmacy (Pharmacist 2) confirmed he was unable to find the □inc Sulfate order in Patient 7□s chart. On March 26, 2014 at 11 a.m., the vice president pharmacy operations (Pharmacist 1) could not find the □inc Sulfate order in the Patient 7□s chart. A review of the Nutrition Recommendation Form	A 405		

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A 405	Continued From page 42 for Patient 7, dated March 25, 2014 at 8:16 a.m., indicated a handwritten check mark in the check box for □Vitamins and Minerals□and another handwritten check mark in the check box for □Multivitamin mineral one table PO (orally) daily.□However, there was no marking by the check box for □□inc Sulfate 220 mg.□ A review of the fax copy of the □Nutrition Recommendation Form□dated March 24, 2014 at 1:05 p.m. indicated the pharmacy received the order on March 25, 2014 at 8:16 a.m. A review of the electronic Medication Administration Record (eMAR) for March 25, 2014, indicated Patient 7 received one □inc Sulfate 220 mg tablet on March 25, 2014 at 9 a.m. As of the medication pass observed on March 26, 2014 at 9:30 a.m., a total of two doses of □inc Sulfate 220 mg tablets were given to Patient 7. On March 26, 2014 at 11:23 a.m., an interview with Pharmacist 1 indicated a staff pharmacist misread the Nutrition Recommendation form as □inc Sulfate being included because of the long handwritten check mark for the multivitamin with mineral, which was located directly above it on the pre-printed Nutrition Recommendation Form. At 1:42 p.m., on March 26, 2014, Pharmacist 1 stated there was no policy and procedure for the chart check process performed by the nursing staff that would verify eMAR with actual physician orders. At 1:49 p.m. on March 26, 2014, during an interview, RN 10 described the process for the 12	A 405		

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A 405	Continued From page 43 hour chart check performed at shift change. The nurses performing the chart check would receive a report from a □supervising nurse,□ they would then confirm physician orders the chart with eMAR and verify in computer program. She stated □This is a routine protocol.□ She also described the 12 hour nursing shifts as 7 a.m. to 7 p.m. and 7 p.m. to 7 a.m. On March 28, 2014 at 11:53 a.m., during a follow-up interview, RN 10 stated the nurses responsible for their patients should have caught the medication entry error during the chart check process. A review of the policy and procedure dated 10/2013, titled, □Drug Distribution and Control□ Number: PHA.025 dated □10/2012,□ indicated □The Pharmacy department shall distribute medication and control the use of medication as follows: Review all medications orders for appropriateness and safety with respect to the current medication profile.□ A review of the policy and procedure dated 11/2012, titled, □Hand Off Communications,□ Number: PAT.043, □indicated□□ A □hand off□ communication is an interactive process of passing patient-specific information from one caregiver to another or from one team of caregivers to another for the purpose of ensuring the continuity and safety of the patient□s care □ This provides the caregivers an opportunity to verify information by using read-back techniques. Critical test results and medication orders received shall be read back by the receiver. The occurrence of the read back shall be documented in the medical record.□	A 405		

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A 432 A 432	Continued From page 44 482.24(a) ORGANI□ATION AND STAFFING The organization of the medical record service must be appropriate to the scope and complexity of the services performed. The hospital must employ adequate personnel to ensure prompt completion, filing, and retrieval of records. This STANDARD is not met as evidence by: Based on medical record review and medical records staff interview, the facility failed to ensure that physician orders were authenticated and that medical records were completed in a timely manner as evidenced by lack of an effective system to ensure authentication and medical records completion of telephone orders at the Van Nuys campus. This deficient practice had the potential to result in delays of pertinent information being available for continuing patient care. Findings: Patient 13 was admitted to the Van Nuys campus on March 25, 2014 with diagnosis including exacerbation of depression (a mood disorder in which feelings of sadness, loss, anger or frustration interfere with everyday life for weeks or longer). The physicians□admission diet order dated March 25, 2014, was a no added salt diet. In an interview on March 27, 2014 beginning at 3 p.m., (Administrative Staff) Staff 7 stated if there is no physician on site when patients are admitted both the medical doctor and the psychiatrist are contacted for telephone admitting orders, including diet orders. Staff 7 stated the orders were then put into the electronic medical record. Upon completion of order entry the medication	A 432 A 432	**Van Nuys** **FINDING 1:** ***Patient 13 Dietary Orders*** **Corrective Actions:** An internal review of dietary processes identified handwritten dietary recommendations were placed into the patient□s medical record and not reviewed in a timely manner. The following improvements have been implemented: • All physicians are required to input orders via the Computerized Physician Order Entry System (CPOE). • All dietary recommendations are required to be input into the electronic medical record (EMR). Input of a dietary recommendation into the EMR triggers a □flag□of a pending diet recommendation and prompts appropriate follow-up for a physician□s order to finalize said dietary recommendation. • The Dietary Department will monitor all diet orders, executed as a result of a diet recommendation, to ensure all diet orders are appropriately fulfilled. Audit results will be reported to the hospital□s Pharmacy and Therapeutics Committee, Quality Council, Medical Executive Committee, and Governing Board. **Date of Implementation** • Internal review of the dietary processes was conducted April through June 2014. — 4/15/2014 • Mandatory input of dietary recommendations into the EMR completed July 22, 2014 for the Culver City campus and August 1, 2014 for the Van Nuys and Hollywood campuses. — 7/22/2014 8/1/2014 • Physicians mandated to input orders via CPOE by July 15, 2014 for the Hollywood and Van Nuys campuses and by August 18, 2014 for the Culver City campus. — 7/15/2014 8/18/2014 • Super-users have been hired and trained to support physician adoption and training. Physician CPOE training commenced June 25, 2014. — 6/25/2014 **Monitoring Process:** • The Dietary Department will monitor all diet orders, executed as a result of a diet recommendation, to ensure diet orders are appropriately fulfilled. Audit results will be reported to the hospital□s Pharmacy and Therapeutics Committee, Quality Council, Medical Executive Committee, and Governing Board. • Compliance will be gauged by reviewing the number of diet recommendations generated (denominator), and of those, the number of orders written and executed (numerator) • Targeted compliance is 90% • Monitoring activity will commence for a period not to exceed 4 months or until optimal compliance is achieved and sustained. • Random audits will be performed thereafter. • Results of the audits will be reported to the hospital□s Pharmacy and Therapeutics Committee, Quality Council, Medical Executive Committee, and Governing Board. **Person Responsible:** Director of Dietary/Food Services or designee. **Finding 2, 3 and 4 –** ***Interview with (Administrative Staff) Staff 7, Staff 8, and Staff 9 (Health Information Manager)*** **Corrective Actions:** An internal assessment identified that incomplete (signed, dated, and timed) physician□s orders in the system existed primarily due to the slow rate of physician adoption to the EMR. Physicians not logging into the EMR system did not receive a prompt of incomplete orders in the system. Once a physician logs into the EMR a system generated prompt requires the physician to appropriately disposition (sign or refuse with reason) each unsigned order. When the physician authenticates an order, the system automatically dates and times the order.	

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A 432	Continued From page 45 order were printed and faxed to the pharmacy for implementation and eventual physician signature. All remaining orders and patient care documentation was maintained in the electronic medical record. She further stated that the intent would be for physicians to electronically authenticate all telephone orders and that each time a physician logged there was a reminder screen that depicted the number of orders that required reviewing. She also acknowledged that physicians did not routinely authenticate orders that were in the electronic medical record. In an interview on March 27, 2014 beginning at 3:40 p.m., Staff 8 was asked to describe the medical record auditing process. She stated the current electronic record was implemented in June 2013 and she routinely requests physicians□sign their orders. Staff 8 stated the orders were reviewed and those that were in the paper format, which were primarily medication orders were reviewed. Staff 8 determine the number of electronic telephone orders that were not authenticated within the last 30 days. In a follow up observation on March 27, 2014 at 4:14 p.m., Staff 7 as able to demonstrate the number of orders that were not authenticated for a random physician. It was noted on the screen shot being viewed the physician had 199 orders that required authentication. In an interview on March 28, 2014 at 9:15 a.m., Staff 9 (Health Information Manager) (HIM) stated the department audited elements such as history and physicals; operative reports and authentication of physicians□orders. Staff 9 stated the authentication of orders was limited to those that were printed; there was no audit of orders that may have been directly entered into	A 432	(Continued from page 45) The following improvements have been implemented: • Physicians mandated to input orders via CPOE by July 15, 2014 for the Hollywood and Van Nuys campuses and by August 18, 2014 for the Culver City campus. • Additional CPOE physician training commenced at the Hollywood, Van Nuys, and Culver City campuses on June 25, 2014. • Previous to the CPOE mandate, the Chief of Staff issued a memo, dated June 13, 2014, to All Medical and Allied Staff Members to serve as a reminder notice that pursuant to the Medical Staff Rules and Regulations that all orders and progress notes must be signed, dated, and timed. • Non-compliance discussed and corrective actions addressed at medical department meetings and the Medical Executive Committee (MEC). • Medical Staff leadership will continue to monitor progress and work with Administration to improve compliance with documentation standards. • Audit results will be reported to the hospital□s Quality Council, Medical Executive Committee, and Governing Board. **Date of Implementation** • Super-users have been hired and trained to support physician adoption and training. Physician CPOE training commenced June 25, 2014. • Physicians mandated to input orders via CPOE by July 15, 2014 for the Hollywood and Van Nuys campuses and by August 18, 2014 for the Culver City campus. • Previous to the CPOE mandate, the Chief of Staff issued a memo, dated June 13, 2014, to All Medical and Allied Staff Members to serve as a reminder notice that pursuant to the Medical Staff Rules and Regulations that all orders and progress notes must be signed, dated, and timed. • Non-compliance discussed and corrective actions addressed at medical department meetings and the Medical Executive Committee (MEC). • Medical Staff leadership will continue to monitor progress and work with Administration to improve compliance with documentation standards. • Audit results will be reported to the hospital□s Quality Council, Medical Executive Committee, and Governing Board. **Monitoring Process:** • The HIM Manager and/or designee will conduct monthly audits of patient charts to review for the completion of all physician orders (timed, dated, and signed). • Numerator = Number of complete physician orders (timed, dated, and signed) / Denominator □ Number of total physician orders reviewed. • The sample size will be based on monthly discharges, per the following guidelines: o Sample all cases for a population size of fewer than 30 cases o Sample 30 cases for a population size of 30□100 cases o Sample 50 cases for a population size of 101□500 cases o Sample 70 cases for a population size of more than 500 cases • Targeted compliance is 90% • Monitoring activity will commence for a period not to exceed 4 months or until optimal compliance is achieved and sustained. • Random audits will be performed thereafter. • Results of the audits will be reported to the hospital□s Quality Council, Medical Executive Committee, and Governing Board. **Person Responsible:** HIM Administrator and/or designee	6/25/2014 7/15/2014 8/18/2014 6/13/2014

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SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	**6245 DE LONGPRE AVE HOLLYWOOD, CA 90028**

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A 432	Continued From page 46 the electronic medical record. He also acknowledged that in the Culver City campus and Hollywood campus staff was instructed to print out all physicians□orders. He was unaware that the Van Nuys campus was not printing orders. Hospital document titled □General Medical Staff Rules and Regulations□dated 12/4/13 noted that it was the responsibility of the attending physician for the clinical accuracy and timely completion of the medical record. The rules also noted □The medical record shall be completed promptly and authenticated by signature by a physician□ □	A 432		
A 454	482.24(c)(1) CONTENT OF RECORD: ORDERS DATED & SIGNED All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner who is responsible for the care of the patient only if such a practitioner is acting in accordance with State law, including scope-of-practice bylaws, rules, and regulations. This STANDARD is not met as evidenced by; Based on record review and interview, the facility failed to ensure the verbal orders of the physicians were dated, timed, and authenticated promptly by the ordering practitioner, as in accordance with the facility□s Medical Staff Rules & Regulations for 6 of 52 sampled patients (Patient 15, 18, 25, 26, 29, and 32). This deficient practice had the potential for the physician orders not to be complete and accurate. Findings:	A 454	**ALL THREE CAMPUSES** **Findings 1-5 Corrective Actions:** An internal assessment identified that incomplete (signed, dated, and timed) physician□s orders in the system existed primarily due to the slow rate of physician adoption to the EMR. Physicians not logging into the EMR system did not receive a prompt of incomplete orders in the system. Once a physician logs into the EMR a system generated prompt requires the physician to appropriately disposition (sign or refuse with reason) each unsigned order. When the physician authenticates an order, the system automatically dates and times the order. The following improvements have been implemented: • Physicians mandated to input orders via CPOE by July 15, 2014 for the Hollywood and Van Nuys campuses and by August 18, 2014 for the Culver City campus. • Previous to the CPOE mandate, the Chief of Staff issued a memo, dated June 13, 2014, to All Medical and Allied Staff Members to serve as a reminder notice that pursuant to the Medical Staff Rules and Regulations that all orders and progress notes must be signed, dated, and timed. • Non-compliance discussed and corrective actions addressed at medical department meetings and the Medical Executive Committee (MEC). • Medical Staff leadership will continue to monitor progress and work with Administration to improve compliance with documentation standards. • Audit results will be reported to the hospital□s Quality Council, Medical Executive Committee, and Governing Board. **Date of Implementation:** • Super-users have been hired and trained to support physician adoption and training. Physician CPOE training commenced June 25, 2014. • Physicians mandated to input orders via CPOE by July 15, 2014 for the Hollywood and Van Nuys campuses and by August 18, 2014 for the Culver City campus. • Previous to the CPOE mandate, the Chief of Staff issued a memo, dated June 13, 2014, to All Medical and Allied Staff Members to serve as a reminder notice that pursuant to the Medical Staff Rules and Regulations that all orders and progress notes must be signed, dated, and timed.	6/25/2014 7/15/2014 8/18/2014 6/13/2014

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A 454	Continued From page 47 1. In the DOU (Definitive Observation Unit) of the Hollywood campus on March 24, 2014, a review of the physician□s order sheet for Patient 25 disclosed one telephone order received on March 15, 2014 at 4:15 p.m. was not dated, timed, and authenticated by the ordering practitioner. Two telephone orders dated March 22, 2014 were not timed and authenticated by the ordering practitioner. A review of the physician□s order sheet for Patient 26 disclosed one telephone order dated March 21, 2014 at 12:25 p.m. was not dated, timed, and authenticated by the ordering practitioner. During the concurrent interview with Registered Nurse 9RN) 1, she stated the physicians failed to date, time and authenticated the telephone orders for Patient 25 and 26. 2. During the initial tour with Staff C and RN 3 in the Medical/Surgical Unit of the Culver City campus on March 25, 2014 between 10:55 a.m. and 11:35 a.m., a review of the physician□s order sheet for Patient 29 disclosed the telephone order received on March 19, 2014 at 8:45 a.m. and 10 p.m., March 2014 at 9:30 a.m., March 21, 2014 at 10 a.m. and March 24, 2014 at 7 a.m., were not dated, timed, and authenticated by the ordering practitioner. During the concurrent interview with Staff C, she stated the physicians failed to date, time and authenticated the telephone orders for Patient 29. 3. During the initial tour with Staff C and RN 4 in the CCU (Critical Care Unit) of the Culver City campus on March 26, 2014 between 10 a.m. and 10:30 a.m., the physician□s order sheet for Patient	A 454	(continued from page 47) • Non-compliance discussed and corrective actions addressed at medical department meetings and the Medical Executive Committee (MEC). • Medical Staff leadership will continue to monitor progress and work with Administration to improve compliance with documentation standards. Audit results will be reported to the hospital□s Quality Council, Medical Executive Committee, and Governing Board. **Monitoring Process:** • The HIM Manager and/or designee will conduct monthly audits of patient charts to review for the completion of all physician orders (timed, dated, and signed). • Numerator = Number of complete physician orders (timed, dated, and signed) / Denominator □ Number of total physician orders reviewed. • The sample size will be based on monthly discharges, per the following guidelines: o Sample all cases for a population size of fewer than 30 cases o Sample 30 cases for a population size of 30□100 cases o Sample 50 cases for a population size of 101□500 cases o Sample 70 cases for a population size of more than 500 cases • Targeted compliance is 90% • Monitoring activity will commence for a period not to exceed 4 months or until optimal compliance is achieved and sustained. • Random audits will be performed thereafter. • Audit results will be reported to the hospital□s Quality Council, Medical Executive Committee, and Governing Board. **Person Responsible**: HIM Administrator and/or designee.	

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A 454	Continued From page 48 32 was reviewed and disclosed the telephone order received on February 29, 2014 was not dated, timed, and authenticated by the ordering practitioner. During the concurrent interview with Staff C ,she stated the physicians failed to date, time and authenticated the telephone orders for Patient 32. 4. During the initial tour with Staff C and RN 6 in the Telemetry Unit of the Culver City campus on March 26, 2014 between 2:12 p.m. and 3:30 p.m., the physician□s order sheet for Patient 32 was reviewed and disclosed the telephone order for admission medications was not dated, timed, and authenticated by the ordering practitioner. During the concurrent interview with Staff C, she stated the physicians failed to date, time and authenticated the telephone orders for Patient 34. According to the Medical Staff Rules & Regulations approved by the Governing Board on December 4, 2013, page 29, number 13: ORDERS, 13.2 □All medication order shall be signed within 48 hours.□ 5.On March 27, 2014, at 2:45 p.m., in the Culver City campus, during a review of the following patient medical records with RN 16 revealed the following: a. Patient 18□s Progress Notes dated March 22 through 25, 2014, were signed, dated but not timed by the physician.	A 454		

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A 454	Continued From page 49 b. Patient 15□s physician telephone orders dated March 22-25, 2014 were not signed, dated and timed by the physician. The telephone orders were Haldol 5 mg IM, Ativan 2 mg IM every 6 hours as needed for agitation and Benadryl 50 mg During a concurrent interview, RN 16 stated there was no time, date and signature by the physician.	A 454		
A 458	482.24(c)(4)(i)(A) CONTENT OF RECORD: HISTORY & PHYSICAL All records must document the following, as appropriate: (i) Evidence of□ (A) A medical history and physical examination completed and documented no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be placed in the patient□s medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the medical history and physical examination were completed within 24 hours after admission for 4 of 52 sampled patients (Patient 12, 29, 33 and 34). This deficient practice had the potential to affect the patient□s course of treatments. Findings:	A 458	**All Three Campuses** **1-3 Corrective Actions:** • Non-compliance discussed and corrective actions addressed at the Medical Executive Committee (MEC). • The Chief of Staff issued a memo, dated June 19, 2014, to All Medical and Allied Staff Members to serve as a reminder notice that pursuant to the Medical Staff Rules and Regulations that a medical history and physical examination must be completed and documented no more than 30 days before or 24 hours after admission or registration, but prior to surgery or procedure requiring anesthesia services. The medical history and physical examination must be placed in the patient□s medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. • Medical Staff leadership will continue to monitor progress and work with Administration to improve compliance with documentation standards. • Audit results reported to the hospital□s Quality and Medical Record Committee and Medical Executive Committee. **Date of Implementation:** • Non-compliance discussed and corrective actions addressed at the Medical Executive Committee meeting on June 17, 2014.	6/17/2014

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A 458	Continued From page 50 1. During the initial tour with Staff C and Registered Nurse (RN) 3 in the Medical-Surgical Unit of the Culver City campus n March 25, 2014 between 10:55 a.m. and 11;35 a.m., the clinical record for Patient 29 was reviewed and disclosed there was no medical history and physical examination since the patient was admitted on March 18, 2014. 2. During the initial tour with Staff C and RN 4 in the SDU (Step-Down Unit) of the Culver City campus on March 26, 2014 between 11:35 a.m. and 12:20 p.m., the clinical record for Patient 12 was reviewed and disclosed the medical history and physical examination had been transcribed on March 18, 2014 but not authenticated by the physician since admission on March 13, 2014. During the concurrent interview with Staff C, she stated the physicians failed to complete the medical history and physical examination within 24-hours of admission for Patient 12. According to Staff B, the medical history and physical examination for Patient 12 should have been authenticated by the physician for completion. 3. During the initial tour with Staff C and RN 6 in the Telemetry Unit of the Culver City campus on March 26, 2014 between the time of 2:12 p.m. and 3:30 p.m., the clinical record for Patient 33 was reviewed and disclosed there was no medical history and physical examination since the patient was admitted on March 18, 2014. Additionally, the clinical record for Patient 34 was reviewed and disclosed the medical history and physical examination was transcribed on March 5, 2014, but not authenticated by the physician since the patient was admitted on March 5, 2014.	A 458	(Continued from page 50) • Chief of Staff communication dated June 19, 2014. • Monitoring of H&P□s □ongoing • Audit results reported to the hospital□s Quality and Medical Record Committee and Medical Executive Committee □ June 2014 and quarterly as required. **Monitoring Process:** • The HIM Manager and/or designee will conduct monthly audits of patient charts to review for the timely completion of history and physical examinations. • Numerator = Number of history and physical present no more than 30 days prior to admission or 24 hours after admission or registration but prior to surgery / Denominator □ Number of total charts reviewed. • The sample size will be based on monthly discharges, per the following guidelines: o Sample all cases for a population size of fewer than 30 cases o Sample 30 cases for a population size of 30□100 cases o Sample 50 cases for a population size of 101□500 cases o Sample 70 cases for a population size of more than 500 cases • Targeted compliance is 90% • Monitoring activity will commence for a period not to exceed 4 months to ensure that compliance is achieved and sustained. • Random audits will be performed thereafter. • Results of the audits will be reported to the hospital□s Quality and Medical Record Committee and Medical Executive Committee. **Person Responsible:** HIM Administrator and/or designee.	6/19/2014 6/2014

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A 458	Continued From page 51 During the concurrent interview with Staff C, stated the medical history and physical examination for Patient 33 should have been authenticated by the physician for completion. According to the Medical Staff Rules & Regulations approved by the Governing Board on December 4, 2013, Page 32, □14.3 A complete history and physical examination, performed by a qualified physician or by another individual approved for such privilege based on demonstrated competence, within the scope of his/her license, shall be recorded on all patients within 24-hours of admission.□	A 458		
A 467	482.24(c)(2)(vi) CONTENT OF RECORD: ORDERS, NOTES, REPORTS □All records must document the following, as appropriate:□ All practitioner□s orders, nursing notes, reports of treatment, medication records, radiology and laboratory reports, and vital signs and other information necessary to monitor the patient□s condition. This STANDARD is not met as evidenced by: Based on review of electronic and paper clinical record review, staff interviews and review of hospital policies and procedures, the facility failed to ensure that the records of 6 out of 52 sampled patients and one (1) randomly selected patient reviewed contained the appropriate information to monitor the progress and condition of the patients (Patients 8, 9, 10, 11, 12 and 14). This deficient practice had the potential for the patients not able to receive appropriate care.	A 467		

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A 467	Continued From page 52 Findings: 1. Patient 11 was admitted on March 9, 2014 with diagnoses including congestive heart failure, hypertension (high blood pressure), diabetes (a condition in which a person has high blood sugar) and chronic kidney disease (a gradual loss of kidney function). The physician ordered a 1500 to 1800 calorie diet on admission. The physician also ordered a fluid restriction of less than 1500 cubic centiliters (cc) on admission. This order was no transcribed as part of the diet order and so the fluid restriction was not implemented as part of the order until three days after admission on March 12, 2014, when the registered dietitian (RD 1) noticed it as an incomplete order while conducting a nutritional assessment on Patient 11. In between the three days the fluid restriction was no implemented, Patient 11 was ordered Boost, a nutritional supplement, three times a day with meals. He received this in addition to the 2000 cc of fluid which is part of his diet, an additional 7320 cc from three boxes of Boost. Clinical record review showed that Patient 11 was refusing dialysis (treatment that does some of the things healthy kidney does) which would have alleviated the fluid his body was retaining. Laboratory values on March 26, 2014 showed that his kidneys were working well and cleaning out toxins in his body. His blood urea nitrogen was 65 (normal 7 to 20) and creatinine was 5.0 (normal 0.6 □ 1.3). The physician had ordered daily weights also as part of the admission orders but nursing staff	A 467	**CULVER CITY** **1).Corrective Actions:** All nursing staff will be re-educated on proper I & O documentation, obtaining weights and documentation of weights. Super users will notify RNs of any discrepancies. RNs will correct discrepancies. SuperUsers are qualified clinical staff with extensive competencies in electronic clinical documentation. They are available on site 24 hrs. a day/ 7 days a week. **Date of Implementation**: 6-19-2014 with full implementation in 30 days. **Monitoring Process**: Super Users will monitor and collect data on a minimum of 200 charts a month and outcomes will be reported up to the Quality Council on a monthly basis. Any level of non-compliance will be reported to the Nursing Director for immediate corrective action. **Person Responsible:** Clinical Education Coordinator/Informatics	6/19/2014

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A 467	Continued From page 53 failed to weigh the patient. As of March 26, 2014, daily weights had not been completed on Patient 11, seventeen days after the order had been placed. Monitoring the weight is one of the ways a physician could monitor how much fluid the body is retaining. This is of significance because Patient 11 suffered from both congestive heart failure and kidney failure, two conditions in which excessive fluid retention is detrimental. 2. Patient 10 was admitted with diagnoses including decubitus ulcer, sacral and bottom. There were several pictures of the different wounds Patient 10 had but there was no description. There had been orders for a wound consult by the physician however, there was no description of the wounds y the wound consultant. Documentation in the RD notes describes these wounds as Stage III, Stage IV and unstageable wounds. In an interview with Staff 13 (Wound Consultant) on March 26, 2014 via telephone, he stated that the hospital policy was by photographic documentation and the present time no other documentation was being done. Review of the hospital policy titled □Management of Skin Integrity- Care of the Patient□dated August 2010 of which the Wound Consultant was the contributor, did not support his assertions. This policy required under the section □Documentation□specific information to be included. These included location, depth, Stage, drainage, presence of necrotic or non-viable tissue among other documentation. In an interview with a charge nurse on one of the Medical-Surgical floors on March 26, 2014 at approximately 3:00 p.m., she provided a poster	A 467	(Continued from page 53) **2).Corrective Actions:** Documentation by Wound Management team is entered in Physician Progress note section of medical record. This documentation will include stage, location, depth, drainage, presence of necrotic or non-viable tissue, and other descriptors as relevant to the specific wounds and follow up notes will be done as needed. Treatment recommendations entered in CPOE are also described in progress note. **Date of Implementation:** 6/13/2014 **Monitoring Process**: Wound Management Team Member to audit wound care progress note on 30 wound records. Any issue of non-adherence will be addressed to the individual staff and referred to Quality department for further intervention as necessary including education and progressive disciplinary action**.** **Person Responsible**: Wound Care Management team	6/13/2014

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A 467	Continued From page 54 titled □Documentation of Pressure Ulcer Care□ that outlined in detail what documentation was required for pressure ulcer care. The information contradicted the information provided the Wound Consultant. The hospital failed to ensure that all information necessary to assess the care of a patient with pressure ulcer was properly documented. 3. Patient 12 was admitted with diagnosis including pneumonia (an infection in the lungs) and hypoxia (a low level of oxygen in tissues and blood). Electronic medical record review was conducted on March 26, 2014 beginning at 2 p.m. Admission diet order dated March 13, 2014 was a cardiac diet. A physician□s order dated March 24, 2012 was for tube feeding through a nasogastric tube (tube through the nose inserted in the stomach for feeding) with Diabetasource (a supplement for patients with diabetes) at a rate of 20 cc (cubic centiliter)/hour. A follow up order dated March 26, 2014 requested water via the NG tube, 150 cc (a metric unit of measure) every 6 hours. The tube feeding was ordered on March 24, 2014, at 3 p.m. An observation of the tube feeding was conducted on March 26, 2014 at 3:00 p.m. It was noted that the tube feeding pump was off. It was also noted that the feeding bad or the tubing was not dated and/or labeled; the volume in the bag at the time of hanging was 1,000 cc and there was approximately 300 cc left. It was also noted that a new bag of Diabetasource was lying on the patient□s bedside table. In a concurrent interview with the director of food services (Staff 3), she stated that the dietary department sent up tube feedings every day at lunch that included labels which were intended to be placed on the tube	A 467	(Continued from page 54) **3).Corrective Actions:** Policy VAS.005 and Policy PAT.057. Re-educate nursing staff: All Feeding bags, IV bags and all tubing must be labeled date and timed and initialed. Hands on competencies for clinical areas that have feeding pump utilization to include pump set up, settings, steps to clearing pump, documentation of amounts provided to patient. Return demonstration will be required to demonstrate competency. **Date of implementation:** 8/16/2014 full implementation **Monitoring Process:** Nursing Leadership from each department will monitor proper labeling of IV bags, Feeding bags and all tubing. Audit of feeding pump settings. Data will be collected on a 30 random patients a month and reported to the Quality Council on a monthly basis. Any level of non-compliance will be reported to the Nursing Director for immediate corrective action. **Person Responsible:** Unit Nursing Director	8/16/2014

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A 467	Continued From page 55 feeding when it was hung. In an interview with RN 17, she stated that she reset the pump at 12 p.m. (3 hours prior). She also stated that she cleared the pump at 12 p.m. and turned the pump off shortly before 3 p.m. to provide personal care and probably forgot to turn it back on. Review of medical record document titled □Daily Assessment Inquiry□dated March 24, 2014 at 8 p.m. was the first time that the tube feeding was noted; however there was no documentation in the electronic medical record when the feeding was actually hung. It was also noted that the actual amount of feeding that was being delivered was not accurately recorded and/or the documentation noted the physician□s order of 20cc/hour. For example on March 26, 2014 at 6 a.m. the amount of tube feeding delivered was recorded as 240cc. Follow up documentation dated March 26, 2014 at 12 p.m., noted an entry of 200 cc. If the feeding was running per the physician□s order, the pump should have read either 360 cc (if the pump was not cleared at the 6am entry) or 120 cc for the 12 p.m. entry rather than the documented 200 cc. In an interview on March 24, 2014 at 2:15 p.m., RN 17 was unable to explain the discrepancy. In a concurrent interview with Staff 3, she acknowledged that the feeding was not likely delivered per the physician□s order. 4. Patient 9 was admitted with diagnoses including anemia (low blood iron), insulin dependent diabetes, sacral decubitus, (open sore on the top of the upper buttocks), end stage renal disease (the kidneys are not able to work at a	A 467	(continued from page 55) **4).Corrective Actions:** (Patient □9) Documentation by Wound Management team is entered in Physician Progress note section of medical record. This documentation will include stage, location, depth, drainage, presence of necrotic or non-viable tissue, and other descriptors as relevant to the specific wounds and follow up notes will be done as needed. Treatment recommendations entered in CPOE are also described in progress note.	

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(□4) ID PREFI□ TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFI□ TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(□5) COMPLETION DATE
A 467	Continued From page 56 level for day □ to day life) with dialysis. Electronic record review showed on March 24, 2014 at 12:25 a.m., there was an order for Novasource Renal, (a specialized feeding for patients with kidney disease) Give 20 milliliters (ml)/hour via PEG (percutaneous endoscopic gastrostomy tube). There were additional instructions □every evening hours.□ RN 18 stated in an interview at approximately 5:45 p.m. on March 24, 2014, on the definition of □evening hours□was 7 p.m. to 7 a.m. The hospital staff was not able to provide evidence as to the definition of evening hours. Inspection of the tube feeding at approximately 5:50 p.m. showed a feeding bag hung in the patient□s room with approximately 150 ml of a light brown colored liquid left in the bag. The tube feeding bag had a blue colored cap which indicated that the tube feeding was poured into the bag. The bag was dated □March 24, 2014□, it was not timed. It could not be determined how long the bag had been hung and how much Patient 9 had received. Review of electronic record flow sheets for March 23, 2014 at 6:30 a.m. showed 120 cc was given to the patient. There was additional documentation for 0700 shift, 120 cc was entered as total. Based on the time the order was written on March 23, 2014 and the definition of evening hours by the RN, Patient 9 should have received a total of between 120 and 140 cc on March 23, 2014 by 6:30 a.m. and no feeding for the 0700 shift. Nursing staff failed to accurately document what care it had provided.	A 467	(Continued from page 56) **Date of Implementation:** 6/13/2014 **Monitoring Process:** Wound Management Team Member to audit wound care progress note on 30 wound records. Any issue of non-adherence will be addressed to the individual staff and referred to Quality department for further intervention as necessary including education and progressive disciplinary action. **Person Responsible:** Wound Care Management team	6/13/2014

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	050135	G. BUILDING **01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD** H. WING _____	**04/01/2014**

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A 467	Continued From page 57 There was no description for the wound on Patient 9. There were pictures but no other information on size, staging, depth and other pertinent information that would be valuable to other professionals providing care to this Patient. According to the hospital policy titled, □Management of Skin Integrity □ Care of the Patient□dated August 2010 □skin integrity, assessment and treatment is an interdisciplinary responsibility.□The physician, registered nurse, physical therapist, food and nutrition, case managers and home health staff were listed as responsible for the care of the patient with pressure ulcer. The lack of adequate documentation would prevent these other professionals from providing adequate care for the patient. 5. Patient 8 was admitted with diagnoses including diabetes mellitus, hypertension (high blood pressure) and asthma. Review of admitting orders revealed that there was no order for his diet. Electronic record review on March 27, 2014 revealed that an order was entered for a No Added Salt later than evening by one of the nurses. RN 20 stated that she received an order but was not sure if the verbal order had been faxed to the physician for authentication as it is customary to do with medical orders. There was no documented evidence that the nurse had called the physician to receive a diet order. Comments made by other unidentified nurses on the unit revealed that they use information on diet orders from previous admission to determine diet orders when physicians do not add diet orders. There was no telephone order authentication by the admitting physician either in the electronic	A 467	(Continued from page 57) **5).Corrective Actions**: All nursing staff re-educated with self-study module to validate that physician orders have been noted, examined, and verified. Caregivers must use SBAR and provide the opportunity to use read-back techniques and medications orders received must be read back by the receiver. 24 hour order/chart check policy & procedure PAT.059 implemented that mandates documentation of chart review before 7am each day. **Date of Implementation:** 5/18/2014 **Monitoring Process**: Random audit of 30 charts will be done per nursing unit. **Person Responsible:** Nursing Leadership	5/18/2014

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A 467	Continued From page 58 paper record. According to the Hospital policy titled □telephone and verbal orders□dated July 2004, states □Telephone orders are to be written and read back too physicians to clarify.□ 6. Review of the hospital Diet report for March 26, 2014, showed height and weight information on several patients (sampled and randomly selected) that were inaccurate and unrealistic. For example, Patient 10□s weight was entered as 2615 pounds, Patient 9□s height was documented as 66 centimeters (cm) or 2 feet 2 inches. A randomly selected patient□s height was similarly entered as 67 cm or 2 feet 6 inches. All of these patients were adults with no history of amputation. Information on height and weight is valuable to examine response to therapy and administration of medication. The facility failed to ensure that documented information was accurate. 7. On March 27, 2014, at 9 a.m., Patient 14□s medical record was reviewed. The verbal physician order dated March 7, 2014, indicated to transfuse one unit of packed red blood cells. The consent form dated March 7, 2014, indicated the patient had signed the consent. On the same day, the patient received the blood transfusion. Further review of the transfusion record failed to indicate documentation that the section on the suspected transfusion reaction was checked. During a concurrent interview RN 12 stated the section on suspected transfusion reaction of the	A 467	(Continued from page 58) **6).Corrective Actions:** Re-education of all nursing staff on timely and accurate collection and documentation of patient height and weights in accordance to hospital policies and physician orders. Evaluation performed regarding ability to implement critical value settings in electronic medical record for Heights and Weights. This feature is currently NOT available but this will be reviewed during system upgrades. **Date of Implementation:** 6/20/2014 with completion over next 30 days. **Monitoring Process:** Data will be collected on a 30 random patients a month and reported to the Quality Council on a monthly basis. Any level of non-compliance will be reported to the Nursing Director for immediate corrective action. **Person Responsible**: Nursing Leadership **7). Corrective Actions:** The blood bank section implemented a new process in which all blood transfusion form are to be returned to Blood bank within 4 hours of completion of transfusion. The forms are to be delivered and brought down to the Blood bank department by the charge nurse for the patient that had been transfused. This is to be presented to the CLS on duty in Blood bank and is to be inspected on the spot by both lab and nursing. **Date of Implementation:** 5/16/2014 **Monitoring Process:** Weekly **Person Responsible:** Lab supervisor; Lab Director	6/20/2014 5/16/2014

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A 467	Continued From page 59 transfusion record should have been filled out.	A 467		
A 468	482.24(c)(2)(vii) CONTENT OF RECORD: DISCHARGE SUMMARY □All records must document the following, as appropriate:□ Discharge summary with outcome of hospitalization, disposition of care and provisions for follow-up care. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the discharge summary with outcome of hospitalization, disposition of case, and provision for follow-up care, was completed for 1 of 52 sampled patients (Patient 43). This deficient practice had the potential for not assuring proper continuity of care. Findings: A review of the closed record on March 27, 2014 with Staff B indicate Patient 43 was admitted to the facility on November 19, 2013, and discharged on December 3, 203. A review of the closed record revealed there was no documentation the discharge summary with outcome of hospitalization, disposition of the case, and provision for follow-up care was completed by the physician as of March 28, 2014. During the interview with Staff B on March 28, 2014 at 9:15 a.m., she stated the discharge summary with outcome of hospitalization, disposition of the case, and provision for follow-up care, had not been complete by the	A 468	**All Three Campuses** **1-3 Corrective Actions:** • Non-compliance discussed and corrective actions addressed at the Medical Executive Committee (MEC). • The Chief of Staff issued a memo, dated June 19, 2014, to All Medical and Allied Staff Members to serve as a reminder notice that pursuant to the Medical Staff Rules and Regulations that a Discharge Summary with outcome of hospitalization, disposition or care and provisions for follow-up care shall be provided by the responsible practitioner and completed within fourteen (14) days after the patient□s discharge. The memo further stated that Medical Staff will be uncompromising in enforcing suspension that result from incomplete and/or delinquent medical records • Medical Staff leadership will continue to monitor progress and work with Administration to improve compliance with documentation standards. • Audit results reported to the hospital□s Quality and Medical Record Committee and Medical Executive Committee. **Date of Implementation:** • Non-compliance discussed and corrective actions addressed at the Medical Executive Committee meeting on June 17, 2014. • Chief of Staff communication dated June 19, 2014. • Monitoring of completion of Discharge Summaries □ ongoing • Audit results reported to the hospital□s Quality and Medical Record Committee and Medical Executive Committee □ June 2014 and quarterly as required. **Monitoring Process:** • The HIM Manager and/or designee will conduct monthly audits of patient charts to review for the timely completion of Discharge Summaries. • Numerator = Number of discharge summaries completed within 14 days / Denominator □ Total number of discharged charts reviewed. • The sample size will be based on monthly discharges, per the following guidelines: o Sample all cases for a population size of fewer than 30 cases	6/17/2014 6/19/2014 6/2014

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A 468	Continued From page 60 physician. According to the Medical Staff Rules & Regulations approved by the Governing Board on December 4, 2013, page 34, 14.18 Completion of the Record, 14.18.1 □In accordance with regulatory standards, medical records shall be completed within two (2) weeks following the patient□s discharge.---□	A 468	(Continued from page 60) o Sample 30 cases for a population size of 30□100 cases o Sample 50 cases for a population size of 101□500 cases o Sample 70 cases for a population size of more than 500 cases • Targeted compliance is 90% • Monitoring activity will commence for a period not to exceed 4 months to ensure that compliance is achieved and sustained. • Random audits will be performed thereafter. • Results of the audits will be reported to the hospital□s Quality and Medical Record Committee and Medical Executive Committee. **Person Responsible:** HIM Administrator and/or designee	
A 490	482.25 PHARMACEUTICAL SERVICES The hospital must have pharmaceutical services that meet the needs of the patients. The institution must have a pharmacy directed by a registered pharmacist or a drug storage area under competent supervision. The medical staff is responsible for developing policies and procedures that minimize drug errors. This function may be delegated to the hospital□s organized pharmaceutical service. This CONDITION is not met as evidenced by: Based on observations, interviews, and records review, the facility failed to ensure and provide services that meet the needs of its patients. The facility failed to meet Condition of Participation for Pharmaceutical Services by failing: 1. Properly label the drawers of the CCU and ICU crash carts. (Hollywood campus) (Refer to A 0500). 2. Properly label three tubes of external ointment found in an open tray of the crash carts (Hollywood campus) (Refer to A 0500). 3. Ensure the ICU Crash Cart Contents Log was readily available. (Hollywood campus) (Refer to A	A 490	**HOLLYWOOD** **1). Corrective Actions:** Standardize all crash carts to include appropriate labels on each drawer with corresponding items and to include list of medications on the drawer. **Date of Implementation:** Will be completed in 30 days, expected date July 17, 2014 **Monitoring Process:** Monitoring will be managed by daily crash cart checks, monthly review by pharmacy and as needed during crash cart exchange **Person Responsible**: Pharmacy and Nursing Leadership in each department **2). Corrective Actions:** Standardize all crash carts, place lubricating jelly inside the drawer with the appropriate labels on each drawer and with all corresponding items. April 21-23, 2014 Education provided included review of policy PHA.052 Preparing and Administration of Medications; any unlabeled medication must not be used. Pharmacy will label all medications. **Date of Implementation:** Target date of completion in 30 days July 17, 2014. **Monitoring Process:** Monitoring will be managed by daily crash cart checks, monthly review by pharmacy and as needed during crash cart exchange. **Person Responsible:** Pharmacy and Nursing Leadership in each department. **3). Corrective Actions:** Standardize all crash carts to include appropriate labels on each drawer with corresponding items and to include list of medications on the drawer. April 21-23, 2014 education provided included review of policy PAT.058 Crash cart and crash cart checks to include presence of crash cart logs on corresponding cart **Date of Implementation:** Target date of completion will be in 30 days July 17, 2014 **Monitoring Process:** Monitoring will be managed by daily crash cart checks, monthly review by pharmacy and as needed during crash cart exchange **Person Responsible:** Pharmacy Department and Nursing Leadership in each department	7/17/2014 7/17/2014 4/21/2014 7/17/2014

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A 490	Continued From page 61 0500). 4. Ensure all components of a specialized emergency supply for the treatment of malignant hyperthermia are immediately accessible. (Culver City campus) (Refer to A 0500). 5. Ensure its patient would not receive medication or supplement that was not prescribed by the physician (Culver City) (Refer to A 0500). 6. Implement its policy and procedures for the use of a single-dose single-use ampule/vial (Culver City campus) (Refer to A 0500). 7. Ensure all medication orders in the Emergency Department be reviewed or verified by a pharmacist for therapeutic appropriateness prior to administration or at least retrospectively in cases of life-threatening emergency (Culver City campus) (Refer to A 0500). 8. Implement its policy and procedure on the safeguard of lock codes to a medication room (Hollywood campus) (Refer to A 0502). 9. Ensure drug storage areas are accessible only to authorized facility staff (Hollywood campus) (Refer to A 0502). 10. Ensure outdated medication in the refrigerator was not available for patient use (Van Nuy campus) (Refer to A 0505). The cumulative effect of these systemic issues resulted in the facility□s inability ensure and provide a safe patient care environment.	A 490	(Continued from page 61) **CULVER CITY** **4.) Corrective Actions:** Ensure all components of a specialized emergency supply for the treatment of malignant hyperthermia are immediately accessible. Malignant hyperthermia kit contents will be added to the monthly Pharmacist Unit Inspection. The malignant hyperthermia items that are refrigerated will be packaged in a kit labeled □Malignant Hyperthermia□and stored in the appropriate refrigerator. **Date of Implementation**: Completed 6/17/14 **Monitoring Process:** Malignant hyperthermia kit will be checked during monthly unit inspections per P&Ps **Person Responsible:** VP of Pharmacy or designee **5).Corrective Actions**: All nursing staff re-educated to validate that physician orders have been noted, examined, and verified. Caregivers must use SBAR and provide the opportunity to use read-back techniques and medications orders received must be read back by the receiver. **Date of Implementation:** 5/18/2014 **Monitoring Process:** Random audit of 30 charts will be done per nursing unit aggregated data will be sent to the Quality Dept, non-compliance will result in progressive discipline actions. **Person Responsible**: Nursing Leadership **6).Corrective Actions:** Implement its policy and procedure □Medication: Care & Handling□SAN.019 for use of single dose vials. Policy revised to be clear on the use of single dose vials. Policy will be sent to medical staff. **Date of Implementation:** July 1st 2014 **Monitoring Process:** DOP or designee will review anesthesia cart sheets, and will check that the SDVs are being used one time only. Any violations will be reported the Quality Counsel. **Person Responsible:** VP of Pharmacy or designee **7).Corrective Actions:** Ensure all medication orders in the Emergency Department be reviewed or verified by the pharmacist for therapeutic appropriateness prior to administration or at least retrospectively in case of life threatening emergency. All ED medication orders will be reviewed by a pharmacist prior to administration, with the exception of emergency medications, in which the orders will be reviewed retrospectively. Emergency medications will be defined as those that are time critical according to hospital P&Ps. These include antibiotics, IV seizure medications, pain medications and other emergency stat medications. Drugs not deemed as non-emergency medication will not be overridable in the automated drug dispensing machine. (ADM) **Date of Implementation:** July 1st 2014 **Monitoring Process:** DOP or designee will review the overridden medications retrospectively for appropriateness. Results will be reported to Quality Counsel. **Person Responsible**: VP of Pharmacy or designee **HOLLYWOOD** **8-9). Corrective Actions**: Inspected all medication rooms to ensure no codes are written on walls, doors and no signs posted indicating the code number for entry. 3rd floor medication room door entry re-painted and signs removed. Plans to change medication room access with ID badge reader to ensure only authorized personnel will have access to med room. Education provided to include review of policy, medication room access by authorized personnel and room to remain closed at all times **Date of Implementation:** April 21- 23, 2014 **Monitoring Process:** Monitoring will be managed through daily nursing rounds and to include in EOC rounds **Person Responsible:** Nursing Leadership in each department, EOC members, ENG, HR, pharmacy **VAN NUYS** **10).Corrective Actions:** Ensure outdated medication in the refrigerator was not available for patient use. All multiple dose vials will be checked in the Pharmacist Monthly Unit Inspection. At the end of the month all MDVs will be replaced. **Date of Implementation:** 7/1/2014 **Monitoring Process:** MDVs will be checked upon Pharmacist Monthly unit inspection. Any discrepancies will be reported to Quality Counsel. **Person Responsible:** VP of Pharmacy or designee	6/17/2014 5/18/2014 7/1/2014 7/1/2014 4/21/2014 7/1/2014
A 500	482.25(b) DELIVERY OF DRUGS	A 500		

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A 500	Continued From page 62 In order to provide patient safety, drugs and biologicals must be controlled and distributed in accordance with applicable standards of practice, consistent with Federal and State law. This STANDARD is not met as evidenced by: Based on observations, interviews and records review, the facility failed to: 1. Properly label the drawers of the CCU and ICU crash carts (Hollywood campus). This deficient practice had the potential for not easily accessing emergency drugs and equipment that are used to treat a person□s medical emergency. 2. Properly label three tubes of external ointment found in an open tray of the crash carts (Hollywood campus). This deficient practice had the potential for the staff to use unlabeled ointments to the patients. 3. Ensure the ICU Crash Cart Contents Log was readily available (Hollywood campus). This deficient practice had the potential for administering the cleaner and supplies for the treatment of Patient 24□s wound which may not be inaccordance with the physician□s order. 4. Ensure all components of a specialized emergency supply for the treatment of Malignant Hyperthermia are immediately accessible (Culver City campus). This deficient practice could result in not providing appropriate interventions for managing the patient with malignant hyperthermia, a deadly adverse outcome. 5. Ensure its patient would not receive medication or supplement that was not prescribed by the	A 500	**Hollywood** **1). Corrective Actions:** Standardize all crash carts, to ensure appropriate label outside the drawers with corresponding items listed **Date of Implementation:** Target date of completion in 30 days July 17, 2014 **Monitoring Process:** Monitoring will be managed through daily crash cart checks, monthly review by pharmacy and as needed during crash cart exchange **Person Responsible:** Pharmacy and Nursing Leadership in each department **2). Corrective Actions:** Standardize all crash carts, place lubricating jelly inside and all meds and all corresponding items in the drawer with the appropriate label outside the drawer. April 21-23, 2014 education provided included review of policy PHA.052 Preparing and Administration of Medications; any unlabeled medication must not be used and discarded. Pharmacy will label all medications **(see Addendum 30, 30a).** **Date of Implementation:** Label of meds implemented immediately by pharmacy, Target date of completion for crash cart standardization in 30 days July 17, 2014 Monitoring Process: Monitoring will be managed through daily crash cart checks, monthly review by pharmacy and as needed during crash cart exchange **Person Responsible:** Pharmacy and Nursing Leadership in each department **3). Corrective Actions:** Standardize all crash carts to include appropriate labels on each drawer with corresponding items and to include list of medications April 21-23, 2014 education provided included review of policy PAT.058 Crash cart and crash cart checks to include presence of crash cart logs on corresponding cart **(see Addendum 30, 30a).** **Date of Implementation:** Target date of completion will be in 30 days July 17, 2014 **Monitoring Process:** Monitoring will be managed through daily crash cart checks, monthly review by pharmacy and as needed during crash cart exchange	7/17/2014 7/17/2014 7/17/2014

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A 500	Continued From page 63 physician (Culver City campus). This deficient practice resulted in the patient receiving 2 doses of □inc Sulfate (dietary supplement) that not ordered by the physician and did not promote safety in the patient□s medication therapy. 6. Follow its policy and procedures for the use of a single-dose single-use ampule/vial (Culver City campus). 7. Ensure all medication orders in the Emergency Department be reviewed or verified by a pharmacist for therapeutic appropriateness prior to administration or at least retrospectively in cases of life-threatening emergency. This deficient practice had the potential to result in adverse drug events. Findings: 1. On March 27, 2014 at 12:53 p.m. on the third floor, the contents of drawers 2, 3, 4 and 6 of the CCU Crash Cart did not match the label affixed to the exterior of each drawer. A review of the facility□s policy and procedure, titled □Crash Cart,□Number: PAT.058, dated 11/2012, indicated □□ the pharmacist shall check the drug and IV contents □ and apply a label to the outside of the cart □ A list of the crash cart medications □ shall be kept on the outside of the cart □ □ 2. On March 27, 2014 at 12:59 p.m., on the third floor, the surveyor observed and identified two used, unlabeled 4-ounce tubes of lubricating jelly in the external open side tray of the CCU Crash Cart; one used, unlabeled 4-ounce tube of	A 500	(Continued from page 63) **Person Responsible:** Pharmacy and Nursing Leadership in each department **Culver City** **4) Corrective Actions:** Ensure all components of a specialized emergency supply for the treatment of malignant hyperthermia are immediately accessible. Malignant hyperthermia kit contents will be added to the monthly Pharmacist Unit Inspection. The malignant hyperthermia items that are refrigerated will be packaged in a kit labeled □Malignant Hyperthermia□ and stored in the appropriate refrigerator. (P&P attached). In addition, Policy SAN.018 has been revised to include the Malignant Hyperthermia cart monthly check will include checking the refrigerated medications for Malignant Hyperthermia**. (see Addendums 31, 31a, 31b)** A designated area in the OR refrigerator has been labeled □IV Normal saline for malignant hyperthermia. **Date of Implementation:** Completed 6/17/14, July 14, 2014 Revised Policy to be submitted to the Surgery and Anesthesia Committee Meeting for approval process. **Monitoring Process:** The Director of Perioperative Services and/or designee will conduct monthly monitoring activity to include the verification of the refrigerated IV Normal Saline as a part of the routine check of the Malignant Hyperthermia cart. Compliance data will be reported to the Medication Safety Committee and the Quality Council on a quarterly basis until optimal compliance is achieved. In addition, malignant hyperthermia kit will be checked during monthly unit inspections per P&Ps **(see Addendum 31, 31a)** **Person Responsible:** Director Perioperative Services, Director of Pharmacy **5).Corrective Actions:** All nursing staff re-educated to validate that physician orders have been noted, examined, and verified. Caregivers must use SBAR and provide the opportunity to use read-back techniques and medications orders received must be read back by the receiver **Date of Implementation:** 5/18/2014	7/14/2014 5/18/2014

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A 500	Continued From page 64 lubricating jelly in the external open side tray of the ICU Crash Cart. A review of the facility□s policy and procedure, titled, □Preparing and Administration of Medication□, Number; PHA.052, dated □02/2012□, indicated □□ An unlabeled medication must never be used □ □ 3. On March 27, 2014 at 12:59 p.m., on the third floor, Nurse 1 failed to located the ICU Crash Cart Contents Log that would disclose the contents of the crash cart. A review of the facility□s policy and procedure, titled □Crash Cart,□Number: PAT.058, dated 11/2012, indicated □□ A list of the crash cart medications□ shall be kept on the outside of the cart□ □ 4. Malignant hyperthermia (MH) is a rare but potentially lethal adverse effect of a commonly used general anesthetic gases and succinylcholine; succinylcholine is a muscle relaxant used by physicians during emergency procedure to insert artificial airways □intubation□ into patients with extreme difficulty in breathing. A defined list of supply has been published by the Malignant Hyperthermia Association of the United States (MHAUS) and the Association of Peri-Operative Registered Nurses (AORN), two nationally recognized organizations that set standards of care for this rare but deadly adverse medical outcome. On March 25, 2014, at 11 a.m., in the surgery department, both the director of peri-operative services (Staff J) and the chief nursing officer (Staff F) confirmed that there was no iced saline	A 500	(Continued from page 64) **Monitoring Process:** Random audit of 30 charts will be done per nursing unit **Person Responsible:** Nursing Leadership **6).Corrective Actions**: Implement its policy and procedure for use of single dose vials. Policy revised to be clear on the use of single dose vials. Policy will be sent to medical staff. **Date of Implementation:** July 1st 2014, Policy revised 5/5/2014, Revised Policy will be submitted through committee approval process. **Monitoring Process:** DOP or designee will review anesthesia cart sheets, and will check that the SDVs are being used one time only. Any violations will be reported the Quality Counsel. Anesthesiologists will be re-educated on the appropriate use of single use/dose vials. The hospital□s Anesthesia policy Medication, Care and Handling Number: SAN.019 policy will be revised to include the following statement: Medications labeled as □single dose□or □single use□is meant for use in a single patient for a single case/procedure/injection; because they typically lack antimicrobial preservative **(see Addendum 32).** **Person Responsible:** VP of Pharmacy or designee, Director Perioperative Services, Director of Anesthesia, and Director of Infection Prevention **7).Corrective Actions:** All ED medication orders will be reviewed by a pharmacist prior to administration, with the exception of emergency medications, in which the orders will be reviewed retrospectively. Emergency medications will be defined as those that are time critical according to hospital P&Ps. These include antibiotics, IV seizure medications, pain medications and other emergency stat medications. Drugs not deemed as non-emergency medication will not be overridable in the automated drug dispensing machine. **Date of Implementation:** July 1st 2014 **Monitoring Process:** DOP or designee will review the overridden medications retrospectively for appropriateness. Results will be reported to Quality Counsel.	7/1/2014 7/1/2014

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	050135	I. BUILDING **01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD** J. WING _____	**04/01/2014**

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SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	**6245 DE LONGPRE AVE** **HOLLYWOOD, CA 90028**

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A 500	Continued From page 65 available as part of the emergency supply for the treatment of Malignant Hyperthermia. On March 25, 2014 at 2:45 p.m. in the Emergency Room, during an interview, the director of the emergency room and one emergency staff (Staff N) indicated that they did not have the required iced saline (sodium chloride 0.9%) bags for the Malignant Hyperthermia kit. On March 25, 2014 at 2:50 p.m. in the emergency room, the clinical pharmacist (Rx 4) stated that the saline for the Malignant Hyperthermia cart would be provided by the central supply. According to the facility policy, titled □Malignant Hyperthermia Cart,□Number: PHA.090; dated □10/2012,□the MH kit should include □Sodium Chloride 0.9% 2 liters (refrigerator).□The same policy also delineated the treatment regimen include initiate cooling with IV (intravenously administered) iced saline solution at a rate of 1000 ml (milliliter) per 10 min (minute) for 30 minutes, which indicates at least three bags of iced saline should be available. According to the facility policy, titled □Malignant Hyperthermia,□Number: SAN.018, dated □11/2012,□ the facility should have iced IV saline immediately available. Both policies listed MHAUS as reference. 5. On March 26, 2014 at 9:30 a.m. in the Telemetry Unit, a surveyor observed a medication pass for one patient, Patient 7. The surveyor observed that the Patient 7 received one tablet of the dietary supplement □inc Sulfate 220 mg but could not locate the physician□s order in the	A 500	(Continued from page 65) **Person Responsible:** VP of Pharmacy or designee	

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A 500	Continued From page 66 patient□s chart. On March 25, 2014 at 10:45 a.m., Rx 3 confirmed he did not find the □inc Sulfate order in the Patient 7□s chart. On March 26, 2014 at 11 a.m., Rx 1 could not find the □inc Sulfate order in the Patient 7□s chart. A review of the Nutrition Recommendation Form for Patient 7 dated March 25, 2014 at 8:16 a.m. indicated a handwritten check mark in the check box for □Vitamins and Minerals□and another handwritten check mark in the check box for □Multivitamin mineral 1 tablet PO (orally) daily.□However, there was no marking by the check box for □□inc Sulfate 220 mg.□ A review of the fax copy of the □Nutrition Recommendation Form□dated March 24, 2014 at 1:05 p.m., indicated the pharmacy received the order on March 25, 2014 at 8:16 a.m. when the pharmacy received the order. A review of the electronic Medication Administration Record (eMAR) for March 25, 2014, the day before, indicated that Patient 7 received one □inc Sulfate 220 mg tablet on March 25, 2014 at 9 a.m. As of the medication pass observed on March 26, 2014 at 9:30 a.m., a total of two doses of □inc Sulfate 220 mg tablets were given to Patient 7. On March 26, 2014 at 11:23 a.m., an interview with (Pharmacist 1) indicated that a staff pharmacist misread the Nutrition Recommendation form as that □inc Sulfate being included because of the long handwritten check	A 500		

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A 500	Continued From page 67 mark for the multivitamin with mineral, which was located directly above it on the pre-printed Nutrition Recommendation Form. At 1:42 p.m., Pharmacist 1 stated that there was no policy and procedure for the chart check process performed by the nursing staff that would verify eMAR with actual physician orders. At 1:49 p.m. during an interview, RN 10 described the process for the 12 hour chart check performed at shift change. The nruses performing the chart check would receive a report from a □supervising nurse,□they would then confirm physician orders the chart with eMAR and would verify in computer program. She stated □This is a routine protocol.□She also described the 12 hour nursing shifts as 7 a.m. to 7 p.m. and 7 p.m. to 7 a.m. On March 28, 2014 at 11:53 a.m., during a follow-up interview, RN 10 stated that the nurses responsible for their patients should have caught the medication entry error during the chart check process. A review of the policy and procedure titled, □Drug Distribution and Control□, Number: PHA.025 dated □10/2012□, indicated □□ The Pharmacy department shall distribute medication and control the use of medication as follow: □ Review all medications orders for appropriateness and safety with respect to the current medication profile □ □ A review of the policy and procedure titled, □Hand Off Communications,□Number: PAT.043, dated □11/2012□, indicated □□ A □hand off□ communication is an interactive process of	A 500		

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A 500	Continued From page 68 passing patient-specific information from one caregivers to another or from one team of caregivers to another for the purpose of ensuring the continuity and safety of the patient□s care□ This provides the caregivers an opportunity to verify information by using read-back techniques. Critical test results and medication orders received shall be read back by the receiver. The occurrence of the read back shall be documented in the medical record.□ 6. On March 24, 2014 at 11:29 a.m., a review of the Anesthesia Controlled Drug Record, dated □March 18, 19, 19 and 21, 2014□indicated that a Fentanyl 250 mg per 5 milliliter (ml) ampule was used for two different patients, that half of the content was used for Patient 3, marked as □0.5□and half the content was used for Patient 2, marked as □0.5.□The inventory count indicated the beginning count of 10 ampules and the ending balance of 9 ampules. The Anesthesia Record dated March 19, 2014 for Patient 3 showed that the Anesthesiologist administered Fentanyl 100 micrograms (mcg) at approximately 10:15 a.m. and 25 mcg at approximately 11:15 a.m., total 125 mcg. The Anesthesia Record dated March 19, 2014 for Patient 2 showed that the same Anesthesiologist administered Fentanyl 50 mcg at approximately 11:45 a.m. and 75 mcg at approximately 12:15 p.m., total 125 mcg. The manufacturer□s package insert indicated □Fentanyl Citrate Injection□ is preservative-free and available as □ 5 ml Single Dose ampules.	A 500		

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A 500	Continued From page 69 On March 25, 2014, at 11:36 a.m., the DOP confirmed those fentanyl ampules are single-use and should not be shared between patients. On March 28, 2014 at 11:20 a.m., during an interview, when the surveyor showed the Anesthesia Controlled Drug Record and the use of the single dose ampule on two different patients to the Director of Infection Prevention and Control, she responded □What does this have to do with me□□ On March 28, 2014 at 11:25 a.m. during an interview, the facility contracted Hospital Epidemiologist (Staff P) stated the single use ampule is not to be used for more than one patient. On March 28, 2014 at 12:45 p.m., a review of the facility policy and procedure titled □Medication, Care and Handling,□Number: SAN.019, dated □11/2012□, indicated □□ Each patient is medicated with either single dose or multiple dose vials. The remainder of each of the multi-dose vial is discarded after each patient.□When the surveyor asked Rx 1 (Pharmacist 1) to clarify this policy, she stated the policy should read □The remainder of each of the single dose vial is discarded after each patient.□ A review of the policy and procedure titled □Handling of Multidose/Single Dose Vials and IV Compounding (Low Risk Condition) Outside Laminar Flow Hood□, Number: PHA.090, dated □10/2012□indicated □□ Single Dose vials/ampoules should be discarded soon after opening and not stored□ Opened single dose ampoules hsall not be stored for any time period	A 500		

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A 500	Continued From page 70 □ □ 7. On March 25, 2014, at 10:15 a.m., during an discussion of the medication process, Rx 3 (Pharmacist 3) stated the pharmacy department does not review or reconcile medication removal report from the automated dispensing cabinet (ADC) located in the emergency department. At 3:15 p.m., Rx 3 also stated the pharmacy department does not regularly review the medication orders prescribed in the emergency room for therapeutic appropriateness. The department received an unknown percentage of those orders but not all. The pharmacy would receive orders for medications that were not stocked in the ADC located in the emergency room. On March 26, 2014, at 9:30 p.m., during another discussion, Rx 3 stated the current computer system does not have the capability to tally or report the physician orders prescribed in the emergency room. Rx 3 could not find out how many prescriptions had been sent to the pharmacy for verification. According to a nationally recognized professional association, American Society of Health-System Pharmacists (ASHP, which published numerous authoritative guidelines in pharmacy practice referred by the industry as the standard of practices), the guideline titled □Minimum Standard for Pharmacies in Hospitals□, dated 4/13/2012, indicated □All medication orders shall be prospectively reviewed by a pharmacist and assessed in relation to pertinent patient and clinical information before the first dose is administered or made available in an automated	A 500		

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A 500	Continued From page 71 dispensing device, except in emergent situation.. There shall be a procedure for retrospective review of these orders.□The guideline further suggested □use of □ADC□shall be structured so as to not hinder the pharmacist□s review of (and opportunity to intervene in) medication orders before the administration of first doses □ □ According to the facility policy, titled □Drug Distribution and Control,□Number: PHA.025, dated □10/2012□, □.The pharmacy department shall□ review all medications orders for appropriateness and safety with respect to the current medication profile.	A 500		
A 502	482.25(b)(2)(i) SECURE STORAGE All drugs and biologicals must be kept in a secure area, and locked when appropriate. This STANDARD is not met as evidenced by: Based on observations, interviews and documents review, the facility failed to: 1. Implement its policy and procedure on the safeguard of lock codes to a medication room (Hollywood campus). 2. Ensure drug storage areas are accessible only to authorized facility staff (Hollywood campus). These deficient practices had the potential for unauthorized persons access to drugs and intravenous solution in the facility□s medication room and drug storage room. Findings: 1. On March 27, 2014 at 1:05 p.m. on the third floor, the surveyors observed the Head nurse of the ICU punching in the lock code for the	A 502	**Hollywood** **1).Corrective Actions:** Inspected all medication rooms to ensure no codes are written on walls, doors and no signs posted indicating the code number for entry. 3rd floor medication room door entry re-painted and signs removed. Plans to change medication room access with ID badge reader to ensure only authorized personnel will have access to med room. Education provided April 21- 23, 2014 to include review of policy, medication room access by authorized personnel and room to remain closed at all times **(see Addendum 33, 33a)** **Date of Implementation**: March 27, 2014, full implementation of badge reader will be in 30 days July 17, 2014 **Monitoring Process**: Monitoring will be managed through daily nursing rounds and to include in EOC rounds **Person Responsible:** Nursing Leadership in each department, EOC members, ENG, HR, pharmacy **2).Corrective Actions:** Inspected all medication rooms to ensure no codes are written on walls, doors and no signs posted indicating the code number for entry. 3rd floor medication room door entry re-painted and signs removed.	3/27/2014

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A 502	Continued From page 72 medication room and simultaneously noticed the four-digit security code was handwritten on a sheet of paper taped to the exterior of the medication room door. Adjacent to this sheet of paper was a sign taped to the inside of the glass window of the secure medication room door that stated □Keep Doors Closed & Do Not Write the Lock Codes on Walls or Doors or This Sign.□The four numbers handwritten on the paper was the lock code. She then removed the sign and discarded it. 2. On March 27, 2014 at 1:55 p.m., on the sixth floor, the surveyor observed the double-door to the Purchasing/Central Supply Room was left wide open with a doorstop. For eight minutes, from 1:55 p.m. to 2:03 p.m., the pharmacy surveyors and Rx 1 (Pharmacist 1) visited the pharmacy across the hallway. Upon leaving the pharmacy at 2:03 p.m., the surveyor observed that the Purchasing/Central Supply Room door was still open. The surveyors and the VPPO entered the Purchasing/Central Supply Room and called out to see if anyone was present, but no one answered. The Purchasing/Central Supply Room was left unattended for approximately eight minutes if not longer. Rx 1 identified cases of I.V. bags (D51/2NS), syringes, and the drug lidocaine in the crash cart kits. A few minutes later, Staff Q walked in and stated he had gone for three to four minutes.□ On March 27, 2014 at 2:36 p.m., on the third floor, Rx 1 identified that the door of the secure medication room with a self-closing door mechanism did not completely close.	A 502	(Continued from page 72) Plans to change medication room access with ID badge reader to ensure only authorized personnel will have access to med room. Education provided April 21- 23, 2014 to include review of policy, medication room access by authorized personnel and room to remain closed at all times **(see Addendum 33, 33a).** **Date of Implementation:** March 27, 2014, full implementation of badge reader will be in 30 days July 17, 2014. **Monitoring Process:** Monitoring will be managed through daily nursing rounds and to include in EOC rounds. **Person Responsible:** Nursing Leadership in each department, EOC members, ENG, HR, pharmacy	3/27/2014

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A 502	Continued From page 73 On March 27, 2014 at 2:36 p.m., two surveyors noted that the access door from the nursing station leading to the secure medication room was not locked while another access door from the hallway was locked with a security code lock. On March 27, 2014 at 3:12 p.m., Rx 1 confirmed that the facility could not produce a policy and procedure for the security of the Purchasing/Central Supply Room. On March 27, 2014 at 3:37 p.m., on the third floor, the secure medication room door was ajar and not securely closed. The surveyor made three attempts within one minute but the door failed to close. Rx 1 also made three more attempts in the next minute and the door failed to close. According to the facility policy, titled □Security of Medications Outside the Main Pharmacy□, Number PHA.084, dated □10/2012□, □□ All drug storage areas are lockable. All drug storage areas are locked when not in use□ □	A 502		
A 505	482.25(b)(3 UNUSABLE DRUGS NOT USED Outdated, mislabeled or otherwise unusable drugs and biologicals must not be available for patient use. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure an outdated medication, such as Tuberculin purified protein derivative, PPD (skin test to determine if a person had been exposed to tuberculosis, a contagious lung infection) was not in the medication refrigerator, available for patient use. This deficient practice had the potential for	A 505	**Van Nuys** **Corrective Actions:** Ensure outdated medication in the refrigerator was not available for patient us. All multiple dose vials will be checked in the Pharmacist Monthly Unit Inspection. At the end of the month all MDVs will be replaced. **Date of Implementation**: 6/16/2014 **Monitoring Process:** MDVs will be checked upon Pharmacist Monthly unit inspection. Any discrepancies will be reported to Quality Counsel**. (see Addendum31a)** **Person Responsible:** Director of Pharmacy	6/16/2014

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A 505	Continued From page 74 administering an outdated Tuberculin PPD, to the patients Findings: On March 2, 2014, at 10:30 a.m., during a medication room inspection, in the Unit 2 of the facility□s psychiatric campus, the medication refrigerator had one Tuberculin (TB 5 units) ampule with an expiration date of November 23, 2013. Licensed Vocational Nurse (LVN) 3 stated the Tuberculin should have been discarded and should have reordered.	A 505		
A 592	482.27(b) POTENTIALLY INFECIOUS BLOOD/BLOOD PRODUCTS Standard: Potentially infectious blood and blood products. (1) Potentially human immunodeficiency virus (HIV) infectious blood and blood components. Potentially HIV infectious blood and blood components are prior to collections from a donor □ (i) Who tested negative at the time of donation but tests reactive for evidence of HIV infection on a later donation; (ii) Who tests positive on the supplemental (additional, more specific) test or other follow-up testing required by FDA; and (iii) For whom the timing of seroconversion cannot be precisely estimated. (2) Potentially hepatitis C virus (HCV) infectious blood and blood components. Potentially HCV infectious blood and blood components are the blood and blood components identified in 21 CFR 610.47.	A 592	**Culver City** **1-8) Corrective Actions:** Look Back Policy BBK.207 **(see Addendum 34)** has been amended to include the hospitals responsibility to the patient if the physician cannot be contacted or located as stated in Procedural notes number 1. **Date of Implementation:** This policy has been approved and implemented on April 2nd 2014. **Monitoring Process**: A monitoring process has been put in effect to address the number of recalled blood products and if there is any need for the clinicians□to be notified also being monitored is if there are any failed attempts to the clinicians. **Person Responsible:** Laboratory Supervisor, Laboratory Director	4/2/2014

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A 592	Continued From page 75 (3) Services furnished by an outside blood collecting establishment. If a hospital regularly uses the services of an outside blood collecting establishment, it must have an agreement with the blood collecting establishment that governs the procurement, transfer, and availability of blood and blood components. The agreement must require that the blood collecting establishment notify the hospital □ (i) Within 3 calendar days if the blood collecting establishment supplied blood and blood components collected from a donor who tested negative at the time of donation but tests reactive for evidence of HIV or HCV infection on a later donation or who is determined to be at increased risk for transmitting HIV or HCV infection; (ii) Within 45 days of the test, of the results of the supplemental (additional, more specific) test for HIV or HCV, as relevant, or other follow-up testing required by FDA; (iii) Within 3 calendar days after the blood collecting establishment supplied blood and blood components collected from an infectious donor, whenever records are available, as set forth at 21 CFR 610.48(b)(3). (4) Quarantine of blood and blood components pending completion of testing. If the blood collecting establishment (either internal or under an agreement) notifies the hospital of the reactive HIV or HCV screening test results, the hospital must determine the disposition of the blood or blood component and quarantine all blood and blood components from previous donations in inventory. (i) If the blood collecting establishment notifies the hospital that the result of the supplemental (additional, more specific) test or other follow-up			

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A 592	Continued From page 76 testing required by FDA is negative, absent other informative test results, the hospital may release the blood and blood components from quarantine. (ii) If the blood collecting establishment notifies the hospital that the result of the supplemental (additional, more specific) test or other follow-up testing required by FDA is positive, the hospital must □ (A) Dispose of the blood and blood components; and (B) Notify the transfusion recipients as set forth in paragraph (b)(6) of this section. (iii) If the blood collecting establishment notifies the hospital that the result of the supplemental (additional, more specific) test or other follow-up testing required by FDA is indeterminate, the hospital must destroy or label prior collections of blood or blood components held in quarantine as set fors at 21 CFR 610.46(b)(2), 610.47(b)(2), and 610.48(c)(2). (5) Recordkeeping by the hospital. The hospital must maintain □ (i) Records of the source and disposition of all units of blood and blood components for at least 10 years from the date of disposition in a manner that permits prompt retrieval; and (ii) A fully funded plan to transfer these records to another hospital or other entity if such hospital ceases operation for any reason. (6) Patient notification. If the hospital has administered potentially HIV or HCV infectious blood or blood components (either directly through its own blood collecting establishment or under an agreement) or released such blood or blood components to another entity or appropriate individual, the hospital must take the following	A 592		

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	050135	K. BUILDING **01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD** L. WING _____	**04/01/2014**

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A 592	Continued From page 77 actions: (i) Make reasonable attempts to notify the patient, or to notify the attending physician who ordered the blood or blood component and ask the physician to notify the patient, or other individual as permitted under paragraph (b)(10) of this section, that potentially HIV or HCV infectious blood or blood components were transfused to the patient and that there may be a need for HIV or HCV testing and counseling. (ii) If the physician is unavailable or declines to make the notification, make reasonable attempts to give this notification to the patient, legal guardian or relative. (iii) Document in the patient□s medical record the notification or attempts to give the required notification. (7) Timeframe for notification. (i) For donors tested on or after February 20, 2008. For notifications resulting from donors tested on or after February 20, 2008 as set forth at 21 CFR 610.46 and 21 CFR 610.47 the notification effort begins when the blood collecting establishment notifies the hospital that is received potentially HIV or HCV infectious blood and blood components. The hospital must make reasonable attempts to give notification over a period of 12 weeks unless □ (A) The patient is located and notified; or (B) The hospital is unable to locate the patient and documents in the patient□s medical record the extenuating circumstances beyond the hospital□s control that caused the notification timeframe to exceed 12 weeks. (ii) For donors tested before February 20, 2008. For notifications from donors tested before February 20, 2008 as set forth at 21 CFR	A 592		

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A 592	Continued From 78 610.48(b) and (c), the notification effort begins when the blood collecting establishment notifies the hospital that it received potentially HCV infectious blood and blood components. The hospital must make reasonable attempts to give notification and must complete the actions within 1 year of the date on which the hospital received notification from the outside blood collecting establishment. (8) Content of notification. The notification must include the following information: (i) A basic explanation of the need for HIV or HCV testing and counseling. (ii) Enough oral or written information so that an informed decision can be made about whether to obtain HIV or HCV testing and counseling (iii) A list of programs or places where the person can obtain HIV or HCV testing and counseling, including any requirements or restrictions the program may impose. (9) Policies and procedures. The hospital must establish policies and procedures for notification and documentation that conform to Federal, State, and local laws, including requirements for the confidentiality of medical records and other patient information. (10) Notification to legal representative or relative. If the patient has been adjudged incompetent by a State court, the physician or hospital must notify a legal representative designated in accordance with State law. If the patient is competent, but State law permits a legal representative or relative to receive the information on the patient□s behalf, the physician or hospital must notify the patient or his or her legal representative or	A 592		

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A 592	Continued From page 79 relative. For possible HIV infectious transfusion recipients that are deceased, the physician or hospital must inform the deceased patient□s legal representative or relative. If the patient is a minor, the parents or legal guardian must be notified. (11) Applicability. HCV notification requirements resulting from donors tested before February 20, 2008 as set forth at 21 CFR 610.48 will expire on August 24, 2015. This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to have a written procedure for the hospital making reasonable attempts to notify a patient that was potentially administered HIV or HCV infectious blood or blood components if the patients physician was unavailable or declined to make the notification. This deficient practice had the potential for not informing the patient regarding the need for HIV or HCV testing and counseling. Finding: On March 31, 2014, between 10:54 a.m. and 11:55 a.m., accompanied by Staff 14 (director of laboratory and pathology) and Staff 15 (lab supervisor), a review of the hospital□s policies and procedures titled, Lookback Policy SOP □2324A (Number BB14) dated effective July 2002; Lookback Programs HIV, HTLV I/II, SOP 2325B (P&P 15) (Number BBK-203) dated effective October 2002; and Lookback Program Recall Notification (Number BBK0204) dated effective July 2002 revealed there was no procedure for the hospital to notify a patient that was potentially administered HIV or HCV infectious blood or	A 592		

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A 592	Continued From page 80 blood components if the patient□s physician was unavailable or declined to make the notification. At the same time, as the review, Staff 14 and Staff 15 were informed that the hospital□s Lookback Program Recall Notification policy and procedure did not indicate the hospital□s procedure to notify a patient that was potentially administered HIV or HCV infectious blood or blood components if the patients physician was unavailable or declined to make the notification. During concurrent interview, when asked what the hospital□s procedure was to notify the patient if the patient□s doctor was not available or if the patient□s doctor refused to notify the patient, the lab supervisor stated the procedure for the hospital was that the blood bank drafts a letter and the lab sends it to the pathologist to sign off on and the lab mails it to the clinician (patient□s doctor) and that the clinician will follow through. Neither the director of laboratory and pathology or the lab supervisor provided the hospital□s procedure for the hospital making reasonable attempts to notify a patient that was potentially administered HIV or HCV infectious blood or blood components if the patient□s physician was unavailable or decline to make the notification.	A 592		
A 618	482.28 FOOD AND DIETETIC SERVICES The hospital must have organized dietary services that are directed and staffed by adequate qualified personnel. However, a hospital that has a contract with an outside food management company may be found to meet this Condition of Participation if the company has a	A 618	**Hollywood** **1) Corrective Actions:** Prior director was replaced with a new Director of Dietary at both locations, Hollywood and Van Nuys. **Hollywood:** A full-time consulting Director of Dietary Department, RD was appointed to provide oversight of the dietary department. A full-time Food Services Supervisor was appointed to oversee the day to day operations of dietary department. A clinical dietitian and a per diem Registered Dietitian provide clinical support. **Date of implementation:** July 31, 2014	7/31/2014

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A 618	Continued From page 81 dietitian who serves the hospital on a full-time, part-time, or consultant basis, and if the company maintains at least the minimum standards specified in this section and provides for constant liaison with the hospital medical staff for recommendations on dietetic policies affecting patient treatment. This CONDITION is not met as evidenced by: Based on observation, review of facility documents and staff interview, the facility failed to meet the Condition of Participation in Food and Dietetic Services by failing to: 1. Provide organized dietetic services as evidenced by findings of unsafe food handling practices and inadequate supervision of the dietary department (Refer to A 619, A 620, A 621, A 628). 2. Ensure accurate nutritional analysis of regular and therapeutic menus, menus that were in compliance with nationally recognized practices (Refer to A 630). 3. Have menus for all physician ordered diets (Refer A to 628). 4. Have effective system to ensure that physician ordered diets were followed (Refer A to 629). 5. Ensure safe and effective food storage/production practices (Refer to A 620). 6. Ensure adequate food and water were on hand for use in an emergency (Refer to A 703). 7. Have policies and procedures, spreadsheets for the distribution of food.	A 618	(Continued from page 81) **Van Nuys:** A full time Director of Dietary Department, RD was placed to provide oversight of dietary department. A full time Food Services supervisor continues to oversee the day to day operations of dietary department. A per diem clinical dietitian is available for clinical support as needed. **Date of implementation:** July 31, 2014 **Both Hollywood and Van Nuys:** Additionally, a contract is in process to retain a Food Service Management company to permanently operate the Food & Nutrition Services Department at both the Hollywood and Van Nuys campuses. This contract will include safe food handling and sanitation compliance requirements to meet all State, Federal, and DNV regulatory requirements. A General Consultant and Chef Consultant are also working between both institutions. A contract is in process with a letter of intent given to retain a Food Service Management company to permanently operate the Food & Nutrition Services Department at both Hollywood and Van Nuys. This contract will include food safe handling and sanitation compliance requirement to meet all State, Federal and DNV regulatory requirements. **Date of Implementation:** Initial correction from May 19, 2014-June 16, 2014. Additional staff of Consulting RD Director and Consulting Staff to meet Organizational needs implemented July 31, 2014. Contract Company Agreement scheduled to start October 1, 2014. **Monitoring Process:** The hospital's leadership will ensure that the Dietary Department is staffed with competent and appropriately credentialed supervisory coverage at all times. The Food & Nutrition Services Contract will be reviewed for service level compliance and regulatory standards on an annual basis by Hospital Administration and the Quality Council for recommendation for continuation. **Person Responsible:** Administrators at both Southern California Hospital at Hollywood and Van Nuys. **2) Corrective Actions:** Menus have been analyzed to meet at least 90% of DRI for all diets with the exception of those noted in the diet manual or addendums as being unable to reach such levels due to their dietary restrictions. An alternate menu or meal substitution with nutritionally equivalent options are available **Date of Implementation:** September 10, 2014 **Monitoring Process:** The nutritional analysis of menus as served are approved by the Med Executive Committee and Governing Board. Patient satisfaction is monitored to determine patient acceptance of menus provided. . **Person Responsible**: RD, Director of Dietary Department and Clinical Dietitian RD **3) Corrective Actions:** Menus are available for all standard physician ordered diets. Diets other than those on the standard list of diets will be calculated as needed by a Registered Dietitian. **Date of Implementation:** September 10, 2014 **Monitoring Process:** Review of nutritional analysis of menus as served are approved by the Med Executive Committee and Governing Board. **Person Responsible:** RD, Director of Dietary Department and Clinical Dietitian RD	7/31/2014 5/19/2014 7/31/2014 10/1/2014 9/10/2014 9/10/2014

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A 618	Continued From page 82 8. Development of menus that were consistent with nutrient parameters as approved by the hospitals' Medical Executive Committee. (Refer to A 631). The cumulative effect of these systemic issues resulted in the facility's inability to ensure and provide a safe patient care environment.	A 618	(Continued from page 81) **4) Corrective Actions:** Implementation of Mandatory CPOE diet order entry and standardization of diet orders available in the system to be in compliance with the facility diet manuals. Dietitians write diet order clarification/recommendations when discrepancies are identified. **Date of Implementation:** September 10, 2014 Continued on Page 83a.	9/10/2014
A 619	482.28(a) ORGANI□ATION Organization This STANDARD is not met as evidenced by: Based on observation, review of hospital documents and staff interviews, the hospital failed to ensure that the food and dietetic services department was properly organized. The person in the position of leadership in two of the three campuses had too many responsibilities, lacked the proper education and training appropriate to the scope and complexity of the food service operations. These failures resulted in deficient practices that affected the quality of care being provided due to failure to meet the nutritional needs of patients, lack of policies and procedures and poor food safety practices. Findings: During an interview on March 24, 2014 with (food service director), Staff 2 revealed that he had responsibilities for four of five hospitals owned by the licensee. His office was not based in any of the hospitals being inspected. The name badge on his shirt did not reflect the name of the hospitals being surveyed but the other two	A 619	**Hollywood & Van Nuys** A Registered Dietitian Director of Food and Nutrition Services was recruited, interviewed, hired or promoted to ensure qualified and competent staff was in place. Responsibilities include: • Provides adequate overall supervision, • Oversight of patient services and menu, • Develops and ensures provision of ongoing training and development of department staff, • Maintains equipment in working order by notifying maintenance of needed repairs and administration for capital replacement, • Demonstrates knowledge of infection control, sanitation and HACCP guidelines related to safe food handling practices to ensure quality and safety of food services. **Corrective Actions:** Prior director was replaced with a new Director of Dietary at both locations, Hollywood and Van Nuys. **Hollywood:** A full-time consulting Director of Dietary Department, RD was appointed to provide oversight of the dietary department. A full-time Food Services Supervisor was appointed to oversee the day to day operations of dietary department. A clinical dietitian and a per diem Registered Dietitian provide clinical support. **Date of implementation**: July 31, 2014 **Van Nuys:** A full time Director of Dietary Department, RD was placed to provide oversight of dietary department. A full time Food Services supervisor continues to oversee the day to day operations of dietary department. A per diem clinical dietitian is available for clinical support as needed. **Date of implementation:** July 31, 2014 **Both Hollywood and Van Nuys:** Additionally, a contract is in process to retain a Food Service Management company to permanently operate the Food & Nutrition Services Department at both the Hollywood and Van Nuys campuses. This contract will include safe food handling and sanitation compliance requirements to meet all State, Federal, and DNV regulatory requirements. A General Consultant and Chef Consultant are also working between both institutions. A contract is in process with a letter of intent given to retain a Food Service Management company to permanently operate the Food & Nutrition Services Department at both Hollywood and Van Nuys. This contract will include food safe handling and sanitation compliance requirement to meet all State, Federal and DNV regulatory requirements.	7/31/2014 7/31/2014

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A 619	Continued From page 83 hospitals that was owned by the licensee. The hospital being surveyed had three campuses of which he had responsibilities for two. He explained that he visits all the hospitals and is helped by the food service supervisors in some of the hospitals. Of the two hospitals he was responsible for only one had a supervisor, who had started three weeks earlier, when he was not visiting the campus. Observations and review of hospital documents revealed that he was not responsible for the day to day management of either of the campuses. The lack of leadership and supervision of dietary staff was evident in the identified concerns about food ordering, failure to follow menu, improperly maintained food service equipment, lack of policies and procedures, poor food safety practices, Food Ordering At the Hollywood campus, there was inadequate food on hand to meet state requirements of seven days of staples and two days of perishable foods. There was inadequate food on hand to meet patient□s need in an emergency. Staff 2 stated in an interview at approximately 3:00p.m. on March 24, 2014 that food he ordered food once per week. This ordering procedure results in food supplies being low and running the risk of inadequate food if the delivery were delayed or interrupted due to catastrophic reasons. DS (dietary staff) 4 was unable to provide information on a product he had prepared when there were concerns about appropriateness for patients on renal diet. (Cross reference A 0622). There was about half box (50 lbs.) of sprouting potatoes. Review of the shipping order showed that the item had been ordered two weeks earlier and had	A 619	(Continued from page 83) **Date of Implementation:** Initial correction from May 19, 2014-June 16, 2014. Additional staff of Consulting RD Director and Consulting Staff to meet Organizational needs implemented July 31, 2014. Contract Company Agreement scheduled to start October 1, 2014. **Monitoring Process:** The hospital□s leadership will ensure that the Dietary Department is staffed with competent and appropriately credentialed supervisory coverage at all times. The Food & Nutrition Services Contract will be reviewed for service level compliance and regulatory standards on an annual basis by Hospital Administration and the Quality Council for recommendation for continuation. **Person Responsible:** Administrators at both Southern California Hospital at Hollywood and Van Nuys. **2a) Food Ordering** **Corrective Actions:** **Hollywood:** Food Delivery frequency has been increased to 3 days per week. Sufficient items are on hand to meet the needs of the menu as served for 7 days of staples and 2 days of perishables. Frequency of Deliveries will continue to be adjusted as needed to ensure minimum food requirements are met. **Van Nuys:** Food delivery frequency has been revised to meet 7 days of staples and 2 days of perishables. Frequency of perishable food deliveries was reviewed and adjusted. Additional adjustments will be made after equipment is repaired and/or replaced allowing for less frequent deliveries A disaster menu and supplies for patients were adjusted to meet the needs of the facility. Disaster food and supplies for patients have been received. A disaster plan to include staff and others is being developed and food products ordered accordingly. Once the plan is finalized, staff will be trained on its use. **Date of implementation**: August 4, 2014, with a completion date of August 29, 2014 **2b) Renal diets:** Food items for Renal and other therapeutic diets are maintained to ensure compliance with 7 days of staples and 2 days of perishables. **Date of implementation:** August 4, 2014	5/19/2014 7/31/2014 10/1/2014 8/4/2014 8/4/2014

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A 619	Continued From page 84 not been used and /or stored properly. There were no pasteurized eggs on hand, but there was fried eggs on the menu, improper cooking of the eggs could result in the exposure of patients who may be already immune-compromised be exposed to bacteria that could cause food borne illness. According to the hospital policy on food supplies dated 11/2012, there should be no less than a one week supply of staple food and less than two days□supply of perishable foods. In addition, the policy states that food is purchased in accordance to the needs of the menu and any items requested for special needs or nourishment of the patient in quantity and quality to ensure sufficient amounts for the number of patients or guests to be served. Menu The cooks had not been following the menu. On March 24, 2014, the lunch menu for patients on regular diet, had the following items: Tossed green salad with dressing, Roast beef or Chef salad, Baked Potato with sour cream, green beans, dinner roll, margarine, tapioca pudding and milk. Items prepared were roast beef, confetti rice, mixed vegetables with broccoli, noodles, macaroni salad and milk. It was not clear why the menu was not followed. Other items served were not identified in the therapeutic spreadsheet. There were no scoop sizes being used to serve vegetables, noodles to ensure that patients were served the correct amount. Review of the hospital policy and procedure titled □General Requirements for Food□ dated 11/12 states □The Clinical Dietitian shall be responsible for substituting food so that the patient has adequate quality and quantity.□The Clinical Dietitian was	A 619	(Continued from page 84) **2c) Food storage:** Spoiled food products were immediately discarded and proper storage of food items according to FDA Food Code 2013 has been implemented. Produce is ordered, stored and utilized in a timely manner to avoid spoilage. **Date of implementation:** August 4, 2014 **2 d) Pasteurized eggs:** Non-pasteurized eggs were discontinued. Only pasteurized Eggs are now ordered in place of non-pasteurized shell eggs. No non-pasteurized eggs are to be purchased or used in the future. **Date of Implementation**: Pasteurized eggs in use as of 7/21/14 **Training for food ordering 2 a, b, c and d:** Staff was trained and competency tested on proper storage of food. **Date of Implementation:** July 31, 2014 **Monitoring Process: Food ordering for a, b, c and d:** Weekly ordering inventory to ensure adequate menu supplies are on hand and only pasteurized eggs are ordered. . Monthly inventory for adequate emergency supplies will be compared to the □Disaster Inventory Sheet□ Results of disaster supply inventory levels will be reported to the hospital□s EOC Committee, Quality Council, and Governing Board on a quarterly basis. **Person Responsible:** RD, Director of Dietary Department **Hollywood & Van Nuys** **3) Menu:** **a) Menu spread not available and portion sizes not followed:** **Corrective Actions:** Copy of the current menu spread was immediately posted on tray line and reviewed with staff. Dietary Staff was in-serviced on menu comprehension, serving sizes, portions and following therapeutic requirements as shown on menu. Menu books have been provided to the Dietary staff for referencing menu items for each type of diet and portions sizes required. **b) Menu substitution:** **Corrective Actions:** The Food Service staff and Supervisor were in-serviced to consult Registered Dietitians for proper food substitution. Dietary staff was provided a routine substitution list on proper food substitution. **c) Policy for double portions, small portions and consistency of pureed foods:** **Corrective Actions:** A procedure was developed and implemented for double and small portion meals and staff was in-serviced. Staff was instructed on the proper preparation and service of puree food items. **Date of Implementation:** Training initiated June 17 and completed July 31, 2014. **Monitoring Process:** Return Demonstration/Comprehension competencies completed by July 31, 2014 and on a bi-annual basis. If staff is found to be incompetent, additional training will be provided and competency reassessed. Competency records will be maintained in employee files. Tray audits will be performed 3-5 times per week to ensure diet tray accuracy and compliance with the menu in relation to portion sizes and food items, appropriate food substitutions and food preparation procedures including pureed diets. Results of audit activity will be reported to the hospital□s Quality Council, MEC, and Governing Board on a quarterly basis. Additional training will be provided based on the results of the audits. **Person Responsible:** RD, Director of Dietary Department	8/4/2014 7/21/2014 7/31/2014 6/17/2014

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A 619	Continued From page 85 not consulted in the determination of substitutes being made. Dietary Staff did not provide diet as planned. Portion sizes were incorrect, items were missing. The therapeutic spreadsheet did not match the menu. There were no policies in place to validate that correct procedures were being followed. There was no policy for small portions. Incorrect consistency of pureed food was prepared was too watery. Policies and Procedures Dietary staff did not follow safe food practices. The roast that had been prepared the day before was not properly monitored to ensure that it was cooled to prevent the growth on bacteria that could cause food borne illness. The kitchen had never used cooling logs to monitor the temperature of leftovers and previously cooked large cuts of meat. There was no written policy on proper cooling. Staff Training OS (Dietary Staff) 3 was observed at approximately 11:20 a.m., on March 24, 2014, returning to the kitchen after emptying the garbage still wearing his apron. The correct procedure is to remove the apron prior to emptying the garbage to prevent cross contamination of his apron. There were food items in the refrigerator that had not been dated. Frozen items in the freezer were not stored in a manner to prevent cross contamination, fresh or ready to eat products were stored below raw meats. Dietary staff was not able to correctly calibrate	A 619	(Continued from page 85) **4) Policies and Procedures cooling:** **Corrective Actions:** A Food Cooling Procedure and Log were created and implemented to ensure the appropriate cooling of food products to prevent bacteria growth according FDA Food Code 2013. The need for Hot food cooling has been limited by preparing all food items on the day of service. All leftover food items are discarded after each meal. Ongoing training is provided to staff on food safety and food cooling procedures with emphasis on time and temperature, food temperature danger zones, food cooling process and corrective action to take when time and temperature are not within acceptable range as per FDA Food Code 2013. Food Cooling Log with acceptable HACCP procedures and standards was implemented and appropriate corrective actions are taken when temperatures are not within acceptable range and recorded on food cooling log. A policy regarding Food Cooling has been written and reviewed and is being approved by MEC and Governing Board. **Date of Implementation:** April 28,2014 training, September 10, 2014 Policy approval **Monitoring Process:** An audit of the Cooling Logs will be conducted on a weekly basis to ensure that leftover and previously cooked foods are not being cooled. . Results of audit activity will be reported to the hospital□s Quality Council, MEC, and Governing Board on a quarterly basis. **Person Responsible:** RD, Director of Dietary Department. **HOLLYWOOD:** **5) Staff training:** **a) Garbage removal:** **Corrective Actions:** Dietary Staff was in-serviced on the hospital□s policy requiring the removal of aprons prior to discarding waste. **b) Labeling and dating:** **Corrective Actions:** Products were immediately labeled and dated or discarded. Staff was in-serviced on proper labeling and dating of food items. **c) Storage of food resulting in cross-contamination:** **Corrective Actions:** Raw foods were immediately stored on bottom shelves. Staff was in-serviced on proper storage of food according FDA Food Code 2013 including raw meats must be stored at the bottom and ready to eat food items on top to prevent cross contamination. Organized training program was developed to prevent cross contamination. Staff was trained regarding preventing cross-contamination and ensuring food safety. All Food Service staff is required to have a food handler□s card. **Date of Implementation:** In-service provided on April 28, 2014 through May 31. Additional training on policy revisions to be completed for all staff by September 10 , 2014 **Monitoring:** All Food Service staff is required to obtain a Food Handlers Card. Food safety and sanitation training with competency testing was implemented. In addition, initial staff competencies of all staff to be completed by July 31, 2014. Bi-annual validation of staff competency will be completed twice yearly and placed in employee files.	4/28/2014 4/28/2014

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A 619	Continued From page 86 thermometers. The posted log did not have clear instructions on thermometer calibration. Food equipment stored away as clean was no properly cleaned. Yellow colored cutting board was badly stained with black colored substance in the grooves of the cut marks was observed being used for meal preparation. The interior components of the ice machine had not been cleaned as recommended by the manufacturer. There were several equipment including the dish machine and plate warmer that was not working resulting in the use of paper plates for patients in the hospitals. The plate warmer had not been working for over week according to OS 4. The dish machine that had been identified as being broken was used by OS 3 to wash cooking utensils. At the Van Nuys Campus, there were similar concerns with food ordering and inadequate supplies for use during emergency, menu/ therapeutic spreadsheets not available, poor food safety practices, Staff Training During initial tour on March 27, 2014 beginning at 8 a.m., it was noted that there were four cases of 4-ounce juices with the manufacturers□ guidance to □keep frozen□ printed on the outside of cartons. It was noted there was an undated, opened case, containing thawed juice. In a concurrent interview with Staff 3, she stated she had just started her position as supervisor and was unsure of the operational processes in the department. She also stated that she was unsure of the expiration date of the juices as it was not printed on the carton. Further review of the manufacturers guidance printed on the carton	A 619	(Continued from page 86) **d) Thermometer calibration:** **Corrective Actions:** Staff was in-serviced on how to calibrate thermometers and record on log to ensure food temperatures are recorded accurately for compliance with food safety. **e) Cleaning of small equipment:** **Corrective Actions:** Blender was immediately re-cleaned. Staff was in-serviced on proper ware washing. **f) Cutting board:** **Corrective Actions:** Yellow cutting board with black stain was immediately discarded. Staff was in-serviced on when to notify management for replacement of cutting boards that are stained or have deep grooves. **g) Ice-machine: Refer to A749** **Corrective Actions:** Cleaning of the ice machine will be monitored to ensure timely completion. Preventative maintenance was set up twice a year by facilities per manufacturer guidelines. Unit is disassembled and internal components (water curtain, water trough, water level probe, ice thickness probe, water distribution tube) are cleaned and sanitized before reassembly. **Date of Implementation:** Service scheduled for August 2014; to re-occur every six months. **Monitoring Process:** Cleaning/sanitizing of ice machine (twice yearly) is documented on log sheet attached to unit. Bi-monthly audits of kitchen and food storage practices with immediate correction and on the job training of staff. **Person Responsible:** Director of Facilities & Director of Food & Nutrition **h) Equipment not working:** **Dish-machine** Corrective Actions: Dish-machine was repaired. Staff was trained regarding the proper wash and final rinse temperatures for the dish-machine and the proper reporting procedures when equipment is not working. When dish-machine is not working, all ware washing will be processed using 3 compartment sinks. **Plate warmer: Refer to A724** **Corrective Actions:** The plate warmer has been determined to be un-repairable and has been removed from the department. Equipment is being specified via meetings with vendors and bids are in the process of being obtained for replacement equipment and an order will be placed. Food temperatures are being monitored to ensure food safety compliance. **Date of Implementation:** Policy and Procedures for all departmental processes will be completed by September 10, 2014. In service dates on manual ware washing will be completed by August 15, 2014. A new plate warmer for the Hollywood campus will be ordered prior to 9/10/14. The Dish machine was repaired on 3/27/14. **Monitoring Process:** Monthly monitoring using Food Service bi-monthly kitchen audits including observations for equipment functionality. **Person Responsible:** RD, Director of Dietary Department **<u>Van Nuys</u>** **6). Staff training:** **Corrective Actions:** Frozen juices kept after 10 days were immediately discarded. Staff was retrained on food handling and storage procedures. The procedure for dating food items was implemented to ensure expired food products were discarded in a timely manner. **Date of Implementation:** In-service began April 28, 2014; Initial staff competency validation completed by July 31, 2012 for all Food Service Staff. Training on revised Food Handling and Storage procedures will be completed by September 10, 2014	8/10/2014 3/27/2014 8/15/2014 9/10/2014 4/28/2014 7/31/2014 9/10/2014

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A 619	Continued From page 87 revealed that the juices expired 10 days after they were thawed. The hospital did not have a dating system to ensure that expired juices were not served to patients. Menu The posted menu in the kitchen was for a Renal CCHO (consistent carbohydrate diet) and not a regular diet as is the standard of practice. The hospital did not have any patients on Renal CCHO diet. The therapeutic spreadsheet for that day's meal was not available to validate that the patients were being served the proper diets. Patients were served scrambled eggs, hash browns, bagel or English muffin, sausage, milk, juice. Several food trays were observed with an usually large amount of food. Staff 1 stated on March 27, 2014 at approximately 9:50a.m. that those patients had orders for double portions. She stated there was no policy on double portions and that patients are given just what the patients want. They provide them every item times two. She stated patients □want double meats not salads□. There was no policy provided on double portions. Staff 2 stated in an interview on March 27, 2014 at approximately 10:00 a.m., that keeping the menus, spreadsheets and policies and procedure was a challenge because former employees who were disciplined would remove them from the department as retaliation. Items served to the patients did not match what was on the □menu.□On March 27, 2014, according to the menu, bread pudding was to be offered for lunch. DS 5 was observed dishing out	A 619	(Continued from page 87) **Monitoring Process:** Monitoring will be conducted through bi-monthly kitchen audits to ensure food storage and handling procedures are being implemented. **Person Responsible:** RD, Director of Dietary Department **7) Menu:** **a) Menu posted** **Corrective Actions:** Copy of the current menu spread was immediately posted on tray line and reviewed with staff. Food Service Staff was in-serviced on menu comprehension, serving sizes, portions and following therapeutic requirements as shown on menu. Menu books have been provided to the Dietary staff for referencing menu items for each type of diet and portions sizes required. Staff was also instructed not to remove any menus posted and to immediately report to management if any menus were missing. **b) Policy for double portions, small portions and consistency of pureed food:** **Corrective Actions:** A procedure was developed and implemented for double and small portion meals and staff was in-serviced. Staff was instructed on the proper preparation and service of puree food items. **c) Menu substitution:** **Corrective Actions:** The Food Service staff and Supervisor were in-serviced to consult Registered Dietitians for proper food substitution. Dietary staff was provided a routine substitution list on proper food substitution. **Date of Implementation:** Training initiated June 17 and completed July 31, 2014. **Monitoring Process:** Return Demonstration/Comprehension competencies completed by July 31, 2014 and on a bi-annual basis. If staff is found to be incompetent, additional training will be provided and competency reassessed. Competency records will be maintained in employee files. Tray audits will be performed 3-5 times per week to ensure diet tray accuracy and compliance with the menu in relation to portion sizes and food items, appropriate food substitutions and food preparation procedures including pureed diets. Results of audit activity will be reported to the hospital□s Quality Council, MEC, and Governing Board on a quarterly basis. Additional training will be provided based on the results of the audits. **Person Responsible:** RD, Director of Dietary Department	6/17/2014

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A 619	Continued From page 88 vanilla pudding. In an interview at approximately 10:30 a.m., OS 5 stated she had checked the refrigerator and there was no bread pudding and Staff 2 had asked her to substitute vanilla pudding for the bread pudding. Hospital policy titled "General Requirements for Food" dated 11/12 states, "The Clinical Dietitian shall be responsible for substituting food so that the patient has adequate quality and quantity." The Clinical Dietitian was not consulted in the determination of substitutes being made (Cross refer A 0701). There was no documented evidence presented to show that the dietary staff received adequate training. Review of the personnel record for Staff 2 revealed there were educational requirements for the position based on the job description. The person currently in the position does not currently meet any of the requirements. In an interview with Staff 12 (Director of Human Resources) on March 27, 2014 at approximately 2:30 p.m., she acknowledged that based on the documents in the file, it appeared Staff 2 did not meet the minimum educational qualifications. She stated that she was unable to provide an explanation as she was not the Human resources Director when the decision was made. The hospital hired and gave responsibilities to the DFS (Director of Food Service) that was not appropriate to the scope and complexity of the food service operations.	A 619	(continued from page 88) **8. Staff received adequate training:** **Corrective Actions:** The unqualified food service director was removed from his position at both the Van Nuys and Hollywood campuses and replaced with qualified individuals. Training records, indicating the date and time and duration of the training and subject matter covered, are being retained in personnel files. The department is in the process of reviewing and revising all food service job descriptions as necessary ensuring individuals in positions meet the minimum requirements for the position. **Date of Implementation**: In-services began April 28, 2014 and training records are maintained in personnel files. Qualified directors were in place July 31, 2014. Job description revisions will be completed by September 10, 2104. **Monitoring Process**: The process for ensuring the appointment of qualified personnel will be monitored by the department directors and HR review on an annual basis to ensure that the staff meet the minimum qualification for the positions held. **Person Responsible:** Directors of Dietary Departments and HR Department	4/28/2014 7/31/2014 9/10/2014
A 621	482.28(a)(2) QUALIFIED DIETITIAN There must be a qualified dietitian, full-time,	A 621		

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A 621	Continued From page 89 part-time, or on a consultant basis. This STANDARD is not met as evidenced by: Based on observation, review of hospital documents and staff interviews, the facility failed to ensure that adequate provisions were made to ensure that the hours of the registered dietitian (RD) was adequate to meet the needs of the patients on two of three campuses. These failures resulted in the RD□s inability to supervise the nutritional aspects of patient care. Finding: Review of the documents in the personnel record for the registered dietitian job description revealed that she was hired in 2005 as a clinical dietitian to cover two hospitals. A review of a position description/Performance Appraisal for the Position of Clinical Dietitian dated 04/2006 indicated that development, evaluation and approval of menus were included in the responsibilities. Observation and implementation of proper food handling and storage to assure safe quality nutrition; evaluate food served for conformance to dietary prescription was also listed as responsibilities. However, there was an Employee Status change, approved in 1/2014 by the administrator, for the position to change from Clinical Dietitian to Dietitian. This Status change did not include a job description for the position of Dietitian. Review of the menus for both the Hollywood and Van Nuys campuses showed the name another registered dietitian (RD), who was not an employee of either hospital, indicating approval of the menu. The menus had not been approved by the hospital RD. The therapeutic spreadsheet	A 621	**Hollywood & Van Nuys** **1. Qualified staff :** Corrective Actions: The organizational structure of Food and Nutrition Services department was reviewed and revised to ensure competent leadership and staff compliance to safe food handling and sanitation practices. □A Registered Dietitian Director of Food and Nutrition Services was recruited, interviewed, hired or promoted to ensure qualified and competent staff was in place. Pertinent responsibilities include: • Provides adequate overall supervision, • Oversight of patient services and menu, • Develops and ensures provision of ongoing training and development of department staff, • Maintains equipment in working order by notifying maintenance of needed repairs and administration for capital replacement, • Demonstrates knowledge of infection control, sanitation and HACCP guidelines related to safe food handling practices to ensure quality and safety of food services. Organization chart was revised to reflect supervisors and clinical dietitians (RD) reporting to the RD Food Service director who in turn reports to hospital administrator. Job descriptions for all positions are in place. **Hollywood:** A full-time consulting Director of Dietary Department, RD was appointed to provide oversight of the dietary department. A full-time Food Services Supervisor was appointed to oversee the day to day operations of dietary department. A clinical Registered dietitian and per diem Registered Dietitian are in place to provide clinical support. **Date of implementation**: July 31, 2014 **Van Nuys:** A full time Director of Dietary Department, RD was placed to provide oversight of dietary department as well as clinical support. A full time Food Services supervisor continues to oversee the day to day operations of dietary department. A per diem clinical Registered Dietitian is available on an as needed basis. **Date of implementation:** July 31, 2014 **Both Hollywood and Van Nuys:** Additionally, a contract is in process to retain a Food Service Management company to permanently operate the Food & Nutrition Services Department at both the Hollywood and Van Nuys campuses. This contract will include safe food handling and sanitation compliance requirements to meet all State, Federal, and DNV regulatory requirements. **Date of Implementation:** July 31, 2014 **Monitoring Process:** The hospital□s leadership will ensure that the Dietary Department is staffed with competent and appropriately credentialed supervisory coverage at all times. The Food & Nutrition Services Contract will be reviewed for service level compliance and regulatory standards on an annual basis by Hospital Administration and the Quality Council for recommendation for continuation. **Person Responsible:** Administrators of Southern California Hospital at Hollywood and Van Nuys. **2) Menu:** **a) Menus approved:** **Corrective Actions:** RD Clinical Dietitian approved and signed the menus for use in the facility. Menus were posted on tray line and reviewed with staff. Food Service Staff was in-serviced on menu comprehension, serving sizes, portions and following therapeutic requirements as shown on menu. Additionally, newly appointed RD Food Service Directors have reviewed and signed the facilities□menus.	7/31/2014 7/31/2014 7/31/2014

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A 621	Continued From page 90 A 621 was not complete and/or available for use during tray line operation, thereby leaving dietary staff (cooks and aides) to determine food choices. The menus were not in compliance with hospital policy and state regulations which require use of select menus. According to the hospital policy titled, □menu,□□The regular diet consists of a selective one -week cycle. Select menus are menus with food options which allows patients to select menu items that they would like to eat." Copies of select menus were stored on a shelf in the kitchen and not offered to patients. The menus lacked variety and color. There were mashed potatoes on the menu every day for lunch and dinner. White rice is on the menu four of seven days per week for lunch; white or Spanish rice seven of seven days at dinner. For example, one of the meals had 'Veil pamejon□(veal parmesan) Chicken Chinese salad, mashed potatoes, white rice, veggies, chicken rice soup, pound cake, pears. These items were white to off-white. The menu was not followed either at Hollywood or Van Nuys campuses. Substitutions and changes were made by staff with limited knowledge and training on appropriate substitution. Items that may not be appropriate on a diet were served. Hospital policy titled Menu states " ... All diet changes must be approved by a registered dietitian. Another policy states □The Clinical Dietitian shall be responsible for substituting food so that the patient has adequate quality and quantity.□ The Clinical Dietitian was not consulted in the determination of substitutes being made. In an interview with AD 1 (Registered Dietitian) on March 24 and March 27, 2014, she stated that	A 621	(Continued from page 90) **Date of implementation:** April 10, 2014, 8/2014 **b) Non-select menus:** **Corrective Actions:** In addition to the current non-select menu, an alternate choice menu was developed by a registered dietitian and implemented. Food service staff was trained on the execution of the alternate choice menu. **Date of implementation**: April 10, 2014 **c) Lack of variety and color:** **Corrective Actions:** Current menus are under revision to ensure variety and color and patient acceptance. Patient satisfaction tool is currently in place to monitor patients meal acceptance. Results of current Patient Satisfaction data concerning food service are exceeding benchmarks. **Date of implementation:** September 10, 2014 **d) Menu substitution clarification:** **Corrective Actions:** The Food Service staff and Supervisor were in-serviced to consult Registered Dietitians for proper food substitution. Dietary staff was provided a routine substitution list on proper food substitution. **Date of implementation:** July 31, 2014 **e) Food Service Director responsibilities:** **Corrective Actions:** The organizational structure of Food and Nutrition Services department was reviewed and revised to ensure competent leadership and staff compliance to safe food handling and sanitation practices. Job duties are defined in the job descriptions/performance appraisals.	4/10/2014 9/10/2014 7/31/2014

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A 621	Continued From page 91 she was not involved in the day to day operation or oversight of the food service operation because she believed it was not in her scope of work. Regarding the menu, nutrient analysis and therapeutic spreadsheet, she stated that the menu had been written by the registered dietitian from the other hospitals owned by the licensee and so she had not participated in the menu development. She stated she had no prior knowledge of the issues that had been identified during the survey because she had concentrated on clinical nutrition responsibilities for two hospitals. She further stated it was not possible to complete some of the responsibilities outlined in the position description/Performance Appraisal because she shuttled daily between the two hospitals completing nutrition assessments. Review of the personnel record of the registered dietitian revealed that her last job evaluation was conducted by the director of food services. It was assessed as satisfactory. According to the hospital organizational structure she reported to the hospital administrator and not the director of food service. In an interview with the Staff 12 (Human Resources Manager) on March 27, 2014 at approximately 2:00 p.m., she was unable to provide an explanation of why the Director of Food Services without a formal education and education in food and nutrition was allowed to evaluate the competency of the registered dietitian with an advanced degree (cross reference A 0622, A 0628, A 0619).	A 621	(Continued from page 91) A Registered Dietitian Director of Food and Nutrition Services was recruited, interviewed, hired or promoted to ensure qualified and competent staff was in place. Pertinent responsibilities include: • Provides adequate overall supervision, • Oversight of patient services and menu, • Develops and ensures provision of ongoing training and development of department staff, • Maintains equipment in working order by notifying maintenance of needed repairs and administration for capital replacement, • Demonstrates knowledge of infection control, sanitation and HACCP guidelines related to safe food handling practices to ensure quality and safety of food services. Organization chart was revised to reflect supervisors and clinical dietitians (RD) reporting to the RD Food Service director who in turn reports to hospital administrator. Job descriptions for all positions are in place. The Food Service Director who is an RD will be responsible for reviewing the job performance of the clinical RDs. HR will be responsible for ensuring the Food Service Director RD□s job performance is evaluated by consulting RD or RD peer review. **Date of implementation:** July 31, 2014 **Monitoring Process:** The hospital□s leadership will ensure that the Dietary Department is staffed with competent and appropriately credentialed supervisory coverage.. **Person Responsible:** Human Resources Director Staff training for menus and menu substitution process with Return Demonstration/Comprehension competencies completed by July 31, 2014. Tray audits will be performed 3-5 times per week to ensure diet tray accuracy and compliance with the menu in relation to portion sizes and food items, appropriate food substitutions and food preparation procedures including pureed diets. Results of audit activity will be reported to the hospital□s Quality Council, MEC, and Governing Board on a quarterly basis. Additional training will be provided based on the results of the audits. **Person Responsible:** Food Service Directors	7/31/2014
A 622	482.28(a)(3) COMPETENT DIETARY STAFF There must be administrative and technical personnel competent in their respective duties. This STANDARD is not met as evidenced by:	A 622	**Hollywood & Van Nuys :** **Corrective Actions:** The organizational structure of Food and Nutrition Services department was reviewed and revised to ensure competent leadership and staff compliance to providing physician diet order administration, safe food handling and sanitation practices.	

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A 622	Continued From page 92 Based on observation, review of facility documents and staff interviews, the hospital failed to ensure that its dietary staff was competent in their duties in the dietetic service area when they were unable to properly calibrate food thermometers, prepare pureed diet to the correct consistency, serve patients correct diets. These failures resulted in improper sanitation and food handling practices that could cause food borne illness. It also resulted in patients receiving incorrect diets and less nutrition than was ordered by their physicians and planned by the dietitian. Findings: Hollywood campus At approximately 11:20 a.m., on March 24, 2014, there was a discrepancy of approximately 60 degrees between the recorded food temperatures of the hospital staff and that of the surveyor. The pasta was 122 degrees Fahrenheit (F), but recorded as 162 degrees in the hospital log. Rice was 182 degrees F and recorded as 172 degrees F. As a result of these discrepancies, hospital staff was asked to recalibrate its thermometer. A review of the posted □Thermometer Calibration Daily Log Sheet□ for March 2014 showed the thermometer had been calibrated earlier that morning at 8:10 a.m. and it read 32 degrees F. The correct procedure to calibrate a bi-metallic thermometer in ice is to immerse thermometer in a 50/50 ice to water ratio. After approximately, three minutes, read thermometer. If thermometer temperature is not 32 (+/- 2) degrees F the thermometer is recalibrated in ice by turning the dial to 32 degrees. During observation of the calibration process,	A 622	(Continued from page 92) A Registered Dietitian Director of Food and Nutrition Services was recruited, interviewed, hired or promoted to ensure qualified and competent staff was in place. Pertinent responsibilities include: • Provides adequate overall supervision, • Oversight of patient services and menu, • Develops and ensures provision of ongoing training and development of department staff, • Maintains equipment in working order by notifying maintenance of needed repairs and administration for capital replacement, • Demonstrates knowledge of infection control, sanitation and HACCP guidelines related to safe food handling practices to ensure quality and safety of food services. Organization chart was revised to reflect supervisors and clinical dietitians (RD) reporting to the RD Food Service director who in turn reports to hospital administrator. Job descriptions for all positions are in place. **Hollywood:** A full-time consulting Director of Dietary Department, RD was appointed to provide oversight of the dietary department. A full-time Food Services Supervisor was appointed to oversee the day to day operations of dietary department. A clinical Registered dietitian and per diem Registered Dietitian are in place to provide clinical support. **Van Nuys:** A full time Director of Dietary Department, RD was placed to provide oversight of dietary department as well as clinical support. A full time Food Services supervisor continues to oversee the day to day operations of dietary department. A per diem clinical Registered Dietitian is available on an as needed basis. **Date of Implementation**: July 31, 2014 Current Food Service staff competency levels were assessed and thereafter will be assessed on a bi-annual basis including skills found lacking during this survey process. After appropriate training and retraining, those staff found to not reach minimum competency requirements, will either be placed in positions that they meet competency levels or if not trainable, will be replaced. **Date of Implementation:** July 31, 2014 **Both Hollywood and Van Nuys:** Additionally, a contract is in process to retain a Food Service Management company to permanently operate the Food & Nutrition Services Department at both the Hollywood and Van Nuys campuses. This contract will include safe food handling and sanitation compliance requirements to meet all State, Federal, and DNV regulatory requirements. Current Management & Supervisory staff probationary competency levels will be assessed. Appropriate actions will be taken as a result of those initial competency assessments. **Date of Implementation:** September 10, 2014.	7/31/2014 7/31/2014 9/10/2014

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A 622	Continued From page 93 Staff 2 (Food Service Director) who was present read the temperature of the thermometer out loud as □32 degrees□ when it was 24 degrees F. When the error was pointed out to him, he then proceeded to recalibrate the thermometer out of the ice water mixture by turning the dial to 32 degrees F. The Calibration procedure on the log directs staff to adjust the dial of the bi-metallic thermometer if the dial does not read 32 degrees F. However, the instructions on the □Thermometer Calibration Daily Log Sheet□did not explain that it needs to remain in the ice and water mixture. During the meal service at approximately 12:15 p.m. on March 24, 2014, a tray for a patient on pureed diet was observed placed on the cart for distribution to the floor. The plate of the unsampled patient contained three small plastic souffle cups. In each cup was pureed meat, pureed vegetable and mashed potatoes. The amounts served appeared smaller than would be expected for an adult. Measurement of the food revealed the meat and vegetables were each 2 oz. The mashed potato was 2/5 c. The consistency of the meat and vegetables was that of soup or liquefied pureed. The correct consistency of pureed food is that of mashed potatoes. In addition, based on the review of the therapeutic spreadsheet presented by hospital staff for that meal, it showed for the pureed diet, the patient did not receive adequate amounts of food. The pureed tray should have received 3 ounces pureed meat (not 2 ounces), 4 ounces vegetables (not 2ounces), 6 ounces soup, amount of mashed potato was not stated, pureed dinner roll, □ c	A 622	(Continued from page 93) **Monitoring Process:** The hospital□s leadership and Human Resources Department will ensure that the Dietary Department is staffed with appropriately credentialed and competent registered dietitians, Certified Dietary Managers, supervisors, cooks, diet aides and food service workers through the initial hiring, orientation and performance evaluation processes. The new Food & Nutrition Services Contract will be reviewed for service level compliance and regulatory standards on an annual basis by Hospital Administration and the Quality Council for recommendation for continuation. **Person Responsible:** Administrators and Human Resource professionals of Southern California Hospital at Hollywood and Van Nuys and Director of Dietary Departments.	

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A 622	Continued From page 94 tapioca pudding and 8 ounces lowfat milk. Another random observation at approximately 12:45 p.m. showed a tray served with food for a patient on a renal diet. The following items were served: Macaroni salad, mandarin oranges in light syrup, confetti rice, chicken, mixed vegetables with broccoli, 1 pat margarine, tapioca pudding and cater blend. The items on the tray were different than was on the spreadsheet approved by the registered dietitian. According to the spreadsheet, a patient on a renal 2 gram sodium, 2 gram potassium diet should have received tossed green salad with dressing (no tomato) 3 ounces meat,% cup green beans, 1dinner roll, 2 pats margarine. The concern is that these items as served such as oranges and broccoli which could be high in potassium and may not be appropriate on the diet. Earlier, the kitchen staff has placed a bowl of cream of chicken soup on the tray for a patient on renal diet. The soup was not observed on the tray for this random patient when the recipe for the soup was requested. The recipe or nutritional information was never provided because the cook stated he no longer had any cans of the product that was used. The concern with the product was that it may contain milk or milk products. Milk contains phosphorus, a mineral that could cause softening of the bones in a patient with impaired kidney function. An interview was conducted at approximately 1:00 p.m. with DS 6 In response to her abilities and knowledge to accurately serve the renal diet in the absence of the spreadsheet (the spreadsheet was not available on the tray line for use to serve the patients during tray line	A 622		

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A 622	Continued From page 95 operation), she indicated that she knew the diets well because she □knows her job□ The hospital did not provide documentation that the dietary staff had been properly trained to correctly serve the diets as planned. DS 7 was observed dishing out applesauce at approximately 12:30 p.m. on March 24, 2014, she was observed to use a □12 scoop or 1/3 cup. The usual serving size for applesauce or most fruits is □ cup. There was no guide to determine the proper size for the applesauce. There was no applesauce on the menu for that day. Review of personnel records for all the Dietary staff showed that all were evaluated in the past year for job related competencies. All were evaluated as a satisfactory based on returned demonstration and verbalization of procedure.	A 622		
A 628	482.28(b) DIETS Menus must meet the needs of the patients. This STANDARD is not met as evidenced by: Based on observation, review of hospital menu, policies and procedures and staff interviews, the hospital failed to ensure that its menus met the nutritional needs of its patients. Portion sizes and correct consistency were not provided to patients. There was no menu written for patients on double portions, substitutions were left to the discretion of the cooks during meal service. There were unsampled patients that did not receive diets as ordered by their physicians or according to recognized professional practices. The deficient practice had the potential for compromising patients□nutritional status.	A 628		

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A 628	Continued From page 96 Hollywood campus 1. During meal service at approximately 12:15 p.m., on March 24, 2014, a tray for a patient on pureed diet was observed placed on the cart for distribution to the floor. The plate of the unsampled patient contained three small plastic souffle cups. In each cup was pureed meat, pureed vegetable and mashed potatoes. The amounts served appeared smaller than would be expected for an adult. Measurement of the food revealed the meat and vegetables were each 2 oz. The mashed potato was 2/5 c. The consistency of the meat and vegetables was that of soup or liquefied pureed. The correct consistency of pureed food is that of mashed potatoes. In addition, based on the review of the therapeutic spreadsheet presented by hospital staff for that meal, it showed for the pureed diet, the patient did not receive adequate amounts of food. The pureed tray should have received 3 ounces pureed meat (not 2 ounces), 4 ounces vegetables (not 2ounces), 6 ounces soup, amount of mashed potato was not stated, pureed dinner roll, □ c tapioca pudding and 8 ounces lowfat milk. 2. Another random observation at approximately 12:45 p.m. showed a tray served with food for a patient on a renal diet. The following items were served: Macaroni salad, mandarin oranges in light syrup, confetti rice, chicken, mixed vegetables with broccoli, 1 pat margarine, tapioca pudding and cater blend. The items on the tray were different than was on the spreadsheet approved by the registered dietitian. According to the spreadsheet, a patient on a renal 2 gram sodium, 2 gram potassium diet should have	A 628	(Continued from page 96) **Hollywood** **1) Pureed food:** **Corrective Actions:** Food service staff was educated on proper preparation of pureed food using food thickener and portioning of pureed food items. **Date of Implementation:** May 19, 2014 **2) Renal diet:** **Corrective Actions:** Incorrect food items on the Renal Diet patient trays were replaced with appropriate food items.	5/19/2014

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A 628	Continued From page 97 received tossed green salad with dressing (no tomato)□3 ounces meat, %cup green beans, 1 dinner roll, 2 pats margarine. The concern is that these items as served such as oranges and broccoli which could be high in potassium and may not be appropriate on the diet. 3. Earlier, the kitchen staff has placed a bowl of cream of chicken soup on the tray for a patient on renal diet. The soup was not observed on the tray for this random patient when the recipe for the soup was requested. The recipe or nutritional information was never provided because the cook stated he no longer had any cans of the product that was used. The concern with the product was that it may contain milk or milk products. Milk contains phosphorus, a mineral that could cause softening of the bones in a patient with impaired kidney function. Culver City campus During tray line observation on March 25, 2014 at approximately 11:45 a.m., several patient trays had pieces of the main entree, pork loin. The portion size of the slices fluctuated from tray to tray with some tray receiving about half of what other trays received. Review of the therapeutic spreadsheet revealed that the portion size for the entree was 3 ounces. One of the trays with a small piece of meat was examined and weighed. The pork loin weighed 1-1/2 ounces, half of what the menu had called for. During the same trayline observation, the tray card of an unsampled patient was examined. The items doubled on the tray were pork loin and mashed potatoes. Review of the spreadsheet did	A 628	(Continued from page 97) **3) Renal diet appropriate food item:** **Corrective Actions**: Food service staff was trained on following the menu spread including therapeutic diets and any substitutions must be approved by RD dietitian. Dietary staff was in-serviced on appropriate portion sizes, correct consistency, menu reading and following therapeutic diet requirements including small and double portions. Menu books were provided to the dietary staff for reference to ensure accurate patient tray preparation. In addition a simplified □snap shot□of items to be used in the prep area was created and posted. Additional changes to these processes will be implemented and staff trained based on audit results. **Date of Implementation:** May 19, 2014 and April 30, 2014 to June 5, 2014. Initial Competency completed by 7/31/14.Additional process training to be completed and competency assessed by September 10-, 2014 **Monitoring Process:** Biannual return Demonstration/Comprehension competencies will be conducted on all food service staff at Hollywood and maintained in employee files. Tray audits will be performed 3-5 times per week to ensure diet tray accuracy and compliance with prescribed menu. Results of audit activity will be reported to the hospital□s Quality Council, MEC, and Governing Board on a quarterly basis. **Person Responsible:** RD, Director of Dietary Department **Culver City** **1. Menu portion sizes:** **Corrective Actions:** The inaccurate portion of pork loin was immediately corrected and patient received the correct portions as reflected on the menu. Verbal Counseling and re-training with cooks on preparing portions, Written Training with supervisors on daily monitoring of portioning for patients. **Date of Implementation**: 4/11/14 **Monitoring Process**: Daily data collection by supervisors and monthly data analysis by Clinical Nutrition Manager on portion accuracy with Semi-annual reporting to Quality Council. **Person Responsible**: R.D. Clinical Nutrition Manager **2. Double portion:** **Corrective Actions:** Policy for Double Portions was added to our current Policy on Special Patient Meals and Services. The policy includes serving double portions of meat, starch and vegetables. Procedure was added to daily menu spreadsheets. **Date of Implementation**: 6/20/2014 **Monitoring Process:** Random monitoring of double portions as part of Quarterly Tray Accuracy. **Person Responsible**: R.D. Clinical Nutrition Manager	5/19/2014 7/31/2014 4/11/2014 6/20/2014

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A 628	Continued From page 98 not include instructions on a Double Portions. Review of the policy titled Double Portions did not specify what food needed to be doubled per meal. It is unclear whether this tray was accurate as there was no formal checking of trays for accuracy except for those on □complicated diets.□ Van Nuys campus Dietary Staff (DS) 1 was observed not using scoops when dishing out patients□food. The assurance that the diet meets the need of the patients cannot be guaranteed when the correct portion size is not used in serving. There were several patient food trays observed with large amounts of food. Each of the trays had 2 large hash browns, two eggs, 2 slices of bagel, 2 sausages, a bowl of cream of wheat and a carton of 2 % milk. Staff 1 stated on March 27, 2014 at approximately 9:50a.m. that those patients had orders for double portions. She stated there was no policy on double portions and that patients are given just what the patients want. They provide them every item times two. She stated patients ..want double meats not salads... There was no policy provided on double portions. Staff 2 stated in an interview on March 27, 2014 at approximately 10:00 a.m. that keeping the menus, spreadsheets and policies and procedure was a challenge because former employees who were disciplined would remove them from the department as retaliation. Items served to the patients did not match what was on the □menu.□ On March 27, 2014	A 628	(Continued from page 98) **3. Tray accuracy:** **Corrective Actions:** To address the lack of formal checking of all patient food trays, the sample size of Tray Accuracy monitoring was increased to 10% to reduce inaccuracies through observation and training. .**Date of Implementation:** April 2014 **Monitoring Process:** Monitor 10% of patient trays on a quarterly basis for accuracy of patient trays against the tray ticket. Analyze data and report to Quality Council on a Semi-Annual Basis. **Person Responsible**: RD, Clinical Nutrition Manager **Van Nuys** **1) Portioning devices:** **Corrective Actions:** Portioning devices were purchased. Staff was in-serviced on using correct portioning devices to match the portions on the menu spreads. **2) Double portion:** **Corrective Actions**: A procedure was developed and implemented for double portions and staff was in-serviced. **3) Tray accuracy, portion sizes and food substitution:** **Corrective Actions**: The Food Service staff and Supervisor were trained to provide portion sizes to match the menu spread. Staff was in-serviced to consult Registered Dietitians for proper food substitution. Dietary staff was provided a routine substitution list on proper food substitution. Dietary staff was in-serviced on appropriate portion sizes, correct consistency, menu reading, menu substitutions procedures and following therapeutic diet requirements including double portions	4/30/2014

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A 628	Continued From page 99 according to the menu, bread pudding was to be offered for lunch. DS 5 was observed dishing out vanilla pudding. In an interview at approximately 10:30 a.m., DS 5 stated she had checked the refrigerator and there was no bread pudding and Director of Food Services A had asked her to substitute vanilla pudding for the bread pudding. She was observed using a □12 scoop (or approximately 3 ounces) to dish the vanilla pudding into containers. The usual portion size for food like vanilla pudding is% cup. The RD who was present during the observation could not validate the correct amount. Hospital policy titled □General Requirements for Food□dated 11/12 states □The Clinical Dietitian shall be responsible for substituting food so that the patient has adequate quality and quantity□The Clinical Dietitian was not consulted in the determination of substitutes being made.	A 628	(Continued from page 99) Menu books were provided to the dietary staff for reference to ensure accurate patient tray preparation. In addition a simplified □snap shot□of items to be used in the prep area was created and posted. Additional changes to these processes will be implemented and staff trained based on audit results. **Date of Implementation:** April 30, 2014 □ June 5, 2014 Initial competency assessed by 7/31/14 **Monitoring Process:** Biannual return Demonstration/Comprehension competencies will be conducted on all food service staff at Van Nuys and maintained in employee files. Tray audits will be performed 3-5 times per week to ensure diet tray accuracy and compliance with prescribed menu. Results of audit activity will be reported to the hospital□s Quality Council, MEC, and Governing Board on a quarterly basis. **Person Responsible:** RD, Director of Dietary Department and Food Services Supervisor	4/30/2014 7/31/2014
A 629	482.28(b)(1) THERAPEUTIC DIETS Therapeutic diets must be prescribed by the practitioner or practitioners responsible for the care of the patients. This STANDARD is not met as evidenced by: Based on food distribution observations, dietary and administrative staff interview and departmental document review, the facility failed to ensure that diets were ordered by the physician as evidenced by inaccurate interpretation of diet orders by dietary and nursing staff. Failure to ensure that physician diet orders are followed may result in the further compromising of patients□medical status. Findings:	A 629	**Corrective Actions:** Only diets ordered by physicians are to be transcribed. Dietitians have compared Diet orders as written by physicians are compared to those transcribed by others i.e. Computerized Physician Order Entry not used. Assessed current status of diet orders to identify potential opportunities for order to not reach food service as ordered by physicians. Errors included- transcription error or lack of deletion of previous diet order, verbal orders or other orders not authenticated by a physician or diets not sent as doctors ordered due to diet ticket errors in the food service department. Memos sent to physicians to use approved diet orders only to be entered in Electronic Medical Record by physicians. List of approved diet orders were streamlined to only include approved diet orders. Require the use of mandatory physician computer ordering to minimize errors. Nursing personnel completed training including procedures related to verbal order and order verification. Training provided to food service staff on properly full filling doctors□ orders or the requirement to contact a registered dietitian to calculate order and obtain clarification from physicians for orders not written according to standard. Dietitian to document requests in medical record for diet clarifications or inform physicians of recommended diet orders. **Date of Implementation:** April 30, 2014 to September 10, 2014 **Monitoring Process:** Diet accuracy of manual orders is monitored by clinical dietitians. These items are monitored including, accuracy of manual diet list completion at Hollywood and Van Nuys and monitoring of diet clerk tray tickets against diet lists. . Results of audit activity will be reported to the hospital□s Quality Council, MEC, and Governing Board on a semi-annual basis. **Person Responsible:** Clinical Dietitian, Clinical Manager or Food Service Director who is a Registered Dietitian	4/30/2014

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A 629	Continued From page 100 1. Patient 8 was admitted with diagnoses including diabetes mellitus (high blood sugar), hypertension (high blood pressure) and asthma. Review of admitting orders revealed that there was no order for diet. Electronic record review on March 27, 2014 revealed that an order was entered for a No Added Salt later than evening by one of the nurses. Registered Nurse (RN) 20 stated that she received an order but was not sure she faxed an authentication of the diet order to the physician was faxed as it is customary to do with medical orders. She stated that another nurse was helping her with the admission and that she assumed the other nurse faxed the diet order. There was no documented evidence that either nurse had called the physician to receive a diet order or authenticate a verbal order. Comments made by other unidentified nurses on the unit revealed that they use information on diet orders from previous admission to determine diet orders when physicians do not add diet orders. There was no telephone order authentication by the admitting physician either in the electronic or paper record. According to the Hospital policy titled 11telephone and verbal orders dated 07/2004, states Telephone orders are too be written and read back to physicians to clarify. 2. Patient 13 was admitted to the Van Nuys campus on March 25, 2014 with diagnosis including exacerbation of depression. Physicians' admission diet order dated March 25, 2014 was a no added salt diet. Review of Patient 13's meal tray ticket on March 27,2014 at 10:30 a.m., revealed that the diet	A 629	(Continued from page 100) **1.) Corrective Actions**: All nursing staff re-educated with self-study module to validate that physician orders have been noted, examined, and verified. Caregivers must use SBAR and provide the opportunity to use read-back techniques and medications orders received must be read back by the receiver. 24 hour order/chart check policy & procedure PAT.059 implemented that mandates documentation of chart review before 7am each day. **Date of Implementation:** 5/18/2014 **Monitoring Process**: Random audit of 30 charts will be done per nursing unit. **Person Responsible:** Nursing Leadership	

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A 629	Continued From page 101 delivered was a 2 grams sodium restriction. In an interview with Staff 1 she stated that on a daily basis she received a diet list from nursing staff. Review of the diet list dated March 27, 2014 noted that nursing staff indicated that Patient 13 was to receive a no added salt diet. A no added salt diet is typically a 4 gram sodium diet. Therefore, Patient 13 was served a more restrictive diet than his physician had ordered. In an interview on March 27, 2014 beginning at 11 a.m., with the Registered Dietitian (RD 1) she stated that it appeared that Staff 1 was transcribing the order from a no added salt to a 2 gram diet. In addition, RN 20 and RN 21 stated in concurrent interviews on March 27, 2014 at approximately 3:15 p.m. that when they receive orders for diabetic diet, they translate that as Non Concentrated Sweets Diet. A non-concentrated sweets diet is one in which desserts, and sugars are avoided. According to the American Diabetes Association, this diet incorrectly teaches patients that sugar intake is the cause of diabetes.	A 629	(continued from page 101) **Corrective Actions:** Non-concentrated sweets diet order is being eliminated from the list of approved diets in CPOE. Physicians who have a justified need for this particular diet order, can order it through other diet options. **Date of Implementation:** August 18, 2014, elimination of non-concentrated sweets, at the Culver City Campus, was put into effect. Elimination of the non-concentrated sweets diet will be put into effect at the Hollywood and Van Nuys Campuses on September 10, 2014. **Person Responsible:** RD, Food Service Director, Clinical Dietitian RD	8/18/2014 9/10/2014
A 630	482.28(b)(2) DIETS Nutritional needs must be met in accordance with recognized dietary practices and in accordance with orders of the practitioner or practitioners responsible for the care of the patients. This STANDARD is not met as evidenced by: Based on patient observations, nursing and dietary department interview and medical record and departmental policy review, the facility failed to ensure the physician diet orders were implemented as ordered for 3 of 7 patients, in a sample of 51, reviewed for clinical nutrition care as evidenced by 1) Patient 12□s tube feeding was	A 630		

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A 630	Continued From page 102 not delivered per physicians orders; 2) Patient 40's diet was implemented with greater restrictions than the physicians' orde; 3) patients with calorie defined diabetic diets were not implemented as ordered; 4) Patient 11's nutritional intervention delayed for five days before implementation. The deficient practice had the potential for compromising patients' nutritional status. Findings: Hollywood campus 1. During meal service at approximately 12:15 p.m. on March 24, 2014, a tray for a patient on pureed diet was observed placed on the cart for. distribution to the floor. The plate of the unsampled patient contained three small plastic souffle cups. In each cup was pureed meat, pureed vegetable and mashed potatoes. The amounts served appeared smaller than would be expected for an adult. Measurement of the food revealed the meat and vegetables were each 2 oz. The mashed potato was 2/5 c or 3.2 ounces. The correct portion for purred meat should have been 3 ounces, 4 ounces for the vegetables and mashed potatoes based on the serving size of the patients on the regular diets. The consistency of the meat and vegetables in each of the cups was that of soup or liquefied pureed. The correct consistency of pureed food is that of mashed potatoes. Incorrect consistency could result in aspiration of food into the lungs resulting in aspiration pneumonia. Aspiration pneumonia is an inflammation of the lungs or bronchial tubes resulting from food, saliva, liquids or vomit breathed into the lungs.	A 630	**Hollywood & Van Nuys** **1.) Pureed food :** **Corrective Actions:** Food service staff was educated on proper preparation of pureed food using food thickener and portioning of pureed food items. Dietary staff was in-serviced on appropriate portion sizes, correct consistency, menu reading and following therapeutic diet requirements. Menu books were provided to the dietary staff for reference to ensure accurate patient tray preparation. In addition a simplified □snap shot□of items to be used in the prep area was created and posted. Additional changes to these processes will be implemented and staff trained based on audit results. **Date of Implementation:** May 19, 2014 and April 30, 2014 to June 5, 2015. Initial Competency will be completed 7/31/14. **Monitoring Process:** Biannual return Demonstration/Comprehension competencies will be conducted on all food service staff at Hollywood and maintained in employee files. Tray audits will be performed 3-5 times per week to ensure diet tray accuracy and compliance with prescribed menu. Results of audit activity will be reported to the hospital□s Quality Council, MEC, and Governing Board on a quarterly basis. **Person Responsible:** RD, Director of Dietary Department	5/19/2014 7/31/2014

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A 630	Continued From page 103 Culver City campus 2. Patient 12 was admitted with diagnosis including pneumonia (an infection in the lungs) and hypoxia (a low level of oxygen in tissues and blood). Electronic medical record review was conducted on March 26, 2014 beginning at 2 p.m. Admission diet order dated March 13, 2014 was a cardiac diet. A physicians' order dated March 24, 2014 was for tube feeding through a nasogastric tube (tube through the nose inserted in the stomach for feeding) with Diabetasource (tube feeding formula for diabetics) at a rate of 20 cc (cubic centiliters)/hour. A follow up order dated March 26, 2014 requested water via the NG tube, 150 cc (a metric unit of measure) every 6 hours. The tube feeding was ordered on March 24, 2014 at 3 p.m. An observation of the tube feeding was conducted on March 26, 2014 at 3:00 p.m. It was noted that the tube feeding pump was off. It was also noted that the feeding bag or the tubing was not dated and/or labeled; the volume in the bag at the time of hanging was 1,000 cc and that there was approximately 300 cc left. It was also noted that a new bag of Diabetasource was lying on the residents' bedside table. In a concurrent interview with Staff 3, she stated that the dietary department sent up tube feedings every day at lunch that included labels which were intended to be placed on the tube feeding when it was hung. In an interview with RN 17, she stated that she reset the pump as 12 p.m. (3 hours prior). She also stated that she cleared the pump at 12 p.m. and turned the pump off shortly before 3 p.m. to provide personal care and probably forgot to turn it back on.	A 630	(Continued from page 103) **Culver City** **Corrective Action:** Policy VAS.005 □Intravenous Therapy □ Initiation and Management of Peripheral Intravenous Lines□and Policy PAT.057 □Enteral Nutrition Support□were used, along with the mandatory online self-study module, to re-educate nursing staff. All feeding bags, IV bags and all tubing must be labeled, dated, timed and initialed. Documentation of tube feeding will be accurate. **Date of Implementation:** 6/16/2014 **Monitoring Process:** Nursing Leadership from each department will monitor proper labeling of IV bags, feeding bags and all tubing using the newly created □IV Fluid P.I.□and □Feeding Formula P.I.□ audit tools. Date will be collected on 30 random patients and then results will be reported to the Quality Council on a monthly basis. **Person Responsible:** Nursing Leadership in each unit.	06/16/2014

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A 630	Continued From page 104 A review of medical record document titled □Daily Assessment Inquiry□dated March 24, 2014 at 8 p.m. was the first time that the tube feeding was noted; however there was no documentation in the electronic medical record when the feeding was actually hung. It was also noted that the actual amount of feeding that was being delivered was not accurately recorded and/or the documentation noted the physician□s order of 20 cc/hour. For example, on March 26, 2014 at 6 a.m. the amount of tube feeding delivered was recorded as 240 cc. Follow up documentation dated March 26, 2014 at 12 p.m., noted an entry of 240 cc. If the feeding was running per the physicians order the pump should have read either 360 cc (if the pump was not cleared at the 6 a.m. entry) or 120 cc for the 12 p.m. entry rather than the documented 200 cc. In an interview on March 24, 2014 at 3:15p.m., RN 17 was unable to explain the discrepancy. In a concurrent interview with Staff 3 she acknowledged that the feeding was not likely delivered per the physicians□order. A review of training dated 10/13 noted that Staff 4 completed a handout at the annual nursing skills fair that reminded staff to □always put a date and hang time on each tube feeding bag even if you do not get a pharmacy label ...□ 3. During a review of physician ordered diets on March 26, 2014 at 9 a.m., it was noted that Patient 49 had a physician ordered 3 gram potassium diet. It was also noted that the physicians□diet was transcribed as a low potassium diet. In an interview on March 26, 2014 at 3:30p.m., with DS 2 she was asked to	A 630	(Continued from page 104) **3)Culver City** **Physician orders not implemented:** **Corrective Actions:** The diet pattern was calculated by the RD dietitian and implemented immediately. Food & Nutrition Services Diet office personnel were retrained on Diet Modifications for K diets and on the requirement to contact a dietitian for diets not found in the diet manual or for diet clarifications. **Date of Implementation:** 4/22/14 **Monitoring Process:** Diet Modification accuracy is monitored quarterly with a sample size of 30 menus per clerk. . Results of audit activity will be reported to the hospital□s Quality Council, MEC, and Governing Board on a semi-annual basis. **Person Responsible:** R.D. Clinical Nutrition Manager	4/22/2014

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A 630	Continued From page 105 describe how this diet was implemented. She stated that she had not yet completed the tray cards for the ensuing day; however she would use the pre-printed menu for renal diets, which limited the potassium to 2 grams/day. She also stated that if the renal diet did not meet the physicians' specific parameters she would decrease the amount of protein in each of the meals to meet the parameters. The example she described was to decrease the noon meal to 1-ounce of protein and the dinner entree selection to 3 ounces. She also stated that once the meal was delivered she would not be able to recount what was actually delivered as there was no system to know what was delivered to patients after the fact. In a concurrent interview with Staff 4; she was asked if there was guidance for dietary staff to follow when referring specialized diets to a registered dietitian (RD) 1 for review. She replied that while there was no guidance this was one that should have been reviewed by an RD 1. Review of the hospitals diet manual on March 26, 2014 at 4 p.m., revealed that a renal diet would restrict protein, sodium and the potassium was limited to 2 grams, a more severe restriction than was ordered by the physician. Sources of potassium include meats, vegetables, and dairy (National Institute of Medicine), a 3 gram potassium diet would have included additional sources of potassium rather than restricting them. On March 28, 2014, the hospital presented a blank document titled □Diet Clerk Competency Test□ which included guidance to contact the RD for modification of complicated diet orders. 4. Patient 11 was admitted on March 9, 2014, with diagnoses including congestive heart failure (a	A 630	(continued from page 105) **Culver City (page 104)** **4) RD recommendation:** **Corrective Actions:** RD recommendations to physicians are a current performance indicator. A letter has been drafted by Food & Nutrition and was sent by Medical Administration reinforcing the importance of the timely acknowledgement and/or ordering of dietitian recommendations. **Date of Implementation:** 6/16/2014	6/16/2014

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A 630	Continued From page 106 condition in which the heart's function as a pump is inadequate to deliver oxygen rich blood to the body), hypertension (high blood pressure), diabetes (a condition in which a person has high blood sugar) and chronic kidney disease (a gradual loss of kidney function). His physician ordered a 1500 to 1800 calorie diet on admission. After a nutritional assessment on March 12, 2014, the registered dietitian recommended a diet change to a 2000 calorie ADA cardiac renal diet. This recommendation was written on a bright colored pink paper placed in the physician's order section of the clinical record for physician acknowledgement and/ or approval of recommendation. The physician did not acknowledge/approve the recommendation until March 16, 2014, four days after the recommendation was made. The diet was not ordered until the next day. Nutrition intervention was delayed for about five days due to physician's delay in acknowledging the RD's recommendation. In addition, the physician ordered a fluid restriction of less than 1500 cc on admission. This order was not transcribed as part of the diet order and so the fluid restriction was not implemented as part of the order until three days later on March 12, 2014 when the RD noticed it while conducting the nutritional assessment. In between the three days that the fluid restriction was not implemented, Patient 11 was ordered Boost, a nutritional supplement three times a day with meals. He received this in addition to the 2000 cc of fluid which is part of his diet, an additional 720 cc from three boxes of Boost. Laboratory values on March 26, 2014 showed	A 630	(Continued from page 106) **Monitoring Process:** Continued tracking of % of dietitian recommended√ acknowledged or ordered for all recommendations made. Results of audit activity will be reported to the hospital□s Quality Council, MEC, and Governing Board on a quarterly basis. **Person Responsible:** R.D. Clinical Nutrition Manager at Culver City **FINDING: PATIENT 11 *Dietary Orders*** **Corrective Actions:** An internal review of dietary processes identified handwritten dietary recommendations were placed into the patient□s medical record and not reviewed in a timely manner. The following improvements have been implemented: • All physicians are required to input orders via the Computerized Physician Order Entry System (CPOE). • All dietary recommendations are required to be input into the electronic medical record (EMR). Input of a dietary recommendation into the EMR triggers a □flag□of a pending diet recommendation and prompts appropriate follow-up for a physician□s order to finalize said dietary recommendation. • The Dietary Department will monitor all diet orders, executed as a result of a diet recommendation, to ensure all diet orders are appropriately fulfilled. Audit results will be reported to the hospital□s Pharmacy and Therapeutics Committee, Quality Council, Medical Executive Committee, and Governing Board. **Date of Implementation** • Internal review of the dietary processes was conducted April through June 2014. • Mandatory input of dietary recommendations into the EMR completed July 22, 2014 for the Culver City campus and August 1, 2014 for the Van Nuys and Hollywood campuses. • Physicians mandated to input orders via CPOE by July 15, 2014 for the Hollywood and Van Nuys campuses and by August 18, 2014 for the Culver City campus. • Super-users have been hired and trained to support physician adoption and training. Physician CPOE training commenced June 25, 2014. **Monitoring Process:** • The Dietary Department will monitor all diet orders, executed as a result of a diet recommendation, to ensure diet orders are appropriately fulfilled. Audit results will be reported to the hospital□s Pharmacy and Therapeutics Committee, Quality Council, Medical Executive Committee, and Governing Board. • Compliance will be gauged by reviewing the number of diet recommendations generated (denominator), and of those, the number of orders written and executed (numerator) • Targeted compliance is 90% • Monitoring activity will commence for a period not to exceed 4 months or until optimal compliance is achieved and sustained. • Random audits will be performed thereafter. • Results of the audits will be reported to the hospital□s Pharmacy and Therapeutics Committee, Quality Council, Medical Executive Committee, and Governing Board. **Person Responsible:** Director of Dietary/Food Services or designee.	4/15/2014 7/22/2014 8/1/2014 7/15/2014 8/18/2014 6/25/2014

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A 630	Continued From page 107 that his kidneys were working well and cleaning out toxins in his body. His blood urea nitrogen (measurement of nitrogen in the blood that comes from waste product urea) was 65 (normal 7-20) and creatinine a byproduct of normal muscle contractions that is cleared by the kidneys) was 5.0 (Normal 0.6 -1.3) Clinical record review showed that Patient 11 was refusing dialysis (treatment that removes wastes in the blood done by healthy kidneys) which would have alleviated the fluid his body was retaining. The physician had ordered daily weights also as part of the admission orders but this was not done. Monitoring weight is one of the ways a physician could monitor how much fluid the body is retaining. This is of significance because Patient 11 suffered from both congestive heart failure and kidney failure, two conditions in which excessive fluid retention is detrimental. 5. During review of physician ordered diets on March 26, 2014 at 9 a.m., it was noted that the diets for patients with diabetes were not consistent with what was transcribed to the electronic diet entry order system. The hospital utilized consistent carbohydrate diets which utilize meal plans without specific calorie levels, rather incorporates consistent levels of carbohydrate from day to day at breakfast, lunch and dinner (American Diabetes Association, 1997); however the physician ordered diets depicted specific calorie levels. For example, if a physician ordered a 2000 calorie American Diabetes Association (ADA) diet it would get transcribed to a 1900-2200 carbohydrate consistent diet. Review of the hospital diet list dated March 28, 2014 for the	A 630	(continued from page 107) **Corrective Actions:** All nursing staff will be re-educated on proper I & O documentation, obtaining weights and documentation of weights. Super users will notify RNs of any discrepancies. RNs will correct discrepancies. SuperUsers are qualified clinical staff with extensive competencies in electronic clinical documentation. They are available on site 24 hrs. a day/ 7 days a week. **Date of Implementation**: 6-19-2014 with full implementation in 30 days **Monitoring Process**: Super Users will monitor and collect data on a minimum of 200 charts a month and outcomes will be reported up to the Quality Council on a monthly basis. Any level of non-compliance will be reported to the Nursing Director for immediate corrective action. **Person Responsible:** Clinical Education Coordinator/Informatics	6/19/2014

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A 630	Continued From page 108 medical/surgical unit (5 east) revealed that 11 of 11 diets were transcribed in this manner. It was also noted that the method of transcription was not consistent within the hospital. For example, the diet list dated March 26, 2014 noted that the physician ordered an 1800 calorie ADA diet (Patient 18) which was transcribed to a 1500-1800 calorie consistent carbohydrate diet. In contrast Patient 50, who was on the medical surgical unit had an 1800 ADA diet order which was transcribed to a diabetic diet/consistent carbohydrate. Additionally, Patient 43 had a 2500 calorie ADA diet which was transcribed to a 1900-2200 calorie diet. On March 26, 2014 beginning at 9:30a.m., the analysis of the hospitals non-select, standard carbohydrate consistent diet which was designed to provide 4-5 carbohydrates/meal (60-75 grams/meal) was reviewed. It was noted that for 6 of 21 meals the carbohydrate level did not meet the hospitals upper limit parameter, ranging from 82-95 grams/meal. It was also noted that only 10 of 21 meals fell within the documented parameters of 60-75 grams/meal. In an interview on March 26, 2014 at 4 p.m., with Staff 4, she stated that the hospital was attempting to eliminate physicians ordering diabetic diets, rather transition to the carbohydrate consistent terminology. She also stated that while there was discussion with medical staff, physicians continued to prefer to use the concept of calorie restriction. On March 28, 2014 at 9 a.m., Staff 4 the hospitals' pharmacy and therapeutics committee approved the translation of the diet orders by the department. Review of hospital document titled "	A 630	(continued from page 108) **b) Consistent Carbohydrate diet:** **Corrective Actions:** Consistent Carbohydrate diets have been modified to fit within the description in the diet manual with appropriate changes noted on the diet spreadsheet. **Date of Implementation**: 6/19/14	6/19/2014

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A 630	Continued From page 109 Medical Staff Bylaws□dated 12/4/13, Section 12.7.2 which described the duties related to the Pharmacy and Therapeutics (P&T) Committee noted that the purpose of the committee was to □Objectively review the clinical use of all drugs□ □and to advise the Medical Executive Committee and Medical Staff on issues related to pharmacy services. There was no indication that the P&T was assigned the duty of reviewing nutrition practices that were not related to medication administration. On March 25, 2014 at 4 p.m., the hospital provided a screen shot of the available diet orders in the electronic medical record. It was noted that there were five different types of consistent carbohydrate diets: 1900-2200 calories (5-6 carbohydrates □CHO□/meal); 1500-1800 (4-5 CHO/meal); 1200-1400 (3-4 CHO/meal); 2300-2500 (6-7 CHO/meal) and a diabetic/consistent carbohydrate diet. Hospital policy titled □Diet Manual□dated 11/12 guided staff that the □diet order should be specified in terms of exact amount of restriction: 1500 calorie □ □ It also noted that if the physician □is unsure of the terminology necessary for desire diet order, he/she should consult the Clinical Diet Manual ...□ It was noted that the policy did not reflect the practice within the department, as the physicians ordered diets in accordance with the policy. Review of the hospitals□diet manual under the section titled 11 □Dietary Management of Diabetes Mellitus□ revealed that this section provided clinical practice recommendations; rather than the elements of a diet manual. Additionally it was noted that referring to the diet manual would not	A 630	(Continued from page 109) **c) Corrective Actions:** A separate document for Alta Hollywood Hospitals Medical Staff Bylaws was found which specifies the responsibilities to assess and make recommendations to the Medical Executive Committee regarding the nutritional products and services provided to the patients in the hospital. **d) Corrective Actions:** A diet manual addendum was added to include 5 different types of Consistent Carbohydrate diets. Diabetic/Consistent Carbohydrate diet was eliminated from the diet order list. **Date of Implementation:** 6/30/14 **e) Corrective Actions:** Dietitians reviewed the physicians□diet orders and requested clarifications from physician when orders were not written according to diet manual. Facility to enforce mandatory use of physician computer order entry which will restrict the possibility of ordering diets that are not present in the diet manual removing the potential for improper transcription or the need to interpret diet orders. Memo sent to physicians concerning the upcoming conversion to all computerized order entry and the diet types that will be present. Until conversion dietitians will monitor order transcription and make recommendations for diet order changes to currently accepted diets Interim plan to provide ADA diets as ordered by physicians until required use of Computerized Physician Order Entry (CPOE) is totally implemented. Diet Spread in the process of being modified to include ADA exchange diet patterns and complete nutritional analysis of these diets. **Date of Implementation:** 8/18/14 **f) Corrective Actions:** A diet manual addendum will be added for Van Nuys and Hollywood to include all required components for diets in the diet manual to ensure physicians can accurately order diets. A list of diets available within the CPOE will be created and distributed to the doctors to improve the ease of ordering. Diets not specifically on the list that are required for physician order will be available through an □other diet□entry system. **Date of Implementation: 9/10/14**	6/30/2014 8/18/2014

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A 630	Continued From page 110 have provided physicians additional guidance for ordering diabetic diets as the document provided clinical practice recommendations rather than guidance for ordering diabetic diets within the hospital. Hospital documents showed that on March 28, 2014 at 9 a.m., the hospital provided education provided to nursing leadership on entering diets into the system. It guided nurses to □transcribe the physician□s diet order correctly from the diets available in the system;□ however, it would not be possible for nursing staff to follow this guideline as ordering calorie specific diets was not an option in the electronic medical record.	A 630	(Continued from page 110) **Monitoring Process:** The Manual of Clinical Nutrition Management (diet manual) is reviewed and approved annually by the medical staff and Registered Dietitians. Audit to monitor physicians ordering approved diets and accurate diet order transcriptions. Clinical nutrition team audits 10% of patients admitted on a weekly basis. Report finding of diet order errors after CPOE mandatory implemented to Quality Council, Med Exec and Governing Board as part of PI program. **Person Responsible:** R.D. Clinical Dietitian or Culver City Clinical Nutrition Manager	
A 631	482.28(b)(3) THERAPEUTIC DIET MANUAL A current therapeutic diet manual approved by the dietitian and medical staff must be readily available to all medical, nursing, and food service personnel. This STANDARD is not met as evidenced by: Based on departmental document review, the facility failed to ensure that the approved hospital diet manual was used as the basis of ordering diets when it used on the Culver City campus, a non-select diet for a low fiber diet. According to the diet manual, a low fiber diet would provide less fiber than its regular diet. Failure to offer diets with as approved by the medical staff may result in further compromising patients□medical status. Findings: 1. On March 26, 2014 beginning at 11 a.m., the hospitals diet manual and nutritional analysis was	A 631		

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	050135	Q. BUILDING **01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD** R. WING _____	**04/01/2014**

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A 631	Continued From page 111 reviewed. It was noted that in the diet manual, a low fiber diet was described as less than 15 grams of fiber/day. Review of the nutritional analysis of the low-fiber menu revealed that for 3 of 7 days the fiber content exceeded the diet manuals specifications ranging from 16.4-18.7 grams of fiber/day. Hospital failed to use the low fiber diet parameters approved by medical staff to develop the menu for patients on low fiber diets. 2. Review of the hospitals' diet manual under the section titled □Dietary Management of Diabetes Mellitus□ revealed that this section provided clinical practice recommendations; rather than the elements of a diet manual. Diet manuals establish a common language based on hospital practices. A diet manual would reflect the purpose and principles of each diet, a meal pattern based on the hospitals menu, foods allowed and not allowed and the inadequacies of each diet. The facility's diet manual should mirror the diets ordered by physicians and the nutritional care provided by the facility. Hospital policy titled □Diet Manual□dated 11/12 guided staff that the □diet order should be specified in terms of exact amount of restriction: 1500 calorie ....□ However, when these diets were ordered with specific caloric restrictions they were changed and interpreted as consistent carbohydrate levels (CCHO). The policy also noted that if the physician □is unsure of the terminology necessary for desire diet order, he/she should consult the Clinical Diet Manual ... □It was noted that referring to the diet manual would not have provided physicians additional guidance for	A 631	(Continued from page 111) **Culver City** **1) Corrective Actions:** Low Fiber diet has been revised so that nutrition analysis is consistent with the Manual of Clinical Nutrition Management, diet manual used at Culver City. Diet spread sheets have been revised. **(see Addendum 55)** **Date of Implementation:** April 5, 2014 **Monitoring Process**: The Manual of Clinical Nutrition Management (diet manual) is reviewed and approved annually by the medical staff and Registered Dietitians. **Person Responsible:** R.D. Clinical Nutrition Manager. **2) Corrective Actions:** The Medical Nutrition Therapy for Diabetes Mellitus addendum to the Manual of Clinical Nutrition Management (Diet Manual) has been modified to reflect the missing components. Policies, Diet Manual and Electronic Medical Record System will be in sync with the requirement of computerized physician ordering in July 2014. The Diet Manual policy referred to is for Hollywood/Van Nuys. Culver City does not require that □diet orders should be specified in terms of exact amount of restriction□pertaining to 1500 calorie diets **(see Addendum 56)** **Date of Implementation:** 6/1/14 **Monitoring Process:** Monitoring of the accuracy of Diet orders in CPOE will be implemented in 8/2014 following implementation. **Person Responsible:** R.D. Clinical Nutrition Manager	4/5/2014 6/1/2014

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A 631	Continued From page 112 ordering diabetic diets as the document provided clinical practice recommendations rather than guidance for ordering diabetic diets within the hospital. The current standard of practice for the nutritional management of diabetes is the consistent carbohydrate meal plan with has the support of the American Diabetes Association. In an interview with Staff 4 on March 28, 2014 at approximately 10:45 a.m., she stated that the desire has been to have physician order the CCHO diets. If the hospital wanted to meet current standards of practice, its policies, diet manual and electronic medical record system were not in sync and did not reflect the requirements of a diet manual (cross reference A0630).	A 631		
A 700	482.41 PHYSICAL ENVIRONMENT The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community. This CONDITION is not met as evidenced by: Based on observation, review of facility documents and staff interview, the facility failed to meet the Condition of Participation in Physical Environment by failing to: 1. Develop and maintain the physical plant in a manner that assured the safety and well-being of patients (Refer A 701). 2. Ensure the safety of patients and staff when it	A 700	Item 1-6. Captured in A-701 Corrective Action Plans.	

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A 700	Continued From page 113 failed to ensure an adequate food supply to be implemented in a widespread disaster; and hand washing sink that did not have an adequate hot water supply. Failure to ensure maintenance of the physical environment may compromise the medical status of patients and the ability for staff to care for patients (Refer to A 701). 3. Ensure an effective water management plan and supplies to be implemented in a widespread disaster (Refer to A 703). 4. Properly store and dispose of trash by having overfilled and uncovered dumpster□s creating conditions conducive to fly breeding and offensive odors (Refer to A 713). 5. Ensure the plumbing in food production areas were designed and maintained in a manner to prevent potential cross contamination of foods (Refer to A 722). 6. Maintain facilities that mitigate cross contamination may result in exposing patients to a foodborne illness (Refer to A 722). The cumulative effect of these systemic issues resulted in the facility□s inability to ensure and provide a safe patient care environment.	A 700		
A 701	482.41(a) MAINTENANCE OF PHYSICAL A PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured.	A 701	**Van Nuys** **1) Corrective Actions** Patient room bathrooms, 101, 102, 103, 104, 105, 106, 107, 108, 109 and 110 grab bars were removed. Only the grab bar in room 110, an ADA accessible room, was replaced with an anti-ligature grab bar. Grab bars in other patient bathrooms will not be replaced. The exposed plumbing pipes in patient room bathrooms, 101- 110 will be covered with stainless steel flush valve vandal resistant covers and p-trap covers. The standard faucets in patient room bathrooms, 101- 110 were replaced with anti-ligature faucets. All accessible mortise hinges that could be used as anchors by patients will be replaced with anti-ligature continuous hinges. **Date of Implementation:** Patient room bathrooms, 101, 102, 103, 104, 105, 106, 107, 108, 109 and 110 grab bars were removed on 4/21/2014. Planned replacement of anti-ligature grab bars for room 110, an ADA accessible room, was completed on 8/16/2014. The exposed plumbing pipes in patient room bathrooms, 101- 110	4/21/2014 8/16/2014

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A 701	Continued From page 114 This STANDARD is not met as evidenced by: Based on observation and interview the acute psychiatric staffs, the facility failed to develop and maintain the physical plant in a manner that assured the safety and well-being of patients by not reducing opportunities for self-harm and eliminating as many risk factors as possible in the patient's environment including fixtures that could be used as anchor points to tie to that can hold a person's weight and other conditions that could be used as opportunities for self-harm. Additionally, the facility failed to ensure the safety of patients and staff when it failed to ensure an adequate food supply to be implemented in a widespread disaster; and hand washing sink that did not have an adequate hot water supply. Failure to ensure maintenance of the physical environment may compromise the medical status of patients and the ability for staff to care for patients. Findings: On March 24, 2014 between 10:05 a.m. and 3:20 p.m. the following conditions existed in the Van Nuys psychiatric campus. Station 1 (Van Nuys campus) There were fixtures throughout that could be used as anchor points to tie to that can hold a person's weight throughout the unit; including pendant sprinkler heads, grab bars, shower handles, soap dishes, exposed plumbing pipes (water supply to toilet and sink drain line), standard faucets, vents, mortise hinges and self-closing door arms. 1. Patient room bathrooms, including those in	A 701	(Continued from page 114) will be covered by stainless steel flush valve vandal resistant covers to be installed by September 26, 2014; P-trap covers will be installed by September 12, 2014. The standard faucets in patient room bathrooms, 101- 110 were replaced with anti-ligature faucets on August 19, 2014.All accessible mortise hinges that could be used as anchors by patients will be replaced with anti-ligature continuous hinges by September 26, 2014. **Monitoring Process:** Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted to ensure patient safety. Once anti-ligature safety features are complete, engineering will monitor via weekly EOC rounds to ensure a safe environment is maintained. **Person Responsible:** Director of Engineering, ACNO **2) Corrective Actions:** The mechanical fan cover that was exposing the spinning blades of the exhaust fan in Room 101 was secured to the ceiling with new securing screws. A hospital-wide review and facility tour made to ensure all covers are secured for all exhaust fans. **(See Addendum 58)** **Date of Implementation:** 3/24/14 **Monitoring Process:** Monitoring of all exhaust fans scheduled through EOC rounds daily by nursing staff. **(see Addendum 57)** **Person Responsible:** ACNO & Director of Engineering **3) Corrective Actions:** The atmospheric ventilation cover was replaced in Room 101. A hospital-wide review and facility tour made to ensure all atmospheric covers are secure and will be monitored in the EOC rounds daily by nursing staff. **(see Addendum 59)** **Date of Implementation**: 3/24/14 **Monitoring Process:** The monitoring of all atmospheric covers will be monitored in the EOC rounds daily by nursing staff. **(see Addendum 57)** **Person Responsible:** ACNO & Director of Engineering **4) Corrective Actions:** Shower room 4 grab bar was removed. New Anti-Ligature grab bar was installed. The mortise hinges that could be used as anchors by patients will be replaced with anti-ligature continuous hinges. The self-closer arm was reversed to the outside. **Date of Implementation:** Shower room 4 grab bar was removed and replaced with a new anti-Ligature grab bar on April 15, 2014. The mortise hinges that could be used as anchors by patients will be replaced with anti-ligature continuous hinges by September 26, 2014.The self-closer arm was reversed to the outside on 8/16/2014. **Monitoring Process:** Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted to ensure patient safety. Once anti-ligature safety features are complete, engineering will monitor via weekly EOC rounds to ensure a safe environment is maintained. **Person Responsible:** Director of Engineering, ACNO **5) Corrective Actions:** Shower room 5 grab bar was removed. New Anti-Ligature grab bar has been installed in shower room 5. The soap dish was removed. Liquid soap is provided upon request form nurses. The mortise hinges that could be used as anchors by patients will be replaced with anti-ligature continuous hinges. The self-closer arms have been reversed to the outside. **Date of Implementation:** New Anti-Ligature grab bar was installed in shower 5 on April 15, 2014. The soap dish was removed on March 30, 2014.The mortise hinges that could be used as anchors by patients was replaced with anti-ligature continuous hinges by September 26, 2014.The self-closer arms was reversed to outside on April 15, 2014.	8/16/2014 9/12/2014 9/26/2014 3/24/2014 3/24/2014 4/15/2014 8/16/2014 9/26/2014 3/30/2014 4/15/2014 9/26/2014

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A 701	Continued From page 115 rooms 101, 102, 103, 104, 105, 106, 107, 108, 109, and 110 had grab bars, exposed plumbing pipes, standard faucets and mortise hinges that could be used as anchors. 2. Room 101 had the mechanical fan *cover* moved one inch exposing the spinning blades of the exhaust fan. 3. Room 101 had the atmospheric ventilation cover missing, exposing the ventilation duct and a damper and its components. 4. Shower room 4 had a grab bar, mortise hinges and self-closer arm at the door that could be used as anchors. 5. Shower room 5 had a grab bar, shower handles, soap dish mortise hinges and self-closer arm at the door that could be used as anchors. During an interview at the same time as the observation, Staff 6 (director of facilities) stated, □We should have the type of (grab) bar that has the safety plate, they can tie something here and lay down on the floor.□ 6. The dining/activity room had pendent sprinkler heads at the ceiling, a standard sink faucet, and exposed sink drain pipe that could be used as anchors. 7. The bathroom of the dining/activity room had grab bars, exposed plumbing pipes, a standard faucet and mortise hinges that could be used as anchors. At the time of the observation a patient had come non-escorted out of the rest room. 8. The women's common bathroom had grab bars, exposed plumbing pipes, and a standard	A 701	(Continued from page 115) **Monitoring Process:** Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted to ensure patient safety. Once anti-ligature safety features are complete, engineering will monitor via weekly EOC rounds to ensure a safe environment is maintained. **Person Responsible:** ACNO & Director of Engineering **6) Corrective Actions:** The dining/activity room pendent sprinkler heads have been changed to a Recessed Sprinkler head by Mid-Valley Automatic Fire System, Inc. Safety, anti-ligature faucets have replaced the standard faucets. P-trap covers have been ordered to cover exposed sink drain pipe in dining/activity room. **Date of Implementation:** The dining/activity room pendent sprinkler heads have been changed to Recessed Sprinkler heads by Mid-Valley Automatic Fire System, Inc. completed July 11, 2014. The replacement of standard faucets to safe, anti-ligature faucets was completed on August 19, 2014. Installation of p-trap covers will be completed by September 12, 2014. **Monitoring Process:** Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted to ensure patient safety. Once anti-ligature safety features are complete, engineering will monitor via weekly EOC rounds to ensure a safe environment is maintained. **Person Responsible:** Director of Engineering & ACNO **7) Corrective Actions**: The grab bar in the bathroom located in the dining/activity room was removed and will not be replaced. The exposed plumbing pipes will be covered by stainless steel flush valve vandal resistant covers and P-trap covers. Safety, anti-ligature faucets have replaced the standard faucet. The mortise hinges that could be used as anchors by patients will be replaced with anti-ligature continuous hinges door hinges have been ordered to replace the standard hinges. **Date of Implementation:** The grab bar was removed on April 21, 2014 and will not be replaced. The exposed plumbing pipes will be covered by stainless steel flush valve vandal resistant covers to be installed by September 26, 2014; P-trap covers will be installed by September 12, 2014.Safety, anti-ligature faucets replaced the standard faucet on August 19, 2014. The mortise hinges that could be used as anchors by patients was replaced with anti-ligature continuous hinges by September 26, 2014. **Monitoring Process:** Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted to ensure patient safety. Once anti-ligature safety features are complete, engineering will monitor via weekly EOC rounds to ensure a safe environment is maintained. **Person Responsible:** Director of Engineering & ACNO **8) Corrective Actions:** The grab bar in the women□s common bathroom was removed and will not be replaced. The exposed plumbing pipes will be covered by stainless steel flush valve vandal resistant covers and P-trap covers. Safety, anti-ligature faucets have replaced the standard faucet. **Date of Implementation:** The grab bar was removed on April 21, 2014 and will not be replaced. The exposed plumbing pipes will be covered by stainless steel flush valve vandal resistant covers to be installed by September 26, 2014; P-trap covers will be installed by September 12, 2014. Safety, anti-ligature faucets replaced the standard faucet on August 19, 2014. **Monitoring Process:** Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted to ensure patient safety. Once anti-ligature safety features are complete, engineering will monitor via weekly EOC rounds to ensure a safe environment is maintained. **Person Responsible:** Director of Engineering & ACNO	7/11/2014 8/19/2014 9/12/2014 8/19/2014 9/12/2014 9/26/2014 4/21/2014 8/19/2014 9/12/2014 9/26/2014

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A 701	Continued From page 116 faucet that could be used as anchors. During an interview, Staff *6* stated the patients are escorted to the bathroom and a staff member needs to unlock the bathroom, but the patient remains in the bathroom by themselves. 9. The men□s common bathroom had grab bars, exposed plumbing pipes, and a standard faucet that could be used as anchors. 10. There were pendent type sprinkler heads throughout the corridor. 11. There was unimpeded access from Unit 1 into an interior stairwell connecting the first floor to the basement. There were hand rails and sprinkler pipes in the stairwell that could be used as anchors. There was also a fourteen foot drop from the top first floor landing rail to the bottom of the stairwell. During an interview at the same time as the observation, Staff 6 stated that on a weekend morning years ago they found a patient hanging around at the top stairwell landing and that when they took the patient to his room they found a sheet in the patients room. Outpatient (Van Nuys campus) 12. Common bathroom by group meeting room had a ceiling pendent sprinkler, grab bars, exposed plumbing pipes, standard faucets, mortise hinges and arm of a self-closing device at the door that could be used as anchors. The bathroom also had a standard porcelain water tank and cover with accessible flush mechanism parts within. 13. Common bathroom by the group meeting	A 701	(Continued from page 116) **9) Corrective Actions**: The grab bar in the men□s common bathroom was removed and will not be replaced. The exposed plumbing pipes will be covered by stainless steel flush valve vandal resistant covers and P-trap covers. Safety, anti-ligature faucets have replaced the standard faucet. **Date of Implementation:** The grab bar was removed on April 21, 2014 and will not be replaced. The exposed plumbing pipes will be covered by stainless steel flush valve vandal resistant covers to be installed by September 26, 2014; P-trap covers will be installed by September 12, 2014. Safety, anti-ligature faucets replaced the standard faucet on August 19, 2014. **Monitoring Process:** Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted to ensure patient safety. Once anti-ligature safety features are complete, engineering will monitor via weekly EOC rounds to ensure a safe environment is maintained. **Person Responsible:** Director of Engineering & ACNO **10) Corrective Actions:** All pendent type sprinkler heads located throughout all corridors have been removed and replaced with Recessed Sprinkler heads by Mid-Valley Automatic Fire System, Inc. **Date of Implementation:** The pendent type sprinkler heads throughout all corridors have been replaced with Recessed Sprinkler heads by Mid-Valley Automatic Fire System, Inc. Completed July 11, 2014. **Monitoring Process:** Engineering will monitor integrity of the recessed sprinkler heads via weekly EOC rounds. EOC rounds are planned to be ongoing to ensure a safe environment is maintained. Monitoring of fire sprinklers will also be part of the Annual Sprinkler Testing Evaluation. **Person Responsible:** Director of Engineering **11) Corrective Actions:** Access from Unit 1 into the interior stairwell, exposing handrails and pipes, leading to the basement was secured with the installation of a lock and alarm. Patients are unable to access the interior stairwell; only authorized personnel can access stairway. **Date of Implementation:** Access from Unit 1 into the interior stairwell, with exposed handrails and pipes, was secured with the installation of a lock and alarm on March 25, 2014. **Monitoring Process**: All doors & locks throughout the hospital are checked 3 times a day by security. **Person Responsible:** Director of Engineering **12) Corrective Actions:** The pendent type sprinkler heads have been replaced with Recessed Sprinkler heads by Mid-Valley Automatic Fire System, Inc. The grab bar in the common bathroom by the group meeting room was removed and will not be replaced. The exposed plumbing pipes will be covered by stainless steel flush valve vandal resistant covers and P-trap covers. Safety, anti-ligature faucet has replaced the standard faucet. The mortise hinges that could be used as anchors by patients will be replaced with anti-ligature continuous hinges. The self-closer arm was reversed to outside. The toilet will be removed and replaced with a commercial vandal resistant toilet. **Date of Implementation**: The pendent type sprinkler heads have been replaced with Recessed Sprinkler heads by Mid-Valley Automatic Fire System, Inc. Completed July 11, 2014. The grab bar was removed on April 21, 2014 and will not be replaced. The exposed plumbing pipes will be covered by stainless steel flush valve vandal resistant covers to be installed by September 26, 2014; P-trap covers will be installed by September 12, 2014. Safety, anti-ligature faucets replaced the standard faucet on August 19, 2014. All accessible mortise hinges that could be used as anchors by patients will be replaced with anti-ligature continuous hinges by September 26, 2014.The self-closer arms was reversed to outside on April 15, 2014. The toilet will be removed and replaced with a commercial vandal resistant toilet by September 26, 2014. **Monitoring Process:** Engineering will monitor integrity of the recessed sprinkler heads via weekly EOC rounds. EOC rounds are planned to be ongoing to ensure a safe environment is maintained. Monitoring of fire sprinklers will also be part of the Annual Sprinkler Testing Evaluation. Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted to ensure patient safety.	4/21/2014 8/19/2014 9/12/2014 9/26/2014 7/11/2014 3/25/2014 4/15/2014 4/21/2014 7/11/2014 8/19/2014 9/12/2014 9/26/2014

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A 701	Continued From page 117 room had a loose toilet. Closer observation revealed the anchor bolt was missing. 14. Common bathroom by the outpatient lounge had grab bars, exposed plumbing pipes, standard faucets and mortise hinges that could be used as anchors. Basement (Van Nuys campus) 15. There was an 8 inch by 5 inch dark brown water stain at the ceiling of the intake department. 16. There was a 10 inch by 10 inch dark brown water stain with a 4 inch by 4 inch black stain at its center at the ceiling of the medical records storage room. 17. There was an exposed plumbing (P-trap) that could be used as an anchor at the corridor near the medical records room. There was unimpeded access from Unit 1 to the basement by use of an interior stairwell or elevator. 18. There was an unlocked laundry room that had a pendent ceiling sprinkler and self-closing device arm at the door that could be used as anchors. There was unimpeded access from Unit 1 to the unlocked laundry in the basement by use of an interior stairwell or elevator. Exterior (Nan Nuys campus) 18. There was overgrown live vegetation and accumulation of dry vegetation conducive to the possible harborage of rodents and other pests at and next to Unit 2 patio. The vegetation was next	A 701	(Continued from page 117) Once anti-ligature safety features are complete, engineering will monitor via weekly EOC rounds to ensure a safe environment is maintained. **Person Responsible:** Director of Engineering & ACNO **13) Corrective Actions:** The common bathroom toilet by the group meeting room was secured with new screws on March 25, 2014. A hospital-wide review and facility tour made to ensure all toilets are secured and will be monitored in the EOC rounds weekly by IOP staff**.** **Date of Implementation:** Bathroom toilet was secured with new screws on March 25, 2014. 3/25/2014 **Monitoring Process:** Monitoring that all toilets are secured in the EOC rounds weekly by IOP Staff**.** **Person Responsible:** Director of IOP & Director of Engineering **14) Corrective Actions:** The grab bars located in the common bathroom by the outpatient lounge was removed and will not be replaced. The exposed plumbing pipes will be covered by stainless steel flush valve vandal resistant covers and P-trap covers. Safety, anti-ligature faucets have replaced the standard faucet. All accessible mortise hinges that could be used as anchors by patients will be replaced with anti-ligature continuous hinges. **Date of Implementation:** The grab bars located in the common bathroom by the outpatient lounge was removed on April 21, 2014 and will not be replaced. 4/21/2014 The exposed plumbing pipes will be covered by stainless steel flush valve vandal resistant covers to be installed by September 26, 2014; 9/12/2014 P-trap covers will be installed by September 12, 2014. 9/26/2014 Replacement of standard faucets to safe, anti-ligature faucets will be completed on September 30, 2014. 9/30/2014 All accessible mortise hinges that could be used as anchors by patients will be replaced with anti-ligature continuous hinges by September 26, 2014. **Monitoring Process:** Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted to ensure patient safety. Once anti-ligature safety features are complete, engineering will monitor via weekly EOC rounds to ensure a safe environment is maintained. **Person Responsible:** Director of Engineering & ACNO **15) Corrective Actions:** The 8 inch by 5 inch dark brown water stain on the ceiling of the intake department was replace and re-tape the A/C lines with rubber tubes on March 27, 2014. A hospital-wide review and facility tour made to ensure all ceilings are clear of stains and will be monitored in the EOC rounds monthly. 3/27/2014 **Date of Implementation:** 3/27/14 **Monitoring Process:** All ceilings in intake departments are to be monitored for any stains in the EOC rounds. **Person Responsible:** Director of Engineering **16) Corrective Actions:** The 10 inch by 10 inch dark brown water stain with a 4 inch by 4 inch black stain at its center of the ceiling tile in medical records storage room was tile replaced on March 27, 2014. **See Addendum 71, 71a)** A hospital-wide review and facility tour made to ensure all ceilings are clear of stains and will be monitored in the EOC rounds monthly. **Date of Implementation:** 3/27/14 3/27/2014 **Monitoring Process:** All ceilings in medical records are to be monitored for any stains in the EOC rounds monthly. **Person Responsible:** Director of Engineering **17) Corrective Actions:** The exposed plumbing (p-trap) that could be used as an anchor at the corridor near the medical records room was removed. The access from Unit 1 to the basement by the use of the interior stairwell door was replaced with a locked handle to ensure only authorized personnel can access stairways. No impact on egress. **Date of Implementation:** In process, expected implementation date July 1, 2014. **Monitoring Process:** All doors & locks throughout the hospital are checked 3 times a day by security. **Person Responsible:** Director of Engineering **18) Corrective Actions:** The laundry room door is now locked and only authorized personnel have access. The access from Unit 1 to the basement by the use of the interior stairwell door was replaced with a locked handle to ensure only authorized personnel can access stairways	

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SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	**6245 DE LONGPRE AVE HOLLYWOOD, CA 90028**

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A 701	Continued From page 118 to, over, and on top of the smoking area canopy, and next to building structure. The vegetation (avocado tree) also created a food source, shelter and natural bridge onto the facility roof for possible rodents. On March 25, 2014 between the hours of 8:30 a.m. and 11:00 a.m. the following conditions existed in the Van Nuys psychiatric facility. Station 2 (Van Nuys campus) There were fixtures throughout that could be used as anchor points to tie to that can hold a person□s weight throughout the unit; including pendant sprinkler heads, grab bars, shower handles, soap dishes, exposed plumbing pipes (water supply to toilet, sink drain line and condensation line), standard faucets, vents, mortise hinges and self-closing door arms. 20. Patient Room bathrooms, including those in Rooms 203, 205, 207, 209, 210, 211, 212, 213, 214,215,216,217,218,219,220,222,226, had fixtures that could be used as anchors including grab bars, exposed plumbing pipes, standard faucets and mortise hinges. 21. Patient Room bathrooms, including those in Rooms 203, 205, 207, 209, 210, 211, 212, 213, 214,215,216,217,218,219,220,222,226,had locksets on the bathroom doors that were lockable from the inside and required an emergency key to unlock from the outside. During a interviews of two registered nurses (RN) at Unit 2 nurses Station, RN 23 stated we don□t have the pin (emergency key) and RN 24 stated I	A 701	(Continued from page 118) **Date of Implementation:** 3/14/2014 **Monitoring Process:** All doors & locks throughout the hospital are checked 3 times a day by security. **Person Responsible**: Director of Engineering **18) Corrective Actions:** The overgrown live vegetation and accumulation of dry vegetation next to Unit 2 patio was cleaned up and trimmed by gardener in March 27, 2014. It will be monitored and maintained by the gardener during routine weekly service as well as during EOC rounds monthly. **Date of Implementation:** 3/27/2014 **Monitoring Process:** The live and dry vegetation will be monitored and maintained by the gardener during routine weekly service as well as during EOC rounds monthly. **Person Responsible:** Director of Engineering **20) Corrective Actions:** Patient room bathrooms, 203, 205, 207, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 222, and 226 grab bars were removed. Only the grab bar in room 226, an ADA accessible room, was replaced with an anti-ligature grab bar. Grab bars in other patient bathrooms will not be replaced. The exposed plumbing pipes in patient room bathrooms, 203, 205, 207, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 222, and 226 will be covered with stainless steel flush valve vandal resistant covers and p-trap covers. The standard faucets in patient room bathrooms, 203, 205, 207, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 222, and 226 were replaced with anti-ligature faucets. All accessible mortise hinges that could be used as anchors by patients will be replaced with anti-ligature continuous hinges. **Date of Implementation:** Patient room bathrooms, 203, 205, 207, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 222, and 226 grab bars were removed on 4/21/2014. Planned replacement of anti-ligature grab bar for room 226, an ADA accessible room, was completed on 8/16/2014. The exposed plumbing pipes in patient room bathrooms, 203, 205, 207, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 222, and 226 will be covered by stainless steel flush valve vandal resistant covers to be installed by September 26, 2014; P-trap covers will be installed by September 12, 2014. The standard faucets in patient room bathrooms, 203, 205, 207, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 222, and 226 were replaced with anti-ligature faucets on August 19, 2014. All accessible mortise hinges that could be used as anchors by patients will be replaced with anti-ligature continuous hinges by September 26, 2014. **Monitoring Process**: Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted to ensure patient safety. Once anti-ligature safety features are complete, engineering will monitor via weekly EOC rounds to ensure a safe environment is maintained. **Person Responsible:** Director of Engineering **21)Corrective Actions:** New Push and Pull latch (GYLNN□Johnson) door handles will be installed for patient bathrooms 203, 205, 207, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 222, and 226. **Date of Implementation:** New Push and Pull latch (GYLNN□Johnson) door handles will be installed for patient bathrooms 203, 205, 207, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 222, and 226 by September 14, 2014. **Monitoring Process:** Engineering will monitor via weekly EOC rounds to ensure proper operation of door handles. **Person Responsible:** Director of Engineering	3/14/2014 3/27/2014 8/16/2014 8/19/2014 9/26/2014 9/14/2014

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A 701	Continued From page 119 don□t know where the pin is. 22. Retention clips were missing from the anti-ligature type ceiling sprinkler heads in Rooms 203,207 209,211,213,222,226 and in the medication room. The missing retaining clips caused the escutcheons to drop one inch from the ceiling exposing the sprinkler pipes that could be used as anchors. The anti-ligature type ceiling sprinkler head in Room 211 had expanding foam between the top of the escutcheon and the ceiling. During an interview the Director of Facilities stated "that's the wrong way to fix it, should have a ring (retention clip)". 23. Room 211 had a loose sink with dislodged caulking and a half inch space between the sink and the wall. 24. Room 213 had a loose toilet. 25. Room 215 had a loose toilet and a 4 foot by 2 foot area of corroded and water damaged ceiling above the doorway. 26. Room 216 had the door handle rosette pulled away from the bathroom side of the bathroom door creating a space between the rosette and the door that could be used as an anchor. 27. Room 205 had a loose exhaust fan cover with a half in gap between the cover and the ceiling. 28. Room 222 had a missing handle at the bathroom sink faucet exposing the valve stem and had a missing anchor bolt cap at the toilet. 29. The shaving room had standard faucet that could be used as an anchor.	A 701	(Continued from page 119) **22) Corrective Actions:** The retention clips missing from the anti-ligature type sprinkler in room 203, 207, 209, 211, 213, 222, 226, and medication room were replaced on April 20, 2014 by Engineering. A hospital-wide review and facility tour of all sprinklers in patient rooms and will be monitored during routine cleaning of sprinkler heads. In room 211 the anti-ligature type ceiling that had expanded foam between the top of the escutcheon and the ceiling was cleaned on March 27, 2014 by Engineering. **Date of Implementation:** 4/20/14 **Monitoring Process:** All sprinklers in patient rooms and will be monitored during routine cleaning of sprinkler heads. **Person Responsible:** Director of Engineering **23) Corrective Actions:** The sink in room 211 was removed and re-installed on the wall, secured, patched and sealed with white caulking by engineering on March 24, 2014. A hospital-wide review and facility tour made to ensure all sinks are secured and will be monitored in the EOC rounds daily by nursing staff. **Date of Implementation**: 3/24/14 **Monitoring Process:** All patient sinks will be monitored in the EOC rounds daily by nursing staff**.** **Person Responsible:** ACNO & Director of Engineering **24) Corrective Actions:** The toilet in room 213 secured with new screws on March 27, 2014. A hospital-wide review and facility tour made to ensure all toilets are secured and will be monitored in the EOC rounds daily by nursing staff. **Date of Implementation:** 3/24/14 **Monitoring Process**: All patient toilets are secured and will be monitored in the EOC rounds daily by nursing staff**.** **Person Responsible:** ACNO & Director of Engineering **25) Corrective Actions**: The toilet in room 213 secured with new screws on March 24, 2014 by Engineering. A hospital-wide review and facility tour made to ensure all toilets are secured and will be monitored in the EOC rounds daily by nursing staff. The 4 foot by 2 foot area of corroded and water damaged ceiling above the doorway was repaired on March 28, 2014. A hospital-wide review and facility tour made to ensure all toilets are secured and will be monitored in the EOC rounds daily by nursing staff. **Date of Implementation:** 3/24/14 **Monitoring Process:** All patient toilets will be monitored in the EOC rounds daily by nursing staff. All ceilings in patient rooms are to be monitored for any stains in the EOC rounds by nursing staff**.** **Person Responsible:** ACNO & Director of Engineering **26) Corrective Actions**: The door handle rosette from the bathroom side in room 216 that created a space between the rosette and door was repaired and the lock was replaced on March 28, 2014. **Date of Implementation:** 3/28/14 **Monitoring Process:** All patient doors to be monitored in the EOC rounds daily by nursing. **Person Responsible:** ACNO & Director of Engineering **27) Corrective Actions:** The loose exhaust fan cover gap between the cover and the ceiling in Room 205 was replaced and that corrected the problem. A hospital-wide review and facility tour made to ensure all fan covers are secured and will be monitored in the EOC rounds daily by nursing staff. **Date of Implementation:** 3/24/14 **Monitoring Process:** All fan covers are secured and will be monitored in the EOC rounds daily by nursing. **Person Responsible:** ACNO & Director of Engineering **28) Corrective Actions:** The missing handle on the bathroom room 222 exposing the valve stem and sink were replaced on March 25, 2014 by maintenance. The anchor bold cap was replaced on the toilet in room 222 on March 25, 2014. A hospital-wide review and facility tour made to ensure all toilet caps are secured on all toilets and will be monitored in the EOC rounds daily by nursing staff. **Date of Implementation:** 3/25/14 **Monitoring Process:** All patient room doors and toilets will be monitored through the EOC rounds daily by nursing**.** **Person Responsible:** ACNO & Director of Engineering	4/20/2014 3/24/14 3/24/2014 3/24/2014 3/28/2014 3/24/2014 3/25/2014

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A 701	Continued From page 120 30. The observation room had a metal bed frame with a painted plywood board in it used as a mattress support. The plywood board could be removed from the bedframe without the need of tools which would leave the metal frame that could be used as an anchor. Also plywood is an absorbent material that is not easily cleaned and disinfected. 31. Shower Rooms 1, 2 and 3 had a grab bars that could be used as an anchors. 32. The hose for use in Shower Room 2 could not be found. Shower room 2 had a quick connect bib at the shower stall. During an interview, Staff 6 (director of facilities) stated the bib was used to connect a hose that is used by nursing in the shower when a patient is very dirty. Staff 6 stated that he did not know where the hose was but would ask the nursing staff. By the end of the survey the Staff 6 stated that the nursing staff did not know where the hose was. The shower hose could be used to tie onto an anchor point. 33. There were pendent type sprinkler heads throughout the corridor and in the recreation room. 34. There was an accumulation of dirt on the agitator and tub of the laundry room washing machine. Culver City Campus 6th floor Pavilion There were anchor points within the patient's	A 701	(Continued from page 120) **29) Corrective Actions:** The standard faucet in the shaving room was replaced with an anti-ligature faucet. **Date of Implementation:** The standard faucet in the shaving room was replaced with an anti-ligature faucet on August 19, 2014. **Monitoring Process:** Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted to ensure patient safety. Once anti-ligature safety features are complete, engineering will monitor via weekly EOC rounds to ensure a safe environment is maintained. **Person Responsible:** Director of Engineering & ACNO **30) Corrective Actions**: The observation room metal bed frame was replaced with plastic bed on April 21, 2014. The plastic bed is cleaned and disinfected daily. **Date of Implementation:** 4/21/14 **Monitoring Process:** Cleanliness will be monitored during routine cleaning of beds done daily by nursing staff and EVS. **Person Responsible:** ACNO & Director of Engineering **31) Corrective Actions:** The grab bars from shower room numbers 1, 2 and 3 were removed and replaced with anti-ligature grab bars. **Date of Implementation**: The grab bars from shower room numbers 1, 2 and 3 were removed and replaced with anti-ligature grab bars on March 30, 2014. **Monitoring Process:** Engineering will monitor via weekly EOC rounds to ensure a safe environment is maintained. **Person Responsible:** Director of Engineering & ACNO **32) Corrective Actions**: The hose from shower room 2 was located in the engineering shop awaiting repair. The shower hose will be kept and locked in the nursing office when not in use. The nurse will check the hose out for use. No hose will be left in the shower room unattended. An in-service will be provided to staff to reiterate proper safety precautions. **Date of Implementation:** The replacement hose will arrive August 21, 2014. The process of checking the hose out for use will be implemented on August 21, 2014. An in-service will be scheduled on August 21, 2014. **Monitoring Process:** A sign-out sheet will be used to monitor the hose usage and a □check for loose equipment□item will be added to the daily nursing checklists used for monitoring patient care areas. **Person Responsible:** ACNO, Nursing Supervisor and Charge Nurse **33) Corrective Actions** All pendent type sprinkler heads located throughout all corridors and the recreation room have been removed and replaced with Recessed Sprinkler heads by Mid-Valley Automatic Fire System, Inc. **Date of Implementation:** All pendent type sprinkler heads located throughout all corridors and the recreation room have been removed and replaced with Recessed Sprinkler heads by Mid-Valley Automatic Fire System, Inc. completed July 11, 2014. **Monitoring Process:** Engineering will monitor integrity of the recessed sprinkler heads via weekly EOC rounds. EOC rounds are planned to be ongoing to ensure a safe environment is maintained. Monitoring of fire sprinklers will also be part of the Annual Sprinkler Testing Evaluation. **Person Responsible:** Director of Engineering **34) Corrective Actions:** The accumulation of dirt on the agitator and tub of the laundry room washing machine was cleaned and disinfected on 3/24/14 by EVS. New washing machine delivered 6/19/14. Routine daily cleanliness to be monitored by mental health workers and EVS. **Date of Implementation:** 6/19/14 New washing machine delivered **Monitoring Process:** Routine daily cleaning by mental health worker and EVS. **Person Responsible:** ACNO & Director of Engineering	8/19/2014 4/21/2014 3/30/2014 8/21/2014 7/11/2014 6/19/2014

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A 701	Continued From page 121 environment and areas accessible to the patient that could be used to tie to that could hold a person□s weight, including mortise hinges & standard faucets throughout. 6th floor Unit A Psychiatric On March 26, 2014 between the time of 10:00 a.m. and 11:15 a.m. the following conditions existed in 6th floor Psychiatric Unit A. 35. Room 602 had burn (arching) marks at the electrical receptacle by the sink, there was damaged plaster the length of one foot at the corner by the bathroom, and there was blistering at the wall along the wall coving by the sink. 36. Room 604 had the door of the night stand hanging loose, and there was an accumulation of dust on the ceiling curtain rails. 37. Room 605 had a 4 inch by 4 inch area of water damage at the bathroom ceiling that included blistering of the paint. 38. Room 606 water damage around the window and at the ceiling that included blistering of the paint, had a broken soap dispenser, and had a loose air conditioning control that was pulled away from the wall by bed C. 39. Room 607 had an accumulation of dust below the air supply, above and on the side of the bathroom door, above the wall mounted light fixture, and had blistering at the corner of a wall by bed B. 40. Room 608 a 2 foot by 4 foot area of water damage at the ceiling above bed B and 2 feet	A 701	(Continued from page 121) **CULVER CITY CAMPUS (6th Floor Pavilion – Unit A)** **35) Corrective Actions:** The electrical receptacle by the sink in Room 602 in the Psych unit was replaced by Engineering on April 4, 2014. The damaged wall was repaired also on April 4, 2014. **Date of Implementation:** Electrical receptacle replaced on April 4, 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas including psych. **Person Responsible:** Director of Engineering **36) Corrective Actions:** The night stand was replaced with a new night stand by Engineering. Upon review of P&P, staff was in-serviced and high dusting was performed on the ceiling curtain rails. **Date of Implementation:** The night stand was replaced on June 19, 2014. High dusting was performed on March 26, 2014, when the room became available. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering & Director of EVS. **37) Corrective Actions:** The water damage at the bathroom ceiling, including blistering of paint, was repaired by Engineering on April 4, 2014. **Date of Implementation:** The water damage at the bathroom ceiling, including blistering of paint, was repaired on April 4, 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas including psych. **Person Responsible:** Director of Engineering **38) Corrective Actions:** The water damage around the window and the AC control switch in room 606 were repaired by Engineering on April 4, 2014. The hand soap dispenser will be replaced in June 2014. **Date of Implementation:** The water damage around the window and the AC control switch in room 606 were repaired by on April 4, 2014. The hand soap dispenser will be replaced in June 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas including psych. **Person Responsible:** Director of Engineering. **39) Corrective Actions:** The water damage along wall near window was repaired by Engineering on April 4, 2014. Dust accumulation in patient rooms was addressed by EVS. Daily rounding is conducted to monitor cleanliness. Deep cleaning is done in patient rooms in the Psych Unit bimonthly. **Date of Implementation:** The water damage along wall near window was repaired on April 4, 2014. Dust accumulation in patient rooms was addressed by EVS immediately on March 26, 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas including psych. Daily rounding is conducted by EVS to monitor cleanliness. Deep cleaning is done in patient rooms in the Psych Unit bimonthly. **Person Responsible:** Director of Engineering & Director of EVS **40) Corrective Actions:** The water damage at the ceiling area Room 608 above bed B and at the area 2 feet along the wall by window of bed B was repaired by Engineering on April 4, 2014. **Date of Implementation**: The water damage at the ceiling area above bed B and at the area 2 feet along the wall by window of bed B was repaired on April 4, 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas including psych. **Person Responsible:** Director of Engineering.	4/4/2014 3/26/2014 6/19/2014 4/4/2014 4/4/2014 6/30/2014 3/26/2014 4/4/2014 4/4/2014

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A 701	Continued From page 122 along the wall by window of bed B. 41. Room 609 had an exposed drain pipe (P-trap) under the sink that could be used as an anchor, and the wall was cracked near the bottom edge of the window by bed B. 42. Shower room 1 had a make-shift safety grab bar. The grab bar had two 2 inch by 1/4 inch spaces between the bar & plate that could be used to tie to. The shower room also had a blistered wall and a missing wall tile. 43. Shower Room 4 had a shower head with a 5 foot hose in it. During an interview at the same time as the observation Staff S (director of the psychiatric unit) stated the hand shower was suppose to remain in the shower because patients can only come in with staff and staff remain during the shower. Review of the hospital's policy titled Standards of Care (Number BHU.064) with an effective date of July 1998 indicated the handheld shower is available for patients who need assistance, the showerheads are held in the medication room on the open unit and are monitored by means of a sign in/out sheet. Staff S was asked to provide a copy of the sign in/out sheet for that included the hand held shower sign out for March 26, 2014. By the end of the survey a copy of or any evidence of the sign in/out sheet was not provided. 44. Shower Room 5 had an accumulation of mold on two of the walls.	A 701	(Continued from page 122) **41) Corrective Actions:** The exposed drain pipe will be covered with a p trap cover. The crack on the wall was repaired by Engineering. **Date of Implementation:** The exposed drain pipe will be covered with a p trap cover by September 19, 2014. The crack on the wall was repaired on April 4, 2014. **Monitoring Process:** Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted at 30-minute intervals to ensure patient safety. Criteria to monitor that integrity of p-trap covers are in place will be added to the Behavioral Safety Rounds sheets, and will be surveyed on a weekly basis. be added to the Behavioral Safety Rounds sheets, and will be surveyed on a weekly basis. Engineering to conduct weekly rounding for routine maintenance repairs in the Psych Unit. **Person Responsible:** Director of Engineering, Director of Behavioral Health **42) Corrective Actions:** Hang-proof grab bars will be purchased and installed in Shower Room □1 and wall damage will be repaired by Engineering scheduled for completion in June 2014. **Date of Implementation:** Hang-proof grab bars will be purchased and installed in Shower Room □1 and wall damage will be repaired in June 2014 or immediately upon receiving. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas including psych. **Person Responsible:** Director of Engineering. **43) Corrective Actions:** The removable shower head has been taken out and kept in the Nurse□s Station and is only re-installed by staff when or as needed. Re-educate of BHU nursing staff regarding monitoring the location (charge nurse office) and use of the hand held showerhead and the required signed in and out and must be visually monitored at all times to ensure patient safety. **Date of Implementation:** Completion of staff education 4/30/2014. **Monitoring Process:** The sign out /in sheet will be monitored by the charge nurse. The showers are monitored every shift by RN rounds. **Person Responsible:** BHU Nursing Leadership on BHU & Director of Engineering. **44) Corrective Actions**: Mold along back wall had been removed and water damage had been repaired in shower room □5 by Engineering on March 31, 2014. **Date of Implementation:** Mold along back wall had been removed and water damage had been repaired in shower room □5 on March 31, 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas including psych. Person Responsible: Director of Engineering.	4/4/2014 9/19/2014 6/30/2014 4/30/2014 3/31/2014

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	050135	S. BUILDING **01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD** T. WING _____	

NAME OF PROVIDER OR SUPPLIER	
SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	

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A 701	Continued From page 123 45. There was a damaged phone cubicle exposing two 2 inch by 1 inch spaces between the metal frame & the metal shelve of the cubicle that could be used as an anchor. 46. There were three loose hand rails at corridor under pay phone by supply room, by secretary office, and by the laundry room. 47. There was a chair with torn upholstery exposing the padding underneath at the pay phone area. 48. There was a broken light diffuser at station kitchen. 49. There was a water damaged ceiling tile at the corridor of the doctors consultation area. 50. There was a sign of water damage at the ceiling of the 6th floor southwest stairway landing. 6th floor Unit B Psychiatric On March 26, 2014 between the time of 11:15 a.m. and 12:12 p.m. the following conditions existed in 6th floor Psychiatric Unit B. 51. Room 622 had a urine stained wall next to toilet, and burn (arching) marks at the electrical receptacle next to the sink. 52. Room 625 had an accumulation of dust at the ceiling light fixture. 53. Room 624 had a small flying insect in it.	A 701	(Continued from page 123) **45) Corrective Actions:** The phone booth shelf on Pavilion 6 was removed by Engineering on April 7, 2014. **Date of Implementation:** The phone booth shelf on Pavilion 6 was removed on April 7, 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas including psych. **Person Responsible**: Director of Engineering. **46) Corrective Actions:** The hand rails were re-secured at corridor by Engineering on April 4, 2014. **Date of Implementation:** The hand rails were re-secured at corridor on April 4, 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas including psych. **Person Responsible:** Director of Engineering. **47) Corrective Actions:** The torn chair was removed by Engineering immediately on March 26, 2014. **Date of Implementation:** The torn chair was removed immediately on March 26, 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas including psych. **Person Responsible:** Director of Engineering. **48) Corrective Actions:** The broken light diffuser at the station kitchen was replaced on June 18, 2014. **Date of Implementation:** The broken light diffuser at the station kitchen will be replaced in June 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas including psych. **Person Responsible:** Director of Engineering. **49) Corrective Actions:** The ceiling tile at the corridor of the doctor□s consultation area was replaced by Engineering on April 4, 2014. **Date of Implementation:** The ceiling tile at the corridor of the doctor□s consultation area was replaced on April 4, 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas including psych. **Person Responsible:** Director of Engineering. **50) Corrective Actions:** The sign of water damage at the ceiling of the southwest stairway landing was investigated by the Director of Engineering. Minor repairs were conducted on June 18, 2014 although no leaks were noted or identified. **Date of Implementation:** Minor repairs were conducted on June 18, 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas including psych. **Person Responsible:** Director of Engineering **51). Corrective Actions:** Urine stain on the wall in room 622 was cleaned by EVS then repainted. The electrical receptacle next to the sink was replaced by Engineering on April 15, 2014. **Date of Implementation:** April 15, 2014 **Monitoring Process:** Daily rounding is conducted by EVS to monitor cleanliness. Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible**: Director of EVS and Director of Engineering **52). Corrective Actions:** Dust accumulation was addressed immediately by EVS. Daily rounding is conducted to monitor cleanliness. Deep cleaning is done in Psych Unit patient rooms bimonthly. **Date of Implementation:** March 26, 2014 **Monitoring Process:** Daily rounding is conducted by EVS to monitor for cleanliness. **Person Responsible:** Director of EVS	4/7/2014 4/4/2014 3/26/2014 6/30/2014 4/4/2014 6/18/2014 4/15/2014 3/26/2014

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SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	**6245 DE LONGPRE AVE HOLLYWOOD, CA 90028**

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A 701	Continued From page 124 54. Room 627 had exposed plumbing pipe (P-trap) under the sink that could be used as an anchor, a blistered water damaged wall under the sink, and laminate pulled away from the base of the closet. 55. Room 628 had burn (arching) marks and a metal bolt in the ground slot of the electrical receptacle next to the sink, had a plastic tube in the ground slot of an emergency power receptacle and the tooth of a comb in another slot of the same receptacle, and was missing soap dispenser. 56. Room 629 had a strong urine odor and urine on the floor in the bathroom, and had wall caving pulled away from the wall next to the bathroom. 57. The men's common bathroom by day room had a standard faucet and an exposed plumbing pipe (P-trap) under the sink that could be used as an anchor. The bathroom also had strong urine odor. 58. The day room had an accumulation of dust around the air supply registers and at 8 foot by 3 foot ceiling areas on both sides of the room. There was also 2 inch by inch area of damage at the wall by the entrance to the room. 59. There were two loose hand rails at the wall by the water fountain and by the phone near the day room. 60. There a piece of broken wall caving with a sharp edge at the corridor between Rooms 622 and 623. 6th floor Unit C	A 701	(Continued from page 124) **53). Corrective Actions:** Steritech, a Pest control company, came on April 7 & 11, 2014 to address small flying insects in room 624. The pest control company also did visual inspection of the whole unit. **Date of Implementation:** April 7 (inspection) and April 11 (work performed) — 4/7/2014 **Monitoring Process:** Daily rounding is conducted by EVS to monitor cleanliness. **Person Responsible:** Director of EVS **54). Corrective Actions:** The water damage in room 627 will be repaired by Engineering in June 2014. The p-trap cover (under sink enclosure) will be purchased and installed in June 2014 or immediately upon receiving them. — 6/30/2014 **Date of Implementation**: June 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **55). Corrective Actions:** The electrical receptacle next to the sink in room 628 was replaced by Engineering on April 15, 2014. The hand soap dispenser was replaced by Engineering on June 18, 2014. **Date of Implementation:** April 15 and June 18, 2014, respectively — 4/15/2014 6/18/2014 **Monitoring Process**: Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible**: Director of Engineering **56). Corrective Actions:** Deep cleaning was performed in Room 629 to address the strong urine odor. The wall coving was replaced on April 7, 2014. **Date of Implementation**: April 7, 2014 — 4/7/2014 **Monitoring Process:** Daily rounding is conducted by EVS to monitor cleanliness. Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of EVS and Director of Engineering **57). Corrective Actions:** Ligature-proof faucets and p-trap cover will be purchased and installed in June 2014 or immediately upon receiving them. Deep cleaning was performed in the men□s common bathroom by EVS to address the strong urine odor. **Date of Implementation:** June 2014 or immediately upon receiving parts. — 6/30/2014 **Monitoring Process:** Daily rounding is conducted by EVS to monitor cleanliness. Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of EVS and Director of Engineering **58). Corrective Actions:** The wall damage at the entrance in the day room was repaired by Engineering. Upon review of P&P, staff was in-serviced and high dusting was performed in the day room around the air supply registers and ceiling area. **Date of Implementation:** The wall damage was repaired on April 30, 2014. High dusting was performed on March 26, 2014, when the room became available. — 3/26/2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. Daily rounding is conducted by EVS in the Psych Unit. Deep cleaning is done in the Psych Unit bimonthly. A dusting calendar is kept to ensure every patient room is dusted, starting in the Psych Unit then house-wide. In addition, EOC Rounding is conducted routinely, covering patient care areas, twice a year and as needed. **Person Responsible**: Director of Engineering & Director of EVS **59). Corrective Actions:** The loose hand rails at the wall by the water fountain and phone were repaired by Engineering on April 4, 2014. **Date of Implementation**: April 4, 2014 — 4/4/2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **60). Corrective Actions:** The broken wall coving at the corridor between rooms 622 and 623 will be repaired in June 2014. — 6/30/2014 **Date of Implementation:** June 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014.	

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A 701	Continued From page 125 On March 26, 2014 between the time of 12:12 p.m. and 12:40 p.m. the following conditions existed in 6th floor psychiatric unit C. 61. Room 630 had a standard faucet that could be used as an anchor, and there was a piece of wall caving missing from behind the bed. During an interview at the same time of the observation the director of engineering stated that all the rooms had standard faucets. 62. Room 631 had burn (arching) marks at the electrical receptacle next to the sink, and there were pieces of porcelain missing from the sink. 63. Room 632 had worn flooring exposing the sub-flooring. 64. Room 634 had had a standard faucet and exposed plumbing (P-trap) that could be used as an anchor, and had a strong urine odor. 65. Room 635 had had a standard faucet and exposed plumbing (P-trap) that could be used as an anchor. 66. Room 636 (seclusion room) had an accumulation of dirt around foot of the bed. 67. Room 639 had had a standard faucet and exposed plumbing (P-trap) that could be used as an anchor, and had a strong urine odor. 68. The recreation room had a standard faucet and exposed plumbing (P-trap) that could be used as an anchor, and had an accumulation of dust at the wall mounted light fixture.	A 701	(Continued from page 125) **Person Responsible**: Director of Engineering **CULVER CITY CAMPUS (6th Floor Pavilion – Unit C)** **61). Corrective Actions:** The ligature-proof faucet will be purchased and installed in June 2014 or immediately upon arrival. The wall coving in room 630 was replaced by Engineering on June 18, 2014. **Date of Implementation:** June 18, 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **62). Corrective Actions:** In room 631, the electrical receptacle was replaced on April 14, 2014 and porcelain sink was replaced by Engineering on June 18 2014. **Date of Implementation:** April 14, 2014 and June 18, 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible**: Director of Engineering **63). Corrective Actions:** The flooring in room 632 will be repaired by Engineering in June 2014. **Date of Implementation:** June 2014 **Monitoring Process**: Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible**: Director of Engineering **64). Corrective Actions**: The standard faucet in the patient bathroom will be replaced with anti-ligature faucet. The exposed drain pipe will be covered with a p trap covers. Room cleaning was performed in Room 634 immediately on March 26, 2014 by EVS to address the strong urine odor. **Date of Implementation:** The standard faucet in the patient bathroom will be replaced with anti-ligature faucet by September 19, 2014. The exposed drain pipe will be covered with a p trap cover by September 19, 2014. Deep cleaning was performed on March 26, 2014. **Monitoring Process:** Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted at 30-minute intervals to ensure patient safety. Criteria to monitor that integrity of anti-ligature faucets and p-trap covers are in place will be added to the Behavioral Safety Rounds sheets, and will be surveyed on a weekly basis. EVS to conduct daily routine at high-touched areas and restrooms. EVS also conducts discharge cleaning by performing daily cleaning routine and thorough cleaning of beds and mattresses, including high dusting. **Person Responsible**: Director of EVS, Director of Behavioral Health, Director of Engineering **65). Corrective Actions:** The standard faucet in the patient bathroom will be replaced with anti-ligature faucet. The exposed drain pipe will be covered with a p trap cover. **Date of Implementation:** The standard faucet in the patient bathroom will be replaced with anti-ligature faucet by September 19, 2014. The exposed drain pipe will be covered with a p trap cover by September 19, 2014. **Monitoring Process:** Engineering to conduct weekly rounding. Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted at 30-minute intervals to ensure patient safety. Criteria to monitor that integrity of anti-ligature faucets and p-trap covers are in place will be added to the Behavioral Safety Rounds sheets, and will be surveyed on a weekly basis. **Person Responsible:** Director of Engineering, Director of Behavioral Health **66). Corrective Actions:** EVS addressed the dirt accumulation in room 636 on March 29, 2014. Daily rounding is conducted to monitor cleanliness. Deep cleaning is done in patient rooms in the Psych Unit bimonthly. **Date of Implementation:** March 29, 2014 **Monitoring Process:** Daily rounding is conducted by EVS to monitor cleanliness. **Person Responsible**: Director of EVS **67). Corrective Actions:** The standard faucet in the patient bathroom will be replaced with anti-ligature faucet. The exposed drain pipe will be covered with a p trap cover. Deep cleaning was performed in Room 639 immediately on March 26, 2014 by EVS to address the strong urine odor. **Date of Implementation** The standard faucet in the patient bathroom will be replaced with anti-ligature faucet by September 19, 2014. The exposed drain pipe will be covered with a p trap cover by September 19, 2014. Deep cleaning was performed on March 26, 2014. **Monitoring Process:** Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted at 30-minute intervals to ensure patient safety. Criteria to monitor that integrity of anti-ligature faucets and p-trap covers are in place will be added to the Behavioral Safety Rounds sheets, and will be surveyed on a weekly basis.	6/18/2014 4/14/2014 6/18/2014 6/30/2014 3/26/2014 9/19/2014 9/19/2014 3/29/2014 3/26/2014 9/19/2014

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A 701	Continued From page 126 69. The light missing in the patient food refrigerator at the nurses station. 6th floor Unit D 70. On March 26, 2014 between the times of 12:40 p.m. and 2:25 p.m. the following conditions existed in 6th floor psychiatric unit D. 71. Room 612 had a water damaged blistered wall under the sink, and had a small flying insect in the room. 72. Room 614 had had a standard faucet and exposed plumbing (P-trap) that could be used as an anchor. 73. Room 615 had had a standard faucet that could be used as an anchor, and had a small flying insect the room. 74. Room 616 had had a standard faucet and exposed plumbing (P-trap) that could be used as an anchor. There was also missing wall caving by the bathroom. 75. Room 617 had a standard faucet and exposed plumbing (P-trap) that could be used as an anchor, and a also had a broken soap dispenser. 76. Room 619 had a standard faucet and exposed plumbing (P-trap) that could be used as an anchor, and also had two drawers missing from a night stand. 77. Room 620 had a standard faucet and	A 701	(Continued from page 126) EVS to conduct daily routine at high-touched areas and restrooms. EVS also conducts discharge cleaning by performing daily cleaning routine and thorough cleaning of beds and mattresses, including high dusting. **Person Responsible:** Director of EVS, Director of Behavioral Health, Director of Engineering **68). Corrective Actions:** The standard faucet in the bathroom will be replaced with anti-ligature faucet. The exposed drain pipe will be covered with a p trap cover. Deep cleaning was performed by EVS in the recreation room to remove dust. **Date of Implementation:** The standard faucet in the patient bathroom will be replaced with anti-ligature faucet by September 19, 2014. The exposed drain pipe will be covered with a p trap cover by September 19, 2014. Deep cleaning was performed on March 26, 2014. **Monitoring Process:** Engineering to conduct weekly rounding for routine maintenance repairs in the Psych Unit. Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted at 30-minute intervals to ensure patient safety. Criteria to monitor that integrity of anti-ligature faucets and p-trap covers are in place will be added to the Behavioral Safety Rounds sheets, and will be surveyed on a weekly basis. Daily rounding is conducted by EVS in the Psych Unit. Deep cleaning is done in patient rooms in the Psych Unit bimonthly. In addition, EOC Rounding is conducted weekly covering patient areas twice a year. **Person Responsible**: Director of EVS, Director of Behavioral Health, Director of Engineering **69). Corrective Actions:** The light bulb in the patient food refrigerator at the nurse's station was replaced by Engineering on April 10, 2014. **Date of Implementation:** April 10, 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **CULVER CITY CAMPUS (6th Floor Pavilion – Unit D** **71). Corrective Actions:** Steritech, pest control, came on April 7 and 11, 2014 to address small flying insects in room 612. The pest control company also did visual inspection of entire unit. Water damage will be repaired in June 2014 by Engineering. Infection Control was notified of the insects in room 612. (A copy of the service report is attached) **Date of Implementation:** April 11, 2014 (pest control) / June 2014 (water damage) **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. Daily rounding is conducted by EVS to monitor cleanliness. **Person Responsible:** Director of EVS and Director of Engineering **72). Corrective Actions:** The standard faucet in the patient bathroom was replaced with anti-ligature faucet. The exposed drain pipe will be covered with a p trap cover. **Date of Implementation:** The standard faucet in the patient bathroom was replaced with anti-ligature faucet on August 19, 2014. The exposed drain pipe will be covered with a p trap cover by September 19, 2014. **Monitoring Process**: Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted at 30-minute intervals to ensure patient safety. Criteria to monitor that integrity of anti-ligature faucets and p-trap covers are in place will be added to the Behavioral Safety Rounds sheets, and will be surveyed on a weekly basis. **Person Responsible:** Director of Engineering, Director of Behavioral Health **73). Corrective Actions:** The standard faucet in the patient bathroom was replaced with anti-ligature faucet. Source of insects, e.g. food tray, was removed from the room by Nursing staff. Steritech, pest control, came on April 7 and 11, 2014 and got rid of small flying insects in room 615. The pest control company also did visual inspection of the entire unit. **Date of Implementation:** The standard faucet in the patient bathroom was replaced with anti-ligature faucet on August 19, 2014. Steritech completed work on April 11, 2014 (pest control). **Monitoring Process:** Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted at 30-minute intervals to ensure patient safety. Criteria to monitor that integrity of anti-ligature faucets and p-trap covers are in place will be added to the Behavioral Safety Rounds sheets, and will be surveyed on a weekly basis. Food trays are brought by staff inside the rooms of Geropsych patients and any patient who is unable to get out of bed. Leftover food is removed by staff immediately after meal time. All the other patients are allowed to dine only in the activity/dining room. Pest control provider comes monthly for routine service at high-risk areas for insects/pests and is on call to areas requiring their service. **Person Responsible:** Director of EVS and Director of Engineering	3/26/2014 9/19/2014 4/10/2014 4/11/2014 6/30/2014 8/19/2014 9/19/2014 4/7/2014 8/19/2014

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A 701	Continued From page 127 exposed plumbing (P-trap) that could be used as an anchor, and also had a broken soap dispenser 78. Room 621 had a standard faucet and exposed plumbing (P-trap) that could be used as an anchor, and also had wall caving that was pulled away from the wall. 79. There were water stains at the ceiling tile of the corridor by Room 610. 80. There was an electric insence burner stuck to the floor between a file cabinet and a wall cabinet in the utility review office. Detox Unit 6th Floor Tower 81. On March 26, 2014 between 3:20 p.m. and 3:35a.m. the following conditions existed in the Detox unit. 82. There were braided nurse call cords that could not be easily cleaned throughout the unit including dirty call bell cords in Rooms 679, 680, and 681. 83. Room 679 had a loose flange at a grab bar. 84. Room 680 was missing a grab bar next to toilet. There were three % inch holes in the bathroom wall where the grab bar use to be. 85. At the east stairway there was plaster missing at the wall around a wet stand by pipe. 4th floor Pavilion	A 701	(Continued from page 127) **74). Corrective Actions:** Safety, anti-ligature faucets and p-trap covers have been ordered to replace all standard faucets and cover exposed plumbing, respectively. The missing wall coving was replaced. **Date of Implementation:** The replacement of standard faucets to safe, anti-ligature faucets is expected to be completed by November 28, 2014 and installation of p-trap covers is expected to be completed by October 31, 2014.The missing wall coving was replaced on June 30, 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **75). Corrective Actions**: The standard faucet in the patient bathroom was replaced with anti-ligature faucet. The exposed drain pipe will be covered with a p trap cover. The hand soap dispenser was replaced by Engineering. **Date of Implementation:** The standard faucet in the patient bathroom was replaced with anti-ligature faucet on August 19, 2014. The exposed drain pipe will be covered with a p trap cover by September 19, 2014. The hand soap dispenser was replaced on June 18, 2014. **Monitoring Process:** Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted at 30-minute intervals to ensure patient safety. Criteria to monitor that integrity of anti-ligature faucets and p-trap covers are in place will be added to the Behavioral Safety Rounds sheets, and will be surveyed on a weekly basis. Daily rounding is conducted by EVS in the Psych Unit. Deep cleaning is done in patient rooms in the Psych Unit bimonthly. In addition, EOC Rounding is conducted weekly covering patient areas twice a year. **Person Responsible:** Director of Engineering, Director of Behavioral Health, Director of EVS. **76). Corrective Actions:** The standard faucet in the patient bathroom was replaced with anti-ligature faucet. The exposed drain pipe will be covered with a p trap cover. The night stand was replaced with a new night stand by Engineering. **Date of Implementation:** The standard faucet in the patient bathroom was replaced with anti-ligature faucet on August 19, 2014. The exposed drain pipe will be covered with a p trap cover by September 19, 2014. The night stand was replaced on June 18, 2014. **Monitoring Process**: Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted at 30-minute intervals to ensure patient safety. Criteria to monitor that integrity of anti-ligature faucets and p-trap covers are in place will be added to the Behavioral Safety Rounds sheets, and will be surveyed on a weekly basis. **Person Responsible**: Director of Engineering, Director of Behavioral Health **77). Corrective Actions:** The standard faucet in the patient bathroom will be replaced with anti-ligature faucet. The exposed drain pipe will be covered with a p trap cover. The broken soap dispenser was replaced with a new soap dispenser by Engineering. **Date of Implementation:** The standard faucet in the patient bathroom will be replaced with anti-ligature faucet by September 19, 2014. The exposed drain pipe will be covered with a p trap cover by September 19, 2014. The broken soap dispenser was replaced on June 18, 2014. **Monitoring Process:** Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted at 30-minute intervals to ensure patient safety. Criteria to monitor that integrity of anti-ligature faucets and p-trap covers are in place will be added to the Behavioral Safety Rounds sheets, and will be surveyed on a weekly basis. **Person Responsible:** Director of Engineering, Director of Behavioral Health **78). Corrective Actions:** The standard faucet in the patient bathroom will be replaced with anti-ligature faucet. The exposed drain pipe will be covered with a p trap cover. The wall coving was repaired by Engineering. **Date of Implementation:** The standard faucet in the patient bathroom will be replaced with anti-ligature faucet by September 19, 2014. Exposed drain pipe will be covered with a p trap cover by September 19, 2014. The wall coving was repaired on June 21, 2014 by Engineering. **Monitoring Process:** Engineering to conduct weekly rounding for routine maintenance repairs in the Psych Unit. Until patient bathrooms are resistant to ligature, continual round the clock rounding by mental health workers will be conducted at 30-minute intervals to ensure patient safety. Criteria to monitor that integrity of anti-ligature faucets and p-trap covers are in place will be added to the Behavioral Safety Rounds sheets, and will be surveyed on a weekly basis. Daily rounding is conducted by EVS in the Psych Unit. Deep cleaning is done in patient rooms in the Psych Unit bimonthly. In addition, EOC Rounding is conducted weekly covering patient areas twice a year. **Person Responsible:** Director of Engineering	6/30/2014 10/31/2014 11/28/2014 6/18/2014 8/19/2014 9/19/2014 6/18/2014 8/19/2014 9/19/2014 6/18/2014 8/19/2014 9/19/2014 6/21/2014 9/19/2014 6/18/2014

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A 701	Continued From page 128 4th floor Rehabilitation Unit On March 28, 2014 between 9:30a.m. and 10:45 a.m. the following conditions existed in 4th floor rehabilitation unit. 86. Room 401 had a sharps container that was filled above the fill line. 87. Room 406 had a broken & loose soap dispenser next to the sink. 88. Room 409 had a dirty braided nurse call cord next to the shower. 89. Room 423 had a broken diffuser at the wall mounted light fixture by the door. 90. In the physical therapy room there four oxygen cylinders with gauges on them. The needles of the gauges of three of the oxygen cylinders were in the red area that indicated □0□. During an interview at the same time as the observation, Registered Nurse (RN) 25 (charge nurse) stated the cylinders were for patient emergency use. 91. The common tub room had a torn shower curtain missing a 2 ft by 3 ft piece of the curtain. 92. In the clean supply room, there was a clean supplies cart that was not covered and a clean supplies cabinet with the doors fully open. During the observation a nurse walked in to the supply room obtained supplies and left without covering the cart or closing the cabinet doors. Supplies in the cart included tape, gauze, mouth swabs and Band-Aid.	A 701	(Continued from page 128) **79). Corrective Actions:** The ceiling tile within the corridor outside of Room 610 was replaced June 18, 2014 by Engineering. **Date of Implementation:** June 18, 2014 **Monitoring Process**: Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **80). Corrective Actions:** The electric incense burner was removed and staff was in-serviced on June 18, 2014. The sign-in sheet is attached herewith. **Date of Implementation:** June 18, 2014 **Monitoring Process:** Monitoring during Engineering daily rounding. **Person Responsible:** Director of Engineering **CULVER CITY CAMPUS (Tower 6 – Detox Unit)** **82) Corrective Actions:** A All braided nurse call cords in the Detox Unit were replaced with cleanable plastic cords by Engineering. **Date of Implementation:** All braided nurse call cords were replaced on April 22, 2014. **Monitoring Process:** Nurse call cords have been replaced with cleanable plastic cords house-wide. Criteria to monitor that the integrity of the cleanable, plastic cords are in place, will be added to the EOC Rounds sheets, and will be surveyed on a semi-annual basis. **Person Responsible**: Director of Engineering **83) Corrective Actions**: The loose flange of the grab bar in room 679 was re-secured by tightening the screws. **Date of Implementation:** The loose flange of the grab bar in room 679 was secured on June 18, 2014. **Monitoring Process:** Engineering to conduct weekly rounding for routine maintenance repairs in the Psych Unit. **Person Responsible:** Director of Engineering **84) Corrective Actions:** The grab bar in room 680 was re-installed thereby covering holes on April 22, 2014 by Engineering. **Date of Implementation:** The grab bar in room 680 was re-installed thereby covering holes on April 22, 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas. **Person Responsible:** Director of Engineering **85) Corrective Actions**: The wall in East Stairway will be patched and repainted in June 2014 by Engineering. **Date of Implementation:** The wall in East Stairway will be patched and repainted in June 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas. **Person Responsible:** Director of Engineering **CULVER CITY CAMPUS (Pavilion 4 Rehabilitation Unit)** **86) Corrective Actions:** The sharps container in room 401 was removed and replaced on March 28, 2014 by EVS. EVS supervisor will in service staff to monitor sharps daily. **Date of Implementation:** The sharps container in room 401 was removed and replaced on March 28, 2014. **Monitoring Process:** Daily rounding is conducted by EVS to monitor cleanliness, including sharps container fill lines. **Person Responsible:** Director of EVS **87) Corrective Actions:** The hand soap dispenser in room 406 was replaced on April 4, 2014 by Engineering. **Date of Implementation:** The hand soap dispenser in room 406 was replaced on April 4, 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas. **Person Responsible**: Director of Engineering **88) Corrective Actions:** The nurse call pull cords have been replaced hospital-wide, including room 409, on April 2014 by Engineering. **Date of Implementation:** The nurse call pull cords have been replaced hospital-wide, including room 409, on April 4, 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas. **Person Responsible:** Director of Engineering **89) Corrective Actions**: The light diffuser in room 423 was replaced by Engineering. **Date of Implementation:** April 3, 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas. **Person Responsible:** Director of Engineering	6/18/2014 6/18/2014 4/22/2014 6/18/2014 4/22/2014 6/30/2014 3/28/2014 4/4/2014 4/4/2014 4/3/2014

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A 701	Continued From page 129 During an interview at the same time as the observation, AN 25 stated the cart was supposed to be covered and the cabinet doors were suppose to be closed. 93. The ice storage of ice machine in unit kitchen had a direct drain instead of an indirect drain (air gap). 94. At the construction separation between the back of the 4th floor and the rehabilitation unit at the front of the 4th floor, the plastic barrier in front of a gypsum board barrier was loose and separating from the drop down ceiling. Closer observation revealed there were also eight unsealed penetrations through the gypsum board barrier at the separation. During an interview Staff 5 (director of engineering) stated that besides being a dust barrier the gypsum board barrier is also suppose to be a fire barrier. 3rd floor Pavilion 3rd floor SICU On March 28, 2014 between the times of 10:45 a.m. and 11:20 a.m. the following conditions existed in 3rd floor SICU (surgical intensive care unit). 95. Room 332A had adhesive paper peeling off of the head wall mounted light fixture. 96. Room 332D had a towel taped onto a camera in the room. Further observation revealed that at the nurses station monitor the patients in the rest	A 701	(Continued from page 129) **90) Corrective Actions:** The oxygen tanks were immediately exchanged for full tanks. Charge nurses educated on use of Environment of Care Log to be completed every shift. This put in place to prevent oxygen tanks from being left empty in the Physical Therapy Room. Initial education completed to charge nurses on 6/19/2014 at 12:00pm. Education will be ongoing to ensure that all charge nurses will be aware. EOC charge nurse log will be kept on unit in separate binder at all times. **Date of Implementation:** 6/19/2014 **Monitoring Process:** Logs to reviewed weekly by Unit Director **Person Responsible:** Nursing Director **91) Corrective Actions:** The shower curtain in the common tub room was replaced by EVS. **Date of Implementation**: March 28, 2014. **Monitoring Process:** Daily rounding is conducted by EVS to monitor for cleanliness. **Person Responsible:** Director of EVS **92) Corrective Actions:** Linen cart cover was present but was not pulled down to provide coverage for the linen. The cover was pulled down and secured. Nursing education developed regarding ensuring cart covers are used and/or cabinet doors closed. **Date of Implementation**: Education started on June 19, 2014 with full implementation in 30 days. **Monitoring Process:** Infection Control Rounds **Person Responsible**: Nursing Director & Infection Control. **93) Corrective Actions**: Drain was redirected to an indirect drain line to provide air gap. **Date of Implementation:** Repairs will be completed by June 30, 2014. **Monitoring Process:** Engineering to conduct quarterly rounding, during performance of the Ice Machine Preventive Maintenance, to ensure integrity of the indirect drain line (air gap) is in place. **Person Responsible:** Director of Engineering **94) Corrective Actions:** Penetrations were sealed around pipes and joints using fire caulk, 3M-CP 25WB+, on the gypsum board barrier (dust barrier), at the construction separation between back of 4th floor and the Rehabilitation Unit on March 29, 2014 by Engineering. Below protocol will be complied: a) Contractors must train their employees in ILSM and provide documentation to the Director of Plant Operations/Safety Officer that this training has been accomplished. Documentation should include the subject matter covered, names of employees receiving the training, and the date the training was provided. In turn, the Director of Plant Operations will provide this documentation to the Chair of EOC. **Date of Implementation:** Penetrations were caulked on March 29, 2014. Protocol will be on going. **Monitoring Process:** During pre-construction meetings, the Director of Engineering will discuss the ILSM with the Contractor. Contractor is to sign on the copy of the ILSM for acknowledgment and agreement in compliance of fire penetrations **Person Responsible:** Director of Engineering **CULVER CITY CAMPUS (Pavilion 3 SICU)** **95).Corrective Actions:** The wall mounted light fixture in room 332A will be repaired in June 2014 by Engineering. **Date of Implementation:** June 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **96. Corrective Action:** Cameras placed on Charge RN daily environmental rounds to ensure their integrity. **Date of Implementation:** June 20, 2014 **Monitoring Process:** Charge RN Environmental Rounds Record**.** Data to be reviewed and aggregated by Nursing Director with report to Quality Dept. **Person Responsible:** Director of Engineering	6/19/2014 3/28/2014 6/19/2014 6/30/2014 3/29/2014 6/30/2014 6/20/2014

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A 701	Continued From page 130 of the unit□s rooms could be observed by the cameras except for Room 333D which had the view obstructed by the towel. During an interview, RN 26 (charge nurse) stated the the purpose of the cameras was to observe the patients for patient safety, she further stated that the patient did not request the towel to be placed over the camera and that she did not know why the towel was taped onto the camera or who taped onto the camera. 97. In Room 332G, there was a loose front panel of head wall mounted light fixture. 98. In the clean supply room, there was a clean supplies cart that was not covered and a clean supplies cabinet with the doors fully open. Supplies in the cart included suction tubing, yankawers, cath plugs, trach holders, suction cather kits, ball and trach care suction systems, tongue depressors and swab sticks. 3rd floor CCU On March 28, 2014 between the time of 11:20 a.m. and 11:50 a.m., the following conditions existed in 3rd floor CCU (critical care unit). 99. There was an accumulation of dust and a gray substance at ceiling of Rooms 333A, 333D, and 333E. 100. Room 333 F/G had six 1/2 inch diameter holes through the wall. 101. During an interview at the time of the observation, Staff 5 stated the holes were from a	A 701	(Continued from page 130) **97. Corrective Actions:** The wall mounted light fixture in room 332G will be repaired in June 2014 by Engineering. **Date of Implementation:** June 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **98. Corrective Actions:** Linen cart cover was present but was not pulled down to provide coverage for the linen. The cover was pulled down and secured. Nursing education developed regarding ensuring cart covers are used and/or cabinet doors closed. **Date of Implementation**: Education started on June 19, 2014 with full implementation in 30 days. **Monitoring Process:** Infection Control Rounds **Person Responsible:** Nursing Director & Infection Control. **CULVER CITY CAMPUS (Pavilion 3 CCU)** **99) Corrective Actions:** Upon review of P&P, staff was in-serviced and high dusting was performed in room nos. 333A, 333D and 333E by EVS. **Date of Implementation:** Dust in rooms 333A, 333D and 333E was removed on March 28, 2014, when the rooms became available. **Monitoring Process:** A dusting calendar is kept by EVS to ensure every patient room is dusted, commencing in the Psych unit and then house-wide. In addition, EOC Rounding is conducted routinely, covering patient areas, twice a year and as needed. **Person Responsible:** Director of Engineering **100-101) Corrective Actions:** Holes on wall were patched and painted in room 333, beds F&G, on April 7, 2014 by Engineering. **Date of Implementation:** Holes in the wall were patched and painted in room 333, beds F&G, on April 7, 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas. **Person Responsible:** Director of Engineering	6/30/2014 6/19/2014 3/28/2014 4/7/2014

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A 701	Continued From page 131 sharps container that use to be mounted on the wall and that the holes need to be sealed. 102. The patient rooms safety monitor was off at the at the nurses. 103. There was a missing cover plate at communication line at corridor wall between Rooms 3338 and 333C. 3rd floor ACU On March 28, 2014, between the time of 11:50 a.m. and 12:10 p.m,. the following conditions existed in 3rd floor ACU (ambulatory care unit). 104. There was no thermometer in the patient food refrigerator holding 8 cold cut sandwiches. 105. The □-Ray room had a two inch diameter hole in wall, and was missing wall caving. 106. There was a one foot crack at floor of common bathroom next to the waiting room. 3rd floor SOU On March 28, 2014 between the time of 12:10 p.m. and 2:00 p.m., the following conditions existed in 3rd floor SOU (step down unit). 107. Room 312 had a missing light shield at wall mounted light fixture exposing four fluorescent glass tubes, and had four 1/2 inch holes through the head wall exposing the wall cavity and particle board around the holes. 108. Room 314A had a loose nurse call at the	A 701	(Continued from page 131) **102) Corrective Actions:** Re-educate RN□s and Monitor Techs to keep safety monitor alarms on. Revised Patient Rhythm Documentation Form to include Alarm monitoring. **Date of Implementation:** Revised form will be implemented June 20, 2014. **Monitoring Process:** Registered Nurses (RN□s) and Monitor Techs (MT□s) will monitor for alarms and document on Patient Rhythm/Alarm Documentation Form. Nursing Director will monitor form for 100% compliance and report compliance to the Quality Department. Non-compliance will be addressed with progressive discipline; will monitor for 30 days. **Person Responsible**: Director of Nursing and/or Designee.	6/20/2014
			103) Corrective Actions: The cover plate in rooms 333B and 333B will be replaced in June 2014 by Engineering. Date of Implementation: The cover plate in rooms 333B and 333B will be replaced in June 2014. **Date of Implementation**: The cover plate in rooms 333B and 333B will be replaced in June 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas. **Person Responsible:** Director of Engineering	6/30/2014
			CULVER CITY CAMPUS (Pavilion 3 ACU) **104) Corrective Actions:** A thermometer was placed in the patient food refrigerator holding sandwiches on June 18, 2014 by Dietary. A log to ensure thermometers are checked daily has been created and is attached herewith. **Date of Implementation**: A thermometer was placed in the patient food refrigerator on June 18, 2014 by Dietary **Monitoring Process**: Dietary will conduct daily monitoring to ensure all patient food refrigerators have thermometers. **Person Responsible:** Director of Food Services.	6/18/2014
			105) Corrective Actions: The hole in the wall and the missing wall coving in the x-ray room will be addressed in June 2014 by Engineering. **Date of Implementation**: The hole in the wall and the missing wall coving in the x-ray room will be addressed in June 2014. **Monitoring Process**: Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas. **Person Responsible:** Director of Engineering.	6/30/2014
			106) Corrective Actions: The crack on the bathroom floor next to Pavilion 4 waiting room was repaired on April 10, 2014 by Engineering. **Date of Implementation:** The crack on the bathroom floor next to Pavilion 4 waiting room was repaired on April 10, 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014 in clinical areas **Person Responsible:** Director of Engineering.	4/10/2014
			CULVER CITY CAMPUS (Pavilion 3 SDU) **107). Corrective Actions:** The light shield at light fixture in room 312 was replaced and the holes in the wall were patched and painted on April 11, 2014 by Engineering. **Date of Implementation**: April 11, 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering	4/11/2014
			108). Corrective Actions: The nurse call was re-secured to the wall in room 314A in March 2014 by Engineering. **Date of Implementation:** March 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering	3/30/2014

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A 701	Continued From page 132 head wall. 109. Room 318 had a three inch by one inch hole at the wall behind the door, and a loose nurse call bell light outside of the room. 110. There was a worn cover with tears and flaking pieces covering the clean linen cart in the corridor. 111. There was missing laminate at corners of nurses station exposing the wood beneath. 112. The common shower/tub room next to SOU had one foot by six inch area of damage at a wall, and three inch by two inch area of damage at a corner of the wall. 2nd floor Pavilion 113. There were braided nurse call cords throughout the southwest and southeast telemetry units. 114. The handrail across from room 244 had a broken corner with two inch wide sharp corner where a piece of the rail was missing. 2nd floor Southwest Telemetry On March 28, 2014 between 2:00 p.m. and 2:20 p.m. the following conditions existed in 2nd floor Telemetry Southwest Unit. 115. Room 203 had peeling paint at the shower stall. 116. Room 204 had a 1/2 inch diameter hole	A 701	(Continued from page 132) **109). Corrective Actions:** The nurse call bell light was re-secured to the wall in room 318 in March 2014 by Engineering. The holes were patched and painted on April 11, 2014 by Engineering. **Date of Implementation:** March 2014 and April 11, 2014, respectively **Monitoring Process**: Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible**: Director of Engineering **110) Corrective Actions**: A representative from Medline came on June 19, 2014 to assess replacement of worn and missing clean linen cart covers. An order has been placed for cart covers and ETA is July 3, 2014. **Date of Implementation:** July 3, 2014 **Monitoring Process**: Daily rounding is conducted by EVS to monitor cleanliness and ensure linen carts are covered at all times. Deficiencies will be addressed immediately. **Person Responsible**: Director of EVS **111). Corrective Actions:** The exposed wood at the corner of the nurse□s station was covered using new laminate sheet. **Date of Implementation:** Repairs will be completed on August 19, 2014. **Monitoring Process:** Engineering to conduct quarterly rounding to monitor work stations to ensure they are in good and safe working condition i.e., free of wood exposure or chipped surface. **Person Responsible**: Director of Engineering **112). Corrective Actions**: Wall damage in shower/tub room next to SDU was repaired on April 9, 2014 by Engineering. **Date of Implementation**: April 9, 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **CULVER CITY CAMPUS (2nd Floor Pavilion/2nd Floor Southwest Telemetry/2nd Floor Southeast Telemetry)** **113). Corrective Actions:** All nurse call pull cords have been replaced in April 2014 hospital-wide by Engineering. **(See Addendum 96)** **Date of Implementation:** April 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **114). Corrective Actions:** The handrail across from room 244 will be repaired in June 2014 by Engineering. **Date of Implementation:** June 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible**: Director of Engineering **115). Corrective Actions:** The shower stall in room 203 was repainted on May 5, 2014 by Engineering. **Date of Implementation**: May 5, 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **116). Corrective Actions:** The hole through the bathroom door in room 204 was patched and painted on April 10, 2014 by Engineering. **Date of Implementation:** April 10, 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in	3/30/2014 4/11/2014 7/3/2014 8/19/2014 4/9/2014 4/30/2014 6/30/2014 5/5/2014 4/10/2014

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A 701	Continued From page 133 through the bathroom door. 117. Room 207 had eight *V4* inch holes at a bathroom wall. Closer observation revealed the toilet paper dispenser was missing and the toilet paper roll was sitting on the bathroom sink counter. 118. Missing cover at two clean supply carts in supply room. 119. In the supply room there were two clean supplies carts that were not covered. During an interview at the same time as the observation, AN 27 (charge nurse) stated that the carts were clean supplies carts and should have been covered, that they were covered before and did not know why they were no longer covered. 2nd floor Southeast Telemetry On March 28, 2014, between the time of 2:23 p.m. and 2:45 p.m., the following conditions existed in 2nd floor Telemetry Southeast Unit. 120. Room 211 had a night stand table with a broken drawer. 121. Room 214 had a grab bar that was off the shower stall wall and laying against bottom of the stall wall. 121. Room 218 was missing the towel bar from the bathroom, and there was also damaged at the corner of a wall. 123. Room 220 had a water leak at the nut of the sink drain pipe (P-trap), and had a loose lockset	A 701	(Continued from page 133) **117) Corrective Actions:** holes at a bathroom wall in room 207 will be patched and painted and the toilet paper dispenser will be installed in June 2014 by Engineering. **Date of Implementation**: June 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible**: Director of Engineering **118) Corrective Actions:** A representative from Medline came on June 19, 2014 to assess replacement of worn and missing clean supply cart covers. An order has been placed for cart covers and ETA is July 3, 2014. **Date of Implementation:** July 3, 2014 **Monitoring Process:** Nursing will be in-serviced to ensure that clean supply carts are covered at all times. Daily rounding is conducted by Nursing and EVS to monitor cleanliness and ensure clean supply carts are covered at all times. Deficiencies will be addressed immediately. **Person Responsible:** Nursing Personnel, Charge Nurses and Nursing Directors on each unit. **119). Corrective Actions:** Nursing education developed, ensuring cart covers are used and cabinet doors closed. **Date of Implementation:** Education started on June 19, 2014 with full implementation in 30 days. **Monitoring Process:** Infection Control Rounds **Person Responsible:** Nursing Director & Infection Control. **120). Corrective Actions:** The night stand table in room 211 will be replaced in June 2014 by Engineering. **Date of Implementation:** June 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible**: Director of Engineering **121). Corrective Actions:** The grab bar in the shower stall in room 214 was remounted on April 29, 2014 by Engineering. **Date of Implementation**: April 29, 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **121). Corrective Actions:** The missing towel bar from the bathroom was replaced on April 22, 2014 and the wall damage was repaired on April 10, 2014 by Engineering. **Date of Implementation**: April 22 and April 10 accordingly **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **123). Corrective Actions**: The water leak in room 220 was repaired on April 22, 2014 and the lockset as re-secured on April 10, 2014 by Engineering. **Date of Implementation:** April 22 and April 10, 2014 accordingly **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering	6/30/2014 7/3/2014 6/19/2014 6/30/2014 4/29/2014 4/10/2014 4/22/2014 4/10/2014 4/22/2014

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A 701	Continued From page 134 handle at the bathroom door. 124. Room 221 had a missing grab bar at shower stall wall, and a three foot crack at shower stall wall. 1st floor Pavilion On March 31, 2014 between the time of 9:04a.m. and 10:20 a.m., the following conditions existed on 1st floor Pavilion. 125. The main laboratory had a missing light shield at a light fixture above the center work station where immunoassay procedures are done. 126. The pharmacy storage room was missing a light diffuser shield exposing four glass fluorescent tubes at at one of three ceiling lights over a rack of clean supplies. 127. The pharmacy had a pharmacy waste incineration container that was filled above the fill line and beginning to overflow out from the top of the container. There was also a missing cover plate at a wall exposing a three inch by two inch hole in the wall. 128. On March 25, 2014, the following conditions were observed in the the Hollywood campus: 4th Floor a. The toilet base was dirty and caulking; the sealant was in disrepair at the Nurse Station.	A 701	(Continued from page 134) **124). Corrective Actions:** The grab bar at the shower stall wall and the crack on the wall will be repaired in June 2014 by Engineering. **Date of Implementation**: June 2014 **Monitoring Process**: Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **CULVER CITY CAMPUS (Pavilion 1)** **125). Corrective Actions:** The missing light shield in the main laboratory above the center work station was replaced on April 11, 2014 by Engineering. **Date of Implementation:** April 11, 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **126). Corrective Actions:** The missing light diffuser shield in the Pharmacy storage room will be replaced in June 2014 by Engineering. **(see Addendum 98)** **Date of Implementation**: June 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **127). Corrective Actions:** The pharmacy waste incinerator container was replaced by EVS. The missing cover plate at a wall will be replaced in June 2014 by Engineering. **Date of Implementation**: Incinerator replaced on March 31, 2014 **Monitoring Process**: Daily rounding is conducted by EVS to monitor cleanliness. **Person Responsible:** Director of EVS **HOLLYWOOD** **Fourth Floor: 128 a-d** **128a). Corrective Actions:** Remove, clean and reset the toilet bowl and reseal with white caulking at the base. **Date of Implementation:** April 2, 2014 cleaning and repairs completed. **Monitoring Process:** Inspection of the toilet rooms will be performed quarterly. **Person Responsible:** Chief Engineer	6/30/2014 4/11/2014 6/30/2014 3/31/2014 4/2/2014

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A 701	Continued From page 135 b. There was leaking water/intrusion in the base cabinet of the Urgent Care base cabinet. c. The plumbing faucet was covered in calcium deposits in the Medication Room and the nurse station shower head. d. The shower/bathroom was in disrepair and the floor nurse station restroom shower enclosure had missing wall tiles. 3rd Floor a. Handwash sink had an unsealed hole measuring 3 inches (in) by 4 in. b. In the Nurse Station, the rest room had unclean shower base, missing shower door handle, missing threshold hardware, and missing facing in the dictation area. c. In Room 316, the wallpaper was torn and damage behind bed 3. d. Room 307, an over the bed table was damaged at a corner and revealed uncleanable particle board. e. In Room 308, the patient had no privacy curtain and a staff stated' 11She is the only one in the room□n 5th Floor a. The toilet base was dirty and caulking; the sealant was in disrepair in Room 507 and Room 508. b. The handwash sink faucets had aerators located in the following areas: respiratory,	A 701	(Continued from page 135) **128 b). Corrective Actions:** Replace defective angle stop to in the base cabinet of the Urgent Care cabinet base. **Date of Implementation**: April 7, 2014 angle stop replaced by Engineering and no more leaks noted. **Monitoring Process:** Continue to monitor sinks for water leaks during EOC rounds. **Responsible Person**: Chief Engineer **128 c). Corrective Actions:** Clean the calcium deposits on the plumbing faucet in the Medication Room and replace the shower head in the Nurse Station shower. **Date of Implementation:** April 5, 2014 faucet cleaned and shower head replaced. **Monitoring Process:** Continue to monitor sink faucets and shower heads for leaks during EOC rounds. **Responsible Person:** Chief Engineer **128 d) Corrective Actions:** Replace and re-caulk the missing wall tiles in the floor nurse station restroom shower enclosure. **Date of Implementation:** June 18, 2014 repairs completed. **Monitoring Process:** Continue to monitor shower/bathroom tiles during EOC rounds. **Responsible Person:** Maintenance Engineer **Third Floor: a-e** **128 a). Corrective Actions:** Seal the Hand wash sink hole (3 in. by 4 in) with 3M fire caulk. **Date of Implementation:** April 10, 2014 repairs completed. **Monitoring Process:** Quarterly Hospital-wide checks for penetrations will be performed. **Department Responsible:** Chief Engineer **128 b. Corrective Actions:** Clean shower base, replace the shower arm and shower head and shower door handle at the Nurse Station Lounge including the missing facing in the dictation area. **Date of Implementation:** June 20, 2014 cleaning and repairs completed. **Monitoring Process:** Continue to monitor during EOC rounds. **Department Responsible:** Chief Engineer **128 c). Corrective Actions:** Repair the torn and damaged wallpaper in ICU Room 316. **Date of Implementation:** June 16, 2014 repairs completed. **Monitoring Process:** Continue to monitor during EOC rounds. **Department Responsible:** Chief Engineer **128 d). Corrective Actions:** Remove and replace damaged over the bed table in room 307. **Date of Implementation**: March 25, 2014 replaced immediately. **Monitoring Process:** Continue to monitor during EOC rounds. **Department Responsible:** Chief Engineer **128 e) Corrective Actions:** Install a patient privacy curtain in Room 308. **Date of Implementation:** March 31, 2014 installation of curtain completed. **Monitoring Process;** Privacy curtains checks will continue to be performed during EVS Daily Rounds. **Department Responsible:** Environmental Services Lead Person **Fifth Floor: a-f** **128 a. Corrective Actions:** Clean toilet bases and reseal with new caulking in Rooms 507 and 508. **Date of Implementation:** March 31, 2014 cleaning and repairs completed. **Monitoring Process:** Continue to monitor during EOC rounds. **Department Responsible:** Engineering/Infection Control/EVS **128 b). Corrective Actions**: Remove all faucet aerators in Respiratory, Medical Supply floor, Basement sink, Recovery Room and Pharmacy hand wash sink. **Date of Implementation:** March 27, 2014 faucet aerators removed. **Monitoring Process;** Continue to monitor thru EOC rounds every six months. **Department Responsible:** Chief Engineer	4/7/2014 4/5/2014 6/18/2014 4/10/2014 6/20/2014 6/16/2014 3/25/2014 3/31/2014 3/27/2014

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A 701	Continued From page 136 medical supply floor, a basement sink, recovery area, and pharmacy handwash sink. c. There was ceiling damage and hole in the boiler room (3 in by 4 in hole). d. There was trash stored in the patient sleeping room 509. e. The ice maker had a direct connection to sewer system. f. In the Medical Supply room, the threshold floor was missing in the shower room and in the janitor room. 6th Floor a. There was missing threshold hardware in the IV (intravenous) Stockroom and one stained ceiling tile. b. The handwash sink faucets had aerators in the respiratory room. c. There were 4 suction containers that were rusted. d. In the Operating Room, the □-ray viewing frame was dirty/marred and the anesthesia cart had discolored white tape on the contact surface. e. The 6th floor pharmacy under the hood and the floor finish pieced together with open and dirty seams. f. The wall finish was damaged on the respiratory room. g. The 6th floor water heater room with a fifteen	A 701	(Continued from page 136) **128 c). Corrective Actions:** Repair the ceiling damage and hole in the boiler room. **Date of Implementation**: April 2, 2014 repair completed **Monitoring Process;** Monthly inspection rounds to be performed for penetrations, ceiling or wall damages. **Department Responsible**: Chief Engineer **128 d). Corrective Actions:** Remove all trash stored in the patient sleeping Room 509. **Date of Implementation:** March 25, 2014 trash immediately removed. **Monitoring Process;** Continue to monitor during EOC rounds. **Department Responsible:** Chief Engineer **128 e). Corrective Actions**: Adjusted Ice maker drain pipe tip/end to maintain (1) one inch clearance from sewer system/line. **Date of Implementation:** April 1, 2014 completed. **Monitoring Process;** Semi-annual inspection during EOC rounds. **Department Responsible:** Chief Engineer **128 f). Corrective Actions:** Reinstall missing threshold floors in the Medical Supply room, Shower Room and Janitors Rooms. **Date of Implementation:** June 16, 2014 started and will be completed June 20, 2014. **Monitoring Process;** Continue to monitor during EOC rounds. **Department Responsible:** Chief Engineer **Sixth Floor: a-i** **128 a). Corrective Actions:** Replace the missing threshold hardware in the IV Stockroom and replace the stained ceiling tile. **Date of Implementation:** April 15, 2014 repairs completed. **Monitoring Process;** Continue to monitor during the EOC rounds. **Department Responsible:** Chief Engineer **128 b). Corrective Actions:** Remove the aerators in the sink faucet located in Respiratory room. **Date of Implementation:** March 25, 2014 faucet aerator removed. **Monitoring Process:** Continue to monitor during the EOC rounds on a semi-annual inspection. **Department Responsible**: Chief Engineer **128 c). Corrective Actions:** Remove from service the 4 suction containers that were rusted and replaced with 4 new suction containers. **Date of Implementation:** April 23, 2014 completed. **Monitoring Process;** Continue to monitor during the EOC rounds. **Department Responsible:** EOC committee **128 d). Corrective Actions:** Replace the dirty/marred □-ray viewing frame and remove the discolored white tape on the contact surface of the anesthesia cart in the Operating Room. **Date of Implementation**: April 23, 2014 repairs completed **Monitoring Process;** Continue to monitor in the EOC rounds. **Department Responsible:** EOC Committee /Surgery Staff **128 e). Corrective Actions:** Remove and replace defective floor finish and clean the seams at the foot of Pharmacy hood. **Date of Implementation:** April 23, 2014 completed. **Monitoring Process;** Continue to monitor during EOC rounds. **Department Responsible:** Chief Engineer **128 f). Corrective Actions:** Remove the damaged wall finish and paint the walls in Respiratory. **Date of Implementation:** April 24, 2014 repairs completed. **Monitoring Process:** Continue to monitor during the EOC rounds. **Department Responsible:** Chief Engineer/Infection Control **128 g). Corrective Actions:** Anchor the copper pipe on the wall with metal clips in the hot water storage room of the 6th Floor.	4/2/2014 3/25/20144 6/16/2014 4/15/2014 3/25/2014 4/23/2014 4/23/2014 4/24/2014

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A 701	Continued From page 137 feet line without support brackets and held up at the ceiling with a mop stick. h. In the Medical File Room, there was one small two drawer file cabinet with missing facing exposing unfinish wood and dirty. i. In the Urgent Care Room, the door was not labeled and there was water intrusion under the handwash sink and inside the base cabinet. Basement a. There was an unfinished wall/plaster in the contaminate room ceiling puffy and damaged 3 in. by 6 in. b. In the □-ray room, the toilet base needed to be serviced/caulk. c. In the Pre-Op room, the floor finish had an one inch adhesive strip which was not cleanable. d. In Operating Room 3, two cabinets had missing facing and a section of the floor had left over adhesive/uncleanable. Culver City campus a. In the emergency room entryway rug runner, in the 1st floor Nurse Station, the floor was very dirty and the carpet was stained; In the 1st floor Transportation Dispatch Office, the rug and base flooring was elevated about 3/4 inch above the adjoining room and the threshold had no hardware. In the 1st floor □-ray room □3, the handwash sink counter top had missing facing and there was no handwash soap available; In the Nuclear Medicine disposal area, the entry door to the area was not labeled and the disposal	A 701	(Continued from page 137) **Date of Implementation:** April 23, 2014 completed. **Monitoring Process:** Continue to monitor by Engineers during rounds. **Department Responsible:** Engineering **128 h). Corrective Actions:** Clean and laminate the two drawer file cabinet in the Medical File Room. **Date of Implementation:** April 19, 2014 cleaning and repair completed. **Monitoring Process;** Continue to monitor during EOC rounds. **Department Responsible:** Chief Engineer **128 i). Corrective Actions:** Install label on the door and replace the angle stop in Urgent care under the sink cabinet. **Date of Implementation:** April 7, 2014 Installed door label and replaced angle stop and no leak noted. **Monitoring Process**: Continue to monitor sinks during the EOC rounds for leaks. **Person Responsible:** Chief Engineer **Basement: a-d** **128 a). Corrective Actions**: Repair and paint the puffy and damaged (3 in x 6 in) area on the ceiling in the contaminate room. **Date of Implementation:** April 9, 2014 started and completed on April 11, 2014. **Monitoring Process:** Continue to monitor during the EOC rounds. **Responsible Person:** Chief Engineer **128 b). Corrective Actions:** Re-caulk the toilet base in the □-ray room with polyurethane high performance sealer. **Date of Implementation:** April 9, 2014 repair completed. **Monitoring Process:** Continue to monitor during the EOC rounds. **Responsible Person**: Chief Engineer **128 c). Corrective Actions:** Remove the one inch adhesive strip on the floor in the Pre-op room. **Date of Implementation:** April 9, 2014 date completed. **Monitoring Process:** Continue to monitor during the EOC rounds. **Department Responsible:** Chief Engineer **128 d). Corrective Actions:** Repair the two cabinets in Operating Room 3 and remove the leftover adhesive from the floor. **Date of Implementation**: April 22, 2014 date completed. **Monitoring Process:** Continue to monitor during the EOC rounds. **Responsible Person:** Chief Engineer **CULVER CITY** **a). Corrective Actions:** The entryway rug runner was removed and the floor stripped and waxed by EVS. **Date of Implementation**: April 2014. **Monitoring Process:** Daily rounding is conducted by EVS to monitor cleanliness. **Person Responsible:** Director of EVS **Corrective Actions:** The transportation dispatch office flooring will be replaced in June 2014 by Starfloors, a flooring vendor. **Date of Implementation**: June 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering & Director of EVS **Corrective Actions:** The sink countertop in x-ray room □3 will be replaced with Formica and hand soap dispenser will be installed by Engineering. **Date of Implementation:** June 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering	4/23/2014 4/19/2014 4/7/2014 4/9/2014 4/9/2014 4/9/2014 4/22/2014 4/30/2014 6/30/2014 6/30/2014

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A 701	Continued From page 138 containers were not maintained; In the Radioactive Laboratory area, the dark room floor sink was very dirty and the floor tile was very dirty, separating, and lifting; In the Nuclear Medicine Imaging, the bathroom floor tiles was lifting. b. In the 1st floor emergency employee lounge, there were twenty plus American Cockroaches desiccate and stuck to 3-glue boards located underneath the employee lounge kitchenette base cabinet. c. In the Radioactive Laboratory, the exam table had missing screw and on screw missing, there was a sleeve to protect patients from the exposed screws. d. In the Emergency Room/ISO, the toilet base needs recaulking at the toilet base. e. In the Emergency Room, the patient bathroom had cracked doorjam; In the 2nd floor staff bathroom, the soap dispenser was relocated and wall not repaired; In the 2nd floor, the Janitor Closet had wall caving separating from the wall; In the 2nd floor kitchenette, the floor tiles was lifting. Basement a. In the dumb waiter, the storage area was unsanitary and dirty. b. In the Central Supply Room, the 5-shelf rack was dirty with dust and dirt, eyewash sink counter top damaged, rusty paper dispenser located over the sink; the sink's caving detached from the sides/wall; the door panel detached.	A 701	(Continued from page 138) **Corrective Actions:** Missing door signs, including the door in Nuclear Medicine, will be addressed by Sign Centrix, who is currently providing a master plan for all interior signage upgrades. Nuclear Medicine created a weekly log and scheduled weekly disposal of radioactive contaminated trash with EVS. (A copy of the log is as attached.) **Date of Implementation:** Weekly monitoring commenced on June17, 2014 **Monitoring Process:** Weekly disposal of radioactive contaminated trash. **Person Responsible**: Director of Engineering & Director of EVS **Corrective Actions:** The flooring in Radioactive Lab area dark room, Nuclear Medicine Imaging bathroom will be addressed by Starfloors, a flooring vendor, in June 2014. **Date of Implementation**: June 2014. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. Daily rounding is conducted by EVS to monitor cleanliness. **Person Responsible:** Director of Engineering & Director of EVS **b) Corrective Actions:** Dead bugs were removed and the cabinet cleaned on March 25, 2014 while EVS staff is tasked to monitor cabinets in the ER Employee Lounge weekly. **Date of Implementation**: March 25, 2014 **Monitoring Process:** Daily rounding is conducted by EVS to monitor cleanliness. **Person Responsible:** Director of EVS **c) Corrective Actions:** The missing screws have been replaced on table of the gamma camera (exam table in the Radioactive Lab) by Bio Med. **Date of Implementation:** June 16, 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **d) Corrective Actions:** The toilet base in the restroom inside the Isolation Room in the ER was cleaned and recaulked by Engineering. **Date of Implementation:** April 11, 2014 Monitoring Process: Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. Person Responsible: Director of Engineering **e) Corrective Actions:** The cracked door jam in the patient bathroom in the Emergency Room will be repaired by Engineering. **Date of Implementation:** June 2014 **Corrective Actions:** The holes on wall in staff bathroom in Pavilion 2 will be patched and repainted by Engineering. **Date of Implementation**: June 2014 **Corrective Actions:** The wall coving in the Janitor Closet was repaired by Engineering. **Date of Implementation**: April 3, 2014 **Corrective Actions:** The floor tiles on the 2nd floor kitchenette will be repaired by Engineering. **Date of Implementation**: June 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **BASEMENT** **a).Corrective Actions:** EVS is scheduled to clean the dumb waiter and will monitor and log weekly. **Date of Implementation**: June 2014 **Monitoring Process**: Daily rounding is conducted by EVS to monitor cleanliness. **Person Responsible**: Director of EVS **b). Corrective Actions:** EVS dusted off the shelf rack in Central Supply on June 17, 2014 and will continue to monitor and log dustings bi-weekly. **Corrective Actions:** The eyewash sink will be repaired in June 2014. **Corrective Actions:** The rusty paper dispenser will be replaced in June 2014 **Corrective Actions:** The door panel will be repaired in June 2014. **Date of Implementation:** Repairs and replacements to be completed by the end of June 2014	6/17/2014 6/30/2014 3/25/2014 6/16/2014 4/11/2014 6/30/2014 6/30/2014 4/3/2014 6/30/2014 6/17/2014 6/30/2014

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A 701	Continued From page 139 c. In the Operating Room area, the floor finish/buckling with open floor seams; the dirty floor finish and caving were discolored and not clean; the corridor metal wall strip had exposed screw holes. d. In the Recovery area, the Nurse Station had damaged counter top with the facing detached or missing; handwash sink had an aerator; soap dispenser was dirty and blacken. e. In the Microbiology Room, the floor finish was removed; air hood with worn down finish and rusted. Van Nuys campus 129. On March 24, 2014, at 10:30 a.m., during an initial tour of locked unit 2 , the housekeeping staff was spraying air freshener in the hallways and walked toward the utility cart. The housekeeping staff opened the cabinet and placed the air fresher can inside. During a concurrent interview, when asked about the utility cart should be closed. She stated, □Yes, the utility cart is in use it should be locked at all times.□ She reached in the drawer and got the	A 701	(Continued from page 139) **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. Daily rounding is conducted by EVS to monitor cleanliness. **Person Responsible:** Director of Engineering & Director of EVS **c).Corrective Actions:** Operating Room • Minor repairs for heat welding seams have been made to the OR flooring while proposals are being obtained to replace the entire OR flooring. • The holes on the corridor metal wall strip were patched with Epoxy on April 7, 2014 by Engineering. **Date of Implementation**: April 7, 2014 **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **d).Corrective Actions & Date of Implementation**: Recovery Area • The damaged counter top in the Nurse Station will be assessed and repaired by Engineering. • The aerator in the Recovery Area hand wash sink was removed immediately on March 25, 2014. In addition, all aerators have been removed hospital-wide on April 4, 2014 by Engineering. • The soap dispenser was replaced on April 3, 2014 by Engineering. **Date of Implementation:** June 2014 for the countertop. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible**: Director of Engineering **e).Corrective Actions:** Microbiology Room • New flooring will be installed in Microbiology Room in July 2014. • The rusted portion of the air hood in Microbiology was refinished on April 11, 2014 by Engineering. **Date of Implementation:** July 2014 for the flooring. **Monitoring Process:** Engineering to conduct daily rounding for routine maintenance repairs commencing in June 2014. **Person Responsible:** Director of Engineering **VAN NUYS** **129). Corrective Actions:** All utility carts in use should be locked at all times, except when removing or replacing cleaning items per policy item number 4.2.20. **Date of Implementation:** 3/24/14 **Monitoring Process:** JIT Training provided to EVS on March 25, 2014 for proper locking of utility carts. **Person Responsible:** Director of Engineering	4/7/2014 3/25/2014 4/3/2014 4/4/2014 4/11/2014 7/30/2014 3/24/2014

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A 701	Continued From page 140 keys to lock the utility cart. According to the facility's policy titled, All Cleaning Supply dated EVS 2011, when the utility cart was in use on the units it should be locked at all times, except when removing or replacing cleaning items. 130. On March 24,2014, at 11:10 a.m., in the patio area of the locked unit, there was an umbrella base turned upside down. There was no umbrella. The inside where the umbrella pole holder had cigarette butts. The patio area of open unit 1 had cigarette butts in the flower beds and smelled of cigarettes. During a concurrent interview with Staff I, she stated the facility was "2 weeks nonsmoking facility... She further stated the patients were informed they were to smoke off the facility grounds. Hollywood campus 131. Staff 2 was interviewed on March 24, 2014 at approximately 3:05 p.m. on the emergency food and water for Hollywood campus. He did not present a plan but stated that there was some food including pasta on hand. The dry storage room where the food would have been stored had just received a delivery of food that completely blocked access to the room. No other supporting information about adequacy of food and water for use during emergency was provided during the survey. Van Nuys campus 132. On March 27,2014 beginning at 10:10 a.m., the hospitals' disaster meal plan was reviewed	A 701	(Continued from page 140) **130). Corrective Actions:** The umbrella base in the patio area of the locked unit was cleaned and removed. (See attached). The inside of the holder is now free of cigarette butts. The patio area of Unit 1 flower beds is free of cigarette butts. Routine monitoring through daily rounds for monitoring patio area by EVS. **Date of Implementation:** 3/24/14 **Monitoring Process:** Routine monitoring through daily rounds for monitoring patio area by EVS. **Person Responsible:** Director of Engineering **HOLLYWOOD** **131) Corrective Actions:** The Disaster menu and supplies for patients were adjusted to meet the needs of the facility. Disaster food and supplies for patients have been received. A disaster plan for staff is in process of being developed and food products will be ordered accordingly. Once the plan is finalized, staff will be trained on its use. **Date of Implementation:** July 31, 2014 Written plan completion, staff training and monthly inventory of disaster supplies will be completed by September 10, 2014 Weekly inventory of all food products to ensure adequate availability will take place starting September 10, 2014 **Monitoring process:** Weekly inventory to ensure adequate menu supplies are on hand. Monthly inventory for adequate emergency supplies will be compared to the □Disaster Inventory Sheet□ Results of disaster supply monitoring activity will be reported to the hospital□s EOC Committee. **Person Responsible:** RD, Director of Dietary Department **Corrective Action:** Just in time training provided to the delivery drivers and dietary staff regarding clearance of E□IT doors at all times **Date of Implementation:** June 19, 2014 **Monitoring process:** Monitoring will be managed through EOC rounds and daily operational rounds **Person Responsible:** Dietary staff, Safety officer **VAN NUYS** **132) Corrective Actions:** The Disaster freeze dried food menu and supplies for patients were adjusted to meet the needs of the facility. Disaster food and supplies for patients have been received. A disaster plan for staff is in process of being developed and food products will be ordered accordingly. Once the plan is finalized, staff will be trained on its use.	3/24/2014 7/31/2014 9/10/2014 6/19/2014

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A 701	Continued From page 141 with Staff 2. She stated that the hospital was preparing to serve 160 patients and staff for a period of 5-7 days. Concurrent review of the hospital document titled □Disaster Plan□ dated 11/12 revealed that the menu was limited to 3 days, despite the hospitals' intent to be self-sufficient for 5-7 days. It was also noted that the food supply was inadequate, with insufficient quantity for some items for 1 meal. As an example the plan called for a tuna sandwich for 2 required 360 servings. It was also noted that the plan was to serve milk; however the hospital did not have any powdered milk and the current milk on hand would also be less than a 1-day supply. Similarly there were either inadequate or non-existent supplies of ravioli, soup, chicken or chili. Staff 1 acknowledged that the supply was not adequate. It was also noted that the menu/food supply consisted of items such as hot cereal, soups, and Sloppy Joes that required cooking. In an interview with the Facilities Director on March 27, 2014 at 10:30 a.m., he stated that he had a large barbeque in the basement that could be utilized. While the hospital had a barbeque, the fuel supply was limited to two 5-gallon tanks of propane. He stated he did not know how long these tanks would last and acknowledged that the use of the barbeque would not likely be practical in a mass disaster due to the unavailability of fuel. 133. During an initial kitchen tour on March 27, 2014 beginning at 8:20a.m., it was noted that the water at the employee hand washing sink was tepid. On March 27, 2014 at 9 a.m., Staff 2 was asked to take the water temperature. It was noted to be 70□F. It would be the standard of practice to ensure that the water temperature of	A 701	(Continued from page 141) **Date of Implementation:** July 31, 2014 Written plan completion, staff training and monthly inventory of disaster supplies will be completed by September 10, 2014 Weekly inventory of all food products to ensure adequate availability will take place starting September 10, 2014 **Monitoring Process:** Weekly inventory to ensure adequate menu supplies are on hand and no non pasteurized eggs are present. Monthly inventory for adequate emergency supplies will be compared to the □Disaster Inventory Sheet□ Results of disaster supply monitoring activity will be reported to the hospital□s EOC Committee. **Person Responsible:** RD, Director of Dietary Department **133) Corrective Action:** Kitchen sink has been fixed and calibrated **Date of Implementation:** March 26, 2014 **Monitoring Process**: Per dietary staff report **Person Responsible:** RD, Director of Dietary Department and Food Services Supervisor	7/31/2014 9/10/2014 3/26/2014

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A 701	Continued From page 142 the hand washing sink was a minimum of 100□F through the use of a hot water mixing valve (USDA Food Code 2013). In a concurrent interview with Foodservices Director 1 he stated he was unaware of the water temperature requirement.	A 701	(Continued from page 142)	
A 703	482.41 (a)(2) EMERGENCY GAS AND WATER There must be facilities for emergency gas and water supply. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to have documented evidence of a system to provide emergency water and failed to ensure an effective water management plan and supplies to be implemented in a widespread disaster as evidenced by a plan that did not effectively meet the hydration and personal care needs of patients and staff.. This deficient practice had the potential to result in inadequate supply of drinking water and water for other purposes to all patients and staff during a disaster affecting the hospital and effectively meet the hydration and personal care needs of patients. Finding: Van Nuys Campus 1. On March 24, 2014 between 2:45p.m. and 3:15p.m., accompanied by Staff 6 (Director of Facilities), a review of the facility□s safety and disaster manual revealed there was no written plan to provide emergency water as needed to provide care to inpatients and other persons who may come to the hospital in need of care.	A 703	**VAN NUYS** **1). Corrective Action:** Water needs for each campus have been calculated and the water is securely stored at each facility in the levels calculated. A system wide policy, EMP.018 Loss of Water Policy and Procedure has been revised to include each hospitals calculated needs, location of the water, prioritized use of water and indicates arrangements made for the provision of emergency sources of water and security for emergency water stored on hospital grounds. The policy is anticipated to be approved by appropriate committees in September 2014. **Date of Implementation:** August 1, 2014 **Monitoring:** Monthly inventory of disaster water supplies with physical inspection of condition of water being stored. Results of audit activity will be reported to the hospital□s Quality Council, MEC, and Governing Board on a quarterly basis. **Person Responsible:** Director of Facilities, each campus.	8/1/2014

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A 703	Continued From page 143 A policy titled, Dietary Responsibilities (Number D-021) dated effective November of 2001 indicated that in the event of water failure, potable water shall be obtained by engineering on a priority needs basis. The policy did not determine the hospital's emergency needs for water, calculations to determine the amount of water needed, location of the water, prioritize the use of the water, indicate if arrangements were made with the local utility company and others for the provision of emergency sources of water, nor indicated how to protect the emergency water. During an interview at the same time as the review, Staff 6 stated that there was no emergency water plan but that he thought the facility was going implement something with a bottled water vendor. On March 26, 2014, the facility provided the evaluator with a policy titled Loss of Water Policy and Procedure (Number EMP.018). The cover page of the policy had no effective date and had no date or other indication that it had been reviewed by the EOC committee, Quality council, medical executive committee, and governing board. Culver City Campus 2. On March 31, 2014, between 10:30 a.m. and 10:54 a.m., there were boxes of emergency drinking water stored in an exterior gated area at the Legion building. The boxes contained six one	A 703	(Continued from page 143) **CULVER CITY** **2).Corrective Actions:** Damaged boxes were disposed of, the bottled water inside the damaged boxes was restacked in clean boxes and the collapsing boxes were re-stacked. The disaster water supply stored in an exterior gated area at the Legion Building will all be replaced in July 2014 prior to its expiration date on July 31, 2014. • The Loss of Water Policy and Procedure went to the Combined EOC Committee meeting in April but was revised to include SCH at Hollywood and SCH at Van Nuys. The policy will be presented to the combined EOC Committee meeting in July and to the executive committees (Quality Council, MEC and the Governing Board) thereafter.	

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A 703	Continued From page 144 gallon bottles of water each and were stack on top of each other. Four of the boxes at the bottom of one side of the stacks had signs of water leakage (wet boxes). At the other side of the stacks six of the boxes at the top of the stacks were collapsing onto the fencing and two of the boxes were crushed at the bottom of the collapsing stack. Between 2:14 p.m. and 3:30 p.m. accompanied by Staff 5 the hospital provided a policy titled Loss of Water Policy and Procedure (Number EMP.018) as documented evidence of a system to provide emergency water. The cover page of the policy had no effective date and had no date or other indication that it had been reviewed by the EOC committee, quality council, medical executive committee, and governing board. The hospital also provided a policy titled, Failure of water supply (Number FSN-007) dated effective July of 2009 indicated that in the event of water failure to obtain water from Water Disaster stores through the disaster command center, to contact the bottle water providers, military organizations or Red Cross to have water trucked in. The policy did not determine the hospital's emergency needs for water, calculations to determine the amount of water needed, location of potable and non-potable water on site, prioritize the use of the water, indicate if arrangements were made with the local utility company and others for the provision of emergency sources of water, nor indicated how to protect the emergency water.	A 703	(Continued from page 144) • The same Loss of Water Policy and Procedure addresses calculations to determine the amount of water needed, location of potable and non-potable water on site, prioritization of the use of water and the hospital has MOUs with on file with appropriate vendors to receive additional emergency water sources. **Date of Implementation:** June 19, 2014. **Monitoring Process:** The Groundskeeper will conduct a visual inspection of the disaster water supply on a weekly basis while performing routine grounds keeping tasks in the area. **Person Responsible:** Director of Engineering	6/19/2014

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A 703	Continued From page 145 During an interview at the same time as the review, Staff 5 stated that the disaster coordinator not available and that the Loss of Water Policy and Procedure (Number EMP.018) is scheduled to go through committee in April. 3. On March 27, 2014 beginning at 10:30 a.m., an evaluation of the hospital disaster water storage was reviewed with the Facility Director (FD), Staff 6. It was noted that the hospital plan was to provide .5 gallons/person/day of potable water with an additional .5 gallons for non-potable water. It was also noted that in the basement the hospital was storing 240 gallons of bottled water. Staff 6 also stated that additional water would be obtained from the facility water heaters. Concurrent observation of the water heaters revealed that there was a discharge valve at the bottom of the water heater that was approximately 3 inches off the ground. Staff 6 director stated that he would use a garden hose to get the water out of the tank. He also stated the hospital did not have a hose specifically intended for the use of transferring potable water. Review on March 28, 2014 at 1 p.m., of an undated draft policy presented by the hospital titled 11 Loss of Water Policy and Procedure revealed that the hospital planned on using the boiler room water as a non-potable source of water, rather than a potable source which would limit the potable source to 240 gallons. It was also noted that the plan did not include any potable water required to implement the disaster menu or direct patient care needs. Additional review of the plan revealed that the hospital utilized a reference document developed by the Centers of Disease Control and the American Water Works Association (2012) that	A 703		

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A 703	Continued From page 146 was specific to water supply planning for health care facilities. Review of the reference document revealed that the amount of water, .5 gallon/person/day, was specific to healthy individuals. The referenced document suggested that individual needs vary, depending on age, physical condition, activity level, diet, climate and that ill people need more water. While the hospital utilized healthcare associated references there was no indication that a comprehensive evaluation of the anticipated water needs based on the hospital□s population was conducted. In a concurrent interview with Staff 5 he stated that the presented plan was a draft copy and was not fully reviewed.	A 703		
A 713	482.41(b)(6) DISPOSAL OF TRASH The hospital must have procedures for the proper routine storage and prompt disposal of trash. This STANDARD is not met as evidenced by: Based on observation, the facility failed to properly store and dispose of trash by having overfilled and uncovered dumpsters creating conditions conducive to fly breeding and offensive odors. Finding: On March 24, 2014 at 11:55 a.m. two of four dumpsters were overfilled with trash. One of the dumpsters had its lids propped open by the overfilled trash. The second dumpster had its lids left fully open behind the dumpster. The two remaining dumpsters were less than half full.	A 713	**CULVER CITY: Corrective Actions:** EVS will monitor the dumpsters in the back alley of the Pavilion Building every 2 hours starting from 7:00 a.m. to 10:00 p.m. to ensure that dumpsters are not overflowing with trash and the lids remain closed. **Date of Implementation:** EVS will commence monitoring log on June 19, 2014. **Monitoring Process:** Monitor log. **(See Addendum 131).** **Person Responsible:** Director of EVS **Corrective Actions:** There is a clear hose placed next to water storage used to transfer potable water on March 28, 2014. **Date of Implementation:** 3/28/14 **Monitoring Process:** EOC rounds done semi-annually. **Person Responsible:** Director of Engineering . **VAN NUYS : Corrective Actions:** On March 24, 2014, the two of four dumpsters that were propped open were emptied to the other less than full dumpsters and all lids were closed**. (see Addendum 131, 132, 132a, 132b, 132c)** JIT In-service for all staff on P&P. EVS to monitor daily when dumping trash. **Date of Implementation:** March 24, 2014 **Monitoring Process**: EVS & Dietary staff to will be monitoring daily. **Person Responsible:** Dietary Supervisor & Director of EVS	6/19/2014 3/28/2014 3/24/2014
A 722	482.41(c) FACILITIES The hospital must maintain adequate facilities for	A 722		

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A 722	Continued From page 147 its services. This STANDARD is not met as evidenced by: Based on kitchen observations and dietary staff interview, the facility failed to ensure the plumbing in food production areas were designed and maintained in a manner to prevent potential cross contamination of foods. Failure to maintain facilities that mitigate cross contamination may result in exposing patients to a foodborne illness. Findings: Culver City campus 1. During kitchen tour on March 25, 2014 beginning at 2:45 p.m., at the Culver City campus it was noted that there were three sinks that were directly plumbed into the waste water system. In a concurrent interview with Staff 3 (Food services Director) she confirmed that each of the sinks was utilized for food production activities. In an observation on March 27, 2014 at 8:20am, at the Van Nuys campus it was also noted that the food production sink was directly plumbed into the waste water system. In a concurrent interview with she confirmed that the identified sink was utilized for food production activities. The standard of practice would be to ensure that plumbing was installed in a manner to ensure the presence of an air gap between the water supply inlet and the flood level rim of the plumbing fixture, equipment, or nonfood equipment and shall be at least twice the diameter of the water supply inlet and may not be less than 1 inch (USDA Food Code 2013). Van Nuys campus 2. During initial kitchen tour on March 27, 2014	A 722	**Culver City** **1). Corrective Actions:** Drains to each of the three sinks in the kitchen were re-plumbed to ensure the presence of air gap between water supply inlet and the flood level rim of the plumbing fixture in June 2014 by Engineering. **(see Addendum 133, 133a)** **Date of Implementation:** The re-plumbing was completed in June 2014. **Monitoring Process:** This is a one -time repair to resolve the issue. **Person Responsible**: Director of Facilities & Director of Food & Nutrition **Van Nuys** **2). Corrective Actions:** On March 27, the racks and refrigerator in the dry storage area were cleaned and found that there was rust. 10 racks were replaced. **Date of Implementation:** Completion of rack replacement by September 10, 2014. **Monitoring Process:** Replacements monitored for any repairs / replacements during EOC Rounds. **Person Responsible:** Dietary Supervisor	6//2014 9/10/2014

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A 722	Continued From page 148 beginning at 8 a.m., it was noted that the racks of the refrigerator located adjacent to the food production sink and the refrigerator in the dry storage area were covered in a brown colored matter, resembling rust, which was able to be removed with a paper towel. It would be the standard of practice to ensure that nonfood-contact surfaces of equipment are kept free of an accumulation of dust, dirt, food residue, and other debris (Food Code, 2013).	A 722		
A 724	482.41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE This STANDARD is not met as evidenced by: Based on observation, review of hospital and staff interviews, the facility failed to maintain the food service equipment to ensure acceptable level of safety and quality. The dish machine, plate warmers, five refrigerators and freezer were not properly maintained. These failures had the potential food safety concern for patients and safety (fall risk) concerns for employees when its equipment were not in good working order, had the potential to result in unclean and unsanitized utensils, to result in cross contamination and growth of microorganisms that could cause food borne illness, and the build-up of ice on the floor from the outside freezer was a potential fall for the hospital employees. Finding: 1. During meal service on March 24, 2014, Dietary Staff (OS) 4 was observed serving all the	A 724	**1) Corrective Actions:** Plate warmer will be sent for further inspection and repair. Staff will be in-serviced on initiating work order process for broken equipment and will educate on policy UTM.015 Preventive maintenance. Will create a list of all kitchen items/equipment to include if internal or external service performance required and will include instructions on notification of broken equipment **Date of Implementation:** Target date of completion for plate warmer inspection/repair June 27, 2014. Target date of completion for education July 1, 2014; target date of completion for inventory list August 1, 2014 **Monitoring Process:** Will be managed through daily operations and to include in EOC rounds **Person Responsible:** RD, Director of Dietary Department and Food Services Supervisor, dietary staff and ENG **2). Corrective Actions:** Dishwashing machine has been repaired and in working condition. Staff will be in-serviced on initiating work order process for broken equipment and will educate on policy UTM.015 Preventive maintenance . Will create a list of all kitchen items/equipment to include if internal or external service performance required and will include instructions on notification of broken equipment **Date of Implementation:** Repair completed March 27, 2014; Target date of completion for education July 1, 2014; target date of completion for inventory list August 1, 2014 **Monitoring Process:** Will be managed through daily operations and to include in EOC rounds **Person Responsible:** RD, Director of Dietary Department and Food Services Supervisor	6/27/2014 3/27/2014

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	050135	Y. BUILDING **01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD** □. WING _____	**04/01/2014**

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A 724	Continued From page 149 patients with disposable plastic plates. In an interview at approximately 11:45 a.m., OS 4 stated that he had to use the disposable plates because the plate warmer was broken. He further stated the disposable plates were better than using unheated plates, because the plates were cold and would cause the hot foods to become cold and unpalatable. 2. At approximately 3:30 p.m. on March 24, 2014, it was determined that the water temperature of the high temperature was not hot enough to properly sanitize dishes and other cooking utensils. The water temperature was 119.5 degrees F. The required minimum temperature for a high temperature is of 180 degrees F. There was a discrepancy between OS 3 and Staff 10 (Chief Engineer) on when hospital staff became aware that the temperature of the machine was not adequate and should not be used to dish washing. Staff 10 stated at approximately 3:35 p.m. that a part in the machine needed to be replaced and that he had informed DS 3. Inside the dish room there were cooking utensils, pots and pans that had been washed in machine. Improper water temperatures could result in unclean and unsanitized utensils. 3. At approximately 3:40p.m. on March 24, 2014, the preventive maintenance for the ice machine was reviewed. It was noted there was a buildup of black particles on both sides of the ice shield (a plastic cover over the ice production area). In an interview with Staff 10 he stated that the machine interior should be cleaned every two months. There was no documented evidence that this was done. 4. Over twelve Patient trays on the van Nuys	A 724	(Continued from page 149) **3). Corrective Actions**: Will provide staff education to include review of policy Infection Control FNS.042; Cleaning, sanitizing of ice machine will be performed twice yearly and will be documented on log sheet attached to unit. **Date of Implementation:** Target date of implementation for education July 1, 2014; target date for cleaning and sanitizing July 31, 2014 **Monitoring Process:** Monitoring will be managed through weekly and monthly cleaning logs **Person Responsible:** RD, Director and Food Services supervisors **4) Corrective Actions:** Will purchase additional trays to ensure patient and staff safety; Will provide education to staff on work order process for broken equipment and reporting process to supervisor **Date of Implementation:** Target date of completion in 30 days July 15, 2014 **Monitoring Process:** Monitoring process will be managed through daily operations by dietary staff and to include in EOC rounds **Person Responsible:** RD, Director of Dietary Department and Food Services Supervisor, dietary staff **Culver City** **4) Corrective Actions**: Twice yearly cleaning/sanitizing of internal components to be performed by outside vendor (Redline Air) **(see Addendum 134, 134a)** **Date of Implementation:** Serviced June 2014; to re-occur every six months. **Monitoring Process:** Cleaning/sanitizing of ice machine (twice yearly) is documented on log sheet attached to unit. **Person Responsible:** Director of Facilities & Director of Food & Nutrition **5) Corrective Actions:** Capital Expenditure Request (CER) has been approved for two roll-in coolers to replace □out of order□units. **Date of Implementation**: units to arrive and be installed July 2014	7/1/2014 7/15/2014 6/30/2014 7/30/2014

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A 724	Continued From page 150 Campus had chipped, broken jagged edges exposing a metal interior. The state of the trays presented a risk of cuts to patients. Staff 1 stated that they had recently purchased 36 trays. She provided no other information on when the other trays will be replaced. On March 25, 2014 beginning at 3 p.m., at the Culver City campus the preventive maintenance of the ice machine was reviewed. In a concurrent interview with Staff 5 he described he process. He stated that a) the hospital installed an automatic cleaning system for the unit; b) that with the installation of this unit required no additional maintenance and c) that the hospital contracted with a vendor to complete manufacturers' required maintenance. The bottle of chemical in the unit was labeled as an ice machine cleaner. In an interview on March 26, 2014 beginning at 9:35a.m., with REP 1 from the contracted vendor described how the automatic cleaning system worked. He described a process whereby the chemical would circulate through the ice producing mechanism two times/month. He also stated that the ice machine cleaner was the only chemical circulated. Posted on the interior panel of the ice machine was manufacturers' guidance for both a cleaning and sanitizing process. There was no evidence that the ice machines were sanitized This could result in cross contamination and growth of microorganisms that could cause food borne illness. 5. During the initial tour of the kitchen on the Culver City campus on March 25, 2014 at approximately 10:30 a.m., approximately five built-in refrigerators and/or freezers was labeled	A 724	(Continued from page 150) **Monitoring Process:** Routine inspection for □out of order□ equipment included on quarterly safety audit. (□All equipment and tools in good working order□). **Person Responsible:** Joseph Pipes (Foodservice), Juanita Jones (Materials Mgmt) **6) Corrective Actions:** Work order (□209410) placed to provide insulation to close □gap□between freezer pipe and wall. **Date of Implementation**: date of service or installation of new unit, expected to be completed by the end of July 2014. **Monitoring Process:** Routine inspection for ice build-up in freezer included on quarterly safety audit. **(see Addendum 135)** **Person Responsible:** Ray La fond (Facilities), Joseph Pipes (Food & Nutrition)	7/30/2014

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A 724	Continued From page 151 as □out of order.□It was not clear how long these equipment had broken down and not repaired or replaced. There were several smaller mobile refrigerators around the kitchen resulting in a cluttered, cramped space. Dietary employees were often overheard warning other employees "I□m behind you." Staff 2 who was present during the tour stated that the equipment have been broken for a while and was not sure how long. She further stated that it was part of the capital expenditure that had been presented to the hospital administration. Staff 11 who was present during the tour acknowledged that it was part of the capital expenditure for this fiscal year. The outside freezer had a build-up of ice on the floor a result of water drips from the condenser. There was a stainless steel pan also observed under the condenser. Dietary Staff 10 stated the pan had been placed under the condenser to "catch the drips... The ice build-up on the floor is a fall risk for the hospital employees. While in the freezer, sunlight was observed through the freezer wall from around the pipes. Inspection of the pipe on the outside revealed a gap around the pipe that fed into the freezer. The gap could have contributed to the condensation and water drips experienced in the freezer as it introduced warm outside temperature into the freezer. The gap could also allow the introduction of other substances and contaminants into the freezer. Review of the work orders from Dietary from the previous six months was done. It did not include request for the built in refrigerators and freezer.	A 724		

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A 724	Continued From page 152 There was an order on 11/13/2013 for water leaking under fan inside walk-in freezer. It showed it was completed on the same day. AA provided a copy of the approval of two refrigerators. Closer review showed that the approvals did not include copies original signatures but copies of signatures cut out and taped on the signature lines. It is not clear whether these equipment were indeed approved for replacement. The hospital failed to ensure that its equipment were in good working order. These failures related in food safety concern for patients and safety (fall risk) concerns for employees.	A 724		
A 747	482.421NFECTION CONTROL The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases. This CONDITION is not met as evidenced by: Based on observation, review of facility documents and staff interview, the facility failed to meet the Condition of Participation in Infection Control by failing to: 1. Ensure the single use ampule/vial was used for one patient. This deficient practice had the potential for transmission of bloodborne viruses (Culver City) (Refer to A748). 2. Reprocess the endoscopes in the reprocessing area which minimize the opportunity	A 747	**Culver City** **1).Corrective Actions:** Director of Infection Prevention and Control will receive & review anesthesia log audits weekly from Pharmacy for appropriate use on single use vial and report monthly to Quality Council. Targeted compliance is 100%. Aggregated data will be reported to Infection Control Committee on a quarterly basis. **Monitoring Process:** Pharmacy/Surgery **Date of Implementation:** June 18, 2014 **Person Responsible:** Director of Infection Prevention and Control, Director of Pharmacy, Director of Peri-Operative Services **Hollywood** **2).Corrective Actions:** OR team re-educated to Policy SGI.006 Cleaning and Disinfection of Endoscopes to ensure policy compliance with procedure to re-process scopes only in the designated re-processing room and not in the procedure room. Policy reviewed for compliance to SGNA Society for Gastrointestinal Nurses and Associates guidelines **(see Addendum 136, 136a, 136b, 136c, 136d)**. Completing competencies on ORT□s on proper steps for cleaning/reprocessing of endoscopes in the proper locations target date for completion by July 31, 2014. **Date of Implementation:** Education provided 6-19-2014; target date of completion for competency tool 7-31-2014 **Monitoring Process**: Monitoring will be 100 % audit of all scope procedures until 100% compliance goal achieved consistently. Data will be reported monthly to PI, Quality and MEC **Person Responsible:** OR team, Infection Control	6/18/2014 6/19/2014

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A 747	Continued From page 153 for cross-contamination (Refer to A 749). 3. Change gloves and wash hands after removal of gloves which minimize the opportunity for cross contamination (Refer to A 749). 4. Develop a written policy and procedure for managing bed bugs to ensure an effective system was identified and developing practices and procedures were followed to prevent the spread of bed bugs. This deficient practice of not ensuring the infection prevention and control strategies for the bed bugs were implemented placed the patients, staff, and visitors at risk for infection and re-infestation (Refer to A 749). 5. Develop an effective systems for identifying, reporting and controlling infections when it failed to ensure safe food handling practices in the dietetic service areas on all three campuses and develop a policy to ensure tube feeding was handled in an effective manner to prevent growth of microorganisms. These failures are evidenced by: a. lack of system to ensure that meats and other leftover food items were monitored and cooled to prevent the growth of microorganisms that could result in food borne illness; b. lack of effective cleaning and sanitation of ice machines at the Hollywood, Culver City and Van Nuys campuses; c. lack of effective sanitation of soda syrup line connectors; d. lack of monitoring system for a cool down of potentially hazardous foods; e. lack of hand washing after handling soiled dishes; f. lack of an effective system to ensure food safety during thawing process of raw meat and	A 747	(Continued from page 153) **Culver City** **3).Corrective Actions**: All nursing staff re-educated starting 06/18/2014 on the hospital's policy titled Hand Hygiene with a focus on the expectation that hand hygiene must be practiced to decontaminate hands when moving from dirty to clean tasks and before donning and after removing gloves. Hand hygiene includes washing hands with soap and water &/or applying alcohol-hand rub. **Date of Implementation:** June 18, 2014 **Monitoring Process:** Director of Infection Control will conduct 30 random observations monthly among nursing staff to observe appropriate hand hygiene practices when moving from dirty to clean sites. Any episodes of non-compliance will immediately be corrected and nurses re-educated on the hand hygiene policy. Data will be aggregated monthly and reported quarterly to the Infection Control Committee and Quality Council. **Person Responsible:** Director of Infection Prevention and Control, Director of Nursing **Hollywood** **3).Corrective Actions**: In-services were conducted on hand hygiene practices and glove use for nursing staff. Hand hygiene audits are on-going. Hand Hygiene task force was initiated to discuss results and to work on ways to improve hand hygiene compliance. **[see Addendum 139, 141, 141a, 141b, 141c, 141d, 141e, 141f, 14 g, 141h]** **Date of Implementation:** 4/10/14; 4/30/14 **Monitoring Process:** On-going hand hygiene audits reported monthly to Hand Hygiene Task force and to Quality committee. **Person Responsible:** Infection Control Coordinator of Hollywood Campus **4).Corrective Actions:** A written policy and procedure **(see Addendum 144)** titled Control and Prevention of Bed Bug Infestation for managing bed bugs was developed and approved by Director of Infection Control on June 16, 2014 and has been sent to the Medical Executive Committee for approval (meeting taking place July 15, 2014). Re-education of all nursing staff will commence June 16th with a targeted and date of 31 days thereafter. **Date of Implementation:** June 18, 2014 **Monitoring Process:** EVS will determine a schedule for the routine assessment of bed bugs by the Pest Control Agency and report any findings to Director of Infection Prevention and Control for tracking and trending. Findings will be reported to Quality Council monthly and to the Infection Control Committee and Environment of Care Committee quarterly. **Person Responsible:** Director of Infection Prevention and Control, Director of Nursing	6/18/2014 4/10/2014 6/18/2014

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A 747	Continued From page 154 the use of wiping cloths to dry food production equipment; g. lack of removal of aprons prior to throwing out the garbage; h. lack of washing and sanitizing dishes manually when the dish machine temperatures would not properly clean and sanitize dishes and develop policies to ensure that hang-times on tube feeding systems are monitored to prevent growth of microorganisms. Failure to ensure operational processes that support safe food handling practices may result in exposure of patients to bacteria associated with foodborne illness. Foodborne illness may result in further compromising patients' medical status and in severe instances may result in death (Refer to A 749). The cumulative effect of these systemic issues resulted in the facility's inability to ensure and provide a safe patient care environment.	A 747	(Continued from page 154) **All Three Campuses** **5a-h). Corrective Actions:** Dietary department instituted several new logs, including cool-down process for foods and audit of enteral feeding bags.**(see Addendum 46, 46a)** Thawing process was revised and staff was in-serviced **(see Addendum 140, 140a)**. Ice machine cleaning was initiated and log was created by dietary. In addition, dietary conducted in-services on proper apron use and sanitizing of work areas. In-service on manual washing and sanitizing of dishes will be conducted by dietary. Infection Control to in-service dietary staff on hand hygiene and general infection control. Infection control reviewed these in-services, logs and processes and will conduct audits on the log sheets during bimonthly dietary infection control rounds for a minimum of 3 months. Dietary supervisor will notify infection control coordinator of any equipment malfunction or needed repairs so that the Infection Control Coordinator will monitor any necessary interventions until repairs are made and assure adherence to proper infection control practices. In addition, dietary conducted in-services on proper apron use and sanitizing of work areas. □see tag A 619 for dietary supporting documents; attached is Infection Control Rounding sheet **(see Addendum 91)**, and IC dietary policy **(see Addendum 137, 137a)** addressing hand hygiene and enteral feeding, among other things□ **Date of Implementation**: 7/1/14 **Monitoring Process:** Infection Control bimonthly rounding and review of logs. **Person Responsible:** Infection Control Coordinator; Dietary Supervisor; Lead Dietician A 747 Continued on page 155a.	7/1/2014
A 748	482.42(a) INFECTION CONTROL OFFICER(S) A person or persons must be designated as infection control officer or officers to develop and implement policies governing control of infections and communicable diseases. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to implement its policy and procedures for the use of a single dose ampule/vial in the facility's Culver City campus by failing to ensure the single use ampule/vial was used for one patient. This deficient practice had	A 748	**Culver City** **Corrective Actions:** Director of Infection Prevention and Control will receive anesthesia log audits weekly from Pharmacy and report monthly to Quality Council. Targeted compliance is 100%. Aggregated data will be reported to Infection Control Committee on a quarterly basis. **Date of Implementation:** June 18, 2014 **Monitoring Process:** Pharmacy/Surgery **Person Responsible:** Director of Infection Prevention and Control, Director of Pharmacy, Director of Peri-Operative Services	6/18/2014

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A 748	Continue From page 155 the potential for transmission of bloodborne viruses. Findings: On March 24, 2014 at 11:29 a.m., a review of the Anesthesia Controlled Drug Record indicated that entries were done in a manual, paper-based process. The Anesthesia Controlled Drug Record, dated ..March 18, 19, and 21, 2014," indicated that a Fentanyl250 mg per 5 milliliter (ml) ampule was used for two different patients, that half of the content was used for Patient 3, marked as "0.5" and half the content was used for Patient 2, marked as "0.5." The inventory count indicated the beginning count of 10 ampules and the ending balance of 9 ampules. The Anesthesia Record dated March 19, 2014 for Patient 3 showed that the Anesthesiologist administered Fentanyl 100 micrograms (meg) at approximately 10:15 a.m. and 25 meg at approximately 11:15 a.m., total125 meg. The Anesthesia Record dated March 19, 2014 for Patient 2 showed that the same Anesthesiologist administered Fentanyl 50 meg at approximately 11:45 a.m. and 75 meg at approximately 12:15 p.m., total125 meg. The manufacturer□s package insert indicated "Fentanyl Citrate Injection ...is preservative-free and available as ...5 ml Single Dose ampules. On March 28, 2014 at 11:20 a.m., during an interview, when the surveyor showed the Anesthesia Controlled Drug Record and the use of the single dose ampule on two different patients to the director of infection prevention and	A 748	**Culver City** **Corrective Action:** Policy revised to be clear on the use of single dose vials. Policy will be sent to medical staff. **Date of Implementation:** July 1, 2014 **Monitoring Process:** DOP or designee will review anesthesia cart sheets, and will check that the SDVs are being used one time only. Any violations will be reported to the Quality Counsel. **Person Responsible:** VP of Pharmacy or designee	7/1/2014

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A 748	Continued From page 156 control, she responded □What does this have to do with me□ □ On March 28, 2014 at 11:25 a.m., during an interview, Staff P stated the single use ampule is not to be used for more than one patient. On March 28, 2014 at 12:45 p.m., a review of the facility policy and procedure titled □Medication, Care and Handling,□ Number: SAN.019, dated □11/2012,□ indicated □.. Each patient is medicated with either single dose or multiple dose vials. The remainder of each of the multi-dose vial is discarded after each patient. □When the surveyor asked Rx 1 to clarify this policy, she stated the policy should read □The remainder of each of the single dose vial is discarded after each patient.□ A review of the policy and procedure titled □Handling of Multidose/Single Dose Vials and IV Compounding (Low Risk Condition) Outside Laminar Flow Hood,□Number: PHA.090, dated □10/2012 □ indicated □□ Single Dose vials / ampoules should be discarded soon after opening and not stored ... Opened single dose ampules shall not be stored for any time period According to Centers for Disease Control and Prevention on Injection Safety, single dose vial should be used for a single patient and single case/procedure/injection. There have been multiple outbreaks resulting from healthcare personnel using single dose or single use vials for multiple patients. The safest practice was to enter a single dose vial once to prevent inadvertent contamination and vial and infection of transmission.	A 748		

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A 749	482.42(a)(1) INFECTION CONTROL PROGRAM The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a system was developed for controlling infections and communicable disease for 4 of 52 Sampled patients (Patient 14, 15, 23, and 25) and 7 randomly selected patients (Patients 53, 54, 55, 56, 57, 58, and 59) by failing to: 1. Reprocess the endoscopes in the reprocessing area which minimize the opportunity for cross-contamination. 2. Apply alcohol-based hand rub for decontaminating hands when moving from a contaminated-body site to a clean-body site and before donning and after removing gloves. This deficient practice had the potential to transmission of infectious agents to the patients. 3. Label the peripheral intravenous (IV) sites with the date, gauge of needle and initials and label the IV tubing with a date. This deficient practice had the potential for not monitoring when the IV sites needed to be changed to ensure patient safety of intravenous therapy. 4. Ensure that in a closed system enteral feeding bottle should be dated, timed and initialed when the formula bottle is spiked. This deficient	A 749	**Hollywood** **1) Corrective Actions:** OR team re-educated to Policy SGI.006 Cleaning and Disinfection of Endoscopes to ensure policy compliance with procedure to re-process scopes only in the designated re-processing room and not in the procedure room. Policy reviewed for compliance to SGNA Society for Gastrointestinal Nurses and Associates guidelines **(see Addendum 136, 136a, 136b, 136c, 136d)**. Completing competencies on ORTs on proper steps for cleaning/reprocessing of endoscopes in the proper locations target date for completion by July 31, 2014. **Date of Implementation**: Education provided 6-19-2014; target date of completion for competency tool July 31, 2014 **Monitoring Process:** Monitoring will be managed by 100 % audit of all scope procedures until 100% goal achieved. Data will be reported monthly to PI, Quality and MEC **Person Responsible:** OR team, Infection Control **2)Corrective Actions:** **(HOLLYWOOD):** Hand hygiene and PPE usage in-services were conducted for nursing staff. Hand Hygiene task force was initiated to discuss results and to work on ways to improve hand hygiene compliance. **(See Addendum 141, 141a, 141b, 141c, 141d, 141e, 141f, 14 g, 141h).** **Date of Implementation:**4/10/14; 4/30/14 **Monitoring Process:** Hand Hygiene audits with results reported to Hand Hygiene Task Force and Quality Committee **Person Responsible:** Infection Control Coordinator **2).Corrective Actions:** **(CULVER CITY):** Director of Infection Prevention and Control has implemented a monthly plan to conduct 30 random observations among nurses to ensure appropriate hand hygiene practice when moving between dirty to clean tasks and/or body sites. **Date of Implementation:** June 18, 2014 **Monitoring Process:** Director of Infection Control will conduct 30 random observations monthly among nursing staff to observe appropriate hand hygiene practices when moving from dirty to clean tasks and/or body sites.	6/19/2014 4/10/2014 6/18/2014

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A 749	Continued From page 158 practice had the potential to not being able to determine when the feeding bottle was hang and had the potential for growth of microorganisms. 5. Develop a written policy and procedure for managing bed bugs to ensure an effective system was identified and developing practices and procedures were followed to prevent the spread of bed bugs. This deficient practice of not ensuring the infection prevention and control strategies for the bed bugs were implemented placed the patients, staff, and visitors at risk for infection and re-infestation. 6. Develop an effective systems for identifying, reporting and controlling infections when it failed to ensure safe food handling practices in the dietetic service areas on all three campuses and develop a policy to ensure tube feeding was handled in an effective manner to prevent growth of microorganisms. These failures are evidenced by: a. lack of system to ensure that meats and other leftover food items were monitored and cooled to prevent the growth of microorganisms that could result in food borne illness; b. lack of effective cleaning and sanitation of ice machines at the Hollywood, Culver City and Van Nuys campuses; c. lack of effective sanitation of soda syrup line connectors; d. lack of monitoring system for a cool down of potentially hazardous foods; e. lack of hand washing after handling soiled dishes; f. lack of an effective system to ensure food safety during thawing process of raw meat and the use of wiping cloths to dry food production equipment;	A 749	(Continued from page 158) Any episodes of non-compliance will immediately be corrected and nurses re-educated on the hand hygiene policy using just-in-time training. Data will be aggregated and reported monthly to Quality Council and quarterly to the Infection Control Committee. **Person Responsible:** Director of Infection Prevention and Control, Director of Nursing **3) Corrective Actions:** Education provided include review of policy and procedure on Intravenous Therapy-Initiation and Management of Peripheral Intravenous Lines, label IV sites with date, gauge of needles and initials, IV tubing changes, accurate and complete documentation **(See Addendum 142).** policy VAS.005) **Date of Implementation:** May 1, 2014 **Monitoring Process:** Daily rounds by Nurse Leadership on each department on all patients with IV, weekly audit will be performed by Infection control/Nurse Educator, data will be reported monthly to PI and Quality until 95 % goal has been achieved. **Person Responsible:** Nursing Leadership in each department and infection control practitioner, nursing staff **4) Corrective Actions:** Nursing in-service conducted on proper hanging of feeding bottle. Dietician to do daily audits on enteral feeding bottles in use. **(See 143)**. **Date of Implementation**: 6/2014 **Monitoring Process:** Dietician to audit feeding bags monthly. **Person Responsible:** Dietician **5) Corrective Actions**: **(CULVER CITY):** A written policy and procedure titled Control and Prevention of Bed Bug Infestation **(see Addendum 144)** for managing bed bugs was developed and approved by Director of Infection Control on June 16, 2014 and has been sent to the Medical Executive Committee for approval (meeting taking place July 15, 2014). Re-education of all nursing staff will commence June 16th with a targeted and date of 31 days thereafter.	5/1/2014 6/30/2014

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A 749	Continued From page 159 g. lack of removal of aprons prior to throwing out the garbage; h. lack of washing and sanitizing dishes manually when the dish machine temperatures would not properly clean and sanitize dishes and develop policies to ensure that hang-times on tube feeding systems are monitored to prevent growth of microorganisms. Failure to ensure operational processes that support safe food handling practices may result in exposure of patients to bacteria associated with foodborne illness. Foodborne illness may result in further compromising patients□medical status and in severe instances may result in death. Findings: 1. During the initial tour with Registered Nurse (RN) 7 in the operating rooms of the Hollywood campus on March 24, 2014 between 9:58a.m. and 11 a.m., AN 7 stated all endoscopes had been reprocessed in Operating Room (OR) □3 (GI) room. According to RN 7, those endoscopes then were transported to a room for high-level disinfection. According to APIC, Chapter 47-Endoscopy, □PREVENTION AND CONTROL OF INFECTIONS ASSOCIATED WITH ENDOSCOPY,□in the Reprocessing Area or Room, reprocessing of contaminated equipment should be performed in a separate area or room, not in the endoscopy procedure room. The area must have adequate space for reprocessing, appropriate airflow and ventilation for the selection and method of disinfection/sterilization, appropriate work flow pattern (movement from dirty to clean minimizing the opportunity for	A 749	(Continued from page 159) **Date of Implementation:** June 18, 2014 **Monitoring Process:** EVS will determine a schedule for the routine assessment of bed bugs by the Pest Control Agency and report any findings to Director of Infection Prevention and Control for tracking and trending. Findings will be reported to Quality Council monthly and to the Infection Control Committee and Environment of Care Committee quarterly. **Person Responsible:** Director of Infection Prevention and Control, Director of Nursing **5). Culver City. Corrective Actions**: Infection Control in-service with Pharmacy staff regarding transportation and handling of Pharmacy items such as cassettes and contamination. **Monitoring Process:** Director of Pharmacy will randomly monitor Pharmacy Techs as they are doing their rounds on the floor. Any violations will be reported to the VP of Pharmacy. **Implementation Date:** 7/1/2014 **Person Responsible:** Director of Pharmacy. **a, c, d, e&f – Hollywood ; b- Culver City, Hollywood, Van Nuys** **Corrective Actions:** Created Policy on □Cool off log□and dietary staff in-serviced for the process; Policy created for Cool off method, staff in-serviced **(see Addendum 46, 46a)** . **Date of Implementation:** Education started April 23, 2014 and April 28, 2014; Policy created and will send for approval June 20, 2014 target approval date August 31, 2014 **Monitoring Process:** Will be managed through Staff competency Validation □Return Demonstration/Comprehension□will be done on a biannual basis and will be maintained in employee file. **Person Responsible:** RD, Director of Dietary Department and Food Services Supervisor **(e) Corrective Actions:** Will educate staff on proper hand hygiene practice, review of policy FNS.042 and will include in staff competency validation twice yearly **(see Addendum 145)**.	6/18/2014 7/1/2014 4/23/2014

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A 749	Continued From page 160 cross-contamination), and appropriate storage facilities. 2. During the initial tour with RN 1 in the mixed unit for DOU (Definitive Observation Unit) & Medical/surgical patients of the Hollywood campus on March 24, 2014 between 11:15 a.m. and 11:45 a.m., Patient 25 was observed resting on the bed with a sign of □Contact Isolation□posted by the door. According to RN 2, Patient 25 was placed in the room for Methicillin Resistant Staphyloccocus Aereus (MRSA) contact isolation. Licensed Vocational Nurse (LVN) 2 was standing by the patient□s right side-rails without any PPE (Personal Protection equipment) including mask, gown and gloves. During the concurrent interview with LVN 2 on March 24, 2014 at 11:35 a.m., he stated he was not required to wear any PPE because he did not touch the patient. An interview with Staff E was conducted on March 2414 at 12:20 p.m. Staff E stated the staff should wear PPE if they anticipated to contact the patient or patient□s environment. According to the facility□s policy for □Contact Precautions□ (Number INF.065) dated 11/2012: 4.2 PROCEDURE 4.1.26 GLOVES: 4.1.27 Wear gloves when hands will be in contact with body fluids (blood, urine, feces, wound drainage, oral secretions, sputum, vomitus, amniotic fluid, mucous membranes or non-intact skin of ALL patients.---. 4.1.28 MASK/GOGGLES: 4.1.31 Gowns are required when entering the room, when having contact with the environment,	A 749	(Continued from page 160) **Date of Implementation:** Will begin July 15-31, 2014 **Monitoring Process:** Will be managed through Staff competency Validation □Return Demonstration/Comprehension□will be done on a biannual basis and will be maintained in employee file. **Person Responsible:** RD, Director of Dietary Department and Food Services Supervisor **(f) Corrective Actions:** Staff education include review of policy Defrosting Meat FNS.010 and a new process □meat pull sheet□has been created and dietary staff have been trained on how to properly defrost meat (see attachment sign in sheet, log, pull sheet sample and policy) **Date of Implementation**: 4/23/2014; Staff validation competency will begin July 15-31, 2014 **Monitoring Process:** Will be managed through Staff Validation Competency □Return Demonstration/Comprehension log□will be done twice yearly and will be maintained in employee file **Responsible person:** RD, Director Dietary Department and Food Services Supervisor **Hollywood** **11). Corrective Actions:** □Cool off log□created and dietary staff in-serviced for the process; Policy created for Cool off method, staff in-serviced **(See Addendum 46, 46a).** **Date of Implementation:** Education started April 23, 2014 and April 28, 2014; Policy created and will send for approval June 20, 2014 target approval date August 31, 2014 **Monitoring Process:** □Return Demonstration/Comprehension□done on at least biannual basis and maintained in employee file. **Person Responsible:** RD, Director of Dietary Department and Food Services Supervisor **12) .Corrective Actions**: Water temp for dishwashing: Dishwasher has been fixed **(See Addendum 146)**. **Date of Implementation:** March 2014 **Monitoring Process:** Dish washer temperature check log implemented and water temperatures will be checked daily and reported. Aggregated data will be provided to the Quality Council.	7/15/2014 4/23/2014 4/23/2014 3/30/2014

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A 749	Continued From page 161 and/or when having contact with the patient. □ Culver City campus 2. On March 25,2014 at 10 a.m., a wound treatment observation for Patient 14 was conducted. Registered Nurse (RN) 11 was wearing gloves and removed the soiled dressing on the left knee and disposed the soiled dressing in the plastic bag. With the same gloves, RN 11 applied wound cleanser to the open wound and wiped with a gauze. RN 11 applied a xerofoam dressing, covered the wound with dry dressing and wrapped with Kerlix. The RN then took off the gloves and applied hand sanitizer. RN 11 donned a new pair of gloves and removed the soiled dressing on the patient□s mid-back wound and discarded the dressing in the plastic bag. With same gloves, RN 11 prepared the xerofoam dressing and started to cleanse the wound with wound cleanser. RN 11 applied the xerofoam dressing on the wound and cover it with optifoam dressing. RN 11 then gathered her residual supplies such as the xerofoam, gauzes and placed them back in the plastic basin container by the bedside table. During a concurrent interview, RN 11 stated hand hygiene/change of glove is performed when moving from dirty task to clean task such as removing soiled dressing, cleaning the wound then to applying new dressing. According to the facility□s policy and procedure on Hand Hygiene dated November 2012, apply alcohol-based hand rub for decontaminating hands if moving from a contaminated-body site to a clean-body site and before donning and after removing gloves. Hand Hygiene included	A 749	(Continued from page 161) **Person Responsible:** RD, Director of Dietary Department and Food Services Supervisor **13) Corrective Actions:** Blender Storage/ Cleanliness; Review of policy □FNS.042 and educated staff. **(See Addendum 147)**. Implementation of a daily cleaning schedule. **(see Addendum 147a)** **Date of Implementation:** June 2014 **Monitoring Process**: Will be monitored through daily □cleaning schedule□ **Person Responsible:** Food Service Supervisor, Dietary Staff **14). Corrective Actions :** Current process is already in place; cleaning and sanitizing of internal components are performed twice yearly **(See Addendum 148, 148a).** **Date of Implementation:** April 29, 2014 Monitoring Process: Monitor quarterly and/or as needed **Person Responsible:** Director of Facilities & Director of Dietary Department and Food Services Supervisor **15) Corrective Actions:** Tube Feedings & Evening hours: Reviewed and revised policy FNS.025 Dispensing Nutritional Products **(see Addendum 143)** and FNS.040 Guidelines for the Use of Parenteral Nutrition Therapy and will send for motions of approval **(See Addendum 149).** **Date of Implementation:** Education started 6/14/2014; target completion of policy August 31, 2014 **Monitoring Process:** On initial dietary assessments and on weekly basis through □Clinical Tube Feeding Audit□form conducted by the dietician. **Person Responsible:** Dietician **Culver City** **16. Corrective Actions:** Completed □Small Equipment Cleaning□in-service with production staff; included roster to document attendance/participation **(See Addendum 150).** **Date of Implementation**: 4/29/14	6/30/2014 4/29/2014 6/14/2014 4/29/2014

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A 749	Continued From page 162 washing hands with soap and water or applying alcohol-hand rub. Hand Hygiene is important prevention strategy for avoiding Healthcare Acquired Infections. The hands of personnel serve as a critical reservoir of infectious agents. 3. On March 25, 2014, at 10:20 a.m., during an observation tour with Staff E, a contact isolation sign was posted on the door of randomly selected patient (Patient 54). Staff E was wearing gown and gloves and checked the patient□s heplock/intravenous line, the oxygen tubing, and the indwelling catheter bag. With the same gloved hands, Staff E touched the gastrostomy tube feeding bag to check the label. During a concurrent interview, Staff E stated she was unaware that she did not wash her hands or apply hand sanitizer after removing the gloves. 4. On March 24, 2014, at 10:20 a.m., during provision of care observation of Patient 23, RN 5 with gloved hands started to check the patient□s indwelling catheter bag to see the amount of urine. The RN proceeded to touching the G-Tube feeding bag to check the label, the wrist restraint and the patient. The RN failed to change gloves and performed hand hygiene when performing dirty task to clean task. During a concurrent interview, RN 5 stated she failed to change gloves in when performing dirty task to clean task. 5. On March 24, 2014 at 10:05 a.m., during observation tour of the intensive care (ICU) unit, the PT (pharmacist technician) was noted to to pull out the medication cassette from the	A 749	(Continued from page 162) **Monitoring Process:** Random audits conducted by executive chef to ensure compliance. **Person Responsible:** Executive Chef **17. Corrective Actions**: Immediate removal/replacement of identified cutting boards was completed. **Date of Implementation:** 3/25/14 **Monitoring Process:** Random audits conducted by executive chef to assess condition of cutting boards and purchase/replace when needed. **Person Responsible:** Executive Chef **18. Corrective Actions:** Twice yearly cleaning/sanitizing of internal components to be performed by outside vendor (Redline Air) **(134, 134a).** **Date of Implementation:** Serviced June 2014; to re-occur every six months. **Monitoring Process:** Cleaning/sanitizing of ice machine (twice yearly) is documented on log sheet attached to unit **(see Addendum 135)**. **Person Responsible**: Director of Facilities & Director of Food & Nutrition **19. Corrective Actions**: Conducted □Soda Fountain Sanitizer□training with retail staff. Daily/Weekly/Monthly sanitizing requirements are documented as completed on log sheet posted on back of dispenser. **(see Addendum 138, 138a)**. **Date of Implementation:** 4/17/14 **Monitoring Process**: Completion documented on □Fountain Beverage Dispenser Cleaning/Sanitizing Log□ and reviewed weekly by executive chef. **Person Responsible**: Executive Chef **Van Nuys** **20) Corrective Actions:** Will provide staff education to include review of policy Infection Control FNS.042; Cleaning, sanitizing of ice machine will be performed twice yearly and will be documented on log sheet attached to unit **(see Addendum 148, 148a).**	3/25/2014 6/30/2014 4/17/2014

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A 749	Continued From page 163 medication refrigerator and put it on the floor. The PT took out a vial of medication, then placed back the insulin cassette to the refrigerator without disinfecting it. During a concurrent interview, PT stated that she should have not placed on the floor and if she did she should have disinfected the medication cassette. Before putting it back together with other cassettes in the medication refrigerator. Hollywood campus 6. On March 24, 2014, at 8:30 a.m., during a provision of care observation with RN 3 the following was noted: a. The randomly selected patient (Patient 56) had a peripheral intravenous (IV) line on the left arm which was not labeled with date, time and initial when it was initially placed. b. Patient 23 had a peripheral intravenous (IV) line on the right hand which was not labeled with date, time and initial when it was initially placed. c. Randomly selected patient (Patient 57) had a peripheral intravenous (IV) line on the right forearm which was not labeled with date, time and initial when it was initially placed. d. Randomly selected patient (Patient 58) had a peripheral intravenous (IV) line on the left forearm which was not labeled with date, time and initial when it was initially placed.	A 749	(Continued from page 163) **Date of Implementation:** Target date of implementation for education July 1, 2014; target date for cleaning and sanitizing July 31, 2014 **Monitoring Process:** Monitoring will be managed through weekly and monthly cleaning logs **Person Responsible:** RD, Director and Food Services supervisors **21) Corrective Action:** The new dietary policy for infection control includes a section on hand hygiene practice and technique for dietary workers **(see Addendum 137).** In-service on proper hand hygiene by the dietary staff will be given by infection control. Hand hygiene will be monitored during the bimonthly Infection Control rounds (see rounds worksheet attached). **Date of Implementation:** Policy (7/2014); In-service (7/15/14); Rounds (7/1/14) **Monitoring:** Rounds to be done bimonthly by infection control with hand hygiene audits during rounds. **Responsible Person**: Infection Control Coordinator **22) Corrective Actions:** Dietary department instituted a new log for the cool-down process for food and staff has been in-serviced. Thawing process was revised and staff was in-serviced. Ice machine cleaning was initiated and log was created by dietary. In addition, dietary conducted in-services on proper apron use and sanitizing of work areas. In-service on manual washing and sanitizing of dishes will be conducted by dietary. Infection Control to in-service dietary staff on hand hygiene and general infection control. Infection control reviewed these in-services, logs and processes and will conduct audits on the log sheets during bimonthly dietary infection control rounds for a minimum of 3 months; attached is Infection Control Rounding sheet, and IC dietary policy addressing hand hygiene, among other things **(see Addendum 91, 46, 46a 137).** **Date of Implementation:** 7/1/14 **Monitoring Process**: Infection Control rounding and review of logs. **Person Responsible**: Infection Control Coordinator; Dietary Supervisor; Lead Dietician	7/1/2014 7/1/2014 7/1/2014

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A 749	Continued From page 164 According to the facility's policy and procedure on Intravenous Therapy-Initiation and Management of Peripheral Intravenous Lines dated November 20, 2012, label the IV sites with the date, gauge of needle and initials. The IV sites may remain in place for up to 96 hours unless there are signs and symptoms of infection. The IV tubing set changes are every 96 hours and label the IV tubing with a date. 7. On March 24, 2014, at 11:30 a.m., during a tour with RN 3, the randomly selected patient (Patient 55) was receiving 2 liters of oxygen via nasal cannula, on a indwelling catheter and was on telemetry monitor. The AN after touching the indwelling catheter bag and tubing proceeded to pick up the telemetry box from the side of the bed and placed it on the patient's chest without performing hand washing or applying hand sanitizer. 8. On March 24, 2014, at 11:30 a.m., the randomly selected patient (Patient 53) had the G-Tube feeding bag label did not have the time when the feeding bag was initially hung. Culver City Campus 9. On March 25, 2014 at 10:20 a.m., during the observation tour of the unit the following was noted:	A 749	(Continued from page 164) **23) Corrective Actions:** Staff re-education to include review of policy Defrosting Meat FNS.010 and a new process □meat pull sheet□has been created and dietary staff have been trained on how to properly defrost meat **(see Addendum 140, 140a).** **Date of Implementation:** 4/23/2014; Staff validation competency will begin July 15-31, 2014 **Monitoring Process:** Will be managed through Staff Validation Competency □Return Demonstration/Comprehension log□will be done twice yearly and will be maintained in employee file **Responsible person:** RD, Director Dietary Department and Food Services Supervisor	4/23/2014

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A 749	Continued From page 165 a. There was a gastrostomy tube (GT) feeding bag of Diabetic Source formula hanging on the feeding pump pole and labeled the bag was hang on March 25, 2014 at 60 milliliters □ml)/hour (hr) for the randomly selected patient (Patient 54). However there was no time when the bag was initially hung. b. The randomly selected patient (Patient 59) had a peripheral intravenous (IV) line on the left forearm which was not labeled with a date, time and initial when it was placed. The patient was also observed receiving Ferlicit (iron medication) by IV and the IV tubing was not labeled with date, time and initial. c. Patient 15 had a midline peripheral IV line located in the right antecubital arm which was not labeled with date, time and intial when it was placed. d. There was a G-Tube feeding bag Fibersource HN running at 50 cc/hr with no date and time it was hung for the Patient 15. There was a 0.9% normal saline IV bag running at 75 cc/hr which did not have a label as to patient name, when it was hung and who hung it. According to the facility□s policy and procedure on Enteral Nutrition Support dated January 2014, closed system enteral feeding bag should be dated, timed and initialed when the formula bottle is spiked. 10. On March 26, 2014, at 10:30 a.m., during an	A 749		

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A 749	Continued From page 166 initial tour, of the open behavior health unit, room 603 had a sign which read □Closed this AM.□There was a man with white coveralls and a disinfectant canister going into the room. Staff S stated the room was closed due to bed bugs. A review of the Census Log dated March 21, 2014, disclosed two patients were in room 603. Shower Room 3, directly across the nurses' station, in the locked unit had a sign which read □Closed Needs to be Sanitized.□ Reviews of Pest Prevention Service Reports revealed the following dated: a. On January 8, 2014, a serviced was done for bed bugs in Room 509. b. On January 15, 2014, a serviced was done for bed bugs in Room 632. c. On March 7, 2014, a serviced was done for bed bugs in Room 603. d. On March 18, 2014, a serviced was done for bed bugs in Room 540. e. On March 21, 2014, a serviced was done for bed bugs in Room 603. An email communication dated April 9, 2014, at 4:22p.m., from Staff B (corporate vice president/quality risk management) disclosed the facility had no policy regarding how to identify, report, investigate and control of infections for bed bugs. The email communication indicated □the bed bug issue was confined to one room 603, on the behavioral health unit. There were three (3) documented incidents of which a service request was put in for pest control company. According to a facility's policy titled Pest Control dated May 2012 disclosed the purpose was to provide a sanitary, rodent, and pest free	A 749		

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A 749	Continued From page 167 environment. The procedure included housekeeping supervisor would log all pest control complaints. The housekeeping supervisor would accompany the pest control technician on treatment rounds within the department1S area responsibility. Hollywood campus 11. On March 241 2014 at approximately 10:40 a.m., a large stainless steel pan containing slices of meat was observed in the refrigerator. Dietary Staff (DS) 4 stated the pan contained the Roast Beef for the lunch meal. A temperature check revealed the roast was 74. 8 degrees Fahrenheit (F). DS 4 stated the roast was approximately 40 pounds and that he had sliced it that morning at approximately 9 a.m. He stated that he had not checked the temperature before slicing and added water after slicing. Staff 2, who was present during the concurrent interview, stated there was no cooling log to show how the roast was monitored during the cooling the period. He stated that cooks cools the roast, leaves it at room temperature for 2 hours till it reaches 160 degrees F. The roast is then put in the refrigerator and the morning cook comes in the next morning and slices it. Improper cooling is a major factor causing food borne illness. Foods that have been cooked and held at improper temperatures promote the growth of disease causing microorganisms that may have survived the cooking process. Large or	A 749		

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A 749	Continued From page 168 dense items such as roasts may require interventions (e.g. placing foods in shallow pans, cutting roasts into smaller portions, utilizing water baths and stirring periodically) in order to be chilled safely within an allowed time period. Cooked foods subject to time and temperature control safety foods are best cooled rapidly within 2 hours from 135 degrees to 70 degrees F and within 4 more hours to the temperature of 41 degrees F. The total time for cooling from 135 degrees to 41 degrees should not exceed *6* hours (Centers for Medicare and Medicaid, Appendix P, State Operations Manual.) 12. At approximately 3:30 p.m. on March 24, 2014, it was determined that the water temperature of the high temperature was not hot enough to properly sanitize dishes and other cooking utensils. The water temperature was 119.5 degrees F. The required minimum temperature for a high temperature is of 180 degrees F. There was a discrepancy between DS 3 and Staff 10 on when hospital staff became aware that the temperature of the machine was not adequate and should not be used to dish washing. Staff 10 stated at approximately 3:35 pm that a part in the machine needed to be replaced and that he had informed DS 3. Inside the dish room were cleaned cooking utensils, pots and pans that had been washed in machine within the time frame after CE stated he had informed Dietary Staff *6* that the dish machine needed a part and should not be used. Staff 2, who was present during the interview, instructed OS 3 to rewash the items and sanitize manually in the sink. 13. At approximately 11:10 a.m. on March 24,	A 749		

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A 749	Continued From page 169 2014, a food blender stored away as clean was observed on the counter. There was a light brown and cream colored substance on the rubber gasket and the base of the plastic food container of the blender. DS 4 stated it had been used earlier that morning to blend oatmeal. The standard of practice is that all removal parts of food service equipment are washed and sanitized. Improperly sanitized food contact surfaces could support the growth of microorganisms that could cause food borne illness resulting in cross-contamination of food prepared in/on the equipment. 14. At approximately 3:40 p.m. on March 24, 2014, the preventive maintenance for the ice machine was reviewed. It was noted there was a build-up of black particles on both sides of the ice shield (a plastic cover over the ice production area). In an interview with Staff 10, he stated that the machine interior should be cleaned every two months. There was no documented evidence that this was done. 15. Patient 9 was admitted with diagnoses including anemia (low blood iron), insulin dependent diabetes (high blood sugar), sacral decubitus (open sore on the top of the upper buttocks), end stage renal disease (when the kidneys are not able to work at a level for day - to day life) with dialysis (treatment that removes wastes in the blood done by healthy kidneys). Electronic record review showed on March 23, 2014 at 12: 25 a.m., there was an order for Novasource Renal, (a specialized tube feeding for patients with kidney disease) Give 20 milliliters □ml)/hour (hr) via PEG (percutaneous endoscopic gastrostomy tube). A medical procedure where a tube is passed into the stomach through the	A 749		

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A 749	Continued From page 170 abdominal wall. There were additional instructions □every evening hours.□ RN 18 stated in an interview at approximately 5:45p.m. on March 24, 2014 on the definition of □evening hours□ was 7 p.m. to 7 a.m. Inspection of the tube at approximately 5:50p.m. showed a feeding bag hung in the patient□s room with approximately 150 ml of a light brown colored liquid left in the bag. The tube feeding bag had a blue colored cap which indicated that the tube feeding was poured into the bag. The bag was dated March 24, 2014 was not timed. It could not be determined how long the bag had been hung and how much Patient 9 received. This kind of tube feeding where hospital nursing staff has to pour the feeding into a bag is called an □open□system. The system where the tube feeding is pre-filled and sealed from the factory is called a closed system. The recommended time that tube feeding in an □open system□ can be left hanging is 4 hours to prevent growth of microorganisms. RN 19 stated that at 7 p.m. the pump is turned on and whatever feeding that is left in the bag is allowed to infuse into the patient. He stated that at midnight all the bags are changed and new bags hung. RN 19 also stated that a new bag is hung at the beginning of each shift while RN 18 stated it was changed at 12 midnight. Neither RN 18 nor RN 19 was able to state how much feeding was poured into the bag, when it was hung. Review of hospital policy titled, □Enteral and Total Parenteral Nutrition□ dated November 2012 did not include information on hang times and how to	A 749		

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A 749	Continued From page 171 prevent microbial growth. The hospital lacked an effective system to ensure that tube feeding in an open system was hung in a manner that would not support the growth of microorganisms that could cause food borne illness. Culver City campus 16. At approximately 11:24 a.m. on March 25, 2014, a food blender stored away as clean was observed on the counter. There was a light brown and cream colored substance on the rubber gasket and the base of the plastic food container of the blender. Next to the blender was a Robot Coupe (food processor) also stored away as clean. There was an unidentifiable light brown colored substance on the lid. Staff 3 who was present during the observation stated that the hospital policy was to remove all the removable parts. She instructed on the dietary staff to remove the two pieces of equipment and rewash. At approximately 3:00p.m. on March 25, 2014, the robot coupe was observed in the same area stored away as clean. There was once again a dried on substance on the lid. Staff 3 who was present during the observation could not provide any explanation as to why the piece of equipment had not been properly cleaned. The standard of practice is that all removal parts of food service equipment are washed and sanitized. Improperly sanitized food contact surfaces could support the growth of microorganisms that could cause food borne illness resulting in cross-contamination of food prepared in/on the equipment. 17. At approximately 3:10p.m. on March 25, 2014, two cutting boards stored away were	A 749		

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A 749	Continued From page 172 observed with dark colored substances in the cut groove marks. Staff 3 acknowledged the presence of the unidentifiable black colored substances and stated the boards will be replaced. Improperly sanitized food contact surfaces could support the growth of microorganisms that could cause food borne illness resulting in cross-contamination of food prepared in/on the equipment. 18. On March 25, 2014 beginning at 3 p.m., at the Culver City campus the preventive maintenance of the ice machine was reviewed. In a concurrent interview with Staff 5 he described he process. He stated that a) the hospital installed an automatic cleaning system for the unit; b) that with the installation of this unit required no additional maintenance and c) that the hospital contracted with a vendor to complete manufacturers' required maintenance. The bottle of chemical in the unit was labeled as an ice machine cleaner. In an interview on March 26, 2014 beginning at 9:35a.m., with REP 1 from the contracted vendor described how the automatic cleaning system worked. He described a process whereby the chemical would circulate through the ice producing mechanism two times/month. He also stated that the ice machine cleaner was the only chemical circulated. Posted on the interior panel of the ice machine was manufacturers' guidance for both a cleaning and sanitizing process. 19. In an interview March 26, 2014 beginning at 9 am, with Dietary Staff (DS) 1 the maintenance of the coke machine syrup connectors was reviewed. DS 1 stated that when she changed the syrup boxes the connectors were rinsed in a	A 749		

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A 749	Continued From page 173 bucket of hot water. On March 26, 2014 at 1:30 p.m., Staff 2 stated that she has previously attempted to obtain manufacturers□instructions for the dispensing unit; however was told by the purchasing group that it was a closed system and did not require any additional maintenance. She also stated that the vendor was trying to contact the manufacturer for guidance. As of April 1, 2014 at 5 p.m., the hospital was unable to provide manufacturers□guidance. On April 2, 2014 at 9 a.m., the surveyor reviewed of the soft drink vendors□web page and noted that it provided comprehensive guidance for daily, weekly and monthly cleaning of the syrup connectors and unit, which included a cleaning and sanitizing procedure. Van Nuys campus 20. In an interview on March 27, 2014 beginning at 10:30 a.m., with Staff 6 at the Van Nuys campus the preventive maintenance for the ice machine was reviewed. It was noted there was a buildup of black particles on both sides of the ice shield (a plastic cover over the ice production area) as well as the water supply tube. He stated he was unsure of the substance but thought it may be a disintegration of the foam on the interior of the shield. It was also noted that in the interior of the machine there was a white calcified substance, identified by Staff 6 as a mineral build up. Staff 6 described a preventive maintenance process that was limited to cleaning the filters, checking the pump and vacuuming dust on the interior of the machine. Review on March 27, 2014 at 4:15p.m., the manufacturers□guidance for cleaning and sanitizing of the ice machine was reviewed with Staff 6. He acknowledged that this process was not being followed.	A 749		

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A 749	Continued From page 174 21. On March 27, 2014 beginning at 8:20 a.m., DS 1 was observed in the dish room of the Van Nuys campus. It was noted that placed dirty Dishes in the dishwasher, wiped his hands dry with a paper towel and returned to food production activities. It was also noted that after the food production activities he placed gloves on his hands and began removing cleaned and Sanitized dishes. Review of hospital policy titled □Hand Hygiene □dated 11/12 guided staff that □ 4.2.1 Soap and water is required: 4.2.1.1Any Time hands are visibly dirty □ □ It was also noted That the hand washing procedure was intended to be used by healthcare workers in a patient Care setting □ □ Additionally it was noted that the procedure included alcohol based hand rub to be used in clinical situations. The policy did not include any specific guidance for food service workers. In an interview on March 28, 2014 at 1:30 pm, with the Vice President of Quality she stated that this was the only policy that the hospital had. 22. Potentially hazardous foods (PHF) are those are capable of supporting bacterial growth associated with foodborne illness. PHF□s require time/temperature control for food safety during all stages of receiving, storage, production and distribution. PHF□s that are cooked and held for use at a later time must be monitored for time/temperature control within specified time/frames (Food Code, 2013). During initial kitchen tour on March 27, 2014 beginning at 8 a.m., it was noted that there were leftover cooked egg rolls and tofu stir fry in the refrigerator adjacent to the trayline. In an interview on March 27, 2014 at 8:55 a.m., with Staff 2 she stated that if leftovers were saved	A 749		

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A 749	Continued From page 175 they would be taken off the steam table, put into Another container, covered, labeled, dated and put in the refrigerator. She also stated that to ensure food safety when the leftovers were served they would be heated to an internal temperature of 165□ She further stated there was not temperature monitoring of these leftovers once they were refrigerated. Additional observation on March 27, 2014 at 9:30 a.m. noted there were 15 packages of five pound rolls of raw, fully thawed ground beef. In a concurrent interview with Staff 1 she stated that the meat was thawed on March 24, 2014 to be used on 3/29/14 for spaghetti. She further stated that the item would be cooked for the cafeteria at lunch time and the leftovers would be used for the patient dinner meal. She also stated that after lunch meal the leftovers would be put in the refrigerator and reheated for dinner and that there would be no temperature monitoring between lunch and dinner. In an interview with Registered Dietitian (RD 1) 3 she stated that she did not do any routine foodservice oversight; however would provide training and guidance if asked to do so. Review of position description titled □Clinical Dietitian□ effective 4/1/06 noted that under the general responsibilities section this position was responsible to □observe and implement proper food handling and storage to assure safe quality nutrition.□ On March 28, 2014 beginning at 10:25 a.m., interviews were held with Staff K. The surveyor requested a description of the environment of care rounds. She stated that 2-3 times a year the department was reviewed for refrigerator/freezer	A 749		

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A 749	Continued From page 176 temperature and dishwasher logs, the physical Environment of the department; dating of food; cleanliness of equipment and the ice machine. She also stated the rounds were usually conducted with a hospital engineer and the department manager. She was also stated that The departmental policies did not go to the Infection control committee for review prior for implementation. Staff K also stated that the Health system recently acquired the Van Nuys campus and that all hospital policies/procedures were combined. Review of a copy of the Van Nuys campus environment of care rounds dated 1/23/14 noted that the evaluation included the cafeteria, kitchen, dishwasher, freezer, dry storage and office areas. It was also noted that cleanliness, labeling of food storage issues were identified. There was no evaluation or identification of the operational processes within the department related to food handling practices, specifically practices related to time/temperature control of potentially hazardous foods (PHF). PHF□s are those foods capable of supporting bacterial growth associated with foodborne illness (USDA Food Code, 2013) and require effective monitoring systems for food safety. Review of departmental document titled □Storage And Use of Leftovers□dated 11/12 noted that while a procedure was developed for handling of leftover foods, it did not meet safe food handling standards, rather was limited to labeling and dating of foods. It did not include monitoring cooling of leftovers. In addition, some of the temperatures identified as requirements were outdated and did not meet current temperatures outlined in the 2013 Food Code.	A 749		

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A 749	Continued From page 177 23. During initial tour on March 27, 2014 beginning at 8 a.m., it was noted there were 15 packages of five pound rolls of raw, fully thawed ground beef. In a concurrent interview with Staff 1 she stated that the meat was thawed on March 24, 2014 to be used on 3/29/14 (5 days after removal from the freezer) for spaghetti. She also stated she was unsure if there was a policy regarding the procedure for thawing meats. Hospital policy titled □Defrosting Meats □dated 11/12 guided staff to remove frozen meats two days in advance. The United States Department of Agriculture, Food Safety and Inspection Service (8/6/13) noted that ground beef may contain multiple bacterial strains. Extensive Holding of thawed meats provide an environment for increased bacterial growth. 16. During food production observation on March 27, 2014 beginning at 10:30 a.m., DS 1 Was observed preparing to transfer food into a Baking pan. He was observed taking a towel from a clean linen bin and wiping excess water from the pan. It would be the standard of practice to ensure that all dishware was dry before storage. Review undated of departmental policy and procedure manual revealed that there was no comprehensive ware washing procedure. In an interview with the RD 1 she stated that she did a cursory review of the policy/procedure manual; however she did not complete routine oversight of dietetic services. The standard of practice for storage of all equipment and utensils would be to ensure that after cleaning and sanitizing they were air-dried. Equipment and utensils may not be cloth dried except utensils that have been air-dried may be polished with cloths that are maintained clean	A 749		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(□1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(□2) MULTIPLE CONSTRUCTION	(□3) DATE SURVEY COMPLETED
	050135	A. BUILDING **01 – SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD** B. WING _____	**04/01/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, □IP CODE
SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	**6245 DE LONGPRE AVE HOLLYWOOD, CA 90028**

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A 749	Continued From page 178 and dry.	A 749		
A 940	482.51 SURGICAL SERVICES If the hospital provides surgical services, the services must be well organized and provided in Accordance with acceptable standards Practice. If outpatient surgical services are Offered the services must be consistent in quality With inpatient care in accordance with the Complexity of services offered. This CONDITION is not met as evidenced by: Based on observation, review of facility documents and staff interview, the facility failed to meet the Condition of Participation in Surgical Services by failing to: 1. Ensure the surgical instruments and sterilized gowns that were opened on the back table prior to the surgery were constantly monitored and not Be left unattended in accordance with the recommendation from the Association of Operative Room Nursing (AORN). This deficient practice had the potential for contamination of the Surgical room with microorganisms which may affect the health and safety of the patients Receiving surgical services in the hospital (Refer To A 951). 2. Ensure the temperature and humidity were monitored in the autoclave room in accordance with recommendation from AAMI (Association for Advanced Medical Instrument). This defiant practice promote microbial growth and can result in contamination of sterile items (Refer to A 951). 3. To ensure a medical history and physical (H&P) examination completed and documented	A 940	**Culver City** **1) Corrective Actions:** Surgical Staff will be re- in serviced on the hospital□s policy Aseptic Technique SUR.002 with a focus on the expectation that the sterile field should be constantly monitored and maintained. Unguarded sterile fields should be considered contaminated. Without direct observation, there is no way to ensure sterility. The sterile field should be prepared as close as possible to the time of use. The sterility of an opened sterile field is event related. There is no specified amount of time that opened sterile supplies in an unused room can remain sterile. **(See Addendum 151, 151a, 151b).** **Date of Implementation:** Staff in-service completed on April 17, 2014. **Monitoring Process:** The Director of Perioperative Services and/ or designee will conduct monitoring activity to include monthly audits of a minimum of 20 OR cases to ensure rooms are not being left unattended after supplies are opened. Targeted compliance is 100%. Compliance data will be reported to the Surgery Committee and the Quality Council and the Governing Board on a quarterly basis until optimal compliance is achieved. **Person Responsible:** Director Perioperative Services **2).Corrective Actions:** Red Line Air Conditioning Service to assess decontamination area for proper exhaust. A temperature and Humidity gauge will be installed in the Decontamination Room in Central Processing. Room temperature and humidity will be monitored and recorded on a daily basis by Plant Operations and Central Processing Staff**. (see Addendum 152, 152a)** Corrective actions will be taken and documented when minimum parameters are not met. . ASHE, AORN, and AAMI, guideline parameters for Soiled/ decontaminated areas are temperature 60-65 degrees and 20-60% humidity. Digital gauges will replace the Analog gauges in those areas where the monitoring of temperature and humidity is required on June 18, 2014. **Date of Implementation:** June 17,2014 Red Line Air Conditioning to assess decontamination area for proper exhaust.; June 18,2014 installation of digital gauges in areas requiring monitoring of temperature and humidity; June 18,2014. Daily Monitoring of Temperature and Humidity in Central Processing **Monitoring Process:** Monitoring activity will include a verification of the Decontamination Room daily temperature and humidity log by the Director of Perioperative Services. Compliance data will be reported to the Infection Prevention Committee and the Quality Council on a quarterly basis until optimal compliance is achieved. **Person(s) Responsible:** Director Perioperative Services & Director Plant Operations **3).Corrective Actions**: The hospital□s leadership will ensure that its medical staff is re-educated on required documentation in the medical record to include the necessity for the signature, date and time of all entries in the medical record.	4/17/2014 6/17/2014

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A 940	Continued From page 179 24 hours after admission prior to the surgery Requiring anesthesia services for Patient 28 (Refer to A 952). 4. Ensure a tracheostomy set was available in the operating room suites in Hollywood campus. This deficient practice created the risk of poor health outcome in the event that a patient required a tracheostomy tray (Refer to A 959). The cumulative effect of these systemic practices Resulted in the hospital□s inability to provide safe and effective surgical services.	A 940	(Continued from page 179) **(see Addendum 153)** **3).Corrective Actions**: The hospital□s leadership will ensure that its medical staff is re-educated on required documentation in the medical record to include the necessity for the signature, date and time of all entries in the medical record. **(see Addendum 153).** Pre-op H & P Update form has been revised to include a designated place for physician signature, date and time**. (see Addendum 153a, 153b)** **Date of Implementation:** Pre-op H & P Update form presented at the Anesthesia and Surgery Committee Meeting of June 9, 2014. **Monitoring Process:** The Director of Perioperative Services will conduct a review of a minimum of 30 Pre-op H& P Update Progress Records per month. Compliance data will be reported through Surgery Committee Meeting, the Quality Council, and the Governing Board on a quarterly basis until compliance is achieved. **Person Responsible**: Director Perioperative Services & Director Medical Staff Office A 940 Continued on page 180a.	6/9/2014
A 951	482.51 (b) OPERATING ROOM POLICIES Surgical services must be consistent with needs and resources. Policies governing surgical care must be designed to assure the achievement and maintenance of high standards of medical practice and patient care. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide a safe environment and maintain high standards of care for patients receiving surgical services by failing to; 1. Ensure the surgical instruments and sterilized gowns that were opened on the back table prior to the surgery were constantly monitored and not be left unattended in accordance with recommendation from the Association of Perioperative room Nursing (AORN). This Deficient practice had the potential for contamination of the surgical room with microorganisms which may affect the health and safety of the patients receiving surgical services	A 951	**Culver City** **1) Corrective Actions:** Surgical Staff will be re- in-serviced on the hospital□s policy Aseptic Technique SUR.002 **(see Addendum 155, 155a, 155b, 155c)** with a focus on the expectation that the sterile field should be constantly monitored and maintained. Unguarded sterile fields should be considered contaminated. Without direct observation, there is no way to ensure sterility. The sterile field should be prepared as close as possible to the time of use. The sterility of an opened sterile field is event related. There is no specified amount of time that opened sterile supplies in an unused room can remain sterile. **Date of Implementation:** Staff in-service completed April 17, 2014. **Monitoring Process:** The Director of Perioperative Services and/ or designee will conduct monitoring activity to include monthly audits of a minimum of 30 OR cases to ensure rooms are not being left unattended after supplies are opened. Targeted compliance is 100%. Compliance data will be reported to the Surgery Committee and the Quality Council and the Governing Board on a quarterly basis until optimal compliance is achieved. **Person Responsible:** Director Perioperative Services	4/17/2014

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SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	**6245 DE LONGPRE AVE HOLLYWOOD, CA 90028**

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A 951	Continued From page 180 in the hospital. 1. Ensure the temperature and humidity were Monitored in the autoclave room in accordance with recommendation from AAMI (Association for Advanced Medical Instrument). This deficient practice promote microbial growth and result in contamination of sterile items. Findings: During the initial tour with Staff D in the operating Room (OR) suites and Autoclave Room of the Culver city campus on March 25, 2014 between 9:03 a.m. and 10 a.m., the following was observed: 1. In OR □2, the surgical instruments and sterilized gowns on the back table were opened to the air at 9:38 a.m. Scrub technician (ST) 1 Was about to go out of the room to scrub his Hands without constantly monitoring the sterile field until the surveyor intervened. During the concurrent interview, ST 1 stated he had to prepare the surgical instruments to be ready for surgical procedures. The patient was brought into the room at 10:15 a.m., which was 37 minutes after the surgical instruments were opened on the back table. According to Perioperative Standards and Recommended Practices for 2013 of the AORN Recommendation VII Sterile fields should be constantly monitored. VII.a. Once created, a sterile field should not be left unattended until the operative or other invasive procedure is completed. 2. There was no thermometer and humidity	A 951	(Continued from page 180) **2) Corrective Actions**: Red Line Air Conditioning Service to assess decontamination area for proper exhaust. A temperature and Humidity gauge will be installed in the Decontamination Room in Central Processing. Room temperature and humidity will be monitored and recorded on a daily basis by Plant Operations and Central Processing Staff **(see Addendum 156, 156a).** Corrective actions will be taken and documented when minimum parameters are not met. . ASHE, AORN, and AAMI, guideline parameters for Soiled/ decontaminated areas are temperature 60-65 degrees and 20-60% humidity. Digital gauges will replace the Analog gauges in those areas where the monitoring of temperature and humidity is required on June 18, 2014. **Date of Implementation**: June 17, 2014 Red Line Air Conditioning to assess decontamination area for proper exhaust. June 18, 2014 installation of digital gauges in areas requiring monitoring of temperature and humidity. June 18, 2014 Daily Monitoring of Temperature and Humidity in Central Processing **Monitoring Process:** Monitoring activity will include a verification of the Decontamination Room daily temperature and humidity log by the Director of Perioperative Services. Compliance data will be reported to the Infection Prevention Committee and the Quality Council on a quarterly basis until optimal compliance is achieved. **Person(s) Responsible:** Director Perioperative Services & Director Plant Operations	6/17/2014

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A 951	Continued From page 181 display in the Autoclave Room, where all surgical instruments trays were wrapped and sterilized in the steam autoclaves. According to Staff D, the temperature and humidity were centrally monitored by the maintenance services. A review of the □Third Shift Surgery Check List □dated March 25. 2-14 disclosed the temperature and Humidity for all operating rooms and recovery room had been monitored and recorded. However, there was no documentation that the temperature and humidity to the Autoclave Room had been monitored and recorded. During an interview with Staff B on March 25, 2014, 2014 at 4 p.m., she stated that the temperature and humidity to the Autoclave Room had not been monitored and recorded. According to AAMI (Association for Advanced Medical Instrument) (2014) Chapter 3: Design Consideration 3.3.6.5 Temperature General work areas should have a temperature controlled between 20˚C and 23˚C (68◦F and 73◦F). The decontamination area should have a temperature controlled between 16˚C and 18˚C (60˚F and 65˚F). The temperature in sterilization equipment access rooms should be controlled between 24˚C and 29˚C (75˚ F and85˚ F) or as recommended by the equipment manufacturer. The temperature in sterile storage and personnel support areas (e.g., toilets, showers, locker room) may be as high as 24 ˚C (75˚ F). Independent monitors should be located in each of the areas where temperature should be controlled; temperature should be recorded daily. Processing personnel in each work area are responsible for monitoring and recording the	A 951		

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A 951	Continued From page 182 temperature to ensure that the correct temperature is being achieved. Rationale: Work areas should be comfortable for properly attired personnel. Comfort is a particular consideration in the decontamination area, where PPE is worn for long periods of time and where temperatures suitable for general work areas might be uncomfortably hot. Also, bacteria thrive at high temperatures; cool temperatures in the Decontamination area might help minimize Bioburden. Although AIA (2006) allows the temperature in clean work areas to be as high as 24° C (75° F), the consensus of the AAMI Committee was to recommend consistent temperature ranges for all general work areas. Controlling the temperature in sterilization equipment access rooms promotes higher efficiency of the equipment contained within the enclosures. For additional information on temperature control, see AIA (2006). 3.3.6.6 Relative humidity Relative humidity should be controlled between 30% and 60% in all work areas except the sterile storage area, where the relative humidity should not exceed 70%. An independent humidity monitor should be located in each area that requires controlled relative humidity. Relative humidity should be recorded daily. Processing personnel in each work area are responsible for monitoring and recording the relative humidity to ensure that the correct relative humidity is being achieved. NOTE-Ideal relative humidity in the preparation And packaging area is 50% and should not be less than 35% for best results in achieving sterilization. In the decontamination area, the recommended range of relative humidity should	A 951		

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A 951	Continued From page 183 be maintained to the extent possible, but temporary elevations might occur because of the type and quantity of cleaning and decontamination equipment. Humidifiers may be installed to maintain the recommended humidity level seasonally (e.g., during the winter months, when the heating system is functioning). If duct humidifiers are located upstream of the final filters, they should be placed at least 15 feet (4.57 meters) upstream of the final filters. For ductwork with duct mounted humidifiers, there should be a means of water removal. An adjustable high-limit humidistat should be locteddownstream of the humidifier to reduce the potential for condensation inside the duct. All duct takeoffs should be sufficiently downstream of the humidifier to ensure complete moisture absorption. Steam humidifiers should be used. Reservoir-type water spray or evaporative pan humidifiers should not be used. Rationale: Relative humidities higher than those recommended can promote microbial growth and thus increase bioburden. Relative humidity lower than 30% will permit absorbent materials to become excessively dry, which can adversely affect certain sterilization parameters (such as steam penetration) and the performance of some products (such as BIs and CIs). Thus, for best results, the committee recommends an ideal relative humidity level of 50% and a minimum level of 35%. The recommended range for relative humidity was largely based on AIA (2006).	A 951		
A 952	482.51 (b) (1) HISTORY AND PHYSICAL Prior to surgery or a procedure requiring	A 952	**Culver City and Hollywood Campuses** **1-3 Corrective Actions:** • Non-compliance discussed and corrective actions addressed at the Medical Executive Committee (MEC).	

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A 952	Continued From page 184 Anesthesia services and except in the case of Emergencies: (i) A medical history and physical examination must be completed and documented no more than 30 days before or 24 hours after admission or registration. (ii) An updated examination of the patient, including any changes in the patient□s condition, must be completed and documented within 24 hours after admission or registration when the medical history and physical examination are completed within 30 days before admission or registration. This STANDARD is not met as evidenced by: Based on record review and interview, the facility Failed to ensure a medical history and physical (H&P) examination completed and documented 24 hours after admission prior to the surgery Requiring anesthesia services for Patient 28. This deficient practice placed the patient at risk of Unrecognized medical conditions and substandard health outcome for that patient. Findings: A review of the Operative/Invasive Procedure Report disclosed Patient 28 had undergone a surgical procedure-retropubic uretheral suspension (used to treat urinary incontinence by lifting the sagging bladder neck and urethra that may have dropped abnormally low in the pelvic area) on March 15, 2014. The clinical record was reviewed and disclosed a History and Physical was completed on March 20, 2014. Another Short Form History and Physical was completed on March 21, 2014. The PRE-OP	A 952	• The Chief of Staff issued a memo, dated June 19, 2014, to All Medical and Allied Staff Members to serve as a reminder notice that pursuant to the Medical Staff Rules and Regulations that a medical history and physical examination must be completed and documented no more than 30 days before or 24 hours after admission or registration, but prior to surgery or procedure requiring anesthesia services. The medical history and physical examination must be placed in the patient□s medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. • Medical Staff leadership will continue to monitor progress and work with Administration to improve compliance with documentation standards. • Audit results reported to the hospital□s Quality and Medical Record Committee and Medical Executive Committee. **Date of Implementation:** • Non-compliance discussed and corrective actions addressed at the Medical Executive Committee meeting on June 17, 2014. • Chief of Staff communication dated June 19, 2014. • Monitoring of H&P□s prior to surgery □ ongoing • Audit results reported to the hospital□s Quality and Medical Record Committee and Medical Executive Committee □ June 2014 and quarterly as required. **Monitoring Process:** • The HIM Manager and/or designee will conduct monthly audits of patient charts to review for the timely completion of history and physical examinations prior to surgery. • Numerator = Number of history and physical present no more than 30 days prior to admission or 24 hours after admission or registration but prior to surgery / Denominator □ Number of total charts reviewed. • The sample size will be based on monthly discharges, per the following guidelines: o Sample all cases for a population size of fewer than 30 cases o Sample 30 cases for a population size of 30□100 cases o Sample 50 cases for a population size of 101□500 cases o Sample 70 cases for a population size of more than 500 cases	6/17/2014 6/19/2014 6/19/2014

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A 952	Continued From page 185 H& P Update was reviewed and disclosed there was no change in H&P. However, there was no documentation when the PRE-OP H& P Update had been completed. During the concurrent interview with Staff J on March 25,2014 at 10:05 a.m., she stated the PRE-OP H& P Update had not been completed.	A 952	(Continued from page 185) • Targeted compliance is 90% • Monitoring activity will commence for a period not to exceed 4 months to ensure that compliance is achieved and sustained. • Random audits will be performed thereafter. • Results of the audits will be reported to the hospital□s Quality and Medical Record Committee and Medical Executive Committee. **Person Responsible:** HIM Administrator and/or designee	
A 956	482.51(b)(3) REQUIRED OPERATING ROOM EQUIPMENT The following equipment must be available to the operating room suites: call-in system, cardiac monitor, resuscitator, defibrillator, aspirator, and tracheotomy set. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a tracheostomy set was available in the operating room suites in Hollywood campus. This deficient practice created the risk of poor health outcome in the event that a patient required a tracheostomy tray. Findings: During the initial tour with RN 7 in the operating room suites of the Hollywood Campus on March 24, 2014 between 9:58a.m. and 11 a.m., there was no tracheostomy set available. According to RN 7, there was no a tracheostomy set available in the operating room suites. According to the facility's policy and procedure for "Required Emergency Equipment:□ 4.1 Policy C. The following equipment will be maintained in the Surgical Services Department: 7. tracheostomy set.□	A 956	**Hollywood** **Corrective Actions:** Emergency tracheostomy tray prepared and are now available in the OR suites Staff meeting with ORT was held immediately on March 25, 2014 include review of Policy Required Emergency Equipment and the need to ensure a tracheostomy tray is prepared and available in OR suites**(157, 157a)** **Date of Implementation:** March 27, 2014 **Monitoring Process:** Monitoring will be managed through daily rounds by OR lead tech to ensure all supplies are accounted for and readily available and to include in EOC rounds **Person Responsible:** ORT, Nursing leadership & EOC members	3/25/2014 3/27/2014

RESPONSE TO DEFICIENCIES
EXHIBIT P CMS Statements of Deficiency

Nix Health System

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

1100 West 49th Street • Austin, Texas 78756
P.O. Box 149347 • Austin, Texas 78714-9347
1-888-963-7111 • www tiqlts.state.tx.us

KIRK COLE
INTERIM COMMISSIONER

2303 SE Military Dr. Bldg. 514
San Antonio, Texas 78223

November 13, 2015

Administrator
Nix Health Care System
414 Navarro, Suite 600
San Antonio, TX 78205

Dear Administrator:

Enclosed is the CMS-2567 Statement of Deficiencies and Plan of Correction Forms for federal deficiencies and the State forms for State deficiencies cited during a Health Survey conducted at your facility on October 29, 2015. Please type your plans of correction and proposed completion dates on the enclosed forms. Your signature is required on page one of each set of deficiencies. The enclosed forms need to be returned to this office within ten days from the date of receipt. Please keep a copy of the forms for your files.

On the enclosed list of deficiencies, please follow these instructions:

1. Enter on the form provided a plan of correction for each deficiency cited; please assure that each plan of correction clearly indicates the corrective action to be taken; rebuttals to or explanations for the deifciencies cannot be construed as acceptable plans of correction; proper names cannot be used. Please include the mechanism for monitoring to assure compliance.
2. The plan should address improving the processes that led to the deficiency cited.
3. The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited.
4. A completion date of correction for each deifciency cited must be included.
5. The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

6. The plan must include the title of the person responsible for implementing the acceptable plan of correction. DO NOT use proper names.
7. Enter a date of completion for each deifciency.
5. Return the completed plans of correction to this office by email, fax or mail.

Please note acceptance of a plan of correction to any alleged noncompliance does not preclude a proposal to assess administrative penalties and/or to otherwise take disciplinary action for that or any alleged noncompliance.

Should you have any questions, please call me at 210-531-4532. Thank you for your cooperation.

Sincerely,

Mr. Larrie Collier, Program Administrator
Health Facility Compliance Division

Enclosure

CMS-2567 Forms

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ B. WING _____	10/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	44 14 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY R LSC IDENTIFYING INFORMATION)	ID PREFIX 1 TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS	A 0001		

Note: The CMS-2567 (Statement of Deficiencies) , is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation (s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (01G) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately.

An unannounced full survey was conducted on site. An entrance conference was held with the hospital delegated-representatives the morning of ! 10/26/15. The hospital delegated-representatives were informed this survey would be conducted according to the survey protocol in the State Operations Manual, Chapter 5, section 5100 and Appendix A, and according to 42 CFR 482 the Conditions of Participation for Hospitals.

Survey findings were presented at an exit conference on the afternoon of 10/29/15 with hospital delegated-representatives. The preliminary survey findings were presented and facility staff were given the opportunity to ask questions and provide additional information.

A 454	482.24(c)(2) CONTENT OF RECORD: ORDERS DATED & SIGNED All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner who is responsible for the care of the patient only if such a practitioner is acting in accordance with State	A 454	1. Policy will be updated to reflect 96 hours as time frame for authentication 2. Flags for the charts will be placed in all nursing units for nurses to use during the 12 and 24 hour chart check	11/27/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | ((6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufifcient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDERSUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ B. WING _____	10/29/2015

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A 454	Continued From page 1 law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure all orders, including verbal and telephone orders were authenticated promptly by the ordering practitioner or by another practitioner who was responsible for the care of the Patient in accordance with State law, Hospital policies, and medical staff by laws, rules, and regulations for 5 of 21 patient records reviewed (#1, #2, #3, #9, and #12). This deficient practice could affect the authenticity and accuracy of Patients verbal and telephone orders taken and transcribed by others that require authentication by physician signature. Findings included: Review of the facility's Medical Staff By Laws approved 05/31/13, and Medical Staff Rules and Regulations revealed the following: , 'Telephone/Verbal ord rs must be authenticated within 48 hours" from the time of order. Patient #1 Record review on 10/28/15 of Patient #1's records revealed he had Telephone/Verbal Physician Orders for medications, g-tube feedings, and discharge orders, during his admission of 09/17/15 to 09/20/15, that were not signed or authenticated by a physician until 10/23/15.	A 454:	3. Education will be conducted with physicians and nursing staff regarding 96 hour compliance 4. Nurses will be instructed on using the flags in the charts during chart checks 5. Directors will conduct weekly audits with the goal of 90% compliance for 96 hour authentication. 6. Results of audits will be reported to PI /Quality, MEC and Governing Board until a sustained compliance of 90% is met for 3 consecutive months. Responsible Person: CNO Quality Director Unit Directors	

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A 464	Continued From page 2 Patient #2 Record review on 10/28/15 of Patient #2's records revealed he had Telephone/Verbal Physician Orders for admission to the facility, a bedside swallow test, a cardiac diet, case management consult, occupational therapy and physical therapy evaluations, and medications, during his admission of 08/07/15 to 08/09/15, that were not signed or authenticated by a physician until 08/27/15. Patient #3 Record review on 10/28/15 of Patient #3's records revealed she had Telephoneverbal Physician Orders for medications and emergency medications for agitation, during her admisson of 08/03/15 to 08/19/15, that were not signed or authenticated by a physician until 09/14/15. Patient #9 Record review on 10/28/15 of Patient #9's records revealed he had TelephoneVerbal Physician Orders for Restraints, Emergency Medications, and Seclusion that had not been signed or authenticated by a physician as of 10/28/15. The following Restraint/Seclusion records were reviewed: 1.) On 10/10/15 at 20:40 Physician A was notified and a Verbal/Telephone Order was obtained for a Physical Restraint for Patient #9 at 20:40. The Restraint/Seclusion Verbal/Telephone Order had not been signed in the area for Physician's Signature to include authentication. 2.) On 10/21/15 at 20:10 Physician B was notified	A 454;		

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A 454	Continued From page 3	A 454		

and Verbal/Telephone Order was obtained for a Mechanical Restraint (Restraint Chair) and Emergency Medications; Ativan and Benadryl to be administered to Patient #9. The Restraint/Seclusion Verbal/Telephone Order had not been signed in the area for Physician's Signature to include authentication.

3.) On 10/22/15 at 1500 Physician C was notified and a Verbal/Telephone Order was obtained for a Physical Hold, Mechanical Restraint (Restraint Chair), and Emergency Medication of Benadryl to be administered to Patient #9. The Restraint/Seclusion Verbal/Telephone Order had not been signed in the area for Physician's Signature to include authentication.

4.) On 10/23/15 at 15:00 Physician C was notified and a Verbal/Telephone Order was obtained for a Physical Hold, Mechanical Restraint (Restraint Chair), Seclusion, and Emergency Medication of Benadryl to be administered to Patient #9. The Restraint/Seclusion Verbal/Telephone Order had not been signed in the area for Physician's Signature to include authentication.

5.) On 10/23/15 at 21:42 Physician C was notified and a Verbal/Telephone Order was obtained for a Physical Hold and Emergency Medication of Benadryl to be administered to Patient #9. The Restraint/Seclusion Verbal/Telephone Order had not been signed in the area for Physician's Signature to include authentication.

6.) On 10/26/15 at 14:50 Physician B was notified and a Verbal/Telephone Order was obtained for a Physical Hold and Emergency Medication of Zyprexa to be administered to Patient #9. The Restraint/Seclusion Verbal/Telephone Order had

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A 454	Continued From page 4	A 454		

not been signed in the area for Physician's Signature to include authentication.

Patient #12

Record review on 10/28/15 of Patient #12's records revealed he was admitted to the facility on 10/22/15. Patient #12's Admission Orders, Medication Orders, and Physician Certification dated 10/22/15 at 00:45 had not been signed or authenticated by a physician as of 10/28/15 (6 days past/144 hours).

Further review of Patient #12's Physician Orders revealed the following Telephone Order (TO) that : had not been signed or authenticated by a physician as of 10/28/15:
10/22/15 at 00:45 TO for the following medications: Tylenol 325 milligrams (mg), Hydroxyzine HCL 25 mg, Loperamide 2mg, Lorazepam (Ativan)1 mg, and milk of magnesium 400 mg.

During an interview on 10/29/15 at 10:40 AM with the facility's Chief Nursing Officer (CNO) and Director of Risk Management confirmed the following Patient records (# **1,** #2 #9, and #12) had Verbal/Telephone Orders that had not been signed or authenticated. The CNO stated that Verbal/Telephone Orders had to be signed within the facility's Policy; By Laws; which was 48 hours from the time of the order. The Director of Risk Management stated that the Psychiatrist would sign their own Restraint/Seclusion Verbal/Telephone Orders when doing rounds and reviewing charts. The Director of Risk Management confirmed that Patient #9 had 6 Restraint/Seclusion Verbal/Telephone Orders that had not been signed or authenticated. The

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A454	Continued From page 5 Director of Risk Management stated there were 3 different Doctors with outstanding Verbal/Telephone Orders and confirmed there was no other method to authenticate other than their signatures.	A 4541		
A 503	482.25(b)(2)(ii) CONTROLLED DRUGS KEPT (LOCKED Drugs listed in Schedules II, Ill, IV, and V of the Comprehensive Drug Abuse Prevention and Control Act of 1970 must be kept locked within a ; secure area. This STANDARD is not met as evidenced by: Based on observation, interviews and record reviews the facility failed to ensure drugs listed in schedules II, Ill, and V of the Comprehensive Drug Abuse Prevention and Control Act were kept locked within a secure area. Findings include: Observations conducted on 10/27/15 from 9:30 a.m. to 12:00 p.m. at the facility's specialty psychiatric hospital revealed the following: An open top red container which was approximately 2 to 3 feet tall was observed in the medication preparation area next to the door leading out to the nurse's station. The medication room door was open/ unlocked. The container was 213 full of various sharps (needles, syringes with liquid in them, suture removal kits, ect ...) and unidentified medications (pills). On the wall behind the container was a hand written note which stated "Not a waste can" In an interview conducted on 10/27/15 at 10:30 a.m., LVN-A stated that she (LVN-A) has voiced concern about the open top container with her	A 503'	1. Process to improve controlled substances involves education of staff regarding securement of Class II, III, IV and V medications and how to return/waste narcotics appropriately. All remaining liquid narcotics will be drawn up and wasted in the sink with running water and two nurses observing/signing off on the waste. 2. Staff will be tested and must pass written test after education with a grade of at least 95%. Staff who do not meet the 95% threshold will have remedial education and retake the test until a satisfactory grade is achieved. 3. 90% of nursing staff will complete the test by Nov 27th with a passing grade. 4. Directors will do observations in the med rooms to ensure compliance with narcotic wasting. Results of audits will be reported to PI /Quality, MEC and Governing Board until a sustained compliance of 90% is met for 3 consecutive months.	

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A 503	A 503 Continued From page 6 manager, because she "got tired of people throwing trash in there (container)." During further i interview, LVN-A further revealed that nursing staff were also disposing of unused narcotic medications in the same open top container. In an interview conducted on 10/27/15 at 10:40 a.m., the Executive Director of the specialty psychiatric hospital confirmed the above findings. Record review of the facility policy entitled Pyxis Drug Administration, Returning, & Wasting, dated November 2003 revealed in part the following: Controlled substances not used must be placed in locked return bin in medstation. If the package is opened, it should be wasted. If the contents of a controlled drug vial or mpule are drawn up and not administered, or partially administered, the contents must be wasted at the pyxis unit and witnessed by another licensed nurse or pharmacist. Wasted controlled medications will be documented via the medstation, flushed in a sink or drain and witnessed by a licensed nurse or pharmacist. Record review of the facility policy entitled Controlled Drugs- Disposition/ Destruction revealed in part the following: * When controlled drugs must be returned, a licensed contract service shall be utilized for the return of products. When controlled drugs cannot be returned to the manufacturer, distributor, or other source of supply, the Director of Pharmacy or designee shall destroy or dispose of these drugs in accordance with current destruction or disposition procedure of the DEA and this state.	A 503	1. Process to improve controlled substances involves education of staff regarding securement of Class II, III, IV and V medications and how to return/waste narcotics appropriately. All remaining liquid narcotics will be drawn up and wasted in the sink with running water and two nurses observing/signing off on the waste. 2. Staff will be tested and must pass written test after education with a grade of at least 95%. Staff who do not meet the 95% threshold will have remedial education and retake the test until a satisfactory grade is achieved. 3. 90% of nursing staff will complete the test by Nov 27th with a passing grade. 4. Directors will do observations in the med rooms to ensure compliance with narcotic wasting. Results of audits will be reported to PI /Quality, MEC and Governing Board until a sustained compliance of 90% is met for 3 consecutive months. Responsible Person: CNO Quality Director Unit Directors	11/27/15

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A 701	! Continued From page 7 482.41(a) MAINTENANCE OF PHYSICAL PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the condition of the overall hospital environment was maintained for the safety and well-being of the patients. The findings include: Observations conducted on 10/27/15 from 9:30 a.m. to 12:00 p.m., at the facility' s Specialty Psychiatric Hospital revealed that the patient bathrooms contained sink faucets with long metal handles. In an interview conducted on 10/27/15 at the time of discovery, the Executive Director of Psychiatric Services revealed that the sink faucets in the facility were not breakaway faucets. On 10/28/15 at 11:15 a.m., observations in the pharmacy revealed: -The pharmacy work counter had chipped paint and exposed plywood, ensuring the counter was no longer a wipe able surface. The face of one cabinet drawer was held together by clear tape. Several of the drawer handles were either missing or loose. -What was described to the surveyor as a portable air conditioning " unit, when the unit is turned on, pools water on the lfoor. - The medication refrigerator had a thick accumulation of dust and debris underneath, with mold observed in the condensation drainage	A 701	1. All sinks in behavioral health units will be retrofitted with appropriate faucet handles to assure a safe environment for this patient population. 2. The pharmacy will have counter tops repaired, air conditioning unit repaired or replaced, and a tiles will be replaced under the refrigerator. Project Authorization will be submitted for approval by 11/30/15. Estimated date for approval and completion of project is 90 days. Counter tops will be refinished by 12/31/15. AC unit was fixed on 11/ 23/15. Work orders for the pharmacy have been placed through maintained to replace floor tile on 11/20/15. 3. Sinks for the behavior health unit will be ordered and changed out by a contractor. Quality Director will round on units to ensure project completion by said date Responsible Person: VP Facilities Management	

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A 701	Continued From page 8 area. Interview with the Director of Pharmacy (DOP) on 10/28/15 at 11:25 a.m. revealed the pharmacy needs a new work counter. The DOP also revealed the water pooling on the floor from the portable air conditioning unit is a problem as it causes mold and a slipping hazard.	A 701		
A 749	482.42(a)(1) INFECTION CONTROL PROGRAM The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop, and implement a system for identifying and controlling infections and communicable diseases within the hospital. The facility failed to: 1.) Ensure staffs were knowledgeable in the use of disinfectant wipes used to disinfect equipment being removed from isolation rooms and 2.) Ensure staffs at the specialty psychiatric hospital disposed of sharps in approved closed top sharps containers for disposal and 3,) Ensure staffs consumed food and/or drinks in approved areas outside the patient care area. Findings included: 1.) Observations conducted on 10/27/15 from 12:30 p.m. to 5:30 p.m. of the medical/ surgical floors revealed the following: Clorox germicidal disinfectant wipes (used for C- Difficille toxin) were not available on the patient care lfoors for staff use.	A 749:	1. ICP produced educational material that address use of disinfectant wipes and dwell time 2. All open sharps containers were removed and replaced with closed top containers on 10/27/15 3. Staff involved were counseled the day of the survey and in-services were conducted with all supervisors. Additionally all staff at the Babcock location will complete a read and sign of the Standard and Transmission Based Precautions by Dec 4, 2015. 1. Instructions for disinfectant wipes were places on all isolation carts on 10/27. Education was conducted at the skills fairs dated 11/3, 11/4, and 11/10. 2. Sharps Containers were replaced on 10/27/15 3. Read and sign with all staff members at Babcock location	1. 2/28/16 2. 10/27/15 3. 12/4/15

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A 749	Continued From page 9 In an interview conducted on 10/27/15 at 4:15 p.m., Registered Nurse (RN)-A stated that if they (staff) receive a patient with C- Difficille (C-Diff) , they have to contact housekeeping services to obtain Clorox germicidal disinfectant wipes, as they are not kept on the floor for use. When asked how long staff waited to remove equipment, which was disinfected with the Clorox wipes, from isolation rooms RN-A stated " Im not sure. " In an interview conducted on 10/27/15 at 4:30 p.m., the facility Chief Nursing Officer (CNO) stated that facility staff should be using Virex wipes to disinfect equipment used in C-Diff isolation rooms. In an interview conducted on 10/27/15 at 4:45 p.m., the facility Infection Control Practitioner revealed that staffs were supposed to be using germicidal Clorox wipes to disinfect C-Diff isolation rooms, with a wait time of **10** minutes before removing any disinfected equipment from isolation rooms. In an interview conducted on 10/27/15 at 5:00 p.m., Certified Nurse' s Aide- A (CNA) stated he routinely disinfects isolation equipment with bleach, but he was not sure how long to wait before removing equipment from the isolation rooms. He further revealed that Clorox wipes were not kept on the patient care lfoors, and that they (Clorox Wipes) must be brought to the floor by housekeeping. In an interview conducted on 10/27/15 at 5:20 p.m. Licensed Vocational Nurse (LVN)-B stated I that he was unsure how long to wait removing equipment from isolation rooms that	A 749	1. ICP will do monthly observation audits to ensure staff are compliant with process for disinfecting equipment. Results of audits will be sent to PI, MEC, and the Board until a sustained compliance of >90% is met for 3 consecutive months. 2. Director of Environment Services doing weekly audits to ensure compliance. Results of audits will be sent to PI, MEC, and the Board until a sustained compliance of >90% is met for 3 consecutive months. 3. Completed read and sign will be sent to Director of Quality and presented at PI/MEC and the Board in December. Responsible person: ICP Environmental Services Director VP BH Services	

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A 7491	Continued From page 10	A 7491		

had been disinfected with the Clorox germicidal wipes. He further stated, " I know it' s less than an hour. "

Record reviews of the facility' s Infection Control Program Plan, dated 2015, revealed in part the following:

VI- Education and Training: Education and training of healthcare workers in infection control interventions that interrupt disease transmission and reduce healthcare associated infection rates.

All new employees received education and training in infection control during general hospital orientation.

Current employees will receive education and training in infection control annually.

The responsibility for staff education falls on the Department Director in close collaboration with the Infection Control Preventionist.

2.) Observations conducted on 10/27/15 from 9:30 a.m. to 12:00 p.m. at the facility's specialty psychiatric hospital revealed the following:

An open top red container which was approximately 2 to 3 feet tall was observed in the medication preparation area next to the door leading out to the nurse ' s station. The medication room door was open/ unlocked. The container was 2/3 full of various sharps (needles, syringes with liquid in them, suture removal kits, ect ...) and unidentified medications (pills). On the wall behind the container was a hand written note which stated " Not a waste can "

In an interview conducted on 10/27/15 at 10:30 a.m., LVN-A stated that she (LVN-A) has voiced I concern about the open top container with her manager, because she " got tired of people

further interview, LVN-A further revealed that

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A 749	Continued From page 11 nursing staff were also disposing of unused narcotic medications in the same open top container. In an interview conducted on 10/27/15 at 10:40 a.m., the Executive Director of the specialty psychiatric hospital confirmed the above findings. 3.) On 10/27/15 at 10:40 am. during a tour of the facility's specialty psychiatric hospital , a facility staff member was observed "squatting" in the work area hallway eating what was observed to be a candy bar. Several patients were walking ! around the staff member. Interview on 10/27/15 at 11:30 am. with the facility Vice President of Clinical Services of Behavioral Services confirmed the facility staff member was employed by the facility. The staff revealed to her "he was eating a breakfast bar, not a candy bar." Further interview confirmed the staff should not have been eating in the hallway. When asked if the facility had a policy in regards to staff not eating or drinking at their work , stations, the facility stated they did not have a policy. But handed the surveyor the following print out from Occupational Safety and Health Administration (OSHA) regulations: " OSHA/Blood Borne Pathogen Regulations Policy 1910.1030" stated in part "OSHA's blood borne pathogens standard prohibits the consumption of food and drink in areas in which work involving exposure or potential exposure to blood or other potentially infectious material place, or where the potential for contamination of work surfaces exist."	A 749		

SODState Forms

Texas Department of State Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000415	A. BUILDING: _____ B. WING _____	**10/29/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	**414 NAVARRO, SUITE** 600 **SAN ANTONIO, TX** 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
X 000	**INITIAL COMMENTS** Note: The State Form is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be referred to the Office of the Texas Attorney General (OAG) for possible fraud. If information is inadvertently changed by the provider/supplier the State Survey Agency (SA) should be notified immediately. An unannounced licensure inspection was conducted on site. An entrance conference was held with the hospital delegated-representatives the morning of 10/26/15. The hospital delegated-representatives were informed this survey would be conducted according to the Texas Administrative Code (TAC), Chapter 133. Survey findings were presented at an exit conference on the afternoon of 10/29/15 with hospital delegated-representatives. The preliminary survey findings were presented and facility staff were given the opportunity to ask questions and provide additional information.	**X** 000		
X 241	133.41(g) infection Control Infection control. There shall be an active program for the prevention, control, and surveillance of infections and communicable diseases.	X 241	1. ICP produced educational material that address use of disinfectant wipes and dwell time 2. All open sharps containers were removed and replaced with closed top containers on 10/27/15 3. Staff involved were counseled the day of the survey and in-services were conducted with all supervisors. Additionally all staff at the Babcock location will complete a read and sign of the Standard and Transmission Based Precautions by Dec 4, 2015.	1. 2/28/16 2. 10/27/15 3. 12/4/15

SOD - State Form
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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X 2414	Continued From page 1 ThisRequirement isnot metasevidencedby: easedonobservationinterviewsandrecord reviews the facility failed to ensure drugs listed in schedules II, III, and V of the Comprehensive Drug Abuse Prevention and Control Act were kept locked within a secure area. Findings include: Observations conducted on 10/27/15 from 9:30 a.m. to 12:00 p.m. at the facility' s specialty psychiatric hospital revealed the following: An open top red container which was approximately 2 to 3 feet tall was observed in the medication preparation area next to the door leading out to the nurse's station. The medication room door was open/ unlocked. The container was 2/3 full of various sharps (needles, syringes with liquid in them, suture removal kits, ect ...) and unidentified medications (pills). On the wall behind the container was a hand written note which stated "Not a waste can" In an interview conducted on 10/27/15 at 10:30 a.m., LVN-A stated that she (LVN-A) has voiced concern about the open top container with her manager, because she "got tired of people throwing trash in there (container)." During further interview, LVN-A further revealed that nursing staff were also disposing of unused narcotic medications in the same open top container. In an interview conducted on 10/27/15 at 10:40 a.m., the Executive Director of the specialty psychiatric hospital confirmed the above findings. Record review of the facility policy entitled Pyxis Drug Administration, Returning, & Wasting, dated November 2003 revealed in part the following: Controlled substances not used must be	X241	1. Instructions for disinfectant wipes were places on all isolation carts on 10/27. Education was conducted at the skills fairs dated 11/3, 11/4, and 11/10. 2. Sharps Containers were replaced on 10/27/15 3. Read and sign with all staff members at Babcock. 1. ICP will do monthly observation audits to ensure staff are compliant with process for disinfecting equipment. Results of audits will be sent to PI, MEC, and the Board until a sustained compliance of >90% is met for 3 consecutive months. 2. Director of Environment Services doing weekly audits to ensure compliance. Results of audits will be sent to PI, MEC, and the Board until a sustained compliance of >90% is met for 3 consecutive months. 3.Completed read and sign will be sent to Director of Quality and presented at PI/MEC and the Board in December. Location. Responsible Person: ICP Environmental Services Director VP BH Services	

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X241	Continued From page 2 placed in locked return bin in medstation. If the package is opened, it should be wasted. If the contents of a controlled drug vial or ampule are drawn up and not administered, or partially administered, the contents must be wasted at the Pyxis unit and witnessed by another licensed nurse or pharmacist. Wasted controlled medications will be documented via the medstation, flushed in a sink or drain and witnessed by a licensed nurse or pharmacist. Record review of the facility policy entitled Controlled Drugs- Disposition/ Destruction revealed in part the following: When controlled drugs must be returned, a licensed contract service shall be utilized for the return of products. When controlled drugs cannot be returned to the manufacturer, distributor, or other source of supply, the Director of Pharmacy or designee shall destroy or dispose of these drugs in accordance with current destruction or disposition procedure of the DEA and this state. Based on observation, interview and record review, the facility failed to develop, and implement a system for identifying and controlling infections and communicable diseases within the hospital. The facility failed to: 1.) Ensure staffs were knowledgeable in the use of disinfectant wipes used to disinfect equipment 1 being removed from isolation rooms and 2.) Ensure staffs at the specialty psychiatric hospital disposed of sharps in approved closed	X241		

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X 241	Continued From page 3 top sharps containers for disposal and 3,) Ensure staffs consumed food and/or drinks in approved areas outside the patient care area. Findings included: 1.) Observations conducted on 10/27/15 from 12:30 p.m. to 5:30 p.m. of the medical/ surgical floors revealed the following: Clorox germicidal disinfectant wipes (used for C- Difficille toxin) were not available on the patient care floors for staff use. In an interview conducted on 10/27/15 at 4:15 p.m., Registered Nurse (RN)-A stated that if they (staff) receive a patient with C- Difficille (C-Diff) they have to contact housekeeping services to obtain Clorox germicidal disinfectant wipes, as they are not kept on the floor for use. When asked how long staff waited to remove equipment, which was disinfected with the Clorox wipes, from isolation rooms RN-A stated " Im not sure. " In an interview conducted on 10/27/15 at 4:30 p.m., the facility Chief Nursing Officer (CNO) stated that facility staff should be using Virex wipes to disinfect equipment used in C-Diff isolation rooms. In an interview conducted on 10/27/15 at 4:45 p.m., the facility Infection Control Practitioner revealed that staffs were supposed to be using germicidal Clorox wipes to disinfect C-Diff isolation rooms, with a wait time of 10 minutes before removing any disinfected equipment from isolation rooms. In an interview conducted on 10/27/15 at 5:00 p.m., Certified Nurse ' s Aide- A (CNA) stated he routinely disinfects isolation equipment with bleach, but he was not sure how long to wait	X 241		

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X 241	Continued From page 4	X 241		

before removing equipment from the isolation rooms, He further revealed that Clorox wipes were not kept on the patient care floors, and that they (Clorox Wipes) must be brought to the floor by housekeeping.

In an interview conducted on 10/27/15 at 5:20 p.m. Licensed Vocational Nurse (LVN)-B stated that he was unsure how long to wait before removing equipment from isolation rooms that had been disinfected with the Clorox germicidal wipes. He further stated, " I know it' s less than an hour. "

Record reviews of the facility' s Infection Control Program Plan, dated 2015, revealed in part the following:

VI- Education and Training: Education and training of healthcare workers in infection control interventions that interrupt disease transmission and reduce healthcare associated infection rates.

All new employees received education and training in infection control during general hospital orientation.

Current employees will receive education and training in infection control annually.

The responsibility for staff education falls on the Department Director in close collaboration with the Infection Control Preventionist.

2.) Observations conducted on **10/27/15** from 9:30 a.m. to 12:00 p.m. at the facility's specialty psychiatric hospital revealed the following:

An open top red container which was approximately 2 to 3 feet tall was observed in the medication preparation area next to the door leading out to the nurse ' s station. The medication room door was open/ unlocked. The container was 2/3 full of various sharps (needles, syringes with liquid in them, suture removal kits,

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X 241	Continued From page 5	X 241		

ect ...) and unidentified medications (pills). On the wall behind the container was a hand written note which stated " Not a waste can "
In an interview conducted on 10/27/15 at 10:30 a.m., LVN-A stated that she (LVN-A) has voiced concern about the open top container with her manager, because she " got tired of people throwing trash in there (container). " During further interview, LVN-A further revealed that nursing staff were also disposing of unused narcotic medications in the same open top container.

In an interview conducted on 10/27/15 at 10:40 a.m., the Executive Director of the specialty psychiatric hospital confirmed the above findings.

3.) On 10/27/15 at 10:40 a.m. during a tour of the facility's specialty psychiatric hospital , a facility staff member was observed "squatting" in the work area hallway eating what was observed to be a candy bar. Several patients were walking around the staff member.

Interview on 10/27/15 at 11:30 a.m. with the facility Vice President of Clinical Services of Behavioral Services confirmed the facility staff member was employed by the facility. The staff revealed to her "he was eating a breakfast bar, not a candy bar." Further interview confirmed the staff should not have been eating in the hallway.

When asked if the facility had a policy in regards to staff not eating or drinking at their work stations, the facility stated they did not have a policy. But handed the surveyor the following print out from Occupational Safety and Health Administration (OSHA) regulations:

" OSHA/Blood Borne Pathogen Regulations

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X 241	Continued From page 6 Policy 1910.1030" stated in part "OSHA's blood borne pathogens standard prohibits the consumption of food and drink in areas in which work involving exposure or potential exposure to blood or other potentially infectious material place, or where the potential for contamination of work surfaces exist."	X 241		
X 288	133.41(j)(7) Authentication of entries ; Medical record services. The hospital shall have a medical record service that has administrative responsibility for medical records. A medical record shall be maintained for every individual who presents to the hospital for evaluation or treatment. All verbal orders must be dated, timed, and authenticated within 96 hours by the prescriber or another practitioner who is responsible for the care of the patient and has been credentialed by the medical staff and granted privileges which are consistent with the written orders.	X 288	1. Policy will be updated to reflect 96 hours as time frame for authentication 2. Flags for the charts will be placed in all nursing units for nurses to use during the 12 and 24 hour chart check 1.Education will be conducted with physicians and nursing staff regarding 96 hour compliance 2. Nurses will be instructed on using the flags in the charts during chart check. Directors will conduct weekly audits with the goal of 90% compliance with 96 hour authentication. Results of audits will be reported to PI /Quality, MEC and Governing Board until a sustained compliance of 90% is met for 3 consecutive months. Responsible Person: CNO Quality Director Unit Directors	11/27/2015

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X 288	Continued From page 7	X 288		

This Requirement is not met as evidenced by:
Based on record review and interview, the facility failed to ensure all orders, including verbal and telephone orders were authenticated promptly by the ordering practitioner or by another practitioner who was responsible for the care of the Patient in accordance with State law, Hospital policies, and medical staff by laws, rules, and regulations for 5 of 21 patient records reviewed (#1, #2, #3, #9, and #12).

This deficient practice could affect the authenticity and accuracy of Patients verbal and telephone orders taken and transcribed by others that require authentication by physician signature.

Findings included:

Review of the facility's Medical Staff By Laws approved 05/31/13, and Medical Staff Rules and Regulations revealed the following: , "TelephoneNerbal orders must be authenticated within 48 hours" from the time of order.

Patient #1

Record review on 10/28/15 of Patient #1's records revealed he had TelephoneNerbal

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X 288	Continued From page 8 Physician Orders for medications, g-tube feedings, and discharge orders, during his admission of 09/17/15 to 09/20/15, that were not signed or authenticated by a physician until 10/23/15. Patient #2 Record review on 10/28/15 of Patient #2's records revealed he had Telephone/Verbal Physician Orders for admission to the facility, a beside swallow test, a cardiac diet, case management consult, occupational therapy and physical therapy evaluations, and medications, during his admission of 08/07/15 to 08/09/15, that were not signed or authenticated by a physician until 08/27/15. Patient #3 Record review on 10/28/15 of Patient #3's records revealed she had TelephoneNerbal Physician Orders for medications and emergency medications for agitation, during her admisson of 08/03/15 to 08/19/15, that were not signed or authenticated by a physician until Patient #9 Record review on 10/28/15 of Patient #9's records revealed he had TelephoneNerbal Physician Orders for Restraints, Emergency Medications, and Seclusion that had not been signed or authenticated by a physician as of 10/28/15. The following Restraint/Seclusion records were reviewed: 1.) On 10/10/15 at 20:40 Physician A was notified and a Verbal/Telephone Order was obtained for a Physical Restraint for Patient #9 at 20:40. The	X 288		

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X 288	Continued From page 9 Restraint/Seclusion Verbal/Telephone Order had not been signed in the area for Physician's Signature to include authentication. 2.) On 10/21/15 at 20:10 Physician B was notified and a Verbal/Telephone Order was obtained for a Mechanical Restraint (Restraint Chair) and Emergency Medications; Ativan and Benadryl to be administered to Patient #9. The Restraint/Seclusion Verbal/Telephone Order had not been signed in the area for Physician's Signature to include authentication. 3.) On 10/22/15 at 1500 Physician C was notified and a Verbal/Telephone Order was obtained for a Physical Hold, Mechanical Restraint (Restraint Chair), and Emergency Medication of Benadryl to be administered to Patient #9. The Restraint/Seclusion Verbal/Telephone Order had not been signed in the area for Physician's Signature to include authentication. 4.) On 10/23/15 at 15:00 Physician C was notified and a Verbal/Telephone Order was obtained for a Physical Hold, Mechanical Restraint (Restraint Chair), Seclusion, and Emergency Medication of Benadryl to be administered to Patient #9. The Restraint/Seclusion Verbal Telephone Order had not been signed in the area for Physician's Signature to include authentication. 5.) On 10/23/15 at 21:42 Physician C was notified and a Verbal Telephone Order was obtained for a Physical Hold and Emergency Medication of Benadryl to be administered to Patient #9. The Restraint/Seclusion Verbal/Telephone Order had not been signed in the area for Physician's Signature to include authentication. 6.) On 10/26/15 at 14:50 Physician B was notified	1 X 288		

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X 288	Continued From page 10	X 288		

and a Verbal/Telephone Order was obtained for a Physical Hold and Emergency Medication of Zyprexa to be administered to Patient #9. The Restraint/Seclusion Verbal/Telephone Order had not been signed in the area for Physician's Signature to include authentication.

Patient #12

Record review on 10/28/15 of Patient #12's records revealed he was admitted to the facility on 10/22/15. Patient #12's Admission Orders, Medication Orders, and Physician Certification dated 10/22/15 at 00:45 had not been signed or authenticated by a physician as of 10/28/15 (6 days past/144 hours).

Further review of Patient #12's Physician Orders revealed the following Telephone Order (TO) that had not been signed or authenticated by a physician as of 10/28/15:
10/22/15 at 00:45 TO for the following medications: Tylenol 325 milligrams (mg), Hydroxyzine HCL 25 mg, Loperamide 2mg, Lorazepam (Ativan)1 mg, and milk of magnesium 400 mg.

During an interview on 10/29/15 at 10:40 AM with the facility's Chief Nursing Officer (CNO) and Director of Risk Management confirmed the following Patient records (# 1, #2 #9, and #12) had Verbal/Telephone Orders that had not been signed or authenticated. The CNO stated that Verbal/Telephone Orders had to be signed within the facility's Policy; By Laws; which was 48 hours from the time of the order, The Director of Risk Management stated that the Psychiatrist would sign their own Restraint/Seclusion Verbal/Telephone Orders when doing rounds and reviewing charts. The Director of Risk

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X 288	Continued From page 11 Management confirmed that Patient #9 had 6 Restraint/Seclusion Verbal/Telephone Orders that had not been signed or authenticated. The Director of Risk Management stated there were 3 different Doctors with outstanding VerbaliTelephone Orders and confirmed there was no other method to authenticate other than their signatures.	X 288		
X 466	133.41(05) Control and distribution Pharmacy Services. Delivery of Services. In order to provide patient safety, drugs and biologicals shall be controlled and distributed in accordance with applicable standards of practice, consistent with federal and state laws. This Requirement is not met as evidenced by: Based on observation, interviews and record reviews the facility failed to ensure drugs listed in schedules II, Ill, and V of the Comprehensive Drug Abuse Prevention and Control Act were kept locked within a secure area. Findings include: Observations conducted on 10/27/15 from 9:30 a.m. to 12:00 p.m. at the facility' s specialty psychiatric hospital revealed the following: An open top red container which was approximately 2 to 3 feet tall was observed in the 1 medication preparation area next to the door	X 466	1. Process to improve controlled substances involves education of staff regarding securement of Class II, III, IV and V medications and how to return/waste narcotics appropriately. All remaining liquid narcotics will be drawn up and wasted in the sink with running water and two nurses observing/signing off on the waste. 1. Staff will be tested and must pass written test after education with a grade of at least 95%. Staff who do not meet the 95% threshold will have remedial education and retake the test until a satisfactory grade is achieved. 1. 90% of nursing staff will complete the test by Nov 27th with a passing grade. 2. Directors will do observations in the med rooms to ensure compliance with narcotic wasting. Results of audits will be reported to PI /Quality, MEC and Governing Board until a sustained compliance of 90% is met for 3 consecutive months. Responsible person: CNO Quality Director Unit Directors	11/27/15

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X 466	Continued From page 12	X 465		

leading out to the nurse's station. The medication room door was open/ unlocked. The container was 2/3 full of various sharps (needles, syringes with liquid in them, suture removal kits, eet ...) and unidentified medications (pills). On the wall behind the container was a hand written note which stated "Not a waste can"

in an interview conducted on 10/27/15 at 10:30 a.m., LVN-A stated that she (LVN-A) has voiced concern about the open top container with her manager, because she "got tired of people throwing trash in there (container)." During further interview, LVN-A further revealed that nursing staff were also disposing of unused narcotic medications in the same open top container.

In an interview conducted on 10/27/15 at 10:40 a.m., the Executive Director of the specialty psychiatric hospital confirmed the above findings.

Record review of the facility policy entitled Pyxis Drug Administration, Returning, & Wasting, dated November 2003 revealed in part the following:

Controlled substances not used must be placed in locked return bin in medstation. If the package is opened, it should be wasted.

If the contents of a controlled drug vial or ampule are drawn up and not administered, or partially administered, the contents must be wasted at the pyxis unit and witnessed by another licensed nurse or pharmacist.

Wasted controlled medications will be documented via the medstation, flushed in a sink or drain and witnessed by a licensed nurse or pharmacist.

Record review of the facility policy entitled Controlled Drugs- Disposition/ Destruction revealed in part the following:

When controlled drugs must be returned, a

Texas Department of State Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(Xi) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000415	A. BUILDING: _____ B. WING _____	10/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 70205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
X 466	Continued From page 13 licensed contract service shall be utilized for the return of products. When controlled drugs cannot be returned to the manufacturer, distributor, or other source of supply, the Director of Pharmacy or designee shall destroy or dispose of these drugs in accordance with current destruction or disposition procedure of the DEA and this state.	X 466		
X1036	133.47(c)(2) Posting requirements Abuse And Neglect Issues. Abuse and neglect of individuals with mental illness, and illegal, unethical, and unprofessional conduct. The requirements of this subsection are in addition to the requirements of subsection (b) of this section. Posting requirements. A facility shall prominently and conspicuously post for display in a public area that is readily visible to patients, residents, volunteers, employees, and visitors a statement of the duty to report abuse and neglect, or illegal, unethical or unprofessional conduct in accordance with HSC, §161.132(e). The statement shall be in English and in a second language appropriate to the demographic makeup of the community served and contain the number of the department's patient information and complaint line at (888) 973-0022. This Requirement is not met as evidenced by: Based on observation and interview, the facility	X1036	1. Temporary signage with required elements regarding the duty to report abuse and neglect, or illegal, unethical or unprofessional conduct with the TDSHS patient information and complaint phone number was placed throughout the system 10/25 - 10/27. 2. Formal permanent signs will replace temporary signs in all waiting areas, elevator landings and admitting by December 4, 2015. Formal permanent signs will be ordered by VP of Plant Operations and replace temporary signs in all waiting areas, all waiting areas, elevator landings and admitting by December 4, 2015. Director of Quality will do walking rounds to ensure all new signs are in place by required date. Responsible Person: VP Facilities Management	12/4/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000415	A. BUILDING: _____ B. WING _____	10/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	4 14 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
X1036	Continued From page 14 failed to prominently and conspicuously post for display in a public area that is readily visible to patients, residents, volunteers, employees, and visitors; a statement of the duty to report abuse and neglect, or illegal,unethical or unprofessional conduct in accordance with the Texas Health and Safety Code (HSC), and ensure the statement contains the number of the department's patient information and complaint line at (888) 973-0022. This deficient practice affected the rights of Patients Findings included: Observation conducted on 10/26/15 at 2:25 PM in the facility's emergency room of the facility's lobby/waiting area revealed a poster of Patient's Rights dated 09/01/2013. The posting failed to contain a statement of the duty to report abuse and neglect, or illegal, unethical or unprofessional conduct in accordance with the HSC §161.132(e); and failed to ensure it contained the number of the Texas Department of State Health Services patient information and complaint line at (888) 973-0022. Further observation conducted on 10/26/15 at 3:00 PM in the facility admission area did not reveal a posting of the department's (DSHS) patient information and complaint line phone number, or a statement of the duty to report abuse and neglect, or illegal, unethical or unprofessional conduct in accordance with the HSC §161.132(e). Continued observation conducted on 10/27/15 at 10:30 AM in the facility outpatient clinic and outpatient rehabilitation area did not reveal a	X1036		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDERSUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000415	A. BUILDING: _____ B. WING _____	10129/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	4 14 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

	SUMMARY STATEMENT OF DEFICIENCIES	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
X1036	Continued From page 15 posting of the department's (DSHS) patient information and complaint line phone number, or a statement of the duty to report abuse and neglect, or illegal, unethical or unprofessional conduct in accordance with the HSC §161.132(e). During an interview on 10/27/15 at 12:30 PM with the facility's Director of Performance Improvement confirmed the department's (DSHS) patient information and complaint line phone number (888-973-0022) were not posted in the facility or a statement of the duty to report abuse and neglect, or illegal, unethical or unprofessional i conduct in accordance with the HSC §161.132(e).	X1036

November 16, 2015

Jeanette Salinas
Patient Quality Care Unit
Health Care Quality Section
Texas Department of State Health Services
2303 SE Military Dr. Bldg. 514
San Antonio, TX 78223

Re: Provider Number 450130
Complaint Number TX00223777

Dear Ms. Salinas:

We acknowledge receipt of your letter in regards to the result of a survey conducted by Texas Department of State Health Services on October 28, 2015 at Nix Health Care System.

We look forward to continuing to work with you in the administration of the Medicare Program.

Sincerely,

Joseph W. Rafferty, Interim CEO

cc: Larrie Collier, Program Administrator

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

DAVID L. LAKEY, M.D.
COMMISSIONER

1100 West 49th Street • Austin, Texas 78756
P.O. Box 149347 • Austin, Texas 78714-9347
1-888-963-7111 • www.dshs.state.tx.us

2303 SE Military Dr. Bldg. 514
San Antonio, Texas 78223

November 13, 2015

Administrator
Nix Health Care System
414 Navarro, Suite 600
San Antonio, TX 78205

Re: Provider Number 450130
Complaint Number TX00223777

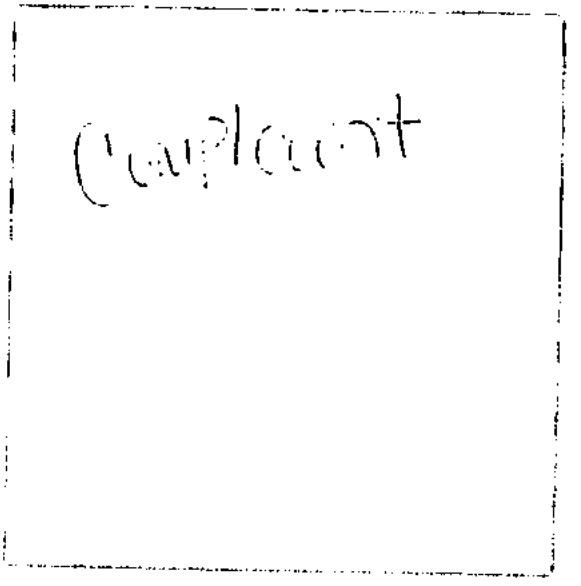
Dear Administrator:

I am pleased to inform you that as a result of the Texas Department of State Health Services substantial allegation survey conducted on **October 28, 2015, Nix Health Care System** was found in compliance with the applicable Medicare Conditions of Participation. We thank you for your cooperation and look forward to working with you on a continuing basis in the administration of the Medicare program. If you have any questions please contact Mr. Larrie Collier, Program Administrator, at 210-531-4532.

Sincerely,

Jeanette Salinas
Patient Quality Care Unit
Health Care Quality Section
Texas Department of State Health Services

CMS-2567 Forms



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ B. WING _____	C 10/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation (s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. An unannounced complaint survey (TX 00223777) was conducted on site. An entrance conference was held with the hospital delegated-representatives the morning of 10/26/15. The hospital delegated-representatives were informed of the purpose and process of the complaint survey with an opportunity for questions was provided. Complaint TX 00223777 was unsubstantiated. Complaint survey findings were presented at an exit conference on the afternoon of 10/29/15 with hospital delegated-representatives. The preliminary survey findings were presented and facility staff were given the opportunity to ask questions and provide additional information.	A 000		

Joseph W. Rafferty — Interim CEO — 11/17/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

SOD-State Forms

Texas Department of State Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000415	A. BUILDING: _____ B. WING _____	C 10/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
X 000	INITIAL COMMENTS Note: The State Form is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be referred to the Office of the Texas Attorney General (OAG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. An unannounced complaint survey (TX 00223777) was conducted on site. An entrance conference was held with the hospital delegated-representatives the morning of 10/26/15. The hospital delegated-representatives were informed of the purpose and process of the complaint survey with an opportunity for questions was provided. Complaint TX 00223777 was unsubstantiated. Complaint survey findings were presented at an exit conference on the afternoon of 10/29/15 with hospital delegated-representatives. The preliminary survey findings were presented and facility staff were given the opportunity to ask questions and provide additional information.	X 000		

Joseph W. Rafferty — Interim CEO — 11/17/15

SOD - State Form
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

November 16, 2015

Mr. Larrie Collier
Program Administrator
Health Facility Compliance Division
Texas Department of State Health Services
2303 SE Military Dr. Bldg. 514
San Antonio, TX 78223

Re: CMS-2567

Dear Mr. Collier:

We acknowledge receipt of your letter in regards to the result of a health survey conducted by Texas Department of State Health Services on October 27, 2015 at Nix Health Care System. We are submitting the signature page as requested.

We look forward to continuing to work with you in the administration of the Medicare Program.

Sincerely,

Joseph W. Rafferty, Interim CEO

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

KIRK COLE
INTERIM COMMISSIONER

1100 W. 49th Street • Austin, Texas 78756
1-888-963-7111 • http://www.dshs.state.tx.us

Health Facility Licensing and Compliance Division
2303 SE Military Dr. Bldg. 514
San Antonio, Texas 78223

11/13/2015

Administrator
Nix Health Care System
, 414 Navarro, Suite 600
San Antonio, TX 78205

Dear Administrator:

Enclosed is the CMS-2567 Statement of Deficiencies Plan of Correction form indicating no deficiencies were cited as a result of a Health Survey conducted at your facility on October 27, 2015. Your signature is required on page one. The enclosed form needs to be returned to this office within ten (10) days of receipt of this letter. You may keep a copy for your files.

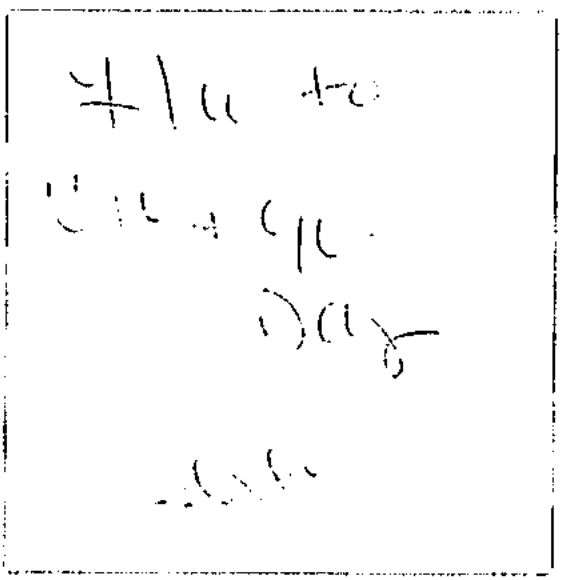
Should you have any questions, please contact me at 210-531-4532. Thank you for your cooperation.

Sincerely,

Mr. Larrie Collier, Program Administrator
Health Facility Compliance Division

Enclosure

CMS-2567 Forms



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ B. WING _____	R-C 10/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 000}	INITIAL COMMENTS The CMS - 2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates and the signature space. Any discrepancy in the original deficiency citation (s) will be reported to Dallas Regional Office (RO) for referral to the Office of Inspector General (OIG) for possible fraud if information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. An unannounced follow up survey visit was conducted from 10/26/15 to 10/27/15 to conduct the follow-up survey for complaint investigation (TX 00218998). An entrance conference was conducted on 10/26/15 in the conference room of the facility with the hospital delegated administrative staff. The purpose and process of the follow-up survey were discussed and an opportunity for questions was provided. An exit conference was conducted on 10/29/15 in the conference room. The hospital delegated administrative staff were in attendance. Preliminary findings of this survey were discussed and an opportunity for questions was provided.	{A 000}		

Joseph W. Rafferty — Interim CED — 11/17/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
450130	A. Building B. Wing	10/27/2015

Name of Facility	Street Address, City, State, Zip Code
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix A0115 Reg. # 482.13 LSC	Correction Completed 10/27/2015	ID Prefix A0145 Reg. # 482.13(c)(3) LSC	Correction Completed 10/27/2015	ID Prefix A0392 Reg. # 482.23(b) LSC	Correction Completed 10/27/2015
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date: 10/27/15
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 8/10/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

SOD-State Forms

Texas Department of State Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000415	A. BUILDING: _____ B. WING _____	R-C 10/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{X 000}	INITIAL COMMENTS Note: The State Form is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be referred to the Office of the Texas Attorney General (OAG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. An unannounced follow up survey visit was conducted from 10/26/15 to 10/27/15 to conduct the follow-up survey for complaint investigation (TX 00218998). An entrance conference was conducted on 10/26/15 in the conference room of the facility with the hospital delegated administrative staff. The purpose and process of the follow-up survey were discussed and an opportunity for questions was provided. An exit conference was conducted on 10/29/15 in the conference room. The hospital delegated administrative staff were in attendance. Preliminary findings of this survey were discussed and an opportunity for questions was provided.	{X 000}		

Joseph W. Rafferty — Interim CEO — 11/17/15

SOD - State Form
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Texas Department of State Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000415	A. BUILDING: _____ B. WING _____	R-C 10/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
(Y 000)	25 TAC 134 INITIAL COMMENTS Note: The State Form is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be referred to the Office of the Texas Attorney General (OAG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. An unannounced follow up survey visit was conducted from 10/26/15 to 10/27/15 to conduct the follow-up survey for complaint investigation (TX 00218998). An entrance conference was conducted on 10/26/15 in the conference room of the facility with the hospital delegated administrative staff. The purpose and process of the follow-up survey were discussed and an opportunity for questions was provided. An exit conference was conducted on 10/29/15 in the conference room. The hospital delegated administrative staff were in attendance. Preliminary findings of this survey were discussed and an opportunity for questions was provided.	(Y 000)		

SOD - State Form

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
000415	A. Building B. Wing	10/27/2015

Name of Facility	Street Address, City, State, Zip Code
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Y0313 Reg. # 134.46(c)(3)(A) LSC	Correction Completed 10/27/2015	ID Prefix Y0523 Reg. # 404.154(24) LSC	Correction Completed 10/27/2015	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor: Laura Longoria	Date: 10/27/15
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 8/10/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
000415	A. Building B. Wing	10/27/2015

Name of Facility	Street Address, City, State, Zip Code
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix X0365 Reg. # 133.41(o)(2)(B) LSC	Correction Completed 10/27/2015	ID Prefix X0794 Reg. # 133.42(a)(1) LSC	Correction Completed 10/27/2015	ID Prefix X1037 Reg. # 133.47(c)(3)(A) LSC	Correction Completed 10/27/2015
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By _____ State Agency	Reviewed By	Date:	Signature of Surveyor: Laura Longoria	Date: 10/27/15
Reviewed By _____ CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 8/10/2015

_____ Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

nix

Terry J. Fontenot, FACHE
Chief Executive Officer
Nix Health Care System

October 1, 2015

Larrie Collier, MPA
HFC Manager-San Antonio Zone
Patient Quality Care Unit
Texas Department of State Health Services

via email: larrie.collier@dshs.state.tx.us

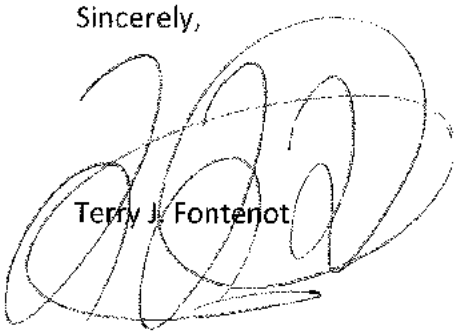
Re: CCN 450130, Intake #TX00218998

Dear Mr. Collier:

Please accept the following pages as the Nix Health Care System plan of correction for deficiencies cited during our August 10, 2015 complaint survey conducted by Texas Department of State Health Services, sent by email to: larrie.collier@dshs.state.tx.us.

Please confirm receipt by return email to: terryjfontenot@nixhealth.com, when you have received these items so we may preserve for our records.

Sincerely,



Terry J. Fontenot

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	460130	A. BUILDING _____ B. WING _____	8/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
A 000	INITIAL COMMENTS The CMS - 2567 (Statement of Deficiencies) is an official, legal document. AU information must remain unchanged except for entering the plan of correction, correction dates and the signature space. Any discrepancy in the original deficiency citation (s) will be reported to Dallas Regional Office (RO) for referral to the Office of Inspector General (010) for possible fraud if information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. An unannounced visit was conducted from 08/06/15 to 08/10/15 to conduct a survey for complaint investigation (TX 00218998). An entrance conference was conducted on 08/06/15 In the conference room of the facility with the Director of Risk Management. The purpose *and* process of the complaint survey were discussed and an opportunity for questions was provided. Complaint, TX 00218998, was substantiated with federal deficiencies cited. An exit conference was conducted on 08/10/15 in the conference room. The Director of Risk Management, the Vice President of clinical Services, the Nursing Clinical Director, and Interim Behavioral Health Administrator were in attendance. Preliminary findings of the survey were discussed and an opportunity for questions was provided.	A 000		

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE CEO | (xe) DATE 10-1-15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the Institution may be excused from correcting providing It Is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction Is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction Is requisite to continued

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIEFUOLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ a.WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	4414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(xs) COMPLETION OATE
A 115	Continuation from page 1 482.13 PATIENT RIGHTS A hospital must protect and promote each patient's rights. This CONDITION Is not met as evidenced by: Based on record review and interview, the facility failed to ensure specific patient rights were protected and promoted, and implement their written policy and procedures that protect and promote each patient's rights for 1 of 1 patients (Patient #1) reviewed with a rights violation complaint. Specifically, the facility failed to ensure Patient #1's rights to be free from all forms of abuse or harassment by failing to prevent, protect, investigate, and report/respond to a sexual assault allegation made by Patient #1 against another Patient (#2); as a result of facility neglect. On 04/27/15, Patient #1 reported to the unit's Registered Nurse (RN) an allegation of sexual assault from another Patient, (#2); who had a history of inappropriate sexual behaviors. The allegation was reported to the Medical Doctor, the Nursing Manager, and local Police Department (PD). However, this allegation was not reported to the state health care regulatory agency by any facility employees, in accordance with their policy. In addition, this allegation was not thoroughly investigated by the facility for the identification of neglect and/or a corrective action plan to prevent repeat incidence in accordance with the facility's policy. Refer to A 0145 for evidence of specific findings. The effect of these deficient practices resulted in the facility's inability to meet the Condition of	A 115	**Plan for Correction, Improving Processes, and Procedure Implementation:** The facility has implemented a policy titled "Managing Inappropriate Sexual Behaviors for Inpatient Hospitalization' which describes the process for identifying and managing patients who display such behaviors and the protective measures that will be taken to ensure that patients and staff are protected from potential sexual abuse. Clinical staff will be educated on the hospital's policy titled "Managing Inappropriate Sexual Behaviors for Inpatient Hospitalization" and moving forward, staff competence will be assessed upon hire and during annual competence assessment. All Behavioral Health Hospital staff members will be re-inserviced on the hospital's policy titled "Assessment and Reporting of Abuse and Neglect" to ensure their full understanding of the hospital's policy and their responsibility for ensuring that all patients are protected from abuse, neglect, or exploitation while under the care of the hospital. **Monitoring and Tracking procedures Monitoring/Tracking Procedures:** A monitoring process has been implemented in which all cases of potential or actual inappropriate sexual behaviors are identified will be escalated up to the VP of Clinical Services to ensure that the hospital's policy for managing such behaviors is implemented to mitigate threats to surrounding patient population and staff. The medical records for such cases will be reviewed to ensure that the documentation reflects adherence to the hospital's policy to include assessment, ongoing reassessment, and treatment planning. Any observations of non-compliance with the hospital's policy will be remediated immediately. The monitoring process will commence for a minimum of 90 days to ensure that the hospital's policy and processes are hardwired. Formal reports of compliance will be reported up to the hospital's Quality Council, MEC, and Governing Body for review and immediate action, if necessary. **Responsible Person**: VP of Clinical Services or designee	October, 6, 2015 September 30, 2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	Continued From page 2			
A 145	482.13(c) (3) PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT The patient has the right to be free from all forms of abuse or harassment. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the patient's rights tr be free from all forms of abuse or harassment by failing to prevent, protect, investigate, and report/respond to an allegation of neglect In accordance with their policy, for 1 of 1 patients reviewed (Patient #1) with a complaint allegation of sexual assault against another patient (Patient #2). On 04/27/15, Patient #1 reported to the unit's Registered Nurse (RN) an allegation of sexual assault from another Patient, (#2); who had a history of Inappropriate sexual behaviors. The allegation was reported to the Medical Doctor, the Nursing Manager, and local Police Department (PD). However, this allegation was not reported to the state health care regulatory agency by any facility employees in accordance with their policy. In addition, this allegation was not thoroughly investigated by the facility for the identification of neglect and/or a corrective action plan to prevent repeat Incidence; in accordance with the facility's policy. This deficient practice could affect the prevention of possible unidentified abuse, neglect, or mistreatment for all patients in the facility; by compromising their safety. Findings Included:	A145	**Plan for Correction, Improving Processes, and Procedure Implementation:** The facility has implemented a policy titled "Managing Inappropriate Sexual Behaviors for Inpatient Hospitalization' which describes the process for identifying and managing patients who display such behaviors and the protective measures that will be taken to ensure that patients and staff are protected from potential sexual abuse. Clinical staff will be educated on the hospital's policy titled "Managing Inappropriate Sexual Behaviors for Inpatient Hospitalization" and moving forward, staff competence will be assessed upon hire and during annual competence assessment. All Behavioral Health Hospital staff members will be re-inserviced on the hospital's policy titled "Assessment and Reporting of Abuse and Neglect" to ensure their full understanding of the hospital's policy and their responsibility for ensuring that all patients are protected from abuse, neglect, or exploitation while under the care of the hospital. **Monitoring and Tracking procedures Monitoring/Tracking Procedures:** A monitoring process has been implemented in which all cases of potential or actual inappropriate sexual behaviors are identified will be escalated up to the VP of Clinical Services to ensure that the hospital's policy for managing such behaviors is implemented to mitigate threats to surrounding patient population and staff. The medical records for such cases will be reviewed to ensure that the documentation reflects adherence to the hospital's policy to include assessment, ongoing reassessment, and treatment planning. Any observations of non-compliance with the hospital's policy will be remediated immediately. The monitoring process will commence for a minimum of 90 days to ensure that the hospital's policy and processes are hardwired. Formal reports of compliance will be reported up to the hospital's Quality Council, MEC, and Governing Body for review and immediate action, if necessary. **Responsible Person**: VP of Clinical Services or designee	October 6, 2015 September 30, 2015

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	4414 NAVARRO, SUITE 800 SAN ANTONIO, TX 78205

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A 145	Continued From page 3 Review of Patient #1's Complaint Form dated 05/15/15, indicated the following in part: On 04/27/15 at approximately 11:30 AM, Patient #1 was admitted to the facility's "Psychiatric Emergency Services (PES) unit and received medication to help her sleep and calm down. Patient #1 reported shortly after she received the medications; she was asleep in her bed when she "felt someone touching my vagina and butt. I felt a hard pressure. I jumped up and another male patient (#2j jumped out from under my covers." Patient #1 stated she went to find a staff member (Mental Health Worker-A), to report what had happened. Patient #1 indicated she noticed her entire "crotch area [paper gown] was torn exposing her "vagina and butt." Patient #1 indicated the facility staff called the Police Department (PD) for Patient #1 to make a report. Patient #1 reported the staff apologized to her for the incident; "but they had an emergency on another floor and they were short staffed, so every staff member had left." Patient #1 indicated she was "so upset and scared; so they gave me more coeds to put me to sleep." Patient #1 stated the facility had done nothing more to help her; there were no witnesses but she believed there were cameras in the hall. Patient #1 stated she found out that Patient #2 had done this before and the Police Officer who responded stated that "he (Patient #21 has a history of doing this, why was he unsupervised?" Review of the facility's Policy titled, Abuse Reporting-External and Internal, last reviewed January 2012 revealed the following definitions: Psychological Abuse Included; humiliation and harassment.	A 145		

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A 145	Continued From page 4 Sexual Abuse included: sexual harassment, sexual coercion, and sexual assault. Review of the facility's Policy titled, Assessment and Reporting of Abuse and Neglect, last reviewed February 2013 revealed Neglect included the failure to provide for one's self the goods or services including medical services, which are necessary to avoid physical or emotional harm or pain or the failure of a caretaker to provide the goods or services. The policy Indicated the facility "prohibits neglect, mental or physical abuse or misappropriation of property, of patients by staff, visitors, or other patients." The facility "will report alldgations and release information to the proper authorities, according to federal regulations, state speciifc rules and regulation and (facility] practice guidelines." Further review of the policy indicated, in part 1. Reporting allegations of abuse and/or neglect occurring while the patient is under the care in the facility: All alleged violations concerning abuse and neglect while the patient is under the care of the facility will be reported to the Compliance Officer or designee, who will advise the on-call administrator/designee. As appropriate, the facility will report the incident to appropriate state, federal and protective/regulatory agencies, and/or law enforcement agencies and conduct an internal investigation within a maximum of five working days of the incident The Texas Department of state Health Services (DSHS) is the regulatory body for reporting concerns of hospitals, psychiatric hospitals (Including private psychiatric facilities), and various other medical facilities.	A 145		

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A 145	Continued From page 5 2. Investigations are always prompt comprehensive and responsive to the situation, well conducted, and contain founded conclusions. The investigation may include, but are not limited to the following: -Interviews conducted with Individuals having first-hand knowledge of the incident -Follow-up resolution -Corrective action plan to prevent repeat incidence. -Reports made to appropriate state health care regulatory agency. Review of the facility's Original Event report dated **04/27/15** at 12:15 PM completed by the unit RN revealed Patient #1 reported, "She was lying in bed asleep, when she felt Patient [#2] putting pressure around *her* buttocks area, and then touching her perineal area. Patient [#1] reported sitting up in bed shock and scared, and found Patient [#2] was up In her face with his finger to his mouth telling her to be quiet not to tell. She found her paper scrub button Corned on the outer left side. MD [Medical Doctor], Nurse Manager notified, Patient made a police comrlième'nt. PD interviewed Patient #1 and accused, Patient #2. "Patient visible distraught, but no other physical problems noted at this time." Further review of the Original Event Indicated the Event was documented as "Attempted Rape/Rape/Sexual Assault." Factors included; "Unit busy code greens called on other unit, and high acute of unit" The Original Event report did not include any documentation that this allegation was reported to the state health care regulatory agency by any facility employees, in accordance with the facility's policy. The Original Event report	A 145		

STATEMENT OF DEFICIENCIES AND PI AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY. STATE, ZIP CODE
NIX **HEALTH CARE SYSTEM**	**414** NAVARRO, SUITE GOO **SAN ANTONIO, TX 18205**

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A 145	Continued From page 8 did not Include documentation that this allegation was thoroughly investigated by the facility for the Identification of neglect and/or a corrective action plan to prevent repeat incidence; in accordance with the facility's policy. The Compliance Ofifcer/Director of Risk Management (RM) acknowledged receipt of the Original Event report dated 04/27/15 at 12:15 PM electronically on 05/06/15 documenting Patient #1 made a Police Report. Review of the local PD report dated 04/27/15 at 12:45PM revealed Patient #1 wanted to report that, "she was a sleep In her room, when she awaken and felt pressure around her buttock and vaginal area. When she fully awaken, she observed [Patient #2] in bed with her." Patient #1 further stated that Patient #2 told her "Don't teil anyone," before he left her room. Patient #1 did not feel Patient #2 penetrate her at any time, but the hospital [paper gown] pajama that she was wearing had a tear between the leg area. Patient #2 denied being in bed with Patient #1, or touching her. The report was deemed as "Disorderly Conduct" and Patient #1 was advised to contact the special victim's unit to4ile charges against Patient #2. "The Hospital staff was advised to monitor [Patient #2's] movement more closely." Record review of the medical record of Patient #1 revealed she was a 37 year-old female admitted to the psychiatric facility on 04/27/18 at 0830 under Emergency Detention (ED) when she cut her wrist and called a friend to call Police. Patient #1 has a history of Depression with Anxiety. Further review of Patient #1's permanent records revealed no documentation following the sexual	A 145		

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A 145	Continued From page 7	A 145		

assault allegation that she made on 04/27/15 against Patient #2. There was no documentation In her record that she received a physical and/or psychological assessment following her allegation on 04/27/15. There was a Telephone Physician Order (PO) on 04/27/15 at 12:30 PM (following the allegation) for Ativan (an anti-anxiety) 2 milligrams by mouth "now" without documentation of the reason for the emergency medication. The only documentation in Patient #1's record regarding her allegation against Patient #2 was a Behavioral Team Progress Note dated 05/01/15 at 12:25 completed by Licensed Social Worker- A that indicated "Patient discussed being sexually assaulted by Patient [#2] in the [facility's] PES unit.

Review of Patient #1's Daily Observation Notes for 04/27/15 revealed the following:
At 11:30-MHW-A documented 10 (1=On unit, and 0=Quiet/Calm).
At 11:45-MHW-A documented 1B (On unit, and B=Irt Bed Awake).
At 12:00-MHW-A documented 1BA On unit, In Bed Awake, and A=agitated/restlesg).
At 12:15 MHW-A documented 1BA.
At 12:30, 12:45, 13:00, 13:15, 13:30, and 13:45-MHW-A documented 1A (On Unit and agitated/restless).

Record review of Patient #2's medical records revealed the following:

Patient #2's Psychiatric Evaluation dated 04/24/15 revealed he was a 30 year old male admitted to the PES unit on 04/24/15 with a history of schizoaffective disorder and traumatic brain injury (TBI). Patient #2 was admitted on an ED basis with a history of aggressive behaviors

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requiring emergency medications to calm him. Patient #2 had recently been discharged from this facility 4-5 weeks prior and has had multiple inpatient treatment episodes over the years (7 inpatient admissions in the previous 5 months). Patient #2 was documented with a known history of aggression and a "history of inappropriate sexual behavior on the unit (masturbating)."

Patient #2 had documented borderline intellectual functioning with poor insight, poor judgment, and poor impulse control.

A Behavioral Nursing Shift Assessment completed by the unit RN on 04/27/15 at 18:08 that Patient #2 was found by a female patient touching on her body while she was asleep in bed. MD, and Nurse Manager notified.

A Telephone PO dated 04/27/15 at 2015 for Patient #2 to be transferred to a higher acuity; sister facility.

A Behavior Team Progress noted dated 04/27/15 at 1855 revealed Patient #2 was transferred to a sister facility by the Sheriff's Department.

Review of the facility's Incident Event dated 04/27/15 at 11:37 AM confirmed a Code Green was called for another Patient (#3] in the Child/Adolescent Unit requiring Restraints/Seclusion. Patient #3 required physical restraint at 11:36 AM, and emergency medications at 11:96 AM. Patient #3 was released from restraint at 12:26 PM. This Code Green occurred during the same time frames of Patient #1's allegation on 04/27/15.

Review of the facility's Policy titled, Psychiatric

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A 145	Continued From page 9 Emergencies-Code Green, last reviewed January 2012 revealed a Code Green was a Psychiatric Emergency. Code Green will be implemented by any unit personnel in the event of unmanageable behavior of an individual to prevent harm to that individual, patients, hospital personnel and/or others the general hospital area. D. Individuals responding to Code Green will meet in announced area. Available personnel is necessary to control atmosphere through a show of strength and caring or to assist in physical management. Interview on 08/06/15 at 12:35 PM with the PES unit RN revealed she completed Patient #1's admission assessment to the PES unit on 04/27/15, The unit RN indicated Patients were provided with paper scrubs to wear without other undergarments. The unit RN stated that on 04/27/15 at approximately 11:30 AM to 12:00 PM, "Code Greens" were going on; and "staff were busy". The unit RN stated there was a Code Green on another unit (child/adoles,n0 and a Code Green was called in the lobby; due to a patient needing to be "put in a [restraint] chair' because they were tearing up the lobby. The unit RN stated she left the unit to respond to the Code Green in the other unit (child/adolescent) and when she arrived; there was another RN responding, so she went to the Code Green in the lobby because they needed an RN to assist with "putting the patient in the [restraint] chair." The unit RN stated she returned to the PES unit following the Code Greens to "something else going on at the end of the unit" that she responded to. The unit RN stated she could not remember if it was LVN-A or LVN-B working on 04/27/15; but that she thought the LVN stayed back in the PES unit when she left *and*	A 145		

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responded to the two Code Greens. The unit RN stated she was notified that during the Code Greens Patient #2 went into Patient #1's bedroom; and Patient #1 made an allegation of sexual assault. The unit RN stated she spoke with Patient #1 who reported that she was asleep in her bedroom and "she felt pressure" causing her to awake to Patient #2 touching her In the buttock and perinea' area. The unit RN stated that Patient #1's paper pants were "torn on the side." The unit RN stated the local PD was called. The unit RN stated she spoke to Patient #2 and he said, "1 touched her, but didn't do anything else." The unit RN stated he admitted that he "touched her and ripped her paper pants." The unit RN stated that Patient **#2** knew that the unit was "chaotic" and knew what Code Green meant; and that is when he "took advantage" of the situation. The unit RN stated she believed that Patient #2 sexually assaulted Patient #1 given the facts, and his own admission. The unit RN stated she notiifed the MD, Social Worker, and Nursing Manager of the allegation. The unit RN Indicated she documented the sexual assault 61legation made by Patient #1 on the Facility's Event Report; however, confirmed she did not document the sexual assault allegation in Patient #1's record following the Incident. The unit RN stated she offered for Patient #1 to have a Sexual Assault Nurse Examination (SANE) completed at another facility If she wanted; but Patient #1 declined, stating she did not believe Patient #2 actually raped her.

Interview on 08/06/15 at 04:45 PM with MHW-A revealed she was the only MHW working on 04/27/15 in the PES unit; along with the unit RN and a Licensed Vocational Nurse (LVN). MHW-A

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A 145	Continued From page 11 stated she was pulled to the PES unit at 9:15 AM and was unfamiliar to the PES unit; but was told by the leaving MHW to "watch it" for Patient #2, however, she did not know the specific reason why. MHW-A stated the females were assigned rooms on one side, and males on the other side. MHW-A stated during the morning on 04/27/15 at approximately 11:30 AM-12:00 PM it was a "hectic/busy" day with "Code Green's being called." MHW-A stated that security was usually on the PES unit; but on 04/27/15 at the time of the allegation; "security could not be found." MHW-A stated on 04/27/15 at around 11:30-12:00 PM she stayed in the unit when the Code Greens were called and was "getting something out of the supply closet." MHW-A indicated the unit RN "responded to the Code Green" leaving the unit; telling her she [unit RN] would be back. IVIHIN-A did not remember if LVN-A or LVN-B was working on 04/27/15; but further staled she did not remember any LVN being in the unit during the time of the allegation made by Patient #1. MHVV-A stated shortly after this Patient #1 "lfagged her (MHW-Al down" to her bedroom, and into the restroom of the bedroom where she reported that Patient #2 came into her room and touched her buttocks and vaginal area while she was sleeping in her bed. MHW-A stated that Patient #1's gown was torn around the buttock area and she offered to call the local PD for Patient #1 to make a report. MHW-A stated she then reported the incidenVailegation to the unit RN. MHW-A stated she was later told that Patient #2 had been an inpatient to the facility many times before, and he "knows the system; knows what Code Green means." MHW-A stated she had seen Patient #2 "walking out of her [Patient #1] room a few times" and further stated "right before she lfagged me down, he had	A 145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450136	A. BUILDING _____ B. WING _____	C 08110/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 500 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 145	Continued From page 12 walked out of her room". MHW-A indicated she told Patient #2 "not to go in to other people's rooms." MHW-A confirmed she had not documented the allegation reported by Patient #1 against Patient #2; but that she "told (unit RN]." interview on 08/10115at 1:20 PM with Patient #1 revealed on 04/27/15 at approximatyy 11:30-11:45 AM she was in her assiOned bedroom sleeping after she received multiple medications following her admission. Patient #1 stated she awoke after she "felt pressur'ein her buttock and vaginal area. Patient #1 stated that Patient #2 was present telling her not to tell anyone. Patient #1 stated that she noticed her paper pants were ripped and she was not actually aware what all Patient #2 actually did because she "was conked out" after taking multiple medications. Patient #1 stated she knows he touched her because that was what woke her up. Patient #1 stated she was very upset, "freaked out," and asked the MD for an "AIDS" test. Patient #1 stated the unit RN indicated to the nursing staff (LVN) to "give her more meds" because she was "upset, crying, and freaking out." Patient #1 stated she then received the Ativan for her anxiety, to "help me calm down." Patient #1 stated the local PD came and she made a report. Patient #1 stated she was told by the unit RN that "Code Green's" were called and "everyone had to leave the unit" which allowed the opportunity for Patient #2 to go into her room unsupervised. Interview on 08/10/15 at 2:20 PM with Security Guard-A revealed he was employed by the facility to maintain security and the safety of patients. The Security Guard-A stated Patient #2 had a	A 145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X0) PROVIDERISUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP C DE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

04) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEbED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVEACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETlON DATE
A 145	Continued From page 13 history of inappropriate sexual behavior of "masturbating in front of females." The Security Guard-A stated he assisted with "viewing the video" footage for evidence following the allegation on 04/27/15 made be Patient #1 against Patient #2. The Security Guard stated the video footage from 04/27/15 showed a total of "four times" that Patient #2 went Into Patient #1's room; and the last time Patient #2 came out of Patient #1's room; she was observed to come out of the room a few minutes later. The Security Guard stated that Patient #2 had already been assigned to the front "seclusion room" of the PES unit as his bedroom due to his history of masturbating. The Security Guard stated on the video footage Patient #2 could be seen coming from his room; "looking side to side" down the hallway, and then going into Patient #1's room. The Security Guard stated that female and male patient rooms were separated and that Patient #2 was not supposed to be going into Fiatient #1's room for any reason. Interview on 08/10/15 at 2:50 PM with MD-A revealed ***he*** was notified of Patient #1's sexual assault allegation against Patient #2 on 04/27/15. MD-A stated he discussed with Patient #1 the option of a "Rape Kit" but she "declined." MD-A stated he understood the allegation made by Patient #1 to be "only touching with no penetration." MD-A stated that Patient #1 was "distressed" about the incident and he ordered Ativan for Patient #1's anxiety following the incident. MD-A stated Patient #1 had already been distressed emotionally because of her ED inpatient admission; and really did not even want to take the Ativan. MD-A stated he recalled there was a Code Green called where staff left the unit In response to the Code Green; which letf less	A 145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTI N	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ B. WING _____	C 88/1012015

NAME OF PROVIDER OR SUPPLIER	STREETADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 500 SAN ANTONIO, TX 78206

(X4) to PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION GATE
A 145	Continued From page 14 staffing in the unit. MD-A confirmed that he did not document In Patient #1's records his contact or discussion with Patient #1 following her allegation. Interview on 08/10/15 at 3:00 PM with the facility's Risk Manager (RM) Indicated that she was aware of the alleged sexual assault allegation made by Patient #1 on 04/27/15 against Patient #2[1]; however, she had not been notified until 05/06/15 via the facility's Incident/Event electronic system because there had not been any harm documented in order to elevate the notification. The RM stated the staffing ratio on the PES unit was 1 staff to 4 patients. The RM indicated on 04/27/15 the patient census in the PES unit was 11; requiring 3 staff. The RM stated the first required staff is an RN, and then second could be a LVN, and/or MHW. The RM confirmed for 11 patients the required staffing would be 3. The RM stated the PES unit was to always have a licensed nurse present and available in the unit. The RM confirmed that she had not reported the sexual assault allegation made by Patient #1 on 04/27/15 against Patient #2 to the state health care regulatory agency, Department of State Health Services (DSHS); which was determined to have occurred as a result of Insufficient staffing in the PES unit during episodes of Code Green's. The RM further confirmed the facility had not completed a thorough investigation with documented findings specific to this allegation for the determination of Neglect and/or a corrective action plan to prevent repeat incidence; in accordance with the facility's policy. The RM stated she had not seen or viewed the video footage following this allegation due to the video being unavailable after 05/06/15; following her	A 145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIEFUCLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ B. WING _____	C 08110/2015

NAME OF PROVIDER OR SUPPLIER	STREETAI)DRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE SOO SAN ANTONIO, TX MOE

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	4X5) COMPLETION DATE
A 145	Continued From page 15 electronic notification. Interview on 08/10/15 at 3:15 PM with Licensed Social Worker (LSW)-A stated she assisted Security Guard-A in viewing the video footage on 04/27/15 after Patient #1 made a sexual assault allegation against Patient #2. LSW-A stated that during the allegation on 04/27/15; Patient #2 could be seen on the camera "looking both ways" and then would go into Patient #1's bedroom. LSW-A st ted they were able to count this event occurring a "couple of limes" where Patient #2 would go into Patient #1's bedroom and remain there "a couple of minutes" each time. LSW-A stated she saw on the video where MHW-A had been in the "Patient evaluation room" during these time periods; where a supply closet *was* located. LSW-A stated Patient #2 had a history of "exposing his self, public masturbatiOn, and talks sexually to other women." LSW-A stated that Patient #2 has publically masturbated in front of her during an assessment interview. Interview on 08/10/15 at 4:15 PM with LVN-A stated he was present and worked the PES unit on 04/27/15. LVN-A stated that on 04/27/15 there were Code Greens called on another unit, and in the facility's lobby about the same time. LVN-A stated he responded to the Code Green in the lobby to assist due to a "fight." LVN-A indicated he had left the unit for approximately 15 minutes. Interview on 08/10/15 at 4:30 PM with the Vice President (VP) of Clinical Services confirmed that she was notified of the sexual allegation made by Patient #1 against Patient #2 on 04127/15;	A 145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45013e	A. BUILDING _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC I ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(9) COMPLETION DATE
A 145	Continued From page 16 however, she had not been notified until 05/06/15 via the facility's Incident/Event electronic system because there ***had*** not been any harm documented in order to elevate the notification. The VP of Clinical Services indicated that an 04/27/15 the Nursing Clinical Directii'r (Nurse Manager) had been notified immediately following Patient #1's allegation and she had not obtained information that indicated Patient #1's allegation had occurred due to insufifcient staffing in the PES unit when Code Green's had been called; leaving the unit without a RN available. The VP of Clinical Services stated that the unit RN was not supposed to leave the unit and there should always be a Licensed Nurse in the unit during a Code Green; that "it is a judgement call." The VP of Clinical Services stated she had not ***seen*** or viewed the video footage following this allegation due to the video being unavallable after 05/06/15; following her electronic notification. Interview on 08/10/15 at 4:40 PM with the Nursing Clinical Director (Nurse Manager) stated she was immediately notified by the PES unit RN on 04/27/15 of Patient #1's sexual allegation against Patient #2. The Nursing Clinical Director Indicated she "separated" the Patients, talked to both of them, and Patient #1 saw the Doctor. The Nursing Clinical Director stated she spoke to the unit RN about the allegation but pad not been notified or received information that the RN and LVN had left the PES unit to respond to Code Greens which letf the unit without a RN and/or licensed nurse available. The Nursing Clinical Director stated she had not seen or viewed the video footage following this allegation.	A 145		
A 392	482.23(b) STAFFING AND DELIVERY OF CARE	A 392		

DEPARTMENT OF
HEALTH AND HUMAN SERVICES

PRINTED: 09/10/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ B. WING _____	C 08110/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM I	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

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A 392	Continued From page 17 The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure there were sufficient numbers of licensed registered nurses (RN), licensed vocational nurses (LVN), and other personnel immediately available at all times in the unit to ensure the provision of care and supervision for patients (Patient #1 and #2) as required resulting in an allegation of neglect. Specifically, on 04/27/15, Patient #1 reported to the unit's Registered Nurse (RN) an allegation of sexual assault from another Patient (#2), who had a history of inappropriate sexual behaviors, after the unit RN and LVN left their assigned unit to respond to "Code Green's" (psychiatric emergencies) in other units/areas of the facility. This deficient practice affected Patient #1's provision of care and compromised her safety resulting In allegation of Neglect due to insufficient staffing in the unit. Findings Included: Review of Patient #1's Complaint Form dated 05/15/15 indicated the following in part: On 04/27/15 at approximately 11:30 AM Patient #1 was admitted to the facility's "Psychiatric	A 392	**Plan for Correction, Improving Processes, and Procedure Implementation:** To mitigate the depletion of hospital staff on the BHU due to Code Green responses in the hospital and to ensure the protection of all patients on the unit, a staff member will be posted in each patient care area of the Behavioral Health Hospital until the Code Green incident is resolved. Hospital Staff will be in-serviced on their roles during Code Green incidents with a specific emphasis on the expectation that all patient care areas be manned throughout the entirety of the incident. Staff competence will be assessed upon hire and annually thereafter. **Monitoring/Tracking Procedures:** Observations of non-compliance will be remediated immediately. Formal reports of compliance will be reported up to the hospital's Quality Council, MEC, and Governing Body for review and immediate action, if necessary. **Responsible Person:** VP of Clinical Services or designee	September 30, 2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ B. WING _____	C 08/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	4414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 392	Continued From page 18	A 392		

Emergency Services (PES) unit and received medication to help her sleep and calm down. Patient #1 reported shortly after she received the medications; she was asleep in her bed when she "felt someone touching my vagina and butt I felt a hard pressure. I jumped up and another male patient (#2) jumped out from under my covers." Patient #1 stated she went to find a staff member (Mental Health Worker-A), to report what had happened. Patient #1 indicated she noticed her entire "crotch area [paper gown] was torn exposing her "vagina and butt." Patient #1 indicated the facility staff called the Police Department (PD) for Patient #1 to make a report. Patient #1 reported the staff apologized to her for the incident; "but they had an emergency on another floor and they were short staffed, so every staff member had left Patient #1 indicated she was upset and scared; so they gave me more meds to put me to sleep." Patient #1 stated the facility had done nothing more to help her; there were no witnesses but she believed there were cameras in the hall. Patient #1 stated she found out that Patient #2 had done this before and the Police Officer who responded stated that; "he [Patient #2] has a history of doing this; why was he unsupervised?"

Review of the facility's Policy titled, Abuse Reporting-External and internal, last reviewed January 2012 revealed the following definitions:
Psychological Abuse included; humiliation and harassment.
Sexual Abuse included; sexual harassment, sexual coercion, and sexual assault.

Review of the facility's Policy titled, Assessment and Reporting of Abuse and Neglect, last reviewed February 2013 revealed Neglect

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ B. WING _____	C 0811012016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY).	(X5) COMPLETION DATE
A 392	Continued From page 19 included the failure to provide for one's self the goods or services including medical services, which are necessary to avoid physical or emotional harm or pain or the failure of a caretaker to provide the goods or services. The policy indicated the facility "prohibits neglect, mental or physical abuse or misappropriation of property, of patients by staff, visitors, or other patients." The facility "will report allegations and release information to the proper authorities, according to federal regulations, state specific rules and regulation and [facility] practice guidelines." Review of the facility's Original Event report dated 04/27/15 at 12:15 PM completed by the unit RN revealed Patient #1 reported, "She was lying in bed asleep, when she felt Patient [#2] putting pressure around her buttocks area, and then touching her perineal area. Patient] #1] reported sitting up in bed shock and scared, and found Patient (#21 was up in her face with his finger to his mouth telling her to be quiet not to tell. She found **her paper** scrub button tomel on the outer left side. MD [Medical Doctor], Nurge Manager notified, Patient made a police complaint." PD interviewed Patient #1 and accused, Patient #2. "Patient visible distraught, but no other physical problems noted at this time." Further review of the Original Event indicated the Event was documented as "Attempted Rape/Rape/Sexual Assault." Factors included; "Unit busy code greens called on other unit, and high acute of unit." Record review of the medical record of Patient #1 revealed she was a 37 year-old female admitted to the psychiatric facility on 04/27/15 at 0830	A 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER1SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

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A 392	Continued From page 20 under Emergency Detention (ED) when she cut her wrist and called a friend to call Police. Patient #1 has a history of Depression with Anxiety. Further review of Patient #1's permanent records revealed no documentation following the sexual assault allegation that she made on 04/27/15 against Patient #2. There was no documentation in her record that she received a physical and/or psychological assessment following her allegation an 04/27/15. There was a Telephone Physician Order (PO) on 04/27/15 at 12:30 PM (following the allegation) for Ativan (an anti-anxiety) 2 milligrams by mouth "now" without documentation of the reason for the emergency medication. The only documentation in Patient #1's record regarding her allegation against Patient #2 was a Behavioral Team Progress Note dated 05/01/15 at 12:28 completed by Licensed Social Worker- A that Indicated "Patient discussed being sexually assaulted by Patient [#2] In the [facility's) PES unit. Review of Patient #1's Daily Observation Notes for 04/27/15 revealed the following: At 11:30-MHW-A documented 14 (1=On unit, and OrQuiet/Calm). At 11:45-MHW-A documented 1B (On unit, and B=In Bed Awake). At 12:00-MHW-A documented IBA (On unit, In Bed Awake, and A=agitated/restless). At 12:15 MHW-A documented 1 BA. At 12:30, 12:45, 13:00, 13:15, 13:30, and 13:45-MHW-A documented IA (On Unit and agitated/restless). Record review of Patient #2's medical records revealed the following:	A 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(Xi) PROVIDER/SUPPLIERICLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY. STATE. ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUM 600 SAN ANTONIO, TX 78205

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A 392	Continued From page 21' Patient #2's Psychiatric Evaluation dated 04/24/15 revealed he was a 30 year old male admitted to the PES unit on 04/24/15 with a history of schizoaffective disorder and traumatic brain injury (TBI). Patient #2 was admitted on an ED basis with a history of aggressive behaviors requiring emergency medications to calm him. Patient #2 had recently been discharged from this facility 4-5 weeks prior and has had multiple inpatient treatment episodes over the years (7 inpatient admissions in the previous,5 months). Patient #2 was documented with a known history of aggression and a "history of Inappropriate sexual behavior on the unit (masturbating)." Patient #2 had documented borderline intellectual functioning with poor insight, poor Judgment, and poor impulse control. A Behavioral Nursing Shift Assessment completed by the unit RN on 04/27/15 at 18:08 that Patient #2 was found by a female patient touching on her body while she was asleep in bed. MD, and Nurse Manager notified. A Telephone PO dated 04/27/15 at 2015 for Patient #2 to be transferred to a higher acuity; sister facility. A Behavior Team Progress noted dgted 04/27/15 at 1855 revealed Patient #2 was transferred to a sister facility by the Sheriff's Department. Review of the facility's Incident Event dated 04/27/15 at 11:37 AM confirmed a Code Green was called for another Patient [#3] in the Child/Adolescent Unit requiring Restraints/Seclusion. Patient #3 required physical restraint at 11:36 AM, and emergency medications at 11:46 AM. Patient #3 was	A 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 000 SAN ANTONIO, TX 70205

(x4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(x5) COMPLETION DATE
A 392	Continued From page 22 released from restraint at 12:26 PM. This Code Green occurred during the same time frames of Patient #1's allegation on 04/27/15. Review of the facility's Policy titled, Psychiatric Emergencies-Code Green, last reviewed January 2012 revealed a Code Green was a Psychiatric Emergency. Code Green will be implemented by any unit personnel in the event of unmanageable behavior of an individual to prevent harm to that individual, patients, hospital personnel and/or others the general hospital area. D. Individuals responding to Code Green will meet In announced area. Available personnel is necessary to control atmosphere through a show of strength and caring or to assist in physical management. Interview on 08/08/15 at 12:35 PM with the PES unit RN revealed she completed Patient #1's admission assessment to the PES unit on 04/27/15. The unit RN indicated Patients were provided with paper scrubs to wear without other undergarments. The unit RN on 04/27/15 at approximately 11:30 AM to 12:00 PM, "Code Greens" were going on; and "staff were busy". The unit RN stated there was a Code Green on another unit (child/adolescent) and a Code Green was called In the lobby; due to a patient needing to be "put in a [restraint] chair" because they were tearing up the lobby. The unit RN stated she left the unit to respond to the Code Green in the other unit (child/adolescent) and when she arrived; there was another RN responding, so she went to the Code Green in the lobby because they needed an RN to assist with putting the patient in the [restraint] chair." The unit RN stated she returned to the PES unit following the Code Greens to "something else	A 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PR VIDEFU3UPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE. ZIP CO E
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 500 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIaIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 392	Continued From page 23 going on at the end of the unit" that she responded to. The unit RN stated she could not remember if it was LVN-A or LVN-B working on 04/27/15; but that she thought the LVN stayed back in the PES unit when she left and responded to the two Code Greens. The unit RN stated she was notified that during the Code Greens Patient #2 went into Patient #1's bedroom; and Patient #1 made an allegation of sexual assault. The unit RN stated she spoke with Patient #1 who reported that she was asleep in her bedroom and "she felt pressure" causing *her* to awake to Patient #2 touching ter in the buttock and perinea! area. The unit RN stated that Patient #1's paper pants were "torn on the side." The unit RN stated the local PD was called. The unit RN stated she spoke to Patient #2 and he said, "I touched her, but didn't do anything else." The unit RN slated he admitted that he "touched her and ripped her paper pants." The unit RN stated that Patient #2 knew that the unit was chaotic" and knew what Code Green meant; and that is when he "took advantage" of the situation. The unit RN slated she believed that Patient #2 sexually assaulted Patient #1 given the facts, and his own admission, The unit RN stated she notified the MD, Social Worker, and Nursing Manager of the allegation. The unit RN indicated she documented the sexual assault allegation made by Patient #1 on the facility's Event Report; however, confirmed she did not document the sexual assault allegation in Patient #1's record following the Incident. The unit RN stated she offered for Patient #1 to have a Sexual Assault Nurse Examination (SANE) completed at another facility if she wanted; but Patient #1 declined, stating she did not believe Patient #2 actually raped her. I	A 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE GOO SAN ANTONIO, TX 78205

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A 392	Continued From page 24 Interview on 08/06/15 at 04:45 PM with MHW-A revealed she was the only MHW w9'king on 04/27/15 in the PES unit; along with the unit RN and a Licensed Vocational Nurse (LVN). MHW-A stated she was pulled to the PES unit at 9:15 AM and was unfamiliar to the PES unit; but was told by the leaving MHW to "watch it" for Patient #2, however, she did not know the specific reason why. MHW-A stated the females were assigned rooms on one side, and males on the other side. MHW-A stated during the morning on 04/27/15 at approximately 11:30 AM-12:00 PM it was a "hectic/busy" day with "Code Green's being called." MHW-A stated that security was usually on the PES unit; but on 04/27/15 at the time of the allegation; "security could not be found." MHW-A stated on 04/27/15 at around 11:30-12:00 PM she stayed In the unit when the Code Greens were called and was "getting something out of the supply closet." MHW-A indicated the unit RN "responded to the Code Green" leaving the unit; telling her she [unit RNJ would be back. MHW-A did not remember if LVN-A or LVN-B was working on 04/27/15; but further stated she did not remember any LVN being in the unit during the time of the allegation made by Patient #1. MHW-A stated shortly after this Patient #1 "flagged her [MHW-A] down" to her bedroom, and into the restroom of the bedroom where she reported that Patient #2 came into her room and touched her buttocks and vaginal area while she was sleeping in her bed. MHW-A stated that Patient #1's gown was torn around the buttock area and she offered to call the local PD for Patient #1 to make a report. MHW-A stated she then reported the incident/allegation to the unit RN. MHW-A stated she was later told that Patient #2 had been an inpatient to the facility many times before, and he "knows the system;	A 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDETUSUPPLIERCUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREETADDRESS, CITY. STATE, MP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSO IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVEACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(xi) COMPLETION OMM
A 392	Continued From page 25 knows what Code Green means." MHW-A stated she had seen Patient #2 "walking out of her [Patient #1] room a few times" and further stated "right before she flagged me down, he had walked out of her room". MHW-A indicated she told Patient #2 "not to go in to other people's rooms." MHW-A confirmed she had not documented the allegation reported by Patient #1 against Patient #2; but that she "told [unit RN]." Interview on 08/10115at 1:20 PM with Patient #1 revealed on 04/27/15 at approximately 11:30-11:45 AM she was in her assigned bedroom sleeping after she received multiple medications following her admission, Patient #1 stated she awoke after she "felt pressure on her buttock and vaginal area. Patient #1 stated that Patient #2 was present telling her not to tell anyone. Patient #1 stated that she noticed her paper pants were ripped ***and*** she was not actually aware what all Patient #2 actually did because she "was conked out" after taking multiple medications. Patient #1 stated she knows he touched her because that was what woke her up. Patient #1 stated she was very upset, "freaked out," and asked the MD for an "AIDS" test. Patient #1 stated the unit RN indicated to the nursing staff (LVN) to "give her more meds" because she was "upset, crying, and freaking out." Patient #1 stated she then received the Ativan for her anxiety, to "help me calm down." Patient #1 stated the local PD came and she made a report. Patient #1 stated she was told by the unit RN that "Code Green's" were called and "everyone had to leave the unit" which allowed the opportunity for Patient #2 to go into her room unsupervised.	A 392		

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NAME OF PROVIDER OR SUPPLIER	STREETADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 **SAN ANTONIO, TX 78205**

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A 392	Continued From page 26 interview on 08/10/15 at 2:20 PM with Security Guard-A revealed he was employed by the facility to maintain security and the safety of patients. The Security Guard-A stated Patient #2 had a history of inappropriate sexual behavior of "masturbating in front of females." The Security Guard-A stated he assisted with "viewing the video" footage for evidence following the allegation on 04/27/15 made be Patent #1 against Patient #2. The Security Guard stated the video footage from 04/27/15 showed a total of "four times" that Patient #2 went into Patient #1's room; and the last time Patient #2 came out of Patient #1's room; she was observed to come out of the room a few minutes later. The Security Guard stated that Patient #2 had already been assigned to the front "seclusion room" of the PES unit as his bedroom due to his history of masturbating. The Security Guard stated on the video footage Patient #2 could be seen coming from his room; "looking side to side" down the hallway, and then going into Patient #1's room. The Security Guard stated that female and male patient rooms were separated and that Patient #2 was not supposed to be going into Patient #1's room for any reason. Interview on 08/10/15 at 2:50 PM with MD-A revealed he was notified of Patient #1's sexual assault allegation against Patient #2 on 04/27/15. MD-A stated he discussed with Patient #1 the option of a "Rape Kit" but she "declined." MD-A stated he understood the allegation made by Patient #1 to be "only touching with tIO penetration." MD-A stated that Patient #1 was "distressed" about the incident and he ordered Ativan for Patient #1's anxiety following the incident. MD-A slated Patient #1 had already been distressed emotionally because of her ED	A 392		

STATEMENT OF EFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDERISUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREETADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

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A 392	Continued From page 27 Inpatient admission; and really did not even want to take the Ativan. MD-A stated he recalled there was a Code Green called where staff left the unit In response to the Code Green; which left less staffing in the unit. Interview on 08/10/15 at 3:00 PM with the facility's Risk Manager (RM) indicated that she was aware of the alleged sexual assault allegation made by Patient #1 on 04/27/15 against Patient #2; however, she had not been notified until 05/06/15 via the facility's Incident/Event electronic system because there had not been any harm documented In order to elevate the notification. The RM stated the stafifng ratio on the PES unit was 1 staff to 4 patients, The RM indicated on 04/27/15 the patient census in the PES unit was 11; requiring 3 staff. The RM stated the first required staff is an RN, and then second could be a LVN, and/or MHW. The RM confirmed for 11 patients the required staffing would ire 3. The RM stated the PES unit was to always have a licensed nurse present and available in the unit. The RM stated she had not seen or viewed the video footage following this allegation due to the video being unavailable after 05/06/15; following her electronic notification. The RM stated there would not be documentation of the Code Green that may have occurred on 04/27/15 in the facility's lobby waiting area; if the patient had not yet been assessed for care. interview on 08/10/15 at 3:15 PM with Licensed Social Worker (LSW)-A stated she assisted Security Guard-A in viewing the video footage on 04/27/15 after Patient #1 made a sexual assault allegation against Patient #2. LSW-A stated that	A 392		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	**414 NAVARRO, SUITE** 800 SAN ANTONIO, TX 70205

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A 392	Continued From page 28 during the allegation on 04127/15; Patient #2 could be seen on the camera "looking both ways" and then would go into Patient #1's bedroom. LSW-A stated they were able to count this event occurring a "couple of times" where Patient #2 would go into Patient #1's bedroom and remain there "a couple of minutes" each time. LSW-A stated she saw on the video where MHW-A had been in the "Patient evaluation room " during these time periods; where a supply ?Inset was located. LSW-A stated Patient #2 hpd a history of "exposing his self, public masturbation, and talks sexually to other women." LSW-A stated that Patient #2 has publically masturbated in front of her during an assessment interview. Interview on 08/10/15 at 415 PM with LVN-A stated he was present and worked the PES unit on 04/27/15. LVN-A staled that on 04/27/15 there were Code Greens called on another unit, and In the facility's lobby about the same time. LVN-A stated he responded to the Code Green in the lobby to assist due to a "fight." LVN-A indicated he had left the unit for approximately 15 minutes. Interview on 08/10/15 at 4:30 PM with the Vice President (VP) of Clinical Services confirmed that she was notified of the sexual allegation made by Patient #1 against Patient #2 on 04/27/15; however, she had not been notified until 05/06/15 via the facility's Incident/Event electronic system because there had not been any harm documented in order to elevate the notification. The VP of Clinical Services I that on 04/27/16 the Nursing Clinica I Direct& (Nurse Manager) had been notified immediately following Patient #1's allegation and she had not obtained	A 392		

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NAME OF PROVI ER OR SUPPLIER	STREETADORESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	**414 NAVARRO, SUITE** Bob SAN ANTONIO, TX 78205

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A 392	Continued From page 29 Information that Indicated Patient #1's allegation had occurred due to Insufficient staffing in the PES unit when Code Green's had been called; leaving the unit without a RN available. The VP of Clinical Services stated that the unit RN was not supposed to leave the unit and there should always be a Licensed Nurse In the unit during a Code Green; that it's a judgement call." The VP of Clinical Services stated she had not seen or viewed the video footage following this allegation due to the video being unavailable after 05/06/15; following her electronic notification. Interview on 08/10/15 at 4:40 PM with the Nursing Clinical Director (Nurse Manager) she was immediately notified by the PES un it RN on 04/27d/15 of Patient #1's sexual allegation against Patient #2. The Nursing Clinical Director indicated she "separated" the Patients, talked to both of them, and Patient #1 saw the Doctor. The Nursing Clinical Director stated she spoke to the unit RN about the allegation but,had.not been notified or received information that the RN and LVN had left the PES unit to respond to Code Greens which letf the unit without a RN and/or licensed nurse available. The Nursing Clinical Director stated she had not seen or viewed the video footage following thls allegation.	A 392		

SOD-State Forms

Texas Department of State Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Y 000	25 TAC 134 INITIAL COMMENTS Note: The State Form is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be referred to the Office of the Texas Attorney General (OAG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. An unannounced visit was conducted from 08/06/15 to 08/10/15 to conduct a survey for complaint investigation (TX 00218998). An entrance conference was conducted on 08/06/15 in the conference room of the facility with the Director of Risk Management. The purpose and process of the complaint survey were discussed and an opportunity for questions was provided. Complaint, TX 00218998, was substantiated with state violations cited. An exit conference was conducted on 08/10/15 in the conference room. The Director of Risk Management, the Vice President of Clinical Services, the Nursing Clinical Director, and Interim Behavioral Health Administrator were in attendance. Preliminary findings of the survey were discussed and an opportunity for questions was provided.	Y 000		
Y 313	134.46(c)(3)(A) Abuse & Neglect: Reporting responsibility Reporting abuse and neglect. A person, including an employee, volunteer, or other person	Y 313	**Plan of Correction** **Y313** Mandatory read and sign in-service for all front-line behavioral health staff to include nursing, MHT, NP, social workers, intake/assessment, security and admitting to be completed by 9/14/15.	**9/14/15**

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Y 313	Continued From page 1 associated with the facility who reasonably believes or who knows of information that would reasonably cause a person to believe that the physical or mental health or welfare of a patient of the facility who is receiving mental health or chemical dependency services has been, is, or will be adversely affected by abuse or neglect (as those terms are defined in this subsection) by any person shall as soon as possible report the information supporting the belief to the department or to the appropriate state health care regulatory agency in accordance with HSC, §161.132(a). This REQUIREMENT is not met as evidenced by: Based on interview and record review, facility employees failed to report an allegation of neglect to the state health care regulatory agency, the Department of State Health Services (DSHS); and in accordance with their policy, for 1 of 1 patients reviewed (Patient #1) with a complaint allegation of sexual assault against another patient (Patient #2). Specifically, on 04/27/15, Patient #1 reported to the unit's Registered Nurse (RN) an allegation of sexual assault from another Patient, (#2); who had a history of inappropriate sexual behaviors. The allegation was reported to the Medical Doctor, the Nursing Manager, and local Police Department (PD); however, this allegation was not reported to the state health care regulatory agency by any facility employees, in accordance with their policy. This deficient practice could affect the prevention of possible unidentified abuse, neglect, or mistreatment for all patients in the facility; by	Y 313	Mandatory In-services to be conducted on 9/14, 9/16, and 9/18 for all behavioral health staff with multiple offerings in order to ensure all staff are able to attend one of these educational events. The mandatory in-service will reinforce the hospital policy regarding Assessment and Reporting of Abuse and Neglect, reinforce the need to document outlier events affecting patients, and roll out the Code Green Response Protocol. The Code Green Response Protocol includes the following: 1.) reinforces assigning a specific Code Green response team to include back up for breaks as appropriate as well as for census level and unit acuity to ensure appropriate staffing is left on inpatient units, 2.) provides instruction for responding in the event multiple codes are called at the same time. to insure patient and staff safety, 3.) Psychiatric Emergency Service Unit (PES) staff will not respond to Code Greens unless the unit is overstaffed for its current population, 4.) reinforces that all supervisors will respond to Code Green, 5.) reinforces what should happen to maintain safety on the units when the Code Green team responds which includes: a.) suspension of non-essential tasks, b.) cohort the patients as much as possible to control the situation and monitor for safety,	

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Y 313	Continued From page 2 compromising their safety. Findings Included: Review of Patient #1's Complaint Form dated 05/15/15 indicated the following in part: On 04/27/15 at approximately 11:30 AM Patient #1 was admitted to the facility's "Psychiatric Emergency Services (PES) unit and received medication to help her sleep and calm down. Patient #1 reported shortly after she received the medications; she was asleep in her bed when she "felt someone touching my vagina and butt. I felt a hard pressure. I jumped up and another male patient [#2] jumped out from under my covers." Patient #1 stated she went to find a staff member (Mental Health Worker-A), to report what had happened. Patient #1 indicated she noticed her entire "crotch area [paper gown] was torn exposing her "vagina and butt." Patient #1 indicated the facility staff called the Police Department (PD) for Patient #1 to make a report. Patient #1 reported the staff apologized to her for the incident; "but they had an emergency on another floor and they were short staffed, so every staff member had left." Patient #1 indicated she was "so upset and scared; so they gave me more meds to put me to sleep." Patient #1 stated the facility had done nothing more to help her; there were no witnesses but she believed there were cameras in the hall. Patient #1 stated she found out that Patient #2 had done this before and the Police Officer who responded stated that; "he [Patient #2] has a history of doing this; why was he unsupervised?" Review of the facility's Policy titled, Abuse Reporting-External and Internal, last reviewed January 2012 revealed the following definitions: Psychological Abuse included; humiliation and	Y 313	c.) response team clearly communicates to their charge when they leave from and return to the unit. Additional topics for the mandatory in-service include: a decision tree to reinforce the policy on reporting and follow-up of suspected/reported allegations of abuse/neglect of a patient during hospitalization and in treating patients identified as having ordered sexual precautions. Follow up in-servicing is planned for February 2016 to include participation by same staff members to continue reinforcement of policies.	

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Y 313	Continued From page 3 harassment. Sexual Abuse included; sexual harassment, sexual coercion, and sexual assault. Review of the facility's Policy titled, Assessment and Reporting of Abuse and Neglect, last reviewed February 2013 revealed Neglect included the failure to provide for one's self the goods or services including medical services, which are necessary to avoid physical or emotional harm or pain or the failure of a caretaker to provide the goods or services. The policy indicated the facility "prohibits neglect, mental or physical abuse or misappropriation of property, of patients by staff, visitors, or other patients." The facility "will report allegations and release information to the proper authorities, according to federal regulations, state specific rules and regulation and [facility] practice guidelines." Further review of the policy indicated, in part: 1. Reporting allegations of abuse and/or neglect occurring while the patient is under the care in the facility: All alleged violations concerning abuse and neglect while the patient is under the care of the facility will be reported to the Compliance Officer or designee, who will advise the on-call administrator/designee. As appropriate, the facility will report the incident to appropriate state, federal and protective/regulatory agencies, and/or law enforcement agencies and conduct an internal investigation within a maximum of five working days of the incident. The Texas Department of state Health Services (DSHS) is the regulatory body for reporting concerns of hospitals, psychiatric hospitals (including private psychiatric facilities), and various other medical facilities.	Y 313		

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Y 313	Continued From page 4 Review of the facility's Original Event report dated 04/27/15 at 12:15 PM completed by the unit RN revealed Patient #1 reported, "She was lying in bed asleep, when she felt Patient [#2] putting pressure around her buttocks area, and then touching her perineal area. Patient[#1] reported sitting up in bed shock and scared, and found Patient [#2] was up in her face with his finger to his mouth telling her to be quiet not to tell. She found her paper scrub button torned on the outer left side. MD [Medical Doctor], Nurse Manager notified, Patient made a police complaint." PD interviewed Patient #1 and accused, Patient #2. "Patient visible distraught, but no other physical problems noted at this time." Further review of the Original Event indicated the Event was documented as "Attempted Rape/Rape/Sexual Assault." Factors included; "Unit busy code greens called on other unit, and high acute of unit." The Original Event report did not include any documentation that this allegation was reported to the state health care regulatory agency by any facility employees, in accordance with the facility's policy. The Original Event report did not include documentation that this allegation was thoroughly investigated by the facility for the identification of neglect and/or a corrective action plan to prevent repeat incidence; in accordance with the facility's policy. The Compliance Officer/Director of Risk Management (RM) acknowledged receipt of the Original Event report dated 04/27/15 at 12:15 PM electronically on 05/06/15 documenting Patient #1 made a Police Report. Review of the local PD report dated 04/27/15 at 12:45PM revealed Patient #1 wanted to report that, "she was a sleep in her room, when she awaken and felt pressure around her buttock and	Y 313		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

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Y 313	Continued From page 5 vaginal area. When she fully awaken, she observed [Patient #2] in bed with her." Patient #1 further stated that Patient #2 told her "Don't tell anyone," before he left her room. Patient #1 did not feel Patient #2 penetrate her at any time, but the hospital [paper gown] pajama that she was wearing had a tear between the leg area. Patient #2 denied being in bed with Patient #1, or touching her. The report was deemed as "Disorderly Conduct" and Patient #1 was advised to contact the special victim's unit to file charges against Patient #2. "The Hospital staff was advised to monitor [Patient #2's] movement more closely." Record review of the medical record of Patient #1 revealed she was a 37 year-old female admitted to the psychiatric facility on 04/27/15 at 0830 under Emergency Detention (ED) when she cut her wrist and called a friend to call Police. Patient #1 has a history of Depression with Anxiety. Further review of Patient #1's permanent records revealed no documentation following the sexual assault allegation that she made on 04/27/15 against Patient #2. There was no documentation in her record that she received a physical and/or psychological assessment following her allegation on 04/27/15. There was a Telephone Physician Order (PO) on 04/27/15 at 12:30 PM (following the allegation) for Ativan (an anti-anxiety) 2 milligrams by mouth "now" without documentation of the reason for the emergency medication. The only documentation in Patient #1's record regarding her allegation against Patient #2 was a Behavioral Team Progress Note dated 05/01/15 at 12:28 completed by Licensed Social Worker- A that indicated "Patient discussed being sexually assaulted by Patient [#2] in the [facility's] PES	Y 313		

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Y 313	Continued From page 6 unit. Review of Patient #1's Daily Observation Notes for 04/27/15 revealed the following: At 11:30-MHW-A documented 1Q (1=On unit, and Q=Quiet/Calm). At 11:45-MHW-A documented 1B (On unit, and B=In Bed Awake). At 12:00-MHW-A documented 1BA (On unit, In Bed Awake, and A=agitated/restless). At 12:15 MHW-A documented 1BA. At 12:30, 12:45, 13:00, 13:15, 13:30, and 13:45-MHW-A documented 1A (On Unit and agitated/restless). Record review of Patient #2's medical records revealed the following: Patient #2's Psychiatric Evaluation dated 04/24/15 revealed he was a 30 year old male admitted to the PES unit on 04/24/15 with a history of schizoaffective disorder and traumatic brain injury (TBI). Patient #2 was admitted on an ED basis with a history of aggressive behaviors requiring emergency medications to calm him. Patient #2 had recently been discharged from this facility 4-5 weeks prior and has had multiple inpatient treatment episodes over the years (7 inpatient admissions in the previous 5 months). Patient #2 was documented with a known history of aggression and a "history of inappropriate sexual behavior on the unit (masturbating)." Patient #2 had documented borderline intellectual functioning with poor insight, poor judgment, and poor impulse control. A Behavioral Nursing Shift Assessment completed by the unit RN on 04/27/15 at 18:08 that Patient #2 was found by a female patient touching on her body while she was asleep in	Y 313		

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Y 313	Continued From page 7 bed. MD, and Nurse Manager notified. A Telephone PO dated 04/27/15 at 2015 for Patient #2 to be transferred to a higher acuity; sister facility. A Behavior Team Progress noted dated 04/27/15 at 1855 revealed Patient #2 was transferred to a sister facility by the Sheriff's Department. Review of the facility's Incident Event dated 04/27/15 at 11:37 AM confirmed a Code Green was called for another Patient [#3] in the Child/Adolescent Unit requiring Restraints/Seclusion. Patient #3 required physical restraint at 11:36 AM, and emergency medications at 11:46 AM. Patient #3 was released from restraint at 12:26 PM. This Code Green occurred during the same time frames of Patient #1's allegation on 04/27/15. Review of the facility's Policy titled, Psychiatric Emergencies-Code Green, last reviewed January 2012 revealed a Code Green was a Psychiatric Emergency. Code Green will be implemented by any unit personnel in the event of unmanageable behavior of an individual to prevent harm to that individual, patients, hospital personnel and/or others the general hospital area. D. Individuals responding to Code Green will meet in announced area. Available personnel is necessary to control atmosphere through a show of strength and caring or to assist in physical management. Interview on 08/06/15 at 12:35 PM with the PES unit RN revealed she completed Patient #1's admission assessment to the PES unit on 04/27/15. The unit RN indicated Patients were provided with paper scrubs to wear without other	Y 313		

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Y 313	Continued From page 8 undergarments. The unit RN stated that on 04/27/15 at approximately 11:30 AM to 12:00 PM, "Code Greens" were going on; and "staff were busy". The unit RN stated there was a Code Green on another unit (child/adolescent) and a Code Green was called in the lobby; due to a patient needing to be "put in a [restraint] chair" because they were tearing up the lobby. The unit RN stated she left the unit to respond to the Code Green in the other unit (child/adolescent) and when she arrived; there was another RN responding, so she went to the Code Green in the lobby because they needed an RN to assist with "putting the patient in the [restraint] chair." The unit RN stated she returned to the PES unit following the Code Greens to "something else going on at the end of the unit" that she responded to. The unit RN stated she could not remember if it was LVN-A or LVN-B working on 04/27/15; but that she thought the LVN stayed back in the PES unit when she left and responded to the two Code Greens. The unit RN stated she was notified that during the Code Greens Patient #2 went into Patient #1's bedroom; and Patient #1 made an allegation of sexual assault. The unit RN stated she spoke with Patient #1 who reported that she was asleep in her bedroom and "she felt pressure" causing her to awake to Patient #2 touching her in the buttock and perineal area. The unit RN stated that Patient #1's paper pants were "torn on the side." The unit RN stated the local PD was called. The unit RN stated she spoke to Patient #2 and he said, "I touched her, but didn't do anything else." The unit RN stated he admitted that he "touched her and ripped her paper pants." The unit RN stated that Patient #2 knew that the unit was "chaotic" and knew what Code Green meant; and that is when he "took advantage" of the situation. The unit RN stated she believed that	Y 313		

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Y 313	Continued From page 9 Patient #2 sexually assaulted Patient #1 given the facts, and his own admission. The unit RN stated she notified the MD, Social Worker, and Nursing Manager of the allegation. The unit RN indicated she documented the sexual assault allegation made by Patient #1 on the facility's Event Report; however, confirmed she did not document the sexual assault allegation in Patient #1's record following the incident. The unit RN stated she offered for Patient #1 to have a Sexual Assault Nurse Examination (SANE) completed at another facility if she wanted; but Patient #1 declined, stating she did not believe Patient #2 actually raped her. The unit RN confirmed she had not reported this allegation to the state health care regulatory agency (DSHS). Interview on 08/06/15 at 04:45 PM with MHW-A revealed she was the only MHW working on 04/27/15 in the PES unit; along with the unit RN and a Licensed Vocational Nurse (LVN). MHW-A stated she was pulled to the PES unit at 9:15 AM and was unfamiliar to the PES unit; but was told by the leaving MHW to "watch it" for Patient #2, however, she did not know the specific reason why. MHW-A stated the females were assigned rooms on one side, and males on the other side. MHW-A stated during the morning on 04/27/15 at approximately 11:30 AM-12:00 PM it was a "hectic/busy" day with "Code Green's being called." MHW-A stated that security was usually on the PES unit; but on 04/27/15 at the time of the allegation; "security could not be found." MHW-A stated on 04/27/15 at around 11:30-12:00 PM she stayed in the unit when the Code Greens were called and was "getting something out of the supply closet." MHW-A indicated the unit RN "responded to the Code Green" leaving the unit; telling her she [unit RN] would be back. MHW-A	Y 313		

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Y 313	Continued From page 10 did not remember if LVN-A or LVN-B was working on 04/27/15; but further stated she did not remember any LVN being in the unit during the time of the allegation made by Patient #1. MHW-A stated shortly after this Patient #1 "flagged her [MHW-A] down" to her bedroom, and into the restroom of the bedroom where she reported that Patient #2 came into her room and touched her buttocks and vaginal area while she was sleeping in her bed. MHW-A stated that Patient #1's gown was torn around the buttock area and she offered to call the local PD for Patient #1 to make a report. MHW-A stated she then reported the incident/allegation to the unit RN. MHW-A stated she was later told that Patient #2 had been an inpatient to the facility many times before, and he "knows the system; knows what Code Green means." MHW-A stated she had seen Patient #2 "walking out of her [Patient #1] room a few times" and further stated "right before she flagged me down, he had walked out of her room". MHW-A indicated she told Patient #2 "not to go in to other people's rooms." MHW-A confirmed she had not documented the allegation reported by Patient #1 against Patient #2; but that she "told [unit RN]." Interview on 08/10/15at 1:20 PM with Patient #1 revealed on 04/27/15 at approximately 11:30-11:45 AM she was in her assigned bedroom sleeping after she received multiple medications following her admission. Patient #1 stated she awoke after she "felt pressure" in her buttock and vaginal area. Patient #1 stated that Patient #2 was present telling her not to tell anyone. Patient #1 stated that she noticed her paper pants were ripped and she was not actually aware what all Patient #2 actually did because she "was conked out" after taking multiple medications. Patient #1 stated she knows he	Y 313		

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Y 313	Continued From page 11 touched her because that was what woke her up. Patient #1 stated she was very upset, "freaked out," and asked the MD for an "AIDS" test. Patient #1 stated the unit RN indicated to the nursing staff (LVN) to "give her more meds" because she was "upset, crying, and freaking out." Patient #1 stated she then received the Ativan for her anxiety, to "help me calm down." Patient #1 stated the local PD came and she made a report. Patient #1 stated she was told by the unit RN that "Code Green's" were called and "everyone had to leave the unit" which allowed the opportunity for Patient #2 to go into her room unsupervised. Interview on 08/10/15 at 2:20 PM with Security Guard-A revealed he was employed by the facility to maintain security and the safety of patients. The Security Guard-A stated Patient #2 had a history of inappropriate sexual behavior of "masturbating in front of females." The Security Guard-A stated he assisted with "viewing the video" footage for evidence following the allegation on 04/27/15 made be Patient #1 against Patient #2. The Security Guard stated the video footage from 04/27/15 showed a total of "four times" that Patient #2 went into Patient #1's room; and the last time Patient #2 came out of Patient #1's room; she was observed to come out of the room a few minutes later. The Security Guard stated that Patient #2 had already been assigned to the front "seclusion room" of the PES unit as his bedroom due to his history of masturbating. The Security Guard stated on the video footage Patient #2 could be seen coming from his room; "looking side to side" down the hallway, and then going into Patient #1's room. The Security Guard stated that female and male patient rooms were separated and that Patient #2	Y 313		

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Y 313	Continued From page 12 was not supposed to be going into Patient #1's room for any reason. Interview on 08/10/15 at 2:50 PM with MD-A revealed he was notified of Patient #1's sexual assault allegation against Patient #2 on 04/27/15. MD-A stated he discussed with Patient #1 the option of a "Rape Kit" but she "declined." MD-A stated he understood the allegation made by Patient #1 to be "only touching with no penetration." MD-A stated that Patient #1 was "distressed" about the incident and he ordered Ativan for Patient #1's anxiety following the incident. MD-A stated Patient #1 had already been distressed emotionally because of her ED inpatient admission; and really did not even want to take the Ativan. MD-A stated he recalled there was a Code Green called where staff left the unit in response to the Code Green; which left less staffing in the unit. MD-A confirmed that he did not document in Patient #1's records his contact or discussion with Patient #1 following her allegation. Interview on 08/10/15 at 3:00 PM with the facility's Risk Manager (RM) indicated that she was aware of the alleged sexual assault allegation made by Patient #1 on 04/27/15 against Patient #2'; however, she had not been notified until 05/06/15 via the facility's Incident/Event electronic system because there had not been any harm documented in order to elevate the notification. The RM stated the staffing ratio on the PES unit was 1 staff to 4 patients. The RM indicated on 04/27/15 the patient census in the PES unit was 11; requiring 3 staff. The RM stated the first required staff is an RN, and then second could be a LVN, and/or MHW. The RM confirmed for 11 patients the required staffing would be 3. The RM	Y 313		

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Y 313	Continued From page 13 stated the PES unit was to always have a licensed nurse present and available in the unit. The RM confirmed that she had not reported the sexual assault allegation made by Patient #1 on 04/27/15 against Patient #2 to the state health care regulatory agency, Department of State Health Services (DSHS); which was determined to have occurred as a result of insufficient staffing in the PES unit during episodes of Code Green's. The RM further confirmed the facility had not completed a thorough investigation with documented findings specific to this allegation for the determination of Neglect and/or a corrective action plan to prevent repeat incidence; in accordance with the facility's policy. The RM stated she had not seen or viewed the video footage following this allegation due to the video being unavailable after 05/06/15; following her electronic notification. Interview on 08/10/15 at 3:15 PM with Licensed Social Worker (LSW)-A stated she assisted Security Guard-A in viewing the video footage on 04/27/15 after Patient #1 made a sexual assault allegation against Patient #2. LSW-A stated that during the allegation on 04/27/15; Patient #2 could be seen on the camera "looking both ways" and then would go into Patient #1's bedroom. LSW-A stated they were able to count this event occurring a "couple of times" where Patient #2 would go into Patient #1's bedroom and remain there "a couple of minutes" each time. LSW-A stated she saw on the video where MHW-A had been in the "Patient evaluation room" during these time periods; where a supply closet was located. LSW-A stated Patient #2 had a history of "exposing his self, public masturbation, and talks sexually to other women." LSW-A stated that Patient #2 has publically masturbated in front of	Y 313		

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Y 313	Continued From page 14 her during an assessment interview. Interview on 08/10/15 at 4:15 PM with LVN-A stated he was present and worked the PES unit on 04/27/15. LVN-A stated that on 04/27/15 there were Code Greens called on another unit, and in the facility's lobby about the same time. LVN-A stated he responded to the Code Green in the lobby to assist due to a "fight." LVN-A indicated he had left the unit for approximately 15 minutes. Interview on 08/10/15 at 4:30 PM with the Vice President (VP) of Clinical Services confirmed that she was notified of the sexual allegation made by Patient #1 against Patient #2 on 04/27/15; however, she had not been notified until 05/06/15 via the facility's Incident/Event electronic system because there had not been any harm documented in order to elevate the notification. The VP of Clinical Services indicated that on 04/27/15 the Nursing Clinical Director (Nurse Manager) had been notified immediately following Patient #1's allegation and she had not obtained information that indicated Patient #1's allegation had occurred due to insufficient staffing in the PES unit when Code Green's had been called; leaving the unit without a RN available. The VP of Clinical Services stated that the unit RN was not supposed to leave the unit and there should always be a Licensed Nurse in the unit during a Code Green; that "it is a judgement call." The VP of Clinical Services stated she had not seen or viewed the video footage following this allegation due to the video being unavailable after 05/06/15; following her electronic notification. The VP of Clinical Services confirmed she had not reported this allegation to the state health care regulatory agency (DSHS).	Y 313		

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Y 313	Continued From page 15 Interview on 08/10/15 at 4:40 PM with the Nursing Clinical Director (Nurse Manager) stated she was immediately notified by the PES unit RN on 04/27d/15 of Patient #1's sexual allegation against Patient #2. The Nursing Clinical Director indicated she "separated" the Patients, talked to both of them, and Patient #1 saw the Doctor. The Nursing Clinical Director stated she spoke to the unit RN about the allegation but had not been notified or received information that the RN and LVN had left the PES unit to respond to Code Greens which left the unit without a RN and/or licensed nurse available. The Nursing Clinical Director stated she had not seen or viewed the video footage following this allegation. The Nursing Clinical Director confirmed she had not reported this allegation to the state health care regulatory agency (DSHS).	Y 313		
Y 523	404.154(24) Rights: Persons Receiving Mental Health Srvs The right to be free from mistreatment, abuse, neglect, and exploitation. See 40 TAC Chapter 710, Subchapter A (concerning Abuse and Neglect of Persons Served by TXMHMR Facilities), 40 TAC Chapter 710, Subchapter B (concerning Client Abuse and Neglect in Community Mental Health and Mental Retardation Centers), and 40 TAC Chapter 710, Subchapter C (concerning Patient Abuse in Private Psychiatric Facilities). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the patient's rights to be free from	Y 523	**Plan of Correction** **Y523** Mandatory read and sign in-service for all front-line behavioral health staff to include nursing, MHT, NP, social workers, intake/assessment, security and admitting to be completed by 9/14/15. Mandatory In-services to be conducted on 9/14, 9/16, and 9/18 for all behavioral health staff with multiple offerings in order to ensure all staff are able to attend one of these educational events. The mandatory in-service will reinforce the hospital policy regarding Assessment and Reporting of Abuse and Neglect, reinforce the need to document outlier events affecting patients, and roll out the	9/14/15

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Y 523	Continued From page 16 all forms of abuse or harassment by failing to prevent, protect, investigate, and report/respond to an allegation of neglect in accordance with their policy, for 1 of 1 patients reviewed (Patient #1) with a complaint allegation of sexual assault against another patient (Patient #2). On 04/27/15, Patient #1 reported to the unit's Registered Nurse (RN) an allegation of sexual assault from another Patient, (#2); who had a history of inappropriate sexual behaviors. The allegation was reported to the Medical Doctor, the Nursing Manager, and local Police Department (PD); however, this allegation was not reported to the state health care regulatory agency by any facility employees, in accordance with their policy. In addition, this allegation was not thoroughly investigated by the facility for the identification of neglect and/or a corrective action plan to prevent repeat incidence; in accordance with the facility's policy. This deficient practice could affect the prevention of possible unidentified abuse, neglect, or mistreatment for all patients in the facility; by compromising their safety. Findings Included: Review of Patient #1's Complaint Form dated 05/15/15 indicated the following in part: On 04/27/15 at approximately 11:30 AM Patient #1 was admitted to the facility's "Psychiatric Emergency Services (PES) unit and received medication to help her sleep and calm down. Patient #1 reported shortly after she received the medications; she was asleep in her bed when she "felt someone touching my vagina and butt. I felt a hard pressure. I jumped up and another male patient [#2] jumped out from under my covers."	Y 523	Code Green Response Protocol. The Code Green Response Protocol includes the following: 1.) reinforces assigning a specific Code Green response team to include back up for breaks as appropriate as well as for census level and unit acuity to ensure appropriate staffing is left on inpatient units, 2.) provides instruction for responding in the event multiple codes are called at the same time. to insure patient and staff safety, 3.) Psychiatric Emergency Service Unit (PES) staff will not respond to Code Greens unless the unit is overstaffed for its current population, 4.) reinforces that all supervisors will respond to Code Green, 5.) reinforces what should happen to maintain safety on the units when the Code Green team responds which includes: a.) suspension of non-essential tasks, b.) cohort the patients as much as possible to control the situation and monitor for safety, c.) response team clearly communicates to their charge when they leave from and return to the unit. Additional topics for the mandatory in-service include: a decision tree to reinforce the policy on reporting and follow-up of suspected/reported allegations of abuse/neglect of a patient during hospitalization and in treating patients identified as having ordered	

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Y 523	Continued From page 17 Patient #1 stated she went to find a staff member (Mental Health Worker-A), to report what had happened. Patient #1 indicated she noticed her entire "crotch area [paper gown] was torn exposing her "vagina and butt." Patient #1 indicated the facility staff called the Police Department (PD) for Patient #1 to make a report. Patient #1 reported the staff apologized to her for the incident; "but they had an emergency on another floor and they were short staffed, so every staff member had left." Patient #1 indicated she was "so upset and scared; so they gave me more meds to put me to sleep." Patient #1 stated the facility had done nothing more to help her; there were no witnesses but she believed there were cameras in the hall. Patient #1 stated she found out that Patient #2 had done this before and the Police Officer who responded stated that; "he [Patient #2] has a history of doing this; why was he unsupervised?" Review of the facility's Policy titled, Abuse Reporting-External and Internal, last reviewed January 2012 revealed the following definitions: Psychological Abuse included; humiliation and harassment. Sexual Abuse included; sexual harassment, sexual coercion, and sexual assault. Review of the facility's Policy titled, Assessment and Reporting of Abuse and Neglect, last reviewed February 2013 revealed Neglect included the failure to provide for one's self the goods or services including medical services, which are necessary to avoid physical or emotional harm or pain or the failure of a caretaker to provide the goods or services. The policy indicated the facility "prohibits neglect, mental or physical abuse or misappropriation of property, of patients by staff, visitors, or other	Y 523	sexual precautions. Follow up in-servicing is planned for February 2016 to include participation by same staff members to continue reinforcement of policies.	

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Y 523	Continued From page 18 patients." The facility "will report allegations and release information to the proper authorities, according to federal regulations, state specific rules and regulation and [facility] practice guidelines." Further review of the policy indicated, in part: 1. Reporting allegations of abuse and/or neglect occurring while the patient is under the care in the facility: All alleged violations concerning abuse and neglect while the patient is under the care of the facility will be reported to the Compliance Officer or designee, who will advise the on-call administrator/designee. As appropriate, the facility will report the incident to appropriate state, federal and protective/regulatory agencies, and/or law enforcement agencies and conduct an internal investigation within a maximum of five working days of the incident. The Texas Department of state Health Services (DSHS) is the regulatory body for reporting concerns of hospitals, psychiatric hospitals (including private psychiatric facilities), and various other medical facilities. 2. Investigations are always prompt, comprehensive and responsive to the situation, well conducted, and contain founded conclusions. The investigation may include, but are not limited to the following: -interviews conducted with individuals having first-hand knowledge of the incident. -Follow-up resolution -Corrective action plan to prevent repeat incidence. -Reports made to appropriate state health care regulatory agency. Review of the facility's Original Event report dated	Y 523		

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Y 523	Continued From page 19 04/27/15 at 12:15 PM completed by the unit RN revealed Patient #1 reported, "She was lying in bed asleep, when she felt Patient [#2] putting pressure around her buttocks area, and then touching her perineal area. Patient[#1] reported sitting up in bed shock and scared, and found Patient [#2] was up in her face with his finger to his mouth telling her to be quiet not to tell. She found her paper scrub button turned on the outer left side. MD [Medical Doctor], Nurse Manager notified, Patient made a police complaint." PD interviewed Patient #1 and accused, Patient #2. "Patient visible distraught, but no other physical problems noted at this time." Further review of the Original Event indicated the Event was documented as "Attempted Rape/Rape/Sexual Assault." Factors included; "Unit busy code greens called on other unit, and high acute of unit." The Original Event report did not include any documentation that this allegation was reported to the state health care regulatory agency by any facility employees, in accordance with the facility's policy. The Original Event report did not include documentation that this allegation was thoroughly investigated by the facility for the identification of neglect and/or a corrective action plan to prevent repeat incidence; in accordance with the facility's policy. The Compliance Officer/Director of Risk Management (RM) acknowledged receipt of the Original Event report dated 04/27/15 at 12:15 PM electronically on 05/06/15 documenting Patient #1 made a Police Report. Record review of the medical record of Patient #1 revealed she was a 37 year-old female admitted to the psychiatric facility on 04/27/15 at 0830 under Emergency Detention (ED) when she cut her wrist and called a friend to call Police. Patient #1 has a history of Depression with Anxiety.	Y 523		

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Y 523	Continued From page 20 Further review of Patient #1's permanent records revealed no documentation following the sexual assault allegation that she made on 04/27/15 against Patient #2. There was no documentation in her record that she received a physical and/or psychological assessment following her allegation on 04/27/15. There was a Telephone Physician Order (PO) on 04/27/15 at 12:30 PM (following the allegation) for Ativan (an anti-anxiety) 2 milligrams by mouth "now" without documentation of the reason for the emergency medication. The only documentation in Patient #1's record regarding her allegation against Patient #2 was a Behavioral Team Progress Note dated 05/01/15 at 12:28 completed by Licensed Social Worker- A that indicated "Patient discussed being sexually assaulted by Patient [#2] in the [facility's] PES unit. Review of Patient #1's Daily Observation Notes for 04/27/15 revealed the following: At 11:30-MHW-A documented 1Q (1=On unit, and Q=Quiet/Calm). At 11:45-MHW-A documented 1B (On unit, and B=In Bed Awake). At 12:00-MHW-A documented 1BA (On unit, In Bed Awake, and A=agitated/restless). At 12:15 MHW-A documented 1BA. At 12:30, 12:45, 13:00, 13:15, 13:30, and 13:45-MHW-A documented 1A (On Unit and agitated/restless). Record review of Patient #2's medical records revealed the following: Patient #2's Psychiatric Evaluation dated 04/24/15 revealed he was a 30 year old male admitted to the PES unit on 04/24/15 with a history of schizoaffective disorder and traumatic	Y 523		

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Y 523	Continued From page 21 brain injury (TBI). Patient #2 was admitted on an ED basis with a history of aggressive behaviors requiring emergency medications to calm him. Patient #2 had recently been discharged from this facility 4-5 weeks prior and has had multiple inpatient treatment episodes over the years (7 inpatient admissions in the previous 5 months). Patient #2 was documented with a known history of aggression and a "history of inappropriate sexual behavior on the unit (masturbating)." Patient #2 had documented borderline intellectual functioning with poor insight, poor judgment, and poor impulse control. A Behavioral Nursing Shift Assessment completed by the unit RN on 04/27/15 at 18:08 that Patient #2 was found by a female patient touching on her body while she was asleep in bed. MD, and Nurse Manager notified. A Telephone PO dated 04/27/15 at 2015 for Patient #2 to be transferred to a higher acuity; sister facility. A Behavior Team Progress noted dated 04/27/15 at 1855 revealed Patient #2 was transferred to a sister facility by the Sheriff's Department. Review of the facility's Incident Event dated 04/27/15 at 11:37 AM confirmed a Code Green was called for another Patient [#3] in the Child/Adolescent Unit requiring Restraints/Seclusion. Patient #3 required physical restraint at 11:36 AM, and emergency medications at 11:46 AM. Patient #3 was released from restraint at 12:26 PM. This Code Green occurred during the same time frames of Patient #1's allegation on 04/27/15. Review of the facility's Policy titled, Psychiatric	Y 523		

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Y 523	Continued From page 22 Emergencies-Code Green, last reviewed January 2012 revealed a Code Green was a Psychiatric Emergency. Code Green will be implemented by any unit personnel in the event of unmanageable behavior of an individual to prevent harm to that individual, patients, hospital personnel and/or others the general hospital area. D. Individuals responding to Code Green will meet in announced area. Available personnel is necessary to control atmosphere through a show of strength and caring or to assist in physical management. Interview on 08/06/15 at 12:35 PM with the PES unit RN revealed she completed Patient #1's admission assessment to the PES unit on 04/27/15. The unit RN indicated Patients were provided with paper scrubs to wear without other undergarments. The unit RN stated that on 04/27/15 at approximately 11:30 AM to 12:00 PM, "Code Greens" were going on; and "staff were busy". The unit RN stated there was a Code Green on another unit (child/adolescent) and a Code Green was called in the lobby; due to a patient needing to be "put in a [restraint] chair" because they were tearing up the lobby. The unit RN stated she left the unit to respond to the Code Green in the other unit (child/adolescent) and when she arrived; there was another RN responding, so she went to the Code Green in the lobby because they needed an RN to assist with "putting the patient in the [restraint] chair." The unit RN stated she returned to the PES unit following the Code Greens to "something else going on at the end of the unit" that she responded to. The unit RN stated she could not remember if it was LVN-A or LVN-B working on 04/27/15; but that she thought the LVN stayed back in the PES unit when she left and responded to the two Code Greens. The unit RN	Y 523		

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Y 523	Continued From page 23 stated she was notified that during the Code Greens Patient #2 went into Patient #1's bedroom; and Patient #1 made an allegation of sexual assault. The unit RN stated she spoke with Patient #1 who reported that she was asleep in her bedroom and "she felt pressure" causing her to awake to Patient #2 touching her in the buttock and perineal area. The unit RN stated that Patient #1's paper pants were "torn on the side." The unit RN stated the local PD was called. The unit RN stated she spoke to Patient #2 and he said, "I touched her, but didn't do anything else." The unit RN stated he admitted that he "touched her and ripped her paper pants." The unit RN stated that Patient #2 knew that the unit was "chaotic" and knew what Code Green meant; and that is when he "took advantage" of the situation. The unit RN stated she believed that Patient #2 sexually assaulted Patient #1 given the facts, and his own admission. The unit RN stated she notified the MD, Social Worker, and Nursing Manager of the allegation. The unit RN indicated she documented the sexual assault allegation made by Patient #1 on the facility's Event Report; however, confirmed she did not document the sexual assault allegation in Patient #1's record following the incident. The unit RN stated she offered for Patient #1 to have a Sexual Assault Nurse Examination (SANE) completed at another facility if she wanted; but Patient #1 declined, stating she did not believe Patient #2 actually raped her. Interview on 08/06/15 at 04:45 PM with MHW-A revealed she was the only MHW working on 04/27/15 in the PES unit; along with the unit RN and a Licensed Vocational Nurse (LVN). MHW-A stated she was pulled to the PES unit at 9:15 AM and was unfamiliar to the PES unit; but was told	Y 523		

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Y 523	Continued From page 24 by the leaving MHW to "watch it" for Patient #2, however, she did not know the specific reason why. MHW-A stated the females were assigned rooms on one side, and males on the other side. MHW-A stated during the morning on 04/27/15 at approximately 11:30 AM-12:00 PM it was a "hectic/busy" day with "Code Green's being called." MHW-A stated that security was usually on the PES unit; but on 04/27/15 at the time of the allegation; "security could not be found." MHW-A stated on 04/27/15 at around 11:30-12:00 PM she stayed in the unit when the Code Greens were called and was "getting something out of the supply closet." MHW-A indicated the unit RN "responded to the Code Green" leaving the unit; telling her she [unit RN] would be back. MHW-A did not remember if LVN-A or LVN-B was working on 04/27/15; but further stated she did not remember any LVN being in the unit during the time of the allegation made by Patient #1. MHW-A stated shortly after this Patient #1 "flagged her [MHW-A] down" to her bedroom, and into the restroom of the bedroom where she reported that Patient #2 came into her room and touched her buttocks and vaginal area while she was sleeping in her bed. MHW-A stated that Patient #1's gown was torn around the buttock area and she offered to call the local PD for Patient #1 to make a report. MHW-A stated she then reported the incident/allegation to the unit RN. MHW-A stated she was later told that Patient #2 had been an inpatient to the facility many times before, and he "knows the system; knows what Code Green means." MHW-A stated she had seen Patient #2 "walking out of her [Patient #1] room a few times" and further stated "right before she flagged me down, he had walked out of her room". MHW-A indicated she told Patient #2 "not to go in to other people's rooms." MHW-A confirmed she had not	Y 523		

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Y 523	Continued From page 25 documented the allegation reported by Patient #1 against Patient #2; but that she "told [unit RN]." Interview on 08/10/15at 1:20 PM with Patient #1 revealed on 04/27/15 at approximately 11:30-11:45 AM she was in her assigned bedroom sleeping after she received multiple medications following her admission. Patient #1 stated she awoke after she "felt pressure" in her buttock and vaginal area. Patient #1 stated that Patient #2 was present telling her not to tell anyone. Patient #1 stated that she noticed her paper pants were ripped and she was not actually aware what all Patient #2 actually did because she "was conked out" after taking multiple medications. Patient #1 stated she knows he touched her because that was what woke her up. Patient #1 stated she was very upset, "freaked out," and asked the MD for an "AIDS" test. Patient #1 stated the unit RN indicated to the nursing staff (LVN) to "give her more meds" because she was "upset, crying, and freaking out." Patient #1 stated she then received the Ativan for her anxiety, to "help me calm down." Patient #1 stated the local PD came and she made a report. Patient #1 stated she was told by the unit RN that "Code Green's" were called and "everyone had to leave the unit" which allowed the opportunity for Patient #2 to go into her room unsupervised. Interview on 08/10/15 at 2:20 PM with Security Guard-A revealed he was employed by the facility to maintain security and the safety of patients. The Security Guard-A stated Patient #2 had a history of inappropriate sexual behavior of "masturbating in front of females." The Security Guard-A stated he assisted with "viewing the video" footage for evidence following the	Y 523		

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Y 523	Continued From page 26 allegation on 04/27/15 made be Patient #1 against Patient #2. The Security Guard stated the video footage from 04/27/15 showed a total of "four times" that Patient #2 went into Patient #1's room; and the last time Patient #2 came out of Patient #1's room; she was observed to come out of the room a few minutes later. The Security Guard stated that Patient #2 had already been assigned to the front "seclusion room" of the PES unit as his bedroom due to his history of masturbating. The Security Guard stated on the video footage Patient #2 could be seen coming from his room; "looking side to side" down the hallway, and then going into Patient #1's room. The Security Guard stated that female and male patient rooms were separated and that Patient #2 was not supposed to be going into Patient #1's room for any reason. Interview on 08/10/15 at 2:50 PM with MD-A revealed he was notified of Patient #1's sexual assault allegation against Patient #2 on 04/27/15. MD-A stated he discussed with Patient #1 the option of a "Rape Kit" but she "declined." MD-A stated he understood the allegation made by Patient #1 to be "only touching with no penetration." MD-A stated that Patient #1 was "distressed" about the incident and he ordered Ativan for Patient #1's anxiety following the incident. MD-A stated Patient #1 had already been distressed emotionally because of her ED inpatient admission; and really did not even want to take the Ativan. MD-A stated he recalled there was a Code Green called where staff left the unit in response to the Code Green; which left less staffing in the unit. MD-A confirmed that he did not document in Patient #1's records his contact or discussion with Patient #1 following her allegation.	Y 523		

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Y 523	Continued From page 27 Interview on 08/10/15 at 3:00 PM with the facility's Risk Manager (RM) indicated that she was aware of the alleged sexual assault allegation made by Patient #1 on 04/27/15 against Patient #2'; however, she had not been notified until 05/06/15 via the facility's Incident/Event electronic system because there had not been any harm documented in order to elevate the notification. The RM stated the staffing ratio on the PES unit was 1 staff to 4 patients. The RM indicated on 04/27/15 the patient census in the PES unit was 11; requiring 3 staff. The RM stated the first required staff is an RN, and then second could be a LVN, and/or MHW. The RM confirmed for 11 patients the required staffing would be 3. The RM stated the PES unit was to always have a licensed nurse present and available in the unit. The RM confirmed that she had not reported the sexual assault allegation made by Patient #1 on 04/27/15 against Patient #2 to the state health care regulatory agency, Department of State Health Services (DSHS); which was determined to have occurred as a result of insufficient staffing in the PES unit during episodes of Code Green's. The RM further confirmed the facility had not completed a thorough investigation with documented findings specific to this allegation for the determination of Neglect and/or a corrective action plan to prevent repeat incidence; in accordance with the facility's policy. The RM stated she had not seen or viewed the video footage following this allegation due to the video being unavailable after 05/06/15; following her electronic notification. Interview on 08/10/15 at 3:15 PM with Licensed Social Worker (LSW)-A stated she assisted Security Guard-A in viewing the video footage on	Y 523		

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Y 523	Continued From page 28 04/27/15 after Patient #1 made a sexual assault allegation against Patient #2. LSW-A stated that during the allegation on 04/27/15; Patient #2 could be seen on the camera "looking both ways" and then would go into Patient #1's bedroom. LSW-A stated they were able to count this event occurring a "couple of times" where Patient #2 would go into Patient #1's bedroom and remain there "a couple of minutes" each time. LSW-A stated she saw on the video where MHW-A had been in the "Patient evaluation room" during these time periods; where a supply closet was located. LSW-A stated Patient #2 had a history of "exposing his self, public masturbation, and talks sexually to other women." LSW-A stated that Patient #2 has publically masturbated in front of her during an assessment interview. Interview on 08/10/15 at 4:15 PM with LVN-A stated he was present and worked the PES unit on 04/27/15. LVN-A stated that on 04/27/15 there were Code Greens called on another unit, and in the facility's lobby about the same time. LVN-A stated he responded to the Code Green in the lobby to assist due to a "fight." LVN-A indicated he had left the unit for approximately 15 minutes. Interview on 08/10/15 at 4:30 PM with the Vice President (VP) of Clinical Services confirmed that she was notified of the sexual allegation made by Patient #1 against Patient #2 on 04/27/15; however, she had not been notified until 05/06/15 via the facility's Incident/Event electronic system because there had not been any harm documented in order to elevate the notification. The VP of Clinical Services indicated that on 04/27/15 the Nursing Clinical Director (Nurse Manager) had been notified immediately following	Y 523		

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Y 523	Continued From page 29 Patient #1's allegation and she had not obtained information that indicated Patient #1's allegation had occurred due to insufficient staffing in the PES unit when Code Green's had been called; leaving the unit without a RN available. The VP of Clinical Services stated that the unit RN was not supposed to leave the unit and there should always be a Licensed Nurse in the unit during a Code Green; that "it is a judgement call." The VP of Clinical Services stated she had not seen or viewed the video footage following this allegation due to the video being unavailable after 05/06/15; following her electronic notification. Interview on 08/10/15 at 4:40 PM with the Nursing Clinical Director (Nurse Manager) stated she was immediately notified by the PES unit RN on 04/27d/15 of Patient #1's sexual allegation against Patient #2. The Nursing Clinical Director indicated she "separated" the Patients, talked to both of them, and Patient #1 saw the Doctor. The Nursing Clinical Director stated she spoke to the unit RN about the allegation but had not been notified or received information that the RN and LVN had left the PES unit to respond to Code Greens which left the unit without a RN and/or licensed nurse available. The Nursing Clinical Director stated she had not seen or viewed the video footage following this allegation.	Y 523		

SOD-State Forms

Texas Department of State Health Services

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X 000	INITIAL COMMENTS Note: The State Form is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be referred to the Office of the Texas Attorney General (OAG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. An unannounced visit was conducted from 08/06/15 to 08/10/15 to conduct a survey for complaint investigation (TX 00218998). An entrance conference was conducted on 08/06/15 in the conference room of the facility with the Director of Risk Management. The purpose and process of the complaint survey were discussed and an opportunity for questions was provided. Complaint, TX 00218998, was substantiated with state violations cited. An exit conference was conducted on 08/10/15 in the conference room. The Director of Risk Management, the Vice President of Clinical Services, the Nursing Clinical Director, and Interim Behavioral Health Administrator were in attendance. Preliminary findings of the survey were discussed and an opportunity for questions was provided.	X 000		
X 365	133.41(o)(2)(B) Staffing: adequate personnel Nursing Services. Staffing and delivery of care.	X 365	**Plan of Correction** **X365** Mandatory In-services to be conducted on 9/14, 9/16, and 9/18 for all behavioral health staff with multiple offerings in	9/18/15

SOD - State Form

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Angela Dreal — TITLE: VP, Behavioral Health Svcs — (X6) DATE: 9/11/15

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X 365	Continued From page 1 (B) There shall be adequate numbers of RNs, licensed vocational nurses (LVNs), and other personnel to provide nursing care to all patients as needed. This Requirement is not met as evidenced by: Based on record review and interview, the facility failed to ensure there were sufficient numbers of licensed registered nurses (RN), licensed vocational nurses (LVN), and other personnel immediately available at all times in the unit to ensure the provision of care and supervision for patients (Patient #1 and #2) as required; resulting in an allegation of Neglect. Specifically, on 04/27/15, Patient #1 reported to the unit's Registered Nurse (RN) an allegation of sexual assault from another Patient (#2), who had a history of inappropriate sexual behaviors, after the unit RN and LVN left their assigned unit to respond to "Code Green's" (psychiatric emergencies) in other units/areas of the facility. This deficient practice affected Patient #1's provision of care and compromised her safety resulting in allegation of Neglect due to insufficient staffing in the unit.	X 365	order to ensure all staff are able to attend one of these educational events. The mandatory in-service will reinforce the hospital policy regarding Assessment and Reporting of Abuse and Neglect, reinforce the need to document outlier events affecting patients, and roll out the Code Green Response Protocol. The Code Green Response Protocol includes the following: 1.) reinforces assigning a specific Code Green response team to include back up for breaks as appropriate as well as for census level and unit acuity to ensure appropriate staffing is left on inpatient units, 2.) provides instruction for responding in the event multiple codes are called at the same time. to insure patient and staff safety, 3.) Psychiatric Emergency Service Unit (PES) staff will not respond to Code Greens unless the unit is overstaffed for its current population, 4.) reinforces that all supervisors will respond to Code Green, 5.) reinforces what should happen to maintain safety on the units when the Code Green team responds which includes: a.) suspension of non-essential tasks, b.) cohort the patients as much as possible to control the situation and monitor for safety, c.) response team clearly communicates to their charge when they leave from and return to the unit. Follow up in-servicing is planned for February 2016 to include participation by same staff members to continue reinforcement of policies.	

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X 365	Continued From page 2 Findings Included: Review of Patient #1's Complaint Form dated 05/15/15 indicated the following in part: On 04/27/15 at approximately 11:30 AM Patient #1 was admitted to the facility's "Psychiatric Emergency Services (PES) unit and received medication to help her sleep and calm down. Patient #1 reported shortly after she received the medications; she was asleep in her bed when she "felt someone touching my vagina and butt. I felt a hard pressure. I jumped up and another male patient [#2] jumped out from under my covers." Patient #1 stated she went to find a staff member (Mental Health Worker-A), to report what had happened. Patient #1 indicated she noticed her entire "crotch area [paper gown] was torn exposing her "vagina and butt." Patient #1 indicated the facility staff called the Police Department (PD) for Patient #1 to make a report. Patient #1 reported the staff apologized to her for the incident; "but they had an emergency on another floor and they were short staffed, so every staff member had left." Patient #1 indicated she was "so upset and scared; so they gave me more meds to put me to sleep." Patient #1 stated the facility had done nothing more to help her; there were no witnesses but she believed there were cameras in the hall. Patient #1 stated she found out that Patient #2 had done this before and the Police Officer who responded stated that; "he [Patient #2] has a history of doing this; why was he unsupervised?" Review of the facility's Policy titled, Abuse Reporting-External and Internal, last reviewed January 2012 revealed the following definitions: Psychological Abuse included; humiliation and harassment.	X 365		

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X 365	Continued From page 3 Sexual Abuse included; sexual harassment, sexual coercion, and sexual assault. Review of the facility's Policy titled, Assessment and Reporting of Abuse and Neglect, last reviewed February 2013 revealed Neglect included the failure to provide for one's self the goods or services including medical services, which are necessary to avoid physical or emotional harm or pain or the failure of a caretaker to provide the goods or services. The policy indicated the facility "prohibits neglect, mental or physical abuse or misappropriation of property, of patients by staff, visitors, or other patients." The facility "will report allegations and release information to the proper authorities, according to federal regulations, state specific rules and regulation and [facility] practice guidelines." Review of the facility's Original Event report dated 04/27/15 at 12:15 PM completed by the unit RN revealed Patient #1 reported, "She was lying in bed asleep, when she felt Patient [#2] putting pressure around her buttocks area, and then touching her perineal area. Patient[#1] reported sitting up in bed shock and scared, and found Patient [#2] was up in her face with his finger to his mouth telling her to be quiet not to tell. She found her paper scrub button turned on the outer left side. MD [Medical Doctor], Nurse Manager notified, Patient made a police complaint." PD interviewed Patient #1 and accused, Patient #2. "Patient visible distraught, but no other physical problems noted at this time." Further review of the Original Event indicated the Event was documented as "Attempted Rape/Rape/Sexual Assault." Factors included; "Unit busy code greens called on other unit, and high acute of unit."	X 365		

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X 365	Continued From page 4 Record review of the medical record of Patient #1 revealed she was a 37 year-old female admitted to the psychiatric facility on 04/27/15 at 0830 under Emergency Detention (ED) when she cut her wrist and called a friend to call Police. Patient #1 has a history of Depression with Anxiety. Further review of Patient #1's permanent records revealed no documentation following the sexual assault allegation that she made on 04/27/15 against Patient #2. There was no documentation in her record that she received a physical and/or psychological assessment following her allegation on 04/27/15. There was a Telephone Physician Order (PO) on 04/27/15 at 12:30 PM (following the allegation) for Ativan (an anti-anxiety) 2 milligrams by mouth "now" without documentation of the reason for the emergency medication. The only documentation in Patient #1's record regarding her allegation against Patient #2 was a Behavioral Team Progress Note dated 05/01/15 at 12:28 completed by Licensed Social Worker- A that indicated "Patient discussed being sexually assaulted by Patient [#2] in the [facility's] PES unit. Review of Patient #1's Daily Observation Notes for 04/27/15 revealed the following: At 11:30-MHW-A documented 1Q (1=On unit, and Q=Quiet/Calm). At 11:45-MHW-A documented 1B (On unit, and B=In Bed Awake). At 12:00-MHW-A documented 1BA (On unit, In Bed Awake, and A=agitated/restless). At 12:15 MHW-A documented 1BA. At 12:30, 12:45, 13:00, 13:15, 13:30, and 13:45-MHW-A documented 1A (On Unit and agitated/restless).	X 365		

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X 365	Continued From page 5 Record review of Patient #2's medical records revealed the following: Patient #2's Psychiatric Evaluation dated 04/24/15 revealed he was a 30 year old male admitted to the PES unit on 04/24/15 with a history of schizoaffective disorder and traumatic brain injury (TBI). Patient #2 was admitted on an ED basis with a history of aggressive behaviors requiring emergency medications to calm him. Patient #2 had recently been discharged from this facility 4-5 weeks prior and has had multiple inpatient treatment episodes over the years (7 inpatient admissions in the previous 5 months). Patient #2 was documented with a known history of aggression and a "history of inappropriate sexual behavior on the unit (masturbating)." Patient #2 had documented borderline intellectual functioning with poor insight, poor judgment, and poor impulse control. A Behavioral Nursing Shift Assessment completed by the unit RN on 04/27/15 at 18:08 that Patient #2 was found by a female patient touching on her body while she was asleep in bed. MD, and Nurse Manager notified. A Telephone PO dated 04/27/15 at 2015 for Patient #2 to be transferred to a higher acuity; sister facility. A Behavior Team Progress noted dated 04/27/15 at 1855 revealed Patient #2 was transferred to a sister facility by the Sheriff's Department. Review of the facility's Incident Event dated 04/27/15 at 11:37 AM confirmed a Code Green was called for another Patient [#3] in the Child/Adolescent Unit requiring	X 365		

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X 365	Continued From page 6 Restraints/Seclusion. Patient #3 required physical restraint at 11:36 AM, and emergency medications at 11:46 AM. Patient #3 was released from restraint at 12:26 PM. This Code Green occurred during the same time frames of Patient #1's allegation on 04/27/15. Review of the facility's Policy titled, Psychiatric Emergencies-Code Green, last reviewed January 2012 revealed a Code Green was a Psychiatric Emergency. Code Green will be implemented by any unit personnel in the event of unmanageable behavior of an individual to prevent harm to that individual, patients, hospital personnel and/or others the general hospital area. D. Individuals responding to Code Green will meet in announced area. Available personnel is necessary to control atmosphere through a show of strength and caring or to assist in physical management. Interview on 08/06/15 at 12:35 PM with the PES unit RN revealed she completed Patient #1's admission assessment to the PES unit on 04/27/15. The unit RN indicated Patients were provided with paper scrubs to wear without other undergarments. The unit RN stated that on 04/27/15 at approximately 11:30 AM to 12:00 PM, "Code Greens" were going on; and "staff were busy". The unit RN stated there was a Code Green on another unit (child/adolescent) and a Code Green was called in the lobby; due to a patient needing to be "put in a [restraint] chair" because they were tearing up the lobby. The unit RN stated she left the unit to respond to the Code Green in the other unit (child/adolescent) and when she arrived; there was another RN responding, so she went to the Code Green in the lobby because they needed an RN to assist with "putting the patient in the [restraint] chair." The	X 365		

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X 365	Continued From page 7 unit RN stated she returned to the PES unit following the Code Greens to "something else going on at the end of the unit" that she responded to. The unit RN stated she could not remember if it was LVN-A or LVN-B working on 04/27/15; but that she thought the LVN stayed back in the PES unit when she left and responded to the two Code Greens. The unit RN stated she was notified that during the Code Greens Patient #2 went into Patient #1's bedroom; and Patient #1 made an allegation of sexual assault. The unit RN stated she spoke with Patient #1 who reported that she was asleep in her bedroom and "she felt pressure" causing her to awake to Patient #2 touching her in the buttock and perineal area. The unit RN stated that Patient #1's paper pants were "torn on the side." The unit RN stated the local PD was called. The unit RN stated she spoke to Patient #2 and he said, "I touched her, but didn't do anything else." The unit RN stated he admitted that he "touched her and ripped her paper pants." The unit RN stated that Patient #2 knew that the unit was "chaotic" and knew what Code Green meant; and that is when he "took advantage" of the situation. The unit RN stated she believed that Patient #2 sexually assaulted Patient #1 given the facts, and his own admission. The unit RN stated she notified the MD, Social Worker, and Nursing Manager of the allegation. The unit RN indicated she documented the sexual assault allegation made by Patient #1 on the facility's Event Report; however, confirmed she did not document the sexual assault allegation in Patient #1's record following the incident. The unit RN stated she offered for Patient #1 to have a Sexual Assault Nurse Examination (SANE) completed at another facility if she wanted; but Patient #1 declined, stating she did not believe Patient #2 actually raped her.	X 365		

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X 365	Continued From page 8 Interview on 08/06/15 at 04:45 PM with MHW-A revealed she was the only MHW working on 04/27/15 in the PES unit; along with the unit RN and a Licensed Vocational Nurse (LVN). MHW-A stated she was pulled to the PES unit at 9:15 AM and was unfamiliar to the PES unit; but was told by the leaving MHW to "watch it" for Patient #2, however, she did not know the specific reason why. MHW-A stated the females were assigned rooms on one side, and males on the other side. MHW-A stated during the morning on 04/27/15 at approximately 11:30 AM-12:00 PM it was a "hectic/busy" day with "Code Green's being called." MHW-A stated that security was usually on the PES unit; but on 04/27/15 at the time of the allegation; "security could not be found." MHW-A stated on 04/27/15 at around 11:30-12:00 PM she stayed in the unit when the Code Greens were called and was "getting something out of the supply closet." MHW-A indicated the unit RN "responded to the Code Green" leaving the unit; telling her she [unit RN] would be back. MHW-A did not remember if LVN-A or LVN-B was working on 04/27/15; but further stated she did not remember any LVN being in the unit during the time of the allegation made by Patient #1. MHW-A stated shortly after this Patient #1 "flagged her [MHW-A] down" to her bedroom, and into the restroom of the bedroom where she reported that Patient #2 came into her room and touched her buttocks and vaginal area while she was sleeping in her bed. MHW-A stated that Patient #1's gown was torn around the buttock area and she offered to call the local PD for Patient #1 to make a report. MHW-A stated she then reported the incident/allegation to the unit RN. MHW-A stated she was later told that Patient #2 had been an inpatient to the facility many times before, and he "knows the system;	X 365		

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X 365	Continued From page 9 knows what Code Green means." MHW-A stated she had seen Patient #2 "walking out of her [Patient #1] room a few times" and further stated "right before she flagged me down, he had walked out of her room". MHW-A indicated she told Patient #2 "not to go in to other people's rooms." MHW-A confirmed she had not documented the allegation reported by Patient #1 against Patient #2; but that she "told [unit RN]." Interview on 08/10/15at 1:20 PM with Patient #1 revealed on 04/27/15 at approximately 11:30-11:45 AM she was in her assigned bedroom sleeping after she received multiple medications following her admission. Patient #1 stated she awoke after she "felt pressure" in her buttock and vaginal area. Patient #1 stated that Patient #2 was present telling her not to tell anyone. Patient #1 stated that she noticed her paper pants were ripped and she was not actually aware what all Patient #2 actually did because she "was conked out" after taking multiple medications. Patient #1 stated she knows he touched her because that was what woke her up. Patient #1 stated she was very upset, "freaked out," and asked the MD for an "AIDS" test. Patient #1 stated the unit RN indicated to the nursing staff (LVN) to "give her more meds" because she was "upset, crying, and freaking out." Patient #1 stated she then received the Ativan for her anxiety, to "help me calm down." Patient #1 stated the local PD came and she made a report. Patient #1 stated she was told by the unit RN that "Code Green's" were called and "everyone had to leave the unit" which allowed the opportunity for Patient #2 to go into her room unsupervised. Interview on 08/10/15 at 2:20 PM with Security	X 365		

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X 365	Continued From page 10 Guard-A revealed he was employed by the facility to maintain security and the safety of patients. The Security Guard-A stated Patient #2 had a history of inappropriate sexual behavior of "masturbating in front of females." The Security Guard-A stated he assisted with "viewing the video" footage for evidence following the allegation on 04/27/15 made be Patient #1 against Patient #2. The Security Guard stated the video footage from 04/27/15 showed a total of "four times" that Patient #2 went into Patient #1's room; and the last time Patient #2 came out of Patient #1's room; she was observed to come out of the room a few minutes later. The Security Guard stated that Patient #2 had already been assigned to the front "seclusion room" of the PES unit as his bedroom due to his history of masturbating. The Security Guard stated on the video footage Patient #2 could be seen coming from his room; "looking side to side" down the hallway, and then going into Patient #1's room. The Security Guard stated that female and male patient rooms were separated and that Patient #2 was not supposed to be going into Patient #1's room for any reason. Interview on 08/10/15 at 2:50 PM with MD-A revealed he was notified of Patient #1's sexual assault allegation against Patient #2 on 04/27/15. MD-A stated he discussed with Patient #1 the option of a "Rape Kit" but she "declined." MD-A stated he understood the allegation made by Patient #1 to be "only touching with no penetration." MD-A stated that Patient #1 was "distressed" about the incident and he ordered Ativan for Patient #1's anxiety following the incident. MD-A stated Patient #1 had already been distressed emotionally because of her ED inpatient admission; and really did not even want to take the Ativan. MD-A stated he recalled there	X 365		

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X 365	Continued From page 11 was a Code Green called where staff left the unit in response to the Code Green; which left less staffing in the unit. Interview on 08/10/15 at 3:00 PM with the facility's Risk Manager (RM) indicated that she was aware of the alleged sexual assault allegation made by Patient #1 on 04/27/15 against Patient #2'; however, she had not been notified until 05/06/15 via the facility's Incident/Event electronic system because there had not been any harm documented in order to elevate the notification. The RM stated the staffing ratio on the PES unit was 1 staff to 4 patients. The RM indicated on 04/27/15 the patient census in the PES unit was 11; requiring 3 staff. The RM stated the first required staff is an RN, and then second could be a LVN, and/or MHW. The RM confirmed for 11 patients the required staffing would be 3. The RM stated the PES unit was to always have a licensed nurse present and available in the unit. The RM stated she had not seen or viewed the video footage following this allegation due to the video being unavailable after 05/06/15; following her electronic notification. The RM stated there would not be documentation of the Code Green that may have occurred on 04/27/15 in the facility's lobby waiting area; if the patient had not yet been assessed for care. Interview on 08/10/15 at 3:15 PM with Licensed Social Worker (LSW)-A stated she assisted Security Guard-A in viewing the video footage on 04/27/15 after Patient #1 made a sexual assault allegation against Patient #2. LSW-A stated that during the allegation on 04/27/15; Patient #2 could be seen on the camera "looking both ways" and then would go into Patient #1's bedroom.	X 365		

Texas Department of State Health Services

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X 365	Continued From page 12 LSW-A stated they were able to count this event occurring a "couple of times" where Patient #2 would go into Patient #1's bedroom and remain there "a couple of minutes" each time. LSW-A stated she saw on the video where MHW-A had been in the "Patient evaluation room" during these time periods; where a supply closet was located. LSW-A stated Patient #2 had a history of "exposing his self, public masturbation, and talks sexually to other women." LSW-A stated that Patient #2 has publically masturbated in front of her during an assessment interview. Interview on 08/10/15 at 4:15 PM with LVN-A stated he was present and worked the PES unit on 04/27/15. LVN-A stated that on 04/27/15 there were Code Greens called on another unit, and in the facility's lobby about the same time. LVN-A stated he responded to the Code Green in the lobby to assist due to a "fight." LVN-A indicated he had left the unit for approximately 15 minutes. Interview on 08/10/15 at 4:30 PM with the Vice President (VP) of Clinical Services confirmed that she was notified of the sexual allegation made by Patient #1 against Patient #2 on 04/27/15; however, she had not been notified until 05/06/15 via the facility's Incident/Event electronic system because there had not been any harm documented in order to elevate the notification. The VP of Clinical Services indicated that on 04/27/15 the Nursing Clinical Director (Nurse Manager) had been notified immediately following Patient #1's allegation and she had not obtained information that indicated Patient #1's allegation had occurred due to insufficient staffing in the PES unit when Code Green's had been called; leaving the unit without a RN available. The VP	X 365		

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X 365	Continued From page 13 of Clinical Services stated that the unit RN was not supposed to leave the unit and there should always be a Licensed Nurse in the unit during a Code Green; that "it is a judgement call." The VP of Clinical Services stated she had not seen or viewed the video footage following this allegation due to the video being unavailable after 05/06/15; following her electronic notification. Interview on 08/10/15 at 4:40 PM with the Nursing Clinical Director (Nurse Manager) stated she was immediately notified by the PES unit RN on 04/27d/15 of Patient #1's sexual allegation against Patient #2. The Nursing Clinical Director indicated she "separated" the Patients, talked to both of them, and Patient #1 saw the Doctor. The Nursing Clinical Director stated she spoke to the unit RN about the allegation but had not been notified or received information that the RN and LVN had left the PES unit to respond to Code Greens which left the unit without a RN and/or licensed nurse available. The Nursing Clinical Director stated she had not seen or viewed the video footage following this allegation.	X 365		
X 794	133.42(a)(1) Patient rights requirements: all hospitals Patient Rights. Patient rights requirements for all hospitals. A hospital shall adopt, implement, and enforce a policy to ensure patients' rights.	X 794	**Plan of Correction** **X 794** Mandatory read and sign in-service for all front-line behavioral health staff to include nursing, MHT, NP, social workers, intake/assessment, security and admitting to be completed by 9/14/15. Mandatory In-services to be conducted on 9/14, 9/16, and 9/18 for all behavioral health staff with multiple offerings in order to ensure all staff are able to attend one of these educational events. The mandatory in-service will reinforce the	9/14/15

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X 794	Continued From page 14 This Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure the patient's rights to be free from all forms of abuse or harassment by failing to prevent, protect, investigate, and report/respond to an allegation of neglect in accordance with their policy, for 1 of 1 patients reviewed (Patient #1) with a complaint allegation of sexual assault against another patient (Patient #2). On 04/27/15, Patient #1 reported to the unit's Registered Nurse (RN) an allegation of sexual assault from another Patient, (#2); who had a history of inappropriate sexual behaviors. The allegation was reported to the Medical Doctor, the Nursing Manager, and local Police Department (PD); however, this allegation was not reported to the state health care regulatory agency by any facility employees, in accordance with their policy. In addition, this allegation was not thoroughly investigated by the facility for the identification of	X 794	hospital policy regarding Assessment and Reporting of Abuse and Neglect, reinforce the need to document outlier events affecting patients, and roll out the Code Green Response Protocol. The Code Green Response Protocol includes the following: 1.) reinforces assigning a specific Code Green response team to include back up for breaks as appropriate as well as for census level and unit acuity to ensure appropriate staffing is left on inpatient units, 2.) provides instruction for responding in the event multiple codes are called at the same time. to insure patient and staff safety, 3.) Psychiatric Emergency Service Unit (PES) staff will not respond to Code Greens unless the unit is overstaffed for its current population, 4.) reinforces that all supervisors will respond to Code Green, 5.) reinforces what should happen to maintain safety on the units when the Code Green team responds which includes: a.) suspension of non-essential tasks, b.) cohort the patients as much as possible to control the situation and monitor for safety, c.) response team clearly communicates to their charge when they leave from and return to the unit. Additional topics for the mandatory in-service include: a decision tree to reinforce the policy on reporting and follow-up of suspected/reported	

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X 794	Continued From page 15 neglect and/or a corrective action plan to prevent repeat incidence; in accordance with the facility's policy. This deficient practice could affect the prevention of possible unidentified abuse, neglect, or mistreatment for all patients in the facility; by compromising their safety. Findings Included: Review of Patient #1's Complaint Form dated 05/15/15 indicated the following in part: On 04/27/15 at approximately 11:30 AM Patient #1 was admitted to the facility's "Psychiatric Emergency Services (PES) unit and received medication to help her sleep and calm down. Patient #1 reported shortly after she received the medications; she was asleep in her bed when she "felt someone touching my vagina and butt. I felt a hard pressure. I jumped up and another male patient [#2] jumped out from under my covers." Patient #1 stated she went to find a staff member (Mental Health Worker-A), to report what had happened. Patient #1 indicated she noticed her entire "crotch area [paper gown] was torn exposing her "vagina and butt." Patient #1 indicated the facility staff called the Police Department (PD) for Patient #1 to make a report. Patient #1 reported the staff apologized to her for the incident; "but they had an emergency on another floor and they were short staffed, so every staff member had left." Patient #1 indicated she was "so upset and scared; so they gave me more meds to put me to sleep." Patient #1 stated the facility had done nothing more to help her; there were no witnesses but she believed there were cameras in the hall. Patient #1 stated she found out that Patient #2 had done this before and the Police Officer who responded stated that;	X 794	allegations of abuse/neglect of a patient during hospitalization and in treating patients identified as having ordered sexual precautions. Follow up in-servicing is planned for February 2016 to include participation by same staff members to continue reinforcement of policies.	

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X 794	Continued From page 16 "he [Patient #2] has a history of doing this; why was he unsupervised?" Review of the facility's Policy titled, Abuse Reporting-External and Internal, last reviewed January 2012 revealed the following definitions: Psychological Abuse included; humiliation and harassment. Sexual Abuse included; sexual harassment, sexual coercion, and sexual assault. Review of the facility's Policy titled, Assessment and Reporting of Abuse and Neglect, last reviewed February 2013 revealed Neglect included the failure to provide for one's self the goods or services including medical services, which are necessary to avoid physical or emotional harm or pain or the failure of a caretaker to provide the goods or services. The policy indicated the facility "prohibits neglect, mental or physical abuse or misappropriation of property, of patients by staff, visitors, or other patients." The facility "will report allegations and release information to the proper authorities, according to federal regulations, state specific rules and regulation and [facility] practice guidelines." Further review of the policy indicated, in part: 1. Reporting allegations of abuse and/or neglect occurring while the patient is under the care in the facility: All alleged violations concerning abuse and neglect while the patient is under the care of the facility will be reported to the Compliance Officer or designee, who will advise the on-call administrator/designee. As appropriate, the facility will report the incident to appropriate state, federal and protective/regulatory agencies, and/or law enforcement agencies and conduct an internal investigation within a maximum of five	X 794		

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X 794	Continued From page 17 working days of the incident. The Texas Department of state Health Services (DSHS) is the regulatory body for reporting concerns of hospitals, psychiatric hospitals (including private psychiatric facilities), and various other medical facilities. 2. Investigations are always prompt, comprehensive and responsive to the situation, well conducted, and contain founded conclusions. The investigation may include, but are not limited to the following: -Interviews conducted with individuals having first-hand knowledge of the incident. -Follow-up resolution -Corrective action plan to prevent repeat incidence. -Reports made to appropriate state health care regulatory agency. Review of the facility's Original Event report dated 04/27/15 at 12:15 PM completed by the unit RN revealed Patient #1 reported, "She was lying in bed asleep, when she felt Patient [#2] putting pressure around her buttocks area, and then touching her perineal area. Patient[#1] reported sitting up in bed shock and scared, and found Patient [#2] was up in her face with his finger to his mouth telling her to be quiet not to tell. She found her paper scrub button torned on the outer left side. MD [Medical Doctor], Nurse Manager notified, Patient made a police complaint." PD interviewed Patient #1 and accused, Patient #2. "Patient visible distraught, but no other physical problems noted at this time." Further review of the Original Event indicated the Event was documented as "Attempted Rape/Rape/Sexual Assault." Factors included; "Unit busy code greens called on other unit, and high acute of	X 794		

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X 794	Continued From page 18 unit." The Original Event report did not include any documentation that this allegation was reported to the state health care regulatory agency by any facility employees, in accordance with the facility's policy. The Original Event report did not include documentation that this allegation was thoroughly investigated by the facility for the identification of neglect and/or a corrective action plan to prevent repeat incidence; in accordance with the facility's policy. The Compliance Officer/Director of Risk Management (RM) acknowledged receipt of the Original Event report dated 04/27/15 at 12:15 PM electronically on 05/06/15 documenting Patient #1 made a Police Report. Review of the local PD report dated 04/27/15 at 12:45PM revealed Patient #1 wanted to report that, "she was a sleep in her room, when she awaken and felt pressure around her buttock and vaginal area. When she fully awaken, she observed [Patient #2] in bed with her." Patient #1 further stated that Patient #2 told her "Don't tell anyone," before he left.her room. Patient #1 did not feel Patient #2 penetrate her at any time, but the hospital [paper gown] pajama that she was wearing had a tear between the leg area. Patient #2 denied being in bed with Patient #1, or touching her. The report was deemed as "Disorderly Conduct" and Patient #1 was advised to contact the special victim's unit to file charges against Patient #2. "The Hospital staff was advised to monitor [Patient #2's] movement more closely." Record review of the medical record of Patient #1 revealed she was a 37 year-old female admitted to the psychiatric facility on 04/27/15 at 0830 under Emergency Detention (ED) when she cut	X 794		

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X 794	Continued From page 19 her wrist and called a friend to call Police. Patient #1 has a history of Depression with Anxiety. Further review of Patient #1's permanent records revealed no documentation following the sexual assault allegation that she made on 04/27/15 against Patient #2. There was no documentation in her record that she received a physical and/or psychological assessment following her allegation on 04/27/15. There was a Telephone Physician Order (PO) on 04/27/15 at 12:30 PM (following the allegation) for Ativan (an anti-anxiety) 2 milligrams by mouth "now" without documentation of the reason for the emergency medication. The only documentation in Patient #1's record regarding her allegation against Patient #2 was a Behavioral Team Progress Note dated 05/01/15 at 12:28 completed by Licensed Social Worker- A that indicated "Patient discussed being sexually assaulted by Patient [#2] in the [facility's] PES unit. Review of Patient #1's Daily Observation Notes for 04/27/15 revealed the following: At 11:30-MHW-A documented 1Q (1=On unit, and Q=Quiet/Calm). At 11:45-MHW-A documented 1B (On unit, and B=In Bed Awake). At 12:00-MHW-A documented 1BA (On unit, In Bed Awake, and A=agitated/restless). At 12:15 MHW-A documented 1BA. At 12:30, 12:45, 13:00, 13:15, 13:30, and 13:45-MHW-A documented 1A (On Unit and agitated/restless). Record review of Patient #2's medical records revealed the following: Patient #2's Psychiatric Evaluation dated 04/24/15 revealed he was a 30 year old male	X 794		

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X 794	Continued From page 20 admitted to the PES unit on 04/24/15 with a history of schizoaffective disorder and traumatic brain injury (TBI). Patient #2 was admitted on an ED basis with a history of aggressive behaviors requiring emergency medications to calm him. Patient #2 had recently been discharged from this facility 4-5 weeks prior and has had multiple inpatient treatment episodes over the years (7 inpatient admissions in the previous 5 months). Patient #2 was documented with a known history of aggression and a "history of inappropriate sexual behavior on the unit (masturbating)." Patient #2 had documented borderline intellectual functioning with poor insight, poor judgment, and poor impulse control. A Behavioral Nursing Shift Assessment completed by the unit RN on 04/27/15 at 18:08 that Patient #2 was found by a female patient touching on her body while she was asleep in bed. MD, and Nurse Manager notified. A Telephone PO dated 04/27/15 at 2015 for Patient #2 to be transferred to a higher acuity; sister facility. A Behavior Team Progress noted dated 04/27/15 at 1855 revealed Patient #2 was transferred to a sister facility by the Sheriff's Department. Review of the facility's Incident Event dated 04/27/15 at 11:37 AM confirmed a Code Green was called for another Patient [#3] in the Child/Adolescent Unit requiring Restraints/Seclusion. Patient #3 required physical restraint at 11:36 AM, and emergency medications at 11:46 AM. Patient #3 was released from restraint at 12:26 PM. This Code Green occurred during the same time frames of Patient #1's allegation on 04/27/15.	X 794		

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X 794	Continued From page 21 Review of the facility's Policy titled, Psychiatric Emergencies-Code Green, last reviewed January 2012 revealed a Code Green was a Psychiatric Emergency. Code Green will be implemented by any unit personnel in the event of unmanageable behavior of an individual to prevent harm to that individual, patients, hospital personnel and/or others the general hospital area. D. Individuals responding to Code Green will meet in announced area. Available personnel is necessary to control atmosphere through a show of strength and caring or to assist in physical management. Interview on 08/06/15 at 12:35 PM with the PES unit RN revealed she completed Patient #1's admission assessment to the PES unit on 04/27/15. The unit RN indicated Patients were provided with paper scrubs to wear without other undergarments. The unit RN stated that on 04/27/15 at approximately 11:30 AM to 12:00 PM, "Code Greens" were going on; and "staff were busy". The unit RN stated there was a Code Green on another unit (child/adolescent) and a Code Green was called in the lobby; due to a patient needing to be "put in a [restraint] chair" because they were tearing up the lobby. The unit RN stated she left the unit to respond to the Code Green in the other unit (child/adolescent) and when she arrived; there was another RN responding, so she went to the Code Green in the lobby because they needed an RN to assist with "putting the patient in the [restraint] chair." The unit RN stated she returned to the PES unit following the Code Greens to "something else going on at the end of the unit" that she responded to. The unit RN stated she could not remember if it was LVN-A or LVN-B working on 04/27/15; but that she thought the LVN stayed	X 794		

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X 794	Continued From page 22 back in the PES unit when she left and responded to the two Code Greens. The unit RN stated she was notified that during the Code Greens Patient #2 went into Patient #1's bedroom; and Patient #1 made an allegation of sexual assault. The unit RN stated she spoke with Patient #1 who reported that she was asleep in her bedroom and "she felt pressure" causing her to awake to Patient #2 touching her in the buttock and perineal area. The unit RN stated that Patient #1's paper pants were "torn on the side." The unit RN stated the local PD was called. The unit RN stated she spoke to Patient #2 and he said, "I touched her, but didn't do anything else." The unit RN stated he admitted that he "touched her and ripped her paper pants." The unit RN stated that Patient #2 knew that the unit was "chaotic" and knew what Code Green meant; and that is when he "took advantage" of the situation. The unit RN stated she believed that Patient #2 sexually assaulted Patient #1 given the facts, and his own admission. The unit RN stated she notified the MD, Social Worker, and Nursing Manager of the allegation. The unit RN indicated she documented the sexual assault allegation made by Patient #1 on the facility's Event Report; however, confirmed she did not document the sexual assault allegation in Patient #1's record following the incident. The unit RN stated she offered for Patient #1 to have a Sexual Assault Nurse Examination (SANE) completed at another facility if she wanted; but Patient #1 declined, stating she did not believe Patient #2 actually raped her. Interview on 08/06/15 at 04:45 PM with MHW-A revealed she was the only MHW working on 04/27/15 in the PES unit; along with the unit RN and a Licensed Vocational Nurse (LVN). MHW-A	X 794		

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X 794	Continued From page 23 stated she was pulled to the PES unit at 9:15 AM and was unfamiliar to the PES unit; but was told by the leaving MHW to "watch it" for Patient #2, however, she did not know the specific reason why. MHW-A stated the females were assigned rooms on one side, and males on the other side. MHW-A stated during the morning on 04/27/15 at approximately 11:30 AM-12:00 PM it was a "hectic/busy" day with "Code Green's being called." MHW-A stated that security was usually on the PES unit; but on 04/27/15 at the time of the allegation; "security could not be found." MHW-A stated on 04/27/15 at around 11:30-12:00 PM she stayed in the unit when the Code Greens were called and was "getting something out of the supply closet." MHW-A indicated the unit RN "responded to the Code Green" leaving the unit; telling her she [unit RN] would be back. MHW-A did not remember if LVN-A or LVN-B was working on 04/27/15; but further stated she did not remember any LVN being in the unit during the time of the allegation made by Patient #1. MHW-A stated shortly after this Patient #1 "flagged her [MHW-A] down" to her bedroom, and into the restroom of the bedroom where she reported that Patient #2 came into her room and touched her buttocks and vaginal area while she was sleeping in her bed. MHW-A stated that Patient #1's gown was torn around the buttock area and she offered to call the local PD for Patient #1 to make a report. MHW-A stated she then reported the incident/allegation to the unit RN. MHW-A stated she was later told that Patient #2 had been an inpatient to the facility many times before, and he "knows the system; knows what Code Green means." MHW-A stated she had seen Patient #2 "walking out of her [Patient #1] room a few times" and further stated "right before she flagged me down, he had walked out of her room". MHW-A indicated she	X 794		

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X 794	Continued From page 24 told Patient #2 "not to go in to other people's rooms." MHW-A confirmed she had not documented the allegation reported by Patient #1 against Patient #2; but that she "told [unit RN]." Interview on 08/10/15at 1:20 PM with Patient #1 revealed on 04/27/15 at approximately 11:30-11:45 AM she was in her assigned bedroom sleeping after she received multiple medications following her admission. Patient #1 stated she awoke after she "felt pressure" in her buttock and vaginal area. Patient #1 stated that Patient #2 was present telling her not to tell anyone. Patient #1 stated that she noticed her paper pants were ripped and she was not actually aware what all Patient #2 actually did because she "was conked out" after taking multiple medications. Patient #1 stated she knows he touched her because that was what woke her up. Patient #1 stated she was very upset, "freaked out," and asked the MD for an "AIDS" test. Patient #1 stated the unit RN indicated to the nursing staff (LVN) to "give her more meds" because she was "upset, crying, and freaking out." Patient #1 stated she then received the Ativan for her anxiety, to "help me calm down." Patient #1 stated the local PD came and she made a report. Patient #1 stated she was told by the unit RN that "Code Green's" were called and "everyone had to leave the unit" which allowed the opportunity for Patient #2 to go into her room unsupervised. Interview on 08/10/15 at 2:20 PM with Security Guard-A revealed he was employed by the facility to maintain security and the safety of patients. The Security Guard-A stated Patient #2 had a history of inappropriate sexual behavior of "masturbating in front of females." The Security	X 794		

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X 794	Continued From page 25 Guard-A stated he assisted with "viewing the video" footage for evidence following the allegation on 04/27/15 made be Patient #1 against Patient #2. The Security Guard stated the video footage from 04/27/15 showed a total of "four times" that Patient #2 went into Patient #1's room; and the last time Patient #2 came out of Patient #1's room; she was observed to come out of the room a few minutes later. The Security Guard stated that Patient #2 had already been assigned to the front "seclusion room" of the PES unit as his bedroom due to his history of masturbating. The Security Guard stated on the video footage Patient #2 could be seen coming from his room; "looking side to side" down the hallway, and then going into Patient #1's room. The Security Guard stated that female and male patient rooms were separated and that Patient #2 was not supposed to be going into Patient #1's room for any reason. Interview on 08/10/15 at 2:50 PM with MD-A revealed he was notified of Patient #1's sexual assault allegation against Patient #2 on 04/27/15. MD-A stated he discussed with Patient #1 the option of a "Rape Kit" but she "declined." MD-A stated he understood the allegation made by Patient #1 to be "only touching with no penetration." MD-A stated that Patient #1 was "distressed" about the incident and he ordered Ativan for Patient #1's anxiety following the incident. MD-A stated Patient #1 had already been distressed emotionally because of her ED inpatient admission; and really did not even want to take the Ativan. MD-A stated he recalled there was a Code Green called where staff left the unit in response to the Code Green; which left less staffing in the unit. MD-A confirmed that he did not document in Patient #1's records his contact or discussion with Patient #1 following her	X 794		

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X 794	Continued From page 26 allegation. Interview on 08/10/15 at 3:00 PM with the facility's Risk Manager (RM) indicated that she was aware of the alleged sexual assault allegation made by Patient #1 on 04/27/15 against Patient #2'; however, she had not been notified until 05/06/15 via the facility's Incident/Event electronic system because there had not been any harm documented in order to elevate the notification. The RM stated the staffing ratio on the PES unit was 1 staff to 4 patients. The RM indicated on 04/27/15 the patient census in the PES unit was 11; requiring 3 staff. The RM stated the first required staff is an RN, and then second could be a LVN, and/or MHW. The RM confirmed for 11 patients the required staffing would be 3. The RM stated the PES unit was to always have a licensed nurse present and available in the unit. The RM confirmed that she had not reported the sexual assault allegation made by Patient #1 on 04/27/15 against Patient #2 to the state health care regulatory agency, Department of State Health Services (DSHS); which was determined to have occurred as a result of insufficient staffing in the PES unit during episodes of Code Green's. The RM further confirmed the facility had not completed a thorough investigation with documented findings specific to this allegation for the determination of Neglect and/or a corrective action plan to prevent repeat incidence; in accordance with the facility's policy. The RM stated she had not seen or viewed the video footage following this allegation due to the video being unavailable after 05/06/15; following her electronic notification. Interview on 08/10/15 at 3:15 PM with Licensed	X 794		

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X 794	Continued From page 27 Social Worker (LSW)-A stated she assisted Security Guard-A in viewing the video footage on 04/27/15 after Patient #1 made a sexual assault allegation against Patient #2. LSW-A stated that during the allegation on 04/27/15; Patient #2 could be seen on the camera "looking both ways" and then would go into Patient #1's bedroom. LSW-A stated they were able to count this event occurring a "couple of times" where Patient #2 would go into Patient #1's bedroom and remain there "a couple of minutes" each time. LSW-A stated she saw on the video where MHW-A had been in the "Patient evaluation room" during these time periods; where a supply closet was located. LSW-A stated Patient #2 had a history of "exposing his self, public masturbation, and talks sexually to other women." LSW-A stated that Patient #2 has publically masturbated in front of her during an assessment interview. Interview on 08/10/15 at 4:15 PM with LVN-A stated he was present and worked the PES unit on 04/27/15. LVN-A stated that on 04/27/15 there were Code Greens called on another unit, and in the facility's lobby about the same time. LVN-A stated he responded to the Code Green in the lobby to assist due to a "fight." LVN-A indicated he had left the unit for approximately 15 minutes. Interview on 08/10/15 at 4:30 PM with the Vice President (VP) of Clinical Services confirmed that she was notified of the sexual allegation made by Patient #1 against Patient #2 on 04/27/15; however, she had not been notified until 05/06/15 via the facility's Incident/Event electronic system because there had not been any harm documented in order to elevate the notification. The VP of Clinical Services indicated that on	X 794		

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X 794	Continued From page 28 04/27/15 the Nursing Clinical Director (Nurse Manager) had been notified immediately following Patient #1's allegation and she had not obtained information that indicated Patient #1's allegation had occurred due to insufficient staffing in the PES unit when Code Green's had been called; leaving the unit without a RN available. The VP of Clinical Services stated that the unit RN was not supposed to leave the unit and there should always be a Licensed Nurse in the unit during a Code Green; that "it is a judgement call." The VP of Clinical Services stated she had not seen or viewed the video footage following this allegation due to the video being unavailable after 05/06/15; following her electronic notification. Interview on 08/10/15 at 4:40 PM with the Nursing Clinical Director (Nurse Manager) stated she was immediately notified by the PES unit RN on 04/27d/15 of Patient #1's sexual allegation against Patient #2. The Nursing Clinical Director indicated she "separated" the Patients, talked to both of them, and Patient #1 saw the Doctor. The Nursing Clinical Director stated she spoke to the unit RN about the allegation but had not been notified or received information that the RN and LVN had left the PES unit to respond to Code Greens which left the unit without a RN and/or licensed nurse available. The Nursing Clinical Director stated she had not seen or viewed the video footage following this allegation.	X 794		
X1037	133.47(c)(3)(A) Reporting responsibility: reporting abuse & n Abuse And Neglect Issues. Abuse and neglect of individuals with mental illness, and illegal, unethical, and unprofessional	X1037	**Plan of Correction** **X 1037** Mandatory read and sign in-service for all front-line behavioral health staff to include nursing, MHT, NP, social workers, intake/assessment, security and	9/14/15

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X1037	Continued From page 29 conduct. Reporting responsibility. Reporting abuse and neglect. A person, including an employee, volunteer, or other person associated with the facility who reasonably believes or who knows of information that would reasonably cause a person to believe that the physical or mental health or welfare of a patient of the facility who is receiving mental health or chemical dependency services has been, is, or will be adversely affected by abuse or neglect (as those terms are defined in this subsection) by any person shall as soon as possible report the information supporting the belief to the department or to the appropriate state health care regulatory agency in accordance with HSC, §161.132(a). This Requirement is not met as evidenced by: Based on interview and record review, facility employees failed to report an allegation of neglect to the state health care regulatory agency, the Department of State Health Services (DSHS); and in accordance with their policy, for 1 of 1 patients reviewed (Patient #1) with a complaint allegation of sexual assault against another patient (Patient #2). Specifically, on 04/27/15, Patient #1 reported to the unit's Registered Nurse (RN) an allegation of sexual assault from another Patient, (#2); who had a history of inappropriate sexual behaviors. The allegation was reported to the Medical Doctor, the Nursing Manager, and local Police	X1037	admitting to be completed by 9/14/15. Mandatory In-services to be conducted on 9/14, 9/16, and 9/18 for all behavioral health staff with multiple offerings in order to ensure all staff are able to attend one of these educational events. The mandatory in-service will reinforce the hospital policy regarding Assessment and Reporting of Abuse and Neglect, reinforce the need to document outlier events affecting patients, and roll out the Code Green Response Protocol. Additional topics for the mandatory in-service include: a decision tree to reinforce the policy on reporting and follow-up of suspected/reported allegations of abuse/neglect of a patient during hospitalization and in treating patients identified as having ordered sexual precautions. Follow up in-servicing is planned for February 2016 to include participation by same staff members to continue reinforcement of policies.	

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X1037	Continued From page 30 Department (PD); however, this allegation was not reported to the state health care regulatory agency by any facility employees, in accordance with their policy. This deficient practice could affect the prevention of possible unidentified abuse, neglect, or mistreatment for all patients in the facility; by compromising their safety. Findings included: Review of Patient #1's Complaint Form dated 05/15/15 indicated the following in part: On 04/27/15 at approximately 11:30 AM Patient #1 was admitted to the facility's "Psychiatric Emergency Services (PES) unit and received medication to help her sleep and calm down. Patient #1 reported shortly after she received the medications; she was asleep in her bed when she "felt someone touching my vagina and butt. I felt a hard pressure. I jumped up and another male patient [#2] jumped out from under my covers." Patient #1 stated she went to find a staff member (Mental Health Worker-A), to report what had happened. Patient #1 indicated she noticed her entire "crotch area [paper gown] was torn exposing her "vagina and butt." Patient #1 indicated the facility staff called the Police Department (PD) for Patient #1 to make a report. Patient #1 reported the staff apologized to her for the incident; "but they had an emergency on another floor and they were short staffed, so every staff member had left." Patient #1 indicated she was "so upset and scared; so they gave me more meds to put me to sleep." Patient #1 stated the facility had done nothing more to help her; there were no witnesses but she believed there were cameras in the hall. Patient #1 stated she found out that Patient #2 had done this before	X1037		

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X1037	Continued From page 31 and the Police Officer who responded stated that; "he [Patient #2] has a history of doing this; why was he unsupervised?" Review of the facility's Policy titled, Abuse Reporting-External and Internal, last reviewed January 2012 revealed the following definitions: Psychological Abuse included; humiliation and harassment. Sexual Abuse included; sexual harassment, sexual coercion, and sexual assault. Review of the facility's Policy titled, Assessment and Reporting of Abuse and Neglect, last reviewed February 2013 revealed Neglect included the failure to provide for one's self the goods or services including medical services, which are necessary to avoid physical or emotional harm or pain or the failure of a caretaker to provide the goods or services. The policy indicated the facility "prohibits neglect, mental or physical abuse or misappropriation of property, of patients by staff, visitors, or other patients." The facility "will report allegations and release information to the proper authorities, according to federal regulations, state specific rules and regulation and [facility] practice guidelines." Further review of the policy indicated, in part: 1. Reporting allegations of abuse and/or neglect occurring while the patient is under the care in the facility: All alleged violations concerning abuse and neglect while the patient is under the care of the facility will be reported to the Compliance Officer or designee, who will advise the on-call administrator/designee. As appropriate, the facility will report the incident to appropriate state, federal and protective/regulatory agencies, and/or law enforcement agencies and conduct an	X1037		

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X1037	Continued From page 32 internal investigation within a maximum of five working days of the incident. The Texas Department of state Health Services (DSHS) is the regulatory body for reporting concerns of hospitals, psychiatric hospitals (including private psychiatric facilities), and various other medical facilities. Review of the facility's Original Event report dated 04/27/15 at 12:15 PM completed by the unit RN revealed Patient #1 reported, "She was lying in bed asleep, when she felt Patient [#2] putting pressure around her buttocks area, and then touching her perineal area. Patient[#1] reported sitting up in bed shock and scared, and found Patient [#2] was up in her face with his finger to his mouth telling her to be quiet not to tell. She found her paper scrub button torned on the outer left side. MD [Medical Doctor], Nurse Manager notified, Patient made a police complaint." PD interviewed Patient #1 and accused, Patient #2. "Patient visible distraught, but no other physical problems noted at this time." Further review of the Original Event indicated the Event was documented as "Attempted Rape/Rape/Sexual Assault." Factors included; "Unit busy code greens called on other unit, and high acute of unit." The Original Event report did not include any documentation that this allegation was reported to the state health care regulatory agency by any facility employees, in accordance with the facility's policy. The Original Event report did not include documentation that this allegation was thoroughly investigated by the facility for the identification of neglect and/or a corrective action plan to prevent repeat incidence; in accordance with the facility's policy. The Compliance Officer/Director of Risk Management (RM) acknowledged receipt of the Original Event report	X1037		

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X1037	Continued From page 33 dated 04/27/15 at 12:15 PM electronically on 05/06/15 documenting Patient #1 made a Police Report. Review of the local PD report dated 04/27/15 at 12:45PM revealed Patient #1 wanted to report that, "she was a sleep in her room, when she awaken and felt pressure around her buttock and vaginal area. When she fully awaken, she observed [Patient #2] in bed with her." Patient #1 further stated that Patient #2 told her "Don't tell anyone," before he left her room. Patient #1 did not feel Patient #2 penetrate her at any time, but the hospital [paper gown] pajama that she was wearing had a tear between the leg area. Patient #2 denied being in bed with Patient #1, or touching her. The report was deemed as "Disorderly Conduct" and Patient #1 was advised to contact the special victim's unit to file charges against Patient #2. "The Hospital staff was advised to monitor [Patient #2's] movement more closely." Record review of the medical record of Patient #1 revealed she was a 37 year-old female admitted to the psychiatric facility on 04/27/15 at 0830 under Emergency Detention (ED) when she cut her wrist and called a friend to call Police. Patient #1 has a history of Depression with Anxiety. Further review of Patient #1's permanent records revealed no documentation following the sexual assault allegation that she made on 04/27/15 against Patient #2. There was no documentation in her record that she received a physical and/or psychological assessment following her allegation on 04/27/15. There was a Telephone Physician Order (PO) on 04/27/15 at 12:30 PM (following the allegation) for Ativan (an anti-anxiety) 2	X1037		

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X1037	Continued From page 34 milligrams by mouth "now" without documentation of the reason for the emergency medication. The only documentation in Patient #1's record regarding her allegation against Patient #2 was a Behavioral Team Progress Note dated 05/01/15 at 12:28 completed by Licensed Social Worker- A that indicated "Patient discussed being sexually assaulted by Patient [#2] in the [facility's] PES unit. Review of Patient #1's Daily Observation Notes for 04/27/15 revealed the following: At 11:30-MHW-A documented 1Q (1=On unit, and Q=Quiet/Calm). At 11:45-MHW-A documented 1B (On unit, and B=In Bed Awake). At 12:00-MHW-A documented 1BA (On unit, In Bed Awake, and A=agitated/restless). At 12:15 MHW-A documented 1BA. At 12:30, 12:45, 13:00, 13:15, 13:30, and 13:45-MHW-A documented 1A (On Unit and agitated/restless). Record review of Patient #2's medical records revealed the following: Patient #2's Psychiatric Evaluation dated 04/24/15 revealed he was a 30 year old male admitted to the PES unit on 04/24/15 with a history of schizoaffective disorder and traumatic brain injury (TBI). Patient #2 was admitted on an ED basis with a history of aggressive behaviors requiring emergency medications to calm him. Patient #2 had recently been discharged from this facility 4-5 weeks prior and has had multiple inpatient treatment episodes over the years (7 inpatient admissions in the previous 5 months). Patient #2 was documented with a known history of aggression and a "history of inappropriate sexual behavior on the unit (masturbating)."	X1037		

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X1037	Continued From page 35 Patient #2 had documented borderline intellectual functioning with poor insight, poor judgment, and poor impulse control. A Behavioral Nursing Shift Assessment completed by the unit RN on 04/27/15 at 18:08 that Patient #2 was found by a female patient touching on her body while she was asleep in bed. MD, and Nurse Manager notified. A Telephone PO dated 04/27/15 at 2015 for Patient #2 to be transferred to a higher acuity; sister facility. A Behavior Team Progress noted dated 04/27/15 at 1855 revealed Patient #2 was transferred to a sister facility by the Sheriff's Department. Review of the facility's Incident Event dated 04/27/15 at 11:37 AM confirmed a Code Green was called for another Patient [#3] in the Child/Adolescent Unit requiring Restraints/Seclusion. Patient #3 required physical restraint at 11:36 AM, and emergency medications at 11:46 AM. Patient #3 was released from restraint at 12:26 PM. This Code Green occurred during the same time frames of Patient #1's allegation on 04/27/15. Review of the facility's Policy titled, Psychiatric Emergencies-Code Green, last reviewed January 2012 revealed a Code Green was a Psychiatric Emergency. Code Green will be implemented by any unit personnel in the event of unmanageable behavior of an individual to prevent harm to that individual, patients, hospital personnel and/or others the general hospital area. D. Individuals responding to Code Green will meet in announced area. Available personnel is necessary to control atmosphere through a show	X1037		

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X1037	Continued From page 36 of strength and caring or to assist in physical management. Interview on 08/06/15 at 12:35 PM with the PES unit RN revealed she completed Patient #1's admission assessment to the PES unit on 04/27/15. The unit RN indicated Patients were provided with paper scrubs to wear without other undergarments. The unit RN stated that on 04/27/15 at approximately 11:30 AM to 12:00 PM, "Code Greens" were going on; and "staff were busy". The unit RN stated there was a Code Green on another unit (child/adolescent) and a Code Green was called in the lobby; due to a patient needing to be "put in a [restraint] chair" because they were tearing up the lobby. The unit RN stated she left the unit to respond to the Code Green in the other unit (child/adolescent) and when she arrived; there was another RN responding, so she went to the Code Green in the lobby because they needed an RN to assist with "putting the patient in the [restraint] chair." The unit RN stated she returned to the PES unit following the Code Greens to "something else going on at the end of the unit" that she responded to. The unit RN stated she could not remember if it was LVN-A or LVN-B working on 04/27/15; but that she thought the LVN stayed back in the PES unit when she left and responded to the two Code Greens. The unit RN stated she was notified that during the Code Greens Patient #2 went into Patient #1's bedroom; and Patient #1 made an allegation of sexual assault. The unit RN stated she spoke with Patient #1 who reported that she was asleep in her bedroom and "she felt pressure" causing her to awake to Patient #2 touching her in the buttock and perineal area. The unit RN stated that Patient #1's paper pants were "torn on the side." The unit RN stated the local PD was called.	X1037		

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X1037	Continued From page 37 The unit RN stated she spoke to Patient #2 and he said, "I touched her, but didn't do anything else." The unit RN stated he admitted that he "touched her and ripped her paper pants." The unit RN stated that Patient #2 knew that the unit was "chaotic" and knew what Code Green meant; and that is when he "took advantage" of the situation. The unit RN stated she believed that Patient #2 sexually assaulted Patient #1 given the facts, and his own admission. The unit RN stated she notified the MD, Social Worker, and Nursing Manager of the allegation. The unit RN indicated she documented the sexual assault allegation made by Patient #1 on the facility's Event Report; however, confirmed she did not document the sexual assault allegation in Patient #1's record following the incident. The unit RN stated she offered for Patient #1 to have a Sexual Assault Nurse Examination (SANE) completed at another facility if she wanted; but Patient #1 declined, stating she did not believe Patient #2 actually raped her. The unit RN confirmed she had not reported this allegation to the state health care regulatory agency (DSHS). Interview on 08/06/15 at 04:45 PM with MHW-A revealed she was the only MHW working on 04/27/15 in the PES unit; along with the unit RN and a Licensed Vocational Nurse (LVN). MHW-A stated she was pulled to the PES unit at 9:15 AM and was unfamiliar to the PES unit; but was told by the leaving MHW to "watch it" for Patient #2, however, she did not know the specific reason why. MHW-A stated the females were assigned rooms on one side, and males on the other side. MHW-A stated during the morning on 04/27/15 at approximately 11:30 AM-12:00 PM it was a "hectic/busy" day with "Code Green's being called." MHW-A stated that security was usually	X1037		

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X1037	Continued From page 38 on the PES unit; but on 04/27/15 at the time of the allegation; "security could not be found." MHW-A stated on 04/27/15 at around 11:30-12:00 PM she stayed in the unit when the Code Greens were called and was "getting something out of the supply closet." MHW-A indicated the unit RN "responded to the Code Green" leaving the unit; telling her she [unit RN] would be back. MHW-A did not remember if LVN-A or LVN-B was working on 04/27/15; but further stated she did not remember any LVN being in the unit during the time of the allegation made by Patient #1. MHW-A stated shortly after this Patient #1 "flagged her [MHW-A] down" to her bedroom, and into the restroom of the bedroom where she reported that Patient #2 came into her room and touched her buttocks and vaginal area while she was sleeping in her bed. MHW-A stated that Patient #1's gown was torn around the buttock area and she offered to call the local PD for Patient #1 to make a report. MHW-A stated she then reported the incident/allegation to the unit RN. MHW-A stated she was later told that Patient #2 had been an inpatient to the facility many times before, and he "knows the system; knows what Code Green means." MHW-A stated she had seen Patient #2 "walking out of her [Patient #1] room a few times" and further stated "right before she flagged me down, he had walked out of her room". MHW-A indicated she told Patient #2 "not to go in to other people's rooms." MHW-A confirmed she had not documented the allegation reported by Patient #1 against Patient #2; but that she "told [unit RN]." Interview on 08/10/15at 1:20 PM with Patient #1 revealed on 04/27/15 at approximately 11:30-11:45 AM she was in her assigned bedroom sleeping after she received multiple medications following her admission. Patient #1	X1037		

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X1037	Continued From page 39 stated she awoke after she "felt pressure" in her buttock and vaginal area. Patient #1 stated that Patient #2 was present telling her not to tell anyone. Patient #1 stated that she noticed her paper pants were ripped and she was not actually aware what all Patient #2 actually did because she "was conked out" after taking multiple medications. Patient #1 stated she knows he touched her because that was what woke her up. Patient #1 stated she was very upset, "freaked out," and asked the MD for an "AIDS" test. Patient #1 stated the unit RN indicated to the nursing staff (LVN) to "give her more meds" because she was "upset, crying, and freaking out." Patient #1 stated she then received the Ativan for her anxiety, to "help me calm down." Patient #1 stated the local PD came and she made a report. Patient #1 stated she was told by the unit RN that "Code Green's" were called and "everyone had to leave the unit" which allowed the opportunity for Patient #2 to go into her room unsupervised. Interview on 08/10/15 at 2:20 PM with Security Guard-A revealed he was employed by the facility to maintain security and the safety of patients. The Security Guard-A stated Patient #2 had a history of inappropriate sexual behavior of "masturbating in front of females." The Security Guard-A stated he assisted with "viewing the video" footage for evidence following the allegation on 04/27/15 made be Patient #1 against Patient #2. The Security Guard stated the video footage from 04/27/15 showed a total of "four times" that Patient #2 went into Patient #1's room; and the last time Patient #2 came out of Patient #1's room; she was observed to come out of the room a few minutes later. The Security Guard stated that Patient #2 had already been	X1037		

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X1037	Continued From page 40 assigned to the front "seclusion room" of the PES unit as his bedroom due to his history of masturbating. The Security Guard stated on the video footage Patient #2 could be seen coming from his room; "looking side to side" down the hallway, and then going into Patient #1's room. The Security Guard stated that female and male patient rooms were separated and that Patient #2 was not supposed to be going into Patient #1's room for any reason. Interview on 08/10/15 at 2:50 PM with MD-A revealed he was notified of Patient #1's sexual assault allegation against Patient #2 on 04/27/15. MD-A stated he discussed with Patient #1 the option of a "Rape Kit" but she "declined." MD-A stated he understood the allegation made by Patient #1 to be "only touching with no penetration." MD-A stated that Patient #1 was "distressed" about the incident and he ordered Ativan for Patient #1's anxiety following the incident. MD-A stated Patient #1 had already been distressed emotionally because of her ED inpatient admission; and really did not even want to take the Ativan. MD-A stated he recalled there was a Code Green called where staff left the unit in response to the Code Green; which left less staffing in the unit. MD-A confirmed that he did not document in Patient #1's records his contact or discussion with Patient #1 following her allegation. Interview on 08/10/15 at 3:00 PM with the facility's Risk Manager (RM) indicated that she was aware of the alleged sexual assault allegation made by Patient #1 on 04/27/15 against Patient #2'; however, she had not been notified until 05/06/15 via the facility's Incident/Event electronic system because there had not been any harm	X1037		

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X1037	Continued From page 41 documented in order to elevate the notification. The RM stated the staffing ratio on the PES unit was 1 staff to 4 patients. The RM indicated on 04/27/15 the patient census in the PES unit was 11; requiring 3 staff. The RM stated the first required staff is an RN, and then second could be a LVN, and/or MHW. The RM confirmed for 11 patients the required staffing would be 3. The RM stated the PES unit was to always have a licensed nurse present and available in the unit. The RM confirmed that she had not reported the sexual assault allegation made by Patient #1 on 04/27/15 against Patient #2 to the state health care regulatory agency, Department of State Health Services (DSHS); which was determined to have occurred as a result of insufficient staffing in the PES unit during episodes of Code Green's. The RM further confirmed the facility had not completed a thorough investigation with documented findings specific to this allegation for the determination of Neglect and/or a corrective action plan to prevent repeat incidence; in accordance with the facility's policy. The RM stated she had not seen or viewed the video footage following this allegation due to the video being unavailable after 05/06/15; following her electronic notification. Interview on 08/10/15 at 3:15 PM with Licensed Social Worker (LSW)-A stated she assisted Security Guard-A in viewing the video footage on 04/27/15 after Patient #1 made a sexual assault allegation against Patient #2. LSW-A stated that during the allegation on 04/27/15; Patient #2 could be seen on the camera "looking both ways" and then would go into Patient #1's bedroom. LSW-A stated they were able to count this event occurring a "couple of times" where Patient #2 would go into Patient #1's bedroom and remain	X1037		

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X1037	Continued From page 42 there "a couple of minutes" each time. LSW-A stated she saw on the video where MHW-A had been in the "Patient evaluation room" during these time periods; where a supply closet was located. LSW-A stated Patient #2 had a history of "exposing his self, public masturbation, and talks sexually to other women." LSW-A stated that Patient #2 has publically masturbated in front of her during an assessment interview. Interview on 08/10/15 at 4:15 PM with LVN-A stated he was present and worked the PES unit on 04/27/15. LVN-A stated that on 04/27/15 there were Code Greens called on another unit, and in the facility's lobby about the same time. LVN-A stated he responded to the Code Green in the lobby to assist due to a "fight." LVN-A indicated he had left the unit for approximately 15 minutes. Interview on 08/10/15 at 4:30 PM with the Vice President (VP) of Clinical Services confirmed that she was notified of the sexual allegation made by Patient #1 against Patient #2 on 04/27/15; however, she had not been notified until 05/06/15 via the facility's Incident/Event electronic system because there had not been any harm documented in order to elevate the notification. The VP of Clinical Services indicated that on 04/27/15 the Nursing Clinical Director (Nurse Manager) had been notified immediately following Patient #1's allegation and she had not obtained information that indicated Patient #1's allegation had occurred due to insufficient staffing in the PES unit when Code Green's had been called; leaving the unit without a RN available. The VP of Clinical Services stated that the unit RN was not supposed to leave the unit and there should always be a Licensed Nurse in the unit during a	X1037		

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X1037	Continued From page 43 Code Green; that "it is a judgement call." The VP of Clinical Services stated she had not seen or viewed the video footage following this allegation due to the video being unavailable after 05/06/15; following her electronic notification. The VP of Clinical Services confirmed she had not reported this allegation to the state health care regulatory agency (DSHS). Interview on 08/10/15 at 4:40 PM with the Nursing Clinical Director (Nurse Manager) stated she was immediately notified by the PES unit RN on 04/27d/15 of Patient #1's sexual allegation against Patient #2. The Nursing Clinical Director indicated she "separated" the Patients, talked to both of them, and Patient #1 saw the Doctor. The Nursing Clinical Director stated she spoke to the unit RN about the allegation but had not been notified or received information that the RN and LVN had left the PES unit to respond to Code Greens which left the unit without a RN and/or licensed nurse available. The Nursing Clinical Director stated she had not seen or viewed the video footage following this allegation. The Nursing Clinical Director confirmed she had not reported this allegation to the state health care regulatory agency (DSHS).	X1037		

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X 000	INITIAL COMMENTS Note: The State Form is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be referred to the Office of the Texas Attorney General (OAG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. An unannounced visit was completed from 04/08/15 to 04/09/15 to conduct a complaint investigation survey (TX 00212197). An entrance conference was conducted in the conference room of the facility. In attendance were the Director of Social Services, and the Vice President of Clinical Services. The purpose and process of the complaint survey were discussed and an opportunity for questions was provided. Complaint TX 00212197 was substantiated with violations cited. An exit conference was conducted in the afternoon of 04/09/15 in the facility conference room. The Director of Risk Management was in attendance. Preliminary findings of the survey were discussed and an opportunity for questions was provided.	X 000		
X 123	133.41(c)(8)(A) Discharge and continuing care plan Comprehensive Medical Rehabilitation Services. Discharge and continuing care plan. The patient's interdisciplinary team shall prepare a written continuing care plan that addresses the	X 123	1) 133.41 c 8 A Discharge and Continuing Care Plan Corrective Action : For all new medical diagnoses the APN will immediately consult with attending psychiatrist and pending approval will be added by the APN immediately in axis as part of the discharge summary. At discharge nursing staff will document	5/15/15

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X 123	Continued From page 1 patient's needs for care after discharge. (A) The continuing care plan for the patient shall include recommendations for treatment and care and information about the availability of resources for treatment or care. This Requirement is not met as evidenced by: Based on a record review and interview, the hospital failed to ensure that discharge instructions included the written referral for follow-up/continuing care as ordered by the Advanced Nurse Practitioner (ANP). Patient #1's discharge summary completed by the Psychiatrist did not include her newly diagnosed Diabetes made by the ANP on 01/17/15; or the follow-up care recommended for her Primary Care Physician (PCP) by the ANP. This deficient practice could affect Patient #1's overall health by failure to follow-up and seek treatment of her health conditions. Findings included: Record review of Patient #1's medical record revealed she was admitted on 01/13/15 and discharged 01/20/15 at 18:40. On 01/17/15 the facility's ANP assessed Patient #1's laboratory results for a Hemoglobin, A1C at 7.24 (normal results less than 6.5) and indicated that she had "[Diabetes Mellitus] (DM)". ANP documented that she would place Patient #1 on a 2000 American Diabetes Association (ADA) diet, have the	X 123	education to patient and or guardian (as appropriate) for need and recommended follow-up with PCP. Ongoing compliance will be checked daily via nursing 12 and 24 hr chart checks. All nursing staff will be in-serviced by Behavioral Health Nursing Administration by 5/15/15.	

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X 123	Continued From page 2 dietician see patient before discharge, and documented that Patient #1 needed to follow up with her PCP. Record review of the Discharge Instructions dated 01/20/15 presented and signed by Patient #1's mother/guardian revealed only "Follow-up appointments" were for the Psychiatrist and Individual Therapist appointments. The area of Follow-up appointments for Primary Care Physician was documented "Deferred." Further review revealed discharge diagnosis for AXIS III: Medical problems were- "Asthma, gastro esophageal reflux disease (GERD)." The Discharge Summary diagnosis did not include Diabetes Mellitus as diagnosed by the ANP on 01/17/15. Record review of Patient #1's written complaint completed by her mother/guardian, undated, revealed when her daughter was discharged on 01/20/15; "they did blood work on her [Patient #1] and never told me she has Diabetes. My daughter told me, I confronted the nurses, they said they don't tell me; papers are sent home when she leaves; and that it's not that bad." Record review of the facility's Medical Staff Bylaws; Rules and Regulations approved by the Board of Control May 31, 2013, revealed the following; Where there is need of a discharge summary, a clinical resume covering the necessary five (5) points including the final diagnosis and authenticated by the attending Practitioner is sufficient to exclude the completion of the face sheet. Necessary five (5) points: (1) Why was the patient admitted?	X 123		

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X 123	Continued From page 3 (2) Pertinent findings. (3) What was done? Procedures performed and treatment rendered (4) Condition on discharge. (5) Instructions, including medications, diet, physical activity, if any, and follow-up. During an interview on 04/08/15 at 4:45 PM with the ANP, she stated that she diagnosed Patient #1 with DM on 01/17/15 following her laboratory test results, Hemoglobin A1C; positive for Diabetes. ANP stated she wanted Patient #1 to follow-up with her PCP following discharge because she did not want to initiate medication therapy that she was not able to monitor. ANP confirmed Patient #1's Discharge Summary and Instructions dated 01/20/15 failed to document her new diagnosis of Diabetes Mellitus and the recommended follow-up with her PCP. ANP stated that the nurse completing the Discharge Instructions did not pick that up from her record and the Psychiatrist did not add it to her final diagnosis upon discharge. During an interview on 04/09/15 at 8:55 AM with Patient #1's mother/guardian revealed she was not told when her daughter was discharged on 01/20/15 that she had Diabetes; or that she needed to follow-up with her PCP.	X 123		
X 795	133.42(a)(1)(A) Patient rights requirements: all hospitals Patient Rights. Patient rights requirements for all hospitals. A hospital shall adopt, implement, and enforce a policy to ensure patients' rights. The written policy shall include:	X 795	2) 133.42 a 1 A Patient Rights Requirements a. Corrective Action - Updated signage in the NMC mailroom and statement with address included in the patient handbooks. Signage in NMC mailroom will be installed and BH patient handbooks will be updated by and completed by the Director of Risk Management.	5/15/15

Texas Department of State Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000415	A. BUILDING: _____ B. WING _____	C 04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

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X 795	Continued From page 4 (A) the right of the patient to the hospital's reasonable response to his or her requests and needs for treatment or service, within the hospital's capacity, its stated mission, and applicable law and regulation; This Requirement is not met as evidenced by: Based on record review and interview, the facility failed to implement and ensure the rights for 1 of 1 Patient (# 1) reviewed for rights. Specifically, the facility failed to: 1.) Ensure prompt resolution of grievances within 30 days; as indicated by the facility's Complaints and Grievances policy and; 2.) Ensure reasonable access to care and services upon request of Patient #1's mother/guardian regarding the need for assessment and treatment. This deficient practice affected Patient #1's rights when the facility failed to address concerns, complaints, and grievances related to the patient	X 795	b. Corrective Action - For medical complaints lasting 24 hours and requiring PRN medication the patient will receive a medical consult within 24 hours. If symptoms persist after the medical consult and any ordered follow-up has been satisfied the APN will address the patient's complaints with the attending psychiatrist for further recommendations. Ongoing compliance will be checked daily via nursing 12 and 24 hr chart checks. All nursing staff will be in-serviced by Behavioral Health Nursing Administration by 5/15/15.	5/15/15

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X 795	Continued From page 5 rights, safety, and satisfaction. Findings included: 1.) Record review of the facility's Patient Complaints and Grievances Policy, last reviewed 11/2013 revealed the following: Grievances: 1.) Upon receipt of a grievance, the receiving department will indicate the date of receipt and sent the grievance to Quality/Risk Department. 2.) The Director of Risk Management or designee will investigate all grievances. 3.) A written response for the initial acknowledgment of the grievance is sent within 7 to 10 days of the person filing the grievance. 4.) A written resolution is sent within a stated number of days, but will not exceed 30 days unless notification is sent to the complainant prior to the expiration of the above stated period. The Director of Risk Management or designee will develop a written response to the patient. 5.) A copy of the completed Grievance From Written Complaint and response letter will be sent to the Chief Compliance Officer or the hospital's General Counsel for review before being mailed to the person filing the grievance. Record review of the Department of State Health Services (DSHS) Complainant Investigative Report (CIR) TX 00212197 revealed that Patient #1's mother/guardian alleged complaints towards the facility which included a substantive quality of care issues, and a perceived violation of her daughter/patient's (#1) rights when she received services on 01/13/2015 to 01/20/2015. Record review of the facility's Complaints and Grievances specific for Patient #1 revealed the facility had received the same alleged complaints	X 795		

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X 795	Continued From page 6 and grievance letter (TX 00212197) towards the facility regarding her daughter's/Patient #1's care while an inpatient at the facility from 01/13/2015 to 01/20/2015. Further review revealed this letter was sent and postmarked from the sender/complainant on 02/02/2015 (over 60 days ago) to the Patient Advocate at the address of the facility that provided the services and care to Patient #1 from 01/13/2015 to 01/20/2015. Record review of the letter provided to this surveyor from Patient #1's mother/guardian/complainant revealed a letter of acknowledgment by the facility's Director of Risk Management, dated 03/08/2015 (over 30 days from the post mark of 02/02/2015); acknowledging receipt of Patient #1's/complainants concerns. Further review revealed the concerns were received by the Quality Review Department, and the complainant could expect a written response within 30 days. Further review of the facility's Complaints and Grievances specifically for Patient #1 revealed the facility's Risk Manager sent an acknowledgment letter to the complainant that was dated 03/11/15 (over 30 days from the post mark of 02/02/2015) that stated the facility would send a written response within 30 days. Review on 04/09/15, over 30 days from the letter sent to the complainant dated 03/08/15, revealed there was no documentation that a written resolution was sent to the complainant or a completed investigation regarding her complaints and grievances towards the facility. During an interview on 04/08/15 at 3:50 PM with Director of Risk Management indicated she did not know exactly what day she received the	X 795		

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X 795	Continued From page 7 complaints and grievance from Patient #1's mother/guardian regarding her daughters services from 01/13/15 to 01/20/15 but stated that Patient #1 was readmitted a second time I February (02/10/15) and, "by that time had the letter." The Director of Risk Management indicated she sent an acknowledgment letter in March 2015 and was still investigating the mother's allegations in the letter. Further interview on 04/09/15 at 1:30 PM with the Director of Risk Management confirmed she was over the 30 days to send a written response to Patient #1's mother/guardian/complainant; in accordance with the facility's Complaint and Grievances Policy stating she missed it. The Director of Risk Management indicated she was responsible to ensure the completion and investigation of the Grievance process; and she had delegated this grievance investigation (TX 00212197) to the facility's Patient Advocate, who no longer was employed at the facility and had not completed this grievance resolution. During a phone interview on 04/09/15 at 8:55 AM with Patient #1's guardian/mother/complainant stated she received a letter dated 03/08/2015 from the Director or Risk Management acknowledging receipt of her concerns/complaints. The complainant stated the letter indicated she would receive a written response within 30 days. Further interview revealed that the complainant had not yet received a written response regarding her alleged allegations regarding her daughter's care and services from her visit dated 01/13/2015 to 01/20/2015.	X 795		

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X 795	Continued From page 8 2.) Record review of the DSHS CIR TX 00212197 revealed that Patient #1's mother/guardian alleged written complaints towards the facility, undated, that indicated on January 17th 2015; Patient #1 "had a sore throat. I told the nurse she said she would tell the Doctor. The next day (01/08/15) I visited; she could hardly talk or swallow. Told [Nurse A] the nurse, he said did I want a medical Doctor to see her; I said yes. They said the Doctor ordered her Lozenges and they're giving her them. I said I want the Doctor to check her for strep throat. [Nurse A] said okay, he'd put the request in. When I visited on Monday [01/19/15] no one had seen her [Patient #1]. Complained again the nurse said, Oh they didn't come in today yet. So on Tuesday [01/20/15] she was checked out [discharged] with No Doctor seeing her. That night I had to take her to [a local hospital] and they said she has strep throat." Record review of Patient #1's medical record revealed the following Physician Orders: 01/17/15: Telephone Order (TO) for Cepacol lozenges every 2 hours for sore throat. 01/19/15 at 0700 TO from Psychiatrist A for a "med [medical] consult for sore throat to [rule out] r/o infection." Record review of Patient #1's medication administration records revealed she was administered Acetaminophen 325 milligrams as follows for sore throat pain: 01/17/15 at 1009 with a pain scale of 7, 01/17/15 at 1754 with a pain scale of 0, 01/19/15 at 0824 with a pain scale of 2, and 01/20/16 at 0752 with a pain scale of 8.	X 795		

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X 795	Continued From page 9 Record review of Patient #1's Psychiatrist Progress notes revealed Patient #1 complained to him during assessment of a sore throat on 01/18/15 and 01/19/15. Review of Patient #1's medical record revealed she was discharged on 01/20/15 at 1840; had not been seen for a medical consult for sore throat to r/o infection prior to her discharge and had not been physically assessed. During an interview on 04/08/15 at 4:45 PM with the Advanced Nurse Practitioner (ANP) stated that Patient #1 should have had a med consult before she was discharged on 01/20/15 or within 24 hours of the TO written on 01/19/15 at 0700. ANP stated that she has experienced communication issues from the weekend nurses to notify her when a med consult was needed. During a phone interview on 04/09/15 at 8:55 AM with the complainant, Patient #1's mother/guardian, indicated that her daughter was never seen for assessment or treatment prior to her discharge on 01/20/15 despite repeated requests for assessment by a Doctor. The complainant stated she took her daughter to the hospital on 01/20/15 following discharge from the facility where her daughter was diagnosed with "Strep throat" and prescribed antibiotics for 10 days.	X 795		
X1036	133.47(c)(2) Posting requirements Abuse And Neglect Issues. Abuse and neglect of individuals with mental illness, and illegal, unethical, and unprofessional conduct.	X1036	3) 133.47 c Posting Requirements Corrective Action: Signage with TxDSHS complaint line will be posted in the lobby at both BH campuses and on each patient unit. Temporary signs will be up in these locations no later than 5/15/15 and	7/1/15

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X1036	Continued From page 10 The requirements of this subsection are in addition to the requirements of subsection (b) of this section. Posting requirements. A facility shall prominently and conspicuously post for display in a public area that is readily visible to patients, residents, volunteers, employees, and visitors a statement of the duty to report abuse and neglect, or illegal, unethical or unprofessional conduct in accordance with HSC, §161.132(e). The statement shall be in English and in a second language appropriate to the demographic makeup of the community served and contain the number of the department's patient information and complaint line at (888) 973-0022. This Requirement is not met as evidenced by: Based on observation and interview, the facility failed to prominently and conspicuously post for display in a public area that is readily visible to patients, residents, volunteers, employees, and visitors; a statement of the duty to report abuse and neglect, or illegal, unethical or unprofessional conduct in accordance with the Texas Health and Safety Code (HSC), and ensure the statement contains the number of the department's patient information and complaint line at (888) 973-0022. This deficient practice affected the rights of Patients. Findings included: Observation conducted on 04/08/15 at 12:15 PM of the facility's lobby/waiting area revealed a	X1036	permanent signs will be up by 7/1/15. This will be completed by the Director of Risk Management.	

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X1036	Continued From page 11 poster of Patient's Rights dated 09/01/2013. The posting failed to contain a statement of the duty to report abuse and neglect, or illegal, unethical or unprofessional conduct in accordance with the HSC §161.132(e); and failed to ensure it contained the number of the Texas Department of State Health Services patient information and complaint line at (888) 973-0022. Further observation conducted on 04/08/15 at 3:40 PM throughout the facility did not reveal a posting of the department's (DSHS) patient information and complaint line phone number, or a statement of the duty to report abuse and neglect, or illegal, unethical or unprofessional conduct in accordance with the HSC §161.132(e). During an interview on 04/09/15 at 1:45 PM with the facility's Risk Manager confirmed the department's (DSHS) patient information and complaint line phone number (888-973-0022) were not posted in the facility or a statement of the duty to report abuse and neglect, or illegal, unethical or unprofessional conduct in accordance with the HSC §161.132(e).	X1036		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	450130	A. BUILDING _____ B. WING _____	C 04/09/2015

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A 000	INITIAL COMMENTS The CMS - 2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates and the signature space. Any discrepancy in the original deficiency citation (s) will be reported to Dallas Regional Office (RO) for referral to the Office of Inspector General (OIG) for possible fraud if information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. An unannounced visit was completed from 04/08/15 to 04/09/15 to conduct a complaint investigation survey (TX 00212197). An entrance conference was conducted in the conference room of the facility. In attendance were the Director of Social Services, and the Vice President of Clinical Services. The purpose and process of the complaint survey were discussed and an opportunity for questions was provided. Complaint TX 00212197 was substantiated with deficiencies cited. An exit conference was conducted in the afternoon of 04/09/15 in the facility conference room. The Director of Risk Management was in attendance. Preliminary findings of the survey were discussed and an opportunity for questions was provided.	A 000		
A 119	482.13(a)(2) PATIENT RIGHTS: REVIEW OF GRIEVANCES [The hospital must establish a process for prompt	A 119	1) 482.3 a 2 Patient Rights: Review of Grievances: Corrective Action: Updated signage in the NMC mailroom and statement with address included in the patient handbooks. Signage in NMC mailroom will be installed and BH	5/15/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: SUP COO — (X6) DATE: 5/1/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 118	Continued From page 1 resolution of patient grievances and must inform each patient whom to contact to file a grievance.) The hospital's governing body must approve and be responsible for the effective operation of the grievance process, and must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure prompt resolution of grievances, and the governing body failed to ensure the effective operation of the grievance process to review and notify complainants of the resolution within 30 days; as indicated by the facility's Complaints and Grievances policy for 1 of 1 patient (#1) reviewed for grievances. Specifically, Patient #1's mother/guardian/ complainant had written a grievance post marked to the facility 02/02/15. The facility's Risk Manager sent an acknowledgment letter to the complainant dated 03/08/15 (over 30 days) stating the facility would send a written response within 30 days. On 04/09/15 (over 30 days) there was no documentation that a written resolution was sent to the complainant or a completed investigation regarding her complaints and grievances. This deficient practice affected Patient #1's rights when the facility failed to address concerns, complaints, and grievances related to the patient rights, safety, and satisfaction. Findings included: Record review of the facility's Patient Complaints and Grievances Policy, last reviewed 11/2013	A 119	patient handbooks will be updated by 5/15/15 and completed by the Director of Risk Management.	

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A 119	Continued From page 2 revealed the following: Grievances: 1.) Upon receipt of a grievance, the receiving department will indicate the date of receipt and sent the grievance to Quality/Risk Department. 2.) The Director of Risk Management or designee will investigate all grievances. 3.) A written response for the initial acknowledgment of the grievance is sent within 7 to 10 days of the person filing the grievance. 4.) A written resolution is sent within a stated number of days, but will not exceed 30 days unless notification is sent to the complainant prior to the expiration of the above stated period. The Director of Risk Management or designee will develop a written response to the patient. 5.) A copy of the completed Grievance From Written Complaint and response letter will be sent to the Chief Compliance Officer or the hospital's General Counsel for review before being mailed to the person filing the grievance. Record review of the Department of State Health Services (DSHS) Complainant Investigative Report (TX 00212197) revealed that Patient #1's mother/guardian alleged complaints towards the facility which included a substantive quality of care issues, and a perceived violation of her daughter/patient's (#1) rights when she received services on 01/13/2015 to 01/20/2015. Record review of the facility's Complaints and Grievances specific for Patient #1 revealed the facility had received the same alleged complaints and grievance letter (TX 00212197) towards the facility regarding her daughter's/Patient #1's care while an inpatient at the facility from 01/13/2015 to 01/20/2015. Further review revealed this letter was sent and postmarked from the	A 119		

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A 119	Continued From page 3 sender/complainant on 02/02/2015 (over 60 days ago) to the Patient Advocate at the address of the facility that provided the services and care to Patient #1 from 01/13/2015 to 01/20/2015. Record review of the letter provided to this surveyor from Patient #1's mother/guardian/complainant revealed a letter of acknowledgment by the facility's Director of Risk Management, dated 03/08/2015 (over 30 days from the post mark of 02/02/2015); acknowledging receipt of Patient #1's/complainants concerns. Further review revealed the concerns were received by the Quality Review Department, and the complainant could expect a written response within 30 days. Further review of the facility's Complaints and Grievances specifically for Patient #1 revealed the facility's Risk Manager sent an acknowledgment letter to the complainant that was dated 03/11/15 (over 30 days from the post mark of 02/02/2015) that stated the facility would send a written response within 30 days. Review on 04/09/15, over 30 days from the letter sent to the complainant dated 03/08/15, revealed there was no documentation that a written resolution was sent to the complainant or a completed investigation regarding her complaints and grievances towards the facility. During an interview on 04/08/15 at 3:50 PM with Director of Risk Management indicated she did not know exactly what day she received the complaints and grievance from Patient #1's mother/guardian regarding her daughters services from 01/13/15 to 01/20/15 but stated that Patient #1 was readmitted a second time f	A 119		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 119	Continued From page 4 February (02/10/15) and, "by that time had the letter." The Director of Risk Management indicated she sent an acknowledgment letter in March 2015 and was still investigating the mother's allegations in the letter. Further interview on 04/09/15 at 1:30 PM with the Director of Risk Management confirmed she was over the 30 days to send a written response to Patient #1's mother/guardian/complainant; in accordance with the facility's Complaint and Grievances Policy stating she missed it. The Director of Risk Management indicated she was responsible to ensure the completion and investigation of the Grievance process; and she had delegated this grievance investigation (TX 00212197) to the facility's Patient Advocate, who no longer was employed at the facility and had not completed this grievance resolution. During a phone interview on 04/09/15 at 8:55 AM with Patient #1's guardian/mother/complainant stated she received a letter dated 03/08/2015 from the Director or Risk Management acknowledging receipt of her concerns/complaints. The complainant stated the letter indicated she would receive a written response within 30 days. Further interview revealed that the complainant had not yet received a written response regarding her alleged allegations regarding her daughter's care and services from her visit dated 01/13/2015 to 01/20/2015.	A 119		
A 468	482.24(c)(2)(vii) CONTENT OF RECORD: DISCHARGE SUMMARY	A 468	2) 482.24 c 2 vii Content of Record: Discharge Summary Corrective Action: For all new medical diagnoses the APN will immediately consult with attending psychiatrist and pending approval will be added by the APN immediately in axis as part of the	5/15/15

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ B. WING _____	C 04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 468	Continued From page 6 [All records must document the following, as appropriate:] Discharge summary with outcome of hospitalization, disposition of care and provisions for follow-up care. This STANDARD is not met as evidenced by: Based on record review and interview, the hospital failed to include a discharge summary with an outcome of hospitalization, a disposition of care, and provisions for follow-up care for 1 of 1 Patient (#1) reviewed. Patient #1's discharge summary completed by the Psychiatrist did not include her newly diagnosed Diabetes Mellitus (DM) made by the Advanced Nurse Practitioner (ANP); or the follow-up care recommended for her Primary Care Physician (PCP) by the ANP. This deficient practice could affect Patient #1's overall health by failure to follow-up and seek treatment of her health conditions. Findings Included: Record review of Patient #1's medical record revealed she was admitted on 01/13/15 and discharged 01/20/15 at 18:40. On 01/17/15 the facility's ANP assessed Patient #1's laboratory results for a Hemoglobin, A1C at 7.24 (normal results less than 6.5) and indicated that she had "DM". ANP documented that she would place Patient #1 on a 2000 American Diabetes Association (ADA) diet, have the dietician see patient before discharge, and documented that Patient #1 needed to follow up with her PCP.	A 468	discharge summary. Ongoing compliance will be checked daily via nursing 12 and 24 hr chart checks. All nursing staff will be in-serviced by Behavioral Health Nursing Administration by 5/15/15	

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A 468	Continued From page 6 Record review of Patient #1's Interdisciplinary Education completed by the Dietician dated 01/19/15 revealed in part; Patient #1 "is newly diagnosed with diabetes, HA1C 7.24, [Registered Dietician] RD discussed principles of a diabetic diet. Also revealed meal plan for 2000 ADA. [Patient] Pt. was responsive to information given. Provided written educational materials in chart for child/parent review upon discharge." Record review of Patient #1's Discharge Summary dated 01/20/15 completed by the Psychiatrist revealed discharge diagnosis for AXIS III: Medical problems were- "Asthma, gastro esophageal reflux disease (GERD)." The Discharge Summary diagnosis did not include Diabetes Mellitus as diagnosed by the ANP on 01/17/15. Record review of the Discharge Instructions dated 01/20/15 presented and signed by Patient #1's mother/guardian revealed only "Follow-up appointments" were for the Psychiatrist and Individual Therapist appointments. Further review for the area of Follow-up appointments for Primary Care Physician was documented "Deferred." Record review of Patient #1's written complaint completed by her mother/guardian, undated, revealed when her daughter was discharged on 01/20/15; "they did blood work on her [Patient #1] and never told me she has Diabetes. My daughter told me, I confronted the nurses, they said they don't tell me; papers are sent home when she leaves; and that it's not that bad." Record review of the facility's Medical Staff Bylaws; Rules and Regulations approved by the	A 468		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ B. WING _____	C 04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 468	Continued From page 7 Board of Control May 31, 2013, revealed the following; Where there is need of a discharge summary, a clinical resume covering the necessary five (5) points including the final diagnosis and authenticated by the attending Practitioner is sufficient to exclude the completion of the face sheet. Necessary five (5) points: (1) Why was the patient admitted? (2) Pertinent findings. (3) What was done? Procedures performed and treatment rendered (4) Condition on discharge. (5) Instructions, including medications, diet, physical activity, if any, and follow-up. During an interview on 04/08/15 at 4:45 PM with the ANP, she stated that she diagnosed Patient #1 with DM on 01/17/15 following her laboratory test results, Hemoglobin A1C; positive for Diabetes. ANP stated she wanted Patient #1 to follow-up with her PCP following discharge because she did not want to initiate medication therapy that she was not able to monitor. ANP confirmed Patient #1's Discharge Summary and Instructions dated 01/20/15 failed to document her new diagnosis of Diabetes Mellitus and the recommended follow-up with her PCP. ANP stated that the nurse completing the Discharge Instructions did not pick that up from her record and the Psychiatrist did not add it to her final diagnosis upon discharge. During an interview on 04/09/15 at 8:55 AM with Patient #1's mother/guardian revealed she was not told when her daughter was discharged on 01/20/15 that she had Diabetes; or that she	A 468		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 468	Continued From page 8 needed to follow-up with her PCP.	A 468	3) 782.43 d Transfer or Referral Corrective Action:	
A 837	482.43(d) TRANSFER OR REFERRAL The hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care. This STANDARD is not met as evidenced by: Based on a record review and interview, the hospital failed to ensure that discharge instructions included the referral for follow-up care as ordered by the Advanced Nurse Practitioner (ANP) along with the necessary medical information. Patient #1's discharge summary completed by the Psychiatrist did not include her newly diagnosed Diabetes Mellitus (DM) made by the ANP on 01/17/15; or the follow-up care recommended for her Primary Care Physician (PCP) by the ANP. This deficient practice could affect Patient #1's overall health by failure to follow-up and seek treatment of her health conditions. Findings Included: Record review of Patient #1's medical record revealed she was admitted on 01/13/15 and discharged 01/20/15 at 18:40. On 01/17/15 the facility's ANP assessed Patient #1's laboratory results for a Hemoglobin, A1C at 7.24 (normal results less than 6.5) and indicated that she had "DM". ANP documented that she would place Patient #1 on a 2000 American Diabetes Association (ADA) diet, have the dietician see	A 837	For all new medical diagnoses the APN will immediately consult with attending psychiatrist and pending approval will be added by the APN immediately in axis as part of the discharge summary. At discharge nursing staff will document education to patient and or guardian (as appropriate) for need and recommended follow-up with PCP. Ongoing compliance will be checked daily via nursing 12 and 24 hr chart checks. All nursing staff will be in-serviced by Behavioral Health Nursing Administration by 5/15/15.	5/15/15

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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A 837	Continued From page 9 patient before discharge, and documented that Patient #1 needed to follow up with her PCP. Record review of the Discharge Instructions dated 01/20/15 presented and signed by Patient #1's mother/guardian revealed only "Follow-up appointments" were for the Psychiatrist and Individual Therapist appointments. The area of Follow-up appointments for Primary Care Physician was documented "Deferred." Further review revealed discharge diagnosis for AXIS III: Medical problems were- "Asthma, gastro esophageal reflux disease (GERD)." The Discharge Summary diagnosis did not include Diabetes Mellitus as diagnosed by the ANP on 01/17/15. Record review of Patient #1's written complaint completed by her mother/guardian, undated, revealed when her daughter was discharged on 01/20/15; "they did blood work on her [Patient #1] and never told me she has Diabetes. My daughter told me, I confronted the nurses, they said they don't tell me; papers are sent home when she leaves; and that it's not that bad." Record review of the facility's Medical Staff Bylaws; Rules and Regulations approved by the Board of Control May 31, 2013, revealed the following; Where there is need of a discharge summary, a clinical resume covering the necessary five (5) points including the final diagnosis and authenticated by the attending Practitioner is sufficient to exclude the completion of the face sheet. Necessary five (5) points: (1) Why was the patient admitted?	A 837		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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A 837	Continued From page 10 (2) Pertinent findings. (3) What was done? Procedures performed and treatment rendered (4) Condition on discharge. (5) Instructions, including medications, diet, physical activity, if any, and follow-up. During an interview on 04/08/15 at 4:45 PM with the ANP, she stated that she diagnosed Patient #1 with DM on 01/17/15 following her laboratory test results, Hemoglobin A1C; positive for Diabetes. ANP stated she wanted Patient #1 to follow-up with her PCP following discharge because she did not want to initiate medication therapy that she was not able to monitor. ANP confirmed Patient #1's Discharge Summary and Instructions dated 01/20/15 failed to document her new diagnosis of Diabetes Mellitus and the recommended follow-up with her PCP. ANP stated that the nurse completing the Discharge Instructions did not pick that up from her record and the Psychiatrist did not add it to her final diagnosis upon discharge. During an interview on 04/09/15 at 8:55 AM with Patient #1's mother/guardian revealed she was not told when her daughter was discharged on 01/20/15 that she had Diabetes; or that she needed to follow-up with her PCP.	A 837		

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

P.O. Box 149347
Austin, Texas 78714-9347
1-888-963-7111

DAVID L. LAKEY, M.D.
COMMISSIONER

TTY: 1-800-735-2989
www.dshs.state.tx.us

Texas Department of State Health Services
Health Facility Compliance Group-San Antonio
2303 SE Military Drive, Bldg 514
San Antonio, TX 78223
Mail Code: 1979

December 16, 2014

NIX Health Care System
414 Navarro, Suite 600
San Antonio Texas 78205

Dear Administrator:

Enclosed are the CMS 2567 and the Statement of Deficiencies forms listing those deficiencies found at your facility on 11-19-14. Please develop a plan of correction for each deficiency cited and return to this office (within ten (10) calendar days from receipt of this letter).

In the space provided on the forms, please provide a plan of correction and completion date for each deficiency. After completing the forms, sign and date at the bottom of page one of each form and return to the address above. It will be necessary to make copies for your records, please make a copy of the Statement of Deficiencies for your records prior to completing the Plan of Correction on that form.

The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should by the provider/supplier; the State Survey Agency (SA) should be notified immediately.

PLEASE DO NOT PUNCH HOLES

An approved plan of correction is requisite to continued program participation. You will be notified only if your plan of correction is unacceptable. Certification of your facility cannot be recommended to the Centers for Medicare/Medicaid Services until I have received the completed forms. Therefore, I am requesting that you give this matter priority and that you return the forms to the address above within ten (10) calendar days from receipt of this letter. If you have any questions, do not hesitate to contact my office.

Sincerely,

/S/

Larrie Collier, HFC Manager
Health Facility Compliance Group-San Antonio
(210)531-4946
larrie.collier@dshs.state.tx.us

LC/js
Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ B. WING _____	C 11/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS The CMS - 2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates and the signature space. Any discrepancy in the original deficiency citation (s) will be reported to Dallas Regional Office (RO) for referral to the Office of Inspector General (OIG) for possible fraud if information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. An unannounced visit was conducted on 11/10/14 to conduct a complaint investigation survey. An entrance conference was conducted in the conference room of the facility. In attendance was the Vice President of Behavioral Health Care and the Patient Advocate. The purpose and process of the complaint survey were discussed and an opportunity for questions was provided. Complaint TX 00203333 was substantiated in the area of patient rights with related standard level deficiencies cited. An exit conference was conducted in the afternoon of 11/19/14 in the facility conference room. The Director of Risk Management was in attendance. Preliminary findings of the survey were discussed and an opportunity for questions was provided.	A 000	Plan of Correction: All Admission, Assessment, Social Work and Nursing Staff will receive formal inservice training to include an attestation to the effect that they have been educated on the legal specifics related to patients with guardians. Staff will demonstrate an understanding of Proper notifications and consents which must be provided to and received from the patient's guardian related to patient's admission, inpatient care and receipt of psychotropic and other medications. The staff member who discovers that a patient has a guardian, regardless of their position, will immediately: 1. Notify the Nursing Supervisor as well as their immediate supervisor upon discovery that the patient has a guardian 2. Contact the Admissions office to inform that patient's guardian must be notified to sign all forms pertaining to the patient's admission and subsequent treatment modalities 3. Work with Supervisor and Admissions staff to ensure that admission, medication and all other consents are reviewed with and signed by the patient's guardian 4. Attempt to acquire copies of legal documents that name the patient's guardian and place such documents in the patient's medical record	
A 131	482.13(b)(2) PATIENT RIGHTS: INFORMED CONSENT The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care	A 131		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Chief Quality & Compliance Officer 12/23/2014

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ B. WING _____	C 11/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 131	Continued From page 1 planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate. This STANDARD is not met as evidenced by: Based on record reviews and interviews, it was determined the facility failed to follow their Informed Consent Policy and Procedure that would ensure one of one patient's (patient #1) guardian was given the right to make informed decisions regarding consent to the use of psychotropic medications. This had the potential to affect any patient who had a guardian and was placed on psychotropic medications. Findings included: Record review on 11/10/14 of Informed Consent Policy and Procedure, last reviewed by facility in February 2011, revealed but was not limited to the following: "Written Consent: A written consent form is to be used to obtain authorization prior to the procedure or treatment. When completed, the form serves as a record and evidence that the patient authorized the procedure and accepted the associated risks as disclosed by the physician. Persons under Guardianship (adults or minors): All persons under legal custody of a guardian or conservator shall have permits signed by their legal guardian (as guardian) and a certified copy of his/her official letters of guardianship shall be obtained and placed in and become part of the patients' permanent medical record, prior to receiving treatment."	A 131	5. Ensure that all signed consents received from the patient's guardian are placed in patient's medical record as soon as they are completed Additionally, a form will be developed and approved by forms committee and implemented to ensure that every effort is made to determine whether any patient requiring admission to our services has a guardian, so that appropriate consents will be received prior to a patient's admission. Completion date for the training and implementation of this process: January 15, 2015	

12-23-2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING _____ B. WING _____	C 11/19/2014

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 131	Continued From page 2 Record review on 11/10/14 of Patient #1's medical record revealed but was not limited to the following: "Annual Report On Condition and Well-Being of Ward and Oath of Guardian signed by Patient's guardian [mother] on 05/07/2014." Patient #1 was documented to have "Mental Retardation" and deemed an Incapacitated person. Record review on 11/10/14 of Patient #1's medical record revealed Consents for Treatment with Psychotropic Medication for Risperdal, dated 08/09/14, for Depakote Extended Release (ER), dated 08/09/14, and Valium, dated 08/11/14. The consents for Risperdal and Depakote ER documented Patient #1 gave verbal consent. The consent for Valium had Patient #1 signing his first name. The guardian did not sign Consents to Treatment with Psychotropic Medication forms. Interview on 11/19/14 at 1:30 PM with Social Worker #1 confirmed she was aware that Patient #1 had a guardian. She stated that information is given to the nursing staff by the social work staff and then it is up to the nursing staff to obtain consents from the guardian.	A 131		

12-23-2014

TRANSMISSION VERIFICATION REPORT

TIME : 05/21/2014 15:21
NAME : NIX HEALTH
FAX : 2102712023
TEL : 2102712188
SER.# : BROJ1J311189

DATE,TIME	05/21 15:19
FAX NO./NAME	9-15128346620
DURATION	00:01:29
PAGE(S)	06
RESULT	OK
MODE	STANDARD ECM

nix HEALTH

FAX:

To:	Glenn Crow/Ginger Smith Texas Department of State Health Services
Fax number:	512-834-6620

From:	Blake Hubbard
Fax number:	210-271-2023
Phone number:	210-579-3133

Date:	May 21, 2014
Number of pages: (including cover)	6

Comments: Please see the attached Plan of Correction

The information contained in the FAX may be confidential and/or privileged. This FAX is intended to be reviewed initially

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

DAVID L. LAKEY, M.D.
COMMISSIONER

P.O. Box 149347
Austin, Texas 78714-9347
1-888-963-7111
TTY: 1-800-735-2989
www.dshs.state.tx.us

May 19, 2014

John Striby, Administrator
Nix Behavioral Health Center
1975 Babcock Rd.
San Antonio, TX 78229

Re: Nix Behavioral Health Center 45-0130

Dear Mr. Striby:

Enclosed are the CMS 2567 form listing deficiencies found at your facility on May 14, 2014, and the guidance sheet on How To Write An Acceptable Plan of Correction. Please develop a plan of correction for each deficiency cited and return to this office within (ten) 10 calendar days from receipt of this letter. **In the space provided on the forms, provide a plan of correction and completion date for each deficiency. After completing the forms, sign and date at the bottom of page one of each form and return the original to the address above.** It will be necessary to make copies for your records. **An approved plan of correction is requisite to continued program participation. You will be notified only if your plan of correction is unacceptable.** It will be necessary to make copies for your records. Certification of your facility cannot be recommended to the Centers for Medicare/Medicaid Services until I have received the completed forms. Therefore, I am requesting that you give this matter priority and that you return the forms to the address above within ten (10) calendar days from receipt of this letter. *Please include the above mail code in addressing your correspondence to this office to ensure prompt delivery.* If you have any questions, do not hesitate to contact my office.

To expedite approval, please forward a copy of your plan of correction to this office by fax. Our fax number is (512) 834-6620. If we can be of further assistance, please contact this office at (512) 834-6649.

Sincerely,

Glenn Crow, Architect
Architectural Review Group
Regulatory Licensing Unit

GC/gns

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING 01 - NIX BEHAVIORAL HEALTH CENTER B. WING _____	05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A life safety code (LSC) investigation survey was conducted on site on 5/14/2014. An entrance conference was held for the Vice President of Facility Operations on 5/14/2014 to discuss the purpose of the LSC survey, and the survey process was explained. Instructions were provided on writing plans of correction. An opportunity was provided for questions and discussion. The LSC survey was conducted under the authority of Chapter 2 of the State Operations Manual, Appendix A, Acute Care Hospitals, 42CFR482 to determine the Hospital ' s compliance. An LSC exit conference was conducted on 5/14/2014 in the hospital. In attendance were the Vice President of Facility Operations and the Security Officer. The preliminary findings of the survey and the next steps in the survey process were explained. An opportunity was provided for questions and discussion.	K 000		
K 029	NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 This STANDARD is not met as evidenced by: Based on observation the facility failed to provide adequate hazardous area separation. The inspector observed, while accompanied by	K 029	This item has been corrected. The door closing and latching mechanism was adjusted and repaired such that automatic closing and latching was achieved. Completed May 20, 2014. Ongoing monitoring of door function is accomplished through environmental rounds and inspections. These rounds are performed by a multi-disciplinary group, including facilities, security and nursing personnel. The individual responsible for assuring ongoing compliance will be our Senior Vice President and Chief Operating Officer.	05/20/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X8) DATE
Blake W. Hubbard, FACHE	Senior Vice President & COO	05/21/2014

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING 01 - NIX BEHAVIORAL HEALTH CENTER B. WING _____	05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 1 the Vice President of Facility Operations and the Security Officer during the hours of the inspection from 10:00 am to 12:15 pm on 5/14/2014 that there was the following issue. The soiled utility door at the " A " wing on the second floor did not close and latch properly.	K 029		
K 034	NFPA 101 LIFE SAFETY CODE STANDARD Stairways and smokeproof towers used as exits are in accordance with 7.2. 18.2.2.4 This STANDARD is not met as evidenced by: Based on observation the facility failed to provide adequate stair enclosures. The inspector observed, while accompanied by the Vice President of Facility Operations and the Security Officer during the hours of the inspection from 10:00 am to 12:15 pm on 5/14/2014 that the stairs were being used for storage of construction materials. The following stairs had storage inside of the enclosure, Stair " B " and " D ". " There shall be no enclosed, usable space within an exit enclosure, including under stairs, nor shall any open space within the enclosure be used for any purpose that has the potential to interfere with egress. " NFPA 101, 2000, 7.2.2.5.3.	K 034	This item has been corrected. Items found in the stairwell were related to ongoing renovation project. Items have been removed. Contractors educated as to requirements for egress routes to be clear of obstructions and storage. Nix Health Security to monitor daily to assure clear egress is maintained. Item corrected as of May 20, 2104. The individual responsible for assuring ongoing compliance will be our Senior Vice President and Chief Operating Officer.	05/20/2014
K 211	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers shall have a minimum spacing	K 211	This item has been corrected. The alcohol based hand rub dispensers have been removed and relocated to an appropriate location. Facilities staff educated as to the appropriate installation of such dispensers. Item corrected as of May 20, 2014. The individual responsible for assuring ongoing compliance will be our Senior Vice President and Chief Operating Officer.	05/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING 01 - NIX BEHAVIORAL HEALTH CENTER B. WING _____	05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 211	Continued From page 2 of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 18.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 This STANDARD is not met as evidenced by: Based on observation the facility failed to provide an acceptable location for alcohol based hand rub dispensers. The inspector observed, while accompanied by the Vice President of Facility Operations and the Security Officer during the hours of the inspection from 10:00 am to 12:15 pm on 5/14/2014 that there were alcohol based hand rubs above or immediately adjacent to electrical switches in the nurse station on the first floor.	K 211		
K9999	FINAL OBSERVATIONS Staff Did Not Have Keys to Locked Fire Extinguisher Cabinets " Physical environment. A physical environment that protects the health and safety of patients, personnel, and the public shall be provided in each facility. The physical premises of the facility and those areas of the facility's physical structure that are used by the patients (including all stairwells, corridors, and passageways) shall meet the local building and fire safety codes and subchapters F and G of this chapter. " - 2004, §134.122 (d)(1)(C). Based on observation the facility failed to provide	K9999	This item has been corrected. All staff were surveyed to ascertain their possession/access to keys necessary to perform their roles within their assigned unit. Any employee found not to have the appropriate keys were immediately issued keys and in-serviced on the associated use and responsibilities. This action was completed on May 20, 2014. Further a multi-disciplinary team, including Administration, Security, Facilities and Nursing has been formed to review the processes surrounding the issuance and use of keys within the facility and units. This team has been charged with a process redesign to assure that all staff have access to necessary keys while on duty. The team will also address unit safety and security and key control.	06/13/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	450130	A. BUILDING 01 - NIX BEHAVIORAL HEALTH CENTER B. WING _____	05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

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K9999	Continued From page 3 adequate keys to the staff for the locked fire extinguisher cabinets. The inspector observed, while accompanied by the Vice President of Facility Operations and the Security Officer during the hours of the inspection from 10:00 am to 12:15 pm on 5/14/2014 that there was the following issue. The inspector asked a nurse on the staff if she could open up one of the locked fire extinguisher cabinets. She was not able to open up the cabinet because she had not been issued a key. The Security Officer stated that the locks had been changed and new keys had not been issued.	K9999	The team has been given until June 13, 2014 to implement new and improved processes. The individual responsible for assuring ongoing compliance will be our Senior Vice President and Chief Operating Officer.	
	Window Screens " In building housing for certain types of patients, detention rooms, or a security section, the facility shall provide detention screens to confine or protect building inhabitants, when necessary. " - 2004, §134.122 (n)(3)(A)(viii)(II) Based on observation the facility failed to provide adequate window screens. The inspector observed, while accompanied by the Vice President of Facility Operations and the Security Officer during the hours of the inspection from 10:00 am to 12:15 pm on 5/14/2014 that there were no window screens on the second floor windows that were directly above the Adolescent Recreation Area. One of the windows had been broken out by a patient throwing a football when within the Recreation Area.		This item in in process. The window screens had been ordered on April 30, 2014. These screens are currently in the manufacturing process. The screens will be delivered and installed by June 6, 2014. The individual responsible for assuring ongoing compliance will be our Senior Vice President and Chief Operating Officer.	06/06/2014

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

DAVID L. LAKEY, M.D.
COMMISSIONER

P.O. Box 149347
Austin, Texas 78714-9347
1-888-963-7111
TTY: 1-800-735-2989
www.dshs.state.tx.us

HOW TO WRITE AN ACCEPTABLE PLAN OF CORRECTION

The content of the plan of correction should include the following information:

Who, by title, will be responsible for the plan? DO NOT USE PROPER NAME
What is the plan going to be?
How is the plan going to be implemented?
How is ongoing compliance going to be monitored?

Once you have the answer to the questions listed above, you are ready to document that information on the statement of deficiencies:

* **Begin each plan of correction in the second column of the statement of deficiencies and plan of correction form next to the tag number (i.e. G224).**

* **Type or write legibly the plan that you have developed.**

* **List the date the deficiencies will be corrected in the far right column:**

  If there are no condition-level deficiencies, the date listed must be within 60 days of the survey date listed on top of the form.

  If there are conditions-level deficiencies, the correction date for deficiencies should be within 30 days or less of the survey date. This will allow sufficient evidence for review by surveyors when a follow-up visit is conducted after the 45th day.

* **Each deficiency must have a plan of correction.**

The administrator or responsible person must sign the first page of the statement of deficiencies and plan of correction form, including their title and the date. Return deficiencies with plans of corrections to:

Texas Department of State Health Services
Architectural Review Group – Austin – Mail Code 2835
Attention: Ginger Smith
PO Box 149347
Austin, TX 78714-9347

An Equal Employment Opportunity Employer and Provider

PRIVACY NOTIFICATION/NOTIFICACION SOBRE PRIVACIDAD

With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 522.021, 522.023, 559.003 and 559.004)

Tan solo por unas cuantas excepciones, usted tiene el derecho de solicitar y de ser informado sobre la informacion que el Estado de Texas reune sobre usted. A usted se le debe conceder el derecho de recibir y revisar la informacion al requerirla. Usted tambien tiene el derecho de pedir que la agencia estatal corrija cualquier informacion que se ha determinado sea incorrecta. Dirijase a http://www.dshs.state.tx.us para mas informacion sobre la Notification sobre privacidad. (Referencia: *Government Code*, seccion 522.021, 522.023, 559.003 y 559.004)

* * * Communication Result Report (Jan. 3. 2014 4:38PM) * * *

Fax Header) NIX Hospital

Date/Time: Jan. 3. 2014 4:37PM

File No.	Mode	Destination	Pg(s)	Result	Page Not Sent
1101	Memory TX	95314533	P. 5	OK	

Reason for error
E. 1) Hang up or line fail
E. 2) Busy
E. 3) No answer
E. 4) No facsimile connection
E. 5) Exceeded max. E-mail size

nix HEALTH

FAX:

To:	Ms Pamela Justice via Sarah Clair
Fax number:	210 531-4533

From:	Adele Giles, SVP, Quality & Compliance
Fax number:	210 587-8141
Phone number:	210 579-3200

Date:	1/3/2014
Number of pages: (including cover)	5

Corrective action plan attached -

Thank you

Adele Giles

The information contained in the FAX may be confidential and/or privileged. This FAX is intended to be reviewed initially by only the individual named above. If the reader of this TRANSMITTAL PAGE is not the intended recipient or a representative of the intended recipient, you are hereby notified that any review, dissemination or copying of this FAX or the information contained herein is prohibited. If you have received this FAX in error, please immediately notify the sender by telephone and return this FAX to the sender at the address below.

Nix Medical Center ■ 414 Navarro, San Antonio, TX 78205 ■ 210.271.1800
Nix Specialty Health Center ■ 4330 Vance Jackson, San Antonio, TX 78230 ■ 210.579.3600
Nix Alamo Heights ■ 5907 Broadway, San Antonio, TX 78209 ■ 210.824.5130
Nix Primary Care Center ■ 700 S. Zarzamora, San Antonio, TX 78207 ■ 210.569.3090
Nix North Orthopaedics Center ■ 9150 Huebner Road, San Antonio, TX 78240 ■ 210.351.6500
Nix Home Care ■ 4402 Vance Jackson, Suite 140, San Antonio, TX 78230 ■ 210.341.0505

nixhealth.com

nix HEALTH

FAX:

To:	Ms Pamela Shelton / Ms Sarai Collier
Fax number:	210 531-4533

From:	Adele Giles, SVP, Quality & Compliance
Fax number:	210 587-8141
Phone number:	210 579-3200

Date:	1/3/2014
Number of pages: (including cover)	5

Corrective action plan attached -

Thank you

Adele Giles

The information contained in the FAX may be confidential and/or privileged. This FAX is intended to be reviewed initially by only the individual named above. If the reader of this TRANSMITTAL PAGE is not the intended recipient or a representative of the intended recipient, you are hereby notified that any review, dissemination or copying of this FAX or the information contained herein is prohibited. If you have received this FAX in error, please immediately notify the sender by telephone and return this FAX to the sender at the address below.

Nix Medical Center ■ 414 Navarro, San Antonio, TX 78205 ■ 210.271.1800
Nix Specialty Health Center ■ 4330 Vance Jackson, San Antonio, TX 78230 ■ 210.579.3800
~~**Nix Alamo Heights** ■ 5307 Broadway, San Antonio, TX 78209 ■ 210.824.3130~~
Nix Primary Care Center ■ 700 S. Zarzamora, San Antonio, TX 78207 ■ 210.569.7090
Nix North Orthopaedics Center ■ 9150 Huebner Road, San Antonio, TX 78240 ■ 210.351.6500
Nix Home Care ■ 4402 Vance Jackson, Suite 140, San Antonio, TX 78230 ■ 210.341.0505

nixhealth.com

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

DAVID L. LAKEY, M.D.
COMMISSIONER

1100 W. 49th Street • Austin, Texas 78756
1-888-963-7111 • http://www.dshs.state.tx.us
TDD: 512-458-7708

December 20, 2013

Administrator of:
Nix Health Care
414 Navarro, Suite 600
San Antonio, TX. 78205

Dear Administrator:

In reference to the complaint survey conducted at your facility on December 17, 2013, enclosed is the Statement of Deficiencies, for state licensure, which lists the deficiencies cited. **In the space provided on the forms, please provide a plan of correction and completion date for each deficiency. After completing the forms, sign and date at the bottom of page one of each form and return to the address below.** It will be necessary to make copies for your records. **An approved plan of correction is requisite to continued program participation.** Certification of your facility cannot be recommended to the Centers for Medicare and Medicaid Services (CMS) until I have received the completed forms. Therefore, I am requesting that you give this matter priority and that you return the forms to the address below within 10 calendar days from receipt of this letter. If you have any questions, do not hesitate to contact my office.

Sincerely,

/s/ Pam Shelton for
Larrie Collier
Program Administrator
2303 SE Military Drive Bldg. 514
San Antonio, TX. 78223

CJ/PS
Enclosure

Texas Department of State Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000415	A. BUILDING: _____ B. WING _____	C 12/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NIX HEALTH CARE SYSTEM	414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205

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X 000	INITIAL COMMENTS Note: The State Form is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be referred to the Office of the Texas Attorney General (OAG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. An unannounced visit was conducted on 12/09/13 to conduct a complaint investigation. An entrance conference was conducted in the conference room of the facility . In attendance was the Vice President of Behavioral Health. The purpose and process of the complaint survey were discussed and an opportunity for questions was provided. Complaint TX 00185836 was unsubstantiated with unrelated state licensure violations cited. An exit conference was conducted in the afternoon of 12/17/13 in the facility conference room. The Vice President of Behavioral Health, The Director of Risk Manager, and The Nurse Manager was in attendance. Preliminary findings of the survey were discussed and an opportunity for questions was provided.	X 000		
X 286	133.41(j)(5) Legible, complete entries Medical record services. The hospital shall have a medical record service that has administrative responsibility for medical records. A medical record shall be maintained for every individual who presents to the hospital for evaluation or treatment. Medical record entries must be legible, complete, dated, timed, and authenticated in written or	X 286		

Texas Department of State Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000415	A. BUILDING: _____ B. WING _____	C 12/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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X 286	Continued From page 1 electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures. . This Requirement is not met as evidenced by: Based on record review and interview, the facility failed to ensure that for one of one patient (Patient #1) clinical records reviewed, all entries were signed, dated and times in accordance with facility policy. Findings included: Record review on 12/09/13 of Patient #1's clinical record revealed the following: Patient #1 was admitted to the facility on 09/13/13 and discharged from the facility on 09/ 20/13. A Pre-Admission Comprehensive Assessment Tool was signed by Physician #1 but was not dated or timed. This Pre-Admission Comprehensive Assessment Tool had a space for a facility social worker to sign and date but was left blank. The Admission Orders and Physician Certification was signed by Physician #1 but was not dated or timed. A Psychiatrist's Progress Note was signed and dated by the physician but no time for the note was noted. Record review on 12/09/13 of three Consents for Psychoactive Medication (Ativan, Risperdal, and Ambien) revealed they were signed by Patient #1 but not dated or timed.	X 286	1. On 1-2-2014, Admission orders policy and procedure was revised: "If the order is a verbal or telephone order, the order is authenticated by the Physician within 48 hours." 2. All physicians in department of psychiatry were re-educated on timing requirements for authentication of telephone/verbal orders. This education was completed on 1-2-2014. 3. Signage reminding physicians and staff to date and time all entries were posted on units 1-2-2014. 4. Date and time "flags" were ordered on 1-2-2014. The flags will be in place and implemented by 1-10-2014. 5. Facility Director of Social Work will re-educate social work staff on requirements for signing, dating, and timing the pre-admission comprehensive assessment tool. This was completed by 1-3-2014. 6. Nursing staff was in-serviced on the requirement to obtain both date and time in addition to patient signature on	

Texas Department of State Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000415	A. BUILDING: _____ B. WING _____	C 12/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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X 286	Continued From page 2 Record review on 12/17/13 of Admission Orders Policy and Procedure, last reviewed January 2012, revealed the following: If the order is a verbal or telephone order, the co-signature by the physician occurs within 24 hours. Orders are always signed with name, credential, date, and time. Record review on 12/17/13 of Inquiry and Preadmission Assessment Policy and Procedure, last reviewed January 2012, revealed the following: Upon admission, assessments, when appropriate and feasible while the family is available, a licensed, masters level therapist and/or social worker meets with the family so they can contribute data concerning the patient's psychosocial history and also receive information about the program. If this is not feasible, the psychosocial history is scheduled within 72 hours of admission. An LMSW or LCSW reviews and completes all psychosocial histories. Interview on 12/17/13 at 10:50 AM with the facility Director of Medical Records confirmed that all entries in Patient #1's clinical record described above should have been signed, dated and timed per facility policy.	X 286	the consent of treatment with psychoactive medication. This was completed by 1-3-2014. Medical staff was in-serviced on this requirement at the Department of Psychiatry Meeting on 1-2-2014. The "consent to treatment with psychoactive medication" form will be revised to include a line for "time." Currently the form only has a line for date. This will be completed and implemented by 1-7-2014. To demonstrate sustained compliance, a minimum of 30 charts will be reviewed in a 4 month period with goal of 90% compliance for all entries to be dated and timed. - # of dated & timed entries / # of entries.	

Greer, Leslie

From: Lazarus, Steven
Sent: Friday, December 11, 2015 11:56 AM
To: Hawes, Gary W.; Martone, Kim; Hansted, Kevin; Cotto, Carmen; Matthews, Rebecca (RMatthews@wiggin.com) (RMatthews@wiggin.com); magsten@wiggin.com
Cc: Greer, Leslie
Subject: FW: 2nd Completeness Letter for Docket Numbers: 15-32016-486 and 15-486-01
Attachments: 32016-3.pdf

Sorry, I missed some people on the last email.

Steve

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

From: Lazarus, Steven
Sent: Friday, December 11, 2015 11:51 AM
To: Matthews, Rebecca (RMatthews@wiggin.com) (RMatthews@wiggin.com); magsten@wiggin.com
Subject: 2nd Completeness Letter for Docket Numbers: 15-32016-486 and 15-486-01

Dear Attorney Matthews,

Please see the attached copy of the 2nd Completeness Letter in the matter of the application regarding the proposed asset
purchase of Eastern Connecticut Health Network Inc.'s by Prospect Medical Holdings, Inc., filed with the Office of the Attorney General (DN: 15-486-01) and the Office of Health Care Access (15-32016-486).

If you have any questions, please do not hesitate to contact Gary Hawes (Office of the Attorney General's) at 860-808-5020 or
gary.hawes@ct.gov or myself (see contact information below).

Sincerely,
Steve

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053



STATE OF CONNECTICUT

OFFICE OF THE ATTORNEY GENERAL

DEPARTMENT OF PUBLIC HEALTH

GEORGE JEPSEN
ATTORNEY GENERAL

DR. JEWEL MULLEN
COMMISSIONER

December 11, 2015

VIA U.S. and ELECTRONIC MAIL

Jonathan Spees
Senior VP, Mergers and Acquisitions
Prospect Medical Holdings, Inc.
10780 Santa Monica Blvd., Suite 400
Los Angeles, CA 90025

Dennis P. McConville
Senior VP and Chief Strategy Officer
Eastern Connecticut Health Network, Inc.
71 Haynes Street
Manchester, CT 06040

Re: Eastern Connecticut Health Network, Inc. Proposed Asset Purchase by Prospect Medical Holdings, Inc.; OHCA Docket Number: 15-32016-486 and Attorney General Docket Number: 15-486-01.

Dear Mr. Spees and Mr. McConville:

On November 23, 2015, the Response to Completeness Questions ("Response") of Eastern Connecticut Health Network, Inc. ("ECHN"), including Manchester Memorial Hospital ("MMH") and Rockville General Hospital ("RGH"), and Prospect Medical Holdings, Inc. ("PMH") was filed with the Office of Health Care Access, Department of Public Health ("OHCA/DPH") and Office of the Attorney General ("OAG").

OHCA/DPH has determined that there are deficiencies in the Response that require clarification and/or additional production. Conn. Gen. Stat. § 19a-486a(d). The OAG has no further questions at this time. Accordingly, please respond to the following questions and/or submit the following materials to the OAG and OHCA by January 9, 2016.

1. On page 2148 of the Response, Applicants state that ECHN is expected to secure a bank loan for $5 million dollars to cover costs of planned capital projects. With respect to this $5 million dollar loan and the referenced capital projects, please answer the following:

a) Clarify whether the $5 million is intended to be expended exclusively on the

behavioral health expansion at RGH mentioned on page 2149 or additional planned capital projects, and, if the latter, identify the projects and estimated expenditure amounts.

b) Elaborate on the specific types of behavioral health conditions the behavioral unit at RGH expects to treat and whether this unit will be utilized for inpatient or outpatient treatment.

2. In connection with Response 2(b) at page 2150, relating to the joint ventures in which ECHN has an ownership interest, please respond to the following questions.

a) Please provide the information on Exhibit A for Connecticut Occupational Partners, LLC.

b) If a joint venture cannot be transferred to PMH, the parties contemplate that ECHN will issue a note to PMH, in an amount equal to the value of that joint venture. The note would be secured by ECHN's interest in the joint venture and payable from future distributions from the joint venture. If the joint venture fails or it does not generate sufficient funds to enable the note to be repaid, will ECHN have any liability?

3. The Applicants state in page 2158 of the Response that PMH has established an independent practice association in Connecticut, Prospect Provider Group CT-ECHN, LLC ("PPGCTE") and a preferred provider network/health system risk taking entity, Prospect Health Services, CT, Inc. ("PHS"), and that physicians currently represented by Eastern Connecticut Individual Provider Group, Inc. ("ECIPG") will make individual decisions about whether to participate in PPGCTE. Please respond to the following questions regarding these entities:

a) Will ECIPG be dissolved after the Closing?

b) If ECIPG physicians do not elect to join PPGCTE, will they still have privileges at the Hospitals?

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a) The typical scenarios in which a physician chooses to be an MOU affiliated physician versus an FCP;

b) Any differences in the types or frequency of services an MOU physician would provide versus an FCP;

c) The typical circumstance where an MOU physician's service would be limited to a particular patient.

5. On page 2162 of the Response and at Exhibit F, Applicants provided a summary of performance metrics for Prospect Health Services in Texas. With respect to this summary, please address the following:

a) Explain what differentiates an acute patient versus a non-acute patient.

b) Whether this Exhibit includes Medicare Advantage Performance patients only and the meaning of the term "Seniors".

c) Explain what the Goals identified in the top right corner of the Exhibit signify.

d) Applicants stated with respect to the trends in Texas that they were "encouraging and positive, but show room for improvement." Please specifically identify those areas needing improvement and explain the specific strategies being implemented to address these deficiencies.

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7. Applicants indicate on page 2175 of the Response that ECHN has struggled to retain, in particular, primary care providers. Tables E and F on page 2174 of the Application indicates an increase to date in Allied Health Professionals employed in the ECHN Medical Foundation. Please elaborate on the role Applicants envision for AHPs post-closing, addressing specifically:

a) Whether AHPs will be utilized to compensate for the lack of primary care physicians.

b) Whether AHPs would be eligible to join PPGTCE or the Medical Foundation PMH will utilize post-closing.

c) Whether AHPs participate as members in any of PMH's existing physician networks and, if not, why not.

8. On page 2175 of the Response, Applicants indicate that a decline in participants in the ECHN Medical Foundation from 2013 to 2014 was related to a decision to contract with a third party for hospitalist services at both Hospitals. Please indicate whether PMH intends to continue outsourcing hospitalists post-closing.

9. Referencing Applicants' response to Question 53 of the Application and page 2178 of the Response, please address the following:

a) Applicants have projected a 1% increase in spending for Community Building Activities through FY 2019. With respect to the screenings and educational programs listed in Exhibit H of the Response, please indicate whether PMH intends to allocate more resources for screenings versus educational programs than is currently the case;

b) Certain screening programs identified in Exhibit H had low utilization rates. Please elaborate how PMH intends to increase community utilization of those screening programs specifically, and screening programs, generally, in coordination with the planned 1% increase in spending year over year.

10. For those Community Health Improvement Services and Community Benefit Operations programs identified on pages 2183-2185 of the Response, please indicate which programs PMH intends to continue funding post-closing and whether any material changes in funding are expected for any of the programs listed.

11. Please explain the role, purpose and function of the Nurse and Survivorship Navigator Program listed on page 2183 of the Response.

12. In reference to Exhibit M, page 2381 of the Response, the Patient Experience survey indicates patient satisfaction levels for Hollywood Community Hospital of Hollywood and Los Angeles Community Hospital well below the national average. Please elaborate on the factors causing these results and detail what policy, programs and procedures PMH has implemented to increase patient satisfaction levels at these hospitals.

13. Please provide clarification as to whether the amounts provided on Table 8, Exhibit B, page 2209, are actual or estimated and if amounts were submitted as of 9/30/15 or 11/4/15.

14. Please provide documentation that supports PMH's available funds in excess of $110 million and its generation of $7.5 million in free cash flow per month as of September 30, 2015, as stated on page 2192.

15. In reference to PMH's Capital Investments and Cost Savings Table, Exhibit L, page 2327, address the following:

a) What do the amounts listed under the columns Profitability, Liquidity and Solvency represent (e.g. total margin, operating margin, EBITDA, cash and cash equivalents, net assets, stock holder's equity, etc.)? Provide documentation that supports the data, for example, calculation methodology, etc. and the measurement period that applies to each of the entries;

b) As previously requested in Question 37(b), for each of the five entities, elaborate on how the cost savings listed were the result of economies of scale inherent of a larger organization;

c) The table shows references to footnotes labeled as "(g)" and "(h)" but the information related to these footnotes is missing. Please provide the missing information.

16. In reference to the Revised Financial Worksheets (C), Exhibit I, pages 2312-2317 and related assumptions, for ECHN, MMH and RGH, explain the following:

a) The factors driving the gains in incremental gross patient revenue for each entity;

b) The positive net income "without the CON" in FY 2019 for MMH and RGH; and

c) The reductions in "other operating revenue" between FY 2014 actual and FY 2015 projected for each entity.

17. In reference to PMH'S credit rating and the revolving line of credit with Morgan Stanley information provided on page 2191 of the Response, address the following:

a) Provide the specific time period (e.g. month, quarter) associated with the credit ratings referenced for PMH; and

b) Provide the total amount available and principal amount related to the credit line. Elaborate on the ability to retain this funding once the engagement with Morgan

Stanley and PMH concludes *"within the next year"* as indicated on page 2206 of the Response.

18. On page 2194 of the Response, the Applicants indicated that PMH's FY 2015 financial statements, reflecting twelve months of financial activity, are not available and that a copy will be provided once they have been received and publicly disclosed. In reference to this response, please provide an estimate for when the copy of the audited financial statements will be available.

19. On page 2195 of the Response, the Applicants indicated that the Other Operating Revenue Detail report, Exhibit J, submission was corrected to reflect the removal of the amount for "Public Support" in the "with CON" scenario. Please define what encompasses "Public Support."

20. In reference to the California Quality Assurance Fee (SB 239) program referred to on page 2192, elaborate on the impact on PMH's future ability to support the cost of this proposal and future capital needs for MMH and RGH in excess of the $75 million, without the additional dollar amounts generated by this program in the form of revenue and cash receipts.

Please mail one (1) complete hard copy and one (1) complete electronic copy of the requested materials for approval to each of the following addresses:

Office of the Attorney General
55 Elm Street, P.O. Box 120
Hartford, Connecticut 06141-0120
Attn: Gary W. Hawes, AAG

Office of Health Care Access, Dept. of Public Health
410 Capitol Avenue
Hartford, Connecticut 06134
Attn: Steven W. Lazarus

After receipt of these requested materials, the OAG and OHCA shall review the submission to determine whether the application for approval is complete. If not, they shall provide written notice of any deficiencies within twenty (20) days of receipt of the information requested.

Should you have any questions regarding these requests or any other issues relating to the Commissioner's and Attorney General's review, please do not hesitate to contact either Steven W. Lazarus at the Department of Public Health (860-418-7012; Steven.Lazarus@ct.gov)

or Assistant Attorney General Gary W. Hawes at the Office of the Attorney General (860-808-5020; gary.hawes@ct.gov).

Very truly yours,

Gary Hawes
Assistant Attorney General
Office of the Attorney General

Very truly yours

Kimberly R. Martone
Director of Operations
Office of Health Care Access

cc: Steven Lazarus (via electronic mail)
Rebecca Matthews, Esq. Wiggin and Dana LLP
Melinda Agsten, Esq. Wiggin and Dana, LLP

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Jewel Mullen, M.D., M.P.H., M.P.A.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

TO: Kevin Hansted, Hearing Officer

FROM: Jewel Mullen, M.D., M.P.H., M.P.A., Commissioner

DATE: December 16, 2015

RE: Certificate of Need Application; Docket Number: 15-32016-486
Eastern Connecticut Health Network, Inc. and Prospect Medical Holdings, Inc.
Eastern Connecticut Health Network, Inc. Proposed Asset Purchase by
Prospect Medical Holdings, Inc..

I hereby designate you to sit as a hearing officer in the above-captioned matter to rule on all motions and recommend findings of fact and conclusions of law upon completion of the hearing.

Connecticut Department of Public Health

Phone: (860) 509-8000 • Fax: (860) 509-7184 • VP: (860) 899-1611
410 Capitol Avenue, P.O. Box 340308
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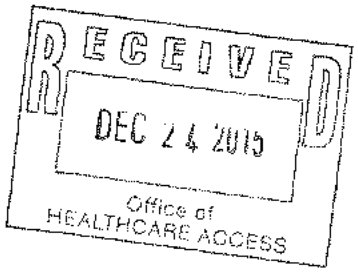
Affirmative Action/Equal Opportunity Employer







CERTIFICATE OF NEED

RESPONSE TO DEFICIENCIES DATED DECEMBER 11, 2015

Eastern Connecticut Health Network, Inc.
Proposed Asset Purchase by
Prospect Medical Holdings, Inc.

OHCA Docket Number: 15-32016-486
Attorney General Docket Number: 15-486-01

December 24, 2015

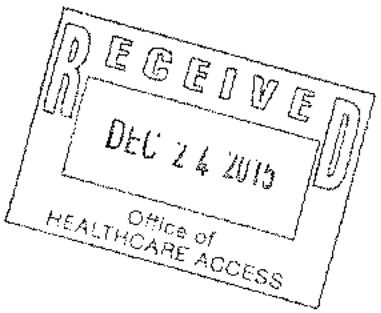
ECHN
Eastern Connecticut Health Network

Eastern Connecticut Health Network
71 Haynes Street
Manchester, CT 06040
860.533.3414
www.echn.org

December 24, 2015

Via Hand Delivery

Office of the Attorney General
55 Elm Street
P.O. Box 120
Hartford, Connecticut 06141-0120
Attn: Gary W. Hawes, Assistant Attorney General



Office of Health Care Access
Department of Public Health
410 Capitol Avenue
Hartford, Connecticut 06134
Attn: Steven W. Lazarus, Health Care Analyst

Re: Eastern Connecticut Health Network, Inc.
Proposed Asset Purchase by Prospect Medical Holdings, Inc.
OHCA Docket Number: 15-32016-486
Attorney General Docket Number: 15-486-01

Dear Mr. Hawes and Mr. Lazarus:

Eastern Connecticut Health Network, Inc. and Prospect Medical Holdings, Inc. (the "Applicants") hereby submit the enclosed responses to the completeness question issued by the Office of the Attorney General and the Office of Health Care Access in a letter dated December 11, 2015.

At your request, one (1) hard copy and one (1) electronic copy have been provided to each Office.

If you have any questions or need anything further, please feel free to contact me at (860) 533-3429. Thank you for your assistance in this matter.

Sincerely,

Dennis P. McConville
Senior Vice President and Chief Strategy Officer

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cc: Melinda A. Agsten, Esq., Wiggin and Dana, LLP
Kevin Hansted, Staff Attorney, Department of Public Health Division of Office of Health Care Access
Kimberly Martone, Director of Operations, Department of Public Health Division of Office of Health Care Access
Perry Zinn Rowthorn, Deputy Attorney General, Office of the Attorney General
Rebecca A. Matthews, Esq., Wiggin and Dana, LLP
Thomas M. Reardon, President, Prospect Medical Holdings-East, Inc.
Frank Saidara, Vice President, Corporate Development, Prospect Medical Holdings, Inc.
Jonathan Spees, Senior Vice President, Corporate Development, Prospect Medical Holdings, Inc.
Joyce Tichy, Senior Vice President and General Counsel, Eastern Connecticut Health Network, Inc.
Michele M. Volpe, Esq., Bershtein, Volpe & McKeon, P.C

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On December 11, 2015, Eastern Connecticut Health Network ("ECHN") and Prospect Medical Holdings ("PMH" and, together with ECHN, the "Applicants") received correspondence from the Office of the Attorney General ("OAG") and the Office of Health Care Access ("OHCA") requesting additional clarification for certain deficiencies identified in the Applicants' Response to Completeness Questions ("Response") submitted on November 23, 2015. The Applicants' response to the deficiencies identified on December 11, 2015 has been provided below:

1. On page 2148 of the Response, Applicants state that ECHN is expected to secure a bank loan for 5 million dollars to cover costs of planned capital projects. With respect to this 5million dollar loan and the referenced capital projects, please answer the following:

   a) Clarify whether the 5 million is intended to be expended exclusively on the behavioral health expansion at RGH mentioned on page 2149 or additional planned capital projects, and, if the latter, identify the projects and estimated expenditure amounts.

      Response:

      The 5 million is intended to be expended exclusively on the behavioral health expansion at RGH.

   b) Elaborate on the specific types of behavioral health conditions the behavioral unit at RGH expects to treat and whether this unit will be utilized for inpatient or outpatient treatment.

      Response:

      The behavioral health unit planned for RGH will be utilized for the inpatient treatment of adults and adolescents with eating disorders.

2. In connection with Response 2(b) at page 2150, relating to the joint ventures in which ECHN has an ownership interest, please respond to the following questions.

   a) Please provide the information on Exhibit A for Connecticut Occupational Partners, LLC.

      Response:

      The joint venture valuations are only applicable to the entities that generate income. Connecticut Occupational Medicine Partners, LLC ("COMP") provides management

services for the occupational health programs of its member hospitals[1] and does not generate revenue for the organization or its members.

b) If a joint venture cannot be transferred to PMH, the parties contemplate that ECHN will issue a note to PMH, in an amount equal to the value of that joint venture. The note would be secured by ECHN's interest in the joint venture and payable from future distributions from the joint venture. If the joint venture fails or it does not generate sufficient funds to enable the note to be repaid, will ECHN have any liability?

Response:

Significant progress has been made to prepare all of the referenced joint ventures for transfer at closing, and therefore the parties do not at this time anticipate that a promissory note will actually be required. ECHN has already obtained all of the necessary third party consents to transfer ECHN's interest in all those joint ventures that require regulatory approval, and is actively securing the necessary consents for all others. For these reasons, ECHN expects to be in a position to transfer its interests in the joint ventures before closing, in which case a promissory note will not be necessary.

In an abundance of caution and in order to eliminate the possibility of disruption to the transaction, however, the parties have also agreed to address the unlikely event that a joint venture interest could not be transferred by providing for a loan from PMH to ECHN, secured by a promissory note, in an amount equal to the deduction made from the purchase price due to the fact that such joint venture interest could not be transferred at closing. This promissory note would be payable from and secured by future distributions from the non-transferred joint venture and would be further secured by ECHN's interests in such joint venture (to the extent permissible under Connecticut law and the joint venture agreement). Any unsecured liability theoretically remaining to ECHN under the promissory note would be addressed in the same manner as ECHN's other post-closing liabilities in accordance with applicable law. An indemnity reserve that will be funded using proceeds from the asset sale will be set up as a vehicle to settle ECHN's post-closing liabilities.

3. The Applicants state in page 2158 of the Response that PMH has established an independent practice association in Connecticut, Prospect Provider Group CT-ECHN, LLC ("PPGCTE") and a preferred provider network/health system risk taking entity, Prospect Health Services, CT, Inc. ("PHS"), and that physicians currently represented by Eastern Connecticut

[1] Member hospitals of COMP include Manchester Memorial Hospital, Bristol Hospital, Saint Francis Hospital and Medical Center, Johnson Memorial Medical Center and Western Connecticut Health Network.

Individual Provider Group, Inc. (□ECIPG□) will make individual decisions about whether to participate in PPGCTE. Please respond to the following □uestions regarding these entities:

a) Will ECIPG be dissolved after the Closing□

Response:

ECIPG is a separately incorporated nonstock corporation and a 50□ member of ECHN□s Eastern Connecticut Physician Hospital Organi□ation (ECPHO). As ECIPG is a separate and independent entity from ECHN, decisions regarding the future of ECIPG will be made by the members of ECIPG.

b) If ECIPG physicians do not elect to join PPGCTE, will they still have privileges at the Hospitals□

Response:

Physicians apply independently for hospital medical staff membership and privileges. Acceptance to the Hospitals□ medical staff is not contingent upon an individual physician□s group affiliation. ECIPG physicians that do not join PPGCTE will still have privileges at the Hospitals following the proposed asset purchase of ECHN by PMH (the □Asset Purchase□), assuming that the physicians continue to meet the membership □ualification criteria outlined in Article 3 of ECHN□s Medical Staff Bylaws. PMH does not have any plans to change the membership □ualification criteria for the Hospitals following the Asset Purchase.

Furthermore, it should be noted that PMH welcomes the affiliation of independent physicians, including physicians who are not part of PMH□s owned physician network to have privileges at its hospitals.

Section 3.2 of ECHN□s Medical Staff Bylaws which outlines the general □ualifications for Medical Staff membership has been included as **Exhibit Q**.

4. On pages 2158-2159 of the Response, Applicants identify two types of physicians that participate in the PMH physician network, fully contracted physicians (□FCP□) and those identified as operating under a Memorandum of Understanding (□MOU□). Please elaborate on the differences between the two categories of physicians. In the detailed response, please clarify the following:

a) The typical scenarios in which a physician chooses to be an MOU affiliated physician versus an FCP;

Response:

MOUs are entered into on an emergent basis or on an as needed basis. It is not unusual for a patient, on an emergent or urgent basis, to choose a physician (primary care or specialist) who is not part of PMH's network. Rather than require the patient to find an in-network physician, PMH typically negotiates one time rates with that physician by entering into MOUs. If the physician provides services within PMH's geographic service area, PMH would invite the physician to join PMH's network. Some physicians will choose to become part of the PMH network and some decide otherwise.

b) Any differences in the types or frequency of services an MOU physician would provide versus an FCP;

Response:

As stated in the response to Question 4a above, MOUs are typically entered into on an emergent or urgent basis. Typically, an MOU physician's service would be limited to a particular patient.

c) The typical circumstance where an MOU physician's service would be limited to a particular patient.

Response:

Please see the response to Question 4a above.

5. On page 2162 of the Response and at Exhibit F, Applicants provided a summary of performance metrics for Prospect Health Services in Texas. With respect to this summary, please address the following:

a) Explain what differentiates an acute patient versus a non-acute patient.

Response:

An acute patient is typically in need of hospital services. Non-acute patients do not require hospital services but may require a lower level of care such as a skilled nursing facility or a board and care home[2].

[2] "Board and care" refers to nonmedical community-based residential settings that house two or more unrelated adults and provide some services such as meals, medication supervision or reminders, organized activities, transportation, or help with bathing, dressing and other activities of daily living.
Source: https://aspe.hhs.gov/report/description-board-and-care-facilities-operators-and-residents

b) Whether this Exhibit includes Medicare Advantage Performance patients only and the meaning of the term "Seniors".

Response:

Seniors are Medicare Advantage enrollees. The Exhibit is in reference of Medicare Advantage patients.

c) Explain what the Goals identified in the top right corner of the Exhibit signify.

Response:

The Goals identified in the top right corner of the Exhibit signify patient bed days per thousand members by payor class.

d) Applicants stated with respect to the trends in Texas that they were "encouraging and positive, but show room for improvement." Please specifically identify those areas needing improvement and explain the specific strategies being implemented to address these deficiencies.

Response:

The immediate areas that PMH is looking to improve are reducing admission and re-admission rates. PMH plans to reduce such rates through (i) further physician training and patient education; and (ii) dedicated approach to PMH's medical management programs for high risk patients with significant co-morbidities at home which entail the following:

- 24/7 direct telephonic access
- Identification of patient "admission drivers" with development of specific action plans
- Patient and family engagement care plans
- Integrated social service coordination for members with psychosocial issues and placement issues
- Integrated behavioral health management
- Disease-specific action plans and self-management
- Advance care planning
- Coordination of ancillary services and physician referrals
- Outpatient palliative care program

- Multidisciplinary team of physicians, nurses, social workers chaplain, and pharmacist available 24 7
- Expedited interventions for Pneumonia, COPD, CHF, Dehydration, and Cellulitis
- Hospital post-discharge follow-up visits within 24hours
- Same day urgent visits
- Phone communication with primary care physician and specialist for intervention
- Telephonic medication therapy management
- Disease management programs (Disease Management & Anticoagulation)
- Post discharge in-home medication therapy management
- Long-term care medication therapy management
- Integrated with inpatient and outpatient clinical teams
- Patient education and assessment of non-adherence

The Objectives of the above programs are to manage symptoms and reduce readmissions with the goal of maximi ing care in home.

When high-risk patients with significant co-morbidities are admitted to a hospital, PMH s hospital care management program provides the following:

- Close monitoring of patients by rounding twice per day until patient is discharged
- Medical Director rounds with hospital case manager and hospitalist twice per day until the patient is discharged
- Ability to direct patients from acute setting to skilled nursing facility when appropriate;
- Ability to direct patients from acute setting to early post discharge visits when appropriate; and
- Close collaboration between hospital case manager, skilled nursing facility case manager, pharmacist, nurse practitioner and primary care physician

When high risk patients with significant co-morbidities are in a sub-acute setting, PMH s medical management program provides the following:

- Monitoring of patients by rounding three to five times per week until patient is stable, then two to three times per week
- Physician rounds supplemented by Prospect nurse practitioners
- Medical Director rounds with case managers and physician twice per week; and
- If patient's status deteriorates, transfer to network hospital

6. On page 2149 of the Response, Applicants state that a $5 million planned renovation at RGH which is expected to be completed by September 2016 will result in RGH having the ability to accommodate an additional 30 patients with behavioral health conditions. Additionally, Applicants state that the acquisition of physicians from Mansfield OB/GYN Associates has added demand for OB services. However, in the table on page 2173 of the Response and the subsequent explanation, Applicants state that projected growth for inpatient discharges is attributable to Medical/Surgical discharges and not to the maternity or behavioral health units at either hospital "as both the maternity unit and behavioral health unit are operating at capacity [at MMH] and RGH does not provide either services at the present time. Based on this assumption, discharge volume for maternity, pediatric (newborn) and psychiatric services will remain constant at the levels projected for FY 2016 through FY 2019." Please clarify why the planned behavioral health unit renovation at RGH and the increased demand for OB services do not result in increases FY 2016 through FY 2019 for Inpatient Discharges in maternity patients for MMH (as the hospital's maternity unit apparently has overflow capacity on the Third West unit) and psychiatric patients for RGH.

Response:

The increased demand for maternity and newborn services resulting from the addition of the Mansfield OB/GYN Associates physicians in FY 2015 will be fully realized in FY 2016. The discharge volume for maternity and pediatric patients reported in Table C on page 2170 reflects the expected twelve-month delivery volume for the OB/GYN physicians on ECHN's Medical Staff and assumes no changes to the number of OB/GYN physicians during the projection period.

The planned behavioral health unit renovation at RGH is only in the developmental stages at this time so projections for RGH do not include any of the volumes, revenues or expenses associated with enhancing behavioral health services at RGH.

7. Applicants indicate on page 217 5 of the Response that ECHN has struggled to retain, in particular, primary care providers. Tables E and F on page 2174 of the Application indicates an increase to date in Allied Health Professionals employed in the ECHN Medical Foundation. Please elaborate on the role Applicants envision for AHPs post-closing, addressing specifically:

   a) Whether AHPs will be utilized to compensate for the lack of primary care physicians.

      Response:

      AHPs are already being utilized to compensate for the shortage of primary care physicians across the state. The Applicants expect this practice to continue in the ECHN service area post-closing. It should be noted that PMH has utilized AHPs in other states for many years. AHPs are an essential part of the care delivery system.

   b) Whether AHPs would be eligible to join PPGCTE or the Medical Foundation PMH will utilize post -closing.

      Response:

      AHPs will be eligible to join PPGCTE and the Medical Foundation PMH will utilize post-closing.

   c) Whether AHPs participate as members in any of PMH's existing physician networks and, if not, why not.

      Response:

      AHPs do participate as members of PMH's existing physician networks because the primary care physician shortage experienced in Connecticut is not unique. The use of AHPs to meet the primary care needs of a given community is common nationwide and a practice that PMH incorporates into its CRC model of care to ensure patients are able to receive needed care in the most appropriate and cost-effective setting.

8. On page 2175 of the Response, Applicants indicate that a decline in participants in the ECHN Medical Foundation from 2013 to 2014 was related to a decision to contract with a third party for hospitalist services at both Hospitals. Please indicate whether PMH intends to continue outsourcing hospitalists post-closing.

Response:

PMH will assume the existing contract with Sound Physicians for hospitalist services post-closing. PMH outsources hospitalist services in other states and expects all hospitalists to comply with PMH's utilization and quality criteria and other outcome measures.

9. Referencing Applicants' response to Question 53 of the Application and page 2178 of the Response, please address the following:

   a) Applicants have projected a 1% increase in spending for Community Building Activities through FY 2019. With respect to the screenings and educational programs listed in Exhibit H of the Response, please indicate whether PMH intends to allocate more resources for screenings versus educational programs than is currently the case;

      Response:

      The projected 1% increase in spending for Community Building Activities through FY 2019 is due to inflation and assumes no change in the Medicaid population served or the complement of community benefit programs offered by the Hospitals.

      As discussed in the Applicants' response to deficiencies Question 53d on page 2179, PMH will reevaluate the healthcare needs of the community with input from the Local Boards as part of its overall planning process post-closing and expects to prioritize capital projects and service improvements based on hospital and community needs. Plans to address the priority needs in ECHN's service area, including the allocation of resources for screenings and educational programs, will be developed post-closing once the priority needs have been confirmed or identified.

   b) Certain screening programs identified in Exhibit H had low utilization rates. Please elaborate how PMH intends to increase community utilization of those screening programs specifically, and screening programs, generally, in coordination with the planned 1% increase in spending year over year.

      Response:

      The projected increase in spending for Community Building Activities is due to inflation and not a result of an increase in screening frequency or community utilization. As stated in the Applicant's response to Question 22 on page 73 of the CON application submitted on October 13, 2015, PMH will continue to focus efforts on improving population health and will utilize its experience and knowledge in population health management to incorporate best-practice recommendations for disease prevention, early detection screenings and treatment options. PMH

recognizes the importance of screening in overall population health; thus specific plans to increase community utilization of screening programs will be developed post-closing pending the confirmation or identification of the communities' priority needs.

10. For those Community Health Improvement Services and Community Benefit Operations programs identified on pages 2183-2185 of the Response, please indicate which programs PMH intends to continue funding post -closing and whether any material changes in funding are expected for any of the programs listed.

Response:

PMH is committed to maintaining ECHN's current policies on community volunteer services and community benefits. Specific plans related to community benefit program offerings will be developed post-closing pending the confirmation or identification of the communities' priority needs.

11. Please explain the role, purpose and function of the Nurse and Survivorship Navigator Program listed on page 2183 of the Response.

Response:

Oncology nurse navigators assist patients and their caregivers by supporting the coordination of care in both inpatient and outpatient settings. Some examples include the management of symptoms, referrals to other specialists, the scheduling of tests and treatments, and referrals for homecare services.

The survivorship navigator is a licensed clinical social worker available to assist patients and their families with financial, insurance and disability concerns resulting from their illness. Some examples of assistance provided by the survivorship navigator include documenting advance directives, smoking cessation, supportive counseling, and referrals to community agencies. The survivorship navigator also provides supervision of ECHN's integrative medicine program.

The women's health nurse navigator oversees ECHN's Breast Care Collaborative which ensures prompt and efficient transition of care for women with suspicious or benign findings following a diagnostic breast exam, mammography or breast biopsy. The navigator is responsible for community and physician education, screening and prevention events and serves as the clinical nurse navigator for the Early Detection Program.

The Commission on Cancer, which is a department of the American College of Surgeons, requires community cancer centers to have both nurse navigators and survivorship programs to receive national accreditation and meet best practice standards. PMH is committed to maintaining ECHN's current policies on community volunteer services and community benefits and will expects to maintain the existing accreditation levels of services currently offered by ECHN and its affiliates.

12. In reference to Exhibit M, page 2381 of the Response, the Patient Experience survey indicates patient satisfaction levels for Hollywood Community Hospital of Hollywood and Los Angeles Community Hospital well below the national average. Please elaborate on the factors causing these results and detail what policy, programs and procedures PMH has implemented to increase patient satisfaction levels at these hospitals.

Response:

PMH believes that a significant factor in the patient satisfaction scores at Los Angeles Community Hospital and Southern California Hospital at Hollywood are primarily due the age of the physical plant.

Some of the upgrades that are planned for 2016 at Los Angeles Community Hospital include the following:

- ER remodel;
- Beautification of OB areas;
- Upgrades to ICU and CCU;
- Modernization of elevators;
- Beautification of the lobby;
- Better signage; and
- Beautification of radiology areas.

Some of the upgrades that PMH is planning for 2016 at Southern California Hospital at Hollywood include the following:

- Upgrades to ICU and CCU;
- Beautification of the lobby areas;
- Better signage; and
- Modernization of elevators.

In addition to the projects described above, we are re-dedicating new hospital leaders to improve all quality and patient satisfaction scores at all California hospitals. We expect that the new leaders will adopt proven measures to increase patient satisfaction, such as patient rounding with a focus on communication with patients.

13. Please provide clarification as to whether the amounts provided on Table 8, Exhibit B, page 2209, are actual or estimated and if amounts were submitted as of 9/30/15 or 11/4/15.

Response:

The amounts provided on Table 8, Exhibit B, page 2210 are the actual amounts for 09/30/2015 based on the unaudited financials updated as of 11/4/2015. The actual amounts for Table 8 will not be considered final until the FY 2015 audited financials have been through all audit review levels and presented to ECHN's Audit Committee.

14. Please provide documentation that supports PMH's available funds in excess of $110 million and its generation of $7.5 million in free cash flow per month as of September 30, 2015, as stated on page 2192.

Response:

Please refer to **Exhibit R** for the documentation that supports PMH's available funds.

15. In reference to PMH's Capital Investments and Cost Savings Table, Exhibit L, page 2327, address the following:

a) What do the amounts listed under the columns Profitability, Liquidity and Solvency represent (e.g. total margin, operating margin, EBITDA, cash and cash equivalents, net assets, stock holder's equity, etc.) Provide documentation that supports the data, for example, calculation methodology, etc. and the measurement period that applies to each of the entries;

Response:

The data provided for Exhibit L are on a standalone company basis. Profitability for each entity is measured by EBITDA for the entity (subject to the footnotes in Exhibit L), on a standalone basis. EBITDA was calculated pursuant Generally Accepted Accounting Principles ("GAAP") the fiscal year ending September 30, 2015.

Liquidity is calculated by measuring the working capital for each entity. The formula for working capital is: current assets less current liabilities for each entity as of September 30, 2015.

Finally, solvency is measured by stockholders equity for each entity as of fiscal year ended September 30, 2015. Stock holders equity is measured by GAAP.

b) As previously requested in Question 37(b), for each of the five entities, elaborate on how the cost savings listed were the result of economies of scale inherent of a larger organization;

Response:

All hospitals acquired by PMH become part of PMH's purchasing programs for supplies and drugs. Under PMH's contracts, higher volume of purchases by PMH as an organization results in lower prices for supplies and drugs. All acquired hospitals benefit from such realized savings. Furthermore, PMH as an organization, because of its growing size, has hired employees with subject matter expertise in operations of hospitals. Such personnel are made available to all PMH hospitals. As such, our hospitals save on hiring consultants.

c) The table shows references to footnotes labeled as "(g)" and "(h)" but the information related to these footnotes is missing. Please provide the missing information.

Response:

Please see **Exhibit S** for the revision of Exhibit L showing the footnotes for (g) and (h) that were inadvertently left off the previously provided version of the exhibit.

16. In reference to the Revised Financial Worksheets (C), Exhibit I, pages 2312-2317 and related assumptions, for ECHN, MMH and RGH, explain the following:

a) The factors driving the gains in incremental gross patient revenue for each entity;

Response:

Gross patient revenue for ECHN, MMH and RGH is expected to increase in FY 2017 through FY 2019 "without the CON" as a result of fee schedule adjustments made in connection with changes to managed care agreements. Additional gains in gross patient revenue are anticipated "with the CON" as a result of incremental volume increases.

b) The positive net income "without the CON" in FY 2019 for MMH and RGH; and

Response:

The positive net income achieved in FY 2019 "without the CON" is due the cumulative effect of annual increases in net patient revenue anticipated as a result of improved managed care contracts and ECHN's continuous efforts to manage expenses and control costs at the Hospitals and other ECHN facilities.

c) The reductions in "other operating revenue" between FY 2014 actual and FY 2015 projected for each entity.

Response:

The other operating revenue amount in FY 2014 includes realized gains from the one-time transfer of ECHN's investment portfolio from volatile, high-risk stock investments to more conservative, fixed-income investments.

17. In reference to PMH's credit rating and the revolving line of credit with Morgan Stanley information provided on page 2191 of the Response, address the following:

a) Provide the specific time period (e.g. month, quarter) associated with the credit ratings referenced for PMH; and

Response:

Please see **Exhibit T** for the most recent credit rating reports for PMH.

b) Provide the total amount available and principal amount related to the credit line. Elaborate on the ability to retain this funding once the engagement with Morgan Stanley and PMH concludes "within the next year" as indicated on page 2206 of the Response.

Response:

Please see Note 8 on page 47 of PMH's consolidated financial statements attached hereto as **Exhibit U** which states that the total amount available under the credit line is $40 million. It is anticipated that the credit line will either remain the same or increase next year due to PMH's positive financial performance.

18. On page 2194 of the Response, the Applicants indicated that PMH's FY 2015 financial statements, reflecting twelve months of financial activity, are not available and that a copy will be provided once they have been received and publicly disclosed. In reference to this

response, please provide an estimate for when the copy of the audited financial statements will be available.

Response:

The FY 2015 consolidated financial statements for PMH are now available and have been provided as **Exhibit U**.

19. On page 2195 of the Response, the Applicants indicated that the Other Operating Revenue Detail report, Exhibit J, submission was corrected to reflect the removal of the amount for "Public Support" in the "with CON" scenario. Please define what encompasses "Public Support."

Response:

Public Support includes the unrestricted charitable donations that ECHN, as a non-profit entity, receives through the ECHN Community Healthcare Foundation, Inc. The post-closing for-profit entity will not receive any charitable support.

20. In reference to the California Quality Assurance Fee (SB 239) program referred to on page 2192, elaborate on the impact on PMH's future ability to support the cost of this proposal and future capital needs for MMH and RGH in excess of the $75 million, without the additional dollar amounts generated by this program in the form of revenue and cash receipts.

Response:

The Quality Assurance Fee program has been part of California law for the past eight years and will be part of California law for the next six years. PMH fully expects the extension of the program after six years. In the next six years, PMH expects an increase in its portion of the net Quality Assurance Fees. Furthermore, PMH is a profitable and growing company with access to capital. As such, we expect to be able to support this proposal to meet the needs of ECHN for the foreseeable future. It should be noted that in 2014, due to a delay in payment of Quality Assurance Fees, PMH did not receive any funds for the program, but was able to meet all of its commitments to close on $70 million of transactions.

RESPONSE TO DEFICIENCIES (DECEMBER 11, 2015)

EXHIBITS

RESPONSE TO DEFICIENCIES (DECEMBER 11, 2015)

EXHIBIT Q – Section 3.2 ECHN's Medical Staff Bylaws

ARTICLE THREE: MEMBERSHIP

3.1 NATURE OF MEMBERSHIP

Membership on the Medical Staff is a privilege that is granted by the Board after considering the recommendations of the Medical Staff, and that shall be extended only to professionally competent Practitioners who continuously comply with and meet the qualifications, standards, and requirements set forth in these bylaws, the rules and regulations of the Medical Staff, and other Medical Staff policies, including the directives and policies of the MEC and the other Medical Staff committees. Appointment to and membership on the Medical Staff shall not confer on the Staff member any Clinical Privileges. A member of the Medical Staff shall only have Clinical Privileges if specifically granted by the Board in accordance with these bylaws.

An individual who fails to satisfy the membership qualifications, standards and requirements is ineligible to apply. A determination of eligibility shall be made prior to submitting the application to the Credentials Committee. A determination of ineligibility does not entitle the individual to the provisions of Article Twelve of these bylaws.

3.2 GENERAL QUALIFICATIONS

Each Practitioner who seeks or enjoys Staff membership shall, at the time of appointment and continuously thereafter, demonstrate to the satisfaction of the Medical Staff and the Board, through documentation and other evidence, the following:

3.2-1 LICENSURE

A currently valid unrestricted license issued by the State of Connecticut to practice medicine, osteopathy, dentistry, or podiatry and have never had such a license to practice revoked by any state licensing agency and currently valid federal and state registrations to prescribe controlled substances except where the Practitioner demonstrates that such registration is not required in order to exercise the Practitioner's current or requested Clinical Privileges.

3.2-2 PERFORMANCE

(a) Professional education, training, experience, current competence, and clinical results documenting a continuing ability to provide optimally achievable patient care services given the resources locally available.

(b) With regard to board certification, all applicants to the Medical Staff, with the exception of general dentists, at the time of being granted Privileges, shall:

(1) Have completed a residency accredited by the Accreditation Council for Graduate Medical Education, the American

Osteopathic Association, the American Dental Association, or the Council on Podiatric Medical Education; or by a program with a reciprocity agreement with the American Board of Medical Specialties or American Osteopathic Association.

3.2-2 (b) (2) If not certified by a board that is a member of the American Board of Medical Specialties, by a board recognized by the American Board of Medical Specialties, by the American Osteopathic Association, by a board recognized by the American Osteopathic Association, by the American Podiatric Medical Association, or by the American Dental Association (limited to the American Board of Oral and Maxillofacial Surgery) be admissible for certification and become certified within the lesser of (i) the period of eligibility as defined by the respective board, or (ii) five years after initial appointment to the Medical Staff. Certification by the Royal College of Physicians and Surgeons of Canada may be accepted based upon a waiver recommended by the MEC and approved by the Board. The boards listed in this section shall be the sole means for certification requirement.

Furthermore, Staff members whose board certificates bear an expiration date shall successfully complete recertification no later than three years following such date. Failure to obtain board certification or recertification shall result in automatic termination of all Privileges accorded to such member and termination of such Practitioner's Staff membership. However, the requirements to obtain board certification and/or recertification are not made retroactive for those Staff members who, prior to obtaining membership on the Medical Staff, had been members of the Medical Staff of MMH continuously since July 1, 1988 or had been members of the Medical Staff of RGH continuously since May 1, 1996.

3.2-3 ATTITUDE

A willingness and capability, based on current attitude and evidence of performance, to work with and relate to other Staff members, members of other health disciplines, the Network Hospitals' management, and employees, visitors, and the community in general, in a cooperative, professional manner conducive to the maintenance of an environment appropriate to quality patient care. The behavior of members of and applicants for membership on the Medical Staff and AHPs constitutes an essential component of professional activity and personal relationships within the Network Hospitals. Civil deportment fosters an environment conducive to excellent patient care. Accordingly, in addition to the other qualifications set forth in this Article Three, all members of Medical Staff and AHPs at all times shall demonstrate an ability to interact on a professional basis with members of the Staff, patients, and others and to behave in a professional and civil manner. This requirement is not in any way intended to

interfere with a Staff member or AHP's privileges: (1) to express opinions freely and to support positions whether or not they are in dispute with those of other Staff members; (2) to engage in honest differences of opinion with respect to diagnosis and treatment or basic program development that are debated in appropriate forums; or (3) to engage in the good faith criticism of others. The following types of behavior, however, which constitute some examples of an inability to interact on a professional basis with others or to behave in a professional and civil manner, are deemed unacceptable for members of the Medical Staff and AHPs:

- Conduct that reasonably could be characterized as sexual and/or racial harassment;
- Threats of physical assault or actual physical assault, harassment, or the placing of others in fear by engaging in threatening behavior;
- The unnecessary and unjustifiable use of loud, profane, or abusive language directed toward Staff members, patients, or others;
- Unnecessary and unjustifiable rude or abusive behavior;
- Written or oral statements that constitute the intentional expression of falsehoods or constitute deliberately disparaging statements made with a reckless disregard for their truth or for the reputation and feelings of others.

Furthermore, all members of the Medical Staff shall demonstrate a willingness and capability, based on current attitude and evidence of performance, to:

(a) Participate equitably in the discharge of Staff obligations appropriate to Staff membership category; and

(b) Adhere to generally recognized standards of professional ethics.

3.2-4 DISABILITY

To be free of, or have under adequate control, any significant physical or behavioral impairment that interferes with, or presents a significant possibility of interfering with, the Practitioner's ability to perform the Privileges requested or granted.

3.2-5 PROFESSIONAL LIABILITY INSURANCE

Professional liability insurance is not less than the minimum amount, as determined from time to time by resolution of the Board. Medico-Administrative Officers with no Clinical Privileges shall be exempt from this requirement.

RESPONSE TO DEFICIENCIES (DECEMBER 11, 2015)

EXHIBIT R – PMH Free Cash Flow

Prospect Medical Holdings
Free Cash Flow
FYE 9/30/2015

Operating Income	$	108,060,000
Change in WC (Increase)	$	34,374,000
Taxes Paid	$	(35,778,000)
Net Change in PP&E	$	(10,863,000)
Free Cash Flow	$	95,793,000
Average Monthly Free cash Flow	**$**	**7,982,750**

RESPONSE TO DEFICIENCIES (DECEMBER 11, 2015)

EXHIBIT S – PMH Capital Investments and Cost Savings Table (Exhibit L Revision)

Table from Question 37a - Capital Investments and Cost Savings Table

Hospital	Investments since Acquistion	Describe Improvements in Financial Performance: Profitability	Liquidity	Solvency	Cost Savings
Los Angeles Community Hospital at Bellflower	$ 3,646,633	N//A (a)	N/A (a)	N/A (a)	N/A (a)
Foothill Regional Medical Center	$ 7,912,807	N/A (a)	N/A (a)	N/A (a)	N/A (a)
Our Lady of Fatima Hospital	$ 11,321,376 (f)	$ 15,184,000 (g)	$ 4,976,828 (c)	$ 67,475,613 (c)	Marginal Cost per day reduced to $1,493 from $1,542 (d)
Roger Williams Medical Center	$ 11,321,376 (f)	$ 15,184,000 (g)	$ 4,976,828 (c)	$ 67,475,613 (c)	Marginal Cost per day reduced to $2,271 from $2,263 (d)
Nix Health System	$ 33,350,077	$ 20,867,000 (h)	$ 15,882,118	$ 63,789,134	Total Costs per day decreased to $1,444 from $1,584 (e)

(a) Both Los Angeles Community Hospital at Bellflower (Bellflower) and Foothill Regional Medical Center (Foothill) were closed prior to PMH acquisition
Bellflower re-opened in July 2015 and Foohill re-opened in September 2015. Both facilities were purchased in May 2014.

(b) Los Angeles Community Hospital at Bellflower is under common corporate ownership structure and license as Los Angeles Community Hospital and
Los Angeles Community Hospital at Norwalk. As such, liquidity and solvency for this campus includes financial information for all three campuses combined

(c) The profitability, liquidity and solvency of Our Lady of Fatima and Roger Williams Medical Center are reported on a consoldiated basis for the CharterCARE system
Prior to the acquisition, the liquidity of CharterCARE system was approximately a negative $2.5 million
Profitability is measured on an EBITDA basis and reported on a consolidated basis for the CharterCARE system

(d) Measured from June 2014 to May 2015

(e) Measured from Dember 2011 to September 2015. Prior to acquisition Nix did not compute Marginal cost per day.

(f) Total capital investment in Our Lay of Fatima and Roger Williams Medical Center (which comprise CharterCARE) is reported on a combined basis.
In addition to the amount already spent, we have committed to spend $20 million in addtion to what has already been spent
on (i) cancer center; (ii) Digestive Diseases Center; (iii) Emergency Department and (iv) physician practice acquisitions.

(g) Profitability based on a consolidated EBITDA basis and adjusted for corporate allocation for nine months endedf 6/30/2015.
Our Lady of Fatima Hospital and Roger Williams Medical Center are part of CharterCARE system
EBITDA of CharterCARE as of 3/31/2013 (one year prior to acquisition) was $7,146,000

(h) Profitablilty reported on an EBITDA basis adjusted for corporate allocations for year ended 9/30/2014.
EBITDA of Nix for 12/31/2011 was $18,774,000.

RESPONSE TO DEFICIENCIES (DECEMBER 11, 2015)

EXHIBIT T – Credit Rating Reports for PMH

MOODY'S
INVESTORS SERVICE

Rating Action: Moody's upgrades Prospect Medical's CFR to B1 from B2; outlook is stable

Global Credit Research - 09 Jul 2015

New York, July 09, 2015 -- Moody's Investors Service upgraded the Corporate Family Rating of Prospect Medical Holdings, Inc. (Prospect) to B1 from B2. The company's Probability of Default Rating was also upgraded to B1-PD from B2-PD and the rating on Prospect's senior secured notes was upgraded to B1 from B2. The rating outlook is stable.

The ratings upgrade primarily reflects Moody's expectation of operational improvements at the company's existing and newly acquired hospitals that will contribute to earnings growth and improved cash flow. Moody's expects Prospect to sustain debt to EBITDA below 4 times over the next twelve to eighteen months.

The following ratings were upgraded

Corporate Family Rating to B1 from B2

Probability of Default Rating to B1-PD from B2-PD

Senior secured notes due 2019 to B1 (LGD 3) from B2 (LGD 4)

The outlook is stable.

RATINGS RATIONALE

Prospect's B1 Corporate Family Rating reflects the company's moderate scale, its high financial leverage, its high concentration in only a few markets, and its significant reliance on California and Texas Medicaid programs. Moody's anticipates that Prospect will remain acquisitive beyond the transactions the company has already announced in New Jersey and Connecticut in order to gain scale and improve geographic diversification. Moody's expects Prospect to generate EBITDA and cash flow growth from both existing and soon-to-be-acquired hospitals. Further, Moody's anticipates that Prospect will use internally generated cash and limit the use of incremental debt to fund future growth so that leverage remains below 4.0 times.

The stable outlook reflects Moody's expectation that Prospect's leverage will remain moderately high but will benefit from near term hospital acquisitions that will be funded with internally generated cash. Moody's also expects that Prospect will maintain good liquidity, despite capital commitments at newly acquired facilities, due to improvement in operating cash flow.

Given Prospect's relatively small size and considerable concentration in only a few markets, Moody's does not anticipate an upgrade of the ratings in the near term. However, over the longer term, the ratings could be upgraded if the company can increase scale and enhance revenue and earnings diversification. Further, the ratings could be upgraded if Prospect maintains debt to EBITDA at around 3.0 and maintains a measured approach towards debt funded acquisitions or shareholder initiatives.

The ratings could be downgraded if operational or integration challenges cause a significant deterioration in financial metrics or the company undertakes a material debt funded acquisition or shareholder distribution. More specifically, ratings could be downgraded if Moody's expects debt to EBITDA to be sustained above 4.0 times or if liquidity weakens.

The principal methodology used in these ratings was Global Healthcare Service Providers published in December 2011. Other methodologies used include Loss Given Default for Speculative-Grade Non-Financial Companies in the U.S., Canada and EMEA published in June 2009. Please see the Credit Policy page on www.moodys.com for a copy of these methodologies.

Headquartered in Los Angeles, California, Prospect Medical Holdings, Inc. provides health care services through a network of 13 acute care and behavioral hospitals located in California, Texas and Rhode Island. Through its Medical Group business unit, the company provides administrative management of health care services to

independent physician organizations that cover over 300,000 members through a network of primary care doctors and specialists. Prospect recognized revenues of approximately $1.2 billion in the twelve months ended March 31, 2015. The company is owned by private equity firm Leonard Green & Partners L.P. and members of the company's management team.

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Research Update:

Prospect Medical Holdings Inc. 'B' Corporate Credit Rating Affirmed; Senior Secured Notes Raised To 'B' (Recovery: '4')

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Submitted December 24, 2015
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Research Update:

Prospect Medical Holdings Inc. 'B' Corporate Credit Rating Affirmed; Senior Secured Notes Raised To 'B' (Recovery: '4')

Overview

- Los Angeles-based health care services provider Prospect Medical Holdings Inc. has expanded EBITDA meaningfully in 2015, reflecting the impact of its 2014 acquisitions and the positive impact of health care coverage expansion.
- We are affirming our 'B' corporate credit rating on Prospect.
- We are raising our rating on Prospect's senior secured notes to 'B' from 'B-' and revising our recovery rating on this debt to '4' from '5', indicating our expectations for average (30% to 50%; at the low end of the range) recovery for bondholders in the event of payment default.
- The rating outlook is stable, reflecting our view that EBITDA margins will remain broadly stable, with improving margins at acquired hospitals offset by persistent, industrywide pressure from reimbursement headwinds.

Rating Action

On Sept. 21, 2015, Standard & Poor's Ratings Services affirmed its 'B' corporate credit rating on Los Angeles-based health care services provider Prospect Medical Holdings Inc. The rating outlook is stable.

At the same time, we raised our rating on Prospect's senior secured notes to 'B' from 'B-' and revised our recovery rating on this debt to '4' from '5'. The '4' recovery rating indicates our expectations for recovery at the low end of the average (30% to 50%) range for bondholders in the event of payment default.

Rationale

The ratings affirmation on Prospect follows several quarters of strong EBITDA growth, reflecting the impact of significant acquisitions completed in 2014, as well as high-single digit same-facility growth in the company's hospital and medical group portfolio, despite a continued high level of competition in Prospect's key markets.

Prospect operates a network of 13 hospitals and related primary-care clinics in Southern California, Texas, and Rhode Island. The company also operates a Medical Group segment that manages the provision of physician services on behalf of health maintenance organization (HMO) customers. While the medical

group segment provides some business diversity, this business also has significant exposure to government reimbursement pressures in the Medicare Advantage program.

We view Prospect's business as geographically concentrated, with the majority of revenues coming from very competitive urban markets in California and Texas. While recent acquisitions in Rhode Island and pending acquisitions in New Jersey and Connecticut will contribute modest geographic diversity, the company still has very significant exposure to the California Hospital Fee Program and other disproportionate share subsidy programs, which at times has contributed to meaningful volatility in the timing of cash flows relative to peers. We expect this factor to continue over time. We view Prospect's EBITDA margins as below average, which in part reflects the company's government-focused payor mix (excluding capitation revenues, the company derives over 55% of revenues from Medicare and Medicaid), as well as acquisitions of underperforming hospital facilities. These factors are only partially offset by our view that Prospect's strategic focus as a cost-efficient provider of coordinated care will aid the company's growth as health care services providers make the eventual transition away from fee-for-service reimbursement and toward payments based on quality and efficiency of care. Collectively, these factors support our assessment of a "vulnerable" business risk profile.

We expect Prospect to generate over 50% revenue growth in fiscal 2015 and high-single-digit revenue growth in 2016, reflecting the impact of acquisitions as well as low- to mid-single-digit same-facility revenue growth. We expect EBITDA margins to remain broadly stable, with improving margins at acquired hospitals offset by persistent, industrywide pressure from reimbursement headwinds. As a result of EBITDA growth, we expect Prospect to generate about $50 million in discretionary cash flow in 2016, which we expect the company will allocate toward acquisitions.

Despite recent improvement in credit measures, we continue to assess Prospect's financial risk profile as "aggressive". Following the completion of several acquisitions in 2014, leverage has declined to below 4x at June 30, 2015, from over 5x at Dec. 31, 2014. While leverage should remain at the stronger end of the range for an aggressive financial risk profile, we expect funds from operations (FFO) to debt to remain in the mid-to-high teens, consistent with the financial risk descriptor. The company's financial sponsor ownership, somewhat aggressive acquisition strategy, and history of debt-funded dividends are key considerations supporting our financial risk assessment, as we believe the company's financial policies are likely to tolerate modest increases to leverage versus current levels. We expect Prospect to pursue hospital acquisitions to diversify and grow its business over the next few years, and we believe the company may increase leverage to finance this strategy.

Liquidity

We assess Prospect's liquidity as "adequate". We expect sources of liquidity to exceed uses by over 1.2x in 2015, and that sources would exceed uses even if EBITDA declined by 15%. Our liquidity assessment is constrained at "adequate" because we do not believe the company could withstand a high-impact, low-probability event without refinancing.

Principal liquidity sources:

- About $40 million of cash at June 30, 2015;
- About $40 million of availability on the company's $60 million revolving credit facility; and
- About $80 million to $90 million in expected 2015 FFO.

Principal liquidity uses:

- About $40 million in capital expenditures; and
- Some investment in working capital in 2015.

Outlook

The rating outlook on Prospect Medical Holdings Inc. is stable. Standard & Poor's Ratings Services expects over 50% revenue growth in 2015, driven primarily by acquisitions. We expect EBITDA margins to remain broadly stable, with improving margins at acquired hospitals offset by persistent, industrywide pressure from reimbursement headwinds. We expect leverage and cash flow metrics to be at the strong end of the range for an "aggressive" financial risk profile, and believe reasonable levels of profitability provide moderate downside cushion to the rating.

Downside scenario

We could lower our rating if Prospect's financials deteriorate to the point where leverage rises above 5x, or if the company stops generating positive free cash flow. We believe this could occur if margins decline about 450 basis points below our expectations. Sharp cuts to disproportionate share payment programs or Medicare reimbursement without offsetting factors could, in our view, cause this to occur. Leverage could also increase above 5x if the company becomes meaningfully more acquisitive. Assuming no acquired EBITDA, we estimate that the company has about $300 million in debt capacity at the existing rating.

Upside scenario

We could raise our rating if the company's acquisition strategy results in better business diversity over time. Specifically, we could consider a higher rating if the company's exposure to California declines, as we would likely view better geographic diversity (and less exposure to California's provider fee programs) as consistent with a stronger business risk assessment and raise the rating accordingly.

Ratings Score Snapshot

Corporate Credit Rating B/Stable/--

Business risk: Vulnerable
- Country risk: Very low
- Industry risk: Intermediate
- Competitive position: Vulnerable

Financial risk: Aggressive
- Cash flow/Leverage: Aggressive

Anchor: b

Modifiers
- Diversification/Portfolio effect: Neutral (no impact)
- Capital structure: Neutral (no impact)
- Financial policy: FS-5 (no additional impact)
- Liquidity: Adequate (no impact)
- Management and governance: Fair (no impact)
- Comparable rating analysis: Neutral (no impact)

SACP: B

Recovery Analysis

Key analytical factors

- We have reassessed our view of Prospect's likely emergence enterprise value following a default given the company's recent acquisitions.
- Our issue-level rating on Prospect's senior secured notes is now 'B', with a recovery rating of '4', indicating our expectation for average (30% to 50%; at the low end of the range) recovery on this debt in the event of payment default.
- Prospect's capital structure includes a $60 million revolver, $425 million in senior secured notes, and approximately $13 million in capital leases. We do not rate the revolver.
- In our default scenario, we assumed the company would be reorganized, and valued the company on a going-concern basis using a 4.0x multiple of our projected emergence EBITDA. This multiple is below that of peers and reflects Prospect's reliance on various disproportionate share subsidy programs.
- We estimate that for the company to default, EBITDA would need to decline significantly, representing a meaningful adverse change to reimbursement or a loss of key customers in the group medical business.

Simulated default assumptions

- Simulated year of default: 2018.
- EBITDA at emergence: $61 million.

- EBITDA multiple: 4.0x.

Simplified waterfall

- Net enterprise value (after 5% admin. costs): $230 million
- Valuation split in % (obligors/nonobligors): 100/0
- Priority claims: $13 million
- ---
- Collateral value available to revolver lenders: $181 million
- Revolver debt (with a first-out provision): $53 million
- --Recovery expectations: N/A
- Collateral value available to secured creditors: $164 million
- Secured first-lien debt: $443 million
- --Recovery expectations: 30% to 50% [low end of the range]

Notes: All debt amounts include six months of prepetition interest. N/A--Not applicable.

Related Criteria And Research

Related Criteria

- Criteria - Corporates - General: Methodology And Assumptions: Liquidity Descriptors For Global Corporate Issuers, Dec. 16, 2014
- Criteria - Corporates - Industrials: Key Credit Factors For The Health Care Services Industry, April 16, 2014
- General Criteria: Group Rating Methodology, Nov. 19, 2013
- Criteria - Corporates - General: Corporate Methodology: Ratios And Adjustments, Nov. 19, 2013
- Criteria - Corporates - General: Corporate Methodology, Nov. 19, 2013
- General Criteria: Methodology: Management And Governance Credit Factors For Corporate Entities And Insurers, Nov. 13, 2012
- Criteria - Corporates - Recovery: Criteria Guidelines For Recovery Ratings On Global Industrials Issuers' Speculative-Grade Debt, Aug. 10, 2009

Ratings List

Ratings Affirmed

Prospect Medical Holdings Inc.		
Corporate Credit Rating	B/Stable/--	
Upgraded; Recovery Rating Revised		
	To	From
Prospect Medical Holdings Inc.		
Senior Secured	B	B-
Recovery Rating	4L	5

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RESPONSE TO DEFICIENCIES (DECEMBER 11, 2015)

EXHIBIT U – Consolidated Financial Statements for PMH

Prospect Medical Holdings, Inc.

Consolidated Financial Statements

For the Years Ended
September 30, 2015 and 2014

The report accompanying these financial statements was issued by BDO USA, LLP, a Delaware limited liability partnership and the U.S. member of BDO International Limited, a UK company limited by guarantee.

Prospect Medical Holdings, Inc.

Consolidated Financial Statements

For the Years Ended September 30, 2015 and 2014

Prospect Medical Holdings, Inc.

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Independent Auditor's Report

Board of Directors
Prospect Medical Holdings, Inc.
Los Angeles, California

We have audited the accompanying consolidated financial statements of Prospect Medical Holdings, Inc. (the "Company"), which comprise the consolidated balance sheets as of September 30, 2015 and 2014, and the related consolidated statements of income, statements of stockholder's equity (deficit), and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Prospect Medical Holdings, Inc. and its subsidiaries as of September 30, 2015 and 2014, and the results of their operations and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

BDO USA, LLP

December 10, 2015

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Consolidated Financial Statements

Prospect Medical Holdings, Inc.

Consolidated Balance Sheets
(in thousands except par value and share amounts)

September 30,	2015	2014
Assets		
Current assets		
Cash and cash equivalents	$ 65,606	$ 39,072
Restricted cash	4,585	4,976
Restricted investments	1,266	642
Patient accounts receivable, net of allowance for doubtful accounts of $52,707 and $49,727	139,696	123,733
Due from government payers	41,586	42,518
Other receivables	6,821	15,947
Inventories	12,294	10,448
Hospital fee program receivable	32,285	-
Prepaid expenses and other current assets	17,889	14,374
Total current assets	322,028	251,710
Property, improvements and equipment, net	240,337	229,474
Deferred financing costs, net	7,233	9,457
Deferred income taxes, net	11,865	1,165
Goodwill	162,296	158,864
Intangible assets, net	29,162	35,274
Other assets	9,930	8,234
Total assets	$ 782,851	$ 694,178

See accompanying notes to the consolidated financial statements.

Prospect Medical Holdings, Inc.

Consolidated Balance Sheets
(in thousands except par value and share amounts)

September 30,	2015	2014
Liabilities and Stockholder's Equity (Deficit)		
Current liabilities:		
Accrued medical claims and other healthcare costs payable	$ 53,531	$ 39,314
Accounts payable and other accrued liabilities	102,936	88,218
Accrued salaries, wages and benefits	57,432	53,808
Hospital fee program liability	15,022	2,806
Due to government payers	27,078	26,584
Income taxes payable, net	15,110	5,879
Revolving line of credit	20,000	20,000
Current portion of capital leases	2,905	4,691
Current portion of long-term debt	135	133
Other current liabilities	2,168	1,659
Total current liabilities	296,317	243,092
Long-term debt, net of current portion	422,700	421,755
Deferred income taxes, net	-	3,308
Malpractice reserves	6,632	4,590
Capital leases, net of current portion	9,296	10,463
Asset retirement obligations	4,583	4,310
Other long-term liabilities	6,883	7,866
Total liabilities	746,411	695,384
Commitments, contingencies and subsequent event		
Stockholder's equity (deficit):		
Common stock, $0.01 par value; 100 shares authorized, issued and outstanding at September 30, 2015 and 2014	1	1
Additional paid-in capital	20,037	18,457
Retained earnings (accumulated deficit)	6,158	(28,481)
Total stockholder's equity (deficit) attributable to Prospect Medical Holdings, Inc.	26,196	(10,023)
Non-controlling interests	10,244	8,817
Total stockholder's equity (deficit)	36,440	(1,206)
Total liabilities and stockholder's equity (deficit)	$ 782,851	$ 694,178

See accompanying notes to the consolidated financial statements.

Prospect Medical Holdings, Inc.

Consolidated Statements of Income
(in thousands)

For the Years Ended September 30,	2015	2014
Revenues:		
Net Hospital Services revenues	$ 1,047,517	$ 619,809
Provision for bad debts	(44,087)	(32,945)
Net Hospital Services revenues less provision for bad debts	1,003,430	586,864
Medical Group revenues	333,238	253,980
Net Global Risk Management revenues	3,440	-
Other revenues	5,436	13,672
Total net revenues	1,345,544	854,516
Operating Expenses:		
Hospital operating expenses	788,366	449,742
Medical Group cost of revenues	224,028	185,342
Global Risk Management cost of revenues	3,119	-
General and administrative	193,997	133,056
Depreciation and amortization	34,374	23,580
Total operating expenses	1,243,884	791,720
Operating income from unconsolidated joint venture	6,400	3,356
Operating income	108,060	66,152
Other (income) expense:		
Interest expense and amortization of deferred financing costs, net	42,063	41,437
Adjustment to (Gain on) bargain purchase	319	(4,817)
Other expense	230	419
Total other (income) expense, net	42,612	37,039
Income before income taxes	65,448	29,113
Income tax provision	31,146	10,561
Net income	34,302	18,552
Net income attributable to non-controlling interests	(337)	(463)
Net income attributable to Prospect Medical Holdings, Inc.	$ 34,639	$ 19,015

See accompanying notes to the consolidated financial statements.

Prospect Medical Holdings, Inc.

Consolidated Statements of Stockholder's Equity (Deficit)
(in thousands except share amounts)

	Number of Common Shares	Common Stock	Additional Paid-in Capital	Retained Earnings (Accumulated Deficit)	Prospect Medical Holdings, Inc. Stockholder's Equity (Deficit)	Non-controlling Interests	Total Stockholder's Equity (Deficit)
Balance at September 30, 2013	100	$ 1	$ 15,334	$ (47,496)	$ (32,161)	$ 120	$ (32,041)
Stock-based compensation	-	-	2,673	-	2,673	-	2,673
Investment in Chaparral Medical Group (see Note 1)	-	-	450	-	450	-	450
Non-controlling interest attributed to PCC Seller (see Note 4)	-	-	-	-	-	9,160	9,160
Net income	-	-	-	19,015	19,015	(463)	18,552
Balance at September 30, 2014	100	1	18,457	(28,481)	(10,023)	8,817	(1,206)
Options exercised	-	-	396	-	396	-	396
Stock-based compensation	-	-	1,184	-	1,184	-	1,184
Non-controlling interest attributed to PCC Seller (see Note 4)	-	-	-	-	-	1,764	1,764
Net income	-	-	-	34,639	34,639	(337)	34,302
Balance at September 30, 2015	100	$ 1	$ 20,037	$ 6,158	$ 26,196	$ 10,244	$ 36,440

See accompanying notes to the consolidated financial statements.

Prospect Medical Holdings, Inc.

Consolidated Statements of Cash Flows
(in thousands)

For the Years Ended September 30,	2015	2014
Operating activities		
Net income	$ 34,302	$ 18,552
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	34,374	23,580
Amortization of deferred financing costs, net	2,223	2,218
Amortization of original issue discount and premium, net	1,080	992
Provision for bad debts	44,087	32,945
Deferred income taxes, net	(14,008)	(8,111)
Stock-based compensation	1,184	2,673
Undistributed earnings from equity method investments	(135)	(178)
Loss on disposal of assets	271	-
Adjustment to (Gain on) bargain purchase	319	(4,817)
Gain on sale of equity method investment	(296)	-
Changes in operating assets and liabilities, net of business combinations:		
Patient accounts receivable and other receivables	(53,076)	(50,596)
Due to/from government payers, net	1,426	(8,827)
Prepaid expenses and other current assets	901	(1,682)
Hospital fee program receivable	(32,285)	18,895
Inventories	(1,839)	(814)
Hospital fee program liability and deferred revenue	12,216	(5,803)
Income taxes payable/receivable, net	9,289	6,899
Deposits and other assets	(660)	1,338
Accrued medical claims and other healthcare costs payable	14,217	8,962
Accounts payable and other accrued liabilities	21,235	16,177
Net cash provided by operating activities	74,825	52,403
Investing activities		
Purchases of property, improvements and equipment	(37,502)	(50,107)
Cash paid for acquisitions, net of cash received and working capital adjustments	(1,740)	(58,300)
Proceeds from sale of property and improvements	987	-
Proceeds from sale of equity method investment	1,233	-
Cash paid for equity method investments	(1,880)	-
Cash paid for investment in Chaparral Medical Group, Inc. (see Note 1)	-	(1,100)
Change in note receivable (net)	70	66
Increase in restricted investments	(624)	(5)
Net cash used in investing activities	(39,456)	(109,446)

Prospect Medical Holdings, Inc.

Consolidated Statements of Cash Flows (Continued)
(in thousands)

For the Years Ended September 30,	2015	2014
Financing activities		
Borrowings on line of credit, net	-	20,000
Repayments of long-term debt	(133)	(176)
Repayments of capital leases	(4,935)	(5,435)
Proceeds from exercise of stock options	396	-
Cash paid for deferred financing costs, net	-	(50)
Change in restricted cash	391	(2,676)
Repayments of insurance premium financing	(4,554)	(1,863)
Net cash (used in) provided by financing activities	(8,835)	9,800
Increase (decrease) in cash and cash equivalents	26,534	(47,243)
Cash and cash equivalents, beginning of year	39,072	86,315
Cash and cash equivalents, end of year	$ 65,606	$ 39,072
Supplemental disclosure of cash flow information		
Interest paid	$ 38,099	$ 37,608
Income taxes paid, net	$ 35,778	$ 12,004
Schedule of non-cash investing and financing activities		
Equipment acquired under capital leases	$ 1,999	$ 2,028
Insurance premium financed	$ 4,472	$ 1,842
Long-term liability assumed from acquisition of PCC (see Note 4)	$ -	$ 6,440
Partial satisfaction of long-term liability assumed from acquisition of PCC (see Note 4)	$ 1,446	$ -

See accompanying notes to the consolidated financial statements.

1. Organization

Prospect Medical Holdings, Inc. ("Prospect" or the "Company" or the "Parent Entity") is a Delaware corporation and a wholly-owned indirect subsidiary of Ivy Holdings Inc. ("Ivy Holdings").

The Company's operations are currently organized into four primary reportable segments: Hospital Services, Medical Group, Global Risk Management and Corporate, as discussed below.

The Global Risk Management segment is a new segment in Prospect's operations and commenced operations during the year ended September 30, 2015. The Global Risk Management segment includes Prospect Health Plan, Inc. ("PHP") with operations in California, Prospect Health Services TX, Inc. ("PHSTX") with operations in Texas, Prospect Health Services RI, Inc. ("PHSRI") with operations in Rhode Island, and Coordinated Regional Care Group, Inc. ("CRCG") with operations in various states. PHP, PHSTX, and PHSRI have entered into global capitation arrangements with certain third-party health plans and manage the provision of care for members in coordination with the Hospital Services and Medical Group segments.

Hospital Services Segment

The Company owns 13 acute care and behavioral hospitals and multi-level elder care facilities in Southern California, the Greater San Antonio, Texas region, and Rhode Island with a total of 2,258 licensed beds, and a network of specialty and primary care clinics, through its subsidiaries, Southern California Healthcare System, Inc. ("SCHS"), Alta Los Angeles Hospitals, Inc. ("Alta Los Angeles Hospitals"), Alta Newport Hospital, Inc., Prospect Hospital Holdings, LLC ("Nix Health"), and Prospect CharterCARE, LLC ("PCC") (collectively, the "Hospital Services segment"). The Hospital Services segment subsidiaries are wholly-owned by Prospect, except for PCC, in which Prospect has an 85% interest (see Note 4).

Effective May 6, 2014, Prospect acquired substantially all of the assets and associated real estate of Newport Specialty Hospital, which was subsequently renamed Foothill Regional Medical Center ("FRMC"), through Prospect's newly created subsidiary, Alta Newport Hospital, Inc., and Bellflower Medical Center (subsequently renamed Los Angeles Community Hospital at Bellflower or "LACH Bellflower") through Prospect's subsidiary Alta Los Angeles Hospitals, Inc. FRMC, located in Tustin, California, was substantially closed in 2013 except for its pediatric sub-acute unit. LACH Bellflower, located in Bellflower, California, was closed in 2013 and was non-operational when acquired by the Company. Bellflower opened its 32-bed voluntary adult behavioral health unit during July 2015. Prospect intends to fully reopen both facilities, including maintaining the FRMC pediatric sub-acute unit.

Effective June 20, 2014, Prospect acquired, through its subsidiary, PCC, substantially all of the assets of CharterCARE Health Partners and its subsidiaries. PCC's operating subsidiaries include Prospect CharterCARE RWMC, LLC ("Roger Williams Medical Center"), Prospect CharterCARE SJHSRI, LLC ("St. Joseph Health Services of Rhode Island"), Prospect CharterCARE Elmhurst, LLC ("Elmhurst Extended Care"), and Prospect CharterCARE Physicians, LLC ("CharterCARE Physicians") which include hospitals, medical centers, multi-level elder care facilities, and a network of approximately 60 contracted primary care and specialist physicians located in Rhode Island with 785 licensed beds (collectively, "CharterCARE"). PCC is 85% owned by Prospect and 15% by CharterCARE Community Board (formerly known as CharterCARE Health Partners).

The Company's three community hospitals in Hollywood, Los Angeles and Norwalk offer a comprehensive range of medical and surgical services, including general acute care hospital services, pediatrics, obstetrics and gynecology, pediatric sub-acute care, general surgery, medical-surgical services, orthopedic surgery, and diagnostic, outpatient, skilled nursing and urgent care services. The Company's psychiatric hospital in Van Nuys provides acute inpatient and outpatient psychiatric services on a voluntary basis. The Company's hospital in Culver City ("SCH Culver City") offers a comprehensive range of inpatient and outpatient services: including general surgery, orthopedic, spine, cardiology, diagnostic outpatient, rehabilitation, psychiatric and detox services. In addition, SCH Culver City has an active emergency room that plays an integral part in providing emergency services to the West Los Angeles area.

Nix Health provides comprehensive service offerings at various locations throughout the greater San Antonio, Texas region. These locations include Nix Medical Center, which provides inpatient acute care, geriatric psychiatry services, and emergency room services; Nix Specialty Health Center, which provides a full range of behavioral health and rehabilitation services for children, adolescents, and adults, and a range of health clinics and provider based clinics throughout San Antonio, Texas; and Nix Community General Hospital ("Nix CGH"), which operates an inpatient acute hospital in Dilley, Texas and a medical clinic in Pearsall, Texas. Nix Health also opened a 73-bed behavioral health center during the year ended September 30, 2014, which provides psychiatric emergency services and a crisis intervention unit.

CharterCARE provides a comprehensive range of services at both Roger Williams Medical Center and St. Joseph's Health Services Rhode Island as well as multiple levels of elder care at Elmhurst Extended Care.

Admitting physicians are primarily practitioners in the local area. The hospitals have payment arrangements with Medicare, Medicaid (Medi-Cal in California) and other third party payers, including commercial insurance carriers, health maintenance organizations ("HMOs") and preferred provider organizations ("PPOs").

Medical Group Segment

The Medical Group segment is a healthcare management services organization that provides management services to affiliated physician organizations that operate as independent physician associations ("Medical Groups" or "IPAs"). The affiliated physician organizations enter into agreements with HMOs to provide HMO enrollees with a full range of medical services in exchange for fixed, prepaid monthly fees known as "capitation" payments. The Medical Groups contract with physicians (primary care and specialist) and other healthcare providers to provide enrollees with medical services. Prospect currently manages the provision of prepaid healthcare services for its affiliated physician organizations in Southern California, Texas and Rhode Island. The network consists of the following physician organizations as of September 30, 2015 (individually referred to as an "Affiliate"):

Prospect Medical Group, Inc. ("PMG")
Prospect Health Source Medical Group, Inc. ("PHS")
Prospect Professional Care Medical Group, Inc. ("PPCM")
Genesis HealthCare of Southern California, Inc. ("Genesis")
Prospect NWOC Medical Group, Inc. ("PNW")
StarCare Medical Group, Inc. ("PSC")
AMVI/Prospect Medical Group ("AMVI/Prospect")
Nuestra Familia Medical Group, Inc. ("Nuestra")
Upland Medical Group, a Professional Medical Group ("UMG")*
Pomona Valley Medical Group, Inc. ("PVMG")*

* PVMG and UMG are collectively referred to as the "ProMed Entities."

These Affiliates are managed by the following two medical management company subsidiaries that are wholly-owned by Prospect (collectively, "MSOs"):

Prospect Medical Systems, Inc. ("PMS")
ProMed Healthcare Administrators ("PHCA")

In addition to the Affiliates and MSOs, the Medical Group segment includes Prospect Health Services, TX, Inc. ("PHSTX") and Prospect Provider Group RI, LLC ("PPGRI"), both of which are indirect wholly-owned subsidiaries of the Company.

All of the Affiliates are wholly-owned by PMG, with the exception of Nuestra, which was 66.95% owned by PMG as of September 30, 2015 and 2014, and AMVI/Prospect which is a 50/50 Joint Venture between AMVI Care Health Network, Inc. ("AMVI") and PMG. The operations of all of these entities, with the exception of AMVI/Prospect, are consolidated in the accompanying consolidated financial statements. PMG is owned by a nominee physician shareholder pursuant to an assignable option agreement described below.

PMG's ownership in Nuestra increased from 62% to 66.95% during the year ended September 30, 2014. On October 7, 2013, Nuestra repurchased 109 shares from a physician shareholder that left Nuestra's group medical practice for a de minimis purchase price in accordance with Nuestra's Agreement Concerning Shares of the Company dated September 19, 1995. The repurchase increased the share percentage holdings of all remaining shareholders and PMG's percentage rose to 66.95% as of October 7, 2013.

The AMVI Joint Venture was formed for the sole purpose of combining enrollment in order to meet minimum enrollment levels required for participation in the CalOptima Medicaid (Medi-Cal in California) program in Orange County, California. The joint venture ownership is set at 50/50 to prevent either party from exerting control over the other; however, AMVI's and PMG's businesses are operated autonomously, and enrollees, financial results and cash flows are each separately tracked and recorded. In accordance with the joint venture partnership agreement, profits and losses are not split in accordance with the partnership ownership interest, but rather, are directly tied to the results generated by each separate portion of the business. Separate from any earnings the Company generates from PMG's portion of business within the joint venture, the Company also earns fees for management services PMS provides to PMG's partner in the joint venture. The Company accounts for PMG's interest in the joint venture partnership using the equity method of accounting. The Company includes in the consolidated financial statements only the net results attributable to those enrollees specifically identified as assigned to the Company, together with the management fee that PMS charges for managing those enrollees specifically assigned to the other joint venture partner.

PMS has entered into an assignable option agreement with PMG and the nominee physician shareholder of PMG. Under the assignable option agreement, Prospect has an assignable option, obtained for a nominal amount from PMG and the nominee shareholder to designate the purchaser (successor physician) for all or part of PMG's issued and outstanding stock held by the nominee physician shareholder (the "Stock Option") in its sole discretion. The Company may also assign the assignable option agreement to any person. The assignable option agreement has an initial term of 30 years and is automatically extended for additional terms of 10 years each, as long as the term of the related management services agreement described below (the "Management Agreement") is automatically extended. Upon termination of the Management Agreement with PMG, the related Stock Option would be automatically and immediately exercised. The Stock Option may be exercised for a purchase price of $1,000. Under these nominee shareholder agreements, Prospect has the unilateral right to establish or

effect a change of the nominee, at will, and without the consent of the nominee, on an unlimited basis and at nominal cost throughout the term of the Management Agreement. In addition to the Management Agreement with PMG, Prospect, through one of its management company subsidiaries, has a management agreement with each Affiliate. The term of the Management Agreements is generally 30 years. PMG is the sole shareholder of PHS, PPCM, Genesis, PNW, PSC, UMG, and PVMG. New Genesis Medical Associates, Inc. ("NGMA") is controlled through a nominee shareholder arrangement like the Stock Option structure utilized for PMG and discussed above.

The Company's Affiliates and NGMA have entered into Management Agreements with PMS or PHCA, as applicable (each of which is a wholly-owned subsidiary of Prospect). Each Affiliate has agreed to pay a management fee to PMS or PHCA, as applicable. The fee is based in part on the costs to the management company and on a percentage of revenues the Affiliate receives (i) for the performance of medical services by the Affiliate's employees and independent contractor physicians and physician extenders, and (ii) for all other services performed by the Affiliates. The revenue from which this fee is determined includes medical capitation (except for NGMA which provides professional and ancillary services), all sums earned from participation in any risk pools and all fee-for-service revenue earned. The management fee also includes a fixed amount for marketing and public relations services. Except in the case of Nuestra and AMVI/Prospect, the Management Agreements had initial terms of 30 years, renewable for successive 10-year periods thereafter, unless terminated by either party for cause. Effective September 1, 2013, the Managements Agreements for the ProMed Entities were consolidated under one new Management Agreement with PHCA. Effective October, 1, 2013, the Management Agreements for the rest of the Affiliates, other than Nuestra and AMVI/Prospect, were consolidated under one new Management Agreement with PMS. Those two new Management Agreements with PHCA and PMS include initial five year terms and are renewable for successive five year periods thereafter. In the case of Nuestra, its Management Agreement had an initial 10 year term renewable for successive one year terms, subsequently amended in January 15, 2009 to an initial 20 year term renewable for two 10 year periods. In the case of AMVI/Prospect, the Management Agreement has a one year term with successive one year renewal terms. The management agreement for NGMA was effective October 1, 2012 with an initial term of 30 years, renewable for successive 10-year periods thereafter, unless terminated by either party for cause. In return for payment of the management fee, Prospect (through PMS and PHCA) has agreed to provide financial management, information systems, marketing, advertising, public relations, risk management, and administrative support, including for utilization review and quality of care. At its cost, Prospect has assumed the obligations for all facilities, medical and non-medical supplies, and employment of non-physician personnel of its affiliated medical clinics.

The management fee earned by Prospect fluctuates based on the profitability of each Affiliate. Prospect is allocated a 50% residual interest in any profits after the first 8% of the profits. The remaining balance is retained by the Affiliates.

The Management Agreements are not terminable by the Affiliates except in the case of gross negligence, fraud or other illegal acts of Prospect, or bankruptcy of the Company.

Further, Prospect's rights under the Management Agreements are unilaterally saleable or transferable. Based on the provisions of the Management Agreements and the assignable option agreement with PMG, Prospect has determined that it has a controlling financial interest in the Affiliates, with the exception of AMVI/Prospect. Consequently, under applicable accounting principles, Prospect consolidates the revenues and expenses of all the Affiliates except AMVI/Prospect from the respective dates of execution of the Management Agreements. All significant inter-entity balances have been eliminated in consolidation. In the case of AMVI/Prospect, only that portion of the results which are contractually identified as Prospect's are recognized in the consolidated financial statements, together with the

management fee that the Company charges AMVI for managing AMVI's share of the joint venture operations.

Prospect has also entered into management agreements with unaffiliated third parties to manage services to their HMO enrollees. These management agreements do not have characteristics that give rise to the consolidation of the entities under current accounting literature.

The affiliated physician organizations provided medical services to a combined total of approximately 258,900 and 264,600 HMO enrollees as of September 30, 2015 and 2014, respectively. The enrollees include approximately 63,700 and 87,000 enrollees that the Company manages for the economic benefit of certain independent third parties, and for which the Company earns management fee income as of September 30, 2015 and 2014, respectively. The total paid member months including managed enrollees, for the fiscal years ended September 30, 2015 and 2014 was approximately 3,067,200 and 2,785,000, respectively.

On December 19, 2013, NGMA, an Affiliate of the Company, purchased stock of Chaparral Medical Group, Inc. ("CMG"), a California medical corporation. Consideration was composed of $1,100,000 in cash at the closing, $700,000 in future cash consideration to be used for the acquired company's general corporate purposes, and 3,750 shares of Ivy Holdings common stock issued at closing to the selling shareholders. As of December 19, 2013, NGMA owned 13.44% of the stock of CMG. During June 2015, CMG repurchased shares from a physician shareholder, which increased NGMA's ownership to 13.57%. After payment of the entire consideration, including the future cash consideration, NGMA will own 18.39% of the stock of CMG. Pursuant to the terms of the stock purchase agreement, NGMA will have the right and option to make additional stock investments at the same share valuations and prices and upon the same applicable terms and conditions as the initially acquired shares, to bring its aggregate ownership up to 50%. CMG is a multi-specialty group serving communities primarily in the Los Angeles and San Bernardino counties. The Company accounts for NGMA's interest in CMG using the equity method as the Company has the ability to exercise significant influence over the operating and financial policies of CMG.

Global Risk Management Segment

The Global Risk Management segment commenced operations during the year ended September 30, 2015 and entered into global capitation arrangements with certain unrelated third-party health plans. The Global Risk Management segment also manages the provision of care for members in coordination with the Hospital and Medical Group segments.

Corporate Segment

The Corporate segment reflects certain expenses incurred at the Parent Entity not specifically allocable to the Hospital Services, Medical Group, or Global Risk Management segments. These include, but are not limited to: salaries, benefits and other compensation for corporate employees; financing expenses; insurance expenses; rent; legal fees; and accounting fees. The Company does not allocate interest expense related to acquisition debt or income taxes to the other reporting segments.

2. Significant Accounting Policies

Basis of Presentation

The consolidated financial statements have been prepared in accordance with accounting principles generally accepted in the United States of America ("GAAP") and include the accounts of all controlled subsidiaries, of which control is effectuated through ownership of voting common stock or by other means, but do not include the accounts of the parent companies, Ivy Holdings and Ivy Intermediate Holding Inc. The Medical Group segment Affiliates and NGMA have been determined to be variable interest entities due to the existence of a call option under which the Company has the ability to require the holders of all of the voting common stock of the underlying subsidiaries to sell their shares at a fixed nominal price ($1,000) to another designated physician chosen by the Company. This call option agreement represents rights provided through a variable interest other than the equity interest itself that limits the returns that could be earned by the equity holders. In addition, the Company has management agreements with the Affiliates and NGMA and the holders of the voting common stock which allows the Company to direct the activities of the Affiliates and NGMA that most significantly impact their economic performance, retain the right to receive expected residual returns and assume the obligation to absorb losses. Although the Company has disproportionately few voting rights (based on the terms of the equity), the Company is considered to be the primary beneficiary of the activities of the Affiliates and NGMA. As a result, the Affiliates and NGMA are consolidated within the accompanying consolidated financial statements.

Operating results for CMG, FRMC and LACH Bellflower, PCC and the CharterCARE Physicians medical practices acquisitions are consolidated with the Company's financial statements from their acquisition dates or inception date in the case of LACH Bellflower (December 19, 2013, May 6, 2014, June 20, 2014, and various dates during the year ended September 30, 2015, respectively) (see Note 4). All significant intercompany balances and transactions have been eliminated in consolidation.

Reclassifications

Certain reclassifications were made to the 2014 consolidated financial statements in order to conform to the 2015 presentation.

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Revenues

Revenues by reportable segment are comprised of the following amounts (in thousands):

For the Years Ended September 30,	2015 *(a)*	2014 *(b)*
Net Hospital Services		
Inpatient	$ 736,340	$ 440,961
Outpatient	195,692	96,802
Capitation	98,993	70,077
Other	16,492	11,969
Total Hospital Services revenues	1,047,517	619,809
Less: Provision for bad debts	(44,087)	(32,945)
Total net Hospital Services revenues less provision for bad debts	1,003,430	586,864
Medical Group		
Capitation	312,031	244,573
Management fees	7,814	6,586
Other	13,393	2,821
Total Medical Group revenues	333,238	253,980
Global Risk Management		
Capitation	3,440	-
Other revenues	5,436	13,672
Total net revenues	$ 1,345,544	$ 854,516

(a) The revenues of various medical practices acquired by CharterCARE Physicians have been included in the accompanying consolidated financial statements from their various dates of acquisition during the year ended September 30, 2015.

(b) CMG, Bellflower and FRMC, and PCC revenues have been included in the accompanying consolidated financial statements for the period from acquisition or inception date in the case of LACH Bellflower, December 19, 2013, May 6, 2014, and June 20, 2014, respectively, through September 30, 2014.

Hospital Services Segment

Net Patient Service Revenues

Operating revenue of the Hospital Services segment consists primarily of net patient service revenue. The Company reports net patient service revenue at the estimated net realizable amounts from patients and third-party payers and others in the period in which services are rendered. The Company has agreements with third-party payers, including Medicare, Medicaid (Medi-Cal in California), managed care and other insurance programs that are paid at negotiated rates. These payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges and per diem payments, as further described below. Estimates of contractual allowances are based upon the payment terms specified in the related contractual agreements. The Company accrues for amounts that it believes may ultimately be due to or from the third-party payers. Normal estimation differences between final settlements and amounts accrued in previous years are reported as changes in estimates

in the current year. Outstanding receivables, net of allowances for contractual discounts and bad debts, are included in patient accounts receivable in the accompanying consolidated balance sheets.

The following is a summary of sources of patient service revenues (net of contractual allowances and discounts) before provision for bad debts:

September 30,	2015	2014
Medicare	$ 321,282	$ 224,984
Medicaid	379,821	189,668
Managed Care	168,553	95,853
Self Pay/Other	62,376	27,258
Capitation	98,993	70,077
Total patient service revenue	$ 1,031,025	$ 607,840

A summary of the payment arrangements with major third-party payers follows:

Medicare: Medicare is a federal program that provides certain hospital and medical insurance benefits to persons aged 65 and over, some disabled persons with end-stage renal disease and certain other beneficiary categories. Inpatient services rendered to Medicare program beneficiaries are paid at prospectively determined rates per discharge, according to a patient classification system based on clinical, diagnostic, and other factors. Outpatient services are paid based on a blend of prospectively determined rates and cost-reimbursed methodologies. The Company is also reimbursed for various disproportionate share and Medicare bad debt components at tentative rates, with final settlement determined after submission of the annual Medicare cost report and audit thereof by the Medicare fiscal intermediary. Normal estimation differences between filed settlements and amounts accrued are reflected in net patient service revenue.

Cost report settlement estimates are recorded based upon as-filed cost reports and are adjusted for tentative settlements, if any, and when a final Notice of Program Reimbursement ("NPR") is issued. The latest updated SSI ratios for 2013 were issued on May 14, 2015. To date, the Company has received final NPRs for SCH Culver City (formerly named Brotman Medical Center, Inc.) through 2012 for cost report years prior to its merger into the Alta Hollywood Hospitals, Inc. subsidiary, SCH Hollywood through 2010, Alta Los Angeles Hospitals through 2011, Nix Health through 2012, and Elmhurst through 2014. No NPR has been issued for Roger Williams Medical Center or St. Joseph's Health Services of Rhode Island.

The Company joined a second round of litigation relating to Medicare's settlement with providers relating to the manner in which the Centers for Medicare and Medicaid Services ("CMS") handled the budget neutrality adjustment associated with the rural floor wage index in setting the Medicare inpatient prospective system rates ("Rural Floor"). The Company entered into a settlement agreement with CMS and, as a result, Alta Los Angeles Hospitals, SCH Culver City, and CharterCARE recognized a net benefit of $2,495,000, $1,230,000, and $1,672,000, respectively, during the year ended September 30, 2014 related to the Rural Floor litigation.

Medicaid: Medicaid is a joint federal-state funded healthcare benefit program that is administered by states to provide benefits to qualifying individuals who are unable to afford care. The Company receives reimbursements under the Medicaid program at prospectively determined rates for both inpatient and outpatient services. Medi-Cal is the version of the federal Medicaid program that is

applicable to California residents. Inpatient services rendered to Medi-Cal fee-for-service program beneficiaries in California are in the process of a three-year transition to payment at prospectively determined rates based on diagnosis related groups from a contracted per diem rate. Outpatient services are paid based on prospectively determined rates per procedure provided. Inpatient and outpatient services rendered to Medi-Cal managed care beneficiaries in California are paid at either contracted rates or at the Medi-Cal fee-for-service rates.

The SCHS and Alta Los Angeles Hospitals are eligible to participate in the State of California Medi-Cal Disproportionate Share ("DSH") programs, under which medical facilities that serve a disproportionate number of low-income patients receive additional reimbursements. Eligibility is determined annually based on prescribed guidelines. The Company accrues revenue based on the expected total annual DSH awards. Differences between the estimated and the actual awards are recorded in the period they become known. DSH amounts are subject to retrospective revision prior to finalization and such revisions could lead to material retractions. The Company records retrospective retractions when they are estimable and probable. Retrospective additional DSH revenues are recorded when the amounts are received. The Medi-Cal DSH receivable as of September 30, 2015 and 2014 totaled approximately $13,787,000 and $9,094,000, respectively, and were included in due from government payers in the accompanying consolidated balance sheets. For the fiscal years ended September 30, 2015 and 2014, total Medi-Cal DSH payments received by the SCHS and Alta Los Angeles Hospitals were approximately $15,690,000 and $16,325,000, respectively, and total Medi-Cal DSH revenues recorded were approximately $19,005,000 and $20,475,000, respectively. Additionally, pursuant to an audit of Medi-Cal cost reports and notification sent to the Company, the Company accrued a cost report liability payable to Medi-Cal of $1,743,000 and $1,803,000 as of September 30, 2015 and 2014, respectively.

Certain of the Company's California hospitals also participate in *the California Hospital Fee Program* (see Note 10).

In Texas, the Medicaid program reimburses under prospectively determined rates for inpatient services and based on costs for outpatient services. Medicaid reimbursement may be subject to periodic adjustment, as well as to changes in existing payment levels and rates, based on the amount of funding available to the Medicaid program. Nix Health has also been receiving payments from the Texas Health and Human Services Commission under the Section 1115 Waiver ("the waiver") that was recently granted to the state of Texas by CMS. Under the first year of the waiver ending September 30, 2012, a transition payment was paid to Nix Health based upon prior levels of payment under the "Upper Payment Limit" ("UPL") program, which the waiver replaced. Payments for years two through five under the waiver are based upon two pools. One pool is for payments for uncompensated care ("UCC") which includes the shortfall in Medicaid reimbursement as compared to cost and the cost of providing services to uninsured patients. The other pool is the Delivery System Reform Initiative Payments ("DSRIP"), where approved programs and services are undertaken to improve access and services provided. Programs are established by regions and approved by the Texas Health and Human Services Commission and CMS. These programs are assigned a value and milestones are established to measure success and the timing and level of payment from the DSRIP funds. Nix Health recorded revenue related to the UCC pool of $10,962,000 and $12,366,000 for the years ended September 30, 2015 and 2014, respectively. Revenue recorded related to the DSRIP pool was $11,356,000 and $9,801,000 for the years ended September 30, 2015 and 2014, respectively. At September 30, 2015 and 2014, amounts receivable under the Section 1115 Waiver totaled $23,615,000 and $23,145,000, respectively.

Nix Health also recorded $12,000,000 and $5,746,000 during the years ended September 30, 2015 and 2014, respectively, in costs for rural community provision of services. No amounts payable related to the provision of such services were included in the consolidated balance sheets as of September 30, 2015 and 2014.

The CharterCARE hospitals are participants in the State of Rhode Island's DSH program, which was established in 1995 to assist hospitals that provide a disproportionate amount of uncompensated care. Under the program, Rhode Island hospitals, including the CharterCARE hospitals, receive federal and state Medicaid funds as additional reimbursement for treating a disproportionate share of low income patients. The CharterCARE hospitals recognized revenue related to DSH and Upper Payment Limit ("UPL") reimbursement of $16,636,000 and $3,965,000 during the year ended September 30, 2015 and the period from June 20, 2014 (acquisition date) through September 30, 2014, respectively. DSH and UPL payments received were $16,135,000 and $3,932,000 during the year ended September 30, 2015 and the period from June 20, 2014 (acquisition date) through September 30, 2014, respectively. The State of Rhode Island also assesses a license fee to all hospitals in Rhode Island based on each hospital's net patient revenue. The CharterCARE hospitals recorded $15,058,000 and $4,036,000 of expense during the year ended September 30, 2015 and from June 20, 2014 through September 30, 2014 as a result of the license fee.

Managed Care: The Company has also entered into payment agreements with certain commercial insurance carriers, HMOs, and PPOs. The basis for payment under these agreements is in accordance with negotiated contracted rates or at the Company's standard charges for services provided. Some of these payments are capitated, meaning that the Company receives an agreed amount per patient for providing an agreed range of services.

Self-Pay: Self-pay patients represent those patients who do not have health insurance and are not covered by some other form of third party arrangement. Such patients are evaluated, at the time of services or shortly thereafter, for their ability to pay based upon federal and state poverty guidelines, qualifications for Medicaid, as well as the Company's local hospital's indigent and charity care policy.

See "Concentrations of Credit Risks" below for discussion of revenues received from the Medicare and Medicaid programs.

Effective August 29, 2014, CMS provided a simplified process and timely partial payment to settle certain previously denied claims with dates of service prior to October 1, 2013 whereby such claims under appeal that had been retracted by CMS were settled with the provider receiving 68% of the face value. As a result, the Company recorded $3,887,000 in revenue during the year ended September 30, 2014 related to claims which were previously subject to ongoing Recovery Audit Contractor ("RAC") audits and other similar programs. As of September 30, 2015 and 2014, the Company accrued $262,000 and none, respectively, in due to government payors in the accompanying consolidated balance sheets related to such programs.

SCH Culver City Outlier Liability

Following the acquisition of a majority stake in SCH Culver City, effective April 14, 2009, the Company consolidated SCH Culver City's estimated liability to CMS arising out of outlier payments received for services provided by the hospital to Medicare eligible inpatients, primarily for the last four months of calendar year 2005 and all of calendar year 2006.

While SCH Culver City (formerly Brotman Medical Center, Inc.) reports financial statements on a fiscal year ending September 30, Medicare cost reports are filed on a calendar year basis. Acute care hospitals receive Medicare reimbursement payments pursuant to a prospective payment methodology primarily based on the diagnosis of the patient, but are entitled to receive additional payments, referred to as "outliers" for patients whose treatment is very costly. When Brotman Medical Center, Inc. acquired the hospital in 2005, CMS provided a ratio of cost to charges (the "RCC") based on the statewide average. Payments received by SCH Culver City on this basis were an interim estimate, subject to final determination upon audit of SCH Culver City's cost reports. SCH Culver City filed its Medicare cost reports, but determined that its outlier reimbursement for services provided in fiscal years 2005, 2006 and part of 2007 might be subject to adjustment based on certain outlier reconciliation rules.

On October 12, 2012, SCH Culver City received from its Medicare fiscal intermediary a proposed outlier adjustment for Medicare fiscal year 2006 in the amount of $12,785,000. SCH Culver City had previously been notified of an adjustment of $2,149,000 for 2005. As of September 30, 2015 and 2014, the Company accrued $13,834,000 of the estimated $14,934,000 liability to CMS included in the accompanying consolidated balance sheets. The difference between the $14,934,000 asserted by CMS and the $13,834,000 accrued by the Company relates to accrued interest of approximately $1,100,000. The Company does not agree, however, with the outlier reconciliation liability. Accordingly, in accordance with relevant literature related to accounting for contingencies, the Company recorded the lower end of the range of the liability.

The Company has also filed an appeal of the outlier issue with the Provider Reimbursement Review Board for the 2006 cost reporting period since it received a notice of program reimbursement for the 2006 cost report. Mediation was held with CMS and the U.S. Department of Justice in March 2015 for settlement of fiscal years 2005 and 2006. The terms of a final settlement have been approved by CMS and the Health and Human Services Office of the General Counsel. As the Company is waiting for final approval of the settlement by the U.S. Department of Justice, the settlement has not been recognized in the accompanying consolidated financial statements.

The following is a summary of due from and due to governmental payers at September 30 (in thousands):

September 30,	2015	2014
Due from government payers:		
Medi-Cal Disproportionate Share (DSH)	$ 13,787	$ 9,094
Medicare cost report settlements	3,953	10,279
Medi-Cal cost report settlements	231	-
Medicaid Section 1115 receivable	23,615	23,145
	$ 41,586	$ 42,518
Due to government payers:		
Outlier liability	$ 13,834	$ 13,834
Medicare cost report settlements	11,501	10,947
Medi-Cal cost report settlements	1,743	1,803
	$ 27,078	$ 26,584

The Company is not aware of any material claims, disputes, or unsettled matters with any payers that would affect revenues that have not been adequately provided for and disclosed in the accompanying consolidated financial statements.

Charity Care

The Company provides charity care to patients whose income level is below 300% of the Federal Poverty Level. Patients at the Company's California facilities with income levels between 300% and 350% of the Federal Poverty Level qualify to pay a discounted rate under the requirements of California State Assembly Bill 774 (AB 774) based on various government program reimbursement levels. Patients without insurance are offered assistance in applying for Medicaid and other programs they may be eligible for, such as state disability. Patient advocates from the Company's Medical Eligibility Program ("MEP") screen patients in the Hospital and determine potential linkage to financial assistance programs. They also expedite the process of applying for these government programs. The approximate cost of providing charity care was $1,683,000 and $2,029,000 for the years ended September 30, 2015 and 2014, respectively. The Company has estimated the cost of charity care based on a ratio of the cost to charges, with cost consisting of operating expenses, excluding depreciation, interest and management fees.

Provisions for Contractual Allowances and Bad Debts

Collection of receivables from third-party payers and patients is the Company's primary source of cash and is critical to its operating performance. The Company closely monitors its historical collection rates, as well as changes in applicable laws, rules and regulations and contract terms, to assure that provisions for contractual allowances are made using the most accurate information available. However, due to the complexities involved in these estimations, actual payments from payers may be materially different from the amounts management estimates and records. The Company's primary collection risks relate to uninsured patients and the portion of the bill which is the patient's responsibility, primarily co-payments and deductibles. Payments for services may also be denied due to issues over patient eligibility for medical coverage, the Company's ability to demonstrate medical necessity for services rendered and payer authorization of hospitalization.

Accounts receivable are reduced by an allowance for doubtful accounts. Valuation of the collectability of accounts receivable and provision for bad debts is based on historical collection experience, payer mix and the age of the receivables. Management routinely reviews accounts receivable balances in conjunction with these factors and other economic conditions which might ultimately affect the collectability of the patient accounts, and makes adjustments to the Company's allowances as warranted. For receivables associated with services provided to patients who have third-party coverage, management analyzes contractually due amounts and subsequently calculates an allowance for doubtful accounts and provision for bad debts once the age of the accounts reaches a specific age category based on historical experience. For receivables associated with self-pay patients, management records a significant provision for bad debts beginning in the period services were provided based on past experience that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The allowance for doubtful accounts as a percent of gross accounts receivable decreased from 29% at September 30, 2014 to 27% at September 30, 2015. The allowance for doubtful accounts was $52,707,000 and $49,727,000 for the years ended September 30, 2015 and 2014, respectively. The decrease in the allowance for doubtful accounts as a percent of gross accounts receivable was due primarily to a reduction in self pay patient admissions and patient dates at the CharterCARE hospitals. As a result of the shift in payor mix, the allowance for doubtful accounts as a

percent of gross accounts receivable decreased from 31% at September 30, 2014 to 20% at September 30, 2015 at the CharterCARE hospitals.

Legislation

All of the Company's hospital facilities are subject to the Emergency Medical Treatment and Active Labor Act ("EMTALA"). This federal law requires any hospital that participates in the Medicare program to conduct an appropriate medical screening examination of every person who presents to the hospital's emergency department for treatment and, if the patient is suffering from an emergency medical condition, to either stabilize that condition or make an appropriate transfer of the patient to a facility that can handle the condition. The obligation to screen and stabilize emergency medical conditions exists regardless of a patient's ability to pay for treatment. There are severe penalties under EMTALA if a hospital fails to screen or appropriately stabilize or transfer a patient or if the hospital delays appropriate treatment in order to first inquire about the patient's ability to pay. Penalties for violations of EMTALA include civil monetary penalties and exclusion from participation in the Medicare program. In addition, an injured patient, the patient's family or a medical facility that suffers a financial loss as a direct result of another hospital's violation of the law can bring a civil suit against that other hospital. The Company believes that it is in compliance with EMTALA and is not aware of any pending or threatened EMTALA investigations involving allegations of potential wrongdoing that would have a material effect on the Company's consolidated financial statements.

See Note 10 regarding the *Affordable Care Act*.

Other Revenues

Other revenues consist primarily of the CMS Rural Floor settlement recognized during the year ended September 30, 2014, meaningful use incentive payments, rental revenue from operating leases, and tuition revenue and totaled $5,436,000 and $13,672,000 for the years ended September 30, 2015 and 2014, respectively.

A summary of other revenues recorded during the years follows:

Rural Floor settlement: Certain of the Company's subsidiaries entered into a settlement agreement with CMS and recognized $6,091,000 of revenue during the year ended September 30, 2014 related to the Rural Floor litigation.

Meaningful Use incentives: The American Recovery and Reinvestment Act of 2009 ("ARRA") established incentive payments under the Medicare and Medicaid programs for certain professionals and hospitals that meaningfully use certified electronic health record ("EHR") technology or adopt or implement such technology. The Medicare incentive payments will be paid out to qualifying hospitals over four consecutive years on a transitional schedule. To qualify for Medicare incentives, hospitals and physicians must meet EHR "meaningful use" criteria that become more stringent over three stages.

Medicaid programs and payment schedules vary from state to state. The Medicaid programs require hospitals to register for the program prior to 2016, to engage in efforts to adopt, implement or upgrade certified EHR technology in order to qualify for the initial year of participation, and to demonstrate meaningful use of certified EHR technology in order to qualify for payment for up to three additional years.

For the years ended September 30, 2015 and 2014, the Company recorded revenues of $1,150,000 and $4,683,000, respectively, related to the Medicare and Medicaid programs in the consolidated statements of income. These incentives have been recognized following the grant accounting model, recognizing income ratably over the applicable reporting period as management becomes reasonably assured of meeting the required criteria. Subsequent changes to these estimates will be recognized in the consolidated statement of operations in the period in which additional information is available. Such estimates are subject to audit by the federal government, the state, or its designee.

Rental Revenue: Rental revenue from operating leases is recorded based on the fixed, minimum required rents (base rents) per the lease agreements. Rental revenue from base rents is recorded on the straight-line method over the terms of the related lease agreements. During the years ended September 30, 2015 and 2014, the Company recorded rental revenues of $2,417,000 and $2,220,000, respectively.

Tuition Revenue: St. Joseph Health Services of Rhode Island operates the St. Joseph School of Nursing and recorded tuition revenue of $1,639,000 and $471,000 during the year ended September 30, 2015 and the period from June 20, 2014 (acquisition date) through September 30, 2014, respectively.

Medical Group Segment

Medical Group Revenues

Operating revenue of the Medical Group segment consists primarily of payments for medical services procured by the Affiliates under capitated contracts with various managed care providers including HMOs. Capitation revenue under HMO contracts is prepaid monthly to the Affiliates based on the number of enrollees electing any one of the Affiliates as their health care provider. See "Concentrations of Credit Risks" below for revenues received from the five largest contracted HMOs.

Capitation revenue (net of capitation withheld to fund risk share deficits discussed below) is recognized in the month in which the Affiliates are obligated to provide services. Minor ongoing adjustments to prior months' capitation, primarily arising from contracted HMOs' finalizing of monthly patient eligibility data for additions or subtractions of enrollees, are recognized in the month they are communicated to the Company. Additionally, Medicare pays capitation using a "Risk Adjustment model," which compensates managed care organizations and providers based on the health status (acuity) of each enrollee. Health plans and providers with higher acuity enrollees will receive more and those with healthier enrollees will receive less. Under Risk Adjustment, capitation is determined based on health severity, measured using patient encounter data. Capitation is paid on an interim basis based on data submitted for the enrollee for the preceding year and is adjusted in subsequent periods (generally in the Company's fourth quarter) after the final data is compiled. Positive or negative capitation adjustments are made for Medicare enrollees with conditions requiring more or less healthcare services than assumed in the interim payments. Since the Company cannot reliably predict these adjustments, periodic changes in capitation amounts earned as a result of Risk Adjustment are recognized generally in the fourth quarter when those changes are communicated by the health plans to the Company. The Company received and recorded as additional revenue, approximately $17,503,000 and $8,889,000, respectively, in positive capitation risk adjustments for the Medical Group segment during the years ended September 30, 2015 and 2014, respectively.

HMO contracts also include provisions to share in the risk for hospitalization, whereby the Affiliate can earn additional incentive revenue or incur penalties based upon the utilization of hospital services. Typically, any shared risk deficits are not payable until and unless the Company generates future risk

sharing surpluses, or if the HMO withholds a portion of the capitation revenue to fund any risk share deficits. At the termination of the HMO contract, any accumulated risk share deficit is typically extinguished. Due to the lack of access to information necessary to estimate the related costs, shared-risk amounts receivable from the HMOs are only recorded when such amounts are known. Risk pools for the prior contract years are generally final settled in the third or fourth quarter of the following fiscal year. For the years ended September 30, 2015 and 2014, Medical Group revenues included approximately $8,402,000 and $2,406,000, respectively, of additional revenues due to favorable settlements on prior year risk-sharing arrangements. At September 30, 2015 and 2014, contingent liabilities for carry-forward risk-pool deficits expected to be forgiven, or offset against future surpluses were approximately $6,422,000 and $5,547,000, respectively, based on the available information from the health plans.

The Company also receives incentives under "pay-for-performance" programs for quality medical care based on various criteria. These incentives, which are included in other revenues within Medical Group revenues, are generally recorded in the third and fourth quarters of the fiscal year when such amounts are known. During the year ended September 30, 2015, the Company recognized $9,059,000 related to a shared savings incentive program with one health plan. Pay-for-performance revenues recorded during the years ended September 30, 2015 and 2014 were $11,387,000 and $1,886,000, respectively.

Management fee revenue is earned in the month the services are rendered. Management fee arrangements with unaffiliated entities provide for compensation ranging from 6.5% to 12% of revenues. Management fee revenues recorded during the years ended September 30, 2015 and 2014 were $7,814,000 and $6,586,000, respectively.

Medical Group Cost of Revenues

The cost of health care services consists primarily of capitation and claims payments, pharmacy costs and incentive payments to contracted providers. These costs are recognized in the period incurred, or when the services are provided. Claims costs also include an estimate of the cost of services which have been incurred but not yet reported to the Company. The estimate for accrued medical costs is based on projections of costs using historical studies of claims paid and adjusted for seasonality, utilization and cost trends. These estimates are subject to trends in loss severity and frequency. Although considerable variability is inherent in such estimates, management records its best estimate of the amount of medical claims incurred at each reporting period. Estimates are continually monitored and reviewed and, as settlements are made or estimates adjusted, differences are reflected in current operations. See Note 12 for changes in claims estimates during the years ended September 30, 2015 and 2014.

In addition to contractual reimbursements to providers, the Company also makes discretionary incentive payments to physicians, which are in large part based on the pay-for-performance and shared risk revenues and favorable senior capitation risk adjustment payments received by the Company. Since the Company records these revenues generally in the third or fourth quarter of each fiscal year when the incentives and capitation adjustments due from the health plans are known, the Company also finalizes the discretionary physician bonuses in the same periods. During the years ended September 30, 2015 and 2014, the Company recorded discretionary physician incentives expense totaling approximately $14,082,000 and $5,067,000, respectively. As of September 30, 2015 and 2014, physician bonus accruals of approximately $9,021,000 and $4,339,000, respectively, were included in accounts payable and other accrued liabilities.

The Company also periodically evaluates the need to establish premium deficiency reserves for the probability that anticipated future health care costs could exceed future capitation payments from HMOs under capitated contracts and, where appropriate, records a premium deficiency reserve.

The Company, for certain matters, maintains stop loss coverage for health care costs that are in excess of set thresholds.

Global Risk Management Segment

Global Risk Management Revenues

Operating revenue of the Global Risk Management segment consists primarily of payments for medical services procured under global capitation arrangements from third-party health plans. Capitation revenue under these global capitation contracts is prepaid monthly to the Global Risk Management segment based on the number of enrollees. Entities within the Global Risk Management segment entered into Management Services Agreements with our Hospital and Medical Group segments, under which 98% of capitation revenue received is transferred to these segments.

Similar to the Medical Group segment, capitation revenue is recognized in the month in which the Global Risk Management segment is obligated to provide services. Minor ongoing adjustments to prior months' capitation, primarily arising from contracted HMOs' finalizing of monthly patient eligibility data for additions or subtractions of enrollees, are recognized in the month they are communicated to the Company. Additionally, Medicare pays capitation using a "Risk Adjustment model," which compensates managed care organizations and providers based on the health status (acuity) of each enrollee. Health plans and providers with higher acuity enrollees will receive more and those with healthier enrollees will receive less. Under Risk Adjustment, capitation is determined based on health severity, measured using patient encounter data. Capitation is paid on an interim basis based on data submitted for the enrollee for the preceding year and is adjusted in subsequent periods (generally in the Company's fourth quarter) after the final data is compiled. Positive or negative capitation adjustments are made for Medicare enrollees with conditions requiring more or less healthcare services than assumed in the interim payments. Since the Company cannot reliably predict these adjustments, periodic changes in capitation amounts earned as a result of Risk Adjustment are recognized generally in the fourth quarter when those changes are communicated by the health plans to the Company. The Global Risk Management Segment did not have any capitation risk adjustments for the year ended September 30, 2015 as it was the segment's first year of operations.

Global Risk Management Cost of Revenues

The cost of health care services consists primarily of the transfer of capitation revenue to the Hospital and Medical Group segments under the Management Services Agreements, and capitation and claims payments. These costs are recognized in the period incurred, or when the services are provided. Claims costs also include an estimate of the cost of services which have been incurred but not yet reported to the Company. The estimate for accrued medical costs is based on projections of costs using historical studies of claims paid and adjusted for seasonality, utilization and cost trends. These estimates are subject to trends in loss severity and frequency. Although considerable variability is inherent in such estimates, management records its best estimate of the amount of medical claims incurred at each reporting period. Estimates are continually monitored and reviewed and, as settlements are made or estimates adjusted, differences are reflected in current operations.

The Company also periodically evaluates the need to establish premium deficiency reserves for the probability that anticipated future health care costs could exceed future capitation payments from HMOs under capitated contracts and, where appropriate, records a premium deficiency reserve.

The Company, for certain matters, maintains stop loss coverage for health care costs that are in excess of set thresholds.

Property, Improvements and Equipment

Property, improvements and equipment are stated on the basis of cost or, in the case of acquisitions, at their acquisition date fair values. Depreciation is provided using the straight-line method over the estimated useful lives of the assets, and amortization of leasehold improvements is provided using the straight-line basis over the shorter of the remaining lease period or the estimated useful lives of the leasehold improvements. Leasehold improvements are generally depreciated over five to ten years, buildings are depreciated over five to 28 years, equipment is depreciated over two to five years and furniture and fixtures are depreciated over two to seven years. Equipment capitalized under capital lease obligations are amortized over the lesser of the life of the lease or the useful life of the asset.

As more fully described in Note 10, the Company is required to comply with certain seismic standards as required by the state of California by January 1, 2020. The useful life of buildings subject to seismic retrofit requirements may be limited if the Company does not make the necessary upgrades by the required compliance date.

Goodwill and Other Intangible Assets

Goodwill totaled $162,296,000 and $158,864,000 at September 30, 2015 and 2014, respectively, and arose as a result of the ProMed, Alta, SCH Culver City, Nix Health (including Nix CGH), and Prospect CharterCARE Physicians medical practices acquisitions. Goodwill represents the excess of the consideration paid and liabilities assumed over the fair value of the net assets acquired, including identifiable intangible assets.

Goodwill is not amortized; rather it is reviewed annually for impairment for each reporting unit, or more frequently if impairment indicators arise. Impairment is the condition that exists when the carrying amount of goodwill exceeds its implied fair value. A two-step impairment test is used to identify potential goodwill impairment and to measure the amount of goodwill impairment loss to be recognized, if any. The Company has five reporting units with goodwill, consisting of the Alta Hospitals (which include SCH Hollywood, SCH Van Nuys, Los Angeles Community Hospital, and Norwalk Community Hospital), SCH Culver City, Nix Health, the MSOs and Medical Groups located in California ("California Medical Groups"), and CharterCARE. The California Medical Groups represent a change in reporting units during the year ended September 30, 2015; see Note 5.

The Company tests for goodwill impairment as of September 30 each year. In evaluating whether indicators of impairment exist, the Company considers adverse changes in market value, laws and regulations, profitability, cash flows, ability to maintain enrollment and renew payer contracts at favorable terms, among other factors. The goodwill impairment test is a two-step process. The first step consists of estimating the fair value of the reporting unit based on a weighted combination of (i) the guideline company method that utilizes revenue or earnings multiples for comparable publicly-traded companies, and (ii) a discounted cash flow model that utilizes expected future cash flows, the timing of those cash flows, and a discount rate (or weighted average cost of capital, which considers the cost of equity and cost of debt financing expected by a typical market participant) representing the time value

of money and the inherent risk and uncertainty of the future cash flows. If the estimated fair value of the reporting unit is less than its carrying value, a second step is performed to compute the amount of the impairment by determining the "implied fair value" of the goodwill, which is compared to its corresponding carrying value. The Company's impairment test related to goodwill during the years ended September 30, 2015 and 2014, resulted in no impairment charge.

Long-Lived Assets and Amortizable Intangibles

Amortizable intangible assets totaled $29,162,000 and $35,274,000, net of accumulated amortization at September 30, 2015 and 2014, respectively, and arose as a result of the ProMed, Alta, SCH Culver City, Nix Health, NGMA, PCC, and CharterCARE Physicians medical practices acquisitions. Intangible assets include customer relationships, trade names, favorable leasehold, and physician guarantees. The Company reviews long-lived assets for impairment whenever events or changes in circumstances indicate that the carrying value of such assets may not be recoverable. The Company considers assets to be impaired and writes them down to fair value if estimated undiscounted cash flows associated with those assets are less than their carrying amounts. Fair value is based upon the present value of the associated cash flows. Changes in circumstances (for example, changes in laws or regulations, technological advances or changes in strategies) may also reduce the useful lives from initial estimates. Changes in planned use of intangibles may result from changes in customer base, contractual agreements, or regulatory requirements. In such circumstances, management will revise the useful life of the long-lived asset and amortize the remaining net book value over the adjusted remaining useful life. There were no impairments recorded during the years ended September 30, 2015 and 2014.

Medical Malpractice Liability Insurance

The individual physicians who contract with the Affiliates carry their own medical malpractice insurance. In the Hospital Services segment, the Company's hospitals carry professional and general liability insurance to cover medical malpractice claims under claims-made policies. Under the policies, insurance premiums cover only those claims actually reported during the policy term. Should the claims-made policy not be renewed or replaced with equivalent insurance, claims related to occurrences during the policy term but reported subsequent to the policy's termination may be uninsured. Effective October 1, 2013, the Company's hospitals renewed the professional and general liability insurance under one consolidated policy with separate retentions for each entity. LACH Bellflower, FRMC, and CharterCARE were included under the consolidated policy from their respective dates of acquisition or inception (LACH Bellflower).

GAAP requires that a health care organization record and disclose the estimated costs of medical malpractice claims in the period of the incident of malpractice, if it is reasonably possible that liabilities may be incurred and losses can be reasonably estimated. The Company has recognized an estimated liability for incurred but not reported claims and the self-insured risks (including deductibles and potential claims in excess of policy limits) based upon an actuarial valuation of the Company's historical claims experience of the Company's hospitals. At September 30, 2015 and 2014, the total gross claims liability was $6,632,000 and $4,590,000 and insurance receivables were $1,406,000 and $618,000, respectively, and were estimated using a discount factor of 4%.

The claims reserve is based on the best data available to the Company. The estimate, however, is subject to a significant degree of inherent variability. The estimate is continually monitored and reviewed, and as the reserve is adjusted, the difference is reflected in current operations. While the ultimate amount of medical malpractice liability is dependent on future developments, management is of the opinion that the associated liabilities recognized in the accompanying consolidated financial

statements are adequate to cover such claims. Management is not aware of any potential medical malpractice claims whose settlement, if any, would have a material adverse effect on the Company's consolidated financial position, results of operations or cash flows.

Workers' Compensation Insurance

The workers' compensation coverage provides the statutory benefits required by law with a $250,000 deductible policy with limits of $1,000,000 per occurrence and aggregate for the hospitals located in California. Nix Health has opted out of the Texas Workers' Compensation system as a non-subscriber, and provides its employees with benefits for occupational injury or disease through an ERISA plan. Nix Health has an Employer's Excess Indemnity policy with a $25,000 deductible policy with limits of $10,000,000 per occurrence and $25,000,000 aggregate. CharterCARE was fully insured for workers' compensation claims with no deductible from June 20, 2014 through September 30, 2015. At September 30, 2015 and 2014, included in accrued salaries, wages and benefits are accruals for uninsured claims and claims incurred but not reported of approximately $8,766,000 and $7,210,000, respectively. The amounts are estimated based upon an actuarial valuation of their claims experience, using a discount factor of 4%.

The claims reserve is based on the best data available to the Company. The estimate, however, is subject to a significant degree of inherent variability. The estimate is monitored and reviewed, and as the reserve is adjusted, the difference is reflected in current operations. While the ultimate amount of the claims liability is dependent on future developments, management is of the opinion that the associated liabilities recognized in the accompanying consolidated financial statements are adequate to cover such claims. Management is not aware of any potential claims whose settlement, if any, would have a material adverse effect on the Company's consolidated financial position, results of operations or cash flows.

Asset Retirement Obligations

The Company recognizes the fair value of a liability for legal obligations associated with asset retirements in the period in which it is incurred, if a reasonable estimate of the fair value of the obligation can be made. Over time, the liability is accreted to its present value each period. Upon settlement of the obligation, any difference between the cost to settle the asset retirement obligation and the liability recorded is recognized as a gain or loss in the statement of operations. The Company has accrued $4,583,000 and $4,310,000 in other long-term liabilities related to asset retirement obligations for the CharterCARE hospitals as of September 30, 2015 and 2014, respectively.

Stock Options

On December 15, 2010, the Board of Directors (the "Ivy Board") of Ivy Holdings adopted the 2010 Stock Option Plan of Ivy Holdings Inc. (the "Ivy Plan") and, on December 16, 2010, the stockholders of Ivy Holdings adopted the Ivy Plan. The Ivy Plan provides that it shall be administered by the Compensation Committee of the Ivy Board. The Ivy Plan includes an Incentive Stock Option Agreement and a Non-Qualified Stock Option Agreement to be used in connection with the grant of options under the Ivy Plan. These options granted under the Ivy Plan are exercisable into Ivy Holdings stock and vest based on a number of criteria.

On June 30, 2015, the Board of Directors of Ivy Holdings adopted the First Amendment to the Ivy Plan and concurrently, on June 30, 2015, the stockholders of Ivy Holdings approved the First Amendment to the Ivy Plan (the "Amended Ivy Plan"). Pursuant to the Amended Ivy Plan, the Board of Directors

authorized the issuance of options exercisable for an additional 13,972 shares of common stock of Ivy Holdings to employees, certain consultants and independent members of the boards of directors of Ivy Holdings and its subsidiaries (including the Company and its subsidiaries). These options granted under the Amended Ivy Plan are exercisable into Ivy Holdings stock and vest based on a number of criteria, including the same criteria as options granted under the Ivy Plan as well as the occurrence of certain corporate transactions, including a change in control of Ivy Holdings, as defined in the Incentive Stock Option Agreements; see Note 9.

Compensation costs for option awards are measured and recognized in the consolidated financial statements based on their grant date fair value, net of estimated forfeitures over the awards' service period. Options subject to variable accounting treatment are subject to revaluation at the end of each reporting period. The Company uses the Black-Scholes option pricing model and a single option award approach to estimate the fair value of stock options granted. The fair value of restricted stock grants are determined on the date of grant, based on the number of shares granted and the quoted price or estimated fair market value of the Company's common stock. Equity-based compensation is classified within the same line items as cash compensation paid to employees. Compensation costs related to stock options that vest or are exercisable when certain corporate transactions occur, including a change in control, are recognized at the time that such an event occurs.

Cash and Cash Equivalents

The Company considers all highly liquid debt instruments with initial maturities of 90 days or less to be cash equivalents. Cash and cash equivalents are primarily comprised of deposits with banks. The Company maintains its cash at banks with high credit-quality ratings.

Restricted Cash

At September 30, 2015 and 2014, $2,000,000 was restricted to meet certain regulatory requirements for PHP. Prospect contributed $2,000,000 of restricted cash to PHP, which is not a guarantor of Prospect's long-term debt, in order for PHP to maintain compliance with tangible net equity requirements (see Note 10). $1,277,000 and $1,993,000 was restricted for research at CharterCARE hospitals as of September 30, 2015 and 2014, respectively. An additional $1,308,000 and $983,000 was restricted for various other purposes including workers' compensation insurance arrangements and various letters of credit as of September 30, 2015 and 2014, respectively.

Restricted Investments

The Company is required to keep restricted deposits by certain HMOs for the payment of claims. Such restricted deposits are classified as a current asset in the accompanying consolidated balance sheets, as they are restricted for payment of current liabilities. Investments also include certificates of deposit with maturity dates of more than 90 days when purchased.

Inventories

Inventories of supplies are valued at the lower of amounts that approximate the weighted average cost or market. Inventories consist primarily of medical and surgical supplies and pharmaceuticals.

Deferred Financing Costs

Deferred financing costs are amortized over the period in which the related debt is outstanding using the effective interest method.

Deferred financing costs at September 30, 2015 and 2014 are as follows (in thousands):

	2015			2014		
	Gross Book Value	Accumulated Amortization	Net Book Value	Gross Book Value	Accumulated Amortization	Net Book Value
Deferred financing costs	$14,398	$7,165	$7,233	$14,398	$4,941	$9,457

Income Taxes

Deferred income tax assets and liabilities are recognized for differences between financial and income tax reporting bases of assets and liabilities based on enacted tax rates and laws. To the extent a deferred tax asset cannot be recognized under the preceding criteria, allowances must be established. The impact on deferred taxes of changes in tax rates and laws, if any, are applied to the years during which temporary differences are expected to be settled and reflected in the financial statements in the period of enactment. The Company recognizes interest and penalties associated with income tax matters and unrecognized tax benefits in the income tax expense line item of the statements of operations. For the years ended September 30, 2015 and 2014, no interest and/or penalties related to incomes taxes were accrued and/or expensed.

An entity is required to evaluate its tax positions using a two-step process. First, the entity should evaluate the position for recognition. An entity should recognize the financial statement benefit of a tax position if it determines that it is more likely than not that the position will be sustained on examination. Next, the entity should measure the amount of benefit that should be recognized for those tax positions that meet the more-likely-than-not test.

Consolidated federal tax returns are filed, with the exception of PMG and NGMA, which file their own federal tax returns. The Company files separate state tax returns for California, Texas, and Rhode Island. The Company's filed tax returns are generally subject to examination by the IRS and state tax boards for 3 to 4 years.

Fair Value of Financial Instruments

Financial instruments consist primarily of cash and cash equivalents, restricted cash investments, patient and other accounts receivables, accrued salaries and benefits, accounts payable and accrued expenses, medical claims and related liabilities, amounts due to government agencies, notes receivable and payable, capital lease obligations, debt, and other liabilities. The carrying amounts of current assets and liabilities approximate their fair value due to the relatively short period of time between the origination of the instruments and their expected realization.

Fair Value Measurement

Relevant accounting guidance establishes a framework for measuring fair value and clarifies that fair value is an exit price, representing the amount that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants.

The guidance requires disclosure about how fair value is determined for assets and liabilities and establishes a hierarchy for which these assets and liabilities must be grouped, based on significant levels of inputs as follows: Level 1 quoted prices in active markets for identical assets or liabilities; Level 2 quoted prices in active markets for similar assets and liabilities and inputs that are observable for the asset or liability; or Level 3 unobservable inputs for the asset or liability, such as discounted cash flow models or valuations. The determination of where assets and liabilities fall within this hierarchy is based upon the lowest level of input that is significant to the fair value measurement.

The Company's Level 1 assets include cash and cash equivalents and investments (certificates of deposit and money market mutual funds). The inputs for fair value of goodwill and intangible assets (including long lived assets and intangible assets subject to amortization) would be based on Level 3 inputs as data used for such fair value calculations would be based on discounted cash flows that are not observable from the market, directly or indirectly.

Financial Items Measured at Fair Value on a Recurring Basis

The following table sets forth the Company's financial assets and liabilities measured at fair value on a recurring basis and where they are classified within the hierarchy (in thousands):

	Total	Level 1	Level 2	Level 3
As of September 30, 2015				
Certificates of deposit and money market mutual funds	$ 1,266	$ 1,266	$ -	$ -
As of September 30, 2014				
Certificates of deposit and money market mutual funds	$ 642	$ 642	$ -	$ -

The Company's investments are classified within Level 1 of the fair value hierarchy because they are valued using quoted market prices.

Nonfinancial Items Measured at Fair Value on a Nonrecurring Basis

Nonfinancial assets such as goodwill and identifiable intangible assets are measured at fair value when there is an indicator of impairment and recorded at fair value only when impairment is recognized. The Company performs an annual impairment test on the goodwill, and performs an impairment test on the intangibles when there are indications of impairment.

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Significant increases or decreases in the Company's weighted average cost of capital may result in a significantly lower or higher fair value measurement, respectively. Significant increases or decreases in the revenue growth rate and royalty rates in isolation may result in a significantly higher or lower fair value measurement, respectively. The fair values of the Company's current financial liabilities approximate their reported carrying amounts. The carrying values and the fair values of non-current financial liabilities that qualify as financial instruments under the guidance are as follows (in thousands):

	2015		2014	
September 30,	Carrying Amount	Fair Value	Carrying Amount	Fair Value
Liabilities:				
Long-term debt	$ 422,835	$ 445,269	$ 421,888	$ 457,620

The fair value of the Company's long-term debt was determined based on market prices.

Concentrations of Credit Risk

Cash and cash equivalents are maintained at financial institutions and, at times, balances may exceed federally insured limits of $250,000 per depositor of each financial institution. The Company has not experienced any losses to date related to these balances.

Financial instruments that potentially subject the Company to concentrations of credit risk consist of receivables due from Medicare, Medicaid (Medi-Cal in California), patients, and health plans including shared-risk arrangements.

The Company invests excess cash in liquid securities at institutions with strong credit ratings, following established guidelines relative to diversification and maturities to maintain safety and liquidity. These guidelines are periodically reviewed and modified to take into consideration trends in yields and interest rates and principal risk. Management attempts to schedule the maturities of the Company's investments to coincide with the Company's expected cash requirements. Credit risk with respect to receivables is limited since amounts are generally due from large HMOs within the Medical Group Management segment and from the Medicare and Medicaid (Medi-Cal in California) programs within the Hospital Services segment. Management reviews the financial condition of these institutions on a periodic basis and does not believe the concentration of cash or receivables results in a high level of risk.

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For the years ended September 30, 2015 and 2014, the Hospital Services segment received a total of 67% of its net patient revenues from Medicare and Medicaid programs, and the Medical Group segment received a total of 59% and 58%, respectively, of their capitation revenues from its five largest HMOs, as follows (in thousands):

Years Ended September 30,	2015	% of Total Revenue	2014	% of Total Revenue
Hospital Services:				
Government Payers:				
Medicare	$ 321,282	31%	$ 224,984	36%
Medicaid	379,821	36%	189,668	31%
Total	$ 701,103	67%	$ 414,652	67%
Medical Group:				
HMO A	$ 39,759	13%	$ 12,721	5%
HMO B	38,934	12%	33,784	14%
HMO C	37,900	12%	31,632	13%
HMO D	34,806	11%	31,481	13%
HMO E	32,239	11%	31,283	13%
Total	$ 183,638	59%	$ 140,901	58%

The Global Risk Management segment received 100% of their revenues from four health plans during the year ended September 30, 2015.

Use of Estimates

The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets, liabilities, revenues and expenses, and the disclosure of contingent assets and liabilities at the dates, and for the periods, that the consolidated financial statements are prepared. Actual results could materially differ from those estimates. Principal areas requiring the use of estimates include third party settlements, settlements under risk sharing programs, allowances for contractual discounts and doubtful accounts, accruals for medical claims, impairment of goodwill, long-lived assets and intangible assets, share-based payments, professional and general liability claims and workers' compensation claims, reserves for outcome of legislation and valuation allowances against deferred tax assets.

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New Accounting Pronouncements

In July 2013, the Financial Accounting Standards Board ("FASB") issued an Accounting Standards Update ("ASU") that requires an unrecognized tax benefit or portion of an unrecognized tax benefit to be presented as a reduction to a deferred tax asset for a net operating loss carryforward, a similar tax loss, or a tax credit carryforward except when certain conditions exist. The amendment is effective for the Company for fiscal years beginning after December 15, 2014, including interim periods in 2014. The Company is currently evaluating the effect of this guidance on its consolidated results of operations and consolidated financial position.

In May 2014, the FASB issued ASU No. 2014-09, "Revenue from Contracts with Customers (ASU 2014-09)," as amended by ASU 2015-14. The core principle of ASU 2014-09 is built on the contract between a vendor and a customer for the provision of goods and services, and attempts to depict the exchange of rights and obligations between the parties in the pattern of revenue recognition based on the consideration to which the vendor is entitled. To accomplish this objective, the standard requires five basic steps: (i) identify the contract with the customer, (ii) identify the performance obligations in the contract, (iii) determine the transaction price, (iv) allocate the transaction price to the performance obligations in the contract, (v) recognize revenue when (or as) the entity satisfies a performance obligation. Nonpublic entities will apply the new standard for annual periods beginning after December 15, 2018, including interim periods therein. Three basic transition methods are available – full retrospective, retrospective with certain practical expedients, and a cumulative effect approach. Under the third alternative, an entity would apply the new revenue standard only to contracts that are incomplete under legacy U.S. GAAP at the date of initial application (e.g. January 1, 2019) and recognize the cumulative effect of the new standard as an adjustment to the opening balance of retained earnings. That is, prior years would not be restated and additional disclosures would be required to enable users of the financial statements to understand the impact of adopting the new standard in the current year compared to prior years that are presented under legacy U.S. GAAP. Early adoption is permitted for fiscal years beginning after December 15, 2016. The Company is currently evaluating the effect of this guidance on its consolidated financial statements.

In August 2014, the FASB issued ASU No. 2014-15, "Presentation of Financial Statements - Going Concern: Disclosures of Uncertainties about an Entity's Ability to Continue as a Going Concern." This ASU provides guidance about management's responsibility to evaluate whether there is substantial doubt about an entity's ability to continue as a going concern and to provide related footnote disclosures. Specifically, this ASU provides a definition of the term substantial doubt and requires an assessment for a period of one year after the date that the financial statements are issued (or available to be issued). It also requires certain disclosures when substantial doubt is alleviated as a result of consideration of management's plans and requires an express statement and other disclosures when substantial doubt is not alleviated. The new standard will be effective for reporting periods beginning after December 15, 2016, with early adoption permitted. The Company will apply the provisions of this standard upon adoption.

In April 2015, the FASB issued ASU No. 2015-03, "Simplifying the Presentation of Debt Issuance Costs." This ASU amends existing guidance to require the presentation of debt issuance cost on the balance sheet as a deduction from the carrying amount of the related debt, instead of an asset. This ASU is effective for reporting periods beginning after December 15, 2015 and early adoption is permitted. The Company is currently evaluating the effect of this guidance on its consolidated financial statements.

In November 2015, the FASB issued ASU No. 2015-17, "Income Taxes (Topic 740), Balance Sheet Presentation of Deferred Tax Assets and Liabilities". This ASU amends existing guidance by simplifying the presentation of deferred income taxes on a net basis as non-current deferred tax assets or liabilities. ASU No. 2015-17 did not modify the requirement that deferred tax assets and liabilities of a tax-paying component of an entity be offset and presented as a single amount. This ASU is effective for reporting reports beginning after December 15, 2017 with earlier adoption permitted.

The Company elected early adoption of ASU No. 2015-17 effective October 1, 2013. The previous requirement to separate deferred income tax assets and liabilities into current and non-current amounts was not beneficial to the users of the consolidated financial statements as classification did not necessarily align with the time period in which the recognized deferred tax amounts were expected to be recovered or settled.

The following table discloses the impact of the adoption of ASU No. 2015-17 on the amounts previously reported in the consolidated balance sheet (in thousands):

Balance Sheet as of September 30, 2014	As Previously Reported	Impact of ASU No. 2015-17	As Reported
Deferred income taxes, net (current asset)	$ 68,304	$ (68,304)	$ -
Total current assets	$ 320,014	$ (68,304)	$ 251,710
Deferred income taxes, net (long-term asset)	$ -	$ 1,165	$ 1,165
Total assets	$ 761,317	$ (67,139)	$ 694,178
Deferred income taxes, net (long-term liability)	$ 70,447	$ (67,139)	$ 3,308
Total liabilities	$ 762,523	$ (67,139)	$ 695,384
Total liabilities and stockholder's equity	$ 761,317	$ (67,139)	$ 694,178

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3. Property, Improvements and Equipment

Property, improvements and equipment, consisted of the following (in thousands):

September 30,	2015	2014
Property, improvements and equipment:		
Land and land improvements	$ 53,416	$ 53,381
Buildings and improvements	136,137	119,163
Leasehold improvements	20,344	22,967
Equipment	107,785	87,249
Furniture and fixtures	6,891	7,187
	324,573	289,947
Less: accumulated depreciation	(84,236)	(60,473)
Property, improvements and equipment, net	$ 240,337	$ 229,474

Effective May 6, 2014, Prospect acquired the property, improvements, and equipment of Bellflower Medical Center, located in Bellflower, California, for cash consideration of $20 million. The assets, including land and building, were named Los Angeles Community Hospital at Bellflower. Bellflower Medical Center was closed in 2013 by its previous owner and was not operational when the Company purchased the related assets. The Company accounted for this transaction as an acquisition of assets. The primary factors influencing the determination that the acquisition should be accounted for in this manner included the complete closure of the hospital, the fact that there were no inputs and/or processes acquired, the requirement for significant additional capital expenditures and development efforts to reopen the hospital, and the lack of acquired workforce. Accordingly, the Company determined that this transaction lacked the key characteristics for business combination accounting. In addition to the $20 million purchase price, Prospect capitalized $546,000 of transaction costs directly related to the purchase of these assets. The purchase price and transaction costs were allocated to the assets acquired based on the relative fair value of the acquired assets.

At September 30, 2015 and 2014, the Company had assets under capitalized leases of approximately $20,299,000 and $19,294,000, respectively, and related accumulated depreciation of $14,356,000 and $11,465,000, respectively.

Depreciation expense was approximately $27,692,000 and $18,386,000 for the years ended September 30, 2015 and 2014, respectively.

4. Acquisitions

CharterCARE Physicians Medical Practices

During the year ended September 30, 2015, CharterCARE Physicians entered into asset purchase agreements to acquire 11 medical practices with primary care physicians as well as physicians with specialties in general surgery, bariatric surgery and urology. Total cash consideration for the medical practices was $3,865,000, with cash consideration for each practice ranging from $9,000 to $2,100,000.

The acquisitions of the medical practices were accounted for as a business combination using purchase accounting. Under the purchase accounting method, assets acquired and liabilities assumed are recorded based on their estimated fair values.

The following table summarizes the assets acquired and liabilities assumed in connection with the CharterCARE Physician medical practices acquisitions (in thousands):

	Purchase Price Allocation (Preliminary)
Inventory	$ 8
Improvements and equipment	328
Intangible assets	97
Goodwill	3,432
Net cash consideration	$ 3,865

As asset purchases, the goodwill and intangible assets acquired are deductible for tax purposes.

University Medical Group

Effective December 18, 2014, New University Medical Group ("New UNMG"), a wholly-owned subsidiary of RWMC, entered into an Asset Purchase Agreement, pursuant to which New UNMG will acquire substantially all of the assets of University Medical Group ("UNMG"), a physician medical practice with approximately 35 primary care and specialist physicians with various specialties. As consideration for the acquisition, New UNMG will assume certain liabilities of UNMG.

As of December 18, 2014, New UNMG acquired certain assets of the practice and assumed certain liabilities related to the administrative functions of UNMG ("Initial Close"). At a later date, New UNMG will acquire certain additional assets and assume certain additional liabilities ("Second Close"). Concurrent with the Initial Close, UNMG and New UNMG entered into an Interim Administrative Services Agreement, which is effective until the Second Close occurs. New UNMG also entered into the First Amendment to the Interim Administrative Services Agreement effective December 18, 2014. In addition, Prospect, RWMC and CharterCARE Physicians have receivables from various transactions of $4,345,000 due from UNMG as of September 30, 2015, which are included in other assets in the accompanying consolidated balance sheet.

Because Second Close had not occurred as of September 30, 2015, the acquisition of UNMG is not reported in the accompanying consolidated financial statements. As a result of the Asset Purchase Agreement, Interim Administrative Services Agreement (as amended), and various transactions, New UNMG has the obligation to absorb certain losses of UNMG and the right to receive certain benefits from UNMG. However, New UNMG does not have the power to direct the activities of UNMG which most significantly impact its performance based on the terms of the Interim Administrative Services Agreement (as amended) and the governance of UNMG. As a result, New UNMG is not the primary beneficiary of UNMG, and the results of UNMG are not consolidated in the accompanying consolidated financial statements.

Newport Specialty Hospital

Effective May 6, 2014, Prospect acquired substantially all of the assets of Newport Specialty Hospital (subsequently renamed Foothill Regional Medical Center) for cash consideration of $15 million. Newport Specialty Hospital, located in Tustin, California was substantially closed prior to acquisition, operating only its pediatric subacute unit as of the acquisition date.

The acquisition of Newport Specialty Hospital was accounted for as a business combination using purchase accounting. This transaction resulted in a bargain gain of $523,000, which is included in other income in the accompanying consolidated statements of income. The Company incurred $556,000 of transaction costs during the year ended September 30, 2014, which are included in General and Administrative expenses in the accompanying consolidated statements of income.

The following table summarizes the assets acquired and liabilities assumed in connection with the Newport Specialty Hospital acquisition, as of May 6, 2014 (in thousands):

	Purchase Price Allocation
Property, improvements and equipment	$ 15,523
Bargain purchase gain	(523)
Net cash consideration	$ 15,000

CharterCARE

Effective June 20, 2014, Prospect, through its newly formed subsidiary, PCC, acquired substantially all of the assets of CharterCARE Health Partners and its subsidiaries in exchange for a 15% interest in PCC, $43.3 million in cash and a commitment to invest at least $50 million in PCC and its subsidiaries for strategic business development and capital improvements over the next four years. As a result of the acquisition, PCC is owned 85% by Prospect and 15% by CharterCARE Health Partners (which was subsequently renamed CharterCARE Community Board).

PCC, through its subsidiaries, operates Roger Williams Medical Center, St. Joseph Health Services of Rhode Island, and Elmhurst Extended Care Facilities, Inc., which operate hospitals, medical centers and assisted living facilities located in Rhode Island with approximately 785 licensed beds.

The acquisition was accounted for as a business combination using purchase accounting. This transaction resulted in a bargain gain of $4,294,000 during the year ended September 30, 2014. Subsequent to September 30, 2014, PCC received $2,125,000 for a working capital adjustment, which is reflected in prepaid expenses and other current assets resulting in an increase in net assets acquired by Prospect and the non-controlling interest. The gain on bargain purchase was reduced by $319,000 during the year ended September 30, 2015, which is the non-controlling interest's 15% interest in the working capital adjustment. The gain on bargain purchase recognized during the years ended September 30, 2015 and 2014 are included in adjustment to (gain on) bargain purchase in the accompanying consolidated statements of income.

The following table summarizes the assets acquired and liabilities assumed in connection with the PCC acquisition, as of June 20, 2014 (in thousands):

	Purchase Price Allocation (Preliminary)	Purchase Price Allocation (Final)
Restricted cash	$ 1,739	$ 1,739
Patient accounts receivable and other receivables	34,264	34,264
Prepaid expenses and other current assets	8,777	10,902
Property, improvements and equipment	53,642	53,642
Intangible assets	8,590	8,590
Other long-term assets	4,698	4,698
Accounts payable and other liabilities	(44,656)	(44,656)
Capital leases	(1,315)	(1,315)
Long-term debt	(25)	(25)
Other long-term liabilities	(4,645)	(4,645)
Net assets acquired	61,069	63,194
Less: amount attributable to non-controlling interest	(9,160)	(9,479)
Net assets acquired by Prospect	51,909	53,715
Total purchase consideration	47,615	49,740
Bargain purchase gain	$ 4,294	$ 3,975

The change in prepaid expenses and other current assets from the preliminary to the final purchase price allocation was due to the working capital adjustment of $2,125,000. The total purchase consideration of $49,740,000 includes net cash consideration of $43,300,000 plus a long-term liability of $6,440,000, which represents the discounted fair value of the non-controlling interest's 15% interest in the $50 million future commitment of the Company to PCC as part of the Purchase Agreement.

During the year ended September 30, 2015, the Company partially satisfied its $50 million future commitment by contributing $9,637,000 to PCC, of which $1,446,000, or 15%, was attributed to the non-controlling interest in PCC. The Company incurred $2,145,000 of transaction costs during the year ended September 30, 2014, which are included in General and Administrative expenses in the accompanying consolidated statements of income.

5. Goodwill and Intangible Assets

As of September 30, 2015 and 2014, goodwill and intangible assets relate to the ProMed, Alta, SCH Culver City, Nix Health, NGMA, Nix CGH, CharterCARE Physicians medical practices acquisitions. The Company performed its annual goodwill impairment analysis for each reporting unit that constitutes a business for which 1) discrete financial information is produced and reviewed by management, and 2) services that are distinct from the other reporting units.

During the year ended September 30, 2015, the Company reorganized its reporting structure for the Medical Group segment due to changes in financial information produced and reviewed by management and the convergence of the economic characteristics of the MSOs and Medical Groups located in

California. Prior to the reorganization of the reporting structure, the Medical Group segment was comprised of two reporting units: PHCA and the ProMed Entities (collectively referred to as the "ProMed IPAs") as well as PMS and the other affiliated physician organizations, including NGMA (collectively, "Prospect IPAs"). As a result of the reorganization of reporting structure, the MSOs and Medical Groups located in California comprise a single reporting unit (collectively, "California Medical Groups").

For the Hospital Services segment, the reporting unit for the annual goodwill impairment analysis has been determined to be at the business unit level. Reporting units consist of Alta Hospitals, SCH Culver City, Nix Health, and CharterCARE.

The carrying value of goodwill by reporting unit is as follows (in thousands):

September 30,	2015	2014
Alta Hospitals	$ 106,539	$ 106,539
SCH Culver City	24,373	24,373
Nix Health	5,613	5,613
CharterCARE	3,432	-
California Medical Groups	22,339	22,339
	$ 162,296	$ 158,864

The following is a roll-forward of goodwill from October 1, 2013 to September 30, 2015 (in thousands):

	Amount
Balance, October 1, 2013	$ 158,864
Balance, September 30, 2014	158,864
Acquisition of CharterCARE Physicians medical practices (see Note 4)	3,432
Balance, September 30, 2015	$ 162,296

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Identifiable intangible assets are comprised of the following (in thousands):

	September 30, 2015						
	Alta	SCH Culver City	Nix Health	Charter CARE (1)	Prospect	Promed	Total
HMO membership	$ -	$ -	$ -	$ -	$ -	$ 25,200	$ 25,200
Trade names, net of impairment	10,310	1,320	2,740	8,590	-	9,450	32,410
Favorable leasehold	-	-	20	-	-	-	20
Physician guarantees	-	-	1,530	-	-	-	1,530
Customer relationships	-	-	-	-	350	-	350
Other	-	-	-	97	-	-	97
Gross carrying value	10,310	1,320	4,290	8,687	350	34,650	59,607
Accumulated amortization	(4,361)	(880)	(2,964)	(2,200)	(150)	(19,890)	(30,445)
Intangible assets, net	$ 5,949	$ 440	$ 1,326	$ 6,487	$ 200	$ 14,760	$ 29,162

(1) CharterCARE includes intangible assets related to the acquisitions of CharterCARE effective June 20, 2014 and various CharterCARE Physicians acquisitions effective on various dates during the year ended September 30, 2015 (see Note 4).

	September 30, 2014						
	Alta	SCH Culver City	Nix Health	Charter CARE	Prospect	Promed	Total
HMO membership	$ -	$ -	$ -	$ -	$ -	$ 25,200	$ 25,200
Trade names, net of impairment	10,310	1,320	2,740	8,590	-	9,450	32,410
Favorable leasehold	-	-	20	-	-	-	20
Physician guarantees	-	-	1,596	-	-	-	1,596
Customer relationships	-	-	-	-	350	-	350
Gross carrying value	10,310	1,320	4,356	8,590	350	34,650	59,576
Accumulated amortization	(3,670)	(440)	(2,171)	(482)	(100)	(17,439)	(24,302)
Intangible assets, net	$ 6,640	$ 880	$ 2,185	$ 8,108	$ 250	$ 17,211	$ 35,274

During the years ended September 30, 2015 and 2014, intangibles related to physician guarantees of $539,000 and $487,000, respectively, were fully amortized and removed from intangible assets.

Amortization is recognized on a straight-line basis (management's best estimate of the period of economic benefit) over the respective useful lives and expense for the years ended September 30, 2015 and 2014 was $6,682,000 and $5,194,000, respectively.

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Estimated amortization expense for each future fiscal year is as follows (in thousands):

Years ended September 30,	
2016	$ 6,312
2017	5,155
2018	4,635
2019	4,099
2020	2,813
Thereafter	6,148
Total	$ 29,162

The following table shows the estimated useful lives for each of the intangible assets:

	Estimated useful lives
HMO membership	14 years
Trade names	3 - 20 years
Favorable leasehold	6 years
Physician guarantees	2 to 3 years
Customer relationships	7 years
Other	5 years

The weighted-average remaining useful life for the intangible assets was 6.4 years as of September 30, 2015.

6. Related Party Transactions

Jeereddi Prasad, M.D., a shareholder of Ivy Holdings, a director of Ivy Holdings and the Company, and an officer of the ProMed Entities, has ownership interests in physician medical groups that provide medical services to ProMed members, including CMG. For the years ended September 30, 2015 and 2014, the ProMed Entities paid these groups approximately $18,170,000 and $12,677,000, respectively. As of September 30, 2015 and 2014, the Company had accounts payable and other accrued liabilities due to these related parties of $531,000 and none, respectively.

Pursuant to a Management Services Agreement, dated December 15, 2010 and amended on May 3, 2012 (the "LGP Management Agreement"), between the Company and Leonard Green & Partners, L.P. ("LGP"), a private equity fund with affiliated funds that collectively constitute the majority shareholder of Ivy Holdings, LGP provides to the Company, (a) certain investment banking services, (b) management, consulting and financial planning services and (c) financial advisory and investment banking services in connection with major financial transactions from time to time. In consideration for the services provided by LGP under the LGP Management Agreement, the Company pays LGP an annual fee of $1,000,000, payable in monthly installments, and reimburses LGP for its related expenses up to $50,000 annually. If approved by the unanimous consent of the Board of Directors of the Company, additional customary fees may be due to LGP pursuant to the terms of the LGP Management Agreement for services rendered in connection with major transactions from time to time. No amounts were payable related to these related party transactions as of September 30, 2015 or 2014.

The Company is a wholly-owned indirect subsidiary of Ivy Holdings. Therefore, Ivy Holdings is the parent of an affiliated group of corporations within the meaning of Section 1504(a) of the Internal Revenue Code of 1986. On December 15, 2010, Ivy Holdings, Ivy Intermediate and the Company entered into a Tax Sharing Agreement. The Tax Sharing Agreement allows the Company to make payments to Ivy Holdings as necessary to fund their payment of any required taxes incurred due to such parent status. During the years ended September 30, 2015 and 2014, the Company made payments under this arrangement of $24,977,000 and $5,703,000, respectively.

7. Income Taxes

The components of the income tax provision are as follows (in thousands):

For the years ended September 30,	2015	2014
Current:		
Federal	$ 35,445	$ 14,430
State	9,709	4,242
	45,154	18,672
Deferred:		
Federal	(12,957)	(4,529)
State	(1,051)	(3,582)
	(14,008)	(8,111)
Total:		
Federal	22,488	9,901
State	8,658	660
	$ 31,146	$ 10,561

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Temporary differences and carry forward items that result in deferred income tax balances as of September 30, are as follows (in thousands):

September 30,	2015	2014
Deferred tax assets:		
State tax benefit	$ 2,306	$ 2,593
Allowances for bad debts	7,889	5,119
Vacation accrual and other	4,800	5,440
Workers compensation	3,991	2,656
Accrued bonuses	4,837	3,898
Malpractice reserves	2,546	1,952
Deferred rent	139	107
Enterprise zone tax credit	1,261	2,433
Net operating losses	302	8,789
Partnership outside basis difference	8,323	-
Capital loss carryforward	-	2,274
Other	157	359
Deferred tax assets	36,551	35,620
Valuation allowance	(984)	(10,737)
Net deferred tax assets	35,567	24,883
Deferred tax liabilities:		
Intangible assets	(6,448)	(7,247)
Fixed assets	(17,035)	(17,664)
Deferred compensation	-	(112)
Partnership outside basis difference	-	(1,982)
Prepaid expenses	-	(21)
Other	(219)	-
Deferred tax liabilities	(23,702)	(27,026)
Net deferred tax assets (liabilities)	$ 11,865	$ (2,143)

Deferred tax assets and liabilities reflect the effect of temporary differences between the assets and liabilities recognized for financial reporting purposes and the amounts recognized for income tax purposes.

As of September 30, 2014, the Company had a valuation allowance of $10,737,000 related to deferred tax assets. Certain deferred tax assets, including carryforwards of net operating losses and capital losses, were written off due to the inability to use certain carryovers as a result of IRC 382 limitations, as well as due to the carry over expiration during the year ended September 30, 2015. However, such removal had no impact on the income tax provision because of the corresponding impact of the change in the valuation allowance. As of September 30, 2015, the Company maintains a valuation allowance of $984,000 on a certain portion of the California Enterprise credit and net operating losses of non-consolidated and separately filed entities for federal and state purposes, as it is more likely than not that the deferred tax asset will not be realized.

As of September 30, 2015, the Company has $1,261,000 of California Enterprise Zone credit carryforwards which can be carried over indefinitely. The Company has approximately $483,000 and $1,506,000 of net operating loss carryforwards for federal and California which expire through September 30, 2036 and September 30, 2026, respectively.

The Company is currently undergoing an IRS examination for fiscal year 2012. Additionally, the Company received a notice of review from the Franchise Tax Board of California for refunds claimed on its California returns reflecting additional Enterprise tax credits.

Generally, the Company's tax years 2011 through 2014 are open for state tax examination. As of September 30, 2015, the Company does not have material unrecognized tax benefits. The Company believes that it is reasonably possible that an increase in unrecognized tax benefits may be necessary within the coming year, and these unrecognized tax benefits would primarily impact deferred taxes and taxes payable, and the expected range of potential increase in the unrecognized tax benefits is not expected to be material to the balance sheet nor the income statement.
The FASB issued ASU No. 2015-17, which requires entities to offset deferred tax assets and liabilities for each tax paying jurisdiction within each tax paying component. The deferred taxes must be reported as non-current. The Company elected early adoption of the ASU (see Note 2 under New Accounting Pronouncements).

The differences between the income tax provision at the federal statutory rate and that reflected in the accompanying consolidated statements of operations are summarized as follows:

For the years ended September 30,	2015	2014
Tax provision at statutory rate	35%	35 %
State taxes, net of federal benefit	7%	6 %
Enterprise zone tax credits	0%	(7)%
Other	6%	2 %
	48%	36 %

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8. Long-Term Debt

Long-term debt consists of the following (in thousands):

September 30,	2015	2014
Prospect's debt:		
Senior secured notes		
2019 Notes	$ 325,000	$ 325,000
Less: discount, net	(4,950)	(6,339)
	320,050	318,661
Additional 2019 Notes	100,000	100,000
Plus: premium, net	1,110	1,419
	101,110	101,419
	421,160	420,080
Nix Health's debt:		
Mortgage debt	1,675	1,801
Other debt:	-	7
Total Debt:	422,835	421,888
Less: current maturities	(135)	(133)
Long-term debt, net of current maturities	$ 422,700	$ 421,755

Prospect's Debt:

Senior Secured Notes

On May 3, 2012, the Company closed the offering of $325 million in 8.375% senior secured notes due May 1, 2019 ("PMH 2019 Notes"). Interest is payable semi-annually in arrears on May 1 and November 1, commencing on November 1, 2012. The offering was executed in accordance with Rule 144A and Regulation S under the Securities Act of 1933. The terms of the PMH 2019 Notes are governed by an indenture among the Company, certain of its subsidiaries and affiliates (as "Guarantors"), and U.S. Bank National Association (as trustee) (the "Indenture"). The Indenture contains certain covenants that, among other things, limit the Company's ability, and the ability of its restricted subsidiaries (as such term is defined in the Indenture) to: retire and pay dividends or distributions on capital stock or equity interests, prepay subordinated indebtedness or make other restricted payments; incur additional debt; make investments; create liens on assets; enter into transactions with affiliates; engage in other businesses; sell or issue capital stock of restricted subsidiaries; merge or consolidate with another company; transfer and sell assets; create dividend and other payment restrictions affecting subsidiaries; and designate unrestricted subsidiaries. The Credit Agreement (defined below), executed in connection with the PMH Senior Secured Credit Facility (discussed below), contains a number of customary covenants as well as covenants requiring the Company to maintain a maximum consolidated secured leverage ratio and limiting the amount of capital expenditures.

Concurrent with the issuance of the PMH 2019 Notes, the Company entered into a five year $50 million revolving senior secured credit facility (the "PMH Senior Secured Credit Facility") which replaced the existing senior secured credit facility. The PMH Senior Secured Credit Facility provides, among other things, for borrowings up to the amount of the facility with sublimits of up to (i) $20 million to be available for the issuance of letters of credit and (ii) $10 million to be available for swingline loans. The commitment under the facility may be increased by up to $10 million upon the Company's request at the discretion of the lenders and subject to certain customary requirements. The interest rate per annum applicable to loans under the PMH Senior Secured Credit Facility will be, at the Company's option, either a rate per annum equal to (i) LIBOR plus 3.50% or (ii) an alternate base rate, which will be the higher of the administrative agent's prime rate, the federal funds rate plus 0.50%, and the 1-month LIBOR rate plus 1.00%, plus in each case, 2.50%. In August 2013, the PMH Senior Secured Credit Facility limit was increased to $60 million. As of September 30, 2015 and 2014, the Company had $20 million outstanding debt related to the PMH Senior Secured Credit Facility. As of September 30, 2015, the interest rate for the PMH Senior Secured Credit Facility was 3.95%.

The PMH 2019 Notes and the PMH Senior Secured Credit Facility are jointly and severally guaranteed on a senior secured basis by all of the Company's subsidiaries (as such term is defined in the Indenture) other than AMVI/Prospect Medical Group, Nuestra, PHP and certain immaterial subsidiaries. The PMH 2019 Notes are secured pari passu with the PMH Senior Secured Credit Facility by first-priority Liens and security interests on substantially all of the tangible and intangible assets of the Guarantors, including, but not limited to, the accounts receivable, inventories, other personal property, real property, fixtures and equipment, in each case now owned or hereafter acquired by the Company and the Subsidiary Guarantors, with certain exceptions. The PMH 2019 Notes are effectively senior to all of the Guarantors' existing and future Indebtedness.

The terms of the PMH Senior Secured Credit Facility are governed by the Credit Agreement, dated as of May 3, 2012, (as amended in connection with the Company's November 2012 offering of additional PMH 2019 Notes - see below) among the Company, Morgan Stanley Senior Funding, Inc. (as administrative agent), Royal Bank of Canada and Credit Suisse AG, Cayman Islands Branch (as co-syndication agents) and the lenders party thereto (the "Credit Agreement").

The Company, at its option, may redeem all or part of the notes at a redemption price equal to 106.281%, 104.188%, 102.094% and 100.0% on or after May 1, 2015, 2016, 2017 and 2018, respectively. Prior to May 1, 2015, the Company, at its option, may (i) redeem up to 35% of the original principal amount of the notes with the proceeds of certain equity offerings at a redemption price of 108.375% (ii) redeem up to 10% of the original principal amount of the PMH 2019 Notes during each 12-month period, commencing on May 1 in each of 2012, 2013 and 2014, at a redemption price of 103.0% of the principal amount thereof (this redemption option was terminated in connection with the Company's November 2012 offering of additional PMH 2019 Notes) or (iii) redeem the PMH 2019 Notes, in whole, but not in part, at a redemption price of 100.0% of the aggregate principal plus a make-whole premium. There are no required principal payments on the PMH 2019 Notes until maturity.

On November 16, 2012, the Company closed the offering of $100 million in aggregate principal amount of 8.375% senior secured notes due 2019 (the "Additional 2019 Notes") at a price equal to 102% of the principal amount of the Additional 2019 Notes. The Additional 2019 Notes were issued in a private placement to qualified institutional buyers and form a part of the same series as the PMH 2019 Notes issued on May 3, 2012.

The Additional 2019 Notes were issued under the Indenture, dated May 3, 2012 and described above, as supplemented by two supplemental indentures entered into in connection with the issuance of the

Additional 2019 Notes (the "Supplemental Indentures"). The Additional 2019 Notes are treated as a single series with the previously issued PMH 2019 Notes for all purposes under the Indenture, including, without limitation, restrictive covenants, waivers, amendments, redemptions and offers to purchase. Prior to closing the issuance of the Additional 2019 Notes, the Company was required to obtain the consent of the majority in interest of its PMH 2019 Notes issued on May 3, 2012 to certain amendments to the Indenture contained in the first Supplemental Indenture. The Company obtained such consent from the holders of approximately $324 million in aggregate principal amount of outstanding PMH 2019 Notes and paid an aggregate consent fee of approximately $8.9 million. The Company determined that the transaction represents a debt modification under the applicable accounting guidance and capitalized the consent fee and recorded it as a debt discount during the year ended September 30, 2013, which is being amortized over the term of the Additional 2019 Notes using the effective interest method.

In connection with the issuance of the Additional 2019 Notes, the Company entered into an amendment of its Credit Agreement governing the PMH Senior Secured Credit Facility that waived and amended certain provisions of the Credit Agreement, including certain restrictive covenants.

As of September 30, 2015 and 2014, the Company was in compliance with the financial covenants of the Indenture and Credit Agreement.

Demand Notes

During the year ended September 30, 2012, the Company obtained a commitment from a bank for a $9.3 million equipment leasing facility to finance various equipment at the Company's hospital facilities. During January 2014, the commitment was increased to $15.0 million. As of September 30, 2015 and 2014, $11.5 million and $10.7 million, respectively, were drawn under the facility and are classified as capital lease arrangements. Draws represent demand notes until conversion to capital leases, and interest accrues on such draws at the bank prime rate plus 1.5% with a floor of 4.5% and payable monthly.

Nix Health's Debt:

Mortgage Debt

In connection with the Nix Health acquisition, Nix SPE, LLC ("Nix SPE") executed a Loan Assumption Agreement, effective as of February 29, 2012, pursuant to which Nix SPE assumed the obligations of the sellers of Nix Health under a mortgage loan facility provided by The Ohio National Life Insurance Company on December 27, 1999. Nix SPE assumed the obligation to pay the outstanding principal amount of the mortgage loan and interest accruing thereafter. The outstanding balance of the mortgage loan as of September 30, 2015 and 2014 was $1,675,000 and $1,801,000, respectively.

Prospect Hospital Holdings, LLC, the parent company of Nix SPE, has provided a guaranty of the obligations of Nix SPE under the loan. The obligations under the loan facility are secured by a deed of trust on a neighborhood medical center known as Nix Alamo Heights. The loan is subject to a 7.0% interest rate and requires monthly installment payments of $21,000, with a balloon payment on the maturity date of November 1, 2019. Prepayment is subject to a fee and the loan contains customary covenants.

Note Payable

Nix Health entered into a note payable during September 2012 due in March of 2014 for $141,000. Interest accrued on this note at 8.96% and was payable monthly. The note payable was repaid during the year ended September 30, 2014.

Scheduled payments under the Company's current and long-term debt as of September 30, 2015 are as follows (in thousands):

Years ending September 30,	
2016	$ 135
2017	145
2018	155
2019	421,326
2020	1,074
	$ 422,835

9. Stockholder's Equity (Deficit)

Equity Based Compensation Plans

Effective December 15, 2010, the Board of Directors of Ivy Holdings adopted the Ivy Plan that authorized the issuance of options exercisable for up to 155,110 shares of the common stock of Ivy Holdings ("Initial Options") to employees, certain consultants and independent members of the boards of directors, of Ivy Holdings and its subsidiaries (including the Company and its subsidiaries). During the years ended September 30, 2015 and 2014, the Compensation Committee of the Board of Directors of Ivy Holdings ("Compensation Committee") granted 37,814 and 4,113 options, respectively, to certain members of the Company's management and employees. These options are exercisable into Ivy Holdings stock and vest based on a number of criteria, including time, Company and Business Unit performance based on EBITDA targets and CEO and Compensation Committee discretion. Since the Ivy Holdings stock options were granted to Company employees for their services related to the Company, the related compensation cost has been recorded in the Company's consolidated financial statements.

Effective June 30, 2015, the Board of Directors of Ivy Holdings adopted the First Amendment to the Ivy Plan, pursuant to which the Board of Directors authorized the issuance of options exercisable for an additional 13,972 shares of common stock of Ivy Holdings ("New Options") to employees, certain consultants and independent members of the boards of directors of Ivy Holdings and its subsidiaries (including the Company and its subsidiaries). Concurrently, the Compensation Committee granted 13,972 options to certain members of the Company's management and employees. The New Options are exercisable into Ivy Holdings stock and vest based on a number of criteria, including the same criteria as the Initial Options however, they only become exercisable on the occurrence of certain corporate transactions, including a change in control of Ivy Holdings, as defined in the Incentive Stock Option Agreements ("Corporate Transaction"). Because the occurrence and timing of a Corporate Transaction is not determinable as of September 30, 2015, no compensation cost has been recorded in the Company's consolidated financial statements.

Under the terms of the Ivy Plan, the exercise price of an incentive stock option ("ISO") may not be less than 100% of the fair market value of the Company's common stock on the date of grant and, if granted

to a shareholder owning more than 10% of the Company's common stock, then not less than 110%. Stock options granted under the Ivy Plan have a maximum term of 10 years from the grant date, and are exercisable at such time and upon such terms and conditions as determined by the Compensation Committee. Stock options granted to employees generally vest over four years, subject to continued service, performance, and other criteria. In the case of an ISO, the amount of the aggregate fair market value of common stock with respect to which the ISO grant is exercisable, for the first time by an employee during any calendar year, may not exceed $100,000.

Stock Options Activity

The following table summarizes information about Ivy Holdings stock options outstanding as of September 30, 2015 and 2014 and activity during the years then ended for the Initial Options and the New Options:

	Shares Subject to Options	Weighted Average Exercise Price	Weighted Average Aggregate Intrinsic Value	Weighted Average Remaining Contractual Term (Months)
Outstanding as of September 30, 2013 *(1)*	118,277	$ 43.44	$ 76.56	95.8
Granted	4,113	120.00	–	–
Exercised	–	–	–	–
Canceled/Forfeited	(6,915)	58.71	–	–
Outstanding as of September 30, 2014	115,475	45.37	74.63	84.1
Granted *(2)*	51,786	176.00	–	–
Exercised	(12,620)	31.38	–	–
Canceled/Forfeited	(3,808)	46.24	–	–
Outstanding as of September 30, 2015	150,833	$ 91.42	$ 436.51	88.2

(1) The number of options at September 30, 2013 includes 100,611 options modified in connection with the Repricing (see below).
(2) The options granted include 37,814 Initial Options and 13,972 New Options.

The aggregate intrinsic value is calculated as the difference between the exercise price of the underlying awards and the estimated fair value of the Company's common stock for those awards that have an exercise price currently below the estimated fair value. As of September 30, 2015, the aggregate intrinsic value of outstanding shares was approximately $60,000,000. As of September 30, 2015, there were 106,078 options that are exercisable at a weighted average exercise price of $55.08.

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A summary of Ivy Holdings non-vested options and the changes during the fiscal years ended September 30, 2015 and 2014 is presented as follows for the Initial Options and New Options:

	Shares	Weighted Average Grant Date Fair Value
Ivy Holdings Stock Options:		
Nonvested at September 30, 2013 *(3)*	43,192	$ 86.99
Granted	4,113	63.81
Vested	(28,797)	92.00
Canceled/Forfeited	(4,871)	85.15
Nonvested at September 30, 2014	13,637	70.47
Granted	51,786	72.03
Vested	(19,267)	73.60
Canceled/Forfeited	(1,401)	88.08
Nonvested at September 30, 2015	44,755	$ 70.38

(3) The number of non-vested options at September 30, 2013 includes 29,930 options modified in connection with the repricing (see below).

On April 5, 2013, the Compensation Committee approved the repricing of the exercise price of all outstanding stock options as of that date. Pursuant to such resolution of the Ivy Holdings Compensation Committee, as of the effective date, all of the previously granted options were exchanged for new options with a lower exercise price granted on a one-for-one basis. As a result of this repricing, the Company repriced 49,380 vested options and 59,748 unvested options from an original exercise price of $100.00 per share to a new exercise price of $30.00 per share. Other than the exercise price, all other terms of the repriced options, such as vesting and contractual life, remained the same. The Company has accounted for the repricing as a modification and recorded any net incremental fair value related to vested awards as compensation expense on the date of modification. In addition, the Company is recording the incremental fair value related to the unvested awards, together with unamortized stock-based compensation expense associated with the unvested awards, over the remaining requisite service period of the option holders. In connection with the repriced options, the Company recorded stock compensation expense of $1,454,000 on the date of the modification. Incremental compensation cost resulting from the modification was $113,000 and $1,097,000 during the years ended September 30, 2015 and 2014, respectively.

The original fair value of the options granted ranged from $50.73 to $98.65 per option. In connection with the repricing, the stock compensation expense related to the stock options granted prior to April 5, 2013 is calculated based on a fair value of $97.75. The fair value was determined using the Black-Scholes option pricing model.

Fair value of the repriced options was estimated with the following assumptions for Ivy Holdings:

For the year ended September 30,	2013
Weighted average fair value of repriced options	$97.75
Estimated fair market value of the Company's common stock on the date of grant	$120.00
Weighted average expected life of the options	8.2 years
Risk-free interest rate	1.7%
Weighted average expected volatility	45.9%
Dividend yield	0.0%

Stock-Based Compensation Expense

Stock-based compensation expense for all share-based payments in exchange for employee services (including stock options and restricted stock) is measured at fair value on the date of grant, estimated using an option pricing model and is recognized in the consolidated financial statements, net of estimated forfeitures over the awards requisite service period.

The Company uses the Black-Scholes option pricing model and a single option award approach to estimate the fair value of options granted. Estimated forfeitures will be revised in future periods if actual forfeitures differ from the estimates and will impact compensation cost in the period in which the change in estimate occurs. The determination of fair value using the Black-Scholes option-pricing model is affected by the Company's estimated stock price as well as assumptions regarding a number of complex and subjective variables, including expected stock price volatility, risk-free interest rate, expected dividends and projected employee stock option exercise behaviors.

Fair value for options granted during the years ended September 30, 2015 and 2014 was estimated with the following assumptions for Ivy Holdings:

For the years ended September 30,	2015	2014
Weighted average fair value of option grants	$ 98.65	$ 63.81
Estimated fair market value of the Company's common stock on the date of grant	$ 176.00	$ 120.00
Weighted average expected life of the options	9.8 years	8.0 years
Risk-free interest rate	1.8%	2.7%
Weighted average expected volatility	45.0%	45.0%
Dividend yield	0.00%	0.00%

Expected Term - The expected term of options granted represents the period of time that they are estimated to be outstanding.

Risk-Free Interest Rate - The Company bases the risk-free interest rate on the implied yield in effect at the time of option grant on U.S. Treasury zero-coupon issues with equivalent remaining terms.

Expected Volatility - The Company estimates the volatility of the common stock at the date of grant based on the average of the historical volatilities of a group of peer companies. The Company has identified a group of comparable companies to calculate historical volatility from publicly available data for sequential periods approximately equal to the expected terms of the option grants. In

selecting comparable companies, Management considered several factors including industry, stage of development, size and market capitalization.

Forfeitures—Share-based compensation is recognized only for those awards that are ultimately expected to vest. Compensation expense is recorded net of estimated forfeitures. Those estimates are revised in subsequent periods if actual forfeitures differ from those estimates. The Company used data since December 2010 to estimate pre-vesting option forfeitures.

Stock-based compensation expense for the Ivy Holdings stock options recognized by the Company during the years ended September 30, 2015 and 2014 was $1,184,000 and $2,673,000 (including the impact of the option repricing noted above), respectively. At September 30, 2015, there were 44,755 unvested options, which could potentially vest over the next three fiscal years, subject to meeting the vesting requirements noted above. The remaining maximum estimated stock compensation expense to be amortized to expense in future periods is approximately $3,000,000. Options which are expected to vest based on CEO and Compensation Committee discretion are treated as variable stock options and are subject to revaluation at each reporting period. Management determined the fair value of the discretionary vested options using a Black Scholes calculation but determined that the change in compensation expense was not material to the consolidated financial statements for the years ended September 30, 2015 and 2014.

10. Commitments and Contingencies

Leases

The Company leases various office facilities and equipment from third parties under non-cancelable operating and capital lease arrangements expiring at various dates through 2026. Certain operating leases contain rent escalation clauses and renewal options, which have been factored into determining rent expense on a straight-line basis over the lease terms. Capital leases bear interest at rates ranging from 2% to 11% per annum.

The future minimum annual lease payments (net of anticipated sublease income) required under leases in effect at September 30, 2015, are as follows (in thousands):

For the Years ending September 30,	Capital Leases	Operating Leases
2016	$ 3,913	$ 4,157
2017	2,589	3,395
2018	1,725	2,693
2019	1,414	2,210
2020	1,274	2,175
Thereafter	6,434	932
Total minimum lease payments	17,349	$ 15,562
Less: amounts representing interest	(5,148)	
	12,201	
Less: current portion	(2,905)	
	$ 9,296	

Rent expense for the years ended September 30, 2015 and 2014 was approximately $15,258,000 and $9,615,000, respectively. Sublease rental income of approximately $107,000 and $271,000, for the years ended September 30, 2015 and 2014, respectively, was recorded as a reduction to rental expense.

Litigation

The Company is subject to a variety of claims and suits that arise from time to time in the ordinary course of its business, acquisitions, or other transactions. While the Company's management currently believes that resolving all of these matters, individually or in the aggregate, will not have a material adverse impact on the Company's consolidated financial position or results of operations, the litigation and other claims that the Company faces are subject to inherent uncertainties and management's view of these matters may change in the future. Should an unfavorable final outcome occur, there exists the possibility of a material adverse impact on the Company's consolidated financial position, results of operations and cash flows for the period in which the effect becomes probable and reasonably estimable.

Following the acquisition of the Company in August 2010, two putative class action complaints were filed against the Company, each of the Company's special committee members, Ivy Holdings, LGP, and certain other parties. These complaints, which were consolidated into a single action, allege generally that defendants breached their fiduciary duties, or aided and abetted others' breaches of their fiduciary duties, in connection with the transaction with the Company by, among other things, authorizing the transaction for what plaintiffs claim to be inadequate consideration and pursuant to what plaintiffs claim to be an inadequate process and with inadequate disclosures.

On December 30, 2010, another lawsuit was filed in Delaware Chancery Court by Terrier Partners and five related entities against the same defendants identified above. The complaint alleges generally that the consideration offered to shareholders in connection with the transaction with the Company was inadequate in light of the revenue received under AB 1383 (see California Hospital Fee Program below), and that defendants breached their fiduciary duties, or aided and abetted others' breaches of their fiduciary duties by not obtaining a higher price in light of this additional revenue.

In May 2012, the Court of Chancery granted motions to consolidate the Terrier Partners case and the class action cases and certified a class as a non-opt out class. On June 11, 2012, plaintiffs filed their Verified Consolidated Third Amended Class Action Complaint. On July 26, 2012, the director defendants answered the Third Amended Complaint. That same day, Prospect moved to dismiss itself as a party to the Third Amended Complaint. The Court granted the motion to dismiss the Company as a defendant, leaving only the individuals as defendants in the case.

The parties subsequently engaged in discovery, and following mediation, have agreed to settle the dispute as to all parties and all claims. Pursuant to the terms of the Settlement Agreement, Prospect and its insurers have agreed to contribute $6.5 million as a settlement amount, which will be used to pay all claims to the class as well as fees for plaintiffs' class counsel. All defendants will be released from all claims in return for entry into the settlement. The settlement is subject to approval by the Delaware Chancery Court, which has scheduled a hearing for January 21, 2016 to consider the proposed settlement and determine, among other things, whether the settlement is fair, reasonable, and adequate to the class and should be approved by the Court. Notice has been sent out advising class members of the settlement, the date of the hearing and their right to object. Because it is a non-opt-out class, if the settlement is approved it should fully dispose of the claim as to all potential plaintiffs. The Company has no reason to believe that the settlement will not be approved by the Court, since it has been stipulated to by all parties and multiple counsel for plaintiffs; however, if the Court rejects

the settlement or for some other reason the settlement is not consummated, the defendants will vigorously defend the lawsuit.

Seismic Standards

Our SCHS Hospitals, Alta Los Angeles Hospitals, and FRMC are required to comply with California's Alfred E. Alquist Hospital Facilities Seismic Safety Act (the "Alquist Act"), which regulates the seismic performance of all aspects of hospital facilities in California. The Alquist Act imposes near-term and long-term compliance deadlines for seismic safety assessment, submission of corrective plans, and the retrofitting or replacement of medical facilities to comply with current seismic standards. The Alquist Act also requires that the California Building Standards Commission adopt earthquake performance categories, seismic evaluation procedures, standards and timeframes for upgrading certain facilities, and seismic retrofit building standards. These regulations require hospitals to meet seismic performance standards to ensure that they are capable of providing medical services to the public after an earthquake or other disaster. The Building Standards Commission completed its adoption of evaluation criteria and retrofit standards in 1998.

The Alquist Act requires that within three years after the Building Standards Commission had adopted evaluation criteria and retrofit standards:

- Hospitals in California must conduct seismic evaluation and submit these evaluations to the Office of Statewide Health Planning and Development ("OSHPD"), Facilities Development Division for its review and approval;

- Hospitals in California must identify the most critical nonstructural systems that represent the greatest risk of failure during an earthquake and submit timetables for upgrading these systems to the OSHPD, Facilities Development Division for its review and approval; and

- Hospitals in California must prepare a plan and compliance schedule for each regulated building demonstrating the steps a hospital will take to bring the hospital buildings into substantial compliance with the regulations and standards.

The Company was required to conduct engineering studies at its hospitals to determine whether and to what extent modifications to the hospital facilities will be required. Management believes that SCH Culver City meets all current requirements; however, it may be required to make significant capital expenditures in the future to comply with the seismic standards, which could impact its earnings. The cost at September 30, 2015, is unknown at this time but could be material. In addition, such modifications to the hospital facilities could potentially result in environmental remediation liabilities which may be material to the Company.

The OSHPD has a voluntary program to re-evaluate the seismic risk of hospital buildings classified as Structural Performance Category ("SPC") 1. These buildings are considered hazardous and at risk of collapse in the event of an earthquake and they were required to be retrofitted, replaced or removed from providing acute care services by 2013, unless granted an extension. OSHPD is using HAZARDS U.S. ("HAZUS"), a state-of-the-art methodology, to reassess the seismic risk of SPC-1 buildings and those that are determined to pose a low seismic risk may be reclassified to SPC-2. The SPC-2 buildings would have until 2030 to comply with the structural seismic safety standards. Participation in the HAZUS program is optional for hospital owners wishing to have their SPC-1 building(s) re-evaluated. Applications for a HAZUS re-evaluation of the seismic risk were submitted for SCH Hollywood, SCH Culver City and Los Angeles Community Hospital, but there is no assurance they will result in extensions.

In addition, in 2011, the California Legislature enacted Senate Bill 90, which permitted some hospitals to apply for up to an additional seven year extension to the seismic retrofit deadlines, not to extend beyond January 1, 2020. SB 90 also permits OSHPD to extend until January 1, 2018 the date by which the hospitals must obtain a building permit and commence the required retrofit project.

SCH Culver City and Los Angeles Community Hospitals both applied for the SB 90 extension from OSHPD. Three of the buildings owned by SCH Culver City were granted SB 90 extensions until January 2019 or July 2019. Also, the facility operated by Los Angeles Community Hospital received an SB 90 extension until January 2019.

OSHPD has discretion to approve or disapprove SB 90 extension requests, and to determine the length of the extension (up to the maximum seven years), based on eligibility factors including seismic risks associated with the affected buildings (which can be impacted by the updated HAZUS findings), community access to essential hospital services in the area and financial hardships facing the applicant.

Effective May 6, 2014, Prospect acquired the hospital facilities FRMC and LACH Bellflower (see Note 4). The Company is in the process of pursuing Non-Structural Performance Category ("NPC") 2 classification and the extension of the compliance deadlines that would result for FRMC. LACH Bellflower is not currently subject to the requirements of SB90 as the facility currently only provides psychiatric services.

These requirements can result in significant operational changes and capital outlays. Management is continuing to assess its options and the methods of financing the required retrofits. Based on management's evaluation, the costs of renovation needed to comply with the California seismic safety standards for its acute-care facilities, including asbestos abatement, are not estimable at this time.

Legislation and HIPAA

The healthcare industry is subject to numerous laws and regulations of federal, state and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government healthcare program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Government activity has continued with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed.

The Company believes that it is in compliance with fraud and abuse regulations as well as other applicable government laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time.

The Health Insurance Portability and Accountability Act ("HIPAA") assures health insurance portability, reduces healthcare fraud and abuse, guarantees security and privacy of health information, and enforces standards for health information. The Health Information Technology for Economic and Clinical Health Act ("HITECH Act") expanded upon HIPAA in a number of ways, including establishing notification requirements for certain breaches of protected health information. In addition to these federal rules, California has also developed strict standards for the privacy and security of health information as well as for reporting certain violations and breaches. The Company may be subject to significant fines and penalties if found not to be compliant with these state or federal provisions.

Affordable Care Act

The Patient Protection and Affordable Care Act ("PPACA") will substantially reform the United States health care system. The legislation impacts multiple aspects of the health care system, including many provisions that change payments from Medicare, Medicaid and insurance companies. Starting in 2014, the legislation requires the establishment of health insurance exchanges, which will provide individuals without employer-provided health care coverage the opportunity to purchase insurance. It is anticipated that some employers currently offering insurance to employees will opt to have employees seek insurance coverage through the insurance exchanges. It is possible that the reimbursement rates paid by insurers participating in the insurance exchanges may be substantially different than rates paid under current health insurance products. Another significant component of the PPACA is the expansion of the Medicaid program to a wide range of newly eligible individuals. In anticipation of this expansion, payments under certain existing programs, such as Medicare disproportionate share, will be substantially decreased. Each state's participation in an expanded Medicaid program is optional.

California Hospital Fee Program

The State of California enacted Assembly Bill 1383 ("AB 1383") effective January 1, 2010, as amended by Assembly Bill 1653 (collectively, the "Program"), to provide supplemental payments to certain hospitals such as the hospitals owned and operated by the Company's subsidiaries. The Program requires participating hospitals to pay fee assessments into a pool of funds to which the federal government contributes matching funds. Most of these funds, including the federal matching funds, are then distributed to qualifying hospitals. In addition, on April 13, 2011 SB 90 was signed into law and provided for a six-month extension of the Hospital Fee Program for dates of service from January 1, 2011 through June 30, 2011. CMS granted final approval of SB 90 on December 29, 2011, at which point the revenue and expense was recognized for the retroactive period. In September 2011, the State of California enacted Senate Bill 335 ("SB 335") which provides a 30-month hospital fee program for dates of service from July 1, 2011 through December 31, 2013. The elements of SB 335 related to the fee for service payments were approved by CMS on June 22, 2012. The payments due under the managed care component are scheduled to be made in three cycles. The first two cycles were previously approved by CMS, and the third cycle was approved by CMS during the year ended September 30, 2015. Certain technical changes to the legislation required by CMS are included in Senate Bill 920.

Governor Brown signed Senate Bill 239 ("SB 239") in October 2013, which enacted a hospital fee program for the period January 1, 2014 through December 31, 2016. SB 239 provides that the hospital fee program will continue through December 31, 2022 in three year cycles and will require authorization of each cycle by the California legislature. The fee for service component of SB 239 was approved by CMS during December 2014, and the first cycle of the managed care component from January 2014 through June 2014 was approved by CMS during July 2015.

For the years ended September 30, 2012 and 2011, SCH Culver City received invoices for fee assessments under AB 1383 and SB 90 of approximately $6,310,000 and $19,000,000, respectively, following payment of which, SCH Culver City was scheduled to receive approximately $5,236,000 and $15,000,000, respectively. Management of SCH Culver City estimated that SCH Culver City would be a "net" payer under the Program, since the fee assessments on SCH Culver City exceeded the supplemental payments by approximately $1,074,000 and $4,000,000, respectively. Accordingly, on October 6, 2010, the Company notified the California Department of Healthcare Services ("DHCS") that SCH Culver City was opting out of the Program.

SCH Culver City did not pay the required fee assessments under the Program. Beginning February 14, 2011, the DHCS began withholding against amounts otherwise due SCH Culver City, in the amount of $65,000 per week indicating that withholdings would continue for 108 weeks and would total approximately $7,000,000. Through September 30, 2012, a total of approximately $2,986,000 had been withheld against SCH Culver City's Medi-Cal fee-for-service payments. As of September 30, 2012, SCH Culver City recorded a liability of approximately $5,494,000, representing the accrued loss above, as well as deferred recognition of payments received from managed care plans. On November 15, 2012 the Company entered into a settlement agreement with DHCS with regards to SCH Culver City's liability under AB 1383, SB 90 and SB 335, as discussed above. Under the terms of the agreement, the DHCS agreed to forgive approximately $2,000,000 of the fees due under AB 1383, which was recorded by the Company during the year ended September 30, 2013. The remaining liability due to DHCS of $4,605,000 will be repaid by the Company monthly over a 10-year period without interest or penalties. The Company recorded a net liability of $3,233,000 as of the settlement date, which represents the net present value of the liability due to DHCS discounted at an effective interest rate of 7.5%. As of September 30, 2015 and 2014, the unamortized balance of the liability amounted to $2,547,000 and $2,806,000, respectively. The DHCS will no longer withhold against any other amounts due to SCH Culver City unless the Company is delinquent on payments owed under the agreement.

As of September 30, 2015, the Company had a receivable related to the California Hospital Fee Program of $32,285,000 in the accompanying consolidated balance sheets. The Company did not have a receivable related to the California Hospital Fee Program as of September 30, 2014. As of September 30, 2015 and 2014, the Company had a liability related to the California Hospital Fee Program of $15,022,000 and $2,806,000, respectively, in the accompanying consolidated balance sheets.

Total California Hospital Fee program revenues and expenses recognized during the years ended September 30, 2015 and 2014 were as follows (in thousands):

Years Ended September 30,	2015	2014
Hospital services revenues	$ 134,604	$ 11,884
Hospital operating expenses	91,325	5,863
Net pre-tax impact	$ 43,279	$ 6,021

Collective Bargaining Agreements

A small group of employees at SCH Hollywood, which is one of the hospitals under the consolidated group of Alta Hospitals System, LLC, and Service Employees International Union, United Healthcare Workers-West ("SEIU") are currently negotiating a new collective bargaining agreement. This agreement expired on May 3, 2015. In addition, approximately 84% of the employees of SCH Culver City are part of a collective bargaining agreement with the SEIU or the California Nurses Association ("CNA"). SCH Culver City and CNA are currently parties to a collective bargaining agreement that expires on December 21, 2015. The parties have commenced negotiations for a new agreement. SEIU and SCH Culver City are currently parties to a three-year term agreement that expires on April 27, 2017.

As of September 30, 2014, approximately 25% of the employees at Our Lady of Fatima Hospital ("Fatima") are subject to a collective bargaining agreement with United Nurses and Allied Professionals ("UNAP"), which expires July 31, 2016. An additional 1% are subject to a collective bargaining agreement with the Federation of Nurses and Health Professionals ("FNHP"), which expires April 30,

2016. During April 2015, a hospital unit consisting of approximately 400 service employees of Fatima elected to be represented by UNAP. Negotiations over a first collective bargaining agreement for this unit are ongoing.

Tangible Net Equity ("TNE") Requirement

The Company's affiliated physician organizations and PHP must comply with a minimum working capital requirement, Tangible Net Equity ("TNE") requirement, cash-to-claims ratio and claims payment requirements prescribed by the California Department of Managed Health Care ("DMHC"). Additionally, PHP has a TNE requirement as prescribed by the California Department of Managed Health Care. TNE is defined as net assets, less intangibles and amounts due from affiliates, plus subordinated obligations. At September 30, 2015, PHP was in compliance with these regulatory requirements.

The California DMHC determined that, as of March 31, 2015, PMG, on a consolidated basis with its subsidiaries, was not in compliance with the California DMHC's positive TNE requirement for a Risk Bearing Organizations ("RBO"). As a result, the California DMHC required PMG to develop and implement a six-month corrective action plan ("CAP") for such deficiency. Such six-month period has expired, and PMG believes that it has fully complied with all related requirements. As of the date of this report, PMG has not yet received the California DMHC's official release of the CAP.

The Company contributed $2,000,000 of Restricted Cash and $300,000 of Restricted Investments to PHP in conjunction with PHP's commencement of operations during the year ended September 30, 2015 (see Note 2 regarding Restricted Cash and Restricted Investments).

Employee Health Plans

Effective January 1, 2013 the Company offered self-insured EPO/HMO and PPO plans to all eligible employees. The CharterCARE hospitals had a separate low-deductible employee health plan from the date of acquisition through December 31, 2014. Effective January 1, 2015, the CharterCARE hospitals changed to self-insured EPO/HMO and PPO plans for all eligible employees.

Employee health benefits are administered by a third party claims administrator, based on plan coverage and eligibility guidelines determined by the Company, as well as by collective bargaining agreements (as reflected above). Commercial insurance policies cover per occurrence losses in excess of $275,000 for the CharterCARE hospitals, $250,000 for all other hospitals and $175,000 for the Medical Group and Corporate segments. An actuarially estimated liability of approximately $3,850,000 and $1,828,000 for incurred but not reported claims has been included in accrued salaries, wages, and benefits as of September 30, 2015 and 2014, respectively.

Provider Contracts

Many of the Company's payer and provider contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of medical services. Such differing interpretations may not come to light until a substantial period of time has passed following contract implementation. Liabilities for claims disputes are recorded when the loss is probable and can be estimated. Any adjustments to reserves are reflected in current operations.

11. Defined Contribution Plan

The Company sponsors two defined contribution plans covering substantially all employees who meet certain eligibility requirements. Under these plans, employees can contribute up to 50% of their compensation up to the IRS deferred annual maximum. There is currently no company match offered under the plans, except at Nix Health and PCC, for which the expense for the employer match was $1,865,000 and $576,000 for the years ended September 30, 2015 and 2014, respectively. Total expenses under the plan were approximately $480,000 and $197,000 during the years ended September 30, 2015 and 2014, respectively.

12. Accrued Medical Claims and Other Healthcare Costs Payable

The following table presents the roll-forward of incurred but not reported ("IBNR"), claims reserves (Medical Group segment, Global Risk Management segment, and full risk contracts) as of and for each of the fiscal years ended September 30, 2015 and 2014 (in thousands):

September 30,	2015	2014
IBNR as of beginning of year	$ 39,314	$ 30,352
Claim expenses incurred during the year:		
Related to current year	203,400	161,088
Related to prior year	1,606	(3,571)
Total incurred	205,006	157,517
Claims paid during the year:		
Related to current year	(156,485)	(124,393)
Related to prior year	(34,304)	(24,162)
Total paid	(190,789)	(148,555)
IBNR as of end of year	$ 53,531	$ 39,314

Following is a table showing the details of the Medical Group and Global Risk Management segments cost of revenues per the consolidated statements of operations (in thousands):

Years Ended September 30,	2015	2014
Capitation expense	$ 93,340	$ 85,754
Fee-for-service claims expense	118,529	94,749
Other physician compensation	14,082	5,066
Other cost of revenues	1,196	(227)
Total cost of revenues	$ 227,147	$ 185,342

13. Joint Ventures and Unconsolidated Equity Investments

AMVI

The Company (through Prospect Medical Group, Inc.) and an unrelated third party, AMVI Care Health Network, Inc. ("AMVI") are partners in a joint venture initially formed to service Medi-Cal members under the CalOptima program in Orange County, California. Healthy Families and OneCare members were subsequently added to the joint venture arrangement. Effective January 1, 2013, all Healthy Family participants were transferred to the Company's Medi-Cal line of business and therefore no longer part of the joint venture. The Company does not consolidate the joint venture. The Company includes in its consolidated financial statements only the net results attributable to those enrollees specifically identified as assigned to it, together with the management fee that it charges the joint venture partner for managing those enrollees specifically assigned to AMVI. Costs incurred by the Company in managing the joint venture are included in general and administrative expenses in the accompanying consolidated financial statements. As of September 30, 2015 and 2014, the net liability balances of the Company investment in the joint venture under the equity method were approximately $1,944,000 and $1,594,000, respectively, and were included in accounts payable and other accrued liabilities in the accompanying consolidated financial statements.

Summarized unaudited financial information for the unconsolidated joint venture as of and for each of the years ended September 30, 2015 and 2014 is as follows (in thousands):

September 30,	2015	2014
Cash	$ (96)	$ 1,753
Receivables	2,344	2,232
Total assets	$ 2,248	$ 3,985
Accrued medical claims	$ 1,652	$ 1,658
Other payables	158	1,470
Other partner's capital	437	856
Prospect's capital	1	1
Total liabilities and partner's capital	$ 2,248	$ 3,985

Years Ended September 30,	2015	2014
Revenues	$ 19,817	$ 19,289
Income before income taxes	$ 4,532	$ 2,915
Prospect's equity income	$ 5,867	$ 3,295
Management fees earned by Prospect	$ 1,106	$ 1,141

RWRT and SNERCC

Roger Williams Medical Center and an unrelated third party are owners of Roger Williams Radiation Therapy ("RWRT") and Southern New England Regional Cancer Center, LLC ("SNERCC"), which provide radiation therapy services. As of September 30, 2014, RWMC owned 29% of RWRT and 20% of SNERCC. On January 6, 2015, RWMC sold a 9% interest in RWRT for $1,233,000, reducing its ownership in RWRT from 29% to 20%. Also on January 6, 2015, RWMC increased its investment in SNERCC by $1,600,000 in

connection with SNERCC's acquisition of a radiation oncology business. RWMC's interest in SNERCC remained at 20% after the additional investment as RWMC's additional investment was its pro rata portion of the radiation oncology business purchase price. Roger Williams accounts for these investments using the equity method of accounting.

RWMC is not liable for any obligations insured by RWRT or SNERCC nor is it obligated to make any further capital contributions or lend funds to RWRT or SNERCC. As of September 30, 2015 and 2014, RWMC's investments in RWRT and SNERCC under the equity method were approximately $4,217,000 and $3,522,000 respectively, and are included in equity method investments in the accompanying consolidated balance sheets. For the year ended September 30, 2015, the Company recognized approximately $455,000 as its share of the financial results of RWRT and SNERCC and received $423,000 in distributions. For the period from June 20, 2014 (Roger Williams Medical Center inception) through September 30, 2014 and for the year ended September 30, 2015, the Company recognized $132,000 as its share of the financial results of RWRT and SNERCC and received no distributions.

Summarized combined unaudited financial information for RWRT and SNERCC as of September 30, 2015 and 2014 and for the year ended September 30, 2015 and for the period from June 20, 2014 (inception) through September 30, 2014 is as follows (in thousands):

September 30,	2015	2014
Cash	$ 1,299	$ 1,165
Receivables	1,547	1,130
Other current assets	274	372
Total current assets	3,120	2,667
Property, improvements and equipment, net	7,432	6,715
Goodwill	7,142	629
Intangible assets	943	-
Other long-term assets	1,663	1,756
Total assets	$ 20,300	$ 11,767
Accounts payable and accrued liabilities	$ 1,618	$ 1,070
Other long-term liabilities	345	336
Equity	18,337	10,361
Total liabilities and partner's capital	$ 20,300	$ 11,767

Years ended September 30,	2015	2014
Revenues	$ 14,626	$ 3,175
Net income	$ 2,000	$ 455
Roger Williams Medical Center's income from equity method investments	$ 455	$ 132

14. Segment Information

The Company's operations are organized into four reporting segments: (i) Hospital Services – which is comprised of the Alta Hospitals, SCH Culver City, Nix Health, and PCC reporting units, owns 13 hospitals and extended care facilities – Los Angeles Community Hospital, Norwalk Community Hospital, Los Angeles Community Hospital at Bellflower, Foothill Regional Medical Center, SCH Hollywood, SCH Van Nuys, SCH Culver City, Nix Medical Center, Nix Specialty Health Center, Nix CGH, Roger Williams Medical Center, Saint Joseph's Health Services of Rhode Island, and Elmhurst Extended Care; (ii) Medical Group – which is comprised of entities which provide management services to affiliated physician organizations that operate as independent physician associations or medical practice groups and certain unaffiliated independent physician associations; (iii) Global Risk Management - which is comprised of PHP, PHSTX and PHSRI which manage the provision of care for its members under global capitation arrangements in coordination with our Hospital and Medical Group segments and (iv) Corporate, which represents expenses incurred in Prospect Medical Holdings, Inc., that were not allocated to the other reporting segments.

The accounting policies of the reporting segments are the same as those described in the summary of significant accounting policies (see Note 2). The Company evaluates financial performance and allocates resources primarily based on earnings from operations before interest expense, interest income, income taxes, depreciation and amortization, as well as income or loss from operations before income taxes, excluding infrequent or unusual items.

The reporting segments are strategic business units that offer different services within the healthcare industry. Business in each reporting segment is conducted by one or more direct or indirect wholly-owned subsidiaries of the Company and certain affiliated physician organizations controlled through assignable option agreements and management services agreements. The Company voluntarily discloses the following table which summarizes certain information for each of the reporting segments regularly provided to and reviewed by the chief operating decision maker (in thousands):

	As of and for the Year Ended September 30, 2015					
	Hospital Services *(3)*	Medical Group *(2)*	Global Risk Management	Corporate *(1)*	Intersegment Eliminations	Consolidated
Revenues from external customers	$ 1,008,866	$ 333,238	$ 3,440	$ -	$ -	$ 1,345,544
Intersegment revenues	-	1,762	16,661	-	(18,423)	-
Total revenues	1,008,866	335,000	20,101	-	(18,423)	1,345,544
Depreciation and amortization	31,148	3,178	-	48	-	34,374
Operating income (loss)	63,413	66,142	(3,163)	(18,332)	-	108,060
Other (income) expense	2,240	(271)	-	42,926	(2,283)	42,612
Income (loss) before income taxes	61,173	66,413	(3,163)	(61,258)	2,283	65,448
Provision for income tax	-	10,600	-	20,546	-	31,146
Net income (loss)	$ 61,173	$ 55,813	$ (3,163)	$ (81,804)	$ 2,283	$ 34,302
Identifiable segment assets	$ 655,540	$ 96,289	$ 6,725	$ 24,297	$ -	$ 782,851
Segment capital expenditures, net of dispositions	$ 35,332	$ 981	$ -	$ 202	$ -	$ 36,515
Segment goodwill	$ 139,957	$ 22,339	$ -	$ -	$ -	$ 162,296

	As of and for the Year Ended September 30, 2014				
	Hospital Services *(3)*	Medical Group *(2)*	Corporate *(1)*	Intersegment Eliminations	Consolidated
Revenues from external customers	$ 600,536	$ 253,980	$ -	$ -	$ 854,516
Intersegment revenues	-	1,039	-	(1,039)	-
Total revenues	600,536	255,019	-	(1,039)	854,516
Depreciation and amortization	20,694	2,846	40	-	23,580
Operating income (loss)	57,748	29,080	(20,676)	-	66,152
Other (income) expense	(3,037)	(26)	38,480	1,622	37,039
Income (loss) before income taxes	60,785	29,106	(59,156)	(1,622)	29,113
Provision for income tax	-	5,765	4,796	-	10,561
Net income (loss)	$ 60,785	$ 29,106	$ (69,717)	$ (1,622)	$ 18,552
Identifiable segment assets	$ 599,516	$ 75,605	$ 19,057	$ -	$ 694,178
Segment capital expenditures, net of dispositions	$ 49,181	$ 924	$ 2	$ -	$ 50,107
Segment goodwill	$ 136,525	$ 22,339	$ -	$ -	$ 158,864

(1) Prospect files consolidated tax returns, with the exception of PMG and NGMA, which file their own federal tax returns, and allocates costs for shared services and corporate overhead to each of the reporting segments. With the exception of Nix Health and PCC, all debt, including debt related to the Medical Group and Hospital Services segment, is recorded at the Parent Entity level. The Company does not allocate interest expense related to acquisition debt to the operating segments.

(2) Prospect Medical Group, Inc. (which serves as a holding company for the other affiliated physician organizations) files consolidated tax returns.

(3) The Hospital Services segment includes the results for LACH Bellflower and FRMC, CharterCARE, and the CharterCARE Physicians medical practices from the acquisition dates of May 6, 2014, June 20, 2014, and various dates during the year ended September 30, 2015, respectively, through September 30, 2015. Included in revenues from external customers are $5,436,000 and $13,672,000 of other revenues related primarily to the CMS Rural Floor settlement, meaningful use incentive payments and rental revenue from operating leases for the years ended September 30, 2015 and 2014, respectively.

15. Subsequent Event (Unaudited)

The Company has evaluated subsequent events through December 10, 2015, the date the Company's consolidated financial statements were available for issuance.

Effective December 1, 2015, NGMA entered into a Stock Purchase Agreement to acquire all issued and outstanding shares of Primary and Multi-Specialty Clinics of Anaheim, Inc. ("PMCA"). PMCA operates a medical practice consisting of primary and multi-specialty clinics in Orange County, California. Concurrent with the Stock Purchase Agreement, NGMA entered into a Promissory Note payable to the former shareholders of PMCA for $3,288,000, for which principal shall be payable on December 8, 2015.

The purchase price consists of $4,445,000 due December 8, 2015, less certain liabilities and certain other adjustments as specified in the Stock Purchase Agreement ("Initial Payment") and an additional $1,080,000 due on December 1, 2016. The Promissory Note represents a portion of the Initial Payment.







CERTIFICATE OF NEED

RESPONSE TO DEFICIENCIES DATED DECEMBER 11, 2015

Eastern Connecticut Health Network, Inc.
Proposed Asset Purchase by
Prospect Medical Holdings, Inc.

OHCA Docket Number: 15-32016-486
Attorney General Docket Number: 15-486-01

December 24, 2015

Eastern Connecticut Health Network
71 Haynes Street
Manchester, CT 06040
860.533.3414
www.echn.org

December 24, 2015

Via Hand Delivery

Office of the Attorney General
55 Elm Street
P.O. Box 120
Hartford, Connecticut 06141-0120
Attn: Gary W. Hawes, Assistant Attorney General



Office of Health Care Access
Department of Public Health
410 Capitol Avenue
Hartford, Connecticut 06134
Attn: Steven W. Lazarus, Health Care Analyst

Re: Eastern Connecticut Health Network, Inc.
Proposed Asset Purchase by Prospect Medical Holdings, Inc.
OHCA Docket Number: 15-32016-486
Attorney General Docket Number: 15-486-01

Dear Mr. Hawes and Mr. Lazarus:

Eastern Connecticut Health Network, Inc. and Prospect Medical Holdings, Inc. (the "Applicants") hereby submit the enclosed responses to the completeness question issued by the Office of the Attorney General and the Office of Health Care Access in a letter dated December 11, 2015.

At your request, one (1) hard copy and one (1) electronic copy have been provided to each Office.

If you have any questions or need anything further, please feel free to contact me at (860) 533-3429. Thank you for your assistance in this matter.

Sincerely,

Dennis P. McConville
Senior Vice President and Chief Strategy Officer

Eastern Connecticut Health Network
71 Haynes Street
Manchester, CT 06040
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Perry Zinn Rowthorn, Deputy Attorney General, Office of the Attorney General
Rebecca A. Matthews, Esq., Wiggin and Dana, LLP
Thomas M. Reardon, President, Prospect Medical Holdings-East, Inc.
Frank Saidara, Vice President, Corporate Development, Prospect Medical Holdings, Inc.
Jonathan Spees, Senior Vice President, Corporate Development, Prospect Medical Holdings, Inc.
Joyce Tichy, Senior Vice President and General Counsel, Eastern Connecticut Health Network, Inc.
Michele M. Volpe, Esq., Bershtein, Volpe & McKeon, P.C

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On December 11, 2015, Eastern Connecticut Health Network ("ECHN") and Prospect Medical Holdings ("PMH" and, together with ECHN, the "Applicants") received correspondence from the Office of the Attorney General ("OAG") and the Office of Health Care Access ("OHCA") requesting additional clarification for certain deficiencies identified in the Applicants' Response to Completeness Questions ("Response") submitted on November 23, 2015. The Applicants' response to the deficiencies identified on December 11, 2015 has been provided below:

1. On page 2148 of the Response, Applicants state that ECHN is expected to secure a bank loan for 5 million dollars to cover costs of planned capital projects. With respect to this 5million dollar loan and the referenced capital projects, please answer the following:

   a) Clarify whether the 5 million is intended to be expended exclusively on the behavioral health expansion at RGH mentioned on page 2149 or additional planned capital projects, and, if the latter, identify the projects and estimated expenditure amounts.

      Response:

      The 5 million is intended to be expended exclusively on the behavioral health expansion at RGH.

   b) Elaborate on the specific types of behavioral health conditions the behavioral unit at RGH expects to treat and whether this unit will be utilized for inpatient or outpatient treatment.

      Response:

      The behavioral health unit planned for RGH will be utilized for the inpatient treatment of adults and adolescents with eating disorders.

2. In connection with Response 2(b) at page 2150, relating to the joint ventures in which ECHN has an ownership interest, please respond to the following questions.

   a) Please provide the information on Exhibit A for Connecticut Occupational Partners, LLC.

      Response:

      The joint venture valuations are only applicable to the entities that generate income. Connecticut Occupational Medicine Partners, LLC ("COMP") provides management

services for the occupational health programs of its member hospitals[1] and does not generate revenue for the organization or its members.

b) If a joint venture cannot be transferred to PMH, the parties contemplate that ECHN will issue a note to PMH, in an amount equal to the value of that joint venture. The note would be secured by ECHN's interest in the joint venture and payable from future distributions from the joint venture. If the joint venture fails or it does not generate sufficient funds to enable the note to be repaid, will ECHN have any liability?

Response:

Significant progress has been made to prepare all of the referenced joint ventures for transfer at closing, and therefore the parties do not at this time anticipate that a promissory note will actually be required. ECHN has already obtained all of the necessary third party consents to transfer ECHN's interest in all those joint ventures that require regulatory approval, and is actively securing the necessary consents for all others. For these reasons, ECHN expects to be in a position to transfer its interests in the joint ventures before closing, in which case a promissory note will not be necessary.

In an abundance of caution and in order to eliminate the possibility of disruption to the transaction, however, the parties have also agreed to address the unlikely event that a joint venture interest could not be transferred by providing for a loan from PMH to ECHN, secured by a promissory note, in an amount equal to the deduction made from the purchase price due to the fact that such joint venture interest could not be transferred at closing. This promissory note would be payable from and secured by future distributions from the non-transferred joint venture and would be further secured by ECHN's interests in such joint venture (to the extent permissible under Connecticut law and the joint venture agreement). Any unsecured liability theoretically remaining to ECHN under the promissory note would be addressed in the same manner as ECHN's other post-closing liabilities in accordance with applicable law. An indemnity reserve that will be funded using proceeds from the asset sale will be set up as a vehicle to settle ECHN's post-closing liabilities.

3. The Applicants state in page 2158 of the Response that PMH has established an independent practice association in Connecticut, Prospect Provider Group CT-ECHN, LLC ("PPGCTE") and a preferred provider network/health system risk taking entity, Prospect Health Services, CT, Inc. ("PHS"), and that physicians currently represented by Eastern Connecticut

[1] Member hospitals of COMP include Manchester Memorial Hospital, Bristol Hospital, Saint Francis Hospital and Medical Center, Johnson Memorial Medical Center and Western Connecticut Health Network.

Individual Provider Group, Inc. (□ECIPG□) will make individual decisions about whether to participate in PPGCTE. Please respond to the following □uestions regarding these entities:

a) Will ECIPG be dissolved after the Closing□

Response:

ECIPG is a separately incorporated nonstock corporation and a 50□ member of ECHN□s Eastern Connecticut Physician Hospital Organi□ation (ECPHO). As ECIPG is a separate and independent entity from ECHN, decisions regarding the future of ECIPG will be made by the members of ECIPG.

b) If ECIPG physicians do not elect to join PPGCTE, will they still have privileges at the Hospitals□

Response:

Physicians apply independently for hospital medical staff membership and privileges. Acceptance to the Hospitals□ medical staff is not contingent upon an individual physician□s group affiliation. ECIPG physicians that do not join PPGCTE will still have privileges at the Hospitals following the proposed asset purchase of ECHN by PMH (the □Asset Purchase□), assuming that the physicians continue to meet the membership □ualification criteria outlined in Article 3 of ECHN□s Medical Staff Bylaws. PMH does not have any plans to change the membership □ualification criteria for the Hospitals following the Asset Purchase.

Furthermore, it should be noted that PMH welcomes the affiliation of independent physicians, including physicians who are not part of PMH□s owned physician network to have privileges at its hospitals.

Section 3.2 of ECHN□s Medical Staff Bylaws which outlines the general □ualifications for Medical Staff membership has been included as **Exhibit Q**.

4. On pages 2158-2159 of the Response, Applicants identify two types of physicians that participate in the PMH physician network, fully contracted physicians (□FCP□) and those identified as operating under a Memorandum of Understanding (□MOU□). Please elaborate on the differences between the two categories of physicians. In the detailed response, please clarify the following:

a) The typical scenarios in which a physician chooses to be an MOU affiliated physician versus an FCP;

Response:

MOUs are entered into on an emergent basis or on an as needed basis. It is not unusual for a patient, on an emergent or urgent basis, to choose a physician (primary care or specialist) who is not part of PMH's network. Rather than require the patient to find an in-network physician, PMH typically negotiates one time rates with that physician by entering into MOUs. If the physician provides services within PMH's geographic service area, PMH would invite the physician to join PMH's network. Some physicians will choose to become part of the PMH network and some decide otherwise.

b) Any differences in the types or frequency of services an MOU physician would provide versus an FCP;

Response:

As stated in the response to Question 4a above, MOUs are typically entered into on an emergent or urgent basis. Typically, an MOU physician's service would be limited to a particular patient.

c) The typical circumstance where an MOU physician's service would be limited to a particular patient.

Response:

Please see the response to Question 4a above.

5. On page 2162 of the Response and at Exhibit F, Applicants provided a summary of performance metrics for Prospect Health Services in Texas. With respect to this summary, please address the following:

a) Explain what differentiates an acute patient versus a non-acute patient.

Response:

An acute patient is typically in need of hospital services. Non-acute patients do not require hospital services but may require a lower level of care such as a skilled nursing facility or a board and care home[2].

[2] "Board and care" refers to nonmedical community-based residential settings that house two or more unrelated adults and provide some services such as meals, medication supervision or reminders, organized activities, transportation, or help with bathing, dressing and other activities of daily living.
Source: https://aspe.hhs.gov/report/description-board-and-care-facilities-operators-and-residents

b) Whether this Exhibit includes Medicare Advantage Performance patients only and the meaning of the term "Seniors".

Response:

Seniors are Medicare Advantage enrollees. The Exhibit is in reference of Medicare Advantage patients.

c) Explain what the Goals identified in the top right corner of the Exhibit signify.

Response:

The Goals identified in the top right corner of the Exhibit signify patient bed days per thousand members by payor class.

d) Applicants stated with respect to the trends in Texas that they were "encouraging and positive, but show room for improvement." Please specifically identify those areas needing improvement and explain the specific strategies being implemented to address these deficiencies.

Response:

The immediate areas that PMH is looking to improve are reducing admission and re-admission rates. PMH plans to reduce such rates through (i) further physician training and patient education; and (ii) dedicated approach to PMH's medical management programs for high risk patients with significant co-morbidities at home which entail the following:

- 24/7 direct telephonic access
- Identification of patient "admission drivers" with development of specific action plans
- Patient and family engagement care plans
- Integrated social service coordination for members with psychosocial issues and placement issues
- Integrated behavioral health management
- Disease-specific action plans and self-management
- Advance care planning
- Coordination of ancillary services and physician referrals
- Outpatient palliative care program

- Multidisciplinary team of physicians, nurses, social workers chaplain, and pharmacist available 24 7
- Expedited interventions for Pneumonia, COPD, CHF, Dehydration, and Cellulitis
- Hospital post-discharge follow-up visits within 24hours
- Same day urgent visits
- Phone communication with primary care physician and specialist for intervention
- Telephonic medication therapy management
- Disease management programs (Disease Management & Anticoagulation)
- Post discharge in-home medication therapy management
- Long-term care medication therapy management
- Integrated with inpatient and outpatient clinical teams
- Patient education and assessment of non-adherence

The Objectives of the above programs are to manage symptoms and reduce readmissions with the goal of maximi ing care in home.

When high-risk patients with significant co-morbidities are admitted to a hospital, PMH s hospital care management program provides the following:

- Close monitoring of patients by rounding twice per day until patient is discharged
- Medical Director rounds with hospital case manager and hospitalist twice per day until the patient is discharged
- Ability to direct patients from acute setting to skilled nursing facility when appropriate;
- Ability to direct patients from acute setting to early post discharge visits when appropriate; and
- Close collaboration between hospital case manager, skilled nursing facility case manager, pharmacist, nurse practitioner and primary care physician

When high risk patients with significant co-morbidities are in a sub-acute setting, PMH s medical management program provides the following:

- Monitoring of patients by rounding three to five times per week until patient is stable, then two to three times per week
- Physician rounds supplemented by Prospect nurse practitioners
- Medical Director rounds with case managers and physician twice per week; and
- If patient's status deteriorates, transfer to network hospital

6. On page 2149 of the Response, Applicants state that a $5 million planned renovation at RGH which is expected to be completed by September 2016 will result in RGH having the ability to accommodate an additional 30 patients with behavioral health conditions. Additionally, Applicants state that the acquisition of physicians from Mansfield OB/GYN Associates has added demand for OB services. However, in the table on page 2173 of the Response and the subsequent explanation, Applicants state that projected growth for inpatient discharges is attributable to Medical/Surgical discharges and not to the maternity or behavioral health units at either hospital "as both the maternity unit and behavioral health unit are operating at capacity [at MMH] and RGH does not provide either services at the present time. Based on this assumption, discharge volume for maternity, pediatric (newborn) and psychiatric services will remain constant at the levels projected for FY 2016 through FY 2019." Please clarify why the planned behavioral health unit renovation at RGH and the increased demand for OB services do not result in increases FY 2016 through FY 2019 for Inpatient Discharges in maternity patients for MMH (as the hospital's maternity unit apparently has overflow capacity on the Third West unit) and psychiatric patients for RGH.

Response:

The increased demand for maternity and newborn services resulting from the addition of the Mansfield OB/GYN Associates physicians in FY 2015 will be fully realized in FY 2016. The discharge volume for maternity and pediatric patients reported in Table C on page 2170 reflects the expected twelve-month delivery volume for the OB/GYN physicians on ECHN's Medical Staff and assumes no changes to the number of OB/GYN physicians during the projection period.

The planned behavioral health unit renovation at RGH is only in the developmental stages at this time so projections for RGH do not include any of the volumes, revenues or expenses associated with enhancing behavioral health services at RGH.

7. Applicants indicate on page 217 5 of the Response that ECHN has struggled to retain, in particular, primary care providers. Tables E and F on page 2174 of the Application indicates an increase to date in Allied Health Professionals employed in the ECHN Medical Foundation. Please elaborate on the role Applicants envision for AHPs post-closing, addressing specifically:

   a) Whether AHPs will be utilized to compensate for the lack of primary care physicians.

      Response:

      AHPs are already being utilized to compensate for the shortage of primary care physicians across the state. The Applicants expect this practice to continue in the ECHN service area post-closing. It should be noted that PMH has utilized AHPs in other states for many years. AHPs are an essential part of the care delivery system.

   b) Whether AHPs would be eligible to join PPGCTE or the Medical Foundation PMH will utilize post -closing.

      Response:

      AHPs will be eligible to join PPGCTE and the Medical Foundation PMH will utilize post-closing.

   c) Whether AHPs participate as members in any of PMH's existing physician networks and, if not, why not.

      Response:

      AHPs do participate as members of PMH's existing physician networks because the primary care physician shortage experienced in Connecticut is not unique. The use of AHPs to meet the primary care needs of a given community is common nationwide and a practice that PMH incorporates into its CRC model of care to ensure patients are able to receive needed care in the most appropriate and cost-effective setting.

8. On page 2175 of the Response, Applicants indicate that a decline in participants in the ECHN Medical Foundation from 2013 to 2014 was related to a decision to contract with a third party for hospitalist services at both Hospitals. Please indicate whether PMH intends to continue outsourcing hospitalists post-closing.

Response:

PMH will assume the existing contract with Sound Physicians for hospitalist services post-closing. PMH outsources hospitalist services in other states and expects all hospitalists to comply with PMH's utilization and quality criteria and other outcome measures.

9. Referencing Applicants' response to Question 53 of the Application and page 2178 of the Response, please address the following:

   a) Applicants have projected a 1% increase in spending for Community Building Activities through FY 2019. With respect to the screenings and educational programs listed in Exhibit H of the Response, please indicate whether PMH intends to allocate more resources for screenings versus educational programs than is currently the case;

      Response:

      The projected 1% increase in spending for Community Building Activities through FY 2019 is due to inflation and assumes no change in the Medicaid population served or the complement of community benefit programs offered by the Hospitals.

      As discussed in the Applicants' response to deficiencies Question 53d on page 2179, PMH will reevaluate the healthcare needs of the community with input from the Local Boards as part of its overall planning process post-closing and expects to prioritize capital projects and service improvements based on hospital and community needs. Plans to address the priority needs in ECHN's service area, including the allocation of resources for screenings and educational programs, will be developed post-closing once the priority needs have been confirmed or identified.

   b) Certain screening programs identified in Exhibit H had low utilization rates. Please elaborate how PMH intends to increase community utilization of those screening programs specifically, and screening programs, generally, in coordination with the planned 1% increase in spending year over year.

      Response:

      The projected increase in spending for Community Building Activities is due to inflation and not a result of an increase in screening frequency or community utilization. As stated in the Applicant's response to Question 22 on page 73 of the CON application submitted on October 13, 2015, PMH will continue to focus efforts on improving population health and will utilize its experience and knowledge in population health management to incorporate best-practice recommendations for disease prevention, early detection screenings and treatment options. PMH

recognizes the importance of screening in overall population health; thus specific plans to increase community utilization of screening programs will be developed post-closing pending the confirmation or identification of the communities' priority needs.

10. For those Community Health Improvement Services and Community Benefit Operations programs identified on pages 2183-2185 of the Response, please indicate which programs PMH intends to continue funding post -closing and whether any material changes in funding are expected for any of the programs listed.

Response:

PMH is committed to maintaining ECHN's current policies on community volunteer services and community benefits. Specific plans related to community benefit program offerings will be developed post-closing pending the confirmation or identification of the communities' priority needs.

11. Please explain the role, purpose and function of the Nurse and Survivorship Navigator Program listed on page 2183 of the Response.

Response:

Oncology nurse navigators assist patients and their caregivers by supporting the coordination of care in both inpatient and outpatient settings. Some examples include the management of symptoms, referrals to other specialists, the scheduling of tests and treatments, and referrals for homecare services.

The survivorship navigator is a licensed clinical social worker available to assist patients and their families with financial, insurance and disability concerns resulting from their illness. Some examples of assistance provided by the survivorship navigator include documenting advance directives, smoking cessation, supportive counseling, and referrals to community agencies. The survivorship navigator also provides supervision of ECHN's integrative medicine program.

The women's health nurse navigator oversees ECHN's Breast Care Collaborative which ensures prompt and efficient transition of care for women with suspicious or benign findings following a diagnostic breast exam, mammography or breast biopsy. The navigator is responsible for community and physician education, screening and prevention events and serves as the clinical nurse navigator for the Early Detection Program.

The Commission on Cancer, which is a department of the American College of Surgeons, requires community cancer centers to have both nurse navigators and survivorship programs to receive national accreditation and meet best practice standards. PMH is committed to maintaining ECHN's current policies on community volunteer services and community benefits and will expects to maintain the existing accreditation levels of services currently offered by ECHN and its affiliates.

12. In reference to Exhibit M, page 2381 of the Response, the Patient Experience survey indicates patient satisfaction levels for Hollywood Community Hospital of Hollywood and Los Angeles Community Hospital well below the national average. Please elaborate on the factors causing these results and detail what policy, programs and procedures PMH has implemented to increase patient satisfaction levels at these hospitals.

Response:

PMH believes that a significant factor in the patient satisfaction scores at Los Angeles Community Hospital and Southern California Hospital at Hollywood are primarily due the age of the physical plant.

Some of the upgrades that are planned for 2016 at Los Angeles Community Hospital include the following:

- ER remodel;
- Beautification of OB areas;
- Upgrades to ICU and CCU;
- Modernization of elevators;
- Beautification of the lobby;
- Better signage; and
- Beautification of radiology areas.

Some of the upgrades that PMH is planning for 2016 at Southern California Hospital at Hollywood include the following:

- Upgrades to ICU and CCU;
- Beautification of the lobby areas;
- Better signage; and
- Modernization of elevators.

In addition to the projects described above, we are re-dedicating new hospital leaders to improve all quality and patient satisfaction scores at all California hospitals. We expect that the new leaders will adopt proven measures to increase patient satisfaction, such as patient rounding with a focus on communication with patients.

13. Please provide clarification as to whether the amounts provided on Table 8, Exhibit B, page 2209, are actual or estimated and if amounts were submitted as of 9/30/15 or 11/4/15.

Response:

The amounts provided on Table 8, Exhibit B, page 2210 are the actual amounts for 09/30/2015 based on the unaudited financials updated as of 11/4/2015. The actual amounts for Table 8 will not be considered final until the FY 2015 audited financials have been through all audit review levels and presented to ECHN's Audit Committee.

14. Please provide documentation that supports PMH's available funds in excess of $110 million and its generation of $7.5 million in free cash flow per month as of September 30, 2015, as stated on page 2192.

Response:

Please refer to **Exhibit R** for the documentation that supports PMH's available funds.

15. In reference to PMH's Capital Investments and Cost Savings Table, Exhibit L, page 2327, address the following:

a) What do the amounts listed under the columns Profitability, Liquidity and Solvency represent (e.g. total margin, operating margin, EBITDA, cash and cash equivalents, net assets, stock holder's equity, etc.) Provide documentation that supports the data, for example, calculation methodology, etc. and the measurement period that applies to each of the entries;

Response:

The data provided for Exhibit L are on a standalone company basis. Profitability for each entity is measured by EBITDA for the entity (subject to the footnotes in Exhibit L), on a standalone basis. EBITDA was calculated pursuant Generally Accepted Accounting Principles ("GAAP") the fiscal year ending September 30, 2015.

Liquidity is calculated by measuring the working capital for each entity. The formula for working capital is: current assets less current liabilities for each entity as of September 30, 2015.

Finally, solvency is measured by stockholders equity for each entity as of fiscal year ended September 30, 2015. Stock holders equity is measured by GAAP.

b) As previously requested in Question 37(b), for each of the five entities, elaborate on how the cost savings listed were the result of economies of scale inherent of a larger organization;

Response:

All hospitals acquired by PMH become part of PMH's purchasing programs for supplies and drugs. Under PMH's contracts, higher volume of purchases by PMH as an organization results in lower prices for supplies and drugs. All acquired hospitals benefit from such realized savings. Furthermore, PMH as an organization, because of its growing size, has hired employees with subject matter expertise in operations of hospitals. Such personnel are made available to all PMH hospitals. As such, our hospitals save on hiring consultants.

c) The table shows references to footnotes labeled as "(g)" and "(h)" but the information related to these footnotes is missing. Please provide the missing information.

Response:

Please see **Exhibit S** for the revision of Exhibit L showing the footnotes for (g) and (h) that were inadvertently left off the previously provided version of the exhibit.

16. In reference to the Revised Financial Worksheets (C), Exhibit I, pages 2312-2317 and related assumptions, for ECHN, MMH and RGH, explain the following:

a) The factors driving the gains in incremental gross patient revenue for each entity;

Response:

Gross patient revenue for ECHN, MMH and RGH is expected to increase in FY 2017 through FY 2019 "without the CON" as a result of fee schedule adjustments made in connection with changes to managed care agreements. Additional gains in gross patient revenue are anticipated "with the CON" as a result of incremental volume increases.

b) The positive net income "without the CON" in FY 2019 for MMH and RGH; and

Response:

The positive net income achieved in FY 2019 "without the CON" is due the cumulative effect of annual increases in net patient revenue anticipated as a result of improved managed care contracts and ECHN's continuous efforts to manage expenses and control costs at the Hospitals and other ECHN facilities.

c) The reductions in "other operating revenue" between FY 2014 actual and FY 2015 projected for each entity.

Response:

The other operating revenue amount in FY 2014 includes realized gains from the one-time transfer of ECHN's investment portfolio from volatile, high-risk stock investments to more conservative, fixed-income investments.

17. In reference to PMH's credit rating and the revolving line of credit with Morgan Stanley information provided on page 2191 of the Response, address the following:

a) Provide the specific time period (e.g. month, quarter) associated with the credit ratings referenced for PMH; and

Response:

Please see **Exhibit T** for the most recent credit rating reports for PMH.

b) Provide the total amount available and principal amount related to the credit line. Elaborate on the ability to retain this funding once the engagement with Morgan Stanley and PMH concludes "within the next year" as indicated on page 2206 of the Response.

Response:

Please see Note 8 on page 47 of PMH's consolidated financial statements attached hereto as **Exhibit U** which states that the total amount available under the credit line is $40 million. It is anticipated that the credit line will either remain the same or increase next year due to PMH's positive financial performance.

18. On page 2194 of the Response, the Applicants indicated that PMH's FY 2015 financial statements, reflecting twelve months of financial activity, are not available and that a copy will be provided once they have been received and publicly disclosed. In reference to this

response, please provide an estimate for when the copy of the audited financial statements will be available.

Response:

The FY 2015 consolidated financial statements for PMH are now available and have been provided as **Exhibit U**.

19. On page 2195 of the Response, the Applicants indicated that the Other Operating Revenue Detail report, Exhibit J, submission was corrected to reflect the removal of the amount for "Public Support" in the "with CON" scenario. Please define what encompasses "Public Support."

Response:

Public Support includes the unrestricted charitable donations that ECHN, as a non-profit entity, receives through the ECHN Community Healthcare Foundation, Inc. The post-closing for-profit entity will not receive any charitable support.

20. In reference to the California Quality Assurance Fee (SB 239) program referred to on page 2192, elaborate on the impact on PMH's future ability to support the cost of this proposal and future capital needs for MMH and RGH in excess of the $75 million, without the additional dollar amounts generated by this program in the form of revenue and cash receipts.

Response:

The Quality Assurance Fee program has been part of California law for the past eight years and will be part of California law for the next six years. PMH fully expects the extension of the program after six years. In the next six years, PMH expects an increase in its portion of the net Quality Assurance Fees. Furthermore, PMH is a profitable and growing company with access to capital. As such, we expect to be able to support this proposal to meet the needs of ECHN for the foreseeable future. It should be noted that in 2014, due to a delay in payment of Quality Assurance Fees, PMH did not receive any funds for the program, but was able to meet all of its commitments to close on $70 million of transactions.

RESPONSE TO DEFICIENCIES (DECEMBER 11, 2015)

EXHIBITS

RESPONSE TO DEFICIENCIES (DECEMBER 11, 2015)

EXHIBIT Q – Section 3.2 ECHN's Medical Staff Bylaws

ARTICLE THREE: MEMBERSHIP

3.1 NATURE OF MEMBERSHIP

Membership on the Medical Staff is a privilege that is granted by the Board after considering the recommendations of the Medical Staff, and that shall be extended only to professionally competent Practitioners who continuously comply with and meet the qualifications, standards, and requirements set forth in these bylaws, the rules and regulations of the Medical Staff, and other Medical Staff policies, including the directives and policies of the MEC and the other Medical Staff committees. Appointment to and membership on the Medical Staff shall not confer on the Staff member any Clinical Privileges. A member of the Medical Staff shall only have Clinical Privileges if specifically granted by the Board in accordance with these bylaws.

An individual who fails to satisfy the membership qualifications, standards and requirements is ineligible to apply. A determination of eligibility shall be made prior to submitting the application to the Credentials Committee. A determination of ineligibility does not entitle the individual to the provisions of Article Twelve of these bylaws.

3.2 GENERAL QUALIFICATIONS

Each Practitioner who seeks or enjoys Staff membership shall, at the time of appointment and continuously thereafter, demonstrate to the satisfaction of the Medical Staff and the Board, through documentation and other evidence, the following:

3.2-1 LICENSURE

A currently valid unrestricted license issued by the State of Connecticut to practice medicine, osteopathy, dentistry, or podiatry and have never had such a license to practice revoked by any state licensing agency and currently valid federal and state registrations to prescribe controlled substances except where the Practitioner demonstrates that such registration is not required in order to exercise the Practitioner's current or requested Clinical Privileges.

3.2-2 PERFORMANCE

(a) Professional education, training, experience, current competence, and clinical results documenting a continuing ability to provide optimally achievable patient care services given the resources locally available.

(b) With regard to board certification, all applicants to the Medical Staff, with the exception of general dentists, at the time of being granted Privileges, shall:

(1) Have completed a residency accredited by the Accreditation Council for Graduate Medical Education, the American

Osteopathic Association, the American Dental Association, or the Council on Podiatric Medical Education; or by a program with a reciprocity agreement with the American Board of Medical Specialties or American Osteopathic Association.

3.2-2 (b) (2) If not certified by a board that is a member of the American Board of Medical Specialties, by a board recognized by the American Board of Medical Specialties, by the American Osteopathic Association, by a board recognized by the American Osteopathic Association, by the American Podiatric Medical Association, or by the American Dental Association (limited to the American Board of Oral and Maxillofacial Surgery) be admissible for certification and become certified within the lesser of (i) the period of eligibility as defined by the respective board, or (ii) five years after initial appointment to the Medical Staff. Certification by the Royal College of Physicians and Surgeons of Canada may be accepted based upon a waiver recommended by the MEC and approved by the Board. The boards listed in this section shall be the sole means for certification requirement.

Furthermore, Staff members whose board certificates bear an expiration date shall successfully complete recertification no later than three years following such date. Failure to obtain board certification or recertification shall result in automatic termination of all Privileges accorded to such member and termination of such Practitioner's Staff membership. However, the requirements to obtain board certification and/or recertification are not made retroactive for those Staff members who, prior to obtaining membership on the Medical Staff, had been members of the Medical Staff of MMH continuously since July 1, 1988 or had been members of the Medical Staff of RGH continuously since May 1, 1996.

3.2-3 ATTITUDE

A willingness and capability, based on current attitude and evidence of performance, to work with and relate to other Staff members, members of other health disciplines, the Network Hospitals' management, and employees, visitors, and the community in general, in a cooperative, professional manner conducive to the maintenance of an environment appropriate to quality patient care. The behavior of members of and applicants for membership on the Medical Staff and AHPs constitutes an essential component of professional activity and personal relationships within the Network Hospitals. Civil deportment fosters an environment conducive to excellent patient care. Accordingly, in addition to the other qualifications set forth in this Article Three, all members of Medical Staff and AHPs at all times shall demonstrate an ability to interact on a professional basis with members of the Staff, patients, and others and to behave in a professional and civil manner. This requirement is not in any way intended to

interfere with a Staff member or AHP's privileges: (1) to express opinions freely and to support positions whether or not they are in dispute with those of other Staff members; (2) to engage in honest differences of opinion with respect to diagnosis and treatment or basic program development that are debated in appropriate forums; or (3) to engage in the good faith criticism of others. The following types of behavior, however, which constitute some examples of an inability to interact on a professional basis with others or to behave in a professional and civil manner, are deemed unacceptable for members of the Medical Staff and AHPs:

- Conduct that reasonably could be characterized as sexual and/or racial harassment;
- Threats of physical assault or actual physical assault, harassment, or the placing of others in fear by engaging in threatening behavior;
- The unnecessary and unjustifiable use of loud, profane, or abusive language directed toward Staff members, patients, or others;
- Unnecessary and unjustifiable rude or abusive behavior;
- Written or oral statements that constitute the intentional expression of falsehoods or constitute deliberately disparaging statements made with a reckless disregard for their truth or for the reputation and feelings of others.

Furthermore, all members of the Medical Staff shall demonstrate a willingness and capability, based on current attitude and evidence of performance, to:

(a) Participate equitably in the discharge of Staff obligations appropriate to Staff membership category; and

(b) Adhere to generally recognized standards of professional ethics.

3.2-4 DISABILITY

To be free of, or have under adequate control, any significant physical or behavioral impairment that interferes with, or presents a significant possibility of interfering with, the Practitioner's ability to perform the Privileges requested or granted.

3.2-5 PROFESSIONAL LIABILITY INSURANCE

Professional liability insurance is not less than the minimum amount, as determined from time to time by resolution of the Board. Medico-Administrative Officers with no Clinical Privileges shall be exempt from this requirement.

RESPONSE TO DEFICIENCIES (DECEMBER 11, 2015)

EXHIBIT R – PMH Free Cash Flow

Prospect Medical Holdings
Free Cash Flow
FYE 9/30/2015

Operating Income	$	108,060,000
Change in WC (Increase)	$	34,374,000
Taxes Paid	$	(35,778,000)
Net Change in PP&E	$	(10,863,000)
Free Cash Flow	$	95,793,000
Average Monthly Free cash Flow	**$**	**7,982,750**

RESPONSE TO DEFICIENCIES (DECEMBER 11, 2015)

EXHIBIT S – PMH Capital Investments and Cost Savings Table (Exhibit L Revision)

Table from Question 37a - Capital Investments and Cost Savings Table

Hospital	Investments since Acquistion	Describe Improvements in Financial Performance: Profitability	Liquidity	Solvency	Cost Savings
Los Angeles Community Hospital at Bellflower	$ 3,646,633	N//A (a)	N/A (a)	N/A (a)	N/A (a)
Foothill Regional Medical Center	$ 7,912,807	N/A (a)	N/A (a)	N/A (a)	N/A (a)
Our Lady of Fatima Hospital	$ 11,321,376 (f)	$ 15,184,000 (g)	$ 4,976,828 (c)	$ 67,475,613 (c)	Marginal Cost per day reduced to $1,493 from $1,542 (d)
Roger Williams Medical Center	$ 11,321,376 (f)	$ 15,184,000 (g)	$ 4,976,828 (c)	$ 67,475,613 (c)	Marginal Cost per day reduced to $2,271 from $2,263 (d)
Nix Health System	$ 33,350,077	$ 20,867,000 (h)	$ 15,882,118	$ 63,789,134	Total Costs per day decreased to $1,444 from $1,584 (e)

(a) Both Los Angeles Community Hospital at Bellflower (Bellflower) and Foothill Regional Medical Center (Foothill) were closed prior to PMH acquisition
Bellflower re-opened in July 2015 and Foohill re-opened in September 2015. Both facilities were purchased in May 2014.

(b) Los Angeles Community Hospital at Bellflower is under common corporate ownership structure and license as Los Angeles Community Hospital and
Los Angeles Community Hospital at Norwalk. As such, liquidity and solvency for this campus includes financial information for all three campuses combined

(c) The profitability, liquidity and solvency of Our Lady of Fatima and Roger Williams Medical Center are reported on a consoldiated basis for the CharterCARE system
Prior to the acquisition, the liquidity of CharterCARE system was approximately a negative $2.5 million
Profitability is measured on an EBITDA basis and reported on a consolidated basis for the CharterCARE system

(d) Measured from June 2014 to May 2015

(e) Measured from Dember 2011 to September 2015. Prior to acquisition Nix did not compute Marginal cost per day.

(f) Total capital investment in Our Lay of Fatima and Roger Williams Medical Center (which comprise CharterCARE) is reported on a combined basis.
In addition to the amount already spent, we have committed to spend $20 million in addtion to what has already been spent
on (i) cancer center; (ii) Digestive Diseases Center; (iii) Emergency Department and (iv) physician practice acquisitions.

(g) Profitability based on a consolidated EBITDA basis and adjusted for corporate allocation for nine months endedf 6/30/2015.
Our Lady of Fatima Hospital and Roger Williams Medical Center are part of CharterCARE system
EBITDA of CharterCARE as of 3/31/2013 (one year prior to acquisition) was $7,146,000

(h) Profitablilty reported on an EBITDA basis adjusted for corporate allocations for year ended 9/30/2014.
EBITDA of Nix for 12/31/2011 was $18,774,000.

RESPONSE TO DEFICIENCIES (DECEMBER 11, 2015)

EXHIBIT T – Credit Rating Reports for PMH

MOODY'S
INVESTORS SERVICE

Rating Action: Moody's upgrades Prospect Medical's CFR to B1 from B2; outlook is stable

Global Credit Research - 09 Jul 2015

New York, July 09, 2015 -- Moody's Investors Service upgraded the Corporate Family Rating of Prospect Medical Holdings, Inc. (Prospect) to B1 from B2. The company's Probability of Default Rating was also upgraded to B1-PD from B2-PD and the rating on Prospect's senior secured notes was upgraded to B1 from B2. The rating outlook is stable.

The ratings upgrade primarily reflects Moody's expectation of operational improvements at the company's existing and newly acquired hospitals that will contribute to earnings growth and improved cash flow. Moody's expects Prospect to sustain debt to EBITDA below 4 times over the next twelve to eighteen months.

The following ratings were upgraded

Corporate Family Rating to B1 from B2

Probability of Default Rating to B1-PD from B2-PD

Senior secured notes due 2019 to B1 (LGD 3) from B2 (LGD 4)

The outlook is stable.

RATINGS RATIONALE

Prospect's B1 Corporate Family Rating reflects the company's moderate scale, its high financial leverage, its high concentration in only a few markets, and its significant reliance on California and Texas Medicaid programs. Moody's anticipates that Prospect will remain acquisitive beyond the transactions the company has already announced in New Jersey and Connecticut in order to gain scale and improve geographic diversification. Moody's expects Prospect to generate EBITDA and cash flow growth from both existing and soon-to-be-acquired hospitals. Further, Moody's anticipates that Prospect will use internally generated cash and limit the use of incremental debt to fund future growth so that leverage remains below 4.0 times.

The stable outlook reflects Moody's expectation that Prospect's leverage will remain moderately high but will benefit from near term hospital acquisitions that will be funded with internally generated cash. Moody's also expects that Prospect will maintain good liquidity, despite capital commitments at newly acquired facilities, due to improvement in operating cash flow.

Given Prospect's relatively small size and considerable concentration in only a few markets, Moody's does not anticipate an upgrade of the ratings in the near term. However, over the longer term, the ratings could be upgraded if the company can increase scale and enhance revenue and earnings diversification. Further, the ratings could be upgraded if Prospect maintains debt to EBITDA at around 3.0 and maintains a measured approach towards debt funded acquisitions or shareholder initiatives.

The ratings could be downgraded if operational or integration challenges cause a significant deterioration in financial metrics or the company undertakes a material debt funded acquisition or shareholder distribution. More specifically, ratings could be downgraded if Moody's expects debt to EBITDA to be sustained above 4.0 times or if liquidity weakens.

The principal methodology used in these ratings was Global Healthcare Service Providers published in December 2011. Other methodologies used include Loss Given Default for Speculative-Grade Non-Financial Companies in the U.S., Canada and EMEA published in June 2009. Please see the Credit Policy page on www.moodys.com for a copy of these methodologies.

Headquartered in Los Angeles, California, Prospect Medical Holdings, Inc. provides health care services through a network of 13 acute care and behavioral hospitals located in California, Texas and Rhode Island. Through its Medical Group business unit, the company provides administrative management of health care services to

independent physician organizations that cover over 300,000 members through a network of primary care doctors and specialists. Prospect recognized revenues of approximately $1.2 billion in the twelve months ended March 31, 2015. The company is owned by private equity firm Leonard Green & Partners L.P. and members of the company's management team.

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Research Update:

Prospect Medical Holdings Inc. 'B' Corporate Credit Rating Affirmed; Senior Secured Notes Raised To 'B' (Recovery: '4')

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Submitted December 24, 2015
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Research Update:

Prospect Medical Holdings Inc. 'B' Corporate Credit Rating Affirmed; Senior Secured Notes Raised To 'B' (Recovery: '4')

Overview

- Los Angeles-based health care services provider Prospect Medical Holdings Inc. has expanded EBITDA meaningfully in 2015, reflecting the impact of its 2014 acquisitions and the positive impact of health care coverage expansion.
- We are affirming our 'B' corporate credit rating on Prospect.
- We are raising our rating on Prospect's senior secured notes to 'B' from 'B-' and revising our recovery rating on this debt to '4' from '5', indicating our expectations for average (30% to 50%; at the low end of the range) recovery for bondholders in the event of payment default.
- The rating outlook is stable, reflecting our view that EBITDA margins will remain broadly stable, with improving margins at acquired hospitals offset by persistent, industrywide pressure from reimbursement headwinds.

Rating Action

On Sept. 21, 2015, Standard & Poor's Ratings Services affirmed its 'B' corporate credit rating on Los Angeles-based health care services provider Prospect Medical Holdings Inc. The rating outlook is stable.

At the same time, we raised our rating on Prospect's senior secured notes to 'B' from 'B-' and revised our recovery rating on this debt to '4' from '5'. The '4' recovery rating indicates our expectations for recovery at the low end of the average (30% to 50%) range for bondholders in the event of payment default.

Rationale

The ratings affirmation on Prospect follows several quarters of strong EBITDA growth, reflecting the impact of significant acquisitions completed in 2014, as well as high-single digit same-facility growth in the company's hospital and medical group portfolio, despite a continued high level of competition in Prospect's key markets.

Prospect operates a network of 13 hospitals and related primary-care clinics in Southern California, Texas, and Rhode Island. The company also operates a Medical Group segment that manages the provision of physician services on behalf of health maintenance organization (HMO) customers. While the medical

group segment provides some business diversity, this business also has significant exposure to government reimbursement pressures in the Medicare Advantage program.

We view Prospect's business as geographically concentrated, with the majority of revenues coming from very competitive urban markets in California and Texas. While recent acquisitions in Rhode Island and pending acquisitions in New Jersey and Connecticut will contribute modest geographic diversity, the company still has very significant exposure to the California Hospital Fee Program and other disproportionate share subsidy programs, which at times has contributed to meaningful volatility in the timing of cash flows relative to peers. We expect this factor to continue over time. We view Prospect's EBITDA margins as below average, which in part reflects the company's government-focused payor mix (excluding capitation revenues, the company derives over 55% of revenues from Medicare and Medicaid), as well as acquisitions of underperforming hospital facilities. These factors are only partially offset by our view that Prospect's strategic focus as a cost-efficient provider of coordinated care will aid the company's growth as health care services providers make the eventual transition away from fee-for-service reimbursement and toward payments based on quality and efficiency of care. Collectively, these factors support our assessment of a "vulnerable" business risk profile.

We expect Prospect to generate over 50% revenue growth in fiscal 2015 and high-single-digit revenue growth in 2016, reflecting the impact of acquisitions as well as low- to mid-single-digit same-facility revenue growth. We expect EBITDA margins to remain broadly stable, with improving margins at acquired hospitals offset by persistent, industrywide pressure from reimbursement headwinds. As a result of EBITDA growth, we expect Prospect to generate about $50 million in discretionary cash flow in 2016, which we expect the company will allocate toward acquisitions.

Despite recent improvement in credit measures, we continue to assess Prospect's financial risk profile as "aggressive". Following the completion of several acquisitions in 2014, leverage has declined to below 4x at June 30, 2015, from over 5x at Dec. 31, 2014. While leverage should remain at the stronger end of the range for an aggressive financial risk profile, we expect funds from operations (FFO) to debt to remain in the mid-to-high teens, consistent with the financial risk descriptor. The company's financial sponsor ownership, somewhat aggressive acquisition strategy, and history of debt-funded dividends are key considerations supporting our financial risk assessment, as we believe the company's financial policies are likely to tolerate modest increases to leverage versus current levels. We expect Prospect to pursue hospital acquisitions to diversify and grow its business over the next few years, and we believe the company may increase leverage to finance this strategy.

Liquidity

We assess Prospect's liquidity as "adequate". We expect sources of liquidity to exceed uses by over 1.2x in 2015, and that sources would exceed uses even if EBITDA declined by 15%. Our liquidity assessment is constrained at "adequate" because we do not believe the company could withstand a high-impact, low-probability event without refinancing.

Principal liquidity sources:

- About $40 million of cash at June 30, 2015;
- About $40 million of availability on the company's $60 million revolving credit facility; and
- About $80 million to $90 million in expected 2015 FFO.

Principal liquidity uses:

- About $40 million in capital expenditures; and
- Some investment in working capital in 2015.

Outlook

The rating outlook on Prospect Medical Holdings Inc. is stable. Standard & Poor's Ratings Services expects over 50% revenue growth in 2015, driven primarily by acquisitions. We expect EBITDA margins to remain broadly stable, with improving margins at acquired hospitals offset by persistent, industrywide pressure from reimbursement headwinds. We expect leverage and cash flow metrics to be at the strong end of the range for an "aggressive" financial risk profile, and believe reasonable levels of profitability provide moderate downside cushion to the rating.

Downside scenario

We could lower our rating if Prospect's financials deteriorate to the point where leverage rises above 5x, or if the company stops generating positive free cash flow. We believe this could occur if margins decline about 450 basis points below our expectations. Sharp cuts to disproportionate share payment programs or Medicare reimbursement without offsetting factors could, in our view, cause this to occur. Leverage could also increase above 5x if the company becomes meaningfully more acquisitive. Assuming no acquired EBITDA, we estimate that the company has about $300 million in debt capacity at the existing rating.

Upside scenario

We could raise our rating if the company's acquisition strategy results in better business diversity over time. Specifically, we could consider a higher rating if the company's exposure to California declines, as we would likely view better geographic diversity (and less exposure to California's provider fee programs) as consistent with a stronger business risk assessment and raise the rating accordingly.

Ratings Score Snapshot

Corporate Credit Rating B/Stable/--

Business risk: Vulnerable
- Country risk: Very low
- Industry risk: Intermediate
- Competitive position: Vulnerable

Financial risk: Aggressive
- Cash flow/Leverage: Aggressive

Anchor: b

Modifiers
- Diversification/Portfolio effect: Neutral (no impact)
- Capital structure: Neutral (no impact)
- Financial policy: FS-5 (no additional impact)
- Liquidity: Adequate (no impact)
- Management and governance: Fair (no impact)
- Comparable rating analysis: Neutral (no impact)

SACP: B

Recovery Analysis

Key analytical factors

- We have reassessed our view of Prospect's likely emergence enterprise value following a default given the company's recent acquisitions.
- Our issue-level rating on Prospect's senior secured notes is now 'B', with a recovery rating of '4', indicating our expectation for average (30% to 50%; at the low end of the range) recovery on this debt in the event of payment default.
- Prospect's capital structure includes a $60 million revolver, $425 million in senior secured notes, and approximately $13 million in capital leases. We do not rate the revolver.
- In our default scenario, we assumed the company would be reorganized, and valued the company on a going-concern basis using a 4.0x multiple of our projected emergence EBITDA. This multiple is below that of peers and reflects Prospect's reliance on various disproportionate share subsidy programs.
- We estimate that for the company to default, EBITDA would need to decline significantly, representing a meaningful adverse change to reimbursement or a loss of key customers in the group medical business.

Simulated default assumptions

- Simulated year of default: 2018.
- EBITDA at emergence: $61 million.

- EBITDA multiple: 4.0x.

Simplified waterfall

- Net enterprise value (after 5% admin. costs): $230 million
- Valuation split in % (obligors/nonobligors): 100/0
- Priority claims: $13 million
- ---
- Collateral value available to revolver lenders: $181 million
- Revolver debt (with a first-out provision): $53 million
- --Recovery expectations: N/A
- Collateral value available to secured creditors: $164 million
- Secured first-lien debt: $443 million
- --Recovery expectations: 30% to 50% [low end of the range]

Notes: All debt amounts include six months of prepetition interest. N/A--Not applicable.

Related Criteria And Research

Related Criteria

- Criteria - Corporates - General: Methodology And Assumptions: Liquidity Descriptors For Global Corporate Issuers, Dec. 16, 2014
- Criteria - Corporates - Industrials: Key Credit Factors For The Health Care Services Industry, April 16, 2014
- General Criteria: Group Rating Methodology, Nov. 19, 2013
- Criteria - Corporates - General: Corporate Methodology: Ratios And Adjustments, Nov. 19, 2013
- Criteria - Corporates - General: Corporate Methodology, Nov. 19, 2013
- General Criteria: Methodology: Management And Governance Credit Factors For Corporate Entities And Insurers, Nov. 13, 2012
- Criteria - Corporates - Recovery: Criteria Guidelines For Recovery Ratings On Global Industrials Issuers' Speculative-Grade Debt, Aug. 10, 2009

Ratings List

Ratings Affirmed

Prospect Medical Holdings Inc.		
Corporate Credit Rating	B/Stable/--	
Upgraded; Recovery Rating Revised		
	To	From
Prospect Medical Holdings Inc.		
Senior Secured	B	B-
Recovery Rating	4L	5

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RESPONSE TO DEFICIENCIES (DECEMBER 11, 2015)

EXHIBIT U – Consolidated Financial Statements for PMH

Prospect Medical Holdings, Inc.

Consolidated Financial Statements

For the Years Ended
September 30, 2015 and 2014

The report accompanying these financial statements was issued by BDO USA, LLP, a Delaware limited liability partnership and the U.S. member of BDO International Limited, a UK company limited by guarantee.

Prospect Medical Holdings, Inc.

Consolidated Financial Statements

For the Years Ended September 30, 2015 and 2014

Prospect Medical Holdings, Inc.

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Independent Auditor's Report

Board of Directors
Prospect Medical Holdings, Inc.
Los Angeles, California

We have audited the accompanying consolidated financial statements of Prospect Medical Holdings, Inc. (the "Company"), which comprise the consolidated balance sheets as of September 30, 2015 and 2014, and the related consolidated statements of income, statements of stockholder's equity (deficit), and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Prospect Medical Holdings, Inc. and its subsidiaries as of September 30, 2015 and 2014, and the results of their operations and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

BDO USA, LLP

December 10, 2015

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Consolidated Financial Statements

Prospect Medical Holdings, Inc.

Consolidated Balance Sheets
(in thousands except par value and share amounts)

September 30,	2015	2014
Assets		
Current assets		
Cash and cash equivalents	$ 65,606	$ 39,072
Restricted cash	4,585	4,976
Restricted investments	1,266	642
Patient accounts receivable, net of allowance for doubtful accounts of $52,707 and $49,727	139,696	123,733
Due from government payers	41,586	42,518
Other receivables	6,821	15,947
Inventories	12,294	10,448
Hospital fee program receivable	32,285	-
Prepaid expenses and other current assets	17,889	14,374
Total current assets	322,028	251,710
Property, improvements and equipment, net	240,337	229,474
Deferred financing costs, net	7,233	9,457
Deferred income taxes, net	11,865	1,165
Goodwill	162,296	158,864
Intangible assets, net	29,162	35,274
Other assets	9,930	8,234
Total assets	$ 782,851	$ 694,178

See accompanying notes to the consolidated financial statements.

Prospect Medical Holdings, Inc.

Consolidated Balance Sheets
(in thousands except par value and share amounts)

September 30,	2015	2014
Liabilities and Stockholder's Equity (Deficit)		
Current liabilities:		
Accrued medical claims and other healthcare costs payable	$ 53,531	$ 39,314
Accounts payable and other accrued liabilities	102,936	88,218
Accrued salaries, wages and benefits	57,432	53,808
Hospital fee program liability	15,022	2,806
Due to government payers	27,078	26,584
Income taxes payable, net	15,110	5,879
Revolving line of credit	20,000	20,000
Current portion of capital leases	2,905	4,691
Current portion of long-term debt	135	133
Other current liabilities	2,168	1,659
Total current liabilities	296,317	243,092
Long-term debt, net of current portion	422,700	421,755
Deferred income taxes, net	-	3,308
Malpractice reserves	6,632	4,590
Capital leases, net of current portion	9,296	10,463
Asset retirement obligations	4,583	4,310
Other long-term liabilities	6,883	7,866
Total liabilities	746,411	695,384
Commitments, contingencies and subsequent event		
Stockholder's equity (deficit):		
Common stock, $0.01 par value; 100 shares authorized, issued and outstanding at September 30, 2015 and 2014	1	1
Additional paid-in capital	20,037	18,457
Retained earnings (accumulated deficit)	6,158	(28,481)
Total stockholder's equity (deficit) attributable to Prospect Medical Holdings, Inc.	26,196	(10,023)
Non-controlling interests	10,244	8,817
Total stockholder's equity (deficit)	36,440	(1,206)
Total liabilities and stockholder's equity (deficit)	$ 782,851	$ 694,178

See accompanying notes to the consolidated financial statements.

Prospect Medical Holdings, Inc.

Consolidated Statements of Income
(in thousands)

For the Years Ended September 30,	2015	2014
Revenues:		
Net Hospital Services revenues	$ 1,047,517	$ 619,809
Provision for bad debts	(44,087)	(32,945)
Net Hospital Services revenues less provision for bad debts	1,003,430	586,864
Medical Group revenues	333,238	253,980
Net Global Risk Management revenues	3,440	-
Other revenues	5,436	13,672
Total net revenues	1,345,544	854,516
Operating Expenses:		
Hospital operating expenses	788,366	449,742
Medical Group cost of revenues	224,028	185,342
Global Risk Management cost of revenues	3,119	-
General and administrative	193,997	133,056
Depreciation and amortization	34,374	23,580
Total operating expenses	1,243,884	791,720
Operating income from unconsolidated joint venture	6,400	3,356
Operating income	108,060	66,152
Other (income) expense:		
Interest expense and amortization of deferred financing costs, net	42,063	41,437
Adjustment to (Gain on) bargain purchase	319	(4,817)
Other expense	230	419
Total other (income) expense, net	42,612	37,039
Income before income taxes	65,448	29,113
Income tax provision	31,146	10,561
Net income	34,302	18,552
Net income attributable to non-controlling interests	(337)	(463)
Net income attributable to Prospect Medical Holdings, Inc.	$ 34,639	$ 19,015

See accompanying notes to the consolidated financial statements.

Prospect Medical Holdings, Inc.

Consolidated Statements of Stockholder's Equity (Deficit)
(in thousands except share amounts)

	Number of Common Shares	Common Stock	Additional Paid-in Capital	Retained Earnings (Accumulated Deficit)	Prospect Medical Holdings, Inc. Stockholder's Equity (Deficit)	Non-controlling Interests	Total Stockholder's Equity (Deficit)
Balance at September 30, 2013	100	$ 1	$ 15,334	$ (47,496)	$ (32,161)	$ 120	$ (32,041)
Stock-based compensation	-	-	2,673	-	2,673	-	2,673
Investment in Chaparral Medical Group (see Note 1)	-	-	450	-	450	-	450
Non-controlling interest attributed to PCC Seller (see Note 4)	-	-	-	-	-	9,160	9,160
Net income	-	-	-	19,015	19,015	(463)	18,552
Balance at September 30, 2014	100	1	18,457	(28,481)	(10,023)	8,817	(1,206)
Options exercised	-	-	396	-	396	-	396
Stock-based compensation	-	-	1,184	-	1,184	-	1,184
Non-controlling interest attributed to PCC Seller (see Note 4)	-	-	-	-	-	1,764	1,764
Net income	-	-	-	34,639	34,639	(337)	34,302
Balance at September 30, 2015	100	$ 1	$ 20,037	$ 6,158	$ 26,196	$ 10,244	$ 36,440

See accompanying notes to the consolidated financial statements.

Prospect Medical Holdings, Inc.

Consolidated Statements of Cash Flows
(in thousands)

For the Years Ended September 30,	2015	2014
Operating activities		
Net income	$ 34,302	$ 18,552
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	34,374	23,580
Amortization of deferred financing costs, net	2,223	2,218
Amortization of original issue discount and premium, net	1,080	992
Provision for bad debts	44,087	32,945
Deferred income taxes, net	(14,008)	(8,111)
Stock-based compensation	1,184	2,673
Undistributed earnings from equity method investments	(135)	(178)
Loss on disposal of assets	271	-
Adjustment to (Gain on) bargain purchase	319	(4,817)
Gain on sale of equity method investment	(296)	-
Changes in operating assets and liabilities, net of business combinations:		
Patient accounts receivable and other receivables	(53,076)	(50,596)
Due to/from government payers, net	1,426	(8,827)
Prepaid expenses and other current assets	901	(1,682)
Hospital fee program receivable	(32,285)	18,895
Inventories	(1,839)	(814)
Hospital fee program liability and deferred revenue	12,216	(5,803)
Income taxes payable/receivable, net	9,289	6,899
Deposits and other assets	(660)	1,338
Accrued medical claims and other healthcare costs payable	14,217	8,962
Accounts payable and other accrued liabilities	21,235	16,177
Net cash provided by operating activities	74,825	52,403
Investing activities		
Purchases of property, improvements and equipment	(37,502)	(50,107)
Cash paid for acquisitions, net of cash received and working capital adjustments	(1,740)	(58,300)
Proceeds from sale of property and improvements	987	-
Proceeds from sale of equity method investment	1,233	-
Cash paid for equity method investments	(1,880)	-
Cash paid for investment in Chaparral Medical Group, Inc. (see Note 1)	-	(1,100)
Change in note receivable (net)	70	66
Increase in restricted investments	(624)	(5)
Net cash used in investing activities	(39,456)	(109,446)

Prospect Medical Holdings, Inc.

Consolidated Statements of Cash Flows (Continued)
(in thousands)

For the Years Ended September 30,	2015	2014
Financing activities		
Borrowings on line of credit, net	-	20,000
Repayments of long-term debt	(133)	(176)
Repayments of capital leases	(4,935)	(5,435)
Proceeds from exercise of stock options	396	-
Cash paid for deferred financing costs, net	-	(50)
Change in restricted cash	391	(2,676)
Repayments of insurance premium financing	(4,554)	(1,863)
Net cash (used in) provided by financing activities	(8,835)	9,800
Increase (decrease) in cash and cash equivalents	26,534	(47,243)
Cash and cash equivalents, beginning of year	39,072	86,315
Cash and cash equivalents, end of year	$ 65,606	$ 39,072
Supplemental disclosure of cash flow information		
Interest paid	$ 38,099	$ 37,608
Income taxes paid, net	$ 35,778	$ 12,004
Schedule of non-cash investing and financing activities		
Equipment acquired under capital leases	$ 1,999	$ 2,028
Insurance premium financed	$ 4,472	$ 1,842
Long-term liability assumed from acquisition of PCC (see Note 4)	$ -	$ 6,440
Partial satisfaction of long-term liability assumed from acquisition of PCC (see Note 4)	$ 1,446	$ -

See accompanying notes to the consolidated financial statements.

1. Organization

Prospect Medical Holdings, Inc. ("Prospect" or the "Company" or the "Parent Entity") is a Delaware corporation and a wholly-owned indirect subsidiary of Ivy Holdings Inc. ("Ivy Holdings").

The Company's operations are currently organized into four primary reportable segments: Hospital Services, Medical Group, Global Risk Management and Corporate, as discussed below.

The Global Risk Management segment is a new segment in Prospect's operations and commenced operations during the year ended September 30, 2015. The Global Risk Management segment includes Prospect Health Plan, Inc. ("PHP") with operations in California, Prospect Health Services TX, Inc. ("PHSTX") with operations in Texas, Prospect Health Services RI, Inc. ("PHSRI") with operations in Rhode Island, and Coordinated Regional Care Group, Inc. ("CRCG") with operations in various states. PHP, PHSTX, and PHSRI have entered into global capitation arrangements with certain third-party health plans and manage the provision of care for members in coordination with the Hospital Services and Medical Group segments.

Hospital Services Segment

The Company owns 13 acute care and behavioral hospitals and multi-level elder care facilities in Southern California, the Greater San Antonio, Texas region, and Rhode Island with a total of 2,258 licensed beds, and a network of specialty and primary care clinics, through its subsidiaries, Southern California Healthcare System, Inc. ("SCHS"), Alta Los Angeles Hospitals, Inc. ("Alta Los Angeles Hospitals"), Alta Newport Hospital, Inc., Prospect Hospital Holdings, LLC ("Nix Health"), and Prospect CharterCARE, LLC ("PCC") (collectively, the "Hospital Services segment"). The Hospital Services segment subsidiaries are wholly-owned by Prospect, except for PCC, in which Prospect has an 85% interest (see Note 4).

Effective May 6, 2014, Prospect acquired substantially all of the assets and associated real estate of Newport Specialty Hospital, which was subsequently renamed Foothill Regional Medical Center ("FRMC"), through Prospect's newly created subsidiary, Alta Newport Hospital, Inc., and Bellflower Medical Center (subsequently renamed Los Angeles Community Hospital at Bellflower or "LACH Bellflower") through Prospect's subsidiary Alta Los Angeles Hospitals, Inc. FRMC, located in Tustin, California, was substantially closed in 2013 except for its pediatric sub-acute unit. LACH Bellflower, located in Bellflower, California, was closed in 2013 and was non-operational when acquired by the Company. Bellflower opened its 32-bed voluntary adult behavioral health unit during July 2015. Prospect intends to fully reopen both facilities, including maintaining the FRMC pediatric sub-acute unit.

Effective June 20, 2014, Prospect acquired, through its subsidiary, PCC, substantially all of the assets of CharterCARE Health Partners and its subsidiaries. PCC's operating subsidiaries include Prospect CharterCARE RWMC, LLC ("Roger Williams Medical Center"), Prospect CharterCARE SJHSRI, LLC ("St. Joseph Health Services of Rhode Island"), Prospect CharterCARE Elmhurst, LLC ("Elmhurst Extended Care"), and Prospect CharterCARE Physicians, LLC ("CharterCARE Physicians") which include hospitals, medical centers, multi-level elder care facilities, and a network of approximately 60 contracted primary care and specialist physicians located in Rhode Island with 785 licensed beds (collectively, "CharterCARE"). PCC is 85% owned by Prospect and 15% by CharterCARE Community Board (formerly known as CharterCARE Health Partners).

The Company's three community hospitals in Hollywood, Los Angeles and Norwalk offer a comprehensive range of medical and surgical services, including general acute care hospital services, pediatrics, obstetrics and gynecology, pediatric sub-acute care, general surgery, medical-surgical services, orthopedic surgery, and diagnostic, outpatient, skilled nursing and urgent care services. The Company's psychiatric hospital in Van Nuys provides acute inpatient and outpatient psychiatric services on a voluntary basis. The Company's hospital in Culver City ("SCH Culver City") offers a comprehensive range of inpatient and outpatient services: including general surgery, orthopedic, spine, cardiology, diagnostic outpatient, rehabilitation, psychiatric and detox services. In addition, SCH Culver City has an active emergency room that plays an integral part in providing emergency services to the West Los Angeles area.

Nix Health provides comprehensive service offerings at various locations throughout the greater San Antonio, Texas region. These locations include Nix Medical Center, which provides inpatient acute care, geriatric psychiatry services, and emergency room services; Nix Specialty Health Center, which provides a full range of behavioral health and rehabilitation services for children, adolescents, and adults, and a range of health clinics and provider based clinics throughout San Antonio, Texas; and Nix Community General Hospital ("Nix CGH"), which operates an inpatient acute hospital in Dilley, Texas and a medical clinic in Pearsall, Texas. Nix Health also opened a 73-bed behavioral health center during the year ended September 30, 2014, which provides psychiatric emergency services and a crisis intervention unit.

CharterCARE provides a comprehensive range of services at both Roger Williams Medical Center and St. Joseph's Health Services Rhode Island as well as multiple levels of elder care at Elmhurst Extended Care.

Admitting physicians are primarily practitioners in the local area. The hospitals have payment arrangements with Medicare, Medicaid (Medi-Cal in California) and other third party payers, including commercial insurance carriers, health maintenance organizations ("HMOs") and preferred provider organizations ("PPOs").

Medical Group Segment

The Medical Group segment is a healthcare management services organization that provides management services to affiliated physician organizations that operate as independent physician associations ("Medical Groups" or "IPAs"). The affiliated physician organizations enter into agreements with HMOs to provide HMO enrollees with a full range of medical services in exchange for fixed, prepaid monthly fees known as "capitation" payments. The Medical Groups contract with physicians (primary care and specialist) and other healthcare providers to provide enrollees with medical services. Prospect currently manages the provision of prepaid healthcare services for its affiliated physician organizations in Southern California, Texas and Rhode Island. The network consists of the following physician organizations as of September 30, 2015 (individually referred to as an "Affiliate"):

Prospect Medical Group, Inc. ("PMG")
Prospect Health Source Medical Group, Inc. ("PHS")
Prospect Professional Care Medical Group, Inc. ("PPCM")
Genesis HealthCare of Southern California, Inc. ("Genesis")
Prospect NWOC Medical Group, Inc. ("PNW")
StarCare Medical Group, Inc. ("PSC")
AMVI/Prospect Medical Group ("AMVI/Prospect")
Nuestra Familia Medical Group, Inc. ("Nuestra")
Upland Medical Group, a Professional Medical Group ("UMG")*
Pomona Valley Medical Group, Inc. ("PVMG")*

* PVMG and UMG are collectively referred to as the "ProMed Entities."

These Affiliates are managed by the following two medical management company subsidiaries that are wholly-owned by Prospect (collectively, "MSOs"):

Prospect Medical Systems, Inc. ("PMS")
ProMed Healthcare Administrators ("PHCA")

In addition to the Affiliates and MSOs, the Medical Group segment includes Prospect Health Services, TX, Inc. ("PHSTX") and Prospect Provider Group RI, LLC ("PPGRI"), both of which are indirect wholly-owned subsidiaries of the Company.

All of the Affiliates are wholly-owned by PMG, with the exception of Nuestra, which was 66.95% owned by PMG as of September 30, 2015 and 2014, and AMVI/Prospect which is a 50/50 Joint Venture between AMVI Care Health Network, Inc. ("AMVI") and PMG. The operations of all of these entities, with the exception of AMVI/Prospect, are consolidated in the accompanying consolidated financial statements. PMG is owned by a nominee physician shareholder pursuant to an assignable option agreement described below.

PMG's ownership in Nuestra increased from 62% to 66.95% during the year ended September 30, 2014. On October 7, 2013, Nuestra repurchased 109 shares from a physician shareholder that left Nuestra's group medical practice for a de minimis purchase price in accordance with Nuestra's Agreement Concerning Shares of the Company dated September 19, 1995. The repurchase increased the share percentage holdings of all remaining shareholders and PMG's percentage rose to 66.95% as of October 7, 2013.

The AMVI Joint Venture was formed for the sole purpose of combining enrollment in order to meet minimum enrollment levels required for participation in the CalOptima Medicaid (Medi-Cal in California) program in Orange County, California. The joint venture ownership is set at 50/50 to prevent either party from exerting control over the other; however, AMVI's and PMG's businesses are operated autonomously, and enrollees, financial results and cash flows are each separately tracked and recorded. In accordance with the joint venture partnership agreement, profits and losses are not split in accordance with the partnership ownership interest, but rather, are directly tied to the results generated by each separate portion of the business. Separate from any earnings the Company generates from PMG's portion of business within the joint venture, the Company also earns fees for management services PMS provides to PMG's partner in the joint venture. The Company accounts for PMG's interest in the joint venture partnership using the equity method of accounting. The Company includes in the consolidated financial statements only the net results attributable to those enrollees specifically identified as assigned to the Company, together with the management fee that PMS charges for managing those enrollees specifically assigned to the other joint venture partner.

PMS has entered into an assignable option agreement with PMG and the nominee physician shareholder of PMG. Under the assignable option agreement, Prospect has an assignable option, obtained for a nominal amount from PMG and the nominee shareholder to designate the purchaser (successor physician) for all or part of PMG's issued and outstanding stock held by the nominee physician shareholder (the "Stock Option") in its sole discretion. The Company may also assign the assignable option agreement to any person. The assignable option agreement has an initial term of 30 years and is automatically extended for additional terms of 10 years each, as long as the term of the related management services agreement described below (the "Management Agreement") is automatically extended. Upon termination of the Management Agreement with PMG, the related Stock Option would be automatically and immediately exercised. The Stock Option may be exercised for a purchase price of $1,000. Under these nominee shareholder agreements, Prospect has the unilateral right to establish or

effect a change of the nominee, at will, and without the consent of the nominee, on an unlimited basis and at nominal cost throughout the term of the Management Agreement. In addition to the Management Agreement with PMG, Prospect, through one of its management company subsidiaries, has a management agreement with each Affiliate. The term of the Management Agreements is generally 30 years. PMG is the sole shareholder of PHS, PPCM, Genesis, PNW, PSC, UMG, and PVMG. New Genesis Medical Associates, Inc. ("NGMA") is controlled through a nominee shareholder arrangement like the Stock Option structure utilized for PMG and discussed above.

The Company's Affiliates and NGMA have entered into Management Agreements with PMS or PHCA, as applicable (each of which is a wholly-owned subsidiary of Prospect). Each Affiliate has agreed to pay a management fee to PMS or PHCA, as applicable. The fee is based in part on the costs to the management company and on a percentage of revenues the Affiliate receives (i) for the performance of medical services by the Affiliate's employees and independent contractor physicians and physician extenders, and (ii) for all other services performed by the Affiliates. The revenue from which this fee is determined includes medical capitation (except for NGMA which provides professional and ancillary services), all sums earned from participation in any risk pools and all fee-for-service revenue earned. The management fee also includes a fixed amount for marketing and public relations services. Except in the case of Nuestra and AMVI/Prospect, the Management Agreements had initial terms of 30 years, renewable for successive 10-year periods thereafter, unless terminated by either party for cause. Effective September 1, 2013, the Managements Agreements for the ProMed Entities were consolidated under one new Management Agreement with PHCA. Effective October, 1, 2013, the Management Agreements for the rest of the Affiliates, other than Nuestra and AMVI/Prospect, were consolidated under one new Management Agreement with PMS. Those two new Management Agreements with PHCA and PMS include initial five year terms and are renewable for successive five year periods thereafter. In the case of Nuestra, its Management Agreement had an initial 10 year term renewable for successive one year terms, subsequently amended in January 15, 2009 to an initial 20 year term renewable for two 10 year periods. In the case of AMVI/Prospect, the Management Agreement has a one year term with successive one year renewal terms. The management agreement for NGMA was effective October 1, 2012 with an initial term of 30 years, renewable for successive 10-year periods thereafter, unless terminated by either party for cause. In return for payment of the management fee, Prospect (through PMS and PHCA) has agreed to provide financial management, information systems, marketing, advertising, public relations, risk management, and administrative support, including for utilization review and quality of care. At its cost, Prospect has assumed the obligations for all facilities, medical and non-medical supplies, and employment of non-physician personnel of its affiliated medical clinics.

The management fee earned by Prospect fluctuates based on the profitability of each Affiliate. Prospect is allocated a 50% residual interest in any profits after the first 8% of the profits. The remaining balance is retained by the Affiliates.

The Management Agreements are not terminable by the Affiliates except in the case of gross negligence, fraud or other illegal acts of Prospect, or bankruptcy of the Company.

Further, Prospect's rights under the Management Agreements are unilaterally saleable or transferable. Based on the provisions of the Management Agreements and the assignable option agreement with PMG, Prospect has determined that it has a controlling financial interest in the Affiliates, with the exception of AMVI/Prospect. Consequently, under applicable accounting principles, Prospect consolidates the revenues and expenses of all the Affiliates except AMVI/Prospect from the respective dates of execution of the Management Agreements. All significant inter-entity balances have been eliminated in consolidation. In the case of AMVI/Prospect, only that portion of the results which are contractually identified as Prospect's are recognized in the consolidated financial statements, together with the

management fee that the Company charges AMVI for managing AMVI's share of the joint venture operations.

Prospect has also entered into management agreements with unaffiliated third parties to manage services to their HMO enrollees. These management agreements do not have characteristics that give rise to the consolidation of the entities under current accounting literature.

The affiliated physician organizations provided medical services to a combined total of approximately 258,900 and 264,600 HMO enrollees as of September 30, 2015 and 2014, respectively. The enrollees include approximately 63,700 and 87,000 enrollees that the Company manages for the economic benefit of certain independent third parties, and for which the Company earns management fee income as of September 30, 2015 and 2014, respectively. The total paid member months including managed enrollees, for the fiscal years ended September 30, 2015 and 2014 was approximately 3,067,200 and 2,785,000, respectively.

On December 19, 2013, NGMA, an Affiliate of the Company, purchased stock of Chaparral Medical Group, Inc. ("CMG"), a California medical corporation. Consideration was composed of $1,100,000 in cash at the closing, $700,000 in future cash consideration to be used for the acquired company's general corporate purposes, and 3,750 shares of Ivy Holdings common stock issued at closing to the selling shareholders. As of December 19, 2013, NGMA owned 13.44% of the stock of CMG. During June 2015, CMG repurchased shares from a physician shareholder, which increased NGMA's ownership to 13.57%. After payment of the entire consideration, including the future cash consideration, NGMA will own 18.39% of the stock of CMG. Pursuant to the terms of the stock purchase agreement, NGMA will have the right and option to make additional stock investments at the same share valuations and prices and upon the same applicable terms and conditions as the initially acquired shares, to bring its aggregate ownership up to 50%. CMG is a multi-specialty group serving communities primarily in the Los Angeles and San Bernardino counties. The Company accounts for NGMA's interest in CMG using the equity method as the Company has the ability to exercise significant influence over the operating and financial policies of CMG.

Global Risk Management Segment

The Global Risk Management segment commenced operations during the year ended September 30, 2015 and entered into global capitation arrangements with certain unrelated third-party health plans. The Global Risk Management segment also manages the provision of care for members in coordination with the Hospital and Medical Group segments.

Corporate Segment

The Corporate segment reflects certain expenses incurred at the Parent Entity not specifically allocable to the Hospital Services, Medical Group, or Global Risk Management segments. These include, but are not limited to: salaries, benefits and other compensation for corporate employees; financing expenses; insurance expenses; rent; legal fees; and accounting fees. The Company does not allocate interest expense related to acquisition debt or income taxes to the other reporting segments.

2. Significant Accounting Policies

Basis of Presentation

The consolidated financial statements have been prepared in accordance with accounting principles generally accepted in the United States of America ("GAAP") and include the accounts of all controlled subsidiaries, of which control is effectuated through ownership of voting common stock or by other means, but do not include the accounts of the parent companies, Ivy Holdings and Ivy Intermediate Holding Inc. The Medical Group segment Affiliates and NGMA have been determined to be variable interest entities due to the existence of a call option under which the Company has the ability to require the holders of all of the voting common stock of the underlying subsidiaries to sell their shares at a fixed nominal price ($1,000) to another designated physician chosen by the Company. This call option agreement represents rights provided through a variable interest other than the equity interest itself that limits the returns that could be earned by the equity holders. In addition, the Company has management agreements with the Affiliates and NGMA and the holders of the voting common stock which allows the Company to direct the activities of the Affiliates and NGMA that most significantly impact their economic performance, retain the right to receive expected residual returns and assume the obligation to absorb losses. Although the Company has disproportionately few voting rights (based on the terms of the equity), the Company is considered to be the primary beneficiary of the activities of the Affiliates and NGMA. As a result, the Affiliates and NGMA are consolidated within the accompanying consolidated financial statements.

Operating results for CMG, FRMC and LACH Bellflower, PCC and the CharterCARE Physicians medical practices acquisitions are consolidated with the Company's financial statements from their acquisition dates or inception date in the case of LACH Bellflower (December 19, 2013, May 6, 2014, June 20, 2014, and various dates during the year ended September 30, 2015, respectively) (see Note 4). All significant intercompany balances and transactions have been eliminated in consolidation.

Reclassifications

Certain reclassifications were made to the 2014 consolidated financial statements in order to conform to the 2015 presentation.

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Revenues

Revenues by reportable segment are comprised of the following amounts (in thousands):

For the Years Ended September 30,	2015 *(a)*	2014 *(b)*
Net Hospital Services		
Inpatient	$ 736,340	$ 440,961
Outpatient	195,692	96,802
Capitation	98,993	70,077
Other	16,492	11,969
Total Hospital Services revenues	1,047,517	619,809
Less: Provision for bad debts	(44,087)	(32,945)
Total net Hospital Services revenues less provision for bad debts	1,003,430	586,864
Medical Group		
Capitation	312,031	244,573
Management fees	7,814	6,586
Other	13,393	2,821
Total Medical Group revenues	333,238	253,980
Global Risk Management		
Capitation	3,440	-
Other revenues	5,436	13,672
Total net revenues	$ 1,345,544	$ 854,516

(a) The revenues of various medical practices acquired by CharterCARE Physicians have been included in the accompanying consolidated financial statements from their various dates of acquisition during the year ended September 30, 2015.

(b) CMG, Bellflower and FRMC, and PCC revenues have been included in the accompanying consolidated financial statements for the period from acquisition or inception date in the case of LACH Bellflower, December 19, 2013, May 6, 2014, and June 20, 2014, respectively, through September 30, 2014.

Hospital Services Segment

Net Patient Service Revenues

Operating revenue of the Hospital Services segment consists primarily of net patient service revenue. The Company reports net patient service revenue at the estimated net realizable amounts from patients and third-party payers and others in the period in which services are rendered. The Company has agreements with third-party payers, including Medicare, Medicaid (Medi-Cal in California), managed care and other insurance programs that are paid at negotiated rates. These payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges and per diem payments, as further described below. Estimates of contractual allowances are based upon the payment terms specified in the related contractual agreements. The Company accrues for amounts that it believes may ultimately be due to or from the third-party payers. Normal estimation differences between final settlements and amounts accrued in previous years are reported as changes in estimates

in the current year. Outstanding receivables, net of allowances for contractual discounts and bad debts, are included in patient accounts receivable in the accompanying consolidated balance sheets.

The following is a summary of sources of patient service revenues (net of contractual allowances and discounts) before provision for bad debts:

September 30,	2015	2014
Medicare	$ 321,282	$ 224,984
Medicaid	379,821	189,668
Managed Care	168,553	95,853
Self Pay/Other	62,376	27,258
Capitation	98,993	70,077
Total patient service revenue	$ 1,031,025	$ 607,840

A summary of the payment arrangements with major third-party payers follows:

Medicare: Medicare is a federal program that provides certain hospital and medical insurance benefits to persons aged 65 and over, some disabled persons with end-stage renal disease and certain other beneficiary categories. Inpatient services rendered to Medicare program beneficiaries are paid at prospectively determined rates per discharge, according to a patient classification system based on clinical, diagnostic, and other factors. Outpatient services are paid based on a blend of prospectively determined rates and cost-reimbursed methodologies. The Company is also reimbursed for various disproportionate share and Medicare bad debt components at tentative rates, with final settlement determined after submission of the annual Medicare cost report and audit thereof by the Medicare fiscal intermediary. Normal estimation differences between filed settlements and amounts accrued are reflected in net patient service revenue.

Cost report settlement estimates are recorded based upon as-filed cost reports and are adjusted for tentative settlements, if any, and when a final Notice of Program Reimbursement ("NPR") is issued. The latest updated SSI ratios for 2013 were issued on May 14, 2015. To date, the Company has received final NPRs for SCH Culver City (formerly named Brotman Medical Center, Inc.) through 2012 for cost report years prior to its merger into the Alta Hollywood Hospitals, Inc. subsidiary, SCH Hollywood through 2010, Alta Los Angeles Hospitals through 2011, Nix Health through 2012, and Elmhurst through 2014. No NPR has been issued for Roger Williams Medical Center or St. Joseph's Health Services of Rhode Island.

The Company joined a second round of litigation relating to Medicare's settlement with providers relating to the manner in which the Centers for Medicare and Medicaid Services ("CMS") handled the budget neutrality adjustment associated with the rural floor wage index in setting the Medicare inpatient prospective system rates ("Rural Floor"). The Company entered into a settlement agreement with CMS and, as a result, Alta Los Angeles Hospitals, SCH Culver City, and CharterCARE recognized a net benefit of $2,495,000, $1,230,000, and $1,672,000, respectively, during the year ended September 30, 2014 related to the Rural Floor litigation.

Medicaid: Medicaid is a joint federal-state funded healthcare benefit program that is administered by states to provide benefits to qualifying individuals who are unable to afford care. The Company receives reimbursements under the Medicaid program at prospectively determined rates for both inpatient and outpatient services. Medi-Cal is the version of the federal Medicaid program that is

applicable to California residents. Inpatient services rendered to Medi-Cal fee-for-service program beneficiaries in California are in the process of a three-year transition to payment at prospectively determined rates based on diagnosis related groups from a contracted per diem rate. Outpatient services are paid based on prospectively determined rates per procedure provided. Inpatient and outpatient services rendered to Medi-Cal managed care beneficiaries in California are paid at either contracted rates or at the Medi-Cal fee-for-service rates.

The SCHS and Alta Los Angeles Hospitals are eligible to participate in the State of California Medi-Cal Disproportionate Share ("DSH") programs, under which medical facilities that serve a disproportionate number of low-income patients receive additional reimbursements. Eligibility is determined annually based on prescribed guidelines. The Company accrues revenue based on the expected total annual DSH awards. Differences between the estimated and the actual awards are recorded in the period they become known. DSH amounts are subject to retrospective revision prior to finalization and such revisions could lead to material retractions. The Company records retrospective retractions when they are estimable and probable. Retrospective additional DSH revenues are recorded when the amounts are received. The Medi-Cal DSH receivable as of September 30, 2015 and 2014 totaled approximately $13,787,000 and $9,094,000, respectively, and were included in due from government payers in the accompanying consolidated balance sheets. For the fiscal years ended September 30, 2015 and 2014, total Medi-Cal DSH payments received by the SCHS and Alta Los Angeles Hospitals were approximately $15,690,000 and $16,325,000, respectively, and total Medi-Cal DSH revenues recorded were approximately $19,005,000 and $20,475,000, respectively. Additionally, pursuant to an audit of Medi-Cal cost reports and notification sent to the Company, the Company accrued a cost report liability payable to Medi-Cal of $1,743,000 and $1,803,000 as of September 30, 2015 and 2014, respectively.

Certain of the Company's California hospitals also participate in *the California Hospital Fee Program* (see Note 10).

In Texas, the Medicaid program reimburses under prospectively determined rates for inpatient services and based on costs for outpatient services. Medicaid reimbursement may be subject to periodic adjustment, as well as to changes in existing payment levels and rates, based on the amount of funding available to the Medicaid program. Nix Health has also been receiving payments from the Texas Health and Human Services Commission under the Section 1115 Waiver ("the waiver") that was recently granted to the state of Texas by CMS. Under the first year of the waiver ending September 30, 2012, a transition payment was paid to Nix Health based upon prior levels of payment under the "Upper Payment Limit" ("UPL") program, which the waiver replaced. Payments for years two through five under the waiver are based upon two pools. One pool is for payments for uncompensated care ("UCC") which includes the shortfall in Medicaid reimbursement as compared to cost and the cost of providing services to uninsured patients. The other pool is the Delivery System Reform Initiative Payments ("DSRIP"), where approved programs and services are undertaken to improve access and services provided. Programs are established by regions and approved by the Texas Health and Human Services Commission and CMS. These programs are assigned a value and milestones are established to measure success and the timing and level of payment from the DSRIP funds. Nix Health recorded revenue related to the UCC pool of $10,962,000 and $12,366,000 for the years ended September 30, 2015 and 2014, respectively. Revenue recorded related to the DSRIP pool was $11,356,000 and $9,801,000 for the years ended September 30, 2015 and 2014, respectively. At September 30, 2015 and 2014, amounts receivable under the Section 1115 Waiver totaled $23,615,000 and $23,145,000, respectively.

Nix Health also recorded $12,000,000 and $5,746,000 during the years ended September 30, 2015 and 2014, respectively, in costs for rural community provision of services. No amounts payable related to the provision of such services were included in the consolidated balance sheets as of September 30, 2015 and 2014.

The CharterCARE hospitals are participants in the State of Rhode Island's DSH program, which was established in 1995 to assist hospitals that provide a disproportionate amount of uncompensated care. Under the program, Rhode Island hospitals, including the CharterCARE hospitals, receive federal and state Medicaid funds as additional reimbursement for treating a disproportionate share of low income patients. The CharterCARE hospitals recognized revenue related to DSH and Upper Payment Limit ("UPL") reimbursement of $16,636,000 and $3,965,000 during the year ended September 30, 2015 and the period from June 20, 2014 (acquisition date) through September 30, 2014, respectively. DSH and UPL payments received were $16,135,000 and $3,932,000 during the year ended September 30, 2015 and the period from June 20, 2014 (acquisition date) through September 30, 2014, respectively. The State of Rhode Island also assesses a license fee to all hospitals in Rhode Island based on each hospital's net patient revenue. The CharterCARE hospitals recorded $15,058,000 and $4,036,000 of expense during the year ended September 30, 2015 and from June 20, 2014 through September 30, 2014 as a result of the license fee.

Managed Care: The Company has also entered into payment agreements with certain commercial insurance carriers, HMOs, and PPOs. The basis for payment under these agreements is in accordance with negotiated contracted rates or at the Company's standard charges for services provided. Some of these payments are capitated, meaning that the Company receives an agreed amount per patient for providing an agreed range of services.

Self-Pay: Self-pay patients represent those patients who do not have health insurance and are not covered by some other form of third party arrangement. Such patients are evaluated, at the time of services or shortly thereafter, for their ability to pay based upon federal and state poverty guidelines, qualifications for Medicaid, as well as the Company's local hospital's indigent and charity care policy.

See "Concentrations of Credit Risks" below for discussion of revenues received from the Medicare and Medicaid programs.

Effective August 29, 2014, CMS provided a simplified process and timely partial payment to settle certain previously denied claims with dates of service prior to October 1, 2013 whereby such claims under appeal that had been retracted by CMS were settled with the provider receiving 68% of the face value. As a result, the Company recorded $3,887,000 in revenue during the year ended September 30, 2014 related to claims which were previously subject to ongoing Recovery Audit Contractor ("RAC") audits and other similar programs. As of September 30, 2015 and 2014, the Company accrued $262,000 and none, respectively, in due to government payors in the accompanying consolidated balance sheets related to such programs.

SCH Culver City Outlier Liability

Following the acquisition of a majority stake in SCH Culver City, effective April 14, 2009, the Company consolidated SCH Culver City's estimated liability to CMS arising out of outlier payments received for services provided by the hospital to Medicare eligible inpatients, primarily for the last four months of calendar year 2005 and all of calendar year 2006.

While SCH Culver City (formerly Brotman Medical Center, Inc.) reports financial statements on a fiscal year ending September 30, Medicare cost reports are filed on a calendar year basis. Acute care hospitals receive Medicare reimbursement payments pursuant to a prospective payment methodology primarily based on the diagnosis of the patient, but are entitled to receive additional payments, referred to as "outliers" for patients whose treatment is very costly. When Brotman Medical Center, Inc. acquired the hospital in 2005, CMS provided a ratio of cost to charges (the "RCC") based on the statewide average. Payments received by SCH Culver City on this basis were an interim estimate, subject to final determination upon audit of SCH Culver City's cost reports. SCH Culver City filed its Medicare cost reports, but determined that its outlier reimbursement for services provided in fiscal years 2005, 2006 and part of 2007 might be subject to adjustment based on certain outlier reconciliation rules.

On October 12, 2012, SCH Culver City received from its Medicare fiscal intermediary a proposed outlier adjustment for Medicare fiscal year 2006 in the amount of $12,785,000. SCH Culver City had previously been notified of an adjustment of $2,149,000 for 2005. As of September 30, 2015 and 2014, the Company accrued $13,834,000 of the estimated $14,934,000 liability to CMS included in the accompanying consolidated balance sheets. The difference between the $14,934,000 asserted by CMS and the $13,834,000 accrued by the Company relates to accrued interest of approximately $1,100,000. The Company does not agree, however, with the outlier reconciliation liability. Accordingly, in accordance with relevant literature related to accounting for contingencies, the Company recorded the lower end of the range of the liability.

The Company has also filed an appeal of the outlier issue with the Provider Reimbursement Review Board for the 2006 cost reporting period since it received a notice of program reimbursement for the 2006 cost report. Mediation was held with CMS and the U.S. Department of Justice in March 2015 for settlement of fiscal years 2005 and 2006. The terms of a final settlement have been approved by CMS and the Health and Human Services Office of the General Counsel. As the Company is waiting for final approval of the settlement by the U.S. Department of Justice, the settlement has not been recognized in the accompanying consolidated financial statements.

The following is a summary of due from and due to governmental payers at September 30 (in thousands):

September 30,	2015	2014
Due from government payers:		
Medi-Cal Disproportionate Share (DSH)	$ 13,787	$ 9,094
Medicare cost report settlements	3,953	10,279
Medi-Cal cost report settlements	231	-
Medicaid Section 1115 receivable	23,615	23,145
	$ 41,586	$ 42,518
Due to government payers:		
Outlier liability	$ 13,834	$ 13,834
Medicare cost report settlements	11,501	10,947
Medi-Cal cost report settlements	1,743	1,803
	$ 27,078	$ 26,584

The Company is not aware of any material claims, disputes, or unsettled matters with any payers that would affect revenues that have not been adequately provided for and disclosed in the accompanying consolidated financial statements.

Charity Care

The Company provides charity care to patients whose income level is below 300% of the Federal Poverty Level. Patients at the Company's California facilities with income levels between 300% and 350% of the Federal Poverty Level qualify to pay a discounted rate under the requirements of California State Assembly Bill 774 (AB 774) based on various government program reimbursement levels. Patients without insurance are offered assistance in applying for Medicaid and other programs they may be eligible for, such as state disability. Patient advocates from the Company's Medical Eligibility Program ("MEP") screen patients in the Hospital and determine potential linkage to financial assistance programs. They also expedite the process of applying for these government programs. The approximate cost of providing charity care was $1,683,000 and $2,029,000 for the years ended September 30, 2015 and 2014, respectively. The Company has estimated the cost of charity care based on a ratio of the cost to charges, with cost consisting of operating expenses, excluding depreciation, interest and management fees.

Provisions for Contractual Allowances and Bad Debts

Collection of receivables from third-party payers and patients is the Company's primary source of cash and is critical to its operating performance. The Company closely monitors its historical collection rates, as well as changes in applicable laws, rules and regulations and contract terms, to assure that provisions for contractual allowances are made using the most accurate information available. However, due to the complexities involved in these estimations, actual payments from payers may be materially different from the amounts management estimates and records. The Company's primary collection risks relate to uninsured patients and the portion of the bill which is the patient's responsibility, primarily co-payments and deductibles. Payments for services may also be denied due to issues over patient eligibility for medical coverage, the Company's ability to demonstrate medical necessity for services rendered and payer authorization of hospitalization.

Accounts receivable are reduced by an allowance for doubtful accounts. Valuation of the collectability of accounts receivable and provision for bad debts is based on historical collection experience, payer mix and the age of the receivables. Management routinely reviews accounts receivable balances in conjunction with these factors and other economic conditions which might ultimately affect the collectability of the patient accounts, and makes adjustments to the Company's allowances as warranted. For receivables associated with services provided to patients who have third-party coverage, management analyzes contractually due amounts and subsequently calculates an allowance for doubtful accounts and provision for bad debts once the age of the accounts reaches a specific age category based on historical experience. For receivables associated with self-pay patients, management records a significant provision for bad debts beginning in the period services were provided based on past experience that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The allowance for doubtful accounts as a percent of gross accounts receivable decreased from 29% at September 30, 2014 to 27% at September 30, 2015. The allowance for doubtful accounts was $52,707,000 and $49,727,000 for the years ended September 30, 2015 and 2014, respectively. The decrease in the allowance for doubtful accounts as a percent of gross accounts receivable was due primarily to a reduction in self pay patient admissions and patient dates at the CharterCARE hospitals. As a result of the shift in payor mix, the allowance for doubtful accounts as a

percent of gross accounts receivable decreased from 31% at September 30, 2014 to 20% at September 30, 2015 at the CharterCARE hospitals.

Legislation

All of the Company's hospital facilities are subject to the Emergency Medical Treatment and Active Labor Act ("EMTALA"). This federal law requires any hospital that participates in the Medicare program to conduct an appropriate medical screening examination of every person who presents to the hospital's emergency department for treatment and, if the patient is suffering from an emergency medical condition, to either stabilize that condition or make an appropriate transfer of the patient to a facility that can handle the condition. The obligation to screen and stabilize emergency medical conditions exists regardless of a patient's ability to pay for treatment. There are severe penalties under EMTALA if a hospital fails to screen or appropriately stabilize or transfer a patient or if the hospital delays appropriate treatment in order to first inquire about the patient's ability to pay. Penalties for violations of EMTALA include civil monetary penalties and exclusion from participation in the Medicare program. In addition, an injured patient, the patient's family or a medical facility that suffers a financial loss as a direct result of another hospital's violation of the law can bring a civil suit against that other hospital. The Company believes that it is in compliance with EMTALA and is not aware of any pending or threatened EMTALA investigations involving allegations of potential wrongdoing that would have a material effect on the Company's consolidated financial statements.

See Note 10 regarding the *Affordable Care Act*.

Other Revenues

Other revenues consist primarily of the CMS Rural Floor settlement recognized during the year ended September 30, 2014, meaningful use incentive payments, rental revenue from operating leases, and tuition revenue and totaled $5,436,000 and $13,672,000 for the years ended September 30, 2015 and 2014, respectively.

A summary of other revenues recorded during the years follows:

Rural Floor settlement: Certain of the Company's subsidiaries entered into a settlement agreement with CMS and recognized $6,091,000 of revenue during the year ended September 30, 2014 related to the Rural Floor litigation.

Meaningful Use incentives: The American Recovery and Reinvestment Act of 2009 ("ARRA") established incentive payments under the Medicare and Medicaid programs for certain professionals and hospitals that meaningfully use certified electronic health record ("EHR") technology or adopt or implement such technology. The Medicare incentive payments will be paid out to qualifying hospitals over four consecutive years on a transitional schedule. To qualify for Medicare incentives, hospitals and physicians must meet EHR "meaningful use" criteria that become more stringent over three stages.

Medicaid programs and payment schedules vary from state to state. The Medicaid programs require hospitals to register for the program prior to 2016, to engage in efforts to adopt, implement or upgrade certified EHR technology in order to qualify for the initial year of participation, and to demonstrate meaningful use of certified EHR technology in order to qualify for payment for up to three additional years.

For the years ended September 30, 2015 and 2014, the Company recorded revenues of $1,150,000 and $4,683,000, respectively, related to the Medicare and Medicaid programs in the consolidated statements of income. These incentives have been recognized following the grant accounting model, recognizing income ratably over the applicable reporting period as management becomes reasonably assured of meeting the required criteria. Subsequent changes to these estimates will be recognized in the consolidated statement of operations in the period in which additional information is available. Such estimates are subject to audit by the federal government, the state, or its designee.

Rental Revenue: Rental revenue from operating leases is recorded based on the fixed, minimum required rents (base rents) per the lease agreements. Rental revenue from base rents is recorded on the straight-line method over the terms of the related lease agreements. During the years ended September 30, 2015 and 2014, the Company recorded rental revenues of $2,417,000 and $2,220,000, respectively.

Tuition Revenue: St. Joseph Health Services of Rhode Island operates the St. Joseph School of Nursing and recorded tuition revenue of $1,639,000 and $471,000 during the year ended September 30, 2015 and the period from June 20, 2014 (acquisition date) through September 30, 2014, respectively.

Medical Group Segment

Medical Group Revenues

Operating revenue of the Medical Group segment consists primarily of payments for medical services procured by the Affiliates under capitated contracts with various managed care providers including HMOs. Capitation revenue under HMO contracts is prepaid monthly to the Affiliates based on the number of enrollees electing any one of the Affiliates as their health care provider. See "Concentrations of Credit Risks" below for revenues received from the five largest contracted HMOs.

Capitation revenue (net of capitation withheld to fund risk share deficits discussed below) is recognized in the month in which the Affiliates are obligated to provide services. Minor ongoing adjustments to prior months' capitation, primarily arising from contracted HMOs' finalizing of monthly patient eligibility data for additions or subtractions of enrollees, are recognized in the month they are communicated to the Company. Additionally, Medicare pays capitation using a "Risk Adjustment model," which compensates managed care organizations and providers based on the health status (acuity) of each enrollee. Health plans and providers with higher acuity enrollees will receive more and those with healthier enrollees will receive less. Under Risk Adjustment, capitation is determined based on health severity, measured using patient encounter data. Capitation is paid on an interim basis based on data submitted for the enrollee for the preceding year and is adjusted in subsequent periods (generally in the Company's fourth quarter) after the final data is compiled. Positive or negative capitation adjustments are made for Medicare enrollees with conditions requiring more or less healthcare services than assumed in the interim payments. Since the Company cannot reliably predict these adjustments, periodic changes in capitation amounts earned as a result of Risk Adjustment are recognized generally in the fourth quarter when those changes are communicated by the health plans to the Company. The Company received and recorded as additional revenue, approximately $17,503,000 and $8,889,000, respectively, in positive capitation risk adjustments for the Medical Group segment during the years ended September 30, 2015 and 2014, respectively.

HMO contracts also include provisions to share in the risk for hospitalization, whereby the Affiliate can earn additional incentive revenue or incur penalties based upon the utilization of hospital services. Typically, any shared risk deficits are not payable until and unless the Company generates future risk

sharing surpluses, or if the HMO withholds a portion of the capitation revenue to fund any risk share deficits. At the termination of the HMO contract, any accumulated risk share deficit is typically extinguished. Due to the lack of access to information necessary to estimate the related costs, shared-risk amounts receivable from the HMOs are only recorded when such amounts are known. Risk pools for the prior contract years are generally final settled in the third or fourth quarter of the following fiscal year. For the years ended September 30, 2015 and 2014, Medical Group revenues included approximately $8,402,000 and $2,406,000, respectively, of additional revenues due to favorable settlements on prior year risk-sharing arrangements. At September 30, 2015 and 2014, contingent liabilities for carry-forward risk-pool deficits expected to be forgiven, or offset against future surpluses were approximately $6,422,000 and $5,547,000, respectively, based on the available information from the health plans.

The Company also receives incentives under "pay-for-performance" programs for quality medical care based on various criteria. These incentives, which are included in other revenues within Medical Group revenues, are generally recorded in the third and fourth quarters of the fiscal year when such amounts are known. During the year ended September 30, 2015, the Company recognized $9,059,000 related to a shared savings incentive program with one health plan. Pay-for-performance revenues recorded during the years ended September 30, 2015 and 2014 were $11,387,000 and $1,886,000, respectively.

Management fee revenue is earned in the month the services are rendered. Management fee arrangements with unaffiliated entities provide for compensation ranging from 6.5% to 12% of revenues. Management fee revenues recorded during the years ended September 30, 2015 and 2014 were $7,814,000 and $6,586,000, respectively.

Medical Group Cost of Revenues

The cost of health care services consists primarily of capitation and claims payments, pharmacy costs and incentive payments to contracted providers. These costs are recognized in the period incurred, or when the services are provided. Claims costs also include an estimate of the cost of services which have been incurred but not yet reported to the Company. The estimate for accrued medical costs is based on projections of costs using historical studies of claims paid and adjusted for seasonality, utilization and cost trends. These estimates are subject to trends in loss severity and frequency. Although considerable variability is inherent in such estimates, management records its best estimate of the amount of medical claims incurred at each reporting period. Estimates are continually monitored and reviewed and, as settlements are made or estimates adjusted, differences are reflected in current operations. See Note 12 for changes in claims estimates during the years ended September 30, 2015 and 2014.

In addition to contractual reimbursements to providers, the Company also makes discretionary incentive payments to physicians, which are in large part based on the pay-for-performance and shared risk revenues and favorable senior capitation risk adjustment payments received by the Company. Since the Company records these revenues generally in the third or fourth quarter of each fiscal year when the incentives and capitation adjustments due from the health plans are known, the Company also finalizes the discretionary physician bonuses in the same periods. During the years ended September 30, 2015 and 2014, the Company recorded discretionary physician incentives expense totaling approximately $14,082,000 and $5,067,000, respectively. As of September 30, 2015 and 2014, physician bonus accruals of approximately $9,021,000 and $4,339,000, respectively, were included in accounts payable and other accrued liabilities.

The Company also periodically evaluates the need to establish premium deficiency reserves for the probability that anticipated future health care costs could exceed future capitation payments from HMOs under capitated contracts and, where appropriate, records a premium deficiency reserve.

The Company, for certain matters, maintains stop loss coverage for health care costs that are in excess of set thresholds.

Global Risk Management Segment

Global Risk Management Revenues

Operating revenue of the Global Risk Management segment consists primarily of payments for medical services procured under global capitation arrangements from third-party health plans. Capitation revenue under these global capitation contracts is prepaid monthly to the Global Risk Management segment based on the number of enrollees. Entities within the Global Risk Management segment entered into Management Services Agreements with our Hospital and Medical Group segments, under which 98% of capitation revenue received is transferred to these segments.

Similar to the Medical Group segment, capitation revenue is recognized in the month in which the Global Risk Management segment is obligated to provide services. Minor ongoing adjustments to prior months' capitation, primarily arising from contracted HMOs' finalizing of monthly patient eligibility data for additions or subtractions of enrollees, are recognized in the month they are communicated to the Company. Additionally, Medicare pays capitation using a "Risk Adjustment model," which compensates managed care organizations and providers based on the health status (acuity) of each enrollee. Health plans and providers with higher acuity enrollees will receive more and those with healthier enrollees will receive less. Under Risk Adjustment, capitation is determined based on health severity, measured using patient encounter data. Capitation is paid on an interim basis based on data submitted for the enrollee for the preceding year and is adjusted in subsequent periods (generally in the Company's fourth quarter) after the final data is compiled. Positive or negative capitation adjustments are made for Medicare enrollees with conditions requiring more or less healthcare services than assumed in the interim payments. Since the Company cannot reliably predict these adjustments, periodic changes in capitation amounts earned as a result of Risk Adjustment are recognized generally in the fourth quarter when those changes are communicated by the health plans to the Company. The Global Risk Management Segment did not have any capitation risk adjustments for the year ended September 30, 2015 as it was the segment's first year of operations.

Global Risk Management Cost of Revenues

The cost of health care services consists primarily of the transfer of capitation revenue to the Hospital and Medical Group segments under the Management Services Agreements, and capitation and claims payments. These costs are recognized in the period incurred, or when the services are provided. Claims costs also include an estimate of the cost of services which have been incurred but not yet reported to the Company. The estimate for accrued medical costs is based on projections of costs using historical studies of claims paid and adjusted for seasonality, utilization and cost trends. These estimates are subject to trends in loss severity and frequency. Although considerable variability is inherent in such estimates, management records its best estimate of the amount of medical claims incurred at each reporting period. Estimates are continually monitored and reviewed and, as settlements are made or estimates adjusted, differences are reflected in current operations.

The Company also periodically evaluates the need to establish premium deficiency reserves for the probability that anticipated future health care costs could exceed future capitation payments from HMOs under capitated contracts and, where appropriate, records a premium deficiency reserve.

The Company, for certain matters, maintains stop loss coverage for health care costs that are in excess of set thresholds.

Property, Improvements and Equipment

Property, improvements and equipment are stated on the basis of cost or, in the case of acquisitions, at their acquisition date fair values. Depreciation is provided using the straight-line method over the estimated useful lives of the assets, and amortization of leasehold improvements is provided using the straight-line basis over the shorter of the remaining lease period or the estimated useful lives of the leasehold improvements. Leasehold improvements are generally depreciated over five to ten years, buildings are depreciated over five to 28 years, equipment is depreciated over two to five years and furniture and fixtures are depreciated over two to seven years. Equipment capitalized under capital lease obligations are amortized over the lesser of the life of the lease or the useful life of the asset.

As more fully described in Note 10, the Company is required to comply with certain seismic standards as required by the state of California by January 1, 2020. The useful life of buildings subject to seismic retrofit requirements may be limited if the Company does not make the necessary upgrades by the required compliance date.

Goodwill and Other Intangible Assets

Goodwill totaled $162,296,000 and $158,864,000 at September 30, 2015 and 2014, respectively, and arose as a result of the ProMed, Alta, SCH Culver City, Nix Health (including Nix CGH), and Prospect CharterCARE Physicians medical practices acquisitions. Goodwill represents the excess of the consideration paid and liabilities assumed over the fair value of the net assets acquired, including identifiable intangible assets.

Goodwill is not amortized; rather it is reviewed annually for impairment for each reporting unit, or more frequently if impairment indicators arise. Impairment is the condition that exists when the carrying amount of goodwill exceeds its implied fair value. A two-step impairment test is used to identify potential goodwill impairment and to measure the amount of goodwill impairment loss to be recognized, if any. The Company has five reporting units with goodwill, consisting of the Alta Hospitals (which include SCH Hollywood, SCH Van Nuys, Los Angeles Community Hospital, and Norwalk Community Hospital), SCH Culver City, Nix Health, the MSOs and Medical Groups located in California ("California Medical Groups"), and CharterCARE. The California Medical Groups represent a change in reporting units during the year ended September 30, 2015; see Note 5.

The Company tests for goodwill impairment as of September 30 each year. In evaluating whether indicators of impairment exist, the Company considers adverse changes in market value, laws and regulations, profitability, cash flows, ability to maintain enrollment and renew payer contracts at favorable terms, among other factors. The goodwill impairment test is a two-step process. The first step consists of estimating the fair value of the reporting unit based on a weighted combination of (i) the guideline company method that utilizes revenue or earnings multiples for comparable publicly-traded companies, and (ii) a discounted cash flow model that utilizes expected future cash flows, the timing of those cash flows, and a discount rate (or weighted average cost of capital, which considers the cost of equity and cost of debt financing expected by a typical market participant) representing the time value

of money and the inherent risk and uncertainty of the future cash flows. If the estimated fair value of the reporting unit is less than its carrying value, a second step is performed to compute the amount of the impairment by determining the "implied fair value" of the goodwill, which is compared to its corresponding carrying value. The Company's impairment test related to goodwill during the years ended September 30, 2015 and 2014, resulted in no impairment charge.

Long-Lived Assets and Amortizable Intangibles

Amortizable intangible assets totaled $29,162,000 and $35,274,000, net of accumulated amortization at September 30, 2015 and 2014, respectively, and arose as a result of the ProMed, Alta, SCH Culver City, Nix Health, NGMA, PCC, and CharterCARE Physicians medical practices acquisitions. Intangible assets include customer relationships, trade names, favorable leasehold, and physician guarantees. The Company reviews long-lived assets for impairment whenever events or changes in circumstances indicate that the carrying value of such assets may not be recoverable. The Company considers assets to be impaired and writes them down to fair value if estimated undiscounted cash flows associated with those assets are less than their carrying amounts. Fair value is based upon the present value of the associated cash flows. Changes in circumstances (for example, changes in laws or regulations, technological advances or changes in strategies) may also reduce the useful lives from initial estimates. Changes in planned use of intangibles may result from changes in customer base, contractual agreements, or regulatory requirements. In such circumstances, management will revise the useful life of the long-lived asset and amortize the remaining net book value over the adjusted remaining useful life. There were no impairments recorded during the years ended September 30, 2015 and 2014.

Medical Malpractice Liability Insurance

The individual physicians who contract with the Affiliates carry their own medical malpractice insurance. In the Hospital Services segment, the Company's hospitals carry professional and general liability insurance to cover medical malpractice claims under claims-made policies. Under the policies, insurance premiums cover only those claims actually reported during the policy term. Should the claims-made policy not be renewed or replaced with equivalent insurance, claims related to occurrences during the policy term but reported subsequent to the policy's termination may be uninsured. Effective October 1, 2013, the Company's hospitals renewed the professional and general liability insurance under one consolidated policy with separate retentions for each entity. LACH Bellflower, FRMC, and CharterCARE were included under the consolidated policy from their respective dates of acquisition or inception (LACH Bellflower).

GAAP requires that a health care organization record and disclose the estimated costs of medical malpractice claims in the period of the incident of malpractice, if it is reasonably possible that liabilities may be incurred and losses can be reasonably estimated. The Company has recognized an estimated liability for incurred but not reported claims and the self-insured risks (including deductibles and potential claims in excess of policy limits) based upon an actuarial valuation of the Company's historical claims experience of the Company's hospitals. At September 30, 2015 and 2014, the total gross claims liability was $6,632,000 and $4,590,000 and insurance receivables were $1,406,000 and $618,000, respectively, and were estimated using a discount factor of 4%.

The claims reserve is based on the best data available to the Company. The estimate, however, is subject to a significant degree of inherent variability. The estimate is continually monitored and reviewed, and as the reserve is adjusted, the difference is reflected in current operations. While the ultimate amount of medical malpractice liability is dependent on future developments, management is of the opinion that the associated liabilities recognized in the accompanying consolidated financial

statements are adequate to cover such claims. Management is not aware of any potential medical malpractice claims whose settlement, if any, would have a material adverse effect on the Company's consolidated financial position, results of operations or cash flows.

Workers' Compensation Insurance

The workers' compensation coverage provides the statutory benefits required by law with a $250,000 deductible policy with limits of $1,000,000 per occurrence and aggregate for the hospitals located in California. Nix Health has opted out of the Texas Workers' Compensation system as a non-subscriber, and provides its employees with benefits for occupational injury or disease through an ERISA plan. Nix Health has an Employer's Excess Indemnity policy with a $25,000 deductible policy with limits of $10,000,000 per occurrence and $25,000,000 aggregate. CharterCARE was fully insured for workers' compensation claims with no deductible from June 20, 2014 through September 30, 2015. At September 30, 2015 and 2014, included in accrued salaries, wages and benefits are accruals for uninsured claims and claims incurred but not reported of approximately $8,766,000 and $7,210,000, respectively. The amounts are estimated based upon an actuarial valuation of their claims experience, using a discount factor of 4%.

The claims reserve is based on the best data available to the Company. The estimate, however, is subject to a significant degree of inherent variability. The estimate is monitored and reviewed, and as the reserve is adjusted, the difference is reflected in current operations. While the ultimate amount of the claims liability is dependent on future developments, management is of the opinion that the associated liabilities recognized in the accompanying consolidated financial statements are adequate to cover such claims. Management is not aware of any potential claims whose settlement, if any, would have a material adverse effect on the Company's consolidated financial position, results of operations or cash flows.

Asset Retirement Obligations

The Company recognizes the fair value of a liability for legal obligations associated with asset retirements in the period in which it is incurred, if a reasonable estimate of the fair value of the obligation can be made. Over time, the liability is accreted to its present value each period. Upon settlement of the obligation, any difference between the cost to settle the asset retirement obligation and the liability recorded is recognized as a gain or loss in the statement of operations. The Company has accrued $4,583,000 and $4,310,000 in other long-term liabilities related to asset retirement obligations for the CharterCARE hospitals as of September 30, 2015 and 2014, respectively.

Stock Options

On December 15, 2010, the Board of Directors (the "Ivy Board") of Ivy Holdings adopted the 2010 Stock Option Plan of Ivy Holdings Inc. (the "Ivy Plan") and, on December 16, 2010, the stockholders of Ivy Holdings adopted the Ivy Plan. The Ivy Plan provides that it shall be administered by the Compensation Committee of the Ivy Board. The Ivy Plan includes an Incentive Stock Option Agreement and a Non-Qualified Stock Option Agreement to be used in connection with the grant of options under the Ivy Plan. These options granted under the Ivy Plan are exercisable into Ivy Holdings stock and vest based on a number of criteria.

On June 30, 2015, the Board of Directors of Ivy Holdings adopted the First Amendment to the Ivy Plan and concurrently, on June 30, 2015, the stockholders of Ivy Holdings approved the First Amendment to the Ivy Plan (the "Amended Ivy Plan"). Pursuant to the Amended Ivy Plan, the Board of Directors

authorized the issuance of options exercisable for an additional 13,972 shares of common stock of Ivy Holdings to employees, certain consultants and independent members of the boards of directors of Ivy Holdings and its subsidiaries (including the Company and its subsidiaries). These options granted under the Amended Ivy Plan are exercisable into Ivy Holdings stock and vest based on a number of criteria, including the same criteria as options granted under the Ivy Plan as well as the occurrence of certain corporate transactions, including a change in control of Ivy Holdings, as defined in the Incentive Stock Option Agreements; see Note 9.

Compensation costs for option awards are measured and recognized in the consolidated financial statements based on their grant date fair value, net of estimated forfeitures over the awards' service period. Options subject to variable accounting treatment are subject to revaluation at the end of each reporting period. The Company uses the Black-Scholes option pricing model and a single option award approach to estimate the fair value of stock options granted. The fair value of restricted stock grants are determined on the date of grant, based on the number of shares granted and the quoted price or estimated fair market value of the Company's common stock. Equity-based compensation is classified within the same line items as cash compensation paid to employees. Compensation costs related to stock options that vest or are exercisable when certain corporate transactions occur, including a change in control, are recognized at the time that such an event occurs.

Cash and Cash Equivalents

The Company considers all highly liquid debt instruments with initial maturities of 90 days or less to be cash equivalents. Cash and cash equivalents are primarily comprised of deposits with banks. The Company maintains its cash at banks with high credit-quality ratings.

Restricted Cash

At September 30, 2015 and 2014, $2,000,000 was restricted to meet certain regulatory requirements for PHP. Prospect contributed $2,000,000 of restricted cash to PHP, which is not a guarantor of Prospect's long-term debt, in order for PHP to maintain compliance with tangible net equity requirements (see Note 10). $1,277,000 and $1,993,000 was restricted for research at CharterCARE hospitals as of September 30, 2015 and 2014, respectively. An additional $1,308,000 and $983,000 was restricted for various other purposes including workers' compensation insurance arrangements and various letters of credit as of September 30, 2015 and 2014, respectively.

Restricted Investments

The Company is required to keep restricted deposits by certain HMOs for the payment of claims. Such restricted deposits are classified as a current asset in the accompanying consolidated balance sheets, as they are restricted for payment of current liabilities. Investments also include certificates of deposit with maturity dates of more than 90 days when purchased.

Inventories

Inventories of supplies are valued at the lower of amounts that approximate the weighted average cost or market. Inventories consist primarily of medical and surgical supplies and pharmaceuticals.

Deferred Financing Costs

Deferred financing costs are amortized over the period in which the related debt is outstanding using the effective interest method.

Deferred financing costs at September 30, 2015 and 2014 are as follows (in thousands):

	2015			2014		
	Gross Book Value	Accumulated Amortization	Net Book Value	Gross Book Value	Accumulated Amortization	Net Book Value
Deferred financing costs	$14,398	$7,165	$7,233	$14,398	$4,941	$9,457

Income Taxes

Deferred income tax assets and liabilities are recognized for differences between financial and income tax reporting bases of assets and liabilities based on enacted tax rates and laws. To the extent a deferred tax asset cannot be recognized under the preceding criteria, allowances must be established. The impact on deferred taxes of changes in tax rates and laws, if any, are applied to the years during which temporary differences are expected to be settled and reflected in the financial statements in the period of enactment. The Company recognizes interest and penalties associated with income tax matters and unrecognized tax benefits in the income tax expense line item of the statements of operations. For the years ended September 30, 2015 and 2014, no interest and/or penalties related to incomes taxes were accrued and/or expensed.

An entity is required to evaluate its tax positions using a two-step process. First, the entity should evaluate the position for recognition. An entity should recognize the financial statement benefit of a tax position if it determines that it is more likely than not that the position will be sustained on examination. Next, the entity should measure the amount of benefit that should be recognized for those tax positions that meet the more-likely-than-not test.

Consolidated federal tax returns are filed, with the exception of PMG and NGMA, which file their own federal tax returns. The Company files separate state tax returns for California, Texas, and Rhode Island. The Company's filed tax returns are generally subject to examination by the IRS and state tax boards for 3 to 4 years.

Fair Value of Financial Instruments

Financial instruments consist primarily of cash and cash equivalents, restricted cash investments, patient and other accounts receivables, accrued salaries and benefits, accounts payable and accrued expenses, medical claims and related liabilities, amounts due to government agencies, notes receivable and payable, capital lease obligations, debt, and other liabilities. The carrying amounts of current assets and liabilities approximate their fair value due to the relatively short period of time between the origination of the instruments and their expected realization.

Fair Value Measurement

Relevant accounting guidance establishes a framework for measuring fair value and clarifies that fair value is an exit price, representing the amount that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants.

The guidance requires disclosure about how fair value is determined for assets and liabilities and establishes a hierarchy for which these assets and liabilities must be grouped, based on significant levels of inputs as follows: Level 1 quoted prices in active markets for identical assets or liabilities; Level 2 quoted prices in active markets for similar assets and liabilities and inputs that are observable for the asset or liability; or Level 3 unobservable inputs for the asset or liability, such as discounted cash flow models or valuations. The determination of where assets and liabilities fall within this hierarchy is based upon the lowest level of input that is significant to the fair value measurement.

The Company's Level 1 assets include cash and cash equivalents and investments (certificates of deposit and money market mutual funds). The inputs for fair value of goodwill and intangible assets (including long lived assets and intangible assets subject to amortization) would be based on Level 3 inputs as data used for such fair value calculations would be based on discounted cash flows that are not observable from the market, directly or indirectly.

Financial Items Measured at Fair Value on a Recurring Basis

The following table sets forth the Company's financial assets and liabilities measured at fair value on a recurring basis and where they are classified within the hierarchy (in thousands):

	Total	Level 1	Level 2	Level 3
As of September 30, 2015				
Certificates of deposit and money market mutual funds	$ 1,266	$ 1,266	$ -	$ -
As of September 30, 2014				
Certificates of deposit and money market mutual funds	$ 642	$ 642	$ -	$ -

The Company's investments are classified within Level 1 of the fair value hierarchy because they are valued using quoted market prices.

Nonfinancial Items Measured at Fair Value on a Nonrecurring Basis

Nonfinancial assets such as goodwill and identifiable intangible assets are measured at fair value when there is an indicator of impairment and recorded at fair value only when impairment is recognized. The Company performs an annual impairment test on the goodwill, and performs an impairment test on the intangibles when there are indications of impairment.

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Significant increases or decreases in the Company's weighted average cost of capital may result in a significantly lower or higher fair value measurement, respectively. Significant increases or decreases in the revenue growth rate and royalty rates in isolation may result in a significantly higher or lower fair value measurement, respectively. The fair values of the Company's current financial liabilities approximate their reported carrying amounts. The carrying values and the fair values of non-current financial liabilities that qualify as financial instruments under the guidance are as follows (in thousands):

	2015		2014	
September 30,	Carrying Amount	Fair Value	Carrying Amount	Fair Value
Liabilities:				
Long-term debt	$ 422,835	$ 445,269	$ 421,888	$ 457,620

The fair value of the Company's long-term debt was determined based on market prices.

Concentrations of Credit Risk

Cash and cash equivalents are maintained at financial institutions and, at times, balances may exceed federally insured limits of $250,000 per depositor of each financial institution. The Company has not experienced any losses to date related to these balances.

Financial instruments that potentially subject the Company to concentrations of credit risk consist of receivables due from Medicare, Medicaid (Medi-Cal in California), patients, and health plans including shared-risk arrangements.

The Company invests excess cash in liquid securities at institutions with strong credit ratings, following established guidelines relative to diversification and maturities to maintain safety and liquidity. These guidelines are periodically reviewed and modified to take into consideration trends in yields and interest rates and principal risk. Management attempts to schedule the maturities of the Company's investments to coincide with the Company's expected cash requirements. Credit risk with respect to receivables is limited since amounts are generally due from large HMOs within the Medical Group Management segment and from the Medicare and Medicaid (Medi-Cal in California) programs within the Hospital Services segment. Management reviews the financial condition of these institutions on a periodic basis and does not believe the concentration of cash or receivables results in a high level of risk.

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For the years ended September 30, 2015 and 2014, the Hospital Services segment received a total of 67% of its net patient revenues from Medicare and Medicaid programs, and the Medical Group segment received a total of 59% and 58%, respectively, of their capitation revenues from its five largest HMOs, as follows (in thousands):

Years Ended September 30,	2015	% of Total Revenue	2014	% of Total Revenue
Hospital Services:				
Government Payers:				
Medicare	$ 321,282	31%	$ 224,984	36%
Medicaid	379,821	36%	189,668	31%
Total	$ 701,103	67%	$ 414,652	67%
Medical Group:				
HMO A	$ 39,759	13%	$ 12,721	5%
HMO B	38,934	12%	33,784	14%
HMO C	37,900	12%	31,632	13%
HMO D	34,806	11%	31,481	13%
HMO E	32,239	11%	31,283	13%
Total	$ 183,638	59%	$ 140,901	58%

The Global Risk Management segment received 100% of their revenues from four health plans during the year ended September 30, 2015.

Use of Estimates

The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets, liabilities, revenues and expenses, and the disclosure of contingent assets and liabilities at the dates, and for the periods, that the consolidated financial statements are prepared. Actual results could materially differ from those estimates. Principal areas requiring the use of estimates include third party settlements, settlements under risk sharing programs, allowances for contractual discounts and doubtful accounts, accruals for medical claims, impairment of goodwill, long-lived assets and intangible assets, share-based payments, professional and general liability claims and workers' compensation claims, reserves for outcome of legislation and valuation allowances against deferred tax assets.

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New Accounting Pronouncements

In July 2013, the Financial Accounting Standards Board ("FASB") issued an Accounting Standards Update ("ASU") that requires an unrecognized tax benefit or portion of an unrecognized tax benefit to be presented as a reduction to a deferred tax asset for a net operating loss carryforward, a similar tax loss, or a tax credit carryforward except when certain conditions exist. The amendment is effective for the Company for fiscal years beginning after December 15, 2014, including interim periods in 2014. The Company is currently evaluating the effect of this guidance on its consolidated results of operations and consolidated financial position.

In May 2014, the FASB issued ASU No. 2014-09, "Revenue from Contracts with Customers (ASU 2014-09)," as amended by ASU 2015-14. The core principle of ASU 2014-09 is built on the contract between a vendor and a customer for the provision of goods and services, and attempts to depict the exchange of rights and obligations between the parties in the pattern of revenue recognition based on the consideration to which the vendor is entitled. To accomplish this objective, the standard requires five basic steps: (i) identify the contract with the customer, (ii) identify the performance obligations in the contract, (iii) determine the transaction price, (iv) allocate the transaction price to the performance obligations in the contract, (v) recognize revenue when (or as) the entity satisfies a performance obligation. Nonpublic entities will apply the new standard for annual periods beginning after December 15, 2018, including interim periods therein. Three basic transition methods are available – full retrospective, retrospective with certain practical expedients, and a cumulative effect approach. Under the third alternative, an entity would apply the new revenue standard only to contracts that are incomplete under legacy U.S. GAAP at the date of initial application (e.g. January 1, 2019) and recognize the cumulative effect of the new standard as an adjustment to the opening balance of retained earnings. That is, prior years would not be restated and additional disclosures would be required to enable users of the financial statements to understand the impact of adopting the new standard in the current year compared to prior years that are presented under legacy U.S. GAAP. Early adoption is permitted for fiscal years beginning after December 15, 2016. The Company is currently evaluating the effect of this guidance on its consolidated financial statements.

In August 2014, the FASB issued ASU No. 2014-15, "Presentation of Financial Statements - Going Concern: Disclosures of Uncertainties about an Entity's Ability to Continue as a Going Concern." This ASU provides guidance about management's responsibility to evaluate whether there is substantial doubt about an entity's ability to continue as a going concern and to provide related footnote disclosures. Specifically, this ASU provides a definition of the term substantial doubt and requires an assessment for a period of one year after the date that the financial statements are issued (or available to be issued). It also requires certain disclosures when substantial doubt is alleviated as a result of consideration of management's plans and requires an express statement and other disclosures when substantial doubt is not alleviated. The new standard will be effective for reporting periods beginning after December 15, 2016, with early adoption permitted. The Company will apply the provisions of this standard upon adoption.

In April 2015, the FASB issued ASU No. 2015-03, "Simplifying the Presentation of Debt Issuance Costs." This ASU amends existing guidance to require the presentation of debt issuance cost on the balance sheet as a deduction from the carrying amount of the related debt, instead of an asset. This ASU is effective for reporting periods beginning after December 15, 2015 and early adoption is permitted. The Company is currently evaluating the effect of this guidance on its consolidated financial statements.

In November 2015, the FASB issued ASU No. 2015-17, "Income Taxes (Topic 740), Balance Sheet Presentation of Deferred Tax Assets and Liabilities". This ASU amends existing guidance by simplifying the presentation of deferred income taxes on a net basis as non-current deferred tax assets or liabilities. ASU No. 2015-17 did not modify the requirement that deferred tax assets and liabilities of a tax-paying component of an entity be offset and presented as a single amount. This ASU is effective for reporting reports beginning after December 15, 2017 with earlier adoption permitted.

The Company elected early adoption of ASU No. 2015-17 effective October 1, 2013. The previous requirement to separate deferred income tax assets and liabilities into current and non-current amounts was not beneficial to the users of the consolidated financial statements as classification did not necessarily align with the time period in which the recognized deferred tax amounts were expected to be recovered or settled.

The following table discloses the impact of the adoption of ASU No. 2015-17 on the amounts previously reported in the consolidated balance sheet (in thousands):

Balance Sheet as of September 30, 2014	As Previously Reported	Impact of ASU No. 2015-17	As Reported
Deferred income taxes, net (current asset)	$ 68,304	$ (68,304)	$ -
Total current assets	$ 320,014	$ (68,304)	$ 251,710
Deferred income taxes, net (long-term asset)	$ -	$ 1,165	$ 1,165
Total assets	$ 761,317	$ (67,139)	$ 694,178
Deferred income taxes, net (long-term liability)	$ 70,447	$ (67,139)	$ 3,308
Total liabilities	$ 762,523	$ (67,139)	$ 695,384
Total liabilities and stockholder's equity	$ 761,317	$ (67,139)	$ 694,178

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3. Property, Improvements and Equipment

Property, improvements and equipment, consisted of the following (in thousands):

September 30,	2015	2014
Property, improvements and equipment:		
Land and land improvements	$ 53,416	$ 53,381
Buildings and improvements	136,137	119,163
Leasehold improvements	20,344	22,967
Equipment	107,785	87,249
Furniture and fixtures	6,891	7,187
	324,573	289,947
Less: accumulated depreciation	(84,236)	(60,473)
Property, improvements and equipment, net	$ 240,337	$ 229,474

Effective May 6, 2014, Prospect acquired the property, improvements, and equipment of Bellflower Medical Center, located in Bellflower, California, for cash consideration of $20 million. The assets, including land and building, were named Los Angeles Community Hospital at Bellflower. Bellflower Medical Center was closed in 2013 by its previous owner and was not operational when the Company purchased the related assets. The Company accounted for this transaction as an acquisition of assets. The primary factors influencing the determination that the acquisition should be accounted for in this manner included the complete closure of the hospital, the fact that there were no inputs and/or processes acquired, the requirement for significant additional capital expenditures and development efforts to reopen the hospital, and the lack of acquired workforce. Accordingly, the Company determined that this transaction lacked the key characteristics for business combination accounting. In addition to the $20 million purchase price, Prospect capitalized $546,000 of transaction costs directly related to the purchase of these assets. The purchase price and transaction costs were allocated to the assets acquired based on the relative fair value of the acquired assets.

At September 30, 2015 and 2014, the Company had assets under capitalized leases of approximately $20,299,000 and $19,294,000, respectively, and related accumulated depreciation of $14,356,000 and $11,465,000, respectively.

Depreciation expense was approximately $27,692,000 and $18,386,000 for the years ended September 30, 2015 and 2014, respectively.

4. Acquisitions

CharterCARE Physicians Medical Practices

During the year ended September 30, 2015, CharterCARE Physicians entered into asset purchase agreements to acquire 11 medical practices with primary care physicians as well as physicians with specialties in general surgery, bariatric surgery and urology. Total cash consideration for the medical practices was $3,865,000, with cash consideration for each practice ranging from $9,000 to $2,100,000.

The acquisitions of the medical practices were accounted for as a business combination using purchase accounting. Under the purchase accounting method, assets acquired and liabilities assumed are recorded based on their estimated fair values.

The following table summarizes the assets acquired and liabilities assumed in connection with the CharterCARE Physician medical practices acquisitions (in thousands):

	Purchase Price Allocation (Preliminary)
Inventory	$ 8
Improvements and equipment	328
Intangible assets	97
Goodwill	3,432
Net cash consideration	$ 3,865

As asset purchases, the goodwill and intangible assets acquired are deductible for tax purposes.

University Medical Group

Effective December 18, 2014, New University Medical Group ("New UNMG"), a wholly-owned subsidiary of RWMC, entered into an Asset Purchase Agreement, pursuant to which New UNMG will acquire substantially all of the assets of University Medical Group ("UNMG"), a physician medical practice with approximately 35 primary care and specialist physicians with various specialties. As consideration for the acquisition, New UNMG will assume certain liabilities of UNMG.

As of December 18, 2014, New UNMG acquired certain assets of the practice and assumed certain liabilities related to the administrative functions of UNMG ("Initial Close"). At a later date, New UNMG will acquire certain additional assets and assume certain additional liabilities ("Second Close"). Concurrent with the Initial Close, UNMG and New UNMG entered into an Interim Administrative Services Agreement, which is effective until the Second Close occurs. New UNMG also entered into the First Amendment to the Interim Administrative Services Agreement effective December 18, 2014. In addition, Prospect, RWMC and CharterCARE Physicians have receivables from various transactions of $4,345,000 due from UNMG as of September 30, 2015, which are included in other assets in the accompanying consolidated balance sheet.

Because Second Close had not occurred as of September 30, 2015, the acquisition of UNMG is not reported in the accompanying consolidated financial statements. As a result of the Asset Purchase Agreement, Interim Administrative Services Agreement (as amended), and various transactions, New UNMG has the obligation to absorb certain losses of UNMG and the right to receive certain benefits from UNMG. However, New UNMG does not have the power to direct the activities of UNMG which most significantly impact its performance based on the terms of the Interim Administrative Services Agreement (as amended) and the governance of UNMG. As a result, New UNMG is not the primary beneficiary of UNMG, and the results of UNMG are not consolidated in the accompanying consolidated financial statements.

Newport Specialty Hospital

Effective May 6, 2014, Prospect acquired substantially all of the assets of Newport Specialty Hospital (subsequently renamed Foothill Regional Medical Center) for cash consideration of $15 million. Newport Specialty Hospital, located in Tustin, California was substantially closed prior to acquisition, operating only its pediatric subacute unit as of the acquisition date.

The acquisition of Newport Specialty Hospital was accounted for as a business combination using purchase accounting. This transaction resulted in a bargain gain of $523,000, which is included in other income in the accompanying consolidated statements of income. The Company incurred $556,000 of transaction costs during the year ended September 30, 2014, which are included in General and Administrative expenses in the accompanying consolidated statements of income.

The following table summarizes the assets acquired and liabilities assumed in connection with the Newport Specialty Hospital acquisition, as of May 6, 2014 (in thousands):

	Purchase Price Allocation
Property, improvements and equipment	$ 15,523
Bargain purchase gain	(523)
Net cash consideration	$ 15,000

CharterCARE

Effective June 20, 2014, Prospect, through its newly formed subsidiary, PCC, acquired substantially all of the assets of CharterCARE Health Partners and its subsidiaries in exchange for a 15% interest in PCC, $43.3 million in cash and a commitment to invest at least $50 million in PCC and its subsidiaries for strategic business development and capital improvements over the next four years. As a result of the acquisition, PCC is owned 85% by Prospect and 15% by CharterCARE Health Partners (which was subsequently renamed CharterCARE Community Board).

PCC, through its subsidiaries, operates Roger Williams Medical Center, St. Joseph Health Services of Rhode Island, and Elmhurst Extended Care Facilities, Inc., which operate hospitals, medical centers and assisted living facilities located in Rhode Island with approximately 785 licensed beds.

The acquisition was accounted for as a business combination using purchase accounting. This transaction resulted in a bargain gain of $4,294,000 during the year ended September 30, 2014. Subsequent to September 30, 2014, PCC received $2,125,000 for a working capital adjustment, which is reflected in prepaid expenses and other current assets resulting in an increase in net assets acquired by Prospect and the non-controlling interest. The gain on bargain purchase was reduced by $319,000 during the year ended September 30, 2015, which is the non-controlling interest's 15% interest in the working capital adjustment. The gain on bargain purchase recognized during the years ended September 30, 2015 and 2014 are included in adjustment to (gain on) bargain purchase in the accompanying consolidated statements of income.

The following table summarizes the assets acquired and liabilities assumed in connection with the PCC acquisition, as of June 20, 2014 (in thousands):

	Purchase Price Allocation (Preliminary)	Purchase Price Allocation (Final)
Restricted cash	$ 1,739	$ 1,739
Patient accounts receivable and other receivables	34,264	34,264
Prepaid expenses and other current assets	8,777	10,902
Property, improvements and equipment	53,642	53,642
Intangible assets	8,590	8,590
Other long-term assets	4,698	4,698
Accounts payable and other liabilities	(44,656)	(44,656)
Capital leases	(1,315)	(1,315)
Long-term debt	(25)	(25)
Other long-term liabilities	(4,645)	(4,645)
Net assets acquired	61,069	63,194
Less: amount attributable to non-controlling interest	(9,160)	(9,479)
Net assets acquired by Prospect	51,909	53,715
Total purchase consideration	47,615	49,740
Bargain purchase gain	$ 4,294	$ 3,975

The change in prepaid expenses and other current assets from the preliminary to the final purchase price allocation was due to the working capital adjustment of $2,125,000. The total purchase consideration of $49,740,000 includes net cash consideration of $43,300,000 plus a long-term liability of $6,440,000, which represents the discounted fair value of the non-controlling interest's 15% interest in the $50 million future commitment of the Company to PCC as part of the Purchase Agreement.

During the year ended September 30, 2015, the Company partially satisfied its $50 million future commitment by contributing $9,637,000 to PCC, of which $1,446,000, or 15%, was attributed to the non-controlling interest in PCC. The Company incurred $2,145,000 of transaction costs during the year ended September 30, 2014, which are included in General and Administrative expenses in the accompanying consolidated statements of income.

5. Goodwill and Intangible Assets

As of September 30, 2015 and 2014, goodwill and intangible assets relate to the ProMed, Alta, SCH Culver City, Nix Health, NGMA, Nix CGH, CharterCARE Physicians medical practices acquisitions. The Company performed its annual goodwill impairment analysis for each reporting unit that constitutes a business for which 1) discrete financial information is produced and reviewed by management, and 2) services that are distinct from the other reporting units.

During the year ended September 30, 2015, the Company reorganized its reporting structure for the Medical Group segment due to changes in financial information produced and reviewed by management and the convergence of the economic characteristics of the MSOs and Medical Groups located in

California. Prior to the reorganization of the reporting structure, the Medical Group segment was comprised of two reporting units: PHCA and the ProMed Entities (collectively referred to as the "ProMed IPAs") as well as PMS and the other affiliated physician organizations, including NGMA (collectively, "Prospect IPAs"). As a result of the reorganization of reporting structure, the MSOs and Medical Groups located in California comprise a single reporting unit (collectively, "California Medical Groups").

For the Hospital Services segment, the reporting unit for the annual goodwill impairment analysis has been determined to be at the business unit level. Reporting units consist of Alta Hospitals, SCH Culver City, Nix Health, and CharterCARE.

The carrying value of goodwill by reporting unit is as follows (in thousands):

September 30,	2015	2014
Alta Hospitals	$ 106,539	$ 106,539
SCH Culver City	24,373	24,373
Nix Health	5,613	5,613
CharterCARE	3,432	-
California Medical Groups	22,339	22,339
	$ 162,296	$ 158,864

The following is a roll-forward of goodwill from October 1, 2013 to September 30, 2015 (in thousands):

	Amount
Balance, October 1, 2013	$ 158,864
Balance, September 30, 2014	158,864
Acquisition of CharterCARE Physicians medical practices (see Note 4)	3,432
Balance, September 30, 2015	$ 162,296

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Identifiable intangible assets are comprised of the following (in thousands):

	September 30, 2015						
	Alta	SCH Culver City	Nix Health	Charter CARE (1)	Prospect	Promed	Total
HMO membership	$ -	$ -	$ -	$ -	$ -	$ 25,200	$ 25,200
Trade names, net of impairment	10,310	1,320	2,740	8,590	-	9,450	32,410
Favorable leasehold	-	-	20	-	-	-	20
Physician guarantees	-	-	1,530	-	-	-	1,530
Customer relationships	-	-	-	-	350	-	350
Other	-	-	-	97	-	-	97
Gross carrying value	10,310	1,320	4,290	8,687	350	34,650	59,607
Accumulated amortization	(4,361)	(880)	(2,964)	(2,200)	(150)	(19,890)	(30,445)
Intangible assets, net	$ 5,949	$ 440	$ 1,326	$ 6,487	$ 200	$ 14,760	$ 29,162

(1) CharterCARE includes intangible assets related to the acquisitions of CharterCARE effective June 20, 2014 and various CharterCARE Physicians acquisitions effective on various dates during the year ended September 30, 2015 (see Note 4).

	September 30, 2014						
	Alta	SCH Culver City	Nix Health	Charter CARE	Prospect	Promed	Total
HMO membership	$ -	$ -	$ -	$ -	$ -	$ 25,200	$ 25,200
Trade names, net of impairment	10,310	1,320	2,740	8,590	-	9,450	32,410
Favorable leasehold	-	-	20	-	-	-	20
Physician guarantees	-	-	1,596	-	-	-	1,596
Customer relationships	-	-	-	-	350	-	350
Gross carrying value	10,310	1,320	4,356	8,590	350	34,650	59,576
Accumulated amortization	(3,670)	(440)	(2,171)	(482)	(100)	(17,439)	(24,302)
Intangible assets, net	$ 6,640	$ 880	$ 2,185	$ 8,108	$ 250	$ 17,211	$ 35,274

During the years ended September 30, 2015 and 2014, intangibles related to physician guarantees of $539,000 and $487,000, respectively, were fully amortized and removed from intangible assets.

Amortization is recognized on a straight-line basis (management's best estimate of the period of economic benefit) over the respective useful lives and expense for the years ended September 30, 2015 and 2014 was $6,682,000 and $5,194,000, respectively.

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Estimated amortization expense for each future fiscal year is as follows (in thousands):

Years ended September 30,	
2016	$ 6,312
2017	5,155
2018	4,635
2019	4,099
2020	2,813
Thereafter	6,148
Total	$ 29,162

The following table shows the estimated useful lives for each of the intangible assets:

	Estimated useful lives
HMO membership	14 years
Trade names	3 - 20 years
Favorable leasehold	6 years
Physician guarantees	2 to 3 years
Customer relationships	7 years
Other	5 years

The weighted-average remaining useful life for the intangible assets was 6.4 years as of September 30, 2015.

6. Related Party Transactions

Jeereddi Prasad, M.D., a shareholder of Ivy Holdings, a director of Ivy Holdings and the Company, and an officer of the ProMed Entities, has ownership interests in physician medical groups that provide medical services to ProMed members, including CMG. For the years ended September 30, 2015 and 2014, the ProMed Entities paid these groups approximately $18,170,000 and $12,677,000, respectively. As of September 30, 2015 and 2014, the Company had accounts payable and other accrued liabilities due to these related parties of $531,000 and none, respectively.

Pursuant to a Management Services Agreement, dated December 15, 2010 and amended on May 3, 2012 (the "LGP Management Agreement"), between the Company and Leonard Green & Partners, L.P. ("LGP"), a private equity fund with affiliated funds that collectively constitute the majority shareholder of Ivy Holdings, LGP provides to the Company, (a) certain investment banking services, (b) management, consulting and financial planning services and (c) financial advisory and investment banking services in connection with major financial transactions from time to time. In consideration for the services provided by LGP under the LGP Management Agreement, the Company pays LGP an annual fee of $1,000,000, payable in monthly installments, and reimburses LGP for its related expenses up to $50,000 annually. If approved by the unanimous consent of the Board of Directors of the Company, additional customary fees may be due to LGP pursuant to the terms of the LGP Management Agreement for services rendered in connection with major transactions from time to time. No amounts were payable related to these related party transactions as of September 30, 2015 or 2014.

The Company is a wholly-owned indirect subsidiary of Ivy Holdings. Therefore, Ivy Holdings is the parent of an affiliated group of corporations within the meaning of Section 1504(a) of the Internal Revenue Code of 1986. On December 15, 2010, Ivy Holdings, Ivy Intermediate and the Company entered into a Tax Sharing Agreement. The Tax Sharing Agreement allows the Company to make payments to Ivy Holdings as necessary to fund their payment of any required taxes incurred due to such parent status. During the years ended September 30, 2015 and 2014, the Company made payments under this arrangement of $24,977,000 and $5,703,000, respectively.

7. Income Taxes

The components of the income tax provision are as follows (in thousands):

For the years ended September 30,	2015	2014
Current:		
Federal	$ 35,445	$ 14,430
State	9,709	4,242
	45,154	18,672
Deferred:		
Federal	(12,957)	(4,529)
State	(1,051)	(3,582)
	(14,008)	(8,111)
Total:		
Federal	22,488	9,901
State	8,658	660
	$ 31,146	$ 10,561

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Temporary differences and carry forward items that result in deferred income tax balances as of September 30, are as follows (in thousands):

September 30,	2015	2014
Deferred tax assets:		
State tax benefit	$ 2,306	$ 2,593
Allowances for bad debts	7,889	5,119
Vacation accrual and other	4,800	5,440
Workers compensation	3,991	2,656
Accrued bonuses	4,837	3,898
Malpractice reserves	2,546	1,952
Deferred rent	139	107
Enterprise zone tax credit	1,261	2,433
Net operating losses	302	8,789
Partnership outside basis difference	8,323	-
Capital loss carryforward	-	2,274
Other	157	359
Deferred tax assets	36,551	35,620
Valuation allowance	(984)	(10,737)
Net deferred tax assets	35,567	24,883
Deferred tax liabilities:		
Intangible assets	(6,448)	(7,247)
Fixed assets	(17,035)	(17,664)
Deferred compensation	-	(112)
Partnership outside basis difference	-	(1,982)
Prepaid expenses	-	(21)
Other	(219)	-
Deferred tax liabilities	(23,702)	(27,026)
Net deferred tax assets (liabilities)	$ 11,865	$ (2,143)

Deferred tax assets and liabilities reflect the effect of temporary differences between the assets and liabilities recognized for financial reporting purposes and the amounts recognized for income tax purposes.

As of September 30, 2014, the Company had a valuation allowance of $10,737,000 related to deferred tax assets. Certain deferred tax assets, including carryforwards of net operating losses and capital losses, were written off due to the inability to use certain carryovers as a result of IRC 382 limitations, as well as due to the carry over expiration during the year ended September 30, 2015. However, such removal had no impact on the income tax provision because of the corresponding impact of the change in the valuation allowance. As of September 30, 2015, the Company maintains a valuation allowance of $984,000 on a certain portion of the California Enterprise credit and net operating losses of non-consolidated and separately filed entities for federal and state purposes, as it is more likely than not that the deferred tax asset will not be realized.

As of September 30, 2015, the Company has $1,261,000 of California Enterprise Zone credit carryforwards which can be carried over indefinitely. The Company has approximately $483,000 and $1,506,000 of net operating loss carryforwards for federal and California which expire through September 30, 2036 and September 30, 2026, respectively.

The Company is currently undergoing an IRS examination for fiscal year 2012. Additionally, the Company received a notice of review from the Franchise Tax Board of California for refunds claimed on its California returns reflecting additional Enterprise tax credits.

Generally, the Company's tax years 2011 through 2014 are open for state tax examination. As of September 30, 2015, the Company does not have material unrecognized tax benefits. The Company believes that it is reasonably possible that an increase in unrecognized tax benefits may be necessary within the coming year, and these unrecognized tax benefits would primarily impact deferred taxes and taxes payable, and the expected range of potential increase in the unrecognized tax benefits is not expected to be material to the balance sheet nor the income statement.
The FASB issued ASU No. 2015-17, which requires entities to offset deferred tax assets and liabilities for each tax paying jurisdiction within each tax paying component. The deferred taxes must be reported as non-current. The Company elected early adoption of the ASU (see Note 2 under New Accounting Pronouncements).

The differences between the income tax provision at the federal statutory rate and that reflected in the accompanying consolidated statements of operations are summarized as follows:

For the years ended September 30,	2015	2014
Tax provision at statutory rate	35%	35 %
State taxes, net of federal benefit	7%	6 %
Enterprise zone tax credits	0%	(7)%
Other	6%	2 %
	48%	36 %

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8. Long-Term Debt

Long-term debt consists of the following (in thousands):

September 30,	2015	2014
Prospect's debt:		
Senior secured notes		
2019 Notes	$ 325,000	$ 325,000
Less: discount, net	(4,950)	(6,339)
	320,050	318,661
Additional 2019 Notes	100,000	100,000
Plus: premium, net	1,110	1,419
	101,110	101,419
	421,160	420,080
Nix Health's debt:		
Mortgage debt	1,675	1,801
Other debt:	-	7
Total Debt:	422,835	421,888
Less: current maturities	(135)	(133)
Long-term debt, net of current maturities	$ 422,700	$ 421,755

Prospect's Debt:

Senior Secured Notes

On May 3, 2012, the Company closed the offering of $325 million in 8.375% senior secured notes due May 1, 2019 ("PMH 2019 Notes"). Interest is payable semi-annually in arrears on May 1 and November 1, commencing on November 1, 2012. The offering was executed in accordance with Rule 144A and Regulation S under the Securities Act of 1933. The terms of the PMH 2019 Notes are governed by an indenture among the Company, certain of its subsidiaries and affiliates (as "Guarantors"), and U.S. Bank National Association (as trustee) (the "Indenture"). The Indenture contains certain covenants that, among other things, limit the Company's ability, and the ability of its restricted subsidiaries (as such term is defined in the Indenture) to: retire and pay dividends or distributions on capital stock or equity interests, prepay subordinated indebtedness or make other restricted payments; incur additional debt; make investments; create liens on assets; enter into transactions with affiliates; engage in other businesses; sell or issue capital stock of restricted subsidiaries; merge or consolidate with another company; transfer and sell assets; create dividend and other payment restrictions affecting subsidiaries; and designate unrestricted subsidiaries. The Credit Agreement (defined below), executed in connection with the PMH Senior Secured Credit Facility (discussed below), contains a number of customary covenants as well as covenants requiring the Company to maintain a maximum consolidated secured leverage ratio and limiting the amount of capital expenditures.

Concurrent with the issuance of the PMH 2019 Notes, the Company entered into a five year $50 million revolving senior secured credit facility (the "PMH Senior Secured Credit Facility") which replaced the existing senior secured credit facility. The PMH Senior Secured Credit Facility provides, among other things, for borrowings up to the amount of the facility with sublimits of up to (i) $20 million to be available for the issuance of letters of credit and (ii) $10 million to be available for swingline loans. The commitment under the facility may be increased by up to $10 million upon the Company's request at the discretion of the lenders and subject to certain customary requirements. The interest rate per annum applicable to loans under the PMH Senior Secured Credit Facility will be, at the Company's option, either a rate per annum equal to (i) LIBOR plus 3.50% or (ii) an alternate base rate, which will be the higher of the administrative agent's prime rate, the federal funds rate plus 0.50%, and the 1-month LIBOR rate plus 1.00%, plus in each case, 2.50%. In August 2013, the PMH Senior Secured Credit Facility limit was increased to $60 million. As of September 30, 2015 and 2014, the Company had $20 million outstanding debt related to the PMH Senior Secured Credit Facility. As of September 30, 2015, the interest rate for the PMH Senior Secured Credit Facility was 3.95%.

The PMH 2019 Notes and the PMH Senior Secured Credit Facility are jointly and severally guaranteed on a senior secured basis by all of the Company's subsidiaries (as such term is defined in the Indenture) other than AMVI/Prospect Medical Group, Nuestra, PHP and certain immaterial subsidiaries. The PMH 2019 Notes are secured pari passu with the PMH Senior Secured Credit Facility by first-priority Liens and security interests on substantially all of the tangible and intangible assets of the Guarantors, including, but not limited to, the accounts receivable, inventories, other personal property, real property, fixtures and equipment, in each case now owned or hereafter acquired by the Company and the Subsidiary Guarantors, with certain exceptions. The PMH 2019 Notes are effectively senior to all of the Guarantors' existing and future Indebtedness.

The terms of the PMH Senior Secured Credit Facility are governed by the Credit Agreement, dated as of May 3, 2012, (as amended in connection with the Company's November 2012 offering of additional PMH 2019 Notes - see below) among the Company, Morgan Stanley Senior Funding, Inc. (as administrative agent), Royal Bank of Canada and Credit Suisse AG, Cayman Islands Branch (as co-syndication agents) and the lenders party thereto (the "Credit Agreement").

The Company, at its option, may redeem all or part of the notes at a redemption price equal to 106.281%, 104.188%, 102.094% and 100.0% on or after May 1, 2015, 2016, 2017 and 2018, respectively. Prior to May 1, 2015, the Company, at its option, may (i) redeem up to 35% of the original principal amount of the notes with the proceeds of certain equity offerings at a redemption price of 108.375% (ii) redeem up to 10% of the original principal amount of the PMH 2019 Notes during each 12-month period, commencing on May 1 in each of 2012, 2013 and 2014, at a redemption price of 103.0% of the principal amount thereof (this redemption option was terminated in connection with the Company's November 2012 offering of additional PMH 2019 Notes) or (iii) redeem the PMH 2019 Notes, in whole, but not in part, at a redemption price of 100.0% of the aggregate principal plus a make-whole premium. There are no required principal payments on the PMH 2019 Notes until maturity.

On November 16, 2012, the Company closed the offering of $100 million in aggregate principal amount of 8.375% senior secured notes due 2019 (the "Additional 2019 Notes") at a price equal to 102% of the principal amount of the Additional 2019 Notes. The Additional 2019 Notes were issued in a private placement to qualified institutional buyers and form a part of the same series as the PMH 2019 Notes issued on May 3, 2012.

The Additional 2019 Notes were issued under the Indenture, dated May 3, 2012 and described above, as supplemented by two supplemental indentures entered into in connection with the issuance of the

Additional 2019 Notes (the "Supplemental Indentures"). The Additional 2019 Notes are treated as a single series with the previously issued PMH 2019 Notes for all purposes under the Indenture, including, without limitation, restrictive covenants, waivers, amendments, redemptions and offers to purchase. Prior to closing the issuance of the Additional 2019 Notes, the Company was required to obtain the consent of the majority in interest of its PMH 2019 Notes issued on May 3, 2012 to certain amendments to the Indenture contained in the first Supplemental Indenture. The Company obtained such consent from the holders of approximately $324 million in aggregate principal amount of outstanding PMH 2019 Notes and paid an aggregate consent fee of approximately $8.9 million. The Company determined that the transaction represents a debt modification under the applicable accounting guidance and capitalized the consent fee and recorded it as a debt discount during the year ended September 30, 2013, which is being amortized over the term of the Additional 2019 Notes using the effective interest method.

In connection with the issuance of the Additional 2019 Notes, the Company entered into an amendment of its Credit Agreement governing the PMH Senior Secured Credit Facility that waived and amended certain provisions of the Credit Agreement, including certain restrictive covenants.

As of September 30, 2015 and 2014, the Company was in compliance with the financial covenants of the Indenture and Credit Agreement.

Demand Notes

During the year ended September 30, 2012, the Company obtained a commitment from a bank for a $9.3 million equipment leasing facility to finance various equipment at the Company's hospital facilities. During January 2014, the commitment was increased to $15.0 million. As of September 30, 2015 and 2014, $11.5 million and $10.7 million, respectively, were drawn under the facility and are classified as capital lease arrangements. Draws represent demand notes until conversion to capital leases, and interest accrues on such draws at the bank prime rate plus 1.5% with a floor of 4.5% and payable monthly.

Nix Health's Debt:

Mortgage Debt

In connection with the Nix Health acquisition, Nix SPE, LLC ("Nix SPE") executed a Loan Assumption Agreement, effective as of February 29, 2012, pursuant to which Nix SPE assumed the obligations of the sellers of Nix Health under a mortgage loan facility provided by The Ohio National Life Insurance Company on December 27, 1999. Nix SPE assumed the obligation to pay the outstanding principal amount of the mortgage loan and interest accruing thereafter. The outstanding balance of the mortgage loan as of September 30, 2015 and 2014 was $1,675,000 and $1,801,000, respectively.

Prospect Hospital Holdings, LLC, the parent company of Nix SPE, has provided a guaranty of the obligations of Nix SPE under the loan. The obligations under the loan facility are secured by a deed of trust on a neighborhood medical center known as Nix Alamo Heights. The loan is subject to a 7.0% interest rate and requires monthly installment payments of $21,000, with a balloon payment on the maturity date of November 1, 2019. Prepayment is subject to a fee and the loan contains customary covenants.

Note Payable

Nix Health entered into a note payable during September 2012 due in March of 2014 for $141,000. Interest accrued on this note at 8.96% and was payable monthly. The note payable was repaid during the year ended September 30, 2014.

Scheduled payments under the Company's current and long-term debt as of September 30, 2015 are as follows (in thousands):

Years ending September 30,	
2016	$ 135
2017	145
2018	155
2019	421,326
2020	1,074
	$ 422,835

9. Stockholder's Equity (Deficit)

Equity Based Compensation Plans

Effective December 15, 2010, the Board of Directors of Ivy Holdings adopted the Ivy Plan that authorized the issuance of options exercisable for up to 155,110 shares of the common stock of Ivy Holdings ("Initial Options") to employees, certain consultants and independent members of the boards of directors, of Ivy Holdings and its subsidiaries (including the Company and its subsidiaries). During the years ended September 30, 2015 and 2014, the Compensation Committee of the Board of Directors of Ivy Holdings ("Compensation Committee") granted 37,814 and 4,113 options, respectively, to certain members of the Company's management and employees. These options are exercisable into Ivy Holdings stock and vest based on a number of criteria, including time, Company and Business Unit performance based on EBITDA targets and CEO and Compensation Committee discretion. Since the Ivy Holdings stock options were granted to Company employees for their services related to the Company, the related compensation cost has been recorded in the Company's consolidated financial statements.

Effective June 30, 2015, the Board of Directors of Ivy Holdings adopted the First Amendment to the Ivy Plan, pursuant to which the Board of Directors authorized the issuance of options exercisable for an additional 13,972 shares of common stock of Ivy Holdings ("New Options") to employees, certain consultants and independent members of the boards of directors of Ivy Holdings and its subsidiaries (including the Company and its subsidiaries). Concurrently, the Compensation Committee granted 13,972 options to certain members of the Company's management and employees. The New Options are exercisable into Ivy Holdings stock and vest based on a number of criteria, including the same criteria as the Initial Options however, they only become exercisable on the occurrence of certain corporate transactions, including a change in control of Ivy Holdings, as defined in the Incentive Stock Option Agreements ("Corporate Transaction"). Because the occurrence and timing of a Corporate Transaction is not determinable as of September 30, 2015, no compensation cost has been recorded in the Company's consolidated financial statements.

Under the terms of the Ivy Plan, the exercise price of an incentive stock option ("ISO") may not be less than 100% of the fair market value of the Company's common stock on the date of grant and, if granted

to a shareholder owning more than 10% of the Company's common stock, then not less than 110%. Stock options granted under the Ivy Plan have a maximum term of 10 years from the grant date, and are exercisable at such time and upon such terms and conditions as determined by the Compensation Committee. Stock options granted to employees generally vest over four years, subject to continued service, performance, and other criteria. In the case of an ISO, the amount of the aggregate fair market value of common stock with respect to which the ISO grant is exercisable, for the first time by an employee during any calendar year, may not exceed $100,000.

Stock Options Activity

The following table summarizes information about Ivy Holdings stock options outstanding as of September 30, 2015 and 2014 and activity during the years then ended for the Initial Options and the New Options:

	Shares Subject to Options	Weighted Average Exercise Price	Weighted Average Aggregate Intrinsic Value	Weighted Average Remaining Contractual Term (Months)
Outstanding as of September 30, 2013 *(1)*	118,277	$ 43.44	$ 76.56	95.8
Granted	4,113	120.00	–	–
Exercised	–	–	–	–
Canceled/Forfeited	(6,915)	58.71	–	–
Outstanding as of September 30, 2014	115,475	45.37	74.63	84.1
Granted *(2)*	51,786	176.00	–	–
Exercised	(12,620)	31.38	–	–
Canceled/Forfeited	(3,808)	46.24	–	–
Outstanding as of September 30, 2015	150,833	$ 91.42	$ 436.51	88.2

(1) The number of options at September 30, 2013 includes 100,611 options modified in connection with the Repricing (see below).
(2) The options granted include 37,814 Initial Options and 13,972 New Options.

The aggregate intrinsic value is calculated as the difference between the exercise price of the underlying awards and the estimated fair value of the Company's common stock for those awards that have an exercise price currently below the estimated fair value. As of September 30, 2015, the aggregate intrinsic value of outstanding shares was approximately $60,000,000. As of September 30, 2015, there were 106,078 options that are exercisable at a weighted average exercise price of $55.08.

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A summary of Ivy Holdings non-vested options and the changes during the fiscal years ended September 30, 2015 and 2014 is presented as follows for the Initial Options and New Options:

	Shares	Weighted Average Grant Date Fair Value
Ivy Holdings Stock Options:		
Nonvested at September 30, 2013 *(3)*	43,192	$ 86.99
Granted	4,113	63.81
Vested	(28,797)	92.00
Canceled/Forfeited	(4,871)	85.15
Nonvested at September 30, 2014	13,637	70.47
Granted	51,786	72.03
Vested	(19,267)	73.60
Canceled/Forfeited	(1,401)	88.08
Nonvested at September 30, 2015	44,755	$ 70.38

(3) The number of non-vested options at September 30, 2013 includes 29,930 options modified in connection with the repricing (see below).

On April 5, 2013, the Compensation Committee approved the repricing of the exercise price of all outstanding stock options as of that date. Pursuant to such resolution of the Ivy Holdings Compensation Committee, as of the effective date, all of the previously granted options were exchanged for new options with a lower exercise price granted on a one-for-one basis. As a result of this repricing, the Company repriced 49,380 vested options and 59,748 unvested options from an original exercise price of $100.00 per share to a new exercise price of $30.00 per share. Other than the exercise price, all other terms of the repriced options, such as vesting and contractual life, remained the same. The Company has accounted for the repricing as a modification and recorded any net incremental fair value related to vested awards as compensation expense on the date of modification. In addition, the Company is recording the incremental fair value related to the unvested awards, together with unamortized stock-based compensation expense associated with the unvested awards, over the remaining requisite service period of the option holders. In connection with the repriced options, the Company recorded stock compensation expense of $1,454,000 on the date of the modification. Incremental compensation cost resulting from the modification was $113,000 and $1,097,000 during the years ended September 30, 2015 and 2014, respectively.

The original fair value of the options granted ranged from $50.73 to $98.65 per option. In connection with the repricing, the stock compensation expense related to the stock options granted prior to April 5, 2013 is calculated based on a fair value of $97.75. The fair value was determined using the Black-Scholes option pricing model.

Fair value of the repriced options was estimated with the following assumptions for Ivy Holdings:

For the year ended September 30,	2013
Weighted average fair value of repriced options	$97.75
Estimated fair market value of the Company's common stock on the date of grant	$120.00
Weighted average expected life of the options	8.2 years
Risk-free interest rate	1.7%
Weighted average expected volatility	45.9%
Dividend yield	0.0%

Stock-Based Compensation Expense

Stock-based compensation expense for all share-based payments in exchange for employee services (including stock options and restricted stock) is measured at fair value on the date of grant, estimated using an option pricing model and is recognized in the consolidated financial statements, net of estimated forfeitures over the awards requisite service period.

The Company uses the Black-Scholes option pricing model and a single option award approach to estimate the fair value of options granted. Estimated forfeitures will be revised in future periods if actual forfeitures differ from the estimates and will impact compensation cost in the period in which the change in estimate occurs. The determination of fair value using the Black-Scholes option-pricing model is affected by the Company's estimated stock price as well as assumptions regarding a number of complex and subjective variables, including expected stock price volatility, risk-free interest rate, expected dividends and projected employee stock option exercise behaviors.

Fair value for options granted during the years ended September 30, 2015 and 2014 was estimated with the following assumptions for Ivy Holdings:

For the years ended September 30,	2015	2014
Weighted average fair value of option grants	$ 98.65	$ 63.81
Estimated fair market value of the Company's common stock on the date of grant	$ 176.00	$ 120.00
Weighted average expected life of the options	9.8 years	8.0 years
Risk-free interest rate	1.8%	2.7%
Weighted average expected volatility	45.0%	45.0%
Dividend yield	0.00%	0.00%

Expected Term - The expected term of options granted represents the period of time that they are estimated to be outstanding.

Risk-Free Interest Rate - The Company bases the risk-free interest rate on the implied yield in effect at the time of option grant on U.S. Treasury zero-coupon issues with equivalent remaining terms.

Expected Volatility - The Company estimates the volatility of the common stock at the date of grant based on the average of the historical volatilities of a group of peer companies. The Company has identified a group of comparable companies to calculate historical volatility from publicly available data for sequential periods approximately equal to the expected terms of the option grants. In

selecting comparable companies, Management considered several factors including industry, stage of development, size and market capitalization.

Forfeitures—Share-based compensation is recognized only for those awards that are ultimately expected to vest. Compensation expense is recorded net of estimated forfeitures. Those estimates are revised in subsequent periods if actual forfeitures differ from those estimates. The Company used data since December 2010 to estimate pre-vesting option forfeitures.

Stock-based compensation expense for the Ivy Holdings stock options recognized by the Company during the years ended September 30, 2015 and 2014 was $1,184,000 and $2,673,000 (including the impact of the option repricing noted above), respectively. At September 30, 2015, there were 44,755 unvested options, which could potentially vest over the next three fiscal years, subject to meeting the vesting requirements noted above. The remaining maximum estimated stock compensation expense to be amortized to expense in future periods is approximately $3,000,000. Options which are expected to vest based on CEO and Compensation Committee discretion are treated as variable stock options and are subject to revaluation at each reporting period. Management determined the fair value of the discretionary vested options using a Black Scholes calculation but determined that the change in compensation expense was not material to the consolidated financial statements for the years ended September 30, 2015 and 2014.

10. Commitments and Contingencies

Leases

The Company leases various office facilities and equipment from third parties under non-cancelable operating and capital lease arrangements expiring at various dates through 2026. Certain operating leases contain rent escalation clauses and renewal options, which have been factored into determining rent expense on a straight-line basis over the lease terms. Capital leases bear interest at rates ranging from 2% to 11% per annum.

The future minimum annual lease payments (net of anticipated sublease income) required under leases in effect at September 30, 2015, are as follows (in thousands):

For the Years ending September 30,	Capital Leases	Operating Leases
2016	$ 3,913	$ 4,157
2017	2,589	3,395
2018	1,725	2,693
2019	1,414	2,210
2020	1,274	2,175
Thereafter	6,434	932
Total minimum lease payments	17,349	$ 15,562
Less: amounts representing interest	(5,148)	
	12,201	
Less: current portion	(2,905)	
	$ 9,296	

Rent expense for the years ended September 30, 2015 and 2014 was approximately $15,258,000 and $9,615,000, respectively. Sublease rental income of approximately $107,000 and $271,000, for the years ended September 30, 2015 and 2014, respectively, was recorded as a reduction to rental expense.

Litigation

The Company is subject to a variety of claims and suits that arise from time to time in the ordinary course of its business, acquisitions, or other transactions. While the Company's management currently believes that resolving all of these matters, individually or in the aggregate, will not have a material adverse impact on the Company's consolidated financial position or results of operations, the litigation and other claims that the Company faces are subject to inherent uncertainties and management's view of these matters may change in the future. Should an unfavorable final outcome occur, there exists the possibility of a material adverse impact on the Company's consolidated financial position, results of operations and cash flows for the period in which the effect becomes probable and reasonably estimable.

Following the acquisition of the Company in August 2010, two putative class action complaints were filed against the Company, each of the Company's special committee members, Ivy Holdings, LGP, and certain other parties. These complaints, which were consolidated into a single action, allege generally that defendants breached their fiduciary duties, or aided and abetted others' breaches of their fiduciary duties, in connection with the transaction with the Company by, among other things, authorizing the transaction for what plaintiffs claim to be inadequate consideration and pursuant to what plaintiffs claim to be an inadequate process and with inadequate disclosures.

On December 30, 2010, another lawsuit was filed in Delaware Chancery Court by Terrier Partners and five related entities against the same defendants identified above. The complaint alleges generally that the consideration offered to shareholders in connection with the transaction with the Company was inadequate in light of the revenue received under AB 1383 (see California Hospital Fee Program below), and that defendants breached their fiduciary duties, or aided and abetted others' breaches of their fiduciary duties by not obtaining a higher price in light of this additional revenue.

In May 2012, the Court of Chancery granted motions to consolidate the Terrier Partners case and the class action cases and certified a class as a non-opt out class. On June 11, 2012, plaintiffs filed their Verified Consolidated Third Amended Class Action Complaint. On July 26, 2012, the director defendants answered the Third Amended Complaint. That same day, Prospect moved to dismiss itself as a party to the Third Amended Complaint. The Court granted the motion to dismiss the Company as a defendant, leaving only the individuals as defendants in the case.

The parties subsequently engaged in discovery, and following mediation, have agreed to settle the dispute as to all parties and all claims. Pursuant to the terms of the Settlement Agreement, Prospect and its insurers have agreed to contribute $6.5 million as a settlement amount, which will be used to pay all claims to the class as well as fees for plaintiffs' class counsel. All defendants will be released from all claims in return for entry into the settlement. The settlement is subject to approval by the Delaware Chancery Court, which has scheduled a hearing for January 21, 2016 to consider the proposed settlement and determine, among other things, whether the settlement is fair, reasonable, and adequate to the class and should be approved by the Court. Notice has been sent out advising class members of the settlement, the date of the hearing and their right to object. Because it is a non-opt-out class, if the settlement is approved it should fully dispose of the claim as to all potential plaintiffs. The Company has no reason to believe that the settlement will not be approved by the Court, since it has been stipulated to by all parties and multiple counsel for plaintiffs; however, if the Court rejects

the settlement or for some other reason the settlement is not consummated, the defendants will vigorously defend the lawsuit.

Seismic Standards

Our SCHS Hospitals, Alta Los Angeles Hospitals, and FRMC are required to comply with California's Alfred E. Alquist Hospital Facilities Seismic Safety Act (the "Alquist Act"), which regulates the seismic performance of all aspects of hospital facilities in California. The Alquist Act imposes near-term and long-term compliance deadlines for seismic safety assessment, submission of corrective plans, and the retrofitting or replacement of medical facilities to comply with current seismic standards. The Alquist Act also requires that the California Building Standards Commission adopt earthquake performance categories, seismic evaluation procedures, standards and timeframes for upgrading certain facilities, and seismic retrofit building standards. These regulations require hospitals to meet seismic performance standards to ensure that they are capable of providing medical services to the public after an earthquake or other disaster. The Building Standards Commission completed its adoption of evaluation criteria and retrofit standards in 1998.

The Alquist Act requires that within three years after the Building Standards Commission had adopted evaluation criteria and retrofit standards:

- Hospitals in California must conduct seismic evaluation and submit these evaluations to the Office of Statewide Health Planning and Development ("OSHPD"), Facilities Development Division for its review and approval;

- Hospitals in California must identify the most critical nonstructural systems that represent the greatest risk of failure during an earthquake and submit timetables for upgrading these systems to the OSHPD, Facilities Development Division for its review and approval; and

- Hospitals in California must prepare a plan and compliance schedule for each regulated building demonstrating the steps a hospital will take to bring the hospital buildings into substantial compliance with the regulations and standards.

The Company was required to conduct engineering studies at its hospitals to determine whether and to what extent modifications to the hospital facilities will be required. Management believes that SCH Culver City meets all current requirements; however, it may be required to make significant capital expenditures in the future to comply with the seismic standards, which could impact its earnings. The cost at September 30, 2015, is unknown at this time but could be material. In addition, such modifications to the hospital facilities could potentially result in environmental remediation liabilities which may be material to the Company.

The OSHPD has a voluntary program to re-evaluate the seismic risk of hospital buildings classified as Structural Performance Category ("SPC") 1. These buildings are considered hazardous and at risk of collapse in the event of an earthquake and they were required to be retrofitted, replaced or removed from providing acute care services by 2013, unless granted an extension. OSHPD is using HAZARDS U.S. ("HAZUS"), a state-of-the-art methodology, to reassess the seismic risk of SPC-1 buildings and those that are determined to pose a low seismic risk may be reclassified to SPC-2. The SPC-2 buildings would have until 2030 to comply with the structural seismic safety standards. Participation in the HAZUS program is optional for hospital owners wishing to have their SPC-1 building(s) re-evaluated. Applications for a HAZUS re-evaluation of the seismic risk were submitted for SCH Hollywood, SCH Culver City and Los Angeles Community Hospital, but there is no assurance they will result in extensions.

In addition, in 2011, the California Legislature enacted Senate Bill 90, which permitted some hospitals to apply for up to an additional seven year extension to the seismic retrofit deadlines, not to extend beyond January 1, 2020. SB 90 also permits OSHPD to extend until January 1, 2018 the date by which the hospitals must obtain a building permit and commence the required retrofit project.

SCH Culver City and Los Angeles Community Hospitals both applied for the SB 90 extension from OSHPD. Three of the buildings owned by SCH Culver City were granted SB 90 extensions until January 2019 or July 2019. Also, the facility operated by Los Angeles Community Hospital received an SB 90 extension until January 2019.

OSHPD has discretion to approve or disapprove SB 90 extension requests, and to determine the length of the extension (up to the maximum seven years), based on eligibility factors including seismic risks associated with the affected buildings (which can be impacted by the updated HAZUS findings), community access to essential hospital services in the area and financial hardships facing the applicant.

Effective May 6, 2014, Prospect acquired the hospital facilities FRMC and LACH Bellflower (see Note 4). The Company is in the process of pursuing Non-Structural Performance Category ("NPC") 2 classification and the extension of the compliance deadlines that would result for FRMC. LACH Bellflower is not currently subject to the requirements of SB90 as the facility currently only provides psychiatric services.

These requirements can result in significant operational changes and capital outlays. Management is continuing to assess its options and the methods of financing the required retrofits. Based on management's evaluation, the costs of renovation needed to comply with the California seismic safety standards for its acute-care facilities, including asbestos abatement, are not estimable at this time.

Legislation and HIPAA

The healthcare industry is subject to numerous laws and regulations of federal, state and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government healthcare program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Government activity has continued with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed.

The Company believes that it is in compliance with fraud and abuse regulations as well as other applicable government laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time.

The Health Insurance Portability and Accountability Act ("HIPAA") assures health insurance portability, reduces healthcare fraud and abuse, guarantees security and privacy of health information, and enforces standards for health information. The Health Information Technology for Economic and Clinical Health Act ("HITECH Act") expanded upon HIPAA in a number of ways, including establishing notification requirements for certain breaches of protected health information. In addition to these federal rules, California has also developed strict standards for the privacy and security of health information as well as for reporting certain violations and breaches. The Company may be subject to significant fines and penalties if found not to be compliant with these state or federal provisions.

Affordable Care Act

The Patient Protection and Affordable Care Act ("PPACA") will substantially reform the United States health care system. The legislation impacts multiple aspects of the health care system, including many provisions that change payments from Medicare, Medicaid and insurance companies. Starting in 2014, the legislation requires the establishment of health insurance exchanges, which will provide individuals without employer-provided health care coverage the opportunity to purchase insurance. It is anticipated that some employers currently offering insurance to employees will opt to have employees seek insurance coverage through the insurance exchanges. It is possible that the reimbursement rates paid by insurers participating in the insurance exchanges may be substantially different than rates paid under current health insurance products. Another significant component of the PPACA is the expansion of the Medicaid program to a wide range of newly eligible individuals. In anticipation of this expansion, payments under certain existing programs, such as Medicare disproportionate share, will be substantially decreased. Each state's participation in an expanded Medicaid program is optional.

California Hospital Fee Program

The State of California enacted Assembly Bill 1383 ("AB 1383") effective January 1, 2010, as amended by Assembly Bill 1653 (collectively, the "Program"), to provide supplemental payments to certain hospitals such as the hospitals owned and operated by the Company's subsidiaries. The Program requires participating hospitals to pay fee assessments into a pool of funds to which the federal government contributes matching funds. Most of these funds, including the federal matching funds, are then distributed to qualifying hospitals. In addition, on April 13, 2011 SB 90 was signed into law and provided for a six-month extension of the Hospital Fee Program for dates of service from January 1, 2011 through June 30, 2011. CMS granted final approval of SB 90 on December 29, 2011, at which point the revenue and expense was recognized for the retroactive period. In September 2011, the State of California enacted Senate Bill 335 ("SB 335") which provides a 30-month hospital fee program for dates of service from July 1, 2011 through December 31, 2013. The elements of SB 335 related to the fee for service payments were approved by CMS on June 22, 2012. The payments due under the managed care component are scheduled to be made in three cycles. The first two cycles were previously approved by CMS, and the third cycle was approved by CMS during the year ended September 30, 2015. Certain technical changes to the legislation required by CMS are included in Senate Bill 920.

Governor Brown signed Senate Bill 239 ("SB 239") in October 2013, which enacted a hospital fee program for the period January 1, 2014 through December 31, 2016. SB 239 provides that the hospital fee program will continue through December 31, 2022 in three year cycles and will require authorization of each cycle by the California legislature. The fee for service component of SB 239 was approved by CMS during December 2014, and the first cycle of the managed care component from January 2014 through June 2014 was approved by CMS during July 2015.

For the years ended September 30, 2012 and 2011, SCH Culver City received invoices for fee assessments under AB 1383 and SB 90 of approximately $6,310,000 and $19,000,000, respectively, following payment of which, SCH Culver City was scheduled to receive approximately $5,236,000 and $15,000,000, respectively. Management of SCH Culver City estimated that SCH Culver City would be a "net" payer under the Program, since the fee assessments on SCH Culver City exceeded the supplemental payments by approximately $1,074,000 and $4,000,000, respectively. Accordingly, on October 6, 2010, the Company notified the California Department of Healthcare Services ("DHCS") that SCH Culver City was opting out of the Program.

SCH Culver City did not pay the required fee assessments under the Program. Beginning February 14, 2011, the DHCS began withholding against amounts otherwise due SCH Culver City, in the amount of $65,000 per week indicating that withholdings would continue for 108 weeks and would total approximately $7,000,000. Through September 30, 2012, a total of approximately $2,986,000 had been withheld against SCH Culver City's Medi-Cal fee-for-service payments. As of September 30, 2012, SCH Culver City recorded a liability of approximately $5,494,000, representing the accrued loss above, as well as deferred recognition of payments received from managed care plans. On November 15, 2012 the Company entered into a settlement agreement with DHCS with regards to SCH Culver City's liability under AB 1383, SB 90 and SB 335, as discussed above. Under the terms of the agreement, the DHCS agreed to forgive approximately $2,000,000 of the fees due under AB 1383, which was recorded by the Company during the year ended September 30, 2013. The remaining liability due to DHCS of $4,605,000 will be repaid by the Company monthly over a 10-year period without interest or penalties. The Company recorded a net liability of $3,233,000 as of the settlement date, which represents the net present value of the liability due to DHCS discounted at an effective interest rate of 7.5%. As of September 30, 2015 and 2014, the unamortized balance of the liability amounted to $2,547,000 and $2,806,000, respectively. The DHCS will no longer withhold against any other amounts due to SCH Culver City unless the Company is delinquent on payments owed under the agreement.

As of September 30, 2015, the Company had a receivable related to the California Hospital Fee Program of $32,285,000 in the accompanying consolidated balance sheets. The Company did not have a receivable related to the California Hospital Fee Program as of September 30, 2014. As of September 30, 2015 and 2014, the Company had a liability related to the California Hospital Fee Program of $15,022,000 and $2,806,000, respectively, in the accompanying consolidated balance sheets.

Total California Hospital Fee program revenues and expenses recognized during the years ended September 30, 2015 and 2014 were as follows (in thousands):

Years Ended September 30,	2015	2014
Hospital services revenues	$ 134,604	$ 11,884
Hospital operating expenses	91,325	5,863
Net pre-tax impact	$ 43,279	$ 6,021

Collective Bargaining Agreements

A small group of employees at SCH Hollywood, which is one of the hospitals under the consolidated group of Alta Hospitals System, LLC, and Service Employees International Union, United Healthcare Workers-West ("SEIU") are currently negotiating a new collective bargaining agreement. This agreement expired on May 3, 2015. In addition, approximately 84% of the employees of SCH Culver City are part of a collective bargaining agreement with the SEIU or the California Nurses Association ("CNA"). SCH Culver City and CNA are currently parties to a collective bargaining agreement that expires on December 21, 2015. The parties have commenced negotiations for a new agreement. SEIU and SCH Culver City are currently parties to a three-year term agreement that expires on April 27, 2017.

As of September 30, 2014, approximately 25% of the employees at Our Lady of Fatima Hospital ("Fatima") are subject to a collective bargaining agreement with United Nurses and Allied Professionals ("UNAP"), which expires July 31, 2016. An additional 1% are subject to a collective bargaining agreement with the Federation of Nurses and Health Professionals ("FNHP"), which expires April 30,

2016. During April 2015, a hospital unit consisting of approximately 400 service employees of Fatima elected to be represented by UNAP. Negotiations over a first collective bargaining agreement for this unit are ongoing.

Tangible Net Equity ("TNE") Requirement

The Company's affiliated physician organizations and PHP must comply with a minimum working capital requirement, Tangible Net Equity ("TNE") requirement, cash-to-claims ratio and claims payment requirements prescribed by the California Department of Managed Health Care ("DMHC"). Additionally, PHP has a TNE requirement as prescribed by the California Department of Managed Health Care. TNE is defined as net assets, less intangibles and amounts due from affiliates, plus subordinated obligations. At September 30, 2015, PHP was in compliance with these regulatory requirements.

The California DMHC determined that, as of March 31, 2015, PMG, on a consolidated basis with its subsidiaries, was not in compliance with the California DMHC's positive TNE requirement for a Risk Bearing Organizations ("RBO"). As a result, the California DMHC required PMG to develop and implement a six-month corrective action plan ("CAP") for such deficiency. Such six-month period has expired, and PMG believes that it has fully complied with all related requirements. As of the date of this report, PMG has not yet received the California DMHC's official release of the CAP.

The Company contributed $2,000,000 of Restricted Cash and $300,000 of Restricted Investments to PHP in conjunction with PHP's commencement of operations during the year ended September 30, 2015 (see Note 2 regarding Restricted Cash and Restricted Investments).

Employee Health Plans

Effective January 1, 2013 the Company offered self-insured EPO/HMO and PPO plans to all eligible employees. The CharterCARE hospitals had a separate low-deductible employee health plan from the date of acquisition through December 31, 2014. Effective January 1, 2015, the CharterCARE hospitals changed to self-insured EPO/HMO and PPO plans for all eligible employees.

Employee health benefits are administered by a third party claims administrator, based on plan coverage and eligibility guidelines determined by the Company, as well as by collective bargaining agreements (as reflected above). Commercial insurance policies cover per occurrence losses in excess of $275,000 for the CharterCARE hospitals, $250,000 for all other hospitals and $175,000 for the Medical Group and Corporate segments. An actuarially estimated liability of approximately $3,850,000 and $1,828,000 for incurred but not reported claims has been included in accrued salaries, wages, and benefits as of September 30, 2015 and 2014, respectively.

Provider Contracts

Many of the Company's payer and provider contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of medical services. Such differing interpretations may not come to light until a substantial period of time has passed following contract implementation. Liabilities for claims disputes are recorded when the loss is probable and can be estimated. Any adjustments to reserves are reflected in current operations.

11. Defined Contribution Plan

The Company sponsors two defined contribution plans covering substantially all employees who meet certain eligibility requirements. Under these plans, employees can contribute up to 50% of their compensation up to the IRS deferred annual maximum. There is currently no company match offered under the plans, except at Nix Health and PCC, for which the expense for the employer match was $1,865,000 and $576,000 for the years ended September 30, 2015 and 2014, respectively. Total expenses under the plan were approximately $480,000 and $197,000 during the years ended September 30, 2015 and 2014, respectively.

12. Accrued Medical Claims and Other Healthcare Costs Payable

The following table presents the roll-forward of incurred but not reported ("IBNR"), claims reserves (Medical Group segment, Global Risk Management segment, and full risk contracts) as of and for each of the fiscal years ended September 30, 2015 and 2014 (in thousands):

September 30,	2015	2014
IBNR as of beginning of year	$ 39,314	$ 30,352
Claim expenses incurred during the year:		
Related to current year	203,400	161,088
Related to prior year	1,606	(3,571)
Total incurred	205,006	157,517
Claims paid during the year:		
Related to current year	(156,485)	(124,393)
Related to prior year	(34,304)	(24,162)
Total paid	(190,789)	(148,555)
IBNR as of end of year	$ 53,531	$ 39,314

Following is a table showing the details of the Medical Group and Global Risk Management segments cost of revenues per the consolidated statements of operations (in thousands):

Years Ended September 30,	2015	2014
Capitation expense	$ 93,340	$ 85,754
Fee-for-service claims expense	118,529	94,749
Other physician compensation	14,082	5,066
Other cost of revenues	1,196	(227)
Total cost of revenues	$ 227,147	$ 185,342

13. Joint Ventures and Unconsolidated Equity Investments

AMVI

The Company (through Prospect Medical Group, Inc.) and an unrelated third party, AMVI Care Health Network, Inc. ("AMVI") are partners in a joint venture initially formed to service Medi-Cal members under the CalOptima program in Orange County, California. Healthy Families and OneCare members were subsequently added to the joint venture arrangement. Effective January 1, 2013, all Healthy Family participants were transferred to the Company's Medi-Cal line of business and therefore no longer part of the joint venture. The Company does not consolidate the joint venture. The Company includes in its consolidated financial statements only the net results attributable to those enrollees specifically identified as assigned to it, together with the management fee that it charges the joint venture partner for managing those enrollees specifically assigned to AMVI. Costs incurred by the Company in managing the joint venture are included in general and administrative expenses in the accompanying consolidated financial statements. As of September 30, 2015 and 2014, the net liability balances of the Company investment in the joint venture under the equity method were approximately $1,944,000 and $1,594,000, respectively, and were included in accounts payable and other accrued liabilities in the accompanying consolidated financial statements.

Summarized unaudited financial information for the unconsolidated joint venture as of and for each of the years ended September 30, 2015 and 2014 is as follows (in thousands):

September 30,	2015	2014
Cash	$ (96)	$ 1,753
Receivables	2,344	2,232
Total assets	$ 2,248	$ 3,985
Accrued medical claims	$ 1,652	$ 1,658
Other payables	158	1,470
Other partner's capital	437	856
Prospect's capital	1	1
Total liabilities and partner's capital	$ 2,248	$ 3,985

Years Ended September 30,	2015	2014
Revenues	$ 19,817	$ 19,289
Income before income taxes	$ 4,532	$ 2,915
Prospect's equity income	$ 5,867	$ 3,295
Management fees earned by Prospect	$ 1,106	$ 1,141

RWRT and SNERCC

Roger Williams Medical Center and an unrelated third party are owners of Roger Williams Radiation Therapy ("RWRT") and Southern New England Regional Cancer Center, LLC ("SNERCC"), which provide radiation therapy services. As of September 30, 2014, RWMC owned 29% of RWRT and 20% of SNERCC. On January 6, 2015, RWMC sold a 9% interest in RWRT for $1,233,000, reducing its ownership in RWRT from 29% to 20%. Also on January 6, 2015, RWMC increased its investment in SNERCC by $1,600,000 in

connection with SNERCC's acquisition of a radiation oncology business. RWMC's interest in SNERCC remained at 20% after the additional investment as RWMC's additional investment was its pro rata portion of the radiation oncology business purchase price. Roger Williams accounts for these investments using the equity method of accounting.

RWMC is not liable for any obligations insured by RWRT or SNERCC nor is it obligated to make any further capital contributions or lend funds to RWRT or SNERCC. As of September 30, 2015 and 2014, RWMC's investments in RWRT and SNERCC under the equity method were approximately $4,217,000 and $3,522,000 respectively, and are included in equity method investments in the accompanying consolidated balance sheets. For the year ended September 30, 2015, the Company recognized approximately $455,000 as its share of the financial results of RWRT and SNERCC and received $423,000 in distributions. For the period from June 20, 2014 (Roger Williams Medical Center inception) through September 30, 2014 and for the year ended September 30, 2015, the Company recognized $132,000 as its share of the financial results of RWRT and SNERCC and received no distributions.

Summarized combined unaudited financial information for RWRT and SNERCC as of September 30, 2015 and 2014 and for the year ended September 30, 2015 and for the period from June 20, 2014 (inception) through September 30, 2014 is as follows (in thousands):

September 30,	2015	2014
Cash	$ 1,299	$ 1,165
Receivables	1,547	1,130
Other current assets	274	372
Total current assets	3,120	2,667
Property, improvements and equipment, net	7,432	6,715
Goodwill	7,142	629
Intangible assets	943	-
Other long-term assets	1,663	1,756
Total assets	$ 20,300	$ 11,767
Accounts payable and accrued liabilities	$ 1,618	$ 1,070
Other long-term liabilities	345	336
Equity	18,337	10,361
Total liabilities and partner's capital	$ 20,300	$ 11,767

Years ended September 30,	2015	2014
Revenues	$ 14,626	$ 3,175
Net income	$ 2,000	$ 455
Roger Williams Medical Center's income from equity method investments	$ 455	$ 132

14. Segment Information

The Company's operations are organized into four reporting segments: (i) Hospital Services – which is comprised of the Alta Hospitals, SCH Culver City, Nix Health, and PCC reporting units, owns 13 hospitals and extended care facilities – Los Angeles Community Hospital, Norwalk Community Hospital, Los Angeles Community Hospital at Bellflower, Foothill Regional Medical Center, SCH Hollywood, SCH Van Nuys, SCH Culver City, Nix Medical Center, Nix Specialty Health Center, Nix CGH, Roger Williams Medical Center, Saint Joseph's Health Services of Rhode Island, and Elmhurst Extended Care; (ii) Medical Group – which is comprised of entities which provide management services to affiliated physician organizations that operate as independent physician associations or medical practice groups and certain unaffiliated independent physician associations; (iii) Global Risk Management - which is comprised of PHP, PHSTX and PHSRI which manage the provision of care for its members under global capitation arrangements in coordination with our Hospital and Medical Group segments and (iv) Corporate, which represents expenses incurred in Prospect Medical Holdings, Inc., that were not allocated to the other reporting segments.

The accounting policies of the reporting segments are the same as those described in the summary of significant accounting policies (see Note 2). The Company evaluates financial performance and allocates resources primarily based on earnings from operations before interest expense, interest income, income taxes, depreciation and amortization, as well as income or loss from operations before income taxes, excluding infrequent or unusual items.

The reporting segments are strategic business units that offer different services within the healthcare industry. Business in each reporting segment is conducted by one or more direct or indirect wholly-owned subsidiaries of the Company and certain affiliated physician organizations controlled through assignable option agreements and management services agreements. The Company voluntarily discloses the following table which summarizes certain information for each of the reporting segments regularly provided to and reviewed by the chief operating decision maker (in thousands):

	As of and for the Year Ended September 30, 2015					
	Hospital Services *(3)*	Medical Group *(2)*	Global Risk Management	Corporate *(1)*	Intersegment Eliminations	Consolidated
Revenues from external customers	$ 1,008,866	$ 333,238	$ 3,440	$ -	$ -	$ 1,345,544
Intersegment revenues	-	1,762	16,661	-	(18,423)	-
Total revenues	1,008,866	335,000	20,101	-	(18,423)	1,345,544
Depreciation and amortization	31,148	3,178	-	48	-	34,374
Operating income (loss)	63,413	66,142	(3,163)	(18,332)	-	108,060
Other (income) expense	2,240	(271)	-	42,926	(2,283)	42,612
Income (loss) before income taxes	61,173	66,413	(3,163)	(61,258)	2,283	65,448
Provision for income tax	-	10,600	-	20,546	-	31,146
Net income (loss)	$ 61,173	$ 55,813	$ (3,163)	$ (81,804)	$ 2,283	$ 34,302
Identifiable segment assets	$ 655,540	$ 96,289	$ 6,725	$ 24,297	$ -	$ 782,851
Segment capital expenditures, net of dispositions	$ 35,332	$ 981	$ -	$ 202	$ -	$ 36,515
Segment goodwill	$ 139,957	$ 22,339	$ -	$ -	$ -	$ 162,296

	As of and for the Year Ended September 30, 2014				
	Hospital Services *(3)*	Medical Group *(2)*	Corporate *(1)*	Intersegment Eliminations	Consolidated
Revenues from external customers	$ 600,536	$ 253,980	$ -	$ -	$ 854,516
Intersegment revenues	-	1,039	-	(1,039)	-
Total revenues	600,536	255,019	-	(1,039)	854,516
Depreciation and amortization	20,694	2,846	40	-	23,580
Operating income (loss)	57,748	29,080	(20,676)	-	66,152
Other (income) expense	(3,037)	(26)	38,480	1,622	37,039
Income (loss) before income taxes	60,785	29,106	(59,156)	(1,622)	29,113
Provision for income tax	-	5,765	4,796	-	10,561
Net income (loss)	$ 60,785	$ 29,106	$ (69,717)	$ (1,622)	$ 18,552
Identifiable segment assets	$ 599,516	$ 75,605	$ 19,057	$ -	$ 694,178
Segment capital expenditures, net of dispositions	$ 49,181	$ 924	$ 2	$ -	$ 50,107
Segment goodwill	$ 136,525	$ 22,339	$ -	$ -	$ 158,864

(1) Prospect files consolidated tax returns, with the exception of PMG and NGMA, which file their own federal tax returns, and allocates costs for shared services and corporate overhead to each of the reporting segments. With the exception of Nix Health and PCC, all debt, including debt related to the Medical Group and Hospital Services segment, is recorded at the Parent Entity level. The Company does not allocate interest expense related to acquisition debt to the operating segments.

(2) Prospect Medical Group, Inc. (which serves as a holding company for the other affiliated physician organizations) files consolidated tax returns.

(3) The Hospital Services segment includes the results for LACH Bellflower and FRMC, CharterCARE, and the CharterCARE Physicians medical practices from the acquisition dates of May 6, 2014, June 20, 2014, and various dates during the year ended September 30, 2015, respectively, through September 30, 2015. Included in revenues from external customers are $5,436,000 and $13,672,000 of other revenues related primarily to the CMS Rural Floor settlement, meaningful use incentive payments and rental revenue from operating leases for the years ended September 30, 2015 and 2014, respectively.

15. Subsequent Event (Unaudited)

The Company has evaluated subsequent events through December 10, 2015, the date the Company's consolidated financial statements were available for issuance.

Effective December 1, 2015, NGMA entered into a Stock Purchase Agreement to acquire all issued and outstanding shares of Primary and Multi-Specialty Clinics of Anaheim, Inc. ("PMCA"). PMCA operates a medical practice consisting of primary and multi-specialty clinics in Orange County, California. Concurrent with the Stock Purchase Agreement, NGMA entered into a Promissory Note payable to the former shareholders of PMCA for $3,288,000, for which principal shall be payable on December 8, 2015.

The purchase price consists of $4,445,000 due December 8, 2015, less certain liabilities and certain other adjustments as specified in the Stock Purchase Agreement ("Initial Payment") and an additional $1,080,000 due on December 1, 2016. The Promissory Note represents a portion of the Initial Payment.

Greer, Leslie

From: Lazarus, Steven
Sent: Thursday, January 14, 2016 7:14 AM
To: Greer, Leslie
Cc: Hansted, Kevin; Martone, Kim; Riggott, Kaila; Cotto, Carmen
Subject: FW: CT Conversion Docket - ECHN/Prospect - Completeness Letter [CTAG-CTAG.FID647701]
Attachments: 2016-01-13 ECHN - Completeness Letter.PDF

Leslie,

Please add to the original record.

Thank you,
Steve

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

From: Hawes, Gary W.
Sent: Wednesday, January 13, 2016 2:58 PM
To: 'rmatthews@wiggin.com'; Agsten, Melinda A.; Dennis P. McConville (dmcconville@echn.org); jonathan.spees@prospectmedical.com; mmv@bvmlaw.com
Cc: Martone, Kim; Lazarus, Steven; Turner, Cheryl A.
Subject: CT Conversion Docket - ECHN/Prospect - Completeness Letter [CTAG-CTAG.FID647701]

Please see the attached letter. Thank you.

Gary

Gary W. Hawes | Assistant Attorney General | Office of the Attorney General
55 Elm Street | P.O. Box 120 | Hartford Connecticut 06106
T: 860.808.5020 | F: 860.808.5347 | gary.hawes@ct.gov

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STATE OF CONNECTICUT

OFFICE OF THE ATTORNEY GENERAL

DEPARTMENT OF PUBLIC HEALTH

GEORGE JEPSEN
ATTORNEY GENERAL

RAUL PINO, M.D., M.P.H.
ACTING COMMISSIONER

January 13, 2016

VIA U.S. and ELECTRONIC MAIL

Jonathan Spees
Senior VP, Mergers and Acquisitions
Prospect Medical Holdings, Inc.
10780 Santa Monica Blvd., Suite 400
Los Angeles, CA 90025

Dennis P. McConville
Senior VP and Chief Strategy Officer
Eastern Connecticut Health Network, Inc.
71 Haynes Street
Manchester, CT 06040

Re: Eastern Connecticut Health Network, Inc. Proposed Asset Purchase by Prospect Medical Holdings, Inc.; OHCA Docket Number: 15-32016-486 and Attorney General Docket Number: 15-486-01

Dear Mr. Spees and Mr. McConville:

This letter is to inform you that, pursuant to § 19a-486a (e) of the Connecticut General Statutes, the Office of the Attorney General ("OAG") and the Department of Public Health, Office of Health Care Access ("DPH") have jointly deemed the above-referenced Application complete as of January 13, 2016.

Please be advised that although the Application is being deemed complete, the OAG and DPH reserve the right to seek additional information or filings as necessary to review and make a determination on this Application.

If you have any questions regarding this matter, please feel free to contact either Steven W. Lazarus at the Department of Public Health (860-418-7012; Steven.Lazarus@ct.gov) or

Assistant Attorney General Gary W. Hawes at the Office of the Attorney General (860-808-5020; gary.hawes@ct.gov).

Very truly yours,

Perry Zinn Rowthorn
Deputy Attorney General
Office of the Attorney General

Very truly yours,

Kimberly R. Martone
Director of Operations
Office of Health Care Access, DPH

cc: Steven Lazarus, OAG (via electronic mail)
Gary W. Hawes, OAG (via electronic mail)
Counsel of Record (via electronic mail)

Greer, Leslie

From: Lazarus, Steven
Sent: Wednesday, January 20, 2016 9:36 AM
To: Matthews, Rebecca (RMatthews@wiggin.com) (RMatthews@wiggin.com); magsten@wiggin.com; Ann H. Zucker; Michele Volpe (mmv@bvmlaw.com)
Cc: Hawes, Gary W.; Martone, Kim; Hansted, Kevin; Riggott, Kaila; Cotto, Carmen; Greer, Leslie
Subject: Re: Docket Numbers: 15-32016-486/15-486-01 and 15-32017-486 and 15-486-02 Administrative Notices
Attachments: 15-32016-486 and 15-486-01 Administrative Notice (ECHN).pdf; 15-32017-486 and 15-486-02 Administrative Notice (Waterbury).pdf

Good Morning,

Please see the attached Administrative Notices for Eastern Connecticut Health Network, Inc. and Greater Waterbury Health Network, Inc.'s proposals involving Prospect Medical Holdings, Inc. filed under the above referenced docket numbers. If you have any questions regarding this matter, please feel free to contact Gary Hawes (gary.hawes@ct.gov) or myself.

Sincerely,
Steven

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

STATE OF CONNECTICUT

OFFICE OF THE ATTORNEY GENERAL

DEPARTMENT OF PUBLIC HEALTH

GEORGE JEPSEN
ATTORNEY GENERAL

RAUL PINO, M.D., M.P.H.
ACTING COMMISSIONER

Docket Nos.: OHCA 15-32016-486
OAG 15-486-01

In re: Eastern Connecticut Health Network, Inc., and Prospect Medical Holdings, Inc.

January 20, 2016

ORDER REGARDING ADMINISTRATIVE NOTICE

The Office of Health Care Access and the Office of the Attorney General are hereby taking administrative notice of the record in ***In re: Greater Waterbury Health Network, Inc., and Prospect Medical Holdings, Inc.***, Docket Nos. OHCA 15-32017-486 and OAG 15-486-02, for purposes of processing the Application filed in ***In re: Eastern Connecticut Health Network, Inc., and Prospect Medical Holdings, Inc.***, Docket Nos. OHCA 15-32016-486 and OAG 15-486-01.

Kevin T. Hansted
Hearing Officer
Office of Health Care Access, DPH

Perry Zinn Rowthorn
Deputy Attorney General
Office of the Attorney General

Law Office of Donna B. Brewer
P.O. Box 427
Mystic, CT 06355

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FEB - 1 2016
Office of
HEALTHCARE ACCESS

January 27, 2016

Perry Zinn Rowthorn
Deputy Attorney General
Office of the Attorney General
55 Elm Street
Hartford, CT 06106

Kevin T. Hansted
Hearing Officer
Office of Health Care Access
Department of Public Health
410 Capitol Avenue
Hartford, CT 06134

Re: ***Eastern Connecticut Health Network, Inc. and Prospect Medical Holdings, Inc., Docket Nos. OHCA 15-32016-486 and OAG 15-486-01***

Dear Attorneys Rowthorn and Hansted,

Please accept this letter as my appearance representing the Town of Vernon in the above referenced matter concerning the acquisition of Eastern Connecticut Health Network, Inc. by Prospect Medical Holdings, Inc.

Respectfully submitted,

Donna B. Brewer, Esq.

cc: (by certified mail)
Rebecca A. Matthews, Wiggin and Dana
Melinda A. Agsten, Wiggin and Dana
Michele M. Volpe, Bershtein, Volpe and McKeon

Greer, Leslie

From: Lazarus, Steven
Sent: Monday, February 01, 2016 4:14 PM
To: Greer, Leslie
Subject: FW: GWHN PMH Application Completeness Questions

Please add to original file.

Thank you,
Steven

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

From: Ann H. Zucker [mailto:AZucker@carmodylaw.com]
Sent: Monday, February 01, 2016 3:40 PM
To: 'Michele Volpe'; Lazarus, Steven; Martone, Kim; Hawes, Gary W.
Cc: jonathan.spees@prospectmedical.com; dstromstad@wtbyhosp.org; Anne D. Peterson; David S. Hardy
Subject: RE: GWHN PMH Application Completeness Questions

Yes, GWHN supports this request.
Ann Zucker

Ann H. Zucker | Bio
Carmody Torrance Sandak & Hennessey LLP
707 Summer St | Stamford, CT 06901-1026
Direct: 203-252-2652 | Fax: 203-325-8608

50 Leavenworth Street | Waterbury, CT 06702
Direct: 203-784-3108 Fax: 203-575-2600
AZucker@carmodylaw.com www.carmodylaw.com

From: Michele Volpe [mailto:mmv@bvmlaw.com]
Sent: Monday, February 01, 2016 3:33 PM
To: Steven Lazarus; Kim Martone; Gary W. Hawes
Cc: Ann H. Zucker; jonathan.spees@prospectmedical.com
Subject: GWHN PMH Application Completeness Questions

Dear Steve and Gary
Steve pursuant to our call on Friday, GWHN and PMH would like to file the completeness □uestions no later than February 23. Please confirm that this extension is acceptable. Thank you.

Michele M. Volpe
Bershtein, Volpe & Mc□eon P.C
105 Court Street
New Haven, CT 06511
Phone: (203) 777-6995
Fax: (203) 777-5806

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HTML

Greer, Leslie

From: Lazarus, Steven
Sent: Friday, February 19, 2016 11:44 AM
To: Greer, Leslie
Subject: FW: ECHN/PMH Scheduling Agreement Final
Attachments: Scheduling Agreement 15-32016-486 and 15-486-01 (ECHN_PMH) 2_18_16.pdf

Please add to the record.

Thank you,
Steve

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

From: Lazarus, Steven
Sent: Friday, February 19, 2016 11:42 AM
To: Matthews, Rebecca (RMatthews@wiggin.com) (RMatthews@wiggin.com); Michele Volpe (mmv@bvmlaw.com); magsten@wiggin.com
Cc: Hawes, Gary W.; Martone, Kim; Hansted, Kevin
Subject: ECHN/PMH Scheduling Agreement Final

Good Morning,

Please see the attached Scheduling Agreement in the ECHN/PMH proposal filed under DNs: 15-32016-486 and 15-486-01.

Please feel free to contact Gary or myself, if you have any questions or concerns.

Sincerely,

Steven

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053



STATE OF CONNECTICUT

OFFICE OF THE ATTORNEY GENERAL

DEPARTMENT OF PUBLIC HEALTH

GEORGE JEPSEN
ATTORNEY GENERAL

RAUL PINO, M.D., M.P.H.
COMMISSIONER

February 18, 2016

VIA U.S. and ELECTRONIC MAIL

Jonathan Spees
Senior VP, Mergers and Acquisitions
Prospect Medical Holdings, Inc.
10780 Santa Monica Blvd., Suite 400
Los Angeles, CA 90025

Dennis P. McConville
Senior VP and Chief Strategy Officer
Eastern Connecticut Health Network, Inc.
71 Haynes Street
Manchester, CT 06040

Re: Revised Scheduling Agreement for OHCA Docket No. 15-32016-486 and Attorney General Docket No. 15-486-01

Dear Mr. Spees and Mr. McConville:

This letter revises the schedule set forth in Connecticut General Statutes § 19a-486b(a) in connection with the hospital conversion dockets OHCA Docket No. 15-32016-486 and Attorney General Docket No. 15-486-01 currently pending in the Department of Public Health, Office of Health Care Access ("OHCA") and the Office of the Attorney General (the "OAG"). The Applicants for both these dockets are Eastern Connecticut Health Network, Inc. ("ECHN") and Prospect Medical Holdings, Inc. ("PMH").

Due to the press of business at OHCA and the increased responsibilities of its review, OHCA has requested an extension of the 120-day review period as set forth below. The OAG, although not in need of an extension, agrees that the 120-day review period should be extended for both dockets so that they stay on parallel tracks.

Therefore, pursuant to Conn. Gen. Stat. § 19a-486b(a) and after discussion, the parties have agreed to the following schedule for completion of the ECHN and PMH hospital conversion review. Specifically, the parties agree to extend the 120-day review period set forth in § 19a-486b(a) until **June 10, 2016**. Our offices will make every effort to proceed in a manner

that will permit our offices to complete its review by June 10, 2016. If it becomes apparent due to unforeseen circumstances that we cannot complete the ECHN/PMH review by the date established above, all parties will convene at the earliest opportunity to agree upon a revised final decision completion date.

If you agree to these scheduling terms, please sign the attached page (the signature page may be signed in counterparts) and return it to our offices at:

Office of the Attorney General
55 Elm Street, P.O. Box 120
Hartford, Connecticut 06141-0120
Attn: Gary W. Hawes, AAG

Department of Public Health
410 Capitol Avenue
Hartford, Connecticut 06134
Attn: Kevin Hansted, Staff Attorney

Very truly yours,

Perry Zinn Rowthorn
Deputy Attorney General
Office of the Attorney General

Very truly yours,

Janet M. Brancifort, MPH, RRT
Deputy Commissioner
Department of Health
Office of Health Care Access

cc: Gary W. Hawes (via electronic mail)
Steven Lazarus (via electronic mail)

Rebecca A. Matthews (via electronic mail)
Melinda A. Agsten (via electronic mail)
Michele Volpe (via electronic mail)

Scheduling Letter Agreement for

OHCA Docket No. 15-32016-486 and Attorney General Docket No. 15-486-01

Signature Page

Dennis P. McConville
Senior VP and Chief Strategy Officer
for Eastern Connecticut Health Network, Inc.

Date

Jonathan Spees
Senior VP, Mergers and Acquisitions
For Prospect Medical Holdings, Inc.

2/12/16
Date

Scheduling Letter Agreement for

OHCA Docket No. 15-32016-486 and Attorney General Docket No. 15-486-01

Signature Page

D. P. McC

Dennis P. McConville
Senior VP and Chief Strategy Officer
for Eastern Connecticut Health Network, Inc.

2/11/16
Date

Jonathan Spees
Senior VP, Mergers and Acquisitions
For Prospect Medical Holdings. Inc.

Date

Greer, Leslie

From: Greer, Leslie
Sent: Friday, February 19, 2016 11:43 AM
To: 'jonathan.spees@prospectmedical.com'; 'dmcconville@echn.org'; 'rmatthews@wiggin.com'
Cc: Michele Volpe (mmv@bvmlaw.com); Hawes, Gary W.; Lazarus, Steven; Cotto, Carmen; Hansted, Kevin; Riggott, Kaila; Martone, Kim
Subject: ECHN and Prospect Medical Holdings, Inc. Hearing Notice
Attachments: 32016_201602191125.pdf

Tracking:

Recipient	Delivery
'jonathan.spees@prospectmedical.com'	
'dmcconville@echn.org'	
'rmatthews@wiggin.com'	
Michele Volpe (mmv@bvmlaw.com)	
Hawes, Gary W.	Delivered: 2/19/2016 11:44 AM
Lazarus, Steven	Delivered: 2/19/2016 11:44 AM
Cotto, Carmen	Delivered: 2/19/2016 11:44 AM
Hansted, Kevin	Delivered: 2/19/2016 11:44 AM
Riggott, Kaila	Delivered: 2/19/2016 11:44 AM
Martone, Kim	Delivered: 2/19/2016 11:44 AM

Please see the attached hearing notice for Eastern Connecticut Health Network, Inc. and Prospect Medical Holdings, Inc.

Leslie M. Greer
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134
Phone: (860) 418-7013 Fax: (860) 418-7053
Website: www.ct.gov/ohca

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Office of Health Care Access

February 19, 2016

Jonathan Spees, Senior Vice President, Mergers and Acquisitions
Prospect Medical Holdings
10780 Santa Monica Blvd.
Suite 400
Los Angeles, CA 90025

Dennis P. McConville, Senior Vice President and Chief Strategy Officer
Eastern Connecticut Health Network
71 Haynes Street
Manchester, CT 06040

RE: Certificate of Need Application, Docket Number 15-32016-86 and 15-486-01
Eastern Connecticut Health Network, Inc. and Prospect Medical Holdings, Inc.
Eastern Connecticut Health Network, Inc. ("ECHN"), and Prospect Medical Holdings, Inc. ("PMH"), are proposing the purchase of substantially of the assets of ECHN by PMH.

Dear Mr. Spees and Mr. McConville,

With the receipt of the completed Certificate of Need ("CON") application information submitted by Eastern Connecticut Health Network, Inc. and Prospect Medical Holdings, Inc. ("Applicants") on January 13, 2016, the Office of Health Care Access ("OHCA") and the Office of Attorney General (OAG) has initiated its review of the CON application identified above.

Pursuant to General Statutes § 19a-639a (f) and 19a-486a (f), the Office of Health Care Access and the Office of Attorney General may hold a hearing with respect to any Certificate of Need application.

Connecticut Department of Public Health

Phone: (860) 509-8000 • Fax: (860) 509-7184
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

ECHN, Inc. and Prospect Medical Holdings, Inc. February 19, 2016
Notice of Public Hearing; Docket Number 15-32016-CON and 15-486-01

This hearing notice is being issued pursuant to General Statutes § 19a-639a (f) and 19a-486 (f)

Applicants:	Eastern Connecticut Health Network, Inc. Prospect Medical Holdings, Inc.
Docket Number:	15-32016-486 and 15-486-01
Proposal:	Eastern Connecticut Health Network, Inc. ("ECHN"), and Prospect Medical Holdings, Inc. ("PMH"), are proposing the purchase of substantially all of the assets of ECHN by PMH. Pursuant to the terms of the proposed Asset Purchase Agreement, PMH will pay either $105,000,000 or $115,000,000 for the assets of ECHN, subject to certain adjustments. In addition, PMH will commit to spend not less than $75,000,000 on capital items for the hospitals and service areas of Manchester Memorial Hospital and Rockville General Hospital, over five years.

Notice is hereby given of a public hearing to be held in this matter to commence on:

1St Hearing

Date:	March 15, 2016
Time:	2:00 p.m.
Place:	Manchester Country Club 305 South Main Street Manchester, CT 06040

2nd Hearing

Date:	March 16, 2016
Time:	2:00 p.m.
Place:	Vernon Town Council Chambers 14 Park Place Vernon, CT 06066

ECHN, Inc. and Prospect Medical Holdings, Inc. February 19, 2016
Notice of Public Hearing; Docket Number 15-32016-CON and 15-486-01

The Applicants are designated as parties in this proceeding. Enclosed for your information is a copy of the hearing notice for the public hearing that will be published in the *Journal Inquirer* pursuant to General Statutes § 19a-639a (f) and 19a-486 (f).

Sincerely,

Kimberly R. Martone
Director of Operations

Enclosure

cc: Henry Salton, Esq., Office of the Attorney General
Antony Casagrande, Department of Public Health
Kevin Hansted, Department of Public Health
Wendy Furniss, Department of Public Health
Maura Downes, Department of Public Health
Jill Kentfield, Department of Public Health
Chris Stan, Department of Public Health
DeVaughn Ward, Department of Public Health
Marielle Daniels, Connecticut Hospital Association

KRM:SWL:CC:lmg

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Office of Health Care Access

February 19, 2016 P.O. #54772

Journal Inquirer
306 Progress Drive
Manchester, CT 06040

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than **Monday, February 22, 2016**. Please provide the following within 30 days of publication:

- Proof of publication (copy of legal ad. acceptable) showing published date along with the invoice.

If there are any questions regarding this legal notice, please contact Kaila Riggott at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Director of Operations

Attachment
cc: Danielle Pare, DPH
Marielle Daniels, Connecticut Hospital Association

KRM:SWL:CC;lmg

Phone: (860) 509-8000 • Fax: (860) 509-7184
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

Journal Inquirer
Notice of Public Hearing, Docket Number 16-32016-486 and 15-486-01

February 19, 2016

PLEASE INSERT THE FOLLOWING:

Office of Health Care Access & Office of the Attorney General Public Hearings

Statute References:	19a-638 and19a-486
Applicants:	Eastern Connecticut Health Network, Inc. Prospect Medical Holdings, Inc.
Towns:	Manchester and Vernon
Docket Numbers:	15-32016-486 and 15-486-01
Proposal:	Eastern Connecticut Health Network, Inc. ("ECHN"), and Prospect Medical Holdings, Inc. ("PMH"), are proposing the purchase of substantially all of the assets of ECHN by PMH. Pursuant to the terms of the proposed Asset Purchase Agreement, PMH will pay either $105,000,000 or $115,000,000 for the assets of ECHN, subject to certain adjustments. In addition, PMH will commit to spend not less than $75,000,000 on capital items for the hospitals and service areas of Manchester Memorial Hospital and Rockville General Hospital, over five years.

1st Hearing

Date:	March 15, 2016
Time:	2:00 p.m.
Place:	Manchester Country Club 305 South Main Street Manchester, CT 06040

2nd Hearing

Date:	March 16, 2016
Time:	2:00 p.m.
Place:	Vernon Town Council Chambers 14 Park Place Vernon, CT 06066

Any person who wishes to request status in the above listed public hearing may file a written petition no later than March 10, 2016 (5 calendar days before the date of the hearing) pursuant to the Regulations of Connecticut State Agencies §§ 19a-9-26 and 19a-9-27. If the request for status is granted, such person shall be designated as a Party, an Intervenor or an Informal Participant in the above proceeding. Please check OHCA's website at www.ct.gov/ohca for more information or call OHCA directly at (860) 418-7001. If you require aid or accommodation to participate fully and fairly in this hearing, please phone (860) 418-7001.


Keeping Connecticut Healthy
DPH
Connecticut Department
of Public Health

Greer, Leslie

From: ADS <ADS@graystoneadv.com>
Sent: Friday, February 19, 2016 11:45 AM
To: Greer, Leslie
Subject: Re: DN: 15-32016-486 Hearing Notice

Good day

Thanks so much for your ad submission.
We will be in touch shortly and look forward to serving you.

Don't forget to ask for ideas to expand your diversity coverage.

PLEASE NOTE: New Department of Labor guidelines allow web based advertising when hiring foreign nationals. To provide required documentation Graystone will retrieve & archive verification for the 1st and 30th days of posting for $115.00/web site. If required, notify Graystone when ad placement is approved.

If you have any questions or concerns, please don't hesitate to contact us at the number below.

We sincerely appreciate your business.

Thank you,
Graystone Group Advertising

2710 North Avenue
Bridgeport, CT 06604
Phone: 800-544-0005
Fax: 203-549-0061

E-mail new ad requests to: ads@graystoneadv.com
http://www.graystoneadv.com/

From: "Greer, Leslie" <Leslie.Greer@ct.gov>
Date: Friday, February 19, 2016 at 11:32 AM
To: Ads Desk <ads@graystoneadv.com>
Subject: DN: 15-32016-486 Hearing Notice

Please run the attached hearing notice in the Journal Inquirer on 2/22/16. For billing purposes, please refer to P.O. #54772. In addition, please forward me a copy of the "proof of publication" when it becomes available.

Thank you,

Leslie M. Greer
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134
Phone: (860) 418-7013 Fax: (860) 418-7053
Website: www.ct.gov/ohca

Greer, Leslie

From: Robert Taylor <RTaylor@graystoneadv.com>
Sent: Friday, February 19, 2016 4:01 PM
To: Greer, Leslie
Subject: FW: DN: 15-32016-486 Hearing Notice
Attachments: 15-32016np Journal Inquirer.docx

Good afternoon,

This notice is set to publish on Monday.
$344.35

Thanks,

Robert Taylor
Graystone Group Advertising
www.graystoneadv.com
2710 North Avenue, Suite 200
Bridgeport, CT 06604
Phone: 203-549-0060
Toll Free: 800-544-0005
Fax: 203-549-0061

From: ADS <ADS@graystoneadv.com>
Date: Fri, 19 Feb 2016 11:44:52 -0500
To: RTaylor <rtaylor@graystoneadv.com>
Subject: FW: DN: 15-32016-486 Hearing Notice

From: "Greer, Leslie" <Leslie.Greer@ct.gov>
Date: Friday, February 19, 2016 at 11:32 AM
To: Ads Desk <ads@graystoneadv.com>
Subject: DN: 15-32016-486 Hearing Notice

Please run the attached hearing notice in the Journal Inquirer on 2/22/16. For billing purposes, please refer to P.O. #54772. In addition, please forward me a copy of the “proof of publication” when it becomes available.

Thank you,

Leslie M. Greer
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134
Phone: (860) 418-7013 Fax: (860) 418-7053
Website: www.ct.gov/ohca

760 MOTORCYCLES

HARLEY DAVIDSON 2012 Dyna Wide Glide 6,000 miles Black Six speed $10,500 obo 860-712-9746

780 TRUCKS

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FORD F250 4X4 with a plow 13,900/b.o. Please Call 860-794-0351

TACOMA 1997 4cyl 5spd cap 233K gd frame runs great $1,500 860-267-0445

A classified ad is an easy way to sell your merchandise, and it is easy on your wallet, too.



For home delivery

Call Circulation Department

860-643-8111

800-237-3606

PUBLIC NOTICE

PUBLIC NOTICE

NOTICE OF PUBLIC SALE: The following self-storage unit contents containing household and other goods will be sold for cash by CubeSmart, 255 Center Street, Manchester, CT 06040 to satisfy a lien on March 3rd, 2016 at approx. 11:00 AM at www.storagetreasures.com

Unit # 550-553 Nancy S. Jorge
Unit # 268 Jennifer Elisabeth Cordeau
Unit # 273 Susan E. Parreira
Unit # 198 Chantelle N Donovan
Unit # 266 John J Smalley 3rd

Journal Inquirer
February 15, 2016
February 22, 2016

PUBLIC NOTICE

LEGAL NOTICE

The Ellington Zoning Board of Appeals will hold a public hearing on Monday, March 7, 2016, at 7:00pm in the Town Hall Annex, 57 Main Street, Ellington, CT to hear the following:

1. #V201601- Ellington Congregational Church, applicant/owner for a variance of Ellington Zoning Regulations Section 3.2.4-Bulk Height & Lot Coverage: to increase lot coverage to 70% for a parking area; Section 6.2.5(B & D)-Location of Parking Facilities: to reduce parking to a side property line to 5' and to reduce parking to a residential zone boundary to 0'; Section 6.3.7(A, B & C)-Landscaping: to allow exemption from screening a parking area from a residence or residential zone and landscaping a parking lot with interior landscaped islands and shade trees; Section 6.2.8-Landscaping and Lighting: to allow exemption from lighting the parking area at 72 Main Street, APN 063-040-0000 in Commercial (C) and Residential (R) Zones.

Application materials are available for review in the office of the Ellington Town Planner, Town Hall Annex, 57 Main Street, Ellington, CT.

A copy of this notice is on file with the Town Clerk.
Dated at Ellington, Connecticut this 18th day of February, 2016.

JOURNAL INQUIRER PUBLISH **TWO** ISSUES:
Monday, February 22, 2016
Monday, February 29, 2016

PUBLIC NOTICE

PUBLIC NOTICE

LEGAL NOTICE
INVITATION TO BID
MANCHESTER PUBLIC SCHOOLS
TOWN OF MANCHESTER, CONNECTICUT

The Manchester Board of Education will receive sealed bids in the Office of the Assistant Superintendent, Finance and Management, 45 North School Street, Manchester, Connecticut 06042 on the date and time listed below for the following:

BID #016-014 STAGE PARTITION INSTALLATION
Keeney Elementary School,
179 Keeney Street, Manchester CT

Bids will be accepted until:
Thursday, March 3, 2016 at 1:30 p.m.

A mandatory site visit is scheduled for:
Thursday, February 25, 2016 at 10:00 a.m.,
Keeney Elementary School,
179 Keeney Street, Manchester CT

The right is reserved to reject any and all bids. Specifications and forms are available on our website www.mpspride.org or in the office of the Assistant Superintendent for Finance and Management, 45 North School Street, Manchester, Connecticut 06042 during regular office hours between 8:00 a.m. and 4:00 p.m. or by calling (860) 647-3445.

Manchester Public Schools is an equal opportunity employer and requires affirmative action policy for all of its contractors and vendors as a condition of doing business with the school district, as per Federal Order 11246.

Patricia F. Brooks
Assistant Superintendent
Finance and Management
Manchester Public Schools

Journal Inquirer
February 18, 2016
February 19, 2016
February 22, 2016

PUBLIC NOTICE

PUBLIC NOTICE

Office of Health Care Access & Office of the Attorney General Public Hearings

Statute References:	19a-638 and19a-486
Applicants:	Eastern Connecticut Health Network, Inc. Prospect Medical Holdings, Inc.
Towns:	Manchester and Vernon
Docket Numbers:	15-32016-486 and 15-486-01
Proposal:	Eastern Connecticut Health Network, Inc. ("ECHN"), and Prospect Medical Holdings, Inc. ("PMH"), are proposing the purchase of substantially all of the assets of ECHN by PMH. Pursuant to the terms of the proposed Asset Purchase Agreement, PMH will pay either $105,000,000 or $115,000,000 for the assets of ECHN, subject to certain adjustments. In addition, PMH will commit to spend not less than $75,000,000 on capital items for the hospitals and service areas ofManchester Memorial Hospital and Rockville General Hospital, over five years.

1st Hearing

Date:	March 15, 2016
Time:	2:00 p.m.
Place:	Manchester Country Club 305 South Main Street Manchester, CT 06040

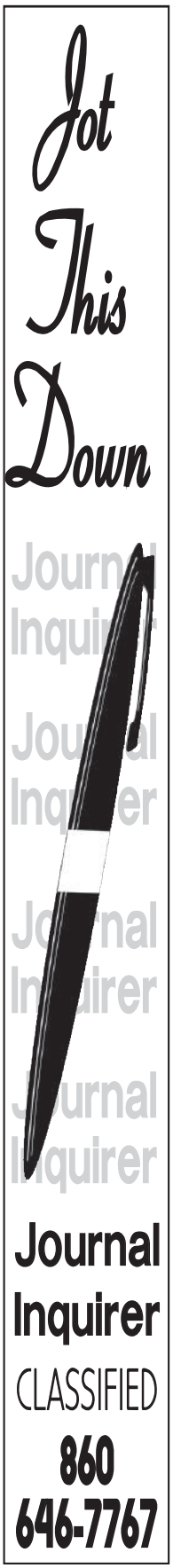
2nd Hearing

Date:	March 16, 2016
Time:	2:00 p.m.
Place:	Vernon Town Council Chambers 14Park Place Vernon, CT 06066

Any person who wishes to request status in the above listed public hearing may file a written petition no later than March 10, 2016 (5 calendar days before the date of the hearing) pursuant to the Regulations of Connecticut State Agencies §§ 19a-9-26 and 19a-9-27. If the request for status is granted, such person shall be designated as a Party, an Intervenor or an Informal Participant in the above proceeding. Please check OHCA's website at www.ct.gov/ohca for more information or call OHCA directly at (860) 418-7001. If you require aid or accommodation to participate fully and fairly in this hearing, please phone (860) 418-7001.

Journal Inquirer
February 22, 2016





Greer, Leslie

From: Lazarus, Steven
Sent: Wednesday, February 24, 2016 2:18 PM
To: jonathan.spees@prospectmedical.com; dmcconville@echn.org
Cc: Michele Volpe (mmv@bvmlaw.com); magsten@wiggin.com; Matthews, Rebecca (RMatthews@wiggin.com) (RMatthews@wiggin.com); Martone, Kim; Hansted, Kevin; Hawes, Gary W.; Greer, Leslie; Cotto, Carmen; Riggott, Kaila
Subject: ECHN and PMH-Request for Prefile and Issues (15-32016 & 15-486-01)
Attachments: 15-32016-486 and 15-486-01 Request for Prfile and Issues.pdf

Dear Mr. Spees and Mr. McConville,

Attached you will find the request for prefile testimony and Issues related to the public hearings to be held on March 15th and 16th in the above reference matter.

If you have any questions, please do not hesitate to contact Gary Hawes or myself.

Sincerely,

Steven

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

STATE OF CONNECTICUT

OFFICE OF THE ATTORNEY GENERAL

DEPARTMENT OF PUBLIC HEALTH

GEORGE JEPSEN
ATTORNEY GENERAL

RAUL PINO, M.D., M.P.H.
COMMISSIONER

February 24, 2016

Via Email Only

Jonathan Spees
Senior VP, Mergers and Acquisitions
Prospect Medical Holdings, Inc.
10780 Santa Monica Blvd., Suite 400
Los Angeles, CA 90025

Dennis P. McConville
Senior VP and Chief Strategy Officer
Eastern Connecticut Health Network, Inc.
71 Haynes Street
Manchester, CT 06040

Re: Eastern Connecticut Health Network, Inc. Proposed Asset Purchase by Prospect Medical Holdings, Inc.; OHCA Docket Number: 15-32016-486 and Attorney General Docket Number: 15-486-01.
Request for Prefiled Testimony and Issues

Dear Mr. McConville and Mr. Spees:

The Office of Health Care Access ("OHCA") and the Office of the Attorney General ("OAG") will hold a public hearing on the above docket number on March 15, 2016 and March 16, 2016. The hearings will begin at 2:00 p.m. on March 15 & 16, 2016 at Manchester Country Club, 305 South Main Street, Manchester and Vernon Town Council Chambers, at 14 Park Place, Vernon, respectively. Pursuant to the Regulations of Connecticut State Agencies § 19a-9-29(e), any party or other participant is required to prefile in written form all substantive, technical, or expert testimony that it proposes to offer at the hearing. OHCA and the OAG request that Eastern Connecticut Health Network, Inc and Prospect Medical Holdings, Inc. ("Applicants") submit prefiled testimony by 4:00 p.m. on March 9, 2016.

Additionally, please find attached Issues. Please respond to the attached Issues in writing to OHCA and OAG as an attachement to the Prefile testimony.

All persons providing prefiled testimony must be present at the public hearing to adopt their written testimony under oath and must be available for cross-examination for the entire duration of the hearing. If

you are unable to meet the specified time for filing the prefiled testimony you must request a time extension in writing, detailing the reasons for not being able to meet the specified deadline.

Please mail one (1) complete hard copy and one (1) complete electronic copy of the requested materials for approval to each of the following addresses:

Office of the Attorney General
55 Elm Street, P.O. Box 120
Hartford, Connecticut 06141-0120
Attn: Gary W. Hawes, AAG

Office of Health Care Access, Dept. of Public Health
410 Capitol Avenue
Hartford, Connecticut 06134
Attn: Steven W. Lazarus

Please contact Gary A. Hawes (Gary.Hawes@ct.gov or (860) 808-5020) or Steven W. Lazarus (Steven.lazarus@ct.gov or (860) 418-7012) if you have any questions concerning this request.

Kevin T. Hansted
Hearing Officer
Office of Health Care Access, DPH

Gary A. Hawes
Assistant Attorney General
Office of the Attorney General

Attachment

Cc: Rebecca Matthews, Esq.
Michelle Volpe, Esq.

ISSUES

Office of Health Care Access Docket No. 15-32016-486
Attorney General Docket No. 15-486-01

Eastern Connecticut Health Network, Inc. Proposed Asset Purchase by Prospect Medical Holdings, Inc.

The Applicants should be prepared to present and discuss supporting evidence on the following issues:

- The clear public need for and the community benefits of the proposal.
- How access to care will be maintained in the service area following the asset purchase of the two Eastern Connecticut Health Network, Inc. ("ECHN") hospitals, Manchester Memorial Hospital ("MMH") and Rockville General Hospital ("RGH"), by Prospect Medical Holdings, Inc. ("PMH").
- PMH's management of Quality Assurance and Performance Improvement (QAPI) across its hospital network and, in particular, the manner in which oversight of the QAPI program will be managed at MMH and RGH.
- The financial feasibility of the proposal.
- How prices for, and the cost of, health care services at MMH and RGH will be affected by PMH's acquisition of those facilities.
- The charity care policies to be implemented at MMH and RGH following the transfer of ownership and how they compare to PMH's current charity care policies.
- The commitment PMH is willing to make to performing future health needs assessments for the communities in ECHN's service area in a manner that allows for widespread public input, collaboration with other health care providers in the community as well public dissemination of the assessments and MMH's and RGH's implementation plan to address the identified needs.
- How PMH's experience with license consolidation (i.e., combining separately licensed hospitals into a single licensed hospital with separate campuses) in the other markets in which it operates might impact the future of MMH and RGH.

Provide a written response on the following as an attachment to the pre-file testimony, as these questions were not fully addressed in the Application completeness process:

1. With respect to PMH's 2014 acquisition of the two CharterCARE hospitals in Rhode Island, Our Lady of Fatima Hospital and Roger Williams Medical Center, please describe all PMH achievements in the following areas:

    a. improvements in care coordination between the two facilities;

b. reducing unnecessary redundancies between the two facilities; and

c. measureable quality and access improvements at the two facilities.

2. Please describe what impact PMH's acquisition of the two CharterCARE hospitals has had on the prices charged to patients and third-party payers at those facilities.

3. Please describe the benefits realized by patients and payers at the PMH acquired hospitals in California and Texas from any change in pricing structure that occurred at those hospitals in the three years immediately following PMH's acquisition of those hospitals and any benefits from changes in pricing structure that may presently exist.

4. In reference to the revised Exhibit S in the December 11, 2015 Response to Deficiencies, PMH's Capital Investments and Cost Savings Table, page 3247, please address the following:

   a. Elaborate on the initiatives that contributed to the decrease in marginal cost and total cost per day at Our Lady of Fatima Hospital, Roger Williams Medical Center and Nix Health System. Indicate if the decline was due to change in patient volume. If yes, explain the decline in volume;

   b. For each of the three entities described in 4(a), elaborate on how the financial performance improvements in the areas of Profitability, Liquidity and Solvency translated into lower health care costs, if any, for the hospitals and their patients; and

   c. For each of the three entities described in 4(a) and 4(b), please complete the following table, as applicable:

Entity	EBITDA			Working Capital			Stockholder's Equity		
	Year prior to acquisition	FY 2014	FY 2015	Year prior to acquisition	FY 2014	FY 2015	Year prior to acquisition	FY 2014	FY 2015

5. Please provide the full Statement of Deficiencies and Plan of Correction pertaining to the California Department of Health ("CDOH") survey completed on November 10, 2015, an excerpt of which is attached at Exhibit Q1c-1 to the February 12, 2016 completeness question responses submitted in PMH's proposed asset purchase of Greater Waterbury Health Network, Inc. under OHCA Docket No. 15-32017-486 and Attorney General Docket No. 15-486-02, which has been administratively noticed in this proceeding, and all correspondence exchanged between Los Angeles Community Hospital and the CDOH concerning MD#6 referenced therein.

6. Please provide the full Statement of Deficiencies and Plan of Correction pertaining to the CDOH survey of Southern California Hospital at Culver City completed on September 25, 2015, an excerpt of which is attached at Exhibit Q1c-2 to the February 12, 2016 completeness questions

submitted under OHCA Docket No. 15-32017-486 and Attorney General Docket No. 15-486-02, which has been administratively noticed in this proceeding, and all correspondence exchanged between Southern California Hospital at Culver City concerning the hospital's sterilization and infection control processes described therein.

7. In reference to Exhibits Q1c-1 and Q1c-2 of the February 12, 2016 submission, please discuss the current status of the Immediate Jeopardy determinations at the Los Angeles Community Hospital and Southern California Hospital at Culver City.

8. With respect to the Immediate Jeopardy determinations identified in Question 7 above, please discuss ECHN's due diligence after having learned about the Immediate Jeopardy determinations and the conclusions based upon that due diligence.

Law Office of Donna B. Brewer
P.O. Box 427
Mystic, CT 06355



March 4, 2016

Perry Zinn Rowthorn
Deputy Attorney General
Office of the Attorney General
55 Elm Street
Hartford, CT 06106

Kevin T. Hansted
Hearing Officer
Office of Health Care Access
Department of Public Health
410 Capitol Avenue
Hartford, CT 06134

Re: Eastern Connecticut Health Network, Inc. and Prospect Medical Holdings, Inc., Docket Nos. OHCA 15-32016-486 and OAG 15-486-01

Dear Attorneys Rowthorn and Hansted,

The Town of Vernon hereby respectfully requests the opportunity to be an "informal participant" pursuant to Section 19a-643-39 of the Regulations and to present one witness to make a statement at the hearing scheduled to be held in Vernon on March 16, 2016, in the above referenced matter. The witness is the Honorable Daniel A. Champagne, Mayor of the Town of Vernon, 14 Park Place, Vernon, CT 06066. His statement is expected to require approximately ten minutes.

Respectfully submitted,

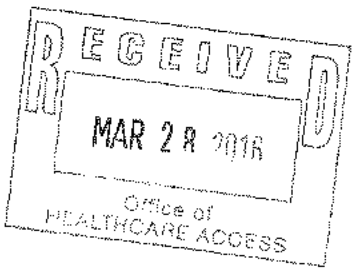
Donna B. Brewer, Esq.

cc (by first class mail):
Rebecca A. Matthews, Wiggin and Dana
Melinda A. Agsten, Wiggin and Dana
Michele M. Volpe, Bershtein, Volpe and McKeon

Telephone: (860) 572-2954 Email: dbunbrewer@gmail.com

Law Office of Donna B. Brewer
P.O. Box 427
Mystic, CT 06355

March 23, 2016



Perry Zinn Rowthorn
Deputy Attorney General
Office of the Attorney General
55 Elm Street
Hartford, CT 06106

Kevin T. Hansted
Hearing Officer
Office of Health Care Access
Department of Public Health
410 Capitol Avenue
Hartford, CT 06134

Re: Eastern Connecticut Health Network, Inc. and Prospect Medical Holdings, Inc., Docket Nos. OHCA 15-32016-486 and OAG 15-486-01

Dear Attorneys Rowthorn and Hansted,

With reference to The Town of Vernon's March 4, 2016 request to participate as an "informal participant" in the above referenced matter pursuant to Section 19a-643-39 of the Regulations ("the Request"), I have subsequently learned that that regulation has been repealed. Therefore, the Request is hereby withdrawn. The Honorable Daniel A. Champagne will instead request to present his testimony on March 30, 2016, in Vernon, during the portion of the hearing when the public is invited to present testimony.

Thank you for your consideration.

Respectfully submitted,

Donna B. Brewer, Esq.

cc (by first class mail):
Rebecca A. Matthews, Wiggin and Dana
Melinda A. Agsten, Wiggin and Dana
Michele M. Volpe, Bershtein, Volpe and McKeon

Telephone: (860) 572-2954 Email: dbunbrewer@gmail.com

Greer, Leslie

From: Lazarus, Steven
Sent: Thursday, March 10, 2016 9:16 AM
To: dmcconville@echn.org; jonathan.spees@prospectmedical.com
Cc: Michele Volpe (mmv@bvmlaw.com); Matthews, Rebecca (RMatthews@wiggin.com) (RMatthews@wiggin.com); magsten@wiggin.com; Hawes, Gary W.; Hansted, Kevin; Martone, Kim; Greer, Leslie; Cotto, Carmen
Subject: re: Docket Numbers: 15-32016-486 and 15-486-01-Rescheduled Hearings
Attachments: 15-32016-486 and 15-486-01 Request for PRefiled Testimony and Issues-Revised.pdf

Good Morning,

Please see the attached document the updates the date the pre-file testimony and additional information requested as part of the Issues is due. This is a result of the public hearings being rescheduled from March 15, 2016 and March 16, 2016 to March 29, 2016 and March 30, 2016, respectively. The hearing notice should be published in the Journal Inquirer tomorrow.

Any questions, please feel free to contact Gary Hawes or myself directly.

Sincerely,

Steven

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

STATE OF CONNECTICUT

OFFICE OF THE ATTORNEY GENERAL

DEPARTMENT OF PUBLIC HEALTH

GEORGE JEPSEN
ATTORNEY GENERAL

RAUL PINO, M.D., M.P.H.
COMMISSIONER

March 10, 2016

Via Email Only

Jonathan Spees
Senior VP, Mergers and Acquisitions
Prospect Medical Holdings, Inc.
10780 Santa Monica Blvd., Suite 400
Los Angeles, CA 90025

Dennis P. McConville
Senior VP and Chief Strategy Officer
Eastern Connecticut Health Network, Inc.
71 Haynes Street
Manchester, CT 06040

Re: Eastern Connecticut Health Network, Inc. Proposed Asset Purchase by Prospect Medical Holdings, Inc.; OHCA Docket Number: 15-32016-486 and Attorney General Docket Number: 15-486-01.
Request for Prefiled Testimony and Issues

Dear Mr. McConville and Mr. Spees:

The public hearings in the above matter, originally scheduled for March 15th (Manchester Community Club) and March 16th (Vernon Town Council Chamber) have been RESCHEDULED, as noted below:

The Office of Health Care Access ("OHCA") and the Office of the Attorney General ("OAG") will hold a public hearing on the above docket number on March 29, 2016 and March 30, 2016. The hearings will begin at 2:00 p.m. on March 29 & 30, 2016 at Manchester Country Club, 305 South Main Street, Manchester and Elks Lodge, 9 North Park Street, Vernon, respectively.

Due to the rescheduling of the hearings, OHCA and OAG deems it appropriate to change the date the prefile testimony and addition information requested as part of the Issues in the corresondance to the Applicants on Feburary 24, 2016, from Wednesday March 9, 2016 to Wednesday March 23, 2016, by 4 pm.

As previously stated, all persons providing prefiled testimony must be present at the public hearing to adopt their written testimony under oath and must be available for cross-examination for the entire duration of the hearing. If you are unable to meet the specified time for filing the prefiled testimony you must request a time extension in writing, detailing the reasons for not being able to meet the specified deadline.

Please mail one (1) complete hard copy and one (1) complete electronic copy of the requested materials for approval to each of the following addresses:

Office of the Attorney General
55 Elm Street, P.O. Box 120
Hartford, Connecticut 06141-0120
Attn: Gary W. Hawes, AAG

Office of Health Care Access, Dept. of Public Health
410 Capitol Avenue
Hartford, Connecticut 06134
Attn: Steven W. Lazarus

Please contact Gary A. Hawes (Gary.Hawes@ct.gov or (860) 808-5020) or Steven W. Lazarus (Steven.lazarus@ct.gov or (860) 418-7012) if you have any questions concerning this request.

Kevin T. Hansted
Hearing Officer
Office of Health Care Access, DPH

Gary A. Hawes
Assistant Attorney General
Office of the Attorney General

Attachment

cc: Rebecca Matthews, Esq.
Michelle Volpe, Esq.

Greer, Leslie

From: Greer, Leslie
Sent: Thursday, March 10, 2016 10:28 AM
To: 'jonathan.spees@prospectmedical.com'; Dennis McConville; 'rmatthews@wiggin.com'
Cc: 'mmv@bvmlaw.com'; Hawes, Gary W.; Lazarus, Steven; Cotto, Carmen; Riggott, Kaila; Hansted, Kevin; Martone, Kim; Olejarz, Barbara
Subject: ECHN and Prospect Medical Hodldings, Inc. Hearing Notice
Attachments: 32016_201603101005.pdf

Tracking:

Recipient	Delivery	Read
'jonathan.spees@prospectmedical.c		
Dennis McConville		
'rmatthews@wiggin.com'		
'mmv@bvmlaw.com'		
Hawes, Gary W.	Delivered: 3/10/2016 10:30 AM	
Lazarus, Steven	Delivered: 3/10/2016 10:30 AM	Read: 3/10/2016 10:35 AM
Cotto, Carmen	Delivered: 3/10/2016 10:30 AM	Read: 3/10/2016 10:30 AM
Riggott, Kaila	Delivered: 3/10/2016 10:30 AM	
Hansted, Kevin	Delivered: 3/10/2016 10:30 AM	
Martone, Kim	Delivered: 3/10/2016 10:30 AM	
Olejarz, Barbara	Delivered: 3/10/2016 10:30 AM	

Good Morning,
Please see the attached rescheduled hearing notice for Eastern Connecticut Health Network, Inc. and Prospect Medical Holdings, Inc.

Leslie M. Greer
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134
Phone: (860) 418-7013 Fax: (860) 418-7053
Website: www.ct.gov/ohca

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Office of Health Care Access

March 10, 2016

Jonathan Spees, Senior Vice President, Mergers and Acquisitions
Prospect Medical Holdings
10780 Santa Monica Blvd.
Suite 400
Los Angeles, CA 90025

Dennis P. McConville, Senior Vice President and Chief Strategy Officer
Eastern Connecticut Health Network
71 Haynes Street
Manchester, CT 06040

RE: Certificate of Need Application, Docket Number 15-32016-86 and 15-486-01
Eastern Connecticut Health Network, Inc. and Prospect Medical Holdings, Inc.
Eastern Connecticut Health Network, Inc. ("ECHN"), and Prospect Medical Holdings, Inc. ("PMH"), are proposing the purchase of substantially of the assets of ECHN by PMH.

Dear Mr. Spees and Mr. McConville,

The hearings originally scheduled for March 15th (Manchester Community Club) and March 16th (Vernon Town Council Chamber) have been RESCHEDULED, as noted below:

Applicants: Eastern Connecticut Health Network, Inc.
Prospect Medical Holdings, Inc.

Docket Number: 15-32016-486 and 15-486-01

Connecticut Department of Public Health

Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

ECHN, Inc. and Prospect Medical Holdings, Inc. March 10, 2016
Notice of Public Hearing; Docket Number 15-32016-CON and 15-486-01

Proposal: Eastern Connecticut Health Network, Inc. ("ECHN"), and Prospect Medical Holdings, Inc. ("PMH"), are proposing the purchase of substantially all of the assets of ECHN by PMH. Pursuant to the terms of the proposed Asset Purchase Agreement, PMH will pay either $105,000,000 or $115,000,000 for the assets of ECHN, subject to certain adjustments. In addition, PMH will commit to spend not less than $75,000,000 on capital items for the hospitals and service areas of Manchester Memorial Hospital and Rockville General Hospital, over five years.

Notice is hereby given of a public hearing to be held in this matter to commence on:

1st Hearing

Date: March 29, 2016

Time: 2:00 p.m.

Place: Manchester Country Club
305 South Main Street
Manchester, CT 06040

2nd Hearing

Date: March 30, 2016

Time: 2:00 p.m.

Place: Elks Lodge (Please note new venue)
9 North Park Street
Vernon, CT 06066

The Applicants are designated as parties in this proceeding. Enclosed for your information is a copy of the hearing notice for the public hearing that will be published in the *Journal Inquirer* pursuant to General Statutes § 19a-639a (f) and 19a-486 (f).

Sincerely,

Kimberly R. Martone
Director of Operations
Enclosure

cc: Henry Salton, Esq., Office of the Attorney General
Antony Casagrande, Department of Public Health
Kevin Hansted, Department of Public Health
Wendy Furniss, Department of Public Health
Maura Downes, Department of Public Health
Jill Kentfield, Department of Public Health
Chris Stan, Department of Public Health
DeVaughn Ward, Department of Public Health
Marielle Daniels, Connecticut Hospital Association

KRM:SWL:CC:lmg

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Office of Health Care Access

March 10, 2016 P.O. #54772

Journal Inquirer
306 Progress Drive
Manchester, CT 06040

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than **Friday, March 11, 2016**. Please provide the following within 30 days of publication:

- Proof of publication (copy of legal ad. acceptable) showing published date along with the invoice.

If there are any questions regarding this legal notice, please contact Kaila Riggott at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Director of Operations

Attachment
cc: Danielle Pare, DPH
Marielle Daniels, Connecticut Hospital Association

KRM:SWL:CC;lmg

Connecticut Department of Public Health

Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

Journal Inquirer March 10, 2016
Notice of Public Hearing, Docket Number 16-32016-486 and 15-486-01

PLEASE INSERT THE FOLLOWING:

Office of Health Care Access & Office of the Attorney General Public Hearings

The hearings originally scheduled for March 15th (Manchester Community Club) and March 16th (Vernon Town Council Chamber) have been RESCHEDULED, as noted below:

Statute References:	19a-638 and19a-486
Applicants:	Eastern Connecticut Health Network, Inc. Prospect Medical Holdings, Inc.
Towns:	Manchester and Vernon
Docket Numbers:	15-32016-486 and 15-486-01
Proposal:	Eastern Connecticut Health Network, Inc. ("ECHN"), and Prospect Medical Holdings, Inc. ("PMH"), are proposing the purchase of substantially all of the assets of ECHN by PMH. Pursuant to the terms of the proposed Asset Purchase Agreement, PMH will pay either $105,000,000 or $115,000,000 for the assets of ECHN, subject to certain adjustments. In addition, PMH will commit to spend not less than $75,000,000 on capital items for the hospitals and service areas of Manchester Memorial Hospital and Rockville General Hospital, over five years.

1st Hearing

Date:	March 29, 2016
Time:	2:00 p.m.
Place:	Manchester Country Club 305 South Main Street Manchester, CT 06040

2nd Hearing

Date:	March 30, 2016
Time:	2:00 p.m.
Place:	Elks Lodge (Please note new venue) 9 North Park Street Vernon, CT 06066

Any person who wishes to request status in the above listed public hearing may file a written petition no later than March 24, 2016 (5 calendar days before the date of the hearing) pursuant to the Regulations of Connecticut State Agencies §§ 19a-9-26 and 19a-9-27. If the request for status is granted, such person shall be designated as a Party, an Intervenor or an Informal Participant in the above proceeding. Please check OHCA's website at www.ct.gov/ohca for

more information or call OHCA directly at (860) 418-7001. If you require aid or accommodation to participate fully and fairly in this hearing, please phone (860) 418-7001.

Greer, Leslie

From: ADS <ADS@graystoneadv.com>
Sent: Thursday, March 10, 2016 10:39 AM
To: Greer, Leslie
Subject: Re: DN: 15-32016-486 Hearing Notice

Good day

Thanks so much for your ad submission.
We will be in touch shortly and look forward to serving you.

Don't forget to ask for ideas to expand your diversity coverage.

PLEASE NOTE: New Department of Labor guidelines allow web based advertising when hiring foreign nationals. To provide required documentation Graystone will retrieve & archive verification for the 1st and 30th days of posting for $115.00/web site. If required, notify Graystone when ad placement is approved.

If you have any questions or concerns, please don't hesitate to contact us at the number below.

We sincerely appreciate your business.

Thank you,
Graystone Group Advertising

2710 North Avenue
Bridgeport, CT 06604
Phone: 800-544-0005
Fax: 203-549-0061

E-mail new ad requests to: ads@graystoneadv.com
http://www.graystoneadv.com/

From: "Greer, Leslie" <Leslie.Greer@ct.gov>
Date: Thursday, March 10, 2016 at 9:23 AM
To: Ads Desk <ads@graystoneadv.com>
Cc: "Olejarz, Barbara" <Barbara.Olejarz@ct.gov>
Subject: DN: 15-32016-486 Hearing Notice

Please run the attached hearing notice in the Journal Inquirer by 3/11/16. For billing purposes, please refer to P.O. #54772. In addition, please forward me a copy of the "proof of publication" when it becomes available.

Thank you,

Leslie M. Greer
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134
Phone: (860) 418-7013 Fax: (860) 418-7053
Website: www.ct.gov/ohca

Greer, Leslie

From: Robert Taylor <RTaylor@graystoneadv.com>
Sent: Thursday, March 10, 2016 1:45 PM
To: Greer, Leslie
Cc: Olejarz, Barbara
Subject: FW: DN: 15-32016-486 Hearing Notice
Attachments: 15-32016np Journal Inquirer (rescheduled).docx

Good afternoon,

This notice is set to publish tomorrow.
$371.36

Thanks,

Robert Taylor
Graystone Group Advertising
www.graystoneadv.com
2710 North Avenue, Suite 200
Bridgeport, CT 06604
Phone: 203-549-0060
Toll Free: 800-544-0005
Fax: 203-549-0061

From: ADS <ADS@graystoneadv.com>
Date: Thu, 10 Mar 2016 10:39:11 -0500
To: RTaylor <rtaylor@graystoneadv.com>
Subject: FW: DN: 15-32016-486 Hearing Notice

From: "Greer, Leslie" <Leslie.Greer@ct.gov>
Date: Thursday, March 10, 2016 at 9:23 AM
To: Ads Desk <ads@graystoneadv.com>
Cc: "Olejarz, Barbara" <Barbara.Olejarz@ct.gov>
Subject: DN: 15-32016-486 Hearing Notice

Please run the attached hearing notice in the Journal Inquirer by 3/11/16. For billing purposes, please refer to P.O. #54772. In addition, please forward me a copy of the “proof of publication” when it becomes available.

Thank you,

Leslie M. Greer
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134
Phone: (860) 418-7013 Fax: (860) 418-7053
Website: www.ct.gov/ohca

PUBLIC NOTICE

Office of Health Care Access & Office of the Attorney General Public Hearings

The hearings originally scheduled for March 15th (Manchester Community Club) and March 16th (Vernon Town Council Chamber) have been RESCHEDULED, as noted below:

Statute References: 19a-638 and19a-486
Applicants: Eastern Connecticut Health Network, Inc.
Prospect Medical Holdings, Inc.
Towns: Manchester and Vernon
Docket Numbers: 15-32016-486 and 15-486-01
Proposal: Eastern Connecticut Health Network, Inc. ("ECHN"), and Prospect Medical Holdings, Inc. ("PMH"), are proposing the purchase of substantially all of the assets of ECHN by PMH. Pursuant to the terms of the proposed Asset Purchase Agreement, PMH will pay either $105,000,000 or $115,000,000 for the assets of ECHN, subject to certain adjustments. In addition, PMH will commit to spend not less than $75,000,000 on capital items for the hospitals and service areas ofManchester Memorial Hospital and Rockville General Hospital, over five years.

1st Hearing

Date: March 29, 2016
Time: 2:00 p.m.
Place: Manchester Country Club
305 South Main Street
Manchester, CT 06040

2nd Hearing

Date: March 30, 2016
Time: 2:00 p.m.
Place: Elks Lodge (Please note new venue)
9North Park Street
Vernon, CT 06066

Any person who wishes to request status in the above listed public hearing may file a written petition no later than March 10, 2016 (5 calendar days before the date of the hearing) pursuant to the Regulations of Connecticut State Agencies §§ 19a-9-26 and 19a-9-27. If the request for status is granted, such person shall be designated as a Party, an Intervenor or an Informal Participant in the above proceeding. Please check OHCA's website at www.ct.gov/ohca for more information or call OHCA directly at (860) 418-7001. If you require aid or accommodation to participate fully and fairly in this hearing, please phone (860) 418-7001.

Journal Inquirer
March 11, 2016

PUBLIC NOTICE

LEGAL NOTICE
EAST WINDSOR PLANNING & ZONING COMMISSION

The East Windsor Planning & Zoning Commission will hold a Special Meeting on Wednesday, March 16, 2016 starting at 6:00 p.m. at St. John's Episcopal Church, 92 Main Street, Warehouse Point, East Windsor, CT.

This will be a **Warehouse Point Revitalization Interactive Workshop** where YOU provide feedback and comments.

For background data and information please go to the Town of East Windsor website: www.eastwindsorct.com

EAST WINDSOR PLANNING & ZONING COMMISSION
Lorraine Devanney, Secretary

Journal Inquirer
March 11, 2016

PUBLIC NOTICE

Town of Stafford
Legal Notice

Notice is hereby given that the Town of Stafford, Planning & Zoning Commission, at a Special meeting, March 8, 2016 at 7:00 P.M. in the Stafford Community Center, 3 Buckley Hwy. Stafford Springs CT, rendered the following:

Proposed Zoning Regulation text amendment to create a Village Overlay District - **Approved**

Proposed Zoning Map amendment to create a Village Overlay District: Main Street Overlay District (portions of West Main St, Main St., Furnace Ave, East Main St., Spring St., River Road, Fisk Ave, Silver St, and High St.) - **Approved**

Proposed Zoning Map amendment to create a Village Overlay District: Stafford Hollow Overlay District (portions of East St., Patten Road, Leonard Rd., Orcuttville Rd., Old Monson Rd., Murphy Rd., Pinney School Rd. Upper Rd. Fluery Rd., Furnace Ave. and Sunset Ridge Rd.) - **Approved**

Nancy Ravetto
Chairman

Journal Inquirer
March 11, 2016

PUBLIC NOTICE

INVITATIONS TO BID

The Town of Manchester, CT will receive sealed bids in the General Services' office, Lincoln Center Building, 494 Main Street until **MARCH 29, 2016 @ 11:00 a.m.** for the following: **REDEVELOPMENT & CLEANING NEW STATE ROAD WELL NO. 6; SCHEDULED REMOVAL OF ABANDONED FIRE ALARM WIRE, BRACKETS & RELATED WORK.** Bid documents are available on the Town webpage at http://generalservices1.townofmanchester.org/index.cfm/bids/. The Town is an equal opportunity employer and requires an affirmative action policy for all of its contractors and vendors as a condition of doing business with the Town, as per Federal Order 11246.

Journal Inquirer
March 10, 2016
March 11, 2016
March 12, 2016



For home delivery
Call
860-643-8111
800-237-3606

PUBLIC NOTICE

NOTICE OF SALES OR OTHER DISPOSITION PURSUANT TO THE CONNECTICUT STATE STATUTES SECTION 42-16 to 42-169
NOTICE IS HEREBY GIVEN THAT PS ORANGECO, INC. WILL SELL AT PUBLIC AUCTION THE PERSONAL PROPERTY CONTAINED WITHIN THE FOLLOWING UNITS TO SATISFY UNPAID STORAGE RENTAL ACCOUNTS.

SALE TO BE HELD ON 3/23/2016 AT 9:30AM AT PUBLIC STORAGE
115D ELM STREET, ENFIELD, CT. 06082

UNIT B011 DAVID DEALBA - BOXES,BAGS,TOTES,FURNITURE
UNIT C121 CHRISTINE TENNEY - BOXES,BAGS,TOTES,FURNITURE
UNIT C140 DIANA CABAN - BOXES,BAGS,TOTES,FURNITURE
UNIT D044 ERNAL MARSH- BOXES,BAGS,TOTES,FURNITURE
UNIT D046 MELISSA ODELIUS- BOXES,BAGS,TOTES,FURNITURE
UNIT D071 AMY KOWAL - BOXES,BAGS,TOTES,FURNITURE
UNIT D082 NICOLE FITZPATRICK - BOXES,BAGS,TOTES,FURNITURE
UNIT D141 JENNEFER GRAHAM - BOXES,BAGS,TOTES,FURNITURE
UNIT E008 PAUL MARTIN - BOXES,BAGS,TOTES,FURNITURE

SALES TO BE PAID BY CASH ONLY AT TIME OF SALE. CONTENTS TO BE REMOVED OFF THE PREMISES WITHIN 48 HOURS. TENANTS MAY CLAIM THEIR GOODS UP UNTIL THE TIME OF THE AUCTION BY PAYING THEIR JUST DEBTS AND VACATING THE STORAGE
UNIT.

Journal Inquirer
March 11, 2016
March 16, 2016

Home Finder and Open House Directory

Use the unique URL in each ad to see photos, maps, driving directions and more.

Price Reduced



Enfield / 27 Lake Dr **$274,900**
Located in the desirable Crescent Lake community you'll find this beautiful 3 bed/3 bath well cared for Colonial ready for a new owners. Nothing to do but move right in. Open Sun 2/14 from 12N-2pm.
ViewWebPage.com/5MXM
Paula Smith **860-748-6801**
Real Living Realty Professionals **413-426-0959**

New To Market-Open Sun



Enfield / 36 Vernon Rd **$179,900**
4 br, 1 ba. w/2 car gar; sunroom; mudroom; lg eat-in kitchen; hardwood fls; living rm w/fp; patio and shed. New roof, windows & heating system. Home has great bones but needs minor updating. Open Sun 1:30-3:30pm.
ViewWebPage.com/5NDQ
Paula Smith **860-748-6801**
Real Living Realty Professionals **413-426-0959**

Open House Sunday 1-3



South Windsor / 318 Quarry Brook Dr **$342,900**
ONE and DONE! This Beautiful 4BR 2.5BA Colonial is the ONE! In perfect condition. Updates include: Roof, Harvey Windows, Baths, Kitchen, Furnace, Garage doors, PRISTINE floors, Family Room addition w/Gas Fireplace.
ViewWebPage.com/5NEB
Holly Keating **860-930-5454**
William Raveis First Town Real Estate

Open House 3/13 #74 11-1



Stafford -92 Furnace Ave **Starting At $189,900**
Spectacular 55+ Active Adult Community nestled in charming Stafford Springs. Easy, practically maintenance free living in private, detached units. High quality construction with model unit & custom floor plans available.
ViewWebPage.com/5LQV
Cindy Casagrande **860-684-2673**
IsabellasCourt@gmail.com

To place your ad here, go to www.journalinquirer.com - Click JIHomes

$59 for Friday / Saturday combo

Greer, Leslie

From: Lazarus, Steven
Sent: Monday, March 21, 2016 1:23 PM
To: Greer, Leslie
Cc: Cotto, Carmen; Hawes, Gary W.; Martone, Kim; Hansted, Kevin; Riggott, Kaila
Subject: FW: ECHN Monthly Financial Statistics Reports
Attachments: CON - Financial Stats Jan FY 16 and FY 15.pdf; CON - Financial Stats July Aug Sept FY15 & FY14.pdf; CON - Financial Stats Oct Nov Dec FY16 & FY15.pdf

Leslie,

Please add the email to the original docket.

Thank you,
Steven

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

From: Basile, Mary C [mailto:mbasile@echn.org]
Sent: Monday, March 21, 2016 12:51 PM
To: Lazarus, Steven
Subject: ECHN Monthly Financial Statistics Reports

Hi Steven,

Attached are the monthly financial statistics reports for the months of July, August and September FY 15 and FY14 and October, November, December and January FY16 and FY15 for Manchester Memorial Hospital, Rockville General Hospital and the Eastern Connecticut Health Network.

These reports were requested in the Eastern Connecticut Health Network, Inc. – Proposed Asset Purchase by Prospect Medical Holdings, Inc. – OHCA Docket No. 15-31216-486 and Attorney General Docket No. 15-486-01.
The reports respond to Item #50 (Page 10 of the request for information in the application for approval on August 6, 2015).

Please let me know if you have any questions or need additional information.

Thank you!

Mary

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OHCA Financial Statistics Report (January FY 2016 and January FY 2015)

	Manchester Memorial Hospital				Rockville General Hospital				Eastern CT Health Network			
	MTD		YTD		MTD		YTD		MTD		YTD	
	January FY 2016	January FY 2015	January FY 2016	January FY 2015	January FY 2016	January FY 2015	January FY 2016	January FY 2015	January FY 2016	January FY 2015	January FY 2016	January FY 2015
A. Operating Performance												
Operating Margin	-4.59%	3.59%	1.40%	2.62%	0.81%	4.56%	-3.51%	1.49%	-4.33%	0.55%	-1.55%	0.18%
Non-Operating Margin	-0.45%	-0.41%	-0.56%	-0.57%	-0.45%	-0.11%	-0.59%	-0.29%	-0.36%	-0.27%	-0.46%	-0.40%
Total Margin	-5.04%	3.18%	0.84%	2.05%	0.36%	4.45%	-4.09%	1.19%	-4.70%	0.28%	-2.01%	-0.22%
Bad Debt as % of Gross Revenue	2.71%	1.04%	1.54%	0.83%	-0.08%	1.32%	0.74%	0.90%	1.90%	1.17%	1.29%	0.92%
B. Liquidity												
Current Ratio	1.30	1.13	1.30	1.13	1.79	1.83	1.79	1.83	1.60	1.47	1.60	1.47
Days Cash on Hand	16	18	29	31	63	61	112	107	62	64	62	64
Days in Net Accounts Receivable	66	52	112	93	56	55	103	104	60	51	103	93
Average Payment Period	54	60	98	104	38	41	68	72	64	63	64	63
C. Leverage and Capital Structure												
Long-term Debt to Equity	3.52	2.07	3.52	2.07	1.29	0.83	1.29	0.83	1.41	1.08	1.41	1.08
Long-term Debt to Capitalization	78	67	78	67	56	45	56	45	76	65	76	65
Unrestricted Cash to Debt	(0.23)	1.37	3.67	4.73	0.94	1.77	0.47	4.50	(0.22)	0.83	1.35	3.00
Times Interest Earned Ratio	0.44	6.89	4.79	6.19	6.18	10.84	2.14	6.97	0.37	4.98	2.84	4.64
Debt Service Coverage Ratio	N/A	N/A	1.33	1.85	N/A	N/A	1.00	4.92	N/A	N/A	1.03	1.60
Equity Financing Ratio	9.59	16.58	9.59	16.58	27.72	38.33	27.72	38.33	22.42	29.08	22.42	29.08
D. Additional Statistics												
Income from Operations	($680,072)	$574,121	$864,479	$1,669,209	$46,191	$277,536	($756,822)	$354,387	($1,130,134)	$155,525	($1,650,097)	$204,864
Revenue Over/(Under) Expense	($746,095)	$508,138	$517,032	$1,304,511	$20,484	$270,781	($883,647)	$284,914	($1,225,108)	$79,732	($2,138,708)	($241,790)
EBITDA	$84,071	$1,361,055	$3,981,552	$4,966,613	$359,645	$609,467	$494,318	$1,705,321	$103,004	$1,453,322	$3,375,431	$5,587,674
Cash from Operations	$13,797,665	$13,797,665	$58,532,206	$58,532,206	$5,023,259	$5,182,780	$20,929,423	$23,781,040	$21,916,976	$23,030,954	$95,829,287	$99,955,239
Cash and Cash Equivalents	$8,140,683	$8,909,450	$8,140,683	$8,909,450	$11,304,738	$11,312,548	$11,304,738	$11,312,548	$46,078,557	$48,959,955	$46,078,557	$48,959,955
Net Working Capital	$8,165,372	$3,808,290	$8,165,372	$3,808,290	$5,437,802	$6,285,777	$5,437,802	$6,285,777	$27,887,912	$22,800,293	$27,887,912	$22,800,293
Unrestricted Assets	$1,852,814	$11,243,924	$1,852,814	$11,243,924	$13,508,694	$23,899,791	$13,508,694	$23,899,791	$40,397,950	$59,273,090	$40,397,950	$59,273,090
Credit Ratings (S&P, FITCH, and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

OHCA Financial Statistics Report (April FY 2015 and April FY 2014)

	Manchester Memorial Hospital				Rockville General Hospital				Eastern CT Health Network			
	MTD		YTD		MTD		YTD		MTD		YTD	
	July FY 2015	July FY 2014	July FY 2015	July FY 2014	July FY 2015	July FY 2014	July FY 2015	July FY 2014	July FY 2015	July FY 2014	July FY 2015	July FY 2014
A. Operating Performance												
Operating Margin	4.12%	3.32%	2.51%	3.23%	-3.13%	0.81%	-2.72%	1.05%	3.71%	0.89%	-0.98%	0.34%
Non-Operating Margin	-1.21%	-1.76%	-0.89%	-0.88%	-1.20%	-1.71%	-0.69%	-0.45%	-0.92%	-1.36%	-0.67%	-0.59%
Total Margin	2.91%	1.56%	1.62%	2.35%	-4.32%	-0.90%	-3.41%	0.60%	2.80%	-0.47%	-1.65%	-0.25%
Bad Debt as % of Gross Revenue	0.58%	0.38%	-0.61%	-0.66%	0.99%	0.35%	-0.72%	-0.63%	-0.76%	0.48%	-0.65%	-0.75%
B. Liquidity												
Current Ratio	1.16	1.31	1.16	1.31	1.54	1.50	1.54	1.50	1.38	1.40	1.38	1.40
Days Cash on Hand	19	28	13	20	66	61	45	45	65	70	65	70
Days in Net Accounts Receivable	53	59	38	43	62	55	42	41	52	55	38	40
Average Payment Period	62	54	43	39	48	47	32	34	64	70	64	70
C. Leverage and Capital Structure												
Long-term Debt to Equity	2.07	1.64	2.07	1.64	0.91	0.74	0.91	0.74	1.11	0.93	1.11	0.93
Long-term Debt to Capitalization	67	62	67	62	48	42	48	42	67	59	67	59
Unrestricted Cash to Debt	1.30	0.90	10.83	12.60	0.08	0.43	2.49	9.86	1.37	0.49	4.36	7.21
Times Interest Earned Ratio	6.75	5.72	5.82	6.03	2.44	4.94	2.99	6.96	7.70	4.40	3.49	4.46
Debt Service Coverage Ratio	N/A	N/A	1.42	1.83	N/A	N/A	0.92	2.66	N/A	N/A	1.40	1.16
Equity Financing Ratio	16.17	21.64	16.17	21.64	35.23	41.31	35.23	41.31	28.11	32.92	28.11	32.92
D. Additional Statistics												
Income from Operations	$633,053	$520,994	$3,919,130	$5,079,849	($166,895)	$49,602	($1,534,668)	$637,755	$1,033,957	$251,617	($2,648,012)	$961,199
Revenue Over/(Under) Expense	$446,906	$244,365	$2,524,988	$3,695,991	($230,700)	($55,083)	($1,924,686)	$362,997	$778,733	($133,319)	($4,472,987)	($691,635)
EBITDA	$1,413,261	$1,163,486	$11,890,204	$13,184,731	$149,301	$305,483	$1,744,517	$4,002,648	$2,291,661	$1,335,849	$10,337,145	$14,344,707
Cash from Operations	$14,290,215	$15,719,667	$213,233,190	$146,614,120	$5,527,405	$5,527,405	$57,671,830	$57,671,830	$21,353,643	$5,298,402	$298,155,253	$35,598,094
Cash and Cash Equivalents	$9,163,954	$13,849,738	$9,163,954	$13,849,738	$11,726,452	$12,105,457	$11,726,452	$12,105,457	$46,307,239	$51,231,181	$46,307,239	$51,231,181
Net Working Capital	$4,709,127	$8,495,203	$4,709,127	$8,495,203	$4,519,871	$4,689,471	$4,519,871	$4,689,471	$18,060,122	$20,490,665	$18,060,122	$20,490,665
Unrestricted Assets	$10,376,011	$19,815,466	$10,376,011	$19,815,466	$20,665,705	$26,324,679	$20,665,705	$26,324,679	$54,034,965	$71,217,658	$54,034,965	$71,217,658
Credit Ratings (S&P, FITCH, and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

OHCA Financial Statistics Report (May FY 2015 and May FY 2014)

	Manchester Memorial Hospital				Rockville General Hospital				Eastern CT Health Network			
	MTD		YTD		MTD		YTD		MTD		YTD	
	August FY 2015	August FY 2014	August FY 2015	August FY 2014	August FY 2015	August FY 2014	August FY 2015	August FY 2014	August FY 2015	August FY 2014	August FY 2015	August FY 2014
A. Operating Performance												
Operating Margin	4.05%	-3.59%	2.65%	2.64%	-2.38%	-0.70%	-2.69%	0.90%	-0.94%	-4.14%	-0.97%	-0.05%
Non-Operating Margin	-1.66%	-0.44%	-0.96%	-0.84%	-1.58%	-0.17%	-0.76%	-0.43%	-1.29%	-0.29%	-0.73%	-0.56%
Total Margin	2.39%	-4.03%	1.69%	1.80%	-3.96%	-0.87%	-3.46%	0.47%	-2.23%	-4.43%	-1.70%	-0.61%
Bad Debt as % of Gross Revenue	1.22%	-0.66%	-0.44%	-0.66%	1.21%	-0.84%	-0.55%	-0.65%	0.96%	-0.79%	-0.51%	-0.75%
B. Liquidity												
Current Ratio	1.19	1.19	1.19	1.19	1.48	1.69	1.48	1.69	1.36	1.39	1.36	1.39
Days Cash on Hand	23	27	15	19	72	62	46	43	66	67	66	67
Days in Net Accounts Receivable	56	64	39	44	64	63	42	44	57	60	39	41
Average Payment Period	67	61	45	44	52	44	34	30	65	67	65	67
C. Leverage and Capital Structure												
Long-term Debt to Equity	2.14	1.74	2.14	1.74	0.92	0.77	0.92	0.77	1.14	0.97	1.14	0.97
Long-term Debt to Capitalization	68	64	68	64	48	44	48	44	67	61	67	61
Unrestricted Cash to Debt	1.20	0.06	11.86	12.11	0.06	0.77	2.55	10.84	0.30	(0.08)	4.60	7.04
Times Interest Earned Ratio	6.91	1.53	6.41	5.64	2.68	5.33	2.96	6.81	3.45	0.91	3.49	4.16
Debt Service Coverage Ratio	N/A	N/A	1.50	1.68	N/A	N/A	0.91	2.72	N/A	N/A	1.41	1.06
Equity Financing Ratio	15.99	20.58	15.99	20.58	34.93	41.46	34.93	41.46	27.76	32.38	27.76	32.38
D. Additional Statistics												
Income from Operations	$597,835	($531,932)	$4,516,964	$4,547,917	($119,527)	($40,468)	($1,654,194)	$597,288	($240,325)	($1,110,535)	($2,888,337)	($149,336)
Revenue Over/(Under) Expense	$353,116	($597,128)	$2,878,103	$3,098,864	($198,666)	($50,522)	($2,123,350)	$312,476	($570,339)	($1,188,772)	($5,043,326)	($1,880,407)
EBITDA	$1,400,713	$316,488	$13,088,122	$13,501,219	$156,631	$307,715	$1,901,150	$4,310,364	$1,003,678	$275,706	$11,340,823	$14,620,413
Cash from Operations	$13,850,383	$14,385,361	$227,083,573	$160,999,481	$5,606,279	$5,606,279	$63,278,109	$63,278,109	$20,910,096	$4,746,587	$319,065,348	$40,344,681
Cash and Cash Equivalents	$10,094,581	$12,933,064	$10,094,581	$12,933,064	$11,578,760	$11,103,202	$11,578,760	$11,103,202	$47,023,731	$49,069,770	$47,023,731	$49,069,770
Net Working Capital	$5,603,489	$5,450,496	$5,603,489	$5,450,496	$4,023,147	$5,397,747	$4,023,147	$5,397,747	$17,639,012	$19,611,711	$17,639,012	$19,611,711
Unrestricted Assets	$10,308,640	$18,971,156	$10,308,640	$18,971,156	$20,279,098	$26,051,748	$20,279,098	$26,051,748	$53,344,364	$70,108,676	$53,344,364	$70,108,676
Credit Ratings (S&P, FITCH, and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

OHCA Financial Statistics Report (June FY 2015 and June FY 2014)

	Manchester Memorial Hospital				Rockville General Hospital				Eastern CT Health Network			
	MTD		YTD		MTD		YTD		MTD		YTD	
	September FY 2015	September FY 2014	September FY 2015	September FY 2014	September FY 2015	September FY 2014	September FY 2015	September FY 2014	September FY 2015	September FY 2014	September FY 2015	September FY 2014
A. Operating Performance												
Operating Margin	27.16%	-1.98%	4.79%	2.26%	-61.17%	26.83%	-5.63%	3.70%	2.93%	2.28%	-0.65%	0.15%
Non-Operating Margin	0.00%	-1.87%	-0.88%	-0.93%	-2.39%	-1.16%	-0.85%	-0.51%	-0.30%	-1.37%	-0.69%	-0.63%
Total Margin	27.16%	-3.85%	3.91%	1.33%	-63.56%	25.67%	-6.47%	3.20%	2.63%	0.91%	-1.34%	-0.48%
Bad Debt as % of Gross Revenue	-8.22%	-4.49%	-1.14%	-0.97%	-13.33%	-7.75%	-1.59%	-1.23%	0.85%	0.66%	-0.39%	-0.64%
B. Liquidity												
Current Ratio	1.19	1.17	1.19	1.17	1.72	1.59	1.72	1.59	1.43	1.37	1.43	1.37
Days Cash on Hand	35	36	21	29	77	66	54	50	74	78	74	78
Days in Net Accounts Receivable	55	64	41	40	77	73	35	47	57	64	43	39
Average Payment Period	82	67	49	54	42	47	29	36	68	71	68	71
					0							
C. Leverage and Capital Structure												
Long-term Debt to Equity	3.30	2.03	3.30	2.03	1.19	0.83	1.19	0.83	1.36	1.06	1.36	1.06
Long-term Debt to Capitalization	77	67	77	67	54	45	54	45	75	65	75	65
Unrestricted Cash to Debt	6.25	(0.06)	17.94	11.20	(6.22)	6.98	(3.54)	17.41	1.23	0.88	5.67	7.68
Times Interest Earned Ratio	45.65	2.24	7.82	5.38	(30.75)	42.56	0.28	9.24	7.62	7.45	3.79	4.38
Debt Service Coverage Ratio	N/A	N/A	1.96	1.60	N/A	N/A	(0.21)	3.99	N/A	N/A	1.27	1.36
Equity Financing Ratio	9.99	16.28	9.99	16.28	29.28	37.96	29.28	37.96	22.46	28.81	22.46	28.81
D. Additional Statistics												
Income from Operations	$4,438,312	($312,411)	$8,955,277	$4,235,507	($1,985,465)	$2,163,409	($3,639,658)	$2,760,694	$784,320	$658,388	($2,104,017)	$509,052
Revenue Over/(Under) Expense	$4,438,503	($606,680)	$7,316,607	$2,492,184	($2,063,001)	$2,069,656	($4,186,350)	$2,382,130	$703,899	$263,708	($4,339,427)	($1,616,699)
EBITDA	$5,138,862	$440,393	$18,429,779	$13,941,613	($1,704,420)	$2,421,228	$196,731	$6,774,667	$1,989,451	$1,850,004	$13,330,274	$16,470,417
Cash from Operations	$14,563,917	$14,901,325	$241,647,490	$175,900,806	$5,514,418	$5,514,418	$68,792,527	$68,792,527	$21,551,495	$4,650,079	$340,616,844	$44,994,760
Cash and Cash Equivalents	$13,188,728	$18,856,818	$13,188,728	$18,856,818	$13,081,652	$12,735,604	$13,081,652	$12,735,604	$53,111,506	$58,713,876	$53,111,506	$58,713,876
Net Working Capital	$5,871,026	$5,986,254	$5,871,026	$5,986,254	$5,073,415	$5,392,746	$5,073,415	$5,392,746	$23,073,998	$20,280,901	$23,073,998	$20,280,901
Unrestricted Assets	$2,829,380	$11,344,473	$2,829,380	$11,344,473	$14,969,088	$24,211,838	$14,969,088	$24,211,838	$42,167,569	$59,544,869	$42,167,569	$59,544,869
Credit Ratings (S&P, FITCH, and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

OHCA Financial Statistics Report (October FY 2016 and October FY 2015)

	Manchester Memorial Hospital				Rockville General Hospital				Eastern CT Health Network			
	MTD		YTD		MTD		YTD		MTD		YTD	
	October FY 2016	October FY 2015	October FY 2016	October FY 2015	October FY 2016	October FY 2015	October FY 2016	October FY 2015	October FY 2016	October FY 2015	October FY 2016	October FY 2015
A. Operating Performance												
Operating Margin	3.51%	1.11%	3.51%	1.11%	-12.22%	-0.64%	-12.22%	-0.64%	-1.97%	-0.35%	-1.97%	-0.35%
Non-Operating Margin	-0.90%	-0.93%	-0.90%	-0.93%	-0.47%	-0.67%	-0.47%	-0.67%	-0.64%	-0.69%	-0.64%	-0.69%
Total Margin	2.61%	0.17%	2.61%	0.17%	-12.70%	-1.31%	-12.70%	-1.31%	-2.61%	-1.05%	-2.61%	-1.05%
Bad Debt as % of Gross Revenue	0.63%	0.66%	0.63%	0.66%	0.60%	0.80%	0.60%	0.80%	0.70%	0.76%	0.70%	0.76%
B. Liquidity												
Current Ratio	1.18	1.11	1.18	1.11	1.86	1.82	1.86	1.82	1.48	1.43	1.48	1.43
Days Cash on Hand	18	23	131	163	61	57	432	403	67	66	67	66
Days in Net Accounts Receivable	56	48	399	340	53	52	371	365	53	48	383	345
Average Payment Period	58	59	408	419	31	35	217	250	62	61	62	61
C. Leverage and Capital Structure												
Long-term Debt to Equity	3.26	2.05	3.26	2.05	1.24	0.85	1.24	0.85	1.38	1.09	1.38	1.09
Long-term Debt to Capitalization	77	67	77	67	55	46	55	46	75	66	75	66
Unrestricted Cash to Debt	1.31	0.84	1.31	0.84	(1.41)	0.63	(1.41)	0.63	0.24	0.59	0.24	0.59
Times Interest Earned Ratio	6.62	5.13	6.62	5.13	(5.42)	4.88	(5.42)	4.88	2.61	4.21	2.61	4.21
Debt Service Coverage Ratio	N/A	N/A	1.93	1.50	N/A	N/A	(3.75)	3.08	N/A	N/A	1.19	1.51
Equity Financing Ratio	10.26	16.63	10.26	16.63	29.08	38.33	29.08	38.33	22.80	28.92	22.80	28.92
D. Additional Statistics												
Income from Operations	$554,185	$178,673	$554,185	$178,673	($624,549)	($40,097)	($624,549)	($40,097)	($522,871)	($101,391)	($522,871)	($101,391)
Revenue Over/(Under) Expense	$412,522	$28,057	$412,522	$28,057	($648,781)	($82,468)	($648,781)	($82,468)	($692,147)	($298,674)	($692,147)	($298,674)
EBITDA	$1,363,716	$1,033,764	$1,363,716	$1,033,764	($312,933)	$295,442	($312,933)	$295,442	$768,569	$1,271,801	$768,569	$1,271,801
Cash from Operations	$15,452,957	$16,077,536	$15,452,957	$16,077,536	$5,280,181	$6,848,006	$5,280,181	$6,848,006	$25,414,035	$27,725,868	$25,414,035	$27,725,868
Cash and Cash Equivalents	$9,106,144	$11,874,779	$9,106,144	$11,874,779	$11,210,738	$11,627,533	$11,210,738	$11,627,533	$46,417,665	$50,958,243	$46,417,665	$50,958,243
Net Working Capital	$5,084,522	$3,217,872	$5,084,522	$3,217,872	$4,850,248	$5,938,396	$4,850,248	$5,938,396	$21,792,409	$20,891,624	$21,792,409	$20,891,624
Unrestricted Assets	$2,961,600	$11,060,535	$2,961,600	$11,060,535	$14,229,387	$23,492,992	$14,229,387	$23,492,992	$41,250,914	$57,524,881	$41,250,914	$57,524,881
Credit Ratings (S&P, FITCH, and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

OHCA Financial Statistics Report (November FY 2016 and November FY 2015)

	Manchester Memorial Hospital				Rockville General Hospital				Eastern CT Health Network			
	MTD		YTD		MTD		YTD		MTD		YTD	
	November FY 2016	November FY 2015	November FY 2016	November FY 2015	November FY 2016	November FY 2015	November FY 2016	November FY 2015	November FY 2016	November FY 2015	November FY 2016	November FY 2015
A. Operating Performance												
Operating Margin	3.25%	-4.33%	3.38%	-1.44%	-1.81%	0.20%	-6.96%	-0.24%	-0.54%	-3.64%	-1.26%	-1.90%
Non-Operating Margin	0.00%	-1.59%	-0.46%	-1.24%	-0.30%	-1.22%	-0.39%	-0.93%	-0.07%	-1.19%	-0.36%	-0.92%
Total Margin	3.26%	-5.93%	2.93%	-2.69%	-2.11%	-1.02%	-7.35%	-1.17%	-0.61%	-4.83%	-1.62%	-2.83%
Bad Debt as % of Gross Revenue	1.42%	0.63%	1.03%	0.65%	1.44%	0.31%	1.02%	0.57%	1.35%	0.65%	1.02%	0.71%
B. Liquidity												
Current Ratio	1.20	1.10	1.20	1.10	1.75	1.71	1.75	1.71	1.45	1.39	1.45	1.39
Days Cash on Hand	21	28	79	105	72	71	269	262	68	70	68	70
Days in Net Accounts Receivable	63	53	240	197	52	59	208	218	57	54	220	200
Average Payment Period	65	68	248	259	39	47	148	173	66	66	66	66
C. Leverage and Capital Structure												
Long-term Debt to Equity	3.24	2.15	3.24	2.15	1.26	0.84	1.26	0.84	1.39	0.96	1.39	0.96
Long-term Debt to Capitalization	76	68	76	68	56	46	56	46	76	67	76	67
Unrestricted Cash to Debt	1.30	(0.22)	2.59	0.61	0.49	0.71	(0.88)	1.32	0.60	(0.06)	0.84	0.51
Times Interest Earned Ratio	5.86	1.22	6.23	3.17	3.71	5.51	(0.86)	5.21	3.63	1.70	3.12	2.94
Debt Service Coverage Ratio	N/A	N/A	2.07	0.80	N/A	N/A	(0.77)	3.21	N/A	N/A	1.25	1.34
Equity Financing Ratio	10.23	15.77	10.23	15.77	28.38	37.99	28.38	37.99	22.40	32.38	22.40	32.38
D. Additional Statistics												
Income from Operations	$484,666	($617,807)	$1,038,851	($439,134)	($94,623)	$11,206	($719,172)	($28,891)	($141,076)	($924,261)	($663,947)	($1,025,652)
Revenue Over/(Under) Expense	$485,190	($845,187)	$897,712	($817,130)	($110,173)	($57,474)	($758,954)	($139,942)	($159,224)	($1,226,090)	($851,371)	($1,524,764)
EBITDA	$1,228,216	$249,367	$2,591,932	$1,283,131	$213,600	$357,458	($99,333)	$652,900	$1,081,351	$524,935	$1,849,920	$1,796,736
Cash from Operations	$13,356,567	$14,014,676	$28,809,524	$30,092,212	$5,149,913	$5,761,100	$10,430,094	$12,609,106	$22,656,723	$24,023,983	$48,070,758	$51,749,850
Cash and Cash Equivalents	$9,267,922	$12,977,823	$9,267,922	$12,977,823	$11,732,274	$12,430,783	$11,732,274	$12,430,783	$47,410,165	$53,283,554	$47,410,165	$53,283,554
Net Working Capital	$5,804,364	$3,065,653	$5,804,364	$3,065,653	$4,824,841	$5,847,770	$4,824,841	$5,847,770	$21,959,313	$20,036,637	$21,959,313	$20,036,637
Unrestricted Assets	$3,079,176	$9,883,749	$3,079,176	$9,883,749	$13,959,228	$23,752,272	$13,959,228	$23,752,272	$40,845,738	$70,108,676	$40,845,738	$70,108,676
Credit Ratings (S&P, FITCH, and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

OHCA Financial Statistics Report (December FY 2016 and December FY 2015)

	Manchester Memorial Hospital				Rockville General Hospital				Eastern CT Health Network			
	MTD		YTD		MTD		YTD		MTD		YTD	
	December FY 2016	December FY 2015	December FY 2016	December FY 2015	December FY 2016	December FY 2015	December FY 2016	December FY 2015	December FY 2016	December FY 2015	December FY 2016	December FY 2015
A. Operating Performance												
Operating Margin	3.14%	8.83%	3.30%	2.29%	-1.50%	3.52%	-5.05%	1.00%	0.52%	3.66%	-0.65%	0.06%
Non-Operating Margin	-0.87%	0.46%	-0.60%	-0.63%	-1.10%	0.83%	-0.64%	-0.35%	-0.74%	0.44%	-0.49%	-0.45%
Total Margin	2.27%	9.28%	2.70%	1.67%	-2.60%	4.35%	-5.68%	0.64%	-0.22%	4.10%	-1.14%	-0.39%
Bad Debt as % of Gross Revenue	1.30%	0.97%	1.12%	0.76%	1.04%	1.12%	1.03%	0.75%	1.16%	1.07%	1.07%	0.83%
B. Liquidity												
Current Ratio	1.30	1.15	1.30	1.15	1.76	1.73	1.76	1.73	1.60	1.44	1.60	1.44
Days Cash on Hand	20	28	62	86	62	73	193	209	67	72	67	72
Days in Net Accounts Receivable	54	44	169	143	47	52	152	151	50	46	158	144
Average Payment Period	55	63	172	194	36	47	111	134	60	67	60	67
					0							
C. Leverage and Capital Structure												
Long-term Debt to Equity	3.24	2.05	3.24	2.05	1.28	0.84	1.28	0.84	1.40	1.06	1.40	1.06
Long-term Debt to Capitalization	76	67	76	67	56	46	56	46	76	65	76	65
Unrestricted Cash to Debt	1.22	2.69	3.86	3.30	0.40	1.67	(0.48)	2.99	0.73	1.64	1.59	2.16
Times Interest Earned Ratio	5.85	11.61	6.10	5.96	4.07	8.58	0.78	6.34	4.53	7.72	3.61	4.53
Debt Service Coverage Ratio	N/A	N/A	1.78	2.03	N/A	N/A	0.12	4.45	N/A	N/A	1.07	1.65
Equity Financing Ratio	10.37	16.35	10.37	16.35	27.98	37.97	27.98	37.97	22.73	29.09	22.73	29.09
D. Additional Statistics												
Income from Operations	$505,704	$1,534,223	$1,544,555	$1,095,089	($83,842)	$205,743	($803,014)	$176,852	$143,984	$1,074,991	($519,963)	$49,339
Revenue Over/(Under) Expense	$365,418	$1,613,504	$1,263,130	$796,374	($145,178)	$254,076	($904,132)	$114,134	($62,229)	$1,203,242	($913,600)	($321,522)
EBITDA	$1,305,554	$2,322,428	$3,897,486	$3,605,559	$234,004	$542,956	$134,671	$1,195,856	$1,422,507	$2,337,616	$3,272,427	$4,134,352
Cash from Operations	$15,466,368	$14,643,053	$44,275,892	$44,735,265	$5,476,070	$5,989,154	$15,906,164	$18,598,260	$25,841,553	$25,175,159	$73,912,311	$76,925,009
Cash and Cash Equivalents	$9,927,631	$14,195,467	$9,927,631	$14,195,467	$11,336,835	$12,906,142	$11,336,835	$12,906,142	$47,804,292	$54,106,561	$47,804,292	$54,106,561
Net Working Capital	$8,246,440	$4,678,359	$8,246,440	$4,678,359	$4,981,022	$5,976,304	$4,981,022	$5,976,304	$26,678,094	$22,211,930	$26,678,094	$22,211,930
Unrestricted Assets	$3,089,534	$11,027,298	$3,089,534	$11,027,298	$13,672,423	$23,806,253	$13,672,423	$23,806,253	$40,751,104	$59,337,036	$40,751,104	$59,337,036
Credit Ratings (S&P, FITCH, and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

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Office of
HEALTHCARE ACCESS

CERTIFICATE OF NEED/ CONVERSION APPLICATION

PREFILE TESTIMONY AND RESPONSES TO ISSUES IDENTIFIED IN HEARING NOTICE

Eastern Connecticut Health Network, Inc.

Proposed Asset Purchase by

Prospect Medical Holdings, Inc.

OHCA Docket Number: 15-32016-486

Attorney General Docket Number: 15-486-01

March 23, 2016

WIGGIN AND DANA

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March 23, 2016

VIA HAND-DELIVERY

Office of the Attorney General
55 Elm Street
P.O. Box 120
Hartford, Connecticut 06141-0120
Attn: Gary W. Hawes, Assistant Attorney General

Office of Health Care Access
Department of Public Health
410 Capitol Avenue
Hartford, Connecticut 06134
Attn: Steven W. Lazarus, Health Care Analyst

Re: Eastern Connecticut Health Network, Inc.
Proposed Asset Purchase by Prospect Medical Holdings, Inc.
OHCA Docket Number: 15-32016-486
Attorney General Docket Number: 15-486-01

Dear Mr. Hawes and Mr. Lazarus:

Eastern Connecticut Health Network, Inc. and Prospect Medical Holdings, Inc. (the "***Applicants***") hereby submit the following:

1. Responses to the issues identified in the letter dated February 24, 2016 from the Office of the Attorney General and the Office of Health Care Access (the "***Hearing Notice***").

2. Prefile testimony of the following individuals, each of whom will be present at the hearings scheduled on March 29, 2016 and March 30, 2016 and available for questions:

   For Eastern Connecticut Health Network, Inc.:

   Dennis O'Neill, MD
   Peter J. Karl
   Joy Dorin

For Prospect Medical Holdings, Inc.:

Von Crockett
Mitchell Lew, MD
Jonathan Spees
Steven Aleman

As requested, the prefile testimony addresses the topics identified in the Hearing Notice. For ease of reference, please find below a chart that shows which speaker's testimony addresses each of the topics you listed:

Topic	Prefile Testimony
1. The clear and public need for and community benefits of the proposal.	All, but particularly the testimony of Peter Karl and Mitchell Lew, MD
2. How access to care will be maintained in the service area following the asset purchase of the two ECHN hospitals (MMH and RGH) by PMH.	All, but particularly the testimony of Peter Karl and Mitchell Lew, MD; see also the testimony of Jonathan Spees regarding the commitment of PMH to provide charity care.
3. PMH's management of Quality Assurance and Performance Improvement (QAPI) across its hospital network and, in particular, the manner in which oversight of the QAPI program will be managed by MMH and RGH.	Testimony of Von Crockett
4. The financial feasibility of the proposal.	Testimony of Jonathan Spees
5. How prices for, and the cost of, health services at MMH and RGH will be affected by PMH's acquisition of those facilities.	Testimony of Mitchell Lew, MD and Jonathan Spees
6. The charity care policies to be implemented at MMH and RGH following the transfer of ownership and how they compare to PMH's current charity care policies.	Testimony of Jonathan Spees
7. The commitment PMH is willing to make to performing future health needs assessments for the communities in ECHN's service area in a manner that allows for widespread public input, collaboration with other health care providers in the community as well as public dissemination of the assessments and MMH's and RGH's implementation plan to address identified needs.	Testimony of Von Crockett

Topic	Prefile Testimony
8. How PMH's experience with license consolidation (i.e., combining separately licensed hospitals into a single licensed hospital with separate campuses) in the other markets in which it operates might impact the future of MMH and RGH.	Testimony of Von Crockett

At your request, one (1) hard copy and one (1) electronic copy of this submission have been provided to each Office.

If you have any questions or need anything further, please feel free to contact Rebecca Matthews at (203) 498-4502 or Melinda Agsten at (203) 498-4326. Thank you for your assistance in this matter.

Sincerely,

Wiggin and Dana LLP

By _____
Rebecca A. Matthews
Its Partner

By _____
Melinda A. Agsten
Its Partner

cc: Kevin Hansted, Staff Attorney, Department of Public Health Division of Office of Health Care Access
Kimberly Martone, Director of Operations, Department of Public Health Division of Office of Health Care Access
Perry Zinn-Rowthorn, Deputy Attorney General, Office of the Attorney General
Dennis P. McConville, Senior Vice President and Chief Strategy Officer, Eastern Connecticut Health Network, Inc.
Thomas M. Reardon, President, Prospect Medical Holdings-East, Inc.
Frank Saidara, Vice President, Corporate Development, Prospect Medical Holdings, Inc.
Jonathan Spees, Senior Vice President, Corporate Development, Prospect Medical Holdings, Inc.
Joyce Tichy, Senior Vice President and General Counsel, Eastern Connecticut Health Network, Inc.
Michele M. Volpe, Esq., Bershtein, Volpe & McKeon, P.C.

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STATE OF CONNECTICUT

OFFICE OF THE ATTORNEY GENERAL

AND

DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

Attorney General Docket No.: 15-486-01
OHCA Docket No.: 15-32016-486
Eastern Connecticut Health Network, Inc.
Proposed Asset Purchase by Prospect
Medical Holdings, Inc.

March 23, 2016

Prefile Testimony of Dennis O'Neill, MD
Chair, Board of Trustees
Eastern Connecticut Health Network, Inc.

I. Introduction

Good afternoon, Mr. Zinn-Rowthorn, Mr. Hansted and other members of the Office of Attorney General and Office of Health Care Access. My name is Dennis O'Neill. I am the chairman of the Eastern Connecticut Health Network, Inc. ("ECHN") board of trustees (the "Board") and also have been for many years a practicing physician on staff at ECHN's two hospitals: Manchester Memorial Hospital and Rockville General Hospital. Thank you for providing us with the opportunity to submit testimony in support of ECHN's proposal to transfer its assets to Prospect Medical Holdings, Inc. ("Prospect").

ECHN is a critical component of the eastern Connecticut community. After nearly three and a half years of review, consideration and due diligence, we are excited by this opportunity to preserve and strengthen ECHN through an acquisition by Prospect.

As you well know, we are in an era of unprecedented health care reform. Hospitals are facing numerous challenges, including declining payments for health care services resulting from recent federal and state legislation, increasing hospital taxes, and prolonged regulatory

uncertainty. In Connecticut in particular, these challenges have been exacerbated by the current budget crisis and the resulting suspension of payments to hospitals for services rendered. At the same time that revenues are decreasing and hospitals face increased financial strain, medical care is becoming more complex and hospitals are required to make significant capital investments to serve their patients and provide quality care.

The acquisition of ECHN by Prospect will enable ECHN to remain an economically viable and vibrant part of the health care system in eastern Connecticut and is expected to provide many benefits to patients and the community. This has been ECHN's primary concern and the driving force behind this acquisition. Prospect's considerable financial resources and access to capital will permit important capital investments to be made in ECHN facilities, allowing quality care to be maintained and enhanced. In addition, Prospect's strong national reputation for partnering with physicians will better prepare the ECHN health system to participate in new value-based care delivery models. This partnership will offer practice options for physicians, including those who are employed by ECHN and those who choose to remain independent. It will strengthen our network of providers and programs, allow us to continue to develop our ambulatory network, reinvest in our hospitals and do a better job of managing the care needed by our patients between sites and providers. And it will preserve ECHN as an economic driver in the community, ensuring the availability of care at a local level and continued jobs for the residents of eastern Connecticut. All of this will ensure a strong future for healthcare in eastern Connecticut and, by extension, strengthen our local community.

II. Decision-Making Process and Regulatory Compliance

As chairman of the Board, I have first-hand knowledge of the significant care and consideration that went into deciding that a partnership with a larger health system made the most sense for ECHN and selecting Prospect as the appropriate partner. The Board and management have worked together throughout the affiliation process and evaluated options and partners with great care and thoughtful deliberation. We have worked hard to consider the interests of all of our constituents and to engage them in this process, including our patients, employees, medical staff, corporators, the communities we serve and legislative and union leadership. During the course of this multiyear effort, we hosted numerous public hearings and

open forums with the community, medical staff and other employees to address questions and get input and comments.

More formally, a Board-appointed Transaction Committee worked diligently to prepare a comprehensive request for proposals and to then evaluate all responses. After careful deliberation, the Transaction Committee proposed to the Board and to the corporators that ECHN pursue an affiliation with Prospect. This decision was formally approved by a unanimous vote of the Board and by a ninety-eight percent (98%) favorable vote of the corporators voting at a meeting held for the purpose of considering the proposed transaction.

Peter Karl, the President and Chief Executive Officer of ECHN, will tell you more about the transaction and the benefits to ECIIN and will explain how the acquisition meets the statutory factors that the Office of Health Care Access must take into account in considering a certificate of need application. But before I turn it over to him, I would like to spend a few minutes to review certain of the criteria under the Conversion Act that have been addressed through the Board's process:

A. The Proposed Transaction is Not Prohibited by Statutory and Common Law (C.G.S. §19a-486c(a)(1))

ECHN has carefully considered its legal obligations as a nonprofit hospital and as a charitable organization. As outlined in its application, ECHN has taken various steps to ensure that the requirements of the Conversion Act, C.G.S. §19a-486 et seq., have been satisfied and that the standards for the granting of a certificate of need under C.G.S. §19a-630 et seq. have been met. In addition, charitable gifts have been evaluated and submitted to the Attorney General with a plan for ensuring that all restricted funds will be transferred to an independent charitable organization and that donor intent will be honored. As such, the proposed transaction is not prohibited by Connecticut statutory or common law governing nonprofit entities, trusts or charities.[1]

[1] We note that, on February 25, 2016, Governor Malloy signed an Executive Order that placed a moratorium on certain hospital acquisitions or consolidations when the combined revenues after the transaction are greater than twenty percent (20%) of the total hospital revenues in the State. Connecticut health systems generated more than $12 billion in operating revenues in FY 2014 and ECHN contributed $328 million, or 2.7%, towards that total. Prospect does not currently own or operate any hospitals in Connecticut so the acquisition of ECHN will not result in combined revenues that exceed twenty percent of the total hospital revenues in the State. In considering other

B. ECHN Exercised Due Diligence in Deciding to Transfer and Selecting the Purchaser (C.G.S. §19a-486c(a)(2)(A) and (B))

As outlined in our application, ECHN exercised due diligence in deciding to transfer the assets of ECHN and in selecting Prospect as the purchaser. The Board sought the advice of counsel and other experts and established specific work groups to evaluate the various options for ensuring continued care to the community. More specifically:

In September, 2011, the ECHN Board authorized the establishment of a workgroup to study the impact of the Patient Protection and Affordable Care Act on ECHN and to evaluate whether benefits would be realized by affiliating with another health care system or whether ECHN would better serve the community by remaining an independent system. This workgroup, which included Board members, corporators, medical staff members and key executives, was assembled in November, 2011.

The workgroup began its study in earnest in December, 2011 and met numerous times over the next several months. With the assistance of The Chartis Group, LLC ("Chartis"), a national healthcare consulting firm, the workgroup evaluated local and national data and met with key constituents (community and Board members, physicians, management and staff) and with prospective partner organizations to obtain their perspectives on ECHN, its current state and its future.

In September of 2012, the workgroup presented its initial findings to the ECHN Board and concluded that affiliation with a larger health system would better position ECHN to achieve the following goals: (i) attract patients and providers based on quality, service, accessibility and affordability; (ii) enhance physician retention and recruitment; (iii) improve ECHN's financial position in order to invest in new equipment and technologies; and (iv) coordinate care to manage risk and participate in new payment vehicles.

With the Board's approval, ECHN conducted its first request for proposals and negotiated an affiliation with VHS Eastern Connecticut, LLC ("VHS") in 2014. After VHS

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proposed acquisitions by Prospect, the combined revenues for ECHN and the Greater Waterbury Health Network still fall well below the twenty percent (20%) threshold, accounting for less than 5% of total hospital revenues. Based on these calculations, the proposed acquisition of ECHN by PMH is not impacted by moratorium.

abandoned the transaction in December 2014, citing concern over restrictive regulatory conditions, ECHN regrouped and issued a second request for proposals in February of 2015.

Proposals were received from a number of potential partners, including both for-profit and non-profit health systems, and were evaluated by the Board's Transaction Committee against the selection criteria approved by the Board. After several months of due diligence, analysis and evaluations by the Transaction Committee, the Board reviewed and discussed committee's recommendations. Following discussion of the proposed transaction and further consideration of alternative proposals presented to ECHN, the Board selected Prospect as its affiliation partner and unanimously approved the Letter of Intent and Asset Purchase Agreement, which were in substantially the form proposed by ECHN as part of the request for proposals process.

C. ECHN Exercised Due Diligence in Obtaining a Fairness Evaluation and Negotiating the Terms of the Transfer (C.G.S. §19a-486c(a)(2)(C) and (D))

ECHN worked with its counsel and with Chartis to identify possible firms to conduct a fairness evaluation as required under the Conversion Act. In total, five firms were solicited for bids to provide a fairness evaluation/opinion including: Goldman Sachs, DGA Partners, Cain Brothers, Duff & Phelps, and Principle Valuation. ECHN selected Duff & Phelps based on its solid reputation in the healthcare fairness marketplace and a strong recommendation from ECHN's transaction counsel. ECHN also received and reviewed documentation from Duff & Phelps regarding its experience and confirmed that no conflict of interest existed that would interfere with its ability to evaluate the fair value of the transaction. The fees paid to Duff & Phelps services were not dependent on the opinion it rendered. As such, ECHN exercised appropriate due diligence in engaging Duff & Phelps to render an opinion that the consideration to be received by the ECHN in the proposed transaction with Prospect is fair from a financial point of view.

The Board was also thorough in developing the transaction structure and negotiating appropriate terms of the transfer that benefit the community. As mentioned above, a thorough request for proposal and review process led ECHN'S Board to accept an offer by VHS to acquire substantially all of ECHN's assets. Because the terms of that transaction were the product of extensive study of the market opportunities, due diligence and negotiations among the parties,

and because they met ECHN's contracting requirements as well as those of our anticipated acquirer, we requested that parties responding to our request for proposals use those terms as the starting point for any negotiated contract terms. With guidance of Chartis and ECHN's transaction counsel, ECHN was able to negotiate terms for the acquisition by Prospect that were consistent with, and in some cases improved upon, those in the prior proposal with VHS.

D. Disclosure of Conflicts of Interest (C.G.S. §19a-486c(a)(3))

ECHN engaged in a thorough conflict disclosure process to ensure that key individuals, including Board and committee members as well as experts and consultants, were free from conflicts of interest that could interfere with their ability to evaluate the proposed transaction. The disclosure process did not reveal any trustees, officers, key employees or experts having a material conflict of interest with Prospect. Because certain trustees are employed by ECHN and expect to have a continued employment relationship following consummation of the transfer to Prospect, the Board conducted two separate votes: the first included all trustees; the second included only those trustees who were independent of any interest in the transaction. Both votes were unanimous to move forward with the proposed transaction with Prospect.

E. ECHN Will Receive Fair Value for its Assets (C.G.S. §19a-486(a)(4))

As noted above, Duff & Phelps has confirmed that the consideration to be paid by Prospect for the assets of ECHN is consistent with fair value. It should also be noted that of the various bids received and considered by the Transaction Committee and the Board, the bid by Prospect was the highest and was determined to best meet the strategic goals established by the Board.

F. No Manipulation of Asset Value (C.G.S. §19a-486c(a)(5))

With regard to whether or not ECHN's assets were "manipulated" in providing the assessment of the fair market value of the transaction, Duff & Phelps adhered to their standard model in evaluating valuation based on market multiples and discounted cash flows. There is no evidence that any improper manipulation of the assets or their value has occurred.

G. Financing of the Transaction Does Not Place Assets at an Unreasonable Risk (C.G.S. §19a-486c(a)(6))

Prospect has represented that it has cash on hand to consummate the transaction and pay the purchase price. As of September 30, 2015, Prospect, on consolidated basis, had in excess of $110 million in funds available. Furthermore, Prospect generates over $7.5 million in free cash flow per month. The amount of cash necessary to close the ECHN transaction is estimated to be approximately $28 million.

With respect to the future capital commitments, Prospect anticipates that such commitments would be funded through the operations of ECHN (if ECHN generates sufficient cash flow at the time of expenditures), PMH's existing cash at the time of expenditure or, if necessary, PMH's corporate level credit facility.

PMH is financially strong and the assets of ECHN will not be placed at unreasonable risk.

H. Management Contracts at Fair Market Value (C.G.S. §19a-486c(a)(7))

There are no management contracts proposed for the transaction between Prospect and ECHN. Management will remain "local" at ECHN.

I. Transfer of Charitable Assets (C.G.S. §19a-486c(a)(8))

As further outlined in our application and as referenced above, ECHN is planning to establish a new, independent charitable entity ("New Foundation"). ECHN's restricted charitable funds will be transferred to the New Foundation at closing. In addition, any funds or other assets remaining in the current ECHN entity after payment of its liabilities will be transferred to the New Foundation once its operations are finally wound down. The New Foundation will ensure that the assets continue to be used for appropriate charitable health care purposes and to support and promote health care generally in the communities traditionally served by ECHN. The New Foundation will also ensure that all restricted assets are held and used consistent with donor consent.

J. Provision of Sufficient Data (C.G.S. §19a-486c(a)(9))

Finally, we believe that we have satisfied all of the requests of the Office of the Attorney General and the Office of Health Care Access for information. We will, of course, provide any further information requested.

III. Conclusion

Given ECHN's economic position and the current regulatory environment, we believe this transaction represents the best opportunity we have to continue to deliver quality care at the lowest possible cost in our communities and also preserve jobs throughout eastern Connecticut.

ECHN has enjoyed caring for our community for nearly 100 years. The proposed transaction will continue to fulfill the mission of ECHN and provide high-quality, compassionate healthcare to communities we serve.

On behalf of all of ECHN, we thank you for your time and careful examination of the transaction before you. I am available to answer any questions you may have.

STATE OF CONNECTICUT

OFFICE OF THE ATTORNEY GENERAL

AND

DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

Attorney General Docket No.: 15-486-01
OHCA Docket No.: 15-32016-486
Eastern Connecticut Health Network, Inc.
Proposed Asset Purchase by Prospect
Medical Holdings, Inc.

March 23, 2016

Prefile Testimony of Peter J. Karl
President and Chief Executive Officer
Eastern Connecticut Health Network, Inc.

I. Introduction

Good afternoon. My name is Peter Karl and I am the President and Chief Executive Officer of Eastern Connecticut Health Network, Inc. ("ECHN"). Thank you for providing us with the opportunity to submit testimony in support of ECHN's proposal to transfer its assets to Prospect Medical Holdings, Inc. ("Prospect").

Dr. O'Neill has provided important background on the proposed transaction and has outlined the extensive process that the Board has undertaken in reviewing the transaction. I would like to provide some additional information on the substance of the proposed transaction and how it will meet the important public need for continued access to care in eastern Connecticut.

II. Background

ECHN has been committed to providing high-quality, compassionate health care to the communities of eastern Connecticut for over one hundred (100) years. Manchester Memorial

and Rockville General Hospitals, Woodlake at Tolland, Visiting Nurse and Health Services of Connecticut, as well as our dozens of affiliates and joint venture companies, are anchors in the regions we serve. Our goal in entering into the proposed transaction with Prospect is to ensure continued local access to care for years to come.

As Dr. O'Neill mentioned, recent regulatory and market changes have challenged the continued financial viability of ECHN as a stand-alone health system. Reduced reimbursement, increased taxes, and increased capital requirements have all combined to put many community hospitals in financial jeopardy. ECHN is no different. In fact, ECHN has lost more than $9 million over the last fifteen (15) years and often operated at a loss. In addition, as a result of pension funding reforms that came at a time when the market crashed in 2008, ECHN's pension liability has grown dramatically. Although various expense reduction efforts have been put in place since I joined ECHN eleven (11) years ago, debt service and pension contributions consume a large portion of ECHN's annual cash flow making capital investments difficult.

Recent increases to the Connecticut hospital tax and reductions in state payments to hospitals have exacerbated an already difficult situation. This is compounded by the announcement on March 2, 2016 that supplemental pool payments will be suspended and that additional Medicaid payments are unlikely to be made during the remainder of the state's fiscal year.

While the recent cuts were not anticipated, the adoption of the Patient Protection and Affordable Care Act in 2010 set the stage for a new era of health care delivery. ECHN proactively considered the changes being introduced, evaluated their potential impact on ECHN, and determined after an informed review, assisted by consultants and legal counsel, that affiliation with a larger system is the best way to ensure continuation of its mission.

Although an initial transaction with VHS Eastern Connecticut, LLC ("VHS") could not be consummated, we are excited about the opportunities that an affiliation with Prospect will provide. Dr. O'Neill outlined in some detail the process that ECHN went through to choose Prospect as an affiliation partner; I'd like to highlight some key terms of the transaction and why they satisfy the regulatory requirements for approval by the Office of the Attorney General and Office of Health Care Access.

III. Benefits of Proposed Transaction

The salient terms of the proposed transaction with Prospect are described in detail in our application. Some key highlights include:

- The consummation of the transaction will permit ECHN to satisfy all of its outstanding debt.

- Any funds remaining after payment of liabilities and completion of a wind-down of operations will be transferred to a new charitable foundation which will ensure that the funds will continue to be used in furtherance of charitable health care purposes and to support and promote health care generally in the communities traditionally served by ECHN.

- For at least three (3) years, Prospect will continue to operate both Manchester Memorial Hospital and Rockville General Hospital as acute care hospitals. Each hospital will have a local advisory board that will permit continued community involvement in operations.

- Prospect will offer employment to substantially all employees of ECHN and its affiliates. It will also assume ECHN's pension obligations to employees.

- Existing union contracts, medical education relationships and ownership in post-acute providers will be maintained.

- Prospect will commit to spend not less than $75,000,000 on capital items at ECHN over five (5) years.

- Prospect will ensure that each hospital maintains and adheres to ECHN's current policies regarding charity care, indigent care, community volunteer services and community benefits (or adopts other policies that are at least as favorable to the community as ECHN's current policies).

Importantly, consummation of the proposed transaction will enable ECHN to move from a small health care system to a fully integrated health care system that offers resources, systems,

and efficiencies which are essential for long term success in the evolving health care marketplace. Prospect will bring the strength of its Coordinated Regional Care model (described in more detail in Prospect's testimony) to the service area of ECHN and provide innovation that ECHN could not possibly provide independently. This model will provide opportunities for collaboration among hospitals, physicians and other providers in the region in new value-based purchasing programs offered by payors. From a resource perspective, Prospect's capital commitments and better access to the capital markets will ensure ongoing investment in hospital operations. In addition, the ability to participate with Prospect's other hospitals in group purchasing will create economies of scale. This, combined with the fact that with ECHN's current debt will be paid and pension liabilities assumed, will better position ECHN financially on a going-forward basis. In simple terms, Prospect's financial strength and health care experience will ensure continued access to care at a local level with the backing of a national health system.

IV. Public Need and Satisfaction of Regulatory Requirements for Approval

As Dr. O'Neill outlined, ECHN has exercised due diligence in determining to enter into the proposed transaction with Prospect and to ensure that charitable assets are preserved as required by the Conversion Act (C.G.S. §19a-486 et seq.). In addition, as detailed in our application, the proposed transaction satisfies the requirements for approval by the Office of Health Care Access as set forth in C.G.S. §19a-486d and C.G.S. §19a-639. A brief summary is set forth below:

A. The Purchaser Has Made a Commitment to Provide Health Care to the Uninsured and the Underinsured (C.G.S. §19a-486d(a)(1)).

As set forth above, Prospect has agreed to ensure that each hospital maintains and adheres to ECHN's current policies regarding charity care, indigent care, community volunteer services and community benefits (or adopts other policies that are at least as favorable to the community as ECHN's current policies). As such, health care for the uninsured and underinsured will continue and access to care for our neediest populations will be preserved.

B. Health Care Providers or Insurers Will Not Be Offered the Opportunity to Invest or Own an Interest in the Purchaser or Entity Related to the Purchaser (C.G.S. §19a-486d(a)(2)).

No health care provider or insurer will be offered the opportunity to invest or own an interest in Prospect or any Prospect affiliate as part of this transaction. In the event that any health care provider or insurer has such an opportunity in the future, Prospect has committed to adopting policies to manage and avoid any conflicts of interest in patient referrals.

C. The Proposed Transaction is Consistent With Applicable Policies and Standards adopted in Regulations by the Department of Public Health (C.G.S. §19a-639(a)(1)).

We understand that the Office of Health Care Access is in the process of establishing its policies and standards as regulations, but that the process is not yet complete. The Office of Health Care Access has, however, adopted various procedural standards in Connecticut Agencies Regulations §§19a-613-1 through 19a-653-4 and has issued an information Certificate of Need Application Guide. ECHN and Prospect have worked to ensure that all procedural requirements have been fulfilled.

D. The Proposed Transaction is Consistent with the Overall Goals of the Statewide Health Care Facilities and Service Plan (C.G.S. §19a-639(a)(2)).

The Office of Health Care Access first published its Statewide Health Care Facilities and Services Plan (the "Plan") in October of 2012 and supplemented it in 2014. Section 1.4 of the Guiding Principles of the Plan states: "The goal of [the Office of Health Care Access]'s planning and regulation activities is to improve the health of Connecticut's residents; increase the accessibility, continuity and quality of health services; prevent unnecessary duplication of health resources; and provide financial stability and cost containment of health care services." The Plan specifically acknowledges that hospital mergers, affiliations and acquisitions are anticipated as a response to major changes in the way health care is delivered and financed. (Plan at pp. 7-8, Sec. 1.8.5).

The proposed affiliation with Prospect will aid ECHN and its provider affiliates to benefit from economies of scale when purchasing supplies and services, sharing of best practices, and will also improve access to capital. This will allow ECHN to make capital investments and

reinvestments in its facilities, equipment, and in medical and information technology to support needed programs and services for patients. These investments will in turn allow ECHN to attract and retain physicians and providers needed to serve its communities. All of this will ensure continued access to primary care, acute care and post-acute care in the communities currently served by ECHN and, as such, is consistent with the overall goals of the Statewide Health Care Facilities and Service Plan.

E. There is a Clear Public Need for the Proposed Transaction ((C.G.S. §19a-639(a)(3)).

As stated above, ECHN has been caring for the community for over one hundred (100) years. Its services cover the continuum from primary care, to home health, to skilled nursing, to acute hospital services. In fact, in 2015:

- 114,000 individuals were treated at ECHN's hospitals;
- 60,000 patients were cared for by community-based physicians employed by ECHN;
- Almost 5,000 patients were cared for at home by Visiting Nurse and Health Services of Connecticut;
- Over 800 patients received homemaker and companion services;
- Numerous patients received behavioral health services; and
- ECHN's hospitals provided emergency care over 61,000 visits.

It is clear from the statistics that ECHN serves a critical need in the community. The proposed transaction will ensure that this need continues to be met and that services remain available in the local community.

Unfortunately, as ECHN has established in its application and related filings, regulatory and financial changes are expected to continue to present challenges to continued viability as an independent health system. If the proposed transaction is not consummated, continued services will be put in jeopardy. Consummation of the transaction will, however, result in an ECHN that

is relieved of its current and significant debt obligations and that has access, through Prospect, to capital needed to enhance and improve care offerings. In addition, implementation of Prospect's Coordinated Regional Care model will permit the ECHN facilities and providers to participate in evolving reimbursement models, providing continued and enhanced access to care. In short, without a strong affiliation partner, ECHN will likely not remain financially solvent and access to care and local jobs will be on the line. The consummation of the proposed transaction, however, will preserve access to care in eastern Connecticut, meeting a clear and established public need.

F. The Proposed Transaction is Financially Feasible (C.G.S. §19a-639(a)(4)).

The Proposed Transaction will result in a stronger and more financially secure ECHN. The purchase price to be paid by Prospect will permit ECHN to pay its debts, including its outstanding bonds and commercial loans. Prospect will also assume ECHN's pension liabilities. This, combined with economies of scale and purchasing power as part of a broader network will better position ECHN to handle the new regulatory and financial reality for community hospitals today.

In addition, Prospect's capital commitments will permit significant capital improvements over the next several years to the infrastructure of the hospitals. Further, implementation of Prospect's Coordinated Regional Care model will offer ECHN facilities access to resources, systems, and efficiencies which are essential for long term success in the evolving health care marketplace.

As Prospect will testify in more detail, Prospect is financially stable and prepared to commit to continued care in the ECHN community.

G. The Proposed Transaction Will Improve Quality, Accessibility and Cost Effectiveness of Health Care Delivery in the Region, Including for Medicaid Recipients and Indigent Persons (C.G.S. §19a-639(a)(5)).

As detailed in the application, the proposed transaction will ensure continued access to care for the residents of eastern Connecticut. Prospect has committed to maintaining Manchester Memorial Hospital and Rockville General Hospitals as acute care hospitals for at least three (3) years post-closing and to also maintain post-acute care services for the same time period.

Through implementation of its innovative Coordinated Regional Care model, quality care will be maintained in a cost-effective manner and ECHN will be poised to participate in newly evolving reimbursement models. And because Prospect has committed to continued charity care and to continued participation in Medicaid, Medicaid recipients and indigent persons will be assured of access to needed services.

H. ECHN's and Prospect's Past and Proposed Provision of Health Care Services to Relevant Patient Populations, Including Medicaid Recipients and Indigent Persons Support Approval of the Transaction (C.G.S. §19a-639(a)(6)).

Prospect has committed to maintaining services for Medicaid recipients and to charity care policies for uninsured and underinsured patients at least as favorable as those currently in place at ECHN. Patient access for all will be maintained and there is no anticipated change in the payor mix as a result of the proposed transaction.

I. ECHN and Prospect Have Satisfactorily Identified the Population to be Served by the Proposed Project and Satisfactorily Demonstrated that the Identified Population has a need for the Proposed Services (C.G.S. §19a-639(a)(7)) and Have Established Sufficient Utilization Statistics (C.G.S. §19a-639(a)(8)).

In the application, ECHN and Prospect have identified the population to be served and submitted volume statistics establishing that ECHN serves a significant number of patients each year. Approval of the proposed transaction will ensure that these services remain available to the community.

J. ECHN and Prospect Have Satisfactorily Demonstrated that the Proposed Transaction Will Not Result in an Unnecessary Duplication of Existing or Approved Health Care Services or Facilities (C.G.S. §19a-639(a)(9)).

The proposed transaction will preserve existing services and will not establish unnecessary duplication. Prospect's Coordinated Regional Care model promotes efficiency by aligning physician interests with the efficient and effective delivery of healthcare, and offering a full continuum of non-acute services in the hospitals' service areas. The goal of this model is to ensure that patients receive appropriate care, at the appropriate time, in the appropriate setting, while avoiding unnecessary, inefficient and duplicative services and reducing medical errors.

K. The Proposed Transaction Will Not Reduce Access to Services by Medicaid Recipients or Indigent Persons (C.G.S. §19a-639(a)(10)).

As referenced above, there are no proposed changes to the current payor mix as a result of this proposed transaction. Services to Medicaid recipients and to indigent persons will be maintained. Charity care will be available on the same, or more favorable, terms as they are currently.

L. The Proposed Transaction Will Not Negatively Impact the Diversity of Health Care Providers and Patient Choice in the Geographic Region (C.G.S. §19a-639(a)(11)).

The proposed transaction will not negatively impact the diversity of health care providers and patient choice in eastern Connecticut. Prospect does not currently have operations in Connecticut, so the addition of Prospect to the market will enhance diversity and patient choice.

M. Consolidation Resulting from the Proposal Will Not Adversely Affect Health Care Costs or Accessibility to Care (C.G.S. §19a-639(a)(12)).

The proposed transaction will not result in any new consolidation, but will preserve current services. As Prospect implements its Coordinated Regional Care model, patient care will be better coordinated and provided in a cost-efficient manner.

As summarized above and as described in significant detail in the application, the applicable regulatory requirements have been satisfied and we urge the agencies to permit the proposed transaction to proceed.[1]

V. Conclusion

Our Board has carefully considered the future of ECHN and believes the reasons to join another system are clear. This affiliation with Prospect will provide needed capital and expertise to allow ECHN to adapt to new health care models of care. Most importantly, it will ensure access to critical health care services to all who reside in eastern Connecticut, including the uninsured and underinsured.

[1] Because the application in this proceeding was filed before December 1, 2015, the provisions of subsections (d) and (e) of C.G.S. §19a-639 are not applicable and are not, therefore, addressed here.

ECHN firmly believes that this transaction with Prospect will allow us to continue to fulfill our mission, all in the public's best interest. It will protect the accessibility and affordability of care for our community, while continuing our focus on the quality and safety of patient care. This will support our efforts to continuously improve patients' satisfaction and enable us to reinvest in programs, technology and facilities for the benefit of our patients.

Thank you again for the opportunity to testify in support of ECHN's application to transfer its assets to Prospect.

STATE OF CONNECTICUT

OFFICE OF THE ATTORNEY GENERAL

AND

DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

Attorney General Docket No.: 15-486-01
OHCA Docket No.: 15-32016-486
Eastern Connecticut Health Network, Inc.
Proposed Asset Purchase by Prospect
Medical Holdings, Inc.

March 23, 2016

Prefile Testimony of Joy Dorin
Vice Chair, Board of Trustees
Chair, Transaction Committee
Eastern Connecticut Health Network, Inc.

I. Introduction

Good afternoon. My name is Joy Dorin and I am the Vice Chair of the Eastern Connecticut Health Network, Inc. ("ECHN") board of trustees (the "Board"). I also serve as Chair of the Transaction Committee which performed a detailed evaluation of the options for the future of ECHN and recommended that we move forward with an acquisition by Prospect Medical Holdings, Inc. ("Prospect").

Dr. O'Neill has outlined for you the significance of this transaction to ECHN and has described the thorough review process that the Board has undertaken in making the decision to partner with a larger health system, in selecting Prospect as that partner, and in negotiating a fair and appropriate deal. Peter Karl has explained in detail how the transaction will ensure the future of ECHN and meet the critical public need for continued access to care for the residents of eastern Connecticut. I would like to take a few minutes to outline for you our focus on quality of care and ensuring a continued focus on quality care for patients in our communities into the future.

II. Background

I received my undergraduate degree in Economics from Elmira College, a Masters in Business Administration from Fairleigh Dickinson University and a Masters in Public Health from the University of Connecticut.

In my professional life I have served in various leadership roles at health care insurers and providers including Cigna Healthplan and Athena Healthcare. In those roles, I have had a long history of involvement in and responsibility for quality and compliance matters, including tracking utilization metrics and satisfaction measures. I also assisted Qualidigm, the state's Quality Improvement Organization, in its work with participating hospitals, visiting nurse organizations, long term care facilities and provider groups in implementing various Center for Medicare and Medicaid ("CMS") quality of care initiatives.

In addition to my professional and educational background, I am a long-time resident of Manchester – nearly 40 years. Although I was born and raised in New Jersey, I consider Manchester my home. This is where my friends live, my son and his young family live and my husband owns a small business. I mention my Manchester roots because ensuring ECHN's future is important to me and it's important to the community.

III. Quality Review

As the Transaction Committee reviewed potential transactions and potential partners, quality of care was of utmost concern. As part of the request for proposal ("RFP") process, ECHN requested comparative quality information for all of its potential acquirers and did a side by side comparison of the quality indicators developed and officially approved by CMS. During the vetting process, ECHN also visited hospitals owned by the potential acquirers and met with staff members involved in quality and performance improvement matters. ECHN staff visited Prospect hospitals in California and in Rhode Island to obtain additional, first-hand information on Prospect's commitment to quality. As these efforts indicate, ECHN expressly considered quality indicators as an important factor when selecting Prospect as a transaction partner.

Hospitals are highly complex regulated organizations and sometimes, despite the best intentions and focus on care, issues arise. Quality improvement is, by definition, a continuous

process. During the regulatory approval process, Prospect brought to ECHN's attention that hospitals under two (2) of Prospect's California licenses had encountered regulatory issues. Upon learning this, the EHCN Board determined that it needed more information and appointed a Quality Evaluation Team to look into it thoroughly and report its findings back to the Board. I was named to the Quality Evaluation Team and was joined by Michele B. Conlon, MD, a member of ECHN's Board who is the Chair of its Performance Assessment and Improvement Committee and a practicing physician in the ECHN community; Linda Quirici, ECHN's Vice President of Quality & Safety; and Linda Stuermer and Diane Hassman, ECHN's Quality Improvement Managers. Over a period of weeks, the Quality Evaluation Team assembled the relevant facts and then worked closely with the Transaction Committee and counsel to evaluate whether those facts called into question Prospect's appropriateness as a transaction partner.

In looking into Prospect's regulatory issues, the Quality Evaluation Team reviewed the most recent accreditation surveys and CMS regulatory surveys that exist for every hospital owned by Prospect. The goal of this review was to determine whether those survey results revealed systemic problems suggesting that Prospect might be an unreliable steward of ECHN from a quality and patient safety perspective. Thus, the team looked to see if the surveys identified unremediated patterns of deficiency, persistent issues with patient care, or remediation plans lacking a demonstrable commitment to improve once issues had been identified. Going beyond the regulatory surveys, the team also looked retrospectively at Quality Assessment and Performance Improvement Indicators for the hospitals throughout the Prospect system, and also looked prospectively at the hospitals' 2016 Quality Assessment and Performance Improvement Plans for 2016. Based on the information we reviewed, we generated a series of follow-up clarifying questions and additional information requests to Prospect, and reviewed those responses in turn. Members of the team also visited Prospect's CharterCARE hospitals in Rhode Island to observe and evaluate the quality, patient safety and environment of care standards there in person. Throughout the process Prospect made its information and personnel fully available to assist us in our review. A representative from Prospect will provide more information on these issues and their corrective action plans, but we concluded that Prospect has taken the matter and swiftly took corrective actions. We have been reassured by the commitment to quality and to continued improvement that we observed at all levels.

After discussing these recent issues with Prospect, reviewing the corrective action plans, and meeting with quality personnel at various Prospect hospitals, including in California and Rhode Island, the Quality Evaluation Team concluded that the recent compliance issues present isolated challenges that Prospect has demonstrated a strong commitment to remediate through corrective actions that are already in progress. The Quality Evaluation Team reported this conclusion to the Transaction Committee. Based on the information presented the Transaction Committee deliberated and concluded that it remains appropriate to recommend Prospect as the best partner for ECHN. After hearing the results of the Quality Evaluation Team's fact finding review and assessment, along with the Transaction Committee's recommendation, the ECHN Board has confirmed its commitment to proceed with the transaction, and remains confident that Prospect is committed to quality improvement and to ensuring quality care in each of its communities.

IV. Future Quality Assurance at ECHN

ECHN's current quality team is exceptional. In fact, ECHN is proud to have both our hospitals, Manchester Memorial and Rockville General Hospitals named as a "2014 Top Performer on Key Quality Measures" by the Joint Commission. Our ECHN hospitals are two of only nine Connecticut hospitals (out of 30 hospitals in Connecticut) to achieve this award. In addition, only 1,043 hospitals out of more than 3,300 eligible hospitals in the United States achieved this distinction based on excellence in accountability measurement performance. Prospect and ECHN are committed to ensuring that this history of quality continues.

Prospect's business model is to support significant local oversight over operations, including quality. As such, the current ECHN quality team will continue its work to ensure quality operations in eastern Connecticut. In addition, it is anticipated that the Prospect "Eastern Region," including Prospect's hospitals in Connecticut and Rhode Island, will collaborate on quality measures that are expected to be implemented in Prospect's hospital's across the country. ECHN looks forward to this collaboration, as we have learned from our onsite visits to Rhode Island that there are a number of opportunities to learn and share best practices in both directions.

Thank you for your time today. I am available to answer any questions you may have.

DEPARTMENT OF PUBLIC HEALTH OFFICE OF HEALTH CARE ACCESS	:	**DOCKET NO. 15-32016-486**
OFFICE OF THE ATTORNEY GENERAL	:	**DOCKET NO. 15-486-01**
IN RE: EASTERN CONNECTICUT HEALTH NETWORK, INC. – PROPOSED ASSET PURCHASE BY PROSPECT MEDICAL HOLDINGS, INC.	:	**March 23, 2016**

PRE-FILED TESTIMONY OF VON CROCKETT

I. Introduction

My name is Von Crockett and I am the Senior Vice President of Corporate Development at Prospect Medical Holdings Inc. ("PMH"). I am here today to speak in support of the conversion application (the "Application") regarding the proposed acquisition of assets of Eastern Connecticut Health Network ("ECHN"), including Manchester Memorial Hospital ("MMH") and Rockville General Hospital ("RGH"), by PMH. Specifically, I will address how PMH's operational resources and industry know-how will benefit ECHN.

Professional Background

Prior to my appointment as Senior Vice President of Corporate Development at PMH, I served as the Chief Executive Officer of Southern California Hospital at Culver City from 2009 to 2012. Prior to joining Southern California Hospital at Culver City, I held various positions in the health care industry including, but not limited to, President and Chief Executive Officer of Centinela Hospital Medical Center in Los Angeles, California; System Chief Operating Officer of Centinela Freeman Health System in Los Angeles, California; Chief Operating Officer and then the Chief Executive Officer for Doctors Medical Center San Pablo/Pinole in San Pablo,

California; Chief Financial Officer of Sutter Healthcare in Antioch, California; and Chief Financial Officer of Sharp Chula Vista Medical Center in San Diego, California.

Summary of PMH's Operations

PMH owns and operates fourteen (14) acute care and behavioral hospitals around the country in various markets. PMH also owns a network of specialty and primary care clinics in each of its regions. Through PMH's medical group segment, PMH manages the provision of physician services to approximately 300,000 patients in Southern California, South Central Texas and Rhode Island through a network of primary care physicians and specialists.

My remarks today will address how PMH's operational resources and strengths are beneficial to ECHN and support the approval of the Application through PMH's (i) quality assurance and performance improvement, (ii) successful track record with healthcare operations; (iii) ability to achieve operational efficiencies; (iv) collaboration with the local board on community insight and needs ("Local Board"); (v) allocation of resources for building comprehensive networks of care; (vi) commitment to engaging in community health needs assessments; and (v) licensure experience.

II. Quality Assurance and Performance Improvement

PMH is dedicated to providing quality care and is continually aiming to improve quality and performance. PMH strives for the best patient outcomes while maintaining high standards of patient safety. Due to certain events (discussed below), PMH has significantly modified its Quality Assurance and Performance Improvement (QAPI) oversight over its network of hospitals. Historically PMH relied on local management and the local advisory boards to provide reports and make requests for resources as necessary with respect to each hospital's QAPI. However, PMH has now hired the following positions at a corporate level:

A. Chief Quality Officer;

B. Chief Clinical Officer;

C. Corporate Chief Nursing Officer; and

D. Associate Vice President of Regulatory and Patient Safety.

The collective duties of these new corporate level officers are to:

1. Monitor the activity and quality programs at all hospitals (including all adopted recommendations by the local advisory boards);
2. Assist in providing necessary resources to implement all quality programs at local hospitals;
3. Assist in providing necessary resources to address corrective action plans in the event that quality goals are not met by the local hospitals;
4. Assist in survey readiness; and
5. Assist in sharing of best practices among all local hospitals.

The increase in corporate oversight over QAPI resulted from recent surveys at PMH's California hospitals that resulted in Immediate Jeopardy status at two of its hospitals. At Los Angeles Community Hospital, an Immediate Jeopardy status citation was issued by CMS due to physician misconduct. A corrective action plan was submitted and a re-survey was conducted. PMH is awaiting the results of the re-survey. At Southern California Hospital At Culver City, two Immediate Jeopardy citations were issued on account of (i) temperature and humidity issues primarily in the operating rooms; and (ii) sterilization of surgical products. Corrective actions plans have been submitted and PMH is awaiting a re-survey by the appropriate authorities.

In response to the Immediate Jeopardy citations, PMH has taken swift action including but not limited to increasing its oversight of QAPI at its network of hospitals, as well as retaining

a nationally recognized consulting firm to conduct a review of the operations and all policies and procedures in California. Based on the recommendations of the consulting firm, PMH has implemented a number of changes in the policies and procedures as well as the operations of its Southern California Hospitals.

PMH has agreed to maintain the respective quality program and goals of Manchester Memorial Hospital and Rockville General Hospital for a period of two years following the transaction. PMH is also committed to provide the necessary staff to support such quality programs. Finally, PMH agrees to share the best practices at its other facilities with the ECHN hospitals.

III. PMH Has a Successful Track Record

PMH has measureable success in all of its acquired hospitals. PMH has a successful track record operating fourteen (14) hospitals in different states for close to a decade. Many of these facilities were financially distressed when acquired by PMH. PMH has never abandoned or closed a hospital that it has purchased. PMH's management team has years of experience in operating community hospitals. PMH even purchased a closed hospital in California and re-opened it. PMH's hospital operations were established in August 2007 with the acquisition of Alta Hospitals System, LLC, a system of four community-based hospitals in Southern California with a combined 339 licensed beds. PMH's experience and know-how in operating hospitals, especially hospitals with financial distress at acquisition, will benefit the ECHN community.

In addition to its operational expertise with hospitals, PMH has thirty (30) years' experience operating and supporting independent physician practice associations (IPAs) under risk-based arrangements with payors in California. PMH has successfully engaged insurers and developed partnerships that result in a full range of risk contracts. PMH manages the provision

of healthcare services to approximately 260,000 members through its network of over 8,900 primary care physicians and specialists. Its hospitals manage the care of 30,000 capitated Medicaid beneficiaries. This experience allows PMH to bring its process knowledge and experience to build and operate health systems to Connecticut.

PMH has been successful in implementing its Coordinated Regional Care ("CRC") model at all of its hospitals. Successful implementation of CRC has brought coordination of care across its hospitals and all providers in its network and is a key to PMH's operational success. My colleague, Dr. Lew, will speak to the specific elements and the achievements of CRC.

PMH has been successful in embracing health care reform measures. PMH is on the forefront of health care reform measures and has the operational resources to integrate such measures into health systems. To align with health care reform, PMH and its affiliated medical groups and hospitals collaborate closely in partnership with health plans to give patients and their families highly coordinated, personalized care. PMH's experience in embracing health care reform will provide the post-transaction health system the ability to adjust to a rapidly changing healthcare delivery environment and improve care coordination.

PMH's know-how derived from its past and current operational success in health care systems and hospitals across the country will benefit the ECHN community and ensure the sustainability of the health system in the service area.

IV. PMH Will Bring Beneficial Operational Efficiencies to ECHN

PMH will bring valuable operational efficiencies to the post-transaction health system. PMH hospitals benefit from PMH's years of experience in hospital ownership and PMH's economies of scale. Affiliation with PMH will offer ECHN economies of scale that include: (i) purchasing power and (ii) supply chain benefits, (iii) employee benefits savings, and (iv)

streamlined revenue collection, among other value added initiatives that will reduce the cost of operations. As with all of its hospitals and affiliated entities, PMH expects to implement cost and clinical efficiencies over time utilizing a planned and coordinated approach. The cost savings to operations will improve finances and help ensure the sustainability of the post-transaction health system well into the future.

Through PMH's economies of scale, the hospitals will enjoy higher discounts for supplies and drugs as part of a larger organization in the first year. Subsequently, the hospitals will be entitled to discounts and pricing through better compliance with purchasing protocols. It should be noted that by affiliating with a larger organization, the post-transaction health system will benefit from economies of scale due to PMH's overall purchasing power. The post-transaction health system will realize benefits in lower supply costs, drug costs and costs related to consultants.

Additionally, costs to provide fringe benefits will decrease in the first full year of operation because PMH is essentially self-insured for providing benefits. Self-insured benefits save on the profit portion of the premium generally paid to third parties in order to provide fringe benefits to employees. Furthermore, the operational resources of PMH will be made available to develop and implement strategic plans, whereas in the past, ECHN may have employed outside consultants to aid in such efforts. Also, revenue collection will be streamlined through PMH's system.

PMH has realized numerous efficiencies at all its hospitals. Examples include the elimination of rental expenses of beds, pumps, ventilators and other equipment at Southern California hospitals by purchasing the items, reduced registry use through proper hiring and management of registry utilization process, development of staffing matrix for all Southern

California hospitals and implementation of real-time monitoring of labor standard adherence. PMH has leveraged surgical volumes and practice standardization to reduce implant pricing. PMH has also implemented pharmacy cost reduction strategies such as auto-substitutions and Group Purchase Organization pricing at all hospitals. PMH will bring operational efficiencies to the ECHN system that result in cost savings.

In today's health care landscape, PMH's operational efficiencies are critical to meeting the requirements of health care reform measures. PMH's operational efficiencies are necessary to improving the financial viability of ECHN to ensure the sustainability of the post-transaction health system.

V. PMH's Utilization of a Local Board

PMH's operational strategy for ECHN includes the use of a Local Board to achieve provider and community insight into health system operations and community needs. Following the closing, MMH and RGH will each maintain a Local Board made up of community representatives, physicians on the Hospital's medical staff, and the Chief Executive Officer of the respective Hospital. The Local Board will serve as a resource to PMH with respect to the investment of capital, assisting with maintenance and implementation of a strategic business plan for the hospitals, making recommendations for medical staff credentialing and quality assurance programs as well as assisting with issues relating to accreditation for the hospitals.

Use of a Local Board results in a delivery model which engages the local community and strengthens the health system, and provider and community alignment. PMH's commitment to including these local advisors into operational discussions ensures that the community values are understood and the community needs are recognized.

VI. PMH's Operational Resources Will Aid in Building Comprehensive Networks of Care

PMH's operational resources, including the proprietary CRC model, will benefit the post-transaction health system by aiding in the integration and expansion of the post-transaction health system's network of providers, as well as its program offerings beyond what can be done by ECHN alone. PMH's operational strategy, as implemented through CRC and other measures, has led to stronger integration with provider affiliates to coordinate care. It has also improved the overall health of the population and enhanced the standard of care for its patients. PMH will implement these operational resources in the ECHN health system.

First, PMH utilizes its operational resources and CRC model to build regional networks with its hospitals and medical groups that contribute to the entire continuum of care. Collaboration with PMH, though the implementation of its CRC model, provides an environment that aligns ECHN's physicians and other providers across the continuum of care, provides access to evidence-based practices to improve quality and patient safety, enhances efficiency through uniform productivity and financial management, and develops integrated information systems. PMH focuses on the management of patients with challenging chronic medical conditions in order to keep patients well in the most appropriate care setting. By utilizing appropriate care settings and resources and managing chronic care patients, PMH avoids unnecessary, inefficient and duplicative services and reduces medical errors which result in improved quality, efficiency and cost savings. My colleague, Dr. Lew, will discuss the CRC model in more depth and the results it has achieved within PMH operated health systems.

Further, the PMH approach to care coordination through the pursuit of delegated risk-based contracts aligns incentives across all healthcare stakeholders. Through collaboration with

healthcare payors, PMH is able to further integrate care delivery among providers and regionalize the health care delivery system in the service area. PMH is also better equipped to more effectively identify patients at risk and build upon existing initiatives. PMH's experience in obtaining these risk-based contracts will benefit the post-transaction health system and provide new incentives for care coordination.

Lastly, PMH has developed and implemented high intensity care management programs that integrate behavioral and physical health capabilities to effectively manage the care of patients with significant co-morbidities in all of its hospitals. PMH will bring this capability to the ECHN system along with other resources to meet health care reform requirements. PMH is committed to succeed in new value-based performance delivery model and has the ability to share best practices among its member hospitals to reduce readmissions. In addition, PMH will work with the medical staff of the hospitals on clinical quality matters to share best practices and establish clinical quality goals and measure progress.

In sum, PMH's operational resources will be beneficial to the post-transaction health system because it will develop regionalized coordinated care systems, enter into risk-based contracts that promote cost effective quality care and integrate PMH's high intensity care management programs.

VII. Community Health Needs Assessment.

PMH specializes in building comprehensive networks of quality healthcare services designed to meet the needs of the specific community. PMH's goal is to best serve the healthcare needs of both the communities in which PMH currently operates and of the communities in other states where PMH seeks to grow. It should be noted that PMH has never been required to conduct a formal Community Health Needs Assessment post-conversion or

acquisition of a nonprofit hospital. Instead, PMH relies on the recommendations of the local advisory boards (which are comprised of local physicians and local community leaders) to make recommendations regarding the health services needs of the community and required investments in technology. Furthermore, PMH's focus on preventative medicine and population health management enable PMH's local hospitals to address the health needs of its communities. Even though PMH maintains a proven track record of meeting the needs of the communities it serves without formal Community Health Needs Assessments, PMH is committed to conducting a Community Health Needs Assessment at ECHN over the next two years and to implement the recommendations of such study as deemed necessary and appropriate. It is PMH's intention to involve the Local Board in the assessment process as a way to facilitate public input and to publicly disseminate, via the website or other means, the final assessments and implementation plans.

VIII. License Consolidation

PMH has substantial experience in consolidating licenses of hospitals. However, there are no plans to combine the licenses at Manchester Hospital and Rockville Hospital.

IX. Conclusion

PMH's vast operational experience, resources and strategies will greatly benefit the post-transaction health system beyond what ECHN can do today. PMH's successful track record, its ability to achieve operational efficiencies, the use of Local Boards to serve as a resource for community insight, and PMH's ability to build comprehensive networks of care are all examples of PMH's valued added operational expertise. Without experienced operational resources, hospitals cannot meet the increasing burdens required to be competitive in today's healthcare environment. PMH has the strategic and operational ability that will directly benefit ECHN and

the community it serves. For all of the foregoing reasons, we respectfully request that the Attorney General and the Department of Public Health division of the Office of Healthcare Access approve this Application.

Thank you for your time and I welcome any questions.

DEPARTMENT OF PUBLIC HEALTH OFFICE OF HEALTH CARE ACCESS	:	**DOCKET NO. 15-32016-486**
OFFICE OF THE ATTORNEY GENERAL	:	**DOCKET NO. 15-486-01**
IN RE: EASTERN CONNECTICUT HEALTH NETWORK, INC. – PROPOSED ASSET PURCHASE BY PROSPECT MEDICAL HOLDINGS, INC.	:	**March 23, 2016**

PRE-FILED TESTIMONY OF MITCHELL LEW, M.D.

I. Introduction

My name is Dr. Mitchell Lew and I am the President of Prospect Medical Holdings Inc. ("PMH"). I am here today to speak in support of the conversion application (the "Application") regarding the proposed acquisition of assets of Eastern Connecticut Health Network ("ECHN"), including Manchester Memorial Hospital ("MMH") and Rockville General Hospital ("RGH"), by PMH. Specifically, I will address PMH's proprietary Coordinated Regional Care ("CRC") model and its ability to drive significant improvement in healthcare to the ECHN community.

Professional Role

In my role as President of PMH, I oversee PMH in its efforts to integrate our regional delivery systems among physicians, hospitals and payors. This includes the development, implementation and oversight of PMH's CRC delivery systems in each of its regional markets. Prior to my current role, I served as CEO of Prospect Medical Systems and Prospect Medical Group, our management service organization and independent practice association, respectively.

Summary of PMH and CRC

PMH is a healthcare services company that owns and operates numerous health care systems across the nation working to benefit patients who access healthcare in our service areas.

PMH aligns its hospitals and physicians under a model referred to as the CRC model. CRC provides clinical integration among hospitals, physicians and other medical, social and community providers and works closely with health plans and other payors under a value-based, global risk reimbursement payment system. The goal is to achieve the triple aim of improved patient care and experience, better patient health, and lower costs.

Although PMH has not adopted a standard business plan for all markets, PMH approaches each market by implementing three (3) simultaneous work streams. The three work streams are: (i) regulatory infrastructure; (ii) provider network development; and (iii) health plan engagement. The first work stream involves investigating and developing the regulatory infrastructure necessary in order for providers to assume and manage value-based risk contracts with health plans. The second work stream is provider network development which entails identifying participating providers and establishing the provider network, which may include the use of a Preferred Provider Network ("PPN") required under law and preferred by health plans. A critical component of this work stream is the development of an independent practice association ("IPA") affiliated with the health system. The third work stream is health plan engagement which involves close collaboration and contracting with health insurers.

The Connecticut marketplace is in a current state of flux and it was imperative for ECHN's viability that PMH use its resources to commence CRC implementation efforts in eastern Connecticut, including review of regulatory requirements, formation of an IPA entity, preliminary discussions with payors and evaluation of the care delivery network. PMH has formed an IPA called Prospect Provider Group CT-ECHN, LLC ("PPGCTE"), which will be the IPA affiliated with the post transaction health system. PMH is currently developing the participation agreements for PPGCTE and has begun contracting with ECHN-affiliated

physicians. PMH has also established a risk-taking entity called Prospect Health Services CT, Inc. Prospect Health Services CT, Inc. received its license to transact business as a PPN from the Connecticut Insurance Commissioner on October 21, 2015. PMH has also had preliminary discussions with major payors in Connecticut to introduce the CRC model. PMH is optimistic that the discussions will result in most payors embracing the skills and expertise that PMH brings to the Connecticut market in its CRC model.

My remarks today will address how PMH's CRC business model will be beneficial to ECHN and supports the approval of the Application through (i) aligning physicians, hospitals, payors, community providers and all healthcare stakeholders; (ii) improving quality, (iii) improving efficiency, (iii) reducing costs, (iv) embracing health care reform, and (v) building comprehensive networks of care.

II. Community Benefits of the Transaction

Prospect's acquisition of ECHN will enable ECHN to remain an economically viable and vibrant part of the health care system in the communities served by ECHN and is expected to provide many benefits to patients. First, ECHN will no longer have a third party debt service obligations. Therefore, ECHN will be in a better position to re-invest in its facilities and equipment.

Furthermore, ECHN will gain immediate access to PMH's experience and knowledge in implementing a population health management model that will prepare ECHN to accept value-based contracts with government and third party payers with the triple aim of improved patient care and experience, better patient health, and lower costs.

Finally, as discussed in Section VIII, below, through the implementation of the CRC model, ECHN will invest in both expansion of access and services to its surrounding communities.

III. CRC Aligns Physicians and Hospitals

The CRC model offers a critical benefit to the post transaction health system by fostering the alignment of physicians and hospitals. The CRC model utilizes meaningful collaboration of the medical staff and the community to provide better coordination of care. Along with the other hospital systems operated by PMH, MMH and RGH will realize many benefits from this physician/hospital alignment including increased physician involvement in governance, ability to accommodate various physician preferences for employment and affiliation, and ability to attract and retain physicians, including specialty physicians.

The alignment of physicians and hospitals under the CRC model includes physicians maintaining central roles in administration and overseeing the development of needed health services and oversight of the quality of care delivered to patients. In addition to stronger leadership and governance opportunities encouraged by the implementation of CRC, physicians will be supported with CRC care management programs to effectively manage patients' health needs.

The post transaction health system will benefit from PMH's status as a physician friendly company and, as part of the CRC model, PMH's aim to accommodate physicians' preferences for practicing medicine. PMH recognizances that some physicians prefer to be employed, some wish to remain independent but seek a hospital environment where independent physicians are valued, and others prefer to remain independent but work on a contracted or other basis in hospital-based clinics. PMH is able to provide the full range of options to physicians under the

CRC model. As a result, PMH is able to attract and align both employed and independent physicians with the health system and the payor community. The CRC model is attractive for its physician alignment strategies, such as physician participation in an IPA or physician-hospital organization, hospital-based clinics staffed by independent contractor physicians, and opportunities to implement pay-for-performance compensation arrangements which incentivize quality, patient satisfaction and better patient outcomes.

Additionally, the use of the CRC model improves PMH's ability to attract and retain physicians, including certain types of specialty physicians, to a community hospital setting that a community hospital may not be able to attract on its own. Under the guidance of the CRC model, PMH has been successful in recruiting physicians, including the most recent success in establishing an IPA in Rhode Island with 105 primary care practitioners and 270 specialist physicians. Of the 105 primary care practitioners in Rhode Island, only 18 were previously employed by the CharterCare System prior to its acquisition by PMH. The CRC model brings significant value to physicians because of PMH's experience and success with risk-based payment arrangements that continue to expand and replace the fee-for-service payment system. By implementing risk-based payment arrangements, all providers are more aligned to improve quality and achieve better patient outcomes all while maintaining efficiencies and cost savings.

The CRC model has been highly successful in aligning physicians with PMH hospitals and improving quality and efficiency in California, and local versions of the model have been implemented in Texas and Rhode Island with similar success. PMH's historical achievement with the CRC model supports PMH's successful implementation in the RGH and MMH service areas.

Because the CRC model emphasizes physician engagement and is adaptive to all forms of physician participation, the CRC model is poised to better align physicians with hospitals than the traditional models now in place. By achieving such alignment, PMH and the post-transaction hospitals will include physician governance and ability to accommodate various physician preferences, as well as attract and retain specialty physicians.

IV. CRC Improves Quality

The aim of the CRC model is to offer patients highly coordinated, personalized care so they can live healthier lives. As the CRC model is implemented in a health system, patients experience improved quality care.

CRC improves quality by utilizing disease and care management programs, ensuring availability of urgent care, and utilizing case management across the continuum. All of the programs will enhance quality at the post transaction health system. For example, PMH will employ the CRC model to create programs to identify patients with significant co-morbidities and then design comprehensive medical and psychosocial high intensity care management services for their care.

The CRC model also promotes quality by building and managing a tightly integrated, coordinated health care system. For example, physician integration between practices and facilities improves communication between providers, patients and institutions; creates universal best practices, standards and metrics; and improves patient access to ancillary services. PMH has received recognition for its quality. I refer you to page 93 of the Application for a summary of PMH's quality awards.

CRC improves quality because the model focuses on providing patients coordinated and personalized care to improve health. Enhanced quality of care is accomplished by utilizing

health management programs, encouraging treatment at appropriate facilities and building integrated systems to improve care coordination.

V. CRC Improves Efficiency

The CRC model also promotes the efficient operation of hospitals and provider groups by aligning physician interests with the delivery of cost effective quality healthcare. One of the goals of CRC is to reduce the overall cost of healthcare by increasing preventative care and early interventions, reducing re-admissions, reducing inpatient utilization and reducing emergency room visits. CRC promotes physician incentives and focuses on promoting coordination and establishing payor relationships that incentivize efficiency.

The implementation of CRC involves rewarding physicians for positive quality outcomes, not output, via shared savings and pay-for-performance standards and benchmarks. These CRC physician incentives have proved effective in Southern California, Texas and Rhode Island - PMH has demonstrated improved clinical outcomes, higher quality scores, higher patient satisfaction, lower re-admission rates, lower average lengths of stay, and lower medical-cost ratios. Bringing CRC to the post transaction health system will involve the implementation of successful CRC best practices regarding efficiency that have been established among its member hospitals to reduce readmissions. CRC also enhances efficiency through uniform productivity and financial management. PMH expects to see similar success in the ECHN service area with the implementation of CRC efficiency efforts.

CRC involves the utilization of resources, systems, and efficiencies which are essential for long term success in the evolving health care marketplace. In order to offer high value health care (and participate in the emerging value-based payment models to provide cost efficient care) CRC focuses on establishing new relationships among providers across the continuum of care.

Essentially, the appropriate level of care must be provided at the right time by the correct provider. To achieve this, CRC methods include, but are not limited to: (i) development and management of an advanced, comprehensive care continuum delivery network; (ii) population health management with the identification of those patients requiring high intensity care and sophisticated care management programs; (iii) actuarial and health economics data analytics; and (iv) integrated information technology.

Overall, the CRC model promotes efficiency through its development of a coordinated system and through physician incentives to utilize PMH's coordinated system in the most effective and efficient manner while keeping the focus on quality.

VI. CRC Embraces Health Care Reform Changes

Implementation of the CRC model allows a hospital or provider group to rebuild and retool itself for the new world of accountable health care delivery. The new model of health care is one that is evolving from federal mandates, changes in health care technology, patient demands, need for cost-containment, and evolving reimbursement models with are moving from volume to value, where providers will no longer be paid strictly on the volume of patients they treat, but on the value of the healthcare they provide. The CRC model offers flexibility to adjust to health care reform and the post-transaction system will benefit from the experience PMH has in implementing and running the CRC model.

Health care reform requires physicians, hospitals and other health care providers to work together, ensuring that all caregivers in a healthcare system align themselves with the patient's wellbeing as the focus. The post transaction health system, under the CRC model, will be able to continuously develop and adjust to new methods of reimbursement and savings due to flexibility built within the model that allows for various forms of provider integration. Because CRC

embraces health care reform changes, opportunities to further integrate care delivery among providers and regionalize the health care delivery system in the MMH and RGH service areas will be realized. In line with health care reform, PMH has developed and implemented high intensity care management programs within its CRC model that integrate behavioral and physical health capabilities to effectively manage the care of patients with significant co-morbidities. The result is identification of patients at risk and building upon existing initiatives already put into action within ECHN's system.

Additionally, PMH's experience in implementing CRC will better enable ECHN to meet the health care reform requirements of the Patient Protection and Affordable Care Act. For example, PMH dedicates resources (and keeps an open dialogue with payors) to ensure that its CRC efforts are reflective and integrative of the latest payor programs. This allows hospitals and provider groups to quickly adjust to the changing healthcare delivery environment. PMH has thirty (30) years' experience operating provider groups, such as IPAs, and working with health care insurers and will bring that experience to ECHN. PMH also has invaluable experience through its operation of hospitals and medical management organizations which will be applied to the post transaction health system.

In sum, CRC embraces health care reform because the CRC model is adaptable to the changing health care environment and PMH management has the experience and ability that result in successful healthcare systems.

VII. CRC Reduces Costs

PMH does not anticipate any increase in costs to patients or insurers as a result of this transaction. PMH plans to assume ECHN's health plan contracts and through the implementation of CRC will add value and reduce costs. Implementing the CRC model requires

the participation in evolving risk-based payment environment. As such, the CRC model will enable ECHN to be successful with new risk-based payment systems and care delivery models that reward value-based care, achieving the best outcomes for patients at lower costs.

Health systems need to ensure efficient use of their assets to maintain a positive financial position and remain competitive. CRC achieves financial performance success by incentivizing physicians and patients to appropriately use urgent cares centers and to keep patients compliant with various homebound and other wellness programs. The result is keeping patients healthier while reducing the over-utilization of healthcare services. By utilizing appropriate care settings and resources, and managing chronic care patients, PMH avoids unnecessary, inefficient and duplicative services; and reduces medical errors which result in improved efficiency and cost savings. By implementing CRC in the post transaction health system, the cost of healthcare will be reduced for all healthcare stakeholders.

VIII. CRC Builds Comprehensive Care Networks

The application of CRC results in the establishment of comprehensive care networks. ECHN's implementation of the CRC model will provide a comprehensive care network by evaluating and promoting the management of care across a complete continuum in order to deliver services in the right place at the right time, aligning ECHN's physicians and other providers across this continuum of care, and developing integrated information systems.

As part of the CRC implementation process, PMH reviews the services offered by its systems and seeks to enhance or expand services. Such enhancements start with the development of primary care and specialty practices and the expansion of ambulatory offerings. These services provide more effective and resourceful alternatives to emergency room and hospital-based surgery. Further, CRC necessitates the management of patients with challenging

chronic medical conditions, and keeps patients well in the appropriate care settings. By utilizing appropriate care settings and resources and managing chronic care patients, PMH avoids unnecessary, inefficient and duplicative services and reduces medical errors which result in improved efficiency and cost savings.

The implementation of CRC will integrate and expand the ECHN's current network of providers and program offerings beyond what can be done currently by ECHN. Examples of development activities in Texas include: formation of a multi-specialty IPA; increasing behavioral health service capacity; expansion of hospital-based outpatient clinics; purchase of a rural hospital resulting in increased access to care; establishment of an emergency room; and leasing and converting additional space for expansion of services. In Rhode Island, PMH has accomplished the following: established an IPA with over 400 physicians, established a risk taking entity to accept delegation of health plan risk, purchased 28 primary care clinics, expanding access to care; joint ventured on a radiation-oncology center; expanded cardiac catheterization services, and worked closely with the Governor to launch a Medicaid pilot program. California is a mature market for PMH. More recent efforts to improve access to services in California include the following: purchasing a closed hospital in south Orange County (which PMH reopened in September 2015) to better serve patients who are members of PMH's owned or managed IPAs; and purchasing primary care and multi-specialty clinics to increase access to care. All of the above are examples of service line expansions and improving access to care. PMH will be able to achieve better care coordination of care for the ECHN community with the implementation of CRC.

CRC aligns ECHN's physicians and other providers across the continuum of care. The implementation of CRC improves the overall health of, and enhances the standard of care for, its

patients. CRC encourages providers to be more clinically integrated with other care givers and enables patients to receive the right care, with the highest levels of quality, in the most appropriate care setting. Through the development of the CRC and the attainment of these objectives, PMH will be successful in reducing unnecessary re-admissions, inpatient utilization, and emergency room visits which will translate into improved outcomes and lower health care costs for patients in the ECHN service area. For example, from 2012 to 2014 in California and Texas where PMH participates in HMO contracts for seniors, PMH has reduced hospital beds days per thousand from 1,260 to 720. Length of hospital stay for this population has been reduced from 5.1 days to 3.9 days, admissions per thousand have dropped from 245 per thousand to 182 per thousand and hospital readmissions within thirty days have dropped from 19% to 13%.

Lastly, CRC involves the development of integrated information systems and best practices to ensure that patient care is coordinated across many levels of care. By introducing CRC, PMH provides access to its evidence-based practices aimed at improving quality and patient safety. In its development of the post transaction health system, PMH will partner with the medical staff to address gaps in care and services to ensure the effective management of all patients across the network.

When CRC is implemented across a health care system, it involves the review of the levels of care offered and the development of any gaps in care, the coordination and alignment of providers across the system and the development and utilization of integrated information systems and best practices. All result in better quality outcomes for patients in a cost effective delivery system.

IX. Conclusion

PMH's vision for Connecticut is to develop and maintain quality-driven hospitals with a robust network of aligned providers operating within its CRC platform. PMH's success in developing its CRC model comes by way of (i) aligning physicians and the hospitals, (ii) improving quality, (iii) improving efficiency, (iii) reducing costs, (iv) embracing health care reform, and (v) building comprehensive care networks. The success of the CRC model in California, Texas and Rhode Island supports that there is a quantifiable benefit for implementing the CRC model in the ECHN service area. This proven success and projected success within ECHN from implementation of the CRC model supports the approval of the Application.

Thank you for your time and I welcome any questions.

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OFFICE OF THE ATTORNEY GENERAL	:	**DOCKET NO. 15-486-01**
IN RE: EASTERN CONNECTICUT HEALTH NETWORK, INC. – PROPOSED ASSET PURCHASE BY PROSPECT MEDICAL HOLDINGS, INC.	:	**March 23, 2016**

PRE-FILED TESTIMONY OF JONATHAN SPEES

I. Introduction

My name is Jonathan Spees and I am the Senior Vice President of Mergers and Acquisitions at Prospect Medical Holdings, Inc. ("PMH"). I am here today to speak in support of the conversion application (the "Application") and the proposed acquisition of assets of Eastern Connecticut Health Network ("ECHN"), including Manchester Memorial Hospital ("MMH") and Rockville General Hospital ("RGH"), by PMH. Specifically, I will address how PMH's financial resources and healthcare expertise will benefit ECHN.

Professional Background

I currently hold the position of Senior Vice President of Mergers and Acquisitions for PMH. Previously, I was Senior Vice President with The Camden Group, where I was a National practice leader for mergers, acquisitions and affiliations. Prior to The Camden Group, I was Chief Financial Officer for the University of Southern California's Keck Hospital of USC and USC Norris Cancer Hospital. I have also held positions as Senior Executive Vice President, Corporate Development and Finance, and a Founder of Merit Health Systems, LLC, a hospital management company; Managing Member of Abacus Ventures, LLC, and Managing Director of Shamrock Investments, LLC (both private investment and investment banking firms specializing

in corporate finance and mergers and acquisitions in the healthcare industry); Associate Director of Corporate Development for American Medical International; and audit manager and designated healthcare industry specialist for Deloitte Haskins +Sells, one of the eight largest public accounting firms worldwide at that time. I am also a Certified Public Accountant. I refer you to page 1834 of the Application for further detail regarding my credentials.

Summary of PMH

PMH is a $1.3 billion dollar healthcare services company that owns and operates fourteen (14) acute care and behavioral hospitals in Rhode Island, Texas, California and (with the closing of our transaction with East Orange General Hospital on March 1, 2016) New Jersey. In addition, PMH has executed a definitive agreement to purchase a hospital system in Pennsylvania. PMH maintains or is developing a robust network of specialty and primary care clinics in each of its regions.

Summary of Financial Benefits

My remarks today will address how PMH's financial resources and industry know-how are beneficial to ECHN and support approval of the Application through (i) putting the post-transaction health system in a positive financial position; (ii) adding stability to the healthcare community; and (iii) allowing the post-transaction health system to build a comprehensive network of care.

II. PMH Will Put ECHN in a Positive Financial Position

PMH has successfully restored the financial position of many health systems by applying its data-driven, disciplined operating strategies, leveraging its corporate capabilities, and investing in growth. Since 2001, ECHN's financial condition has been strained. As a result, capital investments have been deferred and long-term debt and pension liabilities continue to

grow. Pension funding reforms and the market crash in 2008 exacerbated ECHN's already fragile financial condition. Hiring and wage freezes, reductions in workforce, a permanently reduced workweek of 37.5 hours, LEAN program initiatives and group purchasing initiatives were all instituted to respond to ECHN's financial challenges. Despite these measures, a large portion of ECHN's annual cash flow was required to fund debt service and pension obligations, making capital investments difficult. As a result, necessary infrastructure improvements continued to be deferred, as were plans to expand and introduce new programs to help recruit physicians to replace those who were relocating or retiring. Recent health care reform measures, decreasing reimbursement and increased hospital taxes have also added financial stress to ECHN. Even with these setbacks, PMH desires to move forward with the proposed transaction and anticipates a positive financial position for the post-transaction health system. Not only will the cash financial position be improved, PMH's investments in the physical plant and equipment increase the value of the post-transaction health system assets. More importantly, Prospect's proven ability to develop coordinated regional systems of care will position ECHN to thrive in an environment where the reimbursement model changes from fee-for-service to value-based payments.

III. Financial Security Offered by PMH Provides Stability and Support for the Needs of the Community and its Access to Health Care

The financial security that PMH will bring to the post-transaction health system will resonate through the community. A positive financial position and growth of ECHN's delivery network will allow the post-transaction health system to offer increased levels of employment that are critical to the local economy. RGH and MMH are large employers in their respective

communities and, as such, the financial success of the hospitals leads to a more financially secure community.

Prospect has agreed to operate both Manchester Memorial Hospital and Rockville General Hospital as acute care hospitals. Each hospital will have a local advisory board that will permit continued community involvement in operations. Additionally, PMH has agreed to maintain and adhere to ECHN's current policies regarding charity care and indigent care, or adopt other policies that are at least as favorable to the community as ECHN's current policies – which are generally comparable to charity care policies at PMH's other hospitals (as determined by local leadership at such hospitals). PMH's ability to successfully operate the post-transaction health system and thus continue to offer charity care at current levels provides a positive community benefit for indigent and needy populations in the service area. Furthermore, PMH's Coordinated Regional Care model of population health management and preventative medicine will result in more access to outpatient care.

Regarding PMH's history of community benefit, a number of PMH hospitals are "safety-net hospitals." In fact, PMH is a member of Private Essential Access Community Hospitals ("PEACH"). PEACH is a network of private, core safety net hospitals in California that care for disproportionate share or low income, medically vulnerable patients. PMH intends to bring this spirit of community support and benefit to RGH and MMH.

Further, the financial security offered by PMH results in the continued support of community building activities in the Manchester/Rockville area. In accordance with the provisions of the APA, PMH will commit to spend within five years of the closing not less than $75,000,000 in capital for the benefit of the health system. These expenditures may include: (i) capital projects, such as routine and non-routine capital expenditures for the improvement of

facilities; (ii) development, expansion, or acquisition of a department, program, service or facility; (iii) upgrades or renovations generally; (iv) deferred maintenance items; and (v) capital expended in support of the recruitment of the Hospitals' medical staff located in the hospitals' service area. PMH's investments in the post-transaction health system provide financial security and support to the community by way of continued employment and facility upgrades.

IV. PMH's Financial Resources Will Aid the Post-Transaction Health System in Building Comprehensive Networks of Care

PMH's financial position will enable the post-transaction health system to have access to resources for the purpose of integrating and expanding the network of providers and program offerings beyond what exists today. Fostering an environment that aligns physicians and other providers across the continuum of care provides access to evidence-based practices to improve quality and patient safety, enhances efficiency through uniform productivity and financial management, and develops integrated information systems. PMH has access to the financial resources required to develop stronger integration with provider affiliates to coordinate care, create new access points by expanding outpatient services, improve the overall population health and enhance the standard of care for its patients. Our care model actually lowers overall healthcare costs by keeping people healthy, providing care more efficiently, reducing unnecessary hospitalizations, and providing needed care in the right setting at the right time. My colleague, Dr. Mitchell Lew, will discuss in detail PMH's Coordinated Regional Care model which, when successfully implemented, lowers the overall cost of healthcare for consumers, insurers and government payers versus traditional fee-for-service models.

Stand-alone providers have special challenges containing costs while delivering quality care. Without the appropriate financial resources that a national system provides, independent

providers struggle to be both effective and efficient. ECHN has had difficulty recruiting and retaining providers to ECHN's service area. PMH has the financial ability to make the necessary investments in infrastructure and personnel to establish the continuum of care needed to develop a highly integrated and successful health system.

V. Conclusion

The approval of the conversion application and proposed transaction will (i) put ECHN in a positive financial position; (ii) allow PMH's investments in the post-transaction health system to provide financial security and support to the community, and (iii) enable the post-transaction health system to have access to resources for the purpose of integrating and expanding the network of providers and program offerings beyond what exists today.

Thank you for your time and I welcome any questions.

DEPARTMENT OF PUBLIC HEALTH OFFICE OF HEALTH CARE ACCESS	:	**DOCKET NO. 15-32016-486**
OFFICE OF THE ATTORNEY GENERAL	:	**DOCKET NO. 15-486-01**
IN RE: EASTERN CONNECTICUT HEALTH NETWORK, INC. – PROPOSED ASSET PURCHASE BY PROSPECT MEDICAL HOLDINGS, INC.	:	**March 23, 2016**

PRE-FILED TESTIMONY OF STEVEN ALEMAN

I. Introduction

My name is Steve Aleman and I am the Chief Financial Officer of Prospect Medical Holdings, Inc. ("PMH"). I am here today to speak in support of the conversion application (the "Application") and the proposed acquisition of assets of Eastern Connecticut Health Network ("ECHN"), including Manchester Memorial Hospital ("MMH") and Rockville General Hospital ("RGH"), by PMH. Specifically, I will address PMH's financial strength and the benefits of PMH financial resources to ECHN.

Professional Background

I currently hold the position of Chief Financial Officer for PMH. Since 2009, I have served in various capacities at PMH including: Vice President of Corporate Development, Chief Financial Officer at Brotman Medical Center; and Vice President Internal Audit at PMH. Prior to my employment at PMH I was employed at Wellpoint Health Networks, Inc. ("Wellpoint") for ten years in various capacities. My last position at Wellpoint was Staff Vice President, Corporate Risk and Assurance. I am also a Certified Public Accountant.

Summary of PMH

PMH is a $1.3 billion dollar healthcare services company that owns and operates fourteen (14) acute care and behavioral hospitals in Rhode Island, Texas, California and (with the closing of our transaction with East Orange General Hospital on March 1, 2016) New Jersey. In addition, PMH has executed a definitive agreement to purchase a hospital system in Pennsylvania. PMH maintains or is developing a robust network of specialty and primary care outpatient centers in each of its regions.

Summary of Financial Benefits

My remarks today will address how PMH's financial resources and industry know-how are beneficial to ECHN and support approval of the Application through (i) PMH's ability to fund the transaction and ECHN's debts and obligations; and (ii) improving the post-transaction health system's access to capital.

II. PMH Has the Financial Ability to Fund the Transaction

PMH has a proven record of financial success and is able to fund the transaction, allowing ECHN to fully satisfy its increasing debts and discharge its obligations as outlined in the Asset Purchase Agreement ("APA"). It is noteworthy that, as the result of our proposed transaction, nearly $75 million of ECHN's outstanding debt will be paid, freeing the hospital from annual debt service payments of over $9 million. This will allow future income generated from operations of the health system to be invested in equipment, technology, infrastructure, and expansion of health care services, rather than retirement of debt.

PMH is a $1.3 billion healthcare organization and has the financial capacity to provide the capital necessary for this transaction without the need to enter into transaction-specific financing arrangements. PMH has access to existing corporate level credit in addition to its cash

on hand. There is no financing contingency with respect to this transaction. The Applicants anticipate that this acquisition (after giving effect for the assumption of liabilities), will be funded with its existing cash. PMH has agreed to and has the financial capacity to assume and fund certain of ECHN's debts and obligations; specifically, ECHN's mounting pension liability. The unfunded pension liabilities are estimated to be at least $64,000,000 at the time of closing. PMH's post-closing guarantee of this pension obligation adds substantial additional security to the participants of the pension plan beyond what currently exists with ECHN as a stand-alone entity, and assures that all current and former employees of ECHN will receive their full pension benefit.

In sum, PMH can fund the transaction without any associated risk.

III. PMH Improves ECHN's Access to Capital

PMH has access to capital that will make the necessary investments and improvements in ECHN possible. PMH's access to capital includes its favorable credit lines and access to capital markets that will provide the necessary funding for ECHN's facilities.

PMH's access to capital includes a revolving line of credit with Morgan Stanley that has been preapproved and can fund the capital commitment amount in the APA. In order to draw on this line, PMH simply provides a 24-hour advance verbal notice to the lenders. PMH's excellent relationship with creditors will provide needed access to capital that ECHN does not currently maintain. This comes at a critical time as ECHN has experienced trouble obtaining financing and access to capital has impeded the expansion of programs. ECHN's capital needs are significant and necessary in order to offer the latest technology to be a competitive facility in the health care service area and perform needed physical plant renovations. Significant investments

are also necessary for ECHN to develop new competencies, process skills and knowledge, and upgrade electronic medical record systems.

PMH has access to capital and will be investing the resources needed. PMH's access to capital markets that are not currently available to ECHN provides easier and quicker access to funding for replacements and upgrades to systems and infrastructure of the facilities. Capital needs at MMH and RGH are significant and cannot be met with current avenues available to ECHN for funding. Such investments include upgrades in technology in order to improve the collection and documentation of information and increase the availability of data for critical treatment decisions for patients; upgrades to the medical equipment and enhancements to provide patients access to state-of-the-art technology for their diagnosis, care and treatment; and program development to attract and retain physicians to the communities served. Without access to capital that PMH will provide, such upgrades and enhancement at ECHN will have to be delayed or even deferred.

PMH's access to capital will provide the essential financial resources that ECHN has not been able to obtain on its own.

IV. Conclusion

In sum, PMH has a proven record of financial success and is able to fund the transaction as well as ECHN's increasing debts and obligations without placing the post-transaction health system at any unreasonable risk. PMH has access to capital that will help accomplish the needed investments and improvements in ECHN.

Thank you for your time and I welcome any questions.

On February 24, 2016, Eastern Connecticut Health Network ("ECHN") and Prospect Medical Holdings ("PMH" and, together with ECHN, the "Applicants") received correspondence from the Office of the Attorney General ("OAG") and the Office of Health Care Access ("OHCA") requesting written responses to certain issues identified for further discussion at the public hearings to be held in connection with the above-referenced application. The Applicants' responses to the issues identified on February 24, 2016 have been provided below:

1. With respect to PMH's 2014 acquisition of the two CharterCARE hospitals in Rhode Island, Our Lady of Fatima and Roger Williams Medical Center, please describe all PMH achievements in the following areas:

   a. Improvements in care coordination between the two facilities;

   Response:

   Improvements in care coordination between Roger Williams Medical Center and Our Lady of Fatima have been undertaken in the following areas to date:

   - **Consolidation of case management departments resulting in uniform policies of best practices across both hospitals;**
   - **Central intake for all behavioral health patients across both hospitals allowing for coordination of admissions and plans of care;**
   - **Implementation of a single phone number for all services provided by both hospitals;**
   - **Coordinated utilization review between both hospitals; and**
   - **Creation of a joint quality committee which is comprised of members of the advisory boards for both hospitals, as well as clinicians and staff of both hospitals.**

   b. reducing unnecessary redundancies between the two facilities;

   Response:

   The following departments / services have been combined in order to enhance efficiency and to provide consistent services to employees and care to patients:

   - **Combined the Quality departments of the two hospitals;**

- **Combined the Risk departments of the two hospitals;**
- **Combined lab services of the two hospitals;**
- **Combined the Human Resources departments of the two hospitals;**
- **Combined the Safety department of the two hospitals;**
- **Combined the Security department of the two hospitals;**
- **Combined the Diagnostic Imaging services of the two hospitals by have having one Chief of Radiology; and**
- **Combined the Anesthesia services of the two hospitals by have one Chief of Anesthesia.**

c. measureable quality and access improvements at the two facilities.

Response:

There have been measurable quality improvements in the following areas at the two facilities:

a. **Readmission rates;**
b. **C. diff incidence rates; and**
c. **Falls**

Please see Exhibit V for the improvements.

Furthermore, the facilities have completed applications for additional Joint Commission Certification programs in the following areas:

a. **Advance Spine Certification – Our Lady of Fatima Hospital;**
b. **Advance COPD – Roger Williams Medical Center; and**
c. **Blood Management – Roger Williams Medical Center.**

2. Please describe what impact PMH's acquisition of the two CharterCARE hospitals has had on the prices charged to patients and third-party payers at those facilities.

Response:

The acquisition of the two CharterCARE hospitals did not result in any increase in prices charged to patients nor did it result in any increase on the prices charged to third party payers. As part of the transaction, PMH assumed all existing third party payer contracts. Furthermore, PMH did not make any price adjustments to the CharterCARE Charge Description Master.

3. Please describe the benefits realized by patients and payers at the PMH acquired hospitals in California and Texas from any change in pricing structure that occurred at those hospitals in the three years immediately following PMH's acquisition of those hospitals and any benefits from changes in pricing structure that may presently exist.

Response:

There were no changes in the pricing structure of the hospitals acquired by PMH other than (i) changes related to contract rates with third party payers which occur over time in the normal course of business, or (ii) changes in reimbursement as implemented by the Medicare and Medicaid programs.

4. In reference to the revised Exhibit 5 in the December 11, 2015 Response to Deficiencies, PMH's Capital Investments and Cost Savings Table, page 3247, please address the following:

   a. Elaborate on the initiatives that contributed to the decrease in marginal cost and total cost per day at Our Lady of Fatima Hospital, Roger Williams Medical Center and Nix Health System. Indicate if the decline was due to change in patient volume. If yes, explain the decline in volume;

Response:

Reduction in the costs indicated resulted primarily from economies of scale achieved through purchases of supplies, drugs and other items, as well as from following best practices in staffing based on census and acuity levels.

b. For each of the three entities described in 4(a), elaborate on how the financial performance improvements in the areas of Profitability, Liquidity and Solvency translated into lower costs, if any, for the hospitals and their patients;

Response:

Improvements in profitability, liquidity and solvency helped otherwise financially distressed hospitals to stabilize and to continue to provide essential healthcare services to their surrounding communities without sacrificing services provided to the uninsured and the underinsured. The hospitals were able to preserve jobs and to ensure patients continued access to health services.

Furthermore, improvements in profitability, liquidity and solvency, allow the hospitals to re-invest capital to improve the facilities, modernize equipment and expand services. As such, patients benefit from an enhanced patient experience while receiving services. Patients further benefit from additional service offerings.

Finally, such improvements will allow the hospitals to enter into value-based and risk-based contracts with government payers and health plans that may not be optimal for high-cost systems. Such value-based and/or risk based contracts, depending on the design of the plans by the payers, may have lower co-pays and lower deductibles to the patients while improving patient outcomes and the patient experience.

c. For each of the three entities described in 4(a) and 4(b), please complete the following table, as applicable:

Entity	EBITDA			Working Capital			Stockholder's Equity		
	Year prior to acquisition	FY 2014	FY 2015	Year prior to acquisition	FY 2014	FY 2015	Year prior to acquisition	FY 2014	FY 2015

Response:

Please see Exhibit W.

5. Please provide the full Statement of Deficiencies and Plan of Correction pertaining to the California Department of Health ("CDOH") survey completed on November 10, 2015, an excerpt of which is attached at exhibit Q1c-1 to the February 12, 2016 completeness question responses submitted in PMH's proposed asset purchase of Greater Waterbury Health Network, Inc. under OHCA Docket No. 15-32017-486 and Attorney General Docket No. 15-486-02, which has been administratively noticed in this proceeding, and

all correspondence exchanged between Los Angeles Community Hospital and the CDOH concerning MD#6 referenced therein.

Response:

Please see Exhibit X.

6. Please provide the full Statement of Deficiencies and Plan of Correction pertaining to the CDOH survey of Southern California Hospital at Culver City completed on September 25, 2015, an excerpt of which is attached at Exhibit Q1c-2 to the February 12, 2016 completeness questions submitted under OHCA Docket No. 15-32017-486 and Attorney General Docket No. 15-486-02, which has been administratively noticed in this proceeding, and all correspondence exchanged between Southern California Hospital at Culver City concerning the hospital's sterilization and infection control processes described therein.

Response:

Please see Exhibit Y.

7. In reference to Exhibits Q1c-1 and Q1c-2 of the February 12, 2016 submission, please discuss the current status of the Immediate Jeopardy determinations at the Los Angeles Community Hospital and Southern California Hospital at Culver City.

Response:

Each of the Immediate Jeopardy issues have been abated. However, the hospitals are still subject to review. A re-survey was conducted at Los Angeles Community Hospital on February 16, 2016. PMH is awaiting the results of the re-survey. A plan of correction relating to the issues identified at Southern California Hospital at Culver City was submitted to CMS on March 22, 2016. A re-survey will be conducted by CMS after review of the plan of correction.

8. With respect to the Immediate Jeopardy determinations identified in Question 7 above, please discuss ECHN's due diligence after having learned about the Immediate Jeopardy determinations and the conclusions based upon that due diligence.

Response:

For ECHN, considerations of quality and patient safety have been central to its evaluations of potential purchasers throughout the selection process. Therefore, when PMH informed ECHN of the Immediate Jeopardy determinations identified in

Question 7, ECHN concluded that they raised issues of sufficient import to warrant an intensive Board level inquiry. To accomplish this, ECHN's Board Chair appointed two Trustees with backgrounds and expertise in the area of patient quality, patient safety and compliance to investigate the facts and report their findings back to the Board. These two Trustees were the Chair of the Performance Assessment and Improvement Committee (PAIC) who is a practicing physician, and the Board Vice Chair who is also a member of the PAIC along with being the Chair of the ECHN Transaction Committee and a former health care compliance and marketing officer.

ECHN also assigned a management team to assist the Trustees in gathering and vetting the information. This team was composed of Vice President for Quality and Safety and members of the ECHN Quality Department who have expertise in the areas of regulatory surveys, CMS Conditions of Participation and hospital quality standards. The goal of the investigation was to determine whether PMH's experiences in California should give cause for concern that ECHN's current quality and safety standards and its ongoing performance improvement efforts would be threatened once it was acquired by PMH. To accomplish this goal, the quality review team requested, received and reviewed extensive amounts of information from PMH including past regulatory surveys in its hospitals in California, Texas and Rhode Island, its remediation efforts in those hospitals, and its year over year quality metrics and documentation of the quality improvement programs for those hospitals. The quality reviewers focused in particular on the most recent surveys of PMH's hospitals in that these would be the most likely to reveal critical issues or patterns of concern as to the manner in which PMH currently conducts its hospital business in the areas of quality and safety. Given that regulatory standards are applied differently among regions, the quality review team paid special attention to the experiences of PMH's CharterCARE hospitals, Roger Williams Hospital and Our Lady of Fatima Hospital, both of which are located in Providence, Rhode Island and thus are the closest to ECHN geographically. ECHN sent its Quality Department team members to those hospitals for a day-long visit at which all aspects of the CharterCARE quality and safety program were vetted and discussed. The ECHN reviewers found not only that the CharterCARE programs were of high quality but that they had been enhanced in notable positive ways rather than cut back after PMH's acquisition. In addition to these investigatory efforts, the ECHN quality review team requested, and PMH made available, members of PMH's management to be interviewed. They provided extensive detail on the root causes of the Immediate Jeopardy issues in California and the remediation efforts that had been completed or were actively under way to address those issues.

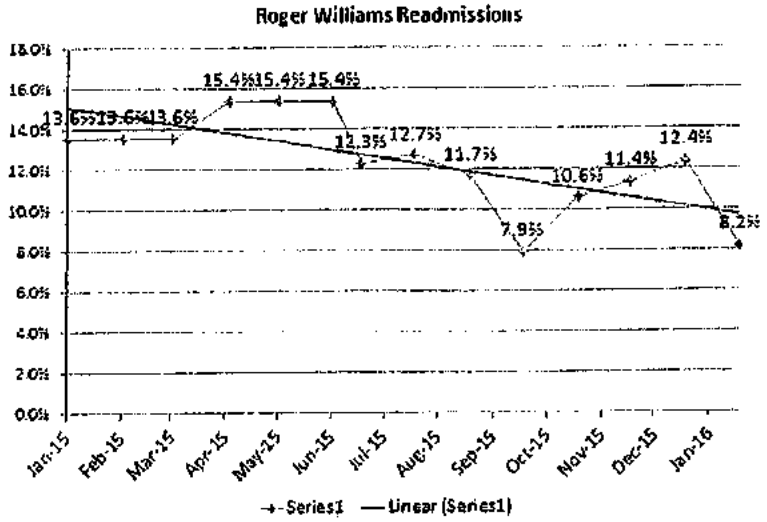
To ensure continuity, transparency and information sharing at the Board Level, the quality review team also met a number of times with the ECHN Board Transaction

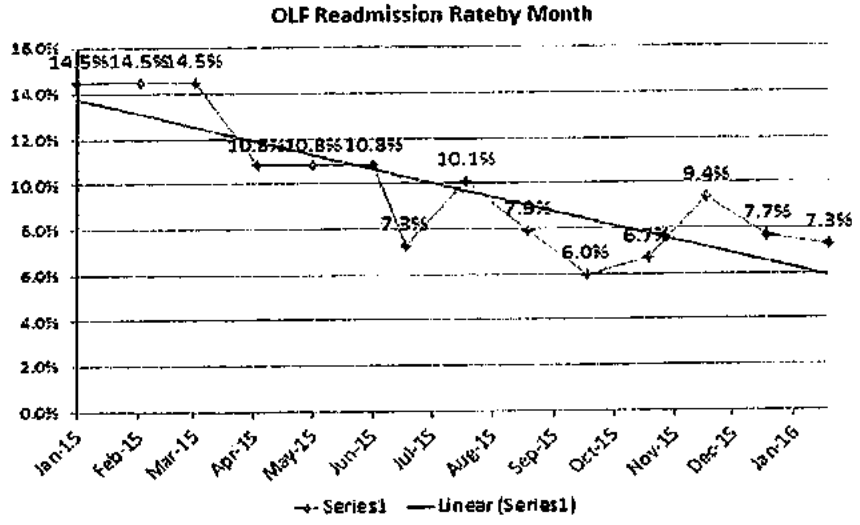
Committee, whose members provided an additional level of analysis and inquiry. The Transaction Committee recommended that ECHN seek a commitment from PMH that ECHN's patient quality, patient experience and safety programs retain their forward momentum for a period of time post-closing. PMH has agreed to continue ECHN's patient quality, patient experience and safety programs and also to facilitate collaboration with other PMH hospitals, including allowing ECHN to benefit from the high quality improvement programs that ECHN's quality reviewers observed at PMH's CharterCARE facilities in Rhode Island. Based on the information learned and the protections gained from this additional commitment from PMH, the Transaction Committee recommended, and the Board confirmed, ECHN's commitment to proceed with the transaction.

EXHIBIT V

Quality and Access Improvements at CharterCARE Hospitals

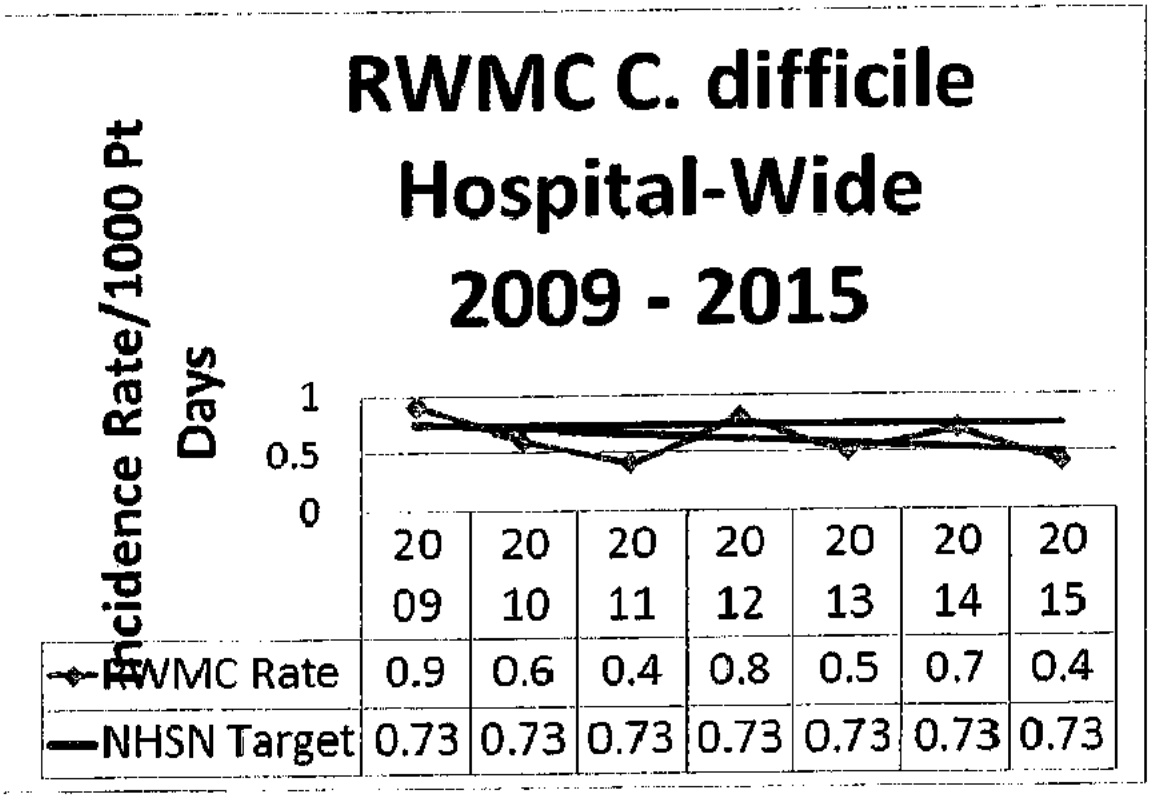
All Cause Readmission Rates (3a)



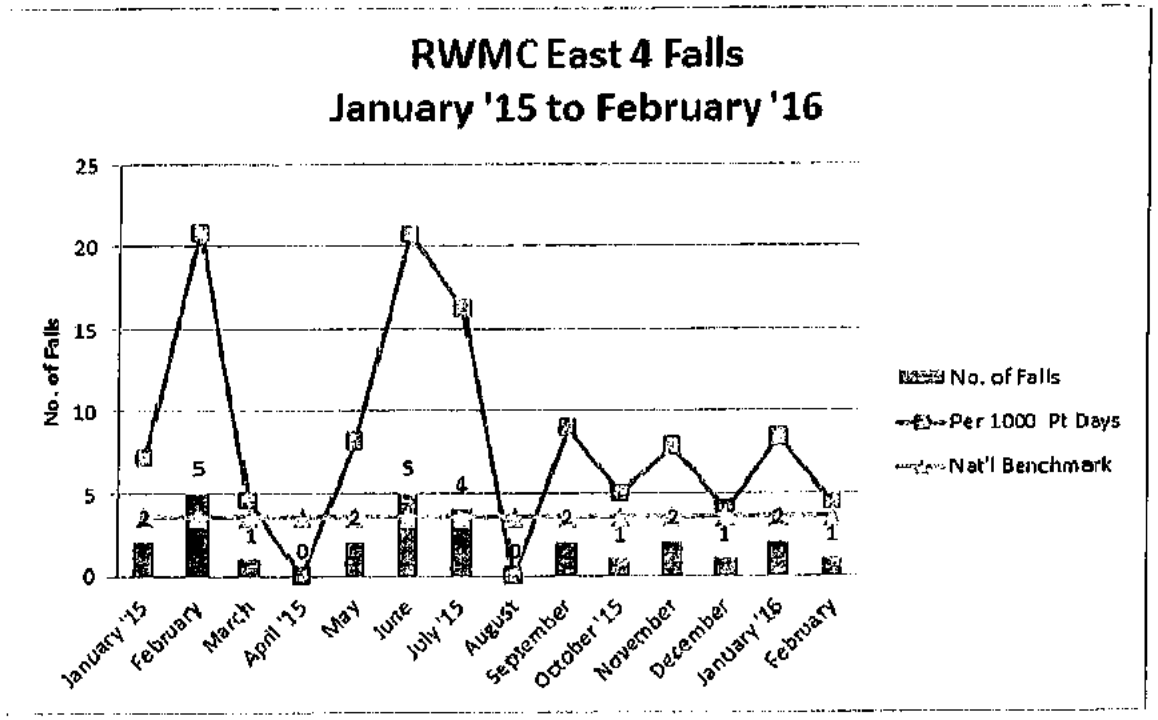


Cdiff Incidence Rate (3b)

OLF HAI	EXECUTIVE SUMMARY MED-SURG UNITS Q4 2015
CDIFF	• Overall SIR BETTER than Nat'l, but not statistically different ➢ Infection Rate BETTER than a year ago • 4 times more Community cases than Hospital-onset • Observed number of actual events is LESS THAN expected Q4 = 2 *dings* from 3rd midnight rule on 2 Pav and 3 Pav



	2009	2010	2011	2012	2013	2014	2015
RWMC Rate	0.9	0.6	0.4	0.8	0.5	0.7	0.4
NHSN Target	0.73	0.73	0.73	0.73	0.73	0.73	0.73


RWMC East 4 Falls
January '15 to February '16
No. of Falls
25
20
15
10
5
0
No. of Falls
Per 1000 Pt Days
Nat'l Benchmark
January '15
February
March
April '15
May
June
July '15
August
September
October '15
November
December
January '16
February

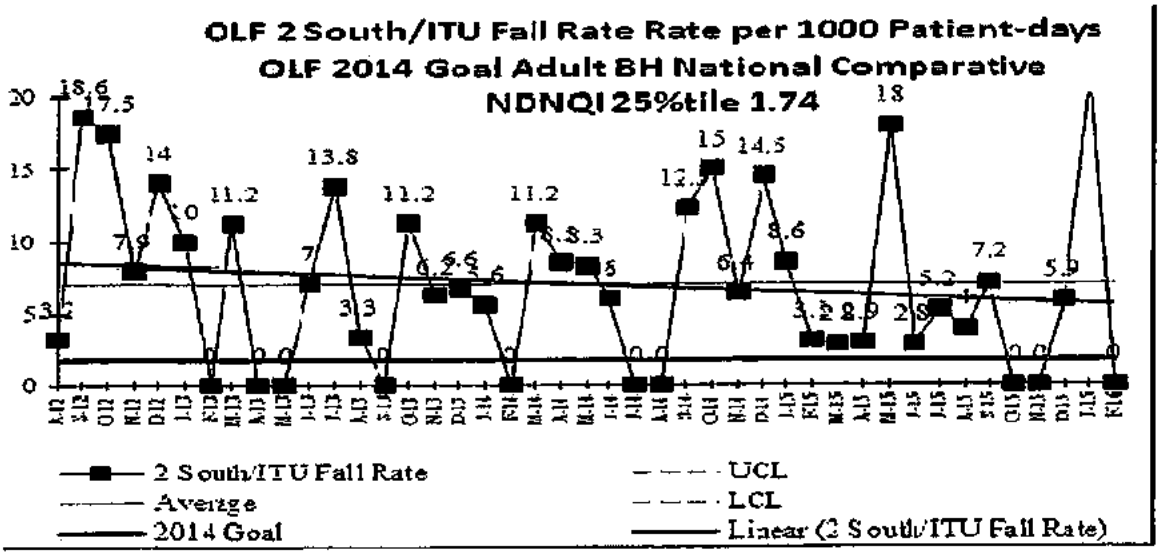

OLF 2 South/ITU Fall Rate Rate per 1000 Patient-days
OLF 2014 Goal Adult BH National Comparative
NDNQI 25%tile 1.74
2 South/ITU Fall Rate
Average
2014 Goal
UCL
LCL
Linear (2 South/ITU Fall Rate)

EXHIBIT W

Table in Response to Question 4c

Question 4c

Entity	EBITDA			Working Capital			Stockholder's Equity			
	Year Prior to Acquisition	FY 2014	FY 2015	Year Prior to Acquisition	FY 2014	FY 2015	Year Prior to Acquisition	FY 2014	FY 2015	
Nix	$ 14,904,666	$ 18,410,889	$ 8,043,349	$ 5,937,385	$ 36,785,183	$ 35,449,130	$ 13,122,391	$ 20,468,235	$ 63,789,134	(a)
Roger Williams Medical Center	$ 3,942,531	$ 1,582,573	$ 9,080,029	$ (1,859,668)	$ 1,114,058	$ 6,229,906	$ 37,183,669	$ 34,098,847	$ 38,256,443	(b)
Our Lady of Fatima Hospital	$ (893,187)	$ 508,563	$ 6,485,338	$ 1,904,480	$ 2,039,870	$ 3,432,993	$ (57,150,507)	$ 27,512,830	$ 28,106,736	(c)

(a) - EBITDA of Nix prior to acquisition is based on reported trailing twelve months ended on 1/31/2011
- Working Capital of Nix prior to acquisition is as of 1/31/2011 and includes cash which was not part of assets acquired by Prospect
- The Working Capital for FY2015 for Nix in 2015 previously reported under Exhibit 37a to first round of completeness questions excluded certain intercompany adjustments. Working Capital reported in this Exhibit is inclusive of intercompany adjustments
- The net benefit of Government supplemental payments in FY2014 was higher than average, while the net benefit of Government Supplemental Payments in FY2015 was below average From an operational perspective, the performance of Nix was slightly better in FY 2015 than FY 2014

(b) - EBITDA for Roger Williams Medical Center for Year Prior to Acquisition is only for 8 months ending on May 31, 2014
- EBITDA for Roger Williams Medical Center for FY2014 is only for three months post acquisition for FYE 9/30/2014
- Working Capital of Roger Williams Medical Center prior to acquisition is as of 5/31/2014 and includes cash which was not part of assets acquired by Prospect
- As Roger Williams Medical Center prior to the acquisition was a non-profit organization, Net Assets are used as a substitute for Stockholder's Equity
- All data reported in Exhibit 37a to first round of completeness questions with respect to Roger Williams were reported on a consolidated basis for the CharterCARE system which includes additional entities other than Roger Williams Medical Center and Our Lady of Fatima Hospital.

(c) - EBITDA for Our Lady of Fatima Hospital for Year Prior to Acquisition is only for 8 months ending on May 31, 2014
- EBITDA for Our Lady of Fatima Hospital for FY2014 is only for three months post acquisition for FYE 9/30/2014
- Working Capital of Our Lady of Fatima Hospital prior to acquisition is as of 5/31/2014 and includes cash which was not part of assets acquired by Prospect
- As Our Lady of Fatima Hospital prior to the acquisition was a non-profit organization, therefore Net Assets are used as a substitute for Stockholder's Equity
- All data reported in Exhibit 37a to first round of completeness questions with respect to Our Lady of Fatima were reported on a consolidated basis for the CharterCARE system which includes additional entities other than Roger Williams Medical Center and Our Lady of Fatima Hospital.

EXHIBIT X

Los Angeles Community Hospital
Statement of Deficiencies and
Plan of Correction

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050663	A. BUILDING _____ B. WING _____	C 11/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOS ANGELES COMMUNITY HOSPITAL	4081 E OLYMPIC BLVD LOS ANGELES, CA 90023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a Complaint Validation survey. Complaint Number: 462024 Representing the Department: 27137, HFEN 30719, HFEN 29618, HFES 32946, HFEN 22711, Medical Consultant Sample size was 26 patients.	A 000	A000 Initial Comments Preparation and execution of this plan of correction does not constitute an admission or agreement of the facts alleged or conclusions set forth on the Statement of Deficiencies. This plan of correction is prepared and executed solely because it is required by federal and state law. The following constitutes Los Angeles Community Hospital's credible allegation of compliance.	
A 043	482.12 GOVERNING BODY There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ... This CONDITION is not met as evidenced by: Based on staff interview and administrative document review, the hospital failed to have a governing body which took full legal responsibility for determining, implementing and monitoring policies to ensure the provision of health care in a safe environment when: 1. No system was in place to ensure the hospital's bylaws governing medical staff membership or the granting of privileges was applied equally to all practitioners: (Refer to A	A 043	A043 482.12 Governing Body The Governing Board has been involved in the development and implementation of this credible allegation of compliance. The Board appreciates that it is ultimately responsible for conduct in the hospital, including ensuring that medical staff procedures and processes are implemented and sustained in accordance with the medial staff bylaws and Medicare Conditions of Participation. Informal discussions and formal meetings have taken place since the survey with various members of the Governing Board and hospital leadership. The Hospital engaged legal counsel and a national healthcare regulatory compliance consulting firm to assist with the credible	2/9/16 1/16/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050003	A. BUILDING _____ B. WING _____	C 11/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOS ANGELES COMMUNITY HOSPITAL	4081 E OLYMPIC BLVD LOS ANGELES, CA 90023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 043	Continued From page 1 0050) a. Four of five members of the medical staff (Medical Doctor (MD) 9, MD 10, MD 11, and MD 12) who had previously been granted privileges were reappointed without being reappraised for competence; b. Two of four provisional members of the medical staff (MD 7 and MD 8) were granted clinical privileges and allowed to practice without being proctored; and, c. One out of a total of one Allied Health Professional (AHP), Physician's Assistant (PA) 13, was granted clinical privileges and allowed to practice without being evaluated for competence on a regular basis. 2. No system was in place to ensure Medical Staff By-Laws, Rules and Regulations were followed and to ensure the medical staff were regularly appraised. There was no means to ensure the medical staff were professionally qualified for the positions to which they were appointed and for the performance of privileges granted. (Refer to A 0340) a. Four of five members of the medical staff (MD 9, MD 10, MD 11, and MD 12) who had previously been granted privileges were reappointed without being reappraised for competence. b. Two of four provisional members of the medical staff (MD 7 and MD 8) were granted clinical privileges and allowed to practice without being proctored; and, c. One out of a total of one AHP, PA 13, was	A 043	allegation of compliance, including correction of the medical staff findings and implementation of improved processes to ensure that practitioner competency and proctoring is maintained in accordance with hospital bylaws. The Chief of Staff resigned, effective 1/31/16 and a new Chief of Staff was nominated by the Medical Executive Committee (MEC) which recommended him to the Governing Board. The Governing Board approved him on 1/27/16. The new Chief of Staff has taken an active role in development and implementation of the credible allegation of compliance. In addition to corrections of the findings for the identified physicians and allied health professional (AHP), the consultants and Medical Staff Team worked collaboratively on reviewing and revising the medical staff bylaws regarding a number of issues identified below. This included revising the Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE) policy and creating a new Peer Review Committee. The Reappointment Evaluation form was reviewed and revised to reflect the current available data for reappointments, including, among other things, practitioner findings on core measures and core competencies (e.g., patient care, medical knowledge, communication, professionalism,	1/31/16 1/27/16 1/18/16 - 1/29/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050693	A. BUILDING _____ B. WING _____	C 11/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOS ANGELES COMMUNITY HOSPITAL	4081 E OLYMPIC BLVD LOS ANGELES, CA 90023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 043	Continued From page 1 0060) a. Four of five members of the medical staff (Medical Doctor [MD] 9, MD 10, MD 11, and MD 12) who had previously been granted privileges were reappointed without being reappraised for competence; b. Two of four provisional members of the medical staff (MD 7 and MD 8) were granted clinical privileges and allowed to practice without being proctored; and, c. One out of a total of one Allied Health Professional (AHP), Physician's Assistant (PA) 13, was granted clinical privileges and allowed to practice without being evaluated for competence on a regular basis. 2. No system was in place to ensure Medical Staff By-Laws, Rules and Regulations were followed and to ensure the medical staff were regularly appraised. There was no means to ensure the medical staff were professionally qualified for the positions to which they were appointed and for the performance of privileges granted. (Refer to A 0340) a. Four of five members of the medical staff (MD 9, MD 10, MD 11, and MD 12) who had previously been granted privileges were reappointed without being reappraised for competence. b. Two of four provisional members of the medical staff (MD 7 and MD 8) were granted clinical privileges and allowed to practice without being proctored; and, c. One out of a total of one AHP, PA 13, was	A 043	practice-based learning and improvement, and systems based practice). In addition, a "Low/ No Volume" Policy was developed, which provides direction to medical staff services when there is a practitioner with no or low volume (activity at the hospital) as to how to assess competency for these providers. *Finally, a compliance and monitoring* process was implemented to assure compliance is ongoing and sustainable. The Director of Medical Staff Services or qualified designee provides a statistical report on the status of the credentialing process and provisional/proctoring status to the MEC every other month, with corrective action taken as needed by the Chief of Staff. Data on compliance is reported every other month to the Governing Board, and is used for performance improvement measures.	2/9/16

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	050693	A. BUILDING _____ B. WING _____	C 11/10/2015

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A 043	Continued From page 2 granted clinical privileges and allowed to practice without being evaluated for competence on a regular basis. The cumulative effect of these systemic problems resulted in the hospital's inability to ensure the provision of quality health care in a safe environment.	A 043		
A 060	482.12(a)(6) MEDICAL STAFF - SELECTION CRITERIA [The governing body must] ensure that criteria for selection are individual character, competence, training, experience, and judgement. This STANDARD is not met as evidenced by: Based on staff interview and administrative document review, the hospital failed to have a governing body which took full legal responsibility for determining, implementing and monitoring policies to ensure the provision of health care in a safe environment when: 1. No system was in place to ensure the hospital's bylaws governing medical staff membership or the granting of privileges was applied equally to all practitioners. (see A 0050) a. Four of five members of the medical staff (Medical Doctor [MD] 9, MD 10, MD 11, and MD 12) who had previously been granted privileges were reappointed without being reappraised for competence; b. Two of four provisional members of the medical staff (MD 7 and MD 8) were granted clinical privileges and allowed to practice without being proctored; and,	A 060	A050 482.12(a)(6) Medical Staff – Selection Criteria Immediate Actions Taken: 1. The Chief Executive Officer (CEO) discussed the survey findings with the Chief of Staff and Medical Staff Services after the survey to investigate the level of compliance and need for necessary resources. 2. The Director of Medical Staff Services identified those practitioners who did not complete proctoring in accordance with the bylaws. Subsequent Actions Taken: 1. Hospital Leadership engaged legal counsel and a national healthcare regulatory consulting firm to assist with correction of medical staff findings and implementation of medical staff procedures and processes to sustain compliance.	11/10/15 11/10/15 1/16/16

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A 050	Continued From page 9 c. One out of a total of one Allied Health Professional (AHP), Physician's Assistant (PA) 13, was granted clinical privileges and allowed to practice without being evaluated for competence on a regular basis. Findings: The Medical Staff Bylaws state on page 38: "PROCTORING REQUIREMENTS FOR INITIAL APPOINTMENT Each Provisional Staff member shall undergo a period of observation by designated monitors as described in Section 4.2. The purpose of observation shall be to evaluate the member's (1) proficiency in the exercise of clinical privileges initially granted and (2) overall eligibility for continued staff membership and advancement within Staff categories. Observations of Provisional Staff members shall follow whatever frequency and format each department deems appropriate in order to adequately evaluate the Provisional Staff member, including but not limited to, concurrent or retrospective chart review, mandatory consultation, and/or direct observation. Appropriate records thereto shall be maintained. The results of the observation shall be communicated by the Department Chair to the Credentials Committee. MODIFICATION IN STAFF CATEGORY AND PRIVILEGES When recommended by the Medical Executive Committee, and approved by the Governing Board, change in Staff category or Department affiliation or the granting of additional privileges, in accordance with Section 5.6 of these Bylaws, shall be made subject to the completion of proctoring. TERM OF PROCTORING PERIOD Each Department may establish, in Rules and	A 050	2. The Chief of Staff resigned, effective 1/31/16. A new Chief of Staff was nominated by the MEC which recommended him to the Governing Board. The Governing Board approved him on 1/27/16. The new Chief of Staff discussed the survey findings with the prior Chief of Staff, CEO and Director of Medical Staff Services and actively participated in development and implementation of the medical staff corrective action plan. 3. The consultants and Medical Staff Team worked collaboratively on reviewing the medical staff bylaws and current processes in place. The following actions were taken between 1/18/16 and 1/29/16: a. A review of the appointment and reappointment process in the bylaws was performed and it was determined that these processes did not require any revisions. b. The medical staff bylaws were revised to incorporate AHP into the reassessment process for reappointment to allow for competency assessments and to clarify situations, such as when an AHP's supervising physician loses or resigns his/her privileges. c. The category of "Associate" medical staff was revised to incorporate those practitioners with no hospital volume who will not require to be granted clinical privileges.	1/27/16 1/18/16 - 1/29/16

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A 050	Continued From page 4 Regulations, a term of proctoring which establishes a longer period of time and/or a greater number of cases, not less than six (6) cases or a specific number of cases applicable to particular clinical privileges, whenever such requirements are appropriate in view of the clinical privileges which are involved. The period of proctoring may be extended in increments of not more than six (6) months each, for a total proctoring period of not more than twenty-four (24) months. If an initial appointee falls within that period to complete the minimum number of cases and/or to furnish the documentation required, his Medical Staff membership or particular clinical privileges, as applicable, shall automatically terminate, and the member shall be entitled to a hearing, upon request, pursuant to Article XII. If a Medical Staff member requesting modification fails to complete the minimum number of cases and/or to furnish the documentation required by the Department, the change in Medical Staff category or Department assignment, or the additional privileges as applicable, shall be terminated. The Medical Executive Committee Chairman shall give the initial appointee or Medical Staff member so affected written notice that his or her Medical Staff membership and/or clinical privileges have been terminated because of failure to satisfactorily complete the proctoring requirements. The affected practitioner has no rights to request a hearing, since this is an administrative action, unless the practitioner's failure is due to medical disciplinary action that is reportable to the Medical Board of California. MODIFICATION OF PROVISIONAL STATUS After a minimum of six months to his/her initial appointment to the Provisional Staff and pursuant to Section 3.6-2, a Medical Staff member may	A 060	d. The medical staff bylaws were revised to define what constitutes OPPE and FPPE and the methods for performing these processes. e. The medical staff bylaws were revised to encourage completion of proctoring within the first six months of the provisional period and to shorten the provisional period to one year. f. After careful consideration of the proctoring process, the medical staff bylaws and accompanying departmental rules and regulations were revised to require three proctored cases instead of six. g. The medical staff bylaws were revised to expand the department chair's responsibilities to include oversight of AHPs assigned to the department, assess and recommend relevant committees and administrative alternative sources for patient care, treatment and services that are not provided for by the department, and to continuously assess and seek to improve the quality of patient care, treatment and services within the department. h. A Medical Staff Peer Review Committee was established, which consists of at least three members of the Active Medical Staff appointed by the Chief of Staff. The Medical Staff Peer Review Committee is responsible for evaluating all practitioner dimensions and indicators recommended by the various departments and to assess	

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A 050	Continued From page 5 request, in writing, that he be advanced to another Staff category, providing that he/she has successfully completed the proctoring, activity and meeting attendance requirements. At the written request of the staff member, evaluations of Provisional Staff members may be done six (6) months following initial appointments. Advancement may be considered at that time, providing the proctoring requirements have been successfully completed. Provisional Staff members must be advanced from said status within twenty-four (24) months of initial appointment date, or automatically be dropped from the Medical Staff. RECIPROCAL PROCTORING ARRANGEMENTS Evidence of proctoring at other hospitals to supplement actual observation at this Hospital, may be accepted only if the following conditions are present: the proctor must be a current member of the Medical Staff; and the proctor must be someone who would have been eligible to serve as a proctor in the second hospital; and the same hospital range and level of privileges must have been requested in both hospitals. Copies of the actual proctoring reports or summaries, are to be kept in confidential files at both hospitals, in compliance with HIPAA Regulations; the number of reciprocal proctoring reports is not to exceed fifty (50) percent of the required proctoring. ARTICLE VII. ALLIED HEALTH PROFESSIONALS 7.1 QUALIFICATIONS Allied Health Professionals (AHP's) holding licenses, certificates, or such other legal credentials, if any, as required by California law, which authorize the AHP's to provide certain professional services, are not eligible for Medical Staff membership. Allied Health Professionals (AHP's) will consist of physicians' assistants and nurse practitioners.	A 050	individual practices against those dimensions and indicators. The Peer Review Committee description was added to the Rules and Regulations. i. Medical Staff Leadership reviewed the existing OPPE/FPPE Policy. The policy was renamed the "Peer Review/Practice Evaluation" Policy and revised to focus on ensuring the medical staff conducts periodic appraisals of all practitioners granted privileges. This appraisal may include peer review, FPPE, OPPE or performance data for practitioners (e.g., physicians and AHP) on an ongoing basis. Data is collected, analyzed and discussed with the practitioner so as to enable the medical staff to assess and ensure the competence of its practitioners, and to take appropriate steps to improve performance of these practitioners as part of its ongoing commitment to high quality care. j. The Reappointment Evaluation form was reviewed and revised to reflect the current available data for reappointments, including, among other things, practitioner findings on core measures and core competencies (e.g., patient care, medical knowledge, communication, professionalism, practice-based learning and improvement, and systems based practice). k. A new policy, entitled "Low/ No Volume" was developed, which provides direction to medical staff services when	

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A 050	Continued From page 6 Such AHP's are eligible to practice privileges in this Hospital only if they: (a) hold a license, certificate or other legal credential in a category of AHP's, which the Governing Board has identified as eligible to apply for practice privileges; (b) document their experience, background, training, demonstrate ability, judgment, physical and mental health status, with sufficient adequacy to demonstrate that any patient treated by them will receive care of the generally recognized professional level of quality and efficiency established by the Hospital, and that they are qualified to exercise practice privileges within the Hospital; and (c) are determined, on the basis of documented references, to adhere strictly to the lawful ethics of their respective professions; to work cooperatively with others in the Hospital setting; and to be willing to commit to and regularly assist the Hospital in fulfilling its obligations related to patient care, within the areas of their professional competence and credentials. Agree to comply with all Medical Staff and Department bylaws, rules and regulations, and protocols to the extent applicable to the AHP. Maintain professional liability insurance coverage, provided by their Supervising Physician, with a suitable insurer, with minimum limits, which have been determined as acceptable by the Medical Executive Committee and Governing Board, in the amount of (1 million/3 million dollars), with no shared limits. EFFECTIVE DATE OF REAPPOINTMENT MODIFICATIONS OF APPOINTMENT AND/OR STAFF PRIVILEGES On the date of the respective Governing Board meetings, a written notification will be forwarded to the physician, acknowledging the Board's decision. DURATION OF APPOINTMENT INITIAL APPOINTMENTS All initial appointments	A 050	there is a practitioner with no or low volume (activity at the hospital) as to how to assess competency for these providers. 4. The medical staff bylaws were provided to active members of the medical staff for review. 5. The Active Staff, MEC and Governing Body approved the revised bylaws. In addition, the MEC and Governing Board approved the policies and related form. 6. The identified physicians 9, 10, 11 and 12 were reappraised for competence through the use of three current peer references and retrospective review of two recent cases. 7. The provisional physicians identified as MD 7 and MD 8 received proctoring and approval. 8. The identified physician assistant was evaluated for competence and the documentation is located in his credential file. 9. The Medical Staff Services Department and physician leadership reviewed recent (2015) initial appointments to assess compliance and sent notices to physicians reminding them of their responsibility to complete proctoring in accordance with bylaw requirements. 10. The Medical Staff Department and physician leadership reviewed AHP files for initial and reappointments in 2015 to ensure that all contain supervising physician evaluations for competency.	1/29/16 2/5/16 2/9/16 2/9/16 2/9/16 2/9/16 2/9/16

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A 050	Continued From page 7 shall be for a minimum of a period of six 6 months with possibly, the recommendation for an eighteen (18) month extension. REAPPOINTMENTS Reappointments to any category of membership and renewals of any designation shall be for a period not to exceed two (2) years. ARTICLE VI. CLINICAL PRIVILEGES EXERCISE OF PRIVILEGES A practitioner providing clinical services at this hospital by virtue of Medical Staff or Allied Health Professional Staff membership or otherwise, shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically granted by the Governing Board,except as provided in subparagraphs 6.4 and 6.5 of this Article VI. DELINEATION OF PRIVILEGES IN GENERAL REQUESTS Each application for appointment and reappointment to the Medical Staff must contain a request for the specific staff privileges desired by the applicant. A request by the Medical Staff member for a modification of privileges must be supported by documentation of training and/or experience that supports the request. Such requests shall be processed in accordance with the procedure outlined in Section 5.4. BASIS FOR DETERMINATION OF PRIVILEGES Privileges shall be determined on the basis of the practitioner's education, training, experience, demonstrated ability and judgment, including observed professional performance, peer recommendations, and documented results of the patient care audit and any other quality review activities required by these Bylaws of the Hospital. Privilege determinations shall also be based upon all of the following factors, without limitation: (a) information concerning professional performance obtained from other sources, especially other institutions and healthcare	A 050	Compliance and Monitoring: Effective 2/9/16, the Director of Medical Staff Services or qualified designee will provide a statistical report on the status of the credentialing process and provisional/ proctoring status to the MEC every other month. Corrective action will be taken by the Chief of Staff as necessary, including communication with applicable practitioners. Data on compliance is reported every other month to the Governing Board, and is used for performance improvement measures. Persons Responsible: Chief of Staff Chief Executive Officer Director of Medical Staff Services	2/9/16

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A 050	Continued From page 8 settings wherein a practitioner exercises privileges; (b) an assessment of the ability of the hospital to provide adequate facilities and support services for the practitioner and his/her patients; current clinical and surgical competence (for the five years immediately preceding the date of application)." Credential files for the medical staff were requested on 11/9/15 at 9 AM. The hospital's policies for credentialing and peer review, complete medical staff roster and the medical staff rules, regulations and bylaws were among those documents requested and reviewed on 11/9/15 at 10 AM as a part of the usual survey process. After discussing credentialing of medical staff including policies and procedures, nine physician credential files (MD 6, MD 7, MD 8, MD 9, MD 10, MD 11, MD 12, MD 14, and MD 15) and one AHP (PA 13) were reviewed on 11/9/15 at 10:30 AM with Credentialing Coordinators (CC) 1 and CC 2. The credential files for were chosen as a part of the credential file review sample because they had all been appointed to the medical staff and granted clinical privileges. Examination of the credential files revealed a. Four of five members of the medical staff (MD 9, MD 10, MD 11, and MD 12) who had previously been granted privileges were reappointed without being reappraised for competence; b. Two of four provisional members of the medical staff (MD 7 and MD 8) were granted clinical privileges and allowed to practice without being proctored; and, c. One out of a total of one AHP, PA 13, was granted clinical privileges and allowed to practice without being evaluated for competence on a	A 050		

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A 050	Continued From page 9 regular basis. CC 1 and CC 2 were interviewed on 11/9/15 at 2 PM. They stated overseeing and managing the credential files was one of their responsibilities within the facility. They stated the credential files had been out of order for some time. They stated they knew there were numerous credentialing issues including lack of proctoring, lack of reappraisals and lack of evaluations for competence. They stated theses were chronic problems that had been brought to the attention of the medical staff leadership and the representatives of the governing body. They stated in spite of their efforts to make leadership aware of the credentialing and medical staff issues, the problems persisted. They stated the physicians were uncooperative in addressing medical staff credentialing issues. They stated they simply did not have enough time or assistance from the medical staff leadership to correct all the problems with the credential files. They stated the Chief of the Medical Staff (CS) 1 had been made aware of the numerous problems and issues with the physician credential files, including lack of documentation of proctoring, lack of documentation of peer review and lack of AHP evaluations for competence. They stated the governing body was usually not actively involved in the credentialing process on a regular basis. The Chief Executive Officer and the Administrator were interviewed together on 11/9/15 at 2:30 PM. They acknowledged their positions of leadership and they stated they knew they had the responsibility for ensuring these duties were performed. They stated they were aware of the fact that there were many problems, irregularities	A 060		

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A 050	Continued From page 10 and issues with regard to the medical staff credential files. They acknowledged the fact that the CC 1 and CC 2 made efforts to inform them of those problems. They stated they had been made aware of the numerous problems and issues with the physician credential files including lack of documentation of proctoring, lack of documentation of peer review and regular reappraisals, and a lack of regular evaluations for allied health professionals. They stated they knew these practices were in violation of the bylaws, rules and regulations as well as the Medical Staff credentialing policy. They stated the governing body was usually not actively involved in the credentialing process on a regular basis. The CS 1 was interviewed on 11/10/15 at 9:15 AM. He acknowledged his position of leadership and he stated he knew he had the responsibility for ensuring these duties were performed. He stated he were aware of the fact that there were many problems, irregularities and issues with regard to the medical staff credential files. He acknowledged the fact that the CC 1 and CC 2 made efforts to inform him of those problems. He stated he had been made aware of the numerous problems and issues with the physician credential files including lack of documentation of proctoring, lack of documentation of peer review and regular reappraisals, and a lack of regular evaluations for allied health professionals. He stated he knew these practices were in violation of the bylaws, rules and regulations as well as the Medical Staff credentialing policy. He stated the governing body was usually not actively involved in the credentialing process on a regular basis.	A 050		
A 116	482.13 PATIENT RIGHTS	A 116	A115 Patient Rights 482.13	

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A 115	Continued From page 11 A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Based on observation, interview, and record review, the hospital failed to: 1. Have informed consents for procedures for two of 26 sampled patients (18 and 20), (Refer to A 0131); and, 2. Ensure a staff physician (Medical Doctor [MD] 6), followed the terms of his probation, specifically, only entering patient rooms with another health care provider, i.e., MD 6 was not to visit a patient alone. (Refer to A 0145). This practice had the potential for patient abuse. (Refer to A 0145) The cumulative effects of these systemic failures resulted in the hospital's inability to ensure their patients' rights were honored by not informing some of risks and benefits of procedures performed by nursing staff, and failing to ensure a safe environment free of the potential for abuse.	A 115	The Hospital assures that it protects and promotes each patient's rights. Finding 1: The "Consent/Informed Consent" Policy was reviewed and did not require any revisions. Informed Consent is required for those procedures which are complex or involve material risks that are not commonly understood. The patient's physician is responsible for providing the information the patient needs in order to make an informed decision and for obtaining the patient's informed consent or refusal for the recommended procedure. Nursing staff were reinserviced, with special emphasis on having an informed consent in the medical record prior to dialysis. Hospital Leadership discussed the survey findings and issue of informed consent for dialysis patients with the MEC. In addition, Hospital Leadership engaged in numerous discussions with the owner of the	1/10/16 - 1/27/16 1/27/16
A 131	482.13(b)(2) PATIENT RIGHTS: INFORMED CONSENT The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be	A 131		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 115	Continued From page 11 A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Based on observation, interview, and record review, the hospital failed to: 1. Have informed consents for procedures for two of 20 sampled patients (16 and 20), (Refer to A 0131); and, 2. Ensure a staff physician (Medical Doctor [MD] 6), followed the terms of his probation, specifically, only entering patient rooms with another health care provider, i.e., MD 6 was not to visit a patient alone. (Refer to A 0145). This practice had the potential for patient abuse. (Refer to A 0145) The cumulative effects of these systemic failures resulted in the hospital's inability to ensure their patients' rights were honored by not informing some of risks and benefits of procedures performed by nursing staff, and failing to ensure a safe environment free of the potential for abuse.	A 115	contracted dialysis regarding, among other things, the need for an informed consent. Ultimately, the CEO terminated the dialysis contract and engaged a new dialysis company, effective 2/8/16. The CEO discussed the survey issues concerning the provision of dialysis services with the new dialysis company, with the expectation that there shall be strict adherence to having an informed consent in the medical record prior to dialysis. Nursing Leadership implemented the process of care facilitation for the monitoring of compliance with informed consents for dialysis patients. A Care Facilitation worksheet was developed for use by the care facilitators. In addition, additional contracted nurse educators were hired to assist with the process of care facilitation. Finding 2: Hospital Leadership implemented immediate actions to address the issue of	2/8/16 2/6/16 11/9/15 - 11/16/15
A 131	482.13(b)(2) PATIENT RIGHTS: INFORMED CONSENT The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be	A 131		

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	050663	A. BUILDING _____ B. WING _____	C 11/10/2015

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A 115	Continued From page 11 A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Based on observation, interview, and record review, the hospital failed to: 1. Have informed consents for procedures for two of 26 sampled patients (16 and 20), (Refer to A 0131); and, 2. Ensure a staff physician (Medical Doctor [MD] 6), followed the terms of his probation, specifically, only entering patient rooms with another health care provider, i.e., MD 6 was not to visit a patient alone. (Refer to A 0145). This practice had the potential for patient abuse. (Refer to A 0145) The cumulative effects of these systemic failures resulted in the hospital's inability to ensure their patients' rights were honored by not informing some of risks and benefits of procedures performed by nursing staff, and failing to ensure a safe environment free of the potential for abuse.	A 116	MD 6. Nursing Leadership talked with the identified patients and no adverse outcomes were identified. In addition, the Chief of Staff suspended MD 6 for failure to comply with the corrective action plan in place. Additional discussions were held with MD 6 and an updated corrective action plan was put in place, including development of an attestation in the EMR system to allow for the chaperone to attest accompanying MD 6 during patient rounds. A log was developed to allow for MD 6 and chaperone documentation upon arrival and departure from the hospital. The log specifies the date, a time of arrival with corresponding signatures by MD 6 and the chaperone, and the time of department with corresponding signatures by MD 6 and the chaperone. The chaperone accompanies MD 6 on all rounds and remains with him in patient rooms. Nursing Leadership inserviced the chaperones on the process. The CEO and MEC met with MD 6 regarding the updated corrective action plan and log. The physician's suspension was lifted 11/17/15.	11/17/15
A 131	482.13(b)(2) PATIENT RIGHTS: INFORMED CONSENT The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be	A 131	A131 482.13(b)(2) Patient Rights: Informed Consent Findings 1-2: Actions Taken: 1. Upon receipt of the Statement of Deficiencies, the CEO and Nursing Leadership discussed the survey findings and the process for obtaining dialysis	1/10/16-1/27/16

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A 131	Continued From page 12 construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the hospital failed to have informed consents for procedures in the clinical record for two of 26 sampled patients (16 and 20). This practice has the potential for patients to receive procedures without knowing the benefits versus risks, and/or to make an informed decision about that procedure. Findings: [Note: "Dialysis" is a process involving a large, portable machine, that is attached to a patient so that all of their blood's toxins and other fluids can be removed when their own kidneys can no longer do it. If these waste products are not removed, the result can be death. Its purpose is to keep the right levels of chemicals, fluids, and salts in one's bloodstream, control blood pressure, and remove waste products. Dialysis treatments typically take between 3 to 4 hours; during this time, all the patient's blood is removed and ran through a filter in the machine, then returned to the patient. Treatments usually occur three times a week. Before the dialysis treatments can happen, a surgical procedure must occur, to make a connection site on the patient. The dialysis machine usually connects to this site via two needles.] 1. During an interview with Registered Nurse (RN) 1 on 11/9/15, at 9:20 AM, she indicated	A 131	consents. The "Consent/Informed Consent" Policy was reviewed and did not require any revisions. Informed Consent is required for those procedures which are complex or involve material risks that are not commonly understood. The patient's physician is responsible for providing the information the patient needs in order to make an informed decision and for obtaining the patient's informed consent or refusal for the recommended procedure. The hospital's role in the informed consent process is to verify that the physician obtained the patient's informed consent before the procedure. Nursing staff were reinserviced, with special emphasis on having an informed consent in the medical record prior to dialysis. 2. Hospital Leadership discussed the survey findings with the contracted dialysis company, with special emphasis that his dialysis staff were to check for the dialysis consent prior to dialysis. 3. Hospital Leadership discussed the issue of informed consent for dialysis patients at the MEC meeting. 4. The CEO terminated the existing dialysis contract. The new dialysis company started 2/8/16. The CEO discussed the survey findings with the new dialysis company, with special emphasis on ensuring that an informed consent for dialysis is in the medical record. 5. Nursing Leadership reviewed the medical records for current dialysis patients to	1/18/16 1/27/16 2/8/16 1/19/16

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A 131	Continued From page 13 Patient 16 was in her care, and was a dialysis patient. During an interview with Patient 16, on 11/9/15, at 9:25 AM, she indicated she had just finished her dialysis treatment a few minutes ago. During a concurrent record review and interview with the Medical Record Specialist (MRS) on 11/10/15, at 9 AM, the clinical record for Patient 16 was noted to not have an informed consent for her dialysis treatment. During an interview with RN 1 on 11/10/15, at 11 AM, she indicated Patient 16 was still her patient, and also reviewed her clinical record. RN 1 indicated Patient 16 did not have an informed consent for her dialysis treatments. 2. During an observation of Patient 20 on 11/9/15, at 9:30 AM, she was receiving a dialysis treatment in the hospital's Intensive Care Unit (ICU). During a concurrent record review and interview with the MRS on 11/10/15, at 9 AM, the clinical record for Patient 20 was noted to not have an informed consent for her dialysis treatment. During an interview with RN 5 on 11/10/15, at 10:30 AM, she also reviewed Patient 20's clinical record and indicated there was no informed consent for her dialysis treatments. RN 5 stated it is normal hospital protocol to obtain these consents prior to the treatments, but could not locate one for Patient 20.	A 131	ensure the presence of an informed consent and any issues identified were immediately corrected. 6. The Chief Nursing Officer (CNO) worked with the consultants to implement facilitation, a process of concurrent record compliance monitoring whereby a "care facilitator" (licensed healthcare professional) identifies any noncompliance with the subject matter, intercepts the nurse/provider in real time, provides "just in time" education and training to correct clinical or documentation process issues. This method allows for role modeling of excellent clinical behavior while allowing staff to replicate improved practices. Care facilitation drives sustainability as staff learns from ongoing facilitation to identify, correct and improve practice weaknesses. A Care Facilitation worksheet was developed for use by the care facilitators, including monitoring for informed consents on dialysis patients. 8. Nursing staff is educated on informed consents upon hire and annually. 9. Compliance with informed consents is monitored through the QAPI program. <u>Compliance and Monitoring:</u> Effective 2/6/16, data is collected by the care facilitators, tracked daily, aggregated and reported to leadership at least weekly to allow for leadership to focus resources on those issues and units where continued vulnerabilities exist. The goal is to achieve	2/6/16 2/6/16
A 146	482.13(c)(3) PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT	A 145		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/25/2015
FORM APPROVED
OMB NO. 0938-0391

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A 131	Continued From page 13 Patient 16 was in her care, and was a dialysis patient. During an interview with Patient 16, on 11/9/15, at 9:25 AM, she indicated she had just finished her dialysis treatment a few minutes ago. During a concurrent record review and interview with the Medical Record Specialist (MRS) on 11/10/15, at 9 AM, the clinical record for Patient 16 was noted to not have an informed consent for her dialysis treatment. During an interview with RN 1 on 11/10/15, at 11 AM, she indicated Patient 16 was still her patient, and also reviewed her clinical record. RN 1 indicated Patient 16 did not have an informed consent for her dialysis treatments. 2. During an observation of Patient 20 on 11/9/15, at 9:30 AM, she was receiving a dialysis treatment in the hospital's Intensive Care Unit (ICU). During a concurrent record review and interview with the MRS on 11/10/15, at 9 AM, the clinical record for Patient 20 was noted to not have an informed consent for her dialysis treatment. During an interview with RN 5 on 11/10/15, at 10:30 AM, she also reviewed Patient 20's clinical record and indicated there was no informed consent for her dialysis treatments. RN 5 stated it is normal hospital protocol to obtain these consents prior to the treatments, but could not locate one for Patient 20.	A 131	100% compliance with obtaining informed consents, including dialysis consents. Data is analyzed and reported every other month to the Quality Council, MEC, and Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will occur until the Quality Council determines sustained compliance has occurred, at which time the Council will determine what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Person Responsible: Chief Nursing Officer	
A 145	482.13(c)(3) PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT	A 145	A145 482.13(c)(3) Patient Rights: Free from Abuse/Harassment	

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A 145	Continued From page 14 The patient has the right to be free from all forms of abuse or harassment. This STANDARD is not met as evidenced by: Based on record review and interview, the hospital failed to ensure a staff physician (Medical Doctor [MD] 6), followed the terms of his probation, specifically, only entering a patient's room with another health care provider, i.e., MD 6 was not to visit a patient alone. This practice had the potential for patient abuse. Findings: During a review of a letter written to the Department, dated 10/16/15, and signed by the Chief Executive Officer (CEO), it read, in part: "Provider's Plan of Correction 1. Ensure that [MD 6] uses a chaperone for each patient visit: a. [MD 6] will be required to check in with Charge Nurse prior to rounding. b. Physician's Assistant (PA)/Nurse Practitioner (NP) will accompany [MD 6] during rounds. c. If PA or NP not available, Charge Nurse will round with [MD 6] or assign staff to accompany [MD 6]. d. Medical Staff Director will notify [MD 6] that he needs to take the PA/NP with him, or round with Charge Nurse or assigned staff. e. This practice will be implemented immediately. f. If [MD 6] fails to round with assigned chaperone, he will be suspended. 2. Nursing staff needs to document in the nursing record that [MD 6] was accompanied during rounds. b. Documentation of Rounding will be done by the	A 145	Immediate Actions Taken: 1. The CNO talked with Patient 21 and no adverse outcome was identified. 2. The CNO talked with Patient 23 and no adverse outcome was identified. 3. The CNO talked with Patient 24 and no adverse outcome was identified. 4. The Chief of Staff suspended MD 6 for failure to comply with the corrective action plan for a chaperone with each patient visit. 5. The CNO discussed the survey findings with RN 3, with special emphasis on strict adherence to the corrective action plan for MD 6. 6. The CEO discussed the survey findings with the Chief of Staff and MD 6, with special emphasis that the corrective action plan regarding a chaperone with each patient visit must be followed by MD 6 at all times. The CEO advised MD 6 that he is to contact Leadership if he has any difficulty with the chaperone. 7. The CEO, CNO, Chief of Staff and Information Technology (IT) staff discussed implementing an attestation in the EMR system to allow for the chaperone to attest accompanying MD 6 during patient rounds. The IT Department finalized the attestation in the EMR on 11/16/15. The chaperones were educated on the attestation and currently document the attestation in the medical record. 8. The CEO, CNO and Chief of Staff reviewed and updated the corrective action	11/9/15 11/9/15 11/9/15 11/9/15 11/9/15 11/9/15 11/16/15 11/9/15 - 11/16/15

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A 145	Continued From page 14 The patient has the right to be free from all forms of abuse or harassment. This STANDARD is not met as evidenced by: Based on record review and interview, the hospital failed to ensure a staff physician (Medical Doctor [MD] 6), followed the terms of his probation, specifically, only entering a patient's room with another health care provider, i.e., MD 6 was not to visit a patient alone. This practice had the potential for patient abuse. Findings: During a review of a letter written to the Department, dated 10/15/15, and signed by the Chief Executive Officer (CEO), it read, in part: "Provider's Plan of Correction 1. Ensure that [MD 6] uses a chaperone for each patient visit: a. [MD 6] will be required to check in with Charge Nurse prior to rounding. b. Physician's Assistant (PA)/Nurse Practitioner (NP) will accompany [MD 6] during rounds. c. If PA or NP not available, Charge Nurse will round with [MD 6] or assign staff to accompany [MD 6]. d. Medical Staff Director will notify [MD 6] that he needs to take the PA/NP with him, or round with Charge Nurse or assigned staff. e. This practice will be implemented immediately. f. If [MD 6] fails to round with assigned chaperone, he will be suspended. 2. Nursing staff needs to document in the nursing record that [MD 6] was accompanied during rounds. b. Documentation of Rounding will be done by the	A 145	plan for MD 6 to clarify the chaperone instructions. A log was developed to allow for MD 6 and chaperone documentation upon arrival and departure from the hospital. The log specifies the date, a time of arrival with corresponding signatures by MD 6 and the chaperone, and the time of departure with corresponding signatures by MD 6 and the chaperone. In addition, the following instructions were put in place: a) MD 6 will sign in upon arrival to hospital and wait for a chaperone to accompany him on clinical rounds; b) the chaperone will sign the log upon MD 6's arrival and will have MD 6's patient census; c) the chaperone will accompany MD 6 on all rounds and remain with him in patient rooms; d) the chaperone will document an attestation in each patient's medical record attesting that he/she accompanied MD 6; e) the chaperone will accompany MD 6 back to the hospital lobby and both MD 6 and the chaperone signs the log indicating MD 6's departure. Nursing Leadership inserviced the chaperones on the process. 9. The CEO and MEC met with MD 6 regarding the updated corrective action plan and log. The physician's suspension was lifted 11/17/15. Compliance and Monitoring: The Chief Nursing Officer or licensed designee receives the logs on days MD 6 provides patient care at the hospital to achieve the goal of 100% compliance with	11/17/15

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A 145	Continued From page 15 PA/NP/Charge Nurse, or assigned staff." During an interview with Patient 21, on 11/9/15, at 11:05 AM, he indicated MD 6 had examined him privately, with no other staff present. During an interview with Patient 23, on 11/9/15, at 11:25 AM, she indicated MD 6 had examined her privately, with no other staff present. During an interview with Patient 24, on 11/9/15, at 11:30 AM, he indicated MD 6 had examined him privately, with no other staff present. During an interview with Registered Nurse (RN) 3, on 11/9/15, at 11:40 AM, she indicated she was a Charge Nurse in the hospital. RN 3 indicated she was familiar with MD 6, and the terms of his probation. RN 3 stated in the absence of a PA/NP, nursing staff accompany MD 6 into patient rooms only "sometimes." During an interview with the CEO on 11/9/15, at 11:45 AM, while discussing the terms of MD 6's probation, she stated "[Our compliance is] not as tight as it should be on the nursing side."	A 145	MD 6 performing patient visits with a chaperone. The Director of Quality or qualified designee performs a weekly review of MD 6's medical records to monitor achieve the goal of 100% compliance with the chaperone attestation form in the EMR. The CNO or licensed designee also perform random weekly rounds on at least 3 of MD 6's patients (if available) to confirm that a chaperone was present and no issues with MD 6 are identified. Corrective action is taken as necessary, including immediate notification of the CEO and Chief of Staff for non-compliance by MD 6, and reeducation of chaperones. Data on compliance is tracked, trended, analyzed and reported every other month to MEC and Governing Board. Persons Responsible: Chief Executive Officer Chief Nursing Officer Chief of Staff	
A 338	482.22 MEDICAL STAFF The hospital must have an organized medical staff that operates under bylaws approved by the governing body, and which is responsible for the quality of medical care provided to patients by the hospital. This CONDITION is not met as evidenced by: Based on staff interview and administrative document review, the hospital failed to have a governing body which took full legal responsibility for determining, implementing and monitoring	A 338	A338 482.22 Medical Staff The Governing Board has been involved in the development and implementation of this credible allegation of compliance. The Hospital engaged legal counsel and a national healthcare regulatory compliance consulting firm to assist with the credible allegation of compliance, including correction of the medical staff findings and implementation of improved processes to	2/9/16 1/16/16

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A 338	Continued From page 16 policies to ensure the provision of health care in a safe environment when: 1. No system was in place to ensure Medical Staff By-Laws, Rules and Regulations were followed and to ensure the medical staff were regularly appraised. There was no means to ensure the medical staff were professionally qualified for the positions to which they were appointed and for the performance of privileges granted; (Refer to A 0340) a. Four of five members of the medical staff (Medical Doctor [MD] 9, MD 10, MD 11, and MD 12) who had previously been granted privileges were reappointed without being reappraised for competence; b. Two of four provisional members of the medical staff (MD 7 and MD 8) were granted clinical privileges and allowed to practice without being proctored; and, c. One out of a total of one Allied Health Professional (AHP), Physician's Assistant (PA) 13, was granted clinical privileges and allowed to practice without being evaluated for competence on a regular basis. The cumulative effect of these systemic problems resulted in the hospital's inability to ensure the provision of quality health care in a safe environment.	A 338	to ensure that practitioner competency and proctoring is maintained in accordance with hospital bylaws. The Chief of Staff resigned, effective 1/31/16 and a new Chief of Staff was nominated and recommended to the MEC on 1/27/16 and approved by the Governing Board on 1/27/16. The new Chief of Staff has taken an active role in development and implementation of the credible allegation of compliance. In addition to correction of the findings for the identified physicians and AHP, the consultants and Medical Staff Team reviewed and revised the medical staff bylaws as referenced below. This included revising the OPPE and FPPE policy and creating a new Peer Review Committee. The Reappointment Evaluation form was reviewed and revised to reflect the current available data for reappointments, including, among other things, practitioner findings on core measures and core competencies (e.g., patient care, medical knowledge, communication, professionalism, practice-based learning and improvement, and systems based practice). In addition, a "Low/ No Volume"	1/27/16 1/18/16 - 1/29/16
A 340	482.22(a)(1) MEDICAL STAFF PERIODIC APPRAISALS The medical staff must periodically conduct appraisals of its members.	A 340		

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A 338	Continued From page 16 policies to ensure the provision of health care in a safe environment when: 1. No system was in place to ensure Medical Staff By-Laws, Rules and Regulations were followed and to ensure the medical staff were regularly appraised. There was no means to ensure the medical staff were professionally qualified for the positions to which they were appointed and for the performance of privileges granted; (Refer to A 0340) a. Four of five members of the medical staff (Medical Doctor [MD] 9, MD 10, MD 11, and MD 12) who had previously been granted privileges were reappointed without being reappraised for competence; b. Two of four provisional members of the medical staff (MD 7 and MD 8) were granted clinical privileges and allowed to practice without being proctored; and, c. One out of a total of one Allied Health Professional (AHP), Physician's Assistant (PA) 13, was granted clinical privileges and allowed to practice without being evaluated for competence on a regular basis. The cumulative effect of these systemic problems resulted in the hospital's inability to ensure the provision of quality health care in a safe environment.	A 338	Policy was developed, which provides direction to medical staff services when there is a practitioner with no or low volume (activity at the hospital) as to how to assess competency. The Director of Medical Staff Services or qualified designee provides a statistical report on the status of the credentialing processes and provisional/proctoring status to MEC every other month, with corrective action taken as needed by the Chief of Staff. Data on compliance is reported every other month to the Governing Board, and is used for performance improvement measures.	2/9/16
A 340	482.22(a)(1) MEDICAL STAFF PERIODIC APPRAISALS The medical staff must periodically conduct appraisals of its members.	A 340	A340 482.22 (a)(1) Medical Staff Periodic Appraisals Immediate Actions Taken: 1. The CEO discussed the survey findings	11/10/15

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	050683	A. BUILDING _____ B. WING _____	C 11/10/2016

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LOS ANGELES COMMUNITY HOSPITAL	4081 E OLYMPIC BLVD LOS ANGELES, CA 90023

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A 840	Continued From page 17 This STANDARD is not met as evidenced by: Based on staff interview and administrative document review, the hospital failed to have a governing body which took full legal responsibility for determining, implementing and monitoring policies to ensure the provision of health care in a safe environment when: 1. No system was in place to ensure the hospital's bylaws governing medical staff membership or the granting of privileges was applied equally to all practitioners: a. Four of five members of the medical staff (Medical Doctor [MD] 9, MD 10, MD 11, and MD 12) who had previously been granted privileges were reappointed without being reappraised for competence; b. Two of four provisional members of the medical staff (MD 7 and MD 9) were granted clinical privileges and allowed to practice without being proctored; and, c. One out of a total of one Allied Health Professional (AHP), Physician's Assistant (PA) 13, was granted clinical privileges and allowed to practice without being evaluated for competence on a regular basis. Findings: The Medical Staff Bylaws state on Page 38: "PROCTORING REQUIREMENTS FOR INITIAL APPOINTMENT Each Provisional Staff member shall undergo a period of observation by designated monitors as described in Section 4.2. The purpose of observation shall be to evaluate	A 840	with the Chief of Staff and Medical Staff Services after the survey to investigate the level of compliance and need for necessary resources. 2. The Director of Medical Staff Services identified those practitioners who did not complete proctoring in accordance with the bylaws. Subsequent Actions Taken: 1. Hospital Leadership engaged legal counsel and a national healthcare regulatory compliance consulting firm to assist with correction of medical staff findings and implementation of medical staff processes to sustain compliance. 2. The Chief of Staff resigned, effective 1/31/16. A new Chief of Staff was nominated by the MEC and approved by the Governing Board on 1/27/16. The new Chief of Staff discussed the survey findings with the prior Chief of Staff, CEO and Director of Medical Staff Services and actively participated in development and implementation of the medical staff corrective action plan. 3. The consultants and Medical Staff Team worked collaboratively on reviewing the medical staff bylaws and current processes in place. The following actions were taken between 1/18/16 and 1/29/16: a. A review of the appointment and reappointment process in the bylaws was	11/10/15 1/16/16 1/27/16 1/18/16 - 11/29/16

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A 340	Continued From page 18 the member's (1) proficiency in the exercise of clinical privileges initially granted and (2) overall eligibility for continued staff membership and advancement within Staff categories. Observations of Provisional Staff members shall follow whatever frequency and format each department deems appropriate in order to adequately evaluate the Provisional Staff member, including but not limited to, concurrent or retrospective chart review, mandatory consultation, and/or direct observation. Appropriate records thereto shall be maintained. The results of the observation shall be communicated by the Department Chair to the Credentials Committee. MODIFICATION IN STAFF CATEGORY AND PRIVILEGES When recommended by the Medical Executive Committee, and approved by the Governing Board, change in Staff category or Department affiliation or the granting of additional privileges, in accordance with Section 5.6 of these Bylaws, shall be made subject to the completion of proctoring. TERM OF PROCTORING PERIOD Each Department may establish, in Rules and Regulations, a term of proctoring which establishes a longer period of time and/or a greater number of cases, not less than six (6) cases or a specific number of cases applicable to particular clinical privileges, whenever such requirements are appropriate in view of the clinical privileges which are involved. The period of proctoring may be extended in increments of not more than six (6) months each, for a total proctoring period of not more than twenty-four (24) months. If an initial appointee fails within that period to complete the minimum number of cases and/or to furnish the documentation required, his Medical Staff membership or particular clinical privileges, as applicable, shall	A 340	performed and it was determined that these processes did not require any revisions. b. The medical staff bylaws were revised to incorporate AHP into the reassessment process for reappointment to allow for competency assessments and to clarify situations, such as when an AHP's supervising physician loses or resigns his/her privileges. c. The category of "Associate" medical staff was revised to incorporate those practitioners with no hospital volume who will not require to be granted clinical privileges. d. The medical staff bylaws were revised to define what constitutes OPPE and FPPE and the methods for performing these processes. e. The medical staff bylaws were revised to encourage completion of proctoring within the first six months of the provisional period and to shorten the provisional period to one year. f. After careful consideration of the proctoring process, the medical staff bylaws and accompanying departmental rules and regulations were revised to require three proctored cases instead of six. g. The medical staff bylaws were revised to expand the department chair's responsibilities to include oversight of AHPs assigned to the department, assess and recommend relevant committees and	

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A 340	Continued From page 19 automatically terminate, and the member shall be entitled to a hearing, upon request, pursuant to Article XII. If a Medical Staff member requesting modification fails to complete the minimum number of cases and/or to furnish the documentation required by the Department, the change in Medical Staff category or Department assignment, or the additional privileges as applicable, shall be terminated. The Medical Executive Committee Chairman shall give the initial appointee or Medical Staff member so affected written notice that his or her Medical Staff -membership and/or clinical privileges have been terminated because of failure to satisfactorily complete the proctoring requirements. The affected practitioner has no rights to request a hearing, since this is an administrative action, unless the practitioner's failure is due to medical disciplinary action that is reportable to the Medical Board of California. MODIFICATION OF PROVISIONAL STATUS After a minimum of six months to his/her initial appointment to the Provisional Staff and pursuant to Section 3.8-2, a Medical Staff member may request, in writing, that he be advanced to another Staff category, providing that he/she has successfully completed the proctoring, activity and meeting attendance requirements. At the written request of the staff member, evaluations of Provisional Staff members may be done six (6) months following initial appointments. Advancement may be considered at that time, providing the proctoring requirements have been successfully completed. Provisional Staff members must be advanced from said status within twenty-four (24) months of initial appointment date, or automatically be dropped from the Medical Staff. RECIPROCAL PROCTORING ARRANGEMENTS	A 340	administrative alternative sources for patient care, treatment and services that are not provided for by the department, and to continuously assess and seek to improve the quality of patient care, treatment and services within the department. h. A Medical Staff Peer Review Committee was established, which consists of at least three members of the Active Medical Staff appointed by the Chief of Staff. The Medical Staff Peer Review Committee is responsible for evaluating all practitioner dimensions and indicators recommended by the various departments and to assess individual practices against those dimensions and indicators. The Peer Review Committee description was added to the Rules and Regulations. i. Medical Staff Leadership reviewed the existing OPPE/FPPE Policy. The policy was renamed the "Peer Review/Practice Evaluation" Policy and revised to focus on ensuring the medical staff conducts periodic appraisals of all practitioners granted privileges. This appraisal may include peer review, FPPE, OPPE or performance data for practitioners (e.g., physicians and AHPs) on an ongoing basis. Data is collected, analyzed and discussed with the practitioner so as to enable the medical staff to assess and ensure the competence of its practitioners, and to take appropriate steps to improve performance of these	

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A 340	Continued From page 20 Evidence of proctoring at other hospitals to supplement actual observation at this Hospital, may be accepted only if the following conditions are present: the proctor must be a current member of the Medical Staff; and the proctor must be someone who would have been eligible to serve as a proctor in the second hospital; and the same hospital range and level of privileges must have been requested in both hospitals. Copies of the actual proctoring reports or summaries, are to be kept in confidential files at both hospitals, in compliance with HIPAA Regulations; the number of reciprocal proctoring reports is not to exceed fifty (50) percent of the required proctoring. ARTICLE VII. ALLIED HEALTH PROFESSIONALS 7.1 QUALIFICATIONS Allied Health Professionals (AHP's) holding licenses, certificates, or such other legal credentials, if any, as required by California law, which authorize the AHP's to provide certain professional services, are not eligible for Medical Staff membership. Allied Health Professionals (AHP's) will consist of physicians' assistants and nurse practitioners. Such AHP's are eligible to practice privileges in this Hospital only if they: (a) hold a license, certificate or other legal credential in a category of AHP's, which the Governing Board has identified as eligible to apply for practice privileges; (b) document their experience, background, training, demonstrate ability, judgment, physical and mental health status, with sufficient adequacy to demonstrate that any patient treated by them will receive care of the generally recognized professional level of quality and efficiency established by the Hospital, and that they are qualified to exercise practice privileges within the Hospital; and (c) are determined, on the basis of documented	A 340	practitioners as part of its ongoing commitment to high quality care. j. The Reappointment Evaluation form was reviewed and revised to reflect the current available data for reappointments, including, among other things, practitioner findings on core measures and core competencies (e.g., patient care, medical knowledge, communication, professionalism, practice-based learning and improvement, and systems based practice). k. A new policy, entitled "Low/ No Volume" was developed, which provides direction to medical staff services when there is a practitioner with no or low volume (activity at the hospital) as to how to assess competency for these providers. 4. The medical staff bylaws were provided to active members of the medical staff for review. 1/29/16 5. The Active Staff, MEC and Governing Body approved the revised bylaws. In addition, the MEC and Governing Body approved the policies and related form. 2/5/16 6. The identified physicians 9, 10, 11 and 12 were reappraised for competence through the use of three current peer references and retrospective review of two recent cases. 2/9/16 7. The provisional physicians identified as MD 7 and MD 8 received proctoring and approval. 2/9/16	

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A 940	Continued From page 21 references, to adhere strictly to the lawful ethics of their respective professions; to work cooperatively with others in the Hospital setting; and to be willing to commit to and regularly assist the Hospital in fulfilling its obligations related to patient care, within the areas of their professional competence and credentials. Agree to comply with all Medical Staff and Department bylaws, rules and regulations, and protocols to the extent applicable to the AHP. Maintain professional liability insurance coverage, provided by their Supervising Physician, with a suitable insurer, with minimum limits, which have been determined as acceptable by the Medical Executive Committee and Governing Board, in the amount of (1 million/3 million dollars), with no shared limits. EFFECTIVE DATE OF REAPPOINTMENT MODIFICATIONS OF APPOINTMENT AND/OR STAFF PRIVILEGES On the date of the respective Governing Board meetings, a written notification will be forwarded to the physician, acknowledging the Board's decision. DURATION OF APPOINTMENT INITIAL APPOINTMENTS All initial appointments shall be for a minimum of a period of six 6 months with possibly, the recommendation for an eighteen (18) month extension. REAPPOINTMENTS Reappointments to any category of membership and renewals of any designation shall be for a period not to exceed two (2) years. ARTICLE VI. CLINICAL PRIVILEGES EXERCISE OF PRIVILEGES A practitioner providing clinical services at this hospital by virtue of Medical Staff or Allied Health Professional Staff membership or otherwise, shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically granted by the Governing Board, except as provided in subparagraphs 6.4	A 940	8. The identified physician assistant was evaluated for competence and the documentation is located in his credential file. 9. The Medical Staff Services Department and physician leadership reviewed recent (2015) initial appointments to assess compliance and sent notices to physicians reminding them of their responsibility to complete proctoring in accordance with bylaw requirements. 10. The Medical Staff Department and physician leadership reviewed AHP files for initial and reappointments in 2015 to ensure that all contain supervising physician evaluations for competency. Compliance and Monitoring: Effective 2/9/16, the Director of Medical Staff Services or qualified designee will provide a statistical report on the status of the credentialing process and provisional/ proctoring status to the MEC every other month. Corrective action will be taken by the Chief of Staff as necessary, including communication with applicable practitioners. Data on compliance is reported every other month to the Governing Board, and is used for performance improvement measures.	2/9/16 2/9/16 2/9/16 2/9/16

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A 340	Continued From page 22 and 6.5 of this Article VI, DELINEATION OF PRIVILEGES IN GENERAL REQUESTS Each application for appointment and reappointment to the Medical Staff must contain a request for the specific staff privileges desired by the applicant. A request by the Medical Staff member for a modification of privileges must be supported by documentation of training and/or experience that supports the request. Such requests shall be processed in accordance with the procedure outlined in Section 6.4, BASIS FOR DETERMINATION OF PRIVILEGES Privileges shall be determined on the basis of the practitioner's education, training, experience, demonstrated ability and judgment, including observed professional performance, peer recommendations, and documented results of the patient care audit and any other quality review activities required by these Bylaws of the Hospital. Privilege determinations shall also be based upon all of the following factors, without limitation: (a) information concerning professional performance obtained from other sources, especially other institutions and healthcare settings wherein a practitioner exercises privileges; (b) an assessment of the ability of the hospital to provide adequate facilities and support services for the practitioner and his/her patients; current clinical and surgical competence (for the five years immediately preceding the date of application)." Credential files for the medical staff were requested on 11/9/15 at 9 AM as a part of the usual survey process. The hospital's policies for credentialing and peer review, complete medical staff roster and the medical staff rules, regulations and bylaws were among those documents requested and reviewed on 11/9/15 at	A 340	Persons Responsible: Chief of Staff Chief Executive Officer Director of Medical Staff Services	

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A 940	Continued From page 23 10 AM as a part of the usual survey process. After discussing credentialing of medical staff including policies and procedures, nine physician credential files (MD 6, MD 7, MD 8, MD 9, MD 10, MD 11, MD 12, MD 14, and MD 16) and one AHP, PA 13 were reviewed on 11/9/15 at 10:30 AM with Credentialing Coordinators (CC) 1 and 2. The credential files were chosen as a part of the credential file review sample because they had all been appointed to the medical staff and granted clinical privileges. Examination of the credential files revealed; a. Four of five members of the medical staff (MD 9, MD 10, MD 11, and MD 12) who had previously been granted privileges were reappointed without being reappraised for competence; b. Two of four provisional members of the medical staff (MD 7 and MD 8) were granted clinical privileges and allowed to practice without being proctored; and, c. One out of a total of one AHP, PA 13, was granted clinical privileges and allowed to practice without being evaluated for competence on a regular basis. CC 1 and CC 2 were interviewed on 11/9/15 at 2 PM. They stated overseeing and managing the credential files was one of their responsibilities within the hospital. They stated the credential files had been out of order for some time. They stated they knew there were numerous credentialing issues including lack of proctoring, lack of reappraisals and lack of evaluations for competence. They stated theses were chronic problems that had been brought to the attention	A 940		

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A 340	Continued From page 24 of the medical staff leadership and the representatives of the governing body. They stated in spite of their efforts to make leadership aware of the credentialing and medical staff issues the problems persisted. They stated the physicians were uncooperative in addressing medical staff credentialing issues. They stated they simply did not have enough time or assistance from the medical staff leadership to correct all the problems with the credential files. They stated the Chief of the Medical Staff (CS) 1 had been made aware of the numerous problems and issues with the physician credential files including lack of documentation of proctoring, lack of documentation of peer review and lack of AHP evaluations for competence. They stated the governing body was usually not actively involved in the credentialing process on a regular basis. The Chief Administrative Officer and the Administrator were interviewed together on 11/9/15 at 2:30 PM. They acknowledged their positions of leadership and they stated they knew they had the responsibility for ensuring these duties were performed. They stated they were aware of the fact that there were many problems, irregularities and issues with regard to the medical staff credential files. They acknowledged the fact that CC 1 and CC 2 made an effort to inform them of those problems. They stated they had been made aware of the numerous problems and issues with the physician credential files including lack of documentation of proctoring, lack of documentation of peer review and regular reappraisals and a lack of regular evaluations for allied health professionals. They stated they knew these practices were in violation of the bylaws, rules and regulations as well as the	A 340		

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A 340	Continued From page 25 Medical Staff credentialing policy. They stated the governing body was usually not actively involved in the credentialing process on a regular basis. The Chief of the Medical Staff was interviewed on 11/10/15 at 9:15 AM. He acknowledged his position of leadership and he stated he knew he had the responsibility for ensuring these duties were performed. He stated he were aware of the fact that there were many problems, irregularities and issues with regard to the medical staff credential files. He acknowledged the fact that CC 1 and CC 2 made an effort to inform him of those problems. He stated he had been made aware of the numerous problems and issues with the physician credential files including lack of documentation of proctoring, lack of documentation of peer review and regular reappraisals and a lack of regular evaluations for AHP. He stated he knew these practices were in violation of the bylaws, rules and regulations as well as the Medical Staff credentialing policy. He stated the governing body was usually not actively involved in the credentialing process on a regular basis.	A 340		
A 385	482.23 NURSING SERVICES The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by: Based on observation, interview, and record review, the hospital failed to ensure: 1. Nursing care plans were put in place for three	A 385	A385 482.23 Nursing Services The Hospital assures that it has an organized nursing service that is furnished or supervised by registered nurses. The Hospital hired an Associate Chief Nursing Officer on 12/16/15. Finding 1: Hospital Nursing Leadership discussed the nursing survey findings and reviewed	12/16/15

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A 385	Continued From page 26 of 26 sampled patients (16, 18, and 20), (Refer to A 0396); and, 2. Documented and completed competencies for six contracted dialysis nurses, (Refer to A 0398); and, 3. Contracted nurses were oriented to the hospital, (Refer to A 0398). The cumulative effects of these systemic failures resulted in the hospital's inability to ensure nursing competency and that nursing care needs of patients were met.	A 385	applicable policies and procedures to ensure adequacy for promoting and maintaining compliance with applicable nursing services. The nursing care plan policy was reviewed and revised. The new policy, entitled "Interdisciplinary Plan of Care" delineates that clinical staff (e.g., nurses and other disciplines) are to develop and maintain a current patient care plan that addresses the patient's individual ongoing needs during the hospital stay. The Governing Board approved the policy on 2/5/16. Nursing Leadership also reviewed and revised the "Language	2/5/16
A 396	482.23(b)(4) NURSING CARE PLAN The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the hospital failed to ensure nursing care plans were put in place for four of 26 sampled patients (16, 18, 20, and 26). This resulted in the potential for unmet care needs. Findings: [Note: "Dialysis" is a process involving a large, portable machine, that is attached to a patient so that all of their blood's toxins and other fluids can be removed when their own kidneys can no longer do it. If these waste products are not removed, the result can be death. Its purpose is to keep the right levels of chemicals, fluids, and salts in one's bloodstream, control blood	A 396		

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A 385	Continued From page 26 of 26 sampled patients (16, 18, and 20), (Refer to A 0396); and, 2. Documented and completed competencies for six contracted dialysis nurses, (Refer to A 0396); and, 3. Contracted nurses were oriented to the hospital, (Refer to A 0396). The cumulative effects of these systemic failures resulted in the hospital's inability to ensure nursing competency and that nursing care needs of patients were met.	A 385	Interpretation Line" Policy to clarify the process for use of interpreters. Language Interpretation is provided to all patients and/or their families on a 24-hour basis, as needed. The policy was approved by the Governing Board on 1/27/16 and on 2/5/16. Nurses were inserviced on developing nursing care plans (including for patients requiring dialysis services and language interpretation services). The CNO collaborated with the consultants to implement care facilitation (as discussed above) to address ongoing compliance with nursing care plans, use of language lines and communication issues	2/5/16 2/8/16
A 396	482.23(b)(4) NURSING CARE PLAN The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the hospital failed to ensure nursing care plans were put in place for four of 26 sampled patients (16, 18, 20, and 26). This resulted in the potential for unmet care needs. Findings: [Note: "Dialysis" is a process involving a large, portable machine, that is attached to a patient so that all of their blood's toxins and other fluids can be removed when their own kidneys can no longer do it. If these waste products are not removed, the result can be death. Its purpose is to keep the right levels of chemicals, fluids, and salts in one's bloodstream, control blood	A 396		

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A 385	Continued From page 26 of 26 sampled patients (16, 18, and 20), (Refer to A 0396); and, 2. Documented and completed competencies for six contracted dialysis nurses, (Refer to A 0398); and, 3. Contracted nurses were oriented to the hospital, (Refer to A 0398). The cumulative effects of these systemic failures resulted in the hospital's inability to ensure nursing competency and that nursing care needs of patients were met.	A 385	with non-English speaking patients. A Care Facilitation worksheet was developed for use by the care facilitators. An external clinical education agency was contracted to provide focused education to staff in these areas. Findings 2-3: The CEO and Nursing Leadership discussed the survey findings and had numerous discussions with the owner of the dialysis company regarding orientation and competencies for the dialysis staff.	11/10/15 - 2/8/16
A 396	482.23(b)(4) NURSING CARE PLAN The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the hospital failed to ensure nursing care plans were put in place for four of 26 sampled patients (16, 18, 20, and 26). This resulted in the potential for unmet care needs. Findings: [Note: "Dialysis" is a process involving a large, portable machine, that is attached to a patient so that all of their blood's toxins and other fluids can be removed when their own kidneys can no longer do it. If these waste products are not removed, the result can be death. Its purpose is to keep the right levels of chemicals, fluids, and salts in one's bloodstream, control blood	A 396		

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	050683	A. BUILDING _____ B. WING _____	C 11/10/2015

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A 385	Continued From page 26 of 26 sampled patients (16, 18, and 20), (Refer to A 0396); and, 2. Documented and completed competencies for six contracted dialysis nurses, (Refer to A 0398); and, 3. Contracted nurses were oriented to the hospital, (Refer to A 0398). The cumulative effects of these systemic failures resulted in the hospital's inability to ensure nursing competency and that nursing care needs of patients were met.	A 385	Ultimately, the CEO terminated the existing dialysis contract on 2/8/16 and contracted with a new dialysis provider, effective 2/8/16. The CEO discussed the survey findings with the new dialysis company, with special emphasis on completion of orientation and competencies for nurses working at the hospital. The new dialysis competency tool was provided to the new company and orientation and competencies for the new dialysis staff are maintained in the nursing office.	2/8/16
A 398	482.23(b)(4) NURSING CARE PLAN The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the hospital failed to ensure nursing care plans were put in place for four of 26 sampled patients (16, 18, 20, and 26). This resulted in the potential for unmet care needs. Findings: [Note: "Dialysis" is a process involving a large, portable machine, that is attached to a patient so that all of their blood's toxins and other fluids can be removed when their own kidneys can no longer do it. If these waste products are not removed, the result can be death. Its purpose is to keep the right levels of chemicals, fluids, and salts in one's bloodstream, control blood	A 398	Nursing Leadership reviewed the "Contract Employees" Policy, to clarify the process for	2/3/18

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A 385	Continued From page 26 of 26 sampled patients (16, 18, and 20), (Refer to A 0396); and, 2. Documented and completed competencies for six contracted dialysis nurses, (Refer to A 0396); and, 3. Contracted nurses were oriented to the hospital, (Refer to A 0396). The cumulative effects of these systemic failures resulted in the hospital's inability to ensure nursing competency and that nursing care needs of patients were met.	A 385	supervising and evaluating contracted nursing staff, including orientation requirements, evaluation of competencies and performance, and personnel file requirements. The policy did not require revision. A file is maintained in the nursing office for contracted nursing staff, including dialysis nurses. The file includes primary source license verification and required competencies. The contacted nursing staff members also receive an orientation packet, with a copy maintained in his/her file. Nursing office staff were reinserviced on the policy.	
A 396	482.23(b)(4) NURSING CARE PLAN The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the hospital failed to ensure nursing care plans were put in place for four of 26 sampled patients (16, 18, 20, and 26). This resulted in the potential for unmet care needs. Findings: [Note: "Dialysis" is a process involving a large, portable machine, that is attached to a patient so that all of their blood's toxins and other fluids can be removed when their own kidneys can no longer do it. If these waste products are not removed, the result can be death. Its purpose is to keep the right levels of chemicals, fluids, and salts in one's bloodstream, control blood	A 396		

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A 385	Continued From page 26 of 26 sampled patients (16, 18, and 20). (Refer to A 0396); and, 2. Documented and completed competencies for six contracted dialysis nurses, (Refer to A 0398); and, 3. Contracted nurses were oriented to the hospital, (Refer to A 0398). The cumulative effects of these systemic failures resulted in the hospital's inability to ensure nursing competency and that nursing care needs of patients were met.	A 385	Monitoring of nursing services is part of the QAPI program and is used for performance improvement measures. Data on compliance is reported through the Quality Council and to the MEC and Governing Board.	
A 396	482.23(b)(4) NURSING CARE PLAN The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the hospital failed to ensure nursing care plans were put in place for four of 26 sampled patients (16, 18, 20, and 26). This resulted in the potential for unmet care needs. Findings: (Note: "Dialysis" is a process involving a large, portable machine, that is attached to a patient so that all of their blood's toxins and other fluids can be removed when their own kidneys can no longer do it. If these waste products are not removed, the result can be death. Its purpose is to keep the right levels of chemicals, fluids, and salts in one's bloodstream, control blood	A 396	A396 482.23(b)(4) Nursing Care Plan Findings 1-4 Actions Taken: 1. Upon receipt of the Statement of Deficiencies, the CEO and Nursing Leadership discussed the survey findings and process for nursing care planning. The nursing care plan policy was reviewed and revised. The new policy, entitled "Interdisciplinary Plan of Care" delineates that clinical staff (e.g., nurses and other disciplines) are to develop and maintain a current patient care plan that addresses the patient's individual ongoing needs during the hospital stay. The Governing Board approved the policy on 2/5/16. 2. The Associate CNO developed a presentation and educated nursing staff on	2/5/16 1/19/16 - 1/28/16

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A 396	Continued From page 27 pressure, and remove waste products. Dialysis treatments typically take between 3 to 4 hours; during this time, all the patient's blood is removed and ran through a filter in the machine, then returned to the patient. Treatments usually occurs three times a week. Before the dialysis treatments can happen, a surgical procedure must occur, to make a connection site on the patient. The dialysis machine usually connects to this site via two needles.] 1. During an interview with Registered Nurse (RN) 1 on 11/9/15, at 9:20 AM, she indicated Patient 16 was a dialysis patient. During an interview with Patient 16, on 11/9/15, at 9:25 AM, she indicated she had just finished her dialysis treatment a few minutes ago. During a concurrent interview and record review with the Medical Record Specialist (MRS), on 11/10/15, at 9 AM, she reviewed Patient 16's medical record and stated there was no nursing care plan for her dialysis treatment, e.g., response to the treatment, fluid volume monitoring, or monitoring of the dialysis access site. During a concurrent interview and record review with RN 1 on 11/10/15, at 11 AM, she indicated Patient 16 was still a patient of the hospital and she was the nurse assigned to her. When asked if there was a care plan for Patient 16's dialysis treatment, RN 1 stated "Actually, I don't have any." 2. During a concurrent interview and record	A 396	nursing care plans, with special emphasis on the ongoing review and updating of nursing care plans as necessary to address the patient's ongoing needs (e.g., dialysis). 3. The CNO and Associate CNO held a leadership meeting with house supervisors and charge nurses to stress the importance of individualized current care plans, including plans for dialysis patients. The leadership meetings are ongoing at least bimonthly to discuss compliance with individualized patient care plans. 4. The CNO collaborated with the consultants to implement care facilitation (as discussed above) to address ongoing compliance with nursing care plans, use of language lines and communication issues with non-English speaking patients. A Care Facilitation worksheet was developed for use by the care facilitators. 5. An external clinical education agency was contracted to provide focused education to staff in these areas. 6. Nursing care plan education is provided to nurses upon hire and has been added to annual nursing skills day. 7. Nursing Leadership reviewed and revised the "Language Interpretation Line" Policy to clarify the process for use of interpreters. Language interpretation is provided to all patients and/or their families on a 24-hour basis, as needed. The policy was approved by the Governing Board on 1/27/16 and 2/5/16. Nursing staff were inserviced on the policy.	1/19/16 2/6/16 2/4/16 2/1/16 1/19/16 - 1/27/16 2/5/16

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A 396	Continued From page 28 review with the MRS, on 11/10/15, at 9:40 AM, Patient 18's physician's orders were noted. Patient 18 had a physician's order for the drug "hydroxyzine" (an antihistamine - class, multipurpose drug, used for anxiety, nausea/vomiting, allergies, skin rashes, and itchiness), to be given via injection directly into a muscle (a "shot"), as needed, up to twice daily, for "anxiety, sedation, or purills [itching]". The record contained no nursing care plan for the drug at all, nothing addressing which of the symptoms Patient 18 was displaying, and what non-medicinal interventions the nursing staff were using, or had tried, if any. The MRS acknowledged the finding. 3. During an observation of Patient 20 on 11/9/15, at 9:30 AM, she was receiving a dialysis treatment in the hospital's Intensive Care Unit (ICU), administered with a dialysis nurse, RN 2. During a concurrent interview and record review with the MRS, on 11/10/15, at 10 AM, she reviewed Patient 20's medical record and stated there was no nursing care plan for her dialysis treatment, e.g., response to the treatment, fluid volume monitoring, or monitoring of the dialysis access site. During a concurrent interview and record review with RN 4 on 11/10/15, at 10:58 AM, she indicated Patient 20 was still in the ICU, and she was the nurse assigned to her. When asked if she had a care plan for Patient 20's dialysis treatment, RN 4 stated "I haven't added a dialysis care plan."	A 396	8. Compliance with nursing care plans is monitored through the QAPI program. The existing audit tool was reviewed and revised to be more comprehensive in the monitoring of nursing care plans. In addition, a new care facilitation tool was also implemented to monitor compliance with care plans. Compliance and Monitoring: Effective 2/6/16, data is collected by the care facilitators, tracked daily, aggregated and reported to leadership at least weekly to allow for leadership to focus resources on those issues and units where continued vulnerabilities exist. The goal is to achieve 100% compliance with obtaining dialysis consents. Data is analyzed and reported every other month to the Quality Council, MEC, and Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will occur until the Quality Council determines sustained compliance has occurred, at which time the Council will determine what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Person Responsible: Chief Nursing Officer	2/6/16 2/6/16

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A 396	Continued From page 29 4. During a concurrent interview and review of Patient 26's clinical record with the MRS on 11/10/15, at 11 AM, she confirmed Patient 26 was a dialysis patient and could not find a care plan for his dialysis treatment. During an interview on 11/10/15, at 9:40 AM, with RN 6, she stated,"[Patient 26] speaks Spanish only, but he follows directions ok." During a concurrent interview and clinical record review on 11/10/15, at 1:40 PM, with RN 7, RN 6, and the Chief Nursing Officer (CNO), they confirmed there was no dialysis care plan nor one for communication in Patient 26's clinical record. RN 6 stated Patient 26 is unable to write and his sister needed to sign his paperwork. She confirmed there was not a care plan for written or oral communication needs. The CNO stated "We are going to do in-services on these issues. It is not our practice to care plan for Spanish speaking patients, since we have several staff who speak Spanish." The CNO indicated there was no policy and procedure for language interpretation. She confirmed there was no Spanish speaking staff currently assigned to Patient 26.	A 396		
A 398	482.23(b)(6) SUPERVISION OF CONTRACT STAFF Non-employee licensed nurses who are working in the hospital must adhere to the policies and procedures of the hospital. The director of nursing service must provide for the adequate supervision and evaluation of the clinical activities of non-employee nursing personnel which occur within the responsibility of the nursing services. This STANDARD is not met as evidenced by:	A 398	A398 482.23(b)(6) Supervision of Contract Staff Findings 1-3 Immediate Actions Taken: 1. The CEO met with the owner of the dialysis company to discuss the survey findings, specifically documented competencies for dialysis staff.	11/10/15

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A 398	Continued From page 30 Based on interview and record review, the hospital failed to: 1. Have documented and completed competencies for six contracted dialysis nurses; and, 2. Ensure contracted nurses are oriented to hospital. This has the potential to result in a lack of qualified nurses providing care to patients and to ensure an acceptable standard of practice is maintained for patient care and safety. Findings: 1. During a record review of the binder titled "[Dialysis Company] 2016 Staff Credentials" (which contained documents regarding the Registered Nurses (RNs) employed by that company, their competencies (a written and dated evaluation conducted by a health care professional), on 11/9/15 at 2:30 PM, the following was noted: RN 9 - No competency located, only a job description RN 10 - Partial competency, not dated or signed by evaluator RN 11 - No competency located, only a job description RN 12 - No competency located, only a job description RN 13 - Partial competency found, not dated or signed by evaluator RN 14 - Partial competency found, not dated or signed by evaluator	A 398	2. The CEO discussed the survey findings with the CNO and the process for providing orientation to contracted staff and obtaining completed competencies. In addition, the CEO and CNO discussed the need for additional nursing resources. Subsequent Actions Taken: 1. An Associate Chief Nursing Officer was hired on 12/16/15. 2. Nursing Leadership reviewed the "Contract Employees" Policy, to clarify the process for supervising and evaluating contracted nursing staff, including orientation requirements, evaluation of competencies and performance, and personnel file requirements. The policy did not require revision. A file is maintained in the nursing office for contracted nursing staff, including dialysis nurses. The file includes primary source license verification and required competencies. The contacted nursing staff members also receive an orientation packet, with a copy maintained in his/her file. Nursing office staff were reinserviced on the policy. 3. Nursing Leadership developed a pre-procedure checklist for the owner of the dialysis company and Medical Director. 4. Nursing Leadership developed a new dialysis competency tool, which addresses, among other things, demonstrated knowledge of electrolyte and fluid	11/10/15 12/16/15 2/3/16 1/14/16 2/3/16

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A 398	Continued From page 91 During an interview with Vice President (VP) 1, on 11/10/15, at 2:45 PM, she reviewed the binder and could not locate the competencies. VP 1 stated this company was an outside entity the hospital contracts with. She stated a missing page containing the evaluator's signature and date of completion did exist, but these pages were not provided during the survey, nor did she explain why these pages were not included in the binder. The [Dialysis Company's] policy and procedure, titled "Staff Qualifications and Competency - Dialysis Services", dated 1/10/13, read, in part: "[Dialysis Company] ...shall demonstrate, assess, maintain and improve staff competence on an ongoing basis. The competency of all staff, whether they are an employee of this facility or an employee of a licensed independent practitioner shall be assessed using a single set of criteria, and at the same frequency as an individual employed by the facility. Staff shall have a documented competency assessment completed as a part of their orientation; after the 90-day period of probation, and once every three (3) years, or more frequently as defined by the facility policy or law and regulation. Assessment methods that are used shall correspond to the skill being assessed. Methods include, but may not be limited to: Direct observation by qualified supervisor or preceptor... Successful completion of a general and unit-specific skills checklist. The competency assessment program is continuous and ongoing, with reports of competency outcomes forwarded to the Governing Body on a regular basis." 2. During an interview with the Assistant Chief	A 398	requirements, aseptic technique and good infection control practices, mixing dialysate, priming the dialyzer, taking vital signs pre and post dialysis, connecting the hemodialysis machine to the access site, explaining the procedure to the patient, inspecting and maintaining equipment settings, including pressures, conductivity, and temperature to ensure conformance to safety standards, calculating fluid removal or replacement to be achieved during dialysis procedure, monitoring the patient for adverse reaction and evaluating the hemodialysis machine for malfunction, and performing machine cleaning per policy and schedule, including heat, vinegar and bleach. The new competency tool was provided to the owner of the dialysis company. 5. The CEO and CNO had multiple discussions with the owner of the dialysis company regarding completing orientation and competency documentation for the dialysis staff. Ultimately, the CEO, terminated the existing dialysis contract on 2/8/16 and contracted with a new dialysis provider, effective 2/8/16. The CEO discussed the survey findings with the new dialysis company, with special emphasis on completion of orientation and competencies for nurses working at the hospital. The new dialysis competency tool was provided to the new company and orientation and competencies for the new dialysis staff are maintained in the nursing office.	2/8/16

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A 398	Continued From page 32 Nursing Officer (ACNO), on 11/9/16, at 1:55 PM, she was asked if the hospital checked competencies for contracted employees. The ACNO stated "No, the company (Dialysis Company) does it (competencies)." The ACNO was asked about hospital orientation for contracted employees and there was no response. During an interview with the Human Resources Director (HR), on 11/10/15, at 8:55 AM, contracted employee files were requested. The HR stated "We don't have files for contracted employees." The HR was asked about orientation for contract employees, and she stated "We don't have orientation for contract employees." The [Dialysis Company] policy and procedure titled "Staff Qualifications and Competency" dated 1/10/13, indicated "General competency requirements established by facility policy, such as attending facility orientation...".	A 398	Compliance and Monitoring Effective 2/8/16, the CNO or designee will perform a monthly audit of 100% of the contracted nursing staff files (for three months and then re-evaluate) to achieve 100% compliance with orientation and documented competencies. Corrective action is taken as necessary. Data on compliance is tracked, trended, analyzed and reported every other month to Quality Council, MEC and Governing Board, and is used for performance improvement measures. Person Responsible: Chief Nursing Officer	2/8/16
A 464	482.24(c)(2) CONTENT OF RECORD: ORDERS DATED & SIGNED All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner who is responsible for the care of the patient only if such a practitioner is acting in accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations. This STANDARD is not met as evidenced by: Based upon record review and interview, the hospital failed to ensure prescribers signed their verbal orders for medications within 48 hours for	A 464	A454 482.24(c)(2) Content of Record: Orders Dated & Signed Findings 1-4 Immediate Actions Taken: 1. Hospital Leadership discussed the survey findings with the Chief of Staff and the current process for enforcing compliance with authenticating orders. Hospital Leadership met with IT Leadership regarding identifying the number of outstanding orders to be	11/10/15

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A 454	Continued From page 33 four of 26 sampled patients (16, 17, 20, and 24). This creates the potential for medication errors. Findings: 1. During a concurrent interview with the Medical Record Specialist (MRS), and review of the clinical record for Patient 16, on 11/10/15, at 9 AM, her medication orders were noted. Patient 16 had been ordered the drug "morphine" (a narcotic pain killer) on 11/3/15, at 3:35 AM, by Medical Doctor (MD) 6. The order had not been signed by MD 6 as of the record review, making it over five days late for signature (it should have been signed by 11/5/15, by 3:35 AM). 2. During a concurrent interview with the MRS, and review of the clinical record for Patient 17, on 11/10/15, at 9 AM, her medication orders were noted. Patient 17 had been ordered the drug "acetaminophen" (an over the counter pain killer and fever reducer) on 11/6/15, at 12:18 AM, by MD 13. The order was signed by MD 13 on 11/8/15, at 10:22 PM, making it over 10 hours late for signature (it should have been signed by 11/8/15, by 12:18 AM). 3. During a concurrent interview with the MRS, and review of the clinical record for Patient 20, on 11/10/15, at 9 AM, her medication orders were noted. Patient 20 had been ordered the drug "clonidine" (to lower blood pressure) on 11/7/15, at 1:02 PM, by MD 13. The order had not been signed by MD 13 as of the record review, making it twenty hours late for signature (it should have been signed by 11/9/15, by 1:02 PM). 4. During a concurrent interview with the MRS, and review of the clinical record for Patient 24, on	A 454	authenticated and a process by which the physicians could complete the authentication process. Subsequent Actions Taken: 1. Hospital Leadership reviewed the "Telephone, Verbal and Written Order for Medication" Policy, which delineates the process for practitioners to authenticate their telephone and verbal medication orders within 48 hours. The policy did not require any revisions. 2. The Chief of Staff sent a memo to physician staff regarding compliance with authenticating telephone and verbal orders. 3. The Chief of Staff and CEO sent a memo on 1/21/16 to physicians regarding strict adherence to hospital policy regarding authenticating orders and that effective 2/3/16, the Allscripts EMR system will require physicians to authenticate their unsigned orders prior to proceeding with any other system function. It was subsequently discovered that IT needed to perform additional measures with the EMR system and the anticipated roll out of this process is now by the end of February 2016. A subsequent memo will be sent to the practitioners when IT has resolved the computer issues. 4. Compliance with authentication of orders was discussed at the 1/27/16 MEC meeting, with an update to MEC and Governing Board on 2/5/16.	1/19/16 1/18/16 1/21/16 2/5/16

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	050663	A. BUILDING _____ B. WING _____	C 11/10/2015

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A 454	Continued From page 33 four of 26 sampled patients (16, 17, 20, and 24). This creates the potential for medication errors. Findings: 1. During a concurrent interview with the Medical Record Specialist (MRS), and review of the clinical record for Patient 16, on 11/10/15, at 9 AM, her medication orders were noted. Patient 16 had been ordered the drug "morphine" (a narcotic pain killer) on 11/3/15, at 3:35 AM, by Medical Doctor (MD) 6. The order had not been signed by MD 6 as of the record review, making it over five days late for signature (it should have been signed by 11/5/15, by 3:36 AM). 2. During a concurrent interview with the MRS, and review of the clinical record for Patient 17, on 11/10/15, at 9 AM, her medication orders were noted. Patient 17 had been ordered the drug "acetaminophen" (an over the counter pain killer and fever reducer) on 11/6/15, at 12:18 AM, by MD 13. The order was signed by MD 13 on 11/8/15, at 10:22 PM, making it over 10 hours late for signature (it should have been signed by 11/8/15, by 12:18 AM). 3. During a concurrent interview with the MRS, and review of the clinical record for Patient 20, on 11/10/15, at 9 AM, her medication orders were noted. Patient 20 had been ordered the drug "clonidine" (to lower blood pressure) on 11/7/15, at 1:02 PM, by MD 13. The order had not been signed by MD 13 as of the record review, making it twenty hours late for signature (it should have been signed by 11/9/15, by 1:02 PM). 4. During a concurrent interview with the MRS, and review of the clinical record for Patient 24, on	A 454	5. The Chief of Staff resigned, effective 1/31/16. A new Chief of Staff was nominated and recommended to the MEC on 1/27/16 and approved by the Governing Board on 1/27/16. The new Chief of Staff will continue to educate and enforce physician noncompliance with authenticating orders. Compliance with authenticating orders is a standing agenda item at individual Medical Staff Department meetings and the annual Medical Staff meeting. 6. The CNO and consultants added the ongoing monitoring of authenticating telephone and verbal orders to the care facilitation process. 7. Compliance with authenticating telephone and verbal orders is monitored through the QAPI program. Compliance and Monitoring The Director of Health Information or qualified designee performs random reviews of at least 20 medical records weekly to achieve the goal of 90% compliance with authenticating telephone and verbal orders. In addition, data is collected by the care facilitators, tracked daily, aggregated and reported to leadership at least weekly to allow for leadership to focus resources on those issues and units where continued vulnerabilities exist.	1/27/16 2/6/16

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A 464	Continued From page 34 11/10/15, at 9 AM, her medication orders were noted. Patient 20 had been ordered the drug "atorvastatin" (lowers cholesterol) on 11/1/15, at 7:53 PM, by MD 6. The order had not been signed by MD 6 as of the record review, making it over six days late for signature (it should have been signed by 11/3/15, by 7:53 PM). The MRS acknowledged the findings. The hospital policy and procedure titled "Telephone, Verbal, and Written Order for Medication", dated 2/2015, read, in part: "Verbal and telephone orders are allowed, however in an effort to reduce medication errors, the use of these types of orders is discouraged. The prescribing practitioner must sign the written record of the verbal/telephone medication order within 48 hours of giving order." A 466 482.24(c)(4)(v) CONTENT OF RECORD: INFORMED CONSENT [All records must document the following, as appropriate:] Properly executed informed consent forms for procedures and treatments specified by the medical staff, or by Federal or State law if applicable, to require written patient consent. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the hospital failed to have documentation to indicate an informed consent was obtained prior to procedures in the clinical record for three of 26 sampled patients (16, 20, and 26). This practice has the potential for patients receiving procedures without knowing the benefits versus risks, and/or to make an informed decision about	A 464 A 466	Data is analyzed and reported every other month to the Quality Council, MEC, and Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will occur until the Quality Council determines sustained compliance has occurred, at which time the Council will determine what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Person Responsible: Director of Health Information Management Chief of Staff Chief Nursing Officer A466 482.24(c)(4)(v) Content of Record: Informed Consent Findings 1-3 Actions Taken: 1. Upon receipt of the Statement of Deficiencies, the CEO and Nursing Leadership discussed the survey findings and the process for obtaining dialysis	1/15/16 - 1/23/16

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A 486	Continued From page 86 that procedure. Findings: 1. During an interview with Registered Nurse (RN) 1 on 11/9/15, at 9:20 AM, she indicated Patient 16 was in her care, and was a dialysis (procedure to remove waste products from the blood when kidneys fail) patient. During an interview with Patient 16, on 11/9/15, at 9:25 AM, she indicated she had just finished her dialysis treatment a few minutes ago. During a concurrent record review and interview with the Medical Record Specialist (MRS) on 11/10/15, at 9 AM, she reviewed the clinical record for Patient 16 and was unable to find any documentation the patient was informed of the benefits and risks of her dialysis treatment. During an interview with RN 1 on 11/10/15, at 11 AM, she indicated Patient 16 was still her patient, and also reviewed her clinical record. RN 1 could not find any documented evidence the patient was informed of the benefits and risks of the dialysis. 2. During an observation of Patient 20 on 11/9/15, at 9:30 AM, she was receiving a dialysis treatment in the hospital's Intensive Care Unit (ICU). During a concurrent record review and interview with the MRS on 11/10/15, at 9 AM, the clinical record for Patient 20 was noted to not have a documented informed consent for her dialysis treatment.	A 486	consents. The "Consent/Informed Consent" Policy was reviewed and did not require any revisions. Informed Consent is required for those procedures which are complex or involve material risks that are not commonly understood. The patient's physician is responsible for providing the information the patient needs in order to make an informed decision and for obtaining the patient's informed consent or refusal for the recommended procedure. The hospital's role in the informed consent process is to verify that the physician obtained the patient's informed consent before the procedure. Nursing staff were reinserviced, with special emphasis on having an informed consent in the medical record prior to dialysis. 2. Hospital Leadership discussed the survey findings with the contracted dialysis company, with special emphasis that his dialysis staff were to check for the dialysis consent prior to dialysis. 3. Hospital Leadership sent a memo to physician staff reminding them of the need for an informed consent for dialysis. 4. The MEC discussed obtaining informed consents for dialysis on 1/27/16.	1/15/16 1/18/16 1/27/16

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A 466	Continued From page 35 that procedure. Findings: 1. During an interview with Registered Nurse (RN) 1 on 11/9/15, at 9:20 AM, she indicated Patient 16 was in her care, and was a dialysis (procedure to remove waste products from the blood when kidneys fail) patient. During an interview with Patient 16, on 11/9/15, at 9:25 AM, she indicated she had just finished her dialysis treatment a few minutes ago. During a concurrent record review and interview with the Medical Record Specialist (MRS) on 11/10/15, at 9 AM, she reviewed the clinical record for Patient 16 and was unable to find any documentation the patient was informed of the benefits and risks of her dialysis treatment. During an interview with RN 1 on 11/10/15, at 11 AM, she indicated Patient 16 was still her patient, and also reviewed her clinical record. RN 1 could not find any documented evidence the patient was informed of the benefits and risks of the dialysis. 2. During an observation of Patient 20 on 11/9/15, at 9:30 AM, she was receiving a dialysis treatment in the hospital's Intensive Care Unit (ICU). During a concurrent record review and interview with the MRS on 11/10/15, at 9 AM, the clinical record for Patient 20 was noted to not have a documented informed consent for her dialysis treatment.	A 466	5. The CEO terminated the existing dialysis contract and a new dialysis company started 2/8/16. The CEO discussed the survey findings with the new dialysis company, with special emphasis on ensuring that an informed consent for dialysis is in the medical record. 6. Nursing Leadership reviewed the medical records for current dialysis patients to ensure the presence of an informed consent and any issues identified were immediately corrected. 7. The CNO and consultants implemented care facilitation to assess and correct in real time any issues with obtaining informed consent for dialysis. A Care Facilitation worksheet was developed for use by the care facilitators, including the issue of obtaining informed consents for dialysis patients. 8. Nursing staff is educated on informed consents, including for dialysis, upon hire and annually. 9. Compliance with informed consents for dialysis is monitored through the QAPI program. <u>Compliance and Monitoring:</u> Data is collected by the care facilitators, tracked daily, aggregated and reported to leadership at least weekly to allow for leadership to focus resources on those issues and units where continued vulnerabilities exist. The goal is to achieve	2/8/16 1/15/16 - 1/19/16 2/8/16 2/8/16

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A 466	Continued From page 96 During an interview with RN 5 on 11/10/15, at 10:30 AM, she also reviewed Patient 20's clinical record and agreed about the findings. RN 5 indicated it is a normal hospital protocol to obtain these consents prior to the treatments. 9. During a concurrent record review and interviews with RN 7, RN 8, and the Chief Nursing Officer (CNO), on 11/10/15, at 1:40 PM, Patient 26's clinical record was reviewed. There was no documentation to indicate Patient 26 was informed of the benefits and risks of the dialysis treatment. RN 8 indicated in addition to being Spanish speaking only, Patient 26 was unable to read and write. The CNO stated there was no signature from Patient 26 regarding his dialysis treatment. The CNO stated, "We are going to do inservices on these issues." The CNO indicated there was no policy and procedure regarding Spanish speaking and/or illiterate patient informed consents.	A 466	100% compliance with obtaining dialysis consents. Data is analyzed and reported every other month to the Quality Council, MEC and Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will occur until the Quality Council determines sustained compliance has occurred, at which time the Council will determine what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Person Responsible: Chief Nursing Officer	
A 504	482.25(b)(2)(iii) ACCESS TO LOCKED AREAS Only authorized personnel may have access to locked areas. This STANDARD is not met as evidenced by: Based on observation and interview, the hospital failed to ensure: 1. The door to a dialysis room was locked on two occasions, and, 2. A pediatric (child) emergency resuscitation cart (crash cart) was locked.	A 504	A504 482.25(b)(2)(iii) Access to Locked Areas Findings 1-2 Immediate Actions Taken: 1. The door to the dialysis room was closed. 2. The door to the dialysis room at Los Angeles Community Hospital was changed to a keypad system to ensure that the door could not be left unlocked. 3. The CEO contacted the owner of the dialysis company regarding strict adherence with keeping the dialysis door locked at all times.	11/10/15 11/10/15 11/9/15

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A 504	Continued From page 37 This resulted in an unsafe environment, with the potential for unauthorized persons to enter the dialysis room and/or pediatric emergency resuscitation cart, and to disturb, remove, and/or contaminate the equipment therein, thereby jeopardizing the safe administration and treatments to patients, including during emergency and life-threatening situations. Findings: [Note: "Dialysis" is a process involving a large, portable machine, that is attached to a patient so that all of their blood's toxins and other fluids can be removed when their own kidneys can no longer do it. If these waste products are not removed, the result can be death. Its purpose is to keep the right levels of chemicals, fluids, and salts in one's bloodstream, control blood pressure, and remove waste products. Dialysis treatments typically take between 3 to 4 hours; during this time, all the patient's blood is removed and ran through a filter in the machine, then returned to the patient. Treatments usually occur three times a week.] During a concurrent interview and observation of the dialysis room with a dialysis Registered Nurse (RN) 2 on 11/9/15, at 10:10 AM, the door to the dialysis room was left unlocked. The dialysis room was located across from patient Room 128, at the end of a hallway that had several patients, some of which were noted to be ambulating in the hallway. Inside the dialysis room were four dialysis machines and assorted dialysis supplies. RN 2 indicated all the machines were in working order, and the door should be locked at all times, to prevent access from unauthorized individuals, including patients who were lost or confused.	A 504	4. The pediatric crash cart drawers were all secured with tamper evident seals. 5. The Assistant Chief Nursing Officer at the Norwalk campus reinserviced the nursing staff on 11/13/15, with special emphasis on strict adherence to policy regarding keeping the crash carts secured with tamper evident seals. Subsequent Actions Taken: 1. Nursing Leadership reviewed and revised the existing "Crash-Cart" Policy, to clarify the process for crash cart checks. The crash carts are to be secured with tamper-evident seals (frequently referred to as "locking" the crash cart). Nursing Staff were re-educated on maintaining security for crash carts. The MEC and the Governing Board approved the policy on 2/5/16. 2. The CNO spoke with the owner of the dialysis company numerous times regarding keeping the dialysis room door closed. 3. Nursing Leadership reeducated nursing staff on the applicable units that the dialysis door is to remain shut at all times. In addition, the Assistant CNO discussed closure of the dialysis room door with House Supervisors. 4. The CNO and consultants implemented care facilitation to address monitoring of the dialysis door and keeping crash carts secure. 5. Education on security of crash carts is provided to nursing staff upon hire.	11/9/15 11/13/15 1/19/16-2/6/16 11/9/15 - 2/6/16 1/19/16-1/27/16 2/6/16

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A 504	Continued From page 98 During a concurrent interview and observation of the dialysis room with the Medical Records Specialist (MRS) on 11/10/15, at 11 AM, the door was again unlocked, and also visibly open an inch or two. The MRS acknowledged the finding. During an observation on 11/9/15, at 8:54 AM, in a patient care area of the hospital emergency department, a posted note on the wall read "PEDS CRASH CART." A nine drawer pediatric crash cart had two unsecured drawers (first and third) allowing staff and non staff access to pediatric patients emergency care supplies. Seven of the nine drawers were individually secured with a single yellow zip tie. The first unsecured drawer contained multiple patient care supplies including the following; a sterile trachea (the windpipe) kit, sterile pediatric foley catheter (a tube into the bladder used to drain urine), peripheral intravenous catheter (small tube placed into a vein in order to administer medication or fluids). During a concurrent observation and interview with RN 16 on 11/9/15, at 8:55 AM, she verified that the two drawers on the pediatric crash cart were unsecure. She stated the cart was used to get supplies to start pediatric foley catheters but was unable to verify when the cart was last used. During an interview with Assistant Chief Nursing Officer, on 11/9/15, at 2 PM, she was asked to provide the hospital policy and procedure regarding hospital practice for maintaining security of the pediatric crash cart. No policy and procedure were provided.	A 504	6. Compliance with securing crash carts and keeping the dialysis room locked is monitored through the QAPI program. Compliance and Monitoring: In addition to care facilitation, the Chief Nursing Officer or qualified designee will perform random weekly audits of crash carts (for 3 months and then re-evaluate) to achieve the goal of 100% compliance with securing carts. Corrective action is taken as necessary, including 1:1 training with nursing staff. The Chief Nursing Officer or qualified designee also performs random reviews (for 3 months and then re-evaluate) of the dialysis room at varying times at least three times/week to achieve the goal of 100% compliance with keeping the dialysis room door closed. Corrective action is taken, including just-in-time training for nursing staff. Data on compliance is tracked, trended, analyzed and reported every other month to the Quality Council, MEC and the Governing Board, and is used for performance improvement measures. Person Responsible: Chief Nursing Officer	2/6/16
A 701	482.41(a) MAINTENANCE OF PHYSICAL	A 701	A701 482.241(a) Maintenance of Physical Plant	

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A 701	Continued From page 39 PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the hospital failed to maintain the hospital ground in a clean and orderly manner which had potential to provide an unsafe environment for its patients, visitors and staff. Findings: During a concurrent observation and interview with the Assistant Chief Nursing Officer (ACNO), Medical Records Specialist (MRS) and the Lead Engineer (LE) on 11/9/15, at 8:40 AM, the following items were identified during a tour of the Norwalk facility. 1. One patient gurney placed in front of a door identified as "Nurses lounge." 2. Dialysis Machine in the hospital dialysis storage room with brownish red substance on the left lower corner of the machine. 3. Pediatric crash cart with the first and third drawers unsecured. 4. One large linen storage (that would not close) container stored outside with exposed linen eastside of the hospital. 5. Several cardboard boxes lying on the ground behind a large gray bin northside of the hospital. 6. One bread rack with spider webbing and tree leaves on the lower base, one wood pallet and six black milk storage containers stored at the westside of the hospital.	A 701	Immediate Actions Taken: 1. The patient gurney in front of the nursing lounge was removed. 11/10/15 2. The Director of Infection Control discussed the cleanliness of the dialysis machines with the owner of the dialysis company, with emphasis on strict adherence to keeping the machines clean. The dialysis machine was removed from service. 11/10/15 3. The pediatric crash cart was rechecked to make sure that it was complete and all sections of the crash cart were secured with tamper-evident seals. 11/10/15 4. The old linen storage container was discarded. A new one was ordered and installed. 11/10/15 5. The cardboard boxes by the large gray bin were discarded and removed from the property. 11/10/15 6. The bread rack, wood pallet and milk storage containers were discarded and removed from the property. 11/10/15 7. The gray two-drawer file cabinet and brown folding table were discarded and removed from the property. 11/10/15 8. The white cloth screen divider was discarded and removed from the property. 11/10/15 9. The hospital beds and mattresses were discarded and removed from the property. 11/10/15 10. The toilet, halogen light bulbs, two metal stands, six wood boards, seven metal pipes, three wood doors, three metal gas containers were discarded and removed from the property. 11/10/15	

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A 701	Continued From page 40 7. One gray two drawer file cabinet and a brown folding table stored against the northside of the hospital. 8. One white cloth screen divider ripped in several places, out side the recovery room. 9. Ten hospital beds with mattresses lined up against the eastside of the hospital. 10. Stored on the ground between storage containers: One toilet, five halogen light bulbs, two metal stands, six wood boards, seven metal pipes on the ground, three wood doors, three green dirty and used metal gas containers. 11. Three patient mattresses stored outside a northside entry of the hospital. 12. One blue cart blocking the exit door on the northside of the hospital. 13. Three metal framed carts stored on the eastside of the hospital. 14. Four trash dumpster's uncovered. 15. One large cardboard box containing trash. 16. One white bucket with a unknown black liquid substance inside. 17. One ladder in the extended position stored against the east wall. 18. One bed side table stored against the eastside of the hospital. 19. One white closet door stored against the east wall of the hospital. 20. One gurney with a white sheet stored outside on the east wall of the hospital. 21. Emergency room waiting area air conditioner wall units electrical cord was not connected to electrical outlet (cord dangling against the wall). 22. Dialysis (is a process for removing waste and excess water from the blood and is used primarily as an artificial replacement for lost kidney function) machine in Intensive Care Unit leaking clear liquid on to a towel on the floor.	A 701	11. The three patient mattresses were discarded and removed from the property. 12. The blue cart was relocated from the exit door. 13. The three metal framed carts were removed from the eastside of the hospital. 14. The four trash dumpsters were covered. The Director of Engineering reinforced with engineering and EVS staff the importance of keeping the dumpsters covered. 15. The cardboard box was removed and discarded. The Director of Engineering ordered a large covered dumpster for cardboard trash. 16. The white bucket was discarded. 17. The ladder was removed from the east wall. 18. The bedside table was discarded and removed from the property. 19. The white closet door was removed and discarded from the property. 20. The gurney was removed and discarded. 21. The air conditioner wall unit electrical cord was connected to the electrical outlet in the ED waiting area. 22. The machine was removed from the hospital. The Director of Infection Control met with the owner of the dialysis company on 11/10/15 to discuss the status of the dialysis machine and the expectation that dialysis machines will be kept in clean working order for use in the hospital.	11/10/15 11/10/15 11/10/15 11/10/15 2/5/16 11/10/15 11/10/15 11/10/15 11/10/15 11/10/15 11/10/15 11/10/15 11/10/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050663	A. BUILDING _____ B. WING _____	C 11/10/2015

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A 701	Continued From page 41 During a concurrent observation and interview of the hospital environment with the ACNO and MRS, on 11/9/15, at 8:48 AM, the above listed findings were verified by the ACNO and the MRS. At 9:50 AM the LE joined the tour, he verified the northside and the eastside findings. The hospital policy and procedure titled "Environmental Services Scope of Services", dated 7/22/09, indicated: "Scope of Services: It is the mission and goal of the Environmental Services Department to maintain a clean environment for all who come into contact with the hospital... Scope of Care: Environmental Services is dedicated to provide a safe and clean environment for all patients, visitors and staff consistent with the values, vision and mission of the hospital." The hospital policy and procedure titled "Infection Control linen and Laundry Storage Regulations," dated 5/2000, indicated: "All shelves must be covered to prevent clean linen from contamination through the air-borne pathogens." The hospital policy and procedure titled "Environmental Services Safety Rules," dated 7/22/09, indicated: "Do not leave soiled rags lying around. Dispose of them... Keep all exits and fire doors free from any obstructions... Be sure all trash cans are covered... Keep all supply and utility rooms in a clean and orderly condition."	A 701	Subsequent Actions: 1. Hospital Leadership reviewed the "Environmental Services Safety Rules," "Environmental Services Scope of Services" and "Infection Control Linen and Linen Storage Regulations" policies, which did not require any revisions.	11/15/15
			2. The CEO discussed the survey findings with the CNO, Director of Infection Control, Director of Engineering, and Director of EVS, with emphasis on strict adherence on maintaining the hospital in a clean and orderly manner.	11/15/15
			3. The Director of EVS and Director of Engineering discussed the survey findings with their department staff, with special emphasis on maintaining a clean, orderly and safe environment.	11/15/15
			4. Hospital Leadership discussed the need for additional resource staff. Additional contracted EVS staff was obtained.	11/16/15
			5. The CEO terminated the dialysis contract and engaged a new dialysis company, effective 2/8/16.	2/8/16
A 713	482.41(b)(6) DISPOSAL OF TRASH The hospital must have procedures for the proper routine storage and prompt disposal of trash. This STANDARD is not met as evidenced by:	A 713		

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A 701	Continued From page 41 During a concurrent observation and interview of the hospital environment with the ACNO and MRS, on 11/9/15, at 8:48 AM, the above listed findings were verified by the ACNO and the MRS. At 9:50 AM the LE joined the tour, he verified the northside and the eastside findings. The hospital policy and procedure titled "Environmental Services Scope of Services", dated 7/22/09, indicated: "Scope of Services: It is the mission and goal of the Environmental Services Department to maintain a clean environment for all who come into contact with the hospital... Scope of Care: Environmental Services is dedicated to provide a safe and clean environment for all patients, visitors and staff consistent with the values, vision and mission of the hospital." The hospital policy and procedure titled "Infection Control linen and Laundry Storage Regulations," dated 5/2000, indicated: "All shelves must be covered to prevent clean linen from contamination through the air-borne pathogens." The hospital policy and procedure titled "Environmental Services Safety Rules," dated 7/22/09, indicated: "Do not leave soiled rags lying around. Dispose of them... Keep all exits and fire doors free from any obstructions... Be sure all trash cans are covered... Keep all supply and utility rooms in a clean and orderly condition."	A 701	Compliance and Monitoring: The Director of Engineering or designee performs weekly scheduled EOC rounds. The Director of Infection Control also participates in weekly scheduled EOC rounds. Corrective action is taken, including just-in-time training with staff. Data on compliance is tracked, trended, analyzed and reported quarterly through the EOC Committee, Quality Council, MEC, and Governing Board, and is used for performance improvement measures. Persons Responsible: Director of Engineering Director of EVS Director of Infection Control.	
A 713	482.41(b)(6) DISPOSAL OF TRASH The hospital must have procedures for the proper routine storage and prompt disposal of trash. This STANDARD is not met as evidenced by:	A 713	A713 482.41(b)(6) Disposal of Trash Immediate Actions: 1. The identified trash bins at Norwalk were covered. 2. The Facilities staff reviewed all trash bins to ensure that they were covered.	11/9/15 11/9/15

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A 713	Continued From page 42 Based on observation, interview, and record review, the Norwalk hospital location failed to maintain a sanitary environment when four of four dumpsters were not covered. This had the potential for insect vermin infestation. Findings: During a concurrent observation and interview with the Assistant Chief Nursing Officer (ACNO), on 11/9/15, at 9:55 AM, on the northside of the Norwalk hospital, it was noted all four blue dumpsters' (used to dispose of the entire hospitals trash) lids were flipped backwards exposing the waste inside. The ACNO verified the findings but could not offer any comment. She stated, "I'll call the maintenance." During a concurrent interview and observation with the Lead Engineer on 11/9/15, at 10:11 AM, he explained why the blue trash dumpsters were not covered. He stated, "It's a constant struggle with the waste company, they come at eight o'clock in the morning. When asked if staff comes out to close them (blue trash dumpster's) he had no comment. The hospital's policy and procedure titled "Environmental Services Scope of Services," dated 7/22/09, indicated: "Scope of Services: It is the mission and goal of the Environmental Services Department to maintain a clean environment for all who come into contact with the hospital... Scope of Care: Environmental Services is dedicated to provide a safe and clean environment for all patients, visitors and staff consistent with the values, vision and mission of the hospital."	A 713	3. The Director of Engineering discussed the survey findings with the EVS Manager and engineering staff, with special emphasis on ensuring that trash bins remain covered. Subsequent Actions: 1. Hospital Leadership reviewed the "Environmental Services Scope of Services" and "Environmental Services Safety Rules" policies, which did not require any revisions. Trash cans (including dumpsters) are to be kept covered. EVS and engineering (plant facilities) staff were reinserviced, with emphasis on strict adherence to keeping dumpster lids closed. 2. Hospital Leadership discussed the process with the Director of Engineering and EVS for ensuring that the dumpster lids remain closed. Engineering staff is making frequent daily rounds when the trash company picks up the trash in the morning. Compliance and Monitoring: The Directors of Engineering and EVS perform random rounds at varying times at least 3 times per week to achieve the goal of 100% compliance with keeping dumpster lids closed. Corrective action is taken as necessary, including closing the dumpster and just-in-time training. Data on compliance is tracked, trended, analyzed and reported quarterly at the	11/10/15 1/19/16 11/16/15

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A 713	Continued From page 43 The hospital's policy and procedure titled "Environmental Services Safety Rules" dated 7/22/09 indicated to "...Be sure all trash cans are covered..."	A 713	EOC Committee, Quality Council, and Governing Board, and is used for performance improvement measures. Persons Responsible Director of Engineering / Director of EVS	
A 724	482.41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the hospital failed to: 1. Ensure the isolation cart contained only required supplies. 2. Ensure the dialysis (is a process for removing waste and excess water from the blood and is used primarily as an artificial replacement for lost kidney function) machine was maintained in safe working order. This had the potential to place patient, staff, and visitors at risk for infection and injury. Findings: 1. During a concurrent observation and interview with Registered Nurse (RN) 19, on 11/9/15, at 11:39 AM, inside the Intensive Care Unit (ICU) at the Norwalk hospital, it was noted just outside of a patient treatment room was a yellow cart, RN 19 explained "it's an Isolation Cart." During further inspection of the cart, the following items were found in the cart: a. First drawer- sterile boarder gauze, unsterile	A 724	A724 482.41(c)(2) Facilities, Supplies, Equipment Maintenance Finding 1 Immediate Actions Taken: 1. The identified cart was reviewed and it was determined that it was not an isolation cart. The cart was removed from the unit. The Director of Infection Control informed the staff that the supply cart was no longer to be used. 2. The Director of Infection Control reviewed the unit and identified that there was sufficient PPE equipment located in wall caddys. Subsequent Actions Taken: 1. The Director of Infection Control provided ongoing education to nursing staff regarding infection control practices, including use of PPE equipment. Compliance and Monitoring: The Director of Infection Control or qualified designee will perform weekly rounds (for three months and then re-evaluate) to achieve the goal of 100 %	1/19/16 1/19/16 1/19/16 – 1/27/16

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A 724	Continued From page 44 boarder gauze, EKG (electrocardiogram - is a test that checks for problems with the electrical activity of your heart) electrodes (patches used in routine EKG testing), open used 10 cubic centimeter (cc) syringe with unknown fluid inside, 6 rolls of cloths tape, three 10 cc saline flushes a spray can of air freshener, and one abdominal pad. b. Second drawer- one used dirty glove, and two rolls of two-inch plastic tape. RN 19 verified the findings and replied "Gown, mask, gloves, and signs" were the items in the isolation cart. During an interview with the Assistant Chief Nursing Officer (ACNO), on 11/9/15, at 2:54 PM, she was made aware of the condition of the isolation cart. She was asked who was responsible for maintaining the isolation cart, the ACNO replied, "The nurse." During an interview with the Infection Control Officer (IC), on 11/9/15, at 3:05 PM, he was asked what items should be stored in the isolation cart. The IC stated, "Personal Protective Equipment (PPE), gloves, mask, and other items for PPE." The IC was informed of the items found in the isolation cart, he stated, "it shouldn't be in there." 2. During an observation on 11/9/15, at 11:50 AM, inside the ICU patient room (104), it was noted a dialysis (is a process for removing waste and excess water from the blood and is used primarily as an artificial replacement for lost kidney function) machine was being used to provide treatment to a patient. There was noted	A 724	compliance with not storing supplies in extra supply carts. Corrective action is taken as necessary, including 1:1 training and removing the cart. Data on compliance is tracked, trended, analyzed and reported every other month through the Infection Control Committee, Quality Council, MEC and Governing Board, and is used for performance improvement measures. Person Responsible: Director of Infection Control Finding 2 Immediate Actions Taken: 1. The identified dialysis machine was removed from service on 11/9/15 and from the hospital on 11/10/15. 2. The CEO and CNO discussed the survey findings with the owner of the dialysis company, with the expectation that machines with leaks will be immediately removed from service and replaced. Subsequent Actions Taken: 1. The CEO terminated the existing dialysis contract and a new dialysis company is in place, effective 2/8/16. The CEO alerted the new company to the survey findings, with the expectation that machines must be in working order (e.g., without leaks)	11/10/15 11/10/15 2/8/16

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A 724	Continued From page 45 a towel lying on the floor at the rear of the dialysis machine to absorb the clear liquid dripping from the tubing connected to the dialysis machine. The dialysis electric power cord and the extension cord connection were lying next to the wet towel. During an interview with RN 18, on 11/9/15, at 11:56 AM, RN 18 verified the findings and stated, "Yes, that's why I have the towel there." During an interview with the Lead Engineer (LE) on, 11/9/15, at 3:16 PM, the LE said he was not aware the dialysis machine was leaking, he had not been notified. The hospital policy and procedure titled "Environmental Services Scope of Services" indicated "Scope of Services and goal of the Environmental Services Department to maintain a clean environment for all who come into contact with the hospital. To achieve the goal and accomplish this mission, we shall work in harmony with other departments, organize efficiently, purchase economically, maintain equipment and train staff following accepted guideline and policies for department operation in an acute care facility... The service to the hospital includes: ...All other departments and areas of the hospital."	A 724	and any issues with the machines must be identified and immediately addressed. The new dialysis company provided policies and procedures for maintenance of dialysis machines. Compliance and Monitoring: The Director of Infection Control or qualified designee shall perform random weekly rounds of patients on dialysis (for three months and then re-evaluate) to achieve the goal of 100% compliance with dialysis machines in working order without leaks. Corrective action is taken as necessary, including 1:1 training with the dialysis nurse. Data on compliance is tracked, trended, analyzed and reported every other month through the Quality Council, MEC, and Governing Board, and is used for performance improvement measures. Persons Responsible: Chief Nursing Officer Director of Infection Control	2/3/16
A 747	482.42 INFECTION CONTROL The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases.	A 747	A747 482.42 Infection Control The Hospital assures that it has a comprehensive infection control program that provides for the prevention, control and investigation of infections and communicable diseases. A sanitary environment is maintained to avoid sources and transmission of infection.	

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A 747	Continued From page 46 This CONDITION is not met as evidenced by: Based on observation, interview and record review, the hospital failed to provide an environment to avoid sources and transmission of infections and communicable disease as evidenced by the hospital's failure to: 1. Remove dirty towels from dialysis machines (a large machine, that is attached to a patient so that all of their blood's toxins and other fluids can be removed when their own kidneys can no longer do it). (Refer to A 0749) 2. Ensure nothing stored on top of dialysis machine. (Refer to A 0749) 3. Ensure staff would wear Personal Protective Equipment (PPE, includes masks, gowns, and gloves) during dialysis. (Refer to A 0749) 4. Use hospital approved disinfectants. (Refer to A 0749) 5. Clean dialysis machine properly. (Refer to A 0749) 6. Maintain its dialysis room in a sanitary condition. (Refer to A 0749) 7. Discard expired supplies. (Refer to A 0749) 8. Discard opened sterile supplies. (Refer to A 0749) 9. Separate storage for nonsterile and sterile supplies. (Refer to A 0749) 10. Ensure isolation cart contained required	A 747	Hospital Leadership and the Director of Infection Control reviewed the survey findings and worked collaboratively to address the identified issues as discussed below. Infection Control practices were reviewed regarding dialysis and sanitation (maintenance of machine, cleaning and storing machine), use of disinfectants, discarding expired supplies, linen storage, storing nonsterile and sterile supplies, trash containers and disposing of trash and broken equipment. Education on infection control has been and continues to be provided to staff on a variety of topics, including maintenance of dialysis machines, use of PPE, approved disinfectants, removal of expired supplies, proper storage for nonsterile and sterile supplies, isolation procedures, storage of linen, disposal of trash and broken equipment, and covering of trash cans. Audit tools were developed and/or revised to ensure that identified issues are being monitored. The Infection Control Plan was reviewed and updated to address infection control practice and was approved by the Infection Control Committee, MEC and Governing Board. The Director of Infection Control attends EOC rounds focusing on infection prevention and infection control practices. The Director of Infection Control also created a CDC Guideline based Infection Control Manual that is in place on each clinical unit.	

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A 747	Continued From page 47 supplies. (Refer to A 0749) 11. Dispose of used cardboard. (Refer to A 0749) 12. Cover trash cans. (Refer to A 0713 and A 0749) 13. Dispose of broken equipment. (Refer to A 0724 and 0749) 14. Store linens in a closed and covered area. (Refer to A 0749) The cumulative effects of these systemic failures resulted in the hospital's inability to ensure a sanitary environment which had placed its patients, staff, and visitors at risk of being exposed to infectious and communicable diseases.	A 747	Data on compliance with infection control practices is monitored through the QAPI program.	
A 749	482.42(a)(1) INFECTION CONTROL PROGRAM The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the hospital's infection control officer failed to develop an effective infection control program which had the potential to mitigate the risks of spreading healthcare-associated infections to its patients as evidenced by: 1. Leaving dirty towels on dialysis machines (a	A 749	A749 482.42(a)(1) Infection Control Program	

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A 749	Continued From page 48 large machine, that is attached to a patient so that all of their blood's toxins and other fluids can be removed when their own kidneys can no longer do it). 2. Storing items on top of dialysis machine. 3. Failure to ensure staff wear Personal Protective Equipment (PPE) during dialysis. 4. Failure to use hospital approved disinfectants. 5. Failure to clean the dialysis machine properly. 6. Failure to maintain a sanitary condition in the dialysis room. 7. Not disposing of expired supplies. 8. Failure to dispose of opened sterile supplies. 9. Storing non-sterile and sterile supplies together. 10. Failure to ensure isolation cart contained only required supplies. 11. Failure to ensure cardboard was disposed of properly. 12. Failure to cover trash cans. 13. Failure to dispose of broken equipment. 14. Failure to store linens in a closed and covered area. Findings:	A 749		

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A 749	Continued From page 49 1. During a concurrent interview and observation of the dialysis room, at the Los Angeles hospital location, with Registered Nurse (RN) 2, on 11/9/15, at 10:10 AM, the door to the dialysis room was noted to be unlocked. The dialysis machines were noted to have large, white terrycloth towels on the lower portions of the machines. RN 2 indicated the towels should not be there, and stated, "They should be removed when in storage." During an observation on 11/9/15, at 8:40 AM, in the Dialysis room at the Norwalk hospital, with RN 15, a dialysis machine was found to have the following items on it: One white towel with brown spots left on the lower base of a dialysis machine, One white towel with brown spots wrapped around the tubing of the dialysis machine; and, One white towel with brown spots hanging from a plastic holder on back of dialysis machine. RN 15 verified the findings and could not provide a policy and procedure how dialysis machines should be stored. 2. During an observation and interview on 11/9/15, at 8:40 AM, with RN 2, in the Intensive Care Unit (ICU), at the Los Angeles hospital location, the dialysis machine next to Patient 20's bed was noted to have a 3-ring binder, an open package of medical gauze, medical tape and several rubber gloves on it. During a concurrent observation and interview with RN 18, on 11/9/15, at 9:20 AM, in the ICU bed 4 at the Norwalk hospital, RN 18 was monitoring the dialysis machine, and the dialysis	A 749	Actions Taken: Findings 1-2 Immediate Actions Taken: 1. The dialysis door was locked. 2. The identified towels and supplies on the dialysis machine were removed. 3. The CEO and CNO discussed the survey findings with the owner of the dialysis company, with special emphasis on closing the dialysis door and maintaining the dialysis machines in clean working order (including no towels on the machines). Subsequent Actions Taken: 1. Nursing Leadership discussed the survey findings with nursing staff, with special emphasis on reporting any issues with dialysis services (e.g., maintenance and storage of machines, cleanliness and failure to lock the dialysis door). 2. The CNO repeatedly met with the owner of the dialysis company regarding strict adherence to proper maintenance and storage of dialysis machines and keeping the dialysis door closed. 3. The CEO terminated the existing dialysis company and engaged a new company, effective 2/8/16. The CEO discussed the survey findings with the new dialysis company, with special emphasis on proper	11/9/15 11/9/15 11/10/15 11/10/15 - 2/8/15 11/10/15 - 2/8/16 2/8/16

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	050663	A. BUILDING _____ B. WING _____	C 11/10/2015

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A 749	Continued From page 50 machine was noted to have the following items on top: 3-ring binder, clipboard, and a box of gloves. RN 18 was asked about the items on top of the machine, and she stated "It's my binder and paperwork." RN 18 removed the items and placed them on the counter. During an observation on 11/9/15, at 11:26 AM, in ICU, bed 4 at the Norwalk hospital, it was noted again the dialysis machine had a box of gloves on top. During an interview with the owner of the Dialysis Company, on 11/9/15, at 3:40 PM, he was asked about items kept on the dialysis machine, he stated "It shouldn't be." When asked for a policy and procedure the Owner stated "I don't have one." 3. During an observation on 11/9/15, at 9: 40 AM, in Patient 20's room at the Los Angeles hospital, it was noted a sign posted outside the patients's room read, "Isolation Contact Precautions," and it indicated a gown, gloves and a mask were required to enter the room. RN 2 was observed inside the room providing care without gloves and a face mask. During observation on 11/9/15, at 11:40 AM, in ICU, bed 4, RN 18 was taking Patient 1 off of the dialysis machine, and RN 18 wore a mask and a pair of gloves. During an interview with RN 18 on 11/9/15, at 11:47 AM, she was asked about wearing PPE during dialysis. RN 18 stated the policy is to wear mask, gloves, and gown. RN 18 was asked should she wear a gown while terminating the patient's dialysis treatment, and she stated "Yes, I	A 749	maintenance and storage of dialysis machines and keeping the dialysis door closed. The new dialysis company provided policies and procedures on maintenance and storage of the dialysis machines. 4. Compliance with dialysis services is monitored through the QAPI program. Compliance and Monitoring: The Director of Infection Control or qualified designee shall perform random weekly rounds of patients on dialysis (for three months and then re-evaluate) to achieve the goal of 100% compliance with keeping the dialysis door closed, and the machines free of unnecessary supplies. Corrective action is taken as necessary, including 1:1 training with the dialysis nurse. Data on compliance is tracked, trended, analyzed and reported every other month through the Infection Control Committee, Quality Council, MEC and Governing Board, and is used for performance improvement measures. Person Responsible: Director of Infection Control Finding 3 Immediate Actions Taken: 1. The CEO and CNO discussed the survey findings with the owner of the dialysis company, with special emphasis on strict adherence with use of PPE.	2/3/16 11/10/15

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A 749	Continued From page 51 just didn't put it on." During an interview with the Infection Control Officer (IC), on 11/9/15, at 3:05 PM, he was asked about PPE the dialysis nurse should wear. The IC stated "I'm new on the job...they received the information on wearing PPE, but I haven't done any training." During an interview with the Owner, on 11/9/15, at 3:30 PM, he was asked what PPE should the nurses wear while terminating patients dialysis treatment. The Owner stated "Gloves, mask, and maybe a gown, but they should follow the policy." The Dialysis Company policy and procedure titled "Standard Precautions" dated 1/10/13, indicated "Standard Precautions apply to all patients regardless of their diagnosis or suspected infection status. Standard Precautions apply to the following: Blood, All body fluids, secretions... Standard Precautions include Personal Protective Equipment (PPE- used to protect staff from contact with infectious agents, and to prevent staff from carrying these infectious agents from patient to patient): Gloves, Gowns, Mouth, Nose, Eye Protection." The Dialysis Company policy and procedure titled "Personal Protective Equipment (PPE)" dated 1/10/13, indicated: "Staff shall wear PPE during: The initiation and termination of dialysis treatment." 4. During an observation with RN 15, on 11/9/16, at 8:40 AM, in the Dialysis Room, it was noted there was a container labeled "Lemon Scent disinfecting wipes (up & up brand from Target), a powerful cleaner for kitchen cuts through grease."	A 749	Subsequent Actions Taken: 1. The Director of Infection Control inserviced clinical staff on isolation precautions and the use of PPE. 2. The CEO terminated the existing dialysis company and engaged a new company, effective 2/8/16. The CEO discussed the survey findings with the new dialysis company, with special emphasis on proper use of PPE equipment. 3. Education to staff on isolation precautions and use of PPE is provided upon hire and during annual skills fair. 4. Compliance with the use of PPE is monitored through the QAPI program. Compliance and Monitoring: The Director of Infection Control conducts clinical surveillance activities and performs at least weekly rounds on clinical units focusing on patients with known infections and on isolation to achieve the goal of 100% compliance with use of PPE. Corrective action is taken as necessary, including 1:1 training with applicable staff. Data on compliance is tracked, trended, analyzed and reported every other month through the Infection Control Committee, Quality Council, MEC, and Governing Board, and is used for performance improvement measures.	11/16/16-11/20/16 2/8/16

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A 749	Continued From page 52 The active ingredients listed: Dioctyl dimethyl ammonium chloride and dimethyl benzyl ammonium chloride. During an interview with RN 18, on 11/9/15, at 9:20 AM, she was asked what is used to clean the dialysis machine. RN 18 stated "I have a technician that I call and he comes to clean it... It's kept in the cabinet in the room, the disinfectant that's used for everytime." During an interview with RN 18, on 11/9/15, at 9:30 AM, she was shown the Lemon Scent up & up brand, and asked if this was the disinfectant. RN 18 stated "Yes, I usually keep it on the machine." During an interview with the Assistant Chief Nursing Officer (ACNO), on 11/9/15, at 11:25 AM, she was asked for an approved list of hospital cleaners. The ACNO called to Central Supply, and said she was told there are two: Micro-Kill One (bleach free disinfectant cleaner) and Micro-Kill bleach (a bleach solution equivalent to a 1:10 dilution). During an interview with RN 18, on 11/9/15, at 11:30 AM, she was asked where the Lemon Scent wipes were from, and she stated "The company (Dialysis Company) provides it." During an interview with Owner, on 11/9/15, at 3:30 PM, he was asked if the company approved the Lemon Scent wipes to clean the dialysis machine. The Owner stated: "They should not use Lemon Scent wipes. It shouldn't be used on the machine. The bleach wipes should be used... maybe use those on the table."	A 749	Person Responsible: Director of Infection Control Findings 4-6 Immediate Actions Taken: 1. The identified cleaning wipes were discarded. The Director of Infection Control re-educated the nurse on the approved disinfectant to be used, the use of PPE and proper technique for cleaning the machine. 2. The identified machine was removed from service and the identified supplies were discarded. 3. The Director of Infection Control and CNO discussed the survey findings with the owner of the dialysis company, with special emphasis on strict adherence to using only approved disinfectants in the hospital, PPE, and proper infection control practices for cleaning the dialysis machines. Subsequent Actions Taken: 1. The Director of Infection Control reviewed and revised the Infection Control Plan to clarify infection control practices. The Infection Control Plan addresses a clean orderly environment of care, free of infectious hazards, which includes the dialysis room. 2. The CNO repeatedly met with the owner of the dialysis company regarding strict adherence to infection control	11/9/15 – 11/16/15 11/9/15 11/10/15 - 2/6/16 2/1/16 2/8/16

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A 749	Continued From page 53 The Dialysis Company policy and procedure titled "Cleaning and Disinfection of Medical Devices and Equipment" dated 1/10/13, indicated "Dialysis Services staff shall clean and disinfect surfaces, medical devices and equipment per manufacturer's instructions and using a facility-approved disinfectant." The Dialysis Machine Model #2008K Operator's Manual, Chapter 5- Disinfection and Maintenance indicated "Cleaning the Exterior Surface- It can be cleaned with a very dilute bleach or other suitable hospital disinfectant. Freshly prepared dilute bleach solution (1:100) is currently recommended by the Center for Disease Control.,. Do not use foaming cleaner or disinfectants containing...dimethyl benzyl ammonium chloride. These ingredients attack the poly carbonate plastics used in the machine." 6. During a concurrent observation and interview with RN 18 on 11/9/15, at 11:50 AM, she was wearing a mask and gloves cleaning the front of the dialysis machine with a disinfectant wipe. RN 18 moved a gallon bottle of vinegar from the bottom shelf of the machine and placed it on the floor, she wiped the bottom shelf, and immediately picked the gallon bottle of vinegar off the floor and placed it back onto the bottom shelf of the machine. RN 18 was asked the wet time (amount of time for disinfectant to kill germs), and she stated "two minutes." The Dialysis Company policy and procedure titled "Personal Protective Equipment (PPE)" dated 1/10/13, indicated: "Staff shall wear PPE during: Cleaning and disinfecting of patient care supplies and equipment."	A 749	practices, including in the dialysis room. Ultimately, the CEO terminated the existing dialysis company and engaged a new company, effective 2/8/16. The CEO discussed the survey findings with the new dialysis company, with special emphasis on infection control practices. The new dialysis company provided policies and procedures that address, among other things, maintenance and storage of dialysis machines. 3. Education to staff on isolation precautions and use of PPE is provided upon hire and during annual skills fair. 4. Contracted dialysis staff receives orientation to the hospital and infection control practice expectations. Competencies are obtained that include maintenance of the dialysis machine and following infection control practices, including practices specific to proper sanitation in the management of dialysis patients, equipment and the dialysis room in general. 5. Compliance with the use of PPE, and infection control practices for dialysis services is monitored through the QAPI program. <u>Compliance and Monitoring:</u> The Director of Infection Control performs at least weekly rounds on clinical units focusing on dialysis patients to achieve the goal of 100% compliance with use of	

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A 749	Continued From page 54 The Dialysis Company policy and procedure titled "Standard Precautions" dated 1/10/19, indicated "Standard Precautions include Personal Protective Equipment (PPE- used to protect staff...: Gloves, Gowns, Mouth, Nose, Eye Protection)." The Dialysis Machine Model #2008K Operator's Manual, Chapter 5- Disinfection and Maintenance indicated "Cleaning the Exterior Surface- It can be cleaned with a very dilute bleach or other suitable hospital disinfectant... Rinse off cleaning solution with a water-dampended cloth, especially if a corrosive, cleaning agent such as bleach is used." 6. During an observation on 11/9/15, at 8:40 AM, in the Dialysis Room with RN 15, the following items were found: A dialysis machine had brownish red substance on left lower corner of the machine, One white towel with brown spots placed on the front lower base of a dialysis machine, One white towel with brown spots wrapped around the tubing on a dialysis machine, One white towel with brown spots in a plastic holder on back of dialysis machine, One dirty white wash cloth on the floor, One blue glove placed on the opening of Bicarbonate Concentrate 9.5 Liter bottle (with a piece of tape dated 11/7/15 2130), One blue glove place over the opening Pure Bright Ultra Bleach 1 gallon bottle; and, Blood bank storage cabinet marked biohazard with a bag of blood inside. The findings were verified by RN 15.	A 749	with use of PPE and proper infection control practices (including sanitation of the dialysis room). Corrective action is taken as necessary, including 1:1 training with applicable staff. Data on compliance is tracked, trended, analyzed and reported every other month through the Infection Control Committee, Quality Council, MEC and Governing Board, and is used for performance improvement measures. Person Responsible: Director of Infection Control	

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A 749	Continued From page 55 There was no policy and procedure provided regarding the sanitary condition of the Dialysis Room. 7. During an observation on 11/9/15, at 8:55 AM, in the Emergency Department, inside a cabinet labeled "Laceration" the following items were found: 13 packages of 2-0 Prolene SH 30 inch suture (a strand or fiber used to sew parts of the living body) with an expiration date of "Jan 2015." One Gen-Probe urine specimen kit (swab used to collect and transport specimens) with an expiration date "1-31-2015." During an interview with the ACNO, on 11/9/15, at 9 AM, she validated the findings and stated, "They (expired items) shouldn't be in there." The hospital policy and procedure titled "Outdated Sterile Supplies" dated 5/2003, indicated "Unless an item is within its expiration date it shall be considered no longer sterile and must be returned to Central Service for processing or disposal, as appropriate. Items distributed to patient care units or departments shall be checked monthly to monitor outdated supplies..." The hospital policy and procedure titled "Outdated Supplies, Handling of" dated 5/2003, indicated "All supplies which have reached the expiration date should be removed from service and returned to Central Service for reprocessing or disposal." 8. During a concurrent observation and interview	A 749	Finding 7 Immediate Actions Taken: 1. The expired suture and urine specimen kit were discarded. 2. The Assistant CNO inserviced the staff at the time of survey regarding discarding expired supplies. Subsequent Actions Taken: 1. Hospital Leadership supervised a team of personnel to review the units to ensure that expired items were discarded. 2. The CEO discussed the survey findings with the Purchasing Department, with the expectation that they will establish par levels, stock and review for expired supplies and discard expired supplies. 3. Nursing Leadership reviewed the "Outdated Sterile Supplies" and Outdated Supplies, Handling of" policies, which did not require any revisions. Expired supplies must be returned to Central Supply for reprocessing or disposal. Morning staff huddles and leadership rounds were conducted to remind staff to dispose of expired supplies. Compliance and Monitoring: The Director of Infection Control performs random weekly rounds on clinical units to achieve the goal of 95% compliance with discarding expired supplies. Corrective action is taken as necessary, including 1:1 training with applicable staff and discarding the supplies. Data on compliance is	11/9/15 11/10/15 1/11/16 – 2/5/16 11/11/16 1/20/16

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A 749	Continued From page 66 with the ACNO on 11/9/15, at 8:55 AM, in the Emergency Department, inside a cabinet labeled "Laceration" a disposable scalpel (out of package) was found stored with sterile scalpels. The ACNO stated, "That's wrong...shouldn't be together." The Centers for Disease Control and Prevention (CDC, the nation's health protection agency, working 24/7 to protect America from health and safety threats, both foreign and domestic. CDC increases the health security of our nation), Infection Control, indicated: "Unwrapped items are susceptible to contamination. Avoid storing items loose in drawers or cabinets because unwrapped items cannot be kept sterile. Items stored in this manner are subject to contamination from dust, aerosols generated during treatment, and the hands of personnel who must handle them." 9. During a concurrent observation and interview with the ACNO, on 11/9/15, at 9:06 AM, in the Emergency Department, inside a lower drawer the following items were found stored together: A blue plastic basket containing multiple loose cotton balls, one vacutainer (translucent plastic holder for needle), 12 - sterile hypodermic needles, 4 - sterile eclipse needles (single-hand activation), and 4 - blood collection tubes Gauze pads (sterile and non sterile), red poly cath rectal tube (tube which is inserted into the rectum in order to relieve gas or feces), and a dirty pressure infuser labeled with a black mark in three areas "ICU". The ACNO verified the findings and stated "They	A 749	tracked, trended, analyzed and reported every other month through the Infection Control Committee, Quality Council, MEC and Governing Board, and is used for performance improvement measures. Person Responsible: Director of Infection Control Findings 8 - 9 Immediate Actions Taken: 1. The disposable scalpel was removed. 2. The identified supplies in the identified lower drawer in the ED were removed, pending reorganization of the drawer. Subsequent Actions Taken: 1. Clean and sterile supplies were separated in the ED drawers. ED nursing staff were reeducated on storing of clean and sterile supplies, with special emphasis on the proper handling of dirty supplies. 2. The Director of Infection Control reviewed and revised the "Separation of Clean and Contaminated Items" policy to clarify storage of clean and dirty utility rooms. The Infection Control Committee, MEC and Governing Board approved the revised policy. Nursing staff were advised on the policy in a laminated posting in each clean/dirty utility room. Compliance and Monitoring: The Director of Infection Control performs at least weekly rounds on clinical units with	11/9/15 11/9/15 2/5/16 2/8/16

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A 749	Continued From page 57 shouldn't be together." The CDC, Infection Control, recommends that sterile supplies should be stored separately from clean supplies. If clean and sterile supplies must be stored within the same shelving unit, the sterile items should be stored on the upper shelves above the clean items. 10. During a concurrent observation and interview with RN 19, on 11/9/15, at 11:39 AM, inside the ICU, outside a patient treatment room was a yellow cart, RN 19 was asked what the cart was, and he stated "It's an Isolation Cart." The following items were found in the cart: 1. In the first drawer- sterile border gauze, unsterile border gauze, EKG (electrocardiogram - a test that checks for problems with the electrical activity of your heart) electrodes (patches used in routine EKG testing), open used 10 cubic centimeter (cc) syringe with unknown fluid inside, 6 rolls of cloth tape, 8 -10 cc saline flushes syringes, spray can of air freshener, abdominal pad. 2. second drawer- used dirty glove and 2- rolls of 2 inch plastic tape. RN 19 verified the findings. RN 19 was asked what should be inside the isolation cart, and he stated "Gown, mask, gloves, and signs." During an interview with the ACNO, on 11/9/15, at 2:54 PM, she was made aware of the condition of the isolation cart. The ACNO was asked who was responsible for maintaining the isolation cart, and she said the nurse.	A 749	the goal of achieving 100% compliance with proper storage of sterile and clean supplies. Corrective action is taken as necessary, including 1:1 training with applicable staff. Data on compliance is tracked, trended, analyzed and reported at least monthly through the Infection Control Committee, Quality Council, MEC and Governing Board, and is used for performance improvement measures. Person Responsible: Director of Infection Control Finding 10 Immediate Actions Taken: 1. The identified cart was reviewed and it was determined that it was not an isolation cart. The cart was removed from the unit. The Director of Infection Control informed the staff that the supply cart was no longer to be used. 2. The Director of Infection Control reviewed the unit and identified that there was sufficient PPE equipment located in wall caddies. Subsequent Actions Taken: 1. The Director of Infection Control provided ongoing education to nursing staff regarding infection control practices, including use of PPE equipment.	11/10/15 11/10/15 1/19/16 – 1/27/16

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A 749	Continued From page 58 During an interview with the IC, on 11/9/15, at 3:05 PM, he was asked what items belong in the isolation cart. The IC stated "Personal Protective Equipment (PPE), gloves, mask, and other items for PPE." The IC was asked about the extra items found inside, and he stated "It shouldn't be in there." During an interview with the ACNO, on 11/9/15, at 2:54 PM, inside the hospital conference room, she was made aware of the items found on the yellow isolation cart. The ACNO was asked who was responsible for maintaining the isolation cart she said the nurses. The hospital policy and procedure for the isolation cart was requested from the ACNO, none were provided. 11. During a concurrent observation and interview with the ACNO, on 11/9/15, at 9:52 AM, near a north wall on the north side of the hospital where the medical surgical unit was, there were two gray bins observed. The bin on right side had a printed sign secured read "CARDBOARD ONLY." Several cardboard boxes were seen on the ground behind the gray bin on the right. The ACNO verified the findings said, "Those shouldn't be there (referring to the cardboard boxes on ground)." 12. During a concurrent observation and interview with the ACNO and the Lead Engineer (LE), on 11/9/15, at 9:56 AM, at the north side of the hospital, it was noted there were four blue dumpsters left uncovered and exposed the waste inside. The ACNO verified the findings and stated "I'll call maintenance." During a concurrent interview and observation	A 749	2. The Infection Control Plan was reviewed and revised to address infection control practices. The Governing Board approved the plan on 2/5/16. Compliance and Monitoring: The Director of Infection Control or qualified designee will perform weekly rounds (for three months and then re-evaluate) to achieve the goal of 95% compliance with not storing supplies in extra supply carts. Corrective action is taken as necessary, including 1:1 training and removing the cart. Data on compliance is tracked, trended, analyzed and reported every other month through the Infection Control Committee , Quality Council, MEC and Governing Board, and is used for performance improvement measures. Person Responsible: Director of Infection Control Finding 11-13 Immediate Actions Taken: 1. The cardboard boxes were discarded. The Director of Engineering ordered a large covered dumpster for cardboard trash. 2. The dumpsters were covered. 3. The storage cart was discarded. 4. The file cabinet and folding table were removed. 5. The screen divider was discarded. 6. The hospital beds and mattresses were removed.	2/5/16 11/10/15 11/10/15 11/10/15 11/10/15 11/10/15 11/10/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050663	A. BUILDING _____ B. WING _____	C 11/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOS ANGELES COMMUNITY HOSPITAL	4061 E OLYMPIC BLVD LOS ANGELES, CA 90023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 749	Continued From page 59 with the LE on 11/9/15, at 10:11 AM, the LE was asked why the blue trash dumpsters were not covered with the lids; LE stated, "It's a constant struggle with the waste company, they come at eight o'clock in the morning. When asked if staff comes out to close them (blue trash dumpster's) he did not offer any comment. The hospital policy and procedure titled "Environmental Services Scope of Services" dated 7/22/09 indicated: "Scope of Services: It is the mission and goal of the Environmental Services Department to maintain a clean environment for all who come into contact with the hospital... Scope of Care: Environmental Services is dedicated to provide a safe and clean environment for all patients, visitors and staff consistent with the values, vision and mission of the hospital." The hospital policy and procedure titled "Environmental Services Safety Rules," dated 7/22/09, read in part, "...Be sure all trash cans are covered..." 13. During a concurrent observation and interview with the ACNO, Medical Records Specialist (MRS), and the LE, on 11/9/15, at 8:40 AM, the following broken and unusable patient items were identified during a tour of the hospital: a. One white two column storage cart containing linen with roll up doors that could not be shut. b. One gray two drawer file cabinet and a brown folding table stored on the ground in a outside entry way (north side of the hospital). c. One white cloth screen divider ripped in	A 749	7. The toilet, halogen light bulbs, metal stands and three wood doors were removed. 8. The three metal cart frames were removed. 9. The white closet door was removed and discarded. Subsequent Actions: 1. Hospital Leadership reviewed the "Environmental Services Safety Rules," and "Environmental Services Scope of Services" policies which did not require any revisions. 2. The CEO discussed the survey findings with the CNO, Director of Infection Control, Director of Engineering, and Director of EVS, with emphasis on strict adherence on maintaining the hospital in a clean and orderly manner. 3. The Director of infection control and the Director of EVS met to discuss best methods to work in tandem toward directing EVS staff in maintaining strong infection control practices when performing environmental disinfecting and other sanitation activities. 4. The Director of EVS and Director of Engineering discussed the survey findings with their department staff, with special emphasis on maintaining a clean, orderly and safe environment. 5. Hospital Leadership discussed the need for additional resource staff. Additional contracted EVS staff were obtained.	11/10/15 11/10/15 11/10/15 11/10/15 11/11/15 11/19/15 11/18/15 11/10/15 - 2/3/16

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LOS ANGELES COMMUNITY HOSPITAL	4081 E OLYMPIC BLVD LOS ANGELES, CA 90023

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A 749	Continued From page 60 several places. d. Ten hospital beds with mattresses lined up in a row at the east wall of the hospital, one of the hospital beds had a sign posted to it that read, "BROKEN keeps falling down." e. One toilet, five halogen light bulbs, two metal stands and three wood doors were stored on the ground in a space between two large storage containers. f. Three patient mattresses stored outside in a north entry of the hospital. g. Three metal cart frames stored on the east wall of the hospital. h. One white closet door stored against the east wall of the hospital. The above findings were verified by the ACNO and MRS. During a concurrent observation and interview with the LE, on 11/9/15, at 9:52 AM, the LE was asked why the beds (10 beds and 10 mattresses) were stored there, he said, "All my broken beds, these are here for parts." The LE verified the unusable equipment needed to be disposed of. The hospital policy and procedure titled "Environmental Services Scope of Services" dated 7/22/08, indicated: "Scope of Services: It is the mission and goal of the Environmental Services Department to maintain a clean environment for all who come into contact with the hospital... Scope of Care: Environmental Services is dedicated to provide a safe and clean	A 749	Compliance and Monitoring: The Director of Engineering or designee performs weekly scheduled EOC rounds. The Director of Infection Control also participates in weekly scheduled EOC rounds. Corrective action is taken, including just-in-time training with staff. Data on compliance is tracked, trended, analyzed and reported every other month through the Infection Control, Quality Council, MEC and Governing Board, and is used for performance improvement measures. Persons Responsible: Director of Engineering Director of EVS Director of Infection Control.	

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A 749	Continued From page 61 environment for all patients, visitors and staff consistent with the values, vision and mission of the hospital." 14. During an observation on 11/9/15, at 9:36 AM, outside the kitchen, a white two column storage cart with four divided sections contained linen (towels). The roll up doors of each divided section could not completely closed exposing the clean linens to outside environment. During an interview with the ACNO, on 11/9/15, at 9:37 AM, she stated these linens may be used by the kitchen staff. During an interview with the Dietician, on 11/9/15, at 9:40 AM, the Dietician was asked what the linen was used for and she stated, "They use it in the kitchen to clean." During an interview with the Dietary Aide, on 11/9/15, 9:44 AM, he was asked who used the linen stored in the white two column storage cart he stated, "We use it to clean the kitchen." The Dietician acted as interpreter. The hospital policy and procedure titled "Infection Control linen and Laundry Storage Regulations" dated 5/2000, indicated that "Procedure: All shelves must be covered to prevent clean linen from contamination through the air-borne pathogens.	A 749	Finding 14 Immediate Actions Taken: 1. The clean linen was moved to a cart that allowed for closure. Subsequent Actions Taken: 1. Hospital Leadership and the Director of Infection Control reviewed the "Infection Control Linen and Laundry Storage Regulations" policy, which did not require revisions. Linen shelves are to be covered to prevent clean linen from contamination. Dietary staff was reeducated, with emphasis on reporting issues to Hospital Leadership with linen storage if they occur. EVS staff was also reinserviced. Compliance and Monitoring: The Director of Infection Control or qualified designee performs weekly rounds (for 3 months and then re-evaluate) in the kitchen to achieve the goal of 100% compliance with covering linen. Corrective action is taken as necessary, including 1:1 training with applicable staff. Data on compliance is tracked, trended, analyzed and reported every other month through the Infection Control Committee, Quality Council, MEC and Governing Board, and is used for performance improvement measures. Person Responsible: Director of Infection Control	11/9/15 11/10/15 - 11/13/15

EXHIBIT Y

Southern California Hospital at Culver City
Statement of Deficiencies and
Plan of Correction

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	6245 DE LONGPRE AVE HOLLYWOOD, CA 90028

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A 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health, Licensing and Certification, during a COMPLAIN VALIDATION SURVEY conducted 9/21/15 through 9/25/15. Reference Federal complaint intake CA00458231. The inspection was limited to specific Conditions of Participation: Governing Body, Patients' Rights, Quality Assessment Performance Improvement (QAPI), Nursing services, Physical Environment, Infection Control, Surgical Services and Emergency Services; and does not reflect the findings of a full inspection of the hospital. Representing the California Department of Public Health: Surveyor 22363, HFEDA Surveyor 25092, HFEN Surveyor 33720, HFEN Surveyor 32661, HFEN Surveyor 35399, HFEN Trainee Medical Consultant, 26881 Medical Consultant, 29775 The census at the Culver City campus was: 200 The census at the Hollywood campus was: 61 The census at the Van Nuys campus was: 46 Patient Records Sampled: 36 Immediate Jeopardy (IJ) 1. On 9/22/15 at 5:40 P.M. an immediate Jeopardy (IJ) was declared for the widespread pattern of potential ineffective sterility of equipment/instruments and surgical suites not	A 000	**The inspection was limited to specific Conditions or Participation: Governing Body, Patients' Rights, Quality Assessment Performance Improvement (QAPI), Nursing Services, Physical Environment, Infection Control, Surgical Services and Emergency Services; and does not reflect the findings of a full inspection of the hospital.** **Hollywood Campus** **(a, b, c)** **Immediate and Permanent Corrective Action** • On 09/22/15 at 7:15pm, Immediate Jeopardy was abated after compliant practices in maintaining surgical suites temperature and humidity within regulatory limits and surgical instruments and endoscopes storage issues were identified. All surgical instruments and endoscopes were reprocessed. All OR activity ceased until compliance could be assured. • On 9/22/15 Johnson Control provided emergency service call for no cooling. • On 9/22/15 temperature and humidity were brought to within acceptable ranges. **Process Improvement:** • When a room is considered out of range, a work order is created and engineering is notified. • Ongoing monitoring with temperature and humidity assessed prior to surgery as well as documented checks throughout the day in both the OR and the Staff has been educated on the process.	9/24/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	6245 DE LONGPRE AVE HOLLYWOOD, CA 90028

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A 000	Continued From page 1 meeting the regulatory temperature and humidity limits when: a) On 9/22/15 at 3:30 p.m. during the Hollywood campus surgical services tour, main tray surgical instruments were observed stored in OR-2 where temperatures were out of regulatory limits. OR-2's thermostat meter indicated temperature of 78.8 Fahrenheit (F) and humidity of 58%. Several instrument trays were found piled on top of each other on a surgical supply storage cart. Concurrent interview was held with the administrator who confirmed that OR-2 was "too hot" and storing surgical instruments was "not good". The Administrator shared there was nowhere else to store the instruments. According to the Administrator and surgical staff interviews, instruments have always been stored in OR-2. b) Endoscopes were observed being stored in OR-3 where the thermostat meter indicated the temperature was 82.4 F and humidity was 46%. Concurrent interview was held with the interim director of infection control (IDIC) who confirmed the room temperature was out of the regulatory limits. c) The sterile processing room thermostat meter indicated a temperature of 82.5 F and humidity of 51%. Concurrent interview was held with surgical staff who confirmed the room was "hot." A review of both facilities Culver City and Hollywood Campus "Temperature and Humidity Reading" logs revealed temperature and humidity readings were out of limits on several dates. d) The index case indicated humidity ranges has been out of range at Culver City in OR # 2 for 13 days, OR # 2 for 10 days and OR # 7 for 20 days. During a tour on 9/22/15, the Department found the facility had difficulty regulating temperature and humidity in the OR's due to maintenance	A 000	Continued From page 1 • Temperatures and humidity are assessed hourly as well as prior to procedure. • When fall out occurs the plant operations team is notified to adjust temperature. Monthly trend reporting to ACNO, IC and Quality Department occurs. No procedures will occur unless temperature and humidity are within normal limits. • When a room is out of range and is not correctable prior to a scheduled procedure, infection control is notified by OR. • Plan for infection control surveillance to monitor and report as well as plant operations at monthly committee meetings. • Electronic/Digital monitoring devices will be installed in December. • Upon completion of the installation staff will be educated on requirements and individuals will be identified for notification, reporting and action. Anticipated completion date is 1/1/2016. **Date of Implementation:** • Immediate concerns corrected on 09-24-15. Installation of new monitoring devices to be completed by 01-01-2016. **Monitoring Process:** • Staff monitors and documents temperature and humidity prior to procedure. Staff monitor daily as well, on an hourly basis. Trending reports to be sent to Quality Council through EOC and Infection Control reports which will flow up to the MEC and Infection Control	

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A 000	Continued From page 2 issues with air handlers and coolers in the facility. According to administrative staff the 3 cooling units at the Culver City Campus were not adequate for the needs of the facility. Administrative staff shared the two cooling units serving the tower and surgical area needed to be replaced and the cooling unit serving the pavilion needed to be rebuilt. The HVAC systems did not have the capability of dehumidification. On 9/22/15 at 1:00 p.m., OR 3's humidity was 66%, OR 3's humidity was 66% and OR 7's humidity was 67 % to 70 %. 2. On 9/22/15 at 5:50 P.M., the CDPH survey team informed the Facility Administrative Team of an Immediate Jeopardy (IJ) identified throughout the facilities regarding questionable sterility of their surgical instruments and endoscopes since both the endoscopes and the surgical instruments were stored in surgical suites where temperatures were out of regulatory limits as well as OR humidity and temperatures ranges in both the Hollywood and Culver City campus being out of regulatory humidity and temperature ranges. 3. On 9/22/2015 at 7:10 P.M., following a meeting to discuss corrected actions taken to ensure sterility of instruments & endoscopes as well as temperature and humidity in the facility surgical suites the hospital submitted a corrective action plan, which included: 1) The immediate cessation of elective surgeries and procedures. 2) Immediately reprocessing of all surgical instruments at the Hollywood Campus. 3) Reprocessing of all the endoscopes prior to use at the Hollywood Campus. 4) All OR's at the Culver City and Hollywood campuses will be monitored for	A 000	Continued From page 2 reports which will flow up to the MEC and Governing Board for review discussion and any further action. **Position Responsible:** • Nursing Leadership, Director of Plant Operations, Director of Quality, Director of Infection Control, CEO. **Culver City Campus** **Immediate and Permanent Corrective Action (a, b, c):** • On 09/22/15 at 7:15pm, Immediate Jeopardy was abated after compliant practices in maintaining surgical suites temperature and humidity within regulatory limits and surgical instruments and endoscopes storage issues were identified. All surgical instruments and endoscopes were reprocessed. All OR activity ceased until compliance could be assured. **Process Improvement:** • When a room is considered out of range, a work order is created and engineering is notified. • Ongoing monitoring with temperature and humidity assessed prior to surgery as well as documented checks throughout the day in both the OR and the sterile supply room. • Sterile instruments were reprocessed on 9/22/15 Sterile supplies were assessed for integrity. • All sterile instruments moved to location where temperature and humidity were in range. • Nursing staff have been educated on the process. Temperatures and humidity are assessed hourly as well	9/22/2015

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A 000	Continued From page 3 temperature ranges every hour each 24 hours and before each procedure for each room. Temperatures will be maintained consistently on a log by nursing and engineering. OR will be taken out of service until temperatures are attained. 5) Surgical instruments will be stored in an area where temperature & humidity are within regulatory limits. 6) Assess room supplies for moisture if moisture permeation. The plan of abatement was accepted on 9/22/2015 by the survey team. 4. On 09/22/2015 at 7:15 P.M., Immediate Jeopardy was abated after compliant practices in maintaining surgical suites temperature & humidity within regulatory limits and surgical instruments & endoscopes storage issues were identified. The cumulative effects of these systemic problems resulted in the hospital's in ability to provide an effective hospital wide infection control program. Resulting in the facilities inability to provide patient care in a safe and effective manner as agreed in accordance with the Condition of Participation for Infection Control Services (A 747). The seriousness of which, resulted in an Immediate Jeopardy identified by the survey team.	A 000	Continued From page 3 as prior to procedure. • When fall out occurs the plant operations team is notified to adjust temperature is performed. Simultaneous reporting to Quality will occur. • No procedures will occur unless temperature and humidity are within normal limits. • When a room is out of range and is not correctable prior to a scheduled procedure, Infection control is notified by OR. • Plan for infection control surveillance to monitor and report as well as plant operations at monthly committee meetings. • Electronic/Digital devices will monitor temperature and humidity in the OR rooms. • On 9/24/15 a temporary cooling tower was installed in Culver City. The permanent completion of the cooling tower was accomplished on 10-28-15 for Culver City. The temporary cooling tower was removed on 11-13-15 from Culver City. **Date of Implementation:** • Immediate concerns corrected on 09-24-15. Electronic monitoring devices to be installed by 01-01- 2016. **Monitoring Process:** • Nursing monitors and documents temperature and humidity prior to procedure. Nursing staff also monitors daily on an hourly basis. Trending reports to be sent to Quality Council through EOC and Infection Control Committee reports which will flow up to the MEC and Governing Board for review discussion and any further action.	
A 043	482.12 GOVERNING BODY There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible			

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A 043	Continued From page 4 for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ... This CONDITION is not met as evidenced by: Based on observation, interview and record review, the Governing Body failed to be responsible for the conduct of the hospital because: 1) The Governing Board failed to ensure the functionality and safety of the physical environment. An immediate jeopardy was declared due to the failure to maintain control over the temperature and humidity in the operating room and sterile storage areas, creating a risk to patient safety due to the increased risk of infection. The hospital was found to have problems in the environment of care due to a failure of facility maintenance activities. (Cross reference A-0700). The Rules and Regulations of the Governing Board dated February, 2015, showed that the functions and duties of the Governing Board included, "Oversee the preparation of the annual operating plan and budget (including capital expenditures) and monitoring performance on a periodic basis." During interviews and record reviews, it was found that a fire occurred on 1/28/15 which resulted in equipment damage. During a review, on 9/25/15, of the Governing Body meeting minutes from March and June, 2015, no discussion of the fire and the pursuant air cooling issues was noted. In a concurrent interview with the director of medical staff (DMS), she was unable to find discussion of the issue in the GB		Continued From page 4 **Position Responsible:** • CNO, Nursing Leadership, Directors of Plant Operations, Director of Quality, Director of Infection Control, CEO.	
		A043	**There is an effective Governing Body that is legally responsible for the conduct of the hospital.** **Immediate and Permanent Corrective Action (1, 2, 3):** • Ad hoc meeting of Governing Board was called on 9/22/15 to outline the immediate jeopardy and need for corrective action to ensure the functionality and safety of the physical environment. • The Governing Board has oversight of the QAPI program, which reflects the complexity of the organization and services offered. • The Governing Board is made aware of the scope and severity of problems for the full range of hospital departments including EOC, Infection Control, Patient Safety and Risk.	9/22/2015

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SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	6245 DE LONGPRE AVE HOLLYWOOD, CA 90026

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A 043	Continued From page 5 meeting minutes. In interviews with the director of facilities2 (DF) on 9/23/15 at 1045 and 1345, he stated that the process for procurement involved filling out a requisition and waiting, sometimes for an extended period. In an interview with the CEO on 9/25/15 at 0845, he concurred that the procurement process required numerous signatures and was protracted. In interviews with the CEO on 9/23/15 at 1715 and on 9/25/15 at 0845, he stated that he was not aware of the extent or severity of the problems with the physical environment of the hospital. 2) The Quality Assurance program was not developed and implemented to ensure the high quality of services provided in the hospital. (Cross reference A-0263). 3) For one patient, Patient M103, the hospital did not ensure that the patient was admitted pursuant to an order from a privileged physician, creating the risk of substandard care for that patient. (Cross reference A-0064). The cumulative effect of these failings meant the Governing Board failed to ensure that high quality healthcare was provided in a safe environment for patients obtaining care in the hospital.	A 043	Continued From page 5 • The QAPI program focuses on ensuring that high quality healthcare is provided in a safe environment for patients obtaining care in the hospital. • PAs do not have admitting privileges. • Bridge orders to provide the patient with initial orders for care until the attending physician or PA is available, are written by the ED physician. • These were approved on 11/10/15 by the Executive Committee. **Process Improvement:** • The minutes from the Quality Council are presented and reviewed at every scheduled Governing Board meeting for review and comments. • The QAPI plan will be annually reviewed and approved by the Governing Board. **Date of Implementation:** • January 2016 **Monitoring Process:** • Changes in California law regarding medical staff and PA privileges is updated in the medical staff rules and regulations and bylaws. • The physician assures that PAs do not write orders to admit patients to the acute hospital through continuing supervision of PA practices. **Position Responsible:** • Chief of Staff, Medical Staff, CEO, Governing Board, Director Quality	11/10/2015
A 064	482.12(c)(1) CARE OF PATIENTS – PRACTITIONERS [...the governing body must ensure that the following requirements are met:] Every Medicare patient is under the care of:	A064	**The Governing Body must ensure that every Medicare patient is under the care of the physician at all times.** **Immediate and Permanent Corrective Action (a, b, c):**	

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A 064	Continued From page 6 (i) A doctor of medicine or osteopathy (This provision is not to be construed to limit the authority of a doctor of medicine or osteopathy to delegate tasks to other qualified health care personnel to the extent recognized under State law or a State's regulatory mechanism); (ii) A doctor of dental surgery or dental medicine who is legally authorized to practice dentistry by the State and who is acting within the scope of his or her license; (iii) A doctor of podiatric medicine, but only with respect to functions which he or she is legally authorized by the State to perform. (iv) A doctor of optometry who is legally authorized to practice optometry by the State in which he or she practices; (v) A chiropractor who is licensed by the State or legally authorized to perform the services of a chiropractor, but only with respect to treatment by means of manual manipulation of the spine to correct a subluxation demonstrated on x-ray to exist; or (vi) A clinical psychologist as defined in §410.71 of this chapter, but only with respect to clinical psychologist services as defined in §410.71 of this chapter and only to the extent permitted by State law. This STANDARD is not met as evidenced by: Based on interview and record review, the hospital did not ensure that Patient M103 was under the care of a physician at all times because the patient was admitted by a physicians assistant (PA), and the patient was sent from the emergency department (ED) to a telemetry bed 1 hour and 45 minutes prior to physician admitting orders being provided. Findings:	A 064	Continued From page 6 **Process Improvement:** • Bridge orders written by the ED physicians were approved by the medical staff to ensure that all patients have appropriate orders upon admission. **Date of Implementation:** • December 2, 2015 **Monitoring Process:** • 30 charts or 10% of admissions will be audited on a monthly basis to identify those incidents where attending physicians are not available to provide admitting orders onsite or over the phone. • Identified practitioners will be trended and reported through the committee structure. **Position Responsible:** • Director Medical Staff, Director Quality	

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A 064	Continued From page 7 The Scope of Service Statement (reviewed 8/2013) for the ED showed that, conversion of an emergency department patient to inpatient status entailed, "Consult PMD (Private Medical Doctor) or appropriate panel MD and obtain an order to admit the patient to In-patient or place in Observation status." The medical record of Patient M103 was reviewed on 9/21/15 and showed that the patient arrived in the telemetry unit from the ED at 2030. However, no order for admission from a privileged physician was seen. Instead, the patient was sent to the telemetry unit by the ED PA, and admission orders were not provided until 1 hour and 45 minutes later. In an interview with the chief nursing officer (CNO) on 9/25/15 at 0925, she reviewed the medical record of Patient M103 and concurred that the patient appeared to have an admitting order from an ED PA, rather than an order from a physician. She concurred that no telephone order for admission from the MD was found.			
A 118	482.13(a)(2) PATIENT RIGHTS: GRIEVANCES The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance. This STANDARD is not met as evidenced by: Based on observation, interview and facility policy review the facility failed to adhere to it's policy and procedures established for grievances when patients complaints of facility temperatures were not elevated to the risk management department.	A 118	**The hospital has established a process for prompt resolution of patient grievances and informs each patient whom to contact to file a grievance.** **Immediate and Permanent Corrective Action:** • On 10/28/15 Quality Council met and approved the formation of a Grievance Committee. The Grievance Committee met on 10/28/15and created a new P&P. On 11/11/15 the grievance committee reviewed the October and November 2015 grievances. • The Grievance Committee meets monthly and reports to the Quality Council.	10/28/2015

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A 118	Continued From page 8 Findings: Review of the facility policy and procedure entitled "Complaints and Grievances" dated 04/2007 and revised 11/2012, indicated in part, under the heading of "Policy: 4.1.1 Patients are encouraged to notify staff with any problems which may arise in patient care service areas. 4.1.4 Complaints/grievances are forwarded to the risk management department and hospital administration to assure appropriate resolution. 4.1.6 A patient grievance is defined as a formal or informal written or verbal complaint regarding the patient's care, abuse or neglect made to the hospital by the patient or patients representative when a patient issue cannot be resolved promptly by the staff." Under the heading of "Procedure" the policy indicated in part, "4.2.7 Complaints are to be documented by the person taking the complaint. 4.2.8 The Form is given to the immediate supervisor. 4.2.10 In addition, a voice mail is left on the Patient Relations hotline. 4.2.13 The written complaint along with documented follow-up is forwarded to the risk manager. 4.2.23 All patient care complaints and grievances will be entered in a tracking system (log) maintained by the risk management department." During a concurrent observation and interview with LN13 on 9/24/15, at 4 p.m., observed Patient N205 in room 501 sitting on side of bed. Open room door has poster of contact isolation on the outside. Patient loudly moaning, "I'm hot, I'm hot." LN13 holding a hand held thermometer held into room 501 it registered 80.2 Fahrenheit. LN13 shared a temperature log for room 501 for 9/23/15 and 9/24/15, of temperatures taken three times a day (6:30 a.m., 12 noon and 7 p.m.), the	A 118	Continued From page 8 • Sought approval from the Governing Board to give written authorization to the Grievance Committee for the effective operation of the grievance process on 12/02/2015. **Process Improvement:** • Grievances received via telephone, verbal, written or faxed are entered into the event reporting system where they are tracked, trended and handled per P&P. • All grievances are responded to in writing within the required timeframe. • Those issues that do not meet the definition of a grievance are handled internally by the department involved. • Concerns requiring a work order are forwarded to Facilities and are trended and reviewed by Administration. • Reports or trending will be sent to EOC, Quality, MEC and Governing Board. • Complaints that evolve into grievances are reported to the Risk Management department. • Initial Orientation is conducted monthly, training and education of staff in the use of the P&P for grievances was provided at the October 2015 Employee Skills Fair. • Grievances received via the patient liaison are entered into the event reporting system. **Date of Implementation:** • 10/28/15 immediate response • 12/2/15 permanent corrective action completed **Monitoring Process:** • Grievances entered in the event reporting system are viewed on a daily basis Monday thru Friday.	12/02/2015

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A 118	Continued From page 9 average temperature was 79 degrees, the log indicated the high temperature limit should be at 77 degrees. LN13 was asked what will happen for this patient with this complaint of heat? LN13 stated, "We will give her ice water because she already has water at the besides, we are attempting to make sure everyone is hydrated." Asked if LN13 would fill out a written complain form, LN12 stated, "No, we just try and deal with it." During an interview on 9/25/15, at 9:15 a.m., outside of room 501, door open Patient N205 layin in bed, asked Patient N205 if she was more comfortable? Patient N205 stated, "No its always hot." During an interview with administrative staff4 (AS) on 9/25/15, at 9 a.m., AS4 was asked if she had received a complaint about the heat from Patient N205 or staff, AS4 stated, "No, I haven't gotten anything." During an interview and concurrent review of facility documents with AS4 on 9/24/15, at 9:15 a.m., AS4 indicated she conducts monthly training for all new employees on complaints and grievance procedures. Review of facility "Patient Complaint and Grievance Log" for the months of August and September 2015 few complaints initiated by staff (all telephonically) and no complaints of environmental concerns. AS4 stated, "Very few times I get complaints forwarded by staff." When asked about procedure that indicates a "form" to be filled out by staff, AS4 stated, "I am not familiar with a form." During an interview with LN9 on 9/24/15, at 10:10 a.m., LN9 was asked how the unit handles complaints, LN9 stated "If unable to resolve at the	A 118	Continued From page 9 • Grievances are trended for location, type, employee involvement, and resolution in compliance with the guidelines. **Position Responsible:** • Governing Board, Director Quality, Director Facilities, CEO, Administration	

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A 118	Continued From page 10 time I would call engineering." Asked if LN9 would fill out a form to communicate with risk management, LN9 stated, "No, I would let the patient fill out a form." During an interview on 9/24/15, at 10:16 a.m., with CNA1, when CN1 was asked about the heat /temperatures on the unit (fifth floor-Med/Psych) CNA1 stated, "It's been really bad all summer. We have nurses who have gone home in the middle of their shifts (because of the heat). We put ice down our shirts to try and keep cool." Asked CNA1 about patient complaints of heat, CNA1 stated, "We try and put a fan in their room or ice packs under their arms, and sometimes that works." Asked what she does if that does work? CNA1 stated, "I'll tell my charge nurse." asked if she ever fills out a "form" to communicate the patient concerns, CNA1 stated, "I don't know anything about a form." During an interview on 9/24/15, at 10:35 a.m., with LN10 when asked about unit temperatures LN10 stated, "It's been hot on the unit all summer long." Asked LN10 what she does when patients continue to complain about the temperatures, LN10 stated, "I call my manager, I tell the administrative staff when they make rounds, bu we continue to complain and complain but nothing gets done." Asked if she ever fills out a form to communicate patient complaints, LN10 stated, "No I sometimes call AS4 but I know she can't do anything about it." During an interview with the CNO on 9/24/15, at 10:45 a.m., the CNO was asked if the staff cannot resolve patient complaints at the bedside what do they do ? The CNO stated, "Well I hear about them in the executive rounds." The facility	A 118		

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A 118	Continued From page 11 procedure to communicate in writing via a "form" and telephonically to risk management was brought forward to the CNO who stated, "I think we need to do better at processes."			
A 119	482.13(a)(2) PATIENT RIGHTS: REVIEW OF GRIEVANCES [The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance.] The hospital's governing body must approve and be responsible for the effective operation of the grievance process, and must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee. This STANDARD is not met as evidenced by: Based on interview and record review, for one patient, M104, the hospital did not ensure that the grievance process was implemented because there was incomplete documentation of investigation of the grievance, creating the risk of a failed grievance process for that patient. Findings: The grievance of M104 from an emergency department (ED) admission on 3/8/15 showed that the patient felt that he was treated with prejudice by physician assistant1 (PA) when he came to the ED seeking medication for migraine pain. The grievance file was reviewed, and did not show that an investigation had taken place. There was no documented review of records or interviews. The grievance had been forwarded to the medical chief of the ED, who wrote back on 3/17/15 to say that the PA had been counseled, but not that there was an investigation into the	A 119	**The Governing Body approves and is responsible for the effective operation of the grievance process, and reviews and resolves grievances, unless it delegates the responsibility in writing to the grievance committee.** **Immediate and Permanent Corrective Action:** • The hospital has established a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance. • Grievances received by the event reporting system involving medical staff are forwarded by Quality Coordinator to the Director of Medical Staff for investigation and possible peer review. **Process Improvement:** • A new admission packet has been developed for patients which includes the grievance and complaints process. • Signage outlining the grievance process is posted throughout the medical center. • A new grievance policy and procedure has been created and approved by the quality committee in October. Governing Board approval to be granted January 2016. • Documentation of the grievance investigation is contained within the electronic reporting system. **Date of Implementation:** • 9/25/15 immediate implementation • New admission packet to arrive 12/30/15.	9/25/2015

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A 119	Continued From page 12 circumstances. In an interview with the director of medical staff (DMS) on 9/22/15 at 3:00 p.m., she concurred that the investigation was not documented. In an interview with the interim director of quality management (IDQM) on 9/24/15 at 0920 a.m., she concurred that documentation of an investigation was lacking.	A 119	Continued From page 12 **Monitoring Process:** • Grievances entered in the event reporting system are viewed on a daily basis Monday thru Friday. • Grievances are trended for location, type, employee involvement, and resolution in compliance with the guidelines. • Trending reports are presented to the Quality Council Committee for review and comment. • Action plans for areas not showing improvements are submitted to Quality Council by the area Directors. • Grievance trending is evergreen. **Position Responsible:** • Patient Liaison, Director Quality, Director Medical Staff, Governing Board, CEO	
A 132	482.13(b)(3) PATIENT RIGHTS: INFORMED DECISION The patient has the right to formulate advance directives and to have hospital staff and practitioners who provide care in the hospital comply with these directives, in accordance with §489.100 of this part (Definition), §489.102 of this part (Requirements for providers), and §489.104 of this part (Effective dates). This STANDARD is not met as evidenced by: Based on observation, interview and record review the hospital to provide written notice of the hospitals advance directives policy at the time of Patient N202's admission. Findings: The hospital's policy and procedure entitled "Patient Determination Act/Advance Health Care Directives," effective 08/2011 and last revised 11/2012 under the heading of "Procedure" indicated in part, "4.2 Procedure, 4.2.1 During the admission process (including out-patient), the Hospital Admitting Staff will perform the following : 4.2.2 Provide the patient with an Admitting Packet that includes a brochure containing the Medical Center's policy and information regarding the patient's right to make decisions concerning his/her healthcare (Advanced Health Care	A 132	**Patients have the right to formulate advance directives and have hospital staff and practitioners providing care comply with these directives.** **Immediate and Permanent Corrective Action (a, b, c):** • On 9/25/2015 all patients directly admitted to SCHCC are given advance directive information, patients asking for additional information are provided with social services consultation. • Admitting and nursing ask patients if they already have an advance directive. • If they do, nursing and/or admitting asks the patient for a copy which becomes a permanent part of the medical record. • If the patient has an advance directive but has not brought it to the hospital, the nursing staff and/or admitting requests a copy from the patient or the patient's	9/25/2015

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A 132	Continued From page 13 Directive)." During a concurrent review of the clinical record for Patient N202 and interview with the administrative staff 3(AS) and licensed nurse11 (LN) on 9/23/15, at 11:30 a.m., revealed that Patient N202 was admitted on 9/15/15 and Patient N202 received and signed for "information regarding Advanced Directives" on 9/21/15. During an interview on 9/25/15, at 10:00 a.m., with AS5 when asked about the delay she stated, "My staff was sick for a couple of days and that's the reason for the delays, I understand this is a problem".	A 132	Continued From page 13 representative. • If the advance directive cannot be obtained, the intent of the advance directive, if known, is documented in the medical record. • The new admission packet will have an advance directive kit information sheet separate from the conditions of admission. **Process Improvement:** • Admitting, nursing and social services staff was in-serviced on the Advance Directive process during the October Skills Fair. • A new advance directive sheet is being developed for patients to explain the process in lay terminology. • Advance Directives are scanned and placed in the legal section of the medical record. • 10/8/2015: Admitting Director created new form (approved via GB) now implemented. New packets where all patients regardless of "yes" or "no" will get the information. 10/9/15 • Presence of advance directive will be made part of nursing shift to shift report. To be completed at December 2015 Skills Fair. **Date of Implementation:** • October 20-22, 2015 • 12/30/15 completion date **Monitoring Process:** • Monthly chart review for the presence of the new advance directive form and response to the question checked as completed. • If advance directive is checked as "yes" the advance directive is included as part of the medical record.	
A 144	482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the cooling system was operating at a level that maintained a comfortable environment for patients, staff and visitors. Temperatures on the fifth and sixth floors were running uncomfortably high with room temperatures between 78 and 80 degrees Fahrenheit (F). Further the facility failed to ensure the right to water availability for handwashing, creating the risk of poor hygiene and the increased risk of infection for patients on the 6th floor because the sensor-activated sinks were not maintained. Findings: 1) During an interview with the director of facilities operations (DFO) on 9/22/15 at 12:05 p.m. he			

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A 144	Continued From page 14 said that staff could call facilities operations directly by dialing 444 and that staff had been made aware of the number. During a tour of the fifth and sixth floors accompanied by the CEO and Vice President of Operations on 9/23/15 beginning at 3 p.m. the temperatures were noted to be uncomfortably high. On the sixth floor there was a portable cooler by the nursing station on the open unit as well as fans in hallways. A digital thermometer was obtained from facilities operations. On the sixth floor in the back hallway between units "C" and "D" the temperature read 78.4 F. In unit "D", a locked geropsych unit, the temperature in the hallway by the nursing station read 79.2 F. Temperatures were taken in 11 rooms and read from 78 to 80.5 degrees F. The patient in room 605 stated "I'm feeling a little warm." The tour proceeded to the fifth floor where the same configuration of a portable cooler and fans was observed. Temperatures were taken in 4 rooms and read from 78 to 80.6 degrees F. At 4:45 p.m. the patient in room 502 stated " it's been kinda hot all day." Both hospital administrators agreed that "there is no question that it is hot up here." During an interview on 9/24/15, at 10:16 a.m., with CNA1, CNA1 was asked about the heat /temperatures on the unit (fifth floor-Med/Psych). CNA1 stated, "It's been really bad all summer. We have nurses who have gone home in the middle of their shifts (because f the heat). We put ice down our shirts to try and keep cool." CNA1 was asked about patient complaints of the heat and CNA1 stated, "We try and put a fan in their room or ice packs under their arms, and sometimes that works." She was asked about what she does if that does not work, CNA1	A144	Continued From page 14 **Position Responsible:** • Director of Admitting, CNO, Director Quality **The patient has the right to receive care in a safe setting. The facility ensures that the cooling system is operating at a level that maintains a comfortable environment for patients.** **Immediate and Permanent Corrective Action:** • Immediately provided cooling measures to patients complaining about the room temperature. Including more cold compresses, provided extra water, provided fans and portable AC units. **Process Improvement:** • Immediately started monitoring room temperatures in all patient rooms. Temperatures that were out of range were called by nursing to engineering and a work order was issued. The work orders were carried out within a 30 minute time frame. • Cooling measures and room monitoring continued throughout the warm weather season. **Date of Implementation:** • 9/25/15 implemented • 10/26/15 completed **Monitoring Process:** • Room temperatures where monitored 3 times a day in each patient room from September 25 thru October 26, 2015. • Work orders were reviewed for rooms that were out of range. • Facilities Director reviewed fall outs with his staff.	9/25/2015

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A 144	Continued From page 15 stated, "I tell my charge nurse." During an interview with licensed nurse (LN) 19 on 9/24/15 at 2:55 p.m. when asked about needing to request maintenance; she said she might tell the charge nurse, call the operator, dial the number directly, or the charge nurse could report it. During an interview with LN 20 on 9/24/15 at 3:05 p.m., when asked how she would request maintenance she said she could use the computer or call them b calling 0 (operator). There is a list of numbers but no direct line to maintenance and she said she has had no training on how to call in a work order directly to maintenance. During a concurrent observation and interview with LN13 on 9/24/15, at 4 p.m., Patient N205 was observed in room 501 sitting on side of the bed. The patient was loudly moaning, "I'm hot, I'm hot." LN13 had a hand held thermometer and when it was held in room 501 it registered 80.2 F. LN13 produced a temperature log for room 501 for 9/23/15 and 9/24/15. Temperatures were taken three times a day (6:30 a.m., 12 noon and 7 p.m.) with the average temperature being 70 degrees F. The log indicated the high end range should be 77 degrees F. LN13 was asked what would happen for this patient with this complaint of heat? LN13 stated, "We will give her ice water because she already has water at the bedside, we are attempting to make sure everyone is hydrated." During an interview on 9/24/15, at 10:35 a.m., with LN10, she was asked about unit	A 144	Continued From page 15 • Patient complaints about room temperatures are tracked through the event reporting system and tracked through QAPI. **Position Responsible:** • Director of Facilities, Director Quality, CNO **Hand washing sinks are now operational and water flow is present when hands are over the sink.** **Immediate and Permanent Corrective Action:** • Batteries under the sink were checked and dead batteries were replaced on 9/25/15. **Process Improvement:** • Sinks are checked daily by nursing. • EOC has quarterly Preventive Maintenance which provides that each tech will check the batteries quarterly. Plant operations will look to see how long they last on average and then begin to replace them based on the mean. • Housekeeping is also assessing the sink operation daily and reporting to EOC. **Date of Implementation:** • 9/25/15 batteries checked and replaced • 10/8/2015 process improvement implemented **Monitoring Process:** • Sinks are checked weekly by nursing and EVS. • Batteries are replaced based on the mean lifespan. **Position Responsible:** • Director Facilities, Director Quality, CNO	A144(2) 9/25/2015

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A 144	Continued From page 16 temperatures and said, "It's been hot on the unit all summer long." LN10 was asked what she does when patients continue to complain about the temperatures she stated, "I call my manager, I tell the administrative staff when they make rounds, we continue to complain and complain but nothing gets done." The maintenance logs reviewed on 9/24/15 with plant operations staff indicated nursing had complained of the heat on the units since June, without resolution. The log indicated the work orders were still open (unresolved). 2) During observations with administrative staff 1 (AS) on the 6th floor locked and open psychiatric units on 9/23/15 at 1610, each patient room contained a toilet room and a handwashing sink. Six of ten handwashing sinks tested were not operable because the detection mechanisms failed to detect the presence of hands over the sink, and no flow of water could be obtained. In a concurrent interview with AS1, he stated that the water was not flowing because the sensors were out. He stated that a report about the outage had been made to the facilities department that afternoon. The sinks in rooms 602, 615, 616, 631 632 and 639 could not be used for hand hygiene. A psychiatric patient was observed coming from the bathroom of room 602. The patient was questioned about the availability of water for handwashing, but she was unable to answer the question because her words did not form clear messages. Patient M106 in room 632 was interviewed on 9/23/15 at 1615, and she stated that there had been no water flowing into the sink	A 144		

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A 144	Continued From page 17 in her room for five days, and that she had informed the staff, but that nothing had been done. She stated that she had to go to the day room to wash her hands. The sink in room 639, a day room, was also tested and was also found to be inoperable. In an interview with Dir Fac 1 on 9/24/15 at 1115, he stated that the sinks should be reported by the nursing staff and housekeeper. He stated there had been no calls regarding sinks not working, and that there were batteries for use as needed for the sink sensors. The electronic tracking record of complaints to maintenance was reviewed on 9/24/15 with plant operations staff. According to the log a complaint was entered on 9/16/15 indicating there was "No water coming out of the taps for rooms 631, 632, 633 and 634". The log indicated the complaint was still open indicating the issue had not been resolved. In an interview with the CEO on 9/23/15 at 1715, he stated that there was no excuse for the sinks not working.	A 144		
A 146	482.13(d) PATIENT RIGHTS: CONFIDENTIALITY OF RECORDS Patient Rights: Confidentiality of Records This STANDARD is not met as evidenced by: Based on observations, interview and record review the facility failed to ensure medical records remained confidential for 25 patients, when individual patient vital signs (temperatures, respirations, pulse and blood pressures) documentation were left within view of anyone	A146	**Medical Records remain confidential for all patients.** **Immediate and Permanent Corrective Action:** • The vital sign records seen during the survey were immediately removed on 9/22/15. • Vital sign records are now entered into the EMR by the CNA, paper vital sign records are no longer used.	9/25/2015

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A 146	Continued From page 18 walking down the hallway. Findings: Review of facilities patients' rights statement given to all patients at time of admission indicated in part, "You have the right to : 12. Confidential treatment of all communications and records pertaining to your care and stay in the hospital." During an observation and concurrent interview with the AS3 on 9/22/15, at 10:30 a.m., outside of room 230, on top of a mobile computer within view were four individual 8 x 11 papers with vital signs hand written on them. Each set of vital signs had a patient's first name and last initial and the patient corresponding room number. AS3 acknowledged the papers were easily visible and disclosed medical information. AS3 asked a licensed nurse, pointing at the paper, "what are these" the licensed nurse stated, "Oh these are not supposed to be here" and she picked them up.	A 146	Continued From page 18 **Process Improvement:** • In-services were provided to all staff on patient confidentiality during October Skills Fair. • CNAs document vital signs in the EMR. **Date of Implementation:** • October 2015 **Monitoring Process:** • Patient confidentiality is observed during director rounding, environmental rounding and infection control rounding 5 days a week. **Position Responsible:** • All hospital directors.	
A 196	482.13(f)(1) PATIENT RIGHTS: RESTRAINT OR SECLUSION Training intervals. Staff must be trained and able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a patient in restraint or seclusion- (i) Before performing any of the actions specified in this paragraph; (ii) As part of orientation; and (iii) Subsequently on a periodic basis consistent with hospital policy. This STANDARD is not med as evidenced by:	A 196	**Training is provided for all staff including, the nine identified, who applied restraints in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a patient in restraint or seclusion.** **Immediate and Permanent Corrective Action:** • Employee files were reviewed for expired training. • Training was provided during the October Skills Fair. • The nine employees were trained during the skills fair.	

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A 196	Continued From page 19 Based on interview, record review and policy review the facility failed to ensure nine of ten employees were trained on restraint and seclusion application either as part of their orientation (five employees) or per facility policy of annual training requirements (four employees). Findings: During an interview with the chief nursing officer (CNO) on 9/22/15, at 5:30 p.m., she confirmed the facility "Behavioral Restraints and Seclusion" policy dated 02/2012 revised 03/2014 was applicable for the emergency room staff. Review of facility policy titled, "Behavioral Restraints and seclusion", in part indicates under sub-header "Education/Human Resources Competency," 4.2.44 "Employees" human resources file must contain a record of competency validation on initial employment and annual unit competencies (management of assaultive behavior, use of restraints, etc)." During a concurrent interview and employee files review with AS3 and the director of education on 9/22/15, at 11 a.m., both concurred that there was no documentation of past training in LN2, LN4 or LN5 employee files. They also agreed that LN3 and security guard 1 training had expired past annual policy time period. During a concurrent interview and employee files review with the director of human resources on 9/22/15, at 2:45 p.m., she confirmed that there was no past training documentation for LN7 and EMT1 in their employee files. She also confirmed that LN6 and LN7 training had expired past annual policy time period.	A 196	Continued From page 19 **Process Improvement:** • The restraint seclusion policy was reviewed with staff during the October Skills Fair and is presented to all new nursing and security employees during New Hire Orientation. • Only securities working in the ED apply restraints. **Date of Implementation:** • October 22, 2015 **Monitoring Process:** • Employee files are reviewed annually for the presence of restraint and seclusion training. • Validation of competency occurs at orientation and annually. • A check list of competencies is included in the employee file in Human Resources. • Competencies to be assessed by observation, written tests or return demonstration. • Human Resources reports results through QAPI. **Position Responsible:** • Director Human Resources (HR), Staff Educator, CNO, Quality Director	

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A 263	482.21 QAPI The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by: Based on observation, interview and document review, the hospital failed to develop an effective and hospital-wide quality management program because: 1.) Errors were found in the way the quality program selected, collected and analyzed data. Data was collected for some parameters for which no need for improvement was established, while data collected for hospital processes with known problems was incomplete or did not reflect the intended variables. (Cross reference A-0273.) 2.) The quality assurance (QA) program failed to focus on high-volume, problem prone areas such as the emergency department (ED), including the ED psychiatry holding area, and failed to use data from that area to improve service to the patients.	A 263(1)	Continued From page 20 **The hospital has developed and implemented and maintains an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program.** **Immediate and Permanent Corrective Action:** • Quality data that reflects 100% compliance for a period of greater than 3 months is no longer monitored unless mandated by regulatory or licensing agencies. • The event reporting system, work order review and other monitoring applications that reflect procedures or processes requiring improvement are incorporated into the QAPI program. • Tracking and trending results are reviewed by the Quality Council with recommendations for areas not showing improvement. **Process Improvement:** • The Governing Board has oversight of the QAPI program, which reflects the complexity of the organization and services offered. The Governing Board is made aware of the scope and severity of problems for the full range of hospital departments including EOC,MEC, Infection Control, Patient Safety and Risk. The QAPI program focuses on ensuring that high quality healthcare is provided in a safe environment for patients obtaining care in the hospital. • A new Director Quality was hired on 11/19/2015. **Date of Implementation:** • To be completed by 1/1/2016.	11/19/2015

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A 263	Continued From page 21 (Cross reference A-0283.) 3.) Although the hospital had a history of problems with equipment failures, and difficulty regulating temperature and humidity, that affected quality of care, these issues were not incorporated into the quality program, and clinical adverse events were not subject to analysis and made the basis of quality improvement activities. (Cross reference A-0286.) The cumulative effect of these failings meant the hospital failed to development and implement a quality assurance program to ensure the high quality of healthcare provided.	A 263(1)	Continued From page 21 **Monitoring Process:** • The event reporting system, work order review and other monitoring applications that reflect procedures or processes requiring improvement are reviewed at monthly Quality Council. • Areas showing improvement are continually monitored until goals are reached. • Monitoring continues until goals are maintained for a period greater than 3 months unless mandated by licensing or regulatory agencies. • Minutes of all QC meetings are presented at all Governing Board meetings for review and comment. **Position Responsible:** • Director Quality, CEO	
A 273	482.21(a), (b)(1), (b)(2)(i), (b)(3) DATA COLLECTION & ANALYSIS (a) Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve health outcomes ... (2) The hospital must measure, analyze, and track quality indicators ... and other aspects of performance that assess processes of care, hospital service and operations. (b)Program Data (1) The program must incorporate quality indicator data including patient care data, and other relevant data, for example, information submitted to, or received from, the hospital's Quality Improvement Organization. (2) The hospital must use the data collected to— (i) Monitor the effectiveness and safety of services and quality of care; and ... (3) The frequency and detail of data collection	A263(2)	**The QAPI program focuses on high volume problem areas including the ED psychiatric holding area.** **Immediate and Permanent Corrective Action:** • The event reporting system, work order review and other monitoring applications that reflect procedures or processes requiring improvement that occur in the ED psychiatric holding area are incorporated into the QAPI program. This includes the use of restraints and seclusion, holding times to bed assignments, behavioral assessment and hand-off communication. **Process Improvement:** • The Governing Board has oversight of the QAPI program to include the ED holding area to ensure reports reflect the complexity of the organization and services offered.	1/1/2016

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A 273	Continued From page 22 must be specified by the hospital's governing body. This STANDARD is not met as evidenced by: Based on observation, interview and record review, errors were found in the way the quality program selected, collected and analyzed data. Data was collected for some parameters for which no need for improvement was established, while data collected for hospital processes with known problems was incomplete or did not reflect the intended variables. 1.) During tours of the operating rooms on 9/21/15, operating rooms and the sterile storage area were found to have a temperature or humidity above the range specific by infection control standards and hospital policy (cross reference A-0749). During tours of patient rooms and hallways from 9/21/15 through 9/25/15, multiple rooms on several floors felt uncomfortably warm. Patients were seen fanning themselves, and staff was heard complaining about the excessive warmth of the hospital (cross reference A-0701). In an interview with the director of facilities (DF) on 9/22/15 at 10:20 a.m. and 12:10 p.m., and on 9/24/15 at 10:40 a.m., he stated that as a result of the January fire, a temporary air handler had been installed and turned on in March, 2015. He stated that the cooling tower needed to be rebuilt or replaced. He stated that a second cooling tower had problems due to aging equipment, and had not been working well enough for two	A263(2)	Continued From page 22 • The Governing Board is made aware of the scope and severity of problems in the ED holding area. • The QAPI program focuses on ensuring that high quality healthcare is provided in a safe environment for patients obtaining care in the ED holding area. **Date of Implementation:** • To be completed by 1/1/2016. **Monitoring Process:** • The event reporting system, work order review and other monitoring applications that reflect procedures or processes requiring improvement in the ED holding area are reviewed at monthly Quality Council. • Areas showing improvement are continually monitored until goals are reached. • Monitoring continues until goals are maintained for a period greater than 3 months unless mandated by licensing or regulatory agencies. • Minutes of all QC meetings are presented at all Governing Board meetings for review and comment. **Position Responsible:** • Director Quality, CEO **The QAPI program includes issues related to temperature and humidity of the facility.** **Immediate and Permanent Corrective Action:** • Facilities reports issues related to operating room temperature and humidity at EOC meetings which are then reported monthly to	A263(3) 11/2/2015

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A 273	Continued From page 23 months. He stated that the unit was not able to chill water to a low enough temperature to decrease humidity in the hospital. The operating room temperature and humidity data was collected by engineering staff at five in the morning, but not later, during the heat of mid-day. He stated that complaints regarding overheating were reported, but not all calls were put on the log for reporting to EOC or quality. He stated the problem with temperature control was reported to the corporate office, but not to the quality program. In interviews with the director of operating rooms (DOR) on 9/22/15 at 11:25 a.m. and on 9/24/15 at 9:40 a.m., she stated that the OR temperature and humidity were checked in the early morning, and she could not identify a system to check later in the day. She stated that the first quarter data was report in May, 2015, and should have been reported to quality assurance (QA), but may have been reported infection control (IC) instead. She was to have reported second quarter data in August, but had not yet done so. There had been no feedback from the QA department regarding the validity of the data. She stated that elevated humidity was noted in the operating rooms on 9/21/15 when the surveyors visited the area. In an interview with the interim director of quality assurance 9IDQA) on 9/24/15 at 10:00 a.m., she stated that the OR temperature and humidity data was not in the QA data from the first quarter. She stated that an increase in temperature was not reported to QA. In an interview with the interim director of infection control 9IDIC) on 9/24/15 at 10:30 a.m., he stated that he had not received any environmental data.	A273 (a1,2) (b1,2,3)	Continued From page 23 Quality Council. • Results of monitoring temperature and humidity are tracked and trended monthly. Results are reviewed by the Quality Council with recommendations areas not showing improvement. **Process Improvement:** • A new tracking system was set up for monitoring temperature and humidity in the OR. • Results are sent to and reviewed by Quality Council. • Staff are in-serviced on the process of tracking the OR temperature and Humidity. **Date of Implementation:** • 11/2/15 implementation • Monitoring process will be ongoing **Monitoring Process:** • Review minutes of Quality Council to ensure inclusion of data related to the monitoring of temperature and humidity. • Review recommendations from Quality Council for areas not showing improvement by 1/1/2016. **Position Responsible:** • Facility Director, Quality Director **Program includes but is not limited to an ongoing program that shows measureable improvement in indicators for which there is evidence that it will improve health outcomes. The hospital measures, analyzes and tracks quality indicators that assess processes of care, hospital service and operations. The program incorporates quality indicator data including patient care data, and other relevant data, for example, information submitted to, or received from, the hospital's Quality improvement**	1/1/2015

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A 273	Continued From page 24 In an interview with the DF1 on 9/24/15 at 10:45 a.m., he stated that EOC rounds were conducted in the operating rooms twice a year, but that the rooms were not entered if in use. He stated that he did not take a thermometer to the area, but would rely on the department's temperature and humidity data. He stated that he was not sure if there was a system for returning to survey the rooms that were in use. In an interview with the corporate director of quality assurance (CDQA) on 9/25/15 at 8:30 a.m., he stated that there was no link from the facilities complaint system to the incident log. He stated that the quality program was not aware of the problem. He stated that there was no trending of environment of care 9EOC) data by the quality program. 2.) During observations with the administrative staff1 (AS) on the 6th floor locked and open psychiatric units on 9/23/15 at 4:10 p.m., each patient room contained a toilet room and a handwashing sink. Six of ten handwashing sinks tested were not operable because the detection mechanisms failed to detect the presence of hands over the sink, and no flow of water could be obtained. In an interview with the IDIC on 9/24/15 at 10:05 a.m., he displayed EOC rounds documents and stated that he conducted random checks of sinks during the rounds. The notes indicated that problems with hand hygiene were observed, but not the location or the staff involved, and there was no description of what particular problem was observed. The IDIC stated the hand hygiene inservice was performed, but that not all staff had been addressed. In an interview with the DF1 on 9/24/15 at 10:45	A273	Continued From page 24 **The Quality program is actively being restructured to reflect meaningful process changes based on internal audits of systems processes and procedures identified as below goals and/or benchmarks in hospital areas that directly or indirectly impact patient safety; deficiencies cited by outside agencies and indicators mandated by Quality, Regulatory, and Accreditation and Licensing organizations as follows:** **Immediate and permanent Corrective Action** • The QAPI program has been modified to include data that can reflect measureable improvement in indicators for processes that improve health outcomes. • Indicators are measured and analyzed to assure that data related to high risk problem prone areas is being captured along with other areas where problems have been identified. **Process Improvement:** • The event reporting system, work order review and other monitoring applications that reflect procedures or processes requiring improvement in the OR, sterile storage areas and patients rooms are reviewed at monthly Quality Council. • Areas showing improvement are continually monitored until goals are reached. • Monitoring continues until goals are maintained for a period greater than 3 months unless mandated by licensing or regulatory agencies. • Minutes of all QC meetings are presented at all Governing Board meetings for review and comment.	

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A 273	Continued From page 25 a.m., he stated patient use areas were checked twice yearly via EOC rounds, but that rooms were not checked if in use, and he was not sure if there was a system to return to check rooms that were I use. He stated that it was not on the EOC rounding audit sheets to check the functionality of fixtures. He stated that he did check sinks, but that he was not present during the last EOC rounds in of the 6th floor.	A 273	Continued From page 25 **Date of Implementation:** • 1/1/2015 **Monitoring Process:** • The event reporting system, work order review and other monitoring applications that reflect procedures or processes requiring improvement in the OR, sterile processing and patient rooms are reviewed at monthly Quality Council. • Areas showing improvement are continually monitored until goals are reached. • Monitoring continues until goals are maintained for a period greater than 3 months unless mandated by licensing or regulatory agencies. • Minutes of all QC meetings are presented at all Governing Board meetings for review and comment. **Position Responsible:** • Director Quality	
A 283	482.21(b)(2)(ii), (c)(1), (c)(3) QUALITY IMPROVEMENT ACTIVITIES (b) Program Data (2) [The hospital must use the data collected to – .....] (ii) Identify opportunities for improvement and changes that will lead to improvement. (c) Program Activities (1) The hospital must set priorities for its performance improvement activities that— (i) Focus on high-risk, high-volume, or problem-prone areas; (ii) Consider the incidence, prevalence, and severity of problems in those areas; and (iii) Affect health outcomes, patient safety, and quality of care. (3) The hospital must take actions aimed at performance improvement and, after implementing those actions, the hospital must measure its success, and track performance to ensure that improvements are sustained. This STANDARD is not met as evidenced by: Based on observation, interview and record			

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A 283	Continued From page 26 review, the quality assurance (QA) program failed to focus on high-volume, problem prone areas such as the emergency department (ED), including the ED psychiatry holding area, and failed to use data from that area to improve service to the patients. The program did not ensure that quality indicators reflected aspects of performance for which quality improvement could be anticipated. 1.) During a review on 9/21/15 of two randomly selected ED records, of patients M102 and M103, both patients missed having a pain reassessment within a hour after pain medication (cross reference A-0392). During a review of hospital QA indicators, nursing indicators included pain reassessment. In an interview with the chief nursing officer 9CNO) on 9/22/15 at 9:05 a.m., she stated that the failure of timely pain reassessment was monitored via a review of randomly selected medical records monthly., In an interview with interim director of quality assurance (IDQA) on 9/24/15 at 11:30 a.m., she stated that the goal is have pain reassessed with one hour of pain medication 100% of the time. She stated that there was no audit of pain reassessment in the ED. In an interview with licensed nurse5 (LN), the ED nursing director, on 9/24/15, she stated that she just found out that pain reassessment was an indicator. She stated that she looked back at the July and August records and found that pain was reassessed within one hour 35-44% of the time. She stated that she was not sure if the ED psychiatry overflow area was included in her audit. She stated that she had not been completely oriented to her position, and had not been informed of the quality indicator.	A273		
		A283	**The hospital takes actions aimed at performance improvement and after implementing those actions; the hospital measures its success and tracks performance to ensure the improvements are sustained.** **Immediate and Permanent Corrective Action:** • The QAPI program is actively being restructured to reflect meaningful process changes based on internal audits of systems processes and procedures identified as below goals and/or benchmarks in hospital areas that directly or indirectly impact patient safety; deficiencies cited by outside agencies and indicators mandated by Quality, Regulatory, Accreditation and Licensing organizations as follows:	1/1/2015

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A 283	Continued From page 27 In an interview with the education registered nurse (ERN) on 9/24/15 at 2:05 p.m., she stated that she collected the data regarding timely reassessment of pain after pain medication. She stated that she had been trained to gather the data 1 ½ years prior, using a template. She stated that she recognized that the standard was to reassess for pain within one hour of giving an oral pain medication, but that the hospital's policy did not specify the time frame for reassessment. She stated that she had therefore been recording that pain was reassessed timely if a reassessment was documented any time within the nurse's 12 hour shift. She stated that she had not been documenting other problems, such as when medication was not provided. In another interview with the IDQA, on 9/24/15 at 2:20 p.m., she stated that she wanted to collect data on reassessment within 1 hour, not within 12 hours, but that the parameter for data collection had not been well defined, and that she had not realized that the parameter assessed by some auditors was not what was intended. In an interview with the corporate director of quality assurance (CDQA) on 9/25/15 at 8:55 a.m., he stated that it was believed some data collection was intuitive and it was not validated. He concurred that data was not collected for some hospital units. 2.) In an interview with the director of emergency department (DED) on 9/22/15 at 9:05 a.m., she stated that the psychiatric holding area of the ED had an average stay of 26 hours in August. During observations in the ED psychiatric holding area on 9/21/15 at 11:20 a.m., the area was	A 283	Continued From page 27 **Immediate and Permanent Corrective Action:** •A new Director of Quality and Risk was hired in November 2015 •A Performance Improvement Measurement (PIM) methodology is being rolled out December 12/15/2015 •The Quality Council reporting structure includes all areas affecting life safety, patient care, patient safety, grievances, and facilities and reports directly to the Governing Board. •The Quality Council reviews data trends, analysis and corrective actions and makes recommendations for revisions, restructuring and system changes as indicated •The Quality Council has the oversight for continuing, closing or modifying systems and processes being scrutinized except those evergreen quality indicators required by Quality, Accreditation, and Regulatory and licensing bodies. •The Quality Council determines what meaningful sources can and should be used for data collection. •The Quality Council approves policies related to Performance Improvement. •The Quality Council assures that education of staff is included in every process change and that staff have an awareness of areas being monitored as well as input into the selection process, including periodic monitoring of inter-rater reliability. •The Quality Council encourages staff development of corrective action plans and a implementation. •The Quality Council in coordination with the CEO and Medical Staff Office strongly encourages active participation of the medical staff as well as the Physician Chair.	

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A 283	Continued From page 28 locked and guarded. It smelled strongly of urine, and the floor near the nursing station was covered with a black material. The area of the floor near the wall had a yellow-brown substance coating the floor and 40 .95-1 cm sized pieces of debris. There were ten patient beds, but there was only one toilet and one sink, and no shower for the area. In an interview with environmental services tech1 (EVST) on 9/21/15 at 12:10 p.m., she concurred that the floor appeared dirty. She stated that she was just helping out for the day, but that the ED psychiatric holding area was not her regular area. In an interview with Patient M101 on 9/21/15 at 12:15 p.m., he stated that no cleaning person had been present during the weekend. A wet paper towel was applied to the floor, and the black substance was removed with three swipes. In interviews with the EVS Lead on 9/24/15 at 11:20 a.m. and 11:50 a.m., she stated that the person assigned to clean the area also had duties in other areas. She stated that she received a lot of calls about the restroom in the ED psychiatric holding area. She stated that there was no log of the calls, but that they occurred daily. She stated that she had not discussed needing extra help in that area. When asked for the documentation of cleaning the area, she produced a large box of cleaning documentation checklists. She looked for documentation that the ED psychiatry holding area was cleaned on the weekend and was able to find documentation of cleaning during the first shift, but not from the second and third shifts. 3.) During random reviews of medical records, some records were identified that did not include provision of information about advanced	A 283	Continued From page 28 **Process Improvement:** • The new Quality Improvement Policy is reviewed by the Quality Council and approved by the Governing Board. • The enhanced role of Quality Council is presented to that body for approval in January 2016. • Attendance at Quality Council is promoted and encouraged • Reporting departments are given guidelines on using new formats and forms and the PIMs methodology. • The Quality Council meeting minutes are sent to members 1 week prior to the meeting for corrections and approvals. • The meeting content is shown via a power point presentation to focus the attention of the group on the issue in question with a hard copy available to review on request. • Minutes reflect discussion, recommendations, concerns and questions brought to the attention of the group and the resolution of unresolved issues. • Departments are reminded 2 weeks prior to Quality Council that there is a report due at the next meeting. • Failure to report as scheduled may result in escalation up the chain of command. • Minutes of Quality Council is presented to MEC and the Governing Board by the CEO or designee at each scheduled meeting for review and comment. **Date of Implementation:** • 1/15/2015 **Monitoring Process:** • Quality Council minutes are reviewed monthly for the presence of quality data trends and corrective action plans from	

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A 283	Continued From page 29 directives to the patients (cross reference A-0132.) In interviews with the director of admitting (DA) on 9/24/15 at 2:50 p.m., and 3:50 p.m., she stated that her department was to offer the patient a kit on completing an advanced directive, and the social services department was to help the patient complete the kit. She stated that her department was not open to perform admitting activities on the weekends. When asked about how patients who were admitted and discharged during the weekend had their admitting paperwork completed, she was unable to stated the method. The DA stated that the QA indicators selected for the admitting department were having a correct facesheet and the correctness of information on the patients' arm bands. She stated that the parameters had been selected on the basis of issues at another hospital, and that there with no concerns identified by her department that could give rise to QA indicators. She stated that her hospital's performance on the two selected parameters had been 100% during the initial and subsequent times measured.	A 283	Continued From page 29 areas assigned including facilities, medical staff, nursing, human resources, grievances, event reporting, security, food and nutrition services, core measures, emergency services. • Incomplete reports are trended for corrective action • Action plans are reviewed to assess for appropriateness as well as staff education and input • Attendance by physicians is tracked and trended • Trends of areas not in compliance are brought to the Governing Board for review and comment. **Position Responsible:** • Director Quality, CEO, Governing Board	
A 286	482.21(a), (c)(2), (e)(3) PATIENT SAFETY (a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors. (2) The hospital must measure, analyze, and track ...adverse patient events ...	A 286	**The patient safety program includes but is not limited to an ongoing program that shows measurable improvement in indicators for which there is evidence that it will identify and reduce medical errors.** **Immediate and Permanent Corrective Action:** • The Patient Safety Committee is actively being restructured to reflect a meaningful analysis of internal audits that are developed based on a review of actual events, verbal and written reports, deficiencies cited during scheduled and non-scheduled agency surveys, and quality indicators identified as below goals and/or benchmarks in hospital areas that directly or indirectly impact patient safety as follows:	

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A 286	Continued From page 30 (c) Program Activities .... (2) Performance Improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital. (e) Executive Responsibilities, The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: ... (3) That clear expectations for safety are established. This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility was unable to show evidence of a method for tracking, analyzing and implementing preventative measures related to adverse events and facility maintenance issues effecting patient safety. Findings: 1.) In an interview with the director of quality assurance (DQA) on 9/22/15 at 8:50 a.m., she stated that there was a fire on 1/27/15, and that smoke from the fire on the roof went into the ventilation system. However, she was not able to find follow-up of the fire and the pursuant mechanical system problems in the Quality Committee meeting minutes. There was no evidence of the quality department performing an analysis of the events leading up to the fire, or	A 286	Continued From page 30 **Immediate and Permanent Corrective Action:** • A new Director of Quality and Risk was hired in November 2015 • The electronic event, security and grievance reporting system is reviewed 5 days per week. Data is tracked and trended to identify areas of increased risk to patient safety. • The Patient Safety Committee reporting structure includes all areas affecting life safety, patient care, patient safety including falls, hospital acquired pressure ulcers and infections, medication errors grievances, and facilities and reports directly Medical Staff Committees and to the Quality Council. • The Quality Council reviews monthly patient safety minutes and makes recommendations for revisions, restructuring and system changes as indicated • The Patient Safety Committee determines what meaningful sources can and should be used for data collection with input from Quality Council and Medical Staff Committees. • The Patient Safety Committee reviews relevant policies and policy revisions for Quality Council Approval. • The Patient Safety Committee encourages staff involvement in data collection, analysis and corrective action within their areas, including periodic assessment of inter-rater reliability. • The Patient Safety Committee in coordination with the Quality Council, CEO and Medical Staff Office, strongly encourages active participation of the medical staff as well as the Physician Chair.	

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A 286	Continued From page 31 using the fire as the basis for activity to improve the quality and safety of the hospital. In interviews with the corporate director of quality assurance 9CDQA) on 9/22/15 at 12:00 p.m. and on 9/25/15 at 8:55 a.m., he stated that, despite the hospital having malfunctioning equipment, there was no paper trail for monitoring of temperature and humidity results, and he was not aware of documentation regarding the problem at the Culver City hospital since April, 2015. He stated that issues uncovered during a previous survey did not get translated in QA indicators at the Culver City hospital. The CDQA stated that he was not aware of issues with the Hollywood hospital's coolers, and that the issue should be brought to the attention of the committee promptly. He stated that the issues with the cooler had not been included in the QA process. He stated that they had been monitoring temperature and humidity at the Hollywood location but, they stopped monitoring in March or April. 2.) On 9/24/15 plant operations staff (POS) were interviewed and the electronic complaint log for maintenance was reviewed. According to administrative staff any staff from nursing to plant operations can lodge an electronic complaint. The process is after lodging the complaint clerical staff review and assign to plant operations who take off the complaints, create work orders and distribute the work orders to the maintenance staff. If the complaint is assigned to a worker or outside vendor the column turns from blue to white, indicating assigned but not necessarily complete. In turn the maintenance staff, after addressing the issue, complete the work order and return the completed paperwork to the	A 286	Continued From page 31 **Process Improvement** • The new Patient Safety Policy is reviewed by the Patient Safety Committee, Quality Council, MEC and approved by the Governing Board. • Attendance at Patient Safety Committee is promoted and encouraged • Reporting departments are given guidelines on using new formats and forms and the PIMs methodology. • Minutes reflect discussion, recommendations, concerns and questions brought to the attention of the group and the resolution of unresolved issues. • Minutes are sent to Quality Council for review, approval and comments. Quality Council minutes are reviewed by the Governing Board. • Departments are reminded 2 weeks prior to Patient Safety Committee that there is a report due at the next meeting. • Failure to report as scheduled will result in escalation up the chain of command. **Date of Completion** • 1/15/2015 **Monitoring Process** • Patient Safety minutes are reviewed monthly for the presence of quality data trends and corrective action plans from areas assigned • Incomplete reports are trended for corrective action • Action plans are reviewed to assess for appropriateness as well as staff education and input • Attendance by physicians is tracked and trended • Trends of areas not in compliance are brought to the Quality Council for review and comment.	

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A 286	Continued From page 32 clerical staff so the clerical staff can remove the complaint from the "Open" system. POS 1 stated he had been with the facility a few months, when POS 1 started the amount of open complaints was (over 3000's) the number of open complaints viewed from June to present was over 390. Staff began complaining of the air conditioning not working back in June, with complaints logged as "Air conditioning doesn't seem to be working. Hot everywhere patients are complaining", "Adjust temp hot", July; "It is warm at the nursing station', August: "Turn on the Air conditioner very hot whole unit, Dr. and patients complaining", "We are sweating fix it! Replace it" September: "Temp high", "Surgery Operating Room (OR) rooms 7&8 temperature 73 Fahrenheit (F) humidity 69% doctors complaining please fix asap (as soon as possible). All of these complaints remained open on the complaint log. According to the complaint log the basement cooling tower circulating pump was leaking on 8/2/15 and the water leak was getting worse in the machine room basement on 8/12/15, pavilion penthouse leaking condensate line was logged on 9/8/15, and the non-return valve was leaking in basements 1 and 2 boiler room on 9/13/15 all of these work orders remained open. On 7/30/15 a complaint was logged indicating "The temp and humidity in scope washing room is out of range temp 80 F and Humidity 63%", On 8/11/15 "GI lab out of range temp 75 F and humidity 65%" On 9/9/15 "GI lab-scope and washroom temp and humidity out of range temp 79 F humidity 65% this has been a problem for weeks please adjust ASAP", all orders remained open on the complaint log. Facility staff stated	A 286	Continued From page 32 **Position Responsible:** • Director Quality	

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A 286	Continued From page 33 they had started working on the GI lab scope area, however, there was no documentation to indicate anything had been started. The temp and humidity in the GI scope processing room on 9/24/15 was 76 F and 70 %, the complaint remained open on the maintenance log. In an interview with the CEO on 9/25/15 at 8:45 a.m., he stated that he was not aware of problems in the facilities department. He stated that although he met regularly with department heads, he was not aware of the huge backlog of work orders and that he did not sense any urgency in the problems presented. He stated that he had not been performing walking rounds of the hospital. 3.) Patient M107 randomly selected from a list of code blue emergency responses for review. Patient M107 was in the subacute unit when he experienced a drop in blood pressure on 3/30/15. The patient was transferred to the emergency department (ED) for a higher level of care. In the ED, the patient experienced prolonged and recurrent periods of low blood pressure for which medications to increase blood pressure were ordered. However, the nurse did not follow the hospital guidelines for administration of the intravenous drip medication. The personnel records for the three nurses who provided care to Patient M107 in the ED were reviewed, and did not show that they were competent for caring for a patient receiving an intravenous drip. Also, the ICU beds were not full on the day that the critically ill patient was cared for in the ED. (Cross reference A-0392). In an interview with the director of emergency department (DED) on 9/22/15 at 3:45 p.m., she	A 286		

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A 286	Continued From page 34 stated that subacute or psychiatric unit patients may be returned to the emergency department or sent to the ICU if it is not full, per the physician preference for a higher level of care. In an interview with the CDQA on 9/25/15 1010, he stated that mortality reviews just started in June, so he did not believe that the death of Patient M107 was reviewed. However, an undated mortality review of Patient M107 was subsequently provided. The review did not identify issues in the care provided to Patient M107. In an interview with QA Staff 1 on 9/25/15 at 1012, she stated that the code blue committee had just reconvened to start reviewing codes, and that the review was very basic. She stated that the committee was not yet reviewing the records for a failure to rescue or other quality of care issues prior to the code.	A 286		
A 309	482.21(e)(1), (e)(2), (e)(5) QAPI EXECUTIVE RESPONSIBILITIES The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: 1) That an ongoing program for quality improvement and patient safety, including the reduction of medical errors, is defined, implemented, and maintained. (2) That the hospital-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety and that all improvement actions are	A 309	**The hospital's Governing Body, Medical Staff and Administrative Officials are responsible and accountable for ensuring and on-going quality improvement and patient safety program and a hospital wide assessment performance improvement program that addresses priorities for improving the quality of care and patient safety. The Governing Board, Medical Staff and Administrative Officials are responsible for determining the number of distinct improvement projects that are conducted annually.** **Immediate and Permanent Corrective Action:** • Minutes from the Quality Council are presented at the Governing Board meetings for review and comment.	12/2/2015

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A 309	Continued From page 35 evaluated. (5) That the determination of the number of distinct improvement projects is conducted annually. This STANDARD is not met as evidenced by: Based on observation, interview and document review, the Governing Board (GB) did not ensure that a program aimed at quality improvement and patient safety was developed and implemented because there was no evidence that the Board was active in reviewing and implementing the quality program. Findings: During observations, interviews and record reviews from 9/21/15 through 9/25/15, gaps in the development and implementation of the quality improvement program were discerned. During a review of the Board meeting minutes for October, 2014, March, 2015, and June, 2015, there was no mention of the quality assurance performance improvement (QAPI) program in the minutes. In an interview with the director of medical staff 9DMS) on 9/25/15 at 10:45 a.m., she reviewed the minutes and concurred that there was no mention of QA program report or discussion on the QA program in the minutes. In an interview with the interim director of quality assurance (IDQA) on 9/24/15 at 9:35 a.m., she stated that she did not recall any directions being provided by the governing board regarding quality program PI projects or indicators. She stated there had been no directive by the governing	A 309	Continued From page 35 **Process Improvement:** • The CEO of the hospitals attends the Governing Board meetings and responds to a review of the Quality Council minutes. • The CEO brings recommendations from the Governing Board to the Quality Council. • The minutes of the Governing Board meetings reflects this process. • The Governing Board can determine which QAPI processes no longer need to be monitored and which processes should be continued if different from recommendations of the Quality Council. **Date of Implementation:** • 12/2/2015 **Monitoring Process:** • Minutes of the Governing Board meetings will be monitored to assure Quality Council minutes are reviewed for comment. **Position Responsible:** • CEO, Governing Board	

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A 309	Continued From page 36 body to provide additional oversight of the physical environment pursuant to issues identified such as failure of the chillers. During an interview with the CEO on 9/25/15 at 8:50 a.m., he stated that the the QA program was not monitoring key parameters and the indicators were not reflecting the parameters to be improved. He was aware that some parameters selected for monitoring were already at 100%. He stated that he had not done enough to try to change the QA program. He stated that the Board needed to take a different role with the quality program.			
A 315	482.21(e)(4) PROVIDING ADEQUATE RESOURCES [The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following:] (4) That adequate resources are allocated for measuring, assessing, improving, and sustaining the hospital's performance and reducing risk to patients. This STANDARD is not med as evidenced by: Based on interview and record review, the hospital did not ensure that adequate resources were allocated for implementation of the quality assurance program, creating the risk of persistent poor practices and substandard healthcare. Findings:	A315	**The hospital's Governing Board, Medical Staff and Administrative Officials assure that adequate resources are allocated for QAPI.** **Immediate and Permanent Corrective Action:** •A Interim Director Quality and Risk Management was hired on 11/19/15. •An administrative assistant was added to the QAPI staff •2 full-time positions were opened in the Quality/Risk Department and are currently being filled by temporary staff. **Process Improvement:** • The Director of Quality oversees the department to assure that all required QAPI processes are in place. • Staff responsible for data collection in their areas expected to report data timely to Quality Council. A Chain of Command is activated for non-compliance.	11/19/2015

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A 315	Continued From page 37 In an interview with the interim director of quality assurance (IDQA) on 9/24/15 at 9:25 a.m., she stated that she requested additional help for the quality and risk management program about six months prior, and that the Governing Body was talking about providing additional help. She stated that the corporate director of quality assurance (CD QA) put in a requisition for a risk manager and a per diem QA person. In an interview with the CDQA on 9/25/15 at 8:56 a.m., he stated that the QA department was short staffed and that expertise was lacking. He stated that the department had been struggling to keep up, and there was no follow-up of issues when personnel changes occurred. He stated that the QA program had trusted department heads and had failed to evaluate the performance Improvement (PI) plans for the departments. In an interview with the CEO on 9/24/15 at 1:50 p.m., he stated that there had been no requisition for additional personnel in the QA department during the past three months. He stated that he was not sure why such a requisition had not been made.	A 315	Continued From page 37 **Date of Implementation:** • 11/19/15 **Monitoring Process:** • Quality Council minutes are reviewed by the Governing Board to reflect the presence of data related to identify problem prone areas as per the QAPI program. **Position Responsible:** • Director Quality	
A 392	482.23(b) STAFFING AND DELIVERY OF CARE The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient.	A392(1,2)	**Director Quality, Governing Board Nursing service has adequate number of licenses registered nurses, practical nurses and other personnel to provide nursing care to all patients as needed. Supervisory and staff are available on the nursing unit to assure immediate availability of an RN for bed side care of any patient.** **Immediate and Permanent Corrective Action:** • Nursing service staff is in adequate numbers to provide nursing care to all patients. Supervisory staff is immediately available for each unit to assist staffing needs. • A plan is in place to utilize an EMR integrated with the inpatient system in January 2016.	1/1/2016

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A 392	Continued From page 38 This STANDARD is not met as evidenced by: Based on observation, interview and record review, the hospital did not ensure the quality of nursing services provided because for two patients, Patients M102 and M105, pain was not reassessed within an hour of the provision of pain medication, and three nurses in the emergency department (ED) provided care for a critically ill patient but did not have required competencies, and for one ED patient, Patient M102, the nurse was not able to access the wound care nurse's assessment and recommendations, creating the risk of substandard nursing care for those patients. Findings: 1) The medical record of Patient M102 was reviewed on 9/21/15, and showed that the patient was being treated for pain associated with wounds to the hand. The record showed that the patient received Norco (combination opioid – pain medication and acetaminophen- pain medication) for pain at 8:30 a.m., but there was no documented pain reassessment. In an interview with LN2 in the ED psychiatric holding area on 9/21/15 at 11:50 a.m., she stated that she forgot to document the pain level reassessment of the Patient 102 an hour after administration of the pain medication. In an interview with LN2 in the ED psychiatric holding area on 9/21/15 at 11:50 a.m., she stated that she was caring for Patient M102. Patient M102 had wounds on the hand, and had an assessment and recommendations made by the wound care nurse. She stated that she received some information about the patient during report, but that she was not able to access the wound care nurse's assessment and recommendations.	A392(1,2)	Continued From page 38 • Pain assessment and reassessment in all patient care areas is carried out before pain medication is administered and within 60 minutes after administration appropriate for the route of administration. • Pain assessment and reassessment will include the level of pain as described by the patient or as the patient presents based on the non-verbal pain scale. **Process Improvement:** • Pain assessment and reassessment re-education was provided at the October Skills Fair and during Nursing New Hire Orientation. • 2015 competencies for all nurses included pain assessment and reassessment including documentation. • Education and training will be provided for the new integrated system. **Date of Implementation:** • January 2016 **Monitoring Process:** • Nursing files are reviewed by HR and Nursing Leadership to assure the presence of current annual competencies for existing staff. • Orientation and unit-based competencies are completed for new hires prior to functioning independently. • Pain assessment and re-assessment is monitored on a monthly basis in all of the Nursing units. The data is reported to Quality Council and to the Governing Board for review and recommendations. **Position Responsible:** • CNO, Staff Educator, HR Director, Directors of Nursing Units	

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A 392	Continued From page 39 as they were in a computer system that she did not have access to. In an interview with LN18 on 9/21/15 at 11:45 a.m., he also stated that LN2's care for Patient M102's wounds was limited to the instructions that she received in report, as she could not access the wound care nurse's notes. He stated that the wound care notes were in a computer system that LN2 did not have access to. 2) The medical record of Patient M105 was reviewed on 9/21/15 at 12:30 p.m., and showed hat the patient was in the ED being treated for pain associated with a leg wound. The record showed that the patient received morphine (oplate pain reliever) at 10:04 a.m., but there was no reassessment documented after the administration of the medication. In a concurrent interview with the Dir ED, she concurred that there was no follow-up assessment documented after the pain medication administration, as should occur per policy. 3) The medical record of Patient M107 was selected for review from a list of code blues. The medical record showed that Patient M107 was transferred from the subacute unit to the ER because he became hypotensive and required a higher level of care. The record of care provided to Patient M107 in the ED showed that the patient arrived at the ED at 4:18 a.m., and that LN15 assumed care a 4:49 a.m., followed by LN16 at 8:16 a.m. The record showed that Patient M107 became hypotensive with a systolic blood pressure of 64 (normally 90-120) at 9:50 a.m. The nurses notes indicated that admission orders for the patient were	A 392(3)	Continued From page 39 **Critical patient from Sub Acute to ED** **Immediate and Permanent Corrective Action:** • When a patient is in critical condition and there is no inpatient bed available or staffing available in the ICU, the patient will be transferred to the ED for stabilization per the Rapid Response and Code Blue protocols. • ACLS is the core competency in the ED. • Admit to the ICU unit as soon as bed and staffing are available. • ED staff was educated specifically in critical care competencies. **Process Improvement:** • New unit based competencies have been developed house wide. **Date of Implementation:** • October 20-22, 2015 immediately • Currently ongoing. **Monitoring Process:** • Current ED staff have been reassessed and signed off on the competencies. • All new hire staff will have the unit based competency completed by the end of the 90-day evaluation period. **Position Responsible:** • Directors of Nursing Units, CNO,	

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A 392	Continued From page 40 obtained at 9:42 a.m., but an order for Levophed drip titrated to raise the systolic blood pressure to greater than 90 was not recorded until 10:12 a.m. The hospital protocol for vasoactive infusions showed that levophed was to be started at 4 mcg (microgram)/minute and titrated at 1 mcg/minute each 5 minutes, for a maximum increase of 12 mcg in 1 hour, and a maximum dosage of 16 mcg/minute after 1 hour. However, the nursing notes indicated that levophed was started at 10:25 a.m., and at 12:11 a.m., more than 1 ½ hours later, the rate was only at 18 mcg/minute. After another 1 ½ hours, at 1:42 p.m., the rate was only at 24 mcg/minute. After another 1 ½ hours, at 3:15 p.m., the rate was 28 mcg/minute. Vital signs for the patient failed to show that the patient's blood pressure rose to greater than 90 during that time, and the nursing notes did not show that the physician was contacted regarding persistent hypotension in the patient until 3:54 p.m. In an interview with Pharmacist1 (P) on 9/25/15 at 9:20 a.m., she concurred that the Levophed provided to Patient M107 was not titrated per the standard protocol. She stated that IV drip competencies were expected for a nurse administering Levophed. She stated that the nurse was expected to call the pharmacy to convey an urgent medication order. In an interview on 9/24/15 at 3:15 p.m. with LN5, the ED nursing director, she reviewed the medical record and concurred that there was no documentation that the nurses called the physician to inform him that the patient had persistent hypotension.	A 392	Continued From page 40	

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A 392	Continued From page 41 A Department Specific Competency Checklist (updated 2015) was presented which showed that ED nurses were expected to have medication administration competencies that included preparation and use of vasoactive drip medications. In an interview with human resources staff1(HRS) on 9/24/15 at 3:05 p.m., she stated that nurses were to be evaluated within 90 days of starting service and annually. She reviewed the personnel files of LN15, LN16 and LN17. She concurred that the last competencies of LN15 were 4/2/14. The last competencies of LN16 were dated 2008. Neither filed contained competencies for IV drip medications. The file of LN17 showed that she started work in March, 2015, and there here only competency was for body mechanics. She stated that the ED director was to check the competencies and that they were behind on follow-up competencies for staff. She stated that the human resources department was to double-check that competencies were completed, but that she was not sure if the ED department had been advised that the competencies were not done. In an interview on 9/24/15 at 3:15 p.m. with LN5, the ED nursing director, she reviewed the personnel files of LN15, LN16 and LN17 and stated that they did not have current competencies. In an interview with the chief nursing officer (CNO) on 9/25/15 at 9:25 a.m., she stated that she was aware that nursing competencies were in arrears. In an interview on 9/24/15 at 3:15 p.m. with LN5	A 392	Continued From page 41	

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A 392	Continued From page 42 the ED nursing director, she stated that during the time that Patient M107 was in the ED, there were 7 patients in the 10 bed ICU. She stated that she had interviewed LN17 about Patient M107's care, and she was caring for two ICU patients in the ED while Patient M107 was there. In an interview with the CNO on 9/25/15 at 8:00 a.m., with the CNO, she stated that the staff in the ED should have current competencies. She stated that a critical care competent nurse was to go to the ED to take of a critical patient, or that ICU staffing was to be expanded to accommodate the patient. She stated that until additional ICU nurses arrived, the ICU charge nurse was to provide patient care.	A 392	Continued From page 42	
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to ensure nursing care was evaluated for one patient (N109). N109's multiple pressure ulcers were not assessed and measured as per facility policy on admission. Findings: Record review on 9/24/15 at 11:30 a.m. revealed N109 was admitted with multiple pressure ulcers and skin issues. Although photographs had been taken of the pressure ulcers and skin issues the day after admission there was no measurements, description or staging of the pressure ulcers. The facility's policy and procedure dated 11/2012 and	A 395	**A registered nurse supervises and evaluates the nursing care for each patient. Ulcers are assessed and measured per policy** **Immediate and Permanent Corrective Action:** • Nursing reviewed staging, describing and measuring pressure ulcers during the October Skills Fair. • The wound care RN provides training to nursing staff on an ongoing basis during his wound care rounds. **Process Improvement:** • A program revision is in place for the first week in January to standardize the wound assessment and care process. • The initial nursing assessment on admission includes skin integrity assessment including documentation, measurement and staging of community acquired pressure ulcers (CAPU).	1/1/2015

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A 395	Continued From page 43 titled, "Management of Skin Integrity – Care of the Patient," states, "Documentation and assessment of the site of impaired skin integrity should include the following criteria: Location and Description. Head to toe (proximal to distal) length and width (document the longest diameter measuring in cm. using the straight edge of a measuring guide. " During an interview and concurrent review of the medical record on 9/24/15 at 11:50 a.m. LN18 confirmed that staging and a description and measurements of the pressure ulcers should have been done at the time of admission.	A 395	Continued From page 43 • CAPUs are recorded in the Event Reporting System for tracking and trending. • Staff in-serviced on the policy and the process during the December Skills Fair and during New Hire Nursing Orientation. • Nursing competencies include the aspects of wound care related to pressure ulcer identification, documentation, staging and treatment recommendations by the wound care team. **Date of Implementation:** • 01/01/2015 **Monitoring Process:** • Pressure ulcer documentation is reviewed for location and description, length and width measurements staging description. • Open record reviews to identify fall outs will be tracked and trended. • Data is collected, submitted and reported to Quality Council, MEC and Governing Board. **Position Responsible:** • CNO, Wound Care Team, Quality Director	
A 405	482.23(c)(1), (c)(1)(i) & (c)(2) ADMINISTRATION OF DRUGS (1) Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice. (i) Drugs and biologicals may be prepared and administered on the orders of other practitioners not specified under §482.12(c) only if such practitioners are acting in accordance with State law, including scope of practice laws, hospital policies, and medical staff bylaws, rules, and regulations. (2) All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures.	A 405	**Drugs and biologicals are prepared and administered in accordance with Federal and State laws.** **Immediate and Permanent Corrective Action:** • Drugs requiring administration on as-needed (PRN) basis have parameters built into the physicians' order which indicate the dose to be given based on the parameters in the order.	10/20/2015

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A 405	Continued From page 44 This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to have timely assessment of pain for Patient N200 and Patient N201 and post pain medication administration assessments for Patient N200, N201, and N203. The facility failed to identify PRN (drugs prescribed on an as needed basis) medications as not eligible for scheduled dosing, when Patient N201 was prescribed PRN pain medications on BID (twice a day), TID (three times a day) and QID (four times a day) schedule. The facility failed to follow acceptable standards of practice when multiple PRN pain medications were prescribed for the same indications for Patient N200 and N201. Findings: A review of the facility policy entitled "Pain Management" effective 07/2004 last revised 11/2012 under header of "Assessment" indicates in part, "4.2.11 The patient will be assessed and monitored for pain by all licensed staff as follows: 4.2.13 A minimum of every shift." Under the heading of "Documentation" indicates in part, "4.2.21 When pain is identified, an assessment will be documented by the RN, using an appropriate pain scale." Under the heading of "Reassessment" indicates in part, "4.2.29 The patient will be reassessed for pain by the RN at a suitable interval each pain control intervention, e.g., medication, relief measures to evaluate effectiveness of the intervention." During a review of the clinical record of Patient N200 on 9/23/15, at 9:45 a.m., the medication	A 405	Continued From page 44 • In-service education provided immediately to pharmacist staff verifying physician orders to ensure delineation of the medication order to the pain scale otherwise the pharmacist will contact the ordering physician for clarification. • Pain assessment and reassessment in all patient care areas is carried out before pain medication is administered and within 60 minutes after administration appropriate for the route of administration. • Pain assessment and reassessment will include the level of pain as described by the patient or as the patient presents based on the non-verbal pain scale. **Process Improvement:** • In-Service was provided during October Skills Fair and during New Hire Nursing Orientation. • Policy PHA.052 Preparation and Administration of Medications was reviewed and revised to exclude PRN medication as not eligible for scheduled dosing time. • The Nursing Pain Management Policy was revised and reviewed at MEC, Quality Council and Governing Board. • Multiple drugs ordered for the same indication are clarified by the physician to avoid poly-pharmacy. • Pain assessment and reassessment documentation in the EMR was provided at the October Skills Fair and during Nursing New Hire Orientation. • Competencies for all nurses include pain assessment and reassessment. • Pharmacy clarifies physician orders that do not meet standard A405. **Date of Implementation:** • 10/20/2015	

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A 405	Continued From page 45 record indicated the Patient N200 was administered acetaminophen (a medication used for pain) 650 milligrams at 7 a.m., on 9/14/15. Further review of the record indicates Patient N200 did not have any documentation of pain level prior to administration of the pain medication. The post assessment of effectiveness of the pain medication administered did not occur until 9:40 p.m. on 9/14/15. During an interview on 9/26/15, at 9:46 a.m., with LN11, LN12 and AS3, while concurrently reviewing clinical record of Patient N200 all acknowledged that pre-assessment for pain was not documented and that the post assessment that occurred 14 hrs and 40 minutes after the medication administered was not a timely assessment. During a review of the clinical record for Patient N201 on 9/23/15, at 10 a.m., the record revealed Patient N201 was administered morphine (a narcotic pain reliever to treat pain) 15 milligrams on 9/19/15, at 3:15 p.m., there was no documentation of pre-assessment for pain and post assessment of effectiveness occurred 6 hours after dose was given. During an interview on 9/23/15, at 10:01 a.m., with the director of pt and LN11, while concurrently reviewing Patient N201 medical record, both acknowledged the patients pain level was not documented prior to the administration of the medication and post assessment of medication administration was not timely. LN11 stated, "It should occur within one hour." During a review of the clinical record for Patient N203 on 9/23/15, at 2:15 p.m., the record revealed Patient N203 was administered hydrocodone-acetaminophen (a medication to treat pain) on 9/22/15, at 5:48 p.m., there was no documentation of post assessment of the the	A 405	Continued From page 45 **Monitoring Process:** • Pharmacy provides concurrent record reviews for orders that do not meet the standard to assure clarification occurs before medication is dispensed. • The presence of documentation of pain assessment and re-assessment is reviewed during monthly unit audits. • Data related to prescribing errors are entered into the event reporting system. • All identified medication errors and documentation fall outs are brought to the Medication Safety Committee, Quality Council and Governing Board. • Trends identified by physician ordering are brought to the MEC for discussion and follow up to peer review as required. **Position Responsible:** • Director Pharmacy, Director Quality, CNO	

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A 405	Continued From page 46 effectiveness of the pain medication. During a concurrent review of the record and interview with LN14, LN15 and LN11 all concurred there was no documentation of post assessment of the pain medication effects. The facility policy and procedure entitled "Preparation and Administration of Medications" dated 10/2008 and revised 06/2014 under the header "Medication Administration Guidelines," indicates in part, "8.6 All medications except IVPB (intravenous piggyback-short term infusion) are to administered on the following schedule;" The policy did not exclude PRN medications as not eligible for scheduled dosing times. During a review of the clinical record for Patient N201 on 9/23/15, at 10:00 a.m., the record revealed that the physician had ordered three BID (twice a day) PRN medication orders, five TID (three times a day) PRN medications orders and two QID (four times a day) medication orders. During an interview and concurrent record review with the AS3 on 9/23/15, at 10 a.m., when asked if the scheduled PRN orders were appropriate, AS3 stated, "No it's not." During a review of the clinical record of Patient N200 on 9/23/15, at 9:45 a.m., the record revealed Patient N200 had the following physician ordered medication dated 9/8/15 at 10:43 p.m., Tylenol (a pain medication) 650 milligrams PO (by mouth) q6h (every 6 hours) PRN pain and Oxycodone (a medication to treat pain) 5 milligrams PO every 4 hrs PRN pain. During a review of the clinical record of Patient N201 on 9/23/15, at 10 a.m., the record revealed Patient N201 had the following physician ordered medications dated 9/10/15, at 4:30 p.m., tramadol (an opioid pain medication) 50 milligrams po q12	A 405	Continued From page 45	

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A 405	Continued From page 47 hr prn pain and morphine (a pain medication of opiate type) 15 milligrams po bid prn pain. During a concurrent record review and interview with the AS3 on 9/23/15, at 10 a.m., when asked if Patient N200 and Patient N201 orders were appropriate she stated, "No these orders are not written right."	A 405	Continued From page 46	
A 454	482.24(c)(2) CONTENT OF RECORD: ORDERS DATED & SIGNED All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner who is responsible for the care of the patient only if such a practitioner is acting in accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations. This STANDARD is not met as evidenced by: 2. Review of the facility's policy entitled " Medication Administration and Ordering Privileges, Verbal Orders" revised 6/2014, indicated that the procedure applies to all departments and services licensed by the facility and crosses interdisciplinary lines and to assure regulatory guidelines are followed and patient safety is maintained. Verbal medication orders: 4.1.22 indicated The order must be countersigned by the person prescribing within 48 hours. The paper and electronic medical record for patient N 400 was reviewed on 9/21/15 at 12:25 p.m. A hand written Physician's Orders sheet dated 9/11/15 indicated a telephone order read back (TORB) for medications. There were six medications listed on the order. During concurrent record review and interview	A 454	**All orders including verbal orders, are dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner who is responsible for the care of the patient only if such a practitioner is acting in accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules and regulations.** **Immediate and Permanent Corrective Action:** • Medical staff office issued a letter written by the Chief of Staff to all Licensed Independent Practitioners on the medical staff hospital regarding physician documentation. **Process Improvement:** • Issue was discussed with Governing Board. • Integration of the electronic medical record in January 2016 will eliminate the need for paper order forms. • ED orders will be required to be placed into the EMR which will require authentication within 48 hours. **Date of Implementation:** • 01/15/2016 **Monitoring Process:** • Health Information Management tracks and trends physician order authentication.	1/15/2015

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A 454	Continued From page 48 with licensed nurse 1 (LN) on 9/23/15 at 9:50 a.m. he stated that there was no physician authentication within 48 hours since it was a hand written order it needed to be signed by hand to authenticate it. The electronic medical record for patient N 401 was reviewed on 9/23/15 at 10:50 a.m. a computerized physician order entry (CPOE) dated 9/1/15 indicated an order for Restoril (a medication for sleep) and Ativan (an antianxiety medication). Further record review of CPOE entries reflected no electronic sign off/authentication by the ordering physician through 9/18/15. During concurrent record review and interview with LN 1 and administrative staff 1 (AS) both agreed there was no electronic sign off/authentication by the ordering physician. Based on interview, record review and facility policy review the facility failed to ensure telephone orders for Patients N200, N201, N202, N 400 AND N401 were authenticated by the ordering physician within 48 hours, per facility policy. Findings: 1. Review of facility policy entitled "Telephone Drug Orders" from medical staff rules and regulations page 28 indicated in part,"Telephone orders must be recorded promptly in the patient's medical record, noting the name f the person giving the telephone order and the signature of the individual receiving the order. The prescriber must countersign the order within 48 hours..." During a review of of the clinical record of Patient N200 on 9/23/15, at 8:55 a.m., the record	A 454	Continued From page 48 • Physicians who are not in compliance with the requirement for order authentication are placed on suspension until the requirement is met. • Physicians on suspension more than 30 days are given a warning. Physicians on suspension over 60 days are removed from the hospital medical staff. **Position Responsible:** • Director Medical Staff Office, Chief of Staff, CEO, Director HIM, Director Quality.	

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A 454	Continued From page 49 revealed that Patient N200 was admitted on 9/8/15, telephone orders for the admission included six medications, various blood panels, and tests. Review of physician e-signature authenticating the telephone orders on all admission orders was absent. During an interview with LN11 and LN12 on 9/23/15, at 8:57 a.m., both acknowledged the absence of a countersignature authenticating the telephone orders. AS3 who was observing stated, "These non co-signed orders are tracked by the medical records department and are sent to the medical staff office." During a review of the clinical record of Patient N201 on 9/23/15, at 10:00 a.m., the clinical record indicated Patient N201 was admitted on 9/10/15, telephone orders for the admission included 17 medications, various blood panels, tests and oxygen orders. A review of the physician E-signature co signing authentication was absent. During an interview with LN11 and AS3 on 9/23/15, at 10:01 a.m., both acknowledged the lack of E-signature authenticating the 9/10/15 admitting orders. During a review of the clinical record of Patient N202 on 9/23/15, at 11:30 a.m., revealed Patient N202 had one telephone medication ordered 9/15/15 and four tests telephonically ordered on 9/16/15. A review of the E-signature co-signing authentication of the orders from the physician was absent. During a interview with LN11 on 9/23/15, at 11:33 a.m., LN11 acknowledged the lack of physician E signature authentication stating, "I am not sure why he signed some of his orders and not the others."	A 454	Continued From page 49	
A 502	482.25(b)(2)(i) SECURE STORAGE	A 502		

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A 502	Continued From page 50 All drugs and biologicals must be kept in a secure area, and locked when appropriate. This STANDARD is not met as evidenced by: Based on observation, interview and facility policy review the facility failed to store drugs in a secure area, when eight tables of seroquel (a drug used to treat symptoms of schizophrenia, bipolar disorder and major depression) was observed to be in a paper folder laying on top of a mobile computer in the psychiatric emergency room. Findings: The facility policy and procedure entitled\ "Dispensing of Medications" dated 10/2010 last revised 10/2012 indicated under header of distribution of medications, 4.1.3 "Medications not stocked in the ADU (automated drug unit) shall be distributed via courier and with daily exchange of cassette containing the individual patient bins. 4.1.7 Each patient bin shall be labeled with the patients name and/or room number." During a concurrent observation and interview on 9/21/15, at 11:15 a.m., in the psychiatric overflow emergency room, eight tablets of seroquel 50 milligrams in unit dose packaging within a plastic bag, was observed laying in a paper folder on top of a mobile computer approximately 3 feet from two patients laying in beds. LN3 stated, "This drug does not dispense from the med machine, pharmacy has to bring it down." When asked if this is how drugs are stored in this area, LN2 stated, "No they are suppose to be stored in the bins." LN2 opened a cabinet with bins that had no	A 502	Continued From page 50 **All drugs and biologicals are kept in a secure area, and locked when appropriate.** **Immediate and Permanent Corrective Action:** • The drugs seen on the top of the mobile computer in the psychiatric overflow room were removed. • All medications delivered to the nursing units are stored in patient specific bins. • The bins are kept locked when not in use. • When the bins are opened a licensed nurse, licensed pharmacist, licensed pharmacy technician or physician is present until relocked. **Process Improvement:** • In-services provided to nursing and pharmacy staff regarding dispensing and storage of medication in patient care areas. • Appropriate medication storage equipment was ordered to assure compliance with this regulation. **Date of Implementation:** • 9/25/2015 **Monitoring Process:** • Medication storage is observed during Director Rounds and Pharmacy rounds. • Data is collected, aggregated and analyzed and reported through Pharmacy, Nursing, MEC, Quality Council and Governing Board. **Position Responsible:** • Director Facilities, Director Pharmacy, CNO, Director Quality	9/25/2015

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A 502	Continued From page 51 drugs in them and no names on the bins.	A 502	Continued From page 51	
A 700	482.41 PHYSICAL ENVIRONMENT The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community. This CONDITION is not met as evidenced by: Based on observation, interview and document review, the hospital failed to ensure the maintenance and functionality of the physical plant and hospital environment to ensure the safety and well being of patients, further the facility did not integrate ongoing maintenance issues into its QAPI program (refer to A- 0263). 1) The facility could not ensure the condition of the physical plant was sufficient to provide an acceptable level of safety and well being for patients (refer to A- 0701, A-0724). 2) The facility could not show adequate ventilation and temperature controls in several areas (refer to A-0726). The cumulative effect of these failings meant the facility failed to ensure that safe healthcare was provided in a safe environment for patients obtaining care in the hospital.	A 700	**The hospital is constructed, arranged and maintained to ensure the safety of the patient and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.** **Immediate and Permanent Corrective Action:** • The plastic zip door was removed. • On 9/22/15 a discussion occurred about the integrity of the 3 coolers which was not accurate. • One cooler is working appropriately, 2 of the 3 coolers needed repair or replacement. • When all coolers are in working order they are able to meet the needs of the facility. • On 9/23/15 it was noted that the fire alarm panel had been disconnected from the PBX panel this was because the PBX panel is not the notification panel for fire. The notification panels are in the main lobby, Pavilion basement and Tower building security office. • Immediately provided cooling measures to patients complaining about the room temperature. Including more cold compresses, provided extra water, provided fans and portable AC units.	10/2015
A 701	482.41(a) MAINTENANCE OF PHYSICAL PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured.			

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A 701	Continued From page 52 This STANDARD is not met as evidenced by: Based on observation, interview and record review, the hospital failed to maintain the safety and functionality of the physical plant because fire alarm, ventilation equipment, coolers and the boiler as well as handwashing sinks were not maintained in working order or promptly repaired or replaced, creating risks to the quality of care provided and to patient safety. Findings: The basement of the Culver City Campus was toured with the Director of Facilities, and Infection Control officer on 9/22/15 at 8:45 a.m. The previous day the area was toured by the department and an inch of water was found in the hallway near the back door of the PACU. On 9/22/15 there was a plastic zip door applied to the entry of the area leaking (unapproved by OSHPD). The pipe in the ceiling was leaking steam due to a "boiler problem". The OR's were found to be out of compliance with humidity ranges (OR 3, 6 and 7 were all over 60 % humidity on 9/22/15)). The autoclaves in the OR (Autoclaves 6 & 7) had issues requiring maintenance due to the boiler causing water in the chamber and a prolonged evacuation stage. During an interview with administrative staff on 9/22/15 they discussed the age of the building and equipment and shared 2 of the 3 coolers needed replacement and 1 cooler needed to be repaired. The Dir of Facilities shared the cooling unit was not able to chill water to a low enough temperature to decease the humidity in the hospital. Administrative staff shared the coolers are not adequate for the needs of the facility.	A700	Continued From page 52 • On 09/22/15 at 7:15pm, Immediate Jeopardy was abated after compliant practices in maintaining surgical suites temperature and humidity within regulatory limits and surgical instruments and endoscopes storage issues were identified. All surgical instruments and endoscopes were reprocessed. All OR activity ceased until compliance could be assured. • On 9/22/15 Johnson Control provided emergency service call for no cooling. • On 9/22/15 temperature and humidity were brought to within acceptable ranges. **Process Improvement:** • A policy was developed regarding the maintenance of the ED portable AC units. • When a room is considered out of range, a work order is created and engineering is notified. • Ongoing monitoring with temperature and humidity assessed prior to surgery as well as documented checks throughout the day in both the OR and the sterile supply room. • Staff in the OR has been educated on the process, Temperatures and humidity are assessed hourly as well as prior to procedure. • When fall out occurs the plant operations team is notified to adjust temperature. Monthly trend reporting to ACNO, IC and Quality Department occurs. • No procedures will occur unless temperature and humidity are within normal limits. • When a room is out of range and is not correctable prior to a scheduled	

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A 701	Continued From page 53 During an interview with the Dir Facilities on 9/22/15 at 1020, he shared the facility had a fire back in January due to a roofing project that was too close to the air handler, the air handler did not shut off due to a relay being removed. He stated that the relay may been removed by previous personnel, but that the hospital now had a new and fully functioning fire alarm system. During additional system testing in the hospital on 9/23/15, it was found that a fire alarm panel had been disconnected from the PBX panel. In an interview with the CEO and CNO on 9/23/15 at 5:15 p.m., he stated that he was not aware of a problem with the fire alarm system due to a fire alarm panel being disconnected. The CNO also indicated that she was not aware of the problem found with the fire alarm system. During an interview with the Dir Facilities on 9/22/15 at 1020 a.m., he stated that as a result of the January fire, a temporary air handler had been installed and turned on in March, 2015. In interviews with the Dir Fac 2 on 9/23/15 at 1045 a.m. and 1:45 p.m., he stated that there had been a catastrophic failure of one of the Hollywood location's chillers. He stated that the process for procurement involved filling out a requisition and waiting, sometimes for an extended period. In an interview with the CEO on 9/25/15 at 0845, he concurred that the procurement process required numerous signatures and was protracted. During an interview with the Dir OR on 9/22/15 at	A 700	Continued From page 53 procedure, infection control is notified by OR. • Plan for infection control surveillance to monitor and report as well as plant operations at monthly committee meetings. • Electronic/Digital devices will monitor to be installed in December • Upon completion of the installation staff will be educated on requirements and individuals will be identified for notification, reporting and action. Anticipated completion date is 1/1/2016. • Immediately started monitoring room temperatures in all patient rooms. Temperatures that were out of range were called by nursing to engineering and a work order was issued. The work orders were carried out within a 30 minute time frame. • Cooling measures and room monitoring continued throughout the warm weather season. **Date of Implementation:** • October 2015 **Monitoring Process:** • The CEO now makes regular walking rounds. • Room temperatures where monitored 3 times a day in each patient room from September 25 thru October 26, 2015. • Work orders were reviewed for rooms that were out of range. • Facilities Director reviewed fall outs with his staff. • Patient complaints about room temperatures are tracked through the event reporting system and tracked through QAPI.	

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A 701	Continued From page 54 1125 a.m., she stated that the OR temperature and humidity were checked in the early morning, and that there was no system to check later in the day. She stated that elevated humidity was noted in the operating rooms on 9/21/15 when the surveyors visited the area. During tours of the hospital on 9/21/15 to 9/25/15, patient rooms on multiple floors were felt to be unusually hot. Patients were seen fanning themselves, and staff members remarked on the high temperature of the hospital. During an observation in the ED on 9/21/15 at 11:20, there were four portable cooling units with ducts extending into the ceiling. In a concurrent interview with the Dir of the ED, she stated that the units were maintained by the facilities department staff, who emptied the chiller at the bottom of the machines. In an interview with the Int Dir IC on 9/21/15 at 2: 15 p.m., he stated that there was no facility policy regarding the maintenance of the ED portable cooling units. On 9/24/15 Plant Operations Staff (POS) were interviewed and the electronic complaint log for maintenance was reviewed. According to administrative staff any staff from nursing to plant operations can lodge an electronic complaint. The process is after lodging the complaint clerical staff review and assign to plant operations who take off the complaints, create work orders and distribute the work orders to the maintenance staff. If the complaint is assigned to a worker or outside vendor the column turns from blue to white, indicating assigned but not necessarily complete. In turn the maintenance staff, after addressing the issue, complete the work order and return the completed paperwork to the	A 700	Continued From page 54 • Staff monitors and documents temperature and humidity prior to procedure in the ORs. Nursing staff monitor daily on an hourly basis, (document attached). Trending reports to be sent to Quality Council through EOC and infection control reports which will flow up to the MEC and Governing Board for review discussion and any further action. • Fire alarm systems are checked according to NFPA code along with the scheduled surprise fire drills. **Position Responsible:** • Director Facilities, CEO, Director Quality **The condition of the physical plant and the overall hospital environment is developed and maintained in such a manner that the safety and well-being of patients is assured.** **Immediate and Permanent Corrective Action:** • The plastic zip door was removed immediately. • On 09/22/15 at 7:15pm, Immediate Jeopardy was abated after compliant practices in maintaining surgical suites temperature and humidity within regulatory limits and surgical instruments and endoscopes storage issues were identified. All surgical instruments and endoscopes were reprocessed. All OR activity ceased until compliance could be assured.	A 701 10/2015

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A 701	Continued From page 55 clerical staff so the clerical staff can remove the complaint from the "Open" system. POS 1 stated he had been with the facility a few months, when POS 1 started the amount of open complaints was "Over 3000", the number of open complaints viewed from June to present was over 390. Staff began complaining of the air conditioning not working back in June, with complaints logged as "Air conditioning doesn't seem to be working. Hot everywhere patients are complaining", "Adjust temp hot" , July: "It is warm at the nursing station", August: "Turn on the Air conditioner very hot whole unit. Dr and patients complaining"., "We are sweating fix it! Replace it" September: "Temp high", "Surgery Operating Room (OR) rooms 7&8 temperature 73 and humidity 69% doctors complaining please fix asap (as soon as possible). All of these complaints remained open on the complaint log. According to the complaint log the basement cooling tower circulating pump was leaking on 8/2/15 and the water leak was getting worse in the machine room basement on 8/12/15, pavilion penthouse leaking condensate line was logged on 9/8/15, and the non-return valve was leaking in basements 1 and 2 boiler room on 9/13/15 all of these worker orders remained open. On 7/30/15 a complaint was logged indicating "The temp and humidity in scope washing room is out of range temp 80 F and Humidity 63%", On 8/11/15 "GI lab out of range temp 75 F and humidity 65%" on 9/9/15 "GI lab-scope and washroom temp and humidity out of range temp 79 F humidity 65% this has been a problem for weeks please adjust ASAP", all orders remained open on the complaint log. Facility staff stated	A 701	Continued From page 55 • On 9/22/15 Johnson Control provided emergency service call for no cooling. • On 9/22/15 temperature and humidity were brought to within acceptable ranges. • A temporary cooling tower was installed on 9/25/15. • The existing cooling tower has been rebuilt and the temporary cooling tower has been removed. • While the other cooling towers are functioning, they are in the process of permanent replacement. • Immediately provided cooling measures to patients complaining about the room temperature. Including more cold compresses, provided extra water, provided fans and portable AC units. • On 9/23/15 it was noted that the fire alarm panel had been disconnected from the PBX panel. Panel was reconnected. **Process Improvement:** • Immediately started monitoring room temperatures in all patient rooms. Temperatures that were out of range were called by nursing to engineering and a work order was issued. The work orders were carried out within a 30 minute time frame. • If unable to adjust temperature patient may be moved to another available room. • A policy was developed regarding the maintenance of the ED portable AC units. • When a room is considered out of range, a work order is created and engineering is notified. • Ongoing monitoring with temperature	

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A 701	Continued From page 56 they had started working on the GI lab scope area, however, there was no documentation to indicate anything had been started. The temp and humidity in the GI scope processing room on 9/24/15 was 76 F and 70 %, the complaint remained open on the maintenance log. In an interview with CEO on 9/25/15 at 0845, he stated that he was not aware of problems in the facilities department. He stated that although he met regularly with department heads, he was not aware of the huge backlog of work orders and that he did not sense any urgency in the problems presented. He stated that he had not been performing walking rounds of the hospital.	A 701	Continued From page 56 and humidity assessed prior to surgery as well as documented checks throughout the day in both the OR and the sterile supply room. • Staff has been educated on the process, Temperatures and humidity are assessed hourly as well as prior to procedure. • When fall out occurs the plant operations team is notified to adjust temperature. Monthly trend reporting to ACNO, IC and Quality Department occurs. No procedures will occur unless temperature and humidity are within normal limits. • When a room is out of range and is not correctable prior to a scheduled procedure, infection control is notified by OR. • Plan for infection control surveillance to monitor and report as well as plant operations at monthly committee meetings. • Electronic/Digital monitoring devices were installed in December. • Upon completion of the installation staff will be educated on requirements and individuals will be identified for notification, reporting and action. Anticipated completion date is 1/1/2016. • Cooling measures and room monitoring continued throughout the warm weather season. **Date of Implementation:** • October 2015 **Monitoring Process:** • The CEO now makes routine walking rounds.	
A 724	482.41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to identify equipment in patient rooms that was nonfunctional. The battery operated sensor activated faucets in patient rooms on the sixth floor had no running water. Findings: During a tour of the sixth floor, locked "D" unit (locked geropsych unit), on 9/23/15 beginning at 3 p.m. with administrative staff (AS) we went into room 602 and attempted to check the water temperature of the sink in the room. The sink had a battery operated sensor on the faucet (put your hand(s) under the faucet to activate water flow) and when we tried to activate it, no water came			

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A 724	Continued From page 57 out.. Rooms 603 and 616 had the same results, as did room 615 where patient N 402 stated that the sink had not been working for the two days since her admission. The faucet in the day room (room 607) was non-working as well. During an interview with mental health tech 1 (MHT) on 9/24/15 at 2:45 p.m., she said she would take patients to another patients bathroom to wash their hands. Staff would go to the nurses station (to the right when you first enter the unit) because it has a working sink and bathroom or staff would go off the unit to the staff bathrooms in the hallway. MHT 1 also said there is alcohol based hand rub in the nurses station but, again, if you are at the back of the unit you have to walk the length of the unit to get to the nurses station. During an interview and concurrent work order review with Plant Operations personnel (POP) on 9/24/1 at 1:00 p.,., the POP said the complaint for room 631, "replace faucet batteries no running water" was placed in the system on 9/16/15. The second complaint for the same issue was placed on 9/23/15 and was for the same issue was placed on 9/23/15 and was for rooms 615, 616, and 621 with the problem being "sinks with no running water replace batteries asap (as soon as possible)." Both complaints remained open in the maintenance log, indicated they were not addressed or completed.	A 701	Continued From page 57 • Room temperatures were monitored 3 times a day in each patient room from September 25 thru October 26, 2015. • Work orders were reviewed for rooms that were out of range. • Facilities Director reviewed fall outs with his staff. • Patient complaints about room temperatures are tracked through the event reporting system and tracked through QAPI. • Staff monitors and documents temperature and humidity prior to procedure in the ORs. Nursing staff monitor daily on an hourly basis. • Trending reports to be sent to Quality Council through EOC and infection control reports which will flow up to the MEC and Governing Board for review discussion and any further action. • Fire alarm systems are checked according to NFPA code along with the scheduled and unannounced fire drills. **Position Responsible:** • Director Facilities, CEO, Director Quality	
A 726	482.41(c)(4) VENTILATION, LIGHT, TEMPERATURE CONTROLS There must be proper ventilation, light, and temperature controls in pharmaceutical, food preparation, and other appropriate areas. This STANDARD is not met as evidenced by: Based on observation, interview and document	A 724	**Facilities supplies and equipment are maintained to ensure an acceptable level of safety and quality.** **Immediate and Permanent Corrective Action:** • Faucets batteries under the sink were checked on the 6th floor locked D unit and dead batteries were replaced on 9/25/15. **Process Improvement:** • Staff is reporting any non-functioning	9/25/2015

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A 726	Continued From page 58 review the facility failed to provide proper ventilation and temperature control. Findings: On 9/21/15 at 10:35 A.M., during a tour of the Culver City Campus surgical services the Sterile Supply room was observed with thermostat readings of a temperature of 69.8 and humidity of 77% which were out of regulatory limits. At 11:35 a.m., endoscopes (scopes with a camera to visualize the G-I tract) were observed being stored in a storage supply room with thermostat indicating readings of temperature of 63.0 and humidity of 70% which were out of regulatory limits. At 3:25 p.m., In OR-6 An endoscopic retrograde cholangioancreatography (ERCP – a diagnostic procedure combining the use of X-rays and an endoscope to to evaluate problems of the liver, gallbladder, bile ducts, and pancreas) was observed being perform in an OR suite with thermostat readings of a temperature of 64.6 and humidity of 70% which were out of regulatory limits. The ICP stated "They have been working on getting humidity down, this is better than before." At 12:20 p.m., during a record review of temperature & humidity readings log with perioperative director (PD), several dates revealed temperature and humidity were out of limits. The PD acknowledged they had been having problems maintaining temperature and humidity readings within regulatory limits and engineering had been working on that issue. During an interview with administrative staff on 9/22/15 they discussed the age of the building and equipment and shared 2 of the 3 coolers needed replacement and 1 cooler needed to be repaired. The Dir of Facilities shared the cooling	A 724	Continued From page 58 department. • Facilities Operations Center (FOC) has quarterly Preventive Maintenance which provides that each tech will check the batteries quarterly. Plant operations will look to see how long they last on average and then begin to replace them based on the mean. • Housekeeping is also assessing the sink operation daily and reporting to FOC. **Date of Implementation:** • 9/25/15 batteries checked and replaced • 10/8/2015 process improvement implemented **Monitoring Process:** • Battery operation faucets are checked daily by BHU and EVS. In addition, facilities operation performs a monthly preventive maintenance to ensure compliance. • Batteries are replaced based on the mean lifespan. **Position Responsible:** • Director Facilities, Director Quality, CNO **Hollywood Campus** **There is proper ventilation, light, and temperature control in pharmaceutical, food preparation, and other appropriate areas.** **Immediate and Permanent Corrective Action:** • All surgical instruments and endoscopes were reprocessed and hourly temperature and humidity checks were implemented immediately, (during survey). **Process Improvement:** • Ongoing monitoring with temperature and humidity assessed prior to surgery as well as documented checks throughout the	9/25/2015

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A 726	Continued From page 59 unit was not able to chill water to a low enough temperature to decrease the humidity in the hospital. Administrative staff shared the coolers are not adequate for the needs of the facility. On 9/22/15 at 3:30 p.m., during a tour of the Hollywood Campus surgical services, main tray surgical instruments were observed stored in OR-2 where temperatures were out of regulatory temperature of 78.8 and humidity of 58%. According to Administrator and surgical staff interviews, instruments have always been stored in OR-2. Endoscopes were observed being stored in OR-3 where thermostat meter indicated temperature was 82.4 F and humidity was 46%. The sterile processing room thermostat reading indicated a temperature of 82.5 F and humidity of 51%. A review of both Hospital A & B "Temperature and Humidity Reading" logs revealed temperature and humidity readings were out of limits on several dates.	A 726	Continued From page 59 day in both the OR and the sterile supply room. • Nursing staff have been educated on the process. • Temperatures and humidity are assessed hourly as well as prior to procedure. • When fall out occurs the plant operations team is notified to adjust temperature is performed. • No procedures will occur unless temperature and humidity are within normal limits. • Electronic/Digital devices were installed in December 2015. • Staff will be educated on requirements and individuals will be identified for notification, reporting and action. **Date of Implementation:** • **9/22/15** **Monitoring Process:** • Nursing monitors and documents temperature and humidity prior to procedure. • Nursing staff monitor daily as well, on an hourly basis. • Trending reports to be sent to Quality Council through EOC and Infection Control Committee and to MEC and the Governing Board for review discussion and any further action.	
A 747	482.42 INFECTION CONTROL The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases. This CONDITION is not met as evidenced by: Based on observation, interview, and document review, the hospital failed to ensure an effective, active system wide infection control program for prevention, control, and investigation of infections and communicable diseases. The infection control program did not meet the needs of all	A726	**Culver City Campus** **Immediate and Permanent Corrective Action:** • OR activity ceased until compliance with temperature and humidity was in range. • Facilities operations made adjustments at the air handler units to bring temperature and humidity into range.	9/25/2015

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A 747	Continued From page 60 patients receiving surgical care and supportive healthcare in the hospital because: 1. Active surveillance to monitor and maintain surgical suites in the Culver City and Hollywood Campuses within regulatory temperature and humidity limits were not in place. 2. The facility was not effective in the monitoring of scopes (GI endoscopes-cameras to visualize the GI tract) and sterile surgical instrument storage throughout the facilities. (refer to A-0749). 3. The facility did not integrate active hospital-wide infection prevention and control program into their QAPI program. (refer to A-0263 and A-0756). The cumulative effects of these systemic problems resulted in the hospital's inability to provide an effective hospital wide infection control program. Resulting in the facilities inability to provide patient care in a safe and effective manner as agreed in accordance with the Condition of Participation for Infection Control Services. The seriousness of which, resulted in an Immediate Jeopardy identified by the survey team.	A 726	Continued From page 60 • Surgical instruments and endoscopes storage issues were identified and all surgical instruments and endoscopes were reprocessed • On 9/22/15 Johnson Control provided emergency service call for no cooling. • On 9/22/15 temperature and humidity were brought to within acceptable ranges. • A temporary cooling tower was installed on 9/25/15. • The existing cooling tower has been rebuilt and the temporary cooling tower has been removed. • While the other cooling towers are functioning, they are in the process of permanent replacement. • Immediately provided cooling measures to patients complaining about the room temperature. Including more cold compresses, provided extra water, provided fans and portable AC units. • If unable to maintain the patients comfort, patient may be moved to another room if room available. **Process Improvement:** • Immediately started monitoring room temperatures in all patient rooms. Temperatures that were out of range were called by nursing to engineering and a work order was issued. The work orders were carried out within a 30 minute time frame. • A policy was developed regarding the maintenance of the ED portable AC units. • When a room is considered out of range, a work order is created and engineering is notified. • Ongoing monitoring with temperature and humidity assessed prior to surgery as well as documented checks throughout the day in both the OR and the sterile supply	
A 749	482.42(a)(1) INFECTION CONTROL PROGRAM The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel.			

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A 749	Continued From page 61 This STANDARD is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain a sanitary physical environment for the provision of safe patient care services. The facility failed to ensure the risk of infection was minimized by implementing measures that were understood and implemented by the staff for prevention and control of infections and communicable diseases within the hospital, including both healthcare-associated infections and community-acquired infections. Findings: 1) On September 21, 2015 at 11:35 a.m., during a tour of the surgery services with the peri-operative director (PD) and Int Dir Infection Control, six surgery staff were observed standing in the middle of the surgery station with their mouth mask around their neck. Other surgery personnel were observed re-applying the mouth mask around their neck back on before going back to the OR suites. This practice was observed several times with various surgery personnel during the surgery tour on September 22, 2015 from 8:10 a.m. until 11:15 a.m. Concurrent interview with PD and Int Dir Infection Control was held at the time, they confirmed the practice and addressed the issue with surgery personnel at the time. On the same date at 3:25 p.m., during an ERCP (endoscopic retrograde cholangiopancreatography (ERCP – a diagnostic procedure combining the use of X-rays and an endoscope to evaluate problems of the liver, gallbladder, bile ducts, and pancreas) procedure in OR-6, the GI doctor was observed in the room	A726	Continued From page 61 room. • Staff has been educated on the process. Temperatures and humidity are assessed hourly as well as prior to procedure. • When fall out occurs the plant operations team is notified to adjust temperature. Monthly trend reporting to ACNO, IC and Quality Department occurs. • No procedures will occur unless temperature and humidity are within normal limits. • When a room is out of range and is not correctable prior to a scheduled procedure, infection control is notified by OR. • Plan for infection control surveillance to monitor and report as well as plant operations at monthly committee meetings. • Electronic/Digital monitoring devices were installed in December. Upon completion of the installation staff will be educated on requirements and individuals will be identified for notification, reporting and action. Anticipated completion date is 1/1/2016. • Cooling measures and room monitoring continued throughout the warm weather season. **Date of Implementation:** • October 2015 **Monitoring Process:** • The CEO now makes routine walking rounds. • Room temperatures were monitored 3 times a day in each patient room from September 25 thru October 26, 2015.	

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A 749	Continued From page 62 without a mouth mask on. Concurrent interview was held with PD a the time; she confirmed the doctor's practice and stated "I guess we need to tell the GI doctors they need to wear a mouth mask". 2) On September 21, 2015 during a tour of the surgery services at 12:00 p.m. a Zeiss eye scope machine was observed standing in the middle of a puddle of water in the hallway outside/behind the PACU. On the same date at 2:40 p.m., the eye scope had been removed but the floor had a residual of the water puddle being there before. Concurrent interview with LN 21 was held who stated surgical equipment is "typically stored in the hallway and when the equipment is ready to be used it's cleaned with cleaning wipes." 3) On September 23, 2015 at 9:56 a.m., during a tour of the Hollywood campus, the walk-in freezer in the kitchen was observed to have a puddle of water at the edge of the door. The freezer's temperature meter revealed temperature of 30-50 degrees Fahrenheit (F), the gauge needle was observed in the "red" color. Concurrent interview was held with the dietary director (DD) who confirmed water puddle at edge of door was not normal. DD stated "The freezer has been thawing on and off for a month. Facilities has been notified, they are working on fixing it." 4) On September 24, 2015 at 10:41 a.m., during a tour of the intensive care unit (ICU) a record review of patients with Foley catheters was performed. A patient sample of 4 patients with Foley catheters was reviewed, 4 out of 4 patients had Foley catheters inserted without an indication. Concurrent interview was held with Int	A726	Continued From page 62 • Work orders were reviewed for rooms that were out of range. • Facilities Director reviewed fall outs with his staff. • Patient complaints about room temperatures are tracked through the event reporting system and tracked through QAPI. • Staff monitors and documents temperature and humidity prior to procedure in the ORs. Nursing staff monitor daily on an hourly basis, (document attached). Trending reports to be sent to Quality Council through EOC and infection control reports which will flow up to the MEC and Governing Board for review discussion and any further action. • Fire alarm systems are checked according to NFPA code along with the scheduled and unannounced fire drills. **Position Responsible:** • Director Facilities, CEO, Director Quality **The hospital provides a sanitary environment to avoid sources and transmission of infections and communicable diseases. There is an active program for the prevention, control, and investigation of infections and communicable diseases.** **Immediate and Permanent Corrective Action:** • Hourly temperature and humidity checks were implemented in the perioperative area. All surgical instruments and endoscopes were reprocessed.	
		A747		9/23/2015

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A 749	Continued From page 63 Dir Infection Control who confirmed the sample patient's did not have an "indication" for insertion of the Foley catheter. LN 11 assisted to navigate the electronic medical record in order to confirm the indication for Foley catheters was omitted by medical personnel. The facility policy titled: Foley Catheter Needs Assessment, revised 1/2014, indicated "Prevention of infection with any invasive device relies on ... using these devices only for an appropriate indication...and removing them promptly." 5) On the same tour of the ICU at 11:00 a.m., a doctor was observed going into an ICU room with Contact Isolation. The doctor was observed coming out of the room into the nurses' station with the isolation gown on. There wasn't a trash container readily available close to the door in order to dispose of the personal protective equipment (PPE) gear prior to exiting the room. Concurrent interview was held with Int Dir Infection Control to confirm the doctor's practice. He addressed concern with the doctor at the time and assisted doctor to dispose of PPE gear correctly. The facility's Policy titled: Isolation Guidelines, revised 5/2015, indicated the purpose of the policy was to provide a safe environment by preventing the spread/transmission of infectious diseases throughout the facility. Under 4.2.4 Contact Precautions the policy indicated "to remove the gown before leaving the patient's room/environment." Furthermore the facility's "Infection Prevention Information for Patients" educational document provided by the facility indicated "Family/Visitors do not have to wear the gown and gloves , because they do not care for other patients, However, they should wash their hands before leaving the room." This document was provided	A 747	Continued From page 62 **Process Improvement:** • Ongoing monitoring with temperature and humidity assessed prior to surgery as well as documented checks throughout the day in both the OR and the sterile supply room. • Nursing staff have been educated on the process. • Temperatures and humidity are assessed hourly as well as prior to procedure. • When fall out occurs the plant operations team is notified to adjust temperature is performed. • Simultaneous reporting to Infection Control will occur. • No procedures will occur unless temperature and humidity are within normal limits. • Plan for infection control surveillance to monitor and report as well as plan operations at monthly committee meetings. • Electronic/Digital devices with every 20 minute monitoring to be installed in January, (Purchase order attached). • Upon completion of the installation staff will be educated on requirements and individuals will be identified for notification, reporting and action. **Date of Implementation:** • 9/23/15 • 12/15/15 completion date **Monitoring Process:** • Nursing monitors and documents temperature and humidity prior to procedure. • Nursing staff monitor daily as well, on an hourly basis, (document attached). • Trending reports to be sent to Quality Council through EOC and infection control reports which will flow up to the	

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A 749	Continued From page 64 to CDPH surveyor by the facility's admission department personnel as one of the documents being given to patients & family upon admission. 6) On September 25, 2015 at 1:15 p.m., during a tour of P-6 Psychiatric Unit with the administrative staff1 (AS) construction/repair workers were observed working with the ceiling tiles. White and dark color powder was observed on the floor. Patients were observed sitting in their wheelchairs around the powder. The workers were observed working on the ceiling without an "enclosed area tent." Concurrent interview was held with AS1 he was asked if workers typically work without an enclosed area tent. AS1 stated I don't know if they are supposed to use an "enclosed area tent." But he did verify workers did not have an enclosed area tent while working with ceiling tiles. The facility's policy titled: "Construction Practices, and Control of Infection", revised 11/2012, indicated the purpose is to "1.1; Infection prevention practices should be implemented whenever there is risk of dust or microbiological contamination from construction activities spreading into any occupied area of the healthcare facility." The Policy Objectives are "3. To protect the patient. 3.2 To protect the healthcare workers, visitor, and others in the healthcare environment." Furthermore the policy indicated "All construction activities should occur within an enclosed isolation construction space." 7) On September 24, 2015 at 8:50 a.m., during a tour of P-6 Psychiatric unit small flying insects were observed flying around a puddle of water under the sink in one of the patient's room (631). Water was leaking from under the sink. Blankets and towels were all over the floor to absorb the	A 747	Continued From page 64 Governing Board for review discussion and any further action. **Position Responsible:** ▪ ACNO, OR Charge Nurse, Director Plant Operation, Director Infection Control. **The infection control officer developed a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel.** **Immediate and Permanent Corrective Action:** ▪ 1. In-services were provided to all staff on the appropriate procedure for gowning, gloving and using mouth masks. • Additional in-servicing took place during October Skills Fair. • 2. Equipment stored in a puddle of water was removed and cleaned. **Hollywood** • 3. Immediately discarded all food in the freezer. On 10/8/15 the lease agreement was Johnson Controls, the rental unit was brought in and a permanent one has been ordered. **Culver City** • 4. Physicians with patients who had Foley Catheters without indications for use were notified and orders to remove the catheters were obtained when appropriate. • The medical records of patients with Foley catheters that needed to be in place were corrected to show the indications for use. • Infection Control is presenting to Medical Staff Committee, indications for Foley Catheter placement. Once approved, the EMR order-set will be revised and indications added to the order. • 5. A receptacle was provided for physicians and staff to dispose of Personal Protective Equipment including gowns when exiting contact isolation rooms. • 6. A construction barrier was provided using an enclosed area tent to protect	A 749 9/25/2015 12/18/2015

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A 749	Continued From page 65 water. Two patients were in the room at the time with the flying small insects. Concurrent interview was held with AS1 who acknowledged the room's condition and stated that he was going to move the patients to another room. 8) On September 25, 2015 at 9:15 a.m., during a tour of the emergency department (ED) overflow unit accompanied by the EVS director, small flying insects were observed flying around the unit. Concurrent interview with environmental services director (EVS) was held, she acknowledge the small flying insects and stated "Oh, I will get pest control in here." The facility's policy titled: "Environmental Services Infection Prevention and Control", revised 11/2012, indicated in "4.2.9 Pest Control: EVS "should oversee...services of a pest control company that should inspect and treat the hospital environment on a regularly scheduled basis and as deemed necessary." 9) On September 24, 2015 at 8:50 a.m., during a tour of P-5 area, shower #5 was observed with dark yellow liquid on the floor. Concurrent interview was held with AS1 who confirmed the yellow liquid on the floor. AS1 stated "That looks like urine I will get the staff to clean it." 10) On September 25, 2015 from 9:15 a.m. to 10:30 a.m., during a tour of the various units of the Culver City campus accompanied by the EVS director the following was observed: A. The facility's random sample of 15 patient's restrooms were observed for cleanliness. 10 out of the 15 restrooms were noted to have dark yellow and brown stains on the floors. B. ED- in the OB-GYN room the hand washing sink was not functioning.	A 749	Continued From page 65 patients and staff from airborne construction debris. • 7. Water leaks were repaired. • Pest control services were notified to treat the hospital on 9/25/2015 environment and on a regular basis. • 9. The shower area on P5 was cleaned of urine on 9/24/15. • 10. Patient restrooms at the Culver City facility were cleaned and the sinks in the OBGYN area of the ED was made functional. • 11. Visitor in room 227 was instructed of the purpose for wearing PPE and how to put on and dispose. • 12. The ED psychiatric holding area (ED Overflow) was cleaned and all debris and urine was removed. • EVS cleaning of the area was logged on the EVS flow sheet. **Process Improvement:** • 1. Staff is observed during infection control rounds, director rounding and Environmental rounding to monitor for appropriate use of gowns, gloves and masks. • 2. Equipment is observed as part of Environmental rounding. Equipment found in areas considered inappropriate due to water or the presence of infectious materials is moved and cleaned. • 3. Ongoing monitoring with education to staff to immediately report any fall out in temperature ranges to both QM as well as plant operations. New freezer is on order, (temporary in place until new unit is installed). Infection control surveillance program to monitor and maintain temperature and humidity instituted.	

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A 749	Continued From page 66 The facility's policy titled: "Environmental Services Infection Prevention and Control", revised 11/2012, indicated its purpose was for "EVS to determine and implement an appropriate written schedule for cleaning and a method of decontamination based upon the location within the facility, type of surface to be cleaned, and the agents to be used." The objectives are: 3.1 To protect the patient. 3.2: To protect the healthcare workers, visitors, and others in the ... environment." Furthermore the policy indicated equipment that may be contaminated with pathogens including those that are in close proximity to the patient and frequently touched surfaces in the patient care environment ...surfaces in and surrounding toilets in patient's rooms." 11) A "Contact isolation" sign was seen posted outside room 227 on 9/21/15 at 1:30 p.m.. The sign indicated that all people entering the room should don a gown and protective gloves. A visitor was seen in the room, and she was not wearing personal protective equipment. The visitor came to the door and volunteered the information that the patient did not have an infection, so no she did not think that it was necessary to don the protective equipment. During an interview with the director of information technology (DIT) on 9/21/15 at 1:40 p.m., she stated there was supposed to be an order for isolation in the medical record, but she did not see such an order. 12) In an interview with the director of emergency department (DED) on 9/22/15 at 9:05 a.m., she stated that the psychiatric holding area of the ED had an average stay of 26 hours in August.	A 749	Continued From page 66 • 4. A process is in place to ensure the appropriateness of Foley Catheter use and the timely removal of catheters once the indicators for use are no longer valid. • 5. Receptacles are provided so that gowns made are discarded before leaving the patient environment. These are observed during FOC rounds, director rounding and infection control rounding. • Staff is oriented to the process at staff meetings and Skills Fairs. • 6. All construction is done using an enclosed area tent as a barrier to protect patients and staff from airborne construction debris. • 7. The facility is inspected during FOC rounding, IC rounds and Director rounding. • 8. Pest control Services are provided on a regularly scheduled basis. • 9, 10, 12. EVS cleans all areas of the hospital and signs and dates the logs for each serviced area each shift. • Sinks are checked by nursing and EVS. Work orders are initiated for any malfunction noted. • 11. Patient and family teaching includes the use of PPE for visitors. Understanding of the process by the patient and family is documented in the EMR. **Date of Implementation:** • Immediately on 9/25/15 and ongoing. **Monitoring Process:** • Data is collected during FOC rounds, Director rounding and infection control rounding for all issues 1-12 is reviewed monthly by EOC. EOC minutes go to Quality Council, MEC and the Governing Board. • Department heads and submitted to Quality Council.	

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A 749	Continued From page 67 During observations in the ED psychiatric holding area on 9/21/15 at 11:20 a.m., the area was locked and guarded. It smelled strongly of urine, and the floor near the nursing station was covered with a black material. The area of the floor near the wall had a yellow-brown substance coating the floor and four 0.95 cm (centimeters) sized pieces of debris. There were ten patient beds, but there was only one toilet and one sink, and no shower for the area. In an interview with environmental services tech1 (EVST) on 9/21/15 at 12:20 p.m., she concurred that the floor appeared dirty. She stated that she was just helping out for the day, but that the ED psychiatric holding area was not her regular area. In an interview with Patient M101 on 9/21/15 at 12:15 p.m., he stated that no cleaning person had been present during the weekend. A wet paper towel was applied to the floor, and the black substance was removed with three swipes. In interviews with the EVS Lead on 9/24/15 at 11:20 a.m. and 11:50 a.m., she stated that the person assigned to clean the area also had duties in other areas. She stated that she received a lot of calls about the restroom in the ED psychiatric holding area. She stated that there was no log of the calls, but that they occurred daily. She stated that she had not discussed needing extra help in that area. When asked for the documentation of cleaning the area, she produced a large box of cleaning documentation checklists. She looked for documentation that the ED psychiatric holding area was cleaned on the weekend and was able to find documentation of cleaning during the first shift, but not from the second and third shifts.	A 749	Continued From page 67 • Issues identified as not showing improvement are reviewed by the Council with recommendations for process improvement. • Ongoing monitoring occurring on a daily basis with hourly checks until new unit installed. • Temperature compliance will be noted in the infection control minutes which will roll up to Quality Council, Medical Executive Committee, and Governing Board meetings for review. **Position Responsible:** • Director of Facilities, Director of Quality; IC Director	
A 756	482.42(b) INFECTION CONTROL LEADERSHIP	A 756		

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A 756	Continued From page 68 RESPONSIBILITIES Standard: Responsibilities of Chief Executive Officer, Medical Staff, and Director of Nursing Services The chief executive officer, the medical staff, and the director of nursing must— (1) Ensure that the hospital-wide quality assessment and performance improvement (QAPI) program and training programs address problems identified by the infection control officer or officers; and (2) Be responsible for the implementation of successful corrective action plans in affected problem areas. This STANDARD is not met as evidenced by: Based on observation, interview and document review the hospital failed to address and integrate infection control issues with the physical environment into their QAPI program to track and implement corrective action. Findings: The index case identified Culver City Operating Rooms to be out of compliance with regulatory humidity ranges for the following OR's: OR # 2 Humidity was out of range for 13 days. OR # 3: Humidity was out of range for 10 days. OR#7: Humidity was out of range for 20 days. On 9/22/15 during a tour the OR's were still found to be out of compliance with humidity ranges (OR 3, 6 and 7 were all over 60 % humidity on	A 756	Continued From page 68 **The CEO, the Medical Staff and the CNO ensure that the hospital-wide quality assessment and performance program and training programs address problems identified by the Infection Control Officer.** **Immediate and Permanent Corrective Action:** • The QAPI program has been modified to include data related to infection control issues with the physical environment which reflect measureable improvements in indicators for processes that improve health outcomes. • Indicators are measured and analyzed to assure that data related to infection control issues with the physical environment is being captured. • The CEO, CNO and Medical Staff actively participate in issues with the physical plant, infection control and quality monitoring. **Process Improvement:** • The event reporting system, work order review and other monitoring applications that reflect infection control issues related to the physical environment are incorporated into the QAPI program. • Tracking and trending results are reviewed by the Quality Council with recommendations for areas not showing improvement. • Staff is in-serviced on the QAPI process. • When a room is considered out of range, a work order is created and engineering is notified.	10/8/2015

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A 756	Continued From page 69 9/22/15). The autoclaves in the OR (Autoclaves 6 & 7) had issues requiring maintenance due to the boiler causing water in the chamber and a prolonged evacuation stage. There were multiple issues throughout the facility related ill or malfunctioning equipment, to include the boiler, the 3 coolers at the Culver City Campus and 1 cooler at the Hollywood campus. The HVAC was temporary and still not working up to par. The facility coolers were having difficulty attempting to reduce temperature in the OR's in order to reduce the humidity. In interviews with the Corp Dir QA on 9/22/15 at 12:00 and on 9/25/15 at 8:55 a.m., he stated that, despite the hospital having malfunctioning equipment, there was no paper trail for monitoring of temperature and humidity results, and he was not aware of documentation regarding the problem at the Culver City hospital since April, 2015. He stated that issues uncovered during a previous survey did not get translated in QA indicators at the Culver City hospital. On 9/24/15 Plant Operations Staff (POS) were interviewed and the electronic complaint log for maintenance was reviewed. POS 1 stated he had been with the facility a few months, when POS 1 started the amount of open complaints was "Over 3000", the number of open complaints viewed from June to present was over 390. The 390 complaints had either had not been assigned or had not been addressed/completed. Staff began complaining of the air conditioning not working back in June and continued logging complaints monthly, the last in September when OR staff complained of "Surgery Operating Room	A 756	Continued From page 69 • Ongoing monitoring with temperature and humidity assessed prior to surgery as well as documented checks throughout the day in both the OR and the sterile supply room. • Staff has been educated on the process. • Temperatures and humidity are assessed hourly as well as prior to procedure. • When fall out occurs the plant operations team is notified to adjust temperature. Monthly trend reporting to IC and Quality Department, MEC and Governing Board occurs. • No procedures will occur unless temperature and humidity are within normal limits. • When a room is out of range and is not correctable prior to a scheduled procedure, OR places the room out of service and infection control is notified by OR. • Plan for infection control surveillance to monitor and report as well as plant operations at monthly committee meetings. • Electronic/Digital devices will monitor to be installed in December. • Upon completion of the installation staff will be educated on requirements and individuals will be identified for notification, reporting and action. Anticipated completion date is 1/1/2016. • Contractor Johnson Controls went through the entire HVAC system in the OR suite and made major repairs. • The CEO, CNO and Medical Staff meets regularly (at least monthly) with the Director of Quality to review new issues and on-going problems with new issues as well as attending quality council meetings.	

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A 756	Continued From page 70 (OR) rooms 7&8 temperature 73 and humidity 69% doctors complaining please fix asap (as soon as possible). All of these complaints remained open on the electronic complaint log. According to the electronic complaint log the basement cooling tower circulating pump was leaking on 8/2/15 and the water leak was getting work in the machine room basement on 8/12/15, the pavilion penthouse had a leaking condensate line which was logged on 9/5/15, and the non-return valve was leaking in basements 1 and 2 boiler room on 9/13/15 all of these work orders remained open. On 7/30/15 a complaint was logged indicating "The temp and humidity in the scope washing room was "out of range" temp 80 F and Humidity 63%", On 8/11/15: "GI lab out of range temp 75 F and humidity 65%" on 9/9/15: "GI lab-scope and washroom temp and humidity out of range temp 79 F humidity 65% this has been a problem for weeks please adjust ASAP", all orders remained open on the complaint log. Facility staff stated they had started working on the GI lab scope area, however, there was no documentation to indicate anything had been started. The temp and humidity in the GI scope processing room on 9/24/15 was 76 F and 70% humidity, the complaint remained open on the electronic complaint log. In an interview with the CEO on 9/25/15 at 8:45 a.m., he stated that he was not aware of problems in the facilities (plant operations) department. He stated that although he met regularly with department heads, he was not aware of the huge backlog of work orders (electronic complaint log) and that he did not	A 756	Continued From page 70 **Date of Implementation:** • 10/8/2015 **Monitoring Process:** • The event reporting system, work order review and other monitoring applications that reflect procedures or processes requiring improvement are reviewed at monthly Quality Council. • Areas showing improvement are continually monitored until goals are reached. • Monitoring continues until goals are maintained for a period greater than 3 months unless mandated by licensing or regulatory agencies. • Minutes of all QC meetings are presented at all Governing Board meetings for review and comment. • Staff monitors and documents temperature and humidity prior to procedure. Staff monitor daily as well, on an hourly basis. • Trending reports are sent to Quality Council through EOC and Infection Control reports which will flow up to the MEC and Governing Board for review discussion and any further action.	

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A 756	Continued From page 71 sense any urgency in the problems. He stated that he had not been performing walking rounds of the hospital.	A 756	Continued From page 71	
A 1077	482.54(a) INTEGRATION OF OUTPATIENT SERVICES Outpatient services must be appropriately organized and integrated with inpatient services. This STANDARD is not met as evidenced by: Based on interview and record review, the hospital failed to ensure a process was in place for providing laboratory results for patients obtaining services in the urgent care center at the Hollywood facility, creating the risk of substandard care for those patients. Findings: The medical record, including lab results, of an urgent care patient, Patient M106, from 9/21/15 were reviewed .The results showed that the patient had multiple blood tests, urine and sputum tests done. However, many of the results required days to perform, and hence were not available before the patient departed from urgent care. The results included an abnormal result for hepatitis B. Documentation of the patient being informed of the lab results was not seen in the record. The hospital policies on laboratory result notification were reviewed, and did not show a specific policy for notification of urgent care patients with positive test results, except for cultures and critical values. In an interview with the laboratory director (LD) on 9/23/15 at 1:00 p.m., he stated that there should	A 1077	**Outpatient services is appropriately organized and integrated with inpatient services.** **Hollywood** **Immediate and Permanent Corrective Action:** • Upon receipt of Form CMS-2567, the process was immediately reviewed and revised to ensure all lab results are communicated to urgent care patients. • Patients discharged with pending lab results will be notified as follows: - Abnormal lab results – physician will attempt to contact the patient by calling the contact number provided by the patient at the time of registration; - Normal lab results – results will be mailed to the address provided by the patient at the time of registration. **Process Improvement:** • Process will be documented and implemented requiring the communication of all lab results for urgent care patients regardless of discharge disposition. • Abnormal lab results available after the patient has been discharged from the urgent care will be communicated to the patient by the urgent care physician. The urgent care physician will attempt to contact the discharged patient with abnormal lab results by calling the contact number provided by the patient at the time of registration. Effort to communicate abnormal lab results to the patient will be documented in the EMR.	12/4/2015

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A 1077	Continued From page 72 be documentation in the record that a physician spoke with the patient regarding the results. In an interview with the corporate director of quality assurance (CDQA) on 9/23/15 at 12:45 p.m., he stated that the follow-up of urgent care lab results for a patient not admitted involved the lab calling the physician, who called the patient. He stated that he thought this contact was not documented in the record but should be.	A 1077	Continued From page 72 • In-service with lab and urgent care staff will be provided as part of the implementation. **Date of Implementation:** • 12/4/15 **Monitoring Process:** • The Lab will track and monitor communication of lab results for urgent patients as one of their annual PI initiatives. • Monthly monitoring and reporting of compliance will occur and be reported through the Quality Committee. • After four (4) consecutive months of 98% compliance is achieved, quarterly monitoring will be implemented to ensure ongoing compliance. **Position Responsible:** • Director Laboratory Services	
A 1103	482.55(a)(2) INTEGREATION OF EMERGENCY SERVICES [If emergency services are provided at the hospital --] (2) The services must be integrated with other departments of the hospital. This STANDARD is not met as evidenced by: Based on interview and record review, the hospital failed to ensure that the emergency department (ED) was integrated with the need for ICU services because one critical patient was not transferred to the ICU when a bed was available, creating the risk of substandard care for that patient. Findings: The ED Scope of Service (effective 1/2013), showed that, "Appropriate triage and transfers are arranged for patients that require a higher level of care. " The medical record of Patient M107 was selected for review from a list of code blues. The medical record showed that Patient M107 was transferred	A 1103	**Emergency services provided at the hospital are integrated with other departments of the hospital.** **Immediate and Permanent Corrective Action:** • When a patient is in critical condition and there is no bed available or staffing available in the ICU, the patient will be transferred to the ED for stabilization. • Admit to the ICU unit as soon as bed and staffing are available. • Supervisory staff is available to assist with staffing needs. **Process Improvement:** • Directors of nursing to review Policy and Procedure to ensure correct placement of patient.	

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A 1103	Continued From page 73 from the subacute unit to the ED because he became hypotensive and required a higher level of care. In an interview on 9/24/15 at 3:15 p.m., with LN5, the ED nursing director, she stated that during the time that Patient M107 was in the ED, there were 7 patients in the 10 bed ICU. She stated that she had interviewed LN17 about Patient M107's care, and she was caring for two ICU patients in the ED while Patient M107 was there. In an interview with the chief nursing officer (CNO) on 9/25/15 at 8:00 a.m., she stated that the staff in the ED should have current competencies. She stated that a critical care competent nurse was to go to the ED to take of a critical patient, or that ICU staffing was to be expanded to accommodate the patient. She stated that until additional ICU nurses arrived, the ICU charge nurse was to provide patient care.	A 1103	Continued From page 73	
A 1112	482.55(b)(2) QUALIFIED EMERGENCY SERVICES PERSONNEL There must be adequate medical and nursing personnel qualified in emergency care to meet the written emergency procedures and needs anticipated by the facility. This STANDARD is not met as evidenced by: Based on interview and record review, the hospital did not ensure that all staff was fully trained and competent to provide services in the emergency department (ED) because one physician (MD 1) lacked documentation to support ED privileging, and three nurses (LN15, LN16 and LN17) lacked documentation of competency, creating the risk of substandard	A 1112	**There are adequate medical and nursing personnel qualified to meet the written emergency procedures and needs anticipated by the facility.** **Immediate and Permanent Corrective Action:** • File of ED physician MD1 was reviewed by medical staff and appropriate staff action under peer review was taken. • 3 ED nurses LN15, LN 16 and LN 17 files were reviewed for competency for IV drip medications. • All ED nursing files were reviewed for current competencies by nursing leadership and Human Resources. • ED staff had in-servicing and were validated on 2015 competencies which	10/20-22/2015

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SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	6245 DE LONGPRE AVE HOLLYWOOD, CA 90028

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A 1112	Continued From page 74 care for patients using the ED. Findings: 1) During a review of the credential file of MD 1 on 9/22/15, the physician was reappointed and had emergency medicine privileges, which included privileges for emergency procedures, renewed on 7/21/15. In an interview with the director medical staff (DMS), she stated that the physician's activity list formed one of the bases for re-privileging the physician. The Provider Activity Report dated January, 2015, was reviewed, and contained a list of patients seen by the provider, and procedures that the patients had undergone. However, the list included procedures that the patients had performed by other physicians, after admission. For example, the procedure list included a flap graft procedure, skin graft, implantation of automatic cardioverter, below knee amputation, and partial resection of the small intestine, all procedures which are not performed by an emergency room physician. There was no procedure clearly specified as performed by MD 1 listed. In a continuing interview with (DMS), she concurred that the list contained procedures that were not done in the ED. The activity list in the credential file did not provide a basis for renewing privileges for MD 1. 2) The Scope of Service Statement (reviewed 8/2013) for the ED showed that "Staff competency is evaluated by the unit Director, Charge Nurses and peers." The medical record of Patient M107 was selected for review from a list of code blues. The medical	A 1112	Continued From page 74 included Medication Titration and Code Blue. • A competency check list for 2015 was sent to Human Resources and placed in their personnel file. **Process Improvement:** • The nursing competency program was reviewed and revised by Nursing and Human Resources department. • HR assures new hire 90-day evaluations are completed and include the completion of unit base competencies. • HR assures Director/Manager is notified of employees who have not had their 90-day evaluations completed. **Date of Implementation:** • October 20-22, 2015 **Monitoring Process:** • Monthly reporting of outstanding 90-day and annual evaluations to the CNO, COO, and CEO. **Position Responsible:** • Director HR, Directors of Nursing Units	

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A 1112	Continued From page 75 record showed that Patient M107 was transferred from the subacute unit to the ER because he became hypotensive and required a higher level of care. During a review of the medical record, deviations from the expected standard of care were noted, including failure to titrate medication per hospital protocol (see A-0392). A Department Specific Competency Checklist (updated 2015) was presented which showed that ED nurses were expected to have medication administration competencies that included preparation and use of vasoactive drip medications. In an interview with human resources staff1 (HRS) on 9/24/15 at 3:05 p.m., she stated that nurses were to be evaluated within 90 days of starting service and annually. She reviewed the personnel files of LN15, LN16 and LN17 She concurred that the last competencies of LN15 were 4/2/14. The last competencies of LN16 were dated 2008. Neither file contained competencies for IV drip medications. The file of LN17 showed that she started work in March, 2015, and there her only competency was for body mechanics. She stated that the ED director was to check the competencies and that they were behind on follow-up of competencies for staff. She stated that the human resources department was to double-check that competencies were completed, but that she was not sure if the ED department had been advised that the competencies were not done. In an interview on 9/24/15 at 3:15 p.m., with LN5, the ED nursing director, she reviewed the personnel files of ED nruses LN15, LN16 and LN17 and stated that they did not have current	A 1112		

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A 1112	Continued From page 76 competencies.	A 1112		

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K 000	INITIAL COMMENTS CULVER CITY CAMPUS: PAVILION K3 BUILDING: 01 K6 PLAN APPROVAL: 1969 K7 SURVEY UNDER: 2000 EXISTING STRUCTURE TYPE: SIX FLOOR WITH MECHANICAL ROOF (PENTHOUSE) AND BASEMENT, CONSTRUCTION TYPE 1, FULLY SPRINKLERED. TOWER K3 BUILDING: 02A K6 PLAN APPROVAL: 1959 K7 SURVEY UNDER 2000 EXISTING STRUCTURE TYPE: SEVEN FLOORS AND BASEMENT, CONSTRUCTION TYPE I, PARTIALLY SPRINKLERED. SINGLE STORY BUILDING ATTACHED TO TOWER K3 BUILDING: 02B K6 PLAN APPROVAL: 1939 K7 SURVEY UNDER: 2000 EXITSING STRUCTURE TYPE: ONE FLOOR, CONSTRUCTION TYPE V(111)., FULLY SPRINKLERED. Census at Culver City on 9/21/15: 247 HOLLYWOOD K3 BUILDING: 03 K6 PLAN APPROVAL: 1960s K7 SURVEY UNDER: 2000 EXISTING STRUCTURE TYPE: SIX FLOORS WITH MECHANICAL ROOF AND BASEMENT, CONSTRUCTION TYPE I, PARTICALLY\ SPRINKLERED.	K 000		

RATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

ncy statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days late of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 he date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ction.

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K 000	Continued From page 1 Census at Hollywood on 9/22/15: 61 VAN NUYS K3 BUILDING: 04 K6 PLAN APPROVAL: 1967 K7 SURVEY UNDER: 2000 EXISTING STRUCTURE TYPE: ONE FLOOR WITH SERVICE BASEMENT, CONSTRUCTION TYPE III(211), FULLY SPRINKLERED. Census at Van Nuys on 9/22/15: 53 The following reflects the findings of the California Department of Public Health, during a Complaint Validation Life Safety Code Survey, using the NFPA 101 2000 Edition of the Life Safety Code for Health Care Facilities and in accordance with 42 CFR 482.41(b)(1) for General Acute Care Hospitals. Representing the California Department of Public Health: 29586, HFE I 29665, HFE I	K 000		
K 012	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Based on observation and record review, the facility failed to maintain the integrity of the building construction. This was evidenced by the	K 012		

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K 012	Continued From page 2 use of combustible construction barriers in areas where the building integrity was damaged due to leaks. This affected one of six floors and the basement of the Pavilion. This finding could result in the faster spread of smoke and fire and the increased risk of injury to patients, staff, and visitors. NFPA 101, 2000 Edition 19.1.1.4.6 Construction, Repair, and Improvement Operations. (See 4.6.10.) 4.6.10 Construction, Repair, and Improvement Operations. 4.6.10.1* Buildings or portions of buildings shall be permitted to be occupied during construction, repair, alterations, or additions only where required means of egress and required fire protection features are in place and continuously maintained for the portion occupied or where alternative life safety measures acceptable to the authority having jurisdiction are in place. 4.6.10.2* In buildings under construction, adequate escape facilities shall be maintained at all times for the use of construction workers. Escape facilities shall consist of doors, walkways, stairs, ramps, fire escapes, ladders, or other approved means or devices arranged in accordance with the general principles of the Code insofar as they can reasonably be applied to buildings under construction. 4.6.10.3 Flammable or explosive substances or equipment for repairs or alterations shall be permitted in a building while the building is occupied if the condition of use and safeguards provided do not create any additional danger or impediment to egress beyond the normally	K 012		

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K 012	Continued From page 3 permissible conditions in the building. Findings: During the facility tour with Facilities Staff 1 and Facilities Staff 2 from 9/21/15 to 9/25/15, the building walls were observed. 9/22/15 Pavilion Basement: 1. At 8:15 a.m., on 9/22/15, there was a non-rated plastic construction barrier in the corridor outside of the fire alarm panel control room. A Construction Advisory Report from the Office of Statewide Health Planning and Development (OSHPD) was provided on 9/23/15. The OSHPD Compliance Officer stated that the construction barrier was installed without a permit. Third Floor: 2. At 3:40 p.m., on 9/23/15, there were missing tiles in the ceiling of the corridor by Room 333. There was a plastic tarp partially covering the area with the missing tiles. The plastic tarp had water stains.	K 012	**Pavilion/Basement** No patients or residents were directly affected by the deficient practice. The corrective action taken removed the potential for other patients and residents to be affected by the deficient practice. **Corrective Action:** 1. The plastic barrier was removed. (Attachment #1, #2) 2. The plastic tarp was removed and the missing ceiling tiles were replaced. The plastic is flame retardant. **Process Improvement:** Environmental Rounding, Infection Control rounding and Director Rounding is used to identify physical plant issues. Issues identified are reported to facilities. A work order is issued by facilities to correct the problem. Work orders are tracked and trended through EOC, Quality Council, MEC and the Governing Board. Staff is educated in the process. **Monitoring Process:** Trending reports from rounding are sent to MEC and Quality Council through EOC and Infection Control. Reports will flow up to the Governing Board for review discussion and any further action. **Date of Implementation:** 9/28/15 **Date of Completion:** 11/12/2015 **Position Responsible:** Director EOC, Director Quality	11/12/2015 9/28/2015
K 018	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 ¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors	K 018		

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K 018	Continued From page 4 are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain their doors. This was evidenced by corridor doors that were obstructed from closing. This affected two of three buildings at the Culver City campus. This could result in the spread of smoke and fire throughout the facility and the increased risk of injury to the patients due to smoke and fire. NFPA 101, Life Safety Code, 2000 Edition. 19.2.2.2.1 Door complying with 7.2.1 shall be permitted. 7.2.1.8.1 A door normally required to be kept closed shall not be secured in the open position at any time and shall be self-closing or automatic-closing in accordance with 7.2.1.8.2. Findings: During facility tour with staff from 9/21/15 to 9/25/15, the corridor doors were observed.	K 018		

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K 018	Continued From page 5 Tower First Floor: 1. At 9:45 a.m., on 9/22/15, the door to the S4 treatment room in the Emergency Department was obstructed from closing by a plastic door wedge. Pavilion Sixth Floor: 2. At 11:02 a.m., on 9/25/15, the door to Room 651 was obstructed from closing by a rolled up towel positioned by the door leaf. 3. At 11:03 a.m., on 9/25/15, the door to Room 622 was obstructed from closing by a rolled up towel positioned by the door leaf. Basement: 4. At 1:08 p.m., on 9/25/15, the corridor door to the kitchen was obstructed from closing by a wooden door wedge. Pavilion Third Floor: 5. At 11:14 a.m., on 9/25/15, the door to Room 332 in the Intensive Care Unit (ICU) was equipped with a self-closing device. The door was propped open and obstructed from closing by a chair. During an interview at 11:15 a.m., Facilities Staff 2 stated that the ICU room doors were equipped with self-closing devices and they sometimes had to prop the doors open for the patients.	K 018	No patients or residents were directly affected by the deficient practice. The corrective action taken removed the potential for other patients and residents to be affected by the deficient practice. **Corrective Action:** Education provided to department managers to ensure doors in their own department are kept closed appropriately. **Tower First Floor:** 1. All doors normally required to be kept closed were closed in the Emergency Department and the plastic door wedge was removed. This door opening will have a magnetic hold open installed. (Attachment #3) **Pavilion Sixth Floor:** 2. The towel was removed in P6 and staff was reminded that door wedges are not allowed. 3. The towel was removed. **Basement:** 4. The wooden door wedge was removed. **Pavilion Third Floor:** 5. The chair was removed. Staff was reminded that doors cannot be propped opened. This door opening will have a magnetic hold open installed. (Attachment #3) **Process Improvement:** Facility Director ensures routine rounds are performed to ensure doors are not propped opened. EOC and environmental rounding, Infection Control rounding, Director rounding is used to insure doors are not left propped opened. **Monitoring Process:** Immediate education is provided and correction is given during daily rounding. **Date of Implementation:** 9/22/15-9/25/2015 **Position Responsible:** Safety Officer	9/22/2015 9/22/2015 9/25/2015 9/25/2015 9/25/2015 9/25/2015

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K 027 K 027	Continued From page 6 NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 ¾ -inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their smoke barrier doors. This was evidenced by smoke barrier doors that failed to close and latch. This affected two of three buildings at the Culver City campus. This could result in the spread of smoke from one smoke compartment to another and the increased risk of injury to patients, visitors, and staff in the event of a fire. NFPA 101, Life Safety Code 2000 Edition 4.61.2 Any requirement that are essential for the safety of building occupants and that are not specifically provided occupants and that are not specifically provided for by this Code shall be determined by the authority having jurisdiction. 19.3.7.6 Doors in smoke barriers shall comply with 8.3.4 and shall be self-closing or automatic-closing in accordance with 19.2.2.2.6. Such doors in smoke barriers shall not be required to swing with egress travel. Positive latching hardware shall not be required.	K 027 K 027		

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K 027	Continued From page 7 8.2.3.2.1 Door assemblies in fire barriers shall be of an approved type with the appropriate fire protection rating for the location in which they are installed and shall comply with the following. (a) Fire doors shall be installed in accordance with NFPA 80, Standard for Fire Doors and Fire Windows. Fire doors shall be of a design that has been tested to meet the conditions of acceptance of NFPA 252, Standard Methods of Fire Tests of Door Assemblies. Exception: The requirement of 8.2.3.2.1(a) shall not apply where otherwise specified by 8.2.3.2.3.1. (b) Fire doors shall be self-closing or automatic-closing in accordance with 7.2.1.8 and, where used within the means of egress, shall comply with the provisions of 7.2.1. NFPA 80, Standard for Fire Doors and Fire Windows, 1999 edition. 2-5.2 Manufacturers' Instructions. All components shall be installed in accordance with the manufacturers' installation instructions and shall be adjusted to function as described in the listing. Findings: During a facility tour with Facilities Staff 1 and Facilities Staff 2 from 9/21/15 to 9/25/15, the smoke barrier doors was observed. Tower First Floor: 1. At 2:41 p.m., on 9/22/15, the smoke barrier double doors by the Paramedic Lounge were held open with electronic automatic-closing devices	K 027	Tower First Floor: The potential existed for patient visitor staff harm from fire before corrective action was taken. A fire watch was in place following completion of corrective action the potential for patient and resident to be affected by the deficient practice was eliminated. Corrective Action: The facility maintains their smoke barrier doors. 1. (Tower by Paramedic Lounge)Doors were adjusted to ensure they positively latch. All fire cross corridor doors are on a monthly PM (Preventive Maintenance) and records are on file in the Facilities Operation Center. Identified deficiencies are prioritized as high priority and repaired.	9/22/2015

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K 027	Continued From page 8 The doors failed to close and latch upon activation of the fire alarm system, leaving a gap between the door leaves. Pavilion Sixth Floor: 2. at 2:40 p.m., on 9/23/15, the smoke barrier double doors by Room 651 were held open with electronic automatic-closing devices. The doors failed to close and latch upon activation of the fire alarm system, leaving a gap between door leaves. Fifth Floor: 3. At 3:11 p.m., on 9/23/15, the smoke barrier double doors by Room 522 were held open with electronic automatic-closing devices. The doors failed to close and latch upon activation of the fire alarm system, leaving a gap between door leaves. Basement: 4. At 9:47 a.m., on 9/24/15, the smoke barrier double doors at the tunnel entrance were held open with electronic automatic-closing devices. The doors failed to close and latch upon activation of the fire alarm system, leaving a gap between door leaves. 5. At 9:48 a.m., on 9/24/15, the smoke barrier double doors by the autoclave room were held open with electronic automatic-closing devices. The doors failed to close and latch upon activation of the fire alarm system, leaving a gap between door leaves.	K 027	**Pavilion Sixth Floor:** 2. (Rm 651) Doors were adjusted to ensure they positively latch.	9/23/2015
			Fifth Floor: 3. (Rm 522) Doors were adjusted to ensure they positively latch. All fire cross corridor doors are on a monthly PM and records are on file in the FOC. Identified deficiencies are prioritized as high priority and repaired quickly.	9/23/2015
			Basement: 4. (Tunnel Entrance) Doors were adjusted to ensure they positively latch. All fire cross corridor doors are on a monthly PM and records are on file in the FOC. Identified deficiencies are prioritized as high priority and repaired quickly.	9/24/2015
			5. (Basement by Autoclave) Doors were adjusted to ensure they positively latch. All fire cross corridor doors are on a monthly PM and records are on file in the FOC. Identified deficiencies are prioritized as high priority and repaired quickly.	9/24/2015
			Pavilion Fifth Floor: 6. (Rm 509) Doors were adjusted to ensure they positively latch. All fire cross corridor doors are on a	9/23/2015

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K 027	Continued From page 8 Pavilion Fifth Floor: 6. At 3:11 p.m., on 9/23/15, the smoke barrier double doors by Room 509 were held open with electronic automatic-closing devices. One lead closed less than 1 inch upon activation of the fire alarm system and remained almost completely open.	K 027	Continued From Page 8 monthly PM and records are on file in the FOC. Identified deficiencies are prioritized as high priority and repaired quickly. **Process Improvement:** Preventive maintenance is scheduled monthly for all fire doors. Fire doors are checked during weekly environmental rounds in specific areas according to a pre-determined scheduled. **Monitoring Process:** Daily FOC management rounding done. Results will be reported through EOC Committee to MEC and Quality Council reports to the Governing Board **Date of Implementation:** 9/22/2015-9/25/2015 **Position Responsible:** Director Facilities	
K 046	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 ½ hour duration is provided in accordance with 7.9. 19.29.1. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to maintain their battery-powered emergency lights. This was evidenced by emergency lights that failed when tested and by no records of testing the battery-powered emergency lights. This affected two of three buildings at the Culver City campus and two of six floors at the Hollywood Building. This could result in a delayed evacuation due to limited visibility, in the event of an emergency. NFPA 101, Life Safety Code, 2000 Edition. 19.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9. 19.7.1.3 Employees of health care occupancies shall be instructed in life safety procedures and devices. 7.9.1.1 Emergency lighting facilities for means of egress shall be provided in accordance with	K 046		

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K 046	Continued From page 10 Section 7.9 for the following: (1) Buildings or structures where required in Chapters 11 through 42 (2) Underground and windowless structures as addressed in Section 11.7 (3) High-rise buildings as required by other sections of this Code (4) Doors equipped with delayed egress locks (5) The stair shaft and vestibule of smokeproof enclosures, which shall be permitted to include a standby generator that is installed for the smokeproof enclosure mechanical ventilation equipment and used for the stair shaft and vestibule emergency lighting power supply For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, ramps, aisles, walkways, and escalators leading to a public way. 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and test shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30 day	K 046		

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K 046	Continued From page 11 functional test, provided that a visual inspection is performed at 30-day intervals. Findings: During a facility tour with staff from 9/21/15 to 9/25/15, the emergency lights were observed and maintenance logs were requested. Tower and Pavilion: 1. At 11:45 a.m., on 9/24/15, no records of monthly and annual tests and inspections of the emergency battery-powered lights were provided. There was no documentation that indicated the emergency battery-powered lights were tested monthly for 30 seconds and annually for 90 minutes. 2. At 11:46 a.m., on 9/24/15, Facilities Staff 2 was asked if the exit stairwells were equipped with emergency lighting. The presence of emergency lighting in the exit stairwells at the Pavilion and Tower Buildings could not be confirmed. During an interview at 11:46 a.m., Facilities Staff 2 stated that he did not know if the stairwells were equipped with emergency lighting and was unsure if the stairwell emergency lights were inspected during the monthly generator load tests. The facility failed to provide documentation showing that emergency lights in stairwells were tested and maintained. Tower Basement:	K 046	<u>Culver City</u> The potential exisied for patient, visitor or staff to be unable to exit the building in an emergency. Following completion of corrective action the potential for patient and resident to be affected by the deficient practice was eliminated. **Tower and Pavilion:** **Corrective Action:** The Facility maintains their battery powered lights. 1. Emergency battery-powered lights were tested per NFPA 101 7.9.3 requirements. Twelve months plus of documents are now on file in the FOC. 2. Emergency lighting was provided in all stairwells and powered by the emergency generator. See attached schedule. (Attachment #4) a. The stairwell lights are tested annually per code. **Tower Basement:** 3. (Tower basement ATS (Automatic Transfer Switch) Room) The battery was changed in the ATS room. **Process Improvement:** Periodic testing of emergency lighting equipment is conducted every 30 days for not less than 30 seconds. An annual test is conducted on every required battery power emergency lighting systems for not less than 1.5 hours. Additional testing includes a 90 minute test once annually. **Monitoring Process:** Testing is conducted per schedule and is reported to EOC and Quality Council, MEC up to the Governing Board. **Date of Implementation:** 9/22/2015 **Position Responsible:** Director Facilities, Director Quality	

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K 046	Continued From page 12 3. At 3:41 p.m., on 9/24/15, in the automatic transfer switch room, the battery-powered emergency lights failed when tested by Facilities Staff 2. Hollywood Fourth Floor: 4. At 2:44 p.m., on 9/25/15, the battery-powered emergency lighting unit, across from the nurses station, failed to illuminate when tested. 5. At 2:51 p.m., on 9/25/15, the ballast light fixture in Stairwell 1 was equipped with battery-operated emergency power. The light failed to illuminate when tested. Third Floor: 6. At 2:58 p.m., on 9/25/15, the battery-powered emergency lighting unit, across from the nurses station, failed to illuminate when tested.	K 046	<u>Hollywood</u> **Fourth Floor:** **4, 5, 6** **Corrective Action:** Contractor Service 1st conducted emergency lighting survey to properly identify all emergency lights. Contractor replaced all batteries in the emergency lights. Contractor re-tested all the emergency lights for proper function, (all functioning appropriately). (Attachment #5, #6, #7) **Process Improvement:** A functional test shall be conducted on every required emergency lighting system at 30 day intervals for not less than 30 seconds. Additional testing includes a 90 minutes test once annually. Documentation via EOC rounding trends reported quarterly to EOM committee and Quality Council and to Governing Board. **Monitoring Process:** Monthly monitoring of emergency lighting to assure proper functioning reported through the EOC committee and up to Quality Council and up to the Governing Board. Emergency lighting will be a topic at quarterly EOC meetings. **Date of Implementation:** 9/8/2015 **Position Responsible:** Director Plant Operations	10/8/2015
K 047	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to maintain their exit signs. This was evidenced by one exit sign with battery-operated emergency illumination that failed to illuminate when tested and by no records	K 047		

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K 047	Continued From page 13 of annually testing of exit signs with battery-operated emergency illumination. This affected four of four smoke compartments at the Van Nuys Building. This could result in a delayed evacuation, in the event of an emergency. NFPA 101, Life Safety Code, 2000 Edition. 7.10.1.1 Where Required. Means of egress shall be marked in accordance with Section 7.10 where required in Chapters 11 through 42. 7.10.4 Power Source. Where emergency lighting facilities are required by the applicable provisions of Chapters 11 through 42 for individual occupancies, the signs, other than approved self-luminous signs, shall be illuminated by the emergency lighting facilities. The level of illumination of the signs shall be in accordance with 7.10.6.3 or 7.10.7 for the required emergency lighting duration as specified in 7.9.2.1. However, the level of illumination shall be permitted to decline to 60 percent at the end of the emergency lighting duration. 7.10.5.1 General. Every sign required by 7.10.1.2 ir 7.10.1.4, other than where operations or processes require low lighting levels, shall be suitably illuminated by a reliable light source. Externally and internally illuminated signs shall be legible in both the normal and emergency lighting mode. 7.10.5.2 Continuous Illumination. Every sign required to be illuminated by 7.10.6.3 and 7.10.7 shall be continuously illuminated as required under the provisions of Section 7.8. Exception: Illumination for signs shall be permitted to flash on and off upon activation of the fire alarm system.	K 047		

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K 047	Continued From page 14 7.10.9.1 Inspection. Exit signs shall be visually inspected for operation of the illumination sources at intervals not to exceed 30 days. 7.10.9.2 Testing. Exit signs connected to or provided with a battery-operated emergency illumination source, where required in 7.10.4, shall be tested and maintained in accordance with 7.9.3. 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and test shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30 day functional test, provided that a visual inspection is performed at 30-deay intervals. Findings: During a facility tour with staff from 9/21/15 to 9/25/15, the exit signs were observed and maintenance records were requested. Van Nuys:	K 047	<u>Van Nuys</u> Corrective Action: Exit and directional signs are displayed with continuous illumination and are also served by the emergency lighting system. Contractor Service 1st conducted emergency lighting survey to properly identify all emergency lights and exit signs including the Administration area. (Attachment #8) Contractor replaced all batteries in the emergency lights and exit signs. Contractor tested all emergency	9/28/2015

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K 047	Continued From page 15 1. At 9:28 a.m., on 9/22/15, the exit sign in the administration area was equipped with battery-operated emergency illumination. The exit sign failed to illuminate when tested by Facilities Staff 1. 2. At 2:52 p.m., on 9/2/15, there were no records of 90minute annual testing of the exit signs with battery-operated emergency illumination. At 10:43 a.m., on 9/23/15, Facilities Staff 3 provided documentation of annually voltage testing of the batteries in the exit signs. During an interview at 10:55 a.m. Facilities Staff 6 confirmed that the exit signs were not tested for 90 minutes annually.	K 047	Continued From page 16 Lights and exit signs and all functioned appropriately. (Attachment #5) **Process Improvement:** The Emergency Lighting System including Exit and Directional signs are inspected during environmental rounds. Additional testing includes a 90 minute test once annually. Immediate corrective action is taken at the time the problem is identified. Trends are identified based on location, nature of the light failure and time to respond. Corrective action plans are developed to improve the process. Staff is educated on the process and/or process changes. **Monitoring Process:** Trends identified during rounds related to the Emergency Lighting System and corrective action plans are sent monthly through the EOC committee to Quality Council and MEC for review discussion and any further action. Quality Council meeting minutes flow up to the Governing Board for review and additional comment. Sustained compliance will result in quarterly monitoring. **Date of Implementation:** 9/28/2015 **Position Responsible:** Director Plant Operations	
K 051	NFPA101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection, or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6	K 051		

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K 051	Continued From page 16	K 051		

This STANDARD is not met as evidenced by:
Based on observation and interview, the facility failed to ensure that their fire alarm system was in reliable operating condition. This was evidenced by a disabled fire alarm sub-panel in the continuously monitored public box exchange (PBX) office. This affected three of three buildings at the Culver City campus and could result in a delayed notification of, and response to, a fire emergency.

NFPA 101, Life Safety Code, 2000 Edition.
4.1.1 Fire and Similar Emergency. The goal of this Code is to provide an environment for the occupants that is reasonably safe from fire and similar emergencies by the following means:
(1) Protection of occupants not intimate with the initial fire development
(2) Improvement of the survivability of occupants intimate with the initial fire development.

4.6.1.2 Any requirements that are essential for the safety of building occupants and that are not specifically provided for by this Code shall be determined by the authority having jurisdiction.

19.3.4.1 General. Health care occupancies shall be provided with a fire alarm system in accordance with Section 9.6.

9.6.1.4 A fire alarm system required for life safety

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K 051	Continued From page 17 shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code, unless an existing installation, which shall be permitted to be continued in use, subject to the approval of the authority having jurisdiction. 9.6.1.5 All systems and components shall be approved for the purpose for which they are installed. 9.6.1.6 Fire alarm system installation wiring or other transmission paths shall be monitored for integrity in accordance with 9.6.1.4. NFPA 72, National Fire Alarm Code, 1999 Edition. 1-5.1.3 System Design. Fire alarm system plans and specifications shall be developed in accordance with this code by persons who are experienced in the proper design, application, installation, and testing of fire alarm systems. The system designer shall be identified on the system design documents. Evidence of qualifications shall be provided when requested by the authority having jurisdiction. 1-5.5.2.1 All systems shall be installed in accordance with the specifications and standards approved by the authority having jurisdiction. 1-5.7.1.1 The primary purpose of fire alarm system annunciation is to enable responding personnel to identify the location of a fire quickly and accurately and to indicate the status of emergency equipment or fire safety functions that might affect the safety of occupants in a fire situation. All required annunciation means shall be readily accessible to responding personnel	K 051		

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K 051	Continued From page 18 and shall be located as required by the authority having jurisdiction to facilitate an efficient response to the fire situation. 1-6.1.1 The authority having jurisdiction shall be notified prior to installation or alteration of equipment or wiring. At its request complete information regarding the system or system alterations, including specifications, wiring diagrams, battery calculation, and floor plans shall be submitted for approval. Findings: During a facility tour with Facilities Staff 2 from 9/21/15 to /25/15, the PBX room was observed. Pavilion Basement: 1. At 4:10 p.m., on 9/22/15, the fire alarm sub-panel in PBX was disconnected form the main fire alarm control panels. During an interview at 4:10 p.m., Facilities Staff 2 stated that he disconnected the fire alarm panel in the PBX office because the continuous trouble alarms were a bother to the PBX staff and he stated that the fire alarm panel in PBX was not a necessary fire alarm panel. During an interview at 1:50 p.m., on 9/23/15, PBX Operator 1 stated that the fire alarm panel in PBX was disconnected approximately 2 weeks ago and was told by the facility that security staff would notify them of any alarms and troubles. During an interview at 1:26 p.m., on 9/23/15, Security Staff 1 stated that if the fire alarm system	K 051	<u>Culver City</u> The potential existed for patient visitor staff harm from fire before corrective action was taken. A fire watch was in place following completion of corrective action the potential for patient and resident to be affected by the deficient practice was eliminated. **Pavilion Basement** **Corrective Action:** A fire alarm system with approved components, devices or equipment is installed according to NFPA. 1. The PBX fire alarm panel has been connected. An additional notification panel is in the main lobby. The new control center is at the Security Desk in the main lobby. This location is manned 24 hours a day and is dispatch for security. **Process Improvement:** We are currently in the process of installation of a new fire alarm system. On the completion of the installation anticipated 02/2016 we will begin testing and monitoring of the alarm system. During this time any removal or replacement of fire alarm components will be done according to code. **Date of Implementation:** 9/25/2015. **Monitoring Process:** Any future requirements to replace or remove fire alarm components will be done according to code. Director of Facilities identifies the need to replace or remove components of the Fire Alarm System. Director of Facilities assures that changes are made according to NFPA codes. This process is reviewed at the EOC committee and approved by Quality Council and MEC after review discussion. Quality Council meeting minutes flow up to the Governing Board for review and additional comment. Staff is educated on the process and/or changes. **Date of Implementation:** 9/25/2015 **Position Responsible:** Director Facilities	9/25/2015

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K 051 K 052	Continued From page 19 activated, he would notify engineering. NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the fire alarm system was maintained in reliable operating condition. This was evidenced by the failure of audible fire alarm notification devices, pull stations that were not readily accessible, fire alarm panel batteries that were not dated, and by ongoing trouble signals on the fire alarm panel. This affected three of three buildings at the Culver City campus. This could result in a malfunctioning fire alarm system and a delayed notification of smoke and fire, in the event of a fire. NFPA 101, Life Safety Code, 2000 Edition. 4.2.3 Systems Effectiveness. Systems utilized to achieve the goals of Section 4.1 shall be effective in mitigating the hazard or condition for which they are being used, shall be reliable, shall be maintained to the level at which they were	K 051 K 052		

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K 052	Continued From page 20 designed to operate, and shall remain operational. 4.6.12.1 Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by the authority having jurisdiction. 19.3.4.1 General. Health care occupancies shall be provided with a fire alarm system in accordance with Section 9.6. 9.6.1.3 The provisions of Section 9.6 cover the basic functions of a complete fire alarm system, including fire detection, alarm, and communications. These systems are primarily intended to provide the indication and warning of abnormal conditions, the summoning of appropriate aid, and the control of occupancy facilities to enhance protection of life. 9.6.1.7 To ensure operational integrity, the fire alarm system shall have an approved maintenance and testing program complying with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code. 9.6.3.8 Audible alarm notification appliances shall be of such character and so distributed as to be effectively heard above the average ambient sound level occurring under normal conditions of occupancy.	K 052		

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K 052	Continued From page 21 NFPA 72, National Fire Alarm Code, 1999 Edition. 1-5.5.1 Voltage, Temperature, and Humidity Variation. Equipment shall be designed so that it is capable of performing its intended functions under the following conditions: (1) At 85 percent and a 110 percent of the nameplate primary (main) and secondary (standby) input voltage(s) (2) At ambient temperatures of 32°F (0°C) and 120°F (49°C) (3) At a relative humidity of 85 percent and an ambient temperature of 86°F (30°C) 1-5.5.2.4 Equipment shall be installed in locations where conditions do not exceed the voltage, temperature, and humidity limits specified in 1-5.5.1. Exception: Equipment specifically listed for use in locations where conditions can exceed the upper and lower limits specified in 1-5.5.1. 1-5.7.1.1 The primary purpose of fire alarm system annunciation is to enable responding personnel to identify the location of a fire quickly and accurately and to indicate the status of emergency equipment or fire safety functions that might affect the safety of occupants in a fire situation. All required annunciation means shall be readily accessible to responding personnel and shall be located as required by the authority having jurisdiction to facilitate an efficient response to the fire situation. 2-1.3.3 Initiating devices shall be installed in all areas where required by other NFPA codes and standards or the authority having jurisdiction. Each installed initiating device shall be accessible for periodic maintenance and testing.	K 052		

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K 052	Continued From page 22 2-8.2.1 Manual fire alarm boxes shall be located throughout the protected area so that they are unobstructed and accessible. Findings: During a facility tour with staff from 9/21/15 to 9/25/15, the fire alarm system was tested and system components were observed. Pavilion Basement: 1. At 8:59 a.m., on 9/22/15, the sealed-lead acid batteries in the Pavilion 1 and Pavilion 2 fire alarm control panels (FACPs) were not labeled with installation dates. The sealed-lead acid batteries in the emergency voice/alarm power supply box was not labeled with installation dates. Information about the dates of installation of the batteries was requested but not provided. Tower and Single Story Building First Floor: 2. AT 2:45 p.m., on 9/22/15, the Inspector's Test Valve (IVT), located between the hallways of the Tower Building and Single Story Building, was activated. The fire alarm strobes were activated but the audible notification devices failed to emit an audible alarm. Tower First Floor: 3. At 3:30 p.m., on 9/22/15, there was a staff work station (desk and chair) positioned directly in-front of the fire alarm panel in the FACP room by the Emergency Department.	K 052	**Pavilion Basement:** The potential existed for patient visitor staff harm from fire before corrective action was taken. A fire watch was in place following completion of corrective action the potential for patient and resident to be affected by the deficient practice was eliminated. **Corrective Action:** 1. All batteries were identified with installation dates. **Tower and Single Story Building** **First Floor:** 2. Audible notification system was repaired. **Tower First Floor:** 3. The chair was removed and staff reminded not to block the FACP in the ED.	10/2/2015 9/24/05 9/22/2015

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K 052	Continued From page 23 Fourth Floor: 4. At 3:02 p.m., on 9/22/15, a smoke detector was activated and he audible notification devices on the 4th floor failed to emit an audible alarm. Pavilion Sixth Floor: 5. At 2:42 p.m., on 9/23/15, five of six staff working in the southeast psychiatric locked unit were unable to activate a manual fire alarm pull box. Five of six staff were not equipped with a key to activate the key-operated manual fire alarm pull boxes. 6. At 2:43 p.m., on 9/23/15, three of three staff working in the southwest psychiatric locked unit were not equipped with a key to activate the key-operated manual fire alarm pull boxes. Pavilion Basement: 7. At 11:41 a.m., on 9/21/15, the Pavilion 1 and the Pavilion 2 FACPs exhibited four trouble signals each. During an interview at 11:42 a.m., Facilities Staff 2 stated that the panels had been in trouble for approximately two weeks. During an interview at 10:15 a.m., on 9/23/15, Administrative Staff 2 stated that the failure of audible alarms during fire alarm testing on 9/22/15, and the continuous troubles exhibited in the FACPs, were caused by the dampness and humidity in the building due to the leaks in pipes.	K 052	**Fourth Floor:** 4. Audible notification devices were adjusted to emit an audible alarm. The fire alarm system is an active OSHPD project and installation is was in progress at the time of the survey. (Attachment #9) **Pavilion Sixth Floor:** 5, 6. Staff was provided with keys to activate the manual fire alarm pull station and they have been instructed to include the key verification during shift-to-shift report. **Pavilion Basement:** 7. The 'trouble signals' were investigated and addressed after which the fire alarm system was fully functional. (Attachment #9) **Process Improvement:** Quarterly Fire alarm testing is completed. Any deficiencies noted will be corrected immediately. BHU employees confirm that they have keys at the beginning of each shift. **Monitoring Process:** Results of the quarterly fire alarm testing are sent to EOC, MEC Quality Council and the Governing Board for review and comment. Processes are reviewed to identify opportunities for improvement. **Date of Implementation:** 9/25/2015 **Position Responsible:** Director Facilities, Director Quality	9/24/2015 9/25/2015

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K 052	Continued From page 24 (Leaks in the steam pipe in the FACP Room is cited in K067)	K 052		
K 054	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on record review, the facility failed to maintain their smoke detectors. This was evidenced by no record of repairs or replacement for smoke detectors that failed sensitivity testing. This affected the mechanical roof, the basement, and one of six floors in the Hollywood Building. This could result in the increased risk of smoke detector failure and a delay in notification, in the event of a fire. NFPA 101, Life Safety Code, 2000 Edition. 19.3.4.5.1 Detection systems, where required, shall be in accordance with Section 9.6. 9.6.1.3 The provisions of Section 9.6 cover the basic functions of a complete fire alarm system, including fire detection, alarm, and communications. These systems are primarily intended to provide the indication and warning of abnormal conditions, the summoning of appropriate aid, and the control of occupancy facilities to enhance protection of life. 9.6.1.7 To ensure operational integrity, the fire alarm system shall have an approved maintenance and testing program complying with	K 054		

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K 054	Continued From page 25 the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code. NFPA 72, National Fire Alarm Code, 1999 Edition. 7-1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this code, shall conform to the equipment manufacturer's recommendations, and shall verify correct operation of the fire alarm system. 7-3.2.1 Detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods: (1) Calibrated test method (2) Manufacturer's calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods	K 054		

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K 054	Continued From page 26 approved by the authority having jurisdiction Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. Exception No. 1: Detectors listed as field adjustable shall be permitted to be either adjusted within the listed and marked sensitivity range and cleaned and recalibrated, or they shall be replaced. Exception No. 2: This requirement shall not apply to single station detectors referenced in 7-3.3 and Table 7-2.2. Findings: During a facility tour with staff from 9/21/15 to 9/25/15, the smoke detectors were tested and maintenance records were requested. Hollywood: 1. At 5:51 p.m., on 9/24/15, records indicated that smoke detector sensitivity testing was conducted on 3/27/14. The report stated that three smoke detectors failed sensitivity testing. The smoke detector in the elevator machine room on the roof, the smoke detector in the sixth floor stairwell, and the smoke detector in the wet elevator lobby in the basement failed sensitivity testing. There were no records of repairing or replacing the failed detectors.	K 054	**Hollywood** The potential existed for patient visitor staff harm from fire before corrective action was taken. A fire watch was in place following completion of corrective action the potential for patient and resident to be affected by the deficient practice was eliminated. **Corrective Action:** All required smoked detectors, including those activating door hold-open devices are approved, maintained, and inspected and tested in accordance with the manufacturer's specification. Sensitivity testing on all alarms occurred following notifications. (Attachments #10, #11) Indicate smoke detectors are functioning correctly. **Process Improvement:** System to assure detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. Reporting to EOC committee, MEC Quality Council and Governing Board for review and comments. **Date of Implementation:** 9/22/2015 **Monitoring Process:** Records of sensitivity testing to be reported through the EOC Committee on an annual basis which includes records of 'detector-caused' nuisance. **Position Responsible:** Director Facilities	3/28/15
K 062	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested	K 062		

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K 062	Continued From page 27 periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to maintain the automatic sprinkler system. This was evidenced by the failure to provide records for three of four quarterly inspections, the failure to maintain fire department connections (FDCs), by sprinkler heads that were corroded, by sprinkler heads that were missing escutcheon rings, by sprinkler pipes subjected to external loads, and by one waterflow valve that failed to activate the fire alarm system. This affected three of three buildings at the Culver City Campus and four of four smoke compartments in the Van Nuys Building. This could result in the increased risk of an automatic sprinkler system failure and a delay in extinguishing a fire. NFPA 101, Life Safety Code, 2000 Edition 19.3.5.1 Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Exception: In Type I and Type II construction, where approved by the authority having jurisdiction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specified areas where the authority having jurisdiction has prohibited sprinklers, without causing a building to be classified as nonsprinklered. 9.7.5 Maintenance and Tetsign. All automatic sprinkler and standpipe systems required by this	K 062		

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K 062	Continued From page 28 Code shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 1998 Edition. 1-8 Records. Records of inspections, tests, and maintenance of the system and its components shall be made available to the authority having jurisdiction upon request. Typical records include, but are not limited to, valve inspections; flow, drain, and pump tests; and trip tests of dry pipe, deluge, and preaction valves. 1-8.1 Records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. 1-8.2 Records shall be maintained by the owner. Original records shall be retained for the life of the system. Subsequent records shall be retained for a period of one year after the next inspection, test, or maintenance required by the standard. 2.2.1.1 Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. 2-2.2 Pipe and Fittings. Sprinkler pipe and fittings shall be inspected annually from the floor level. Pipe and fittings shall be in good condition and	K 062		

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K 062	Continued From page 29 free of mechanical damage, leakage, corrosion, and misalignment. Sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. Exception No. 1: Pipe and fittings installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception NO. 2: Pipe installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown. 2-2.6 Alarm Devices. Alarm devices shall be inspected quarterly to verify that they are free of physical damage. 2-3.3 Alarm Devices. Waterflow alarm devices including, but not limited to, mechanical water motor gongs, vane-type waterflow devices, and pressure switches that provide audible or visual signals shall be tested quarterly. 9-2.7 Waterflow Alarm. All waterflow alarms shall be tested quarterly in accordance with the manufacturer's instructions. 9-5.1.1 All valves shall be inspected quarterly. The inspection shall verify that the valves are in the following condition: (a) In the open position (b) Not leaking (c) Maintaining downstream pressures in accordance with the design criteria (d) In good condition, with handwheels installed and unbroken 9-7 Fire Department Connections. 9-7.1 Fire department connections shall be inspected quarterly. The inspection shall verify	K 062		

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K 062	Continued From page 30 the following: (a) The fire department connections are visible and accessible. (b) Couplings or swivels are not damaged and rotate smoothly. (c) Plugs or caps are in place and undamaged. (d) Gaskets are in place and in good condition. (e) Identification signs are in place. (f) The check valve is not leaking. (g) The automatic drain valve is in place and operating properly. Findings: During a tour of the facility with Facilities Staff 1 and Facilities Staff 2 from 9/21/15 to 9/25/15, the automatic sprinkler system was observed and maintenance records were requested. Pavilion: 1. At 2:26 p.m., on 9/22/15, the shrubs and foliage blocked access to the FDCs near the exterior front stairs. 2. AT 9:30 a.m., on 9/24/15, four of four FDCs by the south Pavilion stairwell were not equipped with caps. 3. At 9:32 a.m., on 9/24/15, four of eight sprinkler heads, under the front entrance overhand, showed signs of corrosion and one of eight sprinkler heads was missing an escutcheon ring. Pavilion and Tower: 4. At 8:40 a.m., on 9/24/15, he facility failed to provide records of three of four quarterly inspections for the buildings at the Culver City	K 062	<u>Culver City</u> The potential existed for patient visitor staff harm from fire before corrective action was taken. A fire watch was in place following completion of corrective action the potential for patient and resident to be affected by the deficient practice was eliminated. **Corrective Action:** Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. Pavilion: 1. Shrubs were trimmed and grounds staff ensure that shrubs do not cover fire life safety features. 2. Fire Department Connections (FDC) caps were installed on all 4 locations on the south end of the pavilion. 3. A third quarter inspection was performed by Tri-Signal on 9/28/15. (Attachment #12) Pavilion and Tower: 4. Testing has been scheduled for the fire alarm system and records for third and fourth quarter are on record in the FOC.	9/28/2015 9/28/2015 9/28/2015 9/22/2015

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K 062	Continued From page 31 campus. During an interview at 8:40 a.m., Facilities Staff 1 acknowledged that the documentation was not provided. Tower: 5. At 11:40 a.m., on 9/25/15, the FDCs on the west exterior wall showed signs of corrosion and were unable to rotate freely. Pavilion Basement: 6. At 12:03 p.m., on 9/21/15, there were two pest strips attached to the sprinkler pipe in the trash chute room. Van Nuys: 7. At 1:36 p.m., on 9/22/, water was flowed through the Inspector's Test Valve (ITV) for more than 2 minutes. The fire alarm system failed to activate within 90 seconds. At 1:40 p.m., the ITV was tested again for 2 minutes 8 seconds and the fire alarm system failed to activate for a second time.	K 062	Tower: 5. The FDC was cleaned of corrosion and the FDC's were loosened to hand tight.	9/23/2015
			Pavilion and Basement: 6. The pest strips were removed immediately. **Process Improvement:** Inspections are scheduled quarterly and results are analyzed and reported to the EOC committee, Quality Council, MEC and Governing Board. **Date of Implementation:** 9/24/2015 **Monitoring Process:** Results of the quarterly fire sprinkler system testing are sent to EOC, Quality Council, MEC and the Governing Board for review and comment. Processes are reviewed to identify opportunities for improvement. **Position Responsible:** Director Facilities	9/22/2015
			<u>Van Nuys</u> 7. **Corrective Action:** Red Star Fire Protection Company was called and repair/replaced the ITV fire alarm system problem. (Attachments #14, #15) **Process Improvement:** Red Star Fire Protection Company will inspect and test the ITV quarterly. **Monitoring Process:** Quarterly testing conducted by the Red Star Fire Protection Company. Engineering department will do visual inspection monthly. **Date of Implementation:** 09/23/15 **Position Responsible:** Director of Plant Operation	9/23/2015
K 064	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1 19.3.5.6, NFPA 10	K 064		

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K 064	Continued From page 32 This STANDARD is not met as evidenced by: Based on observation and int3erview, the facility failed to provide portable fire extinguishers in accordance with NFPA 10. This was evidenced by a patient care corridor where travel distance to a fire extinguisher was more than 75 feet away. This was also evidenced by no fire extinguisher provided at a designated smoking area. This affected one of four smoke compartments and one of two designated smoking areas at the Van Nuys Building. This could result in a delay in extinguishing a fire. NFPA 101, Life Safety Code, 2000 Edition. 19.3.5.6 Portable fire extinguishers shall be provided in all health care occupancies in accordance with 9.7.4.1. 9.7.4.1 Where required by the provisions of another section of this Code, portable fire extinguishers shall be installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 4.6.1.2 Any requirements that are essential for the safety of building occupants and that are not specifically provided for by this Code shall be determined by the authority having jurisdiction. NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition. 1-6.3 Fire extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the vent of fire. Preferably they shall be located along normal paths of travel, including exits from areas. 2-1* General Requirements. The selection of fire extinguishers for a given situation shall be	K 064		

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K 064	Continued From page 33 determined by the character of the fires anticipated, the construction and occupancy of the individual property, the vehicle or hazard to be protected, ambient-temperature conditions, and other factors (see Table A-2-1). The number, size, placement, and limitations of use of fire extinguishers required shall meet the requirements of Chapter 3. 2-2.1 Fire extinguishers shall be selected for the class(es) of hazards to be protected in accordance with the following subdivisions. (For specific hazards, see Section 2-3.) 3-1.2 Fire extinguishers shall be provided for the protection of both the building structure and the occupancy hazards contained therein. 3-1.2.2* Occupancy hazard protection shall be provided by fire extinguishers suitable for such Class A, B, C, D or K fire potentials as might be present. 3-2.4 The protection requirements shall be permitted to be fulfilled with fire extinguishers of higher rating, provided the travel distance to such larger fire extinguishers does not exceed 75 ft (22.7 m). Findings: During a facility tour with staff from 9/21/15 to 9/25/15, the fire extinguishers were observed. Van Nuys: 1. At 9:17 a.m., on 9/22/15, there were no fire extinguishers from the locked cross-corridor door at the far end of Unit 2 to the Unit 2 Nurses	K 064	**Van Nuys** **Corrective Action:** Portable fire extinguishers are provided in all healthcare occupancies in accordance with 9.7.4.1, 19.3.5.6, NFPA 10 All fire extinguishers were placed in a locked fire extinguisher cabinet and all staff was given keys to access the fire extinguisher. All fire extinguishers are visually inspected by engineering every month. 1. Installed a fire extinguisher in the cross corridor door in Unit 2 and placed within 75 feet from the nursing station.	9/23/2015

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K 064	Continued From page 34 Station. During an interview at 9:18 a.m., Facilities Staff 3 and Facilities Staff 6 stated that the distance from the door to the nurse station was approximately 110 feet and confirmed that there was no fire extinguisher down that corridor. 2. At 9:28 a.m., on 9/22/15, there was no fire extinguisher in the Unit 1 smoking area. Facilities Staff 3 confirmed that there was no extinguisher.	K 064	Continued From page 34 2. Fire extinguisher was added and placed in the Unit 1 smoking area. **Monitoring Process:** Monthly visual inspection is conducted by engineering. Minutes of EOC are sent to Quality Council, MEC, and the Governing Board. **Date of Implementation:** 10/1/2015 **Person Responsible:** Director of Facilities	9/25/2015
K 066	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4	K 066		

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K 066	Continued From page 35 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their smoking areas. This was evidenced by a broken safety type ashtray and by a designated smoking area located in close proximity to electrical transformers. This affected two of three buildings at the Culver City campus and could result in the increased risk of a fire. NFPA 101, Life Safety Code, 2000 Edition, 19.7.4 Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. Exception: In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (2) Smoking by patients classified as not responsible shall be prohibited. Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 066		

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K 066	Continued From page 36 Findings: During the tour of the facility with Facilities Staff 4 from 9/21/15 to 9/25/15, the smoking areas were observed. Pavilion: 1. At 11:20 a.m., on 9/25/15, there was a broken safety-type ashtray in the east designated smoking area. Smoke from a lit cigarette was observed in the base of the broken ashtray. Tower: 2. At 11:29 a.m., on 9/25/15, the designated smoking area, located by the valet parking lot, was less than 5 feet from the public electrical circuit panels, electrical poles, and transformers. The smoking area was enclosed with a fence covered in a green colored combustible material. The fire rating and specifications of the material was not provided.	K 066	**Pavilion:** There was a potential for staff visitor patients to be affected from fire from a drop lit cigarette. Following completion of corrective action the potential for patient and resident to be affected by the deficient practice was eliminated. **Corrective Action:** 1. A new ash tray was ordered and installed in both designated smoking areas. **Tower:** 2. The green colored privacy curtain was removed. **Process Improvement:** Grounds keeper and facilities staff was educated that smoking area is maintained with proper equipment. Problems identified during EOC and Groundskeeper rounds are trended and corrected when noted. Staff is educated on the process and/or process changes. **Date of Implementation:** 9/28/2015-10/6/2015 **Monitoring Process:** Check for the presence of equipment and functionality. Trends identified during rounding and the corrective action plans are sent monthly through the EOC committee to MEC Quality Council for review discussion and any further action. Quality Council meeting minutes flow up to the Governing Board for review and additional comment. Sustained compliance will result in quarterly monitoring. **Position Responsible:** Director Facilities	10/6/2015 9/25/2015
K 067	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply With the provisions of section 9.2 and are installed In accordance with the manufacturer's Specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.22 This STANDARD is not met as evidenced by: Based on observation, record review, and	K 067		

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K 067	Continued From page 37 interview, the facility failed to maintain their heating, ventilating, and air conditioning (HVAC) system. This was evidenced by the use of portable air conditioners (ACs) that were exhausted into the ceiling, by the use of temporary chillers without approval from the authority having jurisdiction (AHJ), by a leaking steam pipe, and by the alteration of a temporary HVAC unit without approval. This was also evidenced by an air handler with a leaking condenser. This affected three of three buildings at the Culver City campus, the basements in the Hollywood Building, and four of four smoke compartment in the Van Nuys building. These deficient practices could result in changes in the airflow and air exchange and could compromise the fire rating of the ceilings where the portable ACs were exhausted. NFPA 101, Life Safety Code, 2000 Edition. 19.5.2.1 Heating, ventilating, and air conditioning shall comply with the provisions of Section 9.2 and shall be installed in accordance with the manufacturer's specifications. Exception: As modified in 19.5.2.2. 9.2.1 Air Conditioning, Heating, Ventilating Ductwork, and Related Equipment. Air conditioning, heating, ventilating ductwork, and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems, or NFPA 90B, Standard for the Installation of Warm Air Heating and Air-Conditioning Systems, as applicable, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.	K 067		

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K 067	Continued From page 38 8.2.3.2.4.1 Openings in fire barriers for air-handling duct work or air movement shall be protected in accordance with 9.2.1. NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems, 1999 Edition. 2-1.2 Equipment shall be selected and installed based on its proper application with respect to the manufacturer's installation instructions and listing as applicable. 2-1.3 Equipment shall be guarded for personnel protection and against the intake of foreign matter into the system. 2-1.4 Electrical Wiring and equipment shall be installed in accordance with NFPA 70, National Electrical Code. 2-2.4.1 Installation. Heating and cooling equipment shall be installed in accordance with the applicable NFPA standards and the manufacturer's instructions. The equipment shall be approved for the specific installation. 2-2.4.3 Mechanical Cooling. Mechanical refrigeration used with air duct systems shall be installed in accordance with recognized safety practices. Installations conforming to ANSI/ASHRAE 15, Safety Code for Mechanical Refrigeration, shall be considered in compliance with these requirements. 2-3.1.2 Air ducts shall be permitted to be rigid or flexible and shall be constructed of materials that are reinforced and sealed to satisfy the requirements for the use of the air duct system, such as the supply air system, the return or exhaust air system, and the variable volume/pressure air system. 2-3.1.3 All air duct materials shall be suitable for continuous exposure to the temperature and humidity conditions of the environmental air in the	K 067		

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K 067	Continued From page 39 air duct. 2-3.7 Air Inlets-- Return or Exhaust or Return and Exhaust 2-3.7.1 General. Air shall not be recirculated from any space in which flammable vapors, flyings, or dust is present in quantities and concentrations that would introduce a hazardous condition into the return air system. 2-3.11.1 Egress Corridors. Egress corridors in health care, detention and correctional, and residential occupancies shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas. An air transfer opening(s) shall not be permitted in walls or in doors separating egress corridors from adjoining areas. Exception No. 1: Toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces opening directly onto the egress corridors. Exception No. 2: Where door clearances do not exceed those specified for fire doors in NFPA 80, Standard for Fire Doors and Fire Windows, air transfer caused by pressure differentials shall be permitted. Exception No. 3: Use of egress corridors as part of an engineered smoke-control system. Exception No. 4: In detention and correctional occupancies with corridor separations of open construction (e.g. grating doors or grating partitions). 2-3.12 Smoke Control. Where a smoke-control or exhaust system is required, in shall conform to the requirements of the building code of the authority having jurisdiction. 3-1.4 Other Spaces Housing Air-Handling Units. Other spaces housing air-handling units shall meet the requirements of the building code the authority having jurisdiction 3-3.1.2 Approved fire dampers shall be provided	K 067		

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K 067	Continued From page 40 in all air transfer openings in partitions that are required to have a fire resistance rating and in which other openings are required to be protected. 3-3.3 Floor- or Roof- Ceiling Assemblies having a fire Resistance Rating. Where air ducts and openings for air ducts are used in a floor- or roof-ceiling assembly that is required to have fire resistance rating, all the materials and the construction of the assembly, including the air duct materials and the size and protection of the openings, shall conform with the design of the fire-resistive assembly, as tested in accordance with NFPA251, Standard Methods of Tests of Fire Endurance of Building Construction and Materials. (Where dampers are required, see 3-4.4.) Findings: During a facility tour with staff from 9/21/15 to 9/25/15, the HVAC systems were observed. Culver City: 1. At 11:22 a.m., on 9/21/15, there was a portable AC in the Pavilion conference room with an exhaust pipe that penetrated the ceiling and exhausted hot air into the attic. During an interview at 11:23 a.m., Facilities Staff 2 stated that the hospital was using portable ACs throughout including at all nurses stations in the Pavilion, two in the clinical lab, four in the Emergency Department in the Tower, and several other locations. He stated that the units were either exhausted directly into the attic or into return air ducts but was unsure about the specifics of each unit. He stated that the units	K 067	**Culver City** No patients or residents were directly affected by the deficient practice. The corrective action taken removed the potential for other patients and residents to be affected by the deficient practice. **Corrective Action:** 1. The temporary cooling tower (chiller) has been removed from the facility. Repairs were completed on cooling tower. The portable A/C unit was removed from the conference room. Portable A/C units being used throughout facility were removed .Future equipment rentals will be approved for use in healthcare facilities with oversight from AHJ and will include the manufacturer's recommended preventive maintenance. Temporary cooling tower (chiller) installed in the penthouse was removed.	9/22/2015

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K 067	Continued From page 41 were rented approximately one month ago because of the heat wave. On 9/23/15, at 5:30p.m., Facilities Staff 1 provided records of a rental agreement for 12 portable ACs that had been rented since 8/31/15 and four that were rented since 9/10/15. During the survey, portable ACs were observed on the first floor, third floor, fourth floor, fifth floor, and sixth floor of the Pavilion. Portable ACs were observed in Emergency Department in the Tower. The units were exhausted into the attic or return air ducts without oversight from the AHJ. There were no records that indicated the facility had performed routine maintenance on the portable ACs in accordance with manufacturer's specifications. On 9/25/15, the facility installed a temporary chiller in the penthouse of the Pavilion. At 11:05 a.m., the temporary chiller was turned on but then failed. During an interview at 1:45 p.m., Facilities Staff 2 stated that temporary chiller had "tripped" but was now turned on again. Facilities Staff 1 stated that the vendor had to "babysit" the unit until it was fully operational. At 2:01 p.m., Vendor 2, who installed the temporary chiller, stated that the chiller had to be turned off earlier in the morning to clear the pipes and when it was turned on again at 11 a.m., the unit tripped because they tried to reduce the temperature too quickly. In an email to Facilities Staff 1, dated 9/24/15 at 15:02 p.m., the Office of Statewide Health	K 067		

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K 067	Continued From page 42 Planning and Development (OSHPD) Regional Compliance Officer granted permission for the emergency repair of the HVAC system and the installation of the temporary chiller. The email stated that the authorization was valid for 30 days, and, as a condition of the authorization, the facility was instructed to arrange for plan review and obtain a permit 2. During an interview at 11:23 a.m., on 9/23/15, Facilities Staff 2 stated that the facility was using a temporary HVAC unit after a fire in the HVAC system in January 2015. The temporary HVAC unit was approved by OSHPD in March 2015. An OSHPD Compliance Officer (CO) was onsite on 9/23/15. A Construction Advisory Report from the CO's visit was provided. The report indicated the approved temporary HVAC unit had been worked on by the facility without authorization and the facility had removed the outside air ducting. The CO confirmed the widespread presence of portable ACs in the report and stated that the facility was not getting enough cool air. 3. At 11:43 a.m., on 9/21/15, there was water leaking from the ceiling in the basement of the Pavilion. Leaking water was observed in the fire alarm control panel (FACP) room, the mechanical room, the sump pump room, and the hallway behind the surgical recovery area. In the FACP Room, approximately half the ceiling tiles were missing and at least two ceiling tiles had black mold and water stains. During an interview at 11:44 a.m., Facilities Staff 2 stated that there were leaks in the steam pipes. In the Construction Advisory Report from	K 067	Continued From page 42 2. Statement of temp AHU is accurate. Review OSHPD advisory report and talk to Inspector of Record about temp unit adjustments we made. 3. The water leaks were in the corridor and the sewer pump rooms only. No water was leaking in the FACP control room. The water leaking behind the surgical recovery area was a separate issue due to condensate from the steam shut down. The ceiling tiles were missing in the corridor and had been removed due to the steam leak. All ceiling tiles had water stains and this is why the containment barrier had been installed. The ceiling tiles in the FACP are not required and had been removed due to fire alarm installation work. o The OSHPD construction advisory report states the CDPH surveyor states new pipes have been installed and states we did not have a permit. The IOR report states that no work had been informed and that a permit is not required as this is repair work. **Process Improvement:** When an A/C unit is needed the (AHJ) authority having jurisdiction will be contacted for approval of installations. Staff is educated on the process and/or process changes **Date of Implementation:** Removal completed by 11/1/2015. **Monitoring Process:** A/C portable units are no longer at the facility. Future equipment rentals will be monitored to assure compliance with PM and other manufacturer's recommendations for use. Trends identified during monitoring of rental equipment and the corrective action plans are sent monthly through the EOC committee to MEC, Quality Council for review discussion and any further action. Quality Council meeting minutes flow up to the Governing Board for review and additional comment. Sustained compliance will result in quarterly monitoring. **Position Responsible:** Director Facility.	11/1/2015 Dean, answer this with dates it was cleaned and replaced. Let's make it short.

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K 067	Continued From page 43 OSHPD, dated 9/23/15, the CO confirmed the steam pipe leaks in the basement of the Pavilion. The CO also stated that unauthorized repairs, like the installation of new piping, were conducted on the pipes. Van Nuys: 4. At 10:00 a.m., on 9/22/15, there was a portable AC in the dried food storage room. The unit was surrounded by boxes blocking the air inlet and outlet. The manufacturer's specifications for the unit stated "do not use this appliance for special purposes such as cooling pets, food, or precision machinery." The specifications also stated "Do Not block inlet or outlet of air flow" and stated "clean filter every two weeks." There were no records of cleaning the air filter. 5. At 10:16 a.m., on 9/22/15, there was a temporary chiller on a wheeled portable flat bed in the west parking lot. During an interview at 10:17 a.m., Facilities Staff 3 stated that the temporary chiller was rented and hooked up three weeks ago. He stated that the chiller was installed without approval from OSHPD. An invoice from the HVAC vendor, provided on 9/24/15, indicated that the temporary chiller was installed on 7/17/15 after the vendor got an emergency call from the facility for no cooling. The invoice was for the rental of the 20-ton chiller and the rental of the portable 5-ton unit in the kitchen.	K 067	Van Nuys 4, 5 **Corrective Action:** Portable AC in the Kitchen dry storage room was removed on 10/05/15. (Attachment #17) Letter to OSHPD requesting a permit to use a temporary chiller was sent on 10/08/15. Application for new project to replace kitchen HVAC was sent to OSHPD on 10/22/15. (Attachments #18, #19, #20) Director of Plant Operation will follow up with the requested project from OSHPD. Daily temperature checks are occurring three times per day via engineering staff (Attachment #22, and twice daily by the kitchen staff (Attachment #22) with reporting to plant operations and quality if non-functioning. Automated temperatures and sensory nodes were ordered on 11/10/15 and will be installed once the unit arrives. **Monitoring Process:** Trend reporting to EOC/IC and QC on a monthly/quarterly basis for trending. Daily rounding trends go to EOC which go to Quality Council and then to the Governing Board for review and action as needed. **Date completed:** 4. Completed on 10/05/15 5. Letter was sent to OSHPD on 10/08/15. **Position Responsible:** Director of Plant Operations	10/5/2015 10/08/2015 10/22/2015

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K 067	Continued From page 44 Hollywood: Basement: 6. At 4:33p.m., on 9/22/15, the autoclave room next to OR 3 was 90°F. During an interview at 4:36p.m., Facilities Staff 3 stated that the exhaust fan appeared to be non-operational. At 8:29a.m., on 9/23/15, the temperature in the autoclave room was 89°F. During an interview at 8:30a.m., Facilities Staff 3 stated that the supply air duct in the room was working but the air return was not. Mechanical Basement: 7. At 9:05a.m., on 9/23/15, the air handler in the basement was leaking from beneath the unit. There was a large puddle of water spreading towards the main electrical switch. During an interview at 9:06a.m., Facilities Staff 3 stated that the condenser hose was clogged causing the condensing tray to overflow.	K 067	**Hollywood** **Basement** **6, 7** **Corrective Action:** 10/8/15: Contractor Johnson Controls went through the entire HVAC system in the OR suite and made major repairs, fan now operational, (Attachment #21). Plant operations immediately cleaned water and repaired condensate drain to prevent water leakage. Automated temperature and humidity ordered and to be installed in December, (Attachment #21). Daily temperature checks are occurring hourly via nursing staff, with reporting to plant operations and quality if non-functioning. Daily rounding of "critical utility/equipment" rounds to include documentation regarding water leakage. **Monitoring Process:** Trend reporting to EOC/IC and QC on a monthly/quarterly basis for trending. Reporting of daily rounding trends to EOC which will roll up to Quality Council and then to the Governing Board for review and action as needed. **Date completed:** 11/1/15 **Position Responsible:** Director of Plant Operations, ACNO	
K 068	NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide adequate ventilation for their boiler rooms. This was evidenced by one boiler	K 068		

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K 068	Continued From page 45 room without an operable exhaust fan. This affected one of six floors in the Hollywood Building and could result in the increased risk of a fire. NFPA 101, Life Safety Code, 2000 Edition. 19.5.2.2 Any heating device other than a central heating plant shall be designed and installed so that combustible material will not be ignited by the device or its appurtenances. If fuel-fired, such heating devices shall be chimney connected or vent connected, shall take air for combustion directly from the outside, and shall be designed and installed to provide for complete separation of the combustion system from the atmosphere of the occupied area. Any heating device shall have safety features to immediately stop the flow of fuel and shut down the equipment in case of either excessive temperature or ignition failure. Exception No. 1: Approved, suspended unit heaters shall be permitted in locations other than means of egress and patient sleeping areas, provided that such heaters are located high enough to be out of the reach of persons using the area and are equipped with the safety features required by 19.5.2.2. Exception No. 2: Fireplaces shall be permitted and used only in areas other than patient sleeping areas, provided that such areas are separated from patient sleeping spaces by construction having not less than a 1-hour fire resistance rating and that such fireplaces comply with the provisions of 9.2.2. In addition, the fireplace shall be equipped with a fireplace enclosure guaranteed against breakage up to a temperature of 650°F (343°C) and constructed of heat-tempered glass or other approved material. If, in the opinion of the authority having jurisdiction, special hazards are present, a lock	K 068		

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K 068	Continued From page 46 on the enclosure and other safety precautions shall be permitted to be required. Findings: During a facility tour with staff from 9/21/15 to 9/25/15, the boiler rooms were observed. Hollywood Sixth Floor: 1. At 1:40 p.m., on 9/24/15, the temperature in the boiler room was over 90°F. The exhaust fan located at the window was not turned on. During an interview at 1:41 p.m., Facilities Staff 7 stated that when the exhaust fan is turned on, the pilot light for the domestic hot water line turns off from the airflow so the exhaust fan is not used	K 068	No patients or residents were directly affected by the deficient practice. The corrective action taken removed the potential for other patients and residents to be affected by the deficient practice. **Corrective Action:** 1. Exhaust fan repaired by engineering department so that the fan could function and not affect the "pilot light" and provide adequate ventilation for the boiler rooms. **Process Improvement:** Daily rounding to include inspection and resolution of issues in this regard, (attachment). Reporting to EOC and Quality Council and MEC with trending on a quarterly basis. **Date of Implementation:** 10/8/15 **Monitoring Process:** Rounding and documentation on the critical equipment and utility rounds conducted daily rounding and trend reporting to committee on a monthly/quarterly basis. **Position Responsible:** Director Facilities	10/8/2015
K 069	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to maintain their commercial cooking equipment. This was evidenced by no filters in one kitchen hood, by incomplete documentation of fire suppression system inspections, by one kitchen hood with a filter that was not tight-fitting, and by grease-laden deposits on the kitchen hood and suppression system equipment. This affected one of three buildings at the Culver City campus and one of six floors at the Hollywood Building. This could result in the increased risk of a kitchen grease	K 069		

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K 069	Continued From page 47 fire. NFPA 101, Life Safety Code, 2000 Edition. 19.3.2.6 Cooking Facilities. Cooking facilities shall be protected in accordance with 9.2.3. Exception: Where domestic cooking equipment is used for food-warming or limited cooking, protection or segregation of food preparation facilities shall not be required. 9.2.3 Commercial Cooking Equipment. Commercial cooking equipment shall be in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 1998 Edition. 3-2.3 Grease filters shall be listed and constructed of steel or listed equivalent material and shall be of rigid construction that will not distort or crush under normal operation, handling, and cleaning conditions. Filters shall be tightfitting and firmly held in place. 8-2 Inspection. An inspection and servicing of the fire-extinguishing system and listed exhaust hoods containing a constant or fire-actuated water system shall be made at least every 6 months by properly trained and qualified persons. 8-2.2 Fusible links (including fusible links on fire-actuated damper assemblies) and automatic sprinkler heads shall be replaced at least annually, or more frequently if necessary, to	K 069		

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K 069	Continued From page 48 ensure proper orientation of the system. Other detection devices shall be serviced or replaced in accordance with the manufacturer's recommendations. Exception: Where automatic bulb-type sprinklers or spray nozzles are used and annual examination shows no buildup of grease or other material on the sprinkler or spray nozzle. 8.3.1 Hoods, Grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned to bare metal, it shall not be coated with power or there substance. The entire exhaust system shall be inspected by a properly trained, qualified, and certified company or person(s) acceptable to the authority having jurisdiction in accordance with Table 8-3.1 10.6.6 A signed and dated log of maintenance as performed in accordance with 10-6.4 and 10.6.5 shall be available on the premises for use by the authority having jurisdiction. Findings: During a tour of the facility with Facility Staff 1 from 9/21/15 to 9/25/15, the commercial cooking equipment was observed. Pavilion First Floor: 1. At 10:26 a.m., on 9/24/15, the kitchen hood above the stove was not equipped with grease filters.	K 069	<u>Culver City</u> **Pavilion First Floor:** The potential existed for patient visitor staff harm from fire before corrective action was taken. A fire watch was in place following completion of corrective action the potential for patient and resident to be affected by the deficient practice was eliminated. **Corrective Action:** 1. A contractor has been contacted and grease filters will be custom fabricated for the system. (Attachment #23). Working in the process of ordering custom built filters. 2. The vendor was contracted and proper documentation was provided. (Attachment #23) Work Stations on Wheels (WOWs) were inspected to ensure all were capable of being immediately removed from the hallway in an emergency. **Process Improvement:** Vendor has changed. Filters are inspected according to a predetermined schedule. Trends identified during routine inspections are reported and action plans developed. Staff is educated on the process and/or process changes. **Date of Implementation:** 9/28/2015 **Monitoring Process:** Reporting regulatory items are sent to EOC, MEC and Quality Council and Governing Board. Trends identified during routine inspections and the corrective action plans are sent monthly through EOC and Quality Council meeting minutes flow up to	

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K 069	Continued From page 49 During an interview at 10:27 a.m., Dietary Staff 1 stated the filters were removed approximately 3 months ago and the facility had ordered custom built filters. 2. At 4:50 p.m., on 9/24/15, the facility provided invoices for two semi-annual inspection reports of the fire suppression system in the kitchen hood. The facility failed to provide and maintain the actual inspection reports that would indicate what components were inspected and the results of the inspection. The facility also failed to provide information about the most recent hydrostatic test on the wet chemical fire suppression system. Hollywood First Floor: 3. At 9:38a.m., on 9/23/15, one of four filters in the kitchen hood was not installed in the designed orientation, revealing an approximately 4 inch gap and exposing the interior hood. Facilities Staff 3 confirmed that the filter was not put on correctly and adjusted it to fit. 4. At 9:46a.m., on 9/23/15, Facilities Staff 3 removed the hood filters. The entire kitchen hood, including the exhaust duct and fusible links, was covered in thick grease-laden deposits.	K 069	Continued From page 49 Governing Board for review and comment. Sustained compliance will result in quarterly monitoring. **Position Responsible:** Director Facilities **Hollywood** **First Floor** **3, 4** **Corrective Action:** Hood company ordering appropriate equipment, (contracted with new company). "Flue Steam" steamed cleaned the kitchen hood. **Process Improvement:** All filters were replaced with appropriate sized equipment so that the force of the exhaust fan would not allow any exposure of internal hood. (Attachments #24, #25) **Monitoring Process:** Rounding will be included in EOC rounding for dietary department. Issues and resolution will be included in EOC committee meeting and will be forwarded to the Quality Council, MEC and to the Governing Board. **Date of Implementation:** 10/8/2015 **Position Responsible:** Director Facilities	10/8/2015 10/15/2015
K 072	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10	K 072		

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K 072	Continued From page 50 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that means of egress were free from obstructions. This was evidenced by items blocking the egress paths and corridors. This affected two of three buildings at the Culver City campus and the Van Nuys building. This could result in a delayed evacuation of the facility in the event of an emergency and the increased risk of injury to the patients and staff. NFPA 101, Life Safety Code, 2000 Edition. 19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7. Exception: As modified by 19.2.2 through 19.2.11. 7.1.6.1 General. Walking surfaces in the means of egress shall comply with 7.1.6.2 through 7.1.6.4. Exception: Existing walking surfaces shall be permitted where approved by the authority having jurisdiction. 7.1.6.4 Slip Resistance. Walking surfaces shall be slip resistant under foreseeable conditions. The walking surface of each element in the means of egress shall be uniformly slip resistant along the natural path of travel. 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. 7.1.10.2.1 No furnishings, decorations, or other	K 072		

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K 072	Continued From page 51 objects shall obstruct exits, access thereto, egress therefrom, or visibility thereof. Findings: During a facility tour with staff from 9/21/15 to 9/25/15, the means of egress were observed. Pavilion Basement: 1. At 11:45 a.m., on 9/21/15, there was an approximately 1 inch deep puddle of water in the hallway directly outside the emergency exit door behind the surgical recovery room. The puddle was spread along the entire width of the hallway, that was marked with emergency exit signs, and was approximately 10 feet long. The water caused the egress pathway to be slippery and unsafe. During an interview at 11:46 a.m., Facilities Staff 2 stated that the puddle was caused from condensation on the boiler lines. He stated that the boiler was shut down for repairs from 3 a.m. to 8 a.m. that morning and when it was turned on, the condensation caused the large puddle of water. He confirmed that the hallway was an emergency egress path. During a telephone conference with Facilities Staff 2 at 11:40 a.m., on 9/22/15, he stated that the excess water was caused by a blocked condenser drain. 3. At 11:47 a.m., on 9/21/15, there were two surgical beds and two surgical microscopes in the emergency exit hallway behind the surgical recovery room. The equipment obstructed the	K 072	<u>Culver City</u> **Pavilion Basement** **1-4** **Corrective Action:** The water was cleaned up immediately. The water in question was from steam condensate. The boiler had been repaired on Saturday night and the system was brought back to normal and working appropriately. All equipment was removed that morning 9/21/15. Equipment is no longer kept in the back hallway. Equipment was removed that day. Equipment will no longer be staged in the corridor. Beds were removed that day and staff has been instructed not to place storage in the corridors.	9/21/2015

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K 072	Continued From page 52 egress corridor. During an interview at 12:06 p.m., Surgical Services Staff 1 stated that surgical equipment was always kept in the back of the recovery room, and in the hallway behind the recovery room, until it was sterilized for use during surgery. 3. At 12:03 p.m., on 9/21/15, there were three bariatric wheelchairs in the corridor outside the surgery department, across from Central Supply. The wheelchairs were observed again at 12:55 p.m. and there were two gurneys along the same corridor wall. 4. At 1:02 p.m., on 9/21/15, the tunnel connecting the basement of the Pavilion to the Tower was observed. One side of the ramp in the tunnel was used for the storage of 11 beds. One side of the corridor by the patient elevator was used for the storage of seven beds. The ramp and corridor were labeled as emergency exits. During an interview at 1:05 p.m., Surgical Services Staff 1 and Facilities Staff 2 stated that the tunnel was used to transfer patients from the surgery department to the Tower. Facilities Staff stated that the hospital did not have space to store extra beds so they were kept in the tunnel. Van Nuys: 5. At 8:53 p.m., on 9/22/15, the exit door from the Unit 2 dining room was obstructed from opening. Van Nuys Nursing Staff 1 had to remove a patio chair that was placed directly in front of the door in order to open it. Pavilion	K 072	<u>Van Nuys</u> 5. Chair was removed immediately	9/22/2015

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K 072	Continued From page 53 Fifth Floor: 6. At 3:48p.m., on 9/23/15, there were four workstations on wheels (WOWs) parked in the corridor by Room 533. The WOWs were connected to data cables in the corridor and one WOW was connected to a cable that went through the corridor wall into Room 536. There were also two carts in the corridor. Pavilion Third Floor: 7. At 3:43p.m., on 9/23/15, there was a 2 1/2 foot wide portable air conditioner (AC) in the hallway outside Room 309. Pavilion Basement: 8. At 8:15a.m., on 9/22/15, there was barrier, made from a non-rated combustible material, taped across the entire width of the egress corridor outside the fire alarm panel control room. 9. At 8:30a.m., on 9/22/15, there were wet blankets and water puddles on the floor in the egress corridor near the fire alarm panel room and the surgical recovery unit. Tower Building First Floor: 10. At 9:48a.m., on 9/22/15, there were two portable ACs, with exhaust ducts extended into the ceiling, in the means of egress of the Emergency Department. 11. At 2:39 p.m., on 9/22/15, there were three	K 072	Continued From page 53 **Pavilion Fifth Floor** 6. All Work Stations on Wheels (WOW's) and carts are not permanently attached to the wall and can be quickly moved out of the hallways in an emergency. **Pavilion Third Floor:** 7. Portable A/C unit was removed 9/23/15.The containment barrier was made from fire rated plastic. **Pavilion Basement:** 8. This area of corridor is not part of the egress path. 9. Blankets were used to contain water and changed out throughout the day as necessary. Water was vacuumed up throughout the day. **Tower Building** **First Floor:** 10. Portable A/C units were removed 9/23/15. 11. Gurneys in egress in ED department were removed immediately so as to not block the egress. Portable A/C unit was removed on 9/23/15.	10/23/2015 9/23/2015 9/22/2015 9/23/2015 9/23/2015

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K 072	Continued From page 54 unattended gurneys in the means of egress of the Emergency Department. One of the three gurneys was positioned by the emergency exit doors. 12. At 3:30p.m., on 9/22/15, there was a portable AC in the Emergency Department waiting room that obstructed access to the means of egress. Fourth Floor: 13. At 3:06p.m., on 9/22/15, a garbage bin, approximately 6 feet in height, and a copy machine were in the egress corridor near the nurse station. Sixth Floor: 14. At 3:19p.m., on 9/22/15, the facility used the elevator lobby as a patients pre-admission waiting room. There were chairs in the egress corridor in front of the elevators. Pavilion Sixth Floor: 15. At 2:45p.m., on 9/23/15, there was a telephone mounted on the wall, in a wooden cabinet, by Room 617. The wooden cabinet protruded approximately 12 inches from the wall and into the egress corridor. A vendor walked into the wooden cabinet and stumbled. The cabinet obstructed egress and protruded more than six inches into the corridor. Second Floor: 16. At 9:10a.m., on 9/24/15, there were three unattended WOWs in the egress corridor	K 072	12. Portable A/C unit was removed.	9/23/2015
			Fourth Floor: 13. The dirty linen cart and copier were removed.	9/22/2015
			Sixth Floor: 14. The furniture was removed from the Tower elevator lobby.	9/28/215
			Sixth Floor Pavilion: 15. Removal of the telephone privacy box and the phone is anticipated to be completed by 12/31/2015 in cooperation with the public telephone company. The phone will be relocated in an area convenience for the patient but not intruding into the egress.	12/31/2015
			Second Floor: 16. All Work Station on Wheels (WOWs) are not permanently attached to the wall and can be quickly moved out of the hallways in an emergency.	

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K 072	Continued From page 55 between Rooms 231 and 232. The WOWs were plugged into the electrical wall outlets and were hooked up to data cables in the corridor. 17. At 9:11a.m., on 9/24/15, a portable filtration unit was in the egress hallway by Room 229. 18. At 9:15a.m., on 9/24/15, there was an industrial fan in the egress corridor by Room 235. First Floor: 19. At 9:40a.m., on 9/24/15, a portable AC blocked access to the right exit door in the laboratory. Sixth Floor: 20. At 11:10 a.m., on 9/25/15, there were four unattended WOWs plugged in the electrical wall outlets and hooked up to data cables in the north east egress corridor. There were linen carts in the same corridor that blocked egress.	K 072	17. The portable filtration unit was removed. 18. The industrial fan was removed. **First Floor:** 19. The portable A/C unit was relocated to allow egress. **Sixth Floor:** 20. All Work Stations on Wheels on Tower 6 are not permanently attached to the wall and can be quickly moved out of the hallways in an emergency. **Process Improvement:** Trends identified during monitoring for egress obstruction and the corrective action plans are sent monthly through the EOC committee and Quality Council and MEC for review discussion and any further action. Quality Council meeting minutes flow up to the Governing Board for review and additional comment. Sustained compliance will result in quarterly monitoring. **Date of Implementation:** 9/21/2015 **Monitoring Process:** Egress corridors are checked for obstruction during Environmental and Director rounding on a routinely basis. Staff is educated on the process and practice. Trends are identified related to areas of non-compliance including types of obstacles found, availability of alternative storage. Corrective actions are developed. **Position Responsible:** Director Facilities	9/25/2015 9/25/2015 9/24/2015
K 075	NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5	K 075		

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K 075	Continued From page 56 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the storage of their soiled linen and trash receptacles. This was evidenced by linen and trash room doors that were not maintained. This was also evidenced by the storage of soiled linen receptacles, with capacities greater than 32-gallons, outside of rooms protected as hazardous areas. This affected the basement of the Pavilion and the basement of the Hollywood Building. This could result in the faster spread of smoke and fire. NFPA 101, Life Safety Code, 2000 Edition. 19.7.5.5 Soiled linen or trash collection receptacles shall not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gal/ft2 (20.4 L/m2). A capacity of 32 gal (121 L) shall not be exceeded within any 64-ft2 (5.9-m2) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) shall be located in a room protected as a hazardous area when not attended. Exception: Container size and density shall not be limited in hazardous areas. Findings: During a facility tour with staff from 9/21/15 to 9/25/15, the soiled linen and trash receptacles were observed. Pavilion Basement:	K 075	**Culver City** **Pavilion** **Basement** No patients or residents were directly affected by the deficient practice. The corrective action taken removed the potential for other patients and residents to be affected by the deficient practice. **Corrective Action:** 1. The tape was immediately removed from the strike plate and allowed door to positively latch. 2. The doors and strike plate was replaced. 3. The surgical door latch was repaired. **Process Improvement:** Hazardous areas are tested to make sure they are secure and for the presence of functioning locks during Environmental rounding on a routine basis. EVS notifies Facilities of deficiencies. A work order is issued for repairs. Staff are educated on the process and practice Trends are identified related to areas of non-compliance including areas where locks are broken and/or rooms left unlocked. Corrective actions are developed. **Monitoring Process:** Data related to fire doors collected during Preventive Maintenance rounds are reviewed for trends. Work orders are created for deficiencies. Corrective action plans are developed for trends identified. Reports are submitted to EOC committee on a monthly basis. Trends identified during monitoring hazardous areas to assure they are protected by functioning locks and the corrective action plans are sent monthly through the EOC committee to Quality Council for review discussion and any further action. Quality Council meeting minutes flow up to the Governing Board for review and additional comment. Sustained compliance will result in quarterly monitoring. **Date of Implementation:** 9/27/2015 **Position Responsible:** Director Facilities	9/27/2015 9/27/2015

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K 075	Continued From page 57 1. At 12:00 p.m., on 9/21/15, the latching hardware on the door to the soiled linen chute room was taped down and the door failed to latch. The room contained more than 10 large bags of soiled linen. 2. At 12:02 p.m., on 9/21/15, the strike plate on the door frame of the trash chute room was damaged and missing a screw. The door failed to latch when tested. The room contained a 125-gallon trash receptacle full of trash bags and an additional two trash bags that obstructed the chute hatch from closing. 3. At 12:52 p.m., on 9/21/15, the self-closing door to the biohazard waste room in the surgical department failed to latch. Hollywood Basement: 4. At 4:30 p.m., on 9/22/15, there were two 55-gallon soiled linen bins and one approximately 32-gallon biohazard waste receptacle in the elevator lobby of the surgical department. The three receptacles were observed again at 8:31 a.m., on 9/23/15.	K 075	Continued From page 57 Hollywood **Basement:** **Corrective Action:** Obtained smaller containers 34 gallons. **Process Improvement:** Staff was educated to not use 55 gallon soiled linen bins and relocate to appropriate location. Obtained smaller containers 34 gallons. Staff was educated to not use 55 gallon soiled linen bins and relocate to appropriate location. Daily rounds to assure that there are not any bins blocking walkways and that soiled linen is appropriately stored. **Date of Implementation:** 10/8/15 **Monitoring Process:** Nursing rounding each day to assure that each area is clean and clear. Results will be reported through EOC Committee to MEC, Quality Council up to the Governing Board. **Position Responsible:** Director Facilities, ACNO/ OR Charge Nurse	10/8/2015
K 076	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than	K 076		

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K 076	Continued From page 58 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain their oxygen cylinder storage areas. This was evidenced by the storage of combustibles in close proximity to the oxygen cylinders, by electrical switches that were installed less than 5 feet from the floor, and by the absence of precautionary signage. This affected one of three buildings at the Culver City campus. This could result in the increased risk of hazardous conditions and the increased risk of harm to patients. NFPA 101, Life Safety Code, 2000 Edition 19.3.2.4 Medical Gas. Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. NFPA 99, Standard for Health Care Facilities, 1999 Edition 1-2 Application Chapters 12 through 18 specify the conditions under which the requirements of Chapters 3 through 11 shall apply in Chapters 12 through 18. Chapter 12 Hospital Requirements 12-1 Scope. This chapter addresses safety requirements of hospitals. 12-3.4.1 If installed, patient gas systems shall conform to Level 1 gas systems of Chapter 4. 12-3.6.1 Patient. Equipment shall conform to the	K 076		

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K 076	Continued From page 59 patient equipment requirements in Chapter 8, "Gas Equipment." 12-3.8.2 Nonpatient. Equipment shall conform to the non-patient equipment requirements in Chapter 8, "Gas Equipment." Chapter 8 Gas Equipment 8-3.1.11.2 Storage for nonflammable gases less than 3000 ft3 (85 m3). (c) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or incompatible materials by either: 1. A minimum distance of 20 ft (6.1 m), or 2. A minimum distance of 5 ft (1.5 m) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, or 3. An enclosed cabinet of noncombustible construction having a minimum fire protection rating of one-half hour for cylinder storage. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage. (f) Electrical fixtures in storage locations shall meet 4-3.1.1.2(a)11d. (h) Cylinder or container restraint shall meet 4-35.2.1(b)27. (i) Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 20 ft (6.1 m) of outside storage locations. 8-3.1.11.3 Signs. A precautionary sign, readable from a distance of 5 ft (1.5 m), shall be conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: CAUTION OXIDIZING GAS(ES) STORED WITHIN	K 076		

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K 076	Continued From page 60 NO SMOKING 4-3.1.1.2 Storage Requirements (Location, Construction, Arrangement). (a) Nonflammable Gases (Any Quantity; In-Storage, Connected, or Both) 11. Construction and Arrangement of Supply System Locations. d. Ordinary electrical wall fixtures in supply rooms shall be installed in fixed locations not less than 5 ft (1.5 m) above the floor to avoid physical damage. 4-3.5.2.1 Gases in Cylinders and Liquefied Gases in Containers-Level 1. (b) Special Precautions-Oxygen Cylinders and Manifolds. Great care shall be exercised in handling oxygen to prevent contact of oxygen under pressure with oils, greases, organic lubricants, rubber, or other materials of an organic nature. The following regulations, based on those of the CGA Pamphlet G-4, Oxygen, shall be observed: 27. Freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. Findings: During tour of facility with staff from 9/21/15 to 9/25/15, oxygen storage rooms were observed. Pavilion Basement: 1. At 9:01a.m., on 9/22/15, the oxygen storage area in the post-anesthesia care unit (PACU) was observed. The electrical wall outlet was less than 3 feet from the floor and oxygen cylinders were	K 076	Pavilion Basement: Corrective Action: 1. The oxygen was relocated immediately. Appropriate signage was placed.	9/22/2015

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K 076	Continued From page 61 stored next to the outlet. There were combustible supplies in carts stored next to the oxygen cylinders. The room was not equipped with the precautionary signage required for oxygen storage rooms. Facilities Staff 2 confirmed the findings. Pavilion Basement: 2. At 12:40 p.m., on 9/21/15, the room labeled "Tank Room" in the surgical department was observed. There was a cardboard box of supplies and a plastic tarp placed on top of several oxygen E-cylinders. The room was not provided with the required No Smoking sign. The light switch in the room, next to the oxygen cylinder rack, was installed less than 4 feet from the floor. During an interview at 12:41 p.m., Surgical Services Staff 1 stated that the supplies were not supposed to be stored in the Tank Room.	K 076	**Pavilion** **Basement:** 2. The cardboard box and plastic tarp were removed immediately. **Process Improvement:** Medical gas storage and administration areas are monitored to assure they are protected, secure and stored in a safe area away from flammable substances during Departmental rounding on a routine basis. Immediate corrective action is taken. Staff is educated on the process and practice. Trends are identified related to areas of non-compliance including areas where oxygen tanks are not stored appropriately or are in areas near flammable gases or flammable substances. Corrective actions are developed. **Date of Implementation:** 10/1/15 **Monitoring Process:** Trends are identified during monitoring of locations where medical gasses are stored and administered to assure they are secured in a safe environment. The corrective action plans for non-compliance are developed. Trends and any associated corrective action plans are sent monthly through the EOC committee. Minutes from the EOC committee are sent to Quality Council for review and discussion and any further action. Quality Council meeting minutes flow up to the Governing Board for review and additional comment. **Position Responsible:** Director OR, Safety Officer	9/21/2015
K 077	NFPA 101 LIFE SAFETY CODE STANDARD Piped in medical gas systems comply with NFPA 99, Chapter 4. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to maintain their piped-in medical gas systems. This was evidenced by the absence of emergency shut-off zone valves for the piped-in vacuum systems in anesthetizing locations, by obstructed emergency shut-off valves, and by alarm panels that were not	K 077		

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K 077	Continued From page 62 functioning. This was also evidenced by the absence of an emergency oxygen supply connection. This affected three of three buildings at the Culver City campus and three of three anesthetizing locations at Hollywood. This could result in a malfunctioning piped-in medical gas system or a delayed response to an emergency. NFPA 101, Life Safety Code, 2000 Edition 19.3.2.4 Medical Gas. Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. NFPA 99, Standard for Health Care Facilities, 1999 Edition 1-2 Application Chapters 12 through 18 specify the conditions under which the requirements of Chapters 3 through 11 shall apply in Chapters 12 through 18. Chapter 12 Hospital Requirements 12-1 Scope. This chapter addresses safety requirements of hospitals. 12-3.4.1 If installed, patient gas systems shall conform to Level 1 gas systems of Chapter 4. 12-3.4.3 If installed, patient vacuum systems shall conform to the safe use of electric appliances. to Level 1 vacuum systems of Chapter 4. 4-2 Nature of Hazards. 4-2.2 Vacuum Systems. There are potential fire and explosion hazards associated with medical gas central piping systems and medical-surgical vacuum systems. The various components are usually not independent isolated components, but are parts of a larger system dedicated to total patient care and safety.	K 077		

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	050135	A. BUILDING 01- SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD B. WING _____	09/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	6245 DE LONGPRE AVE HOLLYWOOD, CA 90028

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K 077	Continued From page 63 Many of these components are covered by existing standards to minimize the fire, explosive, and patient safety hazard. With the increased use of vacuum systems, the potential for mistaken interconnection with oxidizing gases, for ingestion of flammable anesthetic gases, and for under capacity requiring extended overheated operation all present potential hazards or compound other hazardous conditions that should be properly addressed. While the potential for these problems exists, the former Subcommittee on Vacuum Systems and Equipment was unaware of the actual occurrence of any significant fire-related hazards with vacuum systems. There are also potential hazards to patients in the unplanned shutdown or failure of the systems secondary to a fire and/or the inability of the system to provide adequate levels of performance under normal or emergency situations. There is also the potential for mistaken interconnection with pressurized nonflammable medical gas systems described in Sections 4-3 through 4-6. 4-3.1.2 Distribution-Level1 (Manifold, Piping, Valving/Controls, Outlets/Terminals, Alarms). 4-3.1.2.2 Gas Warning Systems. (a) General. 4. Where multiple panels are intended to indicate the same condition(s): b. Both master alarms required by 4-3.1.2.2(b)2 shall be connected by dedicated wiring directly to the sensor(s) or switch(es). 8. All wiring from switch or sensors shall be protected as required by Section 517-30(c)(3) of NFPA 70, National Electrical Code, for emergency system circuits. (b) Master Alarms 11. A master alarm system shall be provided to	K 077		

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K 077	Continued From page 64 monitor operation and condition of the source of supply, the reserve (if any), and the pressure of the main lines of all medical gas piping systems. 2. The master alarm system shall consist of two or more alarm panels located in two separate locations. One panel shall be located in the principal working area of the individual responsible for the maintenance of the medical gas piping systems and one or more panels shall be located to assure continuous surveillance during the working hours of the facility (e.g., the telephone switchboard, security office, or other continuously stalled location). 4-3.1.2.3 Gas Shutoff Valves. Shutoff valves accessible to other than authorized personnel shall be installed in valve boxes with frangible or removable windows large enough to permit manual operation of valves. Exception: Shutoff valves for use in certain areas, such as psychiatric or pediatric, shall be permitted to be secured to prevent inappropriate access. (m) A shutoff valve shall be located immediately outside each vital life-support or critical care area in each medical gas line, and located so as to be readily accessible in an emergency. Valves shall be protected and marked in accordance with 4-3.5.4.2. All gas-delivery columns, hose reels, ceiling tracks, control panels, pendants, booms, alarm panels, or other special installations shall be located downstream of this valve. (n) A shutoff valve shall be located outside each anesthetizing location in each medical gas line, so located as to be readily accessible at all times for use in an emergency. These valves shall be so arranged that shutting off the supply of gas to any one operating room or anesthetizing location	K 077		

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K 077	Continued From page 65 will not affect the others. Valves shall be of an approved type, mounted on a pedestal or otherwise properly safeguarded against physical damage, and marked in accordance with 4-3.5.4.2. 4-3.2 Piped Vacuum Systems (Source and Distribution) -- Level 1. 4-3.2.2.6 Vacuum System Shutoff Valves. (g) Zone Valve. A shutoff valve shall be located immediately outside of each vital life-support, critical care, or anesthetizing location in each vacuum line, and located as to be readily accessible in an emergency or for maintenance of the terminals or piping within the individual zone served. 4-3.1.1.8 General Requirements for Gas Central Supply Systems. Piped oxygen and medical air shall not be piped to or used for, any purpose except for use in patient care applications. (h)Emergency Oxygen Supply Connection. I Where the cryogenic oxygen supply is located outside of the building served, there shall be incorporated in the piping system an inlet for connecting a temporary auxiliary source of supply for emergency or maintenance situations. The inlet shall be located on the exterior of the building served and shall be physically protected to prevent tampering and unauthorized access. It shall be labeled "EMERGENCY LOW PRESSURE GASEOUS OXYGEN INLET." This connection shall be installed downstream of the shutoff valve on the main supply line (see 1 4-3.1.2.3(b)) and be suitably controlled with the necessary valves to allow emergency supply of oxygen and isolation of the piping to the normal source of supply. It shall have one check valve in the main line between the main line shutoff valve	K 077		

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K 077	Continued From page 66 and the tee'd connection and one check valve between the tee'd connection and the emergency supply shutoff valve. Findings: During a facility tour with staff from 9/21/15 to 9/25/15, the piped-in medical gas systems were observed. Pavilion Basement: 1. At 12:30 p.m., on 9/21/15, Operating Rooms (ORs) 1, 2, 3, 4, 5, 6, 7, and 8 were all equipped with piped-in oxygen, nitrous oxide, and vacuum systems. All ORs, except OR 7, were not provided with emergency shut-off valves for their piped-in vacuum systems.. Facilities Staff 2 confirmed that there were no vacuum system shut-off valves outside ORs 1, 2, 3, 4, 5, 6, and 8. During an interview at 10:47 a.m., on 9/25/15, Facilities Staff 2 stated that he did not know where the main line shut-off valve for the piped-in vacuum system was located. Hollywood Basement: 2. At 4:05 p.m., on 9/22/15, ORs 1, 2, and 3 were equipped with piped-in oxygen, nitrous oxide, and vacuum systems. All three ORs did not have emergency shut-off valves for their piped-in vacuum system. The main-line vacuum shut-off valve was in the mechanical basement, accessible only to facilities and engineering staff. 3. At 4:13p.m., on 9/22/15, the emergency	K 077	<u>Culver City</u> **Pavilion Basement:** There was a potential for a surgical site infection. The corrective action taken removed the potential for other patients and residents to be affected by the deficient practice. **Corrective Action:** 1. A review of code requirements was done to evaluate need for emergency shut off valves. This was discussed and confirmed with the facility IOR and OSHPD head LA Office. **Monitoring Process:** Trends identified during monitoring of piped-in medical gas systems and the corrective action plans are sent monthly through the EOC committee to Quality Council, MEC for review discussion and any further action. Quality Council meeting minutes flow up to the Governing Board for review and additional comment. Sustained compliance will result in quarterly monitoring. **Position Responsible:** Director Facilities **Hollywood** **Basement:** 2. There is a shut off valve available. There has been no new construction in the OR since built in pre-1980. 3. The broken cover was replaced. Contracted vendor for resolution.	

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K 077	Continued From page 67 Shut-off valve assembly outside OR 2, for the oxygen and nitrous oxide piped-in gas systems, had a cover that was broken and taped to the wall instead of fitted on the box. 4. At 4:15 p.m., on 9/22/15, access to the Emergency shut-off valve for the piped-in oxygen system in the recovery room was blocked by a cart. Facilities Staff 3 removed the cart but the shut-off valve was observed to be blocked again by the same cart at 4:36 p.m. The shut-off valve was blocked again by the same cart at 8:34 a.m. on 9/23/15. 5. At 9:30 a.m., on 9/24/15, records indicated that An inspected of the piped-in medical gas systems was conducted by a vendor on 4/27/15. The documentation indicated that the nitrous oxide area alarms in the surgery department and PBX failed because it had "no electrical wiring." On 6/17/15, when the vendor came back for Corrective actions, the document noted that the Nitrous panels were labeled as "not in service" by The technician. At 10:12 a.m., on 9/24/15, the nitrous oxide alarms in the medical gas warning panel outside OR 3 was labeled "not in service" and none of the LED lights were illuminated. At 10:18 a.m., on 9/24/15, the nitrous oxide alarm panel in PBX was also labeled "not in service" and none of the LED lights were illuminated. During an interview at 3:23p.m., Facilities Staff 3 stated that the power supply for the alarm panel was rated at 12 Amps and the power output was 15 Amps causing the motherboard for the panel to burn out.	K 077	4. Staff education has occurred to assure that there are no carts blocking any mean of egress. 5. The vendor was contracted for the resolution.	9/23/2015

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K 077	Continued From page 68 Pavilion and Tower: 6. At 4:02 p.m., on 9/22/15, the facility was not equipped with an emergency oxygen supply connection (oxygen autofill port). During an interview at 4:02p.m., Facilities Staff 2 confirmed that the facility was not equipped with an emergency oxygen supply connection. He stated that the facility was in the process of obtaining approval for the construction of the emergency oxygen supply and emergency shut-off valve for the cryogenic oxygen supply.	K 077	Pavilion and Tower: 6. Issue was corrected **Process Improvement:** Education of requirements to the plant operations staff. Rounding to assure that replacement is done if any broken covers are noted. Routine rounding with reporting to EOC/Quality Council and up to Governing Board. **Date of Implementation:** 9/23/15 **Monitoring Process:** Review of NFPA requirements to assure that ongoing compliance is maintained. Added monthly rounding form, with reports to EOC, Quality Council and the Governing Board. **Position Responsible:** Director Facilities, ACNO.	
K 078	NFPA 101 LIFE SAFETY CODE STANDARD Anesthetizing locations are protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Shutoff valves are located outside each anesthetizing location and are arranged so that shutting off one room or location will not affect others. (b) Relative humidity is maintained equal to or greater than 35%. NFPA 99 4.3.1.2.3(n) and 5.4.1.1,19.3.2.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain their anesthetizing locations. This was evidenced by operating rooms (ORs) that were not equipped with a means of	K 078		

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K 078	controlling relative humidity (RH) during surgery and by the failure to implement corrective actions when RH levels were out of range. This affected eight of eight ORs in the Pavilion and could result in the increased risk of injury to patients. NFPA 101, Life Safety Code, 2000 Edition. 19.3.2.3 Anesthetizing locations shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. NFPA 99, Standard for Health Care Facilities, 1999 Edition Chapter 5 Environmental Systems 5-4.1.1 The mechanical ventilation system supplying anesthetizing locations shall have the capability of controlling the relative humidity at a level of 35 percent or greater. 5-6.1 Anesthetizing Locations. 5-6.1.1 Ventilating and humidifying equipment for anesthetizing locations shall be kept in operable condition and be continually operating during surgical procedures Findings: During a facility tour with Facilities Staff 2 and Surgical Services Staff 2 on 9/21/15, the ORs were observed. Pavilion Basement: 1. At 12:50 p.m., on 9/21/15, the humidity in OR 6 was 67 percent. Staff were in the OR prepping for a case. During an interview at 12:51 p.m., Surgical	K 078	Corrective Action: 1. Standard design for California is that temperature and Humidity control is addressed by several means in the HVAC field. Dehumidification is controlled by several different options; one of the options is by forcing air through a cooling coil. This process removes humidity and is commonly called "wringing out the moisture". At SCHCC there is no additional dehumidification system other than the cooling coils. This is normal for west coast design. The cooling coils for the OR AHUs were in need of replacement and coils were ordered on 10/9/15 and were installed on 12/5/15. The AHUs for the ORs are equipped with a humidification system that adds humidity as necessary. This system is in place and functioning properly.	

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K 078	Continued From page 70 Services Staff 1 stated that it was the facility policy to maintain the humidity between 30 percent and 60 percent. She stated that if the humidity did not decrease in OR 6, they would relocate the procedure to another room or cancel the case. During an interview at 12:52 p.m., Facilities Staff 1 stated that the RH levels cannot be controlled mechanically by the air handlers in the ORs. They can only try to adjust the RH levels by setting the chillers to their lowest cooling point. Surveyors from the California Department of Public Health (CDPH) observed a case in OR 6 later in the day (9/22/15) at 3:25p.m. when humidity had reached 70 percent. During a telephone conference with Facilities Staff 2 at 11:20 a.m., on 9/22/15, Facilities Staff 2 again confirmed that the humidity in the ORs could not be controlled by the mechanical ventilation system.	K 078	Continued From page 70 **Process Improvement:** Purchased and installed new coils. Evaluating the function of the new coils. **Date of Implementation:** 11/1/15 **Monitoring Process:** Before a room is prepared for surgery the temperature and humidity is checked. A room out of range will require the room be closed until temperature and humidity within range. Surgery will be post-pone or scheduled in a different room. Trend reports with plans of correction go to the Governing Board via EOC and Quality Council and MEC. **Position Responsible:** Director OR, Director Facilities	
K 132	NFPA 101 LIFE SAFETY CODE STANDARD Continuing safety education and supervision is provided, incidents are reviewed monthly, and procedures are reviewed annually in accordance with NFPA 99. 10.2.1.4.2 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure that fire drills were conducted quarterly for laboratory personnel. This was evidenced by the failure to provide documentation	K 132		

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K 132	Continued From page 71 for quarterly drills conducted by laboratory staff and by laboratory staff that were unfamiliar with the location of the fire alarm manual pull stations. This affected one of six floors of the Pavilion. This could result in a delayed staff response to a laboratory fire. NFPA 99, Standard for Health Care Facilities, 1999 Edition Chapter 12 Hospital Requirements 12-3.7.2 Laboratories. Equipment shall conform to the nonpatient electrical equipment requirements in Chapter 7. 112-4.2 Laboratories. Laboratories in hospitals shall comply with the requirements of Chapter 10 as applicable and the requirements of NFPA 45, Standard on Fire Protection for Laboratories Using Chemicals, as applicable. 10-2.1.4.3 Fire exit drills shall be conducted at least quarterly. Drills shall be so arranged that each person shall be included at least annually. Findings: During record review with staff from 9/21/15 to 9/25/15, the fire drills records were reviewed. Pavilion First Floor: 1. During an interview at 10:55 a.m., on 9/24/15, Laboratory Staff 1 stated that laboratory staff participate in an annual safety drill. During an interview at 10:59 a.m., two laboratory staff were unfamiliar with the location of the fire alarm manual pull stations in the laboratory.	K 132	Corrective Action: 1. The hospital fire plan calls for all staff to attend fire drills in areas located on the same floors and on floors above and below their department. While lab staff do attend an annual fire drill that is specific to the lab they are encouraged to attend other drills held on campus. Lab staff has been reinstructed on the local pull station. The Fire drill critique has been revised to include a sign-in sheet for attendees. This process had been addressed identified by the Los Angeles CDPH Sub-Acute survey and a new form was shown to CDPH surveyors in the conference room. The FLS surveyor was not present at that time. **Process Improvement:** The fire drill critique form was changed to include a signature sheet for all attending employees. Drills are scheduled at intervals to allow participation from staff in all departments on all shifts. All staff receives education on fire response and safety during new hire and annual safety skills fair. **Date of Implementation:** 11/1/15.	

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K 132	Continued From page 72 At 4:15p.m., the facility failed to provide documents of laboratory fire drills and failed to provide documentation of laboratory staff participating in the main hospital's quarterly fire drills.	K 132	Continued From page 72 **Monitoring Process:** Human Resources maintain files on all staff completing annual skills fair. Employees who have not completed new hire orientation or skills fair are unable to clock in to work until they have completed the requirement. The fire drill completion schedule goes to Governing Board via EOC and Quality Council and MEC. **Position Responsible:** Director Facilities, Director HR, Department Directors	
K 133	NFPA 101 LIFE SAFETY CODE STANDARD Fume hoods are in accordance with NFPA 99. 5.4.3, 5.6.2 This STANDARD is not met as evidenced by: Based on record review, the facility failed to maintain their laboratory and pharmacy fume hoods. This was evidenced by no records of a current annual certification and by no records of current calibration tests for components of the fume hood system that were due for calibration. This affected two of three buildings at the Culver City campus. This could cause hoods to a malfunction and increase the risk of hazardous conditions. NFPA 99, Standard for Health Care Facilities, 1999 Edition Chapter 12 Hospital Requirements 12-3.7.2 Laboratories. Equipment shall conform to the nonpatient electrical equipment requirements in Chapter 7. 12-4.2 Laboratories. Laboratories in hospitals shall comply with the requirements of Chapter 10 as applicable and the requirements of NFPA 45, Standard on Fire Protection for Laboratories Using Chemicals, as applicable.	K 133		

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K 133	Continued From page 73 10-3.5 Fume Hoods. Fume hoods shall conform to 5-4.3 and 5-6.2. 5-4.3.4 Fume hood ventilating controls shall be so arranged that shutting off the ventilation of one fume hood will not reduce the exhaust capacity or create an imbalance between exhaust and supply for any other hood connected to the same system. The operation of these controls shall be tested annually by a qualified person who shall certify the result of the test. NFPA 45, Standard on Fire Protection for Laboratories Using Chemicals, 1996 Edition 6-13.1 When installed or modified and at least annually thereafter, laboratory hoods, laboratory hood exhaust systems, and laboratory special exhaust systems shall be inspected and tested. The following inspections and tests, as applicable, shall be made: (a) Visual inspection of the physical condition of the hood interior, sash, and ductwork (see 5-5.2); (b) Flow monitor; (c) Low airflow and loss-of-airflow alarms at each alarm location; (d) Face velocity; (e) Verification of inward airflow over the entire hood face; and (f) Changes in work area conditions that might affect hood performance. Findings: During record review with staff from 9/21/15 to 9/25/15, the fume hood maintenance records were reviewed. Tower and Pavilion:	K 133		

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K 133	Continued From page 74 1. At 5:10p.m., on 9/24/15, the annual fume hood certification record for the microbiology lab, dated 9/12/14, indicated that the UV and fluorescent lights were not working and had to be replaced. The facility failed to provide documentation that indicated repairs were made. 2. At 5:11 p.m., on 9/24/15, the annual fume hood certification for the pathology lab was dated 9/12/14. The facility failed to provide documentation of a 2015 annual fume hood certification. 3. At 5:12p.m., on 9/24/15, the fume hood certification records indicated that several fume hood components were due for recalibration in January 2015, February 2015, June 2015, and July 2015. No records for the recalibration of the components were provided. 4. At 11:15 a.m., on 9/25/15, the facility failed to provide records of the annual certification of the pharmacy fume hood.	K 133	**Corrective Action:** 1. The annual hood certification for Pathology was performed in October 2015. 2. The fume hoods were tested and certified. 3. **Need an answer...** 4. The annual certification for Pharmacy was performed 9/25/15. **Process Improvement:** All fume hoods are the responsibility of the FOC to ensure testing and repairs are performed as required. **Date of Implementation:** 11/1/2015 **Monitoring Process:** The monitoring process is now the responsibility of the Director of Facilities. Results go to EOC and then to MEC and Quality Council which sends minutes to the Governing Board. **Position Responsible:** Director Facilities	
K 144	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1	K 144		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050135	A. BUILDING 01- SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD B. WING _____	09/25/2015

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K 144	Continued From page 75 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain their emergency generators. This was evidenced by a generator enclosure that was not equipped with battery-powered emergency lights, by a fuel tank gauge that was inoperable, and by the failure to ensure that facility generators were monitored by remote alarm annunciators. This affected three of three buildings at the Culver City Campus and affected the Van Nuys Building. This could result in a delay in staff notification and response to troubles with the generator and the increased risk of injury to the patients. NFPA 101, Life Safety Code, 2000 Edition. 7.9.2.3 Emergency generators providing power to emergency lighting systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. Stored electrical energy systems, where required in this Code, shall be installed and tested in accordance with NFPA 111, Standard on Stored Electrical Energy Emergency and Standby Power Systems. 9.1.3 Emergency Generators. Emergency generators, where required for compliance with this Code, shall be tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power System. NFPA 99, Standard for Health Care Facilities, 1999 Edition. 3-4.1.1.4 General. Generator sets installed as an alternate source of power for essential electrical systems shall be designed to meet the requirements of such service. (a) Type I and Type II essential electrical system	K 144		

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K 144	Continued From page 76 power (107C) or the engine water-jacket temperature at not less than sources shall be classified as Type 10, Class X, Level 1 generator sets per NFPA 110, Standard for Emergency and Standby Power Systems. 3-4.1.1.15 A remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. (See NFPA 70, National Electrical Code, Section 700-12) The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: (a) Individual visual signals shall indicate: 1. When the emergency power source is operating to supply power to load 2. When the battery charger is malfunctioning. (b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following: 1. Low lubricating oil pressure 2. Low water temperature (below those required in 3-4.1.1.9) 3. Excessive water temperature 4. Low fuel- when the main fuel storage tank contains less than a 3-hour operating supply 5. Over crank (failed to start) 6. Overspeed Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur, but need not display these conditions individually. NFPA 70 , National Electrical Code, Section	K 144		

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K 144	Continued From page 77 700-12). The annunciator shall indicate alarm condition of the emergency or auxiliary power source as follows: (a)Individual visual signals shall indicate the following: 1. When the emergency or auxiliary power source is operating to supply power to load 2. When the battery charger is malfunctioning (b)Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following: 1. Low lubricating oil pressure 2. Low water temperature (below those required in 3-4.1.1.9) 3. Excessive water temperature 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply 5. Overcrank (failed to start) 6. Overspeed 3-5.5.2 (d) Battery powered individual alarm indication to annunciate visually at the control panel the occurrence of any of the conditions in Table 3-5.5.2 (d); additional contacts or circuits for a common audible alarm that signals locally and remotely when any of the itemized conditions occurs. A lamp test switch(es) shall be provided to test the operation of all alarm lamps listed in Table 3-5.5.2(d). 3-5.6.1 A remote.. common audible alarm powered by the storage battery shall be provided as specified in 3-5.5.2(d). This remote alarm shall be located outside of the EPS service room at a work site readily observable by personnel. NFPA 110, Standard for Emergency and Standby Power Systems, 1999 edition.	K 144		

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K 144	Continued From page 78 3-5.5.2 An automatic control and safety panel shall be a part of the EPS and shall contain the following equipment or possess the following characteristics, or both: (a) Cranking control equipment to provide the complete cranking cycle described in 3-5.4.2 and Table 3-5.4.2. (b) A panel-mounted control switch(es) marked " run-off-automatic" to perform the following functions: 1. Run: Manually initiate, start, and run prime mover 2. Off: Stop prime mover or reset safeties, or both 3. Automatic: Allow prime mover to start by closing a remote contact and stop by opening the remote contact (c) Controls to shut down and lock out the prime mover under the following conditions: failing to start after specified cranking time, overspeed, low lubricating-oil pressure, high engine temperature, or operation of remote manual stop station. An automatic engine shutdown device for high lubricating-oil temperature shall not be required. (See 3-5.5.6.) (d) Battery-powered individual alarm indication to annunciate visually at the control panel the occurrence of any of the conditions in Table 3-5.5.2(d); additional contacts or circuits for a common audible alarm that signals locally and remotely when any of the itemized conditions occurs. A lamp test switch(es) shall be provided to test the operation of all alarm lamps listed in Table 3-5.5.2(d). (e) Controls to shut down the prime mover upon removal of the initiating signal or manual emergency shutdown. (f) The ac instruments listed in 3-5.9.7. Where the control panel is mounted on the energy converter, it shall be mounted by means of antivibration	K 144		

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K 144	Continued From page 79 shock mounts, if required, to maximize reliability. 3-5.6 Remote Controls and Alarms 3-5.6.1 A remote, common audible alarm powered by the storage battery shall be provided as specified in 3-5.5.2 (d). This remote alarm shall be located outside of the EPS service room at a work site readily observable by personnel. 3-5.6.2 An alarm-silencing means shall be provided, and the panel shall include repetitive alarm circuitry so that, after the audible alarm is silenced, it is reactivated after clearing the fault condition and must be restored to its normal position to be silenced. Exception: In lieu of the requirement of 3-5.6.2, a manual alarm-silencing means shall be permitted that silences the audible alarm after the occurrence of the alarm condition, provided such I means do not inhibit any subsequent alarms from sounding the audible alarm again without further manual action. 5-3.1 The Level 1 or Level 2 EPS equipment location shall be provided with battery powered emergency lighting. The emergency lighting charging system and the normal service room lighting shall be supplied from the load side of the transfer switch. Findings: During tour of facility with staff from 9/21/15 to 9/25115, the generator room was observed. Tower Basement: 1. At 3:34p.m., on 9/22/15, the generator room	K 144	<u>Culver City</u> **Tower Basement:** **Corrective Action:** 1. A battery-powered emergency light was installed in the tower basement generator room.	

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K 144	Continued From page 80 was not equipped with battery-powered emergency lights. 2. At 4:03p.m., on 9/22/15, there were no remote alarm annunciators for three of three generators at Culver City. During an interview at 4:03p.m., Administrative Staff 3 confirmed that the facility was not equipped with remote alarm annunciators for three of three generators. Van Nuys Building Basement: 3. At 10:40 a.m., on 9/22/15, the diesel day tank connected to the generator had a gauge that showed the fuel level as empty. The tank was approximately 100 percent full upon inspection. Facilities Staff 6 pushed the test button on the day tank and the gauge on the tank did not move. During an interview at 10:41 a.m., Facilities Staff 6 stated that when the test button is pushed, the gauge should have read the accurate level of diesel fuel. During an interview at 2:20p.m., Facilities Staff 3 stated that the gauge would work if the generator was running. Facilities Staff 6 ran the generator and the gauge was still stuck on empty. 4. At 10:45 a.m., on 9/22/15, there was no remote alarm annunciator for the diesel generator at Van Nuys. During an interview at 10:46 a.m., Facilities Staff 6 confirmed that there was no remote alarm annunciator for this generator.	K 144	Continued From page 80 2. The Tower generators have annunciators located in the ED registration area. The Pavilion emergency generator will be installed as part of the O2 fill port and annunciator project. **Process Improvement:** Emergency lighting has been installed where code applicable. **Date of Implementation:** 10/14/15 **Monitoring Process:** Emergency lighting checked during our annual/semi-annual EOC rounding. Results of rounding are reported to EOC Committee. EOC minutes go to Governing Board via EOC and Quality Council and MEC. **Position Responsible:** Director Facilities **Van Nuys** **Basement:** **Corrective Action:** 2. New fuel gauge was installed. **Process Improvement:** **Monitoring Process:** Trend reporting to EOC/IC and QC on a monthly/quarterly basis for trending. Reporting of monthly rounding trends to EOC which will roll up to Quality Council and then to the Governing Board for review and action as needed. **Date of Implementation:** 10/9/2015 **Position Responsible:** Director of Plant Operations	10/09/2015

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K 147	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the integrity of their electrical wiring. This was evidenced by modifications to an electrical panel to power portable air cooling units, by the use of power strips and extension cords, by the failure to safeguard a defective electrical outlet, and by an obstructed electrical panel. These deficient practices affected two of three buildings at the Culver City campus, one of four smoke compartments at the Van Nuys Building, and the Hollywood Building. This could cause an electrical fire and potential harm to residents and staff in the event of a fire emergency. NFPA 101, Life Safety Code, 2000 Edition. 19.5.1 Utilities. Utilities shall comply with the provisions of Section 9.1. Exception: Existing installations shall be permitted to be continued in service, provided that the systems do not present a serious hazard to life. 9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction. NFPA 70, National Electrical Code, 1999 Edition. Section 90-4 Enforcement. This Code is intended	K 147		

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K 147	Continued From page 82 to be suitable for mandatory application by governmental bodies that exercise legal jurisdiction over electrical installations and for use by insurance inspectors. The authority having jurisdiction for enforcement of the Code will have the responsibility for making interpretations of the rules for deciding on the approval of equipment and materials, and for granting the special permission contemplated in a number of the rules. The authority having jurisdiction may waive specific requirements in this Code or permit alternate methods where it is assured that equivalent objectives can be achieved by establishing and maintaining effective safety. This Code may require new products, constructions, or materials that may not yet be available at the time the Code is adopted. In such event, the authority having jurisdiction may permit the use of the products, constructions, or materials that comply with the most recent previous edition of this Code adopted by the jurisdiction. 90-7 Examination of Equipment for Safety. For specific items of equipment and materials referred to in this Code, examinations for safety made under standard conditions will provide a basis for approval where the record is made generally available through promulgation by organization properly equipped and qualified for experimental testing, inspections of the run of goods at factories, and service-value determination through field inspections. This avoids the necess1ty for repetition of examinations by different examiners, frequently with inadequate facilities for such work, and the confusion that would result from conflicting reports as to the suitability of devices and materials examined for a given purpose. It is the intent of this Code that factory-installed	K 147		

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K 147	Continued From page 83 internal wiring or the construction of equipment need not be inspected at the time of installation of the equipment, except to detect alterations or damage, if the equipment has been listed by a qualified electrical testing laboratory that is recognized as having the facilities described above and that require suitability for installation in accordance with this Code. 110-3. Examination, Identification, Installation, and Use of Equipment. (a) Examination. In judging equipment, considerations such as the following shall be evaluated: (1) Suitability for installation and use in conformity with the provisions of this Code FPN: Suitability of equipment use may be identified by a description marked on or provided with a product to identify the suitability of the product for a specific purpose, environment, or application. Suitability of equipment may be evidenced by listing or labeling. (2) Mechanical strength and durability, including, for parts designed to enclose and protect other equipment, the adequacy of the protection thus provided (3) Wire-bending and connection space (4) Electrical insulation (5) Heating effects under normal conditions of use and also under abnormal conditions likely to arise in service (6) Arcing effects (7) Classification by type, size, voltage, current capacity, and specific use (8) Other factors that contribute to the practical safeguarding of persons using or likely to come in contact with the equipment (b) Installation and Use. Listed or labeled equipment shall be installed and used in	K 147		

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K 147	Continued From page 84 accordance with any instructions included in the listing or labeling, 110-12. Mechanical Execution of Work. Electrical equipment shall be installed in a neat and workmanlike manner. (a) Unused Openings. Unused openings in boxes, raceways, auxiliary gutters, cabinets, equipment cases, or housings shall be effectively closed to afford protection substantially equivalent to the wall of the equipment. (b) Subsurface Enclosures. Conductors shall be racked to provide ready and safe access in underground and subsurface enclosures, into which persons enter for installation and maintenance. (c) Integrity of Electrical Equipment and Connections. Internal parts of electrical equipment, including busbars, wiring terminals, insulators, and other surfaces, shall not be damaged or contaminated by foreign materials such as paint, plaster, cleaners, abrasives, or corrosive residues. There shall be no damaged parts that may adversely affect safe operation or mechanical strength of the equipment such as parts that are broken; bent; cut; or deteriorated by corrosion, chemical action, or overheating, 240-4 Flexible cord, including tinsel cord and extension cords, and fixture wires shall be protected against overcurrent by either (a) or (b). (a) Ampacities. Flexible cord shall be protected by an overcurrent device in accordance with its ampacity as specified in Tables 400-5(A) and (B). Fixture wire shall be protected against overcurrent in accordance with its ampacity as specified in Table 402-5. Supplementary overcurrent protection, as in Section 240-10, shall be permitted to be an acceptable means for	K 147		

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K 147	Continued From page 85 providing this protection. 370-25 In completed installations, each box shall have a cover, faceplate, or fixture canopy. 400-8 Uses Not Permitted Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-8. (5) Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (6) Where installed in raceways, except as otherwise permitted in this Code. Findings: During a tour of the facility with staff from 9/21/15 to 9/25/15, the electrical wiring was observed. Tower First Floor 1. At 10:01 a.m., on 9/22/15, the electrical outlet on the wall above Bed S1 in the Emergency Department had a loose faceplate. Basement:	K 147	<u>Culver City</u> Tower First Floor Corrective Action: 1. Electrical outlet above S6 in ED loose.	

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K 147	Continued From page 86 2. At 3:30p.m., on 9/22/15, Electrical Panel BEA was painted shut and was obstructed from opening. Pavilion Basement: 3. At 4:05p.m., on 9/22/15, a refrigerator, a microwave oven, and a coffee pot were plugged into a multi-plug power-strip in the public box exchange office. Sixth Floor: 4. At 2:38 p.m., on 9/23/15, the portable air conditioning unit, located in the egress corridor near the nurse station, was plugged into an extension cord. Second Floor: 5, At 9:05p.m., on 9/24/15, there was white tape placed over the faceplate of the red emergency electrical outlet by Room 208. First Floor: 6. At 9:45a.m., on 9/24/15, the portable air conditioner in the laboratory was plugged into a multi-plug power strip. Pavilion Basement: 7. At 12:24 p.m., on 9/21/15, there was a cautery unit plugged into a four-plug extension in Operating Room (OR) 1. The unit was marked with a "hospital grade only" sticker near its	K 147	2. Maintenance staff cleaned up the paint on panel BEA and the door now functions. **Pavilion** **Basement:** 3. PBX Micro & coffee maker plugged into extension cord was immediately removed. **Sixth Floor:** 4. P6 Portable A/C unit was removed. **Second Floor:** 5. P2 white tape placed faceplate by room 208 was removed immediately. **First Floor:** 6. Portable A/C unit in lab was plugged into a power strip was immediately removed. **Pavilion Basement:** 7. Non Hospital grade plug in OR 1, OR 4 hanging outlet defective have been replaced with hospital grade fixtures.	9/22/2015 10/23/2015 9/24/2015 9/24/2015 11/1/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050135	A. BUILDING 01- SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD B. WING _____	09/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	6245 DE LONGPRE AVE HOLLYWOOD, CA 90028

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K 147	Continued From page 87 electrical adaptor. The extension cord did not have hospital grade plugs. During an interview at 12:25 p.m., Facilities Staff 2 confirmed that the plugs were not hospital grade. 8. At 12:36 p.m., on 9/21/15, there was a four-plug outlet hanging from the ceiling by a cable, near the surgical table in OR 4. The outlet was labeled as "defective" by a biomed technician in 2009. The outlet was only labeled on one side and the plugs were still accessible for use. Van Nuys: 9. At 10:01 a.m., on 9/22/15, the portable AC in the dry kitchen storage room was plugged into an extension cord. Under the Electrical Safety section of the unit manufacturer's manual, it stated "Do not use extension cords." 10. At 10:04 a.m., on 9/22/15, a large cable was wired from behind Electrical Panel KS to power the temporary cooling unit on the main floor of the kitchen. During an interview at 10:04 a.m., Facilities Staff 3 stated that it had been this way for approximately three months and that the . electrical wiring was not approved by the authority having jurisdiction. Hollywood Basement: 11. At 4:25p.m., on 9/22/15, the surgical table in	K 147	8. FOC staff **Process Improvement:** Monthly rounding will include assessment of equipment plugged into the correct receptacle and that no Non-hospital grade power strips are in use. **Date of Implementation:** 10/23/15 and ongoing. **Monitoring Process:** Safety deficiencies are identified during EOC. Work Orders are made for corrective actions. Results of rounding are reported to EOC Committee. EOC minutes go to Governing Board via EOC MEC and Quality Council. **Position Responsible:** Director Facilities, Director OR **Van Nuys** **Corrective Action:** 9. The portable A/C in the dry kitchen was removed. 10. Service 1st Electrical Company was called and installed a new disconnected panel to accommodate the temporary cooling unit in the kitchen. (Attachment #26). Once the proposed project to replace the /C unit in the kitchen is approved by OSHPD. The temporary disconnect switch will be removed. **Monitoring Process:** Trend reporting to EOC/IC and QC on a monthly/quarterly basis for trending. Reporting of monthly rounding trends to EOC which will roll up to Quality Council and then to the Governing Board for review and action as needed. **Date of Completion:** 10/28/2015 **Position Responsible:** Director of Plant Operations **Hollywood** **Basement:** **Corrective Action:** 11. Immediately removed during survey and plugged into wall outlet.	9/22/2015 9/22/2015

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K 147	Continued From page 88 OR 1 was plugged into a multi-plug power strip. First Floor: 12. At 9:32a.m., on 9/23/15, the electrical connection for the portable cooling unit in the kitchen could not be observed. A large cable ran into the same exhaust unit as the faulty swamp cooler. During an interview at 9:34a.m., Facilities Staff 3 stated that the temporary cooling unit was wired into the swamp cooler disconnect and will remain that way until the swamp cooler was repaired. Mechanical Roof: 13. At 1:26 p.m., on 9/24/15, there were two 4 by 4 electrical boxes in the ceiling connected via conduit to the smoke detector in the elevator machine room. The electrical boxes had no covers and the electrical relays were protruding more than 1 inch out of the boxes.	K 147	**First Floor:** 12. Lease agreement obtained from Johnson Controls unit was brought in. **Mechanical Roof:** 13. Lease agreement obtained from Johnson Control unit was brought in. **Process Improvement:** OR staff was educated on the correct outlets to use. Monthly rounding will include assessment of equipment plugged into the correct receptacle and that no Non-hospital grade power strips are in use. **Date of Implementation:** 9/22/2015 **Monitoring Process:** Monitoring of all units for multi-plug power strips, (non-hospital grade) are assessed during EOC rounds and fall outs immediately corrected with trending reports to EOC committee through Quality Council and up to Governing Board. All rental equipment will be assessed for appropriateness of both the unit and the "set up" of named unit. **Position Responsible:** Director Facilities	9/22/2015 9/22/2015

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K 000	INITIAL COMMENTS CULVER CITY CAMPUS: PAVILION K3 BUILDING: 01 K6 PLAN APPROVAL: 1969 K7 SURVEY UNDER: 2000 EXISTING STRUCTURE TYPE: SIX FLOORS WITH MECHANICAL ROOF (PENTHOUSE) AND BASEMENT, CONSTUCTION TYPE I, FULLY SPRINKLERED. TOWER K3 BUILDING: 02A K6 PLAN APPROVAL: 1959 K7 SURVEY UNDER: 2000 EXISTING STRUCTURE TYPE: SEVEN FLOORS AND BASEMENT, CONSTRUCTION TYPE I, PARTIALLY SPRINKLERED. SINGLE STORY BUILDING ATTACHED TO TOWER K3 BUILDING: 02B K6 PLAN APPROVAL: 1939 K7 SURVEY UNDER: 2000 EXISTING STRUCTURE TYPE: ONE FLOOR, CONSTRUCTION TYPE V(111)., FULLY SPRINKLERED. Census at Culver City on 12/14/15: 225 HOLLYWOOD K3 BUILDING: 03 K6 PLAN APPROVAL: 1960s K7 SURVEY UNDER: 2000 EXISTING STRUCTURE TYPE: SIX FLOORS WITH MECHANICAL ROOF AND BASEMENT, CONSTRUCTION TYPE I, PARTIALLY SPRINKLERED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 Census at Hollywood on 12/14/15: 41 VAN NUYS K3 BUILDING: 04 K6 PLAN APPROVAL: 1967 K7 SURVEY UNDER: 2000 EXISTING STRUCTURE TYPE: ONE FLOOR WITH SERVICE BASEMENT, CONSTRUCTION TYPE III(211), FULLY SPRINKLERED. Census at Van Nuys on 12/14/15: 56 CULVER MEDICAL PLAZA - OUTPATIENT SPINE CLINIC K3 BUILDING: 05 K6 PLAN APPROVAL: 1981 K7 SURVEY UNDER: 2000 EXISTING STRUCTURE TYPE: SEVEN FLOORS, CONSTRUCTION TYPE I, NONSPRINKLERED (STANDPIPE HOSE SYSTEM). BROTMAN PHYSICIAN PLAZA - OUTPATIENT IOP CLINIC K3 BUILDING: 06 K6 PLAN APPROVAL: 1964 K7 SURVEY UNDER: 2000 EXISTING STRUCTURE TYPE: EIGHT FLOORS, CONSTRUCTION TYPE I, FULLY SPRINKLERED. The following reflects the findings of the California Department of Public Health, during a Full Validation Life Safety Code Survey, using the NFPA 101 2000 Edition of the Life Safety Code for Health Care Facilities and in accordance with 42 CFR 482.41(b)(1) for General Acute Care Hospitals.	K 000		

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K 000	Continued From page 2 Representing the California Department of Public Health: 29566, HFE I 29665, HFE I	K 000		
K 012	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to maintain the integrity of the building construction. This was evidenced by penetrations in the walls, by the use of nonrated paneling and insulation in the attic of a Type I building, and by missing sheetrock in the wall of the stairwell of a partially sprinklered building. This could result in the faster spread of fire and smoke, increasing the risk of injury to patients. This affected two of six floors in the Pavilion, one of two stairwells in the Tower, and one of six floors in the Hollywood Building. NFPA 101, Life Safety Code, 2000 Edition 19.1.6.2 Health care occupancies shall be limited to the types of building construction shown in Table 19.1.6.2. (See 8.2.1.) 19.1.6.3 All interior walls and partitions in buildings of Type I or Type II construction shall be of noncombustible or limited-combustible materials. 8.2.3.1.1 Floor-ceiling assemblies and walls used as fire barriers, including supporting construction, shall be of a design that has been tested to meet	K 012	NFPA 101 LIFE SAFETY CODE STANDARD Findings 1-5 Actions Taken: 1. The 5-inch diameter exhaust hose connection penetrating the ceiling of the Pavilion Conference room was removed and replaced with a vent cover. 2. The plastic bag around the pipe was removed and the wood paneling discarded. The pipe was wrapped with an insulation wrap to prevent further condensation and the ceiling tiles have been replaced. 3. The pipe was insulated and the wall was patched with sealant. 4. The penetration above the attic access panel in the corridor outside the cafeteria was repaired. 5. The wall of the east stairwell on the first floor has been repaired and restored back to its original fire/smoke integrity as stated in the approved plans.	12/22/2015 12/30/2015 02/29/2016 01/29/2016 01/06/2016

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K 012	Continued From page 3 the conditions of acceptance of NFPA 251, Standard Methods of Tests of Fire Endurance of Building Construction and Materials. Fire barriers shall be continuous in accordance with 8.2.2.2. Findings: During the facility tour with staff from 12/14/15 to 12/18/15, the walls and ceilings were observed. Pavilion First Floor: 1. At 12:36 p.m., on 12/14/15, there was a 5 inch diameter exhaust hose connection penetrating the ceiling of the Pavilion Conference Room. The attic could be observed through the opening caused by the hose connection. This connection was previously attached to the exhaust hose of the portable air conditioner observed during the Life Safety Code survey in September 2015. Pavilion Sixth Floor: 2. At 12:53 p.m., on 12/14/15, two ceiling tiles adjacent to the nurses station in the 6C corridor were completely wet. During an interview at 12:53 p.m., Floor Technician 1 stated that he noticed the wet tiles at 6:50 a.m. and that nursing staff submitted a work order. A copy of Work Request No. 236232 was provided. At 8:33 a.m., on 12/15/15, the ceiling tiles were replaced but there were two wet spots observed on the new tiles. The tiles were removed by facilities staff and a pipe above the tiles was	K 012	6. Hospital Leadership, including the Chief Executive Officer, Senior Vice President of Hospital Operations and Vice-President of Facilities Development, discussed the survey findings with the Director of Facilities, with special emphasis on strict adherence to maintaining compliance with Life Safety requirements. Executive Leadership requested the Director of Facilities provide a copy of any OSHPD reports to Leadership to enable oversight for any follow up issues required by OSHPD for specific projects. 7. Hospital Leadership engaged a national healthcare regulatory compliance consulting firm, which included a Life Safety Expert, to assist with development, implementation and sustainability of the credible allegation of compliance. 8. The Director of Facilities discussed the survey findings with his department staff, with special emphasis on implementing and sustaining the Life Safety plan of correction, including identifying, repairing and monitoring for penetrations. If identified, Plant Department staff complete work orders and repairs are initiated. Evidence of completion is maintained in the Plant Facilities Department. Engineering staff were re-inserviced.	03/11/2016 01/13/2016 03/11/2016

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K 012	Continued From page 4 wrapped in a light colored plastic bag. There was a 1 foot by 1 foot wooden panel near the pipe on the concrete roof above the drop ceiling. During an interview at 9:34 a.m., on 12/15/15, when shown a picture of the pipe and wood panel in the 6C attic, the Project Manager (PM1) stated that wood paneling should not be used for a Type I building. At 9:56 a.m., on 12/18/15, the pipe was still insulated with the plastic bag and the wood panel was still present. Pavilion First Floor: 3. At 3:49 p.m., on 12/14/15, there was an approximately 2 foot by 2 foot penetration in the wall behind the steam pipe in the kitchen closet. The pipe penetrated the floor into the basement and there was an approximately 2 inch penetration in the floor around the pipe. The basement was visible through the penetration. During an interview at 3:50 p.m., the Director of Facilities Services (DFS1) stated that the steam line was recently repaired. He stated that the pipe still needed to be insulated to cover the hole in the floor and the wall still needed to be patched. Hollywood First Floor: 4. At 12:20 p.m., on 12/17/15, there was an approximately 2 foot by 1 foot rectangular hole in the concrete corridor wall into the dietary suite (cafeteria and kitchen). The penetration was	K 012	9. Hospital Leadership and the Director of Facilities discussed the need for additional plant department staff resources. Based on these discussions, job positions were advertised for two general maintenance staff, one plumber, and one HVAC specialist. Interviews were initiated the week of 3/1/16. As of 3/8/16, over 30 candidates have been screened and interviewed. The plumber is pending hire and the Hospital continues to search for qualified candidates for the other three positions. 10. An Environment of Care (EOC) Committee meeting was held on 3/2/16 to discuss the Life Safety survey findings and plan of correction. The EOC Committee is meeting monthly until the Committee (in consultation with the Quality Council) determines that the committee can be held quarterly. 11. The Hospital hired an Environmental Health and Safety Manager, who is responsible for managing and implementing the environmental health and safety program. This includes hazard identification evaluation and control, accident/ injury prevention, hazardous materials/waste management, emergency preparedness, fire/life safety, ergonomics, and environmental regulatory compliance. The Manager works closely the Director of Facilities and reports directly to the Vice President of Facilities Development. 12. Compliance with Life Safety requirements was added as a quarterly standing agenda at Governing Board meetings.	03/08/2016 03/02/2016 02/29/2016

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K 012	Continued From page 5 observed above the attic access panel in the corridor outside the cafeteria. Tower: 5. At 4:15 p.m., on 12/16/15, there was approximately 4 feet by 4 feet opening in the wall of the east stairwell on the first floor. The opening exposed metal-like poles and meshed wiring. During an interview at 4:16 p.m., the Chief Operating Officer (COO) stated he believed the opening was done for seismic testing of the building. During an interview at 10:55 a.m., on 12/18/15, PM 1 confirmed the opening was done for seismic testing of the building. Approved plans for the seismic testing from the Office of Statewide Health Planning and Development (OSHPD), dated 5/20/14, were provided by PM1. Under the "KEYNOTES" section of the approved plans, the facility was to restore the wall back to its original fire/smoke integrity after seismic testing. The facility failed to restore the wall back to its original integrity as stated in the approved plans from the authority having jurisdiction.	K 012	13. Monitoring penetrations is included in the preventive maintenance (PM) program and weekly scheduled EOC Rounds for penetrations below the smoke/fire doors. Quarterly inspections will be done by facilities staff above the smoke/fire doors. In addition, for contracts that do work above the smoke/fire doors, inspections will be done by facilities at the end of the project. Compliance and Monitoring: Data on compliance is tracked, trended, analyzed and is reported monthly at the EOC Committee. Corrective action is taken as necessary. Compliance is reported monthly to the Quality Council (until the Quality Council determines monitoring of the building is sufficiently conducted and then reporting will be provided quarterly to the Quality Council) and quarterly to the Governing Board. Persons Responsible: Vice President of Facilities Development Director of Facilities	03/10/2016
K 018	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20	K 018	NFPA 101 LIFE SAFETY CODE STANDARD Findings 1-4 Actions Taken:	

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K 018	Continued From page 6 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their corridor doors. This was evidenced by doors that were obstructed from closing and by doors that failed to latch. This affected one of six floors in the Pavilion and two of six floors in the Hollywood Building. This could result in the spread of smoke and fire throughout the facility and the increased risk of injury to patients due to smoke and fire. NFPA 101, Life Safety Code, 2000 Edition. 19.2.2.2.1 Doors complying with 7.2.1 shall be permitted. 7.2.1.8.1 A door normally required to be kept closed shall not be secured in the open position at any time and shall be self-closing or automatic-closing in accordance with 7.2.1.8.2. Findings:	K 018	1. The rolled up towel was removed from the door to Room 622 on 12/15/15. The Director of Facilities discussed the survey findings with the Unit Charge Nurse, with special emphasis on reminding staff not to obstruct doors with towels or any other device. 2. The self-closing door to the shower room near Stairwell 1 at Hollywood (4th floor) was repaired and proper latching was validated. 3. The self-closing door to the shower room near Room 408 was repaired and proper latching was validated. 4. The self-closing door to the storage room across from Room 507 was repaired and proper latching was validated. 5. The Hospital issued a notice reminding staff to report any issues with positive latching of doors and not to block doors from properly latching. 6. The Director of Facilities discussed the process for monitoring positive latching of fire doors with department staff. Fire doors that fail to properly latch upon closure are to be reported to the Facilities Department and a work order is generated. Corrective action to ensure the door(s) then positively latch is taken and documented. Facilities staff was re-inserviced. 7. Facilities Department staff made rounds throughout the hospitals to assess for proper door latching. Corrective action was taken as necessary to ensure that the doors positively latch.	12/18/2015 01/07/2016 01/07/2016 01/07/2016 03/11/2016 03/11/2016 04/22/2016

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K 018	Continued From page 7 During the facility tour with staff from 12/14/15 to 12/18/15, the corridor doors were observed. Pavilion Sixth Floor: 1. At 4:09 p.m., on 12/15/15, the door to Room 622 was obstructed from closing by a rolled up towel positioned by the door leaf. This finding was previously cited during a Life Safety Code Survey conducted in September 2015. Hollywood Fourth Floor: 2. At 10:17 a.m., on 12/17/15, the self-closing door to the shower room near Stairwell 1 failed to latch. 3. At 10:26 a.m., on 12/17/15, the self-closing door to the shower room near Room 408 failed to latch. Hollywood Fifth Floor: 4. At 10:36 a.m., on 12/17/15, the self-closing door to the storage room across from Room 507 failed to latch.	K 018	Work commenced with a new commercial door company on 2/22/16. Because of the amount of doors, it may take up to two months to complete all repairs/replacements. 8. Proper closing and latching of self-closing doors is tested through the PM program and scheduled EOC rounds. EOC rounds also include observation of any fire doors that are propped open with any substance or in any manner. Compliance and Monitoring: Data on compliance is tracked, trended, analyzed and is reported monthly at the EOC Committee. Corrective action is taken as necessary. Compliance is reported monthly to the Quality Council (until the Quality Council determines monitoring of the building is sufficiently conducted and then reporting will be provided quarterly to the Quality Council) and quarterly to the Governing Body. Persons Responsible: Vice President of Facilities Development Director of Facilities	
K 025	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two	K 025	NFPA 101 LIFE SAFETY CODE STANDARD	

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K 025	Continued From page 8 separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the fire resistance rating of the smoke barrier walls. This was evidenced by penetrations in one smoke barrier wall. This finding affected one of seven floors in the Tower. This deficient practice could result in the faster spread of smoke and fire between smoke compartments and the increased risk of injury to patients, in the event of a fire. NFPA 101, Life Safety Code, 2000 Edition 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. 8.3.6.1 Pipes, conduits, ducts, cables, wires, air ducts, pneumatic tube and ducts, and similar building services equipment that pass through floors and smoke barriers shall be protected as follows: (1) The space between the penetrating item and the smoke barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed of the specific purpose.	K 025	Actions Taken: 1. The a) penetration around wires and around a conduit in the attic smoke barrier wall by the housekeeping closet outside the emergency department overflow and b) dime size penetration on the opposite side of the wall were repaired with fire retardant sealant. 2. The Director of Facilities emphasized the importance of monitoring for penetrations in smoke barrier walls and instituting corrective action upon identification with Department staff. Work orders are completed, repairs instituted, and documentation of repair is maintained in the Facilities Department. 3. Monitoring penetrations is included in the preventive maintenance (PM) program and weekly scheduled EOC Rounds for penetrations below the smoke/fire doors. Quarterly inspections will be done by facilities staff above the smoke/fire doors. In addition, for contracts that do work above the smoke/fire doors, inspections will be done by facilities at the end of the project.	02/29/2016 03/11/2016 03/10/2016

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K 025	Continued From page 9 (2) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (3) Where designs take transmission of vibration into consideration, any vibration isolation shall meet one of the following: a. It shall be made on either side of the smoke barrier. b. It shall be made by an approved device that is designed for the specific purpose. Findings: During the facility tour with staff from 12/14/15 to 12/18/15, the smoke barrier walls were observed. Tower First Floor: 1. At 9:30 a.m., on 12/18/15, there was a 1 inch penetration around wires and a 1/2 inch penetration around a conduit in the attic smoke barrier wall, by the housekeeping closet outside the emergency department overflow. There was a dime size penetration on the opposite side of the wall. The above findings were acknowledged by the Director of Facilities Services (DFS1).	K 025	Compliance and Monitoring: Data on compliance is tracked, trended, analyzed and is reported monthly at the EOC Committee. Corrective action is taken as necessary. Compliance is reported monthly to the Quality Council (until the Quality Council determines monitoring of the building is sufficiently conducted and then reporting will be provided quarterly to the Quality Council) and quarterly to the Governing Board. Persons Responsible: Vice President of Facilities Development Director of Facilities	
K 027	NFPA 101 LIFE SAFETY CODE STANDARD	K 027	NFPA 101 LIFE SAFETY CODE STANDARD	

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K 027	Continued From page 10 Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain its smoke barrier doors. This was evidenced by smoke barrier doors that failed to close and latch upon activation of the fire alarm system. This affected six of six floors and the basement of the Pavilion. These findings could result in the faster spread of smoke and fire from one smoke compartment to another. This could result in the increased risk of injury to patients, visitors, and staff, in the event of a fire. NFPA 101, Life Safety Code 2000 Edition 4.61.2 Any requirement that are essential for the safety of building occupants and that are not specifically provided for by this Code shall be determined by the authority having jurisdiction. 19.3.7.6 Doors in smoke barriers shall comply with 8.3.4 and shall be self-closing or automatic-closing in accordance with 19.2.2.2.6. Such doors in smoke barriers shall not be required to swing with egress travel. Positive latching hardware shall not be required.	K 027		

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K 027	Continued From page 11 8.2.3.2.1 Door assemblies in fire barriers shall be of an approved type with the appropriate fire protection rating for the location in which they are installed and shall comply with the following. (a) Fire doors shall be installed in accordance with NFPA 80, Standard for Fire Doors and Fire Windows. Fire doors shall be of a design that has been tested to meet the conditions of acceptance of NFPA 252, Standard Methods of Fire Tests of Door Assemblies. Exception: The requirement of 8.2.3.2.1(a) shall not apply where otherwise specified by 8.2.3.2.3.1. (b) Fire doors shall be self-closing or automatic-closing in accordance with 7.2.1.8 and, where used within the means of egress, shall comply with the provisions of 7.2.1. NFPA 80, Standard for Fire Doors and Fire Windows, 1999 edition. 2-5.2 Manufacturers' Instructions. All components shall be installed in accordance with the manufacturers' installation instructions and shall be adjusted to function as described in the listing. Findings: During a facility tour with staff from 12/14/15 to 12/18/15, the smoke barrier doors were observed during fire alarm testing. The fire alarm vendor was present for fire alarm testing. Pavilion First Floor: 1. At 10:18 a.m., on 12/16/15, the smoke barrier double doors to the kitchen were held open with electronic automatic-closing devices. The smoke	K 027	Findings 1-8 Actions Taken: 1. The identified floor mat was removed. The Engineering staff validated proper closure of the smoke barrier door double doors to the kitchen.	02/29/2016

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K 027	Continued From page 12 barrier double doors failed to close and latch upon activation of a fire alarm device. A floor mat obstructed the doors from closing and latching. Second Floor: 2. At 10:21 a.m., on 12/16/15, the smoke barrier double doors by Room 209 were held open with magnetic automatic-closing devices. One leaf failed to close and latch upon activation of a fire alarm device. The fire alarm vendor stated that it was due to a malfunctioning magnetic holder. Third Floor: 3. At 10:50 a.m., on 12/16/15, the smoke barrier double doors by Room 332 were held open with magnetic automatic-closing devices. The doors failed to close and latch upon activation of a fire alarm device. 4. At 10:56 a.m., on 12/16/15, the smoke barrier double doors by Room 310 were held open with magnetic automatic-closing devices. One leaf failed to release from the magnetic holder upon activation of a fire alarm device. Fourth Floor: 5. At 11:04 a.m., on 12/16/15, the smoke barrier double doors by Room 433 were held open with magnetic automatic-closing devices. The double doors failed to close and latch upon activation of a fire alarm device. Fifth Floor: 6. At 11:11 a.m., on 12/16/15, the smoke barrier double doors by Room 509 were held open with magnetic automatic-closing devices. One leaf failed to close upon activation of a fire alarm device. There were drag marks on the floor beneath the door frame.	K 027	2. The Hospital hired a company to perform an assessment of fire door functionality throughout the facility. The hospital then hired a company in January to assess and repair applicable fire doors but it was subsequently determined that their work was ineffective. Hospital Leadership terminated the company, and engaged a new door company on 2/22/16 to perform an assessment of all fire doors and repair/replace all smoke barrier doors as necessary. Repairs to all doors listed in the survey report were made in addition to other doors identified as requiring repair throughout the facility. However because of the volume of doors, it may take up to two months to complete all repairs/replacements. 3. The Director of Facilities emphasized the importance of monitoring for positive latching of smoke barrier doors. Smoke barrier doors that fail to properly latch upon closure are reported to the Facilities Department and a work order is generated. Corrective action is taken and evidence of repairs is maintained in the Facilities Department. 4. The Hospital issued a notice to reminding staff to report any issues with positive latching of smoke barrier doors. 5. Proper latching of smoke barrier doors is tested quarterly through the building PM program and as part of scheduled EOC rounds. All smoke barrier doors are inspected quarterly.	04/22/2016 03/11/2016 03/11/2016

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K 027	Continued From page 13 During an interview at 11:12 a.m., the Chief Operating Officer (COO) observed that the door leaf that failed to close was hanging lower from the top of the door frame than the door leaf that successfully closed. Sixth Floor: 7. At 11:31 a.m., on 12/16/15, the smoke barrier double doors by Room 601 were held open with magnetic automatic-closing devices. The smoke barrier double doors failed to close and latch upon activation of a fire alarm device. Basement: 8. At 2:33 p.m., on 12/16/15, the smoke barrier double doors to the entrance of the Tunnel were held open with magnetic automatic-closing devices. The smoke barrier double doors failed to close and latch upon activation of a fire alarm device. The smoke barrier doors were tested 3 times and failed. The above findings were acknowledged by the fire alarm vendor and COO.	K 027	Compliance and Monitoring: Data on compliance is tracked, trended, analyzed and is reported monthly at the EOC Committee. Corrective action is taken as necessary. Compliance is reported monthly to the Quality Council (until the Quality Council determines monitoring of the building is sufficiently conducted and then reporting will be provided quarterly to the Quality Council) and quarterly to the Governing Board. Persons Responsible: Vice President of Facilities Development Director of Facilities	
K 045	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on record review and interview, the facility	K 045	NFPA 101 LIFE SAFETY CODE STANDARD	

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K 045	Continued From page 14 failed to ensure that emergency lighting is provided in the egress stairwells. This was evidenced by staff that were unfamiliar with the presence of emergency lights in the stairwell and by the absence of documentation of monthly inspections of emergency lights in the stairwells. This affected the Pavilion and Tower stairwells and could result in the increased risk of injury in the event of dim or no lighting during an evacuation. NFPA 101, Life Safety Code, 2000 Edition. 19.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9. 19.7.1.3 Employees of health care occupancies shall be instructed in life safety procedures and devices 7.9.1.1 Emergency lighting facilities for means of egress shall be provided in accordance with Section 7.9 for the following: (1) Buildings or structures where required in Chapters 11 through 42 (2) Underground and windowless structures as addressed in Section 11.7 (3) High-rise buildings as required by other sections of this Code (4) Doors equipped with delayed egress locks (5) The stair shaft and vestibule of smokeproof enclosures, which shall be permitted to include a standby generator that is installed for the smokeproof enclosure mechanical ventilation equipment and used for the stair shaft and vestibule emergency lighting power supply For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways	K 045		

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K 045	Continued From page 15 leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, ramps, aisles, walkways, and escalators leading to a public way. 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and test shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30 day functional test, provided that a visual inspection is performed at 30-day intervals. NFPA 70, National Electrical Code, 1999 Edition. 517-42. Automatic Connection to Life Safety Branch. The life safety branch shall be installed and connected to the alternate source of power so that all functions specified herein shall be automatically restored to operation within 10 seconds after the interruption of the normal source. No functions other than those listed in (a) through (g) shall be connected to the life safety branch. The life safety branch shall supply power for the following lighting, receptacles, and equipment. (a) Illumination of Means of Egress. Illumination	K 045		

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K 045	Continued From page 16 of means of egress as is necessary for corridors, passageways, stairways, landings, and exit doors and all ways of approach to exits. Switching arrangement to transfer patient corridor lighting from general illumination circuits shall be permitted providing only one of two circuits can be selected and both circuits cannot be extinguished at the same time. Findings: During a facility tour with staff from 12/14/15 to 12/18/15, the stairwells were observed. Culver City Campus: 1. The facility failed to provide documentation to show that emergency lights were inspected in the stairway enclosures of the Tower and Pavilion and connection of the lights in the stairwells to emergency power could not be verified by documentation. This finding was previously cited during a Life Safety Code Survey conducted in September 2015 under K046. During the September survey, facilities staff were unsure if the stairwells were equipped with emergency lighting. During an interview at 3:24 p.m., on 12/15/15, the Plant Operations Lead Staff (PO1) was asked if the stairwells were equipped with emergency lights and if they would be continuously illuminated during a power outage. PO1 stated that the lights were hooked up to the generator power but there were no records of inspecting them monthly.	K 045	1. Hospital Leadership engaged an electrical vendor to assess the lights in the stairway enclosures of the Tower and Pavilion. The electrician confirmed that the lights are on emergency power and would be continuously illuminated during a power outage. 2. Inspection of emergency lighting in egress stairwell enclosures for all three campuses was performed and the records are maintained in the Facilities Department. 3. The Director of Facilities inserviced the department staff on emergency lights in egress stairway enclosures of the Tower and Pavilion, with special emphasis on these lights being on emergency power in the event of a power outage, how to perform the inspection and that inspections are to occur on a monthly basis, and documentation is maintained in the Facilities Department. 4. Emergency lighting in egress stairway enclosures is monitored monthly with generator testing. Compliance and Monitoring: Data on compliance is tracked, trended, analyzed and is reported monthly at the EOC Committee. Corrective action is taken as necessary. Compliance is reported monthly to the Quality Council (until the Quality Council determines monitoring of the building is sufficiently conducted and then reporting will be provided quarterly to the Quality Council) and quarterly to the Governing Board.	02/29/2016 02/29/2016 03/11/2016

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K 045	Continued From page 17 During an interview at 4:05 p.m., on 12/17/15, the Facilities Operations Manager did not readily know if the stairwells were equipped with emergency lights.	K 045	Persons Responsible: Vice President of Facilities Development Director of Facilities	
K 046	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to maintain their battery-powered emergency lights. This was evidenced by emergency lights that failed when tested and by no records of testing the battery-powered emergency lights. This affected the offsite Spine Clinic. This could result in a delay in evacuation due to limited visibility, in the event of an emergency. NFPA 101, Life Safety Code, 2000 Edition. 19.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9. 19.7.1.3 Employees of health care occupancies shall be instructed in life safety procedures and devices 7.9.1.1 Emergency lighting facilities for means of egress shall be provided in accordance with Section 7.9 for the following: (1) Buildings or structures where required in Chapters 11 through 42 (2) Underground and windowless structures as addressed in Section 11.7	K 046	NFPA 101 LIFE SAFETY CODE STANDARD Findings 1 and 2 Actions Taken: 1. The battery-powered emergency lighting unit in the exit hallway outside Exam Room 3 in the Outpatient Spine Clinic was repaired and illumination was validated. 2. Hospital Leadership consulted with the Landlord for the outpatient spine center clinic building emphasizing that monthly and annual testing of the battery-powered emergency lights in the Spine Clinic is to be performed and documentation of compliance and/or remedial action taken is to be provided to the Director of Facilities on a monthly basis. 3. Evidence of 2016 monthly testing of the battery-powered emergency lights in the Spine Clinic is available in the Facilities Department. The annual testing was completed.	03/04/2016 02/29/2016 03/07/2016

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K 046	Continued From page 18 (3) High-rise buildings as required by other sections of this Code (4) Doors equipped with delayed egress locks (5) The stair shaft and vestibule of smokeproof enclosures, which shall be permitted to include a standby generator that is installed for the smokeproof enclosure mechanical ventilation equipment and used for the stair shaft and vestibule emergency lighting power supply For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, ramps, aisles, walkways, and escalators leading to a public way. 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and test shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30 day functional test, provided that a visual inspection is performed at 30-day intervals. Findings:	K 046	4. Monitoring compliance with monthly and annual testing of the battery-powered emergency lights in the Spine Clinic is performed through PM and scheduled EOC rounds. Compliance and Monitoring: Data on compliance is tracked, trended, analyzed and is reported monthly at the EOC Committee. Corrective action is taken as necessary. Compliance is reported monthly to the Quality Council (until the Quality Council determines monitoring of the building is sufficiently conducted and then reporting will be provided quarterly to the Quality Council) and quarterly to the Governing Board. Persons Responsible: Vice President of Facilities Development Director of Facilities	

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	050135	A. BUILDING 01 B. WING	12/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	6245 DE LONGPRE AVE HOLLYWOOD, CA 90028

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K 046	Continued From page 19 During a facility tour with staff from 12/14/15 to 12/18/15, the emergency lights were observed and maintenance logs were requested. Outpatient Spine Clinic: 1. At 1:44 p.m., on 12/15/15, the battery-powered emergency lighting unit, in the exit hallway outside Exam Room 3, failed to illuminate when tested by the Plant Operations Lead Staff (PO1). 2. At 1:52 p.m., on 12/15/15, testing records of the battery-powered emergency lights were requested. On 12/18/15, at 8:26 a.m., records of annual 90 minute testing (conducted 9/17/15) of the emergency lights in the common areas outside the Spine Clinic were provided. There were no records of monthly and annual testing the battery-powered emergency lights in the Spine Clinic.	K 046		
K 047	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to maintain their exit signs. This was evidenced by one exit sign with battery-operated emergency illumination that failed when tested, by one exit sign that was not illuminated, and by no records of testing the exit signs. This affected the offsite Spine Clinic and	K 047	NFPA 101 LIFE SAFETY CODE STANDARD Findings 1-4 Actions Taken: 1. Hospital Leadership discussed the survey findings with the Director of Facilities. Monthly checks of the exit signs has been added to the monthly department checks. Documentation is maintained in the Facilities Department. Monthly monitoring of the exit signs was completed on 1/29/16 and 2/27/16. Department staff were inserviced on the monthly/annual monitoring of exit signs. 2. The Hospital repaired the exit sign outside Exam Room 1 and validated its illumination.	03/11/2016 12/29/2015

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K 047	Continued From page 20 the basement of the Pavilion. This could result in a delay in evacuation, in the event of an emergency. NFPA 101, Life Safety Code, 2000 Edition. 7.10.1.1 Where Required. Means of egress shall be marked in accordance with Section 7.10 where required in Chapters 11 through 42. 7.10.4 Power Source. Where emergency lighting facilities are required by the applicable provisions of Chapters 11 through 42 for individual occupancies, the signs, other than approved self-luminous signs, shall be illuminated by the emergency lighting facilities. The level of illumination of the signs shall be in accordance with 7.10.6.3 or 7.10.7 for the required emergency lighting duration as specified in 7.9.2.1. However, the level of illumination shall be permitted to decline to 60 percent at the end of the emergency lighting duration. 7.10.5.1 General. Every sign required by 7.10.1.2 or 7.10.1.4, other than where operations or processes require low lighting levels, shall be suitably illuminated by a reliable light source. Externally and internally illuminated signs shall be legible in both the normal and emergency lighting mode. 7.10.5.2 Continuous Illumination. Every sign required to be illuminated by 7.10.6.3 and 7.10.7 shall be continuously illuminated as required under the provisions of Section 7.8. Exception: Illumination for signs shall be permitted to flash on and off upon activation of the fire alarm system. 7.10.9.1 Inspection. Exit signs shall be visually	K 047	3. The Hospital repaired the exit sign in the waiting room and validated its illumination. 4. The Hospital repaired the exit sign in the back of the Microbiology Lab and validated its illumination. 5. Monitoring illumination of exit signs is part of PM program and scheduled EOC rounds. Compliance and Monitoring: Data on compliance is tracked, trended, analyzed and is reported monthly at the EOC Committee. Corrective action is taken as necessary. Compliance is reported monthly to the Quality Council (until the Quality Council determines monitoring of the building is sufficiently conducted and then reporting will be provided quarterly to the Quality Council) and quarterly to the Governing Board. Persons Responsible: Vice President of Facilities Development Director of Facilities	12/29/2015 12/29/2015

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K 047	Continued From page 21 inspected for operation of the illumination sources at intervals not to exceed 30 days. 7.10.9.2 Testing. Exit signs connected to or provided with a battery-operated emergency illumination source, where required in 7.10.4, shall be tested and maintained in accordance with 7.9.3. 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and test shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30 day functional test, provided that a visual inspection is performed at 30-day intervals. Findings: During a facility tour with staff from 12/14/15 to 12/18/15, the exit signs were observed and maintenance records were requested. Outpatient Spine Clinic: 1. At 1:52 p.m., on 12/15/15, records of monthly and annual testing of the exit signs were not	K 047		

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K 047	Continued From page 22 provided. 2. At 2:02 p.m., on 12/15/15, the exit sign outside Exam Room 1 was equipped with battery-powered emergency illumination. The exit sign failed to illuminate when tested by Plant Operations Lead Staff (PO1). 3. At 2:06 p.m., on 12/15/15, the exit sign in the waiting area was not illuminated. PO1 removed the cover and the bulbs in the exit sign were not lit. Pavilion Basement: 4. At 3:34 p.m., on 12/17/15, the exit sign in the back of the Microbiology Laboratory was not illuminated.	K 047		
K 048	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure that staff members were aware of their duties to protect patients in the event of a fire and other emergencies. This was evidenced by the failure of security staff to implement their fire response procedures during a Code Red (the facility's code word for fire) and by staff that were unfamiliar with the facility's evacuation procedures. This was also evidenced by no records of semi-annual	K 048	NFPA 101 LIFE SAFETY CODE STANDARD	

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K 048	Continued From page 23 disaster drills conducted at the Van Nuys Building. This affected the safety of patients in the Pavilion and Van Nuys Building. These deficient practices could result in a delay in staff response in the event of a fire or other emergency. NFPA 101, Life Safety Code, 2000 Edition. 4.6.1.2 Any requirements that are essential for the safety of building occupants and that are not specifically provided for by this Code shall be determined by the authority having jurisdiction. 19.7.1.1 The administration of every health care occupancy shall have, in effect and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire, for their evacuation to areas of refuge, and for their evacuation from the building when necessary. All employees shall be periodically instructed and kept informed with respect to their duties under the plan. A copy of the plan shall be readily available at all times in the telephone operator's position or at the security center. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.1.3 Employees of health care occupancies shall be instructed in life safety procedures and devices. 19.7.2 Procedure in Case of Fire. 19.7.2.1 For health care occupancies, the proper protection of patients shall require the prompt and effective response of health care personnel. The basic response required of staff shall include the removal of all occupants directly involved with the fire emergency, transmission of an appropriate fire alarm signal to warn other building occupants	K 048		

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K 048	Continued From page 24 and summon staff, confinement of the effects of the fire by closing doors to isolate the fire area, and the relocation of patients as detailed in the health care occupancy's fire safety plan. 19.7.2.2 A written health care occupancy fire safety plan shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire NFPA 99, Standard for Health Care Facilities, 1999 Edition. Chapter 12 Hospital Requirements 12-1 Scope. This chapter addresses safety requirements of hospitals. 12-3.11 Hospitals shall comply with the provisions of Chapter 11 for disaster planning, as appropriate. Chapter 11 Health Care Emergency Preparedness 11-5.3.6 Security. Security plans shall be developed that address facility access, crowd control, security staff needs, and traffic control. 11-5.3.8 Staff Education. Each health care facility shall implement an educational program. This program shall include an overview of the components of the emergency preparedness plan and concepts of the Incident Command System. Education concerning the staff's specific duties and responsibilities shall be conducted upon	K 048		

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K 048	Continued From page 25 reporting to their assigned departments or position. General overview education of the Emergency Preparedness Plan and the Incident Command System shall be conducted at the time of hire. Department/staff specific education shall be conducted upon reporting to their assignments or position and annually thereafter. 11-5.3.9 Drills. Each organizational entity shall implement one or more specific responses of the emergency preparedness plan at least semi-annually. At least one semi-annual drill shall rehearse mass casualty response for health care facilities with emergency services, disaster receiving stations, or both. Findings: During a facility tour with staff from 12/14/15 to 12/18/15, a Code Red incident occurred and staff response was observed. Pavilion: 1. At 12:40 p.m., on 12/14/15, the fire alarm system was activated. An overhead announcement "Code Red Pavilion Sixth Floor" was made by the facility's automatic paging system. PBX staff also made an overhead announcement "Room 633 Code Red." At 12:42 p.m., on the first floor, two security staff with fire extinguishers and four hospital staff entered the elevator. The elevator stopped at every floor before reaching the sixth floor. During an interview at 12:42 p.m., Security Staff (SS2) stated that they did not have the "autokey" that allows the elevator to go directly to the sixth	K 048	Findings 1-2 Pavilion and Van Nuys Actions Taken: 1. Hospital Leadership, the Director of Facilities and Director of Security discussed the survey findings regarding response to Code Reds, disaster drills and employee education. Hospital Leadership emphasized the expectation of strict adherence to the Life Safety Management Plan and Fire Response Plan. The "Life Safety Management" and Fire Response" Plans were reviewed. The Life Safety Management Plan was updated to clarify the process for fire drills. The auto-key is maintained at the security front desk and security is stationed there 24 hours/ day. Security staff was re-educated on their role during fire emergencies, including use of the auto-key and use of the stairs and not the elevators when responding to a fire. The Hospital conducted eight random fire drills on the Culver City Campus on 12/30 and 12/31/15. No issues were identified with use of the auto-key and responding via the stairs versus the elevators. Quarterly fire drills for 2016 were conducted on the Culver City Campus between 2/26/16 and 3/2/16. No issues were identified with use of the auto-key and using the stairs versus the elevators. Documentation of the fire drills is maintained in the Facilities Department.	12/31/2015 03/02/2016

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K 048	Continued From page 26 floor. At 12:45 p.m., two engineering staff arrived to Room 633 and determined that the cause of the fire alarm activation was due to a patient that broke the smoke detector in the bathroom. During an interview at 12:46 p.m., SS2 stated that only the dispatcher and the security supervisor had the autokey for the elevator. She stated that security staff is trained not use the elevator during Code Red events and to use the stairs instead. During an interview at 1:05 p.m., Security Staff/Dispatcher (SS1) stated that during a Code Red event, security staff are supposed to recall the elevators and block people from using them until the Code Red is cleared. He stated that it was the hospital's policy that responding security staff are trained to use the stairs and not the elevators. Van Nuys: 2. At 12:02 p.m., on 12/16/15, there were no records of disaster drills conducted at the Van Nuys facility. During an interview at 12:03 p.m., the disaster coordinator stated that disaster drills are held semi-annually at the Hollywood facility and Van Nuys staff are called over the phone and told to respond. Review of the staff participation list for the earthquake drill on 6/11/15 at Hollywood indicated that only one staff from Van Nuys participated in the drill.	K 048	2. Hospital Leadership reviewed the "Disaster Drill" Policy, which did not require any revisions. Disaster drills are held semi-annually, with documentation maintained in the Facilities Department. On 1/6/16, the Hospital conducted a Command Center Management Training session. This included members of Administration, EOC, Management and Support Staff. The purpose of the training was to clarify their roles in the event of a disaster. On 3/14/16, the Hospital held a Code Silver disaster drill at Van Nuys regarding a person with a weapon/ hostage situation. An evaluation of the drill was conducted with lessons learned from the drill discussed with the disaster planning committee. They will be incorporated into further disaster planning. 3. Hospital Leadership reviewed the "Evacuation" Policy, which did not require any revisions. Education on Fire Safety and Evacuation procedures (including levels of evacuation) is provided as part of hospital orientation. In addition, education is reinforced during Quarterly Fire Drills, with querying of evacuation levels and re-education is provided as necessary. Staff training was provided between 3/2/16 and 3/9/16, on the topics of partial evacuation (to a safe area behind smoke barrier doors) and horizontal and vertical evacuations. Training was also re-emphasized during daily staff huddles on the clinical areas. Hospital Leadership or qualified designees performed random spot checks of staff to confirm understanding of partial, horizontal and vertical evacuations, and if necessary, just-in-time training was provided.	03/14/2016 03/09/2016

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K 048	Continued From page 27 Pavilion: 3. The facility's evacuation policy was reviewed and indicated that partial evacuation was to a safe area behind smoke barrier doors. The policy also indicated that staff should be familiar with horizontal evacuation and vertical evacuation. During an interview at 10:44 a.m., on 12/16/15, a Registered Nurse stated she was unfamiliar with the terms partial evacuation, horizontal evacuation, and vertical evacuation and or the purpose of the smoke barrier doors in an evacuation. During an interview at 11:50 a.m., on 12/16/15, a Mental Health Technician stated he was unfamiliar with the terms partial evacuation, horizontal evacuation, and vertical evacuation or what would be a safe area (behind smoke barrier doors) for a partial evacuation.	K 048	4. Compliance with fire and disaster drills is monitored through scheduled EOC rounds. Compliance and Monitoring: Data on compliance is tracked, trended, analyzed and is reported monthly at the EOC Committee. Corrective action is taken as necessary. Compliance is reported monthly to the Quality Council (until the Quality Council determines monitoring of the building is sufficiently conducted and then reporting will be provided quarterly to the Quality Council) and quarterly to the Governing Board. Persons Responsible: Vice President of Facilities Development Director of Facilities Director of Security	
K 050	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on document review and interview, the	K 050	NFPA 101 LIFE SAFETY CODE STANDARD	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 050	Continued From page 28 facility failed to ensure that staff members were aware of their duties to protect patients in the event of a fire. This was evidenced by no records of a fire drill conducted at the Culver Medical Plaza where the offsite Spine Clinic is located, by a Pavilion fire drill that was not attended by majority of staff, and by staff that were not aware of their responsibilities in the event of a fire. This could result in improper staff response in the event of a fire and an increased risk of injury to patients. This affected the Culver City Campus and the Spine Clinic. NFPA 101 Life Safety Code, 2000 Edition 19.7.1.2 Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9 p.m. (2100 hours) and 6 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to exterior of the building. 19.7.1.3 Employees of health care occupancies shall be instructed in life safety procedures and devices. 39.7.1 Drills. In any business occupancy building occupied by more than 500 persons or more than 100 persons above or below the street level, employees and supervisory personnel shall be periodically instructed in accordance with Section	K 050		

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K 050	Continued From page 29 4.7 and shall hold drills periodically where practicable. 39.7.2 Extinguisher Training. Designated employees of business occupancies shall be periodically instructed in the use of portable fire extinguishers. 4.7.1 Where Required. Emergency egress and relocation drills conforming to the provisions of this Code shall be conducted as specified by the provisions of Chapters 11 through 42, or by appropriate action of the authority having jurisdiction. Drills shall be designed in cooperation with the local authorities. 4.7.2 Drill Frequency. Emergency egress and relocation drills, where required by Chapters 11 through 42 or the authority having jurisdiction, shall be held with sufficient frequency to familiarize occupants with the drill procedure and to establish conduct of the drill as a matter of routine. Drills shall include suitable procedures to ensure that all persons subject to the drill participate. 4.7.5 Simulated Conditions. Drills shall be held at expected and unexpected times and under varying conditions to simulate the unusual conditions that can occur in an actual emergency. 4.7.6 Relocation Area. Drill participants shall relocate to a predetermined location and remain at such location until a recall or dismissal signal is given. Findings: During a facility tour with staff from 12/14/15 to	K 050		

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K 050	Continued From page 30 12/18/15, the fire drill records were reviewed and staff were interviewed about fire response procedures. Outpatient Spine Clinic: 1. At 1:53 p.m., on 12/15/15, the fire drill records were requested. No fire drill records were provided for the Spine Clinic as of 8:25 a.m. on 12/18/15. Pavilion: 2. At 11:12 a.m., on 12/18/15, the facility's fire drill policy, in the disaster manual, indicated that at least 90 percent of hospital staff would participate in the fire drills. At 9:20 a.m., on 12/15/15, records showed that one fire drill was conducted in October 2015 at 9:10 p.m. in the Transitional Care Unit. The sign-in sheet indicated that only five staff participated. Records showed that this was the only fire drill conducted since the last Life Safety Code Survey in September 2015. During an interview at 2:21 p.m., on 12/16/15, the Director of Laboratory Services confirmed that laboratory staff do not participate in facility-wide drills. During an interview at 11:10 a.m., on 12/18/15, the Vice President of Facilities Services confirmed that only five staff signatures were on the fire drill's participation sign-in sheet. The facility failed to ensure that 90% of staff participated in the fire drill per their policy. 3. The fire response plan indicated that, in the	K 050	Findings 1-3 Actions Taken: 1. The Director of Facilities and Hospital Leadership discussed the process for fire drills at the Spine Clinic. Fire Drills are to be performed quarterly. The first Quarter 2016 fire drill was conducted in the Spine Clinic on 3/1/16. Documentation is maintained in the Facilities Department. 2. Hospital Leadership reviewed and revised the "Life Safety Management Plan" to further clarify the process for fire drills. Hospital Leadership discussed the survey findings with department managers, with special emphasis on staff participation in fire drills. The Hospital conducted eight random fire drills on the Culver City Campus (Pavilion) on 12/30 and 12/31/15. Quarterly fire drills for 2016 were conducted on the Culver City Campus between 2/26/15 and 3/2/16. Documentation of the fire drills is maintained in the Facilities Department and shows active participation in the fire drill, including staff from the Lab. 3. Hospital Leadership reviewed the "Fire Response Plan," which did not require any revisions. Security staff monitoring the fire alarm panel (annunciator panel) were educated related to the differences between a supervisory tamper alarm and a fire alarm. Security staff were requested to verbalize what each alarm meant and the required responses from each alarm.	03/02/2016 03/11/2016

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	050135	A. BUILDING 01 B. WING _____	12/18/2015

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K 050	Continued From page 31 event of a fire, staff would follow R.A.C.E. (rescue, alarm, confine, extinguish/evacuate) procedures. The policy stated that staff are to rescue patients in immediate danger, notify the hospital by activating a pull station and dialing extension 5555 (PBX), confine the fire by closing the doors, and extinguish small fires with a fire extinguisher. Facility staff were asked what they would do in the event of a fire: a. During an interview at 10:44 a.m., on 12/16/15, a Registered Nurse (RN1) from the third floor stated that she would rescue the patient, close the door, pull the alarm, and sweep over the fire with a fire extinguisher if she could. She was not familiar with where on the fire she should aim the fire extinguisher and she was unfamiliar with the policy to dial the operator. b. During an interview at 11:18 a.m., on 12/16/15, a Registered Nurse (RN2) from the surgical department stated that she would shout for help, pull the fire alarm, close the doors, and wait for further information. She was unfamiliar with the entire R.A.C.E. procedures and the facility's policy to dial the operator. c. During an interview at 11:48 a.m., on 12/16/15, a Psychiatric Technician stated that he would get the patients out of the room and down the stairs, and call out code red. He was unfamiliar with the entire R.A.C.E. procedure sequence and the facility's policy. d. During an interview at 3:05 p.m., on 12/16/15, security staff at the fire alarm panel stated that she was unfamiliar with the difference between a	K 050	4. An extensive education program was initiated in the Culver City campus, which included daily rounds by managers on all shifts, effective 1/18/16, to query and inservice staff members on the fire response plan and R.A.C.E procedures. In addition, all staff members have been provided with an educational card that is to accompany their name badge (for ease of access) that virtually instructs them of the fire response R.A.C.E. process. 5. Hospital Leadership reviewed the hospital orientation program and annual skills fair, which provide education on the fire response plan. The program did not require any revisions. 6. Monitoring compliance with fire drills, including staff understanding of the fire response plan, is performed on scheduled EOC rounds. Compliance and Monitoring: Data on compliance is tracked, trended, analyzed and is reported monthly at the EOC Committee. Corrective action is taken as necessary. Compliance is reported monthly to the Quality Council (until the Quality Council determines monitoring of the building is sufficiently conducted and then reporting will be provided quarterly to the Quality Council) and quarterly to the Governing Board. Persons Responsible: Vice President of Facilities Development Director of Facilities	02/29/2016 03/18/2016

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 050	Continued From page 32 fire alarm and the supervisory tamper alarm. She incorrectly stated the supervisory tamper alarm was a smoke detector being activated. e. During an interview at 3:43 p.m., on 12/16/15, Registered Nurse (RN3) stated she would dial 5555, call out code red, close the doors, and not open the doors if they were hot. She was unfamiliar with the entire R.A.C.E. sequence. Facility staff were unfamiliar with life safety procedures and equipment.	K 050		
K 052	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the fire alarm system was maintained in reliable operating condition. This was evidenced by fire alarm devices that exhibited trouble conditions, the failure of fire alarm notification devices, and by an area where the fire alarms could not be heard. This was also evidenced by the failure to arrange for smoke	K 052	NFPA 101 LIFE SAFETY CODE STANDARD	

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K 052	Continued From page 33 detector testing at Van Nuys and fire alarm testing at the two offsite clinics. This affected the Tower, the Pavilion, the Van Nuys Building, the Hollywood Building, and two offsite clinics. This could result in delay in notification and response, in the event of a fire, and could result in the increased risk of injury. NFPA 101, Life Safety Code, 2000 Edition. 4.2.3 Systems Effectiveness. Systems utilized to achieve the goals of Section 4.1 shall be effective in mitigating the hazard or condition for which they are being used, shall be reliable, shall be maintained to the level at which they were designed to operate, and shall remain operational. 4.6.12.1 Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by the authority having jurisdiction. 19.3.4.1 General. Health care occupancies shall be provided with a fire alarm system in accordance with Section 9.6. 9.6.1.3 The provisions of Section 9.6 cover the basic functions of a complete fire alarm system, including fire detection, alarm, and communications. These systems are primarily intended to provide the indication and warning of abnormal conditions, the summoning of appropriate aid, and the control of occupancy facilities to enhance protection of life.	K 052		

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K 052	Continued From page 34 9.6.1.7 To ensure operational integrity, the fire alarm system shall have an approved maintenance and testing program complying with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code. 9.6.3.8 Audible alarm notification appliances shall be of such character and so distributed as to be effectively heard above the average ambient sound level occurring under normal conditions of occupancy. NFPA 72, National Fire Alarm Code, 1999 Edition. 2-1.3.3 Initiating devices shall be installed in all areas where required by other NFPA codes and standards or the authority having jurisdiction. Each installed initiating device shall be accessible for periodic maintenance and testing. Findings: During a facility tour with staff from 12/14/15 to 12/18/15, the fire alarm system was observed. Pavilion Basement: 1. At 11:15 a.m., on 12/14/15, the following devices exhibited trouble conditions at the main fire alarm control panels (FACPs): a. Tower 2 waiting room duct detector b. Pavilion 1 smoke detector outside pharmacy c. Tower 2nd, 4th, and 7th floor notification appliance circuit (NAC) expanders. During an interview at 1:03 p.m., on 12/14/15,	K 052	Findings 1-6 Actions Taken: 1. Hospital Leadership reviewed the survey findings with the Director of Facilities. It was determined that the identified devices in Tower 2 waiting room duct detector, Pavilion 1 smoke detector outside the pharmacy, and Tower 2, 4 and 7th floor notification appliance circuit expanders were part of an active OSHPD Fire	12/22/2015

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K 052	Continued From page 35 Facilities Operations Manager (FOM1) stated that the vendor was called to investigate the troubles. He stated that the vendor told him via telephone that the NAC expanders are connected to the notification horns and strobes. The trouble signals were already acknowledged and silenced. At 8:31 a.m., on 12/15/15, the three troubles were still exhibited on the FACP. Penthouse: 2. At 8:49 a.m., on 12/15/15, the combination horn/strobe fire alarm notification device, near the cooling tower, was observed. The audible horn was covered with painters tape on both sides of the strobe. At 10:06 a.m., on 12/18/15, one side of the speaker was still covered with blue painters tape. Offsite IOP and Spine Clinics: 3. At 2:05 p.m., on 12/15/15, the Vice President of Business Development (VPBD1) and the Vice President of Facilities Services were asked to arrange for fire alarm testing to be conducted at the offsite clinics on Friday morning (12/18/15) as part of the validation survey. During an interview at 8:21 a.m., on 12/18/15, VPBD1 stated that we cannot conduct fire alarm testing at the offsite facilities. Maintenance Staff at the Culver Medical Plaza (CMP Maint1) stated that they needed a couple of weeks notice to arrange for alarm testing. Functionality of the fire alarm system was not observed.	K 052	Alarm Panel Replacement Project (OSHPD Project #S142962). The repairs on these devices was completed on 12/22/15 and they have been tested, certified and now operate properly. The Hospital monitors these devices through quarterly and annual fire alarm certification. 2. The painters tape was removed from both sides and all areas of the strobe. Monitoring is performed through scheduled EOC rounds. 3. Hospital Leadership spoke to the new owners of Culver Medical Plaza on 2/26/16 regarding the ability to be able to conduct fire drills at any time. The Culver Medical Plaza owners agreed to this process. Fire alarm testing was successfully performed at this building and documentation is maintained in the Facilities Department. This building will be included in the fire drill coverage area. 4. The Hospital obtained aerosol smoke to test the smoke detectors on 12/18/15. An aerosol smoke can is now stored in the basement next to the fire alarm panel and in the Maintenance Office. Spare cans are maintained in the Engineering Office at all times. Engineering staff was inserviced.	12/18/2015 03/17/2016 12/18/2015

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K 052	Continued From page 36 Van Nuys: 4. At 10:52 a.m., on 12/15/15, the Director of Facilities Services (DFS2) and Maintenance Staff (VN Maint 1) stated that there was no aerosol smoke to test the smoke detectors during the survey. Functionality of the smoke detectors were not observed. Hollywood Basement: 5. At 9:07 a.m., the smoke detector in the FACP room/Radiology Office failed to alarm when tested with aerosol smoke. Pavilion Third Floor: 6. At 10:53 a.m., on 12/16/15, maintenance staff tested the smoke detector in Room 315A and the visual notification light in the corridor above the room's door failed upon activation of the smoke detector. The corridor notification lights are designed to indicate which patient room smoke detector is activated. Penthouse: 7. At 12:05 p.m., on 12/16/15, one of the strobe and chime notification devices in the mechanical room failed to annunciate upon activation of a fire alarm device. Tower Seventh Floor: 8. At 3:50 p.m., on 12/16/15, no audible fire alarm	K 052	5. The smoke detector in the FACP room/ Radiology Office was repaired by a vendor on 1/5/16. The contracted vendor shall perform quarterly smoke detector assessments and provide a written report on compliance/repairs to the Facilities Department. 6. The Hospital repaired the smoke detector in room 315A and the visual notification light in the corridor. The contracted vendor shall perform quarterly smoke detector assessments and provide a written report on compliance/repairs to the Facilities Department. 7. The strobe and chime notification devices in the mechanical room were repaired by a contract vendor on 12/22/15. The contracted vendor shall perform quarterly smoke detector assessments and provide a written report on compliance/repairs to the Facilities Department. 8. The fire alarm in the mechanical room was repaired by a contract vendor on 12/22/15. This is monitored through quarterly fire alarm testing. Documentation is maintained in the Facilities Department. Compliance and Monitoring: Data on compliance is tracked, trended, analyzed and is reported quarterly at the EOC Committee. Corrective action is taken as necessary. Compliance is reported quarterly to the Quality Council (until the Quality Council determines monitoring of the building is sufficiently conducted and then reporting will be provided quarterly to the Quality Council) and Governing Board.	01/05/2016 03/09/2016 12/22/2015 12/22/2015

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K 052	Continued From page 37 could be heard in the Mechanical Room upon activation of a fire alarm device. The Chief Operating Officer (COO) acknowledged the finding.	K 052	Persons Responsible: Vice President of Facilities Development Director of Facilities	
K 061	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that a local alarm will sound when the sprinkler control valves are closed. This was evidenced by the failure of the local supervisory audible alarm at the fire alarm subpanel in the telephone exchange box (PBX) room. This affected the entire Hollywood Building. This could result in a delayed response, in the event of closure of the sprinkler valves, and an increased risk of failure of the sprinkler system. NFPA 101, Life Safety Code, 2000 Edition. 19.3.5.1 Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Exception: In Type I and Type II construction, where approved by the authority having jurisdiction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specified areas where the authority having jurisdiction has prohibited sprinklers,	K 061	NFPA LIFE SAFETY CODE STANDARD	

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K 061	Continued From page 38 without causing a building to be classified as nonsprinklered. 19.3.5.2 Where this Code permits exceptions for fully sprinklered buildings or smoke compartments, the sprinkler system shall meet the following criteria: (1) It shall be in accordance with Section 9.7. (2) It shall be electrically connected to the fire alarm system. (3) It shall be fully supervised. Exception: In Type I and Type II construction, where approved by the authority having jurisdiction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specified areas where the authority having jurisdiction has prohibited sprinklers, without causing a building to be classified as nonsprinklered. 9.7.2 Supervision. 9.7.2.1 Supervisory Signals. Where supervised automatic sprinkler systems are required by another section of this Code, supervisory attachments shall be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm Code, and a distinctive supervisory signal shall be provided to indicate a condition that would impair the satisfactory operation of the sprinkler system. Monitoring shall include, but shall not be limited to, monitoring of control valves, fire pump power supplies and running conditions, water tank levels and temperatures, tank pressure, and air pressure on dry-pipe valves. Supervisory signals shall sound and shall be displayed either at a location within the protected building that is constantly attended by qualified personnel or at an approved, remotely located receiving facility.	K 061		

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K 061	Continued From page 39 NFPA 72, National Fire Alarm Code, 1999 Edition 2-9 Supervisory Signal-Initiating Devices. 2-9.1 Control Valve Supervisory Signal-Initiating Device. 2-9.1.1 Two separate and distinct signals shall be initiated: one indicating movement of the valve from its normal position and the other indicating restoration of the valve to its normal position. The off-normal signal shall be initiated during the first two revolutions of the hand wheel or during one-fifth of the travel distance of the valve control apparatus from its normal position. The off-normal signal shall not be restored at any valve position except normal. Findings: During a facility tour with staff from 12/14/15 to 12/18/15, the supervised sprinkler control valves were observed. Hollywood: 1. At 3:08 p.m., on 12/17/15, the sprinkler control valves on the riser of the sprinkler system were supervised by tamper switches designed to send a trouble signal to the fire alarm panel upon closure of the valves. The sprinkler control valve on the first floor was closed and a visual supervisory notification light was activated at the fire alarm subpanel in PBX. No audible alarm could be heard at the panel in PBX. During an interview at 3:09 p.m., the Director of Facilities Services (DFS2), the Disaster Coordinator, and the Chief Engineer (CE1) all confirmed that an audible trouble signal could not	K 061	Actions Taken: 1. The Hospital engaged an electrical company to assess and repair the PBX alarm panel to ensure that the audible alarm could be heard when the sprinkler control valves on the first floor and second floor were closed. The PBX alarm panel is now functional with an audible alarm. Monitoring is performed through quarterly testing, with documentation maintained in the Facilities Department. Compliance and Monitoring: Data on compliance is tracked, trended, analyzed and is reported quarterly at the EOC Committee. Corrective action is taken as necessary. Compliance is reported quarterly to the Quality Council (until the Quality Council determines monitoring of the building is sufficiently conducted and then reporting will be provided quarterly to the Quality Council) and Governing Board.	01/06/2016

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K 061	Continued From page 40 be heard. CE1 stated that PBX is manned 24 hours a day and respond to trouble lights from the fire alarm panels, medical gas panels, and generator panels located in their office. At 3:11 p.m., the sprinkler control valve on the second floor was closed and only a visual notification light at the PBX panel was activated. There was no audible alarm.	K 061	Persons Responsible: Vice President of Facilities Development Director of Facilities	
K 062	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to maintain their sprinkler system. This was evidenced by the failure to provide records of repairing deficiencies noted during an inspection, by the failure to conduct a five-year test more than one year after it was due, by corroded sprinkler heads, by sprinkler heads that were not free of foreign materials, and by fire department connections that failed to rotate smoothly. This affected two of three buildings in the Culver City Campus and the Van Nuys Building. These deficient practices could result in a delay in extinguishing a fire and the increased risk of injury to patients, staff, and visitors. NFPA 101, Life Safety Code, 2000 Edition 19.3.5.1 Where required by 19.1.6, health care	K 062	NFPA 101 LIFE SAFETY CODE STANDARD	

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K 062	Continued From page 41 facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Exception: In Type I and Type II construction, where approved by the authority having jurisdiction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specified areas where the authority having jurisdiction has prohibited sprinklers, without causing a building to be classified as nonsprinklered. 9.7.5 Maintenance and Testing. All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 1998 Edition. 1-8 Records. Records of inspections, tests, and maintenance of the system and its components shall be made available to the authority having jurisdiction upon request. Typical records include, but are not limited to, valve inspections; flow, drain, and pump tests; and trip tests of dry pipe, deluge, and preaction valves. 1-8.1 Records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. 1-8.2 Records shall be maintained by the owner. Original records shall be retained for the life of the system. Subsequent records shall be retained for a period of one year after the next inspection,	K 062		

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	050135	A. BUILDING 01 B. WING	12/18/2015

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K 062	Continued From page 42 test, or maintenance required by the standard. 2-2.1.1 Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. 2-2.1.2 Unacceptable obstructions to spray patterns shall be corrected. 2-2.2 Pipe and Fittings. Sprinkler pipe and fittings shall be inspected annually from the floor level. Pipe and fittings shall be in good condition and free of mechanical damage, leakage, corrosion, and misalignment. Sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. Exception No. 1:Pipe and fittings installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Pipe installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown. 9-5.1.1 All valves shall be inspected quarterly. The inspection shall verify that the valves are in the following condition: (a) In the open position (b) Not leaking (c) Maintaining downstream pressures in accordance with the design criteria (d) In good condition, with handwheels installed and unbroken	K 062		

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K 062	Continued From page 43 9-7 Fire Department Connections. 9-7.1 Fire department connections shall be inspected quarterly. The inspection shall verify the following: (a) The fire department connections are visible and accessible. (b) Couplings or swivels are not damaged and rotate smoothly. (c) Plugs or caps are in place and undamaged. (d) Gaskets are in place and in good condition. (e) Identification signs are in place. (f) The check valve is not leaking. (g) The automatic drain valve is in place and operating properly. Findings: During a facility tour with staff from 12/14/15 to 12/18/15, the sprinkler system was observed and maintenance records were reviewed. Culver City Campus: 1. At 11:20 a.m., on 12/15/15, records of an inspection of the sprinkler system conducted by a vendor on 9/28/15 was reviewed. Under the Deficiencies and Comments section, it was noted that the waterflow switch corresponding to System Riser ID 1 did not report to the fire alarm control panel (FACP) and the tamper corresponding to System Riser ID 1 did not report to the FACP. Records of repairing the deficiencies were not provided. Pavilion Basement: 2. At 3:42 p.m., on 12/15/15, there were two pest strips attached to the sprinkler pipe in the trash chute room. This finding was previously cited	K 062	Findings 1-7 Actions Taken: 1. The Hospital reviewed the findings from the 9/28/15 inspection of the waterflow swiich corresponding to the System Riser ID 1 and tamper that report to the fire alarm control panel. It was determined that another contracted vendor was in the process of replacing the fire alarm panel. The Hospital had the contractors working on the fire alarm panel review the deficiencies and comments section of the 9/25/15 inspection performed by another vendor. It was determined that the waterflow switch was operating properly on 9/29/15 and again on 2/29/16. The Senior Vice President of Hospital Operations spoke with the Director of Facilities regarding the survey finding, with special emphasis on maintaining follow up documentation on inspections and/or corrective actions taken. 2. The pest strips attached to the sprinkler pipe in the trash chute were removed on 12/17/15. Facilities staff were re-inserviced that pest strips are not to be placed on sprinkler pipes. Staff were also instructed that nothing was to be tied to, affixed or hanging from sprinklers or sprinkler pipes. 3. The sprinkler head in the trash chute room was replaced. 4. The Hospital engaged a Fire Protection Company which has been put on a 5 year testing cycle. The five-year inspection was performed for 2016. The inspection records are maintained in the Facilities Department. The scheduled testing was added to the EOC PM program for monitoring.	02/29/2016 02/29/2016 02/29/2016 01/25/2016

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K 062	Continued From page 44 during a Life Safety Code Survey conducted in September 2015. 3. At 3:45 p.m., on 12/15/15, there was a corroded sprinkler head in the trash chute room. The Chief Operating Officer (COO) acknowledged that the sprinkler head had turned green. Van Nuys: 4. At 2:59 p.m., on 12/16/15, records indicated the most recent five year inspection was conducted in May 2009. The five year inspection was due in May 2014. During an interview at 3:00 p.m., the director of facilities services (DFS2) stated that the five year was scheduled for 12/21/15. He attributed the delay due to a change in vendors. Pavilion: 5. At 2:15 p.m., on 12/16/15, there were four corroded sprinkler heads in the front entrance exterior overhang. This finding was previously cited during a Life Safety Code Survey conducted in September 2015. The COO acknowledged the sprinklers heads were green and the sprinkler heads had rusty escutcheon rings. Single Story Building: 6. At 2:13 p.m., on 12/16/15, the fire department connection (FDC) facing Delmas Terrace, failed to rotate freely when tested by the fire alarm vendor. Pavilion Basement: 7. At 10:25 a.m., on 12/17/15, there were two corroded sprinkler heads in the Decontamination	K 062	5. The Hospital replaced 8 sprinkler heads in the front entrance of the Pavilion building with new moisture resistant sprinkler heads. 6. The Hospital replaced the caps on the fire department connection facing Delmas Terrace and it was verified that the connection rotates freely. 7. The Hospital replaced the two sprinkler heads in the decontamination room and the sprinkler head in the sterilization room. 8. Hospital Leadership discussed the recall of sprinkler heads on the Culver City Campus and the project was approved to replace the 1500 sprinkler heads. A plan was submitted to OSHPD for approval (OSHPD Project Number S160548-19-00). Hospital Leadership engaged a fire sprinkler vendor to replace the sprinkler heads. It is anticipated that the project will be completed within 6 - 8 weeks. 9. An inservice was provided to facilities staff on how to conduct visual inspections as well as the proper cleaning of fire sprinklers. 10. Automatic sprinklers are monitored through the PM program and scheduled EOC rounds. An inservice was provided to facilities staff on how to conduct visual inspections as well as proper cleaning of fire sprinklers. Compliance and Monitoring: Data on compliance is tracked, trended, analyzed and is reported monthly at the EOC Committee. Corrective action is taken as necessary. Compliance is reported monthly to the Quality Council (until the Quality Council determines monitoring of the building is sufficiently conducted and then reporting will be provided quarterly to the Quality Council) and	02/25/2016 12/30/2015 02/29/2016 03/11/2016 03/11/2016

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K 062	Continued From page 45 Room and a white foreign substance on the sprinkler head in the Sterilization Room of Central Sterile.	K 062	quarterly to the Governing Board. Persons Responsible: Vice President of Facilities Development Director of Facilities	
K 064	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain their fire extinguishers. This was evidenced by fire extinguishers with obstructed access, by the failure to provide all staff with keys to locked fire extinguisher cabinets in the acute psychiatric facility, and by fire extinguishers that were overdue for an annual service. This affected the safety of patients in the Van Nuys Building and the offsite Spine Clinic. This could result in a delay in extinguishing a fire. NFPA 101, Life Safety Code, 2000 Edition. 19.3.5.6 Portable fire extinguishers shall be provided in all health care occupancies in accordance with 9.7.4.1. 9.7.4.1 Where required by the provisions of another section of this Code, portable fire extinguishers shall be installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition.	K 064	NFPA 101 LIFE SAFETY CODE STANDARD Findings 1-3 Actions Taken: 1. All fire extinguishers in the Outpatient Spine Clinic were inspected to ensure unobstructed access was present. Staff were reeducated on keeping access to fire extinguishers unobstructed at all times. 2. The identified fire extinguisher in the exit hallway outside Exam Room 3 at the Outpatient Spine Clinic had its annual service performed. The remaining fire extinguishers in the Outpatient Spine Clinic were also checked and are current in their annual inspection. 3. Hospital Leadership discussed the issue of key access to locked fire extinguisher cabinets with the Director of Facilities. Additional keys were obtained and distributed to staff.	03/11/2016 02/26/2016 12/18/2015

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K 064	Continued From page 46 1-6.3 Fire extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of fire. Preferably they shall be located along normal paths of travel, including exits from areas. 1-6.5 Cabinets housing fire extinguishers shall not be locked. Exception: Where fire extinguishers are subject to malicious use, locked cabinets shall be permitted to be used, provided they include means of emergency access. 4-3.2 Procedures. Periodic inspection of fire extinguishers shall include a check of at least the following items: (a) Location in designated place (b) No obstruction to access or visibility (c) Operating instructions on nameplate legible and facing outward (d) Safety seals and tamper indicators not broken or missing (e) Fullness determined by weighing or " hefting " (f) Examination for obvious physical damage, corrosion, leakage, or clogged nozzle (g) Pressure gauge reading or indicator in the operable range or position (h) Condition of tires, wheels, carriage, hose, and nozzle checked (for wheeled units) (i) HMIS label in place 4-4.1 Frequency. Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 year, at the time of hydrostatic test, or when specifically indicated by an inspection. Findings: During a facility tour with staff from 12/14/15 to	K 064	4. The stacked furniture was removed so access to the fire extinguisher in the storage cage at Van Nuys was unobstructed. Hospital Leadership discussed the issue of obstructed fire extinguishers and added monitoring to be performed by Security Staff during their daily rounding. If an issue is identified, they are to ensure that the issue is corrected during the rounds. Security staff were inserviced. 5. Hospital Leadership sent an electronic memorandum to all Department Leadership emphasizing strict adherence with keeping fire extinguishers unobstructed. 6. The issue of fire extinguishers was discussed at a town hall meeting to emphasize the reason for keeping fire extinguishers unobstructed. This issue was stressed as a responsibility for all leaders at all levels and for each and every hospital employee. 7. In addition to the Security rounds referenced above, monitoring of fire extinguishers is part of the monthly fire extinguisher inspection check. Issues with fire extinguishers are addressed and discussions held with Department Managers or designees as necessary.	12/18/2015 03/11/2016 03/11/2016 03/11/2016

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K 064	Continued From page 47 12/18/15, the fire extinguishers were observed. Outpatient Spine Clinic: 1. At 1:39 p.m., on 12/15/15, access to the fire extinguisher in the front office was blocked by a recycling bin. 2. At 1:47 p.m., on 12/15/15, the service tag on the fire extinguisher, located in the exit hallway outside of Exam Room 3, indicated that it was last annually serviced on 9/27/14. The extinguisher was due to be serviced again in September 2015. Van Nuys: 3. At 8:39 a.m., on 12/16/15, housekeeping staff (VN EVS1) did not have the key to the locked fire extinguisher cabinets. At 8:57 a.m., on 12/16/15, mental health worker (VN MHW1) did not have the key to the locked fire extinguisher cabinets. 4. At 9:10 a.m., on 12/16/15, access to the fire extinguisher in the storage cage was obstructed by stacked furniture.	K 064	Compliance and Monitoring: Data on compliance is tracked, trended, analyzed and is reported monthly at the EOC Committee. Corrective action is taken as necessary. Compliance is reported monthly to the Quality Council (until the Quality Council determines monitoring of the building is sufficiently conducted and then reporting will be provided quarterly to the Quality Council) and quarterly to the Governing Board. Persons Responsible: Vice President of Facilities Development Director of Facilities	
K 066	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING	K 066	NFPA 101 LIFE SAFETY CODE STANDARD	

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K 066	Continued From page 48 or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain their smoking areas. This was evidenced by no safety-type ashtrays in one designated smoking area. This affected the smoking area at the Hollywood Building and could result in the increased risk of a fire. NFPA 101, Life Safety Code, 2000 Edition. 19.7.4 Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking.	K 066		

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K 066	Continued From page 49 Exception: In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (2) Smoking by patients classified as not responsible shall be prohibited. Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. Findings: During the tour of the facility with staff from 12/14/15 to 12/18/15, the designated smoking areas were observed. Hollywood: 1. At 8:30 a.m., on 12/17/15, the smoking area in the west parking lot was not provided with safety type ashtrays. There were cigarette butts in open top ceramic planters filled with pebbles. During an interview at 8:31 a.m., the Director of Facilities Services (DFS2) stated that the safety-type ashtrays were stolen so the planters were used because they were too heavy to steal.	K 066	1. The Hospital removed the top ceramic planters from the smoking area in the west parking lot at Hollywood. A new stainless steel safety-type ashtray was installed. 2. Monitoring of safety-type ashtrays in smoking areas is part of the scheduled EOC rounds. Compliance and Monitoring: Data on compliance is tracked, trended, analyzed and is reported monthly at the EOC Committee. Corrective action is taken as necessary. Compliance is reported monthly to the Quality Council (until the Quality Council determines monitoring of the building is sufficiently conducted and then reporting will be provided quarterly to the Quality Council) and quarterly to the Governing Board. Persons Responsible: Vice President of Facilities Development Director of Facilities	12/28/2015
K 067	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply	K 067	NFPA 101 LIFE SAFETY CODE STANDARD	

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K 067	Continued From page 50 with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to maintain their heating, ventilating, and air-conditioning (HVAC) systems. This was evidenced by the failure to provide adequate central heating to the patient rooms, by the failure to test dampers every four years, by the failure to repair dampers that failed inspections, by the use of a portable air conditioner, and by the failure to maintain that air conditioner in accordance with manufacturer guidelines. This was also evidenced by leaks in the hot water tanks and by a boiler that exhibited a low water pressure alarm. This affected the entire Pavilion, the basement of the Tower, three of six floors in the Hollywood Building, and four of four smoke compartments in the Van Nuys Building, These deficient practices could result in the increased risk of injury to patients due to lack of heating capabilities and the faster spread of smoke and fire due to incomplete maintenance of the dampers. NFPA 101, Life Safety Code, 2000 Edition. 19.5.2.1 Heating, ventilating, and air conditioning shall comply with the provisions of Section 9.2 and shall be installed in accordance with the manufacturer's specifications. Exception: As modified in 19.5.2.2. 9.2.1 Air Conditioning, Heating, Ventilating	K 067		

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K 067	Continued From page 51 Ductwork, and Related Equipment. Air conditioning, heating, ventilating ductwork, and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems, or NFPA 90B, Standard for the Installation of Warm Air Heating and Air-Conditioning Systems, as applicable, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction. NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems, 1999 Edition. 2-1.2 Equipment shall be selected and installed based on its proper application with respect to the manufacturer's installation instructions and listing as applicable. 2-1.3 Equipment shall be guarded for personnel protection and against the intake of foreign matter into the system. 2-2.4.1 Installation. Heating and cooling equipment shall be installed in accordance with the applicable NFPA standards and the manufacturer's instructions. The equipment shall be approved for the specific installation. 2-2.4.3 Mechanical Cooling. Mechanical refrigeration used with air duct systems shall be installed in accordance with recognized safety practices. Installations conforming to ANSI/ASHRAE 15, Safety Code for Mechanical Refrigeration, shall be considered in compliance with these requirements. 2-3.1.2 Air ducts shall be permitted to be rigid or flexible and shall be constructed of materials that are reinforced and sealed to satisfy the requirements for the use of the air duct system, such as the supply air system, the return or	K 067		

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K 067	Continued From page 52 exhaust air system, and the variable volume/pressure air system. 2-3.1.3 All air duct materials shall be suitable for continuous exposure to the temperature and humidity conditions of the environmental air in the air duct. 2-3.7 Air Inlets -- Return or Exhaust or Return and Exhaust 2-3.7.1 General. Air shall not be recirculated from any space in which flammable vapors, flyings, or dust is present in quantities and concentrations that would introduce a hazardous condition into the return air system. 3-4.5.4 Dampers shall close against the maximum calculated airflow of that portion of the air duct system in which they are installed. Fire dampers shall be tested in accordance with UL 555, Standard for Safety Fire Dampers. Smoke dampers shall be tested in accordance with UL 555S, Standard for Safety Smoke Dampers. 3-4.6.1 The locations and mounting arrangement of all fire dampers, smoke dampers, ceiling dampers, and fire protection means of a similar nature required by this standard shall be shown on the drawings of the air duct system. 3-4.7 Maintenance. At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they close fully; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary. Findings: During a facility tour with staff from 12/14/15 to 12/18/15, the HVAC systems were observed and maintenance records were reviewed. Pavilion:	K 067		

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K 067	Continued From page 53 1A. At 10:00 a.m., on 12/15/15, records indicated that the facility has used a temporary air handler unit since March 2015. The facility was granted a permit on 12/9/15 from the Office of Statewide Health Planning and Development (OSHPD) to begin installation of the new air handler unit. During an interview at 10:27 a.m., on 12/15/15, the Project Manager (PM2) in charge of restoration of the air handler installation (OSHPD Project #S151262-19-00) stated that the temporary air handler fed the air in the patient rooms of the Pavilion. He stated that he has heard complaints about the rooms being too cold since last Tuesday (12/8/15). PM2 stated that a possible solution to adding central heat to the rooms was to add a heating coil to the temporary air handler unit until the new permanent air handler was installed. PM2 estimated that the new air handler would be installed in approximately five to six months. During an interview at 4:07 p.m., on 12/15/15, the Vice President of Facilities Services stated that the facility will be adding a heating coil to the temporary air handling unit to provide central heat to the rooms. During an interview at 8:32 a.m., on 12/16/15, the Regional Compliance Officer (RCO) from OSHPD stated that the facility must provide heat between 70 to 75°F per state regulations. He stated that if the facility needed to add a heating coil to the HVAC system then the current system was not providing enough heat. Observations, record review, and interviews showed that the facility failed to provide a working central heating system.	K 067		

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K 067	Continued From page 54 Ambient temperatures and temperatures from the supply air vents in the rooms were recorded: 12/15/15 a. At 4:05 p.m., Plant Operations Lead Staff (PO1) recorded the temperature in Room 628 with a handheld thermometer. The temperature in the room was 68.5°F and the thermostat in the room was set to "warm." During an interview at 4:05 p.m., the patient in the room stated that the room was too cold and has been cold for three days. During an interview at 4:06 p.m., PO1 stated that there was no way to add heat to the room and the thermostat only turned off the cold air when it is set to warm. b. At 4:19 p.m., PO1 measured the temperature in Room 630. The temperature was 67.2°F. The thermostat in the room had a broken lever and PO1 could not adjust it. c. At 4:21 p.m., PO1 measured the temperature in Room 634 to be 67°F. d. At 4:30 p.m., PO1 measured the temperature of the air coming out of the supply air vent in Room 302 to be 61.6°F. e. At 4:35 p.m., PO1 measured the temperature of the air coming out of the supply air vent in Room 311 to be 66.2°F. f. At 4:37 p.m., PO1 measured the temperature of the air coming out of the supply air vent in Room 314A to be 63.8°F.	K 067		

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K 067	Continued From page 55 g. At 4:40 p.m., PO1 measured the temperature of the air coming out of the supply air vent in Room 315A to be 67.8°F. h. At 4:45 p.m., PO1 measured the temperature of the air coming out of the supply air vent in Room 207 to be 67.6°F. The room's thermostat was set to warm. i. At 4:47 p.m., PO1 measured the temperature of the air coming out of the supply air vent in Room 206 to be 60°F. The thermostat in the room had no operating button to adjust the settings. During an interview, the patient in the room stated that the room was cold. 12/17/15 j. At 9:15 a.m., PO1 measured the temperature of the air coming out of the supply air vent in Room 209 to be 68.6°F. During an interview, the patient in the room stated it was cold. k. At 9:18 a.m., PO1 measured the temperature of the air coming out of the supply air vent in Room 201 to be 63.4°F. During an interview, the patient in the room stated the room was chilly. l. At 9:25 a.m., PO1 measured the temperature of the air coming out of the supply air vent in Room 204 to be 62.2°F. m. At 9:30 a.m., PO1 measured the temperature of the air coming out of the supply air vent in Room 220 to be 62.2°F. During an interview, the patient in the room stated it was cold. n. At 9:35 a.m., PO1 measured the temperature of the air coming out of the supply air vent in Room 243 to be 61.3°F.	K 067		

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K 067	Continued From page 56 o. At 9:38 a.m., PO1 measured the temperature of the air coming out of the supply air vent in Room 241 to be 61.6°F. During an interview, the patient in the room stated it was cold. p. At 9:45 a.m., PO1 measured the temperature of the air coming out of the supply air vent in Room 226 to be 58°F. The Director of Emergency Services acknowledged that she could feel the chill in the North West wing of the second floor (patient room wing). She stated the rooms in that wing were much cooler than some of the other rooms. 1B. At 4:49 p.m., on 12/15/15, records of room temperatures recorded by staff in the Pavilion were reviewed. The logs showed that staff were recording ambient room temperatures three times daily (at 6:30 a.m., 12:00 p.m., and 7:00 p.m.) and the acceptable temperature range on the log was listed as 68 to 75°F. The logs were reviewed for temperatures below 68°F: Sixth Floor: a. Room temperatures fell below 68°F in 25 of 40 patient rooms on 12/15/15, with the lowest temperature of 64.4°F recorded at 12:00 p.m. in Room 633. b. Room temperatures fell below 68°F in 8 of 40 patient rooms on 12/14/15, with the lowest temperature of 67.4°F recorded at 12:00 p.m. in Room 636. c. Room temperatures fell below 68°F in 25 of 40 patient rooms on 12/13/15, with the lowest temperature of 65.2°F recorded at 6:30 a.m. in	K 067		

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K 067	Continued From page 57 Rooms 631 and 632. d. Room temperatures fell below 68°F in 6 of 40 patient rooms on 12/12/15, with the lowest temperature of 67°F recorded at 12:00 p.m. in Room 638. e. Room temperatures fell below 68°F in 18 of 40 patient rooms on 12/2/15, with the lowest temperature of 66.5°F recorded at 6:30 a.m. in Room 639. Fifth Floor: a. Room temperatures fell below 68°F in 15 of 41 patient rooms on 12/13/15, with the lowest temperature of 66.1°F recorded at 6:30 a.m. in Rooms 536 and 540. b. Room temperatures fell below 68°F in 8 of 41 patient rooms on 12/1/15, with the lowest temperature of 66.8°F recorded at 8:00 a.m. in Room 527. Fourth Floor: a. Room temperatures fell below 68°F in 8 of 19 patient rooms on 12/13/15, with the lowest temperature of 67.3°F recorded at 6:30 a.m. in Room 424. b. Room temperatures fell below 68°F in 19 of 19 patient rooms on 12/12/15, with the lowest temperature of 65.4°F recorded at 6:30 a.m. in Room 406. Second Floor (Unit P2): a. Room temperatures fell below 68°F in 30 of 44 patient rooms on 12/12/15, with the lowest temperature of 65.2°F recorded at 6:30 a.m. in Rooms 223 and 230.	K 067		

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K 067	Continued From page 58 b. Room temperatures fell below 68°F in 20 of 44 patient rooms on 12/12/15, with the lowest temperature of 66.5°F recorded at 6:30 a.m. in Rooms 225 and 228. 1C. On 12/17/15, hospital staff at Pavilion recorded temperatures in patient rooms at 2:00 a.m., 4:00 a.m., and 6:00 a.m. Those temperature logs were reviewed: a. In P6 (Sixth Floor), temperatures in 15 of 40 patient rooms remained below 68°F from 2 a.m. to 6 a.m. with the lowest temperature of 65.2°F recorded at 2:00 a.m. in Room 635. b. In P5 (Fifth Floor), temperatures in 12 of 41 patient rooms remained below 68°F from 2 a.m. to 6 a.m. with the lowest temperature of 65.8°F recorded at 6:00 a.m. in Room 534. c. In P2 (Second Floor), temperatures in 9 of 44 patient rooms remained below 68°F from 2 a.m. to 6 a.m. with the lowest temperature of 64.5°F recorded at 6:00 a.m. in Rooms 224, 225, and 226. Per these observations, log reviews, and interviews, the facility failed to ensure that their HVAC system was capable of providing central heating to the patient rooms. Tower: 2. At 2:33 p.m., on 12/14/15, the Director of Facilities Services (DFS1) stated that the facility did not elect to use any categorical waivers. The facility did not provide documentation of a categorical waiver (per Centers for Medicare & Medicaid Services Survey & Certification Letter	K 067	Finding 1 (A, B, and C) Actions Taken: 1. Hospital Leadership discussed the issues related to the HVAC systems. A heating coil was placed into the temporary air handler 12/31/15 to ensure that the identified rooms/ areas could be heated to appropriate temperatures, or as stated cooled. Nursing staff monitored the identified rooms/areas to ensure that appropriate temperatures were maintained and can be consistently controlled. Temperatures were recorded on log sheets. Random monitoring occurred daily in patient rooms through 3/2/16. Temperatures have been stabilized. Monitoring random rooms now during weekly EOC rounds. Compliance is reported monthly to the Quality Council (until the Quality Council determines monitoring of the building is sufficiently conducted and then reporting will be provided quarterly to the Quality Council) and quarterly to the Governing Board. The permanent unit is being addressed through OSHPD project number S151262-19-00.	

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K 067	Continued From page 59 S&C: 10-04-LSC, dated 10/30/09) allowing for a six year damper testing frequency. At 11:04 a.m., on 12/15/15, records indicated that fire damper testing was conducted on 11/4/10 in the Tower and Pavilion. All dampers in the Pavilion were tested this year as part of an HVAC restoration project but there were no records of testing the Tower fire dampers since 2010. Without utilization of a categorical waiver, the dampers were due to be tested in November 2014. 3. At 11:04 a.m., on 12/15/15, records indicated that five dampers (#2-003, #2-004, #2-005, #2-006, and #2-008) in the second floor of the Tower failed testing on 11/4/10. There were no records of repairing the dampers. Van Nuys: 4. At 8:07 a.m., on 12/16/15, there was a temporary portable air handler connected to the temporary portable chiller in the west parking lot. The portable chiller was cited during the last Life Safety Code Survey in September. The portable chiller, on a wheeled portable flat bed in the west parking lot, did not have an OSHPD permit. An invoice from the HVAC vendor indicated that the temporary chiller was installed on 7/17/15. At 11:37 a.m., a kitchen temperature log indicated that the portable air handler has been installed since 9/30/15. Records indicated that an application for an OSHPD permit was submitted but no permit had been issued for the use of the temporary chiller and air handler. During an interview at 11:55 a.m., the Project	K 067	2. Hospital Leadership discussed the findings with the Director of Facilities and the process for ensuring that timely damper testing is completed and documentation maintained. The schedule for fire damper testing is listed on the PM program schedule. Documentation is to be maintained in the Facilities Department. The Damper Test for the Tower Building was conducted in October and November 2015 and the next due date is November 2019. 3. Hospital Leadership reviewed the survey findings with the Director of Facilities. The Hospital was unable to locate the documents indicating repairs of the five dampers in the second floor of the Tower from 11/4/10. The fire damper testing for the Tower Building was completed in November 2015 and repairs were completed by 3/11/16. Scheduled testing of dampers is monitored through the PM program. If issues arise, documentation indicating repairs is maintained in the Facilities Department. 4. The VP of Facility Operations discussed the survey findings regarding the application for a permit with the OSHPD Regional Compliance Officer, who confirmed that they would not issue a permit because the project was considered to be a repair. The Unit has subsequently been removed and OSHPD project No. S152648-19-00 was closed on 2/20/16.	12/22/2015 03/11/2016 02/20/2016

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K 067	Continued From page 60 Manager (PM1) stated that there was no OSHPD permit for this equipment yet. 5. At 12:15 p.m., on 12/16/15, the mechanical blue prints of the HVAC system showed that the facility was protected by fusible link fire dampers. At 12:20 p.m., the Fire/Smoke Damper Inspection log indicated that maintenance staff (VN Maint 2) inspected the dampers from 1/6/15 to 4/2/15. During an interview at 12:28 p.m., VN Maint 2 stated that he just cleans the ducts but does not exercise the dampers. There were no records of operating the dampers every four years. Hollywood: 6. At 3:19 p.m., on 12/16/15, records indicated that a fire damper inspection was conducted on 5/28/15. The records showed that two dampers (Urgent Care Office First Floor and CCU Third Floor) were not tested because they could not be accessed. One damper failed to close (Fifth Floor corridor adjacent to Room 510) because it was obstructed by a pipe. There were no records or repairing the three deficiencies noted by the vendor. During an interview at 3:20 p.m., the Chief Engineer (CE1) stated that the facility was aware of the issues and was working with the vendor to provide access to those dampers. Hollywood First Floor: 7. At 12:00 p.m., on 12/17/15, there was a portable air conditioner (AC) in the laboratory. It was vented into the return exhaust vent which was covered with a thin piece of vinyl. The AC's	K 067	5. Hospital Leadership reviewed the process for timely completing damper inspections. Timely damper inspections is monitored through the PM program. The fusible link fire dampers were inspected. 6. The Hospital engaged a contractor to install large access panels to provide accessibility of the fire dampers in Urgent Care Office (First Floor), CCU (Third Floor) and Fifth Floor adjacent to Room 510. The project commenced on 3/2/16 and was completed 3/7/16, which included the damper testing.	03/07/2016 03/07/2016

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K 067	Continued From page 61 air filter had a thick accumulation of dust and dirt. During an interview at 12:01 p.m., CE1 stated that the filter was cleaned every month. The AC's manufacturer's manual recommended that the air filter be cleaned once a week. At 4:02 p.m., the Director of Facilities Services (DFS2) stated that the portable AC has been in the laboratory for approximately one year. Pavilion Basement: 8. At 4:05 p.m., on 12/14/15, there was a leaking pipe in the ceiling of Mechanical Room 1. The facilities operations manager acknowledged the finding. 9. At 3:25 p.m., on 12/15/15, there was an audible alarm activated in the basement near Mechanical Room 1. During an interview at 3:26 p.m., PO1 stated that one of the two boilers was leaking and that caused the low water pressure alarm to activate. 10. At 3:27 p.m., on 12/15/15, the hot water tank was leaking and the electrical hot water circulating tank was also leaking. During an interview at 3:28 p.m., PO1 stated that this hot water tank serviced the surgery suite in the basement. Tower Basement: 11. At 8:42 a.m., on 12/18/15, there was a leaking pipe in the ceiling by the door into the	K 067	7. Hospital Leadership reviewed the AC Manufacturer's manual regarding cleaning of the air filter for the portable air condition in the laboratory. A log was developed to document weekly cleaning of the air conditioning unit filter. The weekly filter cleaning commenced 1/22/2016.Engineering staff were inserviced on the weekly cleaning and documentation requirements. This process is being monitored through scheduled EOC rounds. 8. The Hospital repaired the pipe leak in Mechanical Room 1 and there is no further leak. 9. The Hospital repaired the leaking boiler and there are no further leaks. 10. The Hospital repaired the hot water tank and the electric hot water circulating tank. There are no further leaks in the tanks. 11. The Hospital replaced the pipe and there is no further leaking. 12. Compliance with HVAC systems, damper testing and boilers/tanks is monitored through the PM program and scheduled EOC rounds. Compliance and Monitoring: Data on compliance is tracked, trended, analyzed and is reported monthly at the EOC Committee. Corrective action is taken as necessary. Compliance is reported monthly to the Quality Council (until the Quality Council determines monitoring of the building is sufficiently conducted and then reporting will be provided quarterly to the Quality Council) and quarterly to the Governing Board.	01/22/2016 02/09/2016 02/23/2016 02/01/2016 02/11/2016

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K 067	Continued From page 62 mechanical room. During an interview at 8:43 a.m., DFS1 acknowledged the leaking pipe was from the hot water tank.	K 067	Persons Responsible: Vice President of Facilities Development Director of Facilities	
K 069	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain their commercial cooking equipment. This was evidenced by no filters in one kitchen hood and by grease-laden deposits on the kitchen hood and suppression system equipment. This affected one of seven floors in the Pavilion and one of six floors in the Hollywood Building. This could result in the increased risk of a grease fire and the increased risk of injury to patients, staff, and visitors. NFPA 101, Life Safety Code, 2000 Edition. 19.3.2.6 Cooking Facilities. Cooking facilities shall be protected in accordance with 9.2.3. Exception: Where domestic cooking equipment is used for food-warming or limited cooking, protection or segregation of food preparation facilities shall not be required. 9.2.3 Commercial Cooking Equipment. Commercial cooking equipment shall be in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless existing installations, which shall be permitted to be continued in service, subject to approval by the	K 069	NFPA 101 LIFE SAFETY CODE STANDARD	

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K 069	Continued From page 63 authority having jurisdiction. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 1998 Edition. 3-2.3 Grease filters shall be listed and constructed of steel or listed equivalent material and shall be of rigid construction that will not distort or crush under normal operation, handling, and cleaning conditions. Filters shall be tightfitting and firmly held in place. 8.3.1 Hoods, Grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned to bare metal, it shall not be coated with power or there substance. The entire exhaust system shall be inspected by a properly trained, qualified, and certified company or person(s) acceptable to the authority having jurisdiction in accordance with Table 8-3.1 Findings: During a tour of the facility with staff from 12/14/15 to 12/18/15, the commercial cooking equipment was observed. Pavilion First Floor: 1. At 3:51 p.m., on 12/14/15, the kitchen hood above the stove was not equipped with grease filters. This finding was previously cited during a Life Safety Code Survey conducted in September 2015.	K 069	Actions Taken: 1. The Senior VP of Hospital Operations consulted with a repair vendor to assess the particular kitchen hood above the stove in the Pavilion Building for grease filters. The vendor inspected the kitchen and advised the Hospital in writing that this type of stove does not require a grease filter as it is self-cleaning. The Hospital also obtained the manufacturer's manual for the kitchen hood, which stated that the ventilator "extracts 95% of the grease, dust and lint particles from the air stream passing through it without the use of filters, revolving devices, removable parts or running water. This high efficiency eliminates the fire hazard and maintenance problems normally due to the accumulation of these contaminants in the ductwork." The Senior VP of Hospital Operations discussed this issue with the Director of Facilities. 2. The Hospital contacted an outside vendor to inspect and clean the kitchen hood filters above the stove in the Hollywood, First Floor area. The Hospital set up a quarterly hood inspection with the vendor beginning 1/5/16.	12/22/2015 01/05/2016

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K 069	Continued From page 64 During an interview at 3:52 p.m., the Director of Facilities Services (DFS1) stated that custom built filters were ordered for the hood and stated he could provide documentation of the order. Records of ordering the grease filters were requested from DFS1 on 12/14/15 (at 3:52 p.m.) and 12/15/15 (at 11:30 a.m.) but were not provided. Hollywood First Floor: 2. At 2:55 p.m., on 12/17/15, there was grease dripping from the kitchen hood filters above the stove. When the filters were removed, the inside of the hood and the fusible link were approximately 50% covered with grease laden deposits. The back of the filters above the griddle were completely covered with grease laden deposits. This finding was previously cited during a Life Safety Code Survey conducted in September 2015.	K 069	3. Compliance with commercial cooking equipment (including cleaning of hoods/filters) is monitored through the PM program and scheduled EOC rounds. Compliance and Monitoring: Data on compliance is tracked, trended, analyzed and is reported monthly at the EOC Committee. Corrective action is taken as necessary. Compliance is reported monthly to the Quality Council (until the Quality Council determines monitoring of the building is sufficiently conducted and then reporting will be provided quarterly to the Quality Council) then and quarterly to the Governing Board. Persons Responsible: Vice President of Facilities Development Director of Facilities	
K 070	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure that portable space heaters used in non-sleeping staff areas complied with the requirements of	K 070	NFPA 101 LIFE SAFETY CODE STANDARD	

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K 070	Continued From page 65 NFPA 101. This was evidenced by no manufacturer's specifications indicating that the temperature of the portable space heater used in one staff office did not have heating element temperatures exceeding 212°F. This affected the basement of the Pavilion and could result in the increased risk of a fire. NFPA 101, Life Safety Code, 2000 Edition. 19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies. Exception: Portable space-heating devices shall be permitted to be used in nonsleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C). Findings: During a tour of the facility with staff from 12/14/15 to 12/18/15, the public box exchange (PBX) room was observed. Pavilion Basement: 1. At 2:46 p.m., on 12/16/15, a portable fan space heater was turned on and located on the floor of the PBX room. The label on the portable fan space heater indicated power consumption was 750/1500 W. The facility failed to provide manufacturer's specifications of the portable heater to show that the temperature of the heating elements did not exceed 212°F.	K 070	Actions Taken: 1. The space heater on the floor of the PBX room was removed.	12/16/2015
			2. Hospital Leadership discussed the use of space heaters and decided to ban their use in the hospital. Facilities staff reviewed all three campuses and discarded any space heaters if identified. Hospital Leadership discussed the issue with Department Leaders, with special emphasis on strict adherence to the ban on space heaters. Department Managers informed staff that space heaters are not to be utilized at any time.	03/11/2016
			3. Compliance with the prohibition of portable space heating devices is monitored through scheduled EOC rounds. Compliance and Monitoring: Data on compliance is tracked, trended, analyzed and is reported monthly at the EOC Committee. Corrective action is taken as necessary. Compliance is reported monthly to the Quality Council (until the Quality Council determines monitoring of the building is sufficiently conducted and then reporting will be provided quarterly to the Quality Council) and quarterly to the Governing Board. Persons Responsible: Vice President of Facilities Development Director of Facilities	
K 072	NFPA 101 LIFE SAFETY CODE STANDARD	K 072	NFPA 101 LIFE SAFETY CODE STANDARD	

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K 072	Continued From page 66 Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that means of egress are free from obstructions. This was evidenced by items obstructing the egress paths and corridors. This could result in the delay in evacuation and the increased risk of injury to the patients and staff during an emergency. This affected the basement of the Tower and two of six floors and basement of the Pavilion. NFPA 101, Life Safety Code, 2000 Edition. 19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7. Exception: As modified by 19.2.2 through 19.2.11. 7.1.6.1 General. Walking surfaces in the means of egress shall comply with 7.1.6.2 through 7.1.6.4. Exception: Existing walking surfaces shall be permitted where approved by the authority having jurisdiction. 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. 7.1.10.2.1 No furnishings, decorations, or other objects shall obstruct exits, access thereto,	K 072	Actions Taken: 1. The modular table system was removed on 12/22/15. 2. The Workstations on Wheels (WOW's) are not in the hallways/egress areas, unless being used by nursing staff and are not left unattended for more than 30 minutes. Hospital Leadership identified locations for the WOW's to be parked for charging and/or storage that do not interfere with means of egress. Nursing staff was educated. In addition to EOC rounds, Department Managers and Charge Nurse also perform frequent daily rounds to ensure compliance.	12/22/2015 03/08/2016

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K 072	Continued From page 67 egress therefrom, or visibility thereof. Findings: During a facility tour with staff from 12/14/15 to 12/18/15, the egress paths were observed. Pavilion Basement: 1. At 3:58 p.m., on 12/14/15, there was a modular table system stored in the egress corridor, across from the exit sign, in the back of Medical Records. Second Floor: 2. At 10:32 a.m., on 12/16/15, there were workstation on wheels (WOWs) along the egress corridors. During an interview at 10:33 a.m., the charge nurse on the floor stated that the WOWs and their chairs were stored in the corridor even when unattended by staff. Sixth Floor: 3. At 11:35 a.m., on 12/16/15, there was a telephone in a wooden cabinet mounted on the wall of the egress corridor by Room 617. The wooden cabinet protruded approximately 12 inches from the wall into the egress corridor and blocked usage of the handrail. This finding was previously cited during a Life Safety Code Survey conducted in September 2015. Tower Basement: 4. At 8:48 a.m., on 12/18/15, there was a desk with office supplies and a storage box with paper	K 072	3. The wooden cabinet by Room 617 was removed. 4. The desk and storage box in the egress corridor of the Tower Basement were removed. 5. The laundry receptacle in the egress corridor near Housekeeping was removed. Housekeeping staff were reminded not to obstruct means of egress paths and corridors. 6. Hospital Leadership sent a memo to Department Managers reminding them to keep egress paths and corridors free from obstructions. 7. Compliance with maintaining means of egress free from obstructions or impediments is monitored through scheduled EOC rounds. Compliance and Monitoring: Data on compliance is tracked, trended, analyzed and is reported monthly at the EOC Committee. Corrective action is taken as necessary. Compliance is reported monthly to the Quality Council (until the Quality Council determines monitoring of the building is sufficiently conducted and then reporting will be provided quarterly to the Quality Council) and quarterly to the Governing Board. Persons Responsible: Vice President of Facilities Development Director of Facilities	02/03/2016 12/22/2015 12/18/2015 03/08/2016

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K 072	Continued From page 68 in the egress corridor, by the piped-in oxygen gas shut-off valve. 5. At 8:50 a.m., on 12/18/15, there was an industrial-sized laundry receptacle stored in the egress corridor near Housekeeping.	K 072		
K 073	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that highly flammable decorations were not used. This was evidenced by the presence of two live cut Christmas trees. This could result in the faster spread of smoke and fire due to the dry vegetation. This affected one of four smoke compartments in the Van Nuys building and one of six floors in the Pavilion. NFPA 101, Life Safety Code, 2000 Edition. 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant. Exception: Combustible decorations, such as photographs and paintings, in such limited quantities that a hazard of fire development or spread is not present. Findings: During a facility tour with staff from 12/14/15 to 12/18/15, the lobby area was observed. Pavilion	K 073	NFPA 101 LIFE SAFETY CODE STANDARD	

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K 073	Continued From page 69 First Floor: 1. At 4:36 p.m., on 12/14/15, there was an approximately 8 foot tall live cut Christmas tree in the lobby near the security desk. The tree was cut at the roots and dry. During an interview at 4:37 p.m., the Director of Facilities Services (DFS1) stated that the tree was flame resistant and the facility had documentation from the local fire marshal to show this. There was a folded red tag that was stapled at the bottom of the tree but was not legible. DFS1 stated that this was the certificate from the fire marshal about the tree's flame resistance and he had a copy he could provide. A copy of the flame resistance certificate was not provided. Van Nuys: 2. At 8:55 a.m., on 12/16/15, there was an approximately 6 foot tall live cut Christmas tree in the front lobby/waiting room. The tree was cut at the roots and dry.	K 073	Actions Taken: 1. The Christmas tree in the Pavilion First Floor was removed and discarded. Hospital Leadership discontinued use of Christmas trees as a holiday decoration. 2. The Christmas tree was removed and discarded in the front lobby/waiting room at Van Nuys. Hospital Leadership discontinued use of live Christmas trees as a holiday decoration. 3. Hospital Leadership sent a memo to staff that live Christmas trees will not be allowed in the hospital. Persons Responsible: Vice President of Facilities Development Director of Facilities	12/14/2015 12/18/2015 03/11/2016
K 075	NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room	K 075	NFPA 101 LIFE SAFETY CODE STANDARD	

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K 075	Continued From page 70 protected as a hazardous area when not attended. 19.7.5.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the storage of their soiled linen and trash receptacles. This was evidenced by a trash collection room door that failed to latch. This affected the basement of the Pavilion and could result in the faster spread of smoke and fire. NFPA 101, Life Safety Code, 2000 Edition. 19.7.5.5 Soiled linen or trash collection receptacles shall not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gal/ft2 (20.4 L/m2). A capacity of 32 gal (121 L) shall not be exceeded within any 64-ft2 (5.9-m2) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) shall be located in a room protected as a hazardous area when not attended. Exception: Container size and density shall not be limited in hazardous areas. Findings: During a facility tour with staff from 12/14/15 to 12/18/15, the soiled linen and trash collection rooms were observed. Pavilion Basement:	K 075	Actions Taken: 1. The latch on the self-closing door to the trash chute room in the Pavilion Basement was repaired. 2. Compliance with operable latches to trash collection room doors is monitored through scheduled EOC rounds. Compliance and Monitoring: Data on compliance is tracked, trended, analyzed and is reported monthly at the EOC Committee. Corrective action is taken as necessary. Compliance is reported monthly to the Quality Council (until the Quality Council determines monitoring of the building is sufficiently conducted and then reporting will be provided quarterly to the Quality Council) and quarterly to the Governing Board.	02/17/2016

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K 075	Continued From page 71 1. At 3:40 p.m., on 12/15/15, the self-closing door to the trash chute room failed to latch. This finding was previously cited during a Life Safety Code Survey conducted in September 2015. During an interview at 3:41 p.m., Plant Operations Lead Staff (PO1) stated that the latch hardware required adjustment.	K 075	Persons Responsible: Vice President of Facilities Development Director of Facilities	
K 076	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their medical gas cylinder storage. This was evidenced by four medical gas cylinders that were not individually secured. This affected the basement of the Pavilion and could result in the increased risk of injury, in the event a cylinder is knocked over. NFPA 101, Life Safety Code, 2000 Edition 19.3.2.4 Medical Gas.	K 076	NFPA 101 LIFE SAFETY CODE STANDARD	

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K 076	Continued From page 72 Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. NFPA 99, Standard for Health Care Facilities, 1999 Edition 1-2 Application Chapters 12 through 18 specify the conditions under which the requirements of Chapters 3 through 11 shall apply in Chapters 12 through 18. Chapter 12 Hospital Requirements 12-1 Scope. This chapter addresses safety requirements of hospitals. 12-3.4.1 If installed, patient gas systems shall conform to Level 1 gas systems of Chapter 4. 4-3.1.1.1 Cylinder and Container Management. Cylinders in service and in storage shall be individually secured and located to prevent falling or being knocked over. Findings: During a facility tour with staff from 12/14/15 to 12/18/15, the medical gas cylinders were observed. Pavilion Basement: 1. At 3:47 p.m., on 12/14/15, there were four nitrous oxide H-cylinders that were chained together, and not individually secured, in the nitrous oxide piped-in medical gas room.	K 076	Actions Taken: 1. The four nitrous oxide H-cylinders in the medical gas room have been individually secured on 3/1/16. Facility plant staff were inserviced on the need to individually secure nitrous oxide H-cylinders. 2. Compliance with maintained medical gas cylinder storage is monitored through the PM program and scheduled EOC rounds. Compliance and Monitoring: Data on compliance is tracked, trended, analyzed and is reported monthly at the EOC Committee. Corrective action is taken as necessary. Compliance is reported monthly to the Quality Council (until the Quality Council determines monitoring of the building is sufficiently conducted and then reporting will be provided quarterly to the Quality Council) and quarterly to the Governing Board. Persons Responsible: Vice President of Facilities Development Director of Facilities	03/11/2016
K 077	NFPA 101 LIFE SAFETY CODE STANDARD Piped in medical gas systems comply with NFPA 99, Chapter 4.	K 077	NFPA 101 LIFE SAFETY CODE STANDARD	

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K 077	Continued From page 73 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain their piped-in medical gas systems. This was evidenced by the absence of an emergency oxygen supply connection. This affected the patients in the Pavilion and could result in the delay in emergency response and the increased risk of hazardous conditions. NFPA 101, Life Safety Code, 2000 Edition 19.3.2.4 Medical Gas. Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. NFPA 99, Standard for Health Care Facilities, 1999 Edition 1-2 Application Chapters 12 through 18 specify the conditions under which the requirements of Chapters 3 through 11 shall apply in Chapters 12 through 18. Chapter 12 Hospital Requirements 12-1 Scope. This chapter addresses safety requirements of hospitals. 12-3.4.1 If installed, patient gas systems shall conform to Level 1 gas systems of Chapter 4. 12-3.4.3 If installed, patient vacuum systems shall conform to the safe use of electric appliances. to Level 1 vacuum systems of Chapter 4. 4-3.1.1.8 General Requirements for Gas Central Supply Systems. Piped oxygen and medical air shall not be piped to or used for, any purpose except for use in patient care applications.	K 077		

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K 077	Continued From page 74 (h)Emergency Oxygen Supply Connection. Where the cryogenic oxygen supply is located outside of the building served, there shall be incorporated in the piping system an inlet for connecting a temporary auxiliary source of supply for emergency or maintenance situations. The inlet shall be located on the exterior of the building served and shall be physically protected to prevent tampering and unauthorized access. It shall be labeled "EMERGENCY LOW PRESSURE GASEOUS OXYGEN INLET." This connection shall be installed downstream of the shutoff valve on the main supply line (see 4-3.1.2.3(b)) and be suitably controlled with the necessary valves to allow emergency supply of oxygen and isolation of the piping to the normal source of supply. It shall have one check valve in the main line between the main line shutoff valve and the tee'd connection and one check valve between the tee'd connection and the emergency supply shutoff valve. Findings: During a facility tour with staff from 12/14/15 to 12/18/15, the piped-in medical gas system was observed. Pavilion: 1. At 9:05 a.m., on 12/15/15, the cryogenic system was not equipped with an emergency oxygen supply connection (oxygen autofill port). This finding was previously cited during a Life Safety Code Survey conducted in September 2015. During an interview, the Director of Facilities Services (DFS2) stated that the facility was in the	K 077	Actions Taken: 1. The Hospital obtained an OSHPD project number (S160471-19-00) to install an emergency oxygen supply connection on the cryogenic system. The Hospital's Architect is currently designing the plan, which is anticipated to be completed by 4/29/16. 2. Compliance with this project is monitored by the Director of Facilities. Persons Responsible: Vice President of Facilities Development Director of Facilities	04/29/2016

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K 077	Continued From page 75 process of obtaining approval for a project to add an autofill port.	K 077		
K 078	NFPA 101 LIFE SAFETY CODE STANDARD Anesthetizing locations are protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Shutoff valves are located outside each anesthetizing location and are arranged so that shutting off one room or location will not affect others. (b) Relative humidity is maintained equal to or greater than 35%. NFPA 99 4.3.1.2.3(n) and 5.4.1.1, 19.3.2.3 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to maintain the relative humidity levels in the anesthetizing locations. This was evidenced by records of the humidity levels falling below 35% during procedures in operating rooms (ORs) and by ORs that were not equipped with a means to mechanically increase humidity levels. This was also evidenced by the adoption of policies to lower the humidity in ORs below 35% without providing documentation of a categorical waiver in accordance with Centers for Medicare & Medicaid Services Survey & Certification Letter S&C: 13-25-LSC. This affected all the ORs in the Pavilion and all the ORs in the Hollywood Building. This could result in the increased risk of a fire and the increased risk of injury to patients.	K 078	NFPA 101 LIFE SAFETY CODE STANDARD	

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K 078	Continued From page 76 NFPA 101, Life Safety Code, 2000 Edition. 19.3.2.3 Anesthetizing locations shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. NFPA 99, Standard for Health Care Facilities, 1999 Edition Chapter 5 Environmental Systems 5-4.1.1 The mechanical ventilation system supplying anesthetizing locations shall have the capability of controlling the relative humidity at a level of 35 percent or greater. 5-6.1 Anesthetizing Locations. 5-6.1.1 Ventilating and humidifying equipment for anesthetizing locations shall be kept in operable condition and be continually operating during surgical procedures. Findings: During document review with staff from 12/14/15 to 12/18/15, the humidity logs were reviewed. Pavilion and Hollywood: 1. At 10:33 a.m., on 12/15/15, the "Operating Procedure Rooms Temperature and Humidity Monitoring" Policy (#SUR.048) stated that the facility would follow the Association of periOperative Registered Nurses (AORN) standard recommended humidity range of 30 to 60%. The policy stated that it was applicable to the Culver City Campus and Hollywood Campus. At 12:37 p.m., on 12/14/15, the Pavilion "OR Temperature and Humidity Monitoring Sheet" logs	K 078	Findings 1-4 Actions Taken: 1. Hospital Leadership reviewed the "Temperature and Humidity Monitoring" Policy. The Policy was revised and renamed "Temperature and Humidity Monitoring in the Operative and Invasive Procedural Areas." As detailed in the Policy, the Hospital follows the humidity range of 30% to 60%. Formal and informal meetings were held during the weeks of 1/18/16 – 2/12/16 between executive leadership, facilities management, surgical services and ancillary services regarding humidity levels. A presentation was provided on 2/11/16 to Quality Council, Infection Control Committee and Governance regarding temperature and humidity requirements and the organization's compliance level to raise awareness at leadership levels for connection between temperature/humidity and potential infection control and fire safety risk. After repair of the HVAC system, hourly readings were transitioned to daily readings for all areas where surgical/procedural cases were not performed (e.g., sterile supply and other areas where sterile instruments/supplies are required to be stored under specific temperature/humidity ranges). Temperature and humidity readings were taken before each case in surgical/ procedural areas to validate ongoing range stability. A contracted vendor installed remote temperature/humidity readers in the operating rooms and cardiac catheterization laboratory. The Hospital had the vendor re-evaluate the system on 2/10/16 and they identified that the system was operating properly. The contract vendor technician educated facilities	02/12/2016- 03/16/2016

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K 078	Continued From page 77 were reviewed. The top portion of the log indicated that the desired humidity range was 20 to 60%. At 2:33 p.m., on 12/14/15, the Director of Facilities Services (DFS1) stated that the facility did not elect to use any categorical waivers. The facility did not provide documentation of a categorical waiver per Centers for Medicare & Medicaid Services Survey & Certification Letter S&C: 13-25-LSC, dated 4/19/13 to lower relative humidity in the anesthetizing locations to 20%. Pavilion Basement: 2. At 2:34 p.m., on 12/14/15, the humidity monitoring sheets indicated that humidity levels in the ORs fell below 35% immediately preceding procedures during the following dates and times: a. On 12/7/15 at 7:00 a.m., the humidity was recorded as 23.9% before a procedure in OR 2. b. On 12/7/15 at 12:00 p.m., the humidity was recorded as 29% before a procedure in OR 2. c. On 12/7/15 at 6:00 a.m., the humidity was recorded as 28% before a procedure in OR 3. d. On 12/7/15 at 6:00 a.m., the humidity was recorded as 24% before a procedure in OR 4. e. On 12/7/15 at 7:00 a.m., the humidity was recorded as 25.5% before a procedure in OR 5. Hollywood Basement: 3. At 4:30 p.m., on 12/16/15, there were no humidity controls observed in ORs 1, 2, and 3.	K 078	management and infection control staff on how to produce, read and interpret "advanced reports" which display temperature and relative humidity data in numerical value, for all temperature/humidity sensitive locations. Recordings are recorded and viewable via the "advanced report" in 15 minute increments, with the system notifying facilities staff for any prolonged readings out of range. Additionally, the sensors can produce a manual reading "on command" by staff in the sensitive locations. Monitoring is conducted once daily by the Facilities staff through an electronic system. If the temperature and/or humidity is not in range, then corrections are made immediately to bring it back into acceptable ranges. Nursing will document an additional temperature and humidity check prior to each surgical procedure and if out of range, notifying engineering immediately. No surgeries will take place in that room while the temperature or humidity is out of range. Surgical Services and Engineering staff were re-inserviced on the policy. 2. The "OR Temperature and Humidity Monitoring Sheet" was reviewed and revised to be consistent with the hospital policy for humidity ranges of 30 to 60%. Engineering staff were inserviced on the revised temperature/ humidity record sheet/log.	03/11/2016

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K 078	Continued From page 78 Humidity logs showed that humidity levels fell below 35% in the ORs (see Deficiency 4). During an interview at 5:20 p.m., on 12/17/15, the Director of Facilities Services (DFS2) stated that the ORs were not equipped with an air handling system that could mechanically raise the humidity levels. He stated that humidity in the ORs depends on the outside humidity levels. 4. At 4:56 p.m., on 12/17/15, records indicated that humidity levels in the OR fell below 35% immediately preceding procedures during the following dates and times: a. On 11/17/15 at 6:00 p.m., the humidity was recorded as 10% before a procedure in OR 1. b. On 11/17/15 at 7:00 p.m., the humidity was recorded as 12% before a procedure in OR 1. c. On 11/17/15 at 6:00 a.m., the humidity was recorded as 10% before a procedure in OR 3 d. On 11/17/15 at 6:00 p.m., the humidity was recorded as 18% before a procedure in OR 3. e. On 11/20/15 at 12:00 p.m., the humidity was recorded as 24% before a procedure in OR 3. f. On 11/23/15 at 7:30 a.m., the humidity was recorded as 10% before a procedure in OR 1. g. On 12/1/15 at 6:00 a.m., the humidity was recorded as 18.5% before a procedure in OR 3. h. On 12/2/15 at 6:00 a.m., the humidity was recorded as 16.9% before a procedure in OR 1	K 078	3. The Hospital engaged a heating/ventilating company to assess, repair and install controls in air conditioning and heating units. Compliance and Monitoring: The Director of Facilities or designee performs a daily review of the Operating Room and other temperature/humidity sensitive logs to monitor compliance with temperature and humidity within range and/or necessary corrective action taken (including not using a specific operating or procedure room until temperature/humidity is in range). The Director of Facilities reports on compliance at least weekly to Hospital Leadership. Data on compliance is tracked, trended, analyzed and is reported monthly at the EOC Committee. Compliance is reported monthly to the Quality Council (until the Quality Council determines monitoring of the building is sufficiently conducted and then reporting will be provided quarterly to the Quality Council) and quarterly to the Governing Board. Persons Responsible: Vice President of Facilities Development Director of Facilities	03/11/2016

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K 078	Continued From page 79 i. On 12/2/15 at 10:30 a.m., the humidity was recorded as 22% before a procedure in OR 1. j. On 12/3/15 at 7:30 a.m., the humidity was recorded as 15% before a procedure in OR 3. k. On 12/3/15 at 10:30 a.m., the humidity was recorded as 13.8% before a procedure in OR 3. "Operating Procedure Rooms Temperature and Humidity Monitoring" Policy (#SUR.048) stated that the facility will follow the Association of periOperative Registered Nurses (AORN) standard recommended humidity range of 30 to 60%. Section 1.7 of the policy stated, "if temperature and humidity cannot be controlled within specified levels, all scheduled procedures for that specific room will be canceled." During an interview at 5:35 p.m., two surgical staff confirmed that cases were not canceled because of the low humidity readings.	K 078		
K 141	NFPA 101 LIFE SAFETY CODE STANDARD Non-smoking and no smoking signs in areas where oxygen is used or stored are in accordance with 19.3.2.4, NFPA 99, 8.6.4.2. This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their oxygen storage areas. This was evidenced by the absence of precautionary signage in one oxygen storage area. This affected one of six floors in the Pavilion and could	K 141	NFPA 101 LIFE SAFETY CODE STANDARD	

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K 141	Continued From page 80 result in the failure to take the proper precautions required for an oxygen storage room. NFPA 101, Life Safety Code, 2000 Edition 19.3.2.4 Medical Gas. Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. NFPA 99, Standard for Health Care Facilities, 1999 Edition 1-2 Application Chapters 12 through 18 specify the conditions under which the requirements of Chapters 3 through 11 shall apply in Chapters 12 through 18. Chapter 12 Hospital Requirements 12-1 Scope. This chapter addresses safety requirements of hospitals. 12-3.4.1 If installed, patient gas systems shall conform to Level 1 gas systems of Chapter 4. 12-3.8.1 Patient. Equipment shall conform to the patient equipment requirements in Chapter 8, "Gas Equipment." 12-3.8.2 Nonpatient. Equipment shall conform to the non-patient equipment requirements in Chapter 8, "Gas Equipment." Chapter 8 Gas Equipment 8-3.1.11.2 Storage for nonflammable gases less than 3000 ft3 (85 m3). (c) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or incompatible materials by either: 1. A minimum distance of 20 ft (6.1 m), or 2. A minimum distance of 5 ft (1.5 m) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler	K 141		

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K 141	Continued From page 81 Systems, or 3. An enclosed cabinet of noncombustible construction having a minimum fire protection rating of one-half hour for cylinder storage. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage. (f) Electrical fixtures in storage locations shall meet 4-3.1.1.2(a)11d. (h) Cylinder or container restraint shall meet 4-3.5.2.1(b)27. (i) Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 20 ft (6.1 m) of outside storage locations. 8-3.1.11.3 Signs. A precautionary sign, readable from a distance of 5 ft (1.5 m), shall be conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: CAUTION OXIDIZING GAS(ES) STORED WITHIN NO SMOKING Findings: During facility tour with staff from 12/14/15 to 12/18/15, the facility was observed. Pavilion Building Fourth Floor: 1. At 9:57 a.m., on 12/17/15, there were oxygen cylinders stored in the rehabilitation gym. The door to the rehabilitation gym was not labeled with a precautionary sign. The above finding was acknowledged by Director of Emergency Services.	K 141	Actions Taken: 1. A precautionary oxygen storage sign was installed in the rehabilitation gym 2. The Hospital evaluated other locations in Culver City, Hollywood and Van Nuys and precautionary signs regarding the storage of oxygen cylinders are in place. 3. Monitoring compliance with signs indicating oxygen storage is performed through scheduled EOC rounds. Compliance and Monitoring: Data on compliance is tracked, trended, analyzed and is reported monthly at the EOC Committee. Corrective action is taken as necessary. Compliance is reported monthly to the Quality Council (until the Quality Council determines monitoring of the building is sufficiently conducted and then reporting will be provided quarterly to the Quality Council) and quarterly to the Governing Board. Persons Responsible: Vice President of Facilities Development Director of Facilities	12/18/2015 02/29/2016

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K 144	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to maintain their emergency generators. This was evidenced by generators that were not monitored by remote alarm annunciators, by a generator enclosure that was not equipped with battery-powered emergency lights, and by one generator with an inoperable block heater. This affected three of three buildings at the Culver City Campus and the Van Nuys Building. This could result in a delay in staff notification and response to troubles with the generator and the increased risk of injury to the patients. NFPA 101, Life Safety Code, 2000 Edition. 7.9.2.3 Emergency generators providing power to emergency lighting systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. Stored electrical energy systems, where required in this Code, shall be installed and tested in accordance with NFPA 111, Standard on Stored Electrical Energy Emergency and Standby Power Systems.	K 144	NFPA 101 LIFE SAFETY CODE STANDARD	

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K 144	Continued From page 83 9.1.3 Emergency Generators. Emergency generators, where required for compliance with this Code, shall be tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power System. NFPA 99, Standard for Health Care Facilities, 1999 Edition. 3-4.1.1.4 General. Generator sets installed as an alternate source of power for essential electrical systems shall be designed to meet the requirements of such service. (a) Type I and Type II essential electrical system power (107C) or the engine water-jacket temperature at not less than sources shall be classified as Type 10, Class X, Level 1 generator sets per NFPA 110, Standard for Emergency and Standby Power Systems. 3-4.1.1.15 A remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. (See NFPA 70, National Electrical Code, Section 700-12) The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: (a) Individual visual signals shall indicate: 1. When the emergency power source is operating to supply power to load 2. When the battery charger is malfunctioning. (b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following: 1. Low lubricating oil pressure 2. Low water temperature (below those required in 3-4.1.1.9) 3. Excessive water temperature	K 144		

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K 144	Continued From page 84 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply 5. Over crank (failed to start) 6. Overspeed Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur, but need not display these conditions individually. NFPA 70 , National Electrical Code, 1999 Edition 700-12 The annunciator shall indicate alarm condition of the emergency or auxiliary power source as follows: (a)Individual visual signals shall indicate the following: 1. When the emergency or auxiliary power source is operating to supply power to load 2. When the battery charger is malfunctioning (b)Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following: 1. Low lubricating oil pressure 2. Low water temperature (below those required in 3-4.1.1.9) 3. Excessive water temperature 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply 5. Overcrank (failed to start) 6. Overspeed 3-5.5.2 (d) Battery powered individual alarm indication to annunciate visually at the control panel the occurrence of any of the conditions in Table 3-5.5.2 (d); additional contacts or circuits for a common audible alarm that signals locally and remotely when any of the itemized conditions	K 144		

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K 144	Continued From page 85 occurs. A lamp test switch(es) shall be provided to test the operation of all alarm lamps listed in Table 3-5.5.2(d). 3-5.6.1 A remote,, common audible alarm powered by the storage battery shall be provided as specified in 3-5.5.2(d). This remote alarm shall be located outside of the EPS service room at a work site readily observable by personnel. NFPA 110, Standard for Emergency and Standby Power Systems, 1999 edition. 3-5.5.2 An automatic control and safety panel shall be a part of the EPS and shall contain the following equipment or possess the following characteristics, or both: (a) Cranking control equipment to provide the complete cranking cycle described in 3-5.4.2 and Table 3-5.4.2. (b) A panel-mounted control switch(es) marked " run-off-automatic " to perform the following functions: 1. Run: Manually initiate, start, and run prime mover 2. Off: Stop prime mover or reset safeties, or both 3. Automatic: Allow prime mover to start by closing a remote contact and stop by opening the remote contact (c) Controls to shut down and lock out the prime mover under the following conditions: failing to start after specified cranking time, overspeed, low lubricating-oil pressure, high engine temperature, or operation of remote manual stop station. An automatic engine shutdown device for high lubricating-oil temperature shall not be required. (See 3-5.5.6.) (d) Battery-powered individual alarm indication to annunciate visually at the control panel the occurrence of any of the conditions in Table	K 144		

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	050135	A. BUILDING 01 B. WING	12/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	6245 DE LONGPRE AVE HOLLYWOOD, CA 90028

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144	Continued From page 86 3-5.5.2(d); additional contacts or circuits for a common audible alarm that signals locally and remotely when any of the itemized conditions occurs. A lamp test switch(es) shall be provided to test the operation of all alarm lamps listed in Table 3-5.5.2(d). (e) Controls to shut down the prime mover upon removal of the initiating signal or manual emergency shutdown. (f) The ac instruments listed in 3-5.9.7. Where the control panel is mounted on the energy converter, it shall be mounted by means of antivibration shock mounts, if required, to maximize reliability. 3-5.6 Remote Controls and Alarms 3-5.6.1 A remote, common audible alarm powered by the storage battery shall be provided as specified in 3-5.5.2 (d). This remote alarm shall be located outside of the EPS service room at a work site readily observable by personnel. 3-5.6.2 An alarm-silencing means shall be provided, and the panel shall include repetitive alarm circuitry so that, after the audible alarm is silenced, it is reactivated after clearing the fault condition and must be restored to its normal position to be silenced. Exception: In lieu of the requirement of 3-5.6.2, a manual alarm-silencing means shall be permitted that silences the audible alarm after the occurrence of the alarm condition, provided such means do not inhibit any subsequent alarms from sounding the audible alarm again without further manual action. 5-3.1 The Level 1 or Level 2 EPS equipment location shall be provided with battery powered emergency lighting. The emergency lighting charging system and the normal service room	K 144	Actions Taken: 1. Hospital Leadership reviewed the survey findings and obtained an OSHPD project number (S160471-19-00) to install remote alarm annunciators for three generators at Culver City. The Hospital engaged an Architect for the project plan, which is anticipated to be completed by 4/29/16.	04/29/2016

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K 144	Continued From page 87 lighting shall be supplied from the load side of the transfer switch. Findings: During tour of facility with staff from 12/14/15 to 12/18/15, the generators and generator components were observed. Culver City Campus: 1. At 4:21 p.m., on 12/14/15, there were no remote alarm annunciators for three of three generators at Culver City. This finding was previously cited during a Life Safety Code Survey conducted in September 2015. During an interview at 4:22 p.m., Plant Operations Lead Staff (PO1) confirmed that the generators did not have remote alarm annunciators. 2. At 1:04 p.m., on 12/15/15, records indicated that a load bank test was conducted for the North Ramp generator on 12/11/15. Per the Emergency Generator Test Run Log, the North Ramp generator is a 400 kW (kilowatt) diesel generator that supplies emergency power to the surgical basement in Pavilion. The vendor noted in his findings that the block heater was not working and needed to be replaced. There were no records of repairing the block heater. Van Nuys: 3. At 10:34 a.m., on 12/16/15, there was no battery-powered emergency lighting in the generator room.	K 144	2. The block heater was replaced. Monitoring is performed through bi-annual maintenance service maintenance, which is schedule on the PM program. 3. An electrical contractor was hired and the battery-powered emergency lighting in the Van Nuys generator room was installed. 4. Upon further investigation, it was realized that a warning light was installed and not a remote annunciator. An OSHPD Project number S160564-19-00 was opened to install a new annunciation panel for the generator. The Hospital's architect is currently designing the plan, which is anticipated to be completed by 4/29/16. 5. Monitoring compliance on remote alarm annunciators is performed through the PM program. Compliance and Monitoring: Data on compliance is tracked, trended, analyzed and is reported monthly at the EOC Committee. Corrective action is taken as necessary. Compliance is reported monthly to the Quality Council (until the Quality Council determines monitoring of the building is sufficiently conducted and then reporting will be provided quarterly to the Quality Council) and quarterly to the Governing Board. Persons Responsible: Vice President of Facilities Development Director of Facilities	02/16/2016 02/29/2016 04/29/2016

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K 144	Continued From page 88 4. At 11:19 a.m., on 12/16/15, there was a low fuel sensor alarm for the generator's main diesel tank at the Unit 2 nurses station but no remote alarm annunciator. The Director of Facilities Services (DFS2) confirmed this finding. This finding was previously cited during a Life Safety Code Survey conducted in September 2015.	K 144		
K 147	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2 This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to maintain their electrical wiring. This was evidenced by the use of a compromised power strip, by an electrical box with a broken cover, and by the rewiring of electrical circuits without approval from the authority having jurisdiction. This affected one of four smoke compartments in the Van Nuys Building and two of two stairwells in the Hollywood Building. These deficient practices could result in the increased risk of an electrical fire and an increased risk of malfunction of essential electrical equipment. This could result in the increased risk of harm to patients, staff, and visitors. NFPA 101, Life Safety Code, 2000 Edition. 19.5.1 Utilities. Utilities shall comply with the provisions of Section 9.1. Exception: Existing installations shall be permitted to be continued in service, provided that the systems do not present a serious hazard to life.	K 147	NFPA 101 LIFE SAFETY CODE STANDARD	

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K 147	Continued From page 89 9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction. NFPA 70, National Electrical Code, 1999 Edition. Section 90-4 Enforcement. This Code is intended to be suitable for mandatory application by governmental bodies that exercise legal jurisdiction over electrical installations and for use by insurance inspectors. The authority having jurisdiction for enforcement of the Code will have the responsibility for making interpretations of the rules for deciding on the approval of equipment and materials, and for granting the special permission contemplated in a number of the rules. The authority having jurisdiction may waive specific requirements in this Code or permit alternate methods where it is assured that equivalent objectives can be achieved by establishing and maintaining effective safety. This Code may require new products, constructions, or materials that may not yet be available at the time the Code is adopted. In such event, the authority having jurisdiction may permit the use of the products, constructions, or materials that comply with the most recent previous edition of this Code adopted by the jurisdiction. 90-7 Examination of Equipment for Safety. For specific items of equipment and materials referred to in this Code, examinations for safety made under standard conditions will provide a basis for approval where the record is made generally available through promulgation by organization properly equipped and qualified for	K 147		

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K 147	Continued From page 90 experimental testing, inspections of the run of goods at factories, and service-value determination through field inspections. This avoids the necessity for repetition of examinations by different examiners, frequently with inadequate facilities for such work, and the confusion that would result from conflicting reports as to the suitability of devices and materials examined for a given purpose. It is the intent of this Code that factory-installed internal wiring or the construction of equipment need not be inspected at the time of installation of the equipment, except to detect alterations or damage, if the equipment has been listed by a qualified electrical testing laboratory that is recognized as having the facilities described above and that require suitability for installation in accordance with this Code. 110-3. Examination, Identification, Installation, and Use of Equipment. (a) Examination. In judging equipment, considerations such as the following shall be evaluated: (1) Suitability for installation and use in conformity with the provisions of this Code FPN: Suitability of equipment use may be identified by a description marked on or provided with a product to identify the suitability of the product for a specific purpose, environment, or application. Suitability of equipment may be evidenced by listing or labeling. (2) Mechanical strength and durability, including, for parts designed to enclose and protect other equipment, the adequacy of the protection thus provided (3) Wire-bending and connection space (4) Electrical insulation (5) Heating effects under normal conditions of	K 147		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 147	Continued From page 91 use and also under abnormal conditions likely to arise in service (6) Arcing effects (7) Classification by type, size, voltage, current capacity, and specific use (8) Other factors that contribute to the practical safeguarding of persons using or likely to come in contact with the equipment (b) Installation and Use. Listed or labeled equipment shall be installed and used in accordance with any instructions included in the listing or labeling. 110-12. Mechanical Execution of Work. Electrical equipment shall be installed in a neat and workmanlike manner. (a) Unused Openings. Unused openings in boxes, raceways, auxiliary gutters, cabinets, equipment cases, or housings shall be effectively closed to afford protection substantially equivalent to the wall of the equipment. (b) Subsurface Enclosures. Conductors shall be racked to provide ready and safe access in underground and subsurface enclosures, into which persons enter for installation and maintenance. (c) Integrity of Electrical Equipment and Connections. Internal parts of electrical equipment, including busbars, wiring terminals, insulators, and other surfaces, shall not be damaged or contaminated by foreign materials such as paint, plaster, cleaners, abrasives, or corrosive residues. There shall be no damaged parts that may adversely affect safe operation or mechanical strength of the equipment such as parts that are broken; bent; cut; or deteriorated by corrosion, chemical action, or overheating. 240-4 Flexible cord, including tinsel cord and	K 147		

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K 147	Continued From page 92 extension cords, and fixture wires shall be protected against overcurrent by either (a) or (b). (a) Ampacities. Flexible cord shall be protected by an overcurrent device in accordance with its ampacity as specified in Tables 400-5(A) and (B). Fixture wire shall be protected against overcurrent in accordance with its ampacity as specified in Table 402-5. Supplementary overcurrent protection, as in Section 240-10, shall be permitted to be an acceptable means for providing this protection. 370-25 In completed installations, each box shall have a cover, faceplate, or fixture canopy. 400-8 Uses Not Permitted Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-8. (5) Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (6) Where installed in raceways, except as otherwise permitted in this Code. Findings: During a facility tour with staff from 12/14/15 to	K 147		

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K 147	Continued From page 93 12/18/15, the electrical wiring was observed. Pavilion First Floor: 1. At 9:53 a.m., on 12/16/15, there was a 4 inch by 4 inch electrical box with a broken cover in the Green Room. The wiring in the electrical box was exposed. Van Nuys: 2. At 10:05 a.m., on 12/16/15, the medication dispenser in the Unit 2 Medication Room was plugged into a six-plug power strip. The insulation on the power strip cord was ripped and wiring was exposed. Hollywood East and West Stairwells: 3. At 10:38 a.m., on 12/17/15, records indicated that a contractor rewired the stairwell light circuits on 10/23/15 so that they are serviced by the generator. During an interview at 10:39 a.m., the Director of Facilities (DFS2) stated that, after the last Life Safety Code Survey, it was discovered that the stairwell lights are not hooked up to the generator and the stairwells were dark during a power outage. He stated that this contractor was hired to amend that issue. He said that the rewiring of the lighting and emergency circuits was not approved by the Office of Statewide Health Planning and Development.	K 147	Actions Taken: 1. The cover was replaced on the electrical box. 2. The power strip was removed on 12/18/15. The Omnicell was plugged directly to an Emergency outlet. The Van Nuys campus was assessed for power strips and any remaining were removed. 3. An electrical contractor traced the existing wirings and repaired defective part of lighting fixture to function with normal power and when on emergency power supply. As it is a repair, there is no requirement for an OSHPD project. 4. Monitoring of approved electrical safety equipment is performed through scheduled EOC rounds. Compliance and Monitoring: Data on compliance is tracked, trended, analyzed and is reported monthly at the EOC Committee. Corrective action is taken as necessary. Compliance is reported monthly to the Quality Council (until the Quality Council determines monitoring of the building is sufficiently conducted and then reporting will be provided quarterly to the Quality Council) and quarterly to the Governing Board. Persons Responsible: Vice President of Facilities Development Director of Facilities	12/29/2015 03/07/2016 12/26/2015
K 160	NFPA 101 LIFE SAFETY CODE STANDARD	K 160	NFPA 101 LIFE SAFETY CODE STANDARD	

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K 160	Continued From page 94 All existing elevators, having a travel distance of 25 ft. or more above or below the level that best serves the needs of emergency personnel for fire fighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. 19.5.3, 9.4.3.2 This STANDARD is not met as evidenced by: Based on observation, document review, and interview, the facility failed to maintain their elevators. This was evidenced by the failure to ensure conveyance permits are current for the elevators. This was also evidenced by the failure to provide maintenance records for two elevators and the failure to provide repair records for the Phase II fire fighter service of one elevator. This affected the elevators in the Pavilion and the Tower. This could result in the increased risk of malfunction of the elevators and possible harm to patients, visitors, and staff. NFPA 101 Life Safety Code, 2000 Edition 19.5.3 Elevators, Escalators, and Conveyors. Elevators, escalators, and conveyors shall comply with the provisions of Section 9.4. 9.4.6 Elevator Testing. Elevators shall be subject to routine and periodic inspections and test as specified in ASME/ANSI A17.1, Safety Code for Elevators and Escalators. All elevators equipped with fire fighter service in accordance with 9.4.4 and 9.4.5 shall be subject to a monthly operation with a written record of the findings made and kept on the premises as required by ASME/ANSI A17.1, Safety Code for Elevators and Escalators Findings:	K 160		

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K 160	Continued From page 95 During record review with staff from 12/14/15 to 12/18/15, the elevator inspection records were reviewed. Culver City Campus: 1. At 12:20 p.m., on 12/17/15, records indicated that the facility failed to ensure elevator conveyance permits were current since 9/2014. Reports sent to the facility from the State of California Department of Industrial Relations Division of Occupational Safety and Health (CDIRDOSH) were reviewed: a. The facility received a notice, dated 2/1/15, of an overdue payment for a 12/23/14 inspection of Elevator Conveyance Permit #050929. The notice had a compliance date of 2/16/15. b. The facility received a notice, dated 10/7/14, of an overdue payment for a 9/30/14 inspection of Elevator Conveyance Permit #050930. c. The facility received a notice, dated 10/7/14, of an overdue payment for a 9/30/14 inspection of Elevator Conveyance Permit #065766. d. The facility received a final notice, dated 7/12/15, of an overdue payment for a 9/30/15 inspection of Elevator Conveyance Permit #050902. e. The facility received a final notice, dated 7/12/15, of an overdue payment for a 9/30/14 inspection of Elevator Conveyance Permit #051351. e. The facility received a final notice, dated	K 160	Actions Taken: 1. The State Inspector performed an onsite inspection of the identified elevators at Culver City and temporary stickers have been issued and placed in each elevator. The new permits are pending from the State.	02/02/2016

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K 160	Continued From page 96 7/12/15, of an overdue payment for a 9/30/14 inspection of Elevator Conveyance Permit #036094. f. The facility received a final notice, dated 7/12/15, of an overdue payment for a 9/30/14 Inspection of Elevator Conveyance Permit #036088. g. The facility received a final notice, dated 7/12/15, of an overdue payment for a 9/30/14 inspection of Elevator Conveyance Permit #050901. Documents indicated that payments were made by the facility for Elevator Conveyance Permits 036088, 05090, 036094, 051351, and 050902 on 7/23/15, after receiving final notices of shutdown from CDIRDOSH. At 9:04 a.m., on 12/18/15, Elevator Conveyance Permit #036088 had an expiration date of 9/30/14. During an interview at 9:05 a.m., the Director of Facilities Services (DFS1) stated that the final notices were paid and the facility was waiting for CDIRDOSH to send in current permit. During a telephone interview at 3:45 p.m., on 12/22/15, staff at CDIRDOSH stated that the facility is current for 2014 conveyance permits but not for 2015. She stated this was due to the delinquency in compliance and payment for the 9/2014 inspection. 2. At 12/18/15, at 10:00 a.m., the facility failed to provide documents to show maintenance inspections were conducted for Elevators 050930	K 160	2. The Senior Vice President of Hospital Operations discussed payment of elevator permit invoices with the CFO and Accounts Payable. 3. Monitoring compliance with current elevator permits is part of the PM program. Compliance and Monitoring: Data on compliance is tracked, trended, analyzed and is reported quarterly at the EOC Committee. Corrective action is taken as n ecessary. Compliance is reported quarterly to the Quality Council a(until the Quality Council determines monitoring of the building is sufficiently conducted and then reporting will be provided quarterly to the Quality Council) and quarterly to the Governing Board.	03/03/2016

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K 160	Continued From page 97 and 051351. 3. At 12/18/15, at 10:15 a.m., a vendor indicated in December 2014 and 1/25/15 that the Phase II fire fighter service for Elevator 065766 did not function. There were no records of repairing the deficiency noted by the vendor.	K 160	Persons Responsible: Vice President of Facilities Development Director of Facilities	
K 211	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the Alcohol Based Hand Rub (ABHR) dispensers were not installed above or adjacent to an ignition source. This was evidenced by ABHR dispensers that were installed directly above electrical switches or outlets. This could result in the increased risk of an electrical fire and affected two of six floors in	K 211	NFPA 101 LIFE SAFETY CODE STANDARD	

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	050135	A. BUILDING 01 B. WING	12/18/2015

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SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	6245 DE LONGPRE AVE HOLLYWOOD, CA 90028

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K 211	Continued From page 98 the Hollywood Building. Findings: During a facility tour from 12/14/15 to 12/18/15, the Alcohol Based Hand Rub (ABHR) dispensers were observed throughout the facility. Hollywood Fourth Floor: 1. At 11:46 a.m., on 12/17/15, the ABHR dispenser in the corridor outside Room 404 was installed directly over an electrical outlet. The packaging indicated that the solution consisted of 85% ethyl alcohol. 2. At 11:47 a.m., on 12/17/15, the ABHR dispenser in Room 407 was installed directly over a light switch. The packaging indicated that the solution consisted of 85% ethyl alcohol. During an interview at 11:48 a.m., the Director of Facilities Services (DFS2) confirmed the findings and stated that the dispensers were recently installed by a vendor. Fifth Floor: 3. At 12:24 p.m., on 12/17/15, the ABHR dispenser in the corridor outside Room 504 was installed directly over an emergency outlet. The packaging indicated that the solution consisted on 85% ethyl alcohol.	K 211	Findings 1-3 Actions Taken: 1. The organization conducted an assessment of hand sanitizer/gel locations throughout the facility and relocated all sanitizer/gel dispenses away from electrical outlets, including all areas listed in the survey report. 2. Hospital Leadership discussed the process for installing alcohol based hand rub dispensers at Culver City, Hollywood and Van Nuys. The dispenses will now be installed by facility staff and not vendors. Facility staff were inserviced on correct placement of alcohol based hand rub dispensers away from ignition sources. 3. Monitoring of appropriate placement of alcohol based hand rub dispensers is performed through scheduled EOC rounds. Compliance and Monitoring. Data on compliance is tracked, trended, analyzed and is reported monthly at the EOC Committee. Corrective action is taken as necessary. Compliance is reported monthly to the Quality Council (until the Quality Council determines monitoring of the building is sufficiently conducted and then reporting will be provided quarterly to the Quality Council) and quarterly to the Governing Board. Persons Responsible: Vice President of Facilities Development Director of Facilities	01/12/2016 03/04/2016

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A 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health Licensing and Certification during a CMS requested FULL VALIDATION SURVEY conducted on 12/14/15 through 12/22/15 following a COMPLAINT VALIDATION SURVEY conducted on 9/21/15 through 9/25/15. Event ID: GQF611 The following findings reflect a full inspection of the facility. Representing the Department of Public Health Licensing and Certification: Surveyor 25092, HFEN Surveyor 33720, HFEN Surveyor 20161, HFEN Surveyor 35399, HFEN Medical Consultant, 26881 Medical Consultant, 29775 Pharmacy Consultant, 34709 Nutritionist Consultant, 16614 Infection Control Consultant, 29643 Infection Control Consultant, Trainee The census at the Culver City campus was: 225 The census at the Hollywood campus was: 41 The census at the Van Nuys campus was: 56 Patient Records Sampled: 59. 1. On 12/14/15 at 3:15 PM., an Immediate Jeopardy (IJ) was declared for the widespread pattern of potential ineffective cleaning, disinfection and lack of prevention of transference of infectious substances when: a) In the sterile processing unit: Sterility of surgical instruments could not be ensured due to	A 000	A 000 Initial Comments Preparation and execution of this plan of correction does not constitute an admission or agreement of the facts alleged or conclusions set forth on the Statement of Deficiencies. This plan of correction is prepared and executed solely because it is required by federal and state law. The following constitutes Southern California Hospital at Hollywood's credible allegation of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 000	Continued From page 1 the ineffective decontamination/disinfection and sterile processing of the surgical instruments per national recognized standards and the hospitals own policy and procedures. b) The facility did not provide active surveillance to identify policies and procedures that are not implemented correctly in an active infection control program. c) Ensure sanitary condition of the Operating Room Suites environment. d) Did not provide effective monitoring to ensure staff was trained and competent to effectively sterilize hinged surgical instruments. e) Did not provide for and monitor material covering operating room equipment, (i.e. patient gurney, arm board; failed to maintained in a condition that would permit the equipment to be disinfected). f) Did not provide effective monitoring of sterile supplies and sterile surgical instrument storage room. g) Did not ensure Sterile supplies were maintained in accordance with facility policy regarding event-related sterility. h) Ensure the sterility of Surgical instruments and sterile supplies. 2. In addition, the following standard practice deficiencies were found. a) A substance was found around the edges of the decontamination sink and immediately above on the wall and throughout the room. b) The sterile processing room was found with dust and debris throughout the unit. Documentation the facility maintains the unit per	A 000		

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A 000	Continued From page 2 national recognized standards and facility policy was lacking and not evident in the condition of the unit. c) The STERIS's washer was found not to be maintained per Manufactures Instructions when a review of records revealed a lack of documentation. The documentation of the washing cycle was not accurately recorded when the load cycles documentation binder and tape printed out lacked the documentation by SP Tech (Sterile Processing TECH) according to national recognized standards. 3) On 12/14/15 at approximately 3:39 P.M., the CDPH survey team informed the Culver City Hospital Administrative Team of an Immediate Jeopardy identified throughout the facility regarding surgical instruments. a) On 12/14/2015 at approximately 5:15 A.M., following a meeting to discuss corrected actions taken to ensure effective sterilization processes, the hospital submitted a corrective action plan including the following: · The Immediate cessation of elective surgeries and procedures · The Immediate cleaning from top to bottom of the decontamination and all sterile processing unit areas. · The Immediate reprocessing of all surgical instruments. The action plan was accepted on 12/14/2015 at 5:29 PM, by the survey team leader and Chief medical Consultant. (Refer A-749) 4) On 12/22/2015 at 1:06 P.M, Immediate Jeopardy was abated after compliant practices in cleaning, disinfecting, and sterilization were identified. Thus, the parameters were met for the sterility of surgical instruments is confirmed.	A 000		

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A 000	Continued From page 3 The cumulative effects of these systemic problems resulted in the hospital's inability to provide an effective hospital wide infection control program with patient care in a safe and effective manner in accordance with the Condition of Participation for Infection Control Services. The seriousness of which, resulted in an immediate jeopardy identified by the survey team.	A 000		
A 043	482.12 GOVERNING BODY There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ... This Condition is not met as evidenced by: Based on observation, interview and record review, the Governing Body failed to be responsible for the conduct of the hospital because: 1 The medical staff members' competence and judgement were not established as the basis for reappointment and re-privileging (cross reference A-0050). 2 A compounding pharmacy was allowed to provide medication to the facility without a contract or quality review by the hospital (cross reference A-0083). 3 An effective quality assessment performance improvement program had not been implemented to assist in establishing expected practices and outcomes, monitoring for aberrances and correcting deficient practices (cross reference A-0263). 4 An effective infection control program had not been designed and implemented to minimize the risk of the spread of infection and contagious	A 043	A 043 482.12 Governing Body The Governing Board has been involved in the development and implementation of this credible allegation of compliance. The Board appreciates that it is ultimately responsible for conduct in the hospital to ensure safe medical practices that are of high quality are implemented and sustained in accordance with the Medicare Conditions of Participation. Informal discussions and formal meetings have taken place since the survey with various members of the Governing Board and hospital leadership. The Governing Board meets monthly and as necessary to discuss overall operational and patient care issues, including but not limited to: a) medical staff services; b) contracted services; c) implementation of a robust Quality Assessment Performance Improvement (QAPI) program to address hospital operations, expected practices and outcomes and monitoring processes to identify and correct aberrant and deficient practices; and d) an effective infection control program that minimizes the spread of infection. The Hospital engaged legal counsel and a national healthcare regulatory compliance consulting firm to assist with the credible allegation of compliance. In addition, Corporate Leadership assisted with providing additional leadership staff to assist with development and implementation of the corrective action plan, ongoing staff education, and recruitment of middle level management to assist with ongoing oversight and accountability.	3/22/16 1/13/16 - 3/22/16

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A 043	Continued From page 4 disease (cross reference A-0747). During interviews with Governing Body representatives on 12/17/15 and 12/18/15, they acknowledged historic and recruitment difficulties contributing to difficulty meeting performance standards. The cumulative outcome of these failings meant the Governing Body did not ensure the safety and quality of healthcare provided in the hospital.	A 043		
A 050	482.12(a)(6) MEDICAL STAFF - SELECTION CRITERIA [The governing body must] ensure that criteria for selection are individual character, competence, training, experience, and judgement. This Standard is not met as evidenced by: Based on interview and document review, the hospital failed to ensure that medical staff members' competence and judgement were established prior to reappointment because the ongoing provider performance evaluations were incomplete, creating the risk of substandard medical staff performance. Findings: During a review of six physician provider and one CRNA provider credential files, the files lacked specific information about medical staff performance. There were pre-printed forms on which it could be indicated by means of a check mark in a box, if there were concerns with physician performance in medical records, quality measure, and infection prevention. However, it was unclear what the basis for the check marks was. For example, the QAPI department's pre-printed form had the pre-printed statement, " There were no quality of care issues identified for this practitioner during the period requested. " However, it was unclear what data the QAPI department was reviewing before marking the	A 050	A 050 482.12(a)(6) Medical Staff – Selection Criteria Immediate Actions Taken: 1. The Director of Medical Staff Services Department created an "Ongoing Provider Performance and Evaluation Task Force," which consisted of the Director of Quality, Director of Clinical Informatics, Decision Support Director, the CEO and Chief Operating Officer (COO) and a member of the Information Technology (IT) Department. The purpose of the task force was to further the review of the existing OPPE process and to confirm the indicators for the OPPE process and ongoing monitoring. Subsequent Actions Taken: 1. Hospital Leadership engaged legal counsel and a national healthcare regulatory consulting firm to assist with correction of medical staff findings and implementation of medical staff processes to sustain compliance. 2. The consultants and Medical Staff Team worked collaboratively on reviewing the current process for ongoing provider performance evaluations (OPPE). The following actions were taken between 2/15/16 and 3/22/16: a. A review of the appointment and reappointment process in the bylaws was performed and it was determined that these processes did not require any revisions. b. Medical Staff Leadership reviewed the existing "OPPE/FPPE" Policy. The policy was	1/14/16 1/13/16 2/15/16 - 3/22/16

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A 050	Continued From page 5 box opposite the statement. Similarly, the Infection Control Department was providing a pre-printed statement with boxes to check for, "no hospital infection statistics were identified for this practitioner during the period requested.", or "No data identified for this practitioner during the period requested." In an interview with the Dir MS Services on 12/15/15 at 0915, she stated that the medical staff had a meeting eight days prior to discuss selecting criteria that can be collected to evaluate the medical staff, but there were no meeting minutes available for review. In an interview with the ICP 1 on 12/16/15 at 1200, she stated that she believed there was a 6 month gap in surveillance for surgical site infections. She stated that she had not had the opportunity to retrospectively review surgical site infections by surgeon. She stated that a co-worker had been signing the documents from the infection prevention department that were used to support medical staff reappointment, but without current data. In an interview with the Vice Chief MS and GB on 12/17/15 at 1430, he stated that the hospital was working to get the provider performance evaluation process going, including a mechanism to attribute surgical site infections to a particular surgeon, but that it was not yet available. In an interview with the CEO on 12/17/15 at 1530, he stated that the ongoing provider performance evaluation process was broken, and that there were improvements in process.	A 050	revised to focus on ensuring the medical staff conducts periodic appraisals of all practitioners granted privileges. This appraisal may include peer review, FPPE, OPPE and other performance data for practitioners (e.g., physicians and AHP) on an ongoing basis. Data is collected, analyzed and reviewed at time of reappointment by the applicable Department Committee, the Medical Executive Committee (MEC) and the Governing Board as appropriate. This review is conducted to enable the medical staff to fully assess and ensure the competence of its practitioners, and to take appropriate steps to improve performance of these practitioners as part of its ongoing commitment to high quality care. Providers have access to their performance profiles through their department chief and/or direct request from the medical staff office. The MEC approved the revised policy on 3/15/16 and the Governing Board approved on 3/16/16. c. The CEO, Director of Medical Staff Services and Chief of Staff met on 3/2/16 to discuss concerns with the identified pre-printed forms. It was decided to cease using these forms and reinstitute use of the "Practitioner Performance Profile" Form to identify the current available data for reappointments, including, among other things, practitioner findings on core measures and core competencies including patient care, medical knowledge, communication, professionalism, practice-based learning and improvement, and systems based practice. Also included in the profile is data related to department based indicators such as surgical site infections (for the department of surgery) and readmissions within 30 days (for the department of medicine), utilization review,	
A 083	482.12(e) CONTRACTED SERVICES The governing body must be responsible for services furnished in the hospital whether or not they are furnished under contracts. The governing body must ensure that a contractor of services (including one for shared services and	A 083		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050135	A. BUILDING _____ B. WING _____	12/22/2015

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SOUTHERN CALIFORNIA HOSPITAL AT HOLL	6245 DE LONGPRE AVE HOLLYWOOD, CA 90028

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A 050	Continued From page 5 box opposite the statement. Similarly, the Infection Control Department was providing a pre-printed statement with boxes to check for, "no hospital infection statistics were identified for this practitioner during the period requested.", or "No data identified for this practitioner during the period requested." In an interview with the Dir MS Services on 12/15/15 at 0915, she stated that the medical staff had a meeting eight days prior to discuss selecting criteria that can be collected to evaluate the medical staff, but there were no meeting minutes available for review. In an interview with the ICP 1 on 12/16/15 at 1200, she stated that she believed there was a 6 month gap in surveillance for surgical site infections. She stated that she had not had the opportunity to retrospectively review surgical site infections by surgeon. She stated that a co-worker had been signing the documents from the infection prevention department that were used to support medical staff reappointment, but without current data. In an interview with the Vice Chief MS and GB on 12/17/15 at 1430, he stated that the hospital was working to get the provider performance evaluation process going, including a mechanism to attribute surgical site infections to a particular surgeon, but that it was not yet available. In an interview with the CEO on 12/17/15 at 1530, he stated that the ongoing provider performance evaluation process was broken, and that there were improvements in process.	A 050	number of suspension days, blood use, medication use, hospital acquired infections, mortality/morbidity rates, risk management, grievance/complaint, and peer review issues. d. Hospital Leadership and the Director of Medical Staff Services worked collaboratively with the Director of Business Integration to set up an electronic system so that individual Department Leadership can input the necessary data for reporting outcomes, which is used for evaluation by the Medical Staff Services Department for reappointments and for ongoing monitoring. It is anticipated that this electronic system will be functional by 6/1/16. In the interim, the data is being collected manually by the individual Department Leadership, including Quality, Infection Control, Radiology, Laboratory/Blood Bank; Pathology, Case Management, Health Information Management Department and the medical staff departments. e. The Medical Staff Services Department and physician leadership re-evaluated reappointments for all practitioners from January 2016 through March 2016 and reviewed those practitioners due for reappointment in April 2016 to assess compliance with establishing/evaluating the physician's competency prior to re-appointment. The data for reappointment was collected and profile developed, which was resubmitted to the MEC for re-review and approval on 3/15/16. f. The Medical Staff Services Department and physician leadership re-evaluated the reappointments for the identified physicians and the CRNA. A profile is in place for each of these providers, which contains the specific information about medical staff performance, included in the revised performance profiles form, as noted above.	
A 083	482.12(e) CONTRACTED SERVICES The governing body must be responsible for services furnished in the hospital whether or not they are furnished under contracts. The governing body must ensure that a contractor of services (including one for shared services and	A 083		

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A 083	482.12(e) CONTRACTED SERVICES The governing body must be responsible for services furnished in the hospital whether or not they are furnished under contracts. The governing body must ensure that a contractor of services (including one for shared services and	A 083	A 083 482.12(e) Contracted Services Actions Taken: 1. Executive Leadership reviewed the survey findings and the process for monitoring contracted services. The CEO or qualified designee shall maintain a list of all contracted services in the Hospital. The list shall include	3/22/16

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A 083	Continued From page 6 joint ventures) furnishes services that permit the hospital to comply with all applicable conditions of participation and standards for the contracted services. This Standard is not met as evidenced by: Based on interview, the hospital failed to ensure the safety of a compounding pharmacy providing medication to the hospital, because there was no established contract with the pharmacy, creating the risk of substandard pharmaceutical services. Findings: In an interview with the Vice Chief MS and GB on 12/17/15 at 1410, he stated that all outside contracts were recorded on a grid and reviewed annually by the department head, MEC (Medical Executive Committee) and GB (Governing Body). In an interview with the COO on 12/17/15 at 1412, he stated that the compounding pharmacy was providing its own QA data, but there was no contract with the pharmacy.	A 083	the service, the provider of the contracted services, the date of the contract, and the expiration date. Renewals of contracts shall be performed in accordance with the contract provisions. Copies of the current contracts are maintained in the Corporate Legal office. 2. The Hospital sign a contract with a compounding pharmacy and provided it to them for review and signature. The compounding pharmacy anticipates completion by 3/22/16. The Director of Pharmacy met with the compounding company and conducted an inspection and assessment of the services provided. 3. Executive Leadership and Corporate Legal reviewed applicable hospital contracts to ensure the contracts are current. 4. Executive Leadership discussed the survey findings with the Quality Department. Contracts are reviewed to ensure the presence of stated performance expectations by the contracted provider are included in the contract. Evaluation of contracted services are included in the ongoing monitoring activities through the QAPI program to assess the services, identify any	3/22/16 3/22/16 3/22/16
A 131	482.13(b)(2) PATIENT RIGHTS: INFORMED CONSENT The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate. This Standard is not met as evidenced by: Based on interview and record review, for one patient, Patient 505, the hospital failed to ensure that documentation regarding the patient's desire	A 131		

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A 131	482.13(b)(2) PATIENT RIGHTS: INFORMED CONSENT The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate. This Standard is not met as evidenced by: Based on interview and record review, for one patient, Patient 505, the hospital failed to ensure that documentation regarding the patient's desire	A 131	A 131 482.13(b)(2) Patient Rights: Informed Consent Immediate Actions Taken: 1. Hospital Leadership met to discuss the survey finding and the process for obtaining advance directives and informed consents. Subsequent Actions Taken: 1. Executive Leadership reviewed the "Informed Consent" Policy, and made revisions to simplify language to enhance staff understanding of required elements of obtaining and annotating the patient's informed consent. Executive Leadership, clinical staff, the medical staff and governance understand informed consent is required for those procedures which are complex or involve material risks that are not commonly understood. The patient's physician is responsible for providing the information the patient needs in order to make an informed	12/18/15 3/22/16

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A 131	Continued From page 7 for CPR was recorded in the medical record, creating the risk of the patient's wishes regarding emergency treatment not being followed. Findings: During a review of the medical record of Patient 505 on 12/14/15, the record contained a Physician's Orders sheet that was pre-printed with CPR orders that were to be selected by means of checking a box. The order sheet read, " Must be filled out at the time of admission and with any change in code status". There were boxes to select either "full CPR" or "no CPR", but neither was selected. The form bore a date and time, but no signature. The Emergency Admit form showed that the patient was 84 and being admitted for failure to thrive. A Pre-procedure Evaluation on 12/11/15 showed that she was awake and oriented. During an interview with the Sr Mgr of Medical Records on 12/15/15 at 1050, she stated that the form should have been completed upon admission, and that she was not sure why it was not completed.	A 131	decision and for obtaining the patient's informed consent or refusal for the recommended procedure. The hospital's role in the informed consent process is to verify that the physician obtained the patient's informed consent before the procedure. The policy was approved by the MEC on 3/15/16 and the Governing Board on 3/16/16. Nursing staff was educated on the revised policy with implementation by 3/22/16. 2. Additionally, the hospital's consent form (the document on which the patient's consent is annotated) was reviewed and revised to streamline the narrative, simplify the format and reduce the overall form from six (6) pages to two (2) pages. The hospital elected to maintain a separate consent for blood transfusions and the use of psychotropic medications. The consent form was approved by the MEC on 3/15/16 and Governing Board on 3/16/16. Nursing staff was educated on the form, with use of the form implemented by 3/22/16. 3. Executive Leadership reviewed and revised the "Advance Directive" Policy, focusing on the process of ensuring the patient was provided with information on the hospital's policy on advance directives, provision of information to the patient/family about advance directives and	3/22/16 3/22/16
A 143	482.13(c)(1) PATIENT RIGHTS: PERSONAL PRIVACY The patient has the right to personal privacy. This Standard is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide privacy, as evidence by the following: 1. Patients' were physically exposed while receiving care. 2. Patients' clinical and demographic information was not protected. Findings:	A 143		

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A 143	482.13(c)(1) PATIENT RIGHTS: PERSONAL PRIVACY The patient has the right to personal privacy. This Standard is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide privacy, as evidence by the following: 1. Patients' were physically exposed while receiving care. 2. Patients' clinical and demographic information was not protected. Findings:	A 143		

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A 143	482.13(c)(1) PATIENT RIGHTS: PERSONAL PRIVACY The patient has the right to personal privacy. This Standard is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide privacy, as evidence by the following: 1. Patients' were physically exposed while receiving care. 2. Patients' clinical and demographic information was not protected. Findings:	A 143		

b

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A 143	482.13(c)(1) PATIENT RIGHTS: PERSONAL PRIVACY The patient has the right to personal privacy. This Standard is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide privacy, as evidence by the following: 1. Patients' were physically exposed while receiving care. 2. Patients' clinical and demographic information was not protected. Findings:	A 143	A 143 482.13(c)(1) Patient Rights: Personal Privacy Immediate Actions Taken: 1. Nursing Leadership reminded the nursing staff and the identified Echo technician in the CCU at the time of survey that patients have the right to privacy and patients should not be physically exposed while receiving care. 2. The identified transferring packet was removed from the computer area in front of Room 232. 3. Nursing Leadership discussed not leaving patient records out in public view with telemetry staff at the time of survey. 4. Nursing Leadership reviewed the telemetry unit and did not identify any other issues with patient records in public view.	12/17/15 12/15/15 12/15/15 12/15/15

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A 143	Continued From page 8 1. During a tour of the CCU and concurrent interview with the AS and charge nurse (CN) on 12/17/15 at 11:50 a.m., Patient N- 210 was receiving care without the room's window shades being closed, allowing people in the nurses's station to visualize the patient's exposed body from the middle of the nurses' station. The observations were shared with the AS and CN. They both agreed the nurse should have closed the window shades to provide the patient with privacy. On the same date during a tour of the CCU at 3:25 p.m., Patient N-211 was observed during a procedure for which his body was exposed, the door and the window shades were not closed. Concurrent inteview with the AS was held, and the AS agreed the door and window shades need to be closed for patient's privacy. The patient's LN was interviewed at the time and she conceded Patient N-211's window shades and door should have been closed while the echocardiography technician (echo tech) performed the procedure. 2. During a tour of one of theTelemetry hallways and concurrent interview with the telemetry director (TD) on 12/15/15 at 4:20 p.m., a transferring packet containing clinical and demographic information of the patient that was being transferred out of the unit was sitting on top of the computer in front of room 232. The TD was questioned and conceeded the records should not be to the public. The LN for the patient was interviewed a few minutes later.The LN agreed she shouldn't leave patient records available for public view.	A 143	Subsequent Actions Taken: 1. The CEO issued a "Message from the CEO" memo to nursing staff regarding maintaining privacy of patient records and patient's privacy during care and/or procedures (e.g., ensuring that the curtain/door is closed while the patient is receiving care). 2. Nursing huddles were held daily to re-enforce patient privacy issues, including record maintenance and privacy during patient care/ testing. This included keeping screens closed in the portable computers (WOW's) while in use in the hallway. 3. Hospital Leadership held daily huddles with staff, daily leadership meetings with management, and additional employee forums regarding the issue of maintaining patient privacy. In addition, the Leadership team conducted rounds, effective 1/21/16. The purpose of these rounds was to identify issues and bring them forward to the daily leadership meetings to remediate any privacy issues. 4. Education on patient privacy is provided to clinical staff upon hire. 5. Effective 2/5/16, protection of patient privacy is assessed during weekly monitoring rounds by charge nurses and individuals conducting observation rounding. <u>Compliance and Monitoring</u>: Data is collected via observation rounds performed by charge nurses and other designated personnel. Data is reported as rounding occurs to leadership to identify if staff remain compliant with patient privacy for both protection of personal health information and for personal privacy. The goal is to achieve 100% compliance with providing care without exposing patients and protecting patient's clinical and demographic information. Observations are	2/29/16 2/29/16 - 3/10/16 1/21/16 - 3/10/16 2/5/16
A 167	482.13(e)(4)(ii) PATIENT RIGHTS: RESTRAINT OR SECLUSION	A 167		

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A 143	Continued From page 8 1. During a tour of the CCU and concurrent interview with the AS and charge nurse (CN) on 12/17/15 at 11:50 a.m., Patient N- 210 was receiving care without the room's window shades being closed, allowing people in the nurses's station to visualize the patient's exposed body from the middle of the nurses' station. The observations were shared with the AS and CN. They both agreed the nurse should have closed the window shades to provide the patient with privacy. On the same date during a tour of the CCU at 3:25 p.m., Patient N-211 was observed during a procedure for which his body was exposed, the door and the window shades were not closed. Concurrent inteview with the AS was held, and the AS agreed the door and window shades need to be closed for patient's privacy. The patient's LN was interviewed at the time and she conceded Patient N-211's window shades and door should have been closed while the echocardiography technician (echo tech) performed the procedure. 2. During a tour of one of theTelemetry hallways and concurrent interview with the telemetry director (TD) on 12/15/15 at 4:20 p.m., a transferring packet containing clinical and demographic information of the patient that was being transferred out of the unit was sitting on top of the computer in front of room 232. The TD was questioned and conceeded the records should not be to the public. The LN for the patient was interviewed a few minutes later.The LN agreed she shouldn't leave patient records available for public view.	A 143	"teachable moments" with information disseminated in real time to staff verbally. Any variations in privacy protection are corrected immediately (on the spot) with just in time teaching provided to responsible nursing staff. Person Responsible: Chief Nursing Officer	
A 167	482.13(e)(4)(ii) PATIENT RIGHTS: RESTRAINT OR SECLUSION	A 167	A 167 482.13(e)(4)(ii) Patient Rights: Restraint or Seclusion	

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	050135	A. BUILDING _____ B. WING _____	12/22/2015

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A 167	Continued From page 9 [The use of restraint or seclusion must be--] (ii) implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospital policy in accordance with State law. This Standard is not met as evidenced by: Based on observation, interview and review of facility documents, the facility failed to ensure staff implemented the policies and procedures related to seclusion and restraints for two patients. N 401 and N 402 were on 1:1 observation. However, staff assigned to the patients were not always present. These failures placed the patients at risk for injury from themselves or others. Findings: Facility policy titled, "Behavioral Restraints and Seclusion" dated 9/2014 indicated, "4.2.5.2 A patient in restraints or seclusion and restraints simultaneously requires a higher level of monitoring in which the patient is continually monitored face-to-face by an assigned staff member (one to one)." During a tour of the behavioral health unit (BHU) on 12/14/15 at 4:10 p.m., the charge nurse (LN 11) identified N 402 as being on a one-to-one (1:1) observation and N 401 as having been on a 1:1 but ,"Since it was just a nursing order we decided to try him off...but after an hour we had to put him back on 1:1". N 401 was observed in a bed, with no staff in attendance. In a second bed, N 402 was observed in a bed in four point restraints. A staff	A 167	Immediate Actions Taken: 1. Executive Leadership discussed the surveyor's comments from the exit interview regarding the process for 1:1 observation. The "Restraint and Seclusion" policy was reviewed and determined to require revision to more closely align with actual provider practice and the safety practices the organization has in place for managing behavioral health restraint. 12/29/15 Subsequent Actions Taken: 1. The "Restraint and Seclusion" and "Patient Observation Sitter" policies were reviewed. The "Restraint and Seclusion" policy was revised to describe the actual practice of assessing patients in restraints, including a description of the monitoring activities required by staff for patients undergoing restraint/seclusion necessitating direct observation and in-person (1:1) observation. The restraint form for violent/self-destructive restraint/seclusion was revised to clearly express in 15 minute increments the monitoring activities of staff observing patients. The form was revised to use an attestation statement made by the observing staff verifying the patient is assessed every 15 minutes for circulation, skin integrity, range of motion, hygiene, nutrition, hydration, toileting (elimination) needs during the time the patient is observed (i.e., while in restraint/seclusion). In addition to the 15-minute observation monitoring activities, the form also now includes an hourly assessment of the patient by licensed nursing staff for vital signs, respiratory/cardiac status, signs of physical or psychological (mental status) distress or increasing agitation and need for ongoing restraint and/or seclusion, again annotated via an attestation statement of the hourly assessment. The restraint/seclusion documentation/order form was reconfigured to include the face-to-face evaluation by a qualified medical professional trained in	12/29/15 3/22/16

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A 167	Continued From page 9 [The use of restraint or seclusion must be--] (ii) implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospital policy in accordance with State law. This Standard is not met as evidenced by: Based on observation, interview and review of facility documents, the facility failed to ensure staff implemented the policies and procedures related to seclusion and restraints for two patients. N 401 and N 402 were on 1:1 observation. However, staff assigned to the patients were not always present. These failures placed the patients at risk for injury from themselves or others. Findings: Facility policy titled, "Behavioral Restraints and Seclusion" dated 3/2014 indicated, "4.2.5.2 A patient in restraints or seclusion and restraints simultaneously requires a higher level of monitoring in which the patient is continually monitored face-to-face by an assigned staff member (one to one)." During a tour of the behavioral health unit (BHU) on 12/14/15 at 4:10 p.m., the charge nurse (LN 11) identified N 402 as being on a one-to-one (1:1) observation and N 401 as having been on a 1:1 but ,"Since it was just a nursing order we decided to try him off...but after an hour we had to put him back on 1:1". N 401 was observed in a bed, with no staff in attendance. In a second bed, N 402 was observed in a bed in four point restraints. A staff	A 167	restraint/seclusion management within one hour of initiation of restraint/seclusion. This was added to the form to link the observation/ assessment performed for the patient to the face-to-face evaluation so the evaluator can clearly see all issues related to the specific restraint episode. The "Patient Observation Sitter" policy was revised to include the responsibilities for the sitter. The revised policies were approved by the MEC on 3/15/16 and Governing Board on 3/16/16. Education on the policies and implementation of the form was completed by 3/22/16. Compliance and Monitoring: On the Behavioral Health Unit, care facilitation, a process of reviewing the patient's record in real time, interceding with staff to provide teaching/correcting as necessary and revising care practices, was implemented on 2/5/16. Patients in restraint/seclusion were assigned to the care facilitation model to determine ongoing compliance with the organization's policy, form and practice revisions, including compliance with 1:1 observation. Compliance target was set at 100% with output from ongoing monitoring reported daily to the Executive Leadership team on a Monday through Friday basis (with weekends rolled into Monday's outcome data). Monthly data is reported to the Quality Council and MEC, and quarterly to the Governing Board. Outcomes from restraint monitoring will be reviewed by the Quality Council until the Council members feel restraint processes are compliant, with this compliance, sustainable over time. The Quality Council may then request reduction in monitoring to a random "snapshot" basis at a time period to be determined by the Council (e.g., quarterly, semi-annually, annually) to ensure continued compliance occurs. Person Responsible: Chief Nursing Officer	

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A 167	Continued From page 10 member (MHW 1) was seated at a table at the foot of the bed. When asked where the staff member was who was assigned to N 401, LN 11 stated, "Oh, he (MHW) 2 is just down the hall if they need him." N 401 was not receiving 1:1 observation as required by the facility's policy.	A 167		
A 172	482.13(e)(8) PATIENT RIGHTS: RESTRAINT OR SECLUSION [Unless superseded by State law that is more restrictive,] (ii) After 24 hours, before writing a new order for the use of restraint or seclusion for the management of violent or self-destructive behavior, a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c) of this part and authorized to order restraint or seclusion by hospital policy in accordance with State law must see and assess the patient. This Standard is not met as evidenced by: Based on observation, interview, and review of records the facility failed to ensure the physician documented an assessment of two patients in seclusion and/or restraints. Patient N 402 was on 1:1 observation and in four point restraints. Patient N 404 was in the locked seclusion room. This failure placed both patients at risk for not being accurately assessed for the restrictions. Findings: Review of facility policy titled Behavioral Restraints and Seclusion" dated 3/2014 identified	A 172	A 172 482.13(e)(8) Patient Rights: Restraint or Seclusion Immediate Actions Taken: 1. Executive Leadership discussed the surveyor's comments from the exit interview regarding physician documentation of assessments of patients in seclusion and/or restraints. Subsequent Actions Taken: 1. The "Restraint and Seclusion" policy was revised (and approved by the MEC and Governing Board) to discuss the requirement of the physician to assess the patient, however the discussion of documenting this in the progress notes was not made a requirement. The focus for the medical staff is on ensuring the assessment takes place with the restraint/ seclusion integrated into the care planning process where all staff can easily review. A memorandum was disseminated to the medical staff encouraging documentation in the progress notes as well, however, the focus is on performing the assessment, and getting the restraint/seclusion management effectively in the care planning document 2. Executive Leadership engaged two consulting physicians to work with medical staff providers (including nurse practitioners) to ensure understanding of restraint/seclusion requirements. 3. Compliance with ongoing assessments for patients in restraints/seclusion is monitored through the QAPI program.	12/29/15 3/22/16 2/15/16 and 2/29/16

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A 172	Continued From page 11 the following instruction: "4.2.4.6. ..:The treating physician is required to record in the progress notes the seclusion/restraints episode within 24 hours." 1. During the tour of the 6th floor on 12/14/15 N 402 was observed in a room in four point restraints. (The wrists and ankles being tied to a bed). There was a staff member in attendance. On 12/16/15 during a review of the record of N 402, the surveyor requested any seven consecutive days of physician progress notes. The dates given by the facility were 11/2/15 through 11/7/15. The patient was seen daily by the physician. The use of restraints was mentioned in one of six progress notes. During interview and concurrent review of the notes with the chief clinical office (CCO) she stated, "Another doctor was covering for some of those days." 2. During continued tour of the 6th floor, N 404 was observed on a bed in the locked seclusion room. The mental health worker (MHW) stated N 404 was threatening staff and hurting himself. The room was used to reduce stimulation and calm him. On 12/16/15 during a review of the record of N 404, the surveyor requested any seven consecutive days of physician progress notes. The dates given by the facility were 12/1/15 through 12/6/15. The patient was seen daily by the physician. The use of the seclusion room was mentioned in one of six progress notes. During interview and concurrent review of the notes with the chief clinical officer (CCO) she.	A 172	Compliance Monitoring: Care facilitation, a process of reviewing the patient's record in real time, interceding with staff to provide teaching/correcting as necessary and revising care practices, was implemented on 2/5/16. All patients in seclusion/restraint were assigned to the care facilitation model to determine ongoing compliance with ongoing assessments related to restraint/seclusion. Compliance target was set at 100% with output from ongoing monitoring reported daily to the Executive Leadership team on a Monday through Friday basis (with weekends rolled into Monday's outcome data). Monthly data is reported to the Quality Council and MEC, and quarterly to the Governing Board. Outcomes from restraint monitoring will be reviewed by the Quality Council until the Council members feel restraint processes are compliant, with this compliance sustainable over time. The Quality Council may then request reduction in monitoring to a random "snapshot" basis at a time period to be determined by the Council (e.g., quarterly, semi-annually, annually) to ensure continued compliance occurs. Person Responsible: Chief Nursing Officer	

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A 172	Continued From page 12 stated, "Another doctor was covering for some of those days."	A 172		
A 175	482.13(e)(10) PATIENT RIGHTS: RESTRAINT OR SECLUSION The condition of the patient who is restrained or secluded must be monitored by a physician, other licensed independent practitioner or trained staff that have completed the training criteria specified in paragraph (f) of this section at an interval determined by hospital policy. This Standard is not met as evidenced by: Based on observation, interview and record review, the facility failed to assess, monitor and document on Patient N 200, N 201, N 216, and N 217 who had non-behavioral restraints. Failure to monitor and assess for restraints puts patients at risk for negative complications during the use of restraints. Findings: During a tour of the facility on 12/15/15 from 11:00 a.m., to 12:00 p.m., Patients N 200, N 201, N 216, and N 217 were observed with restraints. The clinical records of the patients were reviewed and contained incomplete "Non-Behavioral restratin order and flow sheets". Patient N 201's clinical record had no documentation to indicate attempts or interventions were performed in order to remove the restraints. Concurrent interview with RN 1 was held, and she was questioned as to the incomplete flow sheets. RN 1 stated if the sheets were incomplete that meant the patient was not assessed or monitored in the areas that were incomplete.	A 175	A 175 482.13(e)(10) Patient Rights: Restraint or Seclusion Immediate Action Taken: 1. Executive Leadership discussed the surveyor's comments from the exit interview regarding alternatives to restraints and management of the patient restrained for non-behavioral health reasons. The "Restraint and Seclusion" policy was reviewed and determined to require revision to more closely align with actual provider practice and the regulatory requirement for non-behavioral health restraint. Subsequent Actions Taken: 1. The "Restraint and Seclusion" policy was revised to describe the actual practice of assessing patients in restraint for attempts or consideration and rejection of alternatives to restraint and least restrictive measures. The policy also was revised to describe monitoring activities required by staff for patients undergoing restraint. The restraint form was revised to describe alternatives/less restrictive measures attempted or considered and rejected as unable to be performed, as well as an attestation statement made by the nurse verifying the patient is assessed every 2 hours for circulation, skin integrity, range of motion, hygiene, nutrition, hydration, toileting (elimination needs) physical and psychological needs during his/her shift. The attestation statement is completed at the end of the nurse's shift and confirms the nurse's ongoing assessments on an every 2 hours basis throughout the shift. A one-time attestation replaces multiple check boxes and includes an evaluation of the patient's ability to tolerate restraint on a psychological and physical level. This restraint form revision links the assessment/monitoring activities with an evaluation of the patient, thereby clearly	12/29/15 3/22/16

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A 172	Continued From page 12 stated, "Another doctor was covering for some of those days."	A 172		
A 175	482.13(e)(10) PATIENT RIGHTS: RESTRAINT OR SECLUSION The condition of the patient who is restrained or secluded must be monitored by a physician, other licensed independent practitioner or trained staff that have completed the training criteria specified in paragraph (f) of this section at an interval determined by hospital policy. This Standard is not met as evidenced by: Based on observation, interview and record review, the facility failed to assess, monitor and document on Patient N 200, N 201, N 216, and N 217 who had non-behavioral restraints. Failure to monitor and assess for restraints puts patients at risk for negative complications during the use of restraints. Findings: During a tour of the facility on 12/15/15 from 11:00 a.m., to 12:00 p.m., Patients N 200, N 201, N 216, and N 217 were observed with restraints. The clinical records of the patients were reviewed and contained incomplete "Non-Behavioral restratin order and flow sheets". Patient N 201's clinical record had no documentation to indicate attempts or interventions were performed in order to remove the restraints. Concurrent interview with RN 1 was held, and she was questioned as to the incomplete flow sheets. RN 1 stated if the sheets were incomplete that meant the patient was not assessed or monitored in the areas that were incomplete.	A 175	communicating ongoing patient restraint management needs and outcomes. Completion of the form on a shift-by-shift basis ties the ongoing assessment each shift for need to continue restraints and provides a clear and concise picture for the physician/provider staff of the reason and/or need for ongoing restraint. The policy was revised and approved by the MEC on 3/15/16 and Governing Board on 3/16/16. Forms were revised on 3/1/16 with education and implementation completed on 3/22/16. Compliance and Monitoring: Care facilitation, a process of reviewing the patient's record in real time, interceding with staff to provide teaching/correcting as necessary and revising care practices, was implemented on 2/5/16. All patients in restraint were assigned to the care facilitation model to determine ongoing compliance with policy, form and practice revisions. Compliance target was set at 100% with output from ongoing monitoring reported daily to the Executive Leadership team on a Monday through Friday basis (with weekends rolled into Monday's outcome data). Monthly data is reported to the Quality Council and MEC, and quarterly to the Governing Board. Outcomes from restraint monitoring will be reviewed by the Quality Council until the Council members feel restraint processes are compliant, with this compliance sustainable over time. The Quality Council may then request reduction in monitoring to a random "snapshot" basis at a time period to be determined by the Council (e.g., quarterly, semi-annually, annually) to ensure continued compliance occurs. Person Responsible: Chief Nursing Officer	

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A 175	Continued From page 13 A review of the facility's policy and procedure titled: Non-Behavioral Restraints, PAT.048, dated 5/2015, in section 4.11 Restraint Application and Removal, indicated "Restraints will be released and rotated at least every 2 hours". In Section 4.14 Documentation, indicated "The following shall be documented: Integrity/Effectiveness of restraint, Skin Integrity, Body alignment, Patient basic needs to include nutrition, hydration, elimination...". The facility staff failed to implement policy when managing non-behavioral restraints with patients.	A 175		
A 178	482.13(e)(12) PATIENT RIGHTS: RESTRAINT OR SECLUSION When restraint or seclusion is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others, the patient must be seen face-to-face within 1-hour after the initiation of the intervention -- o By a-- - Physician or other licensed independent practitioner; or - Registered nurse or physician assistant who has been trained in accordance with the requirements specified in paragraph (f) of this section. This Standard is not met as evidenced by: Based on observation, interview and review of documents the facility failed to ensure nursing staff followed policy and procedures related to assessing a patient in restraints. Nursing failed to document assessments hourly for N 402 as required. These failures placed the patient at risk for not	A 178	A 178 482.13(e)(10) Patient Rights: Restraint or Seclusion Immediate Action Taken: 1. Executive Leadership discussed the surveyor's comments from the exit interview regarding alternatives to restraints and management of the patient restrained for non-behavioral health reasons. The "Restraint and Seclusion" policy was reviewed and determined to require revision to more closely align with actual provider practice and the regulatory requirement for restraint/seclusion for the violent/self-destructive patient. Subsequent Actions Taken: 1. The "Restraint and Seclusion" policy was revised to describe the actual practice of assessing patients in restraint. The attestation statement is completed at the end of the nurse's shift and confirms the nurse's ongoing assessments on an hourly basis throughout the shift although the nurse can document the assessment hourly concurrently with performance of the assessment. A one-time attestation replaces multiple check boxes and includes an evaluation of the patient's ability to	12/29/16 3/22/16

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A 178	Continued From page 14 being accurately assessed for change of condition and safety while in four point restraints. Findings: Review of the facility policy titled, "Behavioral Restraints and Seclusion" identified the following requirement for RNs: "4.2.21 Patient assessment every hour." and "4.2.30 RN documentation on flow sheet every hour." During observation of N 402 on 12/14/15 at 4:40 p.m. he was noted to be in four point restraints in bed. MHW 1 was in attendance as N 402 was on one-to-one (1:1) observation. During review of the record of N 402 the following restraint flow sheets were noted to be incomplete, indicating an RN did not see and assess N 402 hourly as required: (military times) 12/11/15 2000, 2100, and 2200. 12/12/15 0900 and 1000 12/13/15 1100, 1200, 1300, 1400, 1500, 1600, 1700, 1800, 1900, 2000, and 2100. 12/14/15 0700, 0800, 0900,1500, 1600, and 1700. During concurrent review and interview with LN 11 on 12/15/15 at 9:35 a.m. LN 11 stated, "But there were 15 minute checks done by the MHW." "Looks like no RN assessed him, but a tech did."	A 178	tolerate restraint/seclusion on a psychological and physical level. This restraint form revision links the assessment/monitoring activities with an evaluation of the patient, thereby clearly communicating ongoing patient restraint management needs and outcomes. Completion of the form on a shift-by-shift basis ties the ongoing assessment each shift for need to continue restraints and provides a clear and concise picture for the physician/provider staff of the reason and/or need for ongoing restraint. The policy was revised and approved by the MEC on 3/15/16 and Governing Board on 3/16/16. Forms were revised on 3/1/16 with education and implementation completed on 3/22/16. Compliance and Monitoring: Care facilitation, a process of reviewing the patient's record in real time, interceding with staff to provide teaching/correcting as necessary and revising care practices, was implemented on 3/11/16. Patients in restraint/seclusion were assigned to the care facilitation model to determine ongoing compliance with policy, form and practice revisions. Compliance target was set at 100% with output from ongoing monitoring reported daily to the Executive Leadership team on an Monday through Friday basis (with weekends rolled into Monday's outcome data). Monthly data is reported to the Quality Council and MEC, and quarterly to the Governing Board. Outcomes from restraint monitoring will be reviewed by the Quality Council until the Council members feel	
A 263	482.21 QAPI The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the	A 263		

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A 178	Continued From page 14 being accurately assessed for change of condition and safety while in four point restraints. Findings: Review of the facility policy titled, "Behavioral Restraints and Seclusion" identified the following requirement for RNs: "4.2.21 Patient assessment every hour." and "4.2.30 RN documentation on flow sheet every hour." During observation of N 402 on 12/14/15 at 4:40 p.m. he was noted to be in four point restraints in bed. MHW 1 was in attendance as N 402 was on one-to-one (1:1) observation. During review of the record of N 402 the following restraint flow sheets were noted to be incomplete, indicating an RN did not see and assess N 402 hourly as required: (military times) 12/11/15 2000, 2100, and 2200. 12/12/15 0900 and 1000 12/13/15 1100, 1200, 1300, 1400, 1500, 1600, 1700, 1800, 1900, 2000, and 2100. 12/14/15 0700, 0800, 0900,1500, 1600, and 1700. During concurrent review and interview with LN 11 on 12/15/15 at 9:35 a.m. LN 11 stated, "But there were 15 minute checks done by the MHW." "Looks like no RN assessed him, but a tech did."	A 178	restraint processes are compliant, with this compliance sustainable over time. The Quality Council may then request reduction in monitoring to a random "snapshot" basis at a time period to be determined by the Council (e.g., quarterly, semi-annually, annually) to ensure continued compliance occurs. Person Responsible: Chief Nursing Officer	
A 263	482.21 QAPI The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the	A 263	A263 482.21 QAPI The Hospital engaged legal counsel and a national healthcare regulatory compliance consulting firm to assist with the credible allegation of compliance, including implementing a new QAPI program. Executive Leadership, the Consultant Team and the Director of Quality discussed the survey findings and the current QAPI program. The QAPI Program resource allotment was restructured	1/13/16 - 3/22/16

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A 263	Continued From page 15 hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This Condition is not met as evidenced by: Based on observation, interview and record review, the hospital did not ensure that a data-driven, hospital wide QAPI program was designed and implemented because: 1) Incidents and errors were not subject to review and analysis, and did not form the basis for performance improvement (cross reference A-0286). 2) The QAPI program did not collect or monitor hospital data regarding discharge planning, surgical site infection and staff influenza screening (cross reference A-0273). 3) The hospital did not focus on high risk, prevalent issue of suicidality among the hospital's patients, and did not analyze and use data regarding mortality, and falls to improve the quality of care provided (cross reference A-0283). 4)The Governing Body voiced awareness of the need to improve the QAPI program, but had not yet implemented changes needed to improve the program (cross reference A-0309). The cumulative effect of these failings meant the hospital did not provide a QAPI program to ensure the quality and safety of the healthcare provided to the patients.	A 263	into Quality/Safety, Risk Management and Education roles. The hospital implemented a process of significant adverse events management improvements and executive awareness through daily "Flash" huddles with weekends rolled into Monday's outcome data. Any significant event on the weekend will be reported to the administrator on call. Executive Leadership participates in these meetings where any significant event occurring over the prior 24 hours is brought before senior leadership for immediate review, ensuring the event is managed timely, by the right individuals, through the right method. The hospital is also rebuilding its QAPI and oversight processes from the bottom up, addressing the Process Oversight, Issue or Problem Management, Regulatory Preparedness and Response, the roll out of a rigorous improvement Process, and the streamlining and focusing of Oversight mechanisms. A revised QAPI program plan was developed and implemented, and now includes a reporting schedule, indicator matrix, departmental breakdown and flow diagram, which was presented and approved at the Quality Council on 1/27/16. The revised QAPI program is comprehensive, data-driven, and robust, reflecting the hospital's operations and services. Identification, measuring, analyzing and tracking of quality indicators is in place to ensure that hospital services and operations are evaluated on an ongoing basis and sufficient performance improvement measures are implemented and monitored to reflect accuracy and effectiveness. High risk, problem prone areas are identified through incident reports (including report at the "flash" meetings described above) or review of departmental quality indicators. The quality indicators were individualized for each campus facility, and approved by the Quality Council (the organization's QAPI oversight committee) on	
A 273	482.21(a), (b)(1),(b)(2)(i), (b)(3) DATA COLLECTION & ANALYSIS	A 273		

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A 263	Continued From page 15 hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This Condition is not met as evidenced by: Based on observation, interview and record review, the hospital did not ensure that a data-driven, hospital wide QAPI program was designed and implemented because: 1) Incidents and errors were not subject to review and analysis, and did not form the basis for performance improvement (cross reference A-0286). 2) The QAPI program did not collect or monitor hospital data regarding discharge planning, surgical site infection and staff influenza screening (cross reference A-0273). 3) The hospital did not focus on high risk, prevalent issue of suicidality among the hospital's patients, and did not analyze and use data regarding mortality, and falls to improve the quality of care provided (cross reference A-0283). 4)The Governing Body voiced awareness of the need to improve the QAPI program, but had not yet implemented changes needed to improve the program (cross reference A-0309). The cumulative effect of these failings meant the hospital did not provide a QAPI program to ensure the quality and safety of the healthcare provided to the patients.	A 263	1/27/16, MEC on 2/17/16 and Governing Board on 2/24/16. Quality indicators address all clinical services and departments ensuring appropriate integration of these departments and services into the organization wide QAPI program. Services provided by contracted providers are now included in the QAPI program, ensuring full integration into the organization's quality and safety monitoring processes. The Quality Council meeting minutes reflect discussion of these indicators. On 1/27/16, the Quality Council and members of the Executive Leadership met to analyze quality monitoring data. The focus of the meeting was to discuss how the organization monitored all departments and services, including mortalities, hospital acquired and surgically related infections, fall preventions, discharge planning and assessment and prevention of suicide. The Quality Council meeting also discussed activities the organization is implementing to sustain quality monitoring of effective systems to identify, report, investigate and control untoward events and patient safety issues. The Quality Program commenced monitoring on 2/1/16. There shall be weekly reporting to Hospital Leadership teams, with monthly reporting to the hospital-wide Quality Council. Compliance monitoring shall be reported to the Governing Body monthly. Revisions to the program included revamping of the data collection and analysis components of the program and initiation of a data collection tool that allows for critical analysis of collected data via a benchmarked analysis report format that drives critical decision - making in relationship to data presented. Data collection includes, but is not limited to, information on behavioral health patient management, infection control and prevention outcomes, and staff compliance with receipt of influenza vaccinations.	3/22/16
A 273	482.21(a), (b)(1),(b)(2)(i), (b)(3) DATA COLLECTION & ANALYSIS	A 273		

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A 263	Continued From page 15 hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This Condition is not met as evidenced by: Based on observation, interview and record review, the hospital did not ensure that a data-driven, hospital wide QAPI program was designed and implemented because: 1) Incidents and errors were not subject to review and analysis, and did not form the basis for performance improvement (cross reference A-0286). 2) The QAPI program did not collect or monitor hospital data regarding discharge planning, surgical site infection and staff influenza screening (cross reference A-0273). 3) The hospital did not focus on high risk, prevalent issue of suicidality among the hospital's patients, and did not analyze and use data regarding mortality, and fails to improve the quality of care provided (cross reference A-0283). 4)The Governing Body voiced awareness of the need to improve the QAPI program, but had not yet implemented changes needed to improve the program (cross reference A-0309). The cumulative effect of these failings meant the hospital did not provide a QAPI program to ensure the quality and safety of the healthcare provided to the patients.	A 263	Selected indicators address high-risk, high-volume, problem-prone issues as well as addressing operational efficiency, clinical excellence, staff retention and staff/patient satisfaction, and are prioritized for use via a matrix rating each indicator as to the above prioritization criteria. Use of this prioritization criteria allows for severity, prevalence, incidence and how these issue qualifiers shape indicator development to meaningfully address health care outcomes and patient safety. Executive Leadership and the Governing Board reviewed and approved of the complete revision and restructuring of the hospital-wide QAPI program, requiring the programs effective implementation to ensure strong patient safety practices and positive outcomes.	3/22/16
A 273	482.21(a), (b)(1),(b)(2)(i), (b)(3) DATA COLLECTION & ANALYSIS	A 273	A 273 482.21 (a)(b)(1), (b)(2)(i), (b)(3) Data Collection and Analysis	

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A 273	Continued From page 16 (a) Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve health outcomes ... (2) The hospital must measure, analyze, and track quality indicators ... and other aspects of performance that assess processes of care, hospital service and operations. (b)Program Data (1) The program must incorporate quality indicator data including patient care data, and other relevant data, for example, information submitted to, or received from, the hospital's Quality Improvement Organization. (2) The hospital must use the data collected to-- (i) Monitor the effectiveness and safety of services and quality of care; and .... (3) The frequency and detail of data collection must be specified by the hospital's governing body. This Standard is not met as evidenced by: Based on interview and record review, the QAPI program did not collect and monitor data regarding hospital processes such as 1) discharge planning for psychiatric patients, 2) staff influenza vaccination and 3) surgical site infections , creating the risk of persistent poor practices and substandard healthcare. Findings: 1) In an interview with the Hosp System Dir Quality on 12/17/15 at 1400, he stated that the data for the quality program was gathered from numerous sources, including the event reporting	A 273	Findings 1-3 Immediate Action Taken: 1. The Executive Leadership, the Consulting Team, and the Director of Quality discussed the survey findings and an in-depth revision and restructure of the QAPI program. Subsequent Actions Taken: 1. A revised QAPI plan was implemented, which is comprehensive, data-driven, and robust and reflects the hospital's operations and services. Identification, measuring, analyzing and tracking of quality indicators is in place to ensure that hospital services and operations are evaluated on an ongoing basis and sufficient performance improvement measures are implemented and monitored to reflect accuracy and effectiveness. Indicator revision and selection is based on those issues that address high-risk, high-volume, problem-prone activities as well as addressing operational efficiency, clinical excellence, staff retention and staff/patient satisfaction, and are prioritized for use via a matrix rating each indicator as to the above prioritization criteria. Use of this prioritization criteria allows for severity, prevalence, incidence and how these issue qualifiers shape indicator development to meaningfully address health care outcomes and patient safety. Quality indicators include, among other things, monitoring of incidents and errors, discharge planning, surgical site infection and staff influenza screening, suicidality of patients, and mortality data indicators were established to reflect improved health outcomes. The performance improvement indicators which fail to meet the benchmark will be analyzed for root cause and corrective action will be implemented. The Quality Council meeting minutes reflect discussion of these indicators. On 1/27/16, the Quality Council and members of the Executive Leadership met to analyze quality monitoring	12/19/15 - 1/18/16 3/16/16

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A 273	Continued From page 17 system, security and grievance logs, work orders and phone calls, and core measures routinely monitored. He stated that each department also had its own quality indicators. During visits to the hospital from 12/14/15 through 12/18/15, the three facilities included a Van Nuys (VN) facility that consisted of 57 beds for psychiatric patients, and a facility with behavioral health units and a detoxification unit in addition to general medical care. QAPI program follow-up of the discharge services offered to patients with psychiatric and behavioral health problems were reviewed. During a review of the medical record of Patient 509, from the VN facility, on 12/17/15, a long term goal for the patient included, "pt will maintain sobriety and follow up with AA and NA groups at discharge". During an interview with a BHU Staff member at the VN campus on 12/17/15 at 1210, he stated that the goals of the facility were to help the patients to relieve crises, and to put in place a support system for assistance prior to discharge. In an interview with the Dir SS at the VN campus on 12/17/15 at 1215, he stated that the QAPI goals included ensuring that there was a social support person identified for each patient prior to discharge, and that the discharge plan was coordinated with that person. He stated that there were no routine follow-up calls or contacts to determine the efficacy of the discharge process. He stated that there had been a study regarding rapid re-hospitalization but it occurred years prior. In an interview with the Coord of QM at the VN campus on 12/17/15 at 1205, he stated that he was not aware of any follow-up of the discharge process to verify the efficacy of the process. 2) During observations and interviews from 12/14/15 through 12/18/15, staff and medical staff were seen at all three facilities without masks or	A 273	data. The focus of the meeting was to ensure that all departments and services were integrated into the hospital-wide QAPI program and to discuss how the organization monitored quality and safety activities throughout the organization. The Quality Council meeting also discussed activities the organization is implementing to sustain quality monitoring of effective systems to identify, report, investigate and improve patient safety and positive outcomes. The Quality Program commenced monitoring on 2/1/16. There shall be ongoing reporting to Hospital Leadership teams, with monthly reporting to the hospital-wide Quality Council. Compliance monitoring shall be reported to the Governing Board monthly. 2. Quality indicators for the Behavioral Health Unit now address discharge processes and follow-up on obtaining information on efficacy of the patient's discharge. 3. Hospital Leadership reviewed and combined the "Facility-Wide Influenza Plan (seasonal) and "Respiratory Etiquette and Mandatory Facility – Wide Vaccinations and Mask Use" policies to include distribution of a colored badge signifying the staff member or LIP has received the influenza vaccine for the current season. The color of this badge will change annually. The policies were approved by the Infection Prevention Committee on 3/10/16, the MEC on 3/15/16 and the Governing Board on 3/16/16. 4. Data includes aggregation and analysis of compliance with vaccination requests, infection control and prevention statistics, including those related to surgical site infections and hospital associated infections. 5. Each department/service was provided with a reporting format that requires numerator/ denominator data and generates a pivot table that displays compliance related to established benchmark. The tool then directs the user to analyze this information for reporting purposes in the situation, background, analysis, recommendation (SBAR) format. This tool, when completed, leads the reader to a clear	3/15/16 3/16/16 3/15/16 2/15/16 -3/22/16

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A 273	Continued From page 18 stickers indicating influenza immunization (see 749). In an interview with the ICP 1 on 12/16/15 at 1200, she stated that the stickers were distributed by the medical staff office or by employee health to put on hospital name badges to indicate influenza immunization. She stated the expectation was that the staff member would wear a mask until documentation of vaccination was submitted. She stated that there was informal checking of the badges, but no study to determine if the stickers or masks were in use. During a continuing interview with the IP Epidemiologist HW, he stated that there had been no study to verify the efficacy of the sticker system used to identify staff members who had the influenza vaccine. In an interview with the QA Staff HW on 12/18/15 at 1200, she stated that people who were vaccinated elsewhere did not have stickers on their badges as the hospital ran out of stickers to give. During a review on 12/15/15 of the credential and health files of DRs 9, 10, 11, 12, 13, 14 and CRNA 1, the files did not contain information about influenza vaccination or declination. In an interview with the Dir MS Services on 12/15/15 at 0750, she stated that there was no influenza vaccine information in the files. In an interview with the Dir Hosp System Quality on 12/17/15 at 0825, he stated that he thought the infection prevention department audited the badges. He stated that there had been a poor response from physicians regarding influenza vaccination requests, but that influenza vaccination tracking was not followed by the QAPI department. 3) The Quality Council Minutes from October 28, 2015, were reviewed, and showed that the report for infection prevention included the detail, "SSI	A 273	understanding of data presented and analyzed with a recommendation by the stakeholder for action if the data so directs. 6. Indicator data on the issues listed in the survey report is included in the revised overall QAPI program with this data tracked, trended, analyzed and reported to the Quality Council pursuant to the approved indicator reporting schedule, with forwarding of this information to the MEC and on to the Governing Board, at the time frame approved for the reporting schedule. Compliance and Monitoring: Data on audits is tracked, trended, analyzed and reported monthly to the Quality Department. Compliance is reported to the Quality Council, MEC and Governing Body on a monthly basis, and is used for performance improvement measures. The Quality Council renders determinations of frequency and volume of reporting data based on the results (in terms of healthcare outcomes) of trended data reported. Person Responsible: Director of Quality	

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A 273	Continued From page 19 rate is high", but no further information suggesting a breakdown by surgeon, equipment used, or other investigative parameters. During a review of surgical site data for the year, the data were shown for infections in four locations, abdominal hysterectomy, colon, hip and knee. However, there were no benchmarks established to show what the comparative rate at other facilities was. In an interview with the Adm Staff 1 on 12/16/15 at 1130, she stated that she was not sure what surveillance mechanisms were in place for identifying surgical site infections. She stated that there was a plan to validate the data that was collected, but that data was not yet being validated. In an interview with the ICP 1 on 12/16/15 at 1200, she stated that she believed there was a 6 month gap in surveillance for surgical site infections. She stated that she had not had the opportunity to retrospectively review surgical site infections by surgeon. In an interview with the Hosp Sys Dir Quality on 12/16/15 at 1310, he stated that he believed there was a two month gap in the surgical site infection data. He concurred that there was no surveillance of physicians to determine if there was an infection seen after discharge. He stated that IP personnel were to follow NHSN and CDC guidelines for surgical site infection surveillance. The CDC Surgical Site Infection (SSI Event procedure-associated module) modified 4/15 showed "Post-discharge and ante-discharge surveillance methods should be used to detect SSIs following inpatient and outpatient operative procedures. These methods include; * Direct examination of patients' wounds during follow-up visits to either surgery clinics or physicians' offices	A 273		

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A 273	Continued From page 20 * Review of medical records or surgery clinic patient records * Surgeon surveys by mail or telephone * Patient surveys by mail or telephone (though patients may have a difficult time assessing their infections). Any combination of these methods was acceptable for use; however, the CDC criteria for SSI must be used. In an interview with the ICP 1 on 12/16/15 at 1200, she stated that there was routine follow-up of NHSN designated procedures for possible surgical site infections through readmissions, culture review, staff reporting and notifications from other facilities. She stated that there was no system for contacting physicians for surveillance, there was no outpatient surgery clinic, and no outpatient clinical records were reviewed to identify infections. She stated that the process for identifying readmissions was a work in progress. She stated that there was no routine follow-up of surgical site infections that were not NHSN reportable infections.	A 273		
A 283	482.21(b)(2)(ii), (c)(1), (c)(3) QUALITY IMPROVEMENT ACTIVITIES (b) Program Data (2) [The hospital must use the data collected to - .....] (ii) Identify opportunities for improvement and changes that will lead to improvement. (c) Program Activities (1) The hospital must set priorities for its performance improvement activities that-- (i) Focus on high-risk, high-volume, or	A 283	A 283 482.21 (b)(2)(ii), (c)(1), (c)(3) Quality Improvement Activities	

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A 283	Continued From page 21 problem-prone areas; (ii) Consider the incidence, prevalence, and severity of problems in those areas; and (iii) Affect health outcomes, patient safety, and quality of care. (3) The hospital must take actions aimed at performance improvement and, after implementing those actions, the hospital must measure its success, and track performance to ensure that improvements are sustained. This Standard is not met as evidenced by: Based on interview and record review the QAPI program failed to perform a quality review of the hospital ' s processes for 1) assessing and treating suicidal patients, 2) performing mortality reviews, and 3) addressing falls, creating the risk of persistent poor practices and poor health outcomes. Findings: 1) During a review of the admitting diagnoses for patients at the VN facility on 12/17/15, 55 of 57 patients were admitted with suicidal ideation. During an interview with the Admin VN and the BHU Staff VN on 12/17/15 at 1230, they were able to recall a couple of suicide attempts in the VN facility during recent months, including an attempted hanging and a cutting incident. The hospital policy, Precautions BHU.053 (revised 6/2014) was obtained at the Van Nuys facility, and the hospital policy, Precautions (reviewed 8/2015), was obtained from the Culver City facility. The policies showed that the " Suicide Potential Rating Scale (addendum A) shall be completed as part of the Initial Nursing Assessment and daily assessment for each patient " , and that the score of the assessment	A 283	Findings 1-3 Immediate Action Taken: 1. Executive Leadership, the Consulting Team, and the Director of Quality discussed the survey findings and an in-depth revision and restructure to the current QAPI program, including a method to prioritize quality indicators to enhance focus on ability to recognize opportunities for improvement and act upon these accordingly. Subsequent Actions Taken: 1. A revised QAPI plan was implemented, which is comprehensive, data-driven, and robust and reflects the hospital's operations and services. Identification, measuring, analyzing and tracking of quality indicators is in place to ensure that hospital services and operations are evaluated on an ongoing basis and sufficient performance improvement measures are implemented and monitored to reflect accuracy and effectiveness. Indicator revision and selection is based on those issues that address high-risk, high-volume, problem-prone activities as well as addressing operational efficiency, clinical excellence, staff retention and staff/ patient satisfaction, and are prioritized for use via a matrix rating each indicator as to	12/29/15 - 1/18/16 3/16/16

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSPITAL AT HOLL'	6245 DE LONGPRE AVE HOLLYWOOD, CA 90028

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A 283	Continued From page 22 would determine the level of observation provided and that a patient was to be placed on " suicide precautions " based on the information obtained from the history, legal holds, initial assessment, and Suicide Potential Rating Scale. During reviews of medical records from the VN facility and the CC facility, several records of patients who presented with suicidal ideation were reviewed. The records did not contain Suicide Potential Rating Scale or resultant risk score (see A-286 and A-392). In an interview with the Dir BHU on 12/17/15 at 1000, she stated that she had many concerns with the quality of documentation in the BHU. She stated that the BHU had been looking at the same quality indicators for years, and that they were not looking at the assessment information, including pain assessments. She stated that they had wanted to begin looking at new quality measures, but then the department director changed again. She stated that the change in personnel resulted in a delay in implementing the request for new quality measures. She stated that currently there was no auditing process for the behavioral health unit assessments because the charting was variable. She stated that the behavioral health department met monthly, but that no one from quality attended the meetings, and that she reported informally to the quality department if issues arose. In an interview with the Hosp Sys Dir Quality on 12/17/15 at 1510, he stated that the medical record audit tool used to review records was very generic, and not adequate to catch the missing suicide risk assessments. 2) The Quality Council Minutes from October 28, 2015, were reviewed and showed that " There would need to be a deeper analysis . " of the code blues, and there was an intention to address	A 283	the above prioritization criteria. Use of this prioritization criteria allows for severity, prevalence, incidence and how these issue qualifiers shape indicator development to meaningfully address health care outcomes and patient safety. The indicators are outcome based quality and safety indicators and include, among other things, a review of the hospital's processes for assessing and treating suicidal patients, performing mortality reviews, and addressing patient falls. Benchmarks are established to assist with identifying non-conformity to desired practice or goal. Performance outcomes reflected via indicator monitoring, failing to meet desired benchmarks will be analyzed for root cause and corrective action will be implemented. The Quality Council meeting minutes reflect discussion of these indicators. On 1/27/16, the Quality Council and members of the Executive Leadership met to analyze quality monitoring data. The focus of the meeting was to ensure that all departments and services were integrated into the hospital-wide QAPI program and to discuss how the organization monitored quality and safety activities throughout the organization. The Quality Council meeting also discussed activities the organization is implementing to sustain quality monitoring of effective systems to identify, report, investigate and improve patient care and safety. The Quality Program commenced monitoring on 2/1/16. There shall be monthly reporting to the hospital-wide Quality Council. Compliance monitoring shall be reported to the Governing Board monthly. 2. A member of the Quality Department now attends the Behavioral Health monthly department meetings to ensure appropriate integration of behavioral health quality processes into the hospital-wide QAPI program. 3. Hospital Leadership reviewed and revised the "Suicide Risk" policy and the EMR system was changed to allow for a hard stop process to capture suicide risk assessments for all patients on admission.	3/11/16 3/22/16

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A 283	Continued From page 23 the follow-up and define the performance improvement process for mortality review. The dashboard of code blue, mortality and rapid response team data for November, 2015, was reviewed, and showed that of seven code blues during the month, three occurred outside of the ER and critical care units, in the telemetry and medical-surgical areas of the hospital, where less acute patients are placed and hence code blues are typically unexpected. The only plan documented appeared to be, "Track and trend. Continue to monitor. Continue to consolidate, as well as reconcile RRT and code blue data from various sources in order to provide accurate reporting." The Code Blue Log for the month of November was reviewed, and showed 100% mortality following code blues in the hospital. In an interview with the ER RN Dir on 12/17/15 at 0900, a member of the Code Blue Committee, she stated that she recognized the high mortality rate with the code blues, but that they had not been able to drill down to see the causes, which could be population-related. Patient 507 experienced a code blue while on the med-surg unit on 11/2/15, and did not survive the event. The incident was reviewed with the Adm Staff 1, and she stated that a code blue shouldn ' t happen outside the ICU, and that it should have been made an incident and reviewed by unit staff and an RCA completed, but this was not done. In an interview with the Hosp Sys Dir Quality on 12/18/15 at 1310, he stated that the mortality review process was incomplete due to limited staff training. 9) The Quality Council Minutes from 10/28/15 were reviewed and showed that falls were identified as increasing and a number of interventions were proposed, including a new policy, education, and fall prevention	A 283	Compliance and Monitoring: Data on audits is tracked, trended, analyzed and reported monthly to the Quality Department. Compliance is reported to the Quality Council, MEC and Governing Board on a monthly basis, and is used for performance improvement measures. The Quality Council renders determinations of frequency and volume of reporting data based on the results (in terms of healthcare outcomes) of trended data reported. Person Responsible: Director of Quality	

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A 283	Continued From page 24 mechanisms. The minutes stated that the goal is to get all of the units to be reported. In an interview with the CNO on 12/17/15 at 1415, the CNO stated that falls data was based on facility, and that a task force had been created to improve the falls data, and that bed alarms had been implemented at the CC facility. She concurred that there was no coordination of individual facility falls data. In an interview with the Coord QM VN on 12/17/15 at 1210, he stated that falls data from VN was presented annually, with quarterly presentations to a subcommittee. He stated that there was no benchmark developed for the expected number of falls, no analysis of why patients fell, such as due to medication, footgear or obstacles, and no intervention plan developed. In an interview with the Adm Staff 1 on 12/17/15 at 1417, she stated that they had just begun the process of analyzing falls data and implementing interventions.	A 283		
A 286	482.21(a), (c)(2), (e)(3) PATIENT SAFETY (a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors. (2) The hospital must measure, analyze, and track ...adverse patient events ... (c) Program Activities ..... (2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital. (e) Executive Responsibilities, The hospital's	A 286	A 286 482.21 (a), (c)(2), (e)(3) Patient Safety	

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A 286	Continued From page 25 governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: ... (3) That clear expectations for safety are established. This Standard is not met as evidenced by: Based on interview and record review, the hospital did not ensure that all incidents were subject to review and made the basis for performance improvement, creating the risk of persistent substandard practices and poor health outcomes for patients using the hospital. Findings: In an interview with the Adm Staff 1 on 12/17/15 at 1445, she stated that the CNO and COO reviewed events and used the RCA process. In an interview with the CNO on 12/17/15 at 1450, she stated that the results of incident reviews were not clearly documented in the incident reporting system yet. In an interview with the CEO on 12/17/15 at 1500, he stated that the investigation documentation was not complete. During an interview with the Hosp Sys Dir Quality on 12/18/15 at 1400, he stated that near misses and other incidents were to be reported through the incident reporting system. He stated that there was no method for double-checking whether incidents were actually being reported, such as checking billing or diagnosis codes against the incident reporting system to see if reportable incidents were actually reported. Three incidents were selected from the incident	A 286		

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A 286	Continued From page 26 reporting system for November, 2015, for review, and one was selected from the Code Blue Log for November, 2015. None of the incidents appeared to have been thoroughly reviewed, and none were used as the basis for performance improvement. Departures from hospital policy and from the standard of care for hospitalized patients were noted during a review of the four incidents. 1) An incident dated 11/14/15 was reviewed on 12/15/15, and showed that a patient, Patient 508, a 21 year old woman with schizoaffective disorder, was admitted to the behavioral health unit at Culver City, and reported an assault during a stay on one of the psychiatric units, "when I was in the other unit yesterday after I got my shoot (sic) Rayan came to the day room he grabbed my ass and kissed me behind the door". The patient reported two different names for the assailant. The only investigation documented appeared to consist of a review of unit patient names and an interview with one LVN, who stated "nobody witnessed anything". There was no documentation that the patient was questioned about the appearance of the alleged assailant, was asked to identify the assailant, or that the review of possible assailants included unit staff and other staff such as cleaning, kitchen, facility or medical staff who may have been in the unit. There was no documentation to support that other possible witnesses were interviewed. The event was documented as forwarded to the CNO, Quality Staff 2, and Adm Staff 1, but the column for "review completed" was blank, there were no manager's comments and no proposed actions documented. In an interview with the Adm Staff 1 on 12/15/15 at 1415, she stated that the department directors were supposed to respond to incidents, but there was no comment added in this case from the	A 286	Findings 1-2 Immediate Action Taken: 1. Executive Leadership, the Consulting Team, and the Director of Quality discussed the survey findings and an in-depth revision and restructure of the QAPI program, including revision of how significant adverse events and incidents are identified, reported and managed. Subsequent Actions Taken: 1. The hospital implemented a process of significant adverse events management improvements and executive awareness through daily "Flash" huddles Monday through Friday (with weekends rolled into Monday's outcome data. Any significant event on the weekend will be reported to the administrator on call). Executive Leadership participates in these meetings where any significant event occurring over the prior 24 hours is brought before senior leadership for immediate review, ensuring the event is managed timely, by the right individuals, through the right method. The hospital is also restructuring its QAPI program and plan to focus on patient safety and improvement in healthcare outcomes. A revised QAPI plan was implemented, which is comprehensive, data-driven, and robust and reflects the hospital's operations and services. Identification, measuring, analyzing and tracking of quality indicators is in place to ensure that hospital services and operations are evaluated on an ongoing basis and sufficient performance improvement measures are implemented and monitored to reflect accuracy and effectiveness. High risk, problem prone areas are identified through incident reports or review of departmental quality indicators and there is a process for analyzing and tracking quality indicators. The quality indicators include, among other things, tracking medical errors and adverse events, analyzing their causes and implementing preventive actions and mechanisms that will help identify and reduce medical errors. The performance	12/29/15 - 1/18/16 1/27/16 – 3/16/16

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A 286	Continued From page 27 director. She stated that on the surface it looked like there were gaps in the investigation. In an interview with the Dir BHU on 12/15/15 at 1445, she stated she started as the Dir BHU in October. She stated that she did not recall the case, and that she was not sure if there was follow-up of the incident. Documentation of further investigation was requested, but was not provided. In another interview with the Adm Staff 1, on 12/17/15 at 1445, she stated that the investigation of the assault incident did not happen. The record showed that Patient 508 did not receive a suicide risk assessment per hospital policy, and did not have a substance withdrawal risk assessment, despite the history of substance abuse (see A-392). 2) An incident dated 11/18/15 was reviewed and showed that a patient, Patient 503, was admitted to the behavioral health unit at Culver City, but remained in the ER overflow area. The nurse could not find the patient medications and profile. The follow-up of the event was reviewed and showed that the ER RN Dir reviewed the incident. A delay of service was identified, and education was documented as the proposed action. However, additional review of the record showed that numerous issues occurred in the care of Patient 503, and the issues were not documented as being identified pursuant to event reporting. The record showed that there was incomplete assessment, care planning and treatment provided to Patient 503 during the Culver City facility admission. The record showed that the patient was transferred from the Van Nuys facility, but there were multiple omissions and inconsistencies in the patient's medical record (see A-392 and A-438). In an interview with the Dir BHU on 12/6/15 at	A 286	improvement indicators which fail to meet the benchmark will be analyzed for root cause and corrective action will be implemented. Revision of the program to focus on healthcare outcomes through a tightly structured, prioritized indicator monitoring program ensures ongoing improvements are realized through implementation of the QAPI program. 2. Hospital Leadership and the Consulting Team reviewed the process for incident reporting, including identification of incidents and assurance that incidents were being reported and properly annotated, aggregated and analyzed. The Quality Department resources were reallocated to provide for a quality director, a risk manager and a director of education, effective 1/22/16, to allow for dedication of resources for incident management. Incidents are reviewed daily (Monday through Friday) with inclusion of trended data resulting from incident review included in QAPI reporting as appropriate to the incident topic. For example, an incident on a restraint issue or an incident on a patient fall would be included in the numerator/ denominator data for indicators related to restraint or fall management. Significant and unique incidents are addressed in the daily flash huddles (Monday through Friday) and to the Quality Council on an as occurrence basis and up to the MEC and Governing Board. A discussion of the event, any causal analysis or event analysis is presented with the QAPI report. Compliance and Monitoring: Data on audits is tracked, trended, analyzed and reported monthly to the Quality Department. Compliance is reported to the Quality Council, MEC and Governing Board on a monthly basis, and is used for performance improvement measures. The Quality Council renders determinations of frequency and volume of reporting data based on the results (in terms of healthcare outcomes) of trended data reported.	3/16/16

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A 286	Continued From page 28 1105, she stated that the patient had a suicide attempt 2 weeks prior to her 11/17/15 admission, and a previous hospital admission for a suicide attempt. She stated that the staff was supposed to do a suicide risk assessment at the Culver City facility, but that no such assessment was seen. Transfer documents obtained from the Van Nuys facility included a Multidisciplinary After Care Instructions form dated 11/16/15 that showed that the patient was being transferred to the Culver City ER "due to breathing". According to the progress note written by the internal medicine physician on 11/18/15, Patient 503 was assessed on 11/18/15 at 1601, and was "still awaiting a bed on D team so she can continue using her CPAP." There was no documentation indicating that the patient was ever provided with the CPAP device for which she was transferred to the Culver City facility on 11/16/15. In an interview with the Adm Staff 1 on 12/16/15 at 0950, she stated that she could not tell from the record if the patient had difficulty breathing or had CPAP during the Culver City facility stay. In an interview with the Dir BHU on 12/16/15 at 1100, she stated that there was no order for the CPAP seen, and no documentation of the CPAP being used. She was not sure why the patient was transferred from the Van Nuys facility, but believed it was for the patient to obtain CPAP. In a second interview, on 12/16/15 at 1145, she stated that she was not sure if the ER triage initiated finding a CPAP machine for the patient, but should have. In an interview with the Dir Hosp System Quality on 12/17/15 at 0825, he stated that the lack of suicide risk assessments for Patients 503 and 508 should have been picked up during the incident review process. 3) A third incident, dated 11/16/15, was reviewed and showed that a patient had seizure like activity	A 286	Person Responsible: Director of Quality	

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A 286	Continued From page 29 while at the intensive outpatient psychiatric program, and was transported to the emergency room. The incident was forwarded to the CNO, Quality Staff 2, and the Adm Staff 1. However, the section for "review completed" showed that none of the three had marked that they reviewed the event, there were no comments in the "comments" section, and the section for Manager's Proposed Action did not have any actions indicated. 4) A fourth incident reviewed was selected from the Code Blue Log for the month of November. The log showed that Patient 507 experienced a code blue while on the medical-surgical unit on 11/2/15, and did not survive the event. The medical record of Patient 507, a 58 year old man who had a procedure at the hospital, was reviewed and showed that his blood pressure was in the normal or elevated ranges on 11/1/15 and 11/2/15, but suddenly dropped to 90/66 on 11/2/15 at 1700. Similarly, his heart rate suddenly dropped from a normal range to 56 at 1804. There was no documentation to show that the abnormal vital signs were rechecked, that the physician was notified, that any orders were obtained or that any assessments or interventions were undertaken by the nurse to address the changes. The patient became pulseless and a code blue was initiated at 1845, but the patient expired. In an interview with the Adm Staff 1 on 12/16/15 at 1120, she stated that the Code Blue Committee should look at events preceding a code blue. She stated it looked like a failure to rescue occurred, and that the time to call for a rapid response or to call the physician was when the change of condition occurred. She stated that a code blue shouldn ' t happen outside the ICU, and that it should have been made an incident and reviewed by unit staff and an RCA	A 286		

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A 286	Continued From page 30 completed, but this was not done. In a second interview with the Adm Staff 1, on 12/17/15 at 1440, she stated there was no review of the 11/2 code blue yet. In an interview with the Hosp Sys Dir Quality on 12/18/15 at 1310, he stated that the mortality review process was incomplete due to limited staff training.	A 286		
A 309	482.21(e)(1), (e)(2), (e)(5) QAPI EXECUTIVE RESPONSIBILITIES The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: 1) That an ongoing program for quality improvement and patient safety, including the reduction of medical errors, is defined, implemented, and maintained. (2) That the hospital-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety and that all improvement actions are evaluated. (5) That the determination of the number of distinct improvement projects is conducted annually. This Standard is not met as evidenced by: Based on interview and record review, the Governing Body failed to ensure the QAPI program was designed, implemented and maintained to maximize the quality of the healthcare provided in the facility, creating the risk of persistent poor practices and substandard	A 309	A 309 482.21 (e)(1), (e)(2), (e)(5) QAPI Executive Responsibilities Immediate Action Taken: 1. Executive Leadership, the Consulting Team; and the Director of Quality discussed the survey findings and an in-depth revision and restructure of the QAPI program. Executive Leadership determined separating the roles of quality director, risk manager and education director would enhance and more effectively operationalize the QAPI program throughout the facility. Subsequent Actions Taken: 1. Executive and Corporate Leadership discussed the need to add resources to the quality department. Corporate leadership approved two additional positions for quality coordinators and a risk manager. 2. A revised QAPI plan was implemented, which is comprehensive, data-driven, and robust and reflects the hospital's operations and services. Identification, measuring, analyzing and tracking of quality indicators is in place to ensure that hospital services and operations are evaluated on an ongoing basis and sufficient performance improvement measures are implemented and monitored to reflect accuracy and effectiveness. High risk, problem prone areas are identified through incident reports or review of departmental quality indicators and there is a process for analyzing and tracking quality indicators. The quality indicators include,	12/29/15 - 1/22/16 1/22/16 3/22/16

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A 309	Continued From page 31 healthcare. Findings: In an interview with the CNO on 12/17/15 at 1450, she stated that the results of incident reviews were not clearly documented in the incident reporting system yet. In an interview with the CEO on 12/17/15 at 1500, he stated that the investigation documentation was not complete. In interviews with the CEO and the GB Member on 12/17/15 at 1515, they stated that they had established patient safety as a priority, but were still determining what was needed to move the quality program forward. They concurred that the implementation of changes had not caught up with the assessed need to advance the quality program. In an interview with the Hosp Sys Dir Quality on 12/18/15 at 1400, he stated that there were still gaps in staffing the QAPI program, and that there had been little success in hiring. He stated that a salary study was underway to determine whether compensation was a significant issue.	A 309	among other things, tracking medical errors and adverse events, analyzing their causes and implementing preventive actions and mechanisms that will help identify and reduce medical errors. The performance improvement indicators which fail to meet the benchmark will be analyzed for root cause and corrective action will be implemented. 3. Data on compliance is reported through Quality Council to the Governing Board on a monthly basis and is used for performance improvement measures. Compliance and Monitoring: Data on audits is tracked, trended, analyzed and reported monthly to the Quality Department. Compliance is reported to the Quality Council, MEC and Governing Body on a monthly basis, and is used for performance improvement measures. The Quality Council renders determinations of frequency and volume of reporting data based on the results (in terms of healthcare outcomes) of trended data reported. Person Responsible: Director of Quality	
A 340	482.22(a)(1) MEDICAL STAFF PERIODIC APPRAISALS The medical staff must periodically conduct appraisals of its members. This Standard is not met as evidenced by: Based on interview and record review, the medical staff failed to have an established process to ensure provider performance evaluations to ensure the ongoing quality of physician services and to inform the reappointment process, creating the risk of persistent poor physician practices and substandard healthcare. Findings: 1) During a review of physician credential files for	A 340	A 340 482.22 (a)(1) Medical Staff Periodic Appraisals Immediate Actions Taken: 1. The Director of Medical Staff Services Department created an "OPPE Task Force," which consisted of the Director of Quality, Director of Clinical Informatics, Decision Support Director, the CEO and COO and a member of the IT Department. The purpose of the task force was to further the review of the existing OPPE process and to confirm the indicators for the OPPE process and ongoing monitoring. Subsequent Actions Taken: 1. Hospital Leadership engaged legal counsel and a national healthcare regulatory consulting	1/14/16 1/13/16

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A 340	Continued From page 32 MD7, 10, 11, 12, and 13 on 12/15/15, the files contained a preprinted page on which the QAPI department indicated by means of checking a box, "There were no quality of care issues identified for this practitioner during the period requested". MD6's form showed that one incident, described as a category one incident was ascribed to him. 2)During a review of six physician provider and one CRNA provider credential files, the files lacked specific information about medical staff performance. There were pre-printed forms on which it could be indicated by means of a check mark in a box, if there were concerns with physician performance in medical records, quality measure, and infection prevention. However, it was unclear what the basis for the check marks was. For example, the QAPI department ' s pre-printed form had the pre-printed statement, " There were no quality of care issues identified for this practitioner during the period requested. " However, it was unclear what data the QAPI department was reviewing before marking the box opposite the statement. Similarly, the Infection Control Department was providing a pre-printed statement with boxes to check for, " no hospital infection statistics were identified for this practitioner during the period requested. " , or " No data identified for this practitioner during the period requested. " In an interview with the Dir MS Services on 12/15/15 at 0915, she stated that the medical staff had a meeting eight days prior to discuss selecting criteria that can be collected to evaluate the medical staff, but there were no meeting minutes available for review. In an interview with the Adm Staff 1 on 12/15/15 at 0945, she stated that if a physician had a risk or quality of care issue, it was reported to the medical staff, but that there was no closure. She	A 340	firm to assist with correction of medical staff findings and implementation of medical staff processes to sustain compliance. 2. The consultants and Medical Staff Team worked collaboratively on reviewing the current process for OPPE. The following actions were taken between 2/15/16 and 3/22/16: a. A review of the appointment and reappointment process in the bylaws was performed and it was determined that these processes did not require any revisions. b. Medical Staff Leadership reviewed the existing "OPPE/FPPE" Policy. The policy was revised to focus on ensuring the medical staff conducts periodic appraisals of all practitioners granted privileges. This appraisal may include peer review, FPPE, OPPE or performance data for practitioners (e.g., physicians and AHP) on an ongoing basis. Data is collected, analyzed and discussed with the practitioner so as to enable the medical staff to assess and ensure the competence of its practitioners, and to take appropriate steps to improve performance of these practitioners as part of its ongoing commitment to high quality care. The MEC approved the revised policy on 3/15/16 and the Governing Board on 3/16/16. c. The CEO, Director of Medical Staff Services and Chief of Staff met on 3/2/16 to discuss concerns with the identified pre-printed forms. It was decided to cease using these forms and reinstitute use of the "Practitioner Performance Profile" Form to identify the current available data for reappointments, including, among other things, practitioner findings on core measures and core competencies (e.g., patient care, medical knowledge, communication, professionalism, practice-based learning and improvement, and systems based practice), surgical site infections (for the department of surgery) and readmissions within 30 days (for the department of medicine), utilization review, number of suspension days, blood use, medication use, mortality/morbidity rates, hospital acquired infections, risk management, grievance/complaint, and peer review issues.	2/15/16 and 3/22/16

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A 340	Continued From page 33 stated that she was unsure if investigation or follow-up occurred. She stated that the form sent to the medical staff office for the physicians at the time of reappointment were filled out by Quality Staff 2. In an interview with the ICP 1 on 12/16/15 at 1200, she stated that she believed there was a 6 month gap in surveillance for surgical site infections. She stated that she had not had the opportunity to retrospectively review surgical site infections by surgeon. She stated that a co-worker had been signing the documents from the infection prevention department that were used to support medical staff reappointment, but without current data. In an interview with the Vice Chief MS and GB on 12/17/15 at 1430, he stated that the hospital was working to get the provider performance evaluation process going, including a mechanism to attribute surgical site infections to a particular surgeon, but that it was not yet available. In an interview with the CEO on 12/17/15 at 1530, he stated that the ongoing provider performance evaluation process was broken, and that there were improvements in process.	A 340	d. Hospital Leadership and the Director of Medical Staff Services worked collaboratively with the Director of Business Integration to set up an electronic system so that individual Department Leadership can input the necessary data for reporting outcomes, which is used for evaluation by the Medical Staff Services Department for reappointments and for ongoing monitoring. It is anticipated that this electronic system will be functional by 6/1/16. In the interim, the data is being collected manually by the individual Department Leadership, including Quality, Infection Control, Radiology, Laboratory/Blood Bank, Pathology, Case Management, Health Information Management Department and other medical staff departments. e. The Medical Staff Services Department and physician leadership re-evaluated reappointments for all practitioners from January 2016 through March 2016 and reviewed those practitioners due for reappointment in April 2016 to assess compliance with establishing/evaluating the physician's competency prior to re-appointment. The data for reappointment was collected and profile developed, which was resubmitted to the MEC for re-review and approval.	3/16/16
A 358	482.22(c)(5)(i) MEDICAL STAFF RESPONSIBILITIES [The bylaws must:] Include a requirement that-- (i) A medical history and physical examination be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician (as defined in section 1861(r) of the Act), an	A 358		

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A 358	482.22(c)(5)(i) MEDICAL STAFF RESPONSIBILITIES [The bylaws must:] Include a requirement that-- (i) A medical history and physical examination be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician (as defined in section 1861(r) of the Act), an	A 358	A 358 482.22 (c)(5)(i) Medical Staff Responsibilities Immediate Actions Taken: 1. Nursing Leadership discussed the existing process for completion of the history and physical and/or updated history and physical prior to surgery with the Chief of Surgery and the CEO, outlining requirements and steps nursing services can take to enhance medical staff compliance. Subsequent Actions Taken: 1. Executive Leadership approved revisions to nursing operations to enhance compliance with ensuring complete and updated history and physical examinations by 1) requiring the	1/16/16 3/22/16

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A 358	Continued From page 34 oromaxillofacial surgeon, or other qualified individual in accordance with State law and hospital policy. This Standard is not met as evidenced by: Based on interview and document review, the hospital did not ensure that a history and physical exam, including all pertinent documentation, was recorded for one patient, Patient 504, creating the increased risk of a poor surgical outcome for that patient. Findings: The hospital's Medical Staff Rules & Regulations (undated, page 3), read, "Each practitioner shall complete an H & P within the first twenty-four (24) hours of admission of his patient. The only exception to this requirement is for patients who have had an H&P examination performed within seven (7) days prior to admission and a durable, legible copy of this report is placed in the patient's medical record." The medical record of Patient 504 showed that he was admitted to the hospital for outpatient surgery on 12/14/15. The record contained H&P documents from 8/5/15 and 11/17/15. The 11/17/15 document consisted of a pre-printed Outpatient Preoperative History and Physical Form on which some information had been handwritten regarding the 70 year old patient. However, the sections of the form to indicate diagnosis, proposed surgery, medications, review of systems, and physical examination were left blank. The section for indicating a problem history included COPD, hypertension and atrial fibrillation. The surgeon signed the form. However, the documentation completed by the anesthesiologist and the nurse showed the patient also had prostatic hypertrophy (enlarged prostate), history of a heart attack, elevated	A 358	history and physical and/or update to be in the medical record prior to the patient being taken to the pre-op holding area and 2) developing a formal communication tool to ensure that the history and physical and/or interval note is completed. The "Universal Protocol Safety Checklist", and "Site Marking Verification and Time Out" forms address, among other things, the nurse assessing for the presence of the history and physical and/or interval note. The revised forms were approved by the Surgery Committee on 3/7/16, MEC on 3/15/16 and Governing Board on 3/16/16. The ambulatory care, pre-op holding, and operating room nurses were educated on the forms. 2. The CEO and Chief of Staff sent a reminder memorandum to all physicians regarding history and physical/interval notes prior to patients being taken to the surgery department (pre-op holding area). 3. The perioperative nursing staff (ambulatory, pre-op holding, and operating room) are oriented to the checklist upon hire. 4. Compliance with completing the surgical checklist to ensure a history and physical and/or interval note prior to surgery is monitored through the QAPI program. <u>Compliance and Monitoring</u>: Effective 3/11/16, the Director of Perioperative Services or qualified designee performs a random weekly review of 20% of surgical cases to achieve the goal of 100% compliance with history and physical/interval notes prior to surgery. Corrective action is taken as necessary, including re-education of staff and physician. Data on compliance is tracked, trended, analyzed and reported monthly to Surgery Committee, Quality Council, MEC, and Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will occur until the Quality Council determines sustained compliance has occurred, at which time the Council will determine what adjustments to monitoring are necessary for ongoing sustainability (e.g.,	3/14/16

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A 358	Continued From page 35 cholesterol, diabetes, asthma and anxiety, conditions not noted by the surgeon. In an Interview with the Sr Mgr Medical Records on 12/15/15 at 1050, she stated that the surgery department was to do its own audit of the H & Ps. She reviewed the medical record documented on 11/17/15 for Patient 504, and concurred that there was no physical exam, no review of systems and no medications listed, and that the history of an MI was not on the form.	A 358	random samples or inclusion of the issue as an ongoing indicator).	
A 392	482.23(b) STAFFING AND DELIVERY OF CARE The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient. This Standard is not met as evidenced by: Based on observation, Interview and record review, the hospital failed to 1) Ensure that suicide risk assessments were performed and documented per policy, creating a risk to the safety of all patients presenting with suicidality, and failed to ensure that the treatment plan was followed for Patient 509, creating the risk of inadequate treatment, and failed to ensure medication was administered as ordered for one patient, Patient 504, creating the risk of substandard health care for that patient, and failed to ensure a timely response to a change in condition was provided to Patient 507, resulting in a possible failure to rescue the patient. 2) The hospital failed to have all ICU RN's (intensive care unit, registered nurses) nursing staff physically present within the ICU at all times, when RN assignments were split between the	A 392	A 392 482.23(b) Staffing and Delivery of Care	

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A 392	Continued From page 36 ICU unit and the MAC (medically acute care) unit. This failure has the potential of not having readily available the assigned RN to manage the care of the intensive care patient population. Findings: 1) Patients did not receive suicide risk screening per hospital policy.The hospital policy, Precautions BHU.053 (revised 6/2014) was obtained at the Van Nuys facility on 12/17/15. The policy showed that the "Suicide Potential Rating Scale (addendum A) shall be completed as part of the Initial Nursing Assessment and daily assessment for each patient", and that the score of the assessment would determine the level of observation provided. The hospital policy, Precautions (reviewed 8/2015), was obtained from the Culver City facility, and showed that a patient was to be placed on "suicide precautions" based on the information obtained from the history, legal holds, initial assessment, and Suicide Potential Rating Scale. The Suicide Potential Rating Scale was to be completed as part of the initial nursing assessment and daily assessment for each patient, and was to generate a risk score that would prompt different levels of observation. The Suicide Potential Raking Scale appended to the policy included assessment of 8 parameters, including age, socialization support system, onset of suicidal ideation, plan, availability of means, symptoms, planned outcomes, and recent stressors. A score was to be determined for each parameter, and based on the total score, precautions were determined, including no precautions for a score of 4-9, Q15 minute rounds, " S/I " indicated on rounds board and documentation in progress notes each shift for a score of 10-19, and 1:1 monitoring until evaluation by attending for patients with scores of	A 392	Finding 1 Immediate Actions Taken: 1. Executive Leadership (including nursing) reviewed the findings from the survey exit. It was determined an in-depth review of staffing was necessary to identify and remediate any staffing vulnerabilities. 2. The staffing matrix was reviewed by Senior Nursing Leadership to ensure each department was appropriately staffed. It could not be identified that issues cited related to nursing failure to follow the precautions policy were related to staffing. Subsequent Actions Taken: 1. Nursing Leadership reviewed and revised the "Precautions" policy to current practice, which included elimination of the Suicide Potential Rating Scale. The policy was renamed the "Suicide Risk" policy. Suicide screening is done on admission (or prior to admission in the ED). If the patient responds yes to any of the suicide questions, a suicide assessment is performed and care initiated based on the individual patient's assessed needs (e.g., 1:1 observation). The facility staff notifies the physician when the patient makes statements related to suicidal ideation. All clinical departments regularly assess the clinical condition of the patient according to policy. The MEC approved the policy on 3/15/16 and Governing Board on 3/16/16. Nursing staff education was performed. 2. Care Facilitation process was implemented to assess on an ongoing basis (in real time) compliance with staffing to allow for appropriate suicide screening and resultant patient protection. Care facilitation is a process of concurrent record compliance monitoring whereby a "care facilitator" (licensed healthcare professional) identifies any noncompliance with the subject matter, intercepts the nurse/ provider in real time, provides "just in time" education and training to correct clinical or documentation process issues. This method	12/29/15 12/22/15 3/22/16 3/10/16

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A 392	Continued From page 37 20 or more. The Suicide Potential Rating scale had ratings for each parameter of 0-4 points, but with 20 points scored for a specific plan. Review of the census list provided by the VN facility showed that almost all of the patients provided a plan that included a specific mechanism for self-harm, and therefore almost all would have qualified for 1:1 monitoring until released with an order by an attending physician. An incident dated 11/18/15 was reviewed and showed that a patient, Patient 503, was admitted to the Van Nuys facility on 11/13/15, and transferred to Culver City on 11/16/15, but remained in the ER overflow area. The Physicians Initial Assessment & Preliminary Treatment Plan dated 11/14/15 showed that the patient had been admitted due to suicidal ideation with a plan. However, no suicide potential rating scale results or score was found. The record showed that the patient was transferred to the Culver City ER on 11/16/15 and the ER MD Note indicated the patient was having suicidal ideation. The triage note from the ER on 11/16/15 showed the chief complaint was suicidal ideation, with a plan to cut herself. Patient 503 was subsequently admitted as an inpatient on 11/17/15 at 1219 (but remained physically in the ER). There was an admission assessment performed at the time of admission that showed for the item, suicide self-harm risk, "no risk" was written. There was no further suicide potential rating scale result found, and no score for suicide risk determined. The patient denied suicidal ideation on 11/18/15 at 1118, and requested discharge. She was documented to have been escorted from the hospital on 11/18/15 at 1212. Patient 508, a 21 year old woman with schizoaffective disorder, was admitted to the behavioral health unit at Culver City, and her record was reviewed because she reported an	A 392	allows for role modeling of excellent clinical behavior while allowing staff to replicate improved practices. Care facilitation drives sustainability as staff learns from ongoing facilitation to identify, correct and improve practice weaknesses. 3. Education on suicide risk screening and assessments was incorporated into clinical provider orientation program upon hire. 4. Compliance with nursing suicide screening and assessments is monitored through the QAPI program. Compliance and Monitoring: Data from care facilitation is collected daily, aggregated and reported to Executive Leadership daily. This allows Nursing Leadership to make real time corrections to ensure all precautions are occurring as required/ordered and that there are not staffing issues. Daily monitoring will occur until Nursing Leadership determines process stabilization has occurred. Person Responsible: Chief Nursing Officer	3/22/16

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A 392	Continued From page 38 Incident. The record showed that the patient was admitted for being a danger to self, as she had jumped from a balcony. The discharge summary indicated that patient had worsening depression with the intent to cut herself and had been hospitalized for suicidal behavior four times in the previous three weeks. During a review of the medical record, no Suicide Potential Rating Scale was found, and no suicide risk score was seen. The observation sheets did not have suicide risk indicated as a reason for observation, and there was no documentation of 1:1 observation seen. In an interview with the Dir BHU on 12/16/15 at 0855, she stated that she did not see the suicide risk assessment for the patient. She stated that they had a paper form available to complete such an assessment during electronic health record downtime, but that there might not be such a form in the electronic health record. Also, although the patient discussed previous consumption of 40 ounces of beer daily, the assessment item for potential for withdrawal problems showed "none known or evident", and the withdrawal risk assessment had not been completed. In an interview with the Dir BHU on 12/17/15 at 0950, she stated there was no symptom screen related to the history of substance abuse for Patient 508. She stated that there were dual diagnosis patients on the P6 psychiatric unit, and that the staff should fill out the "miracle" substance abuse risk assessment, and that the assessment should be in the electronic health record. On 12/17/15, at 1150, Patient 509 was observed in the hallway of the Van Nuys facility, and appeared smiling and calm. BHU STAFF VN stated that Patient 509 was about to be discharged.	A 392		

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A 392	Continued From page 39 The patient roster with diagnoses for the Van Nuys facility was requested. The roster showed that 55 of 57 patients were admitted with a plan to commit suicide. Patient 509 appeared on the census as being admitted for depression and suicidal ideation with a plan to overdose. Patient 509's medical record was reviewed, and no Suicide Potential Rating Scale was found, and no suicide risk score was seen. Other rating scales, such as the Morse Fall Scale and the Braden skin risk assessment, were seen. In an interview with BHU Staff VN on 12/17/15 at 1220, he reviewed the medical record of Patient 509 and stated that there was no scored suicidal ideation worksheet. He stated there was an assessment template in the electronic health record, but it was not equivalent to the worksheet described in the policy. The medical record of Patient 510 at the VN facility was randomly selected for review on 12/17/15. The record showed that the patient presented with suicidal ideation with command hallucinations. However, the record did not contain the Suicide Potential Rating Scale described in the hospital policy. During a concurrent interview with the Admin VN and BHU Staff VN on 12/17/15 at 1245, they concurred that the suicide risk assessment was not being performed per policy. They stated that there had been a couple of suicide attempts in the facility in recent months. In an interview with the CNO on 12/18/15 at 1505, she stated that she was not sure why the Suicide Potential Rating Scale assessment tool was not in use. On 12/17/15, at 1150, Patient 509 was observed in the hallway of the Van Nuys facility, and appeared smiling and calm. BHU STAFF VN stated that Patient 509 was about to be discharged.	A 392		

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A 392	Continued From page 40 The treatment plan for Patient 509 at the Van Nuys facility was reviewed on 12/17/15, and showed that the plan of care initiated 12/9/15 contained items such as, "pt will identify 2 triggers that increase self-harm ideation and discuss with staff 2x week ", and "pt will identify 2 triggers that decrease positive mood and/or increase mania and/or increase anxiety", and "patient will id 2 triggers that increase risk of relapse and discuss with staff during 2x groups per day and during 1:1", and "case manager will encourage pt to identify 2 coping skills that increase/maintain in sobriety in 4x groups per day and during 1:1". In an interview with BHU Staff VN on 12/17/15 at 1225, he reviewed the documentation in the electronic health record and was not able to find documentation that the goals were met during groups or 1:1 time during the patient's stay in the facility. The record of Patient 507 was selected for review because the patient appeared on the Code Blue Log for the month of November. The log showed that Patient 507 experienced a code blue while on the med-surg unit on 11/2/15, and did not survive the event. The medical record of Patient 507, a 58 year old man who had a procedure at the hospital, was reviewed and showed that his blood pressure was in the normal or elevated ranges on 11/1/15 and 11/2/15, but suddenly dropped to 90/66 on 11/2/15 at 1700. Similarly, his heart rate suddenly dropped from a normal range to 56 at 1804. There was no documentation to show that the abnormal vital signs were rechecked, that the physician was notified, that any orders were obtained or that any assessments or interventions were undertaken by the nurse to address the changes. The patient became pulseless and a code blue was initiated at 1845, but the patient expired..	A 392		

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A 392	Continued From page 41 In an interview MR Staff 1 on 12/16/15 at 1145, she reviewed the medical record of Patient 507 and stated that there were no nurses notes prior to the code blue, no evidence of physician notification, and that the last order for the patient recorded prior to the 1845 code blue was at 0813 in the morning. The medical record of Patient 504 was reviewed on 12/14/15 and showed that he was to have outpatient surgery on 12/14/15. The Preoperative Orders included an order to "Instill one drop of the left eye every 5 minutes for 3 doses on call to OR: a) Marcaine 0.75% or equivalent topical anesthetic " . The other four eye drops ordered included Cyclogyl, Mydriacyl, Phenylefrin, and Ciprofloxacin. The record showed that those four drops were given, and the times of administration recorded, but not the Marcaine. During an interview with the Sr Mgr Medical Records on 12/15/16 at 1050, she was unable to find documentation that the Marcaine was administered. 2) On 12/17/15, at 9 a.m., during a tour and interview of the ICU, charge nurse (LN5) was questioned about patient N106's medical condition. LN 5stated, "That's RN3's patient." When asked where RN3 could be found the LN 5 stated, "I think she is caring for her other patient outside of the ICU." RN3 was located outside of the ICU, in room 305C in the MAC unit, RN3 was dressed in a protective isolation gown, caring for Patient N104 outside of the ICU. During an interview with the DON1 on 12/17/15, at 9:15 A.M., DON1 was questioned as to the usual and customary staffing assignments. DON1 stated, "The staffing ratio is 1:2 (nurses to patients) and if the nurse is away from the unit,	A 392	Finding 2 Immediate Actions Taken: 1. Nursing Leadership reviewed the identified patients and there was no adverse findings resulting from the staffing assignment. 2. Nursing Leadership changed the staffing assignment at the time of survey to ensure direct visualization of ICU patients by assigned nurse at all times. One nurse was assigned to care for the patient in the room outside the ICU. 3. Nursing Leadership provided education to Nursing Supervisors and ICU charge nurse to ensure appropriate nursing assignment for ICU patients. ICU staff is either assigned to care for patients inside the ICU or to the room outside the ICU so that there is direct visualization. A log tool was created to show the ICU patient assignments. The Charge nurse or qualified designee is assigned to provide coverage for breaks to the ICU nurse providing care to the patient in the room outside the ICU. Subsequent Action Taken: 1. Nursing Leadership instituted monitoring of staff assignments in the ICU, effective 12/18/15. Nursing Leadership continued ongoing education to Nursing Supervisors and Charge Nurses, which resulted in 100% compliance for March to date. Compliance and Monitoring: Nursing Supervisor or designee performs daily staffing review of ICU assignments to achieve the goal of 100% compliance with appropriate staffing of the room outside the ICU. Data is analyzed and reported monthly to the Quality Council, MEC and Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will occur until the Quality Council determines sustained compliance has occurred, at which time the Council will determine what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator).	12/17/15 12/17/15 12/17/15 3/10/16

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A 392	Continued From page 42 the charge nurse should know what is going on with the patient." During an interview with RN3, RN3 was asked if she could visually see her ICU patients when she is working with a MAC patient in another unit, RN3 stated, "Obviously not, the patients are separated by walls and doors." RN 3 was questioned as to whether she gives report on her patients to other nurses in the ICU when she leaves the unit to care for her other assigned patients. RN3 stated, "I do when I go to lunch, otherwise if they need me they find me." During an interview with the day supr LN8 on 12/17/15, at 3:35 p.m., the day supr LN8 was questioned regarding the practice of having an RN assigned to manage both an ICU patient and a MAC patient in two different units was appropriate. The day supr LN8 stated, "No, not really it would be difficult." When questioned if this was the only time he was aware of this type of staffing assignment, the day supr LN8 stated, "No I believe it has happened before." On 12/17/15, at 4 p.m., a review of staffing assignment for ICU for one week (12/11/15 through 12/17/15) revealed that RN's were assigned to an ICU patient and a MAC patient on 19 separate occasions. On 12/17/15, at 4:45 p.m., during an interview with the DON1 she was shown the assignment sheets indicating the RN assignments were split between two different units the ICU and the MAC units. The DON1 stated, "I didn't know this was happening".	A 392	Person Responsible: Chief Nursing Officer	
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient.	A 395	A 395 482.23(b)(3) RN Supervision of Nursing Care	

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A 395	Continued From page 43 This Standard is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure nursing staff evaluated and implemented nursing care according to professional care standards for patients with Foley catheter devices as evidence by the following: 1. Foley Catheters were inserted without a doctor's order in the Critical Care Unit (CCU), Step Down unit and Emergency Department (ED). 2. Facility staff did not evaluate for urinary catheter insertion indication and daily neccessity as indicated per policy. These failures have the potential to have a negative health outcome for patients' with a Foley Catheter. Findings: According to the California Nursing Practice Act, Scope of Regulation, Section 2, Chapter 6. Article 2, (b) (2) indicates "Direct and indirect patient care services, including, but not limited to, the administration of medications and therapeutic agents, neccessary to implement a treatment, disease prevention, or rehabilitative regimen ordered by and within the scope of licensure of a physician...as defined by Section 1316.5 of the Health and Safety Code. 1. During a tour of the CCU and concurrent interview with Administrative staff (AS) and Charge nurse (CN) on 12/15/15 at 10:05 a.m., Patient N-200, N-201 were observed with a Foley catheter device. The AS and CN were asked to	A 395	Findings 1 and 2 Immediate Actions Taken: 1. Nursing Executive Leadership reviewed the findings after the survey. It was determined nursing staff would benefit from refresher education on multiple topics and a search for an outside education vendor that could provide deep education in a consistent fashion to nursing staff was needed to augment the organization's educational program. An outside education firm was hired, with these skilled educators performing intensive education to staff on many of the core nursing practices. 2. It was determined the foley catheter policy provided at time of survey was not related to management of the acute inpatient population. Subsequent Actions Taken: 1. The referenced "Foley Catheter Need Assessment " Policy was reviewed and identified to be the subacute unit policy. Nursing Leadership developed a new policy for acute inpatients entitled "Indwelling Urethral Catheter Management." The physician is responsible for writing the order and justification for placement of an indwelling urethral catheter to be placed. Healthcare providers must ensure and document an appropriate indication for an indwelling urethral catheter to be placed. The policy was approved by the MEC on 2/16/16 and Governing Board on 2/24/16. Nursing staff was educated on the policy. 2. The Chief of Staff sent a memorandum to medical staff practitioners reminding them of the need for an order and indication for the indwelling catheter. 3. The CNO worked with the consultants to implement facilitation, a process of concurrent record compliance monitoring whereby a "care facilitator" (licensed healthcare professional) identifies any noncompliance with the subject matter, intercepts the nurse/provider in real time, provides "just in time" education and training to correct clinical or documentation process issues. This method allows for role	12/19/15 - 2/19/16 12/29/15 3/22/16 3/18/16 2/5/16

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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A 395	Continued From page 44 assist in locating in the clinical record an order for the device. The AS and CN confirmed there was not a doctor's order in the clinical record for 2 out of 2 patients with a Foley catheter. Patient N-201's license nurse (LN 1) was interviewed on 12/15/15 at 10:30 a.m., she confirmed there was not an order for a Foley catheter and she did not look for an order because the Foley catheter was inserted on 12/9/15 in the ED. LN 1 stated "In the ED there was an order for an In & Out catheter to collect a urine specimen. I think the nurse inserted an indwelling foley catheter instead of an In & Out catheter and left it in, that's why there is not an order for a foley catheter in the unit." During a tour of the Step-down unit and concurrent interview with AS and Telemetry director (TD) on 12/15/15 at 2:49 p.m., in a sample of 8 patients with Foley catheters, 7 out of 8 did not have a doctor's order for the device. Patients N 202, N 203, N 204, N 205, N 206, N 207, and N 209 were found without a Foley catheter order in their clinical record. The AS and TD agreed this was "not a good practice." 2. During the same tour of the Step-down unit, Patient N 208's Foley catheter order did not have an indication for the insertion of the device. At the time, the TD and LNs were interviewed and asked regarding the process of monitoring for the foley catheter neccessity and indication as indicated per their policy. The TD and LNs denied having a monitoring process in place in order to monitor for foley catheter devices. They only have a log where they document how many patients have a foley catheter but that's it. They were asked regarding the " Foley Catheter Daily Assessment" form as indicated per facility's	A 395	modeling of excellent clinical behavior while allowing staff to replicate improved practices. Care facilitation drives sustainability as staff learns from ongoing facilitation to identify, correct and improve practice weaknesses. A Care Facilitation worksheet was developed for use by the care facilitators, including monitoring for indwelling catheter orders and indication for use. 4. Nursing staff is educated on orders and indication for use of indwelling catheters upon hire. 5. Compliance with foley catheter orders and indication for use is monitored through the QAPI program. Compliance and Monitoring: Data is collected by the care facilitators, reported daily, aggregated and reported to leadership at least weekly to allow for leadership to focus resources on those issues and units where continued vulnerabilities exist. The goal is to achieve 100% compliance with foley catheter orders and indication for use. Data is analyzed and reported monthly to the Quality Council, MEC and Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will occur until the Quality Council determines sustained compliance has occurred, at which time the Council will determine what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Person Responsible: Chief Nursing Officer.	

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A 395	Continued From page 45 policy. The form was shown to the staff and TD. They stated they had never seen the form and they don't know what the "Foley Catheter Daily Assessment' is or where to find it. An interview was held with facility's infection control practicioners (ICP's) on 12/17/15 at 8:45 a.m., they were questioned regarding the facility's monitoring process for Foley catheter devices. ICP 1 stated she was new to the facility and is working on a project to take care of the Foley catheter device problem. ICP 2 stated he was aware of the Foley catheter device problem (lack of doctor's orders, insertion indication and device neccessity) monitoring from the last survey. Now the two ICPs are working on the problem. A review of the facility's policy and procedure titled: Foley Catheter Need Assessment, SAA.029, dated 1/2014, indicated "Prevention of infection with any invasive device relies on ...using these devices only for an appropriate indication...and removing them promptly. Indwelling catheters can pose significant infection risks to patients." Furthe the policy indcated in section 4.2 Procedure: "Avoid unneccessary urinary catheters (see attached form Foley Catheter Nursing Evaluation) and Review urinary catheter neccessity daily and remove promptly (see attached form Foley Catheter Daily assessment)." According to the LNs they had never seen those two forms that were mentioned in the facility policy.	A 395		
A 396	482.23(b)(4) NURSING CARE PLAN The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan	A 396	A 396 482.23(b)(4) Nursing Care Plan Immediate Actions Taken: 1. Nursing leadership reviewed the survey findings. It was determined nursing staff would benefit from refresher education on multiple topics and a search for an outside education vendor that could provide deep education in a	12/19/15 -2/19/16

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A 396	Continued From page 46 This Standard is not met as evidenced by: Based on interview and record review, the hospital did not ensure that nurse care planning was performed for Patient 503, creating the risk of substandard health care. Findings: Patient 503's medical record showed that the patient was transferred to the Culver City ER on 11/16/15 with conditions including COPD, hypertension diabetes mellitus, and pain. An ER MD Note indicated the patient was having suicidal ideation, and the triage note from the ER on 11/16/15 showed the chief complaint was suicidal ideation, with a plan to cut herself. The physician progress note dated 11/18/15 showed the patient had coronary artery disease, morbid obesity and obstructive sleep apnea, diabetes, and was awaiting transfer to the inpatient area to use a CPAP machine. Patient 503 was subsequently admitted as an inpatient on 11/17/15 at 1219 (but remained physically in the ER). According to MR Staff 1, no nursing care plans were found for the Culver City admission. The patient denied suicidal ideation on 11/18/15 at 1118, and requested discharge. She was documented to have been escorted from the hospital on 11/18/15 at 1212.	A 396	consistent fashion to nursing staff was needed to augment the organization's educational program. An outside education firm was hired, with these skilled educators performing intensive education to staff on many of the core nursing practices. Subsequent Actions Taken: 1. Nursing Leadership discussed the survey findings and process for nursing care planning. The "Interdisciplinary Plan of Care" Policy was revised and renamed the "Documentation" Policy. The nursing staff develops and keeps current, a nursing care plan for each patient that addresses the patient's individual acute hospitalization needs based on assessment outcomes. Care planning was discussed as those patient needs that require acute response including discharge planning and psychosocial issues, however if a patient was receiving treatment for a chronic issue that was not impacting the current hospitalization, nursing staff were to prioritize the need and focus planning on the acute condition. For those patients in the Emergency Department(ED) awaiting a bed, the ED nurses will initiate the assessment and plan of care for the patient. The MEC approved the policy on 3/15/16 and Governing Board on 3/16/16. Nursing staff was inserviced on the policy.	3/22/16
A 405	482.23(c)(1), (c)(1)(i) & (c)(2) ADMINISTRATION OF DRUGS (1) Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice. (i) Drugs and biologicals may be prepared and administered on the orders of other practitioners not specified under §482.12(c) only if such practitioners are acting in accordance with State	A 405		

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A 405	482.23(c)(1), (c)(1)(i) & (c)(2) ADMINISTRATION OF DRUGS (1) Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice. (i) Drugs and biologicals may be prepared and administered on the orders of other practitioners not specified under §482.12(c) only if such practitioners are acting in accordance with State	A 405		

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A 405	482.23(c)(1), (c)(1)(i) & (c)(2) ADMINISTRATION OF DRUGS (1) Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice. (i) Drugs and biologicals may be prepared and administered on the orders of other practitioners not specified under §482.12(c) only if such practitioners are acting in accordance with State	A 405		

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A 396	Continued From page 46 This Standard is not met as evidenced by: Based on interview and record review, the hospital did not ensure that nurse care planning was performed for Patient 503, creating the risk of substandard health care. Findings: Patient 503's medical record showed that the patient was transferred to the Culver City ER on 11/16/15 with conditions including COPD, hypertension diabetes mellitus, and pain. An ER MD Note indicated the patient was having suicidal ideation, and the triage note from the ER on 11/16/15 showed the chief complaint was suicidal ideation, with a plan to cut herself. The physician progress note dated 11/18/15 showed the patient had coronary artery disease, morbid obesity and obstructive sleep apnea, diabetes, and was awaiting transfer to the inpatient area to use a CPAP machine. Patient 503 was subsequently admitted as an inpatient on 11/17/15 at 1219 (but remained physically in the ER). According to MR Staff 1, no nursing care plans were found for the Culver City admission. The patient denied suicidal ideation on 11/18/15 at 1118, and requested discharge. She was documented to have been escorted from the hospital on 11/18/15 at 1212.	A 396	compliance is achieved and process control is demonstrated. Ongoing monitoring will occur until the Quality Council determines sustained compliance has occurred, at which time the Council will determine what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Person Responsible: Chief Nursing Officer	
A 405	482.23(c)(1), (c)(1)(i) & (c)(2) ADMINISTRATION OF DRUGS (1) Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice. (i) Drugs and biologicals may be prepared and administered on the orders of other practitioners not specified under §482.12(c) only if such practitioners are acting in accordance with State	A 405	A 405 482.23(c)91), (c)(1)(i) & (c)(2) Administration of Drugs	

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A 405	Continued From page 47 law, including scope of practice laws, hospital policies, and medical staff bylaws, rules, and regulations. (2) All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures. This Standard is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure medications were administered according to the prescriber's orders for two randomly observed patients (P100 and P101). Further the facility failed to prepare and administer medications in accordance with the facility's policies and procedures, as evidence by the following: 1. Intravenous medication tubing was not labeled as per policy. 2. Medications administered without indication or pain assessment. 3. Medications were withdrawn by one nurse and administered by a different nurse. Patients potentially did not receive the full benefits of ordered treatments. Failure to follow medication administration policy has the potential of resulting in a negative outcome to patient's health. Findings: 1. During the observation of medication administration on the Telemetry Unit at Culver	A 405	Findings 1-7 Immediate Actions Taken: 1. Nursing Leadership discussed the survey finding regarding registry nurses and administration of narcotic medication. The "Orientation and Competency Registry/ Contract/Temporary Personnel" policy was reviewed which provides that an agency nurse's licensure is deemed competent to perform the duties recognized by the State Board of Registered Nurses. This would include administration of narcotic medications. At the time of the survey, Nursing Leadership instructed the nursing staff that if they pulled the medication from the Omnicell, it was their responsibility to administer the medication to the patient. While Pharmacy addressed issues with the Omnicell, the staff nurses administered narcotic medications for the registry nurses. On 2/26/16, the Omnicell was reset to allow registry nurses to be able to access and dispense their own medication to patients. Charge nurses educated the registry staff to use of the Omnicell. Subsequent Actions Taken: 1. Nursing Leadership reviewed the "Medication Administration" policy, which did not require any revisions. The "Pain Management" policy was reviewed and revised to clarify medication assessments and reassessments and more closely align with actual practice. The nurse assesses the patient in a time frame appropriate for pain medication response, however the documentation of this assessment was not required in a concurrent note. The evaluation of pain effectiveness assessments must, however, be documented by the end of the nurse's shift. The MEC approved the policy on 3/15/16 and the Governing Board on 3/16/16. The "IV Tubing" policy was reviewed and did not require any revisions. Nursing staff was re-educated.	2/26/16 3/22/16

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A 405	Continued From page 48 City, on 12/15/15 starting at 8:10 A.M., RN 2 was preparing pantoprazole (a medication for stomach ulcer) 40 mg injection for Patient P101. RN 2 stated the medication would be administered at 8:30 A.M. At 8:36 A.M., RN 2 proceeded to administer the medication. The medication was administered over 40 seconds. During the same observation, RN 2 verified Patient P101 had cefepime (an antibiotic) 1 g administered earlier and the infusion was complete. The facility used a system where the medication vial (a powder) was attached to an intravenous solution but the powder was not mixed. The nurse would activate the system to dissolve the powder, then mix it with the solution prior to administration. RN 2 noted there was approximately 2 mL of yellow solution left in the vial [the full dose was not mixed in the solution and therefore not administered]. Patient P101's clinical record was reviewed on 12/15/15 starting at 1:55 P.M. with RPh 4 and the VPP. The VPP stated pantoprazole should be administered over 2 minutes. According to LexiComp, a drug information reference, which was also referenced by the facility, pantoprazole 40 mg should be administered "over at least 2 minutes." 2. During the observation of medication administration in the ICU (Intensive Care Unit) at Culver City, on 12/15/15 starting at 8:50 A.M., RN 1 was preparing medications for Patient P100. Medications were crushed, if they were solid, for administration via a tube. RN 1 prepared 12 different medications. Among the medications,	A 405	2. The Hospital engaged a national healthcare regulatory compliance consulting firm to assist with the credible allegation of compliance, including a pharmacist to assist with medication management issues. 3. Medication pass audits were developed 2/10/16. The medication pass audits were implemented to get a baseline on core nursing vulnerabilities related to medication administration. Focused education to nursing staff was provided on myriad medication administration issues essential to safe medication administration, including the five rights of medication administration. Special attention was paid to proper labeling of medication, assessing and re-assessing post medication administration, documenting effectiveness of medication, appropriate indication for medication administration, and appropriate method of medication administration (proper time frames in pushing some intravenous medications, not crushing pills together, etc.). 4. Education on medication administration, pain assessments and IV tubing labeling requirements is provided to nursing staff upon hire. 5. Compliance with medication administration, pain assessments and labeling IV tubing is monitored through the QAPI program. <u>Compliance and Monitoring</u>: Effective data is collected by assigned observers performing medication pass audits. The audits are collected and aggregated weekly and provided to nursing administration for review and remediation as appropriate. The goal is to achieve 90% compliance with medication administration practices, pain assessments and reassessments, and labeling of IV tubing. Data is analyzed and reported monthly to the Quality Council, MEC and Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will occur until the Quality Council determines sustained compliance has	1/13/16 2/10/16 - 3/22/16

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A 405	Continued From page 49 one tablet of metoprolol 50 mg was prepared. At 9:30 A.M., RN 1 stated the medication administration process was complete. It was then observed there was a small white fragment of medication left. RN 1 could not identify which medication was not fully administered. During the same observation, RN 1 verified other intravenous (administered directly into the vein) medications present in the room, either the infusion was completed or ongoing. Diltiazem infusion was not present. Patient P100's clinical record was reviewed on 12/15/15 starting at 1:55 P.M. with RPh 4 and the VPP. On 12/10/15, Patient P100 was prescribed metoprolol 100 mg orally twice daily. RN 1 was observed administering only 50 mg. On 12/8/15, Patient P100 was prescribed diltiazem (a heart medication) infusion. RPh 4 confirmed the order was still current and active. RN 1 verified earlier diltiazem was not being administered 3.) During a tour of the Direct Observation Unit (DOU) and concurrent interview with AS on 12/17/15 at 3:40 p.m., in room 317, an antibiotic medication and primary IV line were missing labels to indicate when they were changed last. In room 310 another IV antibiotic tubing was observed being infused without the tubing being labeled. The AS agreed the IV tubings should be labeled to indicate when they need to be changed. The LN caring for the patient in room 310 was interviewed on 12/1/7/15 at 3:55 p.m., he was	A 405	occurred, at which time the Council will determine what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Person Responsible: Chief Nursing Officer	

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A 405	Continued From page 50 questioned about the IV tubing not being labeled. The LN stated "I thought I labeled my IV tubing, Ok I will label it now" . A review of the facility's policy and procedure titled: Intravenous Therapy-Initiation and Management of Peripheral Intravenous Lines, VAS.005, dated 11/20/2012, indicated "IV tubing set changes are every 96 hours." "Label tubing with date". 4. A clinical record review on 12/17/15, at 4:30 p.m., revealed Patient N104 received acetaminophen 325 mg (a pain medication) on 11/2/15, at 1:50 P.M., and again on 11/11/15, at 1p.m., for a fever, review of original prescription indicated to administer acetaminophen for complaints of pain. Further record review indicated there was no pain assessment for patient N104 at these times. During a concurrent interview with LN4 on 12/17/15 at 4:30 p.m., while reviewing medication administration record of Patient N104, LN4 stated, "There was no order for this medication for fever, this was given for the wrong reason." 5. A review of the facility policy titled "Pain Management" effective 07/2004 last revised 10/2015 revealed under header "1.18 Documentation" indicated "Document pain... " iii. Correct Pain Intensity use for each patient. iv. Reactions, interventions, and effectiveness of pain control." During a concurrent review of Patient N105	A 405		

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A 405	Continued From page 51 medication administration record and interview with LN3 on 12/12/15, record revealed that Patient N105 received tylenol (pain medication) 650 mg on 12/13/15 at 10:43 a.m. There was no documentation of pre-assessment for pain or documentation of post medication administration assessment of pain. LN3 acknowledged there was no documentation in Patient N105 medical record. During a concurrent review of Patient N101 medication administration record and interview with CNO on 12/15/15, record revealed that Patient N101 received hydrocodone-acetaminophen 5-325 mg (a medication used to treat pain) on 12/13/15. There was no documentation of pre-assessment for pain or documentation of post medication administration assessment of pain. CNO acknowledged there was no documentation in Patient N101 medical record adding, "They should have documented the post assessment within 60 minutes." 6. According to Daniels, Grendell, Wilkins "Fundamentals of Nursing", Second Edition, Chapter 30 - page 846: "The nurse should not give medications that have been removed from their unit dose package or drawn up...by anyone else." During observation of the administration of a prn (as needed) medication, on 12/17/15, LN 9 assessed N 403 and determined at 9:55 a.m. the patient required a narcotic pain medication. LN 9 approached the charge nurse (LN 7) and followed LN 7 to the medication room.	A 405		

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A 405	Continued From page 52 LN 7 proceeded to sign out the narcotic (Norco) and handed the tablet to LN 9. At 10:01 a.m. LN 9 went to N 403, scanned the patient's wrist band and the medication package. LN 9 then administered the medication and stated, "I'll be back in 30 minutes to see how you feel." LN 7 then directed LN 9 to document the administration in the patient's medication administration record (MAR) in the electronic chart. During interview with LN 9 at the time, when asked why he did not draw the narcotic from the automated medication cart, LN 9 stated, "I am registry and we cannot access narcotics." During interview with LN 7 at 10:03 a.m., she stated, "He is registry and our policy says registry cannot access narcotics." During interview at 3:10 p.m. with two supervising nurses (LN 6 and LN 8) LN 6 stated, "Registry cannot access narcotics. That is our policy." LN 8 added, "The charge nurse or supervisor withdraws the medication and the registry nurse administers it." During a second interview with LN 9 at 4 p.m., LN 9 stated, "I was oriented to the system by the pharmacist. Then the pharmacist got me an access number. But I cannot access narcotics." At 4:05 p.m. during a second interview with LN 8 she stated, "Charge or supervising RN has to draw it up. Then registry nurse administers." When asked if she thought it was good practice for a nurse to administer a medication drawn up	A 405		

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A 405	Continued From page 53 by a different nurse, LN 8 said, "Yes, because that is our policy." During an interview with RPh 1 at 5:30 p.m., he stated, "We do not have a policy on registry not accessing narcotics. We orient the registry nurses and call IT for an access code for them." He added, "I called my manager to discuss this and there is no reason they cannot access narcotics." Review of the facility's policy titled, "Orientation and Competency Registry/Contract/Temporary Personnel" approved 3/2014 under 4.1.7 identifies the following:" By virtue of the agency nurse's licensure , he/she is deemed competent to perform the duties recognized by the State of California Board of Registered Nurses." 7. Upon administering a narcotic pain medication to N 403 on 12/17/15 at 10:01 a.m., LN 9 stated to N 403, "Ill be back in 30 minutes to see how you feel." Review of the electronic medication administration record printed on 12/18/15 at 11:35 a.m. indicated LN 9 did not document the effectiveness of the pain medication given the prior morning.	A 405		
A 438	482.24(b) FORM AND RETENTION OF RECORDS The hospital must maintain a medical record for each inpatient and outpatient. Medical records must be accurately written, promptly completed, properly filed and retained, and accessible. The hospital must use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries.	A 438	A 438 482.24(b) Form and Retention of Records	

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A 438	Continued From page 54 This Standard is not met as evidenced by: Based on, Interview and record review, for one patient, Patient 505, the hospital failed to ensure that documentation regarding the patient's desire for CPR was recorded in the medical record and failed to ensure that transfer, assessment and treatment records were available in the medical record for one patient, Patient 503, transferred from the VN to the CC facility, creating the risk of the patient's wishes regarding emergency treatment not being followed. Further, the hospital failed to accurately reflect intensive out-patient admissions when they routinely and systematically readmitted every intensive out-patient every month despite the individual patients not being discharged from the program. This failure creates the potential of inaccurately reflecting the patients length of stay and episodes of care within the intensive out-patient program. Findings: 1) During a review of the medical record of Patient 505 on 12/14/15, the record contained a Physician's Orders sheet that was pre-printed with CPR orders that were to be selected by means of checking a box. The order sheet read, "Must be filled out at the time of admission and with any change in code status". There were boxes to select either "full CPR" or "no CPR", but neither was selected. The form bore a date and time, but no signature. The emergency admit form showed that the patient was 84 and being admitted for failure to thrive. A pre-procedure evaluation on 12/11/15 showed that she was awake and oriented. During an interview with the Sr Mgr Medical Records on 12/15/15 at 1050, she stated that the form should have been completed upon admission, and that she was not sure why it was	A 438	Findings 1 and 2 Immediate Actions Taken: 1. Hospital Leadership discussed the survey findings and compliance strategies. Subsequent Actions Taken: 1. The pre-printed Physician Order Sheet for CPR orders was reviewed and eliminated. Nursing Leadership worked with the IT Department to create a section in the nursing assessment to identify/clarify the code status with the patient/patient representative. The EMR system has a "hard stop" in effect that requires the nurse to complete this section before completing the assessment. The patient will remain on a full code status until the code status is clarified. Nursing staff was educated on the process. 2. Hospital Leadership reviewed and revised the process for interfacility transfers. The Nursing Supervisor is responsible for coordinating the transfer, including ensuring that pertinent clinical information from the medical record is provided at the time of transfer. Nursing Supervisors were inserviced. 3. Nursing Leadership discussed the survey findings and process for nursing care planning. The "Interdisciplinary Plan of Care" Policy was revised and renamed the "Documentation" Policy. The nursing staff develops and keeps current, a nursing care plan for each patient that addresses the patient's individual acute hospitalization needs based on assessment outcomes. Care planning was discussed as those patient needs that require acute response including discharge planning and psychosocial issues, however if a patient was receiving treatment for a chronic issue that was not impacting the current hospitalization, nursing staff were to prioritize the need and focus planning on the acute condition. The MEC approved the policy on 3/15/16 and Governing Board on 3/16/16. Nursing staff was inserviced on the policy.	12/29/15 3/22/16 3/22/16 3/22/16

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A 438	Continued From page 55 not completed. An incident dated 11/18/15 was reviewed and showed that a patient, Patient 503, was admitted to the behavioral health unit at Culver City, but remained in the ER overflow area. The nurse could not find the patient medications and profile. The record showed that the patient was transferred from the Van Nuys facility, but there were no transfer documents found in the Culver City record. Records from the Van Nuys admission were requested and showed Patient 503 came to the Van Nuys hospital location on 11/13/16. The Physician's Initial Assessment & Preliminary Treatment Plan dated 11/14/15 showed the patient had schizoaffective disorder and was depressed, suicidal, and had the intention to overdose on pills. The Patient Transfer and Referral Record in the Van Nuys record showed the primary diagnosis as schizoaffective disorder, and did not include information about suicidality. The Multidisciplinary After Care Instructions dated 11/16/15 showed that the patient was to "transfer to ER Culver City due to breathing". The form showed that the absence of suicidal ideation was to be documented, but there was no indication of a psychiatric condition or suicidality documented on the form. A treatment plan was formulated at the Van Nuys facility, including identification of triggers and coping skills. Medical record documentation at the Culver City facility did not include transfer documents and did not include the treatment plan from the Van Nuys facility. The record at Culver City showed that the patient was seen in the ER on 11/16/15 and the MD Note indicated the patient was having suicidal ideation. The triage note from the ER on 11/16/15 showed the chief complaint was suicidal ideation, with a plan to cut herself. Patient 503 was subsequently admitted	A 438	4. Intensive Outpatient Program (IOP) Leadership discussed the discharge planning criteria. The "Discharge Planning and Discharge Criteria" policy was reviewed and did not require any revisions. Patients are discharged from the program based on the following criteria: (a) the treatment team has determined that the patient has adequately accomplished the goals of treatment; (b) the patient's condition necessitates inpatient treatment; (c) the patient's medical condition is such that the required level of nursing care is beyond the capability of the program; and (d) the patient's behavior is violent, threatening or inappropriate. IOP staff was reinserviced on the discharge policy. Compliance and Monitoring: Data is collected by the care facilitators for care planning and code status assessment, reported daily, aggregated and reported to leadership at least weekly to allow for leadership to focus resources on those issues and units where continued vulnerabilities exist. The goal is to achieve 100% compliance with code status assessments and nursing care plans. The Director of Behavioral Health or qualified designee reviews discharge records monthly to monitor compliance with discharge criteria per hospital policy. The goal of compliance is 100%. Data is analyzed and reported monthly to the Quality Council, MEC and Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will occur until the Quality Council determines sustained compliance has occurred, at which time the Council will determine what adjustments to monitoring are necessary for ongoing sustainability. Persons Responsible: Chief Nursing Officer Director of Behavioral Health	3/22/16

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A 438	Continued From page 56 as an Inpatient on 11/17/15 at 1219 (but remained physically in the ER). There was an admission assessment performed at the time of admission that showed for the item, suicide self harm risk, "no risk" was written. There was no Suicide Potential Rating Scale found, and no score for suicide risk determined. According to MR Staff 1, no care plans were found for the patient's stay at the Culver City facility. In an interview with the Dir BHU on 12/16/15 at 1110, she stated that Patient 503 was sent to the ER at Culver City, but there were no transfer orders found in the medical record. In a second interview, on 12/16/15 at 1145, she stated that she was not able to look at the medical records at the Van Nuys facility by computer from the Culver City facility, and that they had not received information from the Van Nuys facility. 2) On 12/16/15, at 12 p.m, a review of Patient N107's medical record revealed Patient N107 was originally admitted to the intensive out-patient program on 8/20/14. Patient N107's Medical record included a new "face sheet" for every month since 8/20/14 indicating a subsequent new admission date (ex 9/2/2014, 10/2/2014, 11/2/2014 etc.....) During a concurrent interview with ADM4 staff, when asked if Patient N107 was discharged every month and readmitted? Adm4 stated, "We admit and discharge every month for billing purposes. Not sure why, but the patient is not technically admitted, discharged and readmitted." Adm4 was asked if this occurs with all patients, Adm4 stated, "Yes, but only on paper." On 12/16/15 at 3 p.m., during an interview with Adm staff business office 1, when asked about the history of inaccurately reflecting new admissions every month, adm business office1 stated, "It was becoming a nightmare posting	A 438		

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	050135	A. BUILDING _____ B. WING _____	12/22/2015

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A 438	Continued From page 57 payments and applying them to the past by month, so we changed the system in 2012 to make it monthly. Effective today we will stop this." During a concurrent interview with behavioral health supr 1, she indicated she was not aware of this practice stating, "I am the interim and have only been here two months."	A 438		
A 441	482.24(b)(3) PROTECTING PATIENT RECORDS The hospital must have a procedure for ensuring the confidentiality of patient records. Information from or copies of records may be released only to authorized individuals, and the hospital must ensure that unauthorized individuals cannot gain access to or alter patient records. Original medical records must be released by the hospital only in accordance with Federal or State laws, court orders, or subpoenas. This Standard is not met as evidenced by: Based on record review and interview the facility failed to ensure confidentiality of patient records when they allowed MD12's hand written notes on Patient N107 to be faxed into the intensive out-patient services. The notes were written on the back of a sheet titled "Centrally stored medication and desturction record" and on another community health centers assessment sheet. There was no authorization for release of Patient N107 records from outside entity nor was there any authorization for release of non admitted patients medical information to be transmitted to the intensive out-patient services. This failure resulted in both Patient N107 and unknown other patient's rights to confidentiality of their medical information. Findings: On 12/16/15 at 12 p.m., the progress notes for	A 441	A 441 482.24(b)(3) Protecting Patient Records Immediate Actions Taken: 1. Hospital Leadership reviewed the "IOP Multidisciplinary Progress Notes" policy, which did not require any revisions. Intensive Outpatient Program Leadership and Health Information Management will enforce the policy of timely physician signatures on medical records. IOP Marriage and Family Therapists (MFT) and/or Supervisor will ensure that charts are signed and updated during physician consultations with the IOP. 2. IOP Leadership discussed the survey findings with the identified physician regarding compliance with monthly visits and the inability to fax progress notes. The Hospital will enforce the monthly visit rule. Physicians will be contacted by IOP staff to consult with patients within the monthly time frame. Staff will implement an audit, with a goal of 100% compliance. Trends of physician non-compliance will be reported to Quality Management for peer review by the Behavioral Medicine Committee, forwarded to the MEC and Governing Board. Subsequent Actions Taken: 1. Hospital Leadership reviewed the medical release form for authorization of health information, which did not require any revision. IOP staff were reinserviced on the form. 2. The Department Chairman of Behavioral Health sent a letter to all IOP physicians regarding the monthly visit requirement.	12/16/15 12/16/15 3/22/16 1/22/16

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A 441	Continued From page 58 Patient N107 (written by MD 12) were reviewed. The progress notes were hand written on pieces of unlined copied paper, or written on copies of notes from an outside community mental health center. Two months of the progress notes were handwritten on the backs of an outside pharmacy medication company title "Centrally stored medication and destruction record" with the names and medications of other non admitted patients. During concurrent review of the progress notes and interview with adm4 when asked if MD12 actually evaluates patients on site of the intensive out-patient program, adm4 stated,"I am not sure he even see's patients here, this has been going on for about one and half years." Adm4 further added, that the notes are either faxed or hand delivered. Adm4 confirmed there was no confidentiality release on file from Patient N107 or unknown other patient to release/ accept medical records from outside entity.	A 441	Compliance and Monitoring: IOP Leadership will forward any variances to the monthly visit rule to the quality department. for inclusion in the peer review program. Reporting will be via the "by exception" method and data will be collected in this fashion. Thus only outliers will be identified, analyzed and sent forward to peer review for medical staff management. This will occur on an ongoing basis. Trends of physician noncompliance will be reported to MEC and Governing Board monthly. Person Responsible: Director of Behavioral Health	
A 450	482.24(c)(1) MEDICAL RECORD SERVICES All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures. This Standard is not met as evidenced by: Based on interview and review of records the facility failed to ensure physician entries in a medical record were legible. Physician progress notes in the records of N 401 were not legible. These failures have the potential for staff not being aware of physician's plans for the patient, which could cause errors in treatment.	A 450	A 450 482.24(c)(1) Medical Records Service Immediate Action Taken: 1. Executive Leadership discussed the surveyor's findings regarding physician compliance with legible notes and strategies to ensure compliance. Subsequent Actions Taken: 1. The Chief of Staff and CEO sent a memo to medical staff members regarding the expectation that hand written notes will be legible. 2. Effective 3/15/16, the HIM Department will perform data collection on illegible documentation and report this as a medical staff indicator reported through the Health Information department. Outcomes from this review will be included in the physicians OPPE reappointment data for review at time of reappointment.	12/29/15 3/15/16 3/15/16

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A 450	Continued From page 59 Findings: 1. Review of the record of N 401 on 12/17/15 identified three physician progress notes, dated 12/11/15, 12/12/15, and 12/14/15 which were not legible. During concurrent review and interview with the chief clinical officer (CCO), she concurred that the notes were not legible. The director of the behavioral unit confirmed that the physician had not dictated progress notes for those dates.	A 450	Compliance and Monitoring: Legibility is an indicator included in the QAPI program and is collected monthly by the HIM department personnel. Data is analyzed and reported monthly to the Quality Council, MEC and Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will occur until the Quality Council determines sustained compliance has occurred, at which time the Council will determine what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator).	
A 454	482.24(c)(2) CONTENT OF RECORD: ORDERS DATED & SIGNED All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner who is responsible for the care of the patient only if such a practitioner is acting in accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations. This Standard is not met as evidenced by: Based on interview, record review and facility policy review the facility failed to ensure telephone orders for Patients N100, N101, N102, and N103 were authenticated by the ordering physician(s) within 48 hours, per facility policy. Findings: Review of facility policy entitled "Telephone Drug Orders" from medical staff rules and regulations page 28 indicated in part,"Telephone orders must be recorded promptly in the patient's medical record, noting the name of the person giving the telephone order and the signature of the individual receiving the order. The prescriber must countersign the order within 48 hours..."	A 454	Person Responsible: Sr. Manager of Health Information Management A 454 482.24(c)(2) Content of Record: Orders Dated & Signed Findings 1-4 Immediate Actions Taken: 1. Hospital Leadership discussed the survey findings with the Chief of Staff and the current process for enforcing compliance with authenticating telephone orders. Subsequent Actions Taken: 1. Nursing and Pharmacy Leadership reviewed the "Telephone/Verbal Order" policy, which did not require any revisions. 2. The Chief of Staff and CEO sent a memo to physician staff regarding compliance with authenticating telephone and verbal orders. 3. The issue of compliance with authentication of verbal and telephone orders was discussed at the 3/15/16 MEC meeting. 4. Compliance with authenticating orders is a standing agenda item at individual Medical Staff Department meetings and the annual Medical Staff meeting.	12/29/15 3/10/16 3/16/16 3/15/16 3/15/16

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A 454	Continued From page 60 1. On 12/15/15, at 9:15 a.m., during a review of Patient N101 clinical record, it was noted Patient N101 was prescribed ativan (a medication prescribed for anxiety) and restoril (a medication prescribed for insomina) by MD2 on 12/10/15, at 2:000a.m. via telephone. These medications, were noted to have no physician signature authentication. 2. On 12/15/15, at 9:15 a.m., during a review of Patient N101 clinical record, it was noted Patient N101 was prescribed seroquel (a major antipsychotic medication) by MD4 on 12/10/15, at 9:20 a.m., this order was not co-signed or authenticated by MD4. 3. On 12/15/15, at 9:15 a.m., during a review of Patient N101 clinical record, it was noted Patient N101 was prescribed over 17 medication orders by MD3 on 12/10/15 at 10 a.m., none of these orders were co-signed or authenticated by MD3. On 12/15/ 15, at 9:15 a.m., during an interview with adm staff1 she stated, "The policy is that they be validated or authenticated by the doctor within 48 hours." 4. On 12/18/15, at 11:30 a.m., during a review of the clinical discharge record for Patient N100, Patient N100 was prescribed Phenobarbital by MD1on 9/27/15 entered by RN1 into electronic medical record, there was no physician e-signature authenticating the order. 5. On 12/15/15, at 3:15 p..m., during a review of Patient N102 clinical record, it was noted Patient N102 was prescribed tylenol for fever by MD5 on 12/10/15 at 10:33 p.m., there was no physician e-signature authenticating the order. 6. On 12/15/14, at 11:30 a.m., during a review of Patient N103 clinical record indicated in part that 8 different medications were prescribed to Patient N103 by MD6 on 12/12/15, at 5:30 p.m.. Review of record reveals there was no physician	A 454	5. The CNO and consultants added the ongoing monitoring of authenticating telephone and verbal orders to the care facilitation process. 6. Compliance with authenticating telephone and verbal orders is monitored through the QAPI program. Compliance and Monitoring: The Senior Manager of Health Information or qualified designee performs random reviews of at least 20 medical records weekly to achieve the goal of 90% compliance with authenticating telephone and verbal orders. In addition, data is collected by the care facilitators, reported daily, aggregated and reported to leadership at least weekly to allow for leadership to focus resources on those issues and units where continued vulnerabilities exist. Data is analyzed and reported monthly to the Quality Council and MEC, and Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will occur until the Quality Council determines sustained compliance has occurred, at which time the Council will determine what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Persons Responsible: Senior Manager of Health Information Management Chief of Staff Chief Nursing Officer	2/5/16

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A 454	Continued From page 61 signature authenticating the order. 7. On 12/15/15, at 3:15 p.m., during an interview with LN3 while concurrently reviewing Patient N102's clinical record , LN3 stated, "This (signature) should have been done by the doctor."	A 454		
A 466	482.24(c)(4)(v) CONTENT OF RECORD: INFORMED CONSENT [All records must document the following, as appropriate:] Properly executed informed consent forms for procedures and treatments specified by the medical staff, or by Federal or State law if applicable, to require written patient consent. This Standard is not met as evidenced by: Based on record review and interview patient N104 and Patient N106 did not consent for procedures while being an in-patient at the hospital. Patient N401 did not consent for an antipsychotic. Findings: 1) On 12/17/15; at 3 P.M., a review of Patient N106 clinical record indicated that Patient N106 received a central line (a catheter inserted into the arm or chest through the skin into a large vein) on 12/16/15, there was no consent found in the chart for this procedure. 2) On 12/17/15, at 3 P.M., a review of Patient N104 clinical record revealed Patient N104 had an upper endoscopy (a thin scope with a light is used to look at the upper digestive track) on 11/30/15 there was no consent located in the medical record. During an interview with LN5 and LN6 on 12/17/15, at 3:15p.m., they both acknowledged	A 466	A 466 482.24(c)(4)(v) Content of Record: Informed Consent Immediate Action Taken: 1. Executive Leadership discussed the survey findings and the process for obtaining consents. 12/29/15 Subsequent Actions Taken: 1. The "Informed Consent" policy was reviewed and revised to align with current practice. Informed Consent is required for those procedures which are complex or involve material risks that are not commonly understood. The patient's physician is responsible for providing the information the patient needs in order to make an informed decision and for obtaining the patient's informed consent or refusal for the recommended procedure. The hospital's role in the informed consent process is to verify that the physician obtained the patient's informed consent before the procedure. Additionally the hospital's consent form (the document on which the patient's consent is annotated) was reviewed and revised to streamline the narrative, simplify the format and reduce the overall form from six (6) pages to two (2) pages. The hospital elected to maintain a separate consent for blood transfusions and psychotropic medications. The consent form was approved by the MEC on 3/15/16 and the Governing Board on 3/16/16. Nursing staff was educated and the form was implemented by 3/22/16. 3/22/16 2. Hospital Leadership sent a memo to physician staff reminding them of the informed consent process. 1/21/16 3. The CNO and consultants implemented care facilitation to assess and correct in real time any 2/5/16	

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A 466	Continued From page 62 that these procedures required consents and they both acknowledged they were not able to locate the consent in the medical records . 3). During a concurrent review of the record of N 401 on 12/15/15 beginning at 9:35 a.m., with the chief clinical officer (CCO) there was no evidence of a consent for Seroquel (an anti-psychotic medication). At 10 a.m. LN (LVN Jeannette) stated she would look in the thinned chart for the consent. At 10:35 a.m. LN (Jeannette) confirmed there was no consent for the Seroquel.	A 466	issues with obtaining informed consents. Care facilitation worksheet was developed for use by the care facilitators, including the issue of obtaining informed consents. 4. Nursing staff is educated on informed consents upon hire. 5. Compliance with informed consents is monitored through the QAPI program. Compliance and Monitoring: Data is collected by the care facilitators, reported daily, aggregated and reported to leadership at least weekly to allow for leadership to focus resources on those issues and units where continued vulnerabilities exist. The goal is to achieve 100% compliance with obtaining informed consents. Data is analyzed and reported monthly to the Quality Council,	
A 467	482.24(c)(4)(vi) CONTENT OF RECORD: ORDERS,NOTES,REPORTS [All records must document the following, as appropriate:] All practitioner's orders, nursing notes, reports of treatment, medication records, radiology and laboratory reports, and vital signs and other information necessary to monitor the patient's condition. This Standard is not met as evidenced by: During interview and record review the facility failed to ensure that Patient N101's practitioner reports of treatment were documented on a daily basis per facility policy. Patients N107 and Patients N109 admitted to the psychiatric intensive out-patient program did not receive monthly visits per facility policy. These failures have the potential of impeding on patients progress towards medical and therapeutic goals. Findings: A review of Medical Staff Rules and Regulations	A 467		

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A 466	Continued From page 62 that these procedures required consents and they both acknowledged they were not able to locate the consent in the medical records . 3). During a concurrent review of the record of N 401 on 12/15/15 beginning at 9:35 a.m., with the chief clinical officer (CCO) there was no evidence of a consent for Seroquel (an anti-psychotic medication). At 10 a.m. LN (LVN Jeannette) stated she would look in the thinned chart for the consent. At 10:35 a.m. LN (Jeannette) confirmed there was no consent for the Seroquel.	A 466	MEC and Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will occur until the Quality Council determines sustained compliance has occurred, at which time the Council will determine what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Person Responsible: Chief Nursing Officer	
A 467	482.24(c)(4)(vi) CONTENT OF RECORD: ORDERS,NOTES,REPORTS [All records must document the following, as appropriate:] All practitioner's orders, nursing notes, reports of treatment, medication records, radiology and laboratory reports, and vital signs and other information necessary to monitor the patient's condition. This Standard is not met as evidenced by: During interview and record review the facility failed to ensure that Patient N101's practitioner reports of treatment were documented on a daily basis per facility policy. Patients N107 and Patients N109 admitted to the psychiatric intensive out-patient program did not receive monthly visits per facility policy. These failures have the potential of impeding on patients progress towards medical and therapeutic goals. Findings: A review of Medical Staff Rules and Regulations	A 467	A 467 482.24(c)(4)(vi) Content of Record: Orders, Notes, Reports Immediate Actions Taken: 1. Hospital Leadership reviewed the "IOP Multidisciplinary Progress Notes" policy, which did not require any revisions. IOP Leadership and Health Information Management will enforce the policy of timely physician signatures on medical records. IOP staff (including MFTs and/or Supervisors) will ensure that charts are signed and updated during physician consultations. 2. The IOP Program Coordinator discussed the survey findings with the identified physician regarding compliance with seeing patients in the clinic monthly. The Hospital will enforce the monthly rule. Physicians will be contacted by IOP staff to consult with patients within the monthly time frame. Staff will implement an audit, with a goal of 100% compliance. Trends of physician non-compliance will be reported to Quality Management for peer review by the Behavioral Medicine Committee, up to the MEC and Governing Board.	12/16/15 12/16/15

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A 467	Continued From page 63 page 7 indicated under header,"2.7 Treatment of Patients. 2.7.2 Each patient in the Hospital shall be seen daily by his/her attending Practitioner or appropriately designated Physician Staff member, with documentation of that daily visit in the medical record....." During a concurrent medical record review and interview with CNO of Patient N101 on 12/15/15, at 9:15 a.m., Patient N101 record indicated he was admitted on 12/10/15 with a diagnosis of encephalopathy (a brain disease that alters brain function or structure) and HIV (a virus that gradually attacks the immune system). A review of the record indicated that Patient N101 was initially seen in the emergency room, a telephone order from MD3 occurred on 12/10/15 to "Admit to the med surg unit" there was no time on the order. A review of the chart (on 12/15/15) indicated the patient had only one documented progress note on 12/13/15 by NP1 not co-signed by MD. During an interview with the CNO, she acknowledged the one visit by the NP, and stated patients are supposed to be seen "Daily" A review of the psychiatric intensive out-patient program policy titled "Scope of Services," dated 09/12 revised 11/2012 under heading "2.4 Types of Treatment/Interventions" indicated in part, "At least monthly psychiatric visit for medication monitoring, treatment planning, assessments...." During a six month record review (June 2015 to present) of Patient N107's record, the record reflected no MD visits for June, August, or November of 2015. All other notes were from outside the mental health environment. During a six month record review (June 2015 until present) of Patient N109's record, the record reflected no MD visits for the months of July, August, September and November of 2015.	A 467	Compliance and Monitoring: Data related to physician signatures and timeliness of physician visits is analyzed and reported monthly to the Quality Council, MEC and Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will occur until the Quality Council determines sustained compliance has occurred, at which time the Council will determine what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Person Responsible: Director of Behavioral Health	

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A 467	Continued From page 64 During an interview with the Behavioral health supr 1 on 12/16/15 at 3:00 p.m., when asked if she was aware of MD visits not following facility policy, the behavioral health supr 1 stated, "No, I was not aware. I am an interim supervisor and I have only been here for two months."	A 467		
A 490	482.25 PHARMACEUTICAL SERVICES The hospital must have pharmaceutical services that meet the needs of the patients. The institution must have a pharmacy directed by a registered pharmacist or a drug storage area under competent supervision. The medical staff is responsible for developing policies and procedures that minimize drug errors. This function may be delegated to the hospital's organized pharmaceutical service. This Condition is not met as evidenced by: The hospital failed to ensure the Condition of Participation: CFR 482.25 Pharmaceutical Services was met by failing to: 1. Ensure (1) the temperatures for medication refrigerators were monitored as specified by policy; (2) out-of-range temperatures for medication refrigerators were acted upon; (3) inconsistent temperatures for medication refrigerators from two different thermometers were addressed; (4) two different medication strengths were not stored together; (5) medications were stored according to manufacturer's specifications; (6) the contents of the crash carts were accurate; (7) the pharmacist had oversight of the crash cart's contents; (8) renal dosing by the pharmacist was consistent; (9) medications were disposed of safely according to policy; and (10) medications were stored under conditions of sanitation. (Refer to A	A 490	A 490 482.25 Pharmaceutical Services Executive Leadership collaborated with hospital and corporate pharmacy leaders, including the Vice President of Pharmacy Operations and regional pharmacy directors. The purpose was to improve the method for ensuring medication temperature consistency in medication refrigerators through repair or installation of new medication refrigerators and thermometers, ensuring proper sanitation in areas where medications are stored, revising storage methodology for storage of the same medications with differing strengths, storing medications pursuant to the manufacturer's recommendations, ensuring accuracy and oversight of medication content in all crash carts through revisions in policy and practice and requiring pharmacy accuracy verification, ensuring consistency in renal dosing via revision of renal dosing policy and practice, and providing for safe medication disposal by reeducation. Accuracy of scheduled drug records and recognition of standards related to identified high alert medications was improved through refresher education of pharmacy staff. Shortages of medications was addressed by revision to the inventory list to provide for a column reflecting appropriate medication alternatives. Use of compounded or repackaged drugs was examined with practice changes implemented to ensure correct formula and accurate beyond use dating. Medication security was addressed through nursing education. Process revision was implemented to ensure mislabeled or unusable medications are not available for use. The inventory for night	3/22/16

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A 490	Continued From page 65 0491) 2. Ensure records for scheduled drugs were accurate. (Refer to A 0494) 3. Ensure patients' safety by failing to follow recognized standards for safe management of high-alert medications, as well as failing to address the shortages of medications designated for emergency uses. (Refer to A 0500) 4. Ensure (1) compounded or repackaged medications were labeled with the appropriate beyond-use-dates (BUD, a date after which the medication should not be stored or used); (2) compounded or repackaged medications were stored in approved devices, or an evaluation was completed for suitable alternatives; (3) medications were compounded using approved formulas; and (4) staff involved in compounding was knowledgeable of the BUD. (Refer to A 0501) 5. Ensure the security of medications. (Refer to A 0502) 6. Ensure mislabeled and unusable medications were not available for patient use. (Refer to A 0505) 7. Maintain an accurate inventory, restock, and update the medication list for its after-hours medication supply (night locker). (Refer to A 0506) The cumulative effect of these systemic practices resulted in the failure of the hospital to deliver care in compliance with the Condition of Participation: Pharmaceutical Services.	A 490	lockers was reviewed on 12/18/15 and updated with all appropriate medications stocked. These medication management issues were brought before the Pharmacy and Therapeutics (P & T) Committee with input from committee members who also approved revisions in practice and policy. The Corporate Vice President of Pharmacy Operations, Hospital Systems assisted with directing changes and worked with the regional pharmacy director to provide oversight to ensure plans related to improving pharmaceutical services were enacted.	
A 491	482.25(a) PHARMACY ADMINISTRATION	A 491	A 491 482.25(a) Pharmacy Administration	

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A 491	Continued From page 66 The pharmacy or drug storage area must be administered in accordance with accepted professional principles. This Standard is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure: 1. The temperatures for medication refrigerators were monitored as specified by policy; 2. Out-of-range temperatures for medication refrigerators were acted upon; 3. Inconsistent temperatures for medication refrigerators from two different thermometers were addressed; 4. Two different medication strengths were not stored together; 5. Medications were stored according to the manufacturer's specifications; 6. The contents of the crash carts were accurate; 7. The pharmacist had oversight of the crash cart's contents; 8. Renal dosing by the pharmacist was consistent; 9. Medications were disposed of safely according to policy; and 10. Medications were stored under conditions of sanitation. As a result, the medications were potentially	A 491		

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A 491	Continued From page 67 unsafe or ineffective for the needs of all the patients at the facility. Findings: 1. During a tour of the Pharmacy at Van Nuys on 12/16/15 at 2:20 P.M. with the VPP and DOP 1, the medication refrigerator temperature log was reviewed. The log indicated the temperatures was recorded twice daily on the weekdays, and not recorded on the weekends. During a concurrent interview, DOP 1 stated she did not know if the temperatures were ever out of range on the weekend. The contents of the refrigerator were inspected, and 11 doses of influenza vaccine were inside. According to the facility's policy, "Medication Refrigerator Temperature Monitoring," effective 7/1/15, "Temperature will be checked and recorded once daily (twice daily for vaccine containing refrigerator)." 2a. During a tour of the Pharmacy at Culver City on 12/14/15 starting at 12:30 P.M. with the COO, VPP, and TS, the temperature range specified on the Main Rx (pharmacy) refrigerator was "36°F to 46°F or 2.2°C to 7.7°C," according to the Daily Temperature Log Sheet posted on the refrigerator. According to the log, the temperatures were outside of the specified range on: 12/5/15 at 6:40 A.M., the temperature recorded was "2.1" 12/7/15 at 2 P.M., the temperature recorded was "1.9"	A 491	Findings 1-3 Immediate Actions Taken: 1. Executive Leadership discussed the survey findings regarding medication refrigerator monitoring. 2. Pharmacy staff discarded duplicative thermometer on Hollywood campus after confirmation of the temperature through the electronic monitoring system. 3. The Director of Pharmacy had informal discussions at the time of survey with Culver City staff involved regarding recording temperatures and action taken if out of range. Subsequent Actions Taken: 1. Medication refrigerators were repaired and/or new ones ordered and obtained for those refrigerators with difficulty maintaining consistent temperatures. 2. A remote monitoring system was installed on the Van Nuys campus to ensure weekend monitoring of the pharmacy refrigerator. 3. Pharmacy Leadership reviewed the "Medication Refrigerator Temperature Monitoring" policy, which did not require any revisions. Temperatures are checked and recorded once daily (with twice daily for vaccine containing refrigerators). If an out-of-range temperature occurs, it is documented on the log with actions taken, and temperature recheck. The log was amended to include a column to document actions taken each day for identified issues. Pharmacists and pharmacy technicians were provided with an education binder on medication refrigerator temperature monitoring and documentation on the log with satisfactory completion of a post-test. 4. The Hospital ordered additional electronic monitoring devices. 5. Pharmacy, Nursing and Facilities Leadership discussed monitoring of medication refrigerator temperatures and implementing/documenting corrective action if temperatures are out of range. Staff were educated about the need to	12/18/15 12/21/15 12/14/15 3/22/16 3/1/16 1/16/16 - 3/22/16 3/8/16 3/22/16

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A 491	Continued From page 68 12/11/15 at 6:39 A.M., the temperature recorded was "2.1" 12/11/15 at 8:15 P.M., the temperature recorded was "2.0" According to the "Refrigerated Drugs" list, provided by the facility, there were 57 medications, in various quantity, stored in the refrigerator. The list included medications for the heart, anti-infectives, vaccines, insulins, "chemo drugs" [medications to treat cancer], and other medications. During a concurrent interview, TS stated the action taken was not documented and he would check with engineering to determine if the issue was reported or what was done to address the out-of-range temperatures. 2b. During a tour of the Store Room, which was part of the Pharmacy at Culver City, on 12/14/15 starting at 4:23 P.M with the COO, VPP, and TS, the temperature range specified on the Narc (narcotic) STN (station) refrigerator was "36°F to 46°F," according to the Daily Temperature Log Sheet posted on the refrigerator. According to the log, the temperatures were outside of the specified range on: 12/9/15 at 10:40 A.M., the temperature recorded was "35.3" 12/10/15 at 10:40 A.M., the temperature recorded was "35.1" 12/12/15 at 10:30 P.M., the temperature recorded was "32.9" [near freezing] During a concurrent interview, TS was not sure what action was taken to address the out-of-range temperatures.	A 491	monitor temperatures daily. Temperatures are now monitored at Van Nuys per policy. Compliance and Monitoring: The Director of Pharmacy or qualified designee shall perform weekly reviews (for three months and then re-evaluate) of the temperature logs to achieve the goal of 100% compliance with addressing out-of-range temperatures and documenting corrective action. Corrective action is taken as necessary, including just-in-time training with staff. Data is analyzed and reported monthly to the Medication Safety Committee, Quality Council and MEC, and Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will occur until the Quality Council determines sustained compliance has occurred, at which time the Council will determine what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Person Responsible: Director of Pharmacy	

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A 491	Continued From page 69 According to the facility's policy, "Medication Refrigerator Temperature Monitoring," effective 7/1/15, out-of-range temperatures "should be documented with action documented/initialed and notified to engineering department. For situations where the refrigerator contains vaccines and the temperature is freezing or may have reached freezing, pharmacy action will be taken in accordance with manufacturer recommendation." The facility was not able to provide documentation regarding actions taken when the temperatures were out of range at the conclusion of the survey. 3. During a tour of the Pharmacy at Hollywood with RPh 1 and the VPP on 12/16/15 starting at 12:15 P.M., the temperature log for the medication refrigerator was reviewed. According to the log posted on the refrigerator, the temperature range should be between 36°F and 46°F. On 12/8/15 at 1:04 P.M., the temperature was recorded at 35°F. The VPP stated there was no documentation of actions taken by staff to address the out-of-range temperatures. The refrigerator contained various vaccines such as tetanus, hepatitis B, pneumococcal, influenza, according to the Vaccine Inventory Control Log posted outside the refrigerator. The VPP provided an electronic temperature log for the refrigerator, indicating the temperatures were within range on 12/8/15. During an interview on 12/17/15 starting at 8:50 A.M., the VPP stated when the temperature was recorded as out of range, the pharmacist logged into the electronic monitoring system and the	A 491		

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A 491	Continued From page 70 temperature was within range, and therefore did not take any further action. The VPP stated there were two different thermometers used in the same refrigerator, and therefore it could not be established which thermometer was more accurate. 4. During a tour of the Pharmacy at Culver City on 12/14/15 starting at 12:30 P.M. with the COO, VPP, and TS, a medication bin labeled vancomycin 125 mg was observed in the refrigerator. Further inspection of the contents revealed four oral syringes of vancomycin 125 mg and two oral syringes of vancomycin 250 mg. During a concurrent interview, the VPP stated there should be one storage bin for each strength of vancomycin [two different strengths should not have been stored together]. According to the facility's policy, "Medication Storage," reviewed 6/14, "Drugs shall be stored under proper conditions of ... segregation...." 5a. During a tour of the Pharmacy at Culver City on 12/14/15 starting at 12:30 P.M. with the COO, VPP, and TS, the observations were: Octreotide (a hormone with various medical uses) 50 mcg per mL injections were outside the original carton, exposed to light; and Haloperidol decanoate (a medication to treat psychiatric disorders) 100 mg per mL injections were exposed to light. According to the manufacturer's directions printed on the medication carton for octreotide, the storage instructions stipulated, "Protect from light," and "Retain in carton until time of use."	A 491	Findings 4-7 Immediate Actions Taken: 1. The identified Vancomycin strengths were separated into individual bins. The Vancomycin labeling was reconfigured in the pharmacy computer to clearly show concentration on the label. The Pharmacy staff also checked the unit to ensure that medications were appropriately separated into bins by strength. 2. Medications identified during survey as exposed to light and without beyond use date were discarded and replaced with proper light protection covering and beyond use dating. 3. Pharmacy staff discussed the survey findings internally regarding crash cart and other medication storage processes. 4. Crash carts were checked to ensure a) medications that require protection from light are packaged to prevent exposure; b) medications were labeled with appropriate beyond-use-dates and still within the appropriate time frame; and c) contained the appropriate medication/IV Fluid and quantity as listed on the content list. Subsequent Actions Taken: 1. Pharmacy Leadership reviewed the "Medication Storage" policy, which did not require any revision. Pharmacy Leadership reviewed and revised the "Crash Carts: Inspection, Maintenance, and Exchange" policy to align with current practices regarding the list of medications and supplies, the need to protect certain medications from light, and the beyond use date (BUD) for medications with short dating once removed from the refrigerator. The medication tray and IV fluids for the crash cart are checked by a pharmacist prior to locking the crash cart. The crash cart is locked with a tamper evident seal by the pharmacist and inspected on a routine basis, no less than every 30 days. The name and date of the earliest expiring drug is posted on the outside of the crash cart. The P & T Committee approved	12/14/15 12/18/15 12/15/15 12/18/15 - 12/24/15 3/22/16

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A 491	Continued From page 71 According to the manufacturer's directions printed on the medication carton for haloperidol, the storage instructions stipulated, "PROTECT FROM LIGHT," and "Keep in carton until empty." During a tour of the Store Room, which was part of the Pharmacy at Culver City, on 12/14/15 starting at 4:23 P.M with the COO, VPP, and TS, ondansetron (a medication to treat nausea) 4 mg per 2 mL injections were exposed to light. According to the manufacturer's directions printed on the medication carton for ondansetron, the storage instructions stipulated, "Protect from light," and "Retain in carton until time of use." During the inspection of a crash cart (a medication cart containing medications for medical emergencies) in the Intensive Care Unit (ICU) at Culver City on 12/15/15 starting at 10:10 A.M. with the COO, VPP, and CN 1, verapamil (a heart medication) 2.5 mg per mL injections were exposed to light. During the inspection of a crash cart in the Telemetry Unit at Culver City on 12/15/15 starting at 10:50 A.M. with the COO, VPP, and CN 3, verapamil 2.5 mg per mL injections were exposed to light. According to the current manufacturer's prescribing information (PI) for verapamil, the storage instructions stipulated, "Protect from light by retaining in package until ready to use." 5b. During the inspection of a crash cart in the ICU at Culver City on 12/15/15 starting at 10:10 A.M. with the COO, VPP, and CN 1, vasopressin (a hormone with various medical uses) 20 unit	A 491	the policy on 2/23/16, MEC on 3/15/16 and Governing Board on 3/16/16. Pharmacy Staff education was completed. 2. The Pharmacy reviewed and revised the content list of medications for the crash carts and identified those medications that require protection from light. 3. Vasopressin will have BUD for one year from the date of removal from the refrigerator. The organization ordered light protected covers for medication trays. 4. Compliance with medication storage, crash cart medications, beyond-use-dates is monitored through the QAPI program. Compliance and Monitoring: The Director of Pharmacy or qualified designee shall perform random weekly observations to monitor compliance with BUDs, expired medications, and drugs properly stored. Corrective action is taken, including just-in-time training with staff. Data is analyzed and reported monthly to the Medication Safety Committee, Quality Council and MEC, and Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will occur until the Quality Council determines sustained compliance has occurred, at which time the Council will determine what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Person Responsible: Director of Pharmacy	1/18/16 1/15/16

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A 491	Continued From page 72 per mL injection were stored in the crash cart at room temperature without a beyond-use-date (BUD, a date after which the medication should not be used or stored). According to the current manufacturer's PI provided by the facility, the storage instructions stipulated, "Store between 2°C to 8°C ... Vials may be held up to 12 months upon removal from refrigeration to room temperature storage conditions .... Once removed from refrigeration, unopened vials should be marked to indicate the revised 12 months expiration date [BUD]." 5c. During a tour of the ICU at Culver City on 12/15/15, the medication room was inspected, starting at 9:54 A.M., with the COO, VPP, and CN 1. Lorazepam (a medication for seizure, anxiety) 2 mg per mL injections were stored at room temperature, with the BUD of 1/9/16. During a concurrent interview, the VPP stated the BUD was 60 days when stored at room temperature. The facility was requested to provide evidence to support this practice. During a tour of the Psychiatric Emergency Department Overflow area at Culver City on 12/15/15, the medication room was inspected with RN 4 and Dir 1 starting at 4:06 P.M. Lorazepam 2 mg per mL injections were stored at room temperature. According to the current manufacturer's PI for lorazepam, the storage instructions stipulated, "Store in a refrigerator." The facility was unable to provide evidence to support room temperature storage for lorazepam at the conclusion of the survey.	A 491		

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A 491	Continued From page 73 6a. During the inspection of a crash cart in the ICU at Culver City on 12/15/15 starting at 10:10 A.M. with the COO, VPP, and CN 1, the content list posted outside was compared to the actual medications stocked inside the cart, and the following discrepancies were observed: D5W (dextrose solution) 150 mL was listed, but not stocked; D5W 50 mL, quantity of 3 were stocked but not listed on the content list; 9% sodium chloride 1000 mL listed, and was stocked with 0.9% sodium chloride; Flumazenil (a medication to reverse the effect of certain sedatives) 0.1 mg per mL 5 mL vial was listed, but stocked with 10 mL vial; Lidocaine (a local numbing agent) 2% 30 mL was stocked, but not listed on the content list; Procainamide (a heart medication) 1 g in 2 mL was listed, but not stocked; and Procainamide 100 mg per mL 10 mL vial was listed, but not stocked. 6b. During the inspection of a crash cart on the Telemetry Unit at Culver City on 12/15/15 starting at 10:50 A.M. with the COO, VPP, and CN 3, the content list posted outside was compared to the actual medications stocked inside the cart, and the following discrepancies were observed: D5W 150 mL was listed, but not stocked; D5W 100 mL, quantity of 1 was listed, but 3 were stocked (2 extra); 9% sodium chloride 1000 mL listed, and was stocked with 0.9% sodium chloride; Lidocaine 2% 30 mL was stocked, but not listed on the content list; Procainamide 1 g in 2 mL was listed, but not stocked; and	A 491		

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A 491	Continued From page 74 Procainamide 100 mg per mL 10 mL vial was listed, but not stocked. According to the facility's policy, "Crash Carts Emergency Medications: Inspection, Maintenance, and Exchange," revised 10/12, the Procedure/Purpose section stipulated, "... ensure that a standard and completely supplied cart of kit for all patient care and surrounding areas ...." 7. During the inspection of a crash cart in the ICU at Culver City on 12/15/15 starting at 10:10 A.M. with the COO, VPP, and CN 1, the content list posted outside was compared to the actual medications stocked inside the cart, and the following discrepancies were observed: D5W 150 mL was listed, but not stocked; D5W 50 mL, quantity of 3 were stocked but not listed on the content list; 9% sodium chloride 1000 mL listed, and was stocked with 0.9% sodium chloride; Flumazenil 0.1 mg per mL 5 mL vial was listed, but stocked with 10 mL vial; Lidocaine 2% 30 mL was stocked, but not listed on the content list; Procainamide 1 g in 2 mL was listed, but not stocked; Procainamide 100 mg per mL 10 mL vial was listed, but not stocked; Vasopressin 20 unit per mL stored at room temperature without the BUD when the manufacturer specified to be refrigerated; and Verapamil 2.5 mg per mL 2 mL injections were not protected from light as specified by the manufacturer. In addition, the expiration dates for D5W 50 mL and D5W 100 mL were 1/16 (January 2016). The expiration date posted outside the crash cart was	A 491		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050135	A. BUILDING _____ B. WING _____	12/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSPITAL AT HOLL	6245 DE LONGPRE AVE HOLLYWOOD, CA 90028

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A 491	Continued From page 75 3/1/16. During the concurrent interview, RPh 3, who checked this particular crash cart earlier in the day, stated the expiration date was based solely on the non-intravenous (IV) medications. RPh 3 stated he did not consider IV medications to be "medications." According to the Food and Drug Administration (FDA), D5W in various strengths and normal saline (salt solution) 0.9% are drugs/medications. According to the facility's policy, "Crash Carts Emergency Medications: Inspection, Maintenance, and Exchange," revised 10/12, "The drug contents of the crash care (sic) shall be routinely inspected by a pharmacist monthly, and the name and date of the earliest expiring drug shall be posted on the outside of the tray." 8. Patient P101's clinical record was reviewed on 12/15/15 starting at 1:55 P.M. with RPh 4, and the VPP. The record indicated, on 12/9/15, the patient was prescribed cefepime (an antibiotic) 2 g every 12 hours and "Pharmacy to adjust for renal function." RPh 4 was asked to demonstrate how he would "adjust for renal function" based on the patient's information available on the date the adjustment was made. RPh 4 was not the pharmacist who adjusted the dose on 12/9/15. RPh 4 calculated the dose to be 2 g every 24 hours. The Medication Administration Record (MAR) indicated Patient 101 was receiving cefepime 1 g every 24 hours. According to the facility's policy, "Renal Dosing	A 491	Finding 8 Immediate Actions Taken: 1. The Director of Pharmacy reviewed Patient 101's clinical record and no adverse outcome was identified. Subsequent Actions Taken: 1. Pharmacy Leadership reviewed the "Renal Dosing Protocol," which was revised to update the list of medications that require renal dosing and ensure consistency among pharmacists. To enhance consistency in renal dosing, all pharmacists will now use the calculated Creatinine Clearance from the pharmacy's software system to determine renal dosing. The P & T Committee approved the protocol on 2/23/16, MEC on 3/15/16 and Governing Board on 3/16/16. Pharmacist staff received education via a self-study packet and quiz. 2. Compliance with renal dosing is monitored through the QAPI program. Compliance and Monitoring: The Director of Pharmacy or qualified licensed designee shall perform random weekly audits of renal dosing. Corrective action is taken, including 1:1 training with staff. Data is analyzed and reported monthly to the Medication Safety Committee, Quality Council and MEC, and Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will occur until the Quality Council determines sustained compliance has occurred, at which time the Council will determine what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Person Responsible: Director of Pharmacy	12/18/15 1/16/16 - 3/22/16

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A 491	Continued From page 76 Protocol," revised 10/12, "The purpose of this policy is to provide standardized drug dosing guidelines for renally eliminated drugs." The policy, however, did not include cefepime in the "Renal Dosing Table." 9. During a random observation of medication administration, on 12/15/15 starting at 8:50 A.M. in the ICU at Culver City, with RN 1 and the COO, RN 1 was observed preparing medications for Patient P100. Potassium chloride (KCl) oral solution was among the medications being prepared. RN 1 prepared the KCl dose, with approximately 7 mL left in the oral syringe. RN 1 then put the syringe with 7 mL KCl still left in it in a gray bin inside the room. According to the facility's policy, "Return, Handling, and Disposal of Medication Waste," revised 10/12, Pharmaceutical Waste was defined as "prescription and non-prescription solid and liquid pharmaceuticals in greater than trace quantities ...Any opened vial or liquid bottle ... shall be placed in the regular Pharmaceutical Waste Containers." During an interview on 12/15/15 at 3:15 P.M., Dir 1 identified "Pharmaceutical Waste" container as the "blue-white container." 10a. During a tour of the Pharmacy at Culver City on 12/14/15 starting at 3:25 P.M. with the COO, VPP, and TS, the storage bins containing the following medications were observed to be dusty: Flumazenil 0.5 mg per 5 mL; Haloperidol decanoate 100 mg per mL; and D5W 500 mL. 10b. During a tour of the Telemetry Unit at Culver	A 491	Findings 9 and 10 Immediate Actions Taken: 1. Hospital and Pharmacy Leadership discussed the survey findings and strategies for compliance. Subsequent Actions Taken: 1. Nursing and Pharmacy Leadership reviewed the "Return, Handling, and Disposal of Medication Waste" and "Medication Storage" policies, which did not require any revisions. Nursing staff were reinserviced on the policies. 2. Medication refrigerators were inspected and cleaned. Refrigerators were placed on a rotating cleaning schedule to ensure each refrigerator is cleaned routinely. Pharmacy staff is responsible for cleaning the refrigerators. 3. The CEO sent a "Message from CEO" memo to staff regarding medication waste. 4. The Director of Infection Control held Infection Control fairs, which included education on medical waste management. 5. Compliance with disposal of medication waste and maintaining medication storage in a sanitary environment is monitored through the QAPI program. Compliance and Monitoring: The Director of Pharmacy or qualified licensed designee shall perform random medication pass audits and medication room inspections to determine compliance of medication storage. Corrective action is taken, including 1:1 training with staff performed to engage the staff in just-in-time training. Data is analyzed and reported monthly to the Medication Safety Committee, Quality Council, MEC, and Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will occur until the Quality Council determines sustained compliance has occurred, at which time the Council will determine what adjustments to monitoring are necessary for	12/29/15 3/22/16 3/22/16 2/4/16 3/7/16 -3/22/16

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A 491	Continued From page 77 City, on 12/15/15 starting at 8:13 A.M., with CN 2 and COO, CN 2 agreed 8 out of 8 medication storage bins in the medication room were not clean. CN 2 also agreed the medication refrigerator was not clean. According to the facility's policy, "Medication Storage," revised 6/14, "Drugs shall be stored under proper conditions of sanitation ...."	A 491	ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Person Responsible: Director of Pharmacy	
A 494	482.25(a)(3) PHARMACY DRUG RECORDS Current and accurate records must be kept of the receipt and distribution of all scheduled drugs. This Standard is not met as evidenced by: Based on interview, and record review, the facility failed to ensure records for scheduled drugs were accurate. As a result, midazolam, a scheduled IV medication (a DEA's designation, Drug Enforcement Administration, scheduled II has the highest abuse potential, and schedule V has the least abuse potential), was not destroyed and recorded accurately, because the facility did not have a policy to address the destruction and recording methods for scheduled III, IV, and V medications. Findings: During a tour of the Pharmacy at Hollywood, on 12/16/15 at 12:35 P.M., the record for midazolam 2 mg injection was audited with RPh 1 and VPP. According to the record, PT 1 was a witness for the destruction of midazolam on 8/20/15. PT 1 confirmed she was the witness, and stated the vial of medication was placed in the "red" container (which was used to store pharmaceutical waste that contained sharp objects) with the medication still inside the vial. PT 1 was again a witness for another destruction	A 494	A 494 482.25(a)(3) Pharmacy Drug Records Immediate Actions Taken: 1. Pharmacy Leadership, including Corporate pharmacy oversight provided by the Vice President of Pharmacy Operations, Hospital Systems, reviewed the survey findings related to controlled substance recording of destruction of drugs. Subsequent Actions Taken: 1. Pharmacy Leadership reviewed the "Controlled Substance System" policy, which did not require any revisions. A flowsheet was created to clarify destruction of drugs. Pharmacy staff was inserviced on the policy and use of the flowsheet. 2. Compliance with narcotic destruction is monitored through the QAPI program. Compliance and Monitoring: The Director of Pharmacy or qualified licensed designee shall perform review and reconciliation of controlled substance wastage recording on a monthly basis. If variances with policy are identified in the recording of waste, corrective action is taken, including 1:1 training with staff. Data is analyzed and reported monthly to the Medication Safety Committee, Quality Council, MEC and Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will occur until the Quality Council determines sustained compliance has occurred, at which time the Council will determine what adjustments to	12/18/15 3/11/16

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A 494	Continued From page 78 of midazolam on 9/24/15. PT 1 could not recall the destruction method on 9/24/15. According to the facility's policy, "Controlled Substance System," reviewed 3/10/15, only the destruction of scheduled II medications was addressed. The policy stipulated, "The expired C-II [scheduled II] drugs shall then be ... added to the destruction log .... stored in the expired narcotic locker pending destruction by a pharmaceutical waste management service." During an interview on 12/17/15 starting at 8:50 A.M., the VPP stated even though only scheduled II medications were addressed in the policy, the same practice applied to all scheduled medications. The VPP clarified that since midazolam was destroyed by pharmacy staff, it would not be in the destruction log pending destruction by a pharmaceutical waste management service.	A 494	monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Person Responsible: Director of Pharmacy	
A 500	482.25(b) DELIVERY OF DRUGS In order to provide patient safety, drugs and biologicals must be controlled and distributed in accordance with applicable standards of practice, consistent with Federal and State law. This Standard is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure patients' safety by failing to follow recognized standards for safe management of high-alert medications, as well as failing to address the shortages of medications designated for emergency uses. As a result, potential medication errors could occur when high-alert medications were not safely managed, and medications in the crash carts were potentially not available to patients in medical emergencies.	A 500	A 500 482.25(b) Delivery of Drugs Immediate Action Taken: 1. Pharmacy Leadership reviewed the survey findings related to high alert medications and shortages of medications. Subsequent Actions Taken: 1. Pharmacy Leadership reviewed the "High Alert Medication Safety" policy, which did not require any revision. The list of medications was reviewed, which will continue on an annual basis. Pharmacy staff was re-inserviced. 2. Pharmacy Leadership reviewed and revised the "Drug Shortages" policy to align with current practice. The MEC approved on 3/15/16 and Governing Board on 3/16/16. The drug shortage list was revised to add a column to provide an alternative medication. Pharmacy Staff was educated.	12/29/15 1/16/16 - 3/22/16 1/16/16 - 3/22/16

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A 500	Continued From page 79 Findings: 1. According to the Institute for Safe Medication Practices (ISMP), a leading national organization in safe medication management, high-alert medications are those that "bear a heightened risk of causing significant harm when they are used in error .... the consequences of an error are clearly more devastating to patients." ISMP identified 22 classes/categories of medications, and 12 specific medications as high-alert medications. (https://www.ismp.org/tools/highalertmedications.pdf) During a tour of Unit 1 at Van Nuys, a facility treating patients with psychiatric disorders, on 12/16/15 at 2:30 P.M., with the VPP and DOP 1, digoxin (a heart medication with narrow therapeutic range, a small change in the drug level could cause harm to the patient) was stored in an open drawer, and was separated from other medications by dividers (staff can mistakenly remove one medication for the other, since they were all available when the drawer was opened). According to the facility's policy, "High Alert Medication Safety," revised 10/12, "High Alert Medications are drugs that have a high risk of causing injury, either as a result of a narrow therapeutic range or a historically high incidence of reported serious adverse events. Specific medications: Insulin Heparin Hydromorphone Injection Morphine Sulfate Injection."	A 500	3. The drug shortage list is now e-mailed by the Director of Pharmacy to the medical staff monthly instead of quarterly. 4. Compliance with high alert medications and medication shortages is monitored through the QAPI program. Compliance and Monitoring: The Director of Pharmacy or qualified licensed designee reviews interchange and dosing errors related to high risk, high alert medications on a monthly basis as a component of the medication error reporting system. Data is analyzed and reported monthly to the Medication Safety Committee, Quality Council, MEC, and Governing Board on a routine basis as medication error reporting related to high risk medication use is a routine indicator and will remain a constant in the overall QAPI program as well as the Medication Safety Program throughout the organization. Person Responsible: Director of Pharmacy	3/9/16

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A 500	Continued From page 80 During an interview on 12/17/15 starting at 8:50 A.M., the VPP stated warfarin (a blood thinner) was considered a "high-alert" medication, would only be dispensed from the pharmacy [to prevent medication errors], and would not be stocked in the Automated Dispensing Cabinet (ADC). The VPP then stated warfarin was stored in the ADC on Unit 1. During the same interview, the VPP added, the facility would review the "ISMP" medication list with the Medical Staff. 2a. On 12/15/15 starting at 10:10 A.M., the crash cart (a medication cart containing medications for use in a medical emergency) in the Intensive Care Unit (ICU) at Culver City was inspected with CN 1, the COO, and VPP. The contents of the crash cart were reviewed. The following discrepancies were observed: Procainamide (a heart medication) 1 g per 2 mL was on the list of content, but not stocked; and Procainamide 100 mg per mL 10 mL vial was on the list of content, but not stocked. 2b. On 12/15/15 starting at 10:50 A.M., the crash cart in the Telemetry Unit at Culver City was inspected with CN 3, the COO, and VPP. The contents of the crash cart were reviewed. The following discrepancies were observed: Procainamide (a heart medication) 1 g per 2 mL was on the list of content, but not stocked; and Procainamide 100 mg per mL 10 mL vial was on the list of content, but not stocked. During an interview on 12/15/15 at 3:50 P.M., the	A 500		

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A 500	Continued From page 81 VPP and TS were interviewed. The VPP stated Procainamide had not been available. TS added it had not been available for six months, and had not been stocked in the crash carts since then. The facility provided a document titled, "Drug Shortages," dated 10/24/15, which included Procainamide. The reason for the shortage was "MFG Backorder" [manufacturer backorder] and there was "No Release Date." During an interview on 12/16/15 at 9:40 A.M., the VPP was asked what actions had been taken to address the drug shortage. The VPP stated she was not sure, but "doubtful" if anything was done. According to the document published by the American Society of Health-System Pharmacist (ASHP, a nationally recognized organization establishing professional policies and practice standards) titled, "ASHP Guidelines: Minimum Standards for Pharmacy in Hospitals," under the topic of Drug Shortages, it stated, "The pharmacy should develop strategies for identifying alternative therapies...." (http://www.ashp.org/DocLibrary/BestPractices/SettingsGdlMinHosp.aspx)	A 500		
A 501	482.25(b)(1) PHARMACIST SUPERVISION OF SERVICES All compounding, packaging, and dispensing of drugs and biologicals must be under the supervision of a pharmacist and performed consistent with State and Federal laws. This Standard is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure: 1. Compounded or repackaged medications	A 501	A 501 482.25(b)(1) Pharmacist Supervision of Services Findings 1-4 Immediate Actions Taken: 1. Pharmacy Leadership, including corporate pharmacy oversight provided by the Vice President of Pharmacy Operations, Hospital Systems, reviewed the survey findings related to medication compounding. 2. Oral syringes are no longer being utilized for medication storage (greater than 24 hours).	12/18/15 12/18/15

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A 501	Continued From page 82 were labeled with the appropriate beyond-use-dates (BUD, a date after which the medication should not be stored or used); 2. Compounded or repackaged medications were stored in approved devices, or an evaluation was completed for suitable alternatives; 3. Medications were compounded using approved formulas; and 4. Staff involved in compounding was knowledgeable of the BUD. As a result, medications were assigned inappropriate BUDs, not properly stored to ensure potency. Patients, therefore, were potentially exposed to expired, less potent, or incorrect medications. Findings: 1a. During a tour of the Pharmacy at Culver City, on 12/14/15 starting at 12:30 P.M., with the COO, VPP, and TS, three syringes of epoetin alfa (Procrit, a medication to stimulate red blood cell growth) for three patients were stored in the Pharmacy. During a concurrent interview, TS stated they were drawn out of the Procrit multi-dose vials, and have a BUD of 28 days. During an interview on 12/14/15 at 3:25 P.M., the VPP, a pharmacist, stated the BUD of 28 days was based on the medication's "package insert." The package insert (PI) is the official document approved by the Food and Drug Administration (FDA) to accompany the approved medication. The VPP then stated she had no information to	A 501	Subsequent Actions Taken: 1. Pharmacy Leadership reviewed the "Sterile Compounding Products" policy, which did not require any revision. The compounding formulas were also reviewed and revised compounding formulas to align with package insert recommendations for beyond use dating when medications are compounded, drawn into individual syringes or any package insertion recommendation related to beyond use dating. Pharmacy staff was educated about expectations for following the medication package insert requirements, with a self-study packet and quiz. 2. The Clinical Pharmacist went through each package insert of medications used as compounded to ensure that the BUD in the Master Formula reflects the most common and current manufacturers information for each product. Pharmacy personnel inserviced Hollywood ICU staff on IV compounding and beyond use dating. Unit compounded IVs are designated for immediate use. 3. Compliance with compounding medications is monitored through the QAPI program. Compliance and Monitoring: The Director of Pharmacy or qualified licensed designee shall perform random spot checks daily at varying times to monitoring compliance with beyond use dating. Corrective action is taken, including 1:1 training with staff. Data is analyzed and reported monthly to the Medication Safety Committee, Quality Council and MEC, and Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will occur until the Quality Council determines sustained compliance has occurred, at which time the Council will determine what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Person Responsible: Director of Pharmacy	1/16/16 - 3/22/16 1/10/16 3/22/16

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A 501	Continued From page 83 support this practice [because there was no information in the PI]. According to the current PI, revised 12/13, under section Preparation and Administration, "Store unused portions of PROCRIT in multidose vials at 36°F to 46°F (2°C to 8°C). Discard 21 days after initial entry." There was no relevant information regarding the practice of storing in syringes for future uses. 1b. During a tour of the Telemetry Unit at Culver City, the medication room was inspected with CN 2, and the COO on 12/15/15 starting at 8:13 A.M. A compounded medication, D5NS 30 mEq KCl (potassium diluted in intravenous fluid), was stored at room temperature. The labeling indicated the medication was prepared on 12/13/15 at 11 A.M., and had a BUD of 12/16/15 at 1 P.M. (74 hours BUD). According to the facility's policy, "Sterile Compounding Products (CSP)," revised 10/12, this medication was in the "low-risk" category, and when stored at room temperature, the BUD should be 48 hours. 1c. During a random observation of medication administration on 12/15/15 at 8:36 A.M. with RN 2, a D5NS (salt-containing solution) was observed being infused at 75 mL per hour to Patient P101. The medication did not have any labeling other than the manufacturing labeling indicating what it was. RN 2 could not determine when the current medication bag was first used. According to the facility's policy, "Intravenous [IV, administered directly into the vein] Therapy-Initiation and Management of Peripheral Intravenous Lines," reviewed 6/14, "IV	A 501		

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A 501	Continued From page 84 Solution/Container solutions should be labeled with infusion rate, date and time hung, name of the person who prepared the solution. Apply the label so that it can be read when hanging on I.V. pole. Do not cover manufacturer's label." 2a. During a tour of the Pharmacy at Culver City on 12/14/15 starting at 12:30 P.M. with the COO, VPP, and TS, three syringes of epoetin alfa for three patients were stored in the Pharmacy. On 12/14/15 at 3:25 P.M., in the presence of the COO, VPP, and TS, it was determined the epoetin alfa were stored in [brand] 1 mL injection syringes. The BUDs were 1/7/16 (one syringe), and 1/12/16 (two syringes). 2b. During a tour of the Pharmacy at Culver City on 12/14/15 starting at 12:30 P.M. with the COO, VPP, and TS, the observations were: Vancomycin (an antibiotic) 100 mg per mL oral solution, in volumes of 1.25 mL and 2.5 mL, were stored in clear oral [brand] syringes. The BUDs were 12/25/15 (two syringes), and 12/1715 (four syringes); Twelve prednisolone (medication for allergy or inflammation) 15 mg per 5 mL were stored in [brand] oral syringes; and Ten promethazine (a nausea medication) 6.25 mg per 5 mL in [brand] oral syringes. During an interview on 12/14/15 at 3:25 P.M., the VPP stated she was not aware of the issues associated with the [brand] syringes when used for storage of compounded or repackaged medications. According to the company's alert dated 8/18/15,	A 501		

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SOUTHERN CALIFORNIA HOSPITAL AT HOLL	6245 DE LONGPRE AVE HOLLYWOOD, CA 90028

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A 501	Continued From page 85 these syringes "are not to be used for drug storage...." In addition, according to the company's letter dated 9/1/15 to United States Customers, "... these syringes are being used for purposes for which they were not designed or cleared [approved by the FDA]." According to the FDA, in a warning letter issued on 9/8/15 regarding compounded or repackaged drugs stored in the [brand] injection and oral syringes, "... certain lots of these syringes can cause some drugs stored in these syringes to lose potency if filled and not used immediately.... Not administer compounded or repackaged drugs that have been stored in any of these syringes unless there is no suitable alternative available." 3. During a tour of the Pharmacy at Culver City on 12/14/15 starting at 12:30 P.M. with the COO, VPP, and TS, vancomycin 100 mg per mL oral solution, in volumes of 1.25 mL and 2.5 mL, were stored in the medication refrigerator. The compounding records and formulas were requested. The facility provided an undated document titled "Vancomycin PO [oral] Formula," which included the ingredients used in compounding: vancomycin and sterile water for injection (SWFI), to produce a final concentration of 16.6 mg per mL, or 250 mg equals to 15 mL. The formula also included the use of "syringe" and "amber bottle" in the compounding process. The compounding records indicated vancomycin was compounded to a final concentration of 100 mg per mL, or 250 mg equals to 2.5 mL and 125 mg equals to 1.25 mL. The records also did not include any information indicating SWFI was	A 501		

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A 501	Continued From page 86 used, or the lot numbers for either products (vancomycin and SWFI), or any information regarding other equipments (such as syringes and amber bottle) used in the compounding process. On 12/16/15 at 10 A.M., the policy for compounding of oral medications were requested from the VPP. During an interview on 12/17/15 starting at 8:50 A.M., the VPP stated the policy for compounding of oral medications was part of the sterile compounding policy. According to the facility's policy, "Sterile Compounded Products (CSP)," revised 10/12, "To compound medication, the pharmacy must have a written master formula sheet that includes the following elements: Active ingredients used, Inactive ingredients used, Process and/or procedure used to prepare the drug...." In addition, the policy stipulated for the Records of Compounded Drug Products, "A record for each compounded drug product includes the following: Master formula record ... Quantity of each component used in compounding the drug product Manufacturer/supplier and lot number of each component. Equipment used in compounding the drug product...." 4a. During a tour of the Pharmacy at Culver City, on 12/14/15 starting at 12:30 P.M., with the COO, VPP, and TS, three syringes of epoetin alfa for three patients were stored in the Pharmacy. One syringe had a BUD of 1/7/16, two syringes had a	A 501		

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A 501	Continued From page 87 BUD of 1/12/16. During an interview on 12/14/15 at 1 P.M., RPh 2 acknowledged she validated these syringes earlier in the day. RPh 2 stated, however, she was not sure what the BUD should be, "not 100% sure." RPh 2 further stated they might have been compounded at different times. 4b. During a tour of the Intensive Care Unit (ICU) at Hollywood, on 12/16/15 at 1:05 P.M., with the VPP, the medication room was inspected. Stored together in a plastic bag was one D5W (dextrose solution) 250 mL and two vials of norepinephrine (medication to increase blood pressure), 4 mg each. During an interview on 12/16/15 at 1:17 P.M., RN 3 said she would compound norepinephrine (usually done by adding the contents of two vials into the solution), in an emergency after the pharmacy was closed. RN 3 stated she would "never put the expiration [BUD]" on the compounded product. RN 3 then stated she would assigned the BUD of 24 hours. During an interview on 12/16/15 at 1:30 P.M., the VPP stated the requirements for BUD applied when the compounding was done by a nurse, and norepinephrine compounded in this situation would be considered for "immediate use." According to the facility's policy, "Sterile Compounding Products (CSP)," revised 10/12, the Procedure/Purpose stated, "To ensure that compounding personnel, including pharmacy and nursing staffs are adequately educated, instructed and skilled to perform their compounding tasks. To prevent harm and death to patients treated with Compounded Sterile	A 501		

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A 501	Continued From page 88 Products (CSP)." In addition, the Scope section stated, "This procedure applies to all departments and services licensed by the facility...." The policy defined "Immediate Use CSPs" as "...where there is need for emergency or immediate patient administration...." and "Unless immediately and completely administered and administration is witnessed by the preparer, the CSP shall bear a label containing the following information: ...the exact one hour beyond use date...."	A 501		
A 502	482.25(b)(2)(i) SECURE STORAGE All drugs and biologicals must be kept in a secure area, and locked when appropriate. This Standard is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the security of medications. As a result, medications were left at a patient's bedside unattended during a randomly observed medication administration. Findings: During a randomly observed medication administration in the ICU (Intensive Care Unit), on 12/15/15 starting at 8:50 A.M., RN 1 mixed 12 medications for Patient P100 together in a plastic bottle, including a gel capsule of docusate (a stool softener). RN 1 placed the plastic bottle on the bedside table with docusate still undissolved in some liquid, and left the room. At 9:12 A.M., RN 1 came back to the room, docusate was still undissolved. The bottle contained approximately 100 mL of orange fluid. Since 12 medications were mixed in the bottle, the orange fluid potentially contained all 12 medications, including the undissolved docusate.	A 502	A 502 482.25(b)(2)(i) Secure Storage Immediate Actions Taken: 1. During the survey, staff members were notified about medication security and the medications were secured. Subsequent Actions Taken: 1. Pharmacy Leadership reviewed the "Medication Storage" policy, which did not require any revisions. Security of medication management was provided to nursing staff with the focus that medications must be stored in a secure area, and locked when appropriate. Nursing staff was educated that a secure area means that drugs and biological are stored in a manner to prevent unmonitored access by unauthorized individuals. Staff was re-oriented to the content of the hospital's medication storage policy. This education was provided for nursing staff by hand-out information and formal education provided by the external education company's onsite staff, dedicated to providing focused education on highly vulnerable topics, which included medication storage. Education was completed by 3/22/16. 2. Compliance with security of medications is monitored through the QAPI program.	12/18/15 3/22/16

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A 502	Continued From page 89 RN 1 again placed the medications on the bedside table and left the room. At 9:27 A.M., RN 1 came back to complete the medication administration for Patient P100. During a concurrent interview and record review on 12/17/15 starting at 8:50 A.M., the VPP stated bedside storage of medication was only allowed when it was for self-administration (patient administers his or her own medication). According to the facility's policy, "Medication Storage," reviewed 6/14, "Once removed [from the approved storage area], the medication must remain with the individual at all times and shall not be left unattended."	A 502	Compliance and Monitoring: Compliance is monitored via direct observation conducted during medication pass audits, and unit observation rounds. The expectation is that all medications are stored securely. Observations are conducted weekly with data reported to executive and nursing leadership for immediate action. If trends are noted, Executive Leadership will request medication security to be added as a formal indicator to the QAPI data collection program. However, currently, any breaches will be addressed by Executive Leadership and managed on an individual level by pharmacy and nursing management. Observation data will be reported to Executive Leadership on a weekly basis until leadership determines sustained compliance has occurred, at which time leadership may request reduction of audits as appropriate to the amount of violations in policy noted (i.e., if sustained compliance is evident, observations will be	
A 505	482.25(b)(3) UNUSABLE DRUGS NOT USED Outdated, mislabeled, or otherwise unusable drugs and biologicals must not be available for patient use. This Standard is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure mislabeled and unusable medications were not available for patient use. As a result, two medications were not labeled with the appropriate beyond-use-dates (BUD, a date after which a medication should be stored or use), and one medication was not stored in the overwrap (a wrap over an item for protection) as specified by the manufacturer. Another medication was used beyond its use. Findings: 1a. During a tour of the Pharmacy at Culver City, on 12/14/15 starting at 12:30 P.M., with the COO	A 505		

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A 502	Continued From page 89 RN 1 again placed the medications on the bedside table and left the room. At 9:27 A.M., RN 1 came back to complete the medication administration for Patient P100. During a concurrent interview and record review on 12/17/15 starting at 8:50 A.M., the VPP stated bedside storage of medication was only allowed when it was for self-administration (patient administers his or her own medication). According to the facility's policy, "Medication Storage," reviewed 6/14, "Once removed [from the approved storage area], the medication must remain with the individual at all times and shall not be left unattended."	A 502	reduced accordingly. If the process remains unstable, observations will continue and may increase). Persons Responsible: Director of Pharmacy Chief Nursing Officer	
A 505	482.25(b)(3) UNUSABLE DRUGS NOT USED Outdated, mislabeled, or otherwise unusable drugs and biologicals must not be available for patient use. This Standard is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure mislabeled and unusable medications were not available for patient use. As a result, two medications were not labeled with the appropriate beyond-use-dates (BUD, a date after which a medication should be stored or use), and one medication was not stored in the overwrap (a wrap over an item for protection) as specified by the manufacturer. Another medication was used beyond its use. Findings: 1a. During a tour of the Pharmacy at Culver City, on 12/14/15 starting at 12:30 P.M., with the COO	A 505	A 505 482.25(b)(3) Unusable Drugs Not Used Findings 1-4 Immediate Actions Taken: 1. The identified medications were discarded. 2. The Pharmacist now reviews all insulin vials leaving the pharmacy to each floor as floor stock. An expiration sticker and high alert sticker are placed and verified for each insulin vial dispensed. The BUD expiration date calendar is posted in the main pharmacy. The Pharmacist will initial each expiration date sticker. Subsequent Actions Taken: 1. Pharmacy Leadership created and implemented a calendar to assist pharmacy staff with 28 day BUD labeling before the medication leaves the pharmacy. Pharmacy staff were educated to this BUD calendar and the BUD system via self-study packet and a quiz. Nursing education at Hollywood campus included beyond use dating and issues that bring a medication into an accelerated expiration dating, such as removal of IV overwraps (e.g., not to remove the overwrap until ready to use or an accelerated BUD applies).	12/18/15 12/18/15 3/22/16

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A 505	Continued From page 90 and VPP, one folic acid (a supplement) 5 mg per mL 10 mL vial, a multi-dose vial, was observed with the labeled open date of 12/3/15 and BUD of 1/31/16 (59 days from the open date). During the concurrent interview, the VPP stated the BUD should be 28 days, and the BUD assigned was more than 28 days. 1b. During a tour of the medication room in the Telemetry Unit at Culver City, on 12/15/15 at 8:13 A.M., with CN 2 and the COO, CN 2 stated the nurse would assign a BUD of 30 days to insulin vials after opening. One vial of insulin R, a multi-dose vial, was labeled with the open date of 12/2/15 and BUD of 1/3/16 (32 days from the open date). According to the facility's policy, revised 10/12, "The expiration date assigned to opened multiple dose vials is twenty-eight days...." 3. During a tour of the medication room in the ICU (Intensive Care Unit) at Culver City, on 12/15/15 starting at 9:54 A.M., with CN 1, the COO, and VPP, one liter bag of D5 1/4 NS (salt-solution) was found without the overwrap and open date or BUD. According to the current manufacturer's labeling, revised 6/13, "Do not remove overwrap until ready for use." 4.) The pharmacy label on an IV (intravenous) bag labeled "Levoved" (Levophed,a medication used to maintain blood pressure) indicated the medication was to be administered on 12/1/15. According to the nurse's documentation on the label, the medication was administered on 12/15/15.	A 505	2. Pharmacy staff reviewed medications on three campuses to ensure BUD dates were current and appropriate for the medication's storage condition. Rounding was performed by the Vice President of Pharmacy Operations, Hospital Systems, the Regional Director of Pharmacy for Southern California and each campus pharmacy director. 3. Compliance with labeling with BUD is monitored through the QAPI program. Compliance and Monitoring: The Director of Pharmacy or qualified licensed designee shall perform weekly inspections for BUD compliance. Corrective action is taken, including 1:1 training with staff. Data is analyzed and reported monthly to the Medication Safety Committee, Quality Council, MEC, and Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will occur until the Quality Council determines sustained compliance has occurred, at which time the Council will determine what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Person Responsible: Director of Pharmacy	1/18/16

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A 505	Continued From page 91 During a bedside observation of Patient N-104 on 12/17/15 at 10:10 a.m., an IV bag labeled Levophed was noted to be empty and hanging on the IV pole. The pharmacy label indicated it was to be administered on 12/1/15. During interview with RN 3 at the time, she stated, "Looks like it was given 12/15/15." During interview with the pharmacist RPh 1 on 12/17/15 at 12:15 p.m. the same day, he confirmed the administration date on the label was 12/1/15. The pharmacist stated, "For that particular medication, after mixing it, it is stable for 24 hours." He added, "it is not safe to administer after 24 hours." Based on observation, interview and review of records the facility failed to ensure outdated medications were available for use as evidenced by:	A 505		
A 506	482.25(b)(4) AFTER-HOURS ACCESS TO DRUGS When a pharmacist is not available, drugs and biologicals must be removed from the pharmacy or storage area only by personnel designated in the policies of the medical staff and pharmaceutical service, in accordance with Federal and State law. This Standard is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain an accurate inventory, restock, and update the medication list for its after-hours medication supply (night locker) at the Hollywood campus. As a result, the supply was not restocked timely, the posted medication list did not reflect the current contents of the night locker, and there were two different versions of	A 506	A 506 482.25(b)(4) After-Hours Access to Drugs	

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A 506	Continued From page 92 the medication list available. Findings: During a tour of the Pharmacy at Hollywood, on 12/16/15 at 12:50 P.M., with RPh 1 and VPP, RPh 1 stated the facility had a night locker, which contained certain medications and quantities. During an inspection of the night locker on 12/16/15 starting at 12:55 P.M. with PT 1 and VPP, four terbutaline (asthma medication) 1 mg per 1 mL injections were inside. The undated Night Locker IV (intravenous, medication given directly into the vein) Medication List posted did not include terbutaline. Further inspection revealed the night locker contained one Nitroglycerin (a heart medication) 50 mg per 250 mL, instead of two as specified by the posted list. During a concurrent interview, in the presence of the VPP, PT 1 stated used medications would be restocked by the end of the day. The accountability log, a log showing when a medication was being removed for a patient, was reviewed with the VPP and PT 1. The log recorded medications being removed from the night locker from the presence and back to December 2, 2015. The VPP and PT 1 could not ascertain when Nitroglycerin was last used, but agreed it was used at least prior to December 2, 2015. The record of when Nitroglycerin was last used was requested, however, the facility did not provide the record at the conclusion of this survey. According to the facility's policy, "After Hours Procurement of Medication," reviewed 3/10/15,	A 506	Findings 1-4 Immediate Actions Taken: 1. Pharmacy Leadership met immediately following the survey to discuss use of night lockers and compliance requirements. The "After Hours Procurement of Medication" policy was reviewed and did not require any revision. The night locker inventory list was analyzed to ensure consistency with contents and appropriate par levels. Pharmacy staff reviewed the night locker at Hollywood to ensure that contents were current and matched the inventory list. The Pharmacist is responsible for checking and monitoring the night locker inventory and par levels on a daily basis. The Director of Pharmacy educated the Hollywood campus pharmacy staff. Compliance and Monitoring: The Director of Pharmacy or qualified licensed designee shall perform night locker inventory daily. Any discrepancies in the inventory list and the actual content of the locker are immediately remediated with the list and the content reconciled. This inventory and reconciliation is ongoing and is a component of usual pharmacy operations. Ongoing discrepancies will be trended, and if identified, this issue will be forwarded to the Medication Safety Committee for process management and resolution. The Director of Pharmacy is responsible for ensuring daily inventory assessments and content reconciliation occurs as a component of his/her job responsibilities. All medication storage areas are inventoried monthly. It is during this required monthly inspection that any variances in the pharmacist's oversight and inspection process are identified. Thus, the monthly inventory serves as a redundant process validation assessment, with reporting to the Medication Safety Committee as stated. Person Responsible: Director of Pharmacy	12/18/15

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A 506	Continued From page 93 "The pharmacy staff shall be responsible for the maintenance of the after hours medication supply by assuring that all drugs are properly labeled and stored. The after hours drug supply shall contain the type and quantity of drugs necessary to meet the immediate needs of patients ...." In addition, "... the nightlocker will be restocked and the PAR [amount that should be available at any time for an item] levels verified daily." The policy also included a list of medications available in the night locker. This list was compared to the undated medication list posted in the night locker, and the following medications did not match: D5 1/2 NS 20 mEq KCl 1,000 mL (potassium-containing IV solution); Potassium Chloride oral liquid; Albumin (a blood product) injection; Mannitol (an osmotic agent) injection; Merrem (an antibiotic) injection.	A 506		
A 536	482.26(b)(1) SAFETY FOR PATIENTS AND PERSONNEL Proper safety precautions must be maintained against radiation hazards. This includes adequate shielding for patients, personnel, and facilities, as well as appropriate storage, use and disposal of radioactive materials. This Standard is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to follow the lead apron testing procedures as indicated in their policies, as evidenced by the following: 1. One lead apron skirt with a hole was found in the Radiology Department. 2. Ten unlabeled, untested thyroid shields found in the Operating Room (OR) lead storage room.	A 536	A 536 482.26(b)(1) Safety for Patients and Personnel	

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A 536	Continued From page 94 3. Catherization Laboratory (Cath-lab) unable to account for a lead vest label "cath-lab' found in the OR lead storage room. These failures have the potential of exposing personnel to radiation which can result in future negative health outcomes. Findings: 1. During a tour of the Radiology Department and concurrent intervew with the radiology clinical coordinator (RCC) and radiology director (RadD) on 12/17/15 at 9:58 a.m., a blue lead skirt (item 8) was observed with a tear/hole. The RadD was questioned about the tear/hole on the lead skirt. RadD agreed that the lead skirt should be retired and he asked the RCC to remove the lead skirt from the radiology department. The facility's policy and procedure titled: Lead Apron Testing for all Imagings CRTs, RAD 6-33, dated 3/6/09, indicated "There should be no cracks or tears... Any aprons or shields damaged will be repaired or retired promptly." 2. During a tour of the Operating Room (OR) lead storage room and concurrent interview with the radiology clinical coordinator (RCC) and radiology director (RadD) on 12/17/15 at 10:10 a.m., ten thyroid shields were observed stacked on top of a cabinet. The thyroid shields were not labeled and therefore the facility was unable to recognize if the shields had been tested for radiation. The RadD and RCC were questioned about the shields found on top of the cabinet. The RadD stated he did not know where those shields came from and he asked the RCC if he had tested the shields for radiation. The RCC stated "I don't know where these shields came from. I don't know if I tested them for radiation because these	A 536	Findings 1-3 Immediate Actions Taken: 1. Executive Leadership met with the Director of Imaging Services and Director of Cardiac Catheterization Lab to discuss the survey findings and the process for ensuring appropriate screenings of lead aprons and other radiation exposure prevention devices. Subsequent Actions Taken: 1. The Director of Imaging Services reviewed and revised the "Lead and Apron Testing, Maintenance & Disposal" policy to indicate an improved, more structured monitoring process. The MEC approved the policy on 2/16/16 and the Governing Board on 2/24/16. Cath Lab, Surgery and Radiology staff were inserviced on the policy. 2. All aprons were pulled and checked with fluoroscopy and renumbered in radiology, Cath lab and surgery departments by 2/9/16. Vests pulled in Surgery were not indicated on the assessment log and were not located. As of 2/11/16, a log was created for surgery with all vests and aprons listed on the log. A unique number system was developed to identify all radiation exposure protection devices (lead aprons, thyroid shield, etc.). A revised log was then created to identify each apron/shield with a description and unique number and date last checked. Imaging services conducted a full inventory and surveillance testing the week of 3/1/16 to ensure the process was effective. The testing was reviewed and approved by the Radiation Physicist on 3/4/16. 3. By 3/22/16, the radiation physicist recertified staff responsible for conducting surveillance and testing of protective lead devices. Compliance and Monitoring: The Chief Operating Officer or qualified designee shall review the inventory of all protective lead devices to ensure all devices are checked per the directive time period on the schedule. To test the process, random devices	12/29/15 3/4/16 3/4/16 3/22/16

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	050135	A. BUILDING _____ B. WING _____	12/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 536	Continued From page 95 shields aren't attached to the lead vest. Normally the thyroid shields are attached to the vest and they are tested together for radiation." 3. During the same tour of the OR lead storage room, a green floral lead vest (label Cath-lab) with thyroid shield was observed. The RCC was asked when this vest & thyroid shield was tested for radiation. The RCC stated he did not recognize the vest & thyroid shield, he had not tested those lead items because they were not items from the Radiology Department. The lead items belong to the Cath-Lab. During an interview with the Cath-lab director (CLD) on 12/17/15 at 10:40 a.m., he was questioned about the radiation testing for the green floral vest & thyroid shield. The CLD and his staff did not recognize the lead items, even though the vest was labeled (Cath-lab). A concurrent interview was held with the Cath-lab radiology technician (CLRT) who is responsible for testing all lead items. He stated he had not seen these lead items in the Cath-lab therefore the vest & thyroid shield had not been tested for radiation. The CLRT stated "This is a custom made lead vest, someone must have brought it in for their personal use." The CLD and RadD agreed there was a lead vest and thyroid shield that were not accounted for, tracked for and not tested for radiation. The facility's policy and procedure titled: Lead Apron Testing for Cardiology/Cath Lab, CAT .021, dated 11/2012, indicated "All protective apparel shall be tested...on a semi-annual basis..."	A 536	will be pulled every quarter from every department using protective lead devices with these devices scanned for full lead protection intact. As this process is a routine component of radiation safety, any outliers will be immediately corrected with the lead device taken out of service and removed from the inventory list. Any trends identified with any device type or department reflecting failure of the device protection or failure to check the device will be reported to the Radiation Safety Committee for oversight and management. The Radiation Safety Committee will address any variances quarterly and will continue on an ongoing quarterly inspection and reporting basis. Person Responsible: Chief Operating Officer	
A 700	482.41 PHYSICAL ENVIRONMENT The hospital must be constructed, arranged, and maintained to ensure the safety of the patient,	A 700	A 700 Physical Environment Condition	

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A 700	Continued From page 96 and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community. This Condition is not met as evidenced by: Based on observation, interview and document review, the hospital failed to ensure the maintenance and functionality of the physical plant and hospital environment to ensure the safety and well being of patients. 1) The facility could not ensure the condition of the physical plant was sufficient to provide an acceptable level of safety and well being for patients (refer to A 701). 2) The facility could not ensure the proper storage and disposal of biohazard waste (refer to 713) 3) The facility could not demonstrate medications and lab specimens were stored in appropriate temperatures or that oxygen canisters were stored safely (refer to 724). The cumulative effect of these failings meant the facility failed to ensure that safe healthcare was provided in a safe environment for patients obtaining care in the hospital.	A 700	Corporate and Hospital Leadership reviewed the survey findings and implemented changes to the physical plant and overall hospital environment to maintain a safe and sanitary environment and to assure the well-being of patients. Corporate Leadership worked on site with the Director of Facilities and Facilities staff on the identified issues. The Hospital engaged a national healthcare regulatory compliance consulting firm, which included a consultant with expertise in the physical environment condition of participation. Hospital Leadership discussed the issues related to the HVAC systems. A heating coil was placed into the temporary air handler on 12/31/15 to ensure that the identified rooms/ areas could be heated to appropriate temperatures, or as stated cooled. Nursing staff monitored the identified rooms/areas to ensure that appropriate temperatures were maintained and can be consistently controlled. Temperatures were recorded on log sheets. Random monitoring occurred daily in patient rooms through 3/2/16. Temperatures have been stabilized and random room monitoring occurs during weekly EOC rounds. The permanent unit is being addressed through OSHPD project number S151262-19-00. The Hospital engaged a heating/ventilating company to assess, repair and install controls in air conditioning and heating units. Hospital Leadership reviewed and revised the	12/29/15 - 3/22/16 1/18/16 – 3/16/16
A 701	482.41(a) MAINTENANCE OF PHYSICAL PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This Standard is not met as evidenced by: Based on observation, interview and record review, the facility failed to	A 701		

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A 701	482.41(a) MAINTENANCE OF PHYSICAL PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This Standard is not met as evidenced by: Based on observation, interview and record review, the facility failed to	A 701		

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A 701	482.41(a) MAINTENANCE OF PHYSICAL PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This Standard is not met as evidenced by: Based on observation, interview and record review, the facility failed to	A 701		

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A 701	482.41(a) MAINTENANCE OF PHYSICAL PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This Standard is not met as evidenced by: Based on observation, interview and record review, the facility failed to	A 701		

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A 701	482.41(a) MAINTENANCE OF PHYSICAL PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This Standard is not met as evidenced by: Based on observation, interview and record review, the facility failed to	A 701	A701 482.241(a) Maintenance of Physical Plant	

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A 701	Continued From page 97 1) Ensure the temporary air handler unit feeding air to certain departments (e.g. 6th, 5th, partial of the 4th, and 2nd floor) was functioning well enough to provide heated air according to state regulations, or hospital policy and at a comfortable level for patients, staff and visitors. 2) The hospital did not ensure that follow-up of out of range OR temperature and humidity was documented, creating the increased risk of substandard OR environmental conditions and poor surgical outcomes. 3)The facility failed to ensure emergency equipment was properly maintained. The fourth floor crash cart had a defibrillator which was not plugged into a red plug to ensure battery was charged should there be a power failure. Findings: 1) According to the facility's record review on 12/12/15 at 10:00 a.m., records indicate the facility had been using a temporary air handler unit since March, 2015. The facility was granted a permit on 12/9/15 from the office of statewide health planning and developement to begin installation of a new air handler unit. Meanwhile the facility is using a temporary air handler that is not providing heated air to patient's rooms in certain areas of the Pavilion (e.g. 6th, 5th, partial of the 4th, 2nd floor, etc.) and patients and staff are complaining that "they are cold". During an interview on 12/15/15, at 10:27 a.m., the project manager (PM2) in charge of restoration of the air handler installation (OSHPD Project #S151262-19-00) stated that the temporary air handler feeds the air into the patient rooms of the Pavilion (hospital building).	A 701	Finding 1 1. Hospital Leadership discussed the issues related to the HVAC systems. A heating coil was placed into the temporary air handler on 12/31/15 to ensure that the identified rooms/ areas could be heated to appropriate temperatures, or as stated cooled. Nursing staff monitored the identified rooms/areas to ensure that appropriate temperatures were maintained and can be consistently controlled. Temperatures were recorded on log sheets. Random monitoring occurred daily in patient rooms through 3/2/16. Temperatures have been stabilized. Monitoring random rooms now during weekly EOC rounds. Compliance is reported monthly to the Quality Council (until the Quality Council determines monitoring of the building is sufficiently conducted and then reporting will be provided quarterly to the Quality Council) and quarterly to the Governing Board. The permanent unit is being addressed through OSHPD project number S151262-19-00. 6 2. Compliance with HVAC systems is monitored through the PM program and scheduled EOC rounds. Compliance and Monitoring: Data on compliance is tracked, trended, analyzed and is reported monthly at the EOC Committee. Corrective action is taken as necessary. Compliance is also reported monthly to the Quality Council (until the Quality Council determines monitoring of the building is sufficiently conducted and then reporting will be provided quarterly to the Quality Council) and quarterly to the Governing Board. Persons Responsible: Vice President of Facilities Development Director of Facilities	3/2/16

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A 701	Continued From page 98 He stated that he had heard complaints about the rooms being "too cold" since last Tuesday (12/8/15). He stated that a possible solution to adding central heat to the rooms is to add a heating coil to the temporary air handler unit until the new permanent air handler is installed. He estimated that the new air handler would be installed in approximately five to six months. During an interview at 4:07 p.m., on 12/15/15, the vice president of facilities services agreed that it was cold and stated that the facility will be adding a heating coil to the temporary air handling unit to provide central heat to the rooms. During an interview at 8:32 a.m., on 12/16/15, with the regional compliance officer from OSHPD, he stated that the facility must provide heat between 70 to 75°F per state regulations. Furthermore he stated that the facility needed to add a heating coil to the current temporary HVAC system if the system was not providing enough heat. On 12/15/15 various departments of the facility were toured accompanied by the plant operations lead. Observations validated that the current air handler was not providing heated air in patient's rooms as per state regulations (70 to 75°F). a) At 4:05 p.m., plant operations lead staff (PO1) recorded the temperature in Room 628 with a handheld thermometer. The temperature in the room was 68.6°F and the thermostat in the room was set to "warm". Concurrent interview with the patient in the room was held and he stated that the room was "too cold and had been cold for three days". During an interview at 4:06 p.m., PO1 stated that there was no way to add heat to the room and the thermostat only turns off the cold air when it is set to warm.	A 701		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSPITAL AT HOLL	6245 DE LONGPRE AVE HOLLYWOOD, CA 90028

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 701	Continued From page 99 b) At 4:19 p.m., PO1 measured the temperature in Room 630 it was 67.2°F. The thermostat in the room had a broken lever and PO1 could not adjust it. c) At 4:21 p.m., PO1 measured the temperature in Room 634 to be 67°F. d) At 4:30 p.m., PO1 measured the temperature of the air coming out of the supply air vent in Room 302 to be 61.6°F. e) At 4:35 p.m., PO1 measured the temperature of the air coming out of the supply air vent in Room 311 to be 66.2°F. f) At 4:37 p.m., PO1 measured the temperature of the air coming out of the supply air vent in Room 314A to be 63.8°F. g) At 4:40 p.m., PO1 measured the temperature of the air coming out of the supply air vent in Room 315A to be 67.8°F. h) At 4:45 p.m., PO1 measured the temperature of the air coming out of the supply air vent in Room 207 to be 67.6°F. The room's thermostat was set to warm. i) At 4:47 p.m., PO1 measured the temperature of the air coming out of the supply air vent in Room 206 to be 60°F. The thermostat in the room had no operating button to adjust the settings. During an interview with the patient in the room he stated that the room was "cold". On 12/15/15, at 4:49 p.m., records of room temperatures recorded by staff in the Pavilion (hospital building) areas were reviewed. The logs showed that staff were recording ambient room temperatures three times daily (at 6:30 a.m., 12:00 p.m., and 7:00 p.m.) and the acceptable temperature range on the log was listed as 68 to 75°F which was different than the state regulatory parameters 70 to 75°F but in any case still not met.	A 701		

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A 701	Continued From page 100 Sixth Floor: a) Room temperatures fell below 68°F in 25 of 40 patient rooms on 12/15/15, with the lowest temperature of 64.4°F recorded at 12:00 p.m. in Room 633. b) Room temperatures fell below 68°F in 8 of 40 patient rooms on 12/14/15, with the lowest temperature of 67.4°F recorded at 12:00 p.m. in Room 638. c) Room temperatures fell below 68°F in 25 of 40 patient rooms on 12/13/15, with the lowest temperature of 65.2°F recorded at 6:30 a.m. in Rooms 631 and 632. d) Room temperatures fell below 68°F in 6 of 40 patient rooms on 12/12/15, with the lowest temperature of 67°F recorded at 12:00 p.m. in Room 638. e) Room temperatures fell below 68°F in 18 of 40 patient rooms on 12/2/15, with the lowest temperature of 66.5°F recorded at 6:30 a.m. in Room 639. Fifth Floor: a) Room temperatures fell below 68°F in 15 of 41 patient rooms on 12/13/15, with the lowest temperature of 66.1°F recorded at 6:30 a.m. in Rooms 536 and 540. b) Room temperatures fell below 68°F in 8 of 41 patient rooms on 12/1/15, with the lowest temperature of 66.8°F recorded at 8:00 a.m. in Room 527. Fourth Floor: a) Room temperatures fell below 68°F in 8 of 19 patient rooms on 12/13/15, with the lowest temperature of 67.3°F recorded at 6:30 a.m. in Room 424. b) Room temperatures fell below 68°F in 19 of 19 patient rooms on 12/12/15, with the lowest temperature of 65.4°F recorded at 6:30 a.m. in	A 701		

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A 701	Continued From page 101 Room 406. Second Floor (Unit P2): a) Room temperatures fell below 68°F in 30 of 44 patient rooms on 12/12/15, with the lowest temperature of 65.2°F recorded at 6:30 a.m. in Rooms 223 and 230. b) Room temperatures fell below 68°F in 20 of 44 patient rooms on 12/12/15, with the lowest temperature of 66.5°F recorded at 6:30 a.m. in Rooms 225 and 228. On 12/17/15 at 9:15 a.m., another tour of the facility accompanied by the plant operations lead took place to validate the current air handler was not providing heated air in patient's rooms as per state regulations (70 to 75°F) and facility policy 68-75 degrees F. The following was observed during the tour: a) At 9:18 a.m., PO1 measured the temperature of the air coming out of the supply air vent in Room 201 to be 63.4°F. During an interview, the patient in the room stated the room was "chilly". b) At 9:25 a.m., PO1 measured the temperature of the air coming out of the supply air vent in Room 204 to be 62.2°F. c) At 9:30 a.m., PO1 measured the temperature of the air coming out of the supply air vent in Room 220 to be 62.2°F. During an interview, the patient in the room stated it was "cold". d) At 9:35 a.m., PO1 measured the temperature of the air coming out of the supply air vent in Room 243 to be 61.3°F. e) At 9:38 a.m., PO1 measured the temperature of the air coming out of the supply air vent in Room 241 to be 61.6°F. During an interview, the patient in the room stated it was "cold". f) At 9:45 a.m., PO1 measured the temperature of the air coming out of the supply air vent in Room 226 to be 58°F.	A 701		

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A 701	Continued From page 102 Concurrent interview was held with the Director of Emergency Services who acknowledged that she can feel the "chill" in the North West wing of the second floor (patient room wing). She stated the rooms in that wing were much cooler than some of the other rooms. On the same date at 11:00 a.m., Patient N 212 in room 432 was interviewed regarding the room being cold. Patient N 212 stated he had been "Cold for a week. Staff checks the temperature in the room, and gives him blankets but nothing is done to fix the heater". On the same date at 11:10 a.m., Patient N 215 in room 406 was interviewed regarding the room being cold. Patient N 215 stated "It was cold last night, very cold so I pulled up the blankets". On the same date at 11:15 a.m., Patient N 214 in room 409 was interviewed regarding the room being cold. Patient N 409 stated "It has been cold for 2 weeks, they turn up the heater but it doesn't work because it gets cold again". On the same date at 11:05 a.m., in room 425 a bair hugger (forced air warming blanket like device) was observed on the bed. Concurrent interview with the charge nurse (CN 4) was held to inquire about the bair hugger device. CN 4 stated the patient in room 425 had been complaining she was very cold, so she was given the bair hugger. During the above interview with CN 4 she was questioned regarding the cold temperatures in the unit. CN 4 stated the CN checks the temperatures in the rooms and asks patients if they can "tolerate the cold" and if they can't then	A 701		

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A 701	Continued From page 103 they are given blankets. The CNs places a call to facilities or bio-med in order for someone to come and adjust the heat. But this cold temperature problem has "Been going on for a while". On the same date after the tour, temperature logs that hospital staff recorded in patient rooms at 2:00 a.m., 4:00 a.m., and 6:00 a.m. were reviewed: a) In P6 (Sixth Floor), temperatures in 15 of 40 patient rooms remained below 68°F from 2 a.m. to 6 a.m. with the lowest temperature of 65.2°F recorded at 2:00 a.m. in Room 635. b) In P5 (Fifth Floor), temperatures in 12 of 41 patient rooms remained below 68°F from 2 a.m. to 6 a.m. with the lowest temperature of 65.8°F recorded at 6:00 a.m. in Room 534. c) In P2 (Second Floor), temperatures in 9 of 44 patient rooms remained below 68°F from 2 a.m. to 6 a.m. with the lowest temperature of 64.5°F recorded at 6:00 a.m. in Rooms 224, 225, and 226. Per these observations, interviews, and log reviews, the facility failed to ensure the provision of adequate central heating to the patient rooms either through the HVAC system or any other means. The temperatures remained under facility policy ranges and state regulations. 2.) During a tour of OR 1 on 12/18/15 at 1445, there was an hourly temperature and humidity monitoring log posted. The log had columns for recording temperature, humidity, time, initials of	A 701	Finding 2 Actions Taken: 1. Hospital Leadership reviewed the "Temperature and Humidity" policy, which was revised and renamed the "Temperature and Humidity Monitoring in Operative and Invasive Procedural Areas" policy. The Hospital follows the humidity range of 30 to 60%. The policy was revised to allow the surgeon to raise or lower the temperature of the operating room temporarily for a given case for specific reasons (e.g., lower temperature during long joint cases with production of sweat under lights for hours, pediatric cases where the surgeon desires a warmer temperature). This policy was approved on 3/15/16 by the MEC and 3/16/16 by the Governing Board. 2. Formal and informal meetings were held during the weeks of 1/18/16 – 2/12/16 between Executive Leadership, facilities management, surgical services and ancillary services regarding humidity levels. A presentation was provided on 2/11/16 to Quality Council, Infection Control Committee and Governance regarding temperature and humidity requirements and the organization's compliance level to raise awareness at leadership levels for connection between temperature/humidity and potential infection control and fire safety risk. After repair of the HVAC system, hourly readings were transitioned to daily readings for all areas where surgical/procedural cases were not performed (e.g., sterile supply and other areas where sterile instruments/supplies are required to be stored under specific temperature/humidity ranges). Temperature and humidity readings were taken before each case in surgical/procedural areas to validate ongoing range stability. A contracted vendor installed remote temperature/humidity readers in the operating rooms and cardiac catheterization laboratory. The Hospital had the vendor re-evaluate the system on 2/10/16 and they identified that the system was operating properly. The contract vendor technician educated facilities	3/16/16 1/18/16 – 3/16/16

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A 701	Continued From page 104 the recording staff member, and comments. The instruction on the log indicated that the acceptable range in the ORs and sterile rooms was to be 68 degrees F to 75 degrees F. The instructions included, "In the event temperature or humidity readings are out of range, please contact plant engineering and on call administrator immediately." Review of the log showed that on 12/18/15, the temperature from 0:00 to 13:00 ranged from 65.8 degrees F to 70.5 degrees F, and that the humidity ranged from 16.5 to 22.2 percent. However, there were no notations in the "comment" column to indicate that engineering or the administrator were aware, or that any other action was being taken to correct the condition. The log from OR 3 for 12/18/15 was also reviewed, and showed a temperature range of 62.1 degrees F to 66.2 degrees F, and a humidity from 17.2 to 27.9 percent. There was a notation at 0800 that the engineer came by to adjust the thermostat, and another at 1000 that the engineer was aware, but no comments after 1000 to indicate whether the engineer or administrator were being advised of the persistently out of range conditions. In an interview with RN 5 on 12/18/15 at 1450, she stated that the staff should call engineering, but it was not documented. 3.) During a tour of the fourth floor on 12/17/15 beginning at 9 20 a.m. a crash cart was observed by the wall. Closer inspection revealed the defibrillator was plugged into a regular outlet, not a red outlet as required. During interview with the supervisor, LN 10, she stated "Oh, Ill fix that."	A 701	management and infection control staff on how to produce, read and interpret "advanced reports" which display temperature and relative humidity data in numerical value, for all temperature/humidity sensitive locations. Recordings are recorded and viewable via the "advanced report" in 15 minute increments, with the system notifying facilities staff for any prolonged readings out of range. Additionally, the sensors can produce a manual reading "on command" by staff in the sensitive locations. Monitoring is conducted once daily by the Facilities staff through an electronic system. If the temperature and/or humidity is not in range, then corrections are made immediately to bring it back into acceptable ranges. Nursing will document an additional temperature and humidity check prior to each surgical procedure and if out of range, notify engineering immediately. No surgeries will take place in that room while the temperature or humidity is out of range. The "OR Temperature and Humidity Monitoring Sheet" was reviewed and revised to be consistent with the hospital policy for humidity ranges of 30 to 60%. Surgical Services and Engineering staff was re-inserviced on the policy. 3. The Hospital engaged a heating/ventilating company to assess, repair and install controls in air conditioning and heating units. <u>Compliance and Monitoring</u>: The Director of Facilities or designee performs a daily review of the Operating Room and other temperature/humidity sensitive logs to monitor compliance with temperature and humidity within range and/or necessary corrective action taken (including not using a specific operating or procedure room until temperature/humidity is in range). The Director of Facilities reports on compliance at least weekly to Hospital Leadership. Data on compliance is tracked, trended, analyzed and is reported monthly at the EOC Committee. Compliance is reported	3/11/16
A 713	482.41(b)(6) DISPOSAL OF TRASH	A 713		

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A 701	Continued From page 104 the recording staff member, and comments. The instruction on the log indicated that the acceptable range in the ORs and sterile rooms was to be 68 degrees F to 75 degrees F. The instructions included, "In the event temperature or humidity readings are out of range, please contact plant engineering and on call administrator immediately." Review of the log showed that on 12/18/15, the temperature from 0:00 to 13:00 ranged from 65.8 degrees F to 70.5 degrees F, and that the humidity ranged from 16.5 to 22.2 percent. However, there were no notations in the "comment" column to indicate that engineering or the administrator were aware, or that any other action was being taken to correct the condition. The log from OR 3 for 12/18/15 was also reviewed, and showed a temperature range of 62.1 degrees F to 66.2 degrees F, and a humidity from 17.2 to 27.9 percent. There was a notation at 0800 that the engineer came by to adjust the thermostat, and another at 1000 that the engineer was aware, but no comments after 1000 to indicate whether the engineer or administrator were being advised of the persistently out of range conditions. In an interview with RN 5 on 12/18/15 at 1450, she stated that the staff should call engineering, but it was not documented. 3.) During a tour of the fourth floor on 12/17/15 beginning at 9 20 a.m. a crash cart was observed by the wall. Closer inspection revealed the defibrillator was plugged into a regular outlet, not a red outlet as required. During interview with the supervisor, LN 10, she stated "Oh, Ill fix that."	A 701	monthly to the Quality Council (until the Quality Council determines monitoring of the building is sufficiently conducted and then reporting will be provided quarterly to the Quality Council) and quarterly to the Governing Board. Persons Responsible: Vice President of Facilities Development Director of Facilities Finding 3 Immediate Action Taken: 1. The issue of crash cart defibrillators not plugged into a red outlet was discussed. The defibrillators manufacturer's recommendations do not require continuous emergency power sourcing as they have battery back-up capacity for 24-48 hours, however the defibrillator must be plugged into an active outlet at all times during storage (e.g., when not in use) to preserve battery power. The particular defibrillator was plugged into a red outlet during the survey until leadership could meet to determine battery life and the manufacturer's recommendations. Subsequent Action Taken: 1. The "Crash Cart" policy was reviewed and renamed the "Crash Cart Inspection, Maintenance, Exchange" policy. It was revised to clearly state the amount of back-up time of defibrillators and that all defibrillators must be plugged into a power source when not in use and plugged into a red power outlet when there is loss of power and the hospital reverts to generator back-up. The MEC approved the policy on 3/15/16 and the Governing Board on 3/16/16. Education was provided to nursing staff during daily huddles and unit meetings.	12/17/15 3/22/16
A 713	482.41(b)(6) DISPOSAL OF TRASH	A 713		

a

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A 701	Continued From page 104 the recording staff member, and comments. The instruction on the log indicated that the acceptable range in the ORs and sterile rooms was to be 68 degrees F to 75 degrees F. The instructions included, "In the event temperature or humidity readings are out of range, please contact plant engineering and on call administrator immediately." Review of the log showed that on 12/18/15, the temperature from 0:00 to 13:00 ranged from 65.8 degrees F to 70.5 degrees F, and that the humidity ranged from 16.5 to 22.2 percent. However, there were no notations in the "comment" column to indicate that engineering or the administrator were aware, or that any other action was being taken to correct the condition. The log from OR 3 for 12/18/15 was also reviewed, and showed a temperature range of 62.1 degrees F to 66.2 degrees F, and a humidity from 17.2 to 27.9 percent. There was a notation at 0800 that the engineer came by to adjust the thermostat, and another at 1000 that the engineer was aware, but no comments after 1000 to indicate whether the engineer or administrator were being advised of the persistently out of range conditions. In an interview with RN 5 on 12/18/15 at 1450, she stated that the staff should call engineering, but it was not documented. 3.) During a tour of the fourth floor on 12/17/15 beginning at 9 20 a.m. a crash cart was observed by the wall. Closer inspection revealed the defibrillator was plugged into a regular outlet, not a red outlet as required. During interview with the supervisor, LN 10, she stated "Oh, Ill fix that."	A 701	Compliance and Monitoring: Status of the crash cart defibrillator plugged into a power source is checked during weekly observation rounding. Any variances to the policy are remediated with responsible nursing staff educated in one-on-one discussions. Person Responsible: Chief Nursing Officer	
A 713	482.41(b)(6) DISPOSAL OF TRASH	A 713	A 713 482.41(b)(6) Disposal of Trash	

b

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A 713	Continued From page 105 The hospital must have procedures for the proper routine storage and prompt disposal of trash. This Standard is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain the bio-hazardous pharmaceutical waste in a designated area, as evidence by the following: 1. Pharmaceutical bio-hazard bins stored in a public parking lot. 2. Biohazard waste bin overflowing in a utility room. 3. One of two five gallon tubs marked bio-hazard waste was open. These failures have the potential to expose persons in the public to bio-hazardous toxins resulting in negative health outcomes. Findings: 1. During a tour of the facility and concurrent interview with two administrative staff (AS) on 12/14/15 at 4:02 p.m., 5 blue pharmaceutical bio-hazardous incineration bins full of medication waste were observed in a corner of the MRI building public parking lot. The two AS were questioned about the bins in the public parking lot. The two AS agreed those pharmaceutical bio-hazardous bins should not be in the public parking lot. One of the AS moved the bins to the inside of a mobile mini-storage unit but the storage area was not locked. The environmental services director (EVSD) was interviewed on 12/16/15 at 3:05 p.m., he was questioned about the process of managing the facility's pharmaceutical bio-hazardous incineration bins. The EVSD admitted the current process to store and dispose of the bins needs	A 713	Findings 1-3 Immediate Actions: 1. The identified pharmaceutical bio-hazardous incineration bins were removed. 2. The identified biohazard waste bin was replaced. 3. The lids for the gallon tubs biohazardous bins were closed. 4. Hospital Leadership contacted the vendor responsible for regulated waste regarding the survey finding, with emphasis on the organization's expectation for waste in the designated area. Subsequent Actions Taken: 1. Hospital Leadership discussed the findings with clinical staff to make sure that carts are not left outside without notifying environmental services. 2. Hospital Leadership met with the vendor to discuss improving the pickup of sharps and pharmaceutical waste containers. The pickup schedule was increased from once per week to twice per week (Wednesday and Friday). 3. Hospital Leadership reviewed the "Return, Handling, and Disposal of Medical Waste" policy, which did not require any revision. Pharmaceutical waste containers will remain in a designated area once picked up by EVS and will be removed and disposed of by the hospital's designated service. EVS and nursing staff were educated on proper management of biohazardous and pharmaceutical waste in the appropriate waste disposal streams. 4. The EVS duty list was changed to increase and revise patrol parameters, including sharps containers. 5. Monitoring compliance with biohazardous waste is monitored through the EOC Committee and as a routine indicator. Compliance and Monitoring: The Directors of Facilities and EVS or qualified designees perform random rounds at varying	12/24/15 12/15/15 12/16/15 12/30/15 2/3/16 2/10/16 3/22/16 2/8/16

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A 713	Continued From page 106 some improvement. He stated the recycling company personnel are not doing what they should be doing in order for the bins not to sit in the MRI parking lot. He stated "I need to rewrite the process of managing the pharmaceutical bio-hazardous bins and educate my staff." A review of the facility's policy and procedure titled: Return, Handing, and Disposal of Medication Waste, PHA.057, dated 10/2012, indicated "All pharmaceutical waste placed in the regular pharmaceutical waste containers and the RCRA hazadous waste containers will be disposed of through environmental services (EVS)". "The pharmaceutical waste containers... will remain in a designated area once picked up by EVS and will then be removed and disposed of by the hospital's designated services." 2. During a tour of the fourth floor of facility on 12/15/15 at 12:15 p.m., a bin marked biohazard waste was observed in a utility room. The lid was not covering the bin and two large red bags of biohazard waste were hanging out and over the side of the bin. 3. During a tour of the Hollywood facility on 12/17/15 at 12:15 p.m. upon entering a utility room, two five-gallon tubs marked "biohazard waste" were observed on top of a biohazard bin. One of the tubs was open, the lid resting half way off. During an interview with the supervisor of manager of housekeeping at 11:10 a.m., he stated, "These should be closed at all times. I'll	A 713	times at least 3 times per week to achieve the goal of 100% compliance with storing biohazardous waste (including in designated area and kept with lids closed.) Corrective action is taken as necessary. Data on compliance is tracked, trended, analyzed and reported monthly at the EOC Committee and Quality Council. Compliance is reported quarterly to the Governing Board, and is used for performance improvement measures. Persons Responsible: Director of Facilities Director of EVS	

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A 713	Continued From page 107 take care of it. Staff cannot touch these after they are in here."	A 713		
A 724	482.41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This Standard is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain the medication refrigerators (refrigerators used to store medications) to ensure specified temperatures were maintained and laboratory refrigerators to ensure specimens are stored at accurate temperatures. Further the facility failed to secure oxygen tanks in two separate areas of the emergency rooms. As a result, medications that were temperature-sensitive, including but not limited to vaccines, were not stored at the specified temperatures and unsecured oxygen tanks had the potential to cause a serious safety hazard. Findings: 1. During a tour of the Pharmacy at Culver City, on 12/14/15 starting at 12:30 P.M., with the COO, VPP, and TS, the temperature range specified on the Main Rx (pharmacy) refrigerator was "36°F to 46°F or 2.2°C to 7.7°C," according to the Daily Temperature Log Sheet posted on the refrigerator. According to the log, the temperatures were outside of the specified range on: 12/5/15 at 6:40 A.M., the temperature recorded was "2.1"	A 724	A 724 482.41(c)(2) Facilities, Supplies, Equipment Maintenance Finding 1 – 6 Immediate Actions Taken: 1. Executive Leadership discussed the survey findings regarding medication refrigerator monitoring and implementing/documenting corrective action if temperatures are out of range. Subsequent Actions Taken: 1. Medication refrigerators were repaired and/or new ones obtained for those refrigerators with difficulty maintaining consistent temperatures. 2. Pharmacy Leadership reviewed the "Medication Refrigerator Temperature Monitoring" policy, which did not require any revisions. Temperatures are checked and recorded once daily (with twice daily for vaccine containing refrigerators). If an out-of-range temperature occurs, it is documented on the log with actions taken, and temperature recheck. The log was amended to include a column to document actions taken each day for identified issues. Pharmacists and pharmacy technicians were provided with an education binder on medication refrigerator temperature monitoring and documentation on the log with satisfactory completion of a post-test. Nursing staff was also educated. 3. The Hospital ordered additional electronic monitoring devices. 4. The identified lab refrigerator was inspected and outdated urine specimens were discarded. The laboratory policy for urine storage was reviewed and changes were not required. Staff was re-educated on the policy through direct discussions with the Laboratory Director. Specimen refrigerator content is now monitored daily.	12/18/15 3/22/16 1/16/16 -3/22/16 3/8/16 2/3/16

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A 724	Continued From page 108 12/7/15 at 2 P.M., the temperature recorded was "1.9" 12/11/15 at 6:39 A.M., the temperature recorded was "2.1" 12/11/15 at 8:15 P.M., the temperature recorded was "2.0" According to the "Refrigerated Drugs" list, provided by the facility, there were 57 medications, in various quantity, stored in the refrigerator. The list included medications for the heart, anti-infectives, vaccines, insulins, "chemo drugs" [medications to treat cancer], and other medications. 2. During a tour of the Store Room, which was part of the Pharmacy at Culver City, on 12/14/15 starting at 4:23 P.M., with the COO, VPP, and TS, the temperature range specified on the Narc (narcotic) STN (station) refrigerator was "36°F to 46°F," according to the Daily Temperature Log Sheet posted on the refrigerator. According to the log, the temperatures were outside of the specified range on: 12/9/15 at 10:40 A.M., the temperature recorded was "35.3" 12/10/15 at 10:40 A.M., the temperature recorded was "35.1" 12/12/15 at 10:30 P.M., the temperature recorded was "32.9" 3. During a tour of the Telemetry Unit at Culver City, on 12/15/15 starting at 8:13 A.M., with CN 2, and the COO, the medication refrigerator was inspected. 4. During a tour of the Intensive Care Unit (ICU) at Culver City, on 12/15/15 starting at 9:35 A.M.,	A 724	5. Compliance with medication refrigerator temperature recording and instituting corrective action if out of range is monitored through the QAPI program. Compliance and Monitoring: The Director of Pharmacy or qualified designee shall perform weekly reviews (for three months and then re-evaluate) of the temperature logs to achieve the goal of 100% compliance with addressing out-of-range temperatures and documenting corrective action. The Director of Laboratory or qualified designee shall perform daily reviews to achieve the goal of 100% compliance with discarding outdated urine specimens. Corrective action is taken as necessary, including just-in-time training with staff. Data is analyzed and reported monthly to the Medication Safety Committee, Quality Council, MEC, and Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will occur until the Quality Council determines sustained compliance has occurred, at which time the Council will determine what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Persons Responsible: Director of Pharmacy Director of Laboratory	

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A 724	Continued From page 109 with CN 1, COO, and VPP, CN 1 stated the medication refrigerator was leaking and was being removed from the medication room. The maintenance record for the refrigerator was requested. On 12/16/15 at 10 A.M., the maintenance records for all four refrigerators were requested from the VPP. On 12/17/15 at 8:50 A.M., the VPP stated there were no maintenance records for the following refrigerator: Telemetry, ICU, Narc Station. The VPP provided three documents titled, "Preventative Maintenance Work Order" (work order) for the Main Rx fridge, which were completed approximately six months apart. According to the work order, the "Instructions" section specified eight elements were inspected during the maintenance, each with a "Pass" or "Fail" checkbox. The checkboxes were left blank. The "Comments" section indicated "PM [preventative maintenance] PASSED." During an interview with BE 1 on 12/17/15 at 10:10 A.M., in the presence of the VPP, BE 1 stated he had been doing the PM for the Main Rx refrigerator, and described the process as comparing the temperature reading from the thermometer in the medication refrigerator, and his thermometer. If the difference between the two thermometers were within 0.5°C then it was "OK." When asked about the eight elements from the "Instructions" section, BE 1 stated they were not individually checked off on paper or documented because they were all in his head, pointing to his head. When requested to recall the eight elements, BE 1 was not able to do so.	A 724		

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A 724	Continued From page 110 On 12/17/15 at 11:07 A.M., the facility's policy for preventative maintenance of medication refrigerators was requested from the VPP. On 12/17/15 at 11:25 A.M., the VPP stated there was no policy regarding preventative maintenance for medication refrigerators. 5)During a tour of the Laboratory Services and concurrent interview with the laboratory director (LD) and the medical technologist (MedT) on 12/15/15 at 8:40 a.m., a refrigerator (R-2) containing chemistry serum specimens was observed having 2 thermometers inside with temperatures out of range. Temperature range should be 2-8 degrees celsius. According to thermometer 1's reading the temperture was 0 celsius. Thermometer 2's reading was 1 celsius. The LD and MedT were questioned about the temperature discrepancies. The LD stated one of the thermometers was not callbrated. The MedT stated "There is something wrong with the thermometers. I already call Bio-med." The Bio-med person arrived and confirmed refrigerator 2's temperature was 0 to -2 celsius. The LD agreed the refrigerator temperature is out of range and chemistry serum specimens should not be stored inside. Facility's policy and procedure titled: Quality Assurance, Internal for Laboratory Quality Management, dated 2/2012, indicated the objective is "To assure that regulatory guidelines are followed and patient safety is maintained." 6) During the same tour and in the same refrigerator (2) urine specimens that were 5 days old were observed inside the refrigerator. Concurrent interviews with the LD and MedT were held. According to the LD and MedT urine specimens are good and only kept for 24 hours then specimens are discarded. LD agreed the	A 724		

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A 724	Continued From page 111 urine specimens should have been discarded after 24 hours. He did not know what had happened or why the specimens were not discarded. Facility's policy and procedure titled: Routine Urinalysis, HEM .308, dated 10/2015, section 4.3.1 Specimen, indicates "The specimen should be kept refrigerated and good for 24 hours." 7) During a tour of the emergency room on 12/14/15 at 10:45 a.m., the "soiled utility room" housed patient belongings and three small portable oxygen tanks that were not secured but standing upright against the side of the wall. During an interview with LN13 on 12/14/15 at 10:45 a.m., LN13 stated , "They (Oxygen tanks) shouldn't be there, they should be secured." During a tour of the psychiatric emergency room "overflow" area, in the room unlabeled but identified by DIR1 as the "utility space," contained current patient belongings, donated belongings, clean linen and a refrigerator. Sitting to the left of the refrigerator unsecured were two small oxygen tanks with oxygen unlabeled tubing and unlabeled unbagged masks attached, one small unsecured oxygen tank was located behind three large empty water bottles. During a concurrent interview with the DIR1 she stated, "Respiratory should have taken those masks off and secured the tanks, because some of those tanks would be difficult to get to." A review of facility policy titled "Oxygen Safety" dated, 02/2011 revised date of 11/2012 under heading "Policy" 4.2.2. "5. In the storage room, oxygen cylinders should be secured, preventing against tipping over."	A 724	Finding 7 Immediate Actions Taken: 1. The oxygen tanks were secured. 12/14/15 Subsequent Actions Taken: 1. Hospital Leadership reviewed the "Oxygen Safety" policy, which details that oxygen cylinders are to be secured so as to prevent tipping over. The policy did not require any revision. Respiratory therapy and nursing staff were reinserviced on the policy, with special emphasis on securing oxygen tanks. 1/25/16 2. Respiratory therapists shall round daily on all departments where oxygen is stored to ensure tanks contain sufficient oxygen and are properly secured. 1/26/16 Compliance and Monitoring: The Director of Respiratory Therapy or qualified designee shall perform random weekly observation rounds (for three months and then re-evaluate) to achieve the goal of 100% compliance with securing oxygen tanks. Corrective action is taken as necessary, including 1:1 training and securing the oxygen tank. Data is analyzed and reported monthly to the Quality Council, MEC and Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will occur until the Quality Council determines sustained compliance has occurred, at which time the Council will determine what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator).. Person Responsible: Director of Respiratory Therapy	
A 747	482.42 INFECTION CONTROL	A 747	A 747 482.42 Infection Control	

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A 747	Continued From page 112 The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases. This Condition is not met as evidenced by: Based on observation, interview, and document review, the hospital failed to ensure an effective, active system wide infection surveillance control program for prevention, control, and investigation of infections and communicable diseases. The infection control program did not meet the needs of all patients receiving care in the hospital as evidenced by, Facility failed to: 1. Provide active surveillance to identify policies and procedures that are not implemented correctly in an active infection control program. (Refer to A-0749 2. Ensure sanitary condition of the Operating Room Suites Environment.(Refer to A-0749) a. Failed to provide effective monitoring to ensure staff was trained and competent to effectively sterilize hinged surgical instruments (refer to A- 0749) b. Failed to provide for and monitor material covering operating room equipment, (i.e. patient gurney, arm board; failed to maintained in a condition that would permit the equipment to be disinfected).(Refer to A749) 3. Ensure the sterility of Surgical instruments and sterile supplies. (Refer to A-0749) a. Failed to provide effective monitoring of sterile supplies and sterile surgical instrument storage room. (Refer to A-0749)	A 747	The Hospital assures that it has a comprehensive infection control program that provides for the prevention, control and investigation of infections and communicable diseases. A sanitary environment is maintained to avoid sources and transmission of infection. Hospital Leadership and the Director of Infection Control reviewed the survey findings and worked collaboratively to address the identified issues as discussed below. Governance approved of changes to the infection control and prevention program and plan. An evaluation of the 2015 infection control and prevention risk assessment was conducted by an APIC certified infection control practitioner (CIC) specialist engaged by the hospital to analyze gaps in the existing infection control program and assist with remediation of vulnerabilities within the program. From the 2016 risk assessment and analysis of the Infection Control program, the hospital-wide infection control program and plan for 2016 was developed. This new program and plan addresses core practices and infection prevention techniques necessary to minimize the risk of spread of infection and contagious disease throughout the organization. The plan was approved at the Infection Control Committee on 3/10/16, the MEC on 3/15/16 and Governing Board on 3/16/16. Additionally, Executive Leadership hired a seasoned full-time Infection Control Preventionist to oversee and deploy the new Infection Control and Prevention Program. Implementation of a structured rounding surveillance process was implemented. Infection Control practices were reviewed regarding maintenance of a sanitary environment and prevention of transmission of infectious and communicable diseases. Education on infection control has been and continues to be provided to staff on a variety of topics, including maintaining sterility of equipment and instruments in the surgical and procedural environment. Audit tools were	3/16/16

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A 747	Continued From page 113 b. Failed to ensure Sterile supplies were maintained in accordance with facility policy regarding event-related sterility standard (Refer to A-A-0749) The cumulative effects of these systemic problems resulted in the hospital's inability to provide an effective hospital wide infection control program; care in a safe and effective manner in accordance with the Condition of Participation for Infection Control Services. Thus, resulting in the facilities inability to provide patient care in a safe and effective manner as agreed in accordance with the Condition of Participation for Infection Control Services. The seriousness of which, resulted in an immediate Jeopardy identified by the survey team.	A 747	developed and/or revised to ensure that identified issues are being monitored. Implementation of a structured rounding surveillance process, including a daily rounding schedule, was implemented on 3/7/16. The Director of Infection Control or qualified designee attends EOC rounds focusing on infection prevention and infection control practices. Data on compliance with infection control practices is monitored through the QAPI program and the Infection Control Committee.	
A 749	482.42(a)(1) INFECTION CONTROL PROGRAM The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. This Standard is not met as evidenced by: Based on observation, interview and document review, the hospital failed to ensure that the policy regarding influenza vaccination was followed, and did not ensure that one medical staff member brought surgical instruments in advance for sterile processing prior to a procedure, creating the increased risk of the spread of infection. Further, the hospital failed to provide a functional and sanitary environment for the provision of surgical services, in order that the types of surgery conducted can be performed in a manner that protects lives and assures the physical safety of all individuals presented for surgery and the	A 749	A 749 482.42(a)(1) Infection Control Program	

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A 749	Continued From page 114 community in the event of an emergency need for surgery. The facility failed to ensure competent staff trained on job/duty specific current national recognized standards and facility policies regarding sterile processing of surgical instruments, the storage of sterile supplies and area specific, facility adopted infection control national recognized standards. Consequently, the facility failed to ensure: 1. Staff is trained and competent to effectively maintain sterile surgical instruments, storage and the environment of care for the decontamination area according to nationally recognized standards and facility policy. a. Failed to ensure restricted areas and traffic patterns in procedure areas are identified and maintained in accordance with nationally accepted standards of practice. 1.Traffic through the pass of decontamination to Sterile Storage is monitored for cross contamination. PPE is not changed and Hand Hygiene is not observed allowing for cross contamination. 2.The cleanliness of the area known as the Decontamination room. 3.The facility staff members were trained and competent to ensure surgical 2. The facility staff members were trained and competent to ensure surgical instruments are effectively decontaminated to ensure the sterility process: The facility failed to ensure: a. Decontamination room maintained in accordance with nationally recognized standards	A 749	Findings 1-4 Immediate Actions Taken: 1. Executive Leadership met immediately following survey and determined an additional infection control practitioner was needed. 2. 100% of instruments were inspected, with any affected instruments either refurbished or discarded and replaced. All instruments were reprocessed following staff re-education on sterilization. Subsequent Actions Taken: 1. Hospital Leadership and the Director of Infection Control reviewed and revised the Infection Control Plan and Program. An evaluation of the 2015 infection control and prevention risk assessment was conducted by an APIC certified infection control practitioner (CIC) specialist engaged by the hospital to analyze gaps in the existing infection control program and assist with remediation of vulnerabilities within the program. From the 2016 risk assessment and analysis of the Infection Control program, the hospital-wide infection control program and plan for 2016 was developed. This new program and plan addresses core practices and infection prevention techniques necessary to minimize the risk of spread of infection and contagious disease throughout the organization. The plan was approved at the Infection Control Committee on 3/10/16, the MEC on 3/15/16 and Governing Board on 3/16/16. 2. The Director of Infection Control and the OR Director conducted extensive education with OR and sterile processing staff regarding a) proper cleaning, sterilization and maintaining sterile surgical instruments/storage and environment of care; b) traffic patterns; and c) use of PPE. 3. The Decontamination Room is on a schedule to be terminally cleaned during usual days of operations. A checklist was developed to ensure compliance with terminal cleaning. EVS	12/18/15 12/18/15 3/16/16 2/16/16 3/22/16

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A 749	Continued From page 115 adopted by the facility and the facilities policies. b. Protect the clean items and detergents for the washers from debris. c. Surgical instruments not reprocessed in accordance with nationally recognized standards. 3. Staff is trained and competent to effectively disinfect the sub sterile and sterile core environment. a. Failed to ensure restricted areas and traffic patterns in procedure areas are identified and maintained in accordance with nationally accepted standards of practice. 1.Prevent cross contamination of the area in restrictive and semi restrictive area 2.Staff members were trained and competent to ensure the sub- sterile decontamination room environment is effectively disinfected. On 12/14/2015 at 12:20 P.M., in an interview ICP and SPTECH 1 staff could not verbalize the facilities policy for Event-Related Sterility. ICP and the SPTECH1 indicated they were not sure what quality assurance policy the facility followed to ensure sterility of instrument and sterile supplies. On 12/14/2015 at 1:00 P.M. an observation of processed sterile instruments indicated the instruments were not maintained in a manner consistent with the facilities policy titled " storage of sterile supplies and sterile instruments ". In a subsequent interview the ICP acknowledged the maintained condition of the supplies were not consistent with hospital policy. The ICP stated she is not aware of the term, " Event Related Sterility. " However, in a subsequent review of the facilities policy and procedure the ICP and the CNO acknowledged the facility followed, " Event Related Sterility " when processing and storing	A 749	staff were re-inserviced on terminal cleaning and the checklist. 4. Central sterile processing staff was educated about proper placement of items for cleaning and proper sterilization of instruments and other requirements of sound decontamination practices pursuant to AORN and AAMI ST79 recommendations. 5. To remediate spotting/discoloration of instruments with potential for non-sterility, the following steps were taken: A detailed water analysis for water used for sterilization processes was obtained, a steam quality analysis was performed and new filters for deionized water supply to washer-disinfector were installed. It was determined the discoloration with steam may occur, however the instruments remain sterile. 6. Daily surveillance rounding in all areas of the OR and Sterile Processing Department are conducted by the Director of Infection Control and/or the OR Director or qualified designee. In addition, the Director of Infection Control developed a surveillance tool for the OR Charge Nurse to utilize in making rounds. Compliance and Monitoring: The Director of the Infection Control Department and department personnel or qualified designees conduct observations daily with remediation to staff in real time. Data is aggregated and reported monthly to the Infection Control Committee Chairperson, with this data integrated into the hospital-wide Quality Council. Compliance is reported to the MEC and Governing Board monthly. Person Responsible: Director of Infection Control	3/16/16 2/16/16 3/1/16

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A 749	Continued From page 116 sterile surgical instruments. The ICP and CNO further acknowledged the Sterile Surgical Instruments and the Sterile Supplies were not maintained consistent with the facilities policy. On 12/14/2015 at 1:45 P.M. with SPTech 1, CNO, ICP observed surgical trays packed inconsistent with Association of PeriOperative Registered Nurse (AORN) Standards all staff indicated they follow AORN standards. Observed: four (4) Processed sterile surgical instruments in rigid trays. Open and inspected: 2 laminectomy tray (instruments used for surgery on the back) also known as a Major Tray ready for transport to the operating room . Assembled in tray 1: · A stringer (typically, approximately a foot long 3 rod type device to assist with the positioning of instruments for sterilizing, o 2 large instruments (approximately 12 inches with each handle approx. 2 inch wide) known as a retractor; stacked flat and inconsistent with standards. § Each retractor observed with discoloration spots and film build-up. o 10 instruments observed wrapped in an absorbent towel and stacked on top of each other. § 10 out of 10 wrapped instruments observed with discoloration spots and bio-film. · One (1) complete set of approximately 50 hinged instruments observed to have different combination of reddish, yellow, black color substance on the instruments. o 36 of the 50 instruments observed with discoloration and heavily covered with substance and debris in the joints of the hinged instruments. o 50 of 50 instruments covered with discoloration and bio film.	A 749		

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A 749	Continued From page 117 § Each subsequent tray opened was observed to be in similar condition to the previous open package with reddish color debris and stains in the joints of the hinged instruments. In a subsequent observation on 12/14/15 at 2:00 P.M, two smaller trays referred to as " Plastics " (instruments utilized for fine surgeries such as the hand) and identified as a minor tray was opened by SPTech1and revealed hinged instruments on a stringer in similar condition to the previous open packages with reddish color debris and stains in the joints of the hinged instruments. Thus, four out of four trays were packed inconsistent with facility policy following the National Recognized Standards to ensure the sterility of instruments. In an interview with ICP and SPTECH1 they agreed this is the typical condition of the instruments. Both staff members acknowledge they were not aware of the facilities policy and procedure for packing surgical instruments for sterilization. Policy and procedures for sterile processing of instruments were requested and not received by exit date. On 12/14/2015 at 2:25 P.M, an interview with the ICP and CNO indicated all instruments are in the same condition as the ones viewed today. When asked if the condition of instruments identified with the discolorations were considered ready for the surgeon. The CNO stated, " We need to do something to replace them. " The ICP further acknowledged the facility does not currently have a process for quality assurance surveillance for facility-wide Infection Control program and specifically event related sterility policy. On 12/14/2015 at 4:30 P.M., a subsequent review	A 749		

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A 749	Continued From page 118 of records with SP TECH 1, revealed Association of PeriOperative Registered Nurse (AORN) Standards and Recommended Practices, 2013 edition. Standard adopted by the facility and in the absence of a facility policy. Recommended Practices for Cleaning and Care of Surgical Instruments and Powered Equipment reviewed. Under Recommendation XII, the following information was provided: " Cleaned surgical instruments should be organized for packaging in a manner to allow the sterilant to contact all exposed surfaces. Proper organization will facilitate sterilant contact on all surfaces and adequate drying. During a concurrent interview with the ICP and the SPTECH 1 they acknowledged the tray as assembled, failed to follow the facility standard to ensure sterility as per the National Recognized Standards the facility adopted. A facility policy and procedure was requested at the time of exit; a copy was not provided. On 12/15/2015 during a tour at 10:05 AM, a tour of the restricted and semi restricted areas was conducted with the ICP1, ICPC, and the CNO. Observation 1: observation of staff passing back and forth to the restricted area of the decontamination room of the SPU over to the restricted sterile side of the SPU was made. SP TECH 1 was observed to cross over from side to side of the units failing to practice hand hygiene per facility policy and Association of PeriOperative Register Nurses (AORN) standards. AORN is the national recognized standards identified by the ICP as the standard adopted by the facility for the policy regarding attire in restricted and semi-restricted areas. In a subsequent interview, SP TECH 1 indicated	A 749		

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A 749	Continued From page 119 that He was " ok " because the unit was not actively processing instruments at the current time. Observation 2: ICP, ICPC and the CNO, SP TECH 1and SP TECH 2 did not utilize clean PPE and therefore wore the same scrubs back and forth between the decontamination room and the sterile storage room. In a subsequent interview, SP TECH1 verbalized that visitors in the Sterile Processing room and decontamination room did not need to wear PPE unless active instrument processing was in progress. After prompting, in a concurrent interview, the ICP 1 and CNO indicated they did not know the standard or policy. However, ICP felt that PPE was probably needed and escorted the survey team down the hall through a semi-restricted area into the restricted OR hallway to retrieve PPE to wear in the sterile Processing unit. One team member Donned scrubs supplied and 2 team members carried the disposable overalls as directed by the ICP. Subsequently, the team retraced steps as they were escorted back through the Restricted and Semi-Restricted hallway and into the open to visitor accessed hallways to the sterile processing unit. At this point the team Donned the PPE before continuing further into the sterile processing unit. In review of policy and procedures, SP TECH 1 stated, " I have policies somewhere. " SP TECH 1 indicated he does not remember the last time he reviewed them. SP TECH 1 indicated that he did not receive on-going job specific infection control education. On 12/15 /2015 at 10:30 A.M., In a concurrent observation and interview ICP revealed the expectation of the staff is to return to the OR restricted area to retrieve PPE each	A 749		

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A 749	Continued From page 120 time employees require PPE to enter Sterile Processing. The CNO and ICP acknowledged the lack of signage indicating restricted and semi-restricted area. Both acknowledged the lack of appropriate PPE (Personal Protected Equipment) in the Sterile Processing room and agreed PPE was not readily available. In a concurrent observation and interview the ICP acknowledged all personnel are not to enter the sterile room without proper hand hygiene and PPE (Personal Protected Equipment). 4 out of 6 random opportunities for observation revealed staff members did not utilize the hand hygiene products. The ICP indicated this was an opportunity for improvement. Review of documentation: Review of The Perioperative Standards and Recommended Practices published by the AORN (Association of perioperative Registered Nurses), 2014 edition indicated "Traffic patterns should be designed to facilitate movement of patients and personnel into, though, and out of defined areas within the surgical suite. Signs should clearly indicate the appropriate environmental controls and surgical attire required. The semi-restricted area includes the peripheral support areas of the surgical suite. It has storage areas for clean and sterile supplies, work areas for storage and processing of instruments, scrub sink areas, and corridors leading to the restricted areas of the surgical suite. Traffic in this area is limited to authorized personnel and patients. The restricted area includes operating rooms, procedure rooms, and the clean core area. " On 12/15/2014 at 10:00 A.M., during a tour on 2 occasions for random opportunity for observation	A 749		

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A 749	Continued From page 121 the Wet time (amount of time a disinfectant must stay wet on the surface of the item being disinfected) In practice was observed: 2 out of 3 employees in the sterile and sub sterile core area did not observe and/or verbalize the wet time per the manufactures instructions and nationally recognized standards. Observed were the SPTECH1 SPTECH2 and SPTECH C. On 12/17/2015 at 4:45 P.M., In a subsequent interview with ICP, the ICPC indicated that staff in the above documented observation did not follow the AORN standards or facility policies. ICP2 acknowledged the lack of understanding by the staff regarding the " wet time " , proper PPE and proper environmental care of the decontamination room. AORN) Recommendation IV Instruments should be kept free of gross soil during surgical procedures. Blood and body fluids can cause pitting of instruments and, if left to dry, can be difficult to remove. If blood and body fluids are not removed, they can prevent adequate sterilization, which could be an avenue for transmission of other potentially infectious materials. IV.a. Instruments should be wiped as needed with sterile surgical sponges moistened with sterile water during the procedure to remove gross soil. Blood and body fluids, as well as saline, are highly corrosive. Corrosion, rusting, and pitting occur when saline, blood, and debris are allowed to dry in or on surgical instruments. Dried blood and debris can be difficult, if not impossible, to remove from all surfaces during the decontamination process; therefore, subsequent disinfection or sterilization may not be achieved.	A 749		

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A 749	Continued From page 122 AORN, Recommended Practices for Cleaning and Care of Surgical Instruments and Powered Equipment, 2013: . Instruments should be inspected for ...corrosion, pitting, burrs, nicks, and cracks ...wear and chipping of ...plated surfaces damage[d] protective surfaces of instruments, contribute to corrosion, impede sterilization surface corrosion damage ...can inhibit sterilization Spotting, Staining, and Corrosion of Surgical Instruments Surgical Instrument Herbert J. Kaiser, PhD; Patrick Schwab, MBA; Jason F. Tirey, MA. (October 1, 2000). Spotting, Staining, and Corrosion of Surgical Instruments. Infection Control Today. Retrieved from: <http://www.infectioncontroltoday.com/articles/2000/10/spotting-staining-and-corrosion-of-surgical-instr.aspx> spotting, staining, and corrosion are serious problems in many healthcare facilities ... Spotting, staining, and corrosion of surgical instruments can impair their function ... Spotting, staining, and corrosion also interfere with sterilization. Spores can be protected from destruction by the layers of iron oxide (rust). Corrosion can result in a shortened instrument life, which results in increased cost. Stainless Steel It is important to remember that stainless steel means stainless steel, not stain-proof steel. All types of stainless steel will eventually become corroded and stained. Also, while a surface of an instrument may look bright and shiny to the naked eye, under microscopic examination the surface is actually very rough. The rough surface allows for entrapment of impurities from soils and water ....Spotting lies loosely on the surface. Staining is integral with the surface. Corrosion penetrates	A 749		

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A 749	Continued From page 123 the surface... Stainless steel is indeed reactive, meaning that it will corrode and become stained under certain conditions. (AORN) Recommendation IV Items to be sterilized should be packaged in a manner that facilitates sterilization and provides for an aseptic presentation of the package contents. ...Incorrect packaging may prevent sterilization from occurring. Inappropriate handling can lead to loss of package integrity. Incorrect packaging can make aseptic delivery of the contents to the sterile field difficult or impossible. IV.c. Items to be sterilized should be positioned within packages to allow sterilant contact with all surfaces.3 [3: Limited Evidence] Sterilant contact is necessary for sterilization to be achieved. IV.e. Instruments composed of more than one part that can be disassembled should be disassembled unless the manufacturer ' s written and validated IFU specifies that disassembly is not required.3 [3: Limited Evidence] Sterilization of assembled instruments can prevent exposure of some areas of the device to the sterilant.3 IV.f. Items to be sterilized that have concave or convex surfaces that create potential for water retention should be positioned within packages in a manner that prevents those surfaces from retaining water.3,4 [1: Strong Evidence] Preventing water retention can help avoid the occurrence of wet packs and sterilization failure. IV.g. Towels placed within instrument sets should be lint-free, freshly laundered, and thoroughly rinsed by a health care-accredited laundry facility. [3: Limited Evidence] Adequate rinsing reduces the risk of leaving	A 749		

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A 749	Continued From page 124 chemical residues that could be transferred from the towels to instruments.28 Lint left on sterile instruments may be transferred to the surgical wound and may cause a foreign-body reaction. IV.h. Items to be sterilized should be placed in the package or tray in an open or unlocked position. [3: Limited Evidence] AORN Standards - Recommended Practices for Selection and Use of Packaging Systems for Sterilization: " Sterilized packages should be considered sterile until an event occurs to compromise the package barrier integrity. Health care organizations should determine the best methods and materials for packaging sterile items, based upon the anticipated storage, handling, and environmental events that may be encountered: Loss of sterility of a packaged sterile item is event related. An event must occur to compromise package content sterility. Events that may affect the sterility of a package include, but are not limited to: · multiple handling that leads to seal breakage or loss of package integrity · compression during storage · moisture penetration · exposure to airborne and other environmental contaminants · storage conditions (eg, type of shelving, cleanliness, temperature, humidity, traffic control) · type and configuration of packaging materials used · use of sterility maintenance covers and method of sealing Sterile packages should be stored under environmentally controlled conditions. Sterile storage area temperature should be controlled and should not exceed 75°F (24°C). The humidity should not exceed 70. There should be a	A 749		

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A 749	Continued From page 125 minimum of four air exchanges per hour, and the air flow should be under positive pressure in relation to adjacent areas. Findings: 4. During an observation in the surgical corridor on 12/14/15 at 1230 p.m., a physician in scrub attire, MD9, was observed handing two large blue-wrapped trays to RN 7 at the desk. He told RN 7 that the trays were "already sterile". In an interview with RN 7 at 1231 p.m., she stated that the trays were for a surgery scheduled for 1230, and that she was not sure why the surgeon brought them in right now. She stated the trays contained special retractors. She was asked to show on the surgical log which surgery they were for, and indicated that they were for a knee surgery scheduled for Patient 501 in OR 4. In an interview on 12/14/15 at 1235p.m., with OR TECH 2 in OR 4, he stated that MD9 often brought his own instruments, such as a rondeur and handle. The surgeon failed to bring instruments in a sufficient time prior to the surgery to allow for sterile processing of the instruments. 5. Employee health policies and procedures did not follow the facility adopted, nationally recognized CDC guidelines for immunizations of health care workers that state: · "Healthcare workers include physicians, nurses, emergency medical personnel, dental professionals and students, medical and nursing students, laboratory technicians, pharmacists, hospital volunteers, and administrative staff ". · " (...recommends that health care providers receive vaccinations for diseases for which routine vaccination or documentation of immunity is recommended because of risks in the workplace (i.e. hepatitis B, seasonal influenza, measles, mumps, rubella, pertussis, and varicella) "	A 749	Finding 5 Immediate Actions Taken: 1. Executive Leadership discussed the survey findings and available staff resources. Subsequent Actions Taken: 1. Hospital Leadership and the Director of Infection Control reviewed and revised the "Facility-wide Influenza Plan (seasonal)" and "Respiratory Etiquette and Mandatory Facility-wide Vaccination" and "Mask Use" policies to include the distribution of a colored badge signifying the staff member or LIP has received the influenza vaccine for the current season. The color of this badge will change annually. The policies were approved by the Infection Prevention Committee in an Ad-hoc meeting 2/29/16, MEC on 3/15/16 and Governing Board on 3/16/16. 2. The Hospital hired an Infection Control Practitioner. 3. The Infection Control Committee reviewed the process for TB testing of medical staff members and an analysis of current community standard was conducted. The process for TB testing coinciding with the two year reappointment cycle was implemented on 2/29/2016. This information will be monitored and required for reappointment to the medical staff. 4. The Infection Control Committee reviewed the process for MMR vaccination and an analysis of current community standard for medical staff members was conducted. The vaccination status is tracked for employees through the HR department. Community standard does not support the documentation of MMR vaccination status for medical staff members in the absence of an exposure or other validated need. Community standard is followed for medical staff members.	12/29/15 3/16/16 2/8/16 2/29/16 2/29/16

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A 749	Continued From page 126 " Healthcare personnel should receive a single dose of Tdap (a vaccine that includes tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis, that prevents the diseases of Diphtheria, Tetanus and Whooping Cough) as soon as feasible upon hire if they have not been vaccinated previously " . " Healthcare organizations should review health care provider vaccination and immunity status at the time of hire and at least annually thereafter " . In an interview with the ICP 1 on 12/16/15 at 1200 p.m., she stated that the stickers were distributed by the medical staff office or by employee health to put on hospital name badges to indicate influenza immunization. She stated that some physicians use different badges, which are harder to check. She stated the expectation was that the staff member would wear a mask until documentation of vaccination was submitted, and that the medical staff were informed of the mandatory mask or immunization policy. In an interview, conducted in a hospital conference room, with the IP Epidemiologist HW on 12/18/15 at 1150, he wore a hospital identification badge with his name, but no sticker to show that he was immunized against influenza. He stated that he had been vaccinated, but did not have the sticker to display because the person responsible for handing them out did not have them to give. During a concurrent interview with IP Staff HW, he stated that he had not had the influenza vaccine, and there was no sticker affixed to his identification badge. Neither staff member was wearing a mask. In an interview with the QA Staff HW on 12/18/15 at 1200 p.m., she stated that people who were vaccinated elsewhere did not have stickers on their badges as the hospital ran out of stickers to	A 749	Compliance and Monitoring Process: The Director of Infection Control will create a database to capture and electronically monitor appropriate vaccinations as required. Person Responsible: Director of Infection Control	

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A 749	Continued From page 127 give. During an observation in the surgical corridor on 12/14/15 at 1230p.m., a physician in scrub attire, MD9, was observed not wearing a mask. During a review on 12/15/15 of the credential and health files of MDs 6, 7, 8, 9, 10, 11 and CRNA 1, the files did not contain information about influenza vaccination or declination. In an interview with the Dir MS Services on 12/15/15 at 0750 a.m., she stated that there was no influenza vaccine information in the files, and that the medical staff had been sent a letter in October about the necessity for providing vaccination information. She stated that the medical staff office sent out the letter and should track the influenza vaccination documentation. In an observation at the VN facility on 12/17/15 at 1255, VN LVN had a badge with no sticker, and was not wearing a mask. In a concurrent interview with VN LVN, she stated that she did not put the sticker on her badge, but had been vaccinated. During a review on 12/15/15 of the credential and health files of MDs 6, 7, 8, 9, 10, 11, and CRNA 1, the files did not contain information about vaccination status for measles, mumps, rubella or hepatitis B. In an interview with the Dir MS Services on 12/15/15 at 0750 a.m., she stated that physician health screening information was maintained by the infection prevention program. In an interview with the ICP 1 on 12/16/15 at 1200 p.m., she stated that all hospital employees were required to present measles, mumps and rubella documentation on hire; but that measles, mumps and rubella were not being tracked for the medical staff as further health information was not required for them. During a review on 12/15/15 of the credential and health file of MD9 the file did not contain evidence	A 749		

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A 749	Continued From page 128 of tuberculosis screening. The file showed that the physician had been reappointed 4/24/14, and that there was a letter from the infection prevention department indicating that it had no concerns about the physician. During a review on 12/16/15 of the credential and health file of MD6, the file contained a TB skin test from 3/12/13, but not thereafter. The physician was reappointed on 1/29/14. In an interview with the Dir MS Services on 12/15/15 at 1:00p.m., she stated that there was no TB skin test in the file for MD9, and that there should have been a subsequent test in the file of MD6. In an interview with the ICP 1 on 12/16/15 at 1200 p.m., she stated that she was not aware of medical staff members without current tuberculosis verification. She stated that she did not check to see if the verification of tuberculosis status was done. In an interview with the ICP 1 on 12/16/15 at 1200 p.m., she stated that there was routine follow-up of NHSN designated procedures for possible surgical site infections through readmissions, culture review, staff reporting and notifications from other facilities. She stated that there was no system for contacting physicians for surveillance, there was no outpatient surgery clinic, and no outpatient clinical records were reviewed to identify infections. She stated that the process for identifying readmissions was a work in progress. She stated that there was no routine follow-up of surgical site infections that were not NHSN reportable infections.	A 749		
A 820	482.43(c)(3), (5) IMPLEMENTATION OF A DISCHARGE PLAN (3) The hospital must arrange for the initial implementation of the patient's discharge plan.	A 820	A 820 482.43(c)(3),(5) Implementation of a Discharge Plan Immediate Actions Taken: 1. Hospital Leadership discussed the survey findings and the process for discharge planning.	12/29/15

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A 820	Continued From page 129 (5) As needed, the patient and family members or interested persons must be counseled to prepare them for post-hospital care. This Standard is not met as evidenced by: Based on record review and interview the facility failed to arrange for initial implementation of hospice care for Patient N105, per patient N105's responsible party (family) requests. This failure created the potential for Patient N105's hospice care not to be initiated. Findings: A review of Patient N105's clinical record on 12/12/15, revealed that Patient N105 was admitted on 12/11/15 from a skilled nursing facility with a diagnoses to include failure to thrive, poor oral intake and dehydration. Review of MD7's progress note dated 12/11/15 indicated in part, "The family states, after a few days of IV fluids we will put her on hospice care... To start hospice care when she returns to the SNF (skilled nursing care)." A review of the "discharge planning record" dated 12/12/15 authored by adm2 under section: "discharge goal plan" the entry was "Return to same level of care." A review of the entire discharge planning document failed to indicate the patient and family's desire to change the level of care from skilled nursing level to hospice care. During a concurrent review of the discharge planning document and interview with LN2 on 12/12/15, at 9:15 a.m., LN 2 was unable to locate any discharge planning in the clinical record (other than the MD note) to indicate the desire of the patient and family to change to hospice care.	A 820	Subsequent Actions Taken: 1. The "Discharge Planning" policy was reviewed and revised to more fully align with the process for discharge planning. The MEC approved the policy on 3/15/16 and the Governing Board on 3/16/16. Case Managers, Discharge Planners and Social Workers were educated. 2. Daily team meetings with Case Managers, Discharge Planners and Social Workers are conducted Monday through Friday. Compliance and Monitoring: A performance improvement indicator was developed to monitor compliance with discharge planning. Data will be tracked, trended, analyzed, and reported monthly to the Quality Council, MEC and Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will occur until the Quality Council determines sustained compliance has occurred, at which time the Council will determine what adjustments to monitoring are necessary for ongoing sustainability. Person Responsible: Director of Case Management	3/22/16
A 891	482.45(a)(5) STAFF EDUCATION Ensure that the hospital works cooperatively with the designated OPO, tissue bank and eye bank in	A 891	A 891 482.45(a)(5) Staff Education	

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A 891	Continued From page 130 educating staff on donation issues; This Standard is not met as evidenced by: Based on observation, interview, and record review, the facility failed to develop a staff education/training program in cooperation with the designated Organ Procurement Organization (OPO). Findings: During a tour of the CCU on 12/15/15 from 10:00 a.m. to 12:00 p.m., two CCU LNs were asked randomly regarding the organ procurement process in the unit. LNs knowledge regarding the process was minimal. The CCU charge nurse (CCUCN) was interviewed on 12/16/15 at 10:50 a.m., and questioned regarding the organ procurement process in the CCU. The CCUCN was unclear of the entire process. An interview was held with the facility's nursing supervisor (FNS) on 12/16/15 at 2:40 p.m. The FNS was unclear about the OPO process, she wasn't aware of the mode for identifying potential organ donor canditates, or who can declare the patient dead. The FSN was unaware of the medical staff to contact if needed, and didn't know about the education/training of patient care staff. FSN stated "I'm not sure about the whole process. I dont' know". The facility's medical director was nearby during the FNS interview and stated if the OPO can provide staff education, then the designated OPO will be contacted to provide the facility's staff education.	A 891	Immediate Action Taken: 1. Executive Leadership met to discuss the survey findings and additional education for nursing staff on organ procurement practices. Subsequent Actions Taken: 1. Hospital Leadership added the OPO education to nursing orientation upon hire and annually to ensure ongoing knowledge and compliance. 2. One Legacy provided additional education to Nursing Leadership and management staff. 3. The CEO sent a "Message from CEO" memo to nursing staff on 2/19/16 regarding tissue and organ donation. This issue was also discussed during daily nursing huddles. Person Responsible: Chief Nursing Officer	12/2915 1/18/16 3/9/16 3/22/16

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A 891	Continued From page 131 An interview was held with the vice president of quality (VPA) on 12/17/15 at 10:03 a.m., the VPA confirmed the facility had not provided any education or training to staff regarding the OPO or process.	A 891		
A1001	482.52(a), (c) ORGANIZATION OF ANESTHESIA SERVICES The organization of anesthesia services must be appropriate to the scope of the services offered. Anesthesia must be administered only by: (1) A qualified anesthesiologist; (2) A doctor of medicine or osteopathy (other than an anesthesiologist); (3) A dentist, oral surgeon, or podiatrist who is qualified to administer anesthesia under State law; (4) A certified registered nurse anesthetist (CRNA), as defined in §410.69(b) of this chapter, who, unless exempted in accordance with paragraph (c) of this section, is under the supervision of the operating practitioner or of an anesthesiologist who is immediately available if needed; or (5) An anesthesiologist's assistant, as defined in Sec. 410.69(b) of this chapter, who is under the supervision of an anesthesiologist who is immediately available if needed. State Exemption (1) A hospital may be exempted from the requirement for MD/DO supervision of CRNAs as described in paragraph (a)(4) of this section, if the State in which the hospital is located submits a letter to CMS signed by the Governor, following consultation with the State's Boards of Medicine and Nursing, requesting exemption from MD/DO supervision of CRNAs. The letter from the Governor must attest that he or she has consulted with State Boards of Medicine and	A1001	A 1001 482.52(a),(c) Organization of Anesthesia Services Immediate Actions Taken: 1. Executive Leadership met to discuss the survey findings. It was determined deep sedation would be provided in the Emergency Department only by Anesthesia providers and ED physician would use only narcotic agents for moderate sedation until ED physicians could be privileged for deep sedation. Subsequent Actions Taken: 1. Hospital and Physician Leadership reviewed and revised the policy entitled "Deep Sedation Non Anesthesiologists," which details the use of deep sedation by non-anesthesia providers. The policy was approved by the Director of Anesthesia with agreement from the Director of Emergency Services via an ad-hoc committee meeting on 1/29/16, the Surgery Committee on 3/7/16, Medicine Committee on 3/8/16, MEC on 3/15/16 and Governing Board on 3/16/16. 2. Emergency Department physicians were required to request deep sedation privileges. The Director of Anesthesia determined that physicians board certified in Emergency Medicine were qualified to provide deep sedation as this is a required component of board certification in this specialty, and therefore any board certified ED physician had the qualifications and competence to administer deep sedation. A deep sedation test was provided (however not mandated for board certified ED physicians) for completion. Any new Emergency Department provider is required to request deep sedation privileges when applying for ED privileges. This process is currently underway but no privileges have	12/29/15 3/16/16 3/22/16

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A1001	Continued From page 132 Nursing about issues related to access to and the quality of anesthesia services in the State and has concluded that it is in the best interests of the State's citizens to opt-out of the current MD/DO supervision requirement, and that the opt-out is consistent with State law. (2) The request for exemption and recognition of State laws, and the withdrawal of the request may be submitted at any time, and are effective upon submission. This Standard is not met as evidenced by: Based on interview and record review, the hospital did not ensure that general anesthetic agents were administered only by medical staff members privileged to do so, creating the increased risk of a poor anesthetic outcome. Findings: The Medical Staff Rules & Regulations (undated, page 43), showed that conscious sedation privileges were available to members of the medical staff who successfully passed a conscious sedation test or had such privileges at another facility. The Moderate Sedation Self Learning Module employed by the medical staff to educate staff wishing conscious sedation privileges was reviewed, and did not contain information about which agents were considered conscious sedation agents, and which were general anesthetics. The Moderate Sedation Post-test and Request for Moderate Sedation Privileges was reviewed, and did not include discussion of which agents were considered moderate sedation vs general anesthetics. The test questions appeared to be simplistic and based on common knowledge, rather than based on specialized knowledge about sedation. In an interview with the Dir Anesthesia on	A1001	been granted to date. Until privileges have been granted, deep sedation is not being provided in the ED by ED physicians. Compliance and Monitoring: Once privileges are granted, proctoring will be performed as a retrospective audit with any adverse events or reversals administered for each provider over the previous six month period identified and submitted to the Director of Anesthesia. Persons Responsible: Medical Staff Office Administrator Medical Director of ED Director of Anesthesia	

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A1001	Continued From page 133 12/15/15 at 1305, he stated that Ketamine and Propofol were not to be used for procedural sedation in the ER. He stated that if a patient needs moderate or deep sedation, anesthesia must be called to provide that service. He concurred that the test for conscious sedation did not mention specific medications to verify complete physician understanding. The Dir 1, in an interview on 12/16/15 at 0900, stated that Propofol and Ketamine were used in the ER for procedural sedation, per the physician ' s choice. She stated that such procedures would be attended by the ER physician, and nurse, and a respiratory tech. She stated there was Ketamine in the ER pyxis, and that she was not aware of a policy on the use of Ketamine and Propofol. In an interview with the VPP on 12/16/15 at 0920, she concurred that the policy on conscious sedation was unclear and should define when the ER physician can use Propofol, and when anesthesia staff were required. A drug utilization report for the general anesthetic, Ketamine, was requested, and showed that the drug was used by non-anesthesiologists such as ER staff. The medical record of Patient 506 was reviewed on 12/17/15 and showed that the 3 year old came to the ER on 8/26/15 with a finger injury requiring surgical repair. The orthopedist ' s procedure note included a description of the patient being unable to undergo the procedure under local sedation, and informed consent for conscious sedation being obtained from the patient ' s mother. The record contained an Authorization and Informed Consent for conscious sedation by the ER physician, DR 2, which was signed by a representative of the patient. The Medical Orders indicated that Ketamine was ordered " to bedside for conscious sedation " at 21:26. The Medical	A1001		

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A1001	Continued From page 134 Orders and MD Notes showed that Ketamine 60mg IM, followed by 40 mg IM was administered by the ER physician at 2345, with IM administration used as IV was not available. An orthopedist performed the surgical repair. The record showed that the patient was documented as still sedated at 2348, and that the patient ' s care was transferred to the subsequent ER physician at 2358, and the patient was approved for discharge at 0127. There was no documentation to show that an anesthesiologist was present to provide the Ketamine, to monitor the patient, or to provide a post anesthetic assessment. During a second interview with the Dir Anesth on 12/16/15 at 1240, via telephone, he stated that he was not aware the ketamine was being given by the ER physicians. He stated that the ER physicians were not privileged to provide general anesthetics, and that he needed to revisit the conscious sedation policy and to clarify the difference between conscious sedation and general anesthesia.	A1001		
A1005	482.52(b)(3) POST-ANESTHESIA EVALUATION [The policies must ensure that the following are provided for each patient:] A post-anesthesia evaluation completed and documented by an individual qualified to administer anesthesia, as specified in paragraph (a) of this section, no later than 48 hours after surgery or a procedure requiring anesthesia services. The post-anesthesia evaluation for anesthesia recovery must be completed in accordance with State law and with hospital policies and procedures, which have been approved by the medical staff and which reflect current standards of anesthesia care.	A1005	A 1005 482.52(b)(3) Post Anesthesia Evaluation Actions Taken: 1. Executive Leadership discussed the survey finding with the Chief of Anesthesia. 2. The CEO and Chief of Staff sent a memo to anesthesiologists regarding their responsibility for performing and documenting a post-anesthesia evaluation. Compliance and Monitoring: Completion of a post anesthesia evaluation when the patient can participate in the evaluation is an indicator that requires monthly data collection and aggregation. Effective 3/16/16, PACU staff will collect initial data to obtain a baseline and report weekly to the Director of Anesthesia for one month. Data will then be collected weekly and is analyzed and	1/29/16 3/15/16

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A1005	Continued From page 135 This Standard is not met as evidenced by: Based on interview and record review, the hospital did not ensure the integrity of the post-anesthesia evaluation for one patient, Patient 502, creating the risk of a substandard anesthetic outcome for that patient. Findings: During a tour of the PACU on 12/14/15 at 1130, with RN 6, she stated that Patient 502 had just arrived in the PACU. Patient 502 was observed in the PACU on 12/14/15 at 1132 and appeared to be unmoving and asleep. Patient 502 ' s medical record was reviewed at 1135. The Critical Care Flowsheet for the patient containing the PACU record was reviewed, and showed that the patient arrived in the PACU at 1129, and that assessments were completed at 1129 and 1135 with the level of consciousness recorded as " 0 " , indicating " not responding " , and the level of physical activity record as " 0 " , indicating " unable to move extremities voluntarily or on command ' , scores of " 1 " for respiration and oxygen saturation, indicating " limited breathing " and " needs oxygen inhalation to maintain oxygen saturation >90% " . The record also contained a post-anesthetic assessment that indicated that the patient had recovered from anesthesia. The pre-printed note included the observations that " Patient ' s mental status is acceptable. " , and " Pain and nausea are adequately controlled " , and " Patient is determined to have stable airway patency and respiratory function including respiratory rate and oxygen saturation. " The note, observed at 1135, was signed by MD7 and timed 1229. The Anesthesia Record also contained a check mark indicating that there were no anesthesia complications.	A1005	reported monthly to the Quality Council, MEC and Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will occur until the Quality Council determines sustained compliance has occurred, at which time the Council will determine what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Persons Responsible: Director of Anesthesia Chief Nursing Officer	

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A1005	Continued From page 136 In an interview with the OR Manager on 12/14/15 at 1135, she observed Patient 502. She concurred that the post-anesthesia assessment had already been signed, and stated that that the patient was sedated and sound asleep.	A1005		
A1076	482.54 OUTPATIENT SERVICES If the hospital provides outpatient services, the services must meet the needs of the patients in accordance with acceptable standards of practice. This Condition is not met as evidenced by: Based on observation, interview and record review the hospital failed to ensure that the outpatient services met the needs of the patients in acceptable standards when : 1) The facility failed to employ a qualified coordinator for the psychiatric intensive out patient services, per the facility job description qualification requirements. The facility failed to employ an adequate number of qualified professional staff at the psychiatric intensive out patient services. These failures resulted in two of three sampled patients and 22 of 52 unsampled patients lacking current individualized treatment plans for the previous six months, potentially impeding the patients progress towards therapeutic goals. (cross reference A-1079)	A1076	A 1076 482.54 Outpatient Services Hospital Leadership discussed the survey findings and obtained registry staff to assist with additional staffing at the time of the survey. A Behavior Health Unit Director was hired on 1/18/16, who has responsibility for oversight of the IOP. The Hospital also hired a full time licensed MFT and continues to use registry staff as needed. There is still an open position for a registered nurse. A job fair was held on 3/3/16 with a repeat fair scheduled for 3/23/16. Hospital Leadership also reviewed and revised the organizational chart to align oversight of the IOP under the full direction of the CNO. The IOP staff files were reviewed with performance reviews conducted to ensure staff met the minimum job qualifications. Hospital Leadership and IOP staff met with Nursing, Social Work and Case Management staff to determine a structured process to implement treatment planning. Treatment planning team meetings are held monthly . The "Interdisciplinary Treatment Planning" policy was reviewed and revised to reflect oversight of the MFT interns.	3/23/16 3/22/16
A1079	482.54(b) OUTPATIENT SERVICES PERSONNEL The hospital must -- (1) Assign one or more individuals to be responsible for outpatient services. (2) Have appropriate professional and nonprofessional personnel available at each location where outpatient services are offered,	A1079		

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A1079	482.54(b) OUTPATIENT SERVICES PERSONNEL The hospital must -- (1) Assign one or more individuals to be responsible for outpatient services. (2) Have appropriate professional and nonprofessional personnel available at each location where outpatient services are offered,	A1079	determines	

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A1005	Continued From page 136 In an interview with the OR Manager on 12/14/15 at 1135, she observed Patient 502. She concurred that the post-anesthesia assessment had already been signed, and stated that that the patient was sedated and sound asleep.	A1005		
A1076	482.54 OUTPATIENT SERVICES If the hospital provides outpatient services, the services must meet the needs of the patients in accordance with acceptable standards of practice. This Condition is not met as evidenced by: Based on observation, interview and record review the hospital failed to ensure that the outpatient services met the needs of the patients in acceptable standards when : 1) The facility failed to employ a qualified coordinator for the psychiatric intensive out patient services, per the facility job description qualification requirements. The facility failed to employ an adequate number of qualified professional staff at the psychiatric intensive out patient services. These failures resulted in two of three sampled patients and 22 of 52 unsampled patients lacking current individualized treatment plans for the previous six months, potentially impeding the patients progress towards therapeutic goals. (cross reference A-1079)	A1076	sustained compliance has occurred, at which time the Council will determine what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator).	
A1079	482.54(b) OUTPATIENT SERVICES PERSONNEL The hospital must -- (1) Assign one or more individuals to be responsible for outpatient services. (2) Have appropriate professional and nonprofessional personnel available at each location where outpatient services are offered,	A1079	A 1079 482.54(b) Outpatient Services Personnel Immediate Actions Taken 1. Hospital Leadership discussed the survey findings and obtained registry staff to assist with additional staffing. Subsequent Actions Taken: 1. The Hospital hired a Behavior Health Unit Director, who has responsibility for oversight of the IOP.	12/18/15 1/18/16

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050135	A. BUILDING _____ B. WING _____	12/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSPITAL AT HOLL	6245 DE LONGPRE AVE HOLLYWOOD, CA 90028

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A1079	Continued From page 137 based on the scope and complexity of outpatient services This Standard is not met as evidenced by: Based on interview and facility record review, the facility failed to employ a qualified coordinator for the psychiatric intensive out patient services, per the facility job description qualification requirements. The facility failed to employ an adequate number of qualified professional staff at the psychiatric intensive out patient services. These failures resulted in two of three sampled patients and 22 of 52 unsampled patients not having current individualized treatment plans for the last six months and potentially impeding the patients progress towards therapeutic goals. Findings: During a concurrent personnel record review and interview with human resource staff 1 on 12/16/15, at 3:40 p.m., personnel record review revealed that Adm4 staff last performance evaluation was for the period of 8/17/12 to 8/17/13 signed by Adm4 on 11/09/15. The evaluation indicated the minimum education requirements for the intensive outpatient program coordinator were "Master's degree in psychology and/or Social work" License requirements were"California LMFT (licensed marriage and family therapist), LCSW (licensed clinical social worked) PHD, or current Ca RN License. Review of Adm4 personnel file indicated that Adm4 only had a bachelors degree in recreation. Human resource staff 1 acknowledged that Adm4 did not meet the minimum qualification of the job description. During a review of facility policy titled, "Scope of Services" dated 09/12, last revised 11/2012. Under section 4.2 Procedure, mechanism for	A1079	2. IOP staff files were reviewed with performance reviews conducted to ensure staff met the minimum job qualifications. 3. Hospital Leadership and IOP staff met with Nursing, Social Work and Case Management staff to determine a structured process to implement treatment planning. The "Interdisciplinary Treatment Planning" policy was reviewed and revised to reflect oversight of the MFT interns. Treatment planning team meetings are held monthly. The MEC approved the policy on 3/15/16 and the Governing Board on 3/16/16. The IOP Program Coordinator met with the disciplines of the treatment planning team and educated team members on the requirements and components of a functional individualized treatment plan in the IOP environment. This included basing the treatment plan on assessed findings and the patient's strengths and weaknesses among other salient factors. The Clinical Supervisor of the MFT interns is responsible for reviewing their treatment plans to ensure treatment plans are individualized to the patient. Education was completed by 3/22/16. Compliance and Monitoring Process: The Director of Behavioral Health or qualified designee shall perform a weekly review of 10 patient records to monitor compliance with the presence of a complete and appropriate treatment plan. Data will then be collected weekly, analyzed and reported monthly to the Quality Council, MEC and Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will occur until the Quality Council determines sustained compliance has occurred, at which time the Council will determine what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Persons Responsible: Director of Behavioral Health Chief Nursing Officer	3/15/16 3/22/16

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050135	A. BUILDING _____ B. WING _____	12/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSPITAL AT HOLL	6245 DE LONGPRE AVE HOLLYWOOD, CA 90028

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A1079	Continued From page 138 identifying patient care needs revealed in part... "Treatment plans are reviewed and revised monthly by the treatment team and psychiatrist." 4.2.1 "Staffing Information" Brotman campus: Program Director 1.0 FTE (full time equivalent) Program Coordinator 1.0 FTE Program Assistant 0.6 FTE therapist 3.2 FTE'Ss A therapist is responsible for providing care to twelve patients with a 1:12 ratio." On 12/16/15, at 12 p.m., during a review of Patient N107's clinical record, the record indicated that patient N107 did not have any monthly updates to treatment plans since 5/29/15. During a review of Patient N108's record the record indicated that Patient N108 was admitted on 5/18/15, all monthly treatment plans since admission have nearly identical goals and all interventions noted were as follows: "Therapist will monitor or assist as needed." All treatment plans were signed by the therapist intern with no co-signature. There were no "strengths" identified in the treatment plans. Review of facility policy and procedure titled, "Interdisciplinary Treatment planning" effective date 10/11 revised 11/2012, indicated in part, under "Procedure" 4.2.4 "The clinician responsible for the patient serves as the treatment coordinator. This individual is responsible for ensuring that the appropriate documentation is entered on the treatment plan...." During an interview with Adm4 on 12/16/15, at 12:15 p.m., and concurrent review of the treatment plans for Patient N107 and N108 Adm 4 was questioned as to why the treatment plans for Patient 107 were not initiated for over 6 months and why Patient N108's treatment plans	A1079		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A1079	Continued From page 139 were not updated or reviewed by licensed staff. Adm4 stated, "Honestly, we have been down by two therapists for over six months and the patients pulled were assigned to them and things didn't get done". During a follow up interview with Adm4 and behavioral health supr1 at 4p.m., Adm4 indicated that since 6/1/15, there has only been one full time therapists and one half time intern. During this period the census was "around 52 patients". Adm4 acknowledged that 14 patients do not have an assigned therapist and the full time licensed therapist has not been able to supervise the intern in treatment planning. Eight patients have not had any treatment planning since 6/2015. Behavioral health supr1 was asked if she was aware of treatment planning not occurring, not being individualized or the vacancy of staff issues, behavioral health supr1 stated, "No, not aware, I am the interim and I have only been here two months." Behavioral health supr 1 acknowledged there was not enough staff and that the treatment planning that occurred and did not occur was a deficient practice.	A1079		

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Rebecca A. Matthews
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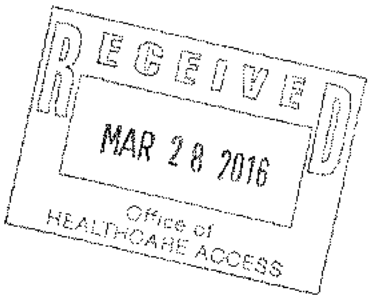
March 23, 2016

VIA HAND-DELIVERY

Office of the Attorney General
55 Elm Street
P.O. Box 120
Hartford, Connecticut 06141-0120
Attn: Gary W. Hawes, Assistant Attorney General



Office of Health Care Access
Department of Public Health
410 Capitol Avenue
Hartford, Connecticut 06134
Attn: Steven W. Lazarus, Health Care Analyst

Re: ***Eastern Connecticut Health Network, Inc.***
Proposed Asset Purchase by Prospect Medical Holdings, Inc.
OHCA Docket Number: 15-32016-486
Attorney General Docket Number: 15-486-01

Dear Mr. Hawes and Mr. Lazarus:

Eastern Connecticut Health Network, Inc. and Prospect Medical Holdings, Inc. (the "***Applicants***") hereby submit the following:

1. Responses to the issues identified in the letter dated February 24, 2016 from the Office of the Attorney General and the Office of Health Care Access (the "***Hearing Notice***").

2. Prefile testimony of the following individuals, each of whom will be present at the hearings scheduled on March 29, 2016 and March 30, 2016 and available for questions:

   For Eastern Connecticut Health Network, Inc.:

   Dennis O'Neill, MD
   Peter J. Karl
   Joy Dorin

For Prospect Medical Holdings, Inc.:

Von Crockett
Mitchell Lew, MD
Jonathan Spees
Steven Aleman

As requested, the prefile testimony addresses the topics identified in the Hearing Notice. For ease of reference, please find below a chart that shows which speaker's testimony addresses each of the topics you listed:

Topic	Prefile Testimony
1. The clear and public need for and community benefits of the proposal.	All, but particularly the testimony of Peter Karl and Mitchell Lew, MD
2. How access to care will be maintained in the service area following the asset purchase of the two ECHN hospitals (MMH and RGH) by PMH.	All, but particularly the testimony of Peter Karl and Mitchell Lew, MD; see also the testimony of Jonathan Spees regarding the commitment of PMH to provide charity care.
3. PMH's management of Quality Assurance and Performance Improvement (QAPI) across its hospital network and, in particular, the manner in which oversight of the QAPI program will be managed by MMH and RGH.	Testimony of Von Crockett
4. The financial feasibility of the proposal.	Testimony of Jonathan Spees
5. How prices for, and the cost of, health services at MMH and RGH will be affected by PMH's acquisition of those facilities.	Testimony of Mitchell Lew, MD and Jonathan Spees
6. The charity care policies to be implemented at MMH and RGH following the transfer of ownership and how they compare to PMH's current charity care policies.	Testimony of Jonathan Spees
7. The commitment PMH is willing to make to performing future health needs assessments for the communities in ECHN's service area in a manner that allows for widespread public input, collaboration with other health care providers in the community as well as public dissemination of the assessments and MMH's and RGH's implementation plan to address identified needs.	Testimony of Von Crockett

Topic	Prefile Testimony
8. How PMH's experience with license consolidation (i.e., combining separately licensed hospitals into a single licensed hospital with separate campuses) in the other markets in which it operates might impact the future of MMH and RGH.	Testimony of Von Crockett

At your request, one (1) hard copy and one (1) electronic copy of this submission have been provided to each Office.

If you have any questions or need anything further, please feel free to contact Rebecca Matthews at (203) 498-4502 or Melinda Agsten at (203) 498-4326. Thank you for your assistance in this matter.

Sincerely,

Wiggin and Dana LLP

By _____
Rebecca A. Matthews
Its Partner

By _____
Melinda A. Agsten
Its Partner

cc: Kevin Hansted, Staff Attorney, Department of Public Health Division of Office of Health Care Access
Kimberly Martone, Director of Operations, Department of Public Health Division of Office of Health Care Access
Perry Zinn-Rowthorn, Deputy Attorney General, Office of the Attorney General
Dennis P. McConville, Senior Vice President and Chief Strategy Officer, Eastern Connecticut Health Network, Inc.
Thomas M. Reardon, President, Prospect Medical Holdings-East, Inc.
Frank Saidara, Vice President, Corporate Development, Prospect Medical Holdings, Inc.
Jonathan Spees, Senior Vice President, Corporate Development, Prospect Medical Holdings, Inc.
Joyce Tichy, Senior Vice President and General Counsel, Eastern Connecticut Health Network, Inc.
Michele M. Volpe, Esq., Bershtein, Volpe & McKeon, P.C.

CERTIFICATE OF NEED/ CONVERSION APPLICATION

SUPPLEMENTAL INFORMATION

Eastern Connecticut Health Network, Inc.

Proposed Asset Purchase by

Prospect Medical Holdings, Inc.

OHCA Docket Number: 15-32016-486

Attorney General Docket Number: 15-486-01

March 28, 2016

WIGGIN AND DANA

Counsellors at Law

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March 28, 2016

VIA EMAIL AND HAND-DELIVERY

Office of the Attorney General
55 Elm Street
P.O. Box 120
Hartford, Connecticut 06141-0120
Attn: Gary W. Hawes, Assistant Attorney General

Office of Health Care Access
Department of Public Health
410 Capitol Avenue
Hartford, Connecticut 06134
Attn: Steven W. Lazarus, Health Care Analyst

Re: Eastern Connecticut Health Network, Inc.
Proposed Asset Purchase by Prospect Medical Holdings, Inc.
OHCA Docket Number: 15-32016-486
Attorney General Docket Number: 15-486-01

Dear Mr. Hawes and Mr. Lazarus:

Eastern Connecticut Health Network, Inc. ("***ECHN***") and Prospect Medical Holdings, Inc. ("***PMH***" and, together with ECHN, the "***Applicants***") hereby submit the following supplemental materials in connection with the above-referenced docket:

1. Letters of support for the proposed transaction from various members of the public and from community leaders.

2. Copy of the PowerPoint presentation that ECHN plans to use as part of its direct testimony at the hearings on March 29, 2016 and March 30, 2016. The PowerPoint Presentation of PMH will be filed separately.

3. Additional information on certain charitable funds held by ECHN and its affiliates.

4. Additional CMS Forms 2567 relating to certain hospitals operated by PMH.

One (1) hard copy and one (1) electronic copy of this submission have been provided to each Office.

If you have any questions or need anything further, please feel free to contact Rebecca Matthews at (203) 498-4502 or Melinda Agsten at (203) 498-4326. Thank you for your assistance in this matter.

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WIGGIN AND DANA

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Office of
HEALTHCARE ACCESS

March 23, 2016

VIA HAND-DELIVERY

Office of the Attorney General
55 Elm Street
P.O. Box 120
Hartford, Connecticut 06141-0120
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Sincerely,

Wiggin and Dana LLP

By_____
Rebecca A. Matthews
Its Partner

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Joyce Tichy, Senior Vice President and General Counsel, Eastern Connecticut Health Network, Inc.
Michele M. Volpe, Esq., Bershtein, Volpe & McKeon, P.C.

February 22, 2016

Ladies and Gentlemen,

I appear before you tonight to share my thoughts and insights on the proposed merger of ECHN with Prospect Medical Holdings. I am a retired physician, a urologist, who has practiced in the Vernon/Manchester community for 37 years, from 1975 through 2012, while on the active medical staffs of Rockville General Hospital, Manchester Memorial Hospital and ultimately at ECHN. During that time I had the privilege to serve terms as Chief of Urology at each hospital, President of the combined medical staffs and a hospital board member. In my retirement I proudly continue as an ECHN Corporator. I take this position quite seriously since, as a resident of South Windsor, my wife and I continue to receive a substantial portion of our continuing medical care at ECHN facilities just as we had when I was in practice. It is important to us that medical services at ECHN remain readily accessible, comprehensive and of the highest quality.

I am well acquainted with the challenges facing health care today, both nationally and at this local level. 20 years ago, before the advent of ECHN, when we first became acutely aware of the profound financial limitations impacting both Manchester and Rockville Hospitals, I served on a select hospital committee to explore our options. We realized we couldn't go it alone without initiating significant cost savings and more efficient measures in order to preserve the level of care our communities expected from us. To this end, with very capable leadership and much due diligence, we formed ECHN.

This action sufficed for many years, but as we all know, the financial burdens brought about by increasingly more expensive technology, progressive limitations on private and government reimbursement, and the burgeoning demand for health care services has again created a nation-wide crisis. In order to meet this reality, we can all agree that if there was a bottomless pool of money to pay for this demand we might continue to practice as we have been with individual, lavishly staffed hospitals providing all manner of specialty services with the latest instrumentation and technology. We know this is no longer possible. Our hospitals need access to capital to stay current, staffing needs to be optimal but realistic, and the pattern of practice needs to encourage the best outcomes for our population, not the most outcomes.

To achieve both access to capital and the implementation of a well-managed, cost efficient delivery system requires a new model that builds on our existing strengths. ECHN is recognized as a lower cost hospital network with excellent professional staff. When integrated into a well-managed, risk based system which incentivizes and equips our quality providers to produce the best outcomes for wellness and disease prevention along with effective chronic disease management, then both lower costs and optimal care are well served. The alternative of affiliating with a regional network that, by its very nature and interest, must funnel patients

into large, expensive downtown hospitals makes little sense. Such changes neither serve the current economic imperative or our local need for ready access to quality care.

For us, in this ECHN service area, our goal should be to maintain a broad range of quality medical services that emphasize coordinated care in a cost efficient environment. Anything less short changes us on access to care, misdirects an emphasis on preventative and wellness services, and diminishes the full range of quality care we expect within our community. Neither the State nor regional competitors can create the proper mix of changes that preserve all these goals. Prospect has access to needed financial resources as well as the proven data driven, management model to deliver the correct health care product for these ever changing times.

Thank you for your attention.

Respectfully submitted,

Robert D. Rodner

11 Rosemary Lane

South Windsor, CT. 06074

r.rodner@cox.net

(860) 644-9601

ECHN℠
Eastern Connecticut Health Network

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The Honorable George C. Jepsen, Attorney General
Office of the Attorney General
55 Elm Street, Hartford, CT 06106

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

Dear Attorney General Jepsen and Commissioner Pino:

As the Chair and Senior Medical Director of the Department of Emergency Medicine and the Service Line Director for Emergency Services at ECHN, I would like to express my excitement about the future acquisition of ECHN by Prospect Medical Holdings (PMH). For the past several years we have been facing one financial challenge after the next in the form of hospital taxes, sequestration, Medicare reimbursement cuts, pension reform, or unfunded quality reporting mandates. The only way we have been able to meet these challenges has been to "do more with less".

My view on Healthcare is that we are facing the same struggles now that the smaller department stores and hardware stores faced a decade or more ago with the emergence of Walmart and Home Depot. Their ability to purchase goods in such large quantities made it impossible to compete with their prices, and many of the mom and pop stores eventually went out of business. This is the path that I believe ECHN would be on if we didn't proceed with this acquisition.

I, as a healthcare provider, and ECHN as a healthcare system, have an obligation to the patients we serve. Our obligation is to be there for them in their time of need and to provide the expertise, staff, and equipment necessary to diagnose and treat them at any hour of the day or night. The acquisition of ECHN by a larger system is the only option that would allow us to continue our mission of "improving your well-being by providing high-quality, compassionate healthcare." Without the ability to join a larger system, our costs will be higher than our competitors, our ability to recruit skilled physicians and

nurses will become more difficult, and we would eventually find ourselves out of business.

I have been asked many times, "Why partner with PMH, rather than with one of the other large systems closer to Manchester and Rockville?" My desire for PMH is based on my belief that they would be the best option for both the patients we serve and for the staff we employ. In order to succeed, PMH has to help grow our system to allow us to directly compete with our local competitors. I feel that if we had chosen to partner with a nearby competitor, we would become victim to consolidations of services and locations. This would directly impact access to healthcare for our patients in our communities.

In my 15 years at ECHN, I have watched our competitors advertise their cutting edge therapies during the prime time news and open healthcare centers in our own neighborhood. I've read about their latest minimally invasive cardiac procedures and have heard on the radio about their world-class stroke therapies. It would be really nice to have the access to capital funding that would allow us to advertise the cutting-edge programs we have here at ECHN. However, the ability to grow and advertise these types of services is becoming virtually impossible under the financial constraints we are facing. With the implementation of the Affordable Care Act, the increase in Medicaid volume, and the State's tax on hospitals, remaining independent is futile and no longer an option. A partnership with PMH will afford us access to the clinical expertise our patients need, as well as access to the desperately needed capital funding so that we can resume investing in our technology, staff, and infrastructure. This partnership will position ECHN competitively for the foreseeable future of healthcare.

Sincerely,

R. Carroll MD

Robert Carroll, MD, FACEP, MBA
Chair and Senior Medical Director
Department of Emergency Medicine, ECHN

Laurence P. Rubinow
239 Cedar Ridge Drive
Glastonbury, CT 06033

February 29, 2016

Office of the Attorney General
55 Elm Street, PO Box 120
Hartford, CT 06141-0120
Attention: Deputy Attorney General Perry Zinn-Rowthorn

Office of Health Care Access, Dept. of Public Health
410 Capitol Avenue
Hartford, CT 06134
Attention: Deputy Commissioner Brancifort

Dear Messrs. Zinn-Rowthorn and Brancifort:

It is my understanding that the Office of the Attorney General and the Office of Health Care Access will hold public hearings March 15th and 16th on the Certificate of Need ("CON") application of Eastern Connecticut Health Care, Inc.("ECHN") relating to its intended partnership with Prospect Medical Holdings, Inc. ("Prospect"). I regret that I will be unable to attend the hearings. In my absence, however, I submit this letter to strongly support and recommend approval of the CON and the proposed partnership between ECHN and Prospect.

I have lived in the Manchester and Glastonbury communities my entire life. I was on the Board of Manchester Memorial Hospital ("MMH") and on its ad hoc committee that recommended the merger between MMH and Rockville General Hospital, a merger that made both institutions stronger.

Since that time, in response to the health-care needs of East of the River communities, ECHN has set high standards for quality of care, innovation, and accessibility. While it has always been a challenge to maintain top health care, ECHN has succeeded. To sustain the delivery of high-quality health care, ECHN must operate with reasonable financial returns in order to reinvest in its facilities, keep up with technological advances, and continue to attract highly qualified clinicians and staff. Unfortunately, due to severe economic constraints attributable to numerous factors, the existing business model is no longer sustainable.

Several years ago, ECHN recognized this economic reality and embarked on a process to find the best health-care provider partner. That partner must be dedicated to maintaining the highest standards of health care and also be able to meet the financial needs that those high standards require. In Prospect, ECHN has found such a partner. This conclusion has been reached by ECHN after substantial due diligence and after overwhelming support from ECHN's board, its incorporators, administration, medical staff, and employees.

I know that ECHN's partnership with Prospect will enable the communities that ECHN serves to continue to have accessibility to the highest quality of health care.

Accordingly, I respectfully request that the CON be approved.

Thank you for your consideration of my recommendation.

Very truly yours,

Laurence P. Rubinow

March 3, 2016

The Honorable George C. Jepsen, Attorney General
Office of the Attorney General
55 Elm Street, Hartford, CT 06106

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

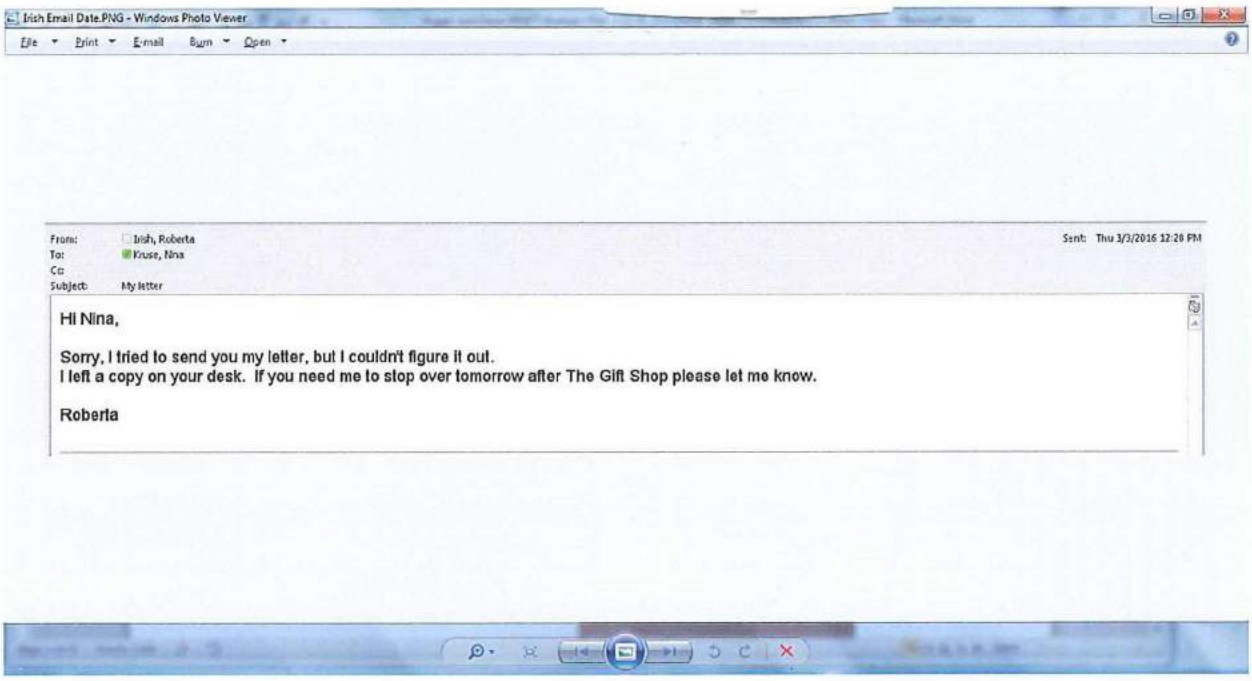
Dear Attorney General Jepsen and Commissioner Pino,

As the President of The Manchester Memorial Hospital Auxiliary, I appreciate the value of a community hospital. Our organization has been active for the last 93 years providing volunteers and fundraising. With our Gift Shop and Thrift Shop, we have raised millions of dollars to support the needs of our hospital, and now we realize things must change to continue to make our hospital as strong as it can be.

I think for ECHN to stay healthy, it must partner with a larger entity so that it can remain a community hospital. Quality care at Manchester Hospital is important to our residents and I don't ever want to see it go away.

We look forward to continuing volunteer opportunities, whatever they may be, in the future. Somewhere there will be a place for our Auxiliary where we can continue to make a difference.

Roberta Irish
President, Manchester Memorial Hospital Auxiliary


Irish Email Date.PNG - Windows Photo Viewer
File Print E-mail Burn Open
From: Irish, Roberta
To: Kruse, Nina
Cc:
Subject: My letter
Sent: Thu 3/3/2016 12:28 PM
Hi Nina,
Sorry, I tried to send you my letter, but I couldn't figure it out.
I left a copy on your desk. If you need me to stop over tomorrow after The Gift Shop please let me know.
Roberta

February 26, 2016

The Honorable George C. Jepsen, Attorney General
Office of the Attorney General
55 Elm Street, Hartford, CT 06106

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

Dear Attorney General Jepsen and Commissioner Pino,

As a Corporator of ECHN, I have always been extremely impressed with the vision, intellect and communication skills of Peter Karl and Dennis O'Neill. I am comfortable with their decisions regarding the ECHN acquisition by Prospect Medical Holdings and it's my hope that the company becomes more viable and successful as a result.

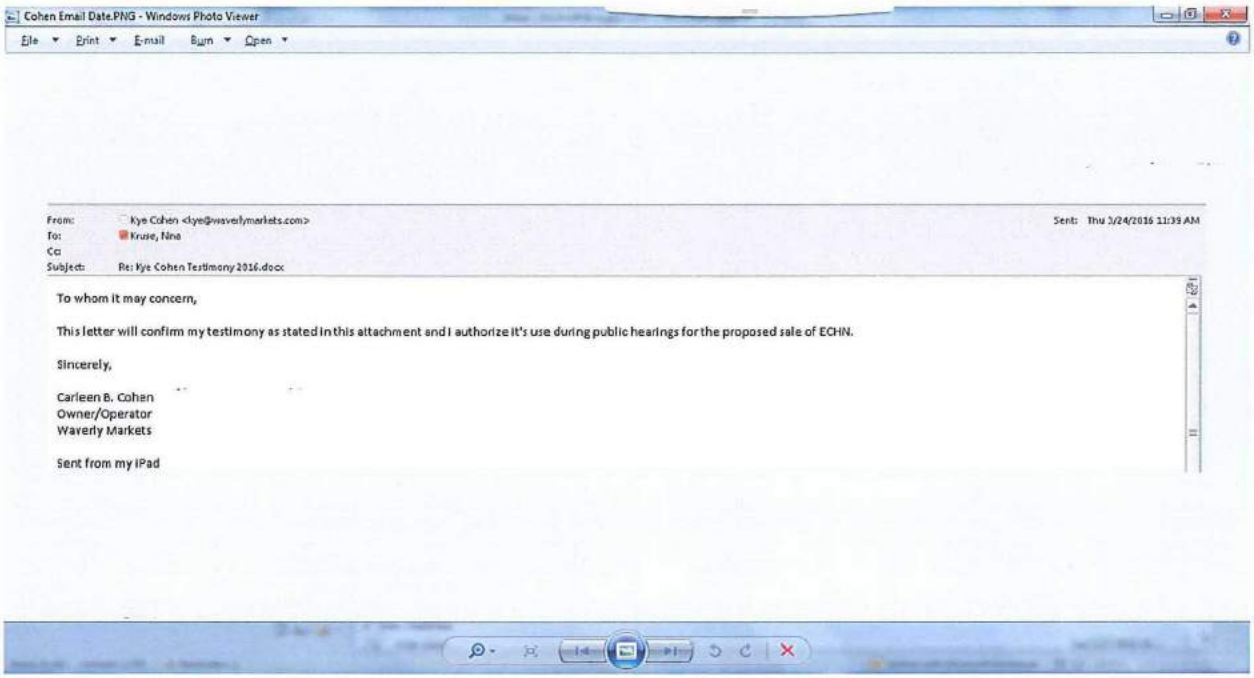
As a business owner, I am keenly aware of the need for "economies of scale". My organization's ability to partner with a larger entity allows us to stay in business, pass immense savings onto our customers and be philanthropic to the greater Manchester community.

The common thread that exists between ECHN and my business is that we both face a highly competitive marketplace.

I truly understand the need for ECHN to adapt to a rapidly changing healthcare environment and fully support the merger so that we may go forward and keep quality healthcare in greater Manchester.

Respectfully submitted,

Kye Cohen
Owner, ShopRite of Manchester and East Hartford


Cohen Email Date.PNG - Windows Photo Viewer
File Print E-mail Burn Open
From: Kye Cohen <kye@waverlymarkets.com>
To: Kruse, Nina
Cc:
Subject: Re: Kye Cohen Testimony 2016.docx
Sent: Thu 3/24/2016 11:39 AM
To whom it may concern,
This letter will confirm my testimony as stated in this attachment and I authorize it's use during public hearings for the proposed sale of ECHN.
Sincerely,
Carleen B. Cohen
Owner/Operator
Waverly Markets
Sent from my iPad

March 22, 2016

The Honorable George C. Jepsen, Attorney General
Office of the Attorney General
55 Elm Street, Hartford, CT 06106

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

Dear Attorney General Jepsen and Commissioner Pino,

I am writing to strongly recommend the proposed acquisition of Eastern Connecticut Health Network by Prospect Medical Holdings. I and my family have lived in the ECHN service area for decades and have received both routine and critical care at its facilities. I am a Trustee of ECHN, having served for more than a decade first as a Corporator and then as a Trustee. I chair the Audit and Corporate Compliance Committee and also serve as Vice Chair of the Finance Committee and as a member of the Transaction Committee which worked with management to develop this proposed transaction, which has the unanimous support of our Board.

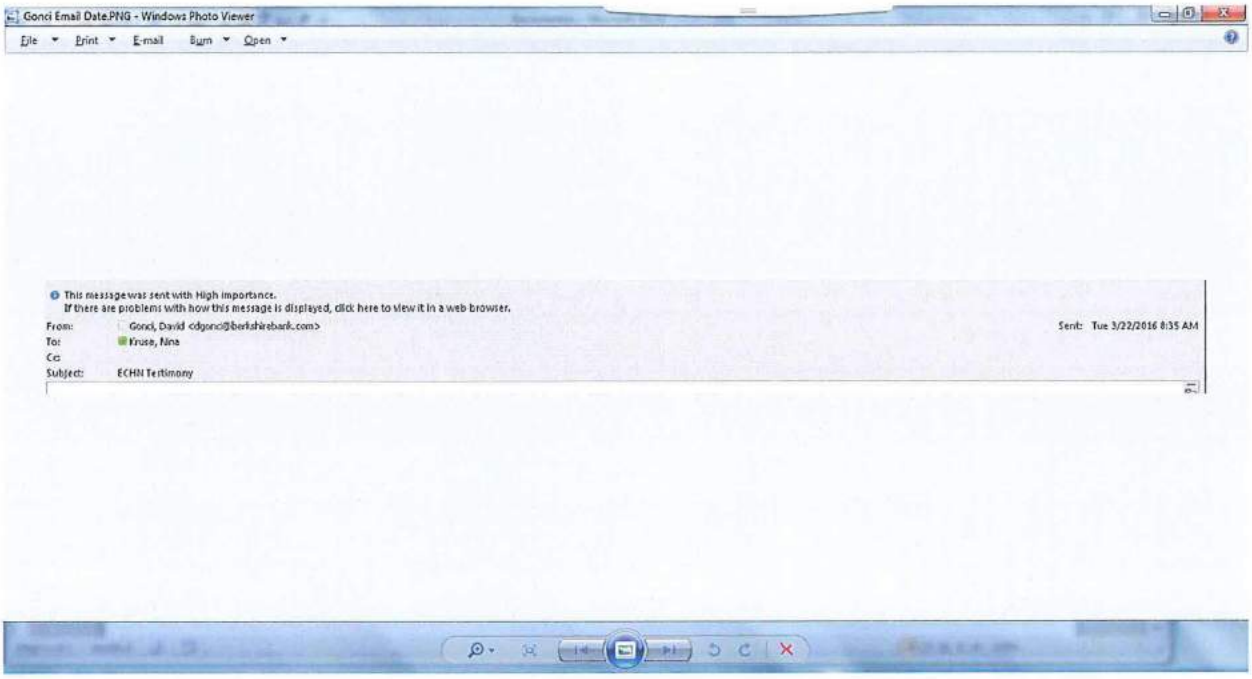
ECHN has demonstrated the compelling need to combine our operations with a larger system due to the sweeping changes in the healthcare environment. The majority of Connecticut community hospitals have arrived at a similar conclusion. The need for a combination has been made more urgent by the State's hospital tax, as well as the reduction and withholding of State payments to Connecticut hospitals.

ECHN has spent several years assessing and developing partnership options. The proposed Prospect transaction follows an early proposed transaction with Tenet Healthcare, which was withdrawn by Tenet following the imposition of burdensome approval conditions. We are convinced that the combination with Prospect provides the best opportunity available to sustain healthcare services in our communities, while meeting important quality and affordability objectives. ECHN cannot sustain its current service delivery in its current form of organization, and the pressures are mounting to complete this process as proposed, and without burdensome conditions that would make the combination unworkable.

Thank you for your prompt consideration of our proposal to implement the needed changes in order to support our communities.

David Gonci

Glastonbury, Connecticut


Gonci Email Date.PNG - Windows Photo Viewer
File
Print
E-mail
Burn
Open
This message was sent with High importance.
If there are problems with how this message is displayed, click here to view it in a web browser.
From:
Gonci, David <dgonci@berkshirebank.com>
Sent: Tue 3/22/2016 8:35 AM
To:
Kruse, Nina
Cc:
Subject:
ECHN Testimony

ERIC L. KLOTER
24 Raisch Drive
Tolland, CT 06084

Tuesday, March 22, 2016
The Honorable George C. Jepsen, Attorney General
Office of the Attorney General
55 Elm Street, Hartford, CT 06106

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

Dear Attorney General Jepsen and Commissioner Pino,

The honor and privilege has been mine to serve on the ECHN Board of Trustees and numerous other ECHN committees including chairing both the Eldercare (Woodlake of Tolland) and VNHSC (Visiting Nurse and Health Services of CT) Boards of Trustees.

One of those "other" ECHN responsibilities has been to serve on the Transaction Committee which has reviewed all aspects of the ECHN – Prospect Medical Holdings, Inc (PMH) acquisition. The complexity and depth of this endeavor has been challenging, forced by the changing landscape of the medical field. For any industry, it is difficult to reduce cost as revenue sources shrink while preserving the highest level of quality and patient satisfaction possible is not a sustainable model. ECHN cannot survive without the benefit of scale and a new focus on program development.

This acquisition process has revealed to me without any doubt that the future of small community hospitals is short – especially in Connecticut. We have chosen Prospect Medical Holdings to acquire ECHN – based on:

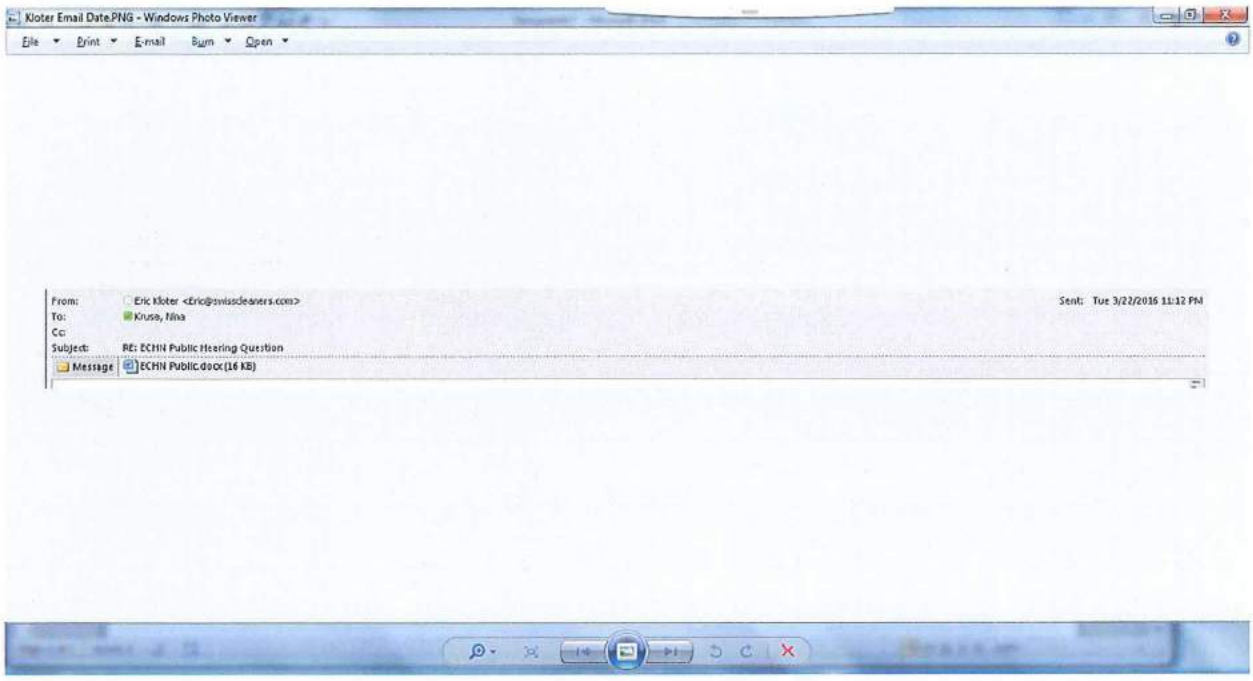
- our visits to PMH facilities and subsequent measures of due diligence in reviewing their practices
- PMH's achievements of high quality which are validated by their measurements and metrics
- the unique PMH vision to empower primary care physicians and oversee patient's as they navigate through a journey to sustain or regain health which leads to better patient outcomes
- implementation and extensive use of electronic medical records to help reduce duplication and cost
- a deep study of how PMH supports local culture and leadership
- and then . . . the resulting level of trust and confidence in PMH leadership and their program for managing population health.

The administrative team that leads PMH is actively committed to a vision that will change the way future healthcare is delivered. ECHN, its staff, and the physicians that serve our local communities have studied the

PMH business plan – Coordinated Regional Care (CRC) – and are eager to engage this new culture that will enhance ECHN's healthcare delivery in our local communities.

Having had the privilege of working closely with the PMH transaction team, I am convinced and confident of ECHN's ability to deliver the finest healthcare under PMH's guidance and with the benefits of PMH's scale and best practices. PMH's leadership has delivered on their commitments and promises. The PMH hospitals successes in California, Texas and Rhode Island further confirms to me that the ECHN Board of Trustees has made the right decision to be acquired by Prospect Medical Holdings and we look forward to integrating our mission, vision and values for healthcare in our region that will benefit our neighbors, family and friends across eastern Connecticut.

Sincerely,
Eric L. Kloter
Member, Transaction Committee and ECHN Board of Trustees


Kloter Email Date.PNG - Windows Photo Viewer
File
Print
E-mail
Burn
Open
From:
Eric Kloter <Eric@swissdeaners.com>
To:
Kruse, Nina
Cc:
Subject:
RE: ECHN Public Hearing Question
Sent: Tue 3/22/2016 11:12 PM
Message
ECHN Public.docx (16 KB)

Letter of support for the partnership between Eastern Connecticut Health Network and Prospect Medical Holdings Inc.

To: Office of Healthcare Access and the State Attorney General

From: M. Saud Anwar MD, MPH, FCCP
Partner Northeastern Pulmonary Associates, LLC,
Chairman of Department of Medicine, Eastern Connecticut Healthcare Network.

RE: Certificate of Need, Application for Hospital Conversion to "For Profit" Status.

Dear Commissioner of the Office of Healthcare Access and State of Connecticut Attorney General Mr. Jepsen,

My name is Saud Anwar, I am a Pulmonary and Critical Care physician affiliated with Eastern Connecticut Health Network for over 17 years. I support the proposed partnership of Eastern Connecticut Health Network and Prospect Medical Holdings. I am an independent physician who has the opportunity to interact not only with the patients in the community, but also the staff essentially in most parts of our hospital and I also have an opportunity to cooperate with the community physicians providing primary care to our community. As a medical director of the Clinically Integrated Network of Eastern Connecticut and also with the Eastern Connecticut Physician Hospital Organization and medical advisor to the care management department of the hospital, I have had the opportunity to closely observe the sustainability challenges our healthcare system has who are struggling to continue to provide best quality to all the patients with ongoing challenges with increasing social challenges and insurance reimbursement and bureaucracy.

I have also had the opportunity to learn first hand from the representatives of the Prospect Medical Holdings and their existing hospitals and their track record of providing quality care to patients with all capabilities of payments. It is quite clear to the physicians that integrated network and coordination of care in a healthcare system with strong primary care delivery along with collaborative specialty care with appropriate transitions according to the patients' needs is the best and the most effective way of maintaining and managing population health. Prospect Medical Holdings has many years of experience and success in managing risks with their delivery models. The size of our healthcare system and the opportunity to collaborate with an experienced partner who believes in collaboration between the independent physician in the community and the hospital will truly strengthen healthcare within our network.

Our hospital continues to employ members in the community and serves as a backbone of the economic engine within our towns. In my other role as a Mayor of the Town of South Windsor, I know that over 250 people in my community are employed by ECHN. Stronger, efficient and sustainable healthcare system allows industry to identify and

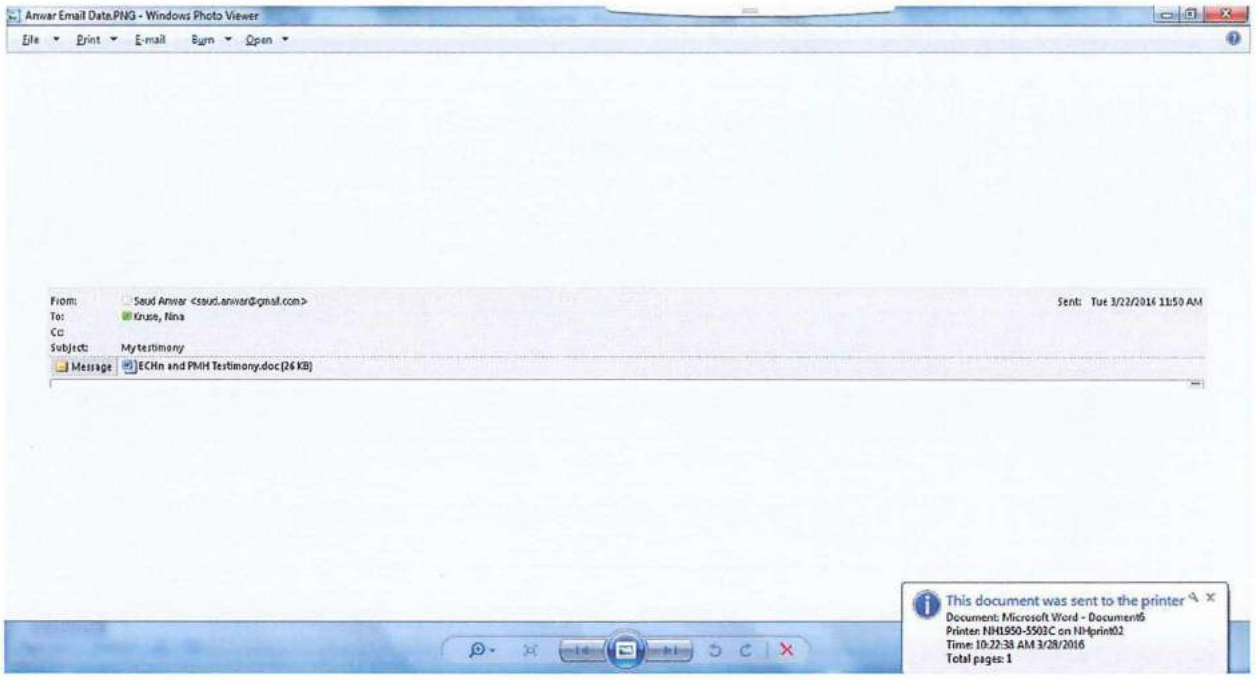
choose communities to invest in. With the growth of population health management, we truly can have an impact at all levels according to the needs of the people.

I strongly feel that the track record and the current system needs to move to "for-profit" model and this partnership will not compromise the quality of care, but actually enhance the quality of care and would be able to provide care to the patients irrespective of their insurance status and abilities to pay.

I thank you for your consideration. Should you have any questions, please do not hesitate to contact me.

Sincerely,

M. Saud Anwar, M.D.
Chairman of Department of Medicine,
Eastern Connecticut Health Network
860-875-2444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Print
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Burn
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From: Saud Anwar <ssud.anwar@gmail.com>
To: Kruse, Nina
Cc
Subject: My testimony
Message
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Sent: Tue 3/22/2016 11:50 AM
This document was sent to the printer
Document: Microsoft Word - Document6
Printer: NH1950-5503C on NHprint02
Time: 10:22:38 AM 3/28/2016
Total pages: 1

March 22, 2016

The Honorable George C. Jepsen, Attorney General
Office of the Attorney General
55 Elm Street, Hartford, CT 06106

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

Dear Attorney General Jepsen and Commissioner Pino,

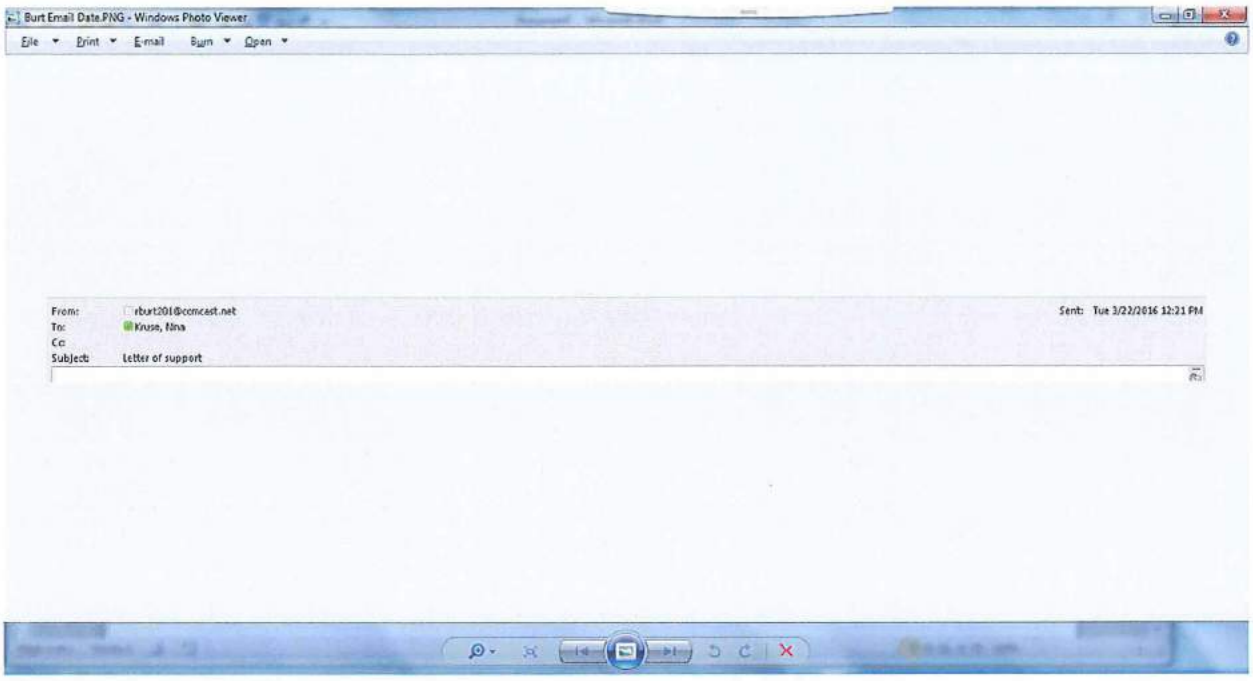
I would like to submit the following statement of my support for the proposed sales transaction of ECHN to Prospect Medical Holdings, for entry into the public record.

As a Connecticut physician practicing in Hartford and Tolland Counties for 30 years, I have been witness to, and very much involved in the evolution of all aspects of delivery of health care in central and eastern Connecticut, very much including those specifically relating to the ECHN organization. ECHN is a critical institution to the continued delivery of health care to the communities it serves. Challenges have never been as daunting as they are now, but the trustees and management of the organization have never been so fully dedicated to the preservation of ECHN's service to their community as they have been over the last several years. In this time, the necessity of all hospitals becoming parts of larger systems has been well recognized by all as the only organizational approach to both surviving, and even thriving, in the new paradigms of health care delivery. I strongly believe that ECHN, with the right corporate partner, has all the elements necessary to move forward successfully and durably. Tremendous expenditures of time, personal, and institutional commitment have been devoted by ECHN and its many supporters to identify the best organization within which to grow, and to negotiate the best possible terms under which to join such an organization. That extended and extraordinarily diligent process has brought ECHN to its current position of proposed acquisition by Prospect Medical Holdings. Prospect has already demonstrated its ability to assist hospitals in Southern New England to traverse the increasingly difficult regulatory and fiscally constrained environments within which health care is delivered in this region, and is extraordinarily well prepared to extend that record of success in furthering the availability and quality of health care services within the ECHN service area. Prospect has not simply been reactive in its responses to the new and continually changing realties of health care delivery, but has been proactive: anticipating, preparing for, and developing successful models of implementation of systems to respond to the need for population health management, cost containment, quality improvement, and successful operation within new models for reimbursement for services.

For all the above reasons, I very strongly support the proposed ECHN/Prospect Medical Holdings transaction and respectfully ask that the ECHN public community and involved Connecticut regulatory bodies support and approve the process.

Respectfully submitted,

Ronald E. Burt, M.D.


Burt Email Date.PNG - Windows Photo Viewer
File Print E-mail Burn Open
From: rburt201@comcast.net
To: Kruse, Nina
Cc:
Subject: Letter of support
Sent: Tue 3/22/2016 12:21 PM

ECHN
Eastern Connecticut Health Network, Inc.
Department of Medical Affairs
860-647-6866

February 22, 2016

The Honorable George C. Jepsen, Attorney General
Office of the Attorney General
55 Elm Street, Hartford, CT 06106

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

Dear Attorney General Jepsen and Commissioner Pino:
I am writing this letter to express my total support for Prospect Medical Holdings acquisition of Eastern Connecticut Health Network. I have lived in this community and have been with ECHN for 32 years as a practicing emergency physician, Chair of Emergency & Ambulatory Care, Medical Director of EMS, and currently as Chief Medical Officer. These roles have enabled me to attain a deep understanding of our community's needs and how our health system can best continue to provide excellent care and improve the health of the residents of the towns we serve.

Clinical advances, maturation of health information technology, increasing economic pressures, and policy and legislative initiatives including the Affordable Care Act have driven unprecedented change in the healthcare system during the past 5 years. What worked before, no longer works today, and certainly won't work in the future.

ECHN has completed a carefully planned due diligence process to determine what best meets our future needs and those of the communities we serve. I was part of the team that visited Prospect Medical Holdings' health systems in Los Angeles, CA and Providence, RI. While health systems address their local needs, we found several things in common: (1) substantial capital investment, (2) significant growth of clinical services, (3) effective population health/community care management programs, and (4) highly satisfied community physicians. It is rare to see *any one* of these, and almost unheard of to see all in one place. Prospect Medical Holdings has applied its extensive experience in health system leadership & management, care coordination, independent physician association alignment, and value-based purchasing contracting to advance high quality patient care, while thoughtfully managing cost.

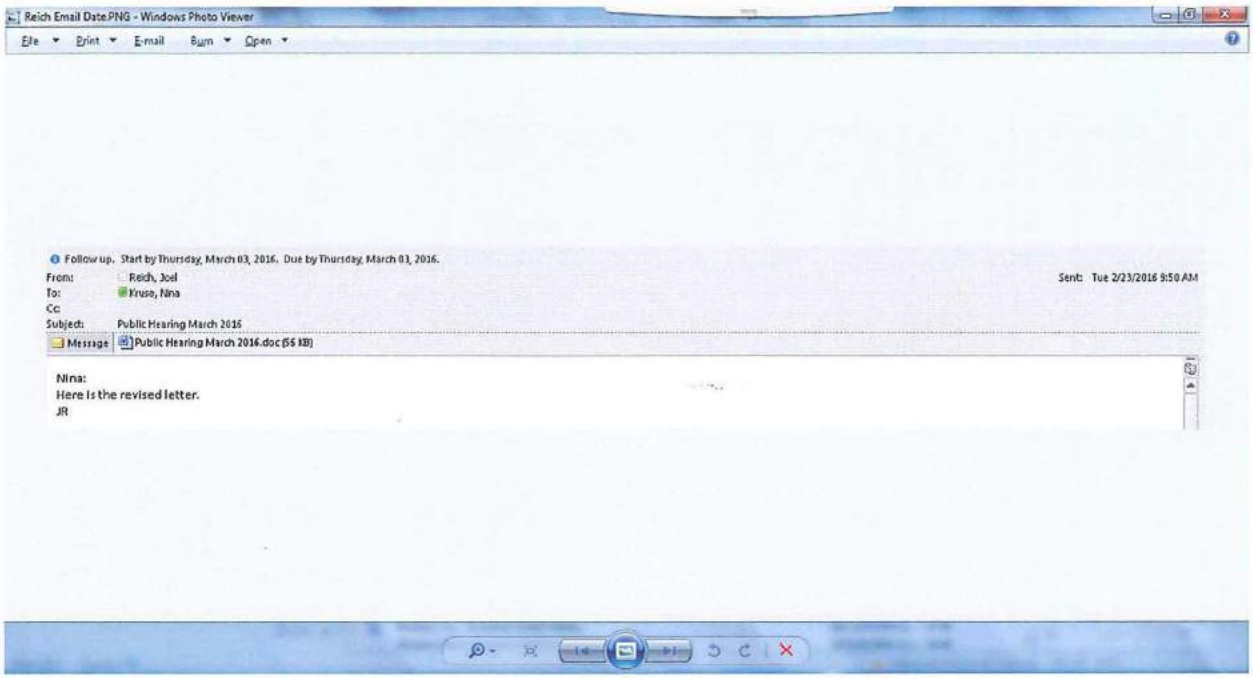
Prospect Medical Holdings is by far the best option for ECHN for the following reasons:

- It is the best "cultural fit". It has extensive experience with community hospitals serving communities very much like our own. Its leadership is focused on innovation and growth and its strategy execution is agile.
- It will bring much-needed capital investment to ECHN to ensure financial stability and future growth.
- Prospect Medical Holdings is much more than a "hospital company". It is healthcare services company. While it very successfully operates its 13 current hospitals, it has fully integrated 9,000 independent physicians, community health care centers, and other community care givers into its system model which is fully compatible with the Affordable Care Act.
- Through its care management programs, health coaching structure, and sophisticated health information and analytics capabilities, it helps patients and families navigate the complexities of the healthcare system, while reducing expenditures for non-value-added services. In short, Prospect Medical Holdings has already mastered what most other health systems are *talking about* doing in the future.

I believe that Prospect Medical Holdings is the best partner for ECHN and hope that you will be able to support this choice through the regulatory process. Thank you for your consideration of this request.

Sincerely,

Joel J. Reich, MD, FACEP
Chief Medical Officer/Senior Vice President for Medical Affairs


Reich Email Date.PNG - Windows Photo Viewer
File Print E-mail Burn Open
Follow up. Start by Thursday, March 03, 2016. Due by Thursday, March 03, 2016.
From: Reich, Joel
To: Kruse, Nina
Cc:
Subject: Public Hearing March 2016
Sent: Tue 2/23/2016 9:50 AM
Message
Public Hearing March 2016.doc (56 KB)
Nina:
Here is the revised letter.
JR

Letter of Recommendation in favor of the Proposed Acquisition of Eastern Connecticut Health Network, Inc. by Prospect Medical Holdings, Inc., Provided for Public Hearing on March 30, 2016

To: The Office of Health Care Access and the State Attorney General

My name is Barbara L. Phillips, M.D., and I speak today as a family physician and as a member of the Board of Trustees of Eastern Connecticut Health Network, Inc. ("ECHN"), in support of the acquisition of ECHN by Prospect Medical Holdings, Inc. ("Prospect").

I have a great interest in preserving access to quality health care for the citizens of Connecticut. I have practiced independent family medicine in Manchester since 2004. I completed my internship and residency training at Middlesex Hospital here in Connecticut and have served on the Board of Directors for the Connecticut Academy of Family Physicians, all of which has informed my understanding of the healthcare needs of our state. My work in the Eastern Connecticut Physician Hospital Organization and our clinically integrated network have deepened and broadened my connections with communities in the ECHN service area. In helping to represent Connecticut family physicians and the physician hospital organization at the national level, I have tried to bring the voices of Connecticut residents into the dialog regarding health care reform, and to place the healthcare issues of our state in the national context. And now as Trustee for ECHN, through due diligence I have developed confidence in and a strong commitment to the choice of Prospect as the appropriate partner with ECHN to ensure the health of all residents of the ECHN service area.

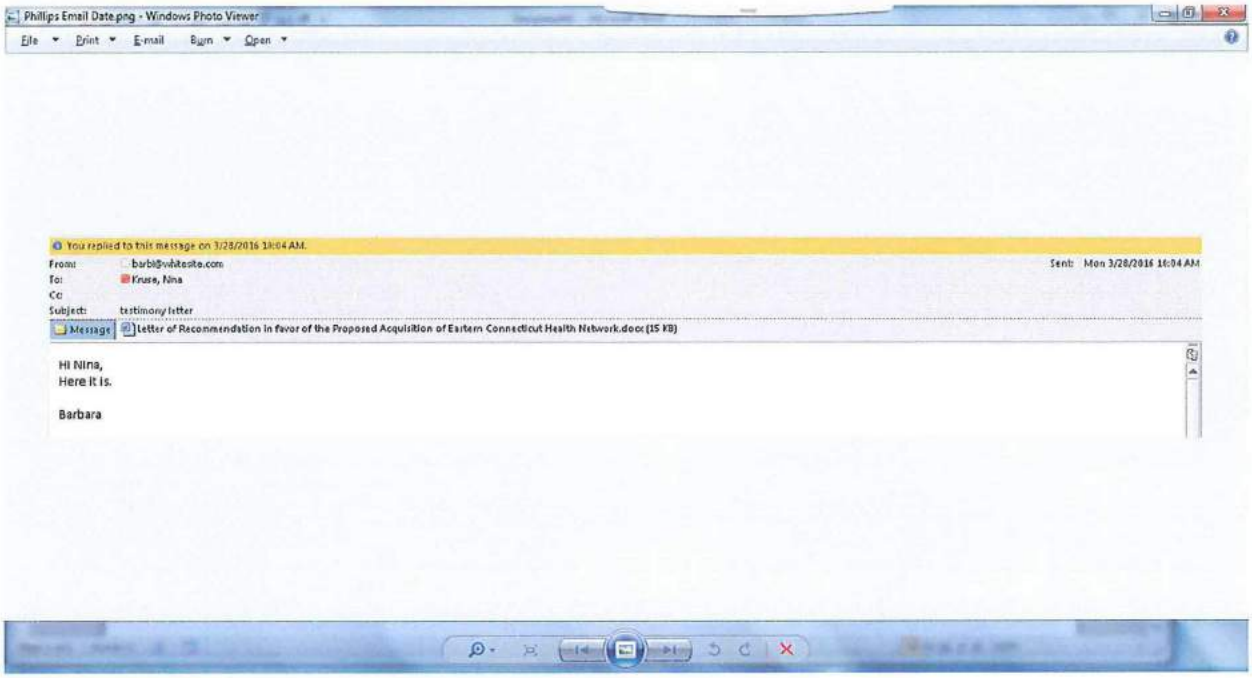
A number of years ago, the ECHN management team, Board of Trustees and medical staff leaders anticipated the significant challenges posed by the accelerating pace of change in healthcare in Connecticut. ECHN, like a number of community hospitals in the state, determined that aligning with a capital partner offered the best means of preserving and improving access and quality of local health care, and of "bending the cost curve" of medicine.

ECHN, with the Board of Trustees, conducted a thorough search to identify the best partner to support its mission to provide high-quality compassionate health care. Simultaneously, a collaborative organization was developed to better unite the efforts of healthcare providers, health system and community, and transition stakeholders toward inevitable risk-contracting. This organization is the ECHN Clinically Integrated Network of Eastern Connecticut, called "CINECT". The formation and growth of CINECT has allowed us to work cooperatively with our health insurance partners to more effectively manage the health of our population. With proper oversight and alignment of all involved in primary, specialty, acute and post-acute care, the clinical integration model has tremendous potential to achieve the Institute for Healthcare Improvement's Triple Aim -- to improve patient experience of care, improve the health of populations, and reduce the cost of health care.

As the health system's search for a partner progressed, it became and remains abundantly clear that Prospect is the most appropriate acquisition partner for ECHN. Prospect is best poised to build upon the bedrock of ECHN's deep community ties and historical stewardship of regional health care, and to bring their expertise to developing the path of clinical integration and

bettering the delivery of regional health care. In contrast to the fears of some regarding the entry into the state of a for-profit health system, Prospect has consistently demonstrated its commitment to the viability of its locally managed health systems and the promotion of robust primary care-driven physician networks. With its proven Coordinated Regional Care model and solid financial health, Prospect will help ensure that we preserve diversity, choice and access to health care in Connecticut, and I urge the State Attorney General and Office of Health Care Access to approve the acquisition.

Thank you and please feel free to contact me for further information.


Phillips Email Date.png - Windows Photo Viewer
File Print E-mail Burn Open
You replied to this message on 3/28/2016 10:04 AM.
From: barbl@whitesite.com
To: Kruse, Nina
Cc:
Subject: testimony letter
Sent: Mon 3/28/2016 10:04 AM
Message
Letter of Recommendation in favor of the Proposed Acquisition of Eastern Connecticut Health Network.docx (15 KB)
Hi Nina,
Here it is.
Barbara

March 22, 2016

The Honorable George C. Jepsen, Attorney General
Office of the Attorney General
55 Elm Street, Hartford, CT 06106

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

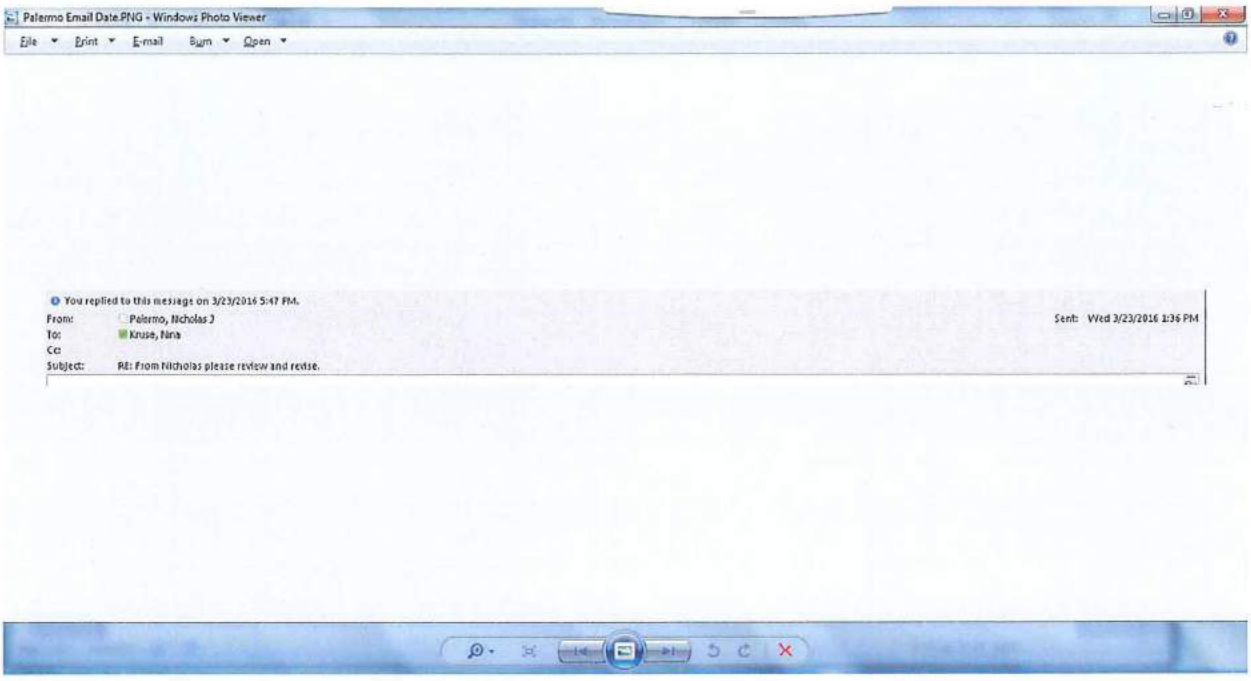
Dear Attorney General Jepsen and Commissioner Pino,

Over six years ago Manchester Memorial Hospital had a vision of expanding primary care for the communities we serve east of the Connecticut River. We developed a Department of Academic Affairs, and together with our academic partner, the University of New England and the College of Osteopathic Medicine, we developed a medical student program for those students to receive their clinical training at ECHN. This was received so well by the local and hospital community that a decision was made to expand our clinical teaching services by starting a Family Medicine Residency Program. The vision for this project was to continue the continuum of medical education training by developing graduate medical education programs. The benefit to developing our own residency programs is that we train our own physicians who will hopefully love our community as much as we do and stay in the area after they graduate.

The Eastern Connecticut Family Medicine Program graduated its first class of physicians in June of 2015. Chad McDonald, D.O., our Chief Resident at the time, is now practicing in South Windsor, CT. Another graduate, Tricia Hall, D.O., is also practicing in our community as a Neuromuscular Medicine Fellow. Keeping this trend alive, this year another one of our graduating physicians and chief resident, Katelyn Zachau, D.O. will also be establishing her practice in Ellington. The mission to bring primary care providers to our area is working and in the spring of 2017 two more graduates will be opening their offices in the Manchester and South Windsor area as well.

Prospect Medical Holdings, LLC has expressed one hundred percent commitment to both the undergraduate and graduate medical programs at Manchester Memorial Hospital. There are natural synergies between their vision to expand clinical services and our vision to provide those physicians for those projects. In addition, Prospect Medical Holdings, LLC shares our opinion that there is a tremendous value in academic medicine as we look to train our future medical providers today. We are confident that Prospect Medical Holdings, LLC's investment in our ECHN Family will be to strengthen our family medicine residency program as it continues to grow and to provide our primary care physicians with ample opportunities to practice in this wonderful community.

Nicholas J. Palermo, D.O., M.S.
Program Director
Eastern Connecticut Family Medicine Residency Program
Associate Regional Assistant Dean, UNECOM
Associate Professor of Family Medicine
p-860.533.4679


Palermo Email Date.PNG - Windows Photo Viewer
File
Print
E-mail
Burn
Open
You replied to this message on 3/23/2016 5:47 PM.
From: Palermo, Nicholas J
To: Kruse, Nina
Cc:
Subject: RE: From Nicholas please review and revise.
Sent: Wed 3/23/2016 1:36 PM

ECHN℠
Eastern Connecticut Health Network

The Proposed Transfer of Assets of Eastern Connecticut Health Network, Inc. and Affiliates to Prospect Medical Holdings, Inc.

Presented to:
The Office of the Attorney General
The Office of Health Care Access
March 29 & 30, 2016

PROSPECT MEDICAL
Quality Service ~ Quality Care

Presenters:
Dr. Dennis O'Neill, Chairman, ECHN Board of Trustees
Joy Dorin, Vice Chairman, ECHN Board of Trustees
Peter J. Karl, President & CEO, ECHN

ECHN℠
Eastern Connecticut Health Network

Overview: ECHN's Journey, Its Mission

Dennis G. O'Neill, M.D.
Chairman, ECHN Board of Trustees

Preparing for the Future at ECHN

Our Mission : Our Community

- Caring for & serving the community, continuing our mission & vision
  - Improving the well-being of those we serve with quality, compassionate health care
  - Preserving ECHN: its name, local institutions, services and programs
  - Developing the next generation of physicians to serve our communities
  - Striving to continuously improve quality, safety, & outcomes with recognition by Joint Commission for the services offered
- While preserving over 3,000 jobs





ECHN
Eastern Connecticut Health Network

Preparing for the Future at ECHN

Serving the public need

- More than our two hospitals, a network of 13 wholly owned companies, 12 joint ventures companies, dozens of facilities serving our communities healthcare needs
- For 2015:
  - 114,000 people treated at its hospitals
  - 60,000 patients under the care of community-based physicians employed by ECHN
  - 4,690 patients cared for by Visiting Nurse and Health Services of CT
  - 805 people received homemaker and companion services
  - Comprehensive behavioral health services
  - 61,000 emergency visits

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Eastern Connecticut Health Network

ECHN℠
Eastern Connecticut Health Network

Understanding Its Past, Preserving Its Future

Peter J. Karl
President & CEO

Impact of Healthcare Reform
(PPACA)

- More than insuring 32M more people
- Declining government payments to hospitals
- Focus on value, lowest cost with best results
- New payment systems put providers at risk
- Community focused delivery models
- Major investments required for programs, technology and facilities

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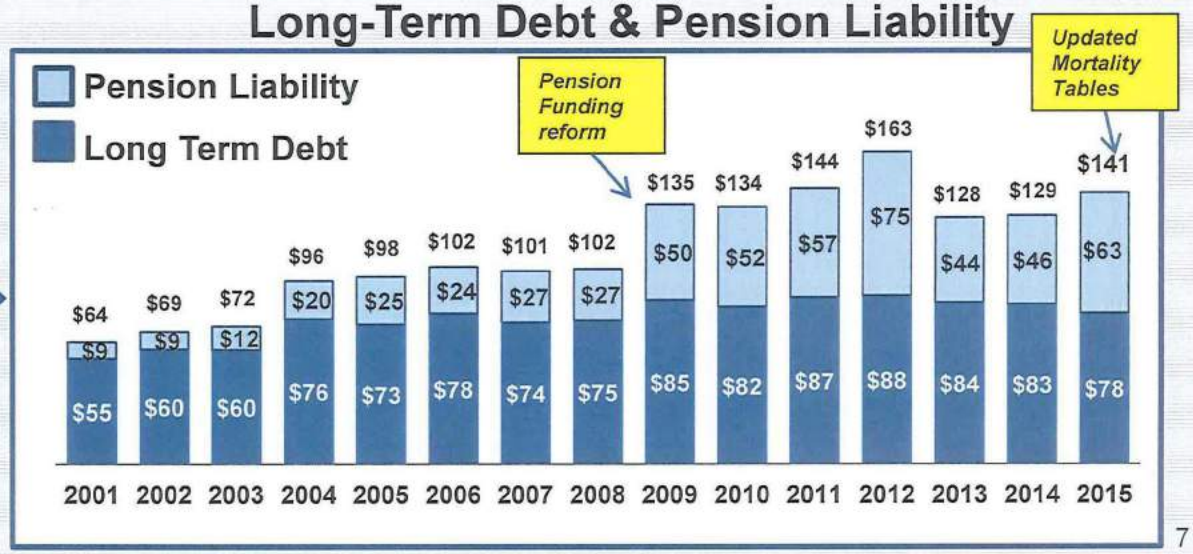
Financial Challenges

Low margins and growth in debt forced ECHN to defer capital investments; our historical financial performance has left the organization with a large debt structure that cannot be mitigated through margin alone.

1. Operations contributed only $9M total over the last 15 years: Operational deficits in 2001-2004 of $23.1 million required 6 years to be overcome



2. Long term debt and pension liabilities have grown 123% ($78M) in the last 15 years– annual debt service and pension contributions now take up the lion's share of annual cash flows



Continuing Financial Challenges
Taxes and Reduced Government Payments

	FY 2014	FY 2015	FY 2016
CT Hospital Tax	(3,914,000)	(7,960,000)	(9,942,000)
CMS Sequestration	(1,104,000)	(2,208,000)	(2,208,000)
Medicaid Inpatient Modernization Program		(1,200,000)	(1,600,000)
Low Cost Hospital Pool Eliminated			(300,000)
Medicare Wage Index		(4,825,000)	(6,525,000)
	($5,018,000)	($16,193,000)	($20,575,000)

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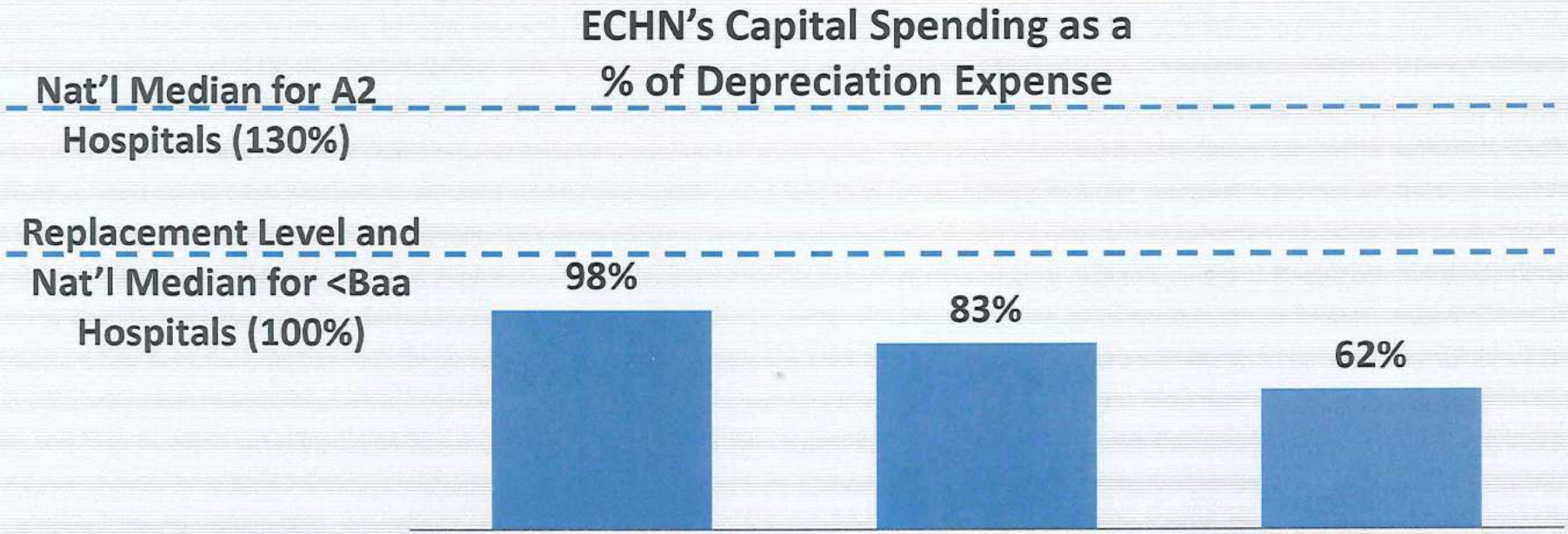
ECHN's Financial Challenges

Historically, and in the future, ECHN's ability to invest in capital is below replacement for depreciation – inherently leading to a decrease in its asset base. The age of plant for our hospitals in 2015 was 21 years.



	2013	2014	2015
Plant/Equipment Purchases	$12.1	$10.1	$7.4
Depreciation	$12.3	$12.2	$11.9

Negative Forces into the Future



-Continued payment erosion from federal government

-Declining levels of payment from state government

-Payment reforms with more financial risk

-Continued pension obligations

-Rising costs

= Unsustainable results with an inability to REINVEST in ECHN

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Eastern Connecticut Health Network

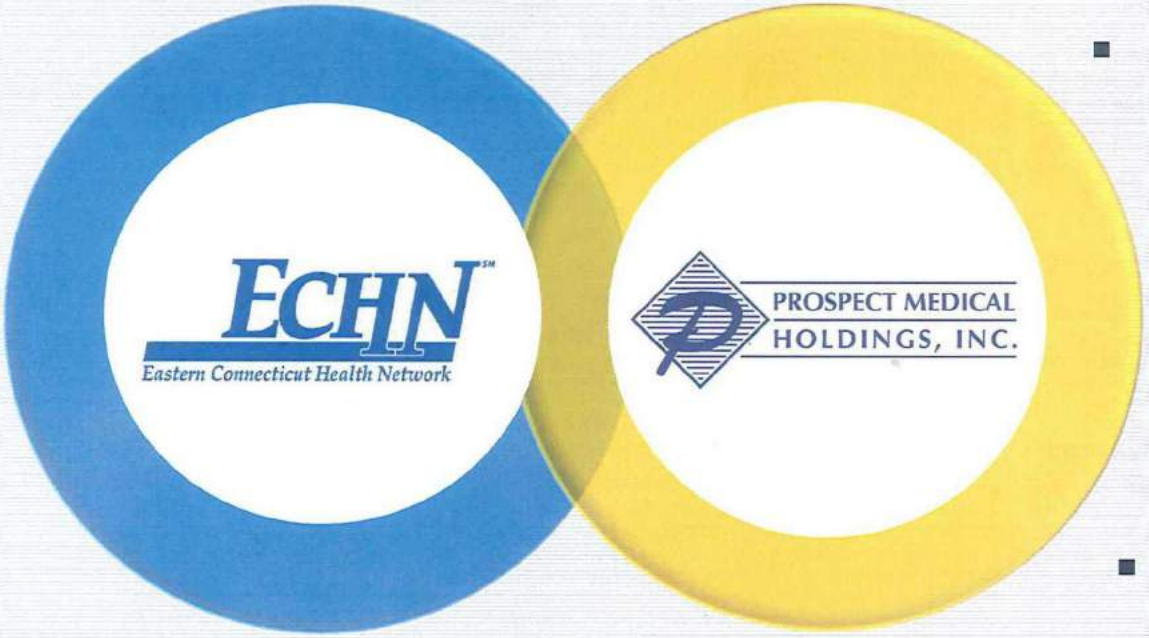
The Proposed Transaction

Prospect Medical Holdings to Buy ECHN

- **$105M** to satisfy all of ECHN's debt and liabilities
- **$75m of capital** to invest in ECHN
- Maintain Manchester Memorial and Rockville General Hospitals, Woodlake at Tolland and Visiting Nurse & Health Services of Connecticut
- Continuation of the ECHN brand and mission
- Community advisory board
- Continued commitment to charity care, indigent care and community benefits
- Employment for all ECHN employees
- Establishment of a community foundation to oversee certain charitable funds



The combination of ECHN with Prospect Medical Holdings will secure the future of care and local access for residents



- Aligned mission, vision & values
- Strong medical staff partner
- Experienced health plan partner with extensive risk management experience
- Long history of population health management
- Resources to invest in programs, staff, facilities and technology

Together with our Medical Staff, building a sustainable, thriving network of value-based care for our communities.

ECHN℠
Eastern Connecticut Health Network

Future Quality Assurance at ECHN

Joy Dorin
Vice Chair, ECHN Board of Trustees
Chair, ECHN Transaction Committee

Due Diligence for the Transaction

- ✓ Serve the public's needs
- ✓ Positive impact on financial strength of our health care system
- ✓ Improve quality, accessibility and cost-effectiveness of health care delivery in the region, etc.
- ECHN's quality and safety efforts and achievements
  - High Reliability Organization
  - MMH and RGH, Joint Commission recognition Top Performers
- Due diligence efforts and results

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PROSPECT MEDICAL
Quality Service ~ Quality Care

ECHN
Eastern Connecticut Health Network





Conclusion







STATE OF CONNECTICUT

OFFICE OF THE ATTORNEY GENERAL

AND

DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

Attorney General Docket No.: 15-486-01
OHCA Docket No.: 15-32016-486
Eastern Connecticut Health Network, Inc.
Proposed Asset Purchase by Prospect
Medical Holdings, Inc. **March 28, 2016**

Supplemental Information for Question 11 and Exhibits Q11-1 and 11-2 of the Certificate of Need Related to ECHN's Charitable Funds

Eastern Connecticut Health Network, Inc. is submitting additional information related to Question 11 and Exhibits Q11-1 and 11-2 of the Certificate of Need concerning the charitable funds held by Manchester Memorial Hospital, Rockville General Hospital, ECHN Foundation, and Woodlake at Tolland. References are to Exhibit and Page numbers of the Certificate of Need.

Fund Number 11-1.1 in Exhibit Q11-2 (page 983) - Dwight W. Blish. A portion of the first page of the copy of Mr. Blish's Will dated September 6, 1923, was not included in the filing. Complete conformed copies of the Will and Codicil are provided as Attachment A.

Fund Number 11.1-30 in Exhibit Q11-1 (page 941) - Interests in the Estate of Raymond F. Damato. As stated in the original submission, Manchester Memorial Hospital is a beneficiary of an unrestricted gift from of the Estate of Raymond F. Damato. The Hospital's vested interest in the Estate has been partially distributed but will likely not be fully distributed to it prior to closing of the contemplated transaction. ECHN has considered the timing and use of the remaining distribution(s). ECHN has been working with the executors of the Estate to develop a plan for use of the gift and now contemplates using the funds to benefit the Manchester community through supporting the continued availability of physicians to serve the community and larger area and furthering medical education. Regardless of whether the remaining gift distributions are received prior to or after the closing, after the payment of all ECHN's debts, ECHN is planning to distribute the gift (or assign the right to receive it) to the University of New England College of Medicine ("UNECOM"), a 501(c)(3) organization that already provides

medical education in Manchester, to support the continued provision of medical education in Manchester, including but not limited to support for the construction and/or purchase of medical education facility space and/or equipment to be located in Manchester, medical education services to be provided within the boundaries of Manchester, and/or financial assistance to medical students and residents receiving their clinical education in Manchester. ECHN also plans to impose gift restrictions to insure that the gift may not be used out of Connecticut. ECHN plans to consult with the Office of the Attorney General in the future about the proposal for use of the gift.

Fund Number 11.1-34 in Exhibit Q11-1 (Page 943) - Stephen Goodale and Emeret Scott Risley. In addition to an endowment created under the Will, the testatrix Mary Risley Adams left her father's diploma and a 1720 clock to Rockville General Hospital. The Hospital has the clock, which is in the library of the mansion of the Hospital, and is looking for the diploma. Because these were outright gifts to the Hospital and not subject to a restriction, ECHN believes they are assets required under the APA to be transferred to PMH. If for some reason PMH does not want one or both of them, then ECHN will consider donating them to the library or the historical society.

Fund 11.1-55 in Exhibit Q11-1 (Page 951) – E. Stevens Henry. As noted in the Certificate of Need, the Hospital has received differing advice about the nature of this fund, which was received by the Hospital in 2003 upon termination of a trust. The Hospital is now evaluating how it believes the fund should be classified and in addition is investigating what the original gift value is.

Fund 11-1.66 in Exhibit Q11-1 (Page 959) – Swindells Fund. This fund contains distributions from a trust held by an outside trustee. Rockville General Hospital is not a named beneficiary of the trust, and the Hospital received its most recent distribution from the trust on October 4, 1996.

Fund 11-1.96 in Exhibit Q11-1 (Page 971) – ECHN Foundation: $10,000 One Life Charitable Gift Annuity. The Foundation has decided to ask the annuitant to accept payment of the present value of the right to receive the annuity payments in satisfaction of this agreement.

Fund 11-1.103 in Exhibit Q11-1 (Page 975) – Trust u/w Gertrude H. Rogers. The language in this trust reflects that the primary interest of the donor was to serve the health and welfare of the Manchester community. ECHN is considering ways in which this intent may continue to be furthered consistent with the structure of the trust overall.

Updated Market Values. ECHN is preparing updated values for the funds and will file them at or immediately after the public hearings.

765/2611/3442765.4

ATTACHMENT A

Complete Conformed Copy of the Will of Dwight W. Blish

M M Hospital Dwight W Blish Fund #1402

M M H Dwight W Blish Fund #1401

BE IT KNOWN TO ALL PERSONS, THAT I, Dwight W. Blish of the Town of Manchester in the County of Hartford in the State of Connecticut being of lawful age, of sound and disposing mind, memory and judgment, do hereby make, publish and declare this to be my last Will and Testament, hereby revoking all previous wills and codicils by me made.

First: I direct that all my just debts and funeral expenses be paid by my executor hereinafter named.

Second: I give to the town of Manchester the sum of One Hundred Dollars, in trust however, to invest the same and to use the income therefrom for the perpetual care of my burial plot in the East Cemetery in said Manchester.

Third: I give to my wife Alice E. C. Blish and to my son Hayward C. Blish all my wearing apparel, watches, jewelry, household furnishings, furniture, tools and my automobile.

Fourth: All the rest and residue of my property both real and personal and wheresever situated I give, devise and bequeath to The Manchester Trust Company of said Manchester, in trust however, to take, hold, invest and reinvest the same and to use the income therefrom for the support and maintenance of my said wife and son or the survivor of them. In case the income from said trust fund is not sufficient for the comfortable support and maintenance of my said wife and son then I authorize said trustee to use any or all of the principal for said purpose. I direct said trustee to pay the funeral expenses of my said son from said trust fund and in the event that there should not be funds available for the funeral expenses of my said wife I direct said trustee to also pay her funeral expenses. It being my desire that my said wife and son shall always have a home of their own during their lifetime I hereby direct said trustee upon the written request of my said wife to sell the house occupied by her and my son and to purchase another home for her upon like request. Unless so requested by my said wife the house occupied by her and my son shall not be sold. I authorize and empower said trustee to sell all other real estate owned by me at the time of my death if it shall deem best. At the death of my said

wife and son I give whatever property may then remain in the hands of said trustee to The Manchester Memorial Hospital to be held by the trustees of said hospital as a trust fund to be known as the Dwight W. Blish fund, the income therefrom to be used for such purposes in connection with said hospital as the trustees shall decide.

I APPOINT The Manchester Trust Company of the Town of Manchester, County of Hartford and State of Connecticut executor of this my Last Will and Testament.

IN WITNESS WHEREOF I have hereunto set my hand and seal at said Manchester on the 6 day of September A. D., One Thousand, Nine Hundred and Twenty-three.

DWIGHT W. BLISH (L.S.)

Signed, sealed, published and declared by the said Dwight W. Blish as and for his Last Will and Testament, in presence of us who at his request, in his presence, and in the presence of each other have hereunto subscribed our names as witnesses, on the 6 day of September A. D., 1923.

THOMAS K. CLARKE
RAYMOND R. BOWERS } Witnesses
WILLIAM S. HYDE

State of Connecticut }
County of Hartford } ss. Manchester, September 6, A. D., 1923

We the within named Thomas K. Clarke and Raymond R. Bowers being duly sworn, make affidavit and say: that we severally attested the within and foregoing Will of the within named testator and subscribed the same in his presence and at his request and in the presence of each other; that the said testator signed, published and declared the said instrument as and for his last Will and Testament in our presence on the 6 day of September A. D., 1923; and at the time of execution of said will, said testator was more than eighteen years of age and of sound mind, memory and judgment and under no improper influence or restraint to the best of our knowledge and belief, and we

make this affidavit at the request of said testator.

THOMAS K. CLARKE

RAYMOND R. BOWERS

State of Connecticut }
County of Hartford } ss. Manchester September 6, A.D., 1923.

Then personally appeared before me a Notary Public duly qualified to administer oaths,

THOMAS K. CLARKE

and RAYMOND R. BOWERS

and subscribed and made oath to the truth of the foregoing affidavit.

WILLIAM S. MUNN

Notary Public

KNOW ALL MEN BY THESE PRESENTS that I, Dwight W. Blish, of the Town of Manchester, County of Hartford, and State of Connecticut, being of lawful age, of sound and disposing mind, memory and judgment, do hereby make, publish and declare this to be a codicil to my Last Will and Testament, dated September 6, 1933.

I.

I appoint The Manchester Trust Company, a Connecticut corporation located in said Manchester, Executor of this my Last Will and Testament

In all other respects I hereby ratify and confirm said Will.

IN WITNESS WHEREOF I have hereunto set my hand and seal at said Manchester, on the 3rd day of July, A. D., One Thousand Nine Hundred and Thirty-three.

DWIGHT W. BLISH (L.S.)

Signed, sealed, published and declared by the said Dwight W. Blish as and for a codicil to his Last Will and Testament, in presence of us, who at his request, in his presence, and in the presence of each other have hereunto subscribed our names as witnesses, on the 3rd day of July, A. D., 1933.

ELIN G. NIELSEN
LOUIS H. MARTE
ROBERT E. HATHAWAY } Witnesses

State of Connecticut: ss. Manchester, July 3rd, A. D., 1933.
County of Hartford :

We the within named Elin G. Nielsen, Louis H. Marte, and Robert E. Hathaway being duly sworn, make affidavit and say: That we severally attested the within and foregoing Codicil of the within named testator, and subscribed the same in his presence and at his request and in the presence of each other; that the said testator si published and declared the said instrument as and for a Codicil to h last Will and Testament in our presence on the 3rd day of July A. D. 1933; and at the time of execution of said Codicil, said testator wa

more than eighteen years of age and of sound mind, memory and judgment and under no improper influence or restraint to the best of our knowledge and belief, and we make this affidavit at the request of said testatrix.

ELIN G. NIELSEN

LOUIS H. MARTE

ROBERT E. HATHAWAY

State of Connecticut }
County of Hartford } ss. Manchester, July 3rd, A. D., 1933.

Then personally appeared before me a Commissioner of Superior Court, duly qualified to administer oaths.

ELIN G. NIELSEN

LOUIS H. MARTE

and ROBERT E. HATHAWAY

and subscribed and made oath to the truth of the foregoing affidavit.

HAROLD G. ALVORD
Notary Public.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Western Division of Survey and Certification
San Francisco Regional Office
90 7th Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

CENTERS FOR MEDICARE & MEDICAID SERVICES

Refer to: WDSC-RA

IMPORTANT NOTICE – PLEASE READ CAREFULLY

March 23, 2016

Deborah Webber, CEO
Los Angeles Community Hospital
4081 East Olympic Blvd
Los Angeles, CA 90023

CMS Certification Number (CCN): 050663

Dear Ms. Webber:

This is to inform you that based on a careful review of the findings of a revisit survey completed on February 17, 2016 by the California Department of Public Health (CDPH), the Centers for Medicare and Medicaid Services (CMS) has concluded that Los Angeles Community Hospital is still not in compliance with the applicable Conditions of Participation for a provider of hospital services in the Medicare program, established by Title XVIII of the Social Security Act.

Previously, in a letter dated January 14, 2016, you were informed that based on the findings of a November 10, 2015 complaint survey, the hospital's Medicare provider agreement could be terminated by April 13, 2016 if the facility did not come into compliance with the Medicare Conditions of Participation. Since that time, you submitted an allegation of correction, based upon which CDPH conducted the February 17, 2016 resurvey noted above. This resurvey demonstrated that the hospital remains out of compliance with the following Condition of Participation:

42 C.F.R. § 482.123 – Nursing Services
42 C.F.R. § 482.42 – Infection Control

The findings of the February 17, 2016 survey are set forth in the attached Statement of Deficiencies (Form CMS-2567). As you are aware, to participate in the Medicare program, a hospital must be in compliance with each of the applicable regulatory Conditions of Participation for hospitals at 42 C.F.R. Part 482.

Because Los Angeles Community Hospital is not in compliance with all Conditions of Participation at 42 C.F.R. Part 482, as determined by the survey completed on February 17,

2016, we must proceed with the process that could result in termination of the hospital's Medicare provider agreement. 42 C.F.R. §§ 489.53(a)(1) & (3). However, with this notice we are extending the date of termination of the hospital's Medicare provider agreement to **June 21, 2016** to provide you more time to achieve and maintain compliance. Accordingly, unless we are able to verify compliance termination is scheduled to take effect by June 21, 2016.

Importantly, termination of Los Angeles Community Hospital's provider agreement may still be avoided if by April 4, 2016 the hospital submits to the CDPH, Bakersfield District Office, credible documentation evidencing correction of all of the cited deficiencies and that the hospital is otherwise in compliance with all Conditions of Participation applicable to hospitals in the Medicare program as set forth at 42 C.F.R. Part 482. At a minimum, such submittal must include documentation detailing the actions taken that resulted in the alleged correction of each deficiency; the title or position of the person responsible for the correction; and a description of the monitoring process established to prevent recurrence of the deficiency. **Please note that mere plans of future correction or evidence of progress toward correction will not be sufficient.**

If we receive such a submittal by the close of business on April 4, 2016, **and** if we find that the submission constitutes a credible allegation of compliance, we will notify you of this finding and authorize a resurvey of Los Angeles Community Hospital.

In the event we do not receive a timely, credible allegation of compliance, or if a resurvey authorized on the basis of such an allegation shows that the hospital remains out of compliance, we will notify you that the termination action is to proceed, notify the public of the forthcoming termination, and advise you of appeal rights, in accordance with regulations at 42 C.F.R. § 489.53(d).

In the event termination does occur, there will be no payment for inpatient services rendered to Medicare beneficiaries admitted on or after the effective date. Payment for those beneficiaries in the hospital prior to the effective date will be limited to thirty (30) days. See 42 C.F.R. § 489.55.

Appeal Rights

If you do not agree with the determination to impose these actions, you may request a hearing before an administrative law judge (ALJ) of the Departmental Appeals Board in accordance with 42 C.F.R. §§ 498.40 through 498.78. A request for hearing must be filed electronically no later than sixty (60) calendar days after the date you receive this notice. 42 C.F.R. § 498.40. You should file your request for an appeal (accompanied by a copy of this letter) to the Departmental Appeals Board Electronic Filing System website (DAB E-file) at https://dab.efile.hhs.gov. Please note: All documents must be submitted in Portable Document Format ("pdf"). You are required to e-file your appeal request unless you do not have access to a computer or internet service. In such circumstances, you may file in writing, but must provide an explanation as to why you cannot file submissions electronically and request a waiver from e-filing in the mailed copy of your request for a hearing. Written request for appeals must also be filed no later than

sixty (60) calendar days from the date you receive this notice, and must be submitted to the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
330 Independence Ave, SW
Cohen Building, Room G-644
Washington, D.C. 20201

A copy of the hearing request should be sent to:

Rufus Arther, Manager
Non Long Term Care Branch
Division of Survey and Certification
90 7th Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

Your request must identify the specific issues as well as the findings of fact and conclusions of law with which you disagree and explain your basis for contending that the findings and conclusions are incorrect. You will have an opportunity to present evidence and further argument at an in-person hearing, where you may be represented by counsel. **Completion of the administrative review process established by 42 C.F.R. Part 498 is a prerequisite to obtaining judicial review.**

Should you have any questions concerning this matter, please contact Rosanna Angeldones at 415.744.3735 or at Rosanna.Angeldones@cms.hhs.gov.

Sincerely,

Rufus Arther, Manager
Non-Long-Term-Care Branch
Division of Survey and Certification

Attachments - Form CMS-2567

cc: CDPH, Medicaid

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050663	A. BUILDING _____ B. WING _____	R-C 02/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOS ANGELES COMMUNITY HOSPITAL	4081 E OLYMPIC BLVD LOS ANGELES, CA 90023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 000}	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a First Revisit Complaint Validation survey. Complaint Number: 462024 Representing the Department: 18790, HFEN 21905, HFEN 32233, HFEN 33399, Infection Control Consultant 22711, Medical Consultant Census was 132 Sample Size was 31 patients	{A 000}		
{A 131}	482.13(b)(2) PATIENT RIGHTS: INFORMED CONSENT The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the hospital failed to obtain adequate informed consents for three of 31 sampled patients (28, 44 and 45). This has the potential for the patients or the patients' responsible	{A 131}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050663	A. BUILDING _____ B. WING _____	R-C 02/17/2016

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{A 131}	Continued From page 1 parties to be unaware of potential risks versus benefits of a proposed treatment prior to consent to the treatment. Findings: 1. During an interview and review of the clinical record of Patient 28 on 2/17/16, at 9:30 AM, the admission record documented she was re-admitted to the sub acute care unit on 1/27/16. It was noted she signed her hemodialysis (a treatment in which a machine filters wastes, salts and fluid from your blood when your kidneys are no longer healthy enough to do this adequately) consent on 1/27/16. It was illegible, but the nurse who witnessed it (Registered Nurse [RN] 7) stated she had obtained Patient 28's signature indicating informed consent. There was another consent for Prozac (antidepressant medication), dated 1/27/16. The signature for the antidepressant consent was different from the markings on the hemodialysis consent. RN 7 stated, "The physician signed that one." During an observation and interview on 2/17/16, at 10 AM, Patient 28 was lying in bed, breathing with a ventilator (breathing machine) connected to a tracheotomy (a surgically created hole through the front of a person's neck to the windpipe [trachea] which provides an air passage to help a person breathe and is often needed with long term ventilator use) and formula connected to Patient 28's feeding tube (a tube that is placed either through the nose and passed through the windpipe down to the stomach or directly to the stomach to provide liquid nutrition). Patient 28 did not wake up when spoken to. During another observation of Patient 28 with RN 7 and Licensed Vocational Nurse (LVN) 1 at 11:15 AM, RN 7	{A 131}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050663	A. BUILDING _____ B. WING _____	R-C 02/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOS ANGELES COMMUNITY HOSPITAL	4081 E OLYMPIC BLVD LOS ANGELES, CA 90023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 131}	Continued From page 2 physically touched the patient and encouraged her to answer questions. Patient 28's speech was difficult to understand and what could be understood did not seem to make a sentence. RN 7 was unable to identify what Patient 28 said with the approximately 6-8 words spoken. During a review of the clinical record of Patient 28, a son was listed by name and a telephone number documented. The Minimum Data Set (MDS, an assessment tool) identified Patient 28's cognitive (ability to think, remember, and understand the environment) status on 9/3/15, as "Severely impaired--never/rarely made decisions." The MDS assessment dated 12/4/15, identified her cognitive status as severely impaired. RN 7 was asked if there was a re-assessment upon admission on 1/27/16. RN 7 stated, "No. Because she hadn't changed." RN 7 was asked if Patient 28's son could give consent. She replied, "The son doesn't return phone calls. Sometimes he's in jail. That's why he doesn't give his consent." RN 7 was asked how she could assess this patient in regards to obtaining an informed consent. RN 7 stated, "I talk to her and she seems to understand. Sometimes we can read her lips." The hospital policy and procedure titled "Consent/Informed Consent" dated 1/2014, indicated: "...Policy:..1. Capacity to Consent. A person may give a valid consent only if he or she has 'capacity' which means he or she is able to understand the nature and consequence of a decision and to make and communicate the decision... If an adult lacks the capacity to make medical decisions, a surrogate decision-maker must be identified... iv. The hospital will establish a multi-disciplinary committee as a subcommittee	{A 131}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{A 131}	Continued From page 3 of the Ethics Committee and delegate to it responsibility for acting as a surrogate decision-maker for patients who have no surrogate decision-maker... 4. 'Informed Consent' is required for those procedures which are complex or involve material risks that are not commonly understood. The patient's physician is responsible for providing the information the patient needs in order to make an informed decision and for obtaining the patient's informed consent or refusal for the recommended procedure. The hospital's role in the informed consent process is to verify that the physician obtained the patient's informed consent before the physician is permitted to perform the procedure..." 2. During a review of the clinical record for Patient 44 and interview with LVN 3, on 2/17/16, at 9:04 AM, the clinical record indicated the patient was admitted on 2/15/16, with an abscess to the left lower extremity. The History and Physical dated 2/15/16, indicated the patient arrived to the Emergency Room (ER) with severe pain and redness to the posterior thigh. The "Assessment and Plan" section indicated the patient had an abscess of the left posterior thigh and a status post incision and drainage (I & D is a minor surgical procedure using a sharp instrument to release the pus and pressure built up under the skin caused by an abscess) was performed to the site. The nursing note dated 2/17/16, at 9:29 AM, read, "Received pt (Patient 44)...Admitting Dx (Diagnosis): cellulitis & abscess on left upper leg...ER nurse stated that pt had I & D at ER..." There was no informed consent noted in the clinical record indicating the physician had described the potential risks and benefits of the treatment prior to performing the I	{A 131}		

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{A 131}	Continued From page 4 & D to the patient's abscess site. LVN 3 confirmed there was no informed consent obtained prior to the procedure, although there should have been one obtained. 3. During an observation on 2/17/16, at 9:44 AM, in the Intensive Care Unit, Patient 45 was observed with a tracheostomy attached to a ventilator. During a review of the clinical record and interview with LVN 3, on 2/17/16, at 10 AM, an informed consent document was noted for the tracheostomy placement signed on 2/11/16. The document was incomplete which was confirmed by LVN 3. No additional information was provided. The hospital policy and procedure titled "Consent/Informed Consent" dated 1/2014, indicated under the POLICY subheading, "...4. Informed Consent is required for those procedures which are complex or involve material risks that are not commonly understood. The patient's physician is responsible for providing the information the patient needs in order to make an informed decision and for obtaining the patient's informed consent or refusal for the recommended procedure. The hospital's role in the informed consent process is to verify that the physician obtained the patient's informed consent before the physician is permitted to perform the procedure..." Also under the subheading titled, Documenting Informed Consent it reads in part, "The doctor will complete the information in the Consent...form or provide the information... The patient's physician must document in the patient record that he or she has conveyed the information required for an informed decision..."	{A 131}		

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{A 385}	482.23 NURSING SERVICES The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by: Based on observation, interview and record review, the hospital failed to ensure: 1. One sampled patient who was waiting in the hallway on an ambulance gurney for a bed in the Urgent Care for 4 hours to receive a nursing re-evaluation or check during his wait. (Refer to A 395, item 1) 2. Five call lights were observed not functioning (Room 111C, 111D, 111F, 111G, 105A) as intended and three call lights were not accessible for the patients to use in Room 111B, 110B, and 110C. (Refer to A 395, item 2) 3. The physician's orders were followed for two sampled patients. (Refer to A 395, item 3) 4. Nursing was aware of the hospital's policy for the crash cart and ensure one crash cart contained all the contents listed. (Refer to A 395, item 4) 5. Pertinent, individualized nursing care plans were developed for 12 sampled patients. (Refer to A 396) 6. One registered nurse was oriented to the emergency department (ED) when she was transferred there from another department. (Refer to A 397)	{A 385}		

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{A 385}	Continued From page 6 7. Adequate supervision was provided to one contracted nursing personnel. (Refer to A 398) The cumulative effects of these systemic failures resulted in the hospital's inability to ensure adequate nursing care to meet the needs of the patients.	{A 385}		
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the registered nurses failed to ensure there was adequate supervision when: 1. One of 31 sampled patients (27) was waiting in the hallway on an ambulance gurney for a bed in the Urgent Care for 4 hours with no nursing re-evaluation or check during his wait. This had the potential to result in medical conditions to go untreated. 2. Five call lights were observed not functioning (Room 111C, 111D, 111F, 111G, 105A) as intended and three call lights were not accessible for the patients to use in Room 111B, 110B, and 110C. This had the potential for the patients to be unable to call for required assistance. 3. The physician's orders were not followed for two of 31 sampled patients (38 and 45). This had the potential to result in untreated medical conditions which could result in an overall decline in the patients.	A 395		

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A 395	Continued From page 7 4. Nursing was unaware of the hospital's policy for the crash cart and one crash cart did not contain all the contents listed. This had the potential to result in the emergency personnel to be unaware of the contents and to ensure the crash cart contained all the emergency contents. Findings: 1. During an observation and interview on 2/16/16, at 9 AM, Patient 27 was noted to be lying on an EMT (emergency medical technician) gurney in the hallway directly outside Urgent Care. An ambulance attendant (EMT 1) was sitting next to him. EMT 1 stated he brought Patient 27 to the hospital about 5 AM. and they have been waiting for a bed in the Urgent Care. EMT 1 stated no nurse has re-evaluated Patient 27 or taken the vital signs (blood pressure, pulse, temperature) since their arrival. During an observation and record review on 2/16/2016, at 9:40 AM, the Chief Nursing Officer (CNO) assisted EMT 1 to bring Patient 27 into the Urgent Care. Patient 27's medical record was reviewed and it documented that vital signs had been taken at 5:45 AM and not repeated until 9:30 AM. The registered nurse in charge of the Urgent Care (RN 6) stated patients who were waiting for a bed in the Urgent Care should have their vital signs taken every two hours. The hospital policy and procedure titled "Triage Treatment Protocols and Admission in the Emergency Department", dated 3/2014, indicated: "....2.12 It is the responsibility of the RN to continually reassess the status of those patients who are awaiting disposition to the treatment area ...."	A 395		

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A 395	Continued From page 8 2a. During an observation and interview with the RN 25 (the charge nurse for the medical surgical unit) and the Certified Nursing Assistant (CNA) 1 on 2/16/16, at 11:46 AM, Room 111 was noted with eight patients. Patient 39 (Room 111) was observed lying in bed G with CNA 1 next to his bed. The patient appeared confused and the call light button was not observed within reach of Patient 39. CNA 1 indicated she removed the call light from the patient because "he is always on it" but he did have it earlier. CNA 1 and RN 25 proceeded to search for the call light. When the call light button was found, the cord was cut at the level of the wall; therefore, could not be accessible for Patient 39 to use. Patient 39 was approximately 2 feet from the call light. RN 25 stated CNA 1 is the assigned staff to care for Patient 39. She was asked how the nurse call system works. She stated the nurse call system includes a button at the wall with a cord that has the call light attached to it. The cord with the call light attached is what is provided to the patient. When the patient presses the red call light, it should be audible and visible above the patient room door and at the nurse's station. During a review of the clinical record for Patient 39 and interview with RN 22, on 2/16/16, at 2 PM, the admitting diagnoses included: Altered Mental Status (AMS), Hypertension (high blood pressure), Diabetes Mellitus (a disease which results in the body's inability to produce enough insulin which results in elevated sugar levels), Abnormal Gait, Dementia and Convulsions. The care plan problem list included a care plan for patient's risk for harming himself, a care plan for pain and a care plan of fall. The fall care plan included an intervention which indicated, "...call	A 395		

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A 395	Continued From page 9 bell within reach..." 2b. During an observation of Room 111 Bed B with RN 25, on 2/16/16, at 11:50 AM, the call light was not noted accessible to Patient 42 who was lying in bed. RN 25 proceeded to search for the call light, which was found on the floor. During a review of the clinical record for Patient 42 with RN 22 and the Assistant Chief Nursing Officer (ACNO), on 2/16/16, at 2:50 PM, the patient was admitted on 2/11/16 with admitting diagnoses of Gastrointestinal (relating to the stomach or intestines) Bleed, Gastric Cancer and Anemia (a condition where you do not have enough healthy red blood cells to carry adequate oxygen to the body's tissue which can can cause weakness, fatigue and dizziness). Additional diagnoses included Failure to Thrive (FTT used to define faultering weight to indicate insufficient weight gain), nausea and vomiting, Schizophrenia (mental disorder), Diabetes, Gastritis (inflammation of the lining of the stomach), and Gastroesophageal Reflux Disease (a chronic digestive disorder which results in the stomach acid to flow back up through the food pipe [esophagus]). The care plan list was reviewed and there was a care plan which addressed his fall risk with an intervention to assist the patient from falling included "...call bell within reach..." A care plan was also developed due to the patient being harmful to himself due to the patient being impulsive and wandering tendencies and an intervention to assist the patient from harming himself is to "ensure safe environment". 2c. During an observation of Room 111 Bed C with RN 25, on 2/16/16, at 11:50 AM, Patient 43 was observed lying in bed. The call light was non	A 395		

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A 395	Continued From page 10 functioning with no audible sound above the room door or at the nurse's station. During a review of the clinical record for Patient 43 with RN 22 and the ACNO, on 2/16/16, at 3:20 PM, the patient was admitted on 2/14/16 with diagnoses of Mysitis (inflammation and degeneration of the muscle tissue), difficulty walking, and diabetes. A care plan problem was noted for fall risk with an intervention which included "call bell within reach". 2d. During an observation of Room 105 Bed A with RN 25, on 2/16/16, at 12 PM, Patient 41 was observed sitting at the edge of the bed with a lunch tray on the bedside table. When the call light was pressed to determine if it was functioning as intended, the call light was not audible or visible above the room door or at the nurse's station. Patient 41 stated, she thought the call light was broken when she called last night and no one came. During an interview with Patient 41, on 2/16/16, at 1:38 PM, she stated she used the call light last night to get assistance to the bathroom. Patient 41 was asked how long she waited, but she was unsure. When no one came to her room, she walked to the door to ask for assistance. She said she used the call light again today to ask for a brief, but RN 22 entered the room as she was using her call light. During a review of the clinical record for Patient 41 with RN 22 and the ACNO, on 2/16/16, at 2:40 PM, the patient was admitted on 2/14/16 for complaints of abdominal pain. The care plan problem list was reviewed and it included a fall care plan. The interventions included "...call bell	A 395		

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A 395	Continued From page 11 within reach..." 2e. During an observation of Patient 40 with RN 25, on 2/16/16, at 11:55 AM, in Room 110 Bed C, the patient was observed lying in bed. A call light to contact the nurse was not noted within reach of the patient. The patient was asked if she had a call light that could be used to call the nurse. As she felt around her bed, she was unable to locate a call light. She stated she was unable to see due to being "Legally Blind and (having) Macular Degeneration (an eye disease that progressively causes severe vision loss)". RN 25 proceeded to feel around the bed for the call light, which was then given to the patient. After being given the call light, Patient 40 proceeded to demonstrate she could use the call light. During a review of the clinical record of Patient 40 and interview with RN 25, on 2/16/16, at 2:15 PM, Patient 40 was admitted on 2/15/16. The care plan list was reviewed. A care plan was developed for the patient's fall risk due to her age, and unfamiliar environment. An intervention for the fall risk care plan included "call bell within reach..." 2f. During an observation of the Medical Surgical unit with RN 25, on 2/16/16, at 11:46 AM to 11:55 AM, in addition to the above call light issues, the following was noted: Room 111 Bed F, the call light cord which extended to the patient, had no button at the end of the call light cord to use; therefore, the call light could not be used as intended. Room 111 Bed D, the call light was non functioning with no audible sound above the room	A 395		

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A 395	Continued From page 12 door or at the nurse's station. Room 110 Bed B, the call light was on the bedside table and not accessible to the patient. During an interview with RN 25, on 2/16/16, at 11:50 AM, she was asked how long have the call lights not been functioning as intended. She stated, they have not been working "on and off" but did not indicate a specific time frame. She was asked the process when repair of equipment, such as the call lights, is required. She stated, a "work order is generated" which goes directly to the maintenance/engineering department. She was not certain whether a work order request was generated and sent to the maintenance/engineering department for the nonfunctioning call lights. During an interview with Engineer Staff 1, on 2/16/16, at 11:52 AM, he stated the maintenance department was aware of the nonfunctioning call lights in Room 111, but the call lights have been on back order for approximately six days. He stated they have no extra call lights available for patient use. During an interview with the ACNO, on 2/16/16, at 1:33 PM, she stated, "I didn't know (referring to being aware the call lights have not been working)." She indicated the problem should have been brought to her attention and was not. She was asked to provide the policy and procedure for the nurse call system and the nurses' responsibility. During a subsequent interview with the ACNO, on 2/16/16, at 3:26 PM, after reviewing the hospital's policies and procedures, she stated they had no policy and procedure for the nurse call system/call light	A 395		

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A 395	Continued From page 13 system and the nurses' responsibility. During an interview with Director of Plant Operations, on 2/16/16, at 1:40 PM, he stated ES 1 informed him of the nonfunctioning call lights. He was informed the call lights have not been functioning for 1 to 1 1/2 weeks. Because he did not know the type of call lights to order from the vendor, no call light replacements had been ordered. He acknowledged there was no work order request for the nonfunctioning call lights for Room 111 or 105. The hospital policy and procedure titled, "Reporting malfunction" effective date 6/15/09, indicated in part, "Equipment Malfunctions - Patient Care Equipment...When a malfunction is evident, the following steps should be taken...Double check procedure techniques to ascertain whether there is a true malfunction... If the malfunction continues to occur, call the Engineering department and inform them of the problem..." 3a. During a review of the clinical record for Patient 38, with RN 25, on 2/16/16, at 10:36 AM, the patient was admitted with diagnoses of cellulitis to the left foot and right big toe wound. In addition he was diagnosed with Diabetes with a physician's order to monitor blood sugars AC&HS (before each meal and at hour of sleep) and administer insulin as needed depending on the blood sugar results. A review of the blood sugar results in the clinical record showed the blood sugars were not monitored as ordered. RN 25 confirmed the blood sugars were not monitored as ordered. No further information was provided. 3b. During a review of the clinical record for	A 395		

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A 395	Continued From page 14 Patient 45 and interview with Licensed Vocational Nurse (LVN) 3, on 2/17/16, at 9:30 AM, the physician's orders were noted. A physician's order dated 2/1/16, for nasogastric tube (NGT) feeding (a flexible tube that is passed through the nose to the stomach to provide nutrition for patients who are unable to take sufficient nutrition orally) at 45 cc/hr (cubic centimeters per hour) was noted. In addition to the order for the liquid nutrition to be taken via the NGT, there was an order for 200 cc's of water every six hours for a total of 800 cc's/24 hr of water daily. From 2/10/16 to 2/16/16, there was insufficient documented evidence the additional 800 cc's of water were provided as ordered. LVN 3 validated the findings. 3c. During a review of the clinical record for Patient 45 and interview with LVN 3, on 2/17/16, at 9:30 AM, the physician's orders were noted. A physician's order was noted to notify the physician if the blood sugar result was less than 60 milligrams per deciliter (mg/dl). On 2/15/16, at 6 PM, the blood sugar was 58 and there was no documented evidence the physician was notified. No further evidence was provided. 4a. During an observation in the emergency room, on 2/16/16, at 9 AM, with RN 26 (Nursing Supervisor), ACNO, and RN 16, the adult crash cart was noted with a red lock on it. A list of the contents was requested. RN 16 and RN 26 stated there is no list of contents, each drawer has a sticker with the list of contents on the sticker. The font size of the content sticker was difficult to read. On the top of the crash cart a sticker read "top of cart to side" included the ambu-bag. After searching for the ambu bag it was noted on another crash cart. The third	A 395		

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A 395	Continued From page 15 drawer's sticker was partially torn off making it difficult to determine the exact contents of the third drawer. At 9:12 AM, the pediatric cart was observed. The pediatric crash cart had nine drawers with each drawer secured with blue plastic lock. It also had each drawer with a sticker indicating the contents inside the drawer. The bottom drawer of the cart indicated there was a "Medication Tray" and 2 IV (intravenous) start kits, 2 - extension sets, 2 - tuberculin syringes, 2 - 5 cc syringes, IV catheters including 2 - 24 gauge (g), 2 - 20 g, 2 - 22 g, 2 - 18 gauge. There were no IV start kits, no extension sets, no tuberculin syringes, no 5 cc syringes, no IV catheters of any size. This was validated by RN 26 and the ACNO. RN 26 stated, maybe it was mislabeled. When RN 26, was asked what happens to ensure the contents of the crash carts gets restocked and what happens to secure the contents of the crash carts until they are restocked. She stated the adult crash cart is secured after the central supply staff restocks it. The central supply staff places a green plastic lock which notifies staff it is ready for pharmacy to secure it and is ready and is fully stocked. She was unable to indicate what happens to the pediatric crash cart when the cart is opened to ensure it is secured until the contents are restocked. RN 26 stated, "once opened no way to secure..." 4b. During an observation and interview with ACNO and RN 28 (Charge Nurse to the Intensive Care Unit [ICU] and the telemetry unit), on 2/16/16, at 9:54 AM, an adult crash cart was noted in the telemetry hallway. The crash cart also had a sticker on each drawer identifying the content of each drawer. RN 28 was asked the process when the items in the crash cart are used. RN 28 stated, if the crash cart is opened	A 395		

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LOS ANGELES COMMUNITY HOSPITAL	4081 E OLYMPIC BLVD LOS ANGELES, CA 90023

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A 395	Continued From page 16 there is no means to secure the contents including the emergency medications inside it. RN 28 stated, she would call the pharmacy to refill it. The policy and procedure for the crash cart was requested from ACNO. The hospital policy and procedure titled, "CRASH CART", undated, indicated, "To ensure the availability of appropriate medications and supplies to effectively resuscitate a cardiac or respiratory arrest patient. Each crash cart shall contain a standardized binder, which includes a crash cart content list... A process shall be employed that ensures drug security, control and the availability of drugs identified by the Medical Staff for emergency use... To ensure that crash carts are standardized throughout the department and the facility... All crash carts shall be sealed with a tamper resistant red breakaway lock and assigned a log number... Crash carts will be open in a Code blue situation... Any time that a crash cart is opened, it will be replaced with a fully stocked cart by central supply staff/ designees, and will be Locked by Pharmacy staff after medication tray is added. Then the cart will be returned to the unit... Immediately after the code, The Nursing Supervisor shall notify Central Supply and a fully restock replacement crash cart will be delivered to the patient care area..."	A 395		
{A 396}	482.23(b)(4) NURSING CARE PLAN The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan This STANDARD is not met as evidenced by: Based on observation, interview and record	{A 396}		

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{A 396}	Continued From page 17 review, the hospital failed to have pertinent, individualized nursing care plans for 12 of 31 sampled patients (29, 30, 38, 40, 42, 45, 47, 48, 49, 51, 52, 55). This had the potential that patients would not receive necessary care or have unmet care needs. Findings: 1. During an interview and review of the clinical record for Patient 29 on 2/17/16, at 8:45 AM, the consents and admission paperwork were in Spanish. The charge nurse, Registered Nurse (RN) 8, stated he only spoke Spanish. Several care plans (anxiety, safety, hemodialysis) care plans were reviewed. There was no notation that Patient 29 only spoke Spanish on any care plan. RN 8 and Licensed Vocational Nurse (LVN) 1 confirmed this. 2. During an interview and review of the clinical record for Patient 30 on 2/17/16, at 10 AM, he was admitted on 2/12/16. One of his diagnoses was influenza and isolation was ordered on 2/13/16. Patient 30's care plans were reviewed (safety, respiratory, anxiety). None of his care plans addressed Patient 30 was on isolation. The hospital policy and procedure titled "Care Plan, Patient Interdisciplinary Plan of Care", dated 11/2012, indicated: "Policy Purpose To provide each patient with an individual interdisciplinary plan of care that is collaborative and goal directed... A care plan outlines the care to be provided to an individual/family patient. It is a set of actions the care provider will implement to resolve/support nursing diagnoses identified by nursing assessment...that will include patient's admitting problems....needs, or other condition..."	{A 396}		

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{A 396}	Continued From page 18 3. During a review of the clinical record for Patient 38, with RN 25, on 2/16/16, at 10:36 AM, the patient was admitted with diagnoses of cellulitis (bacterial skin infection) to the left foot and right big toe wound. There was no individualized care plan for the treatment to the left foot or an individualized care plan for the treatment of the right big toe. During an observation of Patient 38 and interview with RN 26 (the treatment nurse), on 2/16/16, at 11:30 AM, Patient 38's right and left foot wounds were noted. The left fourth toe was uncovered and blackened. The inner portion of the right big toe was reddened. A review of the care plans was conducted and there was one care plan problem that was not specific to either the left foot or right foot. RN 26 stated, there should be two care plans to outline the care of each of the identified areas since they require different treatment interventions. No additional information was provided. 4. During an observation of Patient 40 with RN 25, on 2/16/16, at 11:55 AM, in Room 110 Bed C, the patient was observed lying in bed. A call light to contact the nurse was not noted within reach of the patient. The patient was asked if she had a call light that could be used to call the nurse. As she felt around her bed, she was unable to locate a call light. She stated she was unable to see due to being "Legally Blind and (having) Macular Degeneration (an eye disease that progressively causes severe vision loss)". RN 25 proceeded to feel around the bed for the call light, which was then given to the patient. After being given the call light, Patient 40 proceeded to demonstrate she could use the call light.	{A 396}		

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{A 396}	Continued From page 19 During a review of the clinical record of Patient 40 and interview with RN 25, on 2/16/16, at 2:15 PM, Patient 40 was admitted on 2/15/16. The care plans were reviewed, and there was no care plan to ensure staff were aware of the patient's vision impairment and to ensure staff would implement the care needs of the patient with vision impairment. RN 22 verified the findings. 5. During a review of the clinical record for Patient 42 and interview with RN 22, on 2/16/16, at 2:50 PM, the admitting diagnosis included diabetes mellitus. The physician's orders indicated he was being treated with regular insulin based on the results of the routine fingersticks. The care plans were reviewed and there was no care plan for the diabetes mellitus to ensure staff were aware of appropriate interventions to treat the problem. 6. During a review of the clinical record for Patient 45 and interview with Licensed Vocational Nurse (LVN) 3, on 2/17/16, at 9:30 AM, the physician's orders were noted. A physician's order dated 2/1/16, for nasogastric tube (NGT) feeding (a flexible tube that is passed through the nose to the stomach to provide nutrition for patients who are unable to take sufficient nutrition orally) at 45 cc/hr (cubic centimeters per hour) was noted. The care plan problems for the patient were reviewed. The nutrition care plan included interventions for a patient who was receiving a diet orally and not a diet provided via a nasogastric tube. Documented interventions after the NGT was placed for nutrition included: "demonstrates appropriate selection of meals...eating in response to internal cues other than hunger...encourage water intake..." LVN 3	{A 396}		

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{A 396}	Continued From page 20 acknowledged these were not appropriate interventions for a patient receiving NGT feeding. No additional information was provided. The hospital policy and procedure titled, "CARE PLAN, PATIENT INTERDISCIPLINARY PLAN OF CARE POLICY AND PROCEDURE" effective date 12/2015, indicated the purpose of the care plan is "To establish guidelines for the initiation of Interdisciplinary plan of care for each patient admission...A care plan outlines the care to be provided to an individual/family/patient. It is a set of actions the care provider will implement to resolve/support nursing diagnoses...The plan of care will be based on the assessed needs of the patient and will include goals, problems/needs, proposed intervention(s), expected outcomes..." 7. During an observation with RN 22, on 2/16/16, at 9:32 AM, in the patient's room, Patients 47 and Patient 48 were in bed with the head of the bed elevated at 45 degree angle. Patient 47 had a GT (Gastrostomy tube- a tube that has been surgically inserted in the stomach for the introduction of nutrient solution) formula of Fibersource HN (a nutritionally complete tube feeding formula with fiber) at 50 ml/hr (milliliter per hour). Patient 48 had a GT formula of Pulmocare (a therapeutic nutrition for people with COPD [chronic obstructive pulmonary disease], cystic fibrosis or respiratory failure patient) at 50 ml/hr. Patient 47 and Patient 48's GT tubing were not labeled and dated. During an interview with RN 22, on 2/16/16, at 9:35 AM, she stated Patients 47 and 48 were unable to communicate because of their medical	{A 396}		

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{A 396}	Continued From page 21 condition. RN 22 also stated she was unable to determine Patient 47 and 48's tubing for the formula were new or old. During a review of the clinical record for Patient 47, the Physician's Order dated 1/1/16, indicated Patient 47 to receive a Fibersource HN at 50 ml/hr by Gastrostomy tube. During further review of the clinical record, the nutrition care plan did not indicate Patient 47 was receiving formula through GT. During a review of the clinical record for Patient 48, the Physician's Order dated 2/1/16, indicated Patient 48 to receive Pulmocare at 50 ml/hr for 20 hours through GT. During further review of the clinical record, the nutrition care plan did not indicate Patient 48 was receiving formula through GT. During an interview with RN 22, on 2/16/16, at 10:05 AM, she reviewed the clinical record for Patients 47 and 48 and verified there was no care plan found for the use of GT formula feeding for both patients. 8. During an observation with RN 22, on 2/16/16, at 9:40 AM, in the patients room, Patient 49 was in bed with the head part slightly elevated at 30 degree angle. He has an oxygen inhalation via nasal cannula. Patient 49 waved his hand when he was asked how he was doing. During an interview with RN 22, on 2/16/16, at 9:42 AM, she stated Patient 49 was on Hemodialysis (a procedure in which impurities or wastes are removed from the blood) three times a week. RN 22 also stated Patient 49 was alert and oriented and he was able to make his needs	{A 396}		

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{A 396}	Continued From page 22 known. During a review of the clinical record for Patient 49, the Physician's Order dated 2/16/16, indicated Patient 49 to receive "Hemodialysis STAT ONCE [immediately one time] for 2 hours dry - DX [diagnosis]: Hypoxia [inadequate oxygen tension at the cellular level]." During further review of the clinical record for Patient 49, there was no documentation a care plan for Hemodialysis related to hypoxia was initiated. During an interview with LVN 3, on 2/16/16, at 10:07 AM, she reviewed the clinical record for Patient 49 and verified there was no care plan found for a Hemodialysis order on 2/16/16 due to patient's hypoxia. 9. During a review of the clinical record for Patient 51, the Physician's Order/Blood Product dated 2/10/16, indicated Patient 51 to receive PRBC (packed red blood cells- red blood cells separated from liquid plasma) 2 units. During further review of the clinical record, there was no documentation a care plan for blood transfusion (BT- the administration of whole blood or a component, such as packed red cells, to replace blood lost) of PRBC was developed. During an interview with LVN 3, on 2/16/16, at 10:15 AM, she reviewed the clinical record for Patient 51 and verified there was no care plan found for blood transfusion. 10. During a review of the clinical record for Patient 52, the Physician's Order dated 2/5/16, indicated Patient 52 to receive Lasix (medication to treat Pulmonary edema, edema with CHF, hepatic disease, nephrotic syndrome, ascites,	{A 396}		

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{A 396}	Continued From page 23 hypertension) 40 mg IV [intra-venous] daily. During further review of the clinical record, there was no documentation a care plan for the use of IV Lasix was initiated. During an interview with LVN 3, on 2/16/16, at 10:25 AM, she reviewed the clinical record for Patient 52 and she was unable to find a care plan for the IV Lasix. 11. During a review of the clinical record for Patient 55, the Physician's Order dated 2/14/16, indicated Patient 55 to receive an oxygen therapy of "Albuterol-ipatropium [a bronchodilator-anticholinergic medication to treat asthma, brochospasm, bronchitis and other reversible airway obstructions] inhalation 2.5 mg-0.5 mg - give 3 milliliters (ml) nebulizer [a method of administering a drug by producing a fine spray into the respiratory passages of the patient] every 6 hrs PRN [as necessary]." During further review of the clinical record, there was no documentation a care plan for the use of an oxygen therapy was initiated. During an interview with LVN 3, on 2/16/16, at 2:45 PM, she reviewed the clinical record for Patient 55 and verified there was no care plan found for the oxygen therapy.	{A 396}		
A 397	482.23(b)(5) PATIENT CARE ASSIGNMENTS A registered nurse must assign the nursing care of each patient to other nursing personnel in accordance with the patient's needs and the specialized qualifications and competence of the nursing staff available. This STANDARD is not met as evidenced by:	A 397		

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A 397	Continued From page 24 Based on interview and record review, the hospital failed to provide documented evidence one Registered Nurse (RN 16) was oriented to the emergency department (ED) when she was transferred there from another department. This had the potential to result in RN 16 being unprepared to perform her duties in the ED effectively affecting patient care. Findings: During an interview with RN 16, on 2/16/16, at 8:53 AM, she stated she has been an RN at the hospital for approximately two years. During a review of RN 16's personnel file and interview with Human Resource Coordinator, on 2/17/16, at 11:12 AM, it was noted RN 16 transferred to the ED on 11/1/15. There was no documentation RN 16 was oriented to the ED. No further evidence was provided.	A 397		
{A 398}	482.23(b)(6) SUPERVISION OF CONTRACT STAFF Non-employee licensed nurses who are working in the hospital must adhere to the policies and procedures of the hospital. The director of nursing service must provide for the adequate supervision and evaluation of the clinical activities of non-employee nursing personnel which occur within the responsibility of the nursing services. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the hospital failed to ensure adequate supervision was provided to one contracted nursing personnel (Registered Nurse [RN] 23). This had the potential to result in lack of quality of	{A 398}		

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{A 398}	Continued From page 25 care provided to patients. Findings: During an observation on 2/16/16, at 2 PM, in Patient 49's room, RN 23 was seated on a chair wearing a PPE (Personal Protective Equipment). The yellow gown was worn mid way exposing her chest and back showing her [nurse] uniform. She was also observed wearing a mask but it was underneath her chin. Patient 49 was in bed with the head part slightly elevated at 30 degree angle. Patient 49 was connected to a Dialysis machine. On top of the Dialysis machine was a binder, a tablet computer and a box of blue colored gloves. During further observation on 2/16/16, at 3:50 PM, in Patient 49's room, RN 23 had disconnected the tubing from Patient 49. She was still wearing the yellow gown mid way exposing her chest and back. She was also wearing gloves and a mask. After she had disconnected the tubing from Patient 49, at 3:55 PM, she took a bottle of distilled white vinegar and placed an amount halfway in the canister. She returned the canister back to the machine. She was observed going across the hallway to get some wipes from the purple top container (germicidal ultra bleach wipes) wearing the same gloves. After placing the wipes on top of the Hemodialysis machine, she removed her gloves and disposed of them and proceeded to the station without washing her hands. RN 23 was observed working for two hours but there was no evidence the hospital employees had told her to wear the PPE appropriately. During an interview with RN 23, on 2/16/16, at 4	{A 398}		

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{A 398}	Continued From page 26 PM, she stated it was her first time to do a Hemodialysis treatment in the hospital. She stated she was using the dialysis binder to check for the parameters and the tablet computer was used for her to check the orders. She also stated she placed the box of gloves on top of the Hemodialysis machine as it was more convenient for her. During a review of the clinical record for Patient 49, the Physician's Order dated 2/16/16, indicated Patient 49 to receive "Hemodialysis STAT ONCE [immediately one time] for 2 hours dry - DX [diagnosis]: Hypoxia [inadequate oxygen tension at the cellular level]." The Physician's Order dated 2/12/16, indicated Patient 49 to receive Hemodialysis treatment every Monday, Wednesday and Friday (current Hemodialysis order). During an interview with the Vice President-Hospital Operations(VP) 2 and RN 24, on 2/17/16, at 9:50 AM, they were made aware of RN 23's care during a Hemodialysis treatment. VP 2 and RN 24 both stated RN 23 had violated the infection control practices.	{A 398}		
{A 454}	482.24(c)(2) CONTENT OF RECORD: ORDERS DATED & SIGNED All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner who is responsible for the care of the patient only if such a practitioner is acting in accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations. This STANDARD is not met as evidenced by:	{A 454}		

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{A 454}	Continued From page 27 Based on interview and record review, the hospital failed to follow its policy and procedure of having telephone or verbal orders signed by the physician within 48 hours, for four of 31 sampled patients (28, 31, 32, 52). This has the potential that medical records are not maintained within current clinical record standards. Findings: 1. During a review of the clinical record and interview with Licensed Vocational Nurse (LVN) 1 on 2/17/16, at 9:20 AM, Patient 28 was admitted 1/27/16. Four telephone orders from 1/27/16 had not been signed as of 2/17/16, three weeks. This was verified by LVN 1. 2. During a review of the clinical record and interview with LVN 1 on 2/17/15, at 9:30 AM, Patient 31 was admitted 2/9/16 with the diagnosis of "Diabetic Foot Ulcer". Patient 31's physician's medication orders were reviewed: 1. Eight verbal/telephone orders from 2/9/16 had not been signed by the ordering physician (six days date). 2. One verbal/telephone order from 2/10/16 had not been signed (five days late). 3. Three verbal/telephone orders from 2/13/16 had not been signed (two days late). LVN 1 verified the information. 3. During a review of the clinical record and interview with LVN 1 on 2/17/16, at 9:30 AM, Patient 32 was admitted 12/3/15, with a diagnosis of "leukocytosis" (high white count, usually indicated infection). Robitussin DM (cough suppressant) was ordered verbally or by telephone on 1/8/16. It was not signed by the physician until 1/28/16, three weeks later. Pancrelipase (medication to help the body digest	{A 454}		

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{A 454}	Continued From page 28 food) was ordered 1/21/16, either verbally or by telephone. As of 2/17/16, it had not been signed. Insulin was ordered 1/21/16 either verbally or by telephone. It was signed by the physician on 1/28/16, five days late. The hospital policy and procedure titled "Telephone, Verbal and written order for Medication", dated 2/20/15, indicated: "....The prescribing practitioner must sign the written record of the verbal/telephone medication order within 48 hours of giving order." 4. During a review of the clinical record for Patient 52, the Physician's Order dated 2/5/16, indicated Patient 52 to receive Lasix 40 mg IV daily. During further review of the clinical record, there was no documented evidence the verbal order for Patient 52 was authenticated by the physician since the date it was ordered. During an interview with LVN 3, on 2/16/16, at 10:25 AM, she reviewed the clinical record for Patient 52 and she verified the verbal order was not authenticated since it was ordered on 2/5/16.	{A 454}		
A 467	482.24(c)(4)(vi) CONTENT OF RECORD: ORDERS,NOTES,REPORTS [All records must document the following, as appropriate:] All practitioner's orders, nursing notes, reports of treatment, medication records, radiology and laboratory reports, and vital signs and other information necessary to monitor the patient's condition.	A 467		

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A 467	Continued From page 29 This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the hospital failed to ensure the licensed nurses documentation contained information necessary to monitor one of 31 sampled patient's condition (49) receiving a Hemodialysis (a procedure in which impurities or wastes are removed from the blood) treatment. This failure had the potential to result in unmet care needs. Findings: During an observation with Registered Nurse (RN) 22, on 2/16/16, at 9:40 AM, in the patient's room, Patient 49 was in bed with the head part slightly elevated at 30 degree angle. He had an oxygen inhalation via nasal cannula. Patient 49 waved his hand when he was asked how he was doing. During an interview with RN 22, on 2/16/16, at 9:42 AM, she stated Patient 49 was on Hemodialysis three times a week. RN 22 also stated Patient 49 was alert and oriented and he was able to make his needs known. During a review of the clinical record for Patient 49, the Physician's Order dated 2/16/16, indicated Patient 49 to receive "Hemodialysis STAT ONCE [immediately one time] for 2 hours dry - DX [diagnosis]: Hypoxia [inadequate oxygen tension at the cellular level]." During further review of the clinical record for Patient 49, there was no documentation by the licensed nursing staff for the Hemodialysis treatment ordered on 2/16/16. The Hemodialysis treatment was an additional order by the physician from Patient 49's current order of three times a week (Monday-Wednesday-Friday). It was ordered due	A 467		

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A 467	Continued From page 30 to Patient 49's hypoxia. During an interview with RN 24, on 2/17/16, at 9:15 AM, RN 24 reviewed the licensed nurses documentation and verified there was no information found for the Hemodialysis STAT order. He also stated the licensed staff did not document the reason for the order and Patient 49's response to the treatment. During an interview with Vice President- Hospital Operations (VP) 2 and RN 24, on 2/17/16, at 9:50 AM, they were made aware of the lack of documentation by the licensed nursing staff for the one time STAT order of Patient 49's Hemodialysis treatment. VP 2 and RN 24 both gave no further information. The hospital policy and procedure titled "Assessment/Reassessment of Patient" dated 4/16/15, read in part, "...A-3. The goal of the assessment/reassessment process is to provide the patient the best care and treatment possible... 7. All reported changes in patient condition will be documented, as well as the patient response in the medical record..."	A 467		
{A 701}	482.41(a) MAINTENANCE OF PHYSICAL PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This STANDARD is not met as evidenced by: Based on observation and interview, the hospital failed to maintain a safe environment in the Urgent Care area when one oxygen tank was	{A 701}		

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{A 701}	Continued From page 31 unsecured. This had the potential for the area to be unsafe for patients, visitors and staff. Findings: During an initial observation in the Urgent Care on 2/16/16, at 8:45 AM, a portable oxygen tank was noted to be unsecured, leaning against a wall. The Chief Nursing Officer (CNO) agreed it was an unsafe situation and requested staff call Respiratory Care stat to secure the tank. At 9 AM, the CNO put the oxygen tank into a holder under an Urgent Care gurney.	{A 701}		
{A 724}	482.41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This STANDARD is not met as evidenced by: 2. During an observation of the Medical Surgical (MS) unit with Registered Nurse (RN) 25, on 2/16/16, at 11:46 AM to 11:55 AM, the following was noted: Room 111 Bed C, the call light was nonfunctioning with no audible sound above the room door or at the nurse's station. Room 111 Bed F, the call light cord which extended to the patient, had no button at the end of the call light cord to use; therefore, the call light could not be used as intended. Room 11 Bed G, the call light was found with the cord cut at the level of the wall. Room 111 Bed D, the call light was non	{A 724}		

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{A 724}	Continued From page 32 functioning with no audible sound above the room door or at the nurse's station. Room 105 Bed A, the call light was non functioning and was not audible or visible above the room door or at the nurse's station. During an interview with RN 25, on 2/16/16, at 11:50 AM, she was asked how long have the call lights not been functioning as intended? She stated, they have not been working "on and off" but did not indicate a specific time frame. She was asked the process when repair of equipment, such as the call lights, is required. She stated, a "work order is generated" which goes directly to the maintenance department. She was not certain whether a work order request was generated and sent to the maintenance department for the nonfunctioning call lights. During an interview with Engineer Staff (ES) 1, on 2/16/16, at 11:52 AM, he stated the maintenance department was aware of the nonfunctioning call lights in Room 111 but the call lights have been on back order for approximately six days. He indicated he was the staff who cut the the cord to 111 Bed G otherwise it would keep signaling. He stated they have no extra call lights available for patient use. During an interview with Director of Plant Operations (DPO), on 2/16/16, at 1:40 PM, he stated ES 1 informed him of the nonfunctioning call lights. He was informed by ES 1 the call lights have not been functioning for 1 to 1 1/2 weeks. Because he did not know the type of call lights to order from the vendor, no call light replacements had been ordered. He was asked if the maintenance department has a system to	{A 724}		

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{A 724}	Continued From page 33 monitor the patients' call lights routinely to ensure they are in working order. He acknowledged the maintenance department does not check the call lights to ensure they are in working order. He acknowledged there was no work order request for the nonfunctioning call lights for Room 111 or 105. The hospital policy and procedure titled, "Reporting malfunction" effective date 6/15/09, indicated in part, "Equipment Malfunctions - Patient Care Equipment...When a malfunction is evident, the following steps should be taken...Double check procedure techniques to ascertain whether there is a true malfunction... If the malfunction continues to occur, call the Engineering department and inform them of the problem..." Based on observation, interview, and record review, the hospital failed to ensure a safe environment when: 1. Hazardous chemicals were not stored according to policy and procedures. This had the potential to result in staff lacking awareness for safety. 2. Several call lights were not functioning as intended. This had the potential for patients to be unable to call for assistance which impacts the patient's safety. Findings: 1. During an observation with Lead Engineer (LE) 2, on 2/16/16, at 8:35 AM, at the back of the hospital's driveway, a Water Supply Room (Locked area) had 264 gallon bottles of drinking	{A 724}		

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{A 724}	Continued From page 34 water. There was a total of 1370 gallons of water inside the supply room. Besides the gallons of water, there were six containers (5 gallons each) of Enerex Chemical (a chemical compound used for treating steam boiler water in food and industrial plants) close to the door. One Enerex Chemical container was open and without a cover. The containers were marked as "Corrosive (is one that will destroy and damage other substances with which it comes into contact: it causes chemical burns on contact)." During an interview with LE 2, on 2/16/16, at 8:37 AM, he stated the chemicals were used for the boiler. He also stated the containers should have not been inside the water supply room or close to the water bottles. He was aware the chemicals were marked as corrosive. The hospital policy and procedure titled "Management of Hazardous Chemicals" dated 1/2015, read in part, "...7.5.5 Materials which are toxic as stored or which can decompose into toxic components from contact with heat, moisture, acids, or acid fumes should be stored in a cool, well ventilated place out of the direct rays of the sun...7.5.6 Corrosive materials are stored in a cool, well-ventilated area (i.e., above their freeze point) and in containers that will contain spills or leaks. NOTE: The containers are inspected at regular intervals to ensure they are labeled and kept closed. 7.5.7 Corrosives are isolated from other materials..."	{A 724}		
{A 747}	482.42 INFECTION CONTROL The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an	{A 747}		

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{A 747}	Continued From page 35 active program for the prevention, control, and investigation of infections and communicable diseases. This CONDITION is not met as evidenced by: Based on observations, interviews, and record review, the hospital failed to provide a sanitary environment to avoid sources and transmission of infections and communicable diseases and conduct an active program for the prevention, control and investigation of infections and communicable diseases. These failures place the patient population, visitors and staff at risk for hospital acquired infections when: 1. Terminal cleaning (thorough cleaning done at the end of the work day to eliminate as many disease causing bacteria or viruses) was not performed daily in the areas connected to the operating rooms. The endoscopy processing room (specialized room used to clean medical equipment used for procedures) had no door to prevent the spreading of pathogens (disease causing bacteria or virus) into the restricted area of the operating room. (Refer to A 749, item 1) 2. Clean and sterile supplies were stored in the decontamination room. (Refer to A 749, item 2) 3. Operating room number two (one of two) did not meet state environmental standards. (Refer to A 749, item 3) 4. Surgical instruments were not properly sterilized. (Refer to A 749, item 4) 5. Glucometers (small, portable, hand held instrument that measure blood glucose immediately) were not disinfected between	{A 747}		

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{A 747}	Continued From page 36 patient use. (Refer to A 749, item 5) 6. Healthcare workers did not have adequate vaccination screening. (Refer to A 749, item 6) 7. Within the Urgent Care, employees' personal belongings were placed in clean areas. One employee was observed eating in the nursing station. (Refer to A 749, item 7) 8. On Unit III, family and staff were not following appropriate isolation measures. (Refer to A 749, item 8) 9. Improperly handled soiled linen. (Refer to A 749, item 9) 10. Improperly stored medical waste. (Refer to A 749, item 10) 11. New Gastrostomy (GT, a tube inserted directly into the stomach to provide nutrition) tubing was not labeled with time, date and initials of person hanging the feeding. (Refer to A 749, item 11) 12. In the telemetry unit, Personal Protective Equipment (PPE) was not utilized appropriately by staff. (Refer to A 749, item 12) The cumulative effects of these systemic failures resulted in the hospital's inability to ensure a sanitary environment environment placing all patients, staff and visitors at risk of being exposed to infections and communicable diseases.	{A 747}		
{A 749}	482.42(a)(1) INFECTION CONTROL PROGRAM	{A 749}		

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{A 749}	Continued From page 37 The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: 7. During a concurrent observation and interview with the Chief Nursing Officer (CNO) and the Quality Analyst in the Urgent Care Center on 2/16/16, at 3:10 PM, in the Clean/Dirty utility room, two staff's personal back packs and one jacket are on the counter next to the sink, in the clean area. Binders, Christmas decorations, personal containers are stacked up within approximately 4" of the ceiling. The CNO verified "The top of the stack of boxes, etc, are too close to the ceiling. This room is really like a supply room rather than a Utility Room." During an observation in the Urgent Care Center on 2/17/16, at 8:25 AM with IC 2 and Licensed Vocational Nurse (LVN) 1, LVN 2 was noted to be eating within the nurse' station area. The smell of her food permeated the area. One patient was in the treatment area and the pediatrics' door was shut. IC 2 stated, "She's not supposed to be eating there." 8. During an observation on Unit III on 2/16/16, at 9:30 AM with IC 2 and LVN 1, Patient 30 was in isolation with a diagnosis of influenza. A family member put on the Personal Protection Equipment (PPE) which included a gown, mask and gloves before entering the room. This family member then placed her purse strap over her shoulder and entered Patient 30's room with the purse fully exposed. IC 2 asked the charge nurse	{A 749}		

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{A 749}	Continued From page 38 (RN 10) who had instructed this family member how to protect herself using PPE. RN 10 then put on a gown, mask and gloves and entered Patient 30's room. RN 10 did not tie the isolation gown in the back and the front neckline of the gown dropped down to her right elbow, exposing the top of her uniform, while she spoke to Patient 30 and his family member. During a review of RN 16's personnel file with Human Resource Coordinator, on 2/17/16, at 11:15 AM, the Hepatitis B vaccine acceptance/refusal form dated 12/9/13, was noted. On the form, RN 16 documented that she would accept the Hepatitis B vaccine. There was no documented evidence the Hepatitis B vaccine was offered and/or given to RN 16. No further evidence was provided. 9. During an observation with Lead Engineer (LE) 2, on 2/16/16, at 8:50 AM, at the back of the hospital's driveway, a soiled linen cart full of soiled linens (enclosed in plastic bags) was found unsecured close to the main oxygen supply tank storage area. The linen cart was unattended. During an interview with LE 2, on 2/16/16, at 8:52 AM, he stated the housekeeping staff forgot to store the cart inside the dirty linen locked storage room. He also stated the housekeeping staff collects the carts from the hospital and they would push them inside the dirty linen storage room. 10. During an observation with LE 2 and RN 22, on 2/16/16, at 9:10 AM, at the back patio, the "Biohazardous and Medical Wastes" locked storage area contained nine medical wastes containers. It was observed eight of the nine	{A 749}		

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{A 749}	Continued From page 39 containers were not properly sealed and without the secured tape on both sides. The containers were also found to have several used intravenous medication tubing sticking out of the containers. During an interview with RN 22, on 2/16/16, at 9:12 AM, she stated the staff should have placed the secured tape label on both sides and before the housekeeping staff would bring them to the storage area. The hospital policy and procedure titled "MEDICAL WASTE MANAGEMENT PLAN CHECKLIST" dated 8/2007, read in part, "...Indicate in the medical waste management plan that the accumulation area utilized by the facility to store containers of medical waste for accumulation must be secured so as to prevent or deny access by unauthorized persons and posted with warning signs, on or adjacent to, the exterior of the entry doors, on entry doors, gates, or lids..." 11. During a concurrent observation and interview with RN 22, on 2/16/16, at 9:32 AM, in the patients' room, Patients 47 and Patient 48 were in bed with the head part elevated at 45 degree angle. Patient 47 had a GT formula of Fibersource HN at 50 ml/hr (milliliter per hour). Patient 48 had a GT formula of Pulmocare at 50 ml/hr. Patient 47 and 48's GT tubing were not labeled and dated. During an interview with RN 22, on 2/16/16, at 9:35 AM, she stated Patients 47 and Patient 48 were unable to communicate because of their medical condition. RN 22 also stated she was unable to determine Patient 47 and Patient 48's tubing for the formula were new or old.	{A 749}		

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{A 749}	Continued From page 40 The hospital policy and procedure titled "IV/Enteral Tubing Change" undated, read in part, "...Tubing Changes: Enteral/Tube Feeding - every 24 hours...DOCUMENTATION: 1. All IV (Intravenous)/Enteral tubing changes are to be documented on the nursing flowsheet. 2. New tubing should be labeled with date, time and initials of person doing the tubing change..." 12. During an observation on 2/16/16, at 2 PM, in Patient 49's room, RN 23 was seated on a chair wearing a PPE. The yellow gown was worn mid way exposing her chest and back showing her nurse uniform. She was also observed wearing a mask but it was underneath her chin. Patient 49 was in bed with the head part slightly elevated at 30 degree angle. Patient 49 was connected to a dialysis machine. On top of the dialysis machine was a binder, a tablet computer and a box of blue colored gloves. During further observation on 2/16/16, at 3:50 PM, in Patient 49's room, RN 23 had disconnected the tubing from Patient 49. She was still wearing the yellow gown mid way exposing her chest and back. She was also wearing gloves and a mask. After she had disconnected the tubing from Patient 49, at 3:55 PM, she took a bottle of distilled white vinegar and placed an amount halfway in the canister. She returned the canister back to the machine. She was observed going across the hallway to get some wipes from the purple top container (germicidal ultra bleach wipes) wearing the same gloves. After placing the wipes on top of the Hemodialysis machine, she removed her gloves and disposed of them and proceeded to the station without washing her hands. RN 23 was	{A 749}		

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{A 749}	Continued From page 41 observed working for two hours but there was no evidence the hospital employees had told her to wear the PPE appropriately. During an interview with RN 23, on 2/16/16, at 4 PM, she stated it was her first time to do a Hemodialysis (process involving a large portable machine that is attached to a patient so that their blood toxins and other fluids can be removed when the patient's kidneys no longer do it) treatment in the hospital. She stated she was using the dialysis binder to check for the parameters and the tablet computer was used for her to check the orders. She also stated she placed the box of gloves on top of the Hemodialysis machine as it was more convenient for her. During an interview with the Vice President-Hospital Operations(VP) 2 and RN 24, on 2/17/16, at 9:50 AM, they were made aware of RN 23's care during a Hemodialysis treatment. VP 2 and RN 24 both stated RN 23 had violated the infection control practices. Based on observation, interview, and document review, the hospital failed to maintain a clean hospital with cleaning procedures maintained to minimize and treat infections or communicability of diseases when: 1. Terminal cleaning (thorough cleaning done at the end of the work day to eliminate as many disease causing bacteria or viruses) was not performed daily in the areas connected to the operating rooms. The endoscopy processing room (where examination equipment is cleaned) had no door to prevent the contamination of pathogens (disease causing bacteria or virus) into	{A 749}		

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{A 749}	Continued From page 42 the restricted area of the operating room. 2. Clean and sterile supplies were stored in the decontamination room. 3. Operating room number two (one of two) did not meet state environmental standards. 4. Surgical instruments were not properly sterilized. 5. Glucometers (small, portable, hand held instrument that measure blood glucose immediately) were not disinfected between patient use. 6. Healthcare workers did not have adequate vaccination screening. 7. Within the Urgent Care, employees' personal belongings were placed in clean areas. One employee was observed eating in the nursing station. 8. On Unit III, family and staff were not following appropriate isolation measures. 9. Improperly handled soiled linen. 10. Improperly stored medical waste. 11. New Gastrostomy (GT a tube inserted directly into the stomach to provide nutrition) tubing was not labeled with time, date and initials of staff who hung the feeding. 12. In the telemetry unit, Personal Protective Equipment (PPE) was not utilized appropriately by staff.	{A 749}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050663	A. BUILDING _____ B. WING _____	R-C 02/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOS ANGELES COMMUNITY HOSPITAL	4081 E OLYMPIC BLVD LOS ANGELES, CA 90023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 749}	Continued From page 43 These failures have the potential to transmit infections to patients, staff and visitors. Findings: 1. On 2/16/16 at 8:40 AM in the surgical department of the hospital with Operating Room Technician (ORT) 1, Registered Nurse (RN) 29 (charge nurse) and RN 30 (circulating nurse), it was observed that the specialized room used to clean medical equipment used for procedures was adjacent to Operating Room (OR) 2, separated by a door, but open to the sterile part of the OR. During closer inspection, it was noted that the floor of the cleaning room was sticky to the foot and visibly soiled. RN 29 provided a check list for the terminal cleaning of the department, which is completed by environmental services at the end of each day. The last noted signature was dated 1/23/16 at 2 PM. No hospital policy on terminal cleaning of the perioperative areas was presented upon request prior to the end of the survey. On 2/16/16, during an interview with the Infection Control (IC) at 9:30 AM, he stated that the hospital has adopted the Association of periOperating Registered Nurses Guidelines (AORN) Guidelines for Perioperative Practice as one of the hospital's nationally recognized infection control standards. According to AORN Guidelines for Perioperative Practice, Guideline for Environmental for Environmental Cleaning, Section V.,Terminal cleaning and disinfection of perioperative areas, including sterile processing areas, should be	{A 749}		

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{A 749}	Continued From page 44 performed daily when the areas are being used. AORN Guidelines for Perioperative Practice, Guideline for a Safe Environment of Care, Part 2, Section IIb states that the HVAC (heating, ventilation, air conditioning), surgical attire, and traffic pattern requirements of the surgical suite are designed to be more stringent as one moves from unrestricted to restricted areas. The progression of restrictions is intended to provide the cleanest environment in the restricted area. The designated areas should be separated by ... doors separating the restricted area from the semi-restricted area; and doors, signage, or a line of demarcation to identify the separation between the unrestricted and semi-restricted areas. The doors provide a physical barrier to assist in maintaining control of the HVAC. 2. On 2/16/16 at 9:23 AM, in the decontamination room, clean equipment (sequential compression devices [equipment used to mobilize the knee] wrapped in plastic) were observed to be piled two high on the horizontal surface adjacent to the decontamination area sink. During an interview with the IC at 9:30 AM, he stated the hospital has adopted the Association of periOperating Room Nurses Guidelines for Perioperative Practice as one of the hospital's nationally recognized infection control standards. On 2/17/16 at 1:35 PM during a tour of the second decontamination room, it was noted that both decontamination and sterilization were performed in the same room without an additional sink for handwashing. The hospital policy entitled "Separation of Clean	{A 749}		

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{A 749}	Continued From page 45 and Contaminated Items", dated 2/2/16, indicated: "no clean items will be stored in the decontamination area of central services or the contaminated utility room /area ...at no time will the clean/sterile items go through the decontamination areas of the dirty/contaminated items go through the clean sterile areas." According to AORN, Guidelines for Perioperative Practice, Guideline for Cleaning and Care of Surgical Instruments states that Instruments should be cleaned and decontaminated in an area separate from locations where clean items are handled. Physical separation of decontamination areas from areas where clean items are handled minimizes the risk of cross-contamination. Droplets and aerosols created during cleaning of soiled instruments can cause cross-contamination of any nearby clean items or surfaces. The sterile processing area should have separate clean and decontamination spaces, which may be rooms or areas; decontamination and clean spaces that are separated by one of three methods: a wall with a door or pass-through, a partial wall or partition that is at least 4 ft high and at least the width of the counter, or a distance of 4 ft between the instrument washing sink and the area where the instruments are prepared for sterilization; separate sinks for washing instruments and for hand hygiene. 3. During an interview with the Administrator 1 on 2/17/16 at 11:30 AM the annual air balance and certification report dated, 9/1/15, was reviewed. Under the section Crucial Area Validation Testing, OR 2 was noted to have "failed". According to the report this meant that the air exchanges per hour and space pressurization requirements	{A 749}		

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{A 749}	Continued From page 46 found in the California Mechanical Code were not met. The additional rooms that failed testing were ICU 2, Isolation 104 and SPD Clean/Dirty. Administrator 1 he stated that recommended maintenance, detailed in the report, and re-testing had not been performed since the receipt of the report in 9/2015. During an observation and interview on 2/16/16 at 9:15 AM in OR 2, five peel packs (paper packages that contain sterilized small surgical instruments) were opened. In four out of the five packs opened, the instruments inside were in the closed and locked position. ORT 1 commented that the instruments were not processed correctly and the instrument technician who packaged them (ORT 2) should have known better. 4. During an interview with the IC on 2/16/16 at 9:30 AM, he stated the hospital has adopted the AORN Guidelines for Perioperative Practice as one of the hospital's nationally recognized infection control standards. According to AORN, Guidelines for Perioperative Practice, Guideline for Selection and Use of Packaging Systems for Sterilization, V.h. Items to be sterilized should be placed in the package or tray in an open or unlocked position. The open or unlocked position facilitates sterilant contact of all surfaces of the item. 5. On 2/16/16 at 11:44 AM during an observation of RN 29 performing a glucose test for Patient 53 and Patient 49, it was noted that the glucometer was not cleaned and disinfected between patients and according to the manufacturer's instructions. During an interview and observation of the area	{A 749}		

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{A 749}	Continued From page 47 outside of the emergency room with RN 16, on 2/16/16, at 8:53 AM, there were two containers on the wall. One container with a purple lid, had the manufacturer's label that read "MICRO-KILL ONE...GERMICIDAL ALCOHOL WIPES" and read, in part, "To disinfect hard, non-porous surfaces, use one or more wipes, as necessary to thoroughly wet the surface to be treated. Treated surface must remain visibly wet for one minute to achieve complete disinfection of all pathogens listed..." A second container, with a light blue lid, the label read, "MICRO-KILL Bleach GERMICIDAL BLEACH WIPES" and the product label read, in part, for hospital disinfection, "...Remove pre-saturated 7 in x 8 in wipe...Apply pre-saturated towelette and wipe desired surface to disinfect...CONTACT TIME [amount of time the item should remain visibly wet to kill the listed pathogens]: Allow surface to remain wet for 30 seconds to kill HBV and HCV, for 3 minutes to kill Clostridium difficile sores and 5 minutes to kill HIV..." RN 16 stated she uses the "MICRO-KILL Bleach GERMICIDAL BLEACH WIPES" to disinfect the glucometers (ACCU CHEK Inform II is a medical device that is used to determine the appropriate concentration of glucose [sugar] in the blood) and she stated the contact time is a 30 second contact time. She then indicated the kill/contact time was 3 minutes for these wipes. Although she uses "MICRO-KILL Bleach GERMICIDAL BLEACH WIPES" she was instructed to use "MICRO-KILL ONE...GERMICIDAL ALCOHOL WIPES". During an observation and interview with RN 28 (Charge Nurse for the Intensive Care Unit [ICU] and the telemetry unit), on 2/16/16, at 9:47 AM, she stated there are two glucometers in the ICU and she disinfects them using the "MICRO-KILL	{A 749}		

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{A 749}	Continued From page 48 ONE...GERMICIDAL ALCOHOL WIPES" and she stated, she is the staff who is responsible for disinfecting the devices. She disinfects the glucometers once on her shift (morning) and then the night shift staff will disinfect the devices once on their shift. She was asked how many times are the glucometers being used currently and she stated approximately six times on the morning shift. She then proceeded to demonstrate how she wipes the devices and allows them to remain visibly wet for two minutes. She was again asked, how many times are the devices disinfected, and again she stated once on her shift. No further information was provided. The hospital policy and procedure titled, "ACCU-CHEK Inform Glucose Meter" effective date 2/19/14, indicated in part for the Cleaning/Disinfecting of the meters use "Super Sani-Cloth Wipes or 10% bleach...Frequency 1. In between every patients...3. Whenever there is suspected or true contamination...How to Clean Meters, Bases and Supply Cases 1. Meter...remove a wipe from the PDI Super Sani-Cloth or Clorox wipe tub and close the lid...Allow to air dry before use: 2 min for Sani-Cloth" The "ACCU-CHEK Inform II" Operator's manual Version 3.0, Revision dated 3/2013, with changes that included "Update cleaning and disinfecting chapter" was reviewed. Page 124 through page 131 indicated in part, "Cleaning and disinfecting the exterior surface of the meter is, at minimum, recommended daily for dedicated patient devices. Meters used with multiple patients may require more frequent cleaning and disinfecting...The meter should be cleaned and disinfected between each patient use...Acceptable active ingredients	{A 749}		

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{A 749}	Continued From page 49 and products for cleaning and disinfecting are...Clorox Germicidal Wipes...Super Sani-Cloth Germicidal Disposable Wipes...Always use Clorox Germicidal Wipes...or Super Sani-Cloth Germicidal Disposable Wipes...to clean and disinfect the meter. Do not use any other cleaning or disinfecting solution. Using solutions other than Clorox Germinal Wipes...or Super Sani-Cloth Germicidal Disposable Wipes...could result in damage to the system components..." 6. On 2/16/16 at 1:15 PM, during a review of employee health records, three out of three files did not have complete vaccination records (RN 29, ORT 2, Environmental Services Manager [EVS] 1). RN 29 did not have evidence of tDap (Tetanus (a serious illness caused by bacteria that can enter the body through a deep cut) Diphtheria (a serious bacterial infection), and Pertussis (commonly known as Whooping Cough, an infectious bacterial disease that causes uncontrollable coughing) or varicella (Chickenpox) immunity. ORT 2 did not have evidence of mumps immunity and EVS 1 did not have evidence of tDap and Varicella. The hospital policy entitled Immunizations for Healthcare Workers dated 2/2012 was reviewed on 2/16/16 at 2:30 PM. It states that as part of the preemployment evaluation, employees will be required to complete a questionnaire regarding prior vaccinations for, or exposure to communicable vaccine-preventable diseases. In situations where immunity is questionable or undetermined from the questionnaire the employee will be tested to determine his/her immune status.	{A 749}		

COUNTY OF LOS ANGELES
Public Health

CYNTHIA A. HARDING, M.P.H.
Interim Director

JEFFREY D. GUNZENHAUSER, M.D., M.P.H.
Interim Health Officer

ANGELO J. BELLOMO, REHS, QEP
Deputy Director for Health Protection

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Acting Director of Environmental Health

5050 Commerce Drive
Baldwin Park, California 91706
TEL (626) 430-5100 • FAX (626) 813-3000

www.publichealth.lacounty.gov

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March 17, 2016

Dear Administrator:

FACILITY: Southern California Hospital At Hollywood
COMPLAINT NUMBER: CA00401717

Enclosed is CMS 2567 Statement of Deficiencies and Plan of Correction Form, which resulted from a recent visit to your facility. Please prepare a plan of correction, sign and date the document, return the original to this department within fifteen (15) calendar days, and retain a copy for your file.

The Plan of Correction for each deficiency must contain the following:

a) What corrective action(s) will be accomplished for the patient(s) identified to have been affected by the deficient practice.
b) How other patients having the potential to be affected by the same deficient practice be identified, and what corrective action will be taken.
c) What immediate measures and systemic changes will be put into place to ensure that the deficient practice does not recur.
d) A description of the monitoring process and positions of persons responsible for monitoring (i.e., Administrator, Director of Nursing, or other responsible supervisory personnel). How the facility plans to monitor its performance to ensure corrections are achieved and sustained. The plan of correction must be implemented, corrective action evaluated for its effectiveness, and it must be integrated into the quality assurance system.
e) Dates when corrective action will be completed. The corrective action completion date must be acceptable to the Department. The deficient practice should be corrected immediately. This date shall be no more than 30 calendar days from the date the facility was notified of the non-compliance.

If your Plan of Correction is unacceptable to the Department you will be notified in writing. You are ultimately accountable for compliance, and responsibility is not alleviated where notification of the acceptability of the plan of correction is not timely. Your plan of correction will serve as the facility's allegation of compliance. If an acceptable plan of correction is not received within fifteen (15) calendar days, the Department will recommend to the regional office and/or the State Medicaid Agency that remedies be imposed as soon as the notice requirements are met.

If you have any questions, please contact Eric Stone, Program Manager (626) 312-1134.

Sincerely,

Nwamaka Oranusi, Acting Chief
Health Facilities Inspection Division

Belinda Rancho for
Eric Stone, Program Manager
Acute and Ancillary Unit
3400 Aerojet Avenue, Suite 323
El Monte, CA 91731

Enclosure (CMS 2567)

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA930000064	A. BUILDING: _____ B. WING _____	C 03/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSPITAL AT HOLLY	6245 DE LONGPRE AVE HOLLYWOOD, CA 90028

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E 000	Initial Comments The following reflects the findings of the Department of Public Health during a complaint investigation. Intake Number: CA00401717 - substantiated Inspection was limited to the complaint investigated and does not represent the findings of a full inspection of the facility. Representing the Department of Public Health: 14041	E 000		
E 264	T22 DIV5 CH1 ART3-70213(a) Nursing Service Policies and Procedures. (a) Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to implement its Complaints and Grievances policy and procedure for Patient 1. Finding: On March 8, 2016, the evaluator completed the investigation into an alleged abuse of Patient 1 by Staff 1. During an interview at 1 p.m., the House Supervisor (Admin 1) stated that she recalled the incident in question. Admin 1 stated that she talked to Staff 1 and Staff 1 confirmed that she did remove a snack/candy from Patient 1 without his consent. Admin 1 stated that Staff 1 felt that	E 264		

Licensing and Certification Division
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 264	Continued From page 1 it was part of her job to remove the candy from the patient because of the patient's high glucose level reading, hyperglycemia. Admin 1 stated that another staff (II) was responsible for conducting the abuse investigation but Staff II no longer works at the facility. The evaluator requested all the documentation regarding the abuse / neglect investigation for review. At the time of the survey and investigation the facility had no documentation available and could not show that any investigation was conducted or if the patient was ever notified. Based on a review of the alleged allegation, the patient alleged that on 6/8/2014 at 2:30 p.m., Staff 1 checked his sugar level and saw that the level was very high. Staff 1 asked the patient what did he have in his hand? Staff 1 started to frisk and search the patient and it got physical. According to the complaint, the nurse started to get vocal and called the patient psychotic. The patient reported the incident and he alleged nothing happen. The patient complained that he was scared and felt unsafe with Staff 1. A review of the facility's Complaints and Grievances policy and procedure indicated: Complaints are to be documented by the person taking the complaint; if the issue is unresolved, he/she assist the patient/family to resolve the issue. The facility had no record of any compliance to the policy and procedure regarding a complaint received by the staff or if the patient was notified regarding the investigation.	E 264		

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E 264	Continued From page 2 Based on a review of the Staff 1's personnel file, she voluntarily resigned on 7/15/2015.	E 264		

State of Connecticut

HOUSE OF REPRESENTATIVES
STATE CAPITOL

REPRESENTATIVE PRASAD SRINIVASAN
THIRTY-FIRST ASSEMBLY DISTRICT

LEGISLATIVE OFFICE BUILDING, ROOM 4200
300 CAPITOL AVENUE
HARTFORD, CT 06106-1591

CAPITOL: (860) 240-8700
FAX: (860) 240-0207
Prasad.Srinivasan@housegop.ct.gov

ASSISTANT REPUBLICAN LEADER

RANKING MEMBER
PUBLIC HEALTH COMMITTEE

MEMBER
FINANCE, REVENUE AND BONDING COMMITTEE
PLANNING AND DEVELOPMENT COMMITTEE

March 22, 2016

The Honorable George C. Jepsen, Attorney General
Office of the Attorney General
55 Elm Street, Hartford, CT 06106

The Honorable Raul Pino, Commissioner
Department of Public Health
Office of Healthcare Access
410 Capitol Avenue, Hartford, CT 06134

Dear Attorney General Jepsen and Commissioner Pino,

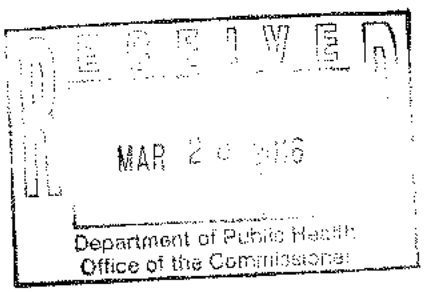
I am pleased to endorse the proposed transaction with public input for Eastern Connecticut Health Network to be acquired by Prospect Medical Holdings. It will preserve and enhance our residents' access to the community-based care that they have relied on for generations, for themselves and their families. Prospect has a strong track record of collaborating with physicians, hospitals, community providers, payers and other key stakeholders to provide quality, cos-effective services to the communities it serves.

I support the efforts of our community hospitals, which are striving to continuously improve quality while reducing cost by struggling with lower payments for services and continued cuts in state and federal reimbursements for care. It is important for state public servants to ensure that our constituents have local access to quality healthcare that is affordable. Prospect has decades of experience and success with provider payment risk arrangements now emerging in the state. With their experience and resources, the result will be better care for individuals, better health for the residents of eastern and lower costs for health care. Access to capital will allow ECHN to reform and strengthen its care delivery network to offer even more community-based services and keep its two hospitals, Manchester Memorial and Rockville General, viable to meet patient needs and expectations.

Therefore, I encourage OHCA and the Office of the Attorney General to look favorably upon the proposed transfer of assets as described in the Certificate of Need filed by ECHN.

Sincerely,

Prasad Srinivasan
State Representative, 31st District
Glastonbury



Why Prospect?

Prospect and ECHN – Our Goals

HIGH Quality Care

HIGHER Patient Satisfaction

HIGHEST Value

ECHN™
Eastern Connecticut Health Network

PROSPECT MEDICAL
Quality Service ~ Quality Care

ECHN℠
Eastern Connecticut Health Network

The Proposed Transfer of Assets of Eastern Connecticut Health Network, Inc. and Affiliates to Prospect Medical Holdings, Inc.

Presented to:
The Office of the Attorney General
The Office of Health Care Access
March 29 & 30, 2016

PROSPECT MEDICAL
Quality Service - Quality Care

Presenters:
Dr. Dennis O'Neill, Chairman, ECHN Board of Trustees
Joy Dorin, Vice Chairman, ECHN Board of Trustees
Peter J. Karl, President & CEO, ECHN

ECHN℠
Eastern Connecticut Health Network

Overview: ECHN's Journey, Its Mission

Dennis G. O'Neill, M.D.
Chairman, ECHN Board of Trustees

Preparing for the Future at ECHN

Our Mission : Our Community

- Caring for & serving the community, continuing our mission & vision
  - Improving the well-being of those we serve with quality, compassionate health care
  - Preserving ECHN: its name, local institutions, services and programs
  - Developing the next generation of physicians to serve our communities
  - Striving to continuously improve quality, safety, & outcomes with recognition by Joint Commission for the services offered
- While preserving over 3,000 jobs



ECHN
Eastern Connecticut Health Network

Preparing for the Future at ECHN

Serving the public need

- More than our two hospitals, a network of 13 wholly owned companies, 12 joint ventures companies, dozens of facilities serving our communities healthcare needs
- For 2015:
  - 114,000 people treated at its hospitals
  - 60,000 patients under the care of community-based physicians employed by ECHN
  - 4,690 patients cared for by Visiting Nurse and Health Services of CT
  - 805 people received homemaker and companion services
  - Comprehensive behavioral health services
  - 61,000 emergency visits

ECHN
Eastern Connecticut Health Network

ECHN℠
Eastern Connecticut Health Network

Understanding Its Past, Preserving Its Future

Peter J. Karl
President & CEO

Impact of Healthcare Reform
(PPACA)

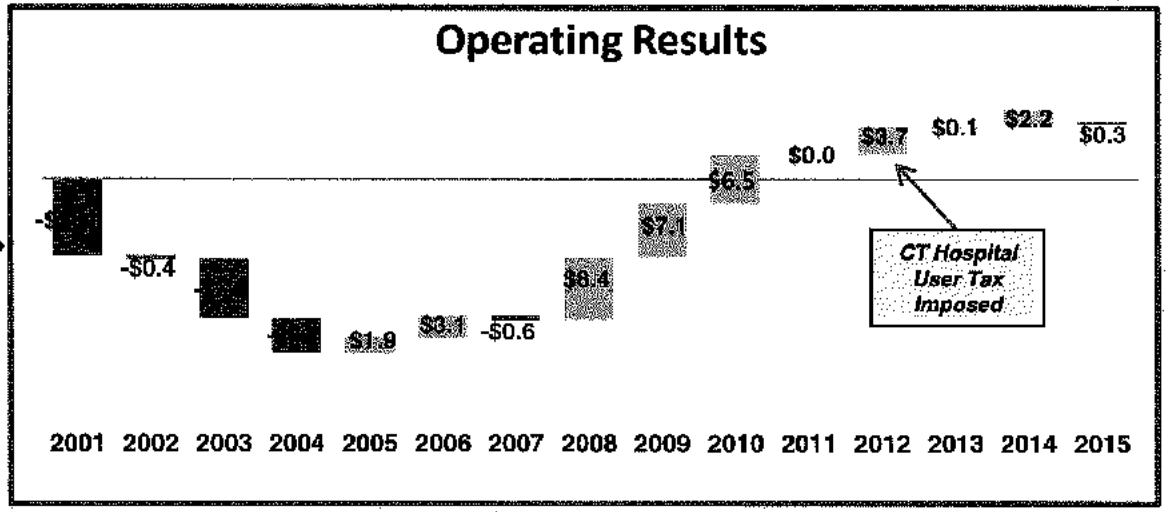
- More than insuring 32M more people
- Declining government payments to hospitals
- Focus on value, lowest cost with best results
- New payment systems put providers at risk
- Community focused delivery models
- Major investments required for programs, technology and facilities

ECHN
Eastern Connecticut Health Network

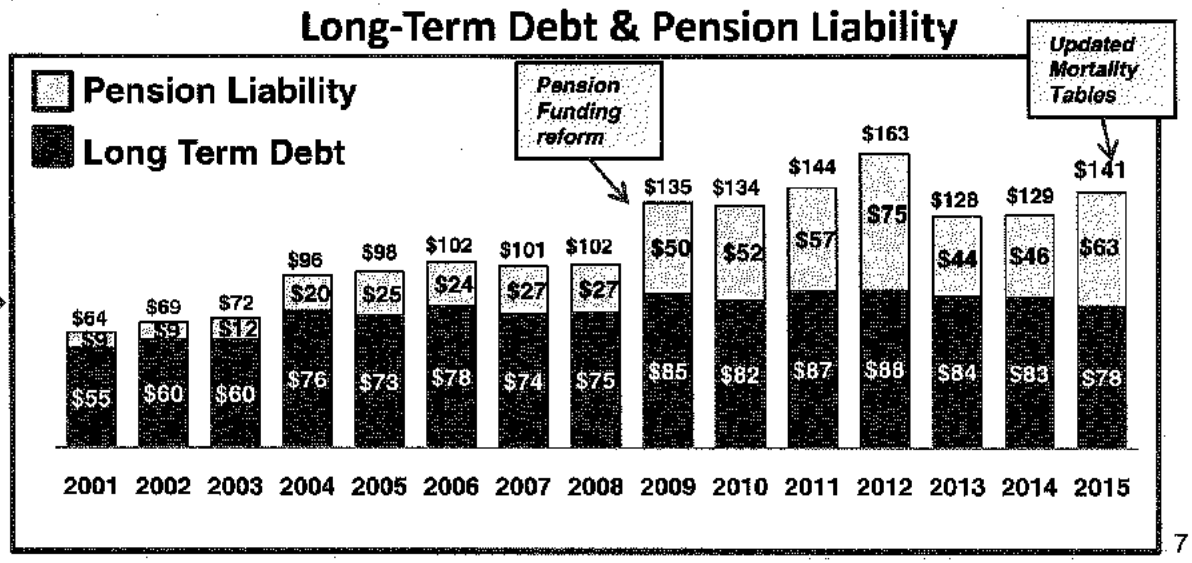
Financial Challenges

Low margins and growth in debt forced ECHN to defer capital investments; our historical financial performance has left the organization with a large debt structure that cannot be mitigated through margin alone.

1. Operations contributed only $9M total over the last 15 years: Operational deficits in 2001-2004 of $23.1 million required 6 years to be overcome



2. Long term debt and pension liabilities have grown 123% ($78M) in the last 15 years– annual debt service and pension contributions now take up the lion's share of annual cash flows

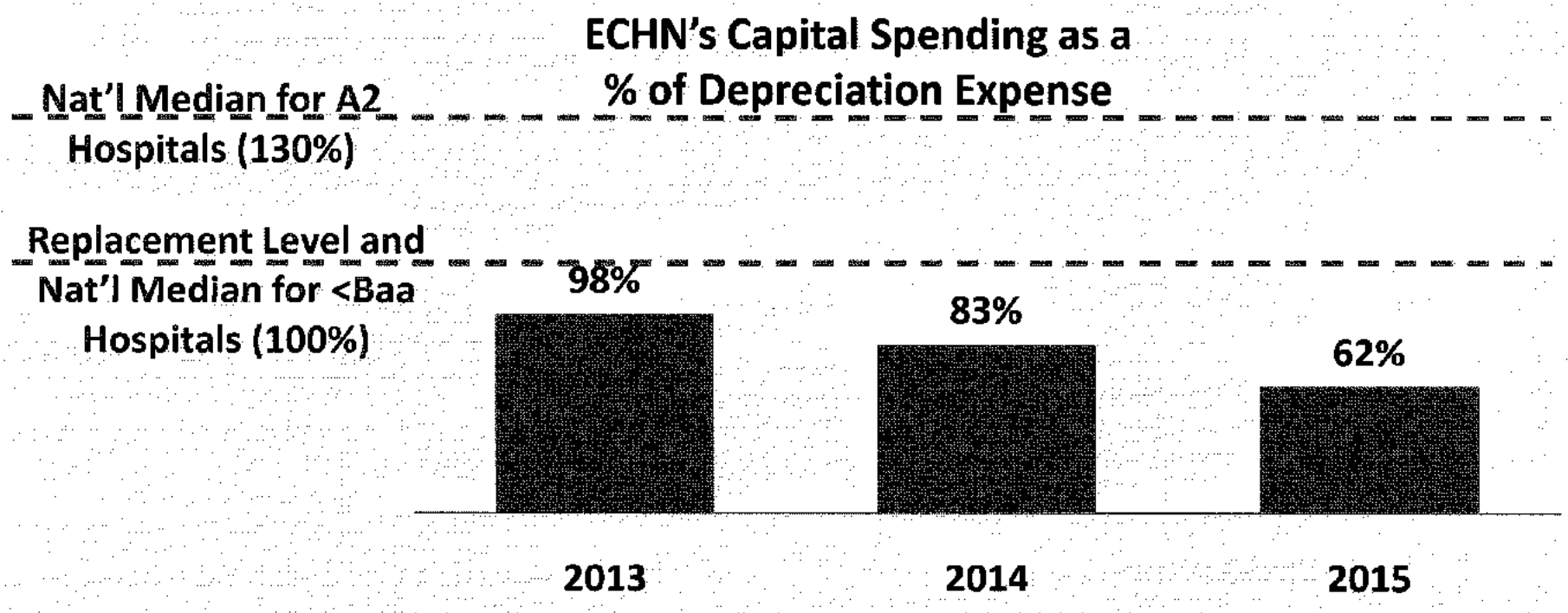


Continuing Financial Challenges
Taxes and Reduced Government Payments

	FY 2014	FY 2015	FY 2016
CT Hospital Tax	(3,914,000)	(7,960,000)	(9,942,000)
CMS Sequestration	(1,104,000)	(2,208,000)	(2,208,000)
Medicaid Inpatient Modernization Program		(1,200,000)	(1,600,000)
Low Cost Hospital Pool Eliminated			(300,000)
Medicare Wage Index		(4,825,000)	(6,525,000)
	($5,018,000)	($16,193,000)	($20,575,000)

ECHN's Financial Challenges

Historically, and in the future, ECHN's ability to invest in capital is below replacement for depreciation – inherently leading to a decrease in its asset base. The age of plant for our hospitals in 2015 was 21 years.



	2013	2014	2015
Plant/Equipment Purchases	$12.1	$10.1	$7.4
Depreciation	$12.3	$12.2	$11.9

Negative Forces into the Future



-Continued payment erosion from federal government

-Declining levels of payment from state government

-Payment reforms with more financial risk

-Continued pension obligations

-Rising costs

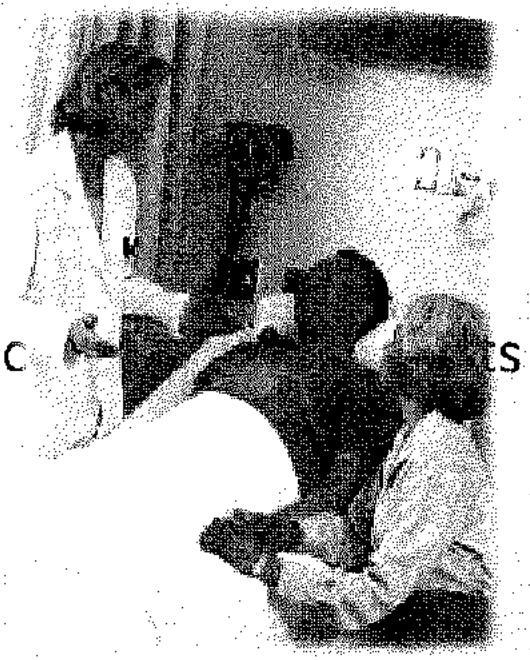
= ***Unsustainable results with an inability to REINVEST in ECHN***

ECHN
Eastern Connecticut Health Network

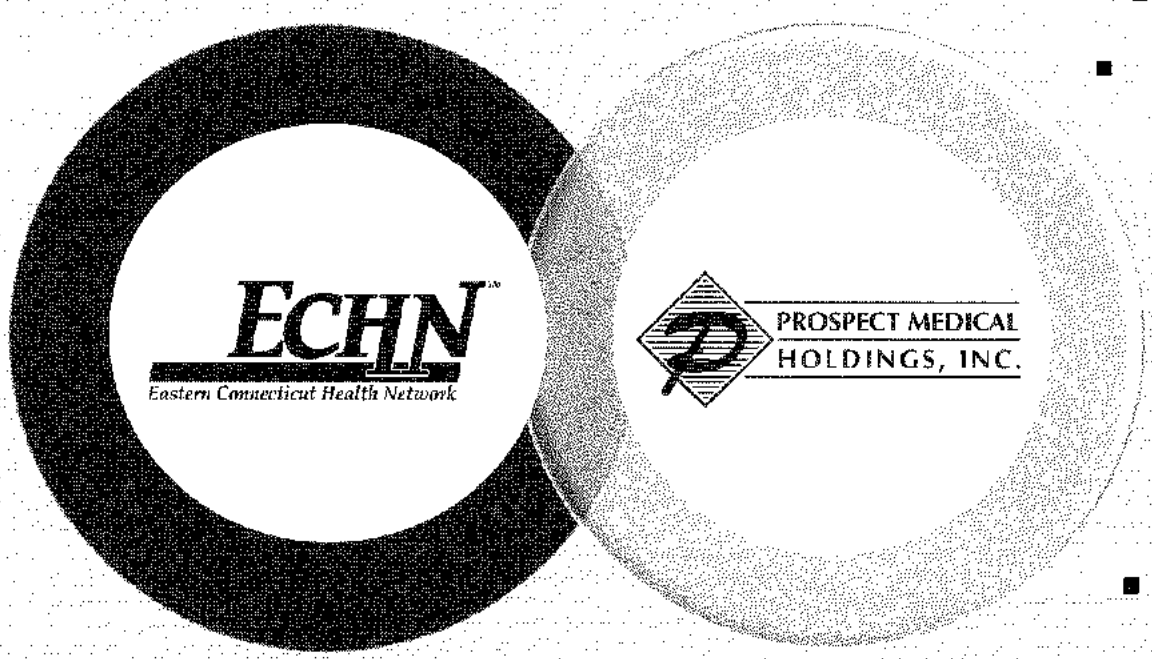
The Proposed Transaction

Prospect Medical Holdings to Buy ECHN

- $105M to satisfy all of ECHN's debt and liabilities
- $75m of capital to invest in ECHN
- Maintain Manchester Memorial and Rockville General Hospitals, Woodlake at Tolland and Visiting Nurse & Health Services of Connecticut
- Continuation of the ECHN brand and mission
- Community advisory board
- Continued commitment to charity care, indigent care and c[illegible]s
- Employment for all ECHN employees
- Establishment of a community foundation to oversee certain charitable funds



The combination of ECHN with Prospect Medical Holdings will secure the future of care and local access for residents



- **Aligned mission, vision & values**
- **Strong medical staff partner**
- **Experienced health plan partner with extensive risk management experience**
- **Long history of population health management**
- **Resources to invest in programs, staff, facilities and technology**

Together with our Medical Staff, building a sustainable, thriving network of value-based care for our communities.

ECHN℠
Eastern Connecticut Health Network

Future Quality Assurance at ECHN

Joy Dorin
Vice Chair, ECHN Board of Trustees
Chair, ECHN Transaction Committee

Due Diligence for the Transaction

- ✓ Serve the public's needs
- ✓ Positive impact on financial strength of our health care system
- ✓ Improve quality, accessibility and cost-effectiveness of health care delivery in the region, etc.
- ECHN's quality and safety efforts and achievements
  - High Reliability Organization
  - MMH and RGH, Joint Commission recognition Top Performers
- Due diligence efforts and results

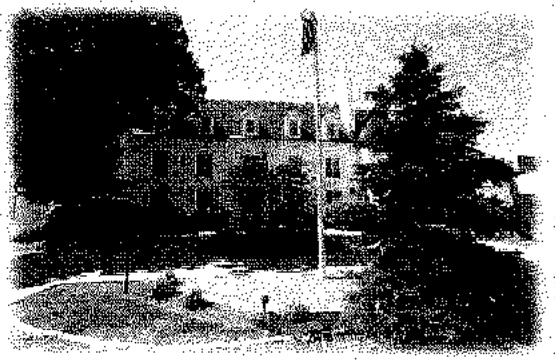
ECHN
Eastern Connecticut Health Network

PROSPECT MEDICAL

Quality Service - Quality Care

ECHN

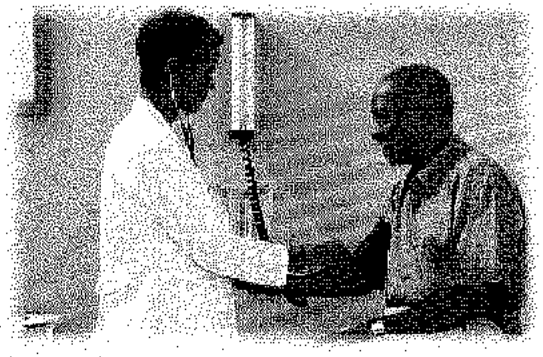
Eastern Connecticut Health Network





Conclusion




App. Exhibit 1

ECHN
Eastern Connecticut Health Network

Eastern Connecticut Health Network
71 Haynes Street
Manchester, CT 06040
860.533.3414
www.echn.org

March 28, 2016

Mitchell Lew, M.D.
President
Prospect Medical Holdings, Inc.
10780 Santa Monica Blvd
Suite 400
Los Angeles, CA 90025

Re: Quality Assurance Commitment

Dear Dr. Lew:

Reference is made to that certain draft Asset Purchase Agreement, attached hereto as Exhibit A (the "Asset Purchase Agreement"), proposed to be executed by and among Eastern Connecticut Health Network, Inc. and its Subsidiaries (collectively, the "Seller"), and Prospect Medical Holdings, Inc. and the Buyer Entities (collectively, the "Buyer") pursuant to which Seller expects to sell substantially all of its assets to Buyer (the "Transaction"). Each of the Buyer and Seller is referred to herein as a "Party" and collectively as the "Parties." Capitalized terms used but not otherwise defined in this side letter (this "Side Letter") shall have the meanings given to such terms in the Asset Purchase Agreement.

For good and valuable consideration, including the agreement by each Party to undertake the expense and effort of obtaining regulatory approvals needed to carry out the Transaction, the Parties hereto hereby agree as follows:

1. Buyer agrees to maintain for two years following the Closing, the following quality programs of Seller at the Hospital Businesses: (i) the Eastern Connecticut Health Network Patient Safety Plan for FY 2016, (ii) the Manchester Memorial Hospital and Rockville General Hospital 2016 Hospital Performance Improvement (PI) Plan, (iii) the Eastern Connecticut Health Network FY2016 Patient Experience Plan, (iv) the FY2016 Performance Improvement Goals as set forth in the document entitled "FY2015 Performance Improvement Accomplishments and FY2016 Performance Improvement Goals," and the ECHN Risk Management Plan FY2016 (collectively the "Seller Quality Programs"), copies of which are attached hereto as Exhibit B; provided however that the ECHN Risk Management Plan complies with the Buyer's insurance, legal department, and claims management requirements. Notwithstanding the foregoing, (i) Risk management will report up through the Buyer's Legal department to ensure confidential and privileged communications and work product, and (ii) settlement authority will be given by Buyer's Legal Department.

2. Buyer agrees to maintain quality assurance and performance improvement programs that are consistent with industry best practices and quality improvement programs as currently implemented in Buyer's Rhode Island facilities, modified as necessary

given local circumstances. Buyer acknowledges that following the Closing, the Local Board shall have oversight over the quality assurance programs.

3. If Buyer believes that modifications are needed to the Seller Quality Programs within two years following the Closing due to changed circumstances following the Closing, Buyer shall submit a request for such modifications in writing to the Local Board, which shall reasonably consider whether to accept such modifications. Buyer shall not implement any modifications to the Seller Quality Programs without first obtaining the approval of the Local Board for such modifications, which approval shall not be unreasonably withheld. Notwithstanding the foregoing, Buyer has sole authority to make any changes necessary to (i) address issues of patient safety, (ii) changes in federal, state, and local laws; or (iii) as mandated by a governmental agency.

4. Notwithstanding anything to the contrary in this Side Letter, in the event the Transaction is terminated or abandoned by either Party, this Side Letter shall be deemed void and of no force and effect.

If this Side Letter is acceptable to Buyer, we ask that Buyer please sign and date this Side Letter where indicated below. Please return an originally signed and completed copy of this Side Letter to me.

Very truly yours,

SELLER:

EASTERN CONNECTICUT HEALTH NETWORK, INC.

By: _____
Name: Peter J. Karl
Title: President & CEO

Acknowledged and agreed.

BUYER:

PROSPECT MEDICAL HOLDINGS, INC.,
ON BEHALF OF ITSELF AND THE BUYER ENTITIES

By: _____
Name: Mitchell Lew, M.D.
Title: President

EASTERN CONNECTICUT HEALTH NETWORK
Patient Safety Plan

FY 2016

I. PURPOSE:

The purpose of the system-wide Patient Safety Plan at the Eastern Connecticut Health Network is to improve patient safety and reduce risk for our patients by using a proactive, non-punitive approach, resulting in recognition as a High Reliability Organization (HRO) with a culture committed to promoting safety as a daily priority.

II. OBJECTIVES:

A. To foster a culture of safety through accountability, responsibility and employee empowerment
B. To strive for zero defects (occurrences) of safety incidents through the recognition and tracking of patient safety risks and through the acknowledgement of medical/health care errors
C. To provide a standardized approach for the reporting of patient safety incidents that focuses on process and systems with minimization of individual blame or retribution
D. To initiate actions to reduce identified patient safety risks
E. To improve the recognition and perception of quality and safety within the organization and the communities we serve
F. To establish a communication mechanism that provides for regular communication of our patient safety priority initiatives and outcomes both internally and externally
G. To utilize a multidisciplinary forum to review and analyze events, disseminate information and provide an avenue for individuals to bring concerns forward.
H. To disseminate the knowledge gained within the organization and in other health care organizations in order to promote changes in processes to improve patient safety
I. To assure compliance with the National Patient Safety Goals and consider best practices such as IHI initiatives, AHRQ, and CHA Collaboratives
J. To conduct annual proactive risk assessments on high-risk processes
K. To improve customer satisfaction by focusing on patient safety and well-being

The Patient Safety Plan will provide a systematic, coordinated and continuous approach to the maintenance and improvement of patient safety through the establishment of mechanisms that support effective responses to actual occurrences; ongoing proactive reduction in medical/health care errors; and integration of patient safety priorities into the new design and redesign of all relevant organization processes, functions and services.

As patient care, and therefore the maintenance and improvement of patient safety, is a coordinated and collaborative effort, the approach to optimal patient safety involves multiple departments and disciplines in establishing the plans, processes and mechanisms that comprise the patient safety activities at Eastern Connecticut Health Network.

III. SCOPE/COMPONENTS OF ACTIVITES

To provide ongoing assessment, using internal and external knowledge and experience to identify, prevent and mitigate patient safety occurrences. Patient safety occurrence information will be reviewed by the Patient Safety Committee to prioritize organizational activity efforts as to the redesign of processes based on the safety occurrences identified. Examples of patient safety occurrences include physical or psychological injury or risk of; medication error, actual or potential; adverse drug reaction; transfusion reaction, etc.

Patient safety occurrences fall into one of the following categories:

A. No Error – has capacity to cause error
B. No Harm- Did not reach patient (Good Catch)
C. No Harm – Did reach patient
D. No Harm – Did reach patient – monitor or intervene
E. Harm – Temporary harm need intervention
F. Harm – Temporary harm need prolonged hospitalization
G. Harm – Permanent harm to patient
H. Harm – Intervention necessary to sustain life
I. DEATH

Sentinel Event: A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or risk thereof. "Serious injury specifically includes loss of limb or function. "Risk thereof, includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome." See Corporate Administrative Policy # 300.01.

A. Perform Broad Spectrum Data Monitoring and Analysis: The creation of a safe patient care environment relies on identifying, reporting, tracking and sharing current and potential problems and aggregate data collected and analyzed through multiple sources of reporting which may include:

1. Incident reporting system
2. Serious Safety Event Rate
3. Daily Safety Huddle for review of system and individual safety concerns
4. Word of mouth reporting/huddles
5. System/process for recall and device failure alerts
6. Failure Mode and Effects Analysis
7. Root Cause Analysis

B. Provide the Codification of Safety Principles: The creation and revision of supporting policies and processes including the associated education that clearly delineates how the organization will react to errors, balancing a non-punitive approach with the need for action for repeated or egregious errors.

1. Embed Patient Safety Habits and Behaviors throughout organization
2. Promote a Just–culture using the accountability algorithm
3. Perform Patient Safety Rounds
4. Enhance Teamwork behaviors
5. Improve the knowledge of safety practices with structure and resources in place
6. Enhance clear structured communication including Huddles, Briefings, Debriefings, and Handoffs/SBAR (Situation, Background, Assessment and Recommendation)
7. Survey the Culture of Safety on a regular basis
8. Spread best-practice across the system

C. Provide a Staff-Centered Safety Infrastructure: through the promotion of multidisciplinary participation that values staff ownership and engagement in the creation of a safe practice environment:

1. Patient Safety Committee (see Attachment)
2. Patient Safety Action Teams
3. Patient Safety Coach Committee and Safety Coaches
4. Patient Safety Rounds, allowing for direct communication of safety concerns

5. Best-practice resources/education as it relates to any patient safety endeavor. For example, pressure ulcer reduction and central line infection prevention, etc.
6. Organization-wide training on safety habits and behaviors

D. Enhance Patient Safety-Focused Decision Support through the adoption of criteria-based protocols and technological innovations such as Checklists/standardization to reduce variation, Care Protocols (Fall, Central line bundle, etc.), Smart pumps, Bar-coding, and On-line incident reporting.

E. Perform Retrospective Internal Assessment: through ongoing evaluation and reevaluation of program and process changes, utilizing proven metrics and benchmark data to monitor improvement, confirm the efficacy of actions taken and/or acknowledge initiatives that fail to produce the intended results.

1. Data from IRIS – monthly/quarterly/yearly
2. Serious Safety Event Rate – monthly
3. Days since last fall with injury, HAPU, CLABSI
4. National benchmarking-NDNQI
5. Internal Dashboards
6. Results of Safety Surveys
7. Quality Monitoring

IV. AUTHORITY AND ACCOUNTABILITY

The Board of Trustees, via the Quality Improvement Council (QIC), delegates the responsibility, authority and accountability for the coordination and oversight of the Patient Safety Program to the interdisciplinary Patient Safety Committee, co-chaired by the Patient Safety Director/Officer and/or Vice President of Quality and Safety and a physician assigned by the QIC. The Patient Safety Committee is a sub-committee of the network's Quality Improvement Council. Patient safety reports and committee minutes will be submitted to the QIC. The Patient Safety Director/Officer and/or the Vice president of Quality and Safety is responsible for the advancement of the ECHN Culture of safety/just culture through a strong clinical presence and administration of the Safety Program on a day-to-day basis.

V. PROGRAM CONFIDENTIALITY

When the Patient Safety Committee engages in quality "review to gather and review information relating to the care and treatment of patients for the purpose of (A) evaluating and improving the quality of health care rendered; (B) reducing morbidity or mortality; (C) establishing and enforcing guidelines designed to keep within reasonable bounds the cost of health care, "it is considered protected under Connecticut State statute 19a-17b.

VI. COMMUNICATION PLAN

Patient safety relies on interactive and open communication through the exchange of ideas and information. Timely communication between all committees and organizational groups responsible for patient care and safety is expected. Safety Information will also be published regularly to provide communication of our patient safety priority initiatives and outcomes both internally and externally.

VII. ANNUAL REAPPRAISAL

The co-chairs, with input from the Patient Safety Committee, will conduct an annual review of the Patient Safety Plan for evaluation of the program's effectiveness and to establish priorities for the next year. Recommendations will be forwarded to the appropriate committees or departments throughout the

organization. The Patient Safety Plan is approved by administration, the medical staff and the governing board.

VIII. ATTACHMENT: Patient Safety Committee (Purpose/Objectives/Composition)

ADOPTION

This Patient Safety Plan has been reviewed and adopted by the Board of Trustees, the Medical Staff acting through its Executive Committee, and by the Hospital's management, as attested by the signatures below:

Dennis G. O'Neill

_____ _____

Chairman, Board of Trustees **Date**

Pamela L. Lewis

_____ _____

President of the Medical Staff **Date**

Peter J. Karl

_____ _____

President/CEO **Date**

ATTACHMENT
to
Patient Safety Plan

EASTERN CONNECTICUT HEALTH NETWORK
Patient Safety Committee

PURPOSE:

Under the direction of the Patient Safety Officer/Vice President of Quality and Safety, the Patient Safety Committee is charged with analyzing and tracking adverse events, auditing hospital procedures to minimize risk, and developing/sustaining a culture of patient safety.

OBJECTIVES:

- Receive occurrence reporting data from Risk Management, review and act on this data to identify trends and/or opportunities for improvement, assign responsibility, and set timelines for action.
- Receive and review complaint information from Patient Representatives related to patient safety.
- Review the Joint Commission's Sentinel Event Alerts and National Patient Safety Goals, assign responsibility for monitoring ECHN's compliance with these requirements, and charter teams to improve areas of deficient compliance or performance.
- Use published information about adverse or sentinel events in other organizations as opportunities to apply "lessons learned" to appropriate ECHN systems and processes.
- Assist in the review and action plan related to adverse events or sentinel events working under the Sentinel event policy and monitor the completion of and compliance with corrective action plans.

Reviews and discusses all Serious Safety Events for lessons learned as well as monthly Serious Safety Event rates

- Inform ECHN leadership and Medical Staff about changes in regulatory requirements that may impact patient safety procedures and practices, and assure compliance with those regulations.
- Provide yearly review and approval of ECHN's Patient Safety Plan.
- Receive and act on reports from the following committees or areas on a scheduled and ad hoc basis:
  - Grievance Committee
    - Patient safety-related complaints
  - Claims Committee Data
    - Incident Reporting*
  - Code and Rapid Response Committee
  - Critical Care Committee
    - VAP
    - CLABSI
    - Best practices related to critical care patient care/safety
  - EOC Safety Committee
  - Fall Committee
  - Infection Control and Prevention Committee (CLABSI, CAUTI, SSI, etc.)
  - Patient Safety Action Teams: i.e.,
    - Safe Patient Handling
    - Needlesticks and Blood Borne Pathogens
  - Pharmacy & Therapeutics
    - Medication Safety Subcommittee

    - Adverse Drug Events
  - Physician Practices
    - Physician Patient Safety Coaches
  - Staff Concerns
    - Patient Safety Rounds/Rounding to Influence
    - Staff Membership on committees
    - Patient Safety Coaches
    - SVP and VP Rounding for Outcomes
  - Patient Concerns:
    - Leadership Rounding with Patients
  - Vascular Access Committee
  - Woodlake at Tolland
  - Wound Committee
- Address any issues identified through Root Cause Analysis Teams, FMEAs, or committee reports that will require data monitoring and ongoing reporting will be followed by the Patient Safety Committee.
- Develop and support a non-punitive approach in the management of errors and occurrences. The focus will be placed on remedial actions rather than punitive actions taken.
- Sustain behaviors of an Accountable/Just Culture

The Patient Safety Committee shall meet at least ten (10) times per calendar year or more often as deemed necessary by the chair.

COMPOSITION:

The committee will be co-chaired by the Patient Safety Officer/Director /Vice President of Quality and Safety and a physician assigned by the QIC. Membership will include representation from the Medical staff, Nursing staff, Medical Imaging, Administration, Risk Management, Pharmacy, Quality Improvement, and Human Resources. Representatives from other departments including, but not limited to, Infection Control, Security, Environmental, Food and Nutrition, Cardiopulmonary, Information Technology, Laboratory, and Finance will be invited to attend as ad hoc members.

Initiated: 05/19/2011
Revised: 01/11/16

MANCHESTER MEMORIAL HOSPITAL (MMH)
ROCKVILLE GENERAL HOSPITAL (RGH)

2016 HOSPITAL PERFORMANCE IMPROVEMENT (PI) PLAN

I. PURPOSE AND MISSION

This plan provides a proactive systematic approach to designing, measuring, assessing, and improving performance in Quality, Patient Safety and Patient Experience, and to ensure that it is accomplished in accordance with the direction of the Board of Trustees, Medical Staff Bylaws, and our Organizational Mission: To improve your well-being by providing high-quality, compassionate healthcare. We will achieve our Mission through a commitment to Caring, Teamwork, Respect and Communication. In doing this, we will accomplish our Vision: To be your first choice for excellence in healthcare. Further, the Organization will demonstrate a consistent effort to deliver safe, high quality patient care and provide an optimal patient experience with achievable goals. We support becoming and maintaining status as a High Reliability Organization by providing a culture of patient safety through Safety habits and behaviors.

This PI Plan is developed in conjunction with and is intended to compliment the Patient Safety, Patient Experience, Environmental, and Risk Management Plans.

II. OBJECTIVES

A. To increase the probability of desired patient outcomes, by assessing and improving those governance, managerial, clinical and support processes that most affect such outcomes, and by providing an ongoing process to improve care, identify and resolve issues.

B. To ensure a proactive integrated patient safety program throughout the hospital with a non-punitive, but accountable, approach to identifying risks to patient safety and reducing factors that contribute to unanticipated adverse events and/or unanticipated outcomes.

C. To establish priorities for performance improvement activities. This is accomplished by using information related to patient safety and unanticipated adverse events and/or outcomes affecting patients, including serious safety and sentinel events in our own and other health care organizations, as well as focusing on those internal and external processes and activities with the greatest potential impact on patient care outcomes and satisfaction. These priorities include National Patient Safety Goals as identified by The Joint Commission (TJC).

D. To carry out and communicate performance improvement activities including findings, conclusions, recommendations, actions taken, and results of those actions, through established channels to appropriate leaders and members of the hospital.

E. To assure that new or modified processes are designed well. Such processes reflect the hospital mission, vision, and strategic plan, the needs and expectations of patients, staff and others, the integration of safety priorities, and the use of up-to-date sources of

information, such as evidence based practice guidelines, and such processes will be evaluated for their effectiveness.

F. To ensure that those carrying out tasks are competent to do so. This is accomplished through performance-based evaluations and ongoing education and training to maintain and improve staff competency.

G. To ensure that Medical Staff credentialing activities comply with Federal, State, TJC regulations and Medical Staff Bylaws.

H. To ensure that processes measured on a continuing basis include those that affect a large percentage of patients, those that place patients at serious risk if not performed well, or those that are performed when not indicated, or not performed when indicated, or are likely to have been problem prone. These include processes related to operative, invasive, and other procedures that place patients at risk, medication management, use of blood and blood products, restraint use, seclusion use, outcomes related to resuscitation, infection control, medical records, utilization management, risk management, quality control, autopsies, organ procurement effectiveness, CORE measures, HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems), human resource measures, environmental, and patient safety.

I. To ensure that data is collected and analyzed on a regular basis regarding patient needs and expectations, including patient, family and staff opinions, perceptions of risks to patients, and when applicable, the effectiveness of pain management.

J. To ensure the appropriate use and effectiveness of services for the provision of patient care and treatment obtained through contract relationships.

III. SCOPE AND ORGANIZATION

All services shall participate in integrated performance improvement efforts. Participation includes, but is not limited to, activities that improve patient safety, patient care and associated functions and services, personnel competency and regulatory compliance. Consideration will be given to such things as Institute for Healthcare Improvement (IHI) initiatives, National Patient Safety Goals and TJC, Center for Medicare and Medicaid Services (CMS), CORE measures, and HCAHPS. The Performance Assessment/Improvement Structure and Membership is shown in Attachment #1a,1b and 1c.

As required by TJC and CMS, we publicly share our CORE measure results related to Venous Thromboembolic Event, Stroke, Perinatal Care, Hospital Based Inpatient Psychiatric Services, Sepsis as well ED throughput and outpatient measures, Immunizations, Readmissions, Mortality, Hospital Acquired Infection and Conditions, and patient satisfaction (HCAHPS). This information is also shared regularly system wide with management and hospital staff, as appropriate.

IV. AUTHORITY AND ACCOUNTABILITY

The organization's leaders include members of the Board of Trustees, Medical Executive Committee (MEC), administrative management, and directors and managers. The organization's leaders set expectations, develop plans, and implement procedures to assess and improve the quality of the organization's governance, management, clinical and support processes. The organization leaders encourage learning about unanticipated adverse events and/or unanticipated outcomes and develop a non-punitive environment that encourages the identification and management of actual and potential risks to patient safety. As appropriate, the Board shall hold the Medical Staff and management responsible for implementing performance improvement and safety efforts. The leaders will assess the need for organizational performance improvement and safety efforts, set priorities, allocate resources for assessment and improvement, assure that staff has the appropriate training available, design communication systems that foster open sharing of information and the coordination of performance improvement and safety activity.

A. The Board of Trustees has the ultimate responsibility for assuring the quality and effectiveness of patient care services provided by its medical staff members and other professional and support staff. The Governing Body meets this responsibility by its oversight of the effective functioning of activities related to performance improvement, risk management, safety, the credentialing of Medical Staff and competency of licensed and non-licensed staff, financial oversight and mechanisms/policies designed to ensure the provision of quality patient care. The Board of Trustees delegates the actual performance assessment and improvement process to the medical, professional, and support staffs.

   The Board will review periodic reports of findings, actions and results from improvement activities, in order to assess the program's efficiency and efficacy. A report for the Board will be prepared at least quarterly by the Vice President, Quality and Patient Safety, and will include an overview of: clinical and non-clinical indicators, relevant monitoring activity, performance improvement team results and status. In addition, the Board receives an Annual Report to Governance/Leadership that includes summary information related to System Failures, Sentinel Events, Reportable Events, and r actions taken to Improve Safety. The Board takes timely and appropriate action to ensure patient safety and the proper delivery of quality patient care.

B. The Quality Improvement Council (QIC) is responsible for guiding quality monitoring and improvement activity, excluding individual Medical Staff peer review which is performed by the Medical Peer Review Committee(s). Membership of QIC includes leaders from the Medical Staff, Senior VP Medical Affairs, VP Quality and Patient Safety, and Senior VP & Chief Nursing Officer, VP of Patient Care Services, , Quality Improvement (QI) Managers, Administrative Director of Patient Care Services, and a Human Resources representative . Other members may be added at the discretion of the QIC or Board of Trustees. The QIC will prioritize projects, provide guidance and support for performance improvement efforts, and is responsible to the Board for its actions. The QIC shall meet at least quarterly.

   The QIC will:

- Assess departmental and interdepartmental needs for performance improvement efforts through periodic review of internal and external data, departmental, administrative, and/or Medical Staff monitoring data, trends related to customer satisfaction, direct requests from the Board, Medical Staff, administration and employees, all within the context of the overall strategic direction of the institution.
- Determine the need for multi-disciplinary teams and will empower teams.
- Determine the need and provide for training and education in performance improvement, patient safety, and patient experience including management training, training related to performance improvement tools and techniques, general employee training on performance improvement through department directors, and training incorporated into orientation programs.
- Consider the need for education of the medical staff concerning identified performance improvement opportunities, pain management, Infection Control, and will communicate such needs to the Medical Education Committee.
- Provide communication to the Board, Medical Staff, and to departments about performance improvement efforts, requirements, and recognition of those efforts.

The responsibilities of QIC Approved Teams include periodic status reports, which may be submitted in writing or may be given verbally to the QIC. Status reports may be submitted on the Performance Improvement (PI) Project Cycle Documentation form (Attachment #4).

The QI Council will receive reports related to Root Cause Analysis and Action Plans.

C. The Patient Safety Committee, composed of organizational leaders, staff, and medical staff, identify patient safety priorities. The committee in collaboration with the Quality Improvement Council promotes education, breaks down barriers, communicates changes, promotes collaboration, ensures accountability for actions, and celebrates successes.

D. The Patient Experience Steering Committee is composed of organizational leaders and medical staff who are charged with identifying, assessing, and evaluating the patient experience throughout ECHN. The Committee is responsible for the overall plan to improve the patient Experience throughout ECHN.

E. Administrative Management is responsible for assuring performance improvement and safety efforts are based on the organization's strategic direction, vision, and identified priorities. Management monitors key business and quality indicators.

Reports of key business indicators, information related to patient safety and unanticipated adverse events and/or unanticipated outcomes affecting patients, including sentinel events in other health care organizations, as well as findings and information received from performance assessment measures, will be used to provide direction for relevant performance improvement activity.

E. Department Directors and managers are responsible for ensuring the following:

- Individual departments will participate in performance improvement and safety activities. Employees at all levels will be included.
- Individual departments will participate in at least one project annually and will focus on improvements related to patient/family/customer satisfaction, efficacy, appropriateness, availability, timeliness, effectiveness, continuity, safety, efficiency and/or respect and caring.
- The departments' Vice President will provide direction in the development of annual departmental PI Plans and project selection. Directors will take responsibility for reporting their monitoring activity and related performance improvement efforts.
- Department Managers and Directors plan and implement programs that evaluate and enhance the competence, skills and abilities of the staff. Vice Presidents/Directors will assure that reports of department performance assessment and improvement activity are submitted and reviewed in a timely manner.
- Forms for planning, recording and documenting quality improvement activity appear in Attachments 2-4.

F. The Medical Staff is responsible for taking an active leadership role in improving the quality and safety of patient care, education of patients and families, and coordination of care with other practitioners and hospital personnel through the involvement in multi-disciplinary teams and committees. The President of the Medical Staff, through the Medical Executive Committee (MEC), coordinates Medical Staff involvement through appointments, delegation of assignments, and support of patient care monitoring. The Medical Staff participates in performance improvement activities to address:

- Clinical monitoring and evaluation of patient care provided by individuals with clinical privileges, which is accomplished as a peer review function by the Medical Staff leadership or their designees. Improvement and safety initiatives and other internal/external data will be analyzed with findings, conclusions, recommendations, actions, and planned follow-up evaluations forwarded to the appropriate staff and department chairpersons.
- Adequate resources for improvement activities, through the assignment of Medical Staff members to participate as needed and the librarian to facilitate access to evidence-based literature.
- The status of identified problems or opportunities to monitor improvement or resolution.
- Collaboration of activity and communication, as appropriate, in improvement activities.
- Written reports of recommendations, actions taken, and the results of these actions.
- Mechanisms of appropriate reporting of improvement and safety activities to members of each Medical Staff department, the QIC, and the Board of Trustees through the Board Performance Assessment /Improvement Committee.
- Participation in the planning and evaluation of the effectiveness of improvement activities, as part of the hospital's annual appraisal of improvement efforts.

V. MONITORING ACTIVITIES

A. Measurement of clinical processes will include:

- Care provided to high-risk populations.
- Operative or other high risk procedures including the use of sedation/anesthetics, adverse events, appropriateness, planning, preparation of procedures, discrepancies between pre-operative and post-operative diagnoses, identified in reports and pathologic review of specimens.
- Processes related to medication management: Quality improvement activities include selection and procurement; storage; ordering and transcribing, preparing and dispensing; administering; and monitoring the medications' effects on patients.
- Process related to the use of blood and blood products including ordering, distribution, handling, dispensing, administration, monitoring the blood and blood products' effects on patients, and monitoring of confirmed transfusion reactions.
- Fall reduction activity.
- Autopsies and pathology review.
- The use of restraints and/or seclusion.
- Quality control and infection surveillance and prevention activities.
- Patient's perceptions of care, treatment and services including their specific needs and expectations, how well their needs are met by the organization, and how the organization can improve patient safety and overall patient satisfaction.
- Patterns and trends in utilization of clinical and non-clinical resources in the treatment of patients.
- Effectiveness of pain management.
- The effectiveness of response to change or deterioration in a patient's condition (Rapid Response data), as well as results of resuscitation efforts.
- Staffing appropriateness.
- Joint Commission CORE Measures and other publicly reported measures.
- Compliance with the National Patient Safety Goals.

B. The integrated safety program monitors all types of occurrences, ranging from no harm/good catches to serious safety events and sentinel events. Serious safety eand sentinel events are investigated using a multidisciplinary approach. A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. The investigation includes conducting a root cause analysis of the event, identifying corrective actions needed to prevent reoccurrence and to improve the process(es), developing specific indicators of the effectiveness of improvement efforts, monitoring the actions taken for a defined period of time, and conducting redesign of process(es) if indicated.
Every 18 months, at least one high-risk process will be selected for intensive proactive risk assessment. The process will be analyzed to identify undesirable variation. (Failure Mode Effect Analysis/FMEA) For each failure point, the seriousness of effect on the patient is weighed for each fail point (Criticality). For the most critical effects, an analysis will identify the underlying reasons and contributing factors to adverse outcomes. The performance improvement process will be followed to redesign and minimize the risk of failure, or to protect the patients from potential of failure.

The Patient Safety Committee integrates risk management and performance improvement processes with activities of organization and medical staff committees including but not limited to Pharmacy and Therapeutics, Infection Control, Fall and Wound Committees, Environment of Care Committee, and Medication Safety.. The goal of this committee is monitoring key indicators, implementing target strategies, and conducting proactive risk assessments, the organization will be able to reduce unanticipated adverse events, improve outcomes, and prevent sentinel events. The Patient Safety Committee will report regularly to the QIC.

C. Risk management: The Director of Risk Management, in collaboration with clinical and administrative leadership, assists in the following: identifying general areas of potential risk in the clinical aspects of patient care and safety; developing identification criteria for potential risks in patient care and safety; coordinating specific corrective actions for problems identified; and designing proactive risk reduction strategies.

The Risk, Safety, and QI staff share findings from high-risk indicators, linking data to provide solutions for potential safety and quality concerns.

VI. DATA

Sources of data for performance improvement review activities shall include, but not be limited to, the following:

Medical records; morbidity/mortality review findings; monitoring activities of the Medical Staff and hospital departments or committees; review of practice patterns; patient and physician trends; pertinent risk management findings; information related to patient safety and unanticipated adverse events and/or outcomes affecting patients, including sentinel events in other health care organizations; PI team activities; financial data; claims; utilization review findings; data obtained from staff interviews and observation; patient surveys or complaints; Qualidigm, fiscal intermediaries or private agencies; committee and department minutes; qualitative and secondary market research and special studies, current literature, and benchmark data.

Retention of Data and Reports:

All formal Medical Staff minutes and reports will be maintained permanently. Physician profiles and review forms will be retained permanently. All other formal PI minutes and reports will be retained from 3 to 7 years, as appropriate.

VII. PROGRAM CONFIDENTIALITY

When the Performance Improvement process, engages in quality "review to gather and review information relating to the care and treatment of patients for the purpose of evaluating and improving the quality of health care rendered, reducing morbidity or mortality, or establishing and enforcing guidelines designed to keep within reasonable bounds the cost of health care," it is considered protected under Connecticut State statute 19a-17b.

VIII. ANNUAL REAPPRAISAL

With input from the QIC and MEC, an annual review of the QI program will be conducted by the Board for evaluation of the program's effectiveness. Findings will guide program revision.

ADOPTION

This Performance Improvement Plan has been reviewed and adopted by the Board of Trustees, the Medical Staff acting through its Executive Committee, and by the Hospital's management, as attested by the signatures below:

Dennis G. O'Neill

Chairman, Board of Trustees **Date**

President of the Medical Staff **Date**

Peter J. Karl

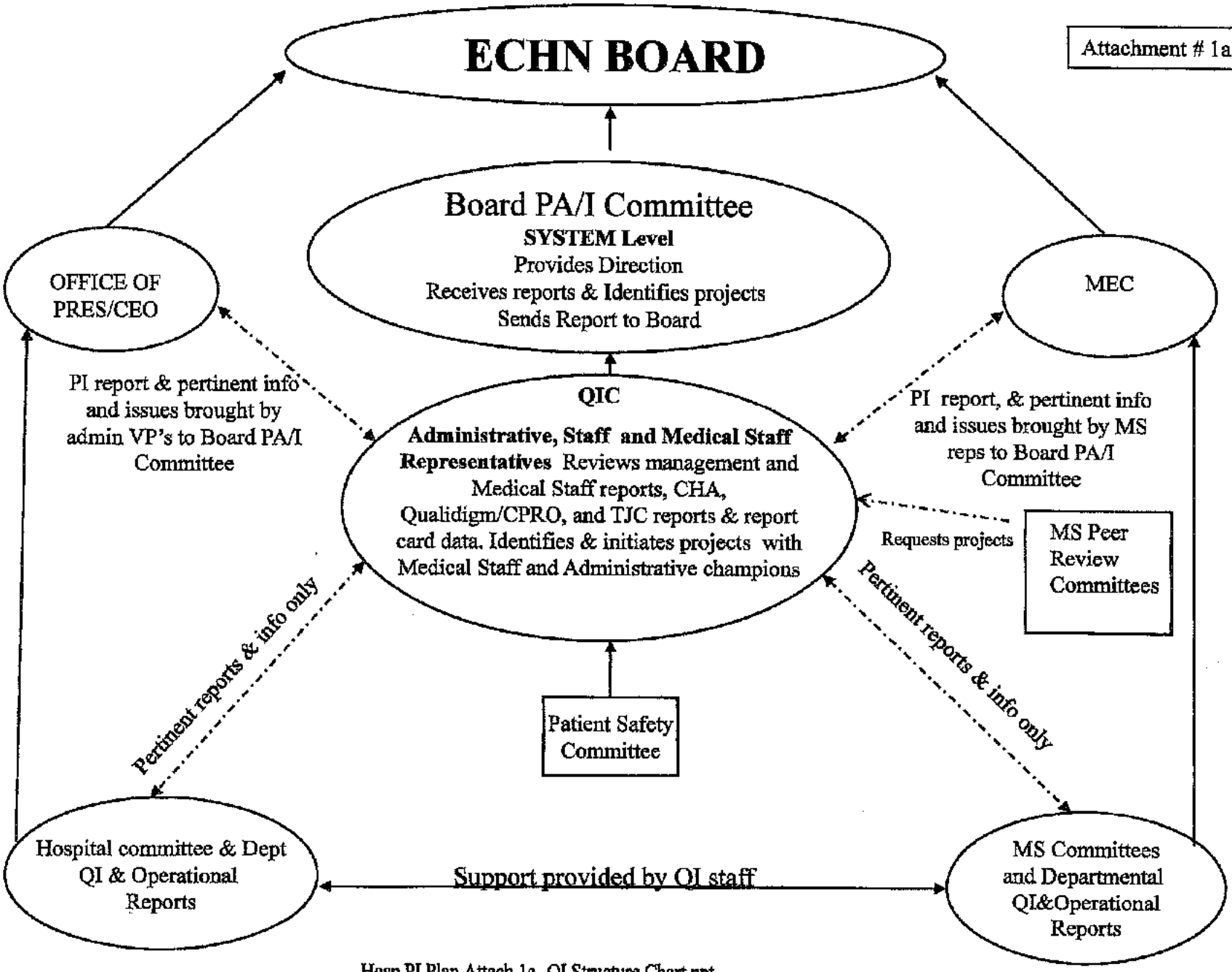
President/CEO **Date**

ATTACHMENTS

#1a QI Council Structure
#1b Safety Committee Structure
#1c Quality Improvement Council Membership
#2 Hospital Performance Improvement Plan Form
#3 QI Quarterly Report Form
#4 Performance Improvement Project Cycle Documentation

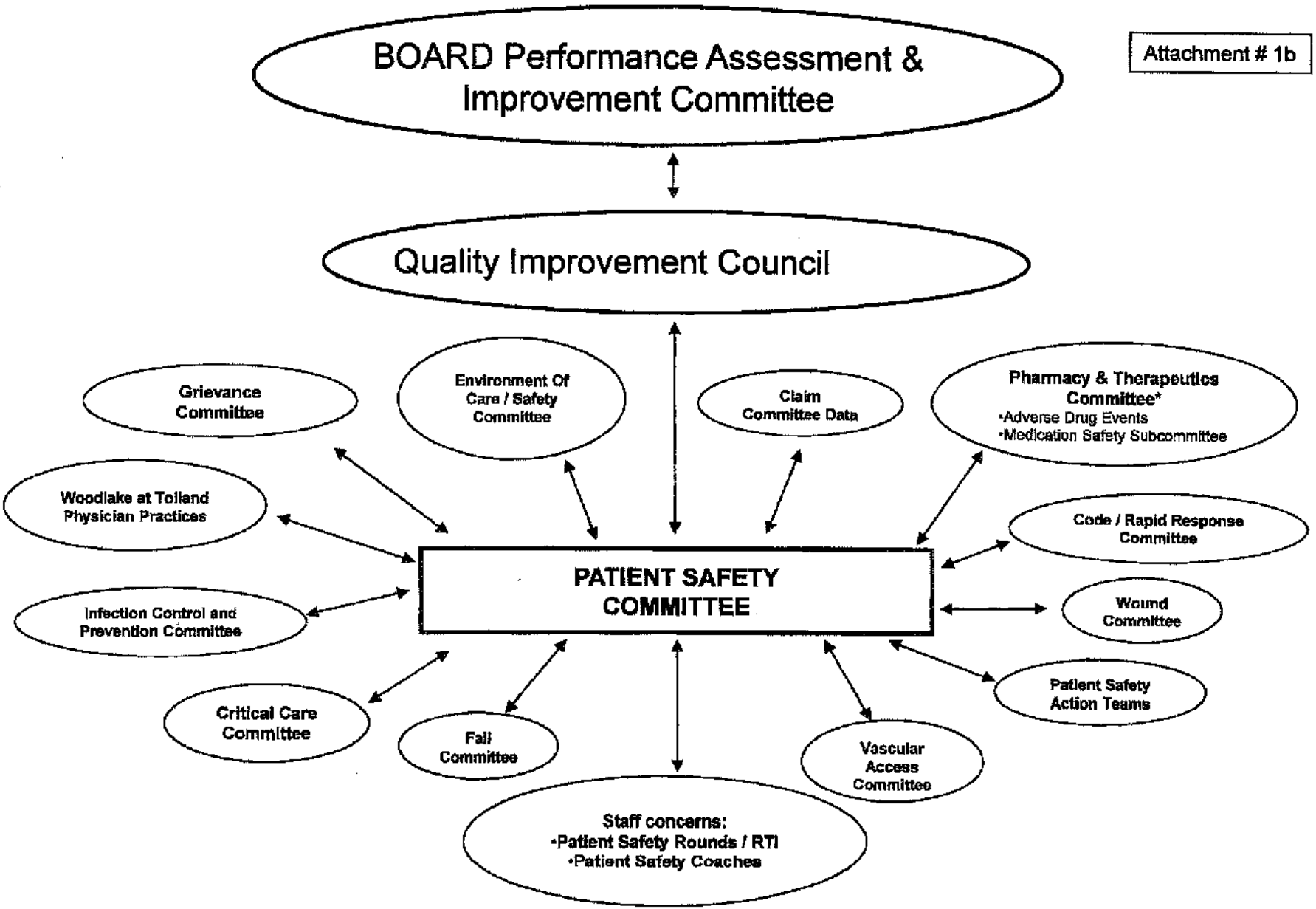
#5 Joint Commission National Patient Safety Goals

Attachment # 1a



Hosp PI Plan Attach 1a- QI Structure Chart.ppt

Attachment # 1b



Revised: August 2014

Attachment # 1c

ECHN
Eastern Connecticut Health Network, Inc.

MEMBERSHIP:
QUALITY IMPROVEMENT COUNCIL

Medical Staff Representation

Vice President Medical Staff (Chair)
Anesthesiology
Emergency
Hospitalists
Family Practice/Internal Medicine
Medical Imaging
OB/GYN
Pathology
Psychiatry
Surgery

Administrative Representation

VP, Quality & Patient Safety
Sr. VP & Chief Medical Officer
Sr. VP, Patient Care Services & Chief Nursing Officer
VP, Patient Care Services
Director, Human Resources
Chief Information Officer
Director, Medical Library

Director, Risk Management
Managers, Quality Improvement
Manager, Safety/Occupational Health

HOSPITAL PERFORMANCE IMPROVEMENT PLAN FY_____
FOR DEPARTMENT:

Attachment # 2

Rationale Is it high volume, high risk, problem-prone, or provide data that suggests room for improvement.	**Indicator/Process** (List Indicators and QI Projects)	**Methodology** What will you measure to know you have made an improvement? Define your numerator\denominator\sample size How will you measure? How often will you measure?
	Indicators:	
	Dept. Projects:	
	Multidisciplinary Teams:	

_____ _____

Signature Date

Hospital

*Quality Improvement Plan, Fiscal Year*_____

Department_____

Quality Control Items	

Attachment # 3

QI Quarterly Report

Qtr Date: ( ) - ( )

Mgr. Signature:_____ Date:_____

Date sent to QI Manager: _____

Indicator	Trend					Analysis (cumulative)	Action (ea. qtr)	Results & Follow Up
	Initial data	1st	2nd	3rd	4th			
Sample Size:								
Sample Size:								
Sample Size:								

Quality Control Items Needing Action:	Action taken:

Date initiated	Department QI Projects	Analysis (Data Driven)	Action Plan	Results of Action Taken	Follow Up

Date Initiated	Multidisciplinary Projects > 2 Depts	Date Initiated	Multidisciplinary Projects > 2 Depts

Request for Multidisciplinary team: _____Yes* _____No (*See attached form)

Attachment # 4

PERFORMANCE IMPROVEMENT CYCLE DOCUMENTATION (Instructions)

Hospital: _____ **Date Project Initiated** _____

Department: _____ **Date of report:** _____

Project Identification	• What do you want to improve? • Who are the team members? • Is there "Initial Data" that told you this is a problem area? ____Yes, ____No • If Yes list the Data. • What goal are you trying to achieve?
Analysis	***During the Analysis Phase you will identify what's really happening now. Ways to analyze include using brainstorming, flow charting the process, gathering data via surveys or chart reviews, developing logs & tick sheets so that you have #'s.*** • Describe the current situation. (**Attach data , charts, process flow,** if available) • What does your data tell you? • What are the main causes for the current situation?
Possible Solutions	• Can you remove time, steps, dollars? • Based on the analysis brainstorm with your team, a list of possible solutions. • Prioritize these solutions in order to create an action plan.
Action	• Describe your action plan. (**Who will do what, when**). • Create a timeline/dates for implementing each step of your action plan. • Implement your plan.
Check	• What will you measure to show you've met your goal, or otherwise made an improvement?
Results	• Compare pre measures to post measures. (USE DATA TO SHOW HOW MUCH IMPROVEMENT YOU'VE MADE)
Follow Up	• When will you re-measure? ___2wks___1month___3months___6months • How often will you re-measure? _____

2016 NATIONAL PATIENT SAFETY GOALS

GOAL 1: IMPROVE THE ACCURACY OF PATIENT IDENTIFICATION

Use at least two patient identifiers when providing care, treatment and services.

- Ask the patient to state their full name and DOB, and/or view the wristband for two identifiers.
- Compare identifiers to document/source.
- All staff are responsible for correct patient identification.
- All specimen labeling MUST be done at the bedside in the presence of the patient.

Eliminate transfusion errors related to patient misidentification.

- Two licensed caregivers at the bedside must verify order to transfuse blood product, blood type, unit number and expiration date, patient name and birth date, and sign name as verification.
- Match the patient to the blood component by using two patient identifier process.

GOAL 2: IMPROVE EFFECTIVENESS OF COMMUNICATION AMONG CAREGIVERS

- Verbal/telephone orders and critical test results, first write down and then read back to confirm.
- Receive and report critical results of tests in a timely manner to a licensed caregiver for timely action as per policy.
- Standardize hand-off communication that includes using SBAR and Ticket to Ride when the patient is transferred from one caregiver to another.

GOAL 3: IMPROVE THE SAFETY OF USING MEDICATIONS

- Identify a list of look-alike/sound-alike medications. Prevent errors with these medications with a flag (!) in Meditech and Pyxis.
- High alert medications are designated with a "++" in the eMAR to bring attention to these medications.
- In perioperative and other procedural settings, label all medications and solutions on an off the sterile field.
  - ✓ Two qualified individuals verify verbally and visually when the person preparing the medication is not the person administering the medication.
- Reduce the likelihood of patient harm associated with the use of anticoagulation therapy.
  - ✓ Patients on Coumadin receive diet instructions from dietician and nursing.
  - ✓ Be alert to order entry and eMAR built-in safety guides.
  - ✓ Use anti-coagulation flow sheets.
  - ✓ Baseline and ongoing lab tests are required for all anticoagulants.

Medication Reconciliation Process

- For inpatient, or if seen as an outpatient, obtain a current list of medications.
- Include as much information as possible, e.g., name, route, dose, frequency and purpose.
- Compare the medication information the patient brought to the hospital with the medications ordered for the patient by the hospital in order to identify and resolve discrepancies.
- Provide the patient (or family) with written information on the medications the patient should take when discharged.
- Explain the importance of maintaining medication information to the patient when he or she is discharged (e.g., providing a list to the primary care physician, or to carry a medication card).
- Medications are reconciled by the physician at admission and at discharge.

GOAL 6: REDUCE HARM ASSOCIATED WITH CLINICAL ALARM SYSTEMS

- Improve the safety of clinical alarm systems.
- Establish alarm safety as an organizational priority.
- Identify the most important alarms to manage based on each hospitals' own internal situations.
- When equipment includes alarms, do not disable or turn down the volume below an audible range.
- Know what the appropriate alarm parameters should be.
- Respond to alarms in a timely fashion.
- Establish policies and procedures for managing alarms.
- Educate staff and practitioners about the proper operation of alarm systems.

GOAL 7: REDUCE RISK OF HEALTH CARE ASSOCIATED INFECTIONS

- Wash hands with soap or antibacterial liquid with friction for 15 seconds OR apply antiseptic liquid (Purell) into the palm of the hands and rub on all surfaces until dry (up to 5 washings). Hand washing only for C-Diff.
- No artificial nail applications with direct patient contact.
- Report all identified cases of unanticipated death or major permanent loss of function related to healthcare infection.
- Evidence based practices to prevent healthcare associated infections are due to MDRO.
  - ✓ Hand hygiene campaign; Wash in. Wash out.
  - ✓ Monitoring isolation compliance with staff and patients and appropriate use of isolation carts.
  - ✓ Appropriate identification and signage for MDRO patients.
- Implement evidence based practices to prevent central line associated bloodstream infections including short and long term venous catheters and PICC lines.
  - ✓ Use packets that have masks, sterile gowns, drapes, and gloves for all central line insertions.
- Implement best practices for preventing surgical site infections.
  - ✓ Routine cleaning of OR rooms.
  - ✓ Good Hand Hygiene.
  - ✓ Clip, do not shave patient.
  - ✓ Keep patients warm.
  - ✓ Give prophylactic antibiotic within 60 minutes of initial incision.
  - ✓ Prep and scrub with CHG 4%.
- Use best practices to prevent indwelling catheter associated UTI (CAUTI)
  - ✓ Educate staff, practitioners, patients and families about CAUTI prevention.
  - ✓ Follow written guidelines based on EBP guidelines for inserting and maintaining an indwelling catheter.
  - ✓ Secure catheters for unobstructed urine flow and drainage.
  - ✓ Evaluate need for indwelling catheter daily.

GOAL 15: IDENTIFY SAFETY RISKS IN OUR PATIENT POPULATION

- Identify patients at risk for suicide through risk assessment and identification of signs and symptoms indicating risk for suicide.
- Address the patient's immediate safety needs.
  - ✓ Distribute prevention information such as the crisis hotline to individuals and their families.

For patients at risk, consider the immediate environment and eliminate access to potential hazards. Monitor for medical conditions that might increase impulsivity.

Universal Protocol

Prior to the start of any surgical or invasive procedure, a final verification process using active communication techniques will be used.

- Universal Protocol
  - ✓ A pre-procedure verification process is conducted.
  - ✓ Marking of the procedure site occurs.
  - ✓ A time out must be performed immediately prior to starting invasive procedures.
  - ✓ Follow the "Universal Protocol" policy and use the "UNIVERSAL PROTOCOL" form to document.
  - ✓ ALL members of the surgical/procedure team (staff, physicians and anesthesia) actively participate in the verification process.

EASTERN CONNECTICUT HEALTH NETWORK

FY2016 Patient Experience Plan

I. PURPOSE:

The purpose of the system-wide Patient Experience Plan at the Eastern Connecticut Health Network is to improve the patient's experience throughout our organization by using a proactive approach, resulting in recognition as an organization of excellence in patient experience with a culture committed to promoting an optimal patient experience as a daily priority.

II. OBJECTIVES:

A. To foster a culture of an exceptional patient experience through accountability, responsibility, and employee empowerment, excellence in communication and in providing the highest level of patient experience possible throughout our organization.

B. To strive for 5-STAR ratings related to Patient Experience through recognition, tracking of patient experience data, stories, and through the acknowledgement of need to put the patient's needs first.

C. To provide a standardized approach for meeting the needs of our patients related to the patient experience that focuses on processes and systems that allow for the maximum positive experience for all of our patients.

D. To initiate actions to reduce identified areas of patient dissatisfaction.

E. To improve the recognition and perception of patient experience within the organization and the communities we serve.

F. To establish a communication mechanism that provides for regular communication of our patient experience priority initiatives and outcomes both internally and externally.

G. To utilize a multidisciplinary forum to review and analyze events and data, disseminate information, and provide an avenue for individuals to bring concerns forward.

H. To disseminate the knowledge gained within the organization and in other health care organizations in order to promote changes in processes to improve patient experience.

I. To assure compliance with the patient needs outlined in HCAHPS questions and consider best practices, such as Press Ganey and Connecticut Hospital Association (CHA) Collaboratives that may address the patient experience.

J. To conduct annual proactive assessment related to patient experience and organizational goals.

K. To improve the patient experience by focusing on patient safety, quality, and satisfaction.

The Patient Experience Plan will provide a systematic, coordinated and continuous approach to the maintenance and improvement of the patient experience through the establishment of mechanisms that support effective responses to actual occurrences; ongoing proactive reduction in complaints and grievances; and integration of patient experience priorities into the new design and redesign of all relevant organization processes, functions, and services.

EASTERN CONNECTICUT HEALTH NETWORK

FY2016 Patient Experience Plan

As patient care, and therefore the maintenance and improvement of patient experience, is a coordinated and collaborative effort, the approach to optimal patient experience involves multiple departments and disciplines in establishing the plans, processes, and mechanisms that comprise the patient experience activities at Eastern Connecticut Health Network.

III. SCOPE/COMPONENTS OF ACTIVITIES:

To provide ongoing assessment, using internal and external knowledge and experience to identify and enhance patient experiences throughout the organization. Patient experience information will be reviewed by the Patient Experience Steering Committee to prioritize organizational efforts as to the redesign of processes based on identified positive and negative patient experiences, and current HCAHPS data.

A. Perform Broad Spectrum Data Monitoring and Analysis: The creation of excellence in patient experience relies on identifying, reporting, tracking, and sharing current and potential problems, as well as successes and aggregate data collected and analyzed through multiple sources of reporting, which may include:

1. Incident reporting system: Feedback Module.
2. Daily Safety Huddle for review of system and individual patient experience concerns.
3. Word of mouth reporting/huddles.
4. Root Cause Analysis.
5. Press Ganey Surveys.
6. STAR Ratings.

B. Provide the Codification of Patient Experience Principles: The creation and revision of supporting policies and processes, including the associated education that clearly delineates how the organization will react to patient experience needs and responses.

1. Embed Patient Experience Habits and Behaviors throughout the organization.
2. Promote a Just Culture using the accountability algorithm to include patient experience.
3. Perform leadership, manager, and staff rounding with patients.
4. Enhance teamwork behaviors.
5. Improve the knowledge of patient experience practices with structure and resources in place.
6. Enhance clear, structured communication, including Huddles, Briefings, Debriefings, and Handoffs/SBAR (Situation, Background, Assessment, and Recommendation).
7. Survey the patient utilizing both electronic and paper surveys to include HCAHPS questions. Monitor results through CMS STAR Rating, Value-Based Purchasing programs, and monthly results provided through Press Ganey.
8. Spread best-practice across the system.

C. Provide a Staff-Centered Patient Experience Infrastructure: Create an excellent patient experience practice environment through the promotion of multidisciplinary participation that values staff ownership and engagement.

1. Patient Experience Steering Committee.
2. Patient Experience Action Teams.
3. Patient Experience Coaches.

4. Leadership, manager, and staff rounding; allowing for direct communication of patient experience concerns.
5. Best-practice resources/education as it relates to any patient experience endeavor. For example, communication to enhance best patient experience, etc.
6. Organization-wide training on patient experience habits and behaviors.

D. Enhance patient Experience-Focused Decision Support: Adopt criteria-based protocols and technological innovations, such as checklists and standardization to reduce variation, such as standardized communication between all care providers and patient (AIDET® program), etc.

E. Perform Retrospective Internal Assessment: Perform ongoing evaluation and re-evaluation of program and process changes utilizing proven metrics and benchmark data to monitor improvement, and to confirm the efficacy of actions taken and/or acknowledge initiatives that fail to produce the intended results.

1. Data from our Incident Reporting Information Systems (IRIS) Feedback Module, monthly/quarterly/yearly.
2. HCAHPS data, monthly.
3. STAR Ratings, quarterly.
4. Value-Based Purchasing Data.
5. Internal Dashboards.
6. Results of Press Ganey Surveys.
7. Patient Comments.
8. Patient Complaints and Grievances.

IV. AUTHORITY AND ACCOUNTABILITY:

The Board of Trustees, via the Quality Improvement Council (QIC), delegates the responsibility, authority, and accountability for the coordination and oversight of the Patient Experience Program to the interdisciplinary patient Experience Steering Committee, which will be chaired by the Patient Experience Coordinator and/or Vice President of Quality and Safety. The Patient Experience Steering Committee is a subcommittee of the network's Quality Improvement Council. Patient Experience reports and meeting minutes will be submitted to the Quality Improvement Council. The Patient Experience Coordinator and/or the Vice President of Quality and Safety is responsible for the advancement of the ECHN Culture of Excellence in patient Experience through a strong clinical presence and administration of the Patient Experience Program on a day-to-day basis.

V. PROGRAM CONFIDENTIALITY:

When the Patient Experience Steering Committee engages in a quality review to gather and review information relating to the care and treatment of a patient for the purpose of evaluating and improving the experience of health care rendered, it is considered protected under Connecticut State Statute 19a-17b.

VI. COMMUNICATION PLAN:

Patient Experience relies on interactive and open communication through the exchange of ideas and information. Timely communication is expected between all committees and organizational groups responsible for patient experience; to include Safety, Quality, and Satisfaction. Patient Experience

Information will also be published regularly to provide communication of our patient experience priority initiatives and outcomes, both internally and externally.

VII. ANNUAL REAPPRAISAL:

The Chair, with input from the Patient Experience Steering Committee, wil conduct an annual review of the Patient Experience Plan for evaluation of the program's effectiveness and to establish priorities for the next year. Recommendations will be forwarded to the appropriate committees or departments throughout the organization. The Patient Experience Plan is approved by administration, the medical staff, and the governing board.

VIII. ATTACHMENT: Patient Experience Steering Committee Purpose, Objectives, and Composition.

Policy Drafted: 01/2016

Policy Approved by:

- Quality Improvement Council (Date)
- Medical Executive Committee (Date)
- Performance Assessment/Improvement Committee (Date)

EASTERN CONNECTICUT HEALTH NETWORK

FY2016 Patient Experience Plan

ADOPTION

This Patient Experience Plan has been reviewed and adopted by the Board of Trustees, the Medical Staff acting through its Executive Committee, and by the hospital's management, as attested by the signatures below:

Chairman, Board of Trustees	**Date**
President of the Medical Staff	**Date**
President/CEO	**Date**

QIC – Reviewed & Approved - 02/10/2016
MEC – Reviewed & Approved - 03/08/2016

ATTACHMENT to
Patient Experience Plan

EASTERN CONNECTICUT HEALTH NETWORK
Patient Experience Steering Committee

PURPOSE:

Under the direction of the Patient Experience Coordinator and/or Vice President of Quality and Safety, the Patient Experience Steering Committee is charged with overall assessment, development, initiative implementation and evaluation of the Patient Experience Program and resulting data. They will analyze and track Press Ganey and HCAHPS data, audit hospital procedures and initiatives to enhance the patient experience, as well as develop and sustain a culture of excellence in patient experience.

OBJECTIVES:

- Assess the patient experience culture and identify areas in need of change to improve that culture.
- Receive patient satisfaction data from Press Ganey, CMS and other agencies. Review and act on this data to identify trends and/or opportunities for improvement. Assign responsibility for improvement and set timelines for action.
- Receive and review complaint and grievance information from the Patient Experience Coordinator, Quality Managers, or other sources related to patient experience.
- Review Press Ganey's best practices for a superior patient experience and lead the organization in full program development. Assign responsibility for monitoring ECHN's compliance with these requirements. Charter teams to improve areas of identified deficiency in performance.
- Use published information about patient experience in other organizations and evidenced based practice related to patient experience improvement as opportunities to apply "lessons learned" to appropriate ECHN systems and processes.
- Assist in the review and action planning related to patient experience working under the Patient Experience Plan and monitor the completion of and compliance with suggested action plans.
- Review and discuss all Press Ganey and HCAHPS data quarterly at a minimum to evaluate progress and identify trends.
- Inform ECHN leadership and Medical Staff about changes in requirements that may impact patient experience procedures and practices, and assure compliance with those regulations.
- Provide yearly review and approval of ECHN's Patient Experience Plan.
- Receive and act on reports from the following committees or areas on a scheduled and ad hoc basis:
  - Grievance Committee
    - Patient Experience-related complaints
  - Claims Committee Data that may be related to the patient experience.
  - Incident Reporting: Information gathered through the Feedback System
  - Patient Experience Action Teams
  - Physician Practices
    - Physician Patient Experience Coaches
  - Staff Concerns
    - Staff Membership on committees
    - Patient Experience Coaches
    - SVP and VP Rounding for Outcomes
  - Patient Concerns:
    - Leadership Rounding with Patients

  - Woodlake at Tolland
  - VNHSC
- Address any issues identified through Root Cause Analysis or committee reports that will require data monitoring. Ongoing reporting will be followed by the Patient Experience Steering Committee.
- Develop and support a non-punitive approach in the management of patient complaints and grievances. Focus will be placed on remedial actions rather than punitive actions taken.
- Sustain behaviors of an Accountable/Just Culture and Culture of Excellence in Patient Experience

The Patient Experience Committee shall meet at least ten (10) times per calendar year, or more often as deemed necessary by the chair.

COMPOSITION:

The committee will be chaired by the Patient Experience Coordinator and/or Vice President of Quality and Safety. Membership will include representation from Environment of Care, Patient Care Services, Communication, Medical Staff Leadership and Hospitalists, Quality , Human Resources, Lab, and additional departments as needed on an ad hoc basis.,

Initiated: 01/22/16

ECHN RISK MANAGEMENT PROGRAM
FY2016

I. Purpose

The Risk Management Program seeks to promote the achievement of the goals of Eastern Connecticut Health Network through risk identification, evaluation and control; reducing the frequency and severity of adverse events thus minimizing loss and contributing to the delivery of quality healthcare within the organization. The Risk Management Plan is developed in conjunction with and is intended to compliment the Performance Improvement, Environmental and Patient Safety Plans, in accordance with the direction of the Board of Trustees.

II. Definitions

Risk management: the process of making and carrying out decisions that will minimize the adverse effects of accidental losses upon an organization in an environment that is non-punitive. These types of risks are considered systemic opportunities for improvement.

Enterprise Risk Management (ERM): provides a holistic structured framework that focuses on identifying, quantifying, prioritizing and eliminating the financial impact of a broad range of diverse risks in order to enhance organizational value. ERM is an enhancement to the risk management process.

III. Objectives

A. To reduce/minimize risks in patient care that in turn, directly or indirectly, improves the quality of care delivered to patients;
B. To help maintain the financial integrity and survival of Eastern Connecticut Health Network through the control and mitigation of losses;
C. To maintain efficiency for all hospital services through the protection of personnel and property assets;
D. To enhance public trust in the health care provided by the hospital through the continuous improvement of services and performances;
E. To provide ongoing assessment to identify, prevent and mitigate patient safety occurrences.

IV. Scope/Components of the ECHN Risk Management Program

A. Incident Reporting System
   1. All incident reports should be completed as close to the recognized event as possible and sent to Risk Management. The Director of Risk Management and/or designee will review the information contained in these reports and utilize this information for three purposes:
      a. Analyze the causes and recommend measures to prevent reoccurrence.
      b. Evaluation of the need to report the occurrence to the appropriate regulatory or accreditation agency.
      c. Review potential compensability.
   2. Trending of incident reports will be completed by Risk Management and will be reported to various committees and individual department directors.

B. Patient Complaint Program

1. Patient complaints are received by the Patient Relations Department from varying sources for investigation and resolution. When appropriate they are referred to ECHN Risk Management.
2. Patient complaints with risk or liability concerns are referred to ECHN Risk Management by Patient Relations for review for potential compensability and/or safety concerns.
3. Risk Management meets regularly with the Patient Representatives to review and track all relevant complaints/grievances, adhering to CMS guidelines.

C. Environment of Care Plan (EOC)

1. The Director of Risk Management and/or designee shall work collaboratively with the chair of the EOC Committee and others to ensure that there is open communication related to inspections of hospital departments deficiencies being reported, improvement plans are initiated and corrective actions are taken.
2. Inspections are conducted through varying sources including outside consultants per EOC plan.

D. Claims Management

1. Professional and general liability claims filed against ECHN are the responsibility of the Director of Risk Management and the Third Party Administrator (TPA). Trending and tracking of these claims are also the responsibility of the Director of Risk Management and are reported to the Claims Committee.
2. Claims filed by or against Eastern Connecticut Health Network are managed by Director of Risk Management and the Risk Management staff: (e.g. professional liability, general liability, workers' compensation, property and automobile) along with TPA.
3. Settlement Authority is made in conjunction with the Sr. Vice President of Finance and Sr. Vice President of Patient Care Services, with input from Claims Committee members and outside legal recommendations.

E. Risk Financing

The Director of Risk Management will provide input and feedback to the Senior VP of Patient Care Services & Chief Nursing Officer and Sr. VP Finance of ECHN when determining the most appropriate retention/deductible levels and types and limits of insurance based on loss history and cash flow considerations.

F. Contract Review

Appropriate Staff works in conjunction with legal counsel to review and/or provide for outside review of contracts to determine:

1. If all appropriate action has been taken to provide adequate protection from claims arising out of the actions/liability of others.
2. That parties contracting with the hospital have and provide proof of adequate liability insurance coverage.
3. That the hospital is adequately covered for activities in which it is involved.

4. Whenever possible, the hospital shall seek to transfer liability contractually and/or be held harmless in contractual arrangements.

G. Education and Training

The Director of Risk Management will collaborate with the Administrative Team and Managers/Directors to identify and coordinate training and continuing education needs of hospital staff. Programs and materials will be provided through both internal and external sources. Departmental requests for specific programs can be submitted directly to the Risk Management Department.

H. Interaction with Medical Staff

1. The Director of Risk Management collaborates with the Medical Staff to actively participate in the ECHN Risk Management Program by helping to identify high-risk areas of operation and the development of high-risk indicators to be used in Medical Staff and departmental monitoring and evaluation activities
2. The Director of Risk Management will facilitate the participation of the Medical Staff in the correction of identified problems concerning clinical patient care and safety, including designing programs to reduce risk in the clinical aspects of patient care and safety.
3. The Director of Risk Management works with the members of the Medical Staff to educate about the importance of reporting any adverse clinical outcomes to ECHN Risk Management upon their occurrence. This allows for immediate investigation and evaluation of the outcome as to the potential compensability and/or investigation and evaluation. Any clinical outcome determined to require continuing quality improvement follow-up would be referred to the Vice President of Quality and Safety for review and referral, and as appropriate, to the Department Chair and Senior Vice President of Medical Affairs.

I. Integration with Quality and Patient Safety

1. ECHN Risk Management will work with Quality and Patient Safety Staff to coordinate the following activities:
   - Information sharing for opportunities for improvement;
   - Problem intervention to reduce or eliminate reoccurrences;
   - Continuous monitoring and tracking systems;
   - Data analysis and partnership efforts between ECHN Risk Management, Patient Safety and Performance Improvement on quality opportunities;
   - Staff education.
2. Participates in patient safety activities/initiatives to strive for zero defects (occurrences) of patient safety risks, and to provide a standardized approach that focuses on process and systems in minimizing risk to the institution.
3. A cross referral process is present for the reporting of quality issues from the Quality Department to Risk Management. Any activities which are considered Sentinel Events and are reported following the Sentinel Event Policy and require a root cause analysis process to be implemented with the active participation of Patient Safety, Risk and Performance Improvement and all others deemed appropriate for the most effective resolution of the event.

4. The Risk Management Department will have representation on the Quality Improvement Council, Patient Safety Committee, and other committess that are deemed necessary for the improvement of patient care. A member of Quality Department will have representation on the Claims Committee.
5. Risk management related data will be reported to the Patient Safety Committee and the Claims Committee. Data can also be provided to other commitees upon request.
6. Risk Management will cooperate with the Quality Department in exchanging information in order to improve patient care and safety.
7. Events must be reported to Risk Management immediately upon awareness, according to the Risk Management Occurrence Reporting System CAP #330 and Medical Device Occurrence Resulting in Injury, Illness or Death CAP #331. ECHN Risk Management will participate as appropriate with the Quality Department in Root Cause Analysis for all events determined to meet the requirements of the Sentinel Event Policy CAP # 300.01 & 300.02.
8. Risk Management is involved in quality improvement activities that are deemed necessary for the improvement of patient care. Risk Management will collaborate with the Quality Department and Administrative Director of Environment of Care on issues that should be communicated to the QI Council and the Board of Trustees.

J. External Reporting
1. The Director of Risk Management will collaborate with members of the Quality and Safety Department, as necessary, regarding adverse event reporting. The Vice President of Quality and Safety is responsible for reporting events to the State of Connecticut Department of Public Health.
2. The Director of Risk Management will collaborate with members of the Quality and Safety Department, as necessary, regarding the Sentinel Event Policy and considering reports to the Joint Commission.

V. Authority and Accountability

A. The Director of Risk Management is accountable for professional and general liability claims and lawsuits filed against the hospital. Claims management activities are outlined in the Claims Handling Standards and Guidelines. They include, but are not limited to, these general steps:
1. Investigation and reporting to TPA,
2. Coordination with insurers and defense counsel to assist with claims management and pretrial processes, and
3. Development of defense strategies, as well as participation in settlement decisions.

B. In all instances, ECHN Risk Management uses the following decision making processes:
1. Risk Identification
2. Risk Analysis
3. Risk Treatment – including risk control and risk financing
4. Evaluation of risk treatment strategies.

FY2015 Performance Improvement Accomplishments and FY2016 Performance Improvement Goals

Objective	FY2015 Goal	Accomplishments Goals
A. In order to increase the probability of desired patient outcomes by assessing and improving those governance, managerial, clinical and support processes that most affect such outcomes, and by providing an ongoing process to improve care, identify and resolve issues.	1. Develop a standardized plan of care for surgical patients. Focus on the prevention of pneumonia/respiratory failure, DVT, SSI, and pain control. Add total hip and knee repair to readmission report.	1. Standardized plan for surgical patients – Have created a standardized post op order set that is in final review. Lit search being done before finalization. Recommended guidelines for care includes preop, intra op and post op. Plan includes prevention of pneumonia/respiratory failure, DVT, SSI (standardized anti biotics), and pain control. Document available. 2. SSI – Committee formed to address SSI. Many initiatives implemented. Document available. 3. Total hip and knee repair was added to the readmission report and are being followed. **2016 Goal**: Focus on decreasing Colon SSIs – will work with CHA to develop and implement a statewide plan. ECHN SSI group will meet regularly to analyze all SSIs and develop and initiate plan to decrease SSIs. Initial analysis available. Goal: Decrease SSI Rate overall by >10% in 2016 Work on decreasing C-Diff rates. Will work with CHA to develop and implement a state wide plan. C-Diff workgroup formed. Has already begun initiatives. Document available. Goal: Decrease SSI rate by >10% in 2016.
B. Ensure a proactive integrated patient safety program throughout the hospital with a non-punitive approach to identifying risks to patient safety and reducing factors that contribute to unanticipated adverse events and outcomes.	1. Work to ensure sustainability of HRO efforts. Continue to build 'rounding to influence' process with leaders. Involve medical staff Safety Coaches/support. Continue to train all new employees and medical staff via orientation class for HRO.	Classes are offered monthly to all new hires and quarterly to all Active Medical staff and Allied Health Professionals. We have added education in the "Safety Absolute: 2 Patient Identifiers" for all newly-hired staff, as well as all Active Medical Staff and Allied Health Professionals. Completion rates are ongoing as new staff is continuously added. End of year 2015 completion rates for HRO training are: Total Medical Staff = 95.2%, Overall Compliance including All ECHN entities = 95.5%. These numbers include new employees who may not have yet gone through training. Training is continuous for all staff and physicians. Leaders are on the unit rounding weekly in all clinical areas to ensure patient satisfaction as well as safety behavior compliance. **2016 Goal**: Continuous training of all newly-hired staff and physicians in HRO – "Patient Safety Starts with Me" Program. Continuous training also in the Safety Absolute: 2 patient Identifiers. Maintain continuous compliance rate of 95% or higher. Continuation of Daily Safety Huddle, Safety Coach

Objective	FY2015 Goal	Accomplishments/Goals
		committee and Patient Safety Committee through 2016. Addition of Rounding for Outcomes Daily by SVP and VPs which focuses on Safety, Quality and Satisfaction. Creation of Safety, Quality and Satisfaction Boards on inpatient units and ancillary areas to promote and improve the patient experience. HCAHPS scores in identified target areas of Communication with Nurses and Communication with Physicians will reach and maintain target goal of 30% of PG Data base. Begin Safety Coach for Physician Program with CMO.
C. Establish priorities for performance improvement activities using information related to unanticipated adverse events, focusing on activities with the greatest potential impact on patient outcomes.	Focus on reducing hospital acquired infections. Use team approach to evaluate catheter associated urinary tract infections and central line infections.	Four groups formed – CLABSI, CAUTI, SSI and C-Diff. Teams met Goals developed along with action planning items. Action items implemented with results of significant decrease in CLABSI and CAUTI rates. ICU CAUTI rates for 2015 decreased by 100% at RGH and by 80% at MMH. CLABSI rate at RGH ICU remains at zero since CY2013 – Qtr. 1 through Dec 31, 2015. MMH CLABSI rate decreased by 50% in 2015. Hospital acquired pressure ulcers (Stage 3, 4, and unstageable) were down significantly at both facilities. MMH saw a 75% decrease and RGH saw a 100% decrease. **2016 Goal**: Maintain and continue work on keeping CLABSI and CAUTI rates down. Goal is Zero for ICU and Med Surg areas. Standardize ordering process for Central Line Placement. Vascular Access Team will meet quarterly to maintain gains in decreasing CLABSI rates. Educate all staff regarding standardize process for catheter insertion will go to all units in 2016. Continue to watch data to ensure maintenance of low or no CAUTI incidences. Goal is Zero CAUTIS in ICU and med surg. SSI group will continue to meet; will redouble efforts and will join CHA initiative for colorectal SSI. Goal is to decrease SSIs overall by >10% in 2016. C-Diff Team continues to meet and will join CHA initiative to decrease C-Diff Rates in 2016. Goal is to Decrease C-Diff Rates by >10% in 2016. Continue to decrease stage 3, 4, and unstageable hospital acquired pressure ulcers.
D. Carry out and communicate improvement activities	Communicate Agency for Healthcare Research & Quality (AHRQ) data to key	Results of the AHRQ Patient Safety Culture Survey were communicated to the Board, Systems Team, Presidents Staff, Patient Safety Committee,

Objective	FY2015 Goal	Accomplishments/Goals
through established channels to appropriate leaders and members of the hospital.	audiences. Continue to share SSER.	Clinical Council, Clinical Executive Committee. Various leaders were shown how to obtain their unit's results for distribution to their individual units. SVPs and VPs worked with leaders to ensure they reviewed and addressed their results. Reporting results occurred over several months in 2015. Results of the AHRQ study were excellent, with improvements noted in almost every category and percentile in both hospitals. SSER shared in many venues through 2015. SSER decreased by 69.3% at MMH and 75.7% at RGH from peak rate by November 30, 2015. **2016 Goal**: Effective Communication and rollout of Targeted and Comprehensive Patient Experience Program and activities and HCAHPS data to all venues throughout ECHN. Continue to follow SSER Rate monthly, maintain low rate with overall goal is always aim for zero. Continue to share SSER in various meetings and venues monthly.
E. We ensure that new or modified processes are designed well.	Ensure Meaningful Use process for Quality indicators accurately reflects care provided to patients. Ensure patient Portal runs well and patients begin to access it post discharge.	IT and Quality have worked on E-CQM to ensure electronic data is an accurate reflection of actual patient care. This process has improved and is more accurate because of changes placed in the documentation process. Has improved the accuracy of abstracted data vs electronic reporting of data. Patient Portal is running well and being utilized at a good rate by patients. Usage is up to 6% and patients are responding well to using the patient portal. This year CMS changes to only one access needed monthly however provisioning continues with percent provisioned before they leave hospital continuing to be followed. **2016 Goal:** Quality will continue to work with IT to ensure electronic data reporting matches abstracted data as closely as possible. Provisioning of patients for Portal will continue to achieve required percentage of 50% of all discharged patients. New process for standard process for Central Line Insertion will be in place and communicated to all providers. Policy and Guidelines will be developed and communicated to ensure a standard process.
F. Ensure staff competency. This includes performance-based evaluations, ongoing	Continue PSSWM education to all uncompleted groups and to all new employees. ECHN training will include	PSSWM education is given to all new employees and statistics are watched monthly to ensure that there is complete compliance. Compliance rates are: Total Medical Staff = 95.2%, Overall Compliance including all ECHN

Objective	FY2015 Goal	Accomplishments/Goals
education and training to maintain and improve competency.	WAT staff and VNHSC staff. Follow CHA directives when establishing Safety Absolutes (red rules).	entities = 95.5%. Safety Absolute went live hospital wide and is continuous to all new employees. Completion percentages for end of year 2015 are: Staff: 98.32%, Leadership: 100.00% **2016 Goal**: Education on fall prevention via Health Stream will be part of competencies this year – expect 100% compliance and resulting decrease in fall rates especially falls with serious injury – Goal: Zero falls with serious injury. Education to all clinical areas related to standardized process for catheter insertion to prevent CAUTI – Goal is zero CAUTI'S or lowest rate possible. Education to all providers related to standard method for Central Line ordering and insertion to decrease CLABSI rates – Goal is zero or lowest rate possible. Education to organization to target needed areas related to the patient experience. Target HCAHPS are Nurse Communication and Physician Communication. Goal is to be at 30% of database.
G. Ensure Medical Staff credentialing activities comply with Federal, State, and TJC regulations, as well as the Medical Staff Bylaws.	Continue to ensure Medical Staff credentialing activities are in compliance with Federal, State, and TJC regulation. Will complete Active Medical Staff HRO training by end of year.	Medical Staff Credentialing activities are in compliance as evidenced by successful surveys by TJC and DPH in 2015. All Active Medical Staff and Allied Health Professionals were trained in HRO in 2015 with medical staff holding the line and insisting on 100% compliance. **2016 Goal**: Continue to work with Medical Staff Credentialing to ensure complete compliance with regulations. Continue to hold classes and educate all new practitioners who come in to ECHN on HRO Training as well as the Safety Absolute and safety expectations.
H. We ensure that processes measured on a continuing basis include those that affect a large percentage of patients, those that place patients at serious risk if not performed well, or those that are performed when not	Create graphic display of Hospital Acquired Infection data to prepare for changes in CMS Value-Based Purchasing.	Graphic displays of HAI data were created and displayed in many venues along with explanations as well as action items for improvement. **2016 Goal:** Continue to improve on displays of infection control data graphs. Check for accuracy each quarter with CMS reports. Bring HAI data to all venues with explanations. Work on separating out numbers for Colo, hyst, total knees and total hip data for improved accuracy of data collection and reporting.

FY2015 Performance Improvement Accomplishments and FY2016 Performance Improvement Goals

Objective	FY2015 Goal	Accomplishments Goals
indicated, not performed when indicated, or are likely to be problem prone.		
I. Ensure data is collected & analyzed related to patient needs and expectations. Include family & staff opinions of risk and when applicable the effectiveness of pain management.	Aggregate results of AHRQ Patient Safety Survey. Share with staff and Leaders. Use results to further improve.	Results of AHRQ survey was aggregated and reported throughout the organization. All data was shared and plans created for further improvement **2016 Goal:** Data Collection through HCAHPS is widely publicized to all groups for transparency as well as to evaluate improvement related to initiatives in place or being put into place. Patient Experience Boards on all units will have individual data related to patient experience to help staff and management stay current on data and initiatives and drive toward improvement.
J. Ensure the appropriate use and effectiveness of services for the provision of patient care and treatment obtained through contract relationships.	Review contracts to ensure quality of contracted service has been evaluated by user. Review significant equipment contracts for quality	All contracts reviewed by quality manager with changes and improvements made especially to quality metrics needed for each contract. As every contract comes due, they are being reviewed for their quality metrics to ensure the proper quality metric is incorporated into policy. Examples: Wound Care - Healogics, Lithotripsy, etc. **2016 Goal:** Quality will continue to review each patient care contract as it comes up for renewal to ensure correct and accurate quality metrics are included in the contract and are being followed with appropriate data submitted. Quality is working with Legal to ensure this process occurs consistently and is followed.

Olejarz, Barbara

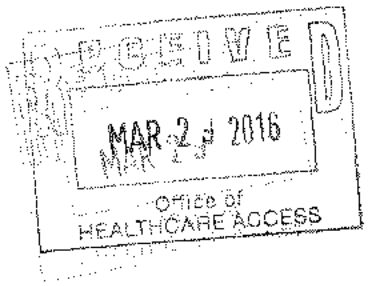
From: Lazarus, Steven
Sent: Tuesday, March 29, 2016 12:23 PM
To: Greer, Leslie; Olejarz, Barbara
Cc: Martone, Kim; Hansted, Kevin; Riggott, Kaila; Cotto, Carmen
Subject: Fw: UPDATED - ECHN Monthly Financial Statistics Reports
Attachments: CON - Financial Stats July August September FY 15 and FY 14.pdf; CON - Financial Stats Oct Nov Dec FY 16 and FY 15.pdf; CON Financial Stats Jan FY 16 and FY 15.pdf

Leslie/Barbara,

Please add to the original file.

Steve

ps. we can update the TOR at tomorrow's hearing.



From: Basile, Mary C <mbasile@echn.org>
Sent: Tuesday, March 29, 2016 12:13 PM
To: Lazarus, Steven
Cc: Mcconville, Dennis P
Subject: UPDATED - ECHN Monthly Financial Statistics Reports

Hi Steven,

Attached are the monthly financial statistics reports for the months of July, August and September FY 15 and FY14 and October, November, December and January FY16 and FY15 for Manchester Memorial Hospital, Rockville General Hospital and the Eastern Connecticut Health Network.

A formula error was found in Section B. Liquidity and the attached reports reflect the correction.

These reports were requested in the Eastern Connecticut Health Network, Inc. – Proposed Asset Purchase by Prospect Medical Holdings, Inc. – OHCA Docket No. 15-31216-486 and Attorney General Docket No. 15-486-01.
The reports respond to Item #50 (Page 10 of the request for information in the application for approval on August 6, 2015).

I apologize for the late notice but please place these reports in the docket if possible.

Thank you,

Mary

Mary Basile, MBA
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mbasile@echn.org www.echn.org

From: Lazarus, Steven [mailto:Steven.Lazarus@ct.gov]
Sent: Monday, March 21, 2016 1:21 PM
To: Basile, Mary C
Subject: RE: ECHN Monthly Financial Statistics Reports

Thank you Mary, I'll have them placed in the docket.

Steve

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053



From: Basile, Mary C [mailto:mbasile@echn.org]
Sent: Monday, March 21, 2016 12:51 PM
To: Lazarus, Steven
Subject: ECHN Monthly Financial Statistics Reports

Hi Steven,

Attached are the monthly financial statistics reports for the months of July, August and September FY 15 and FY14 and October, November, December and January FY16 and FY15 for Manchester Memorial Hospital, Rockville General Hospital and the Eastern Connecticut Health Network.

These reports were requested in the Eastern Connecticut Health Network, Inc. – Proposed Asset Purchase by Prospect Medical Holdings, Inc. – OHCA Docket No. 15-31216-486 and Attorney General Docket No. 15-486-01.
The reports respond to Item #50 (Page 10 of the request for information in the application for approval on August 6, 2015).

Please let me know if you have any questions or need additional information.

Thank you!

Mary

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OHCA Financial Statistics Report (July FY 2015 and July FY 2014)

	Manchester Memorial Hospital				Rockville General Hospital				Eastern CT Health Network			
	MTD		YTD		MTD		YTD		MTD		YTD	
	July FY 2015	July FY 2014	July FY 2015	July FY 2014	July FY 2015	July FY 2014	July FY 2015	July FY 2014	July FY 2015	July FY 2014	July FY 2015	July FY 2014
A. Operating Performance												
Operating Margin	4.12%	3.32%	2.51%	3.23%	-3.13%	0.81%	-2.72%	1.05%	3.71%	0.89%	-0.98%	0.34%
Non-Operating Margin	-1.21%	-1.76%	-0.89%	-0.88%	-1.20%	-1.71%	-0.69%	-0.45%	-0.92%	-1.36%	-0.67%	-0.59%
Total Margin	2.91%	1.56%	1.62%	2.35%	-4.32%	-0.90%	-3.41%	0.60%	2.80%	-0.47%	-1.65%	-0.25%
Bad Debt as % of Gross Revenue	0.58%	0.38%	0.61%	0.66%	0.99%	0.35%	0.72%	0.63%	-0.76%	0.48%	0.65%	0.75%
B. Liquidity												
Current Ratio	1.16	1.31	1.16	1.31	1.54	1.50	1.54	1.50	1.38	1.40	1.38	1.40
Days Cash on Hand	20	29	19	29	68	63	64	64	65	70	65	70
Days in Net Accounts Receivable	55	61	54	61	64	57	60	59	54	57	55	57
Average Payment Period	64	56	61	56	49	48	46	49	64	70	64	70
C. Leverage and Capital Structure												
Long-term Debt to Equity	2.07	1.64	2.07	1.64	0.91	0.74	0.91	0.74	1.11	0.93	1.11	0.93
Long-term Debt to Capitalization	67	62	67	62	48	42	48	42	67	59	67	59
Unrestricted Cash to Debt	1.30	0.90	10.83	12.60	0.08	0.43	2.49	9.86	1.37	0.49	4.36	7.21
Times Interest Earned Ratio	6.75	5.72	5.82	6.03	2.44	4.94	2.99	6.96	7.70	4.40	3.49	4.46
Debt Service Coverage Ratio	N/A	N/A	1.42	1.83	N/A	N/A	0.92	2.66	N/A	N/A	1.40	1.16
Equity Financing Ratio	16.17	21.64	16.17	21.64	35.23	41.31	35.23	41.31	28.11	32.92	28.11	32.92
D. Additional Statistics												
Income from Operations	$633,053	$520,994	$3,919,130	$5,079,849	($166,895)	$49,602	($1,534,668)	$637,755	$1,033,957	$251,617	($2,648,012)	$961,199
Revenue Over/(Under) Expense	$446,906	$244,365	$2,524,988	$3,695,991	($230,700)	($55,083)	($1,924,686)	$362,997	$778,733	($133,319)	($4,472,987)	($691,635)
EBITDA	$1,413,261	$1,163,486	$11,890,204	$13,184,731	$149,301	$305,483	$1,744,517	$4,002,648	$2,291,661	$1,335,849	$10,337,145	$14,344,707
Cash from Operations	$14,290,215	$15,719,667	$213,233,190	$146,614,120	$5,527,405	$5,527,405	$57,671,830	$57,671,830	$21,353,643	$5,298,402	$298,155,253	$35,598,094
Cash and Cash Equivalents	$9,163,954	$13,849,738	$9,163,954	$13,849,738	$11,726,452	$12,105,457	$11,726,452	$12,105,457	$46,307,239	$51,231,181	$46,307,239	$51,231,181
Net Working Capital	$4,709,127	$8,495,203	$4,709,127	$8,495,203	$4,519,871	$4,689,471	$4,519,871	$4,689,471	$18,060,122	$20,490,665	$18,060,122	$20,490,665
Unrestricted Assets	$10,376,011	$19,815,466	$10,376,011	$19,815,466	$20,665,705	$26,324,679	$20,665,705	$26,324,679	$54,034,965	$71,217,658	$54,034,965	$71,217,658
Credit Ratings (S&P, FITCH, and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

OHCA Financial Statistics Report (August FY 2015 and August FY 2014)

	Manchester Memorial Hospital				Rockville General Hospital				Eastern CT Health Network			
	MTD		YTD		MTD		YTD		MTD		YTD	
	August FY 2015	August FY 2014	August FY 2015	August FY 2014	August FY 2015	August FY 2014	August FY 2015	August FY 2014	August FY 2015	August FY 2014	August FY 2015	August FY 2014
A. Operating Performance												
Operating Margin	4.05%	-3.59%	2.65%	2.64%	-2.38%	-0.70%	-2.69%	0.90%	-0.94%	-4.14%	-0.97%	-0.05%
Non-Operating Margin	-1.66%	-0.44%	-0.96%	-0.84%	-1.58%	-0.17%	-0.76%	-0.43%	-1.29%	-0.29%	-0.73%	-0.56%
Total Margin	2.39%	-4.03%	1.69%	1.80%	-3.96%	-0.87%	-3.46%	0.47%	-2.23%	-4.43%	-1.70%	-0.61%
Bad Debt as % of Gross Revenue	-1.22%	0.66%	0.44%	0.66%	-1.21%	0.84%	0.55%	0.65%	-0.96%	0.79%	0.51%	0.75%
B. Liquidity												
Current Ratio	1.19	1.19	1.19	1.19	1.48	1.69	1.48	1.69	1.36	1.39	1.36	1.39
Days Cash on Hand	23	27	21	27	72	62	64	59	66	67	66	67
Days in Net Accounts Receivable	56	64	54	60	64	63	57	60	57	60	54	57
Average Payment Period	67	61	61	60	52	44	47	42	65	67	65	67
C. Leverage and Capital Structure												
Long-term Debt to Equity	2.14	1.74	2.14	1.74	0.92	0.77	0.92	0.77	1.14	0.97	1.14	0.97
Long-term Debt to Capitalization	68	64	68	64	48	44	48	44	67	61	67	61
Unrestricted Cash to Debt	1.20	0.06	11.86	12.11	0.06	0.77	2.55	10.84	0.30	(0.08)	4.60	7.04
Times Interest Earned Ratio	6.91	1.53	6.41	5.64	2.68	5.33	2.96	6.81	3.45	0.91	3.49	4.16
Debt Service Coverage Ratio	N/A	N/A	1.50	1.68	N/A	N/A	0.91	2.72	N/A	N/A	1.41	1.06
Equity Financing Ratio	15.99	20.58	15.99	20.58	34.93	41.46	34.93	41.46	27.76	32.38	27.76	32.38
D. Additional Statistics												
Income from Operations	$597,835	($531,932)	$4,516,964	$4,547,917	($119,527)	($40,468)	($1,654,194)	$597,288	($240,325)	($1,110,535)	($2,888,337)	($149,336)
Revenue Over/(Under) Expense	$353,116	($597,128)	$2,878,103	$3,098,864	($198,666)	($50,522)	($2,123,350)	$312,476	($570,339)	($1,188,772)	($5,043,326)	($1,880,407)
EBITDA	$1,400,713	$316,488	$13,088,122	$13,501,219	$156,631	$207,715	$1,901,150	$4,310,364	$1,003,678	$275,706	$11,340,823	$14,620,413
Cash from Operations	$13,850,283	$14,385,361	$227,083,573	$160,999,481	$5,606,279	$5,606,279	$63,278,109	$63,278,109	$20,910,096	$4,746,587	$319,065,348	$40,344,681
Cash and Cash Equivalents	$10,094,581	$12,933,064	$10,094,581	$12,933,064	$11,578,760	$11,103,202	$11,578,760	$11,103,202	$47,023,731	$49,069,770	$47,023,731	$49,069,770
Net Working Capital	$5,603,489	$5,450,496	$5,603,489	$5,450,496	$4,023,147	$5,397,747	$4,023,147	$5,397,747	$17,639,012	$19,611,711	$17,639,012	$19,611,711
Unrestricted Assets	$10,308,640	$18,971,156	$10,308,640	$18,971,156	$20,279,098	$26,051,748	$20,279,098	$26,051,748	$53,344,364	$70,108,676	$53,344,364	$70,108,676
Credit Ratings (S&P, FITCH, and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

OHCA Financial Statistics Report (September FY 2015 and September FY 2014)

	Manchester Memorial Hospital				Rockville General Hospital				Eastern CT Health Network			
	MTD		YTD		MTD		YTD		MTD		YTD	
	September FY 2015	September FY 2014	September FY 2015	September FY 2014	September FY 2015	September FY 2014	September FY 2015	September FY 2014	September FY 2015	September FY 2014	September FY 2015	September FY 2014
A. Operating Performance												
Operating Margin	27.16%	-1.98%	4.79%	2.26%	-61.17%	26.83%	-5.63%	3.70%	2.93%	2.28%	-0.65%	0.15%
Non-Operating Margin	0.00%	-1.87%	-0.88%	-0.93%	-2.39%	-1.16%	-0.85%	-0.51%	-0.30%	-1.37%	-0.69%	-0.63%
Total Margin	27.16%	-3.85%	3.91%	1.33%	-63.56%	25.67%	-6.47%	3.20%	2.63%	0.91%	-1.34%	-0.48%
Bad Debt as % of Gross Revenue	8.22%	4.49%	1.14%	0.97%	13.33%	7.75%	1.59%	1.23%	-0.85%	-0.66%	0.39%	0.64%
B. Liquidity												
Current Ratio	1.19	1.17	1.19	1.17	1.72	1.59	1.72	1.59	1.43	1.37	1.43	1.37
Days Cash on Hand	35	36	28	39	77	66	73	67	74	78	74	78
Days in Net Accounts Receivable	55	64	55	53	77	73	46	63	57	64	57	52
Average Payment Period	82	67	65	72	42	47	39	48	68	71	68	71
					0							
C. Leverage and Capital Structure												
Long-term Debt to Equity	3.30	2.03	3.30	2.03	1.19	0.83	1.19	0.83	1.36	1.06	1.36	1.06
Long-term Debt to Capitalization	77	67	77	67	54	45	54	45	75	65	75	65
Unrestricted Cash to Debt	6.25	(0.06)	17.94	11.20	(6.22)	6.98	(3.54)	17.41	1.23	0.88	5.67	7.68
Times Interest Earned Ratio	45.65	2.24	7.82	5.38	(30.75)	42.56	0.28	9.24	7.62	7.45	3.79	4.38
Debt Service Coverage Ratio	N/A	N/A	1.95	1.60	N/A	N/A	(0.21)	3.99	N/A	N/A	1.27	1.36
Equity Financing Ratio	9.99	16.28	9.99	16.28	29.28	37.96	29.28	37.96	22.46	28.81	22.46	28.81
D. Additional Statistics												
Income from Operations	$4,438,312	($312,411)	$8,955,277	$4,235,507	($1,985,465)	$2,163,409	($3,639,658)	$2,760,694	$784,320	$658,388	($2,104,017)	$509,052
Revenue Over/(Under) Expense	$4,438,503	($606,680)	$7,316,607	$2,492,184	($2,063,001)	$2,069,656	($4,186,350)	$2,382,130	$703,899	$263,708	($4,339,427)	($1,616,699)
EBITDA	$5,138,862	$440,393	$18,429,779	$13,941,613	($1,704,420)	$2,421,228	$196,731	$6,774,667	$1,989,451	$1,850,004	$13,330,274	$16,470,417
Cash from Operations	$14,563,917	$14,901,325	$241,647,490	$175,900,806	$5,514,418	$5,514,418	$68,792,527	$68,792,527	$21,551,495	$4,650,079	$340,616,844	$44,994,760
Cash and Cash Equivalents	$13,188,728	$18,856,818	$13,188,728	$18,856,818	$13,081,652	$12,735,604	$13,081,652	$12,735,604	$53,111,506	$58,713,876	$53,111,506	$58,713,876
Net Working Capital	$5,871,026	$5,986,254	$5,871,026	$5,986,254	$5,073,415	$5,392,746	$5,073,415	$5,392,746	$23,073,998	$20,280,901	$23,073,998	$20,280,901
Unrestricted Assets	$2,829,380	$11,344,473	$2,829,380	$11,344,473	$14,969,088	$24,211,838	$14,969,088	$24,211,838	$42,167,569	$59,544,869	$42,167,569	$59,544,869
Credit Ratings (S&P, FITCH, and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

OHCA Financial Statistics Report (January FY 2016 and January FY 2015)

	Manchester Memorial Hospital				Rockville General Hospital				Eastern CT Health Network			
	MTD		YTD		MTD		YTD		MTD		YTD	
	January FY 2016	January FY 2015	January FY 2016	January FY 2015	January FY 2016	January FY 2015	January FY 2016	January FY 2015	January FY 2016	January FY 2015	January FY 2016	January FY 2015
A. Operating Performance												
Operating Margin	-4.59%	3.59%	1.40%	2.62%	0.81%	4.56%	-3.51%	1.49%	-4.33%	0.55%	-1.55%	0.18%
Non-Operating Margin	-0.45%	-0.41%	-0.56%	-0.57%	-0.45%	-0.11%	-0.59%	-0.29%	-0.36%	-0.27%	-0.46%	-0.40%
Total Margin	-5.04%	3.18%	0.84%	2.05%	0.36%	4.45%	-4.09%	1.19%	-4.70%	0.28%	-2.01%	-0.22%
Bad Debt as % of Gross Revenue	2.71%	1.04%	1.54%	0.83%	-0.08%	1.32%	0.74%	0.90%	1.90%	1.17%	1.29%	0.92%
B. Liquidity												
Current Ratio	1.30	1.13	1.30	1.13	1.79	1.83	1.79	1.83	1.60	1.47	1.60	1.47
Days Cash on Hand	17	19	17	18	65	63	65	62	62	64	62	64
Days in Net Accounts Receivable	68	54	65	54	57	57	60	60	62	52	60	54
Average Payment Period	56	62	57	61	39	43	39	42	64	63	64	63
C. Leverage and Capital Structure												
Long-term Debt to Equity	3.52	2.07	3.52	2.07	1.29	0.83	1.29	0.83	1.41	1.08	1.41	1.08
Long-term Debt to Capitalization	78	67	78	67	56	45	56	45	76	65	76	65
Unrestricted Cash to Debt	(0.23)	1.37	3.67	4.73	0.94	1.77	0.47	4.50	(0.22)	0.83	1.35	3.00
Times Interest Earned Ratio	0.44	6.89	4.79	6.19	6.18	10.84	2.14	6.97	0.37	4.98	2.84	4.64
Debt Service Coverage Ratio	N/A	N/A	1.33	1.85	N/A	N/A	1.00	4.92	N/A	N/A	1.03	1.60
Equity Financing Ratio	9.59	16.58	9.59	16.58	27.72	38.33	27.72	38.33	22.42	29.08	22.42	29.08
D. Additional Statistics												
Income from Operations	($680,072)	$574,121	$864,479	$1,669,209	$46,191	$277,536	($756,822)	$354,387	($1,130,134)	$155,525	($1,650,097)	$204,864
Revenue Over/(Under) Expense	($746,095)	$508,138	$517,032	$1,304,511	$20,484	$270,781	($883,647)	$284,914	($1,225,108)	$79,732	($2,138,708)	($241,790)
EBITDA	$84,071	$1,361,055	$3,981,552	$4,966,613	$359,645	$609,467	$494,318	$1,705,321	$103,004	$1,453,322	$3,375,431	$5,587,674
Cash from Operations	$13,797,665	$13,797,665	$58,532,206	$58,532,206	$5,023,259	$5,182,780	$20,929,423	$23,781,040	$21,916,976	$23,030,954	$95,829,287	$99,955,239
Cash and Cash Equivalents	$8,140,683	$8,909,450	$8,140,683	$8,909,450	$11,304,738	$11,312,548	$11,304,738	$11,312,548	$46,078,557	$48,959,955	$46,078,557	$48,959,955
Net Working Capital	$8,165,372	$3,808,290	$8,165,372	$3,808,290	$5,437,802	$6,285,777	$5,437,802	$6,285,777	$27,887,912	$22,800,293	$27,887,912	$22,800,293
Unrestricted Assets	$1,852,814	$11,243,924	$1,852,814	$11,243,924	$13,508,694	$23,899,791	$13,508,694	$23,899,791	$40,397,950	$59,273,090	$40,397,950	$59,273,090
Credit Ratings (S&P, FITCH, and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

OHCA Financial Statistics Report (October FY 2016 and October FY 2015)

	Manchester Memorial Hospital				Rockville General Hospital				Eastern CT Health Network			
	MTD		YTD		MTD		YTD		MTD		YTD	
	October FY 2016	October FY 2015	October FY 2016	October FY 2015	October FY 2016	October FY 2015	October FY 2016	October FY 2015	October FY 2016	October FY 2015	October FY 2016	October FY 2015
A. Operating Performance												
Operating Margin	3.51%	1.11%	3.51%	1.11%	-12.22%	-0.64%	-12.22%	-0.64%	-1.97%	-0.35%	-1.97%	-0.35%
Non-Operating Margin	-0.90%	-0.93%	-0.90%	-0.93%	-0.47%	-0.67%	-0.47%	-0.67%	-0.64%	-0.69%	-0.64%	-0.69%
Total Margin	2.61%	0.17%	2.61%	0.17%	-12.70%	-1.31%	-12.70%	-1.31%	-2.61%	-1.05%	-2.61%	-1.05%
Bad Debt as % of Gross Revenue	0.63%	0.66%	0.63%	0.66%	0.60%	0.80%	0.60%	0.80%	0.70%	0.76%	0.70%	0.76%
B. Liquidity												
Current Ratio	1.18	1.11	1.18	1.11	1.86	1.82	1.86	1.82	1.48	1.43	1.48	1.43
Days Cash on Hand	19	24	19	24	63	59	63	59	67	66	67	66
Days in Net Accounts Receivable	58	49	58	50	54	53	54	53	55	50	56	50
Average Payment Period	60	61	60	61	32	37	32	37	62	61	62	61
C. Leverage and Capital Structure												
Long-term Debt to Equity	3.26	2.05	3.26	2.05	1.24	0.85	1.24	0.85	1.38	1.09	1.38	1.09
Long-term Debt to Capitalization	77	67	77	67	55	46	55	46	75	66	75	66
Unrestricted Cash to Debt	1.31	0.84	1.31	0.84	(1.41)	0.63	(1.41)	0.63	0.24	0.59	0.24	0.59
Times Interest Earned Ratio	6.62	5.13	6.62	5.13	(5.42)	4.88	(5.42)	4.88	2.61	4.21	2.61	4.21
Debt Service Coverage Ratio	N/A	N/A	1.93	1.50	N/A	N/A	(3.75)	3.08	N/A	N/A	1.19	1.51
Equity Financing Ratio	10.26	16.63	10.26	16.63	29.08	38.33	29.08	38.33	22.80	28.92	22.80	28.92
D. Additional Statistics												
Income from Operations	$554,185	$178,673	$554,185	$178,673	($624,549)	($40,097)	($624,549)	($40,097)	($522,871)	($101,391)	($522,871)	($101,391)
Revenue Over/(Under) Expense	$412,522	$28,057	$412,522	$28,057	($648,781)	($82,468)	($648,781)	($82,468)	($692,147)	($298,674)	($692,147)	($298,674)
EBITDA	$1,363,716	$1,033,764	$1,363,716	$1,033,764	($312,933)	$295,442	($312,933)	$295,442	$768,569	$1,271,801	$768,569	$1,271,801
Cash from Operations	$15,452,957	$16,077,536	$15,452,957	$16,077,536	$5,280,181	$6,848,006	$5,280,181	$6,848,006	$25,414,035	$27,725,868	$25,414,035	$27,725,868
Cash and Cash Equivalents	$9,106,144	$11,874,779	$9,106,144	$11,874,779	$11,210,738	$11,627,533	$11,210,738	$11,627,533	$46,417,665	$50,958,243	$46,417,665	$50,958,243
Net Working Capital	$5,084,522	$3,217,872	$5,084,522	$3,217,872	$4,850,248	$5,938,396	$4,850,248	$5,938,396	$21,792,409	$20,891,624	$21,792,409	$20,891,624
Unrestricted Assets	$2,961,600	$11,060,535	$2,961,600	$11,060,535	$14,229,387	$23,492,992	$14,229,387	$23,492,992	$41,250,914	$57,524,881	$41,250,914	$57,524,881
Credit Ratings (S&P, FITCH, and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

OHCA Financial Statistics Report (November FY 2016 and November FY 2015)

	Manchester Memorial Hospital				Rockville General Hospital				Eastern CT Health Network			
	MTD		YTD		MTD		YTD		MTD		YTD	
	November FY 2016	November FY 2015	November FY 2016	November FY 2015	November FY 2016	November FY 2015	November FY 2016	November FY 2015	November FY 2016	November FY 2015	November FY 2016	November FY 2015
A. Operating Performance												
Operating Margin	3.25%	-4.33%	3.38%	-1.44%	-1.81%	0.20%	-6.96%	-0.24%	-0.54%	-3.64%	-1.26%	-1.90%
Non-Operating Margin	0.00%	-1.59%	-0.46%	-1.24%	-0.30%	-1.22%	-0.39%	-0.93%	-0.07%	-1.19%	-0.36%	-0.92%
Total Margin	3.26%	-5.93%	2.93%	-2.69%	-2.11%	-1.02%	-7.35%	-1.17%	-0.61%	-4.83%	-1.62%	-2.83%
Bad Debt as % of Gross Revenue	1.42%	0.63%	1.03%	0.65%	1.44%	0.31%	1.02%	0.57%	1.35%	0.65%	1.02%	0.71%
B. Liquidity												
Current Ratio	1.20	1.10	1.20	1.10	1.75	1.71	1.75	1.71	1.45	1.39	1.45	1.39
Days Cash on Hand	20	27	20	26	69	69	68	66	68	70	68	70
Days in Net Accounts Receivable	61	52	60	50	51	57	52	55	55	52	55	50
Average Payment Period	63	66	62	65	38	46	37	44	66	66	66	66
C. Leverage and Capital Structure												
Long-term Debt to Equity	3.24	2.15	3.24	2.15	1.26	0.84	1.26	0.84	1.39	0.96	1.39	0.96
Long-term Debt to Capitalization	76	68	76	68	56	46	56	46	76	67	76	67
Unrestricted Cash to Debt	1.30	(0.22)	2.59	0.61	0.49	0.71	(0.88)	1.32	0.60	(0.06)	0.84	0.51
Times Interest Earned Ratio	5.86	1.22	6.23	3.17	3.71	5.51	(0.86)	5.21	3.63	1.70	3.12	2.94
Debt Service Coverage Ratio	N/A	N/A	2.07	0.80	N/A	N/A	(0.77)	3.21	N/A	N/A	1.25	1.34
Equity Financing Ratio	10.23	15.77	10.23	15.77	28.38	37.99	28.38	37.99	22.40	32.38	22.40	32.38
D. Additional Statistics												
Income from Operations	$484,666	($617,807)	$1,038,851	($439,134)	($94,623)	$11,206	($719,172)	($28,891)	($141,076)	($924,261)	($663,947)	($1,025,652)
Revenue Over/(Under) Expense	$485,190	($845,187)	$897,712	($817,130)	($110,173)	($57,474)	($758,954)	($139,942)	($159,224)	($1,226,090)	($851,371)	($1,524,764)
EBITDA	$1,228,216	$249,367	$2,591,932	$1,283,131	$213,600	$357,458	($99,333)	$652,900	$1,081,351	$524,935	$1,849,920	$1,796,736
Cash from Operations	$13,356,567	$14,014,676	$28,809,524	$30,092,212	$5,149,913	$5,761,100	$10,430,094	$12,609,106	$22,656,723	$24,023,983	$48,070,758	$51,749,850
Cash and Cash Equivalents	$9,267,922	$12,977,823	$9,267,922	$12,977,823	$11,732,274	$12,430,783	$11,732,274	$12,430,783	$47,410,165	$53,283,554	$47,410,165	$53,283,554
Net Working Capital	$5,804,364	$3,065,653	$5,804,364	$3,065,653	$4,824,841	$5,847,770	$4,824,841	$5,847,770	$21,959,313	$20,036,637	$21,959,313	$20,036,637
Unrestricted Assets	$3,079,176	$9,883,749	$3,079,176	$9,883,749	$13,959,228	$23,752,272	$13,959,228	$23,752,272	$40,845,738	$70,108,676	$40,845,738	$70,108,676
Credit Ratings (S&P, FITCH, and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

OHCA Financial Statistics Report (December FY 2016 and December FY 2015)

	Manchester Memorial Hospital				Rockville General Hospital				Eastern CT Health Network			
	MTD		YTD		MTD		YTD		MTD		YTD	
	December FY 2016	December FY 2015	December FY 2016	December FY 2015	December FY 2016	December FY 2015	December FY 2016	December FY 2015	December FY 2016	December FY 2015	December FY 2016	December FY 2015
A. Operating Performance												
Operating Margin	3.14%	8.83%	3.30%	2.29%	-1.50%	3.52%	-5.05%	1.00%	0.52%	3.66%	-0.65%	0.06%
Non-Operating Margin	-0.87%	0.46%	-0.60%	-0.63%	-1.10%	0.83%	-0.64%	-0.35%	-0.74%	0.44%	-0.49%	-0.45%
Total Margin	2.27%	9.28%	2.70%	1.67%	-2.60%	4.35%	-5.68%	0.64%	-0.22%	4.10%	-1.14%	-0.39%
Bad Debt as % of Gross Revenue	1.30%	0.97%	1.12%	0.76%	1.04%	1.12%	1.03%	0.75%	1.16%	1.07%	1.07%	0.83%
B. Liquidity												
Current Ratio	1.30	1.15	1.30	1.15	1.76	1.73	1.76	1.73	1.60	1.44	1.60	1.44
Days Cash on Hand	20	29	21	29	64	75	65	71	67	72	67	72
Days in Net Accounts Receivable	56	45	57	48	49	53	51	51	52	47	53	49
Average Payment Period	56	65	58	65	37	48	37	45	60	67	60	67
					0							
C. Leverage and Capital Structure												
Long-term Debt to Equity	3.24	2.05	3.24	2.05	1.28	0.84	1.28	0.84	1.40	1.06	1.40	1.06
Long-term Debt to Capitalization	76	67	76	67	56	46	56	46	76	65	76	65
Unrestricted Cash to Debt	1.22	2.69	3.86	3.30	0.40	1.67	(0.48)	2.99	0.73	1.64	1.59	2.16
Times Interest Earned Ratio	5.85	11.61	6.10	5.96	4.07	8.58	0.78	6.34	4.53	7.72	3.61	4.53
Debt Service Coverage Ratio	N/A	N/A	1.78	2.03	N/A	N/A	0.12	4.45	N/A	N/A	1.07	1.65
Equity Financing Ratio	10.37	16.35	10.37	16.35	27.98	37.97	27.98	37.97	22.73	29.09	22.73	29.09
D. Additional Statistics												
Income from Operations	$505,704	$1,534,223	$1,544,555	$1,095,089	($83,842)	$205,743	($803,014)	$176,852	$143,984	$1,074,991	($519,963)	$49,339
Revenue Over/(Under) Expense	$365,418	$1,613,504	$1,263,130	$796,374	($145,178)	$254,076	($904,132)	$114,134	($62,229)	$1,203,242	($913,600)	($321,522)
EBITDA	$1,305,554	$2,322,428	$3,897,486	$3,605,559	$234,004	$542,956	$134,671	$1,195,856	$1,422,507	$2,337,616	$3,272,427	$4,134,352
Cash from Operations	$15,466,368	$14,643,053	$44,275,892	$44,735,265	$5,476,070	$5,989,154	$15,906,164	$18,598,260	$25,841,553	$25,175,159	$73,912,311	$76,925,009
Cash and Cash Equivalents	$9,927,631	$14,195,467	$9,927,631	$14,195,467	$11,336,835	$12,906,142	$11,336,835	$12,906,142	$47,804,292	$54,106,561	$47,804,292	$54,106,561
Net Working Capital	$8,246,440	$4,678,359	$8,246,440	$4,678,359	$4,981,022	$5,976,304	$4,981,022	$5,976,304	$26,678,094	$22,211,930	$26,678,094	$22,211,930
Unrestricted Assets	$3,089,534	$11,027,298	$3,089,534	$11,027,298	$13,672,423	$23,806,253	$13,672,423	$23,806,253	$40,751,104	$59,337,036	$40,751,104	$59,337,036
Credit Ratings (S&P, FITCH, and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

OUR CONCERN FOR A VOICE IN HOSPITAL DECISIONS

This whole process of transfering ownership of ECHN has raised questions in the minds of some of us who until now assumed that the top priority in our local hospitals and related service outposts was being given to meeting our health needs. Now we find out that apparently those providing direct services to us may, in some cases, been laid off so that a few very generous salaries could be paid. That doesn't feel like concern for our health care is receiving top priority in the decisions being made. And now, with the transition to a for-profit operation, there is yet another priority which threatens to rise above any concern for our health care, that of a profit for the new owners.

We would like to propose that an independent ombudsman be designed into this new organizational structure who might be empowered to inform and represent those being served, individually and collectively. That could help to lessen our fears.

There are many examples of such positions. Universities like Texas and Arizona have such positions for their students. States like California, North Carolina, Wyoming, and Mississippi (and we assume others) have instituted such positions in support of their senior citizens in long term health care. New Jersey just created such a position for families dealing with special-ed issues. Oregon has a program for foster children and their foster families. There are ample models to draw from.

Eventually, one would assume that the State of Connecticut would institute such a position for its health care providers, but until it does, we would strongly suggest that such an independent office (and <u>independent</u> is a very important part of this) be put in place now for us even as this transfer is taking place.

The Social Concerns Group at
South United Methodist Church

A Union of Professionals
AFT Healthcare

Testimony of
John Brady, RN
Executive Vice President, AFT Connecticut, AFL-CIO
Certificate of Need Determination Letter Public Hearing
Manchester Country Club
March 29, 2016

Good afternoon. My name is John Brady. I am a Registered Nurse and Executive Vice President of AFT Connecticut, a diverse union of nearly 30,000 public and private sector members. We are proud to represent approximately 700 members in four bargaining units at Manchester and Rockville Hospitals. Thank you for the opportunity to speak to you about ECHN's proposal to convert to a for-profit healthcare system by transferring assets to Prospect Medical Holdings, Inc.

AFT Connecticut recognizes that the healthcare landscape is quickly changing and that ECHN has decided that the only path to long term financial stability is to abandon its non-profit status and partner with for-profit healthcare corporations. We recognize that we cannot stop this from happening, but as healthcare professionals with a responsibility to advocate for our patients, their families and our communities, we are concerned about preserving patient access to high quality care and protecting the commitment to community service programs that we have come to expect at ECHN. We want our ECHN hospitals to continue to be responsive to these concerns and provide access to all, not just to those who can afford to pay for profitable services. For these reasons, we strongly urge all actors in this proposed transaction to act openly, honestly and transparently by engaging stakeholders, not shareholders.

When ECHN executives decided to pursue a for-profit partnership with Tenet Healthcare, Inc. in 2014, they initiated substantive discussions with union representatives about their intentions. This process allowed for a frank labor-management dialogue which allowed the fundamental needs and interests of each party to be clarified and communicated at the earliest stages of the process. Ultimately that process resulted in a number of significant changes in collective bargaining agreements and provided an important line of communication between ECHN and its employees throughout the intended transition. Those changes to the collective bargaining agreements will continue, but we have concerns because Prospect has, at best, a checked history in terms of a working relationship with its union partners in Rhode Island.

It is AFT Connecticut's hope that ECHN and its for-profit partners will back away from simply threatening closure and move instead toward responsiveness and accountability to community needs and concerns. We urge the Office of Healthcare Access to place conditions on this acquisition that protect access and quality of care. There are a number of collaborative ways in which this important work can be done.

Community Oversight Board

Similar to the arrangement created for Sharon Hospital, we urge the Attorney General and the Office of Health Care Access to establish a community oversight board with members appointed by elected policy leaders who represent all stakeholders, including direct patient caregivers. If ECHN and its partners will not establish such a board voluntarily, we urge the Attorney General and the Office of Healthcare Access to require it as a condition of the conversion.

Post-Transfer Compliance Reporter

Public Act 15-146 requires the Office of Health Care Access to hire an independent post-transfer compliance reporter for approved conversion applications filed after December 1, 2015. Though law does not require them to do so in this case, we strongly urge the Office of Health Care Access to require a post-transfer compliance reporter be appointed to ensure that ECHN and its partners live up to the terms of the approved conversion and keep the promises they have made to the community. A compliance reporter would produce a baseline report on services, staffing levels, uncompensated care, community programs, employee benefits and other measures at the time of conversion. That way, when performance audits are conducted, cuts made after the conversion could be easily identified and their impacts monitored. Establishing an independent reporter would ultimately facilitate dialogue between the hospital, patients, communities, the Attorney General and the Department of Public Health, creating a mechanism for success. If ECHN and its partners will not create a post-transfer compliance reporter voluntarily, we urge the Attorney General and the Office of Healthcare Access to require it as a condition of the conversion.

Charitable Care/Community Benefits

Public Act 15-146 requires the post-transfer compliance reporter to report to the Office of Health Care Access the level of community benefit and uncompensated care provided by hospitals who have applied for conversion after December 1 2015. Though the law does not require it because their application was filed before December 1, 2015, we call on ECHN and its partners to follow the spirit of Public Act 15-146 and establish a detailed, definitive written community benefits agreement. If they fail to do so, we urge the Attorney General and the Office of Healthcare Access to require it as a condition of the conversion.

In conclusion, there is much ECHN and its corporate partners can do to protect the communities they serve as they attempt to convert from non-profit to for-profit status. We ask that they proactively address the issues outlined in this testimony and seize the opportunity to establish true partnerships with all stakeholders. It is only by working collaboratively that they will succeed. Thank you.

 From Joe Talley 860-646-1030 (Tyler)

Competent, but not daring

Hospitals run by ECHN's new suitor seen as well-run but not interested in treating sickest cases

By Don Michak
Journal Inquirer

Prospect Medical Holdings, the California-company now expected to acquire Eastern Connecticut Health Network, is a for-profit business that scoops up hospitals in financial troubles — just like Tenet Healthcare, the Texas-based corporation that last winter left ECHN at the buyout altar.

Both offer their targets access to new capital, agree to assume debt and pension obligations, and make qualified pledges to maintain services and employment levels and to keep facilities open for several years.

But there are some big differences between ECHN's past and latest suitors, with the most obvious being Tenet's billion-dollar record of settling fraud, overbilling, kickback, and other allegations by its biggest customer, the federal government.

Prospect has not faced any similar allegations, although its San Antonio, Texas, hospital system and one of the two Rhode Island hospitals it purchased last year are among the hundreds of U.S. hospitals penalized by Medicare for high rates of "hospital-acquired conditions" — avoidable mistakes that harm patients.

Prospect, with just over 2,000 employees, also has been merely a regional player in the national health care game. It currently owns 14 hospitals in three states, compared to Tenet's 80 hospitals in 14 states.

Moreover, Prospect has been in the hospital business for only about a decade. The company, which in 1996 began acquiring physician organizations in California, bought a minority interest in its first hospital there in 2005. It bought four more California hospitals in 2007 and two others in Texas in 2012 and 2013.

Prospect in 2012 also announced plans to buy Raritan Medical Center in Perth Amboy, New Jersey, but that deal fell apart when Raritan decided instead to merge with an in-state nonprofit hospital system.

Undeterred, the company in 2014 signed a "definitive partnership agreement" with another nonprofit facility in New Jersey, East Orange General Hospital, under which it would assume ownership and make $84 million in operational and capital commitments. That deal is now under review by the state's health department and attorney general.

Prospect last year also formed a joint venture with CharterCare Health Partners in Rhode Island, owner of the 220-bed Roger Williams Medical Center in Providence and the 278-bed Our Lady of Fatima Hospital in North Providence. The company paid about $45 million for an 85 percent ownership stake, with most of the money going to pay off debt and pension funding. It also promised to invest $95 million over four years, preserve jobs, and maintain all services for a five-year period after the deal is formalized.

In Connecticut, Prospect is poised to buy not only ECHN and its Manchester Memorial and Rockville General hospitals, but also Waterbury Hospital, which like ECHN had been expected to be bought by Tenet.

Prospect now also is reported to be among the possible new suitors for the nonprofit Daughters of Charity Health System, the Catholic owner of six northern California hospitals whose $843 million buyout deal with the for-profit Prime Healthcare Services recently collapsed, according to an industry publication, Healthcare Finance News.

Prospect, which is incorporated in Delaware, is a holding company essentially owned by a Los Angeles-based leveraged-buyout firm, Leonard Green & Partners, through a corporate parent, Ivy Intermediate Holdings Inc. Prospect is led by a buyout industry veteran, Samuel S. Lee.

The privately held company doesn't file reports with federal securities regulators that would describe its financial condition, identify its principal stockholders, and disclose its executives' compensation packages.

But the decision issued last year by the director of Rhode Island's Health Department approving Prospect's takeover of the Providence-area hospitals provides some critical details about the company's business model, its financial status, and the quality of its care.

The 87-page document written by Dr. Michael Fine said that Prospect's purchase of 14 physician organizations in its first decade provided it with "a substantial concentration of HMO enrollees."

Fine, who has since retired, said the company then "used its community hospitals to facilitate growth" at its biggest hospital — Brotman Medical Center, now called Southern California Hospital at Culver City — and "used its medical group enrollment to drive business to its hospital facilities."

Fine added that Prospect also "leveraged its medical groups to enhance payor diversification" and "expanded its HMO contracts by offering a combined hospital-physician provider solution."

Prospect in 2005 had bought the 420-bed Brotman hospital, together with a group of hospital physicians and private investors, from a Tenet Healthcare subsidiary for $27 million, the Los Angeles Times reported.

Faced two years later with an annual loss of $12 million, the hospital filed for bankruptcy protection. Prospect led the reorganization of the hospital, increasing its ownership from 33 percent to 72 percent.

Fine wrote that that during Prospect's "six years of ownership of hospitals," the company has had "success in operating hospitals that had financial difficulties" and that its facilities "enjoy a good reputation for delivery of quality care and service to the under-served."

In a document appended to the decision, a consultant reported that Prospect's earnings before interest, taxes, depreciation, and amortization ranged between 8.9 percent and 13.8 percent between 2010 and 2013, indicating that it could "service existing debt and make routine and strategic investments."

Prospect intended to pay for the Rhode Island deal with cash generated from operations, the consultant added, including $86 million in cash and equivalents, and the company had a $60 million "revolving credit facility."

The consultant also found that Prospect used more debt to finance assets than similar publicly traded companies. And he reported that the company had a deficit in stockholders' equity because of payments made to its corporate parent of $88 million in 2012 and $100 million in 2013, although the company had said it had no intention to make additional "distributions."

In another appended report, a second consultant who reviewed "quality" issues at Prospect described all Prospect's hospitals as "community hospitals, non-academic" with "limited beds and services."

"They rely on hubs in the southern California or Texas regions, none of which they own, to take care of sicker patients who require more complex care," she wrote, adding that as a result Prospect doesn't have to pay for maintaining the more complex facilities.

The medical consultant also reported that she found no "citations of fraud or abuse or any criminal penalties" against Prospect hospitals, and that in the grades handed out by companies including U.S. News, Consumer Reports, and Leapfrog, all the facilities "fared similarly, with C the most common grade."

Meanwhile, Fine disclosed that Prospect had "never been required to undertake" or had "never undertaken" health needs assessments or equivalent studies of the health needs of residents in the communities where it operates. Such studies are required of nonprofit hospitals under the Affordable Care Act, and failure to meet that requirement can result in a $50,000 excise tax and possible revocation of tax-exempt status.

The official also wrote that Prospect's business model and record "do not provide any indication that it will improve hospital care affordability in its service area."

Prospect, Fine added, "will not be seeking to provide essential but under-reimbursed services to its service population but will be looking for services that generate higher margins and revenue growth."

He said the point wasn't that he was critical of the company's business model, "but merely that the business model must be evaluated with regard to its impact on affordable care statewide."



Mel Evans / Associated Press

Preparing the Green

David Clark places flags for the Fourth of July celebrations along the Town Green today in Middlebury, Vt.

STATE OF CONNECTICUT

OFFICE OF THE ATTORNEY GENERAL
Office of Health Care Access

TABLE OF THE RECORD

APPLICANTS: Eastern Connecticut Health Network, Inc. and Prospect Medical Holdings, Inc.

DOCKET NUMBER: OHCA15-32016-486 and OAG15-486-01

PUBLIC HEARINGS: **March 29, 2016 at 2:00pm**
March 30, 2016 at 2:00pm

PLACE: **March 29, 2016**
Manchester Country Club
305 South Main Street
Manchester, CT 06040

March 30, 2016
Elks Lodge
9 North Park Street
Vernon, CT 06066

EXHIBIT	DESCRIPTION
A	Letter from the Eastern Connecticut Health Network (Applicants) dated July 16, 2015 enclosing a Determination form for the proposal to transfer certain of its assets to Prospect Medical Holdings, Inc., received by the Office of Health Care Access (OHCA) on July 16, 2015. (14 pages)
B	Letter from Bershtein, Volpe & McKeon P.C. to OHCA dated July 17, 2015 entering their appearance on behalf of the Applicants. Received by OHCA on 7/21/15. (1 page)
C	Office of the Attorney General (OAG) and Office of Health Care Access' (OHCA) letter to the Applicants dated August 6, 2015 determining that approval is required pursuant to Conn. Gen. Stat. §19a-486 et seq. (16 pages)
D	Applicants' letter dated August 14, 2015 enclosing transcripts and recordings from two public hearings held on ECHN's Certificate of Need Determination Letter, received by OHCA on August 14, 2015. (238 pages)
E	Applicants' letter dated October 1, 2015 requesting a 60 day extension for filing the application, received by OHCA on October 2, 2015 (2 pages)

F	OAG and OHCA letter to the Applicants dated October 2, 2015 approving the request for time extension in the matter of the CON application. (2 pages)
G	Letter from Eastern Connecticut Health Network, Inc. and Pospect Medical Holding, Inc. (Applicants) dated October 13, 2015 enclosing the Certificate of Need (CON) application for the proposed purchase of assets of ECHN and its affiliated by one or more affiliated of PMH under Docket Number: OHCA15-32016-486 and OAG15-486-01, received by OHCA on October 13, 2015. (2,142 pages)
H	Public Comment letter(s) received in the matter of the CON under Docket Number OHCA15-32016-486 and OAG15-486-01, received by OHCA (1 page)
I	OAG and OHCA letter to the Applicants dated October 30, 2015 requesting additional information and/or clarification in the matter of the CON application under Docket Number OHCA15-32016-486 and OAG15-486-01 (15 pages)
J	OAG and OHCA letter to the Applicants dated November 12, 2015 requesting additional information and/or clarification in the matter of the CON application under Docket Number OHCA15-32016-486 and OAG15-486-01 (3 pages)
K	Applicants' responses to OAG and OHCA's letters of October 30, 2015 and November 12, 2015 dated November 24, 2015, in the matter of the CON application under Docket Number OHCA15-32016-486 and OAG15-486-01 received by OHCA November 24, 2015 (287 pages)
L	OAG and OHCA letter to the Applicants dated December 11, 2015 requesting additional information and/or clarification in the matter of the CON application under Docket Number OHCA15-32016-486 and OAG15-486-01 (7 pages)
M	Designation letter dated December 6, 2015 of Hearing Officer in the matter of the CON application under Docket Number OHCA15-32016-486 and OAG15-486-01 (1page)
N	Applicants' responses to OAG and OHCA's letters December 11, 2015 dated December 24, 2015, in the matter of the CON application under Docket Number OHCA15-32016-486 and OAG15-486-01, received by OHCA on December 24, 2015 (106 pages)
O	OAG and OHCA letter dated January 13, 2016 to the Applicants deeming the application complete in the matter of the CON application under Docket Number OHCA15-32016-486 and OAG15-486-01 (1 page)
P	OAG and OHCA letter dated January 20, 2016 to the Applicants enclosing an order regarding administravie notice of Greater Waterbury Health Network, Inc. and Prospect Medical Holding, Inc. (2 pages)

Q	Letter from the Law Office Donna B. Brewer dated January 27, 2016 noticing appearance representing the Town of Vernon in the matter of the CON application under Docket Number OHCA15-32016-486 and OAG15-486-01, received by OHCA on February 1, 2016. (1 page)
R	Email dated February 1, 2016 regarding time extension in the matter of the CON application under Docket Number OHCA15-32016-486 and OAG15-486-01. (2 pages)
S	OAG and OHCA letter dated February 18, 2016 enclosing a scheduling agreement in the matter of the CON application under Docket Number OHCA15-32016-486 and OAG15-486-01. (4 pages)
T	OAG and OHCA request for legal notification in the *Journal Inquirer* of OHCA's Notice to the Applicants of the public hearing scheduled for for March 15, 2016 and March 16, 2016, in the matter of the CON application under Docket Number OHCA15-32016-486 and OAG15-486-01. dated February 19, 2016(4 pages)
U	OAG and OHCA letter to the Applicants dated February 24, 2016 requesting prefile testimony and enclosing issues in the matter of the CON application under Docket Number OHCA15-32016-486 and OAG15-486-01. (5 pages)
V	Letter from Law office of Donna B. Brewer on behalf of the Town of Vernon to OHCA dated March 4, 2016 requesting to be an informal participant in the matter of the CON application under Docket Number OHCA15-32016-486 and OAG15-486-01. Received by OHCA on March 8, 2016. (1 page)
W	Letter from OAG and OHCA to the Applicants dated March 10, 2016 updating the request for prefile testimony and issues in the matter of the CON application under Docket Number OHCA15-32016-486 and OAG15-486-01 (2 pages)
X	OAG and OHCA request for legal notification in the *Journal Inquirer* of OHCA's Notice to the Applicants of the rescheduled public hearing scheduled for March 29, 2016 and March 30, 2016, in the matter of the CON application under Docket Number OHCA15-32016-486 and OAG15-486-01. dated February March 10, 2016(4 pages)
Y	Letter from the Applicants to OHCA dated March 21, 2016 enclosing additional completeness responses in the matter of the CON application under Docket Number OHCA15-32016-486 and OAG15-486-01. dated February March 21, 2016, received by OHCA on March 21, 2016 (9 pages)
Z	Letter from the Applicants enclosing Prefile Testimony and responses to issues dated March 10 2016 in the matter of the CON application under Docket Number OHCA15-32016-486 and OAG15-486-01. dated March 23, 2016, received by OHCA on March 23, 2016 (580 pages)

AA	Letter from the Applicants to OHCA dated March 23, 2016 enclosing a pre-file reference list in the matter of the CON application under Docket Number OHCA15-32016-486 and OAG15-486-01, received by OHCA on March 28, 2016 (3 pages)
BB	Letter from the Applicants to OHCA dated March 28, 2016 enclosing supplemental materials in the matter of the CON application under Docket Number OHCA 15-32016 -486 and OAG 15-286-01, received by OHCA on March 28, 2016. (114 pages)
CC	Support letter from Representative Prasad Srinivasan to OHCA and OAG dated March 22,2016 in the matter of the CON application under Docket Number OHCA 15-32016 -486 and OAG 15-286-01, received by OHCA on March 28, 2016. (1 page)
DD	Letter from the Applicants to OHCA dated March 29, 2016 enclosing corrected completeness responses in the matter of the CON application under Docket Number OHCA 15-32016 -486 and OAG 15-286-01, received by OHCA on March 29, 2016. (8 pages)

OHCA HEARINGS - EXHIBIT AND LATE FILE FORM

Applicants: Eastern Connecticut Health Network

DN: 15-32016-486 and 15-486-01

Hearing Dates: March 29, 2016

Time: 2:00 p.m.

Proposal: Eastern Connecticut Health Network, Inc. ("ECHN"), and Prospect Medical Holdings, Inc. ("PMH"), are proposing the purchase of substantially all of the assets of ECHN by PMH. Pursuant to the terms of the proposed Asset Purchase Agreement, PMH will pay either $105,000,000 or $115,000,000 for the assets of ECHN, subject to certain adjustments. In addition, PMH will commit to spend not less than $75,000,000 on capital items for the hospitals and service areas of Manchester Memorial Hospital and Rockville General Hospital, over five years.

OHCA Exhibit #	Description
1	
2	
3	
4	

Applicant
Exhibit #

Description

1	Quality Assurance Commitment
2	
3	
4	
5	

STATE OF CONNECTICUT

OFFICE OF THE ATTORNEY GENERAL

Office of Health Care Access

AGENDA

HEARING

Docket Number: 15-32016-486 and 15-486-01

Eastern Connecticut Health Network, Inc. (ECHN) and Propect Medical Holdings, Inc. (PMH)

Purchase ECHN Assests by PMH

March 29, 2016 at 2:00 p.m.

I. Convening of the Public Hearing

II. Applicant's Direct Testimony

III. OHCA's Questions

IV. OAG's Questions

V. Public Comment

VI. Closing Remarks

VII. Public Hearing Adjourned

An Equal Opportunity Provider
(If you require aid/accommodation to participate fully and fairly, contact us either by phone, fax or email)
410 Capitol Ave., MS#13HCA, P.O.Box 340308, Hartford, CT 06134-0308
Telephone: (860) 418-7001 Fax: (860) 418-7053 Email: OHCA@ct.gov

PUBLIC HEARING
APPLICANT
SIGN UP SHEET

March 29, 2016
2:00 p.m.

Docket Number: 15-32016-486 and 15-486-01
Eastern Connecticut Health Network
Purchase of ECHN Assets by Prospect Medical Holdings, Inc.

PRINT NAME	Phone	Fax	Representing Organization
Steve Aleman			Prospect
Mitchell Law			Prospect
Von Crockett			P.M.H.
Michele Volpe			Prospect BVM
Thomas Roman			PMH

PUBLIC HEARING

APPLICANT

SIGN UP SHEET

March 30, 2016
2:00 p.m.

Docket Number: 15-32016-486 and 15-486-01
Eastern Connecticut Health Network
Purchase of ECHN Assets by Prospect Medical Holdings, Inc.

PRINT NAME	Phone	Fax	Representing Organization
Rebecca Matthews	(203) 498-4302	(203) 782-2889	WTD/ECHN
Joy Doran	860-646-7751		ECHN BOT
Melinda Agsten	203-498-4326	203-782-2889	WTD/ECHN
Steve Aleman			Prospect Medical Holdings
Dennis McConville	860 208 4591		ECHN

Eastern Connecticut Health Network

PRINT NAME	Phone	Fax	Representing Organization
JONATHAN SPEES	3104889696		PROSPECT
DENNIS O'NEILL MD	860 6476487		ECHN
Michele Volpe	203 7776995		Prospect / BVM
Von Crockett	310.943.4500		Prospect.
Mitchell Lew	310.943.4500		Prospect.
THOMAS REARDON	617-686-3730		PROSPECT
Peter Karl			ECHN

PUBLIC HEARING
GENERAL PUBLIC
SIGN UP SHEET

March 30, 2016
2:00 p.m.

→ Corrine Fisher ✓

Docket Number: 15-32016-486 and 15-486-01
Eastern Connecticut Health Network
Purchase of ECHN Assets by Prospect Medical Holdings, Inc.

PRINT NAME	Representing Organization
Carol Burke ✓	Self
Ronald Burke (same) ✓	Self
Eric Kloter ✓	self
Jean Lynne Ide ✓	Universal Health Care Fdn. of CT *
Dr. Barbara L Phillips (Phillips) ✓	ECHN Board of Trustees, Self
Tom Swan ✓	CCAG
Jim Waites ✓	self

Eastern Connecticut Health Network

PRINT NAME	Representing Organization
Jean Merz ✓	
~~Thomas Mason~~ left	self
Thomasina Clemons (Thomasina Clemons) ✓	self

PUBLIC HEARING
PUBLIC OFFICIAL
SIGN UP SHEET

March 30, 2016
2:00 p.m.

Docket Number: 15-32016-486 and 15-486-01
Eastern Connecticut Health Network
Purchase of ECHN Assets by Prospect Medical Holdings, Inc.

PRINT NAME	Phone	Fax	Representing Organization
✓ Daniel Champagne	(860) 870-3600		Mayor Town of Vernon
✓ Dr. Prasad Srinivasan (attending from 3:30 - 4:15)			State Representative

PUBLIC HEARING
GENERAL PUBLIC
SIGN UP SHEET

March 29, 2016
2:00 p.m.

Docket Number: 15-32016-486 and 15-486-01
Eastern Connecticut Health Network
Purchase of ECHN Assets by Prospect Medical Holdings, Inc.

PRINT NAME	Representing Organization
John Brady	AFT Connecticut ✓
Richard Thompson	Group from South UM Church ✓
~~Kimberly A. Kramer~~	~~Charter Care~~
Joe Tyler	Self ✓
Dr. Robert Rodner	Self ✓

Eastern Connecticut Health Network

PRINT NAME	Representing Organization
~~Phil Jusaq~~	
~~Roberta Avish~~	
Dr. Joel Reich	ECHN ✓
~~Horace Brown~~	
~~[redacted]~~ Geoffrey Naab	myself ✓
~~James Waites~~	Myself ✓
~~Thea Cardamone~~	myself
~~DAN GLENNEY~~	SELF
Dr. Robert Carroll	Chair Emergency Medicine ✓

PUBLIC HEARING
PUBLIC OFFICIAL
SIGN UP SHEET

March 29, 2016
2:00 p.m.

Docket Number: 15-32016-486 and 15-486-01
Eastern Connecticut Health Network
Purchase of ECHN Assets by Prospect Medical Holdings, Inc.

PRINT NAME	Phone	Fax	Representing Organization
~~Kimberly A Martin~~ Signed in on public sheet	(203) 879-7892		Charter Oak
~~Jay Tyler~~	860-646-1030		Self
Jay Moran Jay Moran	860		Mayor

Eastern Connecticut Health Network

PRINT NAME	Phone	Fax	Representing Organization
Melinda A. Agsten	203-498-4326	203-782-2889	ECHN / Wiggin and Dana
Rebecca A. Matthews	(203) 498-4502	"	" "
Joy Dorin	860-646-7751		ECHN / BOT
JONATHAN SPEES	3104889696		PROSPECT
Peter Karl	860 930 2698		ECHN
[illegible]	647 6487		ECHN

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OFFICE OF HEALTH CARE ACCESS

EASTERN CONNECTICUT HEALTH NETWORK, INC. (ECHN) AND PROSPECT MEDICAL HOLDINGS, INC. (PMH)

PURCHASE ECHN ASSETS BY PMH

DOCKET NO. 15-32016-486 AND 15-486-01

MARCH 29, 2016

2:00 P.M.

MANCHESTER COUNTRY CLUB
305 SOUTH MAIN
MANCHESTER, CONNECTICUT

POST REPORTING SERVICE
HAMDEN, CT (800) 262-4102

. . .Verbatim proceedings of a hearing before the State of Connecticut, Department of Public Health, Office of Health Care Access, in the matter of Eastern Connecticut Health Network, Inc. (ECHN) and Prospect Medical Holdings, Inc. (PMH), Purchase ECHN Assets by PMH, held at the Manchester Country Club, 305 South Main, Manchester, Connecticut, on March 29, 2016 at 2:00 p.m. . . .

HEARING OFFICER KEVIN HANSTED: Good afternoon, everyone. This public hearing before the Office of the Attorney General and Office of Health Care Access, identified by Docket Nos. 15-32016-486 and 15-486-01-CON, is being held on March 29, 2016 to consider Eastern Connecticut Health Network and Prospect Medical Holdings, Inc. application for the purchase of the assets of Eastern Connecticut Health Network by Prospect Medical Holdings.

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

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

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

My name is Kevin Hansted, and I have been designated to serve as the Hearing Officer for the Office of Health Care Access in this matter.

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

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

Eastern Connecticut Health Network and Prospect Medical Holdings, Inc. have been designated as parties in this proceeding.

MR. PERRY ZINN ROWTHORN: Good afternoon. My name is Perry Zinn Rowthorn. I'm the Deputy Attorney General for the State of Connecticut. I've been designated the Hearing Officer in this matter by Attorney

General George Jepsen.

I want to thank the Applicants, who are here, the witnesses, any public officials we may hear from, and a special thank you to the members of the public, who are here today.

We recognize that this transaction is important to your community, and it's important to all of the 19 communities that ECHN serves. That's why we're here, and your presence here underscores the importance of this transaction in our review.

We're conducting this hearing jointly with OHCA, but the Attorney General has a different role in reviewing the transaction, a different focus and different criteria, and I want to say a few words about that before we get into the hearing.

The Attorney General's role is defined and limited by the Conversion Act, the statute that Attorney Hansted referred to, Section 19a-486.

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

Non-profit hospitals and hospital systems,

like ECHN, hold their assets for essentially a charitable purpose, providing health care, and not unlike for-profit systems generating profits for shareholders or owners.

The administrators of a non-profit hospital are stewards of its charitable assets with a responsibility to take good care of those assets.

The law does not prohibit hospitals, non-profit hospitals, from converting to for-profit status. When one seeks to do so, as here, the Attorney General's job is to ensure that the non-profit hospital is meeting its obligations of care for charitable assets.

We make sure three things, that the process leading to the sale was responsible, we look at where hospital -- were the hospital administrators careful in deciding to sell and choosing a buyer and negotiating the transaction?

We look at the terms of the sale. Are they fair? Will the hospital system get fair market value for its assets? And we look at the proceeds of the sale. Will they continue to be used for charitable health-related purposes?

Those proceeds remain charitable assets, and we need to ensure that the assets of the sale are protected from being used for the for-profit making

purposes of the new hospital system.

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

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

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

Don't assume if we don't ask a question on a topic that that topic is not important to us. Before today, we have received and reviewed thousands of pages of documents, and we've asked questions and received answers in written form.

All of those materials, by the way, are available for your review on the Attorney General's website, www.ct.gov/ag.

The public's input is important to our review. All the information we receive today and in the hearing we'll hold on this transaction tomorrow in

Vernon, including all the public comments, will become part of the official record of our review.

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

We have sheets at the door that you probably saw when you came in to sign up if you want to speak. We urge you to do that, and we're anxious to hear your commentary.

You can also take sheets. We have instruction sheets at the table for your own review or to give to friends or acquaintances, who may wish to be heard on this transaction, but couldn't be here today.

We are on track to review, to complete this review and issue our decision as early as June 10th of this year. I want to say a word about what that decision might entail.

Under our statute, the Attorney General either must approve the transaction as it is, deny it, or approve it with conditions, and those conditions for our purposes would relate to the purpose of the Conversion Act. That is, they would relate to the Attorney General's focus on protection of charitable assets.

This is a joint hearing. Kevin and I are going to work together to move this along to cover as much business as we can. You can assume that if either of us makes a ruling, that unless we state otherwise, that ruling will apply for both offices, and you can assume that, if either of us asks a question, because we have a joint record, that the question and answer will be applicable in both of our reviews and records.

I'll talk a little bit about how we see this proceeding going forward today. We're going to hear first the Applicant's Direct testimony. Next, OHCA will ask questions. To the extent that we have additional questions after OHCA's, we'll ask questions, then we'll have opportunity for public comment, and then opportunity for closing remarks.

Before I turn it back over to Kevin, who has got some additional important business to discuss, I want to introduce the Attorney General's staff, who is here with me today.

Immediately to my left is Assistant Attorney General Henry Salton, who is providing legal advice to the Attorney General and to OHCA.

Next to him is Assistant Attorney General Gary Hawes, who is coordinating this review for our

office. Soon to be with us is paralegal specialist Cheryl Turner, who has returned to our office to get our name plates, because we see that OHCA has theirs, and we're anonymous to this point at least, so thank you for your attention. I'll turn it back over to Kevin.

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

MR. STEVEN LAZARUS: Good afternoon. Steven Lazarus. For today's record, I would like to enter into the record Exhibits A through CC.

I would like to note that, in item BB, the presentation being provided today by Eastern Connecticut Health Network is included in those documents.

Also, OHCA intends to add to the record Exhibit DD, which will be the PowerPoint presentation submitted by Prospect Medical Holding.

And, also, a new document that we received today that we're in the process of reviewing, the Quality Assurance Commitment, is being added as Exhibit EE.

HEARING OFFICER HANSTED: Thank you, Mr.

Lazarus. Counsel, are there any objections to any of the exhibits?

MS. REBECCA MATTHEWS: No objection. This is Rebecca Matthews from Wiggin and Dana here on behalf of ECHN. There are no objections to the record. We just had a few clarifications that we wanted to make if that's okay.

HEARING OFFICER HANSTED: Sure. Absolutely.

MS. MATTHEWS: The first is with respect to Exhibit E.

HEARING OFFICER HANSTED: If you just bring it closer to you, it might help.

MS. MATTHEWS: Can you hear me now? Is that better? So the first is with respect to Exhibit E. There's a reference to a two-page request for an extension to file the original application. I think there were two separate letters, both of which were two pages, one from each of the Applicants, co-Applicants, so I'm not sure if this is referring to the letter from PMH or ECHN, but we just wanted to make sure that both letters were included in the record since that was a joint request, if possible.

HEARING OFFICER HANSTED: Thank you. Yes.

MS. MATTHEWS: The second is with respect to Exhibit H. There's a reference to a one-page public comment letter. It doesn't say in the Table of Record who it's from or the date.

I think, from looking at the docket, it is referring to an e-mail from a Mr. Tonerowicz(phonetic) from last October. Again, no objection at all to it being in the record.

We just wanted to make sure or to clarify on the record that there are other letters of support that have been filed. Some of them were filed with our initial application. I think that's DD, was the filing, and then additional letters have been filed with our most recent submission or the submission on Monday, the 28th, so I just wanted to note that for the record.

A very small point on Exhibit K, which it says it's dated November 24th, and I think it's dated the 23rd, and you just may hear us reference that filing. I just want to make sure there's no confusion.

Just a couple more. One is P, where the agencies have taken administrative notice of the Greater Waterbury Health Network application, and, again, no objection at all.

As you mentioned, these applications are

very lengthy. They're thousands of pages, so we don't actually have that application with us today, and we may not know everything in it, and we would just ask, if it's possible, if there's anything specific that might be used from that application in this decision that we might not otherwise know about, if you could, please, if we could respectfully request to have some specific notice and an opportunity to respond, because we do not have it with us today.

And I think that is all. I know you've added the quality commitment letter, which we submitted today. Thank you very much.

HEARING OFFICER HANSTED: Thank you. Okay and, at this point, would all the individuals, who are going to testify, would you please stand, raise your right hand and be sworn in by the court reporter?

(Whereupon, the parties were duly sworn in.)

HEARING OFFICER HANSTED: Thank you, everyone. Just a couple more points. First of all, before each of you speaks today, if you've submitted pre-filed testimony, please adopt that testimony for me on the record today before you speak. Thank you.

And if everyone would like to go down the

line and just introduce yourselves, that would be helpful. Start down here.

MS. MELINDA AGSTEN: I'm Melinda Agsten of Wiggin and Dana, counsel to ECHN.

MS. MATTHEWS: Rebecca Matthews, Wiggin and Dana, counsel to ECHN.

MR. PETER KARL: Peter Karl, CEO of ECHN.

MS. JOY DORIN: Joy Dorin, member of the Board of Trustees.

DR. DENNIS O'NEILL: Dennis O'Neill, Chair of the Board of ECHN.

DR. MITCHELL LEW: Dr. Mitchell Lew, President, Prospect Medical Holdings.

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

MR. JONATHAN SPEES: I'm Jonathan Spees. I'm Senior Vice President with Prospect Medical Holdings.

MR. STEVEN ALEMAN: I'm Steve Aleman, Chief Financial Officer, Prospect Medical Holdings.

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

MS. MICHELE VOLPE: And I'm Michele Volpe, Legal Counsel for Prospect Medical Holdings.

HEARING OFFICER HANSTED: Okay. Thank you, all, and welcome. And, at this point, Attorney Matthews, you may proceed with your presentation.

MS. MATTHEWS: Thank you, all, very much for this opportunity. I'd like to introduce first Dr. Dennis O'Neill, who is going to speak on behalf of ECHN.

DR. O'NEILL: Good afternoon.

HEARING OFFICER HANSTED: Good afternoon.

DR. O'NEILL: Mr. Hansted, Mr. Zinn Rowthorn, members of the office of the Attorney General, and members of the office of Health Care Access, my name is Dennis G. O'Neill. I'm the Chair of the Board of Trustees of Eastern Connecticut Health Network.

I'm also a physician in private practice working in the Manchester and Vernon communities for the past 33 years.

Thank you for providing us with the opportunity to submit testimony in support of ECHN's proposal to transfer its assets to Prospect Medical Holdings.

First, I would like to adopt my pre-filed testimony, then I'd like to explain that, after my introductory comments, Peter J. Karl, ECHN's President and CEO sitting to my left, is going to make a brief

presentation on our financial situation.

Joy Dorin to my immediate left, one of our Trustees and Chair of the Board's Transaction Committee, will then present information on the transaction, itself, and ECHN's quality program, after which representatives of Prospect Medical Holdings will offer information on their organization.

Manchester Memorial Hospital and Rockville General Hospital, the flagship hospitals of ECHN, were built about 95 years ago by members of their respective communities in response to the influenza pandemic of 1918 and, also, as memorials to those community members, who died in World War I.

For many decades, these two hospitals functioned as separate community hospitals, and then, about 20 years ago, they joined together to form ECHN.

They were both in good financial shape at the time, but pursued a merger, in order to provide more efficient and better integrated hospital care for their citizens.

Over the last two decades, ECHN has grown beyond the two hospitals into a health care network with 13 wholly-owned subsidiaries, 12 joint venture companies, and dozens of facilities serving the needs of our

communities.

ECHN now employs 3,000 people in eastern Connecticut, and the hospitals in Manchester and Vernon are the largest employers in their communities.

In just this last year, 2015, approximately 115,000 people were treated in our hospitals, 61,000 folks were examined in our emergency departments, 5,000 patients were cared for by our visiting nurses, and we delivered about 1,400 babies.

Needless to say, the citizens of eastern Connecticut need and use our facilities, but the American people, in general, and the members of our communities, more specifically, have told us that they want and need care that is even more integrated than the care they receive today, care that is higher in quality and lower in cost.

In an attempt to respond to these needs and in anticipation of worsening financial conditions, the trustees of ECHN about four and a half years ago formed a work group to evaluate whether or not ECHN should pursue a partnership with another organization.

At that time, we thought we had about five years before our circumstances became dire, due to changes in the health care landscape that we thought were

going to have a negative effect on our organization.

The first year was spent deciding that we should partner, as opposed to going it alone. In the second year, we selected as our best option an asset purchase agreement offered by Vanguard Health System and New Haven Health System.

In the middle of the second year, Vanguard was acquired by Tenet, and we spent the remainder of that year getting to know them.

During year number three, we negotiated a deal with Tenet that would have preserved our hospitals, the jobs of our employees, and the pensions of our retirees, and provided capital for future growth, but, at the end of 2014, Tenet abruptly left the state, citing what it perceived as overly restrictive conditions placed on its acquisitions by state regulatory agencies.

That was a great disappointment to us, because it essentially scuttled three years of work, but, more importantly, we were three years closer to 2016 with still no deal in hand.

But then, in 2015, our fourth year, we were fortunate enough to find Prospect Medical Holdings and spent most of that year negotiating a deal with them and resubmitting our application for regulatory review.

Prospect is a health care company based in California that, through the business acumen of its founders, the perspicacity of its senior management team, and the perseverance of its staff, has in the last two decades become an industry leader in what is referred to as population health.

That is managing all aspects of a health system, inpatient care, outpatient care, physician office care, home health care for a large group of people, in this case the people of eastern Connecticut, with higher quality and lower cost.

Like all health care companies, though, Prospect is not a perfect hospital company. Last year, during inspections at two of its California hospitals, the Centers for Medicare and Medicaid Services, CMS, made determinations that required correction.

You'll hear more about this in a couple of minutes from Joy Dorin, one of our Trustees, and the folks from Prospect.

But it's important to note at this point that our Trustees and Corporators chose overwhelmingly, the Trustees voted unanimously and the Corporators voted with 98 percent approval rate, to transfer our assets to Prospect for at least three important reasons.

First, Prospect is not Tenet. They're smaller in size, they're less threatening as a newcomer within the state of Connecticut, and because they're not affiliated with Yale or Hartford HealthCare, they would actually increase, rather than reduce, competition within our state.

Secondly, the deal we negotiated with Prospect is essentially the same deal we had negotiated with Tenet, with preservation of our hospitals, our employees, our retirees and capital for our future.

And, thirdly, Prospect is a recognized expert in what they refer to as coordinated regional care, taking to a new level what began with the creation of our two hospitals many years ago and continued with the formation of ECHN.

Now, for more detailed information on ECHN's financial condition, I'd like to pass the microphone to Peter J. Karl, ECHN's President and CEO.

MR. KARL: Thank you, Dr. O'Neill. My name is Peter Karl. I'm the CEO of ECHN, and I adopt my pre-filed testimony.

My mandate today is to try to explain how and why we came here today. It really all started back in 2010, as we reflect back and think about the

Affordable Care Act, the thought of decreasing governmental payments, focusing on value, lower cost, but high-quality care.

I'd like to walk you through the story of how we got here. What I would ask is that you take slides seven, eight and nine and put them side-by-side in front of you. That may make it easier for me to explain to all of you. Thank you.

So I started as CEO in December of 2004 and began the leadership of ECHN then. Back in the earlier days, about 11 years ago, you can see how the organization was performing.

It began to find its way in the 2008/2009 time frame. At that same time, if you remember, there was a significant issue with pensions, as it relates to WorldCom and Enron, and organizations not being able to fund their pensions, therefore, the PBGC had to pick up their pensions.

What happened then was the Pension Protection Act went into play, and that Pension Protection Act took the actuarial projections from a 21-year look forward down to a seven-year look forward.

Because of that, the pension liabilities for all organizations grew significantly. To make

matters worse, the market crashed. We all remember 2008 and 2009.

Even though ECHN froze their pension, we now had a pension liability, a pension payment annually that went from zero dollars, because the pension used to fund itself through the market performance, to a total of $12 million per year we had to pay into our pension.

Our pension, because of the market crash, grew significantly. If you follow our debt throughout the years, you can see that we controlled our debt. There was no way for us to take on much more debt, except back in 2009, where we had to invest about $9 million into a new critical care unit at Manchester Memorial Hospital, because of the need of our patients.

On top of all of that, as we're going through this difficulty right now, about $12 million went to the pension, about $12 million went to our debt, so the first $24 million went out the door to pay liabilities. What that left was very little to invest back into the organization.

If you look at the next page, on page eight, you'll see that, at the exact same time, later on in the years, in '14, '15 and '16, the federal government and the state government began imposing certain

reductions in reimbursement and imposing a hospital tax.

The hospital tax began earlier, but, in 2014, it was about $4 million, and, if you all remember, the federal government could not agree on a budget, so there was a two percent cut across the board, called sequestration. That affected us to the tune of $2.2 million per year.

In fiscal year ’16, this year, the Connecticut hospital tax imposed on our organization is nearly $10 million.

Most recently, and you may want to add this to the 9.942, the additional $4.6 million that was promised to our organization by the state government was held back, due to the state’s budget woes, so that $9.9 million jumped an additional $4.6 million.

I would ask you now to reflect back to page seven, please. You look at page seven, you can see that the organization can no longer perform at a positive cash flow or at a profit.

It has to take all of these reductions. You add up about $25.1 million in reductions in reimbursement or tax, and you add that to the current organization, so then you must wonder why how did you get at least the $2.2 million or a loss of only $.3 million?

Well there are only two ways to get to that. One way is to reduce labor. Labor is 60 percent of our operating costs. We reduced approximately 200 FTEs over the past two years, because of these reductions.

And if you go to page nine, there's the other side of the ledger. You look at the organization, and how do you reinvest in the organization if you don't have any money? Well you don't. You can't fund your depreciation, so what happens then?

The age of your plan continues to age. Facilities begin to breakdown, equipment begins to breakdown, and, as Dr. O'Neill mentioned, we're talking about 100-year-old buildings.

Our average age of our plant, as it's measured nationally, is 21 years old. The national average for the age of a plant is 10 years old. We are twice that age.

If you flip to the next page, please, and I'll wrap this up, we are looking at not only these forces, but the continued negative forces into the future; continued erosion from the federal government, declining levels in payment from the state government, payment reforms that include financial risk, these

continued pension obligations that just won't go away, the state of Connecticut is struggling with that right now themselves, all of you, and the continued rising costs. We have to pay our employees. We have to pay for supplies and increases. Cost of living continues to go up.

I can't express enough the dire situation we are in at this point in time. Next page, please.

Let me briefly explain the proposed transaction. What this transaction will do for us it will satisfy our debt and our pension liabilities.

ECHN will have a fresh start. There will be no debt. The pension liabilities will be satisfied by Prospect Medical. Not only that, $75 million in capital will be reinvested in the health network, and what I mean by the health network is what Dr. O'Neill mentioned.

Not only the two hospitals, or long-term care facility, or VNHSC, but into the communities, whether it's additional services, additional physicians, specialists that we currently don't have.

We will continue to have the ECH brand and mission. There will be an Advisory Board, and we will employ all physicians, all employment, all employees. Excuse me.

And my last slide. One of the reasons why we chose Prospect, and as Dr. O'Neill mentioned, is because they know how to survive and thrive in risk-based markets. They've done it in California. You're going to hear a lot more about that as we go forward, but another reason why we wanted to step into the for-profit arena is this.

For-profits can go to the equity markets to raise capital. Not-for-profits can't. Many of the not-for-profits in Connecticut that are interested or were interested in us are cash poor. They cannot come forward. Adding our woes onto their woes is just a recipe in failure.

Thank you. I'll now pass this over to Joy Dorin, Vice Chair of the Board of Trustees.

MS. DORIN: Can you hear me? Okay. Louder? Can you hear me now?

MR. ZINN ROWTHORN: In the back, can you hear the speakers? Thank you.

MS. DORIN: Great. Thank you and good afternoon. My name is Joy Dorin, and I adopt my pre-filed testimony.

I've been a member of the ECHN Board of Trustees since 2004 and currently serve as the Vice Chair

and Chair of the Transaction Committee.

In my professional life, I've held positions in health care organizations, including Cigna Health Plan, Athena Health Care and Qualidigm, the state's quality improvement organization that works with the Centers for Medicare and Medicaid.

Throughout my career, I've been involved in and responsible for quality, patient satisfaction and compliance matters across the health care continuum.

In addition to my professional background, I'm a longtime resident of Manchester, nearly 40 years. While I was born and raised in New Jersey, I consider Manchester my home.

This is where my friends live, my son and his young family live, and my husband owns a small business on Main Street.

I mentioned my Manchester roots, because insuring ECHN's future is important to me, and it's important to every other individual and family, who lives east of the river.

In evaluating our options, we established four goals, that high-quality health care services are accessible, affordable and delivered safely to the people in this part of Connecticut, that clinical services are

expanded, that employees continue to have jobs, and facilities and technology are upgraded.

Dr. O'Neill talked about the importance of preserving ECHN to serve the public need, and Mr. Karl covered the financial challenges and how the Prospect transaction will allow ECHN to meet these challenges.

I'd like to spend the next few minutes focusing on the importance of quality and safety. We are proud of the efforts our staff and physicians have taken.

Of note, ECHN was one of the first networks in Connecticut to become a high-reliability organization.

This decision and journey has changed our culture to the benefit of our patients. It has resulted in process improvements and a reduction in serious safety events.

Our focus on quality has resulted in the Joint Commission recognizing our two hospitals as top performers.

At Manchester Memorial Hospital, we were recognized for heart failure, pneumonia, surgical care, immunization and perinatal care, and, at Rockville Hospital, for pneumonia, surgical care and immunization.

Because of these accomplishments, it was

important that our potential acquirer share our commitment to quality and safety.

As part of our initial due diligence, ECHN requested quality information from all potential acquirers and did a side-by-side comparison of the CMS quality indicators.

We also visited hospitals owned by the potential acquirers and met with staff members involved in quality and performance improvement.

More specifically, visits were made to Prospect hospitals in California and in Rhode Island to obtain additional firsthand information.

When ECHN learned of the immediate jeopardy determinations identified at the Los Angeles Community Hospital and the Southern California hospitals, the Board determined that it needed more information and appointed a quality evaluation team to research and report back to the Transaction Committee and the full Board.

I was appointed to this team, along with Dr. Michelle Conlin, the Chair of the Performance Assessment and Improvement Committee and a practicing physician, and three members of ECHN’s Quality Department, the Vice President of Quality and Safety and

two Quality Improvement Managers.

The team was charged with determining whether Prospect's experiences in California could threaten or diminish ECHN's current quality and safety standards and its ongoing performance improvement initiatives.

To complete our charge, the team first focused on the immediate jeopardy issues and deficiencies and Prospect's plans for correction.

The team found the remediation plans to be comprehensive and appropriate, and, in several minutes, a representative from Prospect will provide more information, the root causes and the corrective action plans.

The evaluation team, however, didn't stop here. We decided to go broader and deeper, and, over the last four and a half weeks, requested, received and reviewed extensive amounts of information from Prospect about its hospitals in California, Texas and Rhode Island.

This information included past regulatory surveys, remediation plans and year-over-year quality metrics. The quality reviewers focused, in particular, on the most recent surveys, as they would be most likely

to reveal any issues or patterns of concern with how Prospect currently conducts its hospital business.

The team also looked retrospectively at quality assessment and performance improvement indicators and prospectively at the 2016 Quality Assessment and Performance Improvement Plans.

Additionally, we reviewed employee turnover statistics and, in a parallel activity, collected and discussed updated financial information.

Given that regulatory standards are applied differently among regions, the evaluation team paid special attention to Prospect’s CharterCARE hospitals in Rhode Island.

The evaluation team sent its Quality Department team members to those hospitals for a day-long visit to observe and evaluate all aspects of the quality and safety programs in person.

The ECHN reviewers found not only that the programs were of high quality, but they had been enhanced, rather than scaled back, after Prospect’s acquisition.

Throughout this review, Prospect made its information and personnel fully available to assist us. As we discussed their plans and approach to quality,

Prospect was asked specifically whether or not they expected to receive any additional survey deficiencies.

Prospect responded that, while immediate jeopardy findings were not expected, because of the new quality controls, structure and processes it had implemented, it was likely that additional deficiencies would be noted in resurveys. This, in fact, did happen.

In the March 23rd CMS response to the Los Angeles Community Hospital resurvey, the hospital was cited for deficiencies in infection control and nursing services.

Prospect communicated this to us on the same day they were notified, and we have since had several follow-up communications with them about these results.

Quality improvement, by definition, is a continuous process. We all know hospitals are complex regulated organizations with many moving parts, and sometimes, despite the best intentions and focus on care, issues do arise.

After the review just outlined, the evaluation team concluded the immediate jeopardy issues were isolated, that Prospect took the California survey results seriously and responded swiftly with corrective

action plans.

The team also collaborated with the Transaction Committee and ECHN Council to evaluate Prospect's continued appropriateness as a transaction partner. The Transaction Committee recommended that ECHN seek a quality commitment letter to ensure ECHN's patient quality, patient experience and safety programs retain their forward momentum for a period of time post-closing.

Prospect has agreed to execute such a letter, which also contains a provision for ECHN to benefit from the quality improvement programs observed at the CharterCARE hospitals.

Based on the findings presented by the evaluation team and the protections gained under the quality commitment letter, the Transaction Committee recommended and the Board confirmed ECHN's commitment to proceed with the transaction.

Prospect's business model depends on significant local oversight for operations, including quality and safety. This means the current ECHN quality team will continue its good work in eastern Connecticut.

In summary, in addition, it is anticipated that Prospect's eastern region, which includes Prospect's hospitals in Connecticut and Rhode Island, will

collaborate on quality and safety measures that are expected to be implemented in Prospect's hospitals across the country.

ECHN looks forward to this collaboration. Thank you very much.

DR. O'NEILL: Thank you, Joy. That concludes ECHN's comments. Next, I'd like to pass the microphone to Mitchell Lew, who is the President and Chief Executive Officer of Prospect Medical Holdings.

MS. MATTHEWS: Before Mitchell talks, if we can just make one clarification point? I know Joy mentioned that the quality commitment letter PMH had agreed to sign it. That is the letter that we have. It has now been executed and signed, and it's been submitted.

MR. ZINN ROWTHORN: Can I ask by way of one clarification? That letter, does it have a duration? Do the commitments in that letter have a duration?

MS. DORIN: Two years.

HEARING OFFICER HANSTED: Can you just speak into the microphone? Thank you.

MS. DORIN: Two years.

MR. ZINN ROWTHORN: I don't want to get ahead of anybody's presentation, and feel free to tell me

that I'm about to hear the answer to this in one of the presentations we're going to hear, but, from a structural perspective, to the extent there were personnel, who were identifiable for quality control in Prospect in those California hospitals that had the immediate jeopardies, what role will those individuals have with respect to quality control in the ECHN system going forward?

MR. CROCKETT: This is Von Crockett. Actually, none of those individuals will have a role, and, during my testimony, I'll go through the structure that we will have for the eastern region new individuals.

MR. ZINN ROWTHORN: Okay. We'll look forward to hearing that. Thank you.

DR. LEW: Good afternoon. My name is Dr. Mitchell Lew. I'm President of Prospect Medical Holdings, PMH. I adopt my pre-filed testimony.

I appreciate the opportunity to speak today in support of the conversion application regarding the proposed acquisition of assets of Eastern Connecticut Health Network, including Manchester Memorial Hospital and Rockville General Hospital by PMH.

I'd like to begin by reintroducing the PMH representatives here with me, so that they can adopt their pre-filed testimony.

First is John Spees. John is Vice President of Mergers and Acquisitions at PMH. John will discuss the transaction, as well as certain aspects of PMH's operations. John?

MR. SPEES: I'm Jonathan Spees, and I adopt my pre-filed testimony.

DR. LEW: Next, I would like to introduce Steve Aleman, who is the Chief Financial Officer of PMH. Steve will be available to answer any questions related to the financial operations of PMH.

MR. ALEMAN: I'm Steve Aleman, and I adopt my pre-filed testimony. Thank you.

DR. LEW: Von Crockett, Von is the Senior Vice President of Corporate Development at PMH. Von will discuss the health care quality matters at the various PMH hospitals and be available to answer questions related to our quality programs. Von?

MR. CROCKETT: Von Crockett, and I adopt my pre-filed testimony.

DR. LEW: In addition, we have Tom Reardon. Tom is President of Prospect East and has been working closely with ECHN from the start of the process, and Tom will speak later in our presentation.

So let's go to the first slide. ECHN and

Prospect, committed to this community. Who is Prospect? We are a health care services company, and we operate local community hospitals, local governance, local physician leadership.

We invest in our hospitals and in our communities. For example, in Rhode Island, we're just finishing up a beautification project, rebuilding the entrance of the hospital. We've enhanced the GI lab, and we're looking to hopefully build a heart lab, also.

We've opened two hospitals in California recently in areas that needed them, specifically, in Bellflower, a psychiatric hospital, and in Orange County a new medical surgical hospital.

And, so, the stability that we do bring to communities are continued employment and creation of new jobs. We also believe in expansion of programs and services to improve access and quality.

For example, in Texas, we built a brand new emergency room at the Nix Health System. We've opened several urgent cares in Rhode Island and the surrounding communities, and, in California, we've opened a lot of urgent cares and, also, wellness clinics, again, to promote access and for convenience for the population.

A little bit about our hospitals. We have

14 community hospitals. Seven are in California, four in Texas, which we've owned for about four years, and two in Rhode Island, which we've owned for roughly two years, and then recently opened or acquired a hospital in New Jersey.

We serve many different communities. In fact, many of the hospitals that we operate are in underserved communities, and we take all types of health insurance. To us, a patient is a patient.

We provide medical, surgical, in some cases tertiary, psychiatric and long-term care services. We have a lot of experience in proving multiple services across our hospitals.

We have over 40 outpatient clinics and centers in our model. Not all of the care is delivered in the hospital. A lot of the care is delivered on an outpatient setting, because we want to be very cost effective.

We don't just own and operate hospitals. We also have a lot of experience at operating and managing medical groups. We've been doing this for many years, and you can think of our model as a multi-specialty health care provider without walls.

They are structured in what we call

Independent Practice Associations, called IPAs, where these are networks of doctors that are working to coordinate care together.

And the beauty of this model is that physicians can remain independent, if that's what their wishes are, or they can be employed. Our IPA model can utilize both, depending on what the doctor wants.

We've been doing this in Southern California for over 20 years. We have quite a presence in Southern California. We've also been growing our physician networks in Texas.

We have over 500 doctors in our network. In Providence, Rhode Island, we have over 350 physicians, and, in New Jersey already, we have 125 physicians.

As I stated earlier, we contract with all major health plans. We have nearly 9,000 physicians in all of our networks taking care of nearly 300,000 patients, and we provide coordination of care across the entire continuum.

And, so, what that means is whether a patient is at home, in a hospital, a skilled nursing facility, clinic, or physician office, we follow their care throughout.

Our goal is to have better outcomes and

high patient satisfaction, so that patients can tell their family and friends come get your care here at ECHN.

As a result of our company's experience of owning and operating hospitals and managing physician groups, we have developed what we think is a very unique model of care, a very unique delivery model, which we call Coordinated Regional Care, or CRC.

Coordinated Regional Care is where we integrate hospitals and physicians and other providers in the community. For example, the local home health company, the local palliative company, the local DME, Durable Medical Equipment company, and they work very closely, we work very closely with the health plans, the payers and the government, because we want to achieve improved patient care and high patient satisfaction.

And this model we've implemented already successfully in seven regions in California, Texas and Rhode Island and currently in development in New Jersey, already here in Connecticut, and soon to be in Pennsylvania.

So you've heard this buzz word, population health management. Let me just put this in simple terms for those, who are not in health care.

We care about the health of everybody in

the community. That matters to us, and we have the experience to ensure that everybody will get good health care.

We have a unique model, which provides higher value, and, so, you can achieve better care, and it doesn't have to necessarily cost more.

So how do we do this? What is our secret to improving care and outcomes? Well it really revolves around patient-centered, yet physician-led approach.

We have multi-disciplinary care teams that take care of our sickest patients, they're available 24/7, teams of providers, such as nurse practitioners, pharmacists, social workers, that are available to be called by these sickest patients that we use data to stratify, to identify who those patients are, and we engage the family, we engage the patient.

We have a homebound program, so we will go to the patient's home if we need to. We have disease-specific care plans to take care of conditions, such as diabetes or heart disease, and we also integrate behavioral health, because behavioral health exists in all populations, and some patients have what we call comorbidities.

They have medical problems, they have

behavioral health problems, and if you can take good care of and address the behavioral health needs, that sometimes is the key to taking care of the medical needs, and that is something that we're working to perfect, is to integrate the two.

We utilize quality care coordinators, which call patients to remind them to go see their doctor, to remind them to get their blood test or have their screening tools.

And, again, we follow patients, hospital, skilled nursing, long-term care, again, across the continuum, and it's a physician-led network.

And, so, we absolutely have a commitment to quality, and, certainly, in our medical groups, quality is not just a word that we throw around. We've actually achieved the highest level of quality.

A very respected trade association, called the California Association of Physician Groups, the largest in the country, has recognized us at the highest level, achieving elite status four years in a row.

Another respected association, IHA, has recognized us for our clinical quality. We've received awards from the Department of Managed Health Care in California, specifically, cardiovascular disease,

cholesterol control and diabetes, and these are some of the disease-specific care plans that I spoke to on the prior slide.

We've achieved four to five STAR out of a possible five star on our Medicare Health Plan Quality and Performance Ratings.

I'm going to turn it over to Von.

MR. CROCKETT: While we're very proud of some of the quality achievements that we've done, I think it's also important for us to pause for just a moment to talk about some of the mistakes we've made, and, specifically, what were the causes of those mistakes? What corrective actions have we taken, and what have we learned, in terms of how to make us a better organization going forward?

Specifically, as you're aware, quality is something that's being assessed on a daily basis, and it is through one of those assessments by our regulatory agencies in California that it was identified that within two of our 13 hospitals in California that two of the facilities had a deficiency, specifically as it related to what's called the CMS Medicare Conditions of Participation.

Specifically with that, there were

violations with what's called immediate jeopardy. Specifically, those immediate jeopardy violations were in one facility. We had an allegation of physician misconduct and then the organization's response associated with that, and then, in another facility, we had immediate jeopardy associated with temperature and humidity, specifically in the OR suites, and then, third, the washing of sterilization of surgical instruments.

I wanted to spend just a second to talk about the root cause associated, and in any event, where there's a breakdown in process or failure, it's not usually just one event.

Specifically, as it's been discussed beforehand, we take great pride in making sure that each of our hospitals have strong local leadership, and, with that, we have delegated the quality programs at an individual level down at the hospital level, and it was being managed and run at the hospital level.

Within both of these facilities, part of the issue that we had was that we had turnover at the executive ranks, as well as within some of the department managers.

When there was a patient complaint made and CMS came in to do the survey, not only did they find

that in some instances were that the care that was being provided was not consistent with the policies that we had in place, care was somewhat inconsistent.

Additionally, when they reviewed the quality program, what they found was a rigid program, where the organization had adopted previously and modified to the issues that were at hand.

At the one facility that had the issues with the temperature and humidity and the washing of sterilization, previously in the year there had been, as we were doing construction within the building, there had been an event, where there had been a small localized fire from a contractor up on the roof, which caused substantial issues with our HVAC system.

That, in itself, is not the issue. The issue was was that our response associated with that was not sufficient to address the needs in resolving the issue.

And when CMS came in, they found that the response should have been a stronger response in making sure that the issues are addressed.

When we look back at the root cause associated with it, there are several issues with that. The first of them is is that, as we had delegated the

role of quality and the responses to the local leadership, there could have been a stronger response from Prospect Medical in making sure that as organization -- that these two organizations had when they had the turnover that they had, that the appropriate resources were provided to them at an executive level, as well as, also, at the director level in resolving these very specific -- in these very specific complaints.

Once the deficiencies were identified by CMS, and I wanted to point out one point, which is that, on the immediate jeopardies that we got for all three, it wasn't -- there was no patient harm that was actually dealt with, but it was more of an issue that the care that was being provided did not meet the conditions of participation, and it wasn't also consistent with our policies of what we had in place.

As soon as we had been notified by CMS, we took immediate action to making sure that the issues were resolved there, as well as developing a corrective plan for any of the other issues that they identified, in addition to the immediate jeopardy.

We have previously disclosed these deficiencies in detail to ECHN, as well as the Attorney General's Office and OHCA, previously to today's

testimony.

As part of that, we have discussed extensively with ECHN and our quality counterparts to review our corrective action plans to making sure that they were appropriate and detailed.

At a more detailed level, when we talk about the corrective actions, the first thing that we did was we engaged a nationally-recognized consulting firm, and the purpose of them was to do two things.

One of them is to come and look at the quality plans that were in place at both of these organizations and making them to be an organic and a responsive quality plan to not only address the issues at hand, but to make sure that the quality plan would be responsive for any future issues that would arise within the organization.

Secondly, we have provided additional resources at the local level of the hospitals by adding strong and experienced leaders, as well as additional capital resources at the facility to making sure that the issues are addressed.

At a corporate level, we have modified our quality program by having additional oversight, not just for these two facilities, but it will be for all

facilities within Prospect.

The new oversight is going to consist of we've got four individuals that are already in place. One of them is a Chief Quality Officer, a Chief Clinical Officer, a Corporate Chief Nursing Officer, and an Associate Vice President of Regulatory and Patient Safety.

The roles of these four individuals is, first of all, is to monitor the quality programs at all hospitals, and the point being there is making sure that, A, that they're on track and that they're responsive to the issues that are being addressed in the organization and that they're timely.

Secondarily is to provide additional resources, if needed, to implement the program, so in the event that a hospital is lacking the resources, they can provide resources or identify what resources need to be provided.

The third is making sure that, when the quality goals are not being achieved within the organization, is to help the organization to take corrective actions in a timely fashion.

Going forward, one of the big things that we anticipate happening is, instead of being reactive, we

want to be proactive, and, to do that, we're going to be looking to have the facilities be survey ready for both the accrediting agencies, as well as the Department of Health.

And then, lastly, the corporate oversight will assist in sharing the best practices among the various hospitals, and what we found is that, as we've got multiple hospitals that have done very well in multiple areas, is to bring those strengths and weaknesses across the entire organization, so that we have an organization that's stronger within the whole.

Lastly, our Quality Assurance and Performance Improvement Plan is being revamped by a national consulting firm, and, with that, we believe it is going to be a much stronger program for all.

One of the things that was important when we looked at the transaction, specifically for ECHN, was that they had a very strong quality program to begin with, and they have achieved some great results, and it was important for us, as well as for them, that they know that we are going to continue on with their quality program, and our role in the oversight of it is to provide additional resources, if needed, the sharing of best practices among the various hospitals, and to

provide them resources that they may be lacking in any of the specific areas.

With that, ECHN is already -- is well on the way for the high reliability organization, and that's something that not only do we support, but we've started the process in Rhode Island, and we look to roll that out actually in our California hospitals, as well, going forward.

We continue to work on the issues that were raised by CMS, and we are confident that the corrections that we have put into place not only will be satisfactory, but that will be shortly corrected.

And with these changes, the organization is going to be a much stronger organization as a result of that, not only for Prospect, but, also, in combination with ECHN.

Switching gears now for just a second, I want to spend just a few moments on slide 10, and when you look at what we hope to achieve in ECHN, it's important to take a look at what has been achieved in the past year in Rhode Island, and what exactly has Prospect brought to the organization?

First of all, probably the most substantial is that, as we've looked at the organization

and the affiliation of the physicians, is that we have formed a multi-specialty IPA that's now over 100-plus primary care physicians.

Part of that was through the employment of physicians, and part of that was through bringing additional independent physicians into the organization.

We've expanded outpatient services within the area, which includes an investment in an outpatient oncology center, and this was all done as a result of providing additional significant capital to them.

The capital is partly being spent on infrastructure needs and deferred maintenance, and the other part of it is being through the development of our relationship with the physicians.

All this is leading up to one of the issues that's facing Rhode Island most substantially, is they're a Medicaid expansion state, like Connecticut, and, as such, their state budget is under substantial pressure in adding on the fee for service Medicaid population with that, as we've worked with the legislation and we're implementing a Medicaid value-based pilot program, in terms of the managing of the Medicaid lives that will hopefully be a solution for the state of Rhode Island.

When we looked at expansion to the east, we looked at several factors that we felt would be important of making sure that our model is going to be one that could be easily adopted and appropriate, and, with that, we looked at Connecticut, specifically, and there are specific things that are attractive for what we believe our model in Connecticut.

With that is a state that, first of all, is a Medicaid expansion state, and, with that, we believe that there’s going to be a need for organizations to have relationships with both the health plan and the physicians that are non-adversarial and, instead, are working for the better of the patient in providing care and the outcomes associated with that.

And, lastly, a state that is able to deal with the changing landscape from both a regulatory perspective, as well as a leadership perspective, as we go through those changes.

What will this lead to? It will lead to an organization, where, instead of having adversarial relationships that normally have existed traditionally in health care, pitting players against players, health plans and hospital and physicians, all working together, in terms of providing better care to the patient.

With that, we believe the patient will have higher satisfaction. We believe that this is going to allow, then, for greater access for capital for ECHN, and, lastly, a sustainable model for health care that will allow for these two community-based hospitals to continue on.

MR. ZINN ROWTHORN: Before we switch gears, thank you, Mr. Crockett, for that, it would be helpful, I know you have submitted some information relating to the immediate jeopardy findings, it would be helpful at some point to have a summary of the status of those matters, whether additional findings have been made, the time frame for resolution, where you are in that process.

For my sake, at least, and perhaps for others, it would be helpful to have a sense of perspective about what those kinds of findings and that process mean to a hospital, whether this is a unique experience for the Prospect medical system.

I'm interested, also, to hear from ECHN about its views about helping us put that process into context, so we'll take that now or whenever, but, while we're here today, it would be helpful to hear about that.

MR. CROCKETT: Let me start off with the

status and the timing. There's two, the two facilities have got the two different immediate jeopardies, and, so, it needs to be separated, because they're on a separate track from a timing and a resolution.

The first hospital is LA Community Hospital, and it had to originally start off with the allegation of physician misconduct.

There was a -- we had put together our plan of correction, and that plan of correction had been submitted back in late January, and, with that, we were resurveyed by the Department of Health, CMS, in the middle of February.

When they came out to do the resurvey, there were, I believe, approximately five or six deficiencies that were in the original report, including the immediate jeopardy, and the issues that were identified in the original report were mostly found to be in compliance, with the exception of two, and those two were nursing care and infection control.

Specifically, on the infection control, there was an issue, as related to the location of how the instruments were being -- where they were being sterilized, and there was a recommendation by one of the surveyors to move the location of the sterilization of

the instruments, as well as what's called our utility rooms, clean and dirty rooms.

As it relates to the issues of patient care, there were several findings associated with it, and, once again, it was an issue of being inconsistent with our policies that had been put into place.

Specifically, there's what's called a plan of care, and it's kind of like the roadmap nursing has for when a patient comes in, in terms of what they hope to achieve with the patient and what the goals of them are, and what they found was is that the plan of cares were inconsistent on a documentation basis associated with that.

The plan of correction from the resurvey is due on April the 7th. We believe we'll either -- we'll have it in by then or before then. Once the plan of correction is ready to be submitted back to CMS, we will be providing that additional response to the regulatory agencies, as well as ECHN, and, so, I anticipate that will be later next week that we'll have that.

With that, we anticipate CMS to be out shortly after that, and, currently, we've been extended, in terms of from a timeline, and it's now the first part

of June, in terms of from the track that we're on with CMS.

MR. ZINN ROWTHORN: Okay, so, by way of clarification, so participation in the program will be terminated by the first part of June, unless there is a resolution before then to CMS's satisfaction?

MR. CROCKETT: Correct.

MR. ZINN ROWTHORN: Okay.

MR. CROCKETT: Originally, it was April 13th, and they have now extended it to the first part of June.

For the Southern California Hospital, we have, from the report that was previously given that was the immediate -- well, there's two immediate jeopardies. One had to do with the temperature and the humidity, specifically in the surgical suite, as well as in the cath lab, and the second one had to do with the washing of sterilization of surgical instruments.

From when CMS is out there, when they give out an immediate jeopardy, they actually don't leave the facility until it's abated during the survey process, and what they look for when you put together your plan of correction is making sure that not only was it abated, but there's a process to continually monitor it, and that

it doesn't reoccur and go forward, and, so, as part of our plan of correction, it was making sure that whatever policies and processes were put into place is to make sure that they weren't to reoccur.

That plan of correction was submitted, and it was submitted last week, and we have actually provided a copy of that submission to the regulatory agencies, as well as to ECHN, and each of you should have that.

It's detailed and very thorough and was put together in conjunction and help with our national -- with our consulting firm to making sure that the response was appropriate and met Medicare's expectations with that.

We expect for them to be on site. Currently, the track that that is on, as it relates to meeting the Medicare conditions of participation, I believe it's May 23rd, and, with that, we anticipate, now that we have submitted the plan of correction, that they will be on site shortly to look at our plan and making sure that the corrections that have been put into place were appropriate.

MR. KARL: Mr. Zinn Rowthorn, there's two points that I'd like to make. One is the seriousness of these events were put in a timeline document from the day

we found out through the day that we felt as though all the answers were brought to us satisfactorily, and we'd probably like to add that as Late File No. 1, so you can see the intensity of this.

Number two, I would like to bring forward Linda Quirici, who is the Vice President of Quality Care for ECHN, just to give an update on what we've done and what we've found.

MR. ZINN ROWTHORN: We'll be happy to take that late file, and I'll request that other documents submitted to CMS or received from CMS while our review is pending we'd appreciate a copy of those being submitted.

I'm happy, also, to hear from Ms. Quirici. She should be sworn, I think, if she hasn't already.

MS. LINDA QUIRICI: Good afternoon. My name is Linda Quirici. I am the Vice President of Quality and Safety for Eastern Connecticut Health Network.

HEARING OFFICER HANSTED: Could you just speak into the microphone?

MS. QUIRICI: Sure.

HEARING OFFICER HANSTED: Thank you.

MS. QUIRICI: Okay, is that better?

HEARING OFFICER HANSTED: That's better.

MS. QUIRICI: Okay, so, the Quality Department was brought in on February 24th, told that they meted jeopardies and of the need to review to give our opinion on the quality process in the California hospitals and the Rhode Island hospitals, so we were very involved in reviewing all of the records.

So, initially, they were the immediate jeopardies that Von talked about, and the initial one was the physician misconduct, and that was already a plan of action was in place, that was already taken care of, and that plan of action was put in place, and the response to that we just got, and he spoke about that, so we reviewed that in detail, as a matter of fact, this weekend.

We looked at all of the elements of that again. He mentioned several things that were still involved in the conditions of participation.

When I reviewed that, really most of the areas were deficiencies that might be seen in any hospital, truthfully, and they are developing now their plan of correction for those deficiencies.

The other immediate jeopardies that Von talked about were in the Southern California hospitals. We reviewed those in detail, as well, and we reviewed their other areas that needed to have review.

We also just got their plan of correction, which we reviewed in detail. It is very comprehensive, as they stated. They had a consulting company that came in, as well as legal assistance, to make sure that their plan was comprehensive and thorough, and it was, and I believe they have submitted that, so we reviewed that in detail, as well.

So that was submitted, and, when that comes back, the findings, we will also review that to make sure that things are comprehensive and that there is nothing still outstanding, so that was reviewed by myself and two quality experts that are experts in the areas of the immediate jeopardy, which were the physician, which were infection control and environment of care safety, so we made sure that we brought in our experts to review all of that thoroughly.

MR. ZINN ROWTHORN: Thank you. And has either ECHN hospital ever received an immediate jeopardy notice?

MS. QUIRICI: Not in my tenure. And something important to notice is that 25 percent of hospitals in California receive immediate jeopardy findings, but, in Connecticut, immediate jeopardies are very rare.

So the hospital practices -- you know, hospitals differ a little bit from one coast to the other. Again, we went to Rhode Island to see something that's analogous, and our practices are analogous, and, in California hospitals, you know, function a little bit differently, as well as their regulatory agencies function a little bit differently.

As a matter of fact, you know, quite differently, to be honest with you, so the differences, as far as having an immediate jeopardy, is much more likely if you're in California than if you were in our areas.

MR. ZINN ROWTHORN: Were these the first immediate jeopardies received by any Prospect hospitals?

MR. CROCKETT: No. There was an immediate jeopardy in 2013, if I'm not mistaken, and, getting back to the California legislative process, the oversight is a little bit different, but, at one of our hospitals, we received a retroactive immediate jeopardy from three years previously, and it had to do with -- it's just a different process in California, so it's not the first.

As she stated previously from a context perspective, within California, you know, one out of four hospitals either has received or is receiving an

immediate jeopardy, and, from a context perspective, it's all sorts of hospitals, everything from community-based hospitals to very well-regarded academic centers, UCLA for one, and then, you know, out on the east coast, Cleveland Clinic was in a process, where they had an extended period of time, where they had to deal with an issue.

This is something, obviously, we take extremely serious, and we have put forth the resources, additional resources to resolve it, not just to resolve this issue, but to put in process to making sure that we don't get into this situation again.

MR. ZINN ROWTHORN: I'll ask one more. I know Attorney Salton has a question. And I know this is not what anybody at that table expects, but I assume that, if, in fact, CMS participation was terminated, that that would have a material impact on at least those hospitals and maybe Prospect's financial condition generally. Am I right to make that assumption?

MR. CROCKETT: I think it would be right to say on any hospital that that would have an impact on it, not just Prospect, but any hospital.

It's rare that it happens, and this is really -- from a process perspective, CMS doesn't have

any way of doing what's called administrative penalties, so their only process of making sure that hospitals comply with the Medicare conditions of participation is it's all or nothing, and, so, from an all or nothing approach, is that when hospitals don't apply, then they issue what's called a termination track, in order to get hospitals back on track.

When you look at hospitals that haven't been able to resolve the issues, it's usually one of two reasons.

One is usually because they're in a process of going through a bankruptcy and actually don't have the resources, in order to resolve the issues that have been addressed, or, two, that they don't actually have the ability, and, so, it's very rare to actually see a termination, and we have 100 percent confidence that we will be able to resolve these issues.

MR. ZINN ROWTHORN: I gather that the quality issues identified by CMS are localized in two facilities, but the way the licenses are structured in California, that the immediate jeopardy is directed at six hospitals. Am I correct about that?

MR. CROCKETT: That is correct. So the license structure is that we have a consolidated license

for each of the two licenses in question, and there's three hospitals within each license, and there's a license process that what you have stated is accurate.

MR. ZINN ROWTHORN: Can you talk, and, again, I know this is not your expectation, as you just said, but can you talk about Prospect's ability to consummate this transaction financially, if, in fact, those immediate jeopardies were effectuated, given how this transaction is intended to be financed?

MR. ALEMAN: We could absolutely finalize this transaction. We're not looking for financing for this transaction and certainly carry through with the commitments as part of this transaction, including capital investments and so forth.

MR. ZINN ROWTHORN: Thank you.

MR. HENRY SALTON: If I could ask, being familiar with the findings in the two immediate jeopardies and in the continued finding of March 23rd of the immediate jeopardy and being familiar with the regional oversight by regulators here, would you be surprised that a regulator in this region would reach a conclusion of immediate jeopardy, based on these same findings?

MS. QUIRICI: I think so. I think so. I

think, again, we saw things that commonly we see in our surveys, so they were nothing that stood out that would be unusual, so I think that an immediate jeopardy related to most of the things that we saw would not have occurred here, and I haven't, again, seen that in my tenure.

MR. SALTON: And you're familiar, I think, I would assume, with the quality programs that are being done in ECHN, which now we understand are going to continue by the seller on a going-forward basis?

MS. QUIRICI: Yes.

MR. SALTON: For at least two years?

MS. QUIRICI: Yes.

MR. SALTON: Would you expect that the quality improvement programs that you have adopted would have prevented or greatly lessened the likelihood of these kind of violations at your two hospitals?

MS. QUIRICI: I think that we have a very strong quality program and a very strong regulatory program, so, again, I saw very similar things in the Rhode Island hospital when we went and visited, so whether they would help in California, is that what you're asking me?

MR. SALTON: Well I'm really trying to anticipate whether or not, and I think that Prospect has

acknowledged that the Los Angeles hospitals needed to upgrade their quality improvement programming and planning, I'm trying to say to you could we anticipate that this is a meaningful remedy, the continuation of the ECHN quality improvement programs, that it would most likely preclude or lessen the likelihood of these violations happening in our hospitals.

MS. QUIRICI: Absolutely. Absolutely. And we are very strong in survey readiness, so that, in and of itself, would preclude these things from happening here and have precluded them from happening here.

MR. SALTON: And let me ask just one final question.

MS. QUIRICI: Sure.

MR. SALTON: We're glad to hear whatever you have to say. In the March 23rd finding, where there were continued findings of problems with infection control, nursing services, I think patient rights, they had been identified in a prior survey.

Is your hospital's experience that you would have, is it common or rare, that you'd have a continued finding on a resurvey of the same types of non-compliance and conditions of participation that were identified in an earlier CMS survey?

MS. QUIRICI: In Connecticut, I have heard that hospitals have that happen, sometimes once or twice. It hasn't happened in my tenure that I've had that, and I have heard that in other hospitals. Sometimes, they are resurveyed several times if that is not corrected.

MR. SALTON: In the context of immediate jeopardy?

MS. QUIRICI: No. I don't know about that. I don't personally know about that, but as far as conditions of participation.

MR. SALTON: Okay, thank you.

MS. QUIRICI: Okay.

MR. ZINN ROWTHORN: And, to clarify, and then perhaps we can get off this topic and move on for the moment, but when you talk about differences between the regulatory environment in Connecticut versus California, you are talking about the same regulator and the same regulations, but talking about different regional applications?

MS. QUIRICI: That's absolutely right, yes. Different methodologies. There is a difference between the two, as far as how they function and how they run, so, yes, there are.

Again, I'm much more familiar with this

area of the country.

MR. ZINN ROWTHORN: Understood. Thank you. And I'll just highlight, bookmark. We heard that a concern in California was that there was perhaps too much localized control over quality, and there's now a commitment to backstop local hospital quality control.

We've also heard that there's a commitment to retaining ECHN's control over, localized control over quality, which, in light of this discussion, sounds like a good idea, so if you have other comments about reconciling those statements, I think we'd be pleased to hear them.

MR. CROCKETT: I'll start off. First of all, when we looked at -- one of the things that was important for us, as well, is looking at what their quality program was, and they provided us not only their quality program, but they provided us, in terms of patient satisfaction, risk management and multiple other practices, and we put that through in comparisons to how we have revised our quality program.

Getting back to your point, the program that they have currently for ECHN I think is a very good program, and I think that it would have prevented some of the things associated with it, so, from our perspective

it was an easy decision for us to adopt what they currently have and the commitment to maintain it.

Part of the reconciliation is quality is an ongoing thing that is evolving and changing, as well, and within our corporate oversight, there's two things that we actually will be taking on as kind of a corporate initiative, and it will be hospital-acquired infections and then, also, fall prevention.

So when we talk about corporate oversight and ensuring best practices, what we hope to do, not just for our Prospect hospitals, but, also, for ECHN, is for, in those specific areas, look to improve their performance on a go-forward basis, as well, and that is really kind of what the whole expectation is of the oversight.

DR. LEW: Perry, I want to just add another comment regarding separation and allowing the local hospitals to maintain, whether it be through an agreement, but, also, point to what we've done in CharterCARE in Rhode Island in supporting their initiative to become a high reliability organization.

I know Lester Schindel, the CEO of CharterCARE, I believe he was going to be here today, and we also brought in someone by the name of Kim Lumia from

Connecticut, who actually is supporting Les in this effort, so that's just a live example of how we support the local initiative to become a high reliability organization. Agreement or no agreement, this is what our model is going to be.

MR. ZINN ROWTHORN: Thank you. So we can move on.

MR. SPEES: Thank you. Good afternoon. I just want to make a few comments about some of the key commitments as part of the transaction from a transaction standpoint.

Some of these were touched on by Peter in his remarks, but I'll just amplify a little bit. The first two points are the key financial terms of the transaction, purchase price of $105 million and capital expenditures of $75 million.

What's significant about the purchase price is not just that it represents fair market value, but, as Peter mentioned, it really, when combined with ECHN's existing resources, allows all of the long-term debt of the health system to be paid off. That frees up over $9 million worth of annual funds that used to go to paying down debt and makes them available for reinvestment in the health system.

And with respect to the capital expenditure commitment, I think it's important to note that this is a minimum capital commitment on the part of Prospect.

We have access to capital, and we're in the business of investing capital in our facilities to help them grow and perform better, so while we've made this minimum commitment to the extent that there's a need and appropriate investment of additional capital, we have the resources to do that.

In addition to the financial commitments, we've made a commitment to maintain the current charity care policy, so that, as Mitchell mentioned in his presentation, Prospect really is about access and providing access to people, and this was a way to assure the community that the existing charity care policies will remain unchanged, or, if we do make any modifications, they will be at least as favorable, if not, more favorable going forward.

One thing that's really important to recognize in these transactions is that this is a very long-term commitment, so we're not just talking about what's going to happen in the next year or two years, but we're talking about 10 and 20 years down the road, and,

so, this commitment gives assurance to the community.

We also, as has been mentioned several times, while we're a California-based company, we're very committed to and understand that health care is a local business, and we provide corporate resources and support to really help the local management team and Board of Directors make the key decisions with respect to the day-to-day operations, and, so, we've committed to maintain management here locally and a local Board of Directors, which I'll talk a little bit more about in a second, and we've committed to the existing medical staff, so, as of the close of the transaction, all of the existing members of the medical staff will become members of the medical staff of Prospect Medical Holdings.

In addition, we've also made the commitment to maintain the services that are currently provided in the community, and our final commitment is to the employees, and we've committed that, as of the closing, we'll hire all employees in good standing.

That begs the question, as to what does good standing mean, which I will answer, and that is that we actually perform a single screen on the employees, and that's to make sure that none are on the Office of Inspector General's excluded list from participation in

the Medicare. That's the only condition to becoming an employee of Prospect Medical.

And then, as we've discussed earlier, we have signed this quality commitment letter, which, again, could be viewed as a very minimum commitment, and, as we've discussed on several occasions, you know, we're committed to grow and expand our quality care services.

A little bit about the local Advisory Board. This is really key for Prospect. As the local resource to assist our management team and our company in being the best community member that we can, we really partner with the local Board, and it serves as a resource to the governing Board on a number of matters, particularly providing input into the capital plan that we'll develop post-closing.

I just wanted to mention, with respect to the capital plan, that the $75 million, in addition to being a minimum, it's not just, you know, bricks and mortar and equipment that is part of that capital investment, so it's not necessarily capital in the traditional sense of accounting, but it's really an investment in the health care system, in total, and it will be likely, as part of our strategic plan, will be invested in increasing access points in the community,

whether that's through new urgent care or ambulatory centers, as Mitchell mentioned, or adding physician prospects and growing the physician network, maybe an investment in behavioral health resources, so that really is an investment in developing the overall coordinated regional care system in the community.

The local Advisory Board, in addition to providing input into that capital plan and our overall strategic plan, really will be responsible for much of the day-to-day oversight of key hospital programs.

Those include, particularly, oversight of all of the accreditation programs, so the Board will be, the local Board will be principally responsible to oversee the accreditation of the hospitals going forward.

It will be delegated authority on the medical staff credentialing, so all issues of medical staff credentialing will be handled by the local Board.

In addition, we will expect, you know, input and communication from the local Board, in terms of all of our growth initiatives, including physician recruitment.

And, again, recognizing that this is a long-term process, in the event there is any sort of leadership succession down the road, then we would look

to the local Board for participation in that process, as well.

MR. ZINN ROWTHORN: Can I ask one follow-up there, which is if you could talk a little bit about the process and time frame by which decisions will be made, as to spending down that $75 million capital commitment?

MR. REARDON: Hi. This is Tom Reardon. Everything is local. Everything starts locally, I should say, and, so, we will be consulting with the local Board and with the local management team, and they will create a strategic plan.

We'll push back. We'll have give and take on it, but it's a process that we go through. So, in Rhode Island, what we agreed to there, as I recall, and I may be wrong on the exact numbers, but my recollection is that we agreed that we would have a strategic plan within six months of close, and then we would sit down with the Attorney General's Office and orally present that plan, rather than put it in the public record, and I think we can make the same kind of commitment here.

MR. ZINN ROWTHORN: Do the transaction documents talk about a time frame by which that $75 million will be expended?

MR. SPEES: They do. The actual commitment in the purchase agreement is, within five years following the closing, the $75 million has to be invested or committed in some way to be invested.

MR. ZINN ROWTHORN: Thank you.

MR. REARDON: Again, I'm Tom Reardon. Let me comment on this slide 15. Please note that it says Health Care Delivery Model.

We are not a hospital-centered company. We're actually a physician-centered company that thinks about population management, and that's the way we approach things.

We really truly believe that it's better care for the community. We don't have to open everything. We will do a coordinated regional care program that includes community mental health, and surgery centers, and all kinds of different community providers to get the best care to a person at the lowest cost at the appropriate time, and that is our motto, and we think we do it very well.

Our model empowers local physicians. We partner very well with managed care plans, but even when managed care plans are trying to work with you, it's difficult for them to get to you the right data, and, so,

we have an infrastructure with respect to population management that does all kinds of things.

We even do claims processing, not because we think it's a very sexy business, but that's how we get the data, and when you get delegated functions from the managed care plans and you do analytics and you do medical management, the physicians actually know how to do this.

As much as the MCOs try to do it, they don't do it as well as the physicians and other community providers do it, so that's our motto. That's the way we approach it.

And the physicians really do feel empowered. I did see, Mitchell, by the way, that Les Schindel and Kim did come in. In Rhode Island, I would say maybe a third of all the physicians, primary care physicians that have joined the IPA there, have joined, because they love the model. It empowers them.

Rather than have a managed care company say, no, you have to have prior authorization, they're making those decisions how to best expend monies.

And the trouble with fee for services there's no money to do population management with real risk contracts, which is what we're talking about. Is

there money to do the right thing? And the physicians love it.

In terms of maintaining and creating local jobs, we're a growth company. We've never closed a hospital. We don't shrink hospitals. We grow hospitals. Sam Lee, our CEO, has a wonderful mantra; more and better for less. If we do a better job and we do it for less money, we're going to get more patients, and that's what we've seen over, and over, and over again. It really does work.

In terms of extensive corporate resources, John has touched on that, but we have all kinds of things. Because we've worked with a lot of safety net hospitals, we have really developed some very good data-driven management tools.

We're not talking about slash and burn here. We're talking about process reengineering, and there's all kinds of other corporate support that we can provide, in terms of savings on purchases of all kinds of material and the like, so there's a whole host of things we can bring.

Again, I'll go back to the CharterCARE example. My recollection, and Les can correct me on this, is, when we started at CharterCARE, all the

employees had a Blue Cross and Blue Shield contract. When we took over, all the employees had a Blue Cross and Blue Shield contract.

The difference was we're now self-insured, and my recollection is that we dropped something like $1.6 or $1.7 million to the bottom line, because of our ability to fund a self-insurance program, so there's a whole host of things we can bring to help the local management.

Again, maintain local leadership with regional oversight, all health care really is local, and we really support that with regional oversight. Whether it's quality or other issues, we will have input on these things.

Investing in capital and facility services and technologies, I'll go back to John's comments. Again, we're talking about a health care delivery model here, so it's not just about putting a new façade on a hospital. It's a whole host of things, in terms of creating this whole coordinated regional care network.

Charity care policies, yes, we've already talked about preserving charity care policies.

Could you go to that last slide, John, for me, please? Or second to last slide.

Why Prospect? Well we are committed to Connecticut. We really are into the northeast in a big way, and it's not just because I live in Boston and can drive down to Connecticut more easily than fly somewhere.

We have the two hospitals in Rhode Island. We're trying to acquire three hospitals in Connecticut. We're close to, well, we've already signed an APA. We're close to finalizing a deal in the Philadelphia region with five hospitals.

And why do we like the northeast? We like the northeast, because, frankly, there's very little managed care penetration in the sense that we think of, with real risk contracting and downside risk contracting and delegated functions.

If you look at the SIM, the State Innovation Model, and what Connecticut is trying to do, they're trying to move, as I recall, 80 percent of patients to value-based payments within two years.

Well we actually know how to do that. We've been doing it for 30 years, and you can't convince somebody overnight. With Blue Cross in Rhode Island, they came out to see us a dozen times. Well I don't know if it was a dozen times. They came out many times to see what our infrastructure looked like and what we did, and

they became convinced.

And, so, in Rhode Island now, we do have the first risk contract in the state. We do have a Medicaid pilot project, which reduces cost. We even committed to Blue Cross and Blue Shield, because the office of its Health Insurance Commissioner asked for a 15 percent reduction of premium product.

We've come together with them on a product that actually provides a 15 percent reduction in premiums for small groups, for small employers, so we actually do know how to save money by developing a coordinated regional care program.

So we actually think that, when you take a look at the metrics in Connecticut and Pennsylvania and Rhode Island, again, for every thousand patients, how many days will they spend in a hospital bed?

I don't recall the numbers in Connecticut, but I think it's like 1,400 days, and some of our hospitals were down in the 700s, so if you can keep a patient out of a hospital, but you can take care of them even better, with more dignity, in their home or in another setting, it's better for everybody. It really does work.

So we think we actually can help be

transformative in the way health care is delivered in Connecticut, and we're really excited about the opportunity.

The initial conversations with the physicians and the development of the IPAs are going swimmingly. We're pretty excited about it all.

So to the last slide, John? Again, we're all about the triple aim. You probably can't guess this from looking at me, but I've actually been around for a couple of years, and I joined Prospect about three and a half years ago, because I was so enamored with the model.

I actually do believe that this model can help move us toward a triple aim of higher quality, lower cost and higher patient satisfaction, so that's what we're about, and that's what we'd love to work with ECHN on, ECHN in developing here in Connecticut.

That concludes our Direct Testimony. Thank you for your attention.

HEARING OFFICER HANSTED: Thank you. Thank you, all. At this point, let's take a 15-minute break, and we'll go back on the record 15 minutes from now. Thank you.

(Off the record)

HEARING OFFICER HANSTED: Welcome back,

everyone. Thank you for that presentation. That was wonderful. We're going to go to OHCA's questions at this point, so I don't know who wants to start. Mr. Lazarus?

MR. LAZARUS: I will. Good afternoon. Steven Lazarus. I'm going to address the questions possibly to one or two people at a time, and you're welcome to bring up anyone --

VOICES: Microphone.

MR. LAZARUS: Can you hear me now?

HEARING OFFICER HANSTED: Move this up a little bit.

MR. LAZARUS: Is that better? All right. Mr. Crockett, in your testimony, you say that PMH now has hired a Chief Quality Officer, a Clinical Officer, Senior Chief Nursing Officer and a VIP Regulatory and Patient Safety person. When were these positions filled?

MR. CROCKETT: The Chief Quality Officer position, actually, her first day is on April the 4th, Monday, and the other three positions were filled approximately about 45 to 60 days ago, and they're currently working on the resolution at our two facilities as we speak.

MR. LAZARUS: And how were these duties and responsibilities covered before filling these

positions at PMH?

MR. CROCKETT: At the corporate level, we really didn't have the positions, and, so, it was delegated to the local entities to a certain degree, and, so, what we're hoping to do with these positions is to provide the additional oversight in making sure that, as the goals are either being met or not met, that we look at resources that are being expended and provide them as necessary.

MR. LAZARUS: What will these positions bring to mitigate an occurrence of immediate jeopardy in our Connecticut hospitals?

MR. CROCKETT: Part of the issue that we got cited on was that the Quality Assurance and Performance Improvement Plan wasn't dynamic, and, as the organizations were experiencing the difficulties that they had, it wasn't modified to address those issues, and, so, they came in and they saw the quality programs off to the left, and the organization was moving in a separate direction going forward.

As organizations go through their various accreditation surveys or they have issues arise associated with any type of other surveys, those findings are inputted into a quality program, so that you can do

the monitoring and the compliance to those things on a go-forward basis.

To be blunt, that's what did not occur within our quality program at the facilities. They continued to be monitoring things that were not outdated, but just not completely as relevant, so lesson learned. This is to make sure that the quality program is updated not just once a year, but actually whenever the issues need to be updated, and that's actually one of the things that we're hoping to achieve with these individuals.

MS. KIM MARTONE: Kim Martone, OHCA staff. You had stated in your testimony that you're currently revamping the QI QA program?

MR. CROCKETT: Correct.

MS. MARTONE: Can you give us a summary at all, in terms of what it contains, when it will be available, who is involved in revamping it?

MR. CROCKETT: Yeah, sure. If we haven't already provided you with the Quality Assurance and Performance Improvement Plan, we can do so, and we will be happy to do so.

It started off with two issues. First, making sure that the 2016 national patient safety goals are addressed associated within the quality program, and

that's more from just a kind of an oversight umbrella.

Specifically, each of the two organizations within that, you know, the issues that have been addressed or identified in the current CMS survey are included in the program, so, for the one facility, we're looking at temperature and humidity, we're looking at infection control, we're looking at nursing services.

For the other facility, once again, we want to make sure that the quality program is not a cookie cutter, and, so, it's modified to the issues specific that were at the LA Community facility.

The other aspect associated with the quality program is making sure that each of the different departments have a quality measure that they're participating in, as well, and that was another deficiency that we had, which is that we had -- that wasn't seen as being completed from a house-wide perspective, and, so, with that, you should see a comprehensive program to monitor.

MS. MARTONE: Okay.

MR. LAZARUS: Can you please identify each of the individuals, and tell us what experience do these individuals have in working with large health care systems and ensuring quality improvement, patient safety

issues of the hospital networks?

MR. CROCKETT: Sure. The Chief Quality Officer has just previously held a position as a divisional quality expert for HCA. I believe it was over the western division for HCA. I don't know the exact number of hospitals, but it was for about half of the company.

With that, she had the responsibility for the quality program, oversight, patient safety and developing the policies and process and reporting tools and kind of assuring of best practices within the HCA division, and that will be the Chief Quality Officer.

The Chief Clinical Officer previously was in a similar role for Kindred and was responsible for the clinical effectiveness of nursing care for the Kindred Corporation.

The background for the Corporate Chief Nursing Officer, she's from the east coast and has held multiple Chief Nursing Officer roles within various companies, and I can provide further background associated with her.

The position for the regulatory affairs and patient safety has also extensive experience, and I don't know it off the top of my head, but I can provide

that, as well.

MS. MARTONE: Yes. If you could provide us a late file of their resumes, we'd appreciate it.

MR. CROCKETT: Yeah, I can do that. It's not a problem.

HEARING OFFICER HANSTED: I just want to clarify the record. The resumes will be Late File No. 3, and Late File No. 2 will be the Quality Performance Improvement Plan that you referenced earlier.

MR. CROCKETT: Actually, more than likely, it would be 2, because, as I said, they're two different plans; one for the LA community and one for the Southern California hospital.

MS. MARTONE: Could you just make sure they're dated, as well, so we know the date that they're actually going into effect?

MR. CROCKETT: Sure.

MS. VOLPE: If we're numbering late files, I believe ECHN wanted to submit an outline, as well, as part of the late file.

HEARING OFFICER HANSTED: The time line is No. 1.

MS. VOLPE: And 2 is the CMS?

HEARING OFFICER HANSTED: Two is the

Quality Performance Improvement plan or plans, and No. 3 are the resumes.

MS. VOLPE: Okay and we'd also like to submit the Corrective Action Plan we mentioned that's due on or about April 8th into the office regarding CMS's corrective action.

MR. CROCKETT: And that's for the LA community license resurvey.

HEARING OFFICER HANSTED: Okay, so, the Corrective Action Plan will be Late File No. 4.

MS. VOLPE: Great. Thank you.

HEARING OFFICER HANSTED: Thank you.

MS. MARTONE: And just one more question. Do you anticipate any changes to those quality assurance plans, based on any -- these surveys, the results of any of these surveys?

MR. CROCKETT: You mean in terms of the ones that were just revised?

MS. MARTONE: Right.

MR. CROCKETT: Well that's actually one of the things that we're going to do differently. As any issues come up that are new, we're going to modify the program, so the answer is that, in any hospital that we have, as issues are identified from a CMS perspective,

the quality programs will be adjusted to make sure that the monitoring goes, so the answer is yes.

MS. MARTONE: Okay and then, as Chief Quality Officer, she obviously, or he, will have a say? I'm assuming will be assessing the hospitals and the quality of programs, and is there anything she's going to be doing when she begins or he begins next week, in terms of reevaluating these current issues and challenges?

MR. CROCKETT: Yeah, several things. The first issue is that we're going to be asking her -- she'll be looking at -- her name is Debbie Barry, but she'll be looking at any of the former either Joint Commission and/or survey results that the facilities had and looking at the responses that they had, and the question is were the responses appropriate, and were they compete, and, more importantly, are the facilities continuing on with the work that they had said that they were going to do with the correction of these facilities, and that's, obviously, for all of them, all of the Prospect hospitals.

Obviously, we've got the two that are the most important at the moment. That it will be her role of making sure the compliance with our plan of corrections to CMS.

MS. MARTONE: Thank you.

MR. LAZARUS: What is PMH's plan to contract with a patient safety organization if they acquire ECHN?

MR. CROCKETT: At the moment, what we have committed to is to continue to -- any quality programs that they have currently in place we're going to maintain that.

In terms of future plans, that will be done in conjunction with the local Advisory Board and with ECHN in consultation with direction from our Chief Quality Officer.

MR. LAZARUS: As a result of the survey, I think it was in your testimony that PMH hired a consulting firm to review the operations and policies and the procedures in California.

Based on the recommendations, PMH implemented new ones. Can you please elaborate on findings or recommendations of the consulting firm? What new policies and procedures were implemented?

MR. CROCKETT: There's actually a couple of things, and let me just talk about the process first of all, then I'll get into some of the more specifics.

There were two things that were occurring.

The first one that was alluded to is that the hospitals recently, in the past couple of years, have gone through a license consolidation, and, as part of the license consolidation, one of the things that's important is making sure that the policies are consistent within that license, and, so, the first thing that they were looking for was making sure that the facilities not just only had a consistent policy, but they were actually practicing consistently to the policy, so that was number one.

The second thing that they looked for is that they would take a look at the policy, specifically, as it related to the Medicare conditions of participation, and what had happened over a period of years, we've gone through multiple surveys by various regulatory agencies, is they had taken a base policy, and whatever the issue at the moment was was that they would add on top of it, and it became an unworkable policy that was really kind of a configuration of multiple past surveys that they thought there were doing right.

And what happened, specifically associated with like our temperature and humidity issue, the intent of what was put in our policy was, for the right reasons, was unworkable.

Specifically, our policy stated on

temperature and humidity that the organization was to check the temperature and humidity every hour and make adjustments accordingly, and that's regardless if there was a surgery being performed there or not. The practice is is that that's actually not a CMS condition of participation, nor is it a requirement, so when they looked at our practice and saw that it wasn't consistent with our policy, we got cited for it, in addition to other things.

So they went through all of our policies and looked at the operations of the organization, streamlined the operations consistent with CMS participation, so that, as we practice, that we're going to be consistent with them, so using the temperature and humidity as an example, it was revised to reflect that we check the temperature and humidity at the start of the day, which is about 4:30 in the morning, and make adjustments, if it's necessary, associated with that, and then we then check the temperature and humidity before each case, making sure that there's proper versus what we had in the past for checking every single hour.

They went through all of our policies related to nursing care and made similar type of adjustments. The total number of policies that were

changed, I don't have it off the top of my head, but I believe it's over 45 of policy modifications that were recently inputted.

MR. LAZARUS: Based off the 45 policies that were modified, are any of these policies and procedures that were specific to California are they going to be implemented in other PMH hospitals that are in Texas and Rhode Island?

MR. CROCKETT: At the moment, we're actually focused just on California, and, once we have our Chief Quality Officer and we get past our survey status and we have the individual in place with her team, the anticipation is then we take our revised policies and take a look at, then, the policies at the other facilities and identify if there's streamlining that needs to occur and/or are they adherent to the policies, and that would be kind of a step two that would happen down the road.

MR. LAZARUS: Okay, now, who is the consulting firm that you had hired?

MR. CROCKETT: We hired two. The consultant firm is called the Greeley Company, and you can either find them on the web or we can provide the information, but it's a nationally-recognized firm that

works with CMS, and then we hired a local law firm, called Hooper and Lundy, so, in tandem, the two of them are assisting us in our response back to CMS.

MR. ZINN ROWTHORN: When you say work for CMS, do you mean specialize on CMS-related issues?

MR. CROCKETT: Specialize in CMS, in resolving issues when hospitals get sideways with CMS.

MR. ZINN ROWTHORN: Okay, thank you.

MR. SALTON: So is that the firm that did the review, your comprehensive review, or are they just doing the review for CMS purposes?

MR. CROCKETT: It is the same firm. They're reviewing the policies, and they also were responsible for the redefining and the development of a quality program, the Quality Assurance Program, as well, as well as in assisting us in our response back to CMS, and they're still on site and will continue to be on site until we resolve and pass the survey.

MR. LAZARUS: Now PMH has agreed to maintain the respective quality programs that you just stated for two years. Can you explain why two years?

MR. CROCKETT: Simply, there really isn't actually a magic number to the two-year mark. It was more of an issue of starting off with a transaction of

taking a look at their quality program, and the question is will PMH change their quality program or maintain it, and the answer is, very simplistically, we took a look at it, and the answer was that they have a great program, and we don't anticipate making any changes to the program.

The issue of why the two-year mark, the answer always gets back to the question of how do things change within the health care industry within two years and what new things will occur, and we want to make sure that, as we improve Prospect's quality program, that we don't have an entity that is going to be isolated, so it was strictly that.

It is meant to be a placeholder, and then, as the organizations have worked together for two years and we moved forward, it was just a placeholder, is really what it was.

MR. LAZARUS: Okay. You also submitted a quality assurance commitment with ECHN at the beginning of the hearing. Could you talk a little bit about that and discuss it from the details incorporated in there?

MR. CROCKETT: Yeah, so, the commitment is several fold, and it really, then, or I think relates back to one of the original questions that we had just

before the break, which is how does the local leadership, as well, comply with kind of a corporate oversight, and I think the three of them kind of tie together.

The commitment starts off with this is it. There's multiple things that ECHN is currently doing on their quality program. A, their quality program, two, the level of staffing that they have associated with it and the people that are doing it, three, they're participating and have been long participants in the high reliability organization, and they've got some other internal programs related to patient satisfaction, risk and some other of those measures.

So the commitment we have is not only just to maintain the program, but to, A, maintain staffing and/or improve the staffing and maintain all the current things that they're currently doing.

The other thing is that, from their visit that they had when they went to Rhode Island, there were some things that our CharterCARE facility was actually doing that they would actually like to bring down to ECHN, so our commitment to them is that anything that we're doing in any of our other organizations then we will make sure that the right resources are brought into ECHN, as well, too.

So, very specifically, how we look at the quality is that we're going to, A, maintain it, and, two, anything we do to change it is going to be an add-on, and it's going to be done in consultation with ECHN.

MR. ZINN ROWTHORN: Steve, can I ask one question?

MR. LAZARUS: Yes.

MR. ZINN ROWTHORN: I meant to ask you before. You referenced that designation of high reliability organization a couple of times. Can you tell me what that is? Who bestows that? What it signifies?

MR. CROCKETT: Yeah. A high reliability organization it's actually a formal program that an organization commits to, and it's a long-term commitment, and the goals of a high reliability organization are to make sure that the processes that are put into place protect the patients and provide a safe environment for the patients to receive care.

It's a significant commitment, not just in financial, but in organizational time and energy associated with it, and it looks at not only the processes that are occurring in the organization, but, more importantly, making sure the organization is committed to understanding when it doesn't work and

fixing the processes, so that the organization becomes consistent in how the care is actually being delivered and reducing the variability and improving the outcomes.

And, so, organizations that participate in it, they do go through outside training specifically to it, and they go through outside audits to make sure that they are continuing with what they're doing and the reporting associated with it.

We actually have seen, you know, I think the Connecticut facilities this is an initiative that's been done for a while now in Connecticut. We were introduced to it through our work with CharterCARE in Rhode Island, and, over this past year and a half, we've been so impressed with the work that they've done up in Rhode Island that we're looking now to actually roll it out into our other facilities in California and Texas.

MR. ZINN ROWTHORN: It's a privately granted accreditation?

MR. CROCKETT: I don't know the answer to that.

MR. ZINN ROWTHORN: It's not a government designation?

MR. KARL: No. No. You volunteer to become designated as an HRO. Just if I can put it in a

nutshell, if you don't mind, the State hospitals would commit to a CHA, Connecticut Hospital Association, committed to becoming a high reliability organization, and it almost, again, in a nutshell, it almost follows the pilot's checklist, okay? Anyone can stop the line. It goes all the way down to the issues that we deal with with the right side surgery, correct side surgery and so on and so forth.

It empowers everyone in the organization. If they see something that doesn't seem to be happening that's appropriate, they can put their hand up and stop it, without any type of repercussions, whether they're telling a physician you need to stop here, I think we have a problem, and that's in a nutshell what HRO is.

MR. ZINN ROWTHORN: Thank you. That's all.

MR. LAZARUS: I have a couple of questions for Ms. Dorin. You had testified that you visited PMH hospitals in California. Which ones did you visit?

MS. DORIN: We visited Southern California at Culver City.

MR. LAZARUS: And you reviewed documentation you had mentioned earlier at those hospitals?

MS. DORIN: Not there. We reviewed documentation on our visit to the Rhode Island hospitals.

MR. LAZARUS: Okay, so, what did you review at the California hospitals in your visit?

MS. DORIN: Well it was actually I would say it was more of a visit than a review. I mean there were several of us from ECHN and several Prospect members that went to the hospital.

We spoke with a number of different departments, and we did some site tours. We were on a couple of different floors of the hospital.

MR. LAZARUS: So what was your goal for visiting the hospitals in California?

MS. DORIN: Well, as part of the process for selecting an acquisition partner, we felt that we really needed to sort of see what was going on firsthand and in person, so that was the primary intent, to go out and put, you know, faces to names and to see how employees are operating in the hospitals.

I don’t mean operating in the traditional sense, but, you know, as a sort of walk around the floors, and we had an opportunity to speak to people extemporaneously to get their thoughts on how it was working for a Prospect hospital. We spoke with doctors.

MR. LAZARUS: When did you visit?

MS. DORIN: We visited last May, May of 2015, and we visited the CharterCARE hospitals in June of 2015. June of 2015.

MR. LAZARUS: When did PMH first bring to ECHN's attention the problems it had at the Southern California hospitals?

MS. DORIN: That's on the timeline, and that is in -- they called February 1st?

MR. KARL: Yeah. If I can answer? February 1st, I was informed by Mr. Reardon that they have some issues regarding inspections at a couple of hospitals out in LA.

MR. LAZARUS: Okay and that's the timeline that we're going to be getting as a late file?

MR. KARL: Yes.

MS. DORIN: Yes.

MR. LAZARUS: Thank you.

MS. MARTONE: Ms. Dorin, Kim Martone, OHCA. Would it be possible to provide any records or reports, findings from the quality evaluation team? Is there anything generated from that? That would be appreciated.

MS. DORIN: Sure. Sure.

HEARING OFFICER HANSTED: Okay. That will be Late File No. 5.

MR. LAZARUS: Ms. Dorin, you had mentioned a collaboration by the eastern region hospitals on the quality issues in your testimony. Can you elaborate on the structure of the structure, and who will comprise -- who will this collaboration team -- what would it be comprised of, what individuals?

MS. DORIN: I would say that that is probably to be determined at this point, but, as we have been talking with Prospect and as our quality team had visited with the CharterCARE hospitals in Rhode Island, we saw great opportunities to further collaborate and share best practices, and Prospect is committed to doing that, as I believe Von referenced and Tom, also.

MR. LAZARUS: All right.

HEARING OFFICER HANSTED: Maybe, just for the benefit of the public here, could you just go through and summarize the timeline that you're going to submit to the panel?

MS. DORIN: Well it's six pages.

HEARING OFFICER HANSTED: Okay.

MS. DORIN: I'd be glad to.

HEARING OFFICER HANSTED: I'm sorry?

DR. O'NEILL: It's sort of a blow-by-blow timeline of what we did once we knew about the IJ issues at Prospect and everything that we did internally with our management team and the Board.

HEARING OFFICER HANSTED: Okay.

MR. KARL: I'll just walk you through a couple of points, if that would be helpful.

HEARING OFFICER HANSTED: That would be helpful, and, for the public that's here, this document will be on OHCA's website if you want to review it in detail.

MR. KARL: So I'm going to condense when we first heard about it, because what we needed to do, again, internally is take a deep dive into the inspection documents.

There's a data room that was downloaded to us that has thousands of pages, and the quality team jumped all over that.

I, then, on February 19th, I met with the Board Chair, Dr. O'Neill, and Vice Chair, Joy Dorin, to discuss the or disclose the regulatory issues in California.

Dr. O'Neill stated that he felt it would need to be brought forward to the Board of Trustees.

There was a meeting with the Board of Trustees on the 25th of February.

The Board of Trustees, at that point, brought forward and appointed a subcommittee of the Transaction Committee, led by Joy Dorin, the Vice Chair, because she was also the Chair of the Transaction Committee.

We brought in our QI experts and, also, our attorneys. They went through a significant due diligence process. On March 2nd, we had detailed phone conversations with those individuals from PMH, Von and so on and so forth.

We then also did a deep dive into, you know, is there any concern, as it relates to any of the equity partners, you know, something like this would occur, and we also looked at that.

Then, on March 4th, our quality team went up to Rhode Island, Our Lady of Fatima and Roger Williams, did a detailed deep dive into their quality program, and, when they came back, they were extremely impressed with the additional resources that were brought forward at CharterCARE that we felt could help bolster some of our quality programs in Connecticut.

They, of course, were very interested in

HRO, because the Connecticut Hospital Association is contracting with the Rhode Island Hospital Association to roll out the HRO initiative.

We, then, again went through detailed meetings twice week, Board members, the Transaction Committee with Prospect. We reviewed all of the inspections. Also, the immediate jeopardy, did some comparisons about how regulators do inspections out in California versus what happens in Rhode Island and Connecticut.

We, then, had a special Board meeting on the 23rd to discuss all of our findings, this is March 23rd, and we felt that our concerns were satisfactorily answered. We created that side letter that obviously is an exhibit, and we will continue to follow-up with, obviously, the responses to the findings.

This is going to be prolonged. This isn't something that CMS is going to come down and say, okay, it's all over with. It's going to be prolonged for a while, so we had agreed to stay very close to that.

The side letter, you know, I guess I would say this. We feel very strongly about our quality program. Obviously, we received awards. Connecticut has a different handle on quality than some of the other

states.

The issue that I think we're dealing with here, as we created this side letter, we wanted some type of written commitment from Prospect that they're not going to jump in and mess with our quality program, and the two-year period was, you know, Joy said she wanted five years, and, you know, a lot of other people said, you know, two years, three years, and, again, it's not really the timing period.

It's a matter of we thought two years would be enough time for the Chief Quality Officer at corporate to get her feet wet, to take care of the issues that happen out in California, to better understand regulatory issues, as it relates to the Texas hospitals, the Rhode Island hospitals, the Connecticut hospitals, and, also, then, form, as they do now for a lot of other scorecards for performance measures, to then have, whether it's weekly or biweekly, calls between all of the quality leaders to do some comparisons and, also, to match outcomes to see who is doing best practices and so on and so forth, so that's kind of it in a nutshell.

HEARING OFFICER HANSTED: Okay, thank you.

MR. SALTON: Can I ask a follow-up question on the remit? Maybe just take a minute on that?

The first provision provides they're going to maintain your programs for two years, the second provision talks about maintaining the QA program. Consistent with best practices in the programs in Rhode Island, which one will govern if there's any consistency?

MR. KARL: That's a great question. If we're following -- much of this is, obviously, the federal HCAHPS CMS, HCAHPS.

Those that pertain to Connecticut obviously will be following ours. Those that pertain separately to Rhode Island will follow by the Rhode Island hospitals.

I would say this, because this is, again, this is brand new, so speaking just from my lips, we have to form an eastern region quality program, and not necessarily even an eastern region. It really has to be a Connecticut and a Rhode Island, so we better understand quality services, so we can do some local comparisons versus nation comparisons.

DR. LEW: Henry, if I could just add, you know, from corporate, if what is happening in Connecticut, as you say, if there's not a meeting of the minds, if it's working, we don't want to come and mess with it.

We're certainly here to support everything that they're doing, and, as we fix our issues in California and our Chief Quality Officer gets on board and really understands extremely well what's happening across segments, you know, I'm sure she'll be able to offer some input and support, but whether we're talking about quality, or business development, or recruitment, or staffing, we defer to the local leadership, and if it's working, there's no reason for us to fix it.

MR. SALTON: Okay. The agreement also provides there's an acknowledgement by Prospect that, following the closing, the local Board, I assume that's the Advisory Board, will have oversight over the quality assurance program.

By oversight, does that mean that they have actual delegated authority, or they're just going to be reviewing it and reporting in an advisory way? I'm not sure what oversight means.

From a regulatory perspective, oversight means one thing. From an advisory concept, it means something else.

MR. CROCKETT: Delegated.

MR. SALTON: Would you elaborate on it for the record?

MR. CROCKETT: Yeah, so, the way that we have reached the agreement is that, obviously, the corporate Board has ultimate responsibility for the financial and quality of any organization, and, with that, there are going to be a delegation of physician credentialing, as well as the quality program to the local Advisory Board.

The local Advisory Board will be made up of physicians within ECHN, as well as some community members associated with that.

MR. SALTON: Have you done a delegation like this in the other hospitals?

MR. CROCKETT: We do, at CharterCARE.

MR. SALTON: Could you give us a copy of that delegation, so we can see that if that's the model?

MR. CROCKETT: I believe, yeah. I think we can.

MR. SALTON: Okay.

HEARING OFFICER HANSTED: That will be Late File No. 6.

MR. SALTON: That's all I have right now. Thank you.

MR. LAZARUS: I'll address the next couple of questions towards ECHN. It's mentioned in the

responses to the pre-hearing questions that ECHN reviewers visited PMH's Rhode Island hospitals as part of its quality review investigation and found that the quality programs had been enhanced in notable ways since Prospect's acquisition.

Can you elaborate a little bit on that and provide some examples?

MR. KARL: I can. Again, I'm going to ask Linda Quirici to come up, please. She was the one, who headed up the inspection.

MS. QUIRICI: So this is for the Rhode Island hospitals, correct?

MR. LAZARUS: Yes.

MS. QUIRICI: Okay, so, myself and two experts came with me on March 4th. We visited both hospitals, which is Roger Williams and Our Lady of Fatima, and we met with the Quality, Safety and Risk Departments and Infection Control, so those are the areas that we concentrated on in both hospitals.

So some of the enhancements that we saw that we were quite excited about, to be honest with you, is PMH brought safe transitions of care, which has significantly reduced their readmission rates. Pharmacists and an LPN were brought on board for follow-

up calls, and they saw a significant decrease in their readmission rates, and that's something that all hospitals are looking at for the betterment of the patient, as well as that's something that CMS looks at, so we really were interested in that.

They are integrating the two hospitals, eliminating duplication of services, which is much more efficient, so that was great.

We saw a huge investment in the renovation of the two hospitals with the patient in mind. They were improving all their handicap access. In places where they had stairs, they were now putting handicap access and elevators to help with handicap, so that it was with the patient in mind.

They improved lighting. They had single rooms, which is much preferred by patients, open concept nursing units, which is definitely best practice for patient care, and they had plans for future renovation there, as well, looking for new emergency departments, etcetera, so we saw physically a lot of construction going on, a lot of improvements in both hospitals, so that's great, and that would be a great help to us, as well.

So they've integrated some of their

departments. They have a very robust quality department. They've supported new positions to ensure that the quality standards and metrics are met.

PMH recognized Roger Williams focused on quality and safety and supported that process that was already in place, which is what they're planning on doing for us, as well, and they increased their staffing and patient satisfaction area, which is great to hear, as well, because that is, you know, patient experience, patient satisfaction is very important. It's something that Eastern Connecticut Health Network is working on, so, again, we're looking for similar kinds of improvements here.

Let's see. We did see their quality improvement diagram, which was very good, how they report up to the Board, which that was great, and, in speaking with the Chief Nursing Officers at both hospitals, PMH allowed autonomy in managing the departments that are meeting their performance measure, so if they're doing it right, you know, they're encouraging that, and those departments that are not meeting expectations are assisted by this corporate oversight that they've talked about, so that's kind of the best of both worlds.

PMH assisted the hospitals in pursuit of

certifications, things, such as stroke, diabetes and total joint replacement. They have a good outreach for primary care doctors and started an IPA there, which has been very helpful.

They were in the process of developing the various VP positions for oversight of the PMH systems, so that was in place, and this is the local leadership talking to us about that. It wasn't PMH. It was the local leadership talking to us about that.

Okay. They provided tools to assist with staffing and productivity, so to make sure that they were efficient, and that was great. They look at processes, PMH looks at processes through evidence-based standards. They analyze cost and outcomes to choose the best pathway, which is best practice, and that's something that we would want to do.

They support a multi-disciplinary review of any events, which is great. They had strong legal support, which the hospitals felt was very helpful. They improved processes in recycling and reprocessing with the support from PMH.

Infection control, there was no cutting corners in infection control, and that was really great for me to hear, because as PMH is putting it number one,

really that's something number one in our organization, as well, and that's in our safety plan, I mean our quality plan for 2016.

So they had a very robust Infection Control Department. Again, fully staffed at both, and I looked at all the job descriptions, and they talked about their processes. Very solid. Very solid. Something that, again, we'll want to talk with them more about as we go forward.

Okay. The other thing is they provided their metrics display and organized dashboard. There was really great dashboard from these two hospitals that looked at all their quality measures and put their targets, you know, what their benchmarks are and what their scores were, so you could very clearly see it was very organized on an Excel spreadsheet, and we're, again, hoping to emulate that, so we had a great visit.

MR. LAZARUS: Thank you. As part of the quality assurance commitment, are these some of the recommendations you're looking to implement say in the next two years at ECHN?

MS. QUIRICI: Well, as part of that, and I think it talked about it, that these things will be available to us, we'll communicate with them, you know,

as we have done, and their best practices we'll adopt those, and they'll adopt our best practices, so, again, the best of both worlds to share between the hospitals.

MR. LAZARUS: All right, thank you.

MS. QUIRICI: Okay.

MR. LAZARUS: As a result of ECHN's investigation into the compliance and quality issues connected with PMH's California hospitals, did ECHN consider asking PMH whether its local Advisory Board could have authority than presently where it would only recommend authority to ensure ongoing quality care to ECHN hospitals? Would you like me to repeat the question?

MR. KARL: Would you please repeat that?

MR. LAZARUS: Yeah. As a result of ECHN's investigation into the compliance and quality issues connected with PMH's California hospitals, did it consider asking PMH whether its local Advisory Board could have more authority than presently to ensure ongoing quality of care at ECHN hospitals?

DR. O'NEILL: We didn't consider that, specifically, as you've phrased it, but what I think -- see, we tried to consider how this is going to work out practically speaking, and, right now, our Board, the

Board of ECHN, has a lot of input into the quality standards that the organization has.

In the future, the Advisory Board is going to have a similar practical role. In other words, the Advisory Board consists of physicians and community members. One of their main roles is to oversee quality and patient safety, so if Prospect is reassuring us that our quality program will be supported, then it will be implemented through the interaction between the Advisory Board and the management team.

So when the Board looked at it, you know, over the past four months, or four weeks, ever since this started, we felt that we had the assurances that we needed to make sure that we were going to maintain quality for the next five years, let's say. Did you want to add something?

MS. DORIN: And beyond, because the commitment letter, you know, does -- oh, okay. Right. So the local Board, the responsibilities the local Board are actually enumerated in the asset purchase agreement, and it says, and I'm reading from page 63, "The local Board shall, among other things, serve as a resource for buyer with respect to buyer's investment of the capital commitment, maintenance and implementation of the

strategic business plan, and be responsible for medical staff credentialing at the hospitals, maintain and oversee the quality assurance programs at the hospitals, and oversee and manage the accreditation process for the hospitals."

MR. ZINN ROWTHORN: But I think what we've just heard is that there's a delegation of actual authority to the local Board with respect to quality issues, is that correct, beyond an advisory capacity?

MR. CROCKETT: I think I understand your question, but I'm not exactly for sure.

A MALE VOICE: Do you want to restate it?

MR. ZINN ROWTHORN: Yeah.

A MALE VOICE: Maybe say it another way?

MR. ZINN ROWTHORN: I think we've heard a little bit about just now about what the asset purchase agreement talks about with respect to the Advisory Board's authority. Subsequent to that, we have the side letter agreement, and your answer, Mr. Crockett, to Attorney Salton's question, which was that there is a delegation of authority on quality issues or will be to the local hospitals, similar to what's done in Rhode Island, is that correct? And that's a delegation, not just advisory authority, as contemplated in the asset

agreement, but actually authority.

MS. VOLPE: I think Mr. Crockett testified that, for physician credentialing, there's certainly a delegation of authority.

MR. ZINN ROWTHORN: I think it was beyond that.

MR. CROCKETT: Well, for the two-year period, I mean what we have committed to is that we're not going to be modifying the program, as setup currently, and only looking to actually enhance it.

MR. ZINN ROWTHORN: Okay. We had a colloquy a few minutes ago about what paragraph two in the side letter means when it refers to local Boards having oversight over the quality assurance program and what oversight means in that context, which was as the answer when a delegation of authority.

MR. SALTON: As opposed to merely oversight, and I think, when we spoke, I said there's advisory and there's authority with oversight, and you said, and I want to clarify this, because this is important, you're delegating actual authority for them to have oversight, meaning something comes up, and the local Board says, wait a minute, we don't want to be here, we want to be over there, or are you saying this is just an

advice, and the management of the hospital, which you guys will now have control over, will decide whether to follow that advice or is it actual authority over the quality assurance program, not accreditation?

MS. MATTHEWS: I'm sorry. I mean if you do look at the language in here, it is serving as a local resource with respect to the investment in capital, of the capital commitment, but then it does end the maintenance and implementation, but then it's actually the local Board is to be responsible for medical staff credentialing and maintain and oversee quality assurance programs, so we read that as a real delegation of authority on those matters, as opposed to serving as a resource and advisory in connection with the spend on the capital commitment.

MR. CROCKETT: Actually, let me read through the actual words.

MR. ZINN ROWTHORN: I just want to put on the record, Attorney Matthews, you were reading from what document?

MS. MATTHEWS: I'm sorry. I was reading from the asset purchase agreement, Section 5.27 of the asset purchase agreement.

MR. ZINN ROWTHORN: Thank you.

MR. CROCKETT: And, so, that's now been updated with a side letter, and I want to just read the one sentence that actually speaks to I think what would be termed a definition of delegation specific to this, and it says that "Buyers shall not implement any modification to the seller of quality programs without first obtaining the approval of the local Board for such modifications, which approval shall not be unreasonably withheld." That's what we tried to do to actually define the delegation.

MR. SALTON: So that's distinct from the end of the prior section, where it says, the end of paragraph two -- do you have letter in front of you?

MR. CROCKETT: I do.

MR. SALTON: "The local Board shall have oversight over the quality assurance program," so is that -- we're trying to figure out how these things interplay, if they do at all.

MR. CROCKETT: Well we're hoping that they overlay each other, not in conflict, which is that the local Board shall have oversight of the program, and the point of paragraph three was to clarify what the role of the oversight was, which is that Prospect cannot make any modification to the program.

MR. SALTON: Okay, so, that's clear. I understand there's obviously a difference there, because, in one instance, you could say status quo, we can't change status quo of the program, as developed by the hospitals, but then the local Board might want to go beyond status quo and not really change it, but maybe augment it or do other kinds of things, decide that more resources are necessary, without changing the program, but that might be considered within the scope of oversight, but what you've clarified, at least from your understanding, and I hope that's what the hospital's understanding is, also, is that, in fact, the oversight merely means what paragraph two provides, which is change in the status quo, without approval of the local Board.

MR. CROCKETT: That's our understanding.

DR. O'NEILL: That's our understanding.

MR. SALTON: Okay.

MR. LAZARUS: The next questions actually have to do with the topic of community needs health assessment.

PMH states in the application that it will support and implement ECHN's community needs health assessment plans through 2016. What does that actually mean by that? I believe that's on page 2178.

MR. KARL: Dennis McConville will respond to that.

MR. LAZARUS: Sure.

MR. DENNIS McCONVILLE: Steven, may I ask you to please repeat the question?

MR. LAZARUS: Sure. PMH states in the application that it will support and implement ECHN's community needs assessment plans through 2016.

MR. McCONVILLE: Yeah, so, filed with the application were the highlights of our community health needs assessment plan that was conducted by ECHN, and we continue to implement that plan and the programs associated with that plan, and Prospect has agreed to support us in that ongoing effort, but, at the same time, it's about time for us to conduct a new community health needs assessment, and that is our plan, and we anticipate that that be supported by PMH.

MR. LAZARUS: And PMH is in support of that?

MR. McCONVILLE: Yes.

MR. LAZARUS: Okay.

MR. ZINN ROWTHORN: Did we have that answered from PMH? Was that your question?

MR. LAZARUS: Yes. We can have PMH say

it, get on the record. That would be even better.

MR. REARDON: This is Tom Reardon again. Let me comment on this. Community needs assessment, I think as you phrase it, relates really to an IRS requirement for 501(c)3 corporations. In order to get tax-exempt status, you need to go through a community needs assessment, among other things, and, so, as a for-profit, it doesn't apply to us, per se.

Having said that, we've agreed to go ahead with the implementation of the community needs assessment through 2016 and to conduct another community needs assessment within the next two years.

Now, having said that, we are all about looking at the community. Everything we do is focused on looking at the community. We do that type of assessment internally constantly. We just don't necessarily use an outside consultant to help us in that regard.

I mean think about it. Many of our hospitals are safety net hospitals. We are constantly looking at the needs of the community.

One of the speakers spoke about what we're trying to do, in terms of knitting together mental health and physical health. That's a huge, huge effort.

I mean, right now, if you take care of a

person, who has a behavioral health problem and you fix their physical health problem and you discharge them and they go under a bridge and do whatever they do, they're going to be back in the hospital in 10 days or 10 weeks.

And, so, what we're trying to do is knit together the two programs, so that we have plenty of resources that actually focus on those patients if they're assigned to us as members under population management, and we also are out there trying to stitch together with our CRC model resources, whether it's mental health resources in the community or even beds in the community, as opposed to in a hospital.

So we're constantly focused on community needs. It's just I wanted to make the distinction between community needs assessment in the sense of a 501(c)3 and the community needs we all always are assessing all the time.

DR. LEW: So if I could just add on to that, it's certainly necessary, as it relates to what's required as a not-for-profit, but it's not sufficient for us and that we need to do more.

We need to look at how we're actually improving the access for the population and be able to have patients flow into our system with all the programs

that I talked about earlier.

So, yes, it's part of our overall strategy, but it's not the only thing that we would need to look at. It's part of it, but not the whole picture.

MS. MARTONE: Thank you for stating that. That's actually, as well, OHCA's mission, is to ensure that residents of the state have improved access, enhanced access to health care service, so, with that, we do ask all hospitals to report and to participate in these assessments, report their findings, report their implementation plan, provide us some times with updates periodically, and, by law, we can't ask for the data that really goes into the collection of that and having all the hospitals in the state report and have, hopefully, at one point, standardized.

We also use that in our Certificate of Need program in evaluating Certificate of Need applications, looking for unmet need, underserved areas, and making sure services are provided to the community there, so that is typically what we ask of the hospitals in this state.

MR. LAZARUS: PMH, I think it was stated in the application that it's PMH's intention to involve the local Board in the assessment process, as well as

facilitate public input, and that PMH will publicly disseminate their community needs assessment and its implementation strategy-wise website, as you mentioned.

Would you involve the local Boards for both Manchester Memorial Hospital and Rockville General Hospital?

MR. REARDON: Absolutely. Absolutely. We rely on community. Look, we desperately want to partner with ECHN. We want to be here in Connecticut, but as much as we want to be here, we'll never know the community as well as the community members, and, so, we absolutely rely on and talk to the Boards in both communities, as well as other community members.

MR. LAZARUS: All right, thank you.

MR. ZINN ROWTHORN: Is it anticipated that a community needs assessment or something in the nature of a community needs assessment will be undertaken, in order to inform the decisions about how to spend down the capital commitment?

MR. McCONVILLE: So the way we'll go about getting to the strategic capital plan is through a strategic planning process that will have several inputs.

It will have the results of the community health needs assessment, which would include both

secondary data, that data that's available through various sources, and primary data, which is often most difficult to collect, which is directly from patients, learning about their health behaviors and lifestyles.

It would also include input from an environmental assessment we would do relative to what's happening around our service area with regards to other providers in the programs that they have available to residents of our communities.

And, importantly, it will also involve input from the IPA Board. We now have this physician-led organization, physician-governed organization that will be assessing the health care that's delivered to our patients.

They will understand what the gaps in the care are, what programs are needed, what resources will need to be deployed to make sure that our continuum is complete, comprehensive, and does the best possible job of caring for the patients.

MR. ZINN ROWTHORN: Thank you.

MR. LAZARUS: Who would be on the local Boards with the qualifications to determine public health needs or disparities impacting minorities and underserved population, and how is this done in other PMH hospital

communities? I guess it's a two-part question.

MR. KARL: So speaking for ECHN going forward, the model that Prospect Medical uses throughout, as I understand, throughout the country that they will implement here, which we're very much in favor of, is the Board will be comprised of 10 members, five community members that are from the primary and secondary towns that we currently serve with diverse backgrounds, obviously to fit the current service area, and five physicians, independent practicing physicians in the surrounding areas.

Those physicians will have -- will be made up of different specialties, and they will, then, act and take the lead as the governing Board of the organization. I will also be on that Board as the leader.

MR. CROCKETT: And that setup is consistent of how we work in our other markets that we modeled ECHN to be consistent.

MR. LAZARUS: The next set of questions actually have to do with the community benefit. The application makes clear that PMH is committed to continuing to treat patients, regardless of ability to pay, and providing financial assistance to patients that qualify, based on the need, in the same manner ECHN by

adopting their charity care policy.

Is the commitment conditioned or limited in any way?

MR. SPEES: It is not. Only subject to any changes in laws or regulations that would require a change.

MR. LAZARUS: Thank you. PMH has said it's spending on community volunteer services and community benefits will be developed, based on confirmation or identification of communities' priority needs.

In the application, ECHN describes that the Maternity Care Center on the Rockville General Hospital campus that was just featured in the CHA Community Benefits Report for the hospital as providing free maternity services to uninsured and underinsured women in Vernon and surrounding towns. Is this a program that would continue?

MR. KARL: Yes. That program will continue. There's a significant community need on the Rockville side for access purposes. Those individuals are seen by rotating OBGYN physicians and Advanced Practice Nurses.

Those patients many times do not have

primary care physicians or OBGYN physicians. Once those patients are worked up, they are, then, when it's time to be delivered, they are, then, moved over to Manchester Memorial Hospital for delivery and follow-up.

MR. LAZARUS: Okay, now, some of the other programs, such as the Manchester Memorial Family Development Center programs, are funded either through the state or federal grants, and, you know, they're featured in the community benefits report.

Has ECHN explored the ability to keep these programs funded if the hospitals are converted to for-profit?

MR. KARL: Yes. We've taken a deep dive in that area, and there are -- most of them can move across, even though it is a for-profit, because these are fully grant funded.

There are some that cannot. Those grants may not be kept whole. That subsidy will be, then, covered by PMH as they come into the community.

I was just corrected, that we were now informed that all are transferrable. That wasn't the case two weeks ago.

MR. LAZARUS: How long will the process of evaluating the community benefits program will continue

to support, continue the support? What will be the finished products, I suppose? Do you want me to repeat the question?

How long will the process of evaluating the community benefits program -- I'm sorry. It's not written well here in my notes.

MR. KARL: That's okay.

MR. LAZARUS: I think I edited it too much. Will you be evaluating the community benefits program and looking at all the different programs that you're supporting within it, and, if so, what's the timeline for that to do that?

MR. KARL: Okay, so, let me answer that in a couple parts. We will be rolling out or beginning a 2016 community needs assessment.

MR. LAZARUS: When?

MR. KARL: Immediately after closing, so we're hoping this gets approved, and, again, as Mr. McConville mentioned, it's quite in depth to construct this community needs assessment.

It's not only the data that you receive, but it's actually phone calls and looking at the current disease states in the areas, what we've seen clearly.

Just for an example is the prevalence of

diabetes, vascular issues associated with that, and now, as of late, that we're all struggling with, and I'm sure that it's going to come across, is the opiate issue that we're dealing with.

We just most recently had a discussion --

MR. LAZARUS: I'm sorry, Mr. Karl. I was specifically asking about the community benefit program, not the community needs assessment.

MR. KARL: Oh, okay. Sorry.

MR. LAZARUS: I'm sorry. I didn't want to cut you off.

MR. KARL: My error. It was getting blinded in my mind, so I apologize for that. Prospect has agreed to continue our community benefit programs going forward.

MR. LAZARUS: And speaking of which, PMH has said they're projecting to an increase in the community building activities through 2019, based solely on inflation, and it assumes no change in Medicaid population served in the community, regarding the community benefit program offered at the hospitals. How do we interpret the statement?

MS. VOLPE: Do you have a bates stamp, as to where that is in the application?

MR. LAZARUS: Yes. Page 3232.

MR. KARL: Can we have a moment just to look that up?

MR. LAZARUS: Absolutely.

MR. KARL: Do you want to continue while we're doing our homework, or would you like us to take a break?

HEARING OFFICER HANSTED: Why don't you go to the next question, then we can come back?

MR. LAZARUS: Well it sort of relates to the same question, so we'll take a moment.

MR. SPEES: Sorry. Could you repeat the question?

MR. LAZARUS: Sure. Absolutely. PMH has said that it is projecting an increase in community building activities through 2019, based solely on inflation, and it assumes no change in Medicaid population served or compliment of the community benefit program offered at the hospitals, so we're trying to understand what that statement really says.

MR. SPEES: Basically, it was just a commitment, in terms of continuing to fund the community need, community benefit programs at the historical levels with an inflation rate over time.

MR. LAZARUS: And that was my next question that I was trying to get to. Thank you. The next couple of questions actually have to do with the underserved areas in primary care, so, on page 2188, ECHN describes some of the safety net services provided in the Rockville section of Vernon and the northwestern part of Mansfield as establishing a family medicine practice in Rockville and in Vernon. How large are these practices?

MR. McCONVILLE: I'm sorry. I might have to ask you to repeat the question. How large is the practice in Vernon, in the Rockville section of Vernon?

MR. LAZARUS: Yeah.

MR. McCONVILLE: Okay. I would have to provide you with the actual numbers of patients that are managed through that practice. I would have to get you that information at a later date, but it is a mature practice.

MR. LAZARUS: We're trying to get the number of physicians in the practice.

MR. McCONVILLE: Okay. There is a physician and an APRN.

MR. LAZARUS: Okay, so, a single physician and single APRN at the Vernon location?

MR. McCONVILLE: At the Rockville

location.

MR. LAZARUS: At the Rockville location.

HEARING OFFICER HANSTED: What about Vernon?

MR. LAZARUS: What about the Mansfield? Yeah, the Mansfield location.

MR. McCONVILLE: We don't have a location in Mansfield.

MR. LAZARUS: Oh.

MR. McCONVILLE: We have independent primary care physicians that practice at locations in Vernon and Tolland and Coventry, all of which draws some patients from Mansfield.

MR. LAZARUS: All right, thank you. It's also stated in the application that ECHN has imaging labs in Tolland and presently no location changes are proposed, although it is expected that ECHN ambulatory network will be expanded and services configured to promote most efficient delivery of care.

If these are professional service areas and PMH says it's going to be aggressively recruiting physicians for these areas, would there be an increase in staffing levels at these locations?

MR. McCONVILLE: That would all depend on

what the data shows. I mean, currently, we offer those services through a combination of services offered through the Tolland Imaging Center, which is a joint venture, through our laboratory services, which are affiliated, obviously, with the hospitals, and then through some independent practices, physician practices, whereas they have found more demand for their services.

We have done what we can to help them with the recruitment of additional providers. We will do a medical staffing plan. We're always looking at what the need is for physicians in service areas, and then we go about recruiting physicians to that plan.

MR. LAZARUS: Is that one of ECHN's goals, to recruit additional physicians?

MR. McCONVILLE: We would like to have as many physicians associated with our Independent Practice Association as possible to get the very best coverage and comprehensive coverage for the population served by ECHN.

That is all to the benefit of the programs that will be available for population health.

MR. LAZARUS: How successful has ECHN been in retaining residents and interns in its GME program for family medicine?

MR. McCONVILLE: So of the first

graduating class, which were four physicians, one of those physicians is a member or an employee of our Medical Foundation, and, for the current graduating class, which has six third year residents, we have recruited and signed up one of those graduates, as well, so we're in the second year of having graduated classes from the program.

MR. LAZARUS: Okay, thank you. I guess this question is more directed towards PMH. How did Rhode Island primary care network grow to 105 from 18 when the Charter hospitals were acquired by PMH in 2014?

DR. LEW: Steven, the 18 were employed physicians, and we've increased that to nearly 80 employed physicians. The over 100 that you're referring to are the primary care physicians that are part of the IPA, and the IPA is made up of and well over 300 physicians, but some of those are employed and some of those are independent, but, basically, what we started doing while we were going through the process of conversion and getting the regulatory approvals is we began to lay the ground work for our model, and what that would entail is going to the state and establishing a risk-taking entity to allow to take financial risk from a health plan, and we've already done that in Connecticut.

We also get other necessary regulatory licenses to act as third party administrators and do utilization review.

We engage the health plans, because our goal, again, is to move from a volume fee-for-service world to a value-based type of payment with the health plans.

And then the third component of building our model is to create the physician network, so we start engaging the physicians well in advance of closing on a hospital, because, you know, it really serves -- it tells the community what we're about, it starts to align the physicians with the hospital, and it gives us a head start on building the model.

And, from that, if I could just share what we've done in Rhode Island, is we took that model and infrastructure that we built and taking a value-based contract from the large payer in Rhode Island, and we went to the Governor of the state of Rhode Island, and we proposed a Medicaid pilot to deliver a coordinated care to the Medicaid population in Rhode Island at a lower cost.

Rhode Island is similar to Connecticut, in that there's a Medicaid spending problem, and our

proposal, which was approved, allowed the state or will allow the state a savings of $6 million a year, but, to do all of these things and to work with the payers and to work with the government on these types of pilots, you've got to set the groundwork, and that's identifying the needs that you've asked Dennis about in figuring out where the gaps are in care, and then for us to go out in the network and build relationships with the community clinics and the FQHCs, the Federally-Qualified Health Centers, to make sure we have a very robust network to take care of a population, if we were to embark on a Medicaid pilot.

MR. ZINN ROWTHORN: Steve, can I ask a follow-up?

MR. LAZARUS: Go ahead.

MR. ZINN ROWTHORN: Dr. Lew, how is the Rhode Island Medicaid operation structured? Is that paid, based on a risk or value model by the state, so PMH hospitals receive a certain amount of money to, at their risk, to treat a Medicaid population?

DR. LEW: We will eventually get there, yes, but we're not quite there yet.

MR. ZINN ROWTHORN: Got it. And just one other question, if I might, Steve.

MR. LAZARUS: Um-hum.

MR. ZINN ROWTHORN: My apologies. The doctors in the IPA, who are employed, and those, who are not employed by the hospitals, but participating, do they have equal access to the electronic medical record system to communicate with the electronic medical record system?

DR. LEW: Yes. If you're part of the IPA network, we interface with the physician EMR the same. Certainly, if doctors are employed and sharing an office on the same system, it makes it a lot easier, but we've figured out a way, through a lot of years of experience in interfacing with hundreds of different EMRs that are being used by physicians out there, so it really doesn't matter to us if it's independent, or employed, or EMR, differences in EMR systems. We treat them the same.

MR. ZINN ROWTHORN: Thank you.

MR. LAZARUS: Dr. Lew, did you mention that you have a risk-taking entity established in Connecticut already?

DR. LEW: Yes, we do.

MR. LAZARUS: Okay.

MR. REARDON: If I can just add to that, Mitchell? In addition to a risk-taking entity, which is a preferred provider network, we've also gotten a TPA

license and a utilization review license.

HEARING OFFICER HANSTED: What is a TPA license?

MR. REARDON: Third Party Administrator.

MR. ZINN ROWTHORN: How many lives are covered in your risk-based operation in California?

DR. LEW: Nearly 300,000.

MR. ZINN ROWTHORN: And from your experience, is there a kind of quantum of lives necessary to successfully operate a risk-based system in a particular service area?

DR. LEW: No, Perry, there’s not a magic number, but if they’re in a tightly-managed geographic area, such as a Manchester and Rockville, Vernon, that would be a lot easier.

You know, certainly would love to start off with a couple of few thousand seniors, maybe 5,000, 10,000 Medicaid recipients, and, you know, if we get 5,000, 10,000 commercial lives, that would be a great start, but we certainly could build the capacity to manage, as we do in certain pockets in Southern California, Orange County, for example, 120,000 members under management.

MR. ZINN ROWTHORN: Thank you. Thank you,

Steve.

MR. LAZARUS: So the lessons you've talked about and learned from Rhode Island, that's a model you're looking to establish in Connecticut and, specifically, at ECHN?

DR. LEW: Yes. Yes. So we would love to support the employed physician model, because, if doctors need the stability and they want to be employed, we want to be available, and let's line up those doctors now, fill the pipeline, so when the deal closes, we can bring them into the family, but, at the same time, we recognize that there are a lot of physicians that still want to remain independent, and that's fine with us, too.

So we have already worked on our contract templates for the physicians within the IPA. We've established the Physician Leadership Board already, and, as everything else we do, we will rely on the local physicians to go out and grow the network and to talk about the virtues of coordinated care.

And, as I've already stated, we've engaged the health plans, and what's really nice in the state of Connecticut is that the payers recognize this migration to value-based payments, and, so, we're getting a lot of traction there, and I think, once we get the network

established and the health plans, a couple of health plans on board and show the proof of the model here in Connecticut, would love to entertain a Medicaid pilot with the State, offer savings with better outcomes.

MR. LAZARUS: All right, thank you. The Prospect provider group, the Connecticut ECHN, LLC that you had mentioned in the application and PMH's other affiliated IPAs, are there any agreements preventing providers from directing patients to providers outside the IPA, out of the network providers?

DR. LEW: If a doctor is part of the IPA, a primary care physician is part of the IPA, and they want to refer the patient to a specialist, they would need to refer the patient to an in-network specialist. That's just part of the contractual agreement that we have, and that's what the health plan wants, also.

MR. LAZARUS: Okay.

MR. REARDON: But, of course, if I could just add to that, even though there are specialists within ECHN, there are also tertiary and quaternary services that we'll need, and we simply contract with that for the network.

MR. LAZARUS: Okay.

DR. LEW: So if there were services that

could not be provided at one of the ECHN hospitals, we would contract for those services at other facilities.

MR. LAZARUS: Thank you.

A FEMALE: VOICE: Excuse me. I'm just wondering when the community members are going to have the time to ask questions. We've all been here three and a half hours, and all I hear is discussion. I would be interested in hearing what the community had to say. Thank you.

MR. ZINN ROWTHORN: Thank you, ma'am. We are also very interested in hearing what the community members have to say, and we'll stay here as late as we need to stay here to hear whoever wants to be heard.

We appreciate your patience. We understand that this is a lot to listen to, but this is an important part of our process.

We do invite you, if you do have a time constraint this evening, to submit a comment online. Every comment that we receive will be available online, so I understand, I suppose, the frustration there, and we do appreciate your patience.

MR. LAZARUS: How successful has PMH been in securing contracts with major payers in launching the IPAs, managing at-risk contracts and complying with

national committee for quality assurance network advocacy standards when you're still growing these physician networks?

DR. LEW: So as far as securing health plan contracts? I think that was the first part of your question.

MR. LAZARUS: Yes.

DR. LEW: We have contracts with all the major payers in California. In Texas, we haven't been around as long. We have probably three contracts and working on getting additional contracts.

Certainly, our relationships and experience in California has helped us with the larger, more national payers.

In Rhode Island, we are contracted with the largest payer in the state, which has about 70 percent of the market, and we are establishing additional contracts for the Medicaid pilot or two MCOs, Managed Care Organizations, in the state. Here in Connecticut, we're currently in conversations.

And the second part of your question, Steven?

MR. LAZARUS: The IPA managing at-risk contracts and complying with the national committee for

quality assurance.

DR. LEW: Right, so, in terms of compliance, I'll refer back to one of the slides that I showed earlier. The largest Trade Association for delegated medical groups, CAPG, California Association Physician Groups, has a standard, based on a lot of NCQA requirements, and it's a very rigid scoring system, and we've reached the highest level, elite status, for four years in a row, so I think, from quality and compliance, we've done a very good job over the last several years and certainly always a focus of ours.

Excuse me. There was another part of your question? Oh, risk, managing risk.

MR. LAZARUS: Um-hum.

DR. LEW: Managing risk is always a challenge, but, again, we see the health plan and the payers migrating to putting more risk onto the providers.

We've got a lot of experience doing it, and I think we're very good at negotiating good contracts, fair contracts, but what it makes us do is assure that care is administered and delivered in the right place at the right time.

When I spoke earlier about a lot of the programs that we have for patients, taking care of them

across the continuum, what that does is it prevents readmissions and unnecessary admissions, and, so, we can reduce the cost, because we're really doing a great job of managing under financial risk.

MR. LAZARUS: All right, thank you.

HEARING OFFICER HANSTED: Before we continue with our questions, we're just going to take a 10-minute break.

(Off the record)

HEARING OFFICER HANSTED: We'll get started again. We're back on the record. Thank you, all, for coming back.

As Perry mentioned before the break, we're going to cut to the public comment portion of tonight's hearing, and then we'll go back to the questioning of the Applicants.

(Whereupon, the public spoke.)

HEARING OFFICER HANSTED: We will continue with OHCA's questioning. Mr. Lazarus?

MR. LAZARUS: Dr. Lew, you had testified that the implementation of CRC involves rewarding physicians for positive quality outcomes, not outputs, by a shared savings, pay for performance standards and benchmarks, and that these incentives would provide

effective and improving quality outcomes in PMH's other markets.

Can you describe the benchmarks and incentives you've referred to?

DR. LEW: Sure. So what are the incentives that we lay out for physicians to ensure quality? We create a report card for our physicians, and there are certain quality measures specifically on this report card, ranging from whether a patient had their screening blood test, cholesterol, hemoglobin A1c, preventive measures, mammograms, bone densitometry, proper medication, refilling their medications.

I mean there's a whole list of probably 35 different measures that we would look at, and we know and, as proven through studies, is that, if a patient has these measures done, they're probably going to have better health than those that don't have these things followed.

And, so, what we do is we incentivize the physician to perform these tests on their patients, and it's a financial incentive to make sure that they perform these measures, and we go even further. We support them.

I'll refer back to one of my slides, when I talked about our Quality Care Coordinators. We have

teams of people that will call the patients to remind them to go see their doctor, to make sure they have these preventive measures, and will coordinate the appointments with the patient and the physician offices.

If physicians' offices are inundated and they can't accommodate, we actually setup within the community what we call wellness clinics, so these are more convenient sites for patients to come to, and, if we need to, we provide transportation, and if they don't have transportation, we will go to the home. I talked about our homebound program.

So we take a lot of different steps to ensure that the patients have the proper quality measures to take care of their health, and, yes, we incentivize the physician to do it, but, a lot of times, they don't have the resources within their office to provide it, so we provide it for them, and we give the doctors the bonus anyways. It's just good relationship.

MR. LAZARUS: Thank you.

MS. CARMEN COTTO: Hi. Carmen Cotto, OHCA staff. My questions are of a financial nature, so I will probably be directing my questions to Mr. Aleman and Mr. Spees.

My first question is please discuss PMH's

future financial stability and ability to provide future financial support to the Connecticut hospitals it is acquiring as it continues to merge and acquire hospitals in other markets that are in poor financial health, such as the one most recently in New Jersey that was in bankruptcy.

MR. ALEMAN: Well let me speak, specifically, to the Connecticut transaction and the health prospect from a financial standpoint.

We had approximately a compound annual growth rate of about 25 percent year-over-year. It's been driven through organic growth in our platform facilities, as well as growth in our acquired facilities.

We work very closely with all acquisitions in the transactions, up to the point of the close of the transaction and post to ensure that the facilities are operating efficiently, are cost effective, work very closely with the teams from a program analysis and bring all of our skill sets that Von and some of the operators can speak to in great detail on how we work with the facility, so they're efficient and cost effective, and, also, in the analysis of programs that ultimately the community supports and, as Tom has stated, can grow programs once again.

So every acquisition that we're taking a look at, inclusive of the New Jersey transaction, will be making a profit from day one, earnings before profitable earnings, where, when we started working them, they were not in opposition, so we have a demonstrated track record of working with acquisitions up to the point of close to improved performance and continue that performance post.

So, to get to your question, I think I've demonstrated or discussed the historical growth of Prospect. So we've taken a look at all the acquisitions, including Connecticut. We are confident in the growth potential of these facilities, and I have the utmost confidence that every commitment that we have made to these transactions on specifically ECHN that we have the financial wherewithal to carry through on those commitments.

MS. COTTO: Thank you. When we asked the Applicants in reference to the funded sources for this proposal, you indicated that, as of September 30, 2015, PMH had in excess of $110 million in funds available, and that you also indicated that PMH generates over $7 million in free cash flow per month. Is that still the case, as of today, they $110 million funds available?

MR. ALEMAN: Yeah. Funds available on

hand currently are in excess of $65 million. By the time this transaction closes, I anticipate we will be, once again, close to the $100 million number. What has transpired during that period is the acquisition of East Orange General Hospital, which is really the differential there, and, then, from a free cash flow standpoint, we're actually in excess of $7 million, so that's what will help grow our available cash up and through the point of the close of this transaction.

MS. COTTO: Okay.

MR. ALEMAN: So no change in the cash flow.

MS. COTTO: Now you also provided the same answer for the proposal related to Waterbury, so could you elaborate how you intend to support both proposals with the same amount of funds available?

MR. ALEMAN: Same answer applies. So, once again, the growth of our capital on a month-in and month-out basis generating anywhere from about $10 to $15 million of free cash flow on a monthly basis, with our capital commitments in place, if you were to take a look at our September 2015 just purely cash generated from operations, it was in excess of $75 million.

Our capital commitments through East

Orange and the Connecticut facilities are under $40 million on an annual basis, and this is without any further growth in some of our recent acquisitions.

During this period, in the last let's call it 12 to 16 months, we've opened up a couple of closed facilities of which are now starting to generate cash into our system, as well as continued growth within our Texas and Rhode Island facilities.

MS. COTTO: And you also indicated that there was an additional $40 million available to a credit line through Morgan Stanley. What is the status of that loan right now, and how much do you have available there? Is it still $40 million?

MR. ALEMAN: It is $10 million. We took out -- we tapped the revolver to help close the East Orange transaction in New Jersey, but, once again, I anticipate, by the time that we get to the close of this transaction, there will be roughly about $30 million available in that revolver.

MS. COTTO: Okay. Do you have any other funds available exclusive of Morgan Stanley? Any other credit line that you will be able to use as a funding source for this proposal?

MR. ALEMAN: None are needed, but the

answer is yes. We're fairly, when you take a look at other for-profit systems, relatively lowly levered on an adjusted EBITDA kind of net of cash, where it's just a little over two. On an EBITDA, debt-to-EBITDA ratio, we're just a little over three.

Some of the larger systems there leverage ratios are over six. I just mention this, that you generally have a lot of capability. We're fairly conservative in the debt that we take on.

Part of that is that, for whatever reason, if we need to tap the credit markets, we can. We have very active relationships with all of the investment banks, and that's part of my role and responsibility, to maintain those relationships.

MS. COTTO: I have one more question in reference to the free cash flow. Has it in the past or will in the future PMH use this free cash flow that's available to pay any dividends?

MR. ALEMAN: No. There are none currently. We haven't paid a dividend to our private equity group since 2012. None are currently planned currently, and I do not anticipate any in the future.

MS. COTTO: I thought that it was a payment of $100 million.

MR. ALEMAN: That was in November 2012.

MS. COTTO: That was ’12?

MR. ALEMAN: Yes.

MS. COTTO: Thank you. As part of our review, we requested that you provide to us supporting documentation related to the credit ratings, and the information that you provided to us indicated that the credit agencies have given PMH an upgrade on the credit ratings, but that rating was based on all the things, on expected increases in revenue, EBITDA and cash flow as a result of soon-to-be-acquired hospitals, including those in Connecticut.

Can you please elaborate on financial gains for PMH’s -- this proposal?

MR. ALEMAN: I’m not sure if understand your question, but let me try and answer, and you can tell me if I address it or not.

MS. COTTO: Okay.

MR. ALEMAN: With the credit agencies, specifically, Moody’s and S & P, I have meetings with them on a quarterly basis.

Part of their -- two of their concerns with Prospect historically have been, A, concentration in California, so they have looked for us to develop and

expand our model outside of California, and then, with the acquisitions of Nix in San Antonio, Texas and CharterCARE in Rhode Island, how did we perform on those transactions? It's easy to go off and you can acquire and bring in the revenue to your system, but do you actually perform? Do you actually work to turn those facilities around and integrate your model into those facilities?

So, through this last credit upgrade by Moody's and S & P, what they focused on was the integration of CharterCARE and the improvement and financial performance at CharterCARE, so I think what you're referencing is, as we look to expand our model into other states, one of their areas of focus is will we continue to be successful in our integration of those facilities and the integration of our model to demonstrate the improvement in financial and operational performance, like we did in CharterCARE, at the other, you know, in other acquisitions.

That's going to be a continued focus of theirs in Connecticut, New Jersey, and Pennsylvania, as well.

MS. COTTO: Okay, thank you. My next question is also related to the credit ratings report.

They also -- the credit rating agencies also expressed some concerns on PMH's ability to achieve sustained revenue growth, due to the exposure to the California Quality Assurance program's timing, cash flow timing.

Please discuss whether the fees, reimbursement timeline will hinder PMH's ability to provide cash to ECHN to support any future cash shortfalls related to the capital community.

MR. ALEMAN: The current program in California is in place through December 2016. There is already -- the process is already in motion to extend that program through 2019.

Where their comment comes from is there are certain facilities that get very large dollars from that program, and their cash flow is solely dependent on that.

There have been delays in the program in the past when they go into place. Prospect is significantly less affected than other systems in California, due to our diverse model, and, specifically, the medical group segment, which is based in California, continues to see strong cash flow from that segment, and it's not just on the hospital side, as well as continued strong cash flow from our Texas facilities, Rhode Island

facilities, and, once again, this gets to concentration.

If you can diversify yourself from purely those hospitals and systems that depend on that cash flow, obviously, then, you're less affected by any delays in payments. We're about as diversified, I think, as any health system there is, not only since a key component of our company is the medical group side, but as well as the hospital services side.

Medical group side makes up roughly about 28 percent of our revenue and, obviously, cash flow that comes from it.

MS. COTTO: In reference to the capital projects plan, can you provide us with the timeline for that?

MR. SPEES: Well, as I mentioned earlier, so the commitment that we have within the purchase agreement is to fund or commit to fund within five years of the closing. We're obviously not going to wait until, you know, year four and a half to deploy that capital, so what we're really -- what we're doing once we close the transaction is immediately start the strategic planning and capital planning process, and, so, we'll begin to layout and identify the projects that we want to invest the capital in, and, so, that will happen relative

quickly after closing.

There will be some projects that have been noted as critical and will be invested fairly quickly after the closing, and then the remainder will be the result of this planning process.

MS. COTTO: Do you have a list of those projects that you deem critical, that you know already that are deemed critical?

MR. SPEES: We included several of the items that were at least being considered as part of the CON application.

MS. COTTO: Those are the ones that we already have. We already have those, yes.

What is the status of PMH's plans to attract a capital investment partner?

MR. ALEMAN: There is no active process currently going on right now.

MS. COTTO: Okay. I have one more question, and it's for Mr. Karl, and my question is related to the audited financial statements.

We would just like you to explain what is meant by the following statement, and I'm going to read it to you. It's note one of the audited financial statements.

It states, “As of September 30, 2015, management has not finalized the purchase agreement, and the trustees believe that the network will continue with its normal operation and as a going concern for the foreseeable future.” What did you mean with that statement?

MR. KARL: Michael Veillette will respond. He’s the Systems CEO, CFO.

MS. COTTO: Okay.

MR. MICHAEL VEILLETTE: So, Carmen, could you just do me a favor and just repeat the question? I did hear it, but I just want to --

MS. COTTO: Sure. We just want you to explain what this means, what you meant under note one in the audited financial statements. The statement reads as follows.

“As of September 30, 2015, management has not finalized a purchase agreement, and the trustees believe that the network will continue with its normal operation as a going concern.”

MR. VEILLETTE: Okay, so, we had actually the same comment in the prior year financial statements, so, in essence, from the auditor perspective, nothing has really changed, in terms of how close we are to having a

deal finalized at the time the audit was concluded.

The APA has not yet been signed, and because in just a general climate in the State of Connecticut what happened the year before, they view the condition and the circumstances as meeting the definition of a going concern.

MS. COTTO: Okay.

MR. VEILLETTE: I mean, if you look at the financial performance of ECHN over the last five years, as Mr. Karl presented earlier in the afternoon, you can see the continued deterioration of the balance sheet and the continued struggle to perform to generate a profit from operations, from core operations, so that, in essence, defines our situation as being considered a going concern.

MS. COTTO: What are you doing right now, aside from this proposal, to address this, or are you relying on this proposal?

MR. VEILLETTE: Absolutely relying on this deal to be completed. There’s no doubt about that. Are we sitting on our hands as stewards of the organization? No.

We’re working on a number of initiatives that you would expect to be going through, in terms of

just, as Mr. Karl, again, referred to earlier, productivity efficiency, looking at our labor opportunity.

We've worked very aggressively I would say in a nimble fashion since the fiscal year began, and we have been -- and we're not the only hospital in the state, but looking at what we had facing, coming into 2016, having some significant news roll out about 12 days prior to the beginning of the fiscal year with the potential recision of all supplemental payments, after we had already put our operating budget before our finance and our Board in September, we then had to go back, you know, to the drawing board, so to speak, and come up with at least one or two other budgets for 2016, with an eye on hopefully, you know, if we had to get through the year, that perhaps we could still get through the year and maybe not trip a bond covenant, okay?

But as you're probably familiar, there's been a lot of fluidity in the current year with regard to supplemental payments and whether we'd be receiving them or not, so our challenges continue to be very, very extraordinary. Nothing has really changed from that, but I assure you we're doing everything possible that we can to continue to operate, as you would expect, but the

condition is quite dire.

If you look at the last five years, our cumulative profit from operations over that five-year window is $7 million, and that is with considering some one-time items in there that I wouldn't consider part of core operations, so you look at that five-year window, and that five-year window isn't going to improve.

If anything, it's become a little bit even darker out there for us, considering the cutbacks. I understand there's been some news today of maybe partial restoration of the restorations, but that's not going to make our outcome any --

Look at our capital, what we're putting in and what we're spending on capital in these last five years. It's not enough. We're not able to -- our free cash flow is very, very meager, and we're getting to the point right now where we are concerned about actually being -- not generating free cash flow. Does that?

MS. COTTO: Yes, it does. Okay.

MS. MARTONE: I just have one question. The four individuals, who are hired and being hired basically to be the management team, in terms of quality assurance, are they available to come to any of these hearings at all, so we could kind of ask them, as a

panel, in terms of, you know, what their plans are, in terms of addressing these deficiencies or confirming that there will be no quality of care concerns at our Connecticut hospitals, maybe to share some of their experiences if they've dealt with any of these types of issues?

Obviously, you can see that our concern at OHCA, and I'll speak for OHCA, is that there are serious deficiencies, and we just want to make sure that our Connecticut hospitals maintain the high quality that they have been providing, so I'm just wondering if that's even a thought or possibility.

MR. CROCKETT: I think it may be -- obviously, I wouldn't be able to get him here for tomorrow's hearing. We could figure out what needs to be done.

MS. MARTONE: Okay. I'd appreciate if you can get back to me on that, because, you know, I think they're the ones that could answer if they truly have the capacity to be able to do this, especially when they're overseeing, what, 14 hospitals?

MR. CROCKETT: The corporate team actually will be supplemented by -- it won't be just four people. The four people that I've identified are going to have

what I consider to be leadership responsibility.

MS. MARTONE: Right.

MR. CROCKETT: There will be people, additional people within the corporate structure to assist them. I anticipate we will have a regional Director of Quality for the east coast, a regional Director for Quality on the west coast, and then support team underneath them, which will include what I call a survey readiness team for the organizations, and there will be several people on that, as well.

The four people I identified are just the four, is the leadership of the quality, not just the entire team.

MS. MARTONE: Okay. They're the ones that are accountable, though, for it? That's what we're trying to get.

MR. CROCKETT: Right.

MS. MARTONE: Is it the corporate level? Is this team? Who can provide us some assurances?

MR. CROCKETT: Well it will be the new individual, as I said, starts on Monday that will have the overall responsibility.

MS. MARTONE: Thank you.

HEARING OFFICER HANSTED: Thank you, all.

At this point, OHCA has concluded with its questions, so I'll turn it over to the Office of the Attorney General for its questions.

MR. ZINN ROWTHORN: Thank you, Kevin. We do have some questions, each of us, and OHCA's questions have been comprehensive and touched on subjects, obviously, that are of interest to us, as well, so we will attempt to be brief in our questions.

I do want to give you the opportunity, and we would be interested to hear your response to some of the public commentary we received tonight, and not to each one, but there were some common themes in those statements having to do with beyond the Advisory Board anticipated in the transaction whether and how the hospital system will continue to engage the community, the broader community or communities served, and serve and engage individual patients within the hospital.

I'd be grateful to hear any thoughts that you have on those themes that we heard. I'll take it from anyone. Mr. Karl, perhaps?

MR. KARL: Sure. So everyone's opinion is heard quite clearly. I have to always take a step back and think about the 300 corporators that we have that represent the communities that we currently serve.

The corporators elect the Board of Trustees. The corporators fill the current existing committees that are in place. The corporators, then, that are on committees then graduate to the Board of Trustees, and this is cyclical, so we're turning our Board of Trustees over on a regular basis.

Personally, I find it interesting, when community members feel as though they're not being properly heard, because the 300 corporators truly are breathing, living in this community, and, as we go forward, the mechanisms that I see that would be kept in place is a rotating group of local Board members, local community members that those five individuals that are on the Board representing the community will continue, and they will have two and three-year terms, so they will be rotating off while new members, then, rotate back on, so we will have new members coming on to the Board of Trustees.

In fact, two of the existing Board members will have two-year terms, and three of the Board members that we'd like to bring on, again, from our corporators will be brand new to the organization, so we are, at least from where I sit, I'm going to have to pass it over to the new owners, we are very open to hearing other

options that may be out there.

I did hear some concerns. We're very open to having other people that are interested in participating on the local Board of Trustees to come in and meet with the current Board, meet with corporators, meet with myself, and bring that forward.

That's what we do as a community organization.

DR. LEW: Perry, I would just add that, you know, with our model, because there are so many touches that we make to patients, I talked about the homebound program and our Quality Care Coordinators that reach out and they call patients, there's plenty of opportunity for the community and patients to give feedback as they're receiving care, and we take those very seriously, because patient satisfaction is the reason why we're able to grow, because patients tell their friends to sign up with this network, because you're going to get great care.

So while we don't have a formal committee, if you will, that patients serve on, or members of the community serve on, because of the multiple touches within our model that patients receive, there's plenty of opportunity for feedback.

MR. ZINN ROWTHORN: Great. Well I appreciate that. I think one of the blessings of running community hospitals for as long as you have is that there is a sense of engagement and expectation of engagement that arises over time, a proprietary sense, in effect, over the direction of the hospitals and the communities.

I'm glad to hear that that's been recognized as an important value to recognize going forward. I'd encourage you to think about that as you go forward with this transaction and share with us as we go any thoughts you have about what's worked to this point and how to preserve that, what's worked in your experiences in your other hospitals, as far as engaging the communities that they serve and the direction of the hospital as you go forward, so I appreciate that, those answers, and I'll turn it over to Henry.

MR. SALTON: Again, as Perry noted, I think a number of the things that we were thinking about asking have been covered by some of the questions in OHCA and some of the answers we've gotten so far.

One area I wanted to explore a little bit more is the capital commitment issues. So the hospitals indicated that one of the reasons why they pursued a sale was because their view was that their capital improvement

needs that could not be met needed to be addressed, and I'm wondering if, again, not asking for accounting level of guarantee, but what would you quantify those kind of capital improvement needs that need to be addressed on the two campuses in the next five years?

MR. KARL: Okay, so, our physical plant internally -- well, you have to look at it a few different ways, so please bear with me as I go through this.

Our physical plant internally aesthetically is ugly. The wallpaper is ripped. There's scratches on the walls in the patient rooms. The beds the patients are in I replaced them when I first started 12 years ago. The floors are worn. Aesthetically, the organization looks as though that it has not been maintained.

I can tell you that, over the past five years, the capital that we have expended has gone into backup generators, boilers, elevators, those behind the scenes costs that keep the organization functioning.

What we need to do now is actually prepare the organization for the future. There's a lot of hospital-acquired conditions. It's something that we live with all the time that scares the bejesus out of all

of us.

The last thing you want to do is get a patient come into the organization with an issue and end up with a hospital acquired issue. What we'd like to be able to do is get our organization into single occupancy beds. We'd like to upgrade our ORs. They are way undersized. They're only 45 years old.

We currently have, you know, as others, as Dr. Karl had mentioned, we've invested in some pieces of equipment that we found were extremely necessary; robots.

We need to upgrade those robots. We need to replace our CAT scanners. We need to replace our MRIs. We need to replace some of the basic necessities to take care of patients.

We have several different patient monitoring systems that we've pieced together over the years. They work extremely well. They need to be replaced.

We need to invest in some subspecialists, whether they're hand surgeons, whether they're neurologists, whether they're bariatric surgeons. There's obviously a significant obesity epidemic and so on and so forth.

We currently have these plans on the

docket. We've had these plans for quite some time. We have a 20-year-old EMR. They used to call them HIS, Hospital Information System. We have an HIS that needs to be upgraded. That's about $25 million.

There aren't returns on investments for a lot of these things, but these are the things that we're going to need to put in place in the future, so we can appropriately and properly care for the patients that we currently care for. That's just off the top of my head.

MR. SALTON: So would you kind of ballpark what you think those needs would require for capital investments?

MR. KARL: What I just threw at you right now?

MR. SALTON: Yeah.

MR. KARL: About 40 million.

MR. SALTON: Okay and I understand that Prospect's commitment of 75 million is to provide improvement, capital improvements to the benefit of the hospital business and for the benefit of the service areas of the two hospitals, and I understand you don't have specifics, as far as allocation, like do we want to put so much in MRI, do we want to put so much in building a new doctor's office building, or a parking garage for

our patients, but is there a sense of commitment that this $40 million out of the 75 million will be going to the campus or somewhere in that, some relative proportion that's close to that?

MR. KARL: Yes.

MR. SALTON: Now I want to make sure your partners agree.

MR. KARL: Okay.

MR. SALTON: Because I see a little glint in the eye.

MR. SPEES: Well my only hesitation is that we haven't reviewed all of those capital plans with the local leadership and the local Board and the management. It certainly sounds like the kinds of things that you would expect to find in circumstances like this, and it all sounds like the kinds of capital investment that we would want to make to actually build on the very significant initial capital investment that we're going to make, so I can't make an unequivocal commitment like that, without having had the opportunity to review the detailed disciplined approach to capital that we'll use.

MR. SALTON: So in doing your due diligence on the acquisition of these hospitals, you guys didn't look at the capital improvement demands that the

hospitals have before signing to acquire them?

MR. SPEES: Well we looked at, generally, the physical condition and the assets, but we haven't prepared a detailed capital expenditure plan. We certainly reviewed the capital needs list and deferred maintenance list, which Peter has described, but have not made a formal commitment, yes, we're going to do that, we're going to do that, we're going to do that.

In fact, we wouldn't. That's really part of our model here, is we work with local management and local leadership to identify those projects, so we would definitely give a lot of credence and weight to Peter's view of and local management's view of what the capital needs are and where they're best allocated.

MR. SALTON: You've made a three-year commitment to keep operating both facilities as acute care hospitals. Why only a three-year commitment?

MR. KARL: That's all we asked for, quite honestly.

MR. SPEES: We stepped into the prior transaction, and that was one of the terms in the prior transaction.

MR. SALTON: Would you be open to a longer commitment?

MS. VOLPE: No. It's not negotiated in a vacuum. You know that, Henry. I mean there's so many provisions in the asset purchase agreement that went into this. I mean, really, when you talked about have they looked at the capital needs, they spent a lot of time figuring out how much it was going to cost to pay all the pension liabilities.

I mean there was a lot of due diligence in recognizing how much money really needed to be spent here to preserve and maintain these hospitals.

MR. ZINN ROWTHORN: I'll ask a different question. Do you foresee circumstances three years out under which Prospect might make a determination that it no longer wishes to run an acute care hospital?

DR. LEW: As you sit here today, the answer is obviously no. The problem that we always run into is you never know what happens from a federal government regulation perspective or even from a state regulation perspective, in terms of how health care is provided.

So, in a vacuum, if all regulations were to stay the same and there were no substantial changes, then I think the answer is I don't see that, but the reality of the situation is that we don't control the

federal or the state regulations.

As a responsible business health care provider, we have to be able to be adaptive to both of those changes, so your point is that, usually, you don't see changes occurring in a short time, but five years down years the road, six years, seven years down the road, I don't know if anybody could sit in our seat and say that there are no changes that would have an impact.

MR. SALTON: So, at this point, you haven't done any assessment or evaluation of a consolidation of services between the two hospitals to try to locate one or close one?

I mean some people weren't around, but we used to have a hospital in the north end of Hartford that was acquired by another hospital, and it got scaled down and then disappeared, so that's one of the concerns I'm trying to anticipate.

MR. CROCKETT: Our commitment is to maintain the services for the three-year period. Getting back to our original sort of our presentation, as we look to go into value-based health care providing, we actually look to expand the service we're providing underneath the management of the population, and, so, is there services that are needed that are currently being provided outside

of the community?

Our goal would be to actually bring those services into the community at both of the facilities and I guess underneath the auspice of being the provider underneath health population management, so, actually, for the next few years, that's actually what our objective is.

MR. ZINN ROWTHORN: So the testimony, if I could summarize it, is that, absent substantial regulatory at the federal and/or state level, you would not anticipate ceasing to operate in these communities these two acute care hospitals?

MR. CROCKETT: I don't see -- I don't think there's anything that we see on the horizon that would change that, so that's accurate.

MR. REARDON: And take a look at our track record. We've never closed a hospital. We are a growth company, not a contraction company, but we can't predict five, 10 years down the line.

MR. SALTON: Okay. One of the conditions to the capital commitment I understand is that PMH is reserving the right to defer the commitment beyond the five-year period of the state or federal authorities, enact requirements after closing that discriminate

against for-profit hospitals and cause the hospital businesses to suffer a decline of EBITDA more than 10 percent in a year.

I just want to clarify. It's both those conditions. It's not one or the other, so the fact that the federal government passes something that seems to be, I don't know how we determine that, discriminates against the for-profit hospital, but doesn't actually impact to the extent indicated your -- hit the 10 percent number, that's not -- that would not, then, be a basis for deferral?

MR. SPEES: That's correct.

MR. SALTON: Okay.

MR. ZINN ROWTHORN: Let me take the opportunity to editorialize a little bit about that condition to the capital commitment.

On this side of the table at least, our function is to evaluate the fairness of the transaction, and that evaluation includes that $75 million commitment.

It doesn't include a $75 million commitment that may evaporate, depending on the regulatory atmosphere and how that changes federally or on a state level.

And, so, this is an issue that we've

confronted in past proposed transactions, and it's one that kind of regulatory legislative change carve out to a commitment that forms a substantial part of the value of the transaction is one that we've had a dim view of, so I'll say that comment for your benefit and give you the opportunity to respond to it.

MR. SPEES: I wish I had the language in front of me, but I'll speak from memory. So it's actually a very, very narrow commitment that is intended if there's some adverse regulatory development that is specific to for-profit hospitals only, so it's really meant to be something very narrow and extremely unlikely.

MR. ZINN ROWTHORN: Okay. One should not be surprised to see a condition that relates to that purported carve out if this transaction were to be approved.

MR. SALTON: Okay. I'm leaving capital commitment, and I only have one other question, which is, if you're a local physician, primary care physician or otherwise, they're participating the CRC and they're saying, okay, what are the obligations or requirements for this local physician to participate in the CRC?

Do they have to be a member of the IPA? Do they have to be employed by the Medical -- part of the

Medical Foundation?

DR. LEW: They can be employed or they can remain independent. That's one of the values of the model, is it can engage physicians, depending on where they are in their career and what their desires are for employment or not.

Contractually, they need to be part of the network and referred to physicians within the network. We're going to hold them to quality standards that are written out in the contract and tell them what quality metrics they're going to get bonused on and what's going to be asked of them, and there are a lot of other requirements related to submission of encounter data or usage of EMR and using best practices, as it relates to taking actually management of a patient.

So, you know, basically, they've got to stay within the network, refer patients that are part of our network, keep them in the network, and we hold them to the quality standards, but they don't have to be employed.

So you could have a doctor, who is part of the IPA, that might go to another hospital. They may actually be employed by someone, a system down the street. That's what's nice about our model and our

system. It's open, and, so, we are not a closed system in all of our markets. We have relationships with our competitors, okay?

We can use our model as a way to reach out and really start to manage population together.

MR. SALTON: Okay, so, just, again, from a layperson's perspective, so someone brings their spouse to the emergency room one day at Manchester Memorial Hospital, their family physician is an old-timer, who is not participating in the IPA, and they're admitted, because they have a condition, which requires some long-term chronic maybe follow-up, that the CRC would be a perfect kind of thing for population management, so if this patient wants or the hospital says we want you to participate in this population management process we have, do they have to then leave their physician?

Do they have to get their physician to sign up, or do they have to go to someone else? When you talk about managing a population, where you have some providers in the community, who may or may not be in your IPA, I'm wondering how that works.

DR. LEW: Yeah, so, Henry, what we would do is offer to have that patient brought into our programs and to be part of the care management program.

We call it Care Plus, and, so, even though they're not part of the IPA, they can still access the services, because it's better for the patient, and you don't want that patient to have to be readmitted.

What happens, so, we're doing this in other markets through an ACO and feeding patients into our model, is they like it, and they want access and to be part of a program, and, so, when it comes time to open enrollment to convert and be part of the network by signing up for a plan, that's what ends up happening.

So, to answer your question, no, they don't have to be part of a network to access the services, because, again, we still need to take good care of the patient and make sure they don't get readmitted.

MR. SALTON: Okay. Gary, do you want to ask some questions?

MR. GARY HAWES: Good evening. My name is Gary Hawes. I work at the Attorney General's Office, and, as noted at the beginning of this hearing, one of our primary responsibilities is the protection of the charitable funds, as those are seen the hospital, itself, being a charitable organization, the investment that the community has in the hospital, and, specifically, the actual charitable funds that the hospitals hold. Lots of

people give funds to the hospitals.

I really only have one question and a couple of requests for some late-filed exhibits, but, before I get there, I want to point out that the reason that I have so little is because the production that I got was wonderful.

I have found ECHN, and I haven't had to ask much at PMH, because I'm more with the ECHN charitable assets, but it's been a great production, so thank you very much.

And there was actually a production yesterday morning, and that's where some of my requests and questions come from, and these relate to the funds. There are about I'd say approximately about 100 funds that ECHN holds, either Manchester, Rockville, or the foundation, itself.

One question I have concerns the fund. My understanding is it's still in the midst of probate, and some distributions have been made. This is the Raymond F. Damato Fund or Estate, excuse me, and the fund number is, as it was submitted in Certificate of Need Application, 11.1-30, and the recently submitted filing talks about the ideas and the plan that ECHN has for the distributions that may come. Although the interest is

vested and some of the distributions have been made, not all of them have been made, and, so, the ECHN has a plan and has discussed with the executor what might happen with that.

My question is to what extent has ECHN committed to this proposal? In discussion at Board meetings, has there been a Board vote about what ECHN would like to happen with the Damato distributions?

DR. O'NEILL: We're going to ask our legal counsel to answer that, and then I'll give you a little side comment.

MR. HAWES: Thank you.

MS. JOYCE TICHY: So far -- can you hear me? My name is Joyce Tichy. So, so far, what we have done with our Board is that we -- the Board has been very interested in and hopeful to ensure that the funds made available through this request fully honor the memory of Mr. Damato.

He was a very well-known, deeply-loved person in the community, and just to give a little bit of background, he owned a number of properties in the Manchester area.

If you drive around Manchester and you happen to see apartment buildings with a covered wagon in

front of them, that was his signature. They are really all over, and, when you drive by, you know that that was his trademark.

He was not only a good and very loyal person in the community. He was also a very successful businessman, and, so, when he left funds to ECHN and others, he really just spread the benefit of all he had done throughout his life.

So, in that regard, knowing the history of Mr. Damato, the interest of the Board was to make sure that the intentions that he expressed through this bequest were honored, and we understood that his primary interest was not only to enhance the health of the community, but, through his other bequests, we knew he was very interested in education.

Actually, another part of his bequest went to Manchester Community College. Another went to another institution, not-for-profit institution of education in Connecticut, I mean in Manchester, East Catholic High School.

So, in thinking about this and knowing, as the Board does, some of the things that were expressed to you earlier, that it’s very important to maintain physicians in the community, to enhance our GME program,

so that physicians want to stay in Manchester and serve Manchester, the thought of the Board was to arrange for the transfer of the funds to the entity, the University of New England College of Medicine, that currently managers are graduate medical education program, with the restriction that the monies generated would and could only be spent in Manchester to further graduate medical education, with the further condition that, insofar as the monies would be needed to pay off ECHN's debts as part of the transaction, which, of course, is foremost for us, it would first be used toward that purpose.

So our Board is very interested in this concept. It meets a lot of where we think it's best for the money to go, and it also is, by its nature, it would be significant enough to matter to show that there was importance to the grant that he gave.

One of the options would be actually to finance a portion of the building where graduate medical education could be done and, insofar as possible, provide a naming opportunity to the building, so that his name would remain there for everyone to see.

So that's where it is. Where our Board has gone at this point is we have -- they have authorized us to pursue this with Unicom, and we have followed that

instruction by continuing conversations with Unicom.

We also, because we know that matters of this nature are of interest to the community and that the function of you all is to ensure that those interests are honored, we are actually waiting to see if you have any comment on it.

Were you to be agreeable to that, and I know that Mr. Hawes may have some thoughts about the structuring of it, we, then, would proceed with this process and continue to converse with Unicom and put together a resolution to the effect that we have described, but, at this point, there is no final Board resolution that sends the money over.

Another thing, just to add to this, is the executor of the estate we've met with him a couple of times, and he is very interested, also, in making sure that this money is used in the way that would be appropriate to Mr. Damato's money, and he has expressed a strong positive view toward this for all the reasons that I've just described.

So that's where we're at, and, certainly, if we could, if you have any thoughts about how to construct this appropriately, we are happy to hear those. We just want to do this right.

DR. O'NEILL: So just to add one more thought, what the Board did was we passed a resolution to pursue this idea with the executor and with the Attorney General. We didn't commit to any program.

MS. TICHY: We actually are hopeful that we could meet with one or more members of your office to describe the various kinds of facilities or possibilities that this money could be used for, one of which could be part of the building.

Another would be possibly this would be second, sort of have a list of things, but sort of lower on the list, but possibly appropriate, as well, would be to finance the actual medical education of the students that come through Manchester.

Getting a medical education is phenomenally expensive. It's an extreme weight on the shoulders of physicians, who then basically spend the first portion of their career just paying back the money, so if we could finance education in that way, with a hope that the person receiving the money would stay in Manchester, that is also a possibility.

Ultimately, the goal would be to make sure that the restriction is for medical education and in a health-related capacity, because that's what clearly his

bequest was intending. Did I forget anything?

MR. HAWES: Thank you. In yesterday's production, too, there were two outstanding issues with respect to funds, and, so, my request is going to be just for I guess a late-filed exhibit that addresses these two issues, and, if there's a problem with that, also, I would like to hear about that.

The E. Stevens Henry fund, it's Fund 11.1-55, this is one that my understanding is there's some difficulty trying to understand exactly how it should be classified, so for those of you, who are wondering about the classification systems we have, some are restricted funds, as to spending and to use, and we try to understand exactly how all that plays out, and then how those funds are going to ultimately be transferred to the new foundation, which is part of, also, of our jurisdiction.

So this one is, I guess, a difficult, well, I know it's a difficult nut to crack, so it indicated that the hospital was currently evaluating this, and, so, a resolution of that, should you be able to get there, would be great as a late-filed exhibit, so I think that would be --

HEARING OFFICER HANSTED: That would be

Late File No. 7.

MR. HAWES: Late File 7. And I think we can just do it in the same exhibit, if that exhibit can be a submission to our office.

You had indicated here that you're updating the values of the funds. I'm trying to remember what they were current as of. It was September 30, 2015, so I don't know the date that you could do that, if it can be March 31, 2016. I'm not sure if you can get us numbers for that, but that would be our most current fund valuation that we would definitely like to use.

As I indicated, too, one of the other areas that we have jurisdiction over and our job starts kind of after the transaction and creating a new foundation, and ECHN has presented to us a good draft Certificate of Incorporation and Bylaws for this new foundation, but one of the things, in addition to all these specific funds that will most likely be transferred there, is whatever charitable assets the fair market value that's remaining the assets of ECHN that's transferred over.

My review shows that the most recent analysis of that is a little outdated, so I just want to ask for an update on this. It's a table, actually. It's

a simple table, something that I can actually follow, and it was submitted to us in the response to the first and second letters of deficiency that were sent out by our offices. It was Table No. 8, and it was on page 2210, and it's the Net Proceeds Analysis.

My understanding is we don't need to go to the $115 million option, that we can just go with the $105 million option, but if that can be updated to, you know, whatever current numbers that exist and be filed, again, it can be filed along with the same document, just to provide us the most current information on that, that would be great, and I understand it's as current as you can be, with lots of things shifting.

That's all I have. Thank you.

MR. ZINN ROWTHORN: So I think that wraps up our collective questions. We took public comment out of order from our agenda, so, at this point, we'll ask if there's anyone, who has come in since the public comment section, or was here, but thought of something they'd like to say, and open that up to the floor. Anybody?

MS. VOLPE: If at all possible, we'd like an opportunity to make sure we address your concerns thoroughly on the capital commitment.

We understand that's an issue and a

concern, and, you know, we've had an opportunity to look at the provision. Again, this is a leftover provision from another transaction, and, you know, we made commitments and to step into it, but if you could indulge us just for a few minutes to talk among ourselves and get back to you?

MR. ZINN ROWTHORN: We'd be happy to do that. We're going to be together again tomorrow, so we could push that over until tomorrow.

MS. VOLPE: Sure.

MR. ZINN ROWTHORN: But I appreciate that, Michele. On behalf of the Attorney General's Office and the Attorney General, I want to thank all of you for your input.

This has been a long, but I think very productive, from our perspective, helpful and informative afternoon. We appreciate your patience with our process.

To the members of the public, who are still here or who were here, we thank you for your input. We were very happy to see such a big crowd, so thank you, all.

For those, who have an appetite for it, we're going to do it again tomorrow in Vernon. All are welcome. Some are required. (Laughter) But thank you,

and have a good evening.

HEARING OFFICER HANSTED: Just one point of housekeeping before we leave. The late files, those will be due April 8th. Does that give enough time for everything?

MS. VOLPE: What is the plan, in terms of keeping this open? I mean do you plan on keeping this open beyond April 8th?

MR. ZINN ROWTHORN: Well I can tell you, with respect to at least the issue of the immediate jeopardies, we would like to keep that open up through our decision date to receive documents that go back and forth between the parties and CMS, so, at least to that respect, I think we'd like to be as up-to-date as possible, and then I don't know if others have thoughts about keeping the record open.

HEARING OFFICER HANSTED: I'm not opposed to it. I just want to set a finite date.

MS. VOLPE: Sure. Could we, depending on what late files we hear for tomorrow, could we agree on a date tomorrow?

HEARING OFFICER HANSTED: That's fine.

MS. VOLPE: So we know the totality of what we're producing, and we'll be in a better position?

HEARING OFFICER HANSTED: Yes. Yes. So we'll set a date at tomorrow's hearing.

MS. VOLPE: Thank you.

HEARING OFFICER HANSTED: Okay, thank you, everyone.

(Whereupon, the hearing adjourned at 7:38 p.m.)

HEARING RE: ECHN AND PMH
MARCH 29, 2016

AGENDA

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Eastern Connecticut Health Network, Inc.
Proposed Asset Purchase by
Prospect Medical Holdings, Inc.

OHCA Docket Number: 15-32016-486
Attorney General Docket Number: 15-486-01

LATE FILES

Number	Description
1	Timeline of ECHN's Review of PMH's Immediate Jeopardy Citations/Deficiencies in California
2	Quality Improvement Plans Adopted at Los Angeles Community Hospital and Southern California Hospital at Culver City
3	Curriculum Vitae of PMH Corporate Quality Personnel
4	Corrective Action Plan for Los Angeles Community Hospital (Responding to Deficiencies Cited as a result of Resurvey Conducted February 16-17, 2016)
5	Reports of ECHN's Quality Evaluation Team to the Board of ECHN
6	Delegation of Authority of Quality/Compliance to Local Boards in Rhode Island
7	Classification of E. Stevens Henry Fund and Updated Values of Charitable Funds as of March 31, 2016
8	Revised/Updated Table 8 – Net Proceeds Analysis
9	Example of Health Needs Assessment Conducted by PMH (e.g., application for OB services in Rhode Island) or Letter describing community involvement in health needs assessments
10	Description of PMH's Corporate Quality Program (to include organizational chart showing staffing)
11	Description of Process for Development of Strategic Plan
12	List of Critical, Immediate (over next 2-3 years) Capital Needs at ECHN
13	Description of Local Board (to include composition, process for appointment and authority)
14	Description of Proposed Allocation of Responsibility for Quality Matters (corporate v. local)
15	Copies of all CMS Statements of Deficiencies for PMH's Rhode Island Hospitals since date of acquisition
16	Updated Information on Pension Obligation and Impact on Cash Flow Projections.
17	Reconciliation of Revised Quarterly Financial data submitted on March 29, 2016 with original submission, on page 2325, and ECHN's AFS. Explain the variances and any increases/decreases to the items listed on Section D between FY 2014 YTD and FY 2015 YTD for the month of September.
18	Revised/Updated Exhibit R – PMH Free Cash Flow
19	Revised/Updated Exhibit W – EBITA, Working Capital and Stockholders' Equity of PMH Hospitals (Prior to and Post Acquisition) inclusive of New Jersey acquisition

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OFFICE OF HEALTH CARE ACCESS

EASTERN CONNECTICUT HEALTH NETWORK, INC. (ECHN) AND PROSPECT MEDICAL HOLDINGS, INC. (PMH)

PURCHASE ECHN ASSETS BY PMH

DOCKET NO. 15-32016-486 AND 15-486-01

MARCH 30, 2016

2:00 P.M.

ELKS LODGE
9 N. PARK STREET
VERNON, CONNECTICUT

POST REPORTING SERVICE
HAMDEN, CT (800) 262-4102

. . .Verbatim proceedings of a hearing before the State of Connecticut, Department of Public Health, Office of Health Care Access, in the matter of Eastern Connecticut Health Network, Inc. (ECHN) and Prospect Medical Holdings, Inc. (PMH), Purchase ECHN Assets by PMH, held at the Elks Lodge, 9 N. Park Street, Vernon, Connecticut, on March 30, 2016 at 2:00 p.m. . . .

HEARING OFFICER KEVIN HANSTED: Good afternoon, everyone. This public hearing before the Office of the Attorney General and Office of Health Care Access, identified by Docket Nos. 15-32016-486 and 15-486-01-CON, is being held on March 30, 2016 to consider Eastern Connecticut Health Network and Prospect Medical Holdings application for the purchase of the assets of Eastern Connecticut Health Network by Prospect Medical Holdings.

This hearing is part of the procedure under what is commonly referred to as the Conversion Statute, which requires the Commissioner of the Department of Public Health and the Attorney General to evaluate any proposal, which would convert a non-profit

Connecticut hospital to a for-profit entity.

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

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

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

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

Eastern Connecticut Health Network and Prospect Medical Holdings have been designated as parties in this proceeding.

At this time, I'll turn it over to the Office of the Attorney General for a few opening remarks.

MR. PERRY ZINN ROWTHORN: Thank you, Kevin.

HEARING OFFICER HANSTED: You're welcome.

MR. ZINN ROWTHORN: Good afternoon, everybody. My name is Perry Zinn Rowthorn. I'm the Deputy Attorney General. I've been designated by Attorney General George Jepsen as the Hearing Officer in this matter for the Office of the Attorney General.

I want to thank the Applicants for being here today, the witnesses, and public officials that we will hear from, and a special thank you to the members of the public, who are here.

We recognize that this transaction is important to your community, to all the communities that ECHN serves. That's why we're here. We're happy to see so many of you here.

We recognize that we have some tight quarters, but we are happy to have you with us today.

We're conducting this hearing jointly with OHCA, but the Attorney General's criteria in evaluating this transaction and his focus are slightly different. I'll say a few words about that.

The Attorney General's role is defined and limited by statute, the Conversion Act that Attorney Hansted referred to, Section 19a-486 of the Connecticut General Statutes.

That Act reflects the Attorney General's

traditional role in protecting the public interest and charitable assets and insuring that monies and properties committed to a charitable purpose are safeguarded and used appropriately.

Non-profit hospitals and hospital systems, like ECHN, hold their assets for essentially a charitable purpose, providing health care, not for generating profits for shareholders or owners, and, in that way, they are different from for-profit hospitals.

The administrators of a non-profit hospital are the stewards of its charitable assets with a responsibility to take good care of those assets.

The law does not prohibit non-profit hospitals from converting to for-profit status. When one seeks to do so, as here, the Attorney General's job is to ensure that the non-profit hospital is meeting its obligations of good care for charitable assets.

We make sure three things, that the process leading to the sale was responsible. Were the hospital administrators careful in deciding to sell and choosing a buyer and negotiating a transaction?

Second, that the terms of the sale are fair. Will the hospital get fair market value for its assets? And, third, that the proceeds of the transaction

will continue to be used for charitable health-related purposes, those proceeds remain charitable assets after the transaction, and we need to ensure that the assets of the sale are protected from being used for the for-profit purposes of the new hospital system.

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

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

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

Don't assume, if we don't ask a question on a topic, that the topic is unimportant to us. Before today, we have received and reviewed thousands of pages of documents, we've asked questions and follow-up questions, and all of the materials that have been generated as part of our review are available on the Attorney General's website. That is www.ct.gov/ag.

Your input is particularly important to

our review. All the information we receive today and in the hearing that we held yesterday in Manchester will become part of the official record of our review.

We'll also take comments in writing, and those comments, if we receive any, will be included in the official record.

We have sheets available at the door, I believe, that discuss the process to sign up to speak, as well as the process for submitting written comments. Please take copies of those sheets for yourself or for anyone you know, who might be interested in submitting a written comment.

We are on track to complete our review under the current schedule as early as June 10th of this year. A word about what our decision might entail.

Under our statute, the Attorney General must approve the transaction as is, deny it, or approve it with conditions that relate to the purposes of the Conversion Act. For the Attorney General, that means conditions that relate to the Attorney General's focus on charitable assets and their future protection.

This is a joint hearing. Kevin and I are going to work together to move this along to cover as much business as we can. You can assume that if either

of us makes a ruling on an objection or a point of evidence, that that ruling applies to both of our offices, unless we otherwise state it, and, if we ask a question, that that question and its answer are part of each of our office's review.

The agenda for today is going to be slightly different than it was yesterday. We received some feedback from the public, that they wanted to be heard earlier in our proceeding, so we'll proceed as follows.

We'll take opening statements from the Applicants. After that, we'll have an opportunity for public comment. It's traditional to hear from public officials first, then we will have questions from OHCA, and, if the Attorney General's Office has questions after OHCA finishes its questions, we'll ask questions, and then we will reopen it for public comment after that.

I'm going to turn it back over to Kevin for some additional important business notes. Before I do that, I want to recognize and thank the staff from the Attorney General's Office, who is here with me today.

To my immediate left is Assistant Attorney General Henry Salton, who is providing legal advice to the Attorney General and to OHCA in this proceeding, and

to his left is Assistant Attorney General Gary Hawes, who is coordinating this review for the Attorney General's Office, and with us somewhere here is paralegal specialist Cheryl Turner. Thank you for your attention.

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

MR. STEVEN LAZARUS: Good afternoon. Steven Lazarus. As of yesterday, we had entered into the record Exhibits A through BB. We also had some additional exhibits added since yesterday, so the Table of Record has been extended to include Exhibit GG.

There were some notes, edits that were brought up by Attorney Matthews. Those are not being included at this point, however, they will be done prior to the close of the hearing, and we will provide you with an updated, revised Table of Record prior to the closing.

MS. REBECCA MATTHEWS: Thank you. This is Rebecca Matthews, counsel for ECHN.

We also made one request about the administrative notice taken regarding the Greater

Waterbury Health Network application. I know that's already on the record. I just wanted to note it again, if that's okay. Thank you.

MR. ZINN ROWTHORN: Can speakers be careful to speak into their microphones and make sure that our audience, which extends into the second room, can hear us? Thank you.

HEARING OFFICER HANSTED: Thank you. Any objections to the exhibits, Attorney Matthews?

MS. MATTHEWS: No.

HEARING OFFICER HANSTED: No? Okay.

MS. MATTHEWS: No objection.

HEARING OFFICER HANSTED: Thank you. And now I'd like all those individuals, who are going to testify here today, to please stand, raise your right hand, and be sworn in by the court reporter. You have to turn around, folks. She's behind you.

(Whereupon, the parties were duly sworn in.)

HEARING OFFICER HANSTED: Okay, thank you, everyone, for doing that. Now, as we did last night, would you just please each identify yourselves for the record, whoever wants to start?

MS. MATTHEWS: Rebecca Matthews, counsel

for ECHN.

MR. PETER KARL: Peter Karl, CEO of ECHN.

DR. DENNIS O'NEILL: Dennis O'Neill, Chair of ECHN.

MS. JOY DORIN: Joy Dorin, Board of Trustees, ECHN.

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

MR. VON CROCKETT: Von Crockett, Senior Vice President for Prospect Medical Holdings.

MR. JONATHAN SPEES: Jonathan Spees, Senior Vice President for Prospect Medical Holdings.

MR. STEVEN ALEMAN: Steve Aleman, Chief Financial Officer, Prospect Medical Holdings.

MR. TOM REARDON: Tom Reardon, President of Prospect East.

MS. MICHELE VOLPE: Michele Volpe, Legal Counsel for Prospect Medical Holdings.

HEARING OFFICER HANSTED: And we had a couple of folks in the audience, who were sworn in. Would you just please identify yourselves for the record? I believe the public comment microphone is on behind you.

MR. DENNIS McCONVILLE: Dennis McConville, Senior Vice President for ECHN.

MS. LINDA QUIRICI: Linda Quirici, Vice President for Patient Safety and Quality.

MS. NINA KRUSE: Nina Kruse, Vice President of Communications.

MR. MICHAEL VEILLETTE: Michael Veillette, Chief Financial Officer of ECHN.

MS. JOYCE TICHY: Joyce Tichy, General Counsel, ECHN.

HEARING OFFICER HANSTED: Thank you, everyone. Attorney Matthews, you may proceed with your opening.

MS. MATTHEWS: Thank you. I'm going to actually just turn it over directly to Dr. Dennis O'Neill.

DR. O'NEILL: Thank you, Rebecca. Good afternoon, Mr. Hansted, Mr. Zinn Rowthorn, members of the Office of the Attorney General and members of the Office of Health Care Access.

My name is Dennis G. O'Neill. I'm the Chair of the Board of Trustees of Eastern Connecticut Health Network.

I'm also a physician in private practice working in the Manchester and Vernon communities for the past 33 years.

Thank you for providing us with the opportunity to submit testimony in support of ECHN's proposal to transfer its assets to Prospect Medical Holdings.

First, I would like to adopt my pre-filed testimony, then I'd like to explain that, after my introductory comments, Peter J. Karl, ECHN's President and CEO, is going to make a brief presentation on our financial situation.

Joy Dorin to my left, one of our Trustees and Chair of the Board's Transaction Committee, will then present information on the transaction, itself, and ECHN's quality program, after which representatives of Prospect Medical Holdings will offer information on their organization.

Manchester Memorial Hospital and Rockville General Hospital, the flagship hospitals of ECHN, were built about 95 years ago by members of their respective communities in response to the influenza pandemic of 1918 and, also, as memorials to those community members, who died in World War I.

For many decades, these hospitals functioned as separate community hospitals, and then, about 20 years ago, they joined together to form ECHN.

They were both in good financial shape at the time, but pursued a merger, in order to provide more efficient and better integrated hospital care for their citizens.

Over the last two decades, ECHN has grown, as the communities have grown, beyond the two hospitals into a health care network with 13 wholly-owned subsidiaries, 12 joint venture companies, and dozens of facilities serving the needs of our communities.

ECHN now employs 3,000 people in eastern Connecticut, and the hospitals in Manchester and Vernon are the largest employers in their communities.

In just this last year, 2015, approximately 115,000 people were treated in our hospitals, 61,000 were examined in our emergency departments, 5,000 folks were cared for by our visiting nurses, and we delivered about 1,400 babies.

Needless to say, the citizens of eastern Connecticut need and use our facilities, but the American people, in general, and the members of our communities, more specifically, have told us that they want and need care that is even more integrated than the care they receive today, care that is higher in quality and lower in cost.

In an attempt to respond to these needs and in anticipation of worsening financial conditions, the trustees of ECHN formed, about four and a half years ago, a work group to evaluate whether or not ECHN should pursue a partnership with another organization.

At that time, we thought we had about five years before our circumstances became dire, due to changes in the health care landscape that we thought were going to have a negative effect on our organization.

The first year was spent deciding that we should partner, as opposed to going it alone. In the second year, we selected as our best option an asset purchase agreement offered by Vanguard Health System and Yale-New Haven Health System.

In the middle of that second year, Vanguard was acquired by Tenet, and we spent the remainder of the year getting to know them.

During year number three, we negotiated a deal with Tenet that would have preserved our hospitals, the jobs of our employees, and the pensions of our retirees, and provided capital for future growth, but, at the end of 2014, Tenet abruptly left the state, citing what it perceived as overly restrictive conditions placed on its acquisitions by state regulatory agencies.

That was a great disappointment to us, because it essentially scuttled three years of work, and because, more importantly, we were three years closer to 2016 with still no deal in hand.

But then, in 2015, our fourth year, we were fortunate enough to find Prospect Medical Holdings and spent most of that year negotiating a deal with them and resubmitting our application for regulatory review.

Prospect is a health care company based in California that, through the business acumen of its founders, the perspicacity of its senior management team, and the perseverance of its staff, has in the last two decades become an industry leader in what is referred to as population health management.

That is managing all aspects of a health system, inpatient care, outpatient care, physician office care and home health care for a large group of people, in this case eastern Connecticut, with higher quality and lower cost.

Like all health care companies, though, Prospect is not a perfect hospital company. Last year, during inspections at two of its California hospitals, the Centers for Medicare and Medicaid Services, CMS, made determinations that required correction. You'll hear

more about this from Joy Dorin and the folks from Prospect.

It's important to note, though, that our trustees and corporators chose overwhelmingly, the trustees voted unanimously, and the Corporators voted with 98 percent in favor to transfer our assets to Prospect for at least three important reasons.

First, Prospect is not Tenet. They're smaller in size, less threatening as a newcomer within the state of Connecticut, and because they're not affiliated with Yale or Hartford HealthCare, they would actually increase, rather than reduce, competition within our state.

Secondly, the deal we negotiated with Prospect is essentially the same deal we negotiated with Tenet, with preservation of our hospitals, employees and retirees and capital for our future.

And, thirdly, Prospect is a recognized expert in what they refer to as and what you'll hear more about in a couple of minutes coordinated regional care, taking to a new level what began with the creation of our two hospitals many years ago and continued with the formation of ECHN.

Now, for more detailed information on

ECHN's financial condition, I'd like to pass the microphone to Peter J. Karl, ECHN's President and CEO.

MR. KARL: Thank you, Dr. O'Neill. If you can think back this far, 2010 was a milestone year for the country. The Affordable Care Act legislation was passed by the federal government, and what that meant was there was going to be a change in the way health care is provided. Hospitals, health systems, positions will be rewarded for value of care.

A lot of the reimbursement risk will fall on the hospital providers, themselves, and the physicians, themselves.

This fee for service methodology that we have lived under for many, many years, as far back as many of us can even think, is going away.

That's when we made the decision to think about partnering. We recognize remaining independent was essentially the kiss of death.

I would ask that the regulators in front of us please take my next three slides and put them side-by-side, as we did yesterday. It helps to follow along for me to tell the story. That would be slide seven, slide eight and slide nine.

I began at ECHN as CEO at the end of 2004.

As you can see by the top chart, ECHN suffered significant losses prior to me coming here. A lot of this had to do with the merger of the two institutions and some of the difficulties associated with the past merger.

As you can see, though, in the earlier years, fiscal year ’08, ’09 and ’10, you could see that the organization was performing relatively well, not great. Two to three percent margin, two percent margin.

But as you can see below, the situation that we’ve all had to deal with, one is pension funding reform, and then, of course, the market crash. All of that happened between 2008 and 2009, so the liability, our pension liability, jumped significantly, and what that really meant was that we had to begin funding our pension significantly.

In the past, because of the performance of the stock market, the pension funded itself, so that was not a concern.

We, then, of course, had our debt payments, as you can see on the bottom graph in dark blue. Our debt payments were taken into account, and we pay approximately $12 million a year to pay down our debt.

As you can see, we really did not increase our debt very much, except for one year in 2009, where we took out additional debt to replace our Critical Care Unit at Manchester Memorial Hospital.

Back in the earlier years, in 2004, you could see there was a jump. That money was used to upgrade the Rockville General Hospital facility.

What we found during these years is that reimbursement was declining, pension liability was increasing, and then, as you can see in 2015, the government updated the mortality tables for a very good reason.

Everyone was living longer, therefore, the mortality tables had another effect on our pension, which our liabilities then grew significantly.

If you look at the next page, you can see that, in 2014, ’15 and ’16, the hospital tax was put into play by the most recent state government. There was also sequestration that was put in place by the federal government, because they were unable to balance their budget, and then, of course, there were other reductions in reimbursement.

So, if you tie back the second page to the first page, you can see why our income had dropped

significantly. You may even wonder how we were able to survive with these significant reductions in reimbursement, and we were still able to either break even or just barely have a loss, but what that has created is an issue that is explained on the next page, and that is our inability to reinvest in our facility.

We can no longer -- we no longer have free cash flow to reimburse, to reinvest in our facilities, and our facilities have aged significantly.

As you can see at the top, the age of plant is 21 years. What that means is it's about twice as old as the average hospital plant is nationally.

The age of the plant that you'd like to have is around between eight and 10 years old, and what that means is replacing equipment, replacing the infrastructure of the organization, keeping it up-to-date. Ours is very, very old.

How are we able to still barely get by in '13, '14, '15, even though we weren't making any type of income, especially with these cuts?

Well we had to reduce our labor costs, and, therefore, 60 percent of our operating budget is labor. We had to reduce employees. We had to reduce jobs to the tune of 200 positions were eliminated.

We also, as I mention on this slide, we did not reinvest in the facility, so we are limping along. Unfortunately, we are at the end of our rope, and the rope is beginning to fray.

So, more or less, to wrap up our condition, our financial condition, there is continued payment erosion, as I've mentioned, declining levels of payment from the state government, payment reforms with more financial risk, increased pension obligations and rising costs. This is just simply unsustainable.

Now, again, we saw this coming four, four and a half years ago. Not to this great extent, thank you. I just lost my mind for a second. But we did see it coming.

So we went through an RFP process. Dr. O'Neill mentioned that we selected Prospect Medical. The RFP process included several other suitors.

We felt, clearly, that Prospect was the best. Prospect stepped into the shoes of Tenet Health Care. We'll be paying $105 million to satisfy our debts and obligations and have agreed to invest $75 million of capital.

They will maintain Manchester Memorial Hospital and Rockville General Hospital, Woodlake at

Tolland and VNHSC, our Visiting Nurse of Connecticut. They'll continue with the brand, and they will still install a Community Advisory Board.

And just to expand on that a little bit to answer one of the questions that Mr. Salton had yesterday, the local Board will have primary responsibility for the quality program and are delegated to make changes, as necessary.

Corporate provides checks and balances. That will be covered more in the PMH presentation, but we did have a little bit of clarification, because I know there was some confusion yesterday. We wanted to make sure we responded from both parties to that.

There will be a continued commitment to charity care, employment for all eligible ECHN employees, and establishment of a community foundation to oversee the charitable funds that are leftover from the deal.

This community foundation will be an arm's length, independent foundation, not controlled by the new ECHN.

We feel the culture fit between ECHN and Prospect is there. We did our site visits. We visited their organizations, as compared to other suitors. There are always questions about why a for-profit, and my

answer is this. For-profits are able to go to the equity markets. We are unable to do that.

I wanted to make a statement, because I think it's very important. People, some people in the community think that there's a benefit for administration, myself, to sell this organization and that I will be making and reaping in a lot of money for this sale.

This is not a leverage buyout. This is not a hostile takeover. This is a sale of the organization that's been agreed upon by both parties. There is no financial benefit or bonuses for me or for any of the administrators that are on my team. I just wanted to make that very clear.

Thank you very much. I will pass the baton over to Joy Dorin, who is the Vice Chair of the Board of Trustees.

MR. ZINN ROWTHORN: Mr. Karl, before you do that, can I ask for one clarification for the benefit of the audience?

You mentioned that for-profits have access to equity markets, which may not mean a lot to some in the audience, but what is the significance of that, based on the condition of the hospital that you just described

to us?

MR. KARL: Okay. Thank you to help me clarify that. Not-for-profits can only go to borrow money through a bond process, so they go out, and they seek loans, bonds, float bonds.

For-profits are able to go out and raise money through the stock market, and PMH can explain that more clearly.

For instance, PMH, 55 percent of its ownership is Leonard Green. Leonard Green is an equity company, and they are able to go out and raise capital by going, as I said clearly, and, Steve, you can -- Steve can explain that a little bit better.

MR. ALEMAN: Sure. The alternative methods that we have as a for-profit, as Peter was stating, is private equity groups, who ultimately become shareholders and can invest money into the company for growth and operations.

In addition to that, we have access to the open markets, whether it’s additional shareholders or investment banks, who look to provide alternative forms of debt, to raise capital for future acquisitions in growth within the company.

All of those are avenues that we have at

our disposal, we have used in the past, and look forward to using in the future for the growth of kind of our -- Prospect, as it stands in future acquisitions.

MR. REARDON: I wonder if I might just add something, Peter. For a long time, tax exempts had a tremendous advantage, in that they could go out and get taxes and financing through bonds, but do you know what taxes and financing can be used for? Bricks and mortar, and that's not where the action is anymore.

You can't use it for purposes of IT systems. You can't use it for purposes of population management infrastructure. Bricks and mortar is not where the action is anymore, and, so, now it's a huge shortcoming for non-profit tax exempt organizations.

MS. DORIN: Thank you and good afternoon. My name is Joy Dorin, and I adopt my pre-filed testimony.

I've been a member of the ECHN Board of Trustees since 2004 and currently serve as the Vice Chair and Chair of the Transaction Committee.

In my professional life, I've held positions in health care organizations, including Cigna Health Plan, Athena Health Care and Qualidigm, the state's quality improvement organization that works with the Centers for Medicare and Medicaid.

Throughout my career, I've been involved in and responsible for quality, patient satisfaction and compliance matters across the health care continuum.

In addition to my professional background, I'm a longtime resident of Manchester, nearly 40 years. While I was born and raised in New Jersey, I consider Manchester my home.

This is where my friends live, my son and his young family live, and my husband owns a small business on Main Street.

I mentioned my Manchester roots, because insuring ECHN's future is important to me, and it's important to every other individual and family, who lives east of the river.

In evaluating our options, we established four goals, that high-quality health care services are accessible, affordable and delivered safely to the people in this part of Connecticut, that clinical services are expanded, that employees continue to have jobs, and that facilities and technology are upgraded.

Dr. O'Neill talked about the importance of preserving ECHN to serve the public need, and Mr. Karl covered the financial challenges and how the Prospect transaction will allow ECHN to meet these challenges.

I'd like to spend a few minutes focusing on the importance of quality and safety. We are proud of the efforts our staff and physicians have taken.

Of note, ECHN was one of the first networks in Connecticut to become a high-reliability organization.

HROs understand that they operate in an environment of high risk. Industry examples are health care, aviation and nuclear power.

These organizations work hard to manage risk and strive to reduce accidents, but, if they do, HROs will work to learn from these accidents to minimize their reoccurrence.

This decision and journey has changed our culture to the benefit of our patients. It has resulted in process improvements and a reduction in serious safety events.

Our focus on quality has resulted in the Joint Commission recognizing our two hospitals as top performers.

At Manchester Memorial Hospital, we were recognized for heart failure, pneumonia, surgical care, immunization and perinatal care and at Rockville General Hospital for pneumonia, surgical care and immunization.

Because of these accomplishments, it was important that our potential acquirer share our commitment to quality and safety.

As part of our initial due diligence, ECHN requested quality information from all potential acquirers and did a side-by-side comparison of the CMS quality indicators.

We also visited hospitals owned by the potential acquirers and met with staff members involved in quality and performance improvement.

More specifically, visits were made to Prospect hospitals in California and in Rhode Island to obtain additional information and to learn more about the Prospect coordinated regional care model.

When ECHN learned of the immediate jeopardy determinations identified at the Los Angeles Community Hospital and the Southern California hospitals, the Board determined that it needed more information and appointed a quality evaluation team to research and report back to the Transaction Committee and the Board.

I was appointed to the team, along with Dr. Michelle Conlin, the Chair of the Performance Assessment and Improvement Committee and a practicing physician, and three members of ECHN’s Quality

Department, the Vice President of Quality and Safety and two Quality Improvement Managers.

The team was charged with determining whether Prospect's experiences in California could threaten or diminish ECHN's current quality and safety standards and its ongoing performance improvement initiatives.

To complete our charge, the team first focused on the immediate jeopardy issues and deficiencies and Prospect's plans for correction.

The team found the remediation plans to be comprehensive and appropriate, and, in several minutes, a representative from Prospect will provide more information on these issues, their root causes and the corrective action plans.

The evaluation team, however, didn't stop here. We decided to go broader and deeper, and, over the last four and a half weeks, we requested, received and reviewed extensive amounts of information from Prospect about its hospitals in California, Texas and Rhode Island.

This information included past regulatory surveys, remediation plans and year-over-year quality metrics. The quality reviewers focused, in particular,

on the most recent surveys, as they would be most likely to reveal any issues or patterns of concern with how Prospect currently conducts its hospital business in the areas of quality and safety.

The team also looked retrospectively at quality assessment and performance improvement indicators and prospectively at the 2016 Quality Assessment and Performance Improvement Plans.

Additionally, we reviewed employee turnover statistics and, in a parallel activity, collected and discussed updated financial information.

Given that regulatory standards are applied differently among regions, the evaluation team paid special attention to Prospect’s CharterCARE hospitals in Rhode Island.

The evaluation team sent its Quality Department team members to those hospitals for a day-long visit to observe and evaluate the aspects of the quality and safety programs in person.

The ECHN reviewers found not only that the programs were of high quality, but they had been enhanced, rather than scaled back, after Prospect’s acquisition.

Throughout this review, Prospect made its

information and personnel fully available to assist us. As we discussed their plans and approach to quality and safety, Prospect was asked specifically whether or not they expected to receive any additional survey deficiencies.

Prospect responded that, while immediate jeopardy findings were not expected, because of the new quality controls, structure and processes it had implemented, it was likely that additional deficiencies would be noted. This, in fact, did happen.

In the March 23rd CMS response to the Los Angeles Community Hospital resurvey, the hospital was cited for deficiencies.

Prospect communicated this to us on the same day they were notified, and we have since had several follow-up communications with them about these results.

Quality improvement, by definition, is a continuous process. We all know hospitals are complex regulated organizations with many moving parts, and sometimes, despite the best intentions and focus on care, issues do arise.

After the review just outlined, the evaluation team concluded the immediate jeopardy issues

were isolated, that Prospect took the California survey results seriously and responded swiftly with corrective actions.

The evaluation team also collaborated with the Transaction Committee and ECHN Council to evaluate Prospect's continued appropriateness as a transaction partner. The Transaction Committee recommended that ECHN seek a quality commitment letter to ensure ECHN's patient quality, patient experience and safety programs retain their forward momentum for a period of time post-closing.

Prospect has agreed to execute such a letter, which also contains a provision for ECHN to benefit from the quality improvement programs observed at the CharterCARE hospitals and to maintain these programs consistent with industry best practices.

Based on the findings presented by the evaluation team and the protections gained under the quality commitment letter, the Transaction Committee recommended and the Board confirmed ECHN's commitment to proceed with the transaction.

With the Prospect acquisition, ECHN will have responsibility for quality and safety. This means the current ECHN quality team will continue its good work in eastern Connecticut.

In addition, it is anticipated that Prospect's eastern region, which includes Prospect's hospitals in Connecticut and Rhode Island, will collaborate on quality and safety measures that are expected to be implemented in Prospect's hospitals across the country.

ECHN looks forward to this collaboration. Thank you for your time.

MR. ZINN ROWTHORN: Thank you. Can I ask for some signal from the back about whether folks can hear what's being said up here? Okay, thank you.

DR. O'NEILL: That concludes ECHN's initial presentation. Next, I'd like to pass the microphone to Dr. Mitchell Lew, the President and CEO of Prospect Medical Holdings.

DR. LEW: Good afternoon. ECHN and Prospect, committed to this community. Who is Prospect? We are a health care services company that operates local community hospitals. We utilize local governance and local physician leadership.

We make investments in our hospitals and in our communities. Some examples of this would be in Rhode Island. We recently completed a beautification project at the hospital, where we redid the entry, we've

enhanced the GI lab, and we're looking to possibly open a cardiac heart lab.

As far as investments in the communities, in California, we identified two community needs that needed to have some facilities, so we opened two new hospitals, one in Bellflower, it's a psych hospital, and one in Orange County, California, which is an acute med surg.

The stability that we offer communities are continued employment and creation of new jobs. We expand programs and services to improve access and quality.

Some examples of this would be, in our hospitals in Texas, we opened up an emergency room. In California, we've opened several urgent cares and wellness clinics, and, also, in Rhode Island, we've opened several urgent cares in and around the community.

Our hospitals. We have 14 community hospitals, seven in California, four in Texas, and we've owned those for about four years, two in Rhode Island, and it's been coming up on two years, and one recently in New Jersey.

We serve many different communities. I'd like to point out that many of the hospitals that we have

are in underserved communities, and we accept all health plans. To us, a patient is a patient.

We provide medical, surgical, in some cases tertiary, psychiatric and long-term services. We have a lot of experience in proving multiple services at our facilities.

We have over 40 outpatient clinics and centers. A lot of the care in our model is delivered outside of a hospital, because we want care to be appropriate in the right setting.

We're not just a hospital company. We also own and operate medical groups. We've been doing this for quite some time in California. You can think of our physician groups as multi-specialty health care provider groups without walls, and our physicians are linked into what we call Independent Practice Associations, or IPAs, and these are just networks of doctors that work very closely together, and, in these networks, the physician can be independent, on their own, or they can be employed.

Either way, it works for us, and important to note that we are an open system.

As I've mentioned, we've been in Southern California for quite some time, over 20 years. Also, in

Texas. We have over 500 doctors in our network, in Rhode Island, over 350 physicians, and, even in New Jersey, we have about 125 physicians.

We're contracted with all major health plans. We have nearly 9,000 physicians under contract. We take care of nearly 300,000 patients, and we provide coordination of care across the entire continuum, so if a patient is in a hospital or in a nursing facility, clinic, physician office, we follow their care throughout.

Our goal is to achieve better outcomes, with higher patient satisfaction. We want patients to go and tell their family and friends to come receive care here.

Now through our experience of operating hospitals and running physician groups, we've developed a very unique model of care, and it's a delivery model that we refer to as Coordinated Regional Care, or CRC.

And, so, the definition of CRC is the integration hospitals, physicians and other medical and community providers, and I want to emphasize community, because we always work with the community and local agencies, whether it be a home health agency, or a DME, Durable Medical Equipment company, or a palliative

company. We always create the network with the surrounding community providers, but we work very closely with the health plans and the government payers in a very strategic way, because we want to achieve the best patient care and the best outcomes.

We've implemented this model in seven regions, in California, Texas and Rhode Island and currently in development in New Jersey, Connecticut and Pennsylvania, and we've already made great strides here in Connecticut, in terms of setting up our model.

We practice population health management, which is a very popular buzz word, but, to us, what that simply means is that we value the care of every person in the community, and we want to make sure that we take the best care of everyone.

With this unique model of care provides higher value, because, in our opinion, better care does not need to cost more.

So what is our secret? How do we do this? How do we improve care and outcomes? We use a patient-centered and a physician-led approach.

We have multi-disciplinary care teams that take care of high-risk patients 24/7. We have the ability to stratify the sickest patients in the

population and really focus with these teams. The teams consist of nurse practitioners, social workers and pharmacists that follow a patient and are available around the clock, and, if necessary, we will go to the house to evaluate a patient and provide care.

We engage the patient and the family. I spoke already to the homebound program. We take care of specific diseases with specific care plans, such as diabetes and heart disease.

We integrate behavioral health, because we've learned that many patients have coexisting diagnoses. Some are medical diagnoses, some are behavioral health, and, in order to really appropriately and efficiently take care of one's health, you've got to approach both, the behavioral health and the medical health, so we've implemented that into our model.

We have Quality Care Coordinators, who are people that just work the phones. They get patients in to see their physician. They make sure they come in for their screening, their wellness, because those are important, obviously, in taking care of a patient and providing the preventive health measures.

We follow patients in the hospital, skilled nursing facilities, long-term care. Again, this

speaks to our care across the continuum, and, of course, this is a physician-led network.

We are absolutely committed to quality, and we've achieved the highest quality scores across our medical groups.

In California, the largest, actually CAPG, California Association of Physician Group, is the largest trade association in the country. We've reached the highest level of quality, it's elite status, and it's been for four straight years.

Another respected trade association, IHA, has recognized us for things, such as clinical quality, and, in California, the Department of Managed Health Care has recognized us for treating cardiovascular disease, diabetes, and this is some of the disease-specific care plans that I spoke to on an earlier slide.

Out of a five STAR rating, we are four to five STAR on our Medicare Health Plan Quality and Performance Ratings.

MR. ZINN ROWTHORN: Dr. Lew, if I could just ask, by way of clarification? What I'm going to try to do here, I know that you've gone to pains to translate your presentation into lay terms, which I appreciate. It's vital that we make sure that the key concepts being

discussed are understood by our audience.

With respect to your comments on coordinated regional care, can you talk a little bit about what that would mean for a patient at an ECHN hospital, how that experience might appear different from what exists, whether that is a model that, if this transaction were to be approved, would be moved to immediately, or is there a transitional period first? Thank you.

DR. LEW: Sure. Thanks, Perry. So, Perry, traditionally, patients will go to their doctor. They may get admitted. They'll get treated at the physician's office. They get sick, they call 9-1-1, they go to the emergency room, they get admitted to the hospital, they have a lot of whole host of tests done, they're released from the hospital on seven different medications.

They go home, they don't really remember how they're supposed to take their medication, when they're supposed to see the doctor, the primary care, the cardiologist. You've got multiple specialists that see a patient in the hospital.

Family members don't always get the directions and the instructions, because they are at

work, and, so, the patient is not sure exactly what's the follow-up. How do I take my medications? They may call their doctor. They go see their doctor within a week or two, and the doctor says, oh, I didn't know you were in the hospital.

What did they do? Let's get some tests. Let's get the records. Let me look at them. Meanwhile, the patient may -- their condition may deteriorate, and you've lost a lot of time, and you've lost the continuity and the coordination of care between what happened in the hospital and what's supposed to happen at the physician's office, and, so, often, the patient will get readmitted.

Maybe they took their medications the wrong way, or they forgot, the family member didn't remind them, and the patient goes back to the hospital, or the patient may go home and get dizzy, may fall and fracture their hip, then they get taken back to the hospital.

This is very common. I'm pointing these things out, because we see these things happen, and, so, in lay terms, the reason why I want to give this example is because I want to illustrate how within our model the likelihood of something like that would be very low.

So the patient gets admitted to a

hospital. Rather than call 9-1-1, we would probably, if this is a patient that we've identified to be at risk, the patient will likely call our nurse practitioner, who would make an evaluation either by phone or go to the house, the patient's house and say, okay, Mrs. Smith may be in a little bit a congestive failure, a little bit of fluid in the lungs, and we should admit her to the hospital, so we would arrange to have Mrs. Smith brought to the hospital and immediately transfer the care to a hospitalist, a physician, who works in the hospital, to take over the care.

Once the patient is admitted, we begin to start planning, okay, what are going to be the needs post-discharge? And, so, we'll get the appropriate tests in the hospital and the appropriate specialist consultants to come and evaluate the patient and do the tests, and then, whether it's a couple of days, we'll transfer Mrs. Smith to a lower level of care. That might be a skilled nursing facility.

And then our multi-disciplinary team of the nurse practitioner and the pharmacist may go to the skilled nursing facility and say, Mrs. Smith, you have these seven medications. Do you know how to take them? Let me explain to you how to take these medications, so

that you don't get readmitted.

So, again, that's the handoff. That's the continuum of care that these Care Plus. We've branded our programs, and we've called it Care Plus.

And, so, we'll go skilled nursing facility, and then we'll evaluate the home. Is she ready to go home? Does she have the proper support and the proper care taking at home, and then we'll transfer, we'll have the patient transferred from skilled nursing to home.

All throughout this, we're letting the primary care physician know what's going on, that your patient has been admitted to the hospital and is now in skilled nursing, and we'll send the records electronically to the primary care, and then, once the patient goes home, our rule of thumb is, when the patient goes home, got to be seen post-discharge clinic or in the primary care within 24 hours.

So we want her to be seen in the physician's office. If the doc is closed, not available, we setup wellness clinics within the community, and our wellness clinics have multiple purposes. One of them would be to evaluate our patients post-discharge, and, so, Mrs. Smith could go to the post-discharge clinic to

be evaluated, or go to the physician's office, and if Mrs. Smith requires transportation, we'll arrange for the transportation, but now she is locked into our system, if she wasn't already.

She's going to have an assigned case manager that will make sure and follow her care throughout. We've learned that, if you can identify really those sickest patients, it's around five, 10 percent, that's a majority of the spending, and you really got to do a good job of focusing on taking care of those patients.

Perry, that's just an example of within our model, a very simplistic way for the audience to understand how it could work, but, obviously, there are a lot more complexities that we could add to it, in terms of, you know, more complex issues, besides congestive heart failure.

We could talk about how we would, when Mrs. Smith is feeling great and needs her wellness exam, or needs to have the quality measures done, we'll make sure and coordinate that with her, with the physician's office, and help make the appointment, so that she can go back for her other types of screenings. We build that into our model, also. Does that help?

MR. ZINN ROWTHORN: It does. Thank you. So I have just one follow-up. It's a model that relies on interaction and relationships with physicians in the community.

Is it anticipated that the physicians, who currently have relationships with -- privileges or other relationships with ECHN hospitals would continue to have those relationships under Prospect?

DR. LEW: Yes. They would still continue to have admitting privileges, and what we found is it tends to be more efficient to have a designated hospitalist group see the patient, but that's just a general rule.

I mean I think that what's important is that the physician adheres to our standards of how quickly you need to see the patient and make sure and stay on top of it and coordinate with the specialist.

It's not something magical that a practicing physician can't see a patient in the hospital and has to be a hospitalist, but it's more that they do -- the hospitalists tend to do this every day, seven days a week, but we have examples in various markets, where groups of primary care physicians said I want to be part of that panel.

And, so, as long as they can adhere to our programs and work closely with our medical directors, who are all local doctors, right, the physician leaders are all local, as long as they can adhere to the policies and procedures that we've established, I could see a scenario, where we could have local physicians participate.

MR. ZINN ROWTHORN: Thank you.

MR. CROCKETT: My name is Von Crockett, and I adopt my pre-filed testimony.

Dr. Lew had just previously mentioned several of our awards that we've won. I wanted to take a few moments to discuss the issues that Mrs. Dorin brought forward regarding the recent events that have occurred in California and some of the mistakes that were made and the corrective actions that this organization is taking to resolve them and to improve our quality program.

Specifically, in late 2005, during a visit by CMS to do surveys at two of our licensed facilities --

MR. ZINN ROWTHORN: Mr. Crockett, do you mean 2015?

MR. CROCKETT: 2015. Thank you. 2015, CMS, during a survey process, had identified areas where the care that was being provided was not meeting the

standards of conditions for Medicare, the CMS conditions of participation, and they had given the two facilities what's called a deficiency notice of immediate jeopardy.

By definition, immediate jeopardy means that the care and the processes that are currently being provided to a patient could cause harm to a patient.

The deficiencies were specific in the one facility at LA Community Hospital for an allegation of physician misconduct, and then there were two immediate jeopardies at the Southern California Hospital license.

The first one had to do with the temperature and humidity in the operating room, and the cath lab was not being maintained consistently, and then the second immediate jeopardy was the infection control specifically for the washing of sterilization of surgical instruments.

In the three situations, there was no specific patient harm that did occur, that, once again, it was for that the processes could potentially cause harm.

When we received the notifications, Prospect took the allegations very seriously and began steps to do remediation of all three.

From a process perspective, once you

receive a notification of immediate jeopardy by CMS, it's expected to be resolved immediately, and they actually don't leave the facility until the allegation has been abated.

Once it's been abated, then they will issue a report, and included in the report will be other deficiencies that they identify, in addition to the immediate jeopardies.

In each of those cases, there were additional deficiencies that were identified, and they were specific to infection control, patient care, the quality program and governance.

Specifically to the quality program, what the found in the organization was that the quality program was a kind of a static program that was continuing to collect data and information and that it wasn't being adapted in a real time fashion to address the issues that were occurring at the facility, and they saw that the quality program was marching off to one degree and that the quality -- I mean the quality program was marching off to one side, and the organization had issues that weren't being addressed, and, so, there was a deficiency from the quality program.

Once the issues were identified, there

were immediate steps and issues taken to resolve them. One of the first things that was done was that Prospect engaged a national consulting firm that has a track record of assisting hospitals and addressing these type of issues, then they were brought on site for both of the locations.

MR. HENRY SALTON: Excuse me. Could you say when that occurred?

MR. CROCKETT: We received reports in January. I don't have the exact date, but it was approximately January. I don't have the exact date in January.

MR. SALTON: And when you brought on this consulting group?

MR. CROCKETT: Oh, I didn't understand the first question, when you say it occurred.

MR. SALTON: Okay, so, when did you bring on the consulting group?

MR. CROCKETT: It was in January of 2016.

MR. SALTON: Okay and the statement you made about the quality program being static, when was that identified to Prospect?

MR. CROCKETT: Well we didn't get the details of the report until approximately January, as

well, for both situations.

MR. SALTON: Was there a verbal conveyance of the concerns on the quality?

MR. CROCKETT: Not at the time. We actually didn't receive that deficiency until January.

MR. SALTON: Okay.

MR. CROCKETT: When they were on site, they were really focused on the immediate jeopardy issue and making sure that that was resolved, in addition to some other patient care concerns.

The role, in addition to that, the corporate office had started the process of providing additional resources, so that the organization could correct the issues that were identified.

In terms of a root cause analysis and lessons learned, and there were several lessons learned there that are applicable as we move forward, the first one had to do -- in terms of some of the causes, first, before we get into lessons learned, on the cause issue is the one facility, Southern California Hospital, is an organization that is needing -- had previously gone through a bankruptcy and had a substantial amount of deferred maintenance, and we were in the process of doing construction up on the roof, when one of the contractors

had a small localized fire that caught fire and ended up damaging our air conditioning system throughout the facility.

Throughout that process, the organization did not have the appropriate response in resolving it to the degree it should have been resolved, as well as from a timing perspective.

Part of the issue, as well, from -- and that caused multiple issues, in addition to the HVAC system. Secondarily, though, as an organization, we had delegated the role of the quality program to a local level, and, with that, as the organization was dealing with these issues, it was being dealt with at a local level, without the proper oversight at a corporate level.

Lastly, as the organization was needing additional resources, those issues weren't brought forward in a timely fashion, as well.

So in terms of steps to resolve, as it relates to the immediate issue, of the immediate jeopardy issues and getting them resolved, is that the national consulting firm was brought in, and they have several roles that they're actually doing.

The first role is to help us prepare the response, what's called a plan of correction, back to

CMS. From a status perspective, we have, on the LA community, we have prepared a plan of correction. CMS had come out and done a resurvey, based upon that plan of correction. That resurvey occurred in the middle of February.

When they were on site, the issues associated with immediate jeopardy, the quality program and several of the other original deficiencies were resolved, but, during the site visit that they did, did identify two issues still outstanding or new issues.

One had to do with nursing services or patient care, and the second one had to do with infection control. That plan of correction on that one is in the process of being written and prepared, and it should be completed approximately by April the 8th.

For the Southern California Hospital, we have submitted our plan of correction to CMS, and that plan of correction has been shared with ECHN, as well as the regulatory officials, and we’re awaiting at this point for CMS to come out and do the resurvey associated with Southern California Hospital.

I should mention, as well, that, as part of this process, CMS has put us on what’s called a termination track, and, currently, the termination track

for the LA community license has currently now been extended to approximately June 13th.

For the Southern California Hospital, that's currently on a track for I believe it's May 23rd, and our expectation is that we are taking every step associated that's needed to resolve these issues.

Getting back to our engagement with a consulting firm --

MR. ZINN ROWTHORN: Mr. Crockett, if you don't mind breaking there for some points of clarification? We had a very extensive discussion on this subject yesterday in Manchester, and I want to make sure that our audience today has received a similar level of clarity or at least information around what this CMS process means and entails and looks like going forward, so, just by way of terminology first, CMS is the federal regulator that manages the Medicare and Medicaid programs, is that correct?

MR. CROCKETT: That's correct.

MR. ZINN ROWTHORN: And when we talk about immediate jeopardy, you mentioned conditions that might pose patient harm, but the immediate jeopardy referenced is not immediate jeopardy to a patient, but it is immediate jeopardy -- you've been notified with respect

to your hospitals that they are in immediate jeopardy of being terminated from participation in the CMS programs, is that right?

MR. CROCKETT: Well you can actually receive an immediate jeopardy and not be terminated from the program. I don't think that actually how you've articulated it is actually accurate. The immediate jeopardy is actually a level -- it's a deficiency level, and it basically is stating that your care processes are not consistent to the point of immediate jeopardy of concern, as it relates to the patient.

MR. ZINN ROWTHORN: Okay, so, let me say it differently. The threat, that you have been notified by CMS, is that, if these conditions aren't corrected to CMS's satisfaction, that the hospitals will be terminated from participation in the CMS programs, is that correct?

MR. CROCKETT: It is correct, and I think, just in terms of from a context perspective, I want to spend just a second on that.

From a context perspective is that the federal government has what's called conditions of participation, what are basically expectations of how care is provided for patients throughout the United States for hospitals to abide by.

From an administrative process, the federal government does not have a way of imposing penalties or fines, in terms of when organizations either are not -- are not failing to adhere to them, and, so, as a process perspective, in the event that organizations find themselves in the unfortunate situation of not adhering to them, then their only possible recourse is to the threat of removing a hospital license.

There is no other administrative process or penalty associated with that, and, so, by default, it is a way to make sure organizations take this very seriously and to provide every recourse necessary for it to be resolved and appropriately so.

CMS has every intent, when these do occur, is to get the organizations back to the level of participation, and it does happen, but it’s pretty rare, for CMS to actually close a hospital down or terminate the license for it, and they usually do it for two reasons.

One, if a hospital is in the process of bankruptcy or they don’t have the cash to correct the issues that are needing to be corrected, or, two, if they just don’t have the desire to adhere to the rules and the policies going forward.

Most often, the time or the circumstance is that they will continue to work with organizations to the point that they believe that the organizations are no longer improving.

There are many hospitals that have actually received immediate jeopardy and/or terminations, and they're everything from community-based hospitals to large teaching organizations with well-known reputations. Two of those that come to mind is UCLA Medical Center, and, actually, the Cleveland Clinic was in the past recent history put onto a termination track, so we have every intention of moving forward.

MR. ZINN ROWTHORN: Thank you. That's helpful. And just one further clarification. We have been talking about immediate jeopardies with respect to two individual hospitals in California, but the way those hospital licenses are structured the immediate jeopardy notices actually pertain to six hospitals, is that correct?

MR. CROCKETT: That is correct. There's seven hospitals in California, and the Los Angeles community license is a three-campus system, and the Southern California Hospital license is also a three-campus license, and, so, from an administrative

perspective, when CMS does its process, it's on the license.

And, so, even though the issues are predominately two of the six, that all six hospital licenses are impacted by the actions that are being undertaken.

MR. ZINN ROWTHORN: Understood. And, so, you know this, but I'll clarify it for our audience. We have asked you and you have agreed that we will keep the record open in our proceeding, so that we can receive all the communications between Prospect and CMS with respect to these immediate jeopardies.

MR. CROCKETT: That's accurate. Moving forward, in terms of our investment in quality, so, in addition to helping them address the plan of correction, the other aspect that they are working on or that they have completed is to revise our quality program, specifically, making sure that the program at each license is specific to each facility, and that it is addressing from a monitoring perspective the areas of concern that have been identified by CMS, so that not only do we correct these immediately, but there's going to be ongoing compliance with the plan of correction and a monitoring associated with that.

The other thing that they have done is they have gone through our process of looking at our policies and making recommendations to them to making sure that all of our policies are adhering to the Medicare conditions of participation and making them workable from the facility, as well.

From an oversight perspective and getting back to kind of the lessons learned, the quality program at these two facilities, as well as our other facilities, have been predominately delegated down to the facility level.

With that, we are now adding additional corporate quality leadership oversight to these two facilities, as well as to our other hospitals, as well. Specifically, we have created four additional positions.

One will be a Chief Quality Officer, the second will be a Chief Clinical Officer, the third is a Chief Corporate Nursing Officer, and the fourth is a Vice President of Regulatory Affairs and Patient Safety.

The role of these four individuals are going to ensure that we have an active quality program at each of the hospitals, that the program is reflective of the individual issues that are being raised and are being monitored and adapted, as appropriate, that the quality

programs are consistent with the industry standards and national patient safety goals, and that when organizations are not -- when each of these facilities are not meeting the components of the quality program, that they identify the resources and a review of the policies and procedures, in order for the facilities to get back on track and meet those objectives.

These positions are relatively new, and we've got three of the four in place, and the fourth one will be on board shortly.

The third issue is we've established regional hospital quality oversight, and the point of that is that we don't intend to have everything running through California, so, for our east coast facilities, we will have an individual on the east coast to assist with what I've said the four individuals will do, but more on a real time basis on the east coast, as well.

And, lastly, this is something that we have learned in conjunction with our work with CharterCARE, and that, recently, CharterCARE has adopted what's called a high-reliability process organization.

MR. ZINN ROWTHORN: CharterCARE is your Rhode Island?

MR. CROCKETT: Correct. And what we've

seen is that, within the first year of them adopting it, we have seen areas on their quality plan that have started to show improvement, and, with that, we have also reviewed the quality program for ECHN, and they have been a long-time member of the HRO process, as well.

As part of the process that we have recently gone through, in conjunction with working with ECHN, what we have agreed to do, and ECHN has a great quality program, it's very thorough, and it's an adaptive quality program that they are achieving high marks on, is that Prospect has agreed for us to adopt the current quality program that's currently at ECHN, as well as that, from a local Advisory Board perspective, is that the local Advisory Board will be responsible for setting the goals and the components of the quality program, and that the role of the corporate oversight will be really a check and a balance, and what does that exactly mean?

A check and a balance is specifically are they on track, or are they on target? Are the goals consistent with hospital and industry best standards? And in the event that they're not meeting the goals, what resources need to be brought in from a policy perspective and/or from a resource perspective, so that would be the role of the corporate oversight. We have agreed this for

a two-year period.

I want to switch gears for just a second now and talk a little bit now in regards to what do we expect of kind of a post-transaction for ECHN? To do that, I wanted to spend just a moment regarding the operations in Rhode Island, CharterCARE.

We have -- the acquisition is a little over almost a year and a half now, and, after a year and a half, there's been some substantial improvements, in terms of the health care delivery model in Rhode Island, and we're hopeful in expecting the same progress to be made in Connecticut.

First of all, is that the Rhode Island market was made up of predominately a lot of independent physician groups, either ones, or twos, or small groups that were not in an organized fashion.

We have come in, and we have organized it into a multi-specialty IPA, with over 100 primary care providers that now have the ability to contract with health plans as a single entity going forward.

We've increased the employed physicians by over 50. Previously, they had around 18, and we're now over 50 employed physicians.

As part of our population management,

we've expanded the outpatient clinics outside of the service area, as well as an investment in an outpatient oncology center.

From a quality perspective, the organization, the cancer centers achieved academic certification from the Joint Commission, and we have expanded a significant strategic capital, in order for this organization to move forward.

They were in a similar situation, where they had deferred maintenance and weren't able to invest in the equipment and technology they needed to care for their patients.

And then, lastly, Rhode Island, like Connecticut, is a Medicaid expansion state, and, as part of the expansion state, the Rhode Island budget, as they expanded Medicaid, has increased their deficit on the state budget through all the fee for service activity that was occurring for Medicaid.

In working with the legislative bodies up there, Prospect is in the process of implementing a Medicaid managed care pilot project, and the goal of this is to, as Dr. Lew was alluding to, is to have the Medicaid population into an environment, where their care is coordinated, and, with that, we believe that this will

save the state of Rhode Island over $6 million on an annual basis through the pilot project.

As part of our expansion outside of the state of California, in addition to Rhode Island and now in New Jersey, when we looked at Connecticut, there were several favorable things that we found that we believed that, when you looked at our model of working with the health plans, as well as the physicians, would be very favorable for the citizens of Connecticut, in conjunction with us.

The first one is that Connecticut is a Medicaid expansion state and, as such, is going to be needing to have a different way or model of how the care is delivered, in order for it to be remaining affordable to the citizens of Connecticut, as well as the state budget.

The health plans within Connecticut, and this is important to us, are actually very receptive to our types of model and changing from a fee for service into a value-based care.

Later on, Dr. Lew can go into some of the work we've already done in engaging the health plans in Connecticut, and it's been significant.

ECHN, as an organization, already has

high-quality physicians with a great reputation, and it's an organization that is looking for value-based health care knowledge and expertise, and, so, lining up what their needs were with us, it looks like a perfect fit.

When we get on a post-acquisition basis, one of the things that Dr. Lew alluded to is that we don't go out of network with the insurers. That's actually part of our business, and, so, what you see is a different type of relationship, where you see the health plans, the physicians and the hospital actually working together, and it's all focused on the patient.

With that coordination of care, we believe that there will be better care for the patients, as well as higher satisfaction.

Through this, ECHN will have improved access to capital and greater financial strength to insure its long-term financial viability.

MR. ZINN ROWTHORN: Let me take a moment there. Thank you for that. I notice we've been joined by State Representative Srinivasan, and our understanding is you have a difficult schedule today, sir, so we'd be happy to hear from you now, if you'd like to be heard.

MR. PRASAD SRINIVASAN: Good afternoon, Mr. Zinn Rowthorn, Mr. Hansted, and members of the Board.

I want to thank you very much for giving me this opportunity to be here this afternoon and very, very grateful to you for accommodating my schedule and letting me get back to the LOB. I appreciate that very much.

I'm Prasad Srinivasan. I'm a State Representative from Glastonbury, and this is my third term. I'm the State Representative. I'm also a practitioner. I'm an allergist in private practice in the Hartford area.

I haven't come here to drum up business during allergy season, so that's not why I'm coming here, to do that, but we do have an office here, incidentally. (Laughter) My partner comes to Ellington, so we're very much here.

The reason I'm here is for you to consider this partnership between ECHN and Prospect Holdings. As you know, the entire landscape in health care has changed, and it's constantly changing, and, in this landscape, where we are at this point, we really don't know what's coming down the pike for us tomorrow and, obviously, months and years to come.

With that in mind, when you look at the needs of the hospital and you look at the needs of the

patients, it is a changing playing field, and we hope to be able to accommodate the needs of our patients.

Patients, for them, access is very, very critical. Thirty-five years ago, I opened my practice in the Hartford area, and my first satellite was on the other side of the river, and I would always ask my senior partner, whom I joined, what is the big difference? Why cannot these people from Manchester, Rockville and Glastonbury cross the river and come to Hartford?

He says, no, Prasad, you don't get it. There is a mental block about that. People do not like to cross and come over, and I've seen that in my 35 years of practice, so the access is my biggest concern with these hospitals.

ECHN, the two hospitals that form ECHN, are so critical in the services that they provide to the area, and, looking at where we are, and I'm sure, between yesterday and already, you've heard the financial story, so I'm not going to go over that at all, that's not my intent, to talk about the finances of the hospitals, but that is of concern, because unless we have the viability, the financial viability, my concern is for our patients, is what's going to happen to these patients, who live here, and this is their home?

Just the end of last year, late last year, my employee's husband got extremely ill, extremely ill, and to the point that it perhaps may have been appropriate for him to go down to either Yale or to Hartford, because of the severity of his illness, but he chose no.

He said I do not want to go there. This is the hospital that I've been to. This is where my kids were born. This is where I belong, and, whatever happens to me, it's going to happen in this hospital.

Fortunately, he did extremely well. He recovered, and he's back home, and that's the mindset of people that we need to be able to realize and recognize how important it is.

So when you look at the needs for the patient, that's what I'm most worried about, that if these doors were to be closed, or partially closed, or whatever happens, because, obviously, because of financial reasons, what will happen to their services, whether it be primary care services or it be specialty services?

All of them are needed right here in the area, and when we have somebody that it is possible for us to have in this day and age a very, very difficult

landscape here in the best of both worlds, I hope you will give that the utmost consideration.

I know you will. I'm well aware of that, but I hope, at the end of the day, it will be that we can go ahead with this merger.

When we look at this, at the hospitals now, as you're well aware of, the needs of the hospital from a patient point of view have increased tremendously.

Medicine is just outpacing itself, in terms of its technology, and we need to keep track of that. We need to provide the top services. We cannot say that, in this hospital, an MRI cannot be done, or a third degree CAT scan, or all of those procedures cannot be done here, and you need to go somewhere else.

We need to be able to provide all of that, so we can take proper care of our patients, and for that message, that we are state-of-the-art, we will continue to be state-of-the-art, and we will continue to stay here, is very critical.

Equally important, rather than being here only, which is obviously very important, is for us to recruit physicians, to recruit health care providers into the area.

I'm sure you're well aware of the

financial state that our state is in, and, given where we are, it is difficult to recruit people. It is very difficult to get people to come to our state, and physicians and health care providers are no exception.

Six years ago, when I ran for my office for the first time, I needed help in my office. I have advertised left, right and center to get another allergist to join me. Long story short, I haven't got one yet, so that's the climate that we are in, unfortunately. That's the message we have been given for small businesses.

So to recruit physicians for us, to recruit top class technicians, health care providers, the PAs and the APRNs, the message to them has to be very clear. This is a viable organization. This hospital is here to stay. The system is here to stay for years to come, and this is a place you could call home.

So I hope, when you look at it from a financial point of view, which you already heard about, but, more importantly, appeals of our patients, that they need to get their access here, and I fully agree, I fully agree we need to have oversight. No question at all about that.

The labor contracts, we need to look at

them carefully. We need to make sure that physicians and other health care providers don't feel that their jobs are at risk, so should there be oversight? Absolutely, yes, but in the right mix.

When you drive a car, you have an accelerator, you have a brake. You need both of them to go from Place A to Place B, so, similarly here, I hope the oversight will be not be so burdensome, so burdensome that nobody is willing to come to Connecticut. We need to find the right balance for you, me, and, more important, for our patients.

Thank you very much for giving me this opportunity today. I appreciate that.

MR. ZINN ROWTHORN: Thank you very much, Representative.

HEARING OFFICER HANSTED: Thank you.

MR. ZINN ROWTHORN: Can I ask, while we're taking this break for comment, do we have Mayor Champagne in the audience? Do we? Oh, I'm sorry. Thank you. We'd be happy to hear from you, as well, sir.

MAYOR DANIEL CHAMPAGNE: Thank you. First of all, I'd like to take the opportunity to thank you for letting me speak today.

My name is Mayor Daniel Champagne of

Vernon, and Rockville General Hospital is here in my town, and Rockville General Hospital means a lot to me. Both my kids were born there. I met my wife there, because I work there. It's very important to me that Rockville stays open.

I'd like to thank the Office of the Attorney General and the Office of Health Care Access for their work in reviewing the proposal to ensure that residents throughout the service area, including those who reside here in Vernon, will continue to have quality, affordable, and, most importantly, accessible health care.

I'd like to begin by saying Rockville General Hospital is our hospital. It has served as a pillar of our community for nearly 100 years. When it was first established on Prospect Street in 1921, our community donations built it.

When it relocated to its current location on Union Street in 1945, the Tolland County region supported it.

For nearly a century, each time the hospital has faced trouble, the community has pulled together, turning it around with our donations and our hard work.

In return, Rockville General Hospital has been a place where generations of our residents have received accessible quality health care. Today, Rockville General Hospital and the Visiting Nurse and Health Services of Connecticut are Vernon's second and third largest employers, respectively.

My largest concern about this proposed sale is that Prospect is only required to state its intentions for Rockville General Hospital for the next three years.

One reassurance was that Prospect had stated they are not in the business of closing hospitals, but I would like a longer commitment just on paper, because that would make me feel better.

I also requested the Attorney General's Office to ensure that all charitable trusts in the foundation funded from prior donations remain true to the goals of the original donors. The trust should continue to be applied for the good of the patients and the community.

In summary, during these tough economic times, it's important to save our local hospitals to ensure every citizen has affordable accessible care at the highest quality right here in our community.

I don't want to leave Rockville. I don't want to leave the Vernon area for health care when we have it here. We've had it here for a century.

Rockville General Hospital provides medical services to all our residents, including many seniors and those, who live in low-income housing.

These services are offered right in our neighborhoods and backyards, so there's no need to travel long distances, especially if the medical needs are a critically urgent matter.

I vow to do everything in my power to make sure Rockville General Hospital remains a vital part of this community.

Vernon and the surrounding communities rely on both medically and financially for the numerous jobs it provides.

Again, I want to stress that Rockville General Hospital is our hospital. We started it. It began here with the generosity of our residents. It has remained here with their continued support and patronage, and we eternally consider -- and will eternally be considered a community asset for the medical care it provides to Tolland County.

And when I refer to Rockville Hospital,

I've had procedures done at Manchester, too, because some were offered there. I think one of the big losses was when we got rid of the maternity ward, and, having both my daughters born there, it was quite a loss to me. I understand why it was done. It just hurt. I think it hurt our community.

I was very surprised with, not unexpected, but when Mr. Karl stated that he realized that, if we don't do something, it's the kiss of death for our hospital. Taxes are on the rise from the State. We're losing money federally. We need to do something, and looking for a partner to come in and save our hospital is something that is necessary.

Thank you for the opportunity to speak today.

HEARING OFFICER HANSTED: Thank you.

MR. ZINN ROWTHORN: Thank you, Mayor.

MR. SPEES: Thank you and good afternoon. I'd like to say a few things just about the commitments that Prospect is making to the community as part of the transaction, and some of these have been mentioned by Mr. Karl in his presentation, but the first couple of points relate to the key financial terms of the transaction and the purchase price of $105 million.

It's significant not just because it represents fair market value for the assets of ECHN, but, also, as Peter mentioned, it eliminates, together with the existing assets of ECHN, it allows the hospital and the health system to pay off all of its debt, so, upon closing of the transaction, the health system at ECHN will be debt-free, and that eliminates in excess of $9 million worth of capital that has been previously required to pay down debt, as opposed to becoming available for investment in the health system.

In addition to the purchase price, we've committed to make a minimum of $75 million in capital expenditures to be spent or committed to be spent within five years of the closing.

A couple of things of significance related to the $75 million capital commitment. It is an investment in the system, so don't think of it as exclusively investment capital for bricks and mortar and equipment.

It really is intended to develop the coordinated regional care model and increase access points in the system, so while the strategic and capital plan has yet to be developed, it's likely to include increasing access points, particularly on the ambulatory

care side in such things as urgent care centers or additional physician locations.

It's also available for service line development in developing new service lines for the community hospitals, as well as the more traditional capital investments in facilities and equipment.

I wanted to mention a couple of things in follow-up to our conversation yesterday regarding the $75 million capital commitment, and I wanted to point out, after having had a chance to review the language in the purchase agreement, that the $75 million is, in fact, not conditional.

There are provisions that merely call for the potential deferral from the five-year capital commitment, but not the $75 million, and that deferral has to occur in consultation with local community members and with the local Advisory Board, and it's limited to the isolated case, where there is a state action that is discriminatory towards for-profit hospital and health system operators.

In addition to the capital expenditures --

MR. ZINN ROWTHORN: Is there an outside time limitation on how long that commitment could be differed, in the event that the --

MR. SPEES: Yeah, that's not specified in the purchase agreement, so the language in the purchase agreement says with consultation with the Board and the community.

MR. ZINN ROWTHORN: I should say, just for the benefit of our audience here, we did have a discussion yesterday about some concerns that we have about any conditions on the capital commitment as part of our charge here.

A significant part of our charge is to evaluate whether the assets are receiving fair market value, and part of, a substantial part of the value of this transaction, as you've highlighted, is the capital commitment, so any conditions, no matter how attenuated, that suggest that that capital commitment could be altered in some substantial fashion, would be of some concern to us.

MR. SPEES: Understood.

MR. ZINN ROWTHORN: Thank you.

MR. SPEES: In addition to the financial terms, the straight financial terms of the transaction, as has been mentioned, we have committed to maintain ECHN's current charity care policies, or, if we make changes, they will result in policies that are at least

as favorable as the existing charity care policies.

Again, Prospect is about access, and we want to assure the community that that access will remain.

While we are a California-based company, we're very strong believers that health care is local, and the key decisions regarding strategy and operations needs to be made locally, so we are committed to our local management team here at ECHN.

We've called for the establishment of a local Advisory Board, which I'll talk a little bit more about in a minute.

And with respect to the existing medical staffs, they will remain, and, as of the closing of the transaction, they will all become members of the Prospect medical staff.

We've also committed, as part of the transaction, to maintain the hospital services, as has been mentioned, for a period of three years.

Obviously, should we make any changes in there, that would be in consultation with the local Board.

In addition, we've committed to hire all 3,000 employees of ECHN, and you'll note on the slide it

says in good standing, so that begs the question what does good standing mean? In the case of ECHN, really, we do one single pre-employment screen, and that is to make sure no employee is on the Office of Inspector General's exclusion list for participation in the Medicare program.

And, lastly, as has been previously mentioned, at the request of ECHN's Board, we entered into a quality commitment letter to provide that we will maintain their existing quality programs for a period of at least two years.

MR. ZINN ROWTHORN: Mr. Spees, was there a commitment to honor the Collective Bargaining Agreements that are in place?

MR. REARDON: May I answer that?

MR. ZINN ROWTHORN: Sure.

MR. REARDON: There is. There is such a commitment.

MR. ZINN ROWTHORN: And I guess, while we're paused, the three-year commitment that you mentioned and the Mayor referenced is a commitment to maintain the hospital as an acute care hospital or the hospitals, I should say?

MR. REARDON: That's correct.

MR. ZINN ROWTHORN: Okay.

MR. SPEES. So I want to talk a little bit about the Advisory Board, and it actually should be more correctly labeled as Advisory Boards, because each of the two ECHN hospitals will have its own local Advisory Board.

This is a key partnership for Prospect and for our local management teams here. This local Advisory Board really serves as a resource for both Prospect, as well as our local management team, regarding our capital commitment and how those funds should be invested in the health system and with respect to our strategic planning process, which will begin almost immediately upon closing.

It's, also, these Boards will be one of many opportunities for our community members to engage in conversations with both the local teams here locally, as well as with Prospect executives.

In addition to its advisory role with respect to the capital commitment and strategic planning of Prospect and ECHN, the Advisory Board will be principally responsible for medical staff credentialing, and will maintain and oversee our quality assurance program, and, also, will be principally responsible and oversee and manage the accreditation process, so those

activities at the Board level will be principally the responsibility of the local Advisory Boards.

Over time, we expect that the Boards will also support us in our physician recruitment efforts, not only providing input into physician needs in the community, but support our efforts to bring new physicians into the community, recognizing that this commitment that we're making in this partnership with ECHN is not just a one or two-year commitment. It is a very long-term commitment.

In the event that at some point in the future there is a leadership change at the hospital, we would look to the local Advisory Board for input into any leadership change.

MR. REARDON: I was delighted to hear Mayor Champagne mention that Rockville Hospital started on Prospect Street. We're hoping that we'll be able to bring that full circle on there.

Prospect offers a unique health care delivery model. I'd like to emphasize the words health care delivery model. It has been mentioned previously, but we are not a hospital-centered company. We are a physician-centered company, but it's about putting together a coordinated regional care model, which

includes all kinds of components in the community.

It may be surgery centers, it's home health agencies, it's community mental health. We need to have the entire network. We don't have to own everything, but we need that entire network, in order to provide coordinated care to our patients.

Think about that for a second. Mitchell was talking about an example, and the fee for service system we have now is so fragmented. It's so fragmented. You can have a situation, where the primary care doc doesn't even know that their patient is in the hospital.

Under our system, we coordinate care. Somebody knows where our patients, where our members are at all times. We will follow them into the home. We'll make sure that they get better care, and, frankly, it is better care.

In terms of cost, think about that for a minute. I'm going to over-simplify this, but think about it. You go to a primary care doc and you get some tests. Nothing wrong with that.

The primary care doc is doing everything they think he or she should do, and then you go to a specialist and you get some tests. Again, nothing wrong with that. They're trying to do the best they can do.

And then you go to a hospital and you get some tests, and some pundits will suggest to you that at least 30 percent of the fee for service dollar is wasted, and you can see how it could be wasted.

With coordination of care, you actually can squeeze dollars out of the system and reduce cost. ECHN hospitals are low-cost hospitals. We like community hospitals.

No disrespect meant to the academic medical centers. They're the crowned jewel of American medicine, but if you compare the cost at ECHN to a Yale or to a Hartford, frankly, the costs are about $5,000 a discharge more at the academic medical centers, and not everything has to be done there.

And, so, we think it really does promote better community care. We think it really does provide lower cost.

In terms of empowering local physicians, I mentioned yesterday, and I'll say it again, at CharterCARE, with our IPA there, I think as much as a third of the physicians have been attracted to the IPA, even though they had nothing to do with CharterCARE hospitals, simply because they feel empowered, and they feel empowered, because, under the current system, fee

for service doesn't provide the monies, in order to develop coordination of care.

And with the monies provided with risk contracts, you can actually build the infrastructure, like we have developed, in terms of population management, to do real population management, and the physicians are in charge.

No disrespect meant to the managed care companies. We work with them, but the physicians are in charge, and they feel empowered, and they actually get better results. Point blank, they get better results.

In terms of maintaining and creating local jobs, I'll say it again. We are a company, we're a growth company. We're not a contraction company.

In terms of extensive corporate resources, I mentioned population management infrastructure. We have hundreds of people, who will do analytics, will even do claims processing, not because we think it's a sexy business, but that's how we get data. When we medical management, we assist the IPAs, and we assist the hospitals in both respects.

In terms of local leadership, all health care is local, and, so, we really do support the local leadership with regional oversight, and Von and others

have alluded to the fact that, with our quality program at this point, we will have checks and balances at the corporate level.

Investing significant capital, again, others have emphasized this, but it's in the system. It's in the network. It's not just about hospitals.

Yes, the hospitals will get investment, but development of networks will get investment, other things will get investment, as well, because we want to develop a network.

In terms of charity care policies, yes, we're going to preserve those policies. I think I mentioned yesterday and I'll say it again, many of our hospitals are safety net hospitals. We embrace Medicaid and indigent populations.

In terms of Medicaid pilots already alluded to in Rhode Island, we've embarked on a Medicaid pilot project. We'd love to do the same thing in Connecticut.

If I could move to the next slide? We like Connecticut. Let me tell you why we like Connecticut, and we like Rhode Island, and we like New England, and there are a variety of reasons for that.

First of all, there's very little

penetration from a managed care standpoint, in terms of real risk contracting. Prospect has been awarded one of 21 organizations in the entire nation that CMS has said you are a next generation ACO, where you can do downside, as well as upside risk.

There's been very little risk management or risk contracting in the state of Connecticut, and if you look at the SIM program, the State Innovation Model, they're talking about moving as many as 80 percent of all patients in Connecticut to a value-based payment in just a couple of years. We know how to do that. We've been doing that for 29 years. We think we can help achieve that.

When we look at the metrics in Connecticut, in Connecticut, if you take 1,000 patients, Medicare patients, and you talk about how many days you expect them to spend in a hospital, I don't remember the exact numbers, but I think it was 1,400, in aggregate, days in a hospital.

We try to keep patients out of a hospital. In our hospitals in California, we've got the days down to about 700, as opposed to 1,400, and that doesn't mean it hurts the hospitals. To the contrary.

We have a saying; more and better for

less. If we do a better job and we do it for less money, we're going to get more patients, and that's what we've seen as volume increases.

There are other things that really -- there's still a fragmented physician market. We work very well with independent physicians, and, in terms of attracting physicians to a marketplace, we've had tremendous success up at CharterCARE.

We've got a whole new vascular surgery group that came in from Massachusetts. We've attracted general surgeons when we've been told, oh, you can't attract those folks. We have, because they feel empowered.

And, so, we think that Connecticut is a tremendous opportunity to really transform the way health care is delivered in the state. Again, our model is disruptive innovation, is what it is.

Last slide, whoever has it. Oh, thanks. So our goal, our goal really is the triple aim. We really do think with our model, and I mentioned yesterday I've been around for a couple of years, but I was attracted to Prospect, because I really do believe they have the special sauce to do this; higher quality care, higher patient satisfaction, highest value, lower cost.

We're very excited about the possibility of working with ECHN in Connecticut. And, with that, that concludes our Direct testimony from Prospect.

MR. ZINN ROWTHORN: So let me ask one question, by way of clarification. Again, for the purpose of making sure we're talking in terms that people can understand, you've mentioned risk or value-based contracting a few times, and I think you're making a contrast to fee for service.

For example, in the Medicaid case, you might, under a fee for service contract, you had paid per procedure that you provide, but am I right in understanding risk base? You would get paid a certain fixed amount per patient or per number of patients, and whatever care they get, you're only going to get paid that one amount?

MR. REARDON: I will defer to Dr. Lew on that, but essentially correct. What we do with these risk contracts, like in California, where it's very advanced, is the managed care companies will pay us 90 cents or 88 cents on the dollar, they will do the marketing, we'll do everything else, and we're basically responsible for the care of that patient completely.

It has to come out of the budget we have,

and we've developed systems to do exactly that. Mitchell, do you want to elaborate?

DR. LEW: Yeah, Perry, that's correct. Traditional fee for service physician, the hospital gets paid per unit, so more volume, more money they make.

We're evolving into a more value-based type contracting system, where I guess the first step would be physicians, hospitals would get rewarded if they are able to save on total cost of care, and then a more mature level beyond that would be to take what we call global capitation, which is, again, a fixed amount to take care of a population, whether they pay for the hospital care, pay for the physician care.

And Tom referenced the ACO, and, so, CMS has come out with ACOs as a way to really move health care delivery models into the direction of coordinating and managing care quality, but, also, cost, so the leaders that are doing this have started and moved along, and, as Tom referenced, our company is fortunate to be one of only 21 health systems in this entire country to be approved as a next generation ACO, which is the most mature model so far that's put out there by the government.

We've been far ahead of the curve in

California, and it's just a matter of time before other states adopt these models, and, so, the sooner that we can come and implement the model I think ECHN will be well ahead, and we will be leaders, leaders in transforming the delivery model in the state, and then be able to go to the Governor and propose Medicaid pilots to provide a better quality of care, but, also, save the state and their Medicaid spending, and that's what we do with the commercial health plans, also, and they get it, but, again, it's a step-wise process.

I don't think we'll go directly to global cap on day one, but it takes time to get there. The initial stages of just setting up the structure, setting up the network, and we talked a little bit about this yesterday, establishing a risk-taking entity and the necessary licenses, we've already done that here in Connecticut, and we've engaged the plan.

Our goal is to hopefully be approved and, when the deal closes, to have our structure established and have engaged in signed contracts with the health plans.

And I think, over the next several years, we'll be all staring at capitation, which is great. It's a good way to do it. The docs love it, and I think the

patients will see the results of it, in terms of better care and higher patient satisfaction.

MR. ZINN ROWTHORN: Thank you. At this time, we'll take a 10-minute break, and, then, when we resume, we'll have public commentary. I don't know where the sign-up sheets are, but this would be a good time to get your name on it, if you want to. Thank you.

(Off the record)

(Whereupon, the public spoke.)

HEARING OFFICER HANSTED: We are going to continue with today's hearing, and we'll turn to OHCA's questioning. Mr. Lazarus, if you want to begin? Just give him a couple of minutes.

MR. ZINN ROWTHORN: Before we lose members of the public, who may be leaving, I'd invite you to stay for this portion of the discussion, because what I'd like to do, with the consent of our friends from OHCA, is ask the Applicants to address some of the concerns that we've heard articulated by members of the public.

And, so, I'll point you to, I think, some concerns that stood out to me as themes, and I know we heard this from Mrs. Fisher when she spoke, and she wanted to know why we ought not wait until the CMS concerns are resolved before you proceed with this

transaction, so I'll open that up to you and be interested in your thoughts in response to that question, and anyone can take that.

MR. KARL: This is Peter Karl, CEO of ECHN. I thought the testimony that was presented by us was quite clear. The burden of the additional taxes, the burden of some of the federal reductions in reimbursement has led to the demise of the independent hospital as we know it, and for us to delay any longer would put the organization as a whole in total jeopardy, as it relates to survival for the long-term.

There are bond covenants that need to be met, and what that means is, with the amount of debt that we currently carry and have carried for many, many, many years, there's certain measures that we have to meet.

With these most recent taxes that were put on by the state of Connecticut, we will no longer be able to meet those bond covenants, and, if that happens, the bond insurers will come in and strip down the organizations and most probably make a significant recommendation to consolidate all services at one institution.

There isn't time to wait, and, very quite honestly, we've done a very deep dive into the quality

issues that occurred out in California.

We spent many hours, day and night, looking into them. We are confident that Prospect is the right partner, and waiting any longer is too dangerous for the survival of the organization.

DR. O'NEILL: This is Dennis O'Neill, Chair of the ECHN Board.

To be perfectly honest, we did entertain that idea. The trustees and the Transaction Committee did discuss at great length whether it would be prudent, more prudent to wait until these issues were resolved, reconciled, and then come back to the bargaining table, so to speak, but the short answer is we're running out of time.

As Peter stated, within months, if not before, we will trip our bond covenants, which will set into motion a number of deleterious effects for the organization from a financial standpoint, so we felt, I'm talking about the trustees, we felt it was better to proceed with the transaction working with Prospect to assure that the quality programs that we have in Connecticut remain intact and are, if anything, enhanced, rather than table the deal for some time period and allow the organization to continue into financial jeopardy.

We thought it was basically better to proceed and work with Prospect to maintain our quality, rather than continue into financial jeopardy.

MR. ZINN ROWTHORN: Dr. Lew?

DR. LEW: Yes, thank you. Again, to review what the agreement and the understanding, as it relates to quality in California and the quality program with ECHN, you know, what happened in California certainly is concerning, and Mr. Crockett went over what we're doing to address it, and we're very proud of what ECHN has developed in the area of quality and being a high-reliability organization.

And, so, we did reach an agreement, and it's in writing and signed, that we will support that program, and, so, we're not bringing California's quality program to Connecticut.

We're going to support the existing program that Connecticut has, as we have done in Rhode Island. Rhode Island has their program, and we let them control locally what that plan is, and they manage it, and we just serve as a check and balance system.

And to use the nice lady's analogy on being an educator and a student, you know, if you want to look at us as performing an F on the test in California,

that student is not coming here to tutor Connecticut on quality, okay?

We're going to tutor that student in California to become an A, and that California student is going to continue to be an A student with our support.

MR. ZINN ROWTHORN: Anybody else want to address that, that point?

MS. MARTONE: I would like to ask Prospect, specifically, if you can address three things that the public brought up last night and tonight, today, and that would be the independent monitor, the independent ombudsman, and the submission of some type of form of the contents of a 990 Form.

HEARING OFFICER HANSTED: We'll take a two-minute break, just so you can converse on that.

(Off the record)

HEARING OFFICER HANSTED: We're back on the record. Thank you.

DR. LEW: Kim, I'm going to have Tom Reardon answer questions one and two.

MS. MARTONE: Sure.

DR. LEW: And Steve Aleman will answer question three.

MS. MARTONE: Thank you.

MR. REARDON: In terms of an independent monitor, we're absolutely open to that for a period of time.

MS. MARTONE: Okay

MR. REARDON: What was the second question?

MS. MARTONE: The ombudsman.

MR. REARDON: Oh, ombudsman.

MS. MARTONE: The independent ombudsman.

MR. REARDON: We think the independent ombudsman would be duplicative of what we have the Advisory Board doing. Furthermore, as Peter will point out to you, we have all kinds of patient advocates within the system, itself, so we think it would be duplicative.

MS. MARTONE: I think the concern that was addressed yesterday was the fact that they wanted to make sure that he was an independent ombudsman that wasn't directly picked from hospital management that people could go to. Is that what will be part of the local Advisory Board?

MR. REARDON: Well the local Advisory Board is independent. Those community members, who will be there to listen, and, as Peter said, there's been a process, whereby the corporators, 300 of them, elect a

Board, and it's constantly rejuvenated, and, so, I think there will be independent folks on that Advisory Board, and, again, we think it would be duplicative to have additional requirements.

MS. MARTONE: Okay.

MR. ALEMAN: And related to the request for disclosure, such as the information, the 990, Prospect has supported transparency in Connecticut, as we have worked through this process and transactions in other states.

This isn't the first time that we've encountered it, and we've worked very closely, for instance, with the Department of Health in New Jersey on transparency and disclosures, and, actually, they moved forward to ensure that for-profits had similar disclosures as the not-for-profits, and we've supported that, worked directly with the Department of Health, and we support that here in Connecticut, as well.

MS. MARTONE: Okay, thank you. And, going to that, do other states, or have other states required you to have independent monitors, or ombudsman, or any type of individual?

MR. REARDON: In Rhode Island, there were conditions of approval, and there was an independent

monitor, my recollection is for three years, to make sure that those conditions were upheld and implemented.

MS. MARTONE: Okay, but not an ombudsman or any type of individual?

MR. REARDON: No. Not to my knowledge, no.

MS. MARTONE: And then Steve had questions about it, but since we're here at this point, in terms of the community health needs assessment, you know, we discussed that last night, and the importance that OHCA puts on that, in terms of not just evaluating Certificate of Need and looking at clear public need, but ensuring that there's access to high quality and affordable services in underserved areas most of the time, so we do require hospitals to participate in community health needs assessments.

All hospitals in Connecticut submit their implementation plans, as well as any data, sometimes that we need in order to evaluate that, and you had confirmed that there was a willingness to participate, correct, and involve the community and its members and other providers in conducting a needs assessment of the area to determine needs, and you also explained how you also have metrics and analytics that are exceptional and enhanced, if you

can talk to that.

DR. LEW: Correct, so everything you said can, in terms of the needs assessment, local input, local advisory, but we certainly want to make sure within our model that there is access to care within the community, whether it be through a physician's office, a community clinic, an urgent care.

I spoke earlier about having these clinic sites for post-discharge patients recently discharged from the hospital. Very important for us to make sure there is access and primary care driven and central around -- primary care being central.

We would look, and we often work with health plans, and in states, where we have pilots, we have to make sure that there is adequate access. There are very strict requirements on that.

And we don't want our patients having to travel far for their care, because, if they have to, they won't go seek care, so it's just part of our overall analysis that we undertake to make sure that it's convenient and comprehensive.

MS. MARTONE: Now, again, the same question. Are you required in other states to participate in a community health needs assessment? Have

you conducted any yourselves, or with other partners?

MR. CROCKETT: Yeah. In the states that we're currently operating in, the answer is, no, we're not required to, and, so, the community needs assessment we do is mostly working through with our physicians and our Advisory Boards, in terms of accessing the information that's needed.

MS. MARTONE: Okay, so, it's not like a community health needs assessment that's required by the federal government, per se, every three years?

MR. CROCKETT: Yeah, not as how you're defining it or how it's currently being operated in Connecticut, no.

MS. MARTONE: Okay.

HEARING OFFICER HANSTED: Is there a specific document that's created by PMH with respect to those findings?

MR. CROCKETT: No. It's going to be a local, I mean it's going to be done at the local level as part of the strategic planning process.

HEARING OFFICER HANSTED: Okay and what is typically done in the other states on the local level, in terms of a, quote, unquote, "community health needs assessment?"

MR. CROCKETT: Well, I mean, by definition, we don't do a community health needs assessment. The issue is, you know, from a community perspective, the issue is are the services being provided, and are they appropriate, and what are the gaps associated with it?

It actually really starts with a process of us moving away from a fee for service environment into a population management program.

When Dr. Lew was mentioning the data analytics associated with it, as we start the process of taking over the total responsibility of care for the patient, it's looking at the outpatient services that are currently being provided, as well as the inpatient services and the tertiary care.

And, so, when community members are having to leave their community to get those services elsewhere, because the hospitals can't provide it or they don't have the outpatient resources for it, then we look at, if it's onesie, twosie, the answer is no, but if there's a substantial amount of the community that needs to go outside of the community and travel outside of the community, then that's a, from our perspective, a need within the community that's currently not being provided

by -- it may be even not even just us, even our competitors, if they're having to leave the community.

From our perspective, it starts off with this. What does it need to do to coordinate, actively coordinate the care of the patient and have the community members not having to leave the community, and that's, from a data analytics perspective, that's where really we start the work at.

DR. LEW: Kevin, let me give you a practical example. Again, we talked about local physician Boards, and they have respective committees.

We will look at -- we have data, and we can look at where patients are going for their care. They're showing up in certain emergency rooms, and then, as we migrate to these value-based contracts and you get more data, you can see that -- let's say you have 10 primary care physicians and 1,000 patients attributed to those 10 doctors. That may be only a small percentage of those patients are actually staying locally for their care, and they're having to go further away for their care.

We have the ability to look at that data, and, so, we have to create better ways to make sure that they can come in and stay in their towns and not have to

cross this river that everybody is talking about, and, so, that, again, is look to see should we open an urgent care? Should we be reaching out to these patients and let them know that we can offer transportation, so it really starts grass roots a lot of times, but supported by data, so the local docs are hearing that their patients are ending up elsewhere, so we come in and support them and figure out the solutions to keep everybody in the community and not have to cross that river.

HEARING OFFICER HANSTED: Okay, thank you for that, Dr. Lew. I appreciate that. What I'm getting at is, yesterday, there was testimony that PMH will support ECHN with respect to community health needs assessments for I think it was through 2018. Correct me if I'm wrong.

What happens after that point? What is submitted to OHCA, if this were to be approved, in terms of a community health needs assessment? And there may very well be you'll continue to support them, and they will continue to submit a community health needs assessment.

Absent a formal community health needs assessment, what does OHCA look at to ensure that the

needs of the community are being met and planned out?

DR. LEW: Well I would say, you know, OHCA should look at making sure that the care is staying local and it's not leaking to other states or other towns within the state.

I would say that OHCA should look at the level of patient satisfaction, look at the outcomes, look at the quality measures within the population that's being managed.

HEARING OFFICER HANSTED: Okay. All right, thank you.

DR. LEW: Sure.

MR. LAZARUS: I have a follow-up. Now you've been in Rhode Island for two years, right?

DR. LEW: Two years in June, yes.

MR. LAZARUS: Have you conducted a CHNA there? Has PMH been involved in doing CHNA there yet?

DR. LEW: A community needs --

MS. VOLPE: Yeah.

MR. CROCKETT: Not a formal one, as it's being defined here.

MR. LAZARUS: Okay. The way you've defined it, has one been done, conducted there?

DR. LEW: Oh, yes. Absolutely. Yeah.

When I spoke to the percentage of leakage outside of the service area, a lot of business and patients were going out of network and going to other systems, and now that we have data and figuring out a way to reach out to patients, we've actually doubled the amount of patients that are coming now to our system and not having to go outside for their care.

And as part of the pilot that we're doing with the state of Rhode Island, very closely, as the population gets mapped through the health plans and assigned to our network, we have to absolutely make sure that there's the behavioral health, the medical health components, and we have to work with the community clinics. That's being looked at very closely.

MR. LAZARUS: Would you be able to provide us a copy of an example, say, from Rhode Island that we could perhaps look at to get an idea of what you're talking about, the analytics?

DR. LEW: Sure.

MR. LAZARUS: Because we understand the community health needs assessment, as it's performed in Connecticut, and we're trying to understand PMH's definition of the community needs health assessment.

DR. LEW: Steven, when you want the

report, what information, like what questions would you want answered, so I can try to get the right --

MR. LAZARUS: Well is there a report that's created, generated that tells you the needs of the community?

MS. MARTONE: Because like what we typically see, say, in the community health needs assessment filed by the hospitals, you know, they hire a consultant, and they have partners and community providers that are part of this big work group, and they may do phone surveys, they may consult with different partners, and they assess the needs of the area, and, so, then they make a list of what they're recommending, in terms of what needs to be done in the area that's not certainly being done, in terms of unmet need.

MR. CROCKETT: In addition to what Dr. Lew was mentioning, and this was done in conjunction with some of the work that the IPA part of our division was doing, as well as our local Advisory Board, that two additional areas that were being underserved within the area was OB services, as well as cardiac care.

And, so, as part of that analysis, CharterCARE has recently submitted applications to the Department of Health in Rhode Island for those services

to be performed at CharterCARE, and, as part of that process, there was a needs assessment that was completed that would be consistent with how you've outlined it, so, from that perspective, we would be willing to provide you with the application that shows the needs assessments for those services.

The needs assessment, from our perspective, is an ongoing issue. We don't do it, you know, once every three years, do it once every four years. It's kind of more of a living, breathing process as we go through population management, so what I would consider for this first two-year process, this would be kind of our first step in looking at those needs, but I think it's substantial when you look at it.

MS. MARTONE: We want to ensure that the community is involved. We want to make sure that physicians, providers, other providers in the community are involved. That's all we're looking for really, in terms of this assessment, so it's not just your assessment, but it's the community's assessment, and that's what we're trying to ensure here, that we want to see an implementation plan that actually shows what you're going to do, how you're going to implement it, who is going to be involved in it, and when it's going to be

done.

So if you're identifying behavioral health as a need, then we want to see a detailed plan, in terms of how you're going to do that. Okay.

MR. LAZARUS: So that's something you have an example of.

HEARING OFFICER HANSTED: Yeah. The Rhode Island application you mentioned that you're willing to submit, why don't you provide that?

MS. VOLPE: To be responsive to you, we will look at that. It may be a needs assessment, like we've seen with other CON applications from consultants, and that isn't what you want.

MS. MARTONE: Thank you.

MS. VOLPE: So I think, just so there's no miscommunication, let us go back and look and see if there have been an assessment, based on the description you've provided, and we will research that.

As has been stated in testimony, as a for-profit, they're not required to do a traditional community health needs assessment, because that is a creature of tax exempt hospitals and a compliance issue, and it's expected that OHCA would get that response, because it's required of tax exempt hospitals.

So let us go back and see if, in fact, we've done an assessment similar, along the lines that you're looking for, okay? Because I think, and I don't know this for sure, but if we were to produce the Rhode Island one, I don't think it's what you'd be interested in, because it could be more of a consultant needs assessment that we all are familiar with that many of the hospitals here use to support a service they want to implement, so it's not different, but I think it is different, in terms of what you're asking for.

MS. MARTONE: Okay, thank you.

HEARING OFFICER HANSTED: Thank you, Attorney Volpe. And if you do have something that you're going to submit, that will be Late File No. 9.

MS. VOLPE: Correct. Yes.

HEARING OFFICER HANSTED: If you do not have one, please send us a letter to that effect.

MS. VOLPE: Yes.

HEARING OFFICER HANSTED: Thank you.

MR. ZINN ROWTHORN: I had a couple more issues I wanted to touch on out of the public commentary, and I know you may feel that like you've addressed this issue in some detail in your materials and last night and perhaps some today, but, clearly, there remains a

question the mind, at least to some of the people in this room, who spoke to us, Mrs. Burke and others, about why ECHN did not partner with one of the local health systems, who are all non-profit.

I'd be interested, maybe Dr. O'Neill or Ms. Dorin, to hear. Perhaps you could address that.

MS. DORIN: So, as mentioned, we've been involved in this process since December 2011. When we first undertook the decision to seek out a partner, we actually established five criteria.

The criteria that we were looking for in a partner was whether or not that partner would bring organizational strength and capability, whether they had a strategic vision for serving the health care needs of our market, Manchester, Rockville, Vernon and the surrounding towns, whether or not they had the financial strength to be able to help us with our debt, and whether or not they would actually be able to implement the deal.

It's probably not a surprise. I mean we got proposals from two of the larger hospital systems within the state, and, for a variety of reasons, those didn't fit the criteria.

Two of them we would have significant implementation risks, because of anti-trust issues. We

felt, considering the five criteria, in conjunction with the visits that we made to California and to Rhode Island and the culture that we could actually see and feel in those facilities and from talking to Prospect, that Prospect was, by far, the best fit for us.

The process that we went through was extensive. It took a long time, and I feel very comfortable that we've made the right decision.

As I mentioned last night and today, I live in Manchester. I've lived there for 40 years. I want to be able to look my friends and family in the eye when I see them in the local supermarket, which is right around the corner from where I live, that we have made the right decision, and I feel that we have. I have no qualms, whatsoever.

MR. ZINN ROWTHORN: I appreciate that, and I think, in fairness, it is worth probably pointing out that, originally, the transaction that you initially sought was with Vanguard, which became Tenet, which did have, as a participant in that transaction, the Yale-New Haven health system, is that correct?

MS. DORIN: Right.

MR. ZINN ROWTHORN: And then, to the point that you make about anti-trust concern, I think, to

clarify that reference, I think what you're suggesting, and you can correct me if I'm wrong, is that were you to partner with an existing health care system in Connecticut, you would be reducing the number of competitor health systems in the state, as opposed to partnering with a system that doesn't currently have a presence in the state. Is that your point?

MS. DORIN: Correct.

MR. ZINN ROWTHORN: Dr. O'Neill, did you want to answer?

DR. O'NEILL: If I can just add, in the latest round, we had offers from Hartford HealthCare and Trinity, the for-profit entity that has recently acquired St. Francis.

In the case of Hartford HealthCare, it was not an acquisition of ECHN. Their most recent offer was a partial purchase of some of our most profitable lines, namely, our VNA, and they didn't offer to diffuse our debt or take on our pension liability, so it was an offer that we thought was financially not feasible.

Added to that was the anti-trust issue. We were advised by legal counsel and Hartford was advised by their legal counsel that the likeliness of an acquisition deal would be very low from an anti-trust

standpoint.

In other words, we would be requested by the FTC to have a second opinion, which would delay it another year, and the likelihood of it being denied was relatively high, so we felt we didn't have enough time to go through that process, even if we wanted to go the Hartford Health route.

In the case of Trinity and St. Francis, it was based on two issues that we felt that it was not feasible. The first was women's health issue. We felt, being part of a Catholic system, would significantly reduce access to women's health for residents in our market, in our 19 towns east of the river, and we heard strenuous objections from our obstetrical department and from a number of community members, that that was not a good alternative for eastern Connecticut.

Added to that was we had an issue with the way Trinity's management would manage ECHN east of the river. We've requested, but we did not get the assurances that we needed, that the management of our health system would be in the best interest of eastern Connecticut, as opposed to the best interest of Trinity corporate and St. Francis in Hartford.

So those are the reasons, basically, that

we decided that Prospect was the best option for us.

MS. DORIN: And if I could just add one other thing to that? Again, when we set out on this selection process, what we wanted to make sure was that care was accessible, affordable to this part of Connecticut.

As many of the individuals, who commented today, maintaining health care locally is very important, and our feeling on the Transaction Committee and, also, on the Board was that, if we were to partner with Hartford HealthCare or Trinity, St. Francis, that, bit-by-bit, year-over-year, services would be taken out of this market and brought into Hartford, so our goal in selecting a partner would not have been satisfied by seeking one of those as our ultimate partner.

MR. ZINN ROWTHORN: Thank you for that. I'll ask a question that I asked last night, and it reflects some of the commentary that we received here this evening, about the continuing engagement of the hospital system with the communities beyond perhaps the Advisory Board, and I think what that question reflects is what you already know and what you're here again tonight, which is that there's a real sense of value in the communities for these hospitals, almost a proprietary

sense that the hospitals are a community asset.

What I'd love to hear you address is, and maybe the way to address that is both to talk about what the local Advisory Board will -- how it will be empowered and constituted, but, also, other thoughts that you would like to share with the folks here tonight, about how the communities will be able to continue to have that sense of engagement with the hospital going forward.

MR. KARL: Thank you. Perry, we had the discussion this morning about that exactly, because I know that was brought up.

So how it works twice per year, and we're happy to go forward, actually, and open it up more, is we do semi-annual updates to our corporators.

We bring them in, 300 people, feed them dinner. That way, we know they'd come, and we give the state of the onion, State of the Union. We speak about truly, you know, what the organization is going through. We've educated them over the past four and a half years about where -- what struggles we're having.

We educate them on, obviously, on the Affordable Care Act, the detail of the Affordable Care Act, really moving towards value care, so on and so forth.

What I see going forward and what I'm very comfortable doing is holding two open forums, community forums per year, perhaps one in Manchester, one in Rockville, inviting the public to come to them, to give them a State of the Union on how the organization is performing, review what's new in the organization, what's happening, what's been invested in the communities, and, you know, truly educate them and educate them on how rapidly health care is changing, and let me just add one thing to that, and we spoke about this this morning.

I hear the community loud and clear. Health care 10 years ago, 60 percent of our revenue and our volume was inpatient. Forty percent was outpatient.

Seventy percent of the revenue that comes into the organization now, ECHN, is ambulatory, is outpatient, so the way we think of hospitals of the past is completely different than how they truly function today.

If you look at a Rockville hospital and you look at a Manchester hospital, 10 years ago our census -- we have licensed beds of 300 at Manchester. Ten years ago, you know, we're running 200 and something beds over there. We have a 100-bed hospital here. Ten years ago, we were running 80 patients. We now run about

36 here, and we run about 110, 115 at Manchester.

There's nothing wrong with that. It's because, 10 years ago, you were admitting patients when they didn't need to be admitted. Technology has changed, has changed dramatically, and I think that's what's getting lost in the public, and shame on us for not being able to educate them well enough, so they better understand that, and, so, you know, I would commit to doing that on an ongoing basis.

MR. ZINN ROWTHORN: Thank you.

DR. O'NEILL: Just to build on that, we have, in our not-for-profit, governance structure right now. We have 300 corporators, and I think we do actually a pretty good job of educating them.

MR. ZINN ROWTHORN: Could you just explain what a corporator is?

DR. O'NEILL: Well a corporator in our governance structure is the body of people that governs the organization, that elects the trustees and approves any major decisions, such as a sale of the organization.

The corporators historically were the ones who gave money to build the hospitals, and, from a governance standpoint, that's how they've been worked into the system, so, as Peter said, we meet with them on

a regular basis. Many of them serve on our committee structure, and I think we do a pretty good job of educating them, as evidenced by the fact that, when we went through this process of explaining to them why we needed to be acquired, and then we went through the whole thing with Tenet, and then we went through the most recent iteration with Prospect, 98 percent of them approved the acquisition, and they're independently-minded people, just like the folks, who have come in today to talk to us.

You can't please everyone. You can't please all 300 of them, but a 98 percent approval rating I think is a testament to the fact that we have educated them over time, and that they do see the wisdom in our course of action.

So going forward, even though, in a for-profit governance structure, we wouldn't have 300 corporators, we would still see the value in meeting with community members on a semi-annual basis to do basically the same process.

MR. REARDON: If I could just make a quick comment, Peter and Dennis? I've had the privilege of attending two of these corporator meetings, and although you're right, there's education that goes on in one

direction, believe me, there are no bashful people at these meetings. There's education that goes both ways.

And I said yesterday, and I'll say it again today, as much as we at Prospect want to be part of this community, we will never know this community as well as the community members do, and, so, we want your input, and the idea of a Town Hall meeting a couple of times a year and open it up to more than just corporators is a terrific idea, I think, so I think we would support that.

MR. ZINN ROWTHORN: Thank you, Tom. Tom, I appreciate that, and I think what I'll ask to hear from you guys on the Prospect side of the table is the community does, as you say, know the folks on this side of the table. They don't know you, just like you don't know them.

Were this transaction to be approved, do you have a commitment to have national leadership from the organization participate in some of these events or other opportunities to hear directly from the community?

DR. LEW: Perry, similar to what we talked about yesterday, in terms of the multiple touches through the model that our network managers would have with the community, that's one way that we would do it, to hear the concerns of the community, as it relates to their

care, but, to specifically answer your question, national presence coming to these meetings, that would be fine. I'd love to.

MR. ZINN ROWTHORN: Okay, thank you, Doctor. I'll raise it here, because you heard it, and it's the issue about local taxation. Now it's not part of our review. It's beyond the scope of our review, obviously, and, currently, as a non-profit, that your organization is not locally taxed, I'll give you the opportunity to address what Prospect's plans are with regard to tax abatement issues.

MR. REARDON: Shall I respond to that, Mitchell? First of all, I heard the comments last night, and I heard them again today.

I think there's, frankly, a complete misconception, as to what we have in mind here, and I've read it in the press, too, and I just think there's a misconception.

Right now, ECHN does not pay taxes. They're a non-profit. On day one, ECHN is a for-profit organization and will pay taxes. It will pay sales taxes, it will pay personal property taxes, and they will pay real property taxes.

We have approached both Vernon and

Manchester, and they're awaiting a proposal from us, and we will submit a proposal. I can't get into the details of what that proposal will be, but what I can tell you is, in Rhode Island, what we did there was we looked at the pilot payments.

The pilot payments are the payments that the state makes when you have a lot of non-profits in your town, and it's not 100 percent of what the property taxes would be.

And what we've done in Rhode Island is we started out with both Providence and North Providence with the pilot payments being a floor for what we would do.

And, by the way, pilot payments, from everything I've heard, they're not guaranteed next year, or the year after that in this state, because everything we've heard is it's not a question of whether, but when there will be cuts to cities and towns.

MR. ZINN ROWTHORN: And, by the way, pilot payments is a payment in lieu of taxes that a municipality would receive --

MR. REARDON: Right.

MR. ZINN ROWTHORN: -- and some compensation for having non-taxed property within its

Board.

MR. REARDON: Right. So what we did in Rhode Island with respect to property taxes was to make sure that the cities and town were made whole, and then we ramped up from there, and the idea was that, to add a huge tax burden on top of an organization that's already in trouble is a tremendous struggle, and, so, what we've asked for is breathing space to make the organization get healthy again, so that we can ramp up to full property taxes, as well as sales taxes and personal property taxes.

MR. ZINN ROWTHORN: Thank you for that. We heard a statistic, and I can't -- I'm not familiar with its source and I can't vouch for it, but there was a statistic that 49 of the 50 (coughing) health care systems are for-profit.

I'll give you the opportunity to talk about costs within your system. I think you've touched on it some tonight. Maybe, Dr. Lew, if you want to?

DR. LEW: Yeah. I'll just add to that. In the markets that we are in, we are considered the lower cost hospital systems.

As I shared earlier, you know, we serve a lot of underserved areas, but even in communities, where

they're not considered underserved, we're considered a lower cost hospital, and we see ourselves, because we think we are able to produce better outcomes, as very high value, because you have competing health systems that will cost double, and it's probably similar here, so you're paying double, but we think we can get as good or better outcomes, so I don't think we're in that 49 out of 50, Perry.

MR. ZINN ROWTHORN: I appreciate that. That's all I have, specifically. I want to, while we're gathered here, give you the opportunity. I know you're paying attention to what the public reaction is, both in our comments that we received, but in coverage in the media.

If there's anything else you want to take the opportunity to address, I think, in fairness, I'm happy to give you that.

DR. LEW: I would just like -- is this the final thing, Perry?

MR. ZINN ROWTHORN: I'm sorry to say to the folks in the back that there was a headshake in response to that question. (Multiple conversations) If you want to save wrap-up commentary for the end, you can do that. I'm all set. Thank you.

HEARING OFFICER HANSTED: Okay, now we're going to move to OHCA's questions. Mr. Lazarus?

MR. SALTON: Hold on. Are you going to let the AG finish their questions?

HEARING OFFICER HANSTED: Sure.

MR. SALTON: Okay.

MR. ZINN ROWTHORN: I may have indicated we were all set, Henry. (Laughter)

HEARING OFFICER HANSTED: We'll go back to the Attorney General's Office for more questioning.

MR. SALTON: One observation I just want to make is that folks should understand that, yesterday, we had almost six hours of hearing, of which about five hours was presentation and questions from this panel, so there were a lot of detailed questions that we covered yesterday, and some of those detailed questions we're not repeating today, so that we don't use all of the time of people here and test their patience.

I do have just a handful of things that I want to ask for. Yesterday, you spoke about, in response to the quality issues in California, that you've brought in this new corporate leadership, the four new corporate officers, and you indicated that's not the sum total, that those individuals will have staff and resources to

support their work and oversight of quality of care.

And you indicated, I think, that you're going to provide us some CVs for those individuals. We'd also like details on the supporting staff and resources budget money, whatever, that you have allocated to that part of your corporate office.

MR. ZINN ROWTHORN: Is that a late file?

MR. SALTON: As a late file.

HEARING OFFICER HANSTED: That will be Late File No. 10.

MR. SALTON: You also indicated that, after the closing, I mean after the approval and the sale is completed, there's going to be a strategic planning process for how the $75 million in capital improvements that serve the hospitals and the larger community are going to be expended over the next five years.

If you have, I assume you've done this in your other acquisitions, give us a detailed description of how that strategic health planning process will take place.

Who is involved? Who is at the table? What input you're going to get, and who exercises authority, or has a vote on how that plan will be done?

I understand that you can't tell us

specifics of where every dollar is going to be spent, but at least, right now, we'd like to know what that process is, so we understand how decisions are going to be made.

Of particular concern is that we know, from the hospital yesterday, there are substantial, millions and millions of dollars in needs on the campus that need to be addressed, so we would like to know -- I would recommend that you submit as a late file, also, a description of that process.

HEARING OFFICER HANSTED: That will be Late File No. 11.

MR. SALTON: I'm trying to go through this real quick. Number three is we'd ask ECHN if you could give us also a list of those capital improvements on the campus that you think are critical to be done in the next two to three years that would affect patient care if they're not done.

I understand there's always a desire to improve the cosmetics of a hospital to attract patients, but I think what we're really talking about are capital improvements over the next two to three years that are critical to patient care.

MR. KARL: We will do that.

HEARING OFFICER HANSTED: That will be

Late File No. 12.

MR. SALTON: Okay, so, then I want to ask just a couple more questions. One is, Prospect and the hospitals gave sort of a little bit more detailed description or variation on this side letter that says that the ECHN quality program is going to be maintained over the next two years, and it was a little bit different description than we heard last night, and we understood that you guys wanted to kind of regroup and provide us a little bit more thorough description, but I just want to make sure that -- my understanding is that the side letter, as written, still governs, and there hasn't been any change to that, based on what you said today.

MS. DORIN: Correct.

MR. SALTON: Okay, now, the other question I have is I understand there are going to be two Boards, and, first, I'd like to know, and I don't think it's been very clear, exactly, when you guys decide to create these two Boards, how are members going to be selected and placed on a local Board, and who is going to do the selection?

DR. O'NEILL: I can answer that. Our intent is to follow the current process, whereas we have

one Board that acts as a mirrored Board, because there's two hospitals, so we open the book for Rockville Hospital, open the book for Manchester Hospital, and that's how we carry this through, so it's two Boards, but it's truly one, okay, because that's what we currently have now. If not, you'd be having Board meeting after Board meeting, so we streamline that, because we've been consolidated for 20 years, so that's one.

How we would pick the new Board and what our plans were was to go out to our corporators, look at our active corporators, look at the diversity of the towns that we currently live in or they currently serve, and then make sure that we have a balance of not only cultural diversity, but diversity in their careers; someone from Highland Park Market, someone from Manchester Community College, and so on and so forth, and we would select that through our corporators, but we would be open to other ways to do it. That's how we've done it in the past, and that's how we plan on continuing doing it.

And the way Prospect sets up their Boards that I mentioned yesterday, there will be five physicians and five community members, and what I would recommend is that we would keep two of the current Board members on

the new Board, just for continuity, but bring on three brand new community member Board members, and then five physicians would come from the community, again, diverse, that would come from the IPA that currently practice in town.

MR. SALTON: Okay and, so, is that also Prospect's understanding?

MR. CROCKETT: It is.

MR. SALTON: And who makes the selection of the physicians?

MR. CROCKETT: The selection of the physicians will come from a recommendation from the CEO and then would be approved by corporate.

MR. SALTON: Okay and as far as the community members go?

MR. CROCKETT: Recommendation, once again, from the CEO, and then approved by corporate.

MR. SALTON: And what would be the criteria for corporate approval of Board members?

MR. CROCKETT: Making sure that it's diverse and well-represented and not overloaded. It's just a check and a balance, nothing, other than that. It's the same criteria that they go through their selection, as well, and just a validation that it was

diverse and it’s appropriate.

MR. KARL: If I just might add, also, when you commit, as you are probably aware, I just want this for the record, if you commit as a Board member, you’re committing not only to a monthly meeting, but you’re committing to being on call when issues arise.

You also commit to serving on several committees, so it is a significant, significant time commitment that is a volunteer time commitment, which will continue, so it isn’t easy finding Board members, simply because they spent mornings, evenings at the hospitals, at VNHSC, at Woodlake, and, so, we are very, very careful when we look at our corporators to see, again, to make sure they’re diverse, but also can afford the time to volunteer, because if you miss a meeting or two, you’re completely out of it, and, so, it’s a very focused process.

MS. MARTONE: Do the Board of Trustees also weigh in on the community members that are chosen?

DR. O'NEILL: Yes. Currently, the Board of Trustees has a Governance Committee.

MS. MARTONE: Okay.

DR. O'NEILL: Made up of trustees, and the Governance Committee goes through an iterative process

every year adding corporators, letting corporators cycle off, and then selecting trustees, and then selecting the committee Chairs and then the committee members, so it's a process.

The Governance Committee does all this work, and then sends it to the full corporate Board for approval, for review and approval.

MS. MARTONE: Okay, thank you. Sorry, Henry.

MR. SALTON: Okay, so, if you would also, then -- I appreciate your description on the record, but if you have something and produce something in writing that would be the defined process for the local Board after the acquisition, we'd like that as a late filing, also.

HEARING OFFICER HANSTED: And that will be Late File No. 13.

MR. SALTON: That's all I have. Thank you for your patience. Thanks, Perry.

MR. ZINN ROWTHORN: Good questions. All good questions. Now that definitively concludes the Office of the Attorney General's questions.

HEARING OFFICER HANSTED: Okay. I'll take a pause here. We have some questions. Mr. Lazarus?

MR. LAZARUS: Just a few questions today. We're not going to have two hours' worth of questions.

What I'm going to do is summarize a couple of the things we talked about yesterday and just make clear that the understanding is correct on both sides.

First of all, PMH said it has hired four individuals at the corporate level to address the quality of its 14 hospitals in the various states.

PMH has entered into a two-year assurance agreement, quality assurance agreement with ECHN to preserve ECHN's quality assurance programs and enhance it as it sees fit for two years, and you provided a copy of that yesterday.

Also, the local ECHN Board will have authority to revise, update and enhance the ECHN's quality program as it sees fit.

To that effect, could you just kind of clarify, when you talked about authority, does that mean it's just simply a matter of recommendation, who will the recommendation to be to, or do can they actually make any changes?

For example, they need to improve the quality of the OR and needs $50,000, is that something that they can recommend, or is it something that they can

actually move forward with? That's just an example.

MR. CROCKETT: Let me best try to answer that. The expectation that we had discussed today, this morning, actually, with ECHN is that the role of the Advisory Board is to have the responsibility for setting the goals associated with it.

In conjunction with that, the role, then, of the corporate team is to make sure that they're best practices and that it's aligned with best practices and national patient safety goals associated with that.

Underneath kind of that framework or that umbrella, my expectation is the goals that you did of an example of improving the quality in the OR would fit within that criteria, then the answer is yes.

I mean I can't definitively say yes or no on every example, but, underneath that umbrella of example, then my answer would be of course we'd want to improve the quality of the OR.

MR. LAZARUS: But they would recommend something to the executive team, to the corporation?

MS. MARTONE: They couldn't just move forward with what he's asking. The Board can't just decide to do that and move forward.

MR. CROCKETT: Say that again?

MS. MARTONE: What he's asking is if the local Board, ECHN Board, would have the authority and enforcement, say they decided something like that was needed to be done to just move forward and do that and spend the funds that they wanted to spend, so our question is what kind of other approvals would they need, if any?

MR. CROCKETT: So, to be clear, the role of the Advisory Board is to set expectations. When you think of quality, I think quality is a little bit of a misnomer, because it means 20 different things to 20 people, and it's a very broad brush associated with it.

When we think of quality, it starts off with what are the outcomes of what is trying to be achieved, and, at the end of the day, that's really the point of it, so, using your example, when we talk about the outcomes that are looking for, I'm looking specifically, then, for the outcomes that need to be achieved within the operating room, and there's various ways of how outcome can be achieved that needs to be achieved.

I don't think it's actually the appropriate role for the Board to identify the pathway to achieve it. That's the role of the actual local

management team to say we want to improve whatever standard, and there's multiple ways to actually improve it, and here's, then, our recommendation back to the Board on how we're going to achieve the outcome.

The point of it is is that it's not the process of achieving it as achieving the outcome. It's the local management team's responsibility to actually figure out how to achieve it. It may be 30,000. It may be 100. There's multiple ways to achieve it.

HEARING OFFICER HANSTED: But just a follow-up on that. So if local management decided, like in Steve's example, that the OR needed to be improved in some manner, would the local management require PMH corporate approval before they could go ahead and do that, or does the decision to take that action stay local?

MR. CROCKETT: Well there's multiple levels of -- let me start off with, once again, when we use the word quality, I think it's a very broad brush that can be misinterpreted on multiple different ways, starting off with issues associated with what's considered patient safety, life safety, CMS requirements.

We don't actually require corporate level of approval associated with that. In fact, we expect

local management to address and resolve any of the issues that are specific to patient safety, life safety, and that's a continuous level of readiness that we expect 24/7, 365, and doesn't need approval associated with that.

As it talks about the process, then, so, from that level, the answer is no.

HEARING OFFICER HANSTED: Okay, thank you.

MR. LAZARUS: That helps clarify. Thank you. PMH also said that they will make every effort for the new Chief Quality Officer to make him available for OHCA and the AG after she begins her position on April 4th.

Considering that -- just be aware that, for the administrative purposes, this docket has been consolidated with PMH's other application, where they're acquiring Greater Waterbury Health Network, so any information that's collected in either one of these records can be utilized towards any of the record.

Having said that, can PMH have the new Chief Quality Officer available to testify in the PMH/Greater Waterbury Health Network hearing that we're in the process of scheduling, which I believe we're looking to schedule on April 26th?

MS. VOLPE: I mean PMH is prepared, you know, for purposes of late file, to provide detail on the job descriptions, the CVs, you know, the qualifications for all the representatives that are going to be in the Quality Department, as well as an organizational chart, you know, and I think Henry today asked for budgeting.

I guess a question we have is what a new person on the job now, if you have their qualifications, you know their job descriptions, you know the organizational chart, you have the details that you need, somebody, who is just hired, what are you hoping to accomplish with speaking with them when they haven't been with the organization?

MR. LAZARUS: I do believe that yesterday it was made clear that this person/position was going to be the person, who was going to be responsible within the corporation for all the quality. The buck stops with that person.

MS. VOLPE: I mean I'll turn it over to Von, but, in terms of responsible for all the quality, we want the local Boards and the local management to be responsible for the quality, absolutely.

The corporate is there as a resource and to make sure that the local hospitals are implementing

best practices, do have good quality plans and programs in place, and are implementing them, so this person is going to be responsible overseeing all of that, but we want the responsibility for quality at the local level, and we want the local management and local Boards to do what they feel needs to be done for quality purposes.

MR. SALTON: I think that, if this group at the corporate level -- I mean it sounds to me from your presentations that the problems in California are a manifestation of some failures at the local level and that you've now decided to backstop the local level of quality assurance by providing this corporate level division on quality assurance.

MS. VOLPE: Correct.

MR. SALTON: And I think that it would be very useful for us to have a sense of who this Chief Quality Officer is, their judgment, her judgment, or his judgment, the way she perceives what's happened in the past, and her approach on a going-forward basis, as far as being someone on the top of a pyramid, who has 14 to 18, 19 hospitals, and how she's going to approach the job.

And even though we don't expect, I don't think anyone expects her to say I've been on the job for

two weeks and I have all the answers, her approach and her judgment, her sense of which way the compass pushes is a useful thing for us in making some determinations about the assurance of access and quality to care.

MR. ZINN ROWTHORN: And I'll just add one further point, that I think this is a discussion, whether through that way or another way, that's worth continuing, because I'll confess that, even after today and yesterday, there remains some uncertainty in my mind about where the allocation of responsibility lies between corporate and the local Board on quality issues.

We had a discussion yesterday that we didn't hear about today, which was that there was some authority delegated to the Rhode Island hospitals that looked more than advisory, but looked actually like a delegation of actual authority on quality issues, so I think we need to -- I think, collectively up here, what we're expressing to you is we need to have a very crisp understanding, to the extent possible, of how quality decisions are going to be allocated between national leadership and local leadership.

MS. VOLPE: And we understand that, Perry, and we want there to be a crisp understanding, so, in order to give that to you, I mean do you want that

detailed in writing, in terms of how the hierarchy is going to work and the organizational chart, or are you saying that your preference would be to have a person new on the job show up? I mean how can we give you that crisp understanding?

MR. ZINN ROWTHORN: I think we should order as a late-filed exhibit some further written explanation on the allocation of quality responsibility, and I'll defer to OHCA and others on the request for live testimony at the Greater Waterbury Health Network proceeding in a couple of weeks.

I think we would approach that, I think, with some understanding that the person would be new to the job, but she's going to be backstopped by a group of folks, who know the organization well, so I think it would be helpful to have both.

HEARING OFFICER HANSTED: Just for the record, the allocation of the quality responsibilities will be Late File No. 14.

MS. MARTONE: And is that going to include the chart of organization you just brought up, Michele?

MS. VOLPE: The organizational chart?

MS. MARTONE: Correct.

MS. VOLPE: Sure. Yes.

MS. MARTONE: Thank you.

MR. CROCKETT: And in regards to the question, yes, we will make her available for the Waterbury hearing.

MR. ZINN ROWTHORN: Thank you.

MR. LAZARUS: Thank you.

MR. ZINN ROWTHORN: Appreciate that.

HEARING OFFICER HANSTED: Just a follow-up on that. OHCA would request that this individual, this new hire, attend the Waterbury hearing in person whenever that is scheduled for. I believe that's the end of April.

MR. CROCKETT: Correct.

HEARING OFFICER HANSTED: Thank you.

MS. VOLPE: Thank you.

MR. LAZARUS: Can you please provide us as a late file copies of any and all deficiencies received by PMH-owned hospitals in Rhode Island for the past three years? And please include any plans of correction related to those deficiencies.

HEARING OFFICER HANSTED: That will be Late File No. 15.

MS. VOLPE: Just a point of clarification on that late file. I mean they haven't owned the

hospitals for three years, so, for Rhode Island, for the time period for which Prospect has owned --

MR. LAZARUS: Two years would be fine, then, yes.

MS. VOLPE: Okay.

MR. LAZARUS: So I'm just confirming that, yesterday, we had discussed the Quality Evaluation Team, and they were going to provide documentation I believe on either reports that were developed or generated by that committee or any of the materials they had reviewed.

I believe we had talked about that yesterday. Would you be handing those in as late files?

MS. VOLPE: I think there was a late file number assigned to those.

HEARING OFFICER HANSTED: There is.

MR. LAZARUS: Okay. Okay, so, just clarifying.

MS. VOLPE: And the last one you requested, Mr. Lazarus, that would be Late File 15?

HEARING OFFICER HANSTED: That's correct.

MR. LAZARUS: Thank you. Yesterday, we had discussed the eastern region quality I believe it was initiative, or team, or something. It's our understanding from yesterday that it's not something

that's been developed yet, but will get developed over time. Do you have a time frame for that development? Is it over the two-year period that you're looking, or is it something relatively soon after the closing --

MS. DORIN: I'd defer to Von as the President of the eastern region.

HEARING OFFICER HANSTED: Remember the microphone, please.

MS. VOLPE: Can you repeat the question for Mr. Crockett?

MR. LAZARUS: Yesterday, we were discussing the eastern region either quality initiative or team that's been put together, and we understand that it's not put together yet, but will be, so I'm trying to get an idea of what time frame would that be for that to occur, and, also, what's the goal and vision for that team or initiative?

MR. CROCKETT: Let me start off with the goal and the vision first, and then we'll talk about implementation.

The goal and the vision is that, as we work with the four individuals, starting off with the Chief Quality Officer, of identifying what resources and best practice is to be shared, as well as policies to be

looked at, and it's really more at an umbrella level.

It's a resource for the local team here to have someone to call upon and to look at a specific care practice, specific policy and understanding, so the point of the east coast regional team is to be an on-site ability within hours in a, you know, in a same time zone conversation to carry out the corporate initiatives, so they're not doing anything independently. It's underneath a corporate umbrella of the oversight and check and a balance.

From a time perspective, I anticipate that, at the time of the close, we will have a regional Director of Quality at the time of the closure, and there will be support staff shortly thereafter, within two to three months, but I would expect to have the leadership position filled.

MR. KARL: If I can just, if you don't mind, just add to that? What we're currently doing now, you heard from Linda Quirici yesterday, our quality person.

What we're doing right now, what we found is extremely helpful, is we're going to be moving onto the same formatted score cards, so when you're looking at them, you're looking at identical score cards, as it

relates to outcomes, whether it's hospital-acquired, so on and so forth.

And what we learned from Rhode Island and what they learned from us is there's certain things that we present better, and there are certain visual scorecards that they present better, and we're hoping to do the same thing when Waterbury comes up, because, currently at CHA, the Connecticut Hospital Association, as you know, there are certain quality items, quality measures that we share between hospitals, but we don't like sharing that type of information with competitors.

Being that we're not going to be competitors, this is going to be of great help for us to see why are you doing so well with falls in the institution? How come your falls are down so far? What they heard from us is that we have a Red Slipper Program. If the patient has red slippers on, that means that they're at a fall risk, and, so, that's how we're going to play this going forward.

MR. LAZARUS: Okay, thank you. Just to clarify, when you talk about eastern region, you mean it's northeast, so it will be Pennsylvania, New Jersey, Rhode Island, Connecticut, or just specific to Connecticut and Rhode Island?

MR. CROCKETT: It would include actually New Jersey and Pennsylvania, so our east coast will be true east coast.

MR. LAZARUS: Okay. I was just confirming. And, just confirming, that yesterday you had said regarding the community benefit that PMH on the record said that they would fund ECHN's community benefit at the current levels after the acquisitions?

MR. CROCKETT: That was correct.

MR. LAZARUS: Okay and as regarding the capital projects plan, can you talk about some timeline for that one after the closing? I know there was some discussion, but I wasn't clear on that.

MR. SPEES: Sorry. Can you repeat the question?

MR. LAZARUS: Sure. The capital project plan that's to be developed after the closing, what's the time frame for that?

MR. SPEES: Well, I mean, that's really the responsibility of local management to implement, but we would expect that the process would begin very quickly after closing, and we'll work with the local leadership team on timing of completion process-wise.

MR. KARL: Steve, in speaking with my

strategic planner and already having conversations about how we would roll this out, I would say, you know, after closing, it would be about a six-month period for us to develop a comprehensive plan that would look out, again, that would look out.

It's very difficult looking forward in health care, as you all know, because of the changes, but the strategic plan would probably look out two to three years, and then, again, it would be updated on a regular basis, as necessary.

MR. LAZARUS: Okay, thank you.

MR. ZINN ROWTHORN: I believe the testimony was that the anticipation is that the money, the $75 million, would be spent or committed within five years.

MR. LAZARUS: Carmen?

MS. CARMEN COTTO: Hi. Carmen Cotto, OHCA staff. I have some questions also related to the capital projects, but more at the local level, so my question will be addressed to you.

In the application on page 3224, indicated that they intended to secure a loan for $5 million to be spent exclusively on behavioral health expansion at Rockville General Hospital as a capital project.

Was the loan secured, and, if so, will the project be completed by closing to increase the commitment amount?

MR. KARL: The answer is, yes, the loan was secured. It falls under, obviously, our Behavioral Health Department. It's an eating disorder center. That's the only one in the State of Connecticut that would specialize in bulimia and anorexia.

And, yes, the loan was secured, and the construction, I can walk you over to Rockville, is currently underway, and we expect it to be completed in the late June -- first phase, meaning 20 beds, will open in June, and then an additional 10 beds will open in September, so it's a two-phased approach, and it has no affect on the purchase price.

MS. COTTO: But on the capital commitment, it does? No? Just confirming.

MR. SPEES: Well that's actually a complicated answer that I can try. We've agreed to assume the loan, the $5 million loan, but the expectation is the loan is currently secured by cash collateral, and, so, if ECHN at closing has the cash collateral available and delivers it to Prospect, then it has no impact on the capital commitment.

If, in fact, ECHN needs the cash to satisfy its obligations or for other reasons and doesn't deliver the cash collateral, the net difference would actually reduce the capital commitment. In essence, we would have pre-funded the capital commitment.

MS. COTTO: So, as you indicated, the capital project is for a 30-bed eating disorder inpatient unit for adolescents and adults. That was stated on our page 2149, and, at page 2173, it was stated that Rockville General Hospital has no other behavioral health inpatient service.

How was that service determined to be a need, as compared to a general psychiatric inpatient unit?

MR. KARL: Approximately, and, Kim, I'd have to go back to OHCA, but approximately five years ago, we entered into a partnership, filed a Certificate of Need, and received approval to open Walden Behavioral Care East, which was an outpatient eating disorder office or center in one of our South Windsor buildings.

We had always expected this to grow to a point, because of the significant need that's out in the community relating to these types of eating disorders.

What has happened in that five-year period

since they've moved in is they've expanded three times at the outpatient unit, and they are at capacity up at their two inpatient units in Massachusetts, so, as a result, they will manage the department. It will be under our license, and it will be our staff.

They will hire the physicians, but it will be our staff taking care of these patients.

MS. COTTO: One more question related to this issue. What inpatient behavioral health capacity does ECHN currently have, and what relationships do both of its hospitals currently have with community-based organizations to maintain continuity of care/follow-up care regarding behavioral health and substance abuse?

MR. KARL: Okay, so, ECHN has an extensive behavioral care division. We have an inpatient adult and adolescent locked unit at Manchester Memorial Hospital, 32 beds, 35 beds. I stand corrected.

We also have an extensive partial day program, whereas those patients that graduate from the inpatient unit go into partial day, until they are, then, released back into the community, back into society.

We also have an extensive ambulatory program at 150 North Main Street. We have over 60,000 visits that we see at that outpatient center.

We also have, believe it or not, we have a day school in the basement of Manchester Memorial Hospital, and let me define what the day school is.

It's those individuals, those sixth graders to seniors in high school, that have behavioral issues that they're unable to function at an everyday high school.

They are taught, as they would be in the school systems, but they are taught at our organization in the basement, not because for any other reason than that's where the space is, but they are taught, and they graduate. They actually graduate from that program, graduate with a degree, a high school degree.

Those patients, those students, most of them are very active in our behavioral health programs, outpatient programs, so that's the behavioral health piece.

And, again, we just recently opened an 11-station locked unit in our emergency department at Manchester, because of the overflow of behavioral health patients. We're in a crisis, as we all know, with behavioral health. We just opened, and, again, it's about $1.2 million behavioral health unit in our ED, to hold those patients there while they are waiting for the

beds that are up on the unit to open up, and that was done for patient safety, and, as important, it was done for employee safety.

You can imagine, after midnight, holding patients in the emergency department while you're getting MIs and car accidents coming in, and then you have behavioral health patients not being properly cared for, so that was done.

MS. MARTONE: And can I just ask? Were any of these initiatives or programs implemented because of the recommendations of the community health needs assessment?

MR. KARL: Absolutely.

MS. MARTONE: Okay.

MR. KARL: Absolutely.

MS. MARTONE: All right.

MR. KARL: And if I just may add, Kim, because I think Carmen asked the second question, about whether it's opiates, or drug abuse, or substance, I'm sorry, substance abuse, yes, we, in fact, there's a lot going on, but we also have volunteer programs at both hospitals, as it relates to substance abuse, whether it's alcohol, Alcoholics Anonymous, or Narcotics Anonymous, and we are in the process of, at this point in time, Dr.

Carroll is in the back, he can speak better, that we're going to be doing hopefully a pilot program with the Town of Manchester, and then we'd like to involve the Town of Rockville, as it relates to the heroin epidemic, mostly because of the Fentanyl issue that's out there currently, so, you know, so, that all, obviously, you don't need a community needs assessment to recognize the problem we're having with the opiates.

As you know, Connecticut has made the decision, and correct me if I'm wrong, Dr. Carroll, that we will no longer, at least in our hospital, be prescribing opiates for any more than seven days, and what that has created is a significant issue associated with heroin abuse and Fentanyl abuse, because these patients are addicted, and they can no longer get their opiates, so now they are going after that high, which is heroin, so what we've created, by not providing additional scripts, because our physicians now review the statewide panel for each patient that gets a prescription, they go onto a panel, so we will not be doing refills, which has now created our whole other issue, which we are now going to begin dealing with at this point in time. I hope that answered your question.

MS. COTTO: My next question is in

reference to the purchase price. I've seen through your presentations that you're only referring to the $105 million. Through the application process, there were two scenarios that were introduced to us.

There were two scenarios submitted to us, and you're only introducing one. Can you explain that?

MR. SPEES: Yeah. At the time of the original submission, there was the possibility that ECHN was going to get an additional loan, which was the genesis of the alternatives. With the passage of time, it's now -- that additional loan is off the table, so it actually makes it much less complicated, so we can deal with just the $105 million scenario.

MR. KARL: Carmen, if I can answer that, also?

MS. COTTO: Sure.

MR. KARL: We felt we may need a bridge, because of the Connecticut state tax, so we were worried about the operating cash, so we're going to go out, borrow $10 million to carry us until this approval went in place, but when we went to banks, they weren't all that friendly about giving up some money, $10 million, so it came back off the table again.

MS. COTTO: Okay. Page 3325, you stated

that all the joint ventures, in terms of ECHN, were to be transferred to PMH as part of the asset purchase were on schedule for transfer. Could you provide an update on the issue associated with the joint venture, venture transfers?

MR. KARL: I'll have Dennis McConville.

MS. COTTO: Yes. Okay.

MR. McCONVILLE: So, yes, we have 12 joint venture companies, and we have obtained consents in hand for all, but the four joint ventures related to real estate that are under ECHN Enterprises, and those are in process, and we should have those prior to closing. I don't see any issue from our partners.

MS. COTTO: I'm going to ask some questions related to the assumption of debt and the pension obligations. Your pre-filed testimony indicated that, and you also mentioned it today, that nearly $75 million of ECHN's outstanding debt will be paid through this transaction, which will free up $9 million of debt service annually for ECHN.

My question on the $9 million is, first of all, how did you estimate that $9 million was the basis for that? What was the basis for estimating the $9 million?

MR. SPEES: That information was given to me by Mike Veillette, the hospital CFO.

MS. COTTO: Is he available?

MR. VEILLETTE: Okay, so, Carmen, the $9 million is a function of the long-term debt, primarily the tax-exempt debt that we've had through CHFA and some more recent direct placements with TD Bank, the energy loan with Santander, there are a couple of other loans, as well as the annual payment on the line of credit, because we've been paying down on the line of credit with TD Bank, so we've been paying that down at about $1.8 million last year and this year, so that $9 million is 1.8 related to the line of credit, 7.2 million of annual debt service related to all the other debt.

The remaining annual debt is capitalized lease payments, and that will be assumed by Prospect.

MS. COTTO: Which is? What's the total now on that?

MR. VEILLETTE: The total number on that is in the neighborhood of around -- it's around $3 million.

MS. COTTO: Now that $9 million you expect to be free up of $9 million annually. For what extended period of time are you expecting that after closing? The

first year? Two years?

MR. VEILLETTE: That's an average over in like the next three years.

MS. COTTO: Three years? Okay. Now there's been different amounts presented to us related to the debt. In some testimony, I heard 75, through your presentation, it was 78, and the audited financial statements indicated a different amount.

I just need you to confirm what is the actual amount for the outstanding debt.

MR. VEILLETTE: If you go to our audited financial statement for 9/30/15, the total number between what I would call traditional debt and then look at the debt related to capitalized lease obligations and then the line of credit, that total number is around $90 million, if you don't take into account the assets, whose use is limited, so payments that we're making as we're going through the year, so you'll record debt on a gross basis and liabilities, but then you will also be making payments on a monthly basis, and it will be going into what we call assets, whose use is limited, and then you also have a handful of asset accounts, debt service reserve funds, and, so, that is netted.

Those funds would be part of the pay down

towards the overall gross debt.

MS. COTTO: Which I did see the audited financial statements, and I saw, the total amount that I saw was close to 90, as you explained.

MR. VEILLETTE: Right.

MS. COTTO: Now, based on that, could you please -- what we're asking you to do is to reconcile those numbers with the revised Table 8 that was requested yesterday by the Attorney General's Office.

MR. VEILLETTE: So we're doing that on a monthly basis, and, so, yeah, Gary and I spoke, and you requested it yesterday.

MS. COTTO: Yes. He requested a late file. I want to make sure that it's reconciled with information --

MR. VEILLETTE: We have both of those pieces of debt, if you will, broken out, so the long-term debt, which gets paid down, is net of those other assets I referred to, debt service reserve funds, assets, whose use is limited, and then the capitalized lease obligations are in the assumed liability cluster on the net proceed schedule.

MS. COTTO: Okay. I have a question on the funding pension obligations. Please explain PMH's

plan for funding the $64 million pension obligation. When will that happen? Right after closing? How will that be taking place, the funding of the $64 million on the pension obligations?

MR. SPEES: Yeah, so, the funding on the pension plan will continue post-closing, just as it does now, and there are a host of very complicated IRS formulas that deal with how and when the pension obligations have to be satisfied, and it depends on the return on the investments that have been mentioned, as well as IRS guidelines for what level of funding currently exists.

MS. COTTO: Okay. Now will you be able to do the same for the pension, the $64 million calculated cash flow associated with that, like you did with debt? Did you come up with the $9 million that you'll free up to use for capital projects? Could you provide us with a calculation that shows the financial benefit coming out of the $64 million cash flow and the cash flow that will come out?

MR. SPEES: I don't know if I can answer that question completely, as I'm not entirely sure if the liability, the unfunded liability is still carried on the post-closing balance sheet of ECHN, or if it has now

moved over to the corporate balance sheet of PMH, so it's difficult for me to say how that's going to be funded going forward, and part of that is because the current asset portfolio, as it is today, is not what it would be traditionally if it were under an entity that was let's just say not in our status right now.

So, in other words, what I mean by that is our portfolio is entirely in fixed income, and that's to preserve any more growing of that pension liability in our balance sheet and not exposing it to potential swings in the equity market.

I would suspect that, post-closing, that portfolio allocation would be re-examined, re-assessed, and be converted to a more traditional portfolio, so that you could benefit from a more diverse portfolio in the long run and close that pension funding gap, and, hopefully, there will be some improvement in interest rates sometime in the near future, because that is the most profound impact on the current status of that funding gap.

We have estimates currently, based on our current portfolio, on what that funding requirement is, but for me to be able to say that there's a -- those numbers are concrete, so to speak, I don't have the

ability to do that, because I don't know what's coming, in terms of interest rate changes. I don't know what's coming, in terms of potential future funding relief.

We've already gone through four measures of pension funding relief just since 2009. It's possible there could be even more funding relief in the future that could change the outlook of pension funding requirements, cash funding requirements for the years 2017 through 2021.

I can tell you that, if you look at that right now, at this point in time, those numbers are projected to be somewhere in the neighborhood of $17 to $19 million when you get out four or five years.

I doubt that that would be the case in the future, once that pension portfolio were reallocated in a more traditional model.

That's a long answer, but that's what I can tell you about potential pension funding.

MS. COTTO: I guess what I'm trying to get at is what are you getting out of this benefit of PMH relieving you of the $64 million?

MR. SPEES: Their ability to be able to help us achieve a greater EBITDA cash flow performance, so, like I said, I'm not sure if that funding requirement

comes from that cash flow or if it comes from another source, but EBITDA performance would be the reason for being able to absorb that potential funding requirement.

MS. COTTO: And you cannot project that for the next --

MR. SPEES: I can only tell you what I have today. I'm sorry. I can only tell you what I have today, based on a projection on what our current model is, based on our current portfolio.

MS. COTTO: Could you submit that information to us?

MR. SPEES: We could submit that.

MS. COTTO: Yes, please.

HEARING OFFICER HANSTED: That will be Late File No. 16.

MS. COTTO: I have a question for Mr. Crockett. In your pre-filed testimony, you indicated that one of the financial benefits for ECHN related to this proposal would be that revenue collection will be streamlined through PMH's system.

Could you please describe this revenue collection process and elaborate how it will be beneficial to both Manchester Hospital and Rockville Hospital?

MS. VOLPE: I'm sorry. Can you --

MS. COTTO: The page?

MS. VOLPE: Yeah, the page. I just want to make sure that was in Mr. Crockett's testimony.

MS. COTTO: Okay, sure.

MS. VOLPE: As opposed to maybe Mr. Spees.

MS. COTTO: Sure.

MS. VOLPE: But we'll want to get your question answered, so go ahead and ask it.

MS. COTTO: It's page 3359.

MR. CROCKETT: So, from a revenue streamline collection process, part of our efforts of looking to assist ECHN, there's many things we're hoping to bring to the table, but one of them is the revenue cycle process.

For us, the revenue cycle process is actually multi-faceted. It actually starts at the time of admission. We look at, from an admission perspective, in making sure that, as they're registering the patient, they're collecting the right information, in order for us to actually bill and collect correctly.

Part of that is going through and looking at the various -- if they don't have insurance currently, we go through an insurance verification process, where we

look to see if they actually -- if they're currently not eligible, if they're currently not on Medicaid, that they're eligible for Medicaid and they're uninsured, then we will hook them up with an eligibility worker to get them insured through the Medicaid program for the uninsured population.

For those that do have insurance, we're making sure that the information that is collected is correct and verified and validated, so that, as we go through the billing process, that they can collect from a charging perspective.

We go through in making sure that the coding is accurate and that it's correct, they're using the right codes most often. Bills are either not paid or denied, because people are using incorrect codes, or the process for coding is incorrect, and, so, we will have a team go through the validation, in terms of the coding and making sure that that's accurate.

From a care perspective, it's not uncommon for bills to be denied associated with eligibility and making sure that, if they do have insurance and that the care is being provided, that they don't do a pre-kind of a verification of insurance, or that it's just not being approved through whatever managed care company insurance

that they have, and, so, we'll have a process to making sure that, as the patients are in the hospital and they're receiving the care that they're having, that it's being validated and verified, and, really, it's keeping the managed care companies up-to-date, in terms of what's happening.

On the back end of the process, from a billing perspective, we do work with some vendors. We always look to look for local vendors associated with it. We usually look for either internally or externally the expertise associated with making sure that the billing is done timely, people don't wait six months to get a hospital bill.

And I'm not saying any of these things are applicable to ECHN. These are more national practices that we look to go through and improve.

We won't be actually applying anything that I've just said. Part of our process is we will go through and do an evaluation with what they currently have and really look in areas where we can improve upon what they're currently doing.

MS. COTTO: Okay, thank you. Would you like to add anything?

MR. ALEMAN: The only thing that I, and

Von was very thorough, the only thing I would emphasize this is one area that we see as a core competency of ours. We work very closely with all of our facilities, and one item that I would want to emphasize is the revenue cycle business office resides at the facility, so that's not something that we do centralized or from another location. It resides in the facilities, and we believe it operates most effectively at the facilities.

We bring our best practices, our data-driven tools for analytics to help them implement the policies and practices, and make sure that we're consistent, you know, company-wide on how we do it.

MS. COTTO: Okay, thank you. I just have a couple of follow-up questions from what we talked about yesterday.

MR. ALEMAN: Sure.

MS. COTTO: And the first one is related to, when we talk about PMH's ability to continue funding ECHN in the future, as you still continue to acquire hospitals that are in poor financial health, including the New Jersey hospital, as you just acquired, you indicated that you'll still be able to and, also, that New Jersey is actually doing better now.

MR. ALEMAN: That's correct.

MS. COTTO: Could you elaborate on that statement? What are the financial gains?

MR. ALEMAN: Yeah, sure. It's been a while, but when we first started being formally engaged with East Orange General Hospital, it was February of 2014, and I believe, if my memory serves me, we signed the APA June of 2014, and, so, we were in the regulatory review process for well over a year and a half in New Jersey.

Now when we signed the APA with East Orange General Hospital, they were losing approximately about a million/two a month, and we worked very closely with the management team on some of the items that we've touched base on, such as revenue cycle and the business office, what Von went through in great detail.

We worked very closely with them to just improve those practices to ultimately ensure that the facility is collecting what they have ultimately earned from operations, and, actually, over that period of time, bridge that gap from the number that I highlighted to basically break even up to the point of close, and then we looked for further improvement, so, as we take a look at and we focus on, as you stated, financially-troubled facilities, we worked to improve processes, so all the

way up to the point of the close of the transaction and beyond, that, certainly, the target is that they're all break even, hopefully, even doing better, or, if they had positive EBITDA, that we've even worked with them to improve that performance.

That is basically kind of our strategy. I think we've been fairly effective with that. I think we have that same track record of turnaround in performance at CharterCARE, certainly, East Orange, so that's part of what I reference when I say, you know, I'm fairly confident, as we move forward here, that none of those acquisitions are going to put a drag on our operating cash flow or free cash flow.

I feel very confident in our projections for not only following through on our commitments to ECHN, but every acquisition that we work through, and in none of our cash projections do I embed what the projected cash projections are from that target, so, in other words, in none of my cash projections for the commitments for ECHN do I have in there any cash that may be generated from ECHN.

In other words, they're not paying for their own commitments. It's the level of conservatism I think that I have in putting together those projections.

MS. COTTO: Okay, so, the Pennsylvania acquisition, what is the status of that?

MR. SPEES: So the Pennsylvania acquisition is in the regulatory process. It's different than in this state. There is no Certificate of Need, so it's with the Attorney General's process currently, and we expect that -- we're actually scheduling the public hearing I think toward the end of this month, as well, and we anticipate that that process, if it runs as expected, will conclude around the same time as this process.

MS. COTTO: Okay. Let's see.

MR. SPEES: I'm sorry. The end of April. That would be tomorrow, wouldn't it? I'm reasonably sure the hearing is not tomorrow.

MS. COTTO: You testified that the $75 million capital expenditures is not necessarily for just brick and mortar, capital projects, but how much of that 75 do you expect to actually invest on bricks and mortar, because now we do have information that you submitted that indicated that ECHN has $40 million dollars already identified as capital projects that it needs to address, so will it be accurate to say that, out of the 75, at least 40 million will be set aside for those that they

actually need?

MR. SPEES: I'll elaborate. I think that we appreciate the nature of the question, but I'll answer it in the same way I answered it previously, is that that will be a product of the capital planning and strategic planning process that we're going through, and, really, to try to do it any other way would sub-optimize the result, and, so, it really needs to be a comprehensive analysis of all of the needs.

There are limitations on capital, and, so, there's competition for capital, and unless it's done thoughtfully and thoroughly and with a big picture in mind, then it won't produce the best result.

MR. ALEMAN: Yeah, and I'll just elaborate. I think it's been addressed a few times. We look at those. We're here to invest in ECHN and invest in Connecticut.

We believe in our model, we believe in the state, we believe in the system, and we'll work very closely with management on the best use of that capital to grow the system.

I go back to our Nix acquisition in San Antonio, Texas, that we acquired that from a for-profit, and we actually had no capital commitment as part of that

transaction, but any capital commitment that we have we look at at as a floor, and even though with the Nix in San Antonio we had no capital commitment in first two years, we invested over $20 million in the building out of the ER and almost the doubling of the behavioral health facilities in infrastructure within the core building, building out other volume streams into the hospital, I use that as an example of the investment that we made into San Antonio, Texas to grow that system, that is our intent here, also, being able to break that down at this point into specific, whether it's bricks or mortar.

The underlying theme is it's to grow the system. It's to grow ECHN. It's to grow services and allocate the capital to the best means to achieve that end.

MS. COTTO: Okay, thank you. My question now is related to the most recent data submitted to OHCA, quarterly data that was submitted within the past week, and I have some questions on the difference between what was submitted these past few days and what was originally submitted through completeness, and this for ECHN.

The submission, the regional submission indicated, for cash flow operations, indicated that, for

fiscal year-to-date, 2014, ECHN generated $305 million.

The submission that we received past week, past few days, yesterday, it has a difference of $200 million from that amount. I need someone to explain to me why is that so different?

MR. VEILLETTE: So, Carmen, in all candor, the quality review or quality control on those reports, they just were shared with me it may have been two days ago, and I found some things in there that didn't appear to be appropriate, correct, and I asked for my team to take another look at it, and we found some formula issues in those reports, so I would rather not try to guess, as to what changed, because I haven't compared the previous.

I just knew, when I looked at a few of them, I knew there was an error, such as in days, days and accounts receivable, for example, where you had Manchester had an individual number, you had Rockville had an individual number, and then the combined number didn't make any sense, and then I asked a few other questions, and then I compared it to the audited financial statements, and I asked that we recheck every number, so everything was re-checked, and there was some other -- I was assured that everything had been corrected, but, quite honestly, I can't tell you, because

I haven't done a full reconciliation of what was submitted originally and what was submitted after, so it would be my preference to respond to that as part of the late filing.

MS. COTTO: The late file, yes. Yes, at the late file.

HEARING OFFICER HANSTED: This will be No. 17.

MS. COTTO: Okay. I think we're almost done here. I just have one more request or two more requests and we can go.

HEARING OFFICER HANSTED: Well, to clarify, she'll be finished.

MS. COTTO: For me. He's the one that will decide that. Sorry. I apologize.

We talked about the $100 million available funding.

MR. ALEMAN: Yes.

MS. COTTO: And you indicated that it's now in excess of 60, not 110?

MR. ALEMAN: That's correct.

MS. COTTO: Okay and, also, that the cash flow, the free cash flow has increased 210 to 15?

MR. ALEMAN: Correct.

MS. COTTO: Through the process, we asked, when we first heard about the 110 million in the free cash flow, we asked for supporting documentation for those numbers. Now they have changed. Could you please revise your form that you sent us, the schedule that you sent us? And that is Schedule R of the December 11, 2015 completeness responses.

MR. ALEMAN: Yes.

MS. COTTO: Could you revise it, just to make sure that it's updated with the new correct amount?

MR. ALEMAN: Yes.

HEARING OFFICER HANSTED: That will be Late File No. 18.

MS. COTTO: And then we have requested a table that includes EBITDA, working capital, stockholder's equity for three earlier prior acquisitions, Nix, Roger Williams Medical Center and Our Lady of Fatima. That's on page 3400.

I just have a question on one of your footnotes. The footnote indicated that, it says that the net benefit of government supplemental payments in 2014 was higher than average, while the net benefit of government supplemental payments in 2015 was below average.

From an operational perspective, the performance of Nix was slightly better in 2015 and ’14. Could you elaborate on those payments, supplemental payments?

MR. ALEMAN: Sure. And this is related to the Nix in San Antonio.

MS. COTTO: Yes.

MR. ALEMAN: Their supplemental program, the 1115 waiver, has a few different pieces related to it, an uncompensated care component and a DSRIP component, of which they receive revenue.

The revenue component has been fairly stable year-over-year. What happened in the 2014 period, there is an unrelated expense, but it’s part of kind of the program to be, and, for them, it’s called the SOS(phonetic) expense, where they actually -- there are costs associated with savings that they kind of carve out of the system with some other systems that they work with.

Bottom line is those costs, in general, run about roughly about a million dollars a month. They were significantly lower in 2014.

And it’s just by virtue of the costs associated with their partners and, basically, what they

have to fund, so that one particular year the costs were about $6 million lower than they normally are.

Once again, roughly, about a million dollars a month or 12 million a year. If my memory serves me, there was about $6 million in that given year, so that's what really drove the increased performance on a net basis in 2014 for the Nix.

MS. COTTO: Okay. That explanation leads to your EBITDA?

MR. ALEMAN: Correct.

MS. COTTO: Because your EBITDA for Nix in 2014 actually decreased between 2014 and 2015.

MR. ALEMAN: It went down from '14 to '15.

MS. COTTO: Okay.

MR. ALEMAN: Right. '14 was good, and then it went down to '15.

MS. COTTO: Okay, now, could you provide a table with numbers, the same numbers for EBITDA, working capital and stockholder's equity, related to New Jersey as it is right now?

MR. ALEMAN: Sure. Update that for New Jersey.

MS. COTTO: Yeah, for New Jersey. Include one line that includes New Jersey.

MR. ALEMAN: Yes.

HEARING OFFICER HANSTED: That will be Late File No. 19.

MS. COTTO: And that's it. Thank you.

HEARING OFFICER HANSTED: All set?

MS. COTTO: Yes.

HEARING OFFICER HANSTED: Do you have anything? Okay. I just want to take a few more minutes of your time and go back to the quality issue.

As you're aware, quality has been an issue in this hearing, last night's hearing. It's been an issue with us, and it's been an issue with the community members.

It's also one of OHCA's criteria that we need to look at in deciding on this application, and I just want to -- I don't want to go into many specifics, but I just want to highlight some of the quality issues that we discussed.

Specifically, in April 2014, there was an immediate jeopardy found at Southern California Hospital at Hollywood. In August 2014, the surveyors found that immediate jeopardy still existed at that hospital.

In September of 2015, Southern California Hospital at Hollywood, Culver City and Hollywood, were

found to be in immediate jeopardy.

In December 2015, immediate jeopardy was found at Southern California Hospital at Hollywood. In November of 2015, deficiencies were found at Los Angeles Community Hospital. And, in February of 2016, a resurvey of Los Angeles Community Hospital found that the hospital failed to address the November 2015 audit deficiencies.

And we've heard testimony about the quality agreement that's in place for two years, and we've heard other testimony about some of the steps you took to rectify the deficiencies and the immediate jeopardy.

I'd like you to take this opportunity to expand upon with more specificity what actions you're taking, not only at the local level, but at the corporate level.

As Perry stated earlier today, there's some confusion with respect to the allocation between corporate and the local level, in terms of who is responsible for quality assurance, so if you can take this opportunity to address us and the community members, I'd appreciate that.

MR. CROCKETT: You know, I think that the way to start the conversation is that, you know, quality

starts and ends on a day-to-day basis, and what you do for quality is interesting in what happened yesterday, but every single day quality needs to occur.

From our perspective, that's something that we strive for and we'll continue to strive for in each of the facilities.

With that, it has always been and will continue to be important for this organization, I mean Prospect and ECHN, that the ability of a local team to be able to resolve issues in real time fashion.

It's not uncommon, when you talk about quality, that it starts with not just a patient, but it also encompasses a physician and what his needs are, in order to provide safe care, as well as complaints from a patient.

From those three areas, it's important for us to make sure that the local team is empowered and remains empowered to resolve issues quickly and timely and appropriately.

As we talk through this, that has always been our mandate, and it continues to be our mandate, and we look to hold our local teams accountable in real time and not have to go through a corporate approval process or off-site approval associated with that.

That being said, obviously, it didn't prevent certain issues arising within the hospitals that you mentioned, and, as we went through and looked at what was causing some of those issues, in particular, one of the common threads that we've seen was a lack or a turnover at the executive level, as well as some at the nurse level.

Some of the challenges we have specifically to this specific market, so this is not an issue that's within all of our California, I mean without all of our Prospect hospitals, but within this specific market, is that Los Angeles County has 73 hospitals just within the county, and, with that, our hospitals are safety net providers working as community-based hospitals in underserved areas, and we are next door neighbors to very large, well-respected, well-regarded organizations.

And, so, with that being said, the competition within our marketplace at an executive level, as well as at a nurse level, is tremendous, and, so, it's not uncommon for the large academic tertiary centers, in order to get their nurses, they will go after the nurses that are already employed and have the ability to do so.

And, so, our challenge within our marketplace, and it continues to be a challenge and

something that we have now spent additional time and energy to focus on, is maintaining consistent leadership within a very, very competitive market, as well as nurse leadership.

And, so, with that, we have multiple initiatives to address those issues, including proper career pathways for nurses, so they feel that they don't have to leave our organization, specialty training for the nurses. We're looking for a mentoring program, a preceptorship program, and ongoing support.

Nursing, at the end of the day, when you talk about quality, it's not 100 percent of the quality, but it's usually a major part of it.

That's not the only cause, obviously, associated with it. So going forward, a couple of different things. One of them is that, as we mentioned previously in our presentation, is, if the organizations do have a lack of resource or expertise, that it's important for us on a go-forward basis to be able to provide leadership and that expertise to backfill as a backstop to organizations that may have some of those concerns, so that's number one.

And we look to have kind of a consistent, high-level leadership expertise that can assist when the

organizations do have turnover, or gaps, or a knowledge deficit associated with it.

On the turnover piece, we have engaged with our corporate HR Department, with our local facility HR Departments, to put in new additional programs to address some of the issues associated with the turnover and retention of the staff.

We believe and we're fully committed to it, in terms of putting the resources that are needed to address it in going forward.

Let's be clear. CMS doesn't enjoy coming out, and they've said the same thing. They have a high expectation, and they told us personally that being on a rollercoaster ride and multiple visits is not what they do, nor what they expect to do, and it's very disruptive in our organization.

And, so, we're committed to resolving the issues, and with some of the things I had outlined beforehand, as well, I hope that you would see that, as well.

DR. LEW: Kevin, let me just add --

HEARING OFFICER HANSTED: Sure.

DR. LEW: -- to what Von said, because I think he probably answered most of your question, but I

think you wanted to hear like --

HEARING OFFICER HANSTED: No, go ahead. Add what you'd like to add.

DR. LEW: Yeah. Quality is going to be of the highest priority, okay, for this company. The silver lining in going through what we're going through is it points out areas that we need to improve, whether it be to build out a corporate infrastructure, bringing the Chief Quality Officer, and a lot more bandwidth in the area of quality, but it's also in other areas related to clinical and medical, and I'm one example, being in the corporate office.

So I can tell you that it is a priority, and it is a commitment at the very highest level, and, so, you know, Von can tell you the details of what's happening at the level of each local hospital, but I can assure you, at the corporate level, it has our attention daily and will continue to.

I'd love to be here in front of you at some point or share with you how we turned it around and how it's something that we're very, very proud of.

HEARING OFFICER HANSTED: Okay, thank you. Does anyone else want to add anything? Okay. All right, that concludes our -- did you want to add something,

Doctor? I see you reaching for the microphone.

DR. O'NEILL: I have a summary, summary comment at the end.

HEARING OFFICER HANSTED: Okay. That concludes our question and answer session. At this point, if counsel or their clients want to give a closing statement, they're welcome to do so.

DR. O'NEILL: Well I just wanted to say, on behalf of ECHN, I wanted to thank all of you again for the opportunity to provide support for this transaction.

We appreciate your insightful questions, because they've served as guideposts for us along the process, and we certainly appreciate your attention to our application.

I'd also like to thank members of the community, who have spoken at both hearings, because it's only through their support that we exist.

Approving this transaction will allow the physicians, nurses and hospitals of eastern Connecticut to continue to provide the services that we think our citizens need and deserve, so, on behalf of ECHN, I'd like to thank you again.

DR. LEW: And, also, on behalf of Prospect Medical Holdings, I also want to thank the communities of

Manchester and Rockville.

To hear the questions and the passion of the people of the community it's very reassuring to us on how the people of the community care, and that's important to us, to come in to regions and communities, where the people really do care about the health care delivery system and how they're going to be impacted.

I also want to thank the AG's Office, Gary and Henry and Perry and Kevin and OHCA, Kim and Steven and Carmen, for your time.

I hope you've learned more about Prospect as a company and, also importantly, learned a little bit more about the senior management team.

We are good citizens, even though we are from California, with the exception of Tom, but we do care about what we're doing as a company.

And you've heard that we operate hospitals, and we operate medical groups, and we've got this unique delivery model, and we also feel like this is a very good fit with ECHN, and I hope that you're convinced that we are, both parties, very committed to making this work in the long-term for both communities.

And I ask that you do approve this conversion application, and just know that we -- that you

approve it in a way that you know that we are a very innovative and an entrepreneurial company, and that we're not your normal company, and I mean that in a good way.

And I understand that you have assets to protect, but you heard Steve share that we use our commitment as a floor, and that we haven't closed hospitals, and we don't close services. We're a growth company. We add services, and we add programs.

And I know that OHCA has a responsibility to assure access, but I hope you understand that access is part of our model, and a community needs type of evaluation is part of the solution, but these things are all very important for us to function and to be successful.

And if this can go through, I am very confident that not only will two hospitals be saved, but, in fact, they will be far better, in terms of services and quality, and we will build a delivery system that can be a choice and another option for the state, and that we can be seen as transformative in a delivery system that Connecticut can be very proud of.

And we're in this for the long-term, okay? This is not something that we're investing this kind of money to, quote, "flip it," okay?

We are in this for the long-term. We've all been in health care all of our careers, so I ask that you just take that, but, again, thank you very much for this opportunity.

MR. ZINN ROWTHORN: Thank you, Doctor, and thank all of you. This is a long and detailed and maybe it might seem laborious process, but it's an important process, and I know we've benefitted from having this exchange today.

I'll close with where I started this morning, which is to emphasize our gratitude to the members of the community, who were with us today and shared their views today and last night, so we appreciate it, and thank you very much.

HEARING OFFICER HANSTED: Thank you, all. Before we leave, before we leave, one moment. I just want to clarify for those folks that may have come in late, is there anyone here that would like to give public comment that did not have an opportunity to do so?

Okay. Thank you, all, again, and, with that, I will adjourn this hearing.

(Whereupon, the hearing adjourned at 7:32 p.m.)

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Greer, Leslie

From: Lazarus, Steven
Sent: Tuesday, April 19, 2016 1:47 PM
To: Greer, Leslie
Cc: Cotto, Carmen; Martone, Kim
Subject: FW: ECHN Late File # 19 Request for an Extension to File

Leslie,

Please add to the record.

Thanks,
Steve

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

From: Michele Volpe [mailto:mmv@bvmlaw.com]
Sent: Tuesday, April 19, 2016 1:45 PM
To: Hansted, Kevin; Hawes, Gary W.; Martone, Kim; Lazarus, Steven
Cc: Matthews, Rebecca (RMatthews@wiggin.com); Jennifer O'Donnell
Subject: ECHN Late File # 19 Request for an Extension to File

Dear Kevin, Gary, Kim and Steve:

ECHN and PMH are getting ready to submit all of the Late Files that were requested as a result of the ECHN hearings. Late File #19 is the request for an updated Exhibit W showing EBITA, Working Capital and Stockholders' Equity of PMH Hospitals (Prior to and Post Acquisition) inclusive of New Jersey acquisition. Because the East Orange New Jersey Hospital was purchased out of bankruptcy, PMH is still awaiting some final financial information in order to be able to update the requested exhibit. Therefore, this schedule will not be ready tomorrow for filing along with all of the other Late Files. May we please have a one-week extension from today, until next Tuesday, April 26, to produce Late File #19? As for timing of production, this is a new acquisition and PMH is still gathering all of the necessary financial information in order to produce the updated Exhibit W.
Thank you for your attention to this request.

Michele M. Volpe
Bershtein, Volpe & McKeon P.C
105 Court Street
New Haven, CT 06511
Phone: (203) 777-6995
Fax: (203) 777-5806

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Greer, Leslie

From: Lazarus, Steven
Sent: Tuesday, April 19, 2016 2:38 PM
To: Greer, Leslie
Cc: Cotto, Carmen; Martone, Kim; Olejarz, Barbara
Subject: FW: ECHN Late File # 19 Request for an Extension to File

Please add to the record.

Steve

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

From: Hansted, Kevin
Sent: Tuesday, April 19, 2016 2:28 PM
To: 'Michele Volpe'; Hawes, Gary W.; Martone, Kim; Lazarus, Steven
Cc: Matthews, Rebecca (RMatthews@wiggin.com); Jennifer O'Donnell
Subject: RE: ECHN Late File # 19 Request for an Extension to File

Michele,

You may submit Late File #19 on April 26.

Kevin T. Hansted
Staff Attorney
Department of Public Health
Office of Health Care Access
410 Capitol Ave., MS 13HCA
P.O. Box 340308
Hartford, CT 06134
Phone: 860-418-7044
Email: kevin.hansted@ct.gov



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From: Michele Volpe [mailto:mmv@bvmlaw.com]
Sent: Tuesday, April 19, 2016 1:45 PM
To: Hansted, Kevin <Kevin.Hansted@ct.gov>; Hawes, Gary W. <Gary.Hawes@ct.gov>; Martone, Kim <Kimberly.Martone@ct.gov>; Lazarus, Steven <Steven.Lazarus@ct.gov>
Cc: Matthews, Rebecca (RMatthews@wiggin.com) <RMatthews@wiggin.com>; Jennifer O'Donnell <jlo@bvmlaw.com>
Subject: ECHN Late File # 19 Request for an Extension to File

Dear Kevin, Gary, Kim and Steve:

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Michele M. Volpe
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105 Court Street
New Haven, CT 06511
Phone: (203) 777-6995
Fax: (203) 777-5806

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CERTIFICATE OF NEED/ CONVERSION APPLICATION

LATE FILES



Eastern Connecticut Health Network, Inc.

Proposed Asset Purchase by

Prospect Medical Holdings, Inc.

OHCA Docket Number: 15-32016-486

Attorney General Docket Number: 15-486-01

April 20, 2016

WIGGIN AND DANA

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April 20, 2016

VIA HAND-DELIVERY

Office of the Attorney General
55 Elm Street
P.O. Box 120
Hartford, Connecticut 06141-0120
Attn: Gary W. Hawes, Assistant Attorney General

Office of Health Care Access
Department of Public Health
410 Capitol Avenue
Hartford, Connecticut 06134
Attn: Steven W. Lazarus, Health Care Analyst

Re: ***Eastern Connecticut Health Network, Inc.***
Proposed Asset Purchase by Prospect Medical Holdings, Inc.
OHCA Docket Number: 15-32016-486
Attorney General Docket Number: 15-486-01

Dear Mr. Hawes and Mr. Lazarus:

On behalf of Eastern Connecticut Health Network, Inc. ("***ECHN***") and Prospect Medical Holdings, Inc. ("***PMH***" and, together with ECHN, the "***Applicants***"), we thank you for your time at the hearings on March 29-30, 2016, and careful consideration of this important proposal.

Enclosed with this letter are the various late file exhibits requested of the Applicants by the Office of Health Care Access and the Office of the Attorney General. As with previous filings, one (1) hard copy and one (1) electronic copy of this submission have been provided to each Office.

Please note that Hearing Officer Kevin Hansted granted an extension to submit Late File #19, Revised/Updated Exhibit W – EBITA, Working Capital and Stockholders' Equity of PMH Hospitals (Prior to and Post Acquisition), until April 26, 2016.

If you have any questions or need anything further, please feel free to contact Rebecca Matthews at (203) 498-4502 or Melinda Agsten at (203) 498-4326. Thank you for your assistance in this matter.

Sincerely,

Wiggin and Dana LLP

By _____
Rebecca A. Matthews
Its Partner

By _____
Melinda A. Agsten
Its Partner

cc: Kevin Hansted, Staff Attorney, Department of Public Health Division of Office of Health Care Access
Kimberly Martone, Director of Operations, Department of Public Health Division of Office of Health Care Access
Perry Zinn-Rowthorn, Deputy Attorney General, Office of the Attorney General
Dennis P. McConville, Senior Vice President and Chief Strategy Officer, Eastern Connecticut Health Network, Inc.
Thomas M. Reardon, President, Prospect Medical Holdings-East, Inc.
Frank Saidara, Vice President, Corporate Development, Prospect Medical Holdings, Inc.
Jonathan Spees, Senior Vice President, Corporate Development, Prospect Medical Holdings, Inc.
Joyce Tichy, Senior Vice President and General Counsel, Eastern Connecticut Health Network, Inc.
Michele M. Volpe, Esq., Bershtein, Volpe & McKeon, P.C.

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1. **Timeline of ECHN's Review of PMH's Immediate Jeopardy Citations/Deficiencies in California**

Please see attached.

ECHN Review of PMH Immediate Jeopardy Issues

Timeline February 1, 2016 through March 28, 2016

Disclosure of Issues to ECHN:

- **February 1, 2016**: PMH representatives contact ECHN to advise ECHN that PMH had recently received additional information on Immediate Jeopardy citations at two of its California Hospitals and to provide some history and facts around this development. ECHN is also informed at the same time that PMH has asked the OAG and OHCA for an extension to file its responses to the January 12, 2016 completeness questions in the Waterbury/PMH CON proceeding in order to provide a detailed response regarding notices of CMS deficiencies and Immediate Jeopardy findings that PMH has received relating to certain of its California hospitals.

- **February 16-17, 2016**: PMH files a response to the Waterbury CON completeness questions with a summary that describes how its California regulatory issues arose and outlines the manner in which the issues are being remedied. PMH provides a copy of the filing to ECHN representatives and starts providing additional information around the latest developments. PMH explains that the initially identified deficiencies have been resolved, but discloses additional regulatory issues and provides excerpts from the following CMS Forms 2567:

    - A report detailing the results of a survey completed on September 25, 2015 (the "**September 25 Survey**") at two hospitals, Southern California Hospital at Hollywood and Culver City; and

    - A report detailing the results of a survey completed on November 10, 2015 (the "**November 10 Survey**") at Los Angeles Community Hospital.

- **February 17, 2016**: As a follow-up to the **November 10 Survey** CMS begins a re-survey at Los Angeles Community Hospital on February 15, 2016 which it completes on February 17, 2016 (the "**February 17 Survey**"). During the exit conference, CMS notifies PMH that there are no new Immediate Jeopardy findings but that there will be some deficiency findings relating to infection control and other matters. The formal results of the survey are provided on March 24, 2016 (see below).

- **February 18, 2016**: PMH SVP Corporate Development Von Crockett conducts a conference call with Peter Karl and other ECHN representatives Dennis McConville and Joyce Tichy in which he describes the outstanding deficiencies being addressed by PMH. Other PMH participants on the call are Thomas Reardon and Frank Saidara. Von Crockett provides background to the recent deficiency findings:

    - **Los Angeles Community Hospital**. Von Crockett reports that this review process began when surveyors responded to a patient's complaint of physician misconduct that PMH had self-reported and as to which it had instituted corrective actions. Surveyors found that PMH had not fully implemented its corrective actions, and as a result issued an Immediate Jeopardy finding. PMH then took further corrective action by suspending the physician and putting additional precautions into place. However, in a subsequent

follow-up survey (the **November 10 Survey**) surveyors identified other issues. As a result, CMS issued a 90 day termination letter for the three hospitals under the Los Angeles Community Hospital license (Los Angeles Community, Norwalk and Bellflower). The letter notified PMH that the Medicare provider agreement would be terminated April 13, 2016 unless deficiencies were satisfactorily corrected. Credible documentation evidencing correction of the issues and compliance with Medicare conditions was to be submitted by January 25, 2016. PMH submitted timely its corrective action plan and was resurveyed (the **February 17 Survey**) and was awaiting further regulatory response.

- **Hollywood/Culver City**: Von Crockett reports that this started with a fire on the roof at Culver City during construction to remediate an aging facility (previously in bankruptcy) in January 2015, in which an air handler pushed smoke into the building which required an evacuation. This led to a series of follow-up regulatory surveys, including the **September 25 Survey,** which found prior issues abated but then identified other issues and issued Immediate Jeopardies. Subsequently CMS conducted a 10-day "Validation Survey" in the third week of December (the "**December 22 Survey**"). The written survey report had not yet been received at the time of the conference call, although PMH had been informed orally that it would receive a 90 day letter notifying it of potential termination as a Medicare participating hospital.

Von Crockett describes various corrective actions taken which include replacement of the local administrative team including the CEO, CNO and Director of Quality Management and the resignation of the Chief of Staff and appointment of a new Chief of Staff; the hiring of consultant Greely and Company and the law firm Hooper Lundy & Bookman to assist in PMH's responses, and the appointment of a new corporate administrative team; i.e., Chief Quality Officer, Chief Clinical Officer, Vice President of Regulatory Affairs and Patient Safety, and the recruitment of a Chief Corporate Nursing Officer.

- **February 19, 2016**: ECHN's CEO Peter Karl meets with Board Chair Dr. O'Neill and Vice Chair Joy Dorin regarding PMH's disclosure of regulatory issues in California. It is determined that this information should be disclosed to the Board at its next meeting, and that a Board-level process should be established to look into the matter further.

- **February 23, 2016**: CMS issues a 90 day termination letter in connection with the **December 22 Survey** for the three hospitals under the Southern California Hospital license. The letter notifies PMH that the Medicare provider agreement will be terminated May 24, 2016 unless deficiencies are satisfactorily corrected; credible documentation evidencing correction of the issues and compliance with Medicare conditions are required to be submitted by March 4, 2016 (later extended to March 22, 2016).

ECHN Board Outlines a Deliberative Process and Begins Work:

- **February 24, 2016**: At a meeting of ECHN's Board of Trustees, Board Chair Dr. O'Neill advises the Board that PMH regulatory issues have come to light and that more information and investigation are needed to determine their scope and any impact on the ECHN/PMH transaction. Dr. O'Neill appoints Board Vice Chair Joy Dorin and Performance Assessment and Quality Committee Chair Dr. Michele Conlon to perform an in-depth review, with support from

Linda Quirici, ECHN Vice President for Quality and Safety, and her appropriate designees in the ECHN Quality Department (together, the "**Quality Evaluation Team**").

- **February 24, 2016**: PMH opens its data room containing regulatory surveys to ECHN. ECHN team begins reviewing the materials.

- **February 25, 2016**: PMH receives two written reports bearing survey dates December 18, 2016 and December 22, 2016 which together comprise the **December 22 Survey**, and releases them to ECHN.

- **February 29, 2016**: PMH representative Von Crockett leads a conference call with the ECHN **Quality Evaluation Team** and other representatives of ECHN. Mr. Crockett outlines the issues in the three hospitals that led to regulatory findings. ECHN's **Quality Evaluation Team** requests additional detail which is furnished. The parties go over next steps regarding exchange of further information, the review process to be conducted, and timeline.

- **March 2, 2016**: ECHN and PMH agree that a brief postponement of the public hearings scheduled for March 15-16 may be appropriate in order that ECHN may look further into the PMH regulatory matters.

- **March 4, 2016**: Members of the ECHN **Quality Evaluation Team** visit PMH's two Rhode Island hospitals, Our Lady of Fatima and Roger Williams, to learn about their quality programs, the experience since PMH acquisition, and the manner in which those programs have been allowed to progress under PMH.

- **March 4, 2016**: ECHN Transaction Committee meets to review the status of information regarding the Immediate Jeopardies and to consider next steps.

- **March 7, 2016**: The ECHN **Quality Evaluation Team** meets on current status and next steps for reviewing PMH regulatory issues in order to make recommendations to the full Board regarding PMH as an appropriate purchaser. ECHN proposes to PMH an agreement pursuant to which PMH will commit to support of ECHN's current quality programs (the "**Quality Commitment Letter**"), which PMH agrees to consider.

- **March 11, 2016**: ECHN Transaction Committee meets to discuss information learned to date including results of **Quality Evaluation Team** trip to Rhode Island, reviews proposed **Quality Commitment Letter**, and outlines further steps/deliverables.

- **March 18, 2016**: PMH provides draft Plan of Correction with summary for **December 22 Survey** to ECHN for review, along with quality performance indicators for its owned hospitals. PMH provides comments to the proposed **Quality Commitment Letter**.

- **March 21, 2016**: Peter Karl and members of the ECHN **Quality Evaluation Team** participate in a conference call with Von Crockett and a number of other PMH representatives to discuss the corrective actions and ECHN's follow-up questions resulting from its review of the **December 22 Survey** response.

- **March 22, 2016**: The ECHN **Quality Evaluation Team** reports back to the Transaction Committee the results of the review of PMH regulatory documents and the March 21, 2016 phone conference with PMH representatives. The Transaction Committee reviews PMH's comments to the **Quality Commitment Letter** and discusses responsive comments for ECHN. The Transaction Committee recommends that the Board approve proposal to proceed with the **Quality Commitment Letter** and to continue with the transaction with PMH.

ECHN Board Resolves to Proceed with the Transaction and Quality Commitment Letter:

- **March 23, 2016**: At a Special Meeting the Board receives a written report from the **Quality Evaluation Team** on the visit to PMH's Rhode Island hospitals and an oral report on PMH's regulatory issues. The Board considers the Transaction Committee recommendation and after deliberation resolves to proceed with the **Quality Commitment Letter** and the PMH transaction.

- **March 24, 2016:** PMH notifies ECHN that it has received the written CMS Forms 2567 from the **February 17 Survey** at Los Angeles Community Hospital, and provides a copy to ECHN. (The CMS cover letter is dated March 23, 2016). As CMS had indicated during the exit conference, there are no new Immediate Jeopardy findings, but there are additional findings relating to nursing services and infection control. The new plan of correction is due April 4, 2016 and the proposed date for terminating the Medicare provider agreement unless corrective actions are taken is extended from April 13, 2016 to June 21, 2016.

- **March 28, 2016: Quality Commitment Letter** finalized and executed by ECHN and PMH.

2. Quality Improvement Plans Adopted at Los Angeles Community Hospital and Southern California Hospital at Culver City.

Attached hereto as Exhibit 2(a) is the Quality and Performance Improvement Plan for Los Angeles Community Hospital.

Attached hereto as Exhibit 2(b) is the Quality and Performance Improvement Plan for Southern California Hospital at Culver City.

EXHIBIT 2(a)

ECHN Proposed Asset Purchase by PMH
Late Files

Los Angeles Community Hospital
2016 Performance Improvement Plan

Indicator(s)	LACH	NCH	LACHB	Target or Goal	Rationale For Selection	Function Measured	Numerator / Denominator	Data Source	Reported to	Reporting Frequency
Behavioral Health Unit										
BHU - Nursing										
1. AMA			•	2%	1,2,5,7	AMA/AWOL	# AMA/AWOL / #DC	AMA/DC Log	UR/QC, MEC, GB	Data by month – Reported minimum of Quarterly
2. Restraints			•	20%	1,2,3,5,7	Providing alternate intervention before restraint application	# Restraint/month	Restraint Log monthly	UR, QC, MEC, GB	Data by month – Reported minimum of Quarterly
3. Falls			•	0%	1,3,4,7	Prevention of fall, fall assessment, fall with and without injury	# Fall	Incident reports	UR, QC, MEC, GB	Data by monthly – reported minimum of Quarterly
4. Crash Cart			•	100%	1,7	Crash Carts equipment checked nt and availability of non-expired medical supplies	# of crash cart checks/ # days in a month	Crash carts monthly check log	UR, QC, MEC, GB	Data by monthly – reported minimum of Quarterly
5. Hand Hygiene			•	100%	1,3,4,7	Hand Hygiene by hand washing and or alcohol	/ # of complaints / # HH observed	HH monitoring tools monthly	UR, QC, MEC, GB	Data by monthly – reported minimum of Quarterly
6. Effectiveness of Pain Management			•	100%	1,2,3,4,5,6,7	Pre and post pain assessment documentation	• Pre Pain assessment/ # pain meds • Effectiveness of pain management / # pain medication administered	Medical Record Review	UR, QC, MEC, GB	Data by monthly – reported minimum of Quarterly
Dietary										
1. RD timeless	•	•	•	98	7	Providing practitioner specific data	#initial assessments, follow ups, calorie counts, consults done by deadline/# total patients due	RD productivity log/EMR	QC	Data by Month – Reported Minimum of Quarterly
2. PO intake of meals recorded	•	•	•	90	5	Providing practitioner	#patients with recorded PO intake in EMR/#	RD productivity	QC	Data by Month – Reported Minimum of

Submitted April 20, 2016
Page 4061

Indicator(s)	LACH	NCH	LACHB	Target or Goal	Rationale For Selection	Function Measured	Numerator / Denominator	Data Source	Reported to	Reporting Frequency
						specific data	total patients with oral diet	log/EMR		Quarterly
3. Correct diet order	•	•	•	100	1, 5	Providing practitioner specific data	# diets ordered correctly (diets ordered from approved list, diets discontinued, etc.)/total # of patients seen	RD productivity log/EMR	QC	Data by Month – Reported Minimum of Quarterly
4. RD recommendations taken within 48 hrs. – (LACH/NCH)	•	•		70	1, 5, 7	Providing practitioner specific data	#nutrition recommendations taken within 48 hours/total # of recommendations made	RD productivity log/EMR	QC	Data by Month – Reported Minimum of Quarterly
5. Actual weight obtained at admit – (LACH/NCH)	•	•		75	1, 5	Quality assurance	#accurate weights obtained at admit/total # of patients seen	RD productivity log/EMR	QC, CNO	Data by Month – Reported Minimum of Quarterly
6. Test Trays (include visual presentation, temperature, taste, timeliness)	•	•	•	95	1, 5, 6	Quality assurance	Total points scored/total possible points	Test Tray evaluation log	QC	Data by Month – Reported Minimum of Quarterly
7. Tray Accuracy Analysis – (LACHB)			•	90	1, 5, 6	Quality assurance	# of accurate trays/total # of tray observed	Tray Accuracy Log	QC	Data by Month – Reported Minimum of Quarterly
Health Information Mgmt										
1. Medical Records Delinquency				50%	7	EHR System Monthly Delinquent Numbers	Total Number of Incomplete Medical Records Over 14 days from discharge/visit / Total Number of Inpatient Discharges, Total Number of Outpatient Surgeries, Total Number of ED Visits	EHR System (HPF)	Quality Management Committee, Medical Executive Committee, Governing Board Committee	Monthly/Quarterly
2. Inpatient H&P completed within 24 hours of admission				100%	1, 2, 5, 7	Check every inpatient chart	Total number of H&P not completed within 24 hrs / Total number of admissions	EHR System (HPF)	Quality Management Committee, Medical Executive Committee, Governing Board Committee	Monthly/Quarterly

Indicator(s)	LACH	NCH	LACHB	Target or Goal	Rationale For Selection	Function Measured	Numerator / Denominator	Data Source	Reported to	Reporting Frequency
3. Valid H&P completed within 24 hours prior to surgery.				100%	1, 2, 5, 7	Check every OPS chart	Total number of H&P not completed prior to surgery / Total number of OPS	EHR System (HPF)	Quality Management Committee, Medical Executive Committee, Governing Board Committee	Monthly/Quarterly
4. Psychiatric Evaluation completed within 24 hours of admission				100%	1, 2, 5, 7	Check every inpatient chart	Total number of PE not completed within 24 hrs / Total number of admissions	EHR System (HPF)	Quality Management Committee, Medical Executive Committee, Governing Board Committee	Monthly/Quarterly
Human Resources										
1. Licensure/Certification	•	•	•	100%	1,7	Provide Mgmt. with specific data	#of lic/cert compliance/#of lic/cert due for the month	HR Database	QC, GB	Data by Month – Reported Minimum of Quarterly
2. Performance Evaluations	•	•	•	90%	5,7	Provide Mgmt. with specific data	#of evals completed/#of evals due	HR Database	QC, GB	Data by Month – Reported Minimum of Quarterly
3. General Orientation Compliance	•	•	•	100%	7	Provide Mgmt. with specific data	#of attendees/#of new hires for the month	HR Database	QC, GB	Data by Month – Reported Minimum of Quarterly
4. Annual Competency	•	•	•	90%	1,7	Provide Mgmt. with specific data	#of competency completed/#of competencies due	HR Database	QC, GB	Data by Month – Reported Minimum of Quarterly
5. Annual Health Questionnaire	•	•	•	95%	1,7	Provide Mgmt with specific data	# of questionnaire due/#of questionnaire completed	HR Database	QC, GB	Data by Month – Reported Minimum of Quarterly
Infection Control										
1. Invasive Devices	•	•		100%	3,5,7	Central line blood stream infections	**Numerator**: All CLBSI cases in all ICU,s in the organization. **Denominator**: # of central line days in all ICU,s	ICU Log book	P&T,QC, MEC,	Data by Month – Reported Minimum of Quarterly

Indicator(s)	LACH	NCH	LACHB	Target or Goal	Rationale For Selection	Function Measured	Numerator / Denominator	Data Source	Reported to	Reporting Frequency
2. Hospital acquired MRSA laboratory confirmed blood stream infections.	•	•		100%	3,5,7	Positive blood culture after 48 hours of admission	**Numerator:** # of hospital acquired MRSA laboratory confirmed **Denominator:** Total number of patient days	Daily laboratory results	P&T,QC, MEC,	Data by Month – Reported Minimum of Quarterly
3. C.difficile	•	•		100%	3,5,7	All positive cultures after 48 hour of admission	**Numerator:** Laboratory confirmed positive cultures. **Denominator:** Total number of patients days	Daily laboratory results	P&T,QC, MEC	Data by Month- Reported Minimum of Quarterly
4. Prevalence Rate	•	•		100%	3,5,7	Final Surveillance	**Numerator:#** of hospital acquired infections. **Denominator:** # of patient days	Daily surveillance activities	P&T, QC MEC	Data by Month- Reported Minimum of Quarterly
5. Reportable Conditions	•	•		100%	1,3,5,7	Daily surveillance	Numerator: # of patients admitted with reportable conditions	Daily surveillance	P&T,QC, MEC	Data by Month- Reported Minimum of Quarterly
Laboratory	•	•								
1. Turn Around Time Urgent Care- Troponin	•	•		100%	1	2	# test meets criteria/ total test	Lab Data	QA	Q
2. Critical Read back Documentation	•	•		100%	1,3	3	# meets criteria/ # total criticals (days)	Lab Data	QA	Q
3. % Blood Cultures Not Contaminated	•	•		>97%	1,3,5	5	# non-contaminated blood cultures/ blood cultures drawn	Lab Data	QA	Q
4. Transfusion Services	•	•		Various	1,7	6,7	NA	Lab Data	QA	Q
5. Phlebotomy- Proper Identified or Labeled Specimens	•	•		100%	1	1	# properly identified/ labeled/# specimens	Lab Data	QA	Q
6. Lab Quality Control- Problems Resolved	•	•		100%	1,7	6,9	# days meeting criteria/ # days	Lab Data	QA	Q
7. Proficiency Testing- Transfusion	•	•		100%	1,7	6,10	# meets criteria/ # events	CAP Data	QA	Q
8. Proficiency Testing- Other Lab Test	•	▪		>80%	1,7	1,6	# meets criteria/ #events	CAP Data	QA	Q
9. No Significant Variations Between Pathological Findings and Clinical Diagnosis for Surgical	•	•		100%	1,7	2,4	# that correlate/ # cases	Pathology	QA	Q

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Indicator(s)	LACH	NCH	LACHB	Target or Goal	Rationale For Selection	Function Measured	Numerator / Denominator	Data Source	Reported to	Reporting Frequency
Cases										
10. No Pathological Diagnostic Discrepancies	•	•		100%	1,7	4	# cases that meet/ cases reviewed	Pathology	QA	Q
11. Glucose Meter: Documentation of steps taken for Criticals as entered on meter	•	•		95%	1	3	Totals that meet criteria/ total of critical results	Lab Data Rals	QA	Q
Medical Staff										
1. Proctoring Evaluation completed within 3 months of practitioners' provisional appointment	•	•	•	100%	2 (NEW)	Practitioner Proctoring Completion	# Reports Submitted/ # Practitioners due for evaluation	Provisional Appointments Report	QC, MEC, GB	Data by Month -- Reported Minimum of Quarterly
2. Ongoing Professional Practice Evaluation at Time of Reappointment/Bi-Annual Evaluation Reports Provided by: • Case Management • Infection Control • Laboratory • Medical Records • Pharmacy • Quality Management PI	•	•	•	100%	5	Obtaining Practitioner – Specific Data	# Reports Submitted/ # Practitioners due for evaluation	Reports received by various departments	QC, MEC, GB	Data by Month – Reported Minimum of Quarterly
Nursing										
ER										
1. Patient Throughput	•			10% decrease	Patient Satisfaction	Door to disposition time	Current time/2015 time	ED Logs	QC	Monthly
2. EMTALA	•			100%	Patient/ Organizational Safety	EMTALA Audit Elements	# Elements Achieved/Possible	Patient Chart	QC	Monthly
3. Triage time by RN was 15 minutes after arrival.		•		100%	7, 1	Chart audit	60/60	Medical Record	QC	Monthly
4. MSE Completed by ER Physician 30 minutes after registration.		•		100%	7, 1	Chart audit	60/60	Medical Record	QC	Monthly
5. Patient should be in bed 1 hour after ER MD makes a decision to admit as inpatient.		•		100%	7, 1	Chart audit	60/60	Medical Record	QC	Monthly
ICU										
1. Pain Management	•			100%	Patient Safety	Pain Assessment/	# audit elements achieved/ # possible	30 Patient Records/Mont	QC	Monthly

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Indicator(s)	LACH	NCH	LACHB	Target or Goal	Rationale For Selection	Function Measured	Numerater / Denominator	Data Source	Reported to	Reporting Frequency
						reassessment/ documentation		h		
2. Moderate Sedation	•			100%	Patient Safety	Propofol sedation vacation	# daily "sedation vacations"/# days sedated	Patient chart	QC	Reported daily and to Quality Council monthly and to P&T monthly
3. Restraints - physical	•			0%	Patient Safety/Patient Rights	Absence of physical restraints	# physical restraints/# patients	Patient Chart and ICU Log	QC	Daily and to Quality Council monthly
4. Care Plan documented with pre-existing condition i.e. Dialysis patient		•		100%	2,7,1	Chart audit	30/30	Medical Record	QC	Monthly
5. Consent signed for Hemodialysis Prior to treatment		•		100%	2, 7, 1	Chart audit	5/5	Medical Record	QC	Monthly
6. For Septicemia Core Measure patient, Lactic Acid is drawn		•		100%	7, 1	Chart audit	Per # of Septicemia admitted 100%	Medical Record	QC	Monthly
7. For Septicemia Core Measure patient, Blood Culture is obtained prior to administration of IV antibiotics		•		100%	7, 1	1:1 Observation	Per # of Septicemia admitted 100%	Direct Observation	QC	Monthly
Med/Surg/Tele										
1. Medication Administration	•			100%	Patient Safety	Timely administration – 1 hour before/after scheduled	# doses given as scheduled/ #doses	Patient Chart	QC	Weekly with report to Quality Council monthly
2. Assessment	•			100%	Patient Safety	Assessment completed/documented/policy	# completed/# patients	Patient Chart	QC	Weekly with report to Quality Council monthly
3. Care Plans	•			100%	Patient Safety	Care Plan initiated/policy	# initiated/ # patients	Patient Chart	QC	Weekly with report to Quality Council monthly
4. Restraints - Physical	•			100%	Patient Rights	Monitoring elements/policy	# elements achieved/ # possible elements	Patient Chart	QC	Daily with report to Quality Council monthly
5. Skin Integrity	•			0%	Patient	Development/p	# adverse alteration	Patient	QC	Weekly with report

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Indicator(s)	LACH	NCH	LACHB	Target or Goal	Rationale For Selection	Function Measured	Numerator / Denominator	Data Source	Reported to	Reporting Frequency
					Safety	rogression of adverse alteration in skin integrity	in skin integrity/ # patients with Braden Scale 18 or higher	Assessment/ Chart		to Quality council monthly
6. Care plan documented with pre-existing condition i.e., Dialysis patient		•		100%	2, 7, 1	Chart audit	30/30	Medical Record	QC	Monthly
7. Consent signed for Hemodialysis prior to treatment		•		100%	2, 7, 1	Chart audit	5/5	Medical Record	QC	Monthly
8. Pain re-assessment after pain medication administration		•		100%	2, 7, 1	Chart audit	5/5	Medical Record	QC	Monthly
9. Medication Pass		•		100%	2, 7, 1	1:1 observation	20/20	Direct Observation	QC	Monthly
Nursing Admin (LACH/NCH/LACHB)										
1 Current Evaluations	•	•	•	90%	Currently less than 20% are completed on time.	Completed and sent to HR by due date.	# on time completed/number to be done	HR evaluation list with due dates.	QC	Monthly
2. Registry Files	•	•	•	100%	Patient safety/regulatory risk	Registry files current/complete for each nurse who works in the hospital	#files completed/standard # staff assigned during2016	Registry sign-in log in Nursing Administration	QC	Quarterly
3. RN Recruitment/ Retention	•	•	•	18%	Patient safety from critical shortages	New Hires and turnover	# Terminations/# of RNs	HR	QC	Quarterly
4. Policy/Procedures Current	•	•	•	100%	Patient Safety	Current date and content	# Nursing departments with current date for review/revision/# of Nursing departments	P&P data base	QC	Quarterly
Pediatrics										
1. Age specific care	•			100%	Patient Safety/Right	Care matched to developmental	# Developmental age specific care	Patient Chart/Observ	QC	Weekly with report to Quality Council

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Indicator(s)	LACH	NCH	LAGNB	Target or Goal	Rationale For Selection	Function Measured	Numerator / Denominator	Data Source	Reported to	Reporting Frequency
					s	stage	plan/interventions/ # patients	ation/Pediatric unit log		monthly
2. IV infusion Safe Guards	•			100%	Patient Safety	IV order/administration size appropriate	# accurate order/administered IVs/# IVs	Patient Chart/Observation	QC	Weekly with report to Quality council monthly
Patient Access										
1. EMTALA Log	•	•		100%	1, 2	LD, PI	Numerator: Total number of patients listed on EMTALA log/Denominator: Total number of patients listed on EMTALA log	EMTALA log	QC	Quarterly
2. Language Line	•	•		100%	1, 2	RI, PI	Numerator: Total Number of Completed Consent Forms in Patient Preferred Language Denominator: Total Inpatient Registrations	Optimum Registration System	QC	Quarterly
3. IMM: Signed, timed and dated			•	100%	2	RI, PI	Numerator: Correctly completed IMM Forms Denominator: 50 patients	Important Message from Medicate	QC	Monthly
4. Preferred Language Log			•	100%	2	RI, PI	Numerator: Preferred language on the face sheets and consent matching Denominator: 50 patients	Face sheet and Consent forms	QC	Monthly
Pharmacy										
1. Medication Errors	•	•		<3.8%	Indicator for patient safety measure by pharmacy	Error reporting by pharmacy/ Nursing	Number of reported errors/total # discharges	Pharmacy reports and Nursing reports	Director of Pharmacy, QC, CNO	Daily to Director of Pharmacy, Monthly to QC and CNO
2. Adverse Reaction	•	•		<0.25%	Indicator for patient safety	Error reporting based on rescue	Number of ADRs/Total discharges	Pharmacy reports and Nursing	Director of pharmacy,	Daily of Director of Pharmacy, Monthly to QC and CNO

Indicator(s)	LACH	NCH	LACHB	Target or Goal	Rationale For Selection	Function Measured	Numerator / Denominator	Data Source	Reported to	Reporting Frequency
					measure by pharmacy	medication dispensed		reports	QC, CNO	
3. End Point Sterility Test	•	•		0%	Compliant to Board of Policy	Steriquot	# test failed/Total # of Test		Director of Pharmacy	Monthly
4. 30 min medication administration	•	•		>95%	Compliant to CMS	Random Chart Review	Specified med given within 30 min of the time due/Total number audited	Daily audit	Director of Pharmacy, QC, CNO	Daily to Director of Pharmacy, Monthly to QC and CNO
5. Controlled Substances documentation in ED	•	•		100%	Compliant to CMS	Weekly Omincell report	# narcotic medications taken from omnicell that have matching entered orders for that patient/# audited	Weekly audit	QC, CNO	Weekly to Director of Pharmacy, Monthly to QC and CNO
6. ED drug dispensing for Pediatric patients	•	•		100%	Compliant to CMS	Daily Monitoring	Inappropriate orders/Total pediatric orders	Daily	Director of Pharmacy, QC, CNO	Daily to Director of Pharmacy, Monthly to QC and CNO
7. Omnicell Override	•	•		100%	Compliant to CMS	Daily Monitoring	Complete orders/Total override	Daily audit	Director of Pharmacy, QC, CNO	Daily to Director of Pharmacy, Monthly to QC and CNO
Physical Environment (EOC)										
1. Sixty (60) second response time for fire response personnel for false alarms and fire drills	•	•		85%	1,5	Staff Response	N- Fire Responses < 60 seconds D- Fire Responses	Drill Reports	EOC, QC, MEC	Quarterly
2. Reduce the number of recordable injuries by 5% from 2015	•	•		NCH: 12 LACH: 35	5	Safety	N- Number of Injuries D- Number of Days	HR	EOC, QC, MEC	Quarterly
3. Maintain level of patient falls at or below 2.8 benchmark fall rate per 1000 patient days	•	•		2.8	1, 6	Patient Handling	N- # of Patient Falls D- # of Patient Days	Quality Management	EOC, QC, MEC	Quarterly
4. Identified deficiencies on EOC rounds are corrected and documented as completed within 45 days	•	•		85%	5,1,6	Work Order Process	N- Deficiencies Identified D- Deficiencies Completed	EOC Rounds Survey Report	EOC, QC, MEC	Quarterly

Indicator(s)	LACH	NCH	LACHB	Target or Goal	Rationale For Selection	Function Measured	Numerator / Denominator	Data Source	Reported to	Reporting Frequency
5. Reduce the number of theft types at Alta Los Angeles Hospitals by 10% from the total thefts reported in 2015.	•	•		LACH: 13 NCH: 13	1,6	Security	N- Thefts reported D- Thirteen	Security Reports	EOC, QC, MEC	Quarterly
6. 15% reduction in number of linen pounds per patient day from 2015.	•	•		LACH: 11.1 NCH:1 1.75	4	Allocation	N- Soiled Linen llb D- Adj Patient Days	Angelica Satisfactory Report	EOC, QC, MEC	Quarterly
7. Conduct Patient Safety Drills Quarterly in Non-Common Areas.	•	•		100%	1	Staff Response	N- Drills Completed D- Drills Scheduled	Drill Report	EOC, QC, MEC	Quarterly
8. Safety check completion rates for vendor life support equipment devices.	•	•		100%	5	Staff Training	N- Equip. Checked D- Equip. Received	Vendor Equipment Log Book	EOC, QC, MEC	Quarterly
9. Safety check completion rates each month for vendor non-life support equipment devices.	•	•		95%	5	Staff Training	N- Equip. Checked D- Equip. Received	Vendor Equipment Log Book	EOC, QC, MEC	Quarterly
10. Completion Rate for Submitted Work Orders	•	•		90%	5,1,6	Work Order Process	N- W.O. Completed D- W.O. Submitted	Work Order System	EOC, QC, MEC	Quarterly
Quality/Risk Management										
LACH/NCH										
1. Response to Grievances within 7 Days	•	•		100%	2,5,6	Grievance Response	# Responses with 7 Days/Grievances	Grievance Log	QC, MEC, GB	Data by Month – Reported Minimum of Quarterly
2. All OPPE to Medical Staff by Deadline	•	•		100%	2,5	Providing Practitioner Specific Data	#OPPE Reports Submitted by Deadline/#OPPE Reports Due	List of Reports Completed/Med Staff List of Reports Due	QC, MEC, GB	Data by Month – Reported Minimum of Quarterly
3. #AMA OPPE to Medical Staff by Deadline	•	•		2%	1,3,5	Patients leaving AMA	# AMAs per admission	AMA Report from IT/Clarity	QC, MEC, GB	Data by Month – Reported Minimum of Quarterly
4. # Falls blow national benchmark	•	•		2.5%	1,3,5	Patients falls by unit/shift	# falls per admission	Fall Report from Clarity	QC, MEC, GB	Data by Month – Reported Minimum of Quarterly
5. Overall Mortality Rate below national benchmark	•	•		2.5%	3,5,7	Total number of deaths	# of deaths per 100 discharges	Mortality Report from IT	QC, MEC, GB	Data by Month – Reported Minimum of Quarterly
6. Core Measures	•	•		100%	3,5,7	AMI, STK, VTE continued; Add Sepsis	Meet CMS Standard requirement for # reviewed	Data from IT	QC, MEC, GB	Data by Month – Reported Minimum of Quarterly

Indicator(s)	LACH	NCH	LACHB	Target or Goal	Rationale For Selection	Function Measured	Numerator / Denominator	Data Source	Reported to	Reporting Frequency
7. Readmissions	•	•		<10%	3,5,7	Patient readmitted within 30 days for same diagnosis	Number readmissions for same Diagnosis	Data from IT: Input from DUI and CM	QC, MEC, GB	Data by Month – Reported Minimum of Quarterly
Radiology										
1. Radiologist required procedures performed in a timely manner	•	•		100%	2,5	Time procedure performed	# of timely procedures/ # of procedures	EMR/PACS	QC	Quarterly
2. Critical result documentation	•	•		100%	1,7	Document in report	# of critical results reported/ # of critical results	Transcribed reports	QC	Quarterly
3. Marker Use	•	•		95%	1,4	Marker use	# of radiographs with marker/ # of radiographs	Image Review	QC	Quarterly
4. Discrepancy in the ED physician and radiologist interpretation	•	•		95%	4,7	Reading Accuracy	# of interpretations with no discrepancies/ # of interpretations by the ED physician	Radiologist	QC	Quarterly
5. Radiation Exposure	•	•		100%	3,7	Exposure	# of staff without exposure issue/ # of staff monitored	Dosimetry reports	QC, EOC	Quarterly
6. Computerized Tomography Dose Reporting	•	•		100%	1,7	Dose	# of CT scans missing dose/ # of CT scans	PACS images	QC	Quarterly
7. Appropriateness of Nuclear Medicine Procedures	•	•		100%	1,7	Reason for Procedure	# of appropriate NM procedures/ # of NM procedures	Contracted Service Manager	QC	Quarterly
Rehabilitation Services										
Wound Care Therapy										
1. Identification, intervention, and documentation of pain during Rehab/WC encounter.	•	•		100%	1,2,5,6,7	Completion of pain parameter entry in all daily encounters including documentation of pain level, applicable treatment, and/or pt's rights to proceed or not.	#of complete pain parameter documentation entries/10 random charts per month or 30 random charts per quarter.	HER, QI data gathering tool ☐ ongoing ☑new	QC Medicine	Quarterly
2. Prevention of pressure	•	•		LACH	1,2,5,6,7	Utilization of	#of hospital acquired	HAPU incident	QC,	Quarterly

Indicator(s)	LACH	NCH	LACHB	Target or Goal	Rationale For Selection	Function Measured	Numerator / Denominator	Data Source	Reported to	Reporting Frequency
ulcers during hospital stay.				1.2% SA 0.1% NCH 0.8%		Braden Screening tool to identify patient with community PU. Monitoring of new pressure ulcer wounds not identified at admission. Tracking of HAPU using internal process.	pressure ulcers/1000 patient days.	reports. ☑ongoing ☐ new	Medicine	
3. Pressure Ulcer Prevention Program (PUPP) provided within 24 hrs upon admission, readmission, or transfer.	•	•		100%	1,2,5,6	Validation of Braden Screening tool compliance. Initiation of protocol supported with documentation.	#of PUPP provided within 24 hrs. upon admission, readmission, or transfer/ 10 random charts per month or 30 random charts per quarter.	HER, QI data gathering tool ☑ongoing ☐ new	QC, Medicine	Quarterly
Rehab Services										
4. Speech Therapy evaluation provided (within 48hrs) when ordered by MD.	•	•		100%	1,2,6,7	Gathering all new consults and checking if patient was seen within the timeframe.	# of Speech Therapy evaluations provided within 48 hours/#of total Speech Therapy orders.	HER, QI data gathering tool. ☑ongoing ☐ new	QC, Medicine	Quarterly
5. Physical Therapy evaluation provided within 24 hrs. when ordered by MD to include a complete documentation such as: ✓ PT evaluation documentation ✓ PT goals ✓ Plan of Care ✓ Clarification of PT orders, if needed, with frequency, duration, and interventions.	•	•		100%	2,6,7	Gathering all new consults and checking if patient was seen within the timeframe with complete entries of documentation parameters.	# of Physical Therapy evaluations provided within 24 hrs. with complete documentation/10 random charts per month or 30 random charts per quarter.	HER, QI data gathering tool. ☑ongoing ☐ new	QC, Medicine	Quarterly

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Indicator(s)	LACH	NCH	LACHB	Target or Goal	Rationale For Selection	Function Measured	Numerator / Denominator	Data Source	Reported to	Reporting Frequency
6. Rehabilitation (Recreation) Therapy Assessment completed by Therapy team within 72 hours of patient admission			•	100%	4,6,7	Patient's Rights and Provision of Care issues	Total # compliance/total # of medical records reviewed.	Medical Record	UR, QC, MEC	Data collected monthly/ Reported at least quarterly
7. Rehabilitation Therapy Discharge Summaries completed within 72 hours of patient discharge.			•	100%	4,6,7	Patient's Rights and Provision of Care issues	Total # compliance/total # of medical records reviewed	Medical Record	UR, QC, MEC	Data collected monthly/ Reported at least quarterly
8. Rehabilitation Services			•	100%	4,6,7	Patient's Right and provision of Care issues	Total # compliance/total # of medical records reviewed.	Medical Record	UR, QC, MEC	Data collected monthly/ Reported at least quarterly
Respiratory										
LACH/NCH	•	•								
1. Ventilator Protocol	•	•		65%	1,6,7		# weaned/total monitored	Log	QC	Quarterly
2. Trach Changed within 30 days	•	•		95%	1,3,5,7		# done/total trach pts	Charting	QC	Quarterly
3. Assessments/Reassessments	•	•		95%	1,5,7		# done/total measured	Charting	QC	Quarterly
4. Trach Ties	•	•		95%	1,5,6,7		#done/Total	Charting	QC	Quarterly
5. Equipment Changes	•	•		95%	1,5,6,7		# changed/Total	Charting	QC	Quarterly
6. Crash Carts	•	•		95%	1,3,5,7		# done/total	Log Book	QC	Quarterly
7. Oral Care	•	•		95%	1,3,4,5,6,7		#documented/total	Observatio	QC	Quarterly
8. Charges checked and submitted	•	•		95%	4,5,7		# checked/total	Charting	QC	Quarterly
9. Tardiness	•	•		95%	1,7		Days tardy/total	JBDEV	QC	Quarterly
10. Attendance	•	•		95%	1,7		Days absent/total	Schedule	QC	Quarterly
11. Continuous Pulse Oximeters for Vents	•	•		100%	1,3,4,5,7		# on pts/total	Observatio	QC	Quarterly
12. Medications ordered for SAU	•	•		100%	1,4,6,7		Not ordered/Total	Log Book	QC	Quarterly
13. Bedside Reporting for Patients	•	•		95%	1,5,6,7		#RTs not compl/total	Observatio	QC	Quarterly
14. Temperature Log (Norwalk Hospital)	•	•		100%	1,2,5		# out of range/total	Log	QC	Quarterly
15. Critical Values Reported in a timely manner	•	•		95%	1,5,7		# out of range/total	Log	QC	Quarterly

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Indicator(s)	LACH	NCH	LACHB	Target or Goal	Rationale For Selection	Function Measured	Numerator / Denominator	Data Source	Reported to	Reporting Frequency
Social Services										
1. Patients will be informed of their right to self-determination specifically their right to formulate an advance directive. Any patient that wants advance directive will be given information and will be followed up within 48 hours.	•	•		100%	5, 6, 7	2, 5	N: # of pts followed up within 48 hours of requesting info D: # of pts requesting information on advance directives	Advance Directives Log	QC	Q
2. All homeless patients will receive social work intervention to aid in placement. Documentation of intervention and final disposition will be reviewed for appropriateness.	•	•		100%	1.3	1,4	N: # of homeless pts seen by social services D: # of of homeless pts admitted	Admission screening	QC	Q
3. Homeless patients completing the informed consent form.	•	•		100%	1,3,5	1,5	N: # of homeless pts admitted to the hospital D: # of patients completing the form	Review of the medical record and forms	QC	Q
4. Psycho-Social Assessments completed with 72 hours of admission			•	100%	4, 6, 7	Social Services timely assessment of their patients	# Psycho-socials completed/Total # Psycho-socials for the sample	Medical Record	UR, QC, MEC, GB	Data by month – reported minimally quarterly
5. Important Message from Medi-Care-signatures obtained at time of admission and prior to discharge			•	100%	3, 4, 7	Timely notification of Medi-Care recipients of their rights.	# of signed IM message forms/Total # of IM messages for the sample	Medical Record	UR, QC, MEC, GB	Data by month reported minimally quarterly
6. Information provided to Care Giver when identified by the patient as part of the Aftercare Plan			•	100%	1, 2, 6, 7	Inclusion of patient Care Giver in the patient's aftercare	# of aftercare forms where Care Giver Identified with information provided/Total # of aftercare forms where Care Giver is identified.	Medical Record	UR, QC MEC, GB	Data by month – reported minimally quarterly
Sub-Acute										

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Indicator(s)	LACH	NCH	LACHB	Target or Goal	Rationale For Selection	Function Measured	Numerator / Denominator	Data Source	Reported to	Reporting Frequency
1. MDS	•			100%	Patient Safety/Regulatory	Completion by required date	MDS forms completed on time/# patients	Patient Charts	Director of SA	Weekly with report to Quality Council Monthly
2. Care Plans	•			100%	Patient Safety/Regulatory	Care Plan initiated within specified time frame	# Completed by due date	Patient Charts	Director of SA	Weekly with report to Quality Council Monthly
3. Medication Administration	•			100%	Patient Safety/Regulatory	Timely administration – 1 hour before/after scheduled time	# doses given "on time"/ # doses	Patient Charts	Director of Pharmacy/Director of SA	Weekly with report to Quality Council Monthly
4. Infection Control	•			100%	Patient Safety/Regulatory	Handwashing	# washings/# required washings	20/week observations	Director of IC and Director of SA	Weekly with report to Quality Council Monthly
5.Care Plan/MDS congruence	•			100%	Patient Safety/Regulatory	Content congruence	# MDS/Care Plans congruent/# patients	Patient Charts	Director of SA	Monthly to Quality Council
6. Consent for Psych. Meds	•			100%	2	Documentation of obtained consent	# of Psych. Meds (last 30 days) /# of Consent Obtained	Chart	QC	Monthly
7. Side Effects Monitoring for Psych. Meds	•			100%	2	Side effects (S/E) monitoringevery shift	#shifts in the last 30 days of patients with Psych. Meds / # of S/E monitoring for Psych. Meds Q shift	Paper MAR	QC	Monthly
8. Foley Catheter (FC) with Indication for use	•			100%	2	Documentation of indication for FC use	# of FC in use (last 30 days)/ # of FC with indication	Chart	QC	Monthly
9. Use of Less Restrictive Measures Prior to Restraint use	•			100%	2	Documentation of less restrictive measures	# of restraints in use (last 30 days)/ # of documented less restrictive measures prior to use of restraint	Chart	QC	Monthly
10.Patency of Hemodialysis access	•			100%	2	Checking of bruit and thrill/	# of shifts requiring patency checks of	Chart	QC	Monthly

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Indicator(s)	LACH	NCH	LACHB	Target or Goal	Rationale For Selection	Function Measured	Numerator / Denominator	Data Source	Reported to	Reporting Frequency
						Patency of HD access site every shift	HD access requiring (last 30 days)/ # of actual Q shift monitoring of HD patient access			
11. PICC Line Consent Form	•			100%	2	Consent form obtained prior to PICC line insertion	# of residents with PICC lines (last 30 days) / # of PICC lines with consent form prior to insertion	Chart	QC	Monthly
12. Post Fall Assessment	•			100%	2	Documen-tation of post fall assessment after a fall	# of Fall in the last 30 days/ # of post fall assessments documented after a fall in the last 30 days	Chart	QC	Monthly
13. Matching of Range of Motion MD Orders on orders in the RNA treatment record	•			100%	2	RNA MD orders matches the tx orders on RNA sheets	# of RNA MD orders in the chart in the last 30 days/ # of RNA orders wherein MD orders matches the RNA orders on tx sheets	Chart	QC	Monthly
14. Treatment (Tx) orders are applied to patients with skin problems	•			100%	2	Skin problems with Tx orders	# of patients having Skin problems with treatment orders (every week in the last 30days)/# of patients with skin problems that received txs as ordered (every week in the last 30 days)	Chart	QC	Monthly
15. MDS Location of Assessment per CAA (Care of Assessment Area)	•			100%	2	CAA indicates location where assessment can be found	# of CAA in the last 30 days / # CAA with indication of the location where the documented assessment can be found	Chart	QC	Monthly

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Indicator(s)	LACH	NCH	LACHB	Target or Goal	Rationale For Selection	Function Measured	Numerator / Denominator	Data Source	Reported to	Reporting Frequency
16. Triggered CAA in the MDS with Corresponding Care Plans	•			100%	2	CAA triggered in the MDS are with Care Plans	# of CAA in the last 30 days/ # of CAA with complete care plans in the last 30 days	Chart	QC	Monthly
Utilization Review										
1. Initial Discharge Assessments are completed within 48 clock hours of patients' admission	•	•		95%	5	PC	N: # patients screened D: # cases reviewed (30 cases / month)	Allscripts Care Mgmt MCG/SS Discharge notes	URC and Quality /PI Committee	Q
2. Admission reviews are completed within 24 clock hours of admission and include required review elements.	•	•		95%	5	PC	N: # patients screened D: # cases reviewed (30 cases / month)	Allscripts Care Mgmt / Milliman Care EMR for scanned copy.	URC and Quality /PI Committee	Q
3. Patient Choice: The CM dept will provide the patient / patient representative with choices pertaining to their post hospital provider choices. This will be prior to DC and includes ,but not limited to acute inpt rehab ,home health, infusion therapy ,hospice care, skilled nursing care , custodial care,etc... Evidence of patient choice is documented in the DC plan.(The organization must respect the choice of the patient or authorized representative except in unusual circumstances.)	•	•		95%	5	PC	N: # patients screened D: # cases reviewed (30 cases / month)		URC and Quality /PI Committee	Q
4. Daily concurrent reviews are completed each calendar day and include the	•	•		95%	5	PC	N: # patients screened D: # cases reviewed	Allscripts Care Mgmt / Milliman	Allscripts Care Mgmt /	Q

Indicator(s)	LACH	NCH	LACHB	Target or Goal	Rationale For Selection	Function Measured	Numerator / Denominator	Data Source	Reported to	Reporting Frequency
essential elements of the review.							(30 cases / month)	Care Guidelines (MCG	Milliman Care Guidelines (MCG	
5..Important Message from Medicare is re-issued to all Medicare and Medicare eligible patients within 48 hours of discharge.	•	•		100%	2	RI	N: # IMMs re issued D: # (ALL Mcare / Mcare Mged care discharges / month)	Medical record audit(Original copy maintained in the patient's MR)	UMC and Quality Council	Q
1. Medi-Cal Denial Rate Acute/Administrative Days			•	<5%	7	PI	N: Total # of Medi-Cal days Denied D: Total # of Medi-Cal Days processed	Processed TARS	UMC, QC	Quarterly
2. Inpatient Length of Stay (Over Utilization)			•	<5%	7	PI	N: Total # of patients with LOS of>14 days D: Total # of discharges	Chart Review	UMC, QC	Quarterly
3. 1st Level Medi-Cal Appeals			•	Trend	7	PI	N: Total Days approved D: Total days Processed	Processed Appeals	UMC, QC	Quarterly

RATIONALE FOR INDICATOR SELECTION:

1. **Patient Safety Issue**
2. **Survey Finding**
3. **High Risk Process**
4. **High Volume Process**
5. **Problem Prone**
6. **Patient Satisfaction Issue**
7. **Required Measure**

There may be more than one rationale for a single indicator. Survey findings should be first priority.

Exhibit 2(b)

Quality Assessment and Performance Improvement Indicators for 2016 (revised as of 3/23/2016)

Note: *Indicators are to be selected from this list. All indicators are not meant to be monitored at all times*

No	Name	Definition	Target*	Accountability	Prioritization Criteria**	Reporting	Comment
			Significant Adverse Occurrences				
1	Sentinel Event (Never Events)	Event leading to death or significant impairment (per Sentinel Event Policy) includes Near Misses (may be reported under significant events on scorecard)	0%	Risk Manager	XX, R, P, C	Quality Steering Committee (QSC) Medical Executive Committee (MEC) Board of Trustees (Board) [Monthly until resolution]	Each sentinel event is reported. The root cause analysis and prevention interventions are also reported.
2	Event Reporting Frequency (RCA)	Number of events reported of the following types: Medication-Related; Other significant	0%	Risk Manager	XX, R, P	QSC, MEC, BOARD [Monthly]	The focus will be to increase reporting of issues
3	Regulatory Citations	Issues identified in this category are monitored until sustained improvement is shown for a minimum of 3 months	TBD	TBD	TBD	TBD	TBD
			Patient Safety				
4	Inpatient Falls per 1000 patient days	**Numerator**: Number of inpatient falls reported during the month. **Denominator**: number of inpatient days per month X 1000.	0.36	Risk Manager	XX, R, P, V	QSC, MEC, BOARD [Monthly]	Quality Steering Committee will oversee the effectiveness of corrective actions
5	Patient falls leading to injury requiring treatment	Number and brief description of the circumstances surrounding any inpatient or outpatient fall that required medical treatment	N/A	Risk Manager	XX, R, P, V	QSC, MEC, BOARD As they occur - monthly	Quality Steering Committee will oversee the effectiveness of corrective actions
			Infection Prevention				
6	MDRO Infection Rate	**Numerator:** Number of cases (HAI) **Denominator**: 1000 pt days	TBD	Infection Control Practitioner	R, P, C.	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
7	Surgical Site HAI rate	**Numerator**: Number SSI **Denominator:** per 1000 clean cases (targeted/specific cases only)	TBD	Infection Control Practitioner	R, C, P, S	QSC, MEC, BOARD [Quarterly]	Surgical procedures for review should be rotated to capture the spectrum of clinical services and operative areas
8	Ventilator Associated Event Rate	**Numerator:** Number of ventilator associated event infections **Denominator**: Number of ventilator patient days X 1000	TBD	Infection Control Practitioner	R, P, C.	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions

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** Prioritization Criteria: XX = Required by External Authorities; R = High Risk; V = High Volume; P = Problem Prone; C = Clinical Excellence; E = Operational Efficiency; S = Patient, Employee and Physician Satisfaction; H = Employee Retention / Recruitment

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9	Central Line/Catheter Related Sepsis Rate	**Numerator:** Number of CLABSI **Denominator:** Number of line insertion patient days X 1000	TBD	Infection Control Practitioner	R, P, C	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
10	MRSA Rate	**Numerator:** Number of cases (HAI) **Denominator:** 1000 pt days ❖	TBD	Infection Control Practitioner	R, P, C, S	QSC, MEC, BOARD Quality Steering Committee [Monthly]	Quality Steering Committee will oversee the effectiveness of corrective actions
11	C. difficile Rate	**Numerator:** Number of cases **Denominator:** 1000 pt days ❖	TBD	Infection Control Practitioner	R, P, C, S	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
12	Rate of Compliance CDC Hand Hygiene Requirements	**Numerator**: Number of observations when the caregiver performed hand hygiene per CDC guidelines. **Denominator**: number of observations (opportunities)	100%	Infection Control Practitioner	XX, R, P, V	At least ten observations per month QSC, MEC, BOARD and Infection Control [Quarterly]	Observations should be rotated to cover all settings and all disciplines
Organ / Tissue Donation							
13	Notification of OPO of imminent patient death/actual death	**Numerator:**# of OPO contacts within time frames per policy **Denominator:** # of deaths per month	75%	Risk Manager	XX, E	QSC, BOARD [Quarterly	Quality Steering Committee will oversee the effectiveness of corrective actions
Environment of Care							
14	Emergency Generator Testing 12 tests required per year with intervals of not less than 20 days and not more than 40 days	**Numerator:** # of tests conducted at required load **Denominator:** # of tests required	TBD	Plant Operations	XX, R, V,P, C,E,S,H	Environment of Care Committee Quality QSC, Board [Quarterly]	EOC Committee will oversee the effectiveness of corrective actions
15	Preventative Maintenance on High Risk Equipment	**Numerator:** # of PM equipment checks per program **Denominator:** # of PM equipment observations conducted	95%	Biomed	R, V,P, C,E,S,H	Environment of Care Committee Quality QSC, Board [Quarterly]	EOC Committee will oversee the effectiveness of corrective actions
16	Emergency Management Activation	2 per year	TBD	Plant Operations	XX, R, V,P, C,E,S,H	Environment of Care Committee Quality QSC, Board [Quarterly]	EOC Committee will oversee the effectiveness of corrective actions

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17	Emergency Management Employee Education	**Numerator:** # of employees correctly describing their role in the event of an internal/external disaster **Denominator:** # of employees interviewed	>90%	Plant Operations	R, V,P, C,E,S,H	Environment of Care Committee Quality QSC, Board [Quarterly]	EOC Committee will oversee the effectiveness of corrective actions
18	Fire Drills	**Numerator:** 1 fire drill per quarter per shift conducted **Denominator:** 12	100%	Plant Operations	XX, R, V,P, E,S,H	Environment of Care Committee Quality QSC, Board [Quarterly]	EOC Committee will oversee the effectiveness of corrective actions
19	Staff knowledge of fire plan	**Numerator:** # of staff articulating fire plan components correctly **Denominator:** # of staff queried	>90%	Plant Operations	R, V,P, E,S,H	Environment of Care Committee Quality QSC, Board [Quarterly]	EOC Committee will oversee the effectiveness of corrective actions
20	Preventative Maintenance on Life Safety System	**Numerator:** # of PM on Fire System **Denominator:** 4 total Fire System PM Conducted	<95%	Plant Operations	R, V,P, E,S,H	Environment of Care Committee Quality QSC, Board [Quarterly]	EOC Committee will oversee the effectiveness of corrective actions
21	Life Safety Assessment Conducted for all construction/ renovation projects	**Numerator:** # of ILSM assessments conducted **Denominator:** # of construction/renovation projects initiated	100%	Plant Operations	XX, R, V,P, E,S,H	Environment of Care Committee Quality QSC, Board [Quarterly]	EOC Committee will oversee the effectiveness of corrective actions
	Patient Complaints / Grievances						
22	Timely Patient Grievance Response Rate	**Numerator:** # of patient grievances responded to w/7 days **Denominator:** # of grievances reviewed	TBD	Patient Advocate	R, P, S	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
	Clinical Excellence / Operational Quality						
	CMS Core Measures						
23	Compliance with Core Measures See core measure descriptions	Indicator sets for AMI, Pneumonia, CHF with related core measure criteria will be reviewed on a quarterly basis (see attached) ❖	TJC Reported mean	Quality Director	XX, V, C, E	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
	HCAHPS						
24a	Patient Satisfaction, overall level of care, Inpatient	Percent of patients indicating positive/slightly positive score❖	Corp mean	Quality Director	V,S,H	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions

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24b	Patient Satisfaction, overall level of care, ED	Percent of patients indicating positive/slightly positive score❖	Corp mean	Quality Director	V,S,H	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
24c	Patient Satisfaction, overall level of care, OP	Percent of patients indicating positive/slightly positive score❖	Corp mean	Quality Director	V,S,H	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
	HBIPS						
25a	HBIPS-1	Admission screening for violence risk, substance use, psychological trauma history and patient strengths completed	Corp mean	Director BHU	V,S,H	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
25b	HBIPS-2	Hours of physical restraint use	Corp mean	Director BHU	V,S,H	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
25c	HBIPS-3	Hours of seclusion use	Corp mean	Director BHU	V,S,H	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
25d	HBIPS-4	Patients discharged on multiple anti-psychotropic medications	Corp mean	Director BHU	V,S,H	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
25e	HBIPS-5	Patients discharged on multiple anti-psychotropic medications with appropriate justification	Corp mean	Director BHU	V,S,H	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
25f	HBIPS-6	Post-discharge continuing care plan created	Corp mean	Director BHU	V,S,H	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
25g	HBIPS-7	Post discharge continuing care plan transmitted to next level of care provider on discharge	Corp mean	Director BHU	V,S,H	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
	Contract Services						
26	Evaluation of Contracted Services	**Numerator:** Number of Contracted Services Evaluated **Denominator:** Total number of Contracted Services	Corp mean	COO	XX	PICC, Board (Annually)	Performance Improvement Coordinating Council will oversee the effectiveness of corrective actions
27	**Effectiveness of Contracted Services**	**Numerator:** # of services with positive evaluation **Denominator:** # of contract services	95%	COO	XX	PICC, Board (Annually)	Performance Improvement Coordinating Council will oversee the effectiveness of corrective actions
	Surgery/GI Lab						
28	Sedation Outcome (Use of Reversals)	**Numerator:** Number of sedation cases with reversal agents used **Denominator:** Total sedation procedures performed	0%	GI Laboratory and Sedation Team Director	R, P, C	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions Will refer physician identified trends to Peer Review Committee for review , determination and action as necessary

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29	Unplanned Returns to the OR	**Numerator:** Number of unplanned patient returns to OR for surgical procedure during same admission as initial procedure **Denominator: Number:** Number of surgical **cases** performed❖	TBD	Surgery Director	R, P, C, S	QSC,, MEC, BOARD Peer Review Committee [Monthly]	Quality Steering Committee will refer physician identified trends to Peer Review Committee for review , determination and action as necessary*
30	PI Project Status Temp and Humidity in the OR suites	**Numerator:** # of times temp and Humidity out of range **Denominator:** # of times temp and humid measured	100%	Surgery Director	R, P, V,C, E,	QSC, MEC, BOARD [Monthly]	Quality Steering Committee will oversee the effectiveness of corrective actions
31	Sterilization of Surgical Instruments PI Project	**Numerator #** of instrument trays with no evidence of discoloration post sterilization/**Denominator#** of instrument trays inspected	100%	Surgery Director	R, P, V,C, E,	QSC, MEC, BOARD [Monthly]	Quality Steering Committee will oversee the effectiveness of corrective actions
32	ALOS in PACU	Average Length of Time in Minutes	TBD	Surgery Director	V, C, E, S	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
Health Outcomes / Complications –1							
33	Inpatient Mortality Rate	**Numerator:** Number of inpatient deaths **Denominator:** Number of patient days per month X 1000	TBD	Quality Director	R, V, P, C, S	QSC, MEC, BOARD Peer Review Committee [Monthly]	Quality Steering Committee will refer physician identified trends to Peer Review Committee for review, determination and action as necessary***
34	Postoperative Mortality Rate (new)	**Numerator:** Number of mortalities post surgical procedure **Denominator:** Total number of surgical **cases** performed	TBD	Quality Director	R, V, P, C, S	QSC, MEC, BOARD Peer Review Committee [Monthly]	Quality Steering Committee will refer physician identified trends to Peer Review Committee for review, determination and action as necessary
Health Outcomes / Emergency Department							
35	Emergency Department LWBS rate	**Numerator:** Number of patients leaving ED WBS **Denominator:** Number of ED patient visits X 1000	<2%	ED Manager	R, V, P, C, S	QSC, BOARD Quality Steering Committee [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
36	Door to Physician Time	Average Monthly Time in Minutes	TBD	ED Manager	R, V, P, C, E	QSC, MEC, BOARD Quality Steering Committee [Monthly]	Quality Steering Committee will oversee the effectiveness of corrective actions
37	Door to Disposition Time	Average Monthly Time in Minutes	TBD	ED Manager	R, V, P, C, E	QSC, MEC, BOARD Quality Steering Committee [Monthly]	Quality Steering Committee will oversee the effectiveness of corrective actions
38	# of Pts in ED >4 hrs & ≤ 6 hrs	**Numerator:** # of registered pts in ED >4 hrs. but ≤ 6 hrs **Denominator:** # of ED visits X 1000❖	90%	ED Manager	V, C, E, S	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions

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39	ED Adult Patient Average Length of Stay	Average Length of Time in Hours	TBD	ED Manager	V, C, E, S	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
Health Outcomes / Complications – Behavioral Health/IOP							
40	Assaultive behavior pt. vs. pt	**Numerator**: # of pt vs pt assaults **Denominator**: 1000 pt days:	<30%	BHU Nursing Manager	R, P, C, S	Quality Steering Committee [Monthly]	Quality Steering Committee will oversee the effectiveness of corrective actions
41	Assaultive behavior pt. vs st.	**Numerator**: # of pt vs st assaults **Denominator**: 1000 pt days::	<15%	BHU Nursing Manager	R, P, C, S	Quality Steering Committee Peer Review Committee [Monthly]	Quality Steering Committee will oversee the effectiveness of corrective actions
42	Assaultive Behavior st. vs. pt	**Numerator**: # of st vs pt assaults **Denominator**: 1000 pt days:	0%	BHU Nursing Manager	R, P, C, S	Quality Steering Committee Peer Review Committee [Monthly]	Quality Steering Committee will oversee the effectiveness of corrective actions
43	Patient rights: appropriate discharge	**Numerator**: # of appropriate discharges/ **Denominator**: # of discharged patients	2%	BHU Nursing Manager	R, P, C, S	Quality Steering Committee Peer Review Committee [Monthly]	Quality Steering Committee will oversee the effectiveness of corrective actions
44	Patient Rights: appropriateness of holds	**Numerator**: # appropriate holds **Denominator**: # of pt holds	<5%	BHU Nursing Manager	R, P, C, S	Quality Steering Committee Peer Review Committee [Monthly]	Quality Steering Committee will oversee the effectiveness of corrective actions
45	Patient Rights: Timely removal of holds	**Numerator**: # of timely removal of holds /**Denominator**: # of holds removed	TBD	BHU Nursing Manager	R, P, C, S	Quality Steering Committee Peer Review Committee [Monthly]	Quality Steering Committee will oversee the effectiveness of corrective actions
46	Patient Rights: Use of seclusion/restraints	**Numerator**: # of pt in restraint/seclusion/ **Denominator**: 1000 pt days:	90%	BHU Nursing Manager	R, V, C, S	Quality Steering Committee	Quality Steering Committee will oversee the effectiveness of corrective actions
47	Patient Rights: Privacy	**Numerator**: # of pt denied privacy **Denominator**: 1000 pt days:	volume	BHU Nursing Manager	R, P, C, S	Quality Steering Committee Peer Review Committee [Monthly]	Quality Steering Committee will oversee the effectiveness of corrective actions
Medical Staff (new)							
Other medical staff indicators determined by individual departments and services and reported to individual department QAPI meetings with routine reporting format							
Resuscitation							
48	Cardiopulmonary Arrests	**Numerator:** Number of cardiopulmonary arrests **Denominator:** 1000 p atient days	Trend	ED Director	R, P, C, E, S,	OSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions

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49	Rapid Response Team (REACT Team) Effectiveness	**Numerator:** Number of Rapid Response Team responses w/in 4 minutes **Denominator:** RRT calls per month (per reporting period)	100%	ED Director	R, V, P, C, E	Code Blue Team, QSC, MEC, Board (Quarterly)	Quality Steering Committee will oversee the effectiveness of corrective actions
		Numerator: Number of Rapid Response Team responses with transfer to higher level of care **Denominator:** RRT calls	Trend	ED Director	R, V, P, C, E	Code Blue Team, QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
50	Resuscitation Outcome – Code Blue Efficiency	**Numerator:** Number of codes where all efficiency criteria is met **Denominator:** Total number full code arrests	100%	ED Director	R, P, C, S, E	Code Blue Team, QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
		Numerator: Number of codes with patients surviving code **Denominator:** Number of full code arrests	Trend	ED Director	R, P, C, S, E	Code Blue Team, QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
		Numerator: Number of codes with patients surviving to discharge **Denominator:** Number of full code arrests	Trend	ED Director	R, P, C, S, E	Code Blue Team, QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
Patient Satisfaction HCAHPS							
51	Patient Satisfaction, overall level of care, inpatient	Percent of patients indicating positive/slightly positive score❖	Corp mean	Quality Director	V,S,H	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
52	Patient Satisfaction, overall level of care, ED	Percent of patients indicating positive/slightly positive score❖	Corp mean	Quality Director	V,S,H	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
53	Patient Satisfaction, overall level of care, OP	Percent of patients indicating positive/slightly positive score❖	Corp mean	Quality Director	V,S,H	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
Pain Management							
54	Pain Assessment	**Numerator:** Pain Assessment per policy **Denominator:** Number of observations		Nursing Admin	H, P, V, C, S,	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
55	Pain Re-Assessment	**Numerator:** Pain Re-assessment post intervention **Denominator:** Number of observations		Nursing Admin	H, P, V, C, S,	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
Hospital Acquired Pressure Ulcers							
56	Prevention of Hospital Acquired Pressure Ulcers	HAPU prevalence -overall	0.xx per CalNoc	Nursing Admin	H, P, V, C, S,	QSC, MEC, BOARD [Quarterly]	Prevalence indicator Quality Steering Committee will oversee the effectiveness of corrective actions

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		HAPU prevalence - Rehab	0.xx per CalNoc	Nursing Admin	H, P, V, C, S	QSC, MEC, BOARD [Quarterly]	Prevalence indicator Quality Steering Committee will oversee the effectiveness of corrective actions
Restraint Usage							
57	Restraint Prevalence	Restraint Prevalence – overall	x.xx per CalNoc	Nursing Admin	R, P, C, S	QSC, MEC, BOARD [Quarterly]	Prevalence indicator Quality Steering Committee will oversee the effectiveness of corrective actions
58	Restraint Usage – Appropriateness of order (Physician) per policy	**Numerator**: Number of orders for restraint meeting restraint criteria per policy **Denominator:** Total number of orders for restraint	100%	Nursing Admin	R, P, C, S	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
59	Restraint Monitoring (Nursing) per policy	**Numerator:** Number of restraint records meeting monitoring criteria **Denominator:** Total number of restraint records reviewed *each episode of restraint reviewed – reported as variance per record❖	100%	Nursing Admin	R, P, C, S	QSC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
Medication Use							
60	Unit based Pharmacy Medication Error Rate	**Numerator:** total number of medication errors occurring in patient care areas **Denominator:** Total medications dispensed (or per 1000 medications dispensed) ❖	TBD	Pharmacy Director	R, V, P, C, E, S	Medication Safety Committee, P&T, QSC, BOARD [MSC monthly, others quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
61	Internal Pharmacy Medication Error Rate	**Numerator:** total number of internal pharmacy medication errors identified **Denominator:** Total number of drugs prepared for dispensing (or per 1000 drugs dispensed) ❖	TBD	Pharmacy Director	R, V, P, C, E, S	Medication Safety Committee, P&T, QSC, BOARD [MSC monthly, others quarterly	Quality Steering Committee will oversee the effectiveness of corrective actions taken by Pharmacy
62	Adverse Drug Reaction Rate	**Numerator:** Number of adverse drug reactions **Denominator:** Number of medications administered ❖	TBD	Pharmacy Director	R, P, C	Medication Safety Committee, P&T, QSC, BOARD [MSC monthly, others quarterly	Quality Steering Committee will oversee the effectiveness of corrective actions
63	MERP program	See MERP Indicators per Facility		Pharmacy Director			

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Medical Records							
64	Medical Records Meeting Review Criteria (timeliness, legibility, authentication of data)	**Numerator**: Number of records meeting criteria at the 100% level **Denominator:** Random 30 record audit	90%	HIM Director	P, C, E	HISC, QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
65	Medical Record Delinquency Rate	**Average monthly discharges over the past 4 quarters** Not greater than 50% of the AMD rate and no single quarterly measurement greater than 50% of the AMD rate	* not < 50%	HIM Director	XX, P, C, E	HISC, QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
66	H&P Content per Medical Staff requirements	**Numerator:** Number of H&Ps performed **Denominator:** # H&Ps meeting MEC requirements❖	TBD	HIM Director	P, C, E	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
Laboratory							
67	Crossmatch to Transfusion Ratio	**Numerator**: Number of units ordered for crossmatch **Denominator**: number of cross matched units transfused	2:1	Clinical Laboratory	R, V,C	QSC, MEC, BOARD [Quarterly]	Negative trends will be analyzed with drill down to identify ordering issues – analysis will include all areas where cross match is ordered
68	Transfusion reaction rate	**Numerator**: Number of identified hemolytic transfusion reactions **Denominator**: Number of units transfused	0%	Clinical Laboratory	R, P, C	QSC, MEC, BOARD As they occur - monthly	Quality Steering Committee will oversee action plan for investigation
69	Average time of reporting of critical results	Mean time from resulting availability to notification of the responsible practitioner (physician or other practitioner who may initiate appropriate intervention) ❖	TBD	Clinical Laboratory	XX, R, P, V	QSC, BOARD All "tier 1" critical non-laboratory testing results Quality Steering Committee [Quarterly].	Quality Steering Committee will oversee the effectiveness of corrective actions
70	Discrepant Pathology Reports		0%	Clinical Laboratory	R, P, C	QSC, MEC, BOARD As they occur - monthly	Quality Steering Committee will oversee action plan for investigation
Utilization/Case Management							
71	Appropriateness of Patient Discharge	**Numerator:** Number of inpatient readmissions within 30 days of discharge for AMI, HF, CAP **Denominator:** Total number of discharges per month AMI, HF, CAP	TBD	Case Manager	V, C, E, S	QSC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
72	Appropriateness of care and treatment – Medicare specific	**Numerator:** Number of Medicare denials **Denominator:** Total number of Medicare patient discharges per month	TBD	Case Manager	V, C, E, S	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions

* Target: N/A = Not Applicable to This Indicator; TBD = Applicable but the target has not been determined ("To Be Determined")
** Prioritization Criteria: XX = Required by External Authorities; R = High Risk; V = High Volume; P = Problem Prone; C = Clinical Excellence; E = Operational Efficiency; S = Patient, Employee and Physician Satisfaction; H = Employee Retention / Recruitment

Monthly statistical calculations unless otherwise stated

73	Appropriateness of care and treatment – Medicaid specific	**Numerator:** Number of Medicaid denials **Denominator:** Total number of Medicaid patient discharges per month	TBD	Case Manager	V, C, E, S	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
Employee Health							
74	Employee Influenza Vaccination Compliance	**Numerator: # of staff who rcvd influenza vaccination Denominator: total number of staff**		Director of Infection Control	XX, R		
Dialysis Services							
75	Contract Service Dialysis	**See Standardized Indicators for Contract Services Dialysis**		Nursing Admin			
76	Contract Service Dialysis	**Numerator:** Daily Patient Schedule Provided **Denominator**: Total number of Observations		Nursing Admin			
Food and Nutrition Services: Refer to Department Audits							
77	Contract Service Food and Nutrition	**See Standardized Indicators for Contract Services Food and Nutrition**		Director of Dietary			
78	Delivered Diet Tray Accuracy (new)	**Numerator**: Number of accurate meal trays delivered to unit **Denominator:** number of meal trays delivered	100%	Director of Dietary	V, P, C, S	P&T, QSC, MEC, BOARD [Quarterly	Quality Steering Committee will oversee the effectiveness of corrective actions
79	Food Safety – Sanitary, Storage and Preparation (Sanitation)	**Numerator**: Number of Compartment Sinks with Correct Temperature for Sanitation **Denominator:** number of Compartment Sinks Tested for Correct Temperature	100%	Director of Dietary	V, P, C, S	P&T, QSC, MEC, BOARD [Quarterly	Quality Steering Committee will oversee the effectiveness of corrective actions
80	Food Safety – Sanitary, Storage and Preparation (Safe Storage – Temperature)	**Numerator**: Number of Refrigerator and Freezer Logs with Temperatures within Range **Denominator**: number of Refrigerator/Freezer Logs Reviewed	100%	Director of Dietary	V, P, C, S	P&T, QSC, MEC, BOARD [Quarterly	Quality Steering Committee will oversee the effectiveness of corrective actions
81	Food Safety – Sanity, Storage and Preparation (Safe Preparation – Hot Food Cooling Process)	**Numerator**: Number of Hot Food Cooling Items Within Temperature Range **Denominator**: Number of Hot Food Items Cooled and with Temperature Checks	100%	Director of Dietary	V, P, C, S	P&T, QSC, MEC, BOARD [Quarterly	Quality Steering Committee will oversee the effectiveness of corrective actions
Imaging Services							
82	Dosimeter Badge Readings	Radiology Reports to QC with fall outs, posted for staff and F/U with employee	NA	Director of Imaging	XX	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions

* Target: N/A = Not Applicable to This Indicator; TBD = Applicable but the target has not been determined ("To Be Determined")
** Prioritization Criteria: XX = Required by External Authorities; R = High Risk; V = High Volume; P = Problem Prone; C = Clinical Excellence; E = Operational Efficiency; S = Patient, Employee and Physician Satisfaction; H = Employee Retention / Recruitment

Monthly statistical calculations unless otherwise stated

83	Result Discrepancies/Re-reads	# of result discrepancies/ Total# of radiology reads/month	<5%	Director of Imaging	R, P	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
84	Radioactivity Monitoring	**Numerator:** The number of environmental swabs without radioactive traces. **Denominator:** The number of environmental swabs taken	100%	Director of Imaging	XX, R, V,P, C,E	Environment of Care Committee Quality QSC, Board [Quarterly]	EOC Committee will oversee the effectiveness of corrective actions
	Rehabilitation Services (Physical Therapy and Habilitation Services)						
85	Functional Independence Measure Scoring (FIMS)	**Numerator:** # of pts with FIMS scoring improving to < national benchmark and range **Denominator:** Number of FIMS scores measured	*target specific to dx process – national average 29	Rehabilitation Services	R, P, C, E, S	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
86	Rehabilitation Patients Discharged to Community	**Numerator:** # of rehabilitation patients discharged to the community **Denominator:** # of patient discharges	72	Rehabilitation Services	R, P, C, E, S	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
87	Therapy Assessments	**Numerator:** # of physical therapy evaluations performed within time frame per policy criteria **Denominator:** # of physical therapy evaluations reviewed	100%	Rehabilitation Services	R, P, C, E, S	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
		Numerator: # of speech therapy evaluations performed within time frame per policy criteria **Denominator:** # of speech therapy evaluations reviewed	100%	Rehabilitation Services	R, P, C, E, S	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
		Numerator: # of occupational therapy evaluations performed within time frame per policy criteria **Denominator:** # of occupational therapy evaluations reviewed	100%	Rehabilitation Services	R, P, C, E, S	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions

* Target: N/A = Not Applicable to This Indicator; TBD = Applicable but the target has not been determined ("To Be Determined")
** Prioritization Criteria: XX = Required by External Authorities; R = High Risk; V = High Volume; P = Problem Prone; C = Clinical Excellence; E = Operational Efficiency; S = Patient, Employee and Physician Satisfaction; H = Employee Retention / Recruitment

Monthly statistical calculations unless otherwise stated

Respiratory Therapy Services							
88	Arterial Blood Gas Management	**Numerator:** # ABGs resulted within 10 minutes of STAT draw **Denominator**: # of ABG STAT specimens requested included in study	100%	Respiratory Therapy Services	R, P, C, E, S	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
89	Timeliness of Treatment	**Numerator:** # of Missed/Delayed Treatments **Denominator**: # of treatments to be administered	0%	Respiratory Therapy Services	R, P, C, E. S	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
Outpatient Services/Spine Clinic							
90	Medication Reconciliation	**Numerator=# of medication recon forms completed with allergies identified/Denominator # of recon forms obtained/month**	90%	Clinic Manager		QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
91	Medication Reconciliation	**Numerator= # of Med recon forms sent to internist/Denominator = # of patients referred to internist**	90%	Clinic Manager		QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
92	Wait Times	**Numerator # of patients seen by physician within 20 minutes of arrival Denominator # of patients seen in center /month**	90%	Clinic Manager		QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
Outpatient Services/Cardiology Clinic							
93							
94	Post Procedure Pathology Reports	**Numerator: # of post-procedure pathology reports available for patient visit/Denominator: # of post-procedure patient visits**	90%	Clinic Manager		QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
	Final Read Cardiology Test Results	**Numerator: # final-read cardiology test results available for patient visit/Denominator: # of cardiology results available for patient visit/month**	90%	Clinic Manager		QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
	Wait Times	**Numerator: # of patients seen by physician within 20 minutes of arrival Denominator # of patients seen in center /month Denominator:**	90%	Clinic Manager		QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
Environmental Services							
95	Contract Service EVS	**See Standardized Indicators for Contract EVS Services**					

* Target: N/A = Not Applicable to This Indicator; TBD = Applicable but the target has not been determined ("To Be Determined")
** Prioritization Criteria: XX = Required by External Authorities; R = High Risk; V = High Volume; P = Problem Prone; C = Clinical Excellence; E = Operational Efficiency, S = Patient, Employee and Physician Satisfaction; H = Employee Retention / Recruitment

Monthly statistical calculations unless otherwise stated

96	Cleanliness and Sanitation	**Composite Score** **Numerator:** # Areas Inspected Properly Cleaned and Disinfected **Denominator:** # of Areas included in Inspection	95%	Environmental Services	V, P, C, E, S, H	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
		Numerator: SPD Terminally Cleaned per policy **Denominator:** # of observations	95%	Environmental Services	V, P, C, E, S, H	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
		Composite Score **Numerator:** # Areas Inspected for Positive Glow Verification (effective disinfection) **Denominator:** # of Areas included in Inspection	TBD	Environmental Services	V, P, C, E, S, H	QSC, MEC, BOARD [Quarterly]	Quality Steering Committee will oversee the effectiveness of corrective actions
Performance Initiatives/Projects							
97	Rate of compliance with structured patient hand-off process	**Numerator:** Number of observations of patient hand-offs during which the hospital's structured process was followed. **Denominator**: number of patient hand-offs observed ❖	TBD	Quality Director	R, P, V	QSC, MEC, BOARD 10 hand-offs per month Quality Steering Committee [Quarterly]	Sampling should focus on various types of hand-offs.

* Target: N/A = Not Applicable to This Indicator; TBD = Applicable but the target has not been determined ("To Be Determined")
** Prioritization Criteria: XX = Required by External Authorities; R = High Risk; V = High Volume; P = Problem Prone; C = Clinical Excellence; E = Operational Efficiency; S = Patient, Employee and Physician Satisfaction; H = Employee Retention / Recruitment

3. Curriculum Vitae of PMH Corporate Quality Personnel.

Please see Exhibits 3(a), 3(b) and 3(c)

EXHIBIT 3(a)

DEBBIE BERRY, RN, MSN, LHRM, CPHQ, CPPS, CWCN, CCN

[redacted]

PROFESSIONAL EXPERIENCE

4/2015 – Present

Vice President of Quality and Patient Safety
Gulf Coast Division (GCD) of HCA, Houston, TX

- Work directly under the GCD Chief Medical Officer to provide oversight for clinical operations and excellence; quality assurance; performance improvement; patient safety, risk prevention and management; infection prevention and control; and medical staff operations for a 13 hospital division.
- Collaborate with the DCMO to build structure and processes to drive improvement in quality, patient safety and clinical excellence outcomes for the GCD by creating and co-chairing a Quality and Patient Safety Steering Council with subcommittees on Medication Safety, Infectious Disease Preparedness, CVAT, Hospital Acquired Conditions/Infection Prevention, and Clinical Excellence.
- Collaborated with the DCMO to build the quality and patient safety strategic plan for 2016 – 2018 that will maximize Value Based Purchasing and other pay-for-performance opportunities; as well as, lead to improved clinical and quality outcomes.
- Provide oversight for Quality and Clinical Operations data mining and analysis for division and facility opportunities.
- Developed and implemented performance improvement strategies and tactics leading to a 25% reduction in catheter associated urinary tract infections, 30% decrease in time to pain management for long bone fractures and a 32% improvement in Outpatient Stroke measures.
- Designed and implemented a Leapfrog "Getting to A" initiative that led to a division average score of "C" to a division average score of "B" and includes a division-wide IRR and validation process.
- Collaborate with the CMO and Performance Improvement team to drive an 11% improvement in sepsis mortality through improving sepsis bundle

compliance by 60%, an 11% improvement in blood utilization, and sustained improvements in 4 of 5 Cardiovascular PCI indicators.

4/2013 - 4/2015 **Assistant Vice President of Quality and Clinical Operations**
West Florida Division (WFD) of HCA, TAMPA, FL

- Work directly under the WFD VP of Quality and Clinical Operations to provide oversight for clinical operations and excellence; quality assurance; performance improvement; patient safety, risk prevention and management; infection prevention and control; and medical staff operations for a 16 hospital division.
- Provide oversight for many of the day to day operations of the Quality and Clinical Operations Department
- Provide oversight to all regulatory and accreditation activities in the 16 hospitals in the WFD of HCA.
- Created a Sentinel Event Webinar preparation program that has led to 100% acceptance of plans of correction and successful completion of measures of success for the past four years.
- Completed due diligence from a quality, patient safety, infection prevention, nursing operations and medical staff perspective for 4 hospitals under consideration for acquisition.
- Provided on-site facilitation for 5 newly acquired facilities to successfully transition to corporate standards and achieve 100% Joint Commission and CMS accreditations within 120 days of acquisition.
- Responsible for successful credentialing and privileging of 100% of the Medical Staff in new WFD facilities.
- Created a multilevel tracking system that enables a 30 day transition of Medical Staff from a closing facility to the closest HCA facility.
- Co-designed and implemented performance improvement "Key Elements" strategies leading to a 60% reduction in hospital acquired conditions in 4 years.
- Participated in the design of the WFD centralized claims management process.
- Co-designed and implemented a Core Measures Playbook II with gap analysis and tool kit leading to 13 of 16 WFD hospitals awarded Top Performers on Key Quality Indicators© by the Joint Commission for 2013.
- Assumed the Severe Sepsis project management in March 2012 leading to a decrease mortality rate from 42% to 32% and ALOS from 12 days to 9.5 days.
- Co-designed a Dependent Healthcare Provider Scope of Service and evaluation program which has been adopted by HCA Corporate.
- Created and provide oversight for the Quality and Patient Safety Leadership Orientation Program.

- Provide oversight for Quality and Clinical Operations data analysis and data presentation.

2/2011 – 4/2013 **Director of Regulatory and Accreditation Programs**
West Florida Division of HCA, Tampa, FL

- Worked directly under the WFD VP of Quality and Clinical Operations; serves as the Division expert on regulation, accreditation, clinical practice and risk prevention and management.
- Provided oversight to all regulatory and accreditation activities in the 16 hospitals in the WFD of HCA.
- Designed a QRS follow-up program for continuous survey readiness which has led to a decrease in TJC RFIs in the WFD.
- Co-designed a TJC Sentinel Event webinar process which has led to 100% acceptance of WFD hospital action plans and attainment of 100% Measures of Success within the required 4 months.
- Co-designed and implemented performance improvement "Key Elements" strategies leading to a 60% reduction in hospital acquired conditions and never events.
- Co-designed and implemented a Core Measures Playbook leading to 12 of 15 WFD hospitals awarded Top Performers on Key Quality Indicators© by the Joint Commission for 2012.
- Assumed the Severe Sepsis project management in March 2012 leading to a decrease mortality rate from 42% to 35% and ALOS from 12 days to 11 days in one year.

8/2009 – 2/2011 **Vice President of Quality, Risk Management and Infection Control**
Northside Hospital, HCA St. Petersburg, FL

- Provided oversight of all Quality, Performance Improvement, Risk Management, and Infection Control activities for Northside Hospital.
- During tenure significantly improved all Core Measures to the 90th percentile and increased HCAHPS composite score by 4%.
- Redesigned Medical Staff peer review, ongoing professional practice evaluation (OPPE) and focused professional practice evaluation (FPPE) program leading to improved oversight of physician and LIP practice.
- Achieved 90% measure of success compliance in 6 months on all QRS identified opportunities from May 2010 QRS survey.
- Facilitated all Root Cause Analysis and Failure Mode Effects Analysis activities and ensured 100% compliance with designed plans of correction.

- Responsible for presentation and facilitation of analysis of quality and performance improvement data in the Quality and Patient Safety Committee, Medical Executive Committee and Board of Trustees.

10/2007 – 6/2009 **Assistant Vice President of Clinical Practice**
Washington Adventist Hospital, Takoma Park, MD

- Provided clinical operation oversight for ED, Critical Care, Medical-Surgical, Telemetry, Women's Services, Surgical Services, and Pharmacy Services.
- Assumed the Interim Chief Nurse Executive role during the 6 month search process.
- Provided leadership for Case Management, Hospitalist Program, and Intensivist Program – decreased hospital LOS by 4% despite a 10% increase in Case Mix Index
- Facilitated the design, implementation and monitoring of a new Neurovascular Surgical Service Line and Stroke Program.
- Designed and implemented the Professional Practice Education Program (PPEP) and other professional practice programs led to a 20% increase in recruitment and retention of nurses
- Redesigned and provided oversight to the Montgomery County Latino Health Care Initiative Nurse-in-Training Program – wrote and was awarded a $259,000 NSPI grant to support the management of the program for four years.
- Improved customer satisfaction scores by 15 % in key clinical areas
- Assisted in a Pharmacy redesign program leading to a 55% decrease in medication errors reaching the bedside.
- Facilitated the design and implemented a Rapid Medical Evaluation process in the ED which decreased patients leaving without treatment by 30% in the first three months.

5/2005 – 10/2007 **Internal Consultant/Corporate Manager, Resource Management and Performance Improvement Department**
MedStar Health, Lutherville, MD (Seven hospital Healthcare System)

- MedStar Visiting Nurses Association (VNA) Error Reduction Project
- Decreased service batch errors by 50% in 6 months
- Decreased Medicare Revenue held by fatal billing errors from $2,687,806 to $1,248,860 in 6 months.

- Served as a clinical consultant to Corporate Supply Chain. Designed a 3- year corporate bed fleet replacement program leading to $400,000 in contract savings.
- Facilitator for System-wide Performance Improvement Task Forces that all led to decrease in mortality, morbidity, LOS and 30-day readmission rates including initiatives in Surviving Sepsis Campaign, pressure ulcer prevention, glycemic control, heart failure, and culture of safety.
- Redesign Projects leading to improved efficiency, improved revenue capture, decrease in length of stay and decreased wait times and improved customer satisfaction
    - Franklin Square Hospital Center– Preadmission Testing
    - Georgetown University Hospital – Case Management Department, Wound Center and Ankle and Foot Center
    - Good Samaritan Hospital – Heart Care Unit and Patient Flow initiative.

10/1999 – 5/2005 **Clinical Nurse and Case Management Specialist, Medicine Service Line**
Franklin Square Hospital, MedStar Health, Baltimore, MD

- Served as a clinical consultant to Corporate Supply Chain. Designed a 3- year corporate bed fleet replacement program leading to $400,000 in contract savings.
- Partnered with physicians to design and implement protocols, guidelines and outcomes measurement for multiple disease entities.
- Provided supervision for all educators and clinical specialists in the Medicine Service Line.
- Planned, implemented and sustained multiple evidence-based, performance improvement programs across the Medicine Service Line.
- Designed and implemented care coordination rounds on all units resulting in a 10% decrease in length of stay.
- Implemented the DRG Assurance Program maximizing coding for complexity of care leading to a 20% increase in CMI in one year.
- Achievements:
    - Delmarva Medicare Excellence Award for three areas of responsibility: CHF, MI, and Pneumonia
    - Solucient 100 recognition for Heart Failure, MI and Pneumonia
    - Achieved recognition in US News & World Report Top 100 Hospitals for cardiology and endocrinology.

4/1998 – **Clinical Liaison Nurse, Corporate Materials Management**

10/1999 *MedStar Health, Baltimore, MD*

- Served as clinical expert and liaison for all corporate contracts
- Served as medical and OR product consensus builder leading to over $1.5 million in systems savings in 18 months.
- Coordinated all new product implementations across the system.

3/1985 – 4/1998 **Nurse Director/Nurse Educator/Staff Nurse/Home Care Case Manager**
Church Hospital, MedStar Health, Baltimore, MD

- Provided Critical Care, Home Care and Medical-Surgical clinical practice, management and education
- Served as member and chairperson on multiple quality, patient safety and performance improvement committees.

9/1988 – 5/2009 **Adjunct Faculty Villa Julie College and Community College of Baltimore County**
Baltimore, MD

10/1981 – 3/1985 **Cardiac Rehabilitation Nurse/ICU Staff Nurse**
Greater Baltimore Medical Center, Baltimore, MD

6/1980 – 10/1981 **Telemetry Nurse**
Wheeling Hospital, Wheeling, WV

EDUCATION

2015 –	Doctoral Student in Nursing Practice	*Capella University, Minneapolis, MN*
2003 – 2005	Masters of Science in Nursing	*University of Phoenix, Phoenix, AZ*
1985 – 1987	Masters of Science in Instructional Technology	*Towson University, Towson, MD*
1976 – 1980	Bachelors of Science in Nursing	*Wheeling Jesuit College, Wheeling, WV*

LICENSES AND CERTIFICATIONS

- Licensed Registered Nurse (RN) Florida and Texas
- Licensed Healthcare Risk Manager (LHRM) Florida
- Certified Professional in Health Care Quality (CPHQ)
- Certified Professional in Patient Safety (CPPS)

- Certified Wound Care (CWCN)
- Certified Continence Nurse (CCN)

PUBLICATIONS

Author/Co-Author

- Hospital Readmission Prevention in Lippincott's Nursing Advisor (2015 in publication). Philadelphia: Wolters Kluwer/Lippincott, Williams & Wilkins.
- Core Measures in Lippincott's Nursing Advisor (2015, 2016). Philadelphia: Wolters Kluwer/Lippincott, Williams & Wilkins.
- Unethical Practices: Recognizing and Reporting in Lippincott's Nursing Advisor (2014). Philadelphia: Wolters Kluwer/Lippincott, Williams & Wilkins.
- Lippincott's CE Module - Mandatory Education, Hospital: National Patient Safety Goals (2013). Philadelphia: Wolters Kluwer/Lippincott, Williams & Wilkins.
- Lippincott's Nursing Advisor Core Measure Content Set for AMI and Heart Failure (2013). Philadelphia: Wolters Kluwer/Lippincott, Williams & Wilkins.
- Bahner, J, Berry, D, & Hooker, J. Nursing Leadership for Safety (Section XIV, Chapter 5) in Patient Safety in Emergency Medicine (2008), Philadelphia: Wolters Kluwer/Lippincott, Williams & Wilkins.

Contributor/Reviewer

- Sentinel Events in Lippincott's Nursing Advisor (2015). Philadelphia: Wolters Kluwer/Lippincott, Williams & Wilkins.
- Lippincott Nursing Procedures & Skills (2010, 2011, 2012, 2013, & 2014 versions). Wolters Kluwer/ Lippincott, Williams & Wilkens.
- Lippincott Patient Safety Program: Communication Among Caregivers and Restraints (2013). Wolters Kluwer/ Lippincott, Williams & Wilkens.
- Preceptor Preparation Program: Web based interactive e-learning course (2012). Wolters Kluwer/ Lippincott, Williams & Wilkens.

AWARDS, HONORS and Professional Activities

- Member of the National Advisory Board for Strayer University RN to BSN program
- Subject matter expert for quality, patient safety and risk management for Rasmussen University
- Subject matter expert for Core Measures for Lippincott, Williams and Wilkins publishing company.
- Alpha Sigma Nu (National Jesuit Honor Society)

- Sigma Theta Tau (International Nursing Honor Society)
- 2003 Nurse of the Year in a Clinical Support Role, Franklin Square Hospital
- 2004 Excellence in Care Coordination Leadership Award, Franklin Square Hospital

PRESENTATIONS

- **2012 FAHQ Annual Conference**: *Sustained Zero HAPU: Northside Hospital's Journey*
- **2007 SAWC Conference Poster Presentation:** *The design and early implementation of pressure ulcer prevention strategies in a large health care system*
- **2007 MedStar Surviving Sepsis Initiative** featured in Maryland Patient Safety Center and MHEI Director of Process Improvement Projects
- **2005 Care Science National Conference:** *Using Risk Adjusted Data to Evaluate Performance and Drive Change*
- **2005 Delmarva Courage to Improve Conference:** *Establishing Core Measure Compliance*

Exhibit 3(b)

Thedosia L. Munford, MBA, MS, BSN, RN, NEA-BC

[redacted]

SUMMARY OF QUALIFICATION: Thirty years of diversified acute health care experience and accomplishments in positions of progressive managerial and executive responsibilities. Extensive involvement in organization redesign, renovation and restructuring; cost reduction; fiscal management; human resource management and development; project management; organizational transition; organization preparation for ANCC magnet designation and direction of clinical departments. Accomplishments include:

- Development and implementation of patient focus delivery systems
- Clinical lead for inpatient and outpatient units, ED renovations and construction
- Participated in building of new bed tower
- Facilitated throughput teams to expedite patient flow and decrease LOS by 16%
- Increased Emergency Department (NPS) patient satisfaction in an inner city hospital by 41%
- Decreased RN vacancy rate by 22%
- Exceeded goal for pressure ulcer rate by 44%
- Eliminated use of restraints in medical/surgical units and exceeded goal for decrease use in critical care by 69%
- Other quality matrix accomplishments included meeting and exceeding goals for hand washing, pneumococcal vaccine and influenza vaccine
- Achievement of TJC accreditation and licensure
- Implementation of management development program
- Labor management/union negotiations
- Patient care unit construction redesign for patient-centered care, and patient flow
- Preparation and management of annual budget in excess of $44 million
- Decreased use on incremental overtime by 60%
- Decreased use of external agency nurses by 50%
- Achieved productivity standards for staffing
- Organization development and change management
- Work redesign
- Reduced OR room turnover time down to <30 minutes

PROFESSIONAL EXPERIENCE AND ACHIEVEMENTS

HealthLinx Transitional Leadership **2014-2015**

A division of HealthLinx Executive Search, Inc. a healthcare-exclusive consulting and search firm specializing in i) leadership assessment, project management and consulting; ii) the identification and recruitment of permanent management and executive healthcare candidates; and iii) the placement, assistance, and management of transitional leaders.

- **Transitional Leader** -December 2014-April 2015
  Interim Director Professional Practice and Nursing Development (December 2014-April 2015)
  Mount Carmel East Hospital, Columbus Ohio
- As a transitional leader, deliverables included i) validate the recently developed on-boarding plan and provide opportunity for improvement with particular focus on new graduate nurses, medical/surgical, critical care and Emergency Department nurses; ii) assess Clinical Education Department, resource allocation, clinical education staff competency and staff competency assessment model for the Hospital; and iii) assess Shared Governance Model with particular

focus on practice council, support structure and current functioning. Selected accomplishments included,

Ascension Health System **2006-2013**

A national healthcare provider in more than 1400 locations in 23 states and District of Columbia rooted in the loving ministry of Jesus as healer and is committed to serving all persons with special attention to those who are poor and vulnerable.

- **Senior Vice President Patient Care Services/CNO (2010-2013)**
  Providence Hospital, Washington DC
  A 408 bed teaching hospital with ADC of 200 inpatients and 40 behavioral health inpatients, offering medical graduate teaching and serving as a rotational site for domestic and international nursing students. Located in northeast District of Columbia with an average of 45,000 ED visits annually. Other specialties include Diabetes, Certified Stroke Center, Bariatric Services and Wellness Programs, Cardiology, Orthopedics, Sleep Wellness and Geriatric Medicine. As SVP/CNO, reported to president/CEO. Responsibilities included management of total operating budget of >$47 million, staff of >600 FTEs, re-design of throughput processes for main hospital portals (IP and OP surgery, and ED), implemented mid-level leadership development and performance standards for accountability. Selected accomplishments included:
    - decreased RN vacancy rate from >9% to 7%
    - decreased LOS from >5 to 4.2 days
    - eliminated use of agency RNs by 50%
    - decreased ED patient throughput by 30%
    - increased ED patient satisfaction from 32% to 54%

- **Vice President, Inpatient Services (2006-2010)**
  Saint Agnes Hospital, Baltimore, Maryland
  A 296 bed full service teaching hospital with residency program and student nurse rotation serving the greater Baltimore area, located in southwest Baltimore serving diverse communities, with ED visits >82,000. Clinical areas of specialties include Cancer Care, Metabolic, Cardiovascular, Women's & Children's Health, Orthopedic & Spine, Plastic & Reconstructive Surgeries, Stroke, Chest Pain Emergency Program. As VP, reported to senior vice president/CNE. Responsibilities included management of inpatient medical/surgical and critical care units, Nursing Operations (House Supervisors, staff float pool, Nursing Office), Care Management, Nursing Education and Development, management of operating budget of >$25 million, and staff of >200 FTEs, and nursing shared decision making and professional development programs. Selected accomplishments included;
    - decreased LOS from 4.49FYTD July 2008 to 3.95 FYTD May 2010
    - developed and implemented RN Professional Clinical Ladder Program
    - facilitated implementation of nursing leadership academy
    - facilitated strategies in preparation of ANCC magnet designation
    - facilitated nursing clinical research with the first NRB approved nursing research study

Senior Director of Nursing **2003-2006**

Mercy Medical Center, Baltimore, Maryland

A 299 bed teaching ANCC Magnet Designated Hospital located in downtown Baltimore with ED visits >62,000 annually. Clinical specialties include Cancer Care, Diabetic & Endocrine, Gastroenterology & GI Surgeries, Geriatrics, Gynecology, Nephrology, Orthopedic and Pulmonology. As senior director, reported senior vice president/CNE. Responsibilities included management of inpatient medical/surgical units, inpatient substance abuse unit, and OP Chemotherapy, management of operating budget of >$10 million and staff of >250 FTEs. Selected accomplishments included:

- developed nursing management and leadership structure of responsibility and accountability
- managed and lead managers through radical change of re-structuring of responsibilities and accountability
- lead coordination, development and implementation of RN clinical ladder for professional practice
- served as interim VP Patient Care Services
- began nursing and organizational preparation for magnet designation

Director, Patient Care Service **1996-2003**
MedStar Harbor Hospital, Baltimore, Maryland
A 179 bed community focused hospital located in south Baltimore on Patapsco River with an average of 40,000 ED visits annually. Clinical specialties include Internal Medicine, Orthopedic, Oncology, Sports Medicine, Back & Spine, and Women's Service. Mission is to provide a quality, caring experience for patients, communities and those who serve with a patient centered care philosophy. As director, reported to vice president/CNO. Responsibilities included management of inpatient medical/surgical units, critical care and Women's Health. Selected accomplishments included:

- facilitated transition from traditional patient care delivery to patient centered care model
- clinically designed, planned and implemented several patient centered care units with external construction team
- chaired Human Resource Design work team for MedStar transition for recruitment, selection, orientation and retention
- co-chaired work re-design team for Hospital-wide patient flow from admission to discharge

ADDITIONAL EXPERIENCES:

- **Vice President, Patient Care Service** **1993-1995**
  Greater Southeast Community Hospital, Washington DC
  A 400 bed acute care community hospital located in southeast Washington DC serving Prince George's County Maryland communities and southeast Washington DC. As vice president reported to president/CEO. Responsible for all nursing services with select accomplishments that included
  -implementation of position control system
  -expansion of home health services which increased visits by 20%
  -reduced management positions by 40%

- **Assistant Executive Director** **1991-1993**
  Howard University Hospital, Washington DC
  A comprehensive and academic teaching hospital located on campus of Howard University in District of Columbia. Level I Trauma Center with average of 60,000 ED visits annually, performing kidney and liver transplants. As assistant executive director, reported to COO and responsible for all nursing services and nurse management team member for labor contract negotiations.

EDUCATION AND DEVELOPMENT

- Class of 2010 *The Leadership Program of the Greater Baltimore Corporate*
- MBA, University of Baltimore, Baltimore Maryland
- MS Human Development, Howard University, Washington DC
- BSN, Howard University, Washington DC
- Diploma in Nursing, Freedmen's Hospital School of Nursing, Washington DC

LICENSURE AND CERTIFICATION

- RN, District of Columbia #R29886
- RN, Maryland #R128737

- RN, Ohio #RN412755
- NEA-BC #2009013543

Exhibit 3(c)

CANDICE PETERS, R.N., B.S., MS

[redacted]

EXPERIENCE

KINDRED HEALTH CARE – HOSPITAL DIVISION – WEST REGION – WESTMINSTER, CA.
SENIOR DIRECTOR CLINICAL OPERATIONS (FEB 2009 – CURRENT)
Kindred is an acute long-term hospital caring for catastrophically ill and medically complex patients. Direct Oversight of 7-13 hospitals providing long term acute care (LTAC) in California. Ensured The Joint Commission accreditation for all assigned hospitals; assisted operations support, Quality and Regulator Review (Joint Commission and CMS survey preparation). In 2014 ensured 7 hospitals that were reviewed were re-accredited Joint Commission. Ensured 2 hospitals (2013 and 2015) achieved first time JC Accreditation. Assisted two hospitals successfully though CMS condition out to achieve full conditions. Serves as an active Governing Board member to multiple Kindred hospitals. Able to review and prepare facilities for both Laboratory and Hospital Joint Commission accreditation.

CONVERGENCE HEALTH CONSULTING, INC.
SENIOR CONSULTANT (JULY 2007- FEB 2009)
ANAHEIM MEMORIAL MEDICAL CENTER – INTERIM CONSULTING POSITION AS RISK MANAGER – Interim Risk Manager to develop complaint and grievance process to meet CMS requirements; continued to fill position as the Risk Manager. AMMC was in the process of a sale. In Oct. advanced to Chief Nursing Officer.

KINDRED HEALTH CARE
REGIONAL DIRECTOR CLINICAL OPERATIONS (2004-2007)
Promoted from COO role (see next)
Had direct oversight over 6 hospitals in the West Region. Assisted all 24 facilities in the West Region as needed for operations support, plan implementation, developing plans of correction. Ensured Joint Commission re-accreditation of 3 facilities that experienced a denial of accreditation. Assisted 2 other facilities in Conditional Accreditation to achieve full Joint Commission accreditation. Assisted one hospital in Joint Commission re-accreditation.

KINDRED HOSPITAL ONTARIO
CHIEF OPERATIONS OFFICER (1996 –SEPTEMBER, 2004)
Had responsibility for all clinical areas including Nursing, Pulmonary, Rehabilitation, Dietary, Radiology, Laboratory, Housekeeping, Social Services, Surgery, Infection Control, Employee Health and Pharmacy.
Chair multiple committees including Quality Council, Policy and Procedure, Employee Activities, Bioethics, Environment of Care, ICU and Medical Records committees. Member of Medical Executive Committee and Governing Board. Served as interim CEO for 8 months until CEO was recruited.

ST. BERNARDINE MEDICAL CENTER, SAN BERNARDINO, CALIFORNIA
Director Patient Care Services (1989-1996)
Started as a manager in 1989 for a 17 bed Intensive Care Unit and 12 bed Coronary Care Unit. In 1992 became Director of Nurses, reporting to the Chief Nurse Executive. Areas included ICU/CCU, Telemetry, Intermediate Care, Medical-Surgical Units, Peri-Operative Surgery, Out Patient Surgery Center, Central Supply, Diabetes Health Services, Hemodialysis and Nursing Services. (1994). Included responsibility for 250 FTE's and 10 managers. Chaired Nursing Policy and Procedure Committee. Active on multiple committees, including Quality Council, Medical Staff Committees, such as ICU and Surgery Committees.

QUEEN OF THE VALLEY HOSPITAL, WEST COVINA, CALIFORNIA
Unit Coordinator, 1981-1989
Manager for the Intermediate Care Unit, an18 bed unit with telemetry monitoring. Responsibilities included interviewing, hiring, firing and counseling. Coordinated patient care and other activities. Worked as staff nurse in the same area for the first three years. Also covered House Supervisor Position.

SANTA TERESITA HOSPITAL, DUARTE CALIFORNIA
Paramedic Liaison Nurse, 1976-1981
Worked as staff nurse in the Emergency Department for the first three years. Promoted to Paramedic Liaison Nurse. Created and developed this position based on L.A. County Health Services Guidelines. Coordinated paramedic and mobile intensive nurse (MICN) training.

LIFE FLIGHT OF SOUTHERN CALIFORNIA
Flight Nurse, Fixed Wing, 1978-1983

HURON ROAD HOSPITAL, E. CLEVELAND OHIO
Circulating and Scrub Nurse, 1974-1976

EDUCATION

CAL STATE UNIVERSITY, SAN BERNARDINO *Masters of Science in Health Services Administration, 1997*

SOUTHERN ILLINOIS UNIVERSITY, CARBONDALE INDIANA
Bachelor of Science in Health Care Management, 1989

HURON ROAD HOSPITAL SCHOOL OF NURSING, EAST CLEVELAND, OHIO
Diploma, Registered Nurse, 1974

4. **Corrective Action Plan for Los Angeles Community Hospital (Responding to Deficiencies Cited as a result of Resurvey Conducted February 16-17, 2016)**

Please see attached for requested Corrective Action Plan. Also attached is an additional Corrective Action Plan filed in response to a CMS Form 2567 received on April 12, 2016 by Los Angeles Community Hospital. The deficiencies cited therein related to a third-party dialysis provider who has since been terminated.

Alta Los Angeles Hospitals, Inc.

Alta Hospitals
SYSTEM, LLC

Los Angeles Community Hospital
4081 East Olympic Blvd.
Los Angeles, CA 90023
(323) 267-0477
(323) 261-0809 Fax

Los Angeles Community Hospital at Bellflower
9542 Artesia Blvd.
Bellflower, CA 90706
(562) 273-1800
(562) 273-1818 Fax

Los Angeles Community Hospital at Norwalk
13222 Bloomfield Avenue
Norwalk, CA 90650
(562) 863-4763
(562) 207-9721 Fax

VIA FEDERAL EXPRESS

April 6, 2016

Rufus Arther
Branch Manager, Non-Long Term Care
Department of Health and Human Services
Centers for Medicare & Medicaid Services
Survey & Certification Operations
90 7th Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

Re: Los Angeles Community Hospital (CCN: 050663)
Complaint Validation Resurvey 02/17/16
Credible Allegation of Compliance

Dear Mr. Arther:

Pursuant to the CMS letter, dated March 23, 2016, enclosed please find Los Angeles Community Hospital's (the "Hospital") timely submission of its credible allegation of compliance for the above-referenced survey.[1] The Hospital takes great pride in delivering quality health care services to the community and on its compliance with the Medicare Conditions of Participation. A copy of this letter and the credible allegation of compliance have been delivered to the Bakersfield District Office of the California Department of Public Health.

Thank you for your attention to this matter. Please contact me at 323-881-2600 if you have any questions or concerns.

Sincerely,

Deborah Webber
Chief Executive Officer

Enclosure
cc: California Department of Public Health, Bakersfield District Office (*via federal express*)

[1] Ms. Angeldones graciously granted an extension to respond by April 7, 2016.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050563	A. BUILDING _____ B. WING _____	R-C 02/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOS ANGELES COMMUNITY HOSPITAL	4081 E OLYMPIC BLVD LOS ANGELES, CA 90023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(A 000)	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a First Revisit Complaint Validation survey. Complaint Number: 462024 Representing the Department: 18790, HFEN 21905, HFEN 32233, HFEN 33399, Infection Control Consultant 22711, Medical Consultant Census was 132 Sample Size was 31 patients	(A 000)	A000 Initial Comments Preparation and execution of this plan of correction does not constitute an admission or agreement of the facts alleged or conclusions set forth on the Statement of Deficiencies. This plan of correction is prepared and executed solely because it is required by federal and state law. The following constitutes Los Angeles Community Hospital's credible allegation of compliance.	
(A 131)	482.13(b)(2) PATIENT RIGHTS: INFORMED CONSENT The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the hospital failed to obtain adequate informed consents for three of 31 sampled patients (28, 44 and 45). This has the potential for the patients or the patients' responsible	(A 131)	A 131 482.13(b)(2) Patient Rights: Informed Consent	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deborah Weinstein — TITLE: Chief Executive Officer — (X6) DATE: 04/06/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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{A 131}	Continued From page 1 parties to be unaware of potential risks versus benefits of a proposed treatment prior to consent to the treatment. Findings: 1. During an interview and review of the clinical record of Patient 28 on 2/17/16, at 9:30 AM, the admission record documented she was re-admitted to the sub acute care unit on 1/27/16. It was noted she signed her hemodialysis (a treatment in which a machine filters wastes, salts and fluid from your blood when your kidneys are no longer healthy enough to do this adequately) consent on 1/27/16. It was illegible, but the nurse who witnessed it (Registered Nurse [RN] 7) stated she had obtained Patient 28's signature indicating informed consent. There was another consent for Prozac (antidepressant medication), dated 1/27/16. The signature for the antidepressant consent was different from the markings on the hemodialysis consent. RN 7 stated, "The physician signed that one." During an observation and interview on 2/17/16, at 10 AM, Patient 28 was lying in bed, breathing with a ventilator (breathing machine) connected to a tracheotomy (a surgically created hole through the front of a person's neck to the windpipe [trachea] which provides an air passage to help a person breathe and is often needed with long term ventilator use) and formula connected to Patient 28's feeding tube (a tube that is placed either through the nose and passed through the windpipe down to the stomach or directly to the stomach to provide liquid nutrition). Patient 28 did not wake up when spoken to. During another observation of Patient 28 with RN 7 and Licensed Vocational Nurse (LVN) 1 at 11:15 AM, RN 7	{A 131}	Findings 1-3: Immediate Actions Taken: 1. The Assistant Chief Nursing Officer (ACNO) discussed the survey findings with RN 7, with special emphasis on evaluating whether the patient is able to understand/sign the informed consent and steps to take if the patient cannot, including escalation to the ethics committee, as appropriate. Subsequent Actions Taken: 1. The Chief Executive Officer (CEO) and Nursing Leadership discussed the survey findings. The "Consent/Informed Consent" policy was reviewed and revised to align with current practice. Informed Consent is required for those procedures which are complex or involve material risks that are not commonly understood. The patient's physician is responsible for providing the	2/17/16 4/7/16

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{A 131}	Continued From page 2 physically touched the patient and encouraged her to answer questions. Patient 28's speech was difficult to understand and what could be understood did not seem to make a sentence. RN 7 was unable to identify what Patient 28 said with the approximately 6-8 words spoken. During a review of the clinical record of Patient 28, a son was listed by name and a telephone number documented. The Minimum Data Set (MDS, an assessment tool) identified Patient 28's cognitive (ability to think, remember, and understand the environment) status on 9/3/15, as "Severely impaired--never/rarely made decisions." The MDS assessment dated 12/4/15, identified her cognitive status as severely impaired. RN 7 was asked if there was a re-assessment upon admission on 1/27/16. RN 7 stated, "No. Because she hadn't changed." RN 7 was asked if Patient 28's son could give consent. She replied, "The son doesn't return phone calls. Sometimes he's in jail. That's why he doesn't give his consent." RN 7 was asked how she could assess this patient in regards to obtaining an informed consent. RN 7 stated, "I talk to her and she seems to understand. Sometimes we can read her lips." The hospital policy and procedure titled "Consent/Informed Consent" dated 1/2014, indicated: "...Policy:...1. Capacity to Consent. A person may give a valid consent only if he or she has 'capacity' which means he or she is able to understand the nature and consequence of a decision and to make and communicate the decision... If an adult lacks the capacity to make medical decisions, a surrogate decision-maker must be identified... iv. The hospital will establish a multi-disciplinary committee as a subcommittee	{A 131}	information the patient/representative needs in order to make an informed decision and for obtaining the patient's informed consent or refusal for the recommended procedure. A person may give a valid consent only if he/she has capacity, which means he/she is able to understand the nature and consequence of a decision and to make and communicate the decision. If an adult lacks the capacity to make medical decision, a surrogate decision-maker will be identified. Except in emergency situations, issues with obtaining an informed consent from the patient/representative will be addressed by the Ethics Committee. The hospital's role in the informed consent process is to verify that the physician obtained the patient's informed consent before the procedure. The witness to the patient/representative signing the informed consent form should legibly print his/her name and sign, date/time the document. The Medical Executive Committee (MEC) and Governing Board approved the policy on 3/30/16 policy and completion of the informed consent form. 2. Additionally the hospital's consent form (the document on which the patient's consent is annotated) was reviewed and revised to streamline the narrative, simplify the format and reduce the overall form from six (6) pages to two (2) pages. The hospital elected to maintain a separate consent for blood transfusions and the use of psychotropic medications. The consent form was approved by the MEC and Governing	4/7/16

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{A 131}	Continued From page 3 of the Ethics Committee and delegate to it responsibility for acting as a surrogate decision-maker for patients who have no surrogate decision-maker... 4. 'Informed Consent' is required for those procedures which are complex or involve material risks that are not commonly understood. The patient's physician is responsible for providing the information the patient needs in order to make an informed decision and for obtaining the patient's informed consent or refusal for the recommended procedure. The hospital's role in the informed consent process is to verify that the physician obtained the patient's informed consent before the physician is permitted to perform the procedure..." 2. During a review of the clinical record for Patient 44 and interview with LVN 3, on 2/17/16, at 9:04 AM, the clinical record indicated the patient was admitted on 2/15/16, with an abscess to the left lower extremity. The History and Physical dated 2/15/16, indicated the patient arrived to the Emergency Room (ER) with severe pain and redness to the posterior thigh. The "Assessment and Plan" section indicated the patient had an abscess of the left posterior thigh and a status post incision and drainage (I & D is a minor surgical procedure using a sharp instrument to release the pus and pressure built up under the skin caused by an abscess) was performed to the site. The nursing note dated 2/17/16, at 9:29 AM, read, "Received pt (Patient 44)...Admitting Dx (Diagnosis): cellulitis & abscess on left upper leg...ER nurse stated that pt had I & D at ER..." There was no informed consent noted in the clinical record indicating the physician had described the potential risks and benefits of the treatment prior to performing the I	{A 131}	Board on 3/30/16. Nursing and medical staff were educated on the form, with use of the form implemented by 4/7/16. 3. The Chief of Staff sent a memorandum on 2/26/16 to medical staff practitioners reminding them of the need for a complete informed consent. 4. The Chief of Staff discussed the survey finding related to informed consents at the MEC and Governing Board meetings on 3/30/16. It was emphasized that informed consents are to be complete. A repeat memo was sent to medical staff practitioners emphasizing the need to date and time their signature on the existing consent form. The revised consent form does not require physician signature, the new form requires patient/representative signature and witness signature, as the physician is not required by regulation to sign a consent form. The physician is required to provide the information so the patient can make an informed decision, which the consent form annotates, and which the patient then attests to. 5. Nursing staff is educated on informed consents upon hire and annually. 6. Compliance with informed consents is monitored through the QAPI program. Compliance and Monitoring: The Chief Nursing Officer or qualified designee performs daily reviews of informed consents (Monday through Friday) to achieve the goal of 100% compliance with obtaining complete and well documented informed consents. Data is analyzed and reported	2/26/16 3/30/16

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{A 131}	Continued From page 4 & D to the patient's abscess site. LVN 3 confirmed there was no informed consent obtained prior to the procedure, although there should have been one obtained. 3. During an observation on 2/17/16, at 9:44 AM, in the Intensive Care Unit, Patient 45 was observed with a tracheostomy attached to a ventilator. During a review of the clinical record and interview with LVN 3, on 2/17/16, at 10 AM, an informed consent document was noted for the tracheostomy placement signed on 2/11/16. The document was incomplete which was confirmed by LVN 3. No additional information was provided. The hospital policy and procedure titled "Consent/Informed Consent" dated 1/2014, indicated under the POLICY subheading, "...4. Informed Consent is required for those procedures which are complex or involve material risks that are not commonly understood. The patient's physician is responsible for providing the information the patient needs in order to make an informed decision and for obtaining the patient's informed consent or refusal for the recommended procedure. The hospital's role in the informed consent process is to verify that the physician obtained the patient's informed consent before the physician is permitted to perform the procedure..." Also under the subheading titled, Documenting Informed Consent it reads in part, "The doctor will complete the information in the Consent...form or provide the information... The patient's physician must document in the patient record that he or she has conveyed the information required for an informed decision..."	{A 131}	monthly to the Quality Council and MEC, and at least every other month to the Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will continue until the Quality Council determines sustained compliance has occurred, at which time the Council will provide direction on what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Person Responsible: Chief Nursing Officer	

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{A 385}	482.23 NURSING SERVICES The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by: Based on observation, interview and record review, the hospital failed to ensure: 1. One sampled patient who was waiting in the hallway on an ambulance gurney for a bed in the Urgent Care for 4 hours to receive a nursing re-evaluation or check during his wait. (Refer to A 395, item 1) 2. Five call lights were observed not functioning (Room 111C, 111D, 111F, 111G, 105A) as intended and three call lights were not accessible for the patients to use in Room 111B, 110B, and 110C. (Refer to A 395, item 2) 3. The physician's orders were followed for two sampled patients. (Refer to A 395, item 3) 4. Nursing was aware of the hospital's policy for the crash cart and ensure one crash cart contained all the contents listed. (Refer to A 395, item 4) 5. Pertinent, individualized nursing care plans were developed for 12 sampled patients. (Refer to A 396) 6. One registered nurse was oriented to the emergency department (ED) when she was transferred there from another department. (Refer to A 397)	{A 385}	A 385 482.23 Nursing Services Executive and Nursing Leadership discussed the nursing survey findings and reviewed applicable policies and procedures to ensure adequacy for promoting and maintaining compliance with reassessing patients in the ED/urgent care, functioning nursing call lights, executing and documenting physician orders, crash carts, individualized nursing care plans, orientation of registry staff, and adequate supervision of contracted nursing personnel. Policies were revised to align with current practices and nursing staff was educated. Hospital Leadership hired a new Director of ICU/ED Services and Director of the Medical/Surgical Units. Monitoring of nursing services is part of the QAPI program and is used for performance improvement measures. Data on compliance is reported through the Quality Council and to the MEC and Governing Board. Finding 1 The identified patient was relocated into the Urgent Care at the time of survey and evaluated by nursing staff. There was no adverse outcome identified. The "Triage Treatment Protocols and Admission in the Emergency Department" policy was reviewed and revised to clarify that a reassessment of the patient is to occur in the Urgent Care/ Emergency Department (ED) based on the acuity of the patient's condition. Urgent Care and ED nursing staff were inserviced on the policy changes. ED and Urgent Care Nurses are educated on performing and	4/7/16 2/26/16 3/28/16 - 4/4/16

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(A 385)	482.23 NURSING SERVICES The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by: Based on observation, interview and record review, the hospital failed to ensure: 1. One sampled patient who was waiting in the hallway on an ambulance gurney for a bed in the Urgent Care for 4 hours to receive a nursing re-evaluation or check during his wait. (Refer to A 395, item 1) 2. Five call lights were observed not functioning (Room 111C, 111D, 111F, 111G, 105A) as intended and three call lights were not accessible for the patients to use in Room 111B, 110B, and 110C. (Refer to A 395, item 2) 3. The physician's orders were followed for two sampled patients. (Refer to A 395, item 3) 4. Nursing was aware of the hospital's policy for the crash cart and ensure one crash cart contained all the contents listed. (Refer to A 395, item 4) 5. Pertinent, individualized nursing care plans were developed for 12 sampled patients. (Refer to A 396) 6. One registered nurse was oriented to the emergency department (ED) when she was transferred there from another department. (Refer to A 397)	(A 385)	documenting patient reassessments upon hire. Compliance with patient reassessments in the ED/Urgent Care is monitored through the QAPI program. Finding 2 Hospital Leadership took immediate action to address the call light findings at the time of survey. All call lights were checked at the L.A. and Norwalk campuses for functionality. The patients at the Norwalk campus with call lights that needed repair were provided with a sitter. The patients at the L.A. campus with call lights that needed repair were relocated to a room with a functioning call light. Nursing Leadership assessed all patients at the time of survey to ensure that functioning call lights were within reach of the patient. Hospital Leadership reviewed the "Reporting Malfunction" policy, which did not require any revisions. It was also identified that there was an existing policy related to the nurse call system. The policy, entitled "Utility Disruption: Nurse Call System" policy, was reviewed and revised to align with current practice in the event of a disruption in the nurse call light system. Upon identification of a malfunctioning call light, the staff is to immediately notify the Director of Engineering or designee and the House Supervisor. The Engineering Department will take the necessary steps to correct any failures of the call light system or notify the proper service or persons when the repair is beyond their capabilities. The Engineering Department will notify the applicable Department Manager or designee	2/16/16 3/1/16 - 4/7/16

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	050663	A. BUILDING _____ B. WING _____	R-C 02/17/2016

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(A 385)	Continued From page 6 7. Adequate supervision was provided to one contracted nursing personnel. (Refer to A 398) The cumulative effects of these systemic failures resulted in the hospital's inability to ensure adequate nursing care to meet the needs of the patients.	(A 385)		
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the registered nurses failed to ensure there was adequate supervision when: 1. One of 31 sampled patients (27) was waiting in the hallway on an ambulance gurney for a bed in the Urgent Care for 4 hours with no nursing re-evaluation or check during his wait. This had the potential to result in medical conditions to go untreated. 2. Five call lights were observed not functioning (Room 111C, 111D, 111F, 111G, 105A) as intended and three call lights were not accessible for the patients to use in Room 111B, 110B, and 110C. This had the potential for the patients to be unable to call for required assistance. 3. The physician's orders were not followed for two of 31 sampled patients (38 and 45). This had the potential to result in untreated medical conditions which could result in an overall decline in the patients.	A 395	A 395 482.23(b)(3) RN Supervision of Nursing Care	

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A 395	Continued From page 7 4. Nursing was unaware of the hospital's policy for the crash cart and one crash cart did not contain all the contents listed. This had the potential to result in the emergency personnel to be unaware of the contents and to ensure the crash cart contained all the emergency contents. Findings: 1. During an observation and interview on 2/16/16, at 9 AM, Patient 27 was noted to be lying on an EMT (emergency medical technician) gurney in the hallway directly outside Urgent Care. An ambulance attendant (EMT 1) was sitting next to him. EMT 1 stated he brought Patient 27 to the hospital about 5 AM, and they have been waiting for a bed in the Urgent Care. EMT 1 stated no nurse has re-evaluated Patient 27 or taken the vital signs (blood pressure, pulse, temperature) since their arrival. During an observation and record review on 2/16/2016, at 9:40 AM, the Chief Nursing Officer (CNO) assisted EMT 1 to bring Patient 27 into the Urgent Care. Patient 27's medical record was reviewed and it documented that vital signs had been taken at 5:45 AM and not repeated until 9:30 AM. The registered nurse in charge of the Urgent Care (RN 6) stated patients who were waiting for a bed in the Urgent Care should have their vital signs taken every two hours. The hospital policy and procedure titled "Triage Treatment Protocols and Admission in the Emergency Department", dated 3/2014, indicated: "...2.12 It is the responsibility of the RN to continually reassess the status of those patients who are awaiting disposition to the treatment area ..."	A 395	Finding 1 Immediate Actions Taken: 1. Patient 27 was moved into the Urgent Care at the time of survey and evaluated (including vital signs) by the nursing staff. There was no adverse outcome identified. 2. The CNO and ACNO discussed the survey findings with the Urgent Care staff at the time of survey, with special emphasis on the registered nurse's responsibility to reassess the status of patients awaiting disposition to the treatment area at least every two hours. Subsequent Actions Taken: 1. Hospital Leadership reviewed and revised the "Triage Treatment Protocols and Admission in the Emergency Department" policy to clarify that a reassessment of the patient is to occur in the Urgent Care/ED based on the acuity of the patient's condition. The Policy and Procedure Committee approved the policy on 3/28/16. The MEC and Governing Board approved the policy on 3/30/16. Urgent Care and ED nursing staff were inserviced on the policy. 2. Hospital Leadership hired a new Director of ED and ICU Services, which includes oversight of the Urgent Care.	2/16/16 2/16/16 3/28/16 - 4/4/16 4/4/16

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A 395	Continued From page 8 2a. During an observation and interview with the RN 25 (the charge nurse for the medical surgical unit) and the Certified Nursing Assistant (CNA) 1 on 2/16/16, at 11:46 AM, Room 111 was noted with eight patients. Patient 39 (Room 111) was observed lying in bed G with CNA 1 next to his bed. The patient appeared confused and the call light button was not observed within reach of Patient 39. CNA 1 indicated she removed the call light from the patient because "he is always on it" but he did have it earlier. CNA 1 and RN 25 proceeded to search for the call light. When the call light button was found, the cord was cut at the level of the wall; therefore, could not be accessible for Patient 39 to use. Patient 39 was approximately 2 feet from the call light. RN 25 stated CNA 1 is the assigned staff to care for Patient 39. She was asked how the nurse call system works. She stated the nurse call system includes a button at the wall with a cord that has the call light attached to it. The cord with the call light attached is what is provided to the patient. When the patient presses the red call light, it should be audible and visible above the patient room door and at the nurse's station. During a review of the clinical record for Patient 39 and interview with RN 22, on 2/16/16, at 2 PM, the admitting diagnoses included: Altered Mental Status (AMS), Hypertension (high blood pressure), Diabetes Mellitus (a disease which results in the body's inability to produce enough insulin which results in elevated sugar levels), Abnormal Gait, Dementia and Convulsions. The care plan problem list included a care plan for patient's risk for harming himself, a care plan for pain and a care plan of fall. The fall care plan included an intervention which indicated, "...call	A 395	Finding 2 a-f Immediate Actions Taken: 1. Hospital Leadership took immediate action to address the call light findings at the time of survey. All call lights were checked at the L.A. and Norwalk campuses for functionality. The patients at the Norwalk campus with call lights that needed repair were provided with a sitter. The patients at the L.A. campus with call lights that needed repair were relocated to a room with a functioning call light. 2. Hospital Leadership notified the House Supervisors that patients were only allowed to be in a room with a call light that needed repair if the patient was provided with a sitter. Otherwise, the bed was to be closed and not for patient use. 3. Nursing Leadership assessed all patients at the time of survey to ensure that functioning call lights were within reach of the patient. Nursing staff was reeducated at the time of survey that call lights are to be within the patient's reach. Subsequent Actions Taken: 1. Hospital Leadership discussed the survey findings. The "Reporting Malfunction" policy was reviewed and did not require any revisions. It was also identified that there was an existing policy related to the nurse call system. The policy, entitled "Utility Disruption: Nurse Call System" policy, was reviewed and revised to align with current practice in the event of a disruption in the nurse call light system. Upon identification of a malfunctioning call light, the staff is to	2/16/16 2/16/16 2/16/16 3/1/16 - 4/7/16

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A 395	Continued From page 9 bell within reach..." 2b. During an observation of Room 111 Bed B with RN 25, on 2/16/16, at 11:50 AM, the call light was not noted accessible to Patient 42 who was lying in bed. RN 25 proceeded to search for the call light, which was found on the floor. During a review of the clinical record for Patient 42 with RN 22 and the Assistant Chief Nursing Officer (ACNO), on 2/16/16, at 2:50 PM, the patient was admitted on 2/11/16 with admitting diagnoses of Gastrointestinal (relating to the stomach or intestines) Bleed, Gastric Cancer and Anemia (a condition where you do not have enough healthy red blood cells to carry adequate oxygen to the body's tissue which can can cause weakness, fatigue and dizziness). Additional diagnoses included Failure to Thrive (FTT used to define faultering weight to indicate insufficient weight gain), nausea and vomiting, Schizophrenia (mental disorder), Diabetes, Gastritis (inflammation of the lining of the stomach), and Gastroesophageal Reflux Disease (a chronic digestive disorder which results in the stomach acid to flow back up through the food pipe [esophagus]). The care plan list was reviewed and there was a care plan which addressed his fall risk with an intervention to assist the patient from falling included "...call bell within reach..." A care plan was also developed due to the patient being harmful to himself due to the patient being impulsive and wandering tendencies and an intervention to assist the patient from harming himself is to "ensure safe environment". 2c. During an observation of Room 111 Bed C with RN 25, on 2/16/16, at 11:50 AM, Patient 43 was observed lying in bed. The call light was non	A 395	immediately notify the Director of Engineering or designee and the House Supervisor. The Engineering Department will take the necessary steps to correct any failures of the call light system or notify the proper service or persons when the repair is beyond their capabilities. The Engineering Department will notify the applicable Department Manager or designee as to when the call light will be repaired. Nursing shall notify the patient(s) when there is an issue with the call system. Patients affected by the call light outage will be assigned a sitter per room or be relocated to a bed with an operational call light. The MEC and Governing Board approved the policy on 3/30/16. Nursing staff was inserviced on the policy, with special emphasis on how to report a non-functioning call light, assigning a sitter if a call light is not functioning, and placing call lights within a patient's reach. Engineering staff was also educated on the revised policy. 2. Hospital Leadership posted a "Be Sure to Know" Poster at each nursing station that details the process for reporting of equipment malfunction. If the repair is an emergency, such as the nurse call system, the staff is to institute emergency procedures to ensure patient care is not compromised, including paging Engineer to report the malfunction and contacting the Nursing Supervisor for assistance in relocating the patient or assigning a sitter. This poster is to serve a dual purpose; to increase awareness of the nurse to the patient's lack of communication when call	4/7/16

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A 395	Continued From page 10 functioning with no audible sound above the room door or at the nurse's station. During a review of the clinical record for Patient 43 with RN 22 and the ACNO, on 2/16/16, at 3:20 PM, the patient was admitted on 2/14/16 with diagnoses of Mysitis (inflammation and degeneration of the muscle tissue), difficulty walking, and diabetes. A care plan problem was noted for fall risk with an intervention which included "call bell within reach". 2d. During an observation of Room 105 Bed A with RN 25, on 2/16/16, at 12 PM, Patient 41 was observed sitting at the edge of the bed with a lunch tray on the bedside table. When the call light was pressed to determine if it was functioning as intended, the call light was not audible or visible above the room door or at the nurse's station. Patient 41 stated, she thought the call light was broken when she called last night and no one came. During an interview with Patient 41, on 2/16/16, at 1:38 PM, she stated she used the call light last night to get assistance to the bathroom. Patient 41 was asked how long she waited, but she was unsure. When no one came to her room, she walked to the door to ask for assistance. She said she used the call light again today to ask for a brief, but RN 22 entered the room as she was using her call light. During a review of the clinical record for Patient 41 with RN 22 and the ACNO, on 2/16/16, at 2:40 PM, the patient was admitted on 2/14/16 for complaints of abdominal pain. The care plan problem list was reviewed and it included a fall care plan. The interventions included "...call bell	A 395	lights are not available and to instruct the nurse on instituting the process for call light repair. 3. The hospital purchased 40 additional call lights to be available as needed for replacements. The Director of Engineering is responsible for ensuring that an adequate number of call lights are available in the event that replacements are necessary. 4. Hospital Leadership met with an outside vendor regarding replacing the existing call light system. An OSHPD project number was obtained (No. S160776-19 for the Norwalk Campus and No. S160777-19 for the L.A. Community campus). 5. Compliance with call lights functioning and within patient reach is monitored through the QAPI program. <u>Compliance and Monitoring:</u> The Director of Engineering or qualified designee makes rounds daily on all patient care units to ensure the call lights are functioning. Corrective action is taken as necessary, including relocating the patient/or obtaining a sitter for the patient room until the call light is repaired. In addition, the CNO or qualified designee makes daily observation rounds in each patient environment to ensure that call lights are within the patient's reach. Corrective action is taken, including just-in-time training with the nurse and relocating the call light within the patient's reach. Data is analyzed and reported monthly to the Quality Council and MEC, and at least every other month to the Governing Board until sustained compliance	3/28/16 3/31/16

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A 395	Continued From page 11 within reach..." 2e. During an observation of Patient 40 with RN 25, on 2/16/16, at 11:55 AM, in Room 110 Bed C, the patient was observed lying in bed. A call light to contact the nurse was not noted within reach of the patient. The patient was asked if she had a call light that could be used to call the nurse. As she felt around her bed, she was unable to locate a call light. She stated she was unable to see due to being "Legally Blind and (having) Macular Degeneration (an eye disease that progressively causes severe vision loss)". RN 25 proceeded to feel around the bed for the call light, which was then given to the patient. After being given the call light, Patient 40 proceeded to demonstrate she could use the call light. During a review of the clinical record of Patient 40 and interview with RN 25, on 2/16/16, at 2:15 PM, Patient 40 was admitted on 2/15/16. The care plan list was reviewed. A care plan was developed for the patient's fall risk due to her age, and unfamiliar environment. An intervention for the fall risk care plan included "call bell within reach..." 2f. During an observation of the Medical Surgical unit with RN 25, on 2/16/16, at 11:46 AM to 11:55 AM, in addition to the above call light issues, the following was noted: Room 111 Bed F, the call light cord which extended to the patient, had no button at the end of the call light cord to use; therefore, the call light could not be used as intended. Room 111 Bed D, the call light was non functioning with no audible sound above the room	A 395	is achieved and process control is demonstrated. Ongoing monitoring will continue until the Quality Council determines sustained compliance has occurred, at which time the Council will provide direction on what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Persons Responsible: Chief Nursing Officer Director of Engineering	

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A 395	Continued From page 12 door or at the nurse's station. Room 110 Bed B, the call light was on the bedside table and not accessible to the patient. During an interview with RN 25, on 2/16/16, at 11:50 AM, she was asked how long have the call lights not been functioning as intended. She stated, they have not been working "on and off" but did not indicate a specific time frame. She was asked the process when repair of equipment, such as the call lights, is required. She stated, a "work order is generated" which goes directly to the maintenance/engineering department. She was not certain whether a work order request was generated and sent to the maintenance/engineering department for the nonfunctioning call lights. During an interview with Engineer Staff 1, on 2/16/16, at 11:52 AM, he stated the maintenance department was aware of the nonfunctioning call lights in Room 111, but the call lights have been on back order for approximately six days. He stated they have no extra call lights available for patient use. During an interview with the ACNO, on 2/16/16, at 1:33 PM, she stated, "I didn't know (referring to being aware the call lights have not been working)." She indicated the problem should have been brought to her attention and was not. She was asked to provide the policy and procedure for the nurse call system and the nurses' responsibility. During a subsequent interview with the ACNO, on 2/16/16, at 3:26 PM, after reviewing the hospital's policies and procedures, she stated they had no policy and procedure for the nurse call system/call light	A 395		

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A 395	Continued From page 13 system and the nurses' responsibility. During an interview with Director of Plant Operations, on 2/16/16, at 1:40 PM, he stated ES 1 informed him of the nonfunctioning call lights. He was informed the call lights have not been functioning for 1 to 1 1/2 weeks. Because he did not know the type of call lights to order from the vendor, no call light replacements had been ordered. He acknowledged there was no work order request for the nonfunctioning call lights for Room 111 or 105. The hospital policy and procedure titled, "Reporting malfunction" effective date 6/15/09, indicated in part, "Equipment Malfunctions - Patient Care Equipment...When a malfunction is evident, the following steps should be taken...Double check procedure techniques to ascertain whether there is a true malfunction... If the malfunction continues to occur, call the Engineering department and inform them of the problem..." 3a. During a review of the clinical record for Patient 38, with RN 25, on 2/16/16, at 10:36 AM, the patient was admitted with diagnoses of cellulitis to the left foot and right big toe wound. In addition he was diagnosed with Diabetes with a physician's order to monitor blood sugars AC&HS (before each meal and at hour of sleep) and administer insulin as needed depending on the blood sugar results. A review of the blood sugar results in the clinical record showed the blood sugars were not monitored as ordered. RN 25 confirmed the blood sugars were not monitored as ordered. No further information was provided. 3b. During a review of the clinical record for	A 395	Finding 3 a – c Immediate Actions Taken: 1. Nursing Leadership reviewed Patient 38's findings and it was determined that nursing staff performed the blood sugar checks but had not documented it. There was no adverse outcome identified. The nurse was educated on documenting blood sugar results as soon as they are received. 2. The ACNO discussed the survey finding with patient 45's nurse, with emphasis on complying with physician orders and documenting care.	2/16/16 2/17/16

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A 395	Continued From page 14 Patient 45 and interview with Licensed Vocational Nurse (LVN) 3, on 2/17/16, at 9:30 AM, the physician's orders were noted. A physician's order dated 2/1/16, for nasogastric tube (NGT) feeding (a flexible tube that is passed through the nose to the stomach to provide nutrition for patients who are unable to take sufficient nutrition orally) at 45 cc/hr (cubic centimeters per hour) was noted. In addition to the order for the liquid nutrition to be taken via the NGT, there was an order for 200 cc's of water every six hours for a total of 800 cc's/24 hr of water daily. From 2/10/16 to 2/16/16, there was insufficient documented evidence the additional 800 cc's of water were provided as ordered. LVN 3 validated the findings. 3c. During a review of the clinical record for Patient 45 and interview with LVN 3, on 2/17/16, at 9:30 AM, the physician's orders were noted. A physician's order was noted to notify the physician if the blood sugar result was less than 60 milligrams per deciliter (mg/dl). On 2/15/16, at 6 PM, the blood sugar was 58 and there was no documented evidence the physician was notified. No further evidence was provided. 4a. During an observation in the emergency room, on 2/16/16, at 9 AM, with RN 26 (Nursing Supervisor), ACNO, and RN 16, the adult crash cart was noted with a red lock on it. A list of the contents was requested. RN 16 and RN 26 stated there is no list of contents, each drawer has a sticker with the list of contents on the sticker. The font size of the content sticker was difficult to read. On the top of the crash cart a sticker read "top of cart to side" included the ambu-bag. After searching for the ambu bag it was noted on another crash cart. The third	A 395	Subsequent Actions Taken: 1. Nursing Leadership discussed the survey findings and determined that nursing staff would benefit from "back to basics" education on following physician orders and documenting such action in the medical record. An end-of-shift chart review was instituted whereby each nurse is required to review all orders received during his/her shift and ensure these are noted and completed (carried out) accordingly. Nursing staff was reeducated via formal inservices, daily huddles (Monday through Friday) and 1:1 instruction. 2. Nursing Leadership developed a "Nursing Tip List," which is a reminder list for nurses to review and complete physician orders and document evidence of such in the medical record. 3. Compliance with following physician orders and documenting care/services rendered in the medical record is monitored through the QAPI program.	2/19/16 – 4/7/16 3/28/16

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A 395	Continued From page 14 Patient 45 and interview with Licensed Vocational Nurse (LVN) 3, on 2/17/16, at 9:30 AM, the physician's orders were noted. A physician's order dated 2/1/16, for nasogastric tube (NGT) feeding (a flexible tube that is passed through the nose to the stomach to provide nutrition for patients who are unable to take sufficient nutrition orally) at 45 cc/hr (cubic centimeters per hour) was noted. In addition to the order for the liquid nutrition to be taken via the NGT, there was an order for 200 cc's of water every six hours for a total of 800 cc's/24 hr of water daily. From 2/10/16 to 2/16/16, there was insufficient documented evidence the additional 800 cc's of water were provided as ordered. LVN 3 validated the findings. 3c. During a review of the clinical record for Patient 45 and interview with LVN 3, on 2/17/16, at 9:30 AM, the physician's orders were noted. A physician's order was noted to notify the physician if the blood sugar result was less than 60 milligrams per deciliter (mg/dl). On 2/15/16, at 6 PM, the blood sugar was 58 and there was no documented evidence the physician was notified. No further evidence was provided. 4a. During an observation in the emergency room, on 2/16/16, at 9 AM, with RN 26 (Nursing Supervisor), ACNO, and RN 16, the adult crash cart was noted with a red lock on it. A list of the contents was requested. RN 16 and RN 26 stated there is no list of contents, each drawer has a sticker with the list of contents on the sticker. The font size of the content sticker was difficult to read. On the top of the crash cart a sticker read "top of cart to side" included the ambu-bag. After searching for the ambu bag it was noted on another crash cart. The third	A 395	Compliance and Monitoring The Chief Nursing Officer or qualified designee shall review at least 20 records weekly to achieve the goal of 100% compliance with following physician orders and documenting execution of such orders in the medical record. Corrective action is taken, including nursing re-education. Data is analyzed and reported monthly to the Quality Council and MEC, and at least every other month to the Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will continue until the Quality Council determines sustained compliance has occurred, at which time the Council will provide direction on what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Person Responsible: Chief Nursing Officer Finding 4 a –b Immediate Actions Taken: 1. The identified crash carts were checked for necessary supplies in accordance with the crash cart content list. Subsequent Actions Taken: 1. Nursing Leadership reviewed and revised the "Crash Cart" policy to align with current practice. The crash carts are sealed with a tamper resistant breakaway lock and	2/16/16 4/7/16

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A 395	Continued From page 15 drawer's sticker was partially torn off making it difficult to determine the exact contents of the third drawer. At 9:12 AM, the pediatric cart was observed. The pediatric crash cart had nine drawers with each drawer secured with blue plastic lock. It also had each drawer with a sticker indicating the contents inside the drawer. The bottom drawer of the cart indicated there was a "Medication Tray" and 2 IV (intravenous) start kits, 2 - extension sets, 2 - tuberculin syringes, 2 - 5 cc syringes, IV catheters including 2 - 24 gauge (g), 2 - 20 g, 2 - 22 g, 2 - 18 gauge. There were no IV start kits, no extension sets, no tuberculin syringes, no 5 cc syringes, no IV catheters of any size. This was validated by RN 26 and the ACNO. RN 26 stated, maybe it was mislabeled. When RN 26, was asked what happens to ensure the contents of the crash carts gets restocked and what happens to secure the contents of the crash carts until they are restocked. She stated the adult crash cart is secured after the central supply staff restocks it. The central supply staff places a green plastic lock which notifies staff it is ready for pharmacy to secure it and is ready and is fully stocked. She was unable to indicate what happens to the pediatric crash cart when the cart is opened to ensure it is secured until the contents are restocked. RN 26 stated, "once opened no way to secure .." 4b. During an observation and interview with ACNO and RN 28 (Charge Nurse to the Intensive Care Unit [ICU] and the telemetry unit), on 2/16/16, at 9:54 AM, an adult crash cart was noted in the telemetry hallway. The crash cart also had a sticker on each drawer identifying the content of each drawer. RN 28 was asked the process when the items in the crash cart are used. RN 28 stated, if the crash cart is opened	A 395	assigned a log number. As detailed in the policy, any time that a crash cart is opened, it will be replaced with a fully stocked cart by central supply staff/designee, and will be locked by pharmacy staff/nursing supervisor (off hours) after the medication tray is added. The cart will then be returned to the unit. The MEC and Governing Board approved the policy on 3/30/16. Nursing staff was re-educated on the policy. 2. Hospital Leadership reviewed and updated the contents of the pediatric and adult crash carts. A new "easy to read" content list is now located on the top of the crash carts. The crash cart defibrillator checklist is on each crash cart, which addresses, among other things, that the nurse checks that all drawers are locked with a numbered lock and the lock number matches the number on the medication drawer tag. If the numbers do not match, the nurse is to notify the pharmacist. Nursing staff was reeducated on the updated content list and checklist. 3. All adult and pediatric crash carts were checked to make sure that they contain the necessary supplies/medications. 4. The Hospital purchased 9 pediatric crash carts which were stocked with supplies and medications. The Hospital also purchased 25 new adult crash carts on 3/2/16, which the vendor anticipates will be delivered by 4/13/16.	3/1/16 -3/31/16 2/16/16 3/2/16 - 4/13/16

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A 395	Continued From page 16 there is no means to secure the contents including the emergency medications inside it. RN 28 stated, she would call the pharmacy to refill it. The policy and procedure for the crash cart was requested from ACNO. The hospital policy and procedure titled, "CRASH CART", undated, indicated, "To ensure the availability of appropriate medications and supplies to effectively resuscitate a cardiac or respiratory arrest patient. Each crash cart shall contain a standardized binder, which includes a crash cart content list... A process shall be employed that ensures drug security, control and the availability of drugs identified by the Medical Staff for emergency use... To ensure that crash carts are standardized throughout the department and the facility... All crash carts shall be sealed with a tamper resistant red breakaway lock and assigned a log number... Crash carts will be open in a Code blue situation... Any time that a crash cart is opened, it will be replaced with a fully stocked cart by central supply staff/ designees, and will be Locked by Pharmacy staff after medication tray is added. Then the cart will be returned to the unit... Immediately after the code, The Nursing Supervisor shall notify Central Supply and a fully restock replacement crash cart will be delivered to the patient care area..."	A 395	Compliance and Monitoring The Chief Nursing Officer or qualified designee performs a daily review of the crash carts to ensure the tamper resistant lock is intact to achieve the goal of 100% compliance with intact crash carts. Corrective action is taken, including nursing re-education. Data is analyzed and reported monthly to the Quality Council and MEC, and at least every other month to the Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will continue until the Quality Council determines sustained compliance has occurred, at which time the Council will provide direction on what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Person Responsible: Chief Nursing Officer	
(A 396)	482.23(b)(4) NURSING CARE PLAN The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan This STANDARD is not met as evidenced by: Based on observation, interview and record	(A 396)	A 396 482.23(b)(4) Nursing Care Plan	

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(A 396)	Continued From page 17 review, the hospital failed to have pertinent, individualized nursing care plans for 12 of 31 sampled patients (29, 30, 38, 40, 42, 45, 47, 48, 49, 51, 52, 55). This had the potential that patients would not receive necessary care or have unmet care needs. Findings: 1. During an interview and review of the clinical record for Patient 29 on 2/17/16, at 8:45 AM, the consents and admission paperwork were in Spanish. The charge nurse, Registered Nurse (RN) 8, stated he only spoke Spanish. Several care plans (anxiety, safety, hemodialysis) care plans were reviewed. There was no notation that Patient 29 only spoke Spanish on any care plan. RN 8 and Licensed Vocational Nurse (LVN) 1 confirmed this. 2. During an interview and review of the clinical record for Patient 30 on 2/17/16, at 10 AM, he was admitted on 2/12/16. One of his diagnoses was influenza and isolation was ordered on 2/13/16. Patient 30's care plans were reviewed (safety, respiratory, anxiety). None of his care plans addressed Patient 30 was on isolation. The hospital policy and procedure titled "Care Plan, Patient Interdisciplinary Plan of Care", dated 11/2012, indicated: "Policy Purpose To provide each patient with an individual interdisciplinary plan of care that is collaborative and goal directed... A care plan outlines the care to be provided to an individual/family patient. It is a set of actions the care provider will implement to resolve/support nursing diagnoses identified by nursing assessment...that will include patient's admitting problems....needs, or other condition..."	(A 396)	Findings 1-11 Immediate Actions Taken: 1. Nursing staff updated the nursing care plans for the identified patients. 2. Nursing staff labeled and dated Patient 47 and 48's gastrostomy tube tubing. 3. The CNO and ACNO educated the applicable nurses at the time of survey regarding documenting individualized nursing care plans based on the patient's condition. Subsequent Actions Taken: 1. The CEO and Nursing Leadership discussed the survey findings regarding nursing care plans. In an attempt to refocus the nursing staff on critical thinking, paper nursing care plans were instituted to bring the nurse "back to basics." This method was pilot tested over a two-week period with nursing staff migrating from electronic care planning to paper care planning. After a two-week period, data collection and analysis revealed the paper process did not improve critical thinking and resultant improved documentation, as anticipated. After input from line nursing staff and analysis by Leadership, the request to revert back to an electronic care planning process was approved. Nursing staff was educated that care planning will revert back to the electronic format and renewed efforts will be applied to identifying the assessed needs of the patient and annotating these in the electronic care planning module. A process of concurrent record compliance monitoring,	2/16/16 2/16/16 2/16/16 4/7/16

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(A 396)	Continued From page 18 3. During a review of the clinical record for Patient 38, with RN 25, on 2/16/16, at 10:36 AM, the patient was admitted with diagnoses of cellulitis (bacterial skin infection) to the left foot and right big toe wound. There was no individualized care plan for the treatment to the left foot or an individualized care plan for the treatment of the right big toe. During an observation of Patient 38 and interview with RN 26 (the treatment nurse), on 2/16/16, at 11:30 AM, Patient 38's right and left foot wounds were noted. The left fourth toe was uncovered and blackened. The inner portion of the right big toe was reddened. A review of the care plans was conducted and there was one care plan problem that was not specific to either the left foot or right foot. RN 26 stated, there should be two care plans to outline the care of each of the identified areas since they require different treatment interventions. No additional information was provided. 4. During an observation of Patient 40 with RN 25, on 2/16/16, at 11:55 AM, in Room 110 Bed C, the patient was observed lying in bed. A call light to contact the nurse was not noted within reach of the patient. The patient was asked if she had a call light that could be used to call the nurse. As she felt around her bed, she was unable to locate a call light. She stated she was unable to see due to being "Legally Blind and (having) Macular Degeneration (an eye disease that progressively causes severe vision loss)". RN 25 proceeded to feel around the bed for the call light, which was then given to the patient. After being given the call light, Patient 40 proceeded to demonstrate she could use the call light.	(A 396)	whereby a "care facilitator" (licensed healthcare professional) identifies any noncompliance with the subject matter, intercepts the nurse/provider in real time, and provides "just in time" education and training to correct clinical or documentation process issues, was implemented. This method allows for role modeling of strong clinical behavior while allowing staff to replicate improved practices. Care facilitation drives sustainability as staff learns from ongoing facilitation to identify, correct and improve practice weaknesses. A Care Facilitation worksheet was developed for use by the care facilitators which includes, among other things, accuracy and completeness of the care plan, and that the care plan reflects the assessed needs of the patient. This process was implemented on 4-7-16. Prior to this time, assigned staff were designated to review the care plan on the nursing units identifying deficiencies and working with staff to enhance understanding and improve the care planning process. 2. The "Care Plan, Patient Interdisciplinary Plan of Care" policy was reviewed and revised to align to current practice. The nursing staff develops and keeps current, a nursing care plan for each patient that addresses the patient's individual acute hospitalization needs based on assessment outcomes. The plan of care is collaborative and goal directed and outlines the care that is to be provided to the patient/family. The MEC and Governing Board approved the policy on 3/30/16. Nursing staff was inserviced on the policy and received	4/7/16

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(A 396)	Continued From page 19 During a review of the clinical record of Patient 40 and interview with RN 25, on 2/16/16, at 2:15 PM, Patient 40 was admitted on 2/15/16. The care plans were reviewed, and there was no care plan to ensure staff were aware of the patient's vision impairment and to ensure staff would implement the care needs of the patient with vision impairment. RN 22 verified the findings. 5. During a review of the clinical record for Patient 42 and interview with RN 22, on 2/16/16, at 2:50 PM, the admitting diagnosis included diabetes mellitus. The physician's orders indicated he was being treated with regular insulin based on the results of the routine fingersticks. The care plans were reviewed and there was no care plan for the diabetes mellitus to ensure staff were aware of appropriate interventions to treat the problem. 6. During a review of the clinical record for Patient 45 and interview with Licensed Vocational Nurse (LVN) 3, on 2/17/16, at 9:30 AM, the physician's orders were noted. A physician's order dated 2/1/16, for nasogastric tube (NGT) feeding (a flexible tube that is passed through the nose to the stomach to provide nutrition for patients who are unable to take sufficient nutrition orally) at 45 cc/hr (cubic centimeters per hour) was noted. The care plan problems for the patient were reviewed. The nutrition care plan included interventions for a patient who was receiving a diet orally and not a diet provided via a nasogastric tube. Documented interventions after the NGT was placed for nutrition included: "demonstrates appropriate selection of meals...eating in response to internal cues other than hunger...encourage water intake..." LVN 3	(A 396)	refreshed education on the precepts of care planning. 3. Hospital Leadership hired additional nursing management staff, including a Director of ED/ICU Services and Director of Medical Surgical Services. 4. Nursing staff is educated on nursing care plans upon hire. 5. Compliance with nursing care plans is monitored through the QAPI program. Compliance and Monitoring: Effective 4/7/16, data is collected by the care facilitators, aggregated and reported to leadership at least weekly to allow for leadership to focus resources on those issues and units where continued vulnerabilities exist. The goal is to achieve 100% compliance. Data is analyzed and reported monthly to the Quality Council and MEC, and at least every other month to the Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will continue until the Quality Council determines sustained compliance has occurred, at which time the Council will provide direction on what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Person Responsible: Chief Nursing Officer	3/14/16

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(A 396)	Continued From page 20	(A 396)		

acknowledged these were not appropriate interventions for a patient receiving NGT feeding. No additional information was provided.

The hospital policy and procedure titled, "CARE PLAN, PATIENT INTERDISCIPLINARY PLAN OF CARE POLICY AND PROCEDURE" effective date 12/2015, indicated the purpose of the care plan is "To establish guidelines for the initiation of interdisciplinary plan of care for each patient admission...A care plan outlines the care to be provided to an individual/family/patient. It is a set of actions the care provider will implement to resolve/support nursing diagnoses...The plan of care will be based on the assessed needs of the patient and will include goals, problems/needs, proposed intervention(s), expected outcomes..."

7. During an observation with RN 22, on 2/16/16, at 9:32 AM, in the patient's room, Patients 47 and Patient 48 were in bed with the head of the bed elevated at 45 degree angle. Patient 47 had a GT (Gastrostomy tube- a tube that has been surgically inserted in the stomach for the introduction of nutrient solution) formula of Fibersource HN (a nutritionally complete tube feeding formula with fiber) at 50 ml/hr (milliliter per hour). Patient 48 had a GT formula of Pulmocare (a therapeutic nutrition for people with COPD [chronic obstructive pulmonary disease], cystic fibrosis or respiratory failure patient) at 50 ml/hr. Patient 47 and Patient 48's GT tubing were not labeled and dated.

During an interview with RN 22, on 2/16/16, at 9:35 AM, she stated Patients 47 and 48 were unable to communicate because of their medical

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(A 396)	Continued From page 21 condition. RN 22 also stated she was unable to determine Patient 47 and 48's tubing for the formula were new or old. During a review of the clinical record for Patient 47, the Physician's Order dated 1/1/16, indicated Patient 47 to receive a Fibersource HN at 50 ml/hr by Gastrostomy tube. During further review of the clinical record, the nutrition care plan did not indicate Patient 47 was receiving formula through GT. During a review of the clinical record for Patient 48, the Physician's Order dated 2/1/16, indicated Patient 48 to receive Pulmocare at 50 ml/hr for 20 hours through GT. During further review of the clinical record, the nutrition care plan did not indicate Patient 48 was receiving formula through GT. During an interview with RN 22, on 2/16/16, at 10:05 AM, she reviewed the clinical record for Patients 47 and 48 and verified there was no care plan found for the use of GT formula feeding for both patients. 8. During an observation with RN 22, on 2/16/16, at 9:40 AM, in the patients room, Patient 49 was in bed with the head part slightly elevated at 30 degree angle. He has an oxygen inhalation via nasal cannula. Patient 49 waved his hand when he was asked how he was doing. During an interview with RN 22, on 2/16/16, at 9:42 AM, she stated Patient 49 was on Hemodialysis (a procedure in which impurities or wastes are removed from the blood) three times a week. RN 22 also stated Patient 49 was alert and oriented and he was able to make his needs	(A 396)		

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(A 396)	Continued From page 22 known. During a review of the clinical record for Patient 49, the Physician's Order dated 2/16/16, indicated Patient 49 to receive "Hemodialysis STAT ONCE (immediately one time) for 2 hours dry - DX [diagnosis]: Hypoxia [inadequate oxygen tension at the cellular level]." During further review of the clinical record for Patient 49, there was no documentation a care plan for Hemodialysis related to hypoxia was initiated. During an interview with LVN 3, on 2/16/16, at 10:07 AM, she reviewed the clinical record for Patient 49 and verified there was no care plan found for a Hemodialysis order on 2/16/16 due to patient's hypoxia. 9. During a review of the clinical record for Patient 51, the Physician's Order/Blood Product dated 2/10/16, indicated Patient 51 to receive PRBC (packed red blood cells- red blood cells separated from liquid plasma) 2 units. During further review of the clinical record, there was no documentation a care plan for blood transfusion (BT- the administration of whole blood or a component, such as packed red cells, to replace blood lost) of PRBC was developed. During an interview with LVN 3, on 2/16/16, at 10:15 AM, she reviewed the clinical record for Patient 51 and verified there was no care plan found for blood transfusion. 10. During a review of the clinical record for Patient 52, the Physician's Order dated 2/5/16, indicated Patient 52 to receive Lasix (medication to treat Pulmonary edema, edema with CHF, hepatic disease, nephrotic syndrome, ascites,	(A 396)		

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{A 396}	Continued From page 23 hypertension) 40 mg IV [intra-venous] daily. During further review of the clinical record, there was no documentation a care plan for the use of IV Lasix was initiated. During an interview with LVN 3, on 2/16/16, at 10:25 AM, she reviewed the clinical record for Patient 52 and she was unable to find a care plan for the IV Lasix. 11. During a review of the clinical record for Patient 55, the Physician's Order dated 2/14/16, indicated Patient 55 to receive an oxygen therapy of "Albuterol-ipatropium [a bronchodilator-anticholinergic medication to treat asthma, brochospasm, bronchitis and other reversible airway obstructions] inhalation 2.5 mg-0.5 mg - give 3 milliliters (ml) nebulizer [a method of administering a drug by producing a fine spray into the respiratory passages of the patient] every 6 hrs PRN [as necessary]." During further review of the clinical record, there was no documentation a care plan for the use of an oxygen therapy was initiated. During an interview with LVN 3, on 2/16/16, at 2:45 PM, she reviewed the clinical record for Patient 55 and verified there was no care plan found for the oxygen therapy.	{A 396}		
A 397	482.23(b)(6) PATIENT CARE ASSIGNMENTS A registered nurse must assign the nursing care of each patient to other nursing personnel in accordance with the patient's needs and the specialized qualifications and competence of the nursing staff available. This STANDARD is not met as evidenced by:	A 397	A 397 482.23(B)(5) Patient Care Assignments Immediate Actions Taken: 1. Hospital Leadership confirmed with RN 16 that she was oriented in October 2015. Documentation is now in RN 16's file as of 2/17/16.	2/17/16

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A 397	Continued From page 24 Based on interview and record review, the hospital failed to provide documented evidence one Registered Nurse (RN 16) was oriented to the emergency department (ED) when she was transferred there from another department. This had the potential to result in RN 16 being unprepared to perform her duties in the ED effectively affecting patient care. Findings: During an interview with RN 16, on 2/16/16, at 8:53 AM, she stated she has been an RN at the hospital for approximately two years. During a review of RN 16's personnel file and interview with Human Resource Coordinator, on 2/17/16, at 11:12 AM, it was noted RN 16 transferred to the ED on 11/1/15. There was no documentation RN 16 was oriented to the ED. No further evidence was provided.	A 397	Subsequent Actions Taken: 1. Hospital Leadership discussed the survey finding with the HR Coordinator. Employee files were checked to ensure that nursing staff has documented evidence of orientation to their work unit. 2. Hospital Leadership developed a "Unit Specific Orientation" policy. The purpose of this policy is to document the requirements for nursing orientation and required education for nursing staff transferring to another department. All transferring employees will receive Unit Based Orientation and Competencies related to their new Department. Department specific orientation is provided for all transferring staff. This program is designed to exhibit and/or review the nurse's competency in, but not limited to the following: location of crash cart and other emergent equipment;	4/7/16 3/30/16
{A 398}	482.23(b)(6) SUPERVISION OF CONTRACT STAFF Non-employee licensed nurses who are working in the hospital must adhere to the policies and procedures of the hospital. The director of nursing service must provide for the adequate supervision and evaluation of the clinical activities of non-employee nursing personnel which occur within the responsibility of the nursing services. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the hospital failed to ensure adequate supervision was provided to one contracted nursing personnel (Registered Nurse [RN] 23). This had the potential to result in lack of quality of	{A 398}		

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{A 398}	482.23(b)(6) SUPERVISION OF CONTRACT STAFF Non-employee licensed nurses who are working in the hospital must adhere to the policies and procedures of the hospital. The director of nursing service must provide for the adequate supervision and evaluation of the clinical activities of non-employee nursing personnel which occur within the responsibility of the nursing services. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the hospital failed to ensure adequate supervision was provided to one contracted nursing personnel (Registered Nurse [RN] 23). This had the potential to result in lack of quality of	{A 398}		

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A 397	Continued From page 24 Based on interview and record review, the hospital failed to provide documented evidence one Registered Nurse (RN 16) was oriented to the emergency department (ED) when she was transferred there from another department. This had the potential to result in RN 16 being unprepared to perform her duties in the ED effectively affecting patient care. Findings: During an interview with RN 16, on 2/16/16, at 8:53 AM, she stated she has been an RN at the hospital for approximately two years. During a review of RN 16's personnel file and interview with Human Resource Coordinator, on 2/17/16, at 11:12 AM, it was noted RN 16 transferred to the ED on 11/1/15. There was no documentation RN 16 was oriented to the ED. No further evidence was provided.	A 397	and MEC, and at least every other month to the Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will continue until the Quality Council determines sustained compliance has occurred, at which time the Council will provide direction on what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Persons Responsible: Chief Nursing Officer Director of Human Resources	
(A 398)	482.23(b)(6) SUPERVISION OF CONTRACT STAFF Non-employee licensed nurses who are working in the hospital must adhere to the policies and procedures of the hospital. The director of nursing service must provide for the adequate supervision and evaluation of the clinical activities of non-employee nursing personnel which occur within the responsibility of the nursing services. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the hospital failed to ensure adequate supervision was provided to one contracted nursing personnel (Registered Nurse [RN] 23). This had the potential to result in lack of quality of	(A 398)	A398 482.23(b)(6) Supervision of Contract Staff Immediate Actions Taken: 1. The identified nurse was immediately educated on infection control practices, including personal protective equipment (PPE) and handwashing. The CEO notified the dialysis contractor and stated the nurse was not to return to the hospital. The CEO also notified the dialysis contractor that failure of the dialysis nurses to follow the hospital's infection control practices would not be tolerated. The dialysis contractor advised the dialysis nurses of strict adherence to infection control practices.	2/17/16

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{A 398}	Continued From page 25 care provided to patients. Findings: During an observation on 2/16/16, at 2 PM, in Patient 49's room, RN 23 was seated on a chair wearing a PPE (Personal Protective Equipment). The yellow gown was worn mid way exposing her chest and back showing her [nurse] uniform. She was also observed wearing a mask but it was underneath her chin. Patient 49 was in bed with the head part slightly elevated at 30 degree angle. Patient 49 was connected to a Dialysis machine. On top of the Dialysis machine was a binder, a tablet computer and a box of blue colored gloves. During further observation on 2/16/16, at 3:50 PM, in Patient 49's room, RN 23 had disconnected the tubing from Patient 49. She was still wearing the yellow gown mid way exposing her chest and back. She was also wearing gloves and a mask. After she had disconnected the tubing from Patient 49, at 3:55 PM, she took a bottle of distilled white vinegar and placed an amount halfway in the canister. She returned the canister back to the machine. She was observed going across the hallway to get some wipes from the purple top container (germicidal ultra bleach wipes) wearing the same gloves. After placing the wipes on top of the Hemodialysis machine, she removed her gloves and disposed of them and proceeded to the station without washing her hands. RN 23 was observed working for two hours but there was no evidence the hospital employees had told her to wear the PPE appropriately. During an interview with RN 23, on 2/16/16, at 4	{A 398}	Subsequent Actions Taken: 1. Nursing Leadership reviewed and revised the "Contract Employees" policy, to address that the ACNO or qualified licensed designee is responsible for oversight/supervision of the contracted nursing staff assigned to their unit (e.g., dialysis nurses). The MEC and Governing Board approved the policy on 4/1/16. Nursing were inserviced on the policy. Compliance and Monitoring The HR designee reviews five samples per month of contracted staff to ensure all components of the individual's personnel files are present, including competency evaluations. Additionally, Unit Directors and/or the ACNO make random weekly observation rounds when contracted staff are on the work schedule to ensure compliance with supervision of contracted staff. Corrective action is taken as necessary. Data on compliance is tracked, trended, analyzed and reported monthly to Quality Council and MEC. Data on compliance is reported at least every other month to the Governing Board, and is used for performance improvement measures. Person Responsible: Chief Nursing Officer	4/7/16

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(A 398)	Continued From page 26 PM, she stated it was her first time to do a Hemodialysis treatment in the hospital. She stated she was using the dialysis binder to check for the parameters and the tablet computer was used for her to check the orders. She also stated she placed the box of gloves on top of the Hemodialysis machine as it was more convenient for her. During a review of the clinical record for Patient 49, the Physician's Order dated 2/16/16, indicated Patient 49 to receive "Hemodialysis STAT ONCE [immediately one time] for 2 hours dry - DX [diagnosis]: Hypoxia [inadequate oxygen tension at the cellular level]." The Physician's Order dated 2/12/16, indicated Patient 49 to receive Hemodialysis treatment every Monday, Wednesday and Friday (current Hemodialysis order). During an interview with the Vice President-Hospital Operations(VP) 2 and RN 24, on 2/17/16, at 9:50 AM, they were made aware of RN 23's care during a Hemodialysis treatment. VP 2 and RN 24 both stated RN 23 had violated the infection control practices.	(A 398)		
(A 454)	482.24(c)(2) CONTENT OF RECORD: ORDERS DATED & SIGNED All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner who is responsible for the care of the patient only if such a practitioner is acting in accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations. This STANDARD is not met as evidenced by:	(A 454)	A454 482.24(c)(2) Content of Record: Orders Dated & Signed Findings 1-4 Immediate Actions Taken: 1. Hospital Leadership met with the Information Technology (IT) Department to discuss the status of implementing a hard stop in the electronic medical record that will require the physician to complete authentication of telephone/verbal orders before being allowed to write new orders.	2/24/16

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{A 454}	Continued From page 27 Based on interview and record review, the hospital failed to follow its policy and procedure of having telephone or verbal orders signed by the physician within 48 hours, for four of 31 sampled patients (28, 31, 32, 52). This has the potential that medical records are not maintained within current clinical record standards. Findings: 1. During a review of the clinical record and interview with Licensed Vocational Nurse (LVN) 1 on 2/17/16, at 9:20 AM, Patient 28 was admitted 1/27/16. Four telephone orders from 1/27/16 had not been signed as of 2/17/16, three weeks. This was verified by LVN 1. 2. During a review of the clinical record and interview with LVN 1 on 2/17/15, at 9:30 AM, Patient 31 was admitted 2/9/16 with the diagnosis of "Diabetic Foot Ulcer". Patient 31's physician's medication orders were reviewed: 1. Eight verbal/telephone orders from 2/9/16 had not been signed by the ordering physician (six days date). 2. One verbal/telephone order from 2/10/16 had not been signed (five days late). 3. Three verbal/telephone orders from 2/13/16 had not been signed (two days late). LVN 1 verified the information. 3. During a review of the clinical record and interview with LVN 1 on 2/17/16, at 9:30 AM, Patient 32 was admitted 12/3/15, with a diagnosis of "leukocytosis" (high white count, usually indicated infection). Robitussin DM (cough suppressant) was ordered verbally or by telephone on 1/8/16. It was not signed by the physician until 1/28/16, three weeks later. Pancrelipase (medication to help the body digest	{A 454}	Subsequent Actions Taken: 1. Hospital Leadership reviewed the "Telephone, Verbal and Written Order for Medication" Policy, which delineates the process for physicians to authenticate their telephone and verbal medication orders within 48 hours. The policy did not require any revisions. 2. Effective 2/24/16, the "Allscripts" EMR system requires physicians to authenticate their unsigned orders prior to proceeding with any other system function. A memo was sent to the practitioners with implementation of the hard stop in the Allscripts EMR system. 3. The issue of compliance with authentication of verbal and telephone orders was discussed at the 3/30/16 MEC meeting. A refresher memo was sent on 3/31/16 to medical staff members regarding authenticating telephone and verbal orders timely. 4. The Medical Staff Office worked with physicians to obtain remote access to the EMR system to allow for timely completion of telephone/verbal order authentication. 5. Compliance with authenticating telephone and verbal orders is monitored through the QAPI program.	2/24/16 2/24/16 3/31/16 4/7/16

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(A 454)	Continued From page 28 food) was ordered 1/21/16, either verbally or by telephone. As of 2/17/16, it had not been signed. Insulin was ordered 1/21/16 either verbally or by telephone. It was signed by the physician on 1/28/16, five days late. The hospital policy and procedure titled "Telephone, Verbal and written order for Medication", dated 2/20/15, indicated: "...The prescribing practitioner must sign the written record of the verbal/telephone medication order within 48 hours of giving order." 4. During a review of the clinical record for Patient 52, the Physician's Order dated 2/5/16, indicated Patient 52 to receive Lasix 40 mg IV daily. During further review of the clinical record, there was no documented evidence the verbal order for Patient 52 was authenticated by the physician since the date it was ordered. During an interview with LVN 3, on 2/16/16, at 10:25 AM, she reviewed the clinical record for Patient 52 and she verified the verbal order was not authenticated since it was ordered on 2/5/16.	(A 454)	Compliance and Monitoring The Director of Health Information or qualified designee performs random reviews of at least 20 medical records weekly to achieve the goal of 90% compliance with authenticating telephone and verbal orders. Data is analyzed and reported monthly to the Quality Council and MEC, and at least every other month to the Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will continue until the Quality Council determines sustained compliance has occurred, at which time the Council will provide direction on what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Persons Responsible Director of Health Information Management Chief of Staff Chief Nursing Officer	
A 467	482.24(c)(4)(vi) CONTENT OF RECORD: ORDERS,NOTES,REPORTS [All records must document the following, as appropriate:] All practitioner's orders, nursing notes, reports of treatment, medication records, radiology and laboratory reports, and vital signs and other information necessary to monitor the patient's condition.	A 467	A 467 482.24(c)(4)(vi) Content of Record: Orders, Notes, Reports.	

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A 467	Continued From page 29 This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the hospital failed to ensure the licensed nurses documentation contained information necessary to monitor one of 31 sampled patient's condition (49) receiving a Hemodialysis (a procedure in which impurities or wastes are removed from the blood) treatment. This failure had the potential to result in unmet care needs. Findings: During an observation with Registered Nurse (RN) 22, on 2/16/16, at 9:40 AM, in the patient's room, Patient 49 was in bed with the head part slightly elevated at 30 degree angle. He had an oxygen inhalation via nasal cannula. Patient 49 waved his hand when he was asked how he was doing. During an interview with RN 22, on 2/16/16, at 9:42 AM, she stated Patient 49 was on Hemodialysis three times a week. RN 22 also stated Patient 49 was alert and oriented and he was able to make his needs known. During a review of the clinical record for Patient 49, the Physician's Order dated 2/16/16, indicated Patient 49 to receive "Hemodialysis STAT ONCE [immediately one time] for 2 hours dry - DX [diagnosis]: Hypoxia [inadequate oxygen tension at the cellular level]." During further review of the clinical record for Patient 49, there was no documentation by the licensed nursing staff for the Hemodialysis treatment ordered on 2/16/16. The Hemodialysis treatment was an additional order by the physician from Patient 49's current order of three times a week (Monday-Wednesday-Friday). It was ordered due	A 467	Immediate Actions Taken: 1. The ACNO discussed the survey findings with the applicable nurse, with special emphasis on reassessing the patient's status and documenting his/her condition in the medical record (e.g., a one time stat order for hemodialysis). Subsequent Actions Taken: 1. Nursing Leadership reviewed the "Assessment/Reassessment of Patient" policy. As delineated in the policy, the nurse shall reassess the Inpatient at least every shift (or more frequent depending on the patient status) to document changes in the patient's condition and/or diagnosis and to determine the patient's response to interventions. Nursing reassessments will be documented in the appropriate section of the EMR. Nursing staff was reeducated on the policy. 2. Nurses are educated on assessments and reassessments upon hire. 3. A process of concurrent record compliance monitoring, whereby a "care facilitator" (licensed healthcare professional) identifies any noncompliance with the subject matter, intercepts the nurse/provider in real time, and provides "just in time" education and training to correct clinical or documentation process issues, was implemented. This method allows for role modeling of strong clinical behavior while allowing staff to replicate improved practices. Care facilitation drives sustainability as staff learns from ongoing	2/17/16 3/1/16 - 3/15/16 4/7/16

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A 467	Continued From page 30 to Patient 49's hypoxia. During an interview with RN 24, on 2/17/16, at 9:15 AM, RN 24 reviewed the licensed nurses documentation and verified there was no information found for the Hemodialysis STAT order. He also stated the licensed staff did not document the reason for the order and Patient 49's response to the treatment. During an interview with Vice President- Hospital Operations (VP) 2 and RN 24, on 2/17/16, at 9:50 AM, they were made aware of the lack of documentation by the licensed nursing staff for the one time STAT order of Patient 49's Hemodialysis treatment. VP 2 and RN 24 both gave no further information. The hospital policy and procedure titled "Assessment/Reassessment of Patient" dated 4/16/15, read in part, "...A-3. The goal of the assessment/reassessment process is to provide the patient the best care and treatment possible... 7. All reported changes in patient condition will be documented, as well as the patient response in the medical record..."	A 467	facilitation to identify, correct and improve practice weaknesses. A Care Facilitation worksheet was developed for use by the care facilitators which includes, among other things, patient assessments and reassessments. This process was implemented on 4-7-16. Prior to this time, assigned staff were designated to review patient assessments and reassessments on the nursing units identifying deficiencies and working with staff to enhance understanding and improve the assessment process. 4. Compliance with assessing and reassessing patients and documenting the evaluation in the medical record is monitored through the QAPI program. Compliance and Monitoring Effective 4/7/16, care facilitation data will be forwarded daily (M-F) to Clinical Leadership and the CEO for immediate intercession if necessary. In addition, the CNO or qualified designee reviews at least 10 random medical records weekly to achieve the goal of 95% compliance with reassessments of the	
(A 701)	482.41(a) MAINTENANCE OF PHYSICAL PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This STANDARD is not met as evidenced by: Based on observation and interview, the hospital failed to maintain a safe environment in the Urgent Care area when one oxygen tank was	(A 701)		

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A 467	Continued From page 30 to Patient 49's hypoxia. During an interview with RN 24, on 2/17/16, at 9:15 AM, RN 24 reviewed the licensed nurses documentation and verified there was no information found for the Hemodialysis STAT order. He also stated the licensed staff did not document the reason for the order and Patient 49's response to the treatment. During an interview with Vice President- Hospital Operations (VP) 2 and RN 24, on 2/17/16, at 9:50 AM, they were made aware of the lack of documentation by the licensed nursing staff for the one time STAT order of Patient 49's Hemodialysis treatment. VP 2 and RN 24 both gave no further information. The hospital policy and procedure titled "Assessment/Reassessment of Patient" dated 4/16/15, read in part, "...A-3. The goal of the assessment/reassessment process is to provide the patient the best care and treatment possible... 7. All reported changes in patient condition will be documented, as well as the patient response in the medical record..."	A 467	patient's condition and documenting the reassessment in the medical record. Corrective action is taken as necessary, including reeducation of staff. Data is analyzed and reported monthly to the Quality Council and MEC, and at least every other month to the Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will continue until the Quality Council determines sustained compliance has occurred, at which time the Council will provide direction on what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Person Responsible: Chief Nursing Officer A 701 482.241(a) Maintenance of Physical Plant Immediate Actions Taken: 1. The portable oxygen tank was secured. 2. The Director of Respiratory Therapy inserviced staff at the time of the survey on securing oxygen tanks. 3. Respiratory staff reviewed all oxygen tanks at the time of survey to ensure that they were properly secured. Subsequent Actions: 1. Additional education was provided to nursing and respiratory therapy staff on the importance of securing oxygen tanks.	2/16/16 2/16/16 2/17/16 3/1/16
(A 701)	482.41(a) MAINTENANCE OF PHYSICAL PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This STANDARD is not met as evidenced by: Based on observation and interview, the hospital failed to maintain a safe environment in the Urgent Care area when one oxygen tank was	(A 701)		

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{A 701}	Continued From page 31 unsecured. This had the potential for the area to be unsafe for patients, visitors and staff. Findings: During an initial observation in the Urgent Care on 2/16/16, at 8:45 AM, a portable oxygen tank was noted to be unsecured, leaning against a wall. The Chief Nursing Officer (CNO) agreed it was an unsafe situation and requested staff call Respiratory Care stat to secure the tank. At 9 AM, the CNO put the oxygen tank into a holder under an Urgent Care gurney.	{A 701}	2. Compliance with securing oxygen tanks is monitored through ongoing Environment of Care (EOC) rounding. Compliance and Monitoring: The Director of Respiratory Therapy or qualified designee performs random daily rounds of patient care areas to achieve the goal of 100% compliance with securing oxygen tanks. Corrective action is taken as necessary, including reeducation of staff. Data is analyzed and reported monthly to the Quality Council and MEC, and at least every other month to the Governing Board until	
{A 724}	482.41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This STANDARD is not met as evidenced by: 2. During an observation of the Medical Surgical (MS) unit with Registered Nurse (RN) 25, on 2/16/16, at 11:46 AM to 11:55 AM, the following was noted: Room 111 Bed C, the call light was nonfunctioning with no audible sound above the room door or at the nurse's station. Room 111 Bed F, the call light cord which extended to the patient, had no button at the end of the call light cord to use; therefore, the call light could not be used as intended. Room 11 Bed G, the call light was found with the cord cut at the level of the wall. Room 111 Bed D, the call light was non	{A 724}	sustained compliance is achieved and	

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{A 724}	482.41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This STANDARD is not met as evidenced by: 2. During an observation of the Medical Surgical (MS) unit with Registered Nurse (RN) 25, on 2/16/16, at 11:46 AM to 11:55 AM, the following was noted: Room 111 Bed C, the call light was nonfunctioning with no audible sound above the room door or at the nurse's station. Room 111 Bed F, the call light cord which extended to the patient, had no button at the end of the call light cord to use; therefore, the call light could not be used as intended. Room 11 Bed G, the call light was found with the cord cut at the level of the wall. Room 111 Bed D, the call light was non	{A 724}	A724 482.41(c)(2) Facilities, Supplies, Equipment Maintenance Finding 2 Immediate Actions Taken: 1. Hospital Leadership took immediate action to address the call light findings at the time of survey. Call lights were checked at the L.A. and Norwalk campuses for functionality. The patients at the Norwalk campus with call lights that needed repair were provided with a sitter. The patients at the L.A. campus with call lights that needed repair were relocated to a room with a functioning call light. 2. Hospital Leadership notified the House Supervisors that patients were only allowed to be in a room with a call light that needed repair if the patient was provided with a sitter. Otherwise, the bed was to be closed and not for patient use.	2/16/16 2/16/16

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{A 724}	Continued From page 32 functioning with no audible sound above the room door or at the nurse's station. Room 105 Bed A, the call light was non functioning and was not audible or visible above the room door or at the nurse's station. During an interview with RN 25, on 2/16/16, at 11:50 AM, she was asked how long have the call lights not been functioning as intended? She stated, they have not been working "on and off" but did not indicate a specific time frame. She was asked the process when repair of equipment, such as the call lights, is required. She stated, a "work order is generated" which goes directly to the maintenance department. She was not certain whether a work order request was generated and sent to the maintenance department for the nonfunctioning call lights. During an interview with Engineer Staff (ES) 1, on 2/16/16, at 11:52 AM, he stated the maintenance department was aware of the nonfunctioning call lights in Room 111 but the call lights have been on back order for approximately six days. He indicated he was the staff who cut the the cord to 111 Bed G otherwise it would keep signaling. He stated they have no extra call lights available for patient use. During an interview with Director of Plant Operations (DPO), on 2/16/16, at 1:40 PM, he stated ES 1 informed him of the nonfunctioning call lights. He was informed by ES 1 the call lights have not been functioning for 1 to 1 1/2 weeks. Because he did not know the type of call lights to order from the vendor, no call light replacements had been ordered. He was asked if the maintenance department has a system to	{A 724}	Subsequent Actions Taken: 1. Hospital Leadership discussed the survey findings. The "Reporting Malfunction" policy was reviewed and did not require any revisions. The "Utility Disruption: Nurse Call System" policy was also reviewed and revised to align with current practice in the event of a disruption in the nurse call light system. Upon identification of a malfunctioning call light, the staff is to immediately notify the Director of Engineering or designee and the House Supervisor. The Engineering Department will take the necessary steps to correct any failures of the call light system or notify the proper service or persons when the repair is beyond their capabilities. The Engineering Department will notify the applicable Department Manager or designee as to when the call light will be repaired. Nursing shall notify the patient(s) when there is an issue with the call system. Patients affected by the call light outage will be assigned a sitter per room or be relocated to a bed with an operational call light. The MEC and Governing Board approved the policy on 3/30/16. Nursing and engineering staff were inserviced on the policy. 2. The Hospital purchased forty (40) additional call lights to be available as replacements as needed. The Director of Engineering is responsible for ensuring that an adequate number of call lights are available in the event that replacements are necessary. 3. Hospital Leadership met with an outside vendor regarding replacing the existing call light system. An OSHPD project number was	3/1/16 - 4/7/16 3/13/16 4/7/16

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	050663	A. BUILDING _____ B. WING _____	R-C 02/17/2016

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(A 724)	Continued From page 33 monitor the patients' call lights routinely to ensure they are in working order. He acknowledged the maintenance department does not check the call lights to ensure they are in working order. He acknowledged there was no work order request for the nonfunctioning call lights for Room 111 or 105. The hospital policy and procedure titled, "Reporting malfunction" effective date 6/15/09, indicated in part, "Equipment Malfunctions - Patient Care Equipment...When a malfunction is evident, the following steps should be taken...Double check procedure techniques to ascertain whether there is a true malfunction... If the malfunction continues to occur, call the Engineering department and inform them of the problem..." Based on observation, interview, and record review, the hospital failed to ensure a safe environment when: 1. Hazardous chemicals were not stored according to policy and procedures. This had the potential to result in staff lacking awareness for safety. 2. Several call lights were not functioning as intended. This had the potential for patients to be unable to call for assistance which impacts the patient's safety Findings: 1. During an observation with Lead Engineer (LE) 2, on 2/16/16, at 8:35 AM, at the back of the hospital's driveway, a Water Supply Room (Locked area) had 264 gallon bottles of drinking	(A 724)	obtained (No. S160887-19 for Norwalk campus and S160777-19 for Los Angeles Community campus). 4. Compliance with call lights functioning is monitored through the QAPI program. Compliance and Monitoring: The Director of Engineering or qualified designee makes rounds daily on all patient care units to ensure the call lights are functioning. Corrective action is taken as necessary, including relocating the patient/ or obtaining a sitter for the patient room until the call light is repaired. Data is analyzed and reported monthly to the EOC Committee, Quality Council and MEC, and at least every other month to the Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will continue until the Quality Council determines sustained compliance has occurred, at which time the Council will provide direction on what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Person Responsible: Director of Engineering Finding 1 Immediate Actions Taken: 1. The identified chemicals were immediately removed from next to the emergency water supply and placed in	2/16/16

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{A 724}	Continued From page 34 water. There was a total of 1370 gallons of water inside the supply room. Besides the gallons of water, there were six containers (5 gallons each) of Enerex Chemical (a chemical compound used for treating steam boiler water in food and industrial plants) close to the door. One Enerex Chemical container was open and without a cover. The containers were marked as "Corrosive (is one that will destroy and damage other substances with which it comes into contact: it causes chemical burns on contact)." During an interview with LE 2, on 2/16/16, at 8:37 AM, he stated the chemicals were used for the boiler. He also stated the containers should have not been inside the water supply room or close to the water bottles. He was aware the chemicals were marked as corrosive. The hospital policy and procedure titled "Management of Hazardous Chemicals" dated 1/2015, read in part, "...7.5.5 Materials which are toxic as stored or which can decompose into toxic components from contact with heat, moisture, acids, or acid fumes should be stored in a cool, well ventilated place out of the direct rays of the sun...7.5.6 Corrosive materials are stored in a cool, well-ventilated area (i.e., above their freeze point) and in containers that will contain spills or leaks. NOTE: The containers are inspected at regular intervals to ensure they are labeled and kept closed. 7.5.7 Corrosives are isolated from other materials..."	{A 724}	area adjacent to the engineering department. 2. The Hospital purchased and installed a corrosive and flammable safety cabinet at the Norwalk campus and the identified chemicals were placed in the cabinet. Subsequent Actions Taken: 1. Hospital Leadership and the Director of Engineering reviewed the types of chemicals stored and the storage containers. In order to assure that all hazardous chemicals are stored in accordance with applicable regulation(s), the Hospital ordered corrosive, as well as flammable safety cabinets, which were installed on the L.A. Campus by 4/7/16. 2. The Director of Engineering reviewed the "Management of Hazardous Chemicals" policy, which did not require any revision. Hazardous materials and their wastes will be handled in a safe and compliant manner. Corrosive materials are isolated away from other materials and stored in a cool, well-ventilated area in containers that will contain spills or leaks. Engineering staff was reinserviced on the policy. 3. Monitoring storage of hazardous chemicals is part of weekly EOC rounds. In addition, hazardous chemical storage areas are inspected at least annually to evaluate the effectiveness of the storage, as well as	2/17/16 4/7/16 2/17/16 - 4/7/16
{A 747}	482.42 INFECTION CONTROL The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an	{A 747}		

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{A 747}	482.42 INFECTION CONTROL The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an	{A 747}	A747 482.42 Infection Control The Hospital assures that it has a comprehensive Infection control program that provides for the prevention, control and investigation of Infections and communicable diseases. The Hospital hired a	4/7/16

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(A 747)	Continued From page 35 active program for the prevention, control, and investigation of infections and communicable diseases. This CONDITION is not met as evidenced by: Based on observations, interviews, and record review, the hospital failed to provide a sanitary environment to avoid sources and transmission of infections and communicable diseases and conduct an active program for the prevention, control and investigation of infections and communicable diseases. These failures place the patient population, visitors and staff at risk for hospital acquired infections when: 1. Terminal cleaning (thorough cleaning done at the end of the work day to eliminate as many disease causing bacteria or viruses) was not performed daily in the areas connected to the operating rooms. The endoscopy processing room (specialized room used to clean medical equipment used for procedures) had no door to prevent the spreading of pathogens (disease causing bacteria or virus) into the restricted area of the operating room. (Refer to A 749, item 1) 2. Clean and sterile supplies were stored in the decontamination room. (Refer to A 749, item 2) 3. Operating room number two (one of two) did not meet state environmental standards. (Refer to A 749, item 3) 4. Surgical instruments were not properly sterilized. (Refer to A 749, item 4) 5. Glucometers (small, portable, hand held instrument that measure blood glucose immediately) were not disinfected between	(A 747)	new Director of Infection Control on 3/14/16, who reviewed the survey findings with Hospital Leadership and worked collaboratively to address the identified issues as discussed below. The Infection Control Annual Plan was reviewed and did not require any revision. The Director of Infection Control makes weekly rounds of patient care areas and also participates in monthly EOC rounds. An Infection Control Committee meeting was held on 4/6/16 to discuss the survey findings and compliance efforts. Data on compliance with infection control practices is monitored through the QAPI program. Finding 1 The identified room received a terminal cleaning. Hospital Leadership and the Director of Infection Control discussed the survey findings with the Director of Environmental Services (EVS) and Interim Director of the Operating Room (OR), with emphasis on compliance with terminal cleaning of the perioperative areas. A policy entitled "The Environmental Sanitation Perioperative Setting" policy was developed to address the terminal cleaning process and the "Perioperative Services EVS Terminal Cleaning Log" was reviewed and revised to be more comprehensive. As detailed in the policy, all procedure rooms, the scrub areas, the sterile instrument room and the sterile processing department are terminally cleaned on a daily basis when the scheduled procedures are completed for the day and each 24-hour period during the regular work	3/14/16 4/6/16 2/17/16 - 4/7/16

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{A 747}	Continued From page 36 patient use. (Refer to A 749, item 5) 6. Healthcare workers did not have adequate vaccination screening. (Refer to A 749, item 6) 7. Within the Urgent Care, employees' personal belongings were placed in clean areas. One employee was observed eating in the nursing station. (Refer to A 749, item 7) 8. On Unit III, family and staff were not following appropriate isolation measures. (Refer to A 749, item 8) 9. Improperly handled soiled linen. (Refer to A 749, item 9) 10. Improperly stored medical waste. (Refer to A 749, item 10) 11. New Gastrostomy (GT, a tube inserted directly into the stomach to provide nutrition) tubing was not labeled with time, date and initials of person hanging the feeding. (Refer to A 749, item 11) 12. In the telemetry unit, Personal Protective Equipment (PPE) was not utilized appropriately by staff. (Refer to A 749, item 12) The cumulative effects of these systemic failures resulted in the hospital's inability to ensure a sanitary environment environment placing all patients, staff and visitors at risk of being exposed to infections and communicable diseases.	{A 747}	Finding 7 The employee belongings and the identified supplies were removed from the clean /dirty utility room in the Urgent Care area. This room is now designated as a dirty utility room only. An alternate area for employee belongings was created in the nursing station. Nursing staff was inserviced on use of this dirty utility room and storage of their belongings. The identified nurse was notified that the facility does not allow food consumption in the nursing station. The break room or cafeteria is where food consumption occurs. The Director of Infection Control, Nursing Leadership and consultants provided real time education to nursing staff in all patient care areas on storage of personal belongs and not eating in the nursing station. Finding 8 The Senior Vice President (VP) of Quality inserviced the identified nurse on proper use of PPE. The family belongings were removed from the room and the family was inserviced on the use of PPE before entering the patient's room. Formal education to nursing staff on use of PPE was implemented. Staff are trained on use of PPE upon hire and during annual skills day. RN 16's file was reviewed and it was identified that her antibody titer indicated that she had immunity and did not require the vaccination. Hospital Leadership reviewed	2/17/16 - 3/17/16 2/17/16 - 4/1/16
{A 749}	482.42(a)(1) INFECTION CONTROL PROGRAM	{A 749}		

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	050663	A. BUILDING _____ B. WING _____	R-C 02/17/2016

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(A 749)	482.42(a)(1) INFECTION CONTROL PROGRAM	(A 749)		

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{A 749}	482.42(a)(1) INFECTION CONTROL PROGRAM	{A 749}	A 749 482.42(a)(1) Infection Control Program	

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{A 749}	Continued From page 37 The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: 7. During a concurrent observation and interview with the Chief Nursing Officer (CNO) and the Quality Analyst in the Urgent Care Center on 2/16/16, at 3:10 PM, in the Clean/Dirty utility room, two staff's personal back packs and one jacket are on the counter next to the sink, in the clean area. Binders, Christmas decorations, personal containers are stacked up within approximately 4" of the ceiling. The CNO verified "The top of the stack of boxes, etc, are too close to the ceiling. This room is really like a supply room rather than a Utility Room." During an observation in the Urgent Care Center on 2/17/16, at 8:25 AM with IC 2 and Licensed Vocational Nurse (LVN) 1, LVN 2 was noted to be eating within the nurse' station area. The smell of her food permeated the area. One patient was in the treatment area and the pediatrics' door was shut. IC 2 stated, "She's not supposed to be eating there." 8. During an observation on Unit III on 2/16/16, at 9:30 AM with IC 2 and LVN 1, Patient 30 was in isolation with a diagnosis of influenza. A family member put on the Personal Protection Equipment (PPE) which included a gown, mask and gloves before entering the room. This family member then placed her purse strap over her shoulder and entered Patient 30's room with the purse fully exposed. IC 2 asked the charge nurse	{A 749}	Finding 7 Actions Taken: 1. The employee belongings and the identified supplies were removed from the clean /dirty utility room in the Urgent Care area. This room is now designated as a dirty utility room only. An alternate area for employee belongings was created in the nursing station. Nursing staff was inserviced on use of this dirty utility room and storage of their belongings. 2. The identified nurse was notified that the facility does not allow food consumption in the nursing station. The break room or cafeteria is where food consumption occurs. 3. The Director of ICU/ED reeducated nursing staff on Infection control practices, including the Hospital's policy on no food consumption in nursing stations. 4. The Director of Infection Control, Nursing Leadership and consultants provided real time education to nursing staff in all patient care areas on storage of personal belongs and not eating in the nursing station. Compliance and Monitoring: The Director of Infection Control or qualified designee makes at least weekly random rounds in nursing care areas to achieve the goal of 100% compliance with proper storage in dirty utility rooms and not eating in nursing stations. Corrective action is taken as necessary, including just-in-time training. Data is analyzed and reported monthly to the Infection Control Committee, Quality Council and MEC, and at least every other month to the Governing Board until sustained	2/19/16 and 3/17/16 2/17/16 2/19/16-3/17/16 2/17/16

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(A 749)	Continued From page 38 (RN 10) who had instructed this family member how to protect herself using PPE. RN 10 then put on a gown, mask and gloves and entered Patient 30's room. RN 10 did not tie the isolation gown in the back and the front neckline of the gown dropped down to her right elbow, exposing the top of her uniform, while she spoke to Patient 30 and his family member. During a review of RN 16's personnel file with Human Resource Coordinator, on 2/17/16, at 11:15 AM, the Hepatitis B vaccine acceptance/refusal form dated 12/9/13, was noted. On the form, RN 16 documented that she would accept the Hepatitis B vaccine. There was no documented evidence the Hepatitis B vaccine was offered and/or given to RN 16. No further evidence was provided. 9. During an observation with Lead Engineer (LE) 2, on 2/16/16, at 8:50 AM, at the back of the hospital's driveway, a soiled linen cart full of soiled linens (enclosed in plastic bags) was found unsecured close to the main oxygen supply tank storage area. The linen cart was unattended. During an interview with LE 2, on 2/16/16, at 8:52 AM, he stated the housekeeping staff forgot to store the cart inside the dirty linen locked storage room. He also stated the housekeeping staff collects the carts from the hospital and they would push them inside the dirty linen storage room. 10. During an observation with LE 2 and RN 22, on 2/16/16, at 9:10 AM, at the back patio, the "Biohazardous and Medical Wastes" locked storage area contained nine medical wastes containers. It was observed eight of the nine	(A 749)	compliance is achieved and process control is demonstrated. Ongoing monitoring will continue until the Quality Council determines sustained compliance has occurred, at which time the Council will provide direction on what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Person Responsible: Director of Infection Control Finding 8 Actions Taken: 1. The Sr. VP of Quality inserviced the identified nurse on proper use of PPE. The family belongings were removed from the room and the family was inserviced on the use of PPE before entering the patient's room. 2. The prior Director of Infection Control inserviced nursing staff on other patient care units on PPE for staff and family at the time of survey. 3. Formal education to nursing staff on use of PPE was implemented. 4. Staff are trained on use of PPE upon hire and during annual skills day. 5. RN 16's file was reviewed and it was identified that her antibody titer indicated that she had immunity and did not require the vaccination. 6. Hospital Leadership reviewed and revised the hepatitis vaccination consent/declination form to clarify that the vaccine is only	2/17/16 2/17/16 3/1/16 - 3/15/16 2/17/16 4/1/16

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{A 749}	Continued From page 39 containers were not properly sealed and without the secured tape on both sides. The containers were also found to have several used intravenous medication tubing sticking out of the containers. During an interview with RN 22, on 2/16/16, at 9:12 AM, she stated the staff should have placed the secured tape label on both sides and before the housekeeping staff would bring them to the storage area. The hospital policy and procedure titled "MEDICAL WASTE MANAGEMENT PLAN CHECKLIST" dated 8/2007, read in part, "...Indicate in the medical waste management plan that the accumulation area utilized by the facility to store containers of medical waste for accumulation must be secured so as to prevent or deny access by unauthorized persons and posted with warning signs, on or adjacent to, the exterior of the entry doors, on entry doors, gates, or lids..." 11. During a concurrent observation and interview with RN 22, on 2/16/16, at 9:32 AM, in the patients' room, Patients 47 and Patient 48 were in bed with the head part elevated at 45 degree angle. Patient 47 had a GT formula of Fibersource HN at 50 ml/hr (milliliter per hour). Patient 48 had a GT formula of Pulmocare at 50 ml/hr. Patient 47 and 48's GT tubing were not labeled and dated. During an interview with RN 22, on 2/16/16, at 9:35 AM, she stated Patients 47 and Patient 48 were unable to communicate because of their medical condition. RN 22 also stated she was unable to determine Patient 47 and Patient 48's tubing for the formula were new or old.	{A 749}	2. Hospital Leadership reviewed the "Medical Waste Management Plan Checklist", which did not require any revision. Nursing and EVS staff were reinserviced on the process for securing the medical waste containers. 3. The Hospital purchased new medical waste containers for pharmaceutical waste to ensure proper disposal of medical/ pharmaceutical waste. Compliance and Monitoring: The Director of Infection Control or qualified designee performs random rounds at least weekly to achieve the goal of 100% compliance with storing and securing medical waste containers. Corrective action is taken as necessary, including reeducation of staff. Data is analyzed and reported monthly to the Infection Control Committee, Quality Council and MEC, and at least every other month to the Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will continue until the Quality Council determines sustained compliance has occurred, at which time the Council will provide direction on what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Person Responsible: Director of Infection Control	4/7/16 4/7/16

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{A 749}	Continued From page 39 containers were not properly sealed and without the secured tape on both sides. The containers were also found to have several used intravenous medication tubing sticking out of the containers. During an interview with RN 22, on 2/16/16, at 9:12 AM, she stated the staff should have placed the secured tape label on both sides and before the housekeeping staff would bring them to the storage area. The hospital policy and procedure titled "MEDICAL WASTE MANAGEMENT PLAN CHECKLIST" dated 8/2007, read in part, "...Indicate in the medical waste management plan that the accumulation area utilized by the facility to store containers of medical waste for accumulation must be secured so as to prevent or deny access by unauthorized persons and posted with warning signs, on or adjacent to, the exterior of the entry doors, on entry doors, gates, or lids..." 11. During a concurrent observation and interview with RN 22, on 2/16/16, at 9:32 AM, in the patients' room, Patients 47 and Patient 48 were in bed with the head part elevated at 45 degree angle. Patient 47 had a GT formula of Fibersource HN at 50 ml/hr (milliliter per hour). Patient 48 had a GT formula of Pulmocare at 50 ml/hr. Patient 47 and 48's GT tubing were not labeled and dated. During an interview with RN 22, on 2/16/16, at 9:35 AM, she stated Patients 47 and Patient 48 were unable to communicate because of their medical condition. RN 22 also stated she was unable to determine Patient 47 and Patient 48's tubing for the formula were new or old.	{A 749}	Finding 11 Actions Taken: 1. The identified GT tubing was changed and labeled and dated. 2/16/16 2. The "IV/Enteral Tubing Change" policy was reviewed and did not require any revision. The policy was dated as of the last date of review. Tubing is to be labeled with the date, time and initials of the person performing the tubing change. Nursing staff were reinserviced on the policy. 4/7/16 3. Compliance with labeling IV/enteral tubing is monitored through the QAPI program. 4. Nursing is educated on IV/enteral tubing change, dating and labeling upon hire. 5. Observation rounds were implemented to measure compliance with proper tubing labeling. A daily "flash" tool is completed by Nursing Supervisors, which include, among other issues, verification of tubing labeling. 2/27/16 Compliance and Monitoring: In addition to other compliance monitoring, the organization instituted an observation based unit inspection process and completion of the "flash" tool. Observation rounding is performed by a designated individual from a criteria driven list and is included in Medication Pass audits. Focused rounding is performed by leadership and includes myriad compliance issue checks, one of which is tubing labeling. Should issues be identified, corrective action is taken as necessary, including just-in time training of staff. Data is analyzed and reported monthly to the Infection Control Committee, Quality Council and MEC, and at least every other	

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{A 749}	Continued From page 40 The hospital policy and procedure titled "IV/Enteral Tubing Change" undated, read in part, "...Tubing Changes: Enteral/Tube Feeding - every 24 hours...DOCUMENTATION: 1. All IV (Intravenous)/Enteral tubing changes are to be documented on the nursing flowsheet. 2. New tubing should be labeled with date, time and initials of person doing the tubing change..." 12. During an observation on 2/16/16, at 2 PM, in Patient 49's room, RN 23 was seated on a chair wearing a PPE. The yellow gown was worn mid way exposing her chest and back showing her nurse uniform. She was also observed wearing a mask but it was underneath her chin. Patient 49 was in bed with the head part slightly elevated at 30 degree angle. Patient 49 was connected to a dialysis machine. On top of the dialysis machine was a binder, a tablet computer and a box of blue colored gloves. During further observation on 2/16/16, at 3:50 PM, in Patient 49's room, RN 23 had disconnected the tubing from Patient 49. She was still wearing the yellow gown mid way exposing her chest and back. She was also wearing gloves and a mask. After she had disconnected the tubing from Patient 49, at 3:55 PM, she took a bottle of distilled white vinegar and placed an amount halfway in the canister. She returned the canister back to the machine. She was observed going across the hallway to get some wipes from the purple top container (germicidal ultra bleach wipes) wearing the same gloves. After placing the wipes on top of the Hemodialysis machine, she removed her gloves and disposed of them and proceeded to the station without washing her hands. RN 23 was	{A 749}	month to the Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will continue until the Quality Council determines sustained compliance has occurred, at which time the Council will provide direction on what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Person Responsible: Director of Infection Control Finding 12 Immediate Actions Taken: 1. The identified nurse was immediately educated on infection control practices, including PPE and handwashing. The CEO notified the dialysis contractor and stated the nurse was not to return to the hospital. The CEO also notified the dialysis contractor that failure of the dialysis nurses to follow the hospital's infection control practices would not be tolerated. The dialysis contractor advised the dialysis nurses of strict adherence to infection control practices. Compliance and Monitoring The Director of Infection Control performs random observations of dialysis cases to ensure dialysis nurses wearing appropriate PPE and performing infection control practices performing hemodialysis procedures to achieve the goal of 100%	2/17/16

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{A 749}	Continued From page 41 observed working for two hours but there was no evidence the hospital employees had told her to wear the PPE appropriately. During an interview with RN 23, on 2/16/16, at 4 PM, she stated it was her first time to do a Hemodialysis (process involving a large portable machine that is attached to a patient so that their blood toxins and other fluids can be removed when the patient's kidneys no longer do it) treatment in the hospital. She stated she was using the dialysis binder to check for the parameters and the tablet computer was used for her to check the orders. She also stated she placed the box of gloves on top of the Hemodialysis machine as it was more convenient for her. During an interview with the Vice President-Hospital Operations(VP) 2 and RN 24, on 2/17/16, at 9:50 AM, they were made aware of RN 23's care during a Hemodialysis treatment. VP 2 and RN 24 both stated RN 23 had violated the infection control practices. Based on observation, interview, and document review, the hospital failed to maintain a clean hospital with cleaning procedures maintained to minimize and treat infections or communicability of diseases when: 1. Terminal cleaning (thorough cleaning done at the end of the work day to eliminate as many disease causing bacteria or viruses) was not performed daily in the areas connected to the operating rooms. The endoscopy processing room (where examination equipment is cleaned) had no door to prevent the contamination of pathogens (disease causing bacteria or virus) into	{A 749}	compliance with infection control practices including use of PPE, hand washing, and maintaining a clean environment. Corrective action is taken as necessary, including reeducation. Data on compliance is tracked, trended, analyzed and reported monthly to Quality Council and MEC. Data on compliance is reported at least every other month to the Governing Board, and is used for performance improvement measures. Person Responsible: Director of Infection Control	

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(A 749)	Continued From page 42 the restricted area of the operating room. 2. Clean and sterile supplies were stored in the decontamination room. 3. Operating room number two (one of two) did not meet state environmental standards. 4. Surgical instruments were not properly sterilized. 5. Glucometers (small, portable, hand held instrument that measure blood glucose immediately) were not disinfected between patient use. 6. Healthcare workers did not have adequate vaccination screening. 7. Within the Urgent Care, employees' personal belongings were placed in clean areas. One employee was observed eating in the nursing station. 8. On Unit III, family and staff were not following appropriate isolation measures. 9. Improperly handled soiled linen. 10. Improperly stored medical waste. 11. New Gastrostomy (GT a tube inserted directly into the stomach to provide nutrition) tubing was not labeled with time, date and initials of staff who hung the feeding. 12. In the telemetry unit, Personal Protective Equipment (PPE) was not utilized appropriately by staff.	(A 749)		

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(A 749)	Continued From page 43 These failures have the potential to transmit infections to patients, staff and visitors. Findings: 1. On 2/16/16 at 8:40 AM in the surgical department of the hospital with Operating Room Technician (ORT) 1, Registered Nurse (RN) 29 (charge nurse) and RN 30 (circulating nurse), it was observed that the specialized room used to clean medical equipment used for procedures was adjacent to Operating Room (OR) 2, separated by a door, but open to the sterile part of the OR. During closer inspection, it was noted that the floor of the cleaning room was sticky to the foot and visibly soiled. RN 29 provided a check list for the terminal cleaning of the department, which is completed by environmental services at the end of each day. The last noted signature was dated 1/23/16 at 2 PM. No hospital policy on terminal cleaning of the perioperative areas was presented upon request prior to the end of the survey. On 2/16/16, during an interview with the Infection Control (IC) at 9:30 AM, he stated that the hospital has adopted the Association of periOperating Registered Nurses Guidelines (AORN) Guidelines for Perioperative Practice as one of the hospital's nationally recognized infection control standards. According to AORN Guidelines for Perioperative Practice, Guideline for Environmental for Environmental Cleaning, Section V., Terminal cleaning and disinfection of perioperative areas, including sterile processing areas, should be	(A 749)	Finding 1 1. The identified room received a terminal cleaning. 2. Hospital Leadership and the Director of Infection Control discussed the survey findings with the Director of EVS and Interim Director of the OR, with emphasis on compliance with terminal cleaning of the perioperative areas. A policy entitled "The Environmental Sanitation Perioperative Setting" policy was developed to address the terminal cleaning process and the "Perioperative Services EVS Terminal Cleaning Log" was reviewed and revised to be more comprehensive. As detailed in the policy, all procedure rooms, the scrub areas, the sterile instrument room and the sterile processing department are terminally cleaned on a daily basis when the scheduled procedures are completed for the day and each 24-hour period during the regular work week. Unused rooms are cleaned once during each 24-hour period during the regular work week. Should any room remain unused over the week-end period, a brief cleaning (i.e., the cleaning used in a room turn-over after a procedure) will be performed prior to staff setting up the room for a case. The terminal cleaning log captures the date and time of the terminal cleaning, the location, the initials of the staff member and allows for comments to be documented. The truncated "Monday morning" cleaning is not required to be documented as this is a regular process for unused rooms every Monday. The MEC and Governing Board approved the policy and checklist on	2/17/16 4/7/16

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(A 749)	Continued From page 43 These failures have the potential to transmit infections to patients, staff and visitors. Findings: 1. On 2/16/16 at 8:40 AM in the surgical department of the hospital with Operating Room Technician (ORT) 1, Registered Nurse (RN) 29 (charge nurse) and RN 30 (circulating nurse), it was observed that the specialized room used to clean medical equipment used for procedures was adjacent to Operating Room (OR) 2, separated by a door, but open to the sterile part of the OR. During closer inspection, it was noted that the floor of the cleaning room was sticky to the foot and visibly soiled. RN 29 provided a check list for the terminal cleaning of the department, which is completed by environmental services at the end of each day. The last noted signature was dated 1/23/16 at 2 PM. No hospital policy on terminal cleaning of the perioperative areas was presented upon request prior to the end of the survey. On 2/16/16, during an interview with the Infection Control (IC) at 9:30 AM, he stated that the hospital has adopted the Association of periOperating Registered Nurses Guidelines (AORN) Guidelines for Perioperative Practice as one of the hospital's nationally recognized infection control standards. According to AORN Guidelines for Perioperative Practice, Guideline for Environmental for Environmental Cleaning, Section V., Terminal cleaning and disinfection of perioperative areas, including sterile processing areas, should be	(A 749)	3/30/13. Education was provided to OR and EVS staff through inservices and 1:1 education with demonstration of terminal cleaning and required return demonstration. 3. The Director of EVS developed a competency tool for EVS staff for terminal cleaning. The Director of EVS selected a core team of EVS staff to work in the OR and perform terminal cleaning. These EVS staff have completed the terminal cleaning competency. 4. Compliance with terminal cleaning is monitored through the QAPI program. Compliance and Monitoring: The Director of Infection Control performs random at least weekly direct observations of terminal cleaning and reviews completion of the terminal cleaning log to achieve the goal of 100% compliance with terminal cleaning. Corrective action is taken as necessary, including reeducation. Data on compliance is tracked, trended, analyzed and reported monthly to the Infection Control Committee, Quality Council and MEC. Data on compliance is reported at least every other month to the Governing Board, and is used for performance improvement measures. Persons Responsible: Director of Infection Control Director of EVS Services	4/7/16

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{A 749}	Continued From page 44 performed daily when the areas are being used. AORN Guidelines for Perioperative Practice, Guideline for a Safe Environment of Care, Part 2, Section IIb states that the HVAC (heating, ventilation, air conditioning), surgical attire, and traffic pattern requirements of the surgical suite are designed to be more stringent as one moves from unrestricted to restricted areas. The progression of restrictions is intended to provide the cleanest environment in the restricted area. The designated areas should be separated by ... doors separating the restricted area from the semi-restricted area; and doors, signage, or a line of demarcation to identify the separation between the unrestricted and semi-restricted areas. The doors provide a physical barrier to assist in maintaining control of the HVAC. 2. On 2/16/16 at 9:23 AM, in the decontamination room, clean equipment (sequential compression devices (equipment used to mobilize the knee) wrapped in plastic) were observed to be piled two high on the horizontal surface adjacent to the decontamination area sink. During an interview with the IC at 9:30 AM, he stated the hospital has adopted the Association of periOperating Room Nurses Guidelines for Perioperative Practice as one of the hospital's nationally recognized infection control standards. On 2/17/16 at 1:35 PM during a tour of the second decontamination room, it was noted that both decontamination and sterilization were performed in the same room without an additional sink for handwashing. The hospital policy entitled "Separation of Clean	{A 749}	Finding 2 1. The identified supplies were removed. The room is now a dedicated sterile processing room. 2. The Hospital installed a handwashing sink and four (4) foot barrier between the decontamination area and the autoclave. 3. Hospital Leadership reviewed the "Separation of Clean and Contaminated Items" policy, which did not require any revision. OR staff was reeducated on storage of sterile supplies versus clean. This has been reinforced through daily huddles and staff meetings.	3/31/16 4/7/16 2/17/16 – 4/7/16

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(A 749)	Continued From page 45 and Contaminated Items", dated 2/2/16, indicated: "no clean items will be stored in the decontamination area of central services or the contaminated utility room /area ...at no time will the clean/sterile items go through the decontamination areas of the dirty/contaminated items go through the clean sterile areas." According to AORN, Guidelines for Perioperative Practice, Guideline for Cleaning and Care of Surgical Instruments states that Instruments should be cleaned and decontaminated in an area separate from locations where clean items are handled. Physical separation of decontamination areas from areas where clean items are handled minimizes the risk of cross-contamination. Droplets and aerosols created during cleaning of soiled instruments can cause cross-contamination of any nearby clean items or surfaces. The sterile processing area should have separate clean and decontamination spaces, which may be rooms or areas; decontamination and clean spaces that are separated by one of three methods: a wall with a door or pass-through, a partial wall or partition that is at least 4 ft high and at least the width of the counter, or a distance of 4 ft between the instrument washing sink and the area where the instruments are prepared for sterilization; separate sinks for washing instruments and for hand hygiene. 3. During an interview with the Administrator 1 on 2/17/16 at 11:30 AM the annual air balance and certification report dated, 9/1/15, was reviewed. Under the section Crucial Area Validation Testing, OR 2 was noted to have "failed". According to the report this meant that the air exchanges per hour and space pressurization requirements	(A 749)	Compliance and Monitoring: The Director of Infection Control performs random at least weekly observations of the decontamination areas to achieve the goal of 100% compliance with AORN guidelines and hospital policy. In addition, the Interim Director of the OR or qualified designee performs daily rounds (Monday through Friday) of the OR, decontamination areas and sterile processing to assure proper storage of sterile supplies. Corrective action is taken as necessary, including reeducation. Data on compliance is tracked, trended, analyzed and reported monthly to the Patient Safety Committee, Quality Council and MEC. Data on compliance is reported at least every other month to the Governing Board, and is used for performance improvement measures. Persons Responsible: Director of Infection Control Interim Director of OR Finding 3 Actions Taken: 1. The Hospital engaged a vendor to perform air balance testing for the identified areas and annual air balance certification was obtained. 2. Hospital Leadership discussed the survey findings with the Director of Engineering, with emphasis on implementing corrective action when deficiencies are identified through testing.	2/19/16 2/17/16

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(A 749)	Continued From page 46 found in the California Mechanical Code were not met. The additional rooms that failed testing were ICU 2, Isolation 104 and SPD Clean/Dirty. Administrator 1 he stated that recommended maintenance, detailed in the report, and re-testing had not been performed since the receipt of the report in 9/2015. During an observation and interview on 2/16/16 at 9:15 AM in OR 2, five peel packs (paper packages that contain sterilized small surgical instruments) were opened. In four out of the five packs opened, the instruments inside were in the closed and locked position. ORT 1 commented that the instruments were not processed correctly and the instrument technician who packaged them (ORT 2) should have known better. 4. During an interview with the IC on 2/16/16 at 9:30 AM, he stated the hospital has adopted the AORN Guidelines for Perioperative Practice as one of the hospital's nationally recognized infection control standards. According to AORN, Guidelines for Perioperative Practice, Guideline for Selection and Use of Packaging Systems for Sterilization, V.h. Items to be sterilized should be placed in the package or tray in an open or unlocked position. The open or unlocked position facilitates sterilant contact of all surfaces of the item. 5. On 2/16/16 at 11:44 AM during an observation of RN 29 performing a glucose test for Patient 53 and Patient 49, it was noted that the glucometer was not cleaned and disinfected between patients and according to the manufacturer's instructions. During an interview and observation of the area	(A 749)	Compliance and Monitoring: The Director of Infection Control reviews the annual air balance testing reports to ensure that corrective action is taken if deficiencies are identified. Corrective action is taken as necessary. Data on compliance is tracked, trended, analyzed and reported annually to the EOC Committee, Infection Control Committee, Quality Council and MEC. Persons Responsible: Director of Infection Control Director of Engineering Finding 4 1. Sterile processing staff inspected all trays and peel packs to ensure that hinged instruments are placed in the package or tray in an open or unlocked position. 2. The sterile process technician working at the time of survey is no longer employed at the hospital. An OR tech certified in sterile processing is now working in the department. 3. The Director of Infection Control and interim OR Director conducted extensive education with sterile processing staff regarding sterilization and maintaining sterile surgical instruments and other requirements of sound decontamination practices pursuant to AAMI ST79.	2/17/16 2/18/16 2/17/16

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(A 749)	Continued From page 47 outside of the emergency room with RN 16, on 2/16/16, at 8:53 AM, there were two containers on the wall. One container with a purple lid, had the manufacturer's label that read "MICRO-KILL ONE...GERMICIDAL ALCOHOL WIPES" and read, in part, "To disinfect hard, non-porous surfaces, use one or more wipes, as necessary to thoroughly wet the surface to be treated. Treated surface must remain visibly wet for one minute to achieve complete disinfection of all pathogens listed..." A second container, with a light blue lid, the label read, "MICRO-KILL Bleach GERMICIDAL BLEACH WIPES" and the product label read, in part, for hospital disinfection, "...Remove pre-saturated 7 in x 8 in wipe...Apply pre-saturated towelette and wipe desired surface to disinfect..CONTACT TIME [amount of time the item should remain visibly wet to kill the listed pathogens]: Allow surface to remain wet for 30 seconds to kill HBV and HCV, for 3 minutes to kill Clostridium difficile sores and 5 minutes to kill HIV..." RN 16 stated she uses the "MICRO-KILL Bleach GERMICIDAL BLEACH WIPES" to disinfect the glucometers (ACCU CHEK Inform II is a medical device that is used to determine the appropriate concentration of glucose [sugar] in the blood) and she stated the contact time is a 30 second contact time. She then indicated the kill/contact time was 3 minutes for these wipes. Although she uses "MICRO-KILL Bleach GERMICIDAL BLEACH WIPES" she was instructed to use "MICRO-KILL ONE...GERMICIDAL ALCOHOL WIPES". During an observation and interview with RN 28 (Charge Nurse for the Intensive Care Unit [ICU] and the telemetry unit), on 2/16/16, at 9:47 AM, she stated there are two glucometers in the ICU and she disinfects them using the "MICRO-KILL	(A 749)	2. The Hospital purchased additional glucometers for the patient care areas. 3. The "Accu-Check Inform Glucose Meter" policy was reviewed and revised to clarify the cleaning process. In addition, a cleaning and disinfectant guide, entitled "Cleaning of Glucometers" was attached to the exterior surface of the glucometers. Glucometers are cleaned with Clorox Healthcare Bleach Germicidal Wipes in accordance with manufacturer's instructions. The cleaning occurs after every glucometer use on each patient, at least every 24 hours (when quality control testing is done), and whenever there is a suspected or true contamination and follows the manufacturer's recommendations. Nurses were educated, with emphasis on proper use of cleaning products, wet contact time, and cleaning in between each use of the glucometer on a patient. 4. Nursing staff and CNAs are educated on use and cleaning of glucometers upon hire. In addition, education is part of the annual skills fair. 5. Compliance with cleaning/disinfecting glucometers is monitored through the QAPI program. <u>Compliance and Monitoring</u>: The Director of Infection Control or qualified designee performs random at least weekly rounds in patient care areas to observe cleaning/disinfecting of glucometers to achieve the goal of 100% compliance. Corrective action is taken as necessary, including just-in-time training. Data on	2/19/16 2/19/16 – 3/17/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050663	A. BUILDING _____ B. WING _____	R-C 02/17/2016

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(A 749)	Continued From page 48 ONE...GERMICIDAL ALCOHOL WIPES" and she stated, she is the staff who is responsible for disinfecting the devices. She disinfects the glucometers once on her shift (morning) and then the night shift staff will disinfect the devices once on their shift. She was asked how many times are the glucometers being used currently and she stated approximately six times on the morning shift. She then proceeded to demonstrate how she wipes the devices and allows them to remain visibly wet for two minutes. She was again asked, how many times are the devices disinfected, and again she stated once on her shift. No further information was provided. The hospital policy and procedure titled, "ACCU-CHEK Inform Glucose Meter" effective date 2/19/14, indicated in part for the Cleaning/Disinfecting of the meters use "Super Sani-Cloth Wipes or 10% bleach...Frequency 1. In between every patients...3. Whenever there is suspected or true contamination...How to Clean Meters, Bases and Supply Cases 1. Meter...remove a wipe from the PDI Super Sani-Cloth or Clorox wipe tub and close the lid...Allow to air dry before use: 2 min for Sani-Cloth" The "ACCU-CHEK Inform II" Operator's manual Version 3.0, Revision dated 3/2013, with changes that included "Update cleaning and disinfecting chapter" was reviewed. Page 124 through page 131 indicated in part, "Cleaning and disinfecting the exterior surface of the meter is, at minimum, recommended daily for dedicated patient devices. Meters used with multiple patients may require more frequent cleaning and disinfecting...The meter should be cleaned and disinfected between each patient use...Acceptable active ingredients	(A 749)	compliance is reported at least every other month to the Governing Board, and is used for performance improvement measures. Person Responsible: Director of Infection Control	

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{A 749}	Continued From page 49 and products for cleaning and disinfecting are...Clorox Germicidal Wipes...Super Sani-Cloth Germicidal Disposable Wipes...Always use Clorox Germicidal Wipes...or Super Sani-Cloth Germicidal Disposable Wipes...to clean and disinfect the meter. Do not use any other cleaning or disinfecting solution. Using solutions other than Clorox Germinal Wipes...or Super Sani-Cloth Germicidal Disposable Wipes...could result in damage to the system components..." 6. On 2/16/16 at 1:15 PM, during a review of employee health records, three out of three files did not have complete vaccination records (RN 29, ORT 2, Environmental Services Manager [EVS] 1). RN 29 did not have evidence of tDap (Tetanus (a serious illness caused by bacteria that can enter the body through a deep cut) Diphtheria (a serious bacterial infection), and Pertussis (commonly known as Whooping Cough, an infectious bacterial disease that causes uncontrollable coughing) or varicella (Chickenpox) immunity. ORT 2 did not have evidence of mumps immunity and EVS 1 did not have evidence of tDap and Varicella. The hospital policy entitled Immunizations for Healthcare Workers dated 2/2012 was reviewed on 2/16/16 at 2:30 PM. It states that as part of the preemployment evaluation, employees will be required to complete a questionnaire regarding prior vaccinations for, or exposure to communicable vaccine-preventable diseases. In situations where immunity is questionable or undetermined from the questionnaire the employee will be tested to determine his/her immune status.	{A 749}	Finding 6 1. Hospital Leadership, including the Director of Human Resources and Director of Infection Control, discussed the survey findings and the process for monitoring immunizations for hospital employees. The "Physical Examinations - Post Employment Offer" policy was reviewed and revised to align with current practice. The MEC and Governing Body approved the policy on 3/30/16. The Director of Infection Control researched the issue of Tdap vaccination for health care workers and discussed mandatory versus recommended guidelines with a representative from the Immunization Branch of the California Department of Public Health. It was confirmed that use of the Tdap vaccination is recommended but not mandatory. Nonetheless, Hospital Leadership elected to offer the Tdap vaccination to employees. The Tdap vaccine was ordered and a flyer distributed for employees (posted at time clocks and in department units) that the vaccine is being offered and when/where they can receive the vaccination. In addition, the Director of HR developed a Tdap consent/declination form for employees to complete, which will be maintained in the employee's personnel file. In addition, the Director of HR developed a spreadsheet that lists all employees and the status of their vaccinations for Tdap, hepatitis, and MMR and varicella. Employee files were reviewed to update the spreadsheet and employees. If information was not present regarding the status of the immunity for hepatitis, MMR	4/7/16

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State of California-Health and Human Services Agency
California Department of Public Health

CDPH

KAREN L. SMITH, MD, MPH
Director and State Health Officer

EDMUND G. BROWN JR.
Governor

April 12, 2016

Los Angeles Community Hospital
4081 E Olympic Blvd
Los Angeles, CA 90023

Dear Administrator:

FACILITY: Los Angeles Community Hosp
COMPLAINT NUMBER: CA00449063

Enclosed is STATE FORM Statement of Deficiencies and Plan of Correction Form, which resulted from a recent visit to your facility. Please prepare a plan of correction, sign and date the document, return the original to this department within ten (10) calendar days from receipt of this STATE FORM Statement of Deficiencies, and retain a copy for your file.

The Plan of Correction for each deficiency must contain the following:

a) What corrective action(s) will be accomplished for the patient(s) identified to have been affected by the deficient practice.
b) How other patients having the potential to be affected by the same deficient practice be identified, and what corrective action will be taken.
c) What immediate measures and systemic changes will be put into place to ensure that the deficient practice does not recur.
d) A description of the monitoring process and positions of persons responsible for monitoring (i.e., Administrator, Director of Nursing, or other responsible supervisory personnel). How the facility plans to monitor its performance to ensure corrections are achieved and sustained. The plan of correction must be implemented, corrective action evaluated for its effectiveness, and it must be integrated into the quality assurance system.
e) Dates when corrective action will be completed. The corrective action completion date must be acceptable to the Department. The deficient practice should be corrected immediately. This date shall be no more than 30 calendar days from the date the facility was notified of the non-compliance.

If your Plan of Correction is unacceptable to the Department you will be notified in writing. You are ultimately accountable for compliance, and responsibility is not

alleviated where notification of the acceptability of the plan of correction is not timely. Your plan of correction will serve as the facility's allegation of compliance. If an acceptable plan of correction is not received within ten (10) calendar days from receipt of the STATE FORM Statement of Deficiencies, the Department will recommend to the regional office and/or the State Medicaid Agency that remedies be imposed as soon as the notice requirements are met.

If you have any questions, please contact Tamara Cleveland , Health Facilities Evaluator Supervisor, at 855-804-4205.

Sincerely,

Mic6ealTioyi

For Colleen Reeves, R.N., HFEM II, Chief
State Facilities Section
Licensing and Certification

CR/mf
Enclosure *(STATE FORM)*

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA930000085	A. BUILDING: _____	C 08/17/2015

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LOS ANGELES COMMUNITY HOSPITAL	4081 E OLYMPIC BLVD LOS ANGELES, CA 90023

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E 000	Initial Comments The following reflects the findings of the California Department of Public Health during the investigation of a complaint. Complaint Number: CA00449063 Representing the California Department of Public Health: 2091, HFEN (Health Facilities Evaluator Nurse) The investigation was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. Two deficiencies were written for complaint CA00449063	E 000	AOOO Initial Comments Preparation and execution of this plan of correction does not constitute an admission or agreement of the facts alleged or conclusions set forth on the Statement of Deficiencies. This plan of correction is prepared and executed solely because it is required by federal and state law. The following constitutes Los Angeles Community Hospital's credible allegation of compliance.	
E 276	T22 DIV5 CH1 ART3-70214(a)(2)(A) Nursing Staff Development (a) There shall be a written, organized in-service education program for all patient care personnel, including temporary staff as described in subsection 70217(m). The program shall include, but shall not be limited to, orientation and the process of competency validation as described in subsection 70213(c). (2) All patient care personnel, including temporary staff as described in subsection 70217(m), shall be subject to the process of competency validation for their assigned patient care unit or units. Prior to the completion of validation of the competency standards for a patient care unit, patient care assignments shall be subject to the following restrictions: (A) Assignments shall include only those duties and responsibilities for which competency has	E 276	E 276 Nursing Staff Development Immediate Actions Taken: The CEO and Nursing Leadership discussed the survey findings and had a discussion with the owner of the dialysis company regarding expectations on orientation and competencies for the dialysis staff. Nursing Leadership reviewed the "Contract Employees" Policy, to clarify the process for supervising and evaluating contracted nursing staff, including orientation requirements, evaluation of competencies and performance, and personnel file requirements. The policy did not require revision. A file is maintained in the nursing office for contracted nursing staff, including dialysis nurses.	8/17/2015 8/17/2015

Licensing and Certification Division
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

California Department of Public Health

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E 276	Continued From page 1 been validated. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure that two of four Registered Nurses (Staff A and Staff B) from a contracted dialysis agency had demonstrated competency to provide hemodialysis treatments (a treatment that will remove harmful waste from the body when the kidneys cannot) for one of one patients (Patient 1). This failure had the potential to result in unsafe care for the patient. Findings: Patient 1 was admitted to the facility on 6/13/15 with diagnoses that included renal failure (a condition in which the kidneys lose the ability to remove waste from the body). Review of Patient 1's clinical record indicated that four RN's from the contracted dialysis agency had provided hemodialysis for Patient 1. During a review of the dialysis agency binder that contained licensure, qualification, and competency evaluations for dialysis staff providing care to patients in the facility indicated that two of the four RN's (Staff A and Staff B) did not have up to date annual competency skills for hemodialysis procedures. During a review of Patient 1's clinical record, the dialysis treatment record dated 6/21/15, indicated Staff A provided hemodialysis treatment that began at 8:00 PM and ended at 11:00 PM. During a review of the dialysis agency binder,	E 276	The file includes primary source license verification and required competencies. The contracted nursing staff members also receive an orientation packet, with a copy maintained in his/her file. Nursing office staff was reinserviced on the policy. The CEO discussed the survey issues concerning the provision of dialysis services with the dialysis company, with special emphasis on completion of orientation and competencies for nurses working at the hospital. Subsequent Actions Taken: Dialysis nurses must check in first at the nursing office prior to going on to the patient care units, where upon their file will be reviewed for completeness. Dialysis nurses with incomplete files will not be allowed to practice. Over the ensuing months, the CNO had numerous conversations with the dialysis company regarding failure to comply consistently with contract obligations on completion of orientation and competencies for dialysis nurses working at the hospital. Staff who did not have a complete file, were not allowed to work until all required documents were submitted. Ultimately, the CEO terminated the dialysis contract and engaged a new dialysis company, effective 2/8/16. A new dialysis competency tool was provided to the new company and orientation and competencies for the new dialysis staff are maintained in the nursing office.	8/24 – 9/4/2015 8/17/2015 August 18, 2015 Aug – Dec 2015. 2/8/2016

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E 276	Continued From page 2 Staff A's Annual Competency Skills Checklist indicated there were no annual competencies for hemodialysis procedures demonstrated for 2014 and 2015. During an interview with the CNO (Chief Nursing Officer) on 7/9/15 at 11:00 AM, she reviewed Staff A's Annual Competency Skills Checklist and verified Staff A's last documented annual skills competency for hemodialysis procedures was 10/15/13. She stated that verification of skills and competencies for contracted staff that provide care within the facility was the responsibility of the contracted agency. She further stated, "We don't keep track of qualifications or expirations" of contracted staff credentials or licenses, and expect that information contained in the folder from the dialysis agency to be current. During a review of Patient I's clinical record, the dialysis treatment record dated 6/22/15, indicated Staff B provided hemodialysis treatment that began at 6:30 PM and ended at 10:00 PM. During an interview with QAC 1 (Quality Assurance Coordinator) on 7/9/15 at 10:15 AM, she reviewed Patient I's dialysis treatment record dated 6/22/15 and stated she did not know the identity of the staff who provided the hemodialysis treatment. During this interview, she reviewed the dialysis agency binder and was unable to locate licensure, competency validation, or qualifications for Staff B. On 7/9/15 at 10:45 AM, QAC 1 provided a copy of Staff B's California Board of Registered Nursing license, California Driver License, CPR (Cardiopulmonary Resuscitation) card, and ACLS (Advanced Cardiovascular Life Support) card. She stated she had just received these	E 276	Monitoring: The CNO or designee will perform a monthly audit of 100% of the contracted nursing staff files (for three months and then re-evaluate) to achieve 100% compliance with orientation and documented competencies. Data is analyzed and reported monthly to Quality Council and MEC, and at least every other month to Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will continue until Quality Council determines sustained compliance has occurred, at which time the Quality Council will provide direction on what adjustments to monitoring are necessary for ongoing sustainability. (e.g.: Random samples or inclusion of the issue as an ongoing indicator). Person Responsible: Chief Nursing Officer	4/7/2016

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E 276	Continued From page 3 documents via email from the contracted dialysis agency. There was no documentation provided to verify Staff B had demonstrated annual skills competency to provide hemodialysis procedures. During an interview with the Corporate Vice President of quality management for the facility, on 8/4/15 at 11:00 AM, she stated, "It was the facility's responsibility to verify licensure, skills, and competencies of all providers in the facility, just like for registry staff." The facility policy and procedure titled "Contracted Services, Performance Monitoring" dated July 2012, currently in "Draft" status under review, indicated dialysis services were included as a service affected by the policy. The policy indicated it was the facility's requirement to maintain required records for proof of staff licensure, training, continuing education, performance measurements and competency validation. The facility policy and procedure titled "Competency & Skills Validation" dated 10/1/2013, indicated the staff providing care would have competencies and skills validated prior to care provided to hospital patients.	E 276		
E2216	T22 DIV5 CH1 ART7-70749(a)(6)(A) Patient Health Record Content (a) Each inpatient medical record shall consist of at least the following items: (6) Nurses' notes which shall include but not be limited to the following: (A) Concise and accurate record of nursing care	E2216	E2216 Health Record Content Immediate Actions Taken: Upon receipt of the Statement of Deficiencies, the CEO and Nursing Leadership discussed the survey findings and process for nursing care planning with the nursing staff, and the owner of the dialysis company regarding expectations on medical record content, specifically the importance of a concise and accurate record of nursing care.	8/17/2015

California Department of Public Health

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E2216	Continued From page 4 administered. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure that Patient I's medical record consisted of nurses' notes that included complete documentation of nursing care administered during CPR (cardiopulmonary resuscitation) that took place during a hemodialysis treatment. This failure had the potential to result in prevention of other members of the healthcare team from having access to accurate, vital medical information important to making care decisions. Findings: Patient 1 was admitted to the facility on 6/13/15 with diagnoses that included renal failure (a condition in which the kidneys lose the ability to remove waste from the body). During a review of the clinical record for Patient 1, the CPR record dated 6/26/15 at 12:12 PM, indicated Patient 1 had a witnessed full cardiac and respiratory arrest with an extreme low heart rate. Patient 1 was resuscitated with restoration of pulse, respirations, and consciousness at 12:22 PM and CPR was terminated. During a review of the clinical record for Patient 1, the Assessment and Cares flowsheet dated 6/26/15 at 12:12 PM, staff documented "HR (heart rate) is down to 59 then 48/min (per minute) and dialysis was stopped and called code blue."	E2216	Hospital Nursing Leadership discussed the nursing survey findings and reviewed the "Code Blue" policy to ensure compliance with applicable standards pertaining to emergency rescue were maintained. The policy did not require revision. Nursing and Dialysis staff were re-educated on the importance of complete and accurate documentation, and that failure to do so had the potential to result in the prevention of other members of the healthcare team from having access to accurate, vital medical information, important to making care decisions. Subsequent Actions Taken: The Hospital assures that it has an organized nursing service that is furnished or supervised by registered nurses. The Hospital hired a new Chief Nursing Officer on 9/9/2015. Her initial focus was centered on reorganizing the nursing structure to support consistent processes, including emergency rescue. An Associate Chief Nursing Officer (ACNO) was hired on 12/16/15. The ACNO developed a presentation and educated nursing staff on nursing documentation, with special emphasis on the ongoing review and updating of nursing documentation as necessary to address the patient's ongoing needs (e.g., emergency rescue). Nursing leadership meetings are ongoing at least bimonthly to discuss compliance with current and accurate documentation in the medical record.	8/19/2015 8/24 – 9/4/2015 9/9/2015 12/16/2015 1/31/2016 3/1/2016

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LOS ANGELES COMMUNITY HOSPITAL	4081 E OLYMPIC BLVD LOS ANGELES, CA 90023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E2216	Continued From page 5 During a review of the clinical record for Patient 1, the dialysis treatment record dated 6/26/15, dialysis staff documented hemodialysis had begun at 8:30 AM and was completed at 12:00 PM. The dialysis treatment record did not include documentation of CPR. During an interview with the Corporate Vice President of quality management for the facility, on 8/4/15 at 11:00 AM, she reviewed the dialysis treatment record dated 6/26/15 and was unable to find documentation of the CPR event by the dialysis staff. The dialysis agency policy and procedure titled "Code Blue Response" dated June 2003, indicated it was the procedure of dialysis staff to document the event, treatment, and patient response when CPR occurred during hemodialysis.	E2216	A Director of ICU and ED Services was hired on 3/1/2016. Her initial focus is centered on assessing and re-educating staff on competencies within their assigned clinical area/department, including emergency rescue procedures. Compliance with nursing documentation is monitored through the QAPI Program. Monitoring: Effective 4/7/2016 data is collected by care facilitators, aggregated and reported to leadership at least weekly to allow for leadership to focus resources on staff education and development. The goal is to achieve 100% compliance. Data is analyzed and reported monthly to Quality Council and MEC, and at least every other month to Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will continue until Quality Council determines sustained compliance has occurred, at which time the Quality Council will provide direction on what adjustments to monitoring are necessary for ongoing sustainability. (e.g.: Random samples or inclusion of the issue as an ongoing indicator). Person Responsible: Chief Nursing Officer	3/1/2016 4/7/2016

5. Reports of ECHN's Quality Evaluation Team to the Board of ECHN

Please see attached report of the ECHN Quality Evaluation Team to the Board of ECHN, together with the resolutions adopted by the Board following such report.

REVIEW OF CHARTERCARE/PROSPECT MEDICAL HOLDINGS

Situation:

The ECHN Quality Department visited CharterCARE Hospitals, Roger Williams Medical Center (RWMC) and Our Lady of Fatima Hospital (OLF), in Providence RI on Friday March 4, 2016 to evaluate their quality improvement systems. RWMC is licensed for 250 beds with an average daily census of 100, OLF is licensed for 359 beds with an average daily census of 107.

Background:

CharterCARE Health Partners has joined in a joint venture with Prospect Medical Holdings (PMH) to develop an innovative regional coordinated health care network, anchored by Roger Williams Medical Center and Our Lady of Fatima Hospital. The two hospitals are not fully integrated; PMH is assisting in this transition. PMH acquired CharterCARE in June of 2014. Each hospital has a President who reports to the CEO of CharterCARE. The Quality Department reports directly to the President of each hospital. Risk management reports directly to both Presidents as well as to general counsel in California. Education and Infection Control report directly to the CNO of each hospital. Corporate Compliance officer reports to the CEO of corporate compliance in California.

Assessment:

- PMH has brought in safe transitions of care which has significantly reduced their readmission rates. Pharmacists and LPN brought on board for follow up calls.
- The integration of the hospitals will assist in eliminating the duplication of services as the two hospitals have a similar market place.
- PMH has invested in the renovation of the two hospitals with the patient in mind. Improving handicap access, improved lighting, single rooms, open concept nursing units (best practice), future renovation of cafeteria and nutritional services. A new diagnostic wing is in the process of being added at RWMC as well as new and larger (double the size) state of the art Emergency Departments which will include Behavioral Health (BH) areas at both hospitals.
- Hospitals have integrated similar departments including Quality, Risk, and Environmental Services and are continuing to evaluate for further integration.
- CharterCARE has a robust Quality Department. PMH has supported new positions to ensure that quality standards and metrics are met and maintained. PMH recognized RWMC's focus on Quality and Safety and supported the process that was already in place. PMH has increased staffing in the patient satisfaction area.
- A Quality Improvement diagram of reporting structure was provided.
- In speaking with the CNO's of each hospital PMH has allowed autonomy in managing departments that are meeting their performance measures. Those

departments that are not meeting expectations are assisted by PMH Corporate oversight.

- PMH has assisted in the pursuit of certifications including stroke, diabetes, and total joint replacement.
- PMH has good outreach for primary care doctors, started an Independent Practice Association (IPA).
- PMH is in the process of developing various VP positions for oversight of the PMH systems.
- PMH has been supportive in the development of safety programs at both hospitals including High Reliability Organization (HRO) training.
- PMH has allowed CharterCARE hospitals autonomy to continue to define and pursue their process improvement initiatives that work well, while also bringing forward and assisting CharterCARE in instituting additional best practices.
- CharterCARE was provided tools to assist with staffing and productivity.
- PMH looks at processes through evidence based standards and then analyzes cost and outcomes to choose the best pathway.
- PMH supports a multidisciplinary, timely review of serious events by medical peer review and nursing peer review processes.
- PMH provides strong legal support which has experience with healthcare unions.
- Recycling and reprocessing has improved with support from PMH.
- CharterCARE uses Meditech at both hospitals.
- Infection Control (IC) is robust, has not yet been integrated between both hospitals. Strong support of IC at both hospitals.
- PMH provides metrics displayed in an organized dashboard with clinical and financial outcomes.

Recommendation:

It is apparent by observation and interview that PMH has provided many new and positive opportunities to CharterCARE and has been supportive of Quality, Safety and Infection Control. Recommend continued contact with CharterCARE hospitals for assimilation of best practices seen in recent visit.

Eastern Connecticut Health Network
71 Haynes Street
Manchester, CT 06040
860.533.3414
www.echn.org

CERTIFICATE OF AUTHORITY

I, Michele B. Conlon, MD, Secretary, Board of Trustees of Eastern Connecticut Health Network, Inc., a corporation organized under the laws of the State of Connecticut, do hereby certify that the following is a full and true copy of a resolution adopted at a meeting of the Board of Trustees of Eastern Connecticut Health Network, Inc., duly held on the **23rd day of March, 2016:**

WHEREAS, the Board of Trustees (the "Board') of Eastern Connecticut Health Network, Inc. (the "Corporation"), following an extensive study of the health care market and future prospects and alternatives facing the Corporation, has determined that an affiliation with, or sale of substantially all of the Corporation's assets to, another healthcare organization is in the best interest of the Corporation and its affiliates; and

WHEREAS, after extensive evaluation of competing bids, the Board determined that a sale of substantially all of the Corporation's assets to subsidiaries of Prospect Medical Holdings, Inc. (collectively, "PMH") (the "Transaction") will best enable the continued availability of high-quality health care for residents of the Corporation's service area; and

WHEREAS, with the approval of the Board, the Corporation entered into that certain Letter of Intent with PMH dated June 25, 2015 (the "Letter of Intent") and negotiated a draft asset purchase agreement with PMH (the "APA"); and

WHEREAS, on October 13, 2015 the Corporation and PMH (i) executed an amendment extending the Letter of Intent and (ii) jointly submitted a Certificate of Need application to the Connecticut Attorney General and the Connecticut Department of Public Health Office of Health Care Access seeking approval for the Transaction; and

WHEREAS, in February 2016 the Corporation was made aware by PMH of certain quality issues that had occurred at certain health care facilities located in California owned by PMH that took place during the Fall of 2015 and Winter of 2016 and included "Immediate Jeopardy" findings by the California Department of Public Health as well as 90-day termination letters issued by the Centers for Medicare and Medicaid Services (collectively, the "Quality Issues"); and

WHEREAS, the management of the Corporation and the Transaction Committee of the Board of Trustees (the "Transaction Committee") have reviewed extensively the nature and extent of the Quality Issues with both internal and external advisors; and

WHEREAS, certain members of the management of the Corporation traveled to California to obtain first hand information concerning the Quality Issues and to meet with PMH executives to discuss the Transaction in February 2016; and

WHEREAS, certain of the Corporation's quality experts visited two PMH-owned health care facilities located in Rhode Island (the "Rhode Island Facilities") to learn about PMH's quality programs and summarized the findings of the visit for the Transaction Committee; and

WHEREAS, to ensure that PMH maintains the Corporation's current quality standards following the closing of the Transaction, the Corporation has drafted a side letter to the APA that binds PMH to (i) continue the Corporation's existing quality programs for two years following the closing of the Transaction; (ii) seek the approval of the local board established by the APA before making changes to such quality programs during the two years following the closing of the Transaction; and (iii) ensure that the Corporation receives the benefit of the quality improvement programs that have been implemented at the Rhode Island Facilities (the "Side Letter"); and

WHEREAS, the Transaction Committee, following its extensive review of the Quality Issues, has recommended that the Board (i) seek PMH approval of the Side Letter, and (ii) reaffirm the Transaction as being in the best interest of the Corporation; and

WHEREAS, the Board has determined that (i) in view of the likelihood of continuing changes in the health care market and ongoing financial pressures, and (ii) in light of its review of the Quality Issues and PMH's responses thereto, the Transaction remains in the best interest of the Corporation.

NOW, THEREFORE, be it resolved as follows:

Approve Side Letter

RESOLVED: That the Board directs management to seek PMH's approval of the Side Letter in such form and with such changes as the President and CEO of the Corporation may determine to be necessary or appropriate.

Reaffirm Transaction

RESOLVED: That the Board reaffirms the Transaction as being in the best interest of the Corporation.

AND I DO FURTHER CERTIFY that the above resolution has not been in any way altered, amended or repealed, and is now in full force and effect.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the corporate seal of said corporation this 23rd day of March, 2016.

Eastern Connecticut Health Network, Inc.

(SEAL)

By: _____
Michele B. Conlon, MD
Its Secretary

6. Delegation of Authority of Quality/Compliance to Local Boards in Rhode Island

Please see attached.

6. Delegation of Authority of Quality/Compliance to Local Boards in Rhode Island.

The Local Boards in Rhode Island are advisory boards without delegated authority over quality or compliance. The ultimate authority rests with the Prospect CCHP Board of Directors (the "Board"). The local advisory boards in RI have the following responsibilities: (a) making recommendations regarding medical staff credentialing, quality assurance and accreditation; (b) reviewing, and making recommendations with respect to, strategic and capital plans; (c) providing guidance and support on local market and community concerns, considerations, strategies, issues and politics; and (d) performing such other duties and providing review an recommendations with respect to other matters, as requested by the Board.

The Board works with hospital executives to provide a critical link between the hospital and the community, facilitating access to quality healthcare. Currently the following roles and responsibilities have been identified for the local advisory boards in RI:

- Monitor and oversee the quality of care being provided by the hospital
- Identify and present for discussion and solution, problems affecting patient care
- Serve as a liaison between the governing board and the community
- Make recommendations and provide key information and materials to the CCHP BOD to support the CCHP BOD's decision making on strategies, community issues, financial improvement, and capital plans
- Consult and advise in matters affecting the hospital's policies and programs as they relate to the citizens of the community
- Obtain information and give feedback to the CCHP BOD regarding the hospital's needs, service areas and programs and how they are perceived by the community
- Ensure that the community is kept informed of the hospital's goals and objectives
- Promote and foster hospital connections and visibility in the community
- Represent the hospital in the community
- Educate the public about the strengths and services provided by the hospital

7. Classification of E. Stevens Henry Fund and Updated Values of Charitable Funds as of March 31, 2016

Please see attached.

Classification of E. Stevens Henry Fund

ECHN has evaluated the classification of the E. Stevens Henry Fund (Fund 11.1-55) and determined that the Fund is properly classified as endowment as was originally reported in Exhibit Q11-1 (Page 951).

As to the Fund's original gift value, ECHN has checked probate court records and determined that the original principal value of the gift to RGH was $1,720,205 and not $1,742,007 as originally reported. The Affidavit of Closing (Revised) of the Trustee, a copy of which is provided, reports a principal distribution to RGH of $1,720, 205; the Affidavit also reports a distribution of income accumulated after the death of the life beneficiary, which is not part of the principal.

This corrected gift number is included in the following Excel chart showing the March 31, 2016, updated values of the charitable funds.

65/2611/3456406.1

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TO THE COURT OF PROBATE FOR THE DISTRICT OF ELLINGTON

AFFIDAVIT OF CLOSING - Revised
FLEET NATIONAL BANK, TRUSTEE
E. STEVENS HENRY ESTATE TRUST
April 3, 2003 through November 6, 2003

A. PRINCIPAL CHARGES

Property on hand, per Supplemental Final account dated April 2, 2003	$702,169.68
Total of reserves held for final expenses, per Supplemental Final account	7,025.00
Gain on sale or maturity of securities - Schedule A-1	1,015,563.09
	$1,724,757.77

B. PRINCIPAL CREDITS

Administration expenses - Schedule B-1	$4,552.40
Distributions to Rockville General Hospital Endowment Fund	1,720,205.37
	$1,724,757.77

C. INFORMATIONAL SCHEDULES - PRINCIPAL

Purchases - Schedule C-1
Transactions with no gain or loss - Schedule C-2

D. INCOME CHARGES

Income on hand, per Supplemental Final account dated April 2, 2003	$11,877.79
Total of reserves held for final expenses, per Supplemental Final account	7,025.00
Income received - Schedule D-1	12,478.95
Additional income received - Schedule D-2	101.27
	$31,483.01

E. INCOME CREDITS

Administration expenses - Schedule E-1	$4,552.43
Distributions to Rockville General Hospital Endowment Fund	26,930.58
	$31,483.01

F. INFORMATIONAL SCHEDULES - INCOME

NONE

G. CASH ACCOUNTS AND RECONCILIATIONS

Principal cash account - Schedule G-1

FLEET NATIONAL BANK, TRUSTEE, by:

Ann McGunnigle
Its: Vice President

On the 21 day of April, 2004 Ann McGunnigle appeared before me and made oath that the foregoing is a true and complete account of all the receipts and disbursements in the capacity of the above mentioned ...that no person entitled to notice of a hearing on this account who has not signed and filed in Court a written appearance and waiver of notice of such hearing is in the military service of the United States or allied nation.

By: Shirley J. Beaulieu

MARILYN J. BEAULIEU
NOTARY PUBLIC
My Commission Expires Aug. 31, 2006

E. Stevens Henry Estate Trust
#304557040

SCHEDULE A-1

Gain on sale or maturity of securities

Date	Units	Description	Received	Inventory	Gain/(Loss)
07/24/03	500	Ameren Corp	$21,159.00	$22,092.00	($933.00)
07/24/03	1,600	Automatic Data Processing Inc	57,517.30	15,588.00	41,919.30
07/24/03	528	BP P L C Sponsored Adr	21,398.83	11,370.29	10,028.54
07/24/03	1,200	Bristol Myers Squibb Co	31,642.51	19,890.71	11,751.80
07/24/03	2,133	Citigroup Inc	97,452.20	1,371.11	96,081.09
07/24/03	1,600	Coca Cola Co	71,916.63	3,193.14	68,723.49
07/24/03	1,800	Dupont E I De Nemours & Co	75,794.44	13,225.00	62,569.44
07/24/03	3,200	Exxon Mobil Corp	114,394.63	732.92	113,661.71
07/24/03	600	First Data Corp	23,968.87	25,092.00	(1,123.13)
07/24/03	3,500	General Electric Co	99,787.32	3,619.12	96,168.20
07/07/03	500	General Mtrs Corp	17,714.16	10,989.42	6,724.74
07/24/03	25,000	Hawaii St 5.125%, 02/01/06	25,397.50	24,768.50	629.00
07/24/03	600	Home Depot Inc	19,889.06	19,842.00	47.06
07/24/03	1,850	J P Morgan Chase & Co	64,839.46	8,379.38	56,460.08
07/24/03	1,600	Lilly Eli & Co	107,402.96	5,144.50	102,258.46
07/07/03	1,200	McDonalds Corp	26,277.76	10,798.50	15,479.26
07/24/03	1,600	Merck & Co Inc	95,195.54	1,874.42	93,321.12
07/24/03	1,000	Microsoft Corp	26,818.74	26,040.00	778.74
07/24/03	1,200	Pepsico Inc	56,673.34	20,834.96	35,838.38
07/24/03	1,200	Procter & Gamble Co	107,394.97	6,585.53	100,809.44
07/07/03	500	SBC Communications Inc	12,928.39	22,378.75	(9,450.36)
07/24/03	800	3M Co	106,275.02	7,744.76	98,530.26
07/24/03	600	Verizon Communications	21,566.98	23,598.00	(2,029.02)
07/24/03	400	Viacom Inc Cl B	17,599.17	17,300.00	299.17
07/24/03	900	Wisconsin Energy Corp	25,153.62	8,134.50	17,019.32
			$1,346,160.60	$330,597.51	$1,015,563.09

SCHEDULE B-1

Administration Expenses

Fleet National Bank, services as Trustee	$3,361.90
Ellington Probate Court, final probate fee	377.00
Day Berry & Howard LLP, final legal fee	813.50
	$4,552.40

SCHEDULE C-1

Purchases

Date	Units	Description	
07/07/03	500	Ameren Corp	$22,092.00
07/07/03	600	First Data Corp	25,092.00
07/07/03	600	Home Depot Inc	19,842.00
07/07/03	1,000	Microsoft Corp	26,040.00
07/07/03	600	Verizon Communications	23,598.00
07/07/03	400	Viacom Inc Cl B	17,300.00
			$133,964.00

SCHEDULE C-2

Transactions with no gain or loss

Galaxy Institutional Money Market Fund	
Balance on hand per last account	$505,536.17
Net purchases and sales	(505,536.17)
Balance on hand, dated November 6, 2003	$0.00

E. Stevens Henry Estate Trust
#304557040

SCHEDULE D-1

Income Received

Automatic Data Processing Inc	$192.00
BP P L C Sponsored Adr	198.00
Bristol Myers Squibb Co	672.00
Citigroup Inc	426.60
Coca Cola Co	352.00
Dupont E I De Nemours & Co	630.00
Exxon Mobil Corp	800.00
Galaxy Institutional Money Market Fund	2,269.39
General Electric Co	1,368.00
General Mtrs Corp	250.00
Hawaii St 5.125%, 02/01/06	615.71
J P Morgan Chase & Co	1,258.00
Lilly Eli & Co	536.00
Merck & Co Inc	576.00
Pepsico Inc	192.00
Procter & Gamble Co	1,038.00
SBC Communications Inc	166.25
3M Co	528.00
Verizon Communications	231.00
Wisconsin Energy Corp	180.00
	$12,478.95

SCHEDULE D-2

Additional Income Received

Galaxy Institutional Money Market Fund - bank management fee credits	$101.27

SCHEDULE E-1

Administration Expenses

Fleet National Bank, services as Trustee	$3,361.93
Ellington Probate Court, final probate fee	377.00
Day Berry & Howard LLP, final legal fee	813.50
	$4,552.43

SCHEDULE G-1

Principal Cash Account

Receipts

Cash on hand, per Supplemental Final account dated April 2, 2003	$505,536.17
Total of reserves held for final expenses, per Supplemental Final account	7,025.00
Proceeds from sale or maturity of securities, per Schedule A-1	1,346,160.60
	$1,858,721.77

Disbursements

Administration expenses, per Schedule B-1	$4,552.40
Purchases, per Schedule C-1	133,964.00
Distributions to Rockville General Hospital Endowment Fund	1,720,205.37
	$1,858,721.77

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EXHIBIT Q 11-1
ECHN ENDOWMENT AND OTHER CHARITABLE FUNDS - FUNDS 11-1.1 - 11-1.84

Explanatory Notes:

1. ECHN has provided a copy of each available gift instrument. In some cases, although it conducted a thorough review of its records as well as the records of local probate courts, it was unable to locate the original gift instrument. In those cases, it has provided other available documentation of the gifts, including copies of minutes of Board meetings and/or copies of old audited financials.
2. References to the 1990 Report of the Attorney General are to the June, 1990 Report of the Office of the Attorney General on Hospital Bed Fund Trusts.
3. Proposed requests for cy pres relief will apply to the balances of the funds remaining at the time and not appropriated or used by ECNH for proper purposes.

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
MANCHESTER MEMORIAL HOSPITAL								
	Endowment: Unrestricted Income Funds							
11-1.1	Dwight W. Blish Fund	$19,920	$189,989	Devise under Article Fourth of the Last Will and Testament of Dwight W. Blish dated September 6, 1923, with Codicil dated July 3, 1933	Upon the deaths of Mr. Blish's wife and son, the testamentary trust he had established for their benefit terminated, and the property then remaining was given outright "to The Manchester Memorial Hospital to be held by the trustees of said hospital as a trust fund to be known as the Dwight W. Blish fund, the income therefrom to be used for such purposes in connection with said hospital as the trustees shall decide." Income unrestricted	The Last Will and Testament of Dwight W. Blish dated September 6, 1923, and Codicil dated July 3, 1933		Request cy pres relief and transfer to the new Foundation
11-1.2	John & Eliza Carpenter	$2,555	$110,546	Unknown	There is no specific documentation for the terms of this gift, but it has been consistently booked on MMH's books for a number of years as endowment with unrestricted income. Income unrestricted	Excerpt from the Hospital's audited financial statements as of 9/30/1996 and 1995; and supporting reconciliation of funds as of 9/30/1995		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.3	Helen G. Chapman	$5,000	$81,614	Bequest under Article FOURTH of the Last Will and Testament of Helen G. Chapman dated July 1, 1938	Bequest of $5,000 "to the Manchester Memorial Hospital, of Manchester, Connecticut, to be held by it in perpetuity, with power of investment, sale and reinvestment, and to apply the income only for the support of the Hospital maintained by it in the town of Manchester." Income unrestricted	The Last Will and Testament of Helen G. Chapman dated July 1, 1938		Request cy pres relief and transfer to the new Foundation
11-1.4	William H. Coates (Costes)	$500	$5,550	Bequest under the Last Will and Testament of William H. Coates (date unknown)	This bequest is documented in the minutes of the August 12, 1925 meeting of the Board of Trustees of the Hospital, which state that "A report was given by the Manchester Trust Company, Executor of the will of William H. Coates, of a gift of $500.00, the interest only to be used for hospital purposes." This bequest is also referenced in a document titled "Exhibit A - Report of the Finance Committee" apparently excerpted from Board minutes. That Exhibit also classifies this fund as an endowment fund and states [the income is to be used] "...as the trustees of said hospital may deem best..." Income unrestricted	Minutes of the August 12, 1925 meeting of the Board of Trustees; and "Exhibit A - Report of the Finance Committee" from other Board minutes.	Note: This fund has sometimes (incorrectly) been identifed as a gift from William H. Costes rather than William H. Coates.	Request cy pres relief and transfer to the new Foundation
11-1.5	Grace K. Dart	$4,007	$123,290	Devise under ARTICLE VI. of the Last Will and Testament of Grace Kingsbury Dart dated December 7, 1931.	Devise of half the residuary estate. Article VI. provides as follows: All the rest, residue and remainder of my property, both real and personal, wherever it may be situated and of whatsoever it may consist I direct be divided into two (2) equal parts. The first of said equal parts, I give, devise and bequeath to The Manchester Memorial Hospital, a Connecticut Corporation, located in said Manchester, to take, hold, manage, invest and reinvest and to use the income therefrom for the general running expenses of said Hospital. Income unrestricted	The Last Will and Testament of Grace Kingsbury Dart dated December 7, 1931		Request cy pres relief and transfer to the new Foundation
11-1-6	The Grace L. House Fund	$2,500	$30,080	Bequest under Article VI. of the Last Will and Testament of Charles E. House dated May 4, 1933	Bequest to the Hospital of $2500 "to be held by said Hospital as a permanent fund, and to be know[n] as "The Grace L. House Fund". The income therefrom is to be used for the running expenses of said Hospital." Income unrestricted	The Last Will and Testament of Charles E. House dated May 4, 1933		Request cy pres relief and transfer to the new Foundation

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Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
10-1.7	The John Porter & Caroline E. Porter Fund	$7,464	$172,767	Devise under Paragraph EIGHTH (c) of the Last Will and Testament of John Porter dated November 4, 1936, with Codicil dated November 4 1937. Devise under Article SIXTH (f) of the Last Will and Testament of Caroline E. Porter, dated July 3, 1956.	Devise of a share in the residue of a testamentary trust established by the Will of John Porter as follows: "Twenty per cent. (20%) [of this trust], ..., I give in equal shares to the following fourteen charitable institutions, in each instance to be known as "The John Porter and Caroline E. Porter Fund", to be held in perpetuity, with power of investment and reinvestment, the income only to be used for the support of the institutions hereinafter named, viz.: ...13. The Manchester Memorial Hospital, of Manchester,..." Subsequent devise by Caroline E. Porter of a portion of another testamentary trust established under the Will of John Porter through her exercise of a power of appointment over one-half of the trust as follows:: "SIXTH: ... Accordingly,...., I nominate and appoint [the following] to receive out of said one-half of said residuary estate of my late husband, John Porter, the following gifts, to wit: ... (f) The balance ... shall be distributed by said trustees in equal shares to the following fourteen charitable institutions, ..., in each instance to be known as "The John Porter and Caroline E. Porter Fund", to be held in perpetuity, with power of investment and reinvestment, the income only to be used for the support of the institutions hereinafter named, viz. ...13. The Manchester Memorial Hospital, of Manchester, Connecticut;..." Income unrestricted	The Last Will and Testament of John Porter dated November 4, 1936, with Codicil dated November 4 1937; the Last Will and Testament of Caroline E. Porter, dated July 3, 1956; and May 23, 1958, letter from Hartford National Bank and Trust Company to Robert Hathaway of the Manchester Trust Company.		Request cy pres relief and transfer to the new Foundation
11-1.8	William & Mary Rice Fund	$122,361	$987,626	Devise under Article FOURTH of the Last Will and Testament of Richard W. Rice dated April 11, 1924	Upon the deaths of the last named life beneficiary, the testamentary trust Mr. Rice had established terminated, "... and the principal thereof, and all accumulations thereto, I give, devise and bequeath to the Manchester Memorial Hospital, of Manchester, Connecticut, in trust, to be known as the William and Mary Rice Fund, the income therefrom to be used for the purposes of uses of said Hospital." Income unrestricted	The Last Will and Testament of Richard W. Rice dated April 11, 1924		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
10-1.9	Robert N. and Florella Stanley Trust Fund	$3,000	$33,921	Bequest under ARTICLE V. of the Last Will and Testament of Flora May Stanley dated December 2, 1940	Bequest of $3000 to The Manchester Memorial Hospital, a Connecticut corporation, "... to be known as the Robert N. and Florella Stanley Trust Fund, to be added to the Endowment Fund of said hospital, and the income to be used for such purposes as the Trustees may deem best." Income unrestricted	The Last Will and Testament of Flora May Stanley dated December 2, 1940		Request cy pres relief and transfer to the new Foundation
11-1.10	George W. Strant and Rose B. Strant Memorial Fund	$128,043	$692,118	Two bequests and a share in the residuary estate as follows: (1) Bequest under Article THIRD 1. of the Last Will and Testament of Rose B. Strant dated December 22, 1954; (2) Bequest under Article THIRD 6. of said Will; and (3) Devise of a share in the residuary estate under Article FOURTH a. of said Will	Rose Strant left three testamentary gifts to Manchester Memorial Hospital, all of which were to the Hospital's endowment,"the income only from which is to be used for the general purposes of said hospital." The Bequest (in Article THIRD 1(b) and (c)) was the remainder interest in a $2000 trust or, if the life beneficary predeceased her, $2000: "b. Upon the death of [my cousin] "... said trust shall thereupon terminate and ...the principal of said trust, together with any unpaid income, [shall] be paid to the MANCHESTER MEMORIAL HOSPITAL, of Manchester, Connecticut, to be added to its endowment fund and the income only from which is to be used for the general purposes of said hospital. c. If my said cousin... shall predecease me, then in that event, I give and bequeath said Two Thousand ($2,000.00) Dollars to the Manchester Memorial Hospital, to be used as set forth above. Article THIRD 6. bequeathed "the sum of Five Thousand ($5,000.00) Dollars to the Manchester Memorial Hospital, to be added to its endowment fund and to be known as the George W. Strant and Rose B. Strant Memorial Fund, the income only from which is to be used for the general purposes of said hospital." Article FOURTH A. left two of three three equal parts "to the MANCHESTER MEMORIAL HOSPITAL, of Manchester, Connecticut, to be added to its endowment fund and to be known as the Geroge W. Strant and Rose B. Strant Memorial Fund, the income only from which is to be used for the general purposes of said hospital." Income unrestricted	The Last Will and Testament of Rose B. Strant dated December 22, 1954		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.11	Minnie R. Strickland	$2,511	$108,629	Devise under ARTICLE IX of the Last Will and Testament of Minnie R. Strickland dated June 29, 1942	Devise of one-third of the residuary estate pursuant to Article IX, which provides as follows: "I direct that all the rest and residue of my property of whatever kind and wherever situated shall be divided into three (3) equal parts: I give one of said equal parts to the Manchester Memorial Hospital; of Manchester, Conn., to be added to the Endowment Fund of said Hospital;..." Income unrestricted	The Last Will and Testament of Minnie R. Strickland dated June 29, 1942		Request cy pres relief and transfer to the new Foundation
11-1.12	Arthur B. and Carrie E. Ellis Trust Fund	$5,000	$55,579	Bequest under ARTICLE IV. of the Last Will and Testament of Carrie E. Ellis dated February 9, 1940, with Codicil dated October 8, 1942	Bequest to The Manchester Memorial Hospital of "the sum of Five Thousand ($5,000.00) Dollars, to be added to the Endowment Fund of said hospital and to be known as "The Arthur B. and Carrie E. Ellis Trust Fund", the income therefrom to be used for such hospital purposes as its Trustees may desire." Income unrestricted	The Last Will and Testament of Carrie E. Ellis dated February 9, 1940; Codicil dated October 8, 1942		Request cy pres relief and transfer to the new Foundation
11-1.13	Ralph and Lula Pinney Fund	$31,031	$312,382	Devise under Article 7th of the Last Will and Testament of Lula M. Pinney dated May 13, 1924	Upon the deaths of the respective life beneficiaries,two testamentary trusts Mrs. Pinney had established terminated, and she gave " ... One-half (1/2) [of the principal] to the Manchester Memorial Hospital as a permanent fund to be known as the Ralph and Lula Pinney Fund, the income of which Fund to be used and applied for the general purposes of said hospital, but as I am now maintaining a room in said hospital in memory of Sanford Keeney, I direct that so much of said income as may be required shall be used and applied towards the maintenance of said room..." Income unrestricted as to this part of the gift; see also Fund 11-1.27.	The Last Will and Testament of Lula M. Pinney dated May 13, 1924	Note: There is no record that Mrs. Pinney endowed a room in memory of Sanford Keeney; rather, it appears that she supported a room for free care through annual gifts. The Hospital historically treated her entire gift as endowment for the general purposes of the Hospital, but it has now allocated one-fourth of the fund to the Sanford Keeney Free Bed Fund, which is included here as Fund 11-1.27.	Request cy pres relief and transfer to the new Foundation
11-1.14	Emil L. G. Hohenthal	$750	$7,735	Unknown	This fund is documented in the June 16, 1953 minutes of a meeting of the Board of Trustees of the Hospital. The minutes do not quote or refer to gift language, but state that the "original amount" of the gift was $750, and the context suggests that this is an endowment. This fund has been consistently booked on MMH's books for a number of years as endowment with unrestricted income. Income unrestricted	The minutes of the June 16, 1953 meeting of the Board of Trustees of the Hospital; the financial records of the Hospital.	Note: The Hospital located the Last Will and Testament of Mr. Hohenthal's wife Hazel, but it did not include this gift.	Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
10-1.16	George Wells Cheney and Harriet Richmond Cheney Memorial Fund	$75,000	$573,735	Devise under Article SEVENTH C. of the Last Will and Testament of Louis R. Cheney dated February 22, 1944	Devise of a share in the residuary estate as follows: "Seventh: I direct my Executors to divide all the rest, residue and remainder of my property both real and personal, and wheresoever situated including any property over which I may have power of disposal or appointment, into one Hundred Fifty-five (155) equal parts, and I give, bequeath and devise said parts as follows: ... C. Ten (10) of said parts to the Manchester Memorial Hospital as a memorial to my father and mother, George Wells Cheney and Harriet Richmond Cheney, to be held as a separate fund and the income only used for the general purposes of said Hospital." Income unrestricted	The Last Will and Testament of Louis R. Cheney dated February 22, 1944		Request cy pres relief and transfer to the new Foundation
11-1.16	Helen Campbell Cheney Fund	$543,562	$4,657,104	Devise under Article Sixth (b) of the Last Will and Testament of Helen Campbell Cheney dated June 29, 1960	Devise of a share in the residuary estate as follows: "Sixth. All the rest, residue and remainder of my estate, both real and personal and wherever situated, I direct my Executor to divide into three (3) equal parts and to transfer and pay over said three (3) equal parts and I so give, devise and bequeath the same as follows: .. (b) One (1) of said equal parts to Manchester Memorial Hospital, a hospital corporation organized and existing under the laws of the State of Connecticut and located in said Manchester, to be held as a permanent fund in memory of my husband, Philip Cheney, with power of investment and reinvestment, the income only to be used and applied for the benefit of said Hospital in such manner as the Trustees of said Hospital may in their discretion determine." Income unrestricted	The Last Will and Testament of Helen Campbell Cheney dated June 29, 1960		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
1201.17	Albert (Herbert) Dewey	$1,498	$64,828	Unknown	There is no original or specific documentation of the terms of this gift, but it has been consistently booked on MMH's books for a number of years as endowment with unrestricted income. Income unrestricted	Excerpt from the Hospital's audited financial statements as of 9/30/1996 and 1995; and supporting reconciliation of funds as of 9/30/1995	Note: The Hospital located the Will of Albert Dewey at the Manchester probate court, but the Will does not include this gift: the Will indicates that Mr. Dewey had an inter vivos trust, but no copy of the trust was in the probate court records. Note: There is some confusion whether this fund is named for Albert or Herbert Dewey; the Hospital believes it is the Albert Dewey Fund. Note: The June 30, 1981, minutes of the Development Committee reference an $8,000 bequest from Albert T. Dewey that will be memorialized with a plaque in the Vestibule on the Second Floor East Building (244) as the "Gift of Albert T. and Jane N. Dewey". This does not appear to be the same gift.	Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.18	Jane (June) Dewey	$936	$40,517	Unknown	There is no specific documentation for the terms of this gift, but it has been consistently booked on MMH's books for a number of years as endowment with unrestricted income. Income unrestricted	Excerpt from the Hospital's audited financial statements as of 9/30/1996 and 1995; and supporting reconciliation of funds as of 9/30/1995	Note: The Hospital located the Will of Jane Dewey at the Manchester probate court, but it does not include this gift; the Will indicates that Jane Dewey had an inter vivos trust, but no copy of the trust was in the probate court records. Note: There is some confusion whether this fund is named for Jane or June; the Hospital believes it is the Jane Dewey Fund. Note: The June 30, 1981, minutes of the Development Committee note a $5,000 bequest from Jane N. Dewey that will be memorialized with a plaque in the Nurses' Lounge in the Surgical Suite "In memory of Hilma N. Dillon and Emily D. Coburn". This does not appear to be the same gift.	Request cy pres relief and transfer to the new Foundation
11-1.19	The Loren Gardner Fund	$25,000	$71,637	Bequest under Article FIFTH of the Last Will and Testament of Ella C. Livermore dated October 12, 1929	Bequest of "twenty five thousand dollars ($25,000) to the Manchester Memorial Hospital, a corporation specially chartered by the State of Connecticut, located at South Manchester in said State, in memory of my father, Loren Gardner, to be held by said Hospital as a fund to be known as The Loren Gardner Fund, the income therefrom to be used for the proper uses of the Hospital I request, but do not make it a condition, that the income, or so much as may be necessary, be applied to the maintenance of a free bed in said Hospital for poor patients." Income unrestricted with a request that it be used for free care	The Last Will and Testament of Ella C. Livermore dated October 12, 1929	Note: The Hospital has historically classified and reported this fund as restricted for free care, and it reported this as a free bed fund to the Office of the Attorney General for inclusion in the 1990 Report of the Attorney General. The donor did not, however, impose that as a binding condition. This income from this endowment fund is thus unrestricted, and the fund has been reclassified.	Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.20	Donald G. Piper and Hazel B. Piper Memorial	$75,000	$119,182	Preliminary distribution of Devise under Article FOURTH of the Last Will and Testament of Hazel B. Piper dated November 30,1990	Preliminary distribution on 6/28/06 of portion of devise of the residuary estate as follows: "FOURTH. All the rest, residue and remainder of my property, both real and personal, and of whatsoever nature, wherever the same may be located or found, which I may own or have the right to dispose of at my death (intending hereby to exercise any power of disposition or appointment that I may have at my death, I give, devise and bequeath unto MANCHESTER MEMORIAL HOSPITAL of Manchester, Connecticut, in memory of DONALD G. PIPER and HAZEL B. PIPER, to be held in the Consolidated Investment Fund, the income only from which is to be used at the discretion of the Board of Trustees of the hospital for its general uses and purposes." Income unrestricted	The Last Will and Testament of Hazel B. Piper dated November 30,1990	Note: The Hospital received two preliminary distributions of $75,000 each from the Estate (reported herein as Funds 11-1.20 and 11-1.21). The remainder of this devise is reported under the ECHN Community Healthcare Foundation as Fund 11-1.81.	Request cy pres relief and transfer to the new Foundation
11-1.21	Donald G. Piper and Hazel B. Piper Memorial	$75,000	$119,182	Preliminary distribution of Devise under Article FOURTH of the Last Will and Testament of Hazel B. Piper dated November 30,1990	Preliminary distribution on 7/26/06 of portion of devise of the residuary estate as follows: "FOURTH. All the rest, residue and remainder of my property, both real and personal, and of whatsoever nature, wherever the same may be located or found, which I may own or have the right to dispose of at my death (intending hereby to exercise any power of disposition or appointment that I may have at my death, I give, devise and bequeath unto MANCHESTER MEMORIAL HOSPITAL of Manchester, Connecticut, in memory of DONALD G. PIPER and HAZEL B. PIPER, to be held in the Consolidated Investment Fund, the income only from which is to be used at the discretion of the Board of Trustees of the hospital for its general uses and purposes." Income unrestricted	The Last Will and Testament of Hazel B. Piper dated November 30,1990	Note: The Hospital received two preliminary distributions of $75,000 each from the Estate (reported herein as Funds 11-1.20 and 11-1.21). The remainder of this devise is reported under the ECHN Community Healthcare Foundation as Fund 11-1.81.	Request cy pres relief and transfer to the new Foundation
Subtotal: Endowment: Unrestricted Income Funds		$1,130,838	$8,558,011					

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
	Free Bed Funds (Endowment Restricted for Free Care)							
11-1.22	Drake Fund	$90,500	$174,202	Devise under Article EIGHTH (c)(2) of the Last Will and Testament of Edith Drake Quimby dated September 7, 1949 with Codicil dated October 4, 1950	Upon the deaths of the life beneficiaries and the payment of specific bequests, Article EIGHTH (c) directs that the Trustees divide the balance of the funds: "into ten(10) equal parts and I give, devise and bequeath said parts as follows:... " (2) Two (2) of said parts to the Manchester Public Hospital, of Manchester, Connecticut, in memory of my father and mother, Levi Drake and Julia Pease Drake, the income therefrom to be used to support a bed in said hospital. It is my wish that said fund shall be known as the "Drake Bed Fund" and I request that the nomination to this bed be vested in the governing body of the Congregational Church in North Manchester, Connecticut, of which my parents were members for many years." Income restricted for free care	The Last Will and Testament of Edith Drake Quimby dated September 7, 1949; and Codicil dated October 4, 1950	Note: MMH has an active contact at the Congregational Church, which is the nominator for this fund.	Request cy pres relief and transfer to the new Foundation
11-1.23	The Mattie Hills Preston Free Bed Endowment	$8,000	$8,006	Bequest under Article FIFTH (a) of the Last Will and Testament of James M. Preston dated April 3, 1924	Bequest of "Eight Thousand ($8,000) Dollars, the same to be held by said Hospital in trust and the income thereof applied for the maintenance of a free bed, such endowment to be known as "The Mattie Hills Preston Free Bed Endowment." Income restricted for free care	The Last Will and Testament of James M. Preston dated April 3, 1924	Note: As stated in the Will and in the 1990 Report of the Attorney General, Article FIFTH (d) of the Will creates a second $8,000 bed fund in the name of James Preston if there is sufficient money. The Hospital's records do not reflect that this second bed fund was established or what happened to the second bequest.	Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
10 1.24	F. O. Boynton	$923	$924	Devise under Last Will and Testament of F.O. Boynton (date and location unknown)	Devise of the residuary estate as follows: "I give and bequeath to the Manchester Memorial Hospital of Manchester, Connecticut,...all the rest, residue and remainder of my estate, to be held as a separate and permanent fund and the income therefrom to be used for the general purposes of the hospital with special reference to the furnishing of hospital facilities to persons then not able to pay for the service so rendered." Income restricted for free care	Excerpt from the Hospital's audited financial statements as of 9/30/1996 and 1995 with supporting reconciliation of funds as of 9/30/1995; excerpt from the 1990 Report of the Attorney General; and undated Exhibit A to Report to Finance Committee		Request cy pres relief and transfer to the new Foundation
11 1.25	Erna W. Loomis	$196,394	$196,547	(1) Bequest under ARTICLE V, paragraph L. of the Last Will and Testament of Erna W. Loomis dated July 20, 1992; and (2) Devise of a share in the residuary estate under ARTICLE V, paragraph R.4. of said Will	Erna W. Loomis left two testamentary gifts to Manchester Memorial Hospital, both of which were endowment restricted for the same purpose: Bequest under ARTICLE V, paragraph L.of "TWENTY-FIVE THOUSAND ($25,000) DOLLARS to MANCHESTER MEMORIAL HOSPITAL of Manchester, Connecticut, to be held in trust, the income only to be included in any program providing for the payment of anyone's expenses who cannot otherwise afford the same." Devise under ARTICLE V, paragraph R.: "All of my property thereafter remaining is to be divided into the following four (4) equal parts: ... 4. The fourth of said parts is to be added to my bequest to MANCHESTER MEMORIAL HOSPITAL, under Article V, Paragraph L of this Will and held and administered in accordance with its terms." Income restricted for free care	The Last Will and Testament of Erna W. Loomis dated July 20, 1992		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
10-1.26	Elsie Cheney Disher (Sophie H. Cheney)	$151,579	$151,697	Gift of an interest in the remainder of a trust created by Elsie C. Disher upon termination of the trust (date of trust unknown.)	The Trust provided as follows: "The remainder in equal shares to the Manchester Memorial Hospital of Manchester, Connecticut, and to _____. The gift to the Manchester Memorial Hospital is to be held as a permanent fund, in memory of my mother, the income thereof to be used so far as is necessary for the support of a private room in said Hospital, to be known as the "Sophie H. Cheney Room", said room in the discretion of the Hospital authorities to be used for the benefit of worthy cases of special need. Any balance of the income not necessary for the foregoing purpose shall be used by the Hospital authorities for the general purposes of the Hospital. I request that said authorities use a portion of the income for the erection of a suitable table in said room to be inscribed with an appropriate reference to my said mother and to her general benefactions to the community." Income restricted for free care	Excerpt from Trust Agreement of Elsie C. Disher.	Note: The Hospital has only a copy of an excerpt from the Trust agreement, which was an inter vivos trust. The Hospital has a copy of Mrs. Disher's Last Will and Testament dated May 11, 1923; that included a contingent unrestricted gift to the Hospital but did not include this trust provision. Mrs. Disher died in 1923.	Request cy pres relief only for funds, if any, not used by the Hospital
11-1.27	Sanford Keeney	$10,344	$10,352	Devise under Article 7th of the Last Will and Testament of Lula M Pinney dated May 13, 1924	Upon the deaths of the respective life beneficiaries,two testamentary trusts Mrs. Pinney had established terminated and she gave " ... One-half (1/2) [of the principal] to the Manchester Memorial Hospital as a permanent fund to be known as the Ralph and Lula Pinney Fund, the income of which Fund to be used and applied for the general purposes of said hospital, but as I am now maintaining a room in said hospital in memory of Sanford Keeney, I direct that so much of said income as may be required shall be used and applied towards the maintenance of said room..." Income restricted for free care as to this part of the gift; see also Fund 11-1.13	The Last Will and Testament of Lula M. Pinney dated May 13, 1924	Note: There is no record that during her lifetime Mrs. Pinney endowed a room in memory of Sanford Keeney; rather, it appears that she supported a room for free care through annual gifts. The Hospital historically treated her entire gift as endowment for the general purposes of the Hospital, but it has now allocated one-fourth of the fund to the Sanford Keeney Free Bed Fund, which is included here as Fund 11-1.27. The balance of her testamentary gift is reported at Fund 11-1.13.	Request cy pres relief and transfer to the new Foundation
Subtotal: Free Bed Funds		$457,740	$541,728					

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
	Endowment Restricted to Purposes Other Than Free Care							
11-1.28	Thomas D. Trotter Memorial Fund	$500	$500	Bequest under ITEM VII of the Last Will and Testament of Thomas D. Trotter dated January 20, 1951	Bequest to Manchester Memorial Hospital of "the sum of Five Hundred (500) Dollars to be known as the Thomas D. Trotter Memorial Fund, and I direct that only the income from this fund is to be used, in the absolute and uncontrolled discretion of the supervisor of said hospital, in some way for the benefit of the children patients." Income restricted to benefit pediatric patients	The Last Will and Testament of Thomas D. Trotter dated January 20, 1951		Request cy pres relief and transfer to the new Foundation
11-1.29	William and Rebecca J. Wright Fund	$6,124	$6,128	Devise under ARTICLE IV of the Last Will and Testament of Rebecca J. Wright dated May 26, 1948	Devise of a share in the residuary estate as follows: "ARTICLE IV. ....In the event my said brother should die before me, I direct my Executor, without the requirement of setting up the Trust, to distribute the funds designated for the Trust directly to the remainder men thereof as hereinafter set forth. I direct my Trustee to divide all funds in its hands into three (3) equal shares and I direct my Trustee to pay over one (1) of said shares to The Manchester Memorial Hospital of Manchester, Connecticut, and that said share shall be kept intact as an endowment fund and that the income therefrom shall be used in the fight again Cancer, and that said share or fund shall be known as the William and Rebecca J. Wright Fund." Income restricted for cancer	The Last Will and Testament of Rebecca J. Wright dated May 26, 1948		Request cy pres relief and transfer to the new Foundation
Subtotal: Endowment Restricted to Purposes Other Than Free Care		$6,624	$6,629					

3336704.1

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
Miscellaneous Funds								
11-1.30	Interests in the Estate of Raymond F. Damato	Unknown at this time	Unknown at this time	(1) Devise under Article SEVENTH D. of the Last Will and Testament of Raymond F. Damato dated July 7, 2009, with Codicils dated April 10, 2010, and February 11, 2011; and (2) bequests of trust termination shares under Article SIXTH of the Will.	Devise of 20% of the residuary estate "to Manchester Memorial Hospital, of Manchester, Connecticut.....Except as set forth in the individual bequests above, the bequests subject to this Paragraph shall be unrestricted in purpose and left to the discretion of the governing board of each of the respective charitable organizations. Article SIXTH provides that, upon the termination of each of the eleven trusts created under that Article, "...the Trustee shal distribute the then remaining Trust of said deceased beneficiary,... absolutely and free of trust, to those beneficiaries and in the respective percentages set forth in Article Seventh of this my last Will and Testament. Unrestricted	The Last Will and Testament of Raymond F. Damato dated July 7, 2009,Codicil dated April 10, 2010; and Codicil dated February 11, 2011;	Note: Mr. Damato died April 25, 2014, and his Will and Codicils were admitted to probate May 6, 2014. It is premature to estimate the values of the Hospital's interests, but the estate is known to be substantial.	Use by the Hospital in the discretion of its Board
11-1.31	Life Insurance Policy (Name of Insured withheld)	NA	$58,147	Life Insurance Policy with face value of $50,000 issued by National Life Insurance Company	Policy owned by the Hospital with a current cash value of $58,147. Unrestricted	Face sheet of the Policy, with the name of the insured redacted		Request cy pres relief and transfer to the new Foundation if the insured is then living
Subtotal: Miscellaneous		$0	$58,147					
Grand Total: Manchester Memorial Hospital		$1,595,003	$9,164,514					

3336704.1

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
	ROCKVILLE GENERAL HOSPITAL							
Endowment: Unrestricted Income Funds								
11-1.32	Alice Farmer Bissell Fund	$25,000	$3,717,384	Bequest under Article Fourth of the Last Will and Testament of Arthur T. Bissell dated September 1, 1932	Bequest to the Rockville City Hospital of "the sum of Twenty-five Thousand Dollars ($25,000) to be kept as a permanent fund in memory of my wife, Alice Farmer Bissell, and to be known as the Alice Farmer Bissell Fund The net income from said fund shall be used and applied for the general purposes of said Hospital." Income unrestricted	The Last Will and Testament of Arthur T. Bissell dated September 1, 1932		Request cy pres relief and transfer to the new Foundation
11-1.33	Frances Taylor Maxwell Memorial Fund	$50,000	$83,261	Devise under Article FOURTEENTH (b) of the Last Will and Testament of Florence Parsons Maxwell dated February 24, 1956, with Codicil dated April 9, 1959	Devise of a share of the residue of a trust upon the death of the life beneficiary as follows: "FOURTEENTH: All the rest, residue and remainder of my estate of every name and nature, real and personal,..., I direct my executors hereinafter named to divide into six (6) equal shares: ..(b) I give, devise and bequeath one (1) of said shares to said Hartford National Bank and Trust Company, absolutely and in fee simple, but in trust, nevertheless,... to pay over, apply or expend for the benefit of my granddaughter VIRGINIA BELDING...the net income thereof ...Upon the death of said VIRGINIA BELDING, I direct my said Trustee to divide the principal of said trust fund into two equal portions. One (1) such portion shall be paid over to ROCKVILLE CITY HOSPITAL, an eleemosynary corporation of Connecticut located in Rockville, the principal to be kept safely invested and known as the FRANCIS TAYLOR MAXWELL MEMORIAL FUND, and the net income only used for its general uses and purposes." Income unrestricted	The Last Will and Testament of Florence Parsons Maxwell dated February 24, 1956; and Codicil dated April 9, 1959		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.34	Stephen Goodale and Emeret Scott Risley Fund	$89,689	$918,485	(1) Bequest under Paragraph NINTH of the Last Will and Testament of May Risley Adams dated February 26, 1944; and (2) Devise under Paragraph TWENTY-FIRST of said Will	May R. Adams left two testamentary gifts to Rockville City Hospital, both of which were endowment restricted for the same purpose as follows. Bequest under Paragraph NINTH to "THE ROCKVILLE CITY HOSPITAL, INC. of said Rockville, the sum of Ten Thousand Dollars, in memory of my father and mother, Stephen Goodale Risley, M.D. and Emeret Scott Risley, for the establishment of a fund to be known as the Stephen Goodale Risley and Emeret Scott Risley Fund, the income thereof to be used for the general uses and purposes of said Hospital; together with the diploma of my late father, Stephen Goodale Risley, M.D. and my John Hamilton clock, made in Glasgow, Scotland, before 1720." Devise of the residue of the estate under Paragraph TWENTY-FIRST: "All the rest, residue and remainder of all my property, of every description, both real and personal, of whatsoever the same may consist or wheresoever it may be situated, I give, devise and bequeath unto said THE ROCKVILLE CITY HOSPITAL, INC., in order that the same may be added to and become a part of the Stephen Goodale Risley and Emeret Scott Risley Fund, which is estabished in paragraph Ninth of this my last will and testament. Income unrestricted	The Last Will and Testament of May Risley Adams dated February 26, 1944		Request cy pres relief and transfer to the new Foundation
11-1.35	United German Society Fund	$10,724	$25,686	Gift from United German Society	Excerpt from "Source and Terms of Fund Held": "Gift from United German Society - considered permanent endowment - income is used for general expenses of the Hospital." Income unrestricted	Document titled "Source and Terms of Funds Held" originally compiled November 24, 1952, and later supplemented through 1957 (at Page 6)		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.36	William H. Prescott	$50,000	$660,877	Bequest under Article 13. of the Last Will and Testament of William H. Prescott dated January 17, 1908 Bequests under Paragraphs 5, 9, and 15 of the Last Will and Testament of Celia E. Prescott dated June 13, 1917	Bequest as follows: "13. I give and bequeath to Francis T. Maxwell, Arthur T. Bissell, J. Alice Maxwell, A. N. Belding and Thomas W. Sykes, all of Rockville, Connecticut, the sum of fifty thousand dollars ($50,000) in perpetual trust to them and their successors in office, for the purpose of establishing and maintaining at said city of Rockville, a general hospital for the sick . . ." Bequests under the Will of Celia E. Prescott of the remainders of three $5,000 trusts upon the deaths of the respective life beneficiaries, the remainder of each given "... to the trustees of the Rockville City Hospital, in trust, for the benefit of said hospital, that the same may be added to the endowment fund provided for in the will of my late husband, William H. Prescott, for the purpose of establishing and maintaining said proposed hospital." Income unrestricted	The Last Will and Testament of William H. Prescott dated January 17, 1908; and The Last Will and Testament of Celia E. Prescott dated June 13, 1917		Request cy pres relief and transfer to the new Foundation
11-1.37	William Maxwell Fund	$171,719	$437,248	Devise under Article FOURTEENTH of the Last Will and Testament of William Maxwell dated December 3, 1938, with Codicils dated December 3, 1938 and January 3, 1939; inter vivos gifts, and life insurance proceeds	Devise of share of residue of estate as follows: "FOURTEENTH: To ROCKVILLE CITY HOSPITAL in Rockville, Connecticut, I give, devise, and bequeath four of said equal [one hundred] parts of my said residuary estate in trust to use the income thereof for the general purposes of said Hospital." Income unrestricted	The Last Will and Testament of William Maxwell dated December 3, 1938; Codicil dated December 3, 1938; Codicl dated January 3, 1939; document titled "Source and Terms of Funds Held" dated in 1952 and updated in 1957 (at Page 3); and minutes of January 20, 1953 meeting of the Board of Trustees of the Hospital.		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.38	Cora Lloyd Smith Fund	$7,658	$19,128	Devise under Article SIXTH (b) of the Last Will and Testament of Cora Lloyd Smith dated May 10, 1940	Devise of a share of the residue of a trust upon the death of the life beneficiary as follows: "...Upon the death of my said husband CLARENCE SMITH, I direct that said trust shall cease and terminate, and I give, devise and bequeath said trust fund remaining at said time, as follows, to wit: ... (b) The remaining one-half thereof unto The ROCKVILLE CITY HOSPITAL, INC. of said town of Vernon, to be known as the Cora Lloyd Smith Fund. I direct the trustees of said Hospital to lawfully invest said legacy and to use the income therefrom for the general uses and purposes of said Hospital." Income unrestricted	The Last Will and Testament of Cora Lloyd Smith dated May 10, 1940		Request cy pres relief and transfer to the new Foundation
11-1.39	Bruno E. and Maud J. Doss	$8,000	$15,180	Bequest under Article THIRD d. of the Last Will and Testament of Bruno E. Doss dated May 4, 1956, as amended by Codicil dated June 17, 1957, with additional Codicils dated October 14, 1958 and January 22, 1959	Bequest under the Codicil of "...Eight Thousand (8,000) Dollars in cash to ROCKVILLE CITY HOSPITAL, INC., in trust for the following purpose: To set up a fund to be known as BRUNO E. DOSS and MAUD J. DOSS fund; to invest and reinvest the same in its discretion and to pay over only the income therefrom, at least annually, to the ROCKVILL CITY HOSPITAL GENERAL OPERATING EXPENSE ACCOUNT." Income unrestricted (for use for operations)	The Last Will and Testament of Bruno E. Doss dated May 4, 1956; Codicil dated June 17, 1957, Second Codicil dated October 14, 1958; and Third Codicil dated January 22, 1959		Request cy pres relief and transfer to the new Foundation
11-1.40	Eva Noble Wood Fund	$1,000	$13,399	Bequest under Article FIFTH of the Last Will and Testament of Eva Noble Wood dated June 18, 1964	Bequest to "...the ROCKVILLE CITY HOSPITAL, INC., of said Town of Vernon, the sum of One Thousand (1,000) Dollars to be held by said Hospital and the income from said sum to be used for its general uses and purposes and said sum is to be known as the Eva Noble Wood Fund." Income unrestricted	The Last Will and Testament of Eva Noble Wood dated June 18, 1964		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.41	Maud Henry	$50,000	$167,491	Bequest under Article Ninth of the Last Will and Testament of Edward Stevens Henry dated April 22, 1914, with Codicil dated March 3, 1920	Bequest "...to the Hospital to be established in Rockville under the provisions of the will of the late William H. Prescott to be known as the "Rockville City Hospital" This bequest is to constitute a special endowment fund of Fifty thousand dollars $50,000, to be set apart and known as the Maud Henry fund in memory of my deceased daughter Maud....The income of [this fund] is to be used for the maintenance of said Hospital..." Income unrestricted	The Last Will and Testament of Edward Stevens Henry dated April 22, 1914; and Codicil dated March 3, 1920	Note: Mr. Henry left two $50,000 bequests, one for each of his deceased daughters, Maud and Lenore.	Request cy pres relief and transfer to the new Foundation
11-1.42	Lenore Henry	$50,000	$148,115	Bequest under Article Ninth of the Last Will and Testament of Edward Stevens Henry dated April 22, 1914, with Codicil dated March 3, 1920	Bequest of "...Fifty thousand dollars $50,000, to said [Rockville City] Hospital also to be set apart as a separate endowment fund and known as the "Lenore Henry" fund in memory of my deceased daughter Lenore. Income of [this fund] is to be used for the maintenance of said Hospital...." Income unrestricted	The Last Will and Testament of Edward Stevens Henry dated April 22, 1914; and Codicil dated March 3, 1920	Note: Mr. Henry left two $50,000 bequests, one for each of his deceased daughters, Maud and Lenore.	Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
10-1.43	George Palmer Charter Fund	$10,000	$14,398	Bequest under Article SECOND of the Last Will and Testament of George Palmer Charter (date unknown)	Bequest "...to the Rockville City Hospital, located in the city of Rockville, State of Connecticut, the sum of Ten Thousand (10,000) dollars, in trust, however, for the following uses and purposes, namely: The governing body of said hospital shall invest said sum of $10,000 and the annual income of said sum shall be used for the general maintenance of said Hospital." In addition, the Hospital's records indicate it was entitled to a share of the residue as follows: "SEVENTEENTH. All the rest, residue and remainder of my estate, of whatsoever nature and wheresoever situated which I may own or have the right to dispose of at the time of my decease, I give, devise and bequeath in equal proportions, share and share alike to the Rockville City Hospital located in the city of Rockville, State of Connecticut, and to the Cyril and Julia C. Johnson Memorial Hospital, Inc. located at Stafford Springs, State of Connecticut, in trust each of said hospitals shall invest the sums derived under this Article of my last Will and Testament and the annual income of said sums shall be used for the general maintenance of each of said hospitals." Income unrestricted	Document titled "Source and Terms of Funds Held" originally compiled November 24, 1952, and later supplemented through 1957 (at Pages 3-4)	Note: This fund holds the bequest of $10,000. Whether the Hospital received any distribution under Article SEVENTEENTH is unknown.	Request cy pres relief and transfer to the new Foundation
11-1.44	Anna & Albert Bilson Fund	$10,372	$14,933	Devise under Article NINTH of the Last Will and Testament of Anna M. Bilson dated October 3, 1952	Devise of a share in the residue of the estate as follows: "NINTH: All the rest, residue and remainder of my estate, both real and personal of whatsoever nature and wheresoever situated is to be sold and one-half of the proceeds are to be given to the Union Congregational Church of Christ, Inc. .... The remaining one-half thereof I give and devise unto the Rockville City Hospital, Inc., of the Town of Vernon to be known as the Anna & Albert Bilson Fund. I direct the trustees of said Hospital to lawfully invest said legacy, and to use the income therefrom for the general uses and purposes of said Hospital." Income unrestricted	The Last Will and Testament of Anna M. Bilson dated October 3, 1952		Request cy pres relief and transfer to the new Foundation

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Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.45	Alvah N. Belding Fund	$3,000	$5,759	Bequest under Paragraph 4. of the Last Will and Testament of Alvah N. Belding dated October 4, 1916	Bequest "...to the trustees of the Rockville City Hospital of Rockville, Connecticut, the sum of Three Thousand (3,000.) Dollars to be used and expended by them for the purposes indicated in the will of the late William H. Prescott regarding the establishment of a City Hospital, as they may deem most advisable." Income unrestricted	The Last Will and Testament of Alvah N. Belding dated October 4, 1916	Note: The Will of William H. Prescott created an endowment with income to be used to establish the Hospital. See Fund 11-1.36	Request cy pres relief and transfer to the new Foundation
11-1.46	Frederick W. Bradley	$2,000	$2,880	Bequest under Article FOURTEENTH of the Last Will and Testament of Frederick W. Bradley dated June 22, 1948	Bequest to "...THE ROCKVILLE CITY HOSPITAL, INC. of said Town of Vernon, the sum of Two Thousand Dollars, in memory of the donor and I direct that said sum be added to the endowment fund of said Hospital, the income thereof to be used for its general uses and purposes." Income unrestricted	The Last Will and Testament of Frederick W. Bradley dated June 22, 1948		Request cy pres relief and transfer to the new Foundation
11-1.47	Ruth T. Britton Fund	$5,000	$7,199	Bequest under Article SIXTEENTH of the Last Will and Testament of Ruth Talcott Britton dated March 12, 1924, with Codicil dated January 26, 1929	Bequest "...to the Rockville Hospital, of Rockville, in the Town of Vernon, Connecticut, the sum of Five Thousand (5,000) Dollars, IN TRUST, NEVERTHELESS, to keep said sum safely invested, and to use and apply the income for the general purposes of said Hospital at the discretion of its trustees." Income unrestricted	The Last Will and Testament of Ruth Talcott Britton dated March 12, 1924; and Codicil dated January 26, 1929		Request cy pres relief and transfer to the new Foundation
11-1.48	William B. and Lizzie Lathrop Sprague Fund	$5,000	$7,199	Bequest under the Will of Lizzie L. Sprague dated February 5, 1921	Bequest of the residue of a testatmentary trust following the death of the life beneficiary as follows: "...at her decease said principal sum of five thousand dollars shall go to The Rockville City Hospital of Rockville, Conn, the same to be known as The Wm. B. and Lizzie Lathrop Sprague Fund." This fund is treated as endowment with income unrestricted.	The Last Will and Testament of Lizzie L. Sprague dated February 5, 1921; and minutes of February 18, 1924 meeting of the Board of Trustees of the Hospital.	Note: The Hospital has treated this as an endowment fund but the language is not clearly so restricted.	Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.49	George S. Doane	$5,000	$7,199	Unknown	The document prepared in 1952 and titled "Source and Terms of Funds Held" states as follows: "No record found of source of this fund. Principal is considered permanent endowment - all income is used for expenses of the Hospital." Income unrestricted	Document titled "Source and Terms of Funds Held" dated in 1952 and updated in 1957 (at Page 1); and minutes of January 20, 1953 meeting of the Board of Trustees of the Hospital.	Note: The Hospital located the Will of a George W. Doane in Springfield, but it did not include a bequest to the Hospital.	Request cy pres relief and transfer to the new Foundation
11-1.50	Edgar Keney (Keeney)	$500	$720	Unknown	The document prepared in 1952 and titled "Source and Terms of Funds Held" states as follows: "No record found of source of this fund. It is believed to have been left for a special purpose. In accordance with the instructions of the Board of Trustees of the Hospital, income accumulates and is transferred to principal for reinvestment." Income unrestricted	Document titled "Source and Terms of Funds Held" dated in 1952 and updated in 1957 (at Page 2); and minutes of January 20, 1953 meeting of the Board of Trustees of the Hospital.	Note: The Hospital located the Will of Edgar Keeney and that of Clara, his wife, but neither included a bequest to the Hospital.	Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.51	Rockville Chapter American Red Cross Fund	$4,000	$5,759	Gift from Rockville Chapter	The minutes of the 1920 meeting of the Board at which the gift was reported do not document any restriction on use. The document prepared in 1952 and titled "Source and Terms of Funds Held" states as follows: "Gift from Rockville Chapter of American Red Cross - considered permanent endowment - income is used for general expenses of the Hospital". Income unrestricted	Minutes of the January 29, 1920 meeting of the Board of Trustees; and document titled "Source and Terms of Funds Held" dated in 1952 and updated in 1957;	Note: The Hospital has treated this as an endowment fund but the 1920 minutes do not document that restriction.	Request cy pres relief and transfer to the new Foundation
11-1.52	Fred Talcott Fund	$5,000	$7,199	Bequest under Article SIXTEENTH of the Last Will and Testament of Fred Talcott dated January 16, 1917	Bequest as follows: "SIXTEENTH. Whereas one William H. Prescott of said Rockville, now deceased, in and by his will bequeathed a large sum of money towards the support and maintenance of a hospital to be thereafterwards established in said Rockville, and it is my desire to make a contribution towards the erection and establishment of such hospital. I give and bequeath to the persons who at the time of my decease may be the custodians of the said fund, bequeathed as aforesaid by said Prescott, the sum of five thousand dollars to be used by them or their successors in such trust towards the erection and establishment of such hospital." Income unrestricted	The Last Will and Testament of Fred Talcott dated January 16, 1917	Note: See Fund 11-1.36 for the William Prescott Fund and its terms	Request cy pres relief and transfer to the new Foundation
11-1.53	J. Alice Maxwell Fund	$6,095	$8,775	Devise under Article NINTH of the Last Will and Testament of J. Alice Maxwell dated March 28, 1941; with Codicil dated April 17, 1942	Devise to the Hospital as follows: "NINTH: To ROCKVILLE CITY HOSPITAL, in Rockville, Connecticut, I give, devise and bequeath four of said equal parts of my said residuary estate in trust to use the income thereof for the general purposes of the said Hospital." Income unrestricted	The Last Will and Testament of J. Alice Maxwell dated March 28, 1941; and Codicil dated April 17, 1942		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.54	William A. and Caroline E. Metcalf Fund	$7,231	$10,411	Devise under Article NINTH of the Last Will and Testament of Caroline E. Steele Metcalf dated February 13, 1941	Devise of all the rest, residue and remainder of the estate "...to the Trustees of the Rockville City Hospital, Inc., a charitable corporation organized and existing under the laws of the State of Connecticut, ...,in trust, nevertheless, to hold, invest and reinvest the same and to use the income thereof for the general uses and purposes of said Hospital as said Trustees shall see fit. Said Trust shall be known as the William A. and Caroline E Metcalf Fund." Income unrestricted	The Last Will and Testament of Caroline E. Steele Metcalf dated February 13, 1941		Request cy pres relief and transfer to the new Foundation
11-1.55	E. Stevens Henry	$1,720,205	$2,690,344	Article Fourteenth of the Last Will and Testament of Edward Stevens Henry dated April 22, 1914; and Codicil dated March 3, 1920	Devise of the residue of a testamentary trust following the death of the last surviving life beneficiary as follows "Fourteenth: I give and bequeath One hundred thousand dollars - $100000- to constitute a Trust Fund to be set apart and in custody of the "Security Trust Company" of Hartford or in some other Connecticut Trust Company to be determined by Executors. The net income of said trust fund shall if my wife survives me be paid to my said wife Lucina E. Henry ... If my said wife does not survive me then upon my death, and if she does survive me then upon her death, this trust fund shall thereupon accumulate, if my grand daughter Lucina Ackerly, is then living until she attains the age of twenty five years and then and thereafter the original fund and its accumulations up to the time she attains the age of twenty five years shall be deemed to be the principal of said trust fund, the net income of said principal after said Lucina Ackerly attains the age of twenty five years, as aforesaid shall be paid to my said grandaughter Lucina Ackerly ... Upon the death of said Lucina Ackerly the entire principal fund then remaining I give, devise and bequeath to the Rockville City Hospital hereinbefore referred to, and the same shall thereupon become part of the endowment fund of that institution, absolutely and forever, it being my intention and will that said Rockville City Hospital shall have and possess all the rest residue and remainder of the said trust fund and the principal aforesaid to it absolutely and forever. Income unrestricted	The Last Will and Testament of Edward Stevens Henry dated April 22, 1914; and Codicil dated March 3, 1920	Note: The Hospital received differing advice about the nature of this fund from outside counsels; one advised the Hospital that this fund is totally unrestricted, and another advised that it is endowment with income only to be spent. The fund has been classified as endowment.	Request cy pres relief only for funds, if any, not used by the Hospital

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
Subtotal: Endowment: Unrestricted Income Funds		$2,297,193	$8,989,027					

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
Free Bed Funds (Endowment Restricted for Free Care)								
1[illegible]56	Trumbull Chapter DAR	$157,268	$219,720	Gift of a free bed fund from the Sabra Trumbull Chapter of the Daughters of the American Revolution	Gift from the Sabra Trumbull Chapter of the D.A.R. Although the early history of the fund is cloudy, it appears that the fund was started at a bank in 1919, and by 1921 it had reached $5,000. In December 1954, the Advisory Board of the Chapter adopted resolutions governing the use of the bed fund summarized as follows: Income from the fund was to be used for free care with preference given to Chapter members, and, if on January 1 of a year, any income from the prior year remained on hand, it could be used for "deserving and needy people," with any unused income added to principal. The Advisory Board of the Chapter had to right to designate use of the fund. The Chapter subsequently dissolved, and by letter to the Hospital's Board of Trustees dated May 29,1962, Mrs. Donald Fisk of the Chapter advised the Hospital of the dissolution of the Chapter. The letter stated that the bank would continue to maintain the fund "with the discretion in you, as trustees, to choose beneficiaries. The former members of the Sabra Trumbull Chapter will appreciate any preference which you may choose to give to them or to other D.A.R. members as beneficiaries of this fund." Income restricted to free care, with a request to consider use for former members of the Chapter or other members of the D.A.R.	Resolution of the Board of Advisors of the Sabra Trumbull Chapter of the Daughters of the American Revolution dated December 4, 1954; letter dated May 29, 1962 from Mrs. Donald C. Fisk to the Board of Trustees, Rockville City Hospital		Request cy pres relief and transfer to the new Foundation

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Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
1201.57	Celia E. Prescott Fund holding (two bed funds): 1. Francis and Eliza Porter Keeney Bed Fund (originally $10,000); and 2. Francis Keeney Prescott Bed Fund (originally $5,000)	$15,000	$15,009	Bequests under Paragraph 34 of the Last Will and Testament of Celia E. Prescott dated June 13, 1917	Two bequests to establish free bed funds as follows: 34. I give to the trustees of the said Rockville City Hospital for the benefit of the same, the sum of Ten Thusand (10,000.) Dollars, for the establishment of a free bed in honor of my late father and mother, Francis and Eliza Porter Keeney, and I request that in the use of the same preference be given, if occasion arises, to any of the descendants of the Keeney family....I also give to the trustees of the said hospital, for the benefit of the same, the sum of Five Thousand (5,000) Dollars, for the establishment of a free bed in loving memory of my late son, Francis Keeney Prescott. Income restricted to free care, with preference for descendants of the Keeney family members for the Francis and Eliza Porter Keeney Bed Fund	The Last Will and Testament of Celia E. Prescott dated June 13, 1917		Request cy pres relief and transfer to the new Foundation

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Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
10-1.58	Charles Phelps Free Bed Fund	$10,000	$10,006	Inter Vivos Gift from Elsie S. Phelps	Inter vivos gift from Elsie S. Phelps to establish a free bed fund in honor of her husband to be known as the Charles Phelps Free Bed Fund. Per the records of the Hospital, the terms are as follows: "Gift of $10,000 from Mrs. Elsie S. Phelps - Permanent endowment - Income for special purposes. Any amount of this fund in excess of $10,000 represents accumulated income and is considered available if necessary. Terms of Gift. 1. For the benefit of any members of my household staff or their families who may be in need of the services which the fund can provide. 2. For the general use and benefit of the residents of the City of Rockville. The fund, aside from the small conditions which I wish to impose for the benefit of my household staff, which will fall within the income limitations of the fund, will be managed by the Board of Trustees and Finance Committee of The Rockville City Hospital with full powers or sale, investment and reinvestment." Income restricted to free care, first for members of Elsie Phelps's household staff and their families and then for residents of Rockville	Document titled "Source and Terms of Funds Held" originally compiled November 24, 1952, and later supplemented through 1957 (at Page 3)		Request cy pres relief and transfer to the new Foundation
11-1.59	Winchell-Foster	$15,000	$15,009	Bequest under ARTICLE THIRD (i) of the Last Will and Testament of Minnie Foster Riley	Bequest of "The sum of Fifteen Thousand ($15000) Dollars to the Rockville City Hospital of Rockville, Connecticut, as a permanent fund to be known as the "Winchell-Foster Free Bed Fund" in memory of my grandparents, Cyrus and Hester Winchell, and my parents, Wilbur and Mary Edna Foster, and which sum shall be held and invested and reinvested as the governing body of said Hospital shall, in its sole discretion deem best, and the income from which shall be used for the maintenance of a free bed in said Hospital." Income restricted for free care	Letter of unclear date (July 31, 19??) from The First National Bank of Denver to the Hospital with the extract from the Will		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.60	Betsey C. Tucker	$2,000	$2,001	Bequest under Article SECOND of the Last Will and Testament of Betsey C. Tucker dated June 21, 1949	Bequest "to the Rockville City Hospital, of Rockville, Connecticut, Two Thousand (2000) Dollars to be its absolutely and forever. This bequest is to be used by said Hospital as an endowment for the partial maintenance of a free bed in said Hospital." Income restricted for free care	The Last Will and Testament of Betsey C. Tucker dated June 21, 1949		Request cy pres relief and transfer to the new Foundation
11-1.61	Anna Shelton Whitlock	$20,120	$20,133	Devise under Article 2. of the Last Will and Testament of Florence R. Whitlock dated August 28, 1929	Upon the death of the life beneficiary of the residuary trust, the remainder of the residue was ro be divided into ten (10) equal parts, to be "disposed of as follows:... The remaining Four-tenths (4/10th) of said residue, I give, devise and bequeath to the Rockville City Hospital for the purpose of establishing a free bed or beds in said Hospital in memory of my mother, Anna Shelton Whitlock." Income restricted for free care	The Last Will and Testament of Florence R. Whitlock dated August 28, 1929		Request cy pres relief and transfer to the new Foundation
11-1.62	Elsie Sykes Phelps Free Bed Fund	$5,975	$5,979	Bequest under Article IV (c) of the Last Will and Testament of Elsie Sykes Phelps dated September 28, 1955	Bequest "To the ROCKVILLE CITY HOSPITAL, of said Rockville, founded by the late William H. Prescott of said Rockville, fifty (50) shares of the capital stock of The Travelers Insurance Company, and I direct that the Trustees of said Hospital add the same to the permanent endowment of a free bed for said Rockville City Hospital, such gift to be called the "Elsie Sykes Phelps Free Bed Fund". Income restricted for free care	The Last Will and Testament of Elsie Sykes Phelps dated September 28, 1955		Request cy pres relief and transfer to the new Foundation
11-1.63	John and Martha Kress Fund	$500	$500	Bequest under Article Fourth of the Last Will and Testament of Martha M. Kress dated April 3, 1918	Bequest of "...the sum of Five Hundred Dollars to the Rockville City Hospital to be used for the purpose of equipping, furnishing and maintaining a room in [the] Hospital to be known and called the "John and Martha Kress room." Income restricted for free care	The Last Will and Testament of Martha M. Kress dated April 3, 1918	Note: The Hospital has historically classified this as a free bed fund, but the language of the bequest is not clear on this point.	Request cy pres relief and transfer to the new Foundation
Subtotal: Free Bed Funds		$225,663	$268,358					
Endowment Restricted to Purpose Other Than Free Care								

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Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
1001.64	Julia and Percy Baker Family Memorial Fund	$145,770	$145,861	Devise under ARTICLE III (a) of the Last Will and Testament of Percy W. Baker dated June 22, 1990, with Codicils dated April 26, 1995 and May 16, 1997	Devise of a share in the residuary estate as follows: "Residue. All the rest, residue and remainder of my property, real and personal, of whatever nature and wherever situated, I give, devise and bequest as follows: (a) twenty (20) per cent to be held in trust to establish a fund known as the Julia and Percy Baker Family Memorial Fund. Said fund is to be used for the upkeep and physical maintenance of the Rockville General Hospital, Rockville, Connecticut. The physical maintenance of the Hospital by said fund is defined to include items such as painting, roof repairs, furnace repairs or replacement carpet repairs or replacement, or any other repairs or replacement of existing fixtures so as to keep the Hospital in good physical condition. The intent is that the principal of the fund so established and known as the Julia and Percy Baker Family Memorial Fund not be invaded. Only interest or other income generated by the Fund shall be used for purposes of physical maintenance, and the corpus of said fund is not to be invaded by the Trustee." Income for the upkeep and physical maintenance of the Hospital	The Last Will and Testament of Percy W. Baker dated June 22, 1990; First Codicil dated April 26, 1995, and Second Codicil dated May 16, 1997		Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
1201.65	Faith S. Schortmann Fund	$132,820	$132,907	(1) Bequest under ARTICLE VI of the Last Will and Testament of Faith S. Schortmann dated November 21, 1990; and (2) Devise of a share in the residuary estate under ARTICLE VIII A of said Will.	Bequest to ROCKVILLE GENERAL HOSPITAL of "the proceeds of all my investments with the IDS Financial Services, Inc., and its related companies, to be held as a separate fund known as the FAITH S. SCHORTMANN FUND. Said Fund shall be restricted, and the Board of Trustees or other governing body of said ROCKVILLE GENERAL HOSPITAL, INC., shall invest and reinvest such Fund in any manner it deems appropriate, but shall use or expend only the income therefrom (without invasion of the principal of said Fund) for such purposes directly related to the operation and/or improvement of the maternity and nursery facilities of said ROCKVILLE GENERAL HOSPITAL, INC., in whatever manner it deems appropriate." Devise of "FORTY-FIVE PERCENT (45%) of my said residuary estate to ROCKVILLE GENERAL HOSPITAL, INC., of Vernon, Connecticut, to be added to and become a part of the FAITH S. SCHORTMANN FUND, to be used and expended in accordance with the terms of Article VI of this, my Last Will and Testament." Income for the operation or improvement of the maternity and nursery facilities of the Hospital.	The Last Will and Testament of Faith S. Schortmann dated November 21, 1990		Request cy pres relief and transfer to the new Foundation
Subtotal: Endowment Restricted to Purpose Other Than Free Care		$278,589	$278,769					

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
Unrestricted Funds								
11-1.66	Swindells Fund	$74,473	$107,224	Gifts from the F.W. Swindells Charitable Foundation, which was established under Article Sixth of the Last Will and Testament of Frederick W. Swindells dated October 15, 1930	The income from the Foundation (Trust) established under the Will is to be paid "... to charitable corporations or societies incorporated for the relief of sick and suffering poor children and/or for the sick, suffering and indigent, aged men and women, and/or for the support of public and charitable hospitals....The ultimate beneficiaries of this charity shall be poor and suffering individuals." Available documentation supports that this fund is fully expendable.	The Last Will and Testament of Frederick W. Swindells dated October 15, 1930; Letters dated October 24, 1933, from The Hartford National Bank and Trust Company and The Travelers Bank and Trust Company, Trustees, transmitting two $500 checks (unrestricted); Minutes of January 27, 1936 meeting of the Board of Trustees documenting receipt of $500; Minutes of January 21, 1941 meeting of the Board of Trustees documenting receipt of $500; and document titled "Source and Terms of Funds Held" dated in 1952 and updated in 1957 (at Page 5)	Note: In an effort to obtain additional information, the Hospital spoke with Kate Kirkheart of the Swindells Charitable Foundation at the Bank of America; although the Bank has some old correspondence related to donations, it declined to release copies of the correspondence or a statement of gifts.	Request cy pres relief only for funds, if any, not used by the Hospital
11-1.67	Harriet K. Maxwell Fund	$5,000	$15,326	Bequest under Article Third of the Will of Harriet K. Maxwell	Bequest "... unto the Rockville City Hospital of Rockville, Connecticut, the sum of Five Thousand Dollars ($5,000)". Unrestricted	Minutes of the January 20, 1953 meeting of the Board of Trustees; and document titled "Source and Terms of Funds Held" originally compiled November 24, 1952, and later supplemented through 1957 (at Page 2)	Note: A Harriet K. Maxwell died in 1996 in Arizona, but her Will does not include this gift, which is believed either to have come from the Will of a different member of the family or have been incorrectly designated in the old Board records as a bequest. A May 11, 1998 letter from William W. Graulty concerning gifts from the Harriet K. Maxwell Foundation also does not include any information about this fund.	

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
10-1.68	Robert Maxwell Fund	$100,000	$143,977	Bequest under Article First of the Last Will and Testament of Robert Maxwell dated November 21, 1919	Bequest to "...my Executors hereinafter named, or the survivors or survivor of them, the sum of One hundred thousand dollars ($100,000.), to be devoted by them to the establishment and maintenance of a suitable building or buildings, grounds and equipment in the City of Rockville, State of Connecticut, where the residents of the City of Rockville and vicinity may, without charge and without regard to race or religion, obtain healthful exercise, recreation, amusement and instruction, or, in the discretion of my Executors, the said principal sum or the income thereof, or both, to be devoted by them in such other manner as they deem suitable for the benefit of the said residents of Rockville and vicinity." Unrestricted	The Last Will and Testament of Robert Maxwell dated November 21, 1919		Request cy pres relief only for funds, if any, not used by the Hospital
11-1.69	F. Maxwell Memorial	$283,919	$1,172,044	Bequest under Article FIRST of the Codicil dated November 19, 1941; and Devise under Article THIRTEENTH of the Last Will and Testament of Francis T. Maxwell dated May 15, 1940	Bequest to Rockville City Hospital of "the sum of One hundred thousand dollars ($100,000)." Devise of a share of trust assets upon termination of various testamentary trusts if no issue of the Testator is living at the time of termination as follows: "THIRTEENTH: All the rest, residue and remainder of my property, real and person, of every kind, nature and description and wheresoever situated, ... I give, devise, bequeath and appoint to my TRUSTEES.....(e) In the event that, upon the termination of any of said trusts, there should be no issue of mine then living, then, and in such event, I direct that the capital of such trust shall be divided into two equal parts, one of which parts I give, devise and bequeath to ROCKVILLE CITY HOSPITAL and the other to HARTFORD HOSPITAL." Unrestricted	The Last Will and Testament of Francis T. Maxwell dated May 15, 1940; and Codicil dated November 13, 1940		Request cy pres relief only for funds, if any, not used by the Hospital

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.70	Memorial Funds	$328,454	$1,284,374	Unknown	This fund holds on a consolidated basis many gifts contributed to the Hospital over the years from many sources. It has been reported as unrestricted endowment for many years. The creation of this fund is referenced in the January 20,1953 Minutes of the Board of Trustees of the Hospital. This fund is believed to be totally unrestricted as to income and principal.	Minutes of January 20, 1953 meeting of the Board of Trustees of the Hospital; and January 24, 1968 letter from Attorney Donald B. Caldwell to Robert C. Hector of CHEFA		Request cy pres relief only for funds, if any, not used by the Hospital
11-1.71	Mary E. Snyder	$1,621	$2,122	Devise under Paragraph SIXTH(hh) of the Last Will and Testament of Mary E. Snyder dated My 20, 1955	Devise of a share in the residuary estate as follows: "SIXTH. All the rest, residue and remainder of all my property, both real and person, of whatsoever the same may consist or wheresoever it may be situated, I direct be divided into thirty-five equal shares and distributed as follows, to wit:... (hh) one equal share to the ROCKVILLE CITY HOSPITAL, INC. of said Rockville, in memory of my late sister Flora C. Snyder and in my memory, for its general uses and purposes." Unrestricted	The Last Will and Testament of Mary E. Snyder dated May 20, 1955		Request cy pres relief only for funds, if any, not used by the Hospital
11-1.72	Charles F. Batz	$4,000	$5,957	Inter Vivos Gift from Emma Batz for her brother, Charles F. Batz	Inter vivos gift of $4,000 Unrestricted	Correspondence between the Hospital and Emma Batz in 1993 and 1994; and the Last Will and Testament of Charles F. Batz dated November 2, 1992.	Note: ARTICLE FIVE of Charles Batz's Last Will and Testament dated November 2, 1992, left the residue of his estate outright to his sister, Emma, and, if she did not survive him, one-fourth of the residue to the Hospital outright. Emma did survive, so the Hospital was not entitled to a portion of the Estate, but Emma Batz made a $4,000 gift to the Hospital in his memory. The correspondence documenting the gift incorrectly says or suggests that this gift was a bequest from the Estate.	Request cy pres relief only for funds, if any, not used by the Hospital

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
11-1.73	Francis J. Gregory	$122,965	$34,241	Devise under Article FOURTH of the Last Will and Testament of Francis J. Gregory dated March 16, 1979	Devise of a share of the residuary estate as follows: "FOURTH: All the rest, residue and remainder of my estate, wherever it may be found, shall be distributed equally among the following [six organizations] ...Rockville General Hospital, Rockville, Connecticut,..." Unrestricted	The Last Will and Testament of Francis J. Gregory dated March 16, 1979		Request cy pres relief only for funds, if any, not used by the Hospital
11-1.74	John A. Duell	$5,000	$7,447	Bequest under Article THIRD of the Last Will and Testament of John A. Duell dated September 14, 1988	Bequest to "ROCKVILLE GENERAL HOSPITAL of Rockville, Connecticut, the sum of FIVE THOUSAND ($5,000) DOLLARS, for its general use and purpose." Unrestricted	The Last Will and Testament of John A. Duell dated September 14, 1988		Request cy pres relief only for funds, if any, not used by the Hospital
11-1.75	Edna O. Rider	$10,000	$14,893	Bequest under Article THIRD A. of the Last Will and Testament of Edna O. Rider dated April 1, 1982	Bequest as follows: "THIRD: I give, devise and bequeath all the rest, residue and remainder of the property which I may own at the time of my death, real, personal and mixed, of whatsoever nature and wheresoever situated, as follows: A. The sum of Ten Thousand ($10,000.00) Dollars to the ROCKVILLE GENERAL HOSPITAL of Rockville, Connecticut to be used and expended for the benefit of such hospital in any manner it deems appropriate." Unrestricted	The Last Will and Testament of Edna O. Rider dated April 1, 1982		Request cy pres relief only for funds, if any, not used by the Hospital
11-1.76	Barbara J. Sadrozinski	$20,739	$30,441	Devise under Article THIRD B. of the Last Will and Testament of Barbara J. Sadrozinski dated January 22, 1993.	Devise of a share of the residuary estate as follows: "THIRD: I give, devise and bequeath all the rest, residue and remainder of my proprty, both real and personal, of which I shall die seized and possessed, wherever situated, as follows: ...B. Twenty (20%) percent thereof to ROCKVILLE GENERAL HOSPITAL, INC., of Vernon, Connecticut, to be its absolutely and forever." Unrestricted	The Last Will and Testament of Barbara J. Sadrozinski dated January 22, 1993.		Request cy pres relief only for funds, if any, not used by the Hospital
Subtotal: Unrestricted Funds		$956,171	$2,818,047					

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Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
Additional Information								
11-1.77	$9,603.46 Two-Life Survivor Charitable Gift Annuity (Names of Annuitants withheld)	NA	NA	Gift of remainder interest in annuity	$9,603.46 Two-Life Survivor Charitable Gift Annuity; remainder to Hospital on the death of the second to die Unrestricted	Two-Life Survivor Charitable Gift Annuity Agreement dated December 20, 1993 (with names redacted)	One of the two joint annuitants has now lived beyond his/her life expectancy determined as of the time of the gift. This annuity therefore now is a contractual liability of the Hospital rather than a charitable asset.	RGH will explore options with the annuitant to terminate this arrangement at fair value.
11-1.78	$10,000 Two-Life Survivor Charitable Gift Annuity (Names of Annuitants withheld)	NA	NA	Gift of remainder interest in annuity	$10,000 Two-Life Survivor Charitable Gift Annuity, remainder to Hospital on the death of the second to die Unrestricted	Two-Life Survivor Charitable Gift Annuity Agreement dated November 3, 1994 (with names redacted)	One of the two joint annuitants has now lived beyond his/her life expectancy determined as of the time of the gift. This annuity therefore now is a contractual liability of the Hospital rather than a charitable asset.	RGH will explore options with the annuitant to erminate this arrangement at fair value
Subtotal: Additional Information		$0	$0					
Grand Total: Rockville General Hospital		$3,757,816	$12,374,200					

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
	ECHN COMMUNITY HEALTHCARE FOUNDATION, INC.							
	Endowment for Benefit of MMH: Unrestricted Income							
11-1.79	Hazel Burgess	$113,624	$113,624	Devise under Article THIRD of the Last Will and Testament of Hazel S. Burgess dated July 20, 1959	Devise of half the residue of a testamentary trust following the death of the last surviving life beneficiary as follows: "THIRD: All the rest, residue and remainder of my estate, both real and personal, of whatsoever the same may consist and wheresoever the same may be located, I give, devise and bequeath to CONNECTICUT BANK AND TRUST COMPANY, IN TRUST NEVERTHELESS, for the following uses and purposes:... (d) Upon the death of all of the beneficiaries hereunder, I direct that this Trust shall thereupon terminate, and the principal, together with any accumulation of income, be paid equally to the Board of Trustees of South Methodist Chruch and the Trustees of Manchester Memorial Hospital, both of Manchester, Connecticut, to be safely invested by each, and the income only therefrom to be used for the general uses and purposes of said Church and Hospital." Income unrestricted	The Last Will and Testament of Hazel S. Burgess dated July 20, 1959	Note: This fund was left to Manchester Memorial Hospital, but it is held by the ECHN Community Healthcare Foundation for the Hospital.	Request cy pres relief and transfer to the new Foundation
11-1.80	Raymond A. St. Laurent and Helen St. Laurent	$10,000	$10,000	Bequest under Article NINTH 2. of the Last Will and Testament of Helen E. St. Laurent dated July 13, 1989	Bequest of "...the sum of TEN THOUSAND ($10,000.00) DOLLARS each unto each of the following named institutions or foundations, the income only from each of said bequest to be used for the general uses and purposes of said institution or foundation, the fund for each to be in memory of RAYMOND A. ST. LAURENT and HELEN E. ST. LAURENT. ... 2. MANCHESTER MEMORIAL HOSPITAL, presently of 71 Haynes St., Manchester, Connecticut; ..." Income unrestricted	The Last Will and Testament of Helen E. St. Laurent dated July 13, 1989	Note: This fund was left to Manchester Memorial Hospital, but it is held by the ECHN Community Healthcare Foundation for the Hospital.	Request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
1001.81	Donald G. Piper and Hazel B. Piper	$1,161,399	$1,161,399	Devise under Article FOURTH of the Last Will and Testament of Hazel B. Piper dated November 30, 1990	Devise of residue of estate as follows: "FOURTH: All the rest, residue and remainder of my property, both real and personal, and of whatsoever nature, wherever the same may be located or found, which I may own or have the right to dispose of at my death (intending hereby to exercise any power of disposition or appointment that I may have at my death), I give, devise and bequeath unto MANCHESTER MEMORIAL HOSPITAL, of Manchester, Connecticut, in memory of DONALD G. PIPER and HAZEL B. PIPER, to be held in the Consolidated Investment Fund, the income only from which is to be used at the discretion of the Board of Trustees of the hospital for its general uses and purposes." Income unrestricted	The Last Will and Testament of Hazel B. Piper dated November 30, 1990	Note: This fund was left to Manchester Memorial Hospital, but it is held by the ECHN Community Healthcare Foundation for the Hospital.	Request cy pres relief and transfer to the new Foundation
Subtotal: Endowment for Benefit of MMH: Unrestricted Income		$1,285,023	$1,285,023					

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
	Endowment for Benefit of RGH Restricted Income							
1211.82	Harriet K. Maxwell Fund	$250,000	$250,000	Grant from the Harriet K. Maxwell Foundation dated May 11, 1998	Grant to the Hospital of $250,000 as follows: "On behalf of the Directors of the Harriet K. Maxwell Foundation, I am pleased to report that the Foundation has made a grant to Rockville Hospital in the aggregate amount of $400,000. This grant consists of two parts, namely, a grant of $250,000 to establish the Harriet K. Maxwell Fund, an endowment fund to provide for the normal maintenance and repair of the Maxwell Home and its grounds and a separate grant of $150,000 to pay for the major structural repairs to the Home which are considered essential for its preservation and continued use as an integral part of the Hospital. With regard to the $250,000 Fund, this grant is conditioned on the continued use of the Maxwell Home as a part of the Hospital; and that if the Home is not so used for a period of 24 consecutive months or if the Home is damaged or destroyed and not restored to its prior level of usefulness within a reasonable time thereafter, then the balance of the Fund shall be transferred to the George Maxwell Library of Rockville, Connecticut, to be held as an endowment fund for its general uses and purposes." Income restricted for the Maxwell House	Letter dated May 11, 1998, from Attorney William W. Graulty to Annette B. Leahy of the Hospital awarding the grant; letter of June 1, 1998, from Mr. Graulty to Ms. Leahy; letter of June 1 from Mr. Graulty to Ms. Leahy forwarding a corrected copy of the May 11, 1998 letter; and press release dated June 11, 1998	Note: This contains a gift over to the George Maxwell Library of Rockville if the Hospital no longer uses the Maxwell Home as part of the Hospital.	Gift over to the George Maxwell Library of Rockville

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
1091.83	Majorie Risley Scholarship Fund	$32,289	$32,289	Established by gifts to the Hospital	Endowment fund restricted as follows: "The Majorie Risley Scholarship Fund is established with the following primary objective: To assist nurses with their continuing education programs. The money to be used would be for educational programs that will help the nurse maintain a high level or expertise. A second use for the money would be to bring educators to this hospital to bring educational programs to a group of nurses. The principal of the fund is to be invested with high interest in mind. The income only is to be used for the above purposes. The Director of Nurses will determine who is to receive the assistance. If she needs advice relative to who should receive assistance she will consult the committee members. The members are: George E. Risley; Bunny Whelton, Geraldine Strong and Margaret Connors, R.N." Income restricted for nursing education	Statement titled "Marjorie Risley Scholarship Fund" and dated February 1, 1982		Request cy pres relief and transfer to the new Foundation
Subtotal: Endowment for Benefit of RGH: Restricted Income		$282,289	$282,289					
Grand Total: ECHN Community Healthcare Foundation, Inc.		$1,567,312	$1,567,312					
GRAND TOTAL FOR ECHN		$6,920,131	$23,106,027					
Additional Information								

Fund Number	Fund Name	Value of Original Gift	Total Market Value 3/31/16	Manner of Contribution (e.g., Will, Inter Vivos Trust, Gift, etc.)	Terms of Gift	Supporting Documents	Notes	Proposed Handling of Fund
1001.84	Katherine Sykes Bissell	-	—	Bequest under Article SEVENTH (a) of the Last Will and Testament of Katherine Sykes Bissell dated March 10, 1969 with two codicils	Seventh: (a) I give and bequeath the sum of Fifty Thousand Dollars ($50,000) to The Rockville General Hospital, Incorporated, of Rockville, Connecticut, in memory of my parents, Mr. and Mrs. Thomas W. Sykes, the income therefrom to be used for the general purposes of said Hospital.	Last Will and Testament of Katherine Sykes Bissell dated March 10, 1969; Codicil dated April 13, 1970; and Codicil dated April 28, 1972	Note: During its search of probate court records for original documentation, the Hospital found this Last Will and Testament, which includes a $50,000 bequest. This bequest is not separately booked or recorded on the Hospital's records, and the Hospital has not located any other records about this bequest.	

EXHIBIT Q11-1
ECHN: SPECIAL PURPOSE FUNDS - FUNDS 11-1.85 - 11-1.96

Notes:

1. The funds are held by ECHN Community HealthCare Foundation ("ECHN Foundation) for the benefit of Manchester Memorial Hospital ("MMH"), Rockville General Hospital ("RGH"), and Woodlake at Tolland ("Woodlake").
2. The names of the donors to various funds have been redacted.
3.The current fund balance of a given fund will generally be less than the total gifts to the fund because funds are being used on an ongoing basis for the specific purpose.

Fund Number	Fund Name	Fund Balance 3/31/16	Terms of Gift	Supporting Documentation	Proposed Handling of Fund
11-1.85	MMH: DeQuattro Cancer Center - Avis Lloyd Tree of Life	$0	Donors make a contribution for a leaf, dove or boulder to be added to the Tree of Life sculpture. Contributions are used for Survivorship Navigation and other services at the Cancer Center and are disbursed quarterly.	Fund profile with list of donations; copies of 2009 and 2012 brochures	To the extent there are funds remaining, request cy pres relief and transfer to the new Foundation
11-1.86	ECHN Foundation: Team Towanda Foundation	$0	For uninsured women over the age of 40 for mammography, breast ultrasounds, surgical consultations, and related services. The fund also provides pharmacy gift cards to purchase medical and personal care items for use after surgery or to purchase medication (Outpatient).	Fund profile with list of donations; copies of representative letters and communications with Team Towanda Foundation re gifts and uses	To the extent there are funds remaining, request cy pres relief and transfer to the new Foundation
11-1.87	ECHN Foundation: Employee Care Fund	$3,797	To provide confidential emergency assistance to employees in need; employee requests are made through a chaplain to the Fund. The Fund no longer solicits (the most recent appeal was in 2009), the existence of the Fund is well-known to employees, who make unsolicited contributions to it.	Fund profile with summary information	To the extent there are funds remaining, request cy pres relief and transfer to the new Foundation
11-1.88	ECHN Foundation: Breast and Cervical Cancer Program	$59	For outreach, education, enrollment, screening and diagnostic follow-up for underinsured women for cancer and heart disease, whether inpatient or outpatient.	Fund profile with list of donations; copy of representative fundraiser flyer from major donor (fire department) and documentation of gifts from another major donor (hospital volunteers)	To the extent there are funds remaining, request cy pres relief and transfer to the new Foundation

Fund Number	Fund Name	Fund Balance 3/31/16	Terms of Gift	Supporting Documentation	Proposed Handling of Fund	
11-1.89	MMH: Adult Ambulatory Administrative Education & Development	$0	To offset costs in excess of ECHN tuition reimbursement for the pursuit and completion of a Master's Degree related to the roles of Adult Ambulatory Behavioral Health Coordinator, Adult Ambulatory Behavioral Health Associate Director, or Adult Ambulatory Behavioral Health Director at Manchester Memorial Hospital. Costs may include tuition, books, supplies, travel, or any other miscellaneous expenses, including computer hardware and software.	Fund profile and list of recent gifts	To the extent there are funds remaining, request cy pres relief and transfer to the new Foundation	
11-1.90	MMH: Drs' Campbell and Oh Trophies	$3,676	The fund maintains the trays for the Daniel Paul Purcell MD Memorial Golf Classic tournament (now called the ECHN Mason & Purcell Golf Classic), an annual fundraising event. It pays for, among other things, the engraving of the names of the low gross winners.	Fund profile	To the extent there are funds remaining, request cy pres relief and transfer to the new Foundation	
11-1.91	Woodlake: Woodlake at Tolland Wishes Program	$1,573	These funds are used to grant "wishes" for long term care residents at Woodlake (long term care facility). Wishes have included a trip to NY, limo rides, luncheon trips, and special outings. Some gifts were made for listing names (honor/memorial) in the Woodlake at Tolland 10th Anniversary Program Book.	Fund profile with list of donations.	To the extent there are funds remaining, request cy pres relief and transfer to the new Foundation	
11-1.92	ECHN Foundation: Van Fund	$0	Donations from members of the Business Alliance for Community Health to purchase a new van for ECHN.	Fund profile with list of donations; email re van	To the extent there are funds remaining, request cy pres relief and transfer to the new Foundation	
11-1.93	RGH: Risley Fund	$35	Supports educational opportunities for nursing staff	Fund profile; this is the income from the Marjorie Risley Scholarship endowment held by the ECHN Foundation.	To the extent there are funds remaining, request cy pres relief and transfer to the new Foundation	
11-1.94	Doris Fields	$582	Funds are used to support the RGH Hospice unit as a memorial to Doris Fields.	Fund profile with list of memorial donations.	To the extent there are funds remaining, request cy pres relief and transfer to the new Foundation	

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Fund Number	Fund Name	Fund Balance 3/31/16	Terms of Gift	Supporting Documentation	Proposed Handling of Fund
11-1.95	Woodlake Resident Council Fund	$254	This account is funded by the residents of Woodlake at Tolland. The goal is to provide the residents a mechanism for self-	Fund profile with list of donations	Continued use by Woodlake residents
GRAND TOTAL		$9,979			
Additional Information					
11-1.96	ECHN Foundation $10,000 One Life Charitable Gift Annuity (Name of Annuitant withheld)	Current value of the residuum is $4,196	If there is a value on termination, to be used for intensive care unit expansion fund	Charitable Gift Annuity Agreement	Gift of remainder interest in annuity. Present value of remainder will be held until the termination of the agreement; depending on the actual life of the donor, this arrangement could eventually become a liability rather then an asset. ECHN Foundation will explore options with the donor to terminate this arrangement at

EXHIBIT Q11-1
ECHN: TRUSTS HELD BY OUTSIDE TRUSTEES - FUNDS 11-1.97 - 11-1.106

Note: The outside Trustee(s) will have primary responsibility for actions and decisions on the distribution of trust income/assets after ECHN ceases operations and will be responsible for requesting any necessary judicial cy pres relief. ECHN will support, to the extent possible and to the extent consistent with the terms of a given trust, the payment of trust income to the new Foundation to be used to promote the health of the ECHN communities.

Fund Number	Name of Trust	Market Value of Trust Held by Trustee 3/31/2016	Current Trustee	Terms of Trust	Supporting Documents	Notes
TRUSTS F/B/O MANCHESTER MEMORIAL HOSPITAL						
11-1.97	Barton Family Trust (Trust u/w Mary K. Barton)	$ 1,187,076.83	Bank of America	"FOURTH: If my sister, ANNA H. BARTON, does not survive me, then all the rest, residue and remainder of my estate, real, personal and mixed, together with any lapsed legacies, I give, devise and bequeath unto the SHAWMUT BANK, with offices in Hartford, Connecticut, or its successors, as Trustee of a certain trust to be known as the BARTON FAMILY TRUST. I ORDER AND DIRECT my Trustee ... to pay all of the net income thereof in convenient installments at least quarter/annually to or for the benefit of, the Manchester Memorial Hospital. If the Manchester Memorial Hospital or its lawful successor is no longer in existence, or if it is not then a charitable organization within the meaning of the Internal Revenue Code, the net income shall be distributed to one or more organizations selected by the trustee, each of which is a charitable organization as defined in Sections 170(c) and 2055(a) of the Internal Revenue Code of 1986, as amended from time to time, in such proportions among such organizations as the trustee shall decide."	Last Will and Testament of Mary K. Barton dated February 1, 1963	Note: This trust directs the trustee to shift the income to one or more charitable organizations if MMH or its lawful successor is no longer in existence.
11-1.98	The Addison L. Clark Fund (Trust u/w Luella C. Hale)	$144,630.89	Bank of America	"ARTICLE XI. I give to THE FIRST NATIONAL BANK OF HARTFORD the sum of Twenty Thousand Dollars ($20,000), in trust, however, to hold and manage, invest and reinvest, and to pay over the income derived therefrom to the TRUSTEES OF THE MANCHESTER MEMORIAL HOSPITAL, to be used for such general hospital charges and expenses as said Trustees shall deem best, said fund to be known as "THE ADDISON L. CLARK FUND." "	Last Will and Testament of of Luella C. Hale dated February 7, 1938	Note: This Will does not provide for another disposition if MMH no longer exists.

3336708.1

Fund Number	Name of Trust	Market Value of Trust Held by Trustee 3/31/2016	Current Trustee	Terms of Trust	Supporting Documents	Notes
11-1.99	The Willie T. Morton Fund (Trust u/w Willie T. Morton)	$215,138.29	Bank of America	"ELEVENTH If the conditions set out in the two preceding clauses shall not be met with, and said sum of One Hundred Thousand (100,000) Dollars shall not be paid to said young Men's Christian Association or used for said The Morton Library Association, then I direct that said sum of One Hundred Thousand (100,000) Dollars, with accumulated interest, shall be disposed of by my said Trustee, as follows: . . . [Sections A-C direct that $20,000 be distributed to two trusts established for other charities and$10,000 given to the residue of the estate] D. The remainder of said sum of One Hundred Thousand (100,000) Dollars, I direct shall be held by my said Trustee, and one-third of said income shall be paid to the Young Men's Christian Association of Hartford, Connecticut; one-third to the Newington Home for Crippled Children of Newington, Connecticut; and one-third to the Memorial Hospital of Manchester, Connecticut. TWELFTH: [The residary estate] I give, devise and bequeath to The Hartford-Connecticut Trust Company, of Hartford, Connecticut, as Trustee, IN TRUST, for the uses and purposes and with the powers and subject to the provisions and limitations hereinafter set out. ...C. If at my death, neither my wife nor any descendants survive me; or if at the death or remarriage of my said wife, no descendants of mine should be living, or if there should be funds in my Trustee's hands under the provisions of sub-section B above and there should be no descendants of mine living at any time, then I direct that the funds in my Trustee's hands shall be used as follows. One-third of the income therefrom shall be paid to the Young Men's Christian Association of Manchester, or to The Morton Library Association of Manchester, whichever institution may take the funds under the provision of Clauses Ninth and Tenth of this Will, One-third of said income shall be paid to the Memorial Hospital of Manchester, Connecticut; and one-third of said income shall be paid to the Newington Home for Crippled Children. If neither the Young Men's Christian Association of Manchester nor The Morton Memorial Library receive the funds under the provisions of Sections Ninth and Tenth of this Will, then I direct that one-half of said income be paid to said Memorial Hospital of Manchester, and one-half said income be paid to the Newington Home for Crippled Children. I direct that the income so held and used for charitable purposes under the provisions of this Clause Twelfth shall be known as "The Willie T. Morton Fund." THIRTEENTH provides for an alternative dispositon of the income interest if any organization receiving income should cease to exist.	Last Will and Testament of Willie T. Morton dated February 27, 1924	Note: The trust provides for a gift over of the income interest if MMH ceases to exist.
11-1.100	Trust u/w Grace Robertson	$134,862.54	Bank of America	Last Will and Testament signed August 20th, 1940. ARTICLE VII. I give to The Manchester Trust Company, a Corporation under the laws of the State of Connecticut, and located in said town of Manchester, the sum of Forty Thousand ($40,000.00) Dollars, in trust, however, to take hold, manage, invest and reinvest, and to pay the net income therefrom to the Trustees of the Manchester Memorial Hospital, a Connecticut corporation, located in said Town of Manchester, to be used for general hospital purposes. Codicil signed August 20th, 1940. ARTICLE I: In case my estate does not amount to enough to pay all of the special bequests or gifts made in said will, it is my will that such special bequests and/or gifts be eliminated in the following order: . . . (g) Gift for the benefit of the Manchester Memorial Hospital set forth in Article VII, to the end that all special bequests be paid in full with the exception of the seven gifts named in this Article and that those be paid in full, if the amount of my estate admits such payment, but if such payment cannot be made, then and in that event, so far as possible, bequests and/or gifts be paid as set forth; First to the Hospital; second to the Playgrounds; Third to the Manchester Y.M.C.A.; Fourth for Education; Fifth for Parks; Sixth to the Connecticut Humane Society; and Seventh to Thorsby Institute	Last Will and Testament of Grace Robertson dated August 20, 1940; Codicil dated August 20, 1940, Codicil dated September 10, 1942; Codicil signed August 29, 1945; and Codicildated November 10, 1953	Note: This Will does not provide for another disposition if MMH no longer exists.

3336705.1

Fund Number	Name of Trust	Market Value of Trust Held by Trustee 3/31/2016	Current Trustee	Terms of Trust	Supporting Documents	Notes
11-1.101	Albert L. Crowell & Maytie Case Crowell Fund (Trust u/w Maytie Case Crowell)	$163,975.63	Bank of America	SIXTH: [This Article makes provision for the perpetuation of a memorial to the Testatrix's mother, Marietta Stanley Case, in the form of an Austin organ given by her family to South Methodist Church, in Manchester, Connecticut,. After reserves for a certain purpose have been accumulated], income from the trust estate herein provided for organ purposes may be distributed from time to time to Manchester Memorial Hospital for its general purposes, but provision for distribution to said Hospital shall not prevent the trustee from again accumulating and using income for organ purposes. SEVENTH: I give and bequeath the sum of fifteen thousand (15,000) dollars IN TRUST to said The Connecticut Bank and Trust Company, and in its successors in this trust upon the following trusts: Said trustee shall have power to take, hold, receive, sell, invest and reinvest this trust estate and the proceeds thereof in such investments as would be selected by a prudent investor, and it may also invest in a common trust fund managed by it; and after the payment of administration expenses it shall pay over the net income therefrom quarterly, or oftener in its discretion, in perpetuity, to The Manchester Memorial Hospital for its general purposes, this gift to be known as the Albert L. Crowell and Maytie Case Crowell Fund. Articles NINTH, ELEVENTH, THIRTEENTH and FOURTEEN provide for contingent additional gifts to the Article SEVENTH trust.	Last Will and Testament of Maytie Case Crowell dated May 17, 1957	Note: This Will does not provide for another disposition if MMH no longer exists.
11-1.102	Trust u/w Andrew Ferguson	$3,532,993.99	Bank of America	ELEVENTH: All the rest, residue and remainder of my estate of every name and nature, both real and personal, including any lapsed or void legacies and devises, I give, devise and bequeath to THE CONNECTICUT BANK AND TRUST COMPANY, absolutely and in fee simple, BUT IN TRUST, NEVERTHELESS, to be held as a permanent fund in memory of ANDREW and ANN FERGUSON, for the benefit of MANCHESTER MEMORIAL HOSPITAL, of Manchester, Connecticut, and the net income therefrom, after the payment of all necessary expenses, including reasonable compensation to my said trustee, to be paid not less often than quarterly to said Manchester Memorial Hospital, for its general uses and purposes.	Last Will and Testament of Andrew Ferguson dated April 4, 1961	Note: This Will does not provide for another disposition if MMH no longer exists

Fund Number	Name of Trust	Market Value of Trust Held by Trustee 3/31/2016	Current Trustee	Terms of Trust	Supporting Documents	Notes
11-1.103	Trust u/w Gertrude H. Rogers	$3,466,457.84	Original Trustees: Phoenix State Bank and Trust Company, and Robert S. Morris, of West Hartford, Connecticut	Article FIFTH creates a trust with $100 each month paid to a life beneficiary. The balance of the net income and, after the death of the life beneficiary, the entire net income "shall be held, used and applied for the benefit of the Manchester Memorial Hospital, a charitable corporation located in said Manchester, for which this fund shall be held as a charitable use in perpetuity, subject to the following limitations: I direct that the net income from this fund shall be used and applied for the support and development of that department of said Hospital which shall be devoted to the medical or pathological service of that Hospital, and more specifically to its research and laboratory work, that is, any investigation towards the alleviation of illness, including payment of salaries of an adequate staff, and the installation and maintenance of proper equipment, to enable that hospital to furnish complete laboratory service of this kind to the staff of that Hospital and to the physicians of the Town of Manchester for their patients of that town, whether they are then patients of that Hospital or not. Accordingly, I direct that the net income each year shall only be disbursed to the said Hospital upon a budget for this department submitted by the Hospital to the trustees under this will and approved in writing by two competent physicians..." [The Will thereafter contains very long and detailed provisions about the physicians, the budget, and the use of funds.] My purpose in creating these limitations and conditions is to keep this fund a living force in building up the quality of medical service in that Hospital and in that community, through the establishment of highly competent technical service in research and laboratory work. If at any time the trustees of my estate shall be satisfied, after conferring with the disinterested physicians whose duty it shall then be to approve the budget as above provided, that The Manchester Memorial Hospital is not devoting said funds to the purposes for which the gift is made, or is not maintaining as adequate and competent a research and laboratory staff and department as the available income will permit, said trustees shall notify the Manchester Memorial Hospital to that effect and if the failure is not corrected within a reasonable time said trustees may terminate the right of The Manchester Memorial Hospital to receive further funds under this will and thereafter said trustees may apply the income of said fund for similar purposes at the Hartford Hospital in Hartford, Connecticut. [The section continues with the requirement that there shall be two trustees, and describes how trustees shall be appointed]. Article FIRST of the Second Codicil amends Article FIFTH but does not modify the requirement that if MMH does not use the funds as specified the trustees may terminate the right of MMH to receive further funds.	Last Will and Testament of Gertrude H. Rogers dated July 13, 1937. Codicil dated October 11, 1939. Codicil dated October 21, 1940	Note. There is no specific gift over if MMH no longer exists as a charitable organization. The Will states that if MMH fails to use the gift as intended, the trustee may apply the income for similar purposes at Hartford Hospital.
	Subtotal: Manchester Memorial Hospital	$ 8,865,336.21				

3336706 1

Fund Number	Name of Trust	Market Value of Trust Held by Trustee 3/31/2016	Current Trustee	Terms of Trust	Supporting Documents	Notes
TRUSTS F/B/O ROCKVILLE GENERAL HOSPITAL						
11-1.104	Emma Dillon Rockville City Hospital Fund (Trust u/w Laurence M. Dillon)	$420,914.72	Bank of America	"9. I hereby give, devise and bequeath all the rest, residue and remainder of my estate, both real and personal, of whatsoever kind or character, including lapsed legacies and devises, and wheresoever situated, to THE CONNECTICUT BANK AND TRUST COMPANY, Hartford, Connecticut, as Trustee. Said Trustee shall hold, manage and control all of the aforesaid property as a trust estate, with all the rights and powers, and subject to the limitations, hereinafter enumerated, for the following uses and purposes: . . . [Part A creates a life estate for Mr. Dillon's cousin, and Part B provides that upon the death of the cousin, or if she does not survive him), the Trustee shall divide the corpus of the trust estate into two (2) equal parts, IN TRUST, NEVERTHELESS , for the following uses and purposes: 1) One of said parts, so divided, shall be set apart for the benefit of the ROCKVILLE CITY HOSPITAL, Rockville, Connecticut, its successors or assigns, in perpetuity, and the Trustee shall pay to it, or its successors or assigns, all of the net annual income derived from its said particular fund, in annual or other convenient installments. It is my wish that said fund be named the EMMA DILLON ROCKVILLE CITY HOSPITAL FUND in memorial of my beloved mother. Said net income shall be used for such general purposes as its governing board shall deem proper, and at its discretion. 2) The remaining second part, so divided, shall be set apart for the benefit of ST. BERNARD'S SOCIETY, INC. of Rockville, Connecticut . . . . In the event any or all the net income of this trust directed to be distributed to said ST. BERNARD'S SOCIETY, INC. is not distributable to said Society for a period of fifty (50) years from the date of my death for any reason, including a disclaimer by said income beneficiary, the net income of this second part shall be distributed to the ROCKVILLE CITY HOSPITAL, Rockville, Connecticut, its successors or assigns, until fifty (50) years from the date of my death, when the remaining net corpus and accretions of said remaining second part shall be paid over absolutely to said ST. BERNARD'S SOCIETY, INC., its successors or assigns.	Last Will and Testament of Laurence M. Dillon dated February 5, 1964	Note: The Will includes the language "its successors or assigns" after naming Rockville City Hospital
11-1.105	The Marguerite E. Moxon and Dorothy Moxon Yost Memorial Trust	$261,108.50	Bank of America	4. Use of Trust Fund. The Trustee shall distribute not less than annually all of the net income from the Trust as follows. One-half of said income to the Trustees of the Rockville General Hospital, Rockville, Connecticut, to be used by the Board of Trustees or other governing body for the benefit of such Rockville General Hospital solely for such capital improvements as the Board of Trustees or other governing body may see fit. The remaining one-half of said income to the Union Congregational Church, now located on Union Street, Rockville, Connecticut, to be used by the Board of Trustees or other governing body for the benefit of the Union Congregational Church in any manner it deems fit.	Trust Agreement dated April 2nd, 1982 between Marguerite E. Moxon and Dorothy Moxon Yost and the Connecticut Bank and Trust Company	Note: The Trust Agreement does not provide for another disposition if MMH no longer exists.
11-1.106	Trust u/w William E. Barton	$1,356,611.63	Bank of America	THIRD: All the rest, residue and remainder of my estate, real, personal and mixed, and wherever the same may be situated, I give, devise and bequeath in manner and form as follows, to wit: . . . [Section a) describes a gift in trust to ST. CATHERINE CEMETERY]. b) I give, devise and bequeath all the rest, residue and remainder of my estate unto the CONNECTICUT NATIONAL BANK, of Hartford, Connecticut, or its successors, as Trustee. I order and direct my trustee to invest and reinvest all the assets in the trust account as it in its absolute discretion deems fit and to pay therefrom all the net income thereof unto my two sisters, ANNA H. BARTON and MARY K. BARTON, both of the Town of South Windsor, for so long as they shall live. Upon their death, I order and direct that all of the net income thereof be paid over and distributed unto the ROCKVILLE GENERAL HOSPITAL, of Rockville, Connecticut, to be used by it as it deems fit.	Last Will and Testament of William E. Barton dated December 9, 1986	Note: The Will does not provide for another disposition if MMH no longer exists.
Subtotal: Rockville General Hospital		$2,038,634.85				
	GRAND TOTAL	$ 10,903,971.06				

3336708.1

8. Revised/Updated Table 8 – Net Proceeds Analysis

Please see attached updated Table 8, together with a document explaining various of the changed values.

APA
PROJECTED NET PROCEEDS

		Actual 9/30/2015	Actual 3/31/2016
ACQUISITION PRICE (EV)	A	105,000,000	105,000,000
ASSUMED ASSETS & LIABILITIES:			
Pension & Retiree Medical		(62,598,000)	(67,598,000)
Captive & Workers Comp.		(1,705,000)	(1,705,000)
Net Working Capital True-up		(9,107,000)	(8,275,000)
RGH Eating Disorder Loan		0	0
Seller's Reimbursable Costs		(424,000)	(424,000)
Capital Leases		(6,764,000)	(5,922,000)
Asbestos Abatement		(1,000,000)	(1,000,000)
TOTAL ACQ LIABILITIES	B	(81,598,000)	(84,924,000)
THRESHOLD on LIABILITIES	C	(77,000,000)	(77,000,000)
GUARANTEED NET PROCEEDS	D A-C	28,000,000	28,000,000
CASH & INVESTMENTS (ECHN) *	E	58,454,000	54,968,000
TOTAL CASH for DEBT PAYOFF	F D+E	86,454,000	82,968,000
LONG TERM DEBT (Net AWUIL)	G	(78,420,000)	(75,896,000)
SURPLUS after DEBT DEFEASANCE	H F-G	8,034,000	7,072,000
Post-Closing Pool "Wind Down" Funds	I	1,000,000	1,000,000
Excess Liabilities Assumed	J B-C	(4,598,000)	(7,924,000)
Funds Remaining after PMH Reimbursed	K H-I+J	2,436,000	(1,852,000)
Deduction to Capital Commitment **	L	0	1,852,000
Available for Indemnity Reserve	M K+L	2,436,000	0
Legacy ECHN ***			2,139,000

* PMH is assuming a $5,000,000 loan for the RGH Eating Disorder Unit without a price deduction. To the extent that cash is available beyond the $1,000,000 for post-closing costs and $4,500,000 for the indemnity reserve, ECHN can mitigate a deduction to the capital commitment up to $5,000,000.

** If line K is less than zero, then there was not sufficient ECHN cash left to make PMH whole on additional liabilities assumed, thus a dollar for dollar reduction to the $75 million capital commitment applies.

*** Estimated value of future settlements on funds due from Medicare and Medicaid less fund due to Medicare and Medicaid for prior years still pending final review.

NWC & CASH NET		49,347,000	46,693,000

NET PROCEEDS

UPDATED as of March 31, 2016

Changes from Previous Table

- Original filing for 9/30/15 was estimated based on incomplete information specifically around the pension, captive and workers compensation liabilities for year end. The revised table 9/30/15 figures are per the audited financial statements and also include other adjustments we did not have estimated impact assessed, i.e. extended reporting period premium cost, debt payoff costs, etc.
- Pension unfunded gap is projected to grow by $5,000,000 due to the performance or decline of interest rates since 9/30/15.
- NWC (net working capital) fluctuates month to month, but at two points of the year it diminishes due to the slowdown of accounts payable, March 31 and September 30. This has an offsetting impact to cash as it increases. These two dates are measurement points for our bond covenants and we hedge the potential slowdown of payments from third party payers, governmental or otherwise.
- Capital lease obligations are now reported separately and not including a deduction to the purchase price for asbestos abatement (FIN47 accounting) as it now is reported on a separate line item. Capital lease obligations and long-term debt were "cleaned up" from previous 9/30/15 due to re-classes from one category to the other for specific financings. The figure for March 31 reflects payments outpacing any new financing.
- Per the Asset Purchase Agreement, ECHN will credit against the purchase price $424,000 of its transaction-related expenses for which is has been previously reimbursed by PMH. This figure is a price deduct but it also increased cash since 9/30/15 so it's a "wash".
- As noted above, asbestos abatement capped at $1,000,000 is a price deduction at closing. Previously reported at book value at 9/30/15 in original filing at $412,000. It will be assessed by an independent expert post-closing.
- The next line notes the "cap" or threshold on the assumed liabilities at $77,000,000. If the sum of the assumed liabilities is over this, then the difference is computed and set aside for settling up further along in the transaction – see line J. The difference between the purchase price line A and the threshold liabilities line C is the guaranteed lowest net purchase price paid to ECHN.
- Cash has been reduced by several factors. First is a re-class of an endowment fund that has been recently reviewed legally as permanently restricted. The permanently restricted amount of the endowment is $1,720,000. Other deductions to cash reflect purchasing extended reporting period insurance policies as well as the legal fees, etc. to pay off the long-term debt. State nonpayment of supplemental payments since June 30, 2015 has also impacted the cash on hand.
- Long-term debt continues to be paid down without any new debt added – see separate reconciliation attached.
- After the pay down of the debt, the remaining funds are to be allocated as follows:

- The first $1,000,000 is set aside for post-closing wind down expenses. If there were insufficient funds to do this, the funding would be made by PMH and deducted from the capital commitment.
- Whatever remains satisfies line J, the excess liabilities assumed. If line H, the surplus after debt is paid off is insufficient to fund the post-closing costs of $1,000,000 and reimburse PMH fully for the excess liabilities assumed, the shortfall will be deducted from the capital commitment of $75,000,000. In this case, PMH would fund this and reduce further the capital commitment by the $1,000,000.
- If line H is sufficient to fund the $1,000,000 and reimburse PMH fully, whatever funds remain up to $4,500,000 will go into an indemnity reserve fund.

Clarifications will be made to the Asset Purchase Agreement related to the above.

- Legacy ECHN would assume the value of any collections post-closing on the net of due from and due to third party payers, specifically Medicare and Medicaid. The current book value is $2,139,000 at March 31. The timing of payments coming in or going out is unknown at this time. Any collection of these funds would become available to reimburse PMH for the funds referenced in the previous bullet and sub-bullets to help restore partially or fully the capital commitment.
- Although it appears unlikely based on figures presented today, if ECHN were to have sufficient cash available at the end of the transaction to fully fund the $1,000,000 wind down expenses, and fund the indemnity reserve to $4,500,000 and not require the $5,000,000 of cash currently securing the RGH Eating Disorder Loan (and convey this to PMH at closing), ECHN would not have a $5,000,000 deduction to the capital commitment due to the loan PMH is assuming without a price deduction.

ECHN, INC.

	SEP 2015	MAR 2016
Assets		
Current assets		
Cash and cash equivalents	$16,286,829	$19,785,945
Current portion of assets whose use is limited	$1,097,600	$2,273,720
Accounts receivable, net	$41,607,499	$41,109,230
Inventory	$5,553,809	$5,546,594
Estimated settlements due from third-party payors	$3,377,723	$2,358,442
Prepaid expenses and other current assets	$6,653,091	$5,964,909
Total current assets	$74,576,551	$77,038,840
Assets whose use is limited, net of current portion		
Donor Restricted investments	$5,590,241	$5,113,603
Board designated investments	$36,824,677	$33,642,774
Investments held in trust for estimated self-insurance liabilities	$5,278,426	$5,614,840
Investments held under bond indentures	$5,172,061	$5,120,641
Beneficial interest in trust assets	$10,809,693	$10,903,971
Total assets whose use is limited, net of current portion	$63,675,098	$60,395,829
Investments	$7,118,433	$5,310,923
Investments in joint ventures	$18,190,809	$18,455,808
Property and equipment, net	$88,275,419	$85,793,506
Other assets		
Due from affiliated entities		
Pledges receivable		
Other accounts receivable, net		
Notes receivable, net		
Estimated settlements due from third-party payors		
Other, net	$4,541,099	$4,923,873
Goodwill	$4,026,827	$3,918,407
Total other assets	$8,567,926	$8,842,280
Total assets	**$260,404,236**	**$255,837,186**

ECHN, INC.

Liabilities and net assets

	SEP 2015	MAR 2016
Current liabilities		
Accounts payable and accrued expenses	$33,429,551	$35,065,970
Current portion of accrued pension and other postretirement benefits	$190,189	$190,189
Estimated settlements due to third-party payors	$2,929,392	$2,657,091
Current portion of long-term debt and capital lease obligations	$7,018,708	$6,458,787
Line of credit	$3,800,000	$2,900,000
Other current liabilities	$4,134,712	$3,720,409
Security deposits and agency funds		
Total current liabilities	$51,502,552	$50,992,446
Other liabilities		
Due to affiliated entities		
Long-term debt and capital lease obligations, net of current portion	$80,122,247	$79,783,737
Estimated self-insurance liabilities	$7,196,797	$7,859,966
Accrued pension and postretirement benefits, net of current portion	$62,407,379	$63,865,959
Annuities payable		
Estimated settlements due to third-party payors		
Conditional asset retirement obligation/Other liabilities	$467,711	$473,975
Total other liabilities	$150,194,134	$151,983,637
Total liabilities	$201,696,686	$202,976,083
Net assets		
Unrestricted	$42,167,566	$36,653,204
Temporarily restricted	$1,486,536	$1,060,174
Permanently restricted	$15,053,448	$15,147,725
Total net assets	$58,707,550	$52,861,103
Total liabilities, equity and net assets	**$260,404,236**	**$255,837,186**
	$0	$0

ECHN, INC.

DEBT RECONCILIATION

BALANCE SHEET

	SEP 2015	MAR 2016
Gross Debt (yellow highlighted accts liabilities)		
Current portion of long-term debt and capital lease obligations	$7,018,708	$6,458,787
Line of credit	$3,800,000	$2,900,000
Long-term debt and capital lease obligations, net of current portion	$80,122,247	$79,783,737
	$90,940,955	$89,142,524
Interim Payments & Debt Service Funds (yellow highlights assets)		
Current portion of assets whose use is limited	$1,097,600	$2,273,720
Investments held under bond indentures	$5,172,061	$5,120,641
Less: Interest payments	($511,173)	($567,589)
	$5,758,488	$6,826,772
Net Debt (Capital Leases + Long-term Debt + Line of Credit)	$85,182,467	$82,315,752
Less: RGH Eating Disorder Loan*	$0	$498,337
Adjusted Net Debt per Balance Sheet	$85,182,467	$81,817,415

APA NET PROCEEDS

Capital Leases (assumed by PMH)	$6,764,000	$5,922,000
Long Term Debt (Net AWUIL)	$78,420,000	$75,896,000
Net Debt per APA Net Proceeds	$85,184,000	$81,818,000
Difference (due to rounding per APA schedule)	($1,533)	($585)

ECHN
Principal and Interest Payments
Fiscal Years 2015-2019

	2015	2016	2017	2018	2019	5 Year Average
Interest payments - debt *	3,194,961	3,116,216	3,296,246	3,120,535	2,989,155	3,143,422
Interest payments - capital leases	297,078	273,918	176,346	107,678	57,696	182,543
	3,492,039	3,390,134	3,472,592	3,228,212	3,046,852	3,325,966
Principal payments - debt *	5,602,278	5,813,346	6,269,252	6,063,944	5,284,227	5,806,610
Principal payments - capital leases	3,227,560	3,256,988	2,093,153	1,109,296	986,203	2,134,640
	8,829,838	9,070,334	8,362,405	7,173,240	6,270,430	7,941,249
Total Annual Debt Service	12,321,877	12,460,468	11,834,998	10,401,453	9,317,281	11,267,215
Total Annual Debt Service -- Gone after Closing	8,797,239	8,929,562	9,565,498	9,184,479	8,273,382	8,950,032

* Includes line of credit

9. Example of Health Needs Assessment Conducted by PMH or Letter describing community involvement in health needs assessments.

Prospect Medical Holdings has not completed a Community Health Needs Assessment in the Rhode Island market. However, attached as Exhibit 9(a) is a 2013 Statewide Community Health Needs Assessment prepared by Hospital Association of Rhode Island ("HARI") which is not specific to the Prospect CharterCARE facilities. The 2013 report was prepared by HARI prior to the Prospect - CharterCARE Health Partners transaction. Because the report was prepared prior to the Prospect transaction, Prospect did not produce or assist in producing the 2013 HARI CHNA. CharterCARE was involved with the Needs Assessment report created by HARI before its transaction with Prospect.

In the fall of 2015, HARI commenced the process of updating the 2013 Community Health Needs Assessment. Prospect CharterCARE is represented on the HARI committee tasked with leading the effort to update the Community Health Needs Assessment and related implementation plans. A report for 2015 has not been issued.

Attached as Exhibit 9(b) are excerpts from the 2013 HARI Community Needs Assessment utilized in application for OB services in Rhode Island.

In Rhode Island, CharterCARE continued its tax exempt status as a joint venture partner with Prospect in operating the CharterCARE hospitals. As such, one of the Rhode Island Department of Health's conditions to the CharterCARE transaction required that PMH collaborate with the Department of Health on one (1) community health needs assessment. In general, CHNAs are a requirement of federal tax exempt charitable hospitals developed to support their continued exemption. Pertinent CHNA information is required to be provided on the Form 990 Schedule H, which is only required to be filed by tax exempt hospitals. Hospitals that do not seek or continue tax exempt status whether independently or part of a joint venture are not required by law to adopt or continue a CHNA, including any previous CHNA developed. In Connecticut, for example, Connecticut General Statutes Section 19a-127k discusses community benefit programs which hospitals may have and suggests that the programs be based on an assessment of the community, but does not require that all hospitals conduct formal community assessments. Similarly, Connecticut General Statutes Section 19a-649 requires only that tax exempt hospitals submit a CHNA required under federal law to OHCA.

PMH is not seeking to continue the tax exempt status of any of the entities in the ECHN transaction nor does the ECHN transaction involve a tax exempt joint venture partner. Although PMH is not tax exempt and therefore not required to engage in a CHNA, PMH is committed to meaningfully investing in and providing needed care to the communities it serves. PMH works with its Local Boards to assess and determine the community health needs of the population served and how to best implement these needs.

EXHIBIT 9(a)

HARI

Community Health Needs Assessment

Final Report

2013

HOLLERAN

Executive Summary

Background

The Hospital Association of Rhode Island, in collaboration with its member hospitals, led a statewide comprehensive Community Health Needs Assessment (CHNA) to assess the health indicators and health needs of residents in the state of Rhode Island. The CHNA was conducted from September 2012 to May 2013. The assessment was conducted in a timeline to comply with requirements set forth in the Affordable Care Act, as well as to foster collaboration among Rhode Island hospitals in their commitment to community health and population health management. The findings from the assessment will be utilized by HARI and its members to guide community health improvement efforts and to engage partners to address the identified health needs.

Research Components

HARI and its hospital members undertook an in-depth, comprehensive approach to identifying the needs in the communities it serves. A variety of quantitative and qualitative research components were implemented as part of the CHNA. These components included the following:

- Analysis of Rhode Island Department of Health BRFSS Data
- Secondary Data
- Key Informant Surveys
- Focus Groups
- Prioritization of Community Health Needs

The following areas were common health issues identified throughout the various research components.

Identified Community Health Issues

- Mental Health and Substance Abuse
- Diabetes
- Overweight/obesity
- Access to Care
- Heart Disease
- Cancer (specifically breast, lung)
- Asthma (adult and child)

Methodology

Rhode Island State BRFSS Data Analysis

The state of Rhode Island annually participates in the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS) survey. The BRFSS study is conducted nationally each year and is led at the state level through the respective state health departments. HARI's intent was not to duplicate existing survey processes, but rather to partner with the Rhode Island Department of Health to utilize the existing state BRFSS data sets. With support from the Department of Health, raw BRFSS data sets were released to Holleran, a third party research and consulting firm, for in-depth analysis. Each hospital's service area was defined and the associated data points were extracted for each hospital. The survey assessed indicators such as general health status, prevention activities (screenings, exercise, etc.), and risky behaviors (alcohol use, etc.). The results were also examined by a variety of demographic indicators such as age, race, ethnicity, and gender.

Secondary Data Profile

HARI and its CHNA partners, contracted with Healthy Communities Institute to gather and present existing secondary data. The secondary data included statistics such as mortality rates, cancer statistics, communicable disease data, and social determinants of health (poverty, crime, education, etc.), among others. This information was used to supplement the primary data and to flesh out research gaps not addressed in the BRFSS results. Where available, the local-level data was compared to state and national benchmarks. This data was also built in a web portal for full access to the public.

Key Informant Surveys

Key informant surveys were conducted with 49 professionals and key contacts from throughout Rhode Island. Working with leadership from each of the hospitals, prospective individuals were identified and invited to participate in the study. The survey included a range of individuals, including elected officials, healthcare providers, health and human services experts, long-term care providers, representatives from the business community, and educators. A detailed list of participants can be found in Appendix A. The content of the questionnaire focused on perceptions of community needs and strengths across three key domains: Perceived key health issues prominent in the community, health care access and challenges, and solutions.

Focus Groups

Two focus groups were facilitated by Holleran in March 2013. The focus groups were intended to gather feedback regarding mental health issues and resources within Rhode Island. The participants included mental health experts, providers, and referral sources. A moderator guide, developed in consultation with the CHNA partners, was used to prompt discussion and guide the facilitation. In total, 21 people participated in the two focus groups. Participants were recruited by the CHNA partners. Each session lasted approximately two hours and was facilitated by Holleran. It is important to note that the focus group results reflect the perceptions of a small sample of community members and may not necessarily represent all mental health professionals in the hospital service areas.

Prioritization of Community Health Needs

HARI and its CHNA partners jointly conducted a prioritization to identify key statewide community health needs. The prioritization session included representatives from HARI, the hospital partners, and public health experts.

Limitations of Study

It should be noted that limitations of the research may have prevented the participation of some community members. The time lag of secondary data, the hospital service area sample, language and cultural barriers, the project timeline, and other factors may present some research limitations. To mitigate limitations of the research, HARI and its CHNA partners sought to include representatives of diverse and underserved populations, public and community health experts, and other community representatives to present the most comprehensive assessment of community health needs given the research constraints.

Research Partner

HARI and its CHNA partners contracted with Holleran, an independent research and consulting firm located in Lancaster, Pennsylvania, to conduct research in support of the CHNA. Holleran has more than 20 years of experience in conducting public health research and community health assessments. The firm provided the following assistance:

- Collected and interpreted secondary data
- Conducted, analyzed, and interpreted data from Household Telephone Survey
- Conducted, analyzed, and interpreted data from Key Informant Interviews
- Conducted Focus Groups with healthcare consumers
- Facilitated a Prioritization and Implementation Planning Session
- Prepared the Final Report and Implementation Strategy

Community engagement and feedback were an integral part of the CHNA process. HARI and its CHNA partners sought community input through interviews with key community stakeholders, focus groups with healthcare providers, and inclusion of partner hospital representatives as well as public health officials in the prioritization and implementation planning process.

Following the completion of the CHNA research, HARI and its CHNA partners will develop a plan to address prioritized community needs.

KEY CHNA FINDINGS

ANALYSIS OF BRFSS DATA

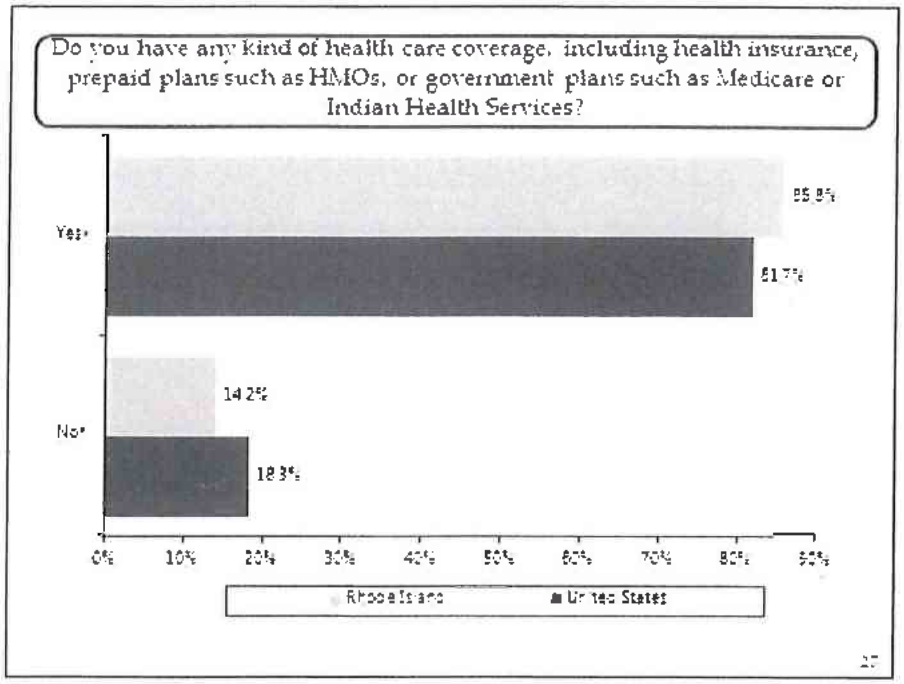
Behavioral Risk Factor Surveillance System data was analyzed between the dates of November 1, 2012 and January 10, 2013. BRFSS data was released to Holleran by the Rhode Island Department of Health on behalf of the Hospital Association of Rhode Island and its members.

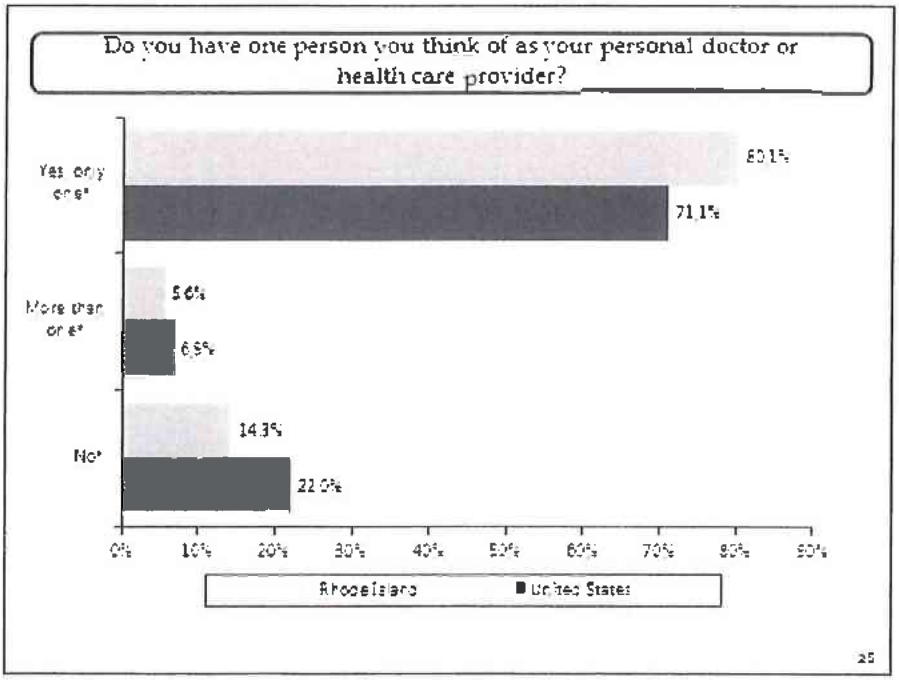
The final sample (6,533) yields an overall error rate of +/-1.2% at a 95% confidence level. This means that if one were to survey all residents within Rhode Island, the final results of that analysis would be within +/-1.2% of what is displayed in the current data set. All comparisons represent 2011 BRFSS data.

Household Survey Findings

A number of the items on the survey assessed **general health status**. When asked to rate their general health, 83% of residents in Rhode Island responded "good," "very good" or "excellent." This is above the 81.8% nationally. However, area residents were more likely to report one or more days of poor physical or mental health in the previous month when compared to residents across the nation. Approximately 40% of adults surveyed in the hospital's service area reported at least one day in the past month when their physical health was not good and 37.9% reported at least one day where their mental health was not good. Just over 45% percent indicated that these poor mental or physical health days keep them from doing their usual activities. This is higher than the nation (42.3%).

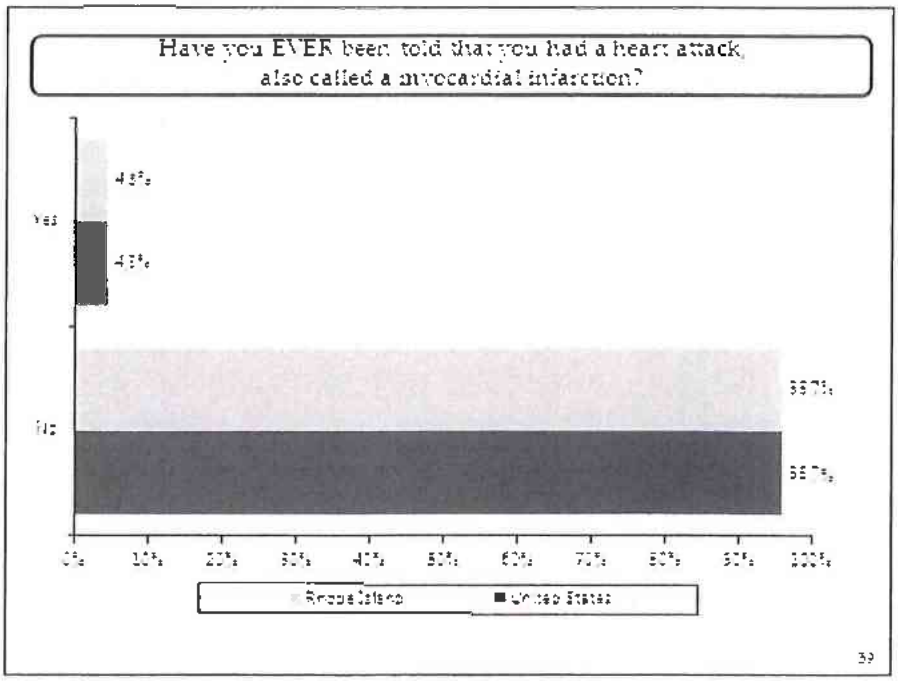
The survey also asked questions regarding **access to care** issues such as health care coverage, having a regular source of care, and cost. As detailed in the graph below, 85.8% of area adults reported having some kind of health care coverage, which is higher than the 81.7% across the U.S. Females in the area are significantly more likely than males to have health insurance coverage (88.7% vs. 82.8%). Roughly 80% of those surveyed reported having one person they think of as their personal doctor or healthcare provider. This is above the nation (71.1%). Cost was less of a barrier to seeking health care in the previous year for local adults. In Rhode Island, 15.8% of those surveyed indicated that there was a time in the past year when they needed to see a doctor, but could not because of cost. This compares to 17% throughout the country. Approximately 75% of respondents visited a doctor for a routine checkup in the previous year. This compares to 66.9% across the U.S.


Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare or Indian Health Services?
Yes*
No*
14.2%
18.3%
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
Rhode Island
United States


Do you have one person you think of as your personal doctor or health care provider?
Yes, only one*
More than one*
No*
71.1%
5.6%
6.9%
14.3%
22.0%
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
Rhode Island
United States

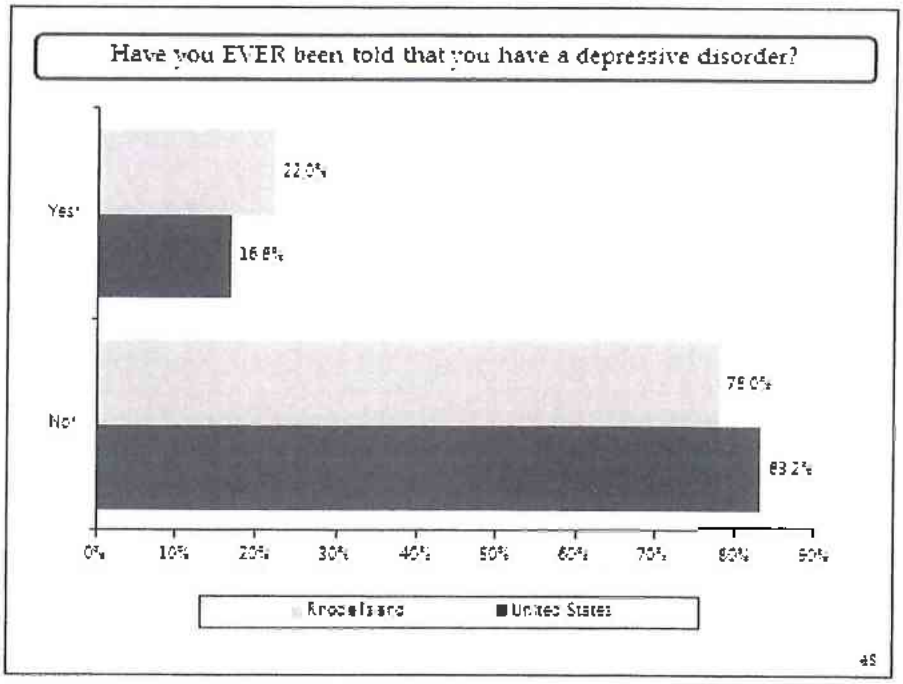
Awareness of individual "numbers" for **blood pressure and cholesterol** has been a national focus in recent years. Locally, 32.9% reported that they have been told by a doctor or health professional that they have high blood pressure. This is similar to the U.S. figure (31.6%). Nearly eight out of 10 residents who have high blood pressure reported that they are currently taking medicine for their high blood pressure. This is similar to the nation (77.3%). Among those with high blood pressure, 78.4% are changing their eating habits, 79.4% are cutting down on salt, 41.8% are drinking less alcohol, and 65.8% are exercising more to help lower or control their condition. These figures are similar to or better than nationally. In addition, a greater percentage of residents with high blood pressure reported being advised by their doctor to change their lifestyle habits to help lower or control their blood pressure than individuals nationally. With respect to blood cholesterol levels, 85.1% of area adults reported having their blood cholesterol checked which is above the national figure (79.4%). The percentage of residents reporting elevated cholesterol levels (38.5%) is in line with the nation (38.5%).

Cardiovascular health was also assessed by asking individuals if they have ever had a heart attack, stroke, or coronary heart disease. Residents living in Rhode Island look fairly similar to or better than those throughout the rest of the country with respect to these conditions. The graph below details the percentage of adults reporting a cardiovascular disease diagnosis.

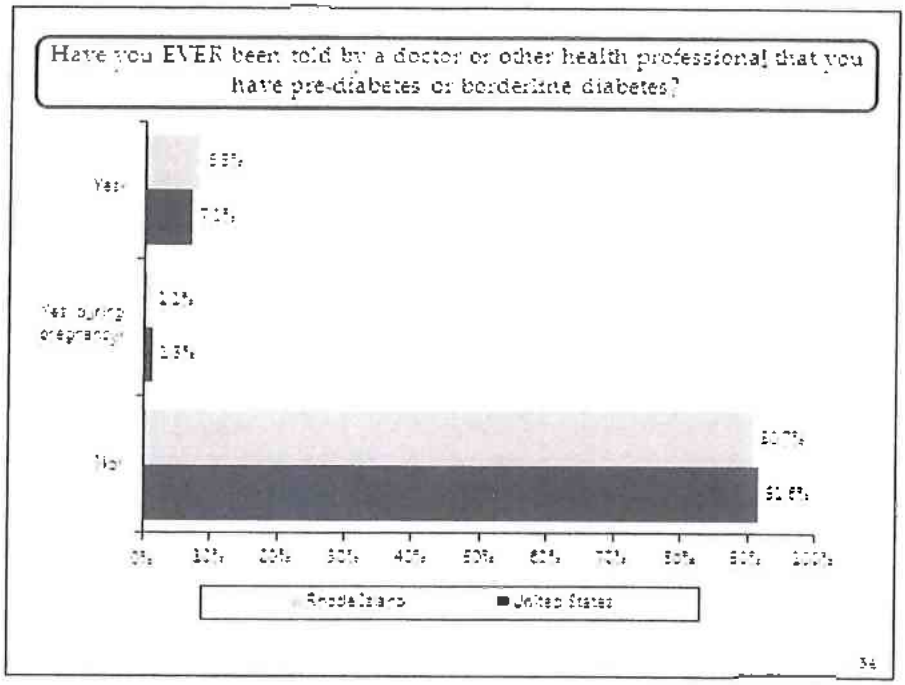


An **asthma** diagnosis was reported by approximately 16% of adults in the state and among this group, 74.1% reported that they still have asthma. The proportion that still has asthma is higher than the national proportion. The percentage of children who have been diagnosed with asthma (18.2%) is above the nation (13.4%). Survey respondents were also asked if they have COPD (chronic obstructive pulmonary disease), emphysema, or chronic bronchitis. The percentage among residents (6.2%) was similar to the U.S. (6.3%).

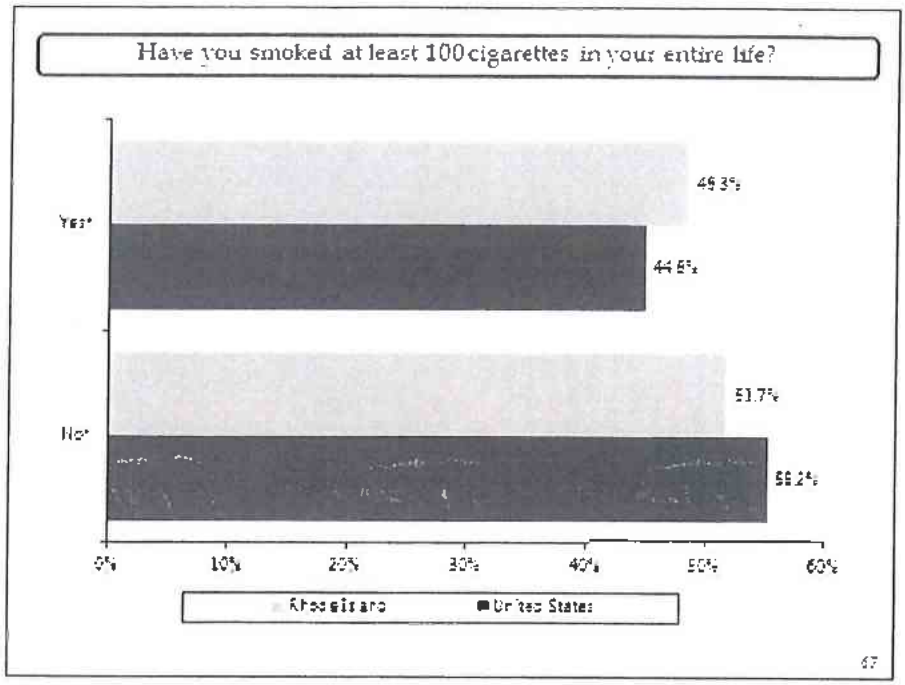
As a follow-up to the initial question regarding poor mental health days, the survey inquired about the incidence of **depressive disorders**. Twenty-two percent of those surveyed reported being told that they had/have a depressive disorder. This is higher than the nation (16.8%). Similar to national trends, females reported a higher incidence of depression than males (25.9% vs. 17.7%). When asked how many days in the previous two weeks they had little interest or pleasure in doing things, 36.5% of adults in Rhode Island mentioned at least one day. This is higher than national percentages. The following graph details a sampling of these findings.

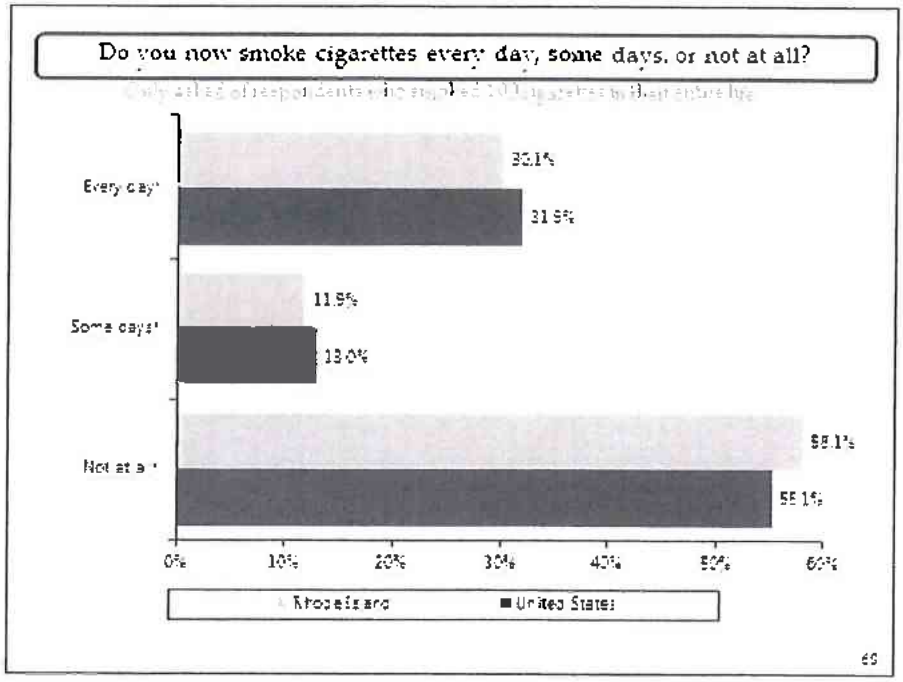


Diabetic conditions such as pre-diabetes, gestational diabetes, and adult diabetes were included in the survey as well. The percentage of residents with diabetes is lower than what is seen throughout Rhode Island and the rest of the country. Approximately 8% of area adults reported having diabetes compared to 9.8% across the nation. An additional 8.3% of residents reported having pre-diabetes or borderline diabetes. Among those with diabetes, 45.1% have taken a class to manage their diabetes compared to 52.2% throughout the U.S. When asked about having a test for high blood sugar or diabetes in the past three years, 59.5% of local adults indicated that they have had such a test. This is above the figure nationally (54.4%).

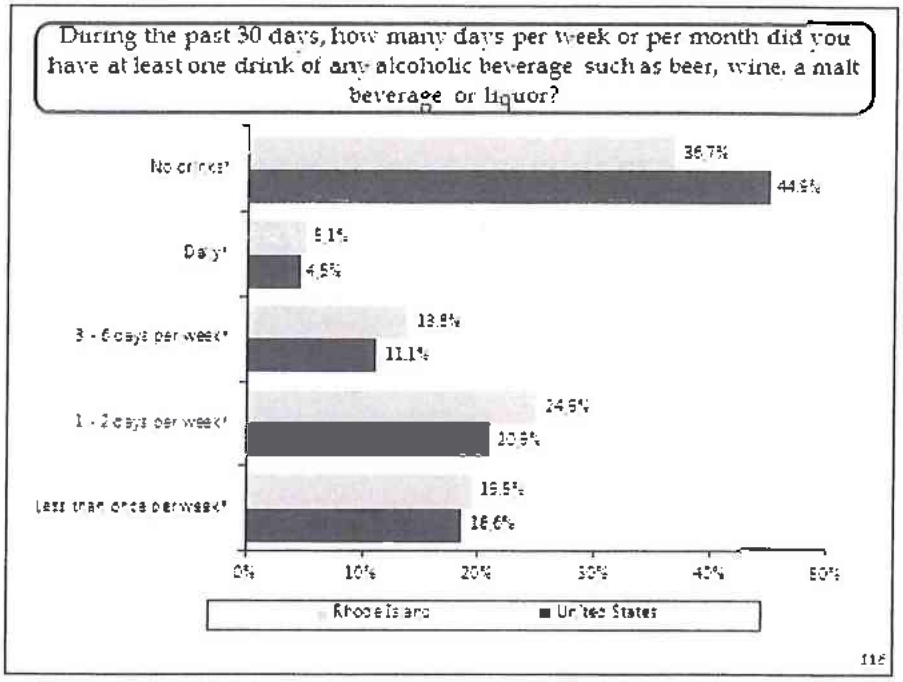


Risky behaviors related to **tobacco and alcohol use** were measured as part of the survey. Roughly 48% of area adults reported smoking at least 100 cigarettes in their lifetime, which is above the U.S. figure (44.8%). However, fewer residents reported that they still smoke. Among those residents who are still smoking, 63.2% have attempted to quit smoking in the past year. This is higher than throughout the U.S. and suggests that there are fewer current smokers in the area, and those who do smoke, are more likely to quit.


Have you smoked at least 100 cigarettes in your entire life?
Yes*
No*
46.3%
44.8%
51.7%
55.2%
0%
10%
20%
30%
40%
50%
60%
Rhode Island
United States
67

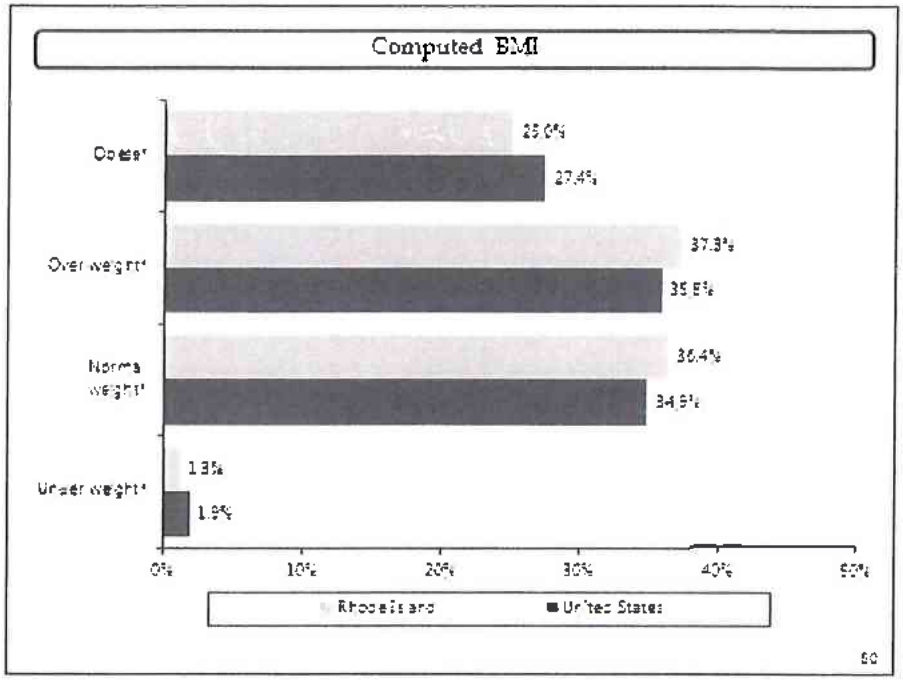

Do you now smoke cigarettes every day, some days, or not at all?
Every day*
Some days*
Not at all*
30.1%
31.9%
11.9%
13.0%
58.1%
55.1%
0%
10%
20%
30%
40%
50%
60%
Rhode Island
United States
68

Around 63% of local adults report at least one day in the previous month when they consumed alcohol. This is above the nation (55.1%). Of those who consumed alcohol, the majority (69.1%) reported having 1-2 drinks per occasion. Roughly 32% reported having four or more drinks (females)/five or more drinks (males) on one or more occasions in the past month. This compares to 33.4% nationally.



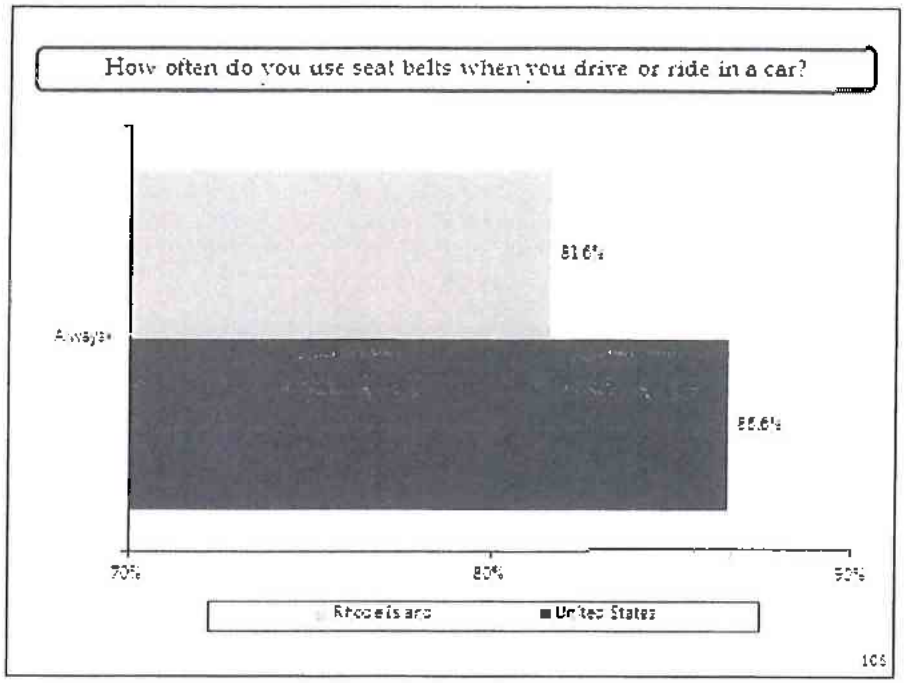
Nutrition and exercise habits were assessed by asking about fruit and vegetable consumption as well as the frequency and duration of physical activity. Approximately 30% of residents reported drinking 100% pure fruit juices once or more per day and 52.5% reported consuming fruit once or more per day. Nearly 26% of adults consumed dark green vegetables, while 9.0% ate orange-colored vegetables daily and 39% ate other vegetables daily. The consumption of fruits and vegetables looks similar to national figures.

Roughly 74% of survey respondents indicated that they participated in physical activities such as running, walking or calisthenics in the previous month. This is similar to the U.S. (74.3%). Walking was the most common form of exercise and was reported by 52.2% of those who exercised. Approximately 58% of residents reported exercising 1 to 5 times a week and 13.4% of residents reported exercising 6 to 10 times per week. The majority, 55.9%, engaged in exercise for less than one hour. **BMI (Body Mass Index)** was calculated from self-reported measures of height and weight. As displayed below, 62.3% of surveyed residents were either obese or overweight, which is similar to the U.S. (63.2%).

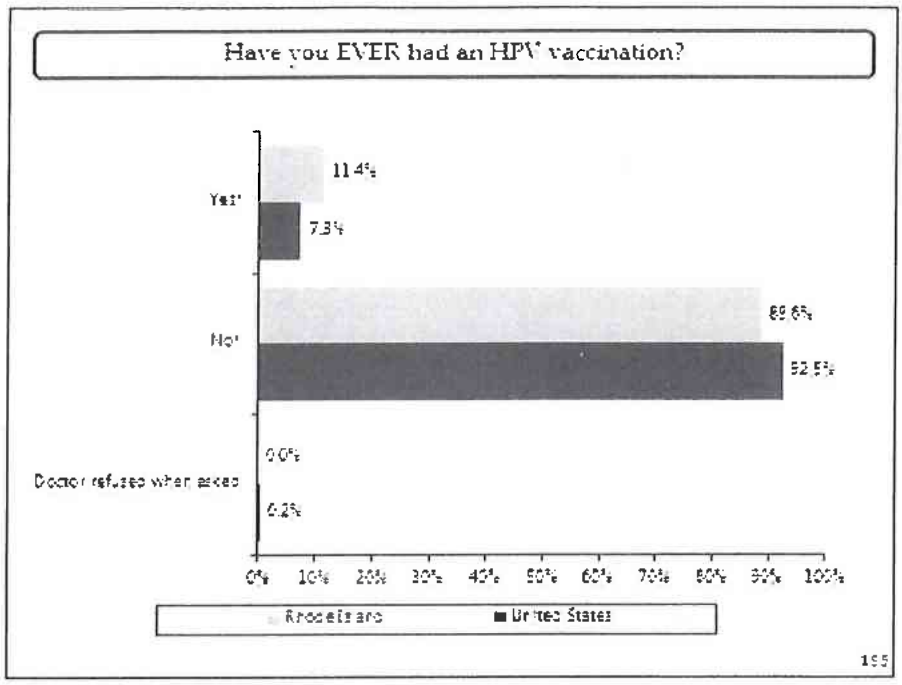


More than half of the surveyed residents (50.4%) indicated that they have limitations because of **arthritis or joint symptoms** and 32.2% reported that these symptoms affect the amount and type of work that they can do. Both of these figures are lower than what is seen among residents throughout the U.S.

Seatbelt use was identified as an area of concern on the survey. As shown below, fewer residents always wear their seatbelt when riding in or driving a car.



Immunization rates were assessed by asking residents about various vaccinations that they or their children may have received. Nearly forty-one percent (40.6%) of adults in Rhode Island had the seasonal flu vaccine in the previous year. This is above the nation (36.7%). When asked about children who live in the household, 73.2% indicated that their child had a seasonal flu vaccination. This compares to 48.2% nationally. Roughly 34% of those surveyed reported that they have had a pneumonia shot at some point in their lifetime. This compares to 30.6% across the U.S. When asked if they received a tetanus shot in the past 10 years, 72.6% indicated that they had. HPV (Adult Human Papillomavirus) vaccinations are slightly more prevalent among residents than what is seen throughout the nation. Roughly 12% have had the HPV vaccination and 72.2% have had all three shots.



In summary, the household survey results reveal a number of areas of opportunity and needs in the community, such as mental health status (depressive disorder and symptoms), alcohol use, and asthma. The household survey results should be examined along with the secondary data, key informant interviews, and focus groups to examine areas of overlap.

SECONDARY DATA PROFILE

Secondary data, such as mortality rates, cancer incidence rates, and social determinants of health (poverty, education, and housing to name a few) were gathered and reported by Healthy Communities Institute (HCI). The Hospital Association of Rhode Island established a relationship with HCI to measure and depict health status and risky behaviors throughout Rhode Island communities. The following information summarizes select health statistics and findings for Rhode Island, compared to U.S. A full, detailed listing of all the indicators collected for all Rhode Island counties, ZIP codes, and census tracts can be found at www.rihealthcarematters.org. All figures and statistics presented below were obtained from the Rhode Island Health Care Matters website.



Access to Health Services

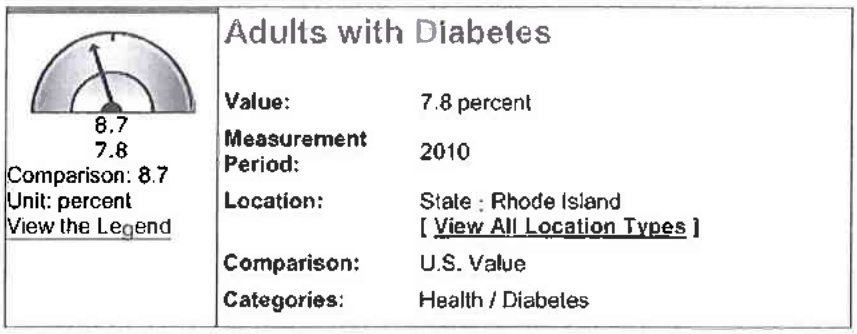
When compared against other U.S. Counties, both adults and children living in Rhode Island are more likely to have health insurance coverage. The primary care provider rate, which is the rate per 100,000 population, is also better locally than what is seen nationwide. Primary care providers include physicians practicing in general practice medicine, family medicine, internal medicine, and pediatrics. For Rhode Island, it is estimated that there are 90 providers per 100,000 population.

Cancer

Cancer statistics were evaluated through an examination of incidence rates and age-adjusted death rates. Specifically, rates for breast, colorectal, lung, cervical, prostate, and oral cavity/pharynx cancers were gathered. The age-adjusted death rates for breast, colorectal, lung, and prostate cancer are all well below the associated rates throughout the country. The area of greatest concern is breast cancer incidence rate. Based on 2005-2009 data, the incidence rate for breast cancer in Rhode Island is 133.2 cases per 100,000 females. This ranks Rhode Island in the bottom quartile of incidence rates nationally. It is important to note that the likelihood of females aged 50 and over having had a mammogram in the past two years in Rhode Island rates favorably against national figures. Nearly 85% of females in this age group have had a mammogram in the past two years. Other cancer incidence rates that were slightly elevated included colorectal cancer and lung or bronchus cancer incidence.

Diabetes

Diabetes statistics related to incidence, mortality, and screenings were reported. According to 2010 figures, 7.8% of Rhode Island adults have diabetes. Nationally, the figure is 8.7%. The picture below details this comparison.



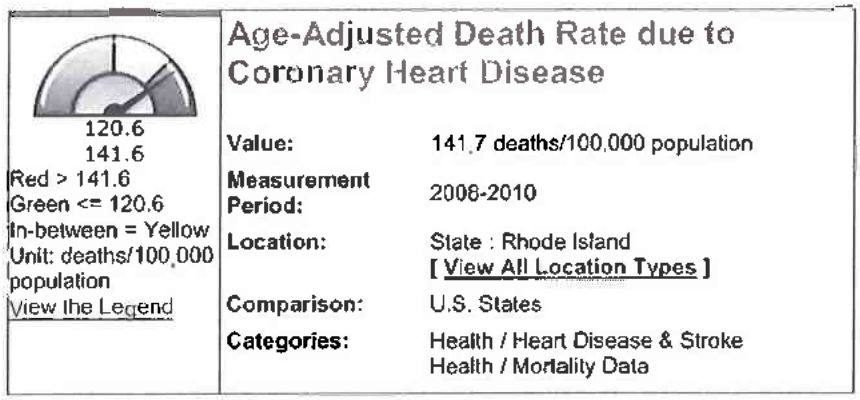
The age-adjusted death rate due to diabetes within Rhode Island is 15.9 deaths per 100,000 population. This is in the top quartile nationally. Among Medicare patients who have diabetes, 84.4% report having had their blood sugar tested in the past year. This is comparable to, or slightly above, what is seen nationally among other Medicare recipients with a diabetes diagnosis.

Exercise, Nutrition, and Weight

It is well documented that individuals who are overweight or obese have a higher incidence of chronic disease and other illnesses. The percentage of Rhode Island residents who are obese is estimated at 25.4% and the percentage of residents who are overweight or obese is 62.5%. It is estimated that there are 1,050,292 adults living in Rhode Island, which translates to roughly 656,433 adults who are overweight or obese. One in four, 26.2%, Rhode Island adults are sedentary, compared to 26.2% nationally.

Heart Disease and Stroke

The age-adjusted death rate for stroke in Rhode Island (32.3 deaths per 100,000 population) is favorable to what is seen nationwide. However, the age-adjusted death rate due to coronary heart disease is elevated. As depicted below, the statewide rate is 141.7 deaths per 100,000 population, which puts it in the bottom quartile nationally.



Immunizations

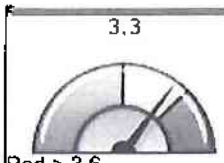
The age-adjusted death rate due to influenza and pneumonia (16.0 per 100,000) is below the national rate. The percentage of adults 65 and over who had an influenza vaccination in the previous year (56.6%) is similar to the nationwide percentage of 61.3%. Pneumonia vaccination rates among county residents 65 and over are also similar to nationwide rates. In Rhode Island, 73.1% of seniors have had a pneumonia vaccination at some point in their lifetime. The national figure is 70.0%.

Maternal, Fetal, and Infant Health

The Healthy People 2020 national health goal is to reduce the proportion of infants born with low birth weight to 7.8%. Low birth weight infants have a birth weight of 2,500 grams (5 pounds, 8 ounces) or less. Rhode Island has not met the Healthy People goal, with a figure of 8.0%. Pre-term births are also an indicator for maternal and child health. Approximately 12% of all births in Rhode Island are pre-term. This is slightly below the national value of 12.5%.

Mental Health & Mental Disorders

According to 2008-2010 statistics, the suicide death rate in Rhode Island is 11.0 deaths per 100,000 population. This is in the bottom quartile nationally for suicide deaths. However, self-reported measures of poor mental health are elevated. On average, Rhode Island adults report 3.5 days a month of poor mental health. This is higher than the 50th percentile figure of 3.3 days.



Poor Mental Health Days

Value:	3.5 days
Measurement Period:	2005-2011
Location:	State : Rhode Island [View All Location Types]
Comparison:	U.S. States
Categories:	Health / Mental Health & Mental Disorders

Additional Mortality Data

In general, Rhode Island has favorable mortality rates compared to the nation. Premature death is less likely and conditions in which the age-adjusted death rates are lower than what is seen nationally include Alzheimer's disease, unintentional injuries, and motor vehicle collisions. The one area that is slightly elevated compared to the nation is death due to falls. Mortality rate due to falls is 9.8 per 100,000 population. The 50th percentile nationally is 8.1 deaths.

Asthma

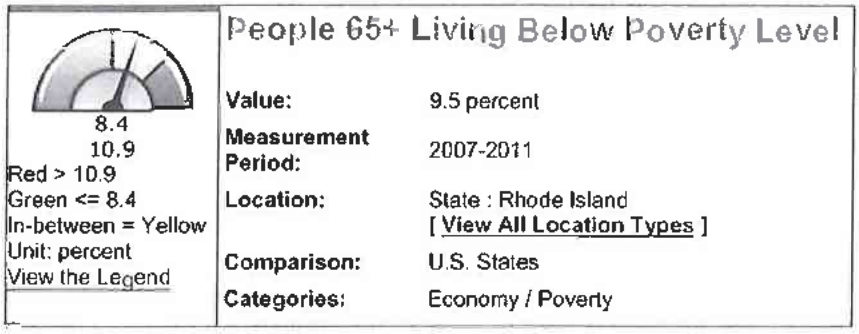
It is estimated that 10.9% of Rhode Island adults have asthma. Nationally, the figure is 9.1%. These statistics reflect adults who have been diagnosed as having asthma by a doctor of health professional.

Tobacco and Alcohol

The percentage of adults who binge drink in Rhode Island is 19.7%. The percentage of adults who smoke in Rhode Island is 20.0%. Both of these statistics are similar to the United States (18.3% and 21.2% respectively).

Economic Indicators

A variety of economic indicators were gathered including education levels, homeownership, income, and poverty. The findings suggest that there may be significant disparities in Rhode Island between demographic populations. Overall per capita income and median household income for the state compare favorably to national comparisons. A number of the poverty indictors also compare favorably. The number of adults 65 and older who live below the poverty level is the one exception. Nearly 10% of adults 65 and older live below the poverty line. This is in comparison to 8.4% as the 50th percentile nationally.



Additional statistics that are in the upper 50th percentile in terms of comparisons to national benchmarks include the unemployment rate, households with cash public assistance income, the home foreclosure rate. The percentage of people 25+ with a high school degree or higher is also less than what is seen nationally.

The Environment

The built environment can play a significant role in a community's health. For Rhode Island, areas of concern are the density of liquor stores, and houses built prior to 1950 compared to the U.S.

Social Environment

The percentage of single-family households in Rhode Island is higher than what is typically seen throughout the country. The percentage of children living in single-parent family households (with a male or female householder and no spouse present) is 34.8%. This ranks in the bottom quartile nationally. It is also estimated that 31.1% of seniors who are 65 years and older in Rhode Island live alone, which is higher than the national average.

Transportation

A variety of transportation measures were gathered. For the most part, Rhode Island compares favorably to national statistics with regard to workers commuting by public transportation and average travel time to work. However, unfavorable comparisons are the percentage of households without a vehicle, and workers who drive alone to work. Approximately nine percent (9.4%) of state households do not have a vehicle. It is important to note, however, that this may be a function of geography (e.g. urban living) and the presence of public transportation options, and may or may not represent a negative statistics.

In closing, the secondary data that was compiled should be examined collectively with the BRFSS analysis and the other research components. As with primary data, these statistics represent point-in-time information and patterns and comparisons can vary over time.

KEY INFORMANT INTERVIEWS

Key informants were interviewed to gather a combination of quantitative ratings and qualitative feedback through open-ended questions. A general summary of the findings is below.

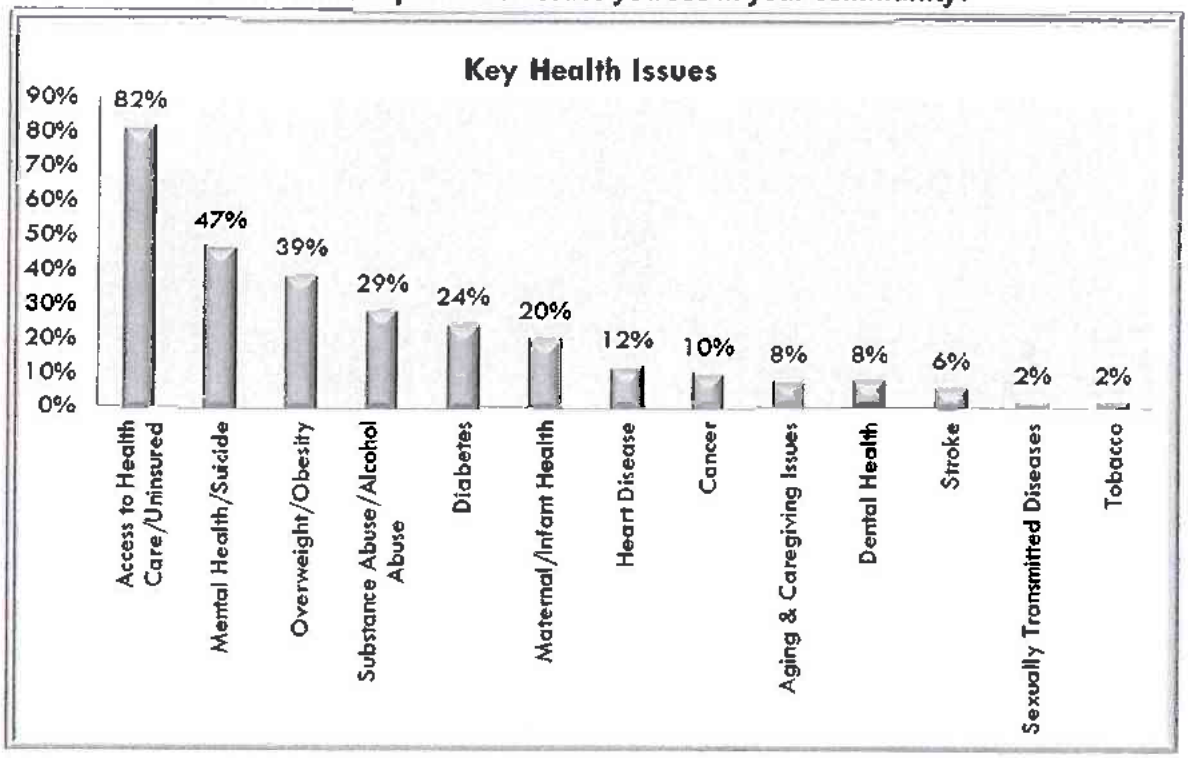
Key Health Issues

The initial section of the survey focused on the key health issues facing the community. Individuals were asked to select the top three health issues that they perceived as being the most significant. The three issues that were most frequently selected were:

- Access to Health Care/Uninsured/Underinsured
- Mental Health/Suicide
- Overweight/Obesity

The bar graph below shows the key informant rankings of all of the key health issues. The bar depicts the total percentage of respondents who ranked the issue among the top three concerns. Additional health concerns that were mentioned included childhood asthma, teenage pregnancy, and health disparities among those living in poverty.

"What are the top 3 health issues you see in your community?"



Access to health care was the most frequently selected health issue with 82% of informants ranking it among the top three key health issues. Forty-one percent of informants ranked it as the most significant issue facing the community. Concerns were voiced about hospitals serving as the safety-net provider for individuals who are uninsured and the number of uninsured patients that providers of free or reduced health care are seeing. While these clinics and options are in place, they do not provide high-level specialty care that is often needed.

The second most frequently selected health issue was **mental health/suicide** with 47% of informants selecting it among the top three key health issues. Sixteen percent of respondents ranked mental health as the most significant issue facing the community. Respondents indicated that the resources available for the treatment of mental health issues are insufficient. The greatest concerns were for the lack of psychiatrists, children's specialists, and professionals trained in co-occurring disorders (mental health and addiction). Key informants reported that emergency rooms are often addressing these mental health issues among residents.

The third most frequently selected health issue was **overweight/obesity** with 39% of informants ranking it among the top three key health issues. Ten percent of informants ranked overweight/obesity as the most significant issue facing the community. Respondents feel that reducing obesity can lead to improvements in many of the other chronic health issues identified as areas of concern. Those interviewed acknowledged that Rhode Island is not alone in its struggle with obesity.

Health Care Access

The survey respondents were asked to elaborate further on access to care issues in the area. They were asked questions regarding access to primary care, specialty care, and bilingual healthcare, and potential transportation barriers. As detailed in the table below, area professionals were least likely to agree that there are a sufficient number of bilingual providers. In addition to limited bilingual providers, the availability of mental/behavioral health providers, providers accepting Medicaid, dentists, specialists, and transportation were also rated as areas of concern. The highest rated statement was with regard to having access to a primary care provider when needed. While this was rated the highest among those interviewed, it only averaged a 3.02 rating on a 5-point scale.

Factor	Mean Response (1=strongly disagree; 5=strong agree)
Residents in the area are able to access a primary care provider when needed (Family Doctor, Pediatrician, General Practitioner)	3.02
Residents in the area are able to access a medical specialist when needed (Cardiologist, Dermatologist, Neurologist, etc.)	2.57
Residents in the area are able to access a dentist when needed.	2.49
There is a sufficient number of providers accepting Medicaid and medical assistance in the area.	2.37
There is a sufficient number of bilingual providers in the area.	1.88
There is a sufficient number of mental/behavioral health providers in the area.	2.20
Transportation for medical appointments is available to residents in the area when needed.	2.41

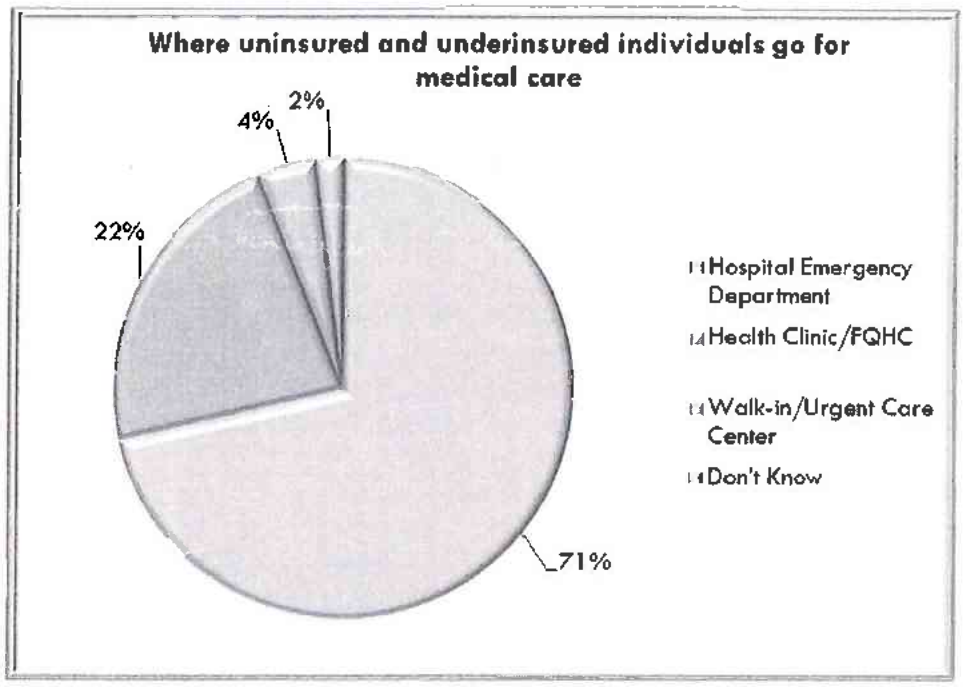
After rating availability of health care services, informants were asked about the most significant barriers that keep people in the community from accessing health care when they need it. The barriers that were most frequently selected were:

- Lack of Health Insurance Coverage
- Lack of Transportation
- Inability to Pay Out of Pocket Expenses

Respondents also identified concerns related to having too few providers, limited appointment times (particularly for the uninsured), language and cultural barriers, and difficulties navigating the health care system. While the greatest concerns were for the uninsured, many commented on increasing barriers for those with health insurance. One barrier that was mentioned was the escalating out-of-pocket expenses for co-pays and prescriptions medications. Another barrier that was mentioned was transportation. Transportation services were identified as "practically non-existent" in some areas. Those areas with bus or other public transportation options also have limitations that present additional barriers such as restricted eligibility requirements or expensive fares.

Informants were then asked whether they thought there were specific populations that were not being adequately served by local health services. The majority of respondents (88%) indicated that there are underserved populations in the community. The immigrant/refugee population was identified as the most underserved followed by the low-income/poor. These groups were followed by the uninsured/underinsured, the Hispanic/Latino population, and individuals with mental health issues as the groups most underserved.

When asked where they think most uninsured and underinsured individuals go when they are in need of medical care, 71% stated the hospital emergency department. The bar chart below details the responses. Health clinics and FQHCs (Federally Qualified Health Centers) were mentioned by 22% of those interviewed.



Respondents were asked to identify key resources or services they felt would be needed to improve access to health care for residents in the community. Many informants indicated that mental health services were needed. Informants also felt there was a need for more health education, information, and outreach. In addition, respondents suggested that additional free and low cost medical and dental services would help improve access. Additional frequent mentions included transportation options, assistance with basic needs (housing, food), and more primary care providers.

Challenges and Solutions

The final section of the survey focused on challenges to maintaining healthy lifestyles, perceptions of current health initiatives, and recommendations for improving the health of the community. When asked what challenges people in the community face in trying to maintain healthy lifestyles, participants suggested the following common challenges:

- Cost/Access
- Motivation/Effort

- Time/Convenience
- Education/Knowledge

Several participants indicated that cost is a barrier. They explained that healthy foods like fresh fruits and vegetables can be expensive, and unhealthy foods are often cheaper. Participants also mentioned that gym memberships and fitness programs can be expensive. In addition, informants expressed concerns about lack of awareness and education. Suggestions were made to integrate more planning activities into community health improvement initiatives. An example that was mentioned was ensuring that communities are walkable and safe. A number of programs and organizations were praised for their efforts, but it was generally agreed that more are needed.

Concluding Thoughts

The key informants expressed appreciation for the opportunity to share their thoughts and experiences and indicated interest and support for efforts to improve community health. Based on the feedback from the key informants, access to health care is a significant issue in the community. A number of barriers contribute to access including health insurance coverage, transportation, and inability to pay out of pocket expenses. The need for mental and behavioral health services was also repeatedly mentioned by informants. In addition, informants expressed concern about the growing problem of obesity and indicated that there are number of challenges that contribute to obesity including cost, accessibility, convenience, education, and motivation. Many respondents indicated the need for increased awareness, education, prevention, and outreach and encouraged more collaboration and coordination among health and human service providers.

The feedback from the key informant surveys will be utilized in conjunction with secondary data, BRFSS analysis, and focus group discussions to understand community health needs and prioritize public health endeavors.

FOCUS GROUPS

On March 26, 2013, Holleran conducted two focus groups with 21 mental and behavioral health care professionals. Both groups were held at Butler Hospital in Providence, Rhode Island. Focus group participants were recruited by HARI and its member hospitals. A full report of the focus groups was provided. A list of participants is included as Appendix B.

The aim of the focus groups was to identify mental and behavioral health needs throughout Rhode Island. Focus group participants discussed Rhode Island's challenges and successes in providing care to residents with mental health needs. Special populations, access to care, community perception, emerging trends, and recommendations were discussed.

Adolescents, the elderly, homeless individuals, and those who do not speak English were seen as some of the most underserved populations when it came to mental health needs. Of particular concern is increased substance abuse, especially among adolescents, and the co-occurring diagnosis of mental illness and substance abuse. The participants also expressed concerns about the complexity of patients' conditions and the relationship between mental and physical health.

Challenges with accessing care included lack of insurance and ability to afford care, as well as provider reimbursement rates and acceptance of insurance. Coordination of services within the system needs to be improved to create a transparent system where providers can easily provide referrals to the appropriate level of care in an efficient and expedient manner.

Stigma, as well as the recognition of signs and symptoms of mental health conditions, continues to be a barrier to treatment. Recommendations were made to continue to explore the integration of primary care and mental health, as well as regular mental health screening of patients with chronic conditions.

Continued collaborations between schools and community-based services were seen as successful and in need of additional support. Advocacy to ensure continued funding successful programs is needed.

A shift from payer-led treatment plans to provider-led treatment plans would enable the appropriate level of care and likely cut costs in the end. Providers feel as though "their hands are tied" when it comes to providing the best treatment for patients.

Participants, encouraged by the dialogue with a cross-section of providers, referral sources, and community agencies, suggested a statewide mental health summit to further explore issues and opportunities.

Identified Areas of Need

Each individual research component provides a unique perspective on the health status of the service area for Rhode Island. While each component provides a different perspective, a number of overlapping health issues are evident. The following list outlines the key themes that stood out across the four research components.

- **Access to Care:** Concerns for healthcare access were seen as greatest for the uninsured and under-insured and those attempting to access specialty care. Specialty care includes medical specialists, dentists, and child and senior providers. The growing immigrant population was also noted as an increasing challenge on the local health care system. Specifically, it was stated that there are too few bilingual providers locally and that cultural competencies are not fully integrated into the health system. The household survey did reveal that residents in the hospital's service area are more likely to have health insurance coverage and one person they think of as their personal doctor or health care provider.

- **Alcohol Use:** The secondary data revealed that there is a high density of liquor stores in Rhode Island. Adults who participated in the household survey were also more likely to report alcohol use in the past month when compared to national statistics. Professionals who participated in the focus groups and key informant interviews voiced concerns about co-occurring disorders with mental health issues and addiction.

- **Asthma:** The household survey revealed a higher proportion of adults who have had a diagnosis of asthma and also a higher proportion that still have asthma when compared against national figures. Elevated asthma statistics were also uncovered for children living in the service area. The secondary data confirmed elevated asthma rates.

- **Breast Cancer Incidence:** The incidence data for cancers shows that Rhode Island has elevated rates for breast cancer. However, death rates are lower in the state, indicating that those with a diagnosis of breast cancer are more likely to have a positive prognosis.

- **Mental Health Status:** The key informants that were interviewed identified mental health issues as one of the primary health concerns for the area. Specifically, concerns were voiced about the limited number of treatment options, particularly for those who are uninsured or underinsured. As a result, individuals with mental health issues often utilize the hospital emergency room. The household survey also reported a higher number of individuals with a depressive disorder and more days when poor physical or mental health interfered with functioning. On a positive note, the suicide rate in the area is not elevated above national figures.

- **Overweight & Obesity:** The BMI statistics for adults in the area show that the majority are either overweight or obese (62.3%). Adults in the area are just as likely to exercise compared to their peers nationally. Key informants also noted their concern with the issue of overweight/obesity and its relationship to chronic diseases such as diabetes.

Prioritization of Community Health Needs

On April 30, 2013, approximately 20 individuals representing the Hospital Association of Rhode Island (HARI), its member hospitals, and the Rhode Island Department of Health gathered to review the results of the 2013 Community Health Needs Assessment (CHNA). A list of attendees can be found in Appendix C. The goal of the meeting was to discuss and prioritize key findings from the CHNA and to set the stage for statewide community health improvement initiatives and the development of the hospitals' Implementation Strategies.

The meeting began with an abbreviated research overview presented by Holleran Consulting. The presentation covered the purpose of the study, research methodologies, and the key findings. Following the research overview, participants were provided with information regarding the prioritization process, criteria to consider when evaluating key areas of focus, and other aspects of health improvement planning, such as goal setting and developing strategies and measures. Holleran then facilitated an open group discussion for attendees to share what they perceived to be the needs and areas of opportunity in the region.

A broad list of needs was identified through the research and discussion. Holleran facilitated group discussion to identify overlapping strategies, cross-cutting issues, and the ability for regional health and human services providers to effectively address the various needs. After dialogue and consolidation, the following "Master List of Needs" was developed by the attendees to be evaluated as potential priority areas for community health improvement activities.

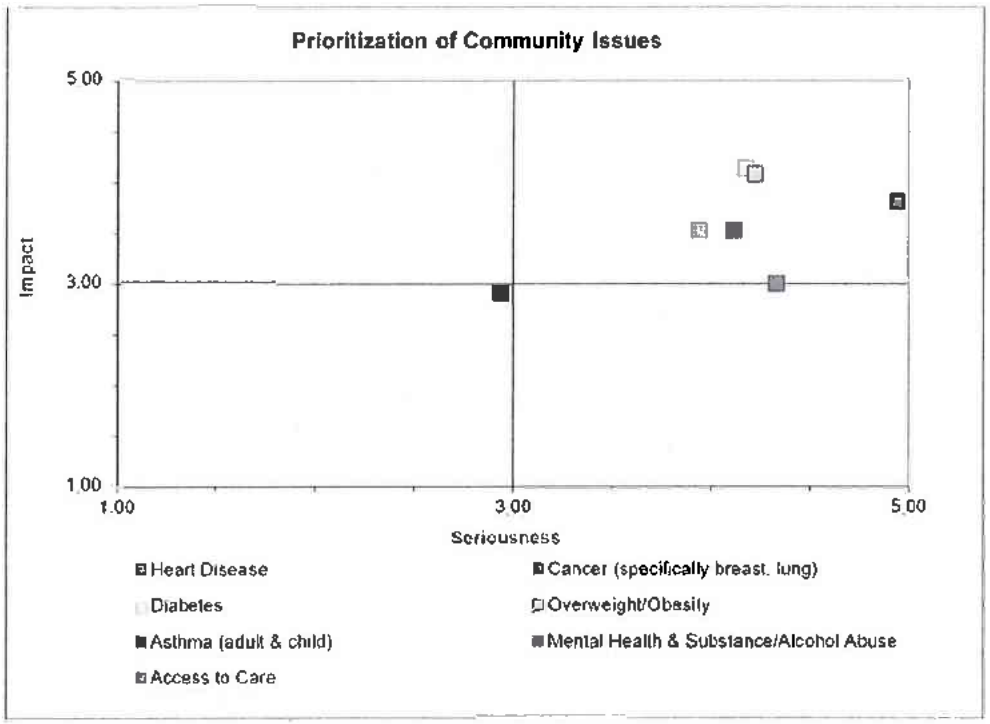
Master list of community priorities (in alphabetical order):

- Access to Care
- Asthma
- Cancer
- Diabetes
- Heart Disease
- Mental Health and Substance Abuse
- Overweight and Obesity

Once the master list was compiled, participants were asked to rate each need based on two criteria. The two criteria included seriousness of the issue and the ability to impact the issue. Respondents were asked to rate each issue on a 1 (not at all serious; no ability to impact) through 5 (very serious; great ability to impact) scale. The ratings were gathered instantly and anonymously through a wireless audience response system. Each attendee received a keypad to register their vote. The following table reveals the results of the voting exercise from highest rated need to lowest based on the average score of the two criterions.

Master List	Seriousness Rating (average)	Impact Rating (average)	Average Total Score
Mental Health and Substance Abuse	4.94	3.78	4.36
Diabetes	4.17	4.11	4.14
Overweight/obesity	4.22	4.06	4.14
Access to Care	4.11	3.50	3.81
Heart Disease	3.94	3.50	3.72
Cancer (specifically breast, lung)	4.33	3.00	3.67
Asthma (adult and child)	2.94	2.89	2.92

The priority area that was perceived as the most serious was Mental Health (4.94 average rating), followed by Cancer (4.33 average rating), and Overweight and Obesity (4.41 average rating). The ability to impact Diabetes was rated the highest at 4.11, followed by Overweight and Obesity with an impact rating of 4.06, and Mental Health, with a score of 3.78. The matrix below outlines the intersection of the seriousness and impact ratings. Those items in the upper right quadrant are rated the most serious and with the greatest ability to impact.



Appendix A: Key Informants

Name	Title	Organization
Ana Novais	Executive Director	Community, Family Health & Equity/HEALTH
Ann Barrone	Chief WIC	Rhode Island Dept. of Health
Ann Nolan	President	Cross Roads
Benedict Lessing Jr.	Executive Director	Family Resources Community Action
Beth Lamarre	Director	Community Health Care Workers Association
Carol Holmqust	President & CEO	Dorcas Place
Catherine Taylor	Director of Elderly Affairs	DHS
Christopher Koller	Health Insurance Commissioner	RI Dept. of Health
Chuck Jones	President and CEO	Thundermist
Cindy Gardiner	Social Services Manager	Wood River Health Services
Clark Rumfelt	Chaplain & Community Volunteer	The Westerly Hospital
Dale Klatzker	President & CEO	Providence Center
Dennis Keefe	President & CEO	Care New England
Dennis Langley	President	Urban League of RI
Rich Leclerc	President	Gateway
Donna Nabb	Family Literacy Coordinator	Westerly Public Schools
Elena Nicolella	RI Medicaid Director	EOHHS/DHS
Elizabeth Burke Bryant	Executive Director	RI Kids Count
Elizabeth Lange	Pediatrics, MD	Coastal Medical of RI
Graciela Fontana	ESL Teacher Assistant & Translator	Westerly Public Schools
Jane Hayward	CEO	RI Health Center Association
Jerry Cutler	VP of Clinical Services	South Shore Mental Health Center
Jim Nyberg	Director	RIAFSA
Jim Berson	President & CEO	YMCA of Greater Providence

Name	Title	Organization
Kate Brewster	Executive Director	Economic Progress Institute
Kelly Lee	Executive Director	Adult Day Services of Westerly
Kristen Edward	HIT Director	TriTown Community Action
Laurie White	President	Greater Providence Chamber of Commerce
Liz Pasqualini	Executive Director	The JonnyCake Center
Louis Giancola	President & CEO	South County Hospital
Mario Bueno	Executive Director	Progreso Latino
Matthew Cox	Executive Director	RI Parent Information Network
Merrill Thomas	CEO	Providence Community Health Center
Michael Van Leesten	CEO	OIC of Rhode Island
Michele Iacoi, RN	School Nurse (Middle School)	Westerly Public Schools
Neil Corkery	Executive Director	DATA
Patricia Nolan	Executive Director	RI Public Health Institute
Patricia Recupero	President	Butler Hospital
Paul Despres	CEO	Eleanor Slater Hospital
Paul Theroux	Pastor	Saint Francis Parish
Raymond Lavoie	Executive Director	Blackstone Valley Community Health Care
Russ Partridge	Executive Director	The Warm Center
Scott Avedisian	Mayor	City of Warwick, RI
Sean Walsh, LICSW	Director, Family Care Community Partnerships	South County Community Action
Steve Florio	Executive Director	RI Commission on Deaf & Hard of Hearing
Susan Orban, LICSW	Coordinator	VNS Home Health Services
Terrie Wetle	Associate Dean of Medicine for Public Health & Public Policy	Brown University
Tony Maione	President & CEO	United Way of Rhode Island
Virginia Burke	President & CEO	RI Health Care Association

Appendix B: Focus Group Participants

Name	Title	Agency
Tom Allen	LICSW, Director, Outpatient Addiction Medicine & Behavioral Health Social Work	Roger Williams Medical Center
Fay Baker	LICSW, Director, Project Implementation and Acute Care Services	The Providence Center
Susan Bruce	LICSW	
Gary Bubly	MD, Director, Department of Emergency Medicine	The Miriam Hospital
Joseph Dziobek	President & CEO	Fellowship Health Resources
Charlene Elie	RN, Chief Nursing Officer	Landmark Medical Center
Peter Erickson	PhD	
Dr. Roberta Feather	Marriage and Family Counseling	Private practice
Diane Ferreira	RN, Director of Social Services	Butler Hospital
Robert Hamel	RN, Director of Psychiatric Partial Hospital Psychiatric Services	Butler Hospital
Margaret Howard	PhD, Director of Post-Partum Depression Day Hospital	Women & Infants Hospital
Sue Jameson		VNS Home Health Services
Dale K. Klatzker	President & CEO	The Providence Center
Rich Marwell		Eleanor Slater Hospital
Sally Mitchell	PsyD	
Caroline Obrecht	LICSW	
Deborah O'Brien	Vice President & COO	The Providence Center
Francis Paranzino	Vice President & COO	Newport County Community Mental Health Center
David Robinson	Office of Primary Care and Rural Health	Rhode Island Department of Health
Lisa Shea	MD, Deputy Medical Director	Butler Hospital
Curt Wilkins	Director of Social Services	Landmark Medical Center

Appendix C: Prioritization Session Participants

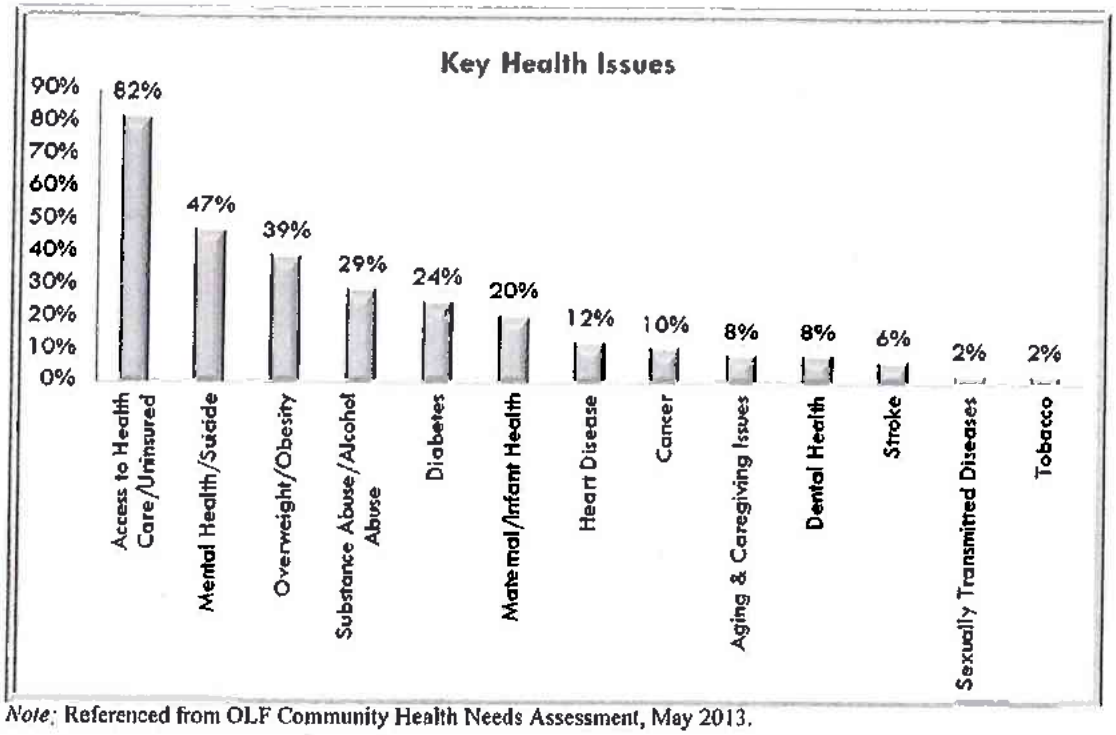
Name	Title	Organization
Mike Souza	Senior Vice President	HARI
Liz Almanzor	Project Coordinator	HARI
Stephanie Anderson	Senior Planning Analyst	Care New England
Gina Rocha	VP, Clinical Affairs	HARI
Ed Quinlan	President	HARI
May Kernan	Senior VP, Marketing Communications	Care New England
Gary Epstein-Lubow	Assistant Unit Chief, inpatient geriatric psychiatry unit	Butler Hospital
Lisa Shea	Associate Medical Director, Quality & Regulation	Butler Hospital
Patti Melaragno	Director, Marketing & Public Affairs	Butler Hospital
Jeff Borkan	Physician-in-Chief of Family Medicine	Memorial Hospital of Rhode Island
Kellie Sullivan	Planning Implementation Manager	Care New England
Gail Costa	Senior VP Planning	Care New England
Cindy Wyman	VP, Planning & Market Development	South County Hospital
Rene Fischer	Senior VP Patient Care Services, CNO	Kent Hospital/Care New England
James Alves	Associate VP	Butler Hospital
Ana Novais	Executive Director, Division of Community, Family Health & Equity	Rhode Island Department of Health
Magaly Angeloni	Performance Improvement and Accreditation Manager	Rhode Island Department of Health
Otis Brown	VP, External Affairs	CharterCARE Health Partners
Darlene Kershaw	Clinical Nurse Manager	Roger Williams Medical Center
Linda Zaman	Director of Perioperative Services	Roger Williams Medical Center
Patricia Nadle	CNO	St Joseph Health Services of RI/CharterCARE
Margaret Duff	Clinical Operations Manager for Behavioral Health	St Joseph Health Services of RI/CharterCARE
Paula DiLeonardo	Interim Director, Nursing Operations	St Joseph Health Services of RI
Michele Danish	Director, Performance Improvement	St Joseph Health Services of RI

Exhibit 9(b)

D. Please identify the health needs of the population in (C) relative to this proposal.

OLF participated in a comprehensive Community Health Needs Assessment (CHNA) from September 2012 to May 2013. The assessment was conducted to identify the health needs of the service population as well as to comply with requirements in the Affordable Care Act. This assessment was an effort to ensure that hospital community health improvement initiatives and community benefit activities are aligned and prioritized with community need. Information was collected through surveys, interviews and consumer focus groups, as well as utilizing available health data statistics.

From the interviews on individual health issues, the following bar graph lists the key health issues perceived as being the most significant. Access to health care/uninsured/underinsured and mental health/suicide were two of the top issues.

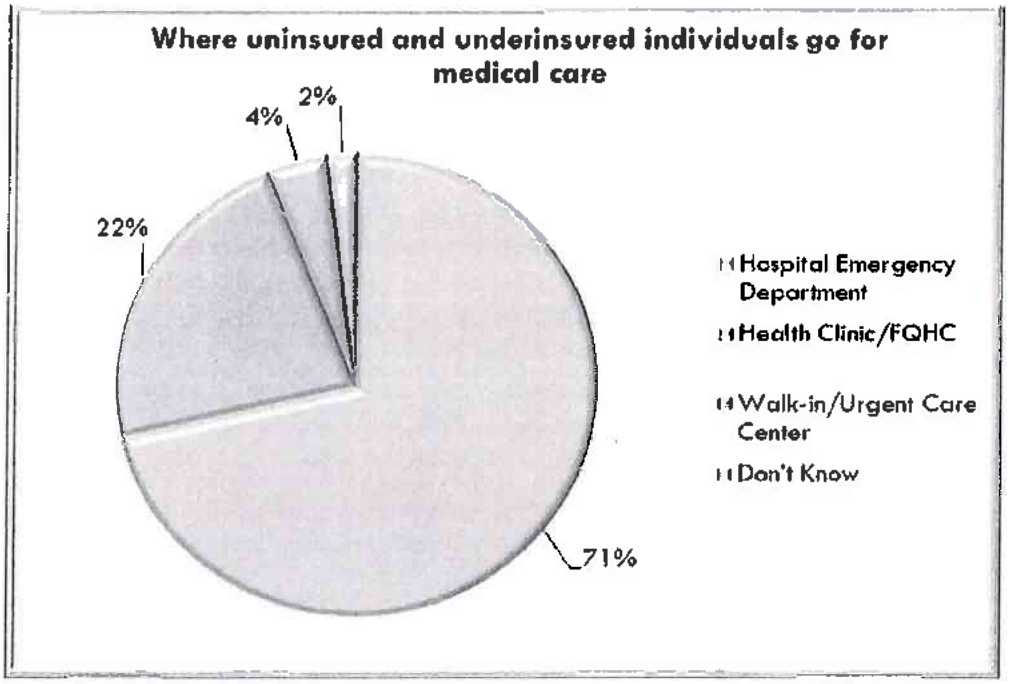


Note: Referenced from OLF Community Health Needs Assessment, May 2013.

Access to health care was the most frequently selected health issue with 82% of participants ranking it among the top three key health issues. Forty-one percent (41%) of participants ranked it as the most significant issue facing the community. Concerns were delineated about hospitals serving as the safety-net provider for individuals who are uninsured and the number of uninsured patients that providers of free or reduced cost health care centers are seeing.

Participants were asked whether they thought there were specific populations that were not being adequately served by local health services. The majority (88%) indicated that there are underserved populations in the community. The immigrant/refugee population was identified as the most underserved population followed by the low-income/poor. These groups were followed by the uninsured/underinsured, the Hispanic/Latino population, and individuals with mental health issues as the groups most underserved. The growing immigration population was also noted as an increasing challenge to the local health care system.

When asked where they think most uninsured and underinsured individuals go when they are in need of medical care, 71% stated the hospital emergency department. The bar chart below details the responses. Health clinics and FQHCs (Federally Qualified Health Centers) were mentioned by 22% of those interviewed.



Note: Referenced from OLF Community Health Needs Assessment, May 2013

While population health management care delivery systems are being established, the hospital emergency department remains one of the most important portals to access care. Women seeking emergent or urgent obstetrical care often seek out care from their local community hospital and/or the hospital that is located closest to their home, often without regard to whether or not the hospital may specialize in, or provide such services. OLF is proposing to open an inpatient OB unit to ensure that such services are immediately available in order for patients to receive the best care and services possible. The proposed OB unit will ensure best practices through access to care for OLF's community and OB patient populations.

10. Description of PMH's Corporate Quality Program (to include organizational chart showing staffing).

Attached hereto as Exhibit 10, is a draft PMH Corporate Performance Improvement, Quality and Patient Safety Program Proposal. Please note that PMH's Corporate Chief Quality Officer was hired on April 4, 2014 and has recently drafted the attached draft proposal. As such, the attached draft PMH Corporate Performance Improvement, Quality and Patient Safety Program is under corporate review and is subject to change.

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PMH Corporate Performance Improvement, Quality and Patient Safety Program Proposal (Draft)

Introduction

Philosophy: To ensure that our patients receive the right care, at the right time, in the right setting, with efficiency and compassion.

Mission: Above all, we are committed to quality in all aspects of healthcare delivery, including:

- Striving for the best possible patient outcomes
- Maintaining the highest standards of patient safety
- Acting with integrity at all times
- Promoting open communication
- Collaborating to better serve the healthcare needs of our communities

Purpose: The PMH Quality and Patient Safety Program will focus on continuous enhancement of quality and safety for all we serve. Every employee plays a crucial role in ensuring patient, visitor and employee safety. We will work to reconnect quality and patient safety to clinical care thereby promoting high quality, safe, effective and efficient care. Additionally, the program will strive to build a just culture of safety by implementing strategies to reduce medical errors. Reducing risk and ensuring safety requires increased attention to systems that prevent and mitigate errors. The corporate quality and patient safety team will work with hospital to provide appropriate solutions to ensure best practices, resulting in quality patient care and service.

Goal: Build corporate and regional structures and processes necessary to become a high reliability organization promoting patient-focused, high quality, safe, compassionate, efficient, and effective care.

Model: We will achieve our mission and purpose through building and sustaining a robust quality and patient safety program at all levels of the organization. The key elements of this program will include: innovation, service, education, transparency, patient and physician partnerships. We will be using the Donabedian Quality of Care Model as our framework for building the program. Our initial focus will be on creating the corporate structure to enhance our ability to build processes and achieve outcomes.



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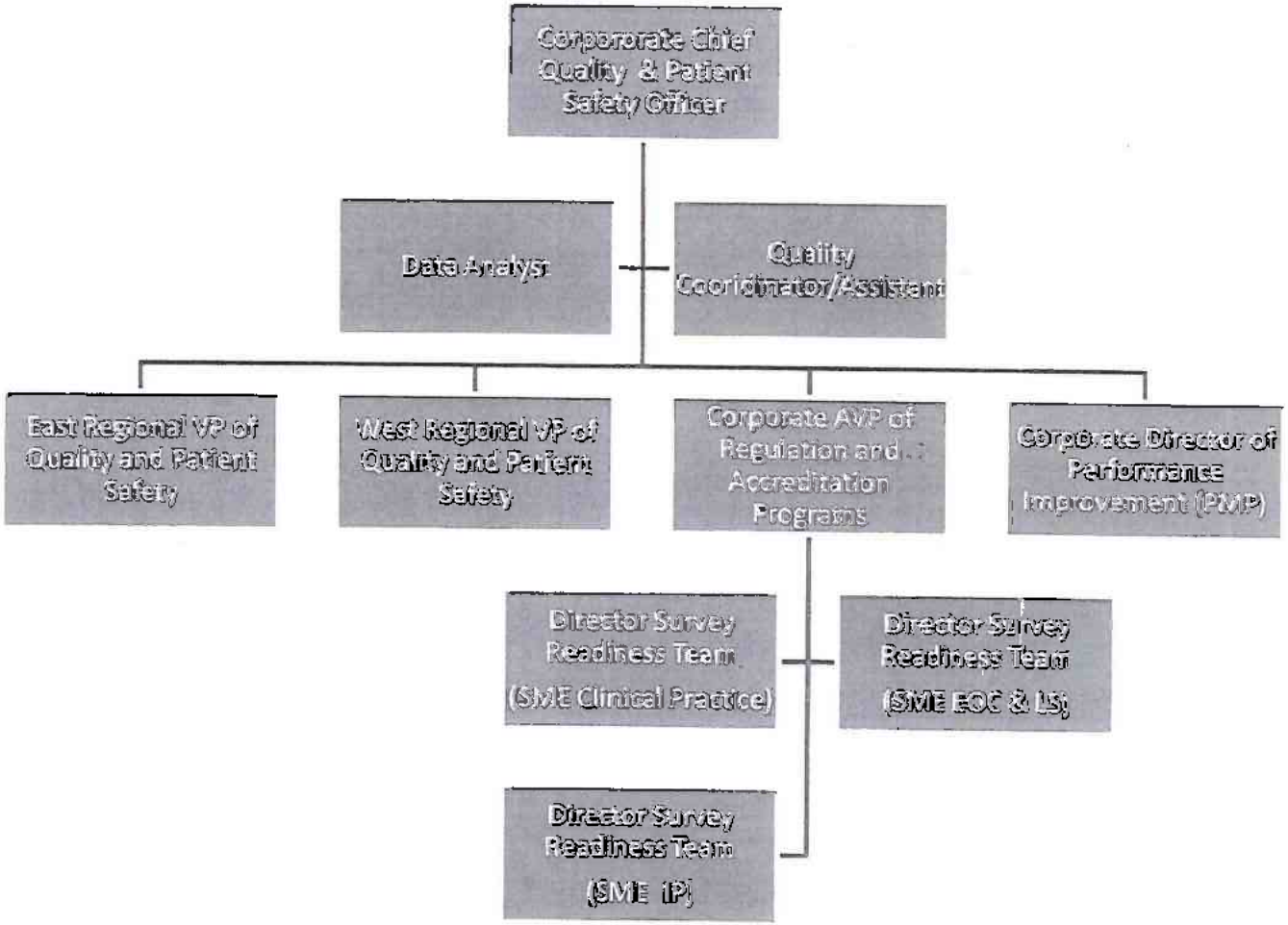
Structure

Corporate and Regional Quality Department Structure



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Roles and Responsibilities

Chief Quality Officer - Provides Oversight to the Corporate Quality and Patient Safety Agenda. Activities may include but are not limited to:

- Collaborates with hospital executives, and engages with hospital leaders and clinicians in identifying and implementing unique and varied initiatives aimed at improving patient care quality and safety
- Leads continuous improvement programs throughout the organization and helps develop a culture of continuous improvement and excellence
- Collaborates with hospital executives and engages with leaders and clinicians throughout the organization to build quality, efficiency, effectiveness and a sense of shared accountability
- Collaborates with hospital executives and engages with leaders to ensure continuous survey readiness.
- Takes a clinical leadership role in evaluating care delivery and develops the infrastructure for improvement
- Strengthens the data and information capabilities of the organization and champions a data-driven environment

Regional VP of Quality and Patient Safety – Reports to the CQO.

- Provides regional support and expertise to hospital leadership
- Leads continuous improvement programs in the assigned region and helps develop a culture of continuous improvement and excellence in those regions
- Reviews all regional hospital serious events and assists the hospital leadership in mitigation as appropriate.
- Collaborates with regional hospital executives and engages with leaders and clinicians throughout the organization to build quality, efficiency, effectiveness and a sense of shared accountability
- Collaborates with hospital executives and engages with leaders to ensure continuous survey readiness and sustainment of performance improvement activities
- Strengthens the data and information capabilities at the regional level and champions a data-driven environment

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Corporate AVP Regulation and Accreditation – Reports to the CQO

- Provides oversight to all aspects of the Survey Readiness program
- Serves as subject matter expert and hospital resource for regulation and accreditation programs
- Creates, implements, and maintains survey readiness tools that meet federal, state, and local statutes and regulations.
- Ensures survey readiness tools meet the applicable accreditation standards i.e. TJC, DNV, etc.
- Deploys and provides oversight to the survey readiness team during hospital site visits.
- Reviews all survey action plans and provides constructive input prior to submission to the appropriate regulatory or accreditation agency.

Director Survey Readiness Team – Reports to AVP of Regulatory and Accreditation Programs

- Serves as a subject matter expert and support person to all hospitals.
- Completes full survey readiness assessments at hospitals and provides recommendations for improvement
- Tracks hospital performance improvement activities based on site visit findings

Director of Performance Improvement – Reports to CQO

- Leads and facilitates system and hospital wide strategic quality and safety improvement projects.
- Develops and coaches performance improvement implementation strategies in support of the strategic goals.
- Collaborates with hospital executives, and engages with hospital leaders and clinicians in designing and implementing quality, patient safety and clinical excellence performance improvement activities.
- Leverages complex decision support/data systems to establish operation and quality related metrics to measure progress and sustainability of improvement efforts/initiatives.
- Ensures seamless hand-off of completed improvement initiatives to hospital operations leadership
- Engages with hospital leadership in Implementing special initiatives to support the high reliability performance improvement initiatives of PMH as required.

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Data Analyst - Reports to CQO

- Interprets data, analyzes results using statistical techniques and provides ongoing quality, patient safety, and clinical effectiveness reports
- Develops and implements data collection systems and other strategies that optimize statistical efficiency and data quality
- Works closely with management to prioritize business and information needs
- Locates and defines new process improvement opportunities
- Prepares tables, charts and graphs to summarize the results of these analyses

Quality Coordinator/Assistant – Reports to CQO

- Serves as Administrative Assistant to the Corporate Quality and Patient Safety program
- Assists with gathering quality and patient safety data for analysis

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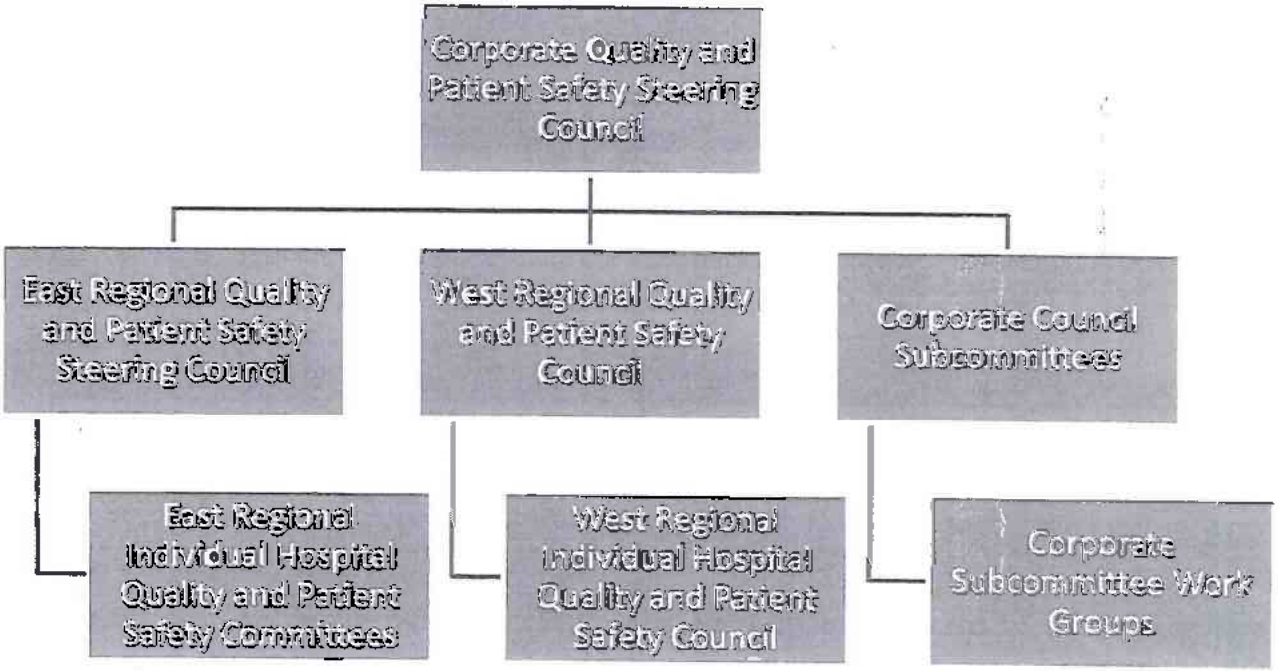
Quality and Patient Safety Communication and Reporting Structure



Note: Hospital Quality and Patient Safety Committees will report up through the appropriate regional steering council which will then report up through the corporate Quality and Patient Safety Steering Council.

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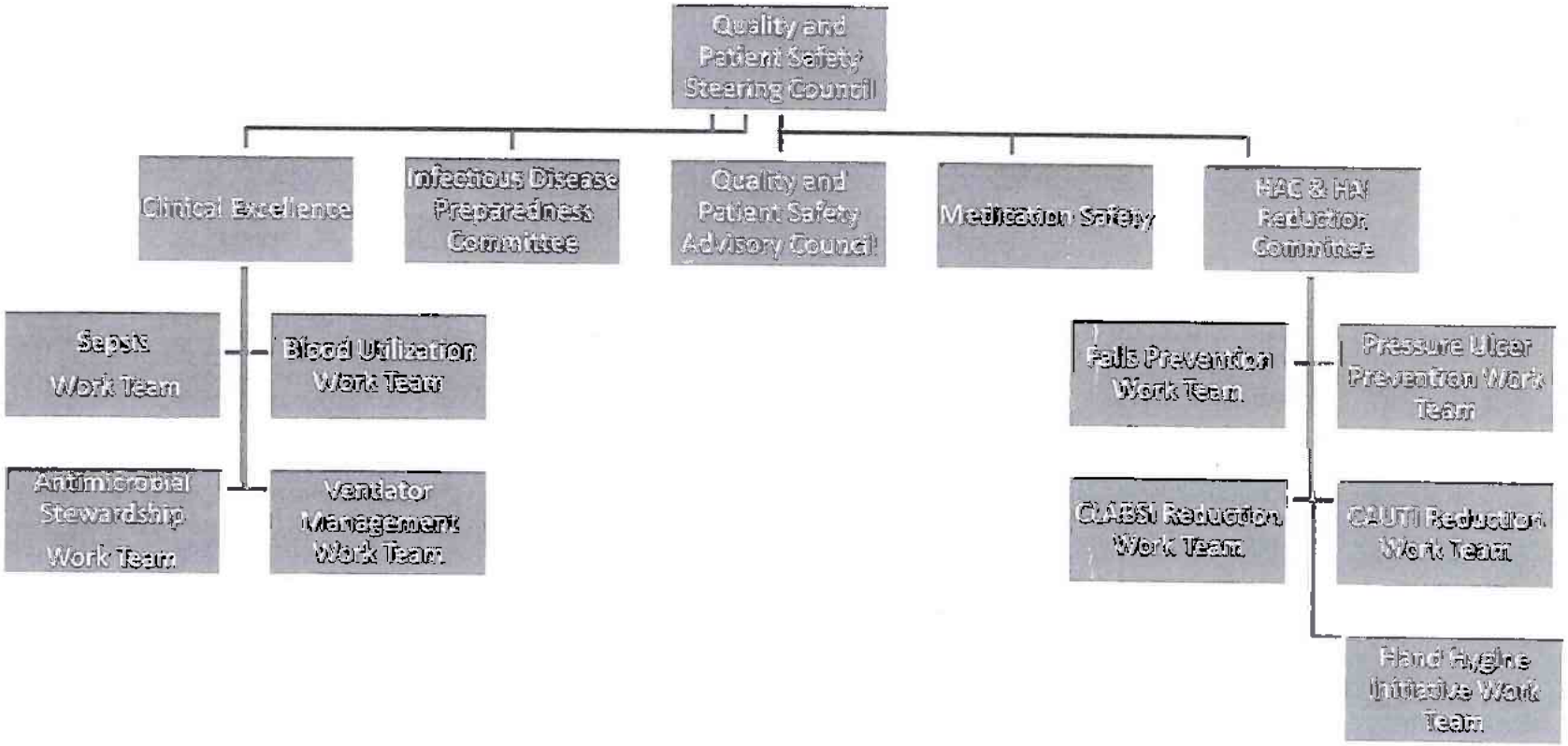
Corporate Quality and Patient Safety Steering Council Subcommittee and Work Group Sample Structure



Note: The above diagram outlines potential subcommittees and work groups. The actual infrastructure will be dependent upon the identified needs at the hospital, regional and corporate levels.

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Corporate Quality and Patient Safety Steering Council Roles and Responsibilities

- Receive reports from and analyze the activities of the regional councils
- Assists with the development of the corporate quality and patient safety strategy
- Prioritizes Quality and Patient Safety activities
- Assist with identification of metrics to be monitored on corporate dashboards.
- Receives and approves reports and activities from chartered committees and work teams
- Engages in identifying ongoing quality and patient safety performance improvement opportunities.
- Ensures follow-up on regional initiative and programs.
- Motivates and strategizes for hospital-based change
- Provides organizational knowledge and a systems approach to quality and patient safety.
- Assist with barrier removal to achieve quality and patient safety strategies.

Regional Quality and Patient Safety Steering Council Roles and Responsibilities

- Receive reports from and analyze the activities of the hospital councils
- Assists with the development of the corporate and regional quality and patient safety strategy
- Prioritizes regional quality and patient safety activities
- Assist with identification of metrics to be monitored on corporate dashboards.
- Receives and approves reports and activities from regional chartered committees and work teams
- Engages in identifying ongoing quality and patient safety performance improvement opportunities for the region.
- Ensures follow-up on hospital initiative and programs.
- Motivates and strategizes for hospital-based change
- Provides organizational knowledge and a systems approach to quality and patient safety at the regional level.
- Assist with barrier removal to achieve quality and patient safety strategies.

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Corporate Steering Council Chair: PMH Chief Quality Officer

Suggested Members: Appropriate Corporate Senior Leadership, Pharmacy Director, Quality Director, Risk Management Director, Legal, CNO, CEO, COO, CMO or Chief of Staff, Infection Control Practitioner, Medical Staff Director, IT&S Director, Supply Chain, others

Regional Steering Council Chair: TBA

Suggested Members: Pharmacy Director, Quality Director, Risk Management Director, Legal, CNO, CEO, COO, CMO or Chief of Staff, Infection Control Practitioner, IT&S Director, Supply Chain,

Ad Hoc Members: Radiology, Lab, Medical Staff, others as appropriate to subject matter

Committees: Responsible for building the infrastructure and provide input for key quality and patient safety activities. Potential Committees may include Medication Safety, Clinical Safety Improvement, Infectious Disease Preparedness, Regulation and Accreditation, Clinical Excellence, others as needed.

Rapid Action Work Groups: Completes rapid work for quick process and outcome improvement as needed. Examples include Core Measure improvement, HAC prevention, HAI prevention, Clinical Excellence etc. The team is responsible for creating and initiating performance improvement programs to include project plan, key elements, tool kits etc. Teams have a limited life depending upon the work product and outcomes.

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Process

High Reliability Organization: A high reliability organization is an organization able to continually manages their environment thoughtfully and assume a constant state of vigilance resulting in the fewest possible number of errors, despite operating in a high stress, high-risk environment. Adapting and applying the lessons of this science to health care offer the promise of enabling hospitals to reach levels of quality and safety that are comparable to those of the best high-reliability organizations.
These changes will be achieved through:

- Leadership's commitment to achieving zero patient harm
- A fully functional just culture of safety throughout the organization
- Widespread deployment of highly effective process improvement tools

PMH is in the process of adopting high reliability behaviors and strategies to ensure a reduction in overall medical errors for our patients. High reliability organizations are built on a foundation of a just culture of safety. A key component of building this foundation is a robust incident reporting and analysis system to better understand trends, opportunities and strengths. We encourage that every unsafe condition, near miss/great save or harm event be reported and analyzed to identify opportunity for improvement to prevent future harm. We commit to maintaining transparency through sharing best practices and lessons learned across all of our hospitals. We further commit to build and share evidence-based, best practice, and performance improvement processes and tools kits to assist with supporting our quality and patient safety high reliability organization initiatives.

Strategies:

- **Accreditation and Regulation Readiness** – Implement an accreditation and regulation survey readiness team to ensure all hospitals are continually in compliance with the highest level of quality care and patient safety standards as defined by CMS, TJC, DNV, NCQA, and applicable State and local statutes and regulations. Provide subject matter expertise and tools to support the facilities in ongoing survey readiness.
- **Patient Experience** – Create and implement a patient experience program to ensure that each patient is treated with respect, compassion, consideration and is an integral partner in his or her plan of care.

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- **Quality Measurement and Process Evaluation** – Build a standardized corporate quality and patient safety dashboard with national benchmarks. Institute monthly Quality and Patient Safety calls to review metrics, analysis and action plans to ensure ongoing improvement.
- **Patient Safety Improvement** – Create and implement a plan to move all hospitals towards a just culture of safety and accountability. Ensure quality and safe delivery of healthcare by defining and promoting consistent processes for identifying situations that may put patients or others at risk and acting to prevent or control those risks i.e. thorough and credible analysis of incidents of harm, near misses/great catches; FMEAs; ongoing learning through transparency, and implementation of patient safety tools.
- **Quality Improvement** - Maximize pay-for-performance for quality performance and outcomes metrics including VBP, readmission reduction program, HAC/HAI reduction program, Medicare spending per beneficiary (MSPB), Meaningful Use etc.
- **Technology Integration** – Maximize available patient safety technologies including CPOE, health information technology, clinical decision support, bar coding and other technologies to enhance the quality and patient safety strategy.
- **Clinical Excellence** – Improve mortality, complications, and length of stay through implementation of clinical excellence initiatives such as sepsis, stroke and STEMI management; effective blood utilization; ventilator management; and antibiotic stewardship.
- **High Reliability Organization** – Implement proven high reliability techniques and nationally recognized best practices to prevent harm and promote quality of care such as Red Rules (limited), SBAR (Situation, Background, Assessment and Recommendation), and STAR (Stop, Think, Act and Review) etc.

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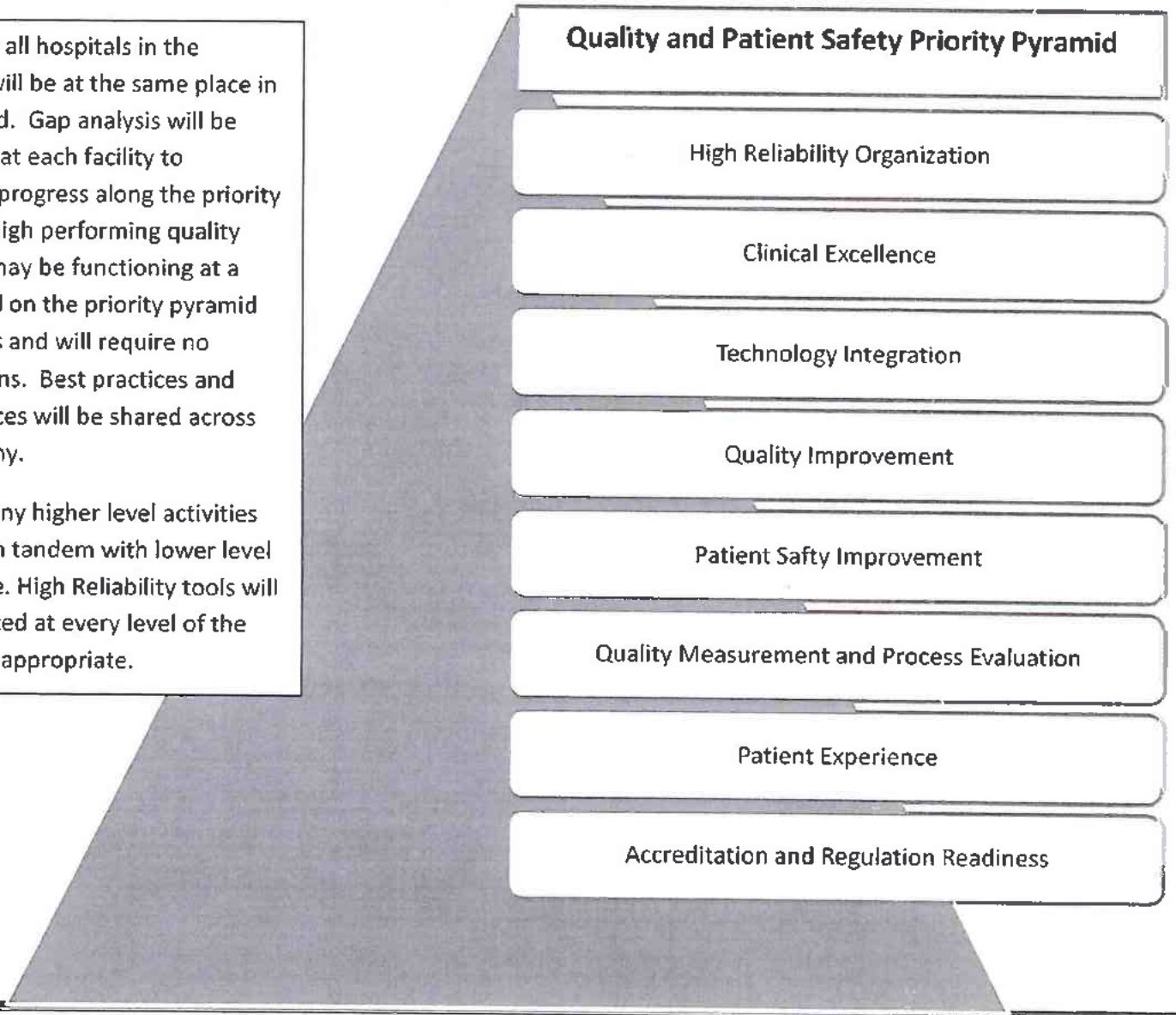
Note I: Not all hospitals in the Company will be at the same place in the pyramid. Gap analysis will be completed at each facility to determine progress along the priority pyramid. High performing quality programs may be functioning at a higher level on the priority pyramid than others and will require no interventions. Best practices and performances will be shared across the company.

Note II: Many higher level activities will occur in tandem with lower level activities i.e. High Reliability tools will be introduced at every level of the pyramid as appropriate.



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Outcomes

Corporate Quality and Patient Safety Dashboard

Quality, clinical and patient safety performance and outcomes will be measured via the newly created corporate Quality and Patient Safety Dashboard. Dashboards will be share across the company for the purpose of benchmarking and learning from other.

Hospital Quality and Patient Safety Call

Outliers will be addressed during the regularly scheduled hospital quality and patient safety calls. Best practices will be identified and shared with other hospitals in the company during these calls. The hospital will implement performance improvement activities to address the root cause and followed-up will occur during the next call. Once well established, the hospital call will occur at the regional level with a summary report forwarded to the corporate CQO.

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11. Description of Process for Development of Strategic Plan

Please see attached.

Prospect ECHN Strategic Planning Process

Overview

The purpose of this document is to describe the development of a Strategic Business Plan to guide the future growth and development of Prospect ECHN, Inc. and its affiliates (ECHN), as well as a related Strategic Capital Plan. In order to offer high value healthcare and participate in the emerging value-based payment models, an essential focus of healthcare reform, providers across the ECHN continuum must establish new relationships, infrastructure and capabilities to provide cost efficient care. The development and management of an advanced, comprehensive care continuum delivery network to manage the health of a defined population of patients requires strategies and significant investments necessary for health systems to develop new competencies, process skills and knowledge.

Goal, Objectives and Timing

The overall goal for the Strategic Business Plan is to develop and implement growth initiatives for the benefit of the surrounding communities served by ECHN, so long as that care can be delivered in a high quality and financially responsible manner. Assuming State approvals are obtained to proceed with the proposed acquisition of Eastern Connecticut Health Network, Inc. by Prospect Medical Holdings, Inc. (PMH) and affiliates, a strategic planning process led by the local management team and the Local Boards and supported by the resources and expertise of PMH will be organized and implemented soon after closing the transaction. It is expected that the Strategic Business will be produced over a 5-6 month period and that the Strategic Capital Plan will follow from the goals and initiatives identified in the Strategic Business Plan.

Structure

A Steering Committee will be formed with membership from the Local Boards, ECHN Medical Staff and representation from PMH to create a Strategic Business Plan including the clinical strategies to best serve the populations in the ECHN service area. The involvement of the Local Boards will provide input and feedback for health issues of concern to the community. The involvement of the medical community will allow for the local healthcare leaders and decision makers to assist in identifying the needs, or gaps, in care and consider the best approaches available to address those needs to the benefit of their patients. PMH will contribute the process skills and knowledge that promote clinical integration and the coordination of care through the alignment of the interests of the physician community, hospitals, post-acute providers and other providers needed to ensure that patients receive appropriate care, at the appropriate time, in the appropriate setting and with the best outcomes.

Strategic Capital Plan

The strategic business planning effort will allow for the development of a Strategic Capital Plan to support the initiatives designed to address the community and health system needs and priorities identified and included in the Strategic Business Plan. The Strategic Capital Plan will include investments at the ECHN hospitals, affiliates and joint ventures. Those investments will be in the form of new and replacement technology, equipment and facilities in support of health programs and services.

12. List of Critical, Immediate (over next 2-3 years) Capital Needs at ECHN

Please see attached.

LATE FILE # 12 - Priority Facility Capital Needs

	YEAR AND PRIORITY		
	1	2	3
Manchester Memorial Hospital			
Masonry Repairs to Buildings and Parking Garage	$ 175,000		
West Elevator Hydraulic Cylinder Replacement	$ 75,000		
Separate Signal Alarm Panel for Medical Gases	$ 65,000		
Upgrade HVAC Control Systems	$ 50,000		
Fire Alarm System Upgrade	$ 35,000		
Access Control System *	$ 275,000		
Infant Security System Replacement	$ 150,000		
Roof Replacements	$ 350,000	$ 350,000	$ 350,000
Emergency Generator, Distribution System		$ 800,000	
Automatic Transfer Switch Upgrade		$ 450,000	
Generator Monitoring Software and Alarms		$ 40,000	
Nurse Call Systems		$ 350,000	
Upgrade HVAC Control Systems		$ 100,000	
Replace Air Handlers	$ 50,000	$ 25,000	$ 25,000
Exhaust Stack		$ 45,000	
Roof Ductwork Insulation		$ 30,000	
Gas Manifolds		$ 20,000	
Oxygen Tank Concrete Pad		$ 15,000	
North Building Elevators			$ 575,000
East Building Elevators			$ 450,000
Ambulatory Building Elevators			$ 270,000
Site Paving and Sidewalks			$ 125,000
CCTV Upgrade			$ 85,000
Fire Extinguisher Management System			$ 20,000
Conference Room Wall Dividers			$ 65,000
Door Replacements, Ambulatory Building			$ 55,000
Maternity Expansion	$1,845,000		
BHU patient room improvements	$ 385,000		
Rockville General Hospital			
Basement Main Entrance flooring	$ 52,000		
Sprinkler System	$ 106,000		
Automatic Electrical Switch Gear	$ 314,000		
Walk-In-Coolers	$ 70,000		
Roof Replacements	$ 80,000	$ 30,000	
Boiler Upgrade	$ 30,000		
Oxygen Tank Concrete Pad	$ 15,000		
Roof Ductwork Insulation	$ 26,000		
Cooling Tower		$ 75,000	
Cooling Tower Sand Filter	$ 9,000		
Chiller Refrigerant		$ 15,000	
IT Data Room Air Conditioning	$ 25,000		

LATE FILE # 12 - Priority Facility Capital Needs

	YEAR AND PRIORITY			
	1	2	3	
Parking Lot, Sidewalk, Exterior Stair Repairs		$ 425,000		
Nurse Call Systems		$ 120,000		
Signage - Wayfinding		$ 80,000		
Air Curtains		$ 60,000		
HVAC Units		$ 40,000	$ 40,000	
Upgrade HVAC Control Systems		$ 60,000		
Helicopter Landing Pad Lighting		$ 11,000		
Elevator Modernization			$ 1,160,000	
Window Replacements			$ 110,000	
MRI Chiller			$ 60,000	
WoodLake at Tolland				
Roof top air handler units (3)	$ 390,000			
HVAC Controls	$ 20,000			
Boiler Room Vent	$ 7,000			
Fire Horns and Strobes Replacements	$ 5,000			
Roam Alert Wander Detection System	$ 17,700			
Nurse Call System		$ 72,000		
Flooring		$ 65,000		
Patient Room Upgrades			$ 475,000	
Hoyer lifts			$ 12,500	
	$4,621,700	**$3,278,000**	**$3,877,500**	
TOTAL				**$11,777,200**

* Includes MMH, RGH and WAT

13. **Description of Local Board (to include composition, process for appointment and authority)**

Please see attached description of the Local Board, together with draft bylaws for such board.

Description of PMH/ECHN Post-Closing Local Board

Relevant APA Provisions

The proposed Asset Purchase Agreement (APA) between Eastern Connecticut Health Network, Inc. (ECHN) and Prospect Medical Holdings, Inc. (PMH) outlines the role of the Local Board. Section 1.01(71) defines the "Local Board" as follows:

> **Local Board** means the advisory board of each Hospital composed of community representatives, physicians on the respective Hospital's medical staff, and the Chief Executive Officer of each respective Hospital (for avoidance of doubt, each Hospital shall have its own Local Board). The initial members of the Local Board shall include at least five members of ECHN's Board of Trustees immediately prior to Closing and five other individuals identified by ECHN prior to Closing.

Sections 5.18, 5.21, 5.26 and 5.27 of the APA outline the Local Board's functions. Pursuant to these provisions, the Local Board shall, among other things:

- consult with PMH in the development of the post-closing Strategic Capital Plan (Section 5.18);
- serve as a resource for PMH with respect to PMH's investment of the Capital Commitment (Section 5.27);
- serve as a resource for PMH with respect to maintenance and implementation of the Strategic Business Plan and in connection with any proposed changes to the Strategic Business Plan (Sections 5.26 and 5.27);
- be responsible for medical staff credentialing at the Hospitals (Section 5.27);
- maintain and oversee the quality assurance program at the Hospitals (Section 5.27);
- collaborate with PMH and management on clinical quality matters of the Hospital Businesses to share best practices, establish clinical quality goals and measure progress (Section 5.21); and
- oversee and manage the accreditation process for the Hospitals (Section 5.27).

The Local Board's role in overseeing quality is further established in the Quality Commitment Letter executed by PMH and ECHN on March 28, 2016. The Quality Commitment Letter clarifies that the Local Board will have oversight over quality assurance programs at the Hospitals and that changes in any programs will require review and approval of the Local Board.

Local Board Structure

Based on ECHN's past experience with the effective and efficient operation of concurrently serving Hospital boards, the post-closing entity PMH/ECHN will structure the two Local Boards to have identical membership, and to meet concurrently. The initial Local Board of PMH/ECHN will be composed of five (5) physicians, the Hospital CEO, and five (5) additional members of the community. At least five (5) of the initial appointees to the Local Board will be individuals who are serving on the ECHN Board of Trustees at the time of the closing of the transaction. The Governance Committee of the ECHN Board of Trustees will nominate, and the ECHN Board of Trustees will elect, the remaining members of the initial Local Board from the community prior to Closing. Thereafter, local PMH/ECHN management, working with PMH regional management, will appoint the Local Board Members.

In appointing the initial Members of the Local Board, ECHN will give strong consideration to the following factors, and post-closing ECHN/PMH will apply the same criteria:

- Assuring diverse Board Member composition as to age, gender, race, and town of residence with the goal of reflecting the composition of the communities served by PMH/ECHN
- Inclusion of individuals involved in the development of ECHN's strategic plan prior to closing, in order to maintain forward momentum for the strategic plan
- Tapping expertise and backgrounds that align with Local Board roles and responsibilities
- For community member slots, consideration will be given to those who have demonstrated a commitment to ECHN's mission by serving as ECHN corporators prior to the closing of the transaction

Terms of Office/Frequency of Meetings/Termination

The Initial Local Board Members will be appointed prior to closing to serve staggered three year terms per the Local Board Bylaws. See additional details in the attached Bylaws.

LOCAL BOARD OF ADVISORS BYLAWS

MANCHESTER MEMORIAL HOSPITAL

ADOPTED _____, 2016

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LOCAL BOARD BYLAWS

ARTICLE I - DEFINITIONS

The following terms, when capitalized, shall have the meanings set forth in these Bylaws; when not capitalized they shall have the meanings generally accorded to them by a dictionary:

1. **"Allied Health Professional Staff"** or **"AHP Staff"** means the allied health professional staff of the Hospital, all of whom have been appointed pursuant to the Medical Staff Bylaws.

2. **"Board of Directors"** means the board of directors of the Hospital.

3. **"Bylaws"** means these Local Board Bylaws.

4. **"Chief Executive Officer"** or **"CEO"** means the administrator of the Hospital who is responsible for the day-to-day management of the Hospital.

5. **"Clinical Privileges"** or **"Privileges"** means the permission granted to a Practitioner by the Health System Parent, on recommendation of the Medical Executive Committee and the Local Board, to render specific diagnostic, therapeutic, medical, dental, podiatric, surgical, or other professional services.

6. **"Health System"** means the system of health care providers under the common control of the Health System Parent, and including the Hospital and Rockville General Hospital.

7. **"Health System Parent"** means Prospect ECHN, Inc., the sole shareholder of the Hospital.

8. **"Health System Parent Board"** means the board of directors of the Health System Parent, designated by the Board of Directors to serve as the governing body of the Hospital with respect to Medical Staff matters.

9. **"Hospital"** means Manchester Memorial Hospital.

10. **"Local Board"** means the Manchester Memorial Hospital Local Board of Advisors.

11. **"Medical Executive Committee"** means the medical executive committee of the Medical Staff.

12. **"Medical Staff"** or **"Staff"** means the medical staff of the Hospital, all of whom have been appointed pursuant to the Medical Staff Bylaws.

13. **"Medical Staff Bylaws"** means the bylaws adopted by the Health System Parent Board governing appointment to, organization of, duties of, and operation of the Medical and AHP Staffs.

14. **"Practitioner"** means a licensed health care professional other than nurses, nursing assistants, technicians, and similar support personnel who are employees of the Hospital, and includes individuals eligible for appointment to either the Medical or AHP Staff.

15. **"Purchase Agreement"** means that certain Asset Purchase Agreement dated as of _____, 2016 by and among Eastern Connecticut Health Network, Inc., Prospect Medical Holdings, Inc. and various of its affiliates, including the Health System Parent.

ARTICLE II - GENERAL PROVISIONS

2.1 PURPOSES

The Hospital is an acute-care hospital providing health care services to the community. These Bylaws have been adopted to facilitate collaboration between the Board of Directors and the Local Board, which includes representatives of the Medical Staff and the community.

2.2 ADVISORY ROLE OF LOCAL BOARD

The Board of Directors retains all general authority and control over the business, policies, operations, and assets of the Hospital.

The Board of Directors has delegated to the Health System Parent the authority to act as the governing body of the Hospital with respect to Medical Staff matters, including adoption of and amendments to the Medical Staff Bylaws and the credentialing and re-credentialing of Medical Staff members.

The Board of Directors has also granted to the Local Board certain responsibilities as further described in these Bylaws. The Local Board shall serve generally in an advisory role and shall not have authority over or responsibility for the business of the Hospital.

The Board of Directors expressly reserves the right to amend, modify or rescind at any time, on reasonable advance notice, any rights or responsibilities given to the Local Board and is not obligated to approve or comply with any recommendations made by the Local Board. Notwithstanding anything herein to the contrary, nothing herein shall permit the Board of Directors to limit any rights of the Local Board in contravention of the terms of the Purchase Agreement.

ARTICLE III – MEMBERS OF LOCAL BOARD

3.1 QUALIFICATIONS OF LOCAL BOARD

The Board of Directors, in consultation with the CEO, shall establish the criteria for selection of members of the Local Board, which shall include, but not be limited to:

(a) Willingness to give as much time as is reasonably requested;

(b) Availability to participate actively in Local Board and committee activities, especially those activities where the member has a special interest and expertise;

(c) Experience in organizational and community activities;

(d) Proficiency in the art of managing people and property; and

(e) Integrity, objectivity, and loyalty.

3.2 COMPOSITION

The Local Board shall consist of at least eleven (11) but no more than fifteen (15) voting members. To the extent practicable, the Local Board should include both appointees to the Medical Staff and a broad representation of lay persons from the community served by the Hospital. The CEO shall serve as a voting member of the Local Board.

3.3 SELECTION

Members of the Local Board, whether they will commence new terms or fill vacancies for the balance of a term, shall be appointed by the Board of Directors. The Board of Directors shall give strong consideration to the nominations made by a nominating committee composed of the existing chairperson of the Local Board, the existing vice chairperson of the Local Board, and the CEO, which committee shall be chaired by the CEO (the "**Governing & Nominating Committee**"). The Governance & Nominating Committee will make Board diversity (in terms of age, gender, race and town of residence) a priority for recruitment of new members to the Local Board.

The Governance & Nominating Committee shall work with the CEO to recruit new Board nominees in order to present each candidate at the Annual Board Meeting in December for election. New Board members' terms will be effective January 1st of each year (introduced at the normally scheduled January Board meeting), unless otherwise determined by the Board of Directors.

Notwithstanding anything to the contrary herein, the initial Local Board shall be composed of the CEO, five (5) physicians and five (5) additional members of the community, all of whom are selected by the Board of Trustees of Eastern Connecticut Health Network, Inc. at the time of the closing of the transactions described in the Purchase Agreement. In the selection of the initial

members of the Local Board, the Board of Trustees of Eastern Connecticut Health Network, Inc. will endeavor to include individuals who have served on such Board prior to closing and who have been involved in strategic planning and/or have otherwise demonstrated a commitment to the mission of Eastern Connecticut Health Network, Inc.

3.4 TERM

The initial members of the Local Board will serve for one (1), two (2) or three (3) year terms. As terms expire, members will be elected or reelected to serve terms of three (3) years; provided, however, that no member of the Local Board will be permitted serve for more than three (3) consecutive three (3) year terms (or any portion thereof of more than one and one-half years). Members rotating off of the Local Board may return after a one year hiatus in membership, and may participate, during this hiatus period, in Hospital committees that do not require a committee member to be a member of the Local Board.

Notwithstanding the foregoing, to promote the objective of having the terms of approximately one-third of the elected members of the Local Board expire each year, a member may be appointed to serve a one (1), two (2) or three (3) year term, as determined by the Board of Directors. A member of the Local Board appointed to fill a vacancy shall serve the remainder of his or her predecessor's term.

3.5 REMOVAL

A member of the Local Board may be removed at any time by the Board of Directors, with or without cause. A member of the Local Board, other than the CEO, who has failed to attend two-thirds of the regular meetings of the Local Board during the calendar year or two-thirds of the meetings of Local Board committees of which he or she is a member may also be removed by a two-thirds affirmative vote of the remaining members of the Local Board. A member of the Local Board may resign at any time by tendering his or her resignation in writing to the Local Board. Resignation or removal as a member of the Local Board shall also constitute resignation or removal as an officer of the Local Board and as a member of any committee of the Local Board.

3.6 CONFLICT OF INTEREST

Members of the Local Board shall comply with all conflict of interest policies and procedures of the Hospital.

3.7 COMPENSATION

Members of the Local Board shall receive no compensation for any services rendered in their capacities as members of the Local Board or as officers or members of committees of the Local Board.

3.8 DUTIES

The duties of the Local Board are:

(a) Make recommendations for appointment to the Medical Staff of only those Practitioners meeting the qualifications prescribed in the Medical Staff Bylaws and other written or unwritten Hospital standards;

(b) Recommend standards for the quality of services to be made available at the Hospital and recommend Hospital policies implementing such standards;

(c) Recommend standards for programs to (i) improve patient safety and (ii) identify and reduce medical errors at the Hospital, and recommend Hospital policies implementing such standards;

(d) Serve as a resource to the CEO and the Board of Directors regarding the Hospital's short-range and long-range plans and goals, including providing input on the development of any strategic capital plan (which shall include plans for investment of the Capital Commitment referenced in the Purchase Agreement) and any strategic business plan or any modification to any of the foregoing;

(e) Review the Hospital's quality assurance programs, plans for improving the organization's quality performance and the quality of patient care rendered at the Hospital on an ongoing basis and, as appropriate, and identify to the CEO, the Board of Directors and the Health System Parent Board opportunities to improve the foregoing;

(f) Cooperate with the CEO on matters relating to obtaining and maintaining accreditation by the applicable accrediting bodies;

(g) Subject to approval of the Board of Directors, adopt such Local Board rules as may be necessary to further the purposes of these Bylaws, which rules shall become a part of these Bylaws; and

(h) Periodically review and propose amendments to these Bylaws.

The Board of Directors may make revisions to the scope of duties and responsibilities of the Local Board from time to time; provided, however, that nothing herein shall permit the Board of Directors to limit any rights of the Local Board in contravention of the terms of the Purchase Agreement.

3.9 INDEMNIFICATION

The Hospital shall indemnify any Indemnified Party (as hereinafter defined) against actual and necessary expenses, costs, and liabilities (including settlements approved by the Hospital) incurred by him in connection with the defense of any pending or threatened action, suit, or proceeding to which he or she is made a party by reason of acting or having acted in an official capacity on behalf

of the Hospital and shall, consistent with any policies of the Hospital, advance funds to pay for any such reasonable expenses or costs expected to be incurred pending the final disposition of any such action, suit or proceeding (including, without limitation, attorneys' fees). As used in these Bylaws, the term "Indemnified Party" shall mean a present or former member of the Local Board acting in good faith on behalf of the Hospital through the Local Board, a committee or other service. This indemnification shall not be exclusive of any other rights of indemnity to which the Indemnified Party may be entitled. Notwithstanding any other provision of these Bylaws to the contrary, no person shall be entitled to indemnity if the acts giving rise to the liability constituted misconduct, breach of fiduciary duty, self-dealing, and/or bad faith. Any indemnification under this Section (unless ordered by a court) shall be made by the Hospital only as authorized in the specific case upon a determination that indemnification is proper in the circumstances because he or she has met the applicable standard of conduct set forth above. Such determination shall be made by the Board of Directors. To the extent, however, that any Indemnified Party has been successful on the merits or otherwise in defense of any action, suit or proceeding described above, or in defense of any claim, issue or matter therein, he or she shall be indemnified against expenses (including attorney's fees) actually and reasonably incurred by him in connection therewith, without the necessity of authorization in the specific case. Notwithstanding the foregoing, nothing in this Section 3.9 shall obligate the Hospital to indemnify an Indemnified Party in excess of the fullest extent permitted by the Connecticut law.

ARTICLE IV - OFFICERS

4.1 IDENTITY; SELECTION; TERM

The officers of the Local Board shall be the chairperson, the vice chairperson, the secretary, and such other officers as the Local Board shall deem advisable. The remaining officers shall be elected annually by the Local Board from its members at its annual meeting. Except for the chairperson and the vice chairperson who shall each serve for a term of two (2) years, all other officers shall hold office for a term of one year and until a successor is appointed.

4.2 REMOVAL

The Local Board may remove an officer at any time with or without cause upon the affirmative vote of a majority of the members of the Local Board excluding the officer. An officer may resign from office at any time by tendering his or her resignation in writing to the chairperson or vice chairperson of the Local Board.

4.3 DUTIES

(a) **Chairperson** - The chairperson of the Local Board shall preside at all meetings of the Local Board. He or she shall appoint all committees and their chairpersons and shall be a member of all committees. He or she hall have such other duties and responsibilities as may be delegated by these Bylaws and by the Board of Directors from time to time.

(b) Vice Chairperson - In the absence of the chairperson of the Local Board or in the event of that individual's inability or refusal to act, the vice chairperson shall perform the duties of the chairperson and in so doing shall have all the powers of the chairperson. The vice chairperson shall perform such other duties as may be assigned by the chairperson from time to time.

(c) Secretary - The secretary shall keep or cause to be kept the minutes of the meetings of the Local Board, send out all notices of meetings, and perform such other duties as may be assigned by the chairperson of the Local Board from time to time. The secretary shall forward copies of all minutes to the appropriate corporate officer.

ARTICLE V - COMMITTEES

5.1 ESTABLISHMENT

The chairperson of the Local Board may appoint standing or special committees as he or she deems necessary and consistent with these Bylaws, and determine their membership, which may include members who are not members of the Local Board. The chairperson shall include members of the Local board who are also Medical Staff appointees on any committee that deliberates upon issues affecting the discharge of Medical Staff responsibilities.

5.2 TERM

Each member of a committee shall serve on such committee until the next annual meeting of the Local Board or until otherwise specified by the chairperson of the Local Board.

5.3 MEETINGS

The provisions of Article VI of these Bylaws (governing meetings of the Local Board) shall apply to all meetings of committees of the Local Board, unless the context clearly indicates otherwise, and references to "Local Board" shall be deemed to include "committees of the Local Board".

ARTICLE VI - MEETINGS

6.1 ANNUAL MEETINGS

The annual meeting of the Local Board shall be held on such day in each year as may be determined by the Local Board. The purpose of the annual meeting shall be to elect officers and to transact such other business as may properly come before the meeting and shall not be limited to the matters set forth in the notice of the meeting.

6.2 REGULAR MEETINGS

Regular meetings of the Local Board shall be held at least quarterly. Business to be transacted at any regular meeting of the Local Board shall not be limited to the matters set forth in the notice of the meeting.

6.3 SPECIAL MEETINGS

Special meetings of the Local Board may be called at any time by the chairperson of the Local Board, the CEO, or any three (3) or more members of the Local Board. The business to be transacted at any special meeting of the Local Board shall be limited to those items of business set forth in the notice of the meeting.

6.4 NOTICE AND PLACE

The Secretary of the Local Board shall give each member of the Local Board notice of each meeting of the Local Board personally, by telephone, by mail to his or her residence or place of business as listed in the CEO's office, or by electronic mail to an address provided by the member for purposes of receiving such notice. This notice shall be received not less than two (2) days prior to the meeting. It shall set forth the time and place of the meeting and notice of the matters of business to be transacted. The meeting shall be held at the Hospital unless the CEO approves another location. Notice of any meeting of the Local Board may be waived by the execution by all members of a written waiver of such notice at any time, which writing shall be filed with or entered upon the records of the meeting. Attendance at any meeting without protesting the lack of notice prior to or at the commencement of the meeting shall be deemed to be a waiver by such member of notice of the meeting. A majority of the members of the Local Board present, whether or not a quorum exists, may adjourn any meeting of the Local Board to another time and place. Notice of any such adjourned meeting shall be given to the members of the Local Board who are not present at the time of adjournment and, unless the time and place of the adjourned meeting are announced at the time of adjournment, to all members of the Local Board.

6.5 ATTENDANCE

Members of the Local Board shall attend as many meetings of the Local Board as possible. The chairperson shall review annually the attendance records of all members and shall counsel each member whose unexcused absences exceed one-third of the regular meetings of the Local Board.

6.6 QUORUM

A majority of the members of the Local Board then in office shall constitute a quorum for the transaction of business. A member of the Local Board shall be deemed to be present at a meeting if such member participates in the meeting using a conference telephone, speaker telephone, or similar communications device by means of which all persons participating in the meeting can hear each other at the same time.

6.7 VOTING

The act of a majority of the members of the Local Board present and voting at a meeting at which a quorum is present shall be the act of the Local Board.

6.8 ACTION WITHOUT A MEETING

Any action that may be taken at a meeting of the Local Board may be taken without a meeting if consent in writing setting forth such action is signed by all of the members of the Local Board and is filed in the minutes of the proceedings of the Local Board.

6.9 MINUTES

A written record of all proceedings of the Local Board, attendance, and actions shall be maintained by the CEO.

ARTICLE VII - AMENDMENTS TO BYLAWS

At least once every two (2) years the Local Board shall review these Bylaws to determine whether they require amending. These Bylaws may be amended only by either of the following methods:

(a) By an affirmative vote of two-thirds of the members of the Local Board, provided a full presentation of such proposed amendments shall have been published in the notice calling the meeting, and provided the amendments are approved in writing by the Board of Directors;

Or

(b) In the event that the Local Board fails to exercise its responsibility and authority, and after notice from the Board of Directors to such effect, including a reasonable period of time for response, by the Board of Directors.

ARTICLE VIII - ADOPTION AND EXECUTION

These Bylaws shall not be effective until they have been approved by the Board of Directors and by the Local Board. The signatures set forth below signify that these Bylaws are the duly adopted Local Board Bylaws of the Hospital.

APPROVED BY THE BOARD OF DIRECTORS ON _____, 2016.

_____
Secretary of the Hospital
(Acting at the direction of the Board of Directors)

APPROVED BY THE LOCAL BOARD OF ADVISORS ON _____, 2016.

_____
Secretary of the Local Board
(Acting at the direction of the Local Board)

14. Description of Proposed Allocation of Responsibility for Quality Matters (corporate v. local)

Please see attached.

Prospect Medical Holdings, Inc. and Prospect ECHN, Inc.

Quality Program Management -- Corporate and Local Roles

The following outlines a proposed allocation of roles between the Prospect Medical Holdings Inc.'s local and corporate organizations in the development and management of the quality program in PMH's ECHN facilities. The proposal covers three areas of activity: (i) the development and management of ECHN's annual quality goals and metrics; (ii) the process for addressing ECHN regulatory and accreditation surveys and implementing corrective actions; and (iii) the process by which the corporate and local roles may be modified.

I. Process for Developing Annual Quality Goals and Metrics

A. **Initiation of Annual Goal Development Process.** The local Quality management of Prospect ECHN, Inc. ("ECHN Local Quality Management") will have the role of initiating Prospect ECHN's Annual Quality Plans and Goals. No later than October 1 of each year, ECHN Local Quality Management will complete the following steps:

1. Review each of the following plans (together, the "Quality Improvement Program Plans") and make appropriate additions, updates and deletions:

    a. **The Annual Quality Assurance Performance Improvement Plan**

    b. **The Annual Patient Safety Plan.**

    c. **The Annual Patient Experience Plan.**

    d. **The Annual Infection Control Plan.**

    e. **The Annual Risk Management Plan.**

    Potential revisions may include but are not limited to any of the following:

- New or revised Goals, Objectives and/or measurement standards
- New or revised planned activities
- Clarifications of authority and accountability
- Changes to communication plans
- Identification of or changes to committee or action team objectives, goals and/or composition
- Revisions to emphasize future initiatives and areas of focus (e.g., patient experience)
- Revisions to reflect regulatory agency reporting requirements
- Revisions to leadership and/or reporting structure
- Revisions to include new information
- Addition of new criteria (e.g., Serious Safety Events)
- Inclusion of new forms of intervention and initiatives to improve patient safety

- Language clarifications
- Other updates as appropriate

2. Create a grid to track current fiscal year and review year-end Quality Improvement Goals and accomplishments and develop upcoming fiscal year Quality Improvement Goals

    a. Review current year goals– Identify and document how goals were met – place information on grid specific to how goals were met

    b. Develop new goals for incoming year related to each objective subject material related to Quality Assurance Performance Improvement Plan Objectives. Ensure that there are goals for each Objective category. Document in SMART goal format. Include all areas identified as highest need for improvement. Place all goals on grid.

B. **Submission for Local Governance Review and Approval.** Beginning no later than October 1 of each year, ECHN Local Quality Management will begin the process to obtain local governance review and approval of the annual Quality Improvement Program Plans and the upcoming fiscal year Quality Improvement Goals (together the "Annual Quality Plans and Goals"), as follows:

1. Quality Improvement Council
2. Medical Executive Council
3. Local Board

C. **Submission for PMH Corporate Chief Quality Officer Review.** On or about the later of (i) November 15 of each year or (ii) the date on which approval has been received from each level of Local Governance Review, ECHN Local Quality Management will submit the Annual Quality Plans and Goals to the PMH Corporate Chief Quality Officer for approval. The PMH Corporate Chief Quality Officer will be authorized to make those changes to the Annual Quality Plans and Goals that are required to comply with law or regulation. The PMH Corporate Chief Quality Officer may additionally recommend changes to the Annual Quality Plans and Goals in order to align them with regulatory and accreditation requirements, quality improvement best practices or with PMH corporate initiatives, which recommendations ECHN management will submit to the ECHN Quality Improvement Council, the ECHN Medical Executive Council and the Local Board for consideration and acceptance in their discretion. A conference call will occur between the PMH Chief Quality Officer, Regional VP of Quality and ECHN Local Quality Management to review rational for rejection of any recommendations and build consensus concerning next steps. The PMH Corporate Chief Quality Officer will notify ECHN Local Quality Management of the required or recommended changes and the reasons for them in writing within thirty (30) days of receipt. If the PMH Corporate Chief Quality Officer does not provide a notification within

the thirty (30) days the Annual Quality Plans and Goals submitted by local ECHN management will be deemed accepted and complete.

D. **Informal Collaboration.** It is anticipated that there will be continuing informal collaboration throughout the year between local ECHN management, the Regional VP of Quality, and the PMH Corporate Chief Quality Officer regarding quality improvement goals, initiatives and best practices, and that the PMH Corporate Chief Quality Officer and Regional VP of Quality, will serve as a continuing resource for the robust exchange of information in order to enhance quality, safety and patient satisfaction in ECHN facilities. In furtherance of such collaboration, the local ECHN Quality management may (but is not required to) share draft Annual Quality Plans and Goals with the Regional VP of Quality and PMH Corporate Chief Quality Officer in order to obtain feedback and suggestions throughout the process outlined above.

E. **Other Matters.** In addition to the foregoing roles, the PMH Corporate Chief Quality Officer and/or Regional VP of Quality will develop policies and procedures in conjunction with local ECHN quality management as appropriate to support Annual Quality Plans and Goals, and will create a framework and mechanism to permit ECHN to share quality best practices with PMH's other health systems while maintaining the flexibility to allow each organization to respond to its specific needs and circumstances.

II. Process for Responding to Quality Surveys and Instituting Corrective Action (corporate and local roles)

A. **Procedure to Follow During Survey:** During any accreditation or regulatory survey, the ECHN Local Quality Management will maintain direct accountability for responding to surveyors and instituting corrective actions

B. **Post-Survey Procedure:**

1. The ECHN Local Quality Management or designee will immediately inform the Regional VP of Quality of the arrival of any accreditation or regulatory survey team via e-mail or phone call. The Regional VP of Quality will serve as the liaison for informing the PMH Corporate Chief Quality Officer.

2. As soon as feasible but no later than close of business after the surveyors' completion of their onsite review, the ECHN Local Quality Management will provide an oral report to the Regional VP of Quality of the information communicated during the surveyors' exit conference, including but not limited to any deficiencies identified. Except in the event of an Immediate Jeopardy finding, which will be reported immediately, a surveyors' onsite review that is completed after business hours may be reported the following morning. If the survey extends beyond one day, the ECHN Local Quality Management will provide a daily oral report to the Regional VP of Quality for the duration of the survey visit. The Regional VP of Quality will be the liaison to update the PMH Corporate Chief Quality Officer.

3. The following time frames will apply to the exchange of information between the ECHN Local Quality Management and the PMH corporate representatives regarding written reports:

    a. **Joint Commission Accreditation Surveys**: The ECHN Local Quality Management will send the written report received from the Joint Commission to the Regional VP of Quality within one business day of receipt, and will submit the proposed corrective action plan to respond to the survey findings to the Regional VP of Quality no later than fifteen (15) days before the due date. Where Conditions of Participation are cited in the written report received from the Joint Commission the ECHN Local Quality Management will outline the findings, the person responsible, the date the corrective actions were completed and the verification seven (7) days before the due date.

    b. **Connecticut Department of Public Health Surveys**: The ECHN Local Quality Management will send the written report received from DPH to the Regional VP of Quality within one business day of receipt, and will submit the proposed corrective action plan to respond to the survey findings to the Regional VP of Quality no later than four (4) days before the due date.

    In each instance, the Regional VP of Quality will forward to the PMH Corporate Chief Quality Officer within one (1) business day of receipt the surveyor's written report or the proposed corrective action plan.

    Upon the completion of the proposed corrective action plan, the ECHN Local Quality Management will confer with the Regional VP of Quality to confirm either that (i) the corrective action taken to date have addressed the identified deficiencies, or (Ii) the corrective actions require supplementation, in which case an additional plan of correction will be developed.

    If the ECHN Local Quality Management considers it infeasible to complete the corrective actions within the time frame expected by the regulatory agency by means of the available local resources, it will identify this issue to the Regional VP of Quality and will outline those additional resources that will be required in order to complete the corrective actions within such expected time frame. The Regional VP of Quality will serve as the liaison to the PMH Corporate Chief Quality Officer in order to review the request and secure the necessary resources to complete the corrective actions as deemed necessary.

    The Regional VP of Quality will review, edit and forward any changes to the proposed corrective action plan to the Chief Quality Officer for final review. Once approved and returned, the local ECHN Quality Management will submit the final form to the surveying agency prior to the due date. The final copy will be sent to the Regional VP of Quality within one (1) business day of submission to the surveying agency. The Regional VP of Quality will then forward to appropriate Corporate Leaders.

4. **Incorporation of Survey Results into Annual Quality Goals.** It shall be an ongoing objective of ECHN Local Quality Management to incorporate the quality and patient safety related results of accrediting and regulatory agencies into the annual Quality Improvement Program Plans. Any revisions to the Quality Improvement Program Plans will be submitted to the Prospect Chief Quality Officer within five (5) days of approval for comment and recommendations as outline in section I subsection C above.

III. Revisions to Procedures

The quality management roles and responsibilities outlined above are intended to be exercised within a collaborative and dynamic process which will be subject to modification in order to better serve the goals patient safety, patient satisfaction, clinical quality and efficiency in PMH's ECHN facilities. When either the local ECHN Quality Management or the PMH Corporate Chief Quality Officer consider a modification to be advisable for any of those reasons, the local and corporate representatives will share and discuss the proposed modification with each other, after which the local, regional and corporate representatives will work in a cooperative and timely fashion to implement the modification.

15. Copies of all CMS Statement of Deficiencies for PMH's Rhode Island Hospitals since the date of Acquisition

Please See Exhibit 15 as attached. Please note that the statement of deficiencies includes corrective action plans which have been implemented.

COPY

WWW.CHARTERCARE.ORG

CharterCARE
HEALTH PARTNERS

March 8, 2016

Via hand delivery

Ms. Seema Dixit, MS, MPH, Chief
Center for Health Facilities and Regulations
Rhode Island Department of Health
Three Capitol Hill
Providence, RI 02908

Re: Investigation completed on February 2, 2016

Dear Ms. Dixit:

Enclosed please Roger Williams Medical Center's corrective action plan pursuant to the above referenced matter.

Very truly yours,

Moshe Berman
General Counsel

cc: Kimberly O'Connell (via email)

STATEMENT OF DEFICIENCES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HOS00133	A. BUILDING _____ B. WING _____	02/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROGER WILLIAMS MEDICAL CENTER	825 CHALKSTONE AVENUE PROVIDENCE RI 02908

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY	(X5) COMPLETION DATE
Z 0	INITIAL COMMENTS A State complaint investigation survey was conducted at this facility. State deficiencies were identified.	Z 0		
Z 850	PATIENT CARE SERVICES 31.1 Pharmaceutical Service Section 31.0 Pharmaceutical Service 31.1 Each hospital shall provide pharmaceutical services either directly within the institution or by contractual arrangement. In either instance, there shall be evidence of a current pharmacy license in compliance with section 5-19-28 of reference 13. Pharmaceutical services shall be provided in accordance with the regulations of reference 62 herein. This requirement is not met as evidenced by: Based upon record review and staff interview, it has been determined that the hospital has failed to ensure patient safety relative to sterile compounding areas in accordance with State Regulation and applicable standards of practice. Findings are as follows: 1) The State of Rhode Island Rules and Regulations Pertaining to Pharmacists, Pharmacies, and Manufacturers, Wholesalers and Distributors, [R5-19.1-PHAR], State of Rhode Island and Providence Plantations, Department of Health, March 1985 and revised April 2014, under 19.28A, States, in part: "...written plan and schedule for the environmental monitoring procedures for viable micro organisms shall be established and followed. The plan shall be adequate to evaluate the various controlled air environment areas	Z850	A written plan and schedule for the environmental monitoring procedures for viable microorganisms was established to ensure patient safety relative to sterile compounding areas in accordance with State Regulation and applicable standards of practice. The Pharmacy Department will at a minimum conduct a monthly evaluation of the sterile compounding area used for low-and-medium-risk preparations conducted by Accuratus Lab Services. Attachment #1 Staff members were trained on the policy changes. A New Regional Director of Pharmacy started February 8, 2016, and is reviewing all pharmacy practices. The results of the monthly environmental testing will be reported to the Regional Director, Pharmacy and Director, Infection Prevention & Control. Any negative results will be immediately reported to the President and CEO. Additionally, the results of the monthly testing and any corrective action will be reported quarterly to the Infection Control Committee. First report will be due to the Infection Control Committee meeting on April 21, 2016. Attachment #2	3/7/2016 Ongoing monthly 2/3/2016 & 2/4/2016 4/21/16 & quarterly

Facilities Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: PRESIDENT — (X6) DATE: 3/8/16
STATE FORM 6899 — NDX11 — IF CONTINUATION SHEET 1 OF 6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HOS00133	A. BUILDING _____ B. WING _____	02/02/2016

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Z850	Continued From Page 1 (LAFW, barrier isolators, biological safety cabinets, buffer or clean room, and anteroom) of the designated sterile compounding area(s). For sterile compounding areas used for low-and medium-risk preparations, a minimum monthly evaluation shall be required ..." Review of the Department of Pharmacy services Corrective Action Plan dated 06/23/2015 revealed that fungus was found in the Ante and Clean Rom of the sterile compounding areas. There was one location in Clean Room (#6 on their diagram) and two locations in Ante Room (#'s 8 and 10 on their diagram). The document further reveals that environmental monitoring was conducted on 09/21/2015 which revealed a fungus was still found in the air sampling for location 10 in the Ante Room. A Testing Certificate dated 12/21/2015 identified bacteria on the floor in the Ante Room. The Director of Pharmacy was interviewed on 2/2/2016 at 2:15 PM and was unable to produce evidence that the monthly testing was conducted as required between June and September and December 2015.	Z850	CAP: The hospital will ensure that all parts of the hospital are maintained in good repair relative to the pharmacy.	
Z1700	ENVIRONMENTAL & MAINTENANCE SERVICES 50.2 Housekeeping & Maintenance Services 50.2 All parts of the hospital and its premises shall be kept clean, neat, free of litter and rubbish, and all furnishings maintained in good repair	Z1700	All floor cracks that were identified had a work order entered into the Meditech work order system in the Maintenance Department. All future environmental safety issues will be entered into the Meditech work order system. Pharmacy staff have been trained and given access to enter work orders into the Meditech work order system. Attachment #3	

PRESIDENT 3/8/16

STATEMENT OF DEFICIENCES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HOS00133	A. BUILDING _____ B. WING _____	02/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY	(X5) COMPLETION DATE
Z1700	Continued From page 2 This Requirement is not met as evidenced by: Based upon surveyor observation, record review and staff interview, it has been determined that the hospital has failed to ensure that all parts of the hospital are maintained in good repair relative to the pharmacy. Findings are as follows: On 2/2/2016 at approximately 10:00 AM in the presence of a pharmacy technician (Staff B), the Clean room was observed with a 2 to 3 inch crack in the wall where it meets the wall. The Chemo room was observed with an 8 to 10 inch crack right above the baseboard where it meets the wall. Another crack was observed near the entrance door measuring approximately 2 to 3 feet in length. This crack was covered with blue tape that was torn/cracked and appeared worn. Subsequent interview with the Director of Pharmacy on 2/2/2016 at 10:15 AM failed to reveal evidence/documentation that these floor cracks were brought to the attention of maintenance services.	Z1700	Identified cracks were repaired on February 4, 2016 and February 19, 2016 respectively. See Attachment #3. The Administrative Assistant in the Maintenance & Engineering Department will be manually tracking all open safety work orders to ensure timely completion. Maintenance will report monthly to the Safety Committee The Pharmacy Department will report adverse environmental findings in the compounding areas to the Infection Prevention and Control Program. The New Regional Director of Pharmacy is overseeing an Inspection of the pharmacy physical environment and reporting all findings to the Maintenance and engineering Department, President and CEO.	2/4/16 & 2/19/16
Z1725	ENVIRONMENTAL & MAINTENANCE SERVICES 51.1 Infection Control Section 51.0 Infection Control 51.1 The medical staff in cooperation with other disciplines shall establish a multidisciplinary group which shall report to the governing body and which shall be responsible for no less than the following: a) establishing and maintaining a hospital-wide infection surveillance program which shall include	Z1725	Quarterly reports will be submitted to the Infection Prevention & Control Program by the Regional Director, Pharmacy on environmental testing for the Pharmacy sterile compounding room including the ante room. An alternate pharmacy staff will be assigned to attend the Infection Prevention & Control Committee Meeting when the Regional Director, Pharmacy is unable to attend.	

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Z1725	Continued From page 3 an infection surveillance officer to conduct all infection surveillance activities; b) developing and implementing written policies and procedures for the surveillance, prevention, and control of infections in all patient care departments/services; c) establishing policies governing the admission and isolation of patients with known or suspected infectious diseases; d) developing, evaluating and revising on a continuing basis infection control policies, procedures and techniques for all appropriate phases of hospital operation and services. e) developing and implementing a system for evaluating and recording the occurrences of all infections among personnel and patients; such records shall be made available to the licensing agency upon request; f) implementing a TB infection control program requiring risk assessment and development of a TB infection control plan; early identification, treatment and isolation of strongly suspected or confirmed infectious TB patients; effective engineering controls; an appropriate respiratory protection program; health care worker TB training, education, counseling and screening; and evaluation of the program's effectiveness, per guidelines in reference 33. g) developing and implementing an institution-specific strategic plan for the prevention and control of vancomycin resistance, with a special focus on vancomycin-resistant enterococci, per guidelines in reference 50. h) developing and implementing protocols for discharge planning of patients with infectious diseases which may present the risk of continuing transmission	Z1725	Monthly EOC rounds will be conducted by Regional DOP or designee and Director of Environment or designee. These results will be reported to the Infection Prevention & Control Committee including any action(s) taken. Attachment #2	4-21-16 & quarterly

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY	(X5) COMPLETION DATE
Z1725	Examples of such diseases include, but are not limited to, tuberculosis (TB), Continued From page 4 Methicillin resistant staphylococcus aureus (MRSA), clostridium difficile, etc. i) assuring that patient care support departments (i.e., central services, laundry, etc) are available to assist in the prevention and control of infectious diseases and are provided with adequate direction, training, staffing and facilities to perform all required infection surveillance, prevention and control functions. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it has been determined that the pharmacy has failed to report adverse environmental findings in the compounding areas to the Infection and Prevention Control Program. Findings are as follows: Review of the hospitals manual titled "Infection Prevention and Control Committee Policy", states, in part, under section IV, Responsibility, ... "Review of results of surveillance activities". This policy also states, in part, under section V, Procedure, "Membership includes representatives from the following departments: ...Pharmacy, ..." Review of the Department of Pharmacy Services Corrective Action Plan dated 6/23/2015 revealed that fungus was found in the Ante and Clean Rooms of the Main Hospital Sterile Compounding) Areas. There was one location in the Clean Room (#6 on their diagram) and two locations in the Ante Room (#s 8 and 10 on their diagram).	Z1725		

STATEMENT OF DEFICIENCES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HOS00133	A. BUILDING _____ B. WING _____	02/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROGER WILLIAMS MEDICAL CENTER	825 CHALKSTONE AVENUE PROVIDENCE RI 02908

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY	(X5) COMPLETION DATE
Z1725	Continued From page 5 The document further reveals that environmental monitoring was conducted on 9/21/2015 which revealed fungus was still found in the air sampling for location 10 in the Ante Room. A Testing Certificate dated 12/21/2015 identified bacteria on the floor in the Ante Room. Review of the Infection Prevention and Control Committee Meeting revealed the meetings were held on 10/15/2015, 11/19/2015, 12/17/2015, and 1/21/2016. There was no evidence that the committee has reviewed the results of the above findings. Additionally, there was no evidence that any representative from pharmacy attended the meetings on 12/17/2015 and 1/21/2016. The Director of Infection and Prevention Control was interviewed on 2/2/2016 at 1:25 PM and was unaware of the above findings as they had not been reported to Infection Control. During a subsequent interview on 2/2/2016 at 2:00 PM, the Director of Pharmacy stated the above findings had not been reported to the Infection Prevention and Control Committee.	Z1725		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED 02/15/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HOS00133	A. BUILDING_____ B. WING_____	02/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROGER WILLIAMS MEDICAL CENTER	825 CHALKSTONE AVENUE PROVIDENCE RI 02908

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIFICENCY	(X5) COMPLETION DATE

PRESIDENT 3/8/16

16. Updated Information on Pension Obligation and Impact on Cash Flow

Please see attached.

ECHN
Pension Funding & Expense
Historical & Projected

Historical

	Funding	Expense
FY 2006	$ -	$ 5,893,968
FY 2007	$ 2,511,000	$ 4,704,480
FY 2008	$ 3,100,000	$ 3,087,800
FY 2009	$ 500,000	$ 1,527,909
FY 2010	$ 2,896,690	$ 907,347
FY 2011	$ 6,570,000	$ 1,972,795
FY 2012	$ 10,910,000	$ 4,795,189
FY 2013	$ 3,000,000	$ 3,232,959
FY 2014	$ 4,800,000	$ 131,191
FY 2015	$ 970,000	$ 2,844,430
FY 2016	$ 1,840,000	$ 4,600,000
	$ 37,097,690	$ 33,698,068

Projected

	Funding	Expense
FY 2017	$ 3,790,000	$ 5,300,000
FY 2018	$ 5,060,000	$ 5,200,000
FY 2019	$ 7,060,000	$ 5,000,000
FY 2020	$ 14,250,000	$ 4,800,000
FY 2021	$ 13,340,000	$ 4,100,000
	$ 43,500,000	$ 24,400,000

Funding & Relief Legislation:

Pension Protection Act -- enacted in 2006, effective 1/1/2008
Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010
Moving Ahead for Progress in the 21st Century (MAP-21) passed in 2012
Highway and Transportation Funding Act of 2014
Bipartisan Budget Act of 2015

MAP-21 provided the most significant funding relief and HATFA continued this as you can see the funding requirements since FY 2012 have been held down; without this relief ECHN would have breached days cash on hand bond covenants by now. Without new relief legislation in the near future the funding requirements start to spike up beginning next fiscal year.

17. Reconciliation of Revised Financials

Please see attached.

OHCA Financial Statistics Report

Most schedules originally provided had roll-up issues and so anything previously provided needed to re-done. We will provide an overview of some of the high level changes for our end September 30, 2015 (as compared to year end September 30, 2014) and for mid-year March 31, 2016 (as compared to March 31, 2015).We have provided the DSCR (debt service coverage ratio) for only the year end and mid-year schedules as they are measurement points per our bond covenants. Furthermore, we have computed for the system only and not for each hospital as we do not report these individually as part of routine bond covenant reporting.

We have computed DCOH (days cash on hand) per the measurement criteria of our bond covenants.

September 2015 YTD vs. September 2014 YTD

- The margins for FY 2015 were negative and lower than the prior year due to the continued pressure of governmental reimbursement reductions at both the federal and state level. The Medicare wage index changes along with the continued reduction in the State supplemental payments were most significant, but we also saw State inpatient reimbursement reduced as it transitioned to a new payment model.
- DCOH closed out 6 days lower than the prior year per the same reasons noted in the first bullet.
- Long-term Debt to Equity and Long-term Debt to Capitalization increased primarily due to a) the increase in the unfunded pension due to the new mortality tables and impact on pension liabilities and b) operating performance.
- DSCR closed out just above the bond covenant minimum of 1.25 again due to the pressures of declining reimbursement.
- All other significant ratios or performance indicators in section D. are essentially impacted by the factors already cited in the prior bullets.
- The Unrestricted Assets decline of over $17,000,000 is mostly due to the pension and the new mortality tables which contributed $14,000,000 of this decline.

March 2016 YTD vs. March 2015 YTD

- The same issues that carried throughout the prior year's performance are prevalent in FY 2016 as we see additional erosion in federal and state reimbursement, again both the Medicare wage index reduction which took place in two phases, and the continued reductions to the State supplemental payments.
- Note the margin performance, DCOH, and DSCR. All trending in the wrong direction.
- It is worth noting that the performance from the prior year is somewhat mitigated by reserves that were still carried on the balance sheet at 9/30/14 that were viewed as conservative and thus were able to reduce these as offsets in the prior year.
- Some of the financial ratios where equity or unrestricted net assets are included will reflect a large delta for this March YTD vs the prior March YTD, as the equity hit for the pension happens at year end only.

OHCA Financial Statistics Report (July FY 2015 and July FY 2014)

	Manchester Memorial Hospital				Rockville General Hospital				Eastern CT Health Network			
	MTD		YTD		MTD		YTD		MTD		YTD	
	July FY 2015	July FY 2014	July FY 2015	July FY 2014	July FY 2015	July FY 2014	July FY 2015	July FY 2014	July FY 2015	July FY 2014	July FY 2015	July FY 2014
A. Operating Performance												
Operating Margin	4.12%	3.32%	2.51%	3.23%	-3.13%	0.81%	-2.72%	1.05%	3.71%	0.89%	-0.98%	0.34%
Non-Operating Margin	-1.21%	-1.76%	-0.89%	-0.88%	-1.20%	-1.71%	-0.69%	-0.45%	-0.92%	-1.36%	-0.67%	-0.59%
Total Margin	2.91%	1.56%	1.62%	2.35%	-4.32%	-0.90%	-3.41%	0.60%	2.80%	-0.47%	-1.65%	-0.25%
Bad Debt as % of Gross Revenue	0.58%	0.38%	0.61%	0.66%	0.99%	0.35%	0.72%	0.63%	-0.76%	0.48%	0.65%	0.75%
B. Liquidity												
Current Ratio	1.16	1.31	1.16	1.31	1.54	1.50	1.54	1.50	1.38	1.40	1.38	1.40
Days Cash on Hand	39	47	37	47	102	92	95	94	63	67	61	67
Days in Net Accounts Receivable	55	61	54	61	64	57	60	59	54	57	55	57
Average Payment Period	64	56	61	56	49	48	46	49	57	57	55	57
C. Leverage and Capital Structure												
Long-term Debt to Equity	2.07	1.64	2.07	1.64	0.91	0.74	0.91	0.74	1.11	0.93	1.11	0.93
Long-term Debt to Capitalization	67	62	67	62	48	42	48	42	67	59	67	59
Unrestricted Cash to Debt	1.30	0.90	10.83	12.60	0.08	0.43	2.49	9.86	1.37	0.49	4.36	7.21
Times Interest Earned Ratio	6.75	5.72	5.82	6.03	2.44	4.94	2.99	6.96	7.70	4.40	3.49	4.46
Debt Service Coverage Ratio	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Equity Financing Ratio	16.17	21.64	16.17	21.64	35.23	41.31	35.23	41.31	28.11	32.92	28.11	32.92
D. Additional Statistics												
Income from Operations	$633,053	$520,994	$3,919,130	$5,079,849	($166,895)	$49,602	($1,534,668)	$637,755	$1,033,957	$251,617	($2,648,012)	$961,199
Revenue Over/(Under) Expense	$446,906	$244,365	$2,524,988	$3,695,991	($230,700)	($55,083)	($1,924,686)	$362,997	$778,733	($133,319)	($4,472,987)	($691,635)
EBITDA	$1,413,261	$1,163,486	$11,890,204	$13,184,731	$149,301	$305,483	$1,744,517	$4,002,648	$2,291,661	$1,335,849	$10,337,145	$14,344,707
Cash from Operations	$14,290,215	$15,719,667	$144,425,712	$146,612,175	$5,527,405	$6,707,356	$57,671,830	$58,437,110	$24,789,135	$27,474,495	$250,964,684	$255,091,516
Cash and Cash Equivalents	$1,272,319	$4,390,167	$1,272,319	$4,390,167	$774,122	$1,311,776	$774,122	$1,311,776	$10,096,797	$13,568,664	$10,096,797	$13,568,664
Net Working Capital	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$22,865,409	$21,212,266	$22,865,409	$21,212,266
Unrestricted Assets	$10,376,011	$19,815,466	$10,376,011	$19,815,466	$20,665,705	$26,324,679	$20,665,705	$26,324,679	$54,034,965	$71,217,658	$54,034,965	$71,217,658
Credit Ratings (S&P, FITCH, and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

OHCA Financial Statistics Report (August FY 2015 and August FY 2014)

	Manchester Memorial Hospital				Rockville General Hospital				Eastern CT Health Network			
	MTD		YTD		MTD		YTD		MTD		YTD	
	August FY 2015	August FY 2014	August FY 2015	August FY 2014	August FY 2015	August FY 2014	August FY 2015	August FY 2014	August FY 2015	August FY 2014	August FY 2015	August FY 2014
A. Operating Performance												
Operating Margin	4.05%	-3.59%	2.65%	2.64%	-2.38%	-0.70%	-2.69%	0.90%	-0.94%	-4.14%	-0.97%	-0.05%
Non-Operating Margin	-1.66%	-0.44%	-0.96%	-0.84%	-1.58%	-0.17%	-0.76%	-0.43%	-1.29%	-0.29%	-0.73%	-0.56%
Total Margin	2.39%	-4.03%	1.69%	1.80%	-3.96%	-0.87%	-3.46%	0.47%	-2.23%	-4.43%	-1.70%	-0.61%
Bad Debt as % of Gross Revenue	-1.22%	0.66%	0.44%	0.66%	-1.21%	0.84%	0.55%	0.65%	-0.96%	0.79%	0.51%	0.75%
B. Liquidity												
Current Ratio	1.19	1.19	1.19	1.19	1.48	1.69	1.48	1.69	1.36	1.39	1.36	1.39
Days Cash on Hand	42	46	39	45	107	93	95	89	67	67	62	65
Days in Net Accounts Receivable	56	64	54	60	64	63	57	60	57	60	54	57
Average Payment Period	67	61	61	60	52	44	47	42	60	58	56	56
C. Leverage and Capital Structure												
Long-term Debt to Equity	2.14	1.74	2.14	1.74	0.92	0.77	0.92	0.77	1.14	0.97	1.14	0.97
Long-term Debt to Capitalization	68	64	68	64	48	44	48	44	67	61	67	61
Unrestricted Cash to Debt	1.20	0.06	11.86	12.11	0.06	0.77	2.55	10.84	0.30	(0.08)	4.60	7.04
Times Interest Earned Ratio	6.91	1.53	6.41	5.64	2.68	5.33	2.96	6.81	3.45	0.91	3.49	4.16
Debt Service Coverage Ratio	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Equity Financing Ratio	15.99	20.58	15.99	20.58	34.93	41.46	34.93	41.46	27.76	32.38	27.76	32.38
D. Additional Statistics												
Income from Operations	$597,835	($531,932)	$4,516,964	$4,547,917	($119,527)	($40,468)	($1,654,194)	$597,288	($240,325)	($1,110,535)	($2,888,337)	($149,336)
Revenue Over/(Under) Expense	$353,116	($597,128)	$2,878,103	$3,098,864	($198,666)	($50,522)	($2,123,350)	$312,476	($570,339)	($1,188,772)	($5,043,326)	($1,880,407)
EBITDA	$1,400,713	$316,488	$13,088,122	$13,501,219	$156,631	$307,715	$1,901,150	$4,310,364	$1,003,678	$275,706	$11,340,823	$14,620,413
Cash from Operations	$13,850,383	$14,385,361	$158,276,095	$160,997,536	$5,606,279	$5,677,456	$63,278,109	$64,114,566	$24,438,646	$24,966,839	$275,403,330	$280,058,355
Cash and Cash Equivalents	$2,171,516	$3,473,258	$2,171,516	$3,473,258	$626,557	$310,037	$626,557	$310,037	$10,397,030	$11,377,699	$10,397,030	$11,377,699
Net Working Capital	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$21,129,948	$21,924,557	$21,129,948	$21,924,557
Unrestricted Assets	$10,308,640	$18,971,156	$10,308,640	$18,971,156	$20,279,098	$26,051,748	$20,279,098	$26,051,748	$53,344,364	$70,108,676	$53,344,364	$70,108,676
Credit Ratings (S&P, FITCH, and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

OHCA Financial Statistics Report (September FY 2015 and September FY 2014)

	Manchester Memorial Hospital				Rockville General Hospital				Eastern CT Health Network			
	MTD		YTD		MTD		YTD		MTD		YTD	
	September FY 2015	September FY 2014	September FY 2015	September FY 2014	September FY 2015	September FY 2014	September FY 2015	September FY 2014	September FY 2015	September FY 2014	September FY 2015	September FY 2014
A. Operating Performance												
Operating Margin	27.16%	-1.98%	4.79%	2.26%	-61.17%	26.83%	-5.63%	3.70%	15.95%	12.12%	-0.09%	0.67%
Non-Operating Margin	0.00%	-1.87%	-0.88%	-0.93%	-2.39%	-1.16%	-0.85%	-0.51%	-0.49%	-2.06%	-0.71%	-0.65%
Total Margin	27.16%	-3.85%	3.91%	1.33%	-63.56%	25.67%	-6.47%	3.20%	15.46%	10.06%	-0.80%	0.01%
Bad Debt as % of Gross Revenue	8.22%	4.49%	1.14%	0.97%	13.33%	7.75%	1.59%	1.23%	8.43%	5.32%	1.19%	1.10%
B. Liquidity												
Current Ratio	1.19	1.16	1.19	1.16	1.47	1.63	1.47	1.63	1.45	1.35	1.45	1.35
Days Cash on Hand	62	52	49	56	111	95	104	98	140	124	72	78
Days in Net Accounts Receivable	55	64	55	53	85	60	51	52	59	64	52	52
Average Payment Period	82	73	71	79	52	47	49	48	120	111	62	70
					0							
C. Leverage and Capital Structure												
Long-term Debt to Equity	3.30	2.03	3.30	2.03	1.19	0.83	1.19	0.83	1.36	1.06	1.36	1.06
Long-term Debt to Capitalization	77	67	77	67	54	45	54	45	75	65	75	65
Unrestricted Cash to Debt	6.25	(0.06)	17.33	10.79	(5.87)	7.00	(3.35)	17.47	2.63	2.02	7.13	8.60
Times Interest Earned Ratio	45.65	2.24	7.82	5.38	(30.75)	42.56	0.28	9.76	19.37	14.16	4.38	4.82
Debt Service Coverage Ratio	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1.27	1.53
Equity Financing Ratio	9.60	16.28	9.60	16.28	28.52	37.89	28.52	37.89	22.53	28.14	22.53	28.14
D. Additional Statistics												
Income from Operations	$4,438,312	($312,411)	$8,955,278	$4,235,504	($1,985,465)	$2,163,409	($3,639,661)	$2,760,693	$2,607,887	$2,322,057	($280,450)	$2,172,721
Revenue Over/(Under) Expense	$4,438,503	($606,680)	$7,316,608	$2,492,182	($2,063,001)	$2,069,656	($4,186,353)	$2,382,129	$2,527,466	$1,927,377	($2,515,860)	$45,970
EBITDA	$5,138,862	$440,393	$18,429,780	$13,941,610	($1,704,420)	$2,421,228	$196,729	$6,731,589	$3,745,382	$3,513,673	$15,086,205	$18,134,086
Cash from Operations	$14,563,917	$14,901,325	$172,840,012	$175,898,861	$5,514,418	$5,768,359	$68,792,527	$69,882,925	$24,854,112	$25,589,485	$300,257,442	$305,647,840
Cash and Cash Equivalents	$5,266,042	$9,361,439	$5,266,042	$9,361,439	$2,130,526	$1,772,696	$2,130,526	$1,772,696	$16,286,829	$18,947,190	$16,286,829	$18,947,190
Net Working Capital	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$15,479,150	$12,036,522	$15,479,150	$12,036,522
Unrestricted Assets	$2,829,380	$11,344,473	$2,829,380	$11,344,473	$14,969,087	$24,211,838	$14,969,087	$24,211,838	$42,167,565	$59,544,873	$42,167,565	$59,544,873
Credit Ratings (S&P, FITCH, and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

OHCA Financial Statistics Report (January FY 2016 and January FY 2015)

	Manchester Memorial Hospital				Rockville General Hospital				Eastern CT Health Network			
	MTD		YTD		MTD		YTD		MTD		YTD	
	January FY 2016	January FY 2015	January FY 2016	January FY 2015	January FY 2016	January FY 2015	January FY 2016	January FY 2015	January FY 2016	January FY 2015	January FY 2016	January FY 2015
A. Operating Performance												
Operating Margin	-4.59%	3.59%	1.40%	2.62%	0.81%	4.56%	-3.51%	1.49%	-4.33%	0.55%	-1.55%	0.18%
Non-Operating Margin	-0.45%	-0.41%	-0.56%	-0.57%	-0.45%	-0.11%	-0.59%	-0.29%	-0.36%	-0.27%	-0.46%	-0.40%
Total Margin	-5.04%	3.18%	0.84%	2.05%	0.36%	4.45%	-4.09%	1.19%	-4.70%	0.28%	-2.01%	-0.22%
Bad Debt as % of Gross Revenue	2.71%	1.04%	1.54%	0.83%	-0.08%	1.32%	0.74%	0.90%	1.90%	1.17%	1.29%	0.92%
B. Liquidity												
Current Ratio	1.30	1.13	1.30	1.13	1.79	1.83	1.79	1.83	1.60	1.47	1.60	1.47
Days Cash on Hand	33	37	34	36	91	95	91	93	60	66	60	66
Days in Net Accounts Receivable	68	54	65	54	57	57	60	60	62	52	60	54
Average Payment Period	56	62	57	61	39	43	39	42	54	55	54	55
C. Leverage and Capital Structure												
Long-term Debt to Equity	3.52	2.07	3.52	2.07	1.29	0.83	1.29	0.83	1.41	1.08	1.41	1.08
Long-term Debt to Capitalization	78	67	78	67	56	45	56	45	76	52	76	52
Unrestricted Cash to Debt	(0.23)	1.37	3.67	4.73	0.94	1.77	0.47	4.50	(0.22)	0.83	1.35	3.00
Times Interest Earned Ratio	0.44	6.89	4.79	6.19	6.18	10.84	2.14	6.97	0.37	4.98	2.84	4.64
Debt Service Coverage Ratio	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Equity Financing Ratio	9.59	16.58	9.59	16.58	27.72	38.33	27.72	38.33	22.42	29.08	22.42	29.08
D. Additional Statistics												
Income from Operations	($680,072)	$574,121	$864,479	$1,669,209	$46,191	$277,536	($756,822)	$354,387	($1,130,134)	$155,525	($1,650,097)	$204,864
Revenue Over/(Under) Expense	($746,095)	$508,138	$517,032	$1,304,511	$20,484	$270,781	($883,647)	$284,914	($1,225,108)	$79,732	($2,138,708)	($241,790)
EBITDA	$84,071	$1,361,055	$3,981,552	$4,966,613	$359,645	$609,467	$494,318	$1,705,321	$103,004	$1,453,322	$3,375,431	$5,587,674
Cash from Operations	$12,827,534	$13,797,665	$57,103,426	$58,532,206	$5,023,259	$5,182,780	$20,929,423	$23,781,040	$22,373,026	$23,611,869	$97,908,556	$102,338,435
Cash and Cash Equivalents	$676,536	$187,209	$676,536	$187,209	$375,383	$357,032	$375,383	$357,032	$12,454,497	$8,315,256	$12,454,497	$8,315,256
Net Working Capital	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$25,233,356	$26,799,174	$25,233,356	$26,799,174
Unrestricted Assets	$1,852,814	$11,243,924	$1,852,814	$11,243,924	$13,508,694	$23,899,791	$13,508,694	$23,899,791	$40,397,950	$59,273,090	$40,397,950	$59,273,090
Credit Ratings (S&P, FITCH, and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

OHCA Financial Statistics Report (February FY 2016 and February FY 2015)

	Manchester Memorial Hospital				Rockville General Hospital				Eastern CT Health Network			
	MTD		YTD		MTD		YTD		MTD		YTD	
	February FY 2016	February FY 2015	February FY 2016	February FY 2015	February FY 2016	February FY 2015	February FY 2016	February FY 2015	February FY 2016	February FY 2015	February FY 2016	February FY 2015
A. Operating Performance												
Operating Margin	-1.08%	-4.46%	0.93%	1.34%	-16.89%	-2.71%	-5.85%	1.04%	-4.86%	-5.46%	-2.17%	-0.85%
Non-Operating Margin	-0.63%	-0.51%	-0.58%	-0.56%	-0.86%	-0.71%	-0.64%	-0.37%	-0.55%	-0.45%	-0.48%	-0.41%
Total Margin	-1.71%	-4.98%	0.35%	0.77%	-17.75%	-3.42%	-6.48%	0.67%	-5.41%	-5.91%	-2.65%	-1.26%
Bad Debt as % of Gross Revenue	1.50%	1.16%	1.53%	0.89%	1.68%	1.44%	0.92%	1.00%	1.47%	1.28%	1.32%	0.99%
B. Liquidity												
Current Ratio	1.28	1.23	1.28	1.23	1.61	1.66	1.61	1.66	1.56	1.46	1.56	1.46
Days Cash on Hand	37	40	38	41	91	87	92	91	62	62	62	65
Days in Net Accounts Receivable	59	58	60	58	58	56	54	57	56	53	55	53
Average Payment Period	58	62	60	64	41	43	42	45	54	54	54	57
C. Leverage and Capital Structure												
Long-term Debt to Equity	3.63	2.16	3.63	2.16	1.37	0.84	1.37	0.84	1.47	1.10	1.47	1.10
Long-term Debt to Capitalization	73	68	78	68	58	46	58	46	76	66	76	66
Unrestricted Cash to Debt	0.44	(0.15)	4.06	4.48	(1.89)	0.27	(1.43)	4.99	(0.29)	(0.64)	1.07	2.31
Times Interest Earned Ratio	3.20	0.76	4.48	5.00	(8.13)	4.32	0.10	6.97	0.20	(1.82)	2.34	3.48
Debt Service Coverage Ratio	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Equity Financing Ratio	9.19	15.77	9.19	15.77	26.41	37.66	26.41	37.66	21.44	28.53	21.44	28.53
D. Additional Statistics												
Income from Operations	($156,488)	($629,128)	$707,993	$1,040,080	($773,124)	($148,581)	($1,529,946)	$305,803	($1,193,898)	($1,370,764)	($2,843,995)	($1,165,900)
Revenue Over/(Under) Expense	($248,519)	($701,662)	$268,515	$602,847	($812,613)	($187,431)	($1,696,260)	$197,481	($1,328,700)	($1,485,069)	($3,467,408)	($1,726,859)
EBITDA	$632,119	$172,056	$4,613,672	$5,138,669	($465,266)	$160,782	$29,051	$1,966,100	$56,153	($477,995)	$3,431,584	$5,109,679
Cash from Operations	$15,819,230	$12,814,988	$72,922,656	$71,347,194	$5,625,773	$5,412,922	$26,555,196	$29,193,962	$26,001,171	$22,558,897	$123,909,726	$124,897,331
Cash and Cash Equivalents	$2,795,549	$3,540,829	$2,795,549	$3,540,829	$541,657	$182,113	$541,657	$182,113	$14,115,498	$10,287,744	$14,115,498	$10,287,744
Net Working Capital	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$22,034,346	$25,718,738	$22,034,346	$25,718,738
Unrestricted Assets	$1,364,644	$10,193,774	$1,364,644	$10,193,774	$12,563,178	$23,532,658	$12,563,178	$23,532,658	$37,485,690	$57,832,005	$37,485,690	$57,832,005
Credit Ratings (S&P, FITCH, and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

OHCA Financial Statistics Report (March FY 2016 and March FY 2015)

	Manchester Memorial Hospital				Rockville General Hospital				Eastern CT Health Network			
	MTD		YTD		MTD		YTD		MTD		YTD	
	March FY 2016	March FY 2015	March FY 2016	March FY 2015	March FY 2016	March FY 2015	March FY 2016	March FY 2015	March FY 2016	March FY 2015	March FY 2016	March FY 2015
A. Operating Performance												
Operating Margin	-2.40%	13.52%	0.38%	3.59%	-7.77%	-9.03%	-6.16%	-0.52%	-3.88%	4.40%	-2.45%	0.07%
Non-Operating Margin	0.34%	-1.09%	-0.42%	-0.66%	1.10%	-0.92%	-0.36%	-0.45%	0.41%	-0.85%	-0.33%	-0.49%
Total Margin	-2.06%	12.43%	-0.05%	2.93%	-6.67%	-9.95%	-6.51%	-0.97%	-3.47%	3.55%	-2.78%	-0.42%
Bad Debt as % of Gross Revenue	2.17%	0.18%	1.64%	0.76%	0.94%	-0.29%	0.92%	0.79%	1.75%	0.07%	1.40%	0.82%
B. Liquidity												
Current Ratio	1.26	1.28	1.26	1.28	1.48	1.62	1.48	1.62	1.53	1.49	1.53	1.49
Days Cash on Hand	47	47	47	46	107	102	102	101	70	71	69	71
Days in Net Accounts Receivable	57	50	55	55	50	59	47	54	52	51	50	53
Average Payment Period	63	65	63	64	50	50	47	50	58	59	57	58
					0							
C. Leverage and Capital Structure												
Long-term Debt to Equity	3.47	1.99	3.47	1.99	1.35	0.86	1.35	0.86	1.51	1.07	1.51	1.07
Long-term Debt to Capitalization	78	67	78	67	58	46	58	46	76	52	76	52
Unrestricted Cash to Debt	0.35	3.39	4.33	7.88	(0.28)	(0.82)	(1.67)	4.05	0.05	1.50	1.10	3.81
Times Interest Earned Ratio	2.21	17.07	4.14	6.84	(1.44)	(2.62)	(0.16)	5.30	0.86	9.34	2.11	4.39
Debt Service Coverage Ratio	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1.06	1.40
Equity Financing Ratio	9.45	16.81	9.45	16.81	26.21	36.66	26.21	36.66	20.79	28.79	20.79	28.79
D. Additional Statistics												
Income from Operations	($364,135)	$2,391,901	$343,857	$3,431,980	($390,250)	($484,731)	($1,920,196)	($178,926)	($1,008,920)	$1,274,585	($3,852,915)	$108,685
Revenue Over/(Under) Expense	($312,094)	$2,199,226	($43,581)	$2,802,073	($334,997)	($534,143)	($2,031,258)	($336,660)	($901,686)	$1,027,537	($4,369,094)	($699,322)
EBITDA	$407,054	$3,150,529	$5,020,726	$8,289,197	($83,791)	($155,704)	($54,739)	$1,810,399	$231,351	$2,514,856	$3,662,935	$7,624,585
Cash from Operations	$15,965,442	$15,273,142	$88,888,098	$86,620,336	$5,737,195	$6,069,379	$32,292,391	$35,263,341	$26,739,615	$26,384,632	$150,649,342	$151,281,963
Cash and Cash Equivalents	$5,964,125	$5,921,692	$5,964,125	$5,921,692	$1,533,320	$1,922,740	$1,533,320	$1,922,740	$19,785,944	$14,322,420	$19,785,944	$14,322,420
Net Working Capital	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$15,533,852	$19,649,222	$15,533,852	$19,649,222
Unrestricted Assets	$2,070,127	$12,023,463	$2,070,127	$12,023,463	$12,770,207	$22,848,732	$12,770,207	$22,848,732	$36,462,098	$59,066,325	$36,462,098	$59,066,325
Credit Ratings (S&P, FITCH, and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

OHCA Financial Statistics Report (October FY 2016 and October FY 2015)

	Manchester Memorial Hospital				Rockville General Hospital				Eastern CT Health Network			
	MTD		YTD		MTD		YTD		MTD		YTD	
	October FY 2016	October FY 2015	October FY 2016	October FY 2015	October FY 2016	October FY 2015	October FY 2016	October FY 2015	October FY 2016	October FY 2015	October FY 2016	October FY 2015
A. Operating Performance												
Operating Margin	3.51%	1.11%	3.51%	1.11%	-12.22%	-0.64%	-12.22%	-0.64%	-1.97%	-0.35%	-1.97%	-0.35%
Non-Operating Margin	-0.90%	-0.93%	-0.90%	-0.93%	-0.47%	-0.67%	-0.47%	-0.67%	-0.64%	-0.69%	-0.64%	-0.69%
Total Margin	2.61%	0.17%	2.61%	0.17%	-12.70%	-1.31%	-12.70%	-1.31%	-2.61%	-1.05%	-2.61%	-1.05%
Bad Debt as % of Gross Revenue	0.63%	0.66%	0.63%	0.66%	0.60%	0.80%	0.60%	0.80%	0.70%	0.76%	0.70%	0.76%
B. Liquidity												
Current Ratio	1.18	1.11	1.18	1.11	1.86	1.82	1.86	1.82	1.48	1.43	1.48	1.43
Days Cash on Hand	41	41	41	41	96	88	96	88	64	67	64	67
Days in Net Accounts Receivable	58	49	58	49	54	53	54	53	55	50	56	50
Average Payment Period	60	61	60	61	32	37	32	37	54	54	54	54
C. Leverage and Capital Structure												
Long-term Debt to Equity	3.26	2.05	3.26	2.05	1.24	0.85	1.24	0.85	1.38	1.09	1.38	1.09
Long-term Debt to Capitalization	77	67	77	67	55	46	55	46	75	66	75	66
Unrestricted Cash to Debt	1.31	0.84	1.31	0.84	(1.41)	0.63	(1.41)	0.63	0.24	0.59	0.24	0.59
Times Interest Earned Ratio	6.62	5.13	6.62	5.13	(5.42)	4.88	(5.42)	4.88	2.61	4.21	2.61	4.21
Debt Service Coverage Ratio	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Equity Financing Ratio	10.26	16.63	10.26	16.63	29.08	38.33	29.08	38.33	22.80	28.92	22.80	28.92
D. Additional Statistics												
Income from Operations	$554,185	$178,673	$554,185	$178,673	($624,549)	($40,097)	($624,549)	($40,097)	($522,871)	($101,391)	($522,871)	($101,391)
Revenue Over/(Under) Expense	$412,522	$28,057	$412,522	$28,057	($648,781)	($82,468)	($648,781)	($82,468)	($692,147)	($298,674)	($692,147)	($298,674)
EBITDA	$1,363,716	$1,033,764	$1,363,716	$1,033,764	($312,933)	$295,442	($312,933)	$295,442	$768,569	$1,271,801	$768,569	$1,271,801
Cash from Operations	$15,452,957	$16,077,536	$15,452,957	$16,077,536	$5,280,181	$6,848,006	$5,280,181	$6,848,006	$26,028,117	$28,483,054	$26,028,117	$28,483,054
Cash and Cash Equivalents	$1,684,265	$2,379,059	$1,684,265	$2,379,059	$348,170	$670,049	$348,170	$670,049	$10,087,005	$11,113,845	$10,087,005	$11,113,845
Net Working Capital	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$21,659,267	$23,289,473	$21,659,267	$23,289,473
Unrestricted Assets	$2,961,600	$11,060,535	$2,961,600	$11,060,535	$14,229,387	$23,492,992	$14,229,387	$23,492,992	$41,250,914	$57,524,881	$41,250,914	$57,524,881
Credit Ratings (S&P, FITCH, and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

OHCA Financial Statistics Report (November FY 2016 and November FY 2015)

	Manchester Memorial Hospital				Rockville General Hospital				Eastern CT Health Network			
	MTD		YTD		MTD		YTD		MTD		YTD	
	November FY 2016	November FY 2015	November FY 2016	November FY 2015	November FY 2016	November FY 2015	November FY 2016	November FY 2015	November FY 2016	November FY 2015	November FY 2016	November FY 2015
A. Operating Performance												
Operating Margin	3.25%	-4.33%	3.38%	-1.44%	-1.81%	0.20%	-6.96%	-0.24%	-0.54%	-3.64%	-1.26%	-1.90%
Non-Operating Margin	0.00%	-1.59%	-0.46%	-1.24%	-0.30%	-1.22%	-0.39%	-0.93%	-0.07%	-1.19%	-0.36%	-0.92%
Total Margin	3.26%	-5.93%	2.93%	-2.69%	-2.11%	-1.02%	-7.35%	-1.17%	-0.61%	-4.83%	-1.62%	-2.83%
Bad Debt as % of Gross Revenue	1.42%	0.68%	1.03%	0.65%	1.44%	0.31%	1.02%	0.57%	1.35%	0.65%	1.02%	0.71%
B. Liquidity												
Current Ratio	1.20	1.10	1.20	1.10	1.75	1.71	1.75	1.71	1.45	1.39	1.45	1.39
Days Cash on Hand	43	45	42	44	104	100	101	96	65	73	65	71
Days In Net Accounts Receivable	61	52	60	50	51	57	52	55	55	52	55	50
Average Payment Period	63	66	62	65	38	46	37	44	57	60	57	59
C. Leverage and Capital Structure												
Long-term Debt to Equity	3.24	2.15	3.24	2.15	1.26	0.84	1.26	0.84	1.39	0.96	1.39	0.96
Long-term Debt to Capitalization	76	68	76	68	56	46	56	46	76	67	76	67
Unrestricted Cash to Debt	1.30	(0.22)	2.59	0.61	0.49	0.71	(0.88)	1.32	0.60	(0.06)	0.84	0.51
Times Interest Earned Ratio	5.86	1.22	6.23	3.17	3.71	5.51	(0.86)	5.21	3.63	1.70	3.12	2.94
Debt Service Coverage Ratio	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Equity Financing Ratio	10.23	15.77	10.23	15.77	28.38	37.99	28.38	37.99	22.40	32.38	22.40	32.38
D. Additional Statistics												
Income from Operations	$484,666	($617,807)	$1,038,851	($439,134)	($94,623)	$11,206	($719,172)	($28,891)	($141,076)	($924,261)	($663,947)	($1,025,652)
Revenue Over/(Under) Expense	$485,190	($845,187)	$897,712	($817,130)	($110,173)	($57,474)	($758,954)	($139,942)	($159,224)	($1,226,090)	($851,371)	($1,524,764)
EBITDA	$1,228,216	$249,367	$2,591,932	$1,283,131	$213,600	$357,458	($99,333)	$652,900	$1,081,351	$524,935	$1,849,920	$1,796,736
Cash from Operations	$13,356,567	$14,014,676	$28,809,524	$30,092,212	$5,149,913	$5,761,100	$10,430,094	$12,609,106	$23,154,591	$24,487,028	$49,182,708	$52,970,081
Cash and Cash Equivalents	$1,845,940	$3,481,745	$1,845,940	$3,481,745	$870,293	$1,473,722	$870,293	$1,473,722	$11,037,049	$13,330,484	$11,037,049	$13,330,484
Net Working Capital	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$21,653,544	$19,750,219	$21,653,544	$19,750,219
Unrestricted Assets	$3,079,176	$9,883,749	$3,079,176	$9,883,749	$13,959,228	$23,752,272	$13,959,228	$23,752,272	$40,845,738	$70,108,676	$40,845,738	$70,108,676
Credit Ratings (S&P, FITCH, and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

OHCA Financial Statistics Report (December FY 2016 and December FY 2015)

	Manchester Memorial Hospital				Rockville General Hospital				Eastern CT Health Network			
	MTD		YTD		MTD		YTD		MTD		YTD	
	December FY 2016	December FY 2015	December FY 2016	December FY 2015	December FY 2016	December FY 2015	December FY 2016	December FY 2015	December FY 2016	December FY 2015	December FY 2016	December FY 2015
A. Operating Performance												
Operating Margin	3.14%	8.83%	3.30%	2.29%	-1.50%	3.52%	-5.05%	1.00%	0.52%	3.66%	-0.65%	0.06%
Non-Operating Margin	-0.87%	0.46%	-0.60%	-0.63%	-1.10%	0.83%	-0.64%	-0.35%	-0.74%	0.44%	-0.49%	-0.45%
Total Margin	2.27%	9.28%	2.70%	1.67%	-2.60%	4.35%	-5.68%	0.64%	-0.22%	4.10%	-1.14%	-0.39%
Bad Debt as % of Gross Revenue	1.30%	0.97%	1.12%	0.76%	1.04%	1.12%	1.03%	0.75%	1.16%	1.07%	1.07%	0.83%
B. Liquidity												
Current Ratio	1.30	1.15	1.30	1.15	1.76	1.73	1.76	1.73	1.60	1.44	1.60	1.44
Days Cash on Hand	38	47	39	47	94	108	95	101	63	72	64	72
Days in Net Accounts Receivable	56	45	57	48	49	53	51	51	52	47	53	49
Average Payment Period	56	65	58	65	37	48	37	45	51	58	52	58
					0							
C. Leverage and Capital Structure												
Long-term Debt to Equity	3.24	2.05	3.24	2.05	1.28	0.84	1.28	0.84	1.40	1.06	1.40	1.06
Long-term Debt to Capitalization	76	67	76	67	56	46	56	46	76	65	76	65
Unrestricted Cash to Debt	1.22	2.69	3.86	3.30	0.40	1.67	(0.48)	2.99	0.73	1.64	1.59	2.16
Times Interest Earned Ratio	5.85	11.61	6.10	5.96	4.07	8.58	0.78	6.34	4.53	7.72	3.61	4.53
Debt Service Coverage Ratio	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Equity Financing Ratio	10.37	16.35	10.37	16.35	27.98	37.97	27.98	37.97	22.73	29.09	22.73	29.09
D. Additional Statistics												
Income from Operations	$505,704	$1,534,223	$1,544,555	$1,095,089	($83,842)	$205,743	($803,014)	$176,852	$143,984	$1,074,991	($519,963)	$49,339
Revenue Over/(Under) Expense	$365,418	$1,613,504	$1,263,130	$796,374	($145,178)	$254,076	($904,132)	$114,134	($62,229)	$1,203,242	($913,600)	($321,522)
EBITDA	$1,305,554	$2,322,428	$3,897,486	$3,605,559	$234,004	$542,956	$134,671	$1,195,856	$1,422,507	$2,337,616	$3,272,427	$4,134,352
Cash from Operations	$15,466,368	$14,643,053	$44,275,892	$44,735,265	$5,476,070	$5,989,154	$15,906,164	$18,598,260	$26,352,822	$25,757,209	$75,535,530	$78,727,290
Cash and Cash Equivalents	$2,504,593	$4,699,318	$2,504,593	$4,699,318	$474,590	$1,950,314	$474,590	$1,950,314	$14,328,446	$14,119,287	$14,328,446	$14,119,287
Net Working Capital	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$21,890,691	$18,384,525	$21,890,691	$18,384,525
Unrestricted Assets	$3,089,534	$11,027,298	$3,089,534	$11,027,298	$13,672,423	$23,806,253	$13,672,423	$23,806,253	$40,751,104	$59,337,036	$40,751,104	$59,337,036
Credit Ratings (S&P, FITCH, and Moody's)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

18. Revised/Updated Exhibit R – PMH Free Cash Flow

Please see attached.

Prospect Medical Holdings
Free Cash Flow

	FYE 9/30/2015	TTM 12/31/15
Operating Income	$ 108,060,000	$ 87,966,000
Change in WC (Increase)	$ 34,374,000	$ 63,971,000
Taxes Paid	$ (35,778,000)	$ (38,367,000)
Net Change in PP&E	$ (10,863,000)	$ (11,459,000)
Free Cash Flow	$ 95,793,000	$ 102,111,000
Average Monthly Free cash Flow	**$ 7,982,750**	**$ 8,509,250**

Greer, Leslie

From: Martone, Kim
Sent: Wednesday, April 27, 2016 12:13 PM
To: Greer, Leslie
Subject: FW: Docket Numbers: 15-32016-486 and 15-486-01 - Late File #19
Attachments: Docket Numbers 15-32016-486 and 15-486-01 - Late File #19.pdf; Docket Numbers 15-32016-486 and 15-486-01 - Late File #19.xlsx

---

From: Kathleen Gedney [mailto:kgg@bvmlaw.com]
Sent: Wednesday, April 27, 2016 12:03 PM
To: Hawes, Gary W.; Hansted, Kevin; Lazarus, Steven
Cc: Martone, Kim; Zinn-Rowthorn, Perry A.; Cotto, Carmen; Michele Volpe; Jennifer O'Donnell
Subject: FW: Docket Numbers: 15-32016-486 and 15-486-01 - Late File #19

Good Morning:

Please confirm receipt of Late File #19 in connection to the above-referenced docket.

Thank you,

Kathleen Gedney-Tommaso
Attorney at Law
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor
New Haven, CT 06511
Tel: (203) 859-6238
Fax: (203) 777-5806
Email: kgg@bvmlaw.com

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From: Kathleen Gedney
Sent: Tuesday, April 26, 2016 2:13 PM
To: 'Gary.hawes@ct.gov' <Gary.hawes@ct.gov>; 'kevin.hansted@ct.gov' <kevin.hansted@ct.gov>; 'Steven.Lazarus@ct.gov' <Steven.Lazarus@ct.gov>
Cc: 'Kimberly.Martone@ct.gov' <Kimberly.Martone@ct.gov>; 'Perry.zinn-rowthorn@ct.gov' <Perry.zinn-rowthorn@ct.gov>; 'carmen.cotto@ct.gov' <carmen.cotto@ct.gov>; Mcconville, Dennis P <dmcconville@echn.org>; 'thomas.reardon@prospectmedical.com' <thomas.reardon@prospectmedical.com>; 'frank.saidara@prospectmedical.com' <frank.saidara@prospectmedical.com>; 'jonathan.spees@prospectmedical.com' <jonathan.spees@prospectmedical.com>; 'jtichy@echn.org' <jtichy@echn.org>; 'RMatthews@wiggin.com' <RMatthews@wiggin.com>; 'MAgsten@wiggin.com' <MAgsten@wiggin.com>; Jennifer O'Donnell <jlo@bvmlaw.com>; Michele Volpe <mmv@bvmlaw.com>
Subject: Docket Numbers: 15-32016-486 and 15-486-01 - Late File #19

Good Afternoon:

Attached please find Late File #19 in connection to the above-referenced docket. We have provided this in both PDF and Excel format.

Please do not hesitate to call if you have questions.

Thank you,

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Attorney at Law
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Revised Exhibit W

Entity	EBITDA			Working Capital			Stockholder's Equity			
	Year Prior to Acquisition	FY 2014	FY 2015	Year Prior to Acquisition	FY 2014	FY 2015	Year Prior to Acquisition	FY 2014	FY 2015	
Nix	$ 14,904,666	$ 18,410,889	$ 8,043,349	$ 5,937,386	$ 36,785,183	$ 35,449,130	$ 13,122,391	$ 20,468,235	$ 63,789,134	(a)
Roger Williams Medical Center	$ 3,942,531	$ 1,582,573	$ 9,080,029	$ (1,859,668)	$ 1,114,068	$ 6,229,906	$ 37,183,669	$ 34,098,847	$ 38,256,443	(b)
Our Lady of Fatima Hospital	$ (893,187)	$ 508,563	$ 6,485,338	$ 1,904,480	$ 2,039,870	$ 3,432,993	$ (57,150,507)	$ 27,512,830	$ 28,106,736	(c)
East Orange General Hospital	$ (4,525,452)	N/A	N/A	$ (21,303,417)	N/A	N/A	$ (5,618,128)	N/A	N/A	(d)

(a) - EBITDA of Nix prior to acquisition is based on reported trailing twelve months ended on 1/31/2011
- Working Capital of Nix prior to acquisition is as of 1/31/2011 and includes cash which was not part of assets acquired by Prospect
- The Working Capital for FY2015 for Nix in 2015 previously reported under Exhibit 37a to first round of completeness questions excluded certain intercompany adjustments. Working Capital reported in this Exhibit is inclusive of intercompany adjustments
- The net benefit of Government supplemental payments in FY2014 was higher than average, while the net benefit of Government Supplemental Payments in FY2015 was below average From an operational perspective, the performance of Nix was slightly better in FY 2015 than FY 2014

(b) - EBITDA for Roger Williams Medical Center for Year Prior to Acquisition is only for 8 months ending on May 31, 2014
- EBITDA for Roger Williams Medical Center for FY2014 is only for three months post acquisition for FYE 9/30/2014
- Working Capital of Roger Williams Medical Center prior to acquisition is as of 5/31/2014 and includes cash which was not part of assets acquired by Prospect
- As Roger Williams Medical Center prior to the acquisition was a non-profit organization, Net Assets are used as a substitute for Stockholder's Equity
- All data reported in Exhibit 37a to first round of completeness questions with respect to Roger Williams were reported on a consolidated basis for the CharterCARE system which includes additional entities other than Roger Williams Medical Center and Our Lady of Fatima Hospital.

(c) - EBITDA for Our Lady of Fatima Hospital for Year Prior to Acquisition is only for 8 months ending on May 31, 2014
- EBITDA for Our Lady of Fatima Hospital for FY2014 is only for three months post acquisition for FYE 9/30/2014
- Working Capital of Our Lady of Fatima Hospital prior to acquisition is as of 5/31/2014 and includes cash which was not part of assets acquired by Prospect
- As Our Lady of Fatima Hospital prior to the acquisition was a non-profit organization, therefore Net Assets are used as a substitute for Stockholder's Equity
- All data reported in Exhibit 37a to first round of completeness questions with respect to Our Lady of Fatima were reported on a consolidated basis for the CharterCARE system which includes additional entities other than Roger Williams Medical Center and Our Lady of Fatima Hospital.

(d) East Orange General Hospital was acquired on March 1, 2016. As such there are no subsequent periods that EBITDA may be reported as of this date
It should be noted that as of March 1, 2016, the date of acquistion, the Working Capital of East Orange General Hospital was $3,660,164 and Stockholder Equity was $32,718,610
EBITDA of East Orange General Hospital is for fiscal year ended on 12/31/2015. Net Assets are used as a substitute for Stockholders' Equity.
Working Capital and Stockholders Equity is as 2/29/2016

Greer, Leslie

From: Cotto, Carmen
Sent: Thursday, May 05, 2016 2:52 PM
To: Michele Volpe (michelemvolpe@aol.com); 'Matthews, Rebecca'
Cc: Martone, Kim; Hansted, Kevin; Lazarus, Steven; Greer, Leslie
Subject: ECHN's Late Files Follow up Questions

Importance: High

Hi Michele,

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Thank you,

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Associate Health Care Analyst
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Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov



www.ct.gov/dph

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Please also address the following in reference to Section B below, Late file#18:

4. Testimony of Mr. Steven Aleman on 3/29/16, pp.151-153, indicated that PMH is generating anywhere between $10 to $15 Million of free cash flow on a monthly basis. The free cash flow data submitted does not support the statement and provides data as of December 2015 not March 2016, please explain.

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Greer, Leslie

From: Kathleen Gedney <kgg@bvmlaw.com>
Sent: Friday, May 06, 2016 11:36 AM
To: Cotto, Carmen
Cc: Martone, Kim; Hansted, Kevin; Lazarus, Steven; Greer, Leslie; Michele Volpe; 'RMatthews@wiggin.com'; Jennifer O'Donnell
Subject: ECHN's Late Files Follow up Questions

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Good Morning Ms. Gedney:

Yes, you can have until Monday, before noon time, to submit the responses.

Carmen

Carmen Cotto, MBA
Associate Health Care Analyst
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Connecticut Department of Public Health

410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134

P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov

www.ct.gov/dph

Greer, Leslie

From: Kathleen Gedney <kgg@bvmlaw.com>
Sent: Friday, May 06, 2016 12:00 PM
To: Cotto, Carmen
Cc: Martone, Kim; Hansted, Kevin; Lazarus, Steven; Greer, Leslie; Michele Volpe; 'RMatthews@wiggin.com'; Jennifer O'Donnell
Subject: RE: ECHN's Late Files Follow up Questions

Thank you and we appreciate the extension. Please recognize that PMH is located on the west coast and is three hours behind.

Regards,

Kathleen Gedney-Tommaso
Attorney at Law
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor
New Haven, CT 06511
Tel: (203) 859-6238
Fax: (203) 777-5806
Email: kgg@bvmlaw.com

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From: Cotto, Carmen [mailto:Carmen.Cotto@ct.gov]
Sent: Friday, May 06, 2016 11:53 AM
To: Kathleen Gedney <kgg@bvmlaw.com>
Cc: Martone, Kim <Kimberly.Martone@ct.gov>; Hansted, Kevin <Kevin.Hansted@ct.gov>; Lazarus, Steven <Steven.Lazarus@ct.gov>; Greer, Leslie <Leslie.Greer@ct.gov>; Michele Volpe <mmv@bvmlaw.com>; 'RMatthews@wiggin.com' <RMatthews@wiggin.com>; Jennifer O'Donnell <jlo@bvmlaw.com>
Subject: RE: ECHN's Late Files Follow up Questions

Good Morning Ms. Gedney:

Yes, you can have until Monday, before noon time, to submit the responses.

Carmen

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov



www.ct.gov/dph

From: Kathleen Gedney [mailto:kgg@bvmlaw.com]
Sent: Friday, May 06, 2016 11:36 AM
To: Cotto, Carmen
Cc: Martone, Kim; Hansted, Kevin; Lazarus, Steven; Greer, Leslie; Michele Volpe; 'RMatthews@wiggin.com'; Jennifer O'Donnell
Subject: ECHN's Late Files Follow up Questions

Good Morning Ms. Cotto:

Prospect Medical Holdings, Inc. ("PMH") is in receipt of the additional questions below and is compiling its responses. However, PMH will not be able to submit by 3pm today. We kindly request an extension to the filing deadline and anticipate that the information will ready for submission on Monday. Please confirm this is acceptable.

Thank you,

Kathleen Gedney-Tommaso
Attorney at Law
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor
New Haven, CT 06511
Tel: (203) 859-6238
Fax: (203) 777-5806
Email: kgg@bvmlaw.com

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From: Cotto, Carmen [mailto:Carmen.Cotto@ct.gov]
Sent: Thursday, May 05, 2016 4:08 PM
To: Michele Volpe (michelemvolpe@aol.com); Matthews, Rebecca
Cc: Martone, Kim; Hansted, Kevin; Lazarus, Steven; Greer, Leslie
Subject: RE: ECHN's Late Files Follow up Questions

Hi Michele,

Please also address the following in reference to Section B below, Late file#18:

4. Testimony of Mr. Steven Aleman on 3/29/16, pp.151-153, indicated that PMH is generating anywhere between $10 to $15 Million of free cash flow on a monthly basis. The free cash flow data submitted does not support the statement and provides data as of December 2015 not March 2016, please explain.

Thank you,

Carmen Cotto, MBA

Associate Health Care Analyst

Office of Health Care Access

Connecticut Department of Public Health

410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134

P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov

www.ct.gov/dph

From: Cotto, Carmen
Sent: Thursday, May 05, 2016 2:52 PM
To: Michele Volpe (michelemvolpe@aol.com); 'Matthews, Rebecca'
Cc: Martone, Kim; Hansted, Kevin; Lazarus, Steven; Greer, Leslie
Subject: ECHN's Late Files Follow up Questions
Importance: High

Hi Michele,

We have some follow up questions related to the financial information submitted through late files 17, 18 and 19. In reference to these late files please address the following and provide responses by 3:00 pm tomorrow, Friday, May 6, 2016:

A. Late file# 17, Quarterly Data Report, p. 4363:

From the table below, explain the variance between what was submitted for Cash from Operations, Section D of the Report vs ECHN's AFS for FY 2015 and FY 2014 on file at OHCA.

Cash From Operations	Late File	OHCA's Records	Variance
FY 2014	$305,647,840	$7,904,018	$297,743,822
FY 2015	$300,257,422	$3,002,684	$297,254,738

B. Late File#18, Free Cash Flow, p.4371:

The amount listed as "Change in WC (Increase)", which OHCA assumes relates to Working Capital does not reconcile with the difference between Total Current Assets and Total Current Liabilities at $25,711,000. However, it reconciles with the amount listed on page 7 of PMH's Audited Financial Statements for Depreciation and Amortization. In reference to this and the numbers provided for TTM 12/31/15, please address the following:

1. Reconcile the amount in total of $34,374,000 with PMH's AFS.
2. Confirm that the acronym for "WC" stands for Working Capital.
3. Provide the source for the 12/31/15 data and indicate what the acronym "TTM" stands for.

C. Late file# 19, Revised Exhibit W, p.4372:

1. For the entity NIX, provide an explanation for the $10.4 million decrease in EBITDA.

2. If the reason for the decrease relates to the net benefit of Government Supplemental Payments (GSP) referred to in the footnotes, indicate what caused these payments to be higher than average in FY 2014 and below average in FY 2015.

3. Provide the GSP's totals for FYs 2014 and 2015 and the total average amount used as the basis to contrast the amounts.

Thank you,

Carmen Cotto, MBA

Associate Health Care Analyst

Office of Health Care Access

Connecticut Department of Public Health

410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134

P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov



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Greer, Leslie

From: Matthews, Rebecca <RMatthews@wiggin.com>
Sent: Monday, May 09, 2016 3:18 PM
To: Kathleen Gedney; Cotto, Carmen
Cc: Martone, Kim; Hansted, Kevin; Lazarus, Steven; Greer, Leslie; Michele Volpe; Jennifer O'Donnell; Agsten, Melinda A.; Dennis P. McConville (dmcconville@echn.org)
Subject: RE: ECHN's Late Files Follow up Questions

Dear Carmen:

Please find below the response to your question A. in your email of Thursday, May 5, 2016. As referenced in the emails from Kate Gedney below, PMH is still working on its responses (and is 3 hours behind on the West Coast). PMH will forward it responses to you as soon as available. We thank you for your patience and understanding.

A. Late file # 17, Quarterly Data Report, p. 4363:

From the table below, explain the variance between what was submitted for Cash from Operations, Section D of the Report vs ECHN's AFS for FY 2015 and FY 2014 on file at OHCA.

Cash From Operations	Late File	OHCA's Records	Variance
FY 2014	$305,647,840	$7,904,018	$297,743,822
FY 2015	$300,257,422	$3,002,684	$297,254,738

Response:

The figures provided in Late File # 17 represent total cash collected by the entire ECHN system in the relevant years. The figures from OHCA's records (and from ECHN's AFS for FY 2015 and FY 2014) represent the net of cash incoming and outgoing activity via the Consolidated Statements of Cash Flows.

The drop of $5,000,000 in the AFS cash flows figure is directly related to declining operational performance in FY 2015 vs. FY 2014. Some of the financial loss from operations in FY 2015 was mitigated by the release of general reserves on the balance sheet that were set aside in the prior year.

Please do not hesitate to contact me if you have questions or need additional information.

-Rebecca

Rebecca A. Matthews
Direct: 203.498.4502 | rmatthews@wiggin.com

Greer, Leslie

From: Jennifer O'Donnell <jlo@bvmlaw.com>
Sent: Monday, May 09, 2016 4:22 PM
To: Cotto, Carmen
Cc: Martone, Kim; Hansted, Kevin; Lazarus, Steven; Greer, Leslie; Michele Volpe; Agsten, Melinda A.; Dennis P. McConville (dmcconville@echn.org); Kathleen Gedney; RMatthews@wiggin.com; 'Frank Saidara <Frank.Saidara@prospectmedical.com> (Frank.Saidara@prospectmedical.com)'; Jonathan Spees
Subject: RE: ECHN's Late Files Follow up Questions
Attachments: Late File Response 5 9 16.xlsx

Ms. Cotto: Attached please find PMH's responses to the questions in your email of May 5, 2016. Please let us know if you have any questions or need anything further. Thank you.

Jennifer L. O'Donnell
Paralegal
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor
New Haven, Connecticut 06511-6957
Telephone: (203) 777-5800 (ext. 104)
Direct Line: (203) 777-5804
Facsimile: (203) 777-5806

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From: Cotto, Carmen [mailto:Carmen.Cotto@ct.gov]
Sent: Monday, May 9, 2016 3:41 PM
To: Matthews, Rebecca <RMatthews@wiggin.com>
Cc: Martone, Kim <Kimberly.Martone@ct.gov>; Hansted, Kevin <Kevin.Hansted@ct.gov>; Lazarus, Steven <Steven.Lazarus@ct.gov>; Greer, Leslie <Leslie.Greer@ct.gov>; Michele Volpe <mmv@bvmlaw.com>; Jennifer O'Donnell <jlo@bvmlaw.com>; Agsten, Melinda A. <MAgsten@wiggin.com>; Dennis P. McConville (dmcconville@echn.org) <dmcconville@echn.org>; Kathleen Gedney <kgg@bvmlaw.com>
Subject: RE: ECHN's Late Files Follow up Questions

Dear Rebecca,

Thank you for the update.

A. Late File#18, Free Cash Flow, p.4371:

The amount listed as "Change in WC (Increase)", which OHCA assumes relates to Working Capital does not reconcile with the difference between Total Current Assets and Total Current Liabilities at $25,711,000. However, it reconciles with the amount listed on page 7 of PMH's Audited Financial Statements for Depreciation and Amortization. In reference to this and the numbers provided for TTM 12/31/15, please address the following:

1. Reconcile the amount in total of $34,374,000 with PMH's AFS.

		FYE 9/30/2015	
Op Inc		108,060,000	Pg 7 AFS 9/2015
Change In WC			
2015 CA <CL>	25,711		Pg 5 & 6 AFS 9/2015
2014 CA <CL>	76,922		Pg 5 & 6 AFS 9/2014
	51,211,000	51,211,000	
Taxes Paid		(35,778,000)	Pg 7 AFS 9/2015
Net Changes in PPE		(10,863,000)	Pg 5 AFS 9/2015
		$ 112,630,000	
Average Free Monthly Cash Flow		$ 9,385,833	

2. Confirm that the acronym for "WC" stands for Working Capital.
   Yes: Working capital

3. Provide the source for the 12/31/15 data and indicate what the acronym "TTM" stands for.
   Trailing Twelve Months

B. Late file# 19, Revised Exhibit W, p.4372:

1. For the entity NIX, provide an explanation for the $10.4 million decrease in EBITDA.

The decrease was primarily driven by the fluction in net reimbursement in the 1115 Waiver program from 2014 to 2015. The 1115 waiver program is comprised of two forms of reimbursement, DSRIP and Uncompensated Care payments, which for anlaytical purposes are netted down by payments made to the Service Oranzation of San Antiono "SOSA" (to fund community benefit programs.) Funding to SOSA is voluntary but it is projected to average approximately $12M a year based on budgeted spending initiatives of the service organization. In 2014 the funding requirements were $5.7M (lower by approximately $6.3M) and in 2015 funding requirements returned to $12M. The remaining difference was comprised of lower volume at the facility as services were reconfigured at the facility and medical staff turnover occurred due to a strategic initiative implemented to better align services with community needs and move the facility from priamrily a referral based facility.

2. If the reason for the decrease relates to the net benefit of Government Supplemental Payments (GSP) referred to in the footnotes, indicate what caused these payments to be higher than average in FY 2014 and below average in FY 2015.

See response to B.1 Late file #19 (previous inquiry)

3. Provide the GSP's totals for FYs 2014 and 2015 and the total average amount used as the basis to contrast the amounts.

2014 Net Benefit: Approximately $27.1M of 1115 waiver revenue offset by ~ $5.7M of SOSA funding
2015 Net Benefit: Approximately $26.7M of 1115 waiver revenue offset by ~ $12M of SOSA funding

Net benefit of the program through December 2017 projected to remain at 2015 levels

Greer, Leslie

From: Cotto, Carmen
Sent: Monday, May 09, 2016 6:38 PM
To: Jennifer O'Donnell
Cc: Martone, Kim; Hansted, Kevin; Lazarus, Steven; Greer, Leslie; Michele Volpe; Agsten, Melinda A.; Dennis P. McConville (dmcconville@echn.org); Kathleen Gedney; RMatthews@wiggin.com; 'Frank Saidara <Frank.Saidara@prospectmedical.com> (Frank.Saidara@prospectmedical.com)'; Jonathan Spees
Subject: RE: ECHN's Late Files Follow up Questions

Ms. O'Donnell,

The document failed to respond to a question listed as number four in a matter related to Late file #18. It was sent as a separate email also on May 5, 2016. For your reference, please see email below highlighted in yellow .

Our request was to please also address the following in reference to Late file#18:

4. Testimony of Mr. Steven Aleman on 3/29/16, pp.151-153, indicated that PMH is generating anywhere between $10 to $15 Million of free cash flow on a monthly basis. The free cash flow data submitted does not support the statement and provides data as of December 2015 not March 2016, please explain.

Thank you,
Carmen

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov

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From: Cotto, Carmen
Sent: Monday, May 09, 2016 6:02 PM
To: 'Jennifer O'Donnell'
Cc: Martone, Kim; Hansted, Kevin; Lazarus, Steven; Greer, Leslie; Michele Volpe; Agsten, Melinda A.; Dennis P. McConville (dmcconville@echn.org); Kathleen Gedney; RMatthews@wiggin.com; 'Frank Saidara

Greer, Leslie

From: Cotto, Carmen
Sent: Tuesday, May 10, 2016 11:40 AM
To: Michele Volpe
Cc: Jennifer O'Donnell; Martone, Kim; Hansted, Kevin; Lazarus, Steven; Greer, Leslie; Agsten, Melinda A.; Dennis P. McConville (dmcconville@echn.org); Kathleen Gedney; RMatthews@wiggin.com; Frank Saidara <Frank.Saidara@prospectmedical.com> (Frank.Saidara@prospectmedical.com); Jonathan Spees
Subject: RE: ECHN's Late Files Follow up Questions

Thank you Michele. I do have one more question that perhaps ECHN members could answer today.

In reference to late file# 8, Net Proceeds table, p.4261, the document did not provide an amount for the "Legacy ECHN" under FY 9/30/15, please provide the missing information. In addition, for the new entry and the $2,139,000, provide the calculation in a simple formula , as it is presented in column 3.

Thank you,
Carmen

From: Michele Volpe [mailto:mmv@bvmlaw.com]
Sent: Tuesday, May 10, 2016 9:09 AM
To: Cotto, Carmen
Cc: Jennifer O'Donnell; Martone, Kim; Hansted, Kevin; Lazarus, Steven; Greer, Leslie; Agsten, Melinda A.; Dennis P. McConville (dmcconville@echn.org); Kathleen Gedney; RMatthews@wiggin.com; Frank Saidara <Frank.Saidara@prospectmedical.com> (Frank.Saidara@prospectmedical.com); Jonathan Spees
Subject: Re: ECHN's Late Files Follow up Questions

Thank you Carmen. We are following up with Prospect on this question and hope to be responsive to you as soon as possible. Thanks for your patience.

Michele M. Volpe
Bershtein, Volpe & McKeon P.C
105 Court Street
New Haven, CT 06511
Phone: (203) 777-6995
Fax: (203) 777-5806

On May 9, 2016, at 6:38 PM, Cotto, Carmen <Carmen.Cotto@ct.gov> wrote:

> Ms. O'Donnell,
>
> The document failed to respond to a question listed as number four in a matter related to Late file #18. It was sent as a separate email also on May 5, 2016. For your reference, please see email below highlighted in yellow .
>
> Our request was to please also address the following in reference to Late file#18:

Greer, Leslie

From: Matthews, Rebecca <RMatthews@wiggin.com>
Sent: Tuesday, May 10, 2016 8:27 PM
To: Cotto, Carmen
Cc: Jennifer O'Donnell; Martone, Kim; Hansted, Kevin; Lazarus, Steven; Greer, Leslie; Agsten, Melinda A.; Dennis P. McConville (dmcconville@echn.org); Kathleen Gedney; Frank Saidara <Frank.Saidara@prospectmedical.com> (Frank.Saidara@prospectmedical.com); Jonathan Spees; Michele Volpe; Veillette, Michael; Joyce Tichy
Subject: RE: ECHN's Late Files Follow up Questions

Dear Carmen:

In response to your questions below:

1. In reference to late file# 8, Net Proceeds table, p.4261, the amount that should have been reported under the 9/30/15 column for "Legacy ECHN" is $2,229,000.
2. With respect entry of $2,139,000 referenced below, there is not a specific formula for this figure. The amount is pulled from the net of various balance sheet accounts that will not be part of the acquisition – all third party receivables and third party payables that will settle up over the next 3 years.

Please let us know if you have any additional questions or need additional information.

-Rebecca

Rebecca A. Matthews
Direct: 203.498.4502 | rmatthews@wiggin.com

WIGGIN AND DANA
Connecticut | New York | Philadelphia | Washington, DC | www.wiggin.com

---

From: Cotto, Carmen [mailto:Carmen.Cotto@ct.gov]
Sent: Tuesday, May 10, 2016 11:40 AM
To: Michele Volpe
Cc: Jennifer O'Donnell; Martone, Kim; Hansted, Kevin; Lazarus, Steven; Greer, Leslie; Agsten, Melinda A.; Dennis P. McConville (dmcconville@echn.org); Kathleen Gedney; Matthews, Rebecca; Frank Saidara <Frank.Saidara@prospectmedical.com> (Frank.Saidara@prospectmedical.com); Jonathan Spees
Subject: RE: ECHN's Late Files Follow up Questions

Thank you Michele. I do have one more question that perhaps ECHN members could answer today.

In reference to late file# 8, Net Proceeds table, p.4261, the document did not provide an amount for the "Legacy ECHN" under FY 9/30/15, please provide the missing information. In addition, for the new entry and the $2,139,000, provide the calculation in a simple formula , as it is presented in column 3.

Thank you,
Carmen

Greer, Leslie

From: Matthews, Rebecca <RMatthews@wiggin.com>
Sent: Wednesday, May 11, 2016 9:10 AM
To: Cotto, Carmen
Cc: Jennifer O'Donnell; Martone, Kim; Hansted, Kevin; Lazarus, Steven; Greer, Leslie; Agsten, Melinda A.; Dennis P. McConville (dmcconville@echn.org); Kathleen Gedney; Frank Saidara <Frank.Saidara@prospectmedical.com> (Frank.Saidara@prospectmedical.com); Jonathan Spees; Michele Volpe; Veillette, Michael; Joyce Tichy
Subject: RE: ECHN's Late Files Follow up Questions

Good morning, Carmen. I will follow up with counsel to PMH on the response to the pending question of related to Late file #18 ("Testimony of Mr. Steven Aleman on 3/29/16, pp.151-153, indicated that PMH is generating anywhere between $10 to $15 Million of free cash flow on a monthly basis. The free cash flow data submitted does not support the statement and provides data as of December 2015 not March 2016, please explain."). I understand that PMH is in the process of preparing the response.

Thank you.
-Rebecca

Rebecca A. Matthews
Direct: 203.498.4502 | rmatthews@wiggin.com

WIGGIN AND DANA
Connecticut | New York | Philadelphia | Washington, DC | www.wiggin.com

---

From: Cotto, Carmen [mailto:Carmen.Cotto@ct.gov]
Sent: Wednesday, May 11, 2016 9:06 AM
To: Matthews, Rebecca
Cc: Jennifer O'Donnell; Martone, Kim; Hansted, Kevin; Lazarus, Steven; Greer, Leslie; Agsten, Melinda A.; Dennis P. McConville (dmcconville@echn.org); Kathleen Gedney; Frank Saidara <Frank.Saidara@prospectmedical.com> (Frank.Saidara@prospectmedical.com); Jonathan Spees; Michele Volpe; Veillette, Michael; Joyce Tichy
Subject: RE: ECHN's Late Files Follow up Questions

Thank you Rebecca.

Could you please also provide us with the status of the response for the question that it still pending?

Carmen

From: Matthews, Rebecca [mailto:RMatthews@wiggin.com]
Sent: Tuesday, May 10, 2016 8:27 PM
To: Cotto, Carmen
Cc: Jennifer O'Donnell; Martone, Kim; Hansted, Kevin; Lazarus, Steven; Greer, Leslie; Agsten, Melinda A.; Dennis P. McConville (dmcconville@echn.org); Kathleen Gedney; Frank Saidara <Frank.Saidara@prospectmedical.com> (Frank.Saidara@prospectmedical.com); Jonathan Spees; Michele Volpe; Veillette, Michael; Joyce Tichy
Subject: RE: ECHN's Late Files Follow up Questions

Dear Carmen:

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-Rebecca

Rebecca A. Matthews
Direct: 203.498.4502 | rmatthews@wiggin.com

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Connecticut | New York | Philadelphia | Washington, DC | www.wiggin.com

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From: Cotto, Carmen [mailto:Carmen.Cotto@ct.gov]
Sent: Tuesday, May 10, 2016 11:40 AM
To: Michele Volpe
Cc: Jennifer O'Donnell; Martone, Kim; Hansted, Kevin; Lazarus, Steven; Greer, Leslie; Agsten, Melinda A.; Dennis P. McConville (dmcconville@echn.org); Kathleen Gedney; Matthews, Rebecca; Frank Saidara <Frank.Saidara@prospectmedical.com> (Frank.Saidara@prospectmedical.com); Jonathan Spees
Subject: RE: ECHN's Late Files Follow up Questions

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Thank you,
Carmen

From: Michele Volpe [mailto:mmv@bvmlaw.com]
Sent: Tuesday, May 10, 2016 9:09 AM
To: Cotto, Carmen
Cc: Jennifer O'Donnell; Martone, Kim; Hansted, Kevin; Lazarus, Steven; Greer, Leslie; Agsten, Melinda A.; Dennis P. McConville (dmcconville@echn.org); Kathleen Gedney; RMatthews@wiggin.com; Frank Saidara <Frank.Saidara@prospectmedical.com> (Frank.Saidara@prospectmedical.com); Jonathan Spees
Subject: Re: ECHN's Late Files Follow up Questions

Thank you Carmen. We are following up with Prospect on this question and hope to be responsive to you as soon as possible. Thanks for your patience.

Michele M. Volpe
Bershtein, Volpe & McKeon P.C

105 Court Street
New Haven, CT 06511
Phone: (203) 777-6995
Fax: (203) 777-5806

On May 9, 2016, at 6:38 PM, Cotto, Carmen <Carmen.Cotto@ct.gov> wrote:

> Ms. O'Donnell,
>
> The document failed to respond to a question listed as number four in a matter related to Late file #18. It was sent as a separate email also on May 5, 2016. For your reference, please see email below highlighted in yellow .
>
> Our request was to please also address the following in reference to Late file#18:
> 4. Testimony of Mr. Steven Aleman on 3/29/16, pp.151-153, indicated that PMH is generating anywhere between $10 to $15 Million of free cash flow on a monthly basis. The free cash flow data submitted does not support the statement and provides data as of December 2015 not March 2016, please explain.
>
> Thank you,
> Carmen
>
> Carmen Cotto, MBA
> Associate Health Care Analyst
> Office of Health Care Access
> Connecticut Department of Public Health
> 410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
> P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov
>
> <image001.png>
> www.ct.gov/dph

From: Cotto, Carmen
Sent: Monday, May 09, 2016 6:02 PM
To: 'Jennifer O'Donnell'
Cc: Martone, Kim; Hansted, Kevin; Lazarus, Steven; Greer, Leslie; Michele Volpe; Agsten, Melinda A.; Dennis P. McConville (dmcconville@echn.org); Kathleen Gedney; RMatthews@wiggin.com; 'Frank Saidara <Frank.Saidara@prospectmedical.com> (Frank.Saidara@prospectmedical.com)'; Jonathan Spees
Subject: RE: ECHN's Late Files Follow up Questions

Ms. O'Donnell,

Thank you.

Carmen

Carmen Cotto, MBA

Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov

www.ct.gov/dph

From: Jennifer O'Donnell [mailto:jlo@bvmlaw.com]
Sent: Monday, May 09, 2016 4:22 PM
To: Cotto, Carmen
Cc: Martone, Kim; Hansted, Kevin; Lazarus, Steven; Greer, Leslie; Michele Volpe; Agsten, Melinda A.; Dennis P. McConville (dmcconville@echn.org); Kathleen Gedney; RMatthews@wiggin.com; 'Frank Saidara <Frank.Saidara@prospectmedical.com> (Frank.Saidara@prospectmedical.com)'; Jonathan Spees
Subject: RE: ECHN's Late Files Follow up Questions

Ms. Cotto: Attached please find PMH's responses to the questions in your email of May 5, 2016. Please let us know if you have any questions or need anything further. Thank you.

Jennifer L. O'Donnell
Paralegal
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor
New Haven, Connecticut 06511-6957
Telephone: (203) 777-5800 (ext. 104)
Direct Line: (203) 777-5804
Facsimile: (203) 777-5806

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From: Cotto, Carmen [mailto:Carmen.Cotto@ct.gov]
Sent: Monday, May 9, 2016 3:41 PM
To: Matthews, Rebecca <RMatthews@wiggin.com>
Cc: Martone, Kim <Kimberly.Martone@ct.gov>; Hansted, Kevin <Kevin.Hansted@ct.gov>; Lazarus, Steven <Steven.Lazarus@ct.gov>; Greer, Leslie <Leslie.Greer@ct.gov>; Michele Volpe <mmv@bvmlaw.com>; Jennifer O'Donnell <jlo@bvmlaw.com>; Agsten, Melinda A. <MAgsten@wiggin.com>; Dennis P. McConville (dmcconville@echn.org) <dmcconville@echn.org>;

Kathleen Gedney <kgg@bvmlaw.com>
Subject: RE: ECHN's Late Files Follow up Questions

Dear Rebecca,

Thank you for the update.

Carmen

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov

<image001.png>
www.ct.gov/dph

From: Matthews, Rebecca [mailto:RMatthews@wiggin.com]
Sent: Monday, May 09, 2016 3:18 PM
To: Kathleen Gedney; Cotto, Carmen
Cc: Martone, Kim; Hansted, Kevin; Lazarus, Steven; Greer, Leslie; Michele Volpe; Jennifer O'Donnell; Agsten, Melinda A.; Dennis P. McConville (dmcconville@echn.org)
Subject: RE: ECHN's Late Files Follow up Questions

Dear Carmen:

Please find below the response to your question A. in your email of Thursday, May 5, 2016. As referenced in the emails from Kate Gedney below, PMH is still working on its responses (and is 3 hours behind on the West Coast). PMH will forward it responses to you as soon as available. We thank you for your patience and understanding.

A. Late file # 17, Quarterly Data Report, p. 4363:

From the table below, explain the variance between what was submitted for Cash from Operations, Section D of the Report vs ECHN's AFS for FY 2015 and FY 2014 on file at OHCA.

Cash From Operations	Late File	OHCA's Records	Variance
FY 2014	$305,647,840	$7,904,018	$297,743,822
FY 2015	$300,257,422	$3,002,684	$297,254,738

Response:

The figures provided in Late File # 17 represent total cash collected by the entire ECHN system in the relevant years. The figures from OHCA's records (and from ECHN's AFS for FY 2015 and FY 2014) represent the net of cash incoming and outgoing activity via the Consolidated Statements of Cash Flows.

The drop of $5,000,000 in the AFS cash flows figure is directly related to declining operational performance in FY 2015 vs. FY 2014. Some of the financial loss from operations in FY 2015 was mitigated by the release of general reserves on the balance sheet that were set aside in the prior year.

Please do not hesitate to contact me if you have questions or need additional information.

-Rebecca

Rebecca A. Matthews
Direct: 203.498.4502 | rmatthews@wiggin.com

WIGGIN AND DANA
Connecticut | New York | Philadelphia | Washington, DC | www.wiggin.com

---

From: Kathleen Gedney [mailto:kgg@bvmlaw.com]
Sent: Friday, May 06, 2016 12:00 PM
To: Cotto, Carmen
Cc: Martone, Kim; Hansted, Kevin; Lazarus, Steven; Greer, Leslie; Michele Volpe; Matthews, Rebecca; Jennifer O'Donnell
Subject: RE: ECHN's Late Files Follow up Questions

Thank you and we appreciate the extension. Please recognize that PMH is located on the west coast and is three hours behind.

Regards,

Kathleen Gedney-Tommaso
Attorney at Law
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor
New Haven, CT 06511
Tel: (203) 859-6238
Fax: (203) 777-5806
Email: kgg@bvmlaw.com

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From: Cotto, Carmen [mailto:Carmen.Cotto@ct.gov]
Sent: Friday, May 06, 2016 11:53 AM
To: Kathleen Gedney <kgg@bvmlaw.com>
Cc: Martone, Kim <Kimberly.Martone@ct.gov>; Hansted, Kevin <Kevin.Hansted@ct.gov>; Lazarus,

Steven <Steven.Lazarus@ct.gov>; Greer, Leslie <Leslie.Greer@ct.gov>; Michele Volpe <mmv@bvmlaw.com>; 'RMatthews@wiggin.com' <RMatthews@wiggin.com>; Jennifer O'Donnell <jlo@bvmlaw.com>
Subject: RE: ECHN's Late Files Follow up Questions

Good Morning Ms. Gedney:

Yes, you can have until Monday, before noon time, to submit the responses.

Carmen

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov

<image001.png>
www.ct.gov/dph

From: Kathleen Gedney [mailto:kgg@bvmlaw.com]
Sent: Friday, May 06, 2016 11:36 AM
To: Cotto, Carmen
Cc: Martone, Kim; Hansted, Kevin; Lazarus, Steven; Greer, Leslie; Michele Volpe; 'RMatthews@wiggin.com'; Jennifer O'Donnell
Subject: ECHN's Late Files Follow up Questions

Good Morning Ms. Cotto:

Prospect Medical Holdings, Inc. ("PMH") is in receipt of the additional questions below and is compiling its responses. However, PMH will not be able to submit by 3pm today. We kindly request an extension to the filing deadline and anticipate that the information will ready for submission on Monday. Please confirm this is acceptable.

Thank you,
Kathleen Gedney-Tommaso
Attorney at Law
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor
New Haven, CT 06511
Tel: (203) 859-6238
Fax: (203) 777-5806
Email: kgg@bvmlaw.com

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From: Cotto, Carmen [mailto:Carmen.Cotto@ct.gov]
Sent: Thursday, May 05, 2016 4:08 PM
To: Michele Volpe (michelemvolpe@aol.com); Matthews, Rebecca
Cc: Martone, Kim; Hansted, Kevin; Lazarus, Steven; Greer, Leslie
Subject: RE: ECHN's Late Files Follow up Questions

Hi Michele,

Please also address the following in reference to Section B below, Late file#18:

4. Testimony of Mr. Steven Aleman on 3/29/16, pp.151-153, indicated that PMH is generating anywhere between $10 to $15 Million of free cash flow on a monthly basis. The free cash flow data submitted does not support the statement and provides data as of December 2015 not March 2016, please explain.

Thank you,

Carmen Cotto, MBA

Associate Health Care Analyst

Office of Health Care Access

Connecticut Department of Public Health

410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134

P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov

<image001.png>

www.ct.gov/dph

From: Cotto, Carmen
Sent: Thursday, May 05, 2016 2:52 PM
To: Michele Volpe (michelemvolpe@aol.com); 'Matthews, Rebecca'
Cc: Martone, Kim; Hansted, Kevin; Lazarus, Steven; Greer, Leslie
Subject: ECHN's Late Files Follow up Questions
Importance: High

Hi Michele,

We have some follow up questions related to the financial information submitted through late files 17, 18 and 19. In reference to these late files please address the following and provide responses by 3:00 pm tomorrow, Friday, May 6, 2016:

A. Late file# 17, Quarterly Data Report, p. 4363:

From the table below, explain the variance between what was submitted for Cash from Operations, Section D of the Report vs ECHN's AFS for FY 2015 and FY 2014 on file at OHCA.

Cash From Operations	Late File	OHCA's Records	Variance
FY 2014	$305,647,840	$7,904,018	$297,743,822
FY 2015	$300,257,422	$3,002,684	$297,254,738

B. Late File#18, Free Cash Flow, p.4371:

The amount listed as "Change in WC (Increase)", which OHCA assumes relates to Working Capital does not reconcile with the difference between Total Current Assets and Total Current Liabilities at $25,711,000. However, it reconciles with the amount listed on page 7 of PMH's Audited Financial Statements for Depreciation and Amortization. In reference to this and the numbers provided for TTM 12/31/15, please address the following:

1. Reconcile the amount in total of $34,374,000 with PMH's AFS.
2. Confirm that the acronym for "WC" stands for Working Capital.
3. Provide the source for the 12/31/15 data and indicate what the acronym "TTM" stands for.

C. Late file# 19, Revised Exhibit W, p.4372:

1. For the entity NIX, provide an explanation for the $10.4 million decrease in EBITDA.

2. If the reason for the decrease relates to the net benefit of Government Supplemental Payments (GSP) referred to in the footnotes, indicate what caused these payments to be higher than average in FY 2014 and below average in FY 2015.

3. Provide the GSP's totals for FYs 2014 and 2015 and the total average amount used as the basis to contrast the amounts.

Thank you,

Carmen Cotto, MBA

Associate Health Care Analyst

Office of Health Care Access

Connecticut Department of Public Health

410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134

P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov

<image001.png>

www.ct.gov/dph

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Greer, Leslie

From: Kathleen Gedney <kgg@bvmlaw.com>
Sent: Wednesday, May 11, 2016 3:24 PM
To: Cotto, Carmen
Cc: Jennifer O'Donnell; Martone, Kim; Hansted, Kevin; Lazarus, Steven; Greer, Leslie; Agsten, Melinda A.; Dennis P. McConville (dmcconville@echn.org); Frank Saidara <Frank.Saidara@prospectmedical.com> (Frank.Saidara@prospectmedical.com); Jonathan Spees; Michele Volpe; Veillette, Michael; Joyce Tichy; Matthews, Rebecca
Subject: RE: ECHN's Late Files Follow up Questions
Attachments: Conn Late Liling FCF Response 5 11 16.pdf

Ms. Cotto:

In response to your question #4 below, please see the attached spreadsheet from Prospect which identifies the average free cash flow for the twelve months ending 3.31.16.

Regards,

Kathleen Gedney-Tommaso
Attorney at Law
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor
New Haven, CT 06511
Tel: (203) 859-6238
Fax: (203) 777-5806
Email: kgg@bvmlaw.com

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From: Cotto, Carmen [mailto:Carmen.Cotto@ct.gov]
Sent: Wednesday, May 11, 2016 9:33 AM
To: Matthews, Rebecca <RMatthews@wiggin.com>
Cc: Jennifer O'Donnell <jlo@bvmlaw.com>; Martone, Kim <Kimberly.Martone@ct.gov>; Hansted, Kevin <Kevin.Hansted@ct.gov>; Lazarus, Steven <Steven.Lazarus@ct.gov>; Greer, Leslie <Leslie.Greer@ct.gov>; Agsten, Melinda A. <MAgsten@wiggin.com>; Dennis P. McConville (dmcconville@echn.org) <dmcconville@echn.org>; Kathleen Gedney <kgg@bvmlaw.com>; Frank Saidara <Frank.Saidara@prospectmedical.com> (Frank.Saidara@prospectmedical.com) <Frank.Saidara@prospectmedical.com>; Jonathan Spees <Jonathan.Spees@prospectmedical.com>; Michele Volpe <mmv@bvmlaw.com>; Veillette, Michael <mveillette@echn.org>; Joyce Tichy <jtichy@echn.org>
Subject: RE: ECHN's Late Files Follow up Questions

Thank you Rebecca for the update.

From: Matthews, Rebecca [mailto:RMatthews@wiggin.com]
Sent: Wednesday, May 11, 2016 9:10 AM
To: Cotto, Carmen

Prospect Medical Holdings
Free Cash Flow Analysis
3/31/16

		12 Months Ended 3/31/16	
EBITDA		**112,777**	
Working capital			
3/31/2016			
Current assets	333,400		
Current liabilities	(349,597)		
NWC	(16,197)		
Beginning of period			
Current assets	397,918		*Source: 3/31/15 Earnings Release*
Current liabilities	(308,217)		*Source: 3/31/15 Earnings Release*
NWC	89,701		
Change		105,898	
Cash paid for income taxes		(36,886)	
Cash paid for PP&E		(35,384)	
Free cash flow		146,404	
Average monthly free cash flow	**12**	**12,200**	***Trailing Twelve Months***
Beginning of Period		**3/31/2015**	

WIGGIN AND DANA

Counsellors at Law

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P.O. Box 1832
New Haven, Connecticut
06508-1832
www.wiggin.com

Melinda A. Agsten
203.498.4362
magsten@wiggin.com

Rebecca A. Matthews
203.498.4502
rmatthews@wiggin.com



May 16, 2016

VIA HAND-DELIVERY

Office of the Attorney General
55 Elm Street
P.O. Box 120
Hartford, Connecticut 06141-0120
Attn: Gary W. Hawes, Assistant Attorney General

Office of Health Care Access
Department of Public Health
410 Capitol Avenue
Hartford, Connecticut 06134
Attn: Steven W. Lazarus, Health Care Analyst

Re: Eastern Connecticut Health Network, Inc.
Proposed Asset Purchase by Prospect Medical Holdings, Inc.
OHCA Docket Number: 15-32016-486
Attorney General Docket Number: 15-486-01

Dear Mr. Hawes and Mr. Lazarus:

On behalf of Eastern Connecticut Health Network, Inc. ("***ECHN***"), we are enclosing with this letter Late File 20 for the above proceedings. As with previous filings, one (1) hard copy and one (1) electronic copy of this submission have been provided to each Office.

Please note that Late File 20 corrects typographical errors in Paragraphs 2 and 14 of Exhibit Q10-1, the draft of the Certificate of Incorporation of the new community foundation that will be established.

If you have any questions or need anything further, please feel free to contact Rebecca Matthews at (203) 498-4502 or Melinda Agsten at (203) 498-4326. Thank you for your assistance in this matter.

Sincerely,

Wiggin and Dana LLP

By_____
Rebecca A. Matthews
Its Partner

By_____
Melinda A. Agsten
Its Partner

cc: Kevin Hansted, Staff Attorney, Department of Public Health Division of Office of Health Care Access
Kimberly Martone, Director of Operations, Department of Public Health Division of Office of Health Care Access
Perry Zinn-Rowthorn, Deputy Attorney General, Office of the Attorney General
Dennis P. McConville, Senior Vice President and Chief Strategy Officer, Eastern Connecticut Health Network, Inc.
Thomas M. Reardon, President, Prospect Medical Holdings-East, Inc.
Frank Saidara, Vice President, Corporate Development, Prospect Medical Holdings, Inc.
Jonathan Spees, Senior Vice President, Corporate Development, Prospect Medical Holdings, Inc.
Joyce Tichy, Senior Vice President and General Counsel, Eastern Connecticut Health Network, Inc.
Michele M. Volpe, Esq., Bershtein, Volpe & McKeon, P.C.

Exhibit Q10-1

CERTIFICATE OF INCORPORATION

[NAME TO BE DETERMINED]

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

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

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

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

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

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

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

(f) To work cooperatively with Prospect Medical Holdings, Inc. ("PMH") to ensure and augment a network of affordable and accessible health and medical care in the region; provided, however, that the Corporation will not support programs operated by or for the direct benefit of PMH while it operates as a for profit entity; and

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

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

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

4. The Corporation shall have no members.

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

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

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

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

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

(d) A member of the governing board or an employee of PMH or one of its affiliates for two years after their service on the board in question or employment ends, as the case may be.

6. No part of the net earnings of the Corporation shall inure to the benefit of or be distributable to the Corporation's Directors, officers or other private persons, except that the Corporation shall be authorized and empowered to pay reasonable compensation for services rendered and to make payments and distributions in furtherance of the purposes set forth in Paragraph 2 hereof. No substantial part of the activities of the Corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation, and the Corporation shall not participate in, or intervene in (including the publishing or distribution of statements), any political campaign on behalf of (or in opposition to) any candidate for public office. Notwithstanding any other provision of this Certificate of Incorporation, the

Corporation shall not carry on any other activities not permitted to be carried on by a corporation exempt from federal income taxation under section 501(c)(3) of the Code or by a corporation contributions to which are deductible under section 170(c)(2) of the Code.

7. If in any taxable year the Corporation is a private foundation as defined by section 509 of the Code, the Corporation will distribute its income for each such tax year at a time and in a manner as not to become subject to the tax on undistributed income imposed by section 4942 of the Code. Further, in any such year the Corporation will not (1) engage in any act of self-dealing as defined in section 4941(d) of the Code, (2) retain any excess business holdings as defined in section 4943(c) of the Code, (3) make any investments in a manner as to subject it to tax under section 4944 of the Code, or (4) make any taxable expenditures as defined in section 4945(d) of the Code.

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

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

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

11. The Corporation's initial registered office is _____ Connecticut _____. The Corporation's initial registered agent at that office is _____, with a business address of _____, Connecticut _____, and a residence address of _____, Connecticut _____.

Acceptance of Appointment

_____

12. The incorporator of the Corporation is _____, with an address of _____, Connecticut.

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

14. This Certificate of Incorporation may be amended at any meeting of the Board of Directors by a two-thirds vote of the Directors present and voting, a quorum being present, provided that notice of the proposed amendment shall have been given to each Director at least ten (10) days in advance of the meeting **[, and further provided, that any amendment of Paragraphs 2, 5, 8, and 14 requires the consent of the Attorney General of the State of Connecticut]**.

Dated at _____, Connecticut, this_____ day of _____, 201_.

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

_____

Incorporator

765/2611/3333909.3

Greer, Leslie

From: Lazarus, Steven
Sent: Thursday, May 19, 2016 11:09 AM
To: Greer, Leslie
Cc: Martone, Kim; Riggott, Kaila; Roberts, Karen; Cotto, Carmen; Hansted, Kevin
Subject: FW: ECHN - Scheduling [CTAG-CTAG.FID647701]
Attachments: 2016-05-19 ECHN - 2d scheduling letter.PDF

Leslie,

Please add it to the original record.

Steve

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

From: Hawes, Gary W.
Sent: Thursday, May 19, 2016 9:38 AM
To: jonathan.spees@prospectmedical.com; Dennis P. McConville (dmcconville@echn.org); 'rmatthews@wiggin.com'; Agsten, Melinda A.; mmv@bvmlaw.com
Cc: Martone, Kim; Lazarus, Steven; Zinn-Rowthorn, Perry A.; Salton, Henry A.; Turner, Cheryl A.
Subject: ECHN - Scheduling [CTAG-CTAG.FID647701]

Please see the attached letter that addresses the schedule for the Proposed Final Decisions and the time for comment on the Proposed Final Decisions. Thanks.

Gary

Gary W. Hawes | Assistant Attorney General | Office of the Attorney General
55 Elm Street | P.O. Box 120 | Hartford Connecticut 06106
T: 860.808.5020 | F: 860.808.5347 | gary.hawes@ct.gov

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STATE OF CONNECTICUT

OFFICE OF THE ATTORNEY GENERAL

DEPARTMENT OF PUBLIC HEALTH

GEORGE JEPSEN
ATTORNEY GENERAL

RAUL PINO, M.D., M.P.H.
COMMISSIONER

May 19, 2016

VIA ELECTRONIC MAIL

Jonathan Spees
Senior VP, Mergers and Acquisitions
Prospect Medical Holdings, Inc.
10780 Santa Monica Blvd., Suite 400
Los Angeles, CA 90025

Dennis P. McConville
Senior VP and Chief Strategy Officer
Eastern Connecticut Health Network, Inc.
71 Haynes Street
Manchester, CT 06040

Re: OHCA Docket No. 15-32016-486 and OAG Docket No. 15-486-01 – Schedule for Proposed Final Decisions and Comments

Dear Mr. Spees and Mr. McConville:

This letter sets forth the schedule for the issuance of the Proposed Final Decisions and the comment period for those decisions in the hospital conversion dockets OHCA Docket No. 15-32016-486 and OAG Docket No. 15-486-01 currently pending in the Department of Public Health, Office of Health Care Access ("OHCA") and the Office of the Attorney General (the "OAG"). The Applicants for both of these dockets are Eastern Connecticut Health Network, Inc. ("ECHN") and Prospect Medical Holdings, Inc. ("PMH").

The OAG and OHCA will issue their Proposed Final Decisions on or before **May 25, 2016**. Comments from the Applicants and the public will be due on or before **June 3, 2016**. And, as previously agreed upon by all parties in the revised scheduling letter dated February 18, 2016, the OAG and OHCA will issue their Final Decisions in these dockets on or before **June 10, 2016**.

Should you have any questions regarding these dates, please do not hesitate to contact either Steven W. Lazarus at the Department of Public Health (860-418-7012; Steven.Lazarus@ct.gov) or Assistant Attorney General Gary W. Hawes at the Office of the Attorney General (860-808-5020; gary.hawes@ct.gov).

Very truly yours,

Gary W. Hawes
Assistant Attorney General

Very truly yours,

Kim Martone
Director, DPH/OHCA

cc: Steven Lazarus (via electronic mail)
Rebecca A. Matthews (via electronic mail)
Melinda A. Agsten (via electronic mail)
Michele Volpe (via electronic mail)

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Salesperson: ANNE FIELDING Printed at 01/21/16 12:09 by afiel-ji

Acct #: 6302 Ad #: 84075 Status: N

PUBLIC NOTICE

Department of Public Health, Office of Health Care Access
Office of the Attorney General
Notice to Public

Statute Reference:	Connecticut General Statutes § 19a-486a(f)
Applicants:	Eastern Connecticut Health Network, Inc., and Prospect Medical Holdings, Inc.
Towns:	Manchester and Rockville
Docket Nos.:	OHCA 15-32016-486; OAG 15-486-01
Deemed Complete:	January 13, 2016
Proposal Summary:	Eastern Connecticut Health Network, Inc. ("ECHN"), and Prospect Medical Holdings, Inc. ("PMH"), are proposing the purchase of substantially all of the assets of ECHN by PMH. Pursuant to the terms of the proposed Asset Purchase Agreement, PMH will pay either $105,000,000 or $115,000,000 for the assets of ECHN, subject to certain adjustments. In addition, PMH will commit to spend not less than $75,000,000 on capital items for the hospitals and service areas of Manchester Memorial Hospital and Rockville General Hospital, over five years.

A complete copy of the application can be viewed at DPH/OHCA's website at **www.ct.gov/ohca** or at the Attorney General's website at **www.ct.gov/ag**. Please be advised that this application is being reviewed jointly by Department of Public Health/Office of Health Care Access ("OHCA") and the Office of the Attorney General ("OAG"). If you have any questions related to this filing, please feel free to contact OHCA at (860) 418-7001 or the OAG at (860) 808-5020.

Journal Inquirer
January 22, 2016

STATE OF CONNECTICUT

OFFICE OF THE ATTORNEY GENERAL

DEPARTMENT OF PUBLIC HEALTH

GEORGE JEPSEN
ATTORNEY GENERAL

RAUL PINO, M.D., M.P.H.
COMMISSIONER

May 19, 2016

VIA ELECTRONIC MAIL

Jonathan Spees
Senior VP, Mergers and Acquisitions
Prospect Medical Holdings, Inc.
10780 Santa Monica Blvd., Suite 400
Los Angeles, CA 90025

Dennis P. McConville
Senior VP and Chief Strategy Officer
Eastern Connecticut Health Network, Inc.
71 Haynes Street
Manchester, CT 06040

Re: OHCA Docket No. 15-32016-486 and OAG Docket No. 15-486-01 – Schedule for Proposed Final Decisions and Comments

Dear Mr. Spees and Mr. McConville:

This letter sets forth the schedule for the issuance of the Proposed Final Decisions and the comment period for those decisions in the hospital conversion dockets OHCA Docket No. 15-32016-486 and OAG Docket No. 15-486-01 currently pending in the Department of Public Health, Office of Health Care Access ("OHCA") and the Office of the Attorney General (the "OAG"). The Applicants for both of these dockets are Eastern Connecticut Health Network, Inc. ("ECHN") and Prospect Medical Holdings, Inc. ("PMH").

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Should you have any questions regarding these dates, please do not hesitate to contact either Steven W. Lazarus at the Department of Public Health (860-418-7012; Steven.Lazarus@ct.gov) or Assistant Attorney General Gary W. Hawes at the Office of the Attorney General (860-808-5020; gary.hawes@ct.gov).

Very truly yours,

Gary W. Hawes
Assistant Attorney General

Very truly yours,

Kim Martone
Director, DPH/OHCA

cc: Steven Lazarus (via electronic mail)
Rebecca A. Matthews (via electronic mail)
Melinda A. Agsten (via electronic mail)
Michele Volpe (via electronic mail)

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

Proposed Final Decision

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

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

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

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

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

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

Findings of Fact

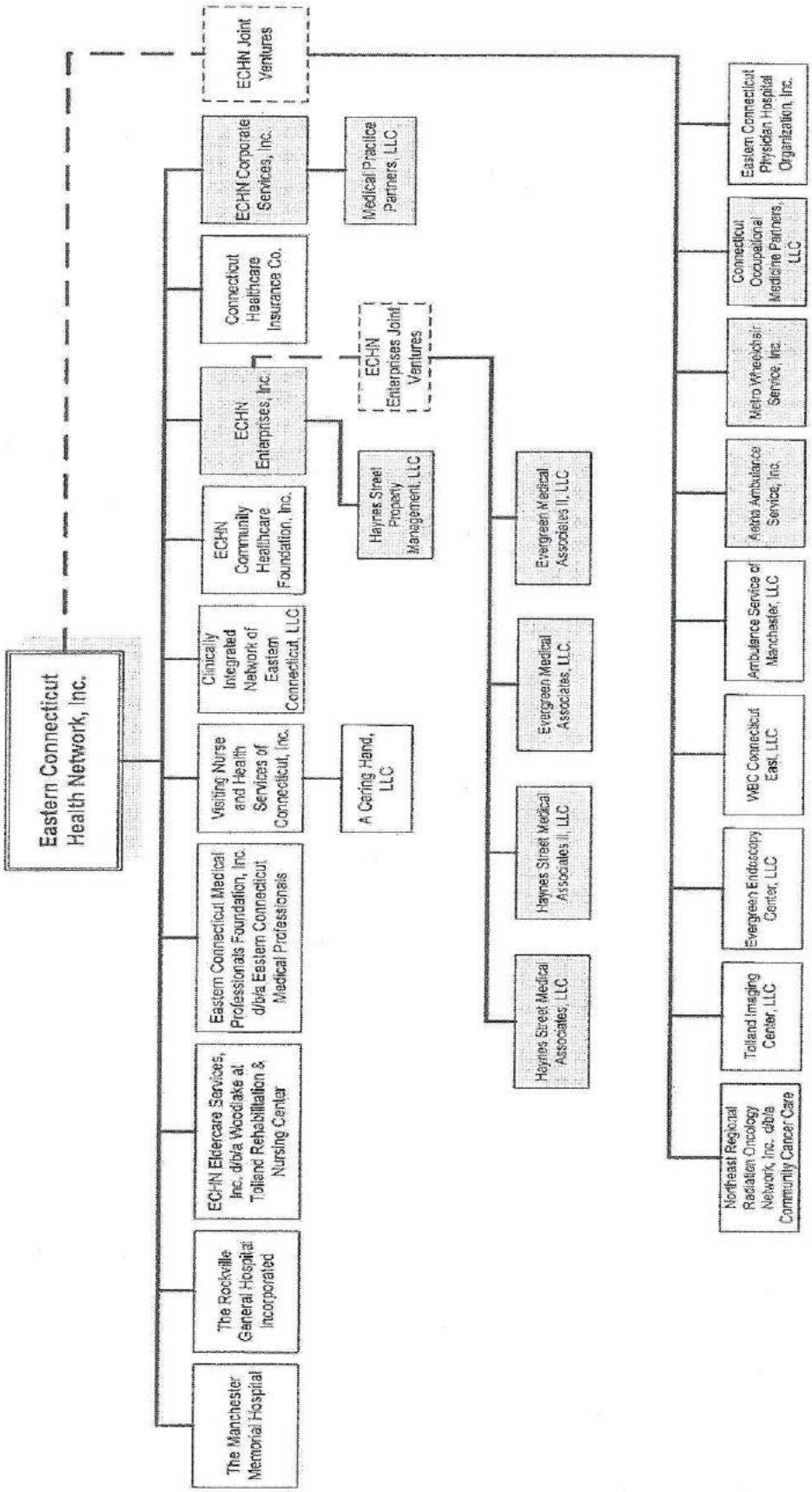
1. ECHN is a not-for-profit health care system that is the parent company of two acute care hospitals in Connecticut, Manchester Memorial Hospital ("MMH") located in Manchester and Rockville General Hospital ("RGH") located in Vernon (at times collectively referred to as the "Hospitals"). Ex. G, p. 24

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

   Ex. G, pp. 24-25

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

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


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

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

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

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

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

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

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

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

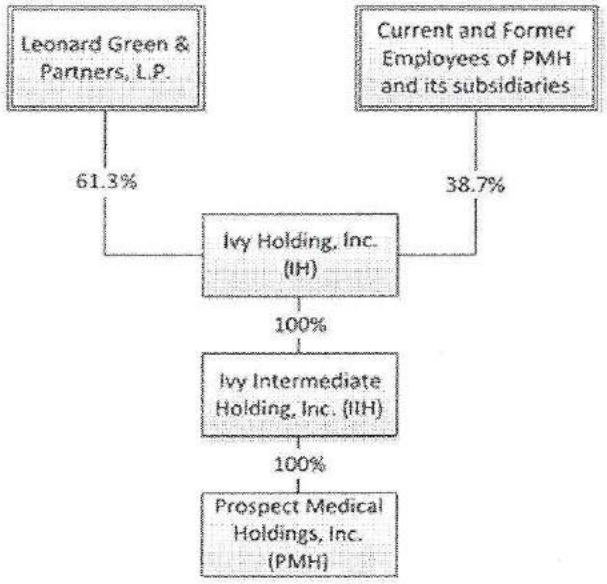
12. The Applicants are requesting approval of the proposed asset purchase (the "Asset Purchase") as a solution to ECHN's long-standing challenges that offers the Service Area continued access to its services and facilities. Ex. G, p. 26

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

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

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

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



Ex. K, p. 2205

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

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

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

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

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

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

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

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

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

TABLE 1

APA PROJECTED NET PROCEEDS AND FLOW OF FUNDS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TABLE 3
PRIORITY FACILITY CAPITAL NEEDS OF ECHN

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

Late File 12, dated Apr. 20, 2016

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

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

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

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

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

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

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

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

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

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

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

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

TABLE 4
SOCIOECONOMIC STATUS OF THE SERVICE AREA

Socioeconomic Data

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

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

(1)2012

(2)2013

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

Ex. G, p. 63

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

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

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

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

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

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

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

TABLE 5
PATIENT POPULATION/PAYER MIX

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

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

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

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

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

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

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

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

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

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

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

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

TABLE 7
MMH PROJECTED REVENUES AND EXPENSES WITH CON

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

Ex. K, p. 2314

TABLE 8
MMH PROJECTED REVENUES AND EXPENSES WITHOUT CON

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

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

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

TABLE 9
RGH PROJECTED REVENUES AND EXPENSES WITH CON

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

Ex. K, p. 2316

TABLE 10
RGH PROJECTED REVENUES AND EXPENSES WITHOUT CON

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

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

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

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

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

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

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

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

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

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

73. The Applicants have satisfactorily demonstrated that this proposal would not result in an unnecessary duplication of existing services in the area. Conn. Gen. Stat. §19a-639(a)(9)

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

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

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

Discussion

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Order

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Financial Measurement/Indicators

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

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

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

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

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

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

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

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

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

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

18. If the New Hospitals' Local Board agrees with PMH to change any of the Seller Quality Programs described in the Quality Commitment Letter other than to make any changes necessary to address (i) an immediate issue of patient safety; (ii) changes in federal, state, and local laws; or (iii) as mandated by a governmental agency, PMH shall notify OHCA and the Health Systems Branch in writing at least thirty (30) days prior to any such change going into effect. If the Independent Monitor disagrees with the change, OHCA may require that a request for modification be submitted and approved as required by C.G.S. §4-181a to make the change. OHCA is imposing this condition to ensure continued access to health care services to the patient population and to verify and monitor compliance with the conditions set forth herein. *Legal and Factual Basis: Stat. §§ 19a-486d, 19a-613(b), 19a-639(a)(1),(2),(5) & (6); FF 30-37*

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

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

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

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

5/25/16
Date

Kevin Hansted, Esq.
Hearing Officer

Greer, Leslie

From: Lazarus, Steven
Sent: Wednesday, May 25, 2016 3:29 PM
To: Martone, Kim; Riggott, Kaila; Cotto, Carmen; Hansted, Kevin; Roberts, Karen; Greer, Leslie
Subject: FW: ECHN Proposed Final Decision and Exhibit [CTAG-CTAG.FID647701]
Attachments: ECHN Proposed Final Decision.PDF; ECHN Proposed Final Decision EXHIBIT A.PDF

FYI-
Steve

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From: Hawes, Gary W.
Sent: Wednesday, May 25, 2016 3:27 PM
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Cc: Zinn-Rowthorn, Perry A.; Salton, Henry A.; Clark, Robert; Turner, Cheryl A.; Kohler, Mark F.; Martone, Kim; Lazarus, Steven; Hansted, Kevin; Jerry M. Chang CFA (jchang@navigant.com)
Subject: ECHN Proposed Final Decision and Exhibit [CTAG-CTAG.FID647701]

Please see the attached Proposed Final Decision of the OAG in connection with the proposed sale of substantially all of the assets of Eastern Connecticut Health Network, Inc., to Prospect Medical Holdings, Inc. Thanks.

Gary

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DOCKET NO. : OAG 15-486-01

IN RE APPLICATION FOR ASSET PURCHASE	**:**	**OFFICE OF THE ATTORNEY GENERAL**
BY PROSPECT MEDICAL HOLDINGS, INC. OF	**:**	
EASTERN CONNECTICUT HEALTH NETWORK	**:**	
INC.	**:**	**MAY 25, 2016**

PROPOSED FINAL DECISION

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I. INTRODUCTION

The proposed asset purchase agreement between Eastern Connecticut Health Network, Inc., and its affiliates ("ECHN"), and Prospect Medical Holdings, Inc. ("PMH")(collectively, the "Applicants"), is the second Application by ECHN filed with the Office of the Attorney General (the "OAG") for its review pursuant to the Nonprofit Hospital Conversion Act, Conn. Gen. Stat. § 19a-486 et seq. (the "Conversion Act").

On June 4, 2014, ECHN submitted a proposed transaction with Tenet Healthcare Corp. ("Tenet") that was withdrawn by Tenet prior to the completion of the OAG's review under the Conversion Act. This Application comes 2 years afterwards.

The difficulties faced by hospitals in delivering quality healthcare services in a changing and increasingly challenging fiscal landscape have become, appropriately, a subject of national concern and debate. A number of forces in recent years have contributed to the financial challenges to local hospitals, including those in Connecticut. Against the backdrop of a changing regulatory and fiscal landscape at the federal and state level, the delivery of healthcare services remains a local issue of extreme importance to the communities in which nonprofit hospitals operate. These issues are no less true for ECHN than for any other community hospital or hospital system in Connecticut. It is in this context that ECHN has decided to sell substantially all of its assets to PMH. Its stated goal in making this decision is to ensure the continued existence of ECHN's facilities and services, to provide sufficient capital to enhance the facilities and services, and to integrate its operations with an established health care system that is prepared navigate the evolving health care system of the future. (Application of ECHN and PMH re a Proposed Asset Purchase Agreement, AG Docket 15-486-01, pp. 25-26; hereinafter, "App., p. __.)

Pursuant to the Conversion Act, the legislature has authorized the Attorney General to review and investigate proposed nonprofit to for-profit hospital transactions, to disapprove them if he finds that any of the criteria set forth in Conn. Gen. Stat. § 19a-486c(a) are not met, or to approve the transaction subject to any modifications or conditions that the Attorney General deems appropriate. Conn. Gen. Stat. § 19a-486b. Under the law, the Attorney General is required to assess both the procedural and financial fairness of the transaction and to protect and preserve the charitable assets of ECHN.

Contemporaneously with the OAG's review of the proposed Asset Purchase Agreement (the "APA"), the Office of Health Care Access, Department of Public Health ("OHCA"), has been reviewing the transaction to determine whether a certificate of need should be issued in this case and also whether OHCA's criteria in the Conversion Act have been fulfilled by the Applicants. In contrast to the Attorney General's focus, OHCA's review encompasses issues involving the impact of the proposed transaction on access to, and the quality of, health care in the ECHN service area.

As explained in detail below, we grant the Application with conditions necessary to conform the proposed transaction to the requirements of the Conversion Act. I would like to thank ECHN and PMH for their cooperation throughout this process. I would also like to thank the many witnesses, public officials, and members of the public who testified or commented on the proposed transaction in our proceedings. Last, I would like to thank my staff, Assistant Attorney General Henry Salton, head of the Health and Education Department, Assistant Attorney General Gary W. Hawes, and Paralegal Specialist Cheryl A. Turner for their diligent efforts on this matter.

II. EXECUTIVE SUMMARY

A. Standard of Review

Pursuant to the requirements of the Conversion Act, the OAG is required to review a proposed transaction for compliance with specifically articulated standards that were established by the legislature. § 19a-486c(a). In sum, these criteria require the OAG to make certain determinations: whether the nonprofit hospital's decision to sell its assets was reasonable, whether it chose the ultimate purchaser in an open and fair process, whether it received fair market value for its assets, whether the funds generated by the sale will be held by a charitable foundation that will use them for the promotion of healthcare in the nonprofit hospital's community, and whether use restrictions on any charitable asset held by ECHN will be preserved.[1]

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[1] Conn. Gen. Stat. § 19a-486c(a) provides in full:

The Attorney General shall deny an application as not in the public interest if the Attorney General determines that one or more of the following conditions exist:

(1) the transaction is prohibited by Connecticut statutory or common law governing nonprofit entities, trusts or charities;
(2) the nonprofit hospital failed to exercise due diligence in (A) deciding to transfer, (B) selecting the purchaser, (C) obtaining a fairness evaluation from an independent person expert in such agreements, or (D) negotiating the terms and conditions of the transfer;
(3) the nonprofit hospital failed to disclose any conflict of interest, including, but not limited to, conflicts of interest pertaining to board members, officers, key employees and experts of Waterbury Hospital, the purchaser or any other party to the transaction;
(4) the nonprofit hospital will not receive fair market value for its assets, which, for purposes of this subsection, means the most likely price that the assets would bring in a sale in a competitive and open market under all conditions requisite to a fair sale, with the buyer and seller each acting prudently, knowledgeably and in their own best interest, and with a reasonable time being allowed for exposure in the open market;
(5) the fair market value of the assets has been manipulated by any person in a manner that causes the value of the assets to decrease;
(6) the financing of the transaction by the nonprofit hospital will place the nonprofit hospital's assets at an unreasonable risk;
(7) any management contract contemplated under the transaction is not for reasonable fair value;

B. The Proposed Transaction

ECHN and PMH propose an asset purchase whereby ECHN will sell substantially all of its assets to PMH or one or more affiliates of PMH. Substantially all of the assets of ECHN will be transferred to PMH in exchange for $105,000,000, subject to certain adjustments.[2] The adjustments include a Net Working Capital reconciliation, reductions for the value of ECHN liabilities assumed by PMH, and adjustments for the value of any ECHN joint venture interest not assigned or transferred to PMH. Pursuant to the APA, PMH will also commit to spend not less than $75,000,000 on capital items over five years. (App., p. 23.)

PMH will continue to operate both Manchester Memorial Hospital ("MMH") and Rockville General Hospital ("RGH") as acute care hospitals for at least three years after the

---

(8) a sum equal to the fair market value of the nonprofit hospital's assets (A) is not being transferred to one or more persons to be selected by the superior court for the judicial district where the nonprofit hospital is located who are not affiliated through corporate structure, governance or membership with either the nonprofit hospital or the purchaser, unless the nonprofit hospital continues to operate on a nonprofit basis after the transaction and such sum is transferred to the nonprofit hospital to provide health care services, and (B) is not being used for one of the following purposes: (i) For appropriate charitable health care purposes consistent with the nonprofit hospital's original purpose, (ii) for the support and promotion of health care generally in the affected community, or (iii) with respect to any assets held by the nonprofit hospital that are subject to a use restriction imposed by a donor, for a purpose consistent with the intent of said donor; or

(9) the nonprofit hospital or the purchaser has failed to provide the Attorney General with information and data sufficient to evaluate the proposed agreement adequately, provided the Attorney General has notified the nonprofit hospital or the purchaser of the inadequacy of the information or data and has provided a reasonable opportunity to remedy such inadequacy.

[2] The Application indicated that the purchase price would be either $105 million or $115 million, depending on whether ECHN obtained an assumable loan to finance certain of its outstanding bond liabilities. At the public hearing on this transaction, it was confirmed that ECHN had not acquired the loan, and the purchase price was going to be $105 million.

transaction closes.[3] Each hospital will maintain a local advisory board, and substantially all of the employees of ECHN and its affiliates will be offered employment by PMH or its affiliates. (App., p. 24.)

In addition, PMH will ensure that MMH and RGH maintain ECHN's current policies on charity care and indigent care or will adopt other policies that are at least as favorable to the ECHN community. (App., p. 32.)

After the closing, ECHN will establish a new charitable entity ("New Foundation") that will receive the net proceeds of the transaction and the appropriate charitable gift assets held by ECHN.

C. The Proposed Transaction Meets the Requirements of the Conversion Act Provided the Applicants Comply with the Attorney General's Modifications.

Based on our review of the record, all testimony provided at the public hearings, all exhibits provided pursuant to this review, and the standards set forth in § 19a-486c(a), we conclude that the proposed transaction meets the requirements of the Conversion Act, provided that ECHN and PMH comply with the modifications and conditions that are imposed herein.

1. Findings and Conclusions

First, we conclude that the process employed by ECHN in deciding to sell its assets to a for-profit healthcare services company reflects proper due diligence by ECHN's Board of Directors. The ECHN Board undertook an extensive process to explore potential strategic options and identify capital alternatives to address its weakening financial

[3] At all times, a hospital must receive approval in the form of a Certificate of Need from OHCA before terminating inpatient or outpatient services offered by the hospital. See Conn. Gen. Stat. § 19a-638(a)(5).

position. The Board's efforts have been diligent and without conflicts of interests, and in our opinion, the Board has met their fiduciary obligations to ECHN.

Second, we conclude that ECHN will receive fair market value for its assets as a result of this transaction. Based primarily on the opinions of two independent financial valuation experts, the price negotiated for the sale of ECHN's assets equals or exceeds the price they would command in an open and competitive market.[4] This conclusion is buttressed by the fact that the process followed by the ECHN Board to select a purchaser was itself open and competitive.

Third, assuming compliance with the modifications and conditions set forth below, we conclude that the charitable assets of ECHN will be adequately protected and preserved after the proposed transaction closes. The charitable assets of ECHN, which have been held in trust for the public, will be held by the New Foundation and safeguarded for their specific charitable uses or to promote healthcare in the ECHN service area. We also conclude that a sum equal to the fair market value of ECHN's assets will be transferred to the New Foundation and will be restricted to charitable uses consistent with ECHN's

[4] The nonprofit hospital conversion review process provides the OAG with the opportunity to have two separate, independent financial experts review the proposed transaction for compliance with the provisions of § 19a-486c(a). The first expert opinion is required by § 19a-486c(a)(2)(C), which provides that the nonprofit hospital obtain a fairness evaluation from an independent person expert in such agreement. ECHN hired Duff & Phelps, LLC, for these purposes, and its opinion is in the record. In addition, § 19a-486c(c) allows the Attorney General to contract with a financial expert to assist in the review of the nonprofit hospital's compliance with the provisions in § 19a-486c(a). Through an RFP process, the OAG retained the services of Navigant Consulting, Inc., to provide an additional independent analysis of the APA.

original purpose and for the support and promotion of healthcare generally in the ECHN community.[5]

2. Modifications and Conditions

The General Assembly has assigned the OAG significant responsibility and flexibility to modify the terms of the proposed transaction, if necessary, to fulfill the statutory mandates of the Conversion Act and—in particular—to fulfill the Attorney General's statutory charge to serve the public interest in the protection of gifts, legacies or devises for public or charitable purposes. Conn. Gen. Stat. § 3-125.

Consequently, although we approve the APA, that approval is contingent on certain modifications and conditions that must be made to the proposed transaction to ensure that the interests of the public and the requirements of the Conversion Act are met. These modifications and conditions, which are more fully described in Section V of this decision, include the following:

1. The Applicants must delete section 5.18(a) from the APA.

2. The Applicants shall notify the OAG in writing of the closing date of the Asset Purchase as soon as reasonably possible after the date has been set. If the closing date changes, the Applicants shall notify the OAG in writing of the change as soon as reasonably possible.

3. The Applicants must submit to the OAG, within 30 days of closing, fully executed copies of the Asset Purchase Agreement, without schedules.

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[5] As discussed in Section IV(H)(1) of this decision, the current estimate on the net proceeds to be transferred to the New Foundation is zero. In other words, after ECHN meets the obligations of its creditors and the provisions in the APA that require capital, there will be very little or nothing left over to transfer to the New Foundation.

4. As soon as reasonably possible after the Applicants have agreed to a Final Closing Statement of the transaction, the Applicants must provide the OAG a final accounting of the transaction that sets forth the balance sheets of ECHN immediately prior to and after the closing and that provides a net proceeds analysis.

5. After the closing, ECHN ("Legacy ECHN") shall hold and protect all charitable gift funds and any net proceeds from the Asset Purchase in its possession until they are transferred to the New Foundation or other charitable organization by order of a court of competent jurisdiction.

6. Legacy ECHN shall report quarterly to the OAG regarding (1) any and all income received by Legacy ECHN post-closing, including, but not limited to, Medicare and Medicaid reimbursements, income from charitable assets held by Legacy ECHN prior to transfer to the New Foundation, and any additional charitable funds received, and (2) all expenditures for Legacy ECHN.

7. When the requirements of the indemnity reserve have been fulfilled, and if there remain any funds in the indemnity reserve, they shall be considered ECHN's net proceeds and be treated accordingly.

8. Any income or unrestricted gifts received by Legacy ECHN post-closing shall be considered net proceeds.

9. The New Foundation shall include paragraph 14 as set forth in the draft Certificate of Incorporation in the final Certificate of Incorporation of the New Foundation, requiring Attorney General approval for changes to paragraphs 2, 5, 8, and 14 of the Certificate of Incorporation.

10. Legacy ECHN must present to the Superior Court, in coordination with the OAG, a petition for equitable deviation and approximation to transfer the unrestricted

endowments to the New Foundation and to change the charitable purpose of the unrestricted endowments to the charitable purpose of the New Foundation.

11. Legacy ECHN must, in coordination with the OAG, include the restricted endowments in the Superior Court petition for an equitable deviation order. With respect to the Trotter, Baker, and Schortman funds, Legacy ECHN must seek an order of approximation, in addition to one for equitable deviation, to adjust the funds' charitable purposes to ones that come as close as possible to the donor's original charitable intent.

12. Legacy ECHN must, in coordination with the OAG, include any special funds that still have money in them in the Superior Court petition for an equitable deviation and approximation order.

13. Legacy ECHN must, in coordination with the OAG and the third-party trustees, bring any third-party trusts in need of approximation before a court of competent jurisdiction for appropriate orders.

14. Legacy ECHN must, in coordination with the OAG, include the Life Insurance Policy in the Superior Court petition for an equitable deviation order.

15. Any net proceeds from this transaction, including the earnings therefrom, shall be transferred to and then held by the New Foundation and used only for the support and promotion of healthcare in the ECHN community. The net proceeds shall never inure to the benefit of the for-profit hospital. The net proceeds shall forever be held by the New Foundation for the purposes articulated in the New Foundation's Draft Certificate of Incorporation, unless and until a court of competent jurisdiction orders otherwise.

16. The net proceeds held by the New Foundation shall be considered an endowment fund, as that term is defined in the Connecticut Uniform Prudent Management of Institutional Funds Act, Conn. Gen. Stat. § 45a-535 et seq. ("CUPMIFA").

III. PROCEDURAL HISTORY

On July 17, 2015, OHCA and the OAG received ECHN's certificate of need determination letter that set forth in summary fashion the terms of the APA between the Applicants.[6] Because the OAG determined that the APA required approval pursuant to § 19a-486 et seq., the OAG and OHCA on August 6, 2015, jointly sent the Applicants an Application Form regarding the APA.

The Applicants requested an extension of time to submit their Application, which both agencies granted, On October 13, 2015, the Applicants filed their Application for an Asset Purchase, which included 45 exhibits. Upon review of the Application, the OAG and OHCA determined that the Applicants' Application was not complete, and on October 30, 2015, it requested additional information from the Applicants. Before the Applicants had an opportunity to respond to the October 30 requests, the OAG and OHCA requested further information on November 12, 2015, related to the reports that PMH was up for sale. On November 23, 2015, the Applicants filed responses to the two sets of additional requests set forth by the OAG and OHCA. On December 11, 2015, OHCA issued one last set of completeness questions, to which the Applicant responded on December 24, 2015. On January 13, 2016, the OAG and OHCA determined that the Application was complete. In order to ensure the completeness of the record, the OAG and OHCA took administrative notice of the record in the Proposed Asset Purchase of Greater Waterbury Health Network, Inc., by Prospect Medical Holdings, Inc., OHCA Docket No. 15-31217-486, OAG Docket No. 15-486-02 (the "GWHN/PMH APA").

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[6] All docket documents referenced in this opinion can be found on the Attorney General's website: www.ct.gov/ag.

Pursuant to Conn. Gen. Stat. § 19a-486e, the OAG and OHCA conducted two public hearings regarding the proposed Asset Purchase, one in Manchester and one in Rockville. The Manchester public hearing was held on March 29, 2016, at 2:00 p.m. at the Manchester Country Club in Manchester, Connecticut. The Rockville public hearing was held on March 30, 2016, at 2:00 p.m. at the Elks Club in Rockville, Connecticut. No person sought intervenor status for the hearings. Conn. Gen. Stat. § 19a-486a(g). All parties submitted pre-filed testimony for the hearings.

The hearings were presided over by representatives from both the OAG and OHCA. Deputy Attorney General Perry Zinn Rowthorn served as the hearing office for the OAG. Also on the panel for the OAG were Assistant Attorney General Henry A. Salton and Assistant Attorney General Gary W. Hawes. Kevin Hansted served as the hearing officer for OHCA. Also on the panel for OHCA were Kimberly Martone, Director for OHCA, Steven W. Lazarus, Associate Health Care Analyst, and Carmen Cotto, Health Care Analyst.

At the hearings, all parties adopted their pre-filed testimony, and all exhibits on the table of record were entered into the record. At both hearings, the Applicants presented full testimony and were subject to cross-examination by OHCA and the OAG. In addition, the hearing panel heard approximately 20 public comments and accepted written public comments. Subsequent to the hearings, the OAG receive one additional public comment.

The Applicants filed late-filed exhibits with OHCA and the OAG on April 20, 2016.

IV. FINDINGS OF FACT

Based upon the entire record of this Application, including all statements, testimony, and exhibits submitted by the Applicants, all public comments made at the hearing or submitted to the OAG in writing, the summary reports and exhibits submitted

by the independent financial experts, and the record in the GWHN/PMH APA, we find the following.

A. Parties and other relevant corporate entities

ECHN is a not-for-profit health care system that serves 19 towns in eastern Connecticut including Andover, Bolton, Coventry, Ellington, Manchester, South Windsor, Tolland, Vernon, Willington, Ashford, Columbia, East Hartford, East Windsor, Glastonbury, Hebron, Mansfield, Somers, Stafford, and Union (the "Service Area"). ECHN was formed in 1995 when Manchester Memorial Hospital and Rockville General Hospital joined as partners.

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

ECHN has ownership interests in a number of community based services including the following joint ventures: Evergreen Endoscopy Center, LLC; WBC Connecticut East, LLC; Aetna Ambulance Service, Inc.; Metro Wheelchair Service, Inc.; Ambulance Service of Manchester, LLC; Connecticut Occupational Medicine Partners, LLC; Eastern Connecticut Physician Hospital Organization, Inc.; Northeast Regional Radiation Oncology Network, Inc.; Tolland Imaging Center, LLC; Haynes Street Medical Associates, LLC; Haynes Street Medical Associates II, LLC; Evergreen Medical Associates, LLC; and Evergreen Medical Associates II, LLC

PMH is a Delaware corporation with its principal place of business located in Los Angeles, California. PMH is a healthcare services company that owns and operates thirteen acute care and behavioral hospitals located in Rhode Island, Texas, and California. PMH also owns a network of specialty and primary care clinics in each of its regions. Through PMH's medical group segment, PMH manages the provision of physician services to approximately 260,000 patients in Southern California, South Central Texas, and Rhode Island through a network of approximately 8,900 physicians.

PMH currently owns the following hospitals: Los Angeles Community Hospital; Los Angeles Community Hospital at Bellflower; Los Angeles Community Hospital at Norwalk; Southern California Hospital at Hollywood; Southern California Hospital at Van Nuys; Southern California Hospital at Culver City; Foothill Regional Medical Center; Nix Health (four campuses); Roger Williams Medical Center (RI); and Our Lady of Fatima Hospital (RI).

PMH aligns its hospitals and physicians under a model referred to as Coordinated Regional Care ("CRC"). CRC provides for clinical integration among hospitals, physicians and other medical, social and community providers working closely with strategic partner health plans and other payers under a value-based, global risk reimbursement payment system to achieve the triple aim of improved patient care and experience, better patient health, and lower costs.

B. ECHN's Fiscal Condition

ECHN's mission has been impeded since 2001 by various factors, including reduced reimbursement from government payors, limited access to the capital required to improve infrastructure and to recruit and maintain needed physicians, and mounting pension liabilities.

Starting in 2001, when ECHN lost more than $10 million, capital investments had to be deferred and long-term debt and pension liabilities continued to grow. The pension funding reforms of 2006 and the market crash of 2008 created additional financial problems for ECHN. Although ECHN took numerous steps to mitigate the losses from these events, it was still unable to make significant capital investments. ECHN's plans to expand and introduce new programs to help recruit physicians were also put off.

In addition to the financial challenges that ECHN faced at that time, federal and state regulation changed the landscape for health care provider reimbursements and tax burdens. These increased financial burdens over the period of ten years led the Board to consider affiliation options.

C. The Search for Solutions and Partners

In 2011 the ECHN Board authorized the establishment of a workgroup to evaluate whether benefits would be realized by affiliating with another health care system, or whether ECHN would better serve the community by remaining an independent system (the "Partnering Workgroup"). To assist the Partnering Workgroup in its evaluation, ECHN engaged The Chartis Group, LLC ("Chartis"), a national healthcare consulting firm. In September of 2012, the Partnering Workgroup presented its initial findings to the ECHN Board. The Partnering Workgroup concluded that affiliation with a larger health system would better position ECHN to achieve its goals, and the Board agreed.

From November 2012 through April 2013, the Partnering Workgroup worked with Chartis to develop and conduct a request for proposal (RFP) process for potential partners. RFPs were mailed to three nonprofit health systems and three for-profit health systems. Based upon an initial review of four indications of interest and the conclusion that

affiliation appeared to be the best alternative, the ECHN Board created the Transaction Committee to thoroughly evaluate the proposals for affiliation.

After proper due diligence by the Transaction Committee and consideration of the Transaction Committee's recommendation by the ECHN Board, the Board selected a proposed joint venture between Yale New Haven Health System ("YNHHS") and Vanguard Health Systems, Inc. ("Vanguard") as the purchaser of ECHN. Before being able to negotiate a definitive Asset Purchase Agreement, however, ECHN learned that Tenet Healthcare Corporation ("Tenet") was going to acquire Vanguard. The Transaction Committee then performed its due diligence with respect to Tenet and recommended to the Board that ECHN continue with the contemplated transaction. The Board voted to approve the Transaction Committee's recommendation.

ECHN and Vanguard began the regulatory approval process in the summer of 2014 and submitted their application to the OAG and OHCA on October 24, 2014, and filed responses to completeness questions on November 25, 2014. On December 11, 2014, Tenet informed ECHN that it was withdrawing its application for the acquisition of ECHN citing the proposed regulatory conditions that had been placed on its Application to form a joint venture with the Greater Waterbury Health Network, Inc. ("GWHN").[7]

While waiting to see if Tenet might return to Connecticut to pursue its acquisition of ECHN, the Board reaffirmed the need for ECHN to partner. To that end, and with the guidance of The Chartis Group, the Transaction Committee conducted a second RFP process. On February 6, 2015, RFPs were sent to the four systems that had expressed

[7] On December 11, 2014, Tenet withdrew its applications with respect to the Greater Waterbury Health Network, Inc., Saint Mary's Health System, Inc., Eastern Connecticut Health Network, Inc., and Bristol Hospital and Health Care Group, Inc.

interest in partnering with ECHN and to two additional out-of-state systems that had approached ECHN with interest in an affiliation. ECHN received three responses.

While considering these proposals, two teams of Transaction Committee members and ECHN executives made visits to Los Angeles to tour PMH's management services organization that supports its independent physician practice associations (IPAs) and hospitals for risk-based contracting and population health management. The groups also toured Prospect's Southern California Hospital in Culver City and met with and interviewed representatives in the areas of governance, medical staff leadership, and administration from Prospect's Los Angeles Coordinated Regional Care Market.

Members of the Transaction Committee and ECHN executives also visited CharterCARE Health Partners' Roger Williams Medical Center in Providence, Rhode Island. CharterCARE Health Partners is PMH's coordinated regional care network comprised of Roger Williams Medical Center, Our Lady of Fatima Hospital, a skilled nursing facility, a regional cancer center, a rehabilitation center, a community primary care center, a home health services company, an IPA, and a physician group practice based in Providence.

Based upon their due diligence with respect to all the proposals, the Transaction Committee chose to negotiate only with PMH in finalizing a proposed asset purchase agreement. After some of the open items in PMH's proposed APA were addressed through negotiations, the Transaction Committee unanimously recommended to the ECHN Board that it accept PMH's proposal to acquire substantially all of the assets of ECHN. After review, the Board unanimously approved the APA in substantially the form presented to them. The draft APA was then submitted to ECHN's Corporators for consideration. The

ECHN Corporators approved the draft APA on July 29, 2015, with 165 voting in favor of the transaction and 4 against.

D. The Proposed Transaction

PMH or a PMH designated subsidiary (hereinafter, "PMH") will purchase substantially all of the assets of ECHN, including the properties, assets and businesses of, or ownership interests of ECHN affiliates. PMH will also purchase ECHN's interests in its or its affiliates' joint ventures.[8]

PMH will acquire real property, leased property, equipment, accounts receivable, and net working capital (*i.e.*, non-cash current assets less the value of all current liabilities) of ECHN and the ECHN affiliates. PMH will assume several key liabilities, including ECHN's unfunded pension liabilities, ECHN's health benefit plan for retirees, ECHN's captive insurer liabilities (*i.e.*, Connecticut Healthcare Insurance Company), and ECHN's workers' compensation obligations.

PMH will exclude some current ECHN liabilities that will then remain the responsibility of ECHN's residual corporation following the transaction ("Legacy ECHN"). For example, PMH will not assume liabilities that could arise from lawsuits or tax settlements based on pre-closing activities. ECHN will exclude certain of its assets from the purchase, including certain cash and cash equivalents of ECHN; all short-term and long-term investments, but excluding ECHN's investment interests in the joint ventures; board-designated, restricted, and trustee-held or escrowed funds (such as funded depreciation, debt service reserves, self-insurance trusts, working capital trust assets, and

[8] The assets of ECHN Community HealthCare Foundation, Inc., will not be included in the assets purchased by PMH.

assets and investments restricted to use), beneficial interests in charitable trusts, and accrued earnings on all of the foregoing.

PMH will pay $105,000,000 subject to the Net Working Capital reconciliation, minus the amount of certain ECHN liabilities assumed by PMH (*e.g.* ECHN's unfunded pension obligations, captive insurer liability, capital leases, and the workers' compensation liability), minus asbestos abatement liability of up to $1,000,000, and minus, in the event that ECHN is unable to assign and transfer to PMH ECHN's interest in an ECHN joint venture, a dollar amount to be fixed in advance for each ECHN Joint Venture.

ECHN's proceeds from the APA will first be used to settle all of ECHN's bond liabilities and all of ECHN's other indebtedness not otherwise assumed by PMH. The remaining proceeds will next be used to fund an indemnity reserve for a period of at least three years (the "Reserve Period") following the closing of the transaction for payment of ECHN liabilities to PMH that may arise post-closing. Any proceeds that remain after settling bond liabilities, settling other indebtedness, and funding the indemnity reserve will be held by the residual ECHN corporation to be used for post-closing liabilities and wind down of operations. After expiration of the Reserve Period, any funds remaining in the Reserve and not used to pay claims will be transferred as directed by the Office of the Attorney General of the State of Connecticut with the expectation that such funds will be transferred to a nonprofit foundation and used to support charitable health related efforts in the ECHN Service Area.

After closing, PMH/ECHN, will develop a strategic capital plan with respect to the Hospital Businesses. PMH has committed to spend within five years of the closing not less than $75,000,000 (the "Commitment Amount") for the benefit of the Hospital Businesses and for the benefit of the Service Area of MMH and RGH. These expenditures may include:

(i) capital projects, including routine and non-routine capital expenditures for the improvement of ECHN's facilities; (ii) development, expansion, or acquisition of a department, program, service or facility; (iii) upgrades or renovations generally; (iv) deferred maintenance items; and (v) capital expended in support of the recruitment of the hospitals' medical staff located in the hospitals' Service Area.

PMH will offer employment as of the closing to substantially all employees of ECHN and its affiliates who work at the hospital businesses, including employees on approved leaves of absence as of the closing. PMH will offer the hired employees salaries that are equal to their salaries as of the closing date and benefits packages that are comparable to those offered to similarly-situated employees at other hospitals operated by PMH. PMH will assume and honor ECHN's (and its affiliates') collective bargaining agreements.

For at least three years after the closing of the transaction, PMH will continue operating MMH and RGH in their current locations as acute care hospitals with emergency departments. Also, for at least three years after the closing of the transaction, PMH will maintain an ownership interest in ECHN's current post-acute care continuum of care network and require any wholly owned entity involved with such post-acute care continuum of care network to maintain appropriate service lines during such three-year period. PMH will also ensure that each Hospital maintains and adheres to ECHN's current policies regarding charity care, indigent care, community volunteer services and community benefits (or adopts other policies that are at least as favorable to the community as ECHN's current policies).

PMH will maintain and support financially ECHN's University of New England medical student and other health professions teaching programs, as well as ECHN's graduate medical education programs, while operating at a level not to exceed the Indirect

Medical Education and Direct Graduate Medical Education caps that may be established by the Centers for Medicare and Medicaid Services.

Following the closing, MMH and RGH will each maintain an advisory board made up of community representatives, physicians on the respective hospital's medical staff, and the Chief Executive Officer of the respective hospital (the "Local Board"). Among other things, the Local Board will serve as a resource for PMH with respect to PMH's investment of the capital commitment, assist with maintenance and implementation of a strategic business plan for the Hospitals, make recommendations for medical staff credentialing at the Hospitals, review and make recommendations regarding the quality assurance program at the Hospitals, and assist in issues relating to accreditation for the Hospitals.

ECHN agrees to maintain an indemnity reserve in the amount of $4,500,000 for a period of three years after the closing date so that PMH will have meaningful recourse against ECHN for any potential indemnification claims. If certain claims arise during this three year period, the indemnification reserve may be extended, but not beyond the fifth anniversary of the closing date. The indemnification obligations of PMH's subsidiary buyer to ECHN are guaranteed by PMH.

E. The Charitable Assets of ECHN

Throughout its history, ECHN has received numerous charitable gifts, legacies and devises from generous individual donors and community fundraising efforts.[9] These gifts were given to one of four entities: Manchester Memorial Hospital, Rockville General

[9] Manchester Memorial Hospital, Rockville General Hospital, the ECHN Community HealthCare Foundation, Inc., and ECHN Eldercare Services, Inc., hold all of ECHN's charitable funds. For the sake of our discussion, we will refer generally to funds as being held by ECHN.

Hospital, the ECHN Community HealthCare Foundation, Inc. (the "ECHN Foundation"), and ECHN Eldercare Services, Inc. As part of its Application, ECHN provided information and documentation of the charitable trusts and gifts of which its hospitals are the beneficiary or in which its hospitals claim an interest. Specifically, it provided copies of the gift documents themselves (Exhibit Q11-2 of the Application) and a spreadsheet (the "Gift Document Analysis"; Exhibit Q11-1 of the Application) that included a narrative description of each charitable gift, succession language where applicable, the name of the trustee of each gift, and a designation of whether each gift was an endowment and restricted as to purpose. The value of all the charitable gifts as of March 30, 2016, was $23,116,006.

The OAG reviewed the Gift Analysis provided by ECHN for accuracy and completeness. In addition, the OAG questioned ECHN on the due diligence undertaken to identify all of the underlying gift documents for the charitable funds. The OAG is satisfied that ECHN has identified all the charitable funds in its possession and has met its burden to produce the underlying gift documents for each fund.

1. Manchester Memorial Hospital

We first catalog the charitable funds held by MMH.

a. MMH Unrestricted Endowments

Unrestricted endowments are charitable funds, the original gift instrument of which specifies that the sum donated is to be held and preserved as "principal," as a "fund," as an "endowment," or directs that the sum be held and invested, or added to an existing endowment fund, and further specifies that the annual income earned on said principal be

applied to the general purposes of the hospital.

The following gifts are unrestricted endowments held by MMH:[10] Blish (11-1.1), Carpenter (11-1.2), Chapman (11-1.3), Coates (11-1.4), Dart (11-1.5), House (11-1.6), Porter (11-1.7), Rice (11-1.8), Stanley (11-1.9), Strant (11-1.10), Strickland (11-1.11), Ellis (11-1.12), Pinney (11-1.13), Hohenthal (11-1.14), Cheney (11-1.15), Campbell Cheney (11-1.16), Dewey (Albert) (11-1.17), Dewey (Jane) (11-1.18), Gardner (11-1.19), Piper 1 (11-1.20), and Piper 2 (11-1.21). As of March 31, 2016, the total value of these restricted endowments was $8,558,001.

b. MMH Endowments Restricted to Purpose

Endowments Restricted to Purpose are charitable funds, the original gift instrument of which specifies that the sum donated is to be held and preserved as "principal," as a "fund," as an "endowment," or directs that the sum be held and invested, but the purposes to which the income may be put are restricted and cannot be applied to the general purposes of the hospital. One of the most common restrictions on hospital gifts directs the funds to be used for free bed care, i.e., to use the funds on behalf of persons unable to pay for the hospital services provided (a "Bed Fund"). MMH holds six Bed Funds: Drake (11-1.22), Hills Preston (11-1.23), Boynton (11-1.24), Loomis (11-1.25), Cheney Disher (11-1.26), and Keeney (11-1.27). MMH's Bed Funds are valued at $541,728 as of March 31, 2016. MMH holds two additional endowments restricted to purpose: Trotter (11-1.28) (for the benefit of children patients) and Wright (11-1.29) (for the benefit of the fight against cancer). The Trotter and Wright funds have a total value of $6,629 as of March 31, 2016.

[10]The numbers following the gifts represent the fund number as identified in the Application, Exhibit Q11-1.

c. MMH Miscellaneous Funds

MMH has interests in two additional funds: Damato (11-1.30) and a life insurance policy (11-1.31). The Damato estate is an unrestricted gift, with an undetermined value at this time. The date of final distribution is unclear at this time due to the complexity of liquidating the assets in the estate, particularly the real estate assets.

The current value of the life insurance policy is $58,147.

The total value of gifts held by MMH as of March 31, 2016, is $9,164,514.

2. Rockville General Hospital

a. RGH Unrestricted Endowments

The following gifts are unrestricted endowments held by RGH: Bissell (11-1.32), Maxwell (11-1.33), Goodale and Risley (11-1.34), United German Society (11-1.35), Prescott (11-1.36), Maxwell (11-1.37), Smith (11-1.38), Doss (11-1.39), Wood (11-1.40), Henry (Maud) (11-1.41), Henry (Lenore) (11-1.42), Charter (11-1.43), Bilson (11-1.44), Belding (11-1.45), Bradley (11-1.46), Britton (11-1.47), Sprague (11-1.48), Doane (11-1.49), Keney (11-1.50), American Red Cross (11-1.51), Talcott (11-1.52), Maxwell (11-1.53), Metcalf (11-1.54), and Henry (11-1.55), As of March 31, 2016, the total value of these unrestricted endowments was $8,989,027.

b. RGH Endowments Restricted to Purpose

RGH holds eight Bed Funds: DAR (11-1.56), Prescott (11-1.57), Phelps (11-1.58), Winchell-Foster (11-1.59), Tucker (11-1.60), Whitlock (11-1.61), Sykes Phelps (11-1.62), and Kress (11-1.63). RGH's Bed Funds are valued at $288,358 as of March 31, 2016. MMH holds two additional endowments restricted to purpose: Baker Family (11-1.64) (for the upkeep and physical maintenance of the Hospital) and Schortmann (11-1.65) (for the operation or improvement of the maternity and nursery facilities of the Hospital). The

Baker Family and Schortmann funds have a total value of $278,769 as of March 31, 2016.

c. RGH Miscellaneous Funds

RGH has interests in two charitable gift annuities, but one of the two joint annuitants has now lived beyond the projected life expectancy. The annuities are now contractual liabilities of the Hospital, and ECHN is looking to terminate these arrangements at fair value. Names of the original grantors have been withheld. (11-1.77 and 11-1.78).

The total value of gifts held by RGH as of March 31, 2016, is $12,374,200.

3. ECHN Community Healthcare Foundations, Inc.

a. Endowments

The ECHN Foundation holds several funds for the benefit of MMH and RGH. With respect to MMH, the ECHN Foundation holds the following unrestricted endowments: Burgess (11-1.79), St. Laurent (11-1.80), and Piper (11-1.81). The total value of these three gifts as of March 31, 2016 is $1,285,023. With respect to RGH, the ECHN Foundation holds the follow endowments with restricted purposes: Maxwell (11-1.82) (for the benefit of the normal maintenance and repair of the Maxwell Home and its grounds) and Risley Scholarship (11-1.83) (for the benefit of nurses' continuing education). The total value of these two funds as of March 31, 2016, is $282,289. The total value of funds held by the ECHN Foundation is $1,567,312.

b. Special Purpose Funds

The ECHN Foundation holds a dozen funds that are fully expendable but have restricted purposes. If ECHN does not deplete these funds for their intended purpose prior to the closing, they will remain with Legacy ECHN to be transferred to the New Foundation or another charitable organization to fulfill the fund's intended charitable purpose. The

special funds are as follows: Avis Lloyd Tree of Life (11-2.1), Team Towanda (11-2.2), Employee Care (11-2.3), Breast and Cervical Cancer (11-2.4), Adult Ambulatory Administrative Education and Development (11-2.5), Purcell Golf Classic Trophies (11-2.6), Woodlake at Tolland Wishes Program (11-2.7), Van (11-2.8), Risley (11-2.9), Fields (11-2.10), and Woodlake: Resident Council (11-2.11). The total value of the special funds held by the ECHN Foundation is $9,979.

4. Trusts Held by Outside Trustees

All the charitable funds identified above are held and administered by ECHN. There is a series of charitable gift funds, however, that are not held by ECHN but by outside trustees and for which ECHN holds the beneficial interest.

a. For the Benefit of MMH

There are seven funds held by outside trustees for the benefit of MMH: Barton (11-3.1), Clark (11-3.2), Morton (11-3.3), Robertson (11-3.4), Crowell (11-3.5), Ferguson (11-3.6), and Rogers (11-3.7).

b. For the Benefit of RGH

There are three funds held by outside trustees for the benefit of GWH: Dillon (11-3.8), Moxon (11-3.9), and Barton (11-3.10).

The market value of the corpus of the trusts held by outside trustees for the benefit of ECHN was $10,903,971 on March 31, 2016.

V. LEGAL ANALYSIS AND REQUIRED MODIFICATIONS

Conn. Gen. Stat. § 19a-486a *et seq*. directs that any nonprofit hospital that enters into an agreement to transfer a material amount of its assets or operations with an entity operated for profit must first obtain the approval of OHCA and the OAG. Any agreement made without these approvals is deemed void.

Conn. Gen. Stat. § 19a-486c mandates that the Attorney General shall disapprove a proposed sale of a nonprofit hospital to a for-profit entity as not in the public interest if he determines that one or more of nine conditions exist.[11] The Conversion Act, however, allows the Attorney General to approve an application while setting forth modifications and/or conditions that would bring the proposed transaction into compliance with the conditions in § 19a-486c. What follows, therefore, is the OAG's analysis and discussion of the statutory criteria in § 19a-486c and the modifications and conditions to the Asset Purchase Agreement that are necessary to satisfy those criteria.

A. The transaction is not prohibited by Connecticut statutory or common law governing nonprofit entities, trusts or charities.

Pursuant to Conn. Gen. Stat. § 19a-486c(a)(1), the Attorney General shall disapprove a proposed agreement if he determines that the transaction is prohibited by Connecticut statutory or common law governing nonprofit entities, trusts, or charities. Subject to the modifications and conditions set forth in Section II(D) of this decision, we conclude that the Asset Purchase is not prohibited by statutory or common law governing nonprofit entities, trusts, or charities.

B. ECHN exercised due diligence.

Pursuant to Conn. Gen. Stat. § 19a-486c(a)(2), the Attorney General is required to determine whether the nonprofit hospital exercised due diligence in four distinct areas. The phrase "due diligence" is not defined by the Conversion Act, but Black's Law Dictionary (6th ed. 1990) defines it as: "Such a measure of prudence, activity, or assiduity, as is properly to be expected from, and ordinarily exercised by, a reasonable and prudent man

[11] See footnote 1.

under the particular circumstances; not measured by any absolute standard, but depending on the relative facts of the special case." In short, therefore, we review the level of care and prudence that the ECHN Board exercised in deciding to enter into the APA with PMH.

Based upon our and our expert's review of the materials presented as a part of the ECHN and PMH Application and the testimony given at the public hearings, it is clear that ECHN undertook an extensive and diligent process to explore strategic options and to identify a capital alternative that would enable it to address its difficult financial position. ECHN has faithfully pursued its mission to ensure quality healthcare for the Manchester and Rockville communities. As noted in the findings of fact, ECHN's efforts began in 2011 with the establishment of the Partnering Workgroup and the hiring of Chartis. Every step that followed in ECHN's pursuit of a capital partner was reviewed by a Transaction Committee, the Board of ECHN, and for significant issues, the ECHN Corporators. ECHN pursued discussions with multiple strategic partners, evaluated a range of transaction structures, and explored multiple strategies to access capital. Our specific due diligence findings follow.

1. ECHN exercised due diligence in deciding to participate in the APA.

Pursuant to Conn. Gen. Stat. § 19a-486c(a)(2)(A), the Attorney General shall disapprove a proposed agreement if he determines that the nonprofit hospital failed to exercise due diligence in deciding to transfer its assets. The record reveals a compelling case for ECHN to transfer substantially all of its assets as a means to assure the long-term viability of MMH and RGH.

ECHN engaged in a decision-making process that was reasonable, thoughtful, and thorough. In short, its ultimate decision to transfer substantially all of its assets to PMH demonstrated due diligence under the circumstances. As noted in the findings of fact,

ECHN pursued a range of strategic initiatives to address the hospital's financial constraints, aging facilities, and limited access to capital. Without a feasible alternative available, the ECHN Board reasonably concluded that the sale of its assets to another hospital system was an appropriate solution for long-term viability of the hospitals. We, therefore, conclude that ECHN exercised due diligence in deciding to transfer substantially all of its assets as a part of the APA.

2. ECHN exercised due diligence in selecting PMH for the Asset Purchase.

Pursuant to Conn. Gen. Stat. § 19a-486c(a)(2)(B), the Attorney General shall disapprove a proposed agreement if he determines that the nonprofit hospital failed to exercise due diligence in selecting the purchaser. Based on the record in this case, ECHN has established that it exercised due diligence in selecting PMH to purchase substantially all of its assets.

The full history of ECHN's search for a capital partner is described in detail in the findings of fact. With respect to the initiative that resulted in the APA with PMH, however, we conclude that ECHN took appropriate and considered steps to identify the best situation for MMH and RGH. ECHN conducted a second RFP process with the guidance of Chartis, delivering the RFP to six potential partners, including PMH. By mid-March in 2015, ECHN had received three proposals. The Transaction Committee reviewed the proposals and evaluated each in light of the selection criteria approved by the Board, including quality of care. The Transaction Committee then performed its due diligence with respect to the potential partners, reviewing financial, quality, and corporate compliance data for each of the potential partners. With respect to PMH, members of the Transaction Committee visited PMH's California and Rhode Island operations.

On June 22, 2015, the Transaction Committee voted unanimously to recommend acceptance of the PMH proposal. On June 25, 2015, the Board held a retreat during which it considered the proposals received from the potential partners, ultimately voting in favor of the PMH proposal. The draft APA was then sent to ECHN's Corporators for their review, who approved entering the transaction in overwhelming numbers.

On or about the beginning of February 2016, after the hospital conversion application process had begun with the OAG and OHCA, ECHN learned that recent Medicare and Medicaid surveys at two of PMH's California hospitals (Los Angeles Community Hospital and Southern California Hospital at Culver City) had resulted in findings of Immediate Jeopardy by regulatory authorities at both hospitals. After learning about these determinations, ECHN appointed a Quality Evaluation Team that looked into the Immediate Jeopardy findings to determine whether the findings were sufficiently substantial to call into question PMH's fitness as a transaction partner. After a thorough investigation, the Quality Evaluation Team determined that "the recent compliance issues present isolated challenges that [PMH] has demonstrated a strong commitment to remediate through corrective actions that are already in progress." (Testimony of Joy Durin, Vice Chair, Board of Trustees, Chair, Transaction Committee, p. 3350.) This conclusion was shared with the Transaction Committee, approved by them, sent to the Board, and the board approved the recommendation. In addition to the investigation performed by the Quality Evaluation Team, ECHN negotiated a Quality Assurance Commitment with PMH that requires PMH to maintain ECHN's quality programs for at least two years following the closing of the transaction. In addition, it requires PMH to maintain quality assurance and performance improvement programs that are consistent with industry best practices and quality improvement programs as currently implemented

in PMH's Rhode Island facilities. Based on the evidence presented to the OAG, we conclude that ECHN exercised due diligence in selecting PMH as its partner for the APA and in confirming that selection after PMH's Immediate Jeopardy findings came to light.

3. ECHN exercised due diligence in obtaining a fairness evaluation.

Pursuant to Conn. Gen. Stat. § 19a-486c(a)(2)(C), the Attorney General shall disapprove a proposed agreement if he determines that the nonprofit hospital failed to exercise due diligence in obtaining a fairness evaluation from an independent person expert in such agreements.

ECHN's fairness evaluation was conducted by Duff & Phelps, LLC ("Duff & Phelps"), who had no previous material relationship with any party to the transaction, except for having previously provided an independent fairness opinion regarding the proposed ECHN/Tenet transaction. In addition, no portion of Duff & Phelps fee was contingent on the conclusion expressed in the fairness opinion or on the successful consummation of the transaction.

Therefore, we conclude that the ECHN Board exercised due diligence in obtaining a fairness evaluation regarding the terms of the proposed APA from an independent entity expert in such agreements.

4. ECHN exercised due diligence in negotiating the terms and conditions of the APA.

Pursuant to Conn. Gen. Stat. § 19a-486c(a)(2)(D), the Attorney General shall disapprove a proposed agreement if he determines that the nonprofit hospital failed to exercise due diligence in negotiating the terms and conditions of the transfer.

Our review of the transaction leads us to conclude that ECHN exercised due diligence in negotiating most of the terms and conditions of the APA. As discussed below, we believe ECHN will receive at least the fair market value for its assets. In addition,

ECHN negotiated a capital commitment of $75 million for the for-profit ECHN hospital system ("PMH/ECHN") over the next five years. Other highlights include PMH's retention of ECHN employees, the assumption by PMH of the unfunded pension liabilities, the formation of local advisory boards for each hospital, and PMH's commitment to maintain ECHN's current policies regarding charity care, indigent care, and community benefits.

One provision in the APA, however, stands out as unreasonable in light of the details of the transaction as a whole. Section 5.18 of the APA concerns PMH's $75 million capital commitment, and subsection (b) of this section provides as follows:

> *Notwithstanding the above capital commitment, in the event that any Legal Requirement is enacted or imposed by the State of Connecticut after Closing that discriminates against, or adversely affects a disproportionate number of for-profit hospitals and causes the Hospital Businesses to suffer a decline in EBITDA of more than ten (10) percent in any year, on a consolidated basis, then, Buyer may defer in its discretion the above capital commitment beyond the five-year period provided in Section 5.18(a) but only to the extent of the decline in EBITDA resulting from the discriminatory Legal Requirement. To the extent Buyer desires to defer the capital commitment as a result of a discriminatory Legal Requirement, (i) Buyer shall make available to the public reasonably detailed information to support Buyer's position (provided that in no event shall Buyer be required to disclose any information that is subject to a confidentiality or other similar arrangement) and (ii) Buyer shall consult with the Local Board to determine an alternate mutually agreeable timeframe to complete the capital commitment that is reasonable and appropriate in light of the changed circumstances caused by the new Legal Requirement.*

(Exhibit Q3-2, Asset Purchase Agreement, p. 182.)

Although PMH may wish to hedge against future changes in the legal landscape, it cannot hold the ECHN capital investment hostage by such a provision. To do so would render the $75 million capital commitment – a key term of the deal – subject to delay upon the future actions of legislators. Put differently, we believe that PMH must bear the risk of future legislation and not PMH/ECHN. The $75 million capital commitment is indeed a

commitment, and the deadline by which it must be spent must be honored. Accordingly, as a condition to approval of the proposed transaction, the OAG requires that the Applicants modify the APA by deleting section 5.18(b) from the APA.

C. ECHN Disclosed Any and All Board Member, Officer, Key Employee, and Expert Conflicts of Interest With Respect to the APA.

Pursuant to Conn. Gen. Stat. § 19a-486c(a)(3), the Attorney General shall disapprove the proposed transaction as not in the public interest if he determines that the nonprofit hospital failed to disclose any conflict of interest, including but not limited to, conflicts of interest pertaining to board members, officers, key employees, or experts of ECHN, the purchaser, or any other party to the transaction.

The Applicants provided the OAG with individual conflict of interest statements for each relevant individual (board member, officer, etc.) employed by ECHN, its experts, and PMH. Each individual was required to respond to individual questions regarding possible financial, beneficial, and/or employment related conflicts of interest. If any of the questions were answered with anything other than an unqualified "No," the individual was required to attach an explanation to the statement. These statements were reviewed by the OAG and Navigant.

Section 5.03 of the APA requires PMH "to employ as of the Closing Date substantially all employees of Seller and its Affiliates who work at the Hospital Businesses." (Exhibit Q3-2, Asset Purchase Agreement, p. 171.) Therefore, employees of ECHN, including ECHN's officers and key employees, have been offered employment with PMH as a part of the transaction. This general provision, however, does not create a conflict of interest for the purposes of this statutory element.

After a careful review of all the conflict of interest responses, there do not appear to be any conflicts of interest with this proposed transaction that exist outside of the APA itself. In addition, no intervenor or other participant in the proceeding has offered any credible evidence that any conflict existed at any time during the negotiation of the APA. Accordingly, we conclude that no conflicts of interest exist that would require disapproval of the APA.[12]

D. ECHN will receive fair market value for its assets.

Pursuant to Conn. Gen. Stat. § 19a-486c(a)(4), the Attorney General shall disapprove the proposed transaction as not in the public interest if he determines that the nonprofit hospital will not receive fair market value for its assets. For purposes of the Conversion Act, "fair market value" is defined as

> the most likely price that the assets would bring in a sale in a competitive and open market under all conditions requisite to a fair sale, with the buyer and seller each acting prudently, knowledgeably and in their own best interest, and with a reasonable time being allowed for exposure in the open market.

Conn. Gen. Stat. § 19a-486c(a)(4).

PMH has agreed to pay $105 million as compensation for substantially all of ECHN's assets. Two independent financial experts have reviewed the transaction to determine whether ECHN will receive fair market value for its assets, and both have concluded that the purchase price of $105 million equals or exceeds the fair market value of ECHN's assets.

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[12] ECHN's process to ensure that no individual with a conflict of interest voted on this transaction was very thorough. Indeed, ECHN created a Conflict of Interest Task Force specifically for this purpose. The Board voted on all transaction-related resolutions pursuant to a two-step process to help ensure that any personal interest in any of the transaction decisions made would be eliminated.

As discussed above, ECHN retained Duff & Phelps to provide it with an independent valuation and fairness opinion regarding the transaction.[13] Duff and Phelps considered three principal methods of valuation: discounted cash flow, guideline company, and M&A transaction. These approaches indicated that the fair market value of ECHN was well below the price PMH had agreed to pay for substantially all of the assets of ECHN. Duff & Phelps's mid-point estimate for ECHN, without the joint ventures, was $57.1 million. Duff & Phelps used a market and a capitalized cash flow approach to estimate the value of ECHN's joint ventures as $13.1 million. The total estimated fair market value for ECHN as determined by Duff & Phelps, therefore, is $70.2 million. As such, Duff and Phelps was able conclude in its fairness opinion that "the consideration to be received by [ECHN] in the Proposed Transaction is fair from a financial point of view to the Company." (Exhibit Q7-4, Duff & Phelps' Fairness Opinion Letter, p. 836.)

Navigant was hired though an RFP process to be the OAG's financial expert for the purposes of reviewing this transaction. Navigant has also concluded that ECHN will receive fair market value for the transfer of its assets.[14] In performing its fair market value analysis, Navigant considered the three generally accepted approaches to value: income, market, and cost. Navigant valued ECHN's assets as value-in-continued use, as part of a going concern. Based upon these valuation methods, Navigant estimated the total fair market value of ECHN, including the joint ventures, to be $63,750,000. Navigant's

[13] The OAG has previously concluded that ECHN exercised due diligence in selecting Duff & Phelps to perform the independent fairness evaluation on its behalf.

[14] Navigant's report is attached hereto as Exhibit A.

analysis supports the conclusion that ECHN will receive fair market value for the transfer of its assets.

Based on the independent financial assessments of two respected hospital valuation firms, and the lack of evidence to the contrary in the record, we conclude that ECHN will receive fair market value for its assets.

E. The fair market value of the assets has not been manipulated by any person in a manner that causes the value of the assets to decrease.

Pursuant to Conn. Gen. Stat. § 19a-486c(a)(5), the Attorney General shall disapprove the proposed transaction as not in the public interest if he determines that the fair market value of the nonprofit hospital's assets has been manipulated by any person in a manner that causes the value of the assets to decrease.

Navigant performed reviews of ECHN's financials and assets and found no indication that the fair market value of ECHN's assets had been manipulated. No intervenor or other participant in the proceeding has offered any evidence that the fair market value of ECHN's assets has been manipulated to artificially lower the payment price. Based on these factors, we conclude that the fair market value of ECHN's assets has not been manipulated.

F. The financing of the transaction will not place ECHN's assets at an unreasonable risk.

Pursuant to Conn. Gen. Stat. § 19a-486c(a)(6), the Attorney General shall disapprove the proposed transaction as not in the public interest if he determines that the financing of the transaction by the nonprofit hospital will place the nonprofit hospital's assets at an unreasonable risk. Consistent with the OAG's interpretation of this provision in *Sharon*, we interpret this statutory provision to require our examination of the proposed financing of the transaction to ensure that the APA does not "burden the for-profit entity

with so much debt that the transferred assets of the former nonprofit hospital, albeit now operated for profit, will be placed at an unreasonable financial risk of closure or bankruptcy—an event that would result in a loss of healthcare for the affected community." *In re Sharon Hospital*, Docket No. 01-486-01, p. 64 (2001).

Based upon the record, we conclude that the financing of this transaction will not place ECHN's assets at risk. PMH confirmed on the record that the $105 million purchase price for ECHN's assets will be financed with operating cash from PMH. More specifically, PMH represented that it has the financial capacity to provide the necessary capital to purchases ECHN's assets without transaction-specific financing arrangements. After its review of the transaction, Navigant concluded that PMH will not incur any debt financing to consummate the transaction, and so, ECHN's assets would not be put at an unreasonable risk.

As such, we conclude that the assets of ECHN will not be placed at an unreasonable risk due to the financing of the transaction.

G. The management contract contemplated under the transaction is for reasonable fair value.

Pursuant to Conn. Gen. Stat. § 19a-486c(a)(7), the Attorney General shall disapprove the proposed transaction as not in the public interest if he determines that any management contract contemplated under the transaction is not for reasonable fair value. No management contract is contemplated under the APA. Accordingly, we conclude that this element of the analysis has been met.

H. Assuming compliance with the modifications imposed below, a sum equal to the fair market value of ECHN's assets is being transferred to the New Foundation to provide only for charitable health care services in the affected community.

Pursuant to Conn. Gen. Stat. § 19a-486c(a)(8), the Attorney General shall disapprove the proposed transaction as not in the public interest if he determines that:

> a sum equal to the fair market value of the nonprofit hospital's assets (A) is not being transferred to one or more persons to be selected by the Superior Court who are not affiliated through corporate structure, governance or membership with either the nonprofit hospital or the purchaser, unless the nonprofit hospital continues to operate on a nonprofit basis after the transaction and such sum is transferred to the nonprofit hospital to provide health care services, and (B) is not being used for one of the following purposes: (i) For appropriate charitable health care purposes consistent with the nonprofit hospital's original purpose, (ii) for the support and promotion of health care generally in the affected community, or (iii) with respect to any assets held by the nonprofit hospital that are subject to a use restriction imposed by a donor, for a purpose consistent with the intent of said donor.

This provision in the Conversion Act advances the important policy that the value of the nonprofit hospital be preserved for charitable healthcare purposes in the service area that the nonprofit hospital previously served. In addition, it restates the OAG's statutory responsibility to protect the public interest in the protection of gifts made for charitable or public purposes codified at Conn. Gen. Stat. § 3-125.

The language of Conn. Gen. Stat. § 19a-486c(a)(8) requires the OAG to assess several different issues in connection with the APA. We must first analyze, determine, and approve a value that is the "sum equal to the fair market value of the nonprofit hospital's assets." Second, we must analyze the nature and purpose of the entity to which that sum is being transferred. Third, we must determine and require that the transferred sum is used only for the statutorily identified charitable purposes. Last, we are required to inventory all gift documents and restricted charitable assets currently held by ECHN and identify any approximation and/or equitable deviation needs in connection with these assets.

1. A Sum Equal to the Fair Market Value of ECHN is Being Transferred to the New Foundation.

The term "fair market value" is used in several places in subsection (a) of § 19a-486c. As discussed in the OAG's *Sharon* decision, and more fully below, fair market value has two distinct meanings depending on which section of the Conversion Act the term is used.

Subsection (4) of § 19a-486c requires us to ensure that the nonprofit hospital receives fair market value for its assets. As discussed earlier, subsection (4) defines "fair market value" as the likely price that the assets would bring in a sale in a competitive and open market. Subsection (4) is looking for the gross asset value.

If fair market value were computed for purposes of subsection (8) as it is for subsection (4), though, the nonprofit hospital might be left transferring to a conversion foundation the proceeds of its sale, but leaving the nonprofit hospital no ability to pay off its liabilities post-closing with some portion of those proceeds. Such a result is nonsensical, because a primary goal of a nonprofit hospital's sale of assets is the extinguishment of corporate liabilities. For example, in the case of ECHN, its long-term bond debt will be paid off with proceeds from the sale of its assets.

The definition we use for fair market value for purposes of subsection (8), therefore, is more appropriately the price paid for the nonprofit hospital's asset minus the amount of its debt obligations and other liabilities that it will resolve using the proceeds of the proposed transaction. In other words, fair market value equals the net proceeds of the nonprofit hospital. *In re Sharon Hospital*, OAG Docket No. 01-486-01, p. 69 (2001). With respect to ECHN, the net asset value calculation must take into account all retained assets and liabilities, including, for example, cash, accounts receivable, any adjustment to the net working capital figure, its long-term debt, workers' compensation and medical malpractice

liability relating to events occurring prior to closing, and any payor liabilities and obligations from reporting periods prior to closing.

Late Filed Exhibit 8 (App., p. 4261) sets forth the most current numbers on what proceeds will remain after netted with ECHN's liabilities. In short, this exhibit projects that nothing will remain after ECHN pays off its liabilities. In fact, it appears that ECHN will not even have sufficient assets to fund the indemnity reserve or to fully pay for its liabilities in excess of $77 million (the excess liability is currently tallied at $7,924,000), both obligations of ECHN. Given these numbers, we conclude that the sum that is equal to the fair market value of ECHN is currently zero.

However, the post-transaction nonprofit ECHN, Legacy ECHN, may receive funds after the close. For example, Legacy ECHN may receive reimbursements due from Medicare and Medicaid for the years prior to the closing. Also, Legacy ECHN will receive income from the unrestricted endowments during the time period between the close of the transaction and the Superior Court order that will transfer all charitable assets from Legacy ECHN to the New Foundation. Moreover, Legacy ECHN may receive charitable distributions from pending estates, i.e., the Damato estate. This income will initially be used to pay off ECHN's liabilities and to fund the indemnity reserve, both obligations of ECHN.[15] After these obligations are paid or funded, however, any funds remaining would constitute net proceeds.

Because the final net proceeds value of the nonprofit hospital cannot be precisely identified prior to the actual closing of the transaction, the determination of a sum equal to

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[15] Legacy ECHN could also use these funds to finance wind-down costs, but Exhibit 8 already includes a line item for "Post-closing Pool 'Wind Down' Funds." Regardless, Wind Down costs are an appropriate expense for Legacy ECHN.

the fair market value for the purposes of subsection (8) must await a post-closing accounting. Accordingly, as soon as reasonably possible after the Applicants have agreed to a Final Closing Statement of the asset purchase, the Applicants must provide the OAG a final accounting of the transaction that sets forth the balance sheets of ECHN immediately prior to, and Legacy ECHN immediately after, the closing and that provides a net proceeds analysis, substantially similar to Late Filed Exhibit 8 with explanations of any changes to the figures. This requirement is a condition of approval for the proposed transaction.

Additionally, because Legacy ECHN will receive income post-closing that may constitute net proceeds, Legacy ECHN shall, as a condition to the OAG's approval of the transaction, report quarterly to the OAG regarding (1) any and all income received by Legacy ECHN post close, including, but not limited to, Medicare and Medicaid reimbursements, income from charitable assets held by Legacy ECHN prior to transfer to the New Foundation, and any additional charitable funds received, and (2) all expenditures for Legacy ECHN.

Last, if the transaction ultimately produces net proceeds, that amount will be transferred to the New Foundation for use consistent with the charitable purpose of the New Foundation.

2. The Nature of the Conversion Foundation Complies with the Conversion Act.

The Conversion Act requires that the net asset value of the nonprofit hospital be transferred to "one or more persons to be selected by the Superior Court who are not affiliated through corporate structure, governance or membership with either the nonprofit hospital or the purchaser, unless the nonprofit hospital continues to operate on a nonprofit basis after the transaction and such sum is transferred to the nonprofit hospital to provide

health care services." Conn. Gen. Stat. § 19a-486c(8)(A). This provision prohibits improper affiliation with the new for-profit hospital.

ECHN has submitted a draft certificate of incorporation ("COI") and draft bylaws for the New Foundation. By these submissions, ECHN is proposing to create an "independent conversion foundation." This particular type of foundation is completely independent from both the nonprofit hospital and the for-profit purchaser and must be approved by the Superior Court. There can be no affiliation by corporate structure, governance, or membership.

The draft documents comply with the requirements of the statute. The New Foundation will have no corporate relationship with PMH/ECHN, and the governing members of the New Foundation will not contemporaneously serve in any governing position at PMH/ECHN or at any of its affiliates. In addition, any individual who serves as member of a governing board at PMH/ECHN must wait two years before serving on the governing board of the New Foundation. (Exhibit Q10-2, New Foundation Bylaws (Draft), pp. 917-18.) The New Foundation meets the affiliation requirements of § 19a-486c(8)(A).

The New Foundation will also be operated for the proper purposes, as set forth in the Conversion Act. Section 19a-486c(a)(8)(B) provides that the New Foundation must be operated:

> (i) For appropriate charitable health care purposes consistent with the nonprofit hospital's original purpose, (ii) for the support and promotion of health care generally in the affected community, or (iii) with respect to any assets held by the nonprofit hospital that are subject to a use restriction imposed by a donor, for a purpose consistent with the intent of said donor . . . ."

§ 19a-486c(a)(8)(B).

In its draft COI, the New Foundation lists it purposes as follows:

> (a) To maintain and improve the health of the residents of the area historically served by Eastern Connecticut Health Network, Inc., Manchester Memorial Hospital, Inc., and Rockville General Hospital, Inc., specifically, the nineteen communities of Manchester, Vernon (including Rockville), Andover, Ashford, Bolton, Columbia, Coventry, East Hartford, East Windsor, Ellington, Glastonbury, Hebron, Mansfield, Somers, South Windsor, Stafford, Tolland, Union, and Willington (the "Communities");
>
> (b) To support or conduct community health needs assessments and encourage and support efforts to improve the health of the Communities, including the poor, the elderly, the disabled, children, and other underserved and at-risk populations;
>
> (c) To support and engage in community projects, activities, and programs that will improve access to care and enhance the health of residents, including, but not limited to, preventative health programs and health education;
>
> (d) To solicit and accept additional funds to support the Corporation's purposes, and to make grants and provide financial and other support to other non-profit organizations engaged in activities that further the Corporation's purposes;
>
> (e) To support and promote the education and training of medical professionals and providers in the area;
>
> (f) To work cooperatively with Prospect Medical Holdings, Inc. ("PMH") to ensure and augment a network of affordable and accessible health and medical care in the region; provided, however, that the Corporation will not support programs operated by or for the direct benefit of PMH while it operates as a for profit entity; and
>
> (g) To engage in any lawful act or activity for which a corporation may be organized under the Revised Nonstock Corporation Act of the State of Connecticut in furtherance of the foregoing.

(Exhibit Q10-1, Certificate of Incorporation (Draft), pp. 911-12.) These purposes are consistent with the requirements in the Conversion Act.

3. The Transferred Sum Will Be Used Only for the Statutorily Identified Charitable Purposes.

ECHN currently predicts that it will have no net proceeds to transfer to the New Foundation after the closing. Should a subsequent accounting of the transaction reveal net

proceeds, however, we must ensure that they will forever be used for their proper charitable purpose. The draft COI established the proper charitable purposes, but the primary mechanism to ensure that they will be used as such forever is the requirement that the New Foundation Board receive the consent of the Attorney General for the amendment of specific sections of the COI, specifically, paragraphs 2, 5, 8, and 14. In this way, the purposes of the New Foundation (paragraph 2 of the COI) cannot change unless the Attorney General agrees. Accordingly, as a condition to the Attorney General's approval of the Application, the New Foundation must include paragraph 14 in the draft COI in the final COI of the New Foundation, requiring Attorney General approval for changes to paragraphs 2, 5, 8, and 14 of the Certificate of Incorporation.

4. Description and Quantification of the Nonprofit Hospital's Charitable Assets to be Held by the New Foundation

Our final area of concern is to ensure that the charitable assets of ECHN, which have been held in trust for the public, are safeguarded and used for the promotion of healthcare in the area served by ECHN after the sale of its assets to PMH. We must also ensure that any restrictions contained in these charitable gifts and trusts are protected.

a. Purpose of Attorney General's Review of Charitable Gifts

A full analysis and review of ECHN's charitable gifts and trusts at this time is essential for several reasons. First, it permits us to fulfill our statutory obligation to ensure that all of ECHN's charitable gifts and trusts are used for a purpose consistent with the intent of the donor. In other words, this review ensures that ECHN's analysis and treatment of charitable funds in the Application correctly interprets the donors' charitable use restrictions. Second, it ensures that, with respect to the charitable gifts, no aspect of the transaction is "prohibited by Connecticut statutory or common law governing nonprofit

entities, trusts or charities." Conn. Gen. Stat. § 19a-486c(a)(1). Finally, it provides subsequent holders of the funds, i.e., the New Foundation, with accurate information about whether and how the gifts are restricted under Connecticut law so that it can administer them in accordance with donor restrictions, charities law, the terms of the contractual agreements, and modifications required in this decision.

b. Documents Reviewed and Legal Standards

As part of the Application, ECHN provided a review and analysis of its charitable gifts and endowments. (Exhibit Q11-1, Detail on Specific Funds, p. 927-976.) ECHN was required to provide copies of the gift instruments (including wills, inter vivos trust agreements, and documentation of inter vivos gifts), to document the current values of the funds, and to describe the donor's restrictions or directives reflecting how the gift was to be used by ECHN. The purpose of the OAG's request was to obtain the information necessary to: (1) review the gift instrument for each of ECHN's gifts to determine whether its language would permit the gift to be transferred to another nonprofit, or whether a reverter clause or gift-over provision would be triggered by the sale of assets that would require the donation to revert to a different person, and (2) determine whether the donor restricted the use of a fully expendable gift, or the income earned on an endowment fund, to a particular charitable purpose set out in the gift instrument, for example, free beds, charity care, maintenance, a building fund, or research.

The OAG reviewed each charitable gift and its supporting documentation to confirm the accuracy of ECHN's conclusions regarding the proper charitable purpose of the fund and any spending restrictions on the fund.

c. Amount Stated by Hospital in Application

ECHN has stated that as of September 30, 2015, it held $23,356,291 in charitable

assets, plus an additional $19,349 in special funds. Thus, according to its figures as of that date, a total of $23,375,640 in charitable gifts would be transferred to the New Foundation. In addition, the value of trusts held by third parties for the benefit of ECHN was $10,809,693 as of September 30, 2015.

We asked ECHN to update the value of the funds as of March 31, 2016, in a late filed exhibit. As of that date, it held $23,106,027 in charitable assets, plus an additional $9,979 in special funds. Thus, according to its figures as of that date, a total of $23,116,006 in charitable gifts would be transferred to the New Foundation.

d. ECHN's Charitable Gifts and Trusts.

The law on approximation, or cy pres, is well-developed in Connecticut. Indeed, the OAG brought an approximation action in the *Sharon* matter to address those charitable purposes that could no longer be fulfilled due to the sale of Sharon Hospital's assets. In that case, the court set forth the standards for approximation.

> In determining the construction of a charitable trust upon the failure of its stated purpose, the court applies the common law doctrine of cy pres, or approximation to as near as possible reflect the donor's intent. When it becomes illegal or otherwise impossible to carry out the terms of a charitable trust, rather than allow it to fail, the court will apply the doctrine of cy pres or approximation in order to carry out the charitable intentions of the donor as near as possible. "The rule of cy pres is a rule for the construction of instruments in equity, by which the intention of the party is carried out *as near as may be,* when it would be impossible or illegal to give it literal effect . . . The doctrine of cy pres may be applied without the consent of the donor." (Citations omitted; emphasis in original; internal quotation marks omitted.) *Carl J. Herzog Foundation, Inc. v. University of Bridgeport, 243 Conn. 1, 10 n.8, 699 A.2d 995 (1997).*

Blumenthal v. Sharon Hosp., Inc., 2003 Conn. Super. LEXIS 1657, 11-12 (Sup. Ct. 2003).

Also relevant to the conversion of a nonprofit hospital is the law on equitable deviation, which is similar to that of approximation but concerns the administration of a gift fund and not its charitable purpose. The equitable doctrine of deviation has been

applied to preserve the "dominant [charitable] purpose by modifying what is described as [a] secondary purpose, often the method or means for carrying out the dominant purpose." 8 G. Bogart, Trusts and Trustees (2d Ed. Rev.Repl.1991) § 396, p. 330. Courts use this legal doctrine to order a change in the administration of a charitable fund from one charitable entity to another. Equitable deviation will be necessary in this case to move the charitable funds from ECHN to the New Foundation or another appropriate entity.

The Attorney General's office inventoried the gift documents in Section IV(E) in the Findings of Facts. Based upon this inventory and ECHN's and our analysis of these charitable gifts, we have determined that as a condition of approval, the following actions must be taken with respect to these funds.

i. Unrestricted Endowments.

An endowment fund is defined as "an institutional fund or any part thereof not wholly expendable by the institution on a current basis under the terms of a gift instrument." Conn. Gen. Stat. § 45a-535a(2). The institution that holds an endowment fund cannot fully expend such fund, but may only appropriate so much of an endowment's funds for expenditure or accumulation as the institution determines to be prudent for the uses, benefits, purposes for which the endowment fund is established. Unless stated otherwise in a gift document, the assets in an endowment fund are donor-restricted assets until appropriated for expenditure by the institution. Conn. Gen. Stat. § 45a-535c(a).

As a condition to the OAG's approval of the Application, Legacy ECHN must present to the Superior Court, in coordination with the OAG, a petition for equitable deviation and approximation to transfer these funds to the New Foundation or another appropriate entity and to change the charitable purpose of the unrestricted endowments to the charitable purpose of the New Foundation. This condition applies to all unrestricted endowments,

whether held by MMH, RGH, or the ECHN Community Healthcare Foundation, Inc.

ii. Restricted Endowments

The Conversion Act requires the recipient of the hospital's gift funds to use assets that are subject to a use restriction imposed by a donor for purposes that are consistent with the intent of the donor. Conn. Gen. Stat. § 19a-486c(a)(8)(B)(iii).

With respect to ECHN's restricted endowments, most of the charitable purposes can be fulfilled even though the funds will not be held by a hospital. For example, a free bed fund, which is used to provide charity care at a hospital, can still be used to pay for hospital bills for indigent individuals. These funds will simply need to be transferred to the New Foundation; no change in charitable purpose is needed. There are, however, several restricted endowments that will need their charitable purposes adjusted by the Superior Court as a result of the sale of ECHN's assets to a for-profit entity.

The Thomas D. Trotter Fund was given for the benefit of pediatric patients. The Julia and Percy Baker Family Memorial Fund was given for the benefit of the upkeep and physical maintenance of RGH. The Faith S. Schortman Fund was given for the benefit of the operation or improvement of the maternity or nursery facilities at RGH. These three funds must be modified so that no charitable income benefits PMH/ECHN.

Accordingly, as a condition to the OAG's approval of the Application, Legacy ECHN must, in coordination with the OAG, include the restricted endowments in the petition for equitable deviation and approximation that will be presented to the Superior Court. With respect to Trotter, Baker, and Schortman, Legacy ECHN must seek an order of approximation for each fund, in addition to one for equitable deviation, to adjust the fund's charitable purpose to one as close as possible to the donor's original charitable intent.

iii. Special Funds

ECHN has categorized eleven (11) funds as special purpose funds. Similar to restricted endowments, these funds have a specific purpose for which they are used. Unlike the restricted endowments, however, these funds can be completely used up; they are fully expendable. Therefore, to the extent that there is any money remaining in a special fund at the time the transaction closes, that fund will need to be a part of the equitable deviation and approximation action in order to transfer it and adjust its charitable purpose, if necessary.

Accordingly, as a condition to the OAG's approval of the Application, Legacy ECHN must, in coordination with the OAG, include any special fund for which any funds remain in the petition for deviation and approximation that will be presented to the Superior Court.

iv. Trust Held by Outside Trustees.

The last category of funds that the OAG must address as part of its hospital conversion review responsibilities are those charitable assets held by third parties for which ECHN holds the beneficial interest. ECHN has identified ten third party trusts for which it holds the beneficial interest.

In each of the ten cases identified by ECHN, the sale of ECHN's assets will not affect the structure of the trust, i.e., will not require the transfer of the trust to another entity. What may be necessary, however, is a switch of the charitable beneficiary and an adjustment to the trust's charitable purpose. Also important in the third-party trust analysis is whether the donors have directed that the charitable funds go elsewhere or have given the third-party trustees the power to redirect the charitable funds themselves if

ECHN were to sell substantially all of its assets. If not, then the trusts must be presented to a court for legal disposition. Consultation with the third-party trustees is necessary in these cases.

Under Connecticut charities law, a gift to one charity, with language providing for a substitution or gift over to another charity upon certain conditions, has long been valid. *See Colonial Trust Co. v. Waldron*, 112 Conn. 216, 233 (1930); *Christ Church v. Trustees*, 67 Conn. 554, 565-66 (1896). When a gift contains an alternate disposition of a fund in case of the failure of the bequest, the equitable doctrine of approximation does not apply. See *Hartford National Bank & Trust Co. v. Oak Bluffs First Baptist Church*, 116 Conn. 347, 351 (1933); *First Congregational Society of Bridgeport v. City of Bridgeport*, 99 Conn. 22, 31-32 (1903); 4 Scott, Trusts (4th Ed.) § 399.2, p. 495-96; Restatement (Second), 2 Trusts § 399, comment c. "The provision for a gift over upon failure of the charity negatives the existence of a general charitable intent, just as the absence of such a provision is evidence of such a purpose." *Connecticut Bank & Trust v. Cyril and Julia C. Johnson Mem. Hosp.*, 30 Conn. Supp. 1, 8 (1972), citing Bogert, Trusts and Trustees (2d Ed.) § 437, p. 426.

Accordingly, as a condition to the OAG's approval of the Application, Legacy ECHN must, in coordination with the OAG and the third-party trustees, bring any third-party trust in need of construction or approximation before a court of competent jurisdiction for appropriate orders.

v. Miscellaneous

The Life Insurance Policy (11-1.31) for which MMH is the beneficiary shall be included in the Superior Court petition for an order of equitable deviation if the insured is still living at that time. Otherwise, the distribution of the insurance proceeds shall be included in the net proceeds of the transaction and treated as such.

ECHN's portion of the distribution in the Damato estate (and any other unrestricted gift to ECHN), if distributed prior to the Superior Court order transferring ECHN's charitable assets to the New Foundation or other charitable organization, shall be included in the net proceeds of the transaction and treated as such.

vi. Future Interests

To the extent there are future charitable interests for the benefit of ECHN, the disposition of those interests will be addressed on a case-by-case basis by a court under the doctrine of approximation. Only when a future interest becomes a present interest can a probate or superior court determine to whom the remainder will pass or whether the gift will fail and revert to the donors' heirs-at-law. Therefore, any future interests that have not yet vested cannot be included in the Superior Court action to address the identified charitable funds.

5. ECHN Must Present the New Foundation and its Restricted Charitable Funds to the Superior Court for Approval and Approximation and Deviation Orders.

Although the Attorney General has approved the purposes of the New Foundation and the other provisions in the draft COI and bylaws, ECHN will be required to present the New Foundation to the Superior Court for its approval and will need to have the court enter orders of approximation and equitable deviation to transfer the charitable assets to the New Foundation, or other eligible entity. The Office of the Attorney General shall participate in this action.

I. ECHN and PMH Have Provided The Attorney General With Information And Data Sufficient To Evaluate The Proposed Joint Venture.

Pursuant to Conn. Gen. Stat. § 19a-486c(a)(9), the Attorney General shall disapprove the proposed transaction as not in the public interest if he determines that the

nonprofit hospital or the purchaser has failed to provide the Attorney General with information and data sufficient to evaluate the proposed agreement adequately, provided the Attorney General has notified the nonprofit hospital or the purchaser of the inadequacy of the information or data and has provided a reasonable opportunity to remedy such inadequacy. The Applicants have provided all relevant information and sufficient data to evaluate adequately the proposed APA.

VII. CONCLUSION

The OAG therefore concludes that the Application for an asset purchase by PMH of substantially all of the assets of ECHN is hereby approved subject to the modifications and conditions listed herein.

Date: May 25, 2016

PERRY ZINN ROWTHORN
DEPUTY ATTORNEY GENERAL

EXHIBIT A

NAVIGANT

Financial Consulting Report related to the Proposed Transfer of Certain Assets from Eastern Connecticut Health Network, Inc. and its Affiliates to Prospect Medical Holdings, Inc.

Presented to



Mr. George Jepsen
Attorney General
State of Connecticut Office of the Attorney General
55 Elm Street, P.O. Box 120
Hartford, CT 06141-0120
Attention: Gary W. Hawes, Assistant Attorney General

FINAL

May 23, 2016

Presented by

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FINAL

May 23, 2016

Mr. George Jepsen
Attorney General
State of Connecticut Office of the Attorney General
55 Elm Street, P.O. Box 120
Hartford, CT 06141-0120
Attention: Gary W. Hawes, Assistant Attorney General

Dear Mr. Jepsen:

Navigant Consulting, Inc. ("Navigant") has completed its analysis with respect to the scope of services requested by your office pursuant to §§ 19a-486a to 19a-486h of the Connecticut General Statutes ("Nonprofit Hospital Conversion Act") and in accordance with the contract with your office effective on June 13, 2013 and including subsequent amendments effective on June 15, 2014 and August 5, 2014 (the "Contract").

Navigant's analysis and conclusions contained in this report pertain to the proposed transfer of certain assets (the "Proposed Transaction") from Eastern Connecticut Health Network, Inc. and its affiliates ("ECHN" or the "Health System") to Prospect Medical Holdings, Inc. ("PMH"). Our analysis was performed as of March 31, 2016 (the "Analysis Date" or the "Valuation Date").

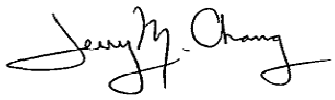
Our compensation for this assignment was not dependent in any way on the substance of our findings or conclusions. Our analysis was based, in part and where indicated, upon information provided by ECHN management and ECHN's designated legal and financial advisors. We have assumed that the information provided to us is complete and free of material misrepresentations. In addition, we have performed our own independent research and analysis related to the issues outlined by the State of Connecticut Office of the Attorney General ("OAG" or the "Attorney General") in the Contract.

We understand that this report will be part of the public record of the Attorney General's review pursuant to the Nonprofit Hospital Conversion Act and we reserve the right to respond to and explain our analysis, reasoning, and conclusions. The following report and accompanying appendices provide a detailed explanation of the basis of our analysis and conclusions. Please contact Jerry Chang at 404.602.3462 or jchang@navigant.com with any questions.

Very truly yours,
Navigant Consulting, Inc.

FINAL

By: Jerry M. Chang, CFA



Managing Director

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INTRODUCTION

Summary of Engagement

Navigant was engaged by the OAG to provide financial consultation and expertise related to the OAG's review of the proposed transfer of certain assets from ECHN to PMH pursuant to Section §§ 19a-486a to 19a-486h of the Nonprofit Hospital Conversion Act, as of a current date.

This report specifically addresses the following conditions under Section §§ 19a-486c of the Nonprofit Hospital Conversion Act:

i. *Whether the nonprofit hospital exercised due diligence in (a) deciding to sell its assets, (b) selecting the purchaser, (c) obtaining a fairness evaluation from an independent person expert in such agreements, and (d) negotiating the terms and conditions of the transaction;*

ii. *Whether the nonprofit hospital disclosed any conflict of interest, including, but not limited to, conflicts of interest pertaining to board members, officers, key employees and experts of the nonprofit hospital, the purchaser, or any other party to the transaction;*

iii. *Whether the nonprofit hospital will receive fair market value for its assets, i.e., the most likely price that the assets would bring in a sale in a competitive and open market under all conditions requisite to a fair sale, with the buyer and seller each acting prudently, knowledgeably, and in their own best interest, and with a reasonable time being allowed for exposure in the open market;*

iv. *Whether the fair market value of the nonprofit hospital's assets have been manipulated by any person in a manner that causes the value of the assets to decrease;*

v. *Whether the financing of the transaction will place the nonprofit hospital's assets at an unreasonable risk; and*

vi. *Whether any management contract contemplated under the transaction is for reasonable fair value.*

Summary of Proposed Transaction

ECHN has agreed to sell all or substantially all of its assets to PMH for $105 million, subject to certain adjustments. Such adjustments include a reconciliation for the value of net working capital, reductions in the value of certain liabilities assumed by PMH, and any joint venture interest not assumed provided the joint venture adjustment does not exceed $22 million. Assets not acquired include cash and equivalents, all short and long-term investments (excluding joint venture interests), board designated, trustee held or escrowed funds, beneficial interests in charitable trusts and the accrued earnings of the foregoing.

The proceeds from the transaction will be used to settle all of ECHN's bond liabilities and other indebtedness and then to fund an indemnity reserve to PMH against ECHN liabilities that may arise after closing. Such excluded liabilities are detailed in Section 2.04 of the draft Asset Purchase Agreement ("APA"). Thereafter, any remaining proceeds will be used to settle post-closing liabilities and wind down the operations of ECHN. Any remainder thereafter will be transferred to an independent charitable organization with the expectation such funds will be used to support charitable health efforts in the ECHN community.

In addition, PMH has committed to invest not less than $75 million in ECHN and its hospital service areas within five years of the closing of the Proposed Transaction. PMH has agreed to increase the purchase price for the assets by up to $10 million in the event that ECHN does not have sufficient cash to close the transaction, which increase would be offset by a corresponding reduction in the $75 million capital commitment amount.

Eastern Connecticut Health Network, Inc.

ECHN is a non-profit health care system serving 19 towns in eastern Connecticut. ECHN was formed in 1995 after the merger of Manchester Memorial Hospital ("MMH") and Rockville General Hospital ("RGH"), though both hospitals can trace their roots to the early 1900's. In addition to the hospitals, ECHN consists of a number of wholly owned outpatient facilities and clinics and ownership interests in multiple joint ventures. A comprehensive overview of ECHN can be found in *Section II. Overview and Background of ECHN.*

Post-Acquisition Commitments

Based on our review of the Certificate of Need ("CON") application (the "Application") submitted by ECHN and PMH, post-acquisition PMH has a number of commitments it must adhere to. The following provides a summary of some of those requirements:

1. Local Governance – MMH and RGH will each maintain an advisory board made up of community representatives, medical staff and the CEO of each respective hospital to consult with PMH with respect to the investment of capital and matters related to clinical quality goals.

2. Capital Commitment – PMH in consultation with ECHN will develop a capital plan in which PMH will commit to spending not less than $75 million in capital expenditures over a five-year period on the Health System Businesses (defined as ECHN and its joint ventures). PMH management indicated that the specific projects would be identified as part of an overall

strategic plan developed within six months of the transaction close date. PMH management indicated at the public hearing that projects would likely include expanding the Health System's physician network, increasing community access points, and increasing outpatient, ambulatory care sites.

3. Employment – PMH will offer employment as of closing to substantially all of the ECHN employees at compensation and benefits comparable to other hospitals operated by PMH. Additionally PMH will assume and honor ECHN's collective bargaining agreements.

4. Commitment to Clinical Operations and Community Support

    a. Operation of Hospitals: For at least three years after closing, PMH will continue operating the Health Systems' hospitals in their current location as acute care hospitals with emergency departments.

    b. Post-Acute Care: For at least three years after closing PMH will maintain its interest in VNHSC and EES, the current post-acute care providers in ECHN's network, and agrees to maintain appropriate service lines during this period.

    c. Medical Education: PMH will maintain and financially support ECHN's teaching programs and graduate medical education programs, while operating at a level not to exceed the Indirect Medical Education and Direct Education caps established by Centers for Medicare and Medicaid Services.

    d. Community Benefits: PMH will ensure each hospital maintains it policies with respect to charity care, indigent care, community volunteer services and community benefits.

The summary above does not purport to describe all of the details and terms of the Proposed Transaction and is included in this report for the purpose of providing general background of the Proposed Transaction. This summary may omit material terms of the final agreement, which may be further revised after the issuance of our final report.

Description of Prospect Medical Holdings, Inc.

Prospect Medical Holdings, Inc. ("PMH") started in 1996 out of Orange County, California, when the medical group, "Prospect Medical Group, Inc." began growing through a series of acquisitions and affiliations with various medical groups in the Southern California area. In 2007, PMH established its hospital operations with the acquisition of Alta Hospital System, LLC, a system of four community-based hospitals in Southern California and further expanded its Southern California presence with acquisition of Southern California Hospital at Culver City. In 2012, PMH's hospital operations expanded into Texas with the acquisition of Nix Health, and again in 2013 with an 18-bed acute care hospital in Dilley, Texas.

Today, PMH spans 13 hospitals with 2,258 licensed beds and 32 primary and specialty care clinics in Southern California, South Central Texas and Rhode Island. In Southern California, PMH has 10 affiliated Independent Physician Associations ("IPAs") which are managed by two of its subsidiaries, Prospect Medical Systems and ProMed Health Care Administrators which also manage several

unaffiliated IPAs. Through PMH's Coordinated-Regional-Care model, its network of physicians, affiliated medical groups, and hospitals contract with and coordinate care with various health plans in the markets it serves. PMH's network currently includes over 9,133 doctors and specialists who arrange care for over 300,317 network members. PMH is accredited by either Det Norske Veritas (DNV GL) Healthcare, Inc. or The Joint Commission. Additionally, PMH's medical groups have been awarded "Elite" status by the California Association of Physician groups and have earned 4 to 5 star ratings with Medicare Advantage Plans.[1]

The company's CEO and Chairman is Sam Lee, who previously served as CEO of Alta Healthcare System, which he co-founded after acquiring seven Los Angeles area hospitals from Paracelsus Healthcare Corporation. Prior to this, Mr. Lee was a General Partner with Kline Hawkes & Co., a private equity firm located in Brentwood, California which focuses on acquisitions in healthcare, technology and business services. Other key PMH leadership are listed below[2]:

- David Topper, President of Alta Hospital System, LLC
- Mitchell Lew, MD, President
- Stephen O'Dell, Senior Vice President, Coordinated Regional Care
- Steve Aleman, Chief Financial Officer
- Ellen J. Shin, General Counsel and Secretary
- Cindra Syverson, Chief Human Resources Officer
- Von Crocket, Senior Vice President, Corporate Development
- Thomas Reardon, President, Prospect East Hospital Advisory Services, Inc.
- Hoyt Sze, Chief Compliance & Privacy Officer
- Jonathan J. Spees, Senior Vice President, Mergers and Acquisitions

Leonard Green & Partners, L.P. ("Leonard Green") is a major investor in PMH. Leonard Green is one of the nation's preeminent private equity firms with over $15 billion of private equity capital raised since its inception. Founded in 1989, the firm has invested in 76 companies in the form of traditional buyouts, going-private transactions, recapitalizations, growth capital investments, corporate carve-outs and selective public equity and debt positions. Based in Los Angeles, CA, Leonard Green invests in established companies that are leaders in their markets.

The affiliated investment funds of Leonard Green own approximately 61.3% of the common stock of Ivy Holding, Inc. ("IH"), a Delaware corporation which owns 100% of the stock in Ivy Intermediate Holding, Inc. ("IIH"). IIH is a Delaware corporation which owns 100% of the stock of PMH. IIH is a holding company for such stock ownership. It has no other assets, liabilities or operations. Current and former employees of PMH and its subsidiaries own the remaining shares of IH stock.

[1] http://www.pmh.com/

[2] Certificate of Need Application by ECHN and PMH dated October 13, 2015.

OVERVIEW AND BACKGROUND OF ECHN

Overview

ECHN is a non-profit health care system serving 19 towns in eastern Connecticut. ECHN was formed in 1995 after the merger of Manchester Memorial Hospital ("MMH") and Rockville General Hospital ("RGH"), though both hospitals can trace their roots to the early 1900's. The ECHN care network consists of several wholly owned entities and multiple joint venture interests. The following provides a description of the wholly owned entities of ECHN.[3] **With the exception of ECHN Community Healthcare Foundation, Inc. ("ECHF")**, all entities described below will be acquired as part of the Potential Transaction.

- **Manchester Memorial Hospital ("MMH")** – MMH is a not-for-profit hospital with 249 licensed beds, located in Manchester, Connecticut. MMH is a short-term, acute-care general hospital, which provides inpatient, outpatient, and emergency care services to the residents of Manchester and 19 nearby towns.

- **Rockville General Hospital ("RGH")** - RGH is a not-for-profit hospital with 102 licensed beds, located in the Rockville section of Vernon, Connecticut. RGH is a short-term, acute-care general hospital, which provides inpatient, outpatient, and emergency care services for residents of Tolland County and nearby towns, for a total service area of 19 towns.

- **ECHN ElderCare Services, Inc. ("EES")** - EES is a not-for-profit, skilled nursing facility with 130 licensed beds and physical, occupational and speech rehabilitation services located in Tolland, Connecticut.

- **ECHN Community Healthcare Foundation, Inc. ("ECHF")** - ECHF is a not-for-profit organization whose purpose is to raise funds on behalf of ECHN and its not-for-profit subsidiaries. It was established in 2000, when the fund raising efforts of ECHN were consolidated into a single not-for-profit foundation. ECHF focuses primarily on the capital and program needs of ECHN and its not-for-profit subsidiaries.

- **Eastern Connecticut Medical Professionals Foundation, Inc. ("ECMPF") -** ECMPF is a not-for-profit organization that currently operates physician office practices in the Network's service area and a hospitalist program that serves MMH and RGH. Its mission allows it to operate other not-for-profit, separately incorporated allied health ventures.

- **ECHN Enterprises, Inc. ("Enterprises") -** Enterprises is a for-profit organization formed under the laws of the State of Connecticut, with ECHN as the sole shareholder. Enterprises owns, leases and has an interest in real estate to support the mission and vision for ECHN. It is also the parent corporation of Haynes Street Property Management, LLC (HSPM). HSPM is a for-profit, limited liability company formed under the laws of the State of Connecticut, which manages the Glastonbury Wellness Center and sublets space to various MMH departments and physician offices, as well as to ECMPF.

[3] Based on information from ECHN's 2014 audited financial statements and the Certificate of Need Application by ECHN and PMH dated October 13, 2015.

- **Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC") -** VNHSC is a not-for-profit, nonstock Connecticut corporation that provides and administers a comprehensive, multi-disciplinary home health program, hospice program and wellness programs to promote the health of individuals, families and groups in the Greater Northern Central Connecticut area. In addition, VNHSC is the sole member of A Caring Hand, LLC, which is a for-profit Connecticut limited liability company providing and administering homemaker, companion, live-in and personal care assistance services to individuals and families in the Greater Northern Central Connecticut area.

- **Connecticut Healthcare Insurance Company ("CHIC") -** CHIC, a captive insurance company, provides hospital and physician professional and general liability coverage to MMH, RGH, EES, and all other subsidiaries.

- **ECHN Corporate Services ("ECHNCS") -** ECHNCS is a for-profit stock corporation formed under the laws of the State of Connecticut, with ECHN as the sole shareholder. ECHNCS provides billing and other practice management services to the Network and other customers. It is also the parent corporation of Medical Practice Partners, LLC (MPP). MPP is a for-profit, limited liability company formed under the laws of the State of Connecticut, which provides practice management services to medical group practices throughout Connecticut.

- **Clinically Integrated Network of Eastern Connecticut, LLC ("CINECT")** - CINECT is a for-profit organization formed to develop a clinically integrated network of community providers to provide better quality healthcare in the communities it serves.

The following is a list and associated ownership interests of ECHN's joint venture interests in community based services to be acquired as part of the Potential Transaction between PMH and ECHN.

- Evergreen Endoscopy Center, LLC (50%)
- Aetna Ambulance Service, Inc. (50%)
- Metro Wheelchair Service, Inc. (50%)
- Ambulance Service of Manchester, LLC (50%)
- Northeast Regional Radiation Oncology Network, Inc. (50%)
- Tolland Imaging Center, LLC (70%)
- Haynes Street Medical Associates, LLC (23%)
- Haynes Street Medical Associates II, LLC (15%)
- Evergreen Medical Associates, LLC (20%)
- Evergreen Medical Associates II, LLC (20%)
- Walden Behavioral Health (16%)

Finance and Operations

Exhibits C-1 through C-10 provide detailed historical financial, operating, and payor mix statistics relating to ECHN and its hospitals (MMH and RGH). Overall, ECHN revenues have decreased to $315 million from $329 million in 2014 and $328 million in 2013. The operating margin was -0.1 percent in 2015 and ECHN's profitability has been marginal over the 2011 to 2016 time frame, with operating margins ranging from -0.1 to 1.7 percent.

As of September 30, 2015, ECHN had a consolidated asset balance of $261 million, which consisted of $75 million in current assets, $88 million of net fixed assets, $18 million in joint venture interests, $71 million held in long-term investments (most of which is restricted), and $9 million in other assets. However, ECHN has significant liabilities consisting of $52 million in current liabilities, $11 million of which was in the form of short-term debt. Long-term liabilities total $150 million which include $80 million of long-term debt and capital leases and $62 million in long-term pension obligations. Debt service on long-term debt and capital leases are projected to be $7 million in 2016 and ECHN anticipates contributing $1.8 million to the pension plan in 2016.

In addition to debt service and pension contributions, ECHN has an aging infrastructure. Depreciation in 2015 was $12 million and is projected to range between $11.7 and $11.8 million over the next several years. ECHN management communicated that its plant and equipment purchases for 2014 and 2015 totaled $10.1 million and $7.4 million, respectively, which were below ECHN's depreciation expense for both of those years and below the national median for <Baa rated hospitals[4]

Given ECHN's significant liabilities and capital needs, combined with its deteriorating financial performance, the Health System is nearing potential financial distress (including not meeting certain debt service coverage ratios) absent an affiliation with a larger and more capitalized partner.

[4] Public hearing presentation entitled, "The Proposed Transfer of Assets of Eastern Connecticut Health Network, Inc. and Affiliates to Prospect Medical Holdings, Inc.", March 29 & 30, 2016.

ECONOMIC OVERVIEW

When valuing a health system or its assets, it is important to consider the condition of, and outlook for, the economy or economies in which the health system operates. This economic analysis is necessary because the financial performance, and consequentially the value, of a health system or its assets are affected to varying degrees by the economic environment in which the health system operates. The following section provides a brief discussion of the economic condition and outlook for the national and local economy and any impact it could have on a health system's business and related assets.

General Economic Conditions[5]

The gross domestic product (GDP), the broadest measure of the U.S. economy slowed for a second consecutive quarter, growing at an annual rate of 0.7 percent in the fourth-quarter of 2015, less than half of the 1.5 percent rate of growth observed in the third-quarter of 2015. In 2015, the economy grew 2.4 percent from the year before, matching 2014 growth. Final sales of domestic product rose in fourth-quarter by 1.2 percent, following an increase of 2.7% in the third-quarter. The Economic Policy Institute has stated that final sales are arguably a better indicator of underlying economic strength than GDP.

The slowing of GDP growth in the fourth-quarter was largely driven by slowed consumer spending, a deterioration in the national trade balance, a sharp drop in private investment, and a smaller build up in business inventories. However, despite the consumer spending losing ground in the fourth-quarter, positive assessments of the job market drove up consumer confidence. Job growth in the fourth-quarter was the strongest of the year, and 2015 capped off the best two year period of hiring since the period ending in 1999.

Consumer Spending

Consumer spending grew at a rate of 2.2 percent during the fourth-quarter of 2015, a deceleration from the third quarter's 3.2 percent increase. Consumer spending—also referred to as personal consumption—accounts for approximately 70 percent of the U.S. GDP.

Government Spending

Total government spending rose at a rate of 0.7 percent in the fourth-quarter of 2015, slower than the rate of 1.8 percent in the prior quarter. Federal government spending rose at a rate of 2.7 percent in the third quarter, the fourth rise in the past 13 quarters and the largest increase since the third quarter of 2014. The fourth-quarter increase in federal government spending added 0.18 percentage point to the fourth-quarter GDP rate.

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[5] All of the contents of the general and U.S. economic outlook section of this valuation report are quoted from the Economic Outlook Update™ 4Q 2015 published by Business Valuation Resources, LLC, © 2016, reprinted with permission. The editors and Business Valuation Resources, LLC, while considering the contents to be accurate as of the date of publication of the Update, take no responsibility for the information contained therein. Relation of this information to this valuation engagement is the sole responsibility of the author of this valuation report.

Business Investment

Business investment, also known as private nonresidential fixed investment, fell at a rate of 1.8 percent in the fourth-quarter of 2015. This was the first decline in business investment since the third quarter of 2012. The drop in business investment subtracted .24 percentage point to fourth-quarter GDP.

Residential fixed investment, often considered a proxy for the housing market, increased at an annual rate of 8.1 percent during the fourth-quarter. This was almost identical to the prior quarter's rate of 8.2 percent. This quarter's growth in residential fixed investment added 0.27 percentage point to the third-quarter GDP. Residential fixed investment increased 1.8 percent in 2014 and 9.5 percent in 2013.

Exports and Imports

Exports fell at a rate of 2.5 percent in the fourth-quarter of 2015, after growing at a rate of 0.7 percent in the previous quarter. Exported goods dropped at a rate of 5.4 percent in the fourth-quarter, while exported services increased at a rate of 3.6 percent. Exports increased 3.4 percent in 2014 and 2.8 percent in 2013.

Unemployment and Personal Income

Hiring ended the year on a strong note, adding 292,000 new jobs in December. This was the second strongest month of the year for employment, only bested by October hiring which topped 307,000. December also marked the greatest two-year period of job growth since the period ending in 1999, while the unemployment rate held at its lowest level since April 2008. Businesses have now added 14.1 million jobs over 70 straight months, extending the longest streak on record. Overall, U.S. businesses have added 5.6 million jobs over the past 24 months.

The Bureau of Economic Analysis reported that current-dollar personal income increased $137.1 billion in the fourth-quarter of 2015, after increasing by $190.8 billion in the third. The BEA found that the acceleration in personal income primarily reflected a downturn in personal interest income and decelerations in wages and salaries and in farm proprietors' income.

Personal outlays increased $72.6 billion in the fourth-quarter, a deceleration from an increase of $131.7 billion the third. Personal saving – disposable personal income less personal outlays- was $739.3 billion in the fourth-quarter, up from $700.6 billion in the third.

United States Economic Outlook

Consensus Economics, Inc., publisher of *Consensus Forecasts - USA*, forecasts real GDP to increase at a seasonally adjusted annual rate of 2.5 percent in the first-quarter of 2016 and 2.7 percent in the second-quarter. Every month, Consensus Economics surveys a panel of 30 prominent U.S. economic and financial forecasters ("the forecasters") for their predictions on a range of variables including future growth, inflation, current account and budget balances, and interest rates. The forecasters expect GDP to grow 2.5 percent in each year in the period from 2016 through 2018.

The forecasters polled by Consensus Economics believe unemployment will average 4.9 percent in the first-quarter of 2016 before ticking down to 4.8% in the second-quarter.

According to the forecasters, consumer prices will rise at a rate of 1.5 percent in the first-quarter of 2016 and 2.1 percent in the second-quarter. They forecast consumer prices to increase 1.7 percent in 2016 before rising to 2.2 percent in 2017. The forecasters project producer prices to increase 1.3 percent in the first-quarter of 2016 and 2.4 percent in the second-quarter. They expect real disposable personal income to grow 2.9 percent in 2016 and 2.8 percent in 2017.

Impact on Valuation of ECHN and Related Assets

The economy of certain areas across the U.S. continues to struggle following the economic downtown. But there is room for cautious optimism amongst economists. However, the economic headwinds will continue to challenge robust growth and increasing economic prospects for hospitals in areas that were hardest hit by the economic downturn, including the Eastern Connecticut markets of Manchester and Vernon.

INDUSTRY OVERVIEW

Introduction

An analysis of the healthcare industry is essential to developing an understanding of the industry's impact on the future outlook of ECHN and its related affiliates. The following sections provide: (i) an overview and general discussion of the healthcare industry, (ii) future trends in the healthcare industry, and (iii) the impact on our valuation.

General Overview[6]

As a primary provider of healthcare in the United States, hospitals are expected to generate $1.0 trillion in revenue in 2015. Revenue is expected to increase 3.7% per year on average since 2009, including growth of 4.4% in 2015. This traditionally fragmented industry has begun consolidating, largely due to the pressures of healthcare reform. Demand for industry services has steadily grown during the past five years, as healthcare reform legislation broadened insurance coverage and the sinking unemployment rate increased disposable income.

To maintain an advantaged position in this competitive industry, hospitals seek the most skilled and specialized healthcare professionals. Consequently, labor costs in this industry are high. However, hospitals have also faced nurse and physician shortages and have struggled to recruit qualified personnel. As a result, wages' share of industry revenue has fallen during the five years to 2015. However, wages are expected to rise as a proportion of revenue during the next five years, as hospitals increase salaries and provide other employment incentives.

Industry profitability has generally risen over the past five years due to increases in service prices. As the 2010 Patient Protection and Affordable Care Act results in more people with insurance, demand for service will likely continue to increase, and the number of uninsured patients that hospitals treat will drop. As a result, IBISWorld expects industry revenue to rise at an average annual rate of 3.9% to $1.2 trillion during the next five years. Average industry profit is estimated to rise over the same period from 6.6% to 8.0% of revenue, buoyed by cost-cutting efforts and the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. Still, reimbursement from Medicaid and Medicare will be strained while the federal government seeks to finance healthcare reform and individual states deal with budget deficits.

Healthcare reform may also have the long-term effect of driving some patients away from hospitals altogether. Hospitals are particularly expensive healthcare settings, and as Medicare and Medicaid begin imposing penalties for readmission, home healthcare will likely become more popular, eventually reducing demand for industry services. Technology will support this trend, as EHR and telemedicine apps enable patients to share information with healthcare providers from the comfort of their own homes.

[6] Hospitals in the US, IBIS World Industry Report 62211, August 2015

Revenue and Profit

Advances in healthcare have helped people live longer lives. According to the Centers for Disease Control and Prevention, the average US citizen is currently expected to live more than 78 years. However, a longer life is generally accompanied by increased healthcare expenditure. As the median age of the US population has increased, so has total domestic spending on healthcare. Hospital care is the largest single category of healthcare expenditure in the United States, so the aging population has generally contributed to industry revenue growth.

The recession slightly reduced patient volumes, as individuals lost access to health insurance and decreased disposable income limited patients' ability to pay for services out of pocket. However, industry services are largely nondiscretionary, so many patients simply accepted care they could not afford, and profit margins for the average industry hospital fell as low as 6.0% in 2011. As industry operators moved to regain profit, many hospitals increased their prices for medical care. As the economy recovered and demand for industry services increased, high prices helped boost industry profitability. Profit margins have been further bolstered by the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, which compensate eligible hospitals that demonstrate meaningful use of certified EHR technology. As a result, IBISWorld estimates the profit margin for the average industry hospital will reach 7.2% in 2015.

Consolidation and Reform

Medicaid expansion and the individual mandate to purchase insurance began to take effect in 2014. Coverage purchased in the health insurance exchanges must meet minimum benefit standards, and this requirement is expected to improve the industry's financial situation. However, many states have chosen not to expand Medicaid coverage, and widespread technical and bureaucratic issues plaguing the introduction of state exchanges has limited the expansion of private coverage. Cuts to Disproportionate Share Hospital payments, which provide additional compensation to care providers to offset the burden of treating an outsize number of uninsured patients, have further limited growth for hospitals in some states.

In the midst of a tightened reimbursement environment, hospitals are consolidating to reduce costs by gaining better negotiating power with suppliers and payers. Operators are also closing underperforming hospitals. In the last five years, the total number industry enterprises is expected to decline at an average rate of 0.9% per year to 2,921 at the end of 2015. Reimbursement from government programs has grown at a slow pace, so hospitals have increasingly sought favorable contracts with nongovernment payers, including health maintenance organizations, preferred provider organizations and other managed-care plans. Revenue derived from these entities and other insurers is estimated to account for about 60.0% of patient revenue. Small hospitals are less able to compete for these lucrative contracts, while consolidated hospital companies can rely on economies of scale to offer a wider portfolio of providers and specialties.

Hospitals are also consolidating to combat competition from other providers. Historically, the Hospitals industry has faced low competition because most communities are home to only a few hospitals. However, during the five years to 2015, the number of new facilities that deliver healthcare services, such as physician-run outpatient surgery centers, specialty hospitals and diagnostic centers,

has grown rapidly. Independent competitors often have lower costs because of their smaller size and simpler infrastructure. Because hospitals use the income from high-margin operations to finance certain unprofitable services and procedures, increased competition has forced hospitals to use other strategies to decrease costs.

Physician and Nurse Shortage

To increase or maintain the breadth of specialized services they offer, hospitals must hire qualified physicians and nurses, which has become an industry-wide challenge because the nation faces a shortage in both professions. Hospitals have increased salaries to attract new hires, but while wages have grown an annualized 3.2% to $346.8 billion in the five years to 2015, industry employment has grown just 1.2% per year on average to 5.5 million people.

The nurse and physician shortage has occurred for a variety of reasons, including a scarcity of relevant education programs. According to a report from the American Association of Colleges of Nursing, US nursing schools turned away 78,089 qualified applicants from baccalaureate and graduate nursing programs in 2013, due to budget constraints and insufficient faculty, clinical sites, classroom space and clinical preceptors. In addition, many physicians are getting older and have retired, or will in coming years.

Acquisitions and Employment

Cash-poor nonprofit hospitals, which are unable to borrow money for needed improvements in facilities and equipment, will likely seek for-profit benefactors in the five years to 2020. Concurrently, for-profit hospital operators and investment firms will look to the nonprofit sector for growth opportunities. Nonprofit operators will also face new challenges due to healthcare reform. Section 9007 of the PPACA adds new requirements for charitable hospitals to become, or remain, exempt from federal taxation, including performance of periodic community needs assessments and development of a policy on financial assistance to patients. These changes will trigger further consolidation between nonprofit and for-profit operators in the industry. For-profit acquisitions of nonprofits are expected to increase during the next five years, reducing the number of industry operators an average of 0.3% per year to 2,876 in 2020. The total number of industry hospitals will decrease concurrently, albeit at the slower annualized rate of 0.3% to 5,358 in 2020.

Unfilled faculty positions at nursing colleges, attrition and a shortage of students preparing to be faculty will pose a threat to the nursing education workforce during the next five years. In light of healthcare reform and the subsequent demand for nursing services, the shortage of nurses will adversely affect the industry. Hospitals will likely enhance wages and benefits to recruit and retain nurses and other medical support personnel. Moreover, they may hire more expensive temporary or contract employees. As a result, IBISWorld expects industry spending on wages to increase an annualized 4.3% in the next five years to $427.2 billion.

Impact on Valuation of ECHN and Related Assets

As an unaffiliated hospital, the Health System is suffering from the enormous demands that the new healthcare environment entails. The consolidation trend within the industry is being driven by a number of factors, including:

- Increased capital needs to meet new healthcare information technology requirements;
- Increased capital needs to maintain and upgrade hospital facilities and medical equipment;
- Increased capital needs to facilitate the trend away from inpatient care to outpatient care;
- Significantly lower reimbursements from government payers;
- Highly competitive environment to recruit physicians and nurses into a hospital's network; and
- Importance of better negotiating power with suppliers and payers to increase profit margins.

As an unaffiliated health system, it has and will continue to be a very challenging environment in which to operate profitably and to compete effectively in its market. Given the Health System's current financial condition and limited access to capital, the Health System's projected performance will likely lag the industry and the Health System will face a difficult environment to operate long-term without affiliating with a strategic capital partner.

LOCAL MARKET OVERVIEW

Introduction

An analysis of the local market is essential to developing an understanding of the historical, current, and future operations of the Health System. The following sections provide: (i) an overview and general demographics of Tolland, Hartford, and Windham counties and the State of Connecticut (ii) overview of other area hospitals, (iii) industry outlook, and (iv) the impact on our valuation.

Demographic Overview

ECHN's facilities provides healthcare services to 19 towns in Eastern Connecticut. The following tables summarizes various demographic and economic statistics applicable to the counties and cities ECHN serves.[7]

County	Cities Included	Population	% of Population > age 65	Median Household Income	Unemployment Rate %	Poverty Rate %
Tolland	Andover, Bolton, Columbia, Coventry, Ellington, Hebron, Mansfield, Somers, Stafford, Tolland, Union, Vernon, Willington	151,367	14.0%	$80,529	4.6%	6.5%
Hartford	East Hartford, East Windsor, Glastonbury, Manchester, South Windsor	897,985	15.6%	$64,967	5.8%	11.6%
Windham	Ashford	116,198	14.7%	$59,333	5.8%	11.4%
Connecticut	N/A	3,596,677	15.5%	$69,461	5.3%	10.2%
United States	N/A	318,857,056	14.5%	$53,046	5.1%	15.4%

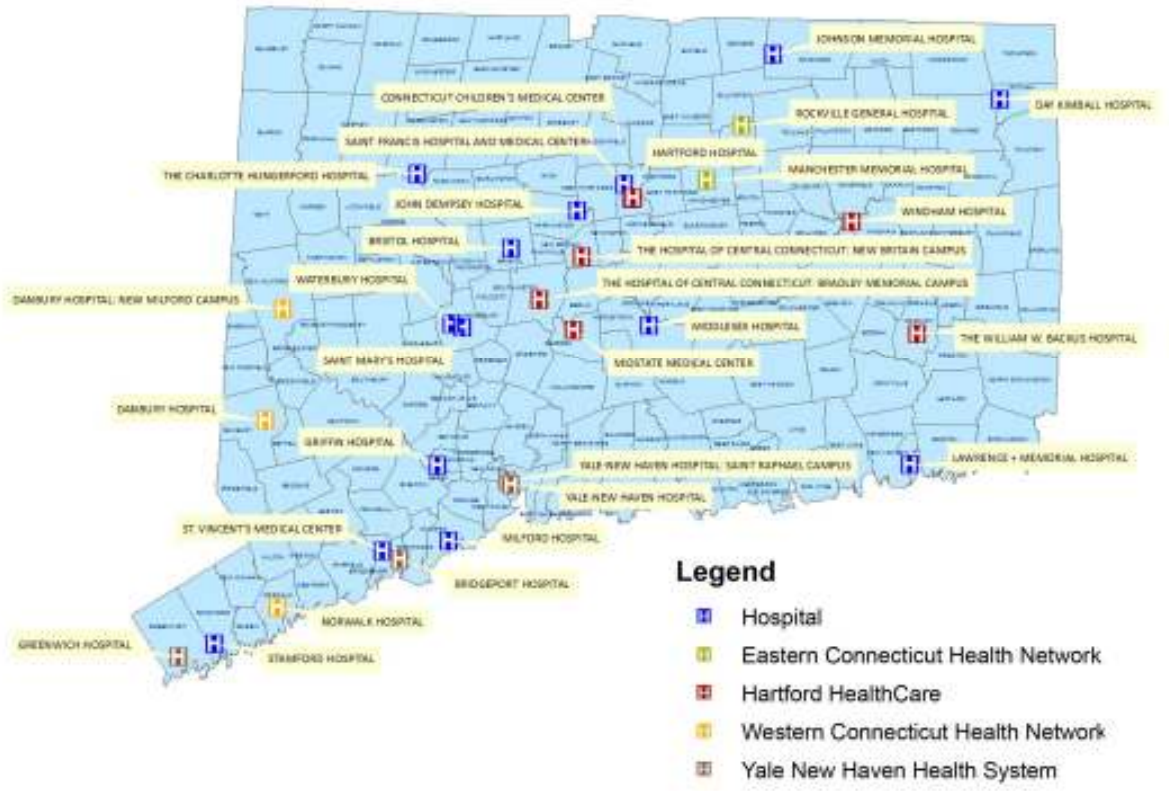
ECHN's combined service area reflects a population of approximately 1.2 million people. On measures of income, Tolland County ranks higher than the overall State of Connecticut, while Hartford and Windham counties rank below. Tolland County also has lower levels of poverty and unemployment than the overall State of Connecticut, though Hartford and Windham rank above the State in these statistics. In terms of its elderly population, the counties were similar to the overall State of Connecticut and national levels, but were significantly above in terms of income and had significantly lower poverty rates. Unemployment was above the national level of Windham and Hartford counties while Tolland County was below national unemployment.

Area Hospitals

ECHN's primary service area is the Eastern Connecticut region. These areas are serviced by a number of acute care providers similar to ECHN, as well as local physicians' offices and outpatient medical centers. The following table identifies competing hospitals which lie in ECHN's service area.[8] Nearby hospitals include Johnson Memorial Hospital, Windham Hospital, the Hospital of Central

[7] Statistics compiled from the US Census Bureau and the US Department of Labor Unemployment Statistics.
[8] Source: http://www.cthosp.org/advocacy/statewide-hospital-profile/

Connecticut: New Britain Campus, St. Francis Hospital and Medical Center, Connecticut Children's Medical Center, and John Dempsey Hospital.



Connecticut Hospital Industry Outlook

In September 2015, Connecticut Governor Daniel P. Malloy ordered budget cuts which will have large implication for state hospitals. The cuts included a decision to cut Medicaid payments to hospitals by $63.4 million, these state cuts would lead to further reductions in federal funding which could total $130 million. This additional loss in federal funding is due to the payment structure of Medicaid, in which the state establishes payment program rates within federal requirements and a portion of those payment are funded by the federal government.

On June 3, 2014, Governor Malloy signed Senate Bill 35 from the 2014 session, which removed the prohibition of for-profit hospital systems from owning medical foundations and essentially cleared the way for five not-for-profit hospitals to be acquired by for-profit hospital companies like Tenet Healthcare. The bill adds state oversight to sales and acquisitions that involve physician practices under provisions of Public Act No. 14-168. In addition, medical practices with at least 30 physicians and medical groups owned by or affiliated with for-profit hospitals are required to report annually to the OAG and Department of Public Health. Tenet later pulled out of its planned Connecticut deals citing that "the approach to regulatory oversight in Connecticut would not enable Tenet to operate the hospitals successfully for the benefit of all stakeholders".

Smaller hospitals and physician groups in the region continue to seek the financial, administrative and group purchasing stability which comes from joining larger health systems. Since Tenet backed out of is acquisitions last year, both Eastern Connecticut Health Network and Greater Waterbury Health Network have continued to struggle and have engaged to be acquired by California-based Prospect Medical Holdings. In July 2015, it was also announced that Lawrence & Memorial Healthcare would join Yale new Haven Health System, and that Day Kimball Hospital in Putnam is evaluating a potential affiliation with Hartford HealthCare. Additionally, Johnson Memorial Hospital in Stafford has entered bankruptcy protection and is seeking to have its assets taken over by St. Francis Care.

The Connecticut market includes 28 acute care hospitals which care for approximately 375,000 people on an inpatient basis and approximately 1.65 million people on an emergency care basis in 2013. Over the same period of time these facilities delivered over 35,000 babies, provided over $200 million in charity care, and incurred $573 million and $588 million in Medicare and Medicaid losses respectively. On average Medicare reimburses 85 percent of treatment costs for patients in the state, while Medicaid reimburses 69%.

Impact on Valuation of ECHN and Related Assets

The recent legislation passed by the General Assembly allowing for-profit hospitals to acquire non-profits presents an opportunity for health systems such as ECHN which are currently non-profit. As healthcare systems move towards increased mergers and integration, smaller health systems such as ECHN will likely need to align with larger systems or hospital companies with access to capital in order to continue to serve the community.

The state budget cuts adversely affect hospitals in the State of Connecticut as a decrease in state spending also reduces federal funding. This becomes an even larger issue when dealing with hospitals and health systems facing capital challenges such as ECHN. While the hospital may be able to alleviate some income challenges through cuts in variable expenses, funding necessary capital expenditures into the future becomes a challenge as operations weaken.

NAVIGANT VALUATION AND TRANSACTION ANALYSIS

The following sections specifically address the conditions analyzed by Navigant under Section §§ 19a-486c of the Nonprofit Hospital Conversion Act:

I. Due Diligence Analysis

II. Conflict of Interest Analysis

III. Fair Market Value of Assets Analysis

IV. Fair Market Value Manipulation Analysis;

V. Financing Analysis; and

VI. Management Contract Valuation Analysis

For each section below, Navigant performed an independent research and analysis that resulted in our findings and conclusions as of the Analysis Date or Valuation Date.

I. DUE DILIGENCE ANALYSIS

In this section, Navigant will address:

Whether the nonprofit hospital exercised due diligence in (a) deciding to sell its assets, (b) selecting the purchaser, (c) obtaining a fairness evaluation from an independent person expert in such agreements, and (d) negotiating the terms and conditions of the transaction.

Review Process

In conducting our analysis, Navigant interviewed the following parties regarding the transaction due diligence process:

- Mr. Dennis McConville, ECHN SVP & Chief Strategy Officer
- Mr. Peter Karl, ECHN President & CEO
- Ms. Joy Dorin, ECHN Vice Chair Board of Trustees
- Dr. Dennis O'Neill, ECHN Chairman of the Board of Trustees
- Ms. Joyce Tichy, ECHN SVP & Chief Legal Counsel
- Mr. Mike Veillette, ECHN SVP & CFO
- Rebecca A. Matthews, Wiggin & Dana LLP
- Chris Regan, The Chartis Group
- Keith Dickey, The Chartis Group
- Todd Kaltman, Duff & Phelps
- Nick Tarditti, Duff & Phelps

In addition, Navigant reviewed the various materials, including but not necessarily limited to:

1) The ECHN and Prospect Medical Holdings Certificate of Need Application for a Proposed Asset Purchase dated October 13, 2015 (the "Application") and in particular Response 5 (pp 35-43) that described the process undertaken by ECHN in pursuing a strategic partner and eventually the Proposed Transaction;
2) The supplemental responses to the Application completeness letters dated November 23, 2015 and December 24, 2015;
3) Draft Asset Purchase Agreement between Eastern Connecticut Health Network, Inc. and Prospect Medical Holdings, Inc.;
4) Engagement Letter between Chartis Group and ECHN dated January 16, 2012;
5) Engagement Letter between Duff & Phelps, LLC an ECHN dated August 14, 2015;
6) Supplemental presentation by Prospect Medical Holdings dated March 28, 2016 and presented at the ECHN public hearings on March 29 & 30, 2016;
7) Duff & Phelps' Fairness Opinion Letter and related "Eastern Connecticut Health Network Fairness Analysis" presentation dated September 9, 2015
8) List of ECHN Board of Director meeting dates (Although requested by Navigant, ECHN representatives did not provide Board meeting minutes)

Findings and Conclusions

Based on the conditions, limitations, and qualifications contained herein and the interviews and document reviews described above, it appears that the ECHN Board undertook an extensive and diligent process to explore potential strategic options and identify strategic and capital alternatives that would enable it to address its relatively weak financial position and continue its mission of providing quality healthcare to the Manchester and Rockville/Vernon communities.

The process extended over a four (4) year period from 2011 to 2015 and includes the retention of the Chartis Group, a national advisory healthcare advisory firm. In connection with this process, the ECHN Board pursued discussions with multiple potential strategic partners, evaluated a range of transaction structures, and explored multiple strategies to access capital.

a. Exercise of due diligence in deciding to sell its assets

ECHN has had financial difficulties since 2001, generating annual net income losses while contending with significant debt service and pension related liabilities. While generating positive operating cash flows since 2011, ECHN's ability to meet both its debt service and pension related liabilities have been challenging, with ECHN reporting negative net income in 2011, 2013 and 2015.

ECHN management stated that it has implemented a number of cost cutting initiatives over the years to mitigate these trends, but at the expense of deferring needed infrastructure improvements. These included hiring freezes, wage freezes, eliminating defined contribution match, reductions in force, a reduced workweek of 37.5 hours, LEAN program initiatives and group purchasing initiatives. With the passage of the Patient Protection and Affordability Act of 2010 ("PPACA"), ECHN's finances were

further strained through reductions in federal and state government reimbursements for services, added requirements to participate in new payment models requiring higher levels of care coordination, and state supplemental payment challenges.

As a result of these developments, in September 2011, the ECHN board authorized the creation of a workgroup to study the impact of the PPACA on ECHN and to evaluate whether benefits would be realized by affiliating with another healthcare system or whether ECHN should remain independent.

- In November 2011, ECHN assembled its workgroup consisting of Trustees, Corporators, medical staff members and key executives. The workgroup hired the consulting firm The Chartis Group, LLC, a national healthcare consulting firm, to assist the workgroup in its evaluation.
- The workgroup began its study in December 2011, and met several times over the ensuing months with various constituents and prospective partner organizations to gain their perspectives on ECHN, its current state, and future.
- In September 2012, the workgroup presented its initial findings to the ECHN board, concluding that affiliating with a larger health system would help ECHN in i) attracting patients and providers based on quality, service, accessibility and affordability; ii) enhancing physician retention and recruitment; iii) improving ECHN's financial position; and iv) coordinating care to manage risk and participate in new payment vehicles.
- Following the presentation, the ECHN board voted to pursue an affiliation and tasked the workgroup with evaluating potential partners and developing key affiliation terms.
- By year end 2011, ECHN had a net income loss of $1.3 million, the first year the new State of Connecticut hospital tax had been implemented. Further, as a result of reduced patient volumes in 2012 and shifts in payer mix to exchange and Medicaid payers as a result of the PPACA, ECHN was projecting net income losses of $6 million per year in 2014 and 2015. Given these significant financial challenges, ECHN management concluded that partnering with another healthcare organization would be essential to maintaining its long term financial viability.

In conclusion, based on the conditions, limitations, and qualifications contained herein and the interviews and document reviews described above, it appears that the steps undertaken by the ECHN Board, as described above, indicate that the ECHN Board exercised due diligence in i) evaluating ECHN's financial and operating and strategic position and ii) deciding to approve a potential sale of its assets as a viable option to preserve the long-term viability of the Health System.

b. Exercise of due diligence in selecting the purchaser

Beginning in 2012, the ECHN Board took a series of deliberate steps to identify, evaluate and select a capital partner which ultimately resulted in its decision to approve the Proposed Transaction. These steps[9] included:

[9] See Section 5 (pp 35-43) from ECHN and Prospect Medical Holdings Certificate of Need Application for a Proposed Asset Purchase dated October 13, 2015 describing such steps.

- Between November 2012 and April 2013, the workgroup worked with The Chartis Group to develop Requests for Proposals ("RFP"'s) to three non-profit health systems and three for-profit health systems.
- The workgroup received and considered four indications of interest, and members of the workgroup met with each respondent for further detail on the proposal submitted, followed up with formal requests for clarification/additional information, conducted site visits to facilities operated by those healthcare systems and performed due diligence for each of the respondents.
- In April 2013, the workgroup made a formal presentation to the ECHN board of the proposals received and the board was asked to consider whether i) the proposals made would meet ECHN's needs and ii) whether other options should be considered. The board determined that other alternatives were unlikely and that further evaluation should be undertaken regarding the proposals received to date.
- On April 27, 2013, the ECHN board authorized the creation of a formal Board Transaction Committee to consider all proposals and evaluate their benefits and risks. The Transaction Committee carefully considered all proposals and also reviewed reverse due diligence information prepared by The Chartis Group.
- In June 2013, the Transaction Committee reviewed final information from the respondents and made its recommendation and report to the ECHN board. Their recommendation was to proceed with a proposal by a joint venture arrangement between Yale New Haven Health System ("YNHHS") and Vanguard Health Systems, Inc. ("Vanguard") (the "JV") in which the JV would acquire all or substantially all of the assets of ECHN. The Board considered and approved the recommendation of the Transaction Committee.
- On June 24, 2013, ECHN was informed by Vanguard that it was to be acquired by Tenet, but that Tenet intended to proceed with negotiating a letter of intent for the acquisition with ECHN.
- In July of 2013, the ECHN board considered the diligence review of Tenet conducted by the Transaction Committee and a proposed Letter of Intent. As a result of that review, the Board approved the Letter of Intent and it authorized management, in consultation with the Transaction Committee, to proceed to negotiation of a definitive APA.
- The letter of intent was executed among ECHN, YNHHS and Vanguard on August 8, 2013. Following its execution, the parties conducted confirmatory due diligence and negotiated an APA which was executed by the ECHN board on April 9, 2014. On October 24, 2014, a certificate of need application for the acquisition of ECHN by the JV was filed with the Office of Attorney General and with the Office of Health Care Access.
- On December 11, 2014, Tenet informed ECHN that it was withdrawing its certificate of need application for the acquisition of ECHN, citing the proposed regulatory conditions that had been placed on its application to partner with Waterbury Hospital.
- While waiting to see if Tenet would return to Connecticut, the ECHN board reaffirmed its need for an affiliation partner and on January 6, 2015, sent letters requesting expressions of interest to five health systems. ECHN in turn received letters back from four Connecticut based systems expressing interest.
- On February 6, 2015, RFPs were sent to the health systems that had expressed interest and to two out-of-state systems that had approached ECHN with interest in an affiliation. On March 16, 2015, three proposals were received.

- The proposals were evaluated by the Transaction Committee against selection criteria approved by the ECHN board. Criteria included their ability with respect to ECHN's financial needs, its obligations to creditors, antitrust considerations and state regulatory acceptance for a hospital conversion.
- The Transaction Committee then met with each respondent for further detail on the proposals and followed up with formal requests for clarification/additional information on April 10, 2015. Following this, the Transaction Committee conducted reverse due diligence on each respondent, reviewing financial, quality, and corporate compliance data. The Transaction Committee also conducted site visits of affiliated hospitals recently acquired or merged with the respondents, meeting with leadership, members of medical staffs and employees of each organization.
- On May 7 and May 14, 2015, two teams of Transaction Committee members and ECHN executives toured Prospect Medical Systems, Inc. ("PMH") Culver City Hospital in Los Angeles, California, meeting with representatives in the areas of governance, medical staff leadership and administration. On June 8, 2015, members of the Transaction Committee and ECHN executives visited CharterCARE Health Partners ("CharterCARE") in Providence, Rhode Island, a PMH affiliated facility. There was a discussion regarding CharterCARE's transaction experience, the PMH organizational culture and PMH's implementation of PMH's CRC Model at CharterCARE.
- On June 1, 2015, requests were made to each of the respondents for best and final offers. At its June 16, 2015 meeting, the Transaction Committee reviewed the information from the respondents and it was agreed that ECHN would negotiate solely with PMH to address open items in their proposed APA.
- On June 22, 2015, the Transaction Committee reviewed and discussed the Letter of Intent and APA negotiated with PMH, and recommended unanimously that the board accept PMH's proposal. On June 25, 2015, the ECHN board met to discuss the Transaction Committee's recommendations and surrounding due diligence. Following the discussion, the ECHN board unanimously approved the Letter of Intent and APA in substantially the same form presented. On July 29, 2015, the Letter of Intent and APA was approved by ECHN's Corporators.
- Subsequent to the signing of the LOI, the ECHN Board and Management continued due diligence efforts. In January of 2016, two Prospect hospitals in California were cited by Medicare with an Immediate Jeopardy ("IJ") findings. Upon learning of the IJ findings, the ECHN Board met to discuss the implications. Due diligence was performed including reviewing PMH's current efforts to remedy the deficiencies, detailed phone conversations with PMH, and a quality team site visit to CharterCARE in Rhode Island. Upon completion of due diligence, the Board conducted a special meeting to address the concerns and concluded that their concerns were satisfactorily answered.

Based on the series of actions described in this subsection (b), our discussions with ECHN representatives, and the conditions, limitations, and qualifications described herein, it appears that the ECHN Board exercised due diligence in selecting PMH as the entity that would purchase ECHN's assets.

c. Obtaining a fairness opinion from an independent person expert in such agreements[10]

The Transaction Committee engaged Duff & Phelps to provide a fairness opinion related to the Proposed Transaction. In selecting Duff & Phelps to perform the fairness opinion, the Transaction Committee considered the advice of Ropes & Gray LLP, its transaction counsel and received additional recommendations by the Chartis Group. In total, five firms were solicited for bids to provide a fairness opinion including Goldman Sachs, DGA Partners, Cain Brothers, Duff & Phelps, and Principle Valuation.

Duff & Phelps was selected based on their favorable reputation in the healthcare fairness opinion marketplace and the strong recommendation from Ropes & Gray LLP. Duff & Phelps is a national and global provider of fairness opinions, with a dedicated healthcare practice. In connection with rendering its fairness opinion, Duff & Phelps evaluated traditional valuation methods, including a discounted cash flow and market multiples, and assigned a 50/50 weighting to each approach. On September 8, 2015, the Transaction Committee met to review the fairness opinion prepared by Duff & Phelps.

Navigant reviewed Duff & Phelps' fairness opinion analysis and held telephone discussions with the Todd Kaltman and Nick Tarditti who performed the analysis in order to gain an understanding of the methodology and key assumptions.

Duff & Phelps compensation for the services was based on a fixed fee and was not contingent on the closing of the Transaction, indicating a level of independence and objectivity in rendering its opinion.

Based solely on our review of the Duff & Phelps fairness opinions and supporting analyses presented by Duff & Phelps, Navigant confirms that the ECHN Board did receive a fairness opinion with respect to the fairness, from a financial point of view, of the consideration proposed to be received in the Proposed Transaction from an independent expert (based solely on the representations contained in Duff & Phelps conflict of interest/financial disclosure forms, its fairness opinion letter and report).

Based on Navigant's review of the Duff & Phelp's fairness opinion, we make note of the following:

- **Duff & Phelps considered three valuation methods in its fairness opinion (discounted cash flow, guideline company, and M&A transaction). Based on their analysis, Duff & Phelps developed a mid-point estimate of $57.1 million for the Health System.**
- **In addition, Duff & Phelps utilized a market approach and a capitalized cash flow approach to estimate the value of ECHN's joint venture interests at $13.1 million. The total fair value of ECHN's business enterprise (including the joint venture interests) estimated by Duff & Phelps was $70.2 million.**

[10] The description of the process undertaken by ECHN to obtain a fairness opinion as well as the actual fairness opinion and supporting analyses are provided in Section 7 (pp 47-48) and Exhibits Q7-2, Q7-3, and Q7-4 (pp 798-841) from the ECHN and Prospect Medical Holdings Certificate of Need Application for an Asset Purchase dated October 13, 2015.

- **Duff & Phelps did not develop an asset-based valuation approach.**

d) Exercised due diligence in negotiating the terms and conditions of the transaction

As highlighted in subsection (b) above, the ECHN Board took a series of deliberate steps to identify, evaluate, negotiate with and finally select a capital partner. In particular, with respect to negotiation of the Proposed Transaction, the ECHN Board undertook the following steps:[11]

- Retained The Chartis Group, an experienced healthcare consulting firm, to orchestrate a competitive solicitation process.
- Appointed a Transaction Committee to work with The Chartis Group in evaluating proposals and developing various levels of reverse due diligence on certain respondents which included on site visits and interviews with management.
- In its second round of RFPs, the Transaction Committee, with the assistance of the Chartis Group solicited a total of six health systems of which three sent responses back.
- With respect to each proposal, ECHN provided a template affiliation agreement and asset purchase agreement reflecting ECHN's contract requirements. ECHN asked all respondents to include any requested or required changes to the templates with their proposals. In addition, ECHN asked respondents to answer the following questions within their proposal:
  1. How the affiliation would help ECHN to achieve its vision and goals, with a focus on access to care, medical staff integration, clinical quality, safety, service and patient satisfaction.
  2. Proposed form or structure of affiliation (e.g., merger, acquisition of assets, member substitution or joint venture).
  3. Financial terms of affiliation, including proposed treatment of ECHN's existing debt, consideration, and future capital commitments.
  4. Proposed governance and management structure.
  5. Plans for retention of employees.
  6. Commitments to continuing and expanding services.
  7. Proposed timing, required regulatory approvals, and material contingencies.
  8. If the organization was subject to any religious or ethical restrictions that would apply to ECHN post-closing and, if so, how ECHN would continue to meet the needs of its community in the event the restrictions applied.
- The Transaction Committee evaluated each proposal against the strategic, financial, and operational goals of ECHN, any antitrust considerations and state regulatory requirements for a hospital conversion. Based on these considerations, the Transaction Committee unanimously approved PMH as being the best health system to partner with.
- On June 25, 2015, after consideration of the risks and uncertainty of each potential partner, and the due diligence performed on each, the ECHN board unanimously approved PMH's letter of intent and APA.
- Pursuant to the signing of the APA, ECHN management negotiated for terms to maximize the value to the Health System.

[11] See Section 5 (pp 18-22) from ECHN and Prospect Medical Holdings Certificate of Need Application for an Asset Purchase dated October 13, 2015.

- The transaction with PMH provided for deal terms consistent with the failed Tenet acquisition. After Tenet withdrew, ECHN conducted their search in an expedited manner, and considered that they had a more limited set of potential suitors. Therefore, ECHN management and Board believed that attaining a similar set of deal terms would be favorable to the Health System.
- PMH also agreed to increase the purchase consideration by up to $10 million in the event that ECHN does not have sufficient cash to close the transaction. The increase would be offset by a corresponding reduction in the $75 million capital commitment amount. Management strongly felt that this increased the probability of being able to close the transaction, even if unforeseen events occurred that would further weaken its financial position.
- Upon signing the LOI, ECHN was in negotiations to secure additional financing. If the assumable loan had been attained, then the purchase price would have been increased by $10 million. Ultimately, this financing was not secured as lenders were unwilling to extend ECHN additional credit.

Based on the series of actions described in subsection (d) above, our discussions with ECHN representatives, and conditions, limitations, and qualifications contained herein, it appears that the ECHN Board exercised due diligence in negotiating the terms of the Proposed Transaction. Navigant would also note that ECHN had limited leverage for negotiations given its relatively weak financial condition, but was able to negotiate a transaction that recapitalized ECHN to stabilize current operations and provide a source of capital for long term growth.[12]

II. CONFLICT OF INTEREST ANALYSIS

In this section, Navigant will address:

Whether the nonprofit hospital disclosed any conflict of interest, including, but not limited to, conflicts of interest pertaining to board members, officers, key employees and experts of the nonprofit hospital, the purchaser, or any other party to the transaction.

Review Process

In conducting its analysis, Navigant reviewed the following materials:

1) The Application from ECHN and PMH dated October 13, 2015 and in particular Response 6 (pp 43-47) that described the process undertaken by the ECHN and PMH for identifying conflicts of interest;
2) Exhibit Q6-1 to the Application that contains i) the August 2015 Conflict of Interest disclosures from ECHN Board of Directors, senior executives and experts advising on the Proposed Transaction, and ii) the August 2015 Conflict of Interest disclosures from PMH's Board of

[12] See Section 5 (pp 18-22) from ECHN and Prospect Medical Holdings Certificate of Need Application for an Asset Purchase dated October 13, 2015.

Directors, senior management and advisors who have a direct involvement in the Proposed Transaction;

During August 2015, conflict of interest and financial disclosure forms were prepared and disseminated to: i) the Board of Trustees of ECHN, MMH, RGH, ECHN Eldercare Services Inc., and Visiting Nurse and Health Services Connecticut, Inc.; ii) experts consulted with respect to the Proposed Transaction; and iii) senior executives of ECHN and PMH who had direct involvement in the Proposed Transaction.

The Conflict of Interest Disclosure forms required the person executing the form to disclose if that individual or any related person (person related by blood, law, or marriage, and individuals in committed relationship) has any financial interest, beneficial interest and/or employment interests in the transaction, ECHN, PMH or in any entity associated with the principals involved in the transaction.

Findings and Conclusions

The following summarizes the conflicts of interest and related financial disclosures information for all persons identified in i), ii) and iii). Based on our review of the conflict of interest and disclosures forms, no individual had expressed having any financial or other beneficial interest in the transaction that would appear to compromise their objectivity and independence based on the Conflict of Interest Forms reviewed by Navigant.

ECHN Conflict Of Interest and Disclosures

Name	Affiliation	Conflicts/Disclosures (1)
Gordon Brodie, MD	ECHN Trustee	None
Thomasina Clemon	ECHN Trustee	None
Michele Conlon, MD	ECHN Trustee	None
Joy Dorin	ECHN Trustee	None
Louise C. England	ECHN Trustee	None
Donald S. Genovesi	ECHN Trustee	None
David H. Gonci	ECHN Trustee	None
Rebecca D. Janenda	ECHN Trustee	None
Peter Karl	ECHN Trustee/Senior Management Team	None
Eric Kloter	ECHN Trustee	None
Pamela Lewis, MD	ECHN Trustee	None
Kathleen O'Neill	ECHN Trustee	None
Dennis O'Neil	ECHN Trustee	None
Keith J. Wolff	ECHN Trustee	None
Natalie Cook	ECHN Senior Management Team	None
Nina Kruse	ECHN Senior Management Team	None
Linda Lemire	ECHN Senior Management Team	None
Dennis McConville	ECHN Senior Management Team	None
Linda Quirici	ECHN Senior Management Team	None
Joel Reich, MD	ECHN Senior Management Team	None
Edward Roberts	ECHN Senior Management Team	None
Todd Rose	ECHN Senior Management Team	None
Joyce Tichy	ECHN Senior Management Team	None
Michael Veillette	ECHN Senior Management Team	None
Gregory Williams	ECHN Senior Management Team	None
Susan Breslau	ElderCare Services Board	None
Richard Bundy	ElderCare Services Board	None
David Engleson	ElderCare Services Board	None
Joanne Renee Irvin	ElderCare Services Board	None
Marianne Lassman-Fisher	ElderCare Services Board	None
Rev Donald Miller	ElderCare Services Board	None
Irene Quong-Conlon	ElderCare Services Board	None
Americo Rodrigues	ElderCare Services Board	None
Kathleen Stavens	ElderCare Services Board	None
Krystal Anderson	ElderCare Senior Management Team	None
Margaret Candito	ElderCare Senior Management Team	None
Catherine Collette	ElderCare Senior Management Team	None
Janet Gallugi	ElderCare Senior Management Team	None
Paul Golino	ElderCare Senior Management Team	None
Rosemary Harding	ElderCare Senior Management Team	None
Christine McGuire	ElderCare Senior Management Team	None
Katherine Mon	ElderCare Senior Management Team	None

(1) A general provision in the asset purchase agreement offered at-will employment at PMH to substantially all employees of ECHN. Beyond this very general provision, no individual had any conflicts of interest or financial interests that would appear to affect their objectivity and independence.

ECHN Conflict Of Interest and Disclosures Continued

Name	Affiliation	Conflicts/Disclosures (2)
Melinda Agsten	Advisor	None
Jonathan Barry	Advisor	None
Aaron Bayer	Advisor	None
David Blackwell	Advisor	None
Cody Braithwaite	Advisor	None
Leslie DesMarteau	Advisor	None
Keith Dickey	Advisor	None
Adam Eckart	Advisor	None
Merton Gollaher	Advisor	None
Patrick Griffin	Advisor	None
Thomas Hurley	Advisor	None
Thomas Kaltman	Advisor	None
Rebecca Matthews	Advisor	None
Michael McDonough	Advisor	None
Anne Ogilby	Advisor	None
David Peloquin	Advisor	None
Lisa Pelta	Advisor	None
R. Christopher Regan	Advisor	None
Joseph Simpson	Advisor	None
Louis Spadaccini	Advisor	None
Nicolas Tarditti	Advisor	None
Lori Stone	Advisor	None
Jane Willis	Advisor	None
Mark Wilson	Advisor	None

(2) The advisors and counsel to the transaction were compensated for their services. However, there were no other conflicts of interest or financial interests that would appear to affect their independence and objectivity.

PMH Conflict Of Interest and Disclosures

Name	Affiliation	Conflicts/Disclosures
Alyse Wagner	Director, BOD	None
John Baumer	Director, BOD	None
Michael Solomon	Director, BOD	None
Sam Lee	Chairman, BOD; CEO, PMH	None
Dr. Jeereddi Prasad	Director, BOD, President, ProMed	None
Dr. Mitchell Lew	President, PMH	None
Steve Aleman	CFO, PMH	None
Ellen Shin	General Counsel & Secretary, PMH	None
David Topper	President, Alta	None
Jonathan Spees	SVP, M&A, PMH	None
Von Crockett	SVP, Corporate Development, PMH	None
Steve O'Dell	SVP, CRC, PMH	None
Thomas Reardon	President, Prospect East	None
Gary Herschman	PMH Advisor, Epstein, Becker	None
Michele Volpe	PMH Advisor, Berstein, Volpe	None
Jay Krupin	PMH Advisor, Baker Hostetler	None
Elizabeth Dold	PMH Advisor, Groom Law Group	None
Alan Weiss	PMH Advisor, Lockton	None
Jim Tinyo	PMH Advisor, Keenan	None
Arthur Rains-McNally	PMH Advisor, Milliman	None
Chris Kujawa	PMH Advisor, Ernst & Young, LLP	None
Rosemary Free	PMH Advisor, Ernst & Young, LLP	None

III. FAIR MARKET VALUATION OF ASSETS ANALYSIS

In this section, Navigant will address:

Whether the nonprofit hospital will receive fair market value for its assets, i.e., the most likely price that the assets would bring in a sale in a competitive and open market under all conditions requisite to a fair sale, with the buyer and seller each acting prudently, knowledgeably, and in their own best interest, and with a reasonable time being allowed for exposure in the open market.

For the purposes of our valuation analysis, we considered the following definitions of fair market value ("FMV") and are assuming no difference in the two definitions.

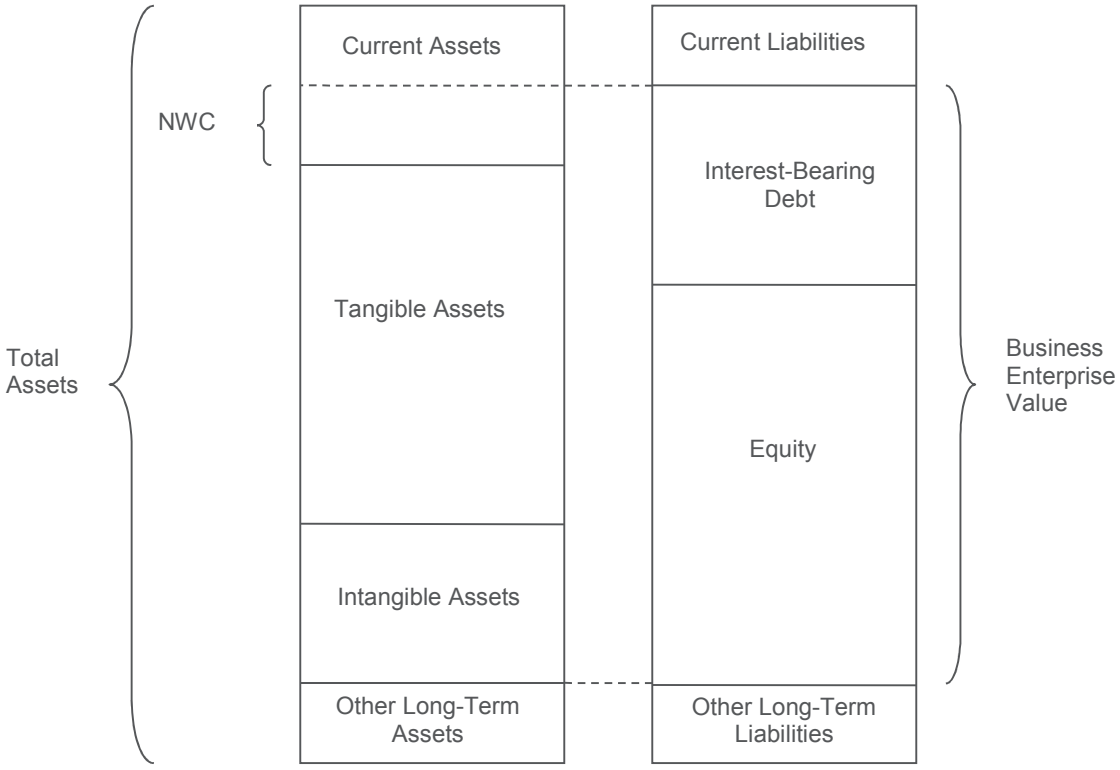
Nonprofit Hospital Conversion Act §§ 19a-486c:

> *…the most likely price that the assets would bring in a sale in a competitive and open market under all conditions requisite to a fair sale, with the buyer and seller each acting prudently, knowledgeably and in their own best interest, and with a reasonable time being allowed for exposure in the open market.*

IRS Revenue Ruling 59-60:

> *…the price at which an entity (asset) would change hands between a willing buyer and willing seller, neither being under compulsion to buy or sell and both having reasonable knowledge of all relevant facts.*

The components of a hospital's total asset value can be depicted as follows:



However, it is our understanding that in the proposed transfer of assets between ECHN and PMH, certain assets will not be contributed, including but not limited to the following:

- All cash, cash equivalents and securities;
- All short and long-term investments (excluding joint venture interests);
- All board-designated, restricted, and trustee-held or escrowed funds;
- The assets of ECHN Community HealthCare Foundation ("ECHF")
- Other Assets identified in Section 2.02 of the APA

PMH will also assume all current liabilities accrued as of the transaction date, in addition to unfunded pension liabilities, ECHN's health benefit plan for retirees, ECHN's captive insurer liabilities of Connecticut Healthcare Insurance Company ("CHIC") and worker's compensation obligations. It is also been determined that all of ECHN's joint venture interests will be included in the Potential Transaction.

In estimating the FMV of the Health System's assets to be included in the Potential Transaction, Navigant conducted various procedures, including but not limited to the following:

- Review and analysis of relevant documents and data provided by ECHN management regarding ECHN, including historical and projected financial and operational results;
- Consideration of factors that would impact future financial and operational performance;
- Review of budgets and long-term financial and operational projections for ECHN;
- On-site interviews with the management of ECHN concerning:
    - the nature and operations of the business, including the historical financial and operational performance of ECHN;
    - existing business plans, future financial and operating performance estimates, and budgets for ECHN;
    - current and future capital expenditure needs; and
    - the assumptions underlying the business plans, estimates, or budgets, as well as the risk factors that could affect planned financial and operating performance, including expected patient volume, payer mix, service line mix, reimbursement expectations, market competition, and physician relationships;
- On-site inspection of ECHN by Navigant professionals to view the Health System's hospital facilities and operations, as well as conducting a field site analysis related to certain real and personal property;
- Review of initial and supplemental completeness question responses submitted to the OAG by ECHN's legal counsel;
- Review of the initial CON application (and responses) related to the Transaction;
- Review of transaction-related documents including the letter of intent and asset purchase agreement;
- Analysis of the industry, as well as the economic and competitive environments in which the ECHN operates;
- Analysis of the performance and market position of ECHN relative to its competitors;
- Analysis of the earning capacity of ECHN;
- Consideration of goodwill or other intangible value;
- Analysis of financial data of similar publicly-traded companies or transactions;
- Valuation analysis of ECHN utilizing accepted valuation methodologies including (as appropriate and applicable):
    - Discounted Cash Flow Method
    - Similar Transactions Method
    - Guideline Company Method
    - Adjusted Net Assets Method; and
- Analysis of other facts and data considered pertinent to this valuation to arrive at our conclusions; and

Valuation Approaches

In performing our FMV analysis, we considered the three generally accepted approaches to value: income, market, and cost. The theory of these approaches is summarized as follows:

Income Approach

There are several variants of the income approach. One of these variants is the discounted cash flow ("DCF") method. In the DCF method, the cash flows anticipated over several periods, plus a terminal value at the end of that time horizon, are discounted to their present value using an appropriate rate of return. The DCF and other prospective models are considered to be the most theoretically correct methods to valuing an income producing business because they explicitly consider the future benefits associated with owning the business.

Another income approach method is based on capitalizing some measure of financial performance such as earnings or dividends, using a capitalization rate that reflects both the risk and long-term growth prospects of the subject firm. In capitalizing a historical measure of financial performance, it is important to remember that historical results serve as a proxy for future performance. Both the required rate of return used in the DCF model and the capitalization rate reflect capital market conditions and the specific circumstances of the subject health system.

Market Approach

In the market approach, the value of a business is estimated by comparing the subject business to similar businesses or "guideline" companies whose securities are actively traded in public markets or have recently been sold in a private transaction. This method is applied as the price per unit of a measure of financial performance or position, and equates to a multiple approach, using price-to-earnings before interest and taxes or similar market/transaction derived multiples applied against the appropriate financial measure generated by the subject to indicate value.

In using merger and acquisition data to develop indications of value, it is important to have adequate knowledge of the terms of the transaction to be able to make appropriate valuation judgments regarding the subject. For example, seller financing or the use of restricted stock to pay for an acquisition may require an adjustment relative to an all cash deal.

Cost Approach

The cost approach estimates a business's value based on an analysis of the value of its individual assets. The adjusted net book value method involves estimating the FMV of all assets on the balance sheet, and then subtracting the estimated FMV of the liabilities. A common application of the adjusted book value method is valuing an entity whose sole function is investing in other businesses.

The Adjusted Net Assets Method represents one methodology employed in the Cost Approach. In this method, a valuation analysis is performed of a business's identified fixed, financial, and other assets. The derived aggregate value of these assets is then "netted" against the estimated value of all existing and potential liabilities, resulting in an indication of the value. An ongoing business enterprise is typically worth more than the FMV of its underlying assets due to several factors: (i) the assets valued independently may not reflect economic value related to the prospective cash flows they could

generate; (ii) this approach may not fully reflect the synergy of the assets but rather their independent values; and (iii) intangible assets inherent in the business such as reputation, superior management, proprietary procedures or systems, or superior growth opportunities are very difficult to measure independent of the cash flow they generate. The value of the assets using the Cost Approach may be perceived as providing a pricing "floor" in the absence of earnings.

Standard of Value

We have concluded that the appropriate standard of value for our valuation analysis is FMV. Our conclusion was based on our review of the Nonprofit Hospital Conversion Act, the nonprofit status of the ECHN, and our experience with similar transactions.

As stated previously, for the purposes of our valuation analysis, we considered the following definitions of FMV and are assuming no difference in the two definitions.

Nonprofit Hospital Conversion Act §§ 19a-486c:

> *…the most likely price that the assets would bring in a sale in a competitive and open market under all conditions requisite to a fair sale, with the buyer and seller each acting prudently, knowledgeably and in their own best interest, and with a reasonable time being allowed for exposure in the open market.*

IRS Revenue Ruling 59-60:

> *…the price at which an entity (asset) would change hands between a willing buyer and willing seller, neither being under compulsion to buy or sell and both having reasonable knowledge of all relevant facts.*

FMV should be distinguished from strategic (or investment) value for the purposes of this valuation. The strategic value is the value to a specific owner or prospective owner. Therefore, strategic value considers the owner's or prospective owner's knowledge, capabilities, expectations of risks and future earnings, and other factors. An example of strategic value is when a transaction provides unique motivators or synergies to a particular buyer that is not available to the typical buyer.

Premises of Value

Various premises of value may be considered under the FMV standard of value. In general, four premises of value are typically considered[13]:

1. ***Value in Continued Use, as Part of a Going Concern***

   Value in continued use, as a mass assemblage of income producing assets, and as a going concern business enterprise.

2. ***Value-in-Place, as Part of a Mass Assemblage of Assets***

   Value-in-place, as part of a mass assemblage of assets, but not in current use in the production of income, and not as a going-concern business enterprise

3. ***Value in Exchange, in an Orderly Disposition***

   Value in exchange, on a piecemeal basis (not part of a mass assemblage of assets), as part of an orderly disposition. This premise contemplates that all of the assets of the business enterprise will be sold individually and that they will enjoy normal exposure to their appropriate secondary market.

4. ***Value in Exchange, in a Forced Liquidation***

   Value in exchange, on a piecemeal basis (not part of a mass assemblage of assets), as part of a forced liquidation. This premise contemplates that all of the assets of the business enterprise will be sold individually and that they will experience less than normal exposure to their appropriate secondary market.

For our valuation analysis, we considered each of the premises of value and selected the premise that was most appropriate based on our analysis of the Health System's current and projected financial and operational outlook, as well as the most likely transaction scenario.

Selected Methodology

Each of the valuation approaches described above may be used to develop an indication of the FMV of the Health System's assets; however, the appropriateness of certain approaches and the premise of value can vary depending on the specific facts and circumstances of the entity being valued, the assumed transaction, and the information available.

For service-oriented, income-producing entities, the income and market approaches are typically performed in order to estimate the FMV of a business on a going concern basis. However, for businesses that are not currently generating positive cash flow from current operations and are not projected to generate positive cash flow in the future, a going concern premise of value may not be possible. In such cases, the valuation exercise may focus on a FMV analysis under a Value-In-Place

[13] Shannon P. Pratt, Robert F. Reilly, and Robert P. Schweihs, Valuing Small Businesses & Professional Practices, Third Edition, 1998, pp 46-47

or Value in Exchange premise as described above utilizing a market and/or asset-based approach.

While ECHN has experienced marginal profitability to significant net income losses historically, it has generated positive cash flow. However, in the absence of an affiliation, ECHN management projects future net income losses and continued cash flow challenges due to the need for capital expenditures to maintain and grow its asset base to remain competitive and to meet community needs.

Based on our analysis and discussions, we concluded that ECHN and its assets should be valued under the premise of **Value-In-Continued Use, as Part of a Going Concern**. In addition, we performed a supplemental asset-based valuation approach to add additional support that the hospital will receive at least FMV for its assets under the Proposed Transaction. Accordingly, all valuation methods and approaches, including the income and market approaches, were considered in our FMV analysis of ECHN.

Valuation Analysis

In completing our valuation analysis, we performed the three generally accepted approaches to value: income, market, and cost. The detail regarding each of these approaches is outlined in the section below:

Income Approach

Discounted Cash Flow Method

The DCF method estimates the FMV of an entity based on expected future economic benefits discounted to present value at a rate of return commensurate with the risk of the investment. ECHN management provided information and assumptions upon which projections for the ECHN are based. Projected debt-free net cash flows ("DFNCF") for ECHN were discounted to present value using an estimated weighted average cost of capital ("WACC"), reflecting returns to both equity and debt investors. Debt-free net cash flow is defined as:

+ Debt-Free Net Income
+ Depreciation and Amortization
- Capital Expenditures
+/- Changes in Net Working Capital Requirements
= Debt-free Net Cash Flow

The annual DFNCFs during the discrete projection period are discounted to present value. Under the premise of a going concern, the cash flow stream of the business is expected to continue for the foreseeable future. The stabilized cash flow (or terminal value) attributable to the business enterprise is estimated, capitalized and discounted back to present value. The sum of the discounted annual net cash flows plus the terminal year value represents the FMV of the subject business enterprise.

The terminal value represents the prospective value at the end of the discrete time period and is calculated by dividing the net cash flow available for distribution in the terminal year by an appropriate capitalization rate, which assumes a constant growth rate into perpetuity. This calculation is known as the Gordon Growth Model and is shown arithmetically below:

$$TV = \frac{CF_t}{K - g}$$

where:

TV = Terminal Value
CFt = Normalized DFNCF
K = Discount Rate (WACC)
g = Sustainable Long-Term Growth Rate

DCF Assumptions

In developing projections, we relied upon financial projections provided by ECHN management. The following details the assumptions used in determining after-tax debt free net income:

Revenues

Our revenues projections are detailed in Exhibit B-3 and summarized as follows:

- Revenue projections for the years 2016 through 2019 were provided by management. In our analysis, we separately valued ECHN's joint venture interests using the market approach. Accordingly, we excluded Management's forecast of income from joint venture interests from the projected revenue stream.

- Net patient revenue is projected to be $290 million in 2016, $299 million in 2017, $306 million in 2018 and $312 million in 2019.

- Other operating revenue is projected to remain flat over the forecast horizon at $12.9 million, while net assets released from restrictions is projected to be $648 thousand in 2016, and $275 thousand each year thereafter through 2019.

Expenses

- Projected operating expenses were provided by Management. Overall, operating expenses are projected to be approximately 96 percent of revenues over the forecast horizon, as compared to 96 to 98 percent of revenues in the years 2013 through 2015.

Capital Expenditures and Depreciation

Capital expenditure estimates were based on comparison to guideline company levels and discussions with Management regarding current and future capital expenditure needs. Based on peer comparisons, capital expenditure levels generally run between 5 and 6 percent of net revenues. However, given the limitations of ECHN's available cash flow to finance debt repayment and other cash operating needs, we have projected a 1.5% annual capital expenditure level. Projections of depreciation were based on age and life estimates of existing fixed assets and future capital expenditures. Our capital expenditure and depreciation forecast is detailed in Exhibit B-5.

Income Taxes

Though ECHN is a non-profit corporation, its earnings stream was tax affected given that likely market participants would be for-profit corporations subject to taxes. Accordingly, the value to a willing buyer would need to consider income taxes in the cash flow projections. Income taxes were estimated to be 40.9% based on a blending of federal and Connecticut state corporate income tax rates.

Working Capital Requirements

Based on an analysis of guideline companies and the ECHN's historical trends in cash-free, debt-free working capital, we estimated working capital requirements to be approximately 9.0% of the change in total net revenue.

Perpetuity Growth Rate

Based on an analysis of the industry and discussions with ECHN management, a sustainable long-term revenue growth rate of 2.0 percent was assumed for the perpetuity cash flow calculation.

Discount Rate - Weighted Average Cost of Capital ("WACC")

The magnitude of a discount rate is related to the perceived risk of the investment as well as current capital costs. The concept of risk involves an investment situation, which lies between complete certainty of monetary return (no risk), and complete uncertainty of monetary return (infinite risk). When an investor contemplates two investments, each having the same expected monetary return, an investor would prefer the investment bearing the least risk. Therefore, the higher the risk, the higher the expected return.

The WACC measures the costs of debt and equity weighted by the percentage of debt and percentage of equity in a company's estimated target capital structure. The formula for calculating an after-tax WACC is:

$$WACC = \left(K_D \times (1 - t) \times \frac{D}{V}\right) + \left(K_E \times \frac{E}{V}\right)$$

SYMBOL	DESCRIPTION
Kd	Cost of debt financing
Ke	Cost of equity financing
D	Estimated market value of debt
E	Estimated market value of equity
V	Value of total invested capital (debt plus equity)
T	Assumed tax rate

Cost of Equity

The Capital Asset Pricing Model ("CAPM")[14] was utilized to estimate the return required by investors given a company's risk profile. The model is deployed arithmetically by the following equation:

$$K_E = r_f + (\beta \times rp_m) + R_c + R_s$$

SYMBOL	DESCRIPTION
Ke	**Cost of equity financing**
Rf	**Risk-free rate of return**: A risk-free rate of return is generally measured by the rate of return on U.S. Treasury securities. The yield on the 20-year U.S. Treasury security as of the Valuation Date was 2.20 percent.[15]
β	**Beta**: Beta is a measure of systematic risk, which represents the covariance of the rate of return on the subject company with the rate of return on the market. A beta coefficient of 1.00 implies that a company's return varies directly with the overall market. The unlevered beta chosen for ECHN was 0.66, based on an analysis of publically traded companies. After re-levering this beta based on ECHN's capital structure, the indicated beta coefficient was 1.05.
Rpm	**Market equity risk premium**: This premium is the excess of the market rate of return over the risk-free rate that investors have historically demanded for an investment in equities. Quantification of the market premium has been the subject of much research by security analysts. Findings stemming from the SBBI Cost of Capital Yearbook, 2015, indicate the total rate of return on large capitalization common stocks using supply side estimates exceeded the risk-free rate by an average of 6.19 percent for a long-term horizon.[16]
R_C	**Small company stock premium**: This premium is the average premium in excess of the cost of equity derived from the CAPM that the overall market investor requires to invest in a business with low market capitalization. Based on our analysis, the Company was categorized in the 10th decile for companies with market capitalization below $302 million using the SBBI Cost of Capital Yearbook, 2015. Therefore, we applied the 5.78 percent small stock premium.[17]
R_S	**Company specific risk premium**: This premium represents the additional risk specific to an investment in a company. We added a company specific risk premium of 5.0 percent to the cost of equity of ECHN to account for relatively low margins, ability to meet capital expenditure needs, state government payment uncertainty, and concentration of services in two markets. We believe that the selected company specific risk premium is appropriate due to the risk inherent in management's forecast of cash flows.

[14] W.F. Sharpe, "Capital Asset Prices: A Theory of Market Equilibrium under Conditions of Risk," *Journal of Finance*, 19:425-442 (September 1964); J. Linter, "The Valuation of Risk Assets and the Selection of Risky Investments in Stock Portfolios and Capital Budgets," *Review of Economics and Statistics*, 47:13-37 (February 1965).

[15] Source: Federal Reserve Statistical Release, H.15, March 31, 2016.

[16] Source: Ibbotson Associates, Stocks, Bonds, Bills, and Inflation 2015 Yearbook.

[17] Source: Ibid

Based on the variables presented above, the rate of return on equity capital was calculated as follows:

Ke = 2.20%+ (1.05 * 6.19%) + 5.78% + 5.00%

= 19.5%

Cost of Debt

The pretax cost of debt for ECHN was determined based on the Baa corporate bond equal to 4.90%, as of the Valuation Date. As interest expense is deductible for income tax purposes, the pretax cost of debt was tax-affected to derive an after-tax cost of debt.

The rate of return on debt capital is calculated as follows:

Kd = 4.90% * (1 – 40.9%)

= 2.9%

Capital Structure

The estimated proportion of debt and equity financing is an important component of the WACC calculation. The capital structure was assumed to be 50.0 percent debt and 50.0 percent equity based on an analysis of the capital structures of publically traded companies in the same industry as ECHN.

The implied WACC of 11.0 percent was utilized to discount the future cash flow projections of the Center to the present value.

Joint Venture Analysis

As discussed in Section II, ECHN has several joint venture interests which are accounted for under the equity method of accounting. As of September 30, 2015, these interests were carried on the books at $18.2 million. To value the joint ventures, we relied on the market approach. We removed the income stream related to the joint ventures from our DCF forecast and applied relevant BEV/EBITDA multiples to each of ECHN's investment's share in EBITDA.

The multiples selected were based on a review of transaction data within the industry associated with each investment, and valuator experience. The details of this analysis can be found in Exhibit F-4. Additionally, several of ECHN's joint venture interests were real estate assets. The valuation of these assets is detailed in Exhibit F-3. Based on our analysis, the concluded value of ECHN's non-real estate joint venture interests was determined to be $13.2 million, while real estate related joint venture interests were determined to be $1.8 million.

Estimated Value Discounted Cash Flow Method

Based on the DCF method, as shown in Exhibit B-1, the indicated BEV value of ECHN including the value of joint ventures, on a marketable, controlling interest basis is $63,750,000 (rounded).

Market Approach – Guideline Company Method Overview

In our application of the guideline company method, we considered valuation multiples derived from public guideline companies that were identified as belonging to a group of industry peers and then calculated and applied selected multiples to ECHN's historical and projected financial metrics.

Guideline Company Research

In applying the guideline company method, we focused on identifying companies that operate in the same or a similar line of business as ECHN. We analyzed comparable companies with significant operations involving general acute-care hospitals.

Based on the above search criteria, we identified five companies as being comparable to ECHN to employ in our analysis. It should be recognized that it is impossible to identify publicly traded companies with operations that are identical to that of the ECHN, as no two companies are exactly alike. For purposes of our analysis, the guideline companies selected represented similar, but alternative investment opportunities to an investment in ECHN. The companies selected were not pure play comparable to ECHN primarily due to size and geographic diversification differences.

Application of the Guideline Company Method

After identifying the guideline company, we developed market-based valuation multiples related to BEV-to-TTM revenue and BEV-to-TTM EBITDA.

The application of the guideline company method includes: (i) the identification of reasonably similar publicly-traded companies operating in the same or a similar industry as ECHN as discussed above; (ii) analysis of the guideline companies' financial and operating performance relative to ECHN; (iii) calculation of market multiples for the selected guideline companies; (iv) adjustment of the market multiples for differences between the guideline companies and ECHN; and (v) application of the market multiples to ECHN's fundamentals to arrive at an indication of FMV.

The BEV-to-TTM revenue of our guideline companies ranged between 0.9 x and 1.7x with a median BEV-to-TTM revenue multiple of 1.0. The BEV-to-TTM EBITDA of our guideline companies ranged between 7.9x and 9.3x with a median BEV-to-TTM EBITDA multiple of 8.5x. BEV-to-NTM revenue multiples ranged from 0.8x to 1.5x with a median of 1.0x while BEV-to-NTM EBITDA multiples ranged from 6.7x to 8.9x with a median of 7.5x.

In our selection of the multiples, we also considered the comparability of the guideline company relative to ECHN and made adjustments for ECHN's size, geographical concentration in the state of Connecticut, and profitability. Based on our analysis, we applied a BEV-to-TTM EBITDA multiple of

4.6x and a BEV-to-NTM EBITDA multiple of 4.3x. We applied a BEV-to-TTM Revenue multiple of 0.2x and a BEV-to-NTM Revenue multiple of 0.2x.

Estimated Value by Guideline Company Method

Application of the multiples discussed above resulted in an estimate of value for the business enterprise of ECHN. The values represent the value of ECHN on a marketable, non-controlling interest basis.

In order to determine the value of ECHN on a marketable, controlling basis we applied a control premium of 10.0%, based on an analysis of control premiums paid in recent transactions in the industry, to arrive at an indicated business enterprise value for ECHN on a marketable, controlling basis. We then added the value of joint venture interests. Based on our analysis, as illustrated in Exhibit C-2, the indicated BEV of ECHN on a marketable, controlling basis, as of the Valuation Date, is approximately $70,344,000 (rounded).

Market Approach – Similar Transaction Method Overview

In our market approach analysis of ECHN, we also considered the Similar Transaction Method. The Similar Transaction Method is a market approach in which the FMV of a business is estimated by analyzing the prices at which companies similar to the subject have sold in controlling interest transactions (mergers and acquisitions). Target companies are compared to the subject company, and multiples paid in transactions are analyzed and applied to subject company data resulting in value indications. Similarity can be affected by, among other things, the product or service produced or sold, geographic markets served, competitive position, profitability, growth expectations, size, risk perception, and capital structure.

Similar Transaction Research

In applying the similar transaction method, we screened companies using published data the Irving Levin Transaction Database based on the following criteria: (i) transactions in the similar service line model; (ii) transactions occurring during the four years that preceded the Valuation Date; (iii) acquired interests representing a majority of common equity to reflect a controlling interest level of value; and (iv) with publicly available transaction information.

In our search, we identified one hundred and thirty-eight relevant transactions with published transaction data. However, all of the transactions were at least four years distant from the Valuation Date. We calculated a range of BEV-to-TTM Revenue and BEV-to-TTM EBITDA multiples produced under the transaction method. For the identified comparable transactions, the BEV-to-TTM Revenue multiples ranged from 0.0x to 9.0x with a median of 0.6x and the BEV-to-TTM EBITDA multiples ranged from 0.2x to 52.7x with a median of 9.1x. We additionally segmented the transaction data by date, revenues and profitability. Based on our analysis, we selected a BEV-to-TTM EBITDA multiple of 4.9x and a BEV-to-TTM Revenue of 0.2x. Our multiple selection was based on ECHN's lower profitability levels and growth prospects.

Estimated Value – Similar Transaction Method

We applied the selected multiple to ECHN's fundamentals to determine an indication of the value of ECHN's BEV on a marketable, controlling basis. We then added the estimated value of ECHN's joint venture interests. Based on our analysis, as illustrated in Exhibit C-1, the indicated BEV of ECHN on a marketable, controlling basis, as of the Valuation Date, is approximately $73,091,000.

Supplemental Asset-Based Valuation Approach

Navigant performed a supplemental asset-based valuation analysis to further support our overall assessment that PMH was not paying less than fair market value for ECHN's assets. As summarized previously, the premise of Value-in-Place assumes that all assets will continue to be used in the manner for which it/they was/were originally intended which is consistent with the prospective buyer's stated intent to operate the Health System's hospitals as general acute care hospitals with similar levels and types of services.

In order to estimate the FMV of the Health System's assets under the premise of Value-in-Place, we performed an independent fair market valuation of the Health System's real and personal property and added this to the Health System's current net working capital balance as of August 31, 2014. Please refer to Appendix C and D for details of Navigant's real and personal property FMV analyses. Summary of each analysis is provided in Exhibits F-2 and F-3. We then added the value of ECHN's joint ventures and the projected value of net working capital as of the valuation date of $21,130,000.

Intangible Assets

As part of Navigant's overall valuation analysis, we considered the potential for intangible assets that could be identified and valued, including under a Value-in-Place premise of value. One intangible asset could possibly include the Health System's CON licenses. However, we understand that the Health System's CON licenses are not separable or transferrable apart from the Health System's real property. Accordingly, we determined the value of ECHN on a Value-In-Place premise did not support an intangible asset value of the CON licenses apart from the Health System's real property.

Asset-Based Conclusion

Based on a valuation of the Health System's assets under the premise of Value-In-Place, the indicated value of ECHN's business enterprise is approximately $101,847,000. A summary of the analysis is provided in Exhibit F-1.

Fair Market Valuation Conclusion

We primarily relied on the Discounted Cash Flow Method in order to estimate the FMV of ECHN and related affiliates with corroborative value indications from two market-based valuation methods. Based on our review of information provided to us, independent research and analysis, and our informed judgment, we estimate the FMV of the Health System's assets as follows:

Summary of Fair Market Value Going Concern Premise of Value	Weighting	FMV
Discounted Cash Flow	100%	$63,750,000
Guideline Company Method	0%	70,344,000
Similar Transaction Method	0%	73,091,000
Unadjusted ECHN Business Enterprise Value		$63,750,000
Less: Net Working Capital Adjustment		(2,870,000)
FMV of ECHN Business Enterprise (Going Concern)		**$60,880,000**

The consideration provided by Prospect to ECHN is summarized below:

Summary of Consideration		As of 2/29/2016
Purchase Price	(1)	$105,000,000
Working Capital Adjustment	(1)	(2,870,000)
Total Consideration		**$102,130,000**

(1) Per Asset Purchase Agreement. Working capital adjustment calculated as working capital contributed less targeted working capital of $24.0M.

As the purchase price of $105 million adjusted for the $2.9 million working capital deficit adjustment exceeds our estimated FMV indications, we conclude that ECHN will receive FMV for the Health System assets, as of the Valuation Date.

IV. FAIR MARKET VALUATION MANIPULATION ANALYSIS

In this section, Navigant will address:

Whether the fair market value of the nonprofit hospital's assets have been manipulated by any person in a manner that causes the value of the assets to decrease.

Findings and Conclusions

Based on our analysis of ECHN's financial position and operations, as well as observations during our valuation and transaction analysis process, we found no indication that ECHN's assets have been manipulated by any person in a manner that causes the value of the assets to decrease.

V. FINANCING ANALYSIS

In this section, Navigant will address:

Whether the financing of the transaction will place the nonprofit hospital's assets at an unreasonable risk.

Findings and Conclusions

PMH will not incur any debt financing to consummate the transaction. As such, there is no financing that would place the Health System's assets at unreasonable risk.

The proceeds from the Proposed Transaction will result in the settlement of ECHN's bond liabilities and other outstanding indebtedness. In addition, PMH will assume ECHN's unfunded pension liabilities, health benefit plan for retirees, captive insurer liabilities, and workers' compensation obligations. Any remaining proceeds will be used to settle post-closing liabilities and wind down the operations of ECHN.

PMH agreed to increase the purchase price for the assets by $10 million in the event that ECHN does not have sufficient cash to close the transaction, which increase would be offset by a corresponding reduction in the $75 million capital commitment amount.[18].

[18] As described in ECHN and PMH's Certificate of Need Application dated October 13, 2015 and supplemental responses to completeness letters dated November 23, 2015 and December 24, 2015.

VI. MANAGEMENT CONTRACT VALUATION ANALYSIS

In this section, Navigant will address:

Whether any management contract contemplated under the transaction is for reasonable fair value.

Findings and Conclusions

It is not currently anticipated that there will be a management contract between PMH and ECHN as of the closing. Therefore, it was not necessary to perform a management fee valuation analysis[19].

[19] Ibid.

APPENDIX A: SOURCES OF INFORMATION

We have relied upon sources including, but not limited to the following:

- Selected audited and unaudited operational and financial data of ECHN;
- The ECHN and Prospect Medical Holdings Certificate of Need Application for a Proposed Asset Purchase dated October 13, 2015 (the "Application") and in particular Response 5 (pp 35-43) that described the process undertaken by ECHN in pursuing a strategic partner and eventually the Proposed Transaction;
- The supplemental responses to the Application completeness letters dated November 23, 2015 and December 24, 2015;
- Draft Asset Purchase Agreement between Eastern Connecticut Health Network, Inc. and Prospect Medical Holdings, Inc.;
- Supplemental presentation by Prospect Medical Holdings dated March 28, 2016 and presented at the ECHN public hearings on March 29 & 30, 2016;
- Engagement Letter between Chartis Group and ECHN dated January 16, 2012;
- Engagement Letter between Duff & Phelps, LLC an ECHN dated August 14, 2015;
- Duff & Phelps' Fairness Opinion Letter and related "Eastern Connecticut Health Network Fairness Analysis" presentation dated September 9, 2015;
- Selected transaction and regulatory documents, including letter of intent, asset purchase agreement, initial and supplemental completeness question responses; and PMH's Certificate of Need application;
- In-person interviews with ECHN Management and Chairman of the Board:
    - Dennis McConville, SVP & Chief Strategy Officer
    - Peter Karl, President & CEO
    - Joy Dorin, Vice Chair Board of Trustees
    - Dr. Dennis O'Neill, Chairman of the Board of Trustees
    - Joyce Tichy, SVP & Chief Legal Counsel
    - Mike Veillette, SVP & CFO
- Telephone interviews with ECHN legal and financial advisors:
    - Rebecca A. Matthews, Wiggin & Dana LLP
    - Chris Regan, The Chartis Group
    - Keith Dickey, The Chartis Group
    - Todd Kaltman, Duff & Phelps
    - Nick Tarditti, Duff & Phelps

- “Selected Interest Rates,” Federal Reserve Statistical Reserve;
- “Economic Outlook Update Q4, 2015” Business Valuation Resources;
- Capital-IQ;
- U.S. Bureau of the Census;
- IBISWorld Industry Report, Hospitals in the US, August 2015;
- Selected Internet sites; and
- Other sources, as noted.

APPENDIX B: ASSUMPTIONS AND LIMITING CONDITIONS

1. **Report Distribution** – This report has been prepared solely for the purpose stated in our engagement letter and should not be used for any other purpose. Except as specifically stated in the report, neither our report nor its contents is to be referred to or quoted, in whole or in part, in any registration statement, prospectus, public filing, loan agreement, or other agreement or document without our prior written approval. In addition, except as set forth in the report, our analysis and report presentation are not intended for general circulation or publication, nor are they to be reproduced nor distributed to other third parties without our prior written consent.
2. **Scope of Analysis** – The appraisal of any financial instrument or business is a matter of informed judgment. The accompanying appraisal has been prepared on the basis of information and assumptions set forth in the attached report, associated appendices, our underlying work papers, and these limiting conditions and assumptions.
3. **Nature of Opinion** – Neither our opinion nor our report are to be construed as a fairness opinion as to the fairness of an actual or proposed transaction, a solvency opinion, or an investment recommendation, but, instead, are the expression of our determination of the fair market value of the underlying assets and liabilities between a hypothetical willing buyer and a hypothetical willing seller in an assumed transaction on an assumed valuation date. For various reasons, the price at which the assets and liabilities might be sold in a specific transaction between specific parties on a specific date might be significantly different from the fair market value as expressed in our report.
4. **Going Concern Assumption, No Undisclosed Contingencies** – Our analysis: (i) assumes that as of the valuation date the Company and its assets will continue to operate as configured as a going concern; (ii) is based on the past and present financial condition of the Company and its assets as of the valuation date; and (iii) assumes that the Company had no undisclosed real or contingent assets or liabilities, no unusual obligations or substantial commitments, other than in the ordinary course of business, nor had any litigation pending or threatened that would have a material effect on our analysis.
5. **Lack of Verification of Information Provided** – With the exception of audited financial statements, we have relied on information supplied by the Company without audit or verification. We have assumed that all information furnished is complete, accurate and reflects Management's good faith efforts to describe the status and prospects of the Company at the valuation date from an operating and a financial point of view. As part of this engagement we have relied upon publicly available data from recognized sources of financial information, which have not been verified in all cases.
6. **Reliance on Forecasted Data** – Any use of Management's projections or forecasts in our analysis does not constitute an examination or compilation of prospective financial statements in accordance with standards established by the American Institute of Certified Public Accountants ("AICPA"). We do not express an opinion or any other form of assurance on the reasonableness of the underlying assumptions or whether any of the prospective financial statements, if used, are presented in conformity with AICPA presentation guidelines. Further, there will usually be differences between prospective and actual results because events and circumstances frequently do not occur as expected and these differences may be material.

7. **Subsequent Events** – The terms of our engagement are such that we have no obligation to update this report or to revise the valuation because of events and transactions occurring subsequent to the Valuation Date.
8. **Legal Matters** – We assume no responsibility for legal matters including interpretations of either the law or contracts. We have made no investigation of legal title and have assumed that owner(s) claim(s) to property are valid. We have given no consideration to liens or encumbrances except as specifically stated. We assumed that all required licenses, permits, etc. are in full force and effect. We assume no responsibility for the acceptability of the valuation approaches used in our report as legal evidence in any particular court or jurisdiction. The suitability of our report and opinion for any legal forum is a matter for the client and the client's legal advisor to determine.
9. **Testimony** – Neither Navigant Consulting, Inc. nor any individual signing or associated with this report shall be required to give testimony or appear in court or other legal proceedings unless specific arrangements have been made in advance.
10. **USPAP** – Unless otherwise stated in our opinion, our engagement is not required to be conducted pursuant to the Uniform Standards of Professional Appraisal Practice.
11. **Verification of Legal Description or Title** – As part of this engagement, we will not assume any responsibility for matters of a legal nature. No investigation of legal description or title to the property will be made and we will assume that your claim to the property is valid. No consideration will be given to liens or encumbrances which may be against the property, except as specifically stated as part of the financial statements you provide to us as part of this engagement. Full compliance with all applicable federal, state, local zoning, environmental and similar laws and regulations is assumed, unless otherwise stated and responsible ownership and competent property management are assumed.

APPENDIX C: PERSONAL PROPERTY VALUATION

Definition of Value

The standard of value used in the valuation of the personal property is Fair Market Value. Fair Market Value is defined as "the estimated amount that may be reasonably be expected for a property, in an exchange between a willing buyer and a willing seller, with equity to both, neither under any compulsion to buy or sell and both fully aware of all relevant facts, as of a specific date.

Fair Market Value In-Place

Fair Market Value In-Place assumes the use of the assets in the ongoing business and therefore includes all normal direct and indirect costs (such as installation and other assemblage costs) to make the property fully operational. Under the premise of Fair Market Value In-Place, we included certain capitalized costs in our valuation such as installation, freight, engineering costs, electrical set-up costs, and other assemblage costs that would be required to make the personal property fully operational.

Approaches to Value

Three approaches are considered in the valuation of personal property: the Cost, Income, and Market (or Sales Comparison) Approaches. The application of each of these approaches is dependent upon the nature of the assets, the availability of appropriate information, and the scope of the analysis. Based on the value indications derived from the application of appropriate methodologies, an opinion of value is estimated using expert judgment within the confines of the appraisal process. Summary descriptions of the three approaches typically used in the valuation of tangible assets are provided in the following paragraphs:

Cost Approach

The Cost Approach recognizes that a prudent investor would not ordinarily pay more for an asset than the cost to replace it new. The first step is to estimate the reproduction/replacement cost new of an asset using current materials, prices, and labor. Reproduction cost and replacement cost are defined as follows:

> Reproduction Cost is the estimated cost to construct, at current prices, an exact duplicate (or replica) of the asset being appraised, using the same materials, construction standards, design, layout and quality of workmanship, and embodying all the subject's deficiencies, super-adequacies, and obsolescence.
>
> Replacement Cost is considered to be the cost of substituting an asset with another asset having equivalent functional utility as the asset being appraised.

The cost new is then reduced by the amount of depreciation resulting from physical deterioration, functional obsolescence, and economic/external obsolescence which are inherent in the asset. The resulting depreciated replacement cost is an indication of the Fair Market Value of an asset providing all elements of depreciation are addressed. The factors of depreciation are defined in the following paragraphs:

> Physical Depreciation as a result of age and wear can be divided into curable and incurable. Curable physical deterioration is a loss in value which can be recovered or offset by repairing or replacing defective items causing the loss, provided that the resulting value increase equals or exceeds the cost of work. Incurable physical deterioration is a loss in value which

cannot be offset or which would involve a cost to correct greater than the resulting increase in value.

Functional Obsolescence is any loss in value resulting from inappropriate design, inefficient process flow, poor construction or layout for the intended use, and changes in the technical state-of-the-art. Functional obsolescence may be either curable or incurable.

Economic/External Obsolescence relates to the loss in value that occurs from factors external to the assets.

Market Approach

The Market (Sales Comparison) Approach estimates value based on what other purchasers and sellers in the market have agreed to as prices for comparable assets. This approach is based on the principle of substitution which states that the limits of prices, rents, and rates tend to be set by the prevailing prices, rents, and rates of equally desirable substitutes. In conducting the Market Approach for the valuation of the personal property, we gather data on reasonably substitutable assets and make adjustments for such factors as market conditions, location, conditions of sale, income characteristics, etc. The resulting adjusted prices lead to an estimate of the price one might expect to realize upon sale of the asset.

The sales comparison approach was used to value the Subject Assets, in cases where asset/data information was readily available. Adjustments were considered based on the following elements of the comparable transaction data:

- Vintage
- Effective Age
- Condition
- Capacity
- Features
- Manufacturer
- Price
- Quality
- Quantity
- Date of sale
- Type of sale
- Assemblage Costs

We contacted used equipment sellers, researched various websites, and publications to gather information regarding recent transactions and offerings of comparable assets. Similar transactions and offering prices were adjusted, as appropriate, to arrive at an estimation of the fair market value of the Subject Assets.

Income Approach

The Income Approach is a valuation technique by which Fair Market Value is estimated based upon the cash flows that the subject asset can be expected to generate over its remaining useful life.

Approaches Utilized

The Cost and Market Approaches were utilized to value the Subject Assets depending on the quality and the quantity of information available related to the specific asset employed. The Income

Approach was considered but not utilized in valuing the Subject Assets due to the difficulty in allocating the revenue or income streams of a business enterprise to a specific asset employed.

Sources of Information

The sources of information used in our valuation of the Personal Property included the following:

- Fixed asset record ("FAR") provided by Management with historical cost and acquisition date information;
- Third party inventory of the Subject Assets with information such as Location, Department, Room, Barcode Asset Number, Floor, Asset Description, Manufacturer, Model No.
- Historical invoices of personal property assets for major assets;
- Capital leases;
- Equipment maintenance contracts;
- Electronic medical record and third party software specifications;
- Data center equipment hardware specifications;
- Health System floor plans;
- Photographs of personal property
- Physical inspection of a sampling of the assets in order to verify fixed asset records and to determine the quality, condition, and utility of the personal property.
- Discussions with Management to obtain an explanation and clarification of the data provided and to obtain additional data and descriptions of the history and future operations of the Personal Property.

We relied on this data as fairly representing the Subject Assets. We have not audited the inventory in the course of our valuation assignment. We relied on this information in:

- Identifying the assets to be valued, acquisition dates and historical costs of the assets to be valued;
- Estimating reproduction cost new and age/life based depreciation;
- Supporting information regarding the condition and operational status of the equipment;
- Identifying certain capitalized costs that would not have resale value to third-parties; and
- Overall support of the value calculations relating to the Subject Assets.

We did not consider supplies, materials on hand, or working capital as part of our analysis. Inventory was estimated at cost based on the value on the balance sheet. Our analysis is limited only to the assets described above.

Assets Valued

The personal property assets valued ('Subject Assets") are located at the following entities of Eastern Connecticut Health Network:

- Manchester Memorial Hospital
- Rockville General Hospital
- ECHN ElderCare Services, Inc.

The assets can be categorized within the following general asset classifications:

- Computer Equipment – includes, but not limited to, servers, desktops, laptops,

monitors, printers, network equipment, etc.

- Furniture & Fixtures – includes, but not limited to, patient beds, chairs, tables, book shelves, book cases, cabinets, carts, couches, desks, file cabinets, etc.
- Kitchen Equipment – includes, but not limited to, ovens, refrigerators, coolers, fryers, broilers, freezers, stoves, toasters, salad bars, skillets, water coolers, etc.
- Machine Tools – includes, but not limited to, hand drills, grinders, planers, routers, sanders, hoists, jack hammers, jig saws, knife sharpeners, nail guns, saws, tool boxes, welders, etc.
- Medical Equipment - includes all medical equipment and devices such as nuclear imaging equipment, surgical equipment & instrumentation, radiology equipment, nuclear imaging equipment, X-ray machines, ultrasound equipment, fetal monitors, defibrillators, laboratory equipment, anesthesia equipment, EKG equipment, etc.
- Office Equipment – includes, but not limited to, copiers, faxes, telephones, etc.
- Other Equipment– includes, but not limited to, televisions, security cameras, exercise equipment, floor scrubbers, snow blowers, humidifiers, time clocks, etc.

Scope of Services

In our valuation analysis, the following steps were performed:

- Conducted hospital site visit to collect equipment information for the Subject Assets such as capacity, type, manufacturer, model, vintage, etc. The verification of major assets was performed through the site visit, gathering equipment listings at the department level, and discussions with department personnel in order to verify the fixed asset inventory listing and to estimate the quality, condition, and utility of the personal property;
- Reviewed the fixed asset inventory listing, and other documentation for the equipment and contents;
- Estimated the current cost of and the cost to install the personal property;
- Conducted industry research of personal property to estimate the replacement cost, obsolescence, and remaining useful life based on asset type, utility, quality and age;
- Held discussions with equipment vendors and distributors of similar pre-owned, refurbished and/or new personal property to determine the market value of assets and compare research results with data from published sources to determine reasonableness;
- Analyzed all the facts and data compiled resulting in a conclusion of value.

Tim Lubbe inspected the Subject Assets at:

- Manchester Memorial Hospital; 71 Haynes Street, Manchester, CT;
- Rockville General Hospital, 31 Union Street, Vernon, CT
- Evergreen Imaging Center, 2800 Tamarack Ave., Suite 002South Windsor, CT
- John DeQuattro Cancer Center, 100 Haynes Street Manchester, CT
- Sterilization Center_460 Hartford Vernon CT- Dialysis
- Tolland Imaging Center, 6 Fieldstone Commons, Tolland, CT
- Women's Wellness Center - 2600 Tamarack- South Windsor, CT
- Woodlake at Tolland Nursing Facility-26 Shenipsit, Tolland CT

Valuation Procedures

Our valuation analysis involved a depreciated cost study of the assets. In order to utilize the cost approach, we used the fixed asset schedule and available historical invoices as accurately representing the assets to be appraised. No adjustments were made to historical costs or in-service dates.

The cost approach establishes reproduction/replacement cost estimates for the assets and was applied using direct and indirect methods. Direct costing relies on standard pricing media or quotations from equipment suppliers, original manufacturers and other industry sources. We applied the direct cost approach to Subject Assets depending on the quality and quantity of asset data/information. Based on the compiled data, we estimated a Replacement Cost New for the property on an uninstalled basis. Installation costs and other indirect costs were added, as appropriate.

We primarily used the indirect approach to value the assets. Indirect costing is the application of inflation indices to historical costs to estimate Reproduction Cost New. The indirect approach will index the historical cost data to provide an estimate of replacement cost new, using cost indices which reflect changes in equipment costs, and installation costs over time. These indices reflect the increase in cost on an asset-specific basis. After replacement cost new for the assets has been developed, depreciation estimates were made based on the relationship of age, as indicated from fixed asset records, condition, functional and economic obsolescence.

We reconciled the various approaches to conclude on one estimate of value for each of the assets and made adjustments to arrive at an indication of value under the presumption of installed and in-place. In valuing the Subject Assets, for items in which there was an active secondary market and recent sales comparables exist, the sales comparison approach was utilized. In instances where market data was available, but deemed too incomplete to apply the sales comparison approach, we used the market relationship data available to support the cost approach analysis. In instances where a Subject Asset is found to have no used market resale exposure, we utilized the cost approach.

Our analysis is limited only to the Subject Assets described above. We investigated the market from both a replacement cost and sales comparable standpoint. Our final conclusions take into account that the Personal Property was (with the exception of items identified by the client as idle or disposed) fully functional and operable and was utilized in its highest and best use in an efficient manner to be expected for the type of equipment (unless noted otherwise by the Client).

We express no opinion or other form of assurance regarding the inventory data accuracy, completeness, or fairness of representation. Our valuation of the personal property considers a value-in-place concept. Based on the analysis described in this report, we estimated the Fair Market Value In-Place of the Personal Property to be approximately $38.9 million as of the Valuation Date (before the capital lease liability of $6.84 million) and $32.0 million after the capital lease liability. (See the next section for a summary of the value by category).

Sample Equipment Photographs



Nuclear Gamma Camera at Manchester Memorial Hospital



Data Center Equipment at Manchester Memorial Hospital



CT Scanner at Manchester Memorial Hospital



Operating Room/ Da Vinci Robot Equipment at Manchester Memorial Hospital



Medical Imaging Equipment at Rockville General Hospital



2-D Mammography Machine at Rockville General Hospital



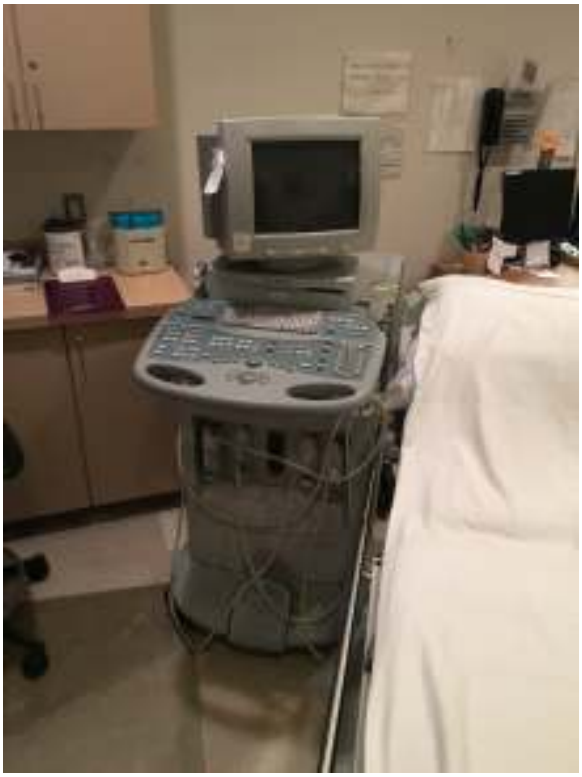
C-Arm Equipment at Rockville General Hospital



Ultrasound Equipment at Rockville General Hospital



CT Scanner at Evergreen Imaging Center



Ultrasound Equipment at Evergreen Imaging Center



Woodlake at Tolland Nursing Facility



Woodlake at Tolland Nursing Facility

APPENDIX D: REAL PROPERTY VALUATION

- Nature of the Assignment
- Property Identification
- Scope of work, definitions and history
- Description of locations
- Highest and Best Use
- Methodologies
- Analysis
    - Major real estate
        - Manchester Memorial Hospital
        - Rockville General Hospital
        - 460 Hartford Turnpike
        - Woodlake at Tolland – Skilled Nursing
    - Minor nonessential real estate
    - Joint Venture real estate

Nature of the Assignment

The real estate is analyzed to opine on fair market value of these fixed assets as a part of a larger valuation of the business entity being acquired. This appendix only address the real estate assets. Given the breadth of the real estate owned, the focus of the analysis is on the larger properties given the greatest materiality. The valuation of the smaller real estate properties is done with the use of recent historic appraisals, recent acquisitions and available public records.

Property Identification

The subject of this real estate analysis is that real estate owned by ECHN. This includes major real estate assets such as the Manchester Memorial Hospital (MMH), the Rockville General Hospital (RGH), the Woodlake at Tolland (WAT) owned by ECHN ElderCare Services and 460 Hartford Turnpike in Vernon, CT. In addition there are a number of small medical office buildings, small general office buildings, single-family residential properties surrounding MMH and RGH, as well as vacant land parcels. Furthermore, ECHN has ownership in four real estate focused joint ventures.

The following is a list of the properties owned by ECHN

REAL ESTATE PROPERTY SUMMARY				
Address	**City**	**Property Type**	**Size (SF)**	**Land (acres)**
71-80 Haynes Street (MMH)	Manchester	Hospital and parking	527,224	15.40
31 Union St (RGH)	Vernon	Hospital	177,348	7.95
460 Hartford Turnpike	Vernon	Medical/Dialysis/Sterilizing	36,000	3.29
26 Shenipsit Lake Road (WAT)	Tolland	Elder Care	65,721	6.39
Properties near MMH				
18 Haynes Street	Manchester	Office Building/Commercial	6,061	0.4
26 Haynes Street	Manchester	Office Building/Commercial	4,256	0.43
36 Haynes Street	Manchester	Office Building/Commercial	7,068	0.46
44 Haynes Street	Manchester	Office Building/Commercial	1,523	0.17
310-312 Main Street	Manchester	Office Building/Commercial	3,954	0.34
320 Main Street	Manchester	Office Building/Commercial	10,640	0.29
353 Main Street	Manchester	Office Building/Commercial	5,348	0.47
150 North Main Street	Manchester	Medical Office Building	20,656	1.28
945 Main St (2 condos)	Manchester	Office Building/Condos	2,330	Condo
319 Broad Street	Manchester	Thrift/retail store	6,236	0.46
W Middle Tpke; Russell; S Alton	Manchester	12 SFR residential properties	15,233	2.61
Hemlock; S Hawthorne; S Alton	Manchester	5 Vacant Residential parcels		11.57
56 Haynes Street	Manchester	Vacant commercial parcel		0.31
Properties near RGH				
Ward, Village and W Main Streets	Vernon	Vacant parcels		1.37
JV - Partially Owned				
100 Haynes Street	Manchester	Cancer Center MOB	30,443	2.59
29 Haynes Street	Manchester	Medical office building	11,241	0.96
2800 Tamarack Avenue	South Windsor	Medical office building	40,000	4.12
2400 + 2600 Tamarack Avenue	South Windsor	Medical office building	52,615	Ground leased

Scope of the Appraisal

Relevant information about the subject property was collected from the Client, discussion with the listing broker, proprietary data bases, appraisal files, and public records. The subject was legally identified through postal addresses, Assessors' records, legal description, and other documents/sources.

Specific steps in the scope of work included:

- Review and compilation of data about the subject property, the terms of the investment, the local market area, national and regional healthcare trends;
- Analysis of the factors considered to impact value including economic life of the improvements, barriers to entry, real estate development trends, operating expenses, competitive landscape, and construction costs of new hospitals and medical office buildings.
- Analysis of the subject in the Cost Approach by valuing the land as if vacant and the depreciated replacement cost new for the building improvements and the site improvements.
- Analysis of the Sales Comparison Approach to provide a framework and support for the Cost Approach.
- Reconciliation to a value conclusion.

Our valuations of the major properties are based on the steps described above. The smaller less material properties are valued with the help of recent historic appraisals, recent acquisitions, and Assessors' valuations supported by a review of small commercial property sales within the market. In addition, the high level analysis of the joint ventures concentrated in real estate involve recently constructed buildings which allowed us to look at the actual costs to construct to help opine on the net partial interest.

The business enterprise and personal property were valued separately by Navigant and are not included in this real estate appraisal appendix.

Effective Dates of Appraisal

The valuation date is March 31, 2016. The appraisal is based upon market conditions observed at that time.

Property History

Manchester Memorial Hospital and Rockville General Hospital are both currently operated as acute care hospitals. Woodlake at Tolland is operated as a skilled nursing facility. The hospitals and nursing facility have not changed ownership within the past three years. Of the additional other 38 properties owned by ECHN, only 353 Main Street, Manchester, CT had been purchased within the past three years. This 5,348 square foot commercial building was purchase May 9, 2014 for $695,000 or nearly $130 per square foot. This was a market transactions between unrelated parties. In discussion with ECHN real estate specialist, it is evident that the hospital has been acquiring properties around the campus for some time and are prudent in their acquisition decisions.

The Proposed Transaction involves the sale of specific asset from ECHN to PMP. See prior sections of this report for more specific details.

Property Rights Appraised and Value Definitions

The property rights appraised are the fee simple estate ownership of the land, site improvements, and buildings (without personal property and the business). The fee simple estate is defined as, *"Absolute ownership unencumbered by any other interest or estate, subject only to the limitations imposed by the governmental powers of taxation, eminent domain, police power, and escheat."* [20]

Exposure Period

The concept of FMV assumes the hypothetical sale of a property given reasonable exposure on the market. Further, the exposure time is presumed to precede the effective date of the appraisal. Exposure time is defined in USPAP Statement on Appraisal Standards No. 6, "Reasonable Exposure Time in Market Value Estimates" as:

> *The estimated length of time the property interest being appraised would have been offered on the market prior to the hypothetical consummation of a sale at market value on the effective date of the appraisal; a retrospective estimate based upon an analysis of past events assuming a competitive and open market.*

Exposure time is different for various types of real estate and under various market conditions. It is noted that the overall concept of reasonable exposure encompasses not only adequate, sufficient, and reasonable time but also adequate, sufficient, and reasonable effort. The best estimate of exposure time is a function of price, time, use, and current market conditions for the cost and availability of funds.

In estimating the length of time the property would have been offered on the market prior to the hypothetical consummation of a sale at market value on the effective date of this appraisal, we considered information gathered on comparable sales and historical and current market conditions.

After analyzing the aforementioned factors, we believe the reasonable exposure time to sell the properties would have been 18 to 24 months.

[20] The Dictionary of Real Estate Appraisal, Sixth Edition, Page 113.

Manchester, Vernon and Tolland – Real Estate Description

ECHN properties are located in the Hartford-West Hartford-East Hartford CBSA. Manchester Memorial Hospital is located in the city of Manchester, Connecticut in Hartford County. The hospital campus is located in central Manchester, equal distance between Interstate 84 and Interstate 384. The area is improved with a mix of residential along the side streets with neighborhood services along the arterials. This is an older well-established area of Manchester. New retail development has occurred in recent years just to the north of Manchester in South Windsor. South Windsor is the location of some of the real estate owned in Joint Ventures. The demographics for Manchester indicate a population within the city limits of 58,241 people. The area has an area median household income of $61,936, just short of the State median of $67,098. And the unemployment rate was 6.4% in 2014.

Rockville General Hospital is located in the Rockville area of the city of Vernon, Connecticut in Tolland County. Rockville area is an area with historic buildings. It is not surprising that the RGH has as a part of its campus a historic mansion. The location is approximately one mile northwest of Interstate 84. The demographics for Vernon indicate a population of 29,179 within the city limits. The area has a median household income of $59,081, below the state median of $67,098. And the unemployment rate was 6.4% in 2014. The median housing or condo value is slightly higher than the median in Manchester.

Woodlake at Tolland is located in the unincorporated area of Tolland County, Connecticut, to the east of Vernon. This area is a low-density suburban/ rural residential area of Tolland County. There are views of the surrounding habitat and access to Interstate 84 about two miles to the southwest.

Of the larger owned properties, the dialysis clinic and sterilization facility at 460 Hartford Turnpike in Vernon is in an attractive commercial area along the I-84, with surrounding commercial office and retail services.

The 37 small owned parcels that surround either the MMH campus or the RGH campus. There are two JV properties adjacent to the MMH. There are two JV investments in three properties in South Windsor. South Windsor is to the north of Manchester and has seen development in the past ten years. The population of South Windsor is just over 25,000 people. And the area median household income is $92,718, significantly above the state median household income and higher than Manchester and Vernon.

[21] A healthcare industry overview, economic overview, and a local market overview are provided in the main section of the overall report.

The following map shows the location of the real estate.



Both Vernon and Manchester are suburban communities to the larger community of Hartford, Connecticut. Both have higher demographics to Hartford.

A closer look at the MMH campus shows the wide variety of properties around the hospital. The following map shows the location of MMH and its surrounding owned properties. These show the hospital in the yellow, the MOB, general office and retail in blue, the single family residential properties in red, the vacant land is green and the joint venture medical office properties in purple.

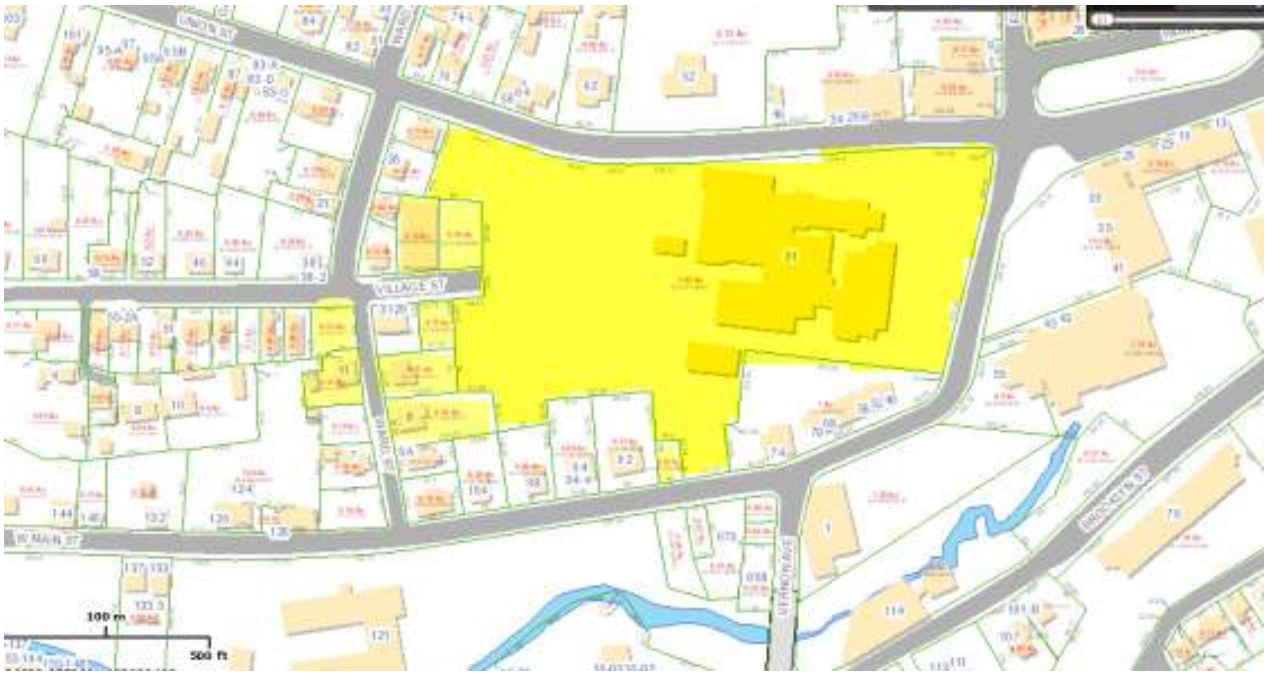
MMH campus area



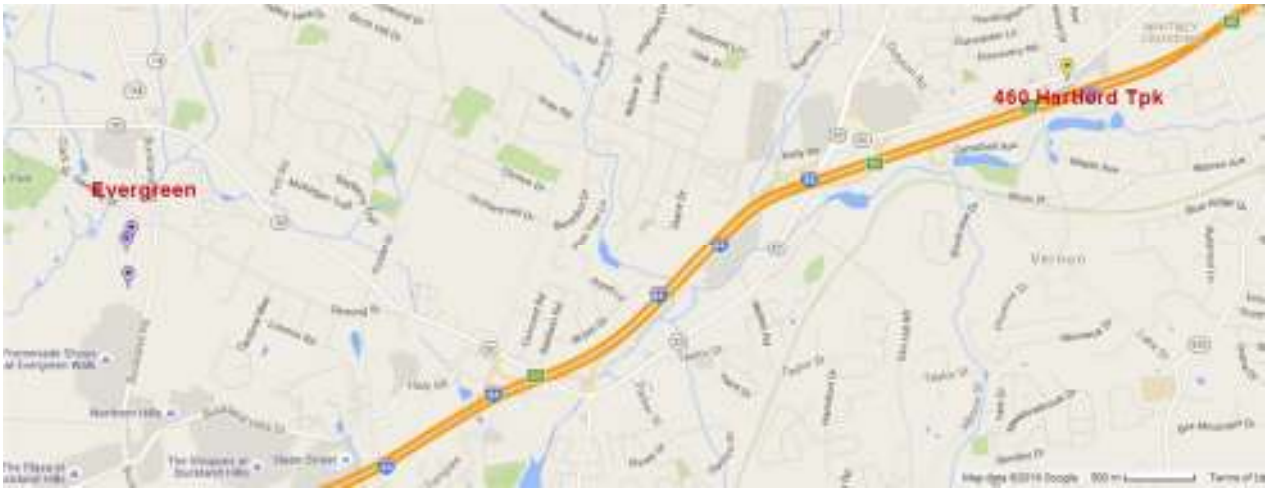
In addition, a parcel map below is used to show the owned parcels (highlighted in yellow) and the two joint venture properties (highlighted in green).



The Rockville General Hospital is in the Rockville section of Vernon, Connecticut. The map below show the Rockville General Hospital campus. The main property is highlighted in yellow and the additional small land and commercial properties are highlighted in light yellow.



This map below shows the location of the joint venture properties in South Windsor on the western side and also shows one of the main owned properties, 460 Hartford Turnpike in Vernon, near I-84.



Property Descriptions - MMH

Property Name	Manchester Memorial Hospital
Property Address	71 Haynes Street, Manchester, CT
Property Type	Acute Care Hospital
Site area	12.54 at 71 Haynes Street (hospital site) and 2.86 acres at 80 Haynes across the street (parking lot)
Years Built	1920, 1942, 1966, 1971, 1976, 1982, 1984 with renovations through the years. Most recently the ICU in 2009 and the Pharmacy in 2014.
No. of Buildings	One, made up of adjoining buildings, constructed over the years.
No. of Stories	Four plus basement level below front street grade but at ground level due to hillside elevation.
Ceiling Height	13 feet
Property Description	Manchester Memorial Hospital is licensed for 249 acute-care beds. Construction is masonry exterior walls. The roof is built-up cover on a flat deck. The hospital contains 527,224 square feet of improved space plus basement area and a four-story parking garage structure with skyway to hospital. Included in the hospital campus are other related MOBs and parking lots. These are on separate parcels and are valued separately.
Construction Class & Quality	Class B –Average
Parking	196,004 square foot parking garage
ADA Compliant:	Yes
HVAC/Utilities	Chilled water, gas-fired. Newly installed Generator outside and new boilers installed. Upgrades to the hospitals electrical distribution system will be necessary, particularly for emergency power.
Interior Finishes	The level of finish is typical for the age of the improvements. The flooring is vinyl, and tile. Walls are painted drywall and ceilings are acoustic drop ceilings.
Sprinklers/Detectors	Building is fully-sprinklered and has smoke detectors

Site improvements include paved parking, curbs, and landscaped buffers around the site perimeter.

Property Descriptions - RGH

Property Name	Rockville General Hospital
Property Address	31 Union Street, Vernon, CT
Property Type	Acute Care Hospital
Site Area	7.95 acres
Years Built	1906, 1964, 1969, 1974, 1980, with renovations through the years. Most recently the Emergency Room 2004.
No. of Buildings	Two adjoining. Original mansion fronting Union Street (now primarily office use) and main hospital building to the rear and side of the historic mansion building.
No. of Stories	Four
Ceiling Height	13 feet
Property Description	Rockville General Hospital is licensed for 102 acute-care beds. Construction is painted stucco over masonry exterior walls. The roof is built-up cover on a flat deck. The hospital contains 149,419 square feet of improved space in the main hospital and 27,929 square feet of improved space in the original mansion building.
Construction Class & Quality	Class B –Average (hospital) and Class D – Fair (mansion). Due to the age and condition of the original mansion, costs to maintain and repair a depreciated structure can outweigh the usefulness.
Parking	Open paved parking lots
ADA Compliant:	Yes
HVAC	Chilled water, gas-fired
Interior Finishes	The level of finish is typical for the age of the improvements; however some of the interior finishes are showing their age and have reached the end of their useful lives. The flooring is vinyl, and tile. Walls are painted drywall and ceilings are acoustic ceilings.
Sprinklers/Detectors	Building is fully-sprinklered and has smoke detectors

Site improvements include paved parking, curbs, and landscaped buffers around the site perimeter.

Property Descriptions – WAT

Property Name	Woodlake at Tolland – Skilled Nursing Facility
Property Address	26 Shenipsit Lake Road, Tolland, CT
Property Type	Skilled Nursing Facility
Site area	6.39 acres
Years Built	1992 (100 beds) with an addition built in 2009 (30 beds).
No. of Buildings	One building
No. of Stories	Two
Ceiling Height	10 - 20 feet
Property Description	Woodlake at Tolland is a skilled nursing facility, licensed for 130 beds. It includes common areas – dining room, kitchen, library, physical therapy. Construction is steel frame with masonry and painted stucco over masonry exterior walls. The roof is pitched metal and areas of flat rolled roofing. The building contains 65,721 square feet.
Construction Class & Quality	Class C –Average
Parking	Open paved parking lots
ADA Compliant:	Yes
HVAC	Chilled water, gas-fired
Interior Finishes	The level of finish is typical for the age of the improvements; however some of the interior finishes are showing their age and have reached the end of their useful lives. The lower level addition reflects contemporary finishes. The flooring is vinyl, and tile. Walls are painted drywall and ceilings are acoustic ceilings.
Sprinklers/Detectors	Building is fully-sprinklered, smoke detectors on site

Site improvements include paved parking, curbs, and landscaped buffers around the site perimeter.

Property Descriptions – 460 Hartford Turnpike

Property Name	460 Hartford Turnpike
Property Address	460 Hartford Turnpike, Vernon, CT
Property Type	MOB with dialysis center, sterilization operation on lower basement level
Site area	3.29 acres
Years Built	1999
No. of Buildings	One building
No. of Stories	Two
Ceiling Height	10 feet
Property Description	Construction is Class C brick masonry over wood frame with basement level of concrete block exterior walls. The roof is pitched metal. The building contains 18,000 square feet on each level for a total of 36,000 square feet.
Construction Class & Quality	Class C –Average
Parking	Open paved parking lots
ADA Compliant:	Yes
HVAC	Gas-fired
Interior Finishes	The level of finish is typical for the age of the improvements. The flooring is vinyl, and tile. Walls are painted drywall and ceilings are acoustic ceilings.
Sprinklers	Building is fully-sprinklered

Site improvements include paved parking, curbs, and landscaped buffers around the site perimeter.

The other real estate owned by ECHN is summarized in the following table. Surrounding the MMH hospital, there are a mix of residential and small commercial uses. The hospital has been acquiring properties as they become available at reasonable prices. These acquisitions include 12 single-family residential properties, five vacant residential parcels, a vacant commercial site and eight general/medical office properties, one commercial condo property and a retail property housing a thrift shop.

The RGH campus has a main hospital property, but in addition there are several small residential and commercial lots, adjacent to the hospital property, previously acquired for future expansion or buffer zone.

As additional consideration of the assets owned, the valuation of the real estate assets of the joint ventures is also considered in the overall valuation. Therefore, a high level analysis of these five properties is presented to be used in the consideration of ECHN's interest in the JV investments.

The follow chart shows the non-essential real estate and the joint venture real estate. Some of these are grouped together, such as the 12 single family homes near MMH.

REAL ESTATE CONSTRUCTION SUMMARY

Address	City	Property Use	Type	Size (SF)	Land (acres)
Properties near MMH					
18 Haynes Street	Manchester	Office Building/Commercial	1-story masonry	6,061	0.4
26 Haynes Street	Manchester	Office Building/Commercial	1-story masonry	4,256	0.43
36 Haynes Street	Manchester	Office Building/Commercial	1-story masonry	7,068	0.46
44 Haynes Street	Manchester	Office Building/Commercial	1-story masonry	1,523	0.17
310-312 Main Street	Manchester	Office Building/Commercial	2-story wood frame	3,954	0.34
320 Main Street	Manchester	Office Building/Commercial	2-story wood frame	10,640	0.29
353 Main Street	Manchester	Office Building/Commercial	1-story masonry	5,348	0.47
150 North Main Street	Manchester	Medical Office Building	2-story masonry	20,656	1.28
945 Main St (2 condos)	Manchester	Office Building/Condos	2-story masonry	2,330	Condo
319 Broad Street	Manchester	Thrift/retail store	1-story masonry	6,236	0.46
W Middle Tpke; Russell; S Alton	Manchester	12 SFR residential properties		15,233	2.61
Hemlock; S Hawthorne; S Alton	Manchester	5 Vacant Residential parcels			11.57
56 Haynes Street	Manchester	Vacant commecial parcel			0.31
Properties near RGH					
Ward, Village, W Main Streets	Vernon	Vacant parcels			1.37
JV - Partially Owned					
100 Haynes Street	Manchester	Cancer Center MOB	2-story masonry	30,443	2.59
29 Haynes Street	Manchester	Medical office building	1-story masonry	11,241	0.96
2800 Tamarack Avenue	South Windsor	Medical office building	2-story masonry	40,000	4.12
2400 + 2600 Tamarack Avenue	South Windsor	Medical office building	2-story masonry	52,615	Ground leased

Highest and Best Use Analysis

According to The Dictionary of Real Estate Appraisal, sixth edition, published by the Appraisal Institute, highest and best use is defined as the reasonably probable and legal use of vacant land or an improved property, which is physically possible, appropriately supported, financially feasible, and that results in the highest value. The four criteria highest and best use must meet are legal permissibility, physical possibility, financial feasibility, and maximum productivity.

The highest and best use was presumed to be as currently improved as the market did not suggest that the current use was not the highest and best use. This is supported by the initial review of generally legally permissible uses according to the zoning, consideration of surrounding uses, and general market trends. It is also supported by the third party appraisal reports that were relied upon in this analysis. No additional detailed highest and best use study was conducted. We conclude that highest and best use of MMH and RGH, as improved, is for continued hospital use. The highest and best use of WAT is continued skilled nursing facility. The highest and best use for the midsize medical office and smaller medical office properties surrounding the hospitals, as improved, is for continued healthcare use.

Approaches to Value

Sales Comparison (Market) Approach

The sales comparison approach estimates the value of a property by comparing it to similar properties sold on the open market. To obtain a supportable estimate of value, the sales price of a comparable property must be adjusted to reflect any dissimilarities between it and the property being appraised.

Income Approach

The income approach analyzes a property's ability to generate financial returns as an investment. The appraisal estimates a property's operating cash flow, projecting revenue and expenses. Inherent to the income approach is the capitalization of the resulting net operating income. Through an income capitalization procedure, the value of the subject property is calculated. The income approach is often selected as the preferred valuation method for operating properties because it most closely reflects the investment rationale of knowledgeable buyers. This approach, however, is utilized for income producing properties, such as lease office buildings and shopping centers, and is not typically relied upon for special use facilities, that are not under lease contract and that are not currently or expected to generate income in the near future.

Cost Approach

The cost approach estimates market value by computing the current cost of replacing the property and subtracting any depreciation resulting from physical deterioration, functional obsolescence, and external (or economic) obsolescence. The value of the land, as if vacant and available, is then added to the depreciated value of the improvements to produce a total value estimate. The cost approach is most reliable for estimating the value of new and/or special-purpose properties; however, as the

improvements deteriorate and market conditions change, the resultant loss in value becomes increasingly difficult to quantify accurately.

The most relevant approaches to value are selected and their concluded values are reconciled in to a final value or value range.

Valuation Approaches Selected

Major Properties –

For MMH and RGH, due to the special purpose nature of the hospital improvements, we have developed the cost approach including a depreciated replacement cost analysis for the buildings and site improvements. We have relied on the sales comparison approach to value the land as though vacant to be used in the cost approach. The analysis of hospital sales, in particular established facilities excluding recently constructed facilities, are used as a check of reasonableness to the cost approach.

Minor Properties –

There are 37 properties considered nonessential and placed in the minor properties category, each by itself considered immaterial. Due to the number of small properties, the timing and resources, these smaller properties were concluded to have fair market values approximate to the Assessors' reported market values, the recent purchase price or the recent third party appraised value. In some cases, properties were recently purchase, as in the case with 353 Main Street, Manchester. In other cases, there were recent third party appraisals, as in the case of 945 Main Street, Manchester. In addition to the Assessor's opinion of market value, recent purchase prices and recent third party appraisals were utilized to opine on fair market value of the minor properties.

Joint Venture Properties –

All four of the joint venture properties have been recently constructed. It is reasonable to consider the actual construction costs as an indicator of the fair market value. In this case, Management has provided cost information of each of the properties at 100 Haynes Street, Manchester; 29 Haynes Street, Manchester; 2800 Tamarack and 2400-2600 Tamarack, South Windsor. In addition, sales of recently constructed MOB buildings of comparable size were considered and presented to provide market support for the recent construction costs as an indicator of fair market value. Furthermore, sales of good quality, recently constructed cancer centers and imaging centers were considered and presented to support the valuation of 100 Haynes Street, Manchester.

Presentation of Analysis

The analysis of the major properties are presented first in exhibits at the end of this Appendix with reference to each exhibit in the following description of analysis.

All of the conclusions included in our summary table presented in Exhibit F-3

Cost Approach

The cost approach is being applied to the major properties, MMH, RGH, WAT and 460 Hartford Turnpike. We have used the market approach to value the land as though vacant, used within the cost approach along with the depreciated replacement costs or the structure, and the site improvements. The Fair Market Value conclusions via the cost approach, summarized in Exhibit G-5, were reconciled with our review and analysis of improved sales of comparable hospitals, skilled nursing facilities and mid-size MOB space presented in Exhibits G-6, G-7, and G-8.

Land Valuation

Land is valued as if vacant and available for development to its highest and best use. Similar land that has recently sold or is offered for sale is investigated, and a comparative analysis is made of factors influencing value. Factors considered included, but were not limited to, interest conveyed; cash equivalency; conditions of sale; date of sale; location and surrounding improvements; and physical characteristics including size, zoning, and density. Notes about the adjustments for comparison with the subjects are found on the exhibits referenced below.

The land value of the sites has been estimated, relying on the market approach, which has been supported with comparable sales data and current listings researched via CoStar, LoopNet, real estate brokerage firms, and other sources. The most appropriate unit of comparison is price per acre. The data selected for direct comparison is summarized in the Exhibit G-1 and G-2

Building Improvements

Building improvements analyzed in the major properties are hospital facilities, a skilled nursing facility and a medical office building. Based on information provided by Management and the County Assessors offices, the buildings were categorized by construction type as either Average Class B general hospitals; Average Class C Nursing Homes/Convalescent hospital or Class C MOB.

The cost new of the building improvements was estimated based on *Marshall and Swift Valuation Service* ("*MVS*"), specifically Section 15, of the February 2016 edition. The hard costs per square foot were estimated based on the construction type and quality as detailed in the exhibit footnotes. Soft costs of 12%, and local multipliers were applied, to arrive at an adjusted cost new. No entrepreneurial profit is considered implied in this market since, these hospitals are typically owner/builders for the purpose of housing their operation, not as a means for generating a profit incentive.

Economic life was estimated based on *MVS* and the estimated effective age reflects the chronological age as well as condition and any recent capital improvements. In addition to this, the recent Facility

Assessment Report by CharterCare Health Partners dated September 23, 2015 was helpful in providing information on capital improvement needs, which are considered against the replacement cost new.

In addition, due to the changing regulations and requirements of the healthcare marketplace, facilities built many years ago do not best meet the needs of the hospital operations. This reduction is usefulness is from a combination of functional and external obsolescence for a hospital facility. For example, dual room occupancy is becoming less desirable as the trend is toward single bed occupancy. This in part is to help control the spread of infectious diseases. A recent study by MMH as to the potential cost of changing to single bed occupancy indicated a cost of $51 million. By applying all $51 million as a curable functional obsolescence, if cured, it would have an offsetting impact on the amount of physical depreciation and may also offset the current external obsolescence discussed below. Therefore, there offsetting consequences of an improved physical plant is recognized, reducing the functional obsolescence to half the cost to cure or 30% of physically depreciated cost.

External obsolescence is applied in the cost approach to recognize the deficient in the utilization of the assets based upon outside external and economic forces that are impacting the value of these real estate assets. This can be measured by considering the use of the real estate at it optimal designed capacity and comparing that with the current demand for the property. In typical commercial properties this can be viewed by comparing the market rent required to support a reasonable return on the cost new versus the current market rent. In the case of hospitals they are not typically leased. An indication of the existence of this negative external force is a look at the licensed bed capacity used to justify the creation of the buildings and then comparing this with the staffed beds in actual use. We can quantify this diminution by comparing the anticipated occupancy levels of the licensed beds with the recent actual occupancy levels of the licensed beds. Typically in a health market, the occupancy level of licensed beds would be 60% on average. As shown in the Historic Operational Analysis –ECHN, Exhibit C-3, the occupancy of licensed beds has continued to decline over the past several years to its 2015 level of 34.5%. The difference in actual occupancy versus standard occupancy indicates an external obsolescence of 43%. There is an oversupply of licensed hospital beds resulting in much fewer staffed beds to meet the demand of the marketplace.

This external obsolescence of 43% is applied to both MMH and RGH since the 43% diminution comes from aggregate ECHN numbers.

RGH is treated similarly with regard to age/life, capital needs and functional and external obsolescence. WAT also has some capital improvement needs used in the cost approach analysis.

Details of the building improvements analysis are presented in Exhibit G-3.

Site Improvements

Site improvements include parking areas and drive/loading areas, landscaping, and miscellaneous items listed in the exhibit footnotes.
The cost new of the site improvements was estimated based on Section 66 of *MVS*. Areas and measurements were scaled from the ALTA survey or aerial photographs as well as from information provided by Management. Soft costs of 12%, and the *MVS* current and local multipliers were applied to arrive at an adjusted cost new. No entrepreneurial profit is considered implied in this market since,

these hospitals are typically owner/builders for the purpose of housing their operation, not as a means for generating a profit incentive.

Depreciation was based on the age/life method; both economic life and effective age were estimated based on discussions with Management, observations during the site inspection, information on the ages of various segments of the facilities and other data provided or researched by Navigant.

Details of the site improvements analysis are presented in Exhibit G-4

Cost Approach Conclusion

The conclusion of the Cost Approach for the four major properties is concluded in Exhibit G-5

MAJOR PROPERTIES - SUMMARY OF COST VALUATION CONCLUSIONS

Address	City	Size	Land Value (1)	Site Imps (2)	Bldg Imps (3)	Fair Market Value
71-80 Haynes Street (MMH)	Manchester	527,224	$ 1,800,000	$ 740,000	$ 18,023,900	$ 20,563,900
					Rounded	$ 20,600,000
31 Union St (RGH)	Vernon	177,348	$ 1,200,000	$ 320,000	$ 2,275,800	$ 3,795,800
					Rounded	$ 3,800,000
460 Hartford Turnpike	Vernon	36,000	$ 500,000	$ 180,000	$ 3,060,000	$ 3,740,000
					Rounded	$ 3,700,000
26 Shenipsit Lake Road (WAT)	Tolland	65,721	$ 800,000	$ 270,000	$ 7,029,000	$ 8,099,000
					Rounded	$ 8,100,000

Improved Sales

Navigant analyzed improved property sales to test the reasonableness of the conclusion via the cost approach. We identified multiple comparable transactions that closed in 2014 to 2016 supplemented with earlier sales, listings and pending. Comparative factors included location, age and condition of the property, land-to-building ratios, and type of construction. The data set represents properties that are considered generally similar to the subjects. The Navigant analysis also included review of the current book values. Assessor's opinions of market value, when available, were also taken into consideration.

Details of the Sales bracketing the concluded Fair Value are presented in Exhibits G-6, G-7 and G-8.

Overall Fair Value – Major Properties

Based on our analysis as summarized in the Exhibit G-5, we conclude that the overall fair value conclusions for the major real properties are reasonable and supported by the comparable data.

Valuation of minor properties

There are 37 nonessential real properties surrounding the campuses of MMH and RGH. Due to the timing and resources, Assessor's opinion of market value, recent purchase prices and recent third party appraisals were utilized to opine on initial value of the minor properties. In some cases, properties were recently purchase, as in the case with 353 Main Street, Manchester. In another case, there was a recent third party appraisal, as in the case of 945 Main Street, Manchester.

But given the nonessential nature of these other smaller properties and the quantity of properties, it is likely that a potential buyer focused on the real estate to house the hospital operation would divest themselves to this nonessential real estate. This is similar to personal property valuations of nonessential personal property for a business operation.

Therefore, the aggregate of initial property prices were used in a short three year cash flow model to reflect the present value of the selloff of these assets. The cash flow included a deduction for sales and marketing costs. The profit incentive was included within the discount rate, based on PwC Investor Survey.

This analysis is presented in Exhibit G-9.

Valuation of Joint Venture properties

There are four joint ventures, Evergreen Medical I and II, Haynes Street Medical I and II, which own a total of five fairly recently constructed buildings. Due to the limited information on financial statements for each property, and the recent construction, the actual construction costs provided by the ECHN management were utilized to opine on fair market value of the JV properties. The actual historic costs between 2007 and 2011 were escalated to current date by using Marshall Valuation Services (MVS) District Comparative Cost Multipliers in Section 98. After begin the actual costs to current date, the appropriate physical depreciation was applied to opine on an "as is" value by the cost approach. This approach is support by review of comparable sales of recently building medical office building of comparable size in the northeast. The sales support the concluded values from the analyzed actual costs.

This analysis is presented in Exhibit G-11 with comparable sales in Exhibits G-12 and G-13.

Valuation Conclusion

Based on the investigation and analyses contained herein, it is our opinion that as of March 31, 2016, the FMV of the fee simple interest in the wholly owned real property appraised, as if available on the open market, is $42,170,000.

The joint venture real estate, net of liabilities is $1,760,000.

This Appendix is not intended to be relied upon apart from the larger valuation report encompassing all assets of ECHN.

PROPERTY BY PROPERTY SUMMARY OF VALUE CONCLUSIONS

Wholly Owned

Address	City	Property Type	Size		Fair Market Value
71-80 Haynes Street (MMH)	Manchester	Hospital and park	527,224		$ 20,600,000
31 Union St (RGH)	Vernon	Hospital	177,348		3,800,000
460 Hartford Turnpike	Vernon	Medical/Dialysis/	36,000		3,700,000
26 Shenipsit Lake Road (WAT)	Tolland	Elder Care	65,721		8,100,000
Additional MMH properties				Base Values	
18 Haynes Street	Manchester	Office Building/C	6,061	$ 770,000	
26 Haynes Street	Manchester	Office Building/C	4,256	$ 500,000	
36 Haynes Street	Manchester	Office Building/C	7,068	$ 780,000	
44 Haynes Street	Manchester	Office Building/C	1,523	$ 160,000	
310-312 Main Street	Manchester	Office Building/C	3,954	$ 320,000	
320 Main Street	Manchester	Office Building/C	10,640	$ 770,000	
353 Main Street	Manchester	Office Building/C	5,348	$ 700,000	
150 North Main Street	Manchester	Medical Office Bu	20,656	$ 1,890,000	
945 Main St (2 condos)	Manchester	Office Building/C	2,330	$ 180,000	
319 Broad Street	Manchester	Thrift/retail store	6,236	$ 620,000	
W Middle Tpke; Russell;	Manchester	12 SFR residenti	15,233	$ 1,320,000	
Hemlock; Hawthorne; Alton	Manchester	5 Vacant Reside	11.57 acres total	$ 440,000	
56 Haynes Street	Manchester	Vacant commeci	0.31 acres	$ 40,000	
Additional RGH properties					
Ward, Village and W Main	Vernon	Vacant parcels	1.37 acres	410,000	
Aggregate of retail values of nonessential real estate				8,900,000	
Net Proceeds - nonessential real estate					$ 5,970,000
Total Fair Market Value of Wholly Owned Real Estate Assets					**$ 42,170,000**

JV - Partially Owned

Address	City	Property Type	Size	Ownership	Fair Market Value - RE	FMV Equity
100 Haynes Street	Manchester	Cancer Center M	30,443	15.0%	$ 1,321,965	$ 378,616
29 Haynes Street	Manchester	Medical office bu	11,241	22.9%	512,479	135,475
2800 Tamarack Avenue	South Winds	Medical office bu	40,000	20.0%	1,186,740	276,123
2400 + 2600 Tamarack Avenue	South Winds	Medical office bu	52,615	20.0%	2,593,280	970,849
					$ 5,614,464	$ 1,761,063
Total Fair Market Value of JV Owned Real Estate Assets					Rounded	**$ 1,760,000**

Certification: Real Property

I certify that, to the best of my knowledge and belief:

- The statements of fact contained in this report are true and correct.
- The reported real property analyses, opinions, and conclusions are limited only by the accompanying assumptions and limiting conditions and are my personal, impartial, and unbiased professional analyses, opinions, and conclusions.
- I have no present or prospective interest in the property that is the subject of this report, and I have no personal interest or bias with respect to the property or parties involved.
- My engagement in this assignment and compensation are not contingent upon developing or reporting of a predetermined value or direction in value that favors the cause of the client, the amount of the value estimate, the attainment of a stipulated result, or the occurrence of a subsequent event.
- The reported analyses, opinions, and conclusions were developed, and this report has been prepared, in conformity with the requirements of the Code of Professional Ethics and Standards of Professional Appraisal Practice of the Appraisal Institute, which include the Uniform Standards of Professional Appraisal Practice.
- The use of this report is subject to the requirements of the Appraisal Institute relating to review by its duly authorized representatives.
- I have not performed services, as an appraiser or in any other capacity, regarding the property that is the subject of this report within the three-year period immediately preceding acceptance of this assignment.
- I have made a personal inspection of selected designated owned assets.
- No one provided significant real property appraisal assistance to the person signing this certification with preparing the report.
- As of the date of this report, Kathryn Sturgis-Bright, MAI, has completed the requirements of the continuing education program for designated members of the Appraisal Institute.



Kathryn Sturgis-Bright, MAI, MBA
Associate Director
Certified General Appraiser - Connecticut Temporary License #RTG.0002824

State of Connecticut, Office of Attorney General

Fair Market Value of

Eastern Connecticut Health Network, Inc.

Valuation Analysis as of March 31, 2016

FINAL

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Valuation Summary

Value as a Going Concern (1)	Notes	Wgt %	FMV
Discounted Cash Flow Method	(2)	*100.0%*	$63,750,000
Guideline Company Method	(3)	*0.0%*	70,344,000
Guideline Transaction Method	(4)	*0.0%*	73,091,000
Unadjusted ECHN Business Enterprise Value			$63,750,000
Net Working Capital Adjustment	(5)		(2,870,000)
FMV of ECHN Business Enterprise Value, Going Concern			**$60,880,000**

Consideration Paid for ECHN Assets	Notes	As of 2/29/2016
Purchase Price for 100% of ECHN	(5)	$105,000,000
Net Working Capital Adjustment	(5)	(2,870,000)
Adjusted Purchase Price (including net working capital adjustment)		**$102,130,000**

Amount By Which Purchase Price Exceeds FMV of Business Enterprise, Going Concern	**$41,250,000**

Notes:

(1) Navigant has assumed that ECHN would continue to be operated as a going concern health system. Our going concern premise of value relied primarily upon the DCF method, with corroborating support from the market approach. Navigant also performed a supplemental asset-based approach as additional support. See Exhibit F-1, Summary of Supplemental Asset-Based Approach.

(2) See Exhibit B-1, Discounted Cash Flow Method.

(3) See Exhibit D-1, Guideline Company - Summary.

(4) See Exhibit E-1, Similar Transaction Method Summary.

(5) Purchase price is based on a review of Asset Purchase Agreement. Based on the agreement, the aggregate purchase price is to be adjusted for the amount by which the net book value of net working capital of ECHN is greater or less than $24.0M. Based on Management's projected net working capital of $21.13M, the adjustment from purchase price is ($2.87M).

State of Connecticut, Office of Attorney General | **Exhibit B-1**

Fair Market Value of

Eastern Connecticut Health Network, Inc.

Valuation Analysis as of March 31, 2016

(Actual Dollars)

NAVIGANT

FINAL

Discounted Cash Flow Method

		FYE		Projections				Terminal
		2015		2016	2017	2018	2019	Year
Net Revenues		$313,562,465	(1)	$303,632,999	$312,541,565	$319,075,166	$325,602,675	$332,114,729
Growth Rate				*(3.2%)*	*2.9%*	*2.1%*	*2.0%*	*2.0%*
EBITDA		10,845,633	(1)	11,281,034	11,971,441	12,266,755	11,905,998	12,144,118
EBITDA margin		*3.5%*		*3.7%*	*3.8%*	*3.8%*	*3.7%*	*3.7%*
Depreciation			(2)	19,427,783	15,129,963	12,031,324	9,809,442	4,981,721
Operating Income (EBIT)				(8,146,749)	(3,158,522)	235,431	2,096,556	7,162,397
Less: Income Taxes	40.9%		(3)	-	0	96,174	856,443	2,925,839
After-Tax Debt-Free Net Income				(8,146,749)	(3,158,522)	139,258	1,240,113	4,236,558
Free Cash Flow Adjustments								
Add: Depreciation			(2)	19,427,783	15,129,963	12,031,324	9,809,442	4,981,721
Less: Working Capital Investment	9.0%		(4)	(893,652)	801,771	588,024	587,476	586,085
Less: Capital Expenditures	1.5%		(2)	4,554,495	4,688,123	4,786,127	4,884,040	4,981,721
After-Tax Debt-Free Cash Flow				7,620,191	6,481,546	6,796,430	5,578,039	3,650,473
Partial Period				0.50	1.00	1.00	1.00	
Mid-Year Period				0.25	1.00	2.00	3.00	
Present Value Factor	11.0%		(5)	0.97	0.90	0.81	0.73	
Present Value of Available Cash Flows				3,711,975	5,839,231	5,516,135	4,078,614	

Sum of Present Value of Cash Flows		19,145,955
Present Value of Terminal Year		29,657,715
Unadjusted Business Enterprise Value ("BEV")		48,803,670
Plus: Joint Venture Interests	(6)	13,187,000
Plus: Real Estate Joint Venture Interests	(7)	1,760,000
Business Enterprise Value (Rounded)		**$63,750,000**

Residual Calculation	
Terminal Year Cash Flow	3,650,473
Capitalization Rate	9.0%
Cash Flow After Terminal Year	40,560,811
Present Value Factor	0.73
Present Value of Terminal Year	29,657,715

Implied Multiples:	
BEV / Base Year Revenue Multiple	0.2x
BEV / Base Year EBITDA Multiple	5.9x
BEV / Year 1 Revenue Multiple	0.2x
BEV / Year 1 EBITDA Multiple	5.7x

Sensitivity Analysis: WACC			
	10.5%	**11.0%**	**11.5%**
1.5%	65,330,000	63,160,000	61,200,000
2.0%	66,060,000	63,750,000	61,680,000
2.5%	66,880,000	64,410,000	62,210,000

Notes:

(1) See Exhibit B-2, Projected Income Statement.

(2) See Exhibit B-5, Tax Depreciation Analysis. Capital expenditures estimated to be 1.5% a year based on comparison to guideline companies and ECHN's avaliable cash flows.

(3) Income taxes are based on a blend of the corporate state income tax for Connecticut and the top federal marginal tax rate on US corporations.

(4) See Exhibit D-3, Guideline Company - Ratios. Working capital based on benchmark based on median debt-free working capital level for guideline companies.

(5) See Exhibit B-4, Weighted Average Cost of Capital. Discount factor reflects a mid period convention.

(6) See Exhibit F-4, Joint Venture Analysis.

(7) See Exhibit F-3, Real Property - Summary of Fair Market Values.

Projected Income Statement (1)

	FYE	Projections			
	2015	2016	2017	2018	2019
Net Revenues	$313,562,465	$303,632,999	$312,541,565	$319,075,166	$325,602,675
Expenses					
Salaries & wages	156,774,464	148,753,683	155,663,010	159,627,792	163,579,059
Fringe benefits	44,024,084	41,467,584	41,437,584	42,207,584	42,897,584
Physician Fees	14,605,651	14,605,651	15,043,821	15,495,135	15,959,989
Supplies & Other Expenses	85,077,223	86,077,223	87,925,709	88,977,900	90,760,045
Total Operating Expenses	300,481,422	290,904,141	300,070,124	306,308,411	313,196,677
Less Non-Operating Expense/(Income)	2,235,410	1,447,824	500,000	500,000	500,000
EBITDA	**$10,845,633**	**$11,281,034**	**$11,971,441**	**$12,266,755**	**$11,905,998**
EBITDA margin%	*3.5%*	*3.7%*	*3.8%*	*3.8%*	*3.7%*

	FYE	Projections			
	2015	2016	2017	2018	2019
Net Revenues	100.0%	100.0%	100.0%	100.0%	100.0%
Expenses					
Salaries & wages	50.0%	49.0%	49.8%	50.0%	50.2%
Fringe benefits	14.0%	13.7%	13.3%	13.2%	13.2%
Physician Fees	4.7%	4.8%	4.8%	4.9%	4.9%
Supplies & Other Expenses	27.1%	28.3%	28.1%	27.9%	27.9%
Total Operating Expenses	95.8%	95.8%	96.0%	96.0%	96.2%
Less Non-Operating Expense/(Income)	0.7%	0.5%	0.2%	0.2%	0.2%
EBITDA	**3.5%**	**3.7%**	**3.8%**	**3.8%**	**3.7%**

Notes:
(1) See Exhibit B-3, Revenue Projections and Operating Expense Projections - ECHN.

Revenue Projections and Operating Expense Projections - ECHN (1)

	FYE			Projected			
	2013	2014	2015	2016	2017	2018	2019
Revenue Projections							
Total Net Patient Revenue	**$298,979,957**	**$299,755,216**	**$297,145,105**	**$290,069,367**	**$299,351,565**	**$305,885,166**	**$312,412,675**
Other Operating Revenue (2)	$25,002,846	$25,687,937	$15,584,752	$12,915,000	$12,915,000	$12,915,000	$12,915,000
Growth		*2.7%*	*-39.3%*	*-17.1%*	*0.0%*	*0.0%*	*0.0%*
Net Assets Released From Restrictions	$1,871,227	$833,650	$832,608	$648,632	$275,000	$275,000	$275,000
		-55.4%	*-0.1%*	*-22.1%*	*-57.6%*	*0.0%*	*0.0%*
Total Net Revenue	**$325,854,030**	**$326,276,803**	**$313,562,465**	**$303,632,999**	**$312,541,565**	**$319,075,166**	**$325,602,675**

	FYE			Projected			
	2013	2014	2015	2016	2017	2018	2019
Operating Expense Projections							
Total Salaries & Wages	$163,729,402	$162,727,445	$156,774,464	$148,753,683	$155,663,010	$159,627,792	$163,579,059
Fringe Benefits	$47,592,094	$43,859,398	$44,024,084	$41,467,584	$41,437,584	$42,207,584	$42,897,584
As a % of Salaries & Wages	*29.1%*	*27.0%*	*28.1%*	*27.9%*	*26.6%*	*26.4%*	*26.2%*
Total Salaries, Wages & Benefits	$211,321,496	$206,586,843	$200,798,548	$190,221,267	$197,100,594	$201,835,376	$206,476,643
Total Supplies & Other Expenses	$100,342,397	$104,034,396	$99,682,874	$100,682,874	$102,969,530	$104,473,035	$106,720,035
Physician Fees	$ -	$14,478,331	$14,605,651	$14,605,651	$15,043,821	$15,495,135	$15,959,989
Growth	*n.a*	*n.a*	*0.9%*	*0.0%*	*3.0%*	*3.0%*	*3.0%*
Supplies & Other Expenses	$100,342,397	$89,556,065	$85,077,223	$86,077,223	$87,925,709	$88,977,900	$90,760,045
Growth	*n.a*	*-10.7%*	*-5.0%*	*1.2%*	*2.1%*	*1.2%*	*2.0%*
Non-Operating (Income)/Expense	$2,138,589	$2,125,751	$2,235,410	$1,447,824	$500,000	$500,000	$500,000
Growth	*n.a*	*-0.6%*	*5.2%*	*-35.2%*	*-65.5%*	*0.0%*	*0.0%*
Total Operating Expenses	**$313,802,482**	**$312,746,990**	**$302,716,832**	**$292,351,965**	**$300,570,124**	**$306,808,411**	**$313,696,677**

Notes:

(1) Revenue and operating expense projections were provided by management.

(2) Other operating revenue excludes joint venture income. We have valued the joint ventures in Exhibit F-4, Joint Venture Analysis.

Weighted Average Cost of Capital

Ticker	Company Name	Stock Price	Shares Outstanding	Market Value of Equity	Interest Bearing Debt	Preferred Stock	Minority Interest	Market Value of Capital	Debt to Capital	Equity to Capital	Effective Tax Rate	Levered Beta (1)	Unlevered Beta
CYH	Community Health Systems, Inc.	$18.51	112.76	$2,087	$17,019	$ -	$680	$19,786	86.0%	14.0%	28.1%	1.30	0.24
UHS	Universal Health Services Inc.	124.72	97.66	12,180	3,289	-	324	15,793	20.8%	79.2%	34.3%	1.48	1.26
LPNT	LifePoint Health, Inc.	69.25	43.13	2,987	2,741	-	155	5,883	46.6%	53.4%	36.0%	0.86	0.55
HCA	HCA Holdings, Inc.	78.05	395.77	30,890	30,674	-	1,557	63,121	48.6%	51.4%	29.9%	1.10	0.66
THC	Tenet Healthcare Corp.	28.93	98.53	2,850	14,522	-	2,682	20,054	72.4%	27.6%	75.3%	1.44	0.87
								Average	54.9%	45.1%	40.8%	1.23	0.72
								Median	48.6%	51.4%	40.9%	1.30	0.66
								Selected	**50.0%**	**50.0%**			**0.66**

Relevered Beta	
Unlevered Beta	0.66
Target Equity to Capital Weight	50.0%
Target Debt to Capital Weight	50.0%
Target Preferred Stock to Capital Weight	0.0%
Target Minority Interest to Capital Weight	0.0%
Subject Tax Rate	40.9%
Calculated Beta	**1.05**

Cost of Equity	ECHN
Risk-free Rate (Rf) (2)	2.20%
Equity Risk Premium (Rm - Rf) (3)	6.2%
Levered Beta	1.05
Small Stock Premium (SSP) (4)	5.8%
Specific Risk Premium (SRP) (5)	5.0%
Calculated Cost of Equity (6)	**19.5%**

Cost of Debt	
Pretax Cost of Debt (7)	4.9%
Combined Effective Tax Rate (8)	40.9%
Calculated Cost of Debt	**2.9%**

Capital Structure and WACC		
Equity to Capital Weight	50.00% x 19.48% =	9.7%
Debt to Capital Weight	50.00% x 2.90% =	1.4%
Calculated WACC (9)		**11.0%**

Notes:

(1) Represents a five-year monthly historical beta, utilizing the S&P 500 as a proxy for the market.

(2) Federal Reserve Statistical Release, H.15 as of March 31, 2016 (20-year treasury bond constant maturity).

(3) SBBI Yearbook 2015, Ibbotson Associates, long-horizon expected equity risk premium (supply side).

(4) SBBI Yearbook 2015, Ibotson Associates, small stock risk premium based on the 10th decile portfolio.

(5) Based on company specific risk factors including relatively low margins, ability to meet capital expenditure needs, state government payment uncertainty, and concentration of services in two geographic markets.

(6) Cost of Equity using the Capital Asset Pricing Model = $R_f + B \times (R_m - R_f) + SSP + SRP$

(7) Federal Reserve Statistical Release, H.15 as of March 31, 2016 (Moody's Seasoned Baa Corporate Bonds).

(8) Estimated tax rate based on top federal marginal tax rate for US corporations and state corporate income tax for the state of Connecticut.

(9) Weighted Average Cost of Capital = Equity Weight x Cost of Equity + Debt Weight x Cost of Debt

Tax Depreciation Analysis

Depreciation of Existing Assets

		Projections			
		2016	2017	2018	2019
Existing Fixed Asset Balance at Beginning of Year	(1)	$65,770,000	$46,978,571	$33,556,122	$23,968,659
Estimated Remaining Tax Life		7.0	6.0	5.0	4.0
Declining Balance Method Depreciation		18,791,429	13,422,449	9,587,464	6,848,188
Straight Line Method Depreciation		9,395,714	7,829,762	6,711,224	5,992,165
Total Existing Fixed Assets Depreciation		18,791,429	13,422,449	9,587,464	6,848,188
Fixed Asset Balance at End of the Year		$46,978,571	$33,556,122	$23,968,659	$17,120,471
Average Tax Life of Existing Fixed Assets		7.0			
Declining Balance		200%			

			Projections			
			2016	2017	2018	2019
Total Projected Capital Expenditures			$4,554,495	$4,688,123	$4,786,127	$4,884,040
Capital Expenditure %						
5 Year Property		40%				
7 Year Property		40%				
39 Year Property		20%				
Five Year Property						
Depreciation Percentages			20.0%	32.0%	19.2%	11.5%
		Additions				
Acquisition Year	2016	$1,821,798	$364,360	$582,975	$349,785	$209,871
	2017	1,875,249		375,050	600,080	360,048
	2018	1,914,451			382,890	612,624
	2019	1,953,616				390,723
Total Five Year Property Depreciation			$364,360	$958,025	$1,332,755	$1,573,267

Notes:
(1) Based on information provided by and discussions with Management.

Tax Depreciation Analysis

			Projections			
			2016	2017	2018	2019
Seven Year Property						
Depreciation Percentages			14.29%	24.49%	17.49%	12.49%
		Additions				
Acquisition Year	2016	$1,821,798	$260,335	$446,158	$318,632	$227,543
	2017	1,875,249		267,973	459,249	327,981
	2018	1,914,451			273,575	468,849
	2019	1,953,616				279,172
Total Seven Year Property Depreciation			$260,335	$714,131	$1,051,456	$1,303,544

			Projections			
			2016	2017	2018	2019
Thirty-Nine Year Property						
Depreciation Percentages			1.28%	2.56%	2.56%	2.56%
		Additions				
Acquisition Year	2016	$910,899	$11,660	$23,355	$23,355	$23,355
	2017	937,625		12,002	24,041	24,041
	2018	957,225			12,252	24,543
	2019	976,808				12,503
Total Thirty-Nine Year Property Depreciation			$11,660	$35,357	$59,649	$84,443
Total Projected Capital Expenditures Depreciation			$636,354	$1,707,514	$2,443,860	$2,961,254
Total Exisiting Depreciation			$18,791,429	$13,422,449	$9,587,464	$6,848,188
Total Projected Capital Expenditures Depreciation			636,354	1,707,514	2,443,860	2,961,254
Total Depreciation			**$19,427,783**	**$15,129,963**	**$12,031,324**	**$9,809,442**

State of Connecticut, Office of Attorney General
Fair Market Value of
Eastern Connecticut Health Network, Inc.
Valuation Analysis as of March 31, 2016
(Actual Dollars)

Exhibit C-1

NAVIGANT

FINAL

Historical Balance Sheet - ECHN

	FYE September 30,					Common-Size				
	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015
ASSETS										
Current Assets										
Cash and cash equivalents	$20,991,180	$20,052,067	$22,439,356	$20,733,601	$16,286,829	8.0%	7.1%	7.9%	7.5%	6.2%
Current portion of investments held under bond indentures	1,504,988	5,435,445	1,850,531	1,163,916	1,097,599	0.6%	1.9%	0.7%	0.4%	0.4%
Accounts receivable, net	39,643,428	46,711,255	46,524,143	44,610,272	41,607,499	15.1%	16.5%	16.5%	16.2%	16.0%
Inventory	4,228,568	4,253,600	5,065,716	5,437,285	5,553,809	1.6%	1.5%	1.8%	2.0%	2.1%
Current portion of estimated settlements due from third-party payers	432,832	4,402,920	3,463,096	3,602,585	3,573,134	0.2%	1.6%	1.2%	1.3%	1.4%
Prepaid expenses and other current assets	5,471,488	5,020,607	5,046,865	5,686,236	6,653,091	2.1%	1.8%	1.8%	2.1%	2.6%
Total Current Assets	72,272,484	85,875,894	84,389,707	81,233,895	74,771,961	27.6%	30.3%	29.9%	29.4%	28.7%
Assets whose use is limited, net of current portion	47,123,518	54,429,142	54,963,606	66,064,543	63,675,098	18.0%	19.2%	19.5%	23.9%	24.4%
Investments	16,944,697	21,510,816	13,009,540	7,138,341	7,118,433	6.5%	7.6%	4.6%	2.6%	2.7%
Investments in joint ventures	16,969,568	13,500,324	13,731,843	14,562,738	18,190,809	6.5%	4.8%	4.9%	5.3%	7.0%
Property, Plant & Equipment - net	96,189,597	96,295,455	96,188,497	94,065,559	88,275,419	36.7%	34.0%	34.1%	34.1%	33.9%
Other Assets	12,789,825	11,678,494	20,183,543	13,022,113	8,567,926	4.9%	4.1%	7.1%	4.7%	3.3%
TOTAL ASSETS	**$262,289,689**	**$283,290,125**	**$282,466,736**	**$276,087,189**	**$260,599,646**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
LIABILITIES AND NET ASSETS										
Current Liabilities										
Accounts payable and accrued expenses	$23,210,287	$30,730,676	$34,874,835	$35,964,615	$33,429,551	8.8%	10.8%	12.3%	13.0%	12.8%
Line of credit	8,272,642	6,500,000	6,500,000	5,600,000	3,800,000	3.2%	2.3%	2.3%	2.0%	1.5%
Current portion of long-term debt	5,652,447	6,904,354	6,832,322	6,660,757	7,018,708	2.2%	2.4%	2.4%	2.4%	2.7%
Current portion of estimated settlements due to third-party payers	2,104,534	2,793,775	4,512,361	5,743,160	3,124,803	0.8%	1.0%	1.6%	2.1%	1.2%
Current portion of accrued pension and other postretirement benefits	11,329,346	3,897,164	6,085,518	193,769	190,189	4.3%	1.4%	2.2%	0.1%	0.1%
Other current Liabilities	5,700,671	8,153,373	5,321,044	5,841,792	4,134,712	2.2%	2.9%	1.9%	2.1%	1.6%
Total Current Liabilities	56,269,927	58,979,342	64,126,080	60,004,093	51,697,963	21.5%	20.8%	22.7%	21.7%	19.8%
Long-Term Liabilities										
Long-term debt and capital lease obligations, net of current	86,635,165	87,541,749	84,416,006	82,424,313	80,122,247	33.0%	30.9%	29.9%	29.9%	30.7%
Estimated self-insurance liabilities	6,311,338	9,521,697	9,243,930	9,683,668	7,196,797	2.4%	3.4%	3.3%	3.5%	2.8%
Accrued pension and postretirement benefits	56,772,305	74,618,608	38,111,463	45,796,486	62,407,379	21.6%	26.3%	13.5%	16.6%	23.9%
Estimated settlements due to third-party payers, net of current	335,416	82,500	122,921	65,838	-	0.1%	0.0%	0.0%	0.0%	0.0%
Other liabilities	803,881	944,968	597,187	419,002	467,711	0.3%	0.3%	0.2%	0.2%	0.2%
Total Long-Term Liabilities	150,858,105	172,709,522	132,491,507	138,389,307	150,194,134	57.5%	61.0%	46.9%	50.1%	57.6%
Net Assets										
Unrestricted	41,815,956	36,549,384	70,965,928	59,544,873	42,167,565	15.9%	12.9%	25.1%	21.6%	16.2%
Temporarily restricted	2,249,963	3,243,522	2,587,301	2,096,313	1,486,536	0.9%	1.1%	0.9%	0.8%	0.6%
Permanently restricted	11,095,738	11,808,355	12,295,920	16,052,603	15,053,448	4.2%	4.2%	4.4%	5.8%	5.8%
Total Net Assets	55,161,657	51,601,261	85,849,149	77,693,789	58,707,549	21.0%	18.2%	30.4%	28.1%	22.5%
TOTAL LIABILITIES AND NET ASSETS	**$262,289,689**	**$283,290,125**	**$282,466,736**	**$276,087,189**	**$260,599,646**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Cash-Free, Debt-free Net Working Capital (1)	*$18,760,824*	*$18,710,558*	*$15,391,580*	*$11,786,811*	*$16,698,467*					
As a % of net revenue	*7.0%*	*6.4%*	*4.7%*	*3.6%*	*5.3%*					

Source: Based on information provided by Management.

Notes:

(1) Net working capital is defined per Asset Purchase Agreement. Excludes cash and equivalents, investments (except joint ventures), debt, including accrued pension and post retirement liabilities.

Historical Income Statement - ECHN

	FYE September 30,					Common-Size				
	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015
Revenues:										
Net Patient Service Revenue	$261,348,876	$277,042,997	$310,122,159	$309,971,310	$308,044,394	96.8%	94.0%	94.6%	94.3%	97.6%
Less Bad Debts	(11,106,480)	(11,285,210)	(11,142,202)	(10,216,094)	(10,899,289)	-4.1%	-3.8%	-3.4%	-3.1%	-3.5%
Net Patient Revenue less Bad Debts	**250,242,396**	**265,757,787**	**298,979,957**	**299,755,216**	**297,145,105**	**92.7%**	**90.2%**	**91.2%**	**91.2%**	**94.2%**
Contributions	732,256	2,243,112	1,614,319	1,163,883	2,194,034	0.3%	0.8%	0.5%	0.4%	0.7%
Other revenues	17,132,518	17,532,328	22,871,370	25,216,442	14,565,493	6.3%	6.0%	7.0%	7.7%	4.6%
Electronic Health Records	975,412	3,833,172	2,630,820	1,786,134	830,386	0.4%	1.3%	0.8%	0.5%	0.3%
Contribution from VNHSC	-	4,592,459	-	-	-	0.0%	1.6%	0.0%	0.0%	0.0%
Net assets released from restrictions	801,123	638,113	1,871,227	833,650	832,608	0.3%	0.2%	0.6%	0.3%	0.3%
Total Net Revenue	**269,883,705**	**294,596,971**	**327,967,693**	**328,755,325**	**315,567,626**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Expenses:										
Salaries & wages	134,218,139	139,915,729	163,729,402	162,727,445	156,774,464	49.7%	47.5%	49.9%	49.5%	49.7%
Fringe benefits	35,696,855	40,155,469	47,592,094	43,859,398	44,024,084	13.2%	13.6%	14.5%	13.3%	14.0%
Total Salaries, Wages, & Benefits	169,914,994	180,071,198	211,321,496	206,586,843	200,798,548	63.0%	61.1%	64.4%	62.8%	63.6%
Supplies and other expenses	83,802,696	93,804,618	100,342,397	104,034,396	99,682,874	31.1%	31.8%	30.6%	31.6%	31.6%
Depreciation and amortization	11,898,918	11,811,633	12,290,822	12,196,877	11,920,720	4.4%	4.0%	3.7%	3.7%	3.8%
Interest and financing costs	4,224,420	3,981,831	3,900,483	3,764,488	3,445,934	1.6%	1.4%	1.2%	1.1%	1.1%
Total Interest, Depreciation & Amortizatio	16,123,338	15,793,464	16,191,305	15,961,365	15,366,654	6.0%	5.4%	4.9%	4.9%	4.9%
Total Operating Expenses	**269,841,028**	**289,669,280**	**327,855,198**	**326,582,604**	**315,848,076**	**100.0%**	**98.3%**	**100.0%**	**99.3%**	**100.1%**
Operating Income	42,677	4,927,691	112,495	2,172,721	(280,450)	0.0%	1.7%	0.0%	0.7%	-0.1%
Non-Operating Income/(Expense)	(1,341,596)	(1,200,536)	(2,138,589)	(2,125,751)	(2,235,410)	-0.5%	-0.4%	-0.7%	-0.6%	-0.7%
Net Income	**(1,298,919)**	**3,727,155**	**(2,026,094)**	**46,970**	**(2,515,860)**	**-0.5%**	**1.3%**	**-0.6%**	**0.0%**	**-0.8%**
EBITDA	**$14,824,419**	**$19,520,619**	**$14,165,211**	**$16,008,335**	**$12,850,794**	**5.5%**	**6.6%**	**4.3%**	**4.9%**	**4.1%**
Capital Expenditures	*$10,620,037*	*$7,498,197*	*$12,104,527*	*$10,073,939*	*$6,130,580*					
As a % of Total Net Revenue	*3.9%*	*2.5%*	*3.7%*	*3.1%*	*1.9%*					

Source: Based on information provided by management

Historical Operational Analysis - ECHN **(1)**

	FYE September 30,					
	2011	2012	2013	2014	2015	
Gross Outpatient Charges	409,922,763	476,021,456	572,644,188	592,717,508	600,758,074	**A**
Gross Inpatient Charges	228,912,612	278,843,185	328,063,718	333,197,293	318,875,465	**B**
Outpatient Adjustment Factor	2.79	2.71	2.75	2.78	2.88	**C = (A + B)/B**
Discharges	11,796	11,350	11,909	11,451	10,918	**D**
Adjusted Discharges	32,920	30,726	32,696	31,821	31,487	**E = C*D**
ER Visits	74,297	72,925	72,201	62,392	60,668	
Patient Days	55,845	58,601	58,987	55,261	50,565	**F**
Adjusted Patient Days	155,849	158,641	161,950	153,564	145,829	**G = C*F**
Beds In Service	237	218	218	218	218	**H**
Licensed Beds	401	401	401	401	401	
Available Patient Days	86,505	79,570	79,570	79,570	79,570	**I = H*365*Months In Period/12**
Occupancy Rate - Beds in Service	64.6%	73.6%	74.1%	69.4%	63.5%	**J = F/I**
Occupancy Rate - Licenced Beds	38.2%	40.0%	40.3%	37.8%	34.5%	
Average Length of Stay	4.7	5.2	5.0	4.8	4.6	**K = F/D**
Average Daily Census	153	161	162	151	139	**L = G/365*Months In Period/12**
Full Time Employees	N/A	N/A	N/A	2,298	2,256	

Notes:
(1) Based on hospital operating data provided by management.

State of Connecticut, Office of Attorney General
Fair Market Value of
Eastern Connecticut Health Network, Inc.
Valuation Analysis as of March 31, 2016
(Actual Dollars)

Exhibit C-4

NAVIGANT
FINAL

Historical Balance Sheet - RGH

	FYE September 30,				Common-Size			
	2011	2012	2013	2014	2011	2012	2013	2014
ASSETS								
Current Assets								
Cash and cash equivalents	$4,739,454	$1,463,823	$1,059,290	$1,772,696	5.7%	1.8%	1.4%	2.4%
Current portion of investments held under bond indentures	501,284	467,222	364,771	323,965	0.6%	0.6%	0.5%	0.4%
Accounts receivable, net	10,246,785	10,959,585	10,269,970	10,900,702	12.2%	13.7%	13.4%	14.6%
Inventory	1,576,966	1,519,666	1,467,009	1,325,483	1.9%	1.9%	1.9%	1.8%
Due from affliliated entities	2,196,771	781,899	58,029	65,011	2.6%	1.0%	0.1%	0.1%
Current portion of estimated settlements due from third-party payers	-	853,555	384,274	148,435	0.0%	1.1%	0.5%	0.2%
Prepaid expenses and other current assets	270,651	218,802	276,211	201,349	0.3%	0.3%	0.4%	0.3%
Total Current Assets	19,531,911	16,264,552	13,879,554	14,737,641	23.3%	20.4%	18.1%	19.7%
Total assets whose use is limited, net of current portion	12,891,345	13,743,382	14,593,721	15,607,066	15.4%	17.2%	19.1%	20.9%
Interest in net assets of ECHN CHF, Inc.	2,629,614	3,254,582	3,616,191	3,599,134	3.1%	4.1%	4.7%	4.8%
Investments	7,740,794	9,554,311	3,088,116	2,068,819	9.3%	12.0%	4.0%	2.8%
Investments in joint ventures	2,858,713	3,127,553	3,208,828	3,489,604	3.4%	3.9%	4.2%	4.7%
Property, Plant & Equipment - net	31,151,854	30,472,774	27,654,664	25,700,876	37.2%	38.2%	36.1%	34.4%
Other Assets	6,854,302	3,451,619	10,502,780	9,583,805	8.2%	4.3%	13.7%	12.8%
TOTAL ASSETS	**$83,658,533**	**$79,868,773**	**$76,543,854**	**$74,786,945**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
LIABILITIES AND NET ASSETS								
Current Liabilities								
Accounts payable and accrued expenses	$4,898,568	$5,969,615	$6,096,840	$6,181,391	5.9%	7.5%	8.0%	8.3%
Current portion of long-term debt	1,247,313	1,271,671	870,081	945,159	1.5%	1.6%	1.1%	1.3%
Current portion of due to affiliates	2,717,350	3,297,172	398,089	-	3.2%	4.1%	0.5%	0.0%
Current portion of estimated settlements due to third-party payers	684,512	1,157,913	1,040,198	1,132,410	0.8%	1.4%	1.4%	1.5%
Current portion of accrued pension and other postretirement benefits	2,650,753	1,164,039	1,401,749	288,603	3.2%	1.5%	1.8%	0.4%
Other current Liabilities	1,240,661	715,430	754,403	732,322	1.5%	0.9%	1.0%	1.0%
Total Current Liabilities	13,439,157	13,575,840	10,561,360	9,279,885	16.1%	17.0%	13.8%	12.4%
Long-Term Liabilities								
Long-term debt and capital lease obligations, net of current	25,860,313	24,394,084	23,519,254	23,392,308	30.9%	30.5%	30.7%	31.3%
Estimated self-insurance liabilities	1,813,842	3,307,458	2,423,371	3,566,892	2.2%	4.1%	3.2%	4.8%
Accrued pension and postretirement benefits	13,402,108	17,147,802	8,855,195	10,081,347	16.0%	21.5%	11.6%	13.5%
Other liabilities	125,749	128,578	132,211	132,211	0.2%	0.2%	0.2%	0.2%
Total Long-Term Liabilities	41,202,012	44,977,922	34,930,031	37,172,758	49.3%	56.3%	45.6%	49.7%
Net Assets								
Unrestricted	24,688,727	17,066,097	26,773,989	24,211,838	29.5%	21.4%	35.0%	32.4%
Temporarily restricted	912,532	615,748	561,463	549,043	1.1%	0.8%	0.7%	0.7%
Permanently restricted	3,416,105	3,633,166	3,717,011	3,573,421	4.1%	4.5%	4.9%	4.8%
Total Net Assets	29,017,364	21,315,011	31,052,463	28,334,302	34.7%	26.7%	40.6%	37.9%
TOTAL LIABILITIES AND NET ASSETS	**$83,658,533**	**$79,868,773**	**$76,543,854**	**$74,786,945**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Debt-free Working Capital	*7,340,067*	*3,960,383*	*4,188,275*	*6,402,915*				
As a % of net revenue	*11.2%*	*5.5%*	*5.6%*	*8.5%*				

Source: Based on information provided by Management.

Historical Income Statement - RGH

	FYE September 30,					Common-Size				
	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015
Revenues:										
Net Patient Service Revenue	$63,387,116	$67,847,638	$73,037,858	$71,329,965		97.1%	95.0%	97.4%	95.2%	0.0%
Less Bad Debts	(2,925,278)	(3,309,948)	(4,127,214)	(2,801,283)		-4.5%	-4.6%	-5.5%	-3.7%	0.0%
Net Patient Revenue less Bad Debts	**60,461,838**	**64,537,690**	**68,910,644**	**68,528,682**	**63,002,481**	**92.7%**	**90.4%**	**91.9%**	**91.5%**	**96.6%**
Change in interest in unrestricted net assets of	237,954	192,851	253,309	315,697	123,590	0.4%	0.3%	0.3%	0.4%	0.2%
Other operating revenue					1,892,379					2.9%
Joint ventures					132,721					0.2%
Investment income/realized gains					26,701					0.0%
Other revenues	3,888,629	5,020,030	4,492,026	5,227,522		6.0%	7.0%	6.0%	7.0%	
Electronic Health Records	618,428	1,626,870	1,220,153	799,300		0.9%	2.3%	1.6%	1.1%	
Net assets released from restrictions	48,044	31,857	112,828	49,147	50,382	0.1%	0.0%	0.2%	0.1%	0.1%
Total Net Revenue	**65,254,893**	**71,409,298**	**74,988,960**	**74,920,348**	**65,228,254**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Expenses:										
Salaries & wages	29,535,778	30,268,391	31,509,639	32,460,253		45.3%	42.4%	42.0%	43.3%	
Fringe benefits	8,838,640	10,223,293	10,024,601	9,360,797		13.5%	14.3%	13.4%	12.5%	
Total Salaries, Wages & Benefits	38,374,418	40,491,684	41,534,240	41,821,050	40,377,767	58.8%	56.7%	55.4%	55.8%	61.9%
Supplies and other expenses	21,930,029	25,886,843	25,888,529	26,367,709	24,653,758	33.6%	36.3%	34.5%	35.2%	37.8%
Depreciation and amortization	3,672,297	3,811,952	3,565,031	3,281,014		5.6%	5.3%	4.8%	4.4%	
Interest and financing costs	1,115,177	719,107	682,298	689,882		1.7%	1.0%	0.9%	0.9%	
Total Interest, Depreciation & Amortization	4,787,474	4,531,059	4,247,329	3,970,896	3,836,390	7.3%	6.3%	5.7%	5.3%	5.9%
Total Operating Expenses	**65,091,921**	**70,909,586**	**71,670,098**	**72,159,655**	**68,867,915**	**99.8%**	**99.3%**	**95.6%**	**96.3%**	**105.6%**
EBITDA	**4,950,446**	**5,030,771**	**7,566,191**	**6,731,589**	**196,729**	**7.6%**	**7.0%**	**10.1%**	**9.0%**	**0.3%**
Operating Income	162,972	499,712	3,318,862	2,760,693	(3,639,661)	0.2%	0.7%	4.4%	3.7%	-5.6%
Non-Operating Income/(Expense)	(855,256)	(179,961)	(660,236)	(378,564)	(546,692)	-1.3%	-0.3%	-0.9%	-0.5%	-0.8%
Net Income	**(692,284)**	**319,751**	**2,658,626**	**2,382,129**	**(4,186,353)**	**-1.1%**	**0.4%**	**3.5%**	**3.2%**	**-6.4%**
Capital Expenditures	*$2,020,432*	*$1,728,554*	*$746,921*	*$1,327,226*	*n.a*					
As a % of Total Net Revenue	*3.1%*	*2.4%*	*1.0%*	*1.8%*	*n.a*					

Source: Based on information provided by management

Historical Operational Analysis - RGH **(1)**

	FYE September 30,					
	2011	2012	2013	2014	2015	
Gross Outpatient Charges	93,948,299	118,179,406	143,414,268	150,411,287	152,882,315	**A**
Gross Inpatient Charges	54,124,324	69,889,867	79,250,361	76,888,785	74,614,647	**B**
Outpatient Adjustment Factor	2.74	2.69	2.81	2.96	3.05	**C = (A + B)/B**
Discharges	2,515	2,519	2,567	2,341	2,112	**D**
Adjusted Discharges	6,881	6,778	7,212	6,921	6,439	**E = C*D**
ER Visits	26,463	26,422	25,136	21,351	20,889	
Outpatient Visits	N/A	N/A	N/A	421,124	NA	
Patient Days	12,370	13,056	12,325	11,155	9,873	**F**
Adjusted Patient Days	33,842	35,133	34,629	32,977	30,102	**G = C*F**
Beds In Service	66	47	47	47	47	**H**
Licensed Beds	118	118	118	118	118	
Available Patient Days	24,090	17,155	17,155	17,155	17,155	**I = H*365*Months In Period/12**
Occupancy Rate - Beds in Service	51.3%	76.1%	71.8%	65.0%	57.6%	**J = F/I**
Occupancy Rate - Licensed Beds	28.7%	30.3%	28.6%	25.9%	22.9%	
Average Length of Stay	4.9	5.2	4.8	4.8	4.7	**K = F/D**
Average Daily Census	34	36	34	31	27	**L = G/365*Months In Period/12**
Full Time Employees	405	377	378	423	373	

Notes:
(1) Based on hospital operating data provided by management.

Historical Balance Sheet - MMH

	FYE September 30,				Common-Size			
	2011	2012	2013	2014	2011	2012	2013	2014
ASSETS								
Current Assets								
Cash and cash equivalents	$10,880,739	$6,414,687	$12,239,488	$9,361,439	7.2%	3.8%	7.2%	5.8%
Current portion of investments held under bond indentures	803,195	4,781,749	1,300,096	653,623	0.5%	2.8%	0.8%	0.4%
Accounts receivable, net	24,700,330	26,534,856	27,182,276	25,099,884	16.3%	15.6%	15.9%	15.5%
Inventory	2,591,838	2,660,785	3,245,125	3,876,042	1.7%	1.6%	1.9%	2.4%
Due from affiliated entities	419,887	484,258	370,120	142,498	0.3%	0.3%	0.2%	0.1%
Current portion of estimated settlements due from third-party payers	432,832	3,549,365	3,078,822	3,454,150	0.3%	2.1%	1.8%	2.1%
Prepaid expenses and other current assets	2,506,129	2,028,449	2,316,130	2,357,425	1.7%	1.2%	1.4%	1.5%
Total Current Assets	42,334,950	46,454,149	49,732,057	44,945,061	27.9%	27.3%	29.1%	27.8%
Assets whose use is limited, net of current portion	18,522,584	20,159,091	17,681,970	25,860,728	12.2%	11.9%	10.3%	16.0%
Interest in net assets of ECHN CHF, Inc.	3,872,533	6,199,192	7,278,631	7,323,190	2.6%	3.6%	4.3%	4.5%
Investments	7,217,602	8,547,933	4,366,493	1,339,234	4.8%	5.0%	2.6%	0.8%
Investments in joint ventures	3,719,835	3,565,975	3,501,635	3,849,302	2.5%	2.1%	2.0%	2.4%
Property, Plant & Equipment - net	52,084,498	51,317,622	54,574,351	55,717,642	34.3%	30.2%	31.9%	34.4%
Other Assets	24,077,486	33,827,422	34,019,637	22,722,234	15.9%	19.9%	19.9%	14.0%
TOTAL ASSETS	**$151,829,488**	**$170,071,384**	**$171,154,774**	**$161,757,391**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
LIABILITIES AND NET ASSETS								
Current Liabilities								
Accounts payable and accrued expenses	$15,290,987	$17,702,182	$21,391,578	$21,842,838	10.1%	10.4%	12.5%	13.5%
Line of credit	6,500,000	6,500,000	6,500,000	5,600,000	4.3%	3.8%	3.8%	3.5%
Current portion of long-term debt	3,467,143	3,898,759	3,909,618	4,092,102	2.3%	2.3%	2.3%	2.5%
Current portion of due to affiliates	2,283,655	818,583	-	23,158	1.5%	0.5%	0.0%	0.0%
Current portion of estimated settlements due to third-party payers	1,420,022	1,343,126	2,943,941	4,285,117	0.9%	0.8%	1.7%	2.6%
Current portion of accrued pension and other postretirement benefits	8,678,593	2,733,125	4,683,769	1,025,166	5.7%	1.6%	2.7%	0.6%
Other current Liabilities	2,557,626	2,426,820	2,482,951	2,653,756	1.7%	1.4%	1.5%	1.6%
Total Current Liabilities	40,198,026	35,422,595	41,911,857	39,522,137	26.5%	20.8%	24.5%	24.4%
Long-Term Liabilities								
Long-term debt and capital lease obligations, net of current	49,708,745	51,672,633	50,793,813	50,421,026	32.7%	30.4%	29.7%	31.2%
Estimated self-insurance liabilities	5,736,899	9,814,802	6,830,954	6,835,215	3.8%	5.8%	4.0%	4.2%
Accrued pension and postretirement benefits	43,370,197	57,470,806	29,256,268	34,595,139	28.6%	33.8%	17.1%	21.4%
Due to affiliates	-	-	7,220,571	5,298,863	0.0%	0.0%	4.2%	3.3%
Other liabilities	673,979	684,775	409,571	283,594	0.4%	0.4%	0.2%	0.2%
Total Long-Term Liabilities	99,489,820	119,643,016	94,511,177	97,433,837	65.5%	70.3%	55.2%	60.2%
Net Assets								
Unrestricted	3,473,307	4,925,515	27,759,929	11,344,473	2.3%	2.9%	16.2%	7.0%
Temporarily restricted	988,702	1,905,069	1,392,902	974,762	0.7%	1.1%	0.8%	0.6%
Permanently restricted	7,679,633	8,175,189	8,578,909	12,479,182	5.1%	4.8%	5.0%	7.7%
Total Net Assets	12,141,642	15,005,773	37,731,740	24,798,417	8.0%	8.8%	22.0%	15.3%
TOTAL LIABILITIES AND NET ASSETS	**$151,829,488**	**$170,071,384**	**$174,154,774**	**$161,754,391**	**100.0%**	**100.0%**	**101.8%**	**100.0%**
Debt-free Working Capital	*$12,535,683*	*$21,441,172*	*$17,512,302*	*$5,422,924*				
As a % of net revenue	*7.2%*	*11.4%*	*9.2%*	*2.9%*				

Source: Based on information provided by Management.

Historical Income Statement - MMH

	FYE September 30,					Common-Size				
	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015
Revenues:										
Net Patient Service Revenue	$166,602,261	$175,217,566	$175,818,082	$178,026,737		96.0%	92.9%	92.7%	93.9%	0.0%
Less Bad Debts	(6,164,670)	(6,382,307)	(5,518,461)	(5,822,470)		-3.6%	-3.4%	-2.9%	-3.1%	0.0%
Net Patient Revenue less Bad Debts	**160,437,591**	**168,835,259**	**170,299,621**	**172,204,267**	**176,292,453**	**92.4%**	**89.5%**	**89.8%**	**90.9%**	**93.4%**
Change in interest in unrestricted net assets of ECHN	455,096	2,035,698	961,465	496,356	1,889,272	0.3%	1.1%	0.5%	0.3%	1.0%
Other operating revenue					9,394,083					5.0%
Joint ventures					337,654					0.2%
Investment income/realized gains					175,415					0.1%
Other revenues	11,857,772	15,303,250	15,458,360	15,370,698		6.8%	8.1%	8.2%	8.1%	
Electronic Health Records	356,984	2,206,302	1,410,667	986,834		0.2%	1.2%	0.7%	0.5%	
Net assets released from restrictions	478,506	316,686	1,458,982	486,908	590,724	0.3%	0.2%	0.8%	0.3%	0.3%
Total Net Revenue	**173,585,949**	**188,697,195**	**189,589,095**	**189,545,063**	**188,679,601**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Expenses:										
Salaries & wages	77,581,560	81,549,825	83,909,349	83,606,297		44.7%	43.2%	44.3%	44.1%	0.0%
Fringe benefits	21,779,464	25,465,287	27,658,791	25,720,253		12.5%	13.5%	14.6%	13.6%	0.0%
Total Salaries, Wages, & Benefits	99,361,024	107,015,112	111,568,140	109,326,550	107,278,932	57.2%	56.7%	58.8%	57.7%	56.9%
Supplies and other expenses	58,149,870	62,035,761	66,966,600	66,276,903	62,970,889	33.5%	32.9%	35.3%	35.0%	33.4%
Depreciation and amortization	7,107,904	6,896,812	7,115,302	7,116,905		4.1%	3.7%	3.8%	3.8%	
Interest and financing costs	2,539,198	2,714,044	2,685,044	2,589,201		1.5%	1.4%	1.4%	1.4%	
Total Interest, Depreciation & Amortization	9,647,102	9,610,856	9,800,346	9,706,106	9,474,502	5.6%	5.1%	5.2%	5.1%	5.0%
Total Operating Expenses	**167,157,996**	**178,661,729**	**188,335,086**	**185,309,559**	**179,724,323**	**96.3%**	**94.7%**	**99.3%**	**97.8%**	**95.3%**
EBITDA	**16,075,055**	**19,646,322**	**11,054,355**	**13,941,610**	**18,429,780**	**9.3%**	**10.4%**	**5.8%**	**7.4%**	**9.8%**
Operating Income	6,427,953	10,035,466	1,254,009	4,235,504	8,955,278	3.7%	5.3%	0.7%	2.2%	4.7%
Non-Operating Income/(Expense)	(364,307)	(868,637)	(1,466,699)	(1,743,322)	(1,638,670)	-0.2%	-0.5%	-0.8%	-0.9%	-0.9%
Net Income	**$6,063,646**	**$9,166,829**	**($212,690)**	**$2,492,182**	**$7,316,608**	**3.5%**	**4.9%**	**-0.1%**	**1.3%**	**3.9%**
Capital Expenditures	*$7,386,712*	*$5,202,968*	*$10,293,692*	*$8,260,196*	*n.a*					
As a % of Total Net Revenue	*4.3%*	*2.8%*	*5.4%*	*4.4%*	*n.a*					

Source: Based on information provided by management

Historical Operational Analysis - MMH **(1)**

	FYE September 30,					
	2011	2012	2013	2014	2015	
Gross Outpatient Charges	270,967,534	306,599,578	337,511,330	369,575,729	379,110,517	**A**
Gross Inpatient Charges	150,353,329	185,302,228	225,513,086	232,383,939	219,935,974	**B**
Outpatient Adjustment Factor	2.80	2.65	2.50	2.59	2.72	**C = (A + B)/B**
Discharges	9,281	8,831	9,342	9,110	8,806	**D**
Adjusted Discharges	26,007	23,443	23,324	23,598	23,985	**E = C*D**
ER Visits	47,834	46,503	47,065	41,041	39,779	
Outpatient Visits	N/A	N/A	N/A	1,631,301	NA	
Patient Days	43,475	45,545	46,662	44,106	40,692	**F**
Adjusted Patient Days	121,826	120,903	116,498	114,251	110,834	**G = C*F**
Beds In Service	171	171	171	171	171	**H**
Licensed Beds	283	283	283	283	283	
Available Patient Days	62,415	62,415	62,415	62,415	62,415	**I = H*365*Months In Period/12**
Occupancy Rate - Beds in Service	69.7%	73.0%	74.8%	70.7%	65.2%	**J = F/I**
Occupancy Rate - Licensed Beds	42.1%	44.1%	45.2%	42.7%	39.4%	
Average Length of Stay	4.7	5.2	5.0	4.8	4.6	**K = F/D**
Average Daily Census	119	125	128	121	111	**L = G/365*Months In Period/12**
Full Time Employees	1139	1076	1109	1153	1,133	

Notes:
(1) Based on hospital operating data provided by management.

Payor Mix Analysis

RGH Gross Charges By Payor % (1)					
Payor	FYE 2012	FYE 2013	FYE 2014	FYE 2015	Benchmark (2)
Medicare	46.0%	46.5%	43.8%	45.2%	**24.1%**
Managed Care/Commercial	32.6%	32.3%	34.0%	31.6%	**53.5%**
Medicaid	16.1%	16.4%	18.0%	19.8%	**11.2%**
Self-pay/Uninsured	3.5%	3.0%	2.4%	1.5%	**12.3%**
Other	1.4%	1.3%	1.1%	1.2%	
Other Governmental	0.5%	0.5%	0.6%	0.6%	
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	

MMH Gross Charges By Payor % (1)					
Payor	FYE 2012	FYE 2013	FYE 2014	FYE 2015	Benchmark (2)
Medicare	42.9%	43.2%	42.5%	43.0%	**24.1%**
Managed Care/Commercial	35.0%	33.9%	33.3%	32.2%	**53.5%**
Medicaid	17.5%	18.4%	20.9%	22.1%	**11.2%**
Self-pay/Uninsured	3.1%	3.0%	1.9%	1.4%	**12.3%**
Other	1.0%	1.0%	0.9%	0.8%	
Other Governmental	0.5%	0.5%	0.4%	0.6%	
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	

Notes:
(1) Based on payor mix data provided by management for Rockville General and Manchester Memorial hospitals.
(2) The benchmarks based on the median payor mix from an analysis of guideline public companies. See Exhibit D-7.

State of Connecticut, Office of Attorney General | **Exhibit D-1**

Fair Market Value of

Eastern Connecticut Health Network, Inc.

Valuation Analysis as of March 31, 2016

(Dollars in Millions)

NAVIGANT

FINAL

Guideline Company - Summary

	BEV	TTM Revenue	TTM EBITDA	NTM Revenue	NTM EBITDA	BEV/ TTM Revenue	BEV/ TTM EBITDA	BEV/ NTM Revenue	BEV/ NTM EBITDA
Community Health Systems, Inc.	$19,449	$19,525	$2,287	$20,153	$2,899	1.0x	8.5x	1.0x	6.7x
Universal Health Services Inc.	15,703	9,268	1,692	10,562	1,766	1.7x	9.3x	1.5x	8.9x
LifePoint Health, Inc.	5,119	5,531	633	6,494	780	0.9x	8.1x	0.8x	6.6x
HCA Holdings, Inc.	62,793	40,262	7,918	41,938	8,318	1.6x	7.9x	1.5x	7.5x
Tenet Healthcare Corp.	19,059	19,254	2,241	19,113	2,462	1.0x	8.5x	1.0x	7.7x
					Median	1.0x	8.5x	1.0x	7.5x
					Average	1.2x	8.5x	1.1x	7.5x
Financial Metric for Eastern Connecticut Health Network, Inc. (In 000's)					(1)	$313,562	$10,846	$303,633	$11,281
Selected Market Multiples					(2)	0.20	4.6x	0.2x	4.3x
Preliminary Indication of Business Enterprise Value - Marketable, Minority Basis						**62,712**	**49,750**	**60,727**	**48,401**
Less: Interest-Bearing Debt					(3)	78,420	78,420	78,420	78,420
Preliminary Indication of Unadjusted Equity Value - Marketable, Minority Basis						(15,708)	(28,670)	(17,693)	(30,019)
Control Premium Calculation									
Actual Equity Weighting (Ea)						(25.0%)	(57.6%)	(29.1%)	(62.0%)
Optimal Equity Weighting (Eo)						50.0%	50.0%	50.0%	50.0%
Control Premium Based on Optimal Capital Structure (C Po)					(4)	10.0%	10.0%	10.0%	10.0%
Control Premium Based on Actual Capital Structure (C Pa)						n.a	n.a	n.a	n.a
Plus: Control Premium					(0)	n.a	n.a	n.a	n.a
Preliminary Indication of Unadjusted Equity Value - Marketable, Control Basis						(15,708)	(28,670)	(17,693)	(30,019)
Plus: Interest-Bearing Debt						78,420	78,420	78,420	78,420
Indicated Business Enterprise Value - Marketable, Control Basis						$62,712	$49,750	$60,727	$48,401
Weighting					(5)	25.0%	25.0%	25.0%	25.0%
Preliminary Business Enterprise Value (In 000's)									$55,397
Plus: Joint Venture Interests					(6)				13,187
Plus: Real Estate Joint Venture Interests					(7)				1,760
Business Enterprise Value (In 000's)									**$70,344**

Notes:

(1) See Exhibit B-2, Projected Income Statement.

(2) Based on analysis of guideline companies and subject company metrics, after adjustments for differences in profitability, future growth, and risk.

(3) Based on Management's Net Proceeds Analysis as of September 30, 2015.

(4) Control premium based on transaction data from Irving Levin Associates, Inc. and CapitalIQ.

(5) Most weight was given to the EBITDA indication as this metric is most commonly used by buyers and sellers in the hospital M&A market.
BEV = Business Enterprise Value
EBITDA = Earnings Before Interest, Tax, Depreciation, and Amortization

(6) See Exhibit F-4, Joint Venture Analysis.

(7) See Exhibit F-3, Real Property - Summary of Fair Market Values.

Guideline Company - Multiples

Company Name:	Community Health Systems, Inc.	Universal Health Services Inc.	LifePoint Health, Inc.	HCA Holdings, Inc.	Tenet Healthcare Corp.
	CYH	UHS	LPNT	HCA	THC
As Of:	9/30/2015	9/30/2015	9/30/2015	9/30/2015	9/30/2015
Stock Price As of: 09/30/2015	$18.51	$124.72	$69.25	$78.05	$28.93
Shares Outstanding	110.3	98.9	44.5	410.6	98.8
Market Value of Equity	$2,042	$12,334	$3,082	$32,045	$2,857
Interest Bearing Debt	16,989	3,098	2,206	29,905	14,754
Preferred Stock	-	-	-	-	-
Minority Interest	604	311	144	1,482	1,898
Market Value of Invested Capital (MVIC)	19,635	15,743	5,432	63,432	19,509
Less: Cash and Cash Equivalents	186	40	313	639	450
Enterprise Value (EV)	$19,449	$15,703	$5,119	$62,793	$19,059
Last Fiscal Year (LFY)					
Revenue	$19,437	$9,043	$5,214	$39,678	$18,634
EBITDA	$2,387	$1,658	$646	$7,869	$2,177
EBITDA %	12.3%	18.3%	12.4%	19.8%	11.7%
EBIT	$1,427	$1,259	$388	$5,965	$1,380
EBIT %	7.3%	13.9%	7.4%	15.0%	7.4%
LFY Multiples					
Revenue	1.0x	1.7x	1.0x	1.6x	1.0x
EBITDA	8.1x	9.5x	7.9x	8.0x	8.8x
EBIT	13.6x	12.5x	13.2x	10.5x	13.8x
Trailing Twelve Months (TTM)					
Revenue	$19,525	$9,268	$5,531	$40,262	$19,254
EBITDA	$2,287	$1,692	$633	$7,918	$2,241
EBITDA %	11.7%	18.3%	11.4%	19.7%	11.6%
EBIT	$1,327	$1,289	$359	$6,008	$1,439
EBIT %	6.8%	13.9%	6.5%	14.9%	7.5%
TTM Multiples					
Revenue	1.0x	1.7x	0.9x	1.6x	1.0x
EBITDA	8.5x	9.3x	8.1x	7.9x	8.5x
EBIT	14.7x	12.2x	14.3x	10.5x	13.2x
Next Twelve Months (NTM)					
Revenue	$20,153	$10,562	$6,494	$41,938	$19,113
EBITDA	$2,899	$1,766	$780	$8,318	$2,462
EBITDA %	14.4%	16.7%	12.0%	19.8%	12.9%
FY1 Multiples					
Revenue	1.0x	1.5x	0.8x	1.5x	1.0x
EBITDA	6.7x	8.9x	6.6x	7.5x	7.7x
2 Years Forward					
Revenue	$20,855	$11,127	$6,854	$44,034	$19,841
EBITDA	$2,971	$1,874	$843	$8,722	$2,600
EBITDA %	14.2%	16.8%	12.3%	19.8%	13.1%
FY2 Multiples					
Revenue	0.9x	1.4x	0.7x	1.4x	1.0x
EBITDA	6.5x	8.4x	6.1x	7.2x	7.3x

	BEV/ LFY Revenue	BEV/ LFY EBITDA	BEV/ TTM Revenue	BEV/ TTM EBITDA	BEV/ NTM Revenue	BEV/ NTM EBITDA
Community Health Systems, Inc.	1.0x	8.1x	1.0x	8.5x	1.0x	6.7x
Universal Health Services Inc.	1.7x	9.5x	1.7x	9.3x	1.5x	8.9x
LifePoint Health, Inc.	1.0x	7.9x	0.9x	8.1x	0.8x	6.6x
HCA Holdings, Inc.	1.6x	8.0x	1.6x	7.9x	1.5x	7.5x
Tenet Healthcare Corp.	1.0x	8.8x	1.0x	8.5x	1.0x	7.7x
Low	1.0x	7.9x	0.9x	7.9x	0.8x	6.6x
25th Percentile	1.0x	8.0x	1.0x	8.1x	1.0x	6.7x
Median	1.0x	8.1x	1.0x	8.5x	1.0x	7.5x
75th Percentile	1.6x	8.8x	1.6x	8.5x	1.5x	7.7x
High	1.7x	9.5x	1.7x	9.3x	1.5x	8.9x
Selected Multiple			**n.a**	**4.6x**	**n.a**	**4.3x**

Notes:
Source: Capital IQ

Guideline Company - Ratios

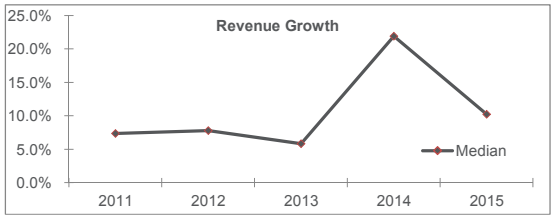
Trailing Twelve Months Ending:	Community Health Systems, Inc. CYH 9/30/2015	Universal Health Services Inc. UHS 9/30/2015	LifePoint Health, Inc. LPNT 9/30/2015	HCA Holdings, Inc. HCA 9/30/2015	Tenet Healthcare Corp. THC 9/30/2015	Eastern Connecticut Health Network, Inc. ECHN 9/30/2015	Range of Ratios for Guideline Companies High	Low	Median	Average
Liquidity Ratios										
Cash & Equivalents / Total Assets	0.7%	0.4%	5.6%	2.0%	1.9%	6.2%	5.6%	0.4%	1.9%	2.1%
Current Ratio	1.8	1.4	2.1	1.5	1.5	1.4	2.1	1.4	1.5	1.7
Quick Ratio	1.6	1.3	1.9	1.2	1.5	1.3	1.9	1.2	1.5	1.5
Days Cash on Hand	4.0	2.0	25.7	7.4	10.4	19.6	25.7	2.0	7.4	9.9
Working Capital Ratios										
Working Capital % of Sales	12.3%	5.7%	13.5%	7.4%	12.2%	7.3%	13.5%	5.7%	12.2%	10.2%
Debt-Free Working Capital % of Sales	13.5%	6.7%	14.0%	11.0%	12.8%	9.5%	14.0%	6.7%	12.8%	11.6%
Cash-Free Debt-Free Working Capital % of Sales	12.5%	6.2%	7.9%	9.3%	10.3%	4.4%	12.5%	6.2%	9.3%	9.3%
Efficiency Ratios										
Accounts Receivable Turnover	5.3	6.6	6.8	6.7	6.2	7.6	6.8	5.3	6.6	6.3
Days' Receivable	68.8	55.3	53.4	54.4	58.7	48.1	68.8	48.1	55.3	58.1
Accounts Payable Turnover	9.9	4.6	20.4	13.0	9.6	9.0	20.4	4.6	9.9	11.5
Days' Payable	37.0	79.2	17.9	28.1	38.2	40.6	79.2	17.9	37.0	40.1
Inventory Turnover	20.9	45.1	27.5	17.7	41.9	54.1	45.1	17.7	27.5	30.6
Days' Inventory	17.4	8.1	13.3	20.6	8.7	6.7	20.6	6.7	13.3	13.6
Net PP&E Turnover	1.9	2.3	2.1	2.7	2.5	3.6	2.7	1.9	2.3	2.3
Asset Turnover	0.7	1.0	0.9	1.2	0.8	1.2	1.2	0.7	0.9	0.9
Cash Conversion Cycle	49.2	(15.8)	48.8	47.0	29.2	14.3	49.2	(15.8)	47.0	31.7
Leverage Ratios										
Interest Coverage	1.8	10.9	3.5	3.4	1.7	0.3	10.9	1.7	3.4	4.2
Debt / Book Capital	77.8%	41.1%	48.1%	124.1%	84.5%	59.7%	124.1%	41.1%	77.8%	75.1%
Debt / Assets	62.5%	33.6%	39.4%	93.8%	63.7%	33.4%	93.8%	33.6%	62.5%	58.6%
Assets / Equity	5.6	2.1	2.4	(5.5)	8.6	4.4	8.6	(5.5)	2.4	2.6
Net Fixed Assets / Total Capital	0.5	0.5	0.5	0.6	0.4	0.6	0.6	0.4	0.5	0.5
Long-Term Debt / Equity	3.5	0.7	0.9	(4.9)	5.4	1.4	5.4	(4.9)	0.9	1.1
Profitability Ratios										
EBITDA Margin	13.2%	18.9%	12.8%	19.7%	12.6%	4.1%	19.7%	12.6%	13.2%	15.4%
EBIT Margin	8.7%	14.4%	7.8%	14.9%	8.0%	0.3%	14.9%	7.8%	8.7%	10.7%
Net Income Margin	1.7%	7.8%	3.0%	5.3%	0.1%	(1.5%)	7.8%	0.1%	3.0%	3.6%
DuPont Return on Equity										
Net Income Margin	1.7%	7.8%	3.0%	5.3%	0.1%	(1.5%)	7.8%	(1.5%)	3.0%	3.6%
Asset Turnover	0.7	1.0	0.9	1.2	0.8	1.2	1.2	0.7	0.9	0.9
Return on Assets	1.3%	7.4%	2.7%	6.5%	0.1%	(1.8%)	7.4%	(1.8%)	2.7%	3.6%
Assets / Equity	5.6	2.1	2.4	(5.5)	8.6	4.4	8.6	(5.5)	2.4	2.6
Return on Equity	7.1%	15.3%	6.4%	(35.7%)	0.7%	(8.1%)	15.3%	(35.7%)	6.4%	(1.3%)
Capital Expenditures / Revenue	5.1%	1.5%	5.3%	5.8%	4.2%	1.9%	5.8%	1.5%	5.1%	4.4%
Price/Earnings (P/E)	5.2x	17.9x	19.7x	14.9x	150.0x	N/A	150.0x	5.2x	17.9x	41.6x

Notes:
Source: Capital IQ

Guideline Company - Historic Revenue Growth and Margin Analysis

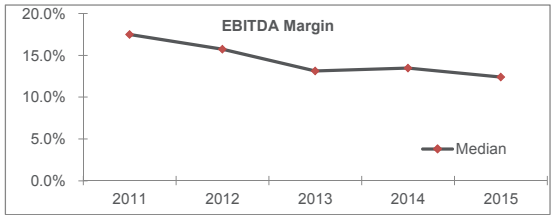
Revenue Growth

	FY 2011	2012	2013	2014	2015	3 FY Avg	5 FY Avg
Community Health Systems, Inc.	7.3%	7.8%	(0.1%)	45.4%	4.3%	16.5%	12.9%
Universal Health Services Inc.	38.0%	3.0%	5.8%	11.4%	10.2%	9.1%	13.7%
LifePoint Health, Inc.	7.4%	12.1%	8.4%	21.9%	16.3%	15.5%	13.2%
HCA Holdings, Inc.	5.9%	11.2%	3.5%	8.0%	7.5%	6.3%	7.2%
Tenet Healthcare Corp.	4.7%	5.4%	21.6%	49.8%	12.2%	27.9%	18.7%
Low	4.7%	3.0%	(0.1%)	8.0%	4.3%	6.3%	7.2%
Median	7.3%	7.8%	5.8%	21.9%	10.2%	15.5%	13.2%
High	38.0%	12.1%	21.6%	49.8%	16.3%	27.9%	18.7%
Mean	12.6%	7.9%	7.9%	27.3%	10.1%	15.1%	13.2%



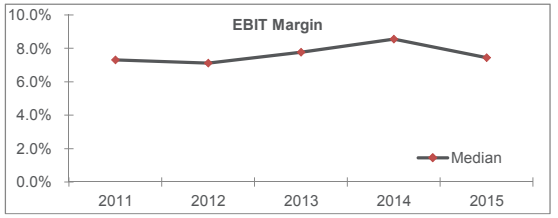
EBITDA Margin

	FY 2011	2012	2013	2014	2015	3 FY Avg	5 FY Avg
Community Health Systems, Inc.	15.1%	15.2%	13.1%	13.5%	12.3%	13.0%	13.8%
Universal Health Services Inc.	17.6%	18.5%	18.4%	18.0%	18.3%	18.2%	18.2%
LifePoint Health, Inc.	17.5%	15.7%	12.8%	12.5%	12.4%	12.5%	14.2%
HCA Holdings, Inc.	19.6%	19.7%	19.1%	20.0%	19.8%	19.7%	19.6%
Tenet Healthcare Corp.	12.9%	13.2%	12.0%	11.7%	11.7%	11.8%	12.3%
Low	12.9%	13.2%	12.0%	11.7%	11.7%	11.8%	12.3%
Median	17.5%	15.7%	13.1%	13.5%	12.4%	13.0%	14.2%
High	19.6%	19.7%	19.1%	20.0%	19.8%	19.7%	19.6%
Mean	16.6%	16.5%	15.1%	15.1%	14.9%	15.0%	15.6%



EBIT Margin

	FY 2011	2012	2013	2014	2015	3 FY Avg	5 FY Avg
Community Health Systems, Inc.	7.3%	7.6%	8.4%	9.1%	11.0%	9.5%	8.7%
Universal Health Services Inc.	7.2%	7.1%	6.4%	5.7%	6.8%	6.3%	6.7%
LifePoint Health, Inc.	11.3%	12.0%	13.1%	10.4%	7.4%	10.3%	10.9%
HCA Holdings, Inc.	8.9%	6.9%	7.8%	8.6%	8.0%	8.1%	8.0%
Tenet Healthcare Corp.	5.7%	7.1%	5.8%	1.9%	3.4%	3.7%	4.8%
Low	5.7%	6.9%	5.8%	1.9%	3.4%	3.7%	4.8%
Median	7.3%	7.1%	7.8%	8.6%	7.4%	8.1%	8.0%
High	11.3%	12.0%	13.1%	10.4%	11.0%	10.3%	10.9%
Mean	8.1%	8.1%	8.3%	7.1%	7.3%	7.6%	7.8%

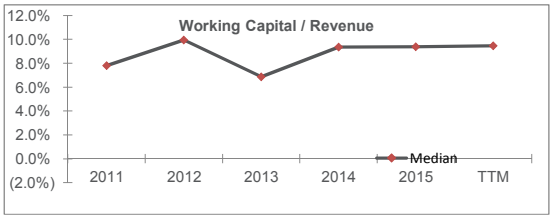


Source: Capital IQ

Guideline Company - Historic Working Capital and Capital Expenditures Analysis

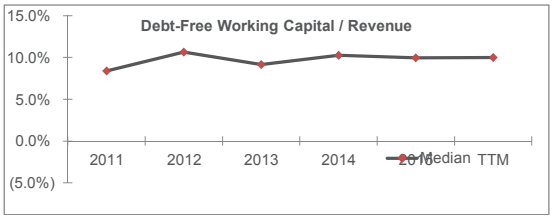
Working Capital / Revenue

	FY 2011	2012	2013	2014	2015	TTM	3 FY Avg	5 FY Avg
Community Health Systems, Inc.	7.9%	9.9%	10.1%	10.6%	10.8%	11.3%	10.5%	9.8%
Universal Health Services Inc.	7.8%	7.4%	5.1%	5.3%	6.8%	(0.5%)	5.7%	6.5%
LifePoint Health, Inc.	15.4%	14.2%	14.6%	14.3%	12.4%	10.8%	13.8%	14.2%
HCA Holdings, Inc.	5.7%	4.8%	6.9%	9.3%	9.4%	9.4%	8.5%	7.2%
Tenet Healthcare Corp.	6.3%	10.1%	5.4%	2.4%	4.6%	4.5%	4.1%	5.7%
Low	5.7%	4.8%	5.1%	2.4%	4.6%	(0.5%)	4.1%	5.7%
Median	7.8%	9.9%	6.9%	9.3%	9.4%	9.4%	8.5%	7.2%
High	15.4%	14.2%	14.6%	14.3%	12.4%	11.3%	13.8%	14.2%
Mean	8.6%	9.3%	8.4%	8.4%	8.8%	7.1%	8.5%	8.7%



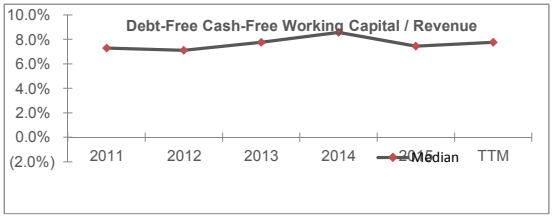
Debt-Free Working Capital / Revenue

	FY 2011	2012	2013	2014	2015	TTM	3 FY Avg	5 FY Avg
Community Health Systems, Inc.	8.4%	10.6%	11.4%	11.9%	12.0%	12.6%	11.7%	10.8%
Universal Health Services Inc.	7.8%	7.4%	6.7%	6.1%	7.5%	4.7%	6.8%	7.1%
LifePoint Health, Inc.	15.5%	14.6%	30.5%	14.7%	12.9%	11.3%	19.4%	17.6%
HCA Holdings, Inc.	10.4%	9.2%	9.2%	10.3%	10.0%	10.0%	9.8%	9.8%
Tenet Healthcare Corp.	7.0%	11.1%	6.8%	3.0%	5.3%	5.4%	5.0%	6.7%
Low	7.0%	7.4%	6.7%	3.0%	5.3%	4.7%	5.0%	6.7%
Median	8.4%	10.6%	9.2%	10.3%	10.0%	10.0%	9.8%	9.8%
High	15.5%	14.6%	30.5%	14.7%	12.9%	12.6%	19.4%	17.6%
Mean	9.8%	10.6%	12.9%	9.2%	9.5%	8.8%	10.5%	10.4%



Debt-Free Cash-Free Working Capital / Revenue

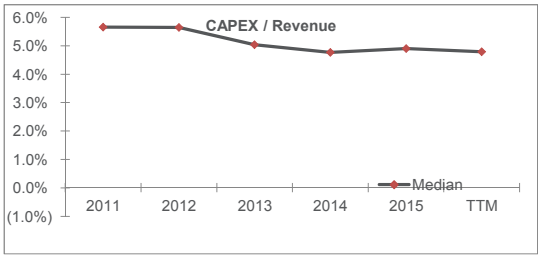
	FY 2011	2012	2013	2014	2015	TTM	3 FY Avg	5 FY Avg
Community Health Systems, Inc.	7.3%	7.6%	8.4%	9.1%	11.0%	11.6%	9.5%	8.7%
Universal Health Services Inc.	7.2%	7.1%	6.4%	5.7%	6.8%	4.1%	6.3%	6.7%
LifePoint Health, Inc.	11.3%	12.0%	13.1%	10.4%	7.4%	7.9%	10.3%	10.9%
HCA Holdings, Inc.	8.9%	6.9%	7.8%	8.6%	8.0%	7.8%	8.1%	8.0%
Tenet Healthcare Corp.	5.7%	7.1%	5.8%	1.9%	3.4%	1.6%	3.7%	4.8%
Low	5.7%	6.9%	5.8%	1.9%	3.4%	1.6%	3.7%	4.8%
Median	7.3%	7.1%	7.8%	8.6%	7.4%	7.8%	8.1%	8.0%
High	11.3%	12.0%	13.1%	10.4%	11.0%	11.6%	10.3%	10.9%
Mean	8.1%	8.1%	8.3%	7.1%	7.3%	6.6%	7.6%	7.8%



Guideline Company - Historic Working Capital and Capital Expenditures Analysis

Capital Expenditures / Revenue

	FY 2011	2012	2013	2014	2015	TTM	3 FY Avg	5 FY Avg
Community Health Systems, Inc.	6.5%	6.0%	4.8%	4.6%	4.9%	4.8%	4.8%	5.4%
Universal Health Services Inc.	4.7%	5.6%	4.9%	4.8%	4.2%	4.3%	4.6%	4.8%
LifePoint Health, Inc.	7.3%	6.5%	5.0%	4.6%	5.3%	5.2%	5.0%	5.7%
HCA Holdings, Inc.	5.7%	5.6%	5.7%	5.9%	6.0%	6.1%	5.9%	5.8%
Tenet Healthcare Corp.	5.4%	5.5%	6.2%	5.6%	4.5%	4.5%	5.5%	5.5%
Low	4.7%	5.5%	4.8%	4.6%	4.2%	4.3%	4.6%	4.8%
Median	5.7%	5.6%	5.0%	4.8%	4.9%	4.8%	5.0%	5.5%
High	7.3%	6.5%	6.2%	5.9%	6.0%	6.1%	5.9%	5.8%
Mean	5.9%	5.9%	5.3%	5.1%	5.0%	5.0%	5.1%	5.4%

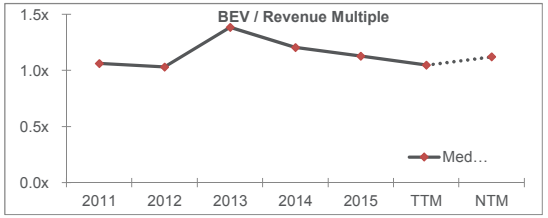


Source: Capital IQ

Guideline Company - Historical Multiple Analysis

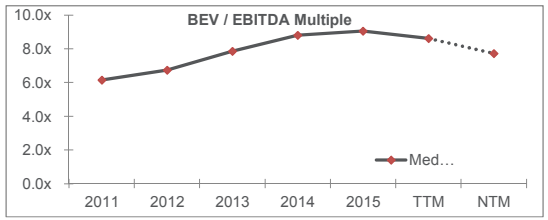
BEV / Revenue Multiple

	FY 2011	2012	2013	2014	2015	TTM	NTM	3 FY Avg	5 FY Avg
Community Health Systems, Inc.	0.9x	1.0x	0.7x	1.2x	1.1x	1.0x	1.1x	1.0x	1.0x
Universal Health Services Inc.	1.1x	1.3x	1.6x	1.8x	1.7x	1.7x	1.5x	1.7x	1.5x
LifePoint Health, Inc.	1.1x	1.0x	0.5x	1.2x	1.1x	1.0x	0.9x	0.9x	1.0x
HCA Holdings, Inc.	1.3x	1.3x	1.5x	1.7x	1.5x	1.6x	1.5x	1.6x	1.5x
Tenet Healthcare Corp.	0.8x	0.9x	1.4x	1.0x	1.1x	1.0x	1.0x	1.2x	1.0x
Low	0.8x	0.9x	0.5x	1.0x	1.1x	1.0x	0.9x	0.9x	1.0x
Median	1.1x	1.0x	1.4x	1.2x	1.1x	1.0x	1.1x	1.2x	1.0x
High	1.3x	1.3x	1.6x	1.8x	1.7x	1.7x	1.5x	1.7x	1.5x
Mean	1.0x	1.1x	1.1x	1.4x	1.3x	1.3x	1.2x	1.3x	1.2x



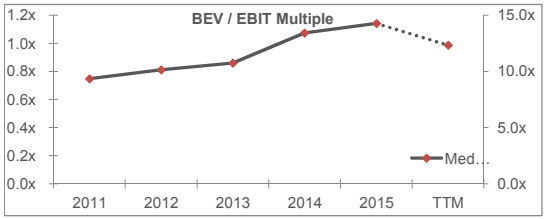
BEV / EBITDA Multiple

	FY 2011	2012	2013	2014	2015	TTM	NTM	3 FY Avg	5 FY Avg
Community Health Systems, Inc.	6.1x	6.4x	5.7x	8.8x	8.6x	8.6x	7.8x	7.7x	7.1x
Universal Health Services Inc.	6.5x	6.8x	8.7x	10.0x	9.4x	9.4x	8.9x	9.4x	8.3x
LifePoint Health, Inc.	6.1x	6.6x	3.9x	9.6x	9.1x	9.1x	7.3x	7.5x	7.0x
HCA Holdings, Inc.	6.6x	6.7x	7.9x	8.5x	7.6x	8.0x	7.5x	8.0x	7.5x
Tenet Healthcare Corp.	6.2x	7.1x	11.6x	8.8x	9.0x	8.6x	7.7x	9.8x	8.5x
Low	6.1x	6.4x	3.9x	8.5x	7.6x	8.0x	7.3x	7.5x	7.0x
Median	6.2x	6.7x	7.9x	8.8x	9.0x	8.6x	7.7x	8.0x	7.5x
High	6.6x	7.1x	11.6x	10.0x	9.4x	9.4x	8.9x	9.8x	8.5x
Mean	6.3x	6.7x	7.5x	9.2x	8.8x	8.7x	7.8x	8.5x	7.7x



BEV / EBIT Multiple

	FY 2011	2012	2013	2014	2015	TTM	NTM	3 FY Avg	5 FY Avg
Community Health Systems, Inc.	9.6x	10.2x	9.1x	13.3x	14.4x	14.7x	13.6x	12.3x	11.3x
Universal Health Services Inc.	8.6x	9.0x	11.5x	13.4x	12.4x	12.3x	11.5x	12.5x	11.0x
LifePoint Health, Inc.	9.3x	10.9x	7.3x	16.7x	15.2x	16.1x	13.1x	13.0x	11.9x
HCA Holdings, Inc.	8.8x	9.1x	10.7x	11.3x	10.0x	10.5x	9.8x	10.7x	10.0x
Tenet Healthcare Corp.	9.6x	11.0x	19.6x	15.7x	14.3x	11.5x	11.5x	16.5x	14.0x
Low	8.6x	9.0x	7.3x	11.3x	10.0x	10.5x	9.8x	10.7x	10.0x
Median	9.3x	10.2x	10.7x	13.4x	14.3x	12.3x	11.5x	12.5x	11.3x
High	9.6x	11.0x	19.6x	16.7x	15.2x	16.1x	13.6x	16.5x	14.0x
Mean	9.2x	10.0x	11.7x	14.1x	13.3x	13.1x	11.9x	13.0x	11.6x



Source: Capital IQ

Guideline Company - Operating Statistics

	Community Health Systems, Inc.	Universal Health Services Inc.	LifePoint Health, Inc.	HCA Holdings, Inc.	Tenet Healthcare Corp.	State of Connecticut, Office of Attorney General	Range for Guideline Companies			
	CYH	UHS	LPNT	HCA	THC	ECHN				
Fiscal Year Ending:	12/31/2015	12/31/2015	12/31/2015	12/31/2015	12/31/2015	9/30/2015	High	Low	Median	Average
Operating Statistics (Last Fiscal Year)										
Number of Hospitals	194	253	67	284	590	1	590	67	253	278
FTEs	123,000	64,500	40,000	203,500	119,148	2,256	203,500	40,000	119,148	110,030
Licensed Beds	29,853	27,620	8,243	43,771	22,525	401	43,771	8,243	27,620	26,402
Admissions	940,292	708,734	236,474	1,868,800	-	10,918	1,868,800	-	708,734	750,860
Adjusted Admissions	2,038,103	NA	617,434	3,122,700	NA	31,487	3,122,700	617,434	2,038,103	1,926,079
ER Visits	NA	NA	1,477,113	8,050,200	NA	60,668	8,050,200	1,477,113	4,763,657	4,763,657
Patient Days	4,175,214	7,054,125	NA	9,155,660	NA	50,565	9,155,660	4,175,214	7,054,125	6,795,000
Adjusted Patient Days	9,049,866	NA	NA	15,298,790	NA	145,829	15,298,790	9,049,866	12,174,328	12,174,328
Inpatient Procedures	NA	NA	65,432	529,900	NA	N/A	529,900	65,432	297,666	297,666
Outpatient Procedures	NA	NA	243,820	909,400	NA	N/A	909,400	243,820	576,610	576,610
Outpatient Adjustment Factor	2.17	NA	2.61	1.67	NA	2.88	2.61	1.67	2.17	2.15
Net Inpatient Revenue	NA	NA	NA	NA	NA	N/A	-	-	NA	NA
Net Outpatient Revenue	NA	NA	NA	NA	NA	N/A	-	-	NA	NA
Total Net Patient Revenue	$19,234	$9,043	$5,214	39,678	-	316	39,678	-	9,043	14,634
EBITDA	$2,387	$1,658	$646	7,869	2,177	12.9	7,869	646	2,177	2,947
Payor Mix										
Medicare %	24.1%	21.0%	29.1%	32.2%	20.4%		32.2%	20.4%	24.1%	25.4%
Medicaid %	11.2%	14.0%	16.1%	9.9%	8.7%		16.1%	8.7%	11.2%	12.0%
Managed Care %	52.4%	52.0%	53.5%	58.5%	70.9%		70.9%	52.0%	53.5%	57.5%
Uninsured %	12.3%	13.0%	16.6%	9.3%	0.0%		16.6%	0.0%	12.3%	10.2%
Total	100.0%	100.0%	115.3%	109.9%	100.0%					
Operating Ratios										
% Inpatient Revenue	NA	NA	NA	NA	NA	NA	0.0%	0.0%	NA	NA
% Outpatient Revenue	NA	NA	NA	NA	NA	NA	0.0%	0.0%	NA	NA
Net Revenue / Bed	$644,290	$327,424	$632,573	$906,491	$ -	786,952	906,491	-	632,573	502,156
Net Revenue / Admission	$20,455	$12,760	$22,050	$21,232	NA	28,903	22,050	12,760	20,844	19,124
Net Revenue / Adjusted Admission	$9,437	NA	$8,445	$12,706	NA	10,022	12,706	8,445	9,437	10,196
Net Revenue / Patient Day	$4,607	$1,282	NA	$4,334	NA	6,241	4,607	1,282	4,334	3,407
Net Revenue / Adjusted Patient Day	$2,125	NA	NA	$2,594	NA	2,164	2,594	2,125	2,359	2,359
EBITDA / Bed	$79,958	$60,029	$78,370	$179,777	$96,648	32,047	179,777	60,029	79,958	98,956
EBITDA / Admission	$2,539	$2,339	$2,732	$4,211	NA	1,177	4,211	2,339	2,635	2,955
EBITDA / Adjusted Admission	$1,171	NA	$1,046	$2,520	NA	408	2,520	1,046	1,171	1,579
EBITDA / Patient Day	$572	$235	NA	$859	NA	254	859	235	572	555
EBITDA / Adjusted Patient Day	$264	NA	NA	$514	NA	88	514	264	389	389
FTEs / Bed	4.1	2.3	4.9	4.6	5.3	5.6	5.3	2.3	4.6	4.2
Average Length of Stay (Days)	4.4	10.0	NA	4.9	NA	4.6	10.0	4.4	4.9	6.4
Occupancy Rate	38.3%	70.0%	NA	57.3%	NA	34.5%	70.0%	38.3%	57.3%	55.2%
Avg. Daily Census (Per Facility)	59.0	76.4	NA	88.3	NA	138.5	88.3	59.0	76.4	74.6

Source: CapitalIQ

Guideline Company - Income Statements

		Community Health Systems, Inc.	Universal Health Services Inc.	LifePoint Health, Inc.	HCA Holdings, Inc.	Tenet Healthcare Corp.	Eastern Connecticut Health Network, Inc.	Community Health Systems, Inc.	Universal Health Services Inc.	LifePoint Health, Inc.	HCA Holdings, Inc.	Tenet Healthcare Corp.	Eastern Connecticut Health Network, Inc.	Range for Guideline Companies	
		CYH	UHS	LPNT	HCA	THC		CYH	UHS	LPNT	HCA	THC			
Latest Twelve Months Ending:		9/30/2015	9/30/2015	9/30/2015	9/30/2015	9/30/2015	9/30/2015	9/30/2015	9/30/2015	9/30/2015	9/30/2015	9/30/2015	9/30/2015	Median	Average
	Total Revenues	$19,557	$8,765	$5,107	$39,065	$18,085	$316	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	Salaries & Benefits	8,935	4,128	2,457	17,791	-	201	45.7%	47.1%	48.1%	45.5%	0.0%	63.6%	45.7%	37.3%
	Supplies	3,038	955	934	6,611	11,520	100	15.5%	10.9%	18.3%	16.9%	63.7%	31.6%	16.9%	25.1%
(1)	Cost of Goods Sold	11,973	5,083	3,391	24,402	11,520	300	61.2%	58.0%	66.4%	62.5%	63.7%	95.2%	62.5%	62.4%
	Gross Profit	**7,584**	**3,682**	**1,716**	**14,663**	**6,565**	**15**	**38.8%**	**42.0%**	**33.6%**	**37.5%**	**36.3%**	**4.8%**	**37.5%**	**37.6%**
	Selling, General & Admin. Exp.	459	94	53	-	264	-	2.3%	1.1%	1.0%	0.0%	1.5%	0.0%	1.1%	1.2%
	Other Operating Expenses	4,542	1,934	1,010	6,972	4,031	2	23.2%	22.1%	19.8%	17.8%	22.3%	0.7%	22.1%	21.0%
	EBITDA	**2,583**	**1,654**	**653**	**7,691**	**2,270**	**13**	**13.2%**	**18.9%**	**12.8%**	**19.7%**	**12.6%**	**4.1%**	**13.2%**	**15.4%**
	Depreciation & Amortization Expense	878	394	256	1,883	829	12	4.5%	4.5%	5.0%	4.8%	4.6%	3.8%	4.6%	4.7%
	EBIT	**1,705**	**1,260**	**396**	**5,808**	**1,441**	**1**	**8.7%**	**14.4%**	**7.8%**	**14.9%**	**8.0%**	**0.3%**	**8.7%**	**10.7%**
								0.0%							
	Net Interest Income (Expense)	(966)	(116)	(114)	(1,684)	(860)	(3)	(4.9%)	(1.3%)	(2.2%)	(4.3%)	(4.8%)	(1.1%)	(4.3%)	(3.5%)
	Non-Operating Income	64	-	45	49	39	(2)	0.3%	0.0%	0.9%	0.1%	0.2%	(0.7%)	0.2%	0.3%
	Non-Recurring Income	(69)	-	(72)	(300)	(402)	-	(0.4%)	0.0%	(1.4%)	(0.8%)	(2.2%)	0.0%	(0.8%)	(0.9%)
	Pretax Income	**734**	**1,144**	**256**	**3,873**	**218**	**(5)**	**3.8%**	**13.1%**	**5.0%**	**9.9%**	**1.2%**	**(1.5%)**	**5.0%**	**6.6%**
	Total Income Taxes	234	394	91	1,239	60	-	1.2%	4.5%	1.8%	3.2%	0.3%	0.0%	1.8%	2.2%
	Minority Interest Expense	102	70	13	560	139		0.5%	0.8%	0.3%	1.4%	0.8%	0.0%	0.8%	0.8%
	Net Income Before Extraordinaries	**398**	**680**	**151**	**2,074**	**19**	**(5)**	**2.0%**	**7.8%**	**3.0%**	**5.3%**	**0.1%**	**(1.5%)**	**3.0%**	**3.6%**
	Extraordinary Items	-	-	-	-	-	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Discontinued Operations	(56)	-	-	-	(1)	-	(0.3%)	0.0%	0.0%	0.0%	(0.0%)	0.0%	0.0%	(0.1%)
	Net Income	**342**	**680**	**151**	**2,074**	**18**	**(5)**	**1.7%**	**7.8%**	**3.0%**	**5.3%**	**0.1%**	**(1.5%)**	**3.0%**	**3.6%**
	Extraordinary Items	-	-	-	-	-	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Discontinued Operations	(56)	-	-	-	(1)	-	(0.3%)	0.0%	0.0%	0.0%	(0.0%)	0.0%	0.0%	(0.1%)
	Non-Operating Income	64	-	45	49	39	(2)	0.3%	0.0%	0.9%	0.1%	0.2%	(0.7%)	0.2%	0.3%
	Non-Recurring Income	(69)	-	(72)	(300)	(402)	-	(0.4%)	0.0%	(1.4%)	(0.8%)	(2.2%)	0.0%	(0.8%)	(0.9%)
	Preference Dividend	-	0	-	-	-	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Effective Tax Rate	*0*	*0*	*0*	*0*	*0*									
	Related Tax Expense	(2)	-	(10)	(80)	(100)		(0.0%)	0.0%	(0.2%)	(0.2%)	(0.6%)	0.0%	(0.2%)	(0.2%)
(2)	**Net Income (Adj.)**	**$401**	**$679**	**$169**	**$2,245**	**$282**	**($3)**	**2.1%**	**7.8%**	**3.3%**	**5.7%**	**1.6%**	**(0.8%)**	**3.3%**	**4.1%**
	Capital Expenditures	$989	$132	$270	$2,265	$765	$6	5.1%	1.5%	5.3%	5.8%	4.2%	1.9%	5.1%	4.4%

Notes:

(1) Cost of Goods Sold includes Salaries and Services, Employee Benefits, and Supplies and Drugs

(2) Net Income (Adj.) = Net Income - Extraordinary Ops - Non Op Income - Non Rec Income - Pref Dividend + [Non Operating Income + Non Recurring Income] * (1 - Tax Rate)

EBITDA = Earnings Before Interest, Tax, Depreciation and Amortization
EBIT = Earnings Before Interest and Tax
Source: Capital IQ

Guideline Company - Balance Sheet

	Community Health Systems, Inc.	Universal Health Services Inc.	LifePoint Health, Inc.	HCA Holdings, Inc.	Tenet Healthcare Corp.	Eastern Connecticut Health Network, Inc.	Community Health Systems, Inc.	Universal Health Services Inc.	LifePoint Health, Inc.	HCA Holdings, Inc.	Tenet Healthcare Corp.	Eastern Connecticut Health Network, Inc.	Range For Guideline Companies	
	CYH	UHS	LPNT	HCA	THC		CYH	UHS	LPNT	HCA	THC			
As of:	9/30/2015	9/30/2015	9/30/2015	9/30/2015	9/30/2015	9/30/2015	9/30/2015	9/30/2015	9/30/2015	9/30/2015	9/30/2015	9/30/2015	Median	Average
Assets														
Cash & Short-Term Investment	$186.0	$39.5	$313.2	$639.0	$450.0	$16.3	0.7%	0.4%	5.6%	2.0%	1.9%	6.2%	1.9%	2.1%
Accounts Receivable	3,686.0	1,328.3	747.7	5,827.0	2,907.0	41.6	13.6%	14.4%	13.4%	18.3%	12.5%	16.0%	13.6%	14.4%
Inventory	572.0	112.7	123.3	1,379.0	275.0	5.6	2.1%	1.2%	2.2%	4.3%	1.2%	2.1%	2.1%	2.2%
Prepaid Expenses	215.0	-	49.3	-	-	-	0.8%	0.0%	0.9%	0.0%	0.0%	0.0%	0.0%	0.3%
Deferred Tax Asset, Curr.	345.0	134.6	61.9	412.0	625.0	-	1.3%	1.5%	1.1%	1.3%	2.7%	0.0%	1.3%	1.6%
Other Current Assets	548.0	81.5	34.7	964.0	2,039.0	11.3	2.0%	0.9%	0.6%	3.0%	8.8%	4.3%	2.0%	3.1%
Total Current Assets	5,552.0	1,696.6	1,330.1	9,221.0	6,296.0	74.8	20.4%	18.4%	23.8%	28.9%	27.2%	28.7%	23.8%	23.7%
Net Property, Plant & Equipment	10,064.0	3,776.1	2,437.1	14,704.0	7,330.0	88.3	37.0%	41.0%	43.5%	46.1%	31.6%	33.9%	41.0%	39.9%
Long-Term Investments	487.0	9.0	-	595.0	1,029.0	89.0	1.8%	0.1%	0.0%	1.9%	4.4%	34.1%	1.8%	1.6%
Goodwill	8,972.0	3,388.4	1,667.5	-	6,606.0	-	33.0%	36.8%	29.8%	0.0%	28.5%	0.0%	29.8%	25.6%
Other Intangibles	158.0	-	72.3	6,540.0	1,585.0	-	0.6%	0.0%	1.3%	20.5%	6.8%	0.0%	1.3%	5.8%
Deferred Charges, Long-Term	-	35.1	27.3	-	245.0	-	0.0%	0.4%	0.5%	0.0%	1.1%	0.0%	0.4%	0.4%
Deferred Tax Asset, Long-Term	-	-	-	-	82.0	-	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.1%
Other Long-Term Assets	1,956.0	301.7	64.7	836.0	-	8.6	7.2%	3.3%	1.2%	2.6%	0.0%	3.3%	2.6%	2.8%
Total Long-Term Assets	21,637.0	7,510.3	4,268.9	22,675.0	16,877.0	185.8	79.6%	81.6%	76.2%	71.1%	72.8%	71.3%	76.2%	76.3%
Total Assets	**$27,189.0**	**$9,206.9**	**$5,599.0**	**$31,896.0**	**$23,173.0**	**$260.6**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Liabilities & Shareholder's Equity														
Accounts Payable	1,214.0	1,102.6	166.6	1,877.0	1,206.0	33.4	4.5%	12.0%	3.0%	5.9%	5.2%	12.8%	5.2%	6.1%
Accrued Expenses	1,548.0	-	213.3	3,059.0	1,313.0	-	5.7%	0.0%	3.8%	9.6%	5.7%	0.0%	5.7%	5.0%
Current Portion of L-T Debt	240.0	84.9	25.1	1,377.0	112.0	7.0	0.9%	0.9%	0.4%	4.3%	0.5%	2.7%	0.9%	1.4%
Current Income Taxes Payable	102.0	8.7	-	-	-	-	0.4%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
Unearned Revenue, Curr.	-	-	-	-	-	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Deferred Tax Liability, Curr.	23.0	-	-	-	-	-	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Other Current Liabilities	27.0	-	234.7	-	1,462.0	11.2	0.1%	0.0%	4.2%	0.0%	6.3%	4.3%	0.1%	2.1%
Total Current Liabilities	3,154.0	1,196.2	639.7	6,313.0	4,093.0	51.7	11.6%	13.0%	11.4%	19.8%	17.7%	19.8%	13.0%	14.7%
Long-Term Debt	16,749.0	3,013.0	2,181.2	28,528.0	14,642.0	80.1	61.6%	32.7%	39.0%	89.4%	63.2%	30.7%	61.6%	57.2%
Capital Leases	-	-	-	-	-	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Unearned Revenue, Non-Curr.	-	-	-	-	-	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Pension & Other Post-Retirement Benefits	-	-	-	-	621.0	62.4	0.0%	0.0%	0.0%	0.0%	2.7%	23.9%	0.0%	0.5%
Deferred Tax Liability, Non-Curr.	847.0	264.4	173.3	-	-	-	3.1%	2.9%	3.1%	0.0%	0.0%	0.0%	2.9%	1.8%
Other Non-Current Liabilities	1,594.0	289.4	225.2	2,867.0	1,117.0	7.7	5.9%	3.1%	4.0%	9.0%	4.8%	2.9%	4.8%	5.4%
Total Long-Term Liabilities	19,190.0	3,566.8	2,579.7	31,395.0	16,380.0	150.2	70.6%	38.7%	46.1%	98.4%	70.7%	57.6%	70.6%	64.9%
Total Liabilities	**22,344.0**	**4,762.9**	**3,219.4**	**37,708.0**	**20,473.0**	**201.9**	**82.2%**	**51.7%**	**57.5%**	**118.2%**	**88.3%**	**77.5%**	**82.2%**	**79.6%**
Minority Interest	604.0	310.8	143.9	1,482.0	1,898.0	-	2.2%	3.4%	2.6%	4.6%	8.2%	0.0%	3.4%	4.2%
Preferred Stock (Carrying Value)	-	-	-	-	-	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Common Equity	4,241.0	4,133.1	2,235.7	(7,294.0)	802.0	-	15.6%	44.9%	39.9%	(22.9%)	3.5%	0.0%	15.6%	16.2%
Total Shareholder's Equity	4,845.0	4,443.9	2,379.6	(5,812.0)	2,700.0	58.7	17.8%	48.3%	42.5%	(18.2%)	11.7%	22.5%	17.8%	20.4%
Total Liabilities & Shareholder's Equity	**$27,189.0**	**$9,206.9**	**$5,599.0**	**$31,896.0**	**$23,173.0**	**$260.6**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Source: Capital IQ

Guideline Company - Descriptions

Name	Stock Symbol	Description
Community Health Systems, Inc.	CYH	Community Health Systems, Inc., together with its subsidiaries, owns, leases, and operates general acute care hospitals in the United States. It offers general acute care, emergency room, general and specialty surgery, critical care, internal medicine, obstetrics, diagnostic, psychiatric, and rehabilitation services, as well as skilled nursing and home care services. The company also provides outpatient services at urgent care centers, occupational medicine clinics, imaging centers, cancer centers, ambulatory surgery centers, and home health and hospice agencies. In addition, it offers management and consulting services to non-affiliated general acute care hospitals. As of February 15, 2016, the company owned, leased, or operated 195 affiliated hospitals in 29 states with approximately 30,000 licensed beds. Community Health Systems, Inc. was founded in 1985 and is headquartered in Franklin, Tennessee.
Universal Health Services Inc.	UHS	Universal Health Services, Inc., through its subsidiaries, owns and operates acute care hospitals, behavioral health centers, surgical hospitals, ambulatory surgery centers, and radiation oncology centers. The company's hospitals provide various services, including general and specialty surgery, internal medicine, obstetrics, emergency room care, radiology, oncology, diagnostic care, coronary care, pediatric services, pharmacy services, and/or behavioral health services. As of February 25, 2016, it owned and/or operated 24 inpatient acute care hospitals, 3 free-standing emergency departments, and 213 inpatient and 16 outpatient behavioral health care facilities located in 37 states, Washington, D.C.; the United Kingdom; Puerto Rico; and the U.S. Virgin Islands. Universal Health Services, Inc. was founded in 1978 and is headquartered in King of Prussia, Pennsylvania.
LifePoint Health, Inc.	LPNT	LifePoint Health, Inc., through its subsidiaries, owns and operates community hospitals, regional health systems, physician practices, outpatient centers, and post-acute facilities in the United States. Its hospitals offer a range of medical and surgical services, such as general surgery, internal medicine, obstetrics, emergency room care, radiology, oncology, diagnostic care, coronary care, rehabilitation, and pediatric services, as well as specialized services, including open-heart surgery, skilled nursing, psychiatric care, and neuro-surgery. The company's hospitals also provide various outpatient services comprising same-day surgery, laboratory, X-ray, respiratory therapy, imaging, sports medicine, and lithotripsy. In addition, it owns and operates schools of nursing and other allied health professions. As of December 31, 2015, the company operated 67 hospitals campuses in 21 states. The company was formerly known as LifePoint Hospitals, Inc. and changed its name to LifePoint Health, Inc. in May 2015. LifePoint Health, Inc. was founded in 1997 and is based in Brentwood, Tennessee.
HCA Holdings, Inc.	HCA	HCA Holdings, Inc., through its subsidiaries, provides health care services in the United States. It operates general, acute care hospitals that offer medical and surgical services, including inpatient care, intensive care, cardiac care, diagnostic, and emergency services; and outpatient services, such as outpatient surgery, laboratory, radiology, respiratory therapy, cardiology, and physical therapy services. The company also operates psychiatric hospitals, which provide therapeutic programs comprising child, adolescent and adult psychiatric care, adult and adolescent alcohol and drug abuse treatment, and counseling. In addition, it operates outpatient health care facilities consisting of freestanding ambulatory surgery centers, freestanding emergency care facilities, urgent care facilities, walk-in clinics, diagnostic and imaging centers, rehabilitation and physical therapy centers, radiation and oncology therapy centers, physician practices, and various other facilities. As of December 31, 2015, the company operated 164 general, acute care hospitals with 43,275 licensed beds; 3 psychiatric hospitals with 396 licensed beds; and 1 rehabilitation hospital, as well as 116 freestanding surgery centers. HCA Holdings, Inc. was founded in 1968 and is headquartered in Nashville, Tennessee.
Tenet Healthcare Corp.	THC	Tenet Healthcare Corporation, together with its subsidiaries, primarily operates acute care hospitals and related healthcare facilities. The company operates through three segments: Hospital Operations and Other, Ambulatory Care, and Conifer. Its general hospitals offer acute care services, operating and recovery rooms, radiology services, respiratory therapy services, clinical laboratories, and pharmacies. The company also provides intensive, critical, and coronary care units; physical therapy, orthopedic, oncology, and outpatient services; tertiary care services, including open-heart surgery, neonatal intensive care, and neurosciences; quaternary care services for heart, liver, kidney, and bone marrow transplants; quaternary pediatric and burn services; gamma-knife brain surgery; and cyberknife radiation therapy for tumors and lesions in the brain, lung, neck, and spine. In addition, it offers clinical research programs related to cardiovascular and pulmonary diseases, musculoskeletal disorders, neurological disorders, genitourinary diseases, and various cancers, as well as drug and medical device studies. Further, the company operates freestanding ambulatory surgery and imaging centers, short-stay surgical facilities, and Aspen's hospitals and clinics. Additionally, it offers operational management for patient access, accounts receivable management, health information management, revenue integrity, and patient financial services; communications and engagement solutions; and clinical integration, financial risk management, and population health management services. As of December 31, 2015, the company operated 86 hospitals, 20 short-stay surgical hospitals, and approximately 475 outpatient centers; and 9 private hospitals and clinics, as well as 249 ambulatory surgery, 20 imaging, and 35 urgent care centers in the United Kingdom. Tenet Healthcare Corporation was founded in 1967 and is headquartered in Dallas, Texas.

Source: Capital IQ

Similar Transaction Method Summary

		BEV/ 2015 Revenue	BEV/ 2015 EBITDA
ECHN Financial Metrics (000's)	(1)	313,562	10,846
Selected Market Multiples	(2)	0.2x	4.9x
Indicated Business Enterprise Value - Marketable, Control Basis		$62,712	$53,575
Weighting	(3)	50.0%	50.0%
Preliminary Business Enterprise Value			$58,144
Plus: Joint Venture Interests	(4)		13,187
Plus: Real Estate Joint Venture Interests	(5)		1,760
Business Enterprise Value (Rounded)			**$73,091**

Notes:

(1) See Exhibit C-2, Historical Income Statement - ECHN

(2) See Exhibit E-2, Similar Transaction Multiples - Hospitals.

(3) Most weight was given to the EBITDA indication as this metric is most commonly used by buyers and sellers in the hospital M&A market.
BEV = Business Enterprise Value
EBITDA = Earnings Before Interest, Tax, Depreciation, and Amortization

(4) See Exhibit F-4, Joint Venture Analysis.

(5) See Exhibit F-3, Real Property - Summary of Fair Market Values.

Similar Transaction Multiples - Hospitals

	Number	Median Revenue	Median EBITDA	Median EBITDA Margin	Median Revenue Multiple	Median EBITDA Multiple
All						
2015	22	$53.6	$0.9	2.4%	0.5x	8.6x
2014 - 2015	41	$77.3	$4.3	5.9%	0.5x	7.2x
2013 - 2015	60	$95.7	$8.2	6.4%	0.5x	7.8x
2012 - 2015	89	$97.2	$7.6	5.9%	0.5x	8.8x
2011 - 2015	138	$105.1	$9.5	6.4%	0.6x	9.1x
Hospitals with EBITDA > 20%	5	$49.5	$15.0	37.2%	0.7x	2.0x
Hospitals with EBITDA > 15% and < 20%	6	$187.7	$30.1	16.2%	0.8x	4.5x
Hospitals with EBITDA > 10% and < 15%	20	$126.4	$17.2	11.7%	0.9x	6.5x
Hospitals with EBITDA > 5% and < 10%	26	$136.3	$9.1	6.4%	0.6x	9.3x
Hospitals with EBITDA > 0% and < 5%	22	$159.6	$1.0	2.3%	0.4x	18.3x
Hospital with EBITDA < 0%	13	$45.9	($2.9)	(4.8%)	0.3x	N/A
Hospitals with Net Revenue > $500 million	10	$1,187.8	$65.3	4.9%	0.8x	17.1x
Hospitals with Net Revenue $400 to $500 million	3	$450.6	$15.4	3.4%	0.6x	10.4x
Hospitals with Net Revenue $300 to $400 million	3	$327.4	$33.0	10.5%	0.2x	4.2x
Hospitals with Net Revenue $200 to $300 million	16	$233.9	$15.8	6.8%	0.6x	9.6x
Hospitals with Net Revenue $100 to $200 million	30	$142.7	$9.1	6.5%	0.6x	9.2x
Hospitals with Net Revenue < $100 million	59	$45.3	$2.8	5.7%	0.5x	7.2x
Low		$3.1	($34.0)	-55.2%	0.0x	0.2x
25th Percentile		$45.9	$1.8	2.1%	0.3x	4.9x
Median		$105.1	$9.5	6.4%	0.6x	9.1x
75th Percentile		$204.7	$17.1	11.6%	0.9x	13.7x
High		$5,846.8	$702.6	38.5%	9.0x	52.7x
(1) **Selected Multiple**					0.2x	4.9x

Notes:

(1) Selection of multiples was based on comparison of ECHN to other transactions based on risk, size and profitability and consideration of unique factors to ECHN including payor mix and utilization statistics.

BEV = Business Enterprise Value

EBITDA = Earnings Before Interest, Tax, Depreciation, and Amortization

Similar Transactions - Hospitals

Date Announced			Target State	Target Status	Transaction Value	Target Revenue	Target EBITDA	Target Beds	Transaction Value[2] / Revenue	Transaction Value[2] / EBITDA	Transaction Value[2] / EBITDA %	Transaction Value[2] / Beds
10/1/2015	Meadville Medical Center	Titusville Area Hospital	Pennsylvania	Nonprofit	8	26.2	(2.5)	72	0.3x	N/A	-9.4%	0.1x
9/30/2015	LCMC Health	West Jefferson Medical Center	Louisiana	Nonprofit	540	243.9	(2.3)	405	2.2x	N/A	-1.0%	1.3x
9/23/2015	Nobilis Health Corp.	Freedom Pain Hospital	Arizona	For-profit	3	10.2	0.2	12	0.3x	14.8x	2.1%	0.3x
8/12/2015	Sympaticare LLC	Summit Park Hospital	New York	Nonprofit	12	73.7	(4.8)	74	0.2x	N/A	-6.5%	0.2x
8/3/2015	Regional Health Network	Clark Memorial Hospital	Indiana	Nonprofit	80	144.0	9.5	241	0.6x	8.4x	6.6%	0.3x
8/1/2015	Banner Health	Payson Regional Medical Center	Arizona	For-profit	25	51.4	19.8	39	0.5x	1.3x	38.5%	0.6x
7/30/2015	Carter Validus Mission Critical REIT II	Warm Spring Specialty Hospital of Luling	Texas	For-profit	10	16.2	0.9	34	0.6x	10.5x	5.7%	0.3x
7/24/2015	Carter Validus Mission Critical REIT II	The Surgical Institute of Reading	Pennsylvania	For-profit	25	24.4	5.8	15	1.0x	4.3x	23.8%	1.7x
6/24/2015	Larkin Community Hospital	Hollywood Pavilion Hospital	Florida	Nonprofit	25	5.5	(0.1)	50	4.5x	N/A	-1.1%	0.5x
6/8/2015	Adventist Health	Lodi Health	California	Nonprofit	100	168.1	4.0	182	0.6x	24.7x	2.4%	0.5x
6/5/2015	St. Mary's Health Care System	Ty Cobb Regional Medical Center	Georgia	Nonprofit	13	27.9	(6.7)	56	0.5x	N/A	-24.1%	0.2x
5/15/2015	LifePoint Health	Watertown Regional Medical Center	Wisconsin	Nonprofit	100	97.4	11.3	95	1.0x	8.8x	11.6%	1.1x
5/11/2015	Nobilis Health Corp.	Victory Healthcare Plano Hospital	Texas	For-profit	13	N/A	N/A	25	N/A	N/A	N/A	0.5x
4/20/2015	Nobilis Health Corp.	Victory Medical Center Houston	Texas	For-profit	4	49.5	18.4	25	0.1x	0.2x	37.2%	0.2x
4/15/2015	Spectrum Health	Pennock Health Services	Michigan	Nonprofit	56	61.4	8.8	88	0.9x	6.4x	14.3%	0.6x
4/6/2015	Ventas, Inc.	Ardent Health Services	Tennessee	For-profit	1,750	2,000.0	N/A	2,045	0.9x	N/A	N/A	0.9x
3/27/2015	LifeBridge Health	Carroll Hospital Center	Maryland	Nonprofit	250	220.3	25.8	193	1.1x	9.7x	11.7%	1.3x
3/18/2015	Benefis Health System	Teton Medical Center	Montana	Nonprofit	1	6.3	(0.2)	10	0.1x	N/A	-3.8%	0.1x
3/2/2015	Prime Healthcare Services	Mercy Suburban Hospital	Pennsylvania	Nonprofit	30	105.9	(34.0)	N/A	0.3x	N/A	-32.1%	N/A
1/16/2015	Griffin-American Healthcare REIT III	Southlake Hospital	Texas	For-profit	128	N/A	N/A	70	N/A	N/A	N/A	1.8x
1/9/2015	TriHealth	McCullough-Hyde Memorial Hospital	Ohio	Nonprofit	17	55.8	4.3	60	0.3x	3.9x	7.8%	0.3x
1/8/2015	Conemaugh Health System	Nason Hospital	Pennsylvania	Nonprofit	12	30.7	0.6	44	0.4x	19.5x	2.0%	0.3x
12/23/2014	Florida Hospital Tampa	Bert Fish Medical Center	Florida	Nonprofit	40	95.5	5.6	112	0.4x	7.2x	5.9%	0.4x
12/16/2014	Center Management Group, LLC	Runnells Specialized Hospital	New Jersey	Nonprofit	26	24.8	N/A	44	1.0x	N/A	N/A	0.6x
12/4/2014	Nueterra and MU Health	Callaway Community Hospital	Missouri	For-profit	6	16.3	0.3	36	0.4x	17.3x	2.1%	0.2x
11/20/2014	Prime Healthcare Services	Saint Joseph Mercy Port Huron	Michigan	Nonprofit	20	81.0	8.3	164	0.2x	2.4x	10.2%	0.1x
11/6/2014	UW Health	SwedishAmerican Health System	Illinois	Nonprofit	255	460.3	40.2	357	0.6x	6.3x	8.7%	0.7x
10/31/2014	HCA	Citrus Memorial Hospital	Florida	Nonprofit	195	179.6	5.7	198	1.1x	34.3x	3.2%	1.0x
10/20/2014	Prime Healthcare Services	Monroe Hospital	Indiana	Nonprofit	2	41.9	(23.1)	132	0.0x	N/A	-55.2%	0.0x
10/6/2014	University of Virginia Medical Center	Culpeper Regional Hospital	Virginia	For-profit	50	69.3	4.0	70	0.7x	12.6x	5.7%	0.7x
9/9/2014	RCHP/Billings Clinic joint venture	Community Medical Center	Montana	Nonprofit	75	161.5	14.4	151	0.5x	5.2x	8.9%	0.5x
8/21/2014	Duke LifePoint Healthcare	Conemaugh Health System	Pennsylvania	Nonprofit	500	516.0	N/A	600	1.0x	N/A	N/A	0.8x
8/1/2014	Duke LifePoint Healthcare	MedWest Haywood	North Carolina	Nonprofit	36	105.5	4.0	138	0.3x	9.1x	3.7%	0.3x
7/1/2014	CNL Healthcare Properties, Inc.	Houston Orthopedic & Spine Hospital campus	Texas	For-profit	76	N/A	N/A	64	N/A	N/A	N/A	1.2x
6/26/2014	Banner Health	UA Health Network	Arizona	Nonprofit	446	1,613.6	97.2	1,339	0.3x	4.6x	6.0%	0.3x
5/29/2014	Prospect Medical Holdings, Inc.	East Orange General Hospital	New Jersey	Nonprofit	84	N/A	N/A	212	N/A	N/A	N/A	0.4x
5/12/2014	South Nassau Communities Hospital	Long Beach Medical Center	New York	Nonprofit	12	N/A	N/A	162	N/A	N/A	N/A	0.1x
3/24/2014	Carter Validus Mission Critical REIT II	Cypress Pointe Surgical Hospital	Louisiana	For-profit	25	30.2	3.5	30	0.8x	7.1x	11.7%	0.8x
2/28/2014	Via Christi Health	Mercy Regional Health Center	Kansas	Nonprofit	7	92.3	12.9	111	0.1x	0.5x	13.9%	0.1x
2/17/2014	Buyer Consortium	Chindex International, Inc.	Maryland	For-profit	461	170.0	15.8	N/A	2.7x	29.3x	9.3%	N/A
1/8/2014	Duke LifePoint Healthcare, LLC	Wilson Medical Center	North Carolina	Nonprofit	96	141.4	25.1	274	0.7x	3.8x	17.8%	0.4x
10/31/2013	Duke LifePoint Healthcare, LLC	WestCare	North Carolina	Non-profit	43.0	96.0	N/A	110	0.4x	N/A	N/A	0.4x
10/25/2013	Rush University Medical Center	Oak Park Hospital	Illinois	Non-profit	21.1	107.5	2.3	237	0.2x	9.2x	2.1%	0.1x
10/22/2013	Sabra Health Care REIT, Inc.	Forest Park Medical Center	Texas	For-profit	119.8	13.3	N/A	54	9.0x	N/A	N/A	2.2x
8/14/2013	Medical Properties Trust, Inc.	3 IASIS Healthcare hospitals	Louisiana	For-profit	283.3	N/A	N/A	670	N/A	N/A	N/A	0.4x
8/6/2013	LifePoint Hospitals, Inc.	Portage Health	Michigan	Non-profit	40.0	82.5	9.1	96	0.5x	4.4x	11.0%	0.4x
7/30/2013	Community Health Systems, Inc.	Health Management Associates, Inc.	Florida	For-profit	7,600.0	5,846.8	702.6	11,000	1.3x	10.8x	12.0%	0.7x
7/18/2013	HCA West Florida	3 IASIS Healthcare Hospitals	Tennessee	For-profit	146.0	231.3	15.8	691	0.6x	9.2x	6.8%	0.2x
7/18/2013	Physicians Realty Trust	El Paso Surgical Center and MOB	Oklahoma	For-profit	40.0	28.1	N/A	40	1.4x	N/A	N/A	1.0x
7/18/2013	HCA West Florida	3 IASIS Healthcare Hospitals	Tennessee	For-profit	146.0	231.3	15.8	691	0.6x	9.2x	6.8%	0.2x
7/18/2013	Physicians Realty Trust	El Paso Surgical Center and MOB	Oklahoma	For-profit	40.0	28.1	N/A	40	1.4x	N/A	N/A	1.0x
7/16/2013	University of Southern California	Verdugo Hills Hospital	California	Non-profit	30.0	92.4	8.6	158	0.3x	3.5x	9.3%	0.2x
7/11/2013	Carolinas HealthCare System	Stanly Health Services	North Carolina	Non-profit	70.0	105.1	14.1	119	0.7x	5.0x	13.4%	0.6x
7/1/2013	Carter Validus Mission Critical REIT	Physicians Specialty Hospital	Arkansas	For-profit	22.6	94.8	1.5	20	0.2x	15.1x	1.6%	1.1x
6/23/2013	UPMC Health System	Altoona Regional Health System	Pennsylvania	Non-Profit	10.0	372.7	61.0	402	0.0x	0.2x	16.4%	0.0x
4/19/2013	Catholic Health Initiatives	St. Luke's Episcopal Health System	Texas	Non-Profit	1,000.0	1,275.7	26.5	1,098	0.8x	37.7x	2.1%	0.9x
3/28/2013	Prime Healthcare Services	Two Kansas Hospitals	Kansas	Non-Profit	54.3	184.8	(8.8)	232	0.3x	N/A	-4.8%	0.2x
3/8/2013	Carolinas HealthCare System	Cleveland County HealthCare System	North Carolina	Non-Profit	101.0	222.3	24.8	504	0.5x	4.1x	11.1%	0.2x
2/21/2013	Tenet Healthcare Corporation	Emanuel Medical Center	California	Non-Profit	5.0	211.2	12.8	354	0.0x	0.4x	6.1%	0.0x
1/2/2013	Prime Healthcare Foundation	Knapp Medical Center	Texas	Non-Profit	110.0	128.6	8.2	209	0.9x	13.5x	6.4%	0.5x
12/13/2012	Montefiore Medical Center	New York Westchester Square Medical Center	New York	Non-Profit	14.0	75.7	(2.4)	140	0.2x	N/A	-3.1%	0.1x
12/10/2012	Licking Memorial Health Systems	Medical Center of Newark	Ohio	Non-Profit	26.0	18.2	(0.2)	20	1.4x	N/A	-0.9%	1.3x

Similar Transactions - Hospitals

Date Announced			Target State	Target Status	Transaction Value	Target Revenue	Target EBITDA	Target Beds	Transaction Value[2] / Revenue	Transaction Value[2] / EBITDA	Transaction Value[2] / EBITDA %	Transaction Value[2] / Beds
12/5/2012	University General Health System, Inc.	South Hampton Community Hospital	Texas	For-Profit	30.0	40.0	15.0	111	0.8x	2.0x	37.5%	0.3x
11/29/2012	Prime Healthcare Services	St. Mary's Hospital	New Jersey	Non-Profit	25.0	166.4	1.3	279	0.2x	19.2x	0.8%	0.1x
11/15/2012	Medical Facilities Corporation	Arkansas Surgical Hospital	Arkansas	For-Profit	36.2	51.4	13.4	51	0.7x	2.7x	26.0%	0.7x
11/14/2012	KentuckyOne Health	University of Louisville Hospital	Kentucky	Non-Profit	543.5	450.6	10.9	345	1.2x	49.8x	2.4%	1.6x
11/9/2012	UNC Health Care System	Caldwell Memorial Hospital	North Carolina	Non-Profit	39.0	N/A	N/A	110	N/A	N/A	N/A	0.4x
11/5/2012	Wise Regional Health System	North Texas Community Hospital	Texas	Non-Profit	20.0	N/A	N/A	21	N/A	N/A	N/A	1.0x
10/25/2012	Health Management Associates, Inc.	Bayfront Medical Center	Florida	Non-Profit	162.0	257.7	13.7	397	0.6x	11.8x	5.3%	0.4x
10/19/2012	HighMark, Inc.	St. Vincent's Health System	Pennsylvania	Non-Profit	65.0	327.4	15.3	400	0.2x	4.2x	4.7%	0.2x
10/10/2012	Atlantic Health System	Chilton Hospital	New Jersey	Non-Profit	43.0	166.9	(2.9)	260	0.3x	N/A	-1.7%	0.2x
8/27/2012	Queen's Health Systems	Hawaii Medical Center - West Campus	Hawaii	Non-Profit	70.0	N/A	N/A	102	N/A	N/A	N/A	0.7x
7/2/2012	Cardiovascular Care Group	Bakersfield Heart Hospital	California	For-Profit	38.1	N/A	N/A	47	N/A	N/A	N/A	0.8x
7/1/2012	Temple University Health System	Fox Chase Cancer Center	Pennsylvania	Non-Profit	83.8	236.6	36.5	100	0.4x	2.3x	15.4%	0.8x
6/12/2012	Highmark, Inc.	Jefferson Regional Medical Center	Pennsylvania	Non-Profit	275.0	204.7	22.6	376	1.3x	12.2x	11.0%	0.7x
6/1/2012	Lawrence & Memorial Hospital	Westerly Hospital	Rhode Island	Non-Profit	69.0	90.6	5.8	101	0.8x	12.0x	6.4%	0.7x
5/3/2012	McLaren Health Care	Cheboygan Memorial Hospital	Michigan	Non-Profit	5.0	45.9	(7.4)	91	0.1x	N/A	-16.1%	0.1x
5/1/2012	MultiCare Health System	Auburn Regional Medical Center	Washington	For-Profit	98.0	135.2	17.0	159	0.7x	5.8x	12.6%	0.6x
4/4/2012	Steward Health Care System	New England Sinai Hospital	Massachusetts	For-Profit	37.0	74.3	N/A	212	0.5x	N/A	N/A	0.2x
4/3/2012	Sacred Heart Health System, Inc.	Bay Medical Center	Florida	Non-Profit	154.0	258.4	9.5	323	0.6x	16.2x	3.7%	0.5x
3/27/2012	Hudson Hospital Holdco, Inc.	Christ Hospital	New Jersey	Non-Profit	43.5	125.1	1.4	227	0.3x	31.1x	1.1%	0.2x
3/20/2012	Cape Fear Valley Health System	Bladen County Hospital	North Carolina	Non-Profit	0.0	18.3	N/A	25	0.0x	N/A	N/A	0.0x
3/9/2012	Tift Regional Medical Center	Memorial Hospital and Convalescent Center	Georgia	For-Profit	8.3	N/A	N/A	155	N/A	N/A	N/A	0.1x
3/6/2012	Duke LifePoint Healthcare, LLC	Marquette General Health System	Michigan	Non-Profit	147.0	244.2	15.6	307	0.6x	9.4x	6.4%	0.5x
3/1/2012	Mayo Clinic Health System	Satilla Health Services	Georgia	Non-Profit	51.0	152.8	4.2	231	0.3x	12.1x	2.7%	0.2x
2/28/2012	Huntsville Hospital	Decatur General Hospital	Alabama	For-Profit	25.0	113.5	5.9	242	0.2x	4.2x	5.2%	0.1x
2/8/2012	Cookeville Regional Medical Center	Cumberland River Hospital	Tennessee	For-Profit	6.8	11.1	N/A	36	0.6x	N/A	N/A	0.2x
2/3/2012	Health Management Associates, Inc.	Integris Health joint venture	Oklahoma	Non-Profit	60.0	96.5	1.8	226	0.6x	34.2x	1.8%	0.3x
1/24/2012	Community Health Systems, Inc.	Memorial Health Systems	Pennsylvania	Non-Profit	45.0	97.0	7.1	100	0.5x	6.3x	7.3%	0.5x
12/19/2011	Huntsville Hospital	Parkway Medical Center	Alabama	For-Profit	37.8	45.3	N/A	109	0.8x	N/A	N/A	0.3x
12/15/2011	Cone Health	Alamance Regional Medical Center	North Carolina	Non-Profit	200.0	213.9	23.6	218	0.9x	8.5x	11.0%	0.9x
12/12/2011	Community Health Systems, Inc.	MetroSouth Medical Center	Illinois	For-Profit	70.5	151.6	N/A	244	0.5x	N/A	N/A	0.3x
12/7/2011	Essentia Health	Virginia Regional Medical Center	Minnesota	Non-Profit	27.0	50.7	N/A	164	0.5x	N/A	N/A	0.2x
11/30/2011	Prime Healthcare Services	Harlingen Medical Center	North Carolina	For-Profit	9.0	N/A	N/A	112	N/A	N/A	N/A	0.1x
11/29/2011	Orlando Health	Health Central	Florida	For-Profit	177.0	131.0	15.5	177	1.4x	11.4x	11.8%	1.0x
11/29/2011	UC Health	The Drake Center	Ohio	For-Profit	15.0	57.5	N/A	166	0.3x	N/A	N/A	0.1x
11/1/2011	Baptist Health System	Leake Memorial Hospital	Mississippi	Non-Profit	2.8	11.7	N/A	25	0.2x	N/A	N/A	0.1x
10/27/2011	Duke LifePoint Healthcare, LLC	Twin County Regional Hospital	Virginia	Non-Profit	30.0	44.0	N/A	86	0.7x	N/A	N/A	0.3x
10/20/2011	New Directions Health Systems, LLC	Cleveland Regional Medical Center	Texas	For-Profit	0.9	57.3	N/A	107	0.0x	N/A	N/A	0.0x
10/3/2011	Cardiovascular Care Group	Louisiana Medical Center and Heart Hospital, LLC	Louisiana	For-Profit	23.0	50.4	N/A	137	0.5x	N/A	N/A	0.2x
9/29/2011	LHP Hospital Group, Inc.	Bay Medical Center	Florida	Non-Profit	155.0	258.4	9.5	323	0.6x	16.3x	3.7%	0.5x
9/6/2011	Trinity Health	Mercy Hospital & Medical Center	Illinois	Non-Profit	150.0	251.4	15.3	449	0.6x	9.8x	6.1%	0.3x
9/1/2011	Mercy	Logan Medical Center	Oklahoma	Non-Profit	7.2	22.3	1.0	25	0.3x	7.2x	4.5%	0.3x
8/26/2011	Kingman Regional Medical Center	Hualapai Mountain Medical Center	Arizona	For-Profit	42.0	N/A	N/A	70	N/A	N/A	N/A	0.6x
7/28/2011	Community Health Systems, Inc.	Tomball Regional Medical Center	Texas	Non-Profit	225.4	151.0	17.6	358	1.5x	12.8x	11.7%	0.6x
7/25/2011	Duke LifePoint Healthcare, LLC	Maria Parham Medical Center	North Carolina	For-Profit	57.9	97.8	11.9	102	0.6x	4.9x	12.2%	0.6x
7/19/2011	Community Health Systems, Inc.	Moses Taylor Health Care System	Pennsylvania	Non-Profit	172.4	148.8	9.5	242	1.2x	18.1x	6.4%	0.7x
7/1/2011	Health Management Associates, Inc.	Mercy Health Partners, Inc.	Tennessee	Non-Profit	532.4	600.0	22.8	833	0.9x	23.4x	3.8%	0.6x
6/28/2011	Ardent Health Services	Southcrest Hospital, Claremore Regional	Oklahoma	For-Profit	154.2	187.7	30.1	269	0.8x	5.1x	16.0%	0.6x
6/28/2011	Steward Health Care System	Quincy Medical Center	Massachusetts	Non-Profit	79.0	78.1	1.5	196	1.0x	52.7x	1.9%	0.4x
6/28/2011	Ardent Health Services	Southcrest Hospital, Claremore Regional	Oklahoma	For-Profit	154.2	187.7	30.1	269	0.8x	5.1x	16.0%	0.6x
6/25/2011	Highmark, Inc.	West Penn Allegheny Health System	Pennsylvania	Non-Profit	1,475.0	1,600.0	33.3	2,000	0.9x	44.3x	2.1%	0.7x
6/22/2011	Capella Healthcare	Cannon County Hospital, LLC	Tennessee	For-Profit	27.7	N/A	N/A	112	N/A	N/A	N/A	0.2x
6/15/2011	HCA, Inc.	Remaining interest in HealthONE	Colorado	For-Profit	1,450.0	N/A	193.0	1,500	N/A	7.5x	N/A	1.0x
6/7/2011	Steward Health Care System	Landmark Medical Center	Rhode Island	Non-Profit	76.6	N/A	N/A	203	N/A	N/A	N/A	0.4x
6/3/2011	Duke LifePoint Healthcare, LLC	Person Memorial Hospital	North Carolina	For-Profit	22.7	41.6	2.1	102	0.5x	10.8x	5.0%	0.2x
5/25/2011	University of Maryland Medical System	Civista Health System	Maryland	Non-Profit	16.5	103.8	N/A	130	0.2x	N/A	N/A	0.1x
5/18/2011	LifeCare Holdings, Inc.	Five long-term acute care hospitals	Alabama	For-Profit	117.5	121.7	17.5	355	1.0x	6.7x	14.4%	0.3x
5/13/2011	South Georgia Medical Center	Smith Northview Hospital	Georgia	For-Profit	40.0	50.2	2.8	45	0.8x	14.3x	5.6%	0.9x
5/10/2011	Franciscan Services Corp.	Twin City Hospital	Ohio	Non-Profit	4.9	15.5	N/A	25	0.3x	N/A	N/A	0.2x
5/9/2011	Ardent Health Services	Heart Hospital of New Mexico	New Mexico	For-Profit	119.0	80.8	15.4	55	1.5x	7.7x	19.1%	2.2x
5/9/2011	AR-MED, LLC	Arkansas Heart Hospital	Arkansas	For-Profit	65.0	117.5	17.4	112	0.6x	3.7x	14.8%	0.6x
4/27/2011	Ascension Health	Alexian Brothers Health System	Illinois	Non-Profit	645.0	952.6	101.9	752	0.7x	6.3x	10.7%	0.9x
4/25/2011	HUMC Holdco, LLC	Hoboken University Medical Center	New Jersey	Non-Profit	91.7	115.3	N/A	230	0.8x	N/A	N/A	0.4x
4/20/2011	Health Management Associates, Inc.	Tri-Lakes Medical Center	Mississippi	For-Profit	38.8	30.3	N/A	112	1.3x	N/A	N/A	0.3x

Similar Transactions - Hospitals

Date Announced			Target State	Target Status	Transaction Value	Target Revenue	Target EBITDA	Target Beds	Transaction Value[2] / Revenue	Transaction Value[2] / EBITDA	Transaction Value[2] / EBITDA %	Transaction Value[2] / Beds
4/18/2011	Adventist Health	Sierra Kings District Hospital	California	Non-Profit	24.8	22.1	N/A	44	1.1x	N/A	N/A	0.6x
4/1/2011	One Cura Wellness, Inc.	Two Oklahoma hospitals	Oklahoma	For-Profit	12.0	12.8	N/A	50	0.9x	N/A	N/A	0.2x
3/31/2011	Steward Health Care System	Morton Hospital and Medical Center	Massachusetts	Non-Profit	178.5	127.3	8.6	153	1.4x	20.8x	6.8%	1.2x
3/31/2011	Sabra Health Care REIT	Texas Regional Medical Center	Texas	For-Profit	62.7	N/A	N/A	70	N/A	N/A	N/A	0.9x
3/25/2011	Yale-New Haven Hospital	Hospital of Saint Raphael	Connecticut	Non-Profit	160.0	450.3	15.4	511	0.4x	10.4x	3.4%	0.3x
3/22/2011	LHP Hospital Group, Inc.	St. Mary's Hospital	Connecticut	Non-Profit	200.0	201.4	17.1	175	1.0x	11.7x	8.5%	1.1x
3/18/2011	Iasis Healthcare, LLC	St. Joseph Medical Center	Texas	Non-Profit	156.8	245.0	N/A	792	0.6x	N/A	N/A	0.2x
3/11/2011	Carle Foundation Hospital	Hoopeston Regional Health Center	Illinois	For-Profit	12.4	20.4	1.4	25	0.6x	8.9x	6.9%	0.5x
3/7/2011	Trinity Health	Loyola University Health System	Illinois	Non-Profit	475.0	1,100.0	N/A	820	0.4x	N/A	N/A	0.6x
2/16/2011	Vanguard Health Systems, Inc.	Valley Baptist Health System	Texas	Non-Profit	201.4	527.0	N/A	866	0.4x	N/A	N/A	0.2x
2/10/2011	Community Health Systems, Inc.	Mercy Health Partners	Pennsylvania	Non-Profit	161.0	183.9	N/A	313	0.9x	N/A	N/A	0.5x
2/1/2011	UPMC Health System	Hamot Medical Center	Pennsylvania	Non-Profit	300.0	315.2	33.0	351	1.0x	9.1x	10.5%	0.9x
1/17/2011	Sisters of Mercy Health System	Johnston Memorial Hospital	Oklahoma	For-Profit	1.6	3.1	N/A	25	0.5x	N/A	N/A	0.1x

Source: Irving Levin Associates Transaction Database

State of Connecticut, Office of Attorney General
Fair Market Value of
Eastern Connecticut Health Network, Inc.
Valuation Analysis as of March 31, 2016
(Actual Dollars)

Exhibit F-1

NAVIGANT

FINAL

Asset-Based Approach - Summary

Supplemental Asset-Based Approach (1)	Notes	FMV
Net Asset Components:		
Personal Property	(2)	$23,600,000
Real Property	(3)	42,170,000
Real Property Joint Ventures Interests	(3)	1,760,000
Joint Ventures Interests	(4)	13,187,000
Net Working Capital	(5)	21,130,000
FMV of ECHN Business Enterprise, Value-in-Place	(6)	**$101,847,000**

Notes:

(1) Navigant performed a supplemental asset-based valuation analysis to further support our overall assessment that PMH was not paying less than fair market value for ECHN's assets.

(2) Based on Navigant analysis. See Exhibit F-2, Personal Property - Summary of Fair Market Values.

(3) Based on Navigant analysis. See Exhibit F-3, Real Property - Summary of Fair Market Values.

(4) See Exhibit F-4, Joint Venture Analysis.

(5) Net working capital adjustment is based on the projected balance of net working capital as of the latest Net Proceeds Analysis provided by Management.

(6) Based on Navigant's analysis, it was determined that any intangible asset value would be negligible given the financial condition of the Health System.

Personal Property - Summary of Fair Market Values

USD $ (Actuals)	Asset Category	Historical Cost	Net Book Value	Fair Market Value (Rounded)
	Manchester Memorial Hospital			
	Capital Leases	$14,732,808	$6,971,978	$5,888,000
	Computer Equipment	8,332,096	894,420	548,000
	Computer Software	8,950,752	536,358	1,077,000
	Furniture & Fixtures	11,782,571	1,556,382	2,637,000
	Lab Equipment	3,329,207	416,725	821,000
	Leasehold Improvements	1,256,314	846,610	562,000
	Medical Equipment	37,856,537	8,452,940	9,061,000
	Vehicles	215,832	21,969	63,000
	Machinery & Equipment	651,598	600,690	419,000
	Manchester Memorial Hospital Total	**$87,107,716**	**$20,298,072**	**$21,076,000**
	Rockville General Hospital			
	Computer Equipment	$2,443,805	$230,745	$148,000
	Computer Software	3,281,066	238,980	364,000
	Furniture & Fixtures	3,567,218	374,846	740,000
	Lab Equipment	1,356,464	200,025	318,000
	Leasehold Improvements	949,902	712,771	485,000
	Medical Equipment	19,472,825	2,559,354	4,000,000
	Vehicles	103,543	1,680	21,000
	Machinery & Equipment	58,701	1,760	3,000
	Rockville General Hospital Total	**$31,233,523**	**$4,320,161**	**$6,079,000**
	South Windsor Primary Care			
	Computer Equipment	$384,836	$78,493	$41,000
	Computer Software	930,764	110,901	170,000
	Furniture & Fixtures	706,475	311,200	230,000
	Lab Equipment	16,801	1,654	3,000
	Leasehold Improvements	1,161,706	674,023	483,000
	Medical Equipment	983,827	433,094	359,000
	South Windsor Primary Care Total	**$4,184,409**	**$1,609,365**	**$1,286,000**
	Other			
	Woodlake at Tolland	$2,178,099	$638,657	$512,000
	Enterprise	13,500	-	4,000
	Other Total	**$13,500**	**$ -**	**$516,000**
	Construction In Progress	$1,495,545	$1,495,545	**$1,500,000**
Personal Property Total		**$124,034,693**	**$27,723,142**	**$30,457,000**
Personal Property Total		**$124,000,000**	**$27,700,000**	**$30,500,000**
Capital Lease Liability (As of December 31, 2015)				(6,840,359)
Personal Property Total (Excluding Capital Lease Liability (As of December 31, 2015))				**$23,600,000**

State of Connecticut, Office of Attorney General **Exhibit F-3**
Fair Market Value of
Eastern Connecticut Health Network, Inc.
Valuation Analysis as of March 31, 2016
(Actual Dollars)

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Real Property - Summary of Fair Market Values

PROPERTY BY PROPERTY SUMMARY OF VALUE CONCLUSIONS

Wholly Owned

Address	City	Property Type	Size	Cost Approach (1) Land, Site and Bldg	Market Approach (2) Low	Market Approach (2) High	Fair Market Value
71-80 Haynes Street (MMH)	Manchester	Hospital and parking	527,224	$ 20,600,000	$15,800,000	$27,400,000	$ 20,600,000
31 Union St (RGH)	Vernon	Hospital	177,348	$ 3,800,000	$ 1,600,000	$ 5,300,000	$ 3,800,000
460 Hartford Turnpike	Vernon	Medical/Dialysis/Sterlizing	36,000	$ 3,700,000	$ 3,600,000	$ 4,500,000	$ 3,700,000
26 Shenipsit Lake Road (WA	Tolland	Elder Care	65,721	$ 8,100,000	$ 7,600,000	$ 9,900,000	$ 8,100,000
Total of Major Properties							$ 36,200,000
Additional MMH properties (3)					Basic Price		
18 Haynes Street	Manchester	Office Building/Commercial	6,061		$ 770,000		
26 Haynes Street	Manchester	Office Building/Commercial	4,256		$ 500,000		
36 Haynes Street	Manchester	Office Building/Commercial	7,068		$ 780,000		
44 Haynes Street	Manchester	Office Building/Commercial	1,523		$ 160,000		
310-312 Main Street	Manchester	Office Building/Commercial	3,954		$ 320,000		
320 Main Street	Manchester	Office Building/Commercial	10,640		$ 770,000		
353 Main Street	Manchester	Office Building/Commercial	5,348		$ 700,000		
150 North Main Street	Manchester	Medical Office Building	20,656		$ 1,890,000		
945 Main St (2 condos)	Manchester	Office Building/Condos	2,330		$ 180,000		
319 Broad Street	Manchester	Thrift/retail store	6,236		$ 620,000		
W Middle Tpke; Russell;	Manchester	12 SFR residential properties	15,233		$ 1,320,000		
Hemlock; Hawthorne; Alton	Manchester	5 Vacant Residential parcels	11.57 acres total		$ 440,000		
56 Haynes Street	Manchester	Vacant commecial parcel	0.31 acres		$ 40,000		
Additional RGH properties (3)							
Ward, Village and W Main	Vernon	Vacant parcels	1.37 acres		$ 410,000		
Aggregate retal of non-essential real estate					$ 8,900,000		
Non essential real estate - sold as a portfolio - and sold off over time							
Discounted for sell off over three years					Net Proceeds - non-essential real estate		$ 5,970,000
Total Fair Market Value of Real Estate Assets							**$ 42,170,000**

JV - Partially Owned

Address	City	Property Type	Size	Costs (4)	Ownership	Fair Market Value	Less Debt	FMV Equity
100 Haynes Street	Manchester	Cancer Center Medical Building	30,443	$ 8,813,100	15.0%	$ 1,321,965	$ 943,349	$ 378,616
29 Haynes Street	Manchester	Medical office building	11,241	2,237,900	22.9%	512,479	377,004	135,475
2800 Tamarack Avenue	South Windsor	Medical office building	40,000	5,933,700	20.0%	1,186,740	910,617	276,123
2400 + 2600 Tamarack Aven	South Windsor	Medical office building	52,615	12,966,400	20.0%	2,593,280	1,622,431	970,849
Total Fair Market Value of Real Estate Assets				$ 29,951,100		$ 5,614,464	$ 3,853,401	$ 1,761,063
							Rounded	**$ 1,760,000**

Notes:
(1) See Exhibits G-1, G-2, G-3, G-4 and G-5
(2) See Exhibit G-6, G-7 and G-8
(3) See Exhibit G-9 and G-10
(4) See Exhibit G-11, G-12 and G-13.

Joint Venture Analysis

Company Name (1), (2)	Business Description	% Ownership	ECHN Net Income 2014	ECHN Net Income 2015	ECHN EBITDA 2014	ECHN EBITDA 2015	Multiple (3)	Indicated BEV
Metro Wheelchair Service, Inc.	Ambulance	50.0%	($54,225)	$4,180	($54,462)	$4,180	5.0x	$20,900
Aetna Ambulance Service, Inc.	Ambulance	50.0%	188,996	(80,067)	495,936	128,329	5.0x	641,643
Ambulance Service of Manchester, LLC	Ambulance	50.0%	1,026,411	1,341,175	1,355,963	1,637,379	5.0x	8,186,893
WBC Connecticut East, LLC	Behavioral Health Center	16.0%	(1,455)	21,473	10,366	29,840	5.0x	149,198
Evergreen Endoscopy Center, Inc.	Endoscopy Surgery Center	50.0%	491,891	204,933	565,547	271,273	5.0x	1,356,363
Tolland Imaging Center, LLC	Imaging Center	70.0%	179,810	291,458	238,046	322,674	4.5x	1,452,033
Northeast Regional Radiation Oncology Network, Inc.	Cancer Center	50.0%	381,743	(26,016)	506,689	306,609	4.5x	1,379,741
	Totals:		**$2,213,171**	**$1,757,136**	**$3,118,085**	**$2,700,282**		**$13,186,770**
	Rounded:							**$13,187,000**

Notes:

(1) Data on joint venture interests and profitability were provided by Management. Investments are accounted for under equity method accounting. EBITDA values represent ECHN's share of EBITDA in affiliates as of 9/30/2015.

(2) Joint ventures represented are exclusive of ECHN's real estate joint ventures, summarized in Exhibit F-3.

(3) Selection of multiples based on consideration of guideline company and comparable transaction data in each JV's respective industry, according to data from the Irving Levin Transaction Database and Capital IQ. Multiples adjusted based on differences in risk, diversification, and marketability.

Land Sales - Commercial land

SUMMARY OF COMPARABLE VACANT LAND SALES

No.	Date	Address	Parcel ID	Land (Acres)	Land (SF)	Price	Price/Acre	Price/SF	Zoning	Proposed Use
L-1	6/30/2013	200 Deming St South Windsor	SWIN-002760-000200	4.62	201,247	$2,000,000	$432,900	$9.94	AA30	Senior Apts
L-2	12/19/2012	444 Center St Manchester	MANC-000102-000000-000444	1.89	82,328	$410,000	$216,931	$4.98	B2	Commercial
L-3	8/6/2014	594 Tolland Tpke Manchester	MANC-000549-000000-000594	6.00	261,360	$450,000	$75,000	$1.72	RR	MultiFamily
L-4	5/15/2015	41 Courtney Dr Ellington	ELLI-002012-000004	2.05	89,298	$120,000	$58,537	$1.34	Industrial	Commercial
L-5	Listing	77-113 Spencer St Manchester	MANC-000519-000000-000089	7.00	304,920	$1,750,000	$250,000	$5.74	GC	Commercial
L-6	Pending	797 John Fitch Blvd South Windsor	SWIN-004770-000797	2.35	102,366	$495,000	$210,638	$4.84	GC	Commercial
L-7	Listing	40-48 Merrow Rd Tolland	TOLL-000022M-000000-000102	14.00	609,840	$2,900,000	$207,143	$4.76	GDD	Commercial

Subject	71 Haynes Street	MANC-000279-00000-000071	12.54	546,242
Major properties	80 Haynes Street	MANC-000279-00000-000080	2.86	124,582
	31 Union Street	146 23-0105-00001	7.95	346,302
	460 Hartford Turnpike	VERN-000019-000016-0000018	3.29	143,312
	26 Shenipsit Lake Road		6.39	278,348

L-1: A recent sale of commercial land purchased for medical office development, rural area but near freeway access.
L-2: Across Highway 36, existing property has 135,000 sf building to be demolished at the buyer's expense included in the purchare price.
L-3: Within a residential area, wooded, elongated, proposed multi-family development, on the market 1,372 days
L-4: Inferior flag lot, indicates the lower end of the range in the market.
L-5: Listed by Drubner Commercial for 1,370 days. Site is close to general commercial.
L-6: Level wooded lot, about 2 acres developable, on US Route 5, commuter route.
L-7: 26 acres gross, 14 acres net, near a four-way interchange New EnglandThroughway. Good visibility from I-84 and Rt. 195. (12 acres swamp area)

Land Sales Adjustment - MMH and RGH Hospitals, WAT

MAJOR PROPERTIES - LAND SALES ADJUSTMENT GRID

DESCRIPTION	Subject	Comparable L-1	Comparable L-2	Comparable L-3	Comparable L-4	Comparable L-5	Comparable L-6	Comparable L-
LOCATION:	71 Haynes St Manchester, CT	200 Deming St South Windsor	444 Center St Manchester	594 Tolland Tpke Manchester	41 Courtney Dr Ellington	77-113 Spencer St Manchester	797 John Fitch Blvd South Windsor	40-48 Merrow Rd Tolland
LAND AREA - ACRES	12.54	4.62	1.89	6.00	2.05	7.00	2.35	14.00
	1,684,465	201,247	82,328	261,360	89,298	304,920	102,366	609,840
SHAPE/TOPOGRAPH	Level / Irregular	Level / Irregular	Level / Rectangular	Level / Rectangular	Level / Rectangular	Level / Rectangular	Level / Rectangula	evel / Rectangula
ZONING:		AA30	B2	RR	Industrial	GC	GC	GDD
SOURCE:	Assessor	CoStar	CoStar	CoStar	CoStar	CoStar	CoStar	CoStar
DATE OF SALE:		Jun-2013	Dec-2012	Aug-2014	May-2015	Listing	Pending	Listing
SALE PRICE:		$2,000,000	$410,000	$450,000	$120,000	$1,750,000	$495,000	$2,900,000
PRICE PER ACRE:		$432,900	$216,931	$75,000	$58,537	$250,000	$210,638	$207,143
ADJUSTMENTS:								
UNIT SALE PRICE:		$432,900	$216,931	$75,000	$58,537	$250,000	$210,638	$207,143
PROPERTY RIGHTS CONVEYED:		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
ADJUSTED UNIT SALE PRICE:		$432,900	$216,931	$75,000	$58,537	$250,000	$210,638	$207,143
FINANCIAL CONSIDERATIONS:		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
ADJUSTED UNIT SALE PRICE:		$432,900	$216,931	$75,000	$58,537	$250,000	$210,638	$207,143
CONDITIONS OF SALE:		0.00%	0.00%	0.00%	0.00%	-20.00%	0.00%	-20.00%
ADJUSTED UNIT SALE PRICE:		$432,900	$216,931	$75,000	$58,537	$200,000	$210,638	$165,714
MARKET CONDITIONS:		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
TIME ADJUSTED UNIT SALE PRICE:		$432,900	$216,931	$75,000	$58,537	$200,000	$210,638	$165,714
PHYSICAL ADJUSTMENTS:								
LOCATION:		-40.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
SIZE:		-20.00%	-30.00%	0.00%	-30.00%	0.00%	-30.00%	0.00%
SHAPE/TOPOGRAPHY:		0.00%	0.00%	50.00%	50.00%	0.00%	0.00%	0.00%
CORNER:		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
ZONING/PROPOSED USE:		0.00%	0.00%	0.00%	25.00%	0.00%	0.00%	0.00%
TOTAL PHYSICAL ADJUSTMENTS:		-60.00%	-30.00%	50.00%	45.00%	0.00%	-30.00%	0.00%
ADJUSTED UNIT PRICE		$173,160	$151,852	$112,500	$84,878	$200,000	$147,447	$165,714

RANGE OF VALUE PER ACRE and AVERAGE	$84,878	to	$200,000	$147,936	
RANGE OF VALUE PER ACRE and AVERAGE - excluding extremes	$112,500	to	$173,160	$150,135	

INDICATED PRICE PER ACRE	Acres	Price per Acre			
71 and 80 Haynes St	15.40	$120,000	$1,848,000	Rounded:	$1,800,000
31 Union Street	7.95	$150,000	$1,192,500	Rounded:	$1,200,000
460 Hartford Turnpik	3.29	$150,000	$493,500	Rounded:	$500,000
26 Shenipsit Lake Rc	6.39	$120,000	$766,800	Rounded:	$800,000

Notes:

Conditions of Sale: The listings are adjusted downward to probably contract closing price. Typically we see a 20% discount off of the listing price.

Location: L-1 is considered a superior commercial location and adjusted downward. No other location adjustments were considered necessary.

Size: L-1, L-2, L-4 and L-6 are smaller sites. We see a diminution is price per acre for larger size parcels, due to diminishing marginal return. Smaller site typically see an increasing price per acre as each acre is more critical. These smaller site sales are adjusted downward.

Shape and Topograph: L-5 is a flag lot, reflecting inferior frontage and visibility; while L-4 is a elongated parcel. Both require upwards adjustments for inferior configurations.

Zoning: Most of the zoning and proposed uses are considered comparable with no quantitative distinction in this market. However, L-5 is an industrial use, requiring an upward adjustment.

Conclusion: The adjusted sales, excluding the extremes, indicate a range from commercial land in the immediate area to be generally $110,000 per acre to $180,000 per acre. The MMH and RGH sites would be expected to fall to the mid range; however, MMH is a very large site, requiring a lower price per acre to account for the larger size. The Woodlake at Tolland site is more rural and would fall to the lower end of the range.

Building Improvements - MMH and RGH Hospitals, WAT

MAJOR PROPERTIES - SUMMARY OF BUILDING IMPROVEMENT COSTS

Manchester Memorial Hospital						Multipliers			Depreciation					Depreciated
Cost/Unit	Hard Cost	Extras	Soft Costs	Profit	Adj. Cost	Current	Local	Adj. Cost	Economic Life (Yrs)	Effective Age (Yrs)	RUL (Yrs)	Depr (%)	Depr ($)	Replacement Cost
General Hospital - Main		527,224 SF												
$244.01	$128,649,879	$1,078,358	$15,567,388	$0	$145,295,625	1.01	1.21	$177,565,783	45	25	20	56%	$98,647,657	$78,920,000
Basement		62,763 SF												
$112.57	$7,065,231	$0	$847,828	$0	$7,913,059	1.03	1.21	$9,862,045	45	25	20	56%	$5,478,914	$4,380,000
Parking Garage		196,004 SF												
$51.75	$10,143,207	$0	$1,217,185	$0	$11,360,392	1.03	1.21	$14,158,456	40	35	5	88%	$12,388,649	$1,770,000
														$85,070,000
										Less				
											Needed Repairs			-$4,945,000
											Functional Obsolescence		30.00%	-$25,521,000
											External Obsolescence		43.00%	-$36,580,100
											Total Depreciated Replacement Costs			**$18,023,900**
Rockville General Hospital														
General Hospital - Main		149,419 SF												
$257.49	$38,474,436	$727,226	$4,704,200	$0	$43,905,862	1.01	1.21	$53,657,354	45	28	17	62%	$33,386,798	$20,270,000
Maxwell - Mansion -office		27,929 SF												
$96.70	$2,700,683	$0	$324,082	$0	$3,024,765	1.01	1.22	$3,727,115	40	35	5	88%	$3,261,226	$470,000
														$20,740,000
										Less:	Needed Repairs			-$3,324,000
											Functional Obsolescence		30.00%	-$6,222,000
											External Obsolescence		43.00%	-$8,918,200
											Total Depreciated Replacement Costs			**$2,275,800**
460 Hartford Turnpike														
MOB, Dialysis		18,000 SF												
$137.61	$2,476,980	$0	$297,238	$0	$2,774,218	1.01	1.22	$3,418,391	35	16	19	46%	$1,562,693	$1,860,000
MOB - Basement level		18,000 SF												
$88.94	$1,600,920	$0	$192,110	$0	$1,793,030	1.01	1.22	$2,209,372	35	16	19	46%	$1,009,999	$1,200,000
											Total Depreciated Replacement Costs			**$3,060,000**
Woodlake at Tolland														
Skilled Nursing		65,721 SF												
$139.62	$9,175,966	$0	$1,101,116	$0	$10,277,082	1.03	1.23	$13,020,035	40	15	25	38%	$4,882,513	$8,140,000
										Less:	Needed Repairs			-$1,111,000
											Total Depreciated Replacement Costs			**$7,029,000**
											For MMH, RGH, WAT and 460			
											Total Depreciated Building Improvements			$30,388,700

Building Improvements - MMH and RGH Hospitals, WAT

MAJOR PROPERTIES - SUMMARY OF BUILDING IMPROVEMENT COSTS - Continued

Footnotes:

Building size, excludes porches and canopies.

MMH - Hospital - Hard Cost per Unit is from *Marshall Valuation Service* February 2016 edition, Section 15, pg 24. MMH -Class B Average; Section 14, pg 34 - Parking Structure - Class C Average. The base cost of $275.10 per square foot is adjusted by perimeter multiplier of .887. Extras account for porches, canopies and non-finished area accounting for the difference between the gross building area and the living area and basement, 17,677 square feet. The Cost per square foot is based on 1/4 of the base costs for living area.

RGH - Hospital - Hard Cost per Unit is from *Marshall Valuation Service* February 2016 edition, Section 15, pg 24. -Class B Average ($275.10 per square foot); and the wood frame original mansion is used for offices, Section 15, pg 17 - Class D Average ($103,31 per square foot). This is adjusted by a perimeter multiplier of 0.936. The Extras account for porches, canopies and non-finished area accounting for the difference between the gross building area and the living area, 11,297 square feet. The Cost per square foot is based on 1/4 of the base costs for living

460 Hartford - Hard Cost per Unit is from *Marshall Valuation Service* February 2016 edition, Section 15, pg 22. -Class C Average for ground floor, and Finished Basement costs for lower level housing sterilizing operation.

WAT - Hard Cost per Unit is from *Marshall Valuation Service* February 2016 edition, Section 15, pg 26. -Class C Average

Soft costs at 12% and profit is not considered realizable in this market.

Multipliers from *MVS*, Section 99, p.745 for Current and p.749 Hartford, CT - the closest metro area.

Economic life from *MVS*, Section 97, pgs 10 & 13, and effective age is based on inspection, discussions with client, and overall age of the improvements in light of past maintenance and upgrades.

Current conditions indicate the hospital improvements are over 50% depreciated from brand new construction. However, other elements influence the various forms of depreciation. Functional obsolescence is considered in light of the current facility configuration and how it meets the demands of the marketplace. There are curable and incurable functional obsolescence. Curable functional obsolescence can be estimated based upon a schedule of immediate repairs to upgrade to desired function. he required upgrade to address identified function obsolescence is based on Facility Assessment by CharterCARE. The functional obsolescence is also based upon the change in the marketplace to command single occupancy/private rooms. The cost to cure the functional obsolescence and convert to adequate single rooms at MMH is $51 million. It must re recognized that in applying the cost to cure for functional obsolescence, this would mitigate the physical depreciation influence, as the repairing of the facility would extend the useful life to some extent. Therefore, the offsetting consequences of an improved physical plant is recognized, reducing the functional obsolescence to half the cost to cure or 30% of physically depreciated cost. External obsolescence is applied in the cost approach to recognize the deficient in the utilization of the assets based upon outside external and economic forces that are impacting the value of these real estate assets. We can quantify this diminution by comparing the anticipated occupancy levels of the licensed beds with the recent actual occupancy levels of the licensed beds. The difference in actual occupancy of 34.5% versus standard occupancy of 60% indicates an external obsolescence of 43%

State of Connecticut, Office of Attorney General **Exhibit G-4**
Fair Market Value of
Eastern Connecticut Health Network, Inc.
Valuation Analysis as of March 31, 2016
(Actual Dollars)

NAVIGANT
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Site Improvements - MMH and RGH Hospitals, WAT

										Depreciation					Depreciated
Manchester Memorial Hospital							Multipliers			Economic	Effective	RUL	Physical	Physical	Replacement
Item	Units	Cost/Unit	Hard Cost	Costs	Profit	Adj. Cost	Current	Local	Adj. Cost	Life (Yrs)	(Yrs)	(Yrs)	%	($)	Cost
Landscaping	54,624	$2.96	$161,688	$19,403	$0	$181,093	1.01	1.23	$224,972	20	5	15	25%	$56,243	$170,000
Surface Parking	536	$1,251	$670,670	$80,480	$0	$752,402	1.01	1.23	$934,709	8	4	4	50%	$467,354	$470,000
Canopies, retaining walls, curbs and sidewalks															$100,000
															$740,000
Rockville General Hospital															
Landscaping	34,630	$2.96	$102,505	$12,301	$0	$114,809	1.03	1.23	$145,452	20	10	10	50%	$72,726	$70,000
Parking	166	$1,251	$207,708	$24,925	$0	$233,884	1.03	1.23	$296,307	8	4	4	50%	$148,154	$150,000
Canopies, retaining walls, curbs and sidewalks															$100,000
															$320,000
460 Hartford															
Landscaping	14,331	$2.96	$42,420	$5,090	$0	$47,514	1.03	1.23	$60,195	20	10	10	50%	$30,098	$30,000
Parking	50	$1,251	$62,563	$7,508	$0	$71,321	1.03	1.23	$90,357	8	4	4	50%	$45,178	$50,000
Canopies, retaining walls, curbs and sidewalks															$100,000
															$180,000
Woodlake and Tolland															
Landscaping	27,835	$2.96	$82,391	$9,887	$0	$92,281	1.03	1.23	$116,911	20	10	10	50%	$58,455	$60,000
Parking	120	$1,251	$150,150	$18,018	$0	$169,419	1.03	1.23	$214,637	8	4	4	50%	$107,319	$110,000
Canopies, retaining walls, curbs and sidewalks															$100,000
															$270,000

MMH, RGH, 460 and WAT
Total Depreciated Site Improvements (rounded) $1,330,000

Footnotes:
Hard Cost per Unit is from *MVS*, February 2016 edition, Section 66, pg. 3; multipliers from Site Improvements section.
Parking based on per space cost and spaces from Google Earth, Landscaping based on cost per sq. ft. applied to an estimated 1/10 of the site area.
Soft costs @ 12% and profit @ 0%
Economic life from *MVS*, Section 97, pgs 18-19 and effective age is based on discussions with client, and capital improvements.

Cost Approach Summary - MMH and RGH Hospitals, WAT

MAJOR PROPERTIES - SUMMARY OF COST VALUATION CONCLUSIONS

Address	City	Property Type	Size	Land Value (1)	Site Imps (2)	Bldg Imps (3)	Fair Market Value
71-80 Haynes Street (MMH)	Manchester	Hospital	527,224	$ 1,800,000	$ 740,000	$ 18,023,900	$ 20,563,900
						Rounded	$ 20,600,000
31 Union St (RGH)	Vernon	Hospital	177,348	$ 1,200,000	$ 320,000	$ 2,275,800	$ 3,795,800
						Rounded	$ 3,800,000
460 Hartford Turnpike	Vernon	Medical/Dialysis/Sterilizi	36,000	$ 500,000	$ 180,000	$ 3,060,000	$ 3,740,000
						Rounded	$ 3,700,000
26 Shenipsit Lake Road (WAT)	Tolland	Elder Care/ Skilled Nurs	65,721	$ 800,000	$ 270,000	$ 7,029,000	$ 8,099,000
						Rounded	$ 8,100,000

State of Connecticut, Office of Attorney General **Exhibit G-6**
Fair Market Value of
Eastern Connecticut Health Network, Inc.
Valuation Analysis as of March 31, 2016
(Actual Dollars)

NAVIGANT
FINAL

Improved Hospital Sales - Occupied - Hospital

SUMMARY OF OCCUPIED HOSPITAL

No.	Sale Date	Address	City	State	Year Built	Size (SF)	Licensed Bed	Land Acres	Sale Price	$/SF	Per lic Bed	Uses
1	1/27/2016	2701 Dekalb Pike	Norristown	PA	1993	372,820	131	4.15	$ 11,000,000	$ 30	$ 83,969	Requires a $30 million upgrade
2	8/28/2014	116 Eddie Dowling Hwy	North Smithfield	RI	1970	92,944	82	4.30	10,056,200	$ 108	$122,637	Rehabilitation Hospital of Rhode Island to Carter Validus Mission
3	8/14/2013	156 West Ave	Brockport	NY	1970	279,140	191	18.90	2,500,000	$ 9	$ 13,089	Lakeside Hospital has gone out of business for financial reasons
4	1/1/2016	1135 Carthage St	Sanford	NC	1981	176,528	137	17.53	14,500,000	$ 82	$105,839	Central Carolina Hospital
5	12/24/2013	115 Cass Ave	Woonsocket	RI	1925	220,182	214	13.95	14,099,430	$ 64	$ 65,885	Court appointed sale of hospital
6	1/3/2013	800 Washington St	Norwood	MA	1920	147,121	292	9.33	2,169,595	$ 15	$ 7,430	Norwood Hospital
	MMH					527,224	283	15.40				
	RGH					177,348	118	7.95				
		Range of Operational Hospitals							Low	$ 9	$ 7,430	
									Median	$ 51	$ 66,475	
									High	$ 108	$122,637	

The sales noted above are from a search of sales of occupied or recently occupied hospital property with purchase prices reported on real estate only. These sales reflect a similar highest and best use. The MMH facilities is one of the largest hospital facilities, larger than the comparables sales. Due to economies of scale and diminishing marginal returns, the per square foot price would be expected to be reduced by that impact and reside on the lower end of the range. The largest properties above show a cost per square foot of $9, $30 and $64. RGH represents a more typical size for a hospital facility; however the mansion area of the building area is not considered to have significant value due to it age and deteriorating condition. Overall, the configuration and location of this facility reduce the marketability. The blended rate per square foot for the modern hospital and mansion building would be at the lowest end of the range.

The concluded cost approach for MMH, at $20 million indicates $39 per square foot, $73,000 per licensed be and $120,000 per staffed bed. For RGH the cost approach conclusion of $3.8 million indicates just over $21 per square foot, $32,000 per licensed bed and $81,000 per staffed bed. Due to the larger size of MMH, while the price per square foot is at the lower end the price per bed is over the median for the sales above. RGH is at the lower end for both price per square foot and price per licensed bed, but is supported by the lower sales.

Indicated Values		Indicated Range		Low/ High
MMH	527,224	Low:	$30	$15,800,000
		High:	$52	$27,400,000
RGH	177,348	Low:	$9	$1,600,000
		High:	$30	$5,300,000

Improved Nursing Facilities Sales - WAT

SUMMARY OF SKILLED NURSING SALES

No.	Sale Date	Address	City	State	Year Built	Size (SF)	Beds	Land Acres	Sale Price	$/SF	$/Bed	Uses
1	7/1/2015	7 Loring Hills Ave	Salem	MA	1993	52,444	123	2.00	$ 10,080,000	$ 192	$ 81,951	Grosvener Park Nursing home
2	5/21/2014	2041 NC 210 N	Lillington	NC	1992	35,878	105	4.00	8,208,293	229	78,174	Green Leaf Care Center, Skilled Nursing
3	9/9/2013	111 Huntoon Memorial Hwy	Rochdale	MA	1994	57,195	179	4.38	5,856,375	102	32,717	Rehab/Skilled Nursing, Kindred to Wellflower
4	12/29/2014	3015 W 29th St	Brooklyn	NY	1992	174,788	360	1.43	32,000,000	183	88,889	Seagate Rehab and Nursing Center
5	5/24/2013	45 N Scott St	Carbondale	PA	1995	32,700	81	3.79	5,600,000	171	69,136	Osprey Ridge Rehab and Skilled Nursing
6	11/25/2013	20 N Woodbury Turnersville F	Blackwood	NJ	1996	226,000	450	25.00	37,070,000	164	82,378	Skilled and Psychiatric/Auction by Marcus & Millichap
6	Listing	46 Maple Street	Kent	CT	1993	60,000	90	11.50	6,000,000	100	66,667	The Kent skilled nursing facility
7	3/18/2015	90 West St	Wilmington	MA	1993	58,574	142	15.64	4,500,000	77	31,690	Woodbriar of Wilmington, Rehab, Skilled Nursing

Range of Skilled Nursing Facilities		$/SF	$/Bed
	Low	$ 77	$ 31,690
	Average	$ 152	$ 66,450
	High	$ 229	$ 88,889

The sales noted above are from a search of sales of occupied, established skilled nursing property. These sales are reported to represent only transactions of real estate. Personal property and business value are not included. Considering the attributes of each and those of the subject property, it is reasonable to conclude a range of value within the lower mid range, the quadrant below the average.

Indicated Values	Built	Size (SF)	Beds	Indicated Range	$/SF	$/Bed	
Woodlake at Tolland	1992	65,721	130	Low	$ 115	$ 50,000	$ 7,600,000
				High	$ 150	$ 66,000	$ 9,900,000

State of Connecticut, Office of Attorney General **Exhibit G-8**
Fair Market Value of
Eastern Connecticut Health Network, Inc.
Valuation Analysis as of March 31, 2016
(Actual Dollars)

NAVIGANT
FINAL

Improved MOB Sales - Dialysis buildings

SUMMARY OF DIALYSIS and MOB SALES

No.	Sale Date	Address	City	State	Year Built	Size (SF)	Land Acres	Sale Price	$/SF	Uses
1	3/25/2014	4802 Broadway	Gary	IN	1992	13,540	0.30	$ 2,550,000	$188.33	Dialysis
2	12/19/2013	109 Overland Dr	Greenwood	SC	1998	12,069	2.01	2,470,000	204.66	Dialysis
3	11/7/2014	3310 Dustin Rd	Oregon	OH	1994	8,400	2.31	1,998,000	237.86	Dialysis
4	9/8/2014	6757 Main St	Cass City	MI	1999	7,822	1.20	1,237,425	158.20	Dialysis
5	1/21/2016	175 Dwight Rd	Longmeadow	MA	1989	28,715	1.83	4,045,000	140.87	Office
6	5/19/2015	999 Silver Ln	Trumbull	CT	2002	27,980	2.03	4,534,750	162.07	MOB
7	12/27/2012	1075 Tolland Tpke	Manchester	CT	1965	9,753	1.11	700,000	71.77	MOB

Similar MOB dialysis centers with DaVita

Low	$ 71.77
Average	$166.25
High	$237.86

The subject property at 460 Hartford Turnpike, Vernon includes a DaVita Dialysis center on the top ground floor; and in addition, the lower portion of the building is operating a sterilization plant. The lower floor is more service commercial oriented, below street grade with no street frontage. In determining a FMV for the whole, a blended rate of medical and service uses is considered appropriate. Therefore the lower half of the range would be appropriate as an indication of fair market value

Indicated Values

Indicated Range

			SF			
460 Hartford Turnpike	Vernon	Renov 1999	36,000	Low	$100	$3,600,000
				High	$125	$4,500,000

Minor Properties - Assessor's Values/Recent Purchases

MINOR PROPERTIES - SUMMARY OF VALUATION CONCLUSIONS

Address	City	Property Type	Size	Assessors FMV	Per SF	Recent Appraisal	Date	Recent Purchase	Date	Indicated Value
										Rounded
18 Haynes Street	Manchester	Office Building/Commercial	6,061	$ 767,500	$ 127	$ 725,000	2012			$ 770,000
26 Haynes Street	Manchester	Office Building/Commercial	4,256	$ 498,300	$ 117					$ 500,000
36 Haynes Street	Manchester	Office Building/Commercial	7,068	$ 762,800	$ 108			$ 775,000	2013	$ 780,000
44 Haynes Street	Manchester	Office Building/Commercial	1,523	$ 162,000	$ 106			$ 220,000	2006	$ 160,000
310-312 Main Street	Manchester	Office Building/Commercial	3,954	$ 316,000	$ 80			$ 299,990	2005	$ 320,000
320 Main Street	Manchester	Office Building/Commercial	10,640	$ 767,200	$ 72					$ 770,000
353 Main Street	Manchester	Office Building/Commercial	5,348	$ 719,500	$ 135			$ 695,000	2014	$ 700,000
150 North Main Street	Manchester	Medical Office Building	20,656	$ 1,890,900	$ 92			$ 982,500	2005	$ 1,890,000
945 Main St (2 condos)	Manchester	Office Building/Condos	2,330	$ 179,429	$ 77	$ 174,000	2015			$ 180,000
319 Broad Street	Manchester	Thrift/retail store	6,236	$ 617,857	$ 99					$ 620,000
W Middle Tpke; Russell;	Manchester	12 SFR residentials (1)	15,233	$ 1,648,800	$ 108					$ 1,320,000
Hemlock; Hawthorne; Al	Manchester	5 Vacant Residential parcels	1.57 acres total	$ 553,400						$ 440,000
56 Haynes Street	Manchester	Vacant commercial parcel	0.31 acres	$ 43,700						$ 40,000
Ward, Village, W Main	Vernon	8 Vacant Res/comls parcel	1.37 acres	$ 512,680						$ 410,000
Aggregate of minor real estate										$ 8,900,000

There are 37 ancillary residential buildings, vacant residential land and small commercial building. These would likely be considered removed from the function of housing operation of the hospitals. This is a time when hospitals are needing less space, as many functions more away from hospital settings and into ambulatory out-patient facilities. a likely buyer would focus on the larger parcels and sell of the smaller non-related properties. For the purpose of valuing the assets of the ECHN business, there smaller properties should be valued in light of their potential sell off.

Sell off Discounted Cash flow

Year	1	2	3
Gross sales	2,966,667	2,966,667	2,966,667
Less: Cost of Sales (8%)	(237,333)	(237,333)	(237,333)
Net Proceeds	2,729,333	2,729,333	2,729,333
Present value of each period	2,319,933	1,971,943	1,676,152
Total present value:	5,968,029		

Concluded FMV - Net Proceeds from Nonessential Properties Rounded **$ 5,970,000**

Inputs:

Number of properties	37 properties	
Sell off period	3 years	1 per month.
Discount rate	15% Includes profit incentive	

Cost of sales include brokers' commissions and closing costs

Improved MOB Sales - MOB

SUMMARY OF SMALLER MOB SALES

No.	Sale Date	Address	City	State	Year Built	Size (SF)	Land Acres	Sale Price	$/SF	Uses
1	3/4/2016	419 Middle Tpke W	Manchester	CT	1985	2,700	0.32	$ 309,000	$ 114	MOB
2	3/20/2015	450 Woodbridge St	Manchester	CT	1952	2,652	0.32	125,000	47	MOB
3	7/11/2014	431 Main St	Manchester	CT	1952	1,588	0.08	130,000	82	MOB
4	5/9/2014	353 Main St	Manchester	CT	1977	5,348	0.47	695,000	130	MOB
5	6/21/2013	73 W Center St	Manchester	CT	1950	2,200	0.23	215,000	98	MOB
6	4/12/2013	16 Main St	Ellington	CT	1990	3,857	0.92	310,000	80	MOB
7	4/10/2013	36 Haynes St	Manchester	CT	1954	7,068	0.46	775,000	110	MOB
8	12/27/2012	1075 Tolland Tpke	Manchester	CT	1965	9,753	1.11	700,000	72	MOB

Medical office buildings

Low	$ 47
Average	$ 92
High	$ 130

The sales of small medical office building within the immediate area , show a range from $47 to $130 per square foot, with a average of $92 per square foot.

The MOB properties along Haynes Street, 18, 26, 38, 44 Haynes Street, and 353 Main Street would be expected to fall to the upper end of the range $100 to $129 per square foot. 150 main Street is considered a similar quality MOB; however, due to its much larger size, it would be anticipated to command a price in the $90 to $110 price range. The lower quality commercial buildings would fall to the lower end of the range of $70 to $90 per square foot.

These sales provide support for the Assessor's market value estimate for the initial retail price of the small nonessential

Valuation By Cost - JV MOB

JV REAL ESTATE PROPERTIES - SUMMARY OF VALUATION CONCLUSIONS

Address	City	Property Type	Size	Original Costs	Year	Appreciation (1)	Depreciation (2)	JV %	Fair Market Value - RE
									Rounded
100 Haynes Street	Manchester	Cancer Center Medical Building	30,443	$ 8,700,000	2010	16.30%	15.00%	15.0%	$ 1,321,965
29 Haynes Street	Manchester	Medical office building	11,241	$ 2,300,000	2007	19.80%	22.50%	22.9%	$ 512,479
2800 Tamarack Avenue	South Windsor	Medical office building	40,000	$ 5,700,000	2006	29.10%	25.00%	20.0%	$ 1,186,740
2400 + 2600 Tamarack Avenue	South Windsor	Medical office building	52,615	$ 12,800,000	2009-11	16.30%	15.00%	20.0%	$ 2,593,280
									$ 5,614,464

Notes:
(1) MVS has cost appreciate rates for Eastern US in Section 98 page 5.
(2) MVS, Section 97, has Economic life of average Class C medical office as 40 years.

State of Connecticut, Office of Attorney General **Exhibit G-12**
Fair Market Value of
Eastern Connecticut Health Network, Inc.
Valuation Analysis as of March 31, 2016
(Actual Dollars)

NAVIGANT
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Improved Newer MOB Sales - JV

SUMMARY OF LARGE NEWER MEDICAL OFFICE

No.	Sale Date	Address	City	State	Year Built	Size (SF)	Land Acres	Sale Price	$/SF	Uses
1	5/19/2015	999 Silver Ln	Trumbull	CT	2002	27,980	2.03	$ 4,534,750	$ 162	Medical
2	2/4/2013	350 Goose Ln	Guilford	CT	2000	13,200	16.00	2,209,000	167	Medical
3	6/9/2014	5 Pequot Park Rd	Westbrook	CT	2007	24,600	4.48	5,900,000	240	Medical
4	11/14/2013	1660 Route 112	Port Jefferson Station	NY	2010	16,302	3.26	3,150,000	193	Medical and general
5	5/28/2013	31 Roche Brothers Way	Easton	MA	2009	42,000	3.00	12,600,000	300	Medical
6	11/9/2015	101 Industrial Park Rd, 102	Taunton	MA	2012	9,720	6.87	2,565,000	264	Medical and general
7	1/7/2015	3199 W Ridge Rd	Rochester	NY	2007	10,720	1.42	1,350,000	126	Medical and general
8	1/9/2015	333 Aviation Rd	Queensbury	NY	2005	7,428	1.69	1,224,000	165	Medical

Range of New Medical Office	Low	$ 126
	Median	$ 202
	High	$ 300

The sales of more recently built medical office buildings in the Northeast, show a range from $162 to $300 per square foot, with a average of $221 per square foot. The three recent sales in Connecticut are at the lower end of the range. The sales of similar medical office buildings support the cost valuation of the JV medical office buildings at 2400, 2600 and 2800 Tamarack Avenue, as well as 29 Haynes Street.

Indicated Values

Indicated Ranges

				SF	Low	High	Low	High
	29 Haynes Street	Manchester	2007	11,241	$180	$205	$ 2,020,000	$ 2,300,000
	2800 Tamarack Avenue	South Windsor	2006	40,000	$150	$200	$ 6,000,000	$ 8,000,000
2 properties	2400 + 2600 Tamarack Avenu	South Windsor	2008-12	52,615	$220	$260	$11,580,000	$13,680,000

Improved Cancer Center/Radiology Sales - JV

SUMMARY OF NEWER CANCER CENTER/RADIOLOGY BUILDINGS

No.	Sale Date	Address	City	State	Year Built	Size (SF)	Land Acres	Sale Price	$/SF	Uses
1	12/31/2012	5340 Holy Cross Pky	Mishawaka	IN	2009	49,410	7.16	$ 21,740,000	$ 440	Michiana Cancer Center
2	8/27/2014	111 Marys Avenue	Kingston	NY	2004	36,479	grd lse	11,200,000	307	Benedictine Cancer Ctr, tenant: Benedictine Hosp.
3	7/17/2014	400 W 144th Ave	Westminster	CO	2012	45,092	6.23	17,173,448	381	Imaging Center with Radiology and CT/MRI
4	2/26/2015	1924-1934 Alcoa Hwy	Knoxville	TN	2012	100,104		33,660,000	336	Cancer Institute building, MOB adj Hospital
5	4/10/2014	2473 McFarland Rd	Rockford	IL	2002	10,000	1.39	2,576,650	258	MOB, former cancer and chemotherapy center
6	12/31/2012	10700 Charter Dr	Columbia	MD	2002	56,212	4.25	20,600,000	366	Multi-tenants, an MRI suite
7	6/26/2015	9020-9024 5th Ave	Brooklyn	NY	1994	24,829	0.18	7,500,000	302	Multi- tenant, includes MRI suite
8	10/7/2013	1300 W Jefferson St	Franklin	IN	2005	28,317	3.85	5,146,000	182	Multi-tenant, 1/3 CT / MRI suite, low density area

			Excluding extremes
Range of Cancer Centers and imaging	Low	$ 182	$ 258
	Average	322	325
	High	440	381

The sales above range from $182 per square foot to $439 per square foot, but the two extremes are outliers. Excluding the extremes the market is reflecting a range of $258 to $381 per square foot with a average of $325 per square foot. Less weight is given to those with higher ambulatory surgery uses. The sales of similar cancer center or imaging facilities support the cost valuation of 100 Haynes Street.

Indicated Values				Indicated Ranges			
			SF	Low	High	Low	High
100 Haynes Street	Manchester	2009	30,443	$290	$320	$8,800,000	$9,700,000

Naugatuck Valley Project, Inc.



16 Church Street Waterbury, CT 06710 Phone: 203-574-2410 Fax: 203-574-3545
Email: nvp@conversent.net website: naugatuckvalleyproject.org

May 31, 2016

imberly R. Martone
Director of Operations, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS 13 CMN, Hartford, Connecticut 06134

Office of Health Care Access

Dear Ms. Martone,

We are writing as leaders of Greater Waterbury faith communities to ask that you condition your approval of the sale of Waterbury Hospital to Prospect Medical Group: East on the inclusion of a Community Benefits Agreement (CBA) between Prospect and the Waterbury Community.

As faith leaders, we hear stories daily from the people whose health and well-being depends upon access to these benefits. We believe that e uity, fairness and justice demand these benefits be preserved in any future ownership arrangement.

The community benefits that are currently provided to low-income and other individuals in accordance with Waterbury Hospital s status as a non-profit hospital provide vital care and services to members of our congregations and the community at large. They also represent an important bond in the relationship between the hospital and the broader community that has supported and relied on it for many years.

We urge you to ensure that the hospital continues its critical role in the community by offering good jobs, providing affordable care to those in need, contributing to its civic and financial welfare, and maintaining a substantive dialogue with the community about any concerns that may arise. We urge you to issue a ruling that reflects that concern.

Sincerely,

Bishop Lionel French
Pastor, Gospel Tabernacle, Waterbury

The Rev. John Thomason
Pastor, Woodbury United Methodist Church, Woodbury

The Rev. John Cooney
Retired Pastor, St. John the Evangelist, Watertown

Bishop Jose Rosa
Pastor, Casa Del Perdon Church, Waterbury

The Rev. Joe Donnelly
Pastor, Sacred Heart, Southbury

The Rev. Derrill Blue
Pastor, Mt. Olive AME □ion Church, Waterbury

The Rev. Ray Odiorne
Pastor, United Church of Christ

The Rev. Paul D. Sinnott Associate to the Bishop
New England Synod Evangelical Lutheran Church in America

The Rev. Scott Nessel
Pastor, St. James Lutheran, Southbury

The Rev. Fredrick Aniello
Pastor, Our Lady of Mt. Carmel Church, Waterbury

The Rev. James T. Gregory
Pastor, Saint Teresa of Avila Parish, Woodbury

The Rev. Daniel Edwards
Senior Pastor, Macedonia Church of God, Waterbury

The Rev. Bertinia □ee
Pastor, Macedonia Church of God, Waterbury

The Rev. Dories French
Pastor, Gospel Tabernacle Ministries International, Waterbury

The Rev. George □ee
Associate Pastor, Gospel Tabernacle Ministries International, Waterbury

The Rev. Eduardo Garcia
Senior Pastor, Arc of Praise Church, Waterbury

The Rev. Madalyn Garcia
Pastor, Arc of Praise Church, Waterbury

Bishop T.C. Brantley
Restoration Spring Church, Waterbury

Jackie Brantley
Pastor, Restoration Spring Church, Waterbury

The Rev. Willie Days
Associate Pastor, Gospel Tabernacle Ministeries International, Waterbury

The Rev. Gloria Rivera
Pastor, Return to Pentecost Church, Waterbury

Greer, Leslie

From: Lazarus, Steven
Sent: Thursday, June 09, 2016 11:09 AM
To: Michele Volpe (mmv@bvmlaw.com); Matthews, Rebecca (RMatthews@wiggin.com) (RMatthews@wiggin.com); magsten@wiggin.com; jonathan.spees@prospectmedical.com; dmcconville@echn.org
Cc: Hawes, Gary W.; Hansted, Kevin; Martone, Kim; Greer, Leslie; Cotto, Carmen; Riggott, Kaila; Olejarz, Barbara
Subject: ECHN/PMH, Docket Numbers: 15-486-01 and 15-32016-486
Attachments: ECHN & PMH Close of Record.pdf

Please see the attached correspondence from the Office of Health Care Access (DPH) and the Office of the Attorney General, closing the record in the above referenced matter. If you have any questions, please do not hesitate to contact Gary Hawes or myself directly.

Sincerely,

Steve

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

STATE OF CONNECTICUT

OFFICE OF THE ATTORNEY GENERAL

DEPARTMENT OF PUBLIC HEALTH

GEORGE JEPSEN
ATTORNEY GENERAL

RAUL PINO, M.D., M.P.H.
COMMISSIONER

June 9, 2016

VIA ELECTRONIC MAIL

Jonathan Spees
Senior VP, Mergers and Acquisitions
Prospect Medical Holdings, Inc.
10780 Santa Monica Blvd., Suite 400
Los Angeles, CA 90025

Dennis P. McConville
Senior VP and Chief Strategy Officer
Eastern Connecticut Health Network, Inc.
71 Haynes Street
Manchester, CT 06040

Re: OHCA Docket No. 15-32016-486 and OAG Docket No. 15-486-01 – Close of Record

Dear Mr. Spees and Mr. McConville:

The Office of the Attorney General ("OAG") and the Department of Public Health, Office of Health Care Access ("OHCA") hereby close their administrative records for the Application for Asset Purchase of Eastern Connecticut Health Network, Inc. ("ECHN") by Prospect Medical Holdings, Inc. ("PMH") filed under OAG Docket No. 13-486-1 and OHCA Docket No. 15-32016-486. The record includes all Application materials submitted in response to the Application Form, the completeness questions, and the interrogatories issued by the OAG and OHCA. In addition, the record includes all written and oral testimony from the applicants and the written and oral statements of the public.

Should you have any questions regarding these dates, please do not hesitate to contact either Steven W. Lazarus at the Department of Public Health (860-418-7012; Steven.Lazarus@ct.gov) or Assistant Attorney General Gary W. Hawes at the Office of the Attorney General (860-808-5020; gary.hawes@ct.gov).

Very truly yours,

Gary W. Hawes

Gary W. Hawes
Assistant Attorney General

Very truly yours,

Kevin Hansted
Hearing Officer, DPH/OHCA

cc: Steven Lazarus (via electronic mail)
Rebecca A. Matthews (via electronic mail)
Melinda A. Agsten (via electronic mail)
Michele Volpe (via electronic mail)

Greer, Leslie

From: Lazarus, Steven
Sent: Thursday, June 09, 2016 2:41 PM
To: Greer, Leslie
Cc: Martone, Kim; Hansted, Kevin; Cotto, Carmen
Subject: FW: Docket Numbers: 15-32016-486 and 15-486-01- Supplemental Materials
Attachments: Mimecast Large File Send Instructions

Please add to the record.

Thank you,

Steve

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

From: rmatthews@wiggin.com [mailto:rmatthews@wiggin.com]
Sent: Thursday, June 09, 2016 8:08 AM
To: Lazarus, Steven; Hawes, Gary W.
Cc: Kathleen (Kate) G. Gedney-Tommaso (kgg@bvmlaw.com); Joyce A. Tichy Esq. (jtichy@echn.org); Agsten, Melinda A.; Zinn-Rowthorn, Perry A.; Dennis P. McConville (dmcconville@echn.org); Hansted, Kevin; Frank Saidara (frank.saidara@prospectmedical.com); Michele M. Volpe - Bershtein, Volpe & McKeon, PC (mmv@bvmlaw.com); Martone, Kim; Thomas Reardon (Thomas.Reardon@prospectmedical.com); jonathan.spees@prospectmedical.com
Subject: Docket Numbers: 15-32016-486 and 15-486-01- Supplemental Materials

I'm using Mimecast to share large files with you. Please see the attached instructions.

Dear Mr. Hawes and Mr. Lazarus:

In response to requests and comments at recent hearings, Eastern Connecticut Health Network, Inc. ("ECHN") and Prospect Medical Holdings, Inc. ("PMH"), hereby submit the following:

1. Amendment to Quality Commitment Letter. As you may recall, ECHN and PMH entered into a written agreement dated March 28, 2016 relating to continuation and support of ECHN's quality

programs. PMH subsequently signed a similar agreement with the Greater Waterbury Health Network ("GWHN"). Because the agreement with the GWHN provided some additional protections, ECHN requested, and PMH agreed, to amend their agreement to include the same additional protections. The amendment to effectuate this is attached.

2. Updates on CMS Survey Activity at PMH's Southern California Hospital. On June 6, 2016, PMH submitted to CMS its response and credible allegation of compliance to the issues cited following a survey completed April 8, 2016. The response is attached in two (2) separate PDF files. The attached have been reviewed and considered by ECHN's quality team.

Please feel free to contact us with any questions.

-Rebecca

Rebecca A. Matthews
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New Haven, Connecticut 06508-1832
Direct: 203.498.4502 | rmatthews@wiggin.com

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ECHN
Eastern Connecticut Health Network

Eastern Connecticut Health Network
71 Haynes Street
Manchester, CT 06040
860.533.3414
www.echn.org

May 24, 2016

Mitchell Lew, M.D.
President
Prospect Medical Holding, Inc.
10780 Santa Monica Boulevard
Suite 400
Los Angeles, CA 90025

Re: Amendment to Quality Assurance Commitment Side Letter

Dear Dr. Lew:

Reference is made to that certain side letter executed on Mach 28, 2016 by and among Eastern Connecticut Health Network, Inc. (the "Seller") and Prospect Medical Holdings, Inc. on behalf of itself and the Buyer Entities (collectively, the "Buyer"), a copy of which is attached hereto as Exhibit A (the "Side Letter"). Capitalized terms used but not otherwise defined in this amendment to the Side Letter (this "Amendment") shall have the meanings given to such terms in that certain draft Asset Purchase Agreement referenced in the Side Letter.

For good and valuable consideration, including the agreement by each Party to undertake the expenses and effort of obtaining regulatory approvals needed to carry out the Transaction, the Parties hereto hereby agree to amend the Side Letter as follows:

1. A new paragraph 4 is added to the Side Letter immediately following the existing paragraph 3 and before the existing paragraph 4 stating as follows:

> 4. Buyer agrees to provide adequate financial resources to assure that facility issues related to quality and patient safety are addressed timely (such financial resources not to be limited following the Closing to the operating funds of the Buyer Entities).

2. The existing paragraph 4 of the Side Letter shall be renumbered as paragraph 5.

3. Except as modified by the previous paragraphs, the Side Letter shall remain unchanged and in full force and effect.

If this Amendment is acceptable to Buyer, we ask that Buyer please sign and date this Amendment where indicated below. Please return an originally signed and completed copy of this Side Letter to me.

Very truly yours,

SELLER:

EASTERN CONNECTICUT HEALTH NETWORK, INC.

By _____
Name: Peter J. Karl
Title: President & CEO

Acknowledged and agreed.

BUYER:

PROSPECT MEDICAL HOLDINGS, INC.,
ON BEHALF OF ITSELF AND THE BUYER ENTITIES

By: _____
Name: Mitchell Lew
Title: President

SOUTHERN CALIFORNIA HEALTHCARE SYSTEM, INC.

Southern California Hospital at Culver City
3828 Delmas Terrace
Culver City, CA 90232
(310) 836-7000
(310) 202-4141 Fax

Southern California Hospital at Hollywood
6245 Delongpre Avenue
Los Angeles, CA 90028
(323) 462-2271
(323)463-3830 Fax

Southern California Hospital at Van Nuys
14433 Emelita Street
Van Nuys, CA 91401
(818) 787-1511
(818) 530-0519 Fax

VIA FEDERAL EXPRESS

June 6, 2016

Rufus Arther
Branch Manager, Non-Long Term Care
Department of Health and Human Services
Centers for Medicare & Medicaid Services
Survey & Certification Operations
90 7th Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

Re: Southern California Hospital at Hollywood (CCN: 050135)
Medicare Re-Survey 4/8/16 (Health and Life Safety Code)
Credible Allegation of Compliance

Dear Mr. Arther:

Pursuant to the CMS letter, dated May 20, 2016, enclosed please find Southern California Hospital at Hollywood's (the "Hospital") timely submission of its credible allegation of compliance for the above-referenced health and Life Safety Code survey.[1] The Hospital takes great pride in delivering quality health care services to the community and is committed to compliance with the Medicare Conditions of Participation and Life Safety Code requirements. A copy of this letter and the credible allegation of compliance (and evidence binders for the health and life safety survey) has also been sent to the Ventura District Office of the California Department of Public Health.

Thank you for your attention to this matter. Please contact me at 310-836-7000 extension 1010 if you have any questions or concerns.

Sincerely,

Catherine Shitara
Chief Executive Officer

Enclosures: A Tags and Life Safety Responses
cc: California Department of Public Health, Ventura District Office (*via federal express)*

[1] Your office graciously granted an extension to respond by June 7, 2016.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050135	A. BUILDING 01 B. WING _____	R 04/08/2016

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{K 000}	INITIAL COMMENTS CULVER CITY CAMPUS: PAVILION K3 BUILDING: 01 K6 PLAN APPROVAL: 1969 K7 SURVEY UNDER: 2000 EXISTING STRUCTURE TYPE: SIX FLOORS WITH MECHANICAL ROOF (PENTHOUSE) AND BASEMENT, CONSTRUCTION TYPE I, FULLY SPRINKLERED. TOWER K3 BUILDING: 02A K6 PLAN APPROVAL: 1959 K7 SURVEY UNDER: 2000 EXISTING STRUCTURE TYPE: SEVEN FLOORS AND BASEMENT, CONSTRUCTION TYPE I, PARTIALLY SPRINKLERED. SINGLE STORY BUILDING ATTACHED TO TOWER K3 BUILDING: 02B K6 PLAN APPROVAL: 1939 K7 SURVEY UNDER: 2000 EXISTING STRUCTURE TYPE: ONE FLOOR, CONSTRUCTION TYPE V(111)., FULLY SPRINKLERED. Census at Culver City on 4/4/16: 150 HOLLYWOOD K3 BUILDING: 03 K6 PLAN APPROVAL: 1960s K7 SURVEY UNDER: 2000 EXISTING STRUCTURE TYPE: SIX FLOORS WITH MECHANICAL ROOF AND BASEMENT, CONSTRUCTION TYPE I, PARTIALLY SPRINKLERED.	{K 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 6-6-2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{K 000}	Continued From page 1 Census at Hollywood on 4/5/16: 53 VAN NUYS K3 BUILDING: 04 K6 PLAN APPROVAL: 1967 K7 SURVEY UNDER: 2000 EXISTING STRUCTURE TYPE: ONE FLOOR WITH SERVICE BASEMENT, CONSTRUCTION TYPE III(211), FULLY SPRINKLERED. Census at Van Nuys on 4/6/16: 52 CULVER MEDICAL PLAZA - OUTPATIENT SPINE CLINIC K3 BUILDING: 05 K6 PLAN APPROVAL: 1981 K7 SURVEY UNDER: 2000 EXISTING STRUCTURE TYPE: SEVEN FLOORS, CONSTRUCTION TYPE I, NONSPRINKLERED (STANDPIPE HOSE SYSTEM). BROTMAN PHYSICIAN PLAZA - OUTPATIENT IOP CLINIC K3 BUILDING: 06 K6 PLAN APPROVAL: 1964 K7 SURVEY UNDER: 2000 EXISTING STRUCTURE TYPE: EIGHT FLOORS, CONSTRUCTION TYPE I, FULLY SPRINKLERED. The following reflects the findings of the California Department of Public Health, during a Revisit Life Safety Code Survey, using the NFPA 101 2000 Edition of the Life Safety Code for Health Care Facilities and in accordance with 42 CFR 482.41(b)(1) for General Acute Care Hospitals. Representing the California Department of Public	{K 000}		

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{K 000}	Continued From page 2 Health: 29566, HFE I 29665, HFE I	{K 000}		
{K 012}	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the integrity of the building construction. This was evidenced by penetrations in the ceiling. This could result in the faster spread of fire and smoke, increasing the risk of injury to patients, staff, and visitors. This affected the penthouse of the Pavilion. NFPA 101, Life Safety Code, 2000 Edition 19.1.6.2 Health care occupancies shall be limited to the types of building construction shown in Table 19.1.6.2. (See 8.2.1.) 19.1.6.3 All interior walls and partitions in buildings of Type I or Type II construction shall be of noncombustible or limited-combustible materials. 8.2.3.1.1 Floor-ceiling assemblies and walls used as fire barriers, including supporting construction, shall be of a design that has been tested to meet the conditions of acceptance of NFPA 251, Standard Methods of Tests of Fire Endurance of Building Construction and Materials. Fire barriers shall be continuous in accordance with 8.2.2.2. Findings:	{K 012}	K012 NFPA 101 LIFE SAFETY CODE STANDARD Actions Taken: 1. The hard top ceiling of the mechanical room, including the large cutouts in the hard top ceiling above the new air handler and the identified areas away from the new air handler, are in the process of being repaired, with a projected completion of the OSHPD project by 8/30/16. The Hospital is submitting a request for a two (2) month time-limited waiver in order to complete this OSHPD project. The Hospital implemented Interim Life Safety Measures (ILSM) to ensure compliance with Life Safety Code requirements, including: a) fire watch protocols are being performed in the Penthouse every 30 minutes through project completion; b) pre-construction assessments were performed on 2/9/16 to ensure ILSM requirements were met; and c) obtained an infection control permit on 2/9/16 before construction started. 2. Monitoring penetrations is included in the preventive maintenance (PM) program and weekly/quarterly scheduled Environment of Care (EOC) rounds.	6/7/16

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{K 012}	Continued From page 3 During the facility tour with staff from 4/4/16 to 4/8/16, the walls and ceilings were observed. Pavilion Penthouse: 1. At 11:10 a.m., on 4/4/16, the hard top ceiling of the mechanical room was not intact. There were large cutouts in the hard top ceiling above the new air handler as part of an ongoing construction project. There were other areas of the ceiling, away from the new air handler, exhibiting extensive water damage. During an interview at 11:11 a.m., the Project Manager (PM12) stated that the ceiling will be restored after construction is completed and stated that there were no issues with water leaking on the equipment during the rain. At 8:45 a.m., on 4/8/16, water was observed leaking onto a duct detector, through a water damaged penetration in the ceiling, near one of the existing air handlers, after it had rained the day before (See K52).	{K 012}	Compliance and Monitoring: Data on compliance with penetrations is tracked, trended, analyzed and reported monthly at the EOC Committee. Corrective action is taken as necessary. Compliance is reported monthly to the Quality Council and quarterly to the Governing Board. Persons Responsible: Vice President of Facilities Development Director of Facilities	
{K 018}	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6	{K 018}	K018 NFPA 101 LIFE SAFETY CODE STANDARD	

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{K 018}	Continued From page 4 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their corridor doors. This was evidenced by doors that were obstructed from closing and by doors that failed to latch. This affected one of six floors of the Pavilion and one of six floors, and the basement, of the Hollywood Building. This could result in the spread of smoke and fire throughout the facility and the increased risk of injury to patients due to smoke and fire. NFPA 101, Life Safety Code, 2000 Edition. 19.2.2.2.1 Doors complying with 7.2.1 shall be permitted. 7.2.1.8.1 A door normally required to be kept closed shall not be secured in the open position at any time and shall be self-closing or automatic-closing in accordance with 7.2.1.8.2. Findings: During facility tour with staff from 4/4/16 to 4/8/16, the corridor doors were observed. Hollywood	{K 018}		

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{K 018}	Continued From page 5 Basement: 1. At 9:06 a.m., on 4/5/16, the self-closing door to Stairwell 1 failed to latch. 2. At 9:31 a.m., on 4/5/16, the surgical recovery room door failed to latch. 3. At 10:11 a.m., on 4/5/16, the double doors into Radiology failed to latch. 4. At 2:21 p.m., on 4/6/16, the door to the Pre-Op Room was obstructed from closing by a chair. 5. At 2:26 p.m., on 4/6/16, the door to the nurses lounge in the surgery department was obstructed from closing by a wooden wedge. First Floor: 6. At 10:27 a.m., on 4/5/16, the self-closing double doors to the Urgent Care Waiting Room were obstructed from closing by chairs. The north leaf of the double doors was obstructed by a chair again at 4:15 p.m. Pavilion Sixth Floor: 7. At 10:25 a.m., on 4/6/16, the corridor door to the Wing D Nurses Station was obstructed from closing by a trash can.	{K 018}	Findings 1-7 Actions Taken: 1. The self-closing door to Stairwell 1 was repaired and proper latching was validated. 2. The surgical recovery room door was repaired and proper latching was validated. 3. The double doors into Radiology were repaired and proper latching was validated. 4. The identified chair by the door to the Pre-Op Room was removed. OR staff at the time of the survey were reminded not to prop open doors with chairs. 5. The identified wedge by the door to the nurses lounge in the surgical department was removed. 6. The chairs were removed from the self-closing double doors to the Urgent Care Waiting Room. 7. The trashcan was removed on 4/6/16 from the corridor door to the Wing D Nurses Station. Education on not obstructing doors was provided with Wing D staff. 8. The Hospital issued a notice reminding staff to report any issues with positive latching of doors and not to block doors from properly latching. The Facilities Department staff and members of Hospital Leadership made rounds throughout the three hospital campuses to identify and immediately discard any wedges.	5/25/16 5/25/16 5/25/16 4/6/16 4/6/16 4/5/16 6/3/16 6/3/16
{K 047}	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1	{K 047}		

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{K 047}	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1	{K 047}	K047 NFPA 101 LIFE SAFETY CODE STANDARD	

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{K 047}	Continued From page 6	{K 047}		

This STANDARD is not met as evidenced by:
Based on observation and interview, the facility failed to maintain their exit signs. This was evidenced by exit signs with battery-operated emergency illumination that were not equipped with a method to test the battery functionality. This was also evidenced by two exit signs that were dimly illuminated due to worn exit sign covers. This affected two of seven floors of the Tower and the offsite Spine Clinic. This could result in a delay in evacuation, in the event of an emergency.

NFPA 101, Life Safety Code, 2000 Edition.
19.2.10.1 Means of egress shall have signs in accordance with Section 7.10.
Exception: Where the path of egress travel is obvious, signs shall not be required in one-story buildings with an occupant load of fewer than 30 persons.

7.10.1.1 Where Required. Means of egress shall be marked in accordance with Section 7.10 where required in Chapters 11 through 42.

7.10.4 Power Source. Where emergency lighting facilities are required by the applicable provisions of Chapters 11 through 42 for individual occupancies, the signs, other than approved self-luminous signs, shall be illuminated by the emergency lighting facilities. The level of illumination of the signs shall be in accordance with 7.10.6.3 or 7.10.7 for the required emergency lighting duration as specified in 7.9.2.1. However, the level of illumination shall be

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{K 047}	Continued From page 7 permitted to decline to 60 percent at the end of the emergency lighting duration. 7.10.5.1 General. Every sign required by 7.10.1.2 or 7.10.1.4, other than where operations or processes require low lighting levels, shall be suitably illuminated by a reliable light source. Externally and internally illuminated signs shall be legible in both the normal and emergency lighting mode. 7.10.5.2 Continuous Illumination. Every sign required to be illuminated by 7.10.6.3 and 7.10.7 shall be continuously illuminated as required under the provisions of Section 7.8. Exception: Illumination for signs shall be permitted to flash on and off upon activation of the fire alarm system. 7.10.9.1 Inspection. Exit signs shall be visually inspected for operation of the illumination sources at intervals not to exceed 30 days. 7.10.9.2 Testing. Exit signs connected to or provided with a battery-operated emergency illumination source, where required in 7.10.4, shall be tested and maintained in accordance with 7.9.3. 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and test shall be kept by the owner for inspection by the authority	{K 047}		

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{K 047}	Continued From page 8 having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30 day functional test, provided that a visual inspection is performed at 30-day intervals. Findings: During a facility tour with staff from 4/4/16 to 4/8/16, the exit signs were observed. Spine Clinic: 1. At 9:52 a.m., on 4/7/16, the exit sign in the lobby and the exit sign outside the doctors office were equipped with battery-powered emergency operation. There were no test buttons or indicator lights to verify their battery's operation. The clinic was not equipped with a generator or an uninterruptible emergency power source and relied on battery-powered lights and exit signs, in the event of a power outage. During an interview at 9:53 a.m., the Vice President of Business Development (VPBD1) stated that the suite underwent a renovation in February. He stated that the exit signs would be modified right away to allow for battery testing. . Tower Building Seventh Floor: 2. At 10:13 a.m., on 4/7/16, the exit sign on the exterior wall of the seventh floor courtyard was not illuminated. The exit sign was exposed to	{K 047}	Findings 1-4 Actions Taken: 1. The Hospital replaced the exit signs in the lobby and outside the doctor's office in the Spine Clinic with new exit signs that have test buttons to verify their battery's operation. The exit sign's battery and light is monitored through the monthly PM rounds. 2. The Hospital repaired the exit sign on the exterior wall of the 7th Floor courtyard on 4/7/16 by changing the bulb and replacing the glass in a contrasting color. The rust on the exit sign was sanded and the sign repainted. 3. The Hospital replaced the exit sign on the third floor stairwell and validated its illumination.. 4. The Director of Facilities inserviced engineering staff on monitoring illumination of exit signs. 5. Monitoring illumination of exit signs is part of PM program and scheduled EOC rounds. Compliance and Monitoring: Data on compliance with exit signs is tracked, trended, analyzed and reported monthly at the EOC Committee. Corrective action is taken as necessary. Compliance is reported monthly to the Quality Council (until the Quality Council determines monitoring of the building is sufficiently conducted and then reporting will be provided quarterly to the Quality Council) and quarterly to the Governing Board. Persons Responsible: Vice President of Facilities Development Director of Facilities	4/7/16 5/24/16 4/8/16 5/31/16

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{K 047}	Continued From page 9 outdoor elements, was rusted, and the glass of the "EXIT" lettering was opaque. During an interview at 10:14 a.m., the Director of Facilities Services (DFS1) confirmed the finding and stated that they needed a new exit sign. Third Floor: 3. At 10:21 a.m., on 4/7/16, the exit sign of the third floor stairwell was not illuminated. The "EXIT" lettering was foggy and opaque and compromised the illumination from the bulbs. During an interview at 10:28 a.m., the Director of Facilities Services (DFS1) confirmed the finding and stated that they needed a new exit sign.	{K 047}		
{K 048}	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure that the emergency plans for disruption of essential building systems were readily available to all staff. This was evidenced by fire and disaster manuals that were incomplete. This affected the Van Nuys building and could result in a delay in restoration of essential building systems in the event they were interrupted. NFPA 99, Standard for Health Care Facilities, 1999 Edition.	{K 048}	K048 NFPA 101 LIFE SAFETY CODE STANDARD 1. The Disruption of Services portion of the fire/disaster manuals at the nurses stations and in Administration were updated to include the water and gas shut off locations and the emergency telephone numbers of the utility companies. The Director of Facilities and Environment of Health and Safety Manager reviewed all fire/disaster manuals to ensure that they were complete. 2. A review of the manuals is performed annually and presented to the EOC Committee annually for approval. The Environment of Health and Safety Manager is responsible for ensuring that each of the fire/disaster manuals is complete and current.	6/3/16

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{K 048}	Continued From page 10 Chapter 12 Hospital Requirements 12-1 Scope. This chapter addresses safety requirements of hospitals. 12-3.11 Hospitals shall comply with the provisions of Chapter 11 for disaster planning, as appropriate. Chapter 11 Health Care Emergency Preparedness 11-5.3.2 Continuity of Essential Building Systems. When designated by the emergency preparedness management plan to provide continuous service in a disaster or emergency, health care facilities shall establish contingency plans for the continuity of essential building systems, as applicable: (a) Electricity (b) Water (c) Ventilation (d) Fire protection systems (e) Fuel sources (f) Medical gas and vacuum systems (if applicable) (g) Communication systems Findings: During a facility tour with staff from 4/4/16 to 4/8/16, the fire/disaster manuals were reviewed. Van Nuys: 1. At 8:34 a.m., on 4/6/16, the Disruption of Services portion of the fire/disaster manuals at the nurses stations and the administration were incomplete. The water and gas shut off locations and the emergency telephone numbers of the utility companies were not listed on their designated areas in the manuals. The manual	{K 048}	Compliance and Monitoring: Data on compliance is tracked, trended, analyzed and reported annually at the EOC Committee. Corrective action is taken as necessary. Compliance is reported annually to the Quality Council and Governing Board. Persons Responsible: Vice President of Facilities Development Director of Facilities Environment of Health and Safety Manager	

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{K 048}	Continued From page 11 from PBX was requested at 8:35 a.m. but not provided until 9:00 a.m. Only the manual from PBX had the Disruption of Services portion filled out completely. During an interview at 9:01 a.m., the Director of Facilities Services (DFS3) stated that the PBX station did not operate nightly from 11 p.m. to 7 a.m. He stated that the facility would update the rest of the fire/disaster manuals right away.	{K 048}		
{K 050}	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure that staff members were aware of their duties to protect patients in the event of a fire. This was evidenced by the failure to activate fire alarms during daytime drills, by the failure to hold overnight fire drills independent of other shifts, and by staff that were not aware of their responsibilities in the event of a fire. This affected three of three buildings at the Culver City Campus and the Van Nuys Building. This could result in improper staff response in the event of a fire and an increased risk of injury to patients.	{K 050}	K050 NFPA 101 LIFE SAFETY CODE STANDARD	

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{K 050}	Continued From page 12 NFPA 101 Life Safety Code, 2000 Edition 19.7.1.2 Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9 p.m. (2100 hours) and 6 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to exterior of the building. 19.7.1.3 Employees of health care occupancies shall be instructed in life safety procedures and devices. 19.7.2.3 All health care occupancy personnel shall be instructed in the use of and response to fire alarms. In addition, they shall be instructed in the use of the code phrase to ensure transmission of an alarm under the following condition: (1) When the individual who discovers a fire must immediately go to the aid of an endangered person (2)During a malfunction of the building fire alarm system Personnel hearing the code announced shall first activate the building fire alarm using the nearest manual fire alarm box and then shall execute immediately their duties as outlined in the fire safety plan.	{K 050}		

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{K 050}	Continued From page 13 4.7.1 Where Required. Emergency egress and relocation drills conforming to the provisions of this Code shall be conducted as specified by the provisions of Chapters 11 through 42, or by appropriate action of the authority having jurisdiction. Drills shall be designed in cooperation with the local authorities. 4.7.2 Drill Frequency. Emergency egress and relocation drills, where required by Chapters 11 through 42 or the authority having jurisdiction, shall be held with sufficient frequency to familiarize occupants with the drill procedure and to establish conduct of the drill as a matter of routine. Drills shall include suitable procedures to ensure that all persons subject to the drill participate. Findings: During a facility tour with staff from 4/4/16 to 4/8/16, the fire drill records were reviewed and staff were interviewed about fire response procedures. 1. At 11:00 a.m., on 4/8/16, fire alarm system monitoring reports for the first three months (first quarter) of 2016 were provided. At that time, all fire alarm signals would have been received by the monitoring company as a fire trouble (See K51). The report showed that no signals, other than the daily scheduled timer test, were received during the 1/28/16 12:30 p.m. AM shift fire drill and none on 2/25/16 5:00 p.m. The facility failed to activate the fire alarm during testing. Culver City Campus: 2. At 3:30 p.m., on 4/4/16, the fire drill records	{K 050}	Finding 1 Actions Taken: 1. The Hospital repaired the loose wire that affected the ability to transmit the signal. The fire alarm was activated to test that the fire alarm signal was received by the monitoring company. 2. The Hospital checked the other two campuses to ensure that there were no issues with transmitting a signal when the fire alarm was tested. 3. Upon completion of each fire drill, facilities staff contact the monitoring company to ensure they received a signal. This is documented on the fire drill critique sheet.	4/7/16 4/8/16 5/27/16

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{K 050}	Continued From page 14 provided showed that there were no overnight drills conducted during the first quarter (January through March) of 2016 and that drills were not conducted at varying times. The records also showed that the facility used one fire drill to include two staff shifts. Records of the fire drill conducted on 2/26/16 at 9 p.m. was marked as including both the evening (swing) shift and the night shift. Records of the fire drill conducted on 3/7/16 at 8 p.m. was marked as including both the evening shift and the night shift. Records of the fire drill conducted on 3/12/16 at 8 p.m. was marked as including both the evening shift and the night shift. At 11:36 a.m., on 4/5/16, documents provide by the Chief Nursing Officer (CNO) showed the overnight shifts of various staff. Overnight security staff worked from 11:00 p.m. to 7:30 a.m., overnight EVS staff worked from 10:00 p.m. to 6:30 a.m., and overnight nursing staff worked from 7:00 p.m. to 7:00 a.m. These records showed that the facility failed to conduct independent night shift fire drills to include all overnight staff and that all the evening shift drills were conducted between 8 p.m. and 9 p.m. Pavilion: The facility's Fire Response Plan, effective 2/2011 and last reviewed on 3/2016, indicated that staff will implement the steps of R.A.C.E. (Rescue any persons in immediate danger, Activate the fire	{K 050}	Findings 2 – 5 Actions Taken: 1. The Director of Facilities and Hospital Leadership discussed the process for fire drills. Fire Drills are conducted once per quarter to include all three shifts (day, evening and night). The identified practice of two shifts (evening overlapping with the night shift) ceased immediately at the time of survey. 2. Hospital Leadership reviewed the "Life Safety Management Plan," which addresses that fire drills are conducted once per quarter per shift. The policy did not require revisions. The schedule for conducting fire drills was revised to reflect fire drills held on three shifts. 3. The Hospital conducted fire drills on each shift on the three hospital campuses. Documentation of the fire drills is maintained in the Facilities Department. 4. Hospital Leadership and the Director of Facilities discussed the survey findings regarding staff's understanding of the process in the event of a fire. An extensive education program was initiated on all three campuses, including daily rounds by managers on all shifts to query and inservice staff members on the fire response plan and R.A.C.E procedures. Department Managers reeducated staff members on use of the educational card that accompanies their name badge (for ease of access), which visually instructs them of the fire response R.A.C.E. process. In addition, staff are queried about fire management processes with just-in-time training provided during Leadership Rounds and morning huddles.	4/8/16 5/26/16 5/26/16 6/3/16

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{K 050}	Continued From page 15 alarm then dial extension 5555 (PBX), Contain the fire by closing doors, and Extinguish only small fires). The plan emphasized that for "Activation" both tasks of activating the fire alarm and dialing 5555 must be performed either individually or by obtaining assistance from another staff. 3. At 10:22 a.m., on 4/5/16, Mental Health Technician (M.H.Tech1) was asked what she would she do upon discovery of a fire. M.H. Tech 1 stated she would bring the patient in the hallway and get ready to evacuate with her team at the nurses station and she would close doors. She failed to mention that she would notify the building by activating a pull station and dialing 5555. She failed to mention the use of a fire extinguisher if possible. 4. At 4:05 p.m., on 4/5/16, Security Officer (SO1) was asked what would he do upon discovery of fire. SO1 stated he would call his dispatcher and the operator, grab a fire extinguisher, keep everyone from the danger and the dispatcher will call the fire department. He failed to mention that he would activate the fire alarm system to notify the rest of the building. 5. At 11:20 a.m., on 4/7/16, Kitchen Supervisor Staff (KSS1), Food Services Staff (FSS1), and Dietary Aide (DA1) were asked what they would do in the event of a fire in the kitchen. They stated they would use the code word R.A.C.E. When asked to explain the R.A.C.E. procedures, they stated that they would get everyone out of the building, check the schedule, and call 5555. KSS1 stated that she would use a K-Class fire extinguisher for a gas fire. The kitchen staff failed to mention activation of the alarm, the	{K 050}	5. Monitoring compliance with fire drills, including staff understanding of the fire response plan, is performed on scheduled EOC rounds. Compliance and Monitoring: Data on compliance is tracked, trended, analyzed and reported monthly at the EOC Committee. Corrective action is taken as necessary. Compliance is reported monthly to the Quality Council (until the Quality Council determines monitoring of the building is sufficiently conducted and then reporting will be provided quarterly to the Quality Council) and quarterly to the Governing Board. Persons Responsible: Vice President of Facilities Development Director of Facilities	

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{K 050}	Continued From page 16 containment of a fire, and the proper usage of the extinguishers.	{K 050}		
K 051	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to maintain their fire alarm system. This was evidenced by the repeated failure of fire alarm notification devices, by the failure to transmit the correct type of fire alarm signal to the monitoring station, and by the	K 051	K051 NFPA 101 LIFE SAFETY CODE STANDARD	

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K 051	Continued From page 17 frequent placement of the fire alarm system in test mode that resulted in the failure to dispatch the fire department during a Code Red event. This was also evidenced by incorrectly addressed smoke detectors that caused personnel to respond to the wrong location during a Code Red event. This affected the entire Culver City Campus and the Van Nuys Building. This could result in a delay in fire department dispatch, a delay in response during a fire, and the increased risk of injury to patients. NFPA 101, Life Safety Code, 2000 Edition. 19.3.4.1 General. Health care occupancies shall be provided with a fire alarm system in accordance with Section 9.6. 9.6.1.3 The provisions of Section 9.6 cover the basic functions of a complete fire alarm system, including fire detection, alarm, and communications. These systems are primarily intended to provide the indication and warning of abnormal conditions, the summoning of appropriate aid, and the control of occupancy facilities to enhance protection of life. 9.6.1.4 A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code, unless an existing installation, which shall be permitted to be continued in use, subject to the approval of the authority having jurisdiction. 9.6.1.5 All systems and components shall be approved for the purpose for which they are installed.	K 051		

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K 051	Continued From page 18 9.6.1.7 To ensure operational integrity, the fire alarm system shall have an approved maintenance and testing program complying with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code. 9.6.3.6 Notification signals for occupants to evacuate shall be by audible and visible signals in accordance with NFPA 72, National Fire Alarm Code, and CABO/ANSI A117.1, American National Standard for Accessible and Usable Buildings and Facilities, or other means of notification acceptable to the authority having jurisdiction shall be provided. Exception No. 1: Areas not subject to occupancy by persons who are hearing impaired shall not be required to comply with the provisions for visible signals. Exception No. 2: Visible-only signals shall be provided where specifically permitted in health care occupancies in accordance with the provisions of Chapters 18 and 19. Exception No. 3: Existing alarm systems shall not be required to comply with the provision for visible signals. Exception No. 4: Visible signals shall not be required in lodging or rooming houses in accordance with the provisions of Chapter 26. NFPA 72, National Fire Alarm Code, 1999 Edition. Definitions 1-4 Central Station. A supervising station that is listed for central station service. Proprietary Supervising Station. A location to which alarm or supervisory signaling devices on proprietary fire alarm systems are connected and where personnel are in attendance at all times to supervise operation and investigate signals.	K 051		

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K 051	Continued From page 19 Proprietary Supervising Station Fire Alarm System. An installation of fire alarm systems that serves contiguous and noncontiguous properties, under one ownership, from a proprietary supervising station located at the protected property, at which trained, competent personnel are in constant attendance. This includes the proprietary supervising station; power supplies; signal-initiating devices; initiating device circuits; signal notification appliances; equipment for the automatic, permanent visual recording of signals; and equipment for initiating the operation of emergency building control services. 1-6.1.1 The authority having jurisdiction shall be notified prior to installation or alteration of equipment or wiring. At its request, complete information regarding the system or system alterations, including specifications, wiring diagrams, battery calculation, and floor plans shall be submitted for approval. 5-2.5.1 The central station shall have sufficient personnel, but not less than two persons, on duty at the central station at all times to ensure disposition of signals in accordance with the requirements of 5-2.6.1. 5-2.5.2 Operation and supervision shall be the primary functions of the operators, and no other interest or activity shall take precedence over the protective service. 5-2.6.1.5.2 Any test signal not received by the central station shall be investigated immediately and action shall be taken to reestablish system integrity. 5-3.2.1 Proprietary supervising stations shall be	K 051		

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K 051	Continued From page 20 operated by trained, competent personnel in constant attendance who are responsible to the owner of the protected property. The requirements of 5-3.5.3 shall apply. 5-3.3.1 The proprietary supervising station shall be located in a fire-resistive, detached building or in a cutoff room and shall not be exposed to the hazardous parts of the premises that are protected. 5-3.4.1 Signal-receiving equipment in a proprietary supervising station shall comply with 5-3.4. 5-3.4.2 Provision shall be made to designate the building in which a signal originates. The floor, section, or other subdivision of the building shall be designated at the proprietary supervising station or at the building that is protected. Exception: Where the area, height, or special conditions of occupancy make detailed designation unessential as approved by the authority having jurisdiction. This detailed designation shall use indicating appliances accepted by the authority having jurisdiction. 5-3.5.1 At least two operators shall be on duty at all times. One of the two operators shall be permitted to be a runner. Exception: If the means for transmitting alarms to the fire department is automatic, at least one operator shall be on duty at all times. 5-3.5.3 The primary duties of the operator(s) shall be to monitor signals, operate the system, and take such action as shall be required by the authority having jurisdiction. The operator(s) shall not be assigned any additional duties that would	K 051		

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K 051	Continued From page 21 take precedence over the primary duties. 5-3.6.6.1 Alarms. Upon receipt of a fire alarm signal, the proprietary supervising station operator shall initiate action to perform the following: (1) Immediately notify the fire department, the plant fire brigade, and such other parties as the authority having jurisdiction requires. (2) Promptly dispatch a runner to the alarm location (travel time shall not exceed 1 hour). (3) Restore the system as soon as possible after disposition of the cause of the alarm signal. Findings: During tour of facility with staff from 4/4/16 to 4/8/16, the fire alarm systems were tested and observed. The Pavilion and the Tower building, located across the street from the Pavilion, shared the same fire alarm system. Van Nuys: 1. From 12:00 p.m., to 12:30 p.m., on 4/6/16, fire alarm testing was conducted and this included initiating devices such as pull stations, smoke detectors, and waterflow switches. At 4:17 p.m., the monitoring report from the testing was provided. The monitoring report showed that the remote monitoring station only received Zone 2 fire trouble signals for all types of initiation devices tested. During a telephone interview at 4:18 p.m., a representative from the monitoring company stated that they would not dispatch the fire department upon receipt of a Zone 2 trouble signal.	K 051	Finding 1 Actions Taken: 1. The Hospital repaired the loose wire that affected the ability to transmit the signal. The fire alarm was activated to test that the fire alarm signal was received by the monitoring company. 2. The Hospital checked the other two campuses to campuses to ensure that there were no issues with transmitting a signal when the fire alarm was tested. 3. Upon completion of each fire drill, facilities staff shall contact the monitoring company to ensure that they received a signal. This is documented on the fire drill critique sheet.	4/7/16 4/8/16 5/27/16

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K 051	Continued From page 22 During a telephone interview at 4:47 p.m., another representative from the monitoring company stated that the last Zone 1 fire alarm signal received from the facility was on 12/30/15. He stated that only fire trouble signals were received on 1/23/16. The annual testing of the fire alarm system was conducted on 1/23/16 and documents showed that all initiation devices were tested on that day. During an interview at 5:00 p.m., the Director of Facilities Services (DFS2) stated that a fire watch would be implemented immediately until the fire alarm panel was fixed. Records showed that a fire alarm vendor fixed the panel on 4/7/16. The vendor reported that there was a loose wire for Zone 1 in the panel that caused all the signals to be reported as Zone 2. Pavilion: 2. At 10:28 a.m., on 4/4/16, the fire alarms sounded and a Code Red was paged overhead. PBX paged "Code Red Sixth Floor" three times. At 10:33 a.m., the Head of Security (HS1) reset the fire alarm system at the notification panel in the lobby. During an interview at 10:33 a.m., HS1 stated that security staff have investigated and saw no signs of fire. He stated that the panel indicated that the smoke detector was activated in the hallway outside the EVS (environmental services) closet on the sixth floor. At 10:35 a.m., there were two security staff	K 051	Finding 2 Actions Taken: 1. The Hospital replaced the smoke detector and the vendor remapped the smoke detector to the alarm panel. The smoke detector was tested to validate that it was correctly mapped on the fire panel. 2. The Hospital engaged the vendor to revalidate the mapping and annunciator display for all hospital locations and devices. Validation was then confirmed through testing of fire alarms. 3. Compliance with smoke detectors and mapping to the alarm panel is monitored by the annual fire alarm testing performed by an independent contractor.	4/5/16 6/3/16

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K 051	Continued From page 23 holding fire extinguishers in Wing A of the sixth floor. They stated that the smoke detector inside Room 605, which was adjacent to an EVS closet, was blinking red. They gave an "all clear" after inspecting that room. At 10:50 a.m., Plant Operations Lead Staff (PO1) removed the detector in Room 605 and an addressable trouble signal on the panel read "Pav 6th Smoke Patient Room 605." During an interview at 10:51 a.m., PO1 and HS1 were unsure if Room 605 was the origin of the fire alarm activation/Code Red and if security staff responded to the wrong location. At 2:37 p.m., a print out from the panel indicated that, "Pav 6th Smoke Patient Room 605" caused a "Common Trbl Act" (a local trouble signal) at 10:24 a.m. and that, "Pav 6th Smoke Hall Outside EVS" caused an "Alarm Active" at 10:28 a.m. During an interview at 2:38 p.m., the Fire Alarm Technician (F.A. Tech2) stated that the source of the fire alarm activation was not Room 605. He said that he and the other technicians were still trying to locate the smoke detector that was addressed incorrectly as "outside EVS." During an interview at 4:05 p.m., F.A. Tech2 stated that the smoke detector that caused the Code Red was actually in a Wing C linen closet, not in the Wing A corridor outside the EVS closet. Facility staff responded to the wrong location during the Code Red incident due to a smoke detector that was not addressed correctly on the panel.	K 051		

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K 051	Continued From page 24 Culver City Campus: 3. Per record review and interviews, it was observed that the fire alarm system was frequently placed on test during the past month. When the system is on test, fire alarm signals received by the remote monitoring station would not result in dispatch of the fire department. During the Code Red on 4/4/16 (Finding 2 above), the fire department was not dispatched. During an interview at 10:33 a.m., on 4/4/16, HS1 stated that the system was on test and PBX would call the fire department upon investigation by the facility and security staff. At 4:05 p.m., on 4/6/16, this surveyor was unable to conduct an interview with the PBX operator. There was only one PBX operator at the time and he was busy with phone calls. The fire alarm annunciator in PBX was across the room from the operator. PBX did not meet the NFPA 72 requirements of a listed central station or proprietary supervising station. During an interview at 1:57 p.m., on 4/5/16, the Los Angeles Fire Prevention Specialist (LAFPS) from Culver City Fire stated that the Fire Department should have been dispatched during the Code Red incident yesterday (Finding 2 above) and the Code Red incident in December (See K48 from the December 2015 Life Safety Code Survey). He stated the last time the fire department was notified of a fire alarm at the facility was on 3/11/16. He stated that the fire department was not notified of the alarms in the building yesterday. He requested to review a month of the monitoring reports from the offsite monitoring stations.	K 051	Finding 3 Actions Taken: 1. Hospital Leadership discussed the survey findings and immediately implemented an action plan. Effective 4/8/16, only the Chief Operating Officer and the Director of Facilities can initiate the test mode of the fire alarm system through a password protected account set up with the alarm monitoring company. Test mode is only utilized when a) working on the system; b) during preventive maintenance; c) during fire drills; and d) if the system is impaired. The Hospital notifies the local Fire Department, PBX and Security when the fire alarm system is put on test mode. This process was reviewed with the local and state Fire Marshall on 4/26/16. In addition, the process for utilizing test mode of the fire alarm system was discussed at the EOC meeting on 4/14/16. Education was provided to PBX, security and engineering staff.	4/26/16

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K 051	Continued From page 25 During an interview at 5:01 p.m., on 4/6/16, Plant Operations Lead Staff (PO1) stated that the facility placed the fire alarm system in test mode daily, for both the Tower and Pavilion, although construction was only conducted in the Pavilion Penthouse. During an interview at 8:49 a.m., on 4/7/16, the LAFPS stated the facility cannot place the fire alarm system on test daily without informing the local AHJ that the system is out of service. He stated he was unaware of any construction work that would require that the entire fire alarm system be put on test daily for both Tower and Pavilion Buildings. During an interview at 8:50 a.m., on 4/7/16, the Los Angeles Fire Inspector (LAFI) from the local Fire Department stated the facility cannot be on test so often without notifying the local AHJ. He stated that the facility must notify the AHJ when the fire alarm system is on test for construction work. During an interview at 11:44 a.m., on 4/7/16, the Office of Statewide Health Planning and Development (OSHPD) Fire Life Safety Officer (FLSO) stated the facility should get approval from the FLSO for putting the system on test during any construction. During an interview at 12:30 p.m., on 4/7/16, the Director of Facilities Services (DFS1) stated that PBX was carrying out instructions from the previous Facilities Director to put the system on test from 5 a.m. to 5 p.m. daily whether the fire alarm system was being worked on or not.	K 051		

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K 051	Continued From page 26 During an interview at 2:48 p.m., on 4/7/16, F.A. Tech1 stated the fire alarm system has the capability to place only certain zones on test, such as specific construction areas or while working on a portion of the fire alarm system. During an interview at 9:50 a.m., on 4/8/16, F.A. Tech1 stated he was unaware that the facility had placed the fire alarm system on test when he and his staff were not working on the system. F.A. Tech1 provided his staff's work schedule for the month of March 2016. He confirmed that they were not in the building during the Code Red incident on 4/4/16. At 10 a.m., on 4/13/16, comparison of the facility's fire alarm monitoring reports and the fire alarm vendor's work schedule showed days that the fire system was placed on test while no work was conducted on the system. The monitoring report indicated that the facility placed the entire fire alarm system on test from 5:00 a.m., to 5:00 p.m. for most days, including Saturdays and Sundays, without notifying the local AHJ. The fire alarm system was placed on test late into the evening on other days: on 3/14/16, the system was placed on test from 7:28 p.m., until 11:30 p.m. and on 3/22/16, from 6:16 p.m., until 11:59 p.m. The monitoring report indicated the system was placed on test on 3/11/16 from 5:00 a.m., to 5:00 p.m., for selective zones only. A fire alarm was activated in an area that was not on test and the fire department was dispatched. Interview with LAFPS above confirmed that this was the last time they received fire alarm signal from the facility.	K 051		

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K 051	Continued From page 27 Per the monitoring report and the fire alarm vendor's schedule for March 2016, the facility had their entire fire alarm system on test from 5:00 a.m., to 5:00 p.m. for 14 days (including Saturdays and Sundays) while there was no fire alarm vendor in the building. The system was on test on 3/9/16 while there was no fire alarm vendor working on the fire alarm panel. The report indicated the panel exhibited a supervisory signal. The signal was not sent to the local fire department. Tower First Floor: 4. At 3:53 p.m., on 4/6/16, the pull station on the first floor in the Emergency Department was tested. The fire alarm chimes failed to activate an audible alarm and no fire alarms could be heard throughout the building. At 3:54 p.m., on 4/6/16, the pull station by the exit door of the Emergency Department was tested. The fire alarm chimes failed to activate an audible alarm and no fire alarms could be heard throughout the building. During an interview at 3:55 p.m., F.A. Tech1 stated he would go and investigate the problem. At 5:52 p.m., the notification devices at the Tower were still not repaired. During an interview at 9:01 a.m., on 4/7/16, F.A. Tech1 stated he finished working on the fire alarm system yesterday at approximately 8:30 p.m., and all the chimes on all the floors of the Tower should be working now.	K 051	Finding 4 Actions Taken: 1. The fire alarm chimes for the pull stations on the first floor and exit in the Emergency Department, and Tower basement were repaired and now function properly. 2. The Hospital tested the pull stations on all three campuses to validate functioning fire alarm chimes that activated an audible alarm. 3. Compliance with fire alarm chimes is monitored through the annual fire testing. Compliance and Monitoring: Data on compliance is tracked, trended, analyzed and reported quarterly at the EOC Committee. Corrective action is taken as necessary. Compliance is reported quarterly to the Quality Council and Governing Board. Persons Responsible: Vice President of Facilities Development Director of Facilities	4/6/16 6/3/16

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K 051	Continued From page 28 Tower Basement: At 10:29 a.m., a pull station was tested and the fire alarm chime box failed. No alarms could be heard in the basement. This deficiency was cited during the September 2015 and December 2015 Life Safety Code surveys under K52. During the survey on 9/22/15, the fire alarm chimes on the first floor and fourth floor of the Tower failed during testing of the fire alarm system. During the survey on 12/16/15, the fire alarm chimes failed on the seventh floor of the Tower while fire alarm testing. Documentation from the Inspector of Record (IOR) showed that, during testing on 1/22/16, the audible fire alarms failed on the first floor, third floor, basement, and fifth floor of the Tower. The items were documented as having been corrected on 1/27/16. The recurring failure of the fire alarm chimes had not been corrected.	K 051		
{K 052}	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	{K 052}	K052 NFPA 101 LIFE SAFETY CODE STANDARD	

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{K 052}	Continued From page 29 This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure that the fire alarm systems are maintained in reliable operating condition. This was evidenced by no records of current smoke detector sensitivity testing for two buildings, by trouble conditions exhibited at fire panels, by the failure to protect an initiation device from mechanical damage, by the failure of one notification device at an offsite clinic, by no records of repairing fire alarm deficiencies, and by fire alarm components that were not readily accessible for inspection. This was also evidenced by the failure to ensure that manual fire alarm pull stations were readily accessible to all staff. This affected two of two offsite outpatient clinics and the Pavilion Building. This could result in delay in notification and response, in the event of a fire, and could result in the increased risk of injury to patients. NFPA 101, Life Safety Code, 2000 Edition. 19.3.4.1 General. Health care occupancies shall be provided with a fire alarm system in accordance with Section 9.6. 9.6.1.3 The provisions of Section 9.6 cover the basic functions of a complete fire alarm system, including fire detection, alarm, and communications. These systems are primarily intended to provide the indication and warning of abnormal conditions, the summoning of appropriate aid, and the control of occupancy facilities to enhance protection of life. 9.6.1.7 To ensure operational integrity, the fire alarm system shall have an approved maintenance and testing program complying with	{K 052}		

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{K 052}	Continued From page 30 the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code. 9.6.3.6 Notification signals for occupants to evacuate shall be by audible and visible signals in accordance with NFPA 72, National Fire Alarm Code, and CABO/ANSI A117.1, American National Standard for Accessible and Usable Buildings and Facilities, or other means of notification acceptable to the authority having jurisdiction shall be provided. Exception No. 1: Areas not subject to occupancy by persons who are hearing impaired shall not be required to comply with the provisions for visible signals. Exception No. 2: Visible-only signals shall be provided where specifically permitted in health care occupancies in accordance with the provisions of Chapters 18 and 19. Exception No. 3: Existing alarm systems shall not be required to comply with the provision for visible signals. Exception No. 4: Visible signals shall not be required in lodging or rooming houses in accordance with the provisions of Chapter 26. 4.2.3 Systems Effectiveness. Systems utilized to achieve the goals of Section 4.1 shall be effective in mitigating the hazard or condition for which they are being used, shall be reliable, shall be maintained to the level at which they were designed to operate, and shall remain operational. NFPA 72, National Fire Alarm Code, 1999 Edition. 1-6.3 Records. A complete, unalterable record of the tests and operations of each system shall be kept until the next test and for 1 year thereafter.	{K 052}		

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{K 052}	Continued From page 31 The record shall be available for examination and, if required, reported to the authority having jurisdiction. Archiving of records by any means shall be permitted if hard copies of the records can be provided promptly when requested. Exception: If off-premises monitoring is provided, records of all signals, tests, and operations recorded at the supervising station shall be maintained for not less than 1 year. 2-1.3.3 Initiating devices shall be installed in all areas where required by other NFPA codes and standards or the authority having jurisdiction. Each installed initiating device shall be accessible for periodic maintenance and testing. 2-8.2.1 Manual fire alarm boxes shall be located throughout the protected area so that they are unobstructed and accessible. 7-1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this code, shall conform to the equipment manufacturer's recommendations, and shall verify correct operation of the fire alarm system. 7-3.2.1 Detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance	{K 052}		

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{K 052}	Continued From page 32 alarms show any increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods: (1) Calibrated test method (2) Manufacturer's calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. Exception No. 1: Detectors listed as field adjustable shall be permitted to be either adjusted within the listed and marked sensitivity range and cleaned and recalibrated, or they shall be replaced. Exception No. 2: This requirement shall not apply to single station detectors referenced in 7-3.3 and Table 7-2.2. Findings: During a facility tour with staff from 4/4/16 to 4/8/16, the fire alarm systems were observed and maintenance records were requested. Offsite IOP and Spine Clinics: 1. At 3:36 p.m., on 4/4/16, smoke detector sensitivity testing was requested for both offsite	{K 052}	Findings 1-6 Actions Taken: 1. The Hospital obtained smoke detector sensitivity testing for the IOP and Spine Clinics. 2. The deficiencies identified in the 3/9/16 annual inspection were repaired. The documentation is maintained by the Facilities Department.	6/3/16 5/24/16

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{K 052}	Continued From page 33 clinics. There were no records of smoke detector sensitivity testing provided. Spine Clinic: 2. At 9:00 a.m., on 4/7/16, fire alarm system maintenance records showed that the system failed the annual inspection on 3/9/16. The deficiencies listed were "no access to first floor pharmacy" and "incorrect identification and location indicated for alarms, supervisory, and trouble signals." There were no records of repairing the system deficiencies. 3. At 9:38 a.m., on 4/7/16, the fire alarm panel at the Culver Medical Plaza was exhibiting a "Power Supply 1 Fault" trouble. During an interview at 9:39 a.m., the Culver Medical Plaza Maintenance Staff (CMP Maint1) stated he was aware of the trouble signal and the vendor has been scheduled to come out to investigate. 4. At 10:07 a.m., on 4/7/16, one of two pull stations in the west exit corridor behind the spine clinic was tested. The fire alarm strobe directly outside the spine clinic exit door failed. The strobe failed again at 10:09 a.m. when the second pull station in the corridor was tested. This fire alarm notification device was the closest in proximity to the spine clinic. Pavilion Penthouse: 5. At 8:34 a.m., on 4/8/16, there was a "ground fault" trouble exhibited on the fire alarm panel.	{K 052}	3. The trouble signal in the Culver Medical Plaza was repaired. 4. The fire alarm strobe outside the spine clinic exit door was repaired by a contracted vendor on 5/24/16. Fire alarm strobes will be checked during quarterly fire drills. 5. The ground fault on the fire alarm panel at the Pavilion Penthouse and the leak was repaired. The plastic wrapped around one side of the detector was removed. 6. Hospital Leadership discussed the issue of keys for the pull station for the Locked Unit since staff had been previously provided with keys. An assessment was performed and additional keys were obtained to ensure that staff in the Locked Unit has the ability to open the pull station. Education was provided to staff, with special emphasis on strict adherence to maintaining a key at all times. Compliance is monitored during scheduled EOC rounds. 7. The 5-gallon water bottles and other supplies were removed from obstructing access to the fire alarm component boxes in the supply room. Hospital Leadership and Facilities staff made rounds on the three campuses to ensure that there were no obstructions to fire alarm component boxes. Compliance is monitored during scheduled EOC rounds. Compliance and Monitoring: Data on compliance is tracked, trended, analyzed and reported quarterly at the EOC Committee. Corrective action is taken as necessary. Compliance is reported quarterly to the Quality Council and Governing Board.	5/24/16 5/24/16 4/28/16 4/11/16 4/8/16

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{K 052}	Continued From page 34 During an interview at 8:40 a.m., the fire alarm technician (F.A. Tech1) stated that water leaked into a device in the penthouse. At 8:45 a.m., drops of water were observed leaking into a heat detector close to the new air handler and there was plastic wrapped around one side of the detector. . Pavilion Sixth Floor: 6. At 10:22 a.m., on 4/6/16, the manual pull stations in the Locked Unit were key-operated. Mental Health Technician (M.H.Tech1) was not equipped with a key to readily activate the manual pull stations. During an interview at 10:23 a.m., M.H. Tech1 stated she would have to find the Charge Nurse to activate the manual pull station. 7. At 10:56 a.m., on 4/6/16, there were 5-gallon water bottles and other supplies that obstructed access to the fire alarm component boxes in the supplies room.	{K 052}	Persons Responsible: Vice President of Facilities Development Director of Facilities	
{K 062}	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, record review, and	{K 062}	K062 NFPA 101 LIFE SAFETY CODE STANDARD	

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{K 062}	Continued From page 35 interview, the facility failed to maintain their automatic sprinkler systems and standpipe hose systems. This was evidenced by incomplete maintenance records for weekly, quarterly, annual, and five-year testing of the automatic sprinkler systems and standpipe hose systems. This was also evidenced by no records of repairing deficiencies listed during inspections, by a sprinkler pipe that was subject to an external load, by storage in close proximity to sprinkler heads, and by one leaking test valve. This could result in a delay in extinguishing a fire and could result in the increased risk of injury to patients, staff, and visitors. This affected the entire Culver City Campus, two of two offsite clinics, and one of six floors in the Hollywood Building. NFPA 101, Life Safety Code, 2000 Edition 19.3.5.1 Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Exception: In Type I and Type II construction, where approved by the authority having jurisdiction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specified areas where the authority having jurisdiction has prohibited sprinklers, without causing a building to be classified as nonsprinklered. 9.7.5 Maintenance and Testing. All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Standard for the Inspection, Testing,	{K 062}		

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{K 062}	Continued From page 36 and Maintenance of Water-Based Fire Protection Systems, 1998 Edition. 1-8 Records. Records of inspections, tests, and maintenance of the system and its components shall be made available to the authority having jurisdiction upon request. Typical records include, but are not limited to, valve inspections; flow, drain, and pump tests; and trip tests of dry pipe, deluge, and preaction valves. 1-8.1 Records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. 1-8.2 Records shall be maintained by the owner. Original records shall be retained for the life of the system. Subsequent records shall be retained for a period of one year after the next inspection, test, or maintenance required by the standard. 2.2.1.1 Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. 2-2.2 Pipe and Fittings. Sprinkler pipe and fittings shall be inspected annually from the floor level. Pipe and fittings shall be in good condition and free of mechanical damage, leakage, corrosion, and misalignment. Sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. Exception No. 1:Pipe and fittings installed in concealed spaces such as above suspended	{K 062}		

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{K 062}	Continued From page 37 ceilings shall not require inspection. Exception No. 2: Pipe installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown. 2-2.6 Alarm Devices. Alarm devices shall be inspected quarterly to verify that they are free of physical damage. 2-3.3 Alarm Devices. Waterflow alarm devices including, but not limited to, mechanical water motor gongs, vane-type waterflow devices, and pressure switches that provide audible or visual signals shall be tested quarterly. 3-2.1 Components of standpipe and hose systems shall be visually inspected quarterly or as specified in Table 3-1. 3-3.1.1 A flow test shall be conducted at the hydraulically most remote hose connection of each zone of a standpipe system to verify the water supply still adequately provides the design pressure at the required flow. Where a flow test of the hydraulically most remote outlet(s) is not practical, the authority having jurisdiction shall be consulted for the appropriate location for the test. A flow test shall be conducted every 5 years. Table 3-1 Summary of Standpipe and Hose System Inspection, Testing, and Maintenance Components Activity Frequency Reference Control valves Inspection Weekly/monthly Table 9-1 Pressure regulating devices Inspection Quarterly Table 9-1 Piping Inspection Quarterly 3-2.1 Hose connections Inspection Quarterly Table 9-1	{K 062}		

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{K 062}	Continued From page 38 Cabinet Inspection Annually NFPA 1962 Hose Inspection Annually NFPA 1962 Hose storage device Inspection Annually NFPA 1962 Alarm device Test Quarterly Table 9-1 Hose nozzle Test Annually NFPA 1962 Hose storage device Test Annually NFPA 1962 Hose Test 5 years/3 years NFPA 1962 Pressure control valve Test 5 years Table 9-1 Pressure reducing valve Test 5 years Table 9-1 Hydrostatic test Test 5 years 3-3.2 Flow test Test 5 years 3-3.1 Main drain test Test Annually Table 9-1 Hose connections Maintenance Annually Valves (all types) Maintenance Annually/as needed Table 9-1 3-4 Maintenance. Maintenance/repairs shall be in accordance with 3-2.3 and Table 3-2.3. Table 3-2.3 Standpipe and Hose Systems If cabinet is break-glass type, is lock functioning properly? Repair or replace 9-2.7 Waterflow Alarm. All waterflow alarms shall be tested quarterly in accordance with the manufacturer's instructions. 9-3.3.1 All valves shall be inspected weekly. Exception No. 1: Valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly. Exception No. 2: After any alterations or repairs, an inspection shall be made by the owner to ensure that the system is in service and all valves are in the normal position and properly sealed, locked, or electrically supervised.	{K 062}		

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{K 062}	Continued From page 39 9-4.2 Check Valves 9-4.2.1 Inspection. Valves shall be inspected internally every 5 years to verify that all components operate properly, move freely, and are in good condition. 9-5.1.1 All valves shall be inspected quarterly. The inspection shall verify that the valves are in the following condition: (a) In the open position (b) Not leaking (c) Maintaining downstream pressures in accordance with the design criteria (d) In good condition, with handwheels installed and unbroken 9-7 Fire Department Connections. 9-7.1 Fire department connections shall be inspected quarterly. The inspection shall verify the following: (a) The fire department connections are visible and accessible. (b) Couplings or swivels are not damaged and rotate smoothly. (c) Plugs or caps are in place and undamaged. (d) Gaskets are in place and in good condition. (e) Identification signs are in place. (f) The check valve is not leaking. (g) The automatic drain valve is in place and operating properly. 3-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of standpipe and hose systems. Table 3-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9.	{K 062}		

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{K 062}	Continued From page 40 10.2.1 To ensure that piping remains clear of all obstructive foreign matter, an obstruction investigating shall be conducted for system or yard main piping wherever any of the following condition exits: (a) Defective intake for fire pumps taking suction from open bodies of water. (b) The discharge of obstructive material during routine water tests. (c) Foreign materials in fire pumps, in dry pipe valves, or in check valves (d) Foreign materials in water during drain tests or plugging of inspector's test connection(s) (e) Plugged sprinklers (f) Plugged piping in sprinklers system dismantled during building alterations. (g) Failure to flush yard piping or surrounding public mains following new installations or repairs (h) A record of broken public mains in the vicinity (i) Abnormally frequent false tripping of a dry pipe valve (s) (j) A system that is returned to service after an extended shutdown (greater than 1 year) (k) There is reason to believe that the sprinkler system contains sodium silicate or highly corrosive fluxes in copper system. (l) A system has been supplied with raw water via the fire department connection. NFPA 13, Standard for the Installation of Sprinkler System, 1999 Edition. 5-14.3.2.1 Where corrosive conditions are known to exist due to moisture or fumes from corrosive chemicals or both, special types of fittings, pipes, and hangers that resist corrosion shall be used or a protective coating shall be applied to all un protected exposed surfaces of the sprinkler system. (see 3-2.6.)	{K 062}		

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{K 062}	Continued From page 41 Findings: During a facility tour with staff from 4/4/16 to 4/8/16, the automatic sprinkler systems and standpipe systems were observed. Offsite Spine Clinic: 1. At 3:30 p.m., on 4/4/16, maintenance records for the standpipe system were requested. At 9:05 a.m., on 4/7/16, records of a 9/21/13 inspection of the Class II wet standpipe system were provided. There were no records of inspecting the system and hoses annually. At 9:56 a.m., on 4/7/16, the inspection tag on the standpipe system in the west exit corridor behind the Spine Clinic was dated January 2008. At 10:27 a.m., on 4/7/16, the inspection tag on the fire hose in the lobby of the Culver Medical Plaza (CMP) was dated September 2012. The hose cabinet could not be opened but the tag was viewed through its window. The Vice President of Facilities (VPFS1) and Maintenance Staff (CMP Maint1) both confirmed the 2012 date of the tag. 2. At 10:30 a.m., on 4/7/16, CMP Maint1 could not find the keys to unlock the fire hose and fire extinguisher cabinets throughout the building. Offsite IOP Clinic: 2. At 3:31 p.m., on 4/4/16, maintenance records for the fire pump and sprinkler system were requested. At 8:58 a.m., on 4/7/16, records showed that a five year inspection of the sprinkler system was conducted on 8/19/15 and that	{K 062}	Offsite Spine Clinic Findings 1 and 2 Actions Taken: 1. The Hospital obtained records of inspecting the system and hoses annually. The standpipe system in the west exit corridor was inspected on 6/3/16 and the inspection tag is dated 6/3/16. The fire hose in the lobby of the Culver Medical Plaza was inspected on 6/3/16 and the tag indicates the 6/3/16 date. The Building Engineer maintains the keys to the hose and fire extinguisher cabinets. Hospital Leadership discussed the survey findings with the Building Management, with emphasis on strict compliance with regulatory requirements. Compliance is monitored through scheduled EOC rounds. Offsite IOP Clinic Finding 2 Actions Taken: 1. Hospital Leadership discussed the survey findings with Building Management. The sprinkler system is being inspected quarterly and again annually. The sprinkler system was inspected on 4/14/16 and documentation is maintained in the Facilities Department.	6/3/16 4/14/16

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{K 062}	Continued From page 42 Brotman Physician Plaza Maintenance Staff (BBP Maint1) was running the fire pump weekly. During an interview at 8:59 a.m., BPP Maint1 stated that only a five year inspection was conducted on the sprinkler system and no quarterly or annual inspections were scheduled for the system. Hollywood Third Floor: 3. At 3:01 p.m., on 4/6/16, the Inspector's Test Valve (ITV) in Stairwell 1 was tested. The valve was leaking at the stem. During at 3:02 p.m., the Director of Facilities Services (DFS2) stated that the valve needed new packing. Culver City Campus: 4. The Culver City Campus was equipped with more than one automatic sprinkler system risers for the multiple buildings. The vendor reports indicated automatic sprinkler systems were tested and inspected at Watseka Street, Delmas Terrace, and Hughes Street. The facility stated that Delmas Terrace corresponded to both the Pavilion and Tower. The facility indicated that the Watsek Street report was for a warehouse. The facility could not clarify which building corresponded to the Hughes Street report. At 10:01 a.m., on 4/5/16, the facility's sprinkler system inspection documents, dated 1/26/16 and 3/14/16, were reviewed. The report dated 1/26/16 indicated that sprinkler heads failed inspection due to approximately 18,800 recalled	{K 062}	Finding 3 Action Taken: 1. The valve was repaired. Finding 4 Actions Taken: 1. The Hospital contacted the vendor to clarify the building that corresponded to the Hughes Street. The vendor provided a clarifying e-mail to confirm which building corresponded to the Hughes Street report. 2. The Hospital is in the process of replacing the 1155 recalled sprinkler heads through an approved OSHPD project (#5160548-19-00). The Hospital anticipates completion of this project by 10/30/16 and is therefore requesting a four (4) month time-limited waiver. The waiver request is submitted with this plan of correction. As Interim Life Safety Measures (ILSM), the Hospital implemented a) a fire watch protocol during the time that the system is drained; b) performed pre-construction	5/25/16 5/26/16 6/7/16

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{K 062}	Continued From page 43 sprinkler heads that needed to be replaced. During an interview at 4:15 p.m., all the maintenance and repairs records for the automatic fire sprinkler system for the Tower and Pavilion were requested from the Vice President of Facilities (VPFS1). A quote for replacing the sprinkler heads was provided. There was no documentation that confirmed when the recalled sprinkler heads would be replaced. 5. At 9:50 a.m., on 4/8/16, there were no documents of quarterly testing conducted for the Tower sprinkler system during the first quarter (January through March) of 2016. There were no records of fourth quarter (October to December) 2015 testing of the Pavilion and Tower sprinkler systems. 6. At 9:55 a.m., on 4/8/16, the facility failed to provide documents to show quarterly, annual, and 5 years/3 year inspections of the standpipe and hose systems of the Tower. 7. At 11: 20 a.m., on 4/8/16, the vendor report, for the five-year test conducted 9/22/14, indicated that interior inspection of the check valves were and fire department connection back flush were "not applicable." The facility was equipped with check valves and fire department connections. The facility failed to provide documentation of a complete five-year test of the Pavilion's automatic sprinkler system. 8. At 10:08 a.m., on 4/5/16, a maintenance log indicated incomplete weekly inspections of the control valves. The facility's policy was to inspect the control valves weekly. The records indicated weekly inspections were not conducted during	{K 062}	assessments on 5/27/16 to ensure ILSM requirements are met; and c) obtained an infection control permit on 5/27/16 before construction started. Automatic sprinklers are monitored through the PM program and scheduled EOC rounds. Finding 5 Actions Taken: 1. The Hospital has testing records for the first quarter of 2016 for the Pavilion and Tower sprinkler system. Finding 6 Actions Taken: 1. The Hospital obtained the documents to show quarterly, annual and 5 years/3 year inspections of the standpipe and hose systems of the Tower. The documents are maintained in the Facilities Department. 2. Review for presence and completeness of these documents is performed annually when the Life Safety Plan is evaluated. Finding 7 Actions Taken: 1. The Hospital obtained a complete five-year test of the Pavilion's automatic sprinkler, including check valves and fire department connections. The documents are maintained in the Facilities Department. Finding 8 Actions Taken: 1. The Director of Facilities located the weekly inspections for January, February and March 2016. The documentation is maintained in the Facilities Department.	4/8/16 4/15/16 6/3/16 5/27/16

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	6245 DE LONGPRE AVE HOLLYWOOD, CA 90028

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{K 062}	Continued From page 44 one week in January 2016, during two weeks in February 2016, and during two weeks in March 2016. Pavilion Sixth Floor: 9. At 10:35 a.m., on 4/6/16, there were several layers of duct tape wrapped around the sprinkler pipe in the environmental services closet. The pipe had a red and silver label that hung from the wrapped pipe. The label indicated that it was an automatic flow control valve. Basement- Surgery Suite: 10. At 10:53 a.m., on 4/7/16, the water dispersion pattern of the sprinkler head in the anesthesia supplies room was blocked by supplies located on two shelves. The supplies were positioned approximately 10 inches directly below the sprinkler head.	{K 062}	2. Weekly inspections are validated by the Director of Facilities management or his designee. Finding 9 Pavilion Sixth Floor Actions Taken: 1. The Director of Facilities reviewed the survey findings and the identified pipe. It was determined to be a chilled water pipe and not a sprinkler pipe. The duct tape was removed and the chilled water pipe insulated and marked as a chilled water pipe. 2. Compliance with pipe condition is monitored through weekly scheduled EOC rounds. Finding 10 Basement Surgery Suite Actions Taken: 1. The supply racks in the Anesthesia Supply Room were lowered to be at least 18 inches below the sprinkler head.	5/26/16 4/15/16
{K 064}	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their portable fire extinguishers. This was evidenced by fire extinguishers that were mounted greater than 5 feet from floor level. This affected one of six floors in the Pavilion and the	{K 064}		

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{K 062}	Continued From page 44 one week in January 2016, during two weeks in February 2016, and during two weeks in March 2016. Pavilion Sixth Floor: 9. At 10:35 a.m., on 4/6/16, there were several layers of duct tape wrapped around the sprinkler pipe in the environmental services closet. The pipe had a red and silver label that hung from the wrapped pipe. The label indicated that it was an automatic flow control valve. Basement- Surgery Suite: 10. At 10:53 a.m., on 4/7/16, the water dispersion pattern of the sprinkler head in the anesthesia supplies room was blocked by supplies located on two shelves. The supplies were positioned approximately 10 inches directly below the sprinkler head.	{K 062}	2. The Facilities Staff reviewed supply rooms on the three campuses to ensure that any supply racks were positioned at least 18 inches below a sprinkler head. 3. Compliance is monitored through scheduled EOC rounds. Compliance and Monitoring: Data on compliance is tracked, trended, analyzed and reported monthly at the EOC Committee. Corrective action is taken as necessary. Compliance is reported monthly to the Quality Council (until the Quality Council determines monitoring of the building is sufficiently conducted and then reporting will be provided quarterly to the Quality Council) and quarterly to the Governing Board. Persons Responsible: Vice President of Facilities Development Director of Facilities	5/26/16
{K 064}	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their portable fire extinguishers. This was evidenced by fire extinguishers that were mounted greater than 5 feet from floor level. This affected one of six floors in the Pavilion and the	{K 064}	K064 NFPA 101 LIFE SAFETY CODE STANDARD	

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{K 064}	Continued From page 45 basement of the Tower. This could result in a delay in accessing a fire extinguisher. NFPA 101, Life Safety Code, 2000 Edition. 19.3.5.6 Portable fire extinguishers shall be provided in all health care occupancies in accordance with 9.7.4.1. 9.7.4.1 Where required by the provisions of another section of this Code, portable fire extinguishers shall be installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition. 1-6.3 Fire extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of fire. Preferably they shall be located along normal paths of travel, including exits from areas. 1-6.10 Fire extinguishers having a gross weight not exceeding 40 lb. (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft. (1.53 m) above the floor. Fire extinguishers having a gross weight greater than 40 lb. (18.14 kg) (except wheeled type) shall be so installed that the top of the fire extinguisher is not more than 3 1/2 ft. (1.07 m) above the floor. In no case shall the clearance between the bottom of the fire extinguisher and the floor be less than 4 in. (10.2 cm). Findings: During a facility tour with staff from 4/4/16 to 4/8/16, the fire extinguishers were observed.	{K 064}		

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{K 064}	Continued From page 46 Pavilion First Floor: 1. At 3:05 p.m., on 4/6/16, the top of the fire extinguisher in the laboratory, by the northeast exit, was mounted approximately 5 feet 7 inches from the floor. 2. At 3:15 p.m., on 4/6/16, the top of the fire extinguisher in the chemistry section of the laboratory was mounted approximately 5 feet 7 inches from the floor. Tower Basement: 3. At 10:39 a.m., on 4/7/16, the top of the fire extinguisher, located by the High Voltage Room, was mounted approximately 5 feet 7 inches from the floor.	{K 064}	Findings 1-3 Actions Taken: 1. The identified fire extinguisher in the laboratory by the northeast exit was remounted to be four (4) feet from floor. 2. The identified fire extinguisher in the chemistry section of the laboratory was remounted to be four (4) feet from the floor. 3. The identified fire extinguisher located by the High Voltage Room in the Tower Basement was remounted to be four (4) feet from the floor. 4. The Director of Facilities discussed the survey findings with department staff. The Facilities Department staff reviewed all fire extinguishers to ensure that they were mounted no more than four (4) feet from the floor.	4/6/16 4/6/16 4/7/16 4/8/16
{K 067}	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain their heating, ventilating, and air conditioning (HVAC) system. This was evidenced by the use of a portable air conditioners (AC) that were exhausted into the return air inlets and by the failure to repair fire dampers that failed	{K 067}		

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{K 064}	Continued From page 46 Pavilion First Floor: 1. At 3:05 p.m., on 4/6/16, the top of the fire extinguisher in the laboratory, by the northeast exit, was mounted approximately 5 feet 7 inches from the floor. 2. At 3:15 p.m., on 4/6/16, the top of the fire extinguisher in the chemistry section of the laboratory was mounted approximately 5 feet 7 inches from the floor. Tower Basement: 3. At 10:39 a.m., on 4/7/16, the top of the fire extinguisher, located by the High Voltage Room, was mounted approximately 5 feet 7 inches from the floor.	{K 064}	5. Monitoring of fire extinguishers is part of the monthly fire extinguisher inspection check. Compliance and Monitoring: Data on compliance is tracked, trended, analyzed and reported monthly at the EOC Committee. Corrective action is taken as necessary. Compliance is reported monthly to the Quality Council (until the Quality Council determines monitoring of the building is sufficiently conducted and then reporting will be provided quarterly to the Quality Council) and quarterly to the Governing Board. Persons Responsible: Vice President of Facilities Development Director of Facilities	
{K 067}	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain their heating, ventilating, and air conditioning (HVAC) system. This was evidenced by the use of a portable air conditioners (AC) that were exhausted into the return air inlets and by the failure to repair fire dampers that failed	{K 067}	K067 NFPA 101 LIFE SAFETY CODE STANDARD	

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{K 067}	Continued From page 47 inspection. This was also evidenced by the use of temporary air handler that was unsecured in a public parking lot without approval from the authority having jurisdiction (AHJ). This affected one of seven floors of the Tower, one of six floors of Hollywood Building, and the Van Nuys Building. These deficient practices could result in the faster spread of smoke and fire through the HVAC system, an unapproved change in the air exchange rate, and the increased risk of injury from the unsecured temporary air handler. NFPA 101, Life Safety Code, 2000 Edition. 19.5.2.1 Heating, ventilating, and air conditioning shall comply with the provisions of Section 9.2 and shall be installed in accordance with the manufacturer ' s specifications. Exception: As modified in 19.5.2.2. 9.2.1 Air Conditioning, Heating, Ventilating Ductwork, and Related Equipment. Air conditioning, heating, ventilating ductwork, and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems, or NFPA 90B, Standard for the Installation of Warm Air Heating and Air-Conditioning Systems, as applicable, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction. 8.2.3.2.4.1 Openings in fire barriers for air-handling duct work or air movement shall be protected in accordance with 9.2.1. NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems, 1999 Edition.	{K 067}		

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{K 067}	Continued From page 48 2-1.2 Equipment shall be selected and installed based on its proper application with respect to the manufacturer's installation instructions and listing as applicable. 2-1.3 Equipment shall be guarded for personnel protection and against the intake of foreign matter into the system. 2-2.4.1 Installation. Heating and cooling equipment shall be installed in accordance with the applicable NFPA standards and the manufacturer's instructions. The equipment shall be approved for the specific installation. 2-2.4.3 Mechanical Cooling. Mechanical refrigeration used with air duct systems shall be installed in accordance with recognized safety practices. Installations conforming to ANSI/ASHRAE 15, Safety Code for Mechanical Refrigeration, shall be considered in compliance with these requirements. 2-3.1.2 Air ducts shall be permitted to be rigid or flexible and shall be constructed of materials that are reinforced and sealed to satisfy the requirements for the use of the air duct system, such as the supply air system, the return or exhaust air system, and the variable volume/pressure air system. 2-3.1.3 All air duct materials shall be suitable for continuous exposure to the temperature and humidity conditions of the environmental air in the air duct. 2-3.7 Air Inlets -- Return or Exhaust or Return and Exhaust 2-3.7.1 General. Air shall not be recirculated from	{K 067}		

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{K 067}	Continued From page 49 any space in which flammable vapors, flyings, or dust is present in quantities and concentrations that would introduce a hazardous condition into the return air system. 3-1.4 Other Spaces Housing Air-Handling Units. Other spaces housing air-handling units shall meet the requirements of the building code the authority having jurisdiction 3-3.1.2 Approved fire dampers shall be provided in all air transfer openings in partitions that are required to have a fire resistance rating and in which other openings are required to be protected. 3-3.3 Floor- or Roof- Ceiling Assemblies having a fire Resistance Rating. Where air ducts and openings for air ducts are used in a floor- or roof-ceiling assembly that is required to have fire resistance rating, all the materials and the construction of the assembly, including the air duct materials and the size and protection of the openings, shall conform with the design of the fire-resistive assembly, as tested in accordance with NFPA 251, Standard Methods of Tests of Fire Endurance of Building Construction and Materials. (Where dampers are required, see 3-4.4.) Findings: During a facility tour with staff from 4/4/16 to 4/8/16, the HVAC systems were observed. Tower Second Floor: 1. At 12:20 p.m., on 4/4/16, records indicated that	{K 067}		

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{K 067}	Continued From page 50 fire dampers on the second floor of the tower were tested on 2/26/16. The "Fire Damper Repair" portion of the testing report indicated that Dampers 2-003, 2-004, 2-005, 2-006, 2-008, 2-017, and 2-019 did not pass inspection because the dampers were "missing." This finding was previously cited during a Life Safety Code Survey conducted in December 2015. During that survey, there were no records of repairing five of these dampers (2-003, 2-004, 2-005, 2-006, and 2-008) after they failed testing on 11/4/10. Van Nuys: 2. At 10:57 a.m., on 4/6/16, there was a temporary air handler on wheels outside the kitchen in the west parking lot. There was no permit for this air handler and it was not anchored. The Director of Facilities Services (DFS3) slightly pushed the unit and it was unstable. The air handler was close to the cars in the parking lot and was not secured. This portable air handler was cited during the last Life Safety Code survey in December 2015. During an interview at 10:58 a.m., DFS2 stated that the temporary air handler has not yet been inspected by the Office of Statewide Health Planning and Development (OSHPD) but an application to replace the kitchen HVAC was requested in October 2015. He stated that Project S152795-19-00 has not yet been approved. Hollywood First Floor:	{K 067}	Finding 1 Tower Second Floor Actions Taken: 1. Hospital Leadership discussed the survey findings with the Director of Facilities and the Fire Damper Report was reviewed. It was determined that the identified dampers were not missing but had been removed after construction and new ones were placed. The Hospital contacted the vendor to validate the dampers and issue a corrected report. Finding 2 Van Nuys Actions Taken: 1. The Hospital obtained a permit from OSHPD (#S161033-19-00) for the temporary air handler on 4/4/16. The anchoring of the temporary air handler will be completed by 6/8/6 with OSHPD approval pending. Therefore, the Hospital is requesting a six (6) month time-limited waiver while the temporary air handler and the permanent air handler projects (#S152795-19-00) are completed. The Hospital implemented ILSM's including a) effective 4/12/15, the temporary air handler was secured with a strap as a temporary means to secure it; b) will perform a pre-construction assessment and c) will obtain an infection control permit before construction starts.	6/3/16 6/3/16

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{K 067}	Continued From page 51 3. At 2:34 p.m., on 4/6/16, there was a portable air conditioner (AC) in the clinical laboratory. It was vented into the return vent which was covered with a thin piece of vinyl. This deficiency was previously cited during the Life Safety Code survey in December 2015. During an interview at 2:35 p.m., the Chief Engineer (CE1) stated that the AC was removed after the last survey and does not know who put it back. Air exchange reports indicated that the clinical laboratories required a minimum air exchange per hour (ACH) of 4. The portable AC was vented into the only return air vent of the laboratory.	{K 067}	Finding 3 Hollywood First Floor Actions Taken: 1. The identified portable air condition in the clinical laboratory was removed. The lab staff were advised at the time of survey that the portable air conditioner was not to be returned to the laboratory. 2. Compliance is monitored through scheduled EOC rounds. Compliance and Monitoring: Data on compliance is tracked, trended, analyzed and reported monthly at the EOC Committee. Corrective action is taken as necessary. Compliance is reported monthly to the Quality Council (until the Quality	4/6/16
{K 069}	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to maintain their commercial cooking equipment. This was evidenced by no records of repairing deficiencies noted during a vendor's hood inspection, by no evidenced of conducting a hydrostatic test on the wet chemical suppression system, and by one K-Class fire extinguisher that required a recharge. This affected one of six floors in the Hollywood Building and one of four smoke compartments in Van Nuys Building. This could result in a delay in extinguishing a grease fire and the increased risk of injury to patients, staff, and visitors.	{K 069}		

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{K 067}	Continued From page 51 3. At 2:34 p.m., on 4/6/16, there was a portable air conditioner (AC) in the clinical laboratory. It was vented into the return vent which was covered with a thin piece of vinyl. This deficiency was previously cited during the Life Safety Code survey in December 2015. During an interview at 2:35 p.m., the Chief Engineer (CE1) stated that the AC was removed after the last survey and does not know who put it back. Air exchange reports indicated that the clinical laboratories required a minimum air exchange per hour (ACH) of 4. The portable AC was vented into the only return air vent of the laboratory.	{K 067}	Council determines monitoring of the building is sufficiently conducted and then reporting will be provided quarterly to the Quality Council) and quarterly to the Governing Board. Persons Responsible: Vice President of Facilities Development Director of Facilities	
{K 069}	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to maintain their commercial cooking equipment. This was evidenced by no records of repairing deficiencies noted during a vendor's hood inspection, by no evidenced of conducting a hydrostatic test on the wet chemical suppression system, and by one K-Class fire extinguisher that required a recharge. This affected one of six floors in the Hollywood Building and one of four smoke compartments in Van Nuys Building. This could result in a delay in extinguishing a grease fire and the increased risk of injury to patients, staff, and visitors.	{K 069}	K069 NFPA 101 LIFE SAFETY CODE STANDARD	

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{K 069}	Continued From page 52 NFPA 101, Life Safety Code, 2000 Edition. 19.3.2.6 Cooking Facilities. Cooking facilities shall be protected in accordance with 9.2.3. Exception: Where domestic cooking equipment is used for food-warming or limited cooking, protection or segregation of food preparation facilities shall not be required. 9.2.3 Commercial Cooking Equipment. Commercial cooking equipment shall be in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 1998 Edition. 1-3.1 Cooking equipment used in processes producing smoke or grease-laden vapors shall be equipped with an exhaust system that complies with all the equipment and performance requirements of this standard, and all such equipment and performance shall be maintained per this standard during all periods of operation of the cooking equipment. Specifically, the following equipment shall be kept in good working condition: (a) Cooking equipment (b) Hoods (c) Ducts (if applicable) (d) Fans (e) Fire suppression system (f) Special effluent or energy control equipment All airflows shall be maintained. Maintenance and repairs shall be performed on all components at intervals necessary to maintain these conditions.	{K 069}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 069}	Continued From page 53 1-3.1.3 All interior surfaces of the exhaust system shall be reasonably accessible for cleaning and inspection purposes. 7-2.1 Fire-Extinguishing equipment shall include both automatic fire-extinguishing systems as primary protection and portable fire extinguishers as secondary backup. 8.3.1 Hoods, Grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned to bare metal, it shall not be coated with power or there substance. The entire exhaust system shall be inspected by a properly trained, qualified, and certified company or person(s) acceptable to the authority having jurisdiction in accordance with Table 8-3.1 Findings: During a tour of the facility with staff from 4/6/14 to 4/8/16, the commercial cooking equipment was observed. Hollywood First Floor: 1. At 11:11 a.m., on 4/5/16, records of the most recent kitchen hood cleaning and inspection was reviewed. The vendor noted, on 3/31/16, that the exhaust fan belt needed to be replaced, there were areas in the hood that were inaccessible for cleaning, and that there was leaking ductwork in the hood. There were no records of repairing the deficiencies.	{K 069}	1. The exhaust fan belt was replaced, the leaking ductwork in the hood repaired, an access panel/cleanout port was installed, and the hood was cleaned. Evidence of completion of the repairs is maintained in the Facilities Department. The Hospital contracted with a vendor to perform quarterly inspections and cleaning of the kitchen hood. 2. The Hospital obtained a hydrostatic test for the kitchen fire suppression system. The next inspection is due in 2028. 3. The K Class fire extinguisher in the kitchen at Van Nuys was replaced on 5/26/16. The Facilities Staff checked K Class fire extinguishers to make sure that they were all charged. Facilities management includes assessment of fire extinguisher charging in the monthly fire extinguisher checks. Compliance with commercial cooking equipment (including cleaning of hoods/filters) is monitored through the PM program and scheduled EOC rounds.	5/13/16 5/26/16 5/26/16

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	050135	A. BUILDING 01 B. WING	R 04/08/2016

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{K 069}	Continued From page 54 During an interview at 11:12 a.m., the Director of Facilities (DFS2) stated that the facility was working on getting a quote for the repairs. 2. At 11:15 a.m., on 4/5/16, records of a 10/15/15 kitchen fire suppression system inspection was reviewed. The vendor indicated that the date of the last hydrostatic test was not known. During an interview at 2:32 p.m., DFS2 stated that the wet chemical cylinder was not marked with the date of its last hydrostatic test and he was unsure if a hydrostatic test was conducted in the last 12 years. Van Nuys: 3. At 11:19 a.m., on 4/6/16, the gauge on the K-Class fire extinguisher in the kitchen indicated that the extinguisher needed to be recharged.	{K 069}	Compliance and Monitoring: Data on compliance is tracked, trended, analyzed and reported monthly at the EOC Committee. Corrective action is taken as necessary. Compliance reported monthly to the Quality Council (until the Quality Council determines monitoring of the building is sufficiently conducted and then reporting will be provided quarterly to the Quality Council) then and quarterly to the Governing Board. Persons Responsible: Vice President of Facilities Development Director of Facilities	
{K 072}	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that means of egress were free from obstructions. This was evidenced by items blocking the egress paths and by walk-in freezers	{K 072}	K072 NFPA 101 LIFE SAFETY CODE STANDARD	

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{K 072}	Continued From page 55 that could not be opened from the inside when locked. This could result in the delay in evacuation and the increased risk of injury to the patients and staff during an emergency. This affected the basement and one of six floors of the Pavilion. NFPA 101, Life Safety Code, 2000 Edition. 19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7. Exception: As modified by 19.2.2 through 19.2.11. 7.1.6.1 General. Walking surfaces in the means of egress shall comply with 7.1.6.2 through 7.1.6.4. Exception: Existing walking surfaces shall be permitted where approved by the authority having jurisdiction. 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. 7.1.10.2.1 No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress therefrom, or visibility thereof. 7.1.10.2.1 No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress therefrom, or visibility thereof. 7.2.1.5.1 Doors shall be arranged to be opened readily from the egress side whenever the building is occupied. Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side. Exception No. 1: This requirement shall not apply where otherwise provided in Chapters 18 through	{K 072}		

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{K 072}	Continued From page 56 23. Exception No. 2: Exterior doors shall be permitted to have key-operated locks from the egress side, provided that the following criteria are met: (a) Permission to use this exception is provided in Chapters 12 through 42 for the specific occupancy. (b) On or adjacent to the door, there is a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high on a contrasting background that reads as follows: THIS DOOR TO REMAIN UNLOCKED WHEN THE BUILDING IS OCCUPIED (c) The locking device is of a type that is readily distinguishable as locked. (d) A key is immediately available to any occupant inside the building when it is locked. Exception No. 2 shall be permitted to be revoked by the authority having jurisdiction for cause. Exception No. 3: Where permitted in Chapters 12 through 42, key operation shall be permitted, provided that the key cannot be removed when the door is locked from the side from which egress is to be made. Findings: During a facility tour with staff from 4/4/16 to 4/8/16, the egress paths were observed. Pavilion Basement: 1. At 10:52 a.m., on 4/7/16, there were surgical supply carts and surgical equipment stored in the means of egress of the surgical suite, leaving less than 4 feet clear width for egress. 2. At 10:57 a.m., on 4/7/16, there were urology	{K 072}	<u>Findings 1-3</u> Actions Taken: 1. The identified surgical supply carts and surgical equipment in the surgical suite were removed to ensure egress paths were free from obstructions. 2. The identified Urology surgical supply carts were relocated to ensure egress paths were free from obstructions.	4/7/16 4/7/16

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{K 072}	Continued From page 57 surgical supplies on carts stored in the means of egress of the surgical suite directly across from the exit door of the suite. The facility failed to ensure that egress paths were free from obstructions. First Floor: 3. At 2:40 p.m., on 4/5/16, there were two walk-in freezers in the kitchen that were equipped with exterior padlocks for closure. The padlocks were hanging from the doors. One walk-in freezer had a broken handle that was broken and modified for use with a padlock. If the freezers were closed and locked, kitchen staff would have no mechanism to exit the freezers from the inside.	{K 072}	3. The two walk-in refrigerator exterior padlocks were removed and replaced with new push handles that have a lock with a key. Kitchen staff has a mechanism to exit the freezers from the inside. The Facilities Staff confirmed that there were no other refrigerators with this issue. 4. Hospital Leadership sent a memo to Department Managers reminding them to keep egress paths and corridors free from obstructions. 5. Compliance with maintaining means of egress free from obstructions or impediments is monitored though scheduled EOC rounds.	4/8/16 6/2/16
{K 076}	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their medical gas storage areas. This	{K 076}		

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{K 072}	Continued From page 57 surgical supplies on carts stored in the means of egress of the surgical suite directly across from the exit door of the suite. The facility failed to ensure that egress paths were free from obstructions. First Floor: 3. At 2:40 p.m., on 4/5/16, there were two walk-in freezers in the kitchen that were equipped with exterior padlocks for closure. The padlocks were hanging from the doors. One walk-in freezer had a broken handle that was broken and modified for use with a padlock. If the freezers were closed and locked, kitchen staff would have no mechanism to exit the freezers from the inside.	{K 072}	Compliance and Monitoring: Data on compliance is tracked, trended, analyzed and reported monthly at the EOC Committee. Corrective action is taken as necessary. Compliance is reported monthly to the Quality Council (until the Quality Council determines monitoring of the building is sufficiently conducted and then reporting will be provided quarterly to the Quality Council) and quarterly to the Governing Board. Persons Responsible: Vice President of Facilities Development Director of Facilities	
{K 076}	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their medical gas storage areas. This	{K 076}	K076 NFPA 101 LIFE SAFETY CODE STANDARD	4/27/16 4/27/16

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{K 076}	Continued From page 58 was evidenced by a light switch in an oxygen storage room that was mounted less than 5 feet from floor level. This affected one of six floors in the Pavilion and could result in the increased risk of hazardous conditions. NFPA 101, Life Safety Code, 2000 Edition 19.3.2.4 Medical Gas. Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. NFPA 99, Standard for Health Care Facilities, 1999 Edition 1-2 Application Chapters 12 through 18 specify the conditions under which the requirements of Chapters 3 through 11 shall apply in Chapters 12 through 18. Chapter 12 Hospital Requirements 12-1 Scope. This chapter addresses safety requirements of hospitals. 12-3.4.1 If installed, patient gas systems shall conform to Level 1 gas systems of Chapter 4. 12-3.8.1 Patient. Equipment shall conform to the patient equipment requirements in Chapter 8, "Gas Equipment." 12-3.8.2 Nonpatient. Equipment shall conform to the non-patient equipment requirements in Chapter 8, "Gas Equipment." Chapter 8 Gas Equipment 8-3.1.11.2 Storage for nonflammable gases less than 3000 ft3 (85 m3). (c) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or incompatible materials by either: 1. A minimum distance of 20 ft (6.1 m), or 2. A minimum distance of 5 ft (1.5 m) if the entire	{K 076}		

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{K 076}	Continued From page 59 storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, or 3. An enclosed cabinet of noncombustible construction having a minimum fire protection rating of one-half hour for cylinder storage. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage. (f) Electrical fixtures in storage locations shall meet 4-3.1.1.2(a)11d. (h) Cylinder or container restraint shall meet 4-3.5.2.1(b)27. (i) Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 20 ft (6.1 m) of outside storage locations. 4-3.1.1.2 Storage Requirements (Location, Construction, Arrangement). (a) Nonflammable Gases (Any Quantity; In-Storage, Connected, or Both) 11. Construction and Arrangement of Supply System Locations. d. Ordinary electrical wall fixtures in supply rooms shall be installed in fixed locations not less than 5 ft (1.5 m) above the floor to avoid physical damage. Findings: During a facility tour with staff from 4/4/16 to 4/8/16, the medical gas cylinders were observed. Pavilion Building Third Floor: 1. At 12:01 p.m., on 4/6/16, there were 4 H-sized oxygen cylinders and 7 E-sized oxygen cylinders	{K 076}	Actions Taken: 1. The switch was relocated to be five (5) feet from the floor. 2. The Facilities staff checked all light switches in the oxygen storage rooms to ensure that the switch is five (5) feet from the floor. 3. Compliance with switches in oxygen storage rooms is monitored through scheduled EOC rounds. Compliance and Monitoring: Data on compliance is tracked, trended, analyzed and reported monthly at the EOC Committee. Corrective action is taken as necessary. Compliance is reported monthly to the Quality Council (until the Quality Council determines monitoring of the building is sufficiently conducted and then reporting will be provided quarterly to the Quality Council) and quarterly to the Governing Board. Persons Responsible: Vice President of Facilities Development Director of Facilities	

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{K 076}	Continued From page 60 stored in the oxygen storage room. The light switch was installed approximately 4 feet 6 inches high from the floor. The above measurement was confirmed by the Director of Facilities Services (DFS1).	{K 076}		
{K 077}	NFPA 101 LIFE SAFETY CODE STANDARD Piped in medical gas systems comply with NFPA 99, Chapter 4. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to maintain their piped-in medical gas systems. This was evidenced by the absence of an emergency oxygen supply connection. This affected the patients in the Pavilion. This could result in the delay in emergency response upon failure of the piped-in system and the increased risk of hazardous conditions. NFPA 101, Life Safety Code, 2000 Edition 19.3.2.4 Medical Gas. Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. NFPA 99, Standard for Health Care Facilities, 1999 Edition 1-2 Application Chapters 12 through 18 specify the conditions under which the requirements of Chapters 3 through 11 shall apply in Chapters 12 through 18. Chapter 12 Hospital Requirements 12-1 Scope. This chapter addresses safety requirements of hospitals.	{K 077}	K077 NFPA 101 LIFE SAFETY CODE STANDARD	

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{K 077}	Continued From page 61 12-3.4.1 If installed, patient gas systems shall conform to Level 1 gas systems of Chapter 4. 12-3.4.3 If installed, patient vacuum systems shall conform to the safe use of electric appliances. to Level 1 vacuum systems of Chapter 4. 4-3.1.1.8 General Requirements for Gas Central Supply Systems. Piped oxygen and medical air shall not be piped to or used for, any purpose except for use in patient care applications. (h)Emergency Oxygen Supply Connection. Where the cryogenic oxygen supply is located outside of the building served, there shall be incorporated in the piping system an inlet for connecting a temporary auxiliary source of supply for emergency or maintenance situations. The inlet shall be located on the exterior of the building served and shall be physically protected to prevent tampering and unauthorized access. It shall be labeled "EMERGENCY LOW PRESSURE GASEOUS OXYGEN INLET." This connection shall be installed downstream of the shutoff valve on the main supply line (see 4-3.1.2.3(b)) and be suitably controlled with the necessary valves to allow emergency supply of oxygen and isolation of the piping to the normal source of supply. It shall have one check valve in the main line between the main line shutoff valve and the tee'd connection and one check valve between the tee'd connection and the emergency supply shutoff valve. Findings: During a facility tour with staff from 4/4/16 to 4/8/16, the piped-in medical gas system was observed.	{K 077}	Actions Taken: 1. The Hospital is currently working to install the oxygen fill port and generator alarm through OSHPD project number S160471-19-00. The project is in design phase for submittal to OSHPD. Therefore, the Hospital is requesting a	6/7/16

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{K 077}	Continued From page 62 Pavilion: 1. The facility was previously cited because the cryogenic system was not equipped with an emergency oxygen supply connection (oxygen autofill port) during a Life Safety Code Survey conducted in December 2015. At 3:52 p.m., on 4/4/16, the Vice President of Facilities (VPFS1) provided an Office of Statewide Health Planning and Development (OSHPD) application for a new project to install the oxygen fill port and generator alarm (See K144). The autofill port was not installed yet. During an interview at 3:53 p.m., VPFS1 stated that Project S160471-19-00 was still in the review phase and has not yet been approved.	{K 077}	six (6) month time-limited waiver. The waiver request is being submitted with this plan of correction. It is anticipated tha the project (including OSHPD approval) will be completed by 11/30/16. The Hospital implemented ILSM's including a) providing temporary portable oxygen tanks for emergency or maintenance situations; b) will perform pre-construction assessments; and c) obtain an infection control permit before construction. Compliance and Monitoring: Data on compliance is tracked, trended, analyzed and reported monthly at the EDC Committee. Corrective action is taken as necessary. Compliance is reported quarterly to the Quality Council and Governing Board. Persons Responsible: Vice President of Facilities Development Director of Facilities	
{K 078}	NFPA 101 LIFE SAFETY CODE STANDARD Anesthetizing locations are protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Shutoff valves are located outside each anesthetizing location and are arranged so that shutting off one room or location will not affect others. (b) Relative humidity is maintained equal to or greater than 35%. NFPA 99 4.3.1.2.3(n) and 5.4.1.1, 19.3.2.3 This STANDARD is not met as evidenced by:	{K 078}	K078 NFPA 101 LIFE SAFETY CODE STANDARD	

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{K 078}	Continued From page 63 Based on observation, record review, and interview, the facility failed to maintain the relative humidity levels in the anesthetizing locations. This was evidenced by the adoption of policies to lower the humidity in Operating Rooms (ORs) below 35% without providing documentation confirming election to utilize a categorical waiver in accordance with Centers for Medicare & Medicaid Services Survey & Certification Letter S&C: 13-25-LSC. This was also evidenced by a major repair of humidifiers after they were abandoned for more than 20 years without the inspection of the authority having jurisdiction (AHJ). This affected all the ORs in the Pavilion and in the Hollywood Building. This could result in the increased risk of a fire and the increased risk of injury to surgical patients. NFPA 101, Life Safety Code, 2000 Edition. 19.3.2.3 Anesthetizing locations shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. 4.6.1.1 The authority having jurisdiction shall determine whether the provisions of this Code are met. 4.6.1.2 Any requirements that are essential for the safety of building occupants and that are not specifically provided for by this Code shall be determined by the authority having jurisdiction. NFPA 99, Standard for Health Care Facilities, 1999 Edition Chapter 5 Environmental Systems 5-4.1.1 The mechanical ventilation system supplying anesthetizing locations shall have the capability of controlling the relative humidity at a level of 35 percent or greater.	{K 078}		

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{K 078}	Continued From page 64 5-6.1 Anesthetizing Locations. 5-6.1.1 Ventilating and humidifying equipment for anesthetizing locations shall be kept in operable condition and be continually operating during surgical procedures. Findings: During document review with staff from 4/4/16 to 4/8/16, the humidity logs were reviewed. Pavilion and Hollywood: 1. At 3:45 p.m., on 4/4/16, there were no categorical waivers provided during, and more than five hours after, the entrance conference. The policy for maintaining humidity in the ORs stated that the facility will follow the Association of periOperative Registered Nurses (AORN) standard recommended humidity range of 30 to 60 percent. This policy stated that it was applicable to the Culver City Campus and Hollywood Campus. The facility did not provide documentation of their election to utilize the categorical waiver per Centers for Medicare & Medicaid Services Survey & Certification Letter S&C: 13-25-LSC, dated 4/19/13 to lower relative humidity in the anesthetizing locations below 35%. This finding was previously cited during a Life Safety Code Survey conducted in December 2015. Hollywood Basement: 2. At 9:12 a.m., on 4/5/16, new humidistats were observed in the three ORs, in Pre-Op, and in the	{K 078}	Finding 1 Pavilion and Hollywood Actions Taken: 1. Hospital Leadership reviewed the survey findings and the MS Survey & Certification Letter S & C: 13-25-LSC. The Hospital elects to use a categorical waiver to follow the Association of PeriOperative Registered Nurses (AORN) standard recommended humidity range of 30 to 60%. The policy was revised to document the facility electing to use a categorical waiver. The EOC approved the facility's election of the categorical waiver. The Governing Board approved the categorical waiver on 6/3/16. The categorical waiver documentation will be presented to the surveyors upon entrance for the resurvey. 2. The Director of Facilities is responsible for discussing and obtaining categorical waivers for applicable issues. Finding 2 Hollywood Basement Action Taken: 1. The Vice President of Facilities contacted OSHPD regarding the survey findings. The	6/3/16 5/13/16

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{K 078}	Continued From page 65 Recovery Room. Above the ceiling, new humidifiers were observed connected to the steam lines. During an interview at 9:13 a.m., the Director of Facilities Services (DFS2) stated that the new humidifiers were installed in March 2016. He said that the rooms were always equipped with humidity controls but they had been put out of service. During an interview at 9:14 a.m., the Chief Engineer (CE1) stated that the previous humidifiers were abandoned more than 20 years ago. At 2:46 p.m., the building's mechanical blue prints from 1960 showed that humidifiers were connected to the steam pipe lines for the ORs and that the rooms were equipped with humidistats and thermostats. During an interview at 2:47 p.m., DFS2 stated that humidifier replacement parts were ordered from an HVAC vendor but the installation was conducted by facility engineers and a general contractor. He stated that the Office of Statewide Health Planning and Development was not notified of the repair.	{K 078}	OSHPD Regional Compliance Officer issued an e-mail stating that notification was not required as this issue related to maintenance. Compliance and Monitoring: The Director of Facilities reports monthly to the EOC on the need for any categorical waivers or OSHPD projects. Compliance is reported monthly to the Quality Council (until the Quality Council determines monitoring of the building is sufficiently conducted and then reporting will be provided quarterly to the Quality Council) and quarterly to the Governing Board. Persons Responsible: Vice President of Facilities Development Director of Facilities	
K 130	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation, record review, and	K 130	K130 NFPA 101 LIFE SAFETY CODE STANDARD	

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K 130	Continued From page 66 interview, the facility failed to ensure that equipment was installed in accordance with manufacturer's specifications and was approved by the authority having jurisdiction (AHJ). This was evidenced by medication dispensers that were not seismically anchored and by a commercial washer and dryer that were installed without field review and approval. This affected the basement of the Hollywood Building and one of six floors of the Pavilion. This could result in the increased risk of injury and could result in the increased risk of a lint fire. NFPA 101, Life Safety Code, 2000 Edition. 4.5.7 Maintenance. Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be maintained unless the Code exempts such maintenance. 4.6.1.1 The authority having jurisdiction shall determine whether the provisions of this Code are met. 4.6.1.2 Any requirements that are essential for the safety of building occupants and that are not specifically provided for by this Code shall be determined by the authority having jurisdiction. NFPA 99, Standard for Health Care Facilities, 1999 Edition. Chapter 9 Manufacturer Requirements 9-1 Scope. This chapter covers the performance, maintenance, and testing, with regard to safety, required of manufacturers of equipment used	K 130		

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K 130	Continued From page 67 within health care facilities. 9-2.1.1.2 Mechanical Stability. The appliance shall be mechanically stable in the position of normal use. If the appliance is intended for use in an anesthetizing location, 12-4.1 applies. 9-2.1.6.3 Chemical Agents. Electric appliances containing hazardous chemicals shall be designed to facilitate the replenishment of these chemicals without spillage to protect the patient, the operating personnel, and the safety features of the appliance from such chemicals. Findings: During a facility tour with staff from 4/4/16 to 4/8/16, the medication dispensers and laundry equipment were observed. Hollywood Basement: 1. At 9:35 a.m., on 4/5/16, there was an approximately 6 foot 5 inch tall medication cabinet directly across from the bed in the recovery room. The medication cabinet was not anchored and this was confirmed by the Director of Facilities Services (DFS2). During an interview at 3:40 p.m., on 4/6/16, Pharmacy Staff 1 stated that the medication cabinet in the recovery room was installed two weeks ago. The manufacturer's specifications for the cabinet contained Seismic Specifications in Appendix B. The instructions contained pre-approved plans for anchoring from the Office of Statewide Health	K 130	Findings 1 & 2 Actions Taken: 1. The Hospital obtained OSHPD project number S161365-19-00 for anchoring the medication cabinet in the Recovery Room and project number S161358-19-00 fo the Pavilion 6th floor. The Hospital anticipates that these projects will be completed (with OSHPD approval) by 11/30/16. Therefore, the Hospital is requesting a six (6) month time-limited waiver, that is being submitted with this plan of correction. The Hospital implemented the following ILSM's: a) secured the medication cabinets with adjustable straps and tightened the straps to remove any slack (while waiting for final approval); b) locked the equipment wheels while waiting for final approval; c) will perform pre-construction assessments before start of the project; and d) will obtain an infection control permit before construction starts.	6/7/16

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K 130	Continued From page 68 Planning and Development (OSHPD) and that were in accordance with the 2013 California Building Code. . Pavilion Sixth Floor: 2. At 11:05 a.m., on 4/5/16, there was an approximately 6 foot high medication cabinet in the medication room that was not anchored. The facility failed to provide documents to show that installation of the cabinet was approved and seismically anchored. The cabinet could fall over, block means of egress, and cause injury during a disaster. 3. At 10:59 a.m., on 4/6/16, the facility installed a commercial washer and dryer in the soiled linen/laundry without approval from the authority having jurisdiction (AHJ). The AHJ would ensure all applicable local, State and Federal safety codes are implemented. The drain pipe was made of a flexible material coming from the back of the washer went up and then down into a pipe behind the commercial dryer. The dryer exhaust was vented into a container on the floor. During an interview at 11:00 a.m., the Vice President of Facilities (VPFS1) stated the flexible pipe was the drain for the washer and could not provide documents to show that the commercial washer and dryer were installed with approval from the AHJ. The facility installed the commercial washer and dryer without field review and approval from the AHJ to ensure the electrical, plumbing, and exhaust systems met the fire and safety codes for healthcare facilities.	K 130	3. The Hospital removed the identified commercial washer and dryer in the soiled linen/laundry room. The Hospital is utilizing the washer and dryer on the fourth floor, which was installed with approval from the AHJ. Compliance and Monitoring: Data on compliance is tracked, trended, analyzed and reported monthly at the EOC Committee. Corrective action is taken as necessary. Compliance is reported monthly to the Quality Council (until the Quality Council determines monitoring of the building is sufficiently conducted and then reporting will be provided quarterly to the Quality Council) and quarterly to the Governing Board. Persons Responsible: Vice President of Facilities Development Director of Facilities	5/17/16

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{K 144}	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to maintain their emergency generators. This was evidenced by generators that were not monitored by remote alarm annunciators, by the use of a portable generator without approval, by the failure to correct a deficiency noted during generator service inspection, and by one generator with a battery charger that required a load study. This affected the Pavilion, the Tower, the Hollywood Building, and the Van Nuys Building. This could result in the increased risk of generator failure, in the event of a power outage, and the increased risk of injury to the patients. NFPA 101, Life Safety Code, 2000 Edition. 7.9.2.3 Emergency generators providing power to emergency lighting systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. Stored electrical energy systems, where required in this Code, shall be installed and tested in accordance with NFPA 111, Standard on Stored Electrical Energy Emergency and Standby Power Systems.	{K 144}	K144 NFPA 101 LIFE SAFETY CODE STANDARD	

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{K 144}	Continued From page 70 9.1.3 Emergency Generators. Emergency generators, where required for compliance with this Code, shall be tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power System. NFPA 99, Standard for Health Care Facilities, 1999 Edition. 3-4.1.1.4 General. Generator sets installed as an alternate source of power for essential electrical systems shall be designed to meet the requirements of such service. (a) Type I and Type II essential electrical system power (107C) or the engine water-jacket temperature at not less than sources shall be classified as Type 10, Class X, Level 1 generator sets per NFPA 110, Standard for Emergency and Standby Power Systems. 3-4.1.1.15 A remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. (See NFPA 70, National Electrical Code, Section 700-12) The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: (a) Individual visual signals shall indicate: 1. When the emergency power source is operating to supply power to load 2. When the battery charger is malfunctioning. (b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following: 1. Low lubricating oil pressure 2. Low water temperature (below those required in 3-4.1.1.9)	{K 144}		

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{K 144}	Continued From page 71 3. Excessive water temperature 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply 5. Over crank (failed to start) 6. Overspeed Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur, but need not display these conditions individually. NFPA 70 , National Electrical Code, 1999 Edition 700-12 The annunciator shall indicate alarm condition of the emergency or auxiliary power source as follows: (a)Individual visual signals shall indicate the following: 1. When the emergency or auxiliary power source is operating to supply power to load 2. When the battery charger is malfunctioning (b)Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following: 1. Low lubricating oil pressure 2. Low water temperature (below those required in 3-4.1.1.9) 3. Excessive water temperature 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply 5. Overcrank (failed to start) 6. Overspeed 3-5.5.2 (d) Battery powered individual alarm indication to annunciate visually at the control panel the occurrence of any of the conditions in Table 3-5.5.2 (d); additional contacts or circuits for a common audible alarm that signals locally	{K 144}		

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{K 144}	Continued From page 72 and remotely when any of the itemized conditions occurs. A lamp test switch(es) shall be provided to test the operation of all alarm lamps listed in Table 3-5.5.2(d). 3-5.6.1 A remote,, common audible alarm powered by the storage battery shall be provided as specified in 3-5.5.2(d). This remote alarm shall be located outside of the EPS service room at a work site readily observable by personnel. NFPA 110, Standard for Emergency and Standby Power Systems, 1999 edition. 1-1.3 This standard covers installation, maintenance, operation, and testing requirements as they pertain to the performance of the emergency power supply system (EPSS). 1-3 Application. This document applies to new installations of EPSSs. Existing systems shall not be required to be modified to conform, except where the authority having jurisdiction determines that nonconformity presents a distinct hazard to life. 1-4 Discretionary Powers of the Authority Having Jurisdiction. Nothing in this document is intended to prevent the use of systems, methods, or devices of equivalent or superior quality, strength, fire resistance, effectiveness, durability, and safety to those prescribed by this document, provided the following: (a) Technical Justification is submitted to the authority having jurisdiction to demonstrate equivalency. (b) The system, method, or device is approved for intended use. 2-2.4 Level. It is recognized that EPSSs are	{K 144}		

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{K 144}	Continued From page 73 utilized in many different locations and for many different purposes. The requirement for one application might not be appropriate for other applications. Therefore, this standard recognizes two levels of equipment installation, performance, maintenance, and testing. 2-2.4.1 Level 1 defines the most stringent equipment performance requirements for applications where failure of the equipment to perform could result in loss of human life or serious injuries. All Level 1 equipment shall be permanently installed. 2-2.4.2 Level 2 defines equipment performance requirements for applications where failure of the EPSS to perform is less critical to human life and safety and where it is expected that the authority having jurisdiction will exercise its option to allow a higher degree of flexibility than provided by Level 1. All Level 2 equipment shall be permanently installed. 3-5.5.2 An automatic control and safety panel shall be a part of the EPS and shall contain the following equipment or possess the following characteristics, or both: (a) Cranking control equipment to provide the complete cranking cycle described in 3-5.4.2 and Table 3-5.4.2. (b) A panel-mounted control switch(es) marked " run-off-automatic " to perform the following functions: 1. Run: Manually initiate, start, and run prime mover 2. Off: Stop prime mover or reset safeties, or both 3. Automatic: Allow prime mover to start by closing a remote contact and stop by opening the remote contact	{K 144}		

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{K 144}	Continued From page 74 (c) Controls to shut down and lock out the prime mover under the following conditions: failing to start after specified cranking time, overspeed, low lubricating-oil pressure, high engine temperature, or operation of remote manual stop station. An automatic engine shutdown device for high lubricating-oil temperature shall not be required. (See 3-5.5.6.) (d) Battery-powered individual alarm indication to annunciate visually at the control panel the occurrence of any of the conditions in Table 3-5.5.2(d); additional contacts or circuits for a common audible alarm that signals locally and remotely when any of the itemized conditions occurs. A lamp test switch(es) shall be provided to test the operation of all alarm lamps listed in Table 3-5.5.2(d). (e) Controls to shut down the prime mover upon removal of the initiating signal or manual emergency shutdown. (f) The ac instruments listed in 3-5.9.7. Where the control panel is mounted on the energy converter, it shall be mounted by means of antivibration shock mounts, if required, to maximize reliability. 3-5.6 Remote Controls and Alarms 3-5.6.1 A remote, common audible alarm powered by the storage battery shall be provided as specified in 3-5.5.2 (d). This remote alarm shall be located outside of the EPS service room at a work site readily observable by personnel. 3-5.6.2 An alarm-silencing means shall be provided, and the panel shall include repetitive alarm circuitry so that, after the audible alarm is silenced, it is reactivated after clearing the fault condition and must be restored to its normal position to be silenced. Exception: In lieu of the requirement of 3-5.6.2, a	{K 144}		

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{K 144}	Continued From page 75 manual alarm-silencing means shall be permitted that silences the audible alarm after the occurrence of the alarm condition, provided such means do not inhibit any subsequent alarms from sounding the audible alarm again without further manual action. 3-5.10 Miscellaneous Considerations. 3-5.10.1 Where applicable, the prime mover and generator shall be factory mounted on a common base of sufficient rigidity in order to maintain satisfactory dynamic alignment of the rotating element of the system prior to shipment to the installation site. 3-5.10.2 A certification shall be supplied with the unit that verifies the torsional vibration compatibility of the rotating element of the prime mover and generator for the intended use of the energy converter. 3-5.10.3 Vibration isolators, as necessary, shall be furnished to minimize vibration transmission to the permanent structure. Where unusual vibration conditions are anticipated, adequate isolation treatment shall be supplied. 5-13 Installation acceptance 5-13.1 Upon completion of the installation of the EPSS, the EPS shall be tested to ensure conformity to the requirements of the standard with respect to both power output and function. The authority having jurisdiction shall be given advance notification of the time at which the final test is to be performed so that the authority can witness the test. Findings:	{K 144}		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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{K 144}	Continued From page 76 During a facility tour with staff on 4/4/16 to 4/8/16, the facility generators were observed. Culver City Campus: 1. The facility was previously cited during a Life Safety Code Survey conducted in December 2015 because there were no remote alarm annunciators monitoring the status of three of three generators. At 3:52 p.m., on 4/4/16, the Vice President of Facilities (VPFS1) provided an Office of Statewide Health Planning and Development (OSHPD) application for a new project to install the oxygen fill port (See K77) and the "generator alarm." The remote annunciators were not installed yet. During an interview at 3:53 p.m., VPFS1 stated that Project S160471-19-00 was still in the review phase and has not yet been approved. 2. At 3:56 p.m., on 4/4/16, a report showed that a vendor was called to the facility on 2/19/16 because the portable generator for the Emergency Department (ED) Decontamination (Decontam) trailer would not start. The vendor indicated on the report that it was due to a bad battery that had been overcharged. He reported that the generator was equipped with a manual plug-in type battery charger but it needed to be replaced by an automatic battery charger to avoid overcharging. During an interview at 4:14 p.m., on 4/7/16, the Plant Operations Lead Staff (PO1) stated that the facility has not changed the battery charger yet because they were waiting for a quote.	{K 144}	Finding 1 Actions Taken: 1. Hospital Leadership reviewed the survey findings and obtained an OSHPD project number (S160471-19-00) to install remote alarm annunciators for three generators at Culver City. The plan is currently in the design phase and once complete, will be submitted to OSHPD for approval. The Hospital anticipates that this project will be completed (including OSHPD approval) by 11/30/16). Therefore, the Hospital is requesting a time-limited waiver of 6 months to complete this project. The time limited waiver request is being submitted with this plan of correction. As an ILSM, weekly rounds are being performed to check for leaks and water, and to make sure that batteries are compliant. 2. Monitoring compliance on remote alarm annunciators is performed through the PM program. Finding 2 Actions Taken: 1. The Hospital changed the identified battery charge with a triple automatic charger battery.	6/7/16 4/7/16

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	050135	A. BUILDING 01 B. WING	R 04/08/2016

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{K 144}	Continued From page 77 Van Nuys: 3. The facility was previously cited during a Life Safety Code Survey conducted in December 2015 because there was no remote alarm annunciators monitoring the status of the generator. At 8:31 a.m., on 4/6/16, the Director of Facilities Services (DFS2) provided a copy of a March 2016 application to OSHPD to install an annunciation panel at the nurses station. At 11:35 a.m., there was a low fuel sensor alarm for the generator's main diesel tank at the Unit 2 nurses station but no remote alarm annunciator. There was a new derangement signal connected to the low fuel sensor alarm. During an interview at 11:36 a.m., DFS2 stated that the derangement signal has been installed temporarily until the annunciator project was approved. Hollywood: 4. At 4:26 p.m., on 4/6/16, the latest field visit report from the OSHPD Compliance Officer (CO) indicated that Project S151968-19-00 for installation of a new generator battery charger was at 95% complete. The report, dated 1/20/16, stated that a load study was needed to complete the project. During a telephone interview at 4:27 p.m., the Project Manager (PM1) stated that he was unsure who was in charge of this project and the load study was not yet completed. Tower:	{K 144}	Finding 3 Actions Taken: 1. There is an open OSHPD project number S160564-19-00 to install a remote annunciator. The design has been completed and approved by OSHPD. The alarm annunciator is on order and is expected to arrive within two weeks. It is anticipated that this project will be completed by 8/30/16. The Hospital is requesting a time-limited waiver for six (6) months to complete the K144 project. The time limited waiver request is being submitted with this plan of correction. As an ILSM, weekly rounds are being conducted to inspect for leaks and water, and to ensure that batteries are compliant. Finding 4 Actions Taken: 1. There is an open OSHPD project number S151968-19-00 to install a new generator battery charger. The load study that was completed in January had some corrections requested from the OSHPD ACO. During the time while the Hospital was facilitating the corrections, a new ACO was assigned. Corrections have been made and are awaiting final approval from the newly appointed ACO. Anticipated completion is by 8/30/16. The Hospital is requesting a six (6) month time-limited waiver for completion of the K144 projects. Level I ILSMs were completed for non-patient care area (executed work to minimize dust and immediately replace ceiling tiles displaced for visual inspection).	6/7/16 6/7/16

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{K 144}	Continued From page 78 5. At 3:40 p.m., on 4/5/16, facility installed temporary Biohazard Decontamination trailer (see Finding 2) with a portable generator in the parking lot next to the Emergency Department without the approval from authority having jurisdiction (AHJ). The portable generator was hooked up to the permanent essential electrical system without approval. During an interview at 3:41 p.m., on 4/5/16, the Plant Operations Lead Staff (PO1) stated the trailer was connected to the facility's generator, electrical power, and water systems. During an interview at 9:12 a.m., on 4/6/16, the OSHPD Fire Life Safety Officer (FLSO) stated that the facility needed permission from state AHJ to ensure the safety of the trailer and ensure that utility connections to the hospital utilities met all local, state, and federal safety codes. During an interview at 2:43 p.m., on 4/6/16, the Manager of Environmental Health and Safety (MEHS1) stated the temporary decontamination trailer was installed approximately 8 years ago (2008). During an interview at 4:35 p.m., on 4/6/16, PM1 stated he was unaware of the temporary biohazard decontamination trailer unit.	{K 144}	Finding 5 Actions Taken: 1. Hospital Leadership discussed the survey findings with the Director of Facilities. It was identified that the portable generator was hooked to a battery charger, which was in turn plugged into an electrical outlet at the facility. The Hospital contacted the FLSO, who performed an onsite visit. The Hospital was advised that OSHPD approval was not required. OSHPD informed the Hospital that it will perform another onsite visit to confirm. Compliance and Monitoring: Data on compliance is tracked, trended, analyzed and reported monthly at the EOC Committee. Corrective action is taken as necessary. Compliance is reported monthly to the Quality Council (until the Quality Council determines monitoring of the building is sufficiently conducted and then reporting will be provided quarterly to the Quality Council) and quarterly to the Governing Board. Persons Responsible: Vice President of Facilities Development Director of Facilities	6/7/16
{K 147}	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	{K 147}	K147 NFPA 101 LIFE SAFETY CODE STANDARD	

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{K 147}	Continued From page 79 This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to maintain their electrical wiring. This was evidenced by the use of power strips and extension cords in lieu of permanent wiring and by electrical boxes with no covers. This was also evidenced by no records of inspecting a power strip mounted on medical equipment. This affected two of six floors and the basement of the Hollywood Building, the basement of the Van Nuys Building, one of six floors of the Pavilion, and one of seven floors of the Tower. These deficient practices could result in the increased risk of an electrical fire and the increased risk of harm to patients, staff, and visitors. NFPA 101, Life Safety Code, 2000 Edition. 19.5.1 Utilities. Utilities shall comply with the provisions of Section 9.1. Exception: Existing installations shall be permitted to be continued in service, provided that the systems do not present a serious hazard to life. 9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction. NFPA 70, National Electrical Code, 1999 Edition. 110-3. Examination, Identification, Installation, and Use of Equipment. (a) Examination. In judging equipment, considerations such as the following shall be evaluated: (1) Suitability for installation and use in conformity	{K 147}		

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{K 147}	Continued From page 80 with the provisions of this Code FPN: Suitability of equipment use may be identified by a description marked on or provided with a product to identify the suitability of the product for a specific purpose, environment, or application. Suitability of equipment may be evidenced by listing or labeling. (2) Mechanical strength and durability, including, for parts designed to enclose and protect other equipment, the adequacy of the protection thus provided (3) Wire-bending and connection space (4) Electrical insulation (5) Heating effects under normal conditions of use and also under abnormal conditions likely to arise in service (6) Arcing effects (7) Classification by type, size, voltage, current capacity, and specific use (8) Other factors that contribute to the practical safeguarding of persons using or likely to come in contact with the equipment (b) Installation and Use. Listed or labeled equipment shall be installed and used in accordance with any instructions included in the listing or labeling. 240-4 Flexible cord, including tinsel cord and extension cords, and fixture wires shall be protected against overcurrent by either (a) or (b). (a) Ampacities. Flexible cord shall be protected by an overcurrent device in accordance with its ampacity as specified in Tables 400-5(A) and (B). Fixture wire shall be protected against overcurrent in accordance with its ampacity as specified in Table 402-5. Supplementary overcurrent protection, as in Section 240-10, shall be permitted to be an acceptable means for providing this protection.	{K 147}		

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{K 147}	Continued From page 81 370-25 In completed installations, each box shall have a cover, faceplate, or fixture canopy. 400-8 Uses Not Permitted Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-8. (5) Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (6) Where installed in raceways, except as otherwise permitted in this Code. Findings: During a facility tour with staff from 4/4/16 to 4/8/16, the electrical wiring was observed. Hollywood Basement: 1. At 9:48 a.m., on 4/5/16, there was a Bovie Cautery plugged into a four-plug power strip in Operating Room (OR) 3. First Floor:	{K 147}	Actions Taken: 1. The four-plug power strip in the Operating Room was removed. 2. The identified extension cord was removed. 3. A cover was placed over the duplex outlet in the nurses lounge. 4. A cover was placed over the duplex outlet in the alcove of Room 308. 5. The identified extension cord was removed.	5/25/16 5/25/16 5/25/16 5/25/16 5/25/16

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{K 147}	Continued From page 82 2. At 2:36 p.m., on 4/6/16, the blood bank freezer in the clinical laboratory was plugged into an extension cord. Third Floor: 3. At 3:08 p.m., on 4/6/16, there was a duplex outlet with no cover in the nurses lounge. 4. At 3:18 p.m., on 4/6/16, there was a duplex outlet with no cover in the alcove of Room 308. Fourth Floor: 5. At 3:30 p.m., on 4/6/16, the refrigerator in the utility room was plugged into a yellow extension cord. Van Nuys Basement: 6. At 10:37 a.m., on 4/6/16, there were water stains in the ceiling tiles around the light ballast in the closet of the Human Resources Office. During an interview at 10:38 a.m., the Directors of Facilities Services (DFS2 2 and 3) stated that the shower in Room 104 was leaking directly above this closet. They stated that it has not been fixed. 7. At 10:47 a.m., on 4/6/16, the junction box near the fan coil in the linen closet was missing a cover. Pavilion Fourth Floor: 8. At 11:55 a.m., on 4/6/16, there was a refrigerator plugged into a multi-plug power strip	{K 147}	6. The shower in Room 104 was repaired and no longer leaking and the ceiling tiles were replaced. 7. A cover was placed on the junction box near the fan coil in the linen closet. 8. The refrigerator and the multi-plug power strip was removed from the Acute Rehab Office. 9. The identified PAL IV stand with the power strip was discarded. The Facilities staff reviewed other IV stands to ensure that there were no other IV stands with power strips. 10. Monitoring of electrical safety equipment is performed through scheduled EOC rounds. Compliance and Monitoring: Data on compliance is tracked, trended, analyzed and reported monthly at the EOC Committee. Corrective action is taken as necessary. Compliance is reported monthly to the Quality Council (until the Quality Council determines monitoring of the building is sufficiently conducted and then reporting will be provided quarterly to the Quality Council) and quarterly to the Governing Board. Persons Responsible: Vice President of Facilities Development Director of Facilities	4/8/16 4/8/16 5/17/16 4/8/16

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{K 147}	Continued From page 83 in the Acute Rehab Office. Tower Third Floor: 9. At 9:31 a.m., on 4/7/16, facility failed to provide documents to show inspection and testing of the power strip attached to the patient Pal I.V. stand located in the equipment room by the nurses station on the 3rd floor. The patient Pal I.V. stand did not have the facility's biomedical engineer sticker of inspection.	{K 147}		
K 154	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Based on record review, the facility failed to ensure that fire watch rounds were conducted in accordance with the instructions from the authority having jurisdiction (AHJ). This affected the penthouse of the Pavilion and could result in a delay in extinguishing a fire in the mechanical room. Findings: During record review with staff from 4/4/16 to	K 154	K154 NFPA 101 LIFE SAFETY CODE STANDARD	

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K 154	Continued From page 84 4/8/16, the fire watch logs were provided. Pavilion Penthouse: 1. At 11:02 a.m., on 4/4/16, there was scaffolding blocking the spray pattern of the sprinkler heads in the mechanical room. The scaffolding was erected as part of an HVAC (heating, ventilating, and air-conditioning) restoration project after a fire in the penthouse destroyed an air handler on 1/29/15. The facility was instructed by the local fire marshal to conduct fire watch rounds in the mechanical room due to the obstructed sprinkler heads. At 11:21 a.m., the fire watch instructions on the Fire Watch Log Sheet read in bold and capital letters that "A PATROL IS TO BE CONDUCTED EVERY 30 MINUTES." The logs from March and April 2016 showed that fire watch patrols were missed during the following dates and times: a. There was one patrol missing between 2:30 p.m. to 3:30 p.m. on 4/3/16. b. There was one patrol missing at 11:30 p.m. on 4/2/16. c. There were two patrols missing between 10:00 p.m. and 11:30 p.m. on 3/31/16. d. There was one patrol missing between 9:30 a.m. and 10:30 a.m. on 3/30/16. e. There was one patrol missing at 11:00 p.m. on 3/25/16. f. There was one patrol missing at 4:00 p.m. on 3/24/16. g. There was one patrol missing at 1:00 p.m. on 3/23/16.	K 154	Finding 1 Actions Taken: 1. Hospital Leadership discussed the survey findings with the Director of Facilities, with the expectation that strict adherence to fire watch monitoring will be maintained. The Director of Security discussed the survey findings with the contracted company performing the fire watch and with Facilities staff. A process was established to cover breaks and any other times that the person needs to be relieved. The Chief of Security or qualified designee is responsible for monitoring the fire watch logs daily and reporting any missed patrols to the Director of Facilities and/or Hospital Leadership for immediate action. The Director of Security will submit a fire watch report to EOC, beginning June 2016. 2. Compliance with fire watch procedures is monitored daily by the Chief of Security or qualified designee. Compliance and Monitoring: Data on compliance is tracked, trended, analyzed and reported quarterly at the EOC Committee. Corrective action is taken as necessary. Compliance is reported quarterly to the Quality Council a(until the Quality Council determines monitoring of the building is sufficiently conducted and then reporting will be provided quarterly to the Quality Council) and quarterly to the Governing Board. Persons Responsible: Vice President of Facilities Development Director of Facilities	6/7/16

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K 154	Continued From page 85 h. There was one patrol missing at 3:00 p.m. on 3/22/16. i. There were three patrols missing between 1:30 p.m. and 3:30 p.m. on 3/21/16.	K 154		
{K 160}	NFPA 101 LIFE SAFETY CODE STANDARD All existing elevators, having a travel distance of 25 ft. or more above or below the level that best serves the needs of emergency personnel for fire fighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. 19.5.3, 9.4.3.2 This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to maintain their elevators. This was evidenced by the failure to conduct testing for the Phase I and Phase II Firefighter services on a monthly basis. This affected one of two elevators in the Hollywood Building and the elevator at the Van Nuys Building. This could result in the increased risk of malfunction of the elevators, in the event of a fire. NFPA 101 Life Safety Code, 2000 Edition 19.5.3 Elevators, Escalators, and Conveyors. Elevators, escalators, and conveyors shall comply with the provisions of Section 9.4. 9.4.6 Elevator Testing. Elevators shall be subject to routine and periodic inspections and test as specified in ASME/ANSI A17.1, Safety Code for Elevators and Escalators. All elevators equipped with fire fighter service in accordance with 9.4.4 and 9.4.5 shall be subject to a monthly operation with a written record of the findings made and	{K 160}	K160 NFPA 101 LIFE SAFETY CODE STANDARD	

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{K 160}	Continued From page 86 kept on the premises as required by ASME/ANSI A17.1, Safety Code for Elevators and Escalators Findings: During record review with staff from 4/4/16 to 4/8/16, the elevator inspection records were reviewed. Hollywood: 1. At 11:33 a.m., on 4/5/16, the elevators' Fire Service Test Logs were provided. The logs indicated that ASME A17.1 requires that all elevators provided with firefighters' emergency operation be tested monthly for the following: Phase 1 recall by use of the key switch and minimum one-floor operation on Phase II. The test logs showed that Phase II was not tested from January 2015 to February 2016 for Conveyance 37307. Van Nuys: 2. At 9:26 a.m., on 4/6/16, the elevator's Fire Service Test log indicated that there were no monthly inspections conducted in January, February, March, April, and August 2015. During an interview at 9:27 a.m., the Director of Facilities Services (DFS3) stated that the elevator service company emails him every time they conduct a service. At 9:41 a.m., the email records matched the test log and there were five missing inspections in 2015.	{K 160}	Actions Taken: 1. The Hospital terminated the elevator vendor. A new elevator vendor started May 2016 and Phase I and II was completed on 5/31/16. 2. The Hospital terminated the elevator vendor. Monthly inspections for January 2016 through May 2016 are available in the facilities department. 3. Monitoring compliance with current elevator inspections is part of the PM program. Compliance and Monitoring: Data on compliance is tracked, trended, analyzed and reported quarterly at the EOC Committee. Corrective action is taken as necessary. Compliance is reported quarterly to the Quality Council a(until the Quality Council determines monitoring of the building is sufficiently conducted and then reporting will be provided quarterly to the Quality Council) and quarterly to the Governing Board. Persons Responsible: Vice President of Facilities Development Director of Facilities	5/31/16 6/1/16

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{A 000}	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health Licensing and Certification during a CMS requested REVISIT SURVEY conducted on 4/4/16 through 4/8/16 following a FULL VALIDATION SURVEY conducted on 12/14/15 through 12/22/15. Representing the Department of Public Health Licensing and Certification: Surveyor 25092, HFEN Surveyor 33720, HFEN Surveyor 28928, HFEN Surveyor 35399, HFEN Surveyor 35483, HFEN Medical Consultant, 26881 Medical Consultant, 29775 Pharmacy Consultant, 25281 Infection Control Consultant, 28020 Infection Control Consultant, 33399 The census at the Culver City campus was: 150 The census at the Hollywood campus was: 51 The census at the Van Nuys campus was: 57 Patient Records Sampled: 43	{A 000}	A 000 Initial Comments Preparation and execution of this plan of correction does not constitute an admission or agreement of the facts alleged or conclusions set forth on the Statement of Deficiencies. This plan of correction is prepared and executed solely because it is required by federal and state law. The following constitutes Southern California Hospital at Hollywood's credible allegation of compliance.	
{A 043}	482.12 GOVERNING BODY There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ... This CONDITION is not met as evidenced by: Based on interview and record review, the	{A 043}	A 043 482.12 Governing Body The Governing Board has been involved in the development and implementation of this credible allegation of compliance. The Board meets monthly, and as needed, to address overall patient care and operational issues for which it provides oversight. Specifically, the Board addressed a) evaluation of contracted service providers, approving an evaluation worksheet (which addresses each provider's performance evaluations and QAPI reporting, among other criteria) and	6/7/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Catherine H Shtaran	CEO	06-06-2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{A 043}	Continued From page 1 hospital's Governing Body failed to be responsible for the quality and safety of services provided because: The contracted alarm installation company had not been subjected to quality review (see A-0083). The fire alarm system was not functioning correctly to minimize the risk of fire hazard (see A-0700). The risk of infection had not been minimized through the implementation of an effective infection control program (see A-0747). The hospital's plan of correction for the survey completed on 12/22/15 showed that significant events would be referred to leadership within 24 hours. However, problems with critical processes such as fire alarm safety and instrument sterilization were not ensured because the Governing Body did not have adequate surveillance mechanisms to identify the problems promptly. During interviews with hospital leadership including the CEO, Sr VP of Hospital Operations and others on 4/4/16 at 1530 and on 4/7/16 at 1510, they were not aware of the recurrent problems with the fire alarm and sterile processing systems, and were not aware of the actions of hospital staff. The cumulative effect of these failings meant the hospital did not ensure high quality healthcare was provided in a safe environment.	{A 043}	operational evaluation reporting tool to governance for standardizing such evaluations; b) effective implementation of the organization's Infection Control program and plan to ensure infections are minimized and infection control and prevention practices are upheld throughout the organization (including proper high-level disinfection and sterilization of instruments and equipment), and c)adequate surveillance mechanisms for immediate identification and management of high risk processes and critical events occurring in the organization. Informal discussions and formal meetings have taken place since the April 2016 survey exit, to ensure governance is aware of, directs and approves actions undertaken by the organization to remediate the specific identified findings as outlined in the survey report, to ensure system-wide processes are developed and implemented to prevent recurrence of these findings, and to establish sustainable system-wide processes to address root causes of the issues leading to identified failures.	
{A 083}	482.12(e) CONTRACTED SERVICES The governing body must be responsible for services furnished in the hospital whether or not they are furnished under contracts. The governing body must ensure that a contractor of services (including one for shared services and joint ventures) furnishes services that permit the	{A 083}	A 083 482.12(e) Contracted Services Actions Taken: 1. An evaluation of the contracted fire alarm contractor was completed. 2. Executive Leadership and the Director of Quality reviewed the survey findings and the process for monitoring annual evaluations of contracted service providers.	5/26/16 4/8/16

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{A 083}	Continued From page 2 hospital to comply with all applicable conditions of participation and standards for the contracted services. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the contracted fire alarm installer had not been the subject of performance review, creating the risk of substandard alarm services. Findings: The Rules and Regulations of the Governing Board (undated) showed that the functions of the Governing Board included, "Assure that all services furnished on a contract basis at or by the Hospital meet the standards set forth by the Governing Board, Hospital Administration and the Medical Staff, and further that such services are being furnished in compliance with all applicable federal, state and accreditation agency requirements." Review of hospital documents showed that there was a fire in the hospital during January, 2015. and that subsequently there were failures of the audible fire alarm system in September, 2015, December, 2015, and during vendor testing on January 22, 2016. Failures in the audible fire alarm system was also noted during this survey (see A-700). In an interview with the Dir of Facilities on 4/7/16 at 1410, he stated that there were problems with the audible alarms during the week. In an interview with the Dir of Facilities on 4/7/16 at 1415, he stated that they were not doing audible alarm testing quarterly, but that an annual review was done in January. During an interview with the Dir QA on 4/7/16 at 1400, she stated that the QAPI program obtained information about the fire alarm system from the EOC minutes. She stated that the minutes should	{A 083}	Contracts are reviewed to ensure the presence of stated performance expectations by the contracted provider are included in the contract. 3. A contracted provider evaluation form was developed and provided to the facility. 4. Evaluation of contracted services are included in the ongoing monitoring activities through the QAPI program to assess the services, identify any quality and performance issues, and to institute any necessary corrective action or performance improvement measures. The Director of Quality coordinates a review of contracted service providers and the schedule for annual reviews, with documentation evidencing receipt and review of the evaluation. The Department Manager is responsible for obtaining the annual evaluation and providing it to the Quality Department. Department Managers were educated on the process. 5. The contracted provider evaluation schedule was revised to include a scoring system resulted from the evaluation process. This grid is presented to the Governing Board annually to ensure governance is aware of contracted provider's performance and can render determinations for any required actions based on substantive information about the contracted provider. The grid includes the action required for any score that presents as an outlier. This new evaluation scoring system is developed for implementation during the calendar year 2016, to provide a sustainable "go forward" method for ensuring a) all contracted providers are evaluated based on criteria, b) all contracted providers are included in the evaluation, c) the evaluation includes	6/1/16 6/6/16 6/1/16

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{A 083}	Continued From page 3 include information about the January alarm system testing results. The EOC minutes were reviewed, and read that the fire marshall had signed off on the fire alarm system. There was no information about the failure of fire alarms in January, 2016. Documentation from the fire marshall showed that the fire alarm system had not been approved due to unresolved problems. During an interview with the Dir QA on 4/8/16 at 0920, she stated that the QA Department provided annual evaluation of contracted service providers using a standard form. During a second interview with the Dir QA, on 4/8/16 at 1120, she stated that the contracted fire alarm contractor had started in January, 2015, and the contractor's work had not been evaluated. She stated that the evaluation should have been done in January, 2016.	{A 083}	performance expectation and quality/safety reporting review and, d) governance is provided with information on actions for improving performance of, or recommendations for replacing contracted providers. The evaluation form and format is completed effective 6/1/16. A review of life safety and clinically-related contracted providers using the aforementioned system began on 6/1/16. 6. Executive Leadership and the Director of Quality reviewed the current list of contracted service providers to ensure that there was an annual evaluation provided and reviewed.	6/1/16
A 119	482.13(a)(2) PATIENT RIGHTS: REVIEW OF GRIEVANCES [The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance.] The hospital's governing body must approve and be responsible for the effective operation of the grievance process, and must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee. This STANDARD is not met as evidenced by: Based on interview and record review, the hospital failed to ensure that one grievance (for Patient M604) was investigated, creating the risk of a failed grievance process and persistent poor practices. Findings:	A 119		

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A 119	482.13(a)(2) PATIENT RIGHTS: REVIEW OF GRIEVANCES [The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance.] The hospital's governing body must approve and be responsible for the effective operation of the grievance process, and must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee. This STANDARD is not met as evidenced by: Based on interview and record review, the hospital failed to ensure that one grievance (for Patient M604) was investigated, creating the risk of a failed grievance process and persistent poor practices. Findings:	A 119	A 119 482.13 (a)(2) Patient Rights: Review of Grievances Immediate Actions Taken: 1. A Leadership meeting convened on 4/21/16 in which the Director of Quality and Chief Executive Officer (CEO) apprised the management team of their responsibility for fully investigating grievances and providing complete follow up to ensure that the patient and/or representative is satisfied with the actions taken on his/her behalf. 2. The Chief Nursing Officer discussed the survey findings with the identified Department Manager immediately following the survey, with special emphasis on accurately documented a patient's grievance and conducting an investigation.	4/21/16 4/8/16

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A 119	Continued From page 4 The grievance of Patient M604 was reviewed on 4/7/16, and showed that the patient reported being discharged prematurely, being provided with conflicting information about the discharge, and had complaints about behavior of one nurse, who he described but did not name. He did not present a complaint about his assigned nurse, but that another nurse, who he described as a hispanic woman, was unpleasant and insisted that he leave the hospital. During a review of the medical record, the discharge order written at approximately 1800 hours on 3/16/16 was contingent upon a consultants approval. The consultant arrived to see the patient at 2100 hours, but indicated in his note that he approved the discharge earlier in the day. The patient was discharged from the hospital an hour prior to midnight on 3/16/16, but returned the following day to complain. In an interview with AS2, she was able to confirm the descriptions of his nurse and the nurse about whom he complained matched the description of his assigned nurse and the charge nurse on duty the night he was discharged. The grievance investigation by the manager restated the complaint incorrectly, confusing the description of the nurse about whom he was complaining. The manager then noted that the patient did not have such a nurse caring for him. The manager also noted that the patient had a signed discharge order, but failed to investigate why a discharge ordered at six in the evening resulted in a discharge at 11pm, and did not show that staff were interviewed about providing conflicting information regarding the discharge or mistreatment of the patient. There was no evidence that any witnesses to the events were interviewed. A response letter that was sent to the	A 119	3. Executive leadership requested notification of initial grievance receipt and status of current grievances at the Daily Leadership Huddle (a meeting of the executive team to discuss daily unit and hospital priorities, and significant events), as an additional method of tracking grievances and ensuring optimal oversight. 4. The Director of Quality/Risk Management reviewed the "Complaints and Grievances" policy, which did not require any revision. As detailed in the policy, the patient and/or their representative is provided with information at the time of admission that the hospital has an established process for responding to all patient complaints/ grievances. Upon receiving a complaint/ grievance, staff members will investigate the facts and resolve the concern as soon as possible. When a patient (or his/her representative) grievance is received, a Patient Grievance & Complaint intake form is completed and forwarded to the responsible Director/Manager and Administration for investigation. A copy is also forwarded to Quality/Risk Management. The complainant receives a written response within seven (7) days with resolution or that the hospital is still working to resolve the issue and that a written response will be sent to them within thirty (30) days. The Quality/Risk Management Director or designee reviews all grievances and ensures that the grievance has been and will be investigated thoroughly and in a timely manner. Department Managers were re-educated on the policy, with special emphasis on accurately documenting a	4/11/16 4/8/16

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SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	6245 DE LONGPRE AVE HOLLYWOOD, CA 90028

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A 119	Continued From page 4 The grievance of Patient M604 was reviewed on 4/7/16, and showed that the patient reported being discharged prematurely, being provided with conflicting information about the discharge, and had complaints about behavior of one nurse, who he described but did not name. He did not present a complaint about his assigned nurse, but that another nurse, who he described as a hispanic woman, was unpleasant and insisted that he leave the hospital. During a review of the medical record, the discharge order written at approximately 1800 hours on 3/16/16 was contingent upon a consultants approval. The consultant arrived to see the patient at 2100 hours, but indicated in his note that he approved the discharge earlier in the day. The patient was discharged from the hospital an hour prior to midnight on 3/16/16, but returned the following day to complain. In an interview with AS2, she was able to confirm the descriptions of his nurse and the nurse about whom he complained matched the description of his assigned nurse and the charge nurse on duty the night he was discharged. The grievance investigation by the manager restated the complaint incorrectly, confusing the description of the nurse about whom he was complaining. The manager then noted that the patient did not have such a nurse caring for him. The manager also noted that the patient had a signed discharge order, but failed to investigate why a discharge ordered at six in the evening resulted in a discharge at 11pm, and did not show that staff were interviewed about providing conflicting information regarding the discharge or mistreatment of the patient. There was no evidence that any witnesses to the events were interviewed. A response letter that was sent to the	A 119	5. Compliance with the grievance policy is monitored through the Grievance Committee and QAPI program. Compliance and Monitoring: The Director of Quality/Risk Management or qualified designee reviews all grievances weekly to achieve the goal of 100% compliance with a thorough investigation of the grievance and complete response to the patient (or representative). Corrective action is taken as necessary, including re-education. Data is analyzed and reported monthly to the Grievance Committee and Quality Council, and at least quarterly to the Medical Executive Committee (MEC) and Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will occur until the Quality Council determines sustained compliance has occurred, at which time the Quality Council will determine what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Person Responsible: Director of Quality and Risk Management	

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A 119	Continued From page 5 complainant 3/31/16 did not address the allegation of mistreatment by the nurse. In an interview with the Dir QA, she concurred that there appeared to be incomplete follow-up of the grievance.	A 119		
A 129	482.13(b) PATIENT RIGHTS: EXERCISE OF RIGHTS Patient Rights: Exercise of Rights This STANDARD is not met as evidenced by: Based on observation, interview and facility policy review, the facility failed to ensure that all patients admitted to the facilities behavioral health unit maintained the right to wear their own clothing. This failure denied patient's rights without due cause. Findings: A review of the facility policy titled, "Patient's Rights" dated 09/15, indicated in part, "3. Policy and Procedure, A. All patients admitted to the Behavioral Health Unit have the right: 1: To wear their own clothing." A review of facility policy titled, "Care of Patient Belongings and Valuables," effective date 02/16, indicated in part, "C: Admission Process. 8. On the Behavioral Health Unit (BHU), two (2) changes of clothing may be in patient's possession, to be stored in the patient's personal closet." A review of facility policy titled, "Patient's Rights, Denial of," effective date 09/15, indicated in part, "3. Policy/ Procedure. A. Psychiatric facilities must uphold the following specific legal rights of	A 129	A 129 482.13 (b) Patient Rights: Exercise of Rights Immediate Actions Taken: 1. Patients in the Behavioral Health Unit were immediately provided access to their personal clothes, with the exception of clothing accessories that can be used as ligatures, such as belts and shoelaces for those patients admitted in an acute suicidal/ homicidal crisis. 2. The Assistant Chief Nursing Officer for Behavioral Health educated behavioral health staff at the time of survey on the patient's right to access and wear their clothing. Subsequent Actions Taken: 1. Executive Leadership reviewed the "Patient's Rights," "Care of Patient Belongings and Valuables," and "Patient Rights, Denial of" policies, which did not require any revisions. All patients presenting to the Behavioral Health Unit have the right to wear their own clothing. Two changes of clothing may be in the patient's possession and stored in the patient's personal closet. Patent rights are upheld unless good cause exists (e.g., the physician orders that the patient is not allowed to have access to their personal clothing due to his/her psychiatric condition). If a patient right, such as the right to wear their own clothing, is denied, the	4/6/16 4/6/16 5/19/16

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A 129	Continued From page 6 patients, which may only be denied when "Good Cause" exists: 1 The right to wear own clothing....." During an observation and tour of the Behavioral Health Unit (BHU) on 4/6/16, starting at 8:45 a.m., accompanied with Adm1, Adm 2, Adm 3, RN 4, and MD 2 patients on all units (open, C and D), were noted to be in the halls and or in bed. All observed patients were noted to be dressed in forest green colored hospital gowns. The activities schedule indicated groups for these units started at 8:30 a.m.. During the tour, the patient rooms had patient personal closets, random openings of these closets did not reveal any patient personal clothing. During a concurrent observation and interview with ADM 1 on 4/6/16, beginning at 8:45 a.m., when asked where the patient's personal clothing was, ADM 1 stated, "We store them, because some patient's wander in and out of rooms and take things." During an interview with Patient N100 on 4/6/16, at 9:15 a.m., accompanied with MD 2 and ADM 2, Patient N100 was observed sitting in her room in a wheelchair, dressed in a hospital issued gown, listening to music playing from a radio on a side table. When asked where her clothes were, Patient N100 stated, "They took them, I came in with a green robe, and pants and they won't give them back to me." When Patient N100 was asked if she would like to wear her own clothing , Patient N100 stated, "Yes." MD 2 was questioned as to whether it was routine to take a patients clothing, MD 2 stated, "No." ADM 2 added, "We can get everyone's clothing back to them today." During an interview with RN 4 on 4/7/16, at 10:05 a.m., when questioned about the process for	A 129	staff shall complete a denial of rights form that will be placed in the medical record. Education on the policies was provided to behavioral unit staff on 4/14/2016 - 5/19/2016 regarding the patient's right to have access to personal clothes unless otherwise ordered. 2. Education on patient rights, including the right to wear their personal clothes, is provided to Behavioral Health Unit staff upon hire. Compliance and Monitoring: The Assistant Chief Nursing Officer for Behavioral Health or qualified designee performs at least weekly random observation rounds to achieve the goal of 100% compliance with patients having access to their personal clothes. Data is analyzed and reported monthly to the Quality Council, MEC and Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will occur until the Quality Council determines sustained compliance has occurred, at which time the Council will determine what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Person Responsible: Assistant Chief Nursing Officer for Behavioral Health	5/19/16

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A 129	Continued From page 7 patient belongings, RN 4 stated, most of the BHU patients come through the ER (emergency room), where their clothes are bagged and the patients are put into a gowns, when they come up to the unit (BHU) their clothes go into storage. RN 4 shared there was no denial of rights form filled out.	A 129		
A 132	482.13(b)(3) PATIENT RIGHTS: INFORMED DECISION The patient has the right to formulate advance directives and to have hospital staff and practitioners who provide care in the hospital comply with these directives, in accordance with §489.100 of this part (Definition), §489.102 of this part (Requirements for providers), and §489.104 of this part (Effective dates). This STANDARD is not met as evidenced by: Based on interview and record review, the hospital failed to provide documentation of follow-up for Patient N300 who requested further information regarding Advance Directives at the time of admission. Findings: The hospital policy and procedure titled "Advance Directives" dated 3/2016. indicated that the hospital "shall provide to each adult individual, at the time of his or her admission as an inpatient, written information describing: i. An individual's right under California statutes and court decisions to...formulate Advance Directives...E. If the patient does not have an Advance Directive and is able to decide for self, the Admitting Clerk will ask the patient if information is desired...ii. If the patient would like further information: a. The	A 132	A 132 482.13(b)(3) Patient Rights: Informed Decision Immediate Actions Taken: 1. The Admitting Manager and Director of Social Services reviewed the survey finding. It was identified that the patient's family requested assistance with executing an advance directive on behalf of the patient who was unable to do so. The Admitting Department staff informed the patient's family that only the patient could execute the advance directive, not a family member. Therefore, a social service referral was not made and included on the list for follow up. 2. The Admitting Manager discussed the survey findings with admitting staff, with special emphasis on the inability of family members to complete an advance directive. Subsequent Actions Taken: 1. Executive Leadership and the Admitting Manager reviewed the "Advance Directive" policy. An advance directive packet is provided to all patients upon admission, which includes the advance directive form and instructions. The patient is informed to let their physician or nurse know if they would like any assistance in preparing an advance directive. The physician or nursing staff is responsible for contacting social	4/8/16 4/12/16 - 4/14/16 5/31/16

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A 132	Continued From page 8 admitting staff will give the patient a packet explaining how to obtain an Advance Directive. The patient's name will be placed on a list entitled "Referral to Social Services for Follow-up on Advance Directives."This list is kept in the admitting office and is picked up by the Case Manager and/or LCSW who will follow-up with the patient in-house and provide counseling, if needed..." During a concurrent review of Patient N300's electronic record (e-record) and interviews with administrative staff (AS)1 and social worker (SW) 1 on 4/5/16 at 2 p.m., a form titled "Conditions of Admission" dated 3/29/16 indicated that Patient N300 wanted more information regarding Advance Directives. SW 1 said that there is a "Referral to Social Services for Follow-up on Advance Directives" binder in admissions which was obtained.SW 1 said that admitting has to put the patient's name in the the referral book for someone to get back to the patient with further information on Advance Directives. The dates for follow-up went from 3/25/16 through 4/5/16. After review, both AS1 and SW 1 agreed that Patient N300's name was not included on the list for follow-up.	A 132	services to see the patient and assist with any issues relative to the advance directive. The Admitting Staff is no longer responsible for initiating a social service referral and completing a follow up list. The Quality Council and Governing Board approved the policy on 6/3/16. The Admitting Manager and Director of Social Services educated admitting and social service staff on the revised policy. 2. The Admitting Manager revised the existing audit tool to allow for a separate line item for advance directives (previously listed under consents). 3. Education on providing advance directive information to patients upon admission is provided to Admitting Staff upon hire. 4. Compliance with advance directives is monitored through the QAPI program. Compliance and Monitoring: The Admitting Manager or qualified designee performs daily auditing Monday through Friday on a random 10% sample of admitted patients to achieve the goal of 100% compliance with patients provided with advance directive information at the	6/3/16 5/27/16
A 166	482.13(e)(4)(i) PATIENT RIGHTS: RESTRAINT OR SECLUSION The use of restraint or seclusion must be-- (i) in accordance with a written modification to the patient's plan of care. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to write a plan of care for Patients N501 and N503 who were placed in wrist	A 166		

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A 132	Continued From page 8 admitting staff will give the patient a packet explaining how to obtain an Advance Directive. The patient's name will be placed on a list entitled "Referral to Social Services for Follow-up on Advance Directives."This list is kept in the admitting office and is picked up by the Case Manager and/or LCSW who will follow-up with the patient in-house and provide counseling, if needed..." During a concurrent review of Patient N300's electronic record (e-record) and interviews with administrative staff (AS)1 and social worker (SW) 1 on 4/5/16 at 2 p.m., a form titled "Conditions of Admission" dated 3/29/16 indicated that Patient N300 wanted more information regarding Advance Directives. SW 1 said that there is a "Referral to Social Services for Follow-up on Advance Directives" binder in admissions which was obtained.SW 1 said that admitting has to put the patient's name in the the referral book for someone to get back to the patient with further information on Advance Directives. The dates for follow-up went from 3/25/16 through 4/5/16. After review, both AS1 and SW 1 agreed that Patient N300's name was not included on the list for follow-up.	A 132	time of admission (or documentation that the patient was not able to receive the information and/or family were not available to receive the information). Data is analyzed and reported monthly to the Quality Council, MEC and Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will occur until the Quality Council determines sustained compliance has occurred, at which time the Council will determine what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Person Responsible: Admitting Manager	
A 166	482.13(e)(4)(i) PATIENT RIGHTS: RESTRAINT OR SECLUSION The use of restraint or seclusion must be-- (i) in accordance with a written modification to the patient's plan of care. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to write a plan of care for Patients N501 and N503 who were placed in wrist	A 166	A 166 482.13(e)(4)(i) Patient Rights: Restraint or Seclusion Immediate Actions Taken: 1. Nursing reviewed and revised the identified nursing care plans to reflect the use of restraints. 2. Nursing reviewed all patients on restraints at the time of survey to ensure that there was a nursing care plan for restraints.	4/4/2016 4/4/16

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A 166	Continued From page 9 restraints for non-violent behavior. This failure to write patient specific plans of care for wrist restraints placed the patients at risk for complications. Findings: Review of the facility's policy and procedure titled "Restraints and Seclusion" dated 2/2016, indicated "Care Plan, the restrained or secluded patient's written plan of care shall be modified to address the appropriate interventions implemented to assure the patient's safety and encourage the least restrictive means of protecting the patient." Review of the facility's policy and procedure titled "Interdisciplinary Plan of Care" dated 2/2016 indicated "An individualized Plan of Care is developed for each patient; each patient's careplan identifies goals that: i. Reflect the patient's unique needs ii. Are realistic and measurable iii. include a time frame for achievement, when appropriate." During an observation and consecutive interview with an RN (RN 1) on 4/4/16 at 2:45 p.m., Patient N501's private room door to the hallway was shut. RN 1 stated the door was shut for the patient's privacy. Patient N501 was overheard yelling "Help me." and "I want to take it off." over and over. Patient N501 was observed lying in bed on her back with both wrists tied to the sides of the bed, the call light was not within reach. Review of Patient N501's clinical record did not reveal a plan of care for the use of wrist restraints.	A 166	3. The Charge Nurse discussed the survey findings with Patient 501's nurse and sitter. 4. The Charge Nurse inserviced sitters at the time of survey on monitoring patients in restraints. Subsequent Actions Taken: 1. Nursing Leadership reviewed the "Restraints and Seclusion" policy, which did not require any revisions. As detailed in the Policy, the restrained or secluded patient's written plan of care shall be modified to address the appropriate interventions (e.g., restraints) to assure the patient's safety and encourage the least restrictive means of protecting the patient. Nursing staff was re-inserviced on developing nursing care plans for patients in restraints. 2. Care facilitation is in process for all patients on restraints/seclusion. Care facilitation, a process of reviewing the patient's record in real time, interceding with staff to provide teaching/correcting as necessary for the "teachable moment" and to correct any deficiencies in care or documentation. 3. Education on nursing care plans for restraints is provided to clinical staff upon hire. 4. Compliance with nursing care plans for patients in restraints is monitored through the QAPI program. Compliance and Monitoring: All patients in restraints are assigned to the care facilitation model to determine ongoing compliance with policy, including development and activation of nursing care plans related to restraints. Compliance	4/4/16 4/4/16 5/18/16 - 5/30/16 4/25/16

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A 166	Continued From page 10 During an interview with RN 2 on 4/4/16 at 4:30 p.m., RN 2 confirmed there was no plan of care for restraints completed for Patient N501. During an observation and concurrent interview of Patient N503 on 4/4/16 between 3:05 and 4:30 p.m., Patient N503 was lying in bed on her back with both wrists tied to the sides of the bed. RN 7 stated the restraints were to keep the patient from scratching herself. Review of Patient N503's clinical record did not reveal a plan of care for wrist restraints. During an interview with RN 2 on 4/8/16 at 10:45 a.m., RN 2 confirmed there was no plan of care for restraints completed for Patient N503.	A 166	target was set at 100% with output from ongoing monitoring reported daily to the Executive Leadership team on a Monday through Friday basis (with weekends rolled into Monday's outcome data). Monthly data is reported to the Quality Council and MEC, and quarterly to the Governing Board. Outcomes from restraint monitoring, including care planning, will be reviewed by the Quality Council until the Council members feel restraint processes are compliant, with this compliance sustainable over time. The Quality Council may then request reduction in monitoring to a random "snapshot" basis at a time period to be determined by the Council (e.g., quarterly, semi-annually, annually) to ensure continued compliance occurs. Person Responsible: Chief Nursing Officer	
{A 175}	482.13(e)(10) PATIENT RIGHTS: RESTRAINT OR SECLUSION The condition of the patient who is restrained or secluded must be monitored by a physician, other licensed independent practitioner or trained staff that have completed the training criteria specified in paragraph (f) of this section at an interval determined by hospital policy. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to assess, monitor and document on Patients N501 and N503 who were placed in wrist restraints for non-violent behavior. Failure to monitor and assess for restraints places these patients at risk for negative complications during the use of restraints. Findings:	{A 175}	A 175 482.13(e)(10) Patient Rights: Restraint or Seclusion Immediate Action Taken: 1. Executive Leadership discussed the surveyor findings regarding assessing, monitoring and documenting restraint use. 2. Nursing staff assessed the identified patients in restraints, including the need for ongoing restraint for protection and tolerance of the restraint. The assessment was documented in the medical record. 3. Nursing reviewed all patients on restraints at the time of survey for documentation of ongoing assessments for the continued need for the restraint, tolerance of the restraint, and temporary	4/8/16 4/4/16 4/4/16

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{A 175}	Continued From page 11 Review of the facility's policy and procedure titled "Restraints and Seclusion" dated 2/2016 indicated "Restraints not used for the management of violent behavior shall be subject to ongoing monitoring and assessment as specified in the patient's plan of care. Monitoring and assessments shall occur at least every 2 hours." During a fifth floor facility tour on 4/4/16 between 11:05 a.m. and 4:30 p.m., Patients N501 and N503 were observed with wrist restraints. During an observation and consecutive interview with an RN (RN 1) on 4/4/16 at 2:45 p.m., Patient N501's private room door to the hallway was shut. RN 1 stated the door was shut for the patient's privacy. Patient N501 was overheard yelling "Help me." and "I want to take it off." over and over. Patient N501 was observed lying in bed on her back with both wrists tied to the sides of the bed, the call light was not within reach. Review of Patient N501's "Protective (Safety) Restraint Doctor's Order and Daily Record" form dated from 3/38/16 to 4/5/16 indicated a check off list for assessment and temporary restraint release during care, however, Patient N501's documentation was inconsistent and assessments were not checked as completed on 3/29, 3/31, 4/1, 4/2, 4/3, and 4/4/16. The Patient's restraints were not temporarily released to provide care on all shifts, the patient was not assessed to require ongoing restraint for protection, and the patient was not assessed to tolerate the restraint without physical or psychological incident on all shifts per the facility policy and procedure.	{A 175}	restraint release during the provision of care. 4. The Department Manager inserviced the sitters at the time of survey regarding ongoing monitoring of patients in restraints. Subsequent Actions Taken: 1. The "Restraint and Seclusion" policy was reviewed and did not require any revisions. The restraint documentation tool was reviewed and revised to reflect policy requirements to assess and ensure patient physical needs are met and to include temporary restraint during care. The restraint form was revised to more clearly annotate temporary release of restraint during the provision of care on 4/25/16 with education and implementation completed on 5/31/16. Clinical staff, including nurses and sitters, were inserviced on the policy and medical record documentation. 2. Care facilitation, a process of reviewing the patient's record in real time, interceding with staff to provide teaching/correcting as necessary for the "teachable moment" and to correct any deficiencies in care or documentation, is in progress for all patients on restraints/seclusion. 3. Education on assessing and monitoring patients on restraints and medical record documentation is provided to clinical staff upon hire. 4. Compliance with assessing and monitoring patients on restraints and complete medical record documentation is monitored through the QAPI program.	4/4/16 5/31/16 4/25/16

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{A 175}	Continued From page 12 During an observation of Patient N503 and concurrent interview on 4/4/16 between 3:05 and 4:30 p.m., Patient N503 was lying in bed on her back with both wrists tied to the sides of the bed. RN 7 stated the restraints were to keep the patient from scratching herself. Review of Patient N50 's "Protective (Safety) Restraint Doctor's Order and Daily Record" forms dated 3/29 and 4/2/16 were not complete and indicated the patient was not assessed to tolerate the restraint without physical or psychological incident consistently.	{A 175}	Compliance and Monitoring: All patients in restraint are assigned to the care facilitation model to determine ongoing compliance with policy, including assessing and monitoring patients and medical record documentation. Compliance target was set at 100% with output from ongoing monitoring reported daily to the Executive Leadership team on a Monday through Friday basis (with weekends rolled into Monday's outcome data). Monthly data is reported to the Quality Council and MEC, and quarterly to the Governing Board. Outcomes from restraint monitoring will be reviewed by the Quality Council until the council members	
{A 283}	482.21(b)(2)(ii), (c)(1), (c)(3) QUALITY IMPROVEMENT ACTIVITIES (b) Program Data (2) [The hospital must use the data collected to - .....] (ii) Identify opportunities for improvement and changes that will lead to improvement. (c) Program Activities (1) The hospital must set priorities for its performance improvement activities that-- (i) Focus on high-risk, high-volume, or problem-prone areas; (ii) Consider the incidence, prevalence, and severity of problems in those areas; and (iii) Affect health outcomes, patient safety, and quality of care. (3) The hospital must take actions aimed at performance improvement and, after implementing those actions, the hospital must measure its success, and track performance to ensure that improvements are sustained.	{A 283}		

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{A 175}	Continued From page 12 During an observation of Patient N503 and concurrent interview on 4/4/16 between 3:05 and 4:30 p.m., Patient N503 was lying in bed on her back with both wrists tied to the sides of the bed. RN 7 stated the restraints were to keep the patient from scratching herself. Review of Patient N50 's "Protective (Safety) Restraint Doctor's Order and Daily Record" forms dated 3/29 and 4/2/16 were not complete and indicated the patient was not assessed to tolerate the restraint without physical or psychological incident consistently.	{A 175}	feel restraint processes are compliant, with this compliance sustainable over time. The Quality Council may then request reduction in monitoring to a random "snapshot" basis at a time period to be determined by the Council (e.g., quarterly, semi-annually, annually) to ensure continued compliance occurs. Person Responsible: Chief Nursing Officer	
{A 283}	482.21(b)(2)(ii), (c)(1), (c)(3) QUALITY IMPROVEMENT ACTIVITIES (b) Program Data (2) [The hospital must use the data collected to - .....] (ii) Identify opportunities for improvement and changes that will lead to improvement. (c) Program Activities (1) The hospital must set priorities for its performance improvement activities that-- (i) Focus on high-risk, high-volume, or problem-prone areas; (ii) Consider the incidence, prevalence, and severity of problems in those areas; and (iii) Affect health outcomes, patient safety, and quality of care. (3) The hospital must take actions aimed at performance improvement and, after implementing those actions, the hospital must measure its success, and track performance to ensure that improvements are sustained.	{A 283}	A 283 482.21 (b)(2)(ii), (c)(1), (c)(3) Quality Improvement Activities	

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{A 283}	Continued From page 13 This STANDARD is not met as evidenced by: Based on interview and record review, the hospital did not ensure the efficacy of the discharge process because there was an incomplete analysis of the discharge planning issues and inaccurate data, creating the risk of persistent poor practices, and did not ensure the quality program provided oversight of fire safety in the hospital, creating the increased risk of unsafe discharges and an unsafe hospital environment. Findings: 1 The hospital's plan of correction from a survey dated 12/22/15 showed that "Quality indicators for the Behavioral Health Unit now address discharge processes and follow-up on obtaining information on efficacy of the patient's discharge." The hospital policy, Discharge Planning (reviewed 11/2012) read, "Discharge planning identifies the patient's needs after he leaves the hospital, delineates plans to meet those needs and teaches the patient and family how to implement the plan." During review of three randomly selected records at the Van Nuys campus, all three showed rapid readmission to the hospital after recent discharges, with the following admission dates: patient M601 admitted 2/18/16 and 4/4/16, patient M602 admitted 2/11/16 and 3/31/16, patient M605 admitted 3/17/16 and 3/23/16. The open medical record of Patient M601 was reviewed. During an interview with SS Staff 1 on 4/6/16 at 0900, she stated that the patient had been admitted previously in December, 2015 and February, 2016. She stated that it was up to the patient to follow up with referrals at discharge,	{A 283}	Finding 1 Immediate Action Taken: 1. Executive Leadership, the Corporate Psychiatric Services Medical Director, the Consulting Team, and the Director of Quality discussed the survey findings, the discharge process and reattributing factors to the discharge/readmission to improve upon the efficacy to reduce behavioral health readmissions. Subsequent Actions Taken: 1. Executive Leadership and the Director of Quality reviewed the existing monitoring of the Behavioral Health Unit discharge process. The post discharge follow-up process and QAPI indicator was revised to ensure the efficacy of the discharge process was being monitored, including follow up with the patient post-discharge and compliance with the discharge plan. 2. Executive Leadership reviewed and revised the Behavioral Health Unit post-discharge record to indicate the following; a) whether a call was placed to the patient within 7 days of discharge for follow up; b) if the patient followed the recommended discharge plan; and c) if applicable, the reasons for why the patient did not follow the discharge plan. Behavioral Health Unit clinical staff were educated on the revised post-discharge record. 3. A Quality Council meeting was held on 5/31/16 & 6/1/16 to discuss the survey findings, revision of the behavioral health quality indicator, and behavioral health unit post-discharge record.	5/24/16 5/26/16 6/1/16 6/1/16

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{A 283}	Continued From page 14 and that there was no documentation of why the patient did not follow up with the resources provided. She stated that the telephone number of an outpatient clinic was provided to the patient during her discharges. The open medical record of Patient M602 was also randomly selected for review at the VN campus, and showed that the patient was homeless, suicidal, and had a previous admission in February, 2016. The list of discharges within the past year indicated the patient had 11 admissions to the hospital within the past 12 months. In an interview with the Dir SS VN on 4/6/18 at 0930, he stated that referrals offered to the patients included a county program referred to as the FSP program. He stated that the program provided assistance to patients after discharge, and that a program representative visited the hospital to meet with patients. He stated that he was unable to find documentation that Patient M602 had been referred to the county FSP program, but that the patient might have refused such a referral. In an interview with Patient M602 on 4/6/16 at 0945, he stated that he had been wanting to enter the county's FSP program and needed assistance to do so. The hospital's QAPI follow-up of discharge planning was reviewed with VN QAPI Staff 1 on 4/6/16, and showed that the hospital attempted to call 31 patients regarding post-discharge follow-up, but that only six had been reached. Three of the six contacted had followed up with the planned post-discharge services. During an interview with the Dir SS VN on 4/6/16 at 1010, he stated that there was often trouble identifying a single fixed point of responsibility (SFPR) person who could assist with discharge	{A 283}	Compliance and Monitoring: 10% of behavioral health discharges are reviewed monthly compliance with the behavioral health process and post-discharge follow up. Data on audits is tracked, trended, analyzed and reported monthly to the Quality Department. Compliance is reported to the Quality Council, MEC and Governing Body on a monthly basis, and is used for performance improvement measures. The Quality Council renders determinations of frequency and volume of reporting data based on the results (in terms of healthcare outcomes) of trended data reported. Person Responsible: Director of Quality	

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{A 283}	Continued From page 15 planning. He estimated that 50-60% of discharges did not have such a contact person. He stated this issue had not yet been discussed in the psychiatry committee. During a review of the QAPI evaluation of the efficacy of discharge planning with Coord QAPI VN on 4/6/16, he stated that it was difficult to follow up on the efficacy of discharge planning due to problems with contact information for the patients. He stated that the problem of patients not obtaining post-discharge services could be related to transportation problems because of the distance from the patients' homes to the outpatient clinics. He stated that they had not contacted the outpatient clinics to see if transportation was available. He stated that he had also been collecting data regarding the readmission rate for the facility since 2014, but had not used the data yet. The QAPI data presentation for the discharge plan efficacy data was reviewed, and the graph depicted 100% efficacy of the discharge plan. In an interview with the Dir QA on 4/7/16 at 0925, she concurred that the goal of the indicator was to validate the efficacy of the discharge plan. She stated that the hospital had been able to contact six of 31 discharged patients, and that three patients followed up with suggested services at discharge. She agreed that the depiction of 100% efficacy did not accurately reflect the data gathered. 2 The Quality Assessment and Performance Improvement Plan (2016) read, "The Quality Council shall provide a systematic and coordinated approach to the maintenance and improvement of patient safety through the establishment of mechanisms that support effective responses to actual occurrences; ongoing proactive reduction in medical/health	{A 283}	Finding 2 A, B and C Immediate Action Taken: 1. Executive Leadership, the Consulting Team, and the Director of Quality discussed the survey findings and the mechanisms for supporting effective responses to occurrences (e.g., code reds), and monitoring of remediated issues (e.g., audible fire alarms).	4/7/16

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{A 283}	Continued From page 16 care errors; and integration of patient safety priorities into the new design and redesign of all relevant organizational processes, functions and services as identified in the Quality Indicator s and Health Care Outcomes". A Review of hospital documents showed that there was a fire in the hospital during January, 2015. and that subsequently there were failures of the audible fire alarm system in September, 2015, December, 2015, and during vendor testing on January 22, 2016. Failures in the audible fire alarm system was also noted during this survey. The Quality Assessment and Performance Improvement Indicators for 2016 included, "Four total fire system PM" (preventive maintenance). The EOC minutes presented to the Quality Council 2/2016 showed that "All audible issues were remediated the same day as survey. This will be monitored on a quarterly and annual basis by the fire alarm vendor." In an interview with the Dir Facilities on 4/7/16 at 1410, he stated that there were problems with the audible alarms during the week. He stated that they were not doing audible alarm testing quarterly, but that an annual review was done in January. B On 4/4/15, at approximately 1030 am, an overhead page announced a "code red". However, no representatives from the fire department appeared at the hospital. Review of hospital documents showed that the fire alarm was not being transmitted to the fire department because the system was being placed in "test" mode daily. In an interview with the Dir Facilities on 4/7/16 at 1425, he stated that the system should never have been put in "test" mode routinely, and that he had just found out about the practice the prior day. He stated that he was currently training the	{A 283}	2. Executive Leadership discussed the survey findings with the Director of Facilities, with special emphasis on complying with the fire alarm vendor monitoring audible fire alarm systems on a quarterly and annual basis. 3. Executive Leadership and the Director of Quality reviewed the "Risk Management Confidential Report" policy, which did not require any revisions. As detailed in the policy, an occurrence is not consistent with the routine operation of the hospital or routine care of a patient. Department Managers, including the Director of Facilities, were inserviced on the policy, with special emphasis on documenting occurrences in the electronic incident reporting system. 4. Effective 4/8/16, only the Chief Operating Officer and the Director of Facilities can initiate the test mode of the fire alarm system through a password protected account set up with the alarm monitoring company. Test mode is only utilized when a) working on the system; b) during preventive maintenance; c) during fire drills; and d) if the system is impaired. The Hospital notifies the local Fire Department, PBX and Security when the fire alarm system is put on test mode. This process was reviewed with the local and state Fire Marshall on 4/26/16. Education was provided to PBX, security and engineering staff.	4/7/16 4/7/16 4/8/16 - 4/26/16

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{A 283}	Continued From page 17 staff not to put the system in "test" mode unless it was required and approved. In an interview with the Alarm Project Mgr on 4/7/16 at 1520, he stated that the contractor had not requested that the system be put in "test" mode, and that the system should not be put in "test" mode without permission. In an interview with the Dir QA on 4/7/16 at 1340, she stated that she thought there would be an occurrence system report of recurrent or persistent physical plant problems, but that she had not seen ongoing reports on those issues. She stated that the issues would be communicated to leadership if in the occurrence reporting system. In an interview with the Sr VP Hospital Operations on 4/7/14 at 1520, he stated that the EOC provided information regarding the safety of the environment, and that the EOC Committee reported to the quality department quarterly, and the information was then reported to the Governing Body. During a review of the EOC Minutes provided to the QAPI Committee, there was no indication that the fire alarm system was being placed in "test" mode, or that there was an intention to refrain from notifying the fire department about fire alarms. C The hospital policy, Risk Management Confidential Report (reviewed 11/12), read, "An occurrence is not consistent with the routine operation of the hospital or routine care of a patient. An occurrence is actual or potential injury and/or property damage." In an interview with the Dir QA on 4/8/16 at 0940, she stated that the EOC critiqued code reds, and that she would expect a summary in the EOC committee report. She stated that code reds were not incidents reported through the occurrence	{A 283}	Subsequent Action Taken: 1. An Environment of Care (EOC) meeting was held on 4/14/16 to discuss the survey findings regarding fire alarm testing and code reds. Efficacy of entering occurrences (e.g., inappropriately placing the fire alarm in test mode and code reds) in the electronic incident reporting system shall be documented in the EOC Committee minutes. Compliance and Monitoring: Monitoring is conducted on an "as occurrence" basis. When the fire alarm system "code red" is triggered or in the event that the system is placed in test mode (under the direction of the Director of Facilities or Chief Operating Officer), an occurrence report is entered into the organization's electronic database reporting system. Data on occurrences is tracked, trended, analyzed and reported monthly to the Quality Department. Compliance is reported to the Quality Council, MEC and Governing Body on a monthly basis, and is used for performance improvement measures. The Quality Council renders determinations of frequency and volume of reporting data based on the results (in terms of healthcare outcomes) of trended data reported. Person Responsible: Director of Quality	4/14/16

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{A 283}	Continued From page 18 reporting system. She stated the code red observed on 4/4/16 was not documented in the incident system.	{A 283}		
{A 286}	482.21(a), (c)(2), (e)(3) PATIENT SAFETY (a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors. (2) The hospital must measure, analyze, and track ...adverse patient events ... (c) Program Activities ..... (2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital. (e) Executive Responsibilities, The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: ... (3) That clear expectations for safety are established. This STANDARD is not met as evidenced by: Based on interview and document review, the hospital failed to ensure a complete investigation and follow-up actions were performed and documented for three incidents reviewed,	{A 286}	A 286 482.21 (a), (c)(2), (e)(3) Patient Safety	

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{A 286}	Continued From page 19 creating the risk of persistent poor practices and substandard health-care. Findings: From the incident log, incidents recorded on 3/23, 3/24 and 3/28/16 were randomly selected for review. The documentation for the three incidents appeared incomplete because not all of the recipients had noted that they reviewed the event, because there was no or incomplete investigation documented, and because there was no follow-up action documented. The incident dated 3/23/16 involved a near miss medication error which was caught by the pharmacy. Review of the incident documentation did not show that an investigation occurred. There was no documentation of interviews of involved staff to determine the source of the error. The department manager had not reviewed the incident, and the section of the form for Manager's Proposed Action was left blank. Three of eight people on the list of reviewers had not reviewed the incident. The incident dated 3/28/16 involved a physician who refused to follow-up on missing documentation. Four of 11 people on the list of reviewers had not reviewed the incident. The department manager checked that the review was completed on 3/30/16, and recommended that the physician be sent to peer review. The Dir Medical Staff Services documented reviewing the incident on 4/1/16, but did not provide information about whether the medical staff concurred with the recommendation for peer review, or whether peer review was scheduled. Another staff member documented on 4/7/16 that the incident was to be sent to peer review, but there was no clear mechanism for documenting whether this had occurred.	{A 286}	Finding 1 Immediate Action Taken: 1. A Leadership meeting convened on 4/21/16 in which the CEO apprised the management team of their responsibility for reviewing incident reports and ensuring a complete investigation and follow up actions are performed and documented. 2. Investigation of the 3/23/16 incident was reviewed. The Department Manager investigated the incident and documented the correct actions taken but not previously recorded. The Department Manager was reminded to initiate and document proposed corrective actions and/or follow-up within 24 hours of incident reports. 3. The Director of Quality reviewed the 3/28/16 physician issue regarding follow upon missing documentation. The matter was referred to peer review. 4. The Department Director performed an investigation of the 3/24/16 wound care incident, concluded that the wound was present on admission, and documented the findings. Subsequent Actions Taken: 1. An in-service on the Clarity occurrence reporting system was provided to the management team on April 21, 2016. Managers were instructed on the use of the system to include how to access the	4/21/16 4/21/16 4/8/16 4/7/16 5/31/16 4/21/16

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{A 286}	Continued From page 19 creating the risk of persistent poor practices and substandard health-care. Findings: From the incident log, incidents recorded on 3/23, 3/24 and 3/28/16 were randomly selected for review. The documentation for the three incidents appeared incomplete because not all of the recipients had noted that they reviewed the event, because there was no or incomplete investigation documented, and because there was no follow-up action documented. The incident dated 3/23/16 involved a near miss medication error which was caught by the pharmacy. Review of the incident documentation did not show that an investigation occurred. There was no documentation of interviews of involved staff to determine the source of the error. The department manager had not reviewed the incident, and the section of the form for Manager's Proposed Action was left blank. Three of eight people on the list of reviewers had not reviewed the incident. The incident dated 3/28/16 involved a physician who refused to follow-up on missing documentation. Four of 11 people on the list of reviewers had not reviewed the incident. The department manager checked that the review was completed on 3/30/16, and recommended that the physician be sent to peer review. The Dir Medical Staff Services documented reviewing the incident on 4/1/16, but did not provide information about whether the medical staff concurred with the recommendation for peer review, or whether peer review was scheduled. Another staff member documented on 4/7/16 that the incident was to be sent to peer review, but there was no clear mechanism for documenting whether this had occurred.	{A 286}	electronic incident report how to conduct an investigation, and how to document subsequent follow-up on to the incident report document. Verbal reports of compliance will be provided to the Leadership team on a weekly basis. As opportunities for improvement are identified, department managers are coached and provided additional resources to ensure compliance. Repeat observations of non-compliance will result in disciplinary action. 2. Executive Leadership and the Consulting Team reviewed the process for incident reporting, including identification of incidents and assurance that incidents were being reported and properly annotated, aggregated and analyzed. Incidents are reviewed daily (Monday through Friday) with inclusion of trended data resulting from incident review included in QAPI reporting as appropriate to the incident topic. Significant and unique incidents are addressed in the daily flash huddles (Monday through Friday) and to the Quality Council on an as occurrence basis and up to the MEC and Governing Board. A discussion of the event, any causal analysis or event analysis is presented with the QAPI report. 3. The Director of Quality will hold overall accountability for oversight of incident report investigation and completion. Compliance and Monitoring: Data on incident report completion and resolution is a component of the quality assessment/performance improvement (QAPI) program. Monthly reports outline type and category of incidents with resultant actions reported to the Quality Department.	5/25/16 6/7/16

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{A 286}	Continued From page 20 In an interview with the Dir QA on 4/7/16 at 1015, she stated that the department manager was to initiate follow-up within 24 hours of the incident. She reviewed the documentation of the 3/23 incident and stated that the review and investigation by the manager was not documented. She reviewed the documentation of the 3/24/16 incident reported by the wound care nurse, and stated that the director was to do an investigation, but it was not documented. She stated that incident reviews were being analyzed and tracked by the QAPI department, with the goal of 90% of incidents being correctly managed.	{A 286}	Compliance with incident investigation and resolution (e.g., completion) will be tracked monthly by the Quality Department and reported to the Quality Council, MEC and Governing Body on a monthly basis, and is used for performance improvement measures. The Quality Council renders determinations of frequency and volume of reporting data based on the results (in termsof healthcare outcomes) of trended data reported. Person Responsible: Director of Quality	
{A 392}	482.23(b) STAFFING AND DELIVERY OF CARE The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient. This STANDARD is not met as evidenced by: Based on interview and record review, the hospital failed to ensure that one patient, Patient M603, was adequately assessed, creating the risk of a substandard health outcome. Findings: 1 The hospital policy, Triage Classification System (reviewed 3/2016) showed that "Level 1 RESUSITATION: Patients who present with a life-threatening complaint and require immediate intervention. This may include patients that are dying, intubated, apneic, pulseless, in severe respiratory distress, with acute mental changes or	{A 392}	A 392 482.23(b) Staffing and Delivery of Care Findings 1 and 2 Immediate Actions Taken: 1. Executive Leadership discussed the survey findings with the Emergency Department (ED) Director, with special emphasis on ongoing patient assessments (including vital signs as necessary for the patient's condition), monitoring vital signs while the patient is on a titratable medication, and documenting vital signs in the medical record. 2. The ED Director discussed the survey findings with the applicable nurses, with special emphasis on performing and documenting vital signs applicable to the patient's condition at time of presentation and in concert with the patient's changing condition.	4/4/16 4/4/16

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{A 392}	Continued From page 21 unresponsive. These patients are placed immediately in bed. Initial nursing assessment is initiated and the physician is immediately notified." In an interview with the ER RN Mgr at 1110 on 4/4/16, she stated that the initial blood pressure of 149/98 at 0428 indicated the patient was stable, so the blood pressure was not reassessed for an hour. She stated that the paramedics report off the patient's condition to the nurse. The triage nursing assessment was reviewed, but no or minimal handoff from the paramedics was documented. The paramedic documentation was requested for review. During a second interview with the ER RN Mgr, at 1130 on 4/4/16, she stated that the paramedics were to fax their documentation over when it was completed, but she did not see it. She was subsequently able to obtain the document, the Prehospital Care Report Summary. The patient's blood pressure had been 79/49 when first assessed by the paramedics at 0413 hours, but rose to 174/126 during the eight minute transport. The report showed that the patient was speaking in full sentences, and upon arrival at the hospital at 0428 had a Glascow Coma Scale score of 15 (full neurologic functioning). The bedside nurse's assessment, documented at 0458, showed that the patient was nonverbal, and had no response to voice or pain. Despite the patient's unstable vital signs in transit and acute change in mental status, there was no blood pressure recorded for the patient in the ER from 0432 (when it was 145/98) until 0530, when it was 49/27. In an interview with the CNO on 4/6/16 at 1310, she stated that the blood pressure was not documented for some time after the admission, and that it was unclear if the change in the patient's condition during transport had	{A 392}	Subsequent Actions Taken: 1. Nursing Leadership reviewed the "Triage Classification System" and "Titration of Drugs in the Critical Care Area" policies, which did not require any revisions. ED clinical staff were reinserviced on vital sign assessment and documentation. 2. Education on performance of vital signs (e.g., upon patient presentation/initial assessment, changes in the patient's condition/physiological status, and while on titratable medications, including cardiogenic drips) and documenting these in the medical record is provided to ED staff upon hire. 3. Compliance with performing vital signs and documenting them in the medical record is monitored through the QAPI program. Compliance and Monitoring: The ED Director or qualified designee reviews at least 10 medical records a week to achieve the goal of 100% compliance with taking vital signs and documenting them in the medical record. Corrective action is taken as necessary, including reeducation. Data is analyzed and reported monthly to the Quality Council, MEC and Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will occur until the Quality Council determines sustained compliance has occurred, at which time the Council will determine what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator).	4/22/16 - 5/9/16

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{A 392}	Continued From page 22 been explained as this was not documented. 2 The hospital policy, Titration of Drugs in the Critical Care Area (reviewed 1/2016) showed that "All patients requiring titratable medications will be monitored, including EKG, blood pressure and SPO2." The Medical Orders showed a medication order for Levophed (a medication to raise blood pressure) was recorded at 0600, with the direction to titrate the medication to maintain a blood pressure of 110/60. The nurse noted that at 0721, "levophed hung to infuse at 18mcg/min ". The ER documentation of the patient's vital signs from 0715 until 1000 were missing from the Vitals page of the record. The Clinical-Interdisciplinary Notes showed free text record of the blood pressure at 0721 (92/47), at 0759 ("systolic blood pressure remains in 90's), but not again until 0950 ("BP is in the 50's systolic"). In a continuing interview with the CNO, she stated that she believed the vital signs for the time period from 0715 until 1000 must be recorded somewhere. In an interview with AS1 on 4/6/16 at 1315, she stated that she was unable to find the missing vital signs for the patient.	{A 392}	Person Responsible: ED Director	
{A 396}	482.23(b)(4) NURSING CARE PLAN The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan This STANDARD is not met as evidenced by: Based on observation, interview and facility policy review, the facility failed to asses and care plan for suicidal ideation for Patient N102, who was admitted to the BHU on an involuntary hold	{A 396}	A 396 482.23(b)(4) Nursing Care Plan	

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{A 396}	Continued From page 23 for suicidal ideation. There was no nursing assement and care plan for suicidal ideation for six days post admission. This failure has the potential to impact patient safety. Findings: The facility policy and procedure titled, "Suicide Risk Assessment," effective date of 01/2016, indicated in part, "A. During the admission process, an individual may be identified as having a need that requires monitoring based on assessments of patient's behavior and needs...." "On the behavioral health unit, precautions are initiated by physician order/ and or nursing staff assessment." The policy included "ii. When a patient is identified as being at risk for self harm, the admitting RN shall initiate a Treatment Plan for destructive behavior directed at self." The facility policy and procedure titled, "Interdisciplinary Plan of Care." effective date of 02/2016, indicated in part, "B. The Interdisciplinary Plan of Care shall be based upon assessments performed by all disciplines, which describes the intentions, rationale, and interventions associated with identified issues..." "C. The admission data collection shall be completed within 24 hours of admission..." During a review of the clinical record for Patient N102 the record revealed that Patient N102 was admitted to the BHU unit on 3/29/16, at 5:29 p.m., on an involuntary hold for suicidal ideation. Admitting physician indicated in part "She (Patient N102) has suicidal ideation with intention to overdose on her medication or cut her wrists." The physician note(s) dated 3/31/16, 4/01/16, 4/02/16, 4/3/16, all indicated Patient N102 had	{A 396}	Immediate Actions Taken: 1. The Department Manager discussed the survey findings with Behavioral Health Unit staff. Short-term goals and interventions were immediately included in the plan of care. 2. Behavior Health Unit clinical staff reviewed all medical records at the time of survey to ensure a suicide assessment, short term goals, and interventions were appropriately addressed. 3. The Department Manager inserviced staff at the time of survey on suicide assessments, short-term goals and interventions documented in the plan of care. Subsequent Actions Taken: 1. Nursing Leadership discussed the survey findings. Behavioral Health treatment plans were revised to specifically include fields for suicidal and homicidal ideation. Nursing staff was educated on both the revisions to the record and the need to include presence of suicidal/homicidal ideation in the treatment plan. 2. Nursing Leadership worked with the consultants to continue the process of care facilitation, a process of concurrent record compliance monitoring whereby a "care facilitator" (licensed healthcare professional) identifies any noncompliance with the subject matter, intercepts the nurse/provider in real time, provides "just in time" education and training to correct clinical or documentation process issues. This method allows for role modeling of excellent clinical behavior while allowing staff to replicate improved practices. Care facilitation drives sustainability as staff	4/6/16 4/6/16 4/6/16 5/19/16 4/14/16

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{A 396}	Continued From page 24 thought content that was "positive for suicidal ideation with intention to overdose or cut her wrist." A review of nursing assessment dated 3/29/16 at 7 p.m., indicated "Assess for auditory hallucinations and paranoid behavior, give medications, re-orient patient to reality, encourage to participate in group interactions, therapy." There were no other updates to the care plan until 4/4/16, where the care plan indicated short term goals, "Patient will not try to hurt herself for two days." A review of the nursing narrative notes from 3/29/16 through 4/4/16 did not indicate patient suicidal ideation or precautions. During an interview with ADM 2 on 4/6/16, at 4 p.m., while concurrently reviewing patient N102's clinical record, Adm 2 acknowledged that nursing clinical records between the time of admission on 3/29/16 through 4/4/16 lacked an assessment and care plan for suicidal ideation. Adm 2 stated, "I need to keep working with the staff, I have told them that safety and suicidal assessment is always first."	{A 396}	with nursing care plan completion that demonstrates changes to the care plan in relationship to changes in the patient's condition. Data is analyzed and reported monthly to the Quality Council, MEC and Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will occur until the Quality Council determines sustained compliance has occurred, at which time the Council will determine what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Person Responsible: Chief Nursing Officer Assistant Chief Nursing Officer for Behavioral Health	
A 405	482.23(c)(1), (c)(1)(i) & (c)(2) ADMINISTRATION OF DRUGS (1) Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice. (i) Drugs and biologicals may be prepared and administered on the orders of other practitioners not specified under §482.12(c) only if such practitioners are acting in accordance with State	A 405	A 405 482.23(c)91), (c)(1)(i) & (c)(2) Administration of Drugs	

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A 405	Continued From page 25 law, including scope of practice laws, hospital policies, and medical staff bylaws, rules, and regulations. (2) All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures. This STANDARD is not met as evidenced by: Based on observation, interview, and document review, the hospital failed to ensure: 1. No significant amount of reconstituted injectable medications for administration via patient's vein was left remaining in the vial potentially under-dosing the patient; and, 2. The rubber top of the injectable vials was wiped with alcohol as per infection control standards consistent with the hospital audit. 3. Based on record review and interviews, the facility failed to ensure nursing services provided by the facility met professional standards related to duplicate therapy without clarification of physicians' orders for two of three patients: A. Patient 400 had pain medication orders for two different potent narcotics (drugs that in moderated doses dulls the senses, relievespain and induces profound sleep) without any instructions when they should be given. The form indicated to order only one pain medication. The nurse caring for Patient 400 noted the orders without clarification of which medication should	A 405		

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A 405	Continued From page 26 be given.. B. Patient 402 had orders for two different medications for high blood pressure (HTN) without any instructions which should be given first. The nurse caring for Patient 402 noted the orders without clarification of which medication should be given. These failures placed patients at risk for over medication that could lead to 1. over sedation or stupor and 2. low blood pressure which ultimately could lead to death. Findings: 1. During a medication pass observation on 4/9/16 at 2:05 P.M., RN 70 prepared for infusion to Patient 600, a Pharmacy-assembled generic injectable antibiotic for Zosyn (antibiotic) 3.375 gram (gm) connected to the 50-ml bag containing 5% Dextrose in Water by a device called addEASE Binary Connector, BC2000, made by B. Braun. The Binary Connector allows for the fluid for infusion to remain separated, until activated, from the additives such as the injectable vial containing Zosyn powder. This assembly adds convenience and longer usable dating compared to the Pharmacy-compounded drug when prepared under sterile conditions. After RN 70 activated the injectable Zosyn and reconstituted the powder inside the Zosyn vial by transferring the fluid from the IVPB (IV piggyback) bag to the vial and back to the bag, she proceeded to programmed the IV pump and administered the medication.	A 405	Findings 1 and 2 Immediate Actions Taken: 1. The Director of Pharmacy discussed the survey findings with RN 70, with special emphasis on accurately reconstituted medication. 2. The Director of Pharmacy discussed disinfecting the medication vial with alcohol before needle penetration with RN 72. 3. Informal huddles with Pharmacy staff were held on how to assist and demonstrate proper technique for nursing staff. Subsequent Actions Taken: 1. Signage was placed in medication rooms on the proper cleaning of vials prior to administration. 2. Proper medication administration provided in daily information huddles to nursing staff beginning on 4/19/16, with just-in-time education of observations during the week of 4/25/16 by the Clinical Educators. A pharmaceutical manufacturer representative also performed inservices to pharmacy and nursing staff. 3. The Hospital continues to use a national healthcare regulatory compliance consulting firm and Nurse Educators to assist with sustaining compliance with medication administration issues. 4. Executive Leadership, the Consulting Team and Pharmacy Leadership discussed the need to continue with medication pass audits and focused education to nursing staff on a myriad medication administration issues essential to safe medication administration, including reconstitution of medications and alcohol cleansing of the vial before needle insertion.	4/5/16 4/5/16 4/11/16 4/21/16 5/14/16 4/8/16 5/13/16

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A 405	Continued From page 27 On closer inspection of the fluid that remained in the vial, approximately a quarter of the vial was filled with the reconstituted fluid. In an interview on 4/5/16, at 2:15 P.M., RN 70 stated about 5 to 10 cc (cubic centimeter; same as milliliter) of reconstituted fluid remained in the antibiotic vial. RN 70 then was observed to be able to transfer completely the remaining fluid from the vial to the IVPB bag. In an interview on 4/5/16 at 3:30 P.M., the DOP stated each Medication Room in the Nursing Stations had the poster on activation and reconstitution of the connected antibiotic system for infusion via the Binary Connector and nurses were periodically educated on the proper techniques. The document posted on the wall of the Medication Room titled, "addEASE - How to activate?" showed, "Step 6: With vial positioned above (referring to the picture of a person holding the connected bag upside down) container (as shown) squeeze or flex and release container to transfer solution from vial to container (repeat twice or until no residual drug is visible)." 2. During a medication pass observation on 4/5/16 at 9:10 A.M., RN 72 was observed not to disinfect with alcohol the rubber top of the vial of the injectable Protonix (a medication used to reduce acid in the stomach) IV 40 mg before the needle penetration.	A 405	5. Nursing Leadership reviewed and revised the nursing orientation program to include education on reconstituted injectable medications for administration and proper cleaning of vials prior to use. 6. Compliance with reconstituting injectable medications and cleaning of vials prior to use is monitored through the QAPI program. Compliance and Monitoring: Medication administration compliance data is collected by assigned observers performing medication pass audits using a worksheet with defined criteria. The audits are collected and aggregated weekly and provided to nursing administration for review and remediation as appropriate. The goal is to achieve 90% compliance with medication administration practices, pain assessments and reassessments, and labeling of IV tubing. Data is analyzed and reported monthly to the Medication Safety Committee, Quality Council, MEC and Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will occur until the Quality Council determines sustained compliance has occurred, at which time the Council will determine what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Persons Responsible: Chief Nursing Officer Director of Pharmacy	6/1/16

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A 405	Continued From page 28 In an interview on 4/5/16 at 3 P.M., the VPPO stated the top of the vials should have been cleaned with the alcohol wipes. In a concurrent interview, the DOP stated the medication pass audit conducted by the Pharmacy would ensure the top of the vials were wiped with alcohol. Review of the hospital document used as a tool for medication pass audits, titled, "Medication Pass Audit Form" showed the following to be asked and checked during a medication pass audit: "Was the administration technique correct as per the drug? Vial swabbed?" According to "WHO (World Health Organization) Best Practices for Injections and Related Procedures Toolkit," "This chapter assimilates the best practices for delivering injections in health-care and related facilities. It is based on a range of evidence and expands the scope of the WHO publication, Best infection control practices for intradermal, subcutaneous, and intramuscular needle injection. The chapter outlines recommended practices, skin preparation, preparation and administration of injections, and related health procedures. Best injection practices described are aimed at protecting patients, health workers and the community... Wipe the access diaphragm (septum) with 70% alcohol (isopropyl alcohol or ethanol) on a swab	A 405		

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A 405	Continued From page 29 or cotton-wool ball before piercing the vial, and allow to air dry before inserting a device into the bottle..." 3. According to "Fundamentals of Nursing-8th edition," (Potter & Perry; Mosby, 2013), page 305 "The health care provider (physician or advanced practice nurse) is responsible for directing medical treatment. Nurses follow health care providers' orders unless they believe the orders are in error or harm patients." A. During a review of the clinical record for Patient 400, the Post Anesthesia Care (PACU) Orders, dated 4/6/16 at 12:30 p.m. indicated: "Fentanyl (a powerful synthetic narcotic medication) 50 micrograms (mcg) intravenous (IV) (injection of medication directly into the vein) every (q) 10 minutes (min) for 10 doses. Hydromorphone (a narcotic pain reliever similar to morphine) 200 mcg IV q 10 min for 10 doses." B. During a review of the clinical record for Patient 402, the Post Anesthesia Care Orders, dated 4/7/16 at 9:32 a.m. indicated: "Labetalol (medication used to treat high blood pressure) 10 milligrams (mg) intravenous push (IVP) (injection of medication directly into the vein) q 10 min prn (as needed) SBP (systolic blood pressure) > (greater than) 180 may repeat x (times) 3 prn. Hydralazine (medication used to treat high blood pressure by relaxing smooth muscle) 5 mg IVP q 10 min prn SBP >180 may repeat x 3 prn." During an interview and concurrent record review of PACU orders for Patients 400 and 401, on 4/7/16 at 10:10 a.m., the Director of Infection Control (ICP 1) and the Interim Director of Surgical Services (RN 3) acknowledged the PACU nurses had no protocols on these medications. The ICP 1 and RN 3 confirmed,	A 405	Finding 3 A and B Immediate Actions Taken: 1. The responsible nurse reviewed and clarified orders with the physician for the PACU patients at the time of survey to ensure that specific indications for medications were ordered. 2. Pharmacy Leadership reviewed and revised the Post-Anesthesia Care Orders form to reflect safe and standardized medication prescribing. Anesthesia providers were inserviced. 3. The Director of Pharmacy discussed medication ordering with the CRNA, with special emphasis on documenting specific indications for use of each medication and to provide parameters when several medications are ordered with the same action and in the same category. Compliance and Monitoring: The Director of Pharmacy or qualified designee shall review three (3) patient records with PACU order sets weekly to ensure medications are ordered with specific parameters for use. Data is analyzed and reported monthly to the Medication Safety Committee, Quality Council, MEC and Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will occur until the Quality Council determines	4/6/16 4/11/16 4/11/16

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A 405	Continued From page 30 physician orders for 2 medications without specific indications of when they should be given is not an acceptable practice. RN 3 reported it is beyond the nurse's scope of practice to decide which medicine should be given and the orders should have been clarified with the physician. During an interview and concurrent review of the PACU orders for Patient 402 on 4/7/16 at 10:10 a.m., the certified registered nurse anesthetist (CRNA 1) explained he was unaware ordering two medications for the same condition was beyond the scope of nursing practice. During an interview and concurrent review of the PACU orders for Patient 400 and 402 on 4/7/16 at 1:35 p.m., the director of nurses (DON) acknowledged orders for 2 medications without specific indications of when they should be administered is an unacceptable practice.	A 405	sustained compliance has occurred, at which time the Council will determine what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Persons Responsible: Chief Nursing Officer Director of Pharmacy	
A 409	482.23(c)(4) BLOOD TRANSFUSIONS AND IV MEDICATIONS Blood transfusions and intravenous medications must be administered in accordance with State law and approved medical staff policies and procedures. If blood transfusions and intravenous medications are administered by personnel other than doctors of medicine or osteopathy, the personnel must have special training for this duty. This STANDARD is not met as evidenced by: Based on interview and record review, the hospital failed to ensure that one medication was correctly administered to Patient M603, creating the risk of substandard health outcome. Findings: The hospital policy, Titration of Drugs in the Critical Care Area (reviewed 1/1016) showed that	A 409	A 409 482.23(c)(4) Blood Transfusions and IV Medications Finding 1 Immediate Actions Taken: 1. Hospital Leadership discussed the survey findings and compliance strategies. 2. Nursing Leadership reviewed patients on intravenous (IV) titratable drips at the time of survey to ensure that the medication was administered and documented appropriately. 3. Nursing Leadership inserviced nurses at the time of survey on administration and documentation of IV titratable medications. Subsequent Actions Taken: 1. Nursing Leadership reviewed the "Titration of Drugs in the Critical Care Area" policy, which did not require any	4/6/16 4/6/16 4/6/16 5/27/16

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A 409	Continued From page 31 Norepinephrine (levophed) should be started at an initial rate of 4 mcg/min, with a titration rate of 1 mcg/min at 5 minute intervals for a target goal of a systolic blood pressure greatern than 90. Patient M603 arrived in the ER on 4/4/16 and was found to have a low blood pressure of 49/27 at 0530. The Medical Orders showed a medication order for Levophed (a medication to raise blood pressure) was recorded at 0600, with the direction to titrate the medication to maintain a blood pressure of 110/60. The nurse noted that at 0721, "levophed hung to infuse at 18mcg/min". The nursing note from 0750 showed, "Levophed at 18.8 ml/hour to maintain BP" and "systolic blood pressure remains in 90's " . There were no additional notes regarding Levophed administration until 0950, when the nurse noted, "Pt's levophed increased to 9 mcg/min". The blood pressure at 0950 was,"in the 50's systolic". Starting at 10:00, upward titration of the Levophed each five minutes, by 1mcg, per protocol, was seen. During an interview with the CNO on 4/6/16 at 1310, she concurred that the documentation of Levophed administration was unclear.	A 409	revisions. ED, ICU and CCU nurses were reeducated on the policy. 2. All smart pumps were located and the pump libraries reprogrammed to correctly configure the proper titration calculation per medication and order. 3. The EMR documentation was revised to include parameters on the physician order sets to ensure consistency on both the nursing and pharmacy views of medication titration parameters (previously the order set was only able to be visualized on the pharmacy application). 4. ICU staff were provided with application individualized training (1:1) by the ICU interim manager, care facilitators and educators. This education included vasoactive and sedating medication intravenous medication administration via smart pump. Every intravenous continuous medication (titratable drip) is reviewed daily to ensure proper programming of the pumps with proper medication delivery.	6/7/16 5/11/16 6/7/16
{A 454}	482.24(c)(2) CONTENT OF RECORD: ORDERS DATED & SIGNED All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner who is responsible for the care of the patient only if such a practitioner is acting in accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations. This STANDARD is not met as evidenced by:	{A 454}		

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{A 454}	482.24(c)(2) CONTENT OF RECORD: ORDERS DATED & SIGNED All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner who is responsible for the care of the patient only if such a practitioner is acting in accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations. This STANDARD is not met as evidenced by:	{A 454}	A 454 482.24(c)(2) Content of Record: Orders Dated & Signed	

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{A 454}	Continued From page 32 Based on interview, record review, and facility policy and procedure review, the facility failed to ensure telephone orders for Patients N-301 and N-303 were authenticated within 48 hours, per facility policy. Findings: The facility policy and procedure titled "Telephone and Verbal Orders" dated 3/2016, indicated that the policy and procedure is organization- wide and applies to all staff that are employed by the hospital. "A. Telephone Orders i. Telephone Orders are to be written and read back to the physician to clarify; medication orders must be signed within 48 hours." Review of the electronic record (e-record) of Patient N-301 on 4/5/16 at 2:35 p.m., reflected the patient was admitted on 3/28/16 and discharged on 4/1/16. Further review indicated computerized physician order entries (CPOE) of a total of 25 different medication orders, both routine and as needed (PRN) for Patient N-301's stay. The e-record indicated that the medications orders were all electronically signed on 4/4/16, 72 hours after the patient was discharged. During a concurrent e-record review and interview with administrative staff (AS) 1 on 4/5/16 at 3:35 p.m., agreed that the orders were not signed within the 48 hours per facility policy. During a concurrent review and interview of the e-record for Patient N-303 on 4/8/16 at 10:40 a.m. with AS 1, the e-record reflected medication orders through CPOE dated 3/30/16 and 4/4/16. AS 1 acknowledged that the medication orders had not been signed within 48 hours, per facility	{A 454}	Findings 1-4 Immediate Actions Taken: 1. Hospital Leadership discussed the survey findings with the Chief of Staff and the current process for enforcing compliance with authenticating telephone orders. Subsequent Actions Taken: 1. Nursing and Pharmacy Leadership reviewed the "Telephone/Verbal Order" policy, which did not require any revisions. 2. The issue of authenticating telephone/ verbal orders for medications was discussed with the Governing Board. 3. The Chief of Staff issued a memorandum to medical staff members advising them of their responsibility for authenticating telephone and verbal medication orders within the 48 hour timeframe. 4. Compliance with authenticating telephone/verbal medication orders is a standing agenda item at individual Medical Staff Department meetings and the annual Medical Staff meeting. 5. Compliance with authenticating telephone/verbal medication orders is monitored through the QAPI program. Compliance and Monitoring: The Senior Manager of Health Information or qualified designee performs random reviews of at least 20 medical records weekly to achieve the goal of 90% compliance with authenticating telephone/ verbal medication orders. In addition, data is collected by the care facilitators, reported daily, aggregated and reported to leadership at least weekly to allow leadership to focus resources on those issues and units where	4/8/16 4/8/16 5/25/16 5/26/16

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{A 454}	Continued From page 33 policy.	{A 454}		
{A 494}	482.25(a)(3) PHARMACY DRUG RECORDS Current and accurate records must be kept of the receipt and distribution of all scheduled drugs. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure accounting procedures for controlled substances in the Culver City Pharmacy were performed in accordance with the facility policy to document consistently that accounted for the overfill in the injectable vials used to compound PCA (Patient Controlled Analgesia) infusion bags containing hydromorphone (a potent Scheduled II narcotic pain medication) resulting in the creation of discrepancies. This failed practice resulted in narcotic medications to be potentially diverted. Findings: During an inspection of the Pharmacy Drug Storage Room at Culver City on 4/5/16 at 10:30 A.M., it was noted there were two Narcotic Towers for storage of controlled substances. It was also noted that during the inventory count for hydromorphone (a federally Scheduled II narcotic pain medication) 40 mg/ 20 ml vials, the logged quantity in the computer inventory log did not match the actual quantity on hand. In a concurrent interview, the DOP stated the hydromorphone vials were used to compound PCA bags according to the master formula that called for 27.5 ml and explained the count was off because of the overfill from the vials that accumulated over time.	{A 494}	A 494 482.25(a)(3) Pharmacy Drug Records Immediate Actions Taken: 1. All medication in narcotic cabinets was changed to blind counts to account for overfill. Subsequent Actions Taken: 1. A function was added in the narcotic cabinet to account for overfill of narcotic vials, which replaced the blind count practice established on 4/7/16, allowing double witness by pharmacists of overfill discrepancies. This revision provided a more accurate method of controlled substance oversight and discrepancy identification. 2. The Director of Pharmacy reviewed the "Controlled Substance System" policy, which did not require any revisions. 3. Compliance with narcotic counts is monitored through the QAPI program. Compliance and Monitoring: The Director of Pharmacy or qualified licensed designee now performs review and reconciliation of controlled substance counts on a monthly basis. If variances with policy are identified, corrective action is taken, including 1:1 training with staff. Data is analyzed and reported monthly to the Medication Safety Committee, Quality Council, MEC and Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will occur until the Quality Council determines sustained compliance	4/7/16 5/16/16 4/11/16

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{A 494}	Continued From page 34 The DOP stated the overfill in the vials was not taken into account each time the medication was accessed and allowed the discrepancy to continue until there was enough difference in volume existed between the inventory count and the visual count of the actual amount remained in stock. The resulting overfill would be added to the inventory count by creating and resolving the discrepancy with another pharmacist. The DOP also stated the amount in volume of hydromorphone used to compound the PCA bags was automatically calculated and deducted each time from the inventory and did not accurately reflected the actual amount that remained in stock. In a concurrent interview, the DOP and the VPPO acknowledged the potential diversion due to the unknown amount of accumulated overfill which was not taken into account and resolved each time the medication was accessed from the Narcotic Tower. On 4/7/16, a review of the hospital document titled, "All NarcStation Events" from 3/11/16 to 4/7/16 showed daily audit of the inventory count for hydromorphone 20 mg/ml conducted to be accurate on 4/2/16 and 4/4/16. There was a discrepancy resolution made on 4/5/16 due to the plus 6-ml difference between actual and the documented amount. According to the hospital P&P titled, "Controlled Substance System" last revised, "10/2012," "Controlled substances include all drugs listed in	{A 494}	has occurred, at which time the Council will determine what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Person Responsible: Director of Pharmacy	

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{A 494}	Continued From page 35 Schedules II, III IV, and V...of the Federal Uniform Controlled Substance Act, as amended, or the California Controlled Substances Act, as amended... The pharmacy shall conduct random audits of all C-II drugs periodically. The physical count shall be verified and confirmed by 2 registered pharmacists..."	{A 494}		
{A 500}	482.25(b) DELIVERY OF DRUGS In order to provide patient safety, drugs and biologicals must be controlled and distributed in accordance with applicable standards of practice, consistent with Federal and State law. This STANDARD is not met as evidenced by: Based on interview and document review, the hospital failed to ensure medication orders were prescribed only by licensed health professionals within their scope of practice authorized by law and per approved hospital protocol. Findings: Review of the hospital P&P titled, "Preparation and Administration of Medications" showed, "...All chronic medication orders must be renewed every thirty days unless the physician specifically orders otherwise. Pharmacy shall evaluate and contact the physician for clarification. Exceptions...The MEC (Medical Executive Committee) has authorized the Clinical Pharmacist to renew certain "Critical Medications", if the prescriber fails to renew the medications..."	{A 500}	A 500 482.25(b) Delivery of Drugs Immediate Action Taken: 1. Pharmacy Leadership reviewed the survey findings. The "Preparation and Administration of Medications" policy was reviewed and revised to delete the Pharmacist's ability to renew medication orders. Informal huddles with pharmacy staff were held on 4/11/16 to confirm the change in procedure regarding renewal of medications. The policy was approved by the Pharmacy and Therapeutics Committee on 5/15/16, MEC on 5/17/16 and Governing Board on 5/25/16. Subsequent Actions Taken: 1. Compliance with physician ordering renewals of medications is monitored through the QAPI program. Compliance and Monitoring: The Director of Pharmacy or qualified licensed designee reviews medication renewals on a daily basis to achieve the goal of 100% compliance with physician's renewing medications. Data is analyzed and reported monthly to the Medication Safety Committee, Quality Council, MEC, and Governing Board.	4/5/16 5/25/16

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{A 500}	Continued From page 36 In an interview on 4/5/16, at 3:30 P.M., the DOP was not able to provide MEC approved protocol, list of critical medications and the definition of what were considered critical medications. In a concurrent interview, the VPPO stated the pharmacists were not allowed to renew medications without a physician order to do so.	{A 500}		
{A 501}	482.25(b)(1) PHARMACIST SUPERVISION OF SERVICES All compounding, packaging, and dispensing of drugs and biologicals must be under the supervision of a pharmacist and performed consistent with State and Federal laws. This STANDARD is not met as evidenced by: Based on interview and document review, the hospital failed to ensure: 1. Pharmacy compounded medications achieved the final concentrations that met the potency and strength as intended; 2. Pharmacy and nursing were aware after activating the compounded medications they should be immediately used and not stored in the medication refrigerator for later use. 3. Pharmacy and nursing was aware of the compounded medications for immediate use should not be stored longer than 1 hour from the time the medications were compounded and not be given an expiration date of 24 hours consistent with the hospital P&P and the standards of practice. Findings:	{A 501}	A 501 482.25(b)(1) Pharmacist Supervision of Services	

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{A 501}	Continued From page 37 1. Review of the Hospital's "Compounding Record" for hydromorphone PCA (Patient Controlled Analgesia) 5.5 mg/55 ml (0.1 mg/ml) showed the following direction: "Draw up 27.5 mL of Hydromorphone 2 mg/ml #20 mL vial. Dilute in 500 mL bag of NS (with 35 mL overfill approximate). Mix solution...Ingredient...Hydromorphone 20 mg/mL...Base Solution...0.9% NaCl (sodium chloride; salt) (option to choose brands from) Baxter, B. Braun, or Hospira..." The resulting concentration of the final compounded product would not be 0.1 mg/ml (55/562.5ml) In an interview on 4/5/16 at 10:30 A.M., the DOP was not able to ensure accuracy and consistency of the overfill amount, 35 ml, in each 500 ml bag of NS (Normal Saline). In an interview on 4/5/16 at 11 A.M., RPH 7 stated last time the 500 ml bag was measured was about a year ago and acknowledged that there could be variability in the overfill volume in different batches, different lot, different manufacturers. Review of the Hospital P&P titled, "Pharmacy Compounding" dated, "03/2016," showed, "The pharmacist performing or supervising the compounding has the responsibility for the integrity, potency, quality, and strength of the compounded product until it is dispensed..." 2. During an inspection of the ICU Mediation	{A 501}	Findings 1-3 Immediate Actions Taken: 1. Pharmacy Leadership completed a revision of the master formula (basic compounding form) and created compounding sheets with revised instructions for hydromorphone PCA and continuous morphine infusions. Education with pharmacy staff started on 4/18/16, and new instructions and forms were implemented on 4/18/16. Subsequent Actions Taken: 1. Pharmacy Leadership constructed and implemented a custom label restricting medication administration for those medications where the manufacturer recommends a one-hour beyond use date time after the medication is mixed by the unit nurse. If a one-hour beyond use date is not recommended, the nursing staff shall follow manufacturer's recommendations for activation and antibiotic hang time. Compliance and Monitoring: The Director of Pharmacy or qualified licensed designee performs random spot checks daily at varying times to monitor compliance with beyond use dating and compounding medications. Corrective action is taken, including 1:1 training with staff. Data is analyzed and reported monthly to the Medication Safety Committee, Quality Council and MEC, and Governing Board until has occurred, at which time the Council will determine what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator).	4/18/16 5/9/16

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{A 501}	Continued From page 38 Room on 4/6/16 at 12:50 P.M. it was noted there was a Pharmacy-assembled injectable Vancomycin (antibiotic) 750 mg vial connected to the infusion fluid bag containing Dextrose 5% in Water by a Binary Connector that provided the physical separation between the powder in the vial and the IV fluid in the bag until activation. The vial was observed to be filled with fluid indicating the Vancomycin powder in the vial was mixed with the fluid from the infusion bag for reconstitution and administration. In an interview on 4/6/16 at 12:55 P.M., RN 71, a nurse manager, stated the antibiotic was placed in the refrigerator because of the change in the administration time from 9 A.M this morning to 2 P.M. In a concurrent interview, VPPO stated the antibiotic should have been disposed because it was not administered to the patient. The American Society of Health-System Pharmacists (ASHP), a nationally recognized pharmacy organization, develops official professional policies, in the form of policy positions and guidance documents and according to "ASHP Guidelines on Compounding Sterile Preparations," "...Activation of the devices should be completed at the point of care just prior to administration." 3. During a tour of the ICU (Intensive Care Unit) at Hollywood on 4/6/16 at 12:45 P.M., it was noted there was in an amber plastic bag one 250-ml injectable Dextrose 5% in Water (D5W) bag and two vials of norepinephrine 4 mg placed in one of the plastic bins in the Medication Room.	{A 501}	Person Responsible: Director of Pharmacy	

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{A 501}	Continued From page 39 It was also noted there was no expiration date/beyond use dating on the label. During an interview on 4/6/16 at 1 P.M., RN 73 stated the compounded norepinephrine infusion bag would be good for 24 hours and the BUD of 24 hours would be written on the Pharmacy Printed label attached to the D5W bag. During a concurrent interview, the VPPO stated the compounded norepinephrine infusion bag would have an expiration date of 24 hours. Review of the hospital P&P titled, "Pharmacy Compounding" dated "3/2016" showed, "Beyond-use dates (BUDs) are assigned according to the risk of contamination and storage conditions consistent with the definitions and standards of USP<797>...When there are no literature references, refer to the standards of USP<797>. See Table 1..." The Table 1 of the P&P showed for "Immediate-Use" risk category, the BUD was 1 hour. United States Pharmacopeia (USP) Chapter <797> sets the minimum practice and quality standards for CSPs to prevent harm to patient and according to USP Chapter <797>, "Beyond-Use Date...the date or time after which a CSP (Compounded Sterile Preparations) shall not be stored or transported. The date is determined from the date or time the preparation is compounded." The American Society of Health-System	{A 501}		

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{A 501}	Continued From page 40 Pharmacists (ASHP), a nationally recognized pharmacy organization, develops official professional policies, in the form of policy positions and guidance documents and according to "ASHP Guidelines on Compounding Sterile Preparations," "The immediate-use category should be reserved for emergent use or situations in which adhering to low-risk compounding procedures would add additional risk due to delays in patient care. Examples of such situations may include cardiopulmonary resuscitation, diagnostic procedures, or short-stability Medications that must be prepared immediately before administration outside health care facilities (e.g., in home infusion or emergency care at the accident site or in an ambulance). Immediate-use CSPs do not need to be compounded in an ISO Class 5 environment and garbing and gowning are not required, as long as all of the following criteria are met...The preparation is labeled with patient identification, names and amounts of all ingredients, name or initials of preparer, and exact 1-hour BUD and time. If CSPs prepared for immediate use are not administered within 1 hour, they must be properly discarded. All medications must be labeled to meet regulatory and accreditation standards and in accordance with facility policy..."	{A 501}		
A 582	482.27(a) ADEQUACY OF LABORATORY SERVICES The hospital must have laboratory services available, either directly or through a contractual agreement with a certified laboratory that meets the requirements of part 493 of this chapter.	A 582	A 582 482.27(a) Adequacy of Laboratory Services	

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A 582	Continued From page 41 This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to collect and process urine specimen as per policy and procedure. Failure to follow specimen collection procedure puts patient at risk for delay in medical treatment or not being treated accurately. Findings: During a tour of the laboratory on 4/6/16 at 8:58 a.m., and cocurrent interview with the laboratory director (LD), patient N 205's urine specimen was observed in refrigerator # 2. The specimen was dated 4/3/16 at 9:45 p.m., according to LD urine specimens are discarded after 24 hours of time of collection. During the interview with the LD, he explained the urine order was acknowledged (this step communicates to the lab that there is an order) and processed (this step prints out a label in the laboratory with name, date and time the specimen was collected) by the nurse on 4/3/16 at 9:45 p.m. The specimen was collected on 4/4/16 at 4:40 a.m., received in the laboratory on 4/4/16 at 6:14 a.m. When the urine specimen arrived in the laboratory, the lab technician attached the print out label (dated 4/3/16 at 9:45 p.m.) to the specimen. The laboratory has no means or method of printing out another label to attach to specimens when they actually arrive in the lab. During an interview on 4/6/16 at 10:30 a.m., with RN 15 she explained once the urine specimen is processed... its logged on the "Laboratory Specimen Tracking Log" in order for the	A 582	Findings 1-3 Actions Taken: 1. Lab Leadership reviewed and revised the Policy on "Retention of Records and Specimens" outlining the new process for handling urine specimens for urine analysis. The urine specimens are checked and monitored every shift (previously once a day) to ensure that no specimens are kept no more than 24 hours. A designated area for storage has been identified to make sure that the specimens are clearly identified an isolated. Laboratory Services staff was inserviced on the policy revisions. Compliance and Monitoring: The Lab Director or qualified designee shall perform random daily observations of lab staff to achieve the goal of 100% compliance with the urine specimen collection processes. Corrective action is taken as necessary, including just-in-time training. Data is analyzed and reported monthly to the Quality Council, MEC, and Governing Board until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will occur until the Quality Council determines sustained compliance has occurred, at which time the Council will determine what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Person Responsible: Director of Laboratory Services	4/6/16 – 5/12/16

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A 582	Continued From page 42 specimen to be transported to the lab. Concurrently, the "Laboratory Specimen Tracking Log" was reviewed to locate patient N 205's urine specimen log in, but the specimen was not found on the log. This patient's specimen collection process was unclear. A review of policy and procedure titled: Retention of Records and Specimens, dated 04/2016, indicated urine specimens are retained for 24 hours. A review of policy and procedure titled: Laboratory Specimen Transport, dated 7/4/12, in part 4.1.4. indicated "All transported specimens are tracked by the specimen tracking log located on all Nursing Units and in the Main Laboratory."	A 582		
{A 700}	482.41 PHYSICAL ENVIRONMENT The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community. This CONDITION is not met as evidenced by: Based on observation, record review, and interview, the facility failed to maintain their fire and life safety systems to ensure a safe environment in accordance with the National Fire Protection Association (NFPA) 101 Life Safety Code (LSC) 2000 Edition and NFPA 72 National Fire Alarm Code 1999 Edition. This was evidenced by the failure to: 1. Ensure that the fire department was dispatched by the approved central station during	{A 700}	A 700 Physical Environment Condition Corporate and Hospital Leadership reviewed the survey findings and implemented changes to the physical plant and overall hospital environment to maintain a safe and sanitary environment and to assure the well-being of patients. Corporate Leadership worked on site with the Director of Facilities and Facilities staff on the identified issues. The Hospital continues to work with a national healthcare regulatory compliance consulting firm, which includes a consultant with expertise in the physical environment condition of participation.	4/18/16 - 6/7/16

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{A 700}	Continued From page 43 an actual Code Red event. (See LSC K51) 2. Ensure that the fire alarm system was continuously monitored by the approved central station. (See LSC K51) 3. Maintain the audible fire alarm signals in the Tower. (See LSC K51) 4. Ensure that the fire alarm system at the acute psychiatric facility transmitted fire alarm signals to the approved central station. (See LSC K51) 5. Ensure that smoke detectors were correctly addressed in the fire alarm system. (See LSC K51) The cumulative effect of these systemic problems, identified during the Life Safety Code (LSC) Survey, resulted in the failure to demonstrate the ability to ensure the provision of quality health care in a safe environment. This affected all patients at the Pavilion, the Tower, and the Van Nuys Acute Psychiatric Hospital and could result in injury due to the delay in notifying occupants of a fire, a delay in evacuation in the event of a fire, and a delay in response from emergency forces. (Refer to the LSC Survey dated 4/8/16) Findings: During tour of facility with staff from 4/4/16 to 4/8/16, the fire alarm systems were tested and observed. The Pavilion and the Tower building, located across the street from the Pavilion, shared the same fire alarm system. Van Nuys: 1. From 12:00 p.m., to 12:30 p.m., on 4/6/16, fire alarm testing was conducted and this included initiating devices such as pull stations, smoke	{A 700}	Finding 1 Actions Taken: 1. The Hospital repaired the loose wire that affected the ability to transmit the signal. The fire alarm was activated to test that the fire alarm signal was received by the monitoring company. 2. The Hospital checked the other two campuses to ensure that there were no issues with transmitting a signal when the fire alarm was tested. 3. Upon completion of each fire drill, facilities staff shall contact the monitoring company to ensure that they received a signal. This is documented on the fire drill critique sheet. Compliance and Monitoring: Data on compliance is tracked, trended, analyzed and reported quarterly at the EOC Committee. Corrective action is taken as necessary. Compliance is reported quarterly to the Quality Council and Governing Board. Persons Responsible: Vice President of Facilities Development Director of Facilities	4/7/16 4/8/16 5/27/16

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{A 700}	Continued From page 44 detectors, and waterflow switches. At 4:17 p.m., the monitoring report from the testing was provided. The monitoring report showed that the remote monitoring station only received Zone 2 fire trouble signals for all types of initiation devices tested. During a telephone interview at 4:18 p.m., a representative from the monitoring company stated that they would not dispatch the fire department upon receipt of a Zone 2 trouble signal. During a telephone interview at 4:47 p.m., another representative from the monitoring company stated that the last Zone 1 fire alarm signal received from the facility was on 12/30/15. He stated that the only fire trouble signals were received on 1/23/16. The annual testing of the fire alarm system was conducted on 1/23/16 and documents showed that all initiation devices were tested on that day. During an interview at 5:00 p.m., the Director of Facilities Services (DFS2) stated that a fire watch would be implemented immediately until the fire alarm panel was fixed. Records showed that a fire alarm vendor fixed the panel on 4/7/16. The vendor reported that there was a loose wire for Zone 1 in the panel that caused all the signals to be reported as Zone 2. Pavilion: 2. At 10:28 a.m., on 4/4/16, the fire alarms sounded and a Code Red was paged overhead. PBX paged "Code Red Sixth Floor" three times.	{A 700}	Finding 2 Actions Taken: 1. The Hospital replaced the smoke detector and the vendor remapped the smoke detector to the alarm panel. The smoke detector was tested to validate that it was correctly mapped on the fire panel.	4/6/16

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{A 700}	Continued From page 45 At 10:33 a.m., the Head of Security (HS1) reset the fire alarm system at the notification panel in the lobby. During an interview at 10:33 a.m., HS1 stated that security staff had investigated and saw no signs of fire. He stated that the panel indicated that the smoke detector was activated in the hallway outside the EVS (environmental services) closet on the sixth floor. At 10:35 a.m., there were two security staff holding fire extinguishers in Wing A of the sixth floor. They stated that the smoke detector inside Room 605, which was adjacent to an EVS closet, was blinking red. They gave an "all clear" after inspecting that room. At 10:50 a.m., Plant Operations Lead Staff (PO1) removed the detector in Room 605 and an addressable trouble signal on the panel read "Pav 6th Smoke Patient Room 605." During an interview at 10:51 a.m., PO1 and HS1 were unsure if Room 605 was the origin of the fire alarm activation/Code Red and if security staff responded to the wrong location. At 2:37 p.m., a print out from the panel indicated that, "Pav 6th Smoke Patient Room 605" caused a "Common Trbl Act" (a local trouble signal) at 10:24 a.m. and that, "Pav 6th Smoke Hall Outside EVS" caused an "Alarm Active" at 10:28 a.m. During an interview at 2:38 p.m., the Fire Alarm Technician (F.A. Tech2) stated that the source of the fire alarm activation was not Room 605. He said that he and the other technicians were still trying to locate the smoke detector that was	{A 700}	2. The Hospital engaged the vendor to validate the mapping and annunciator display for all hospital locations and devices. Compliance with this process was then confirmed through testing of fire alarms. 3. Compliance with smoke detectors and mapping to the alarm panel is monitored by the annual fire alarm testing performed by an independent contractor. Compliance and Monitoring: Data on compliance is tracked, trended, analyzed and reported quarterly at the EOC Committee. Corrective action is taken as necessary. Compliance is reported quarterly to the Quality Council and Governing Board. Persons Responsible: Vice President of Facilities Development Director of Facilities	6/3/16

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{A 700}	Continued From page 46 addressed incorrectly as "outside EVS." During an interview at 4:05 p.m., F.A. Tech 2 stated that the smoke detector that caused the Code Red was actually in a linen closet in Wing C, not in the Wing A corridor outside the EVS closet. Facility staff responded to the wrong location during the Code Red incident due to a smoke detector that was not addressed correctly on the panel. Culver City Campus: 3. Per record review and interviews, it was observed that the fire alarm system was frequently placed on test during the past month. When the system is on test, fire alarm signals received by the remote monitoring station would not result in dispatch of the fire department. During the Code Red on 4/4/16 (Finding 2 above), the fire department was not dispatched. During an interview at 10:33 a.m., on 4/4/16, HS1 stated that the system was on test and PBX would call the fire department upon investigation by the facility and security staff. At 4:05 p.m., on 4/6/16, this surveyor was unable to conduct an interview with the PBX operator. There was only one PBX operator at the time and he was busy with phone calls. The fire alarm annunciator in PBX was across the room from the operator. PBX did not meet the NFPA 72 requirements of a listed central station or proprietary supervising station. During an interview at 1:57 p.m., on 4/5/16, the	{A 700}	Finding 3 Actions Taken: 1. Hospital Leadership discussed the survey findings and immediately implemented an action plan. Effective 4/8/16, only the Chief Operating Officer and the Director of Facilities can initiate the test mode of the fire alarm system through a password protected account set up with the alarm monitoring company. Test mode is only utilized when a) working on the system; b) during preventive maintenance; c) during fire drills; and d) if the system is impaired. The Hospital notifies the local Fire Department, PBX and Security when the fire alarm system is put on test mode. This process was reviewed with the local and state Fire Marshall on 4/26/16. In addition, the process for utilizing test mode of the fire alarm system was discussed at the EOC meeting on 4/14/16. Education was provided to PBX, security and engineering staff.	4/26/16

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{A 700}	Continued From page 47 Los Angeles Fire Prevention Specialist (LAFPS) from Culver City Fire stated that the Fire Department should have been dispatched during the Code Red incident yesterday (Finding 2 above) and the Code Red incident in December (See K48 from the December 2015 Life Safety Code Survey). He stated the last time the fire department was notified of a fire alarm at the facility was on 3/11/16. He stated that the fire department was not notified of the alarms in the building yesterday. He requested to review a month of the monitoring reports from the offsite monitoring stations. During an interview at 5:01 p.m., on 4/6/16, Plant Operations Lead Staff (PO1) stated that the facility placed the fire alarm system in test mode daily, for both the Tower and Pavilion, although construction was only conducted in the Pavilion Penthouse. During an interview at 8:49 a.m., on 4/7/16, the LAFPS stated the facility cannot place the fire alarm system on test daily without informing the local AHJ that the system is out of service. He stated he was unaware of any construction work that would require that the entire fire alarm system be put on test daily for both Tower and Pavilion Buildings. During an interview at 8:50 a.m., on 4/7/16, the Los Angeles Fire Inspector (LAFI) from the local Fire Department stated the facility cannot be on test so often without notifying the local AHJ. He stated that the facility must notify the AHJ when the fire alarm system is on test for construction work. During an interview at 11:44 a.m., on 4/7/16, the	{A 700}	Compliance and Monitoring: Data on compliance is tracked, trended, analyzed and reported quarterly at the EOC Committee. Corrective action is taken as necessary. Compliance is reported quarterly to the Quality Council and Governing Board. Persons Responsible: Vice President of Facilities Development Director of Facilities	

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{A 700}	Continued From page 48 Office of Statewide Health Planning and Development (OSHPD) Fire Life Safety Officer (FLSO) stated the facility should get approval from the FLSO for putting the system on test during any construction. During an interview at 12:30 p.m., on 4/7/16, the Director of Facilities Services (DFS1) stated that PBX was carrying out instructions from the previous Facilities Director to put the system on test from 5 a.m. to 5 p.m. daily whether the fire alarm system was being worked on or not. During an interview at 2:48 p.m., on 4/7/16, F.A. Tech1 stated the fire alarm system has the capability to place only certain zones on test, such as specific construction areas or while working on a portion of the fire alarm system. During an interview at 9:50 a.m., on 4/8/16, F.A. Tech1 stated he was unaware that the facility had placed the fire alarm system on test when he and his staff were not working on the system. F.A. Tech1 provided his staff's work schedule for the month of March 2016. He confirmed that they were not in the building during the Code Red incident on 4/4/16. At 10 a.m., on 4/13/16, comparison of the facility's fire alarm monitoring reports and the fire alarm vendor's work schedule showed days that the fire system was placed on test while no work was conducted on the system. The monitoring report indicated that the facility placed the entire fire alarm system on test from 5:00 a.m., to 5:00 p.m. for most days, including Saturdays and Sundays, without notifying the local AHJ. The fire alarm system was placed on test late into the evening on other days: on 3/14/16, the system	{A 700}		

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{A 700}	Continued From page 49 was placed on test from 7:28 p.m., until 11:30 p.m. and on 3/22/16, from 6:16 p.m., until 11:59 p.m. The monitoring report indicated the system was placed on test on 3/11/16 from 5:00 a.m., to 5:00 p.m., for selective zones only. A fire alarm was activated in an area that was not on test and the fire department was dispatched. Interview with LAFPS above confirmed that this was the last time they received fire alarm signal from the facility. Per the monitoring report and the fire alarm vendor's schedule for March 2016, the facility had their entire fire alarm system on test from 5:00 a.m., to 5:00 p.m. for 14 days (including Saturdays and Sundays) while there was no fire alarm vendor in the building. The system was on test on 3/9/16 while there was no fire alarm vendor working on the fire alarm panel. The report indicated the panel exhibited a supervisory signal. The signal was not sent to the local fire department. Tower First Floor: 4. At 3:53 p.m., on 4/6/16, the pull station on the first floor in the Emergency Department was tested. The fire alarm chimes failed to activate an audible alarm and no fire alarms could be heard throughout the building. At 3:54 p.m., on 4/6/16, the pull station by the exit door of the Emergency Department was tested. The fire alarm chimes failed to activate an audible alarm and no fire alarms could be heard throughout the building.	{A 700}	Finding 4 Actions Taken: 1. The fire alarm chimes for the pull stations on the first floor and exit in the Emergency Department, and Tower basement were repaired. 2. The Hospital tested the pull stations on all three campuses to validate functioning fire alarm chimes that activated an audible alarm. 3. Compliance with fire alarm chimes is monitored through the annual fire testing. Compliance and Monitoring: Data on compliance is tracked, trended, analyzed and reported quarterly at the EOC Committee. Corrective action is taken as necessary. Compliance is reported quarterly to the Quality Council and Governing Board. Persons Responsible: Vice President of Facilities Development Director of Facilities	4/6/16 6/3/16

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{A 700}	Continued From page 50 During an interview at 3:55 p.m., F.A. Tech1 stated he would go and investigate the problem. At 5:52 p.m., the notification devices at the Tower were still not repaired. During an interview at 9:01 a.m., on 4/7/16, F.A. Tech1 stated he finished working on the fire alarm system yesterday at approximately 8:30 p.m., and all the chimes on all the floors of the Tower should be working now. Tower Basement: At 10:29 a.m., a pull station was tested and the fire alarm chime box failed. No alarms could be heard in the basement. This deficiency was cited during the September 2015 and December 2015 Life Safety Code surveys under K52. During the survey on 9/22/15, the fire alarm chimes on the first floor and fourth floor of the Tower failed during testing of the fire alarm system. During the survey on 12/16/15, the fire alarm chimes failed on the seventh floor of the Tower while fire alarm testing. Documentation from the Inspector of Record (IOR) showed that, during testing on 1/22/16, the audible fire alarms failed on the first floor, third floor, basement, and fifth floor of the Tower. The items were documented as having been corrected on 1/27/16. The recurring failure of the fire alarm chimes had not been corrected.	{A 700}		
{A 747}	482.42 INFECTION CONTROL The hospital must provide a sanitary environment	{A 747}	A 747 482.42 Infection Control	

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{A 747}	Continued From page 51 to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases. This CONDITION is not met as evidenced by: Based on observation, interview, and document review, the hospital failed to ensure an effective, active system wide infection surveillance control program for prevention, control, and investigation of infections and communicable diseases for patients. The infection control program failed to meet the needs of all patients and staff as evidenced by failure to: 1. The hospital failed to provide a functional and sanitary environment for the provision of patients who received surgical services. The hospital failed to ensure that surgical instruments were properly cleaned and disinfected in a manner that protected the lives and safety of patients who required these services (refer to (A0749). 2. The hospital failed to provide a functional and sanitary environment for the provision of patient services. The hospital failed to ensure that patient rooms were cleaned and disinfected according to manufacturer's instructions for use or EPA regulations, and risked the lives and safety of patients who required these services (refer to A0749). 3. The hospital failed to provide a functional and sanitary environment for the provision of patient services that required finger stick glucose monitoring. The hospital failed to ensure that glucometers were properly cleaned and disinfected according to manufacturer's instructions for use or EPA regulations that protected the lives and safety of patients who required these services (refer to A0749).	{A 747}	The Hospital assures that it has a comprehensive infection control program that provides for the prevention, control and investigation of infections and communicable diseases. A sanitary environment is maintained to avoid sources and transmission of infection. Hospital Leadership and the Director of Infection Control reviewed the survey findings and worked collaboratively to address the identified issues as discussed below. Infection Control practices were reviewed regarding maintenance of a sanitary environment for patients on the identified issues. A certified SPD technician was onboarded on 5/9/16. The Hospital obtained an onsite visit by the surgical instrument company on 4/6/16 to review the alleged discoloration on surgical instruments and confirmed that the sterility of the instruments was not affected and correct sterilization process was being followed according to AAMI/AORN standards. The SPD staff perform a daily QC on every 5th tray sterilized. The Director of Infection Control or qualified designee also performs a daily (Monday through Friday) inspection of sterilized surgical instruments. It was then determined that one tray from each sterilizer is to be checked daily by the Director of Infection Control or qualified designee. Education of Sterile Processing Department staff on the proper usage of cleaning and disinfections was provided from 5/1/16 – 5/7/16, and is ongoing, with special emphasis on strict adherence to the sterilization process.	6/3/16

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{A 747}	Continued From page 52 4. The hospital failed to provide a functional and sanitary environment for the provision of patient services who received services which required the use of a vaginal transducer (a probe used in the vagina to visualize organs within the pelvic cavity). The hospital failed to properly clean and disinfect vaginal probes according to the manufacturer's guidelines and in a manner that protected the lives and assured the physical safety of patients who required these services (refer to A0749). 5. The hospital failed to provide a functional and sanitary environment for the provision of patient services who received services which required the use of Transesophageal echocardiogram probes (TEE - A specialized probe containing an ultrasound transducer which contains a tip which is passed into the patient's esophagus. This allows images and Doppler evaluation of the heart, which can be recorded). The hospital failed to properly clean and disinfect TEE probes according to the manufacturer's guidelines and in a manner that protected the lives and assured the physical safety of patients who required these services (refer to A0749). The cumulative effects of these systemic problems resulted in the hospital's inability to provide infection control services and care in a safe and effective manner in accordance with the Condition of Participation for Infection Control Services.	{A 747}	The Director of Infection Control and the Director of Environmental Services (EVS) reviewed the survey findings regarding use of floor disinfectant cleaners. EVS staff was reeducated on use of the floor disinfectant cleaners, with special emphasis on wet times for effectiveness. The Director of Infection Control and Director of EVS conduct random observations to monitor compliance with use of floor disinfectants and just-in-time training is initiated if necessary. The finger stick glucose monitoring meters were cleaned with the manufacturer approved disinfectant and in compliance with required wet time of the product. Education was provided to nursing and ancillary departments from 5/5/16 – 5/7/16, including use of the disinfectant between patients with the required wet time, and cleaning of any blood residue prior to disinfection. Education on cleaning of finger stick glucose monitoring meters is provided to nursing and ancillary department staff upon hire.	5/31/16 4/5/16 5/5/16 – 5/7/16
A 748	482.42(a) INFECTION CONTROL OFFICER(S) A person or persons must be designated as infection control officer or officers to develop and implement policies governing control of infections and communicable diseases.	A 748		

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{A 747}	Continued From page 52 4. The hospital failed to provide a functional and sanitary environment for the provision of patient services who received services which required the use of a vaginal transducer (a probe used in the vagina to visualize organs within the pelvic cavity). The hospital failed to properly clean and disinfect vaginal probes according to the manufacturer's guidelines and in a manner that protected the lives and assured the physical safety of patients who required these services (refer to A0749). 5. The hospital failed to provide a functional and sanitary environment for the provision of patient services who received services which required the use of Transesophageal echocardiogram probes (TEE - A specialized probe containing an ultrasound transducer which contains a tip which is passed into the patient's esophagus. This allows images and Doppler evaluation of the heart, which can be recorded). The hospital failed to properly clean and disinfect TEE probes according to the manufacturer's guidelines and in a manner that protected the lives and assured the physical safety of patients who required these services (refer to A0749). The cumulative effects of these systemic problems resulted in the hospital's inability to provide infection control services and care in a safe and effective manner in accordance with the Condition of Participation for Infection Control Services.	{A 747}	Vaginal and Transesophageal echocardiogram probes were cleaned and disinfected using hi-level disinfection in accordance with manufacturer's instructions. The "High Level Disinfection" policy was reviewed and did not require any revisions. Ultrasound technicians were educated on the proper cleaning and high level disinfection of probes on 4/7/16. A structured rounding surveillance process, including a daily rounding schedule, is in place. The Director of Infection Control provides rounding to monitor compliance with infection control practices. Data on compliance with infection control practices is monitored through the QAPI program and the Infection Control Committee.	4/7/16
A 748	482.42(a) INFECTION CONTROL OFFICER(S) A person or persons must be designated as infection control officer or officers to develop and implement policies governing control of infections and communicable diseases.	A 748	A 748 482.42(a) Infection Control Officers	

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A 748	Continued From page 53 This STANDARD is not met as evidenced by: Based on record review, observation, and interview, the facility failed to implement its Transmission-Based Isolation Precautions and Hand Hygiene policies relating to contact plus isolation for Patient N502 and N504. 1. Staff did not follow contact plus isolation precautions for Patient N502. 2. Staff did not place Patient N504 on contact isolation per policy. The failure to implement these policies placed other patients at risk for contracting communicable diseases. Findings: 1. Review of the facility policy and procedure titled "Transmission-Based Isolation Precautions" dated 3/2016 indicated Contact Plus Isolation Precautions is designated for patients who have Clostridium Difficile (C Diff. a bacterium that can cause symptoms ranging from diarrhea to life-threatening inflammation of the colon.) The policy indicated staff must wear gowns and gloves prior to entering when contact with the patient or environment is anticipated and hand hygiene should be done before leaving the room. Review of the facility policy and procedure titled "Hand Hygiene" dated 3/2016 indicated hands should be washed with soap and water if contact with C Diff is anticipated. During an observation on 4/4/16 at 11:15 a.m., Patient N502 was in bed in the room which was labeled "Contact Plus." A licensed vocational	A 748	Finding 1 Immediate Actions Taken: 1. The Chief of Staff issued a memorandum to medical staff members advising them of their responsibility to abide by Infection Control Policies, specifically hand hygiene and personal protective equipment (PPE) for isolation. 2. The Director of Infection Control inserviced the applicable nurse on hand hygiene for patients with C diff infection. 3. The Director of Infection Control inserviced nursing staff at the time of survey on proper hand hygiene (including use of soap and water for C-Difficile patients). 4. The Director of Infection Control implemented an ongoing PPE and hand hygiene campaign. Subsequent Actions Taken: 1. The Director of Infection Control provided mandatory PPE and hand hygiene to clinical staff. 2. An Infection Control Committee meeting was held on 5/12/16 to discuss the survey findings and implementation of the hand hygiene campaign.	4/5/16 4/5/16 4/5/16 4/11/16 5/1/16 - 5/7/16 5/12/16

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A 748	Continued From page 54 nurse (LVN 1) was sitting in the room at the computer on wheels without wearing gloves. LVN 1 was then observed donning gloves without washing hands. During a review of Patient N502's plan of care dated 3/29/16 indicated the patient had a C Diff infection. During an interview and consecutive observation on 4/4/16 at 2:40 p.m., LVN 1 said she cleans patient equipment with a "PDI Sani Cloth with Bleach." She demonstrated how she uses the bleach wipes while she wiped the faucet handles located at Patient N502's bedside. LVN 1 stated the area must remain wet for two minutes to be effective. LVN 1 was then observed to remove her isolation gown and gloves just inside of the patient's door, placing them in the trash receptacle, then used alcohol hand sanitizer located in a container on the wall inside of the patient's room to wash her hands before exiting Patient N502's contact plus isolation room. During an interview with the infection control director (ICP 1) on 4/5/16 at 11:25 a.m., ICP 1 stated staff must use soap and water to wash their hands and alcohol hand sanitizer is "Never" appropriate in a contact plus isolation room when the patient has C Diff. ICP 1 said when cleaning with the bleach wipes the area must remain wet for four minutes. ICP 1 said the use of bleach wipes for two minutes is "ineffective." 2. Review of the facility policy and procedure titled "Transmission-Based Isolation Precautions" dated 3/2016 indicated "Contact Precautions should be applied empirically if the patient being admitted has a history of infection or colonization	A 748	3. In keeping with a just culture (would like staff, given the same set of circumstances commit the same occurrence), staff were informed that progressive disciplinary action would be instituted for individuals that failed to comply with basic hand hygiene practices. This was felt to be necessary and fair, as staff are knowledgeable about and should conform to basic hand hygiene practices. 4. Education on hand hygiene is provided to all staff upon hire. 5. Compliance with hand hygiene is monitored through the QAPI program. Compliance and Monitoring: The Director of the Infection Control Department and department personnel or qualified designees conducts observations daily with remediation to staff in real time. Data is aggregated and reported monthly to the Infection Control Committee Chairperson, with this data integrated into the hospital-wide Quality Council. Compliance is reported to the MEC and Governing Board monthly until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will occur until the Quality Council determines sustained compliance has occurred, at which time the Quality Council will determine what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Person Responsible: Director of Infection Control	5/18/16

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A 748	Continued From page 55 with an MDRO (Multidrug resistant organisms are defined as bacteria that have become resistant to more than one class of antimicrobial agents and usually are resistant to all but one or two commercially available antimicrobial agents, complicating treatment of illnesses they cause)." During a facility tour on 4/4/16 between 3:05 and 4:30 p.m., Patient N504's was observed and was not in an isolation room. Review of Patient N504's clinical record on 4/6/16 indicated the patient had been a patient on the same floor of the facility for almost two months and had been on contact isolation for more than one MDRO. Patient N504 was transferred to a skilled nursing facility on 4/1/16 and was re-admitted to this facility 4/3/16, two days later. During an interview with RN 7 on 4/6/16 at 4:30 p.m., RN 7 confirmed Patient N504 was well known on this floor of the facility because of the previous admission and had been on contact isolation. RN 7 said the patient was not placed on contact isolation upon return from the skilled nursing facility. During an interview with Patient N504's physician (MD 3) on 4/7/16 at 9:05 a.m., MD 3 said Patient N504 should have been placed on contact isolation upon return from the skilled nursing facility due to colonized MDROs.	A 748	Finding 2 Immediate Actions Taken: 1. The Director of Infection Control investigated the survey findings regarding Patient 504 and immediately identified the patient required contact isolation precaution. The patient was immediately placed in isolation appropriately. 2. Hospital Leadership and the Director of Infection Control discussed the survey findings. The Director of Infection Control shall review newly admitted patient charts to identify isolation requirements. Once identified, the information is input into the alert system. Patients requiring isolation are identified on a daily basis via daily lab culture results. Isolation is inputted into the alert system for communication to hospital and nursing staff. The alert system was updated as necessary. 3. The Director of Infection Control educated nursing staff on isolation practices. Compliance and Monitoring: The Director of Infection Control or qualified designee reviews all inpatients requiring isolation daily to ensure proper identification of this patient population. Data is aggregated and reported monthly to the Infection Control Committee Chairperson, with this data integrated into the hospital-wide Quality Council. Compliance is reported to the MEC and Governing Board monthly.	4/4/16 4/4/16 4/5/16
{A 749}	482.42(a)(1) INFECTION CONTROL PROGRAM The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and	{A 749}		

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A 748	Continued From page 55 with an MDRO (Multidrug resistant organisms are defined as bacteria that have become resistant to more than one class of antimicrobial agents and usually are resistant to all but one or two commercially available antimicrobial agents, complicating treatment of illnesses they cause.)." During a facility tour on 4/4/16 between 3:05 and 4:30 p.m., Patient N504's was observed and was not in an isolation room. Review of Patient N504's clinical record on 4/6/16 indicated the patient had been a patient on the same floor of the facility for almost two months and had been on contact isolation for more than one MDRO. Patient N504 was transferred to a skilled nursing facility on 4/1/16 and was re-admitted to this facility 4/3/16, two days later. During an interview with RN 7 on 4/6/16 at 4:30 p.m., RN 7 confirmed Patient N504 was well known on this floor of the facility because of the previous admission and had been on contact isolation. RN 7 said the patient was not placed on contact isolation upon return from the skilled nursing facility. During an interview with Patient N504's physician (MD 3) on 4/7/16 at 9:05 a.m., MD 3 said Patient N504 should have been placed on contact isolation upon return from the skilled nursing facility due to colonized MDROs.	A 748	Person Responsible: Director of Infection Control	
{A 749}	482.42(a)(1) INFECTION CONTROL PROGRAM The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and	{A 749}	A 749 482.42(a)(1) Infection Control Program	

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{A 749}	Continued From page 56 personnel. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the hospital failed to develop and implement a system for the identification, prevention and control of infections and communicable diseases, when: 1. Sterilized surgical Instruments were visibly contaminated and could not be verified as sterile. 2. During environmental cleaning, products were not used according to manufacturer's guidelines or EPA regulations. 3. Glucometers (instrument to measure blood sugar) were not cleaned and disinfected in accordance with manufacturer's guidelines or EPA guidelines. 4. The hospital failed to provide a functional and sanitary environment for the provision of patient services, which required the use of a vaginal transducer (a probe used in the vagina to visualize organs within the pelvic cavity). The hospital failed to properly clean and disinfect vaginal probes according to the manufacturer ' s guidelines and in a manner that protected the lives and assured the physical safety of patients who required these services. 5. The hospital failed to provide a functional and sanitary environment for the provision of patient services who received services which required the use of Transesophageal Echocardiogram probes (TEE - A specialized probe containing an ultrasound transducer which contains a tip which is passed into the patient's esophagus. This allows images and Doppler evaluation of the heart, which can be recorded). The hospital failed to properly clean and disinfect TEE probes	{A 749}		

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{A 749}	Continued From page 57 according to the manufacturer ' s guidelines and in a manner that protected the lives and assured the physical safety of patients who required these services. Findings: 1. On April 4, 2016 at 11:30 am, during an interview, ICP 1 stated that the facility adopted the Centers for Disease Prevention and Control (CDC), Association of peri-Operative Registered Nurses (AORN), Association for the Advancement of Medical Instrumentation (AAMI), Association for Professionals in Infection Prevention and Epidemiology (APIC) and the Healthcare Infection Control Practices Advisory Committee (HICPAC) as their nationally accepted infection control guidelines. On a tour of the sterile supply department on April 4, 2016 at 12:00 pm, the CS obtained a random sterilized major instrument tray (tools are made from surgical stainless steel used by professionals for major surgery). Upon inspection of the instruments, eight instruments had small areas of dark brown residue on the distal ends. This material could be scraped off with a fingertip. This was confirmed by CS. A random sterilized minor instrument tray (used for a minor surgery) was presented and opened by CS. Upon inspection ten instruments were inspected and contained dark brown residue in small amounts on the distal end of the instruments. This was verified with the CS and RN 3. On April 4, 2015 at 1:45 pm, ADM 5 stated that all operating room cases would be cancelled for the remainder of the day [April 4, 2016] and for April	{A 749}	Findings 1 Immediate Actions Taken: 1. Executive Leadership and the Director of Infection Control discussed the survey findings and Infection control practices were reviewed regarding maintenance of a sanitary environment for patients on the identified issues. 2. The Hospital obtained an onsite visit by the surgical instrument company on 4/6/16 to review the alleged discoloration on surgical instruments and confirmed that the sterility of the instruments was not affected and correct sterilization process was being followed according to AAMI/AORN standards. The SPD staff perform a daily QC on every 5th tray sterilized. The Director of Infection Control also performs a daily (Monday through Friday) inspection of sterilized surgical instruments. It was then determined that one tray from each sterilizer is to be checked daily by the Director of Infection Control or qualified designee. Education of Sterile Processing Department staff on the proper usage of cleaning and disinfections was provided from 5/1/16 – 5/7/16, with special emphasis on strict adherence to the sterilization process. 3. A certified SPD technician was onboarded on 5/9/16. 4. Daily surveillance rounding in all areas of the OR and Sterile Processing Department are conducted by the Director of Infection Control and/or the OR Director or qualified designee.	4/6/16 5/7/16 5/9/16

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{A 749}	Continued From page 58 5, 2016. He stated that the automatic instrument washer, which had water issues previously, would immediately be taken out of service and mechanical cleaning by the decontamination staff would remain as the only cleaning process prior to steam sterilization. All of the surgical trays and instruments would be re-cleaned and re-sterilized prior to any scheduled surgery. On April 5, 2016 at 2:55 pm on a tour of the sterile supply department, the CS obtained a random sterilized major instrument tray for inspection. The instruments were examined, there was no brown residue visible but the instruments had some minor clear water staining on the instruments. On April 6, 2016 at 12:15 pm ADM 5 stated that the facility was in contact with the service representative for the chemical cleaning products and had requested water chemistry tests in the decontamination and sterilizing locations. Documentation was provided to support this action. According to the Association for the Advancement of Medical Instrumentation (AAMI TIR30, Section 5.4.): Medical device manufacturers should be familiar with cleaning, disinfection, and sterilization technologies used in health care facilities and with the kinds of soil and microbial contamination encountered as a result of patient use. Organic soil such as blood, serum, lipids, tissue fragments, and inorganic salts can impede the disinfection or sterilization process if it is not removed during cleaning. Most of these soil components are substrates for the	{A 749}	Compliance and Monitoring: The Director of the Infection Control Department and department personnel or qualified designees conduct observations daily with remediation to staff in real time. Data is aggregated and reported monthly to the Infection Control Committee Chairperson, with this data integrated into the hospital-wide Quality Council. Compliance is reported to the MEC and Governing Board monthly until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will occur until the Quality Council determines sustained compliance has occurred, at which time the Quality Council will determine what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Persons Responsible: Director of Infection Control Director of Surgical Services	

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{A 749}	Continued From page 59 sterilants used for disinfection or sterilization; that is, they are competitors for sterilant action. If these soil components are insufficiently removed, they can also protect microorganisms from inactivation by limiting the diffusion of the sterilant to the microorganisms ' location on the medical device. Users must establish an appropriate cleaning protocol for the reusable medical devices used at their sites. The procedures should be based on the recommendations of the device manufacturer and the cleaner manufacturer, published data on cleaner efficacy for the medical devices (if available), and published, validated, recommended practices or guidelines. Cleaning efficacy tests that are performed following reprocessing are used to verify the ability of a cleaning process to remove or reduce to an acceptable level the organic soil and microbial contamination that occurs during the use of reusable devices. A number of methods can be used to evaluate the results of the cleaning process. The most common method is a visual inspection, sometimes involving the use of a lighted magnifying glass. Health care personnel inspect every device for visible organic soil and contamination in a simple functionality check, usually as part of the inspection, preparation, and packaging procedure. However, residual organic soil and microbial contamination might be present on an accessible surface even though the	{A 749}		

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{A 749}	Continued From page 60 device " looks clean. " Furthermore, visual inspection is not possible for the inner components of medical devices that have lumens or that are of nonsealed tubular construction (e.g., flexible endoscope channels, laparoscopic accessory devices, biopsy forceps). Ideally, cleaning verification by users should include (a) visual inspection combined with other verification methods that allow the assessment of both external surfaces and inner housing and channels of medical devices, (b) testing the cleaning efficacy of equipment, and (c) monitoring key cleaning parameters (e.g., temperature). Manufacturers should strive to provide users with such tests so that medical devices can be tested directly after cleaning in a way that will not damage the device or require recleaning. According to ANSI/AAMI ST79:2010 & A1:2010 & A2:2011 & A3:2012 & A4:2013 (Consolidated Text) 10.2 Monitoring of mechanical cleaning equipment: The first step in processing a medical device is decontamination. To ensure that mechanical cleaning equipment is working properly and according to the manufacturer ' s specifications, health care personnel may perform verification tests as part of the overall quality assurance program. Methods of verification include the use of devices that directly test individual instruments for residual soils, challenge cleaning effectiveness with standardized test methods, or measure specific key parameters to evaluate the functionality of the cleaning equipment ...	{A 749}		

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{A 749}	Continued From page 61 Mechanical cleaning equipment should be tested upon installation, weekly (preferably daily) during routine use, and after major repairs. When evaluating or changing to a new type of cleaning chemistry and after all major repairs, all cycles used should be tested to ensure the cleaning chemistry and cleaning action are effective. A major repair is a repair that is outside the scope of routine preventive maintenance and that significantly affects the performance of the equipment. Examples include replacement of the water pump(s), detergent delivery system, heating system, water delivery system, water treatment system, or computer control or an upgrade to software. 2. On April 4, 2016 at 11:30 am, during an interview, ICP 1 stated that the facility adopted the Centers for Disease Prevention and Control (CDC), Association of peri-Operative Registered Nurses (AORN), Association for the Advancement of Medical Instrumentation (AAMI), Association for Professionals in Infection Prevention and Epidemiology (APIC) and the Healthcare Infection Control Practices Advisory Committee (HICPAC) as their nationally accepted infection control guidelines. On April 5, 2016 at 10:40 am during an observation in the housekeeping closet, EVS 1 demonstrated how the floor disinfectant (Clorox® Pro Quaternary) was prepared for use. When	{A 749}	Finding 2 Immediate Actions Taken: 1. The Director of Infection Control and the Director of Environmental Services (EVS) reviewed the survey findings regarding use of floor disinfectant cleaners. EVS staff was reeducated on use of the floor disinfectant cleaners, with special emphasis on wet times for effectiveness. 2. EVS staff are educated on use of disinfectant cleaners (including wet times for effectiveness) upon hire. Compliance and Monitoring Process The Director of Infection Control and Director of EVS or qualified designees conduct observations daily of floor disinfectant practices (including wet times) with remediation to staff in real time. Data is aggregated and reported monthly to the Infection Control Committee Chairperson, with this data integrated into the hospital-wide Quality Council. Compliance is reported to the MEC and Governing Board monthly until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will occur until the Quality Council determines sustained compliance has occurred, at which time the Quality Council will determine what adjustments to monitoring are necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Persons Responsible: Director of Infection Control Director of EVS	4/4/16

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{A 749}	Continued From page 62	{A 749}		

asked how long the product must remain wet on the floor to be effective (to kill pathogens), EVS 1 replied five to ten minutes. This was validated by ICP 1.

On April 6, 2016 at 10:50 am during an observation in the housekeeping closet, EVS 2 demonstrated how the floor disinfectant (Clorox® Pro Quaternary All-Purpose Disinfectant Cleaner) was prepared for use. When asked how long the product must remain wet on the floor to be effective, EVS 2 replied she did not know. This was validated by ICP 2.

According the manufacturer ' s (The Clorox® Company) directions for use of Clorox® Pro Quaternary
All-Purpose Disinfectant Cleaner: To disinfect hard, nonporous surfaces, add 1 ounce per gallon of water. Apply solution with a mop, cloth, sponge, hand pump trigger sprayer or low-pressure coarse sprayer in order to wet all surfaces thoroughly. Allow to remain wet for 10 minutes.

According to the Centers for Disease Prevention and Control (CDC) / Healthcare Infection Control Practices Advisory Committee (HICPAC), Guideline for Disinfection and Sterilization in Healthcare Facilities (2008):

Antimicrobials are regulated by the EPA and FDA, under the authority of the Federal Insecticide, Fungicide, and Rodenticide Act (FIFRA) and the Food, Drug and Cosmetic Act. Any substance or mixture of substances intended to prevent, destroy, repel, or mitigate any pest (including microorganisms) must be registered and users must explicitly follow the labeling directions on

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{A 749}	Continued From page 63 each product, i.e., " It is a violation of federal law to use this product in a manner inconsistent with its labeling. " Thus, health-care workers must follow the safety precautions and use directions on the labeling of each registered product. Failure to follow the specified use-dilution, contact time, method of application, or any other condition of use is considered a misuse of the product and potentially subject to enforcement action. According to the CDC / HICPAC, Guidelines for Environmental Infection Control in Health-Care Facilities (2011), Cleaning and Disinfecting Strategies for Environmental Surfaces in Patient-Care Areas: Cleaning and Disinfecting Strategies for Environmental Surfaces in Patient-Care Areas: Select EPA-registered disinfectants ...and use them in accordance with the manufacturer's instructions. 3. On April 4, 2016 at 11:30 am, during an interview, ICP 1 stated that the facility adopted the Centers for Disease Prevention and Control (CDC), Association of peri-Operative Registered Nurses (AORN), Association for the Advancement of Medical Instrumentation (AAMI), Association for Professionals in Infection Prevention and Epidemiology (APIC) and the Healthcare Infection Control Practices Advisory Committee (HICPAC) as their nationally accepted infection control guidelines. On April 5, 2016 at 10:40 am, in the ICU, RN 16 was asked to demonstrate the disinfection of a glucometer (instrument used to measure blood sugar) in between patient use. RN 16 did not know the product ' s (Clorox Healthcare Bleach	{A 749}	Finding 3 Immediate Actions Taken: 1. The finger stick glucose monitoring meters were cleaned with the manufacturer approved disinfectant and in compliance with required wet time of the product. Subsequent Actions Taken: 1. Education was provided to nursing and ancillary departments from 5/5/16 – 5/7/16, including use of the disinfectant between patients with the required wet time, and cleaning of any blood residue prior to disinfection. 2. Education on cleaning of finger stick glucose monitoring meters is provided to nursing and ancillary department staff upon hire. Compliance and Monitoring: The Director of Infection Control or qualified designees conduct observations daily of glucose meter cleaning (including following required wet times for the disinfectant and cleaning the meter of any blood residue prior to disinfection) with remediation to staff in real time. Data is aggregated and reported monthly to the Infection Control Committee Chairperson, with this data integrated into the hospital-wide Quality Council. Compliance is reported to the MEC and Governing Board monthly until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will occur until the Quality Council determines sustained compliance has occurred, at which time the Quality Council will determine what adjustments to monitoring are	4/5/16 5/7/16

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{A 749}	Continued From page 64 Germicidal Wipes) required wet time. She did not know that the glucometer had to be cleaned of any blood residue prior to disinfection. This was validated by ICP 2. On April 6, 2016 at 11:00 am on unit two, LVN 1 was asked to demonstrate how to disinfect a glucometer in between patients. LVN 1 did not know the required wet time [time the product needed to remain wet on the surface to kill pathogens (bacteria, fungi and viruses)] of the product (Clorox Healthcare® Bleach Germicidal Wipes). This was validated by ICP 2. According to the manufacturer (The Clorox Company) Clorox Healthcare® Bleach Germicidal Wipes [should be] used as directed on precleaned hard, nonporous surfaces [and] must remain wet for three minutes. According to the Centers for Disease Prevention and Control (CDC) / Healthcare Infection Control Practices Advisory Committee (HICPAC), Guideline for Disinfection and Sterilization in Healthcare Facilities (2008): Antimicrobials are regulated by the EPA and FDA, under the authority of the Federal Insecticide, Fungicide, and Rodenticide Act (FIFRA) and the Food, Drug and Cosmetic Act. Any substance or mixture of substances intended to prevent, destroy, repel, or mitigate any pest (including microorganisms) must be registered and users must explicitly follow the labeling directions on each product, i.e., " It is a violation of federal law to use this product in a manner inconsistent with its labeling. " Thus, health-care workers must follow the safety precautions and use directions	{A 749}	necessary for ongoing sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Person Responsible: Director of Infection Control	

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{A 749}	Continued From page 65 on the labeling of each registered product. Failure to follow the specified use-dilution, contact time, method of application, or any other condition of use is considered a misuse of the product and potentially subject to enforcement action. According to the CDC / HICPAC, Guidelines for Environmental Infection Control in Health-Care Facilities (2011), Cleaning and Disinfecting Strategies for Environmental Surfaces in Patient-Care Areas: Cleaning and Disinfecting Strategies for Environmental Surfaces in Patient-Care Areas: Select EPA-registered disinfectants ...and use them in accordance with the manufacturer's instructions. 4. An observation was conducted on April 6, 2016 at 8:35 am of the hospital ' s Ultrasound Department, with the Director of Infection Control & Prevention (ICP 1) present. An Ultrasound Technician (US 1) was asked to demonstrate and explain how the hospital provided high level disinfecting (a method used to kill vegetative bacteria, tubercle bacillus, fungi, lipid and nonlipid virus) of the vaginal probes, a semi-critical instrument (items that contact mucous membranes). During the same observation, a concurrent interview was conducted with US 1. She demonstrated the hospital's practice for cleaning, disinfecting and rinsing the vaginal probes and stated that they used "Cidex OPA" solution (a high level disinfectant {HLD} an observation of the Cidex bottle confirmed her interview). US 1 stated that after they soaked the probe in the Cidex OPA solution, they immersed it in water	{A 749}	Findings 4 and 5 Immediate Actions Taken: 1. Vaginal and Transesophageal echocardiogram probes were cleaned and disinfected using hi-level disinfection in accordance with manufacturer's instructions. Ultrasound technicians were educated on the proper cleaning and high level disinfection of probes on 4/7/11. Subsequent Actions Taken: 1. The "High-Level Disinfection" policy was reviewed and did not require any revisions. Ultrasound staff was inserviced on the policy. 2. Education on cleaning of vaginal and transesophageal probes is provided to ultrasound staff upon hire. Competencies are provided annually, including return demonstration. Compliance and Monitoring Process The Director of Infection Control or qualified designees conduct observations at least weekly (depending on use of probes) of vaginal and transesophageal probe cleaning with remediation to staff in real time. Data is aggregated and reported monthly to the Infection Control Committee Chairperson, with this data integrated into the hospital-wide Quality Council. Compliance is reported to the MEC and Governing Board monthly until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will occur until the Quality Council determines sustained compliance has occurred, at which time the Quality Council will determine what adjustments to monitoring are necessary for ongoing	4/7/16 6/2/16 6/7/16

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{A 749}	Continued From page 66 and rinsed it for 1 minute and then the probe gets rinsed a second time under running water in a sink located in the department. According to US 1, they followed the operator's manual for the soak station system (GUS) that they used to disinfect the probes. 5. On March 6, 2016 at 9 am, a second observation in the same area and a concurrent interview with a Vascular Technician (VT 1) were conducted. VT 1 was asked if she performed HLD of semi - critical instruments, she stated that she performed HLD of the Transesophageal echocardiogram probes (TEE - A specialized probe containing an ultrasound transducer which contains a tip which is passed into the patient's esophagus. This allows images and Doppler evaluation of the heart, which can be recorded). VT 1 stated that they used Cidex OPA to perform HLD on the TEE probes. VT 1 stated that after they soaked the scopes in the Cidex OPA solution, they immersed the scopes in water and rinsed them three (3) different times, allowing them to soak for 30 seconds each time, in 2 gallons of water. She also stated that she used the operator's manual instructions for their soak system (GUS), for disinfecting the probes. On March 6, 2016 at 9:20 am, the hospital's Infection Control and Preventionist (ICP 1) was asked which Nationally recognized Infection Control Guidelines the hospital followed. She stated that they followed Healthcare Infection Control Practices Advisory Committee (HICPAC), Centers for Disease Control (CDC), American Journal of Infection Control (APIC), and manufacturer's guidelines. US 1 and VT 1 were asked to produce the hospital policies for the HLD of vaginal probes and the TEE probes and to also produce a copy	{A 749}	sustainability (e.g., random samples or inclusion of the issue as an ongoing indicator). Person Responsible: Director of Infection Control	

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{A 749}	Continued From page 67 of the manufacturer's guidelines they used for the HLD disinfecting of the probes. During a record review of both policies, on March 6, 2016 at approximately 9:25 am, it was identified that the policies did not reference the manufacturer's guidelines for the use of the Cidex OPA HLD solution, the policies referenced "Society of Diagnostic Medical Sonography", "American Institute of Ultrasound Medicine", "American College of Radiology", and "Department of Public Health - Radiation Health Bureau". The policies also referenced the use of the hospital's HLD soak system (GUS). On March 6, 2016 at approximately 9:30 am, US 1 was asked to produce a copy of the manufacturer's guidelines for the Cidex OPA solution. A copy was produced and reviewed: According to the manufacturer, Cidex OPA is a high-level disinfectant (HLD) used in reprocessing heat sensitive medical devices such as vaginal probes and TEEs. According to the manufacturer: DIRECTIONS FOR USE CIDEX OPA SOLUTION USAGE- Rinsing Procedure 1. Manual Processing: * Following removal from CIDEX OPA Solution, thoroughly rinse the semi-critical medical device by immersing it completely in a large volume (e.g., two gallons) of water. Use sterile water unless potable water is acceptable. See item 2 or 3 below. * Keep the device totally immersed for a minimum of one minute in duration, unless a longer time is specified by the reusable device manufacturer. * Manually flush all lumens with large volumes (not less than 100 mL) of rinse water unless otherwise noted by the device manufacturer. * Remove the device and discard the rinse water. Always use fresh volumes of water for each rinse.	{A 749}		

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{A 749}	Continued From page 68 Do not reuse the water for rinsing or any other purpose. * Repeat the procedure TWO (2) additional times, for a total of THREE 3) RINSES, with large volumes of fresh water to remove CIDEX OPA Solution residues. Residues may cause serious side effects. SEE WARNINGS. THREE (3) SEPARATE, LARGE-VOLUME WATER IMMERSION RINSES ARE REQUIRED ..." Further review of the CIDEX OPA guidelines revealed the following: "Special Instruction for Transesophageal Echocardiography (TEE) probe reprocessing ...not rinsing three times with a fresh quantity of water each time many result in residual CIDEX OPA Solution remaining on the device, the use of which may cause staining, irritation or chemical burns of the mouth, throat, esophagus and stomach ..."	{A 749}		
A 756	482.42(b) INFECTION CONTROL LEADERSHIP RESPONSIBILITIES Standard: Responsibilities of Chief Executive Officer, Medical Staff, and Director of Nursing Services The chief executive officer, the medical staff, and the director of nursing must-- (1) Ensure that the hospital-wide quality assessment and performance improvement (QAPI) program and training programs address problems identified by the infection control officer or officers; and (2) Be responsible for the implementation of successful corrective action plans in affected problem areas.	A 756	A 756 482.42(b) Infection Control Leadership Responsibilities Immediate Actions Taken: 1. The Hospital obtained an onsite visit by the surgical instrument company on 4/6/16 to review the alleged discoloration on surgical instruments and confirmed that the sterility of the instruments was not affected. 2. Executive Leadership, the Director of Infection Control, and the Director of Surgical Services/Sterile Processing Services discussed the survey findings and the expectation that sterile processing shall occur in accordance with hospital approved processes. Any issues that occur, such as a problem with a washer, shall be reported immediately to the Director of Facilities and Executive Leadership for remediation.	4/6/16 4/6/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050135	A. BUILDING _____ B. WING _____	R 04/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN CALIFORNIA HOSPITAL AT HOLLYWOOD	6245 DE LONGPRE AVE HOLLYWOOD, CA 90028

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A 756	Continued From page 69 This STANDARD is not met as evidenced by: Based on observation, interview and record review, the hospital's leadership was not responsible for the implementation of a successful corrective action plan for the sterile processing department, because unresolved or recurrent problems with incomplete sterilization of surgical instruments were noted, creating the increased risk of the spread of infection to surgical patients. Findings: The plan of correction for the survey dated 12/22/15 showed that in response to findings that included sterile instruments that had discolored spots and built up material adherent to them, education, monitoring, and reprocessing of surgical instruments was to occur. However, during observations of trays of sterile instruments on 4/4/16, brown spots and adherent material was again seen on sterilized surgical instruments. In an interview with the Sr VP Hospital Operations on 4/4/16 at 1510, he stated that there was a drain that they had a problem with which was backing up into the washer, and this could be the source of the problem with the surgical instruments. He stated that staff had resumed using the washer without his knowledge.	A 756	Subsequent Actions Taken: 1. Education of Sterile Processing Department staff on proper usage of cleaning and disinfections was provided from 5/1/16-5/7/16, with special emphasis on strict adherence to the sterilization process. It was also emphasized that deviation from the approved sterilization process will result in disciplinary action. Compliance and Monitoring: The Director of Infection Control or qualified designees conduct observations at least daily of sterile processing of instruments to assure compliance with approved sterile processing procedures. Corrective action is taken, including just-in-time training and notification of Executive Leadership if issues identified. Data is aggregated and reported monthly to the Infection Control Committee Chairperson, with this data integrated into the hospital-wide Quality Council. Compliance is reported to the MEC and Governing Board monthly until sustained compliance is achieved and process control is demonstrated. Ongoing monitoring will occur until the Quality Council determines sustained compliance has occurred, at which time the Quality Council will determine what adjustments to monitoring are necessary for ongoing sustainability (e.g.,	5/7/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 756	Continued From page 69 This STANDARD is not met as evidenced by: Based on observation, interview and record review, the hospital's leadership was not responsible for the implementation of a successful corrective action plan for the sterile processing department, because unresolved or recurrent problems with incomplete sterilization of surgical instruments were noted, creating the increased risk of the spread of infection to surgical patients. Findings: The plan of correction for the survey dated 12/22/15 showed that in response to findings that included sterile instruments that had discolored spots and built up material adherent to them, education, monitoring, and reprocessing of surgical instruments was to occur. However, during observations of trays of sterile instruments on 4/4/16, brown spots and adherent material was again seen on sterilized surgical instruments. In an interview with the Sr VP Hospital Operations on 4/4/16 at 1510, he stated that there was a drain that they had a problem with which was backing up into the washer, and this could be the source of the problem with the surgical instruments. He stated that staff had resumed using the washer without his knowledge.	A 756	random samples or inclusion of the issue as an ongoing indicator). Persons Responsible: Director of Infection Control Chief Executive Officer Director of Surgical Services Director of Facilities	

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Office of Health Care Access

Final Decision

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

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

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

Attorney Kevin T. Hansted was designated as the hearing officer in this matter. The hearing was conducted in accordance with the provisions of the Uniform Administrative Procedures Act (Chapter

54 of the Conn. Gen. Stat.) and Conn. Gen. Stat. §19a-639a(f). The public hearing record was closed on June 9, 2016.

In making her decision, Deputy Commissioner Brancifort reviewed the entire record in this matter.

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

Findings of Fact

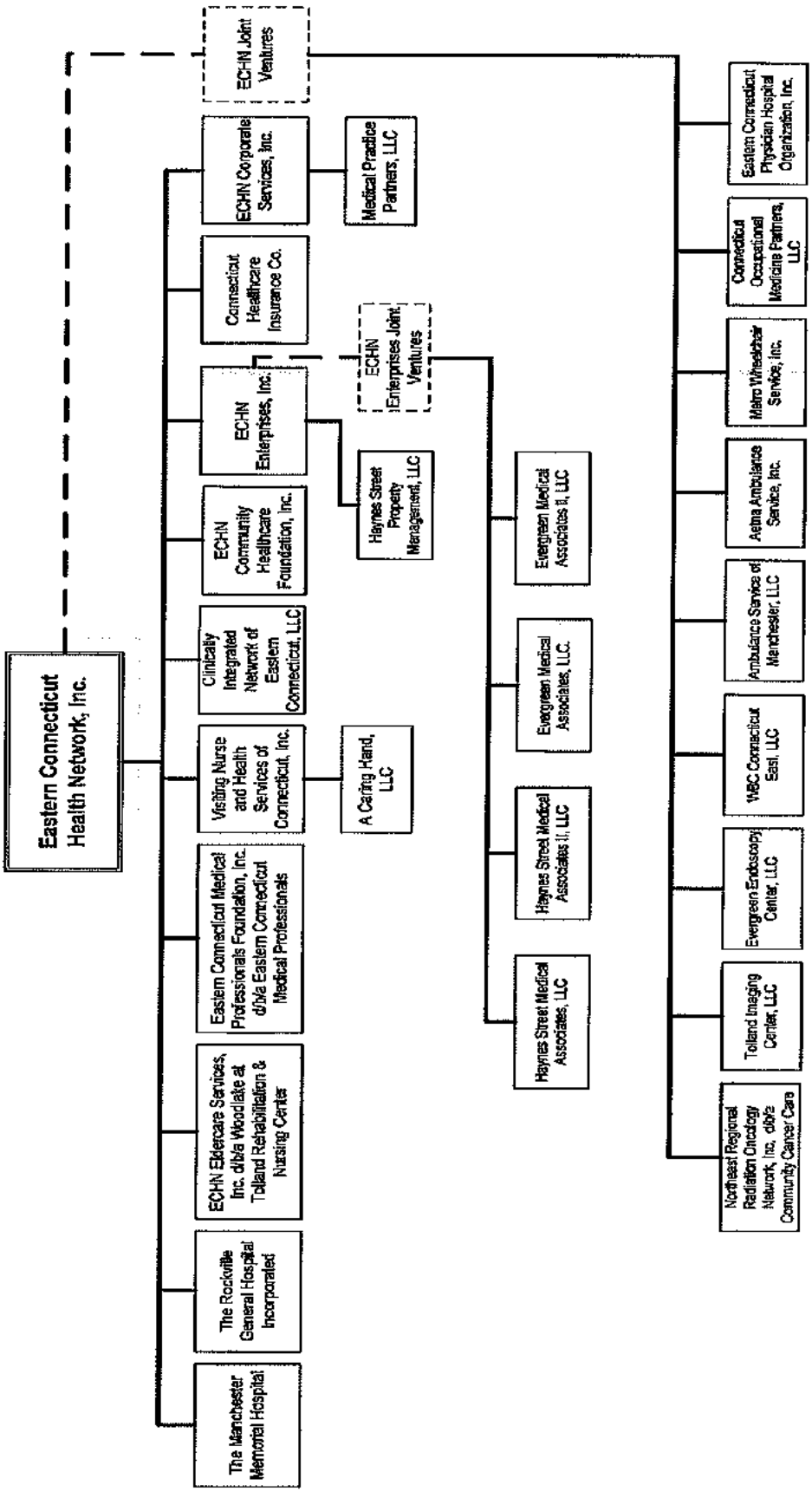
1. ECHN is a not-for-profit health care system that is the parent company of two acute care hospitals in Connecticut, Manchester Memorial Hospital ("MMH") located in Manchester and Rockville General Hospital ("RGH") located in Vernon (at times collectively referred to as the "Hospitals"). Ex. G, p. 24

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

   Ex. G, pp. 24-25

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

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



For Profit Entity

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

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

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

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

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

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

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

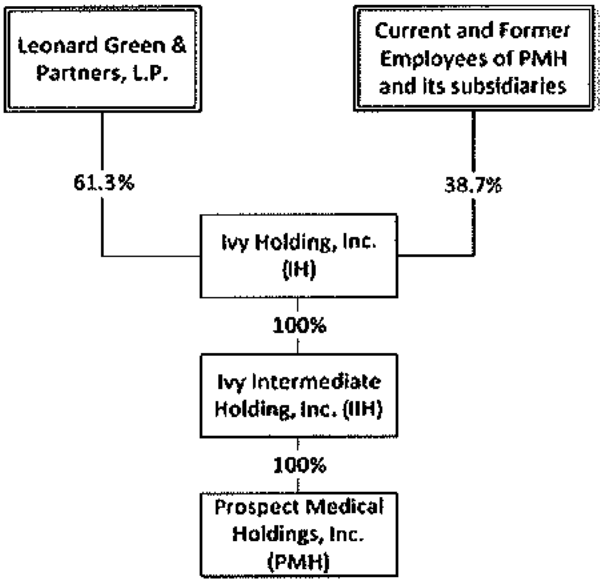
12. The Applicants are requesting approval of the proposed asset purchase (the "Asset Purchase") as a solution to ECHN's long-standing challenges that offers the Service Area continued access to its services and facilities. Ex. G, p. 26

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

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

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

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



Ex. K, p. 2205

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

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

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

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

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

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

to $30 million by the time of closing. Ex. K, p. 2192; Ex. UU; Tr., Testimony of Steven Aleman, on 3/29/2016, p. 152-53

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

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

TABLE 1
APA PROJECTED NET PROCEEDS AND FLOW OF FUNDS

			Actual 9/30/2015	Actual 3/31/2016
ACQUISITION PRICE (EV)	A		105,000,000	105,000,000
ASSUMED ASSETS & LIABILITIES:			(62,598,000)	(67,598,000)
Pension & Retiree Medical				
Captive & Workers Comp.			(1,705,000)	(1,705,000)
Net Working Capital True-up			(9,107,000)	(8,275,000)
RGH Eating Disorder Loan			0	0
Seller's Reimbursable Costs			(424,000)	(424,000)
Capital Leases			(6,764,000)	(5,922,000)
Asbestos Abatement			(1,000,000)	(1,000,000)
TOTAL ACQ LIABILITIES	B		(81,598,000)	(84,924,000)
THRESHOLD on LIABILITIES	C		(77,000,000)	(77,000,000)
GUARANTEED NET PROCEEDS	D	A-C	28,000,000	28,000,000
CASH & INVESTMENTS (ECHN) *	E		58,454,000	54,968,000
TOTAL CASH for DEBT PAYOFF	F	D+E	86,454,000	82,968,000
LONG TERM DEBT	G		(78,420,000)	(75,896,000)
SURPLUS after DEBT DEFEASANCE	H	F-G	8,034,000	7,072,000
Post-Closing Pool "Wind Down" Funds			1,000,000	1,000,000
Excess Liabilities Assumed		B-C	(4,598,000)	(7,924,000)
Funds Remaining after PMH Reimbursed	K	H-I+J	2,436,000	(1,852,000)

Deduction to Capital Commitment**	L		0	1,852,000
Available for Indemnity Reserve	M	K+L	2,436,000	0
Legacy ECHN ***			2,229,000	2,139,000

* PMH is assuming a $5 million loan for the RGH Eating Disorder Unit without a price deduction. To the extent that cash is available beyond the $1 million for post-closing costs and $4.5 million for the indemnity reserve, ECHN can mitigate a deduction to the capital commitment up to $5 million.

** If line K is less than zero, then there was not sufficient ECHN cash left to make PMH whole on additional liabilities assumed, thus a dollar for dollar reduction to the $75 million capital commitment applies.

*** Estimated value of future settlements on funds due from Medicare and Medicaid less funds due to Medicare and Medicaid for prior years that are still pending final review. The amounts are net of various balance sheet accounts that will not be part of the acquisition.
Late File 8, dated Apr. 20, 2016; Ex. TT

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

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

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

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

29. The Local Board will serve as a resource for PMH with respect to investment of the $75 million commitment amount set forth in the APA (the "Commitment Amount"), assist with

maintenance and implementation of a strategic business plan for the New Hospitals, and assist with medical staff credentialing, quality assurance programs and accreditation at the New Hospitals. Ex. G, p. 30

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

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

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

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

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

35. Additionally, as a result of the Immediate Jeopardy citations, PMH has hired a corporate level Chief Quality Officer, Chief Clinical Officer, Chief Nursing Officer and an Associate Vice President of Regulatory and Patient Safety to assist in providing necessary resources to

implement all quality programs at its local hospitals and share best practices among the hospitals. Ex. Z, Prefiled Testimony of Von Crockett, pp. 3355-57

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

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

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

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

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

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

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

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

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

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

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

TABLE 3
PRIORITY FACILITY CAPITAL NEEDS OF ECHN

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

Late File 12, dated Apr. 20, 2016

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

45. After the Asset Purchase, capital will be available to ECHN for replacements and upgrades to systems and the infrastructures of ECHN's facilities; investments to improve the sharing of electronic medical records in order to improve the collection and documentation of information and to enhance the availability of information for critical treatment decisions for patients;

upgrades to medical equipment and technology to provide patients access to state-of-the-art technology for diagnosis, care and treatment; and program development to attract and retain physicians. Ex. G, p. 57

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

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

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

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

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

51. PMH has demonstrated the efficacy of the CRC model in Southern California, Texas and Rhode Island. In these regions, PMH has improved clinical outcomes, increased quality scores, increased patient satisfaction, reduced readmission rates, reduced average lengths of stay, and reduced medical-cost ratios. For example, from 2012 to 2014 in California and Texas, where PMH participates in HMO contracts for seniors, PMH reduced hospital bed days per thousand from 1,260 to 720. Additionally, length of hospital stay for this population has been reduced from 5.1 to 3.9 days, admissions per thousand have dropped from 245 per thousand to 182 per thousand and hospital readmissions within thirty days has dropped from 19% to 13%. The

CRC model has also enabled PMH to attract more primary care providers and has improved access to care. Ex. G, pp. 73, 75-76

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

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

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

TABLE 4
SOCIOECONOMIC STATUS OF THE SERVICE AREA

	Town	Poverty Rate[1]	Median Household Income[1]	Unemployment Rate[2]	Median Age[1]
PSA	Andover	4.9%	$97,762	6.4%	43
	Bolton	2.1%	$87,885	6.0%	47
	Coventry	3.5%	$92,308	7.1%	43
	Ellington	2.7%	$84,934	6.0%	40
	Manchester	8.9%	$63,656	7.4%	37
	South Windsor	4.3%	$91,519	5.9%	42
	Tolland	3.7%	$103,358	5.5%	41
	Vernon	9.2%	$61,848	7.5%	41
	Willington	18.1%	$70,013	5.5%	35
SSA	Ashford	4.2%	$75,242	7.2%	38
	Columbia	3.8%	$92,973	6.4%	47
	East Hartford	15.3%	$48,438	9.8%	39
	East Windsor	5.0%	$71,310	7.4%	42
	Glastonbury	2.6%	$106,872	5.3%	43

Hebron	0.9%	$114,286	5.4%	42
Mansfield	17.9%	$67,615	7.2%	21
Somers	4.8%	$100,100	7.2%	42
Stafford	6.7%	$63,672	8.1%	40
Union	1.1%	$83,500	5.5%	42
State	10.0%	$69,519	7.8%	40

[1]2012

[2]2013

Ex. G, p. 63 (Source: Connecticut Economics Resource Center Town Profile Oct. 2014)

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

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

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

58. PMH has stated that New MMH and New RGH will be in compliance with the following general community benefit standards for at least the first three years: (a) the New Hospitals shall provide public health programs to the community and generally promote the welfare of the community; (b) the New Hospitals shall have open medical staffs and not restrict the use of facilities to a particular group of physicians and surgeons to the exclusion of other qualified doctors; (c) the New Hospitals shall participate in the Medicare and Medicaid programs; and (d) the New Hospitals shall operate 24/7 emergency departments and provide emergency services to patients regardless of their ability to pay. Tr. Testimony of Tom Reardon, President, PMH East, on 5/3/16, pp. 103-04

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

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

TABLE 5

PATIENT POPULATION/PAYER MIX

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

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

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

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

Entity	EBITDA			Working Capital			Stockholder's Equity		
	Year prior to acquisition	FY 2014	FY 2015	Year prior to acquisition	FY 2014	FY 2015	Year prior to acquisition	FY 2014	FY 2015
Nix Health System (a)	$14,905	$18,411	$8,043	$5,937	$36,785	$35,449	$13,122	$20,468	$63,789
Roger Williams Medical Center (b)	$3,942	$1,582	$9,080	($1,860)	$1,114	$6,230	$37,184	$34,099	$38,256
Our Lady of Fatima Hospital(c)	($893)	$509	$6,485	$1,904	$2,040	$3,432	($57,150)	$27,513	$28,107

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

(b) EBITDA for Roger Williams Medical Center ("RWMC"), located in Providence , Rhode Island, for year prior to acquisition is only for 8 months ending on May 31, 2014 and EBITDA for FY2014 is only for three months post acquisition for FYE 9/30/2014. Working capital is for prior to acquisition as of 5/31/2014 and includes cash which was not part of the assets acquired by PMH as prior to the acquisition RWMC was a non-profit organization. Therefore, net assets were used as a substitute for stockholder's equity.

(c) EBITDA for Our Lady of Fatima Hospital ("OLFH") in Rhode Island is for year prior to acquisition and is only for 8 months ending on May 31, 2014 and for FY2014 is only for three months post acquisition. Working capital prior to acquisition is as of 5/31/2014 and includes cash which was not part of the assets acquired by PMH as prior to the acquisition OLFH was a non-profit organization. Therefore, net assets were used as a substitute for stockholder's equity.
Late File 19, dated Apr. 20, 2016; Ex. QQ, dated May 9, 2016

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

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

TABLE 7
MMH PROJECTED REVENUES AND EXPENSES WITH CON

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

Ex. K, p. 2314

TABLE 8
MMH PROJECTED REVENUES AND EXPENSES WITHOUT CON

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

*Provision for income taxes doesn't apply to not-for-profit entities.

Ex. K, p. 2314

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

TABLE 9
RGH PROJECTED REVENUES AND EXPENSES WITH CON

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

Ex. K, p. 2316

TABLE 10
RGH PROJECTED REVENUES AND EXPENSES WITHOUT CON

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

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

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

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

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

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

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

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

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

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

73. The Applicants have satisfactorily demonstrated that this proposal would not result in an unnecessary duplication of existing services in the area. Conn. Gen. Stat. §19a-639(a)(9)

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

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

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

Discussion

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Order

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

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

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

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

3. Applicants shall notify OHCA in writing of the Closing Date of the Asset Purchase authorized by this Order within twenty (20) days of such closing and shall supply final execution copies of all agreements related to same, including but not limited to:

    a. the APA, including any and all schedules and exhibits; and

    b. Bylaws or similar governance documents for New ECHN, as well as for New MMH and New RGH.

    The Applicants may redact from the APA any information that is exempt from disclosure under Conn. Gen. Stat. § 1-210. If the Applicants redact materials in accordance with the

previous sentence, the Applicants shall provide a list to OHCA, which identifies in general terms the nature of the redacted material and why it is claimed to be exempt for public record purposes.

OHCA is imposing this Condition to verify that safeguard procedures are in place to avoid a conflict of interest in patient referral. *Legal and Factual Basis: Conn. Gen. Stat. §§ 19a-486d(a) & 19a-613(b); FF 12*

4. Within one hundred and eighty (180) days following the Closing Date, PMH shall submit a plan (the "Health Needs Plan") for continuing to support and implement ECHN's 2016 CHNA and for conducting the New Hospitals' next comprehensive study of community health needs in the Service Area (the "Community Health Needs Study" or "Study"). The Health Needs Plan shall describe in detail at least the following:

   (i) the data that will be collected and analyzed to systematically assess health status indicators of the Service Area;
   (ii) the identity of key community stakeholders and health organizations, unaffiliated with PMH, including without limitation, representatives of medically underserved populations, that will be enlisted to participate in the Study and the manner and extent of such participation by stakeholders in both the development of health priorities and planned implementation;
   (iii) the qualifications of consultants experienced in performing community health needs assessments who will be retained by PMH to ensure that the priority health needs of the community are accurately determined;
   (iv) the frequency with which the Study will be repeated;
   (v) the manner in which results of the Study and the implementation strategy to address the priority health needs identified therein (the "Implementation Strategy") will be distributed to the community; and
   (vi) the manner in which the Study will complement the population health management objectives of PMH and the New Hospitals.

   OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Conn. Gen. Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(3) & (7); FF 56-57*

5. Within three (3) years following the Closing Date, PMH shall participate with New ECHN and the New Hospitals, and the key community stakeholders and health organizations identified pursuant to Condition 4, in conducting a Community Health Needs Study and shall provide a copy of such Study and its Implementation Strategy to OHCA within thirty (30) days of completion. PMH and the participants shall utilize Healthy Connecticut State Health Improvement Plan data and priorities as the starting point for the Study (available at http://www.ct.gov/dph/lib/dph/state_health_planning/ship/hct2020/hct2020_state_hlth_impv_032514.pdf), as well as any applicable community

health improvement plan issued by any local health department in the Service Area.[1] The Implementation Strategy shall also adopt the evidence-based interventions identified in the Centers for Disease Control 6/18 initiative (available at http://www.cdc.gov/sixeighteen) to the extent the health priorities identified in the Study correlate to the health conditions identified by the CDC and provide information on how any patient outcomes related to the Implementation Strategy will be measured and reported to the community. PMH shall publish the Community Health Needs Study and the Implementation Strategy on the website pages of New MMH and New RGH. Until such time as the Community Health Needs Study and Implementation Strategy are submitted to OHCA, PMH shall continue to support and implement ECHN's current CHNA for MMH and RGH. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d(a) 19a-613(b), 19a-639(a)(3) & (7); FF 56-57*

6. Within one hundred and eighty (180) days following the Closing Date, PMH shall submit a plan demonstrating how health care services will be provided by the New Hospitals for the first three years following the Asset Purchase, including any consolidation, reduction, or elimination of existing services or introduction of new services (the "Services Plan"). The Services Plan will be provided in a format mutually agreed upon by OHCA and the Applicants. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Conn. Stat. §§ 19a-486(a), 19a-613(b), 19a-639(a)(5),(6) (7),(8),(9),(11) & (12); FF 18, 26-27*

7. Until such time as the Services Plan is submitted, PMH shall provide OHCA with notice of any reallocation of inpatient beds and relocation of outpatient services for the New MMH or New RGH specific to those services that existed at each of the Hospitals as of the Decision Date. Such notice shall be provided within ten (10) days of any such reallocation or relocation and published on the website pages of the New Hospitals. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-486(a), 19a-613(b), 19a-639(a)(5),(6) (7),(8),(9),(11) & (12); FF 18, 26-27*

8. Within one hundred and eighty (180) days following the Closing Date and thereafter on the same semi-annual schedule as set forth in Conditions 9 and 10 below until the capital commitment is satisfied, PMH shall submit to OHCA a report on the capital investments ("Capital Investment Report") it has made in the New MMH, New RGH and their affiliates from the $75 million Commitment Amount. The Capital Investment Report shall include the following in a format to be agreed upon:

    a. A list of the capital expenditures that have been made in the prior one hundred and eighty (180) days with descriptions of each associated project; and

[1] Other tools and resources which the Applicants are encouraged to consider include County Health Rankings and CDC Community Health Improvement Navigator in order to assist with the Study process in terms of an understanding of social, behavioral, and environmental conditions that affect health, identifying priorities, and the use of evidence-based interventions.

b. An explanation of why each expenditure was made and a timeframe for the roll out of the associated capital project (including estimated beginning, ending and startup/operation dates); and

c. The dates and amounts of withdrawals from each of the New Hospitals' operating account and/or any other sources of funding used to fulfill the Capital Commitment.

The reports shall be signed by PMH ECHN's Chief Financial Officer. OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify the continued financial feasibility of the project. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(3),(4) & (5); FF 38-45*

9. For three (3) years following the Closing Date, PMH shall file the following information with OHCA on a semi-annual basis for New ECHN, New MMH and New RGH, respectively:

a. The cost saving totals achieved in the following Operating Expense Categories for New ECHN, New MMH and New RGH: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Interest Expense, Malpractice Expense, Utilities, Business Expenses and Other Operating Expenses. The categories shall be consistent with the major operating expense categories (Categories A, B, C, D, E, G, H, I, J, and K) which are in use at the time of reporting in the OHCA Hospital Reporting System ("HRS") Report 175 or successor report. The semi-annual submission shall also contain narratives describing:

1. the major cost savings achieved for each expense category for the semi-annual period; and

2. the effect of these cost savings on the clinical quality of care.

b. A consolidated Balance Sheet, Statement of Operations, and Statement of Cash Flows for New ECHN, New MMH and New RGH. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Reports 100/150, 300/350 or successor reports.

For purposes of this Order, semi-annual periods are October 1-March 31 and April 1 – September 30. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th, beginning November 30, 2016. OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify the continued financial feasibility of the project. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(4) & (5); FF 51, 60-63*

10. For three (3) years following the Closing Date, PMH shall submit to OHCA a financial measurement report. This report shall be submitted on a semi-annual basis and show current month and year-to-date data and comparable prior year period data for New ECHN, New MMH and New RGH, respectively. The required information is due no later than two (2)

months after the end of each semi-annual period. Due dates are May 31st and November 30th, beginning November 30, 2016. The following financial measurements/indicators should be addressed in the report:

Financial Measurement/Indicators

A. Operating Performance
1. Operating Margin
2. Non-Operating Margin
3. Total Margin
B. Liquidity
1. Current Ratio
2. Days Cash on Hand
3. Days in Net Accounts Receivables
4. Average Payment Period
C. Leverage and Capital Structure
1. Long-term Debt to Equity
2. Long-term Debt to Capitalization
3. Unrestricted Cash to Debt
4. Times Interest Earned Ratio
5. Debt Service Coverage Ratio
6. Equity Financing Ratio
D. Additional Statistics
1. Income from Operations
2. Revenue Over/(Under) Expense
3. Cash from Operations
4. Cash and Cash Equivalents
5. Net Working Capital
6. Free Cash Flow (and the elements used in the calculation)
7. Unrestricted Assets/Retained Earnings
8. Bad Debt as % of Gross Revenue
9. Credit Ratings (S&P, FITCH or Moody's)

OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify the continued financial feasibility of the project. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(4) & (5); FF 51, 60-63*

11. PMH shall ensure that New MMH and New RGH maintain and adhere to ECHN's current policies regarding charity care, indigent care and community volunteer services after the Closing Date, or adopt other policies that are at least as generous and benevolent to the community as ECHN's current policies, consistent with state and federal law. These policies shall be posted on the website pages of the New MMH and New RGH, respectively, and as additionally required by applicable law. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(5),(6) & (11); FF 52-55, 59*

12. For three (3) years following the Closing Date, PMH shall provide written notice to OHCA of any modification, amendment or revision to the charity care, indigent care and community volunteer services of New MMH and New RGH within thirty (30) days of such change. The notice of these changes shall be accompanied by copies of any revised policies and the notice and revised policies shall be posted on the website pages of the New Hospitals simultaneously with their submission to OHCA. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(5),(6) & (11); FF 52-55, 59*

13. PMH shall maintain community benefit programs and community building activities for New MMH and New RGH for three (3) years after the Closing Date consistent with the MMH and RGH most recent Schedule H of IRS Form 990 or shall provide such other community benefit programs and community building activities that are at least as generous and benevolent to the community as ECHN's current programs, and PMH shall apply a 1% increase per year for the next three (3) years toward community building activities in terms of dollars spent.

    In determining the New MMH and New RGH participation and investment in both community benefits and community building activities, PMH shall address the health needs identified by the applicable CHNA or Study in effect at the time and the population health management objectives, including social determinants of health, contained in the related Implementation Strategy.

    a. On an annual basis, the Applicants shall identify the amounts and uses related to community benefits and community building and shall discuss how such investments and support are being applied toward the health needs identified in the CHNA or Study and population health management objectives. Such reporting shall be filed within thirty days of the anniversary date of the closing for three years and shall be posted on the applicable Hospital website. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(5),(6) & (11); FF 52-55, 59*

14. New MMH and New RGH agree to comply with the following general community benefit standards for at least the first three years: (a) the New Hospitals shall provide public health programs to the community and generally promote the welfare of the community; (b) the New

Hospitals shall have open medical staffs and not restrict the use of facilities to a particular group of physicians and surgeons to the exclusion of other qualified doctors; (c) the New Hospitals shall participate in the Medicare and Medicaid programs; and (d) the New Hospitals shall operate 24/7 emergency departments and provide emergency services to patients regardless of their ability to pay. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(5),(6) & (11); Tr., Testimony of Tom Reardon, President. PMH East on 5/3/16, pp. 103-04*

15. New MMH and New RGH shall work toward making culturally and linguistically appropriate services available and integrated throughout their hospital operations. Specifically, New MMH and New RGH shall take reasonable steps to provide meaningful access to each individual with limited English proficiency eligible to be served or likely to be encountered in its health programs and activities, in accordance with the implementing regulations of Section 1557 of the Patient Protection and Affordable Care Act. Additionally, New MMH and New RGH shall provide appropriate insurance navigator services for patients and, where appropriate, English as a second language and cultural competency training for employees. In complying with this Condition, New MMH and New RGH shall be guided by the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care published by the U.S. Department of Health and Human Services' Office of Minority Health. For three (3) years following the Closing Date, PMH shall submit a written report on its activities directed at meeting this Condition. Such reporting shall be filed within thirty days of the anniversary date of the closing for three years and shall be posted on the applicable Hospital website. OHCA is imposing this Condition so as to ensure continued access to health care services for the patient population. *Legal and Factual Basis: 45 C.F.R. §92.201; Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(5),(6) & (11); FF 52-55, 59*

16. Within sixty (60) days after the Closing Date, the Applicants shall contract with an Independent Monitor who has experience in hospital administration and regulation, including maintaining quality control in an HRO. The Independent Monitor shall be retained at the sole expense of PMH, at a cost which shall not exceed $300,000 in the aggregate. Representatives of OHCA and the Facility Licensing and Investigations ("FLIS") section of the Department of Public Health ("DPH") will approve the Independent Monitor's appointment. The Independent Monitor shall be engaged for a minimum period of two (2) years following the Closing Date, which may be extended for another year at OHCA's and/or FLIS's discretion. The Independent Monitor will be responsible for monitoring the Applicants' compliance with the Conditions set forth in this Order. PMH shall provide the Independent Monitor with appropriate access to New Hospitals and their applicable records in order to enable the Independent Monitor to fulfill its functions hereunder. OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify and monitor compliance with the Conditions set forth herein. *Legal and Factual Basis: Conn. Gen. §§ Stat. 19a-486(a), 19a-613(b), 19a-639(a)(1),(2),(4),(5),(6),(7),(11) & (12); FF 26-27, 30-45, 52-57, 59*

17. The Independent Monitor will report to both OHCA and FLIS. The Independent Monitor shall conduct on-site visits of New Hospitals on no less than a semi-annual basis to assess PMH's modified QAPI program, each facility's efforts to remain an HRO, and compliance with the Quality Assurance Commitment Letter. The Independent Monitor shall furnish a written

report of his or her assessment to OHCA and FLIS within thirty (30) days of the completion of each on-site review. PMH will have the opportunity to review and provide written responses to the report. As OHCA deems necessary, the Independent Monitor shall meet with OHCA and FLIS personnel to discuss the written report and will perform additional periodic reviews and reviews of other PMH affiliated sites of service. OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify and monitor compliance with the Conditions set forth herein. *Legal and Factual Basis: Conn. Gen. §§ Stat. 19a-486(a), 19a-613(b), 19a-639(a)(1),(2),(4),(5),(6),(7),(11) & (12); FF 26-27, 30-45, 52-57, 59*

18. If, at any time within three (3) years following the Closing Date, the New Hospitals' Local Board agrees with PMH to change any of the Seller Quality Programs described in the Quality Assurance Commitment Letter other than to make any changes necessary to address (i) an immediate issue of patient safety; (ii) changes in federal, state, and local laws; or (iii) as mandated or recommended in guidance by a governmental agency, PMH shall notify OHCA and the Health Systems Branch in writing within thirty (30) days of any such change going into effect. If the Independent Monitor disagrees with the change, OHCA may require that a request for modification be submitted and approved as required by C.G.S. §4-181a to make the change. OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify and monitor compliance with the Conditions set forth herein. *Legal and Factual Basis: Stat. §§ 19a-486d, 19a-613(b), 19a-639(a)(1),(2),(5) & (6); FF 30-37*

19. For three (3) years following the Closing Date, PMH shall hold a joint meeting of the Board of Directors of each of New MMH and New RGH and the Local Board of New MMH and New RGH ("Joint Board Meetings") at least twice annually with one occurring in Manchester and the other occurring in Vernon. Such Joint Board Meetings shall be followed by a meeting to which the public is invited in advance and at which the public is informed of the New Hospitals' activities and afforded an opportunity to ask questions and make comments. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d, 19a-613(b), 19a-639(a)(2),(3),(5),(7),(8),(11) & (12); FF 28-30*

20. For three (3) years following the Closing Date, PMH shall allow for two (2) community representatives to serve as voting members of the New MMH and New RGH Local Board with rights and obligations consistent with other voting members under the Local Board Bylaws. The community representatives shall be selected in consultation with the Mayors of Manchester and Vernon in order to ensure the appointment of two unbiased persons who will fairly represent the interests of the communities served by MMH and RGH, respectively. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d, 19a-613(b), 19a-639(a)(2),(3),(5),(7),(8),(11) & (12); FF 28-30*

21. PMH, New ECHN, New MMH and New RGH shall abide by all requirements of licensure that may be imposed by DPH's Health Systems Branch ("HSB") in any Pre-Licensing Consent Order or similar agreement that HSB may enter into with these parties. OHCA is imposing this Condition to ensure that quality health care services are provided to the patient

population. *Legal and Factual Basis: Stat. §§ 19a-486d, 19a-490, 19a-493, 19a-639(a)(1),(2),(5) & (6); FF 30-37*

All of the foregoing constitutes the final order of the Office of Health Care Access in this matter.

By Order of the
Department of Public Health
Office of Health Care Access

June 10, 2016
Date

Janet M. Brancifort
Janet M. Brancifort, MPH, RRT
Deputy Commissioner

Greer, Leslie

From: Lazarus, Steven
Sent: Tuesday, July 05, 2016 7:35 AM
To: Greer, Leslie
Cc: Martone, Kim; Hansted, Kevin; Carney, Brian
Subject: FW: ECHN/PMH - Corrected Final Decision.PDF [CTAG-CTAG.FID647701]
Attachments: 2016-07-01 ECHN Corrected Final Decision.pdf

Please add to the record.

Thank you,

Steve

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
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From: Hawes, Gary W.
Sent: Friday, July 01, 2016 3:25 PM
To: Agsten, Melinda A.; 'rmatthews@wiggin.com'; mmv@bvmlaw.com; jonathan.spees@prospectmedical.com; Dennis P. McConville (dmcconville@echn.org)
Cc: Martone, Kim; Lazarus, Steven; Zinn-Rowthorn, Perry A.
Subject: ECHN/PMH - Corrected Final Decision.PDF [CTAG-CTAG.FID647701]

Please see the attached corrected Final Decision of the AG in connection with the proposed sale of substantially all of the assets of Eastern Connecticut Health Network, Inc., to Prospect Medical Holdings, Inc. We have changed the reference in Condition 1 to section 5.18(b) of the APA, so it now corresponds to the discussion within the Decision. We have also noted that correction on the last page of the decision. No other changes were made. Please let me know if you have any questions. Thanks.

Gary

Gary W. Hawes | Assistant Attorney General | Office of the Attorney General
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DOCKET NO. : OAG 15-486-01

IN RE APPLICATION FOR ASSET PURCHASE	**:**	**OFFICE OF THE ATTORNEY GENERAL**
BY PROSPECT MEDICAL HOLDINGS, INC. OF	**:**	
EASTERN CONNECTICUT HEALTH NETWORK	**:**	
INC.	**:**	**JULY 1, 2016**

FINAL DECISION

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I. INTRODUCTION

The proposed asset purchase agreement between Eastern Connecticut Health Network, Inc., and its affiliates ("ECHN"), and Prospect Medical Holdings, Inc. ("PMH")(collectively, the "Applicants"), is the second Application by ECHN filed with the Office of the Attorney General (the "OAG") for its review pursuant to the Nonprofit Hospital Conversion Act, Conn. Gen. Stat. § 19a-486 et seq. (the "Conversion Act").

On June 4, 2014, ECHN submitted a proposed transaction with Tenet Healthcare Corp. ("Tenet") that was withdrawn by Tenet prior to the completion of the OAG's review under the Conversion Act. This Application comes 2 years afterwards.

The difficulties faced by hospitals in delivering quality healthcare services in a changing and increasingly challenging fiscal landscape have become, appropriately, a subject of national concern and debate. A number of forces in recent years have contributed to the financial challenges to local hospitals, including those in Connecticut. Against the backdrop of a changing regulatory and fiscal landscape at the federal and state level, the delivery of healthcare services remains a local issue of extreme importance to the communities in which nonprofit hospitals operate. These issues are no less true for ECHN than for any other community hospital or hospital system in Connecticut. It is in this context that ECHN has decided to sell substantially all of its assets to PMH. Its stated goal in making this decision is to ensure the continued existence of ECHN's facilities and services, to provide sufficient capital to enhance the facilities and services, and to integrate its operations with an established health care system that is prepared to navigate the evolving health care system of the future. (Application of ECHN and PMH re a Proposed Asset Purchase Agreement, AG Docket 15-486-01, pp. 25-26; hereinafter, "App., p. __.)

Pursuant to the Conversion Act, the legislature has authorized the Attorney General to review and investigate proposed nonprofit to for-profit hospital transactions, to disapprove them if he finds that any of the criteria set forth in Conn. Gen. Stat. § 19a-486c(a) are not met, or to approve the transaction subject to any modifications or conditions that the Attorney General deems appropriate. Conn. Gen. Stat. § 19a-486b. Under the law, the Attorney General is required to assess both the procedural and financial fairness of the transaction and to protect and preserve the charitable assets of ECHN.

Contemporaneously with the OAG's review of the proposed Asset Purchase Agreement (the "APA"), the Office of Health Care Access, Department of Public Health ("OHCA"), has been reviewing the transaction to determine whether a certificate of need should be issued in this case and also whether OHCA's criteria in the Conversion Act have been fulfilled by the Applicants. In contrast to the Attorney General's focus, OHCA's review encompasses issues involving the impact of the proposed transaction on access to, and the quality of, health care in the ECHN service area.

As explained in detail below, we grant the Application with conditions necessary to conform the proposed transaction to the requirements of the Conversion Act. I would like to thank ECHN and PMH for their cooperation throughout this process. I would also like to thank the many witnesses, public officials, and members of the public who testified or commented on the proposed transaction in our proceedings. Last, I would like to thank my staff, Assistant Attorney General Henry Salton, head of the Health and Education Department, Assistant Attorney General Gary W. Hawes, and Paralegal Specialist Cheryl A. Turner for their diligent efforts on this matter.

II. EXECUTIVE SUMMARY

A. Standard of Review

Pursuant to the requirements of the Conversion Act, the OAG is required to review a proposed transaction for compliance with specifically articulated standards that were established by the legislature. § 19a-486c(a). In sum, these criteria require the OAG to make certain determinations: whether the nonprofit hospital's decision to sell its assets was reasonable, whether it chose the ultimate purchaser in an open and fair process, whether it received fair market value for its assets, whether the funds generated by the sale will be held by a charitable foundation that will use them for the promotion of healthcare in the nonprofit hospital's community, and whether use restrictions on any charitable asset held by ECHN will be preserved.[1]

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[1] Conn. Gen. Stat. § 19a-486c(a) provides in full:

The Attorney General shall deny an application as not in the public interest if the Attorney General determines that one or more of the following conditions exist:

(1) the transaction is prohibited by Connecticut statutory or common law governing nonprofit entities, trusts or charities;
(2) the nonprofit hospital failed to exercise due diligence in (A) deciding to transfer, (B) selecting the purchaser, (C) obtaining a fairness evaluation from an independent person expert in such agreements, or (D) negotiating the terms and conditions of the transfer;
(3) the nonprofit hospital failed to disclose any conflict of interest, including, but not limited to, conflicts of interest pertaining to board members, officers, key employees and experts of Waterbury Hospital, the purchaser or any other party to the transaction;
(4) the nonprofit hospital will not receive fair market value for its assets, which, for purposes of this subsection, means the most likely price that the assets would bring in a sale in a competitive and open market under all conditions requisite to a fair sale, with the buyer and seller each acting prudently, knowledgeably and in their own best interest, and with a reasonable time being allowed for exposure in the open market;
(5) the fair market value of the assets has been manipulated by any person in a manner that causes the value of the assets to decrease;
(6) the financing of the transaction by the nonprofit hospital will place the nonprofit hospital's assets at an unreasonable risk;
(7) any management contract contemplated under the transaction is not for reasonable fair value;

B. The Proposed Transaction

ECHN and PMH propose an asset purchase whereby ECHN will sell substantially all of its assets to PMH or one or more affiliates of PMH. Substantially all of the assets of ECHN will be transferred to PMH in exchange for $105,000,000, subject to certain adjustments.[2] The adjustments include a Net Working Capital reconciliation, reductions for the value of ECHN liabilities assumed by PMH, and adjustments for the value of any ECHN joint venture interest not assigned or transferred to PMH. Pursuant to the APA, PMH will also commit to spend not less than $75,000,000 on capital items over five years. (App., p. 23.)

PMH will continue to operate both Manchester Memorial Hospital ("MMH") and Rockville General Hospital ("RGH") as acute care hospitals for at least three years after the

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(8) a sum equal to the fair market value of the nonprofit hospital's assets (A) is not being transferred to one or more persons to be selected by the superior court for the judicial district where the nonprofit hospital is located who are not affiliated through corporate structure, governance or membership with either the nonprofit hospital or the purchaser, unless the nonprofit hospital continues to operate on a nonprofit basis after the transaction and such sum is transferred to the nonprofit hospital to provide health care services, and (B) is not being used for one of the following purposes: (i) For appropriate charitable health care purposes consistent with the nonprofit hospital's original purpose, (ii) for the support and promotion of health care generally in the affected community, or (iii) with respect to any assets held by the nonprofit hospital that are subject to a use restriction imposed by a donor, for a purpose consistent with the intent of said donor; or

(9) the nonprofit hospital or the purchaser has failed to provide the Attorney General with information and data sufficient to evaluate the proposed agreement adequately, provided the Attorney General has notified the nonprofit hospital or the purchaser of the inadequacy of the information or data and has provided a reasonable opportunity to remedy such inadequacy.

[2] The Application indicated that the purchase price would be either $105 million or $115 million, depending on whether ECHN obtained an assumable loan to finance certain of its outstanding bond liabilities. At the public hearing on this transaction, it was confirmed that ECHN had not acquired the loan, and the purchase price was going to be $105 million.

transaction closes.[3] Each hospital will maintain a local advisory board, and substantially all of the employees of ECHN and its affiliates will be offered employment by PMH or its affiliates. (App., p. 24.)

In addition, PMH will ensure that MMH and RGH maintain ECHN's current policies on charity care and indigent care or will adopt other policies that are at least as favorable to the ECHN community. (App., p. 32.)

After the closing, ECHN will establish a new charitable entity ("New Foundation") that will receive the net proceeds of the transaction and the appropriate charitable gift assets held by ECHN.

C. The Proposed Transaction Meets the Requirements of the Conversion Act Provided the Applicants Comply with the Attorney General's Modifications.

Based on our review of the record, all testimony provided at the public hearings, all exhibits provided pursuant to this review, and the standards set forth in § 19a-486c(a), we conclude that the proposed transaction meets the requirements of the Conversion Act, provided that ECHN and PMH comply with the modifications and conditions that are imposed herein.

1. Findings and Conclusions

First, we conclude that the process employed by ECHN in deciding to sell its assets to a for-profit healthcare services company reflects proper due diligence by ECHN's Board of Directors. The ECHN Board undertook an extensive process to explore potential strategic options and identify capital alternatives to address its weakening financial

[3] At all times, a hospital must receive approval in the form of a Certificate of Need from OHCA before terminating inpatient or outpatient services offered by the hospital. See Conn. Gen. Stat. § 19a-638(a)(5).

position. The Board's efforts have been diligent and without conflicts of interests, and in our opinion, the Board has met their fiduciary obligations to ECHN.

Second, we conclude that ECHN will receive fair market value for its assets as a result of this transaction. Based primarily on the opinions of two independent financial valuation experts, the price negotiated for the sale of ECHN's assets equals or exceeds the price they would command in an open and competitive market.[4] This conclusion is buttressed by the fact that the process followed by the ECHN Board to select a purchaser was itself open and competitive.

Third, assuming compliance with the modifications and conditions set forth below, we conclude that the charitable assets of ECHN will be adequately protected and preserved after the proposed transaction closes. The charitable assets of ECHN, which have been held in trust for the public, will be held by the New Foundation and safeguarded for their specific charitable uses or to promote healthcare in the ECHN service area. We also conclude that a sum equal to the fair market value of ECHN's assets will be transferred to the New Foundation and will be restricted to charitable uses consistent with ECHN's

[4] The nonprofit hospital conversion review process provides the OAG with the opportunity to have two separate, independent financial experts review the proposed transaction for compliance with the provisions of § 19a-486c(a). The first expert opinion is required by § 19a-486c(a)(2)(C), which provides that the nonprofit hospital obtain a fairness evaluation from an independent person expert in such agreement. ECHN hired Duff & Phelps, LLC, for these purposes, and its opinion is in the record. In addition, § 19a-486c(c) allows the Attorney General to contract with a financial expert to assist in the review of the nonprofit hospital's compliance with the provisions in § 19a-486c(a). Through an RFP process, the OAG retained the services of Navigant Consulting, Inc., to provide an additional independent analysis of the APA.

original purpose and for the support and promotion of healthcare generally in the ECHN community.[5]

2. Modifications and Conditions

The General Assembly has assigned the OAG significant responsibility and flexibility to modify the terms of the proposed transaction, if necessary, to fulfill the statutory mandates of the Conversion Act and—in particular—to fulfill the Attorney General's statutory charge to serve the public interest in the protection of gifts, legacies or devises for public or charitable purposes. Conn. Gen. Stat. § 3-125.

Consequently, although we approve the APA, that approval is contingent on certain modifications and conditions that must be made to the proposed transaction to ensure that the interests of the public and the requirements of the Conversion Act are met. These modifications and conditions, which are more fully described in Section V of this decision, include the following:

1. The Applicants must delete section 5.18(b) from the APA.

2. The Applicants shall notify the OAG in writing of the closing date of the Asset Purchase as soon as reasonably possible after the date has been set. If the closing date changes, the Applicants shall notify the OAG in writing of the change as soon as reasonably possible.

3. The Applicants must submit to the OAG, within 30 days of closing, fully executed copies of the Asset Purchase Agreement, without schedules.

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[5] As discussed in Section IV(H)(1) of this decision, the current estimate on the net proceeds to be transferred to the New Foundation is zero. In other words, after ECHN meets the obligations of its creditors and the provisions in the APA that require capital, there will be very little or nothing left over to transfer to the New Foundation.

4. As soon as reasonably possible after the Applicants have agreed to a Final Closing Statement of the transaction, the Applicants must provide the OAG a final accounting of the transaction that sets forth the balance sheets of ECHN immediately prior to and after the closing and that provides a net proceeds analysis.

5. After the closing, ECHN ("Legacy ECHN") shall hold and protect all charitable gift funds and any net proceeds from the Asset Purchase in its possession until they are transferred to the New Foundation or other charitable organization by order of a court of competent jurisdiction. However, Legacy ECHN may apply any charitable funds and/or net proceeds against pre-closing hospital liabilities and obligations, for costs of the winding down of Legacy ECHN, and for costs of establishing the New Foundation.

6. Legacy ECHN shall report quarterly to the OAG regarding (1) any and all income received by Legacy ECHN post-closing, including, but not limited to, Medicare and Medicaid reimbursements, income from charitable assets held by Legacy ECHN prior to transfer to the New Foundation, and any additional charitable funds received, and (2) all expenditures for Legacy ECHN.

7. When the requirements of the indemnity reserve have been fulfilled, and if there remain any funds in the indemnity reserve, they shall be considered ECHN's net proceeds and be treated accordingly.

8. Any income or unrestricted gifts received by Legacy ECHN post-closing shall be considered net proceeds.

9. The New Foundation shall include paragraph 14 as set forth in the draft Certificate of Incorporation in the final Certificate of Incorporation of the New Foundation, requiring Attorney General approval for changes to paragraphs 2, 5, 8, and 14 of the Certificate of Incorporation.

10. Legacy ECHN must present to the Superior Court, in coordination with the OAG, a petition for equitable deviation and approximation to transfer the unrestricted endowments to the New Foundation and to change the charitable purpose of the unrestricted endowments to the charitable purpose of the New Foundation.

11. Legacy ECHN must, in coordination with the OAG, include the restricted endowments in the Superior Court petition for an equitable deviation order. With respect to the Trotter, Baker, and Schortman funds, Legacy ECHN must seek an order of approximation, in addition to one for equitable deviation, to adjust the funds' charitable purposes to ones that come as close as possible to the donor's original charitable intent.

12. Legacy ECHN must, in coordination with the OAG, include any special funds that still have money in them in the Superior Court petition for an equitable deviation and approximation order.

13. Legacy ECHN must, in coordination with the OAG and the third-party trustees, bring any third-party trusts in need of approximation before a court of competent jurisdiction for appropriate orders.

14. Legacy ECHN must, in coordination with the OAG, include the Life Insurance Policy in the Superior Court petition for an equitable deviation order.

15. Any net proceeds from this transaction, including the earnings therefrom, shall be transferred to and then held by the New Foundation and used only for the support and promotion of healthcare in the ECHN community. The net proceeds shall never inure to the benefit of the for-profit hospital. The net proceeds shall forever be held by the New Foundation for the purposes articulated in the New Foundation's Draft Certificate of Incorporation, unless and until a court of competent jurisdiction orders otherwise.

16. Subject to subsequent Court order, the net proceeds held by the New

Foundation shall be considered an endowment fund, as that term is defined in the Connecticut Uniform Prudent Management of Institutional Funds Act, Conn. Gen. Stat. § 45a-535 et seq. ("CUPMIFA").

III. PROCEDURAL HISTORY

On July 17, 2015, OHCA and the OAG received ECHN's certificate of need determination letter that set forth in summary fashion the terms of the APA between the Applicants.[6] Because the OAG determined that the APA required approval pursuant to § 19a-486 et seq., the OAG and OHCA on August 6, 2015, jointly sent the Applicants an Application Form regarding the APA.

The Applicants requested an extension of time to submit their Application, which both agencies granted, On October 13, 2015, the Applicants filed their Application for an Asset Purchase, which included 45 exhibits. Upon review of the Application, the OAG and OHCA determined that the Applicants' Application was not complete, and on October 30, 2015, it requested additional information from the Applicants. Before the Applicants had an opportunity to respond to the October 30 requests, the OAG and OHCA requested further information on November 12, 2015, related to the reports that PMH was up for sale. On November 23, 2015, the Applicants filed responses to the two sets of additional requests set forth by the OAG and OHCA. On December 11, 2015, OHCA issued one last set of completeness questions, to which the Applicant responded on December 24, 2015. On January 13, 2016, the OAG and OHCA determined that the Application was complete. In order to ensure the completeness of the record, the OAG and OHCA took administrative

[6] All docket documents referenced in this opinion can be found on the Attorney General's website: www.ct.gov/ag.

notice of the record in the Proposed Asset Purchase of Greater Waterbury Health Network, Inc., by Prospect Medical Holdings, Inc., OHCA Docket No. 15-31217-486, OAG Docket No. 15-486-02 (the "GWHN/PMH APA").

Pursuant to Conn. Gen. Stat. § 19a-486e, the OAG and OHCA conducted two public hearings regarding the proposed Asset Purchase, one in Manchester and one in Rockville. The Manchester public hearing was held on March 29, 2016, at 2:00 p.m. at the Manchester Country Club in Manchester, Connecticut. The Rockville public hearing was held on March 30, 2016, at 2:00 p.m. at the Elks Club in Rockville, Connecticut. No person sought intervenor status for the hearings. Conn. Gen. Stat. § 19a-486a(g). All parties submitted pre-filed testimony for the hearings.

The hearings were presided over by representatives from both the OAG and OHCA. Deputy Attorney General Perry Zinn Rowthorn served as the hearing office for the OAG. Also on the panel for the OAG were Assistant Attorney General Henry A. Salton and Assistant Attorney General Gary W. Hawes. Kevin Hansted served as the hearing officer for OHCA. Also on the panel for OHCA were Kimberly Martone, Director for OHCA, Steven W. Lazarus, Associate Health Care Analyst, and Carmen Cotto, Health Care Analyst.

At the hearings, all parties adopted their pre-filed testimony, and all exhibits on the table of record were entered into the record. At both hearings, the Applicants presented full testimony and were subject to cross-examination by OHCA and the OAG. In addition, the hearing panel heard approximately 20 public comments and accepted written public comments. Subsequent to the hearings, the OAG receive one additional public comment.

The Applicants filed late-filed exhibits with OHCA and the OAG on April 20, 2016. The record was closed on June 9, 2016.

IV. FINDINGS OF FACT

Based upon the entire record of this Application, including all statements, testimony, and exhibits submitted by the Applicants, all public comments made at the hearing or submitted to the OAG in writing, the summary reports and exhibits submitted by the independent financial experts, and the record in the GWHN/PMH APA, we find the following.

A. Parties and other relevant corporate entities

ECHN is a not-for-profit health care system that serves 19 towns in eastern Connecticut including Andover, Bolton, Coventry, Ellington, Manchester, South Windsor, Tolland, Vernon, Willington, Ashford, Columbia, East Hartford, East Windsor, Glastonbury, Hebron, Mansfield, Somers, Stafford, and Union (the "Service Area"). ECHN was formed in 1995 when Manchester Memorial Hospital and Rockville General Hospital joined as partners.

ECHN's care network consists of a number of wholly owned entities: MMH; RGH; ECHN ElderCare Services, Inc.; Visiting Nurse and Health Services of Connecticut, Inc. ("VNHSC"); A Caring Hand, LLC; Clinically Integrated Network of Eastern Connecticut, LLC; Connecticut Healthcare Insurance Company; ECHN Corporate Services, Inc.; Medical Practice Partners, LLC; ECHN Enterprises, Inc.; Haynes Street Property Management, LLC; Eastern Connecticut Medical Professionals Foundation, Inc.; and ECHN Community HealthCare Foundation, Inc.

ECHN has ownership interests in a number of community based services including the following joint ventures: Evergreen Endoscopy Center, LLC; WBC Connecticut East, LLC; Aetna Ambulance Service, Inc.; Metro Wheelchair Service, Inc.; Ambulance Service of Manchester, LLC; Connecticut Occupational Medicine Partners, LLC; Eastern Connecticut

Physician Hospital Organization, Inc.; Northeast Regional Radiation Oncology Network, Inc.; Tolland Imaging Center, LLC; Haynes Street Medical Associates, LLC; Haynes Street Medical Associates II, LLC; Evergreen Medical Associates, LLC; and Evergreen Medical Associates II, LLC

PMH is a Delaware corporation with its principal place of business located in Los Angeles, California. PMH is a healthcare services company that owns and operates thirteen acute care and behavioral hospitals located in Rhode Island, Texas, and California. PMH also owns a network of specialty and primary care clinics in each of its regions. Through PMH's medical group segment, PMH manages the provision of physician services to approximately 260,000 patients in Southern California, South Central Texas, and Rhode Island through a network of approximately 8,900 physicians.

PMH currently owns the following hospitals: Los Angeles Community Hospital; Los Angeles Community Hospital at Bellflower; Los Angeles Community Hospital at Norwalk; Southern California Hospital at Hollywood; Southern California Hospital at Van Nuys; Southern California Hospital at Culver City; Foothill Regional Medical Center; Nix Health (four campuses); Roger Williams Medical Center (RI); and Our Lady of Fatima Hospital (RI).

PMH aligns its hospitals and physicians under a model referred to as Coordinated Regional Care ("CRC"). CRC provides for clinical integration among hospitals, physicians and other medical, social and community providers working closely with strategic partner health plans and other payers under a value-based, global risk reimbursement payment system to achieve the triple aim of improved patient care and experience, better patient health, and lower costs.

B. ECHN's Fiscal Condition

ECHN's mission has been impeded since 2001 by various factors, including reduced reimbursement from government payors, limited access to the capital required to improve infrastructure and to recruit and maintain needed physicians, and mounting pension liabilities.

Starting in 2001, when ECHN lost more than $10 million, capital investments had to be deferred and long-term debt and pension liabilities continued to grow. The pension funding reforms of 2006 and the market crash of 2008 created additional financial problems for ECHN. Although ECHN took numerous steps to mitigate the losses from these events, it was still unable to make significant capital investments. ECHN's plans to expand and introduce new programs to help recruit physicians were also put off.

In addition to the financial challenges that ECHN faced at that time, federal and state regulation changed the landscape for health care provider reimbursements and tax burdens. These increased financial burdens over the period of ten years led the Board to consider affiliation options.

C. The Search for Solutions and Partners

In 2011 the ECHN Board authorized the establishment of a workgroup to evaluate whether benefits would be realized by affiliating with another health care system, or whether ECHN would better serve the community by remaining an independent system (the "Partnering Workgroup"). To assist the Partnering Workgroup in its evaluation, ECHN engaged The Chartis Group, LLC ("Chartis"), a national healthcare consulting firm. In September of 2012, the Partnering Workgroup presented its initial findings to the ECHN Board. The Partnering Workgroup concluded that affiliation with a larger health system would better position ECHN to achieve its goals, and the Board agreed.

From November 2012 through April 2013, the Partnering Workgroup worked with Chartis to develop and conduct a request for proposal (RFP) process for potential partners. RFPs were mailed to three nonprofit health systems and three for-profit health systems. Based upon an initial review of four indications of interest and the conclusion that affiliation appeared to be the best alternative, the ECHN Board created the Transaction Committee to thoroughly evaluate the proposals for affiliation.

After proper due diligence by the Transaction Committee and consideration of the Transaction Committee's recommendation by the ECHN Board, the Board selected a proposed joint venture between Yale New Haven Health System ("YNHHS") and Vanguard Health Systems, Inc. ("Vanguard") as the purchaser of ECHN. Before being able to negotiate a definitive Asset Purchase Agreement, however, ECHN learned that Tenet Healthcare Corporation ("Tenet") was going to acquire Vanguard. The Transaction Committee then performed its due diligence with respect to Tenet and recommended to the Board that ECHN continue with the contemplated transaction. The Board voted to approve the Transaction Committee's recommendation.

ECHN and Vanguard began the regulatory approval process in the summer of 2014 and submitted their application to the OAG and OHCA on October 24, 2014, and filed responses to completeness questions on November 25, 2014. On December 11, 2014, Tenet informed ECHN that it was withdrawing its application for the acquisition of ECHN citing

the proposed regulatory conditions that had been placed on its Application to form a joint venture with the Greater Waterbury Health Network, Inc. ("GWHN").[7]

While waiting to see if Tenet might return to Connecticut to pursue its acquisition of ECHN, the Board reaffirmed the need for ECHN to partner. To that end, and with the guidance of The Chartis Group, the Transaction Committee conducted a second RFP process. On February 6, 2015, RFPs were sent to the four systems that had expressed interest in partnering with ECHN and to two additional out-of-state systems that had approached ECHN with interest in an affiliation. ECHN received three responses.

While considering these proposals, two teams of Transaction Committee members and ECHN executives made visits to Los Angeles to tour PMH's management services organization that supports its independent physician practice associations (IPAs) and hospitals for risk-based contracting and population health management. The groups also toured Prospect's Southern California Hospital in Culver City and met with and interviewed representatives in the areas of governance, medical staff leadership, and administration from Prospect's Los Angeles Coordinated Regional Care Market.

Members of the Transaction Committee and ECHN executives also visited CharterCARE Health Partners' Roger Williams Medical Center in Providence, Rhode Island. CharterCARE Health Partners is PMH's coordinated regional care network comprised of Roger Williams Medical Center, Our Lady of Fatima Hospital, a skilled nursing facility, a regional cancer center, a rehabilitation center, a community primary care

[7] On December 11, 2014, Tenet withdrew its applications with respect to the Greater Waterbury Health Network, Inc., Saint Mary's Health System, Inc., Eastern Connecticut Health Network, Inc., and Bristol Hospital and Health Care Group, Inc.

center, a home health services company, an IPA, and a physician group practice based in Providence.

Based upon their due diligence with respect to all the proposals, the Transaction Committee chose to negotiate only with PMH in finalizing a proposed asset purchase agreement. After some of the open items in PMH's proposed APA were addressed through negotiations, the Transaction Committee unanimously recommended to the ECHN Board that it accept PMH's proposal to acquire substantially all of the assets of ECHN. After review, the Board unanimously approved the APA in substantially the form presented to them. The draft APA was then submitted to ECHN's Corporators for consideration. The ECHN Corporators approved the draft APA on July 29, 2015, with 165 voting in favor of the transaction and 4 against.

D. The Proposed Transaction

PMH or a PMH designated subsidiary (hereinafter, "PMH") will purchase substantially all of the assets of ECHN, including the properties, assets and businesses of, or ownership interests of ECHN affiliates. PMH will also purchase ECHN's interests in its or its affiliates' joint ventures.[8]

PMH will acquire real property, leased property, equipment, accounts receivable, and net working capital (*i.e.*, non-cash current assets less the value of all current liabilities) of ECHN and the ECHN affiliates. PMH will assume several key liabilities, including ECHN's unfunded pension liabilities, ECHN's health benefit plan for retirees, ECHN's

[8] The assets of ECHN Community HealthCare Foundation, Inc., will not be included in the assets purchased by PMH.

captive insurer liabilities (*i.e.*, Connecticut Healthcare Insurance Company), and ECHN's workers' compensation obligations.

PMH will exclude some current ECHN liabilities that will then remain the responsibility of ECHN's residual corporation following the transaction ("Legacy ECHN"). For example, PMH will not assume liabilities that could arise from lawsuits or tax settlements based on pre-closing activities. ECHN will exclude certain of its assets from the purchase, including certain cash and cash equivalents of ECHN; all short-term and long-term investments, but excluding ECHN's investment interests in the joint ventures; board-designated, restricted, and trustee-held or escrowed funds (such as funded depreciation, debt service reserves, self-insurance trusts, working capital trust assets, and assets and investments restricted to use), beneficial interests in charitable trusts, and accrued earnings on all of the foregoing.

PMH will pay $105,000,000 subject to the Net Working Capital reconciliation, minus the amount of certain ECHN liabilities assumed by PMH (*e.g.* ECHN's unfunded pension obligations, captive insurer liability, capital leases, and the workers' compensation liability), minus asbestos abatement liability of up to $1,000,000, and minus, in the event that ECHN is unable to assign and transfer to PMH ECHN's interest in an ECHN joint venture, a dollar amount to be fixed in advance for each ECHN Joint Venture.

ECHN's proceeds from the APA will first be used to settle all of ECHN's bond liabilities and all of ECHN's other indebtedness not otherwise assumed by PMH. The remaining proceeds will next be used to fund an indemnity reserve for a period of at least three years (the "Reserve Period") following the closing of the transaction for payment of ECHN liabilities to PMH that may arise post-closing. Any proceeds that remain after settling bond liabilities, settling other indebtedness, and funding the indemnity reserve will

be held by the residual ECHN corporation to be used for post-closing liabilities and wind down of operations. After expiration of the Reserve Period, any funds remaining in the Reserve and not used to pay claims will be transferred as directed by the Office of the Attorney General of the State of Connecticut with the expectation that such funds will be transferred to a nonprofit foundation and used to support charitable health related efforts in the ECHN Service Area.

After closing, PMH/ECHN, will develop a strategic capital plan with respect to the Hospital Businesses. PMH has committed to spend within five years of the closing not less than $75,000,000 (the "Commitment Amount") for the benefit of the Hospital Businesses and for the benefit of the Service Area of MMH and RGH. These expenditures may include: (i) capital projects, including routine and non-routine capital expenditures for the improvement of ECHN's facilities; (ii) development, expansion, or acquisition of a department, program, service or facility; (iii) upgrades or renovations generally; (iv) deferred maintenance items; and (v) capital expended in support of the recruitment of the hospitals' medical staff located in the hospitals' Service Area.

PMH will offer employment as of the closing to substantially all employees of ECHN and its affiliates who work at the hospital businesses, including employees on approved leaves of absence as of the closing. PMH will offer the hired employees salaries that are equal to their salaries as of the closing date and benefits packages that are comparable to those offered to similarly-situated employees at other hospitals operated by PMH. PMH will assume and honor ECHN's (and its affiliates') collective bargaining agreements.

For at least three years after the closing of the transaction, PMH will continue operating MMH and RGH in their current locations as acute care hospitals with emergency departments. Also, for at least three years after the closing of the transaction, PMH will

maintain an ownership interest in ECHN's current post-acute care continuum of care network and require any wholly owned entity involved with such post-acute care continuum of care network to maintain appropriate service lines during such three-year period. PMH will also ensure that each Hospital maintains and adheres to ECHN's current policies regarding charity care, indigent care, community volunteer services and community benefits (or adopts other policies that are at least as favorable to the community as ECHN's current policies).

PMH will maintain and support financially ECHN's University of New England medical student and other health professions teaching programs, as well as ECHN's graduate medical education programs, while operating at a level not to exceed the Indirect Medical Education and Direct Graduate Medical Education caps that may be established by the Centers for Medicare and Medicaid Services.

Following the closing, MMH and RGH will each maintain an advisory board made up of community representatives, physicians on the respective hospital's medical staff, and the Chief Executive Officer of the respective hospital (the "Local Board"). Among other things, the Local Board will serve as a resource for PMH with respect to PMH's investment of the capital commitment, assist with maintenance and implementation of a strategic business plan for the Hospitals, make recommendations for medical staff credentialing at the Hospitals, review and make recommendations regarding the quality assurance program at the Hospitals, and assist in issues relating to accreditation for the Hospitals.

ECHN agrees to maintain an indemnity reserve in the amount of $4,500,000 for a period of three years after the closing date so that PMH will have meaningful recourse against ECHN for any potential indemnification claims. If certain claims arise during this three year period, the indemnification reserve may be extended, but not beyond the fifth

anniversary of the closing date. The indemnification obligations of PMH's subsidiary buyer to ECHN are guaranteed by PMH.

E. The Charitable Assets of ECHN

Throughout its history, ECHN has received numerous charitable gifts, legacies and devises from generous individual donors and community fundraising efforts.[9] These gifts were given to one of four entities: Manchester Memorial Hospital, Rockville General Hospital, the ECHN Community HealthCare Foundation, Inc. (the "ECHN Foundation"), and ECHN Eldercare Services, Inc. As part of its Application, ECHN provided information and documentation of the charitable trusts and gifts of which its hospitals are the beneficiary or in which its hospitals claim an interest. Specifically, it provided copies of the gift documents themselves (Exhibit Q11-2 of the Application) and a spreadsheet (the "Gift Document Analysis"; Exhibit Q11-1 of the Application) that included a narrative description of each charitable gift, succession language where applicable, the name of the trustee of each gift, and a designation of whether each gift was an endowment and restricted as to purpose. The value of all the charitable gifts as of March 30, 2016, was $23,116,006.

The OAG reviewed the Gift Analysis provided by ECHN for accuracy and completeness. In addition, the OAG questioned ECHN on the due diligence undertaken to identify all of the underlying gift documents for the charitable funds. The OAG is satisfied

[9] Manchester Memorial Hospital, Rockville General Hospital, the ECHN Community HealthCare Foundation, Inc., and ECHN Eldercare Services, Inc., hold all of ECHN's charitable funds. For the sake of our discussion, we will refer generally to funds as being held by ECHN.

that ECHN has identified all the charitable funds in its possession and has met its burden to produce the underlying gift documents for each fund.

1. Manchester Memorial Hospital

We first catalog the charitable funds held by MMH.

a. MMH Unrestricted Endowments

Unrestricted endowments are charitable funds, the original gift instrument of which specifies that the sum donated is to be held and preserved as "principal," as a "fund," as an "endowment," or directs that the sum be held and invested, or added to an existing endowment fund, and further specifies that the annual income earned on said principal be applied to the general purposes of the hospital.

The following gifts are unrestricted endowments held by MMH:[10] Blish (11-1.1), Carpenter (11-1.2), Chapman (11-1.3), Coates (11-1.4), Dart (11-1.5), House (11-1.6), Porter (11-1.7), Rice (11-1.8), Stanley (11-1.9), Strant (11-1.10), Strickland (11-1.11), Ellis (11-1.12), Pinney (11-1.13), Hohenthal (11-1.14), Cheney (11-1.15), Campbell Cheney (11-1.16), Dewey (Albert) (11-1.17), Dewey (Jane) (11-1.18), Gardner (11-1.19), Piper 1 (11-1.20), and Piper 2 (11-1.21). As of March 31, 2016, the total value of these restricted endowments was $8,558,001.

b. MMH Endowments Restricted to Purpose

Endowments Restricted to Purpose are charitable funds, the original gift instrument of which specifies that the sum donated is to be held and preserved as "principal," as a "fund," as an "endowment," or directs that the sum be held and invested, but the purposes

[10]The numbers following the gifts represent the fund number as identified in the Application, Exhibit Q11-1.

to which the income may be put are restricted and cannot be applied to the general purposes of the hospital. One of the most common restrictions on hospital gifts directs the funds to be used for free bed care, i.e., to use the funds on behalf of persons unable to pay for the hospital services provided (a "Bed Fund"). MMH holds six Bed Funds: Drake (11-1.22), Hills Preston (11-1.23), Boynton (11-1.24), Loomis (11-1.25), Cheney Disher (11-1.26), and Keeney (11-1.27). MMH's Bed Funds are valued at $541,728 as of March 31, 2016. MMH holds two additional endowments restricted to purpose: Trotter (11-1.28) (for the benefit of children patients) and Wright (11-1.29) (for the benefit of the fight against cancer). The Trotter and Wright funds have a total value of $6,629 as of March 31, 2016.

c. MMH Miscellaneous Funds

MMH has interests in two additional funds: Damato (11-1.30) and a life insurance policy (11-1.31). The Damato estate is an unrestricted gift, with an undetermined value at this time. The date of final distribution is unclear at this time due to the complexity of liquidating the assets in the estate, particularly the real estate assets.

The current value of the life insurance policy is $58,147.

The total value of gifts held by MMH as of March 31, 2016, is $9,164,514.

2. Rockville General Hospital

a. RGH Unrestricted Endowments

The following gifts are unrestricted endowments held by RGH: Bissell (11-1.32), Maxwell (11-1.33), Goodale and Risley (11-1.34), United German Society (11-1.35), Prescott (11-1.36), Maxwell (11-1.37), Smith (11-1.38), Doss (11-1.39), Wood (11-1.40), Henry (Maud) (11-1.41), Henry (Lenore) (11-1.42), Charter (11-1.43), Bilson (11-1.44), Belding (11-1.45), Bradley (11-1.46), Britton (11-1.47), Sprague (11-1.48), Doane (11-1.49), Keney (11-1.50), American Red Cross (11-1.51), Talcott (11-1.52), Maxwell (11-1.53), Metcalf (11-1.54), and

Henry (11-1.55), As of March 31, 2016, the total value of these unrestricted endowments was $8,989,027.

b. RGH Endowments Restricted to Purpose

RGH holds eight Bed Funds: DAR (11-1.56), Prescott (11-1.57), Phelps (11-1.58), Winchell-Foster (11-1.59), Tucker (11-1.60), Whitlock (11-1.61), Sykes Phelps (11-1.62), and Kress (11-1.63). RGH's Bed Funds are valued at $288,358 as of March 31, 2016. MMH holds two additional endowments restricted to purpose: Baker Family (11-1.64) (for the upkeep and physical maintenance of the Hospital) and Schortmann (11-1.65) (for the operation or improvement of the maternity and nursery facilities of the Hospital). The Baker Family and Schortmann funds have a total value of $278,769 as of March 31, 2016.

c. RGH Miscellaneous Funds

RGH has interests in two charitable gift annuities, but one of the two joint annuitants has now lived beyond the projected life expectancy. The annuities are now contractual liabilities of the Hospital, and ECHN is looking to terminate these arrangements at fair value. Names of the original grantors have been withheld. (11-1.77 and 11-1.78).

The total value of gifts held by RGH as of March 31, 2016, is $12,374,200.

3. ECHN Community Healthcare Foundations, Inc.

a. Endowments

The ECHN Foundation holds several funds for the benefit of MMH and RGH. With respect to MMH, the ECHN Foundation holds the following unrestricted endowments: Burgess (11-1.79), St. Laurent (11-1.80), and Piper (11-1.81). The total value of these three gifts as of March 31, 2016 is $1,285,023. With respect to RGH, the ECHN Foundation holds the follow endowments with restricted purposes: Maxwell (11-1.82) (for the benefit of the

normal maintenance and repair of the Maxwell Home and its grounds) and Risley Scholarship (11-1.83) (for the benefit of nurses' continuing education). The total value of these two funds as of March 31, 2016, is $282,289. The total value of funds held by the ECHN Foundation is $1,567,312.

b. Special Purpose Funds

The ECHN Foundation holds a dozen funds that are fully expendable but have restricted purposes. If ECHN does not deplete these funds for their intended purpose prior to the closing, they will remain with Legacy ECHN to be transferred to the New Foundation or another charitable organization to fulfill the fund's intended charitable purpose. The special funds are as follows: Avis Lloyd Tree of Life (11-2.1), Team Towanda (11-2.2), Employee Care (11-2.3), Breast and Cervical Cancer (11-2.4), Adult Ambulatory Administrative Education and Development (11-2.5), Purcell Golf Classic Trophies (11-2.6), Woodlake at Tolland Wishes Program (11-2.7), Van (11-2.8), Risley (11-2.9), Fields (11-2.10), and Woodlake: Resident Council (11-2.11). The total value of the special funds held by the ECHN Foundation is $9,979.

4. Trusts Held by Outside Trustees

All the charitable funds identified above are held and administered by ECHN. There is a series of charitable gift funds, however, that are not held by ECHN but by outside trustees and for which ECHN holds the beneficial interest.

a. For the Benefit of MMH

There are seven funds held by outside trustees for the benefit of MMH: Barton (11-3.1), Clark (11-3.2), Morton (11-3.3), Robertson (11-3.4), Crowell (11-3.5), Ferguson (11-3.6), and Rogers (11-3.7).

b. For the Benefit of RGH

There are three funds held by outside trustees for the benefit of GWH: Dillon (11-3.8), Moxon (11-3.9), and Barton (11-3.10).

The market value of the corpus of the trusts held by outside trustees for the benefit of ECHN was $10,903,971 on March 31, 2016.

V. LEGAL ANALYSIS AND REQUIRED MODIFICATIONS

Conn. Gen. Stat. § 19a-486a *et seq*. directs that any nonprofit hospital that enters into an agreement to transfer a material amount of its assets or operations with an entity operated for profit must first obtain the approval of OHCA and the OAG. Any agreement made without these approvals is deemed void.

Conn. Gen. Stat. § 19a-486c mandates that the Attorney General shall disapprove a proposed sale of a nonprofit hospital to a for-profit entity as not in the public interest if he determines that one or more of nine conditions exist.[11] The Conversion Act, however, allows the Attorney General to approve an application while setting forth modifications and/or conditions that would bring the proposed transaction into compliance with the conditions in § 19a-486c. What follows, therefore, is the OAG's analysis and discussion of the statutory criteria in § 19a-486c and the modifications and conditions to the Asset Purchase Agreement that are necessary to satisfy those criteria.

A. The transaction is not prohibited by Connecticut statutory or common law governing nonprofit entities, trusts or charities.

Pursuant to Conn. Gen. Stat. § 19a-486c(a)(1), the Attorney General shall disapprove a proposed agreement if he determines that the transaction is prohibited by

[11] See footnote 1.

Connecticut statutory or common law governing nonprofit entities, trusts, or charities. Subject to the modifications and conditions set forth in Section II(D) of this decision, we conclude that the Asset Purchase is not prohibited by statutory or common law governing nonprofit entities, trusts, or charities.

B. ECHN exercised due diligence.

Pursuant to Conn. Gen. Stat. § 19a-486c(a)(2), the Attorney General is required to determine whether the nonprofit hospital exercised due diligence in four distinct areas. The phrase "due diligence" is not defined by the Conversion Act, but Black's Law Dictionary (6th ed. 1990) defines it as: "Such a measure of prudence, activity, or assiduity, as is properly to be expected from, and ordinarily exercised by, a reasonable and prudent man under the particular circumstances; not measured by any absolute standard, but depending on the relative facts of the special case." In short, therefore, we review the level of care and prudence that the ECHN Board exercised in deciding to enter into the APA with PMH.

Based upon our and our expert's review of the materials presented as a part of the ECHN and PMH Application and the testimony given at the public hearings, it is clear that ECHN undertook an extensive and diligent process to explore strategic options and to identify a capital alternative that would enable it to address its difficult financial position. ECHN has faithfully pursued its mission to ensure quality healthcare for the Manchester and Rockville communities. As noted in the findings of fact, ECHN's efforts began in 2011 with the establishment of the Partnering Workgroup and the hiring of Chartis. Every step that followed in ECHN's pursuit of a capital partner was reviewed by a Transaction Committee, the Board of ECHN, and for significant issues, the ECHN Corporators. ECHN pursued discussions with multiple strategic partners, evaluated a range of transaction

structures, and explored multiple strategies to access capital. Our specific due diligence findings follow.

1. ECHN exercised due diligence in deciding to participate in the APA.

Pursuant to Conn. Gen. Stat. § 19a-486c(a)(2)(A), the Attorney General shall disapprove a proposed agreement if he determines that the nonprofit hospital failed to exercise due diligence in deciding to transfer its assets. The record reveals a compelling case for ECHN to transfer substantially all of its assets as a means to assure the long-term viability of MMH and RGH.

ECHN engaged in a decision-making process that was reasonable, thoughtful, and thorough. In short, its ultimate decision to transfer substantially all of its assets to PMH demonstrated due diligence under the circumstances. As noted in the findings of fact, ECHN pursued a range of strategic initiatives to address the hospital's financial constraints, aging facilities, and limited access to capital. Without a feasible alternative available, the ECHN Board reasonably concluded that the sale of its assets to another hospital system was an appropriate solution for long-term viability of the hospitals. We, therefore, conclude that ECHN exercised due diligence in deciding to transfer substantially all of its assets as a part of the APA.

2. ECHN exercised due diligence in selecting PMH for the Asset Purchase.

Pursuant to Conn. Gen. Stat. § 19a-486c(a)(2)(B), the Attorney General shall disapprove a proposed agreement if he determines that the nonprofit hospital failed to exercise due diligence in selecting the purchaser. Based on the record in this case, ECHN has established that it exercised due diligence in selecting PMH to purchase substantially all of its assets.

The full history of ECHN's search for a capital partner is described in detail in the findings of fact. With respect to the initiative that resulted in the APA with PMH, however, we conclude that ECHN took appropriate and considered steps to identify the best situation for MMH and RGH. ECHN conducted a second RFP process with the guidance of Chartis, delivering the RFP to six potential partners, including PMH. By mid-March in 2015, ECHN had received three proposals. The Transaction Committee reviewed the proposals and evaluated each in light of the selection criteria approved by the Board, including quality of care. The Transaction Committee then performed its due diligence with respect to the potential partners, reviewing financial, quality, and corporate compliance data for each of the potential partners. With respect to PMH, members of the Transaction Committee visited PMH's California and Rhode Island operations.

On June 22, 2015, the Transaction Committee voted unanimously to recommend acceptance of the PMH proposal. On June 25, 2015, the Board held a retreat during which it considered the proposals received from the potential partners, ultimately voting in favor of the PMH proposal. The draft APA was then sent to ECHN's Corporators for their review, who approved entering the transaction in overwhelming numbers.

On or about the beginning of February 2016, after the hospital conversion application process had begun with the OAG and OHCA, ECHN learned that recent Medicare and Medicaid surveys at two of PMH's California hospitals (Los Angeles Community Hospital and Southern California Hospital at Culver City) had resulted in findings of Immediate Jeopardy by regulatory authorities at both hospitals. After learning about these determinations, ECHN appointed a Quality Evaluation Team that looked into the Immediate Jeopardy findings to determine whether the findings were sufficiently substantial to call into question PMH's fitness as a transaction partner. After a thorough

investigation, the Quality Evaluation Team determined that "the recent compliance issues present isolated challenges that [PMH] has demonstrated a strong commitment to remediate through corrective actions that are already in progress." (Testimony of Joy Durin, Vice Chair, Board of Trustees, Chair, Transaction Committee, p. 3350.) This conclusion was shared with the Transaction Committee, approved by them, sent to the Board, and the board approved the recommendation. In addition to the investigation performed by the Quality Evaluation Team, ECHN negotiated a Quality Assurance Commitment with PMH that requires PMH to maintain ECHN's quality programs for at least two years following the closing of the transaction. In addition, it requires PMH to maintain quality assurance and performance improvement programs that are consistent with industry best practices and quality improvement programs as currently implemented in PMH's Rhode Island facilities. Based on the evidence presented to the OAG, we conclude that ECHN exercised due diligence in selecting PMH as its partner for the APA and in confirming that selection after PMH's Immediate Jeopardy findings came to light.

3. ECHN exercised due diligence in obtaining a fairness evaluation.

Pursuant to Conn. Gen. Stat. § 19a-486c(a)(2)(C), the Attorney General shall disapprove a proposed agreement if he determines that the nonprofit hospital failed to exercise due diligence in obtaining a fairness evaluation from an independent person expert in such agreements.

ECHN's fairness evaluation was conducted by Duff & Phelps, LLC ("Duff & Phelps"), who had no previous material relationship with any party to the transaction, except for having previously provided an independent fairness opinion regarding the proposed ECHN/Tenet transaction. In addition, no portion of Duff & Phelps fee was contingent on

the conclusion expressed in the fairness opinion or on the successful consummation of the transaction.

Therefore, we conclude that the ECHN Board exercised due diligence in obtaining a fairness evaluation regarding the terms of the proposed APA from an independent entity expert in such agreements.

4. ECHN exercised due diligence in negotiating the terms and conditions of the APA.

Pursuant to Conn. Gen. Stat. § 19a-486c(a)(2)(D), the Attorney General shall disapprove a proposed agreement if he determines that the nonprofit hospital failed to exercise due diligence in negotiating the terms and conditions of the transfer.

Our review of the transaction leads us to conclude that ECHN exercised due diligence in negotiating most of the terms and conditions of the APA. As discussed below, we believe ECHN will receive at least the fair market value for its assets. In addition, ECHN negotiated a capital commitment of $75 million for the for-profit ECHN hospital system ("PMH/ECHN") over the next five years. Other highlights include PMH's retention of ECHN employees, the assumption by PMH of the unfunded pension liabilities, the formation of local advisory boards for each hospital, and PMH's commitment to maintain ECHN's current policies regarding charity care, indigent care, and community benefits.

One provision in the APA, however, stands out as unreasonable in light of the details of the transaction as a whole. Section 5.18 of the APA concerns PMH's $75 million capital commitment, and subsection (b) of this section provides as follows:

> *Notwithstanding the above capital commitment, in the event that any Legal Requirement is enacted or imposed by the State of Connecticut after Closing that discriminates against, or adversely affects a disproportionate number of for-profit hospitals and causes the Hospital Businesses to suffer a decline in EBITDA of more than ten (10) percent in any year, on a consolidated basis, then, Buyer may defer in its discretion the above capital commitment beyond the five-year period*

> *provided in Section 5.18(a) but only to the extent of the decline in EBITDA resulting from the discriminatory Legal Requirement. To the extent Buyer desires to defer the capital commitment as a result of a discriminatory Legal Requirement, (i) Buyer shall make available to the public reasonably detailed information to support Buyer's position (provided that in no event shall Buyer be required to disclose any information that is subject to a confidentiality or other similar arrangement) and (ii) Buyer shall consult with the Local Board to determine an alternate mutually agreeable timeframe to complete the capital commitment that is reasonable and appropriate in light of the changed circumstances caused by the new Legal Requirement.*

(Exhibit Q3-2, Asset Purchase Agreement, p. 182.)

Although PMH may wish to hedge against future changes in the legal landscape, it cannot hold the ECHN capital investment hostage by such a provision. To do so would render the $75 million capital commitment – a key term of the deal – subject to delay upon the future actions of legislators. Put differently, we believe that PMH must bear the risk of future legislation and not PMH/ECHN. The $75 million capital commitment is indeed a commitment, and the deadline by which it must be spent must be honored. Accordingly, as a condition to approval of the proposed transaction, the OAG requires that the Applicants modify the APA by deleting section 5.18(b) from the APA.

C. ECHN Disclosed Any and All Board Member, Officer, Key Employee, and Expert Conflicts of Interest With Respect to the APA.

Pursuant to Conn. Gen. Stat. § 19a-486c(a)(3), the Attorney General shall disapprove the proposed transaction as not in the public interest if he determines that the nonprofit hospital failed to disclose any conflict of interest, including but not limited to, conflicts of interest pertaining to board members, officers, key employees, or experts of ECHN, the purchaser, or any other party to the transaction.

The Applicants provided the OAG with individual conflict of interest statements for each relevant individual (board member, officer, etc.) employed by ECHN, its experts, and

PMH. Each individual was required to respond to individual questions regarding possible financial, beneficial, and/or employment related conflicts of interest. If any of the questions were answered with anything other than an unqualified "No," the individual was required to attach an explanation to the statement. These statements were reviewed by the OAG and Navigant.

Section 5.03 of the APA requires PMH "to employ as of the Closing Date substantially all employees of Seller and its Affiliates who work at the Hospital Businesses." (Exhibit Q3-2, Asset Purchase Agreement, p. 171.) Therefore, employees of ECHN, including ECHN's officers and key employees, have been offered employment with PMH as a part of the transaction. This general provision, however, does not create a conflict of interest for the purposes of this statutory element.

After a careful review of all the conflict of interest responses, there do not appear to be any conflicts of interest with this proposed transaction that exist outside of the APA itself. In addition, no intervenor or other participant in the proceeding has offered any credible evidence that any conflict existed at any time during the negotiation of the APA. Accordingly, we conclude that no conflicts of interest exist that would require disapproval of the APA.[12]

D. ECHN will receive fair market value for its assets.

Pursuant to Conn. Gen. Stat. § 19a-486c(a)(4), the Attorney General shall disapprove the proposed transaction as not in the public interest if he determines that the

[12] ECHN's process to ensure that no individual with a conflict of interest voted on this transaction was very thorough. Indeed, ECHN created a Conflict of Interest Task Force specifically for this purpose. The Board voted on all transaction-related resolutions pursuant to a two-step process to help ensure that any personal interest in any of the transaction decisions made would be eliminated.

nonprofit hospital will not receive fair market value for its assets. For purposes of the Conversion Act, "fair market value" is defined as

> the most likely price that the assets would bring in a sale in a competitive and open market under all conditions requisite to a fair sale, with the buyer and seller each acting prudently, knowledgeably and in their own best interest, and with a reasonable time being allowed for exposure in the open market.

Conn. Gen. Stat. § 19a-486c(a)(4).

PMH has agreed to pay $105 million as compensation for substantially all of ECHN's assets. Two independent financial experts have reviewed the transaction to determine whether ECHN will receive fair market value for its assets, and both have concluded that the purchase price of $105 million equals or exceeds the fair market value of ECHN's assets.

As discussed above, ECHN retained Duff & Phelps to provide it with an independent valuation and fairness opinion regarding the transaction.[13] Duff and Phelps considered three principal methods of valuation: discounted cash flow, guideline company, and M&A transaction. These approaches indicated that the fair market value of ECHN was well below the price PMH had agreed to pay for substantially all of the assets of ECHN. Duff & Phelps's mid-point estimate for ECHN, without the joint ventures, was $57.1 million. Duff & Phelps used a market and a capitalized cash flow approach to estimate the value of ECHN's joint ventures as $13.1 million. The total estimated fair market value for ECHN as determined by Duff & Phelps, therefore, is $70.2 million. As such, Duff and Phelps was able conclude in its fairness opinion that "the consideration to be received by [ECHN] in the

[13] The OAG has previously concluded that ECHN exercised due diligence in selecting Duff & Phelps to perform the independent fairness evaluation on its behalf.

Proposed Transaction is fair from a financial point of view to the Company." (Exhibit Q7-4, Duff & Phelps' Fairness Opinion Letter, p. 836.)

Navigant was hired though an RFP process to be the OAG's financial expert for the purposes of reviewing this transaction. Navigant has also concluded that ECHN will receive fair market value for the transfer of its assets.[14] In performing its fair market value analysis, Navigant considered the three generally accepted approaches to value: income, market, and cost. Navigant valued ECHN's assets as value-in-continued use, as part of a going concern. Based upon these valuation methods, Navigant estimated the total fair market value of ECHN, including the joint ventures, to be $63,750,000. Navigant's analysis supports the conclusion that ECHN will receive fair market value for the transfer of its assets.

Based on the independent financial assessments of two respected hospital valuation firms, and the lack of evidence to the contrary in the record, we conclude that ECHN will receive fair market value for its assets.

E. The fair market value of the assets has not been manipulated by any person in a manner that causes the value of the assets to decrease.

Pursuant to Conn. Gen. Stat. § 19a-486c(a)(5), the Attorney General shall disapprove the proposed transaction as not in the public interest if he determines that the fair market value of the nonprofit hospital's assets has been manipulated by any person in a manner that causes the value of the assets to decrease.

Navigant performed reviews of ECHN's financials and assets and found no indication that the fair market value of ECHN's assets had been manipulated. No

[14] Navigant's report is attached hereto as Exhibit A.

intervenor or other participant in the proceeding has offered any evidence that the fair market value of ECHN's assets has been manipulated to artificially lower the payment price. Based on these factors, we conclude that the fair market value of ECHN's assets has not been manipulated.

F. The financing of the transaction will not place ECHN's assets at an unreasonable risk.

Pursuant to Conn. Gen. Stat. § 19a-486c(a)(6), the Attorney General shall disapprove the proposed transaction as not in the public interest if he determines that the financing of the transaction by the nonprofit hospital will place the nonprofit hospital's assets at an unreasonable risk. Consistent with the OAG's interpretation of this provision in *Sharon*, we interpret this statutory provision to require our examination of the proposed financing of the transaction to ensure that the APA does not "burden the for-profit entity with so much debt that the transferred assets of the former nonprofit hospital, albeit now operated for profit, will be placed at an unreasonable financial risk of closure or bankruptcy—an event that would result in a loss of healthcare for the affected community." *In re Sharon Hospital*, Docket No. 01-486-01, p. 64 (2001).

Based upon the record, we conclude that the financing of this transaction will not place ECHN's assets at risk. PMH confirmed on the record that the $105 million purchase price for ECHN's assets will be financed with operating cash from PMH. More specifically, PMH represented that it has the financial capacity to provide the necessary capital to purchases ECHN's assets without transaction-specific financing arrangements. After its review of the transaction, Navigant concluded that PMH will not incur any debt financing to consummate the transaction, and so, ECHN's assets would not be put at an unreasonable risk.

As such, we conclude that the assets of ECHN will not be placed at an unreasonable risk due to the financing of the transaction.

G. The management contract contemplated under the transaction is for reasonable fair value.

Pursuant to Conn. Gen. Stat. § 19a-486c(a)(7), the Attorney General shall disapprove the proposed transaction as not in the public interest if he determines that any management contract contemplated under the transaction is not for reasonable fair value. No management contract is contemplated under the APA. Accordingly, we conclude that this element of the analysis has been met.

H. Assuming compliance with the modifications imposed below, a sum equal to the fair market value of ECHN's assets is being transferred to the New Foundation to provide only for charitable health care services in the affected community.

Pursuant to Conn. Gen. Stat. § 19a-486c(a)(8), the Attorney General shall disapprove the proposed transaction as not in the public interest if he determines that:

> a sum equal to the fair market value of the nonprofit hospital's assets (A) is not being transferred to one or more persons to be selected by the Superior Court who are not affiliated through corporate structure, governance or membership with either the nonprofit hospital or the purchaser, unless the nonprofit hospital continues to operate on a nonprofit basis after the transaction and such sum is transferred to the nonprofit hospital to provide health care services, and (B) is not being used for one of the following purposes: (i) For appropriate charitable health care purposes consistent with the nonprofit hospital's original purpose, (ii) for the support and promotion of health care generally in the affected community, or (iii) with respect to any assets held by the nonprofit hospital that are subject to a use restriction imposed by a donor, for a purpose consistent with the intent of said donor.

This provision in the Conversion Act advances the important policy that the value of the nonprofit hospital be preserved for charitable healthcare purposes in the service area that the nonprofit hospital previously served. In addition, it restates the OAG's statutory

responsibility to protect the public interest in the protection of gifts made for charitable or public purposes codified at Conn. Gen. Stat. § 3-125.

The language of Conn. Gen. Stat. § 19a-486c(a)(8) requires the OAG to assess several different issues in connection with the APA. We must first analyze, determine, and approve a value that is the "sum equal to the fair market value of the nonprofit hospital's assets." Second, we must analyze the nature and purpose of the entity to which that sum is being transferred. Third, we must determine and require that the transferred sum is used only for the statutorily identified charitable purposes. Last, we are required to inventory all gift documents and restricted charitable assets currently held by ECHN and identify any approximation and/or equitable deviation needs in connection with these assets.

1. *A Sum Equal to the Fair Market Value of ECHN is Being Transferred to the New Foundation.*

The term "fair market value" is used in several places in subsection (a) of § 19a-486c. As discussed in the OAG's *Sharon* decision, and more fully below, fair market value has two distinct meanings depending on which section of the Conversion Act the term is used.

Subsection (4) of § 19a-486c requires us to ensure that the nonprofit hospital receives fair market value for its assets. As discussed earlier, subsection (4) defines "fair market value" as the likely price that the assets would bring in a sale in a competitive and open market. Subsection (4) is looking for the gross asset value.

If fair market value were computed for purposes of subsection (8) as it is for subsection (4), though, the nonprofit hospital might be left transferring to a conversion foundation the proceeds of its sale, but leaving the nonprofit hospital no ability to pay off its liabilities post-closing with some portion of those proceeds. Such a result is nonsensical, because a primary goal of a nonprofit hospital's sale of assets is the extinguishment of

corporate liabilities. For example, in the case of ECHN, its long-term bond debt will be paid off with proceeds from the sale of its assets.

The definition we use for fair market value for purposes of subsection (8), therefore, is more appropriately the price paid for the nonprofit hospital's asset minus the amount of its debt obligations and other liabilities that it will resolve using the proceeds of the proposed transaction. In other words, fair market value equals the net proceeds of the nonprofit hospital. *In re Sharon Hospital*, OAG Docket No. 01-486-01, p. 69 (2001). With respect to ECHN, the net asset value calculation must take into account all retained assets and liabilities, including, for example, cash, accounts receivable, any adjustment to the net working capital figure, its long-term debt, workers' compensation and medical malpractice liability relating to events occurring prior to closing, and any payor liabilities and obligations from reporting periods prior to closing.

Late Filed Exhibit 8 (App., p. 4261) sets forth the most current numbers on what proceeds will remain after netted with ECHN's liabilities. In short, this exhibit projects that nothing will remain after ECHN pays off its liabilities. In fact, it appears that ECHN will not even have sufficient assets to fund the indemnity reserve or to fully pay for its liabilities in excess of $77 million (the excess liability is currently tallied at $7,924,000), both obligations of ECHN. Given these numbers, we conclude that the sum that is equal to the fair market value of ECHN is currently zero.

However, the post-transaction nonprofit ECHN, Legacy ECHN, may receive funds after the close. For example, Legacy ECHN may receive reimbursements due from Medicare and Medicaid for the years prior to the closing. Also, Legacy ECHN will receive income from the unrestricted endowments during the time period between the close of the transaction and the Superior Court order that will transfer all charitable assets from

Legacy ECHN to the New Foundation. Moreover, Legacy ECHN, including Legacy MMH and Legacy RGH, may receive charitable distributions from pending estates, i.e., the Damato estate. This income will initially be used to pay off ECHN's liabilities and to fund the indemnity reserve, both obligations of ECHN.[15] After these obligations are paid or funded, however, any funds remaining would constitute net proceeds.

Because the final net proceeds value of the nonprofit hospital cannot be precisely identified prior to the actual closing of the transaction, the determination of a sum equal to the fair market value for the purposes of subsection (8) must await a post-closing accounting. Accordingly, as soon as reasonably possible after the Applicants have agreed to a Final Closing Statement of the asset purchase, the Applicants must provide the OAG a final accounting of the transaction that sets forth the balance sheets of ECHN immediately prior to, and Legacy ECHN immediately after, the closing and that provides a net proceeds analysis, substantially similar to Late Filed Exhibit 8 with explanations of any changes to the figures. This requirement is a condition of approval for the proposed transaction.

Additionally, because Legacy ECHN will receive income post-closing that may constitute net proceeds, Legacy ECHN shall, as a condition to the OAG's approval of the transaction, report quarterly to the OAG regarding (1) any and all income received by Legacy ECHN post close, including, but not limited to, Medicare and Medicaid reimbursements, income from charitable assets held by Legacy ECHN prior to transfer to the New Foundation, and any additional charitable funds received, and (2) all expenditures for Legacy ECHN.

---

[15] Legacy ECHN could also use these funds to finance wind-down costs, but Exhibit 8 already includes a line item for "Post-closing Pool 'Wind Down' Funds." Regardless, wind down costs are an appropriate expense for Legacy ECHN.

Last, if the transaction ultimately produces net proceeds, that amount will be transferred to the New Foundation for use consistent with the charitable purpose of the New Foundation.

2. The Nature of the Conversion Foundation Complies with the Conversion Act.

The Conversion Act requires that the net asset value of the nonprofit hospital be transferred to "one or more persons to be selected by the Superior Court who are not affiliated through corporate structure, governance or membership with either the nonprofit hospital or the purchaser, unless the nonprofit hospital continues to operate on a nonprofit basis after the transaction and such sum is transferred to the nonprofit hospital to provide health care services." Conn. Gen. Stat. § 19a-486c(8)(A). This provision prohibits improper affiliation with the new for-profit hospital.

ECHN has submitted a draft certificate of incorporation ("COI") and draft bylaws for the New Foundation. By these submissions, ECHN is proposing to create an "independent conversion foundation." This particular type of foundation is completely independent from both the nonprofit hospital and the for-profit purchaser and must be approved by the Superior Court. There can be no affiliation by corporate structure, governance, or membership.

The draft documents comply with the requirements of the statute. The New Foundation will have no corporate relationship with PMH/ECHN, and the governing members of the New Foundation will not contemporaneously serve in any governing position at PMH/ECHN or at any of its affiliates. In addition, any individual who serves as member of a governing board at PMH/ECHN must wait two years before serving on the governing board of the New Foundation. (Exhibit Q10-2, New Foundation Bylaws (Draft), pp. 917-18.) The New Foundation meets the affiliation requirements of § 19a-486c(8)(A).

The New Foundation will also be operated for the proper purposes, as set forth in the Conversion Act. Section 19a-486c(a)(8)(B) provides that the New Foundation must be operated:

> (i) For appropriate charitable health care purposes consistent with the nonprofit hospital's original purpose, (ii) for the support and promotion of health care generally in the affected community, or (iii) with respect to any assets held by the nonprofit hospital that are subject to a use restriction imposed by a donor, for a purpose consistent with the intent of said donor . . . ."

§ 19a-486c(a)(8)(B).

In its draft COI, the New Foundation lists it purposes as follows:

> (a) To maintain and improve the health of the residents of the area historically served by Eastern Connecticut Health Network, Inc., Manchester Memorial Hospital, Inc., and Rockville General Hospital, Inc., specifically, the nineteen communities of Manchester, Vernon (including Rockville), Andover, Ashford, Bolton, Columbia, Coventry, East Hartford, East Windsor, Ellington, Glastonbury, Hebron, Mansfield, Somers, South Windsor, Stafford, Tolland, Union, and Willington (the "Communities");
>
> (b) To support or conduct community health needs assessments and encourage and support efforts to improve the health of the Communities, including the poor, the elderly, the disabled, children, and other underserved and at-risk populations;
>
> (c) To support and engage in community projects, activities, and programs that will improve access to care and enhance the health of residents, including, but not limited to, preventative health programs and health education;
>
> (d) To solicit and accept additional funds to support the Corporation's purposes, and to make grants and provide financial and other support to other non-profit organizations engaged in activities that further the Corporation's purposes;
>
> (e) To support and promote the education and training of medical professionals and providers in the area;
>
> (f) To work cooperatively with Prospect Medical Holdings, Inc. ("PMH") to ensure and augment a network of affordable and accessible health and medical care in the region; provided, however, that the

> Corporation will not support programs operated by or for the direct benefit of PMH while it operates as a for profit entity; and
>
> (g) To engage in any lawful act or activity for which a corporation may be organized under the Revised Nonstock Corporation Act of the State of Connecticut in furtherance of the foregoing.

(Exhibit Q10-1, Certificate of Incorporation (Draft), pp. 911-12.) These purposes are consistent with the requirements in the Conversion Act.

3. The Transferred Sum Will Be Used Only for the Statutorily Identified Charitable Purposes.

ECHN currently predicts that it will have no net proceeds to transfer to the New Foundation after the closing. Should a subsequent accounting of the transaction reveal net proceeds, however, we must ensure that they will forever be used for their proper charitable purpose. The draft COI established the proper charitable purposes, but the primary mechanism to ensure that they will be used as such forever is the requirement that the New Foundation Board receive the consent of the Attorney General for the amendment of specific sections of the COI, specifically, paragraphs 2, 5, 8, and 14. In this way, the purposes of the New Foundation (paragraph 2 of the COI) cannot change unless the Attorney General agrees. Accordingly, as a condition to the Attorney General's approval of the Application, the New Foundation must include paragraph 14 in the draft COI in the final COI of the New Foundation, requiring Attorney General approval for changes to paragraphs 2, 5, 8, and 14 of the Certificate of Incorporation.

4. Description and Quantification of the Nonprofit Hospital's Charitable Assets to be Held by the New Foundation

Our final area of concern is to ensure that the charitable assets of ECHN, which have been held in trust for the public, are safeguarded and used for the promotion of

healthcare in the area served by ECHN after the sale of its assets to PMH. We must also ensure that any restrictions contained in these charitable gifts and trusts are protected.

a. Purpose of Attorney General's Review of Charitable Gifts

A full analysis and review of ECHN's charitable gifts and trusts at this time is essential for several reasons. First, it permits us to fulfill our statutory obligation to ensure that all of ECHN's charitable gifts and trusts are used for a purpose consistent with the intent of the donor. In other words, this review ensures that ECHN's analysis and treatment of charitable funds in the Application correctly interprets the donors' charitable use restrictions. Second, it ensures that, with respect to the charitable gifts, no aspect of the transaction is "prohibited by Connecticut statutory or common law governing nonprofit entities, trusts or charities." Conn. Gen. Stat. § 19a-486c(a)(1). Finally, it provides subsequent holders of the funds, i.e., the New Foundation, with accurate information about whether and how the gifts are restricted under Connecticut law so that it can administer them in accordance with donor restrictions, charities law, the terms of the contractual agreements, and modifications required in this decision.

b. Documents Reviewed and Legal Standards

As part of the Application, ECHN provided a review and analysis of its charitable gifts and endowments. (Exhibit Q11-1, Detail on Specific Funds, p. 927-976.) ECHN was required to provide copies of the gift instruments (including wills, inter vivos trust agreements, and documentation of inter vivos gifts), to document the current values of the funds, and to describe the donor's restrictions or directives reflecting how the gift was to be used by ECHN. The purpose of the OAG's request was to obtain the information necessary to: (1) review the gift instrument for each of ECHN's gifts to determine whether its language would permit the gift to be transferred to another nonprofit, or whether a reverter

clause or gift-over provision would be triggered by the sale of assets that would require the donation to revert to a different person, and (2) determine whether the donor restricted the use of a fully expendable gift, or the income earned on an endowment fund, to a particular charitable purpose set out in the gift instrument, for example, free beds, charity care, maintenance, a building fund, or research.

The OAG reviewed each charitable gift and its supporting documentation to confirm the accuracy of ECHN's conclusions regarding the proper charitable purpose of the fund and any spending restrictions on the fund.

c. Amount Stated by Hospital in Application

ECHN has stated that as of September 30, 2015, it held $23,356,291 in charitable assets, plus an additional $19,349 in special funds. Thus, according to its figures as of that date, it held a total of $23,375,640 in charitable gifts. In addition, the value of trusts held by third parties for the benefit of ECHN was $10,809,693 as of September 30, 2015.

We asked ECHN to update the value of the funds as of March 31, 2016, in a late filed exhibit. As of that date, it held $23,106,027 in charitable assets, plus an additional $9,979 in special funds. Thus, according to its figures as of that date, it held a total of $23,116,006 in charitable gifts.

To finance the transaction with PMH and to pay off its most significant liabilities, however, ECHN will need to use the net appreciation of the unrestricted endowments. (App., p. 55.) As such, the value of the charitable funds that will be transferred to the New Foundation will be approximately $5,900,000.

d. ECHN's Charitable Gifts and Trusts.

The law on approximation, or cy pres, is well-developed in Connecticut. Indeed, the OAG brought an approximation action in the *Sharon* matter to address those charitable

purposes that could no longer be fulfilled due to the sale of Sharon Hospital's assets. In that case, the court set forth the standards for approximation.

> In determining the construction of a charitable trust upon the failure of its stated purpose, the court applies the common law doctrine of cy pres, or approximation to as near as possible reflect the donor's intent. When it becomes illegal or otherwise impossible to carry out the terms of a charitable trust, rather than allow it to fail, the court will apply the doctrine of cy pres or approximation in order to carry out the charitable intentions of the donor as near as possible. "The rule of cy pres is a rule for the construction of instruments in equity, by which the intention of the party is carried out *as near as may be,* when it would be impossible or illegal to give it literal effect . . . The doctrine of cy pres may be applied without the consent of the donor." (Citations omitted; emphasis in original; internal quotation marks omitted.) *Carl J. Herzog Foundation, Inc. v. University of Bridgeport, 243 Conn. 1, 10 n.8, 699 A.2d 995 (1997).*

Blumenthal v. Sharon Hosp., Inc., 2003 Conn. Super. LEXIS 1657, 11-12 (Sup. Ct. 2003).

Also relevant to the conversion of a nonprofit hospital is the law on equitable deviation, which is similar to that of approximation but concerns the administration of a gift fund and not its charitable purpose. The equitable doctrine of deviation has been applied to preserve the "dominant [charitable] purpose by modifying what is described as [a] secondary purpose, often the method or means for carrying out the dominant purpose." 8 G. Bogart, Trusts and Trustees (2d Ed. Rev.Repl.1991) § 396, p. 330. Courts use this legal doctrine to order a change in the administration of a charitable fund from one charitable entity to another. Equitable deviation will be necessary in this case to move the charitable funds from ECHN to the New Foundation or another appropriate entity.

The Attorney General's office inventoried the gift documents in Section IV(E) in the Findings of Facts. Based upon this inventory and ECHN's and our analysis of these charitable gifts, we have determined that as a condition of approval, the following actions must be taken with respect to these funds.

i. Unrestricted Endowments.

An endowment fund is defined as "an institutional fund or any part thereof not wholly expendable by the institution on a current basis under the terms of a gift instrument." Conn. Gen. Stat. § 45a-535a(2). The institution that holds an endowment fund cannot fully expend such fund, but may only appropriate so much of an endowment's funds for expenditure or accumulation as the institution determines to be prudent for the uses, benefits, purposes for which the endowment fund is established. Unless stated otherwise in a gift document, the assets in an endowment fund are donor-restricted assets until appropriated for expenditure by the institution. Conn. Gen. Stat. § 45a-535c(a).

As a condition to the OAG's approval of the Application, Legacy ECHN must present to the Superior Court, in coordination with the OAG, a petition for equitable deviation and approximation to transfer these funds to the New Foundation or another appropriate entity and to change the charitable purpose of the unrestricted endowments to the charitable purpose of the New Foundation. This condition applies to all unrestricted endowments, whether held by MMH, RGH, or the ECHN Community Healthcare Foundation, Inc.

ii. Restricted Endowments

The Conversion Act requires the recipient of the hospital's gift funds to use assets that are subject to a use restriction imposed by a donor for purposes that are consistent with the intent of the donor. Conn. Gen. Stat. § 19a-486c(a)(8)(B)(iii).

With respect to ECHN's restricted endowments, most of the charitable purposes can be fulfilled even though the funds will not be held by a hospital. For example, a free bed fund, which is used to provide charity care at a hospital, can still be used to pay for hospital bills for indigent individuals. These funds will simply need to be transferred to the New Foundation; no change in charitable purpose is needed. There are, however, several

restricted endowments that will need their charitable purposes adjusted by the Superior Court as a result of the sale of ECHN's assets to a for-profit entity.

The Thomas D. Trotter Fund was given for the benefit of pediatric patients. The Julia and Percy Baker Family Memorial Fund was given for the benefit of the upkeep and physical maintenance of RGH. The Faith S. Schortman Fund was given for the benefit of the operation or improvement of the maternity or nursery facilities at RGH. These three funds must be modified so that no charitable income benefits PMH/ECHN.

Accordingly, as a condition to the OAG's approval of the Application, Legacy ECHN must, in coordination with the OAG, include the restricted endowments in the petition for equitable deviation and approximation that will be presented to the Superior Court. With respect to Trotter, Baker, and Schortman, Legacy ECHN must seek an order of approximation for each fund, in addition to one for equitable deviation, to adjust the fund's charitable purpose to one as close as possible to the donor's original charitable intent.

iii. Special Funds

ECHN has categorized eleven (11) funds as special purpose funds. Similar to restricted endowments, these funds have a specific purpose for which they are used. Unlike the restricted endowments, however, these funds can be completely used up; they are fully expendable. Therefore, to the extent that there is any money remaining in a special fund at the time the transaction closes, that fund will need to be a part of the equitable deviation and approximation action in order to transfer it and adjust its charitable purpose, if necessary.

Accordingly, as a condition to the OAG's approval of the Application, Legacy ECHN must, in coordination with the OAG, include any special fund for which any funds remain

in the petition for deviation and approximation that will be presented to the Superior Court.

iv. Trust Held by Outside Trustees.

The last category of funds that the OAG must address as part of its hospital conversion review responsibilities are those charitable assets held by third parties for which ECHN holds the beneficial interest. ECHN has identified ten third party trusts for which it holds the beneficial interest.

In each of the ten cases identified by ECHN, the sale of ECHN's assets will not affect the structure of the trust, i.e., will not require the transfer of the trust to another entity. What may be necessary, however, is a switch of the charitable beneficiary and an adjustment to the trust's charitable purpose. Also important in the third-party trust analysis is whether the donors have directed that the charitable funds go elsewhere or have given the third-party trustees the power to redirect the charitable funds themselves if ECHN were to sell substantially all of its assets. If not, then the trusts must be presented to a court for legal disposition. Consultation with the third-party trustees is necessary in these cases.

Under Connecticut charities law, a gift to one charity, with language providing for a substitution or gift over to another charity upon certain conditions, has long been valid. *See Colonial Trust Co. v. Waldron*, 112 Conn. 216, 233 (1930); *Christ Church v. Trustees*, 67 Conn. 554, 565-66 (1896). When a gift contains an alternate disposition of a fund in case of the failure of the bequest, the equitable doctrine of approximation does not apply. See *Hartford National Bank & Trust Co. v. Oak Bluffs First Baptist Church*, 116 Conn. 347, 351 (1933); *First Congregational Society of Bridgeport v. City of Bridgeport*, 99 Conn. 22, 31-32

(1903); 4 Scott, Trusts (4th Ed.) § 399.2, p. 495-96; Restatement (Second), 2 Trusts § 399, comment c. "The provision for a gift over upon failure of the charity negatives the existence of a general charitable intent, just as the absence of such a provision is evidence of such a purpose." *Connecticut Bank & Trust v. Cyril and Julia C. Johnson Mem. Hosp.*, 30 Conn. Supp. 1, 8 (1972), citing Bogert, Trusts and Trustees (2d Ed.) § 437, p. 426.

Accordingly, as a condition to the OAG's approval of the Application, Legacy ECHN must, in coordination with the OAG and the third-party trustees, bring any third-party trust in need of construction or approximation before a court of competent jurisdiction for appropriate orders.

v. Miscellaneous

The Life Insurance Policy (11-1.31) for which MMH is the beneficiary shall be included in the Superior Court petition for an order of equitable deviation if the insured is still living at that time. Otherwise, the distribution of the insurance proceeds shall be included in the net proceeds of the transaction and treated as such.

ECHN's portion of the distribution in the Damato estate (and any other unrestricted gift to ECHN), if distributed prior to the Superior Court order transferring ECHN's charitable assets to the New Foundation or other charitable organization, shall be included in the net proceeds of the transaction and treated as such.

vi. Future Interests

To the extent there are future charitable interests for the benefit of ECHN, the disposition of those interests will be addressed on a case-by-case basis by a court under the doctrine of approximation. Only when a future interest becomes a present interest can a probate or superior court determine to whom the remainder will pass or whether the gift will fail and revert to the donors' heirs-at-law. Therefore, any future interests that have

not yet vested cannot be included in the Superior Court action to address the identified charitable funds.

5. ECHN Must Present the New Foundation and its Restricted Charitable Funds to the Superior Court for Approval and Approximation and Deviation Orders.

Although the Attorney General has approved the purposes of the New Foundation and the other provisions in the draft COI and bylaws, ECHN will be required to present the New Foundation to the Superior Court for its approval and will need to have the court enter orders of approximation and equitable deviation to transfer the charitable assets to the New Foundation, or other eligible entity. The Office of the Attorney General shall participate in this action.

I. ECHN and PMH Have Provided The Attorney General With Information And Data Sufficient To Evaluate The Proposed Joint Venture.

Pursuant to Conn. Gen. Stat. § 19a-486c(a)(9), the Attorney General shall disapprove the proposed transaction as not in the public interest if he determines that the nonprofit hospital or the purchaser has failed to provide the Attorney General with information and data sufficient to evaluate the proposed agreement adequately, provided the Attorney General has notified the nonprofit hospital or the purchaser of the inadequacy of the information or data and has provided a reasonable opportunity to remedy such inadequacy. The Applicants have provided all relevant information and sufficient data to evaluate adequately the proposed APA.

VII. CONCLUSION

The OAG therefore concludes that the Application for an asset purchase by PMH of substantially all of the assets of ECHN is hereby approved subject to the modifications and conditions listed herein.

Correction: On the below date, the Office of the Attorney General issued this corrected version of its Final Opinion wherein it has changed the reference in Condition 1 on page 7 from 5.18(a) to 5.18(b) to correspond to the legal discussion of the capital commitment on pages 31 – 32 of the decision.

Date: 7/1/16

GEORGE JEPSEN
ATTORNEY GENERAL

Greer, Leslie

From: Lazarus, Steven
Sent: Tuesday, July 19, 2016 3:29 PM
To: Kathleen Gedney
Cc: Michele Volpe; Jennifer O'Donnell; Hansted, Kevin; Martone, Kim; Riggott, Kaila; Greer, Leslie
Subject: RE: Docket No. 15-32016-486 and 15-32017-486 - Confirmation of approval of Supplemental Imaging Applications

Good Afternoon,

I double checked with OHCA's legal advisor and we can confirm that the two decisions rendered under Docket Numbers: 15-32016-486 and 15-32017-486, include all the assets requested in the two applications, including the MRI, CT and PET/CT scanners requested to be acquired by PMH in the supplemental applications filed in the two dockets. I will place a copy of this email in the original files for the two dockets for future reference. If you have any additional questions, please do not hesitate to contact us.

Sincerely,

Steven

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

From: Kathleen Gedney [mailto:kgg@bvmlaw.com]
Sent: Friday, July 15, 2016 3:29 PM
To: Lazarus, Steven
Cc: Michele Volpe; Jennifer O'Donnell
Subject: Docket No. 15-32016-486 and 15-32017-486 - Confirmation of approval of Supplemental Imaging Applications

Hi Steven:

Thank you for speaking with me yesterday about the supplemental advanced imaging applications included in both the Eastern Connecticut Health Network, Inc. ("ECHN") and Greater Waterbury Health Network, Inc. ("GWHN") Conversion Applications.

In our call yesterday, you stated that it was OHCA's position that the three supplemental applications filed with the ECHN Conversion Application re Docket No. 15-32016-486 ((1) Acquisition of Manchester Memorial Hospital's MRI, PET/CT and CT scanners as part of the Proposed Asset Purchase of Eastern Connecticut Health Network, Inc. by Prospect Medical Holdings, Inc.; (2) Acquisition of Rockville General Hospital's MRI and CT scanner as part of the Proposed Asset Purchase of Eastern Connecticut Health Network, Inc. by Prospect Medical Holdings, Inc.; and (3) Acquisition of Rockville General Hospital's off-site MRI and CT scanner as part of the Proposed Asset Purchase of Eastern Connecticut Health Network, Inc. by Prospect Medical Holdings, Inc.) are approved as part of the Final Decision re Docket No. 15-32016-486. In lieu of any formal correspondence from OHCA regarding the approval of these supplemental applications, would you kindly confirm by responding to this email that the above statement is accurate?

Additionally, please confirm that the GWHN Final Decision Docket No. 15-32017-486 issued today similarly approves the supplemental application (Acquisition of Waterbury Hospital's CT scanners as part of the Proposed Asset Purchase of Greater Waterbury Health Network, Inc. by Prospect Medical Holdings, Inc.) filed with Conversion Application Docket No. 15-32017-486?

Thank you very much,

Kathleen Gedney-Tommaso
Attorney at Law
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Greer, Leslie

From: Lazarus, Steven
Sent: Thursday, August 18, 2016 11:23 AM
To: Greer, Leslie
Cc: Riggott, Kaila; Cotto, Carmen; Roberts, Karen
Subject: FW: OAG Docket No. 15-486-01 / OHCA Docket No. 15-32016-486 - Closing Date
Attachments: ECHN Notice of Closing Date.pdf

Please add to the original file.

Thank you,

Steve

Steven W. Lazarus
Associate Health Care Analyst
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Connecticut Department of Public Health
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Phone: 860-418-7012
Fax: 860-418-7053

From: Kathleen Gedney [mailto:kgg@bvmlaw.com]
Sent: Thursday, August 18, 2016 10:57 AM
To: Hansted, Kevin; Hawes, Gary W.; Martone, Kim; Lazarus, Steven
Cc: Zinn-Rowthorn, Perry A.; Salton, Henry A.; 'RMatthews@wiggin.com'; 'jtichy@echn.org'; Jonathan Spees; Michele Volpe; Jennifer O'Donnell
Subject: OAG Docket No. 15-486-01 / OHCA Docket No. 15-32016-486 - Closing Date

Please see attached regarding the closing date in the above captioned matter.

Kathleen Gedney-Tommaso
Attorney at Law
Bershtein, Volpe & McKeon P.C.
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Michele M. Volpe
203-777-6995

August 17, 2016

VIA EMAIL AND US MAIL (kevin.hansted@ct.gov; gary.hawes@ct.gov; Kimberly.martone@ct.gov; steven.lazarus@ct.gov)

Attorney General George Jepsen
Office of the Attorney General
55 Elm Street, P.O. Box 120
Hartford, Connecticut 06141-0120

Deputy Commissioner Janet M. Brancifort, MPH, RRT
Department of Public Health
410 Capitol Avenue
Hartford, Connecticut 06134

Re: Revised Closing Date for Eastern Connecticut Health Network, Inc. and Prospect Medical Holdings, Inc. – OHCA Docket No. 15-31216-486 and Attorney General Docket No. 15-486-01

Dear Mr. Jepsen and Ms. Brancifort:

On behalf of Prospect Medical Holdings, Inc. in connection with the above referenced matters, this letter shall serve as written notice to your respective offices regarding the closing date of the transaction. On July 21, 2016, we sent written notification that the closing date was scheduled for September 1, 2016. Please note that the closing has since been rescheduled for **October 1, 2016** subject to satisfaction of all required closing conditions. With respect to Condition 2 of the Attorney General Final Decision, this letter shall serve as the requested written notice of any change in closing date. Should this date change again, we will notify your respective offices of such new closing date.

If you have any questions or require anything further, please contact me at 203-777-6995. Thank you for your assistance in this matter.

Very truly yours,

Michele M. Volpe,
Bershtein, Volpe & McKeon, P.C.

Cc: Kimberly Martone, Director of Operations, Department of Public Health Division of Office of Health Care Access
Steven Lazarus, Associate Health Care Analyst, Department of Public Health Division of Office of Health Care Access
Kevin Hansted, Staff Attorney, Department of Public Health Division of Office of Health Care Access
Perry Zinn Rowthorn, Deputy Attorney General, Office of the Attorney General
Henry Salton, Assistant Attorney General, Office of the Attorney General
Gary Hawes, Associate Attorney General, Office of the Attorney General
Rebecca Matthews, Wiggin and Dana LLP
Joyce Tichy, Eastern Connecticut Health Network, Inc.
Jonathan Spees, Prospect Medical Holdings, Inc.

Greer, Leslie

From: Martone, Kim
Sent: Tuesday, September 13, 2016 8:05 AM
To: Greer, Leslie
Subject: FW: PMH/ECHN re CA DPH Survey Letter-OHCA Docket No. 15-32016-486 and Attorney General Docket No. 15-486-01
Attachments: PMH ECHN re CA DPH Survery Letter.pdf; CSMS Survey Letter.pdf

Kimberly R. Martone
Director of Operations, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134
Phone: 860-418-7029 Fax: 860-418-7053
Email: Kimberly.Martone@ct.gov *Website:* www.ct.gov/ohca

From: Jennifer O'Donnell [mailto:jlo@bvmlaw.com]
Sent: Monday, September 12, 2016 4:23 PM
To: Martone, Kim; Lazarus, Steven; Hansted, Kevin; McLellan, Rose; Cass, Barbara; Zinn-Rowthorn, Perry A.; Salton, Henry A.; Hawes, Gary W.; Shapiro, Daniel R.; Matthews, Rebecca; Tichy, Joyce A
Cc: Michele Volpe; Jonathan Spees; 'Von.crockett@prospectmedical.com'; Martone, Kim
Subject: PMH/ECHN re CA DPH Survey Letter-OHCA Docket No. 15-32016-486 and Attorney General Docket No. 15-486-01

All: Attached please find correspondence in connection with the above captioned matter. Thank you.

Jennifer L. O'Donnell
Paralegal
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor
New Haven, Connecticut 06511-6957
Telephone: (203) 777-5800 (ext. 104)
Direct Line: (203) 777-5804
Facsimile: (203) 777-5806

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BERSHTEIN, VOLPE & McKEON, P.C.
ATTORNEYS AT LAW
105 COURT STREET—THIRD FLOOR
NEW HAVEN, CONNECTICUT 06511
TELEPHONE: (203) 777-5800
FACSIMILE: (203) 777-5806

Michele M. Volpe
203-777-6995

September 12, 2016

VIA EMAIL AND US MAIL

Attorney General George Jepsen
Office of the Attorney General
55 Elm Street, P.O. Box 120
Hartford, Connecticut 06141-0120

Deputy Commissioner Janet M. Brancifort, MPH, RRT
Department of Public Health
410 Capitol Avenue
Hartford, Connecticut 06134

Re: Prospect Medical Holdings, Inc./Eastern Connecticut Health Network, Inc. re California Department of Public Health Survey Letter re Southern California Hospital – OHCA Docket No. 15-32016-486 and Attorney General Docket No. 15-486-01

Dear Mr. Jepsen and Ms. Brancifort:

For your records and as a follow up to Prospect Medical Holdings proposed acquisition of Eastern Connecticut Health System entities, attached please find a letter from the California Department of Public Health dated September 8, 2016 clearing Southern California Hospital, a Prospect Medical Holdings entity, from the CSMS licensure termination track.

If you have any questions or require anything further, please contact me at 203-777-6995. Thank you for your assistance in this matter.

Very truly yours,

Michele M. Volpe,
Bershtein, Volpe & McKeon, P.C.

Cc: Kimberly Martone, Director of Operations, Department of Public Health Division of Office of Health Care Access
Steven Lazarus, Associate Health Care Analyst, Department of Public Health Division of Office of Health Care Access
Kevin Hansted, Staff Attorney, Department of Public Health Division of Office of Health Care Access
Rose McLellan, License and Application Supervisor, Facility Licensing & Investigations Section
Barbara S. Cass, R.N., Section Chief, Facility Licensing and Investigations Section
Perry Zinn Rowthorn, Deputy Attorney General, Office of the Attorney General
Henry Salton, Assistant Attorney General, Office of the Attorney General
Gary Hawes, Assistant Attorney General, Office of the Attorney General
Daniel Shapiro, Assistant Attorney General, Office of the Attorney General
Rebecca Matthews, Wiggin and Dana LLP
Joyce Tichy, Eastern Connecticut Health Network, Inc.
Jonathan Spees, Prospect Medical Holdings, Inc.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Western Division of Survey and Certification
San Francisco Regional Office
90 7th Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

CENTERS FOR MEDICARE & MEDICAID SERVICES

Refer to: WDSC- mc

09/08/2016

Administrator
Southern California Hospital at Hollywood
6245 De Longpre Ave
Hollywood, CA 90028

CMS Certification Number (CCN): 050135

Dear Administrator:

The California Department of Public Health (CDPH) has determined that Southern California Hospital at Hollywood now meets the Medicare Conditions of Participation for a provider of hospital services and therefore, this office will not proceed with a termination action. The authority for this decision is found at 42 C.F.R. § 498.20 - 498.25.

The 07/28/2016 revisit survey conducted by the CDPH determined that the hospital demonstrated compliance with Medicare Conditions of Participation (CoP) and provides the basis for the determination of CMS.

Therefore, effective the date of this letter, we are removing your facility from the CDPH survey jurisdiction and restoring your facility's deemed status, based on your continued accreditation by the DNV GL–Healthcare (DNV GL). While the survey found compliance with the CoP there are standard level deficiencies cited. The enclosed Statement of Deficiencies (CMS-2567) documents the findings of the 07/28/2016 survey.

Since your hospital has been determined to be in compliance with the CoP you do not have to submit a plan of correction for any of the Medicare survey deficiencies. However, under Federal disclosure rules a copy of the findings of this Medicare survey must be publicly disclosed within 90 days of the completion. You may therefore wish to submit for public disclosure, your comments on the survey findings, and any plans you may have for correcting the cited deficiencies.

Should you choose to submit a plan for correction, the evidence of correction is to be entered on the right side of Form CMS-2567 for both documents, opposite the deficiency, and must be signed and dated by the administrator or other authorized official. Please submit your evidence of correction to the CDPH, Los Angeles District office by close of business, within ten (10) days of receipt of this letter.

The evidence of correction of each item must contain the following:

1. How the correction was accomplished, both temporarily and permanently for each individual affected by the deficient practice, including any system changes that must be made.

2. The title or position of the person responsible for correction, i.e., Administrator, Director of Nursing or other responsible supervisory personnel.

3. A description of the monitoring process to prevent recurrences of the deficiency, the frequency of the monitoring and the individual(s) responsible for the monitoring.

4. The date when the immediate correction of the deficiency will be accomplished, normally this will be no more than thirty (30) calendar days from the date of the exit conferences.

We have forwarded a copy of this letter and the findings from this survey to the DNV GL for its review. Copies of this letter are being sent to the CDPH and the State Medicaid agency.

If you have any questions about this matter, please contact Alex Garza at 415-744-2830, or Maureen Calacal of my staff at 415-744-3727.

Sincerely,

Rufus Arther, Manager
Non-Long Term Care Branch
Division of Survey and Certification

Enclosure

Greer, Leslie

From: Martone, Kim
Sent: Thursday, October 06, 2016 1:18 PM
To: Roberts, Karen; Cotto, Carmen
Cc: Greer, Leslie
Subject: FW: Eastern Connecticut Health Network, Inc. and Prospect Medical Holdings, Inc. – OHCA Docket No. 15-32016-486
Attachments: Ltr to JBrancifort re ECHN (fwding Certs of Incorp) 10.6.16.pdf; Prospect Manchester Hospital, Inc.-CT-Cert Copy of Articles of Inc &.pdf; PROSPECT ROCKVILLE HOSPITAL, INC.-CT-Cert Copy of Articles of Inc &.pdf

Kimberly R. Martone
Director of Operations, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134
Phone: 860-418-7029 Fax: 860-418-7053
Email: Kimberly.Martone@ct.gov Website: www.ct.gov/ohca

From: Jennifer O'Donnell [mailto:jlo@bvmlaw.com]
Sent: Thursday, October 06, 2016 12:39 PM
To: Brancifort, Janet
Cc: Martone, Kim; Lazarus, Steven; Hansted, Kevin; 'ellen.shin@prospectmedical.com'; Jonathan Spees; Mcconville, Dennis P; Tichy, Joyce A; Michele Volpe
Subject: Eastern Connecticut Health Network, Inc. and Prospect Medical Holdings, Inc. – OHCA Docket No. 15-32016-486

Please see attached letter and Certificates of Incorporation from Michele Volpe. Thank you.

Jennifer L. O'Donnell
Paralegal
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor
New Haven, Connecticut 06511-6957
Telephone: (203) 777-5800 (ext. 104)
Direct Line: (203) 777-5804
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BERSHTEIN, VOLPE & McKEON, P.C.
ATTORNEYS AT LAW
105 COURT STREET—THIRD FLOOR
NEW HAVEN, CONNECTICUT 06511
TELEPHONE: (203) 777-5800
FACSIMILE: (203) 777-5806

Michele M. Volpe
Direct Dial (203) 777-6995

October 6, 2016

VIA EMAIL (janet.brancifort@ct.gov; Kimberly.martone@ct.gov; steven.lazarus@ct.gov; kevin.hansted@ct.gov)

Deputy Commissioner Janet M. Brancifort, MPH, RRT
Department of Public Health
410 Capitol Avenue
Hartford, Connecticut 06134

Re: Eastern Connecticut Health Network, Inc. and Prospect Medical Holdings, Inc. – OHCA Docket No. 15-32016-486

Dear Ms. Brancifort:

Pursuant to Condition Number Two (2.) in the Final Decision for Docket No. 15-32016-486, enclosed please find the following Certificates of Incorporation for the PMH affiliated entities that directly own, operate and hold the hospital licenses of the New MMH and New RGH:

1) Prospect Manchester Hospital, Inc.; and

2) Prospect Rockville Hospital, Inc.

Very truly yours,

Michele M. Volpe,
Bershtein, Volpe & McKeon, P.C.

Cc: Kimberly Martone, Director of Operations, Department of Public Health Division of Office of Health Care Access
Steven Lazarus, Associate Health Care Analyst, Department of Public Health Division of Office of Health Care Access
Kevin Hansted, Staff Attorney, Department of Public Health Division of Office of Health Care Access
Ellen Shin, Prospect Medical Holdings, Inc.
Jonathan Spees, Prospect Medical Holdings, Inc.
Dennis P. McConville, Senior Vice President and Chief Strategy Officer, Eastern Connecticut Health Network, Inc.
Joyce Tichy, Senior Vice President and General Counsel, Eastern Connecticut Health Network, Inc.

FILING #0005537016 PG 01 OF 04 VOL B-02179
FILED 04/12/2016 12:37 PM PAGE 00441
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

CERTIFICATE OF INCORPORATION
OF
PROSPECT ROCKVILLE HOSPITAL, INC.

(a Connecticut business corporation)

FIRST: The name of the corporation shall be PROSPECT ROCKVILLE HOSPITAL, INC. (the "Corporation").

SECOND: The authorized capital stock of the Corporation shall consist of one thousand (1,000) shares of common stock, at par value $0.01 per share.

THIRD: The common stock shall have the following rights and privileges:

(a) Voting Rights. Each holder of record of common stock shall be entitled to one vote for each share of stock held.

(b) Voting Requirements. Stockholder action on any matter whatsoever shall require the affirmative vote of at least a majority of the shares of the common stock issued and outstanding at the time of such vote, and for those matters for which the vote of a greater proportion of such shares may be specified by law, the affirmative vote of the proportion of such shares so specified shall be required.

(c) Preemptive Rights. No holder of the common stock shall be entitled as of right to purchase or subscribe for any unissued shares of the Corporation whether now or hereafter authorized or whether of a class hereafter created, or to purchase or subscribe for any bonds, certificates of indebtedness, debentures, or other obligations convertible into shares of the Corporation.

(d) Dividends. The holders of the common stock shall be entitled to receive dividends as and when declared by the Board of Directors of the Corporation.

FOURTH: The name and address of the Corporation's registered agent and office in the State of Connecticut is C T Corporation System, One Corporate Center, Hartford, Connecticut, 06103-3220.

FIFTH: The name and complete address of the incorporator is as follows:

NAME	MAILING ADDRESS
Shilpa Prem, Esq.	Epstein Becker & Green, P.C. 250 Park Ave New York, NY 10177

SIXTH: The management of the business and the conduct of the affairs of the Corporation shall be vested in a board of directors (the "Board of Directors"). The number of directors which shall constitute the whole Board of Directors shall be fixed by, or

Email None

in the manner provided in the bylaws of the Corporation. No election of directors needs to be by written ballot.

SEVENTH: The nature of the business or purposes to be conducted and promoted by the Corporation shall be to operate a licensed hospital and to engage in any lawful act or activity for which corporations may be organized under Connecticut law. The foregoing provisions of this SEVENTH Article shall be construed both as purposes and powers and each as an independent purpose and power, and shall not be held to limit or restrict in any manner the purposes and powers of the Corporation; provided that the Corporation shall not conduct any business, promote any purposes, or exercise any power or privilege within or without the State of Connecticut which, under the laws thereof, the Corporation may not lawfully conduct, promote, or exercise.

EIGHTH: The Corporation is to have perpetual existence.

NINTH: The Board of Directors of the Corporation has the power to adopt, amend, or repeal the bylaws of the Corporation.

TENTH: The personal liability of a director of the Corporation for monetary damages for breach of duty as a director shall be limited to an amount that is equal to the compensation received by the director for serving as a director of the Corporation during the year of the violation if such breach did not (A) involve a knowing and culpable violation of law by the director, (B) enable the director or an associate, as defined in Section 33-840 of the Connecticut Business Corporation Act, to receive an improper personal economic gain, (C) show a lack of good faith and a conscious disregard of the duty of the director to the Corporation under circumstances in which the director was aware that this conduct or omission created an unjustifiable risk of injury to the Corporation, (D) constitute a sustained and unexcused pattern of inattention that amounted to an abdication of the director's duty to the Corporation, or (E) create liability under Section 33-757 of the Connecticut Business Corporation Act.

ELEVENTH: (a) The Corporation shall indemnify any individual made a party to a proceeding because such individual is or was a director of the Corporation against liability incurred and expenses advanced in connection with the proceeding in all circumstances except those for which the Connecticut Business Corporation Act prohibits the limitation of such individual's liability.

(b) The Corporation shall indemnify any individual made a party to a proceeding because such individual is or was an officer of the Corporation against liability incurred and expenses advanced in connection with the proceeding to the greatest extent allowed under Connecticut General Statues Section 33-776.

IN WITNESS WHEREOF, the undersigned being the incorporator hereinbefore named, for the purpose of forming a corporation pursuant to the Connecticut Business Corporation Act, does make this Certificate, hereby declaring and certifying that this is my act and deed, that the facts herein stated are true and accordingly have hereunto set my hand this 6th day of April, 2016.

Philip F. Murphy, Esq.
Incorporator

C T Corporation System

Business Address:

One Corporate Center,
Hartford, CT 06103-3220

Acceptance of Appointment: C T Corporation System
By: _____
James Halpin, Assistant Secretary
(Signature of Agent)

STATE OF CONNECTICUT
OFFICE OF THE SECRETARY OF THE STATE } SS. HARTFORD

I hereby certify that this is a true copy of record in this Office.

In Testimony whereof, I have hereunto set my hand and affixed the Seal of said State, at Hartford, this 14TH day of APRIL A.D. 2016

SECRETARY OF THE STATE

FILING #0005536992 PG 01 OF 04 VOL B-02179
FILED 04/12/2016 12:37 PM PAGE 00386
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

CERTIFICATE OF INCORPORATION
OF
PROSPECT MANCHESTER HOSPITAL, INC.

(a Connecticut business corporation)

FIRST: The name of the corporation shall be PROSPECT MANCHESTER HOSPITAL, INC. (the "Corporation").

SECOND: The authorized capital stock of the Corporation shall consist of one thousand (1,000) shares of common stock, at par value $0.01 per share.

THIRD: The common stock shall have the following rights and privileges:

(a) Voting Rights. Each holder of record of common stock shall be entitled to one vote for each share of stock held.

(b) Voting Requirements. Stockholder action on any matter whatsoever shall require the affirmative vote of at least a majority of the shares of the common stock issued and outstanding at the time of such vote, and for those matters for which the vote of a greater proportion of such shares may be specified by law, the affirmative vote of the proportion of such shares so specified shall be required.

(c) Preemptive Rights. No holder of the common stock shall be entitled as of right to purchase or subscribe for any unissued shares of the Corporation whether now or hereafter authorized or whether of a class hereafter created, or to purchase or subscribe for any bonds, certificates of indebtedness, debentures, or other obligations convertible into shares of the Corporation.

(d) Dividends. The holders of the common stock shall be entitled to receive dividends as and when declared by the Board of Directors of the Corporation.

FOURTH: The name and address of the Corporation's registered agent and office in the State of Connecticut is C T Corporation System, One Corporate Center, Hartford, Connecticut, 06103-3220.

FIFTH: The name and complete address of the incorporator is as follows:

NAME	MAILING ADDRESS
Shilpa Prem, Esq.	Epstein Becker & Green, P.C. 250 Park Ave New York, NY 10177

SIXTH: The management of the business and the conduct of the affairs of the Corporation shall be vested in a board of directors (the "Board of Directors"). The number of directors which shall constitute the whole Board of Directors shall be fixed by, or

Email: None

in the manner provided in, the bylaws of the Corporation. No election of directors needs to be by written ballot.

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(b) The Corporation shall indemnify any individual made a party to a proceeding because such individual is or was an officer of the Corporation against liability incurred and expenses advanced in connection with the proceeding to the greatest extent allowed under Connecticut General Statues Section 33-776.

IN WITNESS WHEREOF, the undersigned being the incorporator hereinbefore named, for the purpose of forming a corporation pursuant to the Connecticut Business Corporation Act, does make this Certificate, hereby declaring and certifying that this is my act and deed, that the facts herein stated are true and accordingly have hereunto set my hand this 6th day of April, 2016.

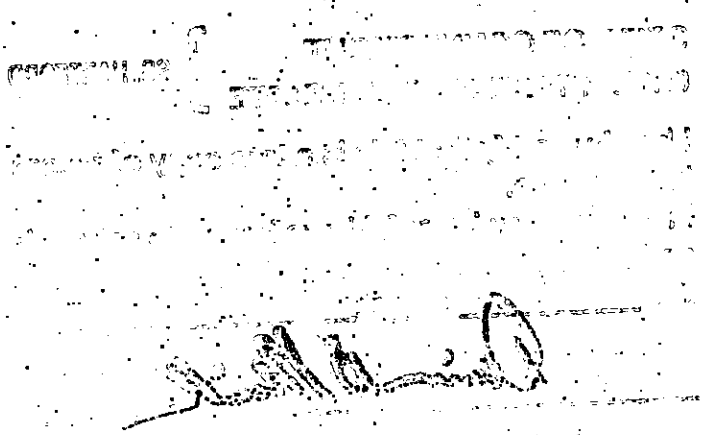
Shilpa Brentesh
Incorporator

C T Corporation System

Business Address:

One Corporate Center,
Hartford, CT 06103-3220

Acceptance of Appointment: C T Corporation System
By: _____
James Halpin, Assistant Secretary
(Signature of Agent)



STATE OF CONNECTICUT
OFFICE OF THE SECRETARY OF THE STATE } SS. HARTFORD

I hereby certify that this is a true copy of record in this Office.

In Testimony whereof, I have hereunto set my hand and affixed the Seal of said State, at Hartford, this 14th day of APRIL A.D. 2016

SECRETARY OF THE STATE

Eastern Connecticut Health Network
71 Haynes Street
Manchester, CT 06040
860.533.3414
www.echn.org

RECEIVED
OCT 20 2016
Office of
HEALTHCARE ACCESS

October 20, 2016

VIA HAND DELIVERY

Deputy Commissioner Janet M. Brancifort, MPH, RRT
Office of Health Care Access
Department of Public Health
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134

Re: **Docket Number: 15-32016-486**

Project Title: **Transfer of assets of Eastern Connecticut Health Network, Inc. to Prospect Medical Holdings, Inc.**

Dear Ms. Brancifort:

Pursuant to Condition Number One (1) of the Order for the above referenced Certificate of Need Final Decision, please find the attached schedules containing "each of MMH's and RGH's inpatient bed allocation and the location and hours of operation for all outpatient services." You will also find the staffing plans for the hospitals included. This information is published on the ECHN website.

Also, pursuant to Condition Number Three (3) of the Order, please find the attached final execution copies of the Asset Purchase Agreement with schedules and the bylaws for Prospect Manchester Hospital, Inc. and for Prospect Rockville Hospital, Inc.

If you have any questions or need anything further, please feel free to contact me at (860) 533-3429.

Very truly yours,

Dennis P. McConville
Senior Vice President
Eastern Connecticut Health Network

cc: Kimberly Martone, Director of Operations, Department of Public Health Division of Office of Health Care Access
Ellen J. Shin, General Counsel, Prospect Medical Holdings, Inc.
Joyce A. Tichy, Senior Vice President and General Counsel, ECHN
Michele M. Volpe, Bershtein, Volpe & McKeon, P.C.
Michael Collins, Interim CEO, ECHN
Jonathan Spees, Senior Vice President, Corporate Development, Prospect Medical Holdings, Inc.
Garrison De Lee, Assistant General Counsel, Prospect Medical Holdings, Inc.

Manchester Memorial Hospital and Rockville General Hospital
Inpatient Bed Allocation - Staffed Beds
As of June, 2016

Service	Manchester Memorial Hospital	Rockville General Hospital
Critical Care	15	4
Medical/Surgical Care	54	22
Behavioral Health*	31	18[1]
Maternity	20	0
Newborn	26	0
Total	146	44

Notes:
The above represents planned census for inpatient nursing beds by service based on demand for inpatient beds. Demand is measured by the historical average daily census of inpatients. The number of staffed beds is adjusted up or down in response to the daily census per the hospital staffing plans and bed availability. (See attached Staffing Plans for each hospital.)

[1] The opening of the inpatient Behavioral Health Eating Disorders Unit in August 2016 will result in staffing for 18 beds bringing the budgeted staffed beds to 44 at Rockville General Hospital.

Nurse Staffing Plan
Manchester Memorial Hospital

The nurse staffing plan at *Manchester Memorial Hospital* is developed through a comprehensive process that draws on multiple sources of data and input from registered nurses and other hospital staff members. The staffing plan is continuously evaluated throughout the year and formally reviewed and updated annually. The annual staffing plan reflects budgeted, core staffing levels for patient care units including inpatient services, critical care, and the emergency department. Actual staffing is adjusted on a daily or more frequent basis to meet patient care needs.

Considerations in Staffing Plan Development and Decisions
A broad range of factors are considered in the development of the core staffing plan and ongoing staffing adjustments, many of which are embodied in the American Nurses Association's (ANA) Principles for Nurse Staffing. Staffing plan development and decisions are carried out with consideration given to patient characteristics and acuity, the number of patients for whom care is provided, levels of individual patient as well as unit intensity, the geography/physical layout of the patient care unit, available technology, and level of preparation and experience of those providing care, among others.

In addition to the factors described above, when developing the annual staffing plan, *Manchester Memorial Hospital* considers historical staffing and patient data, staff input, patient care support services, and any plans for new programs.

1. **Professional Skill Mix For Patient Care Units**
   The professional skill mix for each patient care unit is articulated in this hospital nurse staffing plan.

   Patient Care Services utilizes a staffing matrix based on worked hours per patient day (WHPPD) for all nursing units except the emergency department. The Emergency Department staffing is based on a worked hour per patient visit metric. The worked hour metric only includes those hours worked in direct patient care responsibilities. These responsibilities include patient centered nursing activities by unit based staff such as medication administration, nursing treatments, nursing rounds, admission, transfer, discharge activities, patient teaching, patient communication, coordination of patient care, documentation time, and treatment planning. Unit based staff include RNs, LPNs, and nursing assistants.

   The core staffing plan is adjusted as necessary to meet patient care needs using per diem staff, on call staff, staff picking up extra shifts, and floating staff between units.

2. **Use of Temporary and Traveling Staff Nurses**

   Manchester Memorial Hospital does not use temporary or traveling staff nurses.

3. **Administrative Staffing**
   The annual staffing plan is developed to provide adequate direct care staff for forecasted patient care needs exclusive of nursing management and inclusive of appropriate support.

4. **Review of the Nurse Staffing Plan**
   The staffing plan that reflects core staffing levels is formally established and reviewed annually; it is evaluated as necessary throughout the year. Review of the factors articulated in the section *Considerations in Staffing Plan Development and Decisions* above is conducted through a combination of unit staff meetings, Clinical Ladder Committee, and quarterly review with nurse managers. Leadership rounds also serve as a mechanism for staffing review. Formal annual review occurs during the Clinical Ladder Committee September meeting.

5. **Direct Care Staff Input**
   Direct care staff input regarding the staffing plan is solicited via the Clinical Ladder Committee at Manchester Memorial Hospital. In addition, unit huddles, staff meetings and leadership rounds serve as mechanisms in obtaining staff's input regarding staffing plans. Nurse Quality indicators are monitored to ensure nursing quality standards are supported by the staffing model. Indicators include but are not limited to fall with injury rate, central line associated blood stream infection, pressure ulcer rate, and catheter associated urinary tract infection.

6. **Staffing Ratios**

Critical Care Unit:

Registered Nurses: 1:2-3
Licensed Practical Nurses: does not employee LPN's for critical care
Assistive Personnel: 1:11-16

Medical Unit

Registered Nurses 1:5-7 patients
Licensed Practical Nurses 1:5-7 patients
Assistive Personnel 1:7-10 patients

Surgical Unit

Registered Nurses 1:5-8 patients
Licensed Practical Nurses 1:5-8 patients
Assistive Personnel 1:7-8 patients

Behavioral Health Unit

Registered Nurses: 1:6-10 patients
Licensed Practical Nurses: does not employee LPN's for behavioral health
Assistive Personnel: 1:6-15 patients
Social Workers: 1:8 (day shift only)

Neonatal Intensive Care

Registered Nurses: 1:2-3 patients
Licensed Practical Nurses: does not employee LPN's for Neonatal Intensive Care

Obstetrics

Registered Nurses: 1:1-2 for laboring patients
Registered Nurses: 1: 3-4 mother baby pairs

Licensed Practical Nurses: 1: 3-4 mother baby pairs

Emergency Department

Registered Nurses 1:4 patients

Licensed Practical Nurses does not employee LPN's for the emergency department

Assistive Personnel (Emergency department tech) 1:20

Staffing levels are adjusted as needed based on fluctuations in unit census, pending admissions, discharges, and acuity of the patients. Managers and off shift supervisors will evaluate the activity/acuity of the nursing unit and make staffing adjustments. In addition, staff has the autonomy to adjust staffing levels utilizing staffing guidelines (matrixes) for their respective nursing units.

Supporting personnel include health unit secretaries on day and evening shift. Admission nurse (flexible hours) and transport personnel-day shift; sitters all shifts. Sitters are used for patients requiring constant observation and high fall risk patients (case by case basis). Other support services on the nursing units include; unit based pharmacist, physical therapists, physical therapists techs, respiratory therapists, unit based care managers and EKG techs.

Certification

This hospital nurse staffing plan has been developed through consideration of anticipated patient population care needs, unit geography, technology and support, and competency/expertise required of staff providing care. It has been reviewed and discussed by Nursing Leadership, Clinical Ladder Nursing Committee, and the Workforce Efficiency Workgroup. The hospital nurse staffing plan is appropriate for the provision of patient care as forecasted.

Mary Powers MSN, RN, NEA-BC
Chief Nursing Officer

Nurse Staffing Plan
Rockville General Hospital

The nurse staffing plan at *Rockville General Hospital* is developed through a comprehensive process that draws on multiple sources of data and input from registered nurses and other hospital staff members. The staffing plan is continuously evaluated throughout the year and formally reviewed and updated annually. The annual staffing plan reflects budgeted, core staffing levels for patient care units including inpatient services, critical care, and the emergency department. Actual staffing is adjusted on a daily or more frequent basis to meet patient care needs.

Considerations in Staffing Plan Development and Decisions
A broad range of factors are considered in the development of the core staffing plan and ongoing staffing adjustments, many of which are embodied in the American Nurses Association's (ANA) Principles for Nurse Staffing. Staffing plan development and decisions are carried out with consideration given to patient characteristics and acuity, the number of patients for whom care is provided, levels of individual patient as well as unit intensity, the geography/physical layout of the patient care unit, available technology, and level of preparation and experience of those providing care, among others.

In addition to the factors described above, when developing the annual staffing plan, *Rockville General Hospital* considers historical staffing and patient data, staff input, patient care support services, and any plans for new programs.

1. **Professional Skill Mix For Patient Care Units**
   The professional skill mix for each patient care unit is articulated in this hospital nurse staffing plan.

   Patient Care Services utilizes a staffing matrix based on worked hours per patient day (WHPPD) for all nursing units except the emergency department. The Emergency Department staffing is based on a worked hour per patient visit metric. The worked hour metric only includes those hours worked in direct patient care responsibilities. These responsibilities include patient centered nursing activities by unit based staff such as medication administration, nursing treatments, nursing rounds, admission, transfer, discharge activities, patient teaching, patient communication, coordination of patient care, documentation time, and treatment planning. Unit based staff include RNs, LPNs, and nursing assistants.

   The core staffing plan is adjusted as necessary to meet patient care needs using per diem staff, on call staff, staff picking up extra shifts, and floating staff between units.

2. **Use of Temporary and Traveling Staff Nurses**

   Rockville General Hospital does not use temporary or traveling staff nurses.

3. **Administrative Staffing**
   The annual staffing plan is developed to provide adequate direct care staff for forecasted patient care needs exclusive of nursing management and inclusive of appropriate support.

4. **Review of the Nurse Staffing Plan**
   The staffing plan that reflects core staffing levels is formally established and reviewed annually; it is evaluated as necessary throughout the year. Review of the factors articulated in the section *Considerations in Staffing Plan Development and Decisions* above is conducted through a combination of unit staff meetings, Clinical Ladder Committee, and quarterly review with nurse managers. Leadership rounds also serve as a mechanism for staffing review. Formal annual review occurs during the Clinical Ladder Committee September meeting.

5. **Direct Care Staff Input**
   Direct care staff input regarding the staffing plan is solicited via the Clinical Ladder Committee at Rockville General Hospital. In addition unit huddles, staff meetings and leadership rounds serve as mechanisms in obtaining staff's input regarding staffing plans. Nurse Quality indicators are monitored to ensure nursing quality standards are supported by the staffing model. Indicators include but are not limited to fall with injury rate, central line associated blood stream infection, pressure ulcer rate, and catheter associated urinary tract infection.

6. **Staffing Ratios**
   Critical Care Unit:
   Registered Nurses-1:2 (can be 1:3 if non-ICU patients are boarding in ICU)
   Licensed Practical Nurses does not employee LPN's for critical care
   Assistive Personnel-1-9 (the unit is a 9 bed unit with an average daily census of approximately 4-5 one assistive personnel is scheduled)
   Medical-Surgical Unit
   Registered Nurses 1:4-7 patients
   Licensed Practical Nurses 1:4-7 patients
   Assistive Personnel 1:7-8 patients
   Emergency Department
   Registered Nurses 1:4 patients
   Licensed Practical Nurses does not employee LPN's for the emergency department
   Assistive Personnel (Emergency department tech) 1:20

Staffing levels are adjusted as needed based on fluctuations in unit census, pending admissions, discharges, and acuity of the patients. Managers and off shift supervisors will evaluate the activity/acuity of the nursing unit and make staffing adjustments. In addition, staff has the autonomy to adjust staffing levels utilizing staffing guidelines (matrixes) for their respective nursing units.

Supporting personnel include health unit secretaries on day and evening shift. Transport personnel-day shift; sitters all shift. Sitters are used for patients requiring constant observation, high fall risk patients (case by case basis).

Certification

This hospital nurse staffing plan has been developed through consideration of anticipated patient population care needs, unit geography, technology and support, and competency/expertise required of staff providing care. It has been reviewed and discussed by Nursing Leadership, Clinical Ladder Nursing Committee, and the Workforce Efficiency Workgroup. The hospital nurse staffing plan is appropriate for the provision of patient care as forecasted.

Mary Powers MSN, RN, NEA-BC
Chief Nursing Officer

Eastern Connecticut Health Network

Manchester Memorial Hospital and Rockville General Hospital Outpatient Services - Locations and Hours of Operation

	Outpatient Service Locations																		
Service (by Service Line)	Manchester Memorial Hospital 71 Haynes Street Manchester	Rockville General Hospital 31 Union Street Vernon	Meadowbrook Plaza 1760 Boston Turnpike Coventry	ECHN Rehabilitation Services at the Ellington Y 31 Pinney Street Ellington	ECHN Medical Offices 375 West Road Ellington	Glastonbury Wellness Center 422 Hebron Avenue Glastonbury	John A. DeQuattro Cancer Center 100 Haynes Street Manchester	Manchester Medical Offices 150 Hartford Road Manchester	ECHN Medical Office Building 159 North Main Street Rockville	Tolland Turnpike, East Point 840 Tolland Turnpike Manchester	Evergreen Walk 2800 Tamarack Avenue South Windsor	Women's Center for Wellness 2580 Tamarack Avenue South Windsor	CompClinic Occupational Health 2800 Tamarack Avenue South Windsor	ECHN Medical Office Building at Evergreen Walk 2800 Tamarack Avenue South Windsor	Evergreen Imaging Center 2800 Tamarack Avenue South Windsor	Urgent Care at South Windsor 2800 Tamarack Avenue South Windsor	ECHN Necker Offices 6 Fieldstone Commons Tolland	Hartford Turnpike 428 Hartford Turnpike Vernon	The Rehab Center at Big Sky Fitness 343 Hartford Turnpike Vernon
Behavioral Health Services																			
Adult Behavioral Health Outpatient Services									M,Y,Th 8a-8p W 8a-5p F 8a-4p										
Child and Adolescent Outpatient Services	M-F 8a-7p By Appointment	M,T,Th 9a-5p W,F 8a-4p By Appointment																	
Crisis Services	24/7	24/7																	
Cardiac Diagnostic Testing																			
Cardiac Diagnostic Testing - StressTesting	M-F 7:30a-12:30p	M-F 7:30a-12:30p																	
Cardiac Diagnostic Testing - ECHO	M-F 7:30a-2p By Appointment	M-F 7:30a-2p By Appointment																	
Cardiac Rehabilitation	M-F 6:30a-6:30p	M-F 7:30a-3:30p																	
Pulmonary Laboratory	M-F 7:30a-3:30p	M-F 7:30a-3:30p																	
Sleep Laboratory	M-F 7p-7a M-F 7a-6p By Appointment																		
Emergency Services																			
Emergency Department	24/7	24/7																	
Urgent Care																M-F 9a-8:30p Sat, Sun 9a-3p			
Laboratory Services																			
Laboratory Services - Phlebotomy	M-F 6:45a-6p Sat 7a-12p	M-F 7a-5p Sat 8a-12p	M-F 7:30a-12:30p 1p-3:45p		M-F 6a-12:30p 1p-2:15p	M-F 7a-12p	M-F 8a-4p	M-Th 7a-6p F 7a-4p		M-F 6:30a-12:30p 1p- 3p	M-F 6a-12:30p 3p-2:30p			M,T,W,Th 7p-4:45p Sat 8a-12p			M-F 7a-12p 2p-3:30p	M-F 6:30a-6p Sat 7a-12p	
Medical Imaging Services																			
Bone Density						M-F 7a-12p						M,T 8a-8p W 8a-6p Th 8:30a-6p F 8a-4:30p							
CT Scan	M-F 7a-6p	M-F 7a-8p													M-F 8a-4p				
Diagnostic Radiology (x-ray)	M-F 7a-6p	M-F 8a-8p				M-F 7a-12p									M-F 8a-4p				
Interventional Radiology	M-F 8a-4p	M-F 8a-4p																	
Mammography	M-F 8a-4p	M-F 8a-8:30p				M-F 7a-12p						M 8a-8p T 7:30a-8p W 8a-6p Th 7:30a-6p F 8a-4p							
MRI	M-F 8a-6p	M-F 8a-3p													M-F 8a-4p				
Nuclear Medicine	M-F 7a-2p	M-F 7a-1:30p																	
PET Scan	M-F 7a-4p																		

Eastern Connecticut Health Network

Manchester Memorial Hospital and Rockville General Hospital Outpatient Services - Locations and Hours of Operation

	Outpatient Service Locations																		
Service (by Service Line)	Manchester Memorial Hospital 71 Haynes Street Manchester	Rockville General Hospital 31 Union Street Vernon	Meadowbrook Plaza 1700 Boston Turnpike Coventry	ECHN Rehabilitation Services at the Ellington Y 13 Pinney Street Ellington	ECHN Medical Offices 175 West Road Ellington	Glastonbury Wellness Center 822 Hebron Avenue Glastonbury	John A. DeQuattro Cancer Center 100 Haynes Street Manchester	Manchester Medical Offices 130 Hartford Road Manchester	ECHN Medical Office Building 150 North Main Street Manchester	Tolland Turnpike, East Point 549 Tolland Turnpike Manchester	Evergreen Walk 2140 Tamarack Avenue South Windsor	Women's Center for Wellness 2200 Tamarack Avenue South Windsor	Corp Care Occupational Health 2200 Tamarack Avenue South Windsor	ECHN Medical Office Building at Evergreen Walk 2200 Tamarack Avenue South Windsor	Evergreen Imaging Center 2200 Tamarack Avenue South Windsor	Urgent Care at South Windsor 1800 Tamarack Avenue South Windsor	ECHN Medical Offices 6 Fieldstone Commons Tolland	Hartford Turnpike 428 Hartford Turnpike Vernon	The Rehab Center at Big Sky Fitness 29 Hartford Turnpike Tolland
Ultrasound	M-F 7a-6p	M-F 7a-6p										M 8a-6p T,W,Th 7:30a-5p F 7:30a-4:30p			M-F 8a-4p				
Metabolic Services																			
Diabetes Management	M-F By Appointment																		
Nutritional Services	M-F By Appointment											T 4p-8p Th 8:30a-2p							
Oncology Services																			
Chemotherapy	Daily 7a-3p																		
Rehabilitation Services																			
Occupational Therapy	M-F 7:30a-5p and By Appointment	M-F 8a-5p and By Appointment												M-F 7:30a-5p and By Appointment					M,W 7a-7p T,Th 8a-4:30p F Closed
Physical Therapy	M-F 7:30a-5p and By Appointment	M-F 8a-5p and By Appointment		M,W 8a-2p T,Th 8a-5:30p F 9a-2p		M 8a-6:30p T,Th 7:30a-6:30p W 8a-6p F 7:30a-4:30p								M-F 7:30a-5p and By Appointment					M-Th 8a-5p and By Appointment
Speech Therapy	M-F 9a-4p	M-F 9a-1:30p																	
Surgical Services																			
Elective Ambulatory Surgeries	M-F By Appointment	M-F By Appointment																	
Wound Care	M-F 8a-4p																		
Women and Infant Services																			
Maternity Care Center (Prenatal Care)		M,W 9a-3p F 8a-12p																	
Other - Miscellaneous Services																			
Occupational Medicine													M,T,W,Th 8a-6p F 8a-3p						

EXECUTION VERSION

ASSET PURCHASE AGREEMENT

by and among

EASTERN CONNECTICUT HEALTH NETWORK, INC.

SELLER

and

PROSPECT CT MEDICAL FOUNDATION, INC.
PROSPECT CT MANAGEMENT SERVICES, INC.
PROSPECT ECHN, INC.
PROSPECT MANCHESTER HOSPITAL, INC.
PROSPECT ROCKVILLE HOSPITAL, INC.
PROSPECT ECHN ELDERCARE SERVICES, INC.
PROSPECT ECHN HOME HEALTH, INC.
PROSPECT CARING HAND, INC.
PROSPECT HAYNES STREET PROPERTY MANAGEMENT, INC.

BUYER

and

PROSPECT MEDICAL HOLDINGS, INC.

Dated as of August 24, 2016

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ASSET PURCHASE AGREEMENT

This Asset Purchase Agreement (this "**Agreement**"), dated August 24, 2016, is by and between Eastern Connecticut Health Network, Inc., a Connecticut non-stock corporation ("**Seller**"), on its behalf and on behalf of its Subsidiaries, on the one hand, and Prospect CT Medical Foundation, Inc., a Connecticut nonstock corporation, Prospect CT Management Services, Inc., a Connecticut corporation, Prospect ECHN, Inc., a Connecticut corporation, Prospect Manchester Hospital, Inc., a Connecticut corporation, Prospect Rockville Hospital, Inc., a Connecticut corporation, Prospect ECHN Eldercare Services, Inc., a Connecticut corporation, Prospect ECHN Home Health, Inc., a Connecticut corporation, Prospect Caring Hand, Inc., a Connecticut corporation, and Prospect Haynes Street Property Management, Inc., a Connecticut corporation (each, a "**Buyer Entity**" and, collectively, "**Buyer Entities**"), with Prospect Medical Holdings, Inc. ("**PMH**"), a Delaware corporation and the indirect owner of the Buyer Entities, joining for the limited purposes described herein, on the other hand. For the purposes of this Agreement, the term "**Buyer**" shall refer to the Buyer Entities, collectively, and to one or more of the individual Buyer Entities, as applicable.

RECITALS:

WHEREAS, Seller desires to sell substantially all of its assets, real, personal and mixed, tangible and intangible, and operations to Buyer, including the properties, assets, and businesses of The Manchester Memorial Hospital and The Rockville General Hospital, Incorporated (collectively, the "**Hospitals**"), ECHN Eldercare Services, Inc., Visiting Nurse and Health Services of Connecticut, Inc. including its wholly owned subsidiary A Caring Hand, LLC, Clinically Integrated Network of Eastern Connecticut, LLC, Connecticut Healthcare Insurance Company, ECHN Corporate Services, Inc. including its wholly owned subsidiary Medical Practice Partners, LLC, and ECHN Enterprises, Inc., including its wholly owned subsidiary Haynes Street Property Management, LLC, and Eastern Connecticut Medical Professionals Foundation, Inc. (the entities and businesses operated by the foregoing entities, including the Hospitals, are collectively referred to as the "**Hospital Businesses**"), together with Seller's joint venture interests in Evergreen Endoscopy Center, LLC, WBC Connecticut East, LLC, Aetna Ambulance Service, Inc., Metro Wheelchair Service, Inc., Ambulance Service of Manchester, LLC, Connecticut Occupational Medicine Partners, LLC, and Seller's Affiliates' joint venture interests in Northeast Regional Radiation Oncology Network, LLC (as successor to the business operations of Northeast Regional Radiation Oncology Network, Inc.), TIC, LLC (as successor to the business operations of Tolland Imaging Center, LLC), Haynes Street Medical Associates, LLC, Haynes Street Medical Associates II, LLC, Evergreen Medical Associates, LLC and Evergreen Medical Associates II LLC (the foregoing entities are collectively referred to herein as the "**Joint Ventures**");

WHEREAS, Buyer desires to purchase substantially all of the assets, real, personal and mixed, tangible and intangible, of Seller, including the Hospital Businesses and the equity interests in the Joint Ventures; and

WHEREAS, Seller has concluded that the transactions contemplated by this Agreement are in its best interests and consistent with its charitable mission of the promotion of health care in the communities served by the Hospital Businesses.

NOW, THEREFORE, for and in consideration of the premises, and the agreements, covenants, representations and warranties hereinafter set forth, and other good and valuable consideration, the receipt and adequacy of which are forever acknowledged, the parties, intending to be legally bound, agree as follows:

AGREEMENT:

1. DEFINITIONS AND REFERENCES

1.01. Definitions. For purposes of this Agreement, the following definitions apply:

(1) **45-Day Period** is defined in Section 2.05(i);

(2) **Accountants' Determination** is defined in Section 2.05(i);

(3) **Accounts Receivable** means all accounts receivable of the Hospital Businesses, accrued and unaccrued, including Government Payment Program receivables and accounts that have been written off, but excluding all Cost Report settlement amounts;

(4) **Accumulated Benefit Obligation** means the accumulated benefit obligation of Seller's defined benefit pension plan, determined by an actuarial firm chosen by Seller using GAAP (i) reflecting the assumptions used for purposes of Note 10 of Seller's Audited Financial Statements as of September 30, 2015 (as updated for the MRP-2007 mortality tables as developed by Mercer, which are derived from the Society of Actuaries mortality study) and (ii) assuming continuation of the Seller's defined benefit pension plan and no change in its provisions after September 30, 2015 (other than the freeze of such plan to new participation);

(5) **Additional Liabilities** is defined in Section 2.05(d);

(6) **Affiliate** means any Person that, directly or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with another Person where "control" means the power to direct or cause the direction of the management and policies of a Person, whether through the ownership of securities, election or appointment of directors, by contract or otherwise. For purposes of this Agreement, any reference to Affiliates of Seller shall only mean those persons listed on Schedule 1.01(6) attached hereto;

(7) **Affiliated Group** means any affiliated group within the meaning of section 1504 of the Code or any similar group defined under a similar provision of state, local or foreign law;

(8) **Agreement** is defined in the preamble;

(9) **AOCs** is defined in Section 7.09

(10) **Arbitrating Accountants** is defined in Section 2.05(i);

(11) **Assets** means all assets, real property, personal and mixed property of every kind, character or description, known or unknown, tangible or intangible, owned or leased by Seller wherever located and whether or not reflected in the Financial Statements or referenced or scheduled herein, (i) including those assets owned by a Subsidiary of Seller and held or used in connection with the operation of the Hospital Businesses, but (ii) excluding the Excluded Assets;

(12) **Assumed Contracts** is defined in Section 2.01(f);

(13) **Assumed Liabilities** means (i) the current liabilities included in Net Working Capital, but only to the extent accrued on the Closing Balance Sheets, (ii) all obligations of Seller and its Affiliates arising under the Assumed Contracts with respect to periods (or portions thereof) following the Closing Date, (iii) all participating provider agreements and provider numbers with third party payors, including contracts and provider numbers of Government Payment Programs, to the extent the same are assignable to Buyer, (iv) the Extended Illness Bank Obligations, (v) Permitted Encumbrances, (vi) the Unfunded Pension Liabilities, (vii) the Post-Retiree Health Plan Liability and other retirement obligations described on Schedule 2.03, (viii) the Captive Insurer Liability, (ix) the ED Loan, and (x) the other liabilities and obligations agreed to be assumed by Buyer, if any, described on Schedule 2.03;

(14) **Attorney General** means the Office of the Attorney General of the State of Connecticut;

(15) **Audited Financial Statements** means the audited consolidated balance sheets of Seller and its Subsidiaries for the three most recently ended fiscal years, and the related consolidated statements of operations, of changes in net assets, and of cash flows for the fiscal years then ended, and the notes thereto and the report thereon of Saslow Lufkin & Buggy, LLP, independent certified public accountants;

(16) **Available Cash** means all cash available to Seller as of the Closing, including cash resulting from the payment of the Purchase Price by Buyer at the Closing or pursuant to any adjustments to the Purchase Price pursuant to Section 2.05, other than cash which is determined by the Attorney General to be restricted as to use and not available to satisfy Seller's liabilities;

(17) **Bond Liabilities** means those certain long-term bond liabilities and tax-exempt leases of Seller to be defeased at Closing;

(18) **Buyer** is defined in the preamble;

(19) **Buyer Deductible** is defined in Section 9.04;

(20) **Buyer Entity(ies)** is defined in the preamble;

(21) **Buyer's Indemnified Persons** means Buyer and its respective stockholders, members, partners, Affiliates, directors, trustees, officers, employees, agents, representatives, successors and assigns;

(22) **Buyer's Plan** means a retirement plan qualified under section 401(a) of the Code that is sponsored by Buyer or one of its controlled group or affiliated service group members, as defined in section 414 of the Code;

(23) **Captive Insurer Liability** means all liabilities relating to Seller's captive insurer, the Connecticut Healthcare Insurance Company ("**CHIC**"), regardless of when incurred and including all tail liability and measured by an actuarial firm chosen by Seller reflecting the assumptions used in determining the book value of the Captive Insurer Liability used for purposes of Seller's Audited Financial Statements as of September 30, 2015, subject to the provisions of Section 2.05(h)(iii);

(24) **CHIC** is defined in Section 1.01(23);

(25) **Claim Notice** means written notification of a Third Party Claim by an Indemnitee to an Indemnifying Party under Article 9, including a Third Party Claim set forth in a "Revenue Agent's Report," "Statutory Notice of Deficiency," "Notice of Proposed Assessment," or any other official written notice from a taxing authority that Taxes are due or that a Tax audit will be conducted;

(26) **Closing** is defined in Section 8.01(a);

(27) **Closing Balance Sheets** means the unaudited individual and/or combined balance sheets of Seller and its Subsidiaries as of the close of business on the Closing Date, as finally determined in accordance with Section 2.05 following the resolution of all disputes with respect thereto;

(28) **Closing Date** means the date upon which the Closing occurs;

(29) **Closing Document** means each instrument, agreement, certificate or other document executed or delivered, or required to be executed or delivered, by a party at Closing;

(30) **Closing Estimates** is defined in Section 2.05(f)(i);

(31) **CMS** is defined in Section 2.04(k);

(32) **COBRA** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended;

(33) **Code** means the Internal Revenue Code of 1986, as amended;

(34) **Commitment Amount** is defined in Section 5.18(a);

(35) **CON** is defined in Section 8.04(b);

(36) **CON Preparation Period** is defined in Section 8.04(b);

(37) **Contracts** means all commitments, contracts, leases, licenses, agreements and understandings, written or oral, relating to the Assets or the operation of the Hospital Businesses to which Seller or any Subsidiary of Seller is a party or by which it or any of the Assets are bound, including agreements with payers, physicians and other providers, agreements with health maintenance organizations, independent practice associations, preferred provider organizations and other managed care plans and alternative delivery systems, joint venture and partnership agreements, management, employment, retirement, retention and severance agreements, vendor agreements, real and personal property leases and schedules, maintenance agreements and schedules, agreements with municipalities and labor organizations, and bonds, mortgages and other loan agreements;

(38) **Controlled Group** means with respect to a party, a group consisting of each trade or business (whether or not incorporated) that, together with such party, would be deemed a "*single employer*" within the meaning of section 4001(a) of ERISA;

(39) **Cost Reports** means all cost and other reports filed pursuant to the requirements of the Government Payment Programs for payment or reimbursement of amounts due from them;

(40) **CTDEEP** is defined in Section 5.08;

(41) **Current Seller Plan** is defined in Section 3.22(a);

(42) **Disability Obligations** mean liabilities for long-term or short-term disability benefits to employees of the Hospital Businesses (the Disability Obligations include liabilities of the Hospital Businesses for long-term or short-term disability benefits that may have commenced being paid prior to Closing and that remain ongoing after the Closing);

(43) **EBITDA** means earnings before interest, income Taxes, depreciation and amortization, the components of which shall be determined in accordance with GAAP consistently applied;

(44) **ED Cash Collateral** is defined in Section 2.01(r);

(45) **ED Loan** means that certain loan from Berkshire Bank to Seller in the original principal amount of $5,000,000, pursuant to the terms of that certain Loan Agreement, dated as of February 19, 2016, and evidenced by that certain Promissory Note, dated of even date therewith;

(46) **Employee Benefit Plan** means, with respect to any Person, (i) each plan, fund, program, agreement, arrangement or scheme, in each case, that is at any time sponsored or maintained, or required to be sponsored or maintained, by such Person or to which such Person makes or has made, or has or has had an obligation to make, contributions providing for employee benefits or for the remuneration, direct or indirect, of the employees, former employees, directors, officers, managers, consultants, independent contractors, contingent workers or leased employees of such Person or the dependents of any of them (whether written or oral), including each deferred

compensation, bonus, incentive compensation, pension, retirement, stock purchase, stock option and other equity compensation plan, or "*welfare*" plan (within the meaning of section 3(1) of ERISA, determined without regard to whether such plan is subject to ERISA), (ii) each "*pension*" plan (within the meaning of section 3(2) of ERISA, determined without regard to whether such plan is subject to ERISA), including each Multiemployer Plan, (iii) each severance, retention or change in control plan or agreement, each plan or agreement providing health, vacation or paid time off, summer hours, supplemental unemployment benefit, hospitalization insurance, medical, dental, or legal benefit and (iv) each other employee benefit plan, fund, program, agreement or arrangement, including any of the foregoing that provides cash or non-cash benefits or perquisites to current or former employees of such Person;

(47) **Employee Pension Benefit Plan** is defined in section 3(2) of ERISA;

(48) **Employee Welfare Benefit Plan** is defined in section 3(1) of ERISA;

(49) **Encumbrances** means liabilities, levies, claims, charges, assessments, mortgages, security interests, liens, pledges, conditional sales agreements, title retention contracts, easements, restrictions, rights of first refusal, options to purchase and other encumbrances (including limitations on pledging or mortgaging any of the Assets) and Contracts to create in the future any such Encumbrance or suffer any of the foregoing;

(50) **Environmental Claim** means any written notice (or oral notice reduced to writing by Seller) by a Person alleging potential liability (including potential liability for investigatory costs, cleanup costs, Governmental Authority response costs, natural resource damages, property damages, personal injuries, or penalties) of Seller or any Subsidiary of Seller arising out of, based on or resulting from (i) the presence, or release into the environment, of any Materials of Environmental Concern at any location, whether or not owned by Seller, or (ii) circumstances forming the basis of any violation, or alleged violation, of any Environmental Laws;

(51) **Environmental Laws** means any and all Legal Requirements relating to pollution or protection of human health or the environment (including ground water, land surface or subsurface strata), including Legal Requirements relating to emissions, discharges, releases or threatened releases of Materials of Environmental Concern, or otherwise relating to the manufacture, processing, distribution, use, treatment, storage, disposal, transport, recycling, reporting or handling of Materials of Environmental Concern, including the Comprehensive Environmental Response, Compensation and Liability Act of 1980, as amended, 42 U.S.C. §9601, *et seq.*, the Resource Conservation and Recovery Act, as amended, 42 U.S.C. §6901, *et seq.*, the Clean Air Act, 42 U.S.C. §7401, *et seq.*, the Federal Water Pollution Control Act, 33 U.S.C. §1251 *et seq.*, the Occupational Safety and Health Act, 29 U.S.C. §600, *et seq.*, and any similar state or local Legal Requirements;

(52) **ERISA** means the Employee Retirement Income Security Act of 1974, as amended;

(53) **ERISA Fiduciary** is defined in section 3(21) of ERISA;

(54) **Establishment Real Properties** is defined in Section 5.08;

(55) **Excluded Assets** is defined in Section 2.02;

(56) **Excluded Liabilities** means any and all liabilities of Seller other than the Assumed Liabilities, whether known or unknown, fixed or contingent, recorded or unrecorded, and whether arising before or after Closing, including any line of credit to which Seller is a party, the Bond Liabilities, tax-exempt leases, and any other indebtedness of Seller, any interest accrued on indebtedness of Seller, any settlements due as of Closing to third party payors;

(57) **Extended Illness Bank Obligations** means the Hired Employees' accrued or allocated paid time off that is in the form of an "*extended illness bank*" (i.e., paid time off that may be used by a Hired Employee during the term of employment, but the value of the unused portion of which is not paid in cash to the Hired Employee upon termination of employment);

(58) **Final Closing Statement** is defined in Section 2.05(h);

(59) **Final Determination Date** means the earliest to occur of (i) the forty-sixth (46th) day following the receipt by Seller of the Final Closing Statement and Closing Balance Sheets if Seller shall have failed to deliver the Objection Notice to Buyer within the 45-Day Period, (ii) the date on which Seller gives Buyer written notice to the effect that Seller has no objection to Buyer's determination of the amount of the Subject Items as set forth on the Final Closing Statement, (iii) the date on which Buyer and Seller execute and deliver a Settlement Agreement, (iv) the date as of which Buyer and Seller shall have received the Accountants' Determination, and (v) Buyer's failure to deliver the information set forth in Section 2.05(h) within the ninety (90) day period described therein;

(60) **Financial Statements** means the Audited Financial Statements and the Unaudited Financial Statements;

(61) **GAAP** means United States generally accepted accounting principles;

(62) **Governmental Authority** means any executive, legislative or judicial agency, authority, board, body, commission, court, department, instrumentality or office of any federal, state, city, county, district, municipality, foreign or other government or quasi-government unit or political subdivision;

(63) **Government Payment Programs** means federal and state Medicare, Medicaid and TRICARE programs, and similar or successor programs with or for the benefit of Governmental Authorities;

(64) **Hill-Burton Act** means the Public Health Service Act, 42 U.S.C. §291, *et seq.*;

(65) **Hired Employees** means those employees of Seller or its Affiliates who accept Buyer's offer of employment as of the Closing Date, including those employees who are employed pursuant to an Assumed Contract;

(66) **Hospital Businesses** is defined in the recitals;

(67) **Hospitals** is defined in the recitals;

(68) **HQI Program** is defined in Section 3.17;

(69) **HSR Act** means the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended;

(70) **Immaterial Contract** means any Contract to which Seller or any of its Subsidiaries is a party that requires either the payment by Seller or its Subsidiaries of $50,000 or less or the provision of goods or the performance of services by Seller or any of its Subsidiaries having an annual value of $50,000 or less, in either case during the period from the date of this Agreement until (i) if the Contract is terminable at any time by Seller or the respective Subsidiary without cause upon notice of 90 days or less, the date on which the Contract would terminate if Seller or the respective Subsidiary was to give notice of termination on the date of this Agreement, or (ii) if the Contract is not terminable at any time by Seller or the respective Subsidiary without cause upon notice of 90 days or less, the expiration of the term of the Contract, *provided* that an Immaterial Contract does not include any Contract described in Sections 3.18(a) through 3.18(m);

(71) **Immediate Family Member** means any individual described in the definition of "*Immediate Family Member*" found at 42 C.F.R. §411.351;

(72) **Indemnifying Party** means any Person obligated to indemnify another Person under Article 9;

(73) **Indemnitee** means any Person entitled to indemnification under Article 9;

(74) **Indemnity Notice** means written notification of a claim for indemnity under Article 9, other than a Third Party Claim, made by an Indemnitee to an Indemnifying Party pursuant to Section 9.05(b);

(75) **Indenture** is defined in Section 6.04;

(76) **Information Systems** means the software (including object and source codes as applicable), hardware, application programs and similar systems owned, licensed or leased by Seller and used in the ownership or operation of the Hospital Businesses, whether or not on a system-wide basis;

(77) **Intellectual Properties** means (i) all inventions (whether or not patentable or reduced to practice), all improvements thereto, and all patents, patent applications, and patent disclosures, together with all reissuances, continuations, continuations-in-part, revisions, extensions, and reexaminations thereof, (ii) all trademarks, service marks, trade

dress, logos, trade names, corporate names, and domain names, including all goodwill associated therewith, and all applications, registrations, and renewals in connection therewith, (iii) all copyrightable works, all copyrights, and all applications, registrations, and renewals in connection therewith, and (iv) all trade secrets and confidential business information (including ideas, research and development, know-how, formulas, compositions, manufacturing and production processes and techniques, technical data, designs, drawings, specifications, customer and supplier lists, pricing and cost information, and business and marketing plans and proposals) that are owned, licensed or leased by Seller and used in the ownership or operation of the Hospital Businesses, together with all rights to sue or make any claims for any past, present, or future infringement, misappropriation or unauthorized use of any of the foregoing rights, and the right to all income, royalties, damages and other payments that are now or may hereafter become due or payable with respect to any of the foregoing rights, including damages for past, present or future infringement, misappropriation or unauthorized use thereof;

(78) **Interim Closing Balance Sheets** means the unaudited individual and/or combined balance sheets of Seller and its Subsidiaries as of the most recent month end available before the Closing;

(79) **Investments** means shares of capital stock of any corporation, equity interests in partnerships or limited liability companies, or other equity or debt instruments in any other Person, and proceeds from the sale thereof;

(80) **Joint Venture Promissory Note** is defined in Section 2.07;

(81) **Joint Ventures** is defined in the recitals;

(82) **Leased Real Property** means the real property described on Schedule 2.01(b), together with all buildings, improvements and fixtures thereon, leased by Seller or any Subsidiary of Seller;

(83) **Legal Requirements** means, with respect to any Person, all statutes, laws, ordinances, codes, rules, regulations, restrictions, orders, judgments, rulings, writs, injunctions, decrees, determinations or awards of any Governmental Authority having jurisdiction over such Person or any of such Person's assets or businesses;

(84) **Local Board** means the advisory board of each Hospital composed of community representatives, physicians on the respective Hospital's medical staff, and the Chief Executive Officer of each respective Hospital (for avoidance of doubt, each Hospital shall have its own Local Board). The initial members of the Local Board shall include at least five members of the Seller's Board of Trustees immediately prior to Closing and five other individuals identified by the Seller prior to Closing, two of whom shall be members of the community appointed in consultation with the mayor of the town in which the respective Hospital is located;

(85) **Losses** means any and all damages, costs, losses (including any diminution in value), liabilities, expenses or obligations (including Taxes, interest,

penalties, court costs, costs of preparation and investigation, and attorneys', accountants' and other professional advisors' fees and expenses);

(86) **Material Adverse Change** means a material adverse change, individually or in the aggregate, of the business, assets, liabilities, financial condition or results of operations of Seller and the Hospital Businesses, which taken as a whole (i) has or could reasonably be expected to have a material adverse effect upon the validity or enforceability of this Agreement or (ii) is or could reasonably be expected to be material and adverse to the Hospital Businesses or the Assets, but excluding the effect of (x) matters described in the Schedules, (y) changes in the economy of the United States in general, and (z) changes in Legal Requirements generally applicable to owners and operators of general acute care hospitals in the United States or in Connecticut if such change does not disproportionately affect Seller or the Hospital Businesses; provided, however, that a change resulting from the downward adjustment to the Medicare wage index or the failure of the Seller to meet its debt service coverage ratio, if waived by applicable lender(s), shall not constitute a Material Adverse Change;

(87) **Materials of Environmental Concern** means chemicals, pollutants, contaminants, wastes (including Medical Waste), toxic substances, petroleum and petroleum products listed or regulated under Environmental Laws, including hazardous wastes under the Resource Conservation and Recovery Act, as amended, 42 U.S.C. §6901, *et seq.*, hazardous substances under the Comprehensive Environmental Response, Compensation and Liability Act of 1980, as amended, 42 U.S.C. §9601, *et seq.*, asbestos, polychlorinated biphenyls and urea formaldehyde, and low-level nuclear materials, special nuclear materials or nuclear-byproduct materials, all within the meaning of the Atomic Energy Act of 1954, as amended, and any rules, regulations or policies promulgated thereunder;

(88) **Medical Waste** means any substance, pollutant, material or contaminant listed or regulated under any Medical Waste Law that is generated in the diagnosis, treatment or immunization of human beings, in research pertaining thereto, or in the production or testing of biologicals, including (i) pathological waste, (ii) blood, (iii) sharps, (iv) wastes from surgery or autopsy, (v) dialysis waste, including contaminated disposable equipment and supplies, (vi) cultures and stocks of infectious agents and associated biological agents, (vii) isolation wastes, (viii) contaminated equipment, (ix) laboratory waste, and (x) various other biological waste and discarded materials contaminated with or exposed to blood, excretion, or secretions from human beings;

(89) **Medical Waste Law** means the Medical Waste Tracking Act of 1988, 42 U.S.C. §6992, *et seq.*, the U.S. Public Vessel Medical Waste Anti-Dumping Act of 1988, 33 U.S.C. §2501, *et seq.*, the Marine Protection, Research, and Sanctuaries Act of 1972, 33 U.S.C. §1401, *et seq.*, The Occupational Safety and Health Act, 29 U.S.C. §651, *et seq.*, the United States Department of Health and Human Services, National Institute for Occupational Self-Safety and Health Infectious Waste Disposal Guidelines, Publication No. 88-119, and any other federal, state, regional, county, municipal or other Legal Requirements insofar as they purport to regulate Medical Waste, or impose requirements relating to Medical Waste;

(90) **Multiemployer Plan** is defined in section 3(37) of ERISA or section 4001(a)(3) of ERISA;

(91) **Multiple Employer Plan** means an Employee Pension Benefit Plan that is not a Multiemployer Plan and for which a Person who is not a member of a Controlled Group that includes Seller or any Subsidiary is or has been a contributing sponsor;

(92) **Net Working Capital** means the amount by which (i) the value of all non-cash current assets of the Hospital Businesses acquired by Buyer, including inventory and supplies, Accounts Receivable, other receivables, prepaid expenses, and deposits (including security deposits made by Seller pursuant to Assumed Contracts), that Seller and Buyer agree will be usable after Closing, exceeds (ii) the value of all current liabilities assumed by Buyer, including trade accounts payable, accrued expenses (including payroll), advance payments on patient accounts and employee benefit accruals (as such terms are used in the Financial Statements) (for the purpose of clarity, employee benefit accruals include paid time off accruals for vacation and sick time but exclude Extended Illness Bank Obligations), and Net Working Capital shall be calculated in accordance with the methodology set forth on Annex A;

(93) **Notice Period** is defined in Section 9.05(a)(i);

(94) **Objection Notice** is defined in Section 2.05(i);

(95) **ORYX** is defined in Section 3.17;

(96) **Owned Real Property** means real property owned (legally or beneficially) by Seller or any Subsidiary of Seller, including the real property described on Schedule 2.01(a), together with all buildings, improvements and fixtures thereon owned by Seller or any Subsidiary of Seller and all appurtenances and rights thereto;

(97) **PBGC** means the Pension Benefit Guaranty Corporation;

(98) **Permit** means each license, permit, right, franchise, concession, certificate, authorization, consent, certificate of need or other approval of a Governmental Authority owned or held by Seller or relating to the ownership or operations of the Hospital Businesses and the Assets, including applications for, and pending, Permits;

(99) **Permitted Encumbrances** means the Permitted Personal Property Encumbrances and the Permitted Real Property Encumbrances;

(100) **Permitted Personal Property Encumbrances** means those Encumbrances described on Schedule 3.11 as being Permitted Personal Property Encumbrances;

(101) **Permitted Real Property Encumbrances** means those Encumbrances identified on Schedule 3.12(a) as being Permitted Real Property Encumbrances;

(102) **Person** means any individual, corporation (whether for-profit or not-for-profit), limited liability company, association, partnership, firm, joint venture, trust, trustee or other entity or organization, including a Governmental Authority;

(103) **Phase I Assessment(s)** is defined in Section 7.09;

(104) **Phase II Assessment(s)** is defined in Section 7.09;

(105) **PMH** is defined in the preamble;

(106) **PMH Medical Foundation** is defined in Section 7.11;

(107) **Post-Retiree Health Plan Liability** means the book value of the liability relating to Seller's post-retiree health benefit plan, determined by an actuarial firm chosen by Seller using GAAP (i) reflecting the assumptions used for purposes of Note 10 of Seller's Audited Financial Statements as of September 30, 2015 (as updated for the MRP-2007 mortality tables prepared by the Society of Actuaries) and (ii) assuming continuation of the Seller's post-retiree health benefit plan and no change in its provisions after September 30, 2015 (other than the freeze of such plan to new participation);

(108) **Prior Seller Plan** is defined in Section 3.22(b);

(109) **Proceeding** means any action, arbitration, audit, hearing, investigation, litigation, suit or other proceeding (whether civil, criminal, administrative, judicial or investigative, whether formal or informal, whether public or private) commenced, brought, conducted, heard or held by, before, under the authority or at the direction of any Governmental Authority;

(110) **Prohibited Transaction** is defined in Section 5.09;

(111) **Purchase Price** is defined in Section 2.05;

(112) **Purchase Price Adjustment** is defined in Section 2.05(j);

(113) **QNet** is defined in Section 3.17;

(114) **Reportable Event** is defined in section 4043 of ERISA;

(115) **Restricted Area** is defined in Section 5.10;

(116) **Schedules** means the schedules referred to in this Agreement and attached hereto at the time that this Agreement is executed by each original party hereto;

(117) **Second 45-Day Period** is defined in Section 2.05(i);

(118) **Seller** is defined in the preamble;

(119) **Seller Deductible** is defined in Section 9.02;

(120) **Seller's Indemnified Persons** means Seller and Seller's members, stockholders, Affiliates, and, for all of them, their respective members, directors, trustees, officers, employees, agents, representatives, successors and assigns;

(121) **Settlement Agreement** is defined in Section 2.05(i);

(122) **Space Leases** is defined in Section 3.12(g)(i);

(123) **Strategic Business Plan** means the strategic plan developed prior to Closing by Buyer, in consultation with Seller, and, with respect to clinical service lines, in consultation with Seller-affiliated physicians, as the same may be amended from time to time, *provided, however*, that the Strategic Business Plan does not include the strategic capital plan referenced in Section 5.18 herein;

(124) **Subject Items** means each of the Net Working Capital, Captive Insurer Liability, Unfunded Pension Liabilities, Workers' Compensation Liability, and Post-Retiree Health Plan Liability.

(125) **Subsidiary** means, with respect to any Person, (i) any corporation more than 50% of whose stock of any class or classes having by the terms thereof ordinary voting power to elect a majority of the directors of such corporation (irrespective of whether or not at the time stock of any class or classes of such corporation shall have or might have voting power by reason of the happening of any contingency) is at the time owned by such Person and/or one or more Subsidiaries of such Person, (ii) any partnership, limited liability company, association, joint venture or other entity in which such Person and/or one or more Subsidiaries of such Person has more than a 50% equity interest at the time and the management of which is controlled, directly or indirectly, by such Person or through one or more Subsidiaries of such Person and (iii) any entity that is organized as a not-for-profit business organization and (A) whose accounts are required in accordance with GAAP to be consolidated with the accounts of such Person or (B) whose sole member is such Person;

(126) **Target Net Working Capital** means $24,000,000;

(127) **Tax** means any income, unrelated business income, gross receipts, license, payroll, employment, excise, severance, occupation, privilege, premium, net worth, windfall profits, environmental (including taxes under section 59A of the Code), customs duties, capital stock, franchise, profits, withholding, social security, unemployment, disability, real property, personal property, recording, stamp, sales, use, services, service use, transfer, registration, escheat, unclaimed property, value added, alternative or add-on minimum, estimated or other tax, assessment, charge, levy or fee of any kind whatsoever, including payments or services in lieu of Taxes, interest or penalties on and additions to all of the foregoing, that are due or alleged to be due to any Governmental Authority, whether disputed or not;

(128) **Tax Claims** is defined in Section 5.30;

(129) **Tax Return** means any return, declaration, report, claim for refund, information return, filing obligation of any Code section 501(c)(3) organization, or statement, including schedules and attachments thereto and amendments, relating to Taxes;

(130) **Tenant Leases** is defined in Section 3.12(i);

(131) **Third Party Claim** is defined in Section 9.05(a)(i);

(132) **Threshold Liability** is defined in Section 2.05(c);

(133) **Third Party Debt** means indebtedness of Seller for borrowed money other than the ED Loan and any assumed capital leases. For the avoidance of doubt Third Party Debt shall not include any Assumed Liabilities;

(134) **Transfer Act** means the Connecticut Transfer Act, 22 Conn. Gen. Stat. § 134 *et seq.*;

(135) **Transfer Act Activities** is defined in Section 5.08;

(136) **Transitional Services Agreement** means the agreement between Buyer and Seller whereby Buyer will lease Hired Employees to Seller at cost for the orderly wind down of the benefits and administration of Seller's other post-Closing obligations (*e.g.*, finalizing Cost Reports), in substantially the form of Exhibit A attached hereto;

(137) **Unaudited Financial Statements** means the unaudited consolidated balance sheets of Seller and its Subsidiaries as of May 31, 2016, and the unaudited consolidated statements of operations and changes in net assets and the unaudited consolidated statements of cash flows for the eight (8)-month period then ended, and the financial statements described in clauses (i) and (ii) of Section 5.04(b);

(138) **Unfunded ED Loan Amount** means (i) the unpaid principal amount outstanding on the ED Loan, plus all accrued and unpaid interest, fees and other charges thereon, less (ii) the amount of Available Cash delivered by Seller to Buyer pursuant to Section 2.05(g)(v) or Section 2.05(k)(i)(y).

(139) **Unfunded Pension Liabilities** means the unfunded pension liabilities of Seller's defined benefit pension plan, calculated as the Accumulated Benefit Obligation reduced by the fair market value of the assets of Seller's defined benefit pension plan, all as measured by an actuary chosen by Seller;

(140) **WARN Act** means the Worker Adjustment and Retraining Notification Act, 29 U.S.C. §2101, *et seq*;

(141) **Wind-Down Reserve** is defined in Section 2.05(g)(ii); and

(142) **Workers' Compensation Liability** means all workers' compensation liabilities of Seller and its Affiliates, regardless of when incurred. The book value of the

Workers' Compensation Liability shall be measured by an actuarial firm chosen by Seller reflecting assumptions used in preparing Seller's Audited Financial Statements as of September 30, 2015. For the avoidance of doubt, the Workers' Compensation Liability includes both claims known as of the Closing Date and claims that arise post-closing but that pertain to events occurring pre-closing.

1.02. Certain References. As used in this Agreement:

(a) references to "*this Agreement*" mean this Agreement, as amended from time to time, and all Exhibits and Schedules attached to or referenced in this Agreement;

(b) references to "*Articles*" or "*Sections*" are references to Articles and Sections of this Agreement, unless the context states or implies otherwise;

(c) references to "*include*" or "*including*" mean including without limitation and are intended to be illustrative and not restrictive of the word or phrase to which they refer;

(d) references to "*partners*" include general and limited partners of partnerships and members of limited liability companies;

(e) references to "*partnerships*" include general and limited partnerships;

(f) references to any document are references to that document as amended, consolidated, supplemented, novated or replaced by the parties thereto;

(g) references to any law are references to that law as amended, consolidated, supplemented or replaced, and all rules and regulations promulgated thereunder;

(h) references to time are references to Eastern Time;

(i) references to "*Seller's knowledge*" mean the actual knowledge of each of the Persons whose names or titles are set forth on Schedule 1.02(i), after due inquiry by Seller of such Persons;

(j) the gender of all words includes the masculine, feminine and neuter, and the number of all words includes the singular and plural; and

(k) the Table of Contents, the division of this Agreement into Articles and Sections, and the use of captions and headings in connection therewith are solely for convenience and have no legal effect in construing this Agreement.

2. SALE OF ASSETS AND RELATED MATTERS

2.01. Sale of Assets. Subject to the terms and conditions of this Agreement, at Closing, Seller shall sell, and Buyer shall purchase, all right, title and interest of Seller in and to the Assets, free and clear of all Encumbrances other than the Permitted Encumbrances, including the following Assets:

(a) the Owned Real Property described on Schedule 2.01(a);

(b) the Leased Real Property described on Schedule 2.01(b);

(c) all equipment (including medical and computer equipment located at the Hospital Businesses), vehicles, furniture and furnishings and other tangible personal properties owned or leased by Seller or used in the conduct of the Hospital Businesses; *provided* that any such leased personal property shall be described on Schedule 2.01(c);

(d) all current assets included in Net Working Capital;

(e) all financial, patient, medical staff, personnel and other records of the Hospital Businesses (including equipment records, medical/administrative libraries, medical records, documents, catalogs, books, records, files and operating manuals);

(f) all rights with respect to the Contracts listed or described on Schedule 2.01(f), the leases relating to the Leased Real Property listed or described on Schedule 2.01(b), the leases relating to the leased personal property listed or described on Schedule 2.01(c), and all Immaterial Contracts not listed or described on Schedule 2.02(j) (all such Contracts, collectively, the "**Assumed Contracts**");

(g) all Permits of Seller, to the extent legally assignable, relating to the ownership of the Assets and the conduct of the Hospital Businesses, including those described on Schedule 2.01(g);

(h) the Intellectual Properties, including those Intellectual Properties described on Schedule 2.01(h), and the Information Systems;

(i) all property of Seller, real, personal or mixed, tangible or intangible, arising or acquired between the date of this Agreement and the Closing Date;

(j) the Investment interests in the Joint Ventures, including all transferable rights relating thereto, but only to the extent that the governing instruments of the Joint Ventures permit such transfer;

(k) subject to Section 5.13, all insurance proceeds with respect to the Assets or the Assumed Liabilities (including insurance proceeds received by Seller or payable to Seller and all deductibles, copayments and self-insurance requirements payable by Seller) arising in connection with damage to the Assets occurring on or prior to the Closing Date, to the extent not expended for the repair or restoration of the Assets;

(l) claims of Seller against third parties relating to the Assets or the Assumed Liabilities, choate or inchoate, known or unknown, contingent or otherwise, except for those claims described on Schedule 2.02(p) and any claims relating to Excluded Assets or the Excluded Liabilities;

(m) general intangibles of the Hospital Businesses, including goodwill;

(n) the Investment interests in CHIC, including all transferable rights relating thereto, or in the alternative at Buyer's election, all cash and investments held in CHIC, and all cash and investments held in the workers' compensation trust;

(o) Seller's provider agreements with Government Payment Programs;

(p) all proceeds of the foregoing and, except for the Excluded Assets, all other property of every kind, character or description, tangible and intangible, known or unknown, owned or leased by Seller, wherever located and whether or not reflected in the Financial Statements or similar to the properties described above;

(q) all bank accounts that receive deposits from Government Payment Programs and other third-party payors; provided, however, that all funds in such accounts as of the Closing Date shall be retained by Seller; and

(r) all cash of Seller specifically designated as cash collateral for the ED Loan (the "**ED Cash Collateral**"), provided, that in no event shall the amount of ED Cash Collateral delivered at Closing hereunder exceed $5,000,000.

2.02. Excluded Assets. Notwithstanding the generality of the definition of Assets and of the examples of Assets listed in Section 2.01, the following assets (the "**Excluded Assets**") are not a part of the sale and purchase contemplated by this Agreement and are excluded from the Assets, and Seller shall retain all of its right, title and interest therein and thereto from and after the Closing:

(a) any financial, patient, medical staff, personnel and other records of the Hospital Businesses that Seller cannot transfer to Buyer due to applicable Legal Requirements by which Seller is bound;

(b) all cash (other than ED Cash Collateral, any cash held by CHIC, any cash held by ECHN in an account designated for the payment of workers' compensation claims), bank accounts (except for those that receive deposits from Government Payment Programs and other third party payors), certificates of deposit, treasury bills, treasury notes, marketable securities and other cash equivalents (including the Purchase Price payable to Seller) of Seller or the Hospital Businesses, except for those listed in Section 2.01(n);

(c) all short-term and long-term Investments, but excluding the Investment interests in the Joint Ventures, and, if applicable, pursuant to Section 2.01(n), the Investment interests in CHIC;

(d) board-designated, restricted, and trustee-held or escrowed funds (such as funded depreciation, debt service reserves, self-insurance trusts, working capital trust assets, and assets and Investments restricted as to use), beneficial interests in charitable trusts, and accrued earnings on all of the foregoing;

(e) inventory and supplies disposed of or exhausted after the date of this Agreement and on or before the Closing Date in the ordinary course of the Hospital Businesses, and Assets transferred or disposed of in accordance with Section 5.02(e);

(f) Cost Report settlement receivables for periods ended on or prior to the Closing Date and all appeals and appeal rights relating thereto;

(g) all funds held by trustees pursuant to bond indentures of Seller (including the Indenture) related to the Bond Liabilities;

(h) all deductions, benefits, claims, refunds, receivables and other rights of Seller or any Affiliate of Seller relating to Taxes in respect of periods ending on or before the Closing Date (or portions thereof) or resulting from the consummation of the transactions contemplated by this Agreement;

(i) all other current financial assets not included in Net Working Capital and all deferred expenses;

(j) all Contracts that are listed or described on Schedule 2.02(j) and all other Contracts that are not Assumed Contracts (including this Agreement and the Closing Documents);

(k) all Permits to the extent not legally assignable to Buyer or not relating to the ownership of the Assets and the conduct of the Hospital Businesses;

(l) the corporate or trade names set forth on Schedule 2.02(l) and all Intellectual Property rights relating thereto;

(m) all physician loans and receivables other than repayment obligations under Assumed Contracts;

(n) all right, title and interest of ECHN Community Healthcare Foundation in and to its assets and properties (whether owned, leased or otherwise) described on Schedule 2.02(n);

(o) all insurance proceeds received by Seller or payable to Seller (i) with respect to other Excluded Assets or the Excluded Liabilities or (ii) arising in connection with the operation of the Assets for periods prior to Closing to the extent that all material damage to any such Asset has been repaired and to the extent consistent with Section 5.13 herein;

(p) the claims of Seller against third parties described on Schedule 2.02(p), appeals and other risk settlements of the Hospital Businesses which arose during or relate to a pre-Closing period, and all rights, remedies, claims and defenses against third parties thereunder or otherwise relating solely to the Excluded Assets or to the Excluded Liabilities, whether choate or inchoate, known or unknown, contingent or otherwise;

(q) any other assets identified on Schedule 2.02(q) or excluded after the execution of this Agreement by mutual written agreement of the parties;

(r) any Investment interest in a Joint Venture that did not transfer at Closing because the governing instruments of such Joint Venture did not permit such transfer at Closing and all required consents to such transfer were not obtained from the owners or other participants in the Joint Venture; and

(s) all proceeds of the foregoing.

2.03. Assumed Liabilities. As of the Closing Date, Buyer shall assume from Seller and its Affiliates the Assumed Liabilities, including the Assumed Liabilities described on Schedule 2.03, and agrees to pay and satisfy all such Assumed Liabilities.

2.04. Excluded Liabilities. Notwithstanding anything to the contrary set forth in this Agreement, under no circumstance will Buyer assume or be obligated to pay, and from and after the Closing, none of the Assets will be or become liable for or subject to, any of the Excluded Liabilities, which Excluded Liabilities are and will remain liabilities of Seller, including the following:

(a) all liabilities accrued on the Closing Balance Sheets, other than those included in Net Working Capital constituting Assumed Contracts;

(b) liabilities or obligations for Taxes of the Hospital Businesses in respect of periods ending on or before the Closing Date or resulting from the consummation of the transactions contemplated by this Agreement;

(c) liabilities or obligations for federal or state income Taxes of Seller or any Affiliate of Seller, including any amounts accrued or incurred by the Hospital Businesses as a result of being a member of a consolidated, affiliated, combined, unitary or similar group that includes such other Persons;

(d) liabilities or obligations relating to the Excluded Assets;

(e) liabilities or obligations associated with indebtedness for borrowed money (other than capital lease obligations under any Assumed Contract and the ED Loan);

(f) (i) obligations required to be performed by Seller on or before the Closing Date under the Assumed Contracts, (ii) liabilities or obligations resulting from a breach or default on or before the Closing Date of any Assumed Contracts and (iii) liabilities arising under any Contracts that are not Assumed Contracts;

(g) Proceedings and claims (whether instituted before or after Closing) relating to acts or omissions that occurred on or before the Closing Date, including those relating to peer review activities, except for those Proceedings and Claims listed on Schedule 3.23 that are identified as being included in Assumed Liabilities;

(h) liabilities or obligations under the Hill-Burton Act or other restricted grant or loan programs;

(i) liabilities and obligations to Seller's employees, Seller's Employee Benefit Plans, the Internal Revenue Service, PBGC or any other Governmental Authority arising from or relating to periods on or before the Closing Date (whether or not triggered by the transactions contemplated by this Agreement), including liabilities or obligations arising on or before the Closing Date under any Seller Employee Benefit Plan, United States Equal Employment Opportunity Commission claim, unfair labor practice, and wage and hour practice, and liabilities or obligations arising under the WARN Act, provided that this subsection (i) shall not apply to (i) liabilities or obligations under the Employee Benefit Plans assumed by Buyer under Sections 5.03(d) and 5.03(e), including but not limited to the Unfunded Pension Liabilities and the Post-Retiree Health Plan Liability, (ii) Extended Illness Bank Obligations, (iii) obligations under Assumed Contracts or (iv) the Workers' Compensation Liability;

(j) Cost Report settlement payables relating to all Cost Report periods ending on or before the Closing Date;

(k) liabilities or obligations of Seller, including arising out of the operation of the Hospital Businesses or ownership of the Assets, with respect to periods ending on or before the Closing Date, or resulting from the consummation of the transactions contemplated by this Agreement, including pursuant to third-party payor programs and Government Payment Programs, including recoupment rights of the Centers for Medicare & Medicaid Services ("**CMS**") or the Connecticut Department of Social Services and recapture of previously reimbursed charges or expenses;

(l) penalties, fines, settlements, interest, costs and expenses arising out of or incurred as a result of any actual or alleged violation by Seller of any Legal Requirement prior to the Closing Date; and

(m) liabilities or obligations arising out of or in connection with the Eastern Connecticut Health Network, Inc. Long Term Retention Plan, as amended through August 1, 2016.

2.05. Purchase Price; Purchase Price Adjustment.

(a) Subject to the terms and conditions of this Agreement, in reliance upon the representations and covenants of Seller in this Agreement, and as consideration for the sale of the Assets, Buyer shall assume the Assumed Liabilities from Seller and tender the "**Purchase Price**", determined as follows, subject to the limitations and adjustments, including post-Closing adjustments, described in Sections 2.05(b)-(m):

(i) $105,000,000 (One Hundred Five Million Dollars), *plus*

(ii) the amount, if any, by which Net Working Capital on the Closing Balance Sheets exceeds the Target Net Working Capital, or *minus*

(iii) the amount, if any, by which Net Working Capital on the Closing Balance Sheets is less than the Target Net Working Capital, and *minus*

(iv) the book value (including the current portion) as of the Closing of any indebtedness (including capitalized leases but not including the ED Loan) assumed by Buyer, and *minus*

(v) the Unfunded Pension Liabilities as of the Closing Date, and *minus*

(vi) the Post-Retiree Health Plan Liability as of the Closing Date, and *plus* (in the case of Section 2.05(a)(vii)(w)) or *minus* (in the case of Section 2.05(a)(vii)(x)), as applicable,

(vii) (w) the amount, if any, by which the Workers' Compensation Liability as of the Closing Date is less than the cash and investments held by the workers' compensation trust with respect to such liabilities as of the Closing Date, or (x) the amount, if any, by which the Workers' Compensation Liability as of the Closing Date exceeds the cash and investments held by the workers' compensation trust with respect to such liabilities as of the Closing Date, and *plus* (in the case of Section 2.05(a)(viii)(y) below) or *minus* (in the case of Section 2.05(a)(viii)(z) below), as applicable,

(viii) (y) the amount, if any, by which the Captive Insurer Liability as of the Closing Date is less than the cash and investments held by the CHIC with respect to such liabilities as of the Closing Date, or (z) the amount, if any, by which the Captive Insurer Liability as of the Closing Date exceeds the cash and investments held by CHIC with respect to such liabilities as of the Closing Date, and *minus*

(ix) asbestos abatement liability as determined within five business days of Closing by an independent third party mutually agreed upon by Seller and Buyer; provided, however, that the total asbestos abatement liability shall not exceed $1,000,000 (One Million Dollars), and *minus*

(x) in the event Seller is unable to assign and transfer to Buyer or Buyer's designee all of Seller's Investment in one or more Joint Ventures due to the inability to satisfy the requirements of the governing instruments of such Joint Ventures with respect to such transfer at Closing, an amount equal to the value listed next to the name of such Joint Venture on Schedule 2.05(a), provided, however, that the provisions of this Agreement shall not be construed as an offer to separately purchase Seller's Investment in one or more Joint Ventures, and *minus*

(xi) Any amounts paid to Seller by Buyer to reimburse Seller's out-of-pocket legal, valuation, or consulting expenses pursuant to Section 8.04(b).

(b) Seller and Buyer shall equally share the cost of obtaining updated actuarial valuations, which shall be conducted by an actuarial firm chosen by Seller and calculated

in accordance with Section 2.05(h)(ii)-(v), as applicable, of the Unfunded Pension Liabilities, the Captive Insurer Liabilities, the Workers' Compensation Liability, and the Post-Retiree Health Plan Liability as of the Closing.

(c) The sum of the amounts subtracted from the Purchase Price pursuant to Sections 2.05(a)(iii)-(a)(xi) above shall not exceed $77,000,000 (Seventy Seven Million Dollars) (the "**Threshold Liability**").

(d) If Seller, as of the Closing Date, has liabilities, excluding Third Party Debt and excluding the ED Loan, that exceed the Threshold Liability ("**Additional Liabilities**"), Buyer shall assume such excess Additional Liabilities up to Ten Million Dollars ($10,000,000) at Closing based on the amount estimated pursuant to Section 2.05(f)(i)(f) (and as such amount is finally determined pursuant to the provisions of Sections 2.05(h)-(j), as applicable), subject to Seller's obligation to reimburse Buyer for such assumption of Additional Liabilities pursuant to Section 2.05(g)(iii). Buyer may, at Closing, and based on the Closing Estimates, in its sole discretion, waive the provisions of Section 7.12 and assume liabilities in excess of Ten Million Dollars ($10,000,000) of Additional Liabilities. As an illustration only, examples of how the provisions of this Section 2.05 will be implemented are included in Schedule 2.05.

(e) Notwithstanding the foregoing Section 2.05, no liabilities of Seller or its Affiliates shall be subtracted from the Purchase Price to the extent any such liabilities are already included in Net Working Capital.

(f) The Purchase Price, including estimates at Closing of the Net Working Capital, Captive Insurer Liability, Unfunded Pension Liabilities, Workers' Compensation Liability and the Post-Retiree Health Plan Liability calculated as of Closing, will be calculated as follows:

(i) For purposes of determining the Purchase Price, not more than five (5) but in no event less than two (2) business days prior to the Closing, Seller shall deliver to Buyer a statement setting forth its good faith estimate and calculation as of the Closing, and where actuarially determined, based on the Audited Financial Statements as of September 30, 2015, of the following (collectively, the "**Closing Estimates**"):

(a) Net Working Capital,

(b) Unfunded Pension Liabilities,

(c) Captive Insurer Liability,

(d) Workers' Compensation Liability,

(e) Post-Retiree Health Plan Liability, and

(f) Additional Liabilities.

including, as to each Subject Item, supporting documentation of reasonable specificity and other information reasonably requested by the Buyer to verify such amounts. For the avoidance of doubt, each of the Subject Items shall be subject to a final determination after the Closing pursuant to the provisions of Sections 2.05(h)-(i), and the Purchase Price shall be adjusted accordingly pursuant to the provisions of Section 2.05(j).

(ii) The estimate of Net Working Capital at Closing will be calculated by Buyer and Seller from the physical count of inventory and supplies conducted pursuant to this Section 2.05(f)(ii), if available, the relevant entries in the Interim Closing Balance Sheets (other than inventory and supplies if the physical inventory is available) and the parties' mutual good faith estimate as of the Closing Date of the amount of the prorations to be made pursuant to Section 2.06. The portion of Net Working Capital constituting the value of inventory and supplies will be determined based on a physical count conducted by Seller on a date not more than five (5) business days before the Closing Date. Seller shall give Buyer at least five (5) business days prior notice of the date of the count and permit Buyer to monitor the count. Seller shall count the usable items of inventory and supplies that are not damaged or obsolete, and that are of a type, quality and quantity that may be used in the ordinary course of the Hospital Businesses (having due regard for the services offered by the Hospital Businesses). Seller will conduct the count in the same manner that Seller conducted the count of, and will count the same classes and categories of items that Seller counted to determine the value of, inventory and supplies in the most recent Audited Financial Statements. Upon completion of the count, Seller shall determine the value of the inventory and supplies (determined by the lower of cost or market on a first in, first out basis). If the results of the count and the resulting value of inventory and supplies are available by Closing, then the portion of Net Working Capital attributable to inventory and supplies will be the value determined pursuant to the count (updated for actual usage and purchases between the date of the count and the Closing Date). If the results of the count or the resulting value of inventory and supplies are not available by Closing, then for purposes of the Closing, the value of the inventory and supplies will be the amount set forth in the Interim Closing Balance Sheets and the value of the inventory and supplies determined pursuant to the count (updated for actual usage and purchases between the date of the count and the Closing Date) will be set forth in the Closing Balance Sheets. The portion of Net Working Capital constituting the value of prepaid expenses and deposits will be determined based on mutual agreement of Seller and Buyer.

(g) At Closing, Buyer shall pay such Purchase Price (based on the Closing Estimates provided in a statement delivered by Seller pursuant to Section 2.05(f)) by wire transfer of immediately available funds to an account designated by the Seller to Buyer prior to the Closing Date, and Seller shall immediately use all of its Available Cash in the following manner and priority (recognizing that there may not be sufficient Available Cash to satisfy all of the following obligations):

(i) First, to pay off all Third Party Debt, including to defease the Indenture and all Encumbrances created by or in connection with the Indenture, including the Bond Liabilities and other tax-exempt debt;

(ii) Second, to fund Seller's wind-down operations up to One Million Dollars ($1,000,000) (the "**Wind-Down Reserve**"); *provided, however*, that in the event that Seller fails to fund the Wind-Down Reserve in full, (x) Buyer shall pay such shortfall in the administrative wind-down costs incurred by Seller in accordance with Section 2.05(*l*)(i);

(iii) Third, to reimburse Buyer for Additional Liabilities;

(iv) Fourth, to fund the indemnity reserve in accordance with Section 9.08;

(v) Fifth, to reimburse Buyer up to the total amount of the ED Loan; and

(vi) Sixth, any excess Available Cash shall be retained by Seller.

As an illustration only, an example of how the provisions of this Section 2.05(g) will be implemented is included in Schedule 2.05.

(h) Not more than ninety (90) days after the Closing, Buyer shall prepare and deliver, or cause to be prepared and delivered, to Seller, the Closing Balance Sheet and the final closing statement (the "**Final Closing Statement**") setting forth the following:

(i) its good faith determination of the actual Net Working Capital as of the Closing Date, and a calculation showing the difference between the Net Working Capital estimated by Seller at Closing and the actual Net Working Capital as of the Closing Date,

(ii) the actual Unfunded Pension Liabilities as of the Closing Date, as determined using the updated actuarial report obtained pursuant to Section 2.05(d), provided that such updated report shall be prepared using the same assumptions, principles and methodologies used in the calculation of the Unfunded Pension Liabilities pursuant to Section 2.05(f)(i), and a calculation showing the difference between the Unfunded Pension Liabilities estimated by Seller at Closing and the actual Unfunded Pension Liabilities as of the Closing Date, and

(iii) the actual Captive Insurer Liability as of the Closing Date, as determined using the updated actuarial report obtained pursuant to Section 2.05(d), provided that such updated report shall be prepared using the same assumptions, principles and methodologies used in the calculation of the Captive Insurer Liability pursuant to Section 2.05(f)(i), except that the selected ratio for the calculation of the $1,000,000 basic limit loss cost used in such updated actuarial report shall be 0.90 (versus 0.64 as of September 30, 2015), and a

calculation showing the difference between the Captive Insurer Liability estimated by Seller at Closing and the actual Captive Insurer Liability as of the Closing Date,

(iv) the actual Workers' Compensation Liability as of the Closing Date, as determined using the updated actuarial report obtained pursuant to Section 2.05(d), provided that such updated report shall be prepared using the same assumptions, principles and methodologies used in the calculation of the Workers' Compensation Liability pursuant to Section 2.05(f)(i), and a calculation showing the difference between the Workers' Compensation Liability estimated by Seller at Closing and the actual Workers' Compensation Liability as of the Closing Date,

(v) the actual Post-Retiree Health Plan Liability as of the Closing Date, as determined using the updated actuarial report obtained pursuant to Section 2.05(d), provided that such updated report shall be prepared using the same assumptions, principles and methodologies used in the calculation of the Post-Retiree Health Plan Liability pursuant to Section 2.05(f)(i), and a calculation showing the difference between the Post-Retiree Health Plan Liability estimated by Seller at Closing and the actual Post-Retiree Health Plan Liability as determined by Buyer as of the Closing Date, and

(vi) the actual Additional Liabilities as of the Closing Date, and a calculation showing the difference between the Additional Liabilities estimated by Seller at Closing and the actual Additional Liabilities as determined by Buyer as of the Closing Date,

Simultaneously, with its delivery to Seller of the Closing Balance Sheet and the Final Closing Statement, Buyer shall deliver to Seller supporting documentation of reasonable specificity supporting the calculation of the value of each Subject Item listed in Section 2.05(h)(i)-(v). Except as otherwise expressly provided herein, the Final Closing Statement and the Closing Balance Sheets shall be prepared using the same principles and methodologies, including the determination of Accounts Receivable, doubtful account and the Subject Items, as used in preparing the Interim Closing Balance Sheets. At all reasonable times following delivery by Buyer to Seller of the Final Closing Statement and the Closing Balance Sheets, Buyer shall make available to Seller and its agents all books and records of Buyer included in, or related to, the determination of the value of each Subject Item listed in Section 2.05(h)(i)-(v), including all of Buyer's and its agent's accounting work papers and journal entries underlying such determination or the preparation thereof and shall permit Seller to discuss all such matters with Buyer's agents.

(i) Following receipt of the information set forth in Section 2.05(h), Seller will be afforded a period of forty-five (45) days (the "**45-Day Period**") to review the Final Closing Statement and the Closing Balance Sheets. At or before the end of the 45-Day Period, Seller will either (i) accept the amount of the actual Subject Items calculated

by Buyer and set forth on the Final Closing Statement in their entirety or (ii) deliver to Buyer a written notice (the "**Objection Notice**") containing a reasonably detailed written explanation of those items on the Final Closing Statement or the Closing Balance Sheets that Seller disputes, in which case the items specifically identified by Seller shall be deemed to be in dispute. The failure by Seller to deliver the Objection Notice within the 45-Day Period shall constitute Seller's acceptance of the amount of the actual Subject Items calculated by Buyer. If Seller delivers the Objection Notice in a timely manner, then, within a further period of forty-five (45) days from the end of the 45-Day Period (the "**Second 45-Day Period**"), the parties will attempt to resolve in good faith any disputed items and reach a written agreement (the "**Settlement Agreement**") with respect thereto. Failing such resolution, as promptly as practicable (and no event later than ten (10) days from the end of the Second 45-Day Period), the unresolved disputed items will be referred for final binding resolution to PricewaterhouseCoopers LLP (the "**Arbitrating Accountants**"). In resolving any disputed item, the Arbitrating Accountants may not assign a value to any item greater than the greatest value for such item claimed by either party or less than the smallest value for such item claimed by either party. The fees and expenses of the Arbitrating Accountants shall be allocated between Buyer and Seller in proportion to the amounts by which their proposals of the actual Subject Items differed from the Arbitrating Accountants' final determination. Such determination (the "**Accountants' Determination**") shall be (i) in writing, (ii) furnished to the Buyer and Seller as soon as practicable (and in no event later than thirty (30) days) after the items in dispute have been referred to the Arbitrating Accountants, (iii) made in accordance with GAAP, consistently applied, and (iv) non-appealable and incontestable by Buyer or Seller and each of their respective Affiliates and successors and assigns and not subject to collateral attack for any reason other than manifest error or fraud.

(j) The Purchase Price will be recalculated (based on clauses (i)-(viii) below) (the "**Purchase Price Adjustment**") to reflect:

(i) any such revisions in the amount of the prorations to be made pursuant to Section 2.06,

(ii) the difference between the Net Working Capital (excluding differences in prepaid expenses and deposits calculated in accordance with Section 2.05(f)(ii) and, if a physical inventory was used to calculate the Purchase Price, in inventory and supplies) estimated at Closing and the actual Net Working Capital as of the Closing Date (as finally determined pursuant to the provisions of Sections 2.05(h) and, if applicable, Section 2.05(i)),

(iii) the difference between the Unfunded Pension Liabilities estimated at Closing and the actual Unfunded Pension Liabilities (as finally determined pursuant to the provisions of Sections 2.05(h) and, if applicable, Section 2.05(i)),

(iv) the difference between the Captive Insurer Liability estimated at Closing and the actual Captive Insurer Liability (as finally determined pursuant to the provisions of Sections 2.05(h) and, if applicable, Section 2.05(i))

(v) the difference between the Workers' Compensation Liability estimated at Closing and the actual Workers' Compensation Liability (as finally determined pursuant to the provisions of Sections 2.05(h) and, if applicable, Section 2.05(i)),

(vi) the difference between the Post-Retiree Health Plan Liability estimated at Closing and the actual Post-Retiree Health Plan Liability (as finally determined pursuant to the provisions of Sections 2.05(h) and, if applicable, Section 2.05(i)), and

(vii) the difference between the Additional Liabilities estimated at Closing and the actual Additional Liabilities (as finally determined for and as of the Closing Date and pursuant to the provisions of Sections 2.05(h) and, if applicable, Section 2.05(i)).

As an illustration only, an example of how the provisions of this Section 2.05(j) will be implemented is included in Schedule 2.05.

(k)

(i) Within five (5) business days following the Final Determination Date, if the Purchase Price is adjusted upward by the Purchase Price Adjustment, the Purchase Price Adjustment shall be applied or paid, as applicable, in the following manner and priority (recognizing that the amount of the Purchase Price Adjustment may not be sufficient to satisfy each of the following obligations):

(u) First, if and to the extent Buyer has paid any of Seller's administrative wind-down costs pursuant to Section 2.05(*l*)(i), Buyer shall be entitled to retain any amounts remaining from the Purchase Price Adjustment as reimbursement of such administrative wind-down costs;

(v) Second, if and to the extent Seller is unable to fund fully the Wind-Down Reserve, any amounts remaining from the Purchase Price Adjustment shall be used to fund Seller's Wind-Down Reserve, less the amount retained by Buyer pursuant to Section 2.05(k)(i)(u);

(w) Third, in the event that Seller is unable to fund fully the indemnity reserve establish under Section 9.08 to the maximum amount of $4,500,000 at the Closing, any amounts remaining from the Purchase Price Adjustment shall be used by Seller to fund the indemnity reserve (in an amount not to exceed $4,500,000);

(x) Fourth, Buyer shall be entitled to retain any amounts remaining from the Purchase Price Adjustment up to the aggregate amount of the Additional Liabilities; and

(y) Fifth, to reimburse Buyer up to the total amount of the ED Loan;

(z) Sixth, Buyer shall pay to Seller, by wire transfer of immediately available funds to one or more accounts designated by Seller, any amounts remaining from the Purchase Price Adjustment (after application of clauses (u) through (y) above).

(ii) If the Purchase Price is adjusted downward by the Purchase Price Adjustment, within five (5) business days following the Final Determination Date, Seller shall pay to Buyer the amount by which the Purchase Price is decreased, by wire transfer of immediately available funds to one or more accounts designated by Buyer as a cash payment from Seller to Buyer in an amount up to the remaining Available Cash in excess of the remaining Wind-Down Reserve.

As an illustration only, an example of how the provisions of this Section 2.05(k) will be implemented is included in Schedule 2.05.

(l)

(i) If following completion of the process outlined in Sections 2.05(a)-2.05(k), Available Cash is less than $1,000,000 (One Million Dollars), Buyer shall pay Seller's administrative wind-down costs (*e.g.*, preparation of tax returns, annual audit, legal fees relating to dissolution proceedings) incurred through the third anniversary of the Closing Date to the extent such wind-down costs exceed Available Cash; *provided, however*, that the total amount paid by Buyer for Seller's wind-down costs under this Section 2.05(*l*)(i) shall not exceed an amount equal to One Million Dollars ($1,000,000) less Available Cash determined after the process outlined above.

(ii) To the extent that any funds remain in the Wind-Down Reserve following the wind-down of Seller's operations, and there has been a reduction in the Commitment Amount pursuant to Section 5.18, the remaining Wind-Down Reserve funds shall be paid to Buyer and the Commitment Amount shall be increased, on a dollar-for-dollar basis, up to a maximum of Seventy-Five Million Dollars ($75,000,000), in accordance with Section 5.18(c)(v).

As an illustration only, an example of how the provisions of this Section 2.05(*l*) will be implemented is included in Schedule 2.05.

(m)

(i) If Seller receives any cash payments pursuant to cost report settlements following the Closing, Seller shall use such cash in the following manner and priority, to the extent available and applicable (recognizing that the amount of the cash payments pursuant to cost report settlements may not be sufficient to satisfy each of the following obligations):

(u) First, to reimburse Buyer for any amounts Buyer has expended to pay Seller's wind-down costs pursuant to Section 2.05(*l*)(i);

(v) Second, if and to the extent Seller is unable to fund fully the Wind-Down Reserve, to fund the shortfall in the Wind-Down Reserve less any amount paid to Buyer pursuant to Section 2.05(m)(i)(u);

(w) Third, to fund the indemnity reserve in accordance with Section 9.08;

(x) Fourth, to reimburse Buyer for the Additional Liabilities; and

(y) Fifth, to reimburse Buyer up to the total amount of the ED Loan;

(z) Sixth, to be retained by Seller.

(ii) If Seller is required to make any cash payments pursuant to cost report settlements following the Closing, Seller shall make such payments, first, from Seller's Available Cash (including the indemnity reserve established pursuant to Section 9.08); *provided, however*, that Seller shall indemnify Buyer, in accordance with Section 9.01(d), for any unpaid cash payments required to be paid by Seller pursuant to cost report settlements that are not satisfied in full pursuant to the immediately preceding clause.

As an illustration only, an example of how the provisions of this Section 2.05(m) will be implemented is included in Schedule 2.05.

2.06. Prorations. At Closing, and to the extent not included in Net Working Capital, Buyer and Seller shall prorate real estate and personal property lease payments, real estate and personal property Taxes (except that no such proration of property Taxes will be necessary in respect of the transfer of property by any Person that is a non-profit corporation that does not pay any property Taxes with respect to such property) and other assessments, and all other items of income and expense that are normally prorated upon a sale of assets of a going concern, if any. If any payment of Taxes made by Seller before Closing is credited against real estate Taxes for which Buyer will be liable, the amount of such credit will be applied as a credit against any prorations owing by Seller, to the extent available for offset, and any amounts not so applied will be paid to Seller by Buyer upon Buyer's receipt of such credit.

2.07. Promissory Note. To the extent Seller is unable to transfer to Buyer on the Closing Date Seller's Investment in one or more Joint Ventures as a result of the failure to obtain a consent or to otherwise comply with the governing instruments of such Joint Venture, Buyer shall lend to Seller an amount equal to the value of such Joint Venture(s) as such value is listed on Schedule 2.05(a). The loan described in the previous sentence shall be made pursuant to a promissory note bearing interest at 3% per annum payable solely from, and secured by, future distributions from the Joint Ventures, and further secured by the Joint Venture investments themselves, to the extent the granting of such a security interest is permissible under the laws of the State of Connecticut and the Joint Venture agreements (the "**Joint Venture Promissory Note**"). If, after the Closing Date, one or more of Seller's Joint Venture investments whose value is included in the Joint Venture Promissory Note is transferred to Buyer, the principal

amount of the Joint Venture Promissory Note shall be reduced by an amount equal to the value set forth next to the name of such Joint Venture on Schedule 2.05(a).

3. REPRESENTATIONS OF SELLER

Subject to the exceptions described in the Schedules, Seller makes the following representations to Buyer on and as of the date of this Agreement and will be deemed to make them again at and as of the Closing Date:

3.01. Organization and Qualification. Seller is a non-stock corporation duly organized and validly existing in good standing under the laws of the State of Connecticut. Seller is not licensed, qualified or admitted to do business in any jurisdiction other than in the State of Connecticut and there is no other jurisdiction in which the ownership, use or leasing of Seller's assets or properties, or the conduct or nature of its business, makes such licensing, qualification or admission necessary.

3.02. Corporate Powers; Absence of Conflicts, Etc. Seller has the requisite power and authority to conduct the Hospital Businesses as now being conducted, to enter into this Agreement and to perform its obligations hereunder. The execution, delivery and performance by Seller of this Agreement and the Closing Documents to which Seller is or becomes a party and the consummation by Seller of the transactions contemplated by this Agreement:

(a) are within Seller's powers, are not in contravention of its articles of incorporation, bylaws and other governing documents, and have been duly authorized by all appropriate corporate action;

(b) do not conflict with, result in any breach or contravention of, or permit the acceleration of the maturity of any liabilities of Seller (other than Excluded Liabilities to be satisfied as of the Closing Date), and do not create or permit the creation of any Encumbrance on or affecting any of the Assets;

(c) do not violate any Legal Requirement to which Seller, the Assets, or the Hospital Businesses may be subject other than with respect to the Excluded Liabilities to be satisfied as of the Closing Date; and

(d) assuming the receipt of all consents set forth in Schedule 3.02, do not conflict with or result in a breach or violation of any material Contract to which Seller is a party or by which it is bound and will not be terminated as of the Closing Date.

3.03. Binding Agreement. This Agreement and each of the Closing Documents to which Seller is or becomes a party are (or upon execution will be) valid and legally binding obligations of Seller, enforceable against it in accordance with the respective terms hereof or thereof.

3.04. Subsidiaries and Third Party Rights. Seller holds no Investment interest in any Person involved in the ownership or operation of the Hospital Businesses or the Assets, other than those Persons identified on Schedule 3.04. Schedule 3.04 indicates for each Person identified thereon whether it is currently active or inactive and whether it, together with its

consolidated Subsidiaries, has total assets of $10,000 or more. Schedule 3.04 also indicates, for each Joint Venture, the percentage of equity interests owned by Seller or its Affiliate in such Joint Venture and the name of, and percentage of equity interests owned by, third parties in such Joint Venture. Other than Seller and those Persons set forth on Schedule 3.04, there are no other Persons that own any interest in any of the Hospital Businesses. There are no Contracts with, or rights of, any Person to acquire, directly or indirectly, any material assets, or any interest therein, of Seller, including any of the Assets, other than Contracts entered into in the ordinary course of the Hospital Businesses or Contracts entered into with Buyer with respect to the transactions contemplated by this Agreement.

3.05. Legal and Regulatory Compliance. Except as otherwise provided in this Agreement and other than as set forth on Schedule 3.05, Seller and all of its officers, directors, agents, or employees comply in all material respects with, and have complied in all material respects with, all Legal Requirements, and Seller has timely filed all material reports, data and other information required to be filed with Governmental Authorities. Seller has not received notice of any currently pending or threatened Proceeding against it alleging or based upon an alleged violation of any Legal Requirements. Neither Seller nor any Affiliate of Seller is party to or otherwise bound by (i) a corporate integrity agreement with the Office of Inspector General of the United States Department of Health and Human Services or written agreement with such Governmental Authority to establish or maintain a corporate integrity program applicable to any of the Hospital Businesses or (ii) a settlement or other agreement with any other Governmental Authority, other than participation agreements with Medicare and Medicaid, that imposes continuing obligations on any of the Hospital Businesses or contains obligations that have not been fully discharged.

3.06. Financial Statements. Attached as Schedule 3.06 are copies of the Audited Financial Statements and the Unaudited Financial Statements. The Financial Statements fairly present the financial condition and results of operations of Seller and the Hospital Businesses as of the respective dates thereof and for the periods therein referred to, all in accordance with GAAP, subject, in the case of the Unaudited Financial Statements, to normal recurring year-end adjustments (the effect of which will not, individually or in the aggregate, have a Material Adverse Change) and the absence of notes (which, if presented, would not differ materially from those included in the Audited Financial Statements), and the Financial Statements reflect the consistent application of such accounting principles throughout the periods involved.

3.07. Undisclosed Liabilities. Except and to the extent accrued or disclosed in the Financial Statements, Seller does not have any liabilities or obligations of any nature whatsoever with respect to the Hospital Businesses or the Assets, due or to become due, accrued, absolute, contingent or otherwise, that are required by GAAP to be accrued or disclosed in audited financial statements, except for liabilities and obligations incurred in the ordinary course of business and consistent with past practice since the date of the Unaudited Financial Statements, which are not, individually or in the aggregate, expected to result in a Material Adverse Change.

3.08. Recent Activities. Since September 30, 2014 and except as set forth on Schedule 3.08:

(a) no material damage, destruction or loss (whether or not covered by insurance) has occurred affecting the Assets;

(b) except in the ordinary course of the Hospital Businesses or as set forth on Schedule 3.08(b), consistent with past practice and existing personnel policies of Seller, Seller has not (i) increased or agreed to increase the compensation payable to any employees who work in the Hospital Businesses, (ii) agreed to make any bonus or severance payment to any of the employees who work in the Hospital Businesses or (iii) employed any additional management personnel in respect of the Hospital Businesses;

(c) no labor dispute, enactment or promulgation of a state or local Legal Requirement, or other event or condition, has occurred that has materially adversely affected any of the Hospital Businesses or reasonably could be expected to have such an effect on the Hospital Businesses;

(d) other than as set forth on Schedule 3.08(d), Seller has not sold or factored, or agreed to sell or factor, any Accounts Receivable, and Seller has not sold, distributed or otherwise disposed of any other Assets except in the ordinary course of the Hospital Businesses and, for equipment having an original cost in excess of $25,000, with a comparable replacement thereof;

(e) to Seller's knowledge, no Encumbrance has been imposed on any of the Assets;

(f) Seller has not canceled or waived any material rights in respect of the Assets, except in the ordinary course of the Hospital Businesses;

(g) other than in connection with the freeze of Seller's defined benefit pension plan and post-retiree health plan, there has been no change in any accounting method, policy or practice of Seller with respect to the Hospital Businesses;

(h) other than compensation paid in the ordinary course of employment or ordinary course professional services agreements disclosed to Buyer, Seller has not paid any amount to, sold any Assets to, or entered into any Contract with any officer, director, or trustee of Seller or its Affiliates, or with any Affiliate of any such Person;

(i) Seller has not paid or agreed to pay to any Person any damages, fines, penalties or other amounts in respect of an actual or alleged violation of any Legal Requirement excluding routine workers' compensation claims in amounts no greater than $100,000;

(j) Other than ordinary course plan benefit design changes, Seller has not instituted any new, or terminated or amended any existing, Employee Benefit Plan, except for amendments required to comply with applicable Legal Requirements and the freeze of Seller's defined benefit pension plan and post-retiree health plan;

(k) Seller has not entered into or agreed to enter into any transaction outside the ordinary course of the Hospital Businesses (other than the transactions contemplated by this Agreement); and

(l) no Material Adverse Change has occurred and no event or circumstance has occurred that could reasonably be expected to result, individually or in the aggregate, in a Material Adverse Change.

3.09. Accounts Receivable; Inventory.

(a) The Accounts Receivable, to the extent uncollected, are valid and existing and represent monies due for goods sold and delivered and services performed in bona fide commercial transactions, have been billed or are billable, and are not subject to any Encumbrances. Except as reflected or reserved for in the Financial Statements, no refunds, discounts or setoffs are payable or assessable with respect to the Accounts Receivable.

(b) All Assets consisting of inventory and supplies are carried at the lower of cost or market on a first-in, first-out basis and are properly stated in the Audited Financial Statements as of the dates thereof. All items of inventory and supplies are of a quality usable or saleable in the ordinary course of business, except for those items that are obsolete, below standard quality or in the process of repair and for which adequate reserves have been provided in the Financial Statements. The quantities of inventory and supplies, taken as a whole, are reasonable and justified under the normal operations of the Hospital Businesses.

3.10. Equipment. Schedule 3.10 includes a depreciation schedule as of a recent date that lists all items of equipment associated with, or constituting any part of, the Assets. To Seller's knowledge, and excluding information technology equipment and systems, all major items of Seller's equipment (e.g., heating systems, magnetic resonance imaging units, ultrasound units, robotic surgery and similar equipment) are usable for their intended purposes in the ordinary course of the Hospital Business and are in working condition, subject to reasonable wear and tear.

3.11. Title. Except as provided in Schedule 3.11 and subject to Section 10.03(a), Seller owns and holds good and valid title to all of the Assets, free and clear of any Encumbrances other than the Encumbrances described on Schedule 3.11. At Closing, Seller will convey to Buyer good and valid title to all Assets, free and clear of any Encumbrances other than the Permitted Encumbrances.

3.12. Real Property.

(a) Seller owns fee simple title to the Owned Real Property, free and clear of any Encumbrances other than the Encumbrances described on Schedule 3.12(a). The Owned Real Property described on Schedule 2.01(a) comprises all of the real property owned by Seller or any Subsidiary of Seller that is associated with or utilized in the operation of the Hospital Businesses. At Closing, Seller will convey to Buyer good and

marketable fee simple title to all Owned Real Property, free and clear of any Encumbrances other than the Permitted Real Property Encumbrances.

(b) Seller has not received notice of condemnation or similar Proceedings relating to the Owned Real Property or any part thereof.

(c) Except as set forth on Schedule 3.12(c), to Seller's knowledge, the buildings standing on the Owned Real Property are structurally sound and in need of no material maintenance or repairs, except for ordinary, routine maintenance. All essential utilities (including water, sewer, gas, electricity and telephone service) are available to the Owned Real Property, and, to Seller's knowledge, no conditions exist that are reasonably likely to result in the termination or reduction of the current access from the Owned Real Property to existing roadways. To Seller's knowledge, no part of the Owned Real Property contains, is located within or abuts any flood plain, navigable water or other body of water, tideland, wetland, marshland or other area that is subject to special state, federal or municipal regulation, control or protection (other than Legal Requirements pertaining to zoning or other land use restrictions customarily applicable to all real estate within the applicable jurisdiction).

(d) Except for tenants in possession of the Owned Real Property under Contracts described on Schedule 3.18, no Person other than Seller possesses, or claims possession of, adverse or not, any Owned Real Property, whether as lessee, tenant at sufferance, trespasser or otherwise.

(e) No tenant is entitled to any rebate, concession, or free rent, other than as reflected in the Contract with such tenant; no commitments have been made to any tenant for repairs or improvements other than for normal repairs and maintenance in the future or improvements required by the tenant Contract; and no rents due under any of the Contracts with tenants have been assigned or hypothecated to, or encumbered by, any Person other than in connection with financing. All material obligations of Seller as landlord required to be performed under each of the tenant Contracts have been performed.

(f) All Owned Real Property and, to Seller's knowledge, Leased Real Property currently in use for the operation of the Hospital Businesses is in compliance in all material respects with all applicable Legal Requirements, and all material Permits and requisite certificates of the local board of fire underwriters (or other material body exercising a similar function) have been issued for the Owned Real Property and Leased Real Property.

(g) (i) Seller has provided to Buyer accurate and complete copies of those leases of which Seller or one of its Subsidiaries is landlord (collectively, the "**Space Leases**"), and (ii) attached as Schedule 3.12(g) is a "rent roll" that sets forth the following information, if any, for each of the Space Leases: (A) the names of the current tenants; (B) the rental payments for the then current month under each of the Space Leases; (C) a list of all then delinquent rental payments; (D) a list of all outstanding concessions granted to tenants; (E) a list of all tenant deposits and a description of any

application thereof; (F) the dates that each of the Space Leases commenced and will expire; (G) the square footage of any such space leased pursuant to the Space Leases; (H) any renewal options available to tenants under the Space Leases; and (I) a list of all uncured material defaults under the Space Leases known to Seller.

(h) There are no tenants or other Persons occupying any space in the Owned Real Property, other than pursuant to the Space Leases.

(i) Seller has (A) a valid leasehold estate in all of the Leased Real Property, free and clear of any Encumbrances other than the Encumbrances described on Schedule 3.12(i) pursuant to the leases described on Schedule 2.01(b) (the "**Tenant Leases**"), and (B) provided accurate and complete copies of each of the Tenant Leases to Buyer. The Leased Real Property comprises all of the real property leased by Seller or any Subsidiary of Seller that is associated with or utilized in the operation of the Hospital Businesses.

3.13. Environmental Matters and Medical Waste.

(a) Seller has all material Permits required under applicable Environmental Laws for the operation of the Hospital Businesses, and all such Permits are listed on Schedule 2.01(g). Other than as listed on Schedule 3.13(a), no Environmental Claim is pending, or to Seller's knowledge, threatened by any Person against Seller or, to Seller's knowledge, any other Person the liability for which Seller has retained or assumed, either contractually or by operation of law. To Seller's knowledge, no activities, circumstances, conditions, events or incidents, including the release, emission, discharge or disposal of any Materials of Environmental Concern, have occurred that could reasonably be expected to form the basis of any Environmental Claim by any Person against Seller or any other Person the liability for which Seller has retained or assumed, either contractually or by operation of law.

(b) Without in any way limiting the generality of the foregoing, (i) all on-site and off-site locations where Seller stores, disposes or arranges for the disposal of material quantities or volumes of Materials of Environmental Concern for the Hospital Businesses are identified on Schedule 3.13(b), (ii) all Contracts dealing with the removal, storage, disposal and handling of Materials of Environmental Concern of the Hospital Businesses are with vendors who are, to Seller's knowledge, properly licensed, (iii) all underground storage tanks, and the capacity and contents of such tanks, located on Owned Real Property are identified on Schedule 3.13(b) and (iv) to Seller's knowledge, no polychlorinated biphenyls are used or stored at any Owned Real Property.

(c) Seller and the Hospital Businesses have complied in all material respects with all Medical Waste Laws.

3.14. Intellectual Properties and Information Systems. Seller owns or is licensed to use, free and clear of royalty and other payment obligations, claims of infringement or other Encumbrances, each of the Intellectual Properties and the Information Systems. Seller is not, in any material respect, in conflict with or in violation or infringement of, and has not received any notice alleging any conflict with or violation or infringement of, any rights of any other Person

with respect to any such Intellectual Properties or Information Systems. To Seller's knowledge, no other Person is in conflict with or in violation or infringement of Seller's rights in such Intellectual Properties or Information Systems. Schedule 3.14 identifies those Intellectual Properties and Information Systems used in the conduct of the Hospital Businesses that are owned by or licensed directly to Seller (other than the Intellectual Properties and Information Systems owned by Seller, for which no copyright registration or application has been made and none of which is, individually or in the aggregate, material to the Hospital Businesses) and those Intellectual Properties and Information Systems that are owned by or licensed to third parties who provide information technology services to Seller pursuant to Contracts described in Section 3.18(c).

3.15. Insurance. Schedule 3.15 describes all insurance arrangements, including self-insurance, in place for the benefit of the Assets and the conduct of the Hospital Businesses (other than Current Seller Plans described in Schedule 3.22). Seller has provided to Buyer a true and complete copy of all such policies and endorsements thereto. With respect to third party insurance, Schedule 3.15 sets forth the name of each insurer, whether such insurer is an Affiliate of Seller, and the number, coverage, limits, term and premium for each policy of insurance purchased or held by Seller covering the ownership and operation of the Assets and the Hospital Businesses. Except as set forth on Schedule 3.15, all of such policies are now, and until Closing will remain, valid, outstanding, in full force and effect, and enforceable with no premium arrearages. Since September 30, 2011, Seller has not been denied, or reduced, or requested a reduction in the scope or amount of, any insurance or indemnity bond coverage. No insurance carrier has canceled or reduced, or given written notice of its intention to cancel or reduce, any insurance coverage and, to Seller's knowledge, there exist no reasonable grounds to cancel or void any such policies or the coverage provided thereby. Except as set forth on Schedule 3.15, since September 30, 2011, Seller has not made any claims against any excess insurance coverage set forth on Schedule 3.15 or any predecessor excess insurance policies applicable during such time period.

3.16. Permits. Schedule 2.01(g) describes all material Permits relating to the ownership of the Assets and the conduct of the Hospital Businesses, all of which are in good standing and not subject to meritorious challenge. Seller has not received any written notice from any Governmental Authority relating to the threatened, pending or possible revocation, termination, suspension or limitation of any of such material Permits. Each Hospital is duly licensed as an acute care hospital by the appropriate Governmental Authorities, and all departments or other business units, including the other Hospital Businesses, that are required to be separately licensed are duly licensed by the appropriate Governmental Authorities. The Hospitals and all departments or business units, including the Hospital Businesses, comply in all material respects with the applicable licensing requirements. Each Hospital has complied in all material respects with the requirements and conditions of all certificates of need (including applications therefor, non-review letters and implemented and unimplemented certificates of need if not lapsed and unexpired).

3.17. Government Payment Programs; Accreditation. Each Hospital has a current and valid provider Contract with the Government Payment Programs and/or their fiscal intermediaries, administrative contractors or paying agents and complies in all material respects with the conditions of participation therein. Each Hospital is entitled to receive and is receiving

payment under the Government Payment Programs for services rendered to qualified beneficiaries and, to Seller's knowledge, except as reflected in the Audited Financial Statements, is not subject to any withholds or offsets in respect thereof. Seller has timely filed all Cost Reports due for Cost Report periods through September 30, 2014, and Cost Reports have been audited and notices of program reimbursement have been issued for all Cost Report periods through September 30, 2010. All amounts shown as due from Seller in the Cost Reports were remitted with such reports and all amounts shown in the notices of program reimbursement as due have been paid. Except to the extent liabilities and contractual adjustments of each Hospital under the Government Payment Programs have been properly reflected and adequately reserved in the Financial Statements in the ordinary course of business, neither Hospital has to its knowledge received nor submitted any claim for payment in excess of the amount provided by Legal Requirements or applicable Contract, and Seller has not received notice of any dispute or claim by any Governmental Authority, fiscal intermediary or other Person regarding the Government Payment Programs or each Hospital's participation therein that remains outstanding or unresolved. All Medicare and Medicaid incentive payments for meaningful use of certified electronic health record technology received by Seller under The American Recovery and Reinvestment Act of 2009 were awarded based on truthful attestations made by Seller or its Affiliates, and no such incentive payments were remitted due to any knowingly fraudulent, negligent or unlawful act or omission of Seller or its Affiliates. Seller has registered with the QNet Exchange ("**QNet**") as required by CMS under its Hospital Quality Initiative Program (the "**HQI Program**"). Seller has submitted all quality data required under the HQI Program to CMS or its agent, and all quality data required under the ORYX Core Measure Performance Measurement System ("**ORYX**") to The Joint Commission, for all calendar quarters concluded prior to the date of this Agreement, except for any quarter for which the respective reporting deadlines have not yet expired. All such submissions of quality data have been made materially in the form and manner required by CMS and The Joint Commission, respectively. Seller has not received notice of any reduction in reimbursement under the Medicare program resulting from its failure to report quality data to CMS or its agent as required under the HQI Program. Seller has provided Buyer with the HQI Program "validation results" for all calendar quarters concluded prior to the date of this Agreement, except for any quarter for which the respective reporting deadlines have not yet expired. Each Hospital is duly accredited, with no contingencies except as disclosed on Schedule 3.17, by the Joint Commission and Seller's certification for participation in the Medicare program is based on such Joint Commission accreditation. A copy of the most recent accreditation letter from the Joint Commission pertaining to each Hospital has been made available to Buyer. Seller has delivered to Buyer copies of all accreditation survey reports, deficiency lists, statements of deficiency, and plans of correction since September 30, 2011. Seller has taken or is taking all reasonable steps to correct all material deficiencies noted therein. Schedule 3.17 includes a list and description of all unexpected occurrences involving death or serious physical or psychological injury since September 30, 2011.

3.18. Agreements and Commitments. Schedule 3.18 identifies the Contracts related to the Hospital Businesses in the categories below:

(a) Contracts that relate to the ownership or use of, title to or interest in Owned Real Property or Leased Real Property;

(b) Contracts with (i) a physician or physician group, (ii) an Immediate Family Member of a physician on the medical staff of the Hospitals or (iii) any Person that provides marketing services for Seller or its Subsidiaries;

(c) Contracts relating to Intellectual Properties and Information Systems;

(d) collective bargaining agreements or other Contracts with labor unions or other employee representatives or groups;

(e) Contracts with directors, trustees, officers, employees, or other agents of Seller or its Subsidiaries;

(f) requirements or exclusive Contracts and Contracts that prohibit or limit competition or the conduct by Seller or any Subsidiary of any lawful business;

(g) Contracts with any health plan, health provider, independent practice association or similar Person providing for capitation or risk-sharing arrangements;

(h) Contracts relating to the administration, operation or funding of any Employee Benefit Plan;

(i) Contracts between Seller and any of the Joint Ventures;

(j) Contracts with Governmental Authorities;

(k) Contracts providing for payments based in any manner on the revenue or profits of Seller or any Subsidiary thereof, the Hospital Businesses or the Assets;

(l) loan agreements, indentures, bonds, mortgages, liens, or other security agreements (excluding those that will be terminated at Closing);

(m) equipment leases and other leases that are capital leases; and

(n) all other Contracts which require payment by Seller of amounts in excess of $50,000 annually after the date of this Agreement, unless Seller may terminate the Contract, without cause, within ninety (90) days and all payments due by Seller under the Contract through such termination equal, in the aggregate, less than $50,000 (including any penalty or termination fee).

3.19. The Assumed Contracts. With respect to the Assumed Contracts listed on Schedule 2.01(f):

(a) the Assumed Contracts constitute lawful, valid and legally binding obligations of Seller and, to Seller's knowledge, each other party thereto and are enforceable against Seller and, to Seller's knowledge, against each other party thereto, in accordance with their terms;

(b) each Assumed Contract (together with all amendments and supplements thereto listed on Schedule 2.01(f)) is in full force and effect and constitutes the entire agreement between the parties thereto;

(c) all material obligations required to be performed under the Assumed Contracts by Seller, and, to Seller's knowledge, each other party thereto, have been performed, and no event has occurred or failed to occur that constitutes, or with the giving of notice, the lapse of time or both would constitute, a material default by Seller under the Assumed Contracts that has or would reasonably be expected to have a material impact on the Hospital Businesses;

(d) except as set forth on Schedule 3.19(d), no Assumed Contract contains a prohibition on competition by Seller or any Affiliate or otherwise restricts the ability of Seller or any Affiliate to engage in any lawful business after Closing; and

(e) except as set forth on Schedule 3.19(e), the assignment of any Assumed Contract to, and assumption of such Assumed Contract by, Buyer will not give a third party the right to terminate such Assumed Contract, or result in the payment of any penalty or premium to, or change in the rights, remedies, benefits or obligations of, any party thereunder.

3.20. Transactions with Affiliates. Except as disclosed in the Financial Statements of the Seller, since September 30, 2013, Seller has not purchased, acquired or leased any property or services from, or sold, transferred or leased any property or services to, or lent or advanced any money to, or borrowed any money from, or acquired any capital stock, obligations or securities of, or made any management consulting or similar fee agreement with, any officer, director or trustee of Seller or of any Affiliate of Seller except upon terms that would have been paid or received by Seller in similar transactions with independent parties negotiated at arm's length.

3.21. Employees and Employee Relations.

(a) Seller has delivered to Buyer (i) a list (as of the most recent practicable date) of names, positions, current annual salaries or wage rates, target or actual bonuses, other compensation arrangements, and paid time off or extended illness bank credits of all full-time and part-time non-physician employees of Seller and its Affiliates (indicating in the list whether each employee is classified as exempt or nonexempt by Seller), and (ii) a separate list (as of the most recent practicable date) of names, positions, current annual salaries or wage rates, target or actual bonuses, other compensation arrangements, and paid time off or extended illness bank credits of all full-time and part-time physician employees of Seller and its Affiliates (indicating in both lists whether each employee is part-time or full-time, whether such employee is employed under written Contract, the immigration status of any such employee who is eligible for employment based solely on a temporary work permit and, if such employee is not actively at work, the reason therefor).

(b) To Seller's knowledge, all employees, former employees and independent contractors of Seller and its Subsidiaries are properly classified as such for all purposes under the Code and ERISA and have been properly classified as exempt or nonexempt under the Fair Labor Standards Act and any applicable state Legal Requirement.

(c) Except as set forth in Schedule 3.21(c), Seller is in compliance in all material respects with all Legal Requirements relating to employment, employment practices, terms and conditions of employment, equal employment opportunity, nondiscrimination, immigration, wages, hours, benefits, payment of employment, social security, and similar taxes, occupational safety and health, and plant closing; Seller is not liable for the payment of any material compensation, damages, taxes, fines, penalties, interest, or other amounts, however designated, for failure to comply with any of the foregoing Legal Requirements; there are no pending or, to the knowledge of Seller, threatened claims before the Equal Employment Opportunity Commission (or any comparable state civil or human rights commission or other Governmental Authority), complaints before the Occupational Safety and Health Administration (or any comparable state safety or health administration or other Governmental Authority), wage and hour claims, unemployment compensation claims, workers' compensation claims, or the like.

(d) Schedule 3.21(d) states the number of employees terminated by Seller and its Affiliates within 90 days prior to the Closing Date, laid off by Seller within the six months prior to the Closing Date, or whose hours of work have been reduced by more than 50% by Seller in the six months prior to the Closing Date, and contains a complete and accurate list of the following information for such employees: (i) the date of termination, layoff, or reduction in work hours and (ii) the location to which the employee was assigned. In relation to the foregoing, except as set forth in Schedule 3.21(d), Seller has not violated the WARN Act or any similar state or local Legal Requirements.

(e) To the knowledge of Seller, no officer, director, agent, employee, consultant, or independent contractor of Seller is bound by any contract that purports to limit the ability of such officer, director, agent, employee, consultant, or independent contractor (i) to engage in or continue or perform any conduct, activity, duties, or practice relating to the business of Seller in respect of the Hospital Businesses or the Assets; or (ii) to assign to Seller any rights to any invention, improvement, or discovery. Except as set forth on Schedule 3.21(e), to the knowledge of Seller, no former or current employee of Seller is a party to, or is otherwise bound by, any contract that in any way adversely affected, affects, or will affect the ability of Buyer following Closing to conduct the Hospital Businesses as Seller did prior to Closing.

(f) Except as set forth on Schedule 3.21(f), (i) no employee strike, work stoppage or slowdown, labor dispute, grievance or unfair labor practice at the Hospital Businesses is pending or, to Seller's knowledge, threatened, (ii) no employees of Seller are represented by, or have made demand for recognition of, a labor union or employee organization, and, to Seller's knowledge, no other union organizing or collective bargaining activities by or with respect to any employees of Seller are taking place and (iii) no complaint, charge or claim is pending, or, to Seller's knowledge, threatened to be

brought or filed, with any Governmental Authority or arbitrator relating to the employment or termination of employment of any individual by Seller or the Hospital Businesses.

(g) All necessary visa or work authorization petitions have been timely and properly filed on behalf of any employees of Seller requiring a visa stamp, I-94 status document, employment authorization document or other immigration document to legally work in the United States, and all paperwork retention requirements with respect to such applications and petitions have been met. To the knowledge of Seller, no employee of Seller who is a foreign national has ever worked for Seller without employment authorization from the Department of Homeland Security or any other Government Authority that must authorize such employment, and Seller has complied in all material respects with all applicable immigration laws and other Legal Requirements with respect to the employment of foreign nationals. To the knowledge of Seller, Seller has timely and properly completed I-9 forms for all employees hired since the effective date of the Immigration Reform and Control Act of 1986 and has lawfully retained and re-verified all such I-9 forms. There are no Proceedings pending or, to Seller's knowledge, threatened against Seller relating to Seller's compliance with Legal Requirements relating to immigration, except as set forth on Schedule 3.21(g). Seller has not received any letters or other correspondence from the Social Security Administration regarding the failure of an employee's social security number to match his or her name in the Social Security Administration database, and Seller has not received any letters or other correspondence from the Department of Homeland Security or other Governmental Authorities regarding the employment authorization of any employees of Seller. Seller does not participate in the Department of Homeland Security's e-Verify electronic employment verification system.

3.22. Employee Benefit Plans.

(a) Schedule 3.22 lists each Employee Benefit Plan that Seller or any member of the Controlled Group that includes Seller maintains or to which it contributes (including employee elective deferrals) (each, a "**Current Seller Plan**").

(b) Each Current Seller Plan (and related trust, insurance contract or fund) complies in form and in operation in all material respects with applicable Legal Requirements, and has been administered and operated in all material respects in accordance with the terms of the Current Seller Plan and applicable Legal Requirements. All required reports and descriptions (including form 5500 annual reports, summary annual reports and summary plan descriptions) have been filed or distributed appropriately with respect to each Current Seller Plan. Seller has delivered to Buyer copies of the plan documents and summary plan descriptions, most recent determination letters received from the Internal Revenue Service, most recent form 5500 annual report, and all related trust, insurance and funding Contracts that implement each Current Seller Plan. No Governmental Authority has audited any Current Seller Plan or any other Employee Benefit Plan that Seller or any member of the Controlled Group that includes Seller has maintained, or to which it has contributed or been required to contribute (each,

a "**Prior Seller Plan**"), during the five (5) years preceding the date of this Agreement, and Seller has not received any notice that such an audit will or may be conducted.

(c) Each Current Seller Plan that is an Employee Pension Benefit Plan intended to be qualified under section 401(a) of the Code has a current favorable determination letter or opinion or approval letter from the Internal Revenue Service that the plan is so qualified and its trust is exempt from federal income taxation under section 501(a) of the Code, or the remedial amendment period for such Employee Pension Benefit Plan to be submitted to the Internal Revenue Service for such a determination letter or opinion or approval letter has not yet expired. All contributions (including employer contributions and employee salary reduction contributions) to each such Employee Pension Benefit Plan that are due to be paid have been paid, and all Seller contributions to any Employee Pension Benefit Plan that is a defined contribution plan in respect of periods ending on the Closing Date will be accrued on the Closing Balance Sheets. To Seller's knowledge, nothing has occurred that could reasonably be expected to cause the revocation of such determination letter from the Internal Revenue Service or the unavailability of reliance on such opinion or approval letter from the Internal Revenue Service, as applicable. To Seller's knowledge, nothing has occurred with respect to any Current Seller Plan that has subjected or could reasonably be expected to subject Seller, or, with respect to any period on or after the Closing Date, Buyer or any of its Affiliates, to a penalty under Section 502 of ERISA or to an excise tax under the Code. To Seller's knowledge, with respect to any Current Seller Plan, no event has occurred or is reasonably expected to occur that has resulted in or would subject the Seller or, with respect to any period on or after the Closing Date, Buyer or any of its Affiliates, to a tax under Section 4971 of the Code or the assets of any of the foregoing persons to a lien under Section 430(k) of the Code.

(d) The requirements of part 6 of subtitle B of Title I of ERISA and of section 4980B of the Code have been met in all material respects with respect to each Current Seller Plan that is an Employee Welfare Benefit Plan, and all premiums or other payments that are due have been paid with respect to each such Employee Welfare Benefit Plan.

(e) There have been no "*prohibited transactions*," as defined in section 406 of ERISA and section 4975 of the Code, with respect to any Current Seller Plan that would subject Seller or any member of the Controlled Group that includes Seller to any material liability. No ERISA Fiduciary has any material liability for breach of fiduciary duty or any other failure to act or comply in connection with the administration or investment of the assets of any Current Seller Plan. No Proceeding with respect to the administration or the investment of the assets of any Current Seller Plan (other than routine claims for benefits) is pending or, to Seller's knowledge, threatened and, to Seller's knowledge, there exists no basis for any such Proceeding. To Seller's knowledge, no "*party in interest*" (as defined in section 3(14) of ERISA) and no "*disqualified person*" (as defined in the Code) has any interest in any assets of any Current Seller Plan that is an Employee Pension Benefit Plan other than as a beneficiary by virtue of such Person's participation in the plan.

(f) Except as provided on Schedule 3.22(f), no Current Seller Plan that is an Employee Pension Benefit Plan has been completely or partially terminated or the subject of a Reportable Event, and no Proceeding by the PBGC to terminate any such Employee Pension Benefit Plan has been instituted or, to Seller's knowledge, threatened. Seller has not incurred, and, to Seller's knowledge, Seller will not incur, any material liability to the PBGC (other than PBGC premium payments) or otherwise under Title IV of ERISA (including any withdrawal liability) or under the Code with respect to any Current Seller Plan or Prior Seller Plan that is or was an Employee Pension Benefit Plan.

(g) Neither Seller nor any member of a Controlled Group that includes Seller contributes to, has contributed to, or has been required to contribute to any Multiple Employer Plan or any Multiemployer Plan or has any liability (including withdrawal liability) under any Multiple Employer Plan or any Multiemployer Plan. Except as provided on Schedule 3.22(g), neither Seller nor any member of a Controlled Group that includes Seller maintains or contributes, has maintained or contributed, or has been required to maintain or contribute to any Employee Welfare Benefit Plan providing medical, health or life insurance or other welfare-type benefits for current or future retired or terminated employees, their spouses or their dependents (other than in accordance with section 4980B of the Code).

3.23. Proceedings and Legal Claims. Schedule 3.23 contains a list and summary description of each Proceeding and legal claim (including *qui tam* Proceedings and legal claims) pending or, to Seller's knowledge, threatened against or otherwise affecting the Assets, the Hospital Businesses, Seller or any Affiliate of Seller (together with the reserve amount, if any, included in the Financial Statements for each uninsured Proceeding or legal claim). All such Proceedings and legal claims are or will be fully insured (except for applicable deductibles or self-insurance retentions) and no carrier has issued a "*reservation of rights*" letter or otherwise denied its obligation to insure and defend Seller against covered Losses arising therefrom. None of the Proceedings or legal claims described on Schedule 3.23, if determined adverse to Seller, could reasonably be expected to result, individually or in the aggregate, in a Material Adverse Change.

3.24. Taxes.

(a) Seller has filed all Tax Returns required to be filed by or on behalf of Seller on or prior to the date of this Agreement (taking into account applicable extensions), all such Tax Returns are accurate in all material respects and Seller has duly paid or made provision in the Financial Statements for the payment of all Taxes shown as due and payable on such Tax Returns.

(b) Seller has withheld proper amounts from its employees' compensation in compliance with all applicable withholding and similar provisions of the Code and any and all other applicable Legal Requirements, and has withheld and paid, or caused to be withheld and paid, all Taxes on monies paid by it to independent contractors, creditors and other Persons for which withholding or payment is required by Legal Requirements.

(c) No deficiencies for any Taxes relating to the Assets or the Hospital Businesses have been asserted or, to the knowledge of Seller, threatened, and no audit on any Tax Returns is currently under way or, to the knowledge of Seller, threatened. There are no outstanding agreements by Seller for the extension of time for the assessment of any Taxes (other than ordinary course extensions of time within which to file Tax Returns).

(d) To Seller's knowledge, no Governmental Authority intends to assess any additional Taxes on Seller for any period for which Tax Returns have been filed. No Governmental Authority has disputed in writing any Tax liability of Seller. No claim has ever been made in writing by a Governmental Authority in a jurisdiction where Seller does not file Tax Returns that Seller is or may be subject to Tax in that jurisdiction, and no Encumbrances exist against Seller or the Assets in connection with any failure (or alleged failure) of Seller to pay any Tax that is due and payable.

(e) No waiver of a statute of limitations in respect of Taxes or agreement to extend the time with respect to a Tax assessment or deficiency is currently in effect, in each case with respect to Seller (other than ordinary course extensions of time within which to file Tax Returns).

(f) Seller is not a party to any Tax allocation or sharing Contract. Seller is not and has not been a member of an Affiliated Group filing a consolidated federal income Tax Return.

(g) Each of Seller and its Subsidiaries that is a corporation exempt from federal and state income Tax has received a favorable letter of determination from the Internal Revenue Service and the State of Connecticut regarding such Tax status and, to Seller's knowledge, nothing has occurred, whether by action or failure to act, that could reasonably be expected to cause the loss of such exemption (except with respect to the transactions contemplated by this Agreement).

(h) To Seller's knowledge, Seller has no liability for the Taxes of any other Person (other than a Subsidiary under Internal Revenue Service regulation 1.1502-6), as a transferee or successor, by Contract or otherwise.

3.25. Medical Staff; Physician Relations.

(a) Seller has delivered to Buyer a copy of the bylaws, policies, rules and regulations of the medical staff and medical executive committees of each Hospital. As set forth on Schedule 3.25(a), Seller has also delivered to Buyer a list, current as of the date of this Agreement, that sets forth (i) the name and age of each member of the medical staff of each Hospital (active, associate, consulting, courtesy or other), (ii) the degree (M.D., D.O., etc.), title, specialty and board certification, if any, of each such medical staff member, (iii) the names of the medical staff members (current and former) of each Hospital in respect of whom Seller has made a report to the National Practitioners Data Bank during the last three years, and (iv) the number of current medical staff members of each Hospital in respect of whom any committee of the medical staff of such

Hospital has recommended adverse action with respect to any member of the medical staff of such Hospital that is not yet final.

(b) Except as set forth on Schedule 3.25(b), no material disputes between Seller and any medical staff member of either Hospital are pending or, to Seller's knowledge, threatened and all appeal periods in respect of any medical staff member against whom an adverse action has been taken by Seller have expired. To the knowledge of Seller, no current member of the medical staff of either Hospital has been excluded from participation in any Government Payment Program.

3.26. Restricted Assets. Except as set forth on Schedule 3.26, none of the Assets is subject to any restriction or limitation concerning the purchase, improvement or use of such Assets or the conduct of the Hospital Businesses, including restricted or conditioned grants or donations and monies received under the Hill-Burton Act.

3.27. Brokers and Finders. Neither Seller nor any Affiliate, officer, trustee, director, employee or agent acting on behalf thereof has engaged any finder or broker in connection with the transactions contemplated hereunder.

3.28. Payments. None of the Hospital Businesses has, to Seller's knowledge, made any request for payment from a Government Payment Program in respect of health care services furnished by or directed or prescribed by any physician or other Person who at such time was excluded from participation in such Government Payment Program. Seller has not, directly or indirectly, paid or delivered, or agreed to pay or deliver, any money or item of property, however characterized, to any Person in violation of any Legal Requirement. Neither Seller nor, to Seller's knowledge, any officer, director or trustee of Seller has received, or will receive as a result of the consummation of the transaction contemplated by this Agreement, any rebate, kickback or other improper or illegal payment from any Person with whom Seller conducts or has conducted any of the Hospital Businesses.

3.29. Solvency. As of immediately after Closing, Seller will not, as a result of the transactions contemplated by this Agreement, be rendered insolvent or otherwise unable to pay its debts as they become due. Seller has no intention of filing a petition in bankruptcy or insolvency or for reorganization or for the appointment of a receiver or trustee of all or any portion of Seller's property and, to Seller's knowledge, no other Person has filed or threatened to file such a petition against Seller.

3.30. Hospital Businesses and Joint Ventures.

(a) Each of Seller's Subsidiaries is a corporation duly organized under the laws of the State of Connecticut with full corporate power to carry on its business as it is now being conducted with the exception of CHIC, which is organized with full corporate power to carry on its business as it is now being conducted under the laws of the Cayman Islands. Each of Seller's Subsidiaries is duly licensed, qualified or admitted to do business and is in good standing in the State of Connecticut, which is the only jurisdiction in which the ownership, use or leasing of their respective assets or properties, or the conduct or nature of their respective businesses, makes such licensing, qualification or

admission necessary. All of the issued and outstanding shares of capital stock of Seller's Subsidiaries that are stock corporations are owned as specified on Schedule 3.30(a). All of the issued and outstanding shares of capital stock of Seller's Subsidiaries that are stock corporations have been duly and validly authorized, were validly issued and are fully paid and non-assessable. There are no outstanding rights (including preemptive rights), options, warrants or agreements for the transfer by Seller of any shares of capital stock of Seller's Subsidiaries that are stock corporations and no authorization for any such rights, options, warrants or agreements has been given. Seller has delivered to Buyer a copy of the articles of incorporation and bylaws and other agreements, instruments and documents relating to the creation, ownership and governance of Seller's Subsidiaries and has provided to Buyer a copy of, or access to, the minute books of Seller's Subsidiaries.

(b) To Seller's knowledge, for each Joint Venture that is a for-profit or nonprofit corporation, it (i) is a corporation duly organized under the laws of the state of its incorporation, (ii) has full corporate power to carry on its business as it is now being conducted, and (iii) is duly licensed, qualified or admitted to do business and is in good standing in the state of its incorporation, which is the only jurisdiction in which the ownership, use or leasing of their respective assets or properties, or the conduct or nature of their respective businesses, makes such licensing, qualification or admission necessary. To Seller's knowledge, all of the issued and outstanding shares of capital stock of the corporate Joint Ventures that are stock corporations are owned as specified on Schedule 3.30(b). To Seller's knowledge, all of the issued and outstanding shares of capital stock of the corporate Joint Ventures that are stock corporations have been duly and validly authorized, were validly issued and are fully paid and non-assessable. To Seller's knowledge, there are no outstanding rights (including preemptive rights), options, warrants or agreements for the transfer by Seller of any shares of capital stock of the corporate Joint Ventures and no authorization for any such rights, options, warrants or agreements has been given. Seller has delivered to Buyer a copy of the articles of incorporation and bylaws and other agreements, instruments and documents relating to the creation, ownership and governance of the corporate Joint Ventures in Seller's possession.

(c) To Seller's knowledge, for each Joint Venture that is a limited liability company, it (i) is organized under the laws of the state of its incorporation, (ii) has full limited liability company power to carry on its respective business as it is now being conducted, and (iii) is duly licensed, qualified or admitted to do business and is in good standing in the state of its incorporation, which is the only jurisdiction in which the ownership, use or leasing of its respective assets or properties, or the conduct or nature of its respective businesses, makes such licensing, qualification or admission necessary. To Seller's knowledge, all of the issued and outstanding membership interests of the limited liability company Joint Ventures are owned as specified on Schedule 3.30(c), have been duly and validly authorized, were validly issued and are fully paid and non-assessable. To Seller's knowledge, except as set forth in the operating agreements of the limited liability company Joint Ventures, the transfers to Buyer of the membership interests in the limited liability company Joint Ventures are not subject to any preemptive rights or third party approvals. Seller has delivered to Buyer a copy of the articles of organization

and operating agreements and other agreements, instruments and documents relating to the creation, ownership and governance of the limited liability company Joint Ventures in Seller's possession.

3.31. Operation of the Hospital Businesses. The Assets, together with the Excluded Assets, constitute all assets, properties, goodwill and businesses necessary to operate the Hospital Businesses in the manner in which they have been operated since September 30, 2014, except for property, plant and equipment sold or disposed of since such date in the ordinary course of business. Schedule 3.31 sets forth a list of the ten largest non-governmental payors of the Hospital Businesses, determined on the basis of net patient revenues from services provided during the year ended September 30, 2014. Since September 30, 2013, no payor listed on Schedule 3.31 has terminated its contract with or materially reduced reimbursement rates to, or has notified Seller in writing of its determination to terminate its contract with or to materially reduce reimbursement rates to, the Hospital Businesses.

4. REPRESENTATIONS OF BUYER

Buyer makes the following representations to Seller on and as of the date of this Agreement and will be deemed to make them again at and as of the Closing Date:

4.01. Organization. Buyer is a corporation duly organized and validly existing and in good standing under the laws of Connecticut. Buyer is, or by Closing will be, qualified to do business in the State of Connecticut. Buyer has full power and authority to own, lease and operate its properties and to conduct its business as presently conducted and as proposed to be conducted immediately following the Closing. Buyer has neither conducted any business prior to the date of this Agreement nor will conduct any business, other than in contemplation of the consummation of the transactions contemplated by this Agreement, prior to the Closing. Buyer has made available to Seller a true and complete copy of its organizational documents.

4.02. Power and Authority; Due Authorization. Buyer has full power and authority to (a) execute and deliver this Agreement and the Closing Documents to which it is or becomes a party, (b) perform its obligations under this Agreement and such Closing Documents and (c) consummate the transactions contemplated by this Agreement. The execution and delivery by Buyer of this Agreement and the Closing Documents to which it is or becomes a party, the performance by Buyer of its obligations under this Agreement and such Closing Documents, and the consummation by Buyer of the transactions contemplated by this Agreement have been duly authorized on behalf of Buyer by all necessary corporate action.

4.03. Consents; Absence of Conflicts, Etc. The execution, delivery and performance by Buyer of this Agreement and the Closing Documents to which it is or becomes a party at the Closing, and the consummation of the transactions contemplated by this Agreement:

(a) are within its corporate powers, are not in contravention of its certificate of formation and operating agreement and have been approved by all required limited liability company and member action;

(b) do not violate any Legal Requirement to which it is subject; and

(c) do not conflict with, result in a breach or violation of or require any consent to be obtained or notice to be given under any material agreement to which it is a party or by which it is bound.

4.04. Due Execution; Binding Agreement. This Agreement has been duly and validly executed and delivered by Buyer. Each Closing Document to which Buyer will be a party will be duly and validly executed and delivered by Buyer at the Closing. This Agreement constitutes, and each of the Closing Documents to which Buyer will be a party will constitute (upon execution and delivery thereof by Buyer at the Closing), the valid and legally binding obligations of Buyer, enforceable against it in accordance with the terms hereof and thereof.

4.05. Proceedings. There are no claims, actions, suits, proceedings, or investigations pending or, to Buyer's knowledge, threatened that: (a) adversely affect or seek to prohibit, restrain, or enjoin the execution and delivery of this Agreement, (b) adversely affect or question the validity or enforceability of this Agreement, (c) question the power or authority of Buyer to carry out the transactions contemplated by, or to perform its obligations under, this Agreement, or (d) would result in any change that would adversely affect in any material respect the ability of Buyer to perform any of its obligations hereunder.

4.06. Availability of Funds. Buyer has the ability to obtain funds in cash in amounts equal to the Purchase Price and necessary to perform its obligations hereunder that are to be performed as of Closing by means of credit facilities or otherwise and will at Closing have immediately available funds in cash which will be sufficient to pay the Purchase Price and to perform its obligations hereunder that are required to be performed as of Closing under this Agreement.

4.07. Solvency. Buyer has no intention of filing a petition in bankruptcy or insolvency or for reorganization or for the appointment of a receiver or trustee of all or any portion of Buyer's property and, to the knowledge of Buyer, no other Person has filed or threatened to file such a petition against Buyer.

4.08. Brokers and Finders. Neither Buyer nor any Affiliate of Buyer, nor any officer, director, employee or agent thereof, has engaged or is liable for the payment of any fee to any finder or broker in connection with the transactions contemplated hereunder.

4.09. Full Disclosure. The representations of Buyer in this Agreement do not contain any untrue statement of a material fact or omit to state any material fact necessary to make the statements made therein, in the light of the circumstances under which they were made, not misleading.

5. COVENANTS OF THE PARTIES

5.01. Operations. Until the Closing Date and except as otherwise expressly provided in this Agreement or agreed to in writing by Buyer, Seller will, and will require its Affiliates to:

(a) conduct the Hospital Businesses in substantially the same manner as it has heretofore and not make any material change in personnel, operations, finances,

accounting policies, or real or personal property of the Hospital Businesses except as set forth on Schedule 5.01;

(b) except as set forth on Schedule 5.01(b), maintain the Assets in working condition in the ordinary course of business, ordinary wear and tear excepted, and make all normal, planned and budgeted capital expenditures related to the Assets and/or the Hospital Businesses, *provided* that Seller may (i) make, in its discretion, necessary expenditures in the ordinary course from its designated capital needs fund and provide advance notice to Buyer of any individual expenditure greater than $250,000 and (ii) consult with and solicit Buyer's input on individual capital expenditures (or a series of related capital expenditures) not paid from its designated capital needs fund that exceed $250,000;

(c) comply in all material respects with all Legal Requirements and perform, when due, in all material respects all obligations under Contracts;

(d) deliver to Buyer title to the Assets free and clear of all Encumbrances (except for the Permitted Encumbrances) and to obtain appropriate releases, consents, estoppels, certificates, opinions and other instruments as Buyer may reasonably request;

(e) keep in full force and effect present insurance policies or other comparable insurance benefiting the Assets and the conduct of the Hospital Businesses and maintain sufficient liquid reserves reasonably estimated to be sufficient to meet all deductible, self-insurance and copayment requirements of such policies; and

(f) maintain and preserve its business organizations and operations intact, retain the present employees at the Hospital Businesses (subject to the right of Seller to discharge any employee in the ordinary course of the Hospital Businesses), and maintain in the ordinary course its relationships with physicians, suppliers, patients and other Persons doing business with Seller at the Hospital Businesses.

5.02. Negative Covenants. Until the Closing Date and except as otherwise expressly provided in this Agreement or agreed to by Buyer in writing, Seller will not, and will not permit any Affiliate to:

(a) excluding capital expenditures, amend or terminate any Assumed Contract, or enter into any Contract, except in the ordinary course of the Hospital Businesses consistent with past practices, *provided* that Seller shall obtain Buyer's consent on any new Contract (or a series of related Contracts) that has required payments by Seller that exceed $1,000,000 annually, unless such Contract may be terminated without cause upon no more than 90 days written notice and such termination will not result in any penalty or fee (and excluding any waivers or amendments relating to Bond Liabilities that will be defeased or repaid at Closing);

(b) enter into any tertiary or quaternary affiliation with a third-party healthcare provider other than an agreement for hospitalist services;

(c) other than as set forth on Schedule 5.02(c), increase compensation payable or to become payable to, make a bonus, incentive or severance payment to, or otherwise enter into one or more bonus, severance, profit-sharing, deferred compensation, stock option, purchase, retainer, consulting, retirement, welfare or incentive plan Contracts (including any plan or agreement under which "fringe benefits" are afforded) with any employee, contractor or agent of any of the Hospital Businesses except in the ordinary course of the Hospital Businesses consistent with past practices in accordance with existing personnel policies or pursuant to Contract requirements in force on the date of this Agreement; provided, however, that nothing in this Section 5.02(c) shall prohibit Seller from making payments pursuant to the Eastern Connecticut Health Network, Inc. Long Term Retention Plan, as amended through August 1, 2016, without first receiving Buyer's written agreement;

(d) create, assume or voluntarily consent to any new Encumbrance upon any of the Assets;

(e) sell or otherwise transfer or dispose of any item of property, plant, equipment or other Asset including any interest in a Joint Venture, except in the ordinary course of the Hospital Businesses consistent with past practices with comparable replacement thereof, and with respect to a an interest in a Joint Venture, except as may be required under the governing instruments of the Joint Venture and necessary to satisfy a closing condition in Section 7 that has not been waived by Buyer;

(f) take any action other than execution of this Agreement, which would trigger any right of first refusal, or any similar right to purchase, with respect to any Investment interest in a Joint Venture except as necessary to satisfy a closing condition in Section 7 that has not been waived by Buyer;

(g) distribute any assets, other than Excluded Assets, to any Affiliate of Seller other than its Subsidiaries that are transferring Assets pursuant to this Agreement;

(h) make necessary expenditures in the ordinary course from its designated capital needs fund of more than $100,000 per expenditure without providing advanced notice to Buyer of such expenditure and will not make individual capital expenditures (or a series of related capital expenditures) that are outside the ordinary course in excess of $100,000 individually or $500,000 in the aggregate if such capital expenditures are not included in Seller's annual operating or capital budgets that have been provided to Buyer;

(i) add, modify, or discontinue the provision of any material clinical service by the Hospital Businesses other than entering into an agreement with a third party for the provision of hospitalist services, open a new location for the provision of any material clinical service, or close the location at which any such material clinical service is currently provided without consent of Buyer, which will not be unreasonably withheld or delayed;

(j) create, incur, assume, guarantee or otherwise become liable for any liability or obligation except in the ordinary course of the Hospital Businesses consistent

with past practices in excess of $250,000, other than Seller's customary annual line of credit renewal with TD Bank in the currently issued amount, or agree to do any of the foregoing;

(k) make any loans to physicians without the prior written consent of Buyer;

(l) cancel, forgive, release, discharge or waive any Person's obligation to pay or to perform obligations in respect of Accounts Receivable or other Assets, or agree to do any of the foregoing, except in the ordinary course of the Hospital Businesses consistent with past practices;

(m) amend, change or modify the title or duties of the chief executive officer of Seller;

(n) sell or factor any Accounts Receivable;

(o) change any accounting method, policy or practice or reduce any reserves in the Financial Statements except (i) reductions in reserves pertaining to Government Payment Programs or third party payors made in the ordinary course of business consistent with past practices, and (ii) changes required by GAAP or applicable Legal Requirements;

(p) except with respect to the previously planned freeze of Seller's defined benefit pension plan and post-retiree health plan, terminate, amend or otherwise modify in any material respect any Employee Benefit Plan, except for normal course annual changes and amendments required to comply with this Agreement or applicable Legal Requirements; or

(q) amend or agree to amend the articles of incorporation or the bylaws or articles of formation or operating agreement (or comparable organizational documents) of Seller or any Subsidiary thereof or otherwise take any action relating to any liquidation or dissolution of Seller or any Subsidiary thereof, except as expressly contemplated by this Agreement, provided that Seller may merge any one or more of the Subsidiaries into each other or into the Seller in connection with the proposed transaction;

(r) amend or agree to amend the governing documents of any Joint Venture, except immaterial amendments or amendments required to comply with applicable Legal Requirements or reasonably necessary to assign and transfer to Buyer or Buyer's designee Seller's Investment in, or for Buyer to become a partner, member or shareholder of, such Joint Venture or to restructure such joint Venture to permit Buyer to participate in such Joint Venture; or

(s) take any action outside the ordinary course of the Hospital Businesses other than modifying its bond documents as needed.

5.03. Employee Matters.

(a) Subject to the exclusions set forth in this Section and in reliance upon the representations of Seller in Sections 3.21 and 3.22, Buyer will offer, or cause its Affiliates to offer, to employ as of the Closing Date substantially all employees of Seller and its Affiliates who work at the Hospital Businesses, including but not limited to employees on approved leaves of absence as of the Closing Date for any reason including without limitation by reason of a military leave, family or medical leave, illness, injury, disability or similar situation (provided employment shall not commence until such employees return from such approved leave), on the same terms and conditions with respect to job duties, titles and responsibilities that are applicable to such employees on the date of such offer. Buyer will offer the Hired Employees salaries equal to their salaries as of the Closing Date and Employee Benefit Plans that are consistent with Employee Benefit Plans offered to similarly-situated employees at other hospitals operated by Buyer in similar markets. Notwithstanding the foregoing, Buyer will, and will cause its Affiliates to, in all events provide each Hired Employee terms and conditions of employment, including compensation and employee benefits, sufficient to avoid Seller or its Affiliates from incurring any liability under the WARN Act or any comparable Legal Requirement due to actions or omissions of Buyer and its Affiliates related to the Hired Employees at any time on or after the Closing Date.

(b) Seller acknowledges that all employment offers are for "at will" employment only and are subject to the satisfactory completion of Buyer's usual and customary hiring practices, including employee background checks and pre-employment screenings. Nothing in this Section or elsewhere in this Agreement may be deemed to limit or otherwise affect in any manner the right of Buyer or any Affiliate of Buyer to terminate at will the employment of any Hired Employee or, subject to Buyer's covenants in Section 5.03(a) and (c), to change individual features or plans in the employment compensation and benefits package of the Hired Employees, provided that Buyer will assume and honor all written severance agreements between Seller and Seller's employees existing as of Closing that are provided to Buyer prior to the date hereof, as set forth on Schedule 5.03(b).

(c) Following the Closing Date, each Employee Benefit Plan sponsored by Buyer or any Affiliate of Buyer in which the Hired Employees are eligible to participate shall credit the Hired Employees with their periods of employment with Seller or any Affiliate of Seller for all purposes (other than benefit accrual under any defined benefit pension plan), including, but not limited to, application of any preexisting condition limitation or eligibility period otherwise applicable to the Hired Employees and their eligible dependents. In addition, if prior to the Closing Date a Hired Employee or his or her covered dependents paid any amounts towards a deductible or out-of-pocket maximum in Seller's medical and health plan's current fiscal year, such amounts shall be applied toward satisfaction of the deductible or out-of-pocket maximum in the current fiscal year of Buyer's medical and health plan that covers Hired Employees on and after the Closing Date. Buyer will give all Hired Employees credit for their vacation, holiday, personal time and sick pay (whether in such form or in the forms of so-called "paid time off" or an "extended illness bank"). With respect to the Hired Employees, Buyer will

assume the Workers' Compensation Liability that exists as of Closing and any such claims filed on or after Closing with respect to periods prior to Closing. Except as provided in subsection (b) above, this subsection (c), subsections (d) and (e) below, or Schedule 2.03, or as otherwise required by Legal Requirements, Buyer will not assume or otherwise become liable for, and Seller will remain solely responsible for, (i) Seller's Employee Welfare Benefit Plans and (ii) any other obligations to former or currently retired employees or their dependents. Buyer will make available group health plan continuation coverage required under COBRA to employees and former employees of Seller who are eligible for COBRA, provided that, with respect to COBRA beneficiaries whose qualifying events occurred on or prior to the Closing Date, Seller will reimburse Buyer for all claims of such COBRA beneficiaries paid by Buyer and its Affiliates in excess of the sum of (A) COBRA premiums collected from the COBRA beneficiaries; and (B) amounts reimbursed from stop loss insurance, determined in the aggregate with respect to all such individuals on the first anniversary of the Closing Date and again at the end of the COBRA period for all such COBRA beneficiaries. Buyer agrees to accept rollovers of eligible rollover distributions (within the meaning of Code section 402(c)(4)), including to the extent applicable rollovers of any outstanding loans made as part of a direct rollover, made by Hired Employees from Seller's Employee Pension Benefit Plans to Buyer's Plans.

(d) Seller has frozen its defined benefit pension plan known as the "Eastern Connecticut Health Network, Inc. Pension Plan" to new participation and future accruals and has frozen the post-retiree health plan to new participation. With respect to the post-retiree health plan, Buyer agrees to maintain post-retiree health coverage for the group of employees and former employees eligible for such coverage as of the Closing and shall not amend or terminate the post-retiree health plan unless the members of such group are provided another retiree medical benefit or cash payment of equivalent value (as calculated using reasonable assumptions determined in consultation with an actuary at the time of the determination).

(e) As of the Closing, Buyer agrees to assume, administer, and become the sponsor of Seller's defined benefit pension plan known as the "Eastern Connecticut Health Network, Inc. Pension Plan" (most recently amended as of December 23, 2015 and as it may be amended to reflect Buyer's assumption of sponsorship) and Seller's post-retiree health plan and assume all collective bargaining agreements of Seller that pertain to the Hospital Businesses.

(f) Between the date of this Agreement and Closing, Buyer may run newspaper advertisements, in the name of any of the Hospital Businesses or in the name of Buyer, to recruit employees for the Hospital Businesses to commence on or after the Closing Date.

(g) At Closing, Seller shall deliver to Buyer a list setting forth the names of all employees of the Hospital Businesses whose employment was terminated between the date of this Agreement and the Closing Date.

(h) This Section 5.03 shall not apply to employees employed by Seller under Assumed Contracts, including but not limited to the collective bargaining agreements described in subsection (e) above. Buyer shall offer employment to all such employees, subject to the satisfactory completion of Buyer's usual and customary hiring practices, including employee background checks and pre-employment screenings, and employment of such employees will be governed by the terms and conditions of the Assumed Contracts, if any, relating to the employment of such employees.

(i) On or prior to the Closing Date, Seller will be responsible for compliance with the WARN Act and all similar state and local Legal Requirements with respect to the employees of the Hospital Businesses, and for all obligations or liabilities arising thereunder as a result of any action (or failure to act) of Seller on or prior to the Closing Date, and after the Closing Date, Buyer will be responsible for compliance with the WARN Act and all similar state and local Legal Requirements with respect to the Hired Employees, and for all obligations or liabilities arising thereunder as a result of any action (or failure to act) of Buyer after the Closing Date.

5.04. Access to and Provision of Additional Information.

(a) Except to the extent prohibited by applicable Legal Requirements (including antitrust laws), until the Closing Date, Seller shall (i) give Buyer reasonable access to and the right to inspect, during normal business hours and upon reasonable prior notice, Seller's Assets and books and records relating to the Hospital Businesses, (ii) give Buyer reasonable access to Seller's employees and medical staff members providing services at or for the Hospital Businesses and (iii) give Buyer such additional financial, operating and other data and information (including auditors' workpapers) regarding the Hospital Businesses as Buyer may reasonably request and that is reasonably available to Seller. Buyer shall exercise its rights under this Section 5.04(a) in such a manner as to cause the least possible interference with the normal operations of the Hospital Businesses.

(b) Seller will deliver to Buyer:

(i) within 25 days after the end of each calendar month before the Closing Date, copies of the unaudited balance sheet and the related unaudited statements of income and cash flows of the Hospital Businesses for each such month then ended and for the fiscal year-to-date then ended, in consolidating and consolidated format;

(ii) within 35 days after the end of each fiscal quarter ending on or before the Closing Date, copies of the unaudited balance sheet and the related unaudited statements of income and cash flows of the Hospital Businesses for the fiscal quarter then ended and for the fiscal year-to-date then ended; and

(iii) promptly after prepared, copies of any other financial or operating statements, reports or analyses prepared by or for management relating to the Hospital Businesses.

(c) Until the Closing Date, Seller shall confer regularly with Buyer, as reasonably requested by Buyer, and answer Buyer's reasonable questions regarding matters relating to the conduct of the Hospital Businesses and the status of transactions contemplated by this Agreement. Seller shall notify Buyer of any material changes in the operations, financial condition or prospects of the Hospital Businesses and of any material complaints, investigations, hearings or adjudicatory proceedings (or communications indicating that the same may be contemplated) concerning the Hospital Businesses and shall keep Buyer reasonably informed of the status of such matters.

(d) With respect to any individually identifiable health information disclosed by Seller to Buyer pursuant to this Section, Buyer and Seller shall comply with the Health Insurance Portability and Accountability Act of 1996, as codified at 42 U.S.C. Section 1320d, *et seq.*, as amended by the Health Information Technology for Economic and Clinical Health Act, and any current and future Legal Requirements promulgated thereunder, and with any other federal or state Legal Requirements that govern or pertain to the confidentiality, privacy, security of, and electronic transactions involving, health care information.

(e) For the avoidance of doubt, Buyer shall not, and nothing contained in this Section shall give Buyer, directly or indirectly, the right to, control or direct the Hospital Businesses (or any portion thereof) prior to the Closing.

5.05. Post-Closing Maintenance of and Access to Information.

(a) After Closing, each party may need access to books, records, documents or other information in the control or possession of the other party for purposes of concluding the transactions contemplated by this Agreement, preparing Tax Returns or conducting Tax audits, obtaining insurance, complying with Government Payment Programs and other Legal Requirements, and prosecuting or defending third party claims. Accordingly, each party shall keep and maintain in the ordinary course of business all books, records (including patient medical records), documents and other information in the possession or control of such party for a period of at least five years after the Closing and otherwise in accordance with all applicable Legal Requirements and record retention policies maintained by such party. In addition, to facilitate the foregoing purposes, each party shall also make such books, records, documents and other information available for inspection and copying upon the reasonable request and at the expense (for out-of-pocket costs) of the other party.

(b) Upon Buyer's receipt of appropriate consents and authorizations, Seller may remove and copy from the Hospital Businesses, at Seller's sole risk and expense, any patient or other records that relate to events or periods before Closing for purposes of pending Proceedings involving matters to which such records refer, as certified in writing before removal by counsel retained by Seller in connection with such Proceedings. Seller shall promptly return any records so removed to Buyer following their use.

(c) Each party shall cooperate with, and shall permit and use commercially reasonable efforts to cause its former and present directors, officers and employees to

cooperate with, the other party after Closing in furnishing information, evidence, testimony and other assistance in connection with any Proceeding or claim with respect to (i) the ownership of the Assets or the conduct of the Hospital Businesses or (ii) the Excluded Liabilities.

(d) The exercise by any party of the rights granted in this Section shall not unreasonably interfere with the conduct of business of the other party and nothing in this Section requires any party to maintain or release to any other Persons any medical or other records except in accordance with applicable Legal Requirements and record retention policies.

(e) To the extent Seller remains in existence and maintains sufficient operational control over relevant functions and pursuant to the Transitional Services Agreement, for seven years after the Closing Date, Seller will give Buyer, within 30 days after request, an updated claims history, including losses paid and open reserves, for all claims relating to the conduct of the Hospital Businesses on or before the Closing Date.

5.06. Governmental Authority Approvals; Consents to Assignment.

(a) Until the Closing Date, Seller and Buyer shall (i) promptly apply for, and use commercially reasonable efforts to obtain before Closing, all consents, approvals, authorizations and clearances of Governmental Authorities required to consummate the transactions contemplated by this Agreement, including approvals of the applications to the Attorney General and the Office of Health Care Access of the Connecticut Department of Public Health, (ii) provide such information and communications to Governmental Authorities as the other party or such Governmental Authorities may reasonably request, and (iii) assist and cooperate with the other party to obtain all Permits, including approvals of the applications to the Attorney General and the Office of Health Care Access of the Connecticut Department of Public Health, that the other party deems necessary or appropriate, and to prepare any document or other information reasonably required of it by any such Governmental Authority to consummate the transactions contemplated by this Agreement, *provided* that no party may be required without the party's consent (x) to pay any sum to Governmental Authorities other than filing fees or past due amounts, or (y) to agree to divest assets or limit the conduct of the business.

(b) Until the Closing Date, each party shall file, if and to the extent required by applicable Legal Requirements, all reports and other documents required or requested by Governmental Authorities under the HSR Act concerning the transactions contemplated by this Agreement, and shall promptly comply with any requests by the Governmental Authorities for additional information concerning such transactions, so that the waiting period specified in the HSR Act will expire as soon as reasonably possible. Each party shall furnish to the other party such information as the other party reasonably requires to comply with its obligations under the HSR Act and shall exchange drafts of the relevant portions of each other's report forms before filing. The parties shall also share equally the costs of any fees due in respect of filings required by the HSR Act.

(c) Seller shall promptly apply for and use commercially reasonable efforts to obtain before Closing all consents required to assign the Assumed Contracts to Buyer at Closing, provided that Seller shall not be required to make any payments or economic concessions to landlords to obtain such consents.

(d) To obtain one or more of the consents and approvals described in this Section, Buyer may be required by applicable Legal Requirement or practical necessity to enter into a contract that supersedes or replaces an existing Contract between Seller and a third party. Such new contract may require Buyer to assume, for the benefit of such third party, certain obligations and liabilities of Seller that are Excluded Liabilities. Alternatively, Buyer may be required by Legal Requirements to assume, or may be deemed as a matter of law to have assumed, obligations and liabilities of Seller that are Excluded Liabilities. If Buyer enters into a replacement contract or assumes such Excluded Liabilities, then – as between Seller and Buyer – such contract or assumption of Excluded Liabilities will not affect the contractual rights and remedies provided in this Agreement in respect of such contract or Excluded Liabilities, including Buyer's rights to indemnification from Seller (subject to the limitations set forth in Article 9), or otherwise diminish Seller's obligations to Buyer or enlarge Seller's liabilities to Buyer (or diminish Seller's defenses or limitations on liability) under this Agreement and will under no circumstances be claimed by Seller as a defense (whether of waiver, estoppel, consent, operation of law, or otherwise) against Buyer's assertion of any claim under this Agreement against Seller, and the rights and obligations of the parties to each other under this Agreement will be determined as if such replacement contract did not exist or such assumption of Excluded Liabilities was not required.

5.07. Use of Controlled Substance Permits. To the extent permitted by applicable Legal Requirements, Buyer shall have the right, for a period not to exceed 120 days following the Closing Date, to operate the Hospital Businesses under the licenses and registrations of Seller relating to controlled substances and the operations of pharmacies and laboratories, until Buyer is able to obtain such licenses and registrations for the Hospital Businesses. In furtherance thereof, Seller shall execute and deliver to Buyer at or prior to the Closing limited powers of attorney substantially in the form of Exhibit B hereto. Buyer or its Affiliates shall apply for all such licenses and registrations as soon as reasonably practicable before and after the Closing Date and shall diligently pursue such applications. Buyer shall indemnify and hold harmless Seller and its Affiliates, and their officers, trustees and employees for all claims, liabilities and costs arising from or relating to use of such licenses and registration after the Closing Date.

5.08. Connecticut Transfer Act. Certain components of the Real Property (including the Hospitals) may constitute, in whole or in part, "Establishments" as the term is defined in the Transfer Act (collectively, the "**Establishment Real Properties**"). Accordingly, Seller and Buyer shall prepare an appropriate Transfer Act Form and accompanying ECAF for each Establishment Real Property to satisfy the requirements of the Transfer Act in connection with the transaction contemplated herein. Seller shall execute as transferor and Buyer shall execute as transferee and Certifying Party (as all such terms are defined in the Transfer Act). Within ten (10) days after the Closing Date, Buyer shall (i) file the fully executed Form and ECAF with the Connecticut Department of Energy and Environmental Protection ("**CTDEEP**"); (ii) pay the initial filing fee and any and all subsequent Transfer Act fees (which shall be reimbursed by

Seller); and (iii) provide written confirmation to Seller that the Transfer Act filing has been completed (with a copy of such filing). In order to evaluate the potential scope and cost of Transfer Act obligations that may be required, prior to the Closing, Buyer shall have the right to perform limited Phase II Assessments subject to and in accordance with the provisions of Section 7.09 hereof. Buyer or its designee shall conduct and complete, at Buyer's sole expense, any actions required (as determined by Buyer in its reasonable discretion) as a result of the filing of the Form and the ECAF, to comply with the Transfer Act, and, if appropriate, to obtain written approval from CTDEEP or a "verification" from a "Licensed Environmental Professional" that the Facilities have been remediated in full compliance with the Connecticut Remediation Standard Regulations (collectively "**Transfer Act Activities**"). Buyer shall complete all Transfer Act Activities as soon as practicable, but in any event within any deadline defined by or pursuant to the Transfer Act (as the same may be extended). Notwithstanding the foregoing, Seller shall pay Buyer for all costs and expenses that Buyer incurs in connection with Transfer Act Activities. Seller and Buyer agree to execute and deliver all documents reasonably requested by the other to comply with the Transfer Act. All undefined terms in this Section 5.08 shall have the meanings set forth in the Transfer Act. Notwithstanding anything to the contrary in this Agreement, the parties agree that any and all fees, expenses and other costs to be paid by Seller under this Section 5.08 shall be paid first from funds held as part of the indemnity reserve established pursuant to Section 9.08.

5.09. No-Shop Clause. Until termination of this Agreement, Seller shall not, and shall not permit any Affiliate of Seller or any other Person acting for or on behalf of Seller or any Affiliate of Seller to, without the prior written consent of Buyer: (a) offer for sale, lease or other disposition all or substantially all of the Assets or any material portion thereof, or any ownership interest in any entity owning any of the Assets, whether by virtue of an asset sale transaction, a lease transaction, affiliation transaction, or a change of control, change of membership, merger, consolidation or other combination transaction with respect to Seller or any entity owning any of the Assets (collectively, a "**Prohibited Transaction**"), or negotiate in respect of an unsolicited offer therefor; (b) solicit offers to acquire all or substantially all of the Assets, or any material portion thereof, or offers to acquire any ownership interest in an entity owning any of the Assets, in a Prohibited Transaction; (c) enter into any Contract with any Person with respect to the disposition of all or substantially all of the Assets, or any material portion thereof, or the sale of any ownership interest in an entity owning any of the Assets, in a Prohibited Transaction; or (d) furnish or permit or cause to be furnished any information to any Person that Seller knows or has reason to believe is in the process of considering a Prohibited Transaction. If Seller, any Affiliate of Seller, or any Person acting for or on behalf of any of the foregoing receives from any Person (other than Buyer or its representatives) any offer, inquiry or informational request referred to above, Seller will promptly advise such Person, by written notice, of this Section.

5.10. Noncompetition. For a period of five years after the Closing Date, Seller shall not, directly or indirectly, and Seller shall cause its Affiliates not to, in any capacity: (i) own, lease, manage, operate, control, be employed by, maintain or continue any interest whatsoever or participate in any manner with the ownership, leasing, management, operation, or control of any business or enterprise that offers services in competition with the Hospital Businesses, including any acute care hospital, specialty hospital, rehabilitation facility, diagnostic imaging center, inpatient or outpatient psychiatric or substance abuse facility, ambulatory or other type of surgery center, wellness center, urgent care center, ambulatory service, nursing home, skilled

nursing facility, home health or hospice agency, or physician clinic or physician medical practice, within a 30 mile radius of either Hospital (the "**Restricted Area**"); (ii) employ or solicit the employment of any Hired Employee, other than no more than five (5) individuals employed solely for winding down operations, unless (x) such employee resigns voluntarily (without any solicitation from Seller or any of its Affiliates), (y) Buyer consents in writing to such employment or solicitation, or (z) such employee is terminated by Buyer or its Affiliate after the Closing Date; (iii) induce, cause or attempt to induce or cause any Person (including any physician employee or medical staff member) to replace or terminate any contract for the provision or arrangement of health care services from the Hospital Businesses with products or services of any other Person after the Closing Date; or (iv) request, induce or cause any physician employee or medical staff member to terminate any contract with or change practice patterns at the Hospital Businesses. Notwithstanding the foregoing, however, (i) Seller and its Affiliates will not be precluded from participating in the following activities that promote health care services for residents of the communities historically served by Seller and its Affiliates through the Hospitals: development, ownership, and operation of indigent or charity care clinics and services; preventative care programs and services and educational programs; health screening services; child care services; and other similar services or programs intended to better serve the health care needs of the community's indigent population in the Restricted Area that are not directly competitive with services to be provided by Buyer or its Affiliates. In the event of a breach of this Section, Seller recognizes that monetary damages shall be inadequate to compensate Buyer, and Buyer shall be entitled, without the posting of a bond or similar security, to an injunction restraining such breach, with the costs (including attorneys' fees) of securing such injunction to be borne by Seller. Nothing contained herein shall be construed as prohibiting Buyer from pursuing any other remedy available to it for such breach or threatened breach. All parties hereto hereby acknowledge the necessity of protection against the competition of Buyer and its Affiliates and that the nature and scope of such protection has been carefully considered by the parties. Seller further acknowledges and agrees that the covenants and provisions of this Section form part of the consideration under this Agreement and are among the inducements for Buyer entering into and consummating the transactions contemplated herein. The period provided and the area covered are expressly represented,and agreed to be fair, reasonable, and necessary. The consideration provided for herein is deemed to be sufficient and adequate to compensate for agreeing to the restrictions contained in this Section. If, however, any court determines that the foregoing restrictions are not reasonable, such restrictions shall be modified, rewritten, or interpreted to include as much of their nature and scope as will render them enforceable.

5.11. Allocation of Purchase Price. Within a reasonable time after Closing, Buyer shall provide Seller a proposed allocation of the Purchase Price among the Hospital Businesses and the Assets. Such allocation will be in accordance with section 1060 of the Code. Buyer's proposed allocation will become final and binding on the parties 45 days after Buyer provides the proposed allocation to Seller unless Seller objects to the proposed allocation, in which case Seller shall propose an alternative allocation. The parties shall use good faith efforts to resolve their differences within 60 days after Seller gave its objection to Buyer. If a final resolution is not reached within 60 days after Seller has submitted its objection in writing, each of Buyer and Seller shall make their own independent allocation of the total consideration among the Hospital Businesses and the Assets. If Seller and Buyer reach agreement upon the allocation (or Seller does not object to Buyer's proposed allocation), Seller and Buyer will be bound by the agreed

allocation and (for federal and state Tax purposes) account for and report the transactions contemplated by this Agreement in accordance with such allocation, and will not voluntarily take any position (whether in Tax Returns, Tax audits or other Proceedings) inconsistent with such allocation. Seller and Buyer shall exchange Internal Revenue Service Forms 8594 (including supplemental forms, if required) to report the transactions contemplated by this Agreement to the Internal Revenue Service in accordance with such allocation.

5.12. Further Assurances. After the Closing, upon request of Buyer, Seller shall do, execute, acknowledge and deliver, or cause to be done, executed, acknowledged and delivered, such further acts, deeds, assignments, transfers, conveyances, powers of attorney, confirmations and assurances as Buyer may reasonably request to more effectively convey, assign and transfer to and vest in Buyer full legal right, title and interest in and actual possession of the Assets and the Hospital Businesses, to confirm Seller's capacities and abilities to perform its post-Closing covenants under this Agreement and the Closing Documents, and to generally carry out the purposes and intent of this Agreement. If any interest in a Joint Venture has not been transferred at Closing as a result of the failure to obtain a consent or to otherwise comply with the governing instruments of such Joint Venture, then Seller shall use commercially reasonable efforts following the Closing to obtain such consent or otherwise comply with the governing instruments of the Joint Venture to permit the transfer of such interest to Buyer as soon as practical following the Closing. Seller shall also furnish Buyer with such information and documents in its possession or under its control, or which Seller can execute or cause to be executed, as will enable Buyer to prosecute any and all petitions, applications, claims and demands relating to or constituting a part of the Assets and Hospital Businesses. After the Closing, upon request of Seller, Buyer shall do, execute, acknowledge and deliver, or cause to be done, executed, acknowledged and delivered, such further acts, deeds, assignments, transfers, conveyances, powers of attorney, confirmations and assurances as Seller may reasonably request to more effectively convey, assign and transfer to Buyer each of the Assumed Liabilities, to confirm Buyer's capacities and abilities to perform its post-Closing covenants under this Agreement and the Closing Documents, and to generally carry out the purposes and intent of this Agreement.

5.13. Casualty. If, on or before the Closing Date, any of the Hospital Businesses are destroyed or materially damaged by fire, theft, vandalism or other cause or casualty and as a result thereof any material part of such Hospital Business is rendered unsuitable for its primary intended use and the cost of repair would exceed $1,000,000, Buyer may elect, by giving written notice to Seller within 15 business days after having actual notice of the occurrence of such destruction or damage and the extent of the loss, to: (i) terminate this Agreement in accordance with Section 8.04(a), (ii) consummate the transaction in spite of such destruction or damage but reduce the Purchase Price by the fair market value of the Assets destroyed or damaged (determined as of the date immediately before the destruction or damage) or, if greater, the estimated cost to restore, repair or replace such Assets, in which event Seller will retain all right, title and interest in and to insurance proceeds payable on account of such destruction or damage, or (iii) consummate the transaction in spite of such destruction or damage without any reduction in the Purchase Price, in which event Seller shall pay, transfer and assign to Buyer at Closing the insurance proceeds less any reasonable out-of-pocket costs incurred in collecting the proceeds or in securing or repairing the property (or the right to receive the insurance proceeds) payable on account of such destruction or damage, and Buyer shall receive a credit for any deductibles or

copayments required under the applicable insurance policy in respect of such claim. Notwithstanding the foregoing, Buyer and Seller acknowledge and agree that the Purchase Price shall not be reduced by an amount that would preclude Seller from paying, or providing for payment of, all of its liabilities in full.

5.14. Seller's Cost Reports. Pursuant to the Transitional Services Agreement, Seller will prepare and timely file all Cost Reports required to be filed after Closing for periods ending on or before the Closing Date, including terminating Cost Reports required as a result of the consummation of the transactions described in this Agreement. Buyer will provide information to Seller and reasonably assist Seller in the preparation and filing of the terminating Cost Reports and the Purchase Price will be allocated in the terminating Cost Reports in a manner consistent with the allocation for Tax purposes described in Section 5.11. Buyer will forward to Seller any and all correspondence, remittances and demands relating to Seller's Cost Reports within ten business days after receipt by Buyer. Seller retains all rights to its Cost Reports, including any payables resulting from or reserves relating to the Cost Reports and the right to appeal any Medicare determinations relating to the Cost Reports.

5.15. Continuation of Hospitals and Post-Care Continuum. For at least 3 (three) years after Closing, Buyer will (i) continue operating the Hospitals in their current locations as acute care hospitals with emergency departments, and (ii) maintain an ownership interest in Seller's current post-acute care continuum of care network (e.g., VNA/home care, sub-acute and long-term lines of service) and require any joint venture involving such post-acute care continuum of care network to maintain the applicable service line for such three-year period. During such periods that Buyer operates the Hospitals, Buyer agrees to maintain Seller's commitment to quality, safety, and patient satisfaction, including maintaining appropriate enrollment, certifications, and accreditations necessary to receive reimbursement under Government Payment Programs.

5.16. Charity Care and Community Obligations.

(a) Seller has historically provided significant levels of care for indigent and low-income patients and has also provided support for community volunteer services and care through a variety of community-based health programs. Subject to changes in Legal Requirements or governmental guidelines or policies, Buyer will ensure that each Hospital maintains and adheres to Seller's current policies on charity care, indigent care, community volunteer services and community benefits attached as Schedule 5.16 or adopt other policies and procedures that are at least as favorable to the indigent and uninsured in the aggregate as Seller's existing policies.

(b) During all times that Buyer owns and operates the Hospitals, Buyer will strive to provide care through community-based health programs, including by cooperating with local organizations that sponsor health care initiatives to address community needs and improve the health status of the elderly, poor, and at-risk populations in the community.

5.17. Educational Support. Buyer agrees to maintain and support financially the University of New England medical student and other health professions teaching programs

established by Seller, in addition to Seller's graduate medical education programs, while operating at a level to not exceed the Indirect Medical Education and Direct Graduate Medical Education caps that may be established by CMS.

5.18. Capital Commitment.

(a) Commitment Amount. Post-Closing, Buyer, in consultation with Seller, the Local Board and potentially an outside consultant, will develop a strategic capital plan with respect to the Hospital Businesses (which for purposes of this Section 5.18 includes the Joint Ventures). In accordance with such strategic capital plan, Buyer agrees to spend within five years of Closing or commit in a binding contract to spend (or cause or permit its Affiliates or third parties to spend or commit in a binding contract to spend) within five years of Closing not less than $75,000,000 (the "**Commitment Amount**") at Seller facilities on (i) capital projects, including routine and non-routine capital expenditures for the improvement of Seller's facilities and/or the acquisition, development, expansion and improvement of hospital, ambulatory or other health care services (such as implementation of a comprehensive and system-wide electronic medical record such as the Epic system), (ii) de novo development, expansion, or acquisition of a department, program, service or facility (whether for inpatient or outpatient services), (iii) upgrades or renovations generally, (iv) deferred maintenance items, and (v) capital expended in support of the recruitment of the Hospitals' medical staff located in the Hospitals' service area, limited to physician practice acquisitions, loan security agreements and real estate acquisition or development (including any associated medical equipment) in support of physician practice acquisitions. Buyer shall provide a written report to Seller on an annual basis that verifies its compliance with the capital commitment, which Seller may share publically. For the purposes of determining whether the Commitment Amount has been expended or committed to be expended, (x) only operating leases for (i) buildings or the fit-out or build-out of space used in the provision or support of medical services or (ii) medical equipment with a useful life of more than one year, shall count towards the Commitment Amount, (y) capital leases, and those operating leases that are permitted to be counted toward the Commitment Amount under Sections 5.18(a)(x)(i)-(ii), shall be valued at the net present value of any lease commitments, and (z) solely with respect to expenditures for equipment not currently owned or leased by the Hospital Businesses or space that is renovated, acquired or newly leased (with respect to incremental Buyer improvements) or obtained after Closing consistent with Section 5.18, it shall not be a prerequisite that the applicable expenditure be classified as a capital expenditure for accounting purposes.

(b) Reduction of Commitment Amount. Notwithstanding the foregoing,

(i) the Commitment Amount shall be reduced by the Unfunded ED Loan Amount, if any;

(ii) the Commitment Amount shall be reduced by the amount, if any, of Seller's administrative wind-down costs paid by Buyer in accordance with Section 2.05(*l*)(i);

(iii) if Buyer assumes any unreimbursed Additional Liabilities in accordance with Section 2.05(d), the Commitment Amount shall be further reduced by the amount of such unreimbursed Additional Liabilities;

(iv) the Commitment Amount shall be reduced by the amount by which the Purchase Price Adjustment to be paid by Seller to Buyer pursuant to Section 2.05(k)(ii) exceeds Available Cash; and

(v) the Commitment Amount may be reduced, on a dollar-for-dollar basis, by the aggregate amount of Losses incurred by Buyer's Indemnified Persons under the provisions of Section 9.01 after application of the Seller Deductible (if applicable), to the extent such Losses are not satisfied in full (i.e., regardless of whether such Losses are satisfied from the amounts maintained as an indemnify reserve under Section 9.08 or otherwise) in accordance with Section 9.08; *provided*, that Buyer shall be entitled to make such reduction to the Commitment Amount if and to the extent Seller fails to satisfy such Losses pursuant to Section 9.05(d) after a reasonable period of time following written demand for payment by Buyer, *provided, further*, that any such reduction shall not relieve Seller from its indemnification payment obligations thereunder.

(c) Restoration of Commitment Amount. Notwithstanding the foregoing,

(i) the Commitment Amount shall be increased (up to a maximum of Seventy-Five Million Dollars ($75,000,000)) by any amounts retained by Buyer as reimbursement for the ED Loan assumed by Buyer;

(ii) the Commitment Amount shall be increased (up to a maximum of Seventy-Five Million Dollars ($75,000,000)) by any amounts retained by Buyer to reimburse Buyer for the Additional Liabilities;

(iii) to the extent that the Commitment Amount was decreased in accordance with Section 5.18(b), and Buyer is reimbursed in full for the ED Loan assumed by Buyer and the liabilities assumed by Buyer in excess of the Threshold Liability, the Commitment Amount shall be further increased (up to a maximum of Seventy-Five Million Dollars ($75,000,000)) by any remaining amounts received by Seller from cost report settlements and paid to Buyer in accordance with Section 2.05(m)(i)(z);

(iv) if applicable, the Commitment Amount shall be increased (up to a maximum of Seventy-Five Million Dollars ($75,000,000)) in accordance with Section 9.08; and

(v) if applicable, the Commitment Amount shall be increased (up to a maximum of Seventy-Five Million Dollars ($75,000,000)) in accordance with Section 2.05(*l*)(ii).

(d) Upon any change to the Commitment Amount made in accordance with Section 5.18(b)-(c), Buyer shall provide Seller with an updated calculation of the Commitment Amount.

5.19. Connecticut Transactions. If at any time prior to Closing, Buyer or any of its Affiliates enter into an agreement with another Connecticut hospital that seeks to consummate transactions similar to the transactions described herein, then Buyer shall promptly inform Seller of such fact, subject to such hospital's approval of waiving any nondisclosure obligation in a confidentiality agreement between such hospital and Buyer, or an Affiliate of Buyer.

5.20. Fees and Expenses.

(a) Except as otherwise expressly set forth in this Agreement, whether or not the transactions contemplated by this Agreement are consummated, (i) Buyer or its Affiliates shall bear and pay all expenses incurred by or on behalf of Buyer in connection with Buyer's due diligence investigation of the Assets and the Hospital Businesses, the preparation and negotiation of this Agreement and Buyer's performance of its obligations pursuant to this Agreement, including counsel, accounting, brokerage and investment advisor fees and disbursements, and (ii) Seller or its Affiliates shall bear and pay all expenses incurred by or on behalf of Seller in connection with the preparation and negotiation of this Agreement and Seller's performance of its obligations pursuant to this Agreement, including counsel, accounting, brokerage and investment advisor fees and disbursements.

(b) Seller shall pay all costs reasonably necessary for Seller to remove all Encumbrances on the Assets that are not Permitted Encumbrances and all expenses incurred by Seller in obtaining any third party consents or approvals necessary to assign to Buyer any Assumed Contracts (it being understood that Seller shall have no obligation to make any monetary payment to a third party beyond any nominal review fee of not more than $1,000 or accept any material concession in the terms of any Contract in order to obtain any such consents or approvals).

(c) Buyer shall pay the following: (i) all third party fees and expenses reasonably incurred by Buyer for Buyer's land title surveys and environmental, engineering and other inspections, studies, tests, reviews and analyses undertaken by or on behalf of Buyer for the benefit of Buyer, (ii) all transfer Taxes, sales and use and similar Taxes arising out of the transfer of the Assets (whether or not originally arising with or assessed to Seller or its applicable Subsidiary) and (iii) the premium for Buyer's title insurance policies described in Section 7.06.

(d) If any party incurs legal fees or expenses in connection with any Proceeding to enforce any provision of this Agreement and is the prevailing party in the Proceeding, such party will be entitled to recover from the non-prevailing party in the Proceeding the legal fees and expenses reasonably incurred by such party in connection with the Proceeding, including attorneys' fees, costs and necessary disbursements, in addition to any other relief to which such party is entitled.

5.21. Clinical Quality and Integration. For at least three (3) years after Closing, Buyer shall (i) collaborate with the Local Board and remaining former hospital staff of Seller on clinical quality matters of the Hospital Businesses to share best practices, establish clinical quality goals and measure progress, and (ii) to the extent consistent with antitrust Legal Requirements, consult with physicians on the medical staff of each Hospital, including at least some independent (*i.e.*, non-employed) physicians, in managed care contracting and clinical integration with respect to the Hospital Businesses.

5.22. Insurance Ratings. Seller will take all commercially reasonable actions requested by Buyer to enable Buyer, at Buyer's expense, to succeed to the workers' compensation and unemployment insurance ratings of Seller and the Hospital Businesses for insurance purposes. Buyer shall not be obligated to succeed to any such rating, except as it may elect to do so or as is otherwise required to do so by Legal Requirements.

5.23. Fulfillment of Conditions. If all of the conditions to a party's obligation to consummate the transactions contemplated by this Agreement at the Closing are satisfied (or waived by that party in its sole discretion), such party will execute and deliver at Closing each Closing Document that such party is required by this Agreement to execute and deliver at Closing. Each party will use all commercially reasonable efforts to satisfy each condition to the obligations of the other party to consummate the transactions contemplated by this Agreement, to the extent that satisfaction of any such condition is within the control of such party.

5.24. Release of Encumbrances. Seller shall use all commercially reasonable efforts to cause all Encumbrances on the Assets, other than the Permitted Encumbrances, to be released and discharged at or before Closing.

5.25. Insurance Transition Provisions.

(a) With respect to the Disability Obligations, Buyer and Seller acknowledge and agree that no tail insurance shall be required in connection with the Disability Obligations because Seller is fully insured with respect to the Disability Obligations.

(b) Other than with respect to the Accumulated Benefit Obligation, the Post-Retiree Health Plan Liability, the Captive Insurer Liability and the Workers' Compensation Liability, on or immediately following the Closing Date, Seller will purchase and obtain an extended claims reporting provision for all primary and excess insurance policies listed in Schedule 5.25(b), including but not limited to coverage for directors, trustees and officers of Seller and its Affiliates, in force as of the date of the Closing Date that cover Seller, its Affiliates and each physician employee of Seller or its Affiliates (or for which Seller otherwise has an obligation to provide such insurance), and that are written on a claims-made insuring agreement. Such extended claim endorsements must name Buyer (and other Affiliates of Buyer designated by Buyer prior to the Closing) as named insureds thereunder. Within thirty (30) days following the Closing Date, Seller will provide Buyer with an original or certified copy of the tail insurance policies required by this Section 5.25(b) and receipts evidencing payment of the premiums therefor.

(c) Notwithstanding anything in this Agreement to the contrary and to the extent in the best interests of Seller, Seller may choose in its sole discretion to retain the Captive Insurer Liability, the Workers' Compensation Liability or both and, at or prior to Closing, purchase its own tail insurance policy or policies with respect to the Captive Insurer Liability, the Workers' Compensation Liability or both. To the extent Seller elects to retain the Captive Insurer Liability, the Workers' Compensation Liability or both, Seller shall provide written notice to Buyer of such election, and Buyer will be relieved of its obligations set forth in this Agreement with respect to any liability or liabilities that Seller elects to retain as set forth in such written notice, and there shall be no adjustment in the Purchase Price pursuant to Sections 2.05(a)(vi)-(vii) for any liabilities so retained.

5.26. Strategic Business Plan. After Closing, Buyer will use commercially reasonable efforts to execute and implement the Strategic Business Plan in accordance with its terms, as the Strategic Business Plan may be modified by Buyer, in consultation with the Local Board, from time to time.

5.27. Local Board. The Local Board shall, among other things, serve as a resource for Buyer with respect to Buyer's investment of the Commitment Amount (see Section 5.18 herein) and maintenance and implementation of the Strategic Business Plan, be responsible for medical staff credentialing at the Hospitals, maintain and oversee the quality assurance program at the Hospitals and oversee and manage the accreditation process for the Hospitals.

5.28. Compliance Program. The Buyer and its Affiliates have established and implemented corporate compliance and ethics programs to ensure that high ethical and conduct standards are met in the conduct of their business. Buyer shall extend after Closing its corporate compliance and ethics programs to the Hospital Businesses.

5.29. New and Existing Collective Bargaining Agreement. Seller shall keep Buyer apprised of, and consult with Buyer, regarding the status of the negotiations regarding any collective bargaining agreement. Seller shall not enter into any new collective bargaining agreement or extension of any existing collective bargaining agreement without prior written consent from Buyer, which consent shall not be unreasonably withheld, *provided, further*, that such consent does not interfere with Seller's bargaining obligations under the National Labor Relations Act. Buyer shall comply with its successorship obligations to assume the existing collective bargaining agreements through their stated expiration dates.

5.30. Tax Claims. In the event that any cash recovery is received by either Seller or Buyer relating to the claims described on Schedule 5.30 (collectively, the "**Tax Claims**"), then the Parties agree that proceeds of such claims shall be allocated and paid in the following order to the extent of such proceeds: first, to Buyer to the extent of its external counsel fees and other direct costs of pursuing the Tax Claims (including claim-related assessments from the Connecticut Hospital Association); second, to Seller in the amount of One Hundred Ten Thousand Dollars ($110,000), being the amount of Seller's external counsel fees and direct costs incurred prior to the Closing Date relating to the Tax Claims; and third, to Buyer, to be used by Buyer to pay for capital or operating expenses relating to the delivery of health care in the Seller's primary service area, which may include, but is not limited to, renovation of facilities or

free care. The Parties agree that the decision whether to pursue or settle the Tax Claims and all matters relating to the conduct and pursuit of the Tax Claims after the Closing Date shall be within the sole and absolute discretion of the Buyer, and Seller hereby irrevocably waives any right to challenge or otherwise make any claim against the Buyer with respect to Buyer's pursuit, settlement or conduct of the Tax Claims. The Seller agrees to cooperate reasonably with the Buyer in pursuing the Tax Claims after the Closing Date, at the sole expense of the Buyer, and the Buyer will assume all costs of pursuing or settling the Tax Claims. Seller agrees to execute any documents, agreements or powers of attorney reasonably necessary or desirable to Buyer in connection with effectuating the foregoing provisions.

6. CONDITIONS PRECEDENT TO OBLIGATIONS OF SELLER

The obligations of Seller to consummate the transactions contemplated by this Agreement, including by taking the actions specified in Section 8.02, are subject to the satisfaction on or before Closing of the following conditions, unless waived by Seller:

6.01. Representations; Covenants.

(a) Each of the representations and warranties of Buyer in this Agreement that is qualified as to materiality was true and correct on and as of the date of this Agreement, each of the other representations and warranties of Buyer was true and correct in all material respects on and as of the date of this Agreement, each of the representations and warranties of Buyer in this Agreement that is qualified as to materiality is true and correct on and as of the Closing Date, and each of the other representations and warranties of Buyer in this Agreement is true and correct in all material respects on and as of the Closing Date.

(b) Each of the covenants to be complied with or performed by Buyer on or before Closing (other than actions to be taken at the Closing, including the delivery of the Closing Documents described in Section 8.03) has been complied with and performed in all material respects.

6.02. Adverse Proceeding. No Proceeding by any Governmental Authority (including the Attorney General) has been instituted or threatened to restrain or prohibit the transactions contemplated by this Agreement, no Governmental Authority (including the Attorney General) has taken any other action or made any request of Seller or Buyer as a result of which Seller reasonably and in good faith deems it inadvisable to proceed with the transactions contemplated by this Agreement, and no order is in effect restraining, enjoining or otherwise preventing consummation of the transactions contemplated by this Agreement.

6.03. Pre-Closing Confirmations. Seller has received all consents, approvals, licenses and other authorizations of Governmental Authorities, on terms reasonably satisfactory to Seller, including (i) the certificate of need approval by the Office of Health Care Access of the Connecticut Department of Public Health, (ii) confirmation that the Bond Liabilities have been satisfied, and (iii) approval for the conversion of the Hospitals to a for-profit entity by the Attorney General (including receipt of a fairness evaluation or fairness opinion satisfactory to the Seller and the Attorney General) and approval of the transfer or disposition of all donor restricted

funds of the Hospitals and all Subsidiaries in a manner acceptable to the Attorney General, required for Seller to consummate the transactions contemplated by this Agreement and that all applicable waiting periods under the HSR Act shall have expired or been terminated.

6.04. Redemption of the Bonds/Satisfaction of the Indenture. All actions required to be taken and all conditions required to be satisfied in connection with the defeasance or redemption of all outstanding tax-exempt debt issued by or on behalf of Seller, including the Bond Liabilities, and the satisfaction, discharge, release, and termination of all trust indentures, tax-exempt equipment loans and related documents (collectively, the "**Indenture**") associated with such tax-exempt debt, and all Encumbrances created by or in connection with the Indenture, have been, or at Closing will be, taken and satisfied. The Indenture and all Encumbrances created by or in connection with the Indenture shall have been satisfied, discharged and terminated, and Seller shall have received an opinion from counsel to the Connecticut Health and Education Facilities Authority to the effect that all Bond Liabilities have been defeased or prepaid, together with evidence satisfactory to Buyer of the discharge of all Encumbrances on the Assets under the Indenture.

6.05. Extraordinary Events. Buyer (a) is not in receivership or dissolution, (b) has not made any assignment for the benefit of creditors, (c) has not admitted in writing its inability to pay its debts as they mature, (d) has not been adjudicated a bankrupt, (e) has not filed a petition in voluntary bankruptcy, a petition or answer seeking reorganization, or an arrangement with creditors under the federal bankruptcy law or any other similar Legal Requirement of the United States or any state (and no such petition has been filed against Buyer), or (f) has not entered into any contract to do any of the foregoing on or after the Closing Date.

7. CONDITIONS PRECEDENT TO OBLIGATIONS OF BUYER

The obligations of Buyer to consummate the transactions contemplated by this Agreement, including by taking the actions specified in Section 8.03, are subject to the satisfaction on or before Closing of the following conditions, unless waived by Buyer:

7.01. Representations; Covenants; Schedules.

(a) Each of the representations and warranties of Seller in this Agreement that is qualified as to materiality was true and correct on and as of the date of this Agreement, each of the other representations and warranties of Seller in this Agreement was true and correct in all material respects on and as of the date of this Agreement, each of the representations and warranties of Seller in this Agreement that is qualified as to materiality is true and correct on and as of the Closing Date, and each of the other representations and warranties of Seller in this Agreement is true and correct in all material respects on and as of the Closing Date (other than the representation in Section 3.08(l) which shall be true and correct in all respects).

(b) Each of the covenants to be complied with or performed by Seller on or before Closing (other than actions to be taken at the Closing, including the delivery of the Closing Documents described in Section 8.02) has been complied with and performed in all material respects.

(c) Each of Seller's Schedules, Exhibits and other instruments required under this Agreement has been updated or delivered by Seller, and approved by Buyer, all in accordance with Section 10.01.

7.02. Adverse Action or Proceeding. No Proceeding by any Governmental Authority (including the Attorney General) has been instituted or threatened to restrain or prohibit the transactions contemplated by this Agreement, no Governmental Authority (including the Attorney General) has taken any other action or made any request of Seller or Buyer as a result of which Buyer reasonably and in good faith deems it inadvisable to proceed with the transactions contemplated by this Agreement, and no order is in effect restraining, enjoining or otherwise preventing consummation of the transactions contemplated by this Agreement.

7.03. Material Adverse Change. Since the date hereof, no Material Adverse Change has occurred and no event or condition has occurred or exists that could reasonably be expected to cause a Material Adverse Change.

7.04. Pre-Closing Confirmations and Contractual Consents. Buyer has obtained documentation or other evidence reasonably satisfactory to Buyer that:

(a) All Permits required to operate the Hospital Businesses will be transferred to or issued in the name of Buyer as of the Closing Date, without the imposition of any condition that is materially burdensome to the operation of the Hospital Businesses after Closing;

(b) The applicable Hospital Businesses that participate in the Government Payment Programs as of the date of this Agreement will be qualified effective as of Closing to participate in the Government Payment Programs in which they participate as of the date of this Agreement and will be entitled to receive payment under such Government Payment Programs for services rendered to qualified beneficiaries of such Government Payment Programs immediately after the Closing Date with respect to the Hospitals, and within a reasonable period of time after the Closing Date with respect to the other applicable Hospital Businesses;

(c) All other consents, approvals, licenses and other authorizations of Governmental Authorities, including the certificate of need approval by the Office of Health Care Access of the Connecticut Department of Public Health and approval for the conversion of the Hospitals to a for-profit entity by the Attorney General, required for Buyer to consummate the transactions contemplated by this Agreement and all other material consents, approvals, licenses and other authorizations of Governmental Authorities required for Buyer to operate the Hospital Businesses after Closing shall have been received on terms reasonably satisfactory to Buyer;

(d) Seller has delivered to Buyer copies of consents to assignment of the Assumed Contracts, and certain other consents, waivers and estoppels, that are listed on Schedule 7.04(d);

(e) Seller has obtained approvals from its Board of Trustees, corporators and, to the extent required, the governing boards of its Subsidiaries; and

(f) All applicable waiting periods under the HSR Act have expired or been terminated.

7.05. Extraordinary Events. Seller (a) is not in receivership or dissolution, (b) has not made any assignment for the benefit of creditors, (c) has not admitted in writing its inability to pay its debts as they mature, (d) has not been adjudicated a bankrupt, (e) has not filed a petition in voluntary bankruptcy, a petition or answer seeking reorganization, or an arrangement with creditors under the federal bankruptcy law or any other similar Legal Requirement of the United States or any state (and no such petition has been filed against it), and (f) has not entered into any Contract to do any of the foregoing on or after the Closing Date.

7.06. Title Insurance Policies and Surveys. Buyer has received:

(a) One or more commitments from a recognized national title insurance company chosen by Buyer to issue as of the Closing Date ALTA extended coverage owner's title insurance policies for the Owned Real Property, in amounts reasonably acceptable to Buyer, in form reasonably acceptable to Buyer and with such endorsements as Buyer may reasonably require, at Buyer's sole cost and expense; and

(b) ALTA land title surveys of the Owned Real Property, in form reasonably satisfactory to Buyer and the title insurance company, from a firm designated by Buyer and certified to Buyer and the title insurance company, at Buyer's sole cost and expense.

7.07. [RESERVED].

7.08. The Indenture. The Indenture and all Encumbrances created by or in connection with the Indenture, including the Bond Liabilities and other tax-exempt debt, shall have been satisfied, discharged and terminated, and Buyer shall be entitled to rely on the opinion of Seller's bond counsel described in Section 6.04.

7.09. Environmental Assessments. Buyer shall, at its election, have received a Phase I environmental site assessment in a form reasonably satisfactory to Buyer, on each parcel of Owned Real Property and, at Buyer's option, any portion of the premises forming a part of the Leased Real Property (each, a "**Phase I Assessment**," and, collectively, the "**Phase I Assessments**"). Buyer shall not be permitted to conduct any Phase II environmental site assessments, or other intrusive or destructive testing on or relating to the Owned Real Property or Leased Real Property (each, a "**Phase II Assessment**," and, collectively, the "**Phase II Assessments**") unless pursuant to information contained in the applicable Phase I Assessment and subject to the prior approval of Seller (including any conditions which Seller may impose on such investigations, and, if Seller so requires, memorialized in an environmental access agreement between Buyer and Seller), in Seller's sole discretion. Notwithstanding the foregoing, if, after review of any Phase I Assessment, the parties reasonably determine that the subject real property is an Establishment Real Property (as defined in Section 5.08 hereof) and reasonably identifies any "areas of concern" ("**AOCs**") warranting additional investigation pursuant to the Transfer Act, then, in order to obtain a preliminary (but not definitive) understanding of the nature and extent of any contamination potentially associated with such AOC, Buyer shall have the right to perform a limited Phase II Assessment of each such AOC pursuant to a scope of

work approved by Seller in advance, which approval (including any conditions which Seller may reasonably impose on such investigation) shall not be unreasonably withheld, conditioned or delayed. Buyer shall pay the full costs of any Phase I Assessment(s) and any Phase II Assessment(s) that may occur pursuant to this Section 7.09. Notwithstanding any other provision hereof to the contrary, Buyer shall not provide Seller with copies of any Phase II Assessment(s) (or any of the data contained therein) unless requested by Seller. To the extent any Phase II Assessments are performed in accordance with this provision, Buyer shall be reasonably satisfied with same.

7.10. Hill-Burton Facilities. No Encumbrance affects any of the Assets or Hospital Businesses relating to or arising under the Hill-Burton Act.

7.11. Physician Organization. On or before the Closing, Buyer shall form a medical foundation under Chapter 594b of the Connecticut General Statutes (the "**PMH Medical Foundation**"). The PMH Medical Foundation shall adopt governing documents in substantially the form set forth in Exhibit C. Simultaneous with the Closing, Eastern Connecticut Medical Professionals Foundation, Inc. shall transfer its assets, including its agreements with physicians, to the PMH Medical Foundation. The PMH Medical Foundation shall continue to employ on and after the Closing Date and consistent with the agreements transferred to it hereunder those physicians and other licensed "Providers," as defined in Section 33-182aa of the Connecticut General Statutes, that Eastern Connecticut Medical Professional Foundations, Inc. employed immediately prior to the Closing Date.

7.12. Additional Liabilities. Seller shall not, based on the Closing Estimates, have Additional Liabilities in excess of Ten Million Dollars ($10,000,000), unless Buyer in its sole discretion agrees to assume such Additional Liabilities in accordance with Section 2.05(d).

8. CLOSING; TERMINATION OF AGREEMENT

8.01. Closing.

(a) Consummation of the sale and purchase of the Assets and the other transactions contemplated by this Agreement (the "**Closing**") will take place electronically at 10:00 a.m., or at such other place and time as the parties may mutually agree, on October 1, 2016, or if at such time any conditions to Closing set forth in Articles 6 and 7 have not been satisfied (or waived by the parties entitled to the benefit thereof), on the third business day following satisfaction or waiver of such conditions, or at such time or place as the parties may mutually agree. The Closing shall be effective for all purposes as of 12:01 a.m. on the day of the Closing Date.

(b) At the Closing, Seller shall deliver, or cause to be delivered, to Buyer, each of the Closing Documents and other items set forth in Section 8.02, all in forms reasonably acceptable to Buyer and its counsel, and such Closing Documents, as appropriate, shall be duly executed by, and acknowledged on behalf of, Seller. At the Closing, Buyer shall deliver, or cause to be delivered, to Seller, each of the Closing Documents and the consideration set forth in Section 8.03, all in forms reasonably

acceptable to Seller and its counsel, and such Closing Documents, as appropriate, shall be duly executed by, and acknowledged on behalf of, Buyer and, where applicable, PMH.

(c) All proceedings to be taken and all documents to be executed and delivered by all parties at the Closing will be deemed to have been taken, executed and delivered simultaneously, and no proceedings will be deemed taken nor any documents executed or delivered until all have been taken, executed and delivered. At the conclusion of the Closing, all Closing Documents shall be released to the recipients thereof and Seller shall deliver (or cause to be delivered) to Buyer control and possession of the Assets.

8.02. Action of Seller at Closing. At the Closing, Seller shall deliver to Buyer:

(a) special warranty deeds, duly executed by Seller in recordable form, conveying to Buyer fee simple title to the Owned Real Property, free and clear of Encumbrances other than the Permitted Real Property Encumbrances;

(b) assignment and assumption agreements duly executed by Seller conveying to Buyer all of Seller's right, title and leasehold interest in and to the Leased Real Property;

(c) bills of sale and assignment duly executed by Seller conveying to Buyer good and valid title to all personal property Assets, free and clear of Encumbrances other than the Permitted Personal Property Encumbrances;

(d) assignments duly executed by Seller conveying to Buyer Seller's interests in the Assumed Contracts;

(e) limited powers of attorney to permit Buyer to utilize Seller's DEA registration numbers, in substantially the form of Exhibit B attached hereto, fully executed by Seller;

(f) a copy of resolutions duly adopted by the board of directors of Seller authorizing and approving the execution and delivery of this Agreement and the Closing Documents and the consummation of the transactions contemplated herein and therein, certified as in full force and effect as of the Closing Date by an appropriate officer of Seller;

(g) a certificate of a duly authorized officer of Seller certifying that (i) each of the representations and warranties of Seller in this Agreement that is qualified as to materiality was true and correct on and as of the date of this Agreement, (ii) each of the other representations and warranties of Seller in this Agreement was true and correct in all material respects on and as of the date of this Agreement, (iii) each of the representations and warranties of Seller in this Agreement that is qualified as to materiality is true and correct on and as the Closing Date, (iv) each of the other representations and warranties of Seller in this Agreement was true and correct in all material respects on and as of the Closing Date and (v) each of the covenants to be complied with or performed by Seller on or before Closing (other than actions to be taken

at the Closing, including the delivery of the Closing Documents described in this Section 8.02) has been complied with and performed in all material respects;

(h) a certificate of incumbency for the officers of Seller executing this Agreement and the Closing Documents;

(i) a certificate of legal existence for Seller and each of its Subsidiaries that is organized under the laws of the State of Connecticut from the State of Connecticut, dated no earlier than 15 days prior to the Closing Date;

(j) stock certificates and certificates or other appropriate instruments of transfer of the ownership interests in the Joint Ventures, duly endorsed for transfer to Buyer, and, to the extent obtained prior to Closing, any amendment to the operating agreement, bylaws or other governing documents of each Joint Venture that Buyer determines, in its reasonable discretion, is necessary to fully effectuate the transfer of the ownership interest in the Joint Ventures to Buyer;

(k) a statement pursuant to section 1.1445-2(b)(2)(iv) of the Treasury Regulations under the Code, executed on behalf of Seller or any Affiliate conveying an interest in Owned Real Property to Buyer or its Affiliates, certifying that such entity is not a foreign corporation and is not otherwise a foreign Person;

(l) all certificates of title and other documents evidencing an ownership interest conveyed as part of the Assets, including for all motor vehicles;

(m) all necessary state and local real estate conveyance tax forms duly executed by Seller;

(n) final execution copy of the Transfer Act Form III and ECAF with a $3,000 filing fee, as more fully described in Section 5.08;

(o) UCC termination statements or other releases for all Encumbrances on the Assets not constituting Permitted Encumbrances, which termination statements and releases will be effective as of Closing;

(p) owner's affidavits, certificates, rent rolls and other documentation that may be reasonably necessary to consummate the transactions contemplated by this Agreement and obtain the title policies required to be issued hereunder;

(q) the Transitional Services Agreement, fully executed by Seller; and

(r) such other Closing Documents as Buyer deems reasonably necessary to consummate the transactions contemplated by this Agreement.

8.03. Action of Buyer at Closing. At the Closing, Buyer shall deliver to Seller:

(a) The Purchase Price due to Seller, as adjusted in accordance with Section 2.05;

(b) an assumption agreement duly executed by Buyer pursuant to which Buyer assumes the Assumed Liabilities, as well as any documents Seller may reasonably require to effectuate Buyer's assumption of certain of Seller's Employee Benefit Plans pursuant to Section 5.03(e);

(c) a copy of resolutions duly adopted by the boards of directors, members or managers of PMH and Buyer, as appropriate, authorizing and approving the execution and delivery of this Agreement and the Closing Documents and the consummation of the transactions contemplated herein and therein, certified as in full force and effect as of the Closing Date by an appropriate officer of PMH and Buyer;

(d) a certificate of a duly authorized officer of Buyer certifying that each of the representations and warranties of Buyer in this Agreement that is qualified as to materiality was true and correct on and as of the date of this Agreement, that each of the other representations and warranties of Buyer in this Agreement was true and correct in all material respects on and as of the date of this Agreement, that each of the representations and warranties of Buyer in this Agreement that is qualified as to materiality is true and correct on and as of the Closing Date, that each of the other representations and warranties of Buyer in this Agreement is true and correct in all material respects on and as of the Closing Date, and that each of the covenants to be complied with or performed by Buyer on or before Closing (other than actions to be taken at the Closing, including the delivery of the Closing Documents described in this Section) has been complied with and performed in all material respects;

(e) a certificate of incumbency for the officers of PMH and Buyer executing this Agreement and the Closing Documents;

(f) a certificate of legal existence for Buyer from the State of Connecticut, dated no earlier than 15 days prior to the Closing Date;

(g) the Transitional Services Agreement, fully executed by Buyer; and

(h) such other Closing Documents as Seller deems reasonably necessary to consummate the transactions contemplated by this Agreement.

8.04. Termination Prior to Closing; Termination Fee.

(a) Notwithstanding anything herein to the contrary, this Agreement may be terminated at any time: (i) by mutual consent of Seller and Buyer; (ii) by Buyer, by written notice to Seller if any event occurs or condition exists that causes Seller to be unable to satisfy one or more conditions to the obligations of Buyer to consummate the trasnactions contemplated by this Agreement as set forth in Article 7; (iii) by Seller, by written notice to Buyer if any event occurs or condition exists that causes Buyer to be unable to satisfy one or more conditions to the obligations of Seller to consummate the trasnactions contemplated by this Agreement as set forth in Article 6; (iv) by Seller or Buyer, if the Closing Date shall not have taken place on or before December 31, 2016 (as such date may be extended by mutual agreement of Seller and Buyer); *provided*, however, that no party may terminate this Agreement if the failure of Closing to occur by

such date resulted from a material breach of this Agreement by such party; (v) by Buyer, pursuant to Section 5.13 hereof, or (vi) by Seller pursuant to Section 10.11(b).

(b) For the avoidance of doubt, this Section 8.04(b) shall not be effective unless and until the Certificate of Need ("**CON**") application has been filed with the State of Connecticut. Upon the filing of the CON application with the State of Connecticut, Seller shall present its invoices for reasonable out-of-pocket legal, valuation and consulting expenses incurred by Seller after the execution of that Letter of Intent between Buyer and Seller dated June 25, 2015 up to the time of the filing of the CON application (the "**CON Preparation Period**"). Within 10 days of receipt of such invoices, Buyer shall reimburse Seller for such reasonable out-of-pocket legal, valuation and consulting expenses up to $1,000,000 (One Million Dollars). If, however, the out-of-pocket legal, valuation and consulting expenses incurred by Seller during the CON Preparation Period total less than $1,000,000 (One Million Dollars), then Seller may present Buyer with additional invoices for out-of-pocket legal, valuation and consulting expenses incurred by Seller after the filing of the CON but prior to the closing of the transaction, and Buyer shall reimburse Seller for such additional out-of-pocket legal, valuation, and consulting expenses within 10 days of receipt of such invoices; provided, however, that the total amount of the invoices reimbursed by Buyer for out-of-pocket legal, valuation and consulting expenses paid by Seller during the CON Preparation Period and thereafter shall not in the aggregate exceed $1,000,000 (One Million Dollars). In the event that the transaction closes, the total amount paid by Buyer to Seller pursuant to this Section 8.04(b) shall be credited against the Purchase Price as shown in Section 2.05(a)(xi). In the event that the transaction does not close because Buyer breaches its obligations under this Agreement or refuses to accept regulatory conditions placed on the transaction by the Attorney General and the Office of Health Care Access of the Connecticut Department of Public Health, Seller shall be entitled to retain all amounts it receives pursuant to this Section 8.04(b). In the event that the transaction does not close as a result of (i) a breach by Seller of the provisions of Section 5.23 where such breach is willful and intentional by Seller or (ii) the failure of any material regulatory approval to issue despite the good faith efforts of the parties to cooperate with each other and regulators as part of the regulatory process, then Seller shall refund to Buyer all amounts paid to Seller under this Section 8.04(b).

(c) If this Agreement is validly terminated pursuant to Section 8.04(a), this Agreement will be null and void, and there will be no liability on the part of any party pursuant to this Agreement, except that (i) upon termination of this Agreement pursuant to Section 8.04(a), subject to Section 8.04(b), Seller will remain liable to Buyer and Buyer will remain liable to Seller for any breach of their respective obligations existing at the time of such termination, and each party may seek such remedies or damages against the other with respect to any such breach as are provided in this Agreement or as are otherwise available at law or in equity and (ii) the expense allocation provisions of Section 5.20 and the confidentiality provisions of Section 10.22 shall remain in full force and effect and survive any termination of this Agreement.

(d) Upon termination of this Agreement, each party's existing rights of access to the books and records of the other party shall terminate, and each party shall promptly

return every document furnished it by the other party (or any Affiliate of such other party) in connection with the transactions contemplated hereby, whether obtained before or after execution of this Agreement, and all copies thereof, and will destroy all copies of any analyses, studies, compilations or other documents prepared by it or its representatives to the extent they contain any information with respect to the business of the other parties hereto or their Affiliates, and will cause its representatives to whom such documents were furnished to comply with the foregoing. This Section 8.04 shall survive any termination of this Agreement.

9. INDEMNIFICATION

9.01. Indemnification by Seller. Subject to the conditions and limitations, and solely to the extent provided in this Article 9, Seller shall indemnify, defend and hold harmless Buyer's Indemnified Persons, and each of them, from and against any Losses incurred or suffered by Buyer's Indemnified Persons, directly or indirectly, as a result of or arising from:

(a) any inaccuracy in or breach of any representation or warranty of Seller set forth in this Agreement or in any Closing Document to which Seller is a party, whether or not Buyer's Indemnified Persons relied thereon or had knowledge thereof, *provided* that, in determining whether there has been any such inaccuracy or breach, any qualification as to materiality included in any representation or warranty shall not be taken into account;

(b) any claim asserted against Buyer or Buyer's Affiliates that, if meritorious, would constitute or give rise to a breach of any of Seller's representations and warranties as the direct cause of such claim;

(c) the nonfulfillment or breach of any covenant of Seller set forth in this Agreement or in any Closing Document to which Seller is a party;

(d) the Excluded Liabilities;

(e) any actual damages (including reasonable attorneys' fees) resulting from claims by any creditor of Seller relating to a claim in existence as of the Closing Date that the transfer of any of the Assets constitutes a fraudulent conveyance or transfer, or is avoidable under applicable state or federal insolvency, bankruptcy, bulk sales, fraudulent conveyance or creditors' rights Legal Requirements; and

(f) any liabilities, costs or expenses incurred by Buyer or its Affiliates in connection with the Transfer Act Activities contemplated by Section 5.08.

9.02. Seller's Limitations. Seller will have no liability under Section 9.01(a) and no claim will accrue against Seller under Section 9.01(a) unless and until the total amount of Losses that would otherwise be indemnifiable by Seller in respect of claims arising under Section 9.01(a) exceeds $675,000 (the "**Seller Deductible**") in the aggregate, at which time Buyer's Indemnified Persons shall be entitled to indemnification for all Losses under Section 9.01(a) in excess of the Seller Deductible, *provided* that there shall be no minimum Loss requirement, and liability of Seller shall arise for all Losses, in respect of Losses resulting from Seller's intentional misrepresentation or fraud.

9.03. Indemnification by Buyer. Subject to the conditions and limitations, and solely to the extent, provided in this Article 9, Buyer shall indemnify, defend and hold harmless Seller's Indemnified Persons, and each of them, from and against any Losses incurred or suffered by Seller's Indemnified Persons, directly or indirectly, as a result of or arising from:

(a) the inaccuracy in or breach of any representation or warranty of Buyer set forth in this Agreement or in any Closing Document to which Buyer is a party, whether or not Seller's Indemnified Persons relied thereon or had knowledge thereof, *provided* that, in determining whether there has been any such inaccuracy or breach, any qualification as to materiality included in any representation or warranty shall not be taken into account;

(b) the nonfulfillment or breach of any covenant of Buyer in this Agreement or in any Closing Document to which Buyer is a party;

(c) the Assumed Liabilities; and

(d) the ownership by Buyer of the Assets or the operation by Buyer of the Hospital Businesses after the Closing Date.

9.04. Buyer's Limitations. Buyer will have no liability under Section 9.03(a) and no claim will accrue against Buyer under Section 9.03(a) unless and until the total amount of Losses that would otherwise be indemnifiable by Buyer in respect of claims arising under Section 9.03(a) exceeds $675,000 (the "**Buyer Deductible**") in the aggregate, at which time Seller's Indemnified Persons shall be entitled to indemnification for all Losses under Section 9.03(a) in excess of the Buyer Deductible, *provided* that there shall be no minimum Loss requirement, and liability of Buyer shall arise for all Losses, in respect of Losses resulting from any intentional misrepresentation or fraud by Buyer.

9.05. Notice and Procedure. All claims for indemnification by any Indemnitee against an Indemnifying Party under this Article shall be asserted and resolved as follows:

(a) Third Party Claims.

(i) If the basis for any claim for indemnification against an Indemnifying Party pursuant to this Article 9 is a claim or demand made against an Indemnitee by a Person other than Buyer's Indemnified Person or Seller's Indemnified Person (a "**Third Party Claim**"), the Indemnitee shall deliver a Claim Notice with reasonable promptness to the Indemnifying Party (with copies

of all relevant written documentation, including papers served, if any, and a reasonable summary of any relevant oral discussions with such third party) specifying the nature of and alleged basis for the Third Party Claim and, to the extent then feasible and known, the alleged amount or the estimated amount of the Third Party Claim. If the Indemnitee fails to deliver the Claim Notice (and related materials) to the Indemnifying Party within 60 days after the Indemnitee receives notice of such Third Party Claim, the Indemnifying Party will not be obligated to indemnify the Indemnitee with respect to such Third Party Claim if and only to the extent that the Indemnifying Party's ability to defend the Third Party Claim or otherwise minimize the Losses for which the Indemnifying Party must indemnify the Indemnitee has been prejudiced by such failure. The Indemnifying Party will notify the Indemnitee within 15 days after receipt of the Claim Notice by the Indemnifying Party (the "**Notice Period**") whether the Indemnifying Party elects, at the sole cost and expense of the Indemnifying Party, to assume the defense of the Indemnitee against the Third Party Claim.

(ii) If the Indemnifying Party notifies the Indemnitee within the Notice Period that the Indemnifying Party elects to assume the defense of the Indemnitee against the Third Party Claim, then the Indemnifying Party will defend, at its sole cost and expense, the Third Party Claim by all appropriate proceedings, which proceedings will be diligently prosecuted by the Indemnifying Party to a final conclusion or settled, at the discretion of the Indemnifying Party (with the consent of the Indemnitee, which consent shall not be unreasonably withheld with respect to any settlement that does not include any non-monetary relief). The Indemnifying Party will have full control of such defense and proceedings, including any compromise or settlement thereof; *provided* that, prior to the Indemnitee's receipt of the Indemnifying Party's notice that it elects to assume such defense, the Indemnitee may file, at the sole cost and expense of the Indemnitee, any motion, answer or other pleading that the Indemnitee reasonably deems necessary to protect its interests and that is not prejudicial to the Indemnifying Party (it being understood that, except as provided in this Section 9.05(a)(ii), if an Indemnitee takes any such action that is prejudicial to the Indemnifying Party, the Indemnifying Party will be relieved of its obligations hereunder with respect to that portion of the Third Party Claim (or the Losses attributable thereto) prejudiced by the Indemnitee's action); and *provided further* that, if requested by the Indemnifying Party, the Indemnitee shall reasonably cooperate, at the sole cost and expense of the Indemnifying Party, with the Indemnifying Party and its counsel in contesting any Third Party Claim that the Indemnifying Party elects to contest or, if related to the Third Party Claim, in making any counterclaim or cross-claim against any Person (other than the Indemnitee or its Affiliates). The Indemnitee may participate in, but not control, any defense or settlement of any Third Party Claim assumed by the Indemnifying Party pursuant to this Section 9.05(a)(ii) and, except in respect of cooperation requested by the Indemnifying Party as provided in the preceding sentence, the Indemnitee will bear its own costs and expenses with respect to such participation. Notwithstanding the foregoing, the Indemnifying Party may not assume the defense of the Third Party Claim on behalf of the Indemnitee if (1) the

Persons against whom the Third Party Claim is made, or any impleaded Persons, include both one or more of Buyer's Indemnified Persons and one or more of Seller's Indemnified Persons, and (2) representation of all of such Persons by the same counsel creates an actual or potential conflict of interest that, after giving effect to any waivers made by such Persons, would breach or violate the ethical rules applicable to such counsel, in which case the Indemnitee shall have the right to defend the Third Party Claim on its own behalf and to employ counsel at the expense of the Indemnifying Party.

(iii) If the Indemnifying Party fails to notify the Indemnitee within the Notice Period that the Indemnifying Party intends to defend the Indemnitee against the Third Party Claim, or if the Indemnifying Party gives such notice but fails to diligently prosecute or settle the Third Party Claim, or if the Indemnifying Party is precluded by the last sentence of Section 9.05(a)(ii) from assuming the defense of such Third Party Claim, then (A) the Indemnitee will defend the Third Party Claim by all appropriate proceedings, which proceedings will be diligently prosecuted by the Indemnitee to a final conclusion or settled at the discretion of the Indemnitee (*provided*, however, that no Indemnifying Party shall be liable to any Indemnitee for any Losses arising from any settlement that is made or entered into without an Indemnifying Party's prior, written consent, such consent not to be unreasonably withheld or delayed) and (B) the out-of-pocket costs and expenses reasonably incurred in good faith by the Indemnitee in the defense of such Third Party Claim will be paid by the Indemnifying Party. The Indemnitee will have full control of such defense and proceedings, including any compromise or settlement thereof (subject to the proviso in the first sentence of this clause (iii)), *provided* that, if requested by the Indemnitee, the Indemnifying Party shall reasonably cooperate, at the sole cost and expense of the Indemnifying Party, with the Indemnitee and its counsel in contesting the Third Party Claim which the Indemnitee is contesting or, if related to the Third Party Claim in question, in making any counterclaim or cross-claim against any Person (other than the Indemnifying Party or its Affiliates).

(b) First Party Claims.

(i) If any Indemnitee has a claim against any Indemnifying Party that is not a Third Party Claim, the Indemnitee shall deliver an Indemnity Notice with reasonable promptness to the Indemnifying Party specifying the nature of and specific basis for the claim and, to the extent then feasible, the amount or the estimated amount of the claim. If the Indemnifying Party does not notify the Indemnitee within 60 days following its receipt of the Indemnity Notice that the Indemnifying Party disputes its obligation to indemnify the Indemnitee hereunder, the claim will be presumed to be a liability of the Indemnifying Party hereunder.

(ii) Upon receipt of any Indemnity Notice, the Indemnifying Party will be entitled to request in writing and receive from the Indemnitee a reasonable extension of the 60-day period in which to respond pursuant to Section 9.05(b)(i) for the purpose of investigating the claims made therein or the proper amount

thereof. The Indemnitee, to the extent requested by the Indemnifying Party, shall reasonably cooperate, at the sole cost and expense of the Indemnifying Party, with the Indemnifying Party's investigation of such claims or the proper amount thereof.

(c) Resolution of Disputes. If the Indemnifying Party timely disputes, or is deemed to have disputed, its liability with respect to a claim described in a Claim Notice or an Indemnity Notice, the Indemnifying Party and the Indemnitee shall proceed promptly and in good faith to negotiate a resolution of such dispute within 60 days following receipt by the Indemnifying Party of the Claim Notice or Indemnity Notice and, if such dispute is not resolved through negotiations during such 60-day period, it shall be resolved pursuant to Section 10.04 and, if not resolved thereby, by other appropriate legal process.

(d) Payment of Indemnifiable Losses. Subject to the terms of any final order entered by a court of competent jurisdiction, the Indemnifying Party shall pay the amount of any indemnifiable Losses to the Indemnitee within ten days following the later to occur of (i) the date on which such indemnifiable Losses are incurred or sustained by the Indemnitee or (ii) the date on which the Indemnifying Party has acknowledged its liability for such indemnifiable Losses. Indemnifiable Losses not paid when so due shall accrue interest from (and including) the date on which such indemnifiable Losses were incurred or sustained by the Indemnitee until (but excluding) the date on which such amount is paid, at the interest rate provided in Section 10.20.

(e) Certain Disclaimers. Any estimated amount of a claim submitted in a Claim Notice or an Indemnity Notice shall not be conclusive of the final amount of such claim, and the giving of a Claim Notice when an Indemnity Notice is properly due, or the giving of an Indemnity Notice when a Claim Notice is properly due, shall not impair such Indemnitee's rights hereunder. Notice of any claim comprised in part of Third Party Claims and claims that are not Third Party Claims shall be appropriately bifurcated and given pursuant to each of Section 9.05(a)(i) and Section 9.05(b)(i), as applicable.

9.06. Survival of Representations and Warranties; Indemnity Periods. Notwithstanding any right of Buyer to investigate Seller and the Hospital Businesses or any right of any party to investigate the accuracy of the representations and warranties of the other party in this Agreement, or any actual investigation by or knowledge of a party, Seller has, on the one hand, and Buyer has, on the other hand, the right to rely fully upon the representations and warranties of the other in this Agreement. The representations, warranties and covenants of Seller and Buyer in this Agreement respectively will survive the Closing (a) indefinitely with respect to matters covered by Sections 2.04, 3.01, 3.02, 3.03, 3.11, 4.01, 4.02, 4.04, 8.04(b), 8.04(c), 8.04(d), 9.01(b)-(e), 9.03(b)-(d), 10.15, 10.20, 10.22 and 10.23, (b) until the expiration of all applicable statutes of limitations (including all periods of extension) with respect to matters covered by Sections 3.05, 3.07, 3.11, 3.12(a), 3.13, 3.17, 3.22, 3.24 and 3.28, and (c) until the second anniversary of the Closing Date in the case of all other representations and warranties, except that:

(i) the right to indemnification with respect to any claim relating to a breach or default of any representation and warranty whose survival expires in accordance with clause (b) or (c) above will continue to survive if a Claim Notice or an Indemnity Notice with respect to such claim has been given on or before the expiration of such representation or warranty until the claim for indemnification has been satisfied or otherwise resolved as provided in this Article;

(ii) in the event of intentional misrepresentation or fraud in the making of any representation and warranty, all representations and warranties that are the subject of the intentional misrepresentation, fraud or intentional nonfulfillment or breach shall survive until the expiration of all applicable statutes of limitations (including all periods of extension) with respect to claims made for such intentional misrepresentation, fraud or intentional nonfulfillment or breach; and

(iii) covenants to be performed or complied with after the Closing Date will survive the Closing until 60 days after the end of the term specified in each covenant, or, if no term is specified, indefinitely.

9.07. Mitigation. Each Indemnitee shall take all commercially reasonable steps to mitigate its Losses upon and after becoming aware of any event or condition that has given rise to any Losses for which it may be indemnified pursuant to this Agreement. The amount of Losses for which an Indemnitee may make an indemnification claim pursuant to this Agreement shall be reduced by any amounts actually recovered by the Indemnitee under insurance policies or other collateral sources (such as contractual indemnities of any Person that are contained outside of this Agreement or the Closing Documents) with respect to such Losses. Each Indemnitee must use commercially reasonable efforts to obtain recovery under such insurance policies or other collateral sources. To the extent that any payment received by an Indemnitee under any insurance policy or other collateral source was not previously taken into account to reduce the amount of indemnifiable Losses paid to such Indemnitee, such Indemnitee shall promptly pay over to the Indemnifying Party the amount so recovered or realized (after deducting therefrom the full amount of the expenses incurred by the Indemnitee in procuring such recovery or realization), but such amount paid over to the Indemnifying Party shall not exceed the sum of (a) the amount previously paid by the Indemnifying Party to the Indemnitee in respect of such matter plus (b) the amount expended by the Indemnifying Party in pursuing or defending any third party claim arising out of such matter. Notwithstanding the foregoing, no Indemnitee shall be required to seek recovery under any insurance policy issued by, or other collateral source that is, an Affiliate of the Indemnitee.

9.08. Indemnity Reserve. In accordance with the provisions of Sections 2.05(g), 2.05(k) and 2.05(m), Seller agrees to fund an indemnity reserve up to a maximum of $4,500,000 (Four Million Five Hundred Thousand Dollars) for a period of three years after the Closing so that Buyer will have meaningful financial recourse against Seller for indemnification claims; *provided*, however, that (a) if, as of the third anniversary of the Closing Date, Buyer has pending indemnification claims, then Seller shall maintain an indemnity reserve in the amount of Buyer's Indemnified Person's bona fide claims until final resolution of such matters, and (b) if Buyer has not yet received written approval from CTDEEP or a "verification" from a "Licensed Environmental Professional" as contemplated by Section 5.08 that the Establishment Real

Properties have been remediated in full compliance with the Connecticut Remediation Standard Regulations, then the indemnification reserve shall be extended for an additional period until such written approval has been received by Buyer. Notwithstanding the foregoing, in no circumstance shall the indemnification reserve established by this Section 9.08 be extended beyond the fifth anniversary of the Closing Date. For clarity, in no event shall the indemnity reserve be deemed to be in any respect a cap on the amount of Losses for which the Buyer's Indemnified Persons shall be entitled to recover under Section 9.01. To the extent that any funds remain in the indemnity reserve following the expiration of applicable periods set forth in this Section 9.08, and there has been a reduction in the Commitment Amount pursuant to Section 5.18, the remaining indemnity reserve funds shall be paid to Buyer and the Commitment Amount shall be increased, on a dollar-for-dollar basis, up to Seventy-Five Million Dollars ($75,000,000).

10. GENERAL

10.01. Exhibits; Schedules.

(a) Each Schedule and Exhibit to this Agreement shall be considered a part hereof as if set forth herein in full. From the date hereof until Closing, Seller shall update its Schedules such that all of its representations and warranties are true and accurate as of the Closing Date. Any other provision herein to the contrary notwithstanding, all Schedules, Exhibits, or other instruments provided for herein and not delivered at the time of execution of this Agreement or that are incomplete at the time of execution of this Agreement shall be delivered or completed within ten (10) days after the date hereof or ten (10) days prior to the Closing, whichever is sooner. It shall be deemed a condition precedent to the obligations of Buyer that each of the Schedules, Exhibits and related documents, instruments, books and records shall meet with the approval of Buyer. If Buyer, in its reasonable discretion, determines that it should not consummate the transactions contemplated by this Agreement because of any information contained in a Schedule, Exhibit, or other instrument that is delivered to Buyer after the execution of this Agreement, then Buyer may terminate this Agreement on or before the Closing by giving written notice thereof to Seller.

(b) Nothing in the Schedules shall be deemed adequate to disclose an exception to a representation or warranty made in this Agreement unless the Schedule identifies the exception with reasonable particularity and, without limiting the generality of the foregoing, the mere listing of a document as an exception to any representation and warranty shall not be deemed to disclose the contents of such document as an exception to any representation or warranty (but shall be adequate to disclose the existence of the document itself).

10.02. Equitable Remedies. Subject to Section 8.04(b), each party acknowledges and agrees that its breach of this Agreement, or its failure to perform its obligations pursuant to this Agreement in accordance with its specific terms, would cause the other party to suffer irreparable damage or injury that would not be fully compensable by money damages, or the exact amount of which may be impossible to determine, and, therefore, such other party would not have an adequate remedy available at law. Accordingly, each party agrees that the other

party shall be entitled to seek specific performance, injunctive and/or other equitable relief from any court of competent jurisdiction (without the necessity of posting bond) as may be necessary or appropriate to enforce specifically this Agreement and the terms and provisions hereof and to prevent or curtail any breach (or threatened breach) of the provisions of this Agreement. Such equitable remedies shall not be the exclusive remedy of any party for any such breach or failure to perform by another party, but shall be in addition to all other remedies available to such party at law or in equity (the availability of which remedies shall be, after the Closing, subject to the applicable limitations set forth in Article 9).

10.03. Other Owners of Assets.

(a) Buyer, Seller and its undersigned Subsidiaries acknowledge that certain Assets may be owned by Subsidiaries of Seller and not Seller. Notwithstanding the foregoing, and for purposes of all representations, warranties, covenants, and agreements contained herein, Seller agrees, and, as evidenced by their acknowledgement to this Agreement, its undersigned Subsidiaries agree and acknowledge, that (i) its obligations with respect to any Assets shall be joint and several with any Subsidiary of Seller that owns or controls such Assets, (ii) the representations and warranties herein, to the extent applicable, shall be deemed to have been made by, on behalf of and with respect to such Subsidiaries of Seller in their ownership capacity, and (iii) it has the legal capacity to cause, and it shall cause, any of its Subsidiaries that owns or controls any Assets to meet all of Seller's obligations under this Agreement with respect to such Assets. Seller hereby waives any defense to a claim made by Buyer or its Affiliates under this Agreement based on the failure of any Person who owns or controls the Assets to be a party to this Agreement. Notwithstanding the foregoing, the parties acknowledge and agree that Seller shall not make pursuant to this Agreement, and this Section 10.03(a) shall not otherwise suggest, any representation, warranty or other commitment as to the Subsidiaries of Seller listed on Schedule 10.03(a).

(b) Seller and each of the Buyer Entities acknowledge that certain Assets may be purchased at Closing by one or more of the Buyer Entities (as determined by the Buyer in its discretion). Notwithstanding the foregoing, and for purposes of all representations, warranties, covenants, and agreements contained herein, Buyer agrees and acknowledges, that (i) the representations and warranties herein, to the extent applicable, shall be deemed to have been made by, on behalf of and with respect to each Buyer Entity, as applicable, in its post-Closing ownership capacity, and (ii) each of the Buyer Entities has the legal capacity to meet all of Buyer's obligations under this Agreement with respect to such Assets. Buyer hereby waives any defense to a claim made by Seller or any of its Subsidiaries, or its Affiliates, under this Agreement based on the failure of any Person who will purchase the Assets to be a party to this Agreement.

10.04. Dispute Resolution. The parties hereby agree that, prior to pursuing any other legal remedy, any controversy or claim arising out of this Agreement shall be resolved through the following procedures:

(a) In the event of a controversy or claim arising under this Agreement, either party may give the other party notice of such dispute pursuant to Section 10.14 hereof,

and promptly thereafter the parties will each select two or more senior executives to negotiate in good faith in an effort to resolve the controversy or claim. The senior executives shall meet at such location as from time to time may be mutually agreed by the parties and such meetings shall be in person to the extent practicable.

(b) If the parties are unable to resolve the controversy or claim as provided in Section 10.04(a) within 30 days of the notice of the controversy or claim, then either party may notify the other party that it wants to pursue non-binding mediation in an attempt to resolve the controversy or claim. The parties shall jointly appoint a mutually acceptable mediator to mediate the dispute or, if the parties are unable to agree on a mutually acceptable mediator within 15 days after receipt of notice requesting mediation, then the parties shall request assistance from the American Arbitration Association in finding a mutually acceptable mediator. Each party shall bear its own costs incurred in the mediation and shall bear one-half the costs and expenses of the mediator and any similar parties that may assist in the mediation. The parties agree to participate in good faith in the mediation and negotiations related thereto for a period of 30 days, unless a longer period is otherwise agreed.

10.05. Tax and Government Payment Program Effect. None of the parties (nor such parties' counsel or accountants) has made or is making in this Agreement any representation to any other party (or such party's counsel or accountants) concerning any of the Tax or Government Payment Program effects or consequences on the other party of the transactions provided for in this Agreement. Each party represents that it has obtained, or may obtain, independent Tax and Government Payment Program advice with respect thereto and upon which it, if so obtained, has solely relied.

10.06. Reproduction of Documents. This Agreement and all documents relating hereto, including consents, waivers and modifications that may hereafter be executed, the Closing Documents, financial statements, certificates and other information previously or hereafter furnished to any party, may be reproduced by any party by any photographic, microfilm, electronic or similar process. The parties stipulate that any such reproduction, when rendered in physical form and constituting an identical representation of the original, shall be admissible in evidence as the original itself in any judicial, arbitral or administrative proceeding (whether or not the original is in existence and whether or not such reproduction was made in the ordinary course of business).

10.07. Consented Assignment. Notwithstanding anything in this Agreement to the contrary, this Agreement shall not constitute an agreement to assign any Assumed Contract, claim or other right if the assignment or attempted assignment thereof without the consent of another Person would (i) constitute a breach thereof, (ii) be ineffective or render the Contract, claim or right void or voidable, or (iii) in any material way affect the rights of Seller thereunder (or the rights of Buyer thereunder following any such assignment or attempted assignment). In any such event, until the requisite consent is obtained, Seller shall cooperate in any reasonable arrangement designed to provide for Buyer the benefits under any such Contract, claim or right, including enforcement of any and all rights of Seller against the other Person arising out of the breach or cancellation by such other Person or otherwise. After Closing, the parties shall continue to use commercially reasonable efforts to obtain the consent to the assignment of such

Contract, claim or right; provided, however, that such obligation shall be of no further force and effect if Seller and Buyer determine that such consent or approval will not be forthcoming.

10.08. Time of Essence. Time is of the essence in the performance of this Agreement, *provided* that, if the day on or by which a notice must or may be given, or the performance of any party's obligation is due, is a Saturday, Sunday or other day on which banks in Manchester, Connecticut are permitted or required to be closed, then the day on or by which such notice must or may be given, or that such performance is due, shall be extended to the first day thereafter that is not a Saturday, Sunday or other day on which banks in Manchester, Connecticut are permitted or required to be closed. The parties will use commercially reasonable efforts to file as soon as practicable and pursue all necessary regulatory approvals required in connection with this Agreement.

10.09. Consents, Approvals and Discretion. Except as expressly provided to the contrary in this Agreement, whenever this Agreement requires any consent or approval to be given by any party or any party must or may exercise discretion, such consent or approval shall not be unreasonably withheld or delayed and such discretion shall be reasonably exercised.

10.10. Choice of Law. This Agreement and all matters arising out of or relating to this Agreement shall be governed by and construed in accordance with the laws of the State of Connecticut without regard to any conflicts of laws rules (whether of the State of Connecticut or any other jurisdiction). Any litigation or proceedings among the parties arising out of or relating to this Agreement shall be commenced in a court of the State of Connecticut or the federal district court of Connecticut.

10.11. Benefit and Assignment; Change in Control of PMH.

(a) Subject to the provisions herein to the contrary, this Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective legal representatives, successors and assigns; *provided* however that no party may assign this Agreement without the prior written consent of the other party. Notwithstanding the foregoing, (i) Buyer may designate one or more Affiliates to purchase any or all of the Assets including the Hospital Businesses, provided that PMH hall unconditionally guarantee any and all obligations of such Affiliates pursuant to Section 10.23, and (ii) Buyer and PMH shall be permitted to grant a security interest in and collaterally assign and transfer all their rights, interests and benefits, but not their obligations under this Agreement to any entity providing financing to Buyer and/or Buyer's Affiliates at any time and from time to time without obtaining the written consent of Seller.

(b) If PMH undergoes a "Change in Control" prior to the Closing PMH shall (i) provide 30 days' advance notice to Seller of such Change in Control, and (ii) Seller shall have the right to terminate this Agreement without penalty, including that Seller shall not be required to pay any consulting fees to PMH or Buyer pursuant to any consulting agreement entered into by Seller and PMH or Buyer. For purposes of this Section 10.11(b), the term "Change in Control" means where (i) more than fifty percent (50%) of PMH's outstanding equity interest, or substantially all of PMH's assets, are transferred to a third party, or (ii) any merger, consolidation or acquisition of PMH by or

into another corporation, entity or person. Notwithstanding the forgoing, a "Change in Control" shall not include a transfer of 50% or more of the shares of PMH in connection with one or more public offerings of its shares.

10.12. Third Party Beneficiary. This Agreement (including provisions regarding employee and employee benefit matters) and the Closing Documents are intended solely for the benefit of the parties to this Agreement (and their respective successors and permitted assigns) and (solely in their capacities as Indemnified Persons) Buyer's Indemnified Persons and Seller's Indemnified Persons, and are not intended to confer third-party beneficiary rights upon any other Person (or, in the case of Buyer's Indemnified Persons and Seller's Indemnified Persons, to such Persons in any other capacity). Any reference in this Agreement to one or more Employee Benefit Plans of Buyer includes provisions, if any, in such plans permitting their termination or amendment and any covenant in this Agreement to provide any Employee Benefit Plan shall not be deemed or construed to limit Buyer's right to terminate or amend such plan of Buyer in accordance with its terms (except as otherwise provided in Section 5.03(d)).

10.13. Waiver of Breach, Right or Remedy. The waiver by any party of (a) any breach or violation by the other party of any provision of this Agreement, (b) any condition to the obligations of such party to consummate the transactions contemplated by this Agreement, or (c) any other right or remedy permitted the waiving party in this Agreement, (i) shall not waive or be construed to waive any prior or subsequent breach or violation of the same provision or any subsequent exercise of the same right or remedy, (ii) shall not waive or be construed to waive a breach or violation of any other provision, any other closing condition or any other right or remedy, and (iii) to be effective, must be in writing and signed by the party entitled to the benefit of the provision, condition, right or remedy to be waived, and may not be presumed or inferred from any party's conduct. The election of any one or more available remedies by a party shall not constitute a waiver of the right to pursue other available remedies.

10.14. Notices. Any notice, demand or communication required, permitted or desired to be given hereunder must be in writing and shall be deemed effectively given (i) on the date tendered by personal delivery, (ii) on the date received by fax or other electronic means, (iii) on the date tendered for delivery by nationally recognized overnight courier, or (iv) three days after the date tendered for delivery by United States mail, with postage prepaid thereon, certified or registered mail, return receipt requested, in any event addressed as follows:

If to Buyer: Prospect ECHN, Inc.
c/o Prospect Medical Holdings, Inc.
3415 South Sepulveda Boulevard, 9th Floor
Los Angeles, CA 90034
Attn: General Counsel
Fax: 310-943-4501
Email: ellen.shin@prospectmedical.com

with a copy to (which shall not constitute notice):

Epstein Becker & Green, P.C.
1 Gateway Center
Newark, NJ 07102
Attn: Gary W. Herschman
Fax: 973-639-8924
Email: GHerschman@ebglaw.com
Attn: David E. Weiss
Email: DWeiss@ebglaw.com

If to Seller: Eastern Connecticut Health Network, Inc.
General Counsel
Eastern Connecticut Health Network
71 Haynes Street
Manchester, Connecticut 06040
Attn: Joyce Tichy
Email: jtichy@echn.org

with a copy to (which shall not constitute notice):

Ropes & Gray LLP
Prudential Tower
800 Boylston Street
Boston, MA 02199-3600
Attn: Anne Ogilby
Fax: 617-235-0234
Email: anne.ogilby@ropesgray.com

or to such other address or fax number, and to the attention of such other Person, as any party may designate in writing in conformity with this Section.

10.15. Misdirected Payments; Physician Loans. After Closing, (a) Seller shall remit to Buyer with reasonable promptness any monies received by Seller (or its Affiliates) constituting or in respect of the Assets and Assumed Liabilities, and (b) Buyer shall remit to Seller with reasonable promptness any monies received by Buyer (or its Affiliates) constituting or in respect of the Excluded Assets and Excluded Liabilities. If any funds previously paid or credited to Seller or the Hospital Businesses in respect of services rendered on or before the Closing Date have resulted in an overpayment or must be repaid, Seller shall be responsible for the repayment of said monies (and the defense of such actions), except to the extent that such credit or repayment obligation was included in the calculation of Net Working Capital as shown on the Closing Balance Sheets in which case Seller shall not be liable for any such repayment. If Buyer suffers any deduction to or offset or withhold against amounts due Buyer of funds previously paid or credited to Seller or the Hospital Businesses in respect of services rendered on or before the Closing Date (other than in respect of overpayments addressed by the preceding sentence), Seller shall pay to Buyer the amounts so deducted, offset or withheld within five business days after demand therefor, except to the extent that the amount of such deduction, offset or withholding was included in the calculation of Net Working Capital as shown on the Closing

Balance Sheets. Any amounts payable pursuant to this Agreement that are due Buyer by Seller or one of its Affiliates, or due Seller by Buyer or one of its Affiliates, may be offset against monies or other funds owed by the party entitled to receive payment to the party required to make payment (other than such owed amounts that are being disputed in good faith). Seller shall use, and cause its Affiliates to use, good faith efforts to collect any and all loans and other amounts due from physicians and their Affiliates that constitute Excluded Assets.

10.16. Severability. If any provision of this Agreement is held or determined to be illegal, invalid or unenforceable under any present or future law in the final judgment of a court of competent jurisdiction, then, if the rights or obligations of any party under this Agreement would not be materially and adversely affected thereby: (a) such provision will be fully severable; (b) this Agreement will be construed and enforced as if such illegal, invalid or unenforceable provision had never comprised a part of this Agreement; (c) the remainder of this Agreement will remain in full force and effect and will not be affected by the illegal, invalid or unenforceable provision or by its severance from this Agreement; and (d) instead of such illegal, invalid or unenforceable provision, there will be deemed to be added to this Agreement a legal, valid and enforceable provision as similar in terms to such illegal, invalid or unenforceable provision as may be possible.

10.17. CON Disclaimer. This Agreement shall not be deemed to be an acquisition or obligation of a capital expenditure or of funds within the meaning of the certificate of need statute of any state, until the appropriate governmental agencies shall have granted a certificate of need or the appropriate approval or ruled that no certificate of need or other approval is required.

10.18. Entire Agreement; Amendment. This Agreement supersedes all previous contracts, agreements and understandings and constitutes the entire agreement of whatsoever kind or nature existing between or among the parties respecting the within subject matter and no party shall be entitled to benefits with respect to the Assets or the Hospital Businesses other than those specified in this Agreement. As between or among the parties, any oral or written representation, warranty, covenant, agreement or statement not expressly incorporated in this Agreement, whether given before or on the date of this Agreement, shall be of no force and effect unless and until made in writing and signed by the parties on or after the date of this Agreement. The representations, warranties and covenants set forth in this Agreement shall survive the Closing and remain in full force and effect as provided in Section 9.06, and shall survive the execution and delivery of, and shall not be merged with or into, the Closing Documents and all other agreements, instruments or other documents described, referenced in or contemplated by this Agreement. Each representation, warranty and covenant in this Agreement has independent legal significance and if any party has breached any representation, warranty or covenant in any respect, whether there exists another representation, warranty or covenant relating to the same subject matter (regardless of the relative level of specificity) that such party has not breached shall not detract from or mitigate the party's breach of the first representation, warranty or covenant. This Agreement may not be amended or supplemented except in a written instrument executed by each of the parties.

10.19. Counterparts; Transmission by Electronic Means. This Agreement may be executed in two or more counterparts, each and all of which shall be deemed an original and all

of which together shall constitute but one and the same instrument. This Agreement, and any executed counterpart of a signature page to this Agreement, may be transmitted by fax or e-mail (attaching a .pdf (portable document format) copy thereof), and such delivery of an executed counterpart of a signature page to this Agreement by fax or e-mail shall be effective as delivery of a manually executed counterpart of this Agreement. At the Closing, the Closing Documents may be executed, and the signature pages thereto delivered, in like manner.

10.20. Interest. Any monies required to be paid by any party to another party pursuant to this Agreement shall be due on the date or at the time for payment specified in this Agreement, and monies not paid when due shall accrue interest from and after the due date to, but not including, the date full payment is made at an annual rate equal to the average prime rate of Bank of America, N.A. during such period.

10.21. Drafting. No provision of this Agreement shall be interpreted for or against any Person on the basis that such Person was the draftsman of such provision, and no presumption or burden of proof shall arise favoring or disfavoring any Person by virtue of the authorship of any provision of this Agreement.

10.22. Confidentiality; Public Announcements.

(a) Except as required by Legal Requirements or in order to coordinate the defeasance of tax-exempt debt, Seller and Buyer (and their respective Affiliates) shall keep this Agreement and the Closing Documents and their contents confidential and not disclose the same to any Person (except the parties' attorneys, accountants or other professional advisors who need to know such contents for the purpose of advising such party in connection with the transactions contemplated hereby, and except to the applicable Governmental Authorities in connection with any required notification or application for approval or a license or exemption therefrom) without the prior written consent of the other party.

(b) At all times before and after the Closing, Seller, on the one hand, and PMH and Buyer, on the other hand, will consult with the other before issuing or making any reports, statements or releases to the public with respect to this Agreement or the transactions contemplated by this Agreement and will use good faith efforts to obtain the other party's prior approval of the text of any public report, statement or release to be made by or on behalf of such party. If either party is unable to obtain the prior approval of its public report, statement or release from the other party and such report, statement or release is, in the opinion of legal counsel to such party, necessary to discharge such party's disclosure obligations under applicable Legal Requirements, then such party may make or issue the legally required report, statement or release and promptly furnish the other party a copy thereof.

10.23. Guarantee of Buyer's Obligations. PMH, as principal obligor and not merely as a surety, hereby unconditionally guarantees full, punctual and complete performance by Buyer of all of Buyer's obligations under this Agreement and each of the Closing Documents subject to the terms hereof and thereof and so undertakes to Seller that, if and whenever Buyer is in default, PMH will on demand duly and promptly perform or procure the performance of Buyer's

obligations. The foregoing guarantee is a continuing guarantee and will remain in full force and effect indefinitely (in light of the fact that, as provided in Section 9.06, certain representations, warranties, covenants and indemnification obligations of Buyer survive the Closing indefinitely) and will be reinstated with respect to any sum paid to Seller that must be restored by Seller upon the bankruptcy, liquidation or reorganization of Buyer. PMH's obligations under this Section 10.23 shall not be affected or discharged in any way by any Proceeding with respect to Buyer under any federal or state bankruptcy, insolvency or debtor relief laws (or any order, judgment, ruling, writ, injunction or decree entered or made in connection therewith) or any other fact, development, occurrence or circumstance affecting the legal capacity of Buyer or the enforceability of this Agreement or any of the Closing Documents against Buyer in accordance with their respective terms.

[*Signature Page Follows*]

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed in multiple originals by their authorized officers, all as of the date first above written.

SELLER:

EASTERN CONNECTICUT HEALTH NETWORK, INC.

By: _____
Name: Peter J. Karl
Title: President & CEO

BUYER:

PROSPECT CT MEDICAL FOUNDATION, INC.

By: _____
Name: Samuel S. Lee
Title: President

PROSPECT CT MANAGEMENT SERVICES, INC.

By: _____
Name: Samuel S. Lee
Title: President

PROSPECT ECHN, INC.

By: _____
Name: Samuel S. Lee
Title: President

PROSPECT MANCHESTER HOSPITAL, INC.

By: _____
Name: Samuel S. Lee
Title: President

PROSPECT ROCKVILLE HOSPITAL, INC.

By: _____
Name: Samuel S. Lee
Title: President

PROSPECT ECHN ELDERCARE SERVICES, INC.

By: _____
Name: Samuel S. Lee
Title: President

PROSPECT ECHN HOME HEALTH, INC.

By: _____
Name: Samuel S. Lee
Title: President

PROSPECT CARING HAND, INC.

By: _____
Name: Samuel S. Lee
Title: President

PROSPECT HAYNES STREET PROPERTY MANAGEMENT, INC.

By: _____
Name: Samuel S. Lee
Title: President

PROSPECT MEDICAL HOLDINGS, INC., solely for the limited purposes described in this Agreement

By: _____
Name: Samuel S. Lee
Title: Chief Executive Officer

[*Acknowledgement Page Follows*]

Each of the undersigned Subsidiaries of Seller hereby joins this Agreement to acknowledge that Seller has executed this Agreement on its behalf and that, with respect to the Assets or Hospital Businesses owned or operated by it, it is subject to and bound by the same obligations, representations, and warranties as Seller as provided under Section 10.03(a).

ACKNOWLEDGED BY:

THE MANCHESTER MEMORIAL HOSPITAL

By: _____
Name: Peter J. Karl
Title: President & CEO

THE ROCKVILLE GENERAL HOSPITAL, INCORPORATED

By: _____
Name: Peter J. Karl
Title: President & CEO

ECHN ELDERCARE SERVICES, INC.

By: _____
Name: Peter J. Karl
Title: President & CEO

VISITING NURSE AND HEALTH SERVICES OF CONNECTICUT, INC.

By: _____
Name: Peter J. Karl
Title: Authorized Signatory

A CARING HAND, LLC

By: _____
Name: Peter J. Karl
Title: Authorized Signatory

CLINICALLY INTEGRATED NETWORK OF EASTERN CONNECTICUT, LLC

By: _____
Name: Peter J. Karl
Title: Authorized Signatory

CONNECTICUT HEALTHCARE INSURANCE COMPANY

By: _____
Name: Peter J. Karl
Title: Director

ECHN CORPORATE SERVICES, INC.

By: _____
Name: Peter J. Karl
Title: Authorized Signatory

MEDICAL PRACTICE PARTNERS, LLC

By: _____
Name: Dennis O'Neill, M.D.
Title: Authorized Signatory

ECHN ENTERPRISES, INC.

By: _____
Name: Peter J. Karl
Title: President & CEO

HAYNES STREET PROPERTY MANAGEMENT, LLC

By: _____
Name: Peter J. Karl
Title: Authorized Signatory

EASTERN CONNECTICUT MEDICAL PROFESSIONALS FOUNDATION, INC.

By: _____
Name: Peter J. Karl
Title: President & CEO

Exhibit A

Form of Transitional Services Agreement

See attached.

TRANSITION SERVICES AGREEMENT

This Transition Services Agreement (this "Agreement") is made and entered into as of the ___ day of ____, 2016, by and between Eastern Connecticut Health Network, Inc. (together with affiliates and successors, collectively, "OLDCO") and Prospect ECHN, Inc. (together with affiliates and successors, collectively, "Prospect").

W I T N E S S E T H

WHEREAS, at a closing held on the date hereof pursuant to that certain Asset Purchase Agreement, dated ___ 2016,by and among, Inter Alia, Prospect and OLDCO (the "Purchase Agreement"), Prospect has acquired substantially all of the assets of OLDCO; and

WHEREAS, Prospect has employed substantially all of the former employees of OLDCO;

WHEREAS, following the closing under the Purchase Agreement. Eastern Connecticut Health Network, Inc. and certain of its affiliates will change their respective names to new names that are not substantially similar to the names being used by Prospect;

WHEREAS, OLDCO, having few or no employees, requires certain post-closing services to wind down its business, administer the assets not sold to Prospect and discharge the liabilities of OLDCO not assumed by Prospect; and

WHEREAS, Prospect is willing to provide those certain services to OLDCO for such purposes during the term of this Agreement.

NOW THEREFORE, in consideration of the foregoing and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

1. Term. The term of this Agreement shall commence on the date hereof and shall continue for a period of twelve (12) months (the "Initial Term"). The Initial Term shall be automatically extended for two additional twelve month renewal periods.

2. Transition Services. During the Term, Prospect shall arrange for services to be provided to OLDCO in the manner detailed in Exhibit A (the "Transition Services").

a. Prospect will provide the Transition Services in good faith and with due care consistent with the care Prospect exercises in performing like services for itself. OLDCO acknowledges and agrees that Prospect does not regularly provide the Transition Services to third parties as part of its business, and, except as specifically stated elsewhere herein, Prospect

does not otherwise warrant or assume any responsibility for its performance of the Transition Services.

b. Prospect shall have no obligation to provide any Transition Services in any instance where such Transition Services would create a conflict of interest between Prospect and OLDCO. Prospect at its sole discretion, shall be permitted to identify instances of conflicts of interest between Prospect and OLDCO.

c. OLDCO shall have no obligation to accept any Transition Services in any instance where such Transition Services would create a conflict of interest between Prospect and OLDCO. OLDCO at is sole discretion, shall be permitted to decline any Transition Services from Prospect in instances where a conflict of interest is identified by OLDCO.

d. OLDCO shall appoint Robert A. Schwartz, MD and Michael R. Blezard as representatives of OLDCO following the Closing (the "Representatives"). The Representatives shall be the principal contact persons and shall each, whether acting singly or jointly, have the authority and be responsible for making decisions on behalf of OLDCO under this Agreement. The Representatives shall each, whether acting singly or jointly, be authorized to sign documents (including checks) on behalf of OLDCO and take all other appropriate and necessary actions on behalf of OLDCO.

e. Each party shall make available to the other party any information required or reasonably requested by that other party regarding performance of Transition Services, and shall be responsible for timely providing that information and for the accuracy and completeness of that information. The parties shall cooperate with each other in good faith in all matters relating to the provision and receipt of Transition Services. The parties shall cooperate with each other in making such information available as needed in the event of any and all internal and external audits. If this Agreement is terminated in whole or in part, the parties shall cooperate with each other in all reasonable respects in order to effect an efficient transition and to minimize disruption to the business of both parties.

3. Charges; Payment Terms.

a. OLDCO shall, for each Transition Service performed, reimburse Prospect for any reasonable documented out-of-pocket expenses that are incurred by Prospect in connection with Prospect's provision of the Transition Services ("Expenses"). Prospect shall provide OLDCO with an invoice for all Transition Services provided at the rates described on Exhibit B, and Expenses incurred by Prospect in connection therewith, during the Term, that are payable by OLDCO pursuant to this Agreement, together with all appropriate supporting documentation (each, an "Invoice").

b. Prospect shall provide Invoices to OLDCO on a monthly basis. OLDCO shall, subject to Section 2.05(*l*)(i) of the Purchase Agreement, pay in full to Prospect all fees and Expenses as set forth in the Invoice within thirty (30) days after receipt of the Invoice, unless

OLDCO has provided notice to Prospect that it disputes a given Invoice within fifteen (15) days of receipt of such Invoice, in which case the parties will work in good faith to resolve the dispute.

c. If Prospect terminates any of the Transition Services prior to the expiration of the Term, OLDCO shall be responsible for payment only for the Transition Services provided through the date on which such Transition Services are terminated.

d. If OLDCO exhausts its funds such that it can no longer pay for the Transition Services, Prospect shall continue to provide those Transition Services that are necessary for the timely filing of all governmental forms and filings in order to permit the orderly wind-down of OLDCO and shall not seek payment from OLDCO for such Transition Services.

4. Indemnification.

a. Each party assumes liability for and shall indemnify and hold harmless the other party, its officers, directors, trustees, employees, and agents, from and against any and all losses, damages, penalties, liabilities, claims, actions, suits, costs, and expenses, including reasonable attorneys' fees, whether in law or in equity, of any kind or nature whatsoever, imposed upon, incurred by, or asserted against the other party relating to or arising out of any negligent or other wrongful act or omission of such party, its employees or agents, or any breach of this Agreement by such party.

b. Neither party shall have liability for consequential, exemplary, indirect, special, incidental or punitive damages, including loss of profits, revenues, data or use, incurred by the other party, whether based on contract, tort or any other legal theory, arising out of or related to this Agreement or the Transition Services provided hereunder.

c. Notwithstanding anything contained herein to the contrary, any liability of a party under this Agreement shall in no event exceed the aggregate amount of fees paid to Prospect by OLDCO hereunder, except in the case of such party's gross negligence or reckless or intentional act or omission.

d. The provisions of this Section 4 shall survive the termination of this Agreement.

5. Confidentiality.

a. "Confidential Information" is defined as all information, data and materials furnished or made available by a party to another party in connection with this Agreement, including, without limitation, the identity of patients, the content of any medical records, financial and tax information, and information regarding Medicare and Medicaid claims submission and reimbursements.

b. The party receiving the Confidential Information (the "Receiving Party") from the party who owns or holds in confidence such Confidential Information (the "Owning Party") may use the Confidential Information solely for the purpose of performing its obligations or enforcing its rights under this Agreement.

c. The Receiving Party shall not disclose any of the Confidential Information except to those persons having a need to know for the purpose of performing the Receiving Party's obligations or enforcing its rights under this Agreement. Each party shall take appropriate action, by instruction to or agreement with its affiliates, employees, agents, trustees, subcontractors, consultants, and professional advisors, to maintain the confidentiality of the Confidential Information. The Receiving Party shall promptly notify the Owning Party in the event that the Receiving Party learns of an unauthorized release of Confidential Information.

d. The Receiving Party shall have no obligation with respect to (i) Confidential Information made available to the general public without restriction by the Owning Party or by an authorized third party; (ii) Confidential Information known to the Receiving Party independently of disclosures by the Owning Party under this Agreement; (iii) Confidential Information independently developed by the Receiving Party; or (iv) Confidential Information that the Receiving Party may be required to disclose pursuant to subpoena or other lawful process; provided, however, that the Receiving Party notifies the Owning Party in a timely manner to allow the Owning Party to protect its interests at Owning Party's sole expense.

e. Upon the termination or expiration of this Agreement, unless otherwise provided in this Agreement, each party shall immediately cease to use the other party's Confidential Information and, (a) return to the other party such Confidential Information and all copies thereof within ten (10) days of the termination, or (b) provide the other party with written confirmation that all such Confidential Information and all copies thereof has been destroyed.

f. The parties acknowledge that monetary remedies may be inadequate to protect rights in Confidential Information and that, in addition to legal remedies otherwise available, injunctive relief is an appropriate judicial remedy to protect such rights. The provisions of this Section 5 shall survive the termination of this Agreement.

6. Protected Health Information.

a. Each of Prospect and OLDCO shall comply with all federal and state laws and regulations, regarding the confidentiality of Protected Health Information, as such term is defined in HIPAA (as hereinafter defined). Simultaneously herewith, the parties shall enter into a Business Associate Agreement in the form of Exhibit C in accordance with the applicable provisions of the Administrative Simplification section of the Health Insurance Portability and Accountability Act of 1996, as codified at 42 U.S.C. § 1320, and the requirements of the

regulations promulgated thereunder (45 C.F.R. Parts 160, 162, and 164) as amended by the Health Information Technology for Economic and Clinical Health Act found in the American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, Title XIII (2009, aka HITECH), including regulations promulgated thereunder, as amended, and guidance issued pursuant thereto (collectively "HIPAA"). In addition, each of Prospect and OLDCO acknowledges that in receiving or otherwise dealing with any records or information from the other about patients receiving treatment for alcohol or drug abuse, Prospect and OLDCO respectively and their respective staffs are bound by the provisions of the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, as amended from time to time.

b. To the extent that any records maintained or stored by either Prospect or OLDCO pursuant to this Agreement contain Personal Information (as herein defined) about their respective personnel or patients, they shall comply with Connecticut General Statutes § 36a-701b(a) ("Data Security Breaches Act"). "Personal Information" shall mean: (a) first name or first initial and last name in combination with any one or more of the following data elements: (i) Social Security number; (ii) driver's license or state identification card number; or (iii) account number, credit or debit card number in combination with any required security code, access code or password that would permit access to an individual's financial account. In the event of a Breach of the Security of the System involving such records, Prospect or OLDCO, as the case may be, shall immediately notify the other via telephone and in writing and shall comply fully with the Data Security Breaches Act. For purposes of this paragraph, the term Breach of the Security of the System shall mean unauthorized access to or acquisition of electronic files, media, databases or computerized data containing Personal Information when access to the Personal Information has not been secured by encryption or by any other method or technology that renders the personal information unreadable or unusable. The provisions of this paragraph shall survive the termination of this Agreement.

7. Record Retention. Until the expiration of four years after the termination of this Agreement, the Parties upon request shall make available to the Secretary, United States Department of Health and Human Services, the U.S. Comptroller General or any of their duly authorized representatives, this Agreement and all other books, documents, and records necessary to certify the nature and extent of the costs incurred by the Parties under this Agreement. If a party purchases such services through a subcontract worth Ten Thousand Dollars ($10,000) or more over twelve (12) month period with a related organization, the subcontract shall also contain a clause permitting access by said Secretary, Comptroller General, and their respective representatives to the books and records of the related organization. Each party shall promptly notify the other via telephone and in writing if such access is requested.

8. Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of Connecticut without regard to its conflict of law provisions. Each party hereby consents to jurisdiction in the state or federal courts located in the State of Connecticut should suit to enforce this contract become necessary. If either party hereto shall bring suit to enforce the terms and provisions hereof or to recover damages for breach, the

prevailing party shall be entitled to recover from the other party all costs, expenses and attorneys' fees incurred in connection with the exercise by the prevailing party of its rights and remedies hereunder.

9. Termination. OLDCO may terminate this Agreement prior to the expiration of the Term by giving Prospect at least ninety (90) days' prior written notice of termination. Prospect may terminate this Agreement prior to the expiration of the Term (i) for cause, if OLDCO fails to pay an undisputed invoice presented by Prospect pursuant to Section 3.b above within 90 days of receipt of such invoice provided that OLDCO has sufficient funds in the Wind-Down Reserve established under the Purchase Agreement to pay such invoice, or (ii) by giving OLDCO ninety (90) days' prior written notice of termination, provided that prior to termination, Prospect arranges for an alternate entity to provide the Transition Services to OLDCO on terms reasonably acceptable to OLDCO..

10. Miscellaneous.

a. Any notice or other communication under this Agreement shall be in writing and shall be deemed to have been given: (a) upon actual delivery, if delivered by hand; (b) the first business day following deposit with any nationally recognized overnight carrier; or (c) three (3) days after deposit in the United States mail, postage prepaid, certified or registered mail, return receipt requested. Each such notice shall be sent to the parties, marked to the attention of the signatories to this Agreement, at the following addresses:

If to Prospect: Prospect ECHN, Inc
71 Haynes Street
Manchester, CT 06040
Attention: CEO

With a copy to: Prospect Medical Holdings, Inc.
3415 South Sepulveda Boulevard, 9th Floor
Los Angeles, California 90034
Attention: Legal Department

If to OLDCO: Eastern Connecticut Health Network, Inc.
71 Haynes Street
Manchester, CT 06040
Attention: President of Legacy ECHN, Inc.

b. The parties agree that the relationship between them shall be that of independent contractors. Neither party shall hold itself out as the employee, agent, joint venturer or partner of the other. Neither party has the authority to bind the other in any way. Prospect is responsible for paying or withholding, as required, federal, state, and local employment taxes including, without limitation, FICA and FUTA, for its employees.

c. This Agreement contains the entire agreement of the parties with respect to the matters set forth herein and may not be amended except in writing signed by all of the parties hereto.

d. This Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective successors and assigns. A party shall not assign its rights and obligations under this Agreement without the other party's prior written consent.

e. No delay or failure by either party to exercise any right under this Agreement, and no partial or single exercise of that right, shall constitute a waiver of that or any other right at any time, or from time to time thereafter. The waiver, or any breach, of any term or condition of this Agreement shall not be deemed to constitute the continuing waiver of the same or any other term or condition.

f. If any part of this Agreement should be held to be void or unenforceable, such part shall be treated as severable, leaving valid the remainder of this Agreement, notwithstanding the part or parts found to be void or unenforceable.

g. Headings in this Agreement are for convenience only and shall not be used to interpret or construe its provisions.

h. This Agreement may be executed by facsimile signature and in one or more counterparts, each of which shall be deemed an original but all of which together shall constitute one and the same instrument.

[REMAINDER OF THIS PAGE INTENTIONALLY LEFT BLANK]

IN WITNESS WHEREOF, the parties have executed this Transition Services Agreement as of the date first written above.

EASTERN CONNECTICUT HEALTH NETWORK, INC.

By: _____
Name: _____
Title: _____

PROSPECT ECHN, INC.

By: _____
Name: _____
Title: _____

EXHIBIT A

Services

For a twelve (12) month period after the date of closing, the services to be provided by Prospect to OLDCO may include but not be limited to:

Accounting:

- Monthly financial close
- Management of cash and investment activities as necessary
- Preparation of tax returns
- Monthly reconciliation of balance sheet accounts
- Financial audits including 401(a) and 403(b) plans
- Assistance with the final preparation and submission of the *Cy Pres* litigation and related matters
- Assistance with final cost reports

Accounts Payable:

- Entry and payment of invoices as necessary
- Creation of 1099s through February of 2017
- Assistance with reconciliation of outstanding checks

Payroll:

- Filing of payroll tax reports as necessary
- Creation of W-2's for pre-transition employees
- Management of outstanding checks
- Employee support - providing information to employees for historical payroll data, historical W-2 requests and payroll slips

Human Resources:

- Response to prior plan inquiries
- Transition management of OLDCO's 401(a), 401(k) and 403(b) plans (whether or not subject to ERISA), including:
    1. 403(b), 401(k) and 401(a) audits and Form 5500s for the 2015 and 2016 plan years (and any subsecquent years required until final liquidation of the plans)
    2. Calculation and administration of trailing payroll deductions and 2016 company contributions (payment to be made for 2016 by [date]) (it being understood that provision of funding remains the responsibility of OLDCO)
    3. Liquidation and termination of defined contribution plans
    4. Any additional tasks necessary or appropriate for the proper pre-liquidation operation and liquidation of the plans
- Transition management of welfare benefits, including:

1. Oversight of claims administration for trailing claims under self-insured health plan and flexible spending accounts (it being understood that provision of funding remains the responsibility of OLDCO)
2. Form 5500 filings as required
3. Coordination with insurers for payment of pre-closing claims covered by insurance companies
4. Any other tasks necessary or appropriate for the orderly termination of these benefits

- Final payout (and administration pending final payout) of 457 plans (it being understood that funding remains the responsibility of OLDCO)

Miscellaneous:

- Assist in Preparation of 990 tax returns
- Assist in Preparation of the Community Needs Assessment (990 reporting requirement)
- Insurance management
- Support for OLDCO Board/Finance/Investment Committee meetings, including meetings of the entities identified in the Purchase Agreement as the Hospitals and the Hospital Businesses, as well as Eastern Connecticut Physician Hospital Organization, Inc., Northeast Regional Radiation Oncology Network, Inc. and Tolland Imaging Center, LLC.
- Support and attendance of staff at OLDCO Board meetings, including meetings of the entities identified in the Purchase Agreement as the Hospitals and the Hospital Businesses, as well as Eastern Connecticut Physician Hospital Organization, Inc., Northeast Regional Radiation Oncology Network, Inc. and Tolland Imaging Center, LLC.
- Assist in the planning of and transition to post-closing operations
- Assist in developing a plan for post-closing office space
- Assist with record retention planning
- Assist with necessary reporting to regulatory authorities
- Support for organization and operation of the New Community Foundation

Information Services:

- Assist with support of OLDCO systems, including backup, for all necessary applications, and custom reports as needed
- Maintain and protect all data to meet OLDCO's data retention requirements
- Support all audits/reviews of data

Legal/Risk Management:

- Assist with operational issues
- Assist with resolution of outstanding claims and suits including legacy labor and employment issues (grievances, arbitrations, governmental inquries, etc.)
- Assist with outstanding workers compensation and other insurance claims and matters

EXHIBIT B

Rates

1. Prospect personnel at the level of Vice President and above shall be provided at the rate of One Hundred Fifty Dollars ($150) per hour.

2. All other Prospect personnel shall be provided at the rate of Ninety Dollars ($90) per hour.

EXHIBIT C

Dual Use Business Associate Agreement Attached

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement ("Agreement") is entered into and made effective as of _____, 2016 (the "Effective Date") by and between Prospect ECHN, Inc. and its subsidiaries (collectively "Prospect"), on the one hand, and Eastern Connecticut Health Network, Inc., and its subsidiaries and successors (collectively, "OLDCO"), on the other.

RECITALS

A. Prospect and OLDCO have entered into various agreements, including a Transition Services Agreement, (collectively the "Underlying Contracts") pursuant to which the parties may disclose certain information to one another pursuant to the terms of the Underlying Contracts, some of which may constitute Protected Health Information ("PHI" or "Protected Information") (defined below).

B. Prospect and OLDCO intend to protect the privacy and provide for the security of PHI disclosed to one another and are committed to complying with the patient privacy requirements set forth in California law, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("HITECH Act"), and all regulations promulgated by the U.S. Department of Health and Human Services under HIPAA and the HITECH Act, including the requirements set forth in the HIPAA Final Omnibus Rule issued on January 25, 2013, ("HIPAA Regulations").

C. As part of the HIPAA Regulations, the Privacy, Security, Breach Notification, and Enforcement Rules (defined below as "HIPAA Rules") require the parties to enter into an agreement containing specific requirements concerning the disclosure of PHI, as required by Code of Federal Regulations ("C.F.R.), Title 45, Parts 160 and 164.

In consideration of the mutual promises contained herein and the exchange of information pursuant to this Agreement, and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree as follows:

1. *DEFINITIONS*

All capitalized terms used herein but not otherwise defined in this Agreement shall have the same meaning as in the HIPAA Rules.

a. **Breach** shall have the meaning given to such term under the HIPAA Rules.

b. **Business Associate** ("BA") shall have the meaning given to such term under the HIPAA Rules, as set forth in 42 U.S.C. § 17938 and 45 C.F.R. § 160.103, and, in reference to this Agreement, shall mean either Prospect or OLDCO, depending on which party is receiving the protected information, and the subcontractors, agents, and person(s) or entities under the party's control.

c. **Covered Entity** ("CE") shall have the meaning given to such term under the HIPAA Rules, as set forth in C.F.R. § 160.103. Both Prospect and OLDCO are Covered Entities and may provide protected information to the other party, which will sit in the role as the Business Associate.

d. **Data Aggregation** shall have the meaning given to such term under the HIPAA Rules, as set forth 45 C.F.R. § 164.501.

e. **Designated Record Set** shall have the meaning given to such term under HIPAA Rules, as set forth in 45 C.F.R. § 164.501.

f. **Electronic Protected Health Information or EPHI** means Protected Health Information that is maintained in or transmitted by electronic media, as defined in the HIPAA Rules.

g. **Electronic Health Record** shall have the meaning given to such term in the HIPAA Rules and as set forth in 42 U.S.C. § 17921.

h. **Health Care Operations** shall have the meaning given to such term under the HIPAA Rules, including, but not limited to, the meaning set forth in 45 C.F.R. § 164.501.

i. **HIPAA Rules** shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and 164.

j. **Protected Health Information or PHI** shall have the meaning given to such term under the HIPAA Rules, including 45 C.F.R. § 160.103, which includes any information, whether oral or recorded in any form or medium: (i) that relates to the past, present or future physical or mental condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and (ii) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual. Protected Health Information includes Electronic Protected Health Information.

k. **Protected Information** shall mean PHI provided by CE to BA or created or received by BA on CE's behalf.

l. **Subcontractor** means a person to whom a business associate delegates a function, activity, or service, other than in the capacity of a member of the workforce of such business associate, pursuant to 45 C.F.R. § 160.103.

m. **Unsecured PHI** shall have the meaning given to such term under 42 U.S.C. § 17932(h), 45 C.F.R. § 164.402 and guidance issued pursuant to the HITECH Act including, but not limited to that issued on April 17, 2009 and published in 74 Federal Register 19006 (April 27, 2009), by the Secretary of the U.S. Department of Health and Human Services ("Secretary").

2. *OBLIGATIONS OF BUSINESS ASSOCIATE*

a. **Permitted Access, Use or Disclosure.** The parties shall neither permit the unauthorized or unlawful access to, nor use or disclose, PHI other than as permitted or required by the Underlying Contracts, this Agreement or as permitted or required by law. The parties shall not access, use or disclose Protected Information in any manner that would constitute a violation of HIPAA, the HITECH Act, the HIPAA Regulations, or applicable state law if so accessed, used or disclosed by CE. However, the parties may access, use or disclose Protected Information (i) for the proper management and administration of BA; (ii) to carry out the legal responsibilities of BA; (iii) as required by law; (iv) for Data Aggregation purposes for the Health Care Operations of CE; (v) for the public health activities and purposes set forth at 45 C.F.R. § 164.512(b); or (vi) to the extent such Protected Information is de-identified in accordance with the standards set forth under 45 C.F.R. § 164.514, provided the parties have each other's written consent in advance of any such use or disclosure, which consent may be withheld in CE's sole discretion. If either party permits a third party to use or access Protected Information or otherwise discloses Protected Information to a third party, the party must obtain, prior to making any such disclosure, (i) reasonable written assurances from such third party that such Protected Information will be held confidential as provided pursuant to this Agreement and only disclosed as required by law or for the purposes for which it was disclosed to such third party, and (ii) a written agreement from such third party to immediately notify the other party of any Breaches of confidentiality of the Protected Information, to the extent it has obtained knowledge of such Breach.

b. **Prohibited Uses and Disclosures under HITECH.** Notwithstanding any other provision in this Agreement, the parties to this Agreement shall comply with the following requirements: (i) a party shall not use or disclose Protected Information for fundraising or marketing purposes, except as provided under the Agreement and consistent with the requirements of 42 U.S.C. 17936, 45 C.F.R. § 164.522(a)(vi); (ii) a party shall not disclose Protected Information to a health plan for payment or health care operations purposes if the patient has requested this special restriction, and has paid out of pocket in full for the health care item or service to which the PHI solely relates, 42 U.S.C. § 17935(a); (iii) a party shall not directly or indirectly receive remuneration in exchange for Protected Information, except with the prior written consent of CE and as permitted by the HIPAA Rules and HITECH Act, 42 U.S.C. § 17935(d)(2), 45 C.F.R. 164.502(a)(5)(ii); however, this prohibition shall not affect payment for services provided pursuant to the Agreement.

c. **Appropriate Safeguards.** The parties shall implement appropriate safeguards as are necessary to prevent the access, use or disclosure of Protected Information other than as permitted by the Underlying Contracts or this Agreement. The parties shall comply, where applicable, with the Security Rule with respect to EPHI, including but not limited to 45 C.F.R. §§ 164.308, 164.310, and 164.312 and the policies and procedures and documentation requirements of the HIPAA Security Rule set forth in 45 C.F.R. § 164.316, and shall use administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of EPHI.

d. **Mitigation.** The parties agree to mitigate, to the extent practicable, any harmful effect that is known as a result of use or disclosure of PHI not authorized by the Underlying Contracts, this Agreement or applicable federal or state rules or regulations governing the use, access, maintenance or disclosure of protected health information.

e. **Reporting of Improper Access, Use or Disclosure.** The parties shall promptly report to the other party in writing of any access, use or disclosure of Protected Information exchanged between one another, not permitted by the Underlying Contracts, this Agreement, the HIPAA Rules or any corresponding state privacy or security requirements as well as any security incident of which it becomes aware. The parties shall, following the discovery of any Breach of Unsecured PHI, notify the other in writing of such breach without unreasonable delay and in no case later than ten (10) calendar days after discovery. The party responsible for the improper use or disclosure agrees to pay the actual, reasonable costs of the required notifications.

f. **Business Associate's Subcontractors.** The receiving party of any protected information shall ensure that any Subcontractors that create, maintain or transmit Protected Information, agree in writing to the same restrictions and conditions that apply to the party with respect to such PHI. To the extent a party creates, maintains, receives or transmits Electronic PHI on behalf of the other party, the receiving party shall implement the safeguards required by paragraph 2.c. above with respect to EPHI and shall ensure that any Subcontractor to whom it provides Protected Information agrees in writing to implement the same safeguards.

g. **Access to Protected Information.** To the extent the receiving party maintains a Designated Record Set on behalf of the other party, it shall make Protected Information maintained by it or its Subcontractors in Designated Record Sets available to the other party for inspection and copying within fifteen (15) days of a request by the other party to enable the other party to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 C.F.R. § 164.524. If the receiving party maintains an Electronic Health Record, the receiving party shall provide such information in electronic format to enable the CE to fulfill its obligations under the HIPAA Rules (and the HITECH Act as set forth in 42 U.S.C. § 17935(e)).

h. **Amendment of PHI.** To the extent a party maintains a Designated Record Set on behalf of the other party, within fifteen (15) days of receipt of a request from the other party or an individual for an amendment of Protected Information or a record about an individual contained in a Designated Record Set, the party and/or its Subcontractors shall make any amendments that the other party directs or agrees to in accordance with the HIPAA Rules.

i. **Accounting Rights.** Within fifteen (15) days of notice by a party of a request for an accounting of disclosures of Protected Information, each party and its Subcontractors shall make available to the requesting party the information required to provide an accounting of disclosures to enable the party to fulfill its obligations under the HIPAA Rules, including, but not limited to, 45 C.F.R. § 164.528 and 42 U.S.C. § 17935(c), as determined by the requesting party. The provisions of this subparagraph 2.i. shall survive the termination of this Agreement.

j. **Governmental Access to Records.** The parties shall make their internal practices, books and records relating to the use and disclosure of Protected Information available

to the other party and to the Secretary of the U.S. Department of Health and Human Services (the "Secretary") for purposes of determining the party's compliance with the HIPAA Rules. Each party shall immediately notify the other party of any requests made by the Secretary and provide the other party with copies of any documentation it provides in response to such requests.

k. **Compliance with Privacy Rule.** To the extent that a party carries out the other party's obligations under the Privacy Rule, the party shall comply with the requirements of the Privacy Rule that apply to the other party in the performance of such obligations.

l. **Minimum Necessary**. Each party and their respective Subcontractors shall request, use and disclose only the minimum amount of Protected Information necessary to accomplish the purpose of the request, use or disclosure. The parties understand and agree that the definition of "minimum necessary" shall be the meaning set forth in the HIPAA Rules. The parties agree to make their respective uses, disclosures and requests for Protected Information consistent with the other party's minimum necessary policies and procedures, to the extent such policies and procedures are provided to one another.

m. **Business Associate's Insurance**. The parties shall each obtain insurance for themselves and their respective employees, agents and independent contractors in an amount not less than One Million Dollars ($1,000,000) per occurrence and Two Million Dollars ($2,000,000) annual aggregate of Commercial General Liability insurance and Two Million Dollars ($2,000,000) per occurrence and Four Million Dollars ($4,000,000) annual aggregate of Errors and Omissions insurance. The Errors and Omissions insurance shall cover, among other things, Breaches. Upon request, the parties shall exchange certificates of insurance or other written evidence of the insurance policy or policies required herein prior to execution of this Agreement (or as shortly thereafter as is practicable) and as of each annual renewal of such insurance policies during the period of such coverage. Further, in the event of any material modification, termination, expiration, non-renewal or cancellation of any of such insurance policies, the party shall give written notice to the other party not more than ten (10) days following the party's receipt of such notification. If a party fails to procure, maintain or pay for the insurance required under this section, the other party shall have the right, but not the obligation, to obtain such insurance. In such event, the party shall promptly reimburse the other party for the cost thereof upon written request, and failure to repay the same upon demand by the party shall constitute a material breach of this Agreement.

3. *TERMINATION*

a. **Term.** The term of this Agreement shall be effective as of the Effective Date and shall terminate upon the later of (1) the termination or expiration of the Underlying Contracts; or (2) when all of the PHI provided by CE to BA, or created or received by BA on behalf of CE, is destroyed or returned to CE.

b. **Termination**.

i. **Material Breach**. A breach by either party of any provision of this Agreement, as determined by the other party, shall constitute a material breach of the Agreement

and shall provide grounds for termination of the Agreement, any provision in the Agreement to the contrary notwithstanding, with or without an opportunity to cure the breach. If termination of the Agreement is not feasible, the party may report the problem to the Secretary.

ii. **Material Breach by either CE.** If either party knows of a pattern of activity or practice of the other party that constitutes a material breach or violation of the other party's obligations under the Underlying Contracts, the Agreement or other arrangement, the party shall notify the other party of the pattern or activity or practice and take reasonable steps to assist the other party in curing or ending the breach or violation. If the steps are unsuccessful, the party may be required terminate the Agreement or other arrangement.

c. **Effect of Termination.** Upon termination of the Agreement for any reason, the parties shall, at the option of the other party, return or destroy all Protected Information or its Subcontractors still maintain in any form, and shall retain no copies of such Protected Information. If return or destruction is not feasible, as determined by a party, the other party shall continue to extend the protections of this Agreement to such information, and limit further use of such PHI to those purposes that make the return or destruction of such PHI infeasible. If a party elects destruction of the PHI, the party shall certify in writing to the other party that such PHI has been destroyed.

4. ***INDEMNIFICATION; LIMITATION OF LIABILITY.*** To the extent permitted by law, a party shall indemnify, defend and hold harmless the other party and its directors, officers, employees, parent, subsidiaries, agents and affiliates from any and all liability, claim, lawsuit, injury, loss, expense or damage resulting from or relating to the acts or omissions of the indemnifying party in connection with the representations, duties and obligations of the indemnifying party under this Agreement. Any limitation of liability contained in the Agreement shall not apply to the indemnification requirement of this provision. This provision shall survive the termination of the Agreement.

5. ***ASSISTANCE IN LITIGATION.*** Each party shall make itself and any Subcontractors assisting a party in the performance of its obligations pursuant to the Underlying Contracts available, at no cost to the other party, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against a party, its directors, officers, agents, employees or affiliates based upon a claim of violation of the HIPAA Rules or HITECH Act, or other California or federal laws related to security and privacy, except where the party or its Subcontractor is named as an adverse party.

6. ***COMPLIANCE WITH STATE LAW.*** Nothing in this Agreement shall be construed to require or permit either party to use or disclose Protected Information without a written authorization from an individual who is a subject of the Protected Information, or without written authorization from any other person, where such authorization would be required under state law for such use or disclosure.

7. ***AMENDMENT TO COMPLY WITH LAW.*** The parties acknowledge that state and federal laws relating to data security and privacy are rapidly evolving and that amendment of this Agreement may be required to provide for procedures to ensure compliance with such develop-

ments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA, the HITECH Act, and other applicable laws relating to the security or confidentiality of PHI. The parties understand and agree that they must receive satisfactory written assurance from the other party that it will adequately safeguard all Protected Information. Upon the request of either party, the other party agrees to promptly enter into negotiations concerning the terms of an amendment to this Agreement embodying written assurances consistent with the standards and requirements of HIPAA, the HITECH Act or any other applicable law. A party may terminate the Agreement upon thirty (30) days written notice if (i) the other party does not promptly enter into negotiations to amend the Agreement or Agreement when requested by a party pursuant to this section or (ii) the other party does not enter into an amendment to the Underlying Contracts or Agreement providing assurances regarding the safeguarding of PHI that the other party, in its sole discretion, deems sufficient to satisfy the standards and requirements of applicable laws.

8. ***NO THIRD-PARTY BENEFICIARIES.*** Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer upon any person other than the parties to this Agreement and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

9. ***INTERPRETATION.*** The provisions of this Agreement shall prevail over any provisions in the Underlying Contracts that may conflict or appear inconsistent with any provision in this Agreement. This Agreement and the Underlying Contracts shall be interpreted as broadly as necessary to implement and comply with HIPAA, the HITECH Act, and any other state or federal rules concerning PHI. The parties agree that any ambiguity in this Agreement shall be resolved in favor of a meaning that complies and is consistent with the HIPAA Rules. Except as specifically required to implement the purposes of this Agreement, or to the extent inconsistent with this Agreement, all other terms of the Agreement shall remain in force and effect.

10. ***NOTICES.*** All notices hereunder shall be in writing and delivered by a confirmed facsimile, personally, by certified or registered mail, return receipt requested, or by overnight courier, and shall be deemed to have been duly given when delivered by fax, personally or when deposited in the United States mail, postage prepaid, or deposited with the overnight courier addressed as follows:

If to Prospect

Prospect ECHN, Inc.
Attn: Chief Executive Officer
71 Haynes Street
Manchester, CT 06040
Fax: [(860) 533-3404]

and

Prospect Medical Holdings, Inc.
Attn: Legal Department
10780 Santa Monica Blvd, Suite 400, Los Angeles, CA 90025
Fax: (310) 943-4501

If to OLDCO:_____
_____
_____
Attn: _____
Fax: _____

or to such other persons or places as either party may from time to time designate by written notice to the other.

11. ***ENTIRE AGREEMENT OF THE PARTIES.*** This Agreement supersedes any and all prior and contemporaneous business associate agreements or addenda between the parties and constitutes the final and entire agreement between the parties hereto with respect to the subject matter hereof. Each party to this Agreement acknowledges that no representations, inducements, promises, or agreements, oral or otherwise, with respect to the subject matter hereof, have been made by either party, or by anyone acting on behalf of either party, which is not embodied herein. No other agreement, statement or promise, with respect to the subject matter hereof, not contained in this Agreement shall be valid or binding.

12. ***REGULATORY REFERENCES.*** A reference in this Agreement to a section of regulations means the section as in effect or as amended, and for which compliance is required.

13. ***COUNTERPARTS.*** This Agreement may be executed in one or more counterparts, each of which shall be deemed to be an original, and all of which together shall constitute one and the same instrument.

IN WITNESS WHEREOF, the parties hereto have duly executed this Agreement as of the Effective Date referenced above.

PROSPECT ECHN, INC.	**EASTERN CONNECTICUT HEALTH NETWORK, INC.**
By: _____	By: _____
Name:	Name:
Title:	Title:

Exhibit B

Form of Limited Power of Attorney

See attached.

LIMITED POWER OF ATTORNEY

_____, a Connecticut non-stock corporation ("Registrant"), operates under the certain licenses and registrations relating to controlled substances and the operation of pharmacies and laboratories set forth on Exhibit A hereto (collectively, the "Licenses and Registrations"). This Limited Power of Attorney is being delivered pursuant to that certain Asset Purchase Agreement, dated as of _____, 2016, by and among Registrant, _____, a Connecticut corporation ("Corporation"), and certain other parties (the "Purchase Agreement").

1. To the extent permitted by applicable law:

(a) I, _____, am authorized to sign the current applications for DEA registration on behalf of the Registrant under the Controlled Substances Act or Controlled Substances Import and Export Act, and have made, constituted, and appointed, and by these present, do hereby make, constitute, and appoint Corporation as my true and lawful attorney-in-fact to act for me in my name, place, and stead, to execute applications for Forms 222 and to sign orders for Schedule II controlled substances, whether these orders be on Form 222 or electronic, in accordance with 21 U.S.C. § 828 and Part 1305 of Title 21 of the Code of Federal Regulations, for the Limited Period described in Section 3 below. I hereby ratify and confirm all that Corporation must lawfully do or cause to be done by virtue hereof.

(b) Corporation further grants this Limited Power of Attorney to _____ ("Pharmacist-In-Charge") to act as the true and lawful agent and attorney in-fact of Corporation, and to act in the name, place, and stead of Corporation, to execute applications for Forms 222 and to sign orders for Schedule II controlled substances, whether these orders be on Form 222 or electronic, in accordance with 21 U.S.C. § 828 and Part 1305 of Title 21 of the Code of Federal Regulations, as is necessary for the treatment of pharmacy patients. Corporation hereby ratifies and confirms all that said Pharmacist-In-Charge must lawfully do or cause to be done by virtue hereof.

(c) Corporation shall have the right, for the Limited Period described in Section 3 below, to operate under all of the Licenses and Registrations, until it is able to obtain all requisite licenses and registrations for itself.

2. Registrant recognizes that it remains legally responsible for Licenses and Registrations issued to it, during the period in which this Limited Power of Attorney is in effect. Therefore, Registrant grants this Limited Power of Attorney to Corporation based upon the following covenants and warranties of Corporation: (a) Corporation shall follow and abide by and comply with all federal and state laws governing the regulation of controlled substances, and the operation of the pharmacies, laboratories, blood banks and blood collection facilities set forth on Exhibit A hereto at all times while utilizing this Limited Power of Attorney and shall indemnify and hold Registrant harmless from and against any claims arising out of Corporation's failure to do so; and (b) Corporation, or its designee, shall make application for and pursue its own licenses and registrations relating to controlled substances, and the operation of pharmacies, laboratories, blood banks and blood collection facilities that are required by law as soon as practicable.

3. This Limited Power of Attorney shall remain in effect for a period not to exceed one hundred twenty (120) days following the closing date of the Purchase Agreement (the "Limited Period").

4. Registrant may revoke this Limited Power of Attorney at any time by executing the Notice of Revocation, attached hereto at Exhibit B.

5. This Limited Power of Attorney may be executed in multiple counterparts, each and all of which shall be deemed an original and all of which together shall constitute one and the same instrument. A signature delivered by facsimile or PDF will be sufficient for all purposes among the parties hereto and shall be deemed to have the same legal effect as delivery of an original.

[SIGNATURE PAGE FOLLOWS]

IN WITNESS WHEREOF, Registrant and Corporation have executed this Limited Power of Attorney as of the _____ day of _____, 2016 to be effective as of 12:01 a.m. Eastern Time on the __ day of _____, 2016.

REGISTRANT:

WITNESS

_____

_____

By: _____
Name:
Title:

WITNESS

_____

CORPORATION:

_____

By: _____
Name:
Title:

(Limited Power of Attorney Signature Page – _____)

I, _____, hereby affirm that I am the person named herein as attorney-in-fact pursuant to Section 1(b) of the Limited Power of Attorney and that the signature affixed hereto is my signature.

_____
Name:
Pharmacist-In-Charge

Witness: _____

Witness: _____

(Limited Power of Attorney Signature Page – Pharmacist-In-Charge – _____)

EXHIBIT A

Location	*License/Registration*	*License/Registration #*
	U.S. Drug Enforcement Agency Controlled Substance Registration	
	Controlled Substance Registration	
	Connecticut Laboratory Licenses	
	Connecticut Blood Bank and Blood Collection Facility Registrations	
	CMS Laboratory – CLIAs	

EXHIBIT B

The Limited Power of Attorney, executed on _____ ____, 2016, is hereby revoked by the undersigned, who is authorized to sign the current applications for the Licenses and Registrations. Written notice of this revocation has been given to the attorney-in-fact this same day.

By: _____
Name:
Title:

Witness: _____

Witness: _____

Exhibit C

Form of Governing Documents of PMH Medical Foundation

See attached.

ORGANIZATIONAL ACTION BY
SOLE INCORPORATOR
OF
PROSPECT CT MEDICAL FOUNDATION, INC.

The undersigned, being the sole incorporator named in the Certificate of Incorporation of Prospect CT Medical Foundation, Inc., a Connecticut corporation (the "**Corporation**"), filed with the Secretary of State of the State of Connecticut on April 15, 2016, acting by written consent without a meeting pursuant to Section 33-1029(b) of the Connecticut Revised Nonstock Corporation Act, hereby consents to the adoption of the following specified resolutions:

Number and Election of Directors

RESOLVED: That the number of members that shall constitute the Board of Directors shall initially be two (2); and

RESOLVED, FURTHER: That each of the following persons is hereby elected to the Board of Directors of the Corporation, to hold such office until his or her successor or successors have been duly elected and qualified, or until his or her earlier death, resignation or removal:

Samuel S. Lee

David Topper

IN WITNESS WHEREOF, the undersigned has duly executed this Organizational Action as of this 25th day of July, 2016.

Michele M. Volpe, Esq.
Sole Incorporator

PROSPECT CT MEDICAL FOUNDATION, INC.
(a Connecticut corporation)

UNANIMOUS WRITTEN CONSENT IN LIEU OF MEETING OF THE BOARD OF DIRECTORS

The undersigned, being all of the members of the Board of Directors of Prospect CT Medical Foundation, Inc., a Connecticut corporation (the "**Corporation**"), acting by unanimous written consent without a meeting pursuant to Section 33-1064 of the Connecticut Revised Nonstock Corporation Act, do hereby waive notice of a meeting and consent to the adoption of the following resolutions:

NOW, THEREFORE, BE IT:

Organizational Matters

RESOLVED: That all of the actions of Michele M. Volpe, Esq., as the sole incorporator of the Corporation (the "**Incorporator**"), are hereby approved, ratified and adopted in all respects; and be it hereby

RESOLVED, FURTHER: That the Certificate of Incorporation of the Corporation executed by the Incorporator and filed with the Secretary of State of the State of Connecticut, attached hereto and incorporated herein as Exhibit A (the "**Certificate**"), be, and the same hereby is, approved, ratified and adopted; and be it hereby

Bylaws

RESOLVED, FURTHER: That the Bylaws attached hereto and incorporated herein as Exhibit B be, and the same hereby are, adopted as the Bylaws of the Corporation; and be it hereby

Officers; Delegated Authority

RESOLVED, FURTHER: That the following individuals be, and each of them hereby is, elected to serve in the offices of the Corporation set opposite their respective names, each to hold such offices until his or respective successor is duly elected and qualified or until his or her earlier resignation or removal; and be it hereby:

President	Samuel S. Lee
Chief Executive Officer	David Topper
Secretary	Ellen J. Shin, Esq.
Chief Financial Officer	Steve M. Aleman

RESOLVED, FURTHER: That for the purposes of authorizing the Corporation to do business in any state, territory or dependency of the United States or any foreign country in which it is necessary or expedient for this Corporation to transact business, the proper officers of the Corporation be, and each of them hereby is, authorized to appoint and substitute all necessary agents or attorneys for service of process, to designate and change the location of all necessary statutory offices and to make and file all necessary certificates, reports, powers of attorney, and other instruments as may be required by the laws of such state, territory, dependency or country to authorize the Corporation to transact business therein; and be it hereby

RESOLVED, FURTHER: That the President and the Chief Financial Officer of the Corporation and/or any officers or agents as they may designate be, and each of them hereby is, authorized to make payments from the funds of the Corporation for expenses incurred or to be incurred incident to the organization of the Corporation or to the implementation of authorized corporate action including, but not limited to, all expenses for office and clerical services and professional accounting, investment consultant, and legal services provided to the Corporation, and all filing fees relating to the creation of the Corporation or the implementation of any authorized corporate practice; and be it hereby

Books and Records

RESOLVED, FURTHER: That the President of the Corporation and/or any officers or agents as he may designate be, and each of them hereby is, authorized and directed to procure all books of account and other materials and supplies necessary or appropriate in connection with maintaining the records and conducting the business of the Corporation; and be it hereby

Banking

RESOLVED, FURTHER: That the President and the Chief Financial Officer of the Corporation and/or any officers or agents as they may designate be, and each of them hereby is, authorized to open such bank account(s) on behalf of the Corporation as they deem appropriate or advisable, and that such officers or agents be, and each of them hereby is, authorized to execute and deliver to such banks the resolutions required thereby and such resolutions will be deemed to have been approved by the Board of Directors with the same force and effect as if they had been set forth herein; and be it hereby

RESOLVED, FURTHER: That the President and the Chief Financial Officer of the Corporation and/or any officers or agents as they may designate be, and each of them hereby is, authorized to deposit any of the funds of the Corporation in said bank(s) and that the President or the Chief Financial Officer of the Corporation and/or any officers or agents as they may designate be, and each of them hereby is, authorized to withdraw funds of the Corporation by checks drawn in the name of the Corporation from said bank(s) either at its main office or any of its branches; and be it hereby

General

RESOLVED, FURTHER: That all actions previously taken by any of the officers of the Corporation, or by any of the Corporation's directors, employees, agents or representatives in connection with the organization of the Corporation and the matters contemplated by the

foregoing resolutions be, and each of them hereby is, expressly approved, ratified, and confirmed in all respects as the acts and deeds of the Corporation; and be it hereby

RESOLVED, FURTHER: That the President of the Corporation and/or any officers or agents as he may designate be, and each of them hereby is, authorized to take all such further action, as the President of the Corporation or any such officer or agent, as applicable, may deem necessary, proper, convenient or desirable, in order to carry out each of the foregoing resolutions and fully to effectuate the purposes and intents thereof, and that all actions taken by the President of the Corporation or any such officers or agents, as applicable, to date, in connection with the foregoing resolutions, or otherwise, be, and each of them hereby is, in all respects approved, ratified and confirmed; and be it hereby

RESOLVED, FURTHER: That the officers of the Corporation be, and each of them hereby is, authorized and directed in the name of the Corporation, to prepare and file all such notices and applications and any and all certificates, documents, letters and other instruments with all appropriate state and federal or other governmental authorities as necessary or desirable with respect to hospital licensure and the transactions contemplated by the foregoing resolutions; and be it hereby

RESOLVED, FURTHER: That the Corporation may proceed to carry on the business for which it was incorporated; and be it hereby

RESOLVED, FURTHER: That this unanimous written consent may be signed in two or more counterparts, each of which shall be deemed an original, and all of which shall constitute one and the same instrument, and the undersigned members of the Board of Directors of the Corporation hereby direct the Secretary of the Corporation to file the executed copy of this unanimous written consent in the books and records of the Corporation.

[REMAINDER OF PAGE LEFT INTENTIONALLY BLANK]

[SIGNATURE PAGE FOLLOWS]

IN WITNESS WHEREOF, the undersigned members of the Board of Directors of Prospect CT Medical Foundation, Inc. have duly executed this unanimous written consent as of the 25th day of July, 2016.

By: _____
Print Name: Samuel S. Lee
Title: Director

By: _____
Print Name: David Topper
Title: Director

[Signature Page to Unanimous Written Consent In Lieu of Meeting of the Board of Directors of Prospect CT Medical Foundation, Inc.]

EXHIBIT A

CERTIFICATE OF INCORPORATION

FILING #0005546144 PG 01 OF 05 VOL B-02184
FILED 04/15/2016 12:00 PM PAGE 00997
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

Certificate of Incorporation

of

Prospect CT Medical Foundation, Inc., a Connecticut Nonstock Corporation

1. The name of the corporation shall be **Prospect CT Medical Foundation, Inc.**, a Connecticut Nonstock Corporation (the "Corporation").

2. The nature of the activities to be conducted and the purposes to be promoted or carried out by the Corporation shall include the following:

   a. To provide professional medical services to the patients of hospitals affiliated with Prospect CT, Inc. (the "Hospitals") and other affiliates of Prospect CT, Inc. and to other individuals in the Hospitals' service areas; provided, however, that all professional medical services rendered by the Corporation shall be rendered only through individuals who are authorized by the laws of the State of Connecticut to render professional medical services.

   b. To promote and support the mission and purposes of the Hospitals by providing professional medical services to their patients and engaging in education activities related to patient care and the promotion of good health.

   c. To carry on additional activities related to rendering care to the sick or injured or the promotion of health in the community.

   d. To invest the funds of the Corporation in stocks, bonds, real estate, mortgages, or any other type of investment and to own real property incident to the rendering of professional medical services.

   e. To otherwise engage in any lawful act or activity from which a medical foundation may be organized under Chapter 594b of the Connecticut General Statutes or for which a corporation may be organized under the Connecticut Revised Nonstock Corporation Act (the "Act").

   f. Medical foundation status will not be effective until Member or a Member affiliate owns a Connecticut licensed hospital.

3. The Corporation is nonprofit and shall not have or issue shares of stock or make distributions.

4. The Corporation shall have one member (the "Member") which shall be Prospect CT, Inc., a Delaware corporation. The Member shall have the right to adopt bylaws (the "Bylaws") for the conduct of the affairs of the Corporation and the right to elect the Board of Directors and officers of the Corporation in accordance with the Corporation's Bylaws and shall have all other rights, powers and privileges usually or by law accorded to the members of a non-stock nonprofit corporation and conferred thereby or by the Corporation's Certificate of Incorporation or Bylaws.

5. Subject to the rights and powers of the Member, the Corporation shall operate under the management of its Board of Directors. The Member shall prescribe the number, qualifications (if any) and manner of election of the Directors of the Corporation. The Member may provide that persons occupying certain positions within or without the Corporation shall be ex-officio members of the Board of Directors, who may vote and be counted in determining a quorum.

6. No part of the net earnings of the Corporation shall inure to the benefit of or be distributable to the Corporation's Directors, officers or other private persons, except that the Corporation shall be authorized and empowered to pay reasonable compensation for services rendered and to make payments and distributions in furtherance of the purposes set forth in Paragraph 2 hereof. No substantial part of the activities of the Corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation, and the Corporation shall not participate in, or intervene in (including the publishing or distribution of statements), any political campaign on behalf of (or in opposition to) any candidate for public office.

7. Upon any dissolution or termination of the existence of the Corporation, all its property and assets shall be applied and distributed as follows: (i) All liabilities and other obligations of the Corporation shall be paid, satisfied and discharged, or adequate provision shall be made therefor; (ii) assets held by the Corporation upon condition requiring return, transfer or conveyance, which condition occurs by reason of the dissolution, shall be returned, transferred or conveyed in accordance with such requirements; (iii) assets received and held by the Corporation subject to limitations permitting their use, but not held upon a condition requiring return, transfer or conveyance by reason of the dissolution, shall be transferred or conveyed to one or more domestic or foreign corporations, societies or organizations engaged in activities substantially similar to those of the dissolving corporation, pursuant to a plan of distribution adopted as provided in section 33-1175; (iv) other assets, if any, shall be distributed to the Member except to the extent that the certificate of incorporation provides for distribution to others; and (v) any remaining assets may be distributed to such persons, societies, organizations or domestic or foreign corporations, whether for

profit or nonprofit, as may be specified in a plan of distribution adopted as provided in section 33-1175.

8. The personal liability of a Director of the Corporation to the Corporation for breach of duty as a Director of the Corporation shall be limited to the fullest extent permitted by the Act and as set forth in Section 1104 or any other applicable laws presently or hereafter in effect.

9. The Corporation shall indemnify its Directors and officers as follows:

   a. The Corporation shall, to the fullest extent permitted by law, indemnify its Directors or officers from and against any and all of the liabilities, expenses and other matters referenced in or covered by the Act or any other applicable laws presently or hereafter in effect. In furtherance and not in limitation thereof, the Corporation shall indemnify a Director for a liability, as defined in Section 33-1116 of the Act, to any person for any action taken, or any failure to take any action, as a Director, except a liability that (i) involved a knowing and culpable violation of law by the Director; (ii) enabled the Director or an associate, as defined in Section 33-840 of the Connecticut General Statutes, to receive an improper personal gain; (iii) showed a lack of good faith and a conscious disregard for the duty of the Director to the Corporation under circumstances in which the Director was aware that his or her conduct or omission created an unjustifiable risk of serious injury to the Corporation; or (iv) constituted a sustained and unexcused pattern of inattention that amounted to an abdication of the Director's duty to the Corporation.

   b. In addition to the foregoing, the Corporation shall provide to its Directors and officers the full amount of indemnification that the Corporation is permitted to provide to such Directors and officers pursuant to Sections 33-1116 to 33-1125, inclusive, of the Act or any other applicable laws presently or hereafter in effect. Expenses (including attorneys' fees) incurred by a Director or officer in defending a civil, criminal, administrative or investigative action, suit or proceeding shall be paid by the Corporation in advance of the final disposition of such action, suit or proceeding upon receipt of both (i) a written affirmation by such officer or Director of his or her good faith belief that he or she has met the relevant standard of conduct under the Act or that the proceeding involves conduct for which liability has been limited under Paragraph 8 of this Certificate of Incorporation; and (ii) an undertaking by or on behalf of such Director or officer to repay such amount if it shall ultimately be determined that such Director or officer is not entitled to be indemnified by the Corporation as authorized in this Paragraph 9.

Such expenses (including attorneys' fees) incurred by other employees and agents of the Corporation may be so paid upon such terms and conditions, if any, as the Board of Directors deems appropriate.

c. The indemnification and advancement of expenses provided by, or granted pursuant to this Paragraph 9 shall not be deemed exclusive of any other rights to which those seeking indemnification or advancement of expenses may be entitled under any bylaw, agreement, vote of disinterested Directors or otherwise, both as to action in his or her official capacity and as to action in another capacity while holding such office.

d. No amendment to or repeal of this Paragraph 9 shall apply to or have any effect on the indemnification of any Director or officer for or with respect to any acts or omissions of such Director or officer occurring prior to such amendment or repeal, nor shall any such amendment or repeal apply to or have any effect on the obligations of the Corporation to pay for or reimburse in advance expenses incurred by a Director or officer in defending any action, suit or proceeding arising out of or with respect to any acts or omissions occurring prior to such amendment or repeal.

10. References in this Certificate of Incorporation to the Act shall be deemed to include amendments adopted from time to time to such Act.

11. The Corporation's registered agent shall be:

Name: C T Corporation System

Business Address: One Corporate Center, Hartford, CT 06103

Acceptance of Appointment:

Signature of Agent: Gary Scappini, Special Asst Sec

Email address: NONE

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FILED 04/15/2016 12:00 PM PAGE 01001
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

12. The name and address of the incorporator is:

Name: Michele M. Volpe, Esq.

Address: Bershtein, Volpe & McKeon PC
105 Court Street, 3rd Floor
New Haven, CT 06511

I hereby declare, under penalties of false statement, that the statements made in the foregoing certificate are true.

Dated this 14 of April, 2016

Michele M. Volpe, Esq.
Sole Incorporator

STATE OF CONNECTICUT } SS. HARTFORD
OFFICE OF THE SECRETARY OF THE STATE

I hereby certify that this is a true copy of record in this Office.
In Testimony whereof, I have hereunto set my hand and affixed the Seal of said State, at Hartford, this 22ND day of APRIL A.D. 2016

SECRETARY OF THE STATE

EXHIBIT B

BYLAWS

BYLAWS OF

PROSPECT CT MEDICAL FOUNDATION, INC.

A CONNECTICUT NONSTOCK CORPORATION

Dated: _____, 2016

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BYLAWS OF

PROSPECT CT MEDICAL FOUNDATION, INC.

A CONNECTICUT NONSTOCK CORPORATION

ARTICLE 1 – ORGANIZATION

1.1. Name. The name of the Corporation shall be Prospect CT Medical Foundation, Inc. (herein referred to as the "Corporation").

Purposes. The Corporation is organized and shall be operated exclusively as a medical foundation of the Member pursuant to Chapter 594b of the Connecticut General Statutes (as it may be amended from time to time, the "Foundation Act"), providing medical services and other health care services to patients of the Member and its affiliates and to other individuals ; providing public health services, to include promoting the efficient delivery of quality medical care in and around the service area of the Corporation; meeting the healthcare needs of the public; participating in activities designed to promote the general health of the community; and for the other purposes described in the Corporation's Certificate of Incorporation.

1.2. Offices. The principal office of the Corporation shall be located in the State of Connecticut at such location as may be determined by the Corporation. The Corporation may have such other offices within and without the State of Connecticut as the Member may determine.

1.3. Divisions. The operations of the Corporation shall be divided into divisions representing the service area of each hospital or health system operated by the Member or an affiliate (each such area hereinafter referred to as a "Division") or by a particular specialty all determined by the Member at its sole discretion.

ARTICLE 2 - THE MEMBER

2.1. Membership. Prospect CT, Inc. shall be the sole member (the "Member") of the Corporation, which shall have the right to elect the Board of Directors (the "Board") of the Corporation, and shall have all of the other rights, powers and privileges usually or by law accorded to the member of a medical foundation under the Foundation Act and the member of a nonstock corporation under the Connecticut Revised Nonstock Corporation Act (the "Nonstock Act") that are not conferred by these Bylaws on the Board of Directors of the Corporation.

2.2. **Member's Action; Powers of the Member**. In the exercise of its powers, the Member may act through its President or Chief Executive Officer, or such other officer duly designated by the Member. The President, Chief Executive Officer or duly designated officer shall have the full power and authority to act on behalf of the Member, to vote in person or by proxy on behalf of the Member, and to take all other actions as the Member may be authorized to take by law, the Certificate of Incorporation or these Bylaws. All action of the Member may be taken by written consent in lieu of a meeting, including in lieu of the annual meeting of the Corporation. Whenever approval by the Member is required by law, the Certificate of Incorporation or these Bylaws, the Member shall attempt to act on a request for approval within the time frame set forth in any schedule that may be developed from time to time, or if no such schedule exists, in a timely manner. In addition to any other powers that are provided to the Member by law and to the fullest extent permitted by law, the Member shall have the following rights, powers and privileges:

2.2.1. The power, consistent with Section 3.2.2 hereof, to appoint all Directors to the Board.

2.2.2. The power to approve or initiate all operating and capital budgets of the Corporation.

2.2.3. The power to approve unbudgeted expenditures in such amount or amounts as may be established by the Member or any increase in an approved annual operating or capital budget.

2.2.4. The power to approve or initiate any advances of assets of, or loans by, the Corporation, or the incurring of any indebtedness, secured or unsecured.

2.2.5. The power to appoint the Corporation's auditors and to appoint legal counsel and other consultants whose responsibilities encompass rights or responsibilities of corporations, subsidiaries or entities affiliated with the Corporation or Member (the "Subsidiaries" and "Affiliates").

2.2.6. The power to engage in managed care and other third party payor contracting on behalf of the Corporation.

2.2.7. The power to obtain Director and Officer liability, comprehensive general and other insurance on behalf of the Corporation.

2.2.8. The power, to the extent permitted under applicable law, to exercise supervision and control over the investment of any and all of the Corporation's funds and assets.

2.2.9. The power to approve or initiate the commencement, cessation, location, relocation or consolidation of clinical services provided by the Corporation and to approve or initiate the filing of any application for a Certificate of Need by the Corporation.

2.2.10. The power to adopt system-wide quality, performance and credentialing standards and procedures to which the Corporation is expected to adhere.

2.2.11. The power to approve or initiate any agreement or transaction involving another corporation or entity, including corporations or entities controlled directly by or otherwise affiliated with the Corporation or Member.

2.2.12. The power to approve or initiate the affiliation of the Corporation with any other entities for the purpose of the joint conduct of business or other purposes, whether in the form of participation in said organization or entity or through the holding of stock or by membership or in the form of partnership, joint venture, co-tenancy or any other form of ownership or control.

2.2.13. The power to change, amend or restate the Corporation's Certificate of Incorporation, Bylaws, purposes, membership and rights and responsibilities accruing thereto, fiscal year, principal office or name.

2.2.14. The power to create any corporation of which the Corporation is the sole member or controlling member; to approve any merger or consolidation with another corporation in which the Corporation is a constituent corporation; and to reorganize, liquidate or dissolve the Corporation or any corporation of which the Corporation is the sole member or controlling member.

2.2.15. The power to sell, leases, exchange, or otherwise disposes of all or substantially all of the property or assets of the Corporation.

2.2.16. The power to elect, re-elect and remove Directors, the Chair, the Vice Chair, the Treasurer, the Secretary, the President and Chief Executive Officer and the power to increase or decrease the size of the Board.

2.2.17. The power to establish, appoint and remove members of committees of the Corporation and to delegate certain duties to committees, officers, employees or agents of the Corporation.

2.2.18. The power to approve, amend or adopt policies and procedures governing indemnification of Directors and officers of the Corporation; conflicts or dualities of interest; accounting and investment standards and practices; and such other policies and provisions.

2.2.19. The power to approve or initiate the conveyance of, or the granting of mortgages, trusts, deeds or the creation of other liens on, any real property assets of the Corporation.

2.2.20. The power to adopt a system-wide strategic plan and vision to which the Corporation is expected to adhere.

2.2.21. The power to approve any employee pension and other employee benefit plans for or on behalf of the Corporation.

2.2.22. The power to approve any contract with an unrelated third party for the management of all or substantially all of the assets or operations of the Corporation.

2.2.23. The power to approve any compensation plan of the Corporation and establish any policies and procedures relating to compensation

2.3. Annual Meetings. The annual meeting of the Member shall be held at such date, time and place as shall be determined by the Member. At the annual meeting, the Member shall elect and re-elect Directors and transact such other business relating to the affairs of the Corporation as may properly come before the meeting.

2.4. Special Meetings. Special meetings of the Member may be called by the Member or by the Chair. Notice of such call shall be given at least ten (10) days in advance of the meeting and shall state the purpose for which the meeting is called. No business shall be transacted at the meeting except such business as was set forth in the notice of such meeting.

2.5. Action at Meeting. At any meeting of the Member, the vote of the President and Chief Executive Officer of the Member, or other duly authorized officer of the Member, shall be sufficient to take any action. Any action required or permitted to be taken at a meeting of the Member maybe taken without a meeting of the Member if the Member, acting through the President and Chief Executive Officer of the Member or other duly authorized officer of the Member, consents to the action in writing and such written consent is filed with the

records of the meeting of the Member. Each such consent shall be treated for all purposes as a vote taken at a meeting.

ARTICLE 3 - BOARD OF DIRECTORS

3.1. **Powers.** Subject only to the powers of or reserved to the Member by law, the Certificate of Incorporation or these Bylaws, the Board shall have and may exercise all of the powers of the Corporation and shall have the general direction and control of the activities of the Corporation.

3.2. **Number; Composition and Qualification.** The composition, classification, manner of election or appointment of individuals to the Board, and their term of office, shall be subject to the following provisions:

3.2.1. The Board shall be appointed or elected by the Member as set forth in this Article 3.

3.2.2. The Board shall consist of a minimum of 7 and a maximum of 15 Directors, such number to be determined from time to time by the Member.

3.2.3. In accordance with the Foundation Act, the number of Directors on the Board who are providers within the meaning of the Foundation Act shall equal or exceed the number of Directors on the Board who are employees of the Member and who are not providers.

3.2.4. No employee, director or representative of a nonprofit hospital, nonprofit health system, nonprofit medical school or any entity that owns or controls a nonprofit hospital, nonprofit health system or nonprofit medical school may serve on the Board.

3.2.5. No person shall serve on the Board of the Corporation if prohibited by law.

3.3. **Election and Term.** The initial members of the Board shall, subject to Section 3.5 of these Bylaws, hold office for a term of two (2) years and until their successors are duly elected and qualified. At the second annual meeting of the Corporation, the Member shall elect Directors (other than Directors who serve by virtue of holding a particular office as set forth in Section 3.2.2) to staggered terms of one (1) year, two (2) years, or three (3) years in length such that approximately one-third of such Directors expire each year. Thereafter, the Member shall elect at each annual meeting approximately one-third of the Directors, each to serve a full three (3) year term, to fill the vacancies created by those Directors whose terms are then expiring. The Member may also at any time elect Directors to terms

of less than three (3) years to promote the objective of having the terms of approximately one-third of the Directors expire each year. Directors shall take office at the close of the meeting at which they were elected and, subject to Section 3.5 of these Bylaws, shall hold office for the term specified and until a successor is duly elected and qualified, provided that a Director appointed to fill a vacancy shall serve for the remainder of the applicable term. Each Director shall be counted in determining a quorum and shall have full voting rights.

3.4. **Vacancies.** Any vacancy in the Board caused by the death, resignation or removal of a Director may be filled by the Member, such Director to serve for the unexpired term of such Director's predecessor in office.

3.5. **Resignation and Removal.** Any Director may resign at any time by delivering a written resignation to the Corporation at its principal office, to the Chair, the Secretary or the President and Chief Executive Officer of the Corporation. Such resignation shall be effective upon receipt unless it is specified to be effective at some other time or upon the happening of some other event. A Director may be removed with or without cause by vote of the Member after reasonable notice of the proposed removal to the Director. Notice of a proposed removal shall be given in a notice of a meeting at which such removal shall be considered taken. A Director's failure to comply with the attendance policy and requirements adopted by the Board from time to time shall be considered by the Member as cause for removal of the Director in accordance with this section.

3.6. **Annual Meetings.** The annual meeting of the Board shall be held as soon as practicable following the annual meeting of the Member, at a date, time and place to be determined by the Chair or the Board. At the annual meeting, the Board shall ratify the election of the officers appointed by the Member and may conduct such other business as may properly come before the Board.

3.7. **Regular Meetings.** The Board shall meet at least quarterly, at such times and at such places, as the Chair or the Board may from time to time determine.

3.8. **Special Meetings.** Special meetings of the Board may be held at any time and at any place as designated in a call by the Chair, the President and Chief Executive Officer, the Secretary or any two (2) or more Directors. No business shall be conducted at a special meeting other than as stated in the notice of the meeting.

3.9. **Meetings by Telecommunications.** Directors or members of any committee of the Board may participate in a meeting of the Board or such committee by means of a conference telephone or similar communications equipment by means of which all persons

participating in the meeting can hear each other at the same time, and participation by such means shall constitute presence in person at a meeting.

3.10. Notice of Meetings. Notice of any meeting of the Board shall be given to each Director by the Chair, the President and Chief Executive Officer, or in the event of a special meeting called by two (2) or more Directors, by one of the Directors calling the meeting. In the case of the annual or any regular meeting, notice shall be given to each Director in person, by telephone, or by regular mail, overnight delivery or electronic mail sent to such Director's business or home address at least ten (10) days in advance of the meeting. In the case of a special meeting, notice shall be given to each Director in person, by telephone, or by regular mail, overnight delivery or electronic mail sent to such Director's business or home address at least seventy-two (72) hours in advance of the meeting. Notice need not be given to any Director who executes, before or after the meeting, a written waiver of notice, or to any Director who attends the meeting without protesting prior to the meeting or at its commencement the lack of notice to such Director. Unless otherwise stated in these Bylaws, a notice or waiver of notice of a Board meeting need not specify the purposes of the meeting.

3.11. Quorum and Voting. At any meeting of the Board, a majority of the Directors then currently serving and entitled to vote and who are present at the meeting shall constitute a quorum. Unless otherwise disqualified from voting, each Director shall have one (1) vote to be exercised in person. Voting by proxy shall not be permitted.

3.12. Action at Meeting. At any meeting of the Board at which a quorum is present, the vote of a majority of those Directors present and entitled to vote, unless a different vote is specified by law, by the Certificate of Incorporation, or by these Bylaws, shall be sufficient to take any action.

3.13. Action by Consent. Any action required or permitted to be taken at any meeting of the Board may be taken without a meeting if all the Directors then currently serving consent to the action in writing and the written consents are filed with the records of the Board meetings. Each such consent shall be treated for all purposes as a vote taken at a properly called and held meeting. For purposes hereof, a Director may evidence his or her consent with any manual, facsimile, conformed or electronic signature, including an electronic mail communication from the Director to the Corporation from an electronic mail address provided by the Director to the Corporation.

3.14. Rules of Order. The Board shall adopt formal, parliamentary Rules of Order, that when not inconsistent with the Bylaws, shall govern the meetings of the Board and all committees.

3.15. Compensation. The Board shall serve without compensation for their services as Directors but may be reimbursed by the Corporation for their reasonable expenses and disbursements in that capacity on behalf of the Corporation.

ARTICLE 4-OFFICERS

4.1. Number and Designation. The officers of the Corporation shall be elected by the Member and shall consist of a Chair, President, Secretary, Treasurer and such other officers with such other titles as the Member may from time to time designate.

4.2. Qualification. The Chair, President, Secretary, Treasurer shall be designated by the Member. Any officer may be required to give bond for the faithful performance of such officer's duties to the Corporation in such amount and with such sureties as the Member may determine. The premiums for such bonds shall be paid by the Corporation.

4.3. Election and Term. Each officer shall be elected by the Member at the annual meeting of the Member and shall, subject to Section 4.4 of these Bylaws, hold office until the next annual meeting or until his or her successor shall have been chosen and qualified.

4.4. Resignation and Removal. Any officer may resign by delivering a written resignation to the President, or, if the resigning officer is the President, to the Secretary. Such resignation shall be effective upon receipt unless it is specified to be effective at some other time or upon the happening of some other event. The Member may remove any officer with or without cause after reasonable notice to the officer. Notice of a proposed removal shall be given in the notice of any meeting at which such removal shall be considered or taken. Any such removal shall be without prejudice to the contract rights, if any, of the person so removed, provided, however, that election or appointment to an office shall not in and of itself create any contract rights.

4.5. Vacancies. The Member may fill any vacancy occurring for any reason in any office.

4.6. Chair. The Chair or the Chair's delegate shall preside at all meetings of the Board of Directors and shall perform other duties incident to the office or delegated by the Board of Directors or these Bylaws from time to time. The Chair shall be an ex-officio member of all Committees.

4.7. President. The President shall serve as the chief executive officer of the Corporation and shall be responsible for the integration, operation, administration and performance of the Corporation and its Subsidiaries and Affiliates within the system of health care

organizations operated under the ownership and control of the Member and shall be given the necessary authority for the accomplishment of such responsibility subject to the policies enacted by the Member, of any committees to which the Member or the Board has delegated such responsibilities, and of any Subsidiary subject only to the policies enacted by the board of such Subsidiary. The President shall perform such other duties and shall have such other powers as the Member from time to time may prescribe. In the event of a vacancy in the office of President, the Secretary shall serve as the Acting President during such vacancy.

4.8. **Secretary**. The Secretary shall be responsible for having minutes kept of the proceedings of the Board and the Member; shall give, or cause to be given, all notices in accordance with the provisions of these Bylaws or as required by law; and shall be the custodian of the records of the Corporation. The Secretary shall perform such other duties and shall have such other powers as the Member may from time to time prescribe.

4.9. **Treasurer**. The Treasurer shall supervise the receipt and custody of the Corporation's funds and investments; render a full account and statement of the condition of the Corporation's finances at each annual meeting. The Treasurer shall perform such other duties and shall have such other powers as the Member may from time to time prescribe.

4.10. **Other Powers and Duties**. Each officer, subject to these Bylaws, shall have in addition to the duties and powers specifically set forth in these Bylaws, such duties and powers as are customarily incident to such officer's office, and such duties and powers as the Member may from time to time designate.

ARTICLE 5 – COMMITTEES

5.1. **Committees**. The Member or the Board may designate two (2) or more Directors to constitute a committee, which may be standing or ad hoc. The Chair may, in his or her discretion, appoint a committee chair or delegate the selection of a chair to the committee itself, unless otherwise specified in these Bylaws. The Chair, subject to the approval of the Board if the committee was formed by the Board or the Member if the committee was formed by the Member, may designate or provide for the designation of one or more Directors or others as alternate members of any committee, who may replace any absent or disqualified member at any meeting of such committee. Standing committees shall have such powers and responsibilities as shall be set forth in these Bylaws or in any resolutions establishing such committees; provided, however, that committees may not have any authority prohibited by law.

5.2. **Action by Committee.** A quorum shall be a majority of the number of members of the committee. Any committee member restricted from voting on any matter pursuant to the Corporation's Conflict of Interest Policy shall not be counted in determining the quorum for the matter in question, even where permitted by law. The minutes of the committee meeting should reflect the disclosure, the abstention from voting, and the quorum situation. The act of a majority of the members of any committee present at a meeting at which a quorum is present at the time of the act shall be the act of such committee, unless the act of a greater number is required by the Member, by these Bylaws, by resolution of the Board of Directors or by law. Committees shall have only such authority delegated to them by the Board or the Member as shall be provided in resolutions of appointment, and no committee shall have any other power.

5.3. **Standing Committees:**

5.3.1. **Quality and Performance Committee.** The Quality and Performance Committee shall consist of at least three (3) members of the Board, including one member from each Division, and such other members as the Board determines are necessary to properly perform the functions of the Committee. The Quality and Performance Committee shall assist the Board in providing strategic direction and oversight for all quality improvement, patient safety, risk management, and regulatory compliance activities provided in and by the Corporation.

5.4. **Ad Hoc Committees.** The Board may appoint ad hoc committees from time to time for such special tasks as circumstances warrant. An ad hoc committee shall limit its activities to the accomplishment of the task for which it is appointed and shall have no power to act except as specifically conferred by action of the Board. Upon completion of the task for which appointed, such ad hoc committee shall stand discharged.

5.5. **Other Committees.** The Board may by resolution from time to time establish committees to serve in a purely advisory role to the Board, and such committees may consist of Directors and such other individuals as the Board shall determine.

ARTICLE 6- INDEMNIFICATION

6.1. **Indemnification of Directors and Officers.** The Corporation shall, to the fullest extent permitted by law, indemnify its Directors and Officers from and against any and all of the liabilities, expenses and other matters referenced in or covered by the Act or any other applicable laws presently or hereafter in effect. In furtherance and not in limitation thereof, the Corporation shall indemnify a Director for a liability, as defined in Section 33-1116 of the Act, to any person for any action taken, or any failure to take any action, as

a Director, except a liability that (i) involved a knowing and culpable violation of law by the Director; (ii) enabled the Director or an associate, as defined in Section 33-840 of the Connecticut General Statutes, to receive an improper personal gain; (iii) showed a lack of good faith and a conscious disregard for the duty of the Director to the Corporation under circumstances in which the Director was aware that his or her conduct or omission created an unjustifiable risk of serious injury to the Corporation; or (iv) constituted a sustained and unexcused pattern of inattention that amounted to an abdication of the Director's duty to the Corporation.

6.2. **Advancement of Expenses to Directors and Officers.** The Corporation shall advance funds to pay for or reimburse the reasonable expenses incurred by a current or former Director or officer who is or was a party to a proceeding because he or she is or was a Director or officer if he or she delivers to the Corporation: (i) a written affirmation of his or her good faith belief that he or she has met the relevant standard of conduct or that the proceeding involves conduct for which liability has been eliminated under a provision of the Corporation's Certificate of Incorporation; and (ii) his or her written undertaking to repay any funds advanced if he or she is not entitled to mandatory indemnification under the Nonstock Act and it is ultimately determined that he or she has not met the relevant standard of conduct required by the Corporation's Certificate of Incorporation or by the Nonstock Act.

6.3. **Indemnification of Other Parties.** The Corporation shall indemnify under Sections 33-1116 to 33-1125, inclusive, of the Connecticut General Statutes, a non-Director officer of the Corporation, who is a party to a proceeding because he or she is an officer, to the same extent as the Corporation is obligated to indemnify a Director. The Corporation may, at the discretion of the Board, indemnify any other current or former officer, employee or agent of the Corporation who is not a Director to the fullest extent permitted by law.

6.4. **Advancement of Expenses to Other Parties.** The Corporation shall advance expenses under Sections 33-1116 to 33-1125, inclusive, of the Connecticut General Statutes to a non-Director officer of the Corporation who is a party to a proceeding because he or she is an officer, to the same extent as the Corporation is obligated to advance expenses to a Director. The Corporation may, at the discretion of the Board, advance expenses to any other current or former officer, employee or agent of the Corporation who is not a Director to the fullest extent permitted by law.

6.5. **Predecessors of the Corporation.** Subsections 6.1 through 6.4 of this Article 6 shall obligate the Corporation to indemnify and advance expenses to a Director or officer of a predecessor of the Corporation pertaining to conduct with respect to the predecessor.

6.6. **Insurance**. The Corporation shall have power to purchase and maintain insurance on behalf of any person who is or was a Director, officer, employee or other agent of the Corporation, or is or was serving at the request of the Corporation as a trustee, director, officer, employee or other agent of another organization in which it has an interest, against any liability incurred by such person in any such capacity, or arising out of such person's status as such, whether or not the Corporation would have the power to indemnify such person against such liability.

ARTICLE 7 - CONFLICTS OF INTEREST

7.1. **Conflicts of Interest Policy**. The Board shall adopt and implement, or cause to be implemented, a written policy, which shall apply to all Directors, officers, members of committees, and all employees who regularly exercise general authority to make administrative or policy decisions on behalf of the Corporation ("Interested Persons") and which shall address, without limitation, the standard and procedures for determining when a conflict of interest exists and for addressing any conflicts of interest determined to exist, and for disclosure by Interested Persons of all financial or other interests that might result in a conflict of interest (the "Conflicts of Interest Policy").

7.2. **Standard**. The standard for determining whether a conflict of interest exists shall incorporate all applicable legal requirements, including without limitation the requirements the statutory standard set forth in the Foundation Act and the Nonstock Act, as such requirements may be revised from time to time.

7.3. **Disclosure**. All Interested Persons shall be required to disclose all financial and other interests, and all material facts related thereto, that might lead to a conflict of interest in accordance with the Conflicts of Interest Policy and each Interested Person shall sign an annual statement acknowledging his receipt, understanding of, and agreement to comply with the Conflicts of Interest Policy.

ARTICLE 8 - MISCELLANEOUS PROVISIONS

8.1. **Fiscal Year**. The fiscal year of the Corporation shall be as determined by the Member.

8.2. **Execution of Instruments**. All checks, deeds, leases, transfers, contracts, bonds, notes and other obligations authorized to be executed by an officer of the Corporation on its behalf shall be signed by the Chair or the President and Chief Executive officer, except as the Board may generally or in particular cases otherwise determine.

8.3. Voting of Interest in Other Corporations. When authorized by the Board, the President and Chief Executive Officer may waive notice of, and act as, or appoint any person or persons to act as, proxy or attorney-in-fact for the Corporation (with or without power of substitution) at any meeting of stockholders or members of any other corporation or organization in which this Corporation holds an equity or membership interest.

8.4. Corporate Records. The original, or attested copies of, the Certificate of Incorporation, these Bylaws and records of all meetings of the Member and the Board, shall be kept in the State of Connecticut at the principal office of the Corporation, or at the office of the Secretary and shall be available at all reasonable times for the inspection by any Director for any purpose relative to the affairs of the Corporation.

8.5. Evidence of Authority. A certificate by the Secretary, acting secretary or assistant secretary, as to any action taken by the Board, any committee or any officer or representative of the Corporation shall, as to all persons who rely on the certificate in good faith, be conclusive evidence of such action.

8.6. Certificate of Incorporation. All references in these Bylaws to the Certificate of Incorporation shall be deemed to refer to the Certificate of Incorporation of the Corporation, as amended or restated, and in effect from time to time.

8.7. Days. As used herein, all references to days shall refer to calendar days unless specifically provided otherwise.

ARTICLE 9 – AMENDMENTS

9.1. These Bylaws may be amended only by vote of the Member at any meeting of the Member.

PROSPECT CT MEDICAL FOUNDATION, INC.
(a Connecticut corporation)

UNANIMOUS WRITTEN CONSENT IN LIEU OF MEETING OF THE BOARD OF DIRECTORS

The undersigned, being all of the members of the Board of Directors of Prospect CT Medical Foundation, Inc., a Connecticut corporation (the "**Corporation**"), acting by unanimous written consent without a meeting pursuant to Section 33-1064 of the Connecticut Revised Nonstock Corporation Act, do hereby waive notice of a meeting and consent to the adoption of the following resolutions:

NOW, THEREFORE, BE IT:

RESOLVED: That the Amended and Restated Certificate of Incorporation (Exhibit A) be adopted by the Corporation.

RESOLVED, FURTHER: That Michele Volpe, Esq. be authorized to execute and file the Certificate of Amendment (Exhibit B) with the Connecticut Secretary of State.

RESOLVED, FURTHER: That this unanimous written consent may be signed in two or more counterparts, each of which shall be deemed an original, and all of which shall constitute one and the same instrument, and the undersigned members of the Board of Directors of the Corporation hereby direct the Secretary of the Corporation to file the executed copy of this unanimous written consent in the books and records of the Corporation.

RESOLVED, FURTHER: That, Michele Volpe hereby resigns as the sole incorporator of the Corporation, and the powers and duties of the undersigned shall be and they hereby are terminated.

[REMAINDER OF PAGE LEFT INTENTIONALLY BLANK]

[SIGNATURE PAGE FOLLOWS]

IN WITNESS WHEREOF, the undersigned members of the Board of Directors of Prospect CT Medical Foundation, Inc. have duly executed this unanimous written consent as of the 25th day of July, 2016.

By: _____
Print Name: Samuel S. Lee
Title: Director

By: _____
Print Name: David Topper
Title: Director

[Signature Page to Unanimous Written Consent In Lieu of Meeting of the Board of Directors of Prospect CT Medical Foundation, Inc.]

EXHIBIT A

AMENDED AND RESTATED CERTIFICATE OF INCORPORATION

Exhibit B

RESTATED CERTIFICATE OF INCORPORATION
OF
PROSPECT CT MEDICAL FOUNDATION, INC.

1. The name of the corporation shall be **Prospect CT Medical Foundation, Inc.**, a Connecticut Nonstock Corporation (the "Corporation").

2. The nature of the activities to be conducted and the purposes to be promoted or carried out by the Corporation shall include the following:

   a. To provide professional medical services to the patients of hospitals affiliated with Prospect CT, Inc. (the "Hospitals") and other affiliates of Prospect CT, Inc. and to other individuals in the Hospitals' service areas; provided, however, that all professional medical services rendered by the Corporation shall be rendered only through individuals who are authorized by the laws of the State of Connecticut to render professional medical services.

   b. To provide the following public services: public health (including nurses, nurse practitioners, nurses in a clinical setting, and full-time professionals engaged in health care practitioner occupations and health care support occupations and is not a business organized for profit.

   c. To promote and support the mission and purposes of the Hospitals by providing professional medical services to their patients and engaging in education activities related to patient care and the promotion of good health.

   d. To carry on additional activities related to rendering care to the sick or injured or the promotion of health in the community.

   e. To invest the funds of the Corporation in stocks, bonds, real estate, mortgages, or any other type of investment and to own real property incident to the rendering of professional medical services.

   f. To otherwise engage in any lawful act or activity from which a medical foundation may be organized under Chapter 594b of the Connecticut General

Statutes or for which a corporation may be organized under the Connecticut Revised Nonstock Corporation Act (the "Act").

g. Medical foundation status will not be effective until Member or a Member affiliate owns a Connecticut licensed hospital.

3. The Corporation is nonprofit and shall not have or issue shares of stock or make distributions.

4. The Corporation shall have one member (the "Member") which shall be Prospect CT, Inc., a Delaware corporation. The Member shall have the right to adopt bylaws (the "Bylaws") for the conduct of the affairs of the Corporation and the right to elect the Board of Directors and officers of the Corporation in accordance with the Corporation's Bylaws and shall have all other rights, powers and privileges usually or by law accorded to the members of a non-stock nonprofit corporation and conferred thereby or by the Corporation's Certificate of Incorporation or Bylaws.

5. Subject to the rights and powers of the Member, the Corporation shall operate under the management of its Board of Directors. The Member shall prescribe the number, qualifications (if any) and manner of election of the Directors of the Corporation. The Member may provide that persons occupying certain positions within or without the Corporation shall be ex-officio members of the Board of Directors, who may vote and be counted in determining a quorum.

6. Intentionally Omitted

7. Upon any dissolution or termination of the existence of the Corporation, all its property and assets shall be applied and distributed as follows: (i) All liabilities and other obligations of the Corporation shall be paid, satisfied and discharged, or adequate provision shall be made therefor; (ii) assets held by the Corporation upon condition requiring return, transfer or conveyance, which condition occurs by reason of the dissolution, shall be returned, transferred or conveyed in accordance with such requirements; (iii) assets received and held by the Corporation subject to limitations permitting their use, but not held upon a condition requiring return, transfer or conveyance by reason of the dissolution, shall be transferred or conveyed to one or more domestic or foreign corporations, societies or organizations engaged in activities substantially similar to those of the dissolving corporation, pursuant to a plan of distribution adopted as provided in section 33-1175; (iv) other assets, if any, shall be distributed to the Member except to the extent that the certificate of incorporation provides for distribution to others; and (v) any remaining assets may be distributed to such persons, societies, organizations or domestic or foreign corporations, whether for

profit or nonprofit, as may be specified in a plan of distribution adopted as provided in section 33-1175.

8. The personal liability of a Director of the Corporation to the Corporation for breach of duty as a Director of the Corporation shall be limited to the fullest extent permitted by the Act and as set forth in Section 1104 or any other applicable laws presently or hereafter in effect.

9. The Corporation shall indemnify its Directors and officers as follows:

   a. The Corporation shall, to the fullest extent permitted by law, indemnify its Directors or officers from and against any and all of the liabilities, expenses and other matters referenced in or covered by the Act or any other applicable laws presently or hereafter in effect. In furtherance and not in limitation thereof, the Corporation shall indemnify a Director for a liability, as defined in Section 33-1116 of the Act, to any person for any action taken, or any failure to take any action, as a Director, except a liability that (i) involved a knowing and culpable violation of law by the Director; (ii) enabled the Director or an associate, as defined in Section 33-840 of the Connecticut General Statutes, to receive an improper personal gain; (iii) showed a lack of good faith and a conscious disregard for the duty of the Director to the Corporation under circumstances in which the Director was aware that his or her conduct or omission created an unjustifiable risk of serious injury to the Corporation; or (iv) constituted a sustained and unexcused pattern of inattention that amounted to an abdication of the Director's duty to the Corporation.

   b. In addition to the foregoing, the Corporation shall provide to its Directors and officers the full amount of indemnification that the Corporation is permitted to provide to such Directors and officers pursuant to Sections 33-1116 to 33-1125, inclusive, of the Act or any other applicable laws presently or hereafter in effect. Expenses (including attorneys' fees) incurred by a Director or officer in defending a civil, criminal, administrative or investigative action, suit or proceeding shall be paid by the Corporation in advance of the final disposition of such action, suit or proceeding upon receipt of both (i) a written affirmation by such officer or Director of his or her good faith belief that he or she has met the relevant standard of conduct under the Act or that the proceeding involves conduct for which liability has been limited under Paragraph 8 of this Certificate of Incorporation; and (ii) an undertaking by or on behalf of such Director or officer to repay such amount if it shall ultimately be determined that such Director or officer is not entitled to be indemnified by the Corporation as authorized in this Paragraph 9.

Such expenses (including attorneys' fees) incurred by other employees and agents of the Corporation may be so paid upon such terms and conditions, if any, as the Board of Directors deems appropriate.

c. The indemnification and advancement of expenses provided by, or granted pursuant to this Paragraph 9 shall not be deemed exclusive of any other rights to which those seeking indemnification or advancement of expenses may be entitled under any bylaw, agreement, vote of disinterested Directors or otherwise, both as to action in his or her official capacity and as to action in another capacity while holding such office.

d. No amendment to or repeal of this Paragraph 9 shall apply to or have any effect on the indemnification of any Director or officer for or with respect to any acts or omissions of such Director or officer occurring prior to such amendment or repeal, nor shall any such amendment or repeal apply to or have any effect on the obligations of the Corporation to pay for or reimburse in advance expenses incurred by a Director or officer in defending any action, suit or proceeding arising out of or with respect to any acts or omissions occurring prior to such amendment or repeal.

10. References in this Certificate of Incorporation to the Act shall be deemed to include amendments adopted from time to time to such Act.

11. The Corporation's registered agent shall be:

Name: C T Corporation System

Business Address: One Corporate Center, Hartford, CT 06103

Email address: NONE

12. The name and address of the Incorporator is:

Name: Michele M. Volpe, Esq.

Address: Bershtein, Volpe & McKeon PC
105 Court Street, 3rd Floor
New Haven, CT 06511

EXHIBIT B

CERTIFICATE OF AMENDMENT

SECRETARY OF THE STATE OF CONNECTICUT

MAILING ADDRESS: COMMERCIAL RECORDING DIVISION, CONNECTICUT SECRETARY OF THE STATE, P.O. BOX 150470, HARTFORD, CT 06115-0470
DELIVERY ADDRESS: COMMERCIAL RECORDING DIVISION, CONNECTICUT SECRETARY OF THE STATE, 30 TRINITY STREET, HARTFORD, CT 06106
PHONE: 860-509-6003 WEBSITE: www.concord-sots.ct.gov

CERTIFICATE OF AMENDMENT
NONSTOCK CORPORATION

USE INK. COMPLETE ALL SECTIONS. PRINT OR TYPE. ATTACH 81/2 X 11 SHEETS IF NECESSARY.

FILING PARTY *(CONFIRMATION WILL BE SENT TO THIS ADDRESS):*

NAME: Michele M. Volpe
ADDRESS: Bershtein, Volpe & McKeon, P.C.
105 Court Street, 3rd Floor
CITY: New Haven
STATE: Connecticut ZIP: 06511

FILING FEE: $20

MAKE CHECKS PAYABLE TO "SECRETARY OF THE STATE"

1. NAME OF CORPORATION:

Prospect CT Medical Foundation, Inc.

2. THE CERTIFICATE OF INCORPORATION IS *(check A, B or C):*

☐ A. AMENDED

☐ B. RESTATED

☒ C. AMENDED AND RESTATED

THE RESTATED CERTIFICATE CONSOLIDATES ALL AMENDMENTS INTO A SINGLE DOCUMENT

3. TEXT OF EACH AMENDMENT / RESTATEMENT:

Please see Exhibit A for the text of each amendment.
Please see Exhibit B for the Restated Certificate of Incorporation.

4. VOTE INFORMATION *(CHECK A, B or C)*

☐ A. THE AMENDMENT WAS DULY APPROVED BY THE MEMBERS IN THE MANNER REQUIRED BY SECTIONS 33-1140 TO 33-1147 OF THE CONNECTICUT GENERAL STATUTES, AND BY THE CERTIFICATE OF INCORPORATION.

☒ B. THE AMENDMENT WAS DULY APPROVED BY THE INCORPORATORS AND MEMBER APPROVAL WAS NOT REQUIRED.

☐ C. THE AMENDMENT WAS DULY APPROVED BY THE BOARD OF DIRECTORS AND MEMBER APPROVAL WAS NOT REQUIRED.

6. EXECUTION:

DATED THIS 15TH DAY OF June , 20 16

NAME OF SIGNATORY	CAPACITY/TITLE OF SIGNATORY	SIGNATURE
Michele M. Volpe, Esq.	Incorporator	

Prospect CT Medical Foundation, Inc.

Exhibit A

3. TEXT OF EACH AMENDMENT / RESTATEMENT

1. Article Second is amended by adding new section b. which shall read as follows:

   b. To provide the following public services: public health (including nurses, nurse practitioners, nurses in a clinical setting, and full-time professionals engaged in health care practitioner occupations and health care support occupations and is not a business organized for profit.

2. Article Sixth is deleted in its entirety.

Exhibit B

RESTATED CERTIFICATE OF INCORPORATION
OF
PROSPECT CT MEDICAL FOUNDATION, INC.

1. The name of the corporation shall be **Prospect CT Medical Foundation, Inc.**, a Connecticut Nonstock Corporation (the "Corporation").

2. The nature of the activities to be conducted and the purposes to be promoted or carried out by the Corporation shall include the following:

   a. To provide professional medical services to the patients of hospitals affiliated with Prospect CT, Inc. (the "Hospitals") and other affiliates of Prospect CT, Inc. and to other individuals in the Hospitals' service areas; provided, however, that all professional medical services rendered by the Corporation shall be rendered only through individuals who are authorized by the laws of the State of Connecticut to render professional medical services.

   b. To provide the following public services: public health (including nurses, nurse practitioners, nurses in a clinical setting, and full-time professionals engaged in health care practitioner occupations and health care support occupations and is not a business organized for profit.

   c. To promote and support the mission and purposes of the Hospitals by providing professional medical services to their patients and engaging in education activities related to patient care and the promotion of good health.

   d. To carry on additional activities related to rendering care to the sick or injured or the promotion of health in the community.

   e. To invest the funds of the Corporation in stocks, bonds, real estate, mortgages, or any other type of investment and to own real property incident to the rendering of professional medical services.

   f. To otherwise engage in any lawful act or activity from which a medical foundation may be organized under Chapter 594b of the Connecticut General

Statutes or for which a corporation may be organized under the Connecticut Revised Nonstock Corporation Act (the "Act").

g. Medical foundation status will not be effective until Member or a Member affiliate owns a Connecticut licensed hospital.

3. The Corporation is nonprofit and shall not have or issue shares of stock or make distributions.

4. The Corporation shall have one member (the "Member") which shall be Prospect CT, Inc., a Delaware corporation. The Member shall have the right to adopt bylaws (the "Bylaws") for the conduct of the affairs of the Corporation and the right to elect the Board of Directors and officers of the Corporation in accordance with the Corporation's Bylaws and shall have all other rights, powers and privileges usually or by law accorded to the members of a non-stock nonprofit corporation and conferred thereby or by the Corporation's Certificate of Incorporation or Bylaws.

5. Subject to the rights and powers of the Member, the Corporation shall operate under the management of its Board of Directors. The Member shall prescribe the number, qualifications (if any) and manner of election of the Directors of the Corporation. The Member may provide that persons occupying certain positions within or without the Corporation shall be ex-officio members of the Board of Directors, who may vote and be counted in determining a quorum.

6. Intentionally Omitted

7. Upon any dissolution or termination of the existence of the Corporation, all its property and assets shall be applied and distributed as follows: (i) All liabilities and other obligations of the Corporation shall be paid, satisfied and discharged, or adequate provision shall be made therefor; (ii) assets held by the Corporation upon condition requiring return, transfer or conveyance, which condition occurs by reason of the dissolution, shall be returned, transferred or conveyed in accordance with such requirements; (iii) assets received and held by the Corporation subject to limitations permitting their use, but not held upon a condition requiring return, transfer or conveyance by reason of the dissolution, shall be transferred or conveyed to one or more domestic or foreign corporations, societies or organizations engaged in activities substantially similar to those of the dissolving corporation, pursuant to a plan of distribution adopted as provided in section 33-1175; (iv) other assets, if any, shall be distributed to the Member except to the extent that the certificate of incorporation provides for distribution to others; and (v) any remaining assets may be distributed to such persons, societies, organizations or domestic or foreign corporations, whether for

profit or nonprofit, as may be specified in a plan of distribution adopted as provided in section 33-1175.

8. The personal liability of a Director of the Corporation to the Corporation for breach of duty as a Director of the Corporation shall be limited to the fullest extent permitted by the Act and as set forth in Section 1104 or any other applicable laws presently or hereafter in effect.

9. The Corporation shall indemnify its Directors and officers as follows:

   a. The Corporation shall, to the fullest extent permitted by law, indemnify its Directors or officers from and against any and all of the liabilities, expenses and other matters referenced in or covered by the Act or any other applicable laws presently or hereafter in effect. In furtherance and not in limitation thereof, the Corporation shall indemnify a Director for a liability, as defined in Section 33-1116 of the Act, to any person for any action taken, or any failure to take any action, as a Director, except a liability that (i) involved a knowing and culpable violation of law by the Director; (ii) enabled the Director or an associate, as defined in Section 33-840 of the Connecticut General Statutes, to receive an improper personal gain; (iii) showed a lack of good faith and a conscious disregard for the duty of the Director to the Corporation under circumstances in which the Director was aware that his or her conduct or omission created an unjustifiable risk of serious injury to the Corporation; or (iv) constituted a sustained and unexcused pattern of inattention that amounted to an abdication of the Director's duty to the Corporation.

   b. In addition to the foregoing, the Corporation shall provide to its Directors and officers the full amount of indemnification that the Corporation is permitted to provide to such Directors and officers pursuant to Sections 33-1116 to 33-1125, inclusive, of the Act or any other applicable laws presently or hereafter in effect. Expenses (including attorneys' fees) incurred by a Director or officer in defending a civil, criminal, administrative or investigative action, suit or proceeding shall be paid by the Corporation in advance of the final disposition of such action, suit or proceeding upon receipt of both (i) a written affirmation by such officer or Director of his or her good faith belief that he or she has met the relevant standard of conduct under the Act or that the proceeding involves conduct for which liability has been limited under Paragraph 8 of this Certificate of Incorporation; and (ii) an undertaking by or on behalf of such Director or officer to repay such amount if it shall ultimately be determined that such Director or officer is not entitled to be indemnified by the Corporation as authorized in this Paragraph 9.

Such expenses (including attorneys' fees) incurred by other employees and agents of the Corporation may be so paid upon such terms and conditions, if any, as the Board of Directors deems appropriate.

c. The indemnification and advancement of expenses provided by, or granted pursuant to this Paragraph 9 shall not be deemed exclusive of any other rights to which those seeking indemnification or advancement of expenses may be entitled under any bylaw, agreement, vote of disinterested Directors or otherwise, both as to action in his or her official capacity and as to action in another capacity while holding such office.

d. No amendment to or repeal of this Paragraph 9 shall apply to or have any effect on the indemnification of any Director or officer for or with respect to any acts or omissions of such Director or officer occurring prior to such amendment or repeal, nor shall any such amendment or repeal apply to or have any effect on the obligations of the Corporation to pay for or reimburse in advance expenses incurred by a Director or officer in defending any action, suit or proceeding arising out of or with respect to any acts or omissions occurring prior to such amendment or repeal.

10. References in this Certificate of Incorporation to the Act shall be deemed to include amendments adopted from time to time to such Act.

11. The Corporation's registered agent shall be:

Name: C T Corporation System

Business Address: One Corporate Center, Hartford, CT 06103

Email address: NONE

12. The name and address of the incorporator is:

Name: Michele M. Volpe, Esq.

Address: Bershtein, Volpe & McKeon PC
105 Court Street, 3rd Floor
New Haven, CT 06511

September 29, 2016

Schedules to Asset Purchase Agreement

SCHEDULE

Schedule 1.01(6) List of Seller's Affiliates
Schedule 1.02(i) Persons with "Seller's Knowledge"
Schedule 2.01(a) Owned Real Property
Schedule 2.01(b) Leased Real Property
Schedule 2.01(c) Leased Personal Property
Schedule 2.01(f) Assumed Contracts
Schedule 2.01(g) Material Permits
Schedule 2.01(h) Intellectual Properties
Schedule 2.02(j) Excluded Contracts
Schedule 2.02(l) Excluded Corporate or Trade Names
Schedule 2.02(n) ECHN Community Healthcare Foundation Assets and Properties
Schedule 2.02(p) Claims of Seller against Third Parties
Schedule 2.02(q) Other Excluded Assets
Schedule 2.03 Assumed Liabilities
Schedule 2.05 Examples of Implementation of Section 2.05
Schedule 2.05(a) Joint Venture Valuations
Schedule 3.02 Consents
Schedule 3.04 Subsidiaries and Third Party Rights
Schedule 3.05 Legal and Regulatory Compliance
Schedule 3.06 Audited and Unaudited Financial Statements
Schedule 3.08 Recent Activities
Schedule 3.08(b) Compensation and Personnel Changes
Schedule 3.08(d) Sold Assets
Schedule 3.10 Equipment Depreciation Schedule
Schedule 3.11 Permitted Personal Property Encumbrances
Schedule 3.12(a) Permitted Real Property Encumbrances
Schedule 3.12(c) Buildings Not Structurally Sound or in Need of Material Repairs
Schedule 3.12(g) Rent Roll
Schedule 3.12(i) Tenant Lease Encumbrances
Schedule 3.13(a) Environmental Claims
Schedule 3.13(b) Materials of Environmental Concern Storage Locations/Underground Storage Tanks
Schedule 3.14 Intellectual Properties and Information Systems
Schedule 3.15 Insurance
Schedule 3.17 Unexpected Occurrences
Schedule 3.18 Contracts Related to the Hospital Businesses
Schedule 3.19(d) Prohibition on Competition
Schedule 3.19(e) Contract Change of Control Provisions
Schedule 3.21(c) Claims Involving Legal requirements of Employment
Schedule 3.21(e) Non-Competition Agreements
Schedule 3.21(f) Pending Labor Disputes

Schedule 3.21(g) Pending Immigration Proceedings
Schedule 3.22 Employee Benefit Plans
Schedule 3.22(f) Employee Pension Benefit Plan Reportable Event
Schedule 3.22(g) Employee Welfare Benefit Plan
Schedule 3.23 Proceedings and Claims
Schedule 3.25(a) Medical Staff
Schedule 3.25(b) Material Medical Staff Disputes
Schedule 3.26 Restricted Assets
Schedule 3.30(a) Outstanding Capital Stock of Seller's Subsidiaries
Schedule 3.30(b) Outstanding Capital Stock of Joint Ventures
Schedule 3.30(c) Outstanding Membership Interests
Schedule 3.31 Ten Largest Non-Governmental Payors of Hospital Businesses
Schedule 5.01 Material Hospital Business Changes
Schedule 5.01(b) Asset Expenditures
Schedule 5.02(c) Compensation Increases
Schedule 5.03(b) Written Severance Agreements
Schedule 5.16 Charity Care and Community Obligations
Schedule 5.25(b) ECHN – Extended Reporting Period Options
Schedule 5.30 Tax Claim
Schedule 7.04(d) Consents to Assignment of Assumed Contracts
Schedule 10.03 Certain Subsidiaries of Seller

Schedule 1.01(6)

List of Seller's Affiliates

The Manchester Memorial Hospital
The Rockville General Hospital, Incorporated
ECHN ElderCare Services, Inc.
Eastern Connecticut Medical Professionals Foundation, Inc.
Visiting Nurse and Health Services of Connecticut, Inc.
A Caring Hand, LLC
Clinically Integrated Network of Eastern Connecticut, LLC
ECHN Community Healthcare Foundation, Inc.
Connecticut Healthcare Insurance Company
ECHN Corporate Services, Inc.
Medical Practice Partners, LLC
ECHN Enterprises, Inc.
Haynes Street Property Management, LLC

Schedule 1.02(i)

Persons with "Seller's Knowledge"

[REDACTED PER CONN. GEN. STAT. § 1-210(b)(2)]

Schedule 2.01(a)

Owned Real Property

Owned Real Property Address	City	State	Zipcode	Property Description	Owner
11 South Alton Street	Manchester	CT	06040	Residential	The Manchester Memorial Hospital
17 Armory Street	Manchester	CT	06040	Residential	The Manchester Memorial Hospital
19 Armory Street	Manchester	CT	06040	Residential	The Manchester Memorial Hospital
72 Russell Street	Manchester	CT	06040	Residential	The Manchester Memorial Hospital
110 Russell Street	Manchester	CT	06040	Residential	The Manchester Memorial Hospital
70 West Middle Turnpike	Manchester	CT	06040	Residential	The Manchester Memorial Hospital
74 West Middle Turnpike	Manchester	CT	06040	Residential	The Manchester Memorial Hospital
94 West Middle Turnpike	Manchester	CT	06040	Residential	The Manchester Memorial Hospital
98 West Middle Turnpike	Manchester	CT	06040	Residential	The Manchester Memorial Hospital
104 West Middle Turnpike	Manchester	CT	06040	Residential	The Manchester Memorial Hospital
108 West Middle Turnpike	Manchester	CT	06040	Residential	The Manchester Memorial Hospital
114 West Middle Turnpike	Manchester	CT	06040	Residential	The Manchester Memorial Hospital
18 Haynes Street	Manchester	CT	06040	Office Building/Commercial	The Manchester Memorial Hospital
26 Haynes Street	Manchester	CT	06040	Office Building/Commercial	The Manchester Memorial Hospital
36 Haynes Street	Manchester	CT	06040	Office Building/Commercial	The Manchester Memorial Hospital
44 Haynes Street	Manchester	CT	06040	Office Building/Commercial	ECHN Enterprises, Inc.
56 Haynes Street	Manchester	CT	06040	Vacant Lot	The Manchester Memorial Hospital
71-80 Haynes Street	Manchester	CT	06040	Hospital	The Manchester Memorial Hospital
310-312 Main Street	Manchester	CT	06040	Mixed Use	ECHN Enterprises, Inc.
320 Main Street	Manchester	CT	06040	Office Building/Commercial	The Manchester Memorial Hospital
353 Main Street	Manchester	CT	06040	Office Building/Commercial	The Manchester Memorial Hospital

Owned Real Property Address	City	State	Zipcode	Property Description	Owner
945 Main Street	Manchester	CT	06040	Office Condominium	ECHN Enterprieses, Inc.
150 North Main Street	Manchester	CT	06040	Office Building	The Manchester Memorial Hospital
319 Broad Street	Manchester	CT	06040	Thrift Shop/Commercial	The Manchester Memorial Hospital
37-97 Hemlock Street	Manchester	CT	06040	Vacant Lot	The Manchester Memorial Hospital
62 So. Hawthorne Street	Manchester	CT	06040	Vacant Lot	The Manchester Memorial Hospital
66 So. Hawthorne Street	Manchester	CT	06040	Vacant Lot	The Manchester Memorial Hospital
77 South Alton Street	Manchester	CT	06040	Vacant Lot	The Manchester Memorial Hospital
26 Shenipsit Lake Road	Tolland	CT	06084	Elder Care/Commercial	ECHN Eldercare Services, Inc.
8-11-12 Ward Street	Vernon	CT	06066	Vacant Lot	Rockville General Hospital Incorporated
35 Village Street	Vernon	CT	06066	Vacant Lot	Rockville General Hospital Incorporated
22-25-26 Village Street	Vernon	CT	06066	Vacant Building	Rockville General Hospital Incorporated
88 West Main Street	Vernon	CT	06066	Parking Lot	Rockville General Hospital Incorporated
31 Union Street	Vernon	CT	06066	Hospital	Rockville General Hospital Incorporated
460 Hartford Turnpike	Vernon	CT	06066	Commercial	Rockville General Hospital Incorporated
190 Meadow Street	Lee	MA	01260	Time Share	Rockville General Hospital Incorporated
8 Keynote Drive	Vernon	CT	06066	Office Building (VNHSC)	Visiting Nurse and Health Services of CT, Inc.

Schedule 2.01(b)

Leased Real Property

[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]

Schedule 2.01(c)

Leased Personal Property

[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]

Schedule 2.01(f)

Assumed Contracts

[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]

Schedule 2.01(f) Addendum

Resident Agreements for Residents of ECHN Eldercare Services, Inc. d/b/a Woodlake at Tolland Rehabilitation & Nursing Center

[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]

Schedule 2.01(g)

Material Permits

Entity	Agency from Which Approval or to Which Notice is Required	Approval / License Type & Number	Expiration Date
VNHSC	DPH	Home Health License # HHC.0C81791	12/31/2016
WAT	DPH	Chronic & Convalescent Nursing Home License # CCNH.002099C	12/31/2016
WBC	DPH	Mental Health Day Treatment Facility License# MHDT.0000057	6/30/2016
WBC	DPH	Psychiatric Outpatient Clinic for Adults License# POCA.0000529	6/30/2016
MMH	NRC	Materials License # 06-03413-01	3/31/2024
RGH	NRC	Materials License # 06-13001-02	11/30/2021
MMH	FCC	Radio Service Call Sign KNEK381 FRN: 0007050370 IG - Industrial/Business Pool, Conventional Regulatory Status - PRMS	5/25/2024
MMH	FCC	Radio Service Call Sign WNZF398 FRN: 0007050370 IG - Industrial/Business Pool, Conventional Regulatory Status - PRMS	5/18/2022
RGH	FCC	Radio Service Call Sign WPVZ223 FRN: 0005942677 PW - Public Safety Pool, Conventional Regulatory Status - PRMS	9/17/2022

Entity	Agency from Which Approval or to Which Notice is Required	Approval / License Type & Number	Expiration Date
RGH	FCC	Radio Service Call Sign WPYL558 FRN: 0005942677 IG - Industrial/Business Pool, Conventional Regulatory Status - PRMS	9/3/2023
ECMPF	AG	Notice of acquisition of group practice	N/A
ECHN	AG	Notice of Affiliation of hospital/hospital system	N/A
WAT	Eastern Highlands Health District	Food Service License # 1425	3/31/2017
RGH	North Central District Health Department	Food Service License # 959	10/31/2016
MMH	Town of Manchester Health Department	Food Service Establishment License Permit# 108	3/9/2017
MMH	CMS	CLIA Certificate of Accreditation (Hartford Campus) # 07D0644553 Lab Director: Dennis G. O'Neill, MD	8/9/2017
MMH	CMS	CLIA Certificate of Accreditation (Main Campus) # 07D0092869 Lab Director: Dennis G. O'Neill, MD	2/27/2017
RGH	CMS	CLIA Certificate of Accreditation (Main Campus) # 07D0093263 Lab Director: Dennis G. O'Neill, MD	2/27/2017
MMH	CMS	CLIA Certificate of Accreditation (MMH Cancer Center) # 07D2010712 Lab Director: Dennis G. O'Neill, MD	3/6/2018
Women's Center for Wellness	CMS	CLIA Certificate of PPMP # 07D0866056 Lab Director: David Neuhaus, MD	8/31/2016

Entity	Agency from Which Approval or to Which Notice is Required	Approval / License Type & Number	Expiration Date
MMH	CMS	CLIA Certificate of Waiver (Coventry) # 07D2037531 Lab Director: Dennis G. O'Neill, MD	2/28/2018
WAT	CMS	CLIA Certificate of Waiver # 07D0859878 Lab Director: Faria Mahmood, MD	8/31/2016
CorpCare	CMS	CLIA Certificate of Waiver (CorpCare Occ. Health) # 07D0917545 Lab Director: Katherine B. Tracy, MD	6/6/2017
MMH	CMS	CLIA Certificate of Waiver (MMH Nursing) # 07D0873944 Lab Director: Dennis G. O'Neill, MD	8/1/2017
RGH	CMS	CLIA Certificate of Waiver (RGH Nursing) # 07D0681314 Lab Director: Dennis G. O'Neill, MD	8/31/2016
RGH	CMS	CLIA Certificate of Waiver (ECHN Urgent Care at South Windsor) # 07D2044241 Lab Director: Dennis G. O'Neill, MD[1]	7/18/2016
MMH	CMS	CLIA Certificate of Waiver (Vernon) # 07D2039385 Lab Director: Dennis G. O'Neill, MD	4/8/2018
VNHSC	CMS	CLIA Certificate of Waiver # 07D0093271 Lab Director: Rosemary Harding, MD	8/31/2016
MMH	College of American Pathologists	Lab Accreditation (Coventry)	1/18/2018

[1] Please note that the CLIA Certificate of Waiver issued with this identification number is labeled "ECHN Urgent Care at South Windsor." The relevant location operates as a department of The Rockville General Hospital, Incorporated and is referred to internally as "Urgent Care at South Windsor."

Entity	Agency from Which Approval or to Which Notice is Required	Approval / License Type & Number	Expiration Date
MMH	College of American Pathologists	Lab Accreditation (Eastern CT Cancer Center Lab)	1/18/2018
MMH	College of American Pathologists	Lab Accreditation (Hartford Campus)	1/18/2018
MMH	College of American Pathologists	Lab Accreditation (Main Campus)	1/18/2018
RGH	College of American Pathologists	Lab Accreditation (Main Campus)	1/18/2018
MMH	College of American Pathologists	Lab Accreditation (Vernon)	1/18/2018
ECHN	DPH	Approved Blood Collection Facility (ECHN) License # DS-729 Director: Dennis O'Neill, MD	No expiration date Approval dated 2/28/2006
MMH	DPH	Approved Blood Collection Facility (Evergreen I Patient Service Center) License # DS-737 Director: Dennis O'Neill, MD	No expiration date Approval dated 7/22/2014
ECHN	DPH	Approved Blood Collection Facility (Evergreen II Patient Service Center) License # DS-882 Director: Dennis O'Neill, MD	No expiration date Approval dated 2/1/2011
MMH	DPH	Approved Blood Collection Facility (Glastonbury Diagnostic Center Patient Facility) License # DS-562 Director: Dennis O'Neill, MD	No expiration date Approval dated 7/31/2015
RGH	DPH	Approved Blood Collection Facility (Manchester Medical Patient Service Center) License # DS-808 Director: Dennis O'Neill, MD	No expiration date Approval dated 6/13/2008

Entity	Agency from Which Approval or to Which Notice is Required	Approval / License Type & Number	Expiration Date
MMH	DPH	Approved Blood Collection Facility (MMH Patient Service Center) License # DS-725 Director: Dennis O'Neill, MD	No expiration date Approval dated 5/31/2012
RGH	DPH	Approved Blood Collection Facility (RGH Patient Service Center - Ellington) License # DS-749 Director: Dennis O'Neill, MD	No expiration date Approval dated 6/1/2010
RGH	DPH	Approved Blood Collection Facility (RGH Patient Service Center) License # DS-757 Director: Dennis O'Neill, MD	No expiration date Approval dated 1/4/2007
MMH	DPH	Approved Blood Collection Facility (Tolland Turnpike Patient Service Center) License # DS-391 Director: Dennis O'Neill, MD	No expiration date Approval dated 1/2/2013
MMH	DPH	Approved Public Health Lab (Blood Bank) License # BB-1009	3/31/2018
RGH	DPH	Approved Public Health Lab (Blood Bank) License # BB-1039	3/31/2018
MMH	DPH	Approved Public Health Lab (Main Campus) License # HP-0216	3/31/2018
ECHN	DPH	Approved Public Health Lab (RGH) License # HP-0234	3/31/2016
ECHN	DPH	Clinical Laboratory License (Hartford) License# CL-0751	3/31/2018
ECHN	DPH	Clinical Laboratory License (MMH Cancer Center) License# CLPOL-0502	9/30/2017

Entity	Agency from Which Approval or to Which Notice is Required	Approval / License Type & Number	Expiration Date
A Caring Hand, LLC	DCP	Registered as homemaker companion agency License# HCA - 0000138	10/31/2016
RGH	DPH (Rose)	General Hospital License License # 0036	12/31/2017
MMH	DPH (Rose)	General Hospital License License # 0048	12/31/2017
MMH	FDA	Accreditation (Main Campus - Mammography) Facility ID# 121897	1/4/2019
RGH	FDA	Accreditation (Main Campus - Mammography) Facility ID# 162099	2/28/2017
MMH	FDA	Accreditation as Certified Mammography Center (Glastonbury - Mammography) Facility ID# 217646	2/21/2019
WCW	FDA	Accreditation as Certified Mammography Center Facility ID# 179259	9/12/2018
TIC	FDA	Accreditation as Certified Mammography Center Facility ID# 238393	3/9/2018
EEC	DPH	Ambulatory Surgical Center License # ASC.0000324	12/31/2016
NRRON	DPH	Outpatient Clinic (100 Haynes Street) License# OPC.0000317	3/31/2017
NRRON	DPH	Outpatient Clinic (142 Hazard Ave.) License# OPC.0000306	9/30/2016
MMH	American College of Radiology	Accreditation (Glastonbury - Mammography)	2/21/2019

Entity	Agency from Which Approval or to Which Notice is Required	Approval / License Type & Number	Expiration Date
MMH	American College of Radiology	Accreditation (Main Campus - Mammography)	1/4/2019
RGH	American College of Radiology	Accreditation (Main Campus - Mammography)	2/28/2017
TIC	American College of Radiology	Accreditation (Mammography)	3/9/2018
WCW	American College of Radiology	Accreditation (WCW - Mammography, Rooms 1 & 2)	9/12/2018
NRRON	American College of Radiology	Accreditation	11/30/2017
TIC	American College of Radiology	Accreditation - CT (Adult & Pediatric Head/Neck, Chest, Abdomen)	5/14/2018
TIC	American College of Radiology	Accreditation - MRI (Head, Spine, MSK)	3/10/2018
WCW	American College of Radiology	Accreditation (Breast Ultrasound & U/S-Guided Biopsy)	9/11/2018
RGH	American College of Radiology	Accreditation (Evergreen - Breast MR)	3/15/2018
RGH	American College of Radiology	Accreditation (Evergreen - CT)	3/12/2019
RGH	American College of Radiology	Accreditation (Evergreen - MRI)	2/2/2019
RGH	American College of Radiology	Accreditation (Evergreen - Ultrasound)	3/8/2019
MMH	American College of Radiology	Accreditation (Main Campus - CT)	9/18/2016
RGH	American College of Radiology	Accreditation (Main Campus - CT)	1/17/2019

Entity	Agency from Which Approval or to Which Notice is Required	Approval / License Type & Number	Expiration Date
MMH	American College of Radiology	Accreditation (Main Campus - CT/PET)	2/15/2017
MMH	American College of Radiology	Accreditation (Main Campus - MRI)	6/17/2018
RGH	American College of Radiology	Accreditation (Main Campus - MRI)	7/17/2018
MMH	American College of Radiology	Accreditation (Main Campus - Nuclear Medicine - Oncology)	2/15/2017
MMH	American College of Radiology	Accreditation (Main Campus - Nuclear Medicine, Rooms 1 & 2)	6/13/2017
RGH	American College of Radiology	Accreditation (Main Campus - Nuclear Medicine, Rooms 1 & 2)	6/13/2017
MMH	American College of Radiology	Accreditation (Main Campus - Ultrasound)	9/2/2017
RGH	American College of Radiology	Accreditation (Nuclear Medicine - Planar)	12/15/2017
RGH	American College of Radiology	Accreditation (Nuclear Medicine - Planar, SPECT, Nuc. Cardiology)	12/15/2017
TIC	American College of Radiology	Accreditation (Ultrasound - ob, gyn, & general)	5/21/2018
WCW	American College of Radiology	Accreditation (WCW - Breast Imaging Center of Excellence)	N/A
WCW	American College of Radiology	Accreditation (WCW - Stereotactic Biopsy)	1/11/2019
MMH	American Osteopathic Association	Residency Accreditation - Family Medicine	N/A

Entity	Agency from Which Approval or to Which Notice is Required	Approval / License Type & Number	Expiration Date
MMH	American Osteopathic Association	Residency Accreditation - Transitional Internship	N/A
MMH	The Joint Commission	Behavioral Health Care Accreditation Program ID# 5670	8/5/2018
MMH	The Joint Commission	Hospital Accreditation ID# 5670	8/8/2018
RGH	The Joint Commission	Hospital Accreditation ID# 5689	4/10/2018
ECHN	American Academy of Sleep Medicine	Accreditation - Sleep Disorder Center # 175892 (For center and home sleep apnea testing)	1/15/2020
Aetna Ambulance Service, Inc.	OEMS	License# L. 0L064P2	12/31/2016
Ambulance Service of Manchester, LLC	OEMS	License# L. 0L077P2	12/31/2016
MMH	DCP	Controlled Substance Registration # CSP-0001185-HOSP	2/28/2017
RGH	DCP	Controlled Substance Registration # CSP-0001829-HOSP	2/28/2017
ECMPF	DPH	Notice of acquisition of group practice	N/A
MMH	Town of Manchester Sanitation Department	Sanitation Permit Permit# 365	12/31/2016

Entity	Agency from Which Approval or to Which Notice is Required	Approval / License Type & Number	Expiration Date
RGH	DEA	DEA Registration # AR1562532	4/30/2019
MMH	DEA	DEA Registration # AT2631934	1/31/2018
MMH	American College of Surgeons, Commission on Cancer	Accreditation FIN#6160280	12/31/2015
MMH	American Association of Cardiovascular and Pulmonary Rehabilitation	Cardiac Rehabilitation Accreditation	8/31/2008
RGH	American Association of Cardiovascular and Pulmonary Rehabilitation	Cardiac Rehabilitation Accreditation	8/31/2008
ECHN	American Heart Association	Certificate designation ECHN as a Participating Hospital in "Get with the Guidelines - Stroke" program	N/A
ECHN	American Hospital Association	Membership - Institutional	N/A
ECHN	CT State Medical Society	CME Accreditation	10/5/2016
MMH	Intersocietal Accreditation Commission Echocardiography	Adult Transthoracic Echocardiography Accreditation	7/31/2008
MMH	Town of Manchester Water & Sewer Department	Permit for Discharge of Waste Water Associated with Food Prep Permit# 11132015-0900	10/4/2025
Multiple	CMS	Medicare - **CHOW** CMS Form 855A	N/A
Multiple	CMS	Medicare - **Change of Information** CMS Form 855A or 855B	N/A

Entity	Agency from Which Approval or to Which Notice is Required	Approval / License Type & Number	Expiration Date
Multiple	DSS	Medicaid Provider Agreements	N/A
ECHN	Association for Healthcare Philanthropy	Membership	N/A
MMH	DEEP	Air Quality Permit Registration# 097-0004-GPLPE	4/26/2016
RGH	DEEP	Air Quality Permit Registration# 187-0039-GPLPE	4/26/2011
MMH	DEEP	Certificate of Use for Diagnostic and Therapeutic X-Ray Devices Certificate#?	
RGH	DEEP	Certificate of Use for Diagnostic and Therapeutic X-Ray Devices Certificate#?	
MMH	DEEP	Underground Storage Tank Reg.# 77-1276	N/A
RGH	DEEP	Underground Storage Tank Reg.#146-3014	N/A
MMH	DAS/ Department of Construction Services/ Bureau of Elevators	Elevator Certificate of Operation Elevator #077-0011 Location - 71 Haynes Street (car 2); North Bldg. Center Elev Classification: Passenger	7/13/2016
MMH	DAS/ Department of Construction Services/ Bureau of Elevators	Elevator Certificate of Operation Elevator #077-0012 Location - 71 Haynes Street (car 1); North Bldg. Right Elev Classification: Passenger	7/13/2016

Entity	Agency from Which Approval or to Which Notice is Required	Approval / License Type & Number	Expiration Date
MMH	DAS/ Department of Construction Services/ Bureau of Elevators	Elevator Certificate of Operation Elevator #077-0045 Location - 150 N Main Street Classification: Passenger	7/13/2016
MMH	DAS/ Department of Construction Services/ Bureau of Elevators	Elevator Certificate of Operation Elevator #077-0081 Location - 71 Haynes Street (car 5) Classification: Passenger	7/13/2016
MMH	DAS/ Department of Construction Services/ Bureau of Elevators	Elevator Certificate of Operation Elevator #077-0086 Location - 71 Haynes Street (car 6) Classification: Passenger	7/13/2016
MMH	DAS/ Department of Construction Services/ Bureau of Elevators	Elevator Certificate of Operation Elevator #077-0103 Location - 71 Haynes Street (car A); Decontamination - Clean Classification: Special Freight	7/13/2016
MMH	DAS/ Department of Construction Services/ Bureau of Elevators	Elevator Certificate of Operation Elevator #077-0104 Location - 71 Haynes Street (car B); Decontamination - Dirty Classification: Special Freight	7/13/2016
MMH	DAS/ Department of Construction Services/ Bureau of Elevators	Elevator Certificate of Operation Elevator #077-0105 Location - 71 Haynes Street (car C) Classification: Special Freight	7/13/2016
MMH	DAS/ Department of Construction Services/ Bureau of Elevators	Elevator Certificate of Operation Elevator #077-0108 Location - 71 Haynes Street (car 3) Classification: Dumbwaiter	2/1/2018

Entity	Agency from Which Approval or to Which Notice is Required	Approval / License Type & Number	Expiration Date
MMH	DAS/ Department of Construction Services/ Bureau of Elevators	Elevator Certificate of Operation Elevator #077-0109 Location - 71 Haynes Street (car 3); North Bldg. Service Elev Classification: Passenger	7/13/2016
MMH	DAS/ Department of Construction Services/ Bureau of Elevators	Elevator Certificate of Operation Elevator #077-0117 Location - 71 Haynes Street (car 2); Medical Records Classification: Passenger	7/13/2016
MMH	DAS/ Department of Construction Services/ Bureau of Elevators	Elevator Certificate of Operation Elevator #077-0118 Location - 71 Haynes Street (car 1); Mental Health Elevator Classification: Passenger	7/13/2016
MMH	DAS/ Department of Construction Services/ Bureau of Elevators	Elevator Certificate of Operation Elevator #077-0123 Location - 71 Haynes Street (car 1); West Elev Main Lobby Classification: Passenger	10/25/2017
MMH	DAS/ Department of Construction Services/ Bureau of Elevators	Elevator Certificate of Operation Elevator #077-0129 Location - 71 Haynes Street (car 7) Classification: Passenger	2/25/2018
MMH	DAS/ Department of Construction Services/ Bureau of Elevators	Elevator Certificate of Operation Elevator #077-0152 Location - 36 Haynes Street (car 1); Classification: Passenger	10/4/2017
MMH	DAS/ Department of Construction Services/ Bureau of Elevators	Elevator Certificate of Operation Elevator #077-0189 Location - 71 Haynes Street (car 1); Parking Garage Classification: Passenger	10/2/2017

Entity	Agency from Which Approval or to Which Notice is Required	Approval / License Type & Number	Expiration Date
MMH	DAS/ Department of Construction Services/ Bureau of Elevators	Elevator Certificate of Operation Elevator #077-0200 Location - 71 Haynes Street (car 1); Ambulatory Ctr Lobby Classification: Passenger	4/6/2018
MMH	DAS/ Department of Construction Services/ Bureau of Elevators	Elevator Certificate of Operation Elevator #077-0201 Location - 71 Haynes Street (car 2); Ambulatory Ctr Lobby Classification: Passenger	4/8/2018
MMH	DAS/ Department of Construction Services/ Bureau of Elevators	Elevator Certificate of Operation Elevator #077-0202 Location - 71 Haynes Street (car 3); Ambulatory Center Classification: Passenger	4/8/2018
MMH	DAS/ Department of Construction Services/ Bureau of Elevators	Elevator Certificate of Operation Elevator #077-0231 Location - 320 Main Street (car 1) Classification: Passenger	7/30/2016
RGH	DAS/ Department of Construction Services/ Bureau of Elevators	Elevator Certificate of Operation Elevator #146-0017 Location - 31 Union Street (car 1); Belding BLDG Classification: Passenger	7/25/2016
RGH	DAS/ Department of Construction Services/ Bureau of Elevators	Elevator Certificate of Operation Elevator #146-0020 Location - 31 Union Street (car 3); Maxwell Section-otis Classification: Passenger	7/25/2016
RGH	DAS/ Department of Construction Services/ Bureau of Elevators	Elevator Certificate of Operation Elevator #146-0023 Location - 31 Union Street (car 1); Bissel East otis Classification: Passenger	7/25/2016

Entity	Agency from Which Approval or to Which Notice is Required	Approval / License Type & Number	Expiration Date
RGH	DAS/ Department of Construction Services/ Bureau of Elevators	Elevator Certificate of Operation Elevator #146-0025 Location - 31 Union Street (DW); Pharmacy Classification: Dumbwaiter	2/1/2018
RGH	DAS/ Department of Construction Services/ Bureau of Elevators	Elevator Certificate of Operation Elevator #146-0038 Location - 31 Union Street (car 2); Bissel West otis Classification: Passenger	7/25/2016
RGH	DAS/ Department of Construction Services/ Bureau of Elevators	Elevator Certificate of Operation Elevator #146-0062 Location - 31 Union Street (car 1); Bissel West - meco Classification: Passenger	7/25/2016
RGH	DAS/ Department of Construction Services/ Bureau of Elevators	Elevator Certificate of Operation Elevator #146-0079 Location - 460 Hartford Tpke (car 1); Outpatient Dialysis Center Classification: Passenger	4/20/2018
RGH	DAS/ Department of Construction Services/ Bureau of Elevators	Elevator Certificate of Operation Elevator #146-0083 Location - 31 Union Street (car 4 (4a)); Bissel East -otis Classification: Passenger	7/12/2016
RGH	DAS/ Department of Construction Services/ Bureau of Elevators	Elevator Certificate of Operation Elevator #146-0085 Location - 31 Union Street (car 1); Mason bldg Classification: Passenger	8/22/2017
VNHSC	DAS/ Department of Construction Services/ Bureau of Elevators	Elevator Certificate of Operation Elevator #146-0064 Location - 8 Keynote Drive (car1); Visiting Nurse Comm Ca... Classification: Passenger	3/14/2018

Entity	Agency from Which Approval or to Which Notice is Required	Approval / License Type & Number	Expiration Date
WAT	DAS/ Department of Construction Services/ Bureau of Elevators	Elevator Certificate of Operation Elevator #142-0004 Location - 26 Shenipsit Lake Road (car 1); Tolland County Health Classification: Passenger	11/13/2017
WAT	DAS/ Department of Construction Services/ Bureau of Elevators	Elevator Certificate of Operation Elevator #142-0005 Location - 26 Shenipsit Lake Road (car 2) Classification: Passenger	11/13/2017
ECHN	DAS/ Department of Construction Services/ Bureau of Boilers	Boiler Operating Certificate State Boiler #081461 Type - High Pressure/ Firetube	12/16/2016 (Date of Next Inspection)
ECHN	DAS/ Department of Construction Services/ Bureau of Boilers	Boiler Operating Certificate State Boiler #081462 Type - High Pressure/ Firetube	12/16/2016 (Date of Next Inspection)
ECHN	DAS/ Department of Construction Services/ Bureau of Boilers	Boiler Operating Certificate State Boiler #081463 Type - Low Pressure/ Water Tube Boiler	12/16/2016 (Date of Next Inspection)
ECHN	DAS/ Department of Construction Services/ Bureau of Boilers	Boiler Operating Certificate State Boiler #089683 Type - Low Pressure/ Cast Iron	12/15/2017 (Date of Next Inspection)
ECHN	DAS/ Department of Construction Services/ Bureau of Boilers	Boiler Operating Certificate State Boiler #089684 Type - Low Pressure/ Cast Iron	12/15/2017 (Date of Next Inspection)
MMH	DAS/ Department of Construction Services/ Bureau of Boilers	Boiler Operating Certificate State Boiler #105775 Type - High Pressure/ Firetube Boiler	9/17/2016 (Date of Next Inspection)

Entity	Agency from Which Approval or to Which Notice is Required	Approval / License Type & Number	Expiration Date
MMH	DAS/ Department of Construction Services/ Bureau of Boilers	Boiler Operating Certificate State Boiler #105776 Type - High Pressure/ Firetube Boiler	9/15/2016 (Date of Next Inspection)
MMH	DAS/ Department of Construction Services/ Bureau of Boilers	Boiler Operating Certificate State Boiler #105777 Type - High Pressure/ Firetube Boiler	11/19/2016 (Date of Next Inspection)
MMH	DAS/ Department of Construction Services/ Bureau of Boilers	Boiler Operating Certificate State Boiler #105778 Type - High Pressure/ Firetube Boiler	11/19/2016 (Date of Next Inspection)
RGH	DAS/ Department of Construction Services/ Bureau of Boilers	Boiler Operating Certificate State Boiler #018505 Type - High Pressure/ Firetube Boiler	10/16/2016 (Date of Next Inspection)
RGH	DAS/ Department of Construction Services/ Bureau of Boilers	Boiler Operating Certificate State Boiler #095961 Type - High Pressure/ Firetube Boiler	10/9/2016 (Date of Next Inspection)
VNHSC	DAS/ Department of Construction Services/ Bureau of Boilers	Boiler Operating Certificate State Boiler #063277 Type -- Low Pressure/Firetube Boiler	6/12/2018 (Date of Next Inspection)
WAT	DAS/ Department of Construction Services/ Bureau of Boilers	Boiler Operating Certificate State Boiler #076980 Type - Low Pressure/ Booster Water Heater	4/4/2017 (Date of Next Inspection)
WAT	DAS/ Department of Construction Services/ Bureau of Boilers	Boiler Operating Certificate State Boiler #076981 Type - Low Pressure/ Steam Cooker	3/13/2017 (Date of Next Inspection)
WAT	DAS/ Department of Construction Services/ Bureau of Boilers	Boiler Operating Certificate State Boiler #099908 Type - Low Pressure/ Cast Iron Boiler	3/26/2017 (Date of Next Inspection)
WAT	DAS/ Department of Construction Services/ Bureau of Boilers	Boiler Operating Certificate State Boiler #099975 Type - Low Pressure/ Cast Iron Boiler	3/3/2017 (Date of Next Inspection)

Entity	Agency from Which Approval or to Which Notice is Required	Approval / License Type & Number	Expiration Date
WAT	DAS/ Department of Construction Services/ Bureau of Boilers	Boiler Operating Certificate State Boiler #104184 Type - Low Pressure/Water Tube Boiler	4/5/2017 (Date of Next Inspection)
WAT	DAS/ Department of Construction Services/ Bureau of Boilers	Boiler Operating Certificate State Boiler #104185 Type - Low Pressure/Water Tube Boiler	4/5/2017 (Date of Next Inspection)

Schedule 2.01(h)

Intellectual Properties

Copyrights

Copyright Title	Registration No./Date	Owner
Healthy choices	TX0002992408 – February 2, 1991	Rockville General Hospital
Rockville General Hospital ESRD Unit patient classification/authors, Denise Kessler, Dianne Kessler	TXu000435332 – May 17, 1990	Rockville General Hospital
Renal rehabilitation program	TXu000736487 – March 25, 1996	Rockville General Hospital
Eastern Connecticut Health Network Patient Education Joint Camp (Power Point Presentation)	TX0007272289 – July 3, 2008	Eastern Connecticut Health Network
Eastern Connecticut Health Network Total Joint Replacement Handbook	TX0007172601 – July 3, 2008	Eastern Connecticut Health Network

Trademarks

TRADEMARK	OWNER	APPLICATION/ REGISTRATION NO. STATE/FEDERAL	GOODS/SERVICES	STATUS
A CARING HAND LLC and Design 	Eastern Connecticut Health Network, Inc.	0039463944 Connecticut	Class 42 – Referral services for in-home and onsite facility care providers; providing non-medical in-home and onsite facility personal care services for individuals, namely, assistance with daily living activities, personal hygiene, housekeeping, meal preparations, scheduling appointments, running errands, transportation, and companionship services.	Registered: May 29, 2014 Renewal Due: May 29, 2019
BETTER BEING	Eastern Connecticut Health Network, Inc.	23455 Connecticut	International Class 16 - Publications, namely, magazines in the fields of health, nutrition and wellness.	Registered: August 14, 2009 Renewal due August 14, 2019
BETTER BEING	Eastern Connecticut Health Network, Inc.	3,766,988 USPTO	International Class 16 - Publications, namely, magazines in the fields of health, nutrition and wellness.	Registered: March 30, 2010 Renewal due March 30, 2020

TRADEMARK	OWNER	APPLICATION/ REGISTRATION NO. STATE/FEDERAL	GOODS/SERVICES	STATUS
BUCKLAND IMAGING and Design 	Eastern Connecticut Health Network, Inc.	0039463941 Connecticut	Class 42 – Medical imaging services.	Registered: May 29, 2014 Renewal Due: May 29, 2019

TRADEMARK	OWNER	APPLICATION/ REGISTRATION NO. STATE/FEDERAL	GOODS/SERVICES	STATUS
BUSINESS ALLIANCE FOR COMMUNITY HEALTH and Design 	Eastern Connecticut Health Network, Inc.	4,028,210 USPTO	International Class 41 – Education services, namely, providing presentation and lectures in the field of healthcare, safety and wellness to members. International Class 45 – Providing social networking services in the fields of healthcare, safety and wellness.	Registered: September 20, 2011 Sections 8 & 15 due between September 20, 2016 and September 20, 2017
CARING NEVER CHANGES	Eastern Connecticut Health Network, Inc.	4,591,953 USPTO	International Class 44 – Medical and healthcare services, namely, providing medical services; urgent medical care centers; providing medical information, consultancy advisory, and treatment services; providing medical testing for diagnostic or treatment purposes; providing integrated healthcare services with a network of healthcare providers.	Registered: August 26, 2014 Sections 8 & 15 due between August 26, 2019 and August 26, 2020

TRADEMARK	OWNER	APPLICATION/ REGISTRATION NO. STATE/FEDERAL	GOODS/SERVICES	STATUS
CORPCARE OCCUPATIONAL HEALTH	Eastern Connecticut Health Network, Inc.	21110 Connecticut	International Class 42 – Employee health care program consisting of on-the-job injury care, pre-placement physical examinations.	Registered: December 7, 2000 Renewal due December 7, 2020
CORPCARE OCCUPATIONAL HEALTH	Eastern Connecticut Health Network, Inc.	3,950,366 USPTO	International Class 44 – Health care featuring on-the-job injury care, pre-placement physical examinations, physical therapy, OSHA required and Federal Department of Transportation examinations, injury management tracking, employee assistance, wellness programs, work-site health evaluation and on-site physical and nursing services.	Registered: April 26, 2011 Sections 8 & 15 due between April 26, 2016 and April 26, 2017
ECHN	Eastern Connecticut Health Network, Inc.	21285 Connecticut	International Class 42 – Community-based health care system.	Registered: July 20, 2011 Renewal due July 30, 2016

TRADEMARK	OWNER	APPLICATION/ REGISTRATION NO. STATE/FEDERAL	GOODS/SERVICES	STATUS
ECHN	Eastern Connecticut Health Network, Inc.	3,969,396 USPTO	International Class 42 - Providing health care and hospital services through a network of comprehensive health care providers.	Registered: May 31, 2011 Sections 8 & 15 due between May 31, 2016 and May 31, 2017
ECHN BREAST CARE COLLABORATIVE and Design 	Eastern Connecticut Health Network, Inc.	4,587,810 USPTO	International Class 41 – Educational services, namely, providing classes pertaining to treatment for diseases; providing a website featuring non-downloadable instructional videos in the field of treatment for diseases. International Class 44 – Medical and healthcare services, namely, medical screenings, testing, and diagnostic services.	Registered: August 19, 2014 Sections 8 & 15 due between August 19, 2019 and August 19, 2020

TRADEMARK	OWNER	APPLICATION/ REGISTRATION NO. STATE/FEDERAL	GOODS/SERVICES	STATUS
ECHNCORPCARE OCCUPATIONAL HEALTH and Design 	Eastern Connecticut Health Network, Inc.	4,680,979 USPTO	International Class 44 – Providing physician services; drug and alcohol testing services for substance abuse; medical diagnostic testing, monitoring and reporting services; healthcare services, namely, wellness programs, physical therapy services, and physical rehabilitation patient care services.	Registered: February 3, 2015 Sections 8 & 15 due between February 3, 2020 and February 3, 2021

TRADEMARK	OWNER	APPLICATION/ REGISTRATION NO. STATE/FEDERAL	GOODS/SERVICES	STATUS
ECHN EASTERN CONNECTICUT CANCER INSTITUTE and Design 	Eastern Connecticut Health Network, Inc.	4,050,028 USPTO	International Class 44 - Providing medical information on medical diagnosis, treatments and screening for cancer; providing medical services in the nature of treatment, diagnosis and screening for cancer.	Registered: November 1, 2011 Sections 8 & 15 due between November 1, 2016 and November 1, 2017
ECHN EASTERN CONNECTICUT FAMILY MEDICINE RESIDENCY PROGRAM AT MANCHESTER MEMORIAL HOSPITAL and Design 	Eastern Connecticut Health Network, Inc.	4,683,996 USPTO	International Class 41 – Educational services, namely, providing residency programs, internships, clinics, and providing courses of instruction at the graduate level for master degree programs in the field of healthcare, medicine, and hospital services; teaching in the field of healthcare, medicine and hospital services.	Registered: February 10, 2015 Sections 8 & 15 due between February 10, 2020 and February 10, 2021

TRADEMARK	OWNER	APPLICATION/ REGISTRATION NO. STATE/FEDERAL	GOODS/SERVICES	STATUS
ECHN EASTERN CONNECTICUT HEALTH NETWORK HEALTHIER TOGETHER. and Design 	Eastern Connecticut Health Network, Inc.	4,680,978 USPTO	International Class 42 – Providing health care and hospital services through a network of comprehensive health care providers.	Registered: February 3, 2015 Sections 8 & 15 due between February 3, 2020 and February 3, 2021
ECHN JOINT EFFORT and Design 	Eastern Connecticut Health Network, Inc.	4,691,146 USPTO	International Class 41 – Educational services, namely, providing workshops, presentations, and lectures in the field of joint replacement surgery, healthcare and wellness.	Registered: January 24, 2015 Sections 8 & 15 due between February 24, 2020 and February 24, 2021
ECHN EASTERN CONNECTICUT MEDICAL PROFESSIONALS and Design 	Eastern Connecticut Health Network, Inc.	4,677,852 USPTO	International Class 44 – Providing healthcare and hospital services; physician services.	Registered: January 27, 2015 Sections 8 & 15 due between January 27, 2020 and January 27, 2021

TRADEMARK	OWNER	APPLICATION/ REGISTRATION NO. STATE/FEDERAL	GOODS/SERVICES	STATUS
ECHN SBM CHARITABLE FOUNDATION FAMILY BIRTHING CENTER AT MANCHESTER MEMORIAL HOSPITAL and Design ECHN SBM Charitable Foundation Family Birthing Center at Manchester Memorial Hospital	Eastern Connecticut Health Network, Inc.	4,684,006 USPTO	International Class 16 – Printed materials in the nature of brochures and booklets in the field of childbirth, infant and child care and wellness, and parenting. International Class 41 – Educational services, namely, providing classes, workshops, presentations, and lectures in the field of childbirth, infant and child care and wellness, and parenting. International Class 44 – Medical services; doulas services for birth and postpartum, namely, experienced labor companion who provides families both emotional and physical support throughout the entire labor and delivery; birthing center services; home healthcare services.	Registered: February 10, 2015 Sections 8 & 15 due between February 10, 2020 and February 10, 2021

TRADEMARK	OWNER	APPLICATION/ REGISTRATION NO. STATE/FEDERAL	GOODS/SERVICES	STATUS
ECHN URGENT CARE and Design 	Eastern Connecticut Health Network, Inc.	4,587,809 USPTO	International Class 44 – Medical and healthcare services, namely, providing medical services; urgent medical care centers; providing medical information, consultancy advisory, and treatment services; providing medical testing for diagnostic or treatment purposes.	Registered: August 19, 2014 Sections 8 & 15 due between August 19, 2019 and August 19, 2020
ECHN WOMEN'S CENTER FOR WELLNESS and Design 	Eastern Connecticut Health Network, Inc.	4,587,808 USPTO	International Class 41 – Educational services, namely, offering classes providing a website featuring non-downloadable instructional videos in the field of health and wellness; providing online newsletters in the field of health and wellness. International Class 44 – Medical and healthcare services, namely, medical screening, testing, and diagnostic services; alternative medical services; wellness programs.	Registered: August 19, 2014 Sections 8 & 15 due between August 19, 2019 and August 19, 2020

TRADEMARK	OWNER	APPLICATION/ REGISTRATION NO. STATE/FEDERAL	GOODS/SERVICES	STATUS
ECHN WOODLAKE AT TOLLAND and Design 	Eastern Connecticut Health Network, Inc.	0039463943 Connecticut	Class 42 – Medical services, nursing home care.	Registered: May 29, 2014 Renewal Due: May 29, 2019
EASTERN CONNECTICUT HEALTH NETWORK	Eastern Connecticut Health Network, Inc.	3,950,350 USPTO	International Class 44 - Providing health care and hospital services through a network of comprehensive health care providers.	Registered: April 26, 2011 Sections 8 & 15 due between April 26, 2016 and April 26, 2017
EVERGREEN IMAGING and Design  EVERGREENIMAGING	Eastern Connecticut Health Network, Inc.	0039463942 Connecticut	Class 42 – Medical imaging services.	Registered: May 29, 2014 Renewal Due: May 29, 2019
THE COMMUNITIES' CHOICE	Eastern Connecticut Health Network, Inc.	3,950,349 USPTO	International Class 44 - Providing health care and hospital services through a network of comprehensive health care providers.	Registered: April 26, 2011 Sections 8 & 15 due between April 26, 2016 and April 26, 2017

TRADEMARK	OWNER	APPLICATION/ REGISTRATION NO. STATE/FEDERAL	GOODS/SERVICES	STATUS
TREE OF CARING	Eastern Connecticut Health Network, Inc.	22264 Connecticut	International Class 36 – Fund raising services.	Registered: January 28, 2005 Renewal due January 28, 2020

Domain Names

Domain Name
echn.org
ECPHO.org
vnhsc.org
acaringhand.com
evergreenendoscopy.com
tollandimaging.com
tollandimaging.org

Common Law Trademarks

The Manchester Memorial Hospital

CorpCare Occupational Medicine

ECHN Family Development Center

SBM Charitable Foundation Family Birthing Center

John A. DeQuattro Cancer Center

ECHN Diagnostics Blood Draw Center

ECHN Diagnostics Laboratory

Center For Wound Healing

Glastonbury Diagnostics (Imaging)

ECHN Medical Imaging

Manchester Hospital Physical Therapy

Evergreen Walk Physical Therapy

Glastonbury Wellness Center Physical Therapy

ECHN Center for Weight Loss

The Rockville General Hospital Incorporated

ECHN Urgent Care

Evergreen Imaging Center

Women's Center for Wellness

Breast Care Collaborative

ECHN – Walden Eating Disorders Center

Rockville Hospital Physical Therapy

Big Sky Fitness ECHN Physical Therapy

Ellington Y – ECHN Physical Therapy

ECHN Eldercare Services

Woodlake at Tolland Rehabilitation & Nursing Center

Visiting Nurse and Health Services of Connecticut

Lifeline

A Caring Hand

Eastern Connecticut Medical Professionals Foundation

ECHN Corporate Servcies

Medical Practice Partners

Haynes Street Property Management

ECHN

Eastern Connecticut Health Network

ECHN Eastern Connecticut Cancer Institute

ECHN Enterprises

Schedule 2.02(j)

Excluded Contracts

[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]

Schedule 2.02(l)

Excluded Corporate or Trade Names

ECHN Community Healthcare Foundation, Inc.

Legacy ECHN, Inc.

Legacy MMH, Inc.

Legacy RGH, Inc.

Legacy ECMPF, Inc.

Legacy Corporate Services, Inc.

Legacy Enterprises, Inc.

Legacy ACH, LLC

Schedule 2.02(n)

ECHN Community Healthcare Foundation Assets and Properties

All assets and properties of the ECHN Community Healthcare Foundation, Inc. are excluded from the sale. Below is a balance sheet for the ECHN Community Healthcare Foundation, Inc. as of April 30, 2016. Please note that all assets listed below other than those assets marked as "permanently restricted" are available to Seller to satisfy liabilities at and after the Closing.

ASSETS	**ECHN Community Healthcare Foundation, Inc.**
CURRENT ASSETS:	
Cash and cash equivalents	$ 1,117,459
Due from affiliated entities	-
Prepaid expenses	7,486
Pledges Receivable	38,731
Total current assets	1,163,676
ASSETS WHOSE USE IS LIMITED:	
Donor restricted investments	1,873,644
Board designated investments	15,408,530
Total assets whose use is limited, net of current portion	17,282,174
TOTAL ASSETS	**$ 18,445,850**
LIABILITIES, EQUITY AND NET ASSETS	
CURRENT LIABILITIES:	
Accounts payable and accrued expenses	$ 17,554
Due to affiliated entities	192,532
Total current liabilities	210,086
OTHER LIABILITIES:	
Charitable Gift Annuity (expected future payments)	2,589
Total long-term liabilities	2,589
Total liabilities	212,675
TOTAL NET ASSETS "	**$ 18,233,175**
* NET ASSETS:	
Unrestricted	-
Temporarily restricted	16,665,863
Permanently restricted	1,567,312

Total net assets	$ 18,233,175

Schedule 2.02(p)

Claims of Seller against Third Parties

1. Any payments due from third-party payors and Government Payment Programs that relate to the payment of claims pertaining to periods ending on or before the Closing Date to the extent such payments are not included in the calculation of Net Working Capital, such as in the case in which a claim was underpaid by a third-party payor or Government Payment Program. To the extent that any monies in respect of such claims are paid to Buyer, Buyer shall remit such monies to Seller pursuant to the procedure described in Section 10.15 of the Agreement for payment of funds in respect of the Excluded Assets.

Schedule 2.02(q)

Other Excluded Assets

Eastern Connecticut Health Network, Inc.'s ownership interest in the Eastern Connecticut Physician Hospital Organization, Inc.

Schedule 2.03

Assumed Liabilities

Please note that these scheduled liabilities are in addition to those included in the definition of Assumed Liabilities in Section 1.01(12) of the Asset Purchase Agreement.

Workers' Compensation Liability

Eastern Connecticut Health Network, Inc. Pension Plan (most recently amended as of December 23, 2015 and as it may be amended to reflect Buyer's assumption of sponsorship)

All liabilities pertaining to Seller's 2016 health care and dependent care flexible spending account arrangements established pursuant to Sections 125 and 129 of the Code

Schedule 2.05

Examples of Implementation of Section 2.05

REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]

Schedule 2.05(a)

Joint Venture Valuations

[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]

Schedule 3.02

Consents

[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]

Schedule 3.04

Subsidiaries and Third Party Rights

[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]

Schedule 3.05

Legal and Regulatory Compliance

[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]

Schedule 3.06

Audited and Unaudited Financial Statements

Eastern Connecticut Health Network, Inc. and Subsidiaries Consolidated Financial Statements, September 30, 2015 and 2014 (attached hereto)

Eastern Connecticut Health Network, Inc. and Subsidiaries Independent Auditors Report, Consolidated Financial Statements and Supplemental Information As of and for the Years Ended September 30, 2014 and 2013 (attached hereto)

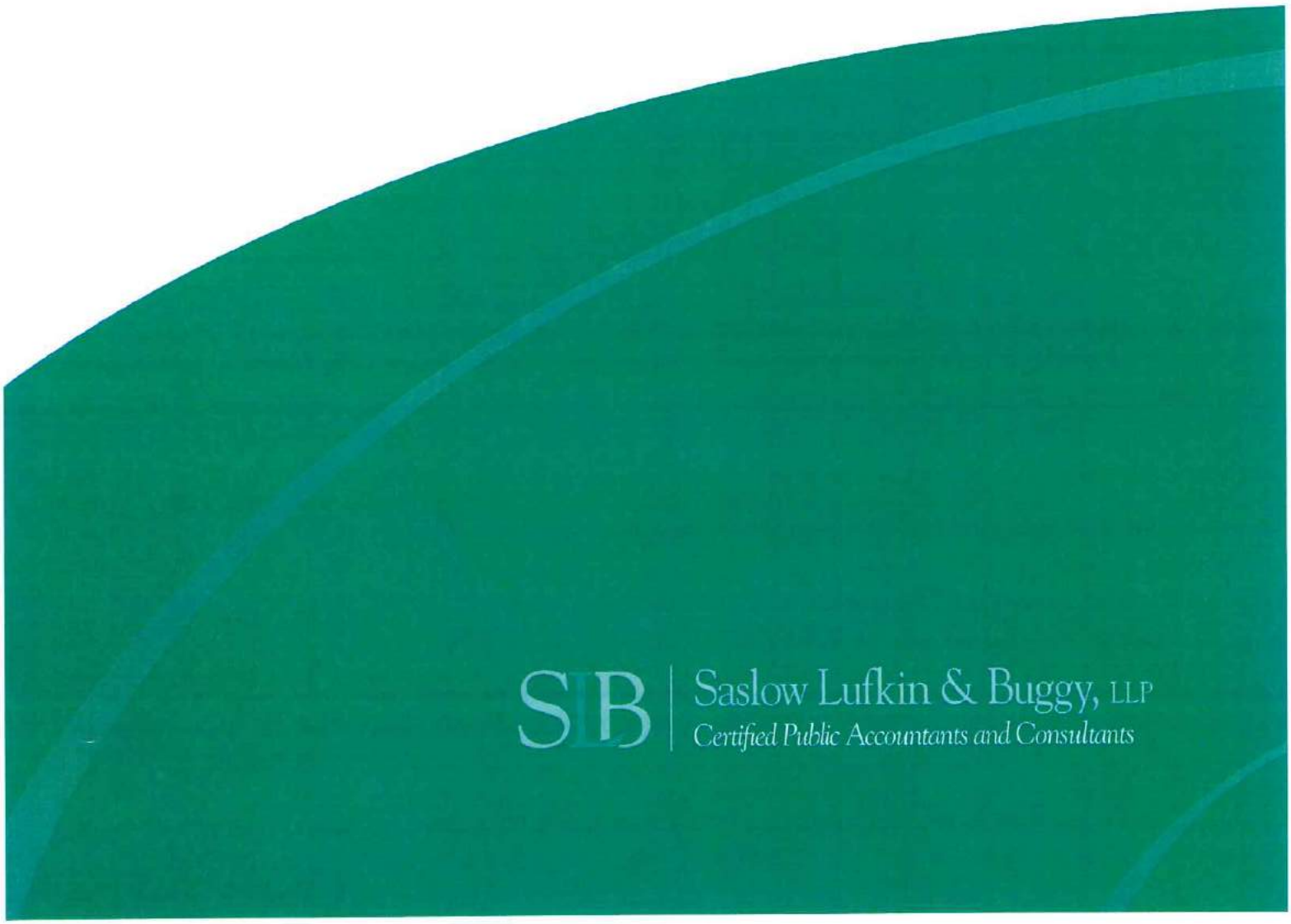
Eastern Connecticut Health Network, Inc. and Subsidiaries Independent Auditors' Report, Consolidated Financial Statements and Supplemental Information As of and for the Years Ended September 30, 2013 and 2012 (attached hereto)

[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]

Eastern Connecticut Health Network, Inc. and Subsidiaries

Independent Auditors' Report,
Consolidated Financial Statements and
Supplemental Information

As of and for the Years Ended
September 30, 2013 and 2012



Eastern Connecticut Health Network, Inc. and Subsidiaries
Independent Auditors' Report, Consolidated Financial Statements and Supplemental Information
As of and for the Years Ended September 30, 2013 and 2012

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Supplemental Information:
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SLB | Saslow Lufkin & Buggy, LLP
Certified Public Accountants and Consultants

Independent Auditors' Report

To the Board of Trustees of
Eastern Connecticut Health Network, Inc. and Subsidiaries:

We have audited the accompanying consolidated financial statements of Eastern Connecticut Health Network, Inc. and Subsidiaries (the Network), a not-for-profit, non-stock corporation, which comprise the consolidated balance sheets as of September 30, 2013 and 2012 and the related consolidated statements of operations and changes in net assets and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

The Network's management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We did not audit the financial statements of Connecticut Healthcare Insurance Company, a wholly owned subsidiary, whose statements reflect total assets of $5,220,598 and $10,802,509, as of September 30, 2013 and 2012, respectively, and total revenues of $2,440,340 and $2,299,700, respectively, for the years then ended. These statements were audited by other auditors whose report has been furnished to us and our opinion, insofar as it relates to the amounts included for Connecticut Healthcare Insurance Company, is based solely on the report of the other auditors. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Network's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Network's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting principles used and the reasonableness of significant account estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, based on our audits and the report of the other auditors, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of Eastern Connecticut Health Network, Inc. and Subsidiaries as of September 30, 2013 and 2012, and the results of its consolidated operations and its consolidated cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

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Avon, Connecticut 06001
Phone 860.678.9200

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40 Main Street, Suite 300
Burlington, Vermont 05401
Phone 802.865.9300

Change in Accounting Principle

As discussed in Note 2 to the financial statements, the Network has elected to change its method of accounting for its defined benefit pension plan costs in 2013. Such changes are reflected in the accompanying September 30, 2013 and 2012 statements of operations and changes in net assets and cash flows for the years then ended. Our opinion was not modified with respect to this matter.

Report on Supplementary Information

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The consolidating information listed within the Table of Contents is presented for purposes of additional analysis of the consolidated financial statements rather than to present the financial position, results of operations and changes in net assets of the individual entities and is not a required part of the consolidated financial statements. Accordingly, we do not express an opinion on the financial position, results of operations and cash flows of the individual companies. The consolidating information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. Such information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the consolidating information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Saslow Lufkin & Buggy, LLP

December 17, 2013

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidated Balance Sheets
For the Years Ended September 30, 2013 and 2012

	2013	2012
Assets		
Current assets:		
Cash and cash equivalents	$ 22,439,356	$ 20,052,067
Current portion of investments held under bond indentures	1,850,531	5,435,445
Accounts receivable, less allowance for bad debts of $10,060,009 in 2013 and $10,509,985 in 2012	46,524,143	46,711,255
Inventory	5,065,716	4,253,600
Current portion of estimated settlements due from third-party payers	3,463,096	4,402,920
Prepaid expenses and other current assets	5,046,865	5,020,607
Total current assets	84,389,707	85,875,894
Assets whose use is limited, net of current portion:		
Donor restricted investments	6,534,923	6,971,970
Board designated investments	33,138,323	26,269,872
Investments held in trust for estimated self-insurance liabilities	2,465,931	8,844,698
Beneficial interest in trust assets	7,882,372	7,400,782
Investments held under bond indentures	4,942,057	4,941,820
Total assets whose use is limited, net of current portion	54,963,606	54,429,142
Investments	13,009,540	21,510,816
Investments in joint ventures	13,731,843	13,500,324
Property, plant and equipment - net	96,188,497	96,295,455
Other assets:		
Estimated settlements due from third-party payers, net of current portion	6,804,542	-
Goodwill and intangible assets, net	7,145,869	6,463,106
Other assets	6,233,132	5,215,388
Total other assets	20,183,543	11,678,494
Total assets	$ 282,466,736	$ 283,290,125
Liabilities and Net Assets		
Current liabilities:		
Accounts payable and accrued expenses	$ 34,874,835	$ 30,730,676
Line of credit	6,500,000	6,500,000
Current portion of long-term debt and capital lease obligations	6,832,322	6,904,354
Current portion of estimated settlements due to third-party payers	4,512,361	2,793,775
Current portion of accrued pension and other postretirement benefits	6,085,518	3,897,164
Other current liabilities	5,540,481	8,153,373
Total current liabilities	64,345,517	58,979,342
Long-term debt and capital lease obligations, net of current portion	84,416,006	87,541,749
Estimated self-insurance liabilities	9,024,493	9,521,697
Accrued pension and other postretirement benefits	38,111,463	74,618,608
Estimated settlements due to third-party payers, net of current portion	122,921	82,500
Other liabilities	597,187	944,968
Total liabilities	196,617,587	231,688,864
Net assets:		
Unrestricted	70,965,928	36,549,384
Temporarily restricted	2,587,301	3,243,522
Permanently restricted	12,295,920	11,808,355
Total net assets	85,849,149	51,601,261
Total liabilities and net assets	$ 282,466,736	$ 283,290,125

The accompanying notes are an integral part of these consolidated financial statements.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidated Statements of Operations and Changes in Net Assets
For the Years Ended September 30, 2013 and 2012

	2013	2012
Revenues:		
Net patient service revenues	$ 310,122,159	$ 277,042,997
Provision for bad debts	(11,142,202)	(11,285,210)
Net patient service revenues less provision for bad debts	298,979,957	265,757,787
Contributions	1,614,319	2,243,112
Other revenues	22,871,370	17,532,328
EHR incentive payment revenue	2,630,820	3,833,172
Contribution of VNHSC	-	4,592,459
Net assets released from restrictions used for operations	1,871,227	638,113
Total revenues	327,967,693	294,596,971
Expenses:		
Salaries and wages	163,729,402	139,915,729
Fringe benefits	47,592,094	40,920,325
Supplies and other expenses	100,335,115	93,818,377
Depreciation and amortization	12,290,822	11,811,633
Interest and financing costs	3,907,765	3,981,831
Total expenses	327,855,198	290,447,895
Income from operations	112,495	4,149,076
Non-operating losses	(2,138,589)	(1,200,536)
Excess of revenues (under) over expenses	$ (2,026,094)	$ 2,948,540

The accompanying notes are an integral part of these consolidated financial statements.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidated Statements of Operations and Changes in Net Assets (continued)
For the Years Ended September 30, 2013 and 2012

	2013	2012
Unrestricted net assets:		
Excess of revenues (under) over expenses	$ (2,026,094)	$ 2,948,540
Change in unrealized appreciation on investments	1,235,494	7,974,260
Net change in interest rate swap agreements	110,862	(123,039)
Net assets released from restrictions for capital acquisitions	468,174	336,077
Pension and postretirement related adjustments	34,634,083	(16,402,410)
Other	(5,975)	-
Change in unrestricted net assets	34,416,544	(5,266,572)
Temporarily restricted net assets:		
Contributions	1,262,993	1,327,278
Investment income	200,796	37,322
Net assets released from restrictions used for operations	(1,871,227)	(638,113)
Net assets released from restrictions for capital acquisitions	(468,174)	(336,077)
Contribution of VNHSC	-	72,586
Change in unrealized appreciation on investments	219,391	530,563
Change in temporarily restricted net assets	(656,221)	993,559
Permanently restricted net assets:		
Change in beneficial interest in trust assets	481,590	712,617
Other	5,975	-
Change in permanently restricted net assets	487,565	712,617
Change in net assets	34,247,888	(3,560,396)
Net assets, beginning of year	51,601,261	55,161,657
Net assets, end of year	$ 85,849,149	$ 51,601,261

The accompanying notes are an integral part of these consolidated financial statements.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidated Statements of Cash Flows
For the Years Ended September 30, 2013 and 2012

	2013	2012
Cash flows from operating activities:		
Change in net assets	$ 34,247,888	$ (3,560,396)
Adjustments to reconcile change in net assets to net cash (used in) provided by operating activities:		
Depreciation and amortization	12,290,822	11,811,633
Contribution of VNHSC	-	(4,665,045)
Provision for bad debts	11,142,202	11,285,210
Change in unrealized appreciation on investments	(1,454,885)	(8,504,823)
Change in unrealized appreciation on joint venture	-	(343,398)
Realized gains on sales of investments	(5,584,750)	-
Change in beneficial interest in trust assets	(481,590)	(712,617)
Income on investments in joint ventures	(2,113,663)	(2,588,091)
Pension and postretirement related adjustments	(34,634,083)	16,402,410
Change in pledges receivable	311,968	(402,218)
Change in interest rate swap agreements	(358,754)	(47,331)
Changes in assets and liabilities:		
Accounts receivable	(10,955,090)	(14,476,440)
Inventory	(812,116)	(25,032)
Prepaid expenses and other current assets	(26,258)	(112,771)
Amortization of intangible assets	(682,763)	(903)
Other assets	(1,310,364)	880,133
Accounts payable and accrued expenses	4,144,159	5,564,691
Accrued pension and other postretirement benefits	315,292	(5,988,289)
Estimated settlements (to)/from third-party payers	(4,105,711)	(452,979)
Other current liabilities	(509,424)	1,522,469
Estimated self-insurance liabilities	(2,600,672)	3,210,359
Other liabilities	10,973	141,087
Net cash (used in) provided by operating activities	(3,166,819)	8,937,659
Cash flows from investing activities:		
Purchases of property and equipment	(12,104,527)	(7,498,197)
Sales (purchases) of investments, net	19,072,951	(3,244,502)
Investment in joint ventures	-	(244,600)
Acquisition of Evergreen Imaging Center	-	(1,450,000)
Cash received from contribution of VNHSC	-	2,917,808
Distributions from joint ventures	1,802,805	1,654,409
Net cash provided by (used in) investing activities	8,771,229	(7,865,082)
Cash flows from financing activities:		
Principal payments on long-term debt	(7,079,140)	(5,217,439)
Net payments on line of credit	-	(1,772,642)
Payments for bond issuance costs	(19,346)	(154,649)
Proceeds from borrowings	3,881,365	5,133,040
Net cash used in financing activities	(3,217,121)	(2,011,690)
Change in cash and cash equivalents	2,387,289	(939,113)
Cash and cash equivalents at beginning of year	20,052,067	20,991,180
Cash and cash equivalents at end of year	$ 22,439,356	$ 20,052,067
Cash paid for interest	$ 4,095,398	$ 4,240,359
Equipment acquisitions under capital lease arrangements	$ 2,351,850	$ 1,742,149

The accompanying notes are an integral part of these consolidated financial statements.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Notes to the Consolidated Financial Statements
As of and for the Years Ended September 30, 2013 and 2012

Note 1 - Organization

Eastern Connecticut Health Network, Inc. (ECHN) and Subsidiaries (collectively the Network) is a not-for-profit, locally governed health system created on September 12, 1995, through the merger of the corporate parents of Manchester Memorial Hospital and Rockville General Hospital, Inc. Its purpose is to provide a health care system for the communities it serves, with quality medical care at a reasonable cost; to foster an environment conducive to health and well-being, whether in the home or in the community; and to enable the health care system to expand to meet the future needs of its communities. ECHN, through its subsidiaries (or members), provides health care, health education, and community services to residents of more than 19 towns in eastern Connecticut, regardless of their ability to pay.

ECHN is the sole member or shareholder of the following subsidiaries:

The Manchester Memorial Hospital (MMH) - MMH is a not-for-profit hospital with 249 licensed beds, located in Manchester, Connecticut. MMH, which admitted its first patient in 1920, is a short-term, acute-care general hospital, which provides inpatient, outpatient, and emergency care services to the residents of Manchester and 19 nearby towns.

The Rockville General Hospital, Inc. (RGH) - RGH is a not-for-profit hospital with 102 licensed beds, located in the Rockville section of Vernon, Connecticut. RGH, which admitted its first patient in 1921, is a short-term, acute-care general hospital, which provides inpatient, outpatient, and emergency care services for residents of Tolland County and nearby towns, for a total service area of 19 towns.

ECHN ElderCare Services, Inc. (EES) - EES is a not-for-profit, skilled nursing facility with 130 licensed beds and physical, occupational and speech rehabilitation services located in Tolland, Connecticut.

ECHN Community Healthcare Foundation, Inc. (ECHF) - ECHF is a not-for-profit organization whose purpose is to raise funds on behalf of ECHN and its not-for-profit subsidiaries. It was established in 2000, when the fund-raising efforts of ECHN were consolidated into a single not-for-profit foundation. ECHF focuses primarily on the capital and program needs of ECHN and its not-for-profit subsidiaries.

Eastern Connecticut Medical Professionals Foundation, Inc. (ECMPF) - ECMPF is a not-for-profit organization that currently operates physician office practices in the Network's service area and a hospitalist program that serves MMH and RGH. Its mission allows it to operate other not-for-profit, separately incorporated allied health ventures.

ECHN Enterprises, Inc. (Enterprises) - Enterprises is a for-profit organization formed under the laws of the State of Connecticut, with ECHN as the sole shareholder. Enterprises owns, leases and has an interest in real estate to support the mission and vision for ECHN. It is also the parent corporation of Haynes Street Property Management, LLC (HSPM). HSPM is a for-profit, limited liability company formed under the laws of the State of Connecticut, which manages the Glastonbury Wellness Center and sublets space to various MMH departments and physician offices, as well as to ECMPF.

Visiting Nurse and Health Services of Connecticut, Inc. (VNHSC) - VNHSC is a not-for-profit, nonstock Connecticut corporation that provides and administers a comprehensive, multi-disciplinary home health program, hospice program and wellness programs to promote the health of individuals, families and groups in the Greater Northern Central Connecticut area. In addition, VNHSC is the sole member of A Caring Hand, LLC, which is a for-profit Connecticut limited liability company providing and administering homemaker, companion, live-in and personal care assistance services to individuals and families in the Greater Northern Central Connecticut area.

Note 1 - Organization (continued)

Connecticut Healthcare Insurance Company (CHIC) - CHIC, a captive insurance company, provides hospital and physician professional and general liability coverage to MMH, RGH, EES, and all other subsidiaries.

ECHN Corporate Services (ECHNCS) - ECHNCS is a for-profit stock corporation formed under the laws of the State of Connecticut, with ECHN as the sole shareholder. ECHNCS provides billing and other practice management services to the Network and other customers. It is also the parent corporation of Medical Practice Partners, LLC (MPP). MPP is a for-profit, limited liability company formed under the laws of the State of Connecticut, which provides practice management services to medical group practices throughout Connecticut.

ECHN and each of its subsidiaries, except for Enterprises and CHIC, are separate Connecticut not-for-profit corporations, qualified as exempt organizations under Section 501(c)(3) of the Internal Revenue Code (IRC) and governed by separate Boards of Trustees (the Board) - although the membership of the ECHN, MMH and RGH boards are currently identical. ECHN, acting through its Board of Trustees, is the sole member of each of its members. ECHN has various powers with regard to each of its members, which include approving all operating and capital budgets; controlling the investment of funds, location of services, agreements and transactions, and affiliations; controlling changes, amendments, or restatements of certificates of incorporation and bylaws; electing trustees and officers; appointing committees; adopting a system-wide vision and strategic plans; and approving debt borrowings.

In August, the ECHN Board of Trustees announced that it had signed a non-binding letter of intent to negotiate the sale of ECHN to a newly formed joint partnership between Tenet Healthcare Corporation (Tenet) and Yale New Haven Health System (YNHHS). Since signing the letter of intent, ECHN, Tenet and YNHHS have been reviewing the opportunity in greater detail, conducting additional due diligence and negotiating a definitive agreement. A definitive agreement is expected to be reached by sometime in early calendar year 2014.

As of September 30, 2013, management has not finalized a purchase agreement and the Trustees believe that the Network will continue with its normal operations and as a going concern for the foreseeable future.

Note 2 - Summary of Significant Accounting Policies

Basis of Presentation - The accompanying consolidated financial statements have been prepared in conformity with accounting principles generally accepted in the United States of America (GAAP), as promulgated by the Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC). The consolidated financial statements include the accounts of ECHN and its subsidiaries. Significant intercompany accounts and transactions have been eliminated in consolidation. The assets of any member of the consolidated group may not be available to meet the obligations of other members in the group.

Change in Accounting Principle - In 2013, the Network retrospectively changed its method of accounting for pension benefits. The Network has elected to immediately recognize actuarial gains and losses in its operating results in the year in which the gains and losses occur and no longer calculates expected return on plan assets using an averaging technique permitted under GAAP for market-related value of plan assets but instead uses actual fair value of plan assets. The effect of this change was to restate the 2012 consolidated statement of operations and changes in net assets, whereby the pension expense was increased by $778,615 and the accumulated pension liability recognized within net assets was reduced by $778,615. The 2012 excess of revenues over expenses of $3,727,155, as previously reported, was restated to $2,948,540. This change in accounting method had no effect on the 2012 Network's net assets.

Note 2 - Summary of Significant Accounting Policies (continued)

Use of Estimates - The preparation of consolidated financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

The Network's significant estimates relate to the valuation of investments and interest rate swap agreements, allowance for doubtful patient accounts receivable, contractual allowances on patient accounts receivable, self-insurance liabilities, estimated settlements due to and from third parties, conditional asset retirement obligations, postretirement and pension benefit costs and the related obligations.

Cash and Cash Equivalents - The Network considers all highly liquid investments with original maturities of three months or less at date of purchase to be cash equivalents, excluding amounts whose use is limited or restricted by Board designation or other arrangements under trust agreements. Cash equivalents include money market funds. Cash balances maintained at banks are insured by the Federal Deposit Insurance Corporation (FDIC). At times, the Network maintains cash balances that are in excess of the $250,000 insured FDIC limits. The Network maintains its cash at various banks and it is the Network's policy to monitor the banks' financial strength on an ongoing basis.

Money market funds are not insured by the FDIC and are not a risk-free investment. Money market funds invest in a variety of instruments including mortgage-backed and asset-backed securities. Although a money market fund seeks to preserve its $1 per share value, it is possible that a money market fund's value can decrease below $1 per share.

Net Assets - Resources are reported for accounting purposes in separate classes of net assets based on the existence or absence of donor-imposed restrictions. In the accompanying consolidated financial statements, net assets that have similar characteristics have been combined as follows:

> ***Permanently Restricted*** - Net assets subject to explicit donor imposed stipulations that they be maintained by the Network in perpetuity are classified as permanently restricted. Such permanently restricted net assets include endowment funds and MMH's and RGH's share of their beneficial interest in trust assets held by third parties. Generally, the donors of these assets permit the members of ECHN to use all or part of the investment return on these assets for operating purposes.
>
> ***Temporarily Restricted*** - Net assets whose use by the Network is subject to explicit donor imposed stipulations that can be fulfilled upon incurrence of expenditures by the Network pursuant to those stipulations or that expire by the passage of time are classified as temporarily restricted.
>
> ***Unrestricted*** - Net assets that are not subject to explicit donor-imposed stipulations are classified as unrestricted. Unrestricted net assets may be designated for specific purposes by action of the Board or may otherwise be limited by contractual agreements with outside parties; such designated assets are classified as assets whose use is limited in the accompanying consolidated balance sheets.

Note 2 - Summary of Significant Accounting Policies (continued)

Revenues are reported as increases in unrestricted net assets, unless use of the related assets is limited by donor imposed restrictions. Expenses are reported as decreases in unrestricted net assets. Gains and losses on investments and other assets or liabilities are reported as increases or decreases in unrestricted net assets, unless their use is restricted by explicit donor stipulations or by law. Expirations of temporary restrictions on net assets, that is, the donor imposed stipulated purpose has been accomplished and/or the stipulated time period has elapsed, are reported as reclassifications between the applicable classes of net assets.

Contributions, including unconditional promises to give, are recognized as revenues at the date the promise is received. Contributions of assets other than cash are recorded at their estimated fair value. Contributions to be received after one year are discounted at a rate commensurate with the risks involved. Amortization of the discount is included in other revenue. Contributions restricted for the acquisition of land, buildings, and equipment are reported as temporarily restricted support. These contributions are reclassified to unrestricted net assets when the capital asset is acquired or constructed and placed in service.

Assets Whose Use is Limited - Assets whose use is limited primarily include cash and investments held by trustees under indenture agreements, cash and investments held for estimated self-insurance liabilities, Board designated investments, which include endowments, cash and investments set aside by the Board for future capital improvements over which the Board retains control and may at its discretion subsequently use for other purposes; and, beneficial interests in trust assets, which are donor restricted and other restricted investments. Amounts required to meet current liabilities of the Network have been classified as current assets in the consolidated balance sheets as of September 30, 2013 and 2012.

The income earned on restricted funds is generally available for operations of the Network and is recorded as revenue in unrestricted net assets, unless restricted by the donor or to pay future annuity obligations, at which time the income is added to the appropriate restricted net asset balance. However, if a specific gift instrument explicitly requires the permanent reinvestment of appreciation, or a portion thereof, such reinvested amounts are classified within permanently restricted net assets. There were no gifts with reinvestment restrictions for the years ended September 30, 2013 and 2012.

Assets received as donations or bequests are recorded as contributions on the date received at the estimated fair value. The average cost method is used to determine realized gains or losses on sales of marketable equity securities.

Beneficial Interest in Trust Assets - MMH and RGH have been named sole or participating beneficiaries in several perpetual trusts, for which third parties act as the trustee. Under the terms of these trusts, MMH and RGH have the irrevocable right to receive the income earned on the trust assets held in perpetuity. The estimated present value of the future payments to MMH and RGH is recorded at the fair value of the assets held in the trust as beneficial interest in trust assets in the respective balance sheets of MMH and RGH and are permanently restricted as to use.

The income from the trusts is included in the change in interest in net assets of ECHF as unrestricted and temporarily restricted support. Fluctuations in the fair value of the trust assets are recognized as changes in permanently restricted net assets. MMH and RGH record their beneficial interest in trust assets when they are notified of the existence of the trust or when information becomes available to record the fair value of the trust assets.

Investments - The Network's investment portfolio is classified as available for sale, with unrealized gains and losses excluded from excess of revenues over expenses, unless the losses are deemed to be other than temporary. Investments with readily determinable fair values are measured at fair value in the consolidated balance sheets.

Note 2 - Summary of Significant Accounting Policies (continued)

Investment income or loss (including realized gains and losses on investments, interest, and dividends) is included in the excess of revenues over expenses, unless the income or loss is restricted by donor or law.

Other-Than-Temporary Impairments on Investments - The Network accounts for other than temporary impairments in accordance with FASB ASC 320, "*Investments - Debt and Equity Securities*" and continually reviews its securities for impairment conditions, which could indicate that an other than temporary decline in market value has occurred. In conducting this review, numerous factors are considered, which include specific information pertaining to an individual company or a particular industry, general market conditions that reflect prospects for the economy as a whole, and the ability and intent to hold securities until recovery. The carrying value of investments is reduced to its estimated realizable value if a decline in fair value is considered to be other-than-temporary. There were no impairments recorded for the years ended September 30, 2013 and 2012.

Property, Plant and Equipment - Property, plant and equipment are stated at cost or, in the case of donated property, at fair value at the date of the gift, less accumulated depreciation and amortization. Major improvements and betterments to existing plant and equipment are capitalized. Expenditures for maintenance and repairs that do not extend the lives of the applicable assets are charged to expense as incurred. Upon disposition or retirement of property, plant and equipment, the cost and related accumulated depreciation and amortization are eliminated from the respective accounts and any resulting gain or loss is included in the results of consolidated operations.

Depreciation expense is computed on a straight-line basis over the following estimated useful lives:

Buildings	10-40 years
Building improvements	5-40 years
Machinery and equipment	3-15 years
Furniture and fixtures	5-20 years

Equipment under capital leases is amortized utilizing the straight-line method over the shorter of the lease term or the estimated useful life of the equipment. Depreciation and amortization expense was $12,137,690 and $12,058,197 for the years ended September 30, 2013 and 2012, respectively.

Interest cost incurred on borrowed funds during the construction period of capital assets is capitalized as a component of the cost of acquiring those assets.

Physician loan amortization totaling $153,132 and $79,493 for the years ended September 30, 2013 and 2012, respectively, is included within depreciation and amortization in the accompanying consolidated statements of operations and changes in net assets.

Gifts of property and equipment are reported as unrestricted support, and are excluded from the excess of revenues over expenses, unless explicit donor stipulations specify how the donated assets must be used. Gifts of property and equipment with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire property and equipment are reported as restricted support. Absent explicit donor stipulations about how long the property and equipment must be maintained, expirations of donor restrictions are reported as released from restrictions when the donated or acquired property and equipment assets are placed in service.

Note 2 - Summary of Significant Accounting Policies (continued)

Investments in Joint Ventures - The Network has invested in several joint ventures with other area hospitals, which are accounted for under the equity method of accounting. These joint ventures as of September 30, 2013 and 2012 include the Network's investments in the following:

	2013	Ownership Percentage	2012	Ownership Percentage
Northeast Regional Radiation Oncology Network, Inc.	$ 6,216,646	50 %	$ 6,110,316	50 %
Tolland Imaging Center	201,010	70 %	144,789	70 %
Medical Practice Partners, LLC	-	-	41,269	50 %
Metro Wheelchair Service Inc.	54,224	50 %	84,681	50 %
Ambulance Service of Manchester, LLC	3,772,317	50 %	3,675,104	50 %
Aetna Ambulance Service Inc.	1,772,500	50 %	1,562,298	50 %
Evergreen Endoscopy Center, LLC	292,807	50 %	397,153	50 %
Haynes Street Medical Associates	150,193	23 %	146,676	23 %
Haynes Street Medical Associates II	236,834	15 %	252,365	15 %
Evergreen Medical Associates, LLC	258,137	20 %	258,818	20 %
Evergreen Medical Associates II, LLC	559,585	20 %	605,854	20 %
Walden Behavioral Health	197,590	16 %	200,000	16 %
Total joint venture assets	13,711,843		13,479,323	
Other miscellaneous assets	20,000		21,001	
Total investments in joint ventures	$ 13,731,843		$ 13,500,324	

Distributions from these joint ventures totaled $1,802,805 and $1,654,409 for the years ended September 30, 2013 and 2012, respectively. ECHN's share of the earnings of the joint ventures is reported within other revenues and are $2,113,663 and $2,931,489 for the years ended September 30, 2013 and 2012, respectively.

Note 2 - Summary of Significant Accounting Policies (continued)

Summarized financial information from the financial statements of these organizations as of September 30, 2013 and 2012 and for the years then ended, is as follows:

2013	Total Assets	Net Assets	Change in Net Assets	Excess of Revenues (Under) Over Expenses
Northeast Regional Radiation Oncology Network, Inc.	$ 12,490,586	$ 12,433,293	$ 212,661	$ 295,288
Metro Wheelchair Service Inc.	$ 221,853	$ 108,449	$ (60,913)	$ (60,914)
Ambulance Service of Manchester, LLC	$ 8,782,743	$ 7,544,633	$ 194,425	$ 2,494,426
Aetna Ambulance Service Inc.	$ 4,269,492	$ 3,544,999	$ 420,403	$ 420,404
Haynes Street Medical Associates	$ 2,542,951	$ 663,153	$ 23,205	$ 79,920
Haynes Street Medical Associates II	$ 8,435,369	$ 1,569,706	$ (112,714)	$ 181,272
Evergreen Endoscopy Center, LLC	$ 1,746,503	$ 585,614	$ (208,332)	$ 370,077
Evergreen Medical Associates, LLC	$ 6,484,054	$ 1,339,457	$ 45,367	$ 239,569
Evergreen Medical Associates II, LLC	$ 11,906,047	$ 2,929,989	$ (99,281)	$ 394,554
Tolland Imaging Center	$ 934,135	$ 287,155	$ 72,449	$ 650,448
Walden Behavioral Health	$ 1,651,417	$ 1,205,183	$ 53,023	$ (16,006)

2012	Total Assets	Net Assets	Change in Net Assets	Excess of Revenues (Under) Over Expenses
Northeast Regional Radiation Oncology Network, Inc.	$ 12,257,336	$ 12,220,632	$ (24,696)	$ 961,990
Metro Wheelchair Service Inc.	$ 289,879	$ 169,362	$ (143,075)	$ (83,559)
Ambulance Service of Manchester, LLC	$ 8,473,110	$ 7,350,208	$ (438,482)	$ 2,434,208
Aetna Ambulance Service Inc.	$ 3,886,956	$ 3,124,596	$ 222,786	$ 354,322
Haynes Street Medical Associates	$ 2,576,327	$ 639,948	$ 179,777	$ 65,951
Haynes Street Medical Associates II	$ 8,380,885	$ 1,682,420	$ (355,210)	$ 205,180
Evergreen Endoscopy Center, LLC	$ 2,199,308	$ 793,946	$ (396,530)	$ 731,378
Evergreen Medical Associates, LLC	$ 6,698,447	$ 1,294,090	$ (47,090)	$ 140,755
Evergreen Medical Associates II, LLC	$ 11,934,962	$ 3,029,270	$ 40,300	$ 440,655
Tolland Imaging Center	$ 1,258,554	$ 214,706	$ 28,745	$ 100,840
Walden Behavioral Health	$ 1,363,512	$ 1,152,160	$ 1,512,160	$ (203,705)
Medical Practice Partners, LLC	$ 1,569,742	$ 185,290	$ 64,960	$ (127,183)

Note 2 - Summary of Significant Accounting Policies (continued)

Unamortized Bond Issue Costs - Financing costs associated with the issuance of long-term debt are amortized over the term of the bonds using the effective interest method. Amortization is included in interest and financing costs in the accompanying consolidated statements of operations and changes in net assets, and the unamortized carrying value is recorded within other - net in the accompanying consolidated balance sheets.

Intangible Assets - Intangible assets, principally license enhancements and goodwill, are amortized over the life of the respective intangible property. On average, this amortization period for license enhancements and goodwill is 18 and 5 years, respectively. Amortization is included in depreciation and amortization in the accompanying consolidated statements of operations and changes in net assets and the unamortized carrying value is recorded within goodwill and intangible assets - net in the accompanying consolidated balance sheets. Any residual value remaining after the amortization period is considered insignificant.

Deferred Revenue - Deferred revenue represents payments received for services to be rendered in the next fiscal year and is recorded within other current liabilities in the accompanying consolidated balance sheets.

Excess of Revenues (Under) Over Expenses - The consolidated statements of operations and changes in net assets include excess of revenues (under) over expenses. Changes in unrestricted net assets, which are excluded from the excess of revenues (under) over expenses, consistent with industry practice, include the changes in unrealized appreciation (depreciation) on investments; net change in fair value of interest rate swap agreements that qualifies for hedge accounting; net assets released from restrictions used for capital acquisitions; pension and postretirement-related adjustments; and other changes in net assets.

For purposes of display, transactions deemed by management to be ongoing, major or central to providing of health care services are reported as operating revenues and operating expenses. Operating revenues include net patient service revenue, grant income and investment income. Peripheral or incidental transactions are reported as non-operating gains and losses. Non-operating gains and losses include investment income and expenses related to property management, losses recognized on investments representing declines in value considered to be other-than-temporary in nature, changes in the fair values of interest rate swaps that do not qualify for hedge accounting (net interest expense) and the costs associated with pursuing business combinations.

Charity Care - MMH and RGH provide care to patients who meet certain criteria under their charity care policies without charge or at amounts less than its established and contractual rates. The hospitals do not pursue collection of amounts determined to qualify as charity care; as such, these amounts are not reported as revenue.

Net Patient Service Revenues - Net patient service revenues are reported at the estimated net realizable amounts from patients, third-party payers, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payers. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined.

Contracts, laws, and regulations governing Medicare, Medicaid, Blue Cross, and the uncompensated care pool programs are complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. The Network records adjustments in amounts accrued for estimated settlements related to prior years.

A portion of the accrual for estimated settlements with third-party payers has been classified as long-term because such amounts, by their nature or by virtue of regulation or legislation, are not expected to be paid within one year.

Note 2 - Summary of Significant Accounting Policies (continued)

MMH and RGH have agreements with third-party payers that provide for payments at amounts different from their established rates. A summary of the payment agreements with major third-party payers is as follows:

Medicare - Acute care hospitals are subject to a federal prospective payment system for most Medicare inpatient hospital services and for certain outpatient services. Under this prospective payment methodology, Medicare pays a prospectively determined per-discharge or per-visit rate for non-physician services. These rates vary according to the Diagnosis Related Group or Ambulatory Payment Classification of each patient.

Inpatient rehabilitation and mental health services, outpatient services, capital and medical education costs related to Medicare beneficiaries are paid based on a prospective payment system, subject to certain limitations. The Hospital is reimbursed for cost-reimbursement for certain items at a tentative rate, with final settlement determined after submission of annual cost reports and audits thereof by the Medicare fiscal intermediary. Certain other outpatient services are reimbursed according to fee screens.

Medicaid - Inpatient services rendered to Medicaid program beneficiaries are paid at prospectively determined rates per discharge. Outpatient services rendered to Medicaid program beneficiaries are reimbursed under a cost-reimbursement methodology. The hospitals are reimbursed at a tentative rate, with final settlement determined after submission of annual cost reports by the hospitals.

Other Payers - The Network has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment under these agreements includes rates per discharge, discounts from established charges, per diem rates, and fee schedule payments.

Health Care Industry - The health care industry is subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not limited to, matters such as licensure, accreditation, government health care program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by health care providers. Violations of these laws and regulations could result in expulsion from government health care programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed.

Management believes that the Network is in compliance with fraud and abuse regulations, as well as other applicable government laws and regulations. Compliance with such laws and regulations can be subject to further governmental review and interpretation, as well as regulatory actions unknown or unasserted at this time.

EHR Incentive Payment Revenue - The American Recovery and Reinvestment Act of 2009 authorized the Centers for Medicare and Medicaid Services (CMS) to award incentive payments to eligible health care providers who demonstrate Meaningful Use of certified electronic health records (EHR). These incentive programs are designed to support providers in this period of health information technology transition and instill the use of EHRs in meaningful ways to help our nation to improve the quality, safety, and efficiency of patient health care. Total received for Medicare amounted to $2,630,820 and $3,507,760, respectively, and the total received for Medicaid amounted to $0 and $325,412, respectively, for the years ended September 30, 2013 and 2012.

Note 2 - Summary of Significant Accounting Policies (continued)

Future Operations - Current trends in the health care industry include mergers and other forms of affiliations among providers, increasing shifts to managed care, overall reduction in inpatient average length of stay, increasingly restrictive reimbursement policies by governmental and private payers, and the prospect of significant changes in legislation at the state and national level. Management cannot assess or project the ultimate effect of these or other items on the future operations of the Network.

Interest in Net Assets of ECHF - ECHF was formed as a not-for-profit organization to supervise the development activities and engage in investment activities for the benefit of all of the ECHN subsidiaries. ECHN is the sole member of ECHF and the ECHF's Board of Directors is appointed by ECHN. ECHN subsidiaries follow the provisions of FASB ASC 958 *"Not-for-Profit Entities"*. Accordingly, the separate ECHN members record their interest in the net assets of ECHF in their separate financial statements. These amounts have been eliminated in consolidation.

Income Taxes - ECHN and its subsidiaries, except for Enterprises and CHIC, are in compliance with the provisions of Internal Revenue Code (the Code) Sec. 501(c)(3) and are exempt from federal tax under IRC Sec. 501(a). At times, the Network is involved with activities that subject minor amounts of unrelated business federal income tax, which are paid as they come due in accordance with the Code and the regulations there under. Such amounts are insignificant to the Network's consolidated financial statements.

The Network accounts for uncertain tax positions in accordance with provisions of FASB ASC 740, *"Income Taxes"*, which provides a framework for how companies should recognize, measure, present and disclose uncertain tax positions in their consolidated financial statements. The Network may recognize the tax benefit from an uncertain tax position only if it is more likely than not that the tax position will be sustained on examination by the taxing authorities, based on the technical merits of the position. The Network does not have any uncertain tax positions as of September 30, 2013 and 2012. As of September 30, 2013 and 2012, the Network did not record any penalties or interest associated with uncertain tax positions. Generally, the Network's prior three tax years are open and subject to examination by the Internal Revenue Service.

Enterprise and its subsidiaries are for-profit entities subject to federal and state taxes. For these entities, ECHN applies the provisions of FASB ASC 740. The tax provisions, and related tax assets and liabilities, are not material. CHIC has received an undertaking from the Cayman Islands government exempting it from all local income, profits, and capital gains taxes until January 3, 2026. No such taxes are currently levied in the Cayman Islands. Accordingly, no provision for federal income taxes has been recorded in the accompanying consolidated financial statements.

Asset Retirement Obligations - The Network recognizes a liability for the fair value of a conditional asset retirement obligation if the fair value of the liability can be reasonably estimated. Uncertainty about the timing and/or method of settlement of a conditional asset retirement obligation is factored into the measurement of the liability when sufficient information exists. The types of asset retirement obligations that the Network recognizes are those for which the Network has a legal obligation to perform an asset retirement activity, however, the timing and/or method of settling the obligation are conditional on a future event that may or may not be within its control.

The fair value of a liability for the legal obligation associated with an asset retirement is recorded in the period in which the obligation is incurred. When the liability is initially recorded, the cost of the asset retirement is capitalized. As of September 30, 2013 and 2012, the Network has recognized $412,007 and $400,687, respectively, as an obligation to remove asbestos from various buildings upon retirement. This total is included in the consolidated balance sheets within other liabilities.

Note 2 - Summary of Significant Accounting Policies (continued)

Accounting for Defined Benefit Pension and Other Postretirement Plans - The Network recognizes the overfunded or underfunded status of their defined benefit pension and other postretirement benefit plans (collectively, postretirement benefit plans) in the consolidated balance sheets as an asset or liability. The Network recognizes changes in the funded status of the plans in the year in which the changes occur as an operating expense and as a change in unrestricted net assets presented below the excess of revenues over expenses in its consolidated statements of operations and changes in net assets.

Inventory - The Network records inventory at cost using the average cost method.

Impairment of Long-Lived Assets - Long-lived assets to be held and used are reviewed for impairment whenever circumstances indicate that the carrying amount of an asset may not be recoverable. Long-lived assets to be disposed of are reported at the lower of carrying amount or fair value, less cost to sell.

Estimated Self-Insurance Liabilities - The liabilities for outstanding losses and loss related expenses, and the related provision for losses and loss related expenses include estimates for malpractice losses, general liability, and workers' compensation incurred but not reported claims, as well as losses pending settlement. Such liabilities are necessarily based on estimates and, while management believes the amounts provided are adequate, the ultimate liability may be in excess of or less than the amounts provided. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. The methods for making such estimates and the resulting liability are actuarially reviewed on an annual basis, and any adjustments required are reflected in operations in the current period. The current portion of estimated self-insurance liabilities is recorded within other current liabilities in the accompanying consolidated balance sheets.

Concentration of Credit Risk - Financial instruments, which potentially subject the Network to concentration of credit risk, consist of accounts receivable, investments, including temporary cash investments, marketable equity and debt securities, mutual funds, government securities and interest rate swap agreements. The Network receives a significant portion of its payments for services rendered from a limited number of government and commercial third-party payers, including Medicare (a federal program), Medicaid (a State of Connecticut program), and various health insurance companies.

Interest Rate Swap Agreements - Interest rate swap agreements are recognized as either assets or liabilities in the consolidated balance sheet at fair value regardless of the purpose or intent for holding them. Changes in the fair value of interest rate swap agreements are recognized in non-operating losses or if designated and effective as hedge transactions, as changes in unrestricted net assets.

Advertising Costs - The Network expenses advertising costs the first time the advertising takes place. The total amount charged to advertising expense was $1,842,135 and $1,596,878 for the years ended September 30, 2013 and 2012, respectively, and is recorded in supplies and other expenses in the accompanying consolidated statements of operations and changes in net assets.

Accounting Pronouncements Adopted - In May 2011, FASB issued Accounting Standards Update (ASU) 2011-04, "*Amendments to Achieve Common Fair Value Measurement and Disclosure Requirements in US. GAAP and IFRSs,*" which amends ASC 820, *Fair Value Measurements and Disclosures.* ASU 2011-04 amends the fair value disclosure requirements regarding transfers between Level 1 and Level 2 of the fair value hierarchy and the categorization by level of the fair value hierarchy for items that are not measured at fair value in the financial statements, but for which the fair value is required to be disclosed. This guidance became effective for the Network beginning on October 1, 2012. The adoption of this guidance had no impact on the Network's consolidated financial statements.

Note 2 - Summary of Significant Accounting Policies (continued)

In July 2011, the FASB issued ASU 2011-07, "*Health Care Entities (Topic 954): Presentation and Disclosure of Patient Service Revenue, Provision of Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities.*" This guidance establishes accounting and disclosure requirements for health care entities that recognize significant amounts of patient service revenue at the time services are rendered even though the entity does not assess a patient's ability to pay. Specifically, the guidance requires that health care entities present bad debt expense associated with net patient service revenue as an offset to net patient service revenue within the consolidated statements of operations and changes in net assets. Additionally, the guidance requires enhanced disclosure of the policies for recognizing revenue and assessing bad debts, as well as qualitative and quantitative information about changes in the allowance for doubtful accounts. The guidance requires retrospective application to all prior periods presented. This guidance became effective for the Network beginning on October 1, 2012. The adoption of this guidance had no impact on the Hospital"s operating income in the statements of operations and changes in net assets, but resulted in additional disclosures in Note 14. All years included have been presented in accordance with the provisions of ASU 2011-07.

Accounting Pronouncements Pending Adoption - In December 2011, the FASB issued ASU 2011-11, "*Disclosures about Offsetting Assets and Liabilities.*" This guidance contains new disclosure requirements regarding the nature of an entity's rights of setoff and related arrangements associated with its financial instruments and derivative instruments. This guidance is effective for the Network beginning October 1, 2013, and retrospective application is required. The Network does not expect this guidance to have an impact on its consolidated financial statements.

In October 2012, the FASB issued ASU 2012-05, "*Statement of Cash Flows (Topic 230): Not-for-Profit Entities: Classification of the Sale Proceeds of Donated Financial Assets in the Statement of Cash Flows.*" This guidance provides clarification on how entities classify cash receipts arising from the sale of certain donated financial assets in the statement of cash flows. This guidance is effective for the Network beginning October 1, 2013, with early adoption permitted. The Network has not yet evaluated the impact this guidance may have on its consolidated financial statements.

In January 2013, the FASB issued ASU 2013-01, "*Clarifying the Scope of Disclosures about Offsetting Assets and Liabilities.*" This guidance provides clarification on the scope of the offsetting disclosure requirements in ASU 2011-11. This guidance is effective for the Network beginning October 1, 2013, with early adoption permitted. The Network does not expect this guidance to have a material impact on its consolidated balance sheets.

In February 2013, the FASB issued ASU 2013-04, "*Obligations Resulting from Joint and Several Liability Arrangements for Which the Total Amount of the Obligation is Fixed at the Reporting Date.*" This guidance requires entities to measure obligations resulting from the joint and several liability arrangements for which the total amount of the obligation within the scope of this guidance is fixed at the reporting date. This guidance is effective for the Network beginning October 1, 2014, with early adoption permitted. The Network has not yet evaluated the impact this guidance may have on its consolidated financial statements.

Reclassification - Certain amounts in the 2012 consolidated financial statements have been reclassified to conform to the 2013 presentation. These reclassifications had no material effect on the 2012 consolidated financial statements.

Subsequent Events - Subsequent events have been evaluated through December 17, 2013, the date through which procedures were performed to prepare the consolidated financial statements for issuance. Management believes that there are no subsequent events having a material impact on the consolidated financial statements.

Note 3 - Assets Whose Use is Limited and Investments

Assets whose use is limited and investments as of September 30, 2013 and 2012, include the following:

	2013		2012	
	Cost	Fair Value	Cost	Fair Value
Board designated and donor-restricted:				
Money market funds	$ 507,386	$ 507,386	$ 265,287	$ 265,287
U.S. equities	215,775	206,426	150,241	163,427
Mutual funds:				
U.S. small/mid cap	2,887,193	3,203,837	196,636	252,510
Investment grade taxable	413,221	403,449	264,483	278,626
Short-term bond fund	2,027,248	2,006,817	4,486,385	4,523,908
Large value fund	11,535,567	12,161,104	6,349,959	6,952,883
Moderate allocation funds	11,605,313	12,765,022	15,795,794	17,344,909
Foreign growth fund	6,058,560	7,104,073	2,838,789	3,151,684
Other	1,038,597	1,315,132	291,414	308,608
Total	$ 36,288,860	$ 39,673,246	$ 30,638,988	$ 33,241,842
Investments held in trust for estimated self-insurance liabilities:				
Money market funds	$ 326,811	$ 326,811	$ 120,455	$ 120,455
U.S. government securities	-	-	2,265,438	2,352,152
Corporate bonds	-	-	1,822,751	1,946,269
U.S. equities	30,000	48,325	539,532	789,253
Mutual funds:				
Bond fund	1,090,954	1,075,321	700,417	720,276
Short-term government fund	-	-	355,932	353,901
Emerging markets fund	86,840	90,905	138,872	152,650
Midcap stock fund	25,000	27,609	103,788	131,765
International stock fund	23,648	30,292	88,053	102,075
Moderate allocation fund	803,904	866,668	1,439,996	1,736,180
Other investments	-	-	379,893	439,722
Total	$ 2,387,157	$ 2,465,931	$ 7,955,127	$ 8,844,698
Investments held under bond indenture:				
Money market funds	$ 5,994,581	$ 5,994,581	$ 9,085,534	$ 9,085,534
U.S. government securities	797,747	798,007	1,292,701	1,291,731
Total	$ 6,792,328	$ 6,792,588	$ 10,378,235	$ 10,377,265
Beneficial interest in trust assets	$ 6,579,883	$ 7,882,372	$ 6,650,295	$ 7,400,782

Note 3 - Assets Whose Use is Limited and Investments (continued)

	2013		2012	
	Cost	Fair Value	Cost	Fair Value
Investments:				
Money market funds	$ 455,766	$ 455,766	$ 468,063	$ 468,063
U.S. equities	239,278	273,569	175,201	196,112
Corporate bonds	15,389	15,427	-	-
Certificates of deposit	100,000	100,751	115,000	116,065
Mutual funds:				
U.S. small/mid cap	933,236	1,042,212	128,060	138,105
Investment grade taxable	399,749	396,103	272,165	283,621
Global high yield taxable	81,205	81,489	94,450	96,902
Emerging markets fund	-	-	47,200	49,593
Short-term bond	5,715,771	5,688,229	1,711,777	1,743,074
Large value fund	1,243,896	1,509,882	7,750,713	8,067,571
Moderate allocation funds	1,694,843	2,017,532	1,786,976	2,030,778
Foreign large fund	1,169,563	1,428,580	7,864,153	8,320,932
Total	$ 12,048,696	$ 13,009,540	$ 20,413,758	$ 21,510,816
Total assets whose use is limited and investments	$ 64,096,924	$ 69,823,677	$ 76,036,403	$ 81,375,403

Fair values and gross unrealized losses for all investment categories whose fair value is below its cost as of September 30, 2013 and 2012, and the length of time that the securities have been in an unrealized loss position as of September 30, 2013 and 2012, are as follows:

2013	Less than 12 months		Greater than 12 months		Total	
	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
U.S. equities	$ 206,426	$ (9,349)	$ -	$ -	$ 206,426	$ (9,349)
Foreign growth fund	-	-	1,375,560	(102,856)	1,375,560	(102,856)
Investment grade taxable	799,552	(13,418)	-	-	799,552	(13,418)
Short-term bond fund	2,367,489	(52,696)	-	-	2,367,489	(52,696)
Bond fund	1,075,321	(15,633)	-	-	1,075,321	(15,633)
U.S. government securities	-	-	798,803	(900)	798,803	(900)
	$ 4,448,788	$ (91,096)	$ 2,174,363	$ (103,756)	$ 6,623,151	$ (194,852)

2012	Less than 12 months		Greater than 12 months		Total	
	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
Large value fund	$ -	$ -	$ 4,106,546	$ (216,359)	$ 4,106,546	$ (216,359)
Foreign growth fund	-	-	400,220	(23,711)	400,220	(23,711)
Short-term government fund	353,901	(2,031)	-	-	353,901	(2,031)
U.S. government fund	-	-	1,291,731	(970)	1,291,731	(970)
	$ 353,901	$ (2,031)	$ 5,798,497	$ (241,040)	$ 6,152,398	$ (243,071)

Note 3 - Assets Whose Use is Limited and Investments (continued)

Based on that evaluation and the Network's ability and intent to hold those investments for a reasonable period of time sufficient for a forecasted recovery of fair value, the Network does not consider those investments to be other-than-temporarily impaired as of September 30, 2013 and 2012.

Interest and dividend income, which is included in other operating revenue, on the assets whose use is limited and investments totaled $1,529,821 and $1,326,767 for the years ended September 30, 2013 and 2012, respectively. There were realized gains of $5,584,750 and $0 for the years ended September 30, 2013 and 2012, respectively.

Note 4 - Fair Value Measurements

FASB ASC 820 provides a framework for measuring fair value. That framework provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to unobservable inputs (Level 3 measurements).

The three levels of the fair value hierarchy under FASB ASC 820 are described as follows:

Level 1 - Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities in active markets that the Network has the ability to access.

Level 2 - Inputs to the valuation methodology include:

- Quoted prices for similar assets or liabilities in active markets;
- Quoted prices for identical or similar assets or liabilities in inactive markets;
- Inputs other than quoted prices that are observable for the asset or liability;
- Inputs that are derived principally from or corroborated by observable market data by correlation or other means.

If the asset or liability has specified (contractual) terms, the Level 2 input must be observable for substantially the full term of the asset or liability.

Level 3 - Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

The asset or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement.

Note 4 - Fair Value Measurements (continued)

The following table presents the financial instruments carried at fair value as of September 30, 2013 and 2012, by the valuation hierarchy.

2013	Level 1	Level 2	Level 3	Total
Assets:				
Money market funds	$ 7,284,544	$ -	$ -	$ 7,284,544
U.S. government securities	798,007	-	-	798,007
Corporate bonds	15,427	-	-	15,427
Certificates of deposit	100,751	-	-	100,751
U.S. equities	528,320	-	-	528,320
Mutual funds:				
U.S. small/mid cap	4,246,049	-	-	4,246,049
Investment grade taxable	799,552	-	-	799,552
Global high yield taxable	81,489	-	-	81,489
Bond fund	1,075,321	-	-	1,075,321
Short-term bond fund	7,695,046	-	-	7,695,046
Large value fund	13,670,986	-	-	13,670,986
Moderate allocation fund	15,649,222	-	-	15,649,222
Foreign growth fund	7,104,073	-	-	7,104,073
Emerging markets fund	90,905	-	-	90,905
Midcap stock fund	27,609	-	-	27,609
International stock fund	30,292	-	-	30,292
Foreign large fund	1,428,580	-	-	1,428,580
Other	1,315,132	-	-	1,315,132
Beneficial interest in trusts	-	-	7,882,372	7,882,372
Total assets at fair value	$ 61,941,305	$ -	$ 7,882,372	$ 69,823,677
Liabilities:				
Obligations under interest rate swap agreements	$ -	$ 181,635	$ -	$ 181,635
Total liabilities at fair value	$ -	$ 181,635	$ -	$ 181,635

Note 4 - Fair Value Measurements (continued)

2012	Level 1	Level 2	Level 3	Total
Assets:				
Money market funds	$ 9,939,339	$ -	$ -	$ 9,939,339
U.S. government securities	3,643,883	-	-	3,643,883
Corporate bonds	-	1,946,269	-	1,946,269
Certificates of deposit	116,065	-	-	116,065
U.S. equities	1,148,792	-	-	1,148,792
Mutual funds:				
U.S. small/mid cap	390,615	-	-	390,615
Investment grade taxable	562,247	-	-	562,247
International developed bonds	21,302	-	-	21,302
Global high yield taxable	159,419	-	-	159,419
Other	96,383	-	-	96,383
Bond fund	720,276	-	-	720,276
Short-term bond fund	6,266,982	-	-	6,266,982
Large value fund	15,020,454	-	-	15,020,454
Moderate allocation fund	21,111,867	-	-	21,111,867
Foreign growth fund	3,151,684	-	-	3,151,684
Short-term government fund	353,901	-	-	353,901
Emerging markets fund	330,649	-	-	330,649
Midcap stock fund	131,765	-	-	131,765
International stock fund	102,075	-	-	102,075
Foreign large fund	8,320,932	-	-	8,320,932
Other investments	439,722	-	-	439,722
Beneficial interest in trusts	-	-	7,400,782	7,400,782
Total assets at fair value	$ 72,028,352	$ 1,946,269	$ 7,400,782	$ 81,375,403
Liabilities:				
Obligations under interest rate swap agreements	$ -	$ 540,389	$ -	$ 540,389
Total liabilities at fair value	$ -	$ 540,389	$ -	$ 540,389

During the years ended September 30, 2013 and 2012, the value of the beneficial interest in trusts increased for a change in market value of $787,751 and $1,141,645, respectively. In addition, the Network received $306,161 and $429,028 in distributions from these trusts in 2013 and 2012, respectively.

The Network's valuation methodologies used to measure financial assets and liabilities at fair value are outlined below. Where applicable, the Network uses quoted prices in active markets for identical assets and liabilities to determine fair value (Level 1 inputs). This pricing methodology applies to money market funds, U.S. government securities, certificates of deposit, U.S. equities and mutual funds.

Note 4 - Fair Value Measurements (continued)

If quoted prices in active markets for identical assets and liabilities are not available, then quoted prices for similar assets and liabilities, quoted prices for identical assets or liabilities in inactive markets or inputs other than quoted prices that are observable for the asset or liability, either directly or indirectly, will be used to determine fair value (Level 2 inputs). The Level 2 classifications include the corporate bonds and interest rate swap agreements. The interest rate swap agreements are valued based on a determination of market expectations relating to the future cash flows associated with the swap contract using sophisticated modeling based on observable market-based inputs, such as interest rate curves.

Assets and liabilities that are valued using significant unobservable inputs, such as extrapolated data, proprietary models, or indicative quotes that cannot be corroborated with market data are classified in Level 3 within the fair value hierarchy. The Level 3 classification includes the Network's beneficial interest in trusts. The value of the Network's assets is based on total fund values and the Network's corresponding beneficiary percentage.

The fair value of the Network's Series A and C Bonds are based on current traded value. The fair value of the Series A and C Bonds as of September 30, 2013 and 2012, is approximately $41,854,230 and $44,721,911, respectively. The fair value of the Network's remaining long-term debt approximates its carrying value.

As of September 30, 2013 and 2012, the Network's other financial instruments included accounts receivable, accounts payable and accrued expenses and estimated settlements due to and from third-party payers. The carrying amounts reported in the consolidated balance sheets for these financial instruments approximate their fair value.

The preceding methods described may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, although the Network believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

Note 5 - Other Assets

Other assets as of September 30, 2013 and 2012 consist of the following:

	2013	2012
Pledges receivable, net	$ 210,112	$ 376,165
Other receivables	887,661	916,543
Notes receivable	307,040	326,935
Unamortized bond issuance costs	2,580,484	2,728,593
Losses recoverable	2,247,835	867,152
Total	$ 6,233,132	$ 5,215,388

As of September 30, 2013 and 2012, $687,146 and $833,061 of pledges receivables have been included within prepaid expenses and other current assets as management anticipates them to be collected within the next year.

Note 5 - Other Assets (continued)

Pledges receivable are expected to be realized as follows:

	2013	2012
In one year or less	$ 688,276	$ 834,922
Between one and five years	213,662	384,003
Greater than five years	-	4,313
Less: discount for present value	(4,680)	(14,012)
Pledges receivable - net	$ 897,258	$ 1,209,226

Pledges receivable are reported at their net present value, discounted at rates from .10% to 4.90%. There was no allowance for uncollectible amounts recorded as of September 30, 2013 and 2012.

As of September 30, 2013 and 2012, unamortized bond issuance costs, which are included within other assets, consist of the following:

	2013	2012
Deferred financing costs	$ 3,735,675	$ 4,162,046
Less accumulated amortization	(1,155,191)	(1,433,453)
Total	$ 2,580,484	$ 2,728,593

Note 6 - Property, Plant and Equipment

Property, plant and equipment as of September 30, 2013 and 2012, consist of the following:

	2013	2012
Land and land improvements	$ 5,333,743	$ 5,311,030
Buildings and building improvements	160,660,529	157,921,015
Fixed equipment	31,817,532	25,744,837
Movable equipment	104,373,295	124,349,089
	302,185,099	313,325,971
Less: accumulated depreciation and amortization	(206,928,185)	(219,601,455)
	95,256,914	93,724,516
Construction in progress	931,583	2,570,939
Total	$ 96,188,497	$ 96,295,455

Note 6 - Property, Plant and Equipment (continued)

For the years ended September 30, 2013 and 2012, the Network capitalized interest related to construction financed with tax-exempt debt of $126,000 and $68,838, respectively. The cost to complete the construction in progress is approximately $2,981,000 and $4,225,000 as of September 30, 2013 and 2012, respectively.

For the years ended September 30, 2013 and 2012, the Network disposed of property, plant and equipment in the amounts of $24,086,313 and $615,306, respectively, all disposals were of fully depreciated assets.

Note 7 - Intangible Assets

The gross carrying amount and accumulated amortization, by class of intangible assets, as of September 30, 2013 and 2012, consisted of the following:

2013	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount
License enhancements	$ 1,898,684	$ (1,349,202)	$ 549,482
Other intangible assets	101,000	-	101,000
Goodwill	7,252,932	(757,545)	6,495,387
Total	$ 9,252,616	$ (2,106,747)	$ 7,145,869

2012	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount
License enhancements	$ 1,898,684	$ (1,319,877)	$ 578,807
Goodwill	6,461,402	(577,103)	5,884,299
Total	$ 8,360,086	$ (1,896,980)	$ 6,463,106

Amortization expense related to intangible assets was $149,767 and $224,027 for the years ended September 30, 2013 and 2012, respectively.

The estimated amortization expense in each of the succeeding five fiscal years and thereafter, as of September 30, 2013, is as follows:

2014	$ 228,222
2015	197,589
2016	189,456
2017	174,913
2018	80,197
Thereafter	402,852
Total	$ 1,273,229

Note 8 - Estimated Self-Insurance Liabilities

The Network is self-insured for workers' compensation insurance coverage. The Network participates in Workers' Compensation Trust, a revocable trust, for the purpose of setting aside assets based on actuarial funding recommendations.

The Network has a $350,000 limit per occurrence for workers' compensation claims. The Network has employed independent actuaries to estimate the ultimate costs, if any, of workers' compensation claims. Accrued workers' compensation reserves have been discounted at 5% as of September 30, 2013 and 2012, and in management's opinion provide an adequate reserve for loss contingencies.

In fiscal year 2007, ECHN established a single-parent captive, CHIC, which covers all of its subsidiaries. The captive provides malpractice and general insurance coverage for ECHN and its subsidiaries at $3,000,000 per occurrence and $9,000,000 in the aggregate for the years ended September 30, 2013 and 2012.

Effective October 1, 2009, CHIC also provided an excess healthcare professional liability and umbrella liability insurance policy on a claims-made basis covering healthcare professional liability, general care liability, automobile liability, employers liability, helipad liability and non-owned aircraft liability. The limit provided is $30,000,000 for each loss event and in the annual aggregate excess of the primary coverage layers described above. This coverage is fully reinsured.

ECHN does not self-insure any malpractice risks other than exposures greater than its excess coverages, however, as of September 30, 2013 and 2012, ECHN has recorded a liability for estimated incurred but not reported claims, as it currently has a claims-made policy with CHIC.

Note 8 - Estimated Self-Insurance Liabilities (continued)

The activity in the reserve for outstanding losses and loss related expenses at ECHN for workers' compensation and malpractice claims, as of September 30, 2013 and 2012, is as follows:

	2013	2012
Balance at beginning of year	$ 14,873,830	$ 9,016,338
Workers' compensation:		
Losses incurred related to:		
Current year	697,778	941,403
Prior year	3,200,111	1,456,175
Total incurred	3,897,889	2,397,578
Paid losses related to:		
Current year	(414,370)	(412,068)
Prior year	(1,732,496)	(1,482,261)
Total paid	(2,146,866)	(1,894,329)
Professional and general:		
Losses incurred related to:		
Current year	997,781	1,062,024
Prior year	6,950,980	4,997,849
Total incurred	7,948,761	6,059,873
Paid losses related to:		
Current year	(45,727)	(11,458)
Prior year	(13,231,777)	(694,172)
Total paid	(13,277,504)	(705,630)
Balance at end of year	$ 11,296,110	$ 14,873,830

Workers' Compensation - The development on prior-year incurred losses increased by approximately $5,185,000 and $1,456,000 as of September 30, 2013 and 2012, respectively.

Professional and General - The development on prior-year incurred losses increased by approximately $6,950,980 and $4,998,000 as of September 30, 2013 and 2012, respectively.

The reserve for losses, which was determined with the assistance of an actuarial consultant, included estimates of claims incurred but not reported. Approximately $2,272,000 and $5,352,000 of the reserve as of September 30, 2013 and 2012, respectively, are included in other current liabilities with the remaining balance of the reserve included in estimated self-insurance liabilities in the accompanying consolidated balance sheets.

Note 9 - Pension and Other Postretirement Benefits

ECHN has a defined benefit pension plan covering substantially all of the employees of MMH and RGH. The benefits are based upon years of service and compensation for the five highest years during the employee's last 10 years of service. The hospitals make contributions in amounts sufficient to meet the minimum funding requirements of the Employee Retirement Income Security Act of 1974, as well as such additional amounts as deemed appropriate.

Effective December 31, 2008, ECHN implemented a soft freeze on the defined benefit pension plan. All employees with age and service credits greater than 65 were given the option to stay in the defined benefit pension plan or freeze their defined benefits and enter into a defined contribution plan. All other employees were required to enter into the defined contribution plan. Under the defined contribution plan, ECHN contributes 3% of eligible employees' salaries. This match is non-guaranteed for all employees except certain union workers. During September 2013 the Trustees passed a resolution to freeze all benefits related to the defined-benefit pension plan. During fiscal year 2013 and 2012, the Network incurred expenses of $2,076,122 and $1,815,351, respectively, related to this plan.

MMH and RGH also sponsor a postretirement benefit plan that provides health care benefits to those employees who retire. The criterion to receive this benefit is to be vested in the pension plan, attain age 55 or older and start collecting under the defined benefit plan described above once retired. The retiree must be enrolled into the medical plan on the date of retirement to be eligible for the continuation. MMH full time registered nurse retirees (retired prior to October 1, 2005 and were eligible per the Union contract) are grandfathered and required to pay at least 50% of the total cost of the medical and dental coverage they elect for themselves under the plan. Grandfathered eligible retirees are required to pay 100% of the total cost of the medical and dental coverage they elect for an eligible spouse. For non-grandfathered retirees, the postretirement health care plan is contributory and the retiree pays 100% of the premium.

The Network, as of September 30, 2013 and 2012, has no unrecognized actuarial losses related to the defined benefit pension plan.

The effects of Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (the Act) were reflected as of September 30, 2013 and 2012, assuming that ECHN will continue to provide a prescription drug benefit to retirees that is at least actuarially equivalent to Medicare Part D and that ECHN will receive the federal subsidy. This reduced plan liabilities by approximately $900,000 and $1,100,000 for the years ended September 30, 2013 and 2012, respectively. Subsidies of $90,769 and $95,241 were received in the years ended September 30, 2013 and 2012, respectively. Future benefits of $385,518 are expected to be paid and future subsidies of $63,055 are expected to be received related to the year ended September 30, 2014.

Note 9 - Pension and Other Postretirement Benefits (continued)

The pension and postretirement plans' change in benefit obligation and change in plan assets for the years ended September 30, 2013 and 2012, are as follows:

	Pension Benefits		Other Postretirement Benefits	
	2013	2012	2013	2012
Change in benefit obligation:				
Benefit obligation, beginning of year	$ 223,101,495	$ 188,714,944	$ 4,633,005	$ 4,680,687
Service cost	2,709,867	2,233,145	72,548	63,127
Interest cost	9,475,222	10,105,635	162,852	226,498
Plan curtailments	(7,795,069)	-	-	-
Plan participants' contributions	-	-	296,951	507,918
Receipt of Medicare Part D reimbursement	-	-	90,769	95,241
Actuarial loss (gain)	(26,124,678)	30,013,892	(499,239)	(140,180)
Benefits paid	(9,072,578)	(7,966,121)	(563,314)	(800,286)
Benefit obligation, end of year	$ 192,294,259	$ 223,101,495	$ 4,193,572	$ 4,633,005
Change in plan assets:				
Fair value of plan assets, beginning of year	$ 149,218,728	$ 125,293,980	$ -	$ -
Actual return on plan assets	9,144,700	20,980,869	-	-
Employer contributions	3,000,000	10,910,000	175,594	197,127
Plan participants' contributions	-	-	296,951	507,918
Receipt of Medicare Part D reimbursement	-	-	90,769	95,241
Benefits paid	(9,072,578)	(7,966,121)	(563,314)	(800,286)
Fair value of plan assets, end of year	$ 152,290,850	$ 149,218,728	$ -	$ -
Accrued pension and other postretirement benefits	$ (40,003,409)	$ (73,882,767)	$ (4,193,572)	$ (4,633,005)
Accumulated benefit obligation	$ (192,294,259)	$ (213,696,232)	$ -	$ -

The amount recognized in the Network's consolidated balance sheets as of September 30, 2013 and 2012, are as follows:

	Pension Benefits		Other Postretirement Benefits	
	2013	2012	2013	2012
Current liabilities	$ 5,700,000	$ 3,500,000	$ 385,518	$ 397,164
Noncurrent liabilities	34,303,409	70,382,767	3,808,054	4,235,841
Net amount recognized	$ 40,003,409	$ 73,882,767	$ 4,193,572	$ 4,633,005

Note 9 - Pension and Other Postretirement Benefits (continued)

The allocation of the accrued pension and postretirement benefits for the years ended September 30, 2013 and 2012 is as follows:

	Pension Benefits		Other Postretirement Benefits	
	2013	2012	2013	2012
MMH	$ 30,733,610	$ 56,594,968	$ 3,206,427	$ 3,608,963
RGH	9,269,799	17,287,799	987,145	1,024,042
Total	$ 40,003,409	$ 73,882,767	$ 4,193,572	$ 4,633,005

The plans' components of net periodic benefit cost for the years ended September 30, 2013 and 2012, are as follows (pension benefits information presented is for MMH and RGH combined):

	Pension Benefits		Other Postretirement Benefits	
	2013	2012	2013	2012
Service cost	$ 2,709,867	$ 2,233,145	$ 72,548	$ 63,127
Interest cost	9,475,222	10,105,635	162,852	226,498
Expected return on plan assets	(11,692,676)	(10,242,476)	-	-
Amortization of prior service (credits) costs	(234,992)	(234,992)	77,724	77,724
Recognized actuarial (gain) loss	4,123,868	2,933,877	(55,153)	(43,699)
Curtailment actuarial (gain) loss	(1,148,330)	-	-	-
Net periodic benefit cost	$ 3,232,959	$ 4,795,189	$ 257,971	$ 323,650

The allocation of the net periodic benefit cost for the years ended September 30, 2013 and 2012, is as follows:

	Pension Benefits		Other Postretirement Benefits	
	2013	2012	2013	2012
MMH	$ 2,475,143	$ 3,658,275	$ 197,246	$ 252,113
RGH	757,816	1,136,914	60,725	71,537
Total	$ 3,232,959	$ 4,795,189	$ 257,971	$ 323,650

Note 9 - Pension and Other Postretirement Benefits (continued)

The assumptions used to determine net periodic benefit cost of the pension and postretirement plans for the years ended September 30, 2013 and 2012, were as follows:

	Pension Benefits		Other Postretirement Benefits	
	2013	2012	2013	2012
Discount rate	5.27%	4.32%	4.54%	3.64%
Expected long-term rate of return	8.00%	8.00%	N/A	N/A
Rate of compensation increase	3.00%	2.75%	N/A	N/A
Initial medical trend rate	N/A	N/A	7.62%	7.91%
Ultimate medical trend rate	N/A	N/A	4.50%	4.50%
Number of years to ultimate medical trend rate	N/A	N/A	17 years	17 years

The assumptions used to determine pension and postretirement benefit obligations as of September 30, 2013 and 2012, are as follows:

	Pension Benefits		Other Postretirement Benefits	
	2013	2012	2013	2012
Discount rate	4.32%	5.47%	3.64%	5.03%
Expected long-term rate of return	8.00%	8.00%	N/A	N/A
Rate of compensation increase	3.00%	2.75%	N/A	N/A
Initial medical trend rate	N/A	N/A	7.62%	7.91%
Ultimate medical trend rate	N/A	N/A	4.50%	4.50%
Number of years to ultimate medical trend rate	N/A	N/A	14 years	15 years

The medical trend rate has a significant effect on the amounts reported. A one-percentage-point change in assumed health care cost trend rates would have the following effects:

	One Percentage Point Increase	One Percentage Point Decrease
Effect on year-end postretirement benefit obligation	$ 324,552	$ (289,352)
Effect on total of service and interest cost components	$ 20,058	$ (17,776)

Note 9 - Pension and Other Postretirement Benefits (continued)

The pension plan's weighted-average asset allocations as of September 30, 2013 and 2012, by asset category, are as follows:

	Pension Benefits	
	2013	2012
Asset category:		
Equity securities	56%	51%
Debt securities	43%	48%
Cash and cash equivalents	1%	1%
	100%	100%

The investment objective of ECHN is to invest the plan assets in a manner that, together with contributions, will provide for sufficient resources to pay current and projected obligations over the life of the plan. The plan shall be diversified across asset classes to achieve an optimal balance between risk and return and between income and growth of assets through capital appreciation.

Consistent with funding requirements, a secondary objective of the plan is to source benefit payments primarily through existing plan assets and anticipated future returns thereby minimizing future cash contributions. The investment objectives shall be implemented in a de-risking framework designed to manage the plan's funded status volatility and minimize future cash contributions. The funded status of the plan shall be measured by the ratio of plan assets to the projected benefit obligation. To reduce the volatility as much as possible, the goal is to attain and/or maintain a funded status of at least a 105% funding level and allocate its assets as outlined below.

The plan has approved an asset allocation strategy that shall change over time in response to future changes in the plan's funded status. Such changes in asset allocation strategy are intended to allocate additional assets to the fixed income asset class should the plan's funded status improve. Accordingly, the fixed income asset class shall be invested in such a manner that its interest rate sensitivity correlates highly with that of the plan's liabilities. Other asset classes are intended to provide additional return with associated higher levels of risk. If the plan's funded status deteriorates beyond stated thresholds, the strategy dictates that additional assets will not be re-allocated to the return-seeking assets.

Note 9 - Pension and Other Postretirement Benefits (continued)

Fair value methodologies used to assign plan assets to levels in accordance with ASC 820 are consistent with the inputs described in Note 4. The following table presents the investments of the defined benefit plan carried at fair value as of September 30, 2013 and 2012, by the valuation hierarchy.

2013	Level 1	Level 2	Level 3	Total
Cash and cash equivalents	$ 633,333	$ -	$ -	$ 633,333
Fixed income mutual funds:				
Long duration	64,833,809	-	-	64,833,809
US Core Opportunistic	13,328,905	-	-	13,328,905
US Passive	2,935,983	-	-	2,935,983
Guaranteed investment contract	-	-	3,230,137	3,230,137
Equities:				
Small/mid cap	8,925,030	-	-	8,925,030
Large cap	31,678,381	-	-	31,678,381
International	26,725,272	-	-	26,725,272
Total plan assets at fair value	$ 149,060,713	$ -	$ 3,230,137	$ 152,290,850

2012	Level 1	Level 2	Level 3	Total
Cash and cash equivalents	$ 944,555	$ -	$ -	$ 944,555
Fixed income mutual funds:				
Long duration	53,025,749	-	-	53,025,749
US Core Opportunistic	12,088,551	-	-	12,088,551
US Passive	2,983,658	-	-	2,983,658
Guaranteed investment contract	183,256	-	3,195,313	3,378,569
Equities:				
Small/mid cap	8,232,969	-	-	8,232,969
Active long corp	11,917,531	-	-	11,917,531
Large cap	30,277,740	-	-	30,277,740
International	26,369,406	-	-	26,369,406
Total plan assets at fair value	$ 146,023,415	$ -	$ 3,195,313	$ 149,218,728

Note 9 - Pension and Other Postretirement Benefits (continued)

The changes within the Level 3 investments as of September 30, 2013 and 2012, are as follows:

2013	Guaranteed Investment Contract
Balance as of October 1, 2012	$ 3,195,313
Investment income	326,682
Expenditures	(291,858)
Balance as of September 30, 2013	$ 3,230,137

2012	Guaranteed Investment Contract
Balance as of October 1, 2011	$ 3,374,535
Investment income	194,239
Expenditures	(373,461)
Balance as of September 30, 2012	$ 3,195,313

During fiscal year 2013, ECHN anticipates contributing $5,700,000 to the defined benefit pension plan.

The benefit payments, which reflect estimated future service, expected to be paid from the plans for the year ended September 30, 2013, are as follows:

	Pension Benefits	Other Postretirement Benefits
2014	$ 7,839,728	$ 397,164
2015	$ 8,177,609	$ 409,051
2016	$ 8,613,029	$ 401,768
2017	$ 9,079,307	$ 405,187
2018	$ 9,773,496	$ 418,484
2019-2022	$ 58,816,410	$ 2,087,013

Note 9 - Pension and Other Postretirement Benefits (continued)

The Network also has a defined contribution employee savings plan covering substantially all employees. Eligible employees who contribute to the plan will have 20% - 50%, depending upon years of service, of contributions matched by the Network, up to a maximum of 6% of annual compensation. The Network incurred expenses related to the employee savings plan amounting to $2,199,235 and $1,203,448, for the years ended September 30, 2013 and 2012, respectively.

Note 10 - Long-term Debt and Lines of Credit

Long-term debt and capital lease obligations, as of September 30, 2013 and 2012, consist of the following:

	2013	2012
Connecticut Health and Educational Facilities Authority (CHEFA) Hospital Revenue Bonds, ECHN Series A Bonds, bearing interest at rates ranging from 5.625% to 6.375% - net of unamortized original issue discount of $46,505 and $53,729 for 2013 and 2012, respectively.	$ 9,093,495	$ 9,886,271
CHEFA Hospital Revenue Bonds, ECHN Series C Bonds, bearing interest ranging from 4.00% to 5.125% - net of unamortized original issue premium of $350,960 and $371,605 for 2013 and 2012, respectively.	33,760,059	34,506,605
CHEFA Hospital Revenue Bonds, ECHN Series D Bonds bearing interest at a variable rate, adjusted weekly.	14,049,000	14,342,000
CHEFA Hospital Demand Revenue Bonds, ECHN Series E Bonds, bearing interest at a variable rate, adjusted weekly.	17,580,000	18,070,000
Loan due to Sovereign Bank, face amount $5,200,000 due and payable in semi-annual principal and interest installments maturing on January 3, 2022 and bearing interest at 3.38%	4,674,222	5,194,222
Promissory note payable to Rockville Bank due and payable in monthly principal and interest installments maturing on January 15, 2015, bearing interest at a fixed rate of 3.75%.	883,270	1,595,192
Promissory note payable to Rockville Bank due and payable in monthly principal and interest installments maturing on July 1, 2025, bearing interest at 5.87%.	791,933	1,092,218
Promissory note payable to Webster Bank due and payable in monthly principal and interest installments with a balloon payment due on May 1, 2018, bearing interest at 4.22%	615,659	-
Promissory note payable to Webster Bank due and payable in monthly principal and interest installments with a balloon payment due on December 1, 2017, bearing interest at 4.11%	568,058	-

Note 10 - Long-term Debt and Lines of Credit (continued)

	2013	2012
Loan due to Chase Equipment Leasing Inc., face amount of $4,000,000 due and payable in monthly principal and interest installments maturing on March 20, 2013, and bearing interest at 3.24%.	-	429,743
Promissory note payable to 428 Hartford Turnpike Associates, LLP payable in monthly principal and interest installments, maturing September 1, 2021, bearing interest at 6%.	247,832	270,972
Debt of ECHN Corporate Services, various due dates and interest rates	210,556	-
Mortgage payable to Rockville Bank - 15 years, due April 1, 2022, bearing interest at 6.5% for the first five years, adjustable thereafter every five years.	160,955	176,605
Promissory note payable to Joseph Hanna MD, LLC due and payable in one principal payment due in December 2013. This is a non interest bearing note.	119,890	-
Mortgage payable to Rockville Bank - 20 years, due January 1, 2007 bearing interest at 6.6% for the first five years, adjustable thereafter, every five years.	138,019	145,836
Capital lease obligations (see Note 12)	8,355,380	8,736,439
Total long-term debt and capital lease obligations	91,248,328	94,446,103
Less: current maturities	(6,832,322)	(6,904,354)
Total long-term debt and capital lease obligations - net of current portion	$ 84,416,006	$ 87,541,749

Lines of credit as of September 30, 2013 and 2012 consist of the following:

	2013	2012
Revolving line of credit with TD Bank, bearing interest at a variable rate.	$ 6,500,000	$ 6,500,000

In February 2000, MMH, RGH and EES (collectively, the Series A Obligated Group) entered into an agreement and open-ended mortgage with Connecticut Health and Educational Facilities Authority (CHEFA) in connection with the issuance of CHEFA Hospital Revenue Bonds, Eastern Connecticut Health Network, Issue Series 2000A (the Series A Bonds). A portion of the proceeds from the Series 2000A Bonds, net of the original issue discount and amounts used to establish required reserve accounts, was placed in an irrevocable trust from which the remaining debt service payments for defeased CHEFA bonds will be paid. The remainder was used to finance additions and renovations for various facilities. The Series A Obligated Group has been legally released from any future debt service on the defeased bonds. The Series A Bonds are due on various due dates through July 1, 2030.

In July 2004, MMH, RGH, EES, and ECHF (collectively, the Series B Obligated Group) entered into an agreement and open-ended mortgage with CHEFA in connection with the issuance of CHEFA Hospital Revenue Bonds, Eastern Connecticut Health Network Issue, Series B (the Series B Bonds). A portion of the proceeds from the Series B Bonds, net of the original issue discount and amounts used to establish required reserve accounts, was used to finance additions, renovations, and purchases of equipment for RGH and MMH.

Note 10 - Long-term Debt and Lines of Credit (continued)

The additions and renovations financed by the Series B Bonds consist of improvements and expansion of the emergency department at RGH; the purchase, renovation, and equipping of the Dialysis Center at RGH; construction of the heliport at RGH, improvements to the Gastrointestinal and Rehabilitation Departments at RGH, and capital equipment purchases for MMH and RGH.

The Series B bonds were refinanced as part of the issuance of Series E bonds as described below.

On October 1, 2005, MMH, RGH, EES, and ECHF (collectively, the Series C Obligated Group) entered into an agreement and open-ended mortgage with CHEFA to borrow $37,065,000 in connection with the issuance of CHEFA Hospital Revenue Bonds, Eastern Connecticut Health Network Issue, Series C (the Series C Bonds). The proceeds from the Series C Bonds, net of the original issue premium and amounts used to establish required reserve accounts, were placed in an irrevocable trust to advance refund and defease a portion of the Series 2000A Bonds. MMH, RGH, and EES have been legally released from any future debt service on the portion of defeased Series 2000A Bonds. The Series C Bonds are due on various due dates through July 1, 2034, bearing interest at rates ranging from 4.00% to 5.125%.

In May 2009, MMH, RGH, EES, and ECHF (collectively, the Series D Obligated Group) entered into an agreement and open-ended mortgage with CHEFA in connection with the issuance of CHEFA Hospital Revenue Bonds, Eastern Connecticut Health Network, Issue Series D (the Series D Bonds). A portion of the proceeds from the Series D Bonds, net of amounts used to establish required reserve accounts, were used to finance renovations at MMH, an expansion at EES, and other campus improvements. The Series D Bonds are due on various due dates through May 14, 2039.

In December 2010, MMH, RGH, EES, and ECHF (collectively, the Series E Obligated Group) entered into an agreement and open-ended mortgage with CHEFA in connection with the issuance of CHEFA Hospital Revenue Bonds, Eastern Connecticut Health Network, Issue Series E (the Series E Bonds). The proceeds from the Series E Bonds, net of amounts used to establish required reserve accounts, were used to redeem the Series B Bonds and fund interest rate swap agreement termination payments relating to the Series B Bonds. The Series E Bonds are due on various due dates through July 1, 2034.

Under the terms of the Series A, Series B, Series C, Series D, and Series E Bonds, the Series A Obligated Group, Series B Obligated Group, Series C Obligated Group, Series D Obligated Group, and Series E Obligated Group (the Obligated Groups) are required to maintain certain deposits with a trustee. Such deposits are included in assets whose use is limited. The indenture also places limits on the incurrence of additional borrowings and dispositions of property and requires that the Obligated Groups satisfy certain measures of financial performance as long as the notes are outstanding.

Under the terms of the CHEFA agreements, each member of the Obligated Groups is jointly and severally liable for the full and prompt payment of the amounts owed by the Obligated Groups. Total debt of the Obligated Groups was $78,853,222 and $81,681,222 as of September 30, 2013 and 2012, respectively. The debt is also secured by the gross receipts of the Obligated Groups.

In June 2012, the Obligated Group entered into a loan agreement with Sovereign Bank, through CHEFA's Tax-Exempt Equipment Loan Program, for $5,200,000 in connection with purchase of equipment and renovation costs. The proceeds of the loan, net of disbursements, were included in the current portion of assets whose use is limited as of September 30, 2012. Semi-annual principal and interest payments are due through January 2022.

Note 10 - Long-term Debt and Lines of Credit (continued)

The loans due to Chase Equipment Leasing, Inc. were collateralized by the related equipment, accessories, attachments, software, and other property relating thereto.

The Hospital is party to various capital leases, which are described in Note 12.

The annual maturities of the long-term debt and capital lease obligations in each of the succeeding five years and thereafter, as of September 30, 2013, are as follows:

2014	$ 6,832,322
2015	6,043,234
2016	5,181,475
2017	4,360,978
2018	4,962,866
Thereafter	63,562,998
	90,943,873
Plus - premium	304,455
Total	$ 91,248,328

On November 11, 2010, ECHN entered into a $6,500,000 unsecured line of credit with TD Bank, N.A. This line of credit carries an interest rate of LIBOR plus 2.25% and expires one year after issuance date. Subsequent to year end, ECHN renewed this line of credit. As of September 30, 2013 and 2012, MMH had $6,500,000 outstanding.

The Network is subject to various financial covenants related to these debt agreements. The Network received a waiver for violating a debt service coverage ratio for 2013 and the Network was in compliance with these covenants in 2012.

Note 11 - Derivatives

The Network uses derivative instruments, specifically interest rate swap agreements, to manage its exposure to changes in the interest rate on its CHEFA bonds. The use of derivative instruments exposes the Network to additional risks related to the derivative instrument, including market risk, credit risk and termination risk as described below, and the Network has defined risk management practices to mitigate these risks, as appropriate.

Market risk represents the potential adverse effect on the fair value and cash flow of a derivative instrument due to changes in interest rates or rate spreads. Market risk is managed through ongoing monitoring of interest rate exposure based on set parameters regarding the type and degree of market risk that the Network will accept. Credit risk is the risk that the counterparty on a derivative instrument may be unable to perform its obligation during the term of the contract. When the fair value of a derivative contract is positive, the counterparty owes the Network, which creates credit risk.

Credit risk is managed by setting stringent requirements for qualified counterparties at the date of execution of a derivative transaction and requiring counterparties to post collateral in the event of a credit rating downgrade or if the fair value of the derivative contract exceeds a negotiated threshold.

Note 11 - Derivatives (continued)

Termination risk represents the risk that the Network may be required to make a significant payment to the counterparty, if the derivative contract is terminated early. Termination risk is assessed at onset by performing a statistical analysis of the potential for a significant termination payment under various scenarios designed to encompass expected interest rate changes over the life of the proposed contract. The test measures the ability to make a termination payment without a significant impairment to the Network's ability to meet its debt or liquidity covenants.

In May 2009, ECHN entered into an interest rate swap agreement to manage the interest cost and risk associated with $15,250,000 of its variable rate Series D Bonds. Under the terms of this agreement, ECHN pays a fixed rate of 3.89%. Changes in the fair value of this swap are recorded in the consolidated statements of operations and changes in net assets. The Network's portion of the swap agreement in force related to this strategy as of September 30, 2013 and 2012, and the liability and interest expense recognized by the Network are as follows:

	2013	2012
Notional amount of contract	$ **14,049,000**	$ 14,342,000
Fair value of swap contract recognized in other liabilities	$ **170,000**	$ 417,000
Net interest income recognized in non-operating losses	$ **(248,000)**	$ (170,000)

In June 2012, ECHN entered into an interest rate swap agreement to manage the interest cost and risk associated with $5,200,000 of its debt with Sovereign Bank. Under the terms, ECHN pays a fixed rate of 3.38%. The swap is accounted for as a cash flow hedge in accordance with ASC 815 "*Accounting for Derivative Instruments and Hedging Activities*". This accounting treatment requires the effective portion of the gain or loss on a derivative instrument designated and qualifying as a cash flow hedging instrument to be reported as a component of other changes in unrestricted net assets and to be reclassified into operations in the same period or periods during which the hedged forecasted transaction affects earnings. The remaining gain or loss on the derivative instrument, if any, shall be recognized currently in non-operating losses.

The Network's portion of the swap agreement in force related to this strategy as of September 30, 2013 and 2012, and the liability and unrealized (gain) loss recognized by the Network are as follows:

	2013	2012
Notional amount of contract	$ **4,674,222**	$ 5,194,222
Fair value of swap contract recognized in other liabilities	$ **12,000**	$ 123,000
Unrealized (gain) loss recognized in unrestricted net assets	$ **(111,000)**	$ 123,000

The counterparty to the above swap transactions is a major financial institution that meets ECHN's criteria for financial stability and creditworthiness.

Note 12 - Lease Commitments

ECHN leases equipment under capital lease agreements, which begin to expire in 2015. The interest rates range from 4% to 8%. The net carrying value of equipment under the capital lease was $8,332,943 and $9,876,879 as of September 30, 2013 and 2012, respectively. ECHN leases various office space and certain equipment under operating leases that expire in various years through fiscal year 2024. Certain leases may be renewed at the end of their term.

Future minimum payments under capital leases and non-cancelable operating leases as of September 30, 2013, consisted of the following:

	Capital Leases	Operating Leases
2014	$ 3,205,332	$ 5,252,091
2015	2,706,145	4,952,239
2016	2,029,795	4,554,735
2017	821,597	3,641,042
2018	70,625	2,727,478
Thereafter	67,711	15,235,800
	8,901,205	$ 36,363,385
Less: interest on capital lease	545,825	
Principal amount of capital lease	$ 8,355,380	

Rent expense under operating and month-to-month leases was $6,264,706 and $6,009,478 for the years ended September 30, 2013 and 2012, respectively.

Note 13 - Concentrations of Credit Risk

ECHN grants credit without collateral to its patients, most of whom are insured under third-party payer agreements. The mix in patient accounts receivable as of September 30, 2013 and 2012, before allowances for doubtful accounts, consists of the following:

	2013	2012
Medicare	24%	29%
Self-pay	40%	28%
Managed care	17%	21%
Medicaid	4%	13%
Commercial insurance	9%	6%
Other	6%	3%
	100 %	100 %

Note 14 - Net Patient Service Revenues

Net patient service revenues for the years ended September 30, 2013 and 2012, consists of the following:

	2013	2012
Patient service revenues:		
Inpatient services	$ 328,063,718	$ 278,843,185
Outpatient services	572,644,188	476,021,456
Gross patient service revenues	900,707,906	754,864,641
Deductions - allowances	(590,585,747)	(477,821,644)
Net patient service revenues	$ 310,122,159	$ 277,042,997

In addition, the Network provides for a provision for bad debts. For receivables associated with services provided to patients who have third-party coverage, the Network analyzes contractually due amounts and provides an allowance for doubtful accounts and a provision for bad debts (for example, for expected uncollectible deductibles and copayments on accounts for which the third-party payor has not yet paid, or for payors who are known to be having financial difficulties that make the realization of amounts due unlikely). For receivables associated with self-pay patients (which includes both patients without insurance and patients with deductible and co-payment balances due for which third-party coverage exists for part of the bill), the Network records a significant provision for bad debts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible.

For uninsured patients that do not qualify for financial assistance, the Network offers a discount off its standard rates for services provided. The difference between the discounted rates and the amounts actually collected after all reasonable collection efforts have been exhausted is written off against the allowance for doubtful accounts in the period they are determined uncollectible. The Network's allowance for doubtful accounts covers all accounts greater than 6 months for both self-pay accounts receivable and third party payors as of September 30, 2013. The Network's self-pay and third-party payors write-offs totaled $11,403,046 and $10,998,492 for 2013 and 2012, respectively. The Network did not change its charity care or financial assistance policy during 2013 or 2012.

At September 30, 2013 and 2012, 32.3% and 35.0% of net patient accounts receivable were from governmental payors (Medicare and Medicaid) and 67.7% and 65.0% were from nongovernmental payors, respectively. Nongovernmental payors are primarily insurance companies and self-pay payors. Management has recorded an allowance for doubtful accounts, as noted above, which, in its opinion, is sufficient to provide for risk of nonpayment.

Note 15 - Community Benefit

ECHN's mission is to improve the health of the people and the communities ECHN serves.

ECHN provides quality health care to all, regardless of their ability to pay. Charity care is provided to those who are eligible based on ECHN's policy. ECHN also incurs unpaid costs for government programs because reimbursement is not sufficient to cover costs associated with Medicare and Medicaid patients. In addition to the charity care responsibilities, ECHN provides numerous other community benefits. These community benefits include medical education and research, community health education, screenings, support groups, counseling services, and in-kind support. To address the need for health care providers, a number of programs are offered for young people who may be interested in a career in health care.

Note 15 - Community Benefit (continued)

ECHN utilizes guidelines developed by various organizations to quantify community benefit activities. ECHN defines community benefit activities as those that improve access to care, as well as the health of the broader community. In addition to charity care and the unpaid costs of government sponsored health care (Medicare and/or Medicaid shortfalls), community benefit activities will normally fall into one of the following categories: nonbilled community health services / community health improvement services, health professions education, subsidized health services, research, financial and in-kind contributions, community building activities, and community benefit operations.

MMH and RGH provide care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Because MMH and RGH do not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue. The amount of traditional charity care provided, determined on the basis of cost, was $2,591,214 and $3,398,899 for the years ended September 30, 2013 and 2012, respectively.

Note 16 - Functional Expenses

ECHN provides general health care services to residents within its geographical location. For the years ended September 30, 2013 and 2012, expenses relating to providing these services are as follows:

	2013	2012
Health care services	$ 272,099,247	$ 239,552,240
Fund raising	544,391	396,574
General and administrative	55,211,560	50,499,081
Total	$ 327,855,198	$ 290,447,895

Note 17 - Temporarily and Permanently Restricted Net Assets

The temporarily restricted net assets available, as of September 30, 2013 and 2012, are available for the following purposes:

	2013	2012
Departmental and endowment purposes	$ 2,114,039	$ 2,565,533
Capital campaign and pledges	473,262	677,989
Total	$ 2,587,301	$ 3,243,522

Note 17 - Temporarily and Permanently Restricted Net Assets (continued)

As of September 30, 2013 and 2012, permanently restricted net assets consist of the following:

	2013	2012
Beneficial interest in trust assets	$ 7,882,372	$ 7,400,782
Endowments restricted for:		
Other departmental purposes	3,709,665	3,709,665
Charity care	546,180	540,205
Special needs	151,579	151,579
Cancer research	6,124	6,124
Total	$ 12,295,920	$ 11,808,355

The composition of the Network's endowment by net asset class as of September 30, 2013 and 2012, was as follows:

2013	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Donor-restricted endowment funds	$ -	$ 2,121,375	$ 4,413,548	$ 6,534,923
Board-designated endowment funds	33,138,323	-	-	33,138,323
Net assets, September 30, 2013	$ 33,138,323	$ 2,121,375	$ 4,413,548	$ 39,673,246

2012	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Donor-restricted endowment funds	$ -	$ 2,564,396	$ 4,407,574	$ 6,971,970
Board-designated endowment funds	26,269,872	-	-	26,269,872
Net assets, September 30, 2012	$ 26,269,872	$ 2,564,396	$ 4,407,574	$ 33,241,842

The Network's endowments consist of multiple funds established for a variety of purposes. The endowments include both donor-restricted endowment funds, funds designated by the Board of Trustees to function as endowments and assets held in trust by others. As required by GAAP, endowments, including funds designated by the Board of Trustees to function as endowments, are classified and reported based on the existence or absence of donor restrictions.

The Network has interpreted the relevant laws as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure by the Network.

Note 17 - Temporarily and Permanently Restricted Net Assets (continued)

The Network considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds: (1) the duration and preservation of the fund; (2) the purposes of the Network and the donor-restricted endowment fund; (3) general economic conditions; (4) the possible effect of inflation and deflation; (5) the expected total return from income and the appreciation of investments; (6) other resources of the Network; and (7) the investment policies of the Network.

The Network has adopted investment and spending policies for endowment assets that attempt to provide a reasonably stable and predictable stream of earnings to support the operations of the endowments and to preserve and enhance over time the real value of the endowment assets. Under this policy, as approved by the Board of Trustees, the endowment assets are invested in a manner that is intended to produce a real return, net of inflation and investment and management costs, over the long-term. Actual returns in any given year may vary from this amount.

The Investment Committee of the Board is responsible for defining and reviewing the investment policy to determine an appropriate long-term asset allocation policy. The asset allocation policy reflects the objective with allocations structured for capital growth and inflation protection over the long-term.

To satisfy its long-term rate-of-return objectives, the Network relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and current yield (interest and dividends). The Network targets a diversified asset allocation that places a greater emphasis on equity based investments to achieve its long-term return objectives within prudent risk constraints.

The Network has not appropriated funds for expenditure from its endowment funds for the years ending September 30, 2013 and 2012.

Changes in endowment net assets for the fiscal year ended September 30, 2013 were as follows:

2013	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Net assets, October 1, 2012	$ 26,269,872	$ 2,564,396	$ 4,407,574	$ 33,241,842
Interest income and dividends	808,111	55,220	-	863,331
Realized gains	2,082,211	145,575	-	2,227,786
Unrealized appreciation on investments	2,118,875	219,391	-	2,338,266
Released from restrictions	780,616	(2,339,401)	-	(1,558,785)
Contributions	183,500	1,473,843	-	1,657,343
Distributions	(1,500,000)	-	-	(1,500,000)
Transfers to (from) Endowment	2,395,138	2,351	5,974	2,403,463
Net assets, September 30, 2013	$ 33,138,323	$ 2,121,375	$ 4,413,548	$ 39,673,246

Note 17 - Temporarily and Permanently Restricted Net Assets (continued)

Changes in endowment net assets for the fiscal year ended September 30, 2012 were as follows:

2012	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Net assets, October 1, 2011	$ 19,558,790	$ 1,677,008	$ 4,407,574	$ 25,643,372
Interest income and dividends	174,204	37,521	-	211,725
Unrealized appreciation on investments	4,639,604	530,565	-	5,170,169
Contributions and releases from restrictions	2,146,543	70,033	-	2,216,576
Transfers to (from) Endowment	(249,269)	249,269	-	-
Net assets, September 30, 2012	$ 26,269,872	$ 2,564,396	$ 4,407,574	$ 33,241,842

From time to time, the fair value of assets associated with individual donor restricted endowment funds may fall below the level that the donor or relevant law requires the Network to retain as a fund of perpetual duration. In accordance with GAAP, deficiencies of this nature are reported in unrestricted net assets. As of September 30, 2013 and 2012, there were no funds that were below the level required by donor or law.

Note 18 - Commitments and Contingencies

The Network is involved in various legal actions arising from its activities. Although the ultimate outcome is not determinable at this time, management, after taking into consideration the advice of legal counsel, believes that the resolution of these pending matters will not have a material adverse effect, individually or in the aggregate, on the consolidated balance sheets or on the related consolidated statements of operations and changes in net assets, or consolidated cash flows of the Network.

The Network and the Network's defined benefit pension plans invest in various investment securities. Investment securities are exposed to various risks such as interest rate, market and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term.

Note 19 - Statutory Capital and Surplus

CHIC was incorporated in the Cayman Islands on September 15, 2006 and was granted an Unrestricted Class "B" insurance license under the Insurance Law of the Cayman Islands with an effective date of September 26, 2006. CHIC is regulated by the Cayman Islands Monetary Authority (CIMA) and related relations, and is obligated to comply with CIMA regulations regarding minimum levels of solvency and liquidity.

Statutory capital and surplus as of September 30, 2013 was ($856,588) with a minimum amount required to be maintained by CHIC of $120,000. CHIC's equity was below the minimum required capital amount as of September 30, 2013, which was primarily the result of adverse loss development experienced on a limited number of claims relating to prior years. Subsequent to September 30, 2013, ECHN contributed $1,200,000 of additional capital to ensure that the capital balance is in compliance with the CIMA's statutory regulations.

Note 19 - Statutory Capital and Surplus (continued)

ECHN reports all of CHIC's investments as investments held in trust for estimated self-insurance liabilities in the accompanying consolidated balance sheets.

CHIC's Board of Directors has recommended that equity of $973,000 be retained to pay claims in the event of adverse development. Distribution of dividends is subject to approval by the Board of Directors. No dividends were declared or paid during the years ended September 30, 2013 and 2012.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidating Balance Sheet
September 30, 2013

	The Manchester Memorial Hospital	The Rockville General Hospital, Inc.	ECHN ElderCare Services, Inc.	Eliminations	Subtotal Series A Obligated Group	ECHN Community Healthcare Foundation, Inc.	Eliminations	Subtotal Series C, Series D, and Series E Obligated Group
Assets								
Current assets:								
Cash and cash equivalents	$ 12,239,488	$ 1,059,290	$ 887,544	$ -	$ 14,186,322	$ 1,936,006	$ -	$ 16,122,328
Current portion of investments held under bond indentures	1,300,096	364,771	185,664	-	1,850,531	-	-	1,850,531
Accounts receivable - net	27,182,276	10,269,970	1,772,700	-	39,224,946	-	-	39,224,946
Inventory	3,245,125	1,467,009	38,816	-	4,750,950	-	-	4,750,950
Due from affiliated entities	370,120	58,029	282,558	(79,590)	631,117	19,043	-	650,160
Current portion of estimated settlements due from third-party payers	3,078,822	384,274	-	-	3,463,096	-	-	3,463,096
Prepaid expenses and other current assets	2,316,130	276,211	4,671	-	2,597,012	720,233	-	3,317,245
Total current assets	49,732,057	13,879,554	3,171,953	(79,590)	66,703,974	2,675,282	-	69,379,256
Assets whose use is limited - net of current portion:								
Donor restricted investments	1,806,681	1,709,690	-	-	3,516,371	2,931,819	-	6,448,190
Board designated investments	8,595,367	9,895,326	-	-	18,490,693	12,031,955	-	30,522,648
Investments held in trust for estimated self-insurance liabilities	1,258,026	-	-	-	1,258,026	-	-	1,258,026
Beneficial interest in trust assets	5,700,200	2,182,172	-	-	7,882,372	-	-	7,882,372
Investments held under bond indentures	3,321,696	806,533	813,828	-	4,942,057	-	-	4,942,057
Total assets whose use is limited	20,681,970	14,593,721	813,828	-	36,089,519	14,963,774	-	51,053,293
Interest in net assets of ECHN CHF, Inc.	7,278,631	3,616,191	181,832	-	11,076,654	-	(11,076,654)	-
Investments	4,366,493	3,088,116	3,630,706	-	11,085,315	283,179	-	11,368,494
Investments in joint ventures	3,501,635	3,208,828	-	-	6,710,463	-	-	6,710,463
Property, plant and equipment - net	54,574,351	27,654,664	7,672,388	-	89,901,403	-	-	89,901,403
Other assets:								
Estimated settlements due from third-party payers - net of current portion	6,135,548	668,994	-	-	6,804,542	-	-	6,804,542
Due from affiliated entities - net of current portion	25,064,484	9,022,571	-	(7,220,571)	26,866,484	-	-	26,866,484
Goodwill and intangible assets - net	-	-	549,482	-	549,482	-	-	549,482
Other assets	2,819,605	811,215	454,422	-	4,085,242	210,111	-	4,295,353
Total other assets	34,019,637	10,502,780	1,003,904	(7,220,571)	38,305,750	210,111	-	38,515,861
Total assets	$ 174,154,774	$ 76,543,854	$ 16,474,611	$ (7,300,161)	$ 259,873,078	$ 18,132,346	$ (11,076,654)	$ 266,928,770

See accompanying independent auditors' report.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidating Balance Sheet (continued)
September 30, 2013

	Eastern CT Medical Professionals Foundation, Inc.	ECHN Corporate Services	ECHN Enterprises, Inc. and Subsidiaries	Visiting Nurse & Health Services of Connecticut Inc.	Eastern Connecticut Health Network, Inc.	Connecticut Healthcare Insurance Company	Eliminations	Total
Assets								
Current assets:								
Cash and cash equivalents	$ 93,515	$ 129,143	$ 101,334	$ 2,766,681	$ 243,530	$ 2,982,825	$ -	$ 22,439,356
Current portion of investments held under bond indentures	-	-	-	-	-	-	-	1,850,531
Accounts receivable - net	2,881,621	748,991	35	3,338,073	328,616	1,861	-	46,524,143
Inventory	15,926	298,840	-	-	-	-	-	5,065,716
Due from affiliated entities	-	-	-	-	847,173	-	(1,497,333)	-
Current portion of estimated settlements due from third-party payers	-	-	-	-	-	-	-	3,463,096
Prepaid expenses and other current assets	295,148	14,498	3,903	159,247	1,235,148	21,676	-	5,046,865
Total current assets	3,286,210	1,191,472	105,272	6,264,001	2,654,467	3,006,362	(1,497,333)	84,389,707
Assets whose use is limited - net of current portion:								
Donor restricted investments	-	-	-	86,733	-	-	-	6,534,923
Board designated investments	-	-	-	2,615,675	-	-	-	33,138,323
Investments held in trust for estimated self-insurance liabilities	-	-	-	-	-	1,207,905	-	2,465,931
Beneficial interest in trust assets	-	-	-	-	-	-	-	7,882,372
Investments held under bond indentures	-	-	-	-	-	-	-	4,942,057
Total assets whose use is limited	-	-	-	2,702,408	-	1,207,905	-	54,963,606
Interest in net assets of ECHN CHF, Inc.	-	-	-	-	4,015,385	-	(4,015,385)	-
Investments	-	-	-	1,641,046	(909,061)	-	909,061	13,009,540
Investments in joint ventures	-	-	1,204,749	-	5,816,631	-	-	13,731,843
Property, plant and equipment - net	2,847,719	212,916	1,190,334	1,734,534	301,591	-	-	96,188,497
Other assets:								
Estimated settlements due from third-party payers - net of current portion	-	-	-	-	-	-	-	6,804,542
Due from affiliated entities - net of current portion	-	-	-	-	-	-	(26,866,484)	-
Goodwill and intangible assets - net	517,746	206,000	-	-	5,872,641	-	-	7,145,869
Other assets	-	-	-	624,407	307,041	1,006,331	-	6,233,132
Total other assets	517,746	206,000	-	624,407	6,179,682	1,006,331	(26,866,484)	20,183,543
Total assets	$ 6,651,675	$ 1,610,388	$ 2,500,355	$ 12,966,396	$ 18,058,695	$ 5,220,598	$ (31,470,141)	$ 282,466,736

See accompanying independent auditors' report.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidating Balance Sheet (continued)
September 30, 2013

	The Manchester Memorial Hospital	The Rockville General Hospital, Inc.	ECHN ElderCare Services, Inc.	Eliminations	Subtotal Series A Obligated Group	ECHN Community Healthcare Foundation, Inc.	Eliminations	Subtotal Series C, Series D, and Series E Obligated Group
Liabilities and Net Assets (Deficit)								
Current liabilities:								
Accounts payable and accrued expenses	$ 21,391,578	$ 6,096,840	$ 870,615	$ -	$ 28,359,033	$ 96,089	$ -	$ 28,455,122
Line of credit	6,500,000	-	-	-	6,500,000	-	-	6,500,000
Current portion of long-term debt	3,909,618	870,081	588,866	-	5,368,565	-	-	5,368,565
Current portion of due to affiliates	-	398,089	83,694	(79,590)	402,193	348,957	-	751,150
Current portion of estimated settlements due to third-party payers	2,943,941	1,040,198	408,222	-	4,392,361	-	-	4,392,361
Current portion of accrued pension and other postretirement benefits	4,683,769	1,401,749	-	-	6,085,518	-	-	6,085,518
Other current liabilities	2,482,951	754,403	389,999	-	3,627,353	-	-	3,627,353
Total current liabilities	41,911,857	10,561,360	2,341,396	(79,590)	54,735,023	445,046	-	55,180,069
Long-term debt and capital lease obligations, net of current portion	50,793,813	23,519,254	8,462,882	-	82,775,949	-	-	82,775,949
Estimated self-insurance liabilities	6,830,954	2,423,371	821,571	-	10,075,896	-	-	10,075,896
Accrued pension and postretirement benefits	29,256,268	8,855,195	-	-	38,111,463	-	-	38,111,463
Estimated settlements due to third-party payers, net of current portion	-	-	-	-	-	-	-	-
Due to affiliates	7,220,571	-	-	(7,220,571)	-	-	-	-
Other liabilities	409,571	132,211	51,860	-	593,642	3,545	-	597,187
Total liabilities	136,423,034	45,491,391	11,677,709	(7,300,161)	186,291,973	448,591	-	186,740,564
Net assets (deficit):								
Unrestricted	27,759,929	26,773,989	4,772,427	-	59,306,345	2,591,715	-	61,898,060
Temporarily restricted	1,392,902	561,463	24,475	-	1,978,840	13,524,728	(9,509,342)	5,994,226
Permanently restricted	8,578,909	3,717,011	-	-	12,295,920	1,567,312	(1,567,312)	12,295,920
Total net assets (deficit)	37,731,740	31,052,463	4,796,902	-	73,581,105	17,683,755	(11,076,654)	80,188,206
Total liabilities and net assets (deficit)	$ 174,154,774	$ 76,543,854	$ 16,474,611	$ (7,300,161)	$ 259,873,078	$ 18,132,346	$ (11,076,654)	$ 266,928,770

See accompanying independent auditors' report.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidating Balance Sheet (continued)
September 30, 2013

	Eastern CT Medical Professionals Foundation, Inc.	ECHN Corporate Services	ECHN Enterprises, Inc. and Subsidiaries	Visiting Nurse & Health Services of Connecticut Inc.	Eastern Connecticut Health Network, Inc.	Connecticut Healthcare Insurance Company	Eliminations	Total
Liabilities and Net Assets (Deficit)								
Current liabilities:								
Accounts payable and accrued expenses	$ 2,272,436	$ 923,287	$ 16,422	$ 1,834,866	$ 1,301,847	$ 70,855	$ -	$ 34,874,835
Lines of credit	-	-	-	-	-	-	-	6,500,000
Current portion of long-term debt	143,567	33,458	24,357	51,971	1,210,404	-	-	6,832,322
Current portion of due to affiliates	-	89,856	-	-	-	-	(841,006)	-
Current portion of estimated settlements due to third-party payers	-	-	-	120,000	-	-	-	4,512,361
Current portion of accrued pension and other postretirement benefits	-	-	-	-	-	-	-	6,085,518
Other current liabilities	-	-	-	861,394	-	1,051,734	-	5,540,481
Total current liabilities	2,416,003	1,046,601	40,779	2,868,231	2,512,251	1,122,589	(841,006)	64,345,517
Long-term debt and capital lease obligations, net of current portion	223,265	183,678	274,616	6,488	952,010	-	-	84,416,006
Estimated self-insurance liabilities	-	-	-	-	-	4,954,597	(6,006,000)	9,024,493
Accrued pension and postretirement benefits	-	-	-	-	-	-	-	38,111,463
Estimated settlements due to third-party payers, net of current portion	122,921	-	-	-	-	-	-	122,921
Due to affiliates	3,917,177	-	2,269,134	-	18,031,973	-	(24,218,284)	-
Other liabilities	-	-	-	-	-	-	-	597,187
Total liabilities	6,679,366	1,230,279	2,584,529	2,874,719	21,496,234	6,077,186	(31,065,290)	196,617,587
Net assets (deficit):								
Unrestricted	(27,691)	380,109	(84,174)	10,004,944	(3,959,262)	(856,588)	3,610,530	70,965,928
Temporarily restricted	-	-	-	86,733	521,723	-	(4,015,381)	2,587,301
Permanently restricted	-	-	-	-	-	-	-	12,295,920
Total net assets (deficit)	(27,691)	380,109	(84,174)	10,091,677	(3,437,539)	(856,588)	(404,851)	85,849,149
Total liabilities and net assets (deficit)	$ 6,651,675	$ 1,610,388	$ 2,500,355	$ 12,966,396	$ 18,058,695	$ 5,220,598	$ (31,470,141)	$ 282,466,736

See accompanying independent auditors' report.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidating Statement of Operations and Changes in Net Assets
For the Year Ended September 30, 2013

	The Manchester Memorial Hospital	The Rockville General Hospital, Inc.	ECHN ElderCare Services, Inc.	Eliminations	Subtotal Series A Obligated Group	ECHN Community Healthcare Foundation, Inc.	Eliminations	Subtotal Series C, Series D, and Series E Obligated Group
Revenues:								
Net patient service revenues	$ 175,818,082	$ 73,037,858	$ 14,748,717	$ -	$ 263,604,657	$ -	$ -	$ 263,604,657
Provision for bad debts	(5,518,461)	(4,127,214)	(110,000)	-	(9,755,675)	-	-	(9,755,675)
Net patient service revenues less provision for bad debts	170,299,621	68,910,644	14,638,717	-	253,848,982	-	-	253,848,982
Contributions	961,465	253,309	14,404	-	1,229,178	-	-	1,229,178
Other revenues	15,458,360	4,492,026	271,583	(141,268)	20,080,701	1,655,029	(832,862)	20,902,868
EHR incentive payment revenue	1,410,667	1,220,153	-	-	2,630,820	-	-	2,630,820
Net assets released from restrictions used in operations	1,458,982	112,828	3,500	-	1,575,310	288,075	-	1,863,385
Total revenues	189,589,095	74,988,960	14,928,204	(141,268)	279,364,991	1,943,104	(832,862)	280,475,233
Expenses:								
Salaries and wages	83,909,349	31,509,639	7,249,363	-	122,668,351	515,044	(376,115)	122,807,280
Fringe benefits	27,658,791	10,024,601	2,721,924	-	40,405,316	129,343	(94,462)	40,440,197
Supplies and other expenses	66,966,600	25,888,529	3,792,677	(141,268)	96,506,538	496,670	(362,285)	96,640,923
Depreciation and amortization	7,115,302	3,565,031	551,609	-	11,231,942	-	-	11,231,942
Interest and financing costs	2,685,044	682,298	485,961	-	3,853,303	-	-	3,853,303
Total expenses	188,335,086	71,670,098	14,801,534	(141,268)	274,665,450	1,141,057	(832,862)	274,973,645
Income (loss) from operations	1,254,009	3,318,862	126,670	-	4,699,541	802,047	-	5,501,588
Non-operating (losses) gains	(1,466,699)	(660,236)	52,019	-	(2,074,916)	-	-	(2,074,916)
Excess of revenues (under) over expenses	$ (212,690)	$ 2,658,626	$ 178,689	$ -	$ 2,624,625	$ 802,047	$ -	$ 3,426,672

See accompanying independent auditors' report.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidating Statement of Operations and Changes in Net Assets (continued)
For the Year Ended September 30, 2013

	Eastern CT Medical Professionals Foundation, Inc.	ECHN Corporate Services	ECHN Enterprises, Inc. and Subsidiaries	Visiting Nurse & Health Services of Connecticut Inc.	Eastern Connecticut Health Network, Inc.	Connecticut Healthcare Insurance Company	Eliminations	Total
Revenues:								
Net patient service revenues	$ 21,949,662	$ -	$ -	$ 24,638,275	$ -	$ -	$ (70,435)	$ 310,122,159
Provision for bad debts	(1,249,472)	-	-	(137,055)	-	-	-	(11,142,202)
Net patient service revenues less provision for bad debts	20,700,190	-	-	24,501,220	-	-	(70,435)	298,979,957
Contributions	-	-	-	385,141	345,435	-	(345,435)	1,614,319
Other revenues	8,353,432	3,232,600	425,834	717,140	3,048,899	2,440,340	(16,249,743)	22,871,370
EHR incentive payment revenue	-	-	-	-	-	-	-	2,630,820
Net assets released from restrictions used in operations	-	-	-	2,353	5,489	-	-	1,871,227
Total revenues	29,053,622	3,232,600	425,834	25,605,854	3,399,823	2,440,340	(16,665,613)	327,967,693
Expenses:								
Salaries and wages	21,887,013	1,880,216	-	17,154,890	11,400,866	-	(11,400,863)	163,729,402
Fringe benefits	3,477,219	320,611	-	3,354,064	2,316,394	-	(2,316,391)	47,592,094
Supplies and other expenses	9,246,348	869,285	284,772	4,119,020	(12,524,809)	8,133,343	(6,433,767)	100,335,115
Depreciation and amortization	545,428	57,332	71,228	384,891	228,411	-	(228,410)	12,290,822
Interest and financing costs	15,629	22,498	11,681	4,654	138,065	-	(138,065)	3,907,765
Total expenses	35,171,637	3,149,942	367,681	25,017,519	1,558,927	8,133,343	(20,517,496)	327,855,198
Income (loss) from operations	(6,118,015)	82,658	58,153	588,335	1,840,896	(5,693,003)	3,851,883	112,495
Non-operating (losses) gains	-	-	(63,728)	55	(1,840,896)	-	1,840,896	(2,138,589)
Excess of revenues (under) over expenses	$ (6,118,015)	$ 82,658	$ (5,575)	$ 588,390	$ -	$ (5,693,003)	$ 5,692,779	$ (2,026,094)

See accompanying independent auditors' report.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidating Statement of Operations and Changes in Net Assets (continued)
For the Year Ended September 30, 2013

	The Manchester Memorial Hospital	The Rockville General Hospital, Inc.	ECHN ElderCare Services, Inc.	Eliminations	Subtotal Series A Obligated Group	ECHN Community Healthcare Foundation, Inc.	Eliminations	Subtotal Series C, Series D, and Series E Obligated Group
Unrestricted net assets:								
Excess of revenues (under) over expenses	$ (212,690)	$ 2,658,626	$ 178,689	$ -	$ 2,624,625	$ 802,047	$ -	$ 3,426,672
Change in unrealized appreciation on investments	430,760	696,651	205,847	-	1,333,258	-	-	1,333,258
Net change in interest rate swap agreement	110,862	-	-	-	110,862	-	-	110,862
Net assets released from restrictions for capital acquisitions	401,528	47,604	19,042	-	468,174	-	-	468,174
Equity transfer to ECHN	(4,282,611)	(1,835,404)	-	-	(6,118,015)	-	-	(6,118,015)
Equity transfer from ECHN	-	-	-	-	-	-	-	-
ECHN Corporate Services transfer	-	-	-	-	-	-	-	-
Transfers (to) from other affiliates - net	(94,598)	(6,530)	5,000	-	(96,128)	96,861	-	733
Pension and postretirement related adjustments	26,481,163	8,152,920	-	-	34,634,083	-	-	34,634,083
Other	-	(5,975)	-	-	(5,975)	-	-	(5,975)
Change in unrestricted net assets	22,834,414	9,707,892	408,578	-	32,950,884	898,908	-	33,849,792
Temporarily restricted net assets:								
Contributions	580,157	32,787	14,288	-	627,232	2,475,669	(1,573,241)	1,529,660
Investment income	178,208	16,725	-	-	194,933	32,862	(26,999)	200,796
Net assets released from restrictions for operations	(1,458,982)	(112,828)	(3,500)	-	(1,575,310)	(1,093,192)	799,630	(1,868,872)
Net assets released from restrictions for capital acquisitions	(401,528)	(47,604)	(19,042)	-	(468,174)	(468,173)	468,173	(468,174)
Change in unrealized appreciation on investments	39,846	47,603	1,388	-	88,837	1,041,967	(627,530)	503,274
Transfers (to) from affiliates	550,132	9,032	-	-	559,164	-	(497,634)	61,530
Change in temporarily restricted net assets	(512,167)	(54,285)	(6,866)	-	(573,318)	1,989,133	(1,457,601)	(41,786)
Permanently restricted net assets:								
Change in beneficial interest in trust assets	403,720	77,870	-	-	481,590	-	-	481,590
Other	-	5,975	-	-	5,975	-	-	5,975
Change in permanently restricted net assets	403,720	83,845	-	-	487,565	-	-	487,565
Change in net assets (deficit)	22,725,967	9,737,452	401,712	-	32,865,131	2,888,041	(1,457,601)	34,295,571
Net assets (deficit), beginning of year	15,005,773	21,315,011	4,395,190	-	40,715,974	14,795,714	(9,619,053)	45,892,635
Net assets (deficit), end of year	$ 37,731,740	$ 31,052,463	$ 4,796,902	$ -	$ 73,581,105	$ 17,683,755	$ (11,076,654)	$ 80,188,206

See accompanying independent auditors' report.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidating Statement of Operations and Changes in Net Assets (continued)
For the Year Ended September 30, 2013

	Eastern CT Medical Professionals Foundation, Inc.	ECHN Corporate Services	ECHN Enterprises, Inc. and Subsidiaries	Visiting Nurse & Health Services of Connecticut Inc.	Eastern Connecticut Health Network, Inc.	Connecticut Healthcare Insurance Company	Eliminations	Total
Unrestricted net assets:								
Excess of revenues (under) over expenses	$ (6,118,015)	$ 82,658	$ (5,575)	$ 588,390	$ -	$ (5,693,003)	$ 5,692,779	$ (2,026,094)
Change in unrealized appreciation on investments	-	-	-	159,050	283,886	(540,700)	-	1,235,494
Net change in interest rate swap agreement	-	-	-	-	-	-	-	110,862
Net assets released from restrictions for capital acquisitions	-	-	-	-	-	-	-	468,174
Equity transfer to ECHN	-	-	-	-	6,118,015	-	-	-
Equity transfer from ECHN	6,118,015	-	-	-	(6,118,015)	-	-	-
ECHN Corporate Services transfer	-	297,451	-	-	(297,451)	-	-	-
Transfers (to) from other affiliates - net	-	-	-	-	(733)	5,373,092	(5,373,092)	-
Pension and postretirement related adjustments	-	-	-	-	-	-	-	34,634,083
Other	-	-	-	-	-	-	-	(5,975)
Change in unrestricted net assets	-	380,109	(5,575)	747,440	(14,298)	(860,611)	319,687	34,416,544
Temporarily restricted net assets:								
Contributions	-	-	-	16,500	432,285	-	(715,452)	1,262,993
Investment income	-	-	-	-	-	-	-	200,796
Net assets released from restrictions for operations	-	-	-	(2,353)	(5,489)	-	5,487	(1,871,227)
Net assets released from restrictions for capital acquisitions	-	-	-	-	-	-	-	(468,174)
Change in unrealized appreciation on investments	-	-	-	-	35,316	-	(319,199)	219,391
Transfers (to) from affiliates	-	-	-	-	(559,164)	-	497,634	-
Change in temporarily restricted net assets	-	-	-	14,147	(97,052)	-	(531,530)	(656,221)
Permanently restricted net assets:								
Change in beneficial interest in trust assets	-	-	-	-	-	-	-	481,590
Other	-	-	-	-	-	-	-	5,975
Change in permanently restricted net assets	-	-	-	-	-	-	-	487,565
Change in net assets (deficit)	-	380,109	(5,575)	761,587	(111,350)	(860,611)	(211,843)	34,247,888
Net assets (deficit), beginning of year	(27,691)	-	(78,599)	9,330,090	(3,326,189)	4,023	(193,008)	51,601,261
Net assets (deficit), end of year	$ (27,691)	$ 380,109	$ (84,174)	$ 10,091,677	$ (3,437,539)	$ (856,588)	$ (404,851)	$ 85,849,149

See accompanying independent auditors' report.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidating Balance Sheet
September 30, 2012

	The Manchester Memorial Hospital	The Rockville General Hospital, Inc.	ECHN ElderCare Services, Inc.	Eliminations	Subtotal Series A Obligated Group	ECHN Community Healthcare Foundation, Inc.	Eliminations	Subtotal Series C, Series D, and Series E Obligated Group	Eastern CT Medical Professionals Foundation, Inc.	ECHN Enterprises, Inc. and Subsidiaries	Visiting Nurse & Health Services of Connecticut Inc.	Eastern Connecticut Health Network, Inc.	Connecticut Healthcare Insurance Company	Eliminations	Total
Assets															
Current assets:															
Cash and cash equivalents	$ 6,414,687	$ 1,463,823	$ 2,104,524	$ -	$ 9,983,034	$ 3,322,992	$ -	$ 13,306,026	$ 693,999	$ 140,014	$ 2,917,808	$ 115,453	$ 2,878,767	$ -	$ 20,052,067
Current portion of investments held under bond indentures	4,781,749	467,212	186,474	-	5,435,445	-	-	5,435,445	-	-	-	-	-	-	5,435,445
Accounts receivable - net	26,534,856	10,959,585	1,858,191	-	39,352,632	-	-	39,352,632	2,958,828	-	3,438,643	926,570	34,582	-	46,711,255
Inventory	2,660,785	1,519,666	57,223	-	4,237,674	-	-	4,237,674	15,926	-	-	-	-	-	4,253,600
Due from affiliated entities	484,258	781,899	138,837	(822,530)	582,464	29,255	-	611,719	-	-	-	3,631,838	-	(4,243,557)	-
Current portion of estimated settlements due from third-party payers	3,549,365	853,555	-	-	4,402,920	-	-	4,402,920	-	-	-	-	-	-	4,402,920
Prepaid expenses and other current assets	2,028,449	218,802	12,150	-	2,259,401	852,507	-	3,111,908	321,126	3,712	159,877	1,390,039	33,945	-	5,029,607
Total current assets	46,454,149	16,264,552	4,357,399	(822,530)	66,253,570	4,204,754	-	70,458,324	3,989,879	143,726	6,516,328	6,063,900	2,947,294	(4,243,557)	85,875,894
Assets whose use is limited - net of current portion:															
Donor restricted investments	2,312,582	1,696,049	-	-	4,008,631	2,893,106	-	6,901,737	-	-	70,233	-	-	-	6,971,970
Board designated investments	7,434,591	9,011,067	-	-	16,445,658	7,677,672	-	24,123,330	-	-	2,146,542	-	-	-	26,269,872
Investments held in trust for estimated self-insurance liabilities	1,856,635	-	-	-	1,856,635	-	-	1,856,635	-	-	-	-	6,988,063	-	8,844,698
Beneficial interest in trust assets	5,296,479	2,104,303	-	-	7,400,782	-	-	7,400,782	-	-	-	-	-	-	7,400,782
Investments held under bond indentures	3,258,804	931,965	751,053	-	4,941,820	-	-	4,941,820	-	-	-	-	-	-	4,941,820
Total assets whose use is limited	20,159,091	13,743,382	751,053	-	34,653,526	10,570,778	-	45,224,304	-	-	2,216,775	-	6,988,063	-	54,429,142
Interest in net assets of ECHN CHF, Inc.	6,199,191	3,254,582	165,279	-	9,619,053	-	(9,619,053)	-	-	-	-	3,483,853	-	(3,483,853)	-
Investments	8,547,933	9,554,811	2,021,333	-	20,123,577	259,390	-	20,382,967	-	-	1,127,849	(589,367)	-	589,367	21,510,816
Investments in joint ventures	3,565,975	3,127,558	-	-	6,693,528	-	-	6,693,528	-	1,263,713	-	5,543,083	-	-	13,500,324
Property, plant and equipment - net	51,317,622	30,472,774	7,868,327	-	89,658,723	-	-	89,658,723	3,213,132	1,261,561	1,785,171	376,868	-	-	96,295,455
Other assets:															
Due from affiliated entities - net of current portion	31,960,910	2,620,000	250,000	-	34,830,910	-	-	34,830,910	-	-	-	-	-	(34,830,910)	-
Goodwill and intangible assets - net	-	-	578,808	-	578,808	-	-	578,808	256,271	-	-	5,628,027	-	-	6,463,106
Other assets	1,866,512	831,619	355,605	-	3,053,736	376,164	-	3,429,900	-	-	591,402	326,934	867,152	-	5,215,388
Total other assets	33,827,422	3,451,619	1,184,413	-	38,463,454	376,164	-	38,839,618	256,271	-	591,402	5,954,961	867,152	(34,830,910)	11,678,494
Total assets	$ 170,071,384	$ 79,868,773	$ 16,347,804	$ (822,530)	$ 265,463,431	$ 15,411,086	$ (9,619,053)	$ 271,257,464	$ 7,459,282	$ 2,669,000	$ 12,237,525	$ 20,833,298	$ 10,802,509	$ (41,968,953)	$ 283,290,125

See accompanying independent auditors' report.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidating Balance Sheet (continued)
September 30, 2012

	The Manchester Memorial Hospital	The Rockville General Hospital, Inc.	ECHN ElderCare Services, Inc.	Eliminations	Subtotal Series A Obligated Group	ECHN Community Healthcare Foundation, Inc.	Eliminations	Subtotal Series C, Series D, and Series E Obligated Group	Eastern CT Medical Professionals Foundation, Inc.	ECHN Enterprises, Inc. and Subsidiaries	Visiting Nurse & Health Services of Connecticut Inc.	Eastern Connecticut Health Network, Inc.	Connecticut Healthcare Insurance Company	Eliminations	Total
Liabilities and Net Assets (Deficit)															
Current liabilities:															
Accounts payable and accrued expenses	$ 17,702,182	$ 5,969,615	$ 1,430,433	$ -	$ 25,102,230	$ 70,933	$ -	$ 25,173,163	$ 1,870,967	$ 16,376	$ 2,005,029	$ 1,572,926	$ 94,215	$ -	$ 30,730,676
Lines of credit	6,500,000	-	-	-	6,500,000	-	-	6,500,000	-	-	-	-	-	-	6,500,000
Current portion of long-term debt	3,398,759	1,271,671	524,668	-	5,695,098	-	-	5,695,098	23,160	23,469	-	1,162,697	-	-	6,904,354
Due to affiliates	818,589	3,297,172	3,947	(822,530)	3,297,172	540,547	-	3,837,719	5,345,034	2,403,282	-	19,489,410	-	(31,080,945)	-
Current portion of estimated settlements due to third-party payers	1,343,126	1,157,913	292,736	-	2,793,775	-	-	2,793,775	-	-	-	-	-	-	2,793,775
Current portion of accrued pension and other postretirement benefits	2,733,125	1,164,039	-	-	3,897,164	-	-	3,897,164	-	-	-	-	-	-	3,897,164
Other current liabilities	2,426,820	715,430	179,157	-	3,321,407	-	-	3,321,407	-	-	707,490	-	4,124,476	-	8,153,373
Total current liabilities	35,422,595	13,575,840	2,430,941	(822,530)	50,606,846	611,480	-	51,218,326	7,239,161	2,443,627	2,710,519	22,224,983	4,218,691	(31,080,945)	58,979,342
Long-term debt and capital lease obligations, net of current portion	51,672,633	24,394,084	8,879,308	-	84,946,025	-	-	84,946,025	247,832	298,972	114,416	1,954,504	-	-	87,561,749
Estimated self-insurance liabilities	9,814,802	3,307,458	514,642	-	13,636,902	-	-	13,636,902	-	-	-	-	6,579,795	(10,695,000)	9,521,697
Accrued pension and postretirement benefits	57,470,806	17,147,802	-	-	74,618,608	-	-	74,618,608	-	-	-	-	-	-	74,618,608
Estimated settlements due to third-party payers, net of current portion	-	-	-	-	-	-	-	-	-	-	82,500	-	-	-	82,500
Other liabilities	684,775	128,578	127,723	-	941,076	3,892	-	944,968	-	-	-	-	-	-	944,968
Total liabilities	155,065,611	58,553,762	11,952,614	(822,530)	224,749,457	615,372	-	225,364,829	7,486,993	2,742,599	2,907,435	24,179,487	10,798,486	(41,775,945)	231,688,864
Net assets (deficit):															
Unrestricted	4,925,515	17,066,097	4,368,849	-	26,360,461	1,692,807	-	28,053,268	(27,691)	(78,599)	9,257,504	(3,944,864)	4,023	5,290,843	36,549,384
Temporarily restricted	1,905,069	615,748	31,341	-	2,552,158	11,535,595	(8,051,741)	6,036,012	-	-	72,586	618,775	-	(3,483,851)	3,243,522
Permanently restricted	8,175,189	3,653,166	-	-	11,828,355	1,567,312	(1,567,312)	11,828,355	-	-	-	-	-	-	11,828,355
Total net assets (deficit)	15,005,773	21,315,011	4,395,190	-	40,740,974	14,795,714	(9,619,053)	45,892,635	(27,691)	(78,599)	9,330,090	(3,326,189)	4,023	(198,008)	51,601,261
Total liabilities and net assets (deficit)	$ 170,071,384	$ 79,868,773	$ 16,347,804	$ (822,530)	$ 265,465,431	$ 15,411,086	$ (9,619,053)	$ 271,257,464	$ 7,459,282	$ 2,663,000	$ 12,237,525	$ 20,853,298	$ 10,802,509	$ (41,968,953)	$ 283,290,125

See accompanying independent auditors' report.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidating Statement of Operations and Changes in Net Assets
For the Year Ended September 30, 2012

	The Manchester Memorial Hospital	The Rockville General Hospital, Inc.	ECHN ElderCare Services, Inc.	Eliminations	Subtotal Series A Obligated Group	ECHN Community Healthcare Foundation, Inc.	Eliminations	Subtotal Series B, Series C, and Series D Obligated Group	Eastern CT Medical Professionals Foundation, Inc.	ECHN Enterprises, Inc. and Subsidiaries	Visiting Nurse & Health Services of Connecticut Inc.	Eastern Connecticut Health Network, Inc.	Connecticut Healthcare Insurance Company	Eliminations	Total
Revenues:															
Net patient service revenue	$ 175,217,566	$ 67,847,638	$ 14,598,768	$ -	$ 257,663,972	$ -	$ -	$ 257,663,972	$ 19,379,025	$ -	$ -	$ -	$ -	$ -	$ 277,042,997
Provision for bad debts	(6,382,307)	(3,309,948)	(162,851)	-	(9,855,106)	-	-	(9,855,106)	(1,430,104)	-	-	-	-	-	(11,285,210)
Net patient service revenue less provision for bad debts	168,835,259	64,537,690	14,435,917	-	247,808,866	-	-	247,808,866	17,948,921	-	-	-	-	-	265,757,787
Contributions	2,055,698	192,851	14,565	-	2,243,112	-	-	2,243,112	-	-	-	264,366	-	(264,366)	2,243,112
Other revenues	15,303,250	5,020,036	192,114	(780,629)	19,734,765	820,595	(814,140)	19,741,220	7,309,670	330,791	-	3,436,821	2,299,700	(16,085,874)	17,532,328
EHR initiative payment revenue	2,206,302	1,626,870	-	-	3,833,172	-	-	3,833,172	-	-	-	-	-	-	3,833,172
Contribution of VNHSC	-	-	-	-	-	-	-	-	-	-	-	4,592,459	-	-	4,592,459
Net assets released from restrictions used for operations	316,686	31,857	19	-	348,562	289,326	-	637,888	-	-	-	225	-	-	638,113
Total revenues	188,697,195	71,409,298	14,642,613	(780,629)	273,968,477	1,109,921	(814,140)	274,264,258	25,258,591	330,791	-	8,293,871	2,299,700	(16,350,240)	294,596,971
Expenses:															
Salaries and wages	81,549,825	30,268,391	7,011,831	-	118,830,047	477,716	(349,888)	118,957,875	20,957,854	-	-	11,551,692	-	(11,551,692)	139,915,729
Fringe benefits	25,465,287	10,225,293	2,219,761	-	37,908,341	116,129	(379,360)	37,645,210	3,275,112	-	-	2,287,709	-	(2,287,706)	40,920,325
Supplies and other expenses	62,035,761	25,886,843	4,320,634	(780,629)	91,462,609	516,076	(84,992)	91,893,693	7,327,377	353,981	-	(5,746,516)	6,134,132	(5,144,290)	99,818,377
Depreciation and amortization	6,896,812	3,811,952	539,694	-	11,248,458	-	-	11,248,458	477,564	85,611	-	150,759	-	(150,759)	11,811,633
Interest and financing costs	2,714,044	719,107	508,782	-	3,941,933	-	-	3,941,933	21,703	18,195	-	219,413	-	(219,413)	3,981,831
Total expenses	178,661,729	70,909,586	14,600,702	(780,629)	263,391,388	1,109,921	(814,140)	263,687,169	32,059,610	457,787	-	7,463,057	6,134,132	(19,353,860)	290,447,895
Income (loss) from operations	10,035,466	499,712	41,911	-	10,577,089	-	-	10,577,089	(6,301,019)	(126,996)	-	830,814	(3,834,432)	3,003,620	4,149,076
Non-operating (losses) gains	(868,637)	(179,961)	41,454	-	(1,007,144)	-	-	(1,007,144)	-	(193,392)	-	(830,814)	-	830,814	(1,200,536)
Excess of revenues over (under) expenses	$ 9,166,829	$ 319,751	$ 83,365	$ -	$ 9,569,945	$ -	$ -	$ 9,569,945	$ (6,301,019)	$ (320,388)	$ -	$ -	$ (3,834,432)	$ 3,834,434	$ 2,948,540

See accompanying independent auditors' report.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidating Statement of Operations and Changes in Net Assets (continued)
For the Year Ended September 30, 2012

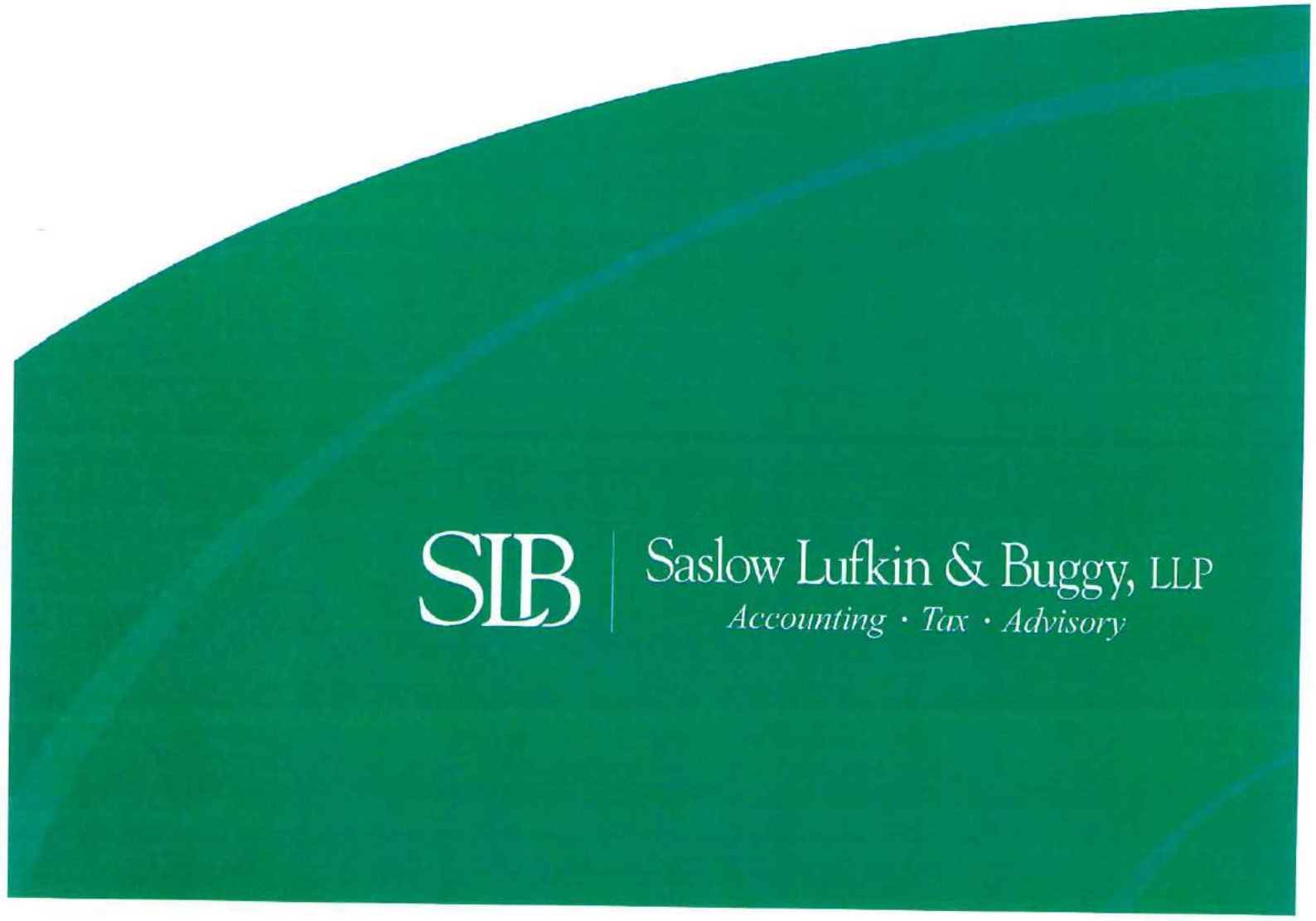
	The Manchester Memorial Hospital	The Rockville General Hospital, Inc.	ECHN ElderCare Services, Inc.	Eliminations	Subtotal Series A Obligated Group	ECHN Community Healthcare Foundation, Inc.	Eliminations	Subtotal Series B, Series C, and Series D Obligated Group	Eastern CT Medical Professionals Foundation, Inc.	ECHN Enterprises, Inc. and Subsidiaries	Visiting Nurse & Health Services of Connecticut Inc.	Eastern Connecticut Health Network, Inc.	Connecticut Healthcare Insurance Company	Eliminations	Total
Unrestricted net assets:															
Excess of revenues over (under) expenses	$ 9,166,829	$ 319,751	$ 83,565	$ -	$ 9,569,945	$ -	$ -	$ 9,569,945	$ (6,301,019)	$ (320,388)	$ -	$ -	$ (3,834,432)	$ 3,834,434	$ 2,948,540
Change in unrealized appreciation on investments	3,361,907	3,413,298	224,010	-	6,999,215	-	-	6,999,215	-	-	-	646,773	328,272	-	7,974,260
Net change in interest rate swap agreements	(123,039)	-	-	-	(123,039)	-	-	(123,039)	-	-	-	-	-	-	(123,039)
Net assets released from restrictions for capital acquisitions	231,566	48,524	55,987	-	336,077	-	-	336,077	-	-	-	-	-	-	336,077
Equity transfer to ECHN	(4,095,662)	(8,205,357)	-	-	(12,301,019)	-	-	(12,301,019)	-	-	-	12,301,019	-	-	-
Equity transfer from ECHN	6,000,000	-	-	-	6,000,000	-	-	6,000,000	6,301,019	-	-	(12,301,019)	-	-	-
VNHSC transfer	-	-	-	-	-	-	-	-	-	-	9,257,504	(9,257,504)	-	-	-
Transfer (to) from other affiliates - net	(310,801)	424,971	2,654	-	116,824	(92,176)	-	24,648	-	-	-	(24,648)	-	-	-
Pension and postretirement-related adjustments	(12,778,592)	(3,623,818)	-	-	(16,402,410)	-	-	(16,402,410)	-	-	-	-	-	-	(16,402,410)
Change in unrestricted net assets	1,452,208	(7,622,031)	366,016	-	(5,804,407)	(92,176)	-	(5,896,583)	-	(320,388)	9,257,504	(8,635,379)	(3,506,160)	3,834,434	(5,266,572)
Temporarily restricted net assets:															
Contributions	450,324	54,836	3,902	-	509,062	3,570,388	(2,487,806)	1,591,644	-	-	-	528,889	-	(793,255)	1,327,278
Investment income	18,520	18,801	-	-	37,321	26,602	(26,601)	37,322	-	-	-	-	-	-	37,322
Net assets released from restrictions for operations	(316,686)	(31,857)	(19)	-	(348,562)	(1,098,260)	808,709	(638,113)	-	-	-	(225)	-	225	(638,113)
Net assets released from restrictions for capital acquisitions	(231,566)	(48,524)	(55,987)	-	(336,077)	(336,077)	336,077	(336,077)	-	-	-	-	-	-	(336,077)
Change in unrealized appreciation on investments	345,177	119,637	9,958	-	474,772	1,918,625	(1,511,167)	1,082,230	-	-	-	55,791	-	(607,458)	530,563
Contribution of VNHSC	-	-	-	-	-	-	-	-	-	-	72,586	-	-	-	72,586
Transfer (to) from affiliates	650,598	(409,676)	-	-	240,922	-	(265,570)	(24,648)	-	-	-	(240,922)	-	265,570	-
Change in temporarily restricted net assets	916,367	(296,783)	(42,146)	-	577,438	4,081,278	(2,946,358)	1,712,358	-	-	72,586	343,533	-	(1,134,918)	993,559
Permanently restricted net assets:															
Change in beneficial interest in trust assets	495,556	217,061	-	-	712,617	-	-	712,617	-	-	-	-	-	-	712,617
Change in permanently restricted net assets	495,556	217,061	-	-	712,617	-	-	712,617	-	-	-	-	-	-	712,617
Change in net assets (deficit)	2,864,131	(7,702,353)	323,870	-	(4,514,352)	3,989,102	(2,946,358)	(3,471,608)	-	(320,388)	9,330,090	(8,291,846)	(3,506,160)	2,699,516	(3,560,396)
Net assets (deficit), beginning of year	12,141,642	29,017,364	4,071,320	-	45,230,326	10,806,612	(6,672,695)	49,364,243	(27,691)	241,789	-	4,965,657	3,510,183	(2,892,524)	55,161,657
Net assets (deficit), end of year	$ 15,005,773	$ 21,315,011	$ 4,395,190	$ -	$ 40,715,974	$ 14,795,714	$ (9,619,053)	$ 45,892,635	$ (27,691)	$ (78,599)	$ 9,330,090	$ (3,326,189)	$ 4,023	$ (193,008)	$ 51,601,261

See accompanying independent auditors' report.

Eastern Connecticut Health Network, Inc. and Subsidiaries

Independent Auditors' Report,
Consolidated Financial Statements and
Supplemental Information

As of and for the Years Ended
September 30, 2014 and 2013



Eastern Connecticut Health Network, Inc. and Subsidiaries
Independent Auditors' Report, Consolidated Financial Statements and Supplemental Information
As of and for the Years Ended September 30, 2014 and 2013

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Independent Auditors' Report

To the Board of Trustees of
Eastern Connecticut Health Network, Inc. and Subsidiaries:

We have audited the accompanying consolidated financial statements of Eastern Connecticut Health Network, Inc. and Subsidiaries (the Network), a not-for-profit, non-stock corporation, which comprise the consolidated balance sheets as of September 30, 2014 and 2013, and the related consolidated statements of operations and changes in net assets and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

The Network's management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We did not audit the financial statements of Connecticut Healthcare Insurance Company, a wholly owned subsidiary, whose statements reflect total assets of $7,384,595 and $5,220,598, as of September 30, 2014 and 2013, respectively, and total revenues of $2,251,542 and $2,440,340, respectively, for the years then ended. These statements were audited by other auditors whose report has been furnished to us and our opinion, insofar as it relates to the amounts included for Connecticut Healthcare Insurance Company, is based solely on the report of the other auditors. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Network's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Network's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting principles used and the reasonableness of significant account estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, based on our audits and the report of the other auditors, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of Eastern Connecticut Health Network, Inc. and Subsidiaries as of September 30, 2014 and 2013, and the results of its consolidated operations and its consolidated cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

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Report on Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The consolidating information listed within the Table of Contents is presented for purposes of additional analysis of the consolidated financial statements rather than to present the financial position, results of operations and changes in net assets of the individual entities and is not a required part of the consolidated financial statements. Accordingly, we do not express an opinion on the financial position, results of operations and cash flows of the individual companies. The consolidating information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. Such information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the consolidating information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Saslow Lufkin & Buggy, LLP

January 27, 2015

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidated Balance Sheets
September 30, 2014 and 2013

	2014	2013
Assets		
Current assets:		
Cash and cash equivalents	$ 20,733,601	$ 22,439,356
Current portion of investments held under bond indentures	1,163,916	1,850,531
Accounts receivable, less allowance for bad debts of $8,915,132 in 2014 and $10,060,009 in 2013	44,610,272	46,524,143
Inventory	5,437,285	5,065,716
Current portion of estimated settlements due from third-party payers	3,602,585	3,463,096
Prepaid expenses and other current assets	5,686,236	5,046,865
Total current assets	81,233,895	84,389,707
Assets whose use is limited, net of current portion:		
Donor restricted investments	6,097,747	6,534,923
Board designated investments	37,980,275	33,138,323
Investments held in trust for estimated self-insurance liabilities	5,005,755	2,465,931
Beneficial interest in trust assets	11,809,221	7,882,372
Investments held under bond indentures	5,171,545	4,942,057
Total assets whose use is limited, net of current portion	66,064,543	54,963,606
Investments	7,138,341	13,009,540
Investments in joint ventures	14,562,738	13,731,843
Property, plant and equipment - net	94,065,559	96,188,497
Other assets:		
Estimated settlements due from third-party payers, net of current portion	685,669	6,804,542
Goodwill and intangible assets, net	6,967,353	7,145,869
Other assets	5,369,091	6,233,132
Total other assets	13,022,113	20,183,543
Total assets	$ 276,087,189	$ 282,466,736
Liabilities and Net Assets		
Current liabilities:		
Accounts payable and accrued expenses	$ 35,964,615	$ 34,874,835
Line of credit	5,600,000	6,500,000
Current portion of long-term debt and capital lease obligations	6,489,656	6,832,322
Current portion of estimated settlements due to third-party payers	5,743,160	4,512,361
Current portion of accrued pension and other postretirement benefits	1,313,769	6,085,518
Other current liabilities	5,841,792	5,321,044
Total current liabilities	60,952,992	64,126,080
Long-term debt and capital lease obligations, net of current portion	82,595,414	84,416,006
Estimated self-insurance liabilities	9,683,668	9,243,930
Accrued pension and other postretirement benefits	44,676,486	38,111,463
Estimated settlements due to third-party payers, net of current portion	65,838	122,921
Other liabilities	419,002	597,187
Total liabilities	198,393,400	196,617,587
Net assets:		
Unrestricted	59,544,873	70,965,928
Temporarily restricted	2,096,313	2,587,301
Permanently restricted	16,052,603	12,295,920
Total net assets	77,693,789	85,849,149
Total liabilities and net assets	$ 276,087,189	$ 282,466,736

The accompanying notes are an integral part of these consolidated financial statements.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidated Statements of Operations and Changes in Net Assets
For the Years Ended September 30, 2014 and 2013

	2014	2013
Revenues:		
Net patient service revenues	$ 309,971,310	$ 310,122,159
Provision for bad debts	(10,216,094)	(11,142,202)
Net patient service revenues less provision for bad debts	299,755,216	298,979,957
Contributions	1,163,883	1,614,319
Other revenues	25,216,442	22,871,370
EHR incentive payment revenue	1,786,134	2,630,820
Net assets released from restrictions used for operations	833,650	1,871,227
Total revenues	328,755,325	327,967,693
Expenses:		
Salaries and wages	162,727,445	163,729,402
Fringe benefits	43,859,398	47,592,094
Supplies and other expenses	104,034,396	100,342,397
Depreciation and amortization	12,196,877	12,290,822
Interest and financing costs	3,764,488	3,900,483
Total expenses	326,582,604	327,855,198
Income from operations	2,172,721	112,495
Non-operating losses	(2,125,751)	(2,138,589)
Excess of revenues over (under) expenses	$ 46,970	$ (2,026,094)

The accompanying notes are an integral part of these consolidated financial statements.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidated Statements of Operations and Changes in Net Assets (continued)
For the Years Ended September 30, 2014 and 2013

	2014	2013
Unrestricted net assets:		
Excess of revenues over (under) expenses	$ 46,970	$ (2,026,094)
Unrealized (depreciation) appreciation on investments	(5,476,925)	1,235,494
Net change in interest rate swap agreements	8,379	110,862
Net assets released from restrictions for capital acquisitions	437,676	468,174
Pension and postretirement related adjustments	(6,438,240)	34,634,083
Other	1,085	(5,975)
Change in unrestricted net assets	(11,421,055)	34,416,544
Temporarily restricted net assets:		
Contributions	580,515	1,262,993
Investment income	533,939	200,796
Net assets released from restrictions used for operations	(833,650)	(1,871,227)
Net assets released from restrictions for capital acquisitions	(437,676)	(468,174)
Unrealized (depreciation) appreciation on investments	(334,116)	219,391
Change in temporarily restricted net assets	(490,988)	(656,221)
Permanently restricted net assets:		
Contributions - beneficial interest trust assets	3,751,750	-
Change in beneficial interest in trust assets	176,043	481,590
Reclassifications of donations	(171,110)	5,975
Change in permanently restricted net assets	3,756,683	487,565
Change in net assets	(8,155,360)	34,247,888
Net assets, beginning of year	85,849,149	51,601,261
Net assets, end of year	$ 77,693,789	$ 85,849,149

The accompanying notes are an integral part of these consolidated financial statements.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidated Statements of Cash Flows
For the Years Ended September 30, 2014 and 2013

	2014	2013
Cash flows from operating activities:		
Change in net assets	$ (8,155,360)	$ 34,247,888
Adjustments to reconcile change in net assets to net cash provided by (used in) operating activities:		
Depreciation and amortization	12,196,877	12,290,822
Provision for bad debts	10,216,094	11,142,202
Unrealized depreciation (appreciation) on investments	5,811,041	(1,454,885)
Realized gains on sales of investments	(8,307,110)	(5,584,750)
Change in beneficial interest in trust assets	(3,926,849)	(481,590)
Income on investments in joint ventures	(2,478,524)	(2,113,663)
Pension and postretirement related adjustments	6,438,240	(34,634,083)
Change in pledges receivable	668,567	311,968
Change in interest rate swap agreements	177,835	(358,754)
Changes in assets and liabilities:		
Accounts receivable	(8,302,223)	(10,955,090)
Inventory	(371,569)	(812,116)
Prepaid expenses and other current assets	(1,097,826)	(26,258)
Amortization of intangible assets	178,516	(682,763)
Other assets	653,929	(1,310,364)
Accounts payable and accrued expenses	1,089,780	4,144,159
Accrued pension and other postretirement benefits	(4,644,966)	315,292
Estimated settlements (to)/from third-party payers	7,153,100	(4,105,711)
Other current liabilities	301,311	(509,424)
Estimated self-insurance liabilities	659,175	(2,600,672)
Other liabilities	(356,020)	10,973
Net cash provided by (used in) operating activities	7,904,018	(3,166,819)
Cash flows from investing activities:		
Purchases of property and equipment	(10,073,939)	(12,104,527)
Sales of investments, net	1,879,795	19,072,951
Distributions from joint ventures	1,647,629	1,802,805
Net cash (used in) provided by investing activities	(6,546,515)	8,771,229
Cash flows from financing activities:		
Principal payments on long-term debt	(7,235,595)	(7,079,140)
Net payments on line of credit	(900,000)	-
Payments for bond issuance costs	-	(19,346)
Proceeds from borrowings	5,072,337	3,881,365
Net cash used in financing activities	(3,063,258)	(3,217,121)
Change in cash and cash equivalents	(1,705,755)	2,387,289
Cash and cash equivalents at beginning of year	22,439,356	20,052,067
Cash and cash equivalents at end of year	$ 20,733,601	$ 22,439,356
Cash paid for interest	$ 3,880,091	$ 4,095,398
Equipment acquisitions under capital lease arrangements	$ 2,266,700	$ 2,351,850

The accompanying notes are an integral part of these consolidated financial statements.

Note 1 - Organization

Eastern Connecticut Health Network, Inc. (ECHN) and Subsidiaries (collectively the Network) is a not-for-profit, locally governed health system created on September 12, 1995, through the merger of the corporate parents of Manchester Memorial Hospital and Rockville General Hospital, Inc. Its purpose is to provide a health care system for the communities it serves, with quality medical care at a reasonable cost; to foster an environment conducive to health and well-being, whether in the home or in the community; and to enable the health care system to expand to meet the future needs of its communities. ECHN, through its subsidiaries (or members), provides health care, health education, and community services to residents of more than 19 towns in eastern Connecticut, regardless of their ability to pay.

ECHN is the sole member or shareholder of the following subsidiaries:

The Manchester Memorial Hospital (MMH) - MMH is a not-for-profit hospital with 249 licensed beds, located in Manchester, Connecticut. MMH, which admitted its first patient in 1920, is a short-term, acute-care general hospital, which provides inpatient, outpatient, and emergency care services to the residents of Manchester and 19 nearby towns.

The Rockville General Hospital, Inc. (RGH) - RGH is a not-for-profit hospital with 102 licensed beds, located in the Rockville section of Vernon, Connecticut. RGH, which admitted its first patient in 1921, is a short-term, acute-care general hospital, which provides inpatient, outpatient, and emergency care services for residents of Tolland County and nearby towns, for a total service area of 19 towns.

ECHN ElderCare Services, Inc. (EES) - EES is a not-for-profit, skilled nursing facility with 130 licensed beds and physical, occupational and speech rehabilitation services located in Tolland, Connecticut.

ECHN Community Healthcare Foundation, Inc. (ECHF) - ECHF is a not-for-profit organization whose purpose is to raise funds on behalf of ECHN and its not-for-profit subsidiaries. It was established in 2000, when the fund-raising efforts of ECHN were consolidated into a single not-for-profit foundation. ECHF focuses primarily on the capital and program needs of ECHN and its not-for-profit subsidiaries.

Eastern Connecticut Medical Professionals Foundation, Inc. (ECMPF) - ECMPF is a not-for-profit organization that currently operates physician office practices in the Network's service area and a hospitalist program that serves MMH and RGH. Its mission allows it to operate other not-for-profit, separately incorporated allied health ventures.

ECHN Enterprises, Inc. (Enterprises) - Enterprises is a for-profit organization formed under the laws of the State of Connecticut, with ECHN as the sole shareholder. Enterprises owns, leases and has an interest in real estate to support the mission and vision for ECHN. It is also the parent corporation of Haynes Street Property Management, LLC (HSPM). HSPM is a for-profit, limited liability company formed under the laws of the State of Connecticut, which manages the Glastonbury Wellness Center and sublets space to various MMH departments and physician offices, as well as to ECMPF.

Visiting Nurse and Health Services of Connecticut, Inc. (VNHSC) - VNHSC is a not-for-profit, nonstock Connecticut corporation that provides and administers a comprehensive, multi-disciplinary home health program, hospice program and wellness programs to promote the health of individuals, families and groups in the Greater Northern Central Connecticut area. In addition, VNHSC is the sole member of A Caring Hand, LLC, which is a for-profit Connecticut limited liability company providing and administering homemaker, companion, live-in and personal care assistance services to individuals and families in the Greater Northern Central Connecticut area.

Note 1 - Organization (continued)

Connecticut Healthcare Insurance Company (CHIC) - CHIC, a captive insurance company, provides hospital and physician professional and general liability coverage to MMH, RGH, EES, and all other subsidiaries.

ECHN Corporate Services (ECHNCS) - ECHNCS is a for-profit stock corporation formed under the laws of the State of Connecticut, with ECHN as the sole shareholder. ECHNCS provides billing and other practice management services to the Network and other customers. It is also the parent corporation of Medical Practice Partners, LLC (MPP). MPP is a for-profit, limited liability company formed under the laws of the State of Connecticut, which provides practice management services to medical group practices throughout Connecticut.

CINECT - CINECT is a for-profit organization formed to develop a clinically integrated network of community providers that offers high-quality care, value, and an enhanced patient experience. CINECT's mission is to better manage the health of the communities that we serve. While formed during 2014 CINECT has not commenced operations as of September 30, 2014.

ECHN and each of its subsidiaries, except for Enterprises, CHIC, ECHNCS and CINECT, are separate Connecticut not-for-profit corporations, qualified as exempt organizations under Section 501(c)(3) of the Internal Revenue Code (IRC) and governed by separate Boards of Trustees (the Board) - although the membership of the ECHN, MMH and RGH boards are currently identical. ECHN, acting through its Board of Trustees, is the sole member of each of its members. ECHN has various powers with regard to each of its members, which include approving all operating and capital budgets; controlling the investment of funds, location of services, agreements and transactions, and affiliations; controlling changes, amendments, or restatements of certificates of incorporation and bylaws; electing trustees and officers; appointing committees; adopting a system-wide vision and strategic plans; and approving debt borrowings.

In August 2013, the ECHN Board of Trustees announced that it had signed a non-binding letter of intent to negotiate the sale of ECHN to a newly formed joint partnership between Tenet Healthcare Corporation (Tenet) and Yale New Haven Health System (YNHHS). On May 12, 2014, Corporators of ECHN voted favorably on the health system's proposed Asset Purchase Agreement (APA) between ECHN and a historic joint venture between Tenet and YNHHS.

On October 24, 2014, ECHN filed its Certificate of Need (CON) application with the Connecticut State regulatory offices, including the Department of Public Health Office of Health Care Access (OCHA) and the Office of the Attorney General. This formal application process is part of the continued pursuit of the acquisition of ECHN by a joint venture between Tenet and YNHHS.

It is anticipated that the state government's review of the application will continue over the next few months and ECHN is working diligently with state and federal regulators to meet all criteria for final approval of the proposed transaction. A definitive agreement is expected to be reached by sometime in early calendar year 2015.

As of September 30, 2014, management has not finalized a purchase agreement and the Trustees believe that the Network will continue with its normal operations and as a going concern for the foreseeable future.

Basis of Presentation - The accompanying consolidated financial statements have been prepared in conformity with accounting principles generally accepted in the United States of America (GAAP), as promulgated by the Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC). The consolidated financial statements include the accounts of ECHN and its subsidiaries. Significant intercompany accounts and transactions have been eliminated in consolidation. The assets of any member of the consolidated group may not be available to meet the obligations of other members in the group.

Note 2 - Summary of Significant Accounting Policies

Use of Estimates - The preparation of consolidated financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

The Network's significant estimates relate to the valuation of investments and interest rate swap agreements, allowance for doubtful patient accounts receivable, contractual allowances on patient accounts receivable, self-insurance liabilities, estimated settlements due to and from third parties, conditional asset retirement obligations, postretirement and pension benefit costs and the related obligations.

Cash and Cash Equivalents - The Network considers all highly liquid investments with original maturities of three months or less at date of purchase to be cash equivalents, excluding amounts whose use is limited or restricted by Board designation or other arrangements under trust agreements. Cash equivalents include money market funds. Cash balances maintained at banks are insured by the Federal Deposit Insurance Corporation (FDIC). At times, the Network maintains cash balances that are in excess of the $250,000 insured FDIC limits. The Network maintains its cash at various banks and it is the Network's policy to monitor the banks' financial strength on an ongoing basis.

Money market funds are not insured by the FDIC and are not a risk-free investment. Money market funds invest in a variety of instruments including mortgage-backed and asset-backed securities. Although a money market fund seeks to preserve its $1 per share value, it is possible that a money market fund's value can decrease below $1 per share.

Net Assets - Resources are reported for accounting purposes in separate classes of net assets based on the existence or absence of donor-imposed restrictions. In the accompanying consolidated financial statements, net assets that have similar characteristics have been combined as follows:

> ***Permanently Restricted*** - Net assets subject to explicit donor imposed stipulations that they be maintained by the Network in perpetuity are classified as permanently restricted. Such permanently restricted net assets include endowment funds and MMH's and RGH's share of their beneficial interest in trust assets held by third parties. Generally, the donors of these assets permit the members of ECHN to use all or part of the investment return on these assets for operating purposes.
>
> ***Temporarily Restricted*** - Net assets whose use by the Network is subject to explicit donor imposed stipulations that can be fulfilled upon incurrence of expenditures by the Network pursuant to those stipulations or that expire by the passage of time are classified as temporarily restricted.
>
> ***Unrestricted*** - Net assets that are not subject to explicit donor-imposed stipulations are classified as unrestricted. Unrestricted net assets may be designated for specific purposes by action of the Board or may otherwise be limited by contractual agreements with outside parties; such designated assets are classified as assets whose use is limited in the accompanying consolidated balance sheets.

Note 2 - Summary of Significant Accounting Policies (continued)

Revenues are reported as increases in unrestricted net assets, unless use of the related assets is limited by donor imposed restrictions. Expenses are reported as decreases in unrestricted net assets. Gains and losses on investments and other assets or liabilities are reported as increases or decreases in unrestricted net assets, unless their use is restricted by explicit donor stipulations or by law. Expirations of temporary restrictions on net assets, that is, the donor imposed stipulated purpose has been accomplished and/or the stipulated time period has elapsed, are reported as reclassifications between the applicable classes of net assets.

Contributions, including unconditional promises to give, are recognized as revenues at the date the promise is received. Contributions of assets other than cash are recorded at their estimated fair value. Contributions to be received after one year are discounted at a rate commensurate with the risks involved. Amortization of the discount is included in other revenue. Contributions restricted for the acquisition of land, buildings, and equipment are reported as temporarily restricted support. These contributions are reclassified to unrestricted net assets when the capital asset is acquired or constructed and placed in service.

Assets Whose Use is Limited - Assets whose use is limited primarily include cash and investments held by trustees under indenture agreements, cash and investments held for estimated self-insurance liabilities, Board designated investments, which include endowments, cash and investments set aside by the Board for future capital improvements over which the Board retains control and may at its discretion subsequently use for other purposes; and, beneficial interests in trust assets, which are donor restricted and other restricted investments. Amounts required to meet current liabilities of the Network have been classified as current assets in the consolidated balance sheets as of September 30, 2014 and 2013.

The income earned on restricted funds is generally available for operations of the Network and is recorded as revenue in unrestricted net assets, unless restricted by the donor or to pay future annuity obligations, at which time the income is added to the appropriate restricted net asset balance. However, if a specific gift instrument explicitly requires the permanent reinvestment of appreciation, or a portion thereof, such reinvested amounts are classified within permanently restricted net assets. There were no gifts with reinvestment restrictions for the years ended September 30, 2014 and 2013.

Assets received as donations or bequests are recorded as contributions on the date received at the estimated fair value. The average cost method is used to determine realized gains or losses on sales of marketable equity securities.

Beneficial Interest in Trust Assets - MMH and RGH have been named sole or participating beneficiaries in several perpetual trusts, for which third parties act as the trustee. Under the terms of these trusts, MMH and RGH have the irrevocable right to receive the income earned on the trust assets held in perpetuity. The estimated present value of the future payments to MMH and RGH is recorded at the fair value of the assets held in the trust as beneficial interest in trust assets in the respective balance sheets of MMH and RGH and are permanently restricted as to use.

The income from the trusts is included in the change in interest in net assets of ECHF as unrestricted and temporarily restricted support and other income. Fluctuations in the fair value of the trust assets are recognized as changes in permanently restricted net assets. MMH and RGH record their beneficial interest in trust assets when they are notified of the existence of the trust or when information becomes available to record the fair value of the trust assets.

Note 2 - Summary of Significant Accounting Policies (continued)

Investments - The Network's investment portfolio is classified as available for sale, with unrealized gains and losses excluded from excess of revenues over expenses, unless the losses are deemed to be other than temporary. Investments with readily determinable fair values are measured at fair value in the consolidated balance sheets.

Investment income or loss (including realized gains and losses on investments, interest, and dividends) is included in the excess of revenues over expenses, unless the income or loss is restricted by donor or law.

Other-Than-Temporary Impairments on Investments - The Network accounts for other than temporary impairments in accordance with FASB ASC 320, "*Investments - Debt and Equity Securities*" and continually reviews its securities for impairment conditions, which could indicate that an other than temporary decline in market value has occurred. In conducting this review, numerous factors are considered, which include specific information pertaining to an individual company or a particular industry, general market conditions that reflect prospects for the economy as a whole, and the ability and intent to hold securities until recovery. The carrying value of investments is reduced to its estimated realizable value if a decline in fair value is considered to be other-than-temporary. There were no impairments recorded for the years ended September 30, 2014 and 2013.

Property, Plant and Equipment - Property, plant and equipment are stated at cost or, in the case of donated property, at fair value at the date of the gift, less accumulated depreciation and amortization. Major improvements and betterments to existing plant and equipment are capitalized. Expenditures for maintenance and repairs that do not extend the lives of the applicable assets are charged to expense as incurred. Upon disposition or retirement of property, plant and equipment, the cost and related accumulated depreciation and amortization are eliminated from the respective accounts and any resulting gain or loss is included in the results of consolidated operations.

Depreciation expense is computed on a straight-line basis over the following estimated useful lives:

Buildings	10-40 years
Building improvements	5-40 years
Machinery and equipment	3-15 years
Furniture and fixtures	5-20 years

Equipment under capital leases is amortized utilizing the straight-line method over the shorter of the lease term or the estimated useful life of the equipment. Depreciation and amortization expense was $11,988,770 and $12,137,690 for the years ended September 30, 2014 and 2013, respectively.

Interest cost incurred on borrowed funds during the construction period of capital assets is capitalized as a component of the cost of acquiring those assets.

Physician loan amortization totaling $208,107 and $153,132 for the years ended September 30, 2014 and 2013, respectively, is included within depreciation and amortization in the accompanying consolidated statements of operations and changes in net assets.

Gifts of property and equipment are reported as unrestricted support, and are excluded from the excess of revenues over expenses, unless explicit donor stipulations specify how the donated assets must be used. Gifts of property and equipment with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire property and equipment are reported as restricted support. Absent explicit donor stipulations about how long the property and equipment must be maintained, expirations of donor restrictions are reported as released from restrictions when the donated or acquired property and equipment assets are placed in service.

Note 2 - Summary of Significant Accounting Policies (continued)

Investments in Joint Ventures - The Network has invested in several joint ventures with other area hospitals, which are accounted for under the equity method of accounting. These joint ventures as of September 30, 2014 and 2013 include the Network's investments in the following:

	2014	Ownership Percentage	2013	Ownership Percentage
Northeast Regional Radiation Oncology Network, Inc.	$ 6,598,390	50 %	$ 6,216,646	50 %
Tolland Imaging Center	380,818	70 %	201,010	70 %
Metro Wheelchair Service Inc.	-	50 %	54,224	50 %
Ambulance Service of Manchester, LLC	3,798,727	50 %	3,772,317	50 %
Aetna Ambulance Service Inc.	1,961,496	50 %	1,772,500	50 %
Evergreen Endoscopy Center, LLC	359,698	50 %	292,807	50 %
Haynes Street Medical Associates	149,808	23 %	150,193	23 %
Haynes Street Medical Associates II	249,744	15 %	236,834	15 %
Evergreen Medical Associates, LLC	264,503	20 %	258,137	20 %
Evergreen Medical Associates II, LLC	583,419	20 %	559,585	20 %
Walden Behavioral Health	196,135	16 %	197,590	16 %
Total joint venture assets	14,542,738		13,711,843	
Other miscellaneous assets	20,000		20,000	
Total investments in joint ventures	$ 14,562,738		$ 13,731,843	

Distributions from these joint ventures totaled $1,647,629 and $1,802,805 for the years ended September 30, 2014 and 2013, respectively. ECHN's share of the earnings of the joint ventures is reported within other revenues and amounted to $2,478,524 and $2,113,663 for the years ended September 30, 2014 and 2013, respectively.

Note 2 - Summary of Significant Accounting Policies (continued)

Summarized financial information from the financial statements of these organizations as of September 30, 2014 and 2013 and for the years then ended, is as follows:

2014	Total Assets	Net Assets	Change in Net Assets	Excess of Revenues (Under) Over Expenses
Northeast Regional Radiation Oncology Network, Inc.	$ 13,250,462	$ 13,196,779	$ 763,486	$ 335,328
Metro Wheelchair Service Inc.	$ 151,744	$ (23,958)	$ (132,407)	$ (132,412)
Ambulance Service of Manchester, LLC	$ 9,224,170	$ 7,597,455	$ 52,822	$ 2,052,822
Aetna Ambulance Service Inc.	$ 4,926,263	$ 3,922,991	$ 377,992	$ 378,000
Haynes Street Medical Associates	$ 2,516,732	$ 705,640	$ 42,487	$ 66,803
Haynes Street Medical Associates II	$ 8,596,515	$ 1,888,090	$ 318,384	$ 275,998
Evergreen Endoscopy Center, LLC	$ 1,595,233	$ 429,991	$ (155,623)	$ 944,374
Evergreen Medical Associates, LLC	$ 6,612,745	$ 1,632,513	$ 293,056	$ 215,698
Evergreen Medical Associates II, LLC	$ 11,786,731	$ 3,059,097	$ 129,108	$ 365,789
Tolland Imaging Center	$ 775,884	$ 544,026	$ 256,871	$ 241,197
Walden Behavioral Health	$ 1,955,576	$ 1,190,586	$ (14,597)	$ 44,830

2013	Total Assets	Net Assets	Change in Net Assets	Excess of Revenues (Under) Over Expenses
Northeast Regional Radiation Oncology Network, Inc.	$ 12,490,586	$ 12,433,293	$ 212,661	$ 295,288
Metro Wheelchair Service Inc.	$ 221,853	$ 108,449	$ (60,913)	$ (60,914)
Ambulance Service of Manchester, LLC	$ 8,782,743	$ 7,544,633	$ 194,425	$ 2,494,426
Aetna Ambulance Service Inc.	$ 4,269,492	$ 3,544,999	$ 420,403	$ 420,404
Haynes Street Medical Associates	$ 2,542,951	$ 663,153	$ 23,205	$ 79,920
Haynes Street Medical Associates II	$ 8,435,369	$ 1,569,706	$ (112,714)	$ 181,272
Evergreen Endoscopy Center, LLC	$ 1,746,503	$ 585,614	$ (208,332)	$ 370,077
Evergreen Medical Associates, LLC	$ 6,484,054	$ 1,339,457	$ 45,367	$ 239,569
Evergreen Medical Associates II, LLC	$ 11,906,047	$ 2,929,989	$ (99,281)	$ 394,554
Tolland Imaging Center	$ 934,135	$ 287,155	$ 72,449	$ 65,048
Walden Behavioral Health	$ 1,651,417	$ 1,205,183	$ 53,023	$ (16,006)

Unamortized Bond Issue Costs - Financing costs associated with the issuance of long-term debt are amortized over the term of the bonds using the effective interest method. Amortization is included in interest and financing costs in the accompanying consolidated statements of operations and changes in net assets, and the unamortized carrying value is recorded within other - net in the accompanying consolidated balance sheets.

Note 2 - Summary of Significant Accounting Policies (continued)

Intangible Assets - Intangible assets, principally license enhancements and goodwill, are amortized over the life of the respective intangible property. On average, this amortization period for license enhancements and goodwill is 18 and 5 years, respectively. Amortization is included in depreciation and amortization in the accompanying consolidated statements of operations and changes in net assets and the unamortized carrying value is recorded within goodwill and intangible assets - net in the accompanying consolidated balance sheets. Any residual value remaining after the amortization period is considered insignificant.

Deferred Revenue - Deferred revenue represents payments received for services to be rendered in the next fiscal year and is recorded within other current liabilities in the accompanying consolidated balance sheets.

Excess of Revenues (Under) Over Expenses - The consolidated statements of operations and changes in net assets include excess of revenues (under) over expenses. Changes in unrestricted net assets, which are excluded from the excess of revenues (under) over expenses, consistent with industry practice, include the changes in unrealized appreciation (depreciation) on investments; net change in fair value of interest rate swap agreements that qualifies for hedge accounting; net assets released from restrictions used for capital acquisitions; pension and postretirement related adjustments; and other changes in net assets.

For purposes of display, transactions deemed by management to be ongoing, major or central to providing of health care services are reported as operating revenues and operating expenses. Operating revenues include net patient service revenue, grant income and investment income. Peripheral or incidental transactions are reported as non-operating gains and losses. Non-operating gains and losses include investment income and expenses related to property management, losses recognized on investments representing declines in value considered to be other-than-temporary in nature, changes in the fair values of interest rate swaps that do not qualify for hedge accounting (net interest expense) and the costs associated with pursuing business combinations.

Charity Care - MMH and RGH provide care to patients who meet certain criteria under their charity care policies without charge or at amounts less than its established and contractual rates. The hospitals do not pursue collection of amounts determined to qualify as charity care; as such, these amounts are not reported as revenue.

Net Patient Service Revenues - Net patient service revenues are reported at the estimated net realizable amounts from patients, third-party payers, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payers. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined.

Contracts, laws, and regulations governing Medicare, Medicaid, Blue Cross, and the uncompensated care pool programs are complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. The Network records adjustments in amounts accrued for estimated settlements related to prior years.

A portion of the accrual for estimated settlements with third-party payers has been classified as long-term because such amounts, by their nature or by virtue of regulation or legislation, are not expected to be paid within one year.

Note 2 - Summary of Significant Accounting Policies (continued)

MMH and RGH have agreements with third-party payers that provide for payments at amounts different from their established rates. A summary of the payment agreements with major third-party payers is as follows:

Medicare - Acute care hospitals are subject to a federal prospective payment system for most Medicare inpatient hospital services and for certain outpatient services. Under this prospective payment methodology, Medicare pays a prospectively determined per-discharge or per-visit rate for non-physician services. These rates vary according to the Diagnosis Related Group or Ambulatory Payment Classification of each patient.

Inpatient rehabilitation and mental health services, outpatient services, capital and medical education costs related to Medicare beneficiaries are paid based on a prospective payment system, subject to certain limitations. The Hospital is reimbursed for cost-reimbursement for certain items at a tentative rate, with final settlement determined after submission of annual cost reports and audits thereof by the Medicare fiscal intermediary. Certain other outpatient services are reimbursed according to fee screens.

Medicaid - Inpatient services rendered to Medicaid program beneficiaries are paid at prospectively determined rates per discharge. Outpatient services rendered to Medicaid program beneficiaries are reimbursed under a cost-reimbursement methodology. The hospitals are reimbursed at a tentative rate, with final settlement determined after submission of annual cost reports by the hospitals.

Other Payers - The Network has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment under these agreements includes rates per discharge, discounts from established charges, per diem rates, and fee schedule payments.

Health Care Industry - The health care industry is subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not limited to, matters such as licensure, accreditation, government health care program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by health care providers. Violations of these laws and regulations could result in expulsion from government health care programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed.

Management believes that the Network is in compliance with fraud and abuse regulations, as well as other applicable government laws and regulations. Compliance with such laws and regulations can be subject to further governmental review and interpretation, as well as regulatory actions unknown or unasserted at this time.

EHR Incentive Payment Revenue - The American Recovery and Reinvestment Act of 2009 authorized the Centers for Medicare and Medicaid Services (CMS) to award incentive payments to eligible health care providers who demonstrate Meaningful Use of certified electronic health records (EHR). These incentive programs are designed to support providers in this period of health information technology transition and instill the use of EHRs in meaningful ways to help our nation to improve the quality, safety, and efficiency of patient health care. Total revenue recorded for Medicare amounted to $1,786,134 and $2,630,820, for the years ended September 30, 2014 and 2013, respectively.

Note 2 - Summary of Significant Accounting Policies (continued)

Future Operations - Current trends in the health care industry include mergers and other forms of affiliations among providers, increasing shifts to managed care, overall reduction in inpatient average length of stay, increasingly restrictive reimbursement policies by governmental and private payers, and the prospect of significant changes in legislation at the state and national level. Management cannot assess or project the ultimate effect of these or other items on the future operations of the Network.

Interest in Net Assets of ECHF - ECHF was formed as a not-for-profit organization to supervise the development activities and engage in investment activities for the benefit of all of the ECHN subsidiaries. ECHN is the sole member of ECHF and the ECHF's Board of Directors is appointed by ECHN. ECHN subsidiaries follow the provisions of FASB ASC 958 *"Not-for-Profit Entities"*. Accordingly, the separate ECHN members record their interest in the net assets of ECHF in their separate financial statements. These amounts have been eliminated in consolidation.

Income Taxes - ECHN and its subsidiaries, except for Enterprises, CHIC, ECHNCS and CINECT, are in compliance with the provisions of Internal Revenue Code (the Code) Sec. 501(c)(3) and are exempt from federal tax under IRC Sec. 501(a). At times, the Network is involved with activities that subject minor amounts of unrelated business federal income tax, which are paid as they come due in accordance with the Code and the regulations there under. Such amounts are insignificant to the Network's consolidated financial statements.

The Network accounts for uncertain tax positions in accordance with provisions of FASB ASC 740, *"Income Taxes"*, which provides a framework for how companies should recognize, measure, present and disclose uncertain tax positions in their consolidated financial statements. The Network may recognize the tax benefit from an uncertain tax position only if it is more likely than not that the tax position will be sustained on examination by the taxing authorities, based on the technical merits of the position. The Network does not have any uncertain tax positions as of September 30, 2014 and 2013. As of September 30, 2014 and 2013, the Network did not record any penalties or interest associated with uncertain tax positions. Generally, the Network's prior three tax years are open and subject to examination by the Internal Revenue Service.

Enterprise and its subsidiaries, ECHNCS and CINECT are for-profit entities subject to federal and state taxes. For these entities, ECHN applies the provisions of FASB ASC 740. The tax provisions, and related tax assets and liabilities, are not material. CHIC has received an undertaking from the Cayman Islands government exempting it from all local income, profits, and capital gains taxes until January 3, 2026. No such taxes are currently levied in the Cayman Islands. Accordingly, no provision for federal income taxes has been recorded in the accompanying consolidated financial statements.

Asset Retirement Obligations - The Network recognizes a liability for the fair value of a conditional asset retirement obligation if the fair value of the liability can be reasonably estimated. Uncertainty about the timing and/or method of settlement of a conditional asset retirement obligation is factored into the measurement of the liability when sufficient information exists. The types of asset retirement obligations that the Network recognizes are those for which the Network has a legal obligation to perform an asset retirement activity, however, the timing and/or method of settling the obligation are conditional on a future event that may or may not be within its control.

The fair value of a liability for the legal obligation associated with an asset retirement is recorded in the period in which the obligation is incurred. When the liability is initially recorded, the cost of the asset retirement is capitalized. As of September 30, 2014 and 2013, the Network has recognized $412,007, as an obligation to remove asbestos from various buildings upon retirement. This total is included in the consolidated balance sheets within other liabilities.

Note 2 - Summary of Significant Accounting Policies (continued)

Accounting for Defined Benefit Pension and Other Postretirement Plans - The Network recognizes the overfunded or underfunded status of their defined benefit pension and other postretirement benefit plans (collectively, postretirement benefit plans) in the consolidated balance sheets as an asset or liability. The Network recognizes changes in the funded status of the plans in the year in which the changes occur as an operating expense and as a change in unrestricted net assets presented below the excess of revenues over expenses in its consolidated statements of operations and changes in net assets.

Inventory - The Network records inventory at cost using the average cost method.

Impairment of Long-Lived Assets - Long-lived assets to be held and used are reviewed for impairment whenever circumstances indicate that the carrying amount of an asset may not be recoverable. Long-lived assets to be disposed of are reported at the lower of carrying amount or fair value, less cost to sell.

Estimated Self-Insurance Liabilities - The liabilities for outstanding losses and loss related expenses, and the related provision for losses and loss related expenses include estimates for malpractice losses, general liability, and workers' compensation incurred but not reported claims, as well as losses pending settlement. Such liabilities are necessarily based on estimates and, while management believes the amounts provided are adequate, the ultimate liability may be in excess of or less than the amounts provided. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. The methods for making such estimates and the resulting liability are actuarially reviewed on an annual basis, and any adjustments required are reflected in operations in the current period. The current portion of estimated self-insurance liabilities is recorded within other current liabilities in the accompanying consolidated balance sheets.

Concentration of Credit Risk - Financial instruments, which potentially subject the Network to concentration of credit risk, consist of accounts receivable, investments, including temporary cash investments, marketable equity and debt securities, mutual funds, government securities and interest rate swap agreements. The Network receives a significant portion of its payments for services rendered from a limited number of government and commercial third-party payers, including Medicare (a federal program), Medicaid (a State of Connecticut program), and various health insurance companies.

Interest Rate Swap Agreements - Interest rate swap agreements are recognized as either assets or liabilities in the consolidated balance sheet at fair value regardless of the purpose or intent for holding them. Changes in the fair value of interest rate swap agreements are recognized in non-operating losses or if designated and effective as hedge transactions, as changes in unrestricted net assets.

Advertising Costs - The Network expenses advertising costs the first time the advertising takes place. The total amount charged to advertising expense was $1,576,106 and $1,842,135 for the years ended September 30, 2014 and 2013, respectively, and is recorded in supplies and other expenses in the accompanying consolidated statements of operations and changes in net assets.

Accounting Pronouncements Adopted - In December 2011, the FASB issued Accounting Standards Update (ASU) 2011-11, "*Disclosures about Offsetting Assets and Liabilities*", which was later clarified by ASU 2013-01, "*Clarifying the Scope of Disclosures about Offsetting Assets and Liabilities*". This guidance contained new disclosure requirements regarding the nature of an entity's rights of setoff and related arrangements associated with its financial instruments and derivative instruments. This guidance became effective for the Network beginning on October 1, 2013, and did not have an impact on its consolidated financial statements.

Note 2 - Summary of Significant Accounting Policies (continued)

In October 2012, the FASB issued ASU 2012-05, *"Statement of Cash Flows (Topic 230): Not-for-Profit Entities: Classification of the Sale Proceeds of Donated Financial Assets in the Statement of Cash Flows"*. This guidance provides clarification on how entities classify cash receipts arising from the sale of certain donated financial assets in the statement of cash flows. This guidance became effective for the Network beginning on October 1, 2013, and did not have a material impact on its consolidated statements of cash flows.

Accounting Pronouncements Pending Adoption - In February 2013, the FASB issued ASU 2013-04, *"Obligations Resulting from Joint and Several Liability Arrangements for Which the Total Amount of the Obligation is Fixed at the Reporting Date"*. This guidance requires entities to measure obligations resulting from the joint and several liability arrangements for which the total amount of the obligation within the scope of this guidance is fixed at the reporting date. This guidance is effective for the Network beginning October 1, 2014, with early adoption permitted. The Network has not yet evaluated the impact this guidance may have on its consolidated financial statements.

Subsequent Events - Subsequent events have been evaluated through January 27, 2015, the date through which procedures were performed to prepare the consolidated financial statements for issuance. Management believes that there are no subsequent events having a material impact on the consolidated financial statements.

Note 3 - Assets Whose Use is Limited and Investments

Assets whose use is limited and investments as of September 30, 2014 and 2013, include the following:

	2014		2013	
	Cost	Fair Value	Cost	Fair Value
Board designated and donor-restricted:				
Money market funds	$ 44,043,227	$ 44,043,227	$ 507,386	$ 507,386
U.S. equities	-	-	215,775	206,426
Other investments	34,368	34,795	-	-
Mutual funds:				
U.S. small/mid cap	-	-	2,887,193	3,203,837
Investment grade taxable	-	-	413,221	403,449
Short-term bond fund	-	-	2,027,248	2,006,817
Large value fund	-	-	11,535,567	12,161,104
Moderate allocation funds	-	-	11,605,313	12,765,022
Foreign growth fund	-	-	6,058,560	7,104,073
Other	-	-	1,038,597	1,315,132
Total	$ 44,077,595	$ 44,078,022	$ 36,288,860	$ 39,673,246

Note 3 - Assets Whose Use is Limited and Investments (continued)

	2014		2013	
	Cost	Fair Value	Cost	Fair Value
Investments held in trust for estimated self-insurance liabilities:				
Money market funds	$ 96,364	$ 96,364	$ 326,811	$ 326,811
U.S. equities	247,911	255,038	30,000	48,325
Mutual funds:				
Bond fund	3,605,105	3,625,132	1,090,954	1,075,321
Equity mututal funds	704,180	798,211	-	-
Emerging markets fund	101,840	101,014	86,840	90,905
Midcap stock fund	68,647	77,581	25,000	27,609
International stock fund	-	-	23,648	30,292
Moderate allocation fund	50,000	52,415	803,904	866,668
Total	$ 4,874,047	$ 5,005,755	$ 2,387,157	$ 2,465,931
Investments held under bond indenture:				
Money market funds	$ 5,174,324	$ 5,174,324	$ 5,994,581	$ 5,994,581
U.S. government securities	1,160,527	1,161,137	797,747	798,007
Total	$ 6,334,851	$ 6,335,461	$ 6,792,328	$ 6,792,588
Beneficial interest in trust assets	$ 10,331,633	$ 11,809,221	$ 6,579,883	$ 7,882,372
Investments:				
Money market funds	$ 7,138,341	$ 7,138,341	$ 455,766	$ 455,766
U.S. equities	-	-	239,278	273,569
Corporate bonds	-	-	15,389	15,427
Certificates of deposit	-	-	100,000	100,751
Mutual funds:				
U.S. small/mid cap	-	-	933,236	1,042,212
Investment grade taxable	-	-	399,749	396,103
Global high yield taxable	-	-	81,205	81,489
Short-term bond	-	-	5,715,771	5,688,229
Large value fund	-	-	1,243,896	1,509,882
Moderate allocation funds	-	-	1,694,843	2,017,532
Foreign large fund	-	-	1,169,563	1,428,580
Total	$ 7,138,341	$ 7,138,341	$ 12,048,696	$ 13,009,540
Total assets whose use is limited and investments	$ 72,756,467	$ 74,366,800	$ 64,096,924	$ 69,823,677

Interest and dividend income, which is included in other operating revenue, on the assets whose use is limited and investments totaled $1,327,419 and $1,556,974 for the years ended September 30, 2014 and 2013, respectively. There were realized gains of $7,812,247 and $5,584,750 for the years ended September 30, 2014 and 2013, respectively, which are included within other revenues.

Note 4 - Fair Value Measurements

FASB ASC 820 provides a framework for measuring fair value. That framework provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to unobservable inputs (Level 3 measurements).

The three levels of the fair value hierarchy under FASB ASC 820 are described as follows:

Level 1 - Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities in active markets that the Network has the ability to access.

Level 2 - Inputs to the valuation methodology include:

- Quoted prices for similar assets or liabilities in active markets;
- Quoted prices for identical or similar assets or liabilities in inactive markets;
- Inputs other than quoted prices that are observable for the asset or liability;
- Inputs that are derived principally from or corroborated by observable market data by correlation or other means.

Level 3 - Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

The asset or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement.

The following table presents the financial instruments carried at fair value as of September 30, 2014 and 2013, by the valuation hierarchy.

2014	Level 1	Level 2	Level 3	Total
Assets:				
Money market funds	$ 56,452,256	$ -	$ -	$ 56,452,256
U.S. government securities	1,161,137	-	-	1,161,137
U.S. equities	255,038	-	-	255,038
Other investments	34,795	-	-	34,795
Mutual funds:				
Bond fund	3,625,132	-	-	3,625,132
Equity mututal funds	798,211	-	-	798,211
Emerging markets fund	101,014	-	-	101,014
Midcap stock fund	77,581	-	-	77,581
Moderate allocation fund	52,415	-	-	52,415
Beneficial interest in trusts	-	-	11,809,221	11,809,221
Total assets at fair value	$ 62,557,579	$ -	$ 11,809,221	$ 74,366,800
Liabilities:				
Obligations under interest rate swap agreements	$ -	$ 3,800	$ -	$ 3,800
Total liabilities at fair value	$ -	$ 3,800	$ -	$ 3,800

Note 4 - Fair Value Measurements (continued)

2013	Level 1	Level 2	Level 3	Total
Assets:				
Money market funds	$ 7,284,544	$ -	$ -	$ 7,284,544
U.S. government securities	798,007	-	-	798,007
Corporate bonds	15,427	-	-	15,427
Certificates of deposit	100,751	-	-	100,751
U.S. equities	528,320	-	-	528,320
Mutual funds:				
U.S. small/mid cap	4,246,049	-	-	4,246,049
Investment grade taxable	799,552	-	-	799,552
Global high yield taxable	81,489	-	-	81,489
Bond fund	1,075,321	-	-	1,075,321
Short-term bond fund	7,695,046	-	-	7,695,046
Large value fund	13,670,986	-	-	13,670,986
Moderate allocation fund	15,649,222	-	-	15,649,222
Foreign growth fund	7,104,073	-	-	7,104,073
Emerging markets fund	90,905	-	-	90,905
Midcap stock fund	27,609	-	-	27,609
International stock fund	30,292	-	-	30,292
Foreign large fund	1,428,580	-	-	1,428,580
Other	1,315,132	-	-	1,315,132
Beneficial interest in trusts	-	-	7,882,372	7,882,372
Total assets at fair value	$ 61,941,305	$ -	$ 7,882,372	$ 69,823,677
Liabilities:				
Obligations under interest rate swap agreements	$ -	$ 181,635	$ -	$ 181,635
Total liabilities at fair value	$ -	$ 181,635	$ -	$ 181,635

During the years ended September 30, 2014 and 2013, the value of the beneficial interest in trusts increased for a change in market value of $676,292 and $787,751, respectively. In addition, the Network received $500,251 and $306,161 in distributions from these trusts in 2014 and 2013, respectively. During 2014, the Network recorded additional beneficial interest in trust assets in the amount of $3,750,808. There were no additional amounts recorded in 2013.

The Network's valuation methodologies used to measure financial assets and liabilities at fair value are outlined below. Where applicable, the Network uses quoted prices in active markets for identical assets and liabilities to determine fair value (Level 1 inputs). This pricing methodology applies to money market funds, U.S. government securities, certificates of deposit, U.S. equities and mutual funds.

Note 4 - Fair Value Measurements (continued)

If quoted prices in active markets for identical assets and liabilities are not available, then quoted prices for similar assets and liabilities, quoted prices for identical assets or liabilities in inactive markets or inputs other than quoted prices that are observable for the asset or liability, either directly or indirectly, will be used to determine fair value (Level 2 inputs). The Level 2 classifications include the corporate bonds and interest rate swap agreements. The interest rate swap agreements are valued based on a determination of market expectations relating to the future cash flows associated with the swap contract using sophisticated modeling based on observable market-based inputs, such as interest rate curves.

Assets and liabilities that are valued using significant unobservable inputs, such as extrapolated data, proprietary models, or indicative quotes that cannot be corroborated with market data are classified in Level 3 within the fair value hierarchy. The Level 3 classification includes the Network's beneficial interest in trusts. The value of the Network's assets is based on total fund values and the Network's corresponding beneficiary percentage.

The fair value of the Network's Series A and C Bonds are based on current traded value. The fair value of the Series A and C Bonds as of September 30, 2014 and 2013, is approximately $41,166,328 and $41,854,230, respectively. The fair value of the Network's remaining long-term debt approximates its carrying value.

As of September 30, 2014 and 2013, the Network's other financial instruments included accounts receivable, accounts payable and accrued expenses and estimated settlements due to and from third-party payers. The carrying amounts reported in the consolidated balance sheets for these financial instruments approximate their fair value.

The preceding methods described may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, although the Network believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

Note 5 - Other Assets

Other assets as of September 30, 2014 and 2013 consist of the following:

	2014	2013
Pledges receivable, net	$ -	$ 210,112
Other receivables	795,005	887,661
Notes receivable	134,014	307,040
Unamortized bond issuance costs	2,282,438	2,580,484
Losses recoverable	2,157,634	2,247,835
Total	$ 5,369,091	$ 6,233,132

As of September 30, 2014 and 2013, $228,691 and $687,146 of pledges receivables have been included within prepaid expenses and other current assets as management anticipates them to be collected within the next year.

Note 5 - Other Assets (continued)

Pledges receivable are expected to be realized as follows:

	2014	2013
In one year or less	**$ 237,691**	$ 688,276
Between one and five years	**-**	213,662
Greater than five years	**-**	-
Less: discount for present value and allowance for uncollectible amounts	**(9,000)**	(4,680)
Pledges receivable - net	**$ 228,691**	$ 897,258

Pledges receivable are reported at their net present value, discounted at rates from .10% to 4.90%. There was no allowance for uncollectible amounts recorded as of September 30, 2013.

As of September 30, 2014 and 2013, unamortized bond issuance costs, which are included within other assets, consist of the following:

	2014	2013
Deferred financing costs	**$ 3,735,675**	$ 3,735,675
Less: accumulated amortization	**(1,453,237)**	(1,155,191)
Total	**$ 2,282,438**	$ 2,580,484

Note 6 - Property, Plant and Equipment

Property, plant and equipment as of September 30, 2014 and 2013, consist of the following:

	2014	2013
Land and land improvements	**$ 5,395,243**	$ 5,333,743
Buildings and building improvements	**159,603,375**	160,660,529
Fixed equipment	**32,403,097**	31,817,532
Movable equipment	**112,056,204**	104,373,295
	309,457,919	302,185,099
Less: accumulated depreciation and amortization	**(218,033,560)**	(206,928,185)
	91,424,359	95,256,914
Construction in progress	**2,641,200**	931,583
Total	**$ 94,065,559**	$ 96,188,497

Note 6 - Property, Plant and Equipment (continued)

For the years ended September 30, 2014 and 2013, the Network capitalized interest related to construction financed with tax-exempt debt of $20,850 and $126,000, respectively. The cost to complete the construction in progress is approximately $4,154,000 and $2,981,000 as of September 30, 2014 and 2013, respectively.

For the years ended September 30, 2014 and 2013, the Network disposed of property, plant and equipment in the amounts of $657,588 and $24,086,313, respectively and all disposals were of fully depreciated assets.

Note 7 - Intangible Assets

The gross carrying amount and accumulated amortization, by class of intangible assets, as of September 30, 2014 and 2013, consisted of the following:

2014	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount
License enhancements	$ 1,898,684	$ (1,378,528)	$ 520,156
Other intangible assets	101,000	(95,950)	5,050
Goodwill	7,317,518	(875,371)	6,442,147
Total	$ 9,317,202	$ (2,349,849)	$ 6,967,353

2013	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount
License enhancements	$ 1,898,684	$ (1,349,202)	$ 549,482
Other intangible assets	101,000	-	101,000
Goodwill	7,252,932	(757,545)	6,495,387
Total	$ 9,252,616	$ (2,106,747)	$ 7,145,869

Amortization expense related to intangible assets was $243,102 and $149,767 for the years ended September 30, 2014 and 2013, respectively.

The estimated amortization expense in each of the succeeding five fiscal years and thereafter, as of September 30, 2014, is as follows:

2015	$ 228,440
2016	215,257
2017	200,714
2018	108,831
2019	73,359
Thereafter	439,526
Total	$ 1,266,127

Note 8 - Estimated Self-Insurance Liabilities

The Network is self-insured for workers' compensation insurance coverage. The Network participates in Workers' Compensation Trust, a revocable trust, for the purpose of setting aside assets based on actuarial recommendations.

As of September 30, 2014 and 2013, the Hospital has a $450,000 and $400,000, respectively limit per occurrence for workers' compensation claims. Prior to September 30, 2013, the per occurrence limit was $350,000. The Network has employed independent actuaries to estimate the ultimate costs, if any, of workers' compensation claims. Accrued workers' compensation reserves have been discounted at 5% as of September 30, 2014 and 2013, and in management's opinion provide an adequate reserve for loss contingencies.

In fiscal year 2007, ECHN established a single-parent captive, CHIC, which covers all of its subsidiaries. The captive provides malpractice and general insurance coverage for ECHN and its subsidiaries at $3,000,000 per occurrence and $9,000,000 in the aggregate for the years ended September 30, 2014 and 2013.

Effective October 1, 2009, CHIC also provided an excess healthcare professional liability and umbrella liability insurance policy on a claims-made basis covering healthcare professional liability, general care liability, automobile liability, employers liability, helipad liability and non-owned aircraft liability. The limit provided is $30,000,000 for each loss event and in the annual aggregate excess of the primary coverage layers described above. This coverage is fully reinsured.

ECHN does not self-insure any malpractice risks other than exposures greater than its excess coverages, however, as of September 30, 2014 and 2013, ECHN has recorded a liability for estimated incurred but not reported claims, as it currently has a claims-made policy with CHIC.

The activity in the reserve for outstanding losses and loss related expenses at ECHN for workers' compensation and malpractice claims, as of September 30, 2014 and 2013, is as follows:

	2014	2013
Balance at beginning of year	$ 11,296,110	$ 14,873,830
Workers' compensation:		
Losses incurred related to:		
Current year	820,878	697,778
Prior year	293,054	3,200,111
Total incurred	1,113,932	3,897,889
Paid losses related to:		
Current year	(502,541)	(414,370)
Prior year	(1,260,229)	(1,732,496)
Total paid	(1,762,770)	(2,146,866)
Professional and general:		
Losses incurred related to:		
Current year	2,500,000	997,781
Prior year	(476,182)	6,950,980
Total incurred	2,023,818	7,948,761
Paid losses related to:		
Current year	(35,098)	(45,727)
Prior year	(628,237)	(13,231,777)
Total paid	(663,335)	(13,277,504)
Balance at end of year	$ 12,007,755	$ 11,296,110

Note 8 - Estimated Self-Insurance Liabilities (continued)

Workers' Compensation - The development on prior-year incurred losses increased by $293,054 and $3,200,111 for the years ended September 30, 2014 and 2013, respectively.

Professional and General - The development on prior-year incurred losses (decreased) increased by $476,182 and $6,950,980 for the years ended September 30, 2014 and 2013, respectively.

The reserve for losses, which was determined with the assistance of an actuarial consultant, included estimates of claims incurred but not reported. Approximately $2,324,000 and $2,272,000 of the reserve as of September 30, 2014 and 2013, respectively, are included in other current liabilities with the remaining balance of the reserve included in estimated self-insurance liabilities in the accompanying consolidated balance sheets.

Note 9 - Pension and Other Postretirement Benefits

ECHN has a defined benefit pension plan that covered substantially all of the employees of MMH and RGH. The benefits are based upon years of service and compensation for the five highest years during the employee's last 10 years of service. The hospitals contribute amounts sufficient to meet the minimum funding requirements of the Employee Retirement Income Security Act of 1974, as well as such additional amounts as deemed appropriate.

On December 31, 2008, ECHN implemented a soft freeze on the defined-benefit pension plan. During September 2013 the Trustees passed a resolution to freeze all benefits related to the defined-benefit pension plan. Qualifying employees with age and service credits greater than 65 were given the option to stay in the defined-benefit pension plan or freeze their defined benefits and enter into a defined contribution plan. All other employees were required to enter into the defined contribution plan. Under the defined contribution plan, ECHN contributes 3% of eligible employees' salaries. This contribution is non-guaranteed for all employees except certain union workers. During fiscal year 2014 and 2013, the Hospital incurred expenses of $2,259,145 and $2,076,122, respectively, related to this plan.

MMH and RGH also sponsor a postretirement benefit plan that provides health care benefits to those employees who retire. The criterion to receive this benefit is to be vested in the pension plan, attain age 55 or older and start collecting under the defined benefit plan described above once retired. The retiree must be enrolled into the medical plan on the date of retirement to be eligible for the continuation. MMH full-time registered nurse retirees (retired prior to October 1, 2005 and were eligible per the Union contract) are grandfathered and required to pay at least 50% of the total cost of the medical and dental coverage they elect for themselves under the plan.

Grandfathered eligible retirees are required to pay 100% of the total cost of the medical and dental coverage they elect for an eligible spouse.

For non-grandfathered retirees, the postretirement health care plan is contributory and the retiree pays 100% of the premium.

The Network, as of September 30, 2014 and 2013, has no unrecognized actuarial losses related to the defined benefit pension plan.

Note 9 - Pension and Other Postretirement Benefits (continued)

The effects of Medicare Prescription Drug, Improvement and Modernization Act of 2003 were reflected as of September 30, 2014 and 2013, assuming that ECHN will continue to provide a prescription drug benefit to retirees that is at least actuarially equivalent to Medicare Part D and that ECHN will receive the federal subsidy. The subsidy reduced plan liabilities by approximately $60,000 and $900,000 for the years ended September 30, 2014 and 2013, respectively. Subsidies of $82,280 and $90,769 were received in the years ended September 30, 2014 and 2013, respectively. Future benefits of $193,769 are expected to be paid and future subsidies of $57,671 are expected to be received related to the year ended September 30, 2015.

The pension and postretirement plans' change in benefit obligation and change in plan assets for the years ended September 30, 2014 and 2013, are as follows:

	Pension Benefits		Other Postretirement Benefits	
	2014	2013	2014	2013
Change in benefit obligation:				
Benefit obligation, beginning of year	$ 192,294,259	$ 223,101,495	$ 4,193,572	$ 4,633,005
Service cost	1,511,408	2,709,867	54,345	72,548
Interest cost	9,912,203	9,475,222	183,189	162,852
Plan participants' contributions	-	-	252,224	296,951
Receipt of Medicare Part D reimbursement	-	-	82,280	90,769
Plan amendments	-	-	(1,500,168)	-
Plan curtailments	-	(7,795,069)	-	-
Actuarial loss (gain)	18,293,175	(26,124,678)	103,272	(499,239)
Benefits paid	(9,352,892)	(9,072,578)	(520,055)	(563,314)
Benefit obligation, end of year	$ 212,658,153	$ 192,294,259	$ 2,848,659	$ 4,193,572
Change in plan assets:				
Fair value of plan assets, beginning of year	$ 152,290,850	$ 149,218,728	$ -	$ -
Actual return on plan assets	21,778,598	9,144,700	-	-
Employer contributions	4,800,000	3,000,000	185,551	175,594
Plan participants' contributions	-	-	252,224	296,951
Receipt of Medicare Part D reimbursement	-	-	82,280	90,769
Benefits paid	(9,352,891)	(9,072,578)	(520,055)	(563,314)
Fair value of plan assets, end of year	$ 169,516,557	$ 152,290,850	$ -	$ -
Accrued pension and other postretirement benefits	$ (43,141,596)	$ (40,003,409)	$ (2,848,659)	$ (4,193,572)
Accumulated benefit obligation	$ (212,658,153)	$ (192,294,259)	$ -	$ -

Note 9 - Pension and Other Postretirement Benefits (continued)

The amount recognized in the Network's consolidated balance sheets as of September 30, 2014 and 2013, are as follows:

	Pension Benefits		Other Postretirement Benefits	
	2014	2013	2014	2013
Current liabilities	$ 1,120,000	$ 5,700,000	$ 193,769	$ 385,518
Noncurrent liabilities	42,021,596	34,303,409	2,654,890	3,808,054
Net amount recognized	$ 43,141,596	$ 40,003,409	$ 2,848,659	$ 4,193,572

The allocation of the accrued pension and postretirement benefits for the years ended September 30, 2014 and 2013, is as follows:

	Pension Benefits		Other Postretirement Benefits	
	2014	2013	2014	2013
MMH	$ 33,243,046	$ 30,733,610	$ 2,377,259	$ 3,206,427
RGH	9,898,550	9,269,799	471,400	987,145
Total	$ 43,141,596	$ 40,003,409	$ 2,848,659	$ 4,193,572

The plans' components of net periodic benefit cost for the years ended September 30, 2014 and 2013, are as follows (pension benefits information presented is for MMH and RGH combined):

	Pension Benefits		Other Postretirement Benefits	
	2014	2013	2014	2013
Service cost	$ 1,511,408	$ 2,709,867	$ 54,345	$ 72,548
Interest cost	9,912,203	9,475,222	183,189	162,852
Expected return on plan assets	(12,179,861)	(11,692,676)	-	-
Amortization of prior service (credits) costs	-	(234,992)	77,724	77,724
Curtailment actuarial gain	-	(1,148,330)	-	-
Recognized actuarial (gain) loss	887,441	4,123,868	(105,864)	(55,153)
Net periodic benefit cost	$ 131,191	$ 3,232,959	$ 209,394	$ 257,971

The allocation of the net periodic benefit cost for the years ended September 30, 2014 and 2013, is as follows:

	Pension Benefits		Other Postretirement Benefits	
	2014	2013	2014	2013
MMH	$ 103,762	$ 2,475,143	$ 174,744	$ 197,246
RGH	27,429	757,816	34,650	60,725
Total	$ 131,191	$ 3,232,959	$ 209,394	$ 257,971

Note 9 - Pension and Other Postretirement Benefits (continued)

The assumptions used to determine pension and postretirement benefit obligations as of September 30, 2014 and 2013, are as follows:

	Pension Benefits		Other Postretirement Benefits	
	2014	**2013**	**2014**	**2013**
Discount rate	**4.54%**	5.27%	**4.11%**	4.54%
Expected long-term rate of return	**8.00%**	8.00%	**N/A**	N/A
Rate of compensation increase	**0.00%**	3.00%	**N/A**	N/A
Initial medical trend rate	**N/A**	N/A	**9.44%**	7.62%
Ultimate medical trend rate	**N/A**	N/A	**4.50%**	4.50%
Number of years to ultimate medical trend rate	**N/A**	N/A	**13 years**	14 years

The assumptions used to determine net periodic benefit cost of the pension and postretirement plans for the years ended September 30, 2014 and 2013, were as follows:

	Pension Benefits		Other Postretirement Benefits	
	2014	**2013**	**2014**	**2013**
Discount rate	**5.27%**	4.32%	**4.54%**	3.64%
Expected long-term rate of return	**8.00%**	8.00%	**N/A**	N/A
Rate of compensation increase	**3.00%**	3.00%	**N/A**	N/A
Initial medical trend rate	**N/A**	N/A	**9.44%**	7.62%
Ultimate medical trend rate	**N/A**	N/A	**4.50%**	4.50%
Number of years to ultimate medical trend rate	**N/A**	N/A	**13 years**	14 years

The medical trend rate has a significant effect on the amounts reported. A one-percentage-point change in assumed health care cost trend rates would have the following effects:

	One Percentage Point Increase	One Percentage Point Decrease
Effect on year-end postretirement benefit obligation	$ 225,033	$ (233,728)
Effect on total of service and interest cost components	$ 20,880	$ (18,565)

Note 9 - Pension and Other Postretirement Benefits (continued)

The pension plan's weighted-average asset allocations as of September 30, 2014 and 2013, by asset category, are as follows:

	Pension Benefits	
	2014	**2013**
Asset category:		
Equity securities	**0%**	56%
Debt securities	**99%**	43%
Cash and cash equivalents	**1%**	1%
	100%	100%

The investment objective of ECHN is to invest the plan assets in a manner that, together with contributions, will provide for sufficient resources to pay current and projected obligations over the life of the plan. The plan shall be diversified across asset classes to achieve an optimal balance between risk and return and between income and growth of assets through capital appreciation. Consistent with funding requirements, a secondary objective of the plan is to source benefit payments primarily through existing plan assets and anticipated future returns thereby minimizing future cash contributions. The investment objectives shall be implemented in a de-risking framework designed to manage the plan's funded status volatility and minimize future cash contributions. The funded status of the plan shall be measured by the ratio of plan assets to the projected benefit obligation. To reduce the volatility as much as possible, the goal is to attain and/or maintain a funded status of at least a 105% funding level and allocate its assets as outlined below.

The plan has approved an asset allocation strategy that shall change over time in response to future changes in the plan's funded status. Such changes in asset allocation strategy are intended to allocate additional assets to the fixed income asset class should the plan's funded status improve. Accordingly, the fixed income asset class shall be invested in such a manner that its interest rate sensitivity correlates highly with that of the plan's liabilities. Other asset classes are intended to provide additional return with associated higher levels of risk. If the plan's funded status deteriorates beyond stated thresholds, the strategy dictates that additional assets will not be re-allocated to the return-seeking assets.

Fair value methodologies used to assign plan assets to levels in accordance with ASC 820 are consistent with the inputs described in Note 4.

Note 9 - Pension and Other Postretirement Benefits (continued)

The following table presents the investments of the defined benefit plan carried at fair value as of September 30, 2014 and 2013, by the valuation hierarchy.

2014	Level 1	Level 2	Level 3	Total
Cash and cash equivalents	$ 708,333	$ -	$ -	$ 708,333
Fixed income mutual funds:				
Long duration	150,668,190	-	-	150,668,190
U.S. Core Opportunistic	7,500,003	-	-	7,500,003
U.S. Passive	7,558,893	-	-	7,558,893
Guaranteed investment contract	-	-	3,081,138	3,081,138
Total plan assets at fair value	$ 166,435,419	$ -	$ 3,081,138	$ 169,516,557

2013	Level 1	Level 2	Level 3	Total
Cash and cash equivalents	$ 633,333	$ -	$ -	$ 633,333
Fixed income mutual funds:				
Long duration	64,833,809	-	-	64,833,809
U.S. Core Opportunistic	13,328,905	-	-	13,328,905
U.S. Passive	2,935,983	-	-	2,935,983
Guaranteed investment contract	-	-	3,230,137	3,230,137
Equities:				
Small/mid cap	8,925,030	-	-	8,925,030
Active long corp	-	-	-	-
Large cap	31,678,381	-	-	31,678,381
International	26,725,272	-	-	26,725,272
Total plan assets at fair value	$ 149,060,713	$ -	$ 3,230,137	$ 152,290,850

Note 9 - Pension and Other Postretirement Benefits (continued)

The changes within the Level 3 investments as of September 30, 2014 and 2013, are as follows:

2014	Guaranteed Investment Contract
Balance as of October 1, 2013	$ 3,230,137
Investment income	133,795
Expenditures	(282,794)
Balance as of September 30, 2014	$ 3,081,138

2013	Guaranteed Investment Contract
Balance as of October 1, 2012	$ 3,195,313
Investment income	326,682
Expenditures	(291,858)
Balance as of September 30, 2013	$ 3,230,137

During fiscal year 2015, ECHN anticipates contributing $1,120,000 to the defined benefit pension plan.

The benefit payments, which reflect estimated future service, expected to be paid from the plans for the year ended September 30, 2014, are as follows:

	Pension Benefits	Other Postretirement Benefits
2015	$ 9,255,587	$ 193,769
2016	$ 9,656,312	$ 205,006
2017	$ 10,171,865	$ 224,486
2018	$ 10,703,439	$ 235,707
2019	$ 11,264,848	$ 247,455
2020-2024	$ 63,572,682	$ 1,227,224

The Network also has a defined contribution employee savings plan covering substantially all employees. Eligible employees who contribute to the plan will have 20% - 50%, depending upon years of service, of contributions matched by the Network, up to a maximum of 6% of annual compensation. The Network incurred expenses related to the employee savings plan amounting to $2,558,753 and $2,199,235, for the years ended September 30, 2014 and 2013, respectively.

Note 10 - Long-term Debt and Lines of Credit

Long-term debt and capital lease obligations, as of September 30, 2014 and 2013, consist of the following:

	2014	2013
Connecticut Health and Educational Facilities Authority (CHEFA) Hospital Revenue Bonds, ECHN Series A Bonds, bearing interest at rates ranging from 5.625% to 6.375% - net of unamortized original issue discount of $39,281 and $46,505 for 2014 and 2013, respectively.	$ 8,245,719	$ 9,093,495
CHEFA Hospital Revenue Bonds, ECHN Series C Bonds, bearing interest ranging from 4.00% to 5.125% - net of unamortized original issue premium of $330,315 and $350,960 for 2014 and 2013, respectively.	32,990,315	33,760,059
CHEFA Hospital Revenue Bonds, ECHN Series D Bonds bearing interest at a variable rate, adjusted weekly.	13,743,000	14,049,000
CHEFA Hospital Demand Revenue Bonds, ECHN Series E Bonds, bearing interest at a variable rate, adjusted weekly.	17,090,000	17,580,000
Loan due to Sovereign Bank, face amount $5,200,000 due and payable in semi-annual principal and interest installments maturing on January 3, 2022 and bearing interest at 3.38%	4,154,222	4,674,222
Promissory note payable to Rockville Bank due and payable in monthly principal and interest installments maturing on January 15, 2015, bearing interest at a fixed rate of 3.75%.	172,331	883,270
Promissory note payable to Rockville Bank due and payable in monthly principal and interest installments maturing on July 1, 2025, bearing interest at 5.87%.	742,092	791,933
Promissory note payable to Webster Bank due and payable in monthly principal and interest installments with a balloon payment due on May 1, 2018, bearing interest at 4.22%	601,219	615,659
Promissory note payable to Webster Bank due and payable in monthly principal and interest installments with a balloon payment due on December 1, 2017, bearing interest at 4.11%	554,013	568,058
Promissory note payable to Webster Bank due and payable in monthly principal and interest installments with a balloon payment due on May 1, 2019 bearing interest at 5.14%	517,406	-
Promissory note payable to 428 Hartford Turnpike Associates, LLP payable in monthly principal and interest installments, maturing September 1, 2021, bearing interest at 6%.	223,265	247,832

Note 10 - Long-term Debt and Lines of Credit (continued)

	2014	2013
Debt of ECHN Corporate Services. Various due dates and interest rates.	**43,215**	210,556
Mortgage payable to Rockville Bank, maturing April 1, 2022, bearing interest at 6.5% for the first five years, adjustable thereafter every five years.	**144,715**	160,955
Promissory note payable to Joseph Hanna MD, LLC due and payable in one principal payment due in December 2013. This is a non interest bearing note.	-	119,890
Promissory notes with Philips Medical Capital, payable in monthly installments, maturing in fiscal year 2021 and bearing interest at rates between 4.3% and 6.8%	**2,542,664**	-
Mortgage payable to Rockville Bank, maturing January 1, 2027 bearing interest at 6.6% for the first five years, adjustable thereafter, every five years.	**129,901**	138,019
Capital lease obligations (see Note 12)	**7,190,993**	8,355,380
Total long-term debt and capital lease obligations	**89,085,070**	91,248,328
Less: current maturities	**(6,489,656)**	(6,832,322)
Total long-term debt and capital lease obligations - net of current portion	**$ 82,595,414**	$ 84,416,006

Lines of credit as of September 30, 2014 and 2013 consist of the following:

	2014	2013
Revolving line of credit with TD Bank, bearing interest at a variable rate.	**$ 5,600,000**	$ 6,500,000

In February 2000, MMH, RGH and EES (collectively, the Series A Obligated Group) entered into an agreement and open-ended mortgage with Connecticut Health and Educational Facilities Authority (CHEFA) in connection with the issuance of CHEFA Hospital Revenue Bonds, Eastern Connecticut Health Network, Issue Series 2000A (the Series A Bonds). A portion of the proceeds from the Series 2000A Bonds, net of the original issue discount and amounts used to establish required reserve accounts, was placed in an irrevocable trust from which the remaining debt service payments for defeased CHEFA bonds will be paid. The remainder was used to finance additions and renovations for various facilities. The Series A Obligated Group has been legally released from any future debt service on the defeased bonds. The Series A Bonds are due on various due dates through July 1, 2030.

In July 2004, MMH, RGH, EES, and ECHF (collectively, the Series B Obligated Group) entered into an agreement and open-ended mortgage with CHEFA in connection with the issuance of CHEFA Hospital Revenue Bonds, Eastern Connecticut Health Network Issue, Series B (the Series B Bonds). A portion of the proceeds from the Series B Bonds, net of the original issue discount and amounts used to establish required reserve accounts, was used to finance additions, renovations, and purchases of equipment for RGH and MMH.

Note 10 - Long-term Debt and Lines of Credit (continued)

The additions and renovations financed by the Series B Bonds consist of improvements and expansion of the emergency department at RGH; the purchase, renovation, and equipping of the Dialysis Center at RGH; construction of the heliport at RGH, improvements to the Gastrointestinal and Rehabilitation Departments at RGH, and capital equipment purchases for MMH and RGH.

The Series B bonds were refinanced as part of the issuance of Series E bonds as described below.

On October 1, 2005, MMH, RGH, EES, and ECHF (collectively, the Series C Obligated Group) entered into an agreement and open-ended mortgage with CHEFA to borrow $37,065,000 in connection with the issuance of CHEFA Hospital Revenue Bonds, Eastern Connecticut Health Network Issue, Series C (the Series C Bonds). The proceeds from the Series C Bonds, net of the original issue premium and amounts used to establish required reserve accounts, were placed in an irrevocable trust to advance refund and defease a portion of the Series 2000A Bonds. MMH, RGH, and EES have been legally released from any future debt service on the portion of defeased Series 2000A Bonds. The Series C Bonds are due on various due dates through July 1, 2034, bearing interest at rates ranging from 4.00% to 5.125%.

In May 2009, MMH, RGH, EES, and ECHF (collectively, the Series D Obligated Group) entered into an agreement and open-ended mortgage with CHEFA in connection with the issuance of CHEFA Hospital Revenue Bonds, Eastern Connecticut Health Network, Issue Series D (the Series D Bonds). A portion of the proceeds from the Series D Bonds, net of amounts used to establish required reserve accounts, were used to finance renovations at MMH, an expansion at EES, and other campus improvements. The Series D Bonds are due on various due dates through May 14, 2039.

In December 2010, MMH, RGH, EES, and ECHF (collectively, the Series E Obligated Group) entered into an agreement and open-ended mortgage with CHEFA in connection with the issuance of CHEFA Hospital Revenue Bonds, Eastern Connecticut Health Network, Issue Series E (the Series E Bonds). The proceeds from the Series E Bonds, net of amounts used to establish required reserve accounts, were used to redeem the Series B Bonds and fund interest rate swap agreement termination payments relating to the Series B Bonds. The Series E Bonds are due on various due dates through July 1, 2034.

Under the terms of the Series A, Series B, Series C, Series D, and Series E Bonds, the Series A Obligated Group, Series B Obligated Group, Series C Obligated Group, Series D Obligated Group, and Series E Obligated Group (the Obligated Groups) are required to maintain certain deposits with a trustee. Such deposits are included in assets whose use is limited. The indenture also places limits on the incurrence of additional borrowings and dispositions of property and requires that the Obligated Groups satisfy certain measures of financial performance as long as the notes are outstanding.

Under the terms of the CHEFA agreements, each member of the Obligated Groups is jointly and severally liable for the full and prompt payment of the amounts owed by the Obligated Groups. Total debt of the Obligated Groups was $75,932,222 and $78,853,222 as of September 30, 2014 and 2013, respectively. The debt is also secured by the gross receipts of the Obligated Groups.

In June 2012, the Obligated Group entered into a loan agreement with Sovereign Bank, through CHEFA's Tax-Exempt Equipment Loan Program, for $5,200,000 in connection with purchase of equipment and renovation costs. Semi-annual principal and interest payments are due through January 2022.

Note 10 - Long-term Debt and Lines of Credit (continued)

The Hospital is party to various capital leases, which are described in Note 12.

The annual maturities of the long-term debt and capital lease obligations in each of the succeeding five years and thereafter, as of September 30, 2014, are as follows:

2015	$	6,489,656
2016		5,988,958
2017		5,168,357
2018		5,809,969
2019		5,048,249
Thereafter		60,288,847
		88,794,036
Plus - premium		291,034
Total	$	89,085,070

On November 11, 2010, ECHN entered into a $6,500,000 unsecured line of credit with TD Bank, N.A. This line of credit carries an interest rate of LIBOR plus 2.25% and expires one year after issuance date. ECHN renewed this line of credit in 2013. In 2014, the line of credit agreement was modified. The amount available was reduced to $5,750,000, the interest rate was increased to LIBOR plus 2.5% and the maturity was extended to September 29, 2015. As of September 30, 2014 and 2013, MMH had $5,600,000 and $6,500,000, respectively, outstanding under this line of credit.

The Network is subject to various financial covenants related to these debt agreements. The Network was in compliance with these covenants in 2014. The Network received a waiver for violating a debt service coverage ratio for 2013.

Note 11 - Derivatives

The Network uses derivative instruments, specifically interest rate swap agreements, to manage its exposure to changes in the interest rate on its CHEFA bonds. The use of derivative instruments exposes the Network to additional risks related to the derivative instrument, including market risk, credit risk and termination risk as described below, and the Network has defined risk management practices to mitigate these risks, as appropriate.

Market risk represents the potential adverse effect on the fair value and cash flow of a derivative instrument due to changes in interest rates or rate spreads. Market risk is managed through ongoing monitoring of interest rate exposure based on set parameters regarding the type and degree of market risk that the Network will accept. Credit risk is the risk that the counterparty on a derivative instrument may be unable to perform its obligation during the term of the contract. When the fair value of a derivative contract is positive, the counterparty owes the Network, which creates credit risk.

Credit risk is managed by setting stringent requirements for qualified counterparties at the date of execution of a derivative transaction and requiring counterparties to post collateral in the event of a credit rating downgrade or if the fair value of the derivative contract exceeds a negotiated threshold.

Note 11 - Derivatives (continued)

Termination risk represents the risk that the Network may be required to make a significant payment to the counterparty, if the derivative contract is terminated early. Termination risk is assessed at onset by performing a statistical analysis of the potential for a significant termination payment under various scenarios designed to encompass expected interest rate changes over the life of the proposed contract. The test measures the ability to make a termination payment without a significant impairment to the Network's ability to meet its debt or liquidity covenants.

In May 2009, ECHN entered into an interest rate swap agreement to manage the interest cost and risk associated with $15,250,000 of its variable rate Series D Bonds. Under the terms of this agreement, ECHN pays a fixed rate of 3.89%. Changes in the fair value of this swap are recorded in the consolidated statements of operations and changes in net assets. Effective May 14, 2014, the interest rate swap agreement on the Series D variable rate debt expired. The Network's portion of the swap agreement in force related to this strategy as of September 30, 2014 and 2013, and the liability and interest expense recognized by the Network are as follows:

	2014	2013
Notional amount of contract	$ -	$ 14,049,000
Fair value of swap contract recognized in other liabilities	$ -	$ 170,000
Net interest income recognized in non-operating losses	$ (170,000)	$ (248,000)

In June 2012, ECHN entered into an interest rate swap agreement to manage the interest cost and risk associated with $5,200,000 of its debt with Sovereign Bank. Under the terms, ECHN pays a fixed rate of 3.38%. The swap is accounted for as a cash flow hedge in accordance with ASC 815 "*Accounting for Derivative Instruments and Hedging Activities*". This accounting treatment requires the effective portion of the gain or loss on a derivative instrument designated and qualifying as a cash flow hedging instrument to be reported as a component of other changes in unrestricted net assets and to be reclassified into operations in the same period or periods during which the hedged forecasted transaction affects earnings. The remaining gain or loss on the derivative instrument, if any, shall be recognized currently in non-operating losses.

The Network's portion of the swap agreement in force related to this strategy as of September 30, 2014 and 2013, and the liability and unrealized (gain) loss recognized by the Network are as follows:

	2014	2013
Notional amount of contract	$ 4,154,222	$ 4,674,222
Fair value of swap contract recognized in other liabilities	$ 3,800	$ 12,000
Unrealized (gain) loss recognized in unrestricted net assets	$ (8,200)	$ (111,000)

The counterparty to the above swap transactions is a major financial institution that meets ECHN's criteria for financial stability and creditworthiness.

Note 12 - Lease Commitments

ECHN leases equipment under capital lease agreements, which begin to expire in 2015. The interest rates range from 4% to 8%. The net carrying value of equipment under the capital lease was $8,111,729 and $8,332,943 as of September 30, 2014 and 2013, respectively. ECHN leases various office space and certain equipment under operating leases that expire in various years through fiscal year 2024. Certain leases may be renewed at the end of their term.

Future minimum payments under capital leases and non-cancelable operating leases as of September 30, 2014, consisted of the following:

	Capital Leases	Operating Leases
2015	$ 3,174,905	$ 5,689,694
2016	2,493,549	5,204,009
2017	1,255,956	4,128,009
2018	500,418	2,902,495
2019	173,140	2,437,115
Thereafter	26,426	12,606,442
	7,624,394	$ 32,967,764
Less: interest on capital lease	433,401	
Principal amount of capital lease	$ 7,190,993	

Rent expense under operating and month-to-month leases was $6,622,257 and $6,264,706 for the years ended September 30, 2014 and 2013, respectively.

Note 13 - Concentrations of Credit Risk

ECHN grants credit without collateral to its patients, most of whom are insured under third-party payer agreements. The mix in patient accounts receivable as of September 30, 2014 and 2013, before allowances for doubtful accounts, consists of the following:

	2014	2013
Medicare	23%	24%
Self-pay	32%	40%
Managed care	24%	17%
Medicaid	13%	4%
Commercial insurance	3%	9%
Other	5%	6%
	100 %	100 %

Note 14 - Net Patient Service Revenues

Net patient service revenues for the years ended September 30, 2014 and 2013, consists of the following:

	2014	2013
Patient service revenues:		
Inpatient services	$ 333,197,293	$ 328,063,718
Outpatient services	592,717,508	572,644,188
Gross patient service revenues	925,914,801	900,707,906
Deductions - allowances	(615,943,491)	(590,585,747)
Net patient service revenues	$ 309,971,310	$ 310,122,159

In addition, the Network provides for a provision for bad debts. For receivables associated with services provided to patients who have third-party coverage, the Network analyzes contractually due amounts and provides an allowance for doubtful accounts and a provision for bad debts (for example, for expected uncollectible deductibles and copayments on accounts for which the third-party payor has not yet paid, or for payors who are known to be having financial difficulties that make the realization of amounts due unlikely). For receivables associated with self-pay patients (which includes both patients without insurance and patients with deductible and co-payment balances due for which third-party coverage exists for part of the bill), the Network records a significant provision for bad debts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible.

For uninsured patients that do not qualify for financial assistance, the Network offers a discount off its standard rates for services provided. The difference between the discounted rates and the amounts actually collected after all reasonable collection efforts have been exhausted is written off against the allowance for doubtful accounts in the period they are determined uncollectible. The Network's allowance for doubtful accounts covers all accounts greater than 6 months for both self-pay accounts receivable and third party payors as of September 30, 2014 and 2013. The Network's self-pay and third-party payors write-offs totaled $11,700,441 and $11,403,046 for 2014 and 2013, respectively. The Network did not change its charity care or financial assistance policy during 2014 or 2013.

At September 30, 2014 and 2013, 30.4% and 32.3% of net patient accounts receivable were from governmental payors (Medicare and Medicaid) and 69.6% and 67.7% were from nongovernmental payors, respectively. Nongovernmental payors are primarily insurance companies and self-pay payors. Management has recorded an allowance for doubtful accounts, as noted above, which, in its opinion, is sufficient to provide for risk of nonpayment.

Note 15 - Community Benefit

ECHN's mission is to improve the health of the people and the communities ECHN serves.

ECHN provides quality health care to all, regardless of their ability to pay. Charity care is provided to those who are eligible based on ECHN's policy. ECHN also incurs unpaid costs for government programs because reimbursement is not sufficient to cover costs associated with Medicare and Medicaid patients. In addition to the charity care responsibilities, ECHN provides numerous other community benefits. These community benefits include medical education and research, community health education, screenings, support groups, counseling services, and in-kind support. To address the need for health care providers, a number of programs are offered for young people who may be interested in a career in health care.

Note 15 - Community Benefit (continued)

ECHN utilizes guidelines developed by various organizations to quantify community benefit activities. ECHN defines community benefit activities as those that improve access to care, as well as the health of the broader community. In addition to charity care and the unpaid costs of government sponsored health care (Medicare and/or Medicaid shortfalls), community benefit activities will normally fall into one of the following categories: nonbilled community health services / community health improvement services, health professions education, subsidized health services, research, financial and in-kind contributions, community building activities, and community benefit operations.

MMH and RGH provide care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Because MMH and RGH do not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue. The amount of traditional charity care provided, determined on the basis of cost, was $2,144,342 and $2,591,214 for the years ended September 30, 2014 and 2013, respectively.

Note 16 - Functional Expenses

ECHN provides general health care services to residents within its geographical location. For the years ended September 30, 2014 and 2013, expenses relating to providing these services are as follows:

	2014	2013
Health care services	$ 273,670,130	$ 272,099,247
Fund raising	1,210,885	544,391
General and administrative	51,701,589	55,211,560
Total	$ 326,582,604	$ 327,855,198

Note 17 - Temporarily and Permanently Restricted Net Assets

The temporarily restricted net assets available, as of September 30, 2014 and 2013, are available for the following purposes:

	2014	2013
Departmental and endowment purposes	$ 1,910,003	$ 2,114,039
Capital campaign and pledges	186,310	473,262
Total	$ 2,096,313	$ 2,587,301

Note 17 - Temporarily and Permanently Restricted Net Assets (continued)

As of September 30, 2014 and 2013, permanently restricted net assets consist of the following:

	2014	2013
Beneficial interest in trust assets	$ 11,809,221	$ 7,882,372
Endowments restricted for:		
Other departmental purposes	3,553,655	3,709,665
Charity care	532,024	546,180
Special needs	151,579	151,579
Cancer research	6,124	6,124
Total	$ 16,052,603	$ 12,295,920

The composition of the Network's endowment by net asset class as of September 30, 2014 and 2013, was as follows:

2014	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Donor-restricted endowment funds	$ -	$ 1,854,365	$ 4,243,382	$ 6,097,747
Board-designated endowment funds	37,980,275	-	-	37,980,275
Net assets, September 30, 2014	$ 37,980,275	$ 1,854,365	$ 4,243,382	$ 44,078,022

2013	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Donor-restricted endowment funds	$ -	$ 2,121,375	$ 4,413,548	$ 6,534,923
Board-designated endowment funds	33,138,323	-	-	33,138,323
Net assets, September 30, 2013	$ 33,138,323	$ 2,121,375	$ 4,413,548	$ 39,673,246

The Network's endowments consist of multiple funds established for a variety of purposes. The endowments include both donor-restricted endowment funds, funds designated by the Board of Trustees to function as endowments and assets held in trust by others. As required by GAAP, endowments, including funds designated by the Board of Trustees to function as endowments, are classified and reported based on the existence or absence of donor restrictions.

The Network has interpreted the relevant laws as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure by the Network.

Note 17 - Temporarily and Permanently Restricted Net Assets (continued)

The Network considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds: (1) the duration and preservation of the fund; (2) the purposes of the Network and the donor-restricted endowment fund; (3) general economic conditions; (4) the possible effect of inflation and deflation; (5) the expected total return from income and the appreciation of investments; (6) other resources of the Network; and (7) the investment policies of the Network.

The Network has adopted investment and spending policies for endowment assets that attempt to provide a reasonably stable and predictable stream of earnings to support the operations of the endowments and to preserve and enhance over time the real value of the endowment assets. Under this policy, as approved by the Board of Trustees, the endowment assets are invested in a manner that is intended to produce a real return, net of inflation and investment and management costs, over the long-term. Actual returns in any given year may vary from this amount.

The Investment Committee of the Board is responsible for defining and reviewing the investment policy to determine an appropriate long-term asset allocation policy. The asset allocation policy reflects the objective with allocations structured for capital growth and inflation protection over the long-term.

To satisfy its long-term rate-of-return objectives, the Network relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and current yield (interest and dividends). The Network targets a diversified asset allocation that places a greater emphasis on equity based investments to achieve its long-term return objectives within prudent risk constraints.

The Network has appropriated $1,271,326 and $2,339,401 for expenditure from its endowment funds for the years ending September 30, 2014 and 2013, respectively.

Changes in endowment net assets for the fiscal year ended September 30, 2014 were as follows:

2014	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Net assets, October 1, 2013	$ 33,138,323	$ 2,121,375	$ 4,413,548	$ 39,673,246
Interest income and dividends	940,682	47,448	-	988,130
Realized gains	6,547,406	486,492	-	7,033,898
Unrealized depreciation on investments	(4,673,650)	(334,112)	-	(5,007,762)
Released from restrictions	122,263	(1,271,326)	-	(1,149,063)
Contributions	237,342	804,488	-	1,041,830
Reclassification of donations	-	-	(170,166)	(170,166)
Fees	(32,211)	-	-	(32,211)
Transfers to Endowment	1,700,120	-	-	1,700,120
Net assets, September 30, 2014	$ 37,980,275	$ 1,854,365	$ 4,243,382	$ 44,078,022

Note 17 - Temporarily and Permanently Restricted Net Assets (continued)

Changes in endowment net assets for the fiscal year ended September 30, 2013 were as follows:

2013	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Net assets, October 1, 2012	$ 26,269,872	$ 2,564,396	$ 4,407,574	$ 33,241,842
Interest income and dividends	808,111	55,220	-	863,331
Realized gains	2,082,211	145,575	-	2,227,786
Unrealized appreciation on investments	2,118,875	219,391	-	2,338,266
Released from restrictions	780,616	(2,339,401)	-	(1,558,785)
Contributions	183,500	1,473,843	-	1,657,343
Distributions	(1,500,000)	-	-	(1,500,000)
Transfers to Endowment	2,395,138	2,351	5,974	2,403,463
Net assets, September 30, 2013	$ 33,138,323	$ 2,121,375	$ 4,413,548	$ 39,673,246

From time to time, the fair value of assets associated with individual donor restricted endowment funds may fall below the level that the donor or relevant law requires the Network to retain as a fund of perpetual duration. In accordance with GAAP, deficiencies of this nature are reported in unrestricted net assets. As of September 30, 2014 and 2013, there were no funds that were below the level required by donor or law.

Note 18 - Commitments and Contingencies

The Network is involved in various legal actions arising from its activities. Although the ultimate outcome is not determinable at this time, management, after taking into consideration the advice of legal counsel, believes that the resolution of these pending matters will not have a material adverse effect, individually or in the aggregate, on the consolidated balance sheets or on the related consolidated statements of operations and changes in net assets, or consolidated cash flows of the Network.

The Network and the Network's defined benefit pension plans invest in various investment securities. Investment securities are exposed to various risks such as interest rate, market and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term.

Note 19 - Statutory Capital and Surplus

CHIC was incorporated in the Cayman Islands on September 15, 2006 and was granted an Unrestricted Class "B" insurance license under the Insurance Law of the Cayman Islands with an effective date of September 26, 2006. As of October 14, 2013, in accordance with Section 4(3)(b) of The Insurance Law, 2010, the company is now classified as a Class B (i) insurer. CHIC is regulated by the Cayman Islands Monetary Authority (CIMA) and related relations, and is obligated to comply with CIMA regulations regarding minimum levels of solvency and liquidity.

Statutory capital and surplus as of September 30, 2014 was $501,168 with a minimum amount required to be maintained by CHIC of $100,000. Distribution of dividends is subject to approval by the Board of Directors. No dividends were declared or paid during the years ended September 30, 2014 and 2013.

ECHN reports all of CHIC's investments as investments held in trust for estimated self-insurance liabilities in the accompanying consolidated balance sheets.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidating Balance Sheet
September 30, 2014

	The Manchester Memorial Hospital	The Rockville General Hospital, Inc.	ECHN ElderCare Services, Inc.	Eliminations	Subtotal Series A Obligated Group	ECHN Community Healthcare Foundation, Inc.	Eliminations	Subtotal Series C, Series D, and Series E Obligated Group
Assets								
Current assets:								
Cash and cash equivalents	$ 9,361,439	$ 1,772,696	$ 1,363,027	$ -	$ 12,497,162	$ 1,107,266	$ -	$ 13,604,428
Current portion of investments held under bond indentures	653,623	323,965	186,328	-	1,163,916	-	-	1,163,916
Accounts receivable - net	25,099,884	10,900,702	1,681,218	-	37,681,804	-	-	37,681,804
Inventory	3,873,042	1,325,483	38,849	-	5,237,374	-	-	5,237,374
Due from affiliated entities	142,498	65,011	23,158	(78,353)	152,314	8,485	-	160,799
Current portion of estimated settlements due from third-party payers	3,454,150	148,435	-	-	3,602,585	-	-	3,602,585
Prepaid expenses and other current assets	2,357,425	201,349	5,768	-	2,564,542	252,432	-	2,816,974
Total current assets	44,942,061	14,737,641	3,298,348	(78,353)	62,899,697	1,368,183	-	64,267,880
Assets whose use is limited - net of current portion:								
Donor restricted investments	1,778,680	1,575,184	-	-	3,353,864	2,669,078	-	6,022,942
Board designated investments	9,495,379	10,962,908	-	-	20,458,287	14,611,914	-	35,070,201
Investments held in trust for estimated self-insurance liabilities	1,488,787	-	-	-	1,488,787	-	-	1,488,787
Beneficial interest in trust assets	9,599,529	2,209,692	-	-	11,809,221	-	-	11,809,221
Investments held under bond indentures	3,498,353	859,282	813,910	-	5,171,545	-	-	5,171,545
Total assets whose use is limited	25,860,728	15,607,066	813,910	-	42,281,704	17,280,992	-	59,562,696
Interest in net assets of ECHN CHF, Inc.	7,323,190	3,599,134	195,587	-	11,117,911	-	(11,117,911)	-
Investments	1,339,234	2,068,819	3,730,288	-	7,138,341	-	-	7,138,341
Investments in joint ventures	3,849,302	3,489,604	-	-	7,338,906	-	-	7,338,906
Property, plant and equipment - net	55,717,642	25,700,876	7,264,624	-	88,683,142	-	-	88,683,142
Other assets:								
Estimated settlements due from third-party payers - net of current portion	685,669	-	-	-	685,669	-	-	685,669
Due from affiliated entities - net of current portion	20,113,458	7,814,717	-	(5,298,863)	22,629,312	-	-	22,629,312
Goodwill and intangible assets - net	-	-	520,156	-	520,156	-	-	520,156
Other assets	1,923,107	1,769,088	456,032	-	4,148,227	-	-	4,148,227
Total other assets	22,722,234	9,583,805	976,188	(5,298,863)	27,983,364	-	-	27,983,364
Total assets	$ 161,754,391	$ 74,786,945	$ 16,278,945	$ (5,377,216)	$ 247,443,065	$ 18,649,175	$ (11,117,911)	$ 254,974,329

See accompanying independent auditors' report.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidating Balance Sheet (continued)
September 30, 2014

	Eastern CT Medical Professionals Foundation, Inc.	ECHN Corporate Services	ECHN Enterprises, Inc. and Subsidiaries	Visiting Nurse & Health Services of Connecticut Inc.	Eastern Connecticut Health Network, Inc.	Connecticut Healthcare Insurance Company	Eliminations	Total
Assets								
Current assets:								
Cash and cash equivalents	$ 192,024	$ 66,259	$ 76,614	$ 4,558,501	$ 162,984	$ 2,072,791	$ -	$ 20,733,601
Current portion of investments held under bond indentures	-	-	-	-	-	-	-	1,163,916
Accounts receivable - net	2,090,800	827,182	36	3,835,448	169,322	5,680	-	44,610,272
Inventory	15,926	183,985	-	-	-	-	-	5,437,285
Due from affiliated entities	-	-	-	-	4,049	-	(164,848)	-
Current portion of estimated settlements due from third-party payers	-	-	-	-	-	-	-	3,602,585
Prepaid expenses and other current assets	405,503	24,503	4,046	232,277	970,358	1,232,575	-	5,686,236
Total current assets	2,704,253	1,101,929	80,696	8,626,226	1,306,713	3,311,046	(164,848)	81,233,895
Assets whose use is limited - net of current portion:								
Donor restricted investments	-	-	-	74,805	-	-	-	6,097,747
Board designated investments	-	-	-	2,910,074	-	-	-	37,980,275
Investments held in trust for estimated self-insurance liabilities	-	-	-	-	-	3,516,968	-	5,005,755
Beneficial interest in trust assets	-	-	-	-	-	-	-	11,809,221
Investments held under bond indentures	-	-	-	-	-	-	-	5,171,545
Total assets whose use is limited	-	-	-	2,984,879	-	3,516,968	-	66,064,543
Interest in net assets of ECHN CHF, Inc.	-	-	-	-	4,480,831	-	(4,480,831)	-
Investments	-	-	-	-	463,940	-	(463,940)	7,138,341
Investments in joint ventures	-	-	1,247,474	-	5,976,358	-	-	14,562,738
Property, plant and equipment - net	2,469,251	366,651	1,120,456	1,426,059	-	-	-	94,065,559
Other assets:								
Estimated settlements due from third-party payers - net of current portion	-	-	-	-	-	-	-	685,669
Due from affiliated entities - net of current portion	-	-	-	-	867,580	-	(23,496,892)	-
Goodwill and intangible assets - net	592,420	153,550	-	-	5,701,227	-	-	6,967,353
Other assets	-	-	-	530,269	134,014	556,581	-	5,369,091
Total other assets	592,420	153,550	-	530,269	6,702,821	556,581	(23,496,892)	13,022,113
Total assets	$ 5,765,924	$ 1,622,130	$ 2,448,626	$ 13,567,433	$ 18,930,663	$ 7,384,595	$ (28,606,511)	$ 276,087,189

See accompanying independent auditors' report.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidating Balance Sheet (continued)
September 30, 2014

	The Manchester Memorial Hospital	The Rockville General Hospital, Inc.	ECHN ElderCare Services, Inc.	Eliminations	Subtotal Series A Obligated Group	ECHN Community Healthcare Foundation, Inc.	Eliminations	Subtotal Series C, Series D, and Series E Obligated Group
Liabilities and Net Assets (Deficit)								
Current liabilities:								
Accounts payable and accrued expenses	$ 21,842,838	$ 6,181,391	$ 1,055,957	$ -	$ 29,080,186	$ 31,007	$ -	$ 29,111,193
Line of credit	5,600,000	-	-	-	5,600,000	-	-	5,600,000
Current portion of long-term debt	4,092,102	945,159	624,756	-	5,662,017	-	-	5,662,017
Current portion of due to affiliates	23,158	-	60,602	(78,353)	5,407	150,797	-	156,204
Current portion of estimated settlements due to third-party payers	4,285,117	1,132,410	248,895	-	5,666,422	-	-	5,666,422
Current portion of accrued pension and other postretirement benefits	1,025,166	288,603	-	-	1,313,769	-	-	1,313,769
Other current liabilities	2,653,756	732,322	391,627	-	3,777,705	-	-	3,777,705
Total current liabilities	39,522,137	9,279,885	2,381,837	(78,353)	51,105,506	181,804	-	51,287,310
Long-term debt and capital lease obligations, net of current portion	50,421,026	23,392,308	7,841,125	-	81,654,459	-	-	81,654,459
Estimated self-insurance liabilities	6,835,215	3,566,892	493,923	-	10,896,030	-	-	10,896,030
Accrued pension and postretirement benefits	34,595,139	10,081,347	-	-	44,676,486	-	-	44,676,486
Estimated settlements due to third-party payers, net of current portion	-	-	-	-	-	-	-	-
Due to affiliates	5,298,863	-	-	(5,298,863)	-	-	-	-
Other liabilities	283,594	132,211	-	-	415,805	3,197	-	419,002
Total liabilities	136,955,974	46,452,643	10,716,885	(5,377,216)	188,748,286	185,001	-	188,933,287
Net assets (deficit):								
Unrestricted	11,344,473	24,211,838	5,537,374	-	41,093,685	2,865,431	-	43,959,116
Temporarily restricted	974,762	549,043	24,686	-	1,548,491	14,031,431	(9,550,599)	6,029,323
Permanently restricted	12,479,182	3,573,421	-	-	16,052,603	1,567,312	(1,567,312)	16,052,603
Total net assets (deficit)	24,798,417	28,334,302	5,562,060	-	58,694,779	18,464,174	(11,117,911)	66,041,042
Total liabilities and net assets (deficit)	$ 161,754,391	$ 74,786,945	$ 16,278,945	$ (5,377,216)	$ 247,443,065	$ 18,649,175	$ (11,117,911)	$ 254,974,329

See accompanying independent auditors' report.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidating Balance Sheet (continued)
September 30, 2014

	Eastern CT Medical Professionals Foundation, Inc.	ECHN Corporate Services	ECHN Enterprises, Inc. and Subsidiaries	Visiting Nurse & Health Services of Connecticut Inc.	Eastern Connecticut Health Network, Inc.	Connecticut Healthcare Insurance Company	Eliminations	Total
Liabilities and Net Assets (Deficit)								
Current liabilities:								
Accounts payable and accrued expenses	$ 2,145,168	$ 283,874	$ 15,665	$ 2,170,645	$ 2,159,817	$ 78,253	$ -	$ 35,964,615
Lines of credit	-	-	-	-	-	-	-	5,600,000
Current portion of long-term debt	26,082	58,633	25,279	6,488	711,157	-	-	6,489,656
Current portion of due to affiliates	-	-	-	-	-	-	(156,204)	-
Current portion of estimated settlements due to third-party payers	-	-	-	76,738	-	-	-	5,743,160
Current portion of accrued pension and other postretirement benefits	-	-	-	-	-	-	-	1,313,769
Other current liabilities	-	-	-	851,726	-	1,212,361	-	5,841,792
Total current liabilities	2,171,250	342,507	40,944	3,105,597	2,870,974	1,290,614	(156,204)	60,952,992
Long-term debt and capital lease obligations, net of current portion	197,183	50,687	249,337	-	443,748	-	-	82,595,414
Estimated self-insurance liabilities	-	-	-	-	-	5,592,813	(6,805,175)	9,683,668
Accrued pension and postretirement benefits	-	-	-	-	-	-	-	44,676,486
Estimated settlements due to third-party payers, net of current portion	65,838	-	-	-	-	-	-	65,838
Due to affiliates	2,813,908	474,706	2,030,668	-	11,381,079	-	(16,700,361)	-
Other liabilities	-	-	-	-	-	-	-	419,002
Total liabilities	5,248,179	867,900	2,320,949	3,105,597	14,695,801	6,883,427	(23,661,740)	198,393,400
Net assets (deficit):								
Unrestricted	517,745	754,230	127,677	10,387,031	3,761,845	501,168	(463,939)	59,544,873
Temporarily restricted	-	-	-	74,805	473,017	-	(4,480,832)	2,096,313
Permanently restricted	-	-	-	-	-	-	-	16,052,603
Total net assets (deficit)	517,745	754,230	127,677	10,461,836	4,234,862	501,168	(4,944,771)	77,693,789
Total liabilities and net assets (deficit)	$ 5,765,924	$ 1,622,130	$ 2,448,626	$ 13,567,433	$ 18,930,663	$ 7,384,595	$ (28,606,511)	$ 276,087,189

See accompanying independent auditors' report.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidating Statement of Operations and Changes in Net Assets
For the Year Ended September 30, 2014

	The Manchester Memorial Hospital	The Rockville General Hospital, Inc.	ECHN ElderCare Services, Inc.	Eliminations	Subtotal Series A Obligated Group	ECHN Community Healthcare Foundation, Inc.	Eliminations	Subtotal Series C, Series D, and Series E Obligated Group
Revenues:								
Net patient service revenues	$ 178,026,737	$ 71,329,965	$ 15,194,102	$ -	$ 264,550,804	$ -	$ -	$ 264,550,804
Provision for bad debts	(5,822,470)	(2,801,283)	(181,495)	-	(8,805,248)	-	-	(8,805,248)
Net patient service revenues less provision for bad debts	172,204,267	68,528,682	15,012,607	-	255,745,556	-	-	255,745,556
Contributions	496,356	315,697	9,235	-	821,288	-	-	821,288
Other revenues	15,370,698	5,227,522	282,491	(143,096)	20,737,615	548,340	(537,649)	20,748,306
EHR incentive payment revenue	986,834	799,300	-	-	1,786,134	-	-	1,786,134
Net assets released from restrictions used in operations	486,908	49,147	1,794	-	537,849	197,133	-	734,982
Total revenues	189,545,063	74,920,348	15,306,127	(143,096)	279,628,442	745,473	(537,649)	279,836,266
Expenses:								
Salaries and wages	83,606,297	32,460,253	7,495,632	-	123,562,182	300,253	(217,087)	123,645,348
Fringe benefits	25,720,253	9,360,797	1,961,418	-	37,042,468	91,045	(65,731)	37,067,782
Supplies and other expenses	66,276,903	26,367,709	4,016,613	(143,096)	96,518,129	354,175	(254,831)	96,617,473
Depreciation and amortization	7,116,905	3,281,014	557,532	-	10,955,451	-	-	10,955,451
Interest and financing costs	2,589,201	689,882	431,848	-	3,710,931	-	-	3,710,931
Total expenses	185,309,559	72,159,655	14,463,043	(143,096)	271,789,161	745,473	(537,649)	271,996,985
Income (loss) from operations	4,235,504	2,760,693	843,084	-	7,839,281	-	-	7,839,281
Non-operating (losses) gains	(1,743,322)	(378,564)	27,867	-	(2,094,019)	-	-	(2,094,019)
Excess of revenues (under) over expenses	$ 2,492,182	$ 2,382,129	$ 870,951	$ -	$ 5,745,262	$ -	$ -	$ 5,745,262

See accompanying independent auditors' report.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidating Statement of Operations and Changes in Net Assets (continued)
For the Year Ended September 30, 2014

	Eastern CT Medical Professionals Foundation, Inc.	ECHN Corporate Services	ECHN Enterprises, Inc. and Subsidiaries	Visiting Nurse & Health Services of Connecticut Inc.	Eastern Connecticut Health Network, Inc.	Connecticut Healthcare Insurance Company	Eliminations	Total
Revenues:								
Net patient service revenues	$ 20,269,147	$ -	$ -	$ 25,151,359	$ -	$ -	$ -	$ 309,971,310
Provision for bad debts	(1,261,083)	-	-	(149,763)	-	-	-	(10,216,094)
Net patient service revenues less provision for bad debts	19,008,064	-	-	25,001,596	-	-	-	299,755,216
Contributions	-	-	-	342,595	335,662	-	(335,662)	1,163,883
Other revenues	7,661,388	4,207,997	542,446	1,372,276	3,258,466	2,251,542	(14,825,979)	25,216,442
EHR incentive payment revenue	-	-	-	-	-	-	-	1,786,134
Net assets released from restrictions used in operations	-	-	-	86,733	11,935	-	-	833,650
Total revenues	26,669,452	4,207,997	542,446	26,803,200	3,606,063	2,251,542	(15,161,641)	328,755,325
Expenses:								
Salaries and wages	19,262,878	2,414,238	-	17,488,152	10,582,722	-	(10,665,893)	162,727,445
Fringe benefits	2,966,456	376,616	-	3,473,859	2,404,890	-	(2,430,205)	43,859,398
Supplies and other expenses	10,846,227	1,001,633	302,414	4,462,199	(11,783,558)	2,078,542	509,466	104,034,396
Depreciation and amortization	634,455	140,684	69,878	396,409	208,107	-	(208,107)	12,196,877
Interest and financing costs	14,202	26,708	10,745	1,902	85,197	-	(85,197)	3,764,488
Total expenses	33,724,218	3,959,879	383,037	25,822,521	1,497,358	2,078,542	(12,879,936)	326,582,604
Income (loss) from operations	(7,054,766)	248,118	159,409	980,679	2,108,705	173,000	(2,281,705)	2,172,721
Non-operating (losses) gains	-	-	(31,732)	-	(2,108,705)	-	2,108,705	(2,125,751)
Excess of revenues (under) over expenses	$ (7,054,766)	$ 248,118	$ 127,677	$ 980,679	$ -	$ 173,000	$ (173,000)	$ 46,970

See accompanying independent auditors' report.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidating Statement of Operations and Changes in Net Assets (continued)
For the Year Ended September 30, 2014

	The Manchester Memorial Hospital	The Rockville General Hospital, Inc.	ECHN ElderCare Services, Inc.	Eliminations	Subtotal Series A Obligated Group	ECHN Community Healthcare Foundation, Inc.	Eliminations	Subtotal Series C, Series D, and Series E Obligated Group
Unrestricted net assets:								
Excess of revenues (under) over expenses	$ 2,492,182	$ 2,382,129	$ 870,951	$ -	$ 5,745,262	$ -	$ -	$ 5,745,262
Unrealized depreciation on investments	(2,455,966)	(1,806,881)	(113,134)	-	(4,375,981)	-	-	(4,375,981)
Net change in interest rate swap agreement	8,379	-	-	-	8,379	-	-	8,379
Net assets released from restrictions for capital acquisitions	385,647	51,083	-	-	436,730	-	-	436,730
Equity transfer to ECHN	(4,937,674)	(2,116,146)	-	-	(7,053,820)	-	-	(7,053,820)
Equity transfer from ECHN	-	-	-	-	-	-	-	-
ECHN Corporate Services transfer	-	-	-	-	-	-	-	-
Transfers (to) from other affiliates - net	(6,541,891)	(229)	7,130	-	(6,534,990)	273,716	-	(6,261,274)
Pension and postretirement related adjustments	(5,366,133)	(1,072,107)	-	-	(6,438,240)	-	-	(6,438,240)
Other	-	-	-	-	-	-	-	-
Change in unrestricted net assets	(16,415,456)	(2,562,151)	764,947	-	(18,212,660)	273,716	-	(17,938,944)
Temporarily restricted net assets:								
Contributions	44,454	19,798	(33)	-	64,219	1,066,825	(290,398)	840,646
Investment income	321,703	131,269	2,038	-	455,010	2,408,300	(1,663,779)	1,199,531
Net assets released from restrictions for operations	(486,908)	(49,147)	(1,794)	-	(537,849)	(829,423)	619,265	(748,007)
Net assets released from restrictions for capital acquisitions	(385,647)	(51,083)	-	-	(436,730)	(436,730)	436,730	(436,730)
Unrealized depreciation on investments	(95,535)	(67,641)	-	-	(163,176)	(1,702,269)	1,044,231	(821,214)
Transfers (to) from affiliates	183,793	4,384	-	-	188,177	-	(187,306)	871
Change in temporarily restricted net assets	(418,140)	(12,420)	211	-	(430,349)	506,703	(41,257)	35,097
Permanently restricted net assets:								
Contributions - beneficial interest trust assets	3,751,750	-	-	-	3,751,750	-	-	3,751,750
Change in beneficial interest in trust assets	148,523	27,520	-	-	176,043	-	-	176,043
Reclassifications of donations	-	(171,110)	-	-	(171,110)	-	-	(171,110)
Change in permanently restricted net assets	3,900,273	(143,590)	-	-	3,756,683	-	-	3,756,683
Change in net assets (deficit)	(12,933,323)	(2,718,161)	765,158	-	(14,886,326)	780,419	(41,257)	(14,147,164)
Net assets (deficit), beginning of year	37,731,740	31,052,463	4,796,902	-	73,581,105	17,683,755	(11,076,654)	80,188,206
Net assets (deficit), end of year	$ 24,798,417	$ 28,334,302	$ 5,562,060	$ -	$ 58,694,779	$ 18,464,174	$ (11,117,911)	$ 66,041,042

See accompanying independent auditors' report.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidating Statement of Operations and Changes in Net Assets (continued)
For the Year Ended September 30, 2014

	Eastern CT Medical Professionals Foundation, Inc.	ECHN Corporate Services	ECHN Enterprises, Inc. and Subsidiaries	Visiting Nurse & Health Services of Connecticut Inc.	Eastern Connecticut Health Network, Inc.	Connecticut Healthcare Insurance Company	Eliminations	Total
Unrestricted net assets:								
Excess of revenues (under) over expenses	$ (7,054,766)	$ 248,118	$ 127,677	$ 980,679	$ -	$ 173,000	$ (173,000)	$ 46,970
Unrealized depreciation on investments	-	-	-	(598,592)	(487,108)	(15,244)	-	(5,476,925)
Net change in interest rate swap agreement	-	-	-	-	-	-	-	8,379
Net assets released from restrictions for capital acquisitions	946	-	-	-	-	-	-	437,676
Equity transfer to ECHN	-	-	-	-	7,053,820	-	-	-
Equity transfer from ECHN	7,053,820	-	-	-	(7,053,820)	-	-	-
ECHN Corporate Services transfer	-	-	-	-	-	-	-	-
Transfers (to) from other affiliates - net	545,436	125,000	84,174	-	8,208,215	1,200,000	(3,901,551)	-
Pension and postretirement related adjustments	-	-	-	-	-	-	-	(6,438,240)
Other	-	1,003	-	-	-	-	82	1,085
Change in unrestricted net assets	545,436	374,121	211,851	382,087	7,721,107	1,357,756	(4,074,469)	(11,421,055)
Temporarily restricted net assets:								
Contributions	-	-	-	74,805	79,003	-	(413,939)	580,515
Investment income	-	-	-	-	73,349	-	(738,941)	533,939
Net assets released from restrictions for operations	-	-	-	(86,733)	(11,935)	-	13,025	(833,650)
Net assets released from restrictions for capital acquisitions	(946)	-	-	-	-	-	-	(437,676)
Change in unrealized appreciation on investments	-	-	-	-	-	-	487,098	(334,116)
Transfers (to) from affiliates	946	-	-	-	(189,123)	-	187,306	-
Change in temporarily restricted net assets	-	-	-	(11,928)	(48,706)	-	(465,451)	(490,988)
Permanently restricted net assets:								
Contributions - beneficial interest trust assets	-	-	-	-	-	-	-	3,751,750
Change in beneficial interest in trust assets	-	-	-	-	-	-	-	176,043
Reclassifications of donations	-	-	-	-	-	-	-	(171,110)
Change in permanently restricted net assets	-	-	-	-	-	-	-	3,756,683
Change in net assets (deficit)	545,436	374,121	211,851	370,159	7,672,401	1,357,756	(4,539,920)	(8,155,360)
Net assets (deficit), beginning of year	(27,691)	380,109	(84,174)	10,091,677	(3,437,539)	(856,588)	(404,851)	85,849,149
Net assets (deficit), end of year	$ 517,745	$ 754,230	$ 127,677	$ 10,461,836	$ 4,234,862	$ 501,168	$ (4,944,771)	$ 77,693,789

See accompanying independent auditors' report.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidating Balance Sheet
September 30, 2013

	The Manchester Memorial Hospital	The Rockville General Hospital, Inc.	ECHN ElderCare Services, Inc.	Eliminations	Subtotal Series A Obligated Group	ECHN Community Healthcare Foundation, Inc.	Eliminations	Subtotal Series C, Series D, and Series E Obligated Group
Assets								
Current assets:								
Cash and cash equivalents	$ 12,239,488	$ 1,059,290	$ 887,544	$ -	$ 14,186,322	$ 1,936,006	$ -	$ 16,122,328
Current portion of investments held under bond indentures	1,300,096	364,771	185,664	-	1,850,531	-	-	1,850,531
Accounts receivable - net	27,182,276	10,269,970	1,772,700	-	39,224,946	-	-	39,224,946
Inventory	3,245,125	1,467,009	38,816	-	4,750,950	-	-	4,750,950
Due from affiliated entities	370,120	58,029	282,558	(79,590)	631,117	19,043	-	650,160
Current portion of estimated settlements due from third-party payers	3,078,822	384,274	-	-	3,463,096	-	-	3,463,096
Prepaid expenses and other current assets	2,316,130	276,211	4,671	-	2,597,012	720,233	-	3,317,245
Total current assets	49,732,057	13,879,554	3,171,953	(79,590)	66,703,974	2,675,282	-	69,379,256
Assets whose use is limited net of current portion:								
Donor restricted investments	1,806,681	1,709,690	-	-	3,516,371	2,931,819	-	6,448,190
Board designated investments	8,595,367	9,895,326	-	-	18,490,693	12,031,955	-	30,522,648
Investments held in trust for estimated self-insurance liabilities	1,258,026	-	-	-	1,258,026	-	-	1,258,026
Beneficial interest in trust assets	5,700,200	2,182,172	-	-	7,882,372	-	-	7,882,372
Investments held under bond indentures	3,321,696	806,533	813,828	-	4,942,057	-	-	4,942,057
Total assets whose use is limited	20,681,970	14,593,721	813,828	-	36,089,519	14,963,774	-	51,053,293
Interest in net assets of ECHN CHF, Inc.	7,278,631	3,616,191	181,832	-	11,076,654	-	(11,076,654)	-
Investments	4,366,493	3,088,116	3,630,706	-	11,085,315	283,179	-	11,368,494
Investments in joint ventures	3,501,635	3,208,828	-	-	6,710,463	-	-	6,710,463
Property, plant and equipment - net	54,574,351	27,654,664	7,672,388	-	89,901,403	-	-	89,901,403
Other assets:								
Estimated settlements due from third-party payers - net	6,135,548	668,994	-	-	6,804,542	-	-	6,804,542
Due from affiliated entities - net of current portion	25,064,484	9,022,571	-	(7,220,571)	26,866,484	-	-	26,866,484
Goodwill and intangible assets - net	-	-	549,482	-	549,482	-	-	549,482
Other assets	2,819,605	811,215	454,422	-	4,085,242	210,111	-	4,295,353
Total other assets	34,019,637	10,502,780	1,003,904	(7,220,571)	38,305,750	210,111	-	38,515,861
Total assets	$ 174,154,774	$ 76,543,854	$ 16,474,611	$ (7,300,161)	$ 259,873,078	$ 18,132,346	$ (11,076,654)	$ 266,928,770

See accompanying independent auditors' report.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidating Balance Sheet (continued)
September 30, 2013

	Eastern CT Medical Professionals Foundation, Inc.	ECHN Corporate Services	ECHN Enterprises, Inc. and Subsidiaries	Visiting Nurse & Health Serices of Connecticut Inc.	Eastern Connecticut Health Network, Inc.	Connecticut Healthcare Insurance Company	Eliminations	Total
Assets								
Current assets:								
Cash and cash equivalents	$ 93,515	$ 129,143	$ 101,334	$ 2,766,681	$ 243,530	$ 2,982,825	$ -	$ 22,439,356
Current portion of investments held under bond indentures	-	-	-	-	-	-	-	1,850,531
Accounts receivable - net	2,881,621	748,991	35	3,338,073	328,616	1,861	-	46,524,143
Inventory	15,926	298,840	-	-	-	-	-	5,065,716
Due from affiliated entities	-	-	-	-	847,173	-	(1,497,333)	-
Current portion of estimated settlements due from third-party payers	-	-	-	-	-	-	-	3,463,096
Prepaid expenses and other current assets	295,148	14,498	3,903	159,247	1,235,148	21,676	-	5,046,865
Total current assets	3,286,210	1,191,472	105,272	6,264,001	2,654,467	3,006,362	(1,497,333)	84,389,707
Assets whose use is limited net of current portion:								
Donor restricted investments	-	-	-	86,733	-	-	-	6,534,923
Board designated investments	-	-	-	2,615,675	-	-	-	33,138,323
Investments held in trust for estimated self-insurance liabilities	-	-	-	-	-	1,207,905	-	2,465,931
Beneficial interest in trust assets	-	-	-	-	-	-	-	7,882,372
Investments held under bond indentures	-	-	-	-	-	-	-	4,942,057
Total assets whose use is limited	-	-	-	2,702,408	-	1,207,905	-	54,963,606
Interest in net assets of ECHN CHF, Inc.	-	-	-	-	4,015,385	-	(4,015,385)	-
Investments	-	-	-	1,641,046	(909,061)	-	909,061	13,009,540
Investments in joint ventures	-	-	1,204,749	-	5,816,631	-	-	13,731,843
Property, plant and equipment - net	2,847,719	212,916	1,190,334	1,734,534	301,591	-	-	96,188,497
Other assets:								
Estimated settlements due from third-party payers - net	-	-	-	-	-	-	-	6,804,542
Due from affiliated entities - net of current portion	-	-	-	-	-	-	(26,866,484)	-
Goodwill and intangible assets - net	517,746	206,000	-	-	5,872,641	-	-	7,145,869
Other assets	-	-	-	624,407	307,041	1,006,331	-	6,233,132
Total other assets	517,746	206,000	-	624,407	6,179,682	1,006,331	(26,866,484)	20,183,543
Total assets	$ 6,651,675	$ 1,610,388	$ 2,500,355	$ 12,966,396	$ 18,058,695	$ 5,220,598	$ (31,470,141)	$ 282,466,736

See accompanying independent auditors' report.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidating Balance Sheet (continued)
September 30, 2013

	The Manchester Memorial Hospital	The Rockville General Hospital, Inc.	ECHN ElderCare Services, Inc.	Eliminations	Subtotal Series A Obligated Group	ECHN Community Healthcare Foundation, Inc.	Eliminations	Subtotal Series C, Series D, and Series E Obligated Group
Liabilities and Net Assets (Deficit)								
Current liabilities:								
Accounts payable and accrued expenses	$ 21,391,578	$ 6,096,840	$ 870,615	$ -	$ 28,359,033	$ 96,089	$ -	$ 28,455,122
Lines of credit	6,500,000	-	-	-	6,500,000	-	-	6,500,000
Current portion of long-term debt	3,909,618	870,081	588,866	-	5,368,565	-	-	5,368,565
Due to affiliates	-	398,089	83,694	(79,590)	402,193	348,957	-	751,150
Current portion of estimated settlements due to third-party payers	2,943,941	1,040,198	408,222	-	4,392,361	-	-	4,392,361
Current portion of accrued pension and other postretirement benefits	4,683,769	1,401,749	-	-	6,085,518	-	-	6,085,518
Other current liabilities	2,482,951	754,403	170,562	-	3,407,916	-	-	3,407,916
Total current liabilities	41,911,857	10,561,360	2,121,959	(79,590)	54,515,586	445,046	-	54,960,632
Long-term debt and capital lease obligations, net of current portion	50,793,813	23,519,254	8,462,882	-	82,775,949	-	-	82,775,949
Estimated self-insurance liabilities	6,830,954	2,423,371	1,041,008	-	10,295,333	-	-	10,295,333
Accrued pension and postretirement benefits	29,256,268	8,855,195	-	-	38,111,463	-	-	38,111,463
Estimated settlements due to third-party payers, net of current portion	-	-	-	-	-	-	-	-
Due to affiliates	7,220,571	-	-	(7,220,571)	-	-	-	-
Other liabilities	409,571	132,211	51,860	-	593,642	3,545	-	597,187
Total liabilities	136,423,034	45,491,391	11,677,709	(7,300,161)	186,291,973	448,591	-	186,740,564
Net assets (deficit):								
Unrestricted	27,759,929	26,773,989	4,772,427	-	59,306,345	2,591,715	-	61,898,060
Temporarily restricted	1,392,902	561,463	24,475	-	1,978,840	13,524,728	(9,509,342)	5,994,226
Permanently restricted	8,578,909	3,717,011	-	-	12,295,920	1,567,312	(1,567,312)	12,295,920
Total net assets (deficit)	37,731,740	31,052,463	4,796,902	-	73,581,105	17,683,755	(11,076,654)	80,188,206
Total liabilities and net assets (deficit)	$ 174,154,774	$ 76,543,854	$ 16,474,611	$ (7,300,161)	$ 259,873,078	$ 18,132,346	$ (11,076,654)	$ 266,928,770

See accompanying independent auditors' report.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidating Balance Sheet (continued)
September 30, 2013

	Eastern CT Medical Professionals Foundation, Inc.	ECHN Corporate Services	ECHN Enterprises, Inc. and Subsidiaries	Visiting Nurse & Health Serices of Connecticut Inc.	Eastern Connecticut Health Network, Inc.	Connecticut Healthcare Insurance Company	Eliminations	Total
Liabilities and Net Assets (Deficit)								
Current liabilities:								
Accounts payable and accrued expenses	$ 2,272,436	$ 923,287	$ 16,422	$ 1,834,866	$ 1,301,847	$ 70,855	$ -	$ 34,874,835
Lines of credit	-	-	-	-	-	-	-	6,500,000
Current portion of long-term debt	143,567	33,458	24,357	51,971	1,210,404	-	-	6,832,322
Due to affiliates	-	89,856	-	-	-	-	(841,006)	-
Current portion of estimated settlements due to third-party payers	-	-	-	120,000	-	-	-	4,512,361
Current portion of accrued pension and other postretirement benefits	-	-	-	-	-	-	-	6,085,518
Other current liabilities	-	-	-	861,394	-	1,051,734	-	5,321,044
Total current liabilities	2,416,003	1,046,601	40,779	2,868,231	2,512,251	1,122,589	(841,006)	64,126,080
Long-term debt and capital lease obligations, net of current portion	223,265	183,678	274,616	6,488	952,010	-	-	84,416,006
Estimated self-insurance liabilities	-	-	-	-	-	4,954,597	(6,006,000)	9,243,930
Accrued pension and postretirement benefits	-	-	-	-	-	-	-	38,111,463
Estimated settlements due to third-party payers, net of current portion	122,921	-	-	-	-	-	-	122,921
Due to affiliates	3,917,177	-	2,269,134	-	18,031,973	-	(24,218,284)	-
Other liabilities	-	-	-	-	-	-	-	597,187
Total liabilities	6,679,366	1,230,279	2,584,529	2,874,719	21,496,234	6,077,186	(31,065,290)	196,617,587
Net assets (deficit):								
Unrestricted	(27,691)	380,109	(84,174)	10,004,944	(3,959,262)	(856,588)	3,610,530	70,965,928
Temporarily restricted	-	-	-	86,733	521,723	-	(4,015,381)	2,587,301
Permanently restricted	-	-	-	-	-	-	-	12,295,920
Total net assets (deficit)	(27,691)	380,109	(84,174)	10,091,677	(3,437,539)	(856,588)	(404,851)	85,849,149
Total liabilities and net assets (deficit)	$ 6,651,675	$ 1,610,388	$ 2,500,355	$ 12,966,396	$ 18,058,695	$ 5,220,598	$ (31,470,141)	$ 282,466,736

See accompanying independent auditors' report.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidating Statement of Operations and Changes in Net Assets
For the Year Ended September 30, 2013

	The Manchester Memorial Hospital	The Rockville General Hospital, Inc.	ECHN ElderCare Services, Inc.	Eliminations	Subtotal Series A Obligated Group	ECHN Community Healthcare Foundation, Inc.	Eliminations	Subtotal Series B, Series C, and Series D Obligated Group
Revenues:								
Net patient service revenue	$ 175,818,082	$ 73,037,858	$ 14,748,717	$ -	$ 263,604,657	$ -	$ -	$ 263,604,657
Provision for bad debts	(5,518,461)	(4,127,214)	(110,000)	-	(9,755,675)	-	-	(9,755,675)
Net patient service revenue less provision for bad debts	170,299,621	68,910,644	14,638,717	-	253,848,982	-	-	253,848,982
Contributions	961,465	253,309	14,404	-	1,229,178	-	-	1,229,178
Other revenues	15,458,360	4,492,026	271,583	(141,268)	20,080,701	1,655,029	(832,862)	20,902,868
EHR initiative payment revenue	1,410,667	1,220,153	-	-	2,630,820	-	-	2,630,820
Net assets released from restrictions used for operations	1,458,982	112,828	3,500	-	1,575,310	288,075	-	1,863,385
Total revenues	189,589,095	74,988,960	14,928,204	(141,268)	279,364,991	1,943,104	(832,862)	280,475,233
Expenses:								
Salaries and wages	83,909,349	31,509,639	7,249,363	-	122,668,351	515,044	(376,115)	122,807,280
Fringe benefits	27,658,791	10,024,601	2,721,924	-	40,405,316	129,343	(94,462)	40,440,197
Supplies and other expenses	66,966,600	25,888,529	3,792,677	(141,268)	96,506,538	496,670	(362,285)	96,640,923
Depreciation and amortization	7,115,302	3,565,031	551,609	-	11,231,942	-	-	11,231,942
Interest and financing costs	2,685,044	682,298	485,961	-	3,853,303	-	-	3,853,303
Total expenses	188,335,086	71,670,098	14,801,534	(141,268)	274,665,450	1,141,057	(832,862)	274,973,645
Income (loss) from operations	1,254,009	3,318,862	126,670	-	4,699,541	802,047	-	5,501,588
Non-operating (losses) gains	(1,466,699)	(660,236)	52,019	-	(2,074,916)	-	-	(2,074,916)
Excess of revenues over (under) expenses	$ (212,690)	$ 2,658,626	$ 178,689	$ -	$ 2,624,625	$ 802,047	$ -	$ 3,426,672

See accompanying independent auditors' report.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidating Statement of Operations and Changes in Net Assets (continued)
For the Year Ended September 30, 2013

	Eastern CT Medical Professionals Foundation, Inc.	ECHN Corporate Services	ECHN Enterprises, Inc. and Subsidiaries	Visiting Nurse & Health Serices of Connecticut Inc.	Eastern Connecticut Health Network, Inc.	Connecticut Healthcare Insurance Company	Eliminations	Total
Revenues:								
Net patient service revenue	$ 21,949,662	$ -	$ -	$ 24,638,275	$ -	$ -	$ (70,435)	$ 310,122,159
Provision for bad debts	(1,249,472)	-	-	(137,055)	-	-	-	(11,142,202)
Net patient service revenue less provision for bad debts	20,700,190	-	-	24,501,220	-	-	(70,435)	298,979,957
Contributions	-	-	-	385,141	345,435	-	(345,435)	1,614,319
Other revenues	8,353,432	3,232,600	425,834	717,140	3,048,899	2,440,340	(16,249,743)	22,871,370
EHR initiative payment revenue	-	-	-	-	-	-	-	2,630,820
Net assets released from restrictions used for operations	-	-	-	2,353	5,489	-	-	1,871,227
Total revenues	29,053,622	3,232,600	425,834	25,605,854	3,399,823	2,440,340	(16,665,613)	327,967,693
Expenses:								
Salaries and wages	21,887,013	1,880,216	-	17,154,890	11,400,866	-	(11,400,863)	163,729,402
Fringe benefits	3,477,219	320,611	-	3,354,064	2,316,394	-	(2,316,391)	47,592,094
Supplies and other expenses	9,246,348	876,567	284,772	4,119,020	(12,524,809)	8,133,343	(6,433,767)	100,342,397
Depreciation and amortization	545,428	57,332	71,228	384,891	228,411	-	(228,410)	12,290,822
Interest and financing costs	15,629	15,216	11,681	4,654	138,065	-	(138,065)	3,900,483
Total expenses	35,171,637	3,149,942	367,681	25,017,519	1,558,927	8,133,343	(20,517,496)	327,855,198
Income (loss) from operations	(6,118,015)	82,658	58,153	588,335	1,840,896	(5,693,003)	3,851,883	112,495
Non-operating (losses) gains	-	-	(63,728)	55	(1,840,896)	-	1,840,896	(2,138,589)
Excess of revenues over (under) expenses	$ (6,118,015)	$ 82,658	$ (5,575)	$ 588,390	$ -	$ (5,693,003)	$ 5,692,779	$ (2,026,094)

See accompanying independent auditors' report.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidating Statement of Operations and Changes in Net Assets (continued)
For the Year Ended September 30, 2013

	The Manchester Memorial Hospital	The Rockville General Hospital, Inc.	ECHN ElderCare Services, Inc.	Eliminations	Subtotal Series A Obligated Group	ECHN Community Healthcare Foundation, Inc.	Eliminations	Subtotal Series B, Series C, and Series D Obligated Group
Unrestricted net assets:								
Excess of revenues over (under) expenses	$ (212,690)	$ 2,658,626	$ 178,689	$ -	$ 2,624,625	$ 802,047	$ -	$ 3,426,672
Change in unrealized appreciation on investments	430,760	696,651	205,847	-	1,333,258	-	-	1,333,258
Net change in interest rate swap agreements	110,862	-	-	-	110,862	-	-	110,862
Net assets released from restrictions for capital acquisitions	401,528	47,604	19,042	-	468,174	-	-	468,174
Equity transfer to ECHN	(4,282,611)	(1,835,404)	-	-	(6,118,015)	-	-	(6,118,015)
Equity transfer from ECHN	-	-	-	-	-	-	-	-
ECHN Corporate Services Transfer	-	-	-	-	-	-	-	-
Transfer (to) from other affiliates - net	(94,598)	(6,530)	5,000	-	(96,128)	96,861	-	733
Pension and postretirement-related adjustments	26,481,163	8,152,920	-	-	34,634,083	-	-	34,634,083
Other	-	(5,975)	-	-	(5,975)	-	-	(5,975)
Change in unrestricted net assets	22,834,414	9,707,892	408,578	-	32,950,884	898,908	-	33,849,792
Temporarily restricted net assets:								
Contributions	580,157	32,787	14,288	-	627,232	2,475,669	(1,573,241)	1,529,660
Investment income	178,208	16,725	-	-	194,933	32,862	(26,999)	200,796
Net assets released from restrictions for operations	(1,458,982)	(112,828)	(3,500)	-	(1,575,310)	(1,093,192)	799,630	(1,868,872)
Net assets released from restrictions for capital acquisitions	(401,528)	(47,604)	(19,042)	-	(468,174)	(468,173)	468,173	(468,174)
Change in unrealized appreciation on investments	39,846	47,603	1,388	-	88,837	1,041,967	(627,530)	503,274
Transfer (to) from affiliates	550,132	9,032	-	-	559,164	-	(497,634)	61,530
Change in temporarily restricted net assets	(512,167)	(54,285)	(6,866)	-	(573,318)	1,989,133	(1,457,601)	(41,786)
Permanently restricted net assets:								
Change in beneficial interest in trust assets	403,720	77,870	-	-	481,590	-	-	481,590
Other	-	5,975	-	-	5,975	-	-	5,975
Change in permanently restricted net assets	403,720	83,845	-	-	487,565	-	-	487,565
Change in net assets (deficit)	22,725,967	9,737,452	401,712	-	32,865,131	2,888,041	(1,457,601)	34,295,571
Net assets (deficit), beginning of year	15,005,773	21,315,011	4,395,190	-	40,715,974	14,795,714	(9,619,053)	45,892,635
Net assets (deficit), end of year	$ 37,731,740	$ 31,052,463	$ 4,796,902	$ -	$ 73,581,105	$ 17,683,755	$ (11,076,654)	$ 80,188,206

See accompanying independent auditors' report.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidating Statement of Operations and Changes in Net Assets (continued)
For the Year Ended September 30, 2013

	Eastern CT Medical Professionals Foundation, Inc.	ECHN Corporate Services	ECHN Enterprises, Inc. and Subsidiaries	Visiting Nurse & Health Services of Connecticut Inc.	Eastern Connecticut Health Network, Inc.	Connecticut Healthcare Insurance Company	Eliminations	Total
Unrestricted net assets:								
Excess of revenues over (under) expenses	$ (6,118,015)	$ 82,658	$ (5,575)	$ 588,390	$ -	$ (5,693,003)	$ 5,692,779	$ (2,026,094)
Change in unrealized appreciation on investments	-	-	-	159,050	283,886	(540,700)	-	1,235,494
Net change in interest rate swap agreements	-	-	-	-	-	-	-	110,862
Net assets released from restrictions for capital acquisitions	-	-	-	-	-	-	-	468,174
Equity transfer to ECHN	-	-	-	-	6,118,015	-	-	-
Equity transfer from ECHN	6,118,015	-	-	-	(6,118,015)	-	-	-
ECHN Corporate Services Transfer	-	297,451	-	-	(297,451)	-	-	-
Transfer (to) from other affiliates - net	-	-	-	-	(733)	5,373,092	(5,373,092)	-
Pension and postretirement-related adjustments	-	-	-	-	-	-	-	34,634,083
Other	-	-	-	-	-	-	-	(5,975)
Change in unrestricted net assets	-	380,109	(5,575)	747,440	(14,298)	(860,611)	319,687	34,416,544
Temporarily restricted net assets:								
Contributions	-	-	-	16,500	432,285	-	(715,452)	1,262,993
Investment income	-	-	-	-	-	-	-	200,796
Net assets released from restrictions for operations	-	-	-	(2,353)	(5,489)	-	5,487	(1,871,227)
Net assets released from restrictions for capital acquisitions	-	-	-	-	-	-	-	(468,174)
Change in unrealized appreciation on investments	-	-	-	-	35,316	-	(319,199)	219,391
Transfer (to) from affiliates	-	-	-	-	(559,164)	-	497,634	-
Change in temporarily restricted net assets	-	-	-	14,147	(97,052)	-	(531,530)	(656,221)
Permanently restricted net assets:								
Change in beneficial interest in trust assets	-	-	-	-	-	-	-	481,590
Other	-	-	-	-	-	-	-	5,975
Change in permanently restricted net assets	-	-	-	-	-	-	-	487,565
Change in net assets (deficit)	-	380,109	(5,575)	761,587	(111,350)	(860,611)	(211,843)	34,247,888
Net assets (deficit), beginning of year	(27,691)	-	(78,599)	9,330,090	(3,326,189)	4,023	(193,008)	51,601,261
Net assets (deficit), end of year	$ (27,691)	$ 380,109	$ (84,174)	$ 10,091,677	$ (3,437,539)	$ (856,588)	$ (404,851)	$ 85,849,149

See accompanying independent auditors' report.

EASTERN CONNECTICUT
HEALTH NETWORK, INC. AND SUBSIDIARIES

CONSOLIDATED FINANCIAL STATEMENTS
September 30, 2015 and 2014

EASTERN CONNECTICUT HEALTH NETWORK, INC. AND SUBSIDIARIES

CONSOLIDATED FINANCIAL STATEMENTS
September 30, 2015 and 2014

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Crowe Horwath.

Crowe Horwath LLP
Independent Member Crowe Horwath International

INDEPENDENT AUDITOR'S REPORT

To the Board of Trustees of Eastern Connecticut Health Network, Inc.
Manchester, Connecticut

Report on the Consolidated Financial Statements

We have audited the accompanying consolidated financial statements of Eastern Connecticut Health Network, Inc. and Subsidiaries (the Network), a not-for-profit, non-stock corporation, which comprise the consolidated balance sheet as of September 30, 2015, and the related consolidated statements of operations and changes in net assets and cash flows for the year then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audit. We did not audit the financial statements of Connecticut Healthcare Insurance Company, a wholly owned subsidiary, whose statements reflect total assets of $6,093,108, as of September 30, 2015, respectively, and total revenues of $2,747,065 for the year then ended. Those statements were audited by other auditors in accordance with international standards on auditing, whose report has been furnished to us, and our opinion, insofar as it relates to the amounts included for Connecticut Healthcare Insurance Company, is based solely on the report of, and additional audit procedures to meet the relevant requirements of auditing standards generally accepted in the United States of America performed by, the other auditors. We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Network's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Network's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting principles used and the reasonableness of significant account estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

(Continued)

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, based on our audit and the report of, and additional audit procedures performed by, the other auditors, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Eastern Connecticut Health Network as of September 30, 2015, and the results of its operations and its cash flows for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matters

The consolidated balance sheet, consolidated statements of operations and changes in net assets and cash flows of Eastern Connecticut Health Network, Inc. and Subsidiaries as of and for the year ended September 30, 2014, were audited by Saslow, Lufkin & Buggy, LLP, who combined with Crowe Horwath, LLP as of July 1, 2015 and whose report dated January 27, 2015, expressed an unmodified opinion on those statements.

Our audit was conducted for the purpose of forming an opinion on the 2015 financial statements as a whole. The consolidating statement of operations and changes in net assets for the year then ended is presented for purposes of additional analysis of the consolidated financial statements rather than to present the financial position, results of operations, and cash flows of the individual companies, and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the 2015 financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, based on our audit and the report of the other auditors, the 2015 information is fairly stated in all material respects in relation to the 2015 financial statements as a whole.

The consolidating balance sheet as of September 30, 2014 and the consolidating statement of operations and changes in net assets for the year then ended is presented for purposes of additional analysis of the consolidated financial statements rather than to present the financial position, results of operations, and cash flows of the individual companies, and is not a required part of the consolidated financial statements. The 2014 information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the 2014 financial statements. The information has been subjected to the auditing procedures applied by other auditors in the audit of the 2014 financial statements and certain additional procedures, including comparing and reconciling other information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America and whose report dated January 27, 2015 expressed an opinion that such information was fairly stated in all material respects in relation to the 2014 financial statements as a whole.

Crowe Horwath LLP

Simsbury, Connecticut
January 20, 2016

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidated Balance Sheet
Years Ended September 30, 2015 and 2014

	2015	2014
ASSETS		
Current assets:		
Cash and cash equivalents	$ 16,286,829	$ 20,733,601
Current portion of investments held under bond indentures	1,097,599	1,163,916
Accounts receivable, less allowance for bad debts of $10,641,264 in 2015 and $8,915,132 in 2014	41,607,499	44,610,272
Inventory	5,553,809	5,437,285
Current portion of estimated settlements due from third-party payers	3,573,134	3,602,585
Prepaid expenses and other current assets	6,653,091	5,686,236
Total current assets	74,771,961	81,233,895
Assets whose use is limited, net of current portion:		
Donor restricted investments	5,590,241	6,097,747
Board designated investments	36,824,677	37,980,275
Investments held in trust for estimated self-insurance liabilities	5,278,426	5,005,755
Beneficial interest in trust assets	10,809,693	11,809,221
Investments held under bond indentures	5,172,061	5,171,545
Total assets whose use is limited, net of current portion	63,675,098	66,064,543
Investments	7,118,433	7,138,341
Investments in joint ventures	18,190,809	17,274,825
Property and equipment, net	88,275,419	94,065,559
Other assets:		
Estimated settlements due from third-party payers, net of current portion	-	585,689
Goodwill and intangible assets, net	4,026,827	4,255,266
Other assets	4,541,099	5,369,091
Total other assets	8,567,926	10,310,026
Total assets	$ 260,599,646	$ 276,087,189
LIABILITIES AND NET ASSETS		
Current liabilities:		
Accounts payable and accrued expenses	$ 33,429,551	$ 35,964,615
Line of credit	3,600,000	5,600,000
Current portion of long-term debt and capital lease obligations	7,018,708	6,660,757
Current portion of estimated settlements due to third-party payers	3,124,803	5,743,160
Current portion of accrued pension and other postretirement benefits	190,189	193,769
Other current liabilities	4,134,712	5,841,792
Total current liabilities	51,697,963	60,004,093
Long-term debt and capital lease obligations, net of current portion	80,122,247	82,424,313
Estimated self-insurance liabilities, net of current portion	7,196,797	9,683,668
Accrued pension and other postretirement benefits	62,407,379	45,796,486
Estimated settlements due to third-party payers, net of current portion	-	65,838
Other liabilities	467,711	419,002
Total liabilities	201,892,097	198,393,400
Net assets:		
Unrestricted	42,167,565	59,544,873
Temporarily restricted	1,486,536	2,096,313
Permanently restricted	15,053,448	16,052,603
Total net assets	58,707,549	77,693,789
Total liabilities and net assets	$ 260,599,646	$ 276,087,189

See accompanying notes to consolidated financial statements.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidated Statements of Operations and Changes In Net Assets
Years Ended September 30, 2015 and 2014

	2015	2014
Revenues:		
Patient service revenue, net of contractual allowances and discounts	$ 308,044,394	$ 309,971,310
Provision for bad debts	(10,899,289)	(10,216,094)
Net patient service revenues less provision for bad debts	297,145,105	299,755,216
Contributions	2,194,034	1,163,883
Other revenue	14,565,493	25,216,442
EHR incentive payment revenue	830,386	1,786,134
Net assets released from restrictions, used for operations	832,608	833,650
Total revenues	315,567,626	328,755,325
Expenses:		
Salaries and wages	156,774,464	162,727,445
Fringe benefits	44,024,084	43,859,398
Supplies and other expenses	99,682,874	104,034,396
Depreciation and amortization	11,920,720	12,196,877
Interest and financing costs	3,445,934	3,764,488
Total expenses	315,848,076	326,582,604
(Loss) income from operations	(280,450)	2,172,721
Non-operating losses	(2,235,410)	(2,125,751)
Excess (deficiency) of revenues over expenses	$ (2,515,860)	$ 46,970

See accompanying notes to consolidated financial statements.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidated Statements of Operations and Changes in Net Assets (continued)
Years Ended September 30, 2015 and 2014

	2015	2014
Unrestricted net assets:		
Excess (deficiency) of revenues over expenses	$ (2,515,860)	$ 46,970
Unrealized loss on investments	(210,755)	(5,476,925)
Net change in interest rate swap agreements	(49,056)	8,379
Net assets released from restrictions for capital acquisitions	309,327	437,676
Pension and postretirement related adjustments	(14,910,964)	(6,438,240)
Other	-	1,085
Change in unrestricted net assets	(17,377,308)	(11,421,055)
Temporarily restricted net assets:		
Contributions	531,215	580,515
Investment income	943	533,939
Net assets released from restrictions used for operations	(832,608)	(833,650)
Net assets released from restrictions used for capital acquisitions	(309,327)	(437,676)
Unrealized depreciation on investments	-	(334,116)
Change in temporarily restricted net assets	(609,777)	(490,988)
Permanently restricted net assets:		
Contributions - beneficial interest trust assets	373	3,751,750
Change in beneficial interest in trust assets	(999,528)	176,043
Reclassifications of donations	-	(171,110)
Change in permanently restricted net assets	(999,155)	3,756,683
Change in net assets	(18,986,240)	(8,155,360)
Net assets, beginning of year	77,693,789	85,849,149
Net assets, end of year	$ 58,707,549	$ 77,693,789

See accompanying notes to consolidated financial statements.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidated Statements of Cash Flows
Years Ended September 30, 2015 and 2014

	2015	2014
Cash flows from operating activities:		
Change in net assets	$ (18,986,240)	$ (8,155,360)
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation and amortization	11,920,720	12,198,677
Provision for bad debts	10,899,289	10,216,094
Unrealized depreciation on investments	83,591	5,811,041
Realized gains on sales of investments	(7,708)	(8,307,110)
Change in beneficial interest in trust assets	999,528	(3,926,849)
Income from investments in joint ventures	(2,005,181)	(2,478,524)
Pension and postretirement related adjustments	14,910,984	6,438,240
Impairment of joint venture goodwill	64,197	-
Amortization of intangible assets	228,439	176,516
Change in interest rate swap agreements	49,056	177,836
Changes in assets and liabilities:		
Accounts receivable	(7,896,518)	(8,302,223)
Inventory	(116,524)	(371,569)
Prepaid expenses and other current assets	(966,855)	(429,259)
Other assets	827,992	663,929
Accounts payable and accrued expenses	(2,535,084)	1,089,780
Accrued pension and other postretirement benefits	1,698,349	(4,644,966)
Estimated settlements (to) from third-party payers	(1,969,075)	7,153,100
Other current liabilities	(1,707,080)	301,311
Estimated self-insurance liabilities	(2,486,871)	659,176
Other liabilities	(347)	(356,020)
Net cash provided by operating activities	3,002,684	7,904,018
Cash flows from investing activities:		
Purchases of property and equipment	(6,130,560)	(10,073,939)
Purchases of investments	(4,875,098)	(9,318,926)
Sales of investments	6,075,357	11,198,721
Distributions from joint ventures	1,024,960	1,647,629
Net cash used in investing activities	(3,705,341)	(6,546,515)
Cash flows from financing activities:		
Principal payments on long-term debt	(7,094,912)	(7,235,595)
Net payments on line of credit	(1,800,000)	(900,000)
Proceeds from borrowings	5,150,797	5,072,337
Net cash used in financing activities	(3,744,115)	(3,063,258)
Change in cash and cash equivalents	(4,446,772)	(1,705,755)
Cash and cash equivalents at beginning of year	20,733,601	22,439,356
Cash and cash equivalents at end of year	$ 16,286,829	$ 20,733,601
Supplemental disclosure of cash flow information:		
Cash paid for interest, net of amounts capitalized	$ 3,631,350	$ 3,880,091
Supplemental disclosure of non-cash information:		
Equipment acquisitions under capital lease arrangements (non-cash)	$ 4,126,026	$ 2,266,700

See accompanying notes to consolidated financial statements.

NOTE 1 - ORGANIZATION

Eastern Connecticut Health Network, Inc. (ECHN) and Subsidiaries (collectively the Network) is a not-for-profit, locally governed health system created on September 12, 1995, through the merger of the corporate parents of Manchester Memorial Hospital and Rockville General Hospital, Inc. Its purpose is to provide a health care system for the communities it serves, with quality medical care at a reasonable cost; to foster an environment conducive to health and well-being, whether in the home or in the community; and to enable the health care system to expand to meet the future needs of its communities. ECHN, through its subsidiaries (or members), provides health care, health education, and community services to residents of more than 19 towns in eastern Connecticut, regardless of their ability to pay.

ECHN is the sole member or shareholder of the following subsidiaries:

The Manchester Memorial Hospital (MMH) - MMH is a not-for-profit hospital with 249 licensed beds, located in Manchester, Connecticut. MMH, which admitted its first patient in 1920, is a short-term, acute-care general hospital, which provides inpatient, outpatient, and emergency care services to the residents of Manchester and 19 nearby towns.

The Rockville General Hospital, Inc. (RGH) - RGH is a not-for-profit hospital with 102 licensed beds, located in the Rockville section of Vernon, Connecticut. RGH, which admitted its first patient in 1921, is a short-term, acute-care general hospital, which provides inpatient, outpatient, and emergency care services for residents of Tolland County and nearby towns, for a total service area of 19 towns.

ECHN ElderCare Services, Inc. (EES) - EES is a not-for-profit, skilled nursing facility with 130 licensed beds and physical, occupational and speech rehabilitation services located in Tolland, Connecticut.

ECHN Community Healthcare Foundation, Inc. (ECHF) - ECHF is a not-for-profit organization whose purpose is to raise funds on behalf of ECHN and its not-for-profit subsidiaries. It was established in 2000, when the fund-raising efforts of ECHN were consolidated into a single not-for-profit foundation. ECHF focuses primarily on the capital and program needs of ECHN and its not-for-profit subsidiaries.

Eastern Connecticut Medical Professionals Foundation, Inc. (ECMPF) - ECMPF is a not-for-profit organization that currently operates physician office practices in the Network's service area and a hospitalist program that serves MMH and RGH. Its mission allows it to operate other not-for-profit, separately incorporated allied health ventures.

ECHN Enterprises, Inc. (Enterprises) - Enterprises is a for-profit organization formed under the laws of the State of Connecticut, with ECHN as the sole shareholder. Enterprises owns, leases and has an interest in real estate to support the mission and vision for ECHN. It is also the parent corporation of Haynes Street Property Management, LLC (HSPM). HSPM is a for-profit, limited liability company formed under the laws of the State of Connecticut, which manages the Glastonbury Wellness Center and sublets space to various MMH departments and physician offices, as well as to ECMPF.

Visiting Nurse and Health Services of Connecticut, Inc. (VNHSC) - VNHSC is a not-for-profit, nonstock Connecticut corporation that provides and administers a comprehensive, multi-disciplinary home health program, hospice program and wellness programs to promote the health of individuals, families and groups in the Greater Northern Central Connecticut area. In addition, VNHSC is the sole member of A Caring Hand, LLC, which is a for-profit Connecticut limited liability company providing and administering homemaker, companion, live-in and personal care assistance services to individuals and families in the Greater Northern Central Connecticut area.

(Continued)

NOTE 1 - ORGANIZATION (Continued)

Connecticut Healthcare Insurance Company (CHIC) - CHIC, a captive insurance company, provides hospital and physician professional and general liability coverage to MMH, RGH, EES, and all other subsidiaries.

ECHN Corporate Services (ECHNCS) - ECHNCS is a for-profit stock corporation formed under the laws of the State of Connecticut, with ECHN as the sole shareholder. ECHNCS provides billing and other practice management services to the Network and other customers. It is also the parent corporation of Medical Practice Partners, LLC (MPP). MPP is a for-profit, limited liability company formed under the laws of the State of Connecticut, which provides practice management services to medical group practices throughout Connecticut.

CINECT - CINECT is a for-profit organization formed to develop a clinically integrated network of community providers that offers high-quality care, value, and an enhanced patient experience. CINECT's mission is to better manage the health of the communities that we serve. While formed during 2014 CINECT has not commenced operations as of September 30, 2015.

ECHN and each of its subsidiaries, except for Enterprises, CHIC, ECHNCS and CINECT, are separate Connecticut not-for-profit corporations, qualified as exempt organizations under Section 501(c)(3) of the Internal Revenue Code (IRC) and governed by separate Boards of Trustees (the Board) - although the membership of the ECHN, MMH and RGH boards are currently identical. ECHN, acting through its Board of Trustees, is the sole member of each of its members. ECHN has various powers with regard to each of its members, which include approving all operating and capital budgets; controlling the investment of funds, location of services, agreements and transactions, and affiliations; controlling changes, amendments, or restatements of certificates of incorporation and bylaws; electing trustees and officers; appointing committees; adopting a system-wide vision and strategic plans; and approving debt borrowings.

On June 25, 2015, the ECHN Board of Trustees agreed to the terms of a letter of intent for ECHN to be acquired by Prospect Medical Holdings (PMH) of Los Angeles, CA.

In June 2015, ECHN's Board of Trustees agreed to the sale of substantially all assets of ECHN to PMH. On July 29, 2015, the ECHN corporators voted in favor of the acquisition of ECHN by PMH.

On October 13, 2015, ECHN and PMH filed a Certificate of Need (CON) application with the Connecticut State Department of Public Health's Office of Health Care Access and the Office of the Attorney General to approve the acquisition of ECHN by Prospect.

As of September 30, 2015, management has not finalized a purchase agreement and the Trustees believe that the Network will continue with its normal operations and as a going concern for the foreseeable future.

Basis of Presentation - The accompanying consolidated financial statements have been prepared in conformity with accounting principles generally accepted in the United States of America (GAAP), as promulgated by the Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC). The consolidated financial statements include the accounts of ECHN and its subsidiaries. Significant intercompany accounts and transactions have been eliminated in consolidation. The assets of any member of the consolidated group may not be available to meet the obligations of other members in the group.

(Continued)

NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Use of Estimates: The preparation of consolidated financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

The Network's significant estimates relate to the valuation of investments and interest rate swap agreements, allowance for doubtful patient accounts receivable, contractual allowances on patient accounts receivable, self-insurance liabilities, estimated settlements due to and from third parties, conditional asset retirement obligations, postretirement and pension benefit costs and the related obligations.

Cash and Cash Equivalents: - The Network considers all highly liquid investments with original maturities of three months or less at date of purchase to be cash equivalents, excluding amounts whose use is limited or restricted by Board designation or other arrangements under trust agreements. Cash equivalents include money market funds. Cash balances maintained at banks are insured by the Federal Deposit Insurance Corporation (FDIC). At times, the Network maintains cash balances that are in excess of the $250,000 insured FDIC limits. The Network maintains its cash at various banks and it is the Network's policy to monitor the banks' financial strength on an ongoing basis.

Money market funds are not insured by the FDIC and are not a risk-free investment. Money market funds invest in a variety of instruments including mortgage-backed and asset-backed securities. Although a money market fund seeks to preserve its $1 per share value, it is possible that a money market fund's value can decrease below $1 per share.

Net Assets: Resources are reported for accounting purposes in separate classes of net assets based on the existence or absence of donor-imposed restrictions. In the accompanying consolidated financial statements, net assets that have similar characteristics have been combined as follows:

Unrestricted: Net assets that are not subject to explicit donor-imposed stipulations are classified as unrestricted. Unrestricted net assets may be designated for specific purposes by action of the Board or may otherwise be limited by contractual agreements with outside parties; such designated assets are classified as assets whose use is limited in the accompanying consolidated balance sheets.

Temporarily Restricted: Net assets whose use by the Network is subject to explicit donor imposed stipulations that can be fulfilled upon incurrence of expenditures by the Network pursuant to those stipulations or that expire by the passage of time are classified as temporarily restricted.

Permanently Restricted: Net assets subject to explicit donor imposed stipulations that they be maintained by the Network in perpetuity are classified as permanently restricted. Such permanently restricted net assets include endowment funds and MMH's and RGH's share of their beneficial interest in trust assets held by third parties. Generally, the donors of these assets permit the members of ECHN to use all or part of the investment return on these assets for operating purposes.

(Continued)

NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Revenue are reported as increases in unrestricted net assets, unless use of the related assets is limited by donor imposed restrictions. Expenses are reported as decreases in unrestricted net assets. Gains and losses on investments and other assets or liabilities are reported as increases or decreases in unrestricted net assets, unless their use is restricted by explicit donor stipulations or by law. Expirations of temporary restrictions on net assets, that is, the donor imposed stipulated purpose has been accomplished and/or the stipulated time period has elapsed, are reported as reclassifications between the applicable classes of net assets.

Contributions, including unconditional promises to give, are recognized as revenue at the date the promise is received. Contributions of assets other than cash are recorded at their estimated fair value. Contributions to be received after one year are discounted at a rate commensurate with the risks involved. Amortization of the discount is included in other revenue. Contributions restricted for the acquisition of land, buildings, and equipment are reported as temporarily restricted support. These contributions are reclassified to unrestricted net assets when the capital asset is acquired or constructed and placed in service.

Assets Whose Use is Limited: Assets whose use is limited primarily include cash and investments held by trustees under indenture agreements, cash and investments held for estimated self-insurance liabilities, Board designated investments, cash and investments set aside by the Board for future capital improvements over which the Board retains control and may at its discretion subsequently use for other purposes, beneficial interests in trust assets, and donor restricted and other restricted investments. Amounts required to meet current liabilities of the Network have been classified as current assets in the consolidated balance sheets as of September 30, 2015 and 2014.

The income earned on restricted funds, other than the endowment, is generally available for operations of the Network and is recorded as revenue in unrestricted net assets, unless restricted by the donor or to pay future annuity obligations, at which time the income is added to the appropriate restricted net asset balance. However, if a specific gift instrument explicitly requires the permanent reinvestment of appreciation, or a portion thereof, such reinvested amounts are classified within permanently restricted net assets. There were no gifts with reinvestment restrictions for the years ended September 30, 2015 and 2014.

Assets received as donations or bequests are recorded as contributions on the date received at the estimated fair value. The average cost method is used to determine realized gains or losses on sales of marketable equity securities.

Beneficial Interest in Trust Assets: MMH and RGH have been named sole or participating beneficiaries in several perpetual trusts, for which third parties act as the trustee. Under the terms of these trusts, MMH and RGH have the irrevocable right to receive the income earned on the trust assets held in perpetuity. The estimated present value of the future payments to MMH and RGH is recorded at the fair value of the assets held in the trust as beneficial interest in trust assets in the respective balance sheets of MMH and RGH and are permanently restricted as to use.

The income from the trusts is included in the change in interest in net assets of ECHF as unrestricted and temporarily restricted support and other income. Fluctuations in the fair value of the trust assets are recognized as changes in permanently restricted net assets. MMH and RGH record their beneficial interest in trust assets when they are notified of the existence of the trust or when information becomes available to record the fair value of the trust assets.

Investments: The Network's investment portfolio is classified as available for sale, with unrealized gains and losses excluded from excess of revenues over expenses, unless the losses are deemed to be other than temporary. Investments with readily determinable fair values are measured at fair value in the consolidated balance sheets.

(Continued)

NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Investment income or loss (including realized gains and losses on investments, interest, and dividends) is included in the excess of revenues over expenses within other revenue within the statement of operations, unless the income or loss is restricted by donor or law.

Other-Than-Temporary Impairments on Investments: The Network accounts for other than temporary impairments in accordance with FASB ASC 320, "Investments - Debt and Equity Securities" and continually reviews its securities for impairment conditions, which could indicate that an other than temporary decline in fair value has occurred. In conducting this review, numerous factors are considered, which include specific information pertaining to an individual company or a particular industry, general market conditions that reflect prospects for the economy as a whole, and the ability and intent to hold securities until recovery. The carrying value of investments is reduced to its estimated realizable value if a decline in fair value is considered to be other-than-temporary. There were no impairments recorded for the years ended September 30, 2015 and 2014.

Property and Equipment: Property and equipment are stated at cost or, in the case of donated property, at fair value at the date of the gift, less accumulated depreciation and amortization. Major improvements and betterments to existing plant and equipment are capitalized. Expenditures for maintenance and repairs that do not extend the lives of the applicable assets are charged to expense as incurred. Upon disposition or retirement of property and equipment, the cost and related accumulated depreciation and amortization are eliminated from the respective accounts and any resulting gain or loss is included in the results of consolidated operations.

Depreciation expense is computed on a straight-line basis over the following estimated useful lives:

Buildings	10-40 years
Building improvements	5-40 years
Machinery and equipment	3-15 years
Furniture and fixtures	5-20 years

Equipment under capital leases is amortized utilizing the straight-line method over the shorter of the lease term or the estimated useful life of the equipment. Depreciation and amortization expense was $11,873,770 and $11,988,770 for the years ended September 30, 2015 and 2014, respectively.

Interest cost incurred on borrowed funds during the construction period of capital assets is capitalized as a component of the cost of acquiring those assets.

Gifts of property and equipment are reported as unrestricted support, and are excluded from the excess of revenues over expenses, unless explicit donor stipulations specify how the donated assets must be used. Gifts of property and equipment with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire property and equipment are reported as restricted support. Absent explicit donor stipulations about how long the property and equipment must be maintained, expirations of donor restrictions are reported as released from restrictions when the donated or acquired property and equipment assets are placed in service.

Investments in Joint Ventures: The Network accounts for its investments in joint ventures in accordance with FASB ASC 323 "Investments – Equity Method and Joint Ventures". The Network records the difference between the cost of an investment and the underlying equity in net assets of the investee as goodwill on joint ventures. Equity method investments including the goodwill associated with those investments are reviewed for impairment under the provisions of FASB ASC 323.

(Continued)

NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Investments in Joint Ventures: The Network has invested in several joint ventures with other area hospitals, which are accounted for under the equity method of accounting. These joint ventures as of September 30, 2015 and 2014 include the Network's investments in the following:

	2015	Ownership Percentage	2014	Ownership Percentage
Northeast Regional Radiation Oncology Network, Inc.	$ 6,572,374	50 %	$ 6,598,390	50 %
Tolland Imaging Center	672,276	70 %	380,818	70 %
Ambulance Service of Manchester, LLC	4,344,083	50 %	3,798,727	50 %
Aetna Ambulance Service Inc.	1,881,429	50 %	1,961,496	50 %
Evergreen Endoscopy Center, LLC	564,632	50 %	359,698	50 %
Haynes Street Medical Associates	163,652	23 %	149,808	23 %
Haynes Street Medical Associates II	254,299	15 %	249,744	15 %
Evergreen Medical Associates, LLC	277,629	20 %	264,503	20 %
Evergreen Medical Associates II, LLC	584,937	20 %	583,419	20 %
Walden Behavioral Health	217,608	16 %	196,135	16 %
Total joint venture assets	15,522,919		14,542,738	
Goodwill on joint ventures	2,647,890		2,712,087	
Other miscellaneous assets	20,000		20,000	
Total investments in joint ventures	$ 18,190,809		$ 17,274,825	

Distributions from these joint ventures totaled $1,024,980 and $1,647,629 for the years ended September 30, 2015 and 2014, respectively. ECHN's share of the earnings of the joint ventures is reported within other revenues and amounted to $2,005,161 and $2,478,524 for the years ended September 30, 2015 and 2014, respectively.

During 2015, ECHN wrote off $64,197 of goodwill related to a joint venture that ceased operations. There were no write offs or impairments of goodwill in 2014.

Summarized financial information from the unaudited financial statements of these organizations as of September 30, 2015 and for the year then ended, is as follows:

2015	Total Assets	Net Assets	Change in Net Assets	Excess (deficiency) of Revenues Over Expenses
Northeast Regional Radiation Oncology Network, Inc.	$ 13,356,858	$ 13,144,745	$ (111,240)	$ (111,240)
Ambulance Service of Manchester, LLC	$ 10,483,268	$ 8,888,188	$ 1,114,668	$ 2,575,436
Aetna Ambulance Service Inc.	$ 4,915,552	$ 3,762,858	$ (160,133)	$ (160,132)
Haynes Street Medical Associates	$ 2,427,308	$ 670,383	$ 16,772	$ 71,978
Haynes Street Medical Associates II	$ 8,218,931	$ 1,695,326	$ 30,361	$ 289,623
Evergreen Endoscopy Center, LLC	$ 1,698,935	$ 826,898	$ 398,907	$ 398,907
Evergreen Medical Associates, LLC	$ 6,364,532	$ 1,601,696	$ 69,383	$ 234,137
Evergreen Medical Associates II, LLC	$ 11,115,755	$ 2,710,936	$ 3,839	$ 378,689
Tolland Imaging Center	$ 1,139,778	$ 960,395	$ 416,369	$ 395,249
Walden Behavioral Health	$ 1,835,791	$ 1,325,261	$ 134,675	$ 44,227

(Continued)

NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Summarized financial information from the unaudited financial statements of these organizations as of September 30, 2014 and for the year then ended, is as follows:

2014	Total Assets	Net Assets	Change in Net Assets	Excess (deficiency) of Revenues Over Expenses
Northeast Regional Radiation Oncology Network, Inc.	$ 13,250,462	$ 13,255,985	$ 763,486	$ 335,328
Metro Wheelchair Service Inc.	$ 151,744	$ (23,958)	$ (132,407)	$ (132,412)
Ambulance Service of Manchester, LLC	$ 9,224,170	$ 7,597,456	$ 52,822	$ 2,052,822
Aetna Ambulance Service Inc.	$ 4,926,263	$ 3,922,991	$ 377,992	$ 378,000
Haynes Street Medical Associates	$ 2,464,703	$ 853,611	$ (9,542)	$ 66,803
Haynes Street Medical Associates II	$ 8,373,390	$ 1,664,965	$ 95,259	$ 275,998
Evergreen Endoscopy Center, LLC	$ 1,595,233	$ 429,991	$ (155,623)	$ 944,374
Evergreen Medical Associates, LLC	$ 6,612,745	$ 1,532,513	$ 196,056	$ 215,698
Evergreen Medical Associates II, LLC	$ 11,434,731	$ 2,707,097	$ (222,892)	$ 365,769
Tolland Imaging Center	$ 775,884	$ 544,026	$ 256,871	$ 241,197
Walden Behavioral Health	$ 1,955,576	$ 1,190,586	$ (14,597)	$ 44,830

Intangible Assets: License enhancements included in intangible assets, are amortized over the life of the respective intangible property. On average, this amortization period for license enhancements is 5 years, respectively. Other intangible assets consists of various intangibles acquired through the purchase of physician practices. Other intangible assets are amortized over the life of the intangible, which on average is a 3 to 5 year period. Amortization is included in depreciation and amortization in the accompanying consolidated statements of operations and changes in net assets and the unamortized carrying value is recorded within goodwill and intangible assets, net in the accompanying consolidated balance sheets.

Unamortized Bond Issue Costs: Financing costs associated with the issuance of long-term debt are amortized over the term of the bonds using the effective interest method. Amortization is included in interest and financing costs in the accompanying consolidated statements of operations and changes in net assets, and the unamortized carrying value is recorded within other assets in the accompanying consolidated balance sheets.

Deferred Revenue: Deferred revenue represents payments received for services to be rendered in the next fiscal year and is recorded within other current liabilities in the accompanying consolidated balance sheets.

Excess (Deficiency) of Revenues Over Expenses: The consolidated statements of operations and changes in net assets include excess (deficiency) of revenues over expenses. Changes in unrestricted net assets, which are excluded from the excess (deficiency) of revenues over expenses, consistent with industry practice, include the changes in unrealized appreciation (depreciation) on investments; net change in fair value of interest rate swap agreements that qualifies for hedge accounting; net assets released from restrictions used for capital acquisitions; pension and postretirement related adjustments; and other changes in net assets.

(Continued)

NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

For purposes of display, transactions deemed by management to be ongoing, major or central to providing of health care services are reported as operating revenues and operating expenses. Operating revenues include net patient service revenue, grant income and investment income. Peripheral or incidental transactions are reported as non-operating gains and losses. Non-operating gains and losses include investment income and expenses related to property management, losses recognized on investments representing declines in value considered to be other-than-temporary in nature, changes in the fair values of interest rate swaps that do not qualify for hedge accounting (net interest expense) and the costs associated with pursuing business combinations.

Charity Care: MMH and RGH provide care to patients who meet certain criteria under their charity care policies without charge or at amounts less than its established and contractual rates. The hospitals do not pursue collection of amounts determined to qualify as charity care; as such, these amounts are not reported as revenue.

Net Patient Service Revenue: Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payers, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payers. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined.

Contracts, laws, and regulations governing Medicare, Medicaid, Blue Cross, and the uncompensated care pool programs are complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. The Network records adjustments in amounts accrued for estimated settlements related to prior years.

A portion of the accrual for estimated settlements with third-party payers has been classified as long-term because such amounts, by their nature or by virtue of regulation or legislation, are not expected to be paid within one year.

MMH and RGH have agreements with third-party payers that provide for payments at amounts different from their established rates. A summary of the payment agreements with major third-party payers is as follows:

Medicare: Acute care hospitals are subject to a federal prospective payment system for most Medicare inpatient hospital services and for certain outpatient services. Under this prospective payment methodology, Medicare pays a prospectively determined per-discharge or per-visit rate for non-physician services. These rates vary according to the Diagnosis Related Group or Ambulatory Payment Classification of each patient.

Inpatient rehabilitation and mental health services, outpatient services, capital and medical education costs related to Medicare beneficiaries are paid based on a prospective payment system, subject to certain limitations. The Hospital is reimbursed for cost-reimbursement for certain items at a tentative rate, with final settlement determined after submission of annual cost reports and audits thereof by the Medicare fiscal intermediary. Certain other outpatient services are reimbursed according to fee screens.

(Continued)

NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Medicaid: Inpatient services rendered to Medicaid program beneficiaries are paid at prospectively determined rates per discharge. Outpatient services rendered to Medicaid program beneficiaries are reimbursed under a cost-reimbursement methodology. The hospitals are reimbursed at a tentative rate, with final settlement determined after submission of annual cost reports by the hospitals.

Other Payers: The Network has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment under these agreements includes rates per discharge, discounts from established charges, per diem rates, and fee schedule payments.

Health Care Industry: The health care industry is subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not limited to, matters such as licensure, accreditation, government health care program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by health care providers. Violations of these laws and regulations could result in expulsion from government health care programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed.

Management believes that the Network is in compliance with fraud and abuse regulations, as well as other applicable government laws and regulations. Compliance with such laws and regulations can be subject to further governmental review and interpretation, as well as regulatory actions unknown or unasserted at this time.

EHR Incentive Payment Revenue: The American Recovery and Reinvestment Act of 2009 authorized the Centers for Medicare and Medicaid Services (CMS) to award incentive payments to eligible health care providers who demonstrate Meaningful Use of certified electronic health records (EHR). These incentive programs are designed to support providers in this period of health information technology transition and instill the use of EHRs in meaningful ways to help our nation to improve the quality, safety, and efficiency of patient health care. The Network uses a grant model to recognize revenue for the Medicare and Medicaid EHR incentive payments. Under this accounting policy, EHR incentive payment revenue is recognized as revenue after the Network has demonstrated that it complied with the meaningful use criteria over the entire applicable compliance period and the 12-month cost report period that will be used to determine the final incentive payment has ended. The Network recognizes revenue from Medicaid incentive payments after it has demonstrated compliance with the meaningful use criteria. Total revenue recorded for Medicare amounted to $830,386 and $1,786,134, for the years ended September 30, 2015 and 2014, respectively. These amounts have also been reflected within amounts due from third party payors as of September 30, 2015 and 2014, respectively.

Future Operations: Current trends in the health care industry include mergers and other forms of affiliations among providers, increasing shifts to managed care, overall reduction in inpatient average length of stay, increasingly restrictive reimbursement policies by governmental and private payers, and the prospect of significant changes in legislation at the state and national level. Management cannot assess or project the ultimate effect of these or other items on the future operations of the Network.

Interest in Net Assets of ECHF: ECHF was formed as a not-for-profit organization to supervise the development activities and engage in investment activities for the benefit of all of the ECHN subsidiaries. ECHN is the sole member of ECHF and the ECHF's Board of Directors is appointed by ECHN. ECHN subsidiaries follow the provisions of FASB ASC 958 "Not-for-Profit Entities". Accordingly, the separate ECHN members record their interest in the net assets of ECHF in their separate financial statements. These amounts have been eliminated in consolidation.

(Continued)

NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Income Taxes: ECHN and its subsidiaries, except for Enterprises, CHIC, ECHNCS and CINECT, are in compliance with the provisions of Internal Revenue Code (the Code) Sec. 501(c)(3) and are exempt from federal tax under IRC Sec. 501(a). At times, the Network is involved with activities that subject minor amounts of unrelated business federal income tax, which are paid as they come due in accordance with the Code and the regulations there under. Such amounts are insignificant to the Network's consolidated financial statements.

The Network accounts for uncertain tax positions in accordance with provisions of FASB ASC 740, *"Income Taxes"*, which provides a framework for how companies should recognize, measure, present and disclose uncertain tax positions in their consolidated financial statements. The Network may recognize the tax benefit from an uncertain tax position only if it is more likely than not that the tax position will be sustained on examination by the taxing authorities, based on the technical merits of the position. The Network does not have any uncertain tax positions as of September 30, 2015 and 2014. The Network's policy is to include penalties and interest as a component of income tax expense, when applicable. As of September 30, 2015 and 2014, the Network did not record any penalties or interest associated with uncertain tax positions. Generally, the Network's prior three tax years are open and subject to examination by the Internal Revenue Service.

Enterprise and its subsidiaries, ECHNCS and CINECT are for-profit entities subject to federal and state taxes. For these entities, ECHN applies the provisions of FASB ASC 740. The tax provisions, and related tax assets and liabilities, are not material. CHIC has received an undertaking from the Cayman Islands government exempting it from all local income, profits, and capital gains taxes until January 3, 2026. No such taxes are currently levied in the Cayman Islands. Accordingly, no provision for federal income taxes has been recorded in the accompanying consolidated financial statements.

Asset Retirement Obligations: The Network recognizes a liability for the fair value of a conditional asset retirement obligation if the fair value of the liability can be reasonably estimated. Uncertainty about the timing and/or method of settlement of a conditional asset retirement obligation is factored into the measurement of the liability when sufficient information exists. The types of asset retirement obligations that the Network recognizes are those for which the Network has a legal obligation to perform an asset retirement activity, however, the timing and/or method of settling the obligation are conditional on a future event that may or may not be within its control.

The fair value of a liability for the legal obligation associated with an asset retirement is recorded in the period in which the obligation is incurred. When the liability is initially recorded, the cost of the asset retirement is capitalized. As of September 30, 2015 and 2014, the Network has recognized $412,007, as an obligation to remove asbestos from various buildings upon retirement. This total is included in the consolidated balance sheets within other liabilities.

Accounting for Defined Benefit Pension and Other Postretirement Plans: The Network recognizes the overfunded or underfunded status of their defined benefit pension and other postretirement benefit plans (collectively, postretirement benefit plans) in the consolidated balance sheets as an asset or liability. The Network recognizes changes in the funded status of the plans in the year in which the changes occur as an operating expense and as a change in unrestricted net assets presented below the excess of revenues over expenses in its consolidated statements of operations and changes in net assets.

Inventory: The Network records inventory at cost using the average cost method.

Impairment of Long-Lived Assets: Long-lived assets to be held and used are reviewed for impairment whenever circumstances indicate that the carrying amount of an asset may not be recoverable. Long-lived assets to be disposed of are reported at the lower of carrying amount or fair value, less cost to sell.

(Continued)

NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Estimated Self-Insurance Liabilities: The liabilities for outstanding losses and loss related expenses, and the related provision for losses and loss related expenses include estimates for malpractice losses, general liability, and workers' compensation incurred but not reported claims, as well as losses pending settlement. Such liabilities are necessarily based on estimates and, while management believes the amounts provided are adequate, the ultimate liability may be in excess of or less than the amounts provided. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. The methods for making such estimates and the resulting liability are actuarially reviewed on an annual basis, and any adjustments required are reflected in operations in the current period. The current portion of estimated self-insurance liabilities is recorded within other current liabilities in the accompanying consolidated balance sheets.

Concentration of Credit Risk: Financial instruments, which potentially subject the Network to concentration of credit risk, consist of accounts receivable, investments, including temporary cash investments, marketable equity and debt securities, mutual funds, government securities and interest rate swap agreements. The Network receives a significant portion of its payments for services rendered from a limited number of government and commercial third-party payers, including Medicare (a federal program), Medicaid (a State of Connecticut program), and various health insurance companies.

Interest Rate Swap Agreements: Interest rate swap agreements are recognized as either assets or liabilities in the consolidated balance sheet at fair value regardless of the purpose or intent for holding them. Changes in the fair value of interest rate swap agreements if designated and effective as hedge transactions are recognized as changes in unrestricted net assets and excluded from excess (deficiency) of revenue over expenses. Interest rate swap agreements if designated as an ineffective hedge are recognized in non-operating losses and included in excess (deficiency) of revenue over expenses.

Advertising Costs: The Network expenses advertising costs the first time the advertising takes place. The total amount charged to advertising expense was $706,427 and $1,576,106 for the years ended September 30, 2015 and 2014, respectively, and is recorded in supplies and other expenses in the accompanying consolidated statements of operations and changes in net assets.

Reclassifications: Certain reclassifications to the 2014 consolidated financial statements have been made in order to conform with the 2015 presentation. Such reclassifications did not have a material effect on the consolidated financial statements and had no impact on the total net assets or changes in net assets of the Network.

Subsequent Events: Subsequent events have been evaluated through January 20, 2016, the date the consolidated financial statements were issued. Management believes that there are no subsequent events having a material impact on the consolidated financial statements.

(Continued)

NOTE 3 - ASSETS WHOSE USE IS LIMITED AND INVESTMENTS

Assets whose use is limited and investments as of September 30, 2015 and 2014, include the following:

	2015		2014	
	Cost	Fair Value	Cost	Fair Value
Board designated and donor-restricted:				
Money market funds	$ 42,414,918	$ 42,414,918	$ 44,043,227	$ 44,043,227
Other investments	-	-	34,368	34,795
Total	$ 42,414,918	$ 42,414,918	$ 44,077,595	$ 44,078,022
Investments held in trust for estimated self-insurance liabilities:				
Money market funds	$ 65,000	$ 65,000	$ 96,364	$ 96,364
U.S. equities	230,954	216,816	247,911	255,038
Convertible corporate debt	27,582	25,034	25,655	25,803
Other non-exchange traded funds	262,718	239,248	258,116	293,579
Mutual funds:				
Fixed income mutual funds	3,699,356	4,044,212	3,541,821	3,536,760
Equity mututal funds	650,170	688,116	704,180	798,211
Total	$ 4,935,780	$ 5,278,426	$ 4,874,047	$ 5,006,755
Investments held under bond indenture:				
Money market funds	$ 6,269,660	$ 6,269,660	$ 5,174,324	$ 5,174,324
U.S. government securities	-	-	1,160,527	1,161,137
Total	$ 6,269,660	$ 6,269,660	$ 6,334,851	$ 6,335,461
Beneficial interest in trust assets	$ 9,835,851	$ 10,809,693	$ 10,331,633	$ 11,809,221

	2015		2014	
	Cost	Fair Value	Cost	Fair Value
Investments:				
Money market funds	$ 7,118,433	$ 7,118,433	$ 7,138,341	$ 7,138,341
Total	$ 7,118,433	$ 7,118,433	$ 7,138,341	$ 7,138,341
Total assets whose use is limited and investments	$ 70,574,642	$ 71,891,130	$ 72,756,467	$ 74,366,800

Interest and dividend income, which is included in other revenue, on the assets whose use is limited and investments totaled $116,935 and $1,327,419 for the years ended September 30, 2015 and 2014, respectively. There were realized gains of $7,708 and $7,812,247 for the years ended September 30, 2015 and 2014, respectively, which are included within other revenue. Interest from cash and insurance payments totaled $101,470 and $60,552 for the years ended September 30, 2015 and 2014.

(Continued)

NOTE 4 - FAIR VALUE MEASUREMENTS

FASB ASC 820 provides a framework for measuring fair value. That framework provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to unobservable inputs (Level 3 measurements).

The three levels of the fair value hierarchy under FASB ASC 820 are described as follows:

Level 1 - Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities in active markets that the Network has the ability to access.

Level 2 - Inputs to the valuation methodology include:

- Quoted prices for similar assets or liabilities in active markets;
- Quoted prices for identical or similar assets or liabilities in inactive markets;
- Inputs other than quoted prices that are observable for the asset or liability;
- Inputs that are derived principally from or corroborated by observable market data by correlation or other means.

Level 3 - Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

The asset or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement.

The following table presents the financial instruments carried at fair value as of September 30, 2015 and 2014, by the valuation hierarchy.

2015	Level 1	Level 2	Level 3	Total
Assets:				
Money market funds	$ 55,868,011	$ -	$ -	$55,868,011
U.S. equities	216,816	-	-	216,816
Convertible corporate debt	25,034	-	-	25,034
Other non-exchange traded funds	239,248	-	-	239,248
Mutual funds:				
Bond fund	4,044,212	-	-	4,044,212
Equity mututal funds	688,116	-	-	688,116
Beneficial interest in trusts	-	-	10,809,693	10,809,693
Total assets at fair value	$ 61,081,437	$ -	$ 10,809,693	$71,891,130
Liabilities:				
Obligations under interest rate swap agreements	$ -	$ 52,854	$ -	$ 52,854
Total liabilities at fair value	$ -	$ 52,854	$ -	$ 52,854

(Continued)

NOTE 4 - FAIR VALUE MEASUREMENTS (Continued)

The following table presents the financial instruments carried at fair value as of September 30, 2015 and 2014, by the valuation hierarchy.

2014	Level 1	Level 2	Level 3	Total
Assets:				
Money market funds	$ 56,452,256	$ -	$ -	$56,452,256
U.S. government securities	1,161,137	-	-	1,161,137
Corporate bonds	-	-	-	-
U.S. equities	255,038	-	-	255,038
Other investments	34,795	-	-	34,795
Mutual funds:				
Bond fund	3,625,132	-	-	3,625,132
Equity mututal funds	798,211	-	-	798,211
Emerging markets fund	101,014	-	-	101,014
Midcap stock fund	77,581	-	-	77,581
Moderate allocation fund	52,415	-	-	52,415
Beneficial interest in trusts	-	-	11,809,221	11,809,221
Total assets at fair value	$ 62,557,579	$ -	$ 11,809,221	$74,366,800
Liabilities:				
Obligations under interest rate swap agreements	$ -	$ 3,800	$ -	$ 3,800
Total liabilities at fair value	$ -	$ 3,800	$ -	$ 3,800

During the years ended September 30, 2015 and 2014, the value of the beneficial interest in trusts (decreased) increased for a change in market value of ($438,712) and $676,292, respectively. In addition, the Network received $560,816 and $500,251 in distributions from these trusts in 2015 and 2014, respectively. During 2014, the Network recorded additional beneficial interest in trust assets in the amount of $3,750,808. There were no additional amounts recorded in 2015.

The Network's valuation methodologies used to measure financial assets and liabilities at fair value are outlined below. Where applicable, the Network uses quoted prices in active markets for identical assets and liabilities to determine fair value (Level 1 inputs). This pricing methodology applies to money market funds, U.S. government securities, U.S. equities and mutual funds.

If quoted prices in active markets for identical assets and liabilities are not available, then quoted prices for similar assets and liabilities, quoted prices for identical assets or liabilities in inactive markets or inputs other than quoted prices that are observable for the asset or liability, either directly or indirectly, will be used to determine fair value (Level 2 inputs). The Level 2 classifications include the interest rate swap agreements. The interest rate swap agreements are valued based on a determination of market expectations relating to the future cash flows associated with the swap contract using sophisticated modeling based on observable market-based inputs, such as interest rate curves.

Assets and liabilities that are valued using significant unobservable inputs, such as extrapolated data, proprietary models, or indicative quotes that cannot be corroborated with market data are classified in Level 3 within the fair value hierarchy. The Level 3 classification includes the Network's beneficial interest in trusts. The value of the Network's assets is based on total fund values and the Network's corresponding beneficiary percentage.

(Continued)

NOTE 4 - FAIR VALUE MEASUREMENTS (Continued)

The fair value of the Network's Series A and C Bonds are based on current traded value. The fair value of the Series A and C Bonds as of September 30, 2015 and 2014, is approximately $39,334,314 and $41,166,328, respectively. The fair value of the Network's remaining long-term debt approximates its carrying value.

As of September 30, 2015 and 2014, the Network's other financial instruments included accounts receivable, accounts payable and accrued expenses and estimated settlements due to and from third-party payers. The carrying amounts reported in the consolidated balance sheets for these financial instruments approximate their fair value.

The preceding methods described may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, although the Network believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

NOTE 5 - OTHER ASSETS

Other assets as of September 30, 2015 and 2014 consist of the following:

	2015	2014
Other receivables	$ 709,994	$ 795,005
Notes receivable	624,630	134,014
Unamortized bond issuance costs	2,136,639	2,282,438
Losses recoverable	1,069,836	2,157,634
Total	$ 4,541,099	$ 5,369,091

Include within other assets are certain loans to physicians which the Network makes to expand its practice. Physician loans are usually forgiven and amortized over the contract period. Physician loan amortization totaling $46,950 and $208,107 for the years ended September 30, 2015 and 2014, respectively, is included within depreciation and amortization in the accompanying consolidated statements of operations and changes in net assets.

As of September 30, 2015 and 2014, $1,571,500 and $228,691 of pledges receivables have been included within prepaid expenses and other current assets as management anticipates them to be collected within the next year.

Pledges receivable are expected to be realized as follows:

	2015	2014
In one year or less	$ 1,580,500	$ 237,691
Between one and five years	-	-
Greater than five years	-	-
Less: allowance for uncollectible amounts	(9,000)	(9,000)
Pledges receivable - net	$ 1,571,500	$ 228,691

(Continued)

NOTE 5 - OTHER ASSETS (Continued)

As of September 30, 2015 and 2014, unamortized bond issuance costs, which are included within other assets, consist of the following:

	2015	2014
Deferred financing costs	$ 3,735,675	$ 3,735,675
Less: accumulated amortization	(1,599,036)	(1,453,237)
Total	$ 2,136,639	$ 2,282,438

NOTE 6 – PROPERTY AND EQUIPMENT

Property and equipment as of September 30, 2015 and 2014, consist of the following:

	2015	2014
Land and land improvements	$ 5,395,243	$ 5,395,243
Buildings and building improvements	161,551,674	159,603,375
Fixed equipment	33,819,206	32,403,097
Movable equipment	115,646,936	112,056,204
	316,413,059	309,457,919
Less: accumulated depreciation and amortization	(229,410,757)	(218,033,560)
	87,002,302	91,424,359
Construction-in-progress	1,273,117	2,641,200
Total	$ 88,275,419	$ 94,065,559

For the years ended September 30, 2015 and 2014, the Network capitalized interest related to construction financed with tax-exempt debt of $67,635 and $20,850, respectively. The cost to complete the construction-in-progress is approximately $6,070,930 and $4,154,000 as of September 30, 2015 and 2014, respectively.

For the years ended September 30, 2015 and 2014, the Network disposed of property, plant and equipment in the amounts of $228,440 and $657,588, respectively and all disposals were of fully depreciated assets.

(Continued)

NOTE 7 - INTANGIBLE ASSETS

The gross carrying amount and accumulated amortization, by class of intangible assets, as of September 30, 2015 and 2014, consisted of the following:

2015	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount
License enhancements	$ 1,898,684	$ (1,407,854)	$ 490,830
Other intangible assets	1,717,291	(1,170,434)	546,857
Goodwill	2,989,140	-	2,989,140
Total	$ 6,605,115	$ (2,578,288)	$ 4,026,827

2014	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount
License enhancements	$ 1,898,684	$ (1,378,528)	$ 520,156
Other intangible assets	1,717,291	(971,321)	745,970
Goodwill	2,989,140	-	2,989,140
Total	$ 6,605,115	$ (2,349,849)	$ 4,255,266

Amortization expense related to intangible assets was $228,440 and $243,102 for the years ended September 30, 2015 and 2014, respectively.

The estimated amortization expense in each of the succeeding five fiscal years and thereafter, as of September 30, 2015, is as follows:

2016	$ 215,257
2017	200,714
2018	108,831
2019	73,359
2020	45,826
Thereafter	393,700
Total	$ 1,037,687

NOTE 8 - ESTIMATED SELF-INSURANCE LIABILITIES

The Network is self-insured for workers' compensation insurance coverage. The Network participates in Workers' Compensation Trust, a revocable trust, for the purpose of setting aside assets based on actuarial recommendations.

(Continued)

NOTE 8 - ESTIMATED SELF-INSURANCE LIABILITIES (Continued)

As of September 30, 2015 and 2014, the Hospital has a $450,000 limit per occurrence for workers' compensation claims. Prior to September 30, 2013, the per occurrence limit was $350,000. The Network has employed independent actuaries to estimate the ultimate costs, if any, of workers' compensation claims. Accrued workers' compensation reserves have been discounted at 5% as of September 30, 2015 and 2014, and in management's opinion provide an adequate reserve for loss contingencies. As of September 30, 2015 the discount on workers' compensation reserve amounted to approximately $275,000.

In fiscal year 2007, ECHN established a single-parent captive, CHIC, which covers all of its subsidiaries. The captive provides malpractice ($3,000,000 per occurrence and $9,000,000 in the aggregate) and general liability ($1,000,000 per occurrence and $3,000,00 in the aggregate) coverage for ECHN and its subsidiaries for the years ended September 30, 2015 and 2014.

Effective October 1, 2009, CHIC also provided an excess healthcare professional liability and umbrella liability insurance policy on a claims-made basis covering healthcare professional liability, general care liability, automobile liability, employers liability, helipad liability and non-owned aircraft liability. The limit provided is $30,000,000 for each loss event and in the annual aggregate excess of the primary coverage layers described above. This coverage is fully reinsured.

ECHN does not self-insure any malpractice risks other than exposures greater than its excess coverages, however, as of September 30, 2015 and 2014, ECHN has recorded a liability for estimated incurred but not reported claims, as it currently has a claims-made policy with CHIC.

The activity in the reserve for outstanding losses and loss related expenses at ECHN for workers' compensation, professional and general liability claims, as of September 30, 2015 and 2014, is as follows:

	2015	2014
Balance at beginning of year	$ 12,007,755	$ 11,296,110
Workers' compensation:		
Losses incurred related to:		
Current year	1,355,535	820,878
Prior years	(307,298)	293,054
Total incurred	1,048,237	1,113,932
Paid losses related to:		
Current year	(593,187)	(502,541)
Prior years	(1,084,338)	(1,260,229)
Total paid	(1,677,525)	(1,762,770)
Professional and general:		
Losses incurred related to:		
Current year	1,450,000	2,500,000
Prior years	129,945	(476,182)
Total incurred	1,579,945	2,023,818
Paid losses related to:		
Current year	(11,415)	(35,098)
Prior years	(3,421,661)	(628,237)
Total paid	(3,433,076)	(663,335)
Balance at end of year	$ 9,525,336	$ 12,007,755

(Continued)

NOTE 8 - ESTIMATED SELF-INSURANCE LIABILITIES (Continued)

Workers' Compensation: The development on prior-year incurred losses (decreased) increased by ($307,298) and $293,054 for the years ended September 30, 2015 and 2014, respectively.

Professional and General: The development on prior-year incurred losses increased (decreased) by $129,94 and ($476,182) for the years ended September 30, 2015 and 2014, respectively.

The reserve for losses, which was determined with the assistance of an actuarial consultant, included estimates of claims incurred but not reported. Approximately $2,328,000 and $2,324,000 of the reserve as of September 30, 2015 and 2014, respectively, are included in other current liabilities with the remaining balance of the reserve included in estimated self-insurance liabilities in the accompanying consolidated balance sheets.

NOTE 9 - PENSION AND OTHER POSTRETIREMENT BENEFITS

ECHN had a defined benefit pension plan that covered substantially all of the employees of MMH and RGH. The benefits were based upon years of service and compensation for the five highest years during the employee's last 10 years of service. The hospitals contribute amounts sufficient to meet the minimum funding requirements of the Employee Retirement Income Security Act of 1974, as well as such additional amounts as deemed appropriate.

Effective December 31, 2013, ECHN froze the defined-benefit for all remaining participants. During September 2013, the Trustees passed a resolution to freeze all benefits related to the defined-benefit pension plan. On December 31, 2008, ECHN implemented a soft freeze on the defined-benefit pension plan. All qualified employees are eligible to enter into the Under the defined contribution plan, ECHN contributes 3% of eligible employees' salaries. This contribution is non-guaranteed for all employees except certain union workers. During fiscal year 2015 and 2014, the Hospital incurred expenses of $588,503 and $2,259,145, respectively, related to this plan.

MMH and RGH also sponsor a postretirement benefit plan that provides health care benefits to those employees who retire. The criteria to receive this benefit is to be vested in the pension plan, attain age 55 or older and start collecting under the defined benefit plan described above once retired. The retiree must be enrolled into the medical plan on the date of retirement to be eligible for the continuation. MMH full-time registered nurse retirees (retired prior to October 1, 2005 and were eligible per the Union contract) are grandfathered and required to pay at least 50% of the total cost of the medical and dental coverage they elect for themselves under the plan.

For non-grandfathered retirees, the postretirement health care plan is contributory and the retiree pays 100% of the premium.

The effects of Medicare Prescription Drug, Improvement and Modernization Act of 2003 were reflected as of September 30, 2015 and 2014, assuming that ECHN will continue to provide a prescription drug benefit to retirees that is at least actuarially equivalent to Medicare Part D and that ECHN will receive the federal subsidy. The subsidy reduced plan liabilities by approximately $0 and $60,000 for the years ended September 30, 2015 and 2014, respectively. Subsidies of $72,784 and $82,280 were received in the years ended September 30, 2015 and 2014, respectively. Future benefits of $190,189 are expected to be paid. There are no future subsidies expected to be received related the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

(Continued)

NOTE 9 - PENSION AND OTHER POSTRETIREMENT BENEFITS (Continued)

The pension and postretirement plans' change in benefit obligation and change in plan assets for the years ended September 30, 2015 and 2014, are as follows:

	Pension Benefits		Other Postretirement Benefits	
	2015	2014	2015	2014
Change in benefit obligation:				
Benefit obligation, beginning of year	$ 212,658,153	$ 192,294,259	$ 2,848,659	$ 4,193,572
Service cost	1,540,000	1,511,408	48,328	54,345
Interest cost	9,444,578	9,912,203	114,339	183,189
Plan participants' contributions	-	-	411,972	252,224
Receipt of Medicare Part D reimbursement	-	-	72,784	82,280
Plan amendments	-	-	-	(1,500,168)
Actuarial loss (gain)	7,967,757	18,293,175	(241,294)	103,272
Benefits paid	(14,814,936)	(9,352,892)	(543,945)	(520,055)
Benefit obligation, end of year	$ 216,795,552	$ 212,658,153	$ 2,710,843	$ 2,848,659
Change in plan assets:				
Fair value of plan assets, beginning of year	$ 169,516,557	$ 152,290,850	$ -	$ -
Actual return on plan assets	1,237,206	21,778,598	-	-
Employer contributions	970,000	4,800,000	59,189	185,551
Plan participants' contributions	-	-	411,972	252,224
Receipt of Medicare Part D reimbursement	-	-	72,784	82,280
Benefits paid	(14,814,936)	(9,352,891)	(543,945)	(520,055)
Fair value of plan assets, end of year	$ 156,908,827	$ 169,516,557	$ -	$ -
Accrued pension and other postretirement benefits	$ (59,886,725)	$ (43,141,596)	$ (2,710,843)	$ (2,848,659)
Accumulated benefit obligation	$ (216,795,552)	$ (212,658,153)	$ -	$ -

The amount recognized in the Network's consolidated balance sheets as of September 30, 2015 and 2014, are as follows:

	Pension Benefits		Other Postretirement Benefits	
	2015	2014	2015	2014
Current liabilities	$ -	$ -	$ 190,189	$ 193,769
Noncurrent liabilities	59,886,725	43,141,596	2,520,654	2,654,890
Net amount recognized	$ 59,886,725	$ 43,141,596	$ 2,710,843	$ 2,848,659

(Continued)

NOTE 9 - PENSION AND OTHER POSTRETIREMENT BENEFITS (Continued)

The allocation of the accrued pension and postretirement benefits for the years ended September 30, 2015 and 2014, is as follows:

	Pension Benefits		Other Postretirement Benefits	
	2015	2014	2015	2014
MMH	$ 46,334,359	$ 33,243,046	$ 2,262,167	$ 2,377,259
RGH	13,552,366	9,898,550	448,676	471,400
Total	$ 59,886,725	$ 43,141,596	$ 2,710,843	$ 2,848,659

The plans' components of net periodic benefit cost for the years ended September 30, 2015 and 2014, are as follows (pension benefits information presented is for MMH and RGH combined):

	Pension Benefits		Other Postretirement Benefits	
	2015	2014	2015	2014
Service cost	$ 1,540,000	$ 1,511,408	$ 48,328	$ 54,345
Interest cost	9,444,578	9,912,203	114,339	183,189
Expected return on plan assets	(8,676,394)	(12,179,861)	-	-
Amortization of prior service (credits) costs	-	-	(179,878)	77,724
Recognized actuarial loss (gain)	536,246	867,441	(101,681)	(105,864)
Net periodic benefit cost	$ 2,844,430	$ 131,191	$ (118,892)	$ 209,394

The allocation of the net periodic benefit cost for the years ended September 30, 2015 and 2014, is as follows:

	Pension Benefits		Other Postretirement Benefits	
	2015	2014	2015	2014
MMH	$ 2,191,794	$ 103,762	$ (99,214)	$ 174,744
RGH	652,636	27,429	(19,678)	34,650
Total	$ 2,844,430	$ 131,191	$ (118,892)	$ 209,394

Included in unrestricted net assets are the following amounts that have not yet been recognized in net period cost:

	Pension Benefits		Other Postretirement Benefits	
	2015	2014	2015	2014
Unrecognized prior service costs	$ -	$ -	$ 1,311,468	$ 1,491,346
Unrecognized actuarial losses	(50,648,410)	(35,777,711)	1,415,873	1,276,260
Total	$ (50,648,410)	$ (35,777,711)	$ 2,727,341	$ 2,767,606

(Continued)

NOTE 9 - PENSION AND OTHER POSTRETIREMENT BENEFITS (Continued)

Changes in benefit obligations recognized in unrestricted net assets include:

	Pension Benefits		Other Postretirement Benefits	
	2015	2014	2015	2014
Acturial losses (gains)	$ 15,406,945	$ 8,694,437	$ (241,294)	$ 103,272
New prior service costs	-	-	-	(1,500,168)
Amortization or curtailment of prior service credit (cost)	-	-	179,978	(77,724)
Amortization or settlement recognition of net gain (loss)	(536,246)	(887,441)	101,681	105,863
Total	$ 14,870,699	$ 7,806,996	$ 40,365	$ (1,368,757)

The prior service costs and actuarial gains (losses) included in unrestricted net assets and expected to be recognized in net periodic cost during the year ending September 30, 2016 are $188,700 and ($949,904), respectively.

The assumptions used to determine pension and postretirement benefit obligations as of September 30, 2015 and 2014, are as follows:

	Pension Benefits		Other Postretirement Benefits	
	2015	2014	2015	2014
Discount rate	4.65%	4.54%	4.19%	4.11%
Expected long-term rate of return	5.25%	8.00%	N/A	N/A
Rate of compensation increase	0.00%	0.00%	N/A	N/A
Initial medical trend rate	N/A	N/A	7.20%	9.44%
Ultimate medical trend rate	N/A	N/A	4.50%	4.50%
Number of years to ultimate medical trend rate	N/A	N/A	13 years	13 years

The assumptions used to determine net periodic benefit cost of the pension and postretirement plans for the years ended September 30, 2015 and 2014, were as follows:

	Pension Benefits		Other Postretirement Benefits	
	2015	2014	2015	2014
Discount rate	4.54%	5.27%	4.11%	5.54%
Expected long-term rate of return	5.25%	8.00%	N/A	N/A
Rate of compensation increase	N/A	3.00%	N/A	N/A
Initial medical trend rate	N/A	N/A	7.20%	9.44%
Ultimate medical trend rate	N/A	N/A	4.50	4.50%
Number of years to ultimate medical trend rate	N/A	N/A	13 years	13 years

(Continued)

NOTE 9 - PENSION AND OTHER POSTRETIREMENT BENEFITS (Continued)

The medical trend rate has a significant effect on the amounts reported. A one-percentage-point change in assumed health care cost trend rates would have the following effects:

	One Percentage Point Increase	One Percentage Point Decrease
Effect on year-end postretirement benefit obligation	$ 227,273	$ 225,033
Effect on total of service and interest cost components	$ 1,405	$ 20,880

The pension plan's weighted-average asset allocations as of September 30, 2015 and 2014, by asset category, are as follows:

	Pension Benefits	
	2015	2014
Asset category:		
Equity securities	0%	0%
Debt securities	99%	99%
Cash and cash equivalents	1%	1%
	100%	100%

The investment objective of ECHN is to invest the plan assets in a manner that, together with contributions, will provide for sufficient resources to pay current and projected obligations over the life of the plan. The plan shall be diversified across asset classes to achieve an optimal balance between risk and return and between income and growth of assets through capital appreciation. Consistent with funding requirements, a secondary objective of the plan is to source benefit payments primarily through existing plan assets and anticipated future returns thereby minimizing future cash contributions. The investment objectives shall be implemented in a de-risking framework designed to manage the plan's funded status volatility and minimize future cash contributions. The funded status of the plan shall be measured by the ratio of plan assets to the projected benefit obligation. To reduce the volatility as much as possible, the goal is to attain and/or maintain a funded status of at least a 105% funding level and allocate its assets as outlined below.

The plan has approved an asset allocation strategy that shall change over time in response to future changes in the plan's funded status. Such changes in asset allocation strategy are intended to allocate additional assets to the fixed income asset class should the plan's funded status improve. Accordingly, the fixed income asset class shall be invested in such a manner that its interest rate sensitivity correlates highly with that of the plan's liabilities. Other asset classes are intended to provide additional return with associated higher levels of risk. If the plan's funded status deteriorates beyond stated thresholds, the strategy dictates that additional assets will not be re-allocated to the return-seeking assets.

(Continued)

NOTE 9 - PENSION AND OTHER POSTRETIREMENT BENEFITS (Continued)

Fair value methodologies used to assign plan assets to levels in accordance with ASC 820 are consistent with the inputs described in Note 4 and the following:.

Guaranteed insurance contract: A contract with an insurance entity under which related payments to the insurance entity are accumulated in an unallocated fund to be used to meet benefit payments when employees retire, either directly or through the purchase of annuities. Funds in an unallocated contract may also be withdrawn and otherwise invested. The fund's value is established by multiplying client contributions by an established interest rate. Because the participants transact at contract value, fair value is determined annually for financial statement reporting purposes only. In determining the reasonableness of the methodology, the Investment Committee evaluates a variety of factors including review of existing contracts, economic conditions, industry and market developments, and overall credit ratings. Certain unobservable inputs are assessed through review of contract terms (for example, duration or payout date) while others are substantiated utilizing available market data (for example, swap curve rate).

The following table presents the investments of the defined benefit plan carried at fair value as of September 30, 2015 and 2014, by the valuation hierarchy.

2015	Level 1	Level 2	Level 3	Total
Cash and cash equivalents	$ 929,519	$ -	$ -	$ 929,519
Fixed income mutual funds:				
Long duration	139,490,485	-	-	139,490,485
U.S. Core Opportunistic	6,641,878	-	-	6,641,878
U.S. Passive	6,865,329	-	-	6,865,329
Guaranteed investment contract	-	-	2,981,616	2,981,616
Total plan assets at fair value	$ 153,927,211	$ -	$ 2,981,616	$ 156,908,827

2014	Level 1	Level 2	Level 3	Total
Cash and cash equivalents	$ 708,333	$ -	$ -	$ 708,333
Fixed income mutual funds:				
Long duration	150,668,190	-	-	150,668,190
U.S. Core Opportunistic	7,500,003	-	-	7,500,003
U.S. Passive	7,558,893	-	-	7,558,893
Guaranteed investment contract	-	-	3,081,138	3,081,138
Total plan assets at fair value	$ 166,435,419	$ -	$ 3,081,138	$ 169,516,557

(Continued)

NOTE 9 - PENSION AND OTHER POSTRETIREMENT BENEFITS (Continued)

The changes within the Level 3 investments as of September 30, 2015 and 2014, are as follows:

2015	Guaranteed Investment Contract
Balance as of October 1, 2014	$ 3,081,138
Investment income	123,390
Expenditures	(222,912)
Balance as of September 30, 2015	$ 2,981,616

2014	Guaranteed Investment Contract
Balance as of October 1, 2013	$ 3,230,137
Investment income	133,795
Expenditures	(282,794)
Balance as of September 30, 2014	$ 3,081,138

During fiscal year 2016, ECHN anticipates contributing $1,840,000 to the defined benefit pension plan.

The benefit payments, which reflect estimated future service, expected to be paid from the plans for the year ended September 30, 2015, are as follows:

	Pension Benefits	Other Postretirement Benefits
2016	$ 9,806,322	$ 190,189
2017	$ 10,326,550	$ 206,505
2018	$ 10,915,238	$ 213,426
2019	$ 11,476,209	$ 225,015
2020	$ 12,035,372	$ 238,865
2021-2025	$ 66,839,679	$ 1,161,098

The Network also has a defined contribution employee savings plan covering substantially all employees. Eligible employees who contribute to the plan will have 20% - 50%, depending upon years of service, of contributions matched by the Network, up to a maximum of 6% of annual compensation. The Network incurred expenses related to the employee savings plan amounting to $788,247 and $2,558,753, for the years ended September 30, 2015 and 2014, respectively.

(Continued)

NOTE 10 - LONG-TERM DEBT AND LINES OF CREDIT

Long-term debt and capital lease obligations, as of September 30, 2015 and 2014, consist of the following:

	2015	2014
Connecticut Health and Educational Facilities Authority (CHEFA) Hospital Revenue Bonds, ECHN Series A Bonds, bearing interest at rates ranging from 6.000% to 6.375% - net of unamortized original issue discount of $32,057 and $39,281 for 2015 and 2014, respectively.	$ 7,347,943	$ 8,245,719
CHEFA Hospital Revenue Bonds, ECHN Series C Bonds, bearing interest ranging from 4.125% to 5.125% - net of unamortized original issue premium of $309,670 and $330,315 for 2015 and 2014, respectively.	32,184,670	32,990,315
CHEFA Hospital Revenue Bonds, ECHN Series D Bonds bearing interest at a variable rate, adjusted weekly.	13,425,000	13,743,000
CHEFA Hospital Demand Revenue Bonds, ECHN Series E Bonds, bearing interest at a variable rate, adjusted weekly.	16,600,000	17,090,000
Loan due to Sovereign Bank, face amount $5,200,000 due and payable in semi-annual principal and interest installments maturing on January 3, 2022 and bearing interest at 3.38%	3,634,222	4,154,222
Promissory note payable to Rockville Bank due and payable in monthly principal and interest installments maturing on January 15, 2015, bearing interest at a fixed rate of 3.75%.	-	172,331
Promissory note payable to Rockville Bank due and payable in monthly principal and interest installments maturing on July 1, 2025, bearing interest at 5.87%.	688,717	742,092
Promissory note payable to Webster Bank due and payable in monthly principal and interest installments with a balloon payment due on May 1, 2018, bearing interest at 4.22%	586,153	601,219
Promissory note payable to Webster Bank due and payable in monthly principal and interest installments with a balloon payment due on December 1, 2017, bearing interest at 4.11%	539,375	554,013
Promissory note payable to Webster Bank due and payable in monthly principal and interest installments with a balloon payment due on May 1, 2019 bearing interest at 5.14%	506,701	517,406

(Continued)

NOTE 10 - LONG-TERM DEBT AND LINES OF CREDIT (Continued)

	2015	2014
Promissory note payable to 428 Hartford Turnpike Associates, LLP payable in monthly principal and interest installments, maturing September 1, 2021, bearing interest at 6%.	197,183	223,265
Debt of ECHN Corporate Services. Various due dates and interest rates.	10,575	43,215
Mortgage payable to Rockville Bank, maturing April 1, 2022, bearing interest at 6.5% for the first five years, adjustable thereafter every five years.	127,866	144,715
Promissory notes with Philips Medical Capital, payable in monthly installments, maturing in fiscal year 2021 and bearing interest at rates between 4.3% and 6.8%	2,359,215	2,542,664
Mortgage payable to Rockville Bank, maturing January 1, 2027 bearing interest at 6.6% for the first five years, adjustable thereafter, every five years.	121,471	129,901
Promissory notes with GE HealthCare Financial Services, payable in monthly installments, maturing in fiscal years 2019 and 2020 and bearing interest at rates ranging from 4.4% to 5.3%	549,719	661,435
Promissory note with Stryker Flex Financial, payable in monthly installments, maturing in fiscal year 2020 and bearing interest at 4.00%	994,500	-
Promissory note with Siemens Financial Services, payable in monthly installments, maturing in fiscal year 2019 and bearing interest at 3.85%	504,096	643,154
Capital lease obligations (see Note 12)	6,763,549	5,886,404
Total long-term debt and capital lease obligations	87,140,955	89,085,070
Less: current maturities	(7,018,708)	(6,660,757)
Total long-term debt and capital lease obligations - net of current portion	$ 80,122,247	$ 82,424,313

Lines of credit as of September 30, 2015 and 2014 consist of the following:

	2015	2014
Revolving line of credit with TD Bank, bearing interest at a variable rate.	$ 3,800,000	$ 5,600,000

(Continued)

NOTE 10 - LONG-TERM DEBT AND LINES OF CREDIT (Continued)

In February 2000, MMH, RGH and EES (collectively, the Series A Obligated Group) entered into an agreement and open-ended mortgage with Connecticut Health and Educational Facilities Authority (CHEFA) in connection with the issuance of CHEFA Hospital Revenue Bonds, Eastern Connecticut Health Network, Issue Series 2000A (the Series A Bonds). A portion of the proceeds from the Series 2000A Bonds, net of the original issue discount and amounts used to establish required reserve accounts, was placed in an irrevocable trust from which the remaining debt service payments for defeased CHEFA bonds will be paid. The remainder was used to finance additions and renovations for various facilities. The Series A Obligated Group has been legally released from any future debt service on the defeased bonds. The Series A Bonds are due on various due dates through July 1, 2030.

In July 2004, MMH, RGH, EES, and ECHF (collectively, the Series B Obligated Group) entered into an agreement and open-ended mortgage with CHEFA in connection with the issuance of CHEFA Hospital Revenue Bonds, Eastern Connecticut Health Network Issue, Series B (the Series B Bonds). A portion of the proceeds from the Series B Bonds, net of the original issue discount and amounts used to establish required reserve accounts, was used to finance additions, renovations, and purchases of equipment for RGH and MMH.

The additions and renovations financed by the Series B Bonds consist of improvements and expansion of the emergency department at RGH; the purchase, renovation, and equipping of the Dialysis Center at RGH; construction of the heliport at RGH, improvements to the Gastrointestinal and Rehabilitation Departments at RGH, and capital equipment purchases for MMH and RGH.

The Series B bonds were refinanced as part of the issuance of Series E bonds as described below.

On October 1, 2005, MMH, RGH, EES, and ECHF (collectively, the Series C Obligated Group) entered into an agreement and open-ended mortgage with CHEFA to borrow $37,065,000 in connection with the issuance of CHEFA Hospital Revenue Bonds, Eastern Connecticut Health Network Issue, Series C (the Series C Bonds). The proceeds from the Series C Bonds, net of the original issue premium and amounts used to establish required reserve accounts, were placed in an irrevocable trust to advance refund and defease a portion of the Series 2000A Bonds. MMH, RGH, and EES have been legally released from any future debt service on the portion of defeased Series 2000A Bonds. The Series C Bonds are due on various due dates through July 1, 2034, bearing interest at rates ranging from 4.125% to 5.125%.

In May 2009, MMH, RGH, EES, and ECHF (collectively, the Series D Obligated Group) entered into an agreement and open-ended mortgage with CHEFA in connection with the issuance of CHEFA Hospital Revenue Bonds, Eastern Connecticut Health Network, Issue Series D (the Series D Bonds). A portion of the proceeds from the Series D Bonds, net of amounts used to establish required reserve accounts, were used to finance renovations at MMH, an expansion at EES, and other campus improvements. The Series D Bonds are due on various due dates through May 14, 2039.

In December 2010, MMH, RGH, EES, and ECHF (collectively, the Series E Obligated Group) entered into an agreement and open-ended mortgage with CHEFA in connection with the issuance of CHEFA Hospital Revenue Bonds, Eastern Connecticut Health Network, Issue Series E (the Series E Bonds). The proceeds from the Series E Bonds, net of amounts used to establish required reserve accounts, were used to redeem the Series B Bonds and fund interest rate swap agreement termination payments relating to the Series B Bonds. The Series E Bonds are due on various due dates through July 1, 2034.

(Continued)

NOTE 10 - LONG-TERM DEBT AND LINES OF CREDIT (Continued)

Under the terms of the Series A, Series B, Series C, Series D, and Series E Bonds, the Series A Obligated Group, Series B Obligated Group, Series C Obligated Group, Series D Obligated Group, and Series E Obligated Group (the Obligated Groups) are required to maintain certain deposits with a trustee. Such deposits are included in assets whose use is limited. The indenture also places limits on the incurrence of additional borrowings and dispositions of property and requires that the Obligated Groups satisfy certain measures of financial performance as long as the notes are outstanding.

Under the terms of the CHEFA agreements, each member of the Obligated Groups is jointly and severally liable for the full and prompt payment of the amounts owed by the Obligated Groups. Total debt under the CHEFA agreements of the Obligated Groups was $72,914,222 and $75,932,222 as of September 30, 2015 and 2014, respectively. The debt is also secured by the gross receipts of the Obligated Groups.

In June 2012, the Obligated Group entered into a loan agreement with Sovereign Bank, through CHEFA's Tax-Exempt Equipment Loan Program, for $5,200,000 in connection with purchase of equipment and renovation costs. Semi-annual principal and interest payments are due through January 2022.

The Hospital is party to various capital leases, which are described in Note 12.

The annual maturities of the long-term debt and capital lease obligations in each of the succeeding five years and thereafter, as of September 30, 2015, are as follows:

2016	$ 7,018,708
2017	6,297,881
2018	6,682,574
2019	5,969,084
2020	5,197,338
Thereafter	55,697,757
	86,863,342
Plus - premium	277,613
Total	$ 87,140,955

On December 21, 2010, ECHN entered into a $6,500,000 unsecured line of credit with TD Bank, N.A. In 2014, the line of credit agreement was modified. The amount available was reduced to $5,750,000, the interest rate was increased to LIBOR plus 2.5% and the maturity was extended to September 29, 2015. In 2015, the line of credit agreement was further modified. The amount available was reduced to $3,950,000 and the maturity date was extended to September 29, 2016. As of September 30, 2015 and 2014, MMH had $3,800,000 and $5,600,000, respectively, outstanding under this line of credit.

The Network is subject to various financial covenants related to these debt agreements. The Network was in compliance with these covenants in 2015 and 2014.

NOTE 11 - DERIVATIVES

The Network uses derivative instruments, specifically interest rate swap agreements, to manage its exposure to changes in the interest rate on its CHEFA bonds. The use of derivative instruments exposes the Network to additional risks related to the derivative instrument, including market risk, credit risk and termination risk as described below, and the Network has defined risk management practices to mitigate these risks, as appropriate.

(Continued)

NOTE 11 - DERIVATIVES (Continued)

Market risk represents the potential adverse effect on the fair value and cash flow of a derivative instrument due to changes in interest rates or rate spreads. Market risk is managed through ongoing monitoring of interest rate exposure based on set parameters regarding the type and degree of market risk that the Network will accept. Credit risk is the risk that the counterparty on a derivative instrument may be unable to perform its obligation during the term of the contract. When the fair value of a derivative contract is positive, the counterparty owes the Network, which creates credit risk.

Credit risk is managed by setting stringent requirements for qualified counterparties at the date of execution of a derivative transaction and requiring counterparties to post collateral in the event of a credit rating downgrade or if the fair value of the derivative contract exceeds a negotiated threshold.

Termination risk represents the risk that the Network may be required to make a significant payment to the counterparty, if the derivative contract is terminated early. Termination risk is assessed at onset by performing a statistical analysis of the potential for a significant termination payment under various scenarios designed to encompass expected interest rate changes over the life of the proposed contract. The test measures the ability to make a termination payment without a significant impairment to the Network's ability to meet its debt or liquidity covenants.

In May 2009, ECHN entered into an interest rate swap agreement to manage the interest cost and risk associated with $15,250,000 of its variable rate Series D Bonds. Under the terms of this agreement, ECHN pays a fixed rate of 3.89%. Changes in the fair value of this swap are recorded in the consolidated statements of operations and changes in net assets. Effective May 14, 2014, the interest rate swap agreement on the Series D variable rate debt expired. The Network's portion of the swap agreement in force related to this strategy as of September 30, 2014, and the liability and interest expense recognized by the Network are as follows:

		2014
Notional amount of contract	$	-
Fair value of swap contract recognized in other liabilities	$	-
Net interest income recognized in non-operating losses	$	(170,000)

In June 2012, ECHN entered into an interest rate swap agreement to manage the interest cost and risk associated with $5,200,000 of its debt with Sovereign Bank. Under the terms, ECHN pays a fixed rate of 3.38%. The swap is accounted for as a cash flow hedge in accordance with ASC 815 "*Accounting for Derivative Instruments and Hedging Activities*". This accounting treatment requires the effective portion of the gain or loss on a derivative instrument designated and qualifying as a cash flow hedging instrument to be reported as a component of other changes in unrestricted net assets and to be reclassified into operations in the same period or periods during which the hedged forecasted transaction affects earnings. The remaining gain or loss on the derivative instrument, if any, shall be recognized currently in non-operating losses.

(Continued)

NOTE 11 - DERIVATIVES (Continued)

The Network's portion of the swap agreement in force related to this strategy as of September 30, 2015 and 2014, and the liability and unrealized (gain) loss recognized by the Network are as follows:

	2015	2014
Notional amount of contract	$ 3,634,222	$ 4,154,222
Fair value of swap contract recognized in other liabilities	$ 52,900	$ 3,800
Unrealized (gain) loss recognized in unrestricted net assets	$ 49,100	$ (8,200)

The counterparty to the above swap transactions is a major financial institution that meets ECHN's criteria for financial stability and creditworthiness.

NOTE 12 - LEASE COMMITMENTS

ECHN leases equipment under capital lease agreements, which begin to expire in 2015. The interest rates range from 4% to 8%. The net carrying value of equipment under the capital lease was $8,594,610 and $8,111,729 as of September 30, 2015 and 2014, respectively. ECHN leases various office space and certain equipment under operating leases that expire in various years through fiscal year 2024. Certain leases may be renewed at the end of their term.

Future minimum payments under capital leases and non-cancelable operating leases as of September 30, 2015, consisted of the following:

	Capital Leases	Operating Leases
2016	$ 3,273,452	$ 5,614,395
2017	1,965,770	4,151,050
2018	906,877	2,814,112
2019	733,989	2,363,973
2020	378,844	2,261,254
Thereafter	-	10,319,656
	7,258,932	$ 27,524,440
Less: interest on capital lease	495,383	
Principal amount of capital lease	$ 6,763,549	

Rent expense under operating and month-to-month leases was $6,421,813 and $6,735,147 for the years ended September 30, 2015 and 2014, respectively.

(Continued)

NOTE 13 - CONCENTRATIONS OF CREDIT RISK

ECHN grants credit without collateral to its patients, most of whom are insured under third-party payer agreements. The mix in patient accounts receivable as of September 30, 2015 and 2014, before allowances for doubtful accounts, consists of the following:

	2015	2014
Medicare	29%	23%
Self-pay	24%	32%
Managed care	23%	24%
Medicaid	15%	13%
Commercial insurance	4%	3%
Other	5%	5%
	100%	100%

NOTE 14 - NET PATIENT SERVICE REVENUE

Net patient service revenue for the years ended September 30, 2015 and 2014, consists of the following:

	2015	2014
Patient service revenues:		
Inpatient services	$ 318,875,465	$ 333,197,293
Outpatient services	600,758,074	592,717,508
Gross patient service revenues	919,633,539	925,914,801
Deductions - contractual allowances and discounts	(611,589,145)	(615,943,491)
Patient service revenue, net of contractual allowances and discounts	$ 308,044,394	$ 309,971,310

Net patient service revenues by primary payor for the years ended September 30, 2015 and 2014, is as follows:

	2015	2014
Managed care	$ 123,129,276	$ 122,972,772
Medicare	113,011,679	115,689,688
Medicaid	48,753,827	46,594,882
Commercial insurance	15,409,231	14,529,384
Self-pay	3,126,653	4,766,685
Other	4,613,728	5,417,899
Total	$ 308,044,394	$ 309,971,310

(Continued)

NOTE 14 - NET PATIENT SERVICE REVENUE (Continued)

In addition, the Network provides for a provision for bad debts. For receivables associated with services provided to patients who have third-party coverage, the Network analyzes contractually due amounts and provides an allowance for doubtful accounts and a provision for bad debts (for example, for expected uncollectible deductibles and copayments on accounts for which the third-party payor has not yet paid, or for payors who are known to be having financial difficulties that make the realization of amounts due unlikely). For receivables associated with self-pay patients (which includes both patients without insurance and patients with deductible and co-payment balances due for which third-party coverage exists for part of the bill), the Network records a significant provision for bad debts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible.

For uninsured patients that do not qualify for financial assistance, the Network offers a discount off its standard rates for services provided. The difference between the discounted rates and the amounts actually collected after all reasonable collection efforts have been exhausted is written off against the allowance for doubtful accounts in the period they are determined uncollectible. The Network's allowance for doubtful accounts covers all accounts greater than 6 months for both self-pay accounts receivable and third party payors as of September 30, 2015 and 2014. The Network's self-pay and third-party payors write-offs totaled $9,273,157 and $11,700,441 for 2015 and 2014, respectively. The Network did not change its charity care or financial assistance policy during 2015 or 2014.

At September 30, 2015 and 2014, 36.3% and 30.4% of net patient accounts receivable were from governmental payors (Medicare and Medicaid) and 63.7% and 69.6% were from nongovernmental payors, respectively. Nongovernmental payors are primarily insurance companies and self-pay payors. Management has recorded an allowance for doubtful accounts, as noted above, which, in its opinion, is sufficient to provide for risk of nonpayment.

NOTE 15 - COMMUNITY BENEFIT

ECHN's mission is to improve the health of the people and the communities ECHN serves.

ECHN provides quality health care to all, regardless of their ability to pay. Charity care is provided to those who are eligible based on ECHN's policy. ECHN also incurs unpaid costs for government programs because reimbursement is not sufficient to cover costs associated with Medicare and Medicaid patients. In addition to the charity care responsibilities, ECHN provides numerous other community benefits. These community benefits include medical education and research, community health education, screenings, support groups, counseling services, and in-kind support. To address the need for health care providers, a number of programs are offered for young people who may be interested in a career in health care.

ECHN utilizes guidelines developed by various organizations to quantify community benefit activities. ECHN defines community benefit activities as those that improve access to care, as well as the health of the broader community. In addition to charity care and the unpaid costs of government sponsored health care (Medicare and/or Medicaid shortfalls), community benefit activities will normally fall into one of the following categories: nonbilled community health services / community health improvement services, health professions education, subsidized health services, research, financial and in-kind contributions, community building activities, and community benefit operations.

MMH and RGH provide care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Because MMH and RGH do not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue. The amount of traditional charity care provided, determined on the basis of cost, was $1,650,100 and $2,144,342 for the years ended September 30, 2015 and 2014, respectively.

(Continued)

NOTE 16 - FUNCTIONAL EXPENSES

ECHN provides general health care services to residents within its geographical location. For the years ended September 30, 2015 and 2014, expenses relating to providing these services are as follows:

	2015	2014
Health care services	$ 255,729,581	$ 266,901,859
Fund raising	508,490	1,210,885
General and administrative	59,610,005	58,469,860
Total	$ 315,848,076	$ 326,582,604

NOTE 17 - TEMPORARILY AND PERMANENTLY RESTRICTED NET ASSETS

The temporarily restricted net assets available, as of September 30, 2015 and 2014, are available for the following purposes:

	2015	2014
Departmental and endowment purposes	$ 1,402,125	$ 1,910,003
Capital campaign and pledges	84,411	186,310
Total	$ 1,486,536	$ 2,096,313

As of September 30, 2015 and 2014, permanently restricted net assets consist of the following:

	2015	2014
Beneficial interest in trust assets	$ 10,809,693	$ 11,809,221
Endowments restricted for:		
Other departmental purposes	3,554,028	3,553,655
Charity care	532,024	532,024
Special needs	151,579	151,579
Cancer research	6,124	6,124
Total	$ 15,053,448	$ 16,052,603

(Continued)

NOTE 17 - TEMPORARILY AND PERMANENTLY RESTRICTED NET ASSETS (Continued)

The composition of the Network's endowment by net asset class as of September 30, 2015 and 2014, was as follows:

2015	Permanently Restricted	Total
Donor-restricted endowment funds	$ 4,243,755	$ 4,243,755
Net assets, September 30, 2015	$ 4,243,755	$ 4,243,755

2014	Permanently Restricted	Total
Donor-restricted endowment funds	$ 4,243,382	$ 4,243,382
Net assets, September 30, 2014	$ 4,243,382	$ 4,243,382

The Network's endowments consist of multiple funds established for a variety of purposes. The endowments include donor-restricted endowment funds. As required by GAAP, endowments, are classified and reported based on the existence or absence of donor restrictions.

The Network has interpreted the relevant laws as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure by the Network.

The Network considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds: (1) the duration and preservation of the fund; (2) the purposes of the Network and the donor-restricted endowment fund; (3) general economic conditions; (4) the possible effect of inflation and deflation; (5) the expected total return from income and the appreciation of investments; (6) other resources of the Network; and (7) the investment policies of the Network.

The Network has adopted investment and spending policies for endowment assets that attempt to provide a reasonably stable and predictable stream of earnings to support the operations of the endowments and to preserve and enhance over time the real value of the endowment assets. Under this policy, as approved by the Board of Trustees, the endowment assets are invested in a manner that is intended to produce a real return, net of inflation and investment and management costs, over the long-term. Actual returns in any given year may vary from this amount.

The Investment Committee of the Board is responsible for defining and reviewing the investment policy to determine an appropriate long-term asset allocation policy. The asset allocation policy reflects the objective with allocations structured for capital growth and inflation protection over the long-term.

To satisfy its long-term rate-of-return objectives, the Network relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and current yield (interest and dividends). The Network targets a diversified asset allocation that places a greater emphasis on equity based investments to achieve its long-term return objectives within prudent risk constraints.

(Continued)

NOTE 17 - TEMPORARILY AND PERMANENTLY RESTRICTED NET ASSETS (Continued)

The Network has appropriated $14,664 and $107,171 for expenditure from its endowment funds for the years ending September 30, 2015 and 2014, respectively.

Changes in endowment net assets for the fiscal year ended September 30, 2015 were as follows:

2015	Temporarily Restricted	Permanently Restricted	Total
Net assets, October 1, 2014	$ -	$ 4,243,382	$ 4,243,382
Interest income	14,664	-	14,664
Released from restrictions	(14,664)	-	(14,664)
Contributions	-	373	373
Net assets, September 30, 2015	$ -	$ 4,243,755	$ 4,243,755

Changes in endowment net assets for the fiscal year ended September 30, 2014 were as follows:

2014	Temporarily Restricted	Permanently Restricted	Total
Net assets, October 1, 2013	$ -	$ 4,413,548	$ 4,413,548
Interest income	107,171	-	107,171
Released from restrictions	(107,171)	-	(107,171)
Reclassification of donations	-	(170,166)	(170,166)
Net assets, September 30, 2014	$ -	$ 4,243,382	$ 4,243,382

From time to time, the fair value of assets associated with individual donor restricted endowment funds may fall below the level that the donor or relevant law requires the Network to retain as a fund of perpetual duration. In accordance with GAAP, deficiencies of this nature are reported in unrestricted net assets. As of September 30, 2015 and 2014, there were no funds that were below the level required by donor or law.

NOTE 18 - COMMITMENTS AND CONTINGENCIES

The Network is involved in various legal actions arising from its activities. Although the ultimate outcome is not determinable at this time, management, after taking into consideration the advice of legal counsel, believes that the resolution of these pending matters will not have a material adverse effect, individually or in the aggregate, on the consolidated balance sheets or on the related consolidated statements of operations and changes in net assets, or consolidated cash flows of the Network.

The Network and the Network's defined benefit pension plans invest in various investment securities. Investment securities are exposed to various risks such as interest rate, market and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term.

(Continued)

NOTE 19 - STATUTORY CAPITAL AND SURPLUS

CHIC was incorporated in the Cayman Islands on September 15, 2006 and was granted an Unrestricted Class "B" insurance license under the Insurance Law of the Cayman Islands with an effective date of September 26, 2006. As of October 14, 2013, in accordance with Section 4(3)(b) of The Insurance Law, 2010, the company is now classified as a Class B (i) insurer. CHIC is regulated by the Cayman Islands Monetary Authority (CIMA) and related relations, and is obligated to comply with CIMA regulations regarding minimum levels of solvency and liquidity.

Statutory capital and surplus as of September 30, 2015 was $704,717 with a minimum amount required to be maintained by CHIC of $100,000. Distribution of dividends is subject to approval by the Board of Directors. No dividends were declared or paid during the years ended September 30, 2015 and 2014.

ECHN reports all of CHIC's investments as investments held in trust for estimated self-insurance liabilities in the accompanying consolidated balance sheets.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidating Balance Sheet
September 30, 2015

Assets	The Manchester Memorial Hospital	The Rockville General Hospital, Inc.	ECHN ElderCare Services, Inc.	Eliminations	Subtotal Series A Obligated Group	ECHN Community Healthcare Foundation, Inc.	Eliminations	Subtotal Series C, Series D, and Series E Obligated Group
Current assets:								
Cash and cash equivalents	$ 5,266,042	$ 2,130,527	$ 1,540,254	$ -	$ 8,936,823	$ 1,024,794	$ -	$ 9,961,617
Current portion of investments held under bond indentures	646,423	265,258	185,918	-	1,097,599	-	-	1,097,599
Accounts receivable, net	25,143,982	8,279,947	1,509,562	-	34,933,491	-	-	34,933,491
Inventory	4,086,699	1,266,636	33,849	-	5,387,184	-	-	5,387,184
Due from affiliated entities	393,192	14,916	8,037	(17,104)	399,041	26,267	-	425,308
Current portion of estimated settlements due from third-party payers	2,821,878	751,256	-	-	3,573,134	-	-	3,573,134
Prepaid expenses and other current assets	1,678,056	209,439	13,938	-	1,901,433	1,615,865	-	3,517,298
Total current assets	40,036,272	12,917,979	3,291,558	(17,104)	56,228,705	2,666,926	-	58,895,631
Assets whose use is limited, net of current portion:								
Donor restricted investments	1,719,190	1,575,472	-	-	3,294,662	2,169,541	-	5,464,203
Board designated investments	7,922,686	10,951,124	-	-	18,873,810	15,100,474	-	33,974,284
Investments held in trust for estimated self-insurance liabilities	1,429,733	-	-	-	1,429,733	-	-	1,429,733
Beneficial interest in trust assets	8,801,448	2,008,244	-	-	10,809,693	-	-	10,809,693
Investments held under bond indentures	3,488,702	859,367	813,992	-	5,172,061	-	-	5,172,061
Total assets whose use is limited, net of current portion	23,371,760	15,394,207	813,992	-	39,579,959	17,270,015	-	56,849,974
Interest in net assets of ECHN CHF, Inc.	8,751,305	3,664,214	177,536	-	12,593,055	-	(12,593,055)	-
Investments	1,333,656	2,056,658	3,727,919	-	7,118,433	-	-	7,118,433
Investments in joint ventures	4,188,957	3,622,325	-	-	7,809,282	-	-	7,809,282
Property and equipment, net	53,573,130	23,002,822	6,858,867	-	83,434,819	-	-	83,434,819
Other assets:								
Estimated settlements due from third-party payers, net of current portion	-	-	-	-	-	-	-	-
Due from affiliated entities, net of current portion	23,392,434	4,608,276	-	(3,280,506)	24,720,204	-	-	24,720,204
Goodwill and intangible assets, net	-	-	490,830	-	490,830	-	-	490,830
Other assets	1,656,971	936,314	382,232	-	2,975,517	-	-	2,975,517
Total other assets	25,049,405	5,544,590	873,062	(3,280,506)	28,186,551	-	-	28,186,551
Total assets	$ 156,302,485	$ 66,202,995	$ 15,742,934	$ (3,297,610)	$ 234,950,804	$ 19,936,941	$ (12,593,055)	$ 242,294,690

See accompanying independent auditor's report.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidating Balance Sheet (continued)
September 30, 2015

	Eastern CT Medical Professionals Foundation, Inc.	ECHN Corporate Services	ECHN Enterprises, Inc. and Subsidiaries	Visiting Nurse & Health Services of Connecticut Inc.	Eastern Connecticut Health Network, Inc.	Connecticut Healthcare Insurance Company	Eliminations	Total
Assets								
Current assets:								
Cash and cash equivalents	$ 806,142	$ 38,866	$ 43,862	$ 4,188,799	$ 93,135	$ 1,154,408	$ -	$ 16,286,829
Current portion of investments held under bond indentures	-	-	-	-	-	-	-	1,097,599
Accounts receivable, net	1,951,462	709,837	36	3,926,991	79,222	6,460	-	41,607,499
Inventory	40,300	126,325	-		-	-	-	5,553,809
Due from affiliated entities	-	-	-	-	1,070,968	-	(1,496,276)	-
Current portion of estimated settlements due from third-party payers	-	-	-	-	-	-	-	3,573,134
Prepaid expenses and other current assets	410,611	137,477	4,132	142,228	1,758,409	672,936	-	6,653,091
Total current assets	3,208,515	1,012,505	48,030	8,258,018	3,011,734	1,833,804	(1,496,276)	74,771,961
Assets whose use is limited, net of current portion:								
Donor restricted investments	-	-	-	126,038	-	-	-	5,590,241
Board designated investments	-	-	-	2,850,393	-	-	-	36,824,677
Investments held in trust for estimated self-insurance liabilities	-	-	-	-	-	3,848,693	-	5,278,426
Beneficial interest in trust assets	-	-	-	-	-	-	-	10,809,693
Investments held under bond indentures	-	-	-	-	-	-	-	5,172,061
Total assets whose use is limited, net of current portion	-	-	-	2,976,431	-	3,848,693	-	63,675,098
Interest in net assets of ECHN CHF, Inc.	-	-	-	-	4,448,741	-	(4,448,741)	-
Investments	-	-	-	-	794,647	-	(794,647)	7,118,433
Investments in joint ventures	-	-	1,270,517	-	9,111,010	-	-	18,190,809
Property and equipment, net	2,034,427	290,352	1,051,928	1,463,893	-	-	-	88,275,419
Other assets:								
Estimated settlements due from third-party payers, net of current portion	-	-	-	-	-	-	-	-
Due from affiliated entities, net of current portion	-	-	-	-	879,852	-	(25,600,056)	-
Goodwill and intangible assets, net	414,857	132,000	-	-	2,989,140	-	-	4,026,827
Other assets	-	-	-	530,269	624,630	410,683	-	4,541,099
Total other assets	414,857	132,000	-	530,269	4,493,622	410,683	(25,600,056)	8,567,926
Total assets	$ 5,657,799	$ 1,434,857	$ 2,370,475	$ 13,228,611	$ 21,859,754	$ 6,093,180	$ (32,339,720)	$ 260,599,646

See accompanying independent auditor's report.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidating Balance Sheet (continued)
September 30, 2015

Liabilities and Net Assets	The Manchester Memorial Hospital	The Rockville General Hospital, Inc.	ECHN ElderCare Services, Inc.	Eliminations	Subtotal Series A Obligated Group	ECHN Community Healthcare Foundation, Inc.	Eliminations	Subtotal Series C, Series D, and Series E Obligated Group
Current liabilities:								
Accounts payable and accrued expenses	$ 21,650,353	$ 5,623,272	$ 994,567	$ -	$ 28,268,192	$ 34,295	$ -	$ 28,302,487
Line of credit	3,800,000	-	-	-	3,800,000	-	-	3,800,000
Current portion of long-term debt and capital lease obligations	4,792,543	917,356	661,399	-	6,371,298	-	-	6,371,298
Current portion of due to affiliates	-	984,268	17,104	(17,104)	984,268	155,014	-	1,139,282
Current portion of estimated settlements due to third-party payers	1,503,251	1,056,682	273,006	-	2,832,939	-	-	2,832,939
Current portion of accrued pension and other postretirement benefits	157,857	32,332	-	-	190,189	-	-	190,189
Other current liabilities	1,768,051	200,005	482,963	-	2,451,019	-	-	2,451,019
Total current liabilities	33,772,055	8,813,915	2,429,039	(17,104)	44,997,905	189,309	-	45,187,214
Long-term debt and capital lease obligations, net of current portion	49,494,875	22,469,386	7,182,727	-	79,146,990	-	-	79,146,990
Estimated self-insurance liabilities, net of current portion	5,978,271	1,939,861	207,196	-	8,125,328	-	-	8,125,328
Accrued pension and postretirement benefits	48,438,669	13,968,710		-	62,407,379	-	-	62,407,379
Estimated settlements due to third-party payers, net of current portion	-	-	-	-	-	-	-	-
Due to affiliates	3,280,506	-	-	(3,280,506)	-	-	-	-
Other liabilities	332,650	132,211	-	-	464,861	2,850	-	467,711
Total liabilities	141,297,026	47,324,085	9,818,962	(3,297,610)	195,142,463	192,159	-	195,334,622
Net assets:								
Unrestricted	2,829,380	14,969,067	5,919,060	-	23,717,527	2,702,985	-	26,420,512
Temporarily restricted	494,603	537,851	4,912	-	1,037,366	15,474,485	(11,025,743)	5,486,108
Permanently restricted	11,681,476	3,371,972	-	-	15,053,448	1,567,312	(1,567,312)	15,053,448
Total net assets	15,005,459	18,878,910	5,923,972	-	39,808,341	19,744,782	(12,593,055)	46,960,068
Total liabilities and net assets	$ 156,302,485	$ 66,202,995	$ 15,742,934	$ (3,297,610)	$ 234,950,804	$ 19,936,941	$ (12,593,055)	$ 242,294,690

See accompanying independent auditor's report.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidating Balance Sheet (continued)
September 30, 2015

	Eastern CT Medical Professionals Foundation, Inc.	ECHN Corporate Services	ECHN Enterprises, Inc. and Subsidiaries	Visiting Nurse & Health Services of Connecticut Inc.	Eastern Connecticut Health Network, Inc.	Connecticut Healthcare Insurance Company	Eliminations	Total
Liabilities and Net Assets								
Current liabilities:								
Accounts payable and accrued expenses	$ 1,907,476	$ 255,012	$ 11,412	$ 1,443,365	$ 1,432,414	$ 77,365	$ -	$ 33,429,551
Line of credit	-	-	-	-	-	-	-	3,800,000
Current portion of long-term debt and capital lease obligations	27,691	43,029	26,211	-	550,479	-	-	7,018,708
Current portion of due to affiliates	-	-	-	-	-	-	(1,139,282)	-
Current portion of estimated settlements due to third-party payers	93,818	-	-	98,046	-	-	-	3,124,803
Current portion of accrued pension and other postretirement benefits	-	-	-	-	-	-	-	190,189
Other current liabilities	-	-	-	693,421	61,740	928,532	-	4,134,712
Total current liabilities	2,028,985	298,041	37,623	2,234,832	2,044,633	1,005,917	(1,139,282)	51,697,963
Long-term debt and capital lease obligations, net of current portion	169,493	4,430	223,127	-	578,207	-	-	80,122,247
Estimated self-insurance liabilities, net current portion	-	-	-	-	-	4,382,546	(5,311,077)	7,196,797
Accrued pension and postretirement benefits	-	-	-	-	-	-	-	62,407,379
Estimated settlements due to third-party payers, net of current portion	-	-	-	-	-	-	-	-
Due to affiliates	2,941,576	461,779	1,852,916	237,764	15,151,937	-	(20,645,972)	-
Other liabilities	-	-	-	-	-	-	-	467,711
Total liabilities	5,140,054	764,250	2,113,666	2,472,596	17,774,777	5,388,463	(27,096,331)	201,892,097
Net assets:								
Unrestricted	517,745	670,607	256,809	10,629,977	3,761,845	704,717	(794,647)	42,167,565
Temporarily restricted	-	-	-	126,038	323,132	-	(4,448,742)	1,486,536
Permanently restricted	-	-	-	-	-	-	-	15,053,448
Total net assets	517,745	670,607	256,809	10,756,015	4,084,977	704,717	(5,243,389)	58,707,549
Total liabilities and net assets	$ 5,657,799	$ 1,434,857	$ 2,370,475	$ 13,228,611	$ 21,859,754	$ 6,093,180	$ (32,339,720)	$ 260,599,646

See accompanying independent auditor's report.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidating Statement of Operations and Changes in Net Assets
For the Year Ended September 30, 2015

	The Manchester Memorial Hospital	The Rockville General Hospital, Inc.	ECHN ElderCare Services, Inc.	Eliminations	Subtotal Series A Obligated Group	ECHN Community Healthcare Foundation, Inc.	Eliminations	Subtotal Series C, Series D, and Series E Obligated Group
Revenue:								
Patient service revenue, net of contractual allowances and discounts	$ 183,098,753	$ 66,613,109	$ 15,214,035	$ -	$ 264,925,907	$ -	$ -	$ 264,925,907
Provision for bad debts	(6,806,310)	(3,610,528)	(205,175)	-	(10,622,113)	-	-	(10,622,113)
Net patient service revenue less provision for bad debts	176,292,453	63,002,481	15,008,860	-	254,303,794	-	-	254,303,794
Contributions	1,889,272	123,590	3,256	-	2,016,118	-	-	2,016,118
Other revenues	9,478,566	1,650,001	41,326	(145,035)	11,024,858	251,766	(198,848)	11,077,776
EHR initiative payment revenue	428,586	401,800	-	-	830,386	-	-	830,386
Net assets released from restrictions used for operations	590,724	50,382	4,127	-	645,233	25,672	-	670,905
Total revenues	188,679,601	65,228,254	15,057,569	(145,035)	268,820,389	277,438	(198,848)	268,898,979
Expenses:								
Salaries and wages	81,709,452	30,678,558	7,603,846	-	119,991,856	148,988	(106,794)	120,034,050
Fringe benefits	25,569,480	9,699,209	1,995,605	-	37,264,294	16,007	(11,473)	37,268,828
Supplies and other expenses	62,870,889	24,653,758	4,181,597	(145,035)	91,661,209	112,443	(80,581)	91,693,071
Depreciation and amortization	7,116,439	3,138,917	533,693	-	10,789,049	-	-	10,789,049
Interest and financing costs	2,358,063	697,473	345,894	-	3,401,430	-	-	3,401,430
Total expenses	179,724,323	68,867,915	14,660,635	(145,035)	263,107,838	277,438	(198,848)	263,186,428
Income (loss) from operations	8,955,278	(3,639,661)	396,934	-	5,712,551	-	-	5,712,551
Non-operating (losses) gains	(1,638,670)	(546,692)	(24,848)	-	(2,210,210)	-	-	(2,210,210)
Excess of revenues over (under) expenses	$ 7,316,608	$ (4,186,353)	$ 372,086	$ -	$ 3,502,341	$ -	$ -	$ 3,502,341

See accompanying independent auditor's report.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidating Statement of Operations and Changes in Net Assets (continued)
For the Year Ended September 30, 2015

	Eastern CT Medical Professionals Foundation, Inc.	ECHN Corporate Services	ECHN Enterprises, Inc. and Subsidiaries	Visiting Nurse & Health Services of Connecticut Inc.	Eastern Connecticut Health Network, Inc.	Connecticut Healthcare Insurance Company	Eliminations	Total
Revenue:								
Patient service revenue, net of contractual allowances and discounts	$ 18,137,911	$ -	$ -	$ 24,980,576	$ -	$ -	$ -	$ 308,044,394
Provision for bad debts	(217,527)	-	-	(59,649)	-	-	-	(10,899,289)
Net patient service revenue less provision for bad debts	17,920,384	-	-	24,920,927	-	-	-	297,145,105
Contributions	-	-	-	177,916	117,796	-	(117,796)	2,194,034
Other revenues	7,072,058	3,763,736	530,353	310,906	2,565,451	2,747,065	(13,501,852)	14,565,493
EHR initiative payment revenue	-	-	-	-	-	-	-	630,386
Net assets released from restrictions used for operations	1,450	-	-	124,992	35,261	-	-	832,608
Total revenues	24,993,892	3,763,736	530,353	25,534,741	2,718,508	2,747,065	(13,619,648)	315,567,626
Expenses:								
Salaries and wages	17,380,737	2,284,951	-	17,116,920	10,981,787	-	(11,023,981)	156,774,464
Fringe benefits	2,768,935	379,030	-	3,611,828	2,249,685	-	(2,254,222)	44,024,084
Supplies and other expenses	10,493,641	1,046,128	297,669	4,259,708	(12,537,632)	2,972,181	1,458,108	99,682,874
Depreciation and amortization	644,548	115,256	68,528	303,339	46,950	-	(46,950)	11,920,720
Interest and financing costs	12,686	21,994	9,825	-	66,358	-	(66,359)	3,445,934
Total expenses	31,300,547	3,847,359	376,022	25,291,795	807,148	2,972,181	(11,933,404)	315,848,076
Income (loss) from operations	(6,306,655)	(83,623)	154,331	242,946	1,911,360	(225,116)	(1,686,244)	(280,450)
Non-operating (losses) gains	-	-	(25,199)	-	(1,911,360)	-	1,911,359	(2,235,410)
Excess of revenues (under) over expenses	$ (6,306,655)	$ (83,623)	$ 129,132	$ 242,946	$ -	$ (225,116)	$ 225,115	$ (2,515,860)

See accompanying independent auditor's report.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidating Statement of Operations and Changes in Net Assets (continued)
For the Year Ended September 30, 2015

	The Manchester Memorial Hospital	The Rockville General Hospital, Inc.	ECHN ElderCare Services, Inc.	Eliminations	Subtotal Series A Obligated Group	ECHN Community Healthcare Foundation, Inc.	Eliminations	Subtotal Series C, Series D, and Series E Obligated Group
Unrestricted net assets:								
Excess (deficiency) of revenues over expenses	$ 7,316,608	$ (4,186,353)	$ 372,086	$ -	$ 3,502,341	$ -	$ -	$ 3,502,341
Unrealized loss on investments	(83,807)	193	17	-	(83,597)	-	-	(83,597)
Net change in interest rate swap agreement	(49,056)	-	-	-	(49,056)	-	-	(49,056)
Net assets released from restrictions for capital acquisitions	263,258	41,401	4,668	-	309,327	-	-	309,327
Equity transfer to ECHN	(4,405,594)	(1,888,111)	-	-	(6,293,705)	-	-	(6,293,705)
Equity transfer from ECHN	-	-	-	-	-	-	-	-
ECHN Corporate Services transfer	-	-	-	-	-	-	-	-
Transfers (to) from other affiliates, net	146,267	(1,686)	4,915	-	149,496	(162,446)	-	(12,950)
Pension and postretirement related adjustments	(11,702,769)	(3,208,195)	-	-	(14,910,964)	-	-	(14,910,964)
Other	-	-	-	-	-	-	-	-
Change in unrestricted net assets	(8,515,093)	(9,242,751)	381,686	-	(17,376,158)	(162,446)	-	(17,538,604)
Temporarily restricted net assets:								
Contributions	159,368	32,526	(10,979)	-	179,915	2,408,114	(2,115,244)	472,785
Investment income	424	288	-	-	712	1,280	(1,049)	943
Net assets released from restrictions used for operations	(590,724)	(50,382)	(4,127)	-	(645,233)	(657,013)	596,080	(706,166)
Net assets released from restrictions used for capital acquisitions	(263,258)	(41,401)	(4,668)	-	(309,327)	(309,327)	309,327	(309,327)
Transfers (to) from affiliates	215,031	47,777	-	-	262,808	-	(264,258)	(1,450)
Change in temporarily restricted net assets	(480,159)	(11,192)	(19,774)	-	(511,125)	1,443,054	(1,475,144)	(543,215)
Permanently restricted net assets:								
Contributions - beneficial interest trust assets	373	-			373	-		373
Change in beneficial interest in trust assets	(798,079)	(201,449)	-	-	(999,528)	-	-	(999,528)
Change in permanently restricted net assets	(797,706)	(201,449)	-	-	(999,155)	-	-	(999,155)
Change in net assets (deficit)	(9,792,958)	(9,455,392)	361,912	-	(18,886,438)	1,280,608	(1,475,144)	(19,080,974)
Net assets (deficit), beginning of year	24,798,417	28,334,302	5,562,060	-	58,694,779	18,464,174	(11,117,911)	66,041,042
Net assets (deficit), end of year	$ 15,005,459	$ 18,878,910	$ 5,923,972	$ -	$ 39,808,341	$ 19,744,782	$ (12,593,055)	$ 46,960,068

See accompanying independent auditor's report.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidating Statement of Operations and Changes in Net Assets (continued)
For the Year Ended September 30, 2015

	Eastern CT Medical Professionals Foundation, Inc.	ECHN Corporate Services	ECHN Enterprises, Inc. and Subsidiaries	Visiting Nurse & Health Services of Connecticut Inc.	Eastern Connecticut Health Network, Inc.	Connecticut Healthcare Insurance Company	Eliminations	Total
Unrestricted net assets:								
Excess (deficiency) of revenues over expenses	$ (6,306,655)	$ (83,623)	$ 129,132	$ 242,946	$ -	$ (225,116)	$ 225,115	$ (2,515,860)
Unrealized loss on investments	-	-	-	-	-	(127,158)	-	(210,755)
Net change in interest rate swap agreement	-	-	-	-	-	-	-	(49,056)
Net assets released from restrictions for capital acquisitions	-	-	-	-	-	-	-	309,327
Equity transfer to ECHN	-	-	-	-	6,293,705	-	-	-
Equity transfer from ECHN	6,293,705	-	-	-	(6,293,705)	-	-	-
ECHN Corporate Services transfer	-	-	-	-	-	-	-	-
Transfers (to) from other affiliates, net	12,950	-	-	-	-	555,823	(555,823)	-
Pension and postretirement related adjustments	-	-	-	-	-	-	-	(14,910,964)
Other	-	-	-	-	-	-	-	-
Change in unrestricted net assets	-	(83,623)	129,132	242,946	-	203,549	(330,708)	(17,377,308)
Temporarily restricted net assets:								
Contributions	-	-	-	176,225	149,633	-	(267,428)	531,215
Investment income	-	-	-	-	-	-	-	943
Net assets released from restrictions used for operations	(1,450)	-	-	(124,992)	(35,261)	-	35,261	(832,508)
Net assets released from restrictions used for capital acquisitions	-	-	-	-	-	-	-	(309,327)
Transfers (to) from affiliates	1,450	-	-	-	(264,257)	-	264,257	-
Change in temporarily restricted net assets	-	-	-	51,233	(149,885)	-	32,090	(609,777)
Permanently restricted net assets:								
Contributions - beneficial interest trust assets	-	-	-	-	-	-	-	373
Change in beneficial interest in trust assets	-	-	-	-	-	-	-	(999,528)
Change in permanently restricted net assets	-	-	-	-	-	-	-	(999,155)
Change in net assets (deficit)	-	(83,623)	129,132	294,179	(149,885)	203,549	(298,618)	(18,986,240)
Net assets (deficit), beginning of year	517,745	754,230	127,677	10,461,836	4,234,862	501,168	(4,944,771)	77,693,789
Net assets (deficit), end of year	$ 517,745	$ 670,607	$ 256,809	$ 10,756,015	$ 4,084,977	$ 704,717	$ (5,243,389)	$ 58,707,549

See accompanying independent auditor's report.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidating Balance Sheet
September 30, 2014

	The Manchester Memorial Hospital	The Rockville General Hospital, Inc.	ECHN ElderCare Services, Inc.	Eliminations	Subtotal Series A Obligated Group	ECHN Community Healthcare Foundation, Inc.	Eliminations	Subtotal Series C, Series D, and Series E Obligated Group
Assets								
Current assets:								
Cash and cash equivalents	$ 9,361,439	$ 1,772,696	$ 1,363,027	$ -	$ 12,497,162	$ 1,107,266	$ -	$ 13,604,428
Current portion of investments held under bond indentures	653,623	323,965	186,328	-	1,163,916	-	-	1,163,916
Accounts receivable, net	25,099,884	10,900,702	1,681,218	-	37,681,804	-	-	37,681,804
Inventory	3,873,042	1,325,483	38,849	-	5,237,374	-	-	5,237,374
Due from affiliated entities	142,498	65,011	23,158	(78,353)	152,314	8,485	-	160,799
Current portion of estimated settlements due from third-party payers	3,454,150	148,435	-	-	3,602,585	-	-	3,602,585
Prepaid expenses and other current assets	2,357,425	201,349	5,766	-	2,564,542	252,432	-	2,816,974
Total current assets	44,942,061	14,737,641	3,298,346	(78,353)	62,899,697	1,368,183	-	64,267,880
Assets whose use is limited, net of current portion:								
Donor restricted investments	1,778,680	1,575,184	-	-	3,353,864	2,669,078	-	6,022,942
Board designated investments	9,495,379	10,962,908	-	-	20,458,287	14,611,914	-	35,070,201
Investments held in trust for estimated self-insurance liabilities	1,488,787	-	-	-	1,488,787	-	-	1,488,787
Beneficial interest in trust assets	9,599,529	2,209,692	-	-	11,809,221	-	-	11,809,221
Investments held under bond indentures	3,498,353	859,282	813,910	-	5,171,545	-	-	5,171,545
Total assets whose use is limited, net of current portion	25,860,728	15,607,066	813,910	-	42,281,704	17,280,992	-	59,562,696
Interest in net assets of ECHN CHF, Inc	7,323,190	3,599,134	195,587	-	11,117,911	-	(11,117,911)	-
Investments	1,339,234	2,068,819	3,730,288	-	7,138,341	-	-	7,138,341
Investments in joint ventures	3,849,302	3,489,604	-	-	7,338,906	-	-	7,338,906
Property, plant and equipment, net	55,717,642	25,700,876	7,264,624	-	88,683,142	-	-	88,683,142
Other assets:								
Estimated settlements due from third-party payers, net of current portion	685,669	-	-	-	685,669	-	-	685,669
Due from affiliated entities, net of current portion	20,113,458	7,814,717	-	(5,298,863)	22,629,312	-	-	22,629,312
Goodwill and intangible assets, net	-	-	520,156	-	520,156	-	-	520,156
Other assets	1,923,107	1,769,088	456,032	-	4,148,227	-	-	4,148,227
Total other assets	22,722,234	9,583,805	976,188	(5,298,863)	27,983,364	-	-	27,983,364
Total assets	$ 161,754,391	$ 74,786,945	$ 16,278,945	$ (5,377,216)	$ 247,443,065	$ 18,649,175	$ (11,117,911)	$ 254,974,329

See accompanying independent auditor's report.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidating Balance Sheet (continued)
September 30, 2014

	Eastern CT Medical Professionals Foundation, Inc.	ECHN Corporate Services	ECHN Enterprises, Inc. and Subsidiaries	Visiting Nurse & Health Services of Connecticut Inc.	Eastern Connecticut Health Network, Inc.	Connecticut Healthcare Insurance Company	Eliminations	Total
Assets								
Current assets:								
Cash and cash equivalents	$ 192,024	$ 66,259	$ 76,614	$ 4,558,501	$ 162,984	$ 2,072,791	$ -	$ 20,733,601
Current portion of investments held under bond indentures	-	-	-	-	-	-	-	1,163,916
Accounts receivable, net	2,090,600	827,182	36	3,835,448	169,322	5,680	-	44,610,272
Inventory	15,926	183,985	-	-	-	-	-	5,437,285
Due from affiliated entities	-	-	-	-	4,048	-	(164,848)	-
Current portion of estimated settlements due from third-party payers	-	-	-	-	-	-	-	3,692,585
Prepaid expenses and other current assets	405,503	24,503	4,046	232,277	970,358	1,232,575	-	5,686,236
Total current assets	2,704,253	1,101,929	80,696	8,626,226	1,306,713	3,311,046	(164,848)	81,233,895
Assets whose use is limited, net of current portion:								
Donor restricted investments	-	-	-	74,805	-	-	-	6,097,747
Board designated investments	-	-	-	2,910,074	-	-	-	37,960,275
Investments held in trust for estimated self-insurance liabilities	-	-	-	-	-	3,516,968	-	5,005,755
Beneficial interest in trust assets	-	-	-	-	-	-	-	11,809,221
Investments held under bond indentures	-	-	-	-	-	-	-	5,171,545
Total assets whose use is limited, net of current portion	-	-	-	2,984,879	-	3,516,968	-	66,064,543
Interest in net assets of ECHN CHF, Inc.	-	-	-	-	4,480,831	-	(4,480,831)	-
Investments	-	-	-	-	463,940	-	(463,940)	7,138,341
Investments in joint ventures	-	-	1,247,474	-	8,698,445	-	-	17,274,625
Property, plant and equipment, net	2,469,251	366,651	1,120,456	1,426,059	-	-	-	94,085,559
Other assets:								
Estimated settlements due from third-party payers, net of current portion	-	-	-	-	-	-	-	685,669
Due from affiliated entities, net of current portion	-	-	-	-	867,580	-	(23,486,892)	-
Goodwill and intangible assets, net	592,420	153,550	-	-	2,989,140	-	-	4,255,266
Other assets	-	-	-	530,269	134,014	556,581	-	5,369,091
Total other assets	592,420	153,550	-	530,269	3,990,734	556,581	(23,486,892)	10,310,026
Total assets	$ 5,765,924	$ 1,622,130	$ 2,448,626	$ 13,567,433	$ 18,930,663	$ 7,384,595	$ (28,606,511)	$ 276,087,189

See accompanying independent auditor's report.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidating Balance Sheet (continued)
September 30, 2014

Liabilities and Net Assets	The Manchester Memorial Hospital	The Rockville General Hospital, Inc.	ECHN ElderCare Services, Inc.	Eliminations	Subtotal Series A Obligated Group	ECHN Community Healthcare Foundation, Inc.	Eliminations	Subtotal Series C, Series D, and Series E Obligated Group
Current liabilities:								
Accounts payable and accrued expenses	$ 21,842,838	$ 6,181,391	$ 1,055,957	$ -	$ 29,080,186	$ 31,007	$ -	$ 29,111,193
Line of credit	5,600,000	-	-	-	5,600,000	-	-	5,600,000
Current portion of long-term debt and capital lease obligations	4,092,102	946,159	624,756	-	5,662,017	-	-	5,662,017
Current portion of due to affiliates	23,156	-	60,602	(78,353)	5,407	150,797	-	156,204
Current portion of estimated settlements due to third-party payers	4,285,117	1,132,410	248,895	-	5,666,422	-	-	5,666,422
Current portion of accrued pension and other postretirement benefits	162,766	31,003	-	-	193,769	-	-	193,769
Other current liabilities	2,653,756	732,322	391,627	-	3,777,705	-	-	3,777,705
Total current liabilities	38,659,737	9,022,285	2,381,837	(78,353)	49,985,506	181,804	-	50,167,310
Long-term debt and capital lease obligations, net of current portion	50,421,026	23,392,308	7,841,125	-	81,654,459	-	-	81,654,459
Estimated self-insurance liabilities, net of current portion	6,835,215	3,566,892	493,923	-	10,896,030	-	-	10,896,030
Accrued pension and postretirement benefits	35,457,539	10,338,947	-	-	45,796,486	-	-	45,796,486
Estimated settlements due to third-party payers, net of current portion	-	-	-	-	-	-	-	-
Due to affiliates	5,298,863	-	-	(5,298,863)	-	-	-	-
Other liabilities	283,594	132,211	-	-	415,805	3,197	-	419,002
Total liabilities	136,955,974	46,452,643	10,716,885	(5,377,216)	188,748,286	185,001	-	188,933,287
Net assets:								
Unrestricted	11,344,473	24,211,838	5,537,374	-	41,093,685	2,865,431	-	43,959,116
Temporarily restricted	974,762	549,043	24,686	-	1,548,491	14,031,431	(9,550,599)	6,029,323
Permanently restricted	12,479,182	3,573,421	-	-	16,052,603	1,567,312	(1,567,312)	16,052,603
Total net assets	24,798,417	28,334,302	5,562,060	-	58,694,779	18,464,174	(11,117,911)	66,041,042
Total liabilities and net assets	$ 161,754,391	$ 74,786,945	$ 16,278,945	$ (5,377,216)	$ 247,443,065	$ 18,649,175	$ (11,117,911)	$ 254,974,329

See accompanying independent auditor's report.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidating Balance Sheet (continued)
September 30, 2014

	Eastern CT Medical Professionals Foundation, Inc.	ECHN Corporate Services	ECHN Enterprises, Inc. and Subsidiaries	Visiting Nurse & Health Services of Connecticut Inc.	Eastern Connecticut Health Network, Inc.	Connecticut Healthcare Insurance Company	Eliminations	Total
Liabilities and Net Assets								
Current liabilities:								
Accounts payable and accrued expenses	$ 2,145,168	$ 283,874	$ 15,665	$ 2,170,645	$ 2,159,817	$ 78,253	$ -	$ 35,964,615
Line of credit	-	-	-	-	-	-	-	5,600,000
Current portion of long-term debt and capital lease obligations	197,183	58,633	25,279	6,488	711,157	-	-	6,660,757
Current portion of due to affiliates	-	-	-	-	-	-	(156,204)	-
Current portion of estimated settlements due to third-party payers	-	-	-	76,738	-	-	-	5,743,160
Current portion of accrued pension and other postretirement benefits	-	-	-	-	-	-	-	193,769
Other current liabilities	-	-	-	851,726	-	1,212,361	-	5,841,792
Total current liabilities	2,342,351	342,507	40,944	3,105,597	2,870,974	1,290,614	(156,204)	60,004,093
Long-term debt and capital lease obligations, net of current portion	26,082	50,667	249,337	-	443,748	-	-	82,424,313
Estimated self-insurance liabilities, net of current portion	-	-	-	-	-	5,592,813	(6,805,175)	9,683,668
Accrued pension and postretirement benefits	-	-	-	-	-	-	-	45,796,486
Estimated settlements due to third-party payers, net of current portion	65,838	-	-	-	-	-	-	65,838
Due to affiliates	2,813,908	474,706	2,030,668	-	11,381,079	-	(16,700,361)	-
Other liabilities	-	-	-	-	-	-	-	419,002
Total liabilities	5,248,179	867,900	2,320,949	3,105,597	14,695,801	6,883,427	(23,661,740)	198,393,400
Net assets:								
Unrestricted	517,745	754,230	127,677	10,387,031	3,761,845	501,168	(463,939)	59,544,873
Temporarily restricted	-	-	-	74,805	473,017	-	(4,480,832)	2,096,313
Permanently restricted	-	-	-	-	-	-	-	16,052,603
Total net assets	517,745	754,230	127,677	10,461,836	4,234,862	501,168	(4,944,771)	77,693,789
Total liabilities and net assets	$ 5,765,924	$ 1,622,130	$ 2,448,626	$ 13,567,433	$ 18,930,663	$ 7,384,595	$ (28,606,511)	$ 276,087,189

See accompanying independent auditor's report.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidating Statement of Operations and Changes in Net Assets
For the Year Ended September 30, 2014

	The Manchester Memorial Hospital	The Rockville General Hospital, Inc.	ECHN ElderCare Services, Inc.	Eliminations	Subtotal Series A Obligated Group	ECHN Community Healthcare Foundation, Inc.	Eliminations	Subtotal Series B, Series C, and Series D Obligated Group
Revenues:								
Patient service revenue, net of contractual allowances and discounts	$ 178,026,737	$ 71,329,965	$ 15,194,102	$ -	$ 264,550,804	$ -	$ -	$ 264,550,804
Provision for bad debts	(5,822,470)	(2,801,283)	(181,495)	-	(8,805,248)	-	-	(8,805,248)
Net patient service revenue less provision for bad debts	172,204,267	68,528,682	15,012,607	-	255,745,556	-	-	255,745,556
Contributions	496,356	315,697	9,235	-	821,288	-	-	821,288
Other revenues	15,370,698	5,227,522	282,491	(143,096)	20,737,615	548,340	(537,649)	20,748,306
EHR initiative payment revenue	986,834	799,300	-	-	1,786,134	-	-	1,786,134
Net assets released from restrictions used for operations	486,908	49,147	1,794	-	537,849	197,133	-	734,982
Total revenues	189,545,063	74,920,348	15,306,127	(143,096)	279,628,442	745,473	(537,649)	279,836,266
Expenses:								
Salaries and wages	83,606,297	32,460,253	7,495,632	-	123,562,182	300,253	(217,087)	123,645,348
Fringe benefits	25,720,253	9,360,797	1,961,418	-	37,042,468	91,045	(65,731)	37,067,782
Supplies and other expenses	66,276,903	26,367,709	4,016,613	(143,096)	96,518,129	354,175	(254,831)	96,617,473
Depreciation and amortization	7,116,905	3,281,014	557,532	-	10,955,451	-	-	10,955,451
Interest and financing costs	2,589,201	689,882	431,848	-	3,710,931	-	-	3,710,931
Total expenses	185,309,559	72,159,655	14,463,043	(143,096)	271,789,161	745,473	(537,649)	271,996,985
Income (loss) from operations	4,235,504	2,760,693	843,084	-	7,839,281	-	-	7,839,281
Non-operating (losses) gains	(1,743,322)	(378,564)	27,867	-	(2,094,019)	-	-	(2,094,019)
Excess of revenues over (under) expenses	$ 2,492,182	$ 2,382,129	$ 870,951	$ -	$ 5,745,262	$ -	$ -	$ 5,745,262

See accompanying independent auditor's report.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidating Statement of Operations and Changes in Net Assets (continued)
For the Year Ended September 30, 2014

	Eastern CT Medical Professionals Foundation, Inc.	ECHN Corporate Services	ECHN Enterprises, Inc. and Subsidiaries	Visiting Nurse & Health Services of Connecticut Inc.	Eastern Connecticut Health Network, Inc.	Connecticut Healthcare Insurance Company	Eliminations	Total
Revenues:								
Patient service revenue, net of contractual allowances and discounts	$ 20,269,147	$ -	$ -	$ 25,151,359	$ -	$ -	$ -	$ 309,971,310
Provision for bad debts	(1,261,083)	-	-	(149,763)	-	-	-	(10,216,094)
Net patient service revenue less provision for bad debts	19,008,064	-	-	25,001,596	-	-	-	299,755,216
Contributions	-	-	-	342,595	335,662	-	(335,662)	1,163,883
Other revenues	7,661,388	4,207,997	542,446	1,372,276	3,258,466	2,251,542	(14,825,979)	25,216,442
EHR initiative payment revenue	-	-	-	-	-	-	-	1,786,134
Net assets released from restrictions used for operations	-	-	-	86,733	11,935	-	-	833,650
Total revenues	26,669,452	4,207,997	542,446	26,803,200	3,606,063	2,251,542	(15,161,641)	328,755,325
Expenses:								
Salaries and wages	19,262,878	2,414,238	-	17,466,152	10,582,722	-	(10,665,893)	162,727,445
Fringe benefits	2,966,456	376,616	-	3,473,858	2,404,890	-	(2,430,205)	43,859,398
Supplies and other expenses	10,846,227	1,001,633	302,414	4,462,199	(11,783,558)	2,078,542	509,456	104,034,396
Depreciation and amortization	534,455	140,684	69,876	396,409	208,107	-	(208,107)	12,196,877
Interest and financing costs	14,202	26,708	10,745	1,902	85,197	-	(85,197)	3,764,488
Total expenses	33,724,218	3,959,879	383,037	25,822,521	1,497,358	2,078,542	(12,879,936)	326,582,604
Income (loss) from operations	(7,054,766)	248,118	159,409	980,679	2,108,705	173,000	(2,281,705)	2,172,721
Non-operating (losses) gains	-	-	(31,732)	-	(2,108,705)	-	2,108,705	(2,125,751)
Excess of revenues (under) over expenses	$ (7,054,766)	$ 248,118	$ 127,677	$ 980,679	$ -	$ 173,000	$ (173,000)	$ 46,970

See accompanying independent auditor's report.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidating Statement of Operations and Changes in Net Assets (continued)
For the Year Ended September 30, 2014

	The Manchester Memorial Hospital	The Rockville General Hospital, Inc.	ECHN ElderCare Services, Inc.	Eliminations	Subtotal Series A Obligated Group	ECHN Community Healthcare Foundation, Inc.	Eliminations	Subtotal Series B, Series C, and Series D Obligated Group
Unrestricted net assets:								
Excess of revenues (under) over expenses	$ 2,492,182	$ 2,382,129	$ 870,951	$ -	$ 5,745,262	$ -	$ -	$ 5,745,262
Unrealized depreciation on investments	(2,455,986)	(1,808,881)	(113,134)	-	(4,375,981)	-	-	(4,375,981)
Net change in interest rate swap agreement	8,379	-	-	-	8,379	-	-	8,379
Net assets released from restrictions for capital acquisitions	385,647	51,083	-	-	436,730	-	-	436,730
Equity transfer to ECHN	(4,937,674)	(2,116,146)	-	-	(7,053,820)	-	-	(7,053,820)
Equity transfer from ECHN	-	-	-	-	-	-	-	-
ECHN Corporate Services transfer	-	-	-	-	-	-	-	-
Transfers (to) from other affiliates, net	(6,541,891)	(229)	7,130	-	(6,534,990)	273,716	-	(6,261,274)
Pension and postretirement related adjustments	(5,366,133)	(1,072,107)	-	-	(6,438,240)	-	-	(6,438,240)
Other	-	-	-	-	-	-	-	-
Change in unrestricted net assets	(16,415,456)	(2,562,151)	764,947	-	(18,212,660)	273,716	-	(17,938,944)
Temporarily restricted net assets:								
Contributions	44,454	19,798	(33)	-	64,219	1,066,826	(290,398)	840,646
Investment income	321,703	131,269	2,038	-	455,010	2,408,300	(1,663,779)	1,199,531
Net assets released from restrictions used for operations	(486,908)	(49,147)	(1,794)	-	(537,849)	(829,423)	619,265	(748,007)
Net assets released from restrictions used for capital acquisitions	(385,647)	(51,083)	-	-	(436,730)	(436,730)	436,730	(436,730)
Unrealized depreciation on investments	(95,535)	(67,641)	-	-	(163,176)	(1,702,269)	1,044,231	(821,214)
Transfer (to) from affiliates	183,793	4,384	-	-	188,177	-	(187,306)	871
Change in temporarily restricted net assets	(418,140)	(12,420)	211	-	(430,349)	506,703	(41,257)	35,097
Permanently restricted net assets:								
Contributions - beneficial interest trust assets	3,751,750	-			3,751,750	-		3,751,750
Change in beneficial interest in trust assets	148,523	27,520	-	-	176,043	-	-	176,043
Reclassifications of donations	-	(171,110)	-	-	(171,110)	-	-	(171,110)
Change in permanently restricted net assets	3,900,273	(143,590)	-	-	3,756,683	-	-	3,756,683
Change in net assets (deficit)	(12,933,323)	(2,718,161)	765,158	-	(14,886,326)	780,419	(41,257)	(14,147,164)
Net assets (deficit), beginning of year	37,731,740	31,052,463	4,796,902	-	73,581,105	17,683,755	(11,076,654)	80,188,206
Net assets (deficit), end of year	$ 24,798,417	$ 28,334,302	$ 5,562,060	$ -	$ 58,694,779	$ 18,464,174	$ (11,117,911)	$ 66,041,042

See accompanying independent auditor's report.

Eastern Connecticut Health Network, Inc. and Subsidiaries
Consolidating Statement of Operations and Changes in Net Assets (continued)
For the Year Ended September 30, 2014

	Eastern CT Medical Professionals Foundation, Inc.	ECHN Corporate Services	ECHN Enterprises, Inc. and Subsidiaries	Visiting Nurse & Health Services of Connecticut Inc.	Eastern Connecticut Health Network, Inc.	Connecticut Healthcare Insurance Company	Eliminations	Total
Unrestricted net assets:								
Excess of revenues (under) over expenses	$ (7,054,766)	$ 248,118	$ 127,677	$ 980,678	$ -	$ 173,000	$ (173,000)	$ 46,970
Unrealized depreciation on investments	-	-	-	(598,592)	(487,108)	(15,244)	-	(5,476,825)
Net change in interest rate swap agreement	-	-	-	-	-	-	-	8,379
Net assets released from restrictions for capital acquisitions	946	-	-	-	-	-	-	437,676
Equity transfer to ECHN	-	-	-	-	7,053,820	-	-	-
Equity transfer from ECHN	7,053,820	-	-	-	(7,053,820)	-	-	-
ECHN Corporate Services transfer	-	-	-	-	-	-	-	-
Transfers (to) from other affiliates, net	545,436	125,000	84,174	-	8,208,215	1,200,000	(9,901,551)	-
Pension and postretirement related adjustments	-	-	-	-	-	-	-	(6,438,240)
Other	-	1,003	-	-	-	-	82	1,085
Change in unrestricted net assets	545,436	374,121	211,851	382,087	7,721,107	1,357,756	(4,074,469)	(11,421,055)
Temporarily restricted net assets:								
Contributions	-	-	-	74,805	79,003	-	(413,939)	580,515
Investment income	-	-	-	-	73,349	-	(738,941)	533,939
Net assets released from restrictions used for operations	-	-	-	(86,733)	(11,935)	-	13,025	(833,650)
Net assets released from restrictions used for capital acquisitions	(946)	-	-	-	-	-	-	(437,676)
Unrealized depreciation on investments	-	-	-	-	-	-	487,098	(334,116)
Transfer (to) from affiliates	946	-	-	-	(189,123)	-	187,306	-
Change in temporarily restricted net assets	-	-	-	(11,928)	(48,706)	-	(465,451)	(490,988)
Permanently restricted net assets:								
Contributions - beneficial interest trust assets	-	-	-	-	-	-	-	3,751,750
Change in beneficial interest in trust assets	-	-	-	-	-	-	-	176,043
Reclassifications of donations	-	-	-	-	-	-	-	(171,110)
Change in permanently restricted net assets	-	-	-	-	-	-	-	3,756,683
Change in net assets (deficit)	545,436	374,121	211,851	370,159	7,672,401	1,357,756	(4,539,920)	(8,155,360)
Net assets (deficit), beginning of year	(27,691)	380,109	(84,174)	10,091,677	(3,437,539)	(856,588)	(404,851)	85,849,149
Net assets (deficit), end of year	$ 517,745	$ 754,230	$ 127,677	$ 10,461,836	$ 4,234,862	$ 501,168	$ (4,944,771)	$ 77,693,789

See accompanying independent auditor's report.

Schedule 3.08

Recent Activities

[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]

Schedule 3.08(b)

Compensation and Personnel Changes

None.

Schedule 3.08(d)

Sold Assets

[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]

Schedule 3.10

Equipment Depreciation Schedule

[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]

Schedule 3.11

Permitted Personal Property Encumbrances

Clinically Integrated Network of Eastern Connecticut, LLC

None.

Connecticut Healthcare Insurance Co.

None.

ECHN Corporate Services, Inc.

None.

Eastern Connecticut Medical Professionals Foundation, Inc.

None.

A Caring Hand, LLC

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
A Caring Hand, LLC (f/k/a The Manchester Memorial Hospital)	283097 pursuant to Equipment schedule No. 33 to Master Lease Agreement 2084948	UCC-1 Financing	8/15/11	Philips Medical Capital, LLC	All Equipment leased or financed to Secured Party's Contract Number 101010
	2978057	UCC Amendment	1/31/14	Philips Medical Capita, LLC	Amended to UCC Financing Statement 2830978 - Changing name of Debtor to A Caring Hand, LLC
A Caring Hand, LLC	3094494	UCC-1 Financing Statement	12/22/2016	Philips Medical Capital, LLC	Equipment
A Caring Hand, LLC	3139361	UCC-1 Financing Statement	9/2016	Philips Medical Capital, LLC	Equipment

Eastern Connecticut Health Network, Inc.

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
Eastern Connecticut Health Network, Inc.	2628985	UCC-1 Financing Statement	4/17/08	De Lage Landen Financial Services, Inc.	Davinci "S" Surgical Robotic System
	2629113	Office Correct	4/18/08	De Lage Landen Financial Services, Inc.	Office Correction of UCC Statement 2628985 correcting date of original filing
	2920368	UCC Amendment Continuation	2/19/13	De Lage Landen Financial Services, Inc.	Continuation of UCC Statement 2628985
Eastern Connecticut Health Network, Inc.	2636092	UCC-1 Financing Statement	5/23/08	Winthrop Resources Corporation	Equipment Lease
	2919299	UCC Amendment Continuation	2/11/13	Winthrop Resources Corporation	Continuation of UCC Statement 2636092
Eastern Connecticut Health Network, Inc.	2748251	UCC-1 Financing Statement	4/22/10	Winthrop Resources Corporation	Computer Equipment Lease
	3036746	UCC Amendment Continuation	1/20/15	Winthrop Resources Corporation	Continuation of UCC Statement 2748251

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
Eastern Connecticut Health Network, Inc. **[TERMINATED]**	2759123	UCC-1 Financing Statement	6/18/10	CSI Leasing, Inc.	Master Lease
	2843931	UCC Amendment	11/7/11	CSI Leasing, Inc.	Termination of UCC Statement 2759123
Eastern Connecticut Health Network, Inc.	2775479	UCC-1 Financing Statement	9/28/10	CSI Leasing, Inc.	Computer Equipment Lease
Eastern Connecticut Health Network, Inc.	2777858	UCC-1 Financing Statement	10/4/10	Philips Medical Capital, LLC	Computer Equipment Lease
	3065431	UCC Amendment Continuation	7/2/15	Philips Medical Capital, LLC	Continuation of UCC Statement No. 3065431
	3065442	Office Correct	7/7/15	Philips Medical Capital, LLC	Office Correction of UCC Statement 2777858 correcting Continuation filing
Eastern Connecticut Health Network, Inc.	2830413	UCC-1 Financing Statement	8/11/11	De Lage Landen Financial Services, Inc.	Equipment Lease

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
	2837591	UCC Amendment	9/30/11	De Lage Landen Financial Equipment Lease Services, Inc.	Amendment to UCC Statement 2830413 amending name of Debtor from Eastern Connecticut Health Network, Inc. to The Manchester Memorial Hosptial
	2842067	UCC Amendment	10/26/11	De Lage Landen Financial Services, Inc.	Amendment to UCC Statement 2830413 changing name of Debtor from The Manchester Memorial Hospital to Eastern Connecticut Health Network
Eastern Connecticut Health Network, Inc.	2831259	UCC-1 Financing Statement	8/17/11	De Lage Landen Financial Services, Inc.	Equipment
Eastern Connecticut Health Network, Inc.	2842239	UCC-1 Financing Statement	10/26/11	Winthrop Resources Corporation	Computer Equipment Lease
Eastern Connecticut Health Network, Inc.	2864988	UCC-1 Financing Statement	3/15/12	CSI Leasing, Inc.	Equipment Lease
	3097533	UCC Assignment	1/8/16	GE HFS, LLC	Assignment of UCC Statement 2864988 to GE HFS, LLC

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
Eastern Connecticut Health Network, Inc.	2868957	UCC-1 Financing Statement	4/9/12	General Electric Capital Corporation	GE Healthcare GE 9000 Elite System
Eastern Connecticut Health Network, Inc.	2871289	UCC-1 Financing Statement	4/18/12	CSI Leasing, Inc.	Xerox Master Lease
Eastern Connecticut Health Network, Inc.	2883979	UCC-1 Financing Statement	6/26/12	CSI Leasing, Inc.	Equipment Lease
	2913728	UCC Amendment	1/3/13	CSI Leasing, Inc.	Amendment to UCC Statement 2883979 adding collateral information
Eastern Connecticut Health Network, Inc.	2886952	UCC-1 Financing Statement	7/12/12	Winthrop Resources Corporation	Equipment Lease
	2945659	UCC Amendment	6/26/13	Winthrop Resources Corporation	Amendment to UCC Statement 2886952 adding collateral per Lease Agreement # EA112107 Lease Schedule B02
Eastern Connecticut Health Network, Inc.	2897293	UCC-1 Financing Statement	9/21/12	General Electric Capital Corporation	GE Healthcare OEC 9900 Elite Digital C-Arm System

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
	2920529	UCC Amendment	2/20/13	General Electric Capital Corporation	Amendment to UCC Statement 2897293 Deleting The Rockville General Hospital as Debtor
	3096699	UCC Amendment	1/5/16	GE HFS, LLC	Assignment of UCC Statement 2897293 to GE HFS, LLC
	6097549	UCC Amendment	1/7/16	GE HFS, LLC	Assignment of UCC Statement 2897293 to GE HFS, LLC
	6098482	UCC Amendment	1/13/16	GE HFS, LLC	Assignment of UCC Statement 2897293 to GE HFS, LLC
Eastern Connecticut Health Network, Inc.	2897295	UCC-1 Financing Statement	9/21/12	General Electric Capital Corporation	Direct Supply The Black Group Boiler DHW Upgrades Systems
	3097734	UCC Amendment	1/11/2016	GE HFS, LLC	Assignment to GE HFS, LLC
Eastern Connecticut Health Network, Inc.	2908898	UCC-1 Financing Statement	11/30/12	Corporation Service Company, as Representative	Equipment lease as described in the Master Lease Agreement No. 2012284

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
Eastern Connecticut Health Network, Inc.	2911846	UCC-1 Financing Statement	12/19/12	CSI Leasing, Inc.	Equipment, software and personal property leased to Lessee pursuant to Equipment schedule No. 33 to Master Lease Agreement 208494
	2924992	UCC Amendment Assignment	3/19/13	First Bank of Highland Park	Assignment of UCC Statement 2911846
	2925328	UCC Amendment	3/19/13	First Bank of Highland Park	Amendment to UCC Statement 2911846 amending to specify collateral and serial numbers
Eastern Connecticut Health Network, Inc. **[TERMINATED]**	2912119	UCC-1 Financing Statement	12/20/12	Technology Investment Partners, L.L.C.	Master Lease
	2916780	UCC Amendment Termination	1/22/13	Technology Investment Partners, L.L.C.	Termination of UCC Statement 2912119
Eastern Connecticut Health Network, Inc.	2912121	UCC-1 Financing Statement	12/20/12	Technology Investment Partners, L.L.C.	Equipment, etc listed on Schedule no. 001 to Master Lease Agreement dated 12/20./2012

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
	2917225	UCC Amendment	1/24/13	Technology Investment Partners, L.L.C.	Amendment to UCC Statement 2912121 amending name of debtor (correcting spelling)
	2918908	UCC Amendment Assignment	2/6/13	First Independent Bank	Assignment of UCC Statement 2912121 to First Independent Bank
Eastern Connecticut Health Network, Inc. **[TERMINATED]**	2913737	UCC-1 Financing Statement	12/31/12	De Lage Landen Financial Services, Inc.	Equipment
	2939435	UCC Amendment Termination	5/24/13	De Lage Landen Financial Services, Inc.	Termination of UCC Statement 2913737
Eastern Connecticut Health Network, Inc.	2919282	UCC-1 Financing Statement	2/11/13	CSI Leasing, Inc.	Equipment lease as described in Equipment Schedule No. 34 to Master Lease 208494
	2960389	UCC Amendment Assignment	10/8/13	First Bank of Highland Park	Assignment of UCC Statement 2919282 to First Bank of Highland Park

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
	2960823	UCC Amendment	10/8/13	First Bank of Highland Park	Amendment to UCC Statement 2919282 to specify collateral and serial numbers pursuant to Scheudle 34 to Master lease No. 208494
Eastern Connecticut Health Network, Inc.	2921468	UCC-1 Financing Statement	2/26/13	General Electric Capital Corporation	GE Healthcare Muse System
Eastern Connecticut Health Network, Inc.	2939989	UCC-1 Financing Statement	5/29/13	General Electric Capital Corporation	One Iatric Systems IATRIC INTERFACE System
Eastern Connecticut Health Network, Inc.	2940005	UCC-1 Financing Statement	5/29/13	General Electric Capital Corporation	One Dell Computer Corporation Dell PC Upgrades Software and Accessories System
Eastern Connecticut Health Network, Inc.	2940819	UCC-1 Financing Statement	5/30/13	General Electric Capital Corporation	One Softmart SQLSVR LICENSES System
Eastern Connecticut Health Network, Inc.	2945194	UCC-1 Financing Statement	6/25/13	CSI Leasing, Inc.	Equipment Lease (Equipment Schedule No. 35 to Master Lease 208494)

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
	2966818	UCC Amendment Assignment	11/15/13	First Bank of Highland Park	Assignment of UCC Statement 2945194 to First Bank of Highland Park
	2966937	UCC Amendment	11/15/13	CSI Leasing, Inc.	Amendment to UCC Statement 2945194 amending collateral to specify collateral and serial numbers
Eastern Connecticut Health Network, Inc.	2959238	UCC-1 Financing Statement	9/30/13	Olympus America Inc.	Hospital Equipment Lease
Eastern Connecticut Health Network, Inc.	2959239	UCC-1 Financing Statement	9/30/13	Olympus America Inc.	Computer Equipment Lease as described in Master Agreement Number 0008798
Eastern Connecticut Health Network, Inc.	2959240	UCC-1 Financing Statement	9/30/13	Olympus America Inc.	Hospital Equipment Lease described in Quote Number 201475-19
Eastern Connecticut Health Network, Inc.	2961181	UCC-1 Financing Statement	10/11/13	CSI Leasing, Inc.	Equipment Lease (Equipment Schedule No. 36 to Master Lease No. 208494)

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
	3011261	UCC Amendment Assignment	8/20/14	First Bank of Highland Park	Assignment of UCC Statement 2961181 to First Bank of Highland Park
	3011600	UCC Amendment	8/20/14	First Bank of Highland Park	Amendment to UCC Statement 2861181 amending collateral to specify collateral and serial numbers
Eastern Connecticut Health Network, Inc.	2961390	UCC-1 Financing Statement	10/11/13	Winthrop Resources Corporation	Equipment Lease Agreement # EA112107, Lease Schedule # 003X
	2983722	UCC Amendment Assignment	3/13/14	Banc of America Leasing & Capital, LLC	Assignment to Bank of America Leasing & Capital, LLC
Eastern Connecticut Health Network, Inc.	2968854	UCC-1 Financing Statement	12/4/13	Olympus America Inc.	Equipment Lease
Eastern Connecticut Health Network, Inc.	2972504	UCC-1 Financing Statement	12/19/13	Winthrop Resources Corporation	Equipment Lease Agreement # EA112107 Lease Schedule 004X
	2983756	UCC Amendment Assignment	3/13/14	Banc of America Leasing & Capital, LLC	Assignment of UCC Statement 2972504 to Banc of America Leasing & Capital, LLC

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
Eastern Connecticut Health Network, Inc.	2988299	UCC-1 Financing Statement	4/9/14	CSI Leasing, Inc.	Equipment Lease
Eastern Connecticut Health Network, Inc.	2997249	UCC-1 Financing Statement	5/17/14	General Electric Capital Corporation	Equipment Lease
	3097878	UCC Amendment Assignment	1/12/16	GE HFS, LLC	Assignment of UCC Statement 2997249 – GE HFS, LLC
Eastern Connecticut Health Network, Inc.	3003807	UCC-1 Financing Statement	7/2/14	CSI Leasing, Inc.	Equipment Lease Schedule No. 37 to Master Lease 208494
	3036271	UCC Amendment Assignment	1/15/15	First Bank of Highland Park	Assignment to First Bank of Highland Park
	3036483	UCC Amendment	1/15/15	First Bank of Highland Park	Amendment to UCC Statement 3003807 amending collateral to specify collateral and serial numbers
Eastern Connecticut Health Network, Inc.	3005839	UCC-1 Financing Statement	7/16/14	Technology Investment Partners, L.L.C.	Master Equipment Lease

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
	3034832	UCC Amendment Assignment	1/7/15	Crestmark Equipment Finance, Inc.	Assignment of UCC Statement 3005839 to Crestmark Equipment Finance, Inc.
	3034835	UCC Amendment Assignment	1/7/15	MB Financial	Assignment of UCC Statement 3005839 to MB Financial
Eastern Connecticut Health Network, Inc.	3017866	UCC-1 Financing Statement	9/24/14	CSI Leasing, Inc.	Equipment Lease
	3036273	UCC Amendment Assignment	1/15/15	First Bank of Highland Park	Assignment of UCC Statement 3017866 to First Bank of Highland Park
	3036482	UCC Amendment	1/15/15	CSI Leasing	Amendment to UCC Statement 3017866 amending collateral to specify collateral and serial numbers
Eastern Connecticut Health Network, Inc. **[TERMINATED]**	3032062	UCC-1 Financing Statement	12/17/14	CSI Leasing, Inc.	Equipment Lease
	3055591	UCC Amendment Termination	5/14/15	Winthrop Resources Corporation	Termination of UCC Statement 3032062

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
Eastern Connecticut Health Network, Inc.	3032921	UCC-1 Financing Statement	12/19/14	Winthrop Resources Corporation	Equipment Lease
Eastern Connecticut Health Network, Inc.	3034568	UCC-1 Financing Statement	1/6/15	Crestmark Equipment Finance, Inc.	Equipment Lease
Eastern Connecticut Health Network, Inc.	3069621	UCC-1 Financing Statement	7/31/15	CSI Leasing, Inc.	Equipment Lease
	3079088	UCC Amendment	9/28/15	CSI Leasing, Inc.	Amendment to UCC Statement 3069621 adding Collateral
Eastern Connecticut Health Network, Inc.	3074549	UCC-1 Financing Statement	9/2/15	Olympus America Inc.	Equipment Lease
Eastern Connecticut Health Network, Inc.	3086530	UCC-1 Financing Statement	1/3/15	Winthrop Resources Corporation	Equipment Lease
Eastern Connecticut Health Network, Inc.	3096014	UCC-1 Financing Statement	12/31/15	CSI Leasing	Equipment Lease
Eastern Connecticut Health Network, Inc.	3096763	UCC-1 Financing Statement	1/5/16	CSI Leasing	Equipment Lease

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
Eastern Connecticut Health Network, Inc.	3117858	UCC-1 Financing Statement	5/4/16	Intuitive Surgical, Inc.	One (i) daVinci Xi Surgical System single console
Eastern Connecticut Health Network, Inc.	3124053	UCC-1 Financing Statement	6/2/16	Winthrop Resources Corporation	Agreement #EA112107
Eastern Connecticut Health Network, Inc.	3138680	UCC-1 Financing Statement	9/1/16	CSI Leasing	Equipment Lease
Eastern Connecticut Health Network, Inc.	5917030003 Book 4209, Page 167-169	UCC-1 Financing Statement	11/06/14	Crestmark Equipment Finance, Inc. dba TIP Capital	Equipment Lease for Pharmacy Build Out
	5917030003 Book 4223, P. 287-289	UCC Amendment	1/13/15	MB Financial Bank, N.A.	Assignment of UCC Statement to MB Financial Bank, N.A.

ECHN Eldercare Services, Inc.

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
ECHN Eldercare Services, Inc. (f/k/a Tolland County Health Care, Inc.)	1979611	UCC Financing Statement	2/25/00	State Street Bank and Trust Company, as Master Trustee	All collateral and proceeds thereof
	2301592	UCC Amendment	11/22/04	State Street Bank and Trust Company, as Master Trustee	Amendment to UCC Statement 1979611 changing name of Debtor from Tolland County Healthcare, Inc. to ECHN Eldercare Services, Inc.
	2301593	UCC Amendment Assignment	11/22/04	U.S. Bank National Association	Assignment of UCC Statement 1979611 to U.S. Bank National Association
	2301594	UCC Amendment Continuation	11/22/04	U.S. Bank National Association	Continuation of UCC Statement 1979611
	2712759	UCC Amendment Continuation	9/9/09	U.S. Bank National Association	Continuation of UCC Statement 1979611
	3028883	UCC Amendment Continuation	11/25/14	U.S. Bank National Association	Continuation of UCC Statement 1979611
ECHN Eldercare Services, Inc.	2361293	UCC Financing	11/9/05	U.S. Bank National Association, as Master Trustee	Gross Receipts

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
		Statement			
	2759899	UCC Amendment Continuation	6/10/10	U.S. Bank National Association, as Series C Bond Trustee	Continuation of UCC Statement 2361293
	2884715	UCC Amendment	6/28/12	U.S. Bank National Association, as Trustee	Amendment to UCC Statement 2361293 deleting collateral
	3071231	UCC Amendment Continuation	8/11/15	U.S. Bank National Association, as Master Trustee	Continuation of UCC Statement 2361293
ECHN Eldercare Services, Inc.	2695326	UCC Financing Statement	5/19/09	U.S. Bank National Association, as Master Trustee	Gross Receipts
	2884717	UCC Amendment	6/28/12	U.S. Bank National Association, as Master Trustee	Amendment to UCC Statement 2695326 deleting collateral
	2976568	UCC Amendment Continuation	1/21/14	U.S. Bank National Association, as Master Trustee	Continuation of UCC Statement 2695326
ECHN Eldercare Services, Inc.	2695366	UCC Financing Statement	5/15/09	TD Bank, N.A.	Gross Receipts
	2884719	UCC Amendment	6/28/12	TD Bank, N.A.	Amendment to UCC Statement 2695366

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
					deleting collateral
	2974315	UCC Amendment Continuation	1/8/14	TD Bank, N.A.	Continuation of UCC Statement 2695366
ECHN Eldercare Services, Inc.	2790291	UCC Financing Statement	12/21/10	U.S. Bank National Association, as Master Trustee	Gross Receipts
	2884721	UCC Amendmnet	6/28/12	U.S. Bank National Association, as Master Trustee	Amendment to UCC Statement 2790291 deleting collateral
	2068296	UCC Amendment Continuation	7/23/15	U.S. Bank National Association, as Master Trustee	Continuation of UCC Statement 2790291
ECHN Eldercare Services, Inc.	2791048	UCC Financing Statement	12/22/10	TD Bank, N.A.	Gross Receipts
	2884723	UCC Amendmnet	6/28/12	TD Bank, N.A.	Amendment to UCC Statement 2791048 deleting collateral
ECHN Eldercare Services, Inc.	2897295	UCC Financing Statement	9/21/12	General Electric Capital Corporation	One Direct Supply the Blake Group Boiler DHW Upgrades system
	3097734	UCC Amendment	1/11/16	GE HFS, LLC	Assignment of UCC Statement 2897295 to GE

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
		Assignment			HFS, LLC
ECHN Eldercare Services, Inc.	3020870	UCC Financing Statement	10/7/14	TD Bank, N.A.	All Assets

ECHN Enterprises, Inc.

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
ECHN Enterprises, Inc.	2442834	UCC-1 Financing Statement	3/6/07	Rockville Bank	Goods, fixtures, equipment and inventory, except for furniture or equipment utilized in medical practice
	2860904	UCC Amendment Continuation	2/21/12	Rockville Bank	Continuation of UCC Statement 2442834

Haynes Street Property Management, LLC

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
Haynes Street Property Management, LLC	3093962	UCC-1 Financing Statement	12/18/2015	Town of Glastonbury	Furniture, Fixtures & Office/EDP Equipment, Accounts Receivable, Inventory, all other Goods & Chattels 2014 GL

The Manchester Memorial Hospital

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
The Manchester Memorial Hospital	1979610	UCC-1 Financing Statement	2/25/00	State Street Bank and Trust Company as Master Trustee	All receipts, revenues, income and other moneys received by or on behalf of any Obligated Group Member.
	2301595	UCC Amendment Assignment	11/22/04	U.S. Bank, National Association	Assignment of UCC Statement 1979610 to U.S. Bank, National Association
	2301596	UCC Amendment Continuation	11/22/04	U.S. Bank, National Association	Continuation of UCC Statement 1979610
	2712757	UCC Amendment Continuation	9/9/09	U.S. Bank, National Association	Continuation of UCC Statement 1979610
	2884712	UCC Amendment	6/28/12	U.S. Bank, National Association	Amendment to UCC Statement 1979610 deleting collateral
	3028881	UCC Amendment Continuation	11/25/14	U.S. Bank, National Association	Continuation of UCC Statement 1979610

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
The Manchester Memorial Hospital	2361293	UCC-1 Financing Statement	11/9/05	U.S. Bank National Association, as Master Trustee	Gross Receipts
	2759899	UCC Amendment Continuation	6/21/10	U.S. Bank National Association, as Master Trustee	Continuation of UCC Statement 2361293
	2884715	UCC Amendment	6/28/12	U.S. Bank National Association, as Master Trustee	Amendment to UCC Statement 2361293 deleting collateral
	3071231	UCC Amendment Continuation	8/11/15	U.S. Bank National Association, as Master Trustee	Continuation of UCC Statement 2361293
The Manchester Memorial Hospital	2361298	UCC-1 Financing Statement	11/9/05	U.S. Bank National Association, as Series A Bond Trustee	Service Equipment
	2411078	UCC Amendment	8/24/06	U.S. Bank National Association, as Series A Bond Trustee	Amendment to UCC Statement 2361298 deleting collateral
	2414848	UCC Amendment	9/18/06	U.S. Bank National Association	Amendment to UCC Statement 2361298 deleting collateral
	2624608	UCC Amendment	3/25/08	U.S. Bank National Association, as Series A Bond Trustee	Amendment to UCC Statement 2361298 deleting collateral

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
	2695329	UCC Amendment	5/18/09	U.S. Bank National Association, as Series A Bond Trustee	Amendment to UCC Statement 2361298 restating collateral
	2759896	UCC Amendment Continuation	6/21/10	U.S. Bank National Association, as Series A Bond Trustee	Continuation of UCC Statement 2361298
	2884713	UCC Amendment	6/28/12	U.S. Bank National Association, as Trustee	Amendment to UCC Statement 2361298 Deleting Collateral
	3068294	UCC Amendment Continuation	7/23/15	U.S. Bank National Association, as Series A Bond Trustee	Continuation of UCC Statement 2361298
The Manchester Memorial Hospital **[TERMINATED]**	2361303	UCC-1 Financing Statement	11/9/05	U.S. Bank National Association, as Series B Bond Trustee	Service Equipment
	2411077	UCC Amendment	8/24/06	U.S. Bank National Association, as Series B Bond Trustee	Amendment to UCC Statement 2361303 Deleting Collateral
	2414849	UCC Amendment	9/18/06	U.S. Bank National Association, as Series B Bond Trustee	Amendment to UCC Statement 2361303 Deleting Collateral
	2624610	UCC Amendment	3/25/08	U.S. Bank National Association, as Series B Bond Trustee	Amendment to UCC Statement 2361303 Deleting Collateral

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
	2695331	UCC Amendment	5/18/09	U.S. Bank National Association, as Series B Bond Trustee	Amendment to UCC Statement 2361303 Deleting Collateral
	2759897	UCC Amendment	6/21/10	U.S. Bank National Association, as Series B Bond Trustee	Amendment to UCC Statement 2361303
	2791064	UCC Amendment Termination	12/22/10	U.S. Bank National Association, as Series B Bond Trustee	Termination of UCC Statement 2361303
The Manchester Memorial Hospital	2361309	UCC-1 Financing Statement	11/9/05	U.S. Bank National Association	Service Equipment
	2411079	UCC Amendment	8/24/06	U.S. Bank National Association, as Series C Bond Trustee	Amendment to UCC Statement 2361309 Deleting collateral
	2414850	UCC Amendment	9/18/06	U.S. Bank National Association, as Series C Bond Trustee	Amendment to UCC Statement 2361309 deleting collateral
	2624613	UCC Amendment	3/25/08	U.S. Bank National Association, as Series C Bond Trustee	Amendment to UCC Statement 2361309 Deleting Collateral
	2695333	UCC Amendment	5/18/09	U.S. Bank National Association, as Series C Bond Trustee	Amendment to UCC Statement 2361309 Restating Collateral

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
	2759900	UCC Amendment Continuation	6/21/10	U.S. Bank National Association, as Series C Bond Trustee	Continuation of UCC Statement 2361309
	2884716	UCC Amendment	6/28/12	U.S. Bank National Association, as Trustee	Amendment to UCC Statement 2361309 – Deleting Collateral
	3071230	UCC Amendment Continuation	8/11/15	U.S. Bank National Association, as Series C Bond Trustee	Continuation of UCC Statement 2361309
The Manchester Memorial Hospital	2365603	UCC-1 Financing Statement	12/7/05	Siemens Financial Services, Inc.	Equipment
	2393479	UCC Amendment	5/15/06	Siemens Financial Services, Inc.	Amendment to UCC Statement 2365603 Amending Debtors Address
	2774210	UCC Amendment Continuation	9/21/10	Siemens Financial Services, Inc.	Continuation of UCC Statement 2365603
	3071941	UCC Amendment Continuation	8/11/15	Siemens Financial Services, Inc.	Continuation of UCC Statement 2365603
The Manchester Memorial Hospital	2365605	UCC-1 Financing Statement	12/7/05	Siemens Financial Services, Inc.	Equipment

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
	2370903	UCC Amendment	1/10/06	Siemens Financial Services, Inc.	Amendment to UCC Statement 2365605 Amending Debtors Address
	2384256	UCC Amendment	3/29/06	Siemens Financial Services, Inc.	Amendment to UCC Statement 2365605 Restating Collateral
	2774208	UCC Amendment Continuation	9/21/10	Siemens Financial Services, Inc.	Continuation of UCC Statement 2365605
	3070860	UCC Amendment Continuation	8/10/15	Siemens Financial Services, Inc.	Continuation of UCC Statement 2365605
The Manchester Memorial Hospital **[TERMINATED]**	2366260	UCC-1 Financing Statement	12/12/05	Siemens Financial Services, Inc.	Equipment
	2369620	UCC Amendment	12/30/05	Siemens Financial Services, Inc.	Amendment to UCC Statement 2366260
	2774209	UCC Amendment Continuation	9/21/10	Siemens Financial Services, Inc.	Continuation of UCC Statement 2366260
	3071661	UCC Amendment Continuation	8/14/15	Siemens Financial Services, Inc.	Continuation of UCC Statement 2366260

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
	3071781	UCC Amendment Termination	8/14/15	Siemens Financial Services, Inc.	Termination of UCC Statement 2366260
The Manchester Memorial Hospital	2628913	UCC-1 Financing Statement	4/17/08	Cardinal Health 200, Inc.	Equipment
	2916968	UCC Amendment Continuation	1/23/13	Cardinal Health 200, Inc.	Continuation of UCC Statement 2628913
The Manchester Memorial Hospital	2636148	UCC-1 Financing Statement	5/23/08	Winthrop Resources Corporation	Equipment Lease
	2919300	UCC Amendment Continuation	2/11/13	Winthrop Resources Corporation	Continuation of UCC Statement 2636148
The Manchester Memorial Hospital	2671504	UCC-1 Financing Statement	12/19/08	Cardinal Health 200, Inc.	Equipment
	2959844	UCC Amendment Continuation	09/30/13	Cardinal Health 200, Inc.	Continuation of UCC Statement 2671504
The Manchester Memorial Hospital	2695326	UCC-1 Financing Statement	5/18/09	U.S. Bank National Association, as Master Trustee	Gross Receipts

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
	2884717	UCC Amendment	6/28/12	U.S. Bank National Association, as Trustee	Amendment to UCC Statement 2695326 Deleting Collateral
	2976568	UCC Amendment Continuation	1/21/14	U.S. Bank National Association, as Master Trustee	Continuation of UCC Statement 2695326
The Manchester Memorial Hospital	2695328	UCC-1 Financing Statement	5/18/09	U.S. Bank National Association, as Series D Bond Trustee	Service Equipment
	2884718	UCC Amendment	6/28/12	U.S. Bank National Association	Amendment to UCC Statement 2695328 Deleting Collateral
	2976569	UCC Amendment Continuation	1/21/14	U.S. Bank National Association, as Master Trustee	Continuation of UCC Statement 2695328
The Manchester Memorial Hospital	2695366	UCC-1 Financing Statement	5/15/09	TD Bank, N.A.	Gross Receipts
	2884719	UCC Amendment	6/28/12	TD Bank, N.A.	Amendment to UCC Statement 2695366 deleting collateral
	2974315	UCC Amendment Continuation	1/8/14	TD Bank, N.A.	Continuation of UCC Statement 2695366

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
The Manchester Memorial Hospital	2695367	UCC-1 Financing Statement	5/15/09	TD Bank, N.A.	Service Equipment
	2884720	UCC Amendment	6/28/12	TD Bank, N.A.	Amendment to UCC Statement 2695367 deleting collateral
	2974314	UCC Amendment Continuation	1/8/14	TD Bank, N.A.	Continuation of UCC Statement 2695367
The Manchester Memorial Hospital	2748250	UCC-1 Financing Statement	4/22/10	Winthrop Resources Corporation	Equipment Lease Agreement
	3036747	UCC Amendment Continuation	1/20/15	Winthrop Resources Corporation	Continuation of UCC Statement 2748250
The Manchester Memorial Hospital	2790291	UCC-1 Financing Statement	12/21/10	U.S. Bank National Association, as Master Trustee	Gross Receipts
	2884721	UCC Amendment	6/28/12	U.S. Bank National Association, as Master Trustee	Amendment to UCC Statement 2790291 deleting collateral
	3068296	UCC Amendment Continuation	7/23/15	U.S. Bank National Association, as Master Trustee	Continuation of UCC Statement 2790291

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
The Manchester Memorial Hospital	2790292	UCC-1 Financing Statement	12/21/10	U.S. Bank National Association, as Series E Bond Trustee	Service Equipment
	2884722	UCC Amendment	6/28/12	U.S. Bank National Association, as Trustee	Amendment to UCC Statement 2790292 Deleting Collateral
	3068297	UCC Amendment Continuation	7/23/15	U.S. Bank National Association, as Series E Bond Trustee	Continuation of UCC Statement 2790292
Manchester Memorial Hospital **[TERMINATED]**	2793757	UCC-1 Financing Statement	1/13/11	Toshiba America Medical Systems, Inc.	Equipment
	2890178	UCC Amendment Termination	8/1/12	Toshiba America Medical Systems, Inc.	Termination of UCC Statement 2793757
The Manchester Memorial Hospital	2816756	UCC-1 Financing Statement	5/23/11	Siemens Financial Services, Inc.	Equipment Lease
	2817250	UCC Amendment	5/25/11	Siemens Financial Services, Inc.	Amendment to UCC Statement 2816756 changing address of Debtor
	3099574	UCC Amendment Continuation	1/25/16	Siemens Financial Services, Inc.	Continuation of UCC Statement 2816756

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
The Manchester Memorial Hospital	2816883	UCC-1 Financing Statement	5/23/11	Siemens Financial Services, Inc.	Equipment Lease
	3099575	UCC Amendment Continuation	1/25/16	Siemens Financial Services, Inc.	Continuation of UCC Statement 2816883
The Manchester Memorial Hospital	2816885	UCC-1 Financing Statement	5/23/11	Siemens Financial Services, Inc.	Equipment Lease
	3099576	UCC Amendment Continuation	1/25/16	Siemens Financial Services, Inc.	Continuation of UCC Statement 2816885
The Manchester Memorial Hospital	2817010	UCC-1 Financing Statement	5/24/11	Siemens Financial Services, Inc.	Equipment Lease
	3099699	UCC Amendment Continuation	1/26/16	Siemens Financial Services, Inc.	Continuation of UCC Statement 2817010
The Manchester Memorial Hospital	2817015	UCC-1 Financing Statement	5/24/11	Siemens Financial Services, Inc.	Equipment Lease
	3099698	UCC Amendment Continuation	1/26/16	Siemens Financial Services, Inc.	Continuation of UCC Statement 2817015

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
The Manchester Memorial Hospital	2817106	UCC-1 Financing Statement	5/25/11	Siemens Financial Services, Inc.	Equipment Lease
	3099905	UCC Amendment Continuation	1/27/16	Siemens Financial Services, Inc.	Continuation of UCC Statement 2817106
The Manchester Memorial Hospital	2817175	UCC-1 Financing Statement	5/25/11	Siemens Financial Services, Inc.	Equipment Lease
	3099907	UCC Amendment Continuation	1/27/16	Siemens Financial Services, Inc.	Continuation of UCC Statement 2817175
The Manchester Memorial Hospital	2817176	UCC-1 Financing Statement	5/25/11	Siemens Financial Services, Inc.	Equipment Lease
	3099906	UCC Amendment Continuation	1/27/16	Siemens Financial Services, Inc.	Continuation of UCC Statement 2817176
The Manchester Memorial Hospital	2830413	UCC-1 Financing Statement	8/11/11	De Lage Landen Financial Services, Inc.	Equipment

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
	2837591	UCC Amendment	9/30/11	De Lage Landen Financial Services, Inc.	Amendment to UCC Statement 2830413 Amending name of Debtor from Eastern Connecticut Health Network to The Manchester Memorial Hospital
	2842067	UCC Amendment	10/26/11		Amendment to UCC Statement 2830413 changing name of Debtor from The Manchester Memorial Hospital to Eastern Connecticut Health Network
The Manchester Memorial Hospital	2830978	UCC-1 Financing Statement	8/15/11	Sovereign Bank, National Association	Equipment
	2978057	UCC Amendment	1/31/14	Philips Medical Capital, LLC	Amendment to UCC Statement 2830978 changing name of Debtor to A Caring Hand, LLC
The Manchester Memorial Hospital	2846408	UCC-1 Financing Statement	11/22/11	Siemens Financial Services, Inc.	Equipment Lease
The Manchester Memorial Hospital	2865170	UCC-1 Financing Statement	3/16/12	Siemens Financial Services, Inc.	Equipment

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
The Manchester Memorial Hospital	2883103	UCC-1 Financing Statement	6/18/12	Siemens Financial Services, Inc.	Equipment Lease
The Manchester Memorial Hospital	2885198	UCC-1 Financing Statement	6/29/12	Sovereign Bank, National Association	Master Financing
The Manchester Memorial Hospital	2885201	UCC-1 Financing Statement	6/29/12	Sovereign Bank, National Association	Master Financing
The Manchester Memorial Hospital	2896985	UCC-1 Financing Statement	9/19/12	Siemens Financial Services, Inc.	Equipment Lease
The Manchester Memorial Hospital	2901978	UCC-1 Financing Statement	10/15/12	Siemens Financial Services, Inc.	Equipment Lease
The Manchester Memorial Hospital	2908898	UCC-1 Financing Statement	11/30/12	Corporation Service Company, as Representative	Master Equipment Lease
The Manchester Memorial Hospital	2912275	UCC-1 Financing Statement	12/21/12	General Electric Capital Corporation	GE Helathcare OEC 9900 Digital C-Arm
	3096701	UCC Amendment Assignment	1/5/16	GE HFS, LLC	Assignment of UCC Statement 2912275 to GE HFS, LLC

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
The Manchester Memorial Hospital	2919901	UCC-1 Financing Statement	2/13/13	Winthrop Resources Corporation	Equipment Lease
The Manchester Memorial Hospital	2933828	UCC-1 Financing Statement	4/30/13	Rockville Bank	Inventory, Chattel Paper, Accounts, Equipment and General Intangibles
The Manchester Memorial Hospital	2956249	UCC-1 Financing Statement	9/9/13	Siemens Financial Services, Inc.	Equipment Lease
The Manchester Memorial Hospital	2961388	UCC-1 Financing Statement	10/11/13	Winthrop Resources Corporation	Equipment Lease
	2983727	UCC Amendment Assignment	3/13/14	Banc of America Leasing & Capital, LLC	Assignment of UCC Statement 2961388 to Banc of America Leasing & Capital, LLC
The Manchester Memorial Hospital	2961555	UCC-1 Financing Statement	10/15/13	Siemens Financial Services, Inc.	Equipment Lease
The Manchester Memorial Hospital	2972503	UCC-1 Financing Statement	12/19/13	Winthrop Resources Corporation	Equipment Lease

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
	2984186	UCC Amendment Assignment	3/17/14	Banc of America Leasing & Capital, LLC	Assignment of UCC Statement 2972503 to Banc of America Leasing & Capital, LLC
The Manchester Memorial Hospital	2976605	UCC-1 Financing Statement	1/21/14	Philips Medical Capital, LLC	Equipment
The Manchester Memorial Hospital	2976606	UCC-1 Financing Statement	1/21/14	Philips Medical Capital, LLC	Equipment
The Manchester Memorial Hospital	2980004	UCC-1 Financing Statement	2/14/14	Philips Medical Capital, LLC	Equipment
The Manchester Memorial Hospital	2997249	UCC-1 Financing Statement	5/27/14	General Electric Capital Corporation	Six (6) Soma Technology Skytron 6701 Electro-Hydraulik Table Standard Systems
	3097878	UCC Amendment Assignment	1/12/16	GE HFS, LLC	Assignment of UCC Statement 3097878 to GE HFS, LLC
The Manchester Memorial Hospital	3017218	UCC-1 Financing Statement	9/23/14	Crestmark Equipment Finance, Inc. Technology Investment Partners, L.L.C.	Equipment Lease

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
The Manchester Memorial Hospital	3020870	UCC-1 Financing Statement	10/7/14	TD Bank, N.A.	All Assets
The Manchester Memorial Hospital	3032898	UCC-1 Financing Statement	12/19/14	Winthrop Resources Corporation	Equipment Lease
The Manchester Memorial Hospital	3042207	UCC-1 Financing Statement	2/27/15	Siemens Financial Services, Inc.	Equipment Lease
The Manchester Memorial Hospital	3049908	UCC-1 Financing Statement	4/17/15	MB Financial Bank, N.A.	Equipment Lease
	3072272	UCC Amendment	8/18/15	MB Financial Bank, N.A.	Amendment to UCC Statement 3049908 restating collateral
	3073210	UCC Amendment	8/21/15	MB Financial Bank, N.A.	Amendment to UCC Statement 3049908 restating collateral
The Manchester Memorial Hospital	3049909	UCC-1 Financing Statement	4/17/15	MB Financial Bank, N.A.	Equipment Lease

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
	3052267	UCC Amendment	4/29/15	MB Financial Bank, N.A.	Amendment to UCC Statement 3049909 adding Debtor (The Rockville General Hospital, Incorporated)
	3093430	UCC Amendment	12/10/15	MB Financial Bank, N.A.	Amendment to UCC Statement 3049909 amending collateral to include detailed equipment description and serial numbers
The Manchester Memorial Hospital	3056251	UCC-1 Financing Statement	5/19/15	MB Financial Bank, N.A.	Equipment Lease
	3088886	UCC Amendment	11/17/15	MB Financial Bank, N.A.	Amendment to UCC Statement 3056251 amending collateral to include detailed equipment description and serial numbers
The Manchester Memorial Hospital	3070451	UCC-1 Financing Statement	8/5/15	Stryker Finance, A Division of Stryker Sales Corporation	Equipment Lease
The Manchester Memorial Hospital	3071631	UCC-1 Financing Statement	8/11/15	Roche Diagnostics Corporation	Equipment Lease

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
The Manchester Memorial Hospital	3084003	UCC-1 Financing Statement	10/19/15	MB Financial Bank, N.A.	Leased Property (Lease Schedule No. 3556A04 to Master Lease No. PML-3557A)
	3095846	UCC Amendment	12/30/15	MB Financial Bank, N.A	Amendment to UCC Statement 3084003 amending collateral to include detailed equipment description and serial numbers
The Manchester Memorial Hospital	3086531	UCC-1 Financing Statement	11/3/15	Winthrop Resources Corporation	Lease Agreement #EA112107 Lease Schedule #D01
The Manchester Memorial Hospital	3098683	UCC-1 Financing Statement	1/14/16	MB Financial Bank, N.A	Leased Property (Lease Schedule No. 3557A04 to Master Lease No. PML-3557A)
	3113324	UCC Amendment	4/11/16	MB Financial Bank, N.A	Amendment to UCC Statement 3098683 amending collateral to include detailed equipment description and serial numbers

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
	3115920	UCC Amendment	4/22/16	MB Financial Bank, N.A	Amendment to UCC Statement 3098683 amending collateral to include detailed equipment description and serial numbers
The Manchester Memorial Hospital	3114131	UCC-1 Financing Statement	4/13/16	MB Financial Bank, N.A	Leased Property (Lease Schedule No. 3557A06 to Master Lease No. PML-3557A)
	3124093	UCC Amendment	6/2/16	MB Financial Bank, N.A	Amendment to UCC Statement 3114131 amending collateral to include detailed equipment description and serial numbers
The Manchester Memorial Hospital	3124051	UCC-1 Financing Statement	6/2/16	Wintrhop Resources Corporation	Lease Agreement # EA112107 Schedule # D02
The Manchester Memorial Hospital	2896150	UCC-1 Financing Statement	9/13/12	Winthrop Resources Corporation	Equipment

Medical Practice Partners LLC

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
Medical Practice Partners, LLC	2745233	UCC Financing Statement	4/7/10	Rockville Bank	All Inventory, Chattel Paper, Accounts, Equipment and General Intangibles
	3045959	UCC Amendment	3/30/15	United Bank	Amendment to UCC Statement 2745233 changing name of Secured Party to United Bank
	3046047	UCC Amendment Continuation	3/30/15	United Bank	Continuation of UCC Statement 2745233
Medical Practice Partners, LLC **[TERMINATED]**	2751640	UCC Financing Statement	5/11/10	Rockville Bank	All Inventory, Chattel Paper, Accounts, Equipment and General Intangibles
	2938094	UCC Amendment Termination	5/14/13	Rockville Bank	Termination of UCC Statement 2751640
	3052464	UCC Amendment	4/30/15	United Bank	Amendment of UCC Statement 2751640 changing name of Secured Party to United Bank

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
	3052544	UCC Amendment Continuation	4/30/15	United Bank	Continuation of of UCC Statement 2751640
Medical Practice Partners, LLC	2803997	UCC Financing Statement	3/22/11	Rockville Bank	All Inventory, Chattel Paper, Accounts, Equipment and General Intangibles
	3103180	UCC Amendment	2/18/16	United Bank	Amendment to UCC Statement 2803997 changing name of Secured Party to United Bank
	3103219	UCC Continuation	2/18/16	United Bank	Continuation of UCC Statement 2803997
Medical Practice Partners, LLC	2861158	UCC Financing Statement	2/21/12	CIT Finance LLC	True Lease - Xerox Copiers
Medical Practice Partners, LLC	2944632	UCC Financing Statement	6/21/13	Susquehanna Commercial Finance, Inc. and assignor, Baytree National Bank & Trust Company	Kaseya Perpetual P-ONP-K-2-ESP Essentials for Service Providers including Kaeya Success Track 1 Services
Medical Practice Partners, LLC	2971340	UCC Financing Statement	12/17/13	Var Resources, Inc.	Equipment

The Rockville General Hospital, Incorporated

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
Rockville General Hospital, Incorporated	1979612	UCC-1 Financing Statement	2/25/00	State Street Bank and Trust Company as Master Trustee	All collateral and proceeds thereof
	2301598	UCC Amendment Continuation	11/22/04	State Street Bank and Trust Company as Master Trustee	Continuation of UCC Statement 1979612
	2301597	UCC Amendment	11/22/04	U.S. Bank, National Association	Amendment to UCC Statement 1979612 changing name of Secured Party to U.S. Bank, National Association
	2712889	UCC Amendment Continuation	9/10/09	U.S. Bank, National Association	Continuation of UCC Statement 1979612
	3028884	UCC Amendment Continuation	11/25/14	U.S. Bank, National Association	Continuation of UCC statement 1979612
The Rockville General Hospital, Incorporated	2361293	UCC-1 Financing Statement	11/9/05	U.S. Bank National Association, as Trustee	Gross Receipts

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
	2759899	UCC Amendment Continuation	6/21/10	U.S. Bank National Association, as Trustee	Continuation of UCC Statement 2361293
	2884715	UCC Amendment	6/28/12	U.S. Bank National Association, as Trustee	Amendment to UCC Statement 2361293 Deleting Collateral
	3071231	UCC Amendment Continuation	8/11/15	U.S. Bank National Association, as Trustee	Continuation of UCC Statement 2361293
The Rockville General Hospital, Incorporated	2361298	UCC-1 Financing Statement	11/9/05	U.S. Bank National Association, as Series A Bond Trustee	Service Equipment
	2411078	UCC Amendment	8/24/06	U.S. Bank National Association, as Trustee	Amendment to UCC Statement 2361298 deleting collateral
	2414848	UCC Amendment	9/18/06	U.S. Bank National Association, as Trustee	Amendment to UCC Statement 2361298 deleting collateral
	2624608	UCC Amendment	3/25/08	U.S. Bank National Association, as Trustee	Amendment to UCC Statement 2361298 deleting collateral
	2695329	UCC Amendment	5/18/09	U.S. Bank National Association, as Trustee	Amendment to UCC Statement 2361298 restating collateral

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
	2759896	UCC Amendment Continuation	6/21/10	U.S. Bank National Association, as Trustee	Continuation of UCC Statement 2361298
	2884713	UCC Amendment	6/28/12	U.S. Bank National Association, as Trustee	Amendment to UCC Statement 2361298 Deleting Collateral
	3068294	UCC Amendment Continuation	7/23/15	U.S. Bank National Association, as Series A Bond Trustee	Continuation of UCC Statement 2361298
The Rockville General Hospital, Incorporated **[TERMINATED]**	2361303	UCC-1 Financing Statement	11/9/05	U.S. Bank National Association, as Series B Bond Trustee	Service Equipment
	2411077	UCC Amendment	8/24/06	U.S. Bank National Association, as Series B Bond Trustee	Amendment to UCC Statement 2361303 Deleting Collateral
	2414849	UCC Amendment	9/18/06	U.S. Bank National Association, as Series B Bond Trustee	Amendment to UCC Statement 2361303 Deleting Collateral
	2624610	UCC Amendment	3/25/08	U.S. Bank National Association, as Series B Bond Trustee	Amendment to UCC Statement 2361303 Deleting Collateral
	2695331	UCC Amendment	5/18/09	U.S. Bank National Association, as Series B Bond Trustee	Amendment to UCC Statement 2361303 Deleting Collateral

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
	2759897	UCC Continuation	6/21/10	U.S. Bank National Association, as Series B Bond Trustee	Continuation of UCC Statement 23611303
	2791064	UCC Amendment Termination	12/21/10	U.S. Bank National Association, as Series B Bond Trustee	Termination of UCC Statement 23611303
The Rockville General Hospital, Incorporated	2361309	UCC-1 Financing Statement	11/9/05	U.S. Bank National Association, as Series C Bond Trustee	Service Equipment
	2411079	UCC Amendment	8/24/06	U.S. Bank National Association	Amendment to UCC Statement 2361309 Deleting Collateral
	2414850	UCC Amendment	9/18/06	U.S. Bank National Association, as Series C Bond Trustee	Amendment to UCC Statement 2361309 Deleting Collateral
	2624613	UCC Amendment	3/25/08	U.S. Bank National Association, as Series C Bond Trustee	Amendment to UCC Statement 2361309 Deleting Collateral
	2695333	UCC Amendment	5/18/09	U.S. Bank National Association, as Series C Bond Trustee	Amendment to UCC Statement 2361309 restating collateral
	2759900	UCC Amendment Continuation	7/21/10	U.S. Bank National Association, as Series C Bond Trustee	Continuation of UCC Statement 2361309

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
	2884716	UCC Amendment	6/28/12	U.S. Bank National Association, as Trustee	Amendment to UCC Statmeent 2361309 – Deleting Collateral
	3071230	UCC Amendment Continuation	8/11/15	U.S. Bank National Association, as Series C Bond Trustee	Continuation of UCC Statement 2361309
The Rockville General Hospital, Incorporated	2365603	UCC-1 Financing Statement	12/7/05	Siemens Financial Services, Inc.	Equipment Lease
	2393479	UCC Amendment	5/15/06	Siemens Financial Services, Inc.	Amendment to UCC Statement 2365603 amending Debtor's address
	2774210	UCC Amendment Continuation	9/21/10	Siemens Financial Services, Inc.	Continuation of UCC Statement 2365603
	3071941	UCC Amendment Continuation	8/11/15	Siemens Financial Services, Inc.	Continuation of UCC Statement 2365603
The Rockville General Hospital, Incorporated	2365605	UCC-1 Financing Statement	12/7/05	Siemens Financial Services, Inc.	Equipment Lease

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
	2370903	UCC Amendment	1/10/06	Siemens Financial Services, Inc.	Amendment to UCC Statement 2365605 amending Debtor's Address
	2384256	UCC Amendment	3/29/06	Siemens Financial Services, Inc.	Amendment to UCC Statement 2365605 restating collateral
	2774208	UCC Amendment Continuation	9/21/10	Siemens Financial Services, Inc.	Continuation of UCC Statement 2365605
	3070860	UCC Amendment Continuation	8/10/15	Siemens Financial Services, Inc.	Continuation of UCC Statement 2365605
The Rockville General Hospital, Incorporated **[TERMINATED]**	2366260	UCC-1 Financing Statement	12/12/05	Siemens Financial Services, Inc.	Equipment Lease
	2369620	UCC Amendment	12/30/05	Siemens Financial Services, Inc.	Amendment to UCC Statement 2366260
	2774209	UCC Amendment Continuation	9/21/10	Siemens Financial Services, Inc.	Continuation of UCC Statement 2366260
	3071661	UCC Amendment Continuation	8/14/15	Siemens Financial Services, Inc.	Continuation of UCC Statement 2366260

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
	3071781	UCC Amendment Termination	8/14/15	Siemens Financial Services, Inc.	Termination of UCC Statement 2366260
The Rockville General Hospital, Incorporated	2695326	UCC-1 Financing Statement	5/18/09	U.S. Bank National Association, as Master Trustee	Gross Receipts
	2884717	UCC Amendment	6/28/12	U.S. Bank National Association, as Master Trustee	Amendment to UCC Statement 2695326 Deleting Collateral
	2976568	UCC Amendment Continuation	1/21/14	U.S. Bank National Association, as Master Trustee	Continuation of UCC Statement 2695326
The Rockville General Hospital, Incorporated	2695328	UCC-1 Financing Statement	5/18/09	U.S. Bank National Association, as Series D Bond Trustee	Service Equipment
	2884718	UCC Amendment	6/28/12	U.S. Bank National Association, as Series D Bond Trustee	Amendment to UCC Statement 2695328 Deleting Collateral
	2976569	UCC Amendment Continuation	1/21/14	U.S. Bank National Association, as Series D Bond Trustee	Continuation of UCC Statement 2695328
The Rockville General Hospital, Incorporated	2695366	UCC-1 Financing Statement	5/15/09	TD Bank, N.A.	Gross Receipts

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
	2884719	UCC Amendment	6/28/12	TD Bank, N.A.	Amendment to UCC Statement 2695366 Deleting Collateral
	2974315	UCC Amendment Continuation	1/8/14	TD Bank, N.A.	Continuation of UCC Statement 2695366
The Rockville General Hospital, Incorporated	2695367	UCC-1 Financing Statement	5/15/09	TD Bank, N.A.	Service Equipment
	2884720	UCC Amendment	6/28/12	TD Bank, N.A.	Amendment to UCC Statement 2695367 deleting collateral
	2974314	UCC Amendment Continuation	1/8/14	TD Bank, N.A.	Continuation of UCC Statement 2695367
The Rockville General Hospital, Incorporated	2748249	UCC-1 Financing Statement	4/22/10	Winthrop Resources Corporation	Equipment Lease
	3036748	UCC Amendment Continuation	1/20/15	Winthrop Resources Corporation	Continuation of UCC Statement 2748249
The Rockville General Hospital, Incorporated	2790291	UCC-1 Financing Statement	12/21/10	U.S. Bank National Association, as Master Trustee	Gross Receipts

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
	2884721	UCC Amendment	6/28/12	U.S. Bank National Association, as Trustee	Amendment to UCC Statement 2790291 Deleting Collateral
	3068296	UCC Amendment Continuation	7/23/15	U.S. Bank National Association, as Master Trustee	Continuation of UCC Statement2790291
The Rockville General Hospital, Incorporated	2790292	UCC-1 Financing Statement	12/21/10	U.S. Bank National Association, as Series E Bond Trustee	Service Equipment
	2884722	UCC Amendment	6/28/12	U.S. Bank National Association, as Trustee	Amendment to UCC Statement 2790292 deleting collateral
	3068297	UCC Amendment Continuation	7/23/15	U.S. Bank National Association, as Series E Bond Trustee	Continuation of UCC Statement 2790292
The Rockville General Hospital, Incorporated **[TERMINATED]**	2793756	UCC-1 Financing Statement	1/13/11	Toshiba America Medical Systems, Inc.	Equipment
	2890177	UCC Amendment Termination	8/1/12	Toshiba America Medical Systems, Inc.	Termination of UCC Statement 2793756
The Rockville General Hospital, Incorporated	2816953	UCC-1 Financing Statement	5/24/11	Siemens Financial Services, Inc.	Equipment Lease

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
	3099700	UCC-1 Amendment Continuation	1/26/16	Siemens Financial Services, Inc.	Continuation of UCC Statement 2816953
The Rockville General Hospital, Incorporated	2817028	UCC-1 Financing Statement	5/24/11	Siemens Financial Services, Inc.	Equipment Lease
	3099701	UCC-1 Amendment Continuation	1/26/16	Siemens Financial Services, Inc.	Continuation of UCC Statement 2817028
The Rockville General Hospital, Incorporated	2817038	UCC-1 Financing Statement	5/24/11	Siemens Financial Services, Inc.	Equipment Lease
	3099702	UCC-1 Amendment Continuation	1/26/16	Siemens Financial Services, Inc.	Continuation of UCC Statement 2817038
The Rockville General Hospital, Incorporated	2817122	UCC-1 Financing Statement	5/25/11	Siemens Diagnostic Finance Co. LLC	Equipment Lease
	2819052	UCC Amendment	6/3/11	Siemens Financial Services, Inc.	Amendment to UCC Statement 2817122 adding Siemens Financial Services, Inc. as Secured Party

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
	3099908	UCC Amendment Continuation	1/27/16	Siemens Financial Services, Inc.	Continuation of UCC Statement 2817122
The Rockville General Hospital, Incorporated	2817675	UCC-1 Financing Statement	5/27/11	Siemens Financial Services, Inc.	Equipment
	3100317	UCC Amendment Continuation	1/29/16	Siemens Financial Services, Inc.	Continuation of UCC Statement 2817675
The Rockville General Hospital, Incorporated	2819211	UCC-1 Financing Statement	6/3/11	Siemens Financial Services, Inc.	Equipment Lease
	3101302	UCC Amendment Continuation	2/5/16	Siemens Financial Services, Inc.	Continuation of UCC Statement 2819211
The Rockville General Hospital, Incorporated	2819224	UCC-1 Financing Statement	6/3/11	Siemens Financial Services, Inc.	Equipment Lease
	3101301	UCC Amendment Continuation	2/5/16	Siemens Financial Services, Inc.	Continuation of UCC Statement 2819224
The Rockville General Hospital, Incorporated	2858872	UCC-1 Financing Statement	2/8/12	Siemens Financial Services, Inc.	Equipment Lease

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
The Rockville General Hospital, Incorporated	2858873	UCC-1 Financing Statement	2/8/12	Siemens Financial Services, Inc.	Equipment Lease
The Rockville General Hospital, Incorporated	2897293	UCC-1 Financing Statement	9/21/12	General Electric Capital Corporation	Equipment
	2920529	UCC Amendment (deleted Debtor)	2/20/13	General Electric Capital Corporation	Amendment to UCC Statement 2897293 deleting The Rockford General Hospital, Incorporated as a Debtor
	3096699	UCC Amendment Assignment	1/5/16	GE HFS, LLC	Assignment of UCC Statement 2897293 to GE HFS, LLC
	3097549	UCC Amendment Assignment	1/7/16	GE HFS, LLC	Assignment of UCC Statement 2897293 to GE HFS, LLC
	3098482	UCC Amendment Assignment	1/13/16	GE HFS, LLC	Assignment of UCC Statement 2897293 to GE HFS, LLC
The Rockville General Hospital, Incorporated	2919905	UCC-1 Financing Statement	2/13/13	Winthrop Resources Corporation	Equipment Lease

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
The Rockville General Hospital, Incorporated	2961364	UCC-1 Financing Statement	10/11/13	Winthrop Resources Corporation	Equipment Lease
	2983739	UCC Amendment Assignment	3/13/14	Banc of America Leasing & Capital, LLC	Assignment of UCC Statement 2961364 to Banc of America Leasing and Capital, LLC
The Rockville General Hospital, Incorporated	2972502	UCC-1 Financing Statement	12/19/13	Winthrop Resources Corporation	Equipment
	2983926	UCC Amendment Assignment	3/14/14	Banc of America Leasing & Capital, LLC	Assignment of UCC Statement 2972502 to Banc of America Leasing and Capital, LLC
The Rockville General Hospital, Incorporated	2976605	UCC-1 Financing Statement	1/21/14	Philips Medical Capital, LLC	Equipment
The Rockville General Hospital, Incorporated	2976606	UCC-1 Financing Statement	1/21/14	Philips Medical Capital, LLC	Equipment
The Rockville General Hospital, Incorporated	2980003	UCC-1 Financing Statement	2/14/14	Philips Medical Capital, LLC	Equipment

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
The Rockville General Hospital, Incorporated	3020870	UCC-1 Financing Statement	10/7/14	TD Bank, N.A.	All Assets
The Rockville General Hospital, Incorporated	3032876	UCC-1 Financing Statement	12/19/14	Winthrop Resources Corporation	Equipment
The Rockville General Hospital, Incorporated	3042107	UCC-1 Financing Statement	3/3/15	Winthrop Resources Corporation	Equipment Lease
The Rockville General Hospital, Incorporated	3049909	UCC-1 Financing Statement	4/17/15	MB Financial Bank, N.A.	Equipment
	3052267	UCC Amendment	4/29/15	MB Financial Bank, N.A.	Amendment to UCC Statement 349909 adding The Rockford General Hospital, Inc. as a Debtor (Original Debtor Was Manchester)
	3093430	UCC Amendment	12/10/15	MB Financial Bank, N.A.	Amendment to UCC Statement 3049909 to include detailed equipment description and serial numbers

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
The Rockville General Hospital, Incorporated	3086543	UCC-1 Financing Statement	11/3/15	Winthrop Resources Corporation	Lease Agreement #EA112107 Lease Schedule # D01
The Rockville General Hospital, Incorporated	3124048	UCC-1 Financing Statement	6/2/16	Winthrop Resources Corporation	Lease Agreement #EA112107 Lease Schedule # D02

Tolland Imaging Center, LLC

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
Tolland Imaging Center, L.L.C.	2640167	UCC-1 Financing Statement	6/18/08	National City Commercial Capital Company, LLC	Equipment Lease
	2937355	UCC Amendment Continuation	5/14/13	National City Commercial Capital Company, LLC	Continuation of UCC Statement 2640167
Tolland Imaging Center, L.L.C.	2650236	UCC-1 Financing Statement	8/15/08	National City Commercial Capital Company, LLC	Equipment Lease
	2948369	UCC Amendment Continuation	7/16/13	National City Commercial Capital Company, LLC	Continuation of UCC Statement 2650236

Visiting Nurse and Health Services of Connecticut, Inc.

Debtor	Filing Number	Type of Filing	Filing Date	Secured Party	Collateral
Visiting Nurse & Health Services of Connecticut, Inc.	2724846	UCC-1 Financing Statement	12/1/09	General Electric Capital Corporation	Equipment Lease
	3005606	UCC Continuation	7/14/14	General Electric Capital Corporation	Contiuation of UCC Statement 2724846
Visiting Nurse & Health Services of Connecticut, Inc.	2856311	UCC-1 Financing Statement	1/23/12	De Lage Landen Financial Services, Inc.	Equipment Lease
Visiting Nurse & Health Services of Connecticut, Inc.	3103562	UCC-1 Financing Statement	2/19/16	Bekrshire Bank	All of Debtor's right, title and interest in and to the Debtor's Account No. 422470713

Schedule 3.12(a)

Permitted Real Property Encumbrances

Property Address	City	State	Zipcode	Property Description	Encumbrance
17-27-29 Haynes Street	Manchester	CT	06040		Parking Easement
Russell/Alpine/Haynes Street	Manchester	CT	06040		Reciprocal Drainage Easement
71 Haynes Street	Manchester	CT	06040	Parking lot	Reciprocal Access & Parking Easement for 100 Haynes Street, Manchester
71 Haynes Street	Manchester	CT	06040	Parking lot	Parking Easement to use 10 spaces granted to 29 Haynes Street, Manchester
West Middle Turnpike	Manchester	CT	06040	Parking lot	Utility Easement
18 Haynes Street	Manchester	CT	06040	Commercial Bldg	Mortgage
36 Haynes Street	Manchester	CT	06040	Commercial Bldg	Mortgage
44 Haynes Street	Manchester	CT	06040	Commercial Bldg	Mortgage
56 Haynes Street	Manchester	CT	06040	Lot	Mortgage
71 Haynes Street	Manchester	CT	06040	Hospital	Mortgage
945 Main Street	Manchester	CT	06040	Office Condominium	Mortgage
353 Main Street	Manchester	CT	06040	Commercial Bldg	Mortgage
150 North Main Street	Manchester	CT	06040	Commercial Bldg	Mortgage
31 Union Street	Vernon	CT	06066	Hospital	Mortgage*

*The mortgage on 31 Union Street (The Rockville General Hospital, Incorporated) is being filed in advance of the Closing Date at the request of Buyer to permit the release of the cash collateral used to secure the loan granted pursuant to that certain Loan Agreement dated as of February 19, 2016 pursuant to which Berkshire Bank extended a loan to Visiting Nurse & Health Services of Connecticut, Inc. in the original principal amount of up to $5,000,000.

Schedule 3.12(c)

Buildings Not Structurally Sound or in Need of Material Repairs

[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]

Schedule 3.12(g)

Rent Roll

[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]

Schedule 3.12(i)

Tenant Lease Encumbrances

None.

Schedule 3.13(a)

Environmental Claims

[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]

Schedule 3.13(b)

Materials of Environmental Concern Storage Locations/Underground Storage Tanks

[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]

Schedule 3.14

Intellectual Properties and Information Systems

[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]

Schedule 3.15

Insurance

[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]

Schedule 3.17

Unexpected Occurrences

[REDACTED PER CONN. GEN. STAT. § 1-210(b)(2)]

Schedule 3.18

Contracts Related to the Hospital Businesses

Please refer to Schedule 2.01(f), which contains the information required for this schedule.

Schedule 3.19(d)

Prohibitions on Competition

[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]

Schedule 3.19(e)

Contract Change of Control Provisions.

Please refer to Schedule 3.02 for a List of Contracts that Require Consent Prior to Assignment.

Schedule 3.21(c)

Claims Involving Legal Requirements of Employment

[REDACTED PER CONN. GEN. STAT. § 1-210(b)(2)]

Schedule 3.21(d)

Recently Terminated Employees

[REDACTED PER CONN. GEN. STAT. § 1-210(b)(2)]

Schedule 3.21(e)

Non-Competition Agreements

[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]

Schedule 3.21(f)

Pending Labor Disputes

None.

Schedule 3.21(g)

Pending Immigration Proceedings

None.

Schedule 3.22

Employee Benefit Plans

[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]

Schedule 3.22(f)

Employee Pension Benefit Plans Complete or Partial Termination and Reportable Events

None.

Schedule 3.22(g)

Employee Welfare Benefit Plan

[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]

Schedule 3.23

Proceedings and Claims

[REDACTED PER CONN. GEN. STAT. § 1-210(b)(2)]

Schedule 3.25(a)

Medical Staff

[REDACTED PER CONN. GEN. STAT. § 1-210(b)(2)]

Schedule 3.25(a)

Medical Staff Members Reported to National Practitioner Databank Reports within Past Three Years

[REDACTED PER CONN. GEN. STAT. § 1-210(b)(2)]

Schedule 3.25(b)

Material Medical Staff Disputes

[REDACTED PER CONN. GEN. STAT. § 1-210(b)(2)]

Schedule 3.26

Restricted Assets

State and Federal Grants

Awarding Agency(ies)	Program Name	Program Description	Grant Award and Period
US Department of Health and Human Services, passed through City of Hartford Department of Health and Human Services	Ryan White I Program	Outpatient/Ambulatory medical care services for the treatment of HIV infection.	$89,935 (March 1, 2015 – February 28, 2016)
US Department of Health and Human Services, passed through State of Connecticut Department of Public Health	National Bioterrorism Program (RGH)	Hospital emergency preparedness activities.	$26,605 (July 1, 2014 - June 30, 2015)
US Department of Health and Human Services, Administration for Children and Families	Early Head Start Program	Early Head Start provides early, continuous, intensive, and comprehensive child development and family support services to low-income infants and toddlers and their families, and pregnant women and their families.	$555,153 (September 1, 2014 – August 31, 2015)
State of CT Department of Education	Manchester Family Resource Center	To promote the optimal growth and development of children and their families through the establishment of a comprehensive, integrated, community-based system of family support and early childhood services linked to the public schools.	$109,500 (July 1, 2014 – June 30, 2015)
State of CT Department of Education	Vernon Family Resource Center	To promote the optimal growth and development of children and their families through the establishment of a comprehensive, integrated, community-based system of family support and early childhood services linked to the public schools.	$109,500 (July 1, 2014 – June 30, 2015)

Awarding Agency(ies)	Program Name	Program Description	Grant Award and Period
State of CT Department of Social Services	Nurturing Families Network	To promote positive parenting and reduce the incidence of child abuse and neglect.	$390,980 (October 1, 2014 – September 30, 2015)
US Department of Health and Human Services, passed through State of CT Department of Social Services	MIEC Visiting	To improve outcomes for families that reside in at risk areas.	$243,750 (March 31, 2015 – December 31, 2015)
US Department of Health and Human Services, passed through State of CT Department of Public Health	National Bioterrorism Program (MMH)	Hospital emergency preparedness activities.	$26,605 (July 1, 2014 – June 30, 2015)
State of CT Department of Children and Families	Positive Parenting Program (Triple P)	A CT State Department of Children and Families funded grant program. Triple P is suitable for parents with concerns about child's behavior or who wish to learn a variety of parenting skills that will promote their child's/teenager's development and potential.	$122,027 (July 1, 2014 – June 30, 2015)
Town of Manchester, Connecticut	Teen Parent Program	The program is a grant funded through the Town of Manchester, which has developed intervention strategies to ensure that teen mothers avoid second pregnancies, are empowered to provide for their child's immediate needs, and are prepared for a prosperous future. Services offered are one-to-one mentoring, group sessions, and parenting workshops	$6,429 (November 1, 2014 – June 30, 2015)

Awarding Agency(ies)	Program Name	Program Description	Grant Award and Period
State of Connecticut Department of Public Health	Early Detection Program	The Connecticut Cancer and Heart Disease Integrated Health Screening Program (CHDIHSP) will deliver integrated early detection health screening services that must include breast and cervical cancer screening for women ages 21-64 with a focus on women rarely or never screened, cardiovascular risk reduction screening for women ages 40-64 who have participated in the breast and cervical cancer program, and colorectal cancer screening for women and men ages 50-64. Twenty-five percent (25%) of all participants screened for colorectal cancer in the CHDIHSP must be men. Program services are targeted to persons who are at or below 250% of the Federal Poverty Level (FPL), are uninsured, or underinsured.Providers may deliver these services directly, via satellite sites, or through providers in subcontractor capacities	$180,732 (July 1, 2014 – June 30, 2015)
US Department of Health and Human Services, passed through State of CT Department of Public Health	Hospital Emergency Preparedness – Ebola (RGH)	Funding for work that enables the hospitals to plan and respond appropriately to Ebola and/or other emerging infectious diseases while maintaining patient and health care worker safety.	$6,614 (July 1, 2015 – June 30, 2016)
US Department of Health and Human Services, passed through State of CT Department of Public Health	Hospital Emergency Preparedness – Ebola (MMH)	Funding for work that enables the hospitals to plan and respond appropriately to Ebola and/or other emerging infectious diseases while maintaining patient and health care worker safety.	$24,063 (July 1, 2015 – June 30, 2016)

Schedule 3.30(a)

Outstanding Capital Stock of Seller's Subsidiaries that are Stock Corporations

Corporation	Ownership of Outstanding Shares of Capital Stock
ECHN Enterprises, Inc.	Eastern Connecticut Health Network, Inc. – 100%
ECHN Corporate Services, Inc.	Eastern Connecticut Health Network, Inc. – 100%

Schedule 3.30(b)

Outstanding Capital Stock of Joint Ventures

Corporation	Ownership of Outstanding Shares of Capital Stock
Aetna Ambulance Service, Inc.	**2,548 Total Issued and Outstanding Shares Owned as Follows:** Eastern Connecticut Health Network, Inc. - 1,274 Shares Hartford Health Care Corporation - 1,274 Shares
Metro Wheelchair Service, Inc.	**78 Total Issued and Outstanding Shares Owned as Follows:** Eastern Connecticut Health Network, Inc. - 39 Shares Hartford Health Care Corporation - 39 Shares

Schedule 3.30(c)

Outstanding Membership Interests

[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]

Schedule 3.31

Ten Largest Non-Governmental Payors of Hospital Businesses

[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]

Schedule 5.01

Material Hospital Business Changes

None.

Schedule 5.01(b)

Asset Expenditures

None.

Schedule 5.02(c)

Compensation Increases

None.

Schedule 5.03(b)

Written Severance Agreements

[REDACTED PER CONN. GEN. STAT. § 1-210(b)(2)]

Schedule 5.16

Charity Care and Community Obligations

Policies and Procedures

- MMH Lobby Coffee Cart – Revised 3/31/2011
- Credit & Collection / Bad Debt Policy – Revised 2/2/2014
- Escort Messenger Volunteer – Revised 1/20/2012
- Eucharistic Volunteers
- Greeter Volunteer – Revised 1/9/2012
- Family Development Center Advisory Council Bylaws
- Financial Assistance Policy and Procedure – Revised 6/30/2015
- Healing Hands Volunteer Program – 1/9/2012
- Kitchen Work Experience Volunteer (Shadowing Program) –1/9/2012
- Notice of Availability for Uncompensated Care – Revised 2/1/2016
- Patient Care Visiting Volunteer – 1/9/2012
- Pet Therapy Volunteer Program – Revised 1/20/2012
- Pharmacy Volunteer – 1/9/2012
- Pre-Collect and Bad Debt Policy – 3/2011
- Read to Grow Volunteer
- Student Educational Affiliation Agreement – Revised 2016
- Visiting Nurse and Health Services of Connecticut Professional Advisory Committee Charter – 4/2013
- Visiting Nurse and Health Services of CT Hospice Volunteer
- Volunteer Patient Safety Program -1/3/2012
- Woodlake at Tolland Recreation Volunteer

Other Documents

- Manchester Memorial Hospital – A Summary of Community Benefits Activities – Fiscal Year 2015
- Manchester Memorial Hospital – Executive Summary Including Non Community Benefit (Medicare and Bad Debt) for Period October 1, 2014 through September 30, 2015 – Dated June 1/2016
- New Adult Volunteer Packet
- New Teen Volunteer Packet
- Rockville General Hospital - A Summary of Community Benefit Activities – Fiscal Year 2015
- Rockville General Hospital - Executive Summary Including Non Community Benefit (Medicare and Bad Debt) for Period October 1, 2014 through September 30, 2015 – Dated June 1/2016

Policies Included on Schedule 5.16
(Charity Care and Community Obligations)

Policies and Procedures

- MMH Lobby Coffee Cart – Revised 3/31/2011
- Credit & Collection / Bad Debt Policy – Revised 2/2/2014
- Escort Messenger Volunteer – Revised 1/20/2012
- Eucharistic Volunteers
- Greeter Volunteer – Revised 1/9/2012
- Family Development Center Advisory Council Bylaws
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- New Teen Volunteer Packet
- Rockville General Hospital - A Summary of Community Benefit Activities – Fiscal Year 2015
- Rockville General Hospital - Executive Summary Including Non Community Benefit (Medicare and Bad Debt) for Period October 1, 2014 through September 30, 2015 – Dated June 1/2016

I. TITLE: MMH Lobby Coffee Cart

II. Purpose and Scope:

A. Volunteers make and sell coffee for employees and visitors in the lobby of MMH. The proceeds from the Coffee Cart are proudly given to support cancer programs. Coffee is provided from approximately 7AM-6PM.

I. Procedure

A. Make a variety of coffee flavors as needed.
B. Order milk and cream, sugar and napkins from Food Services using the Food Services order form and leaving it with the kitchen supervisor or in the kitchen office.
C. Retrieve necessary supplies (i.e. coffee packages, cups, sleeves and lids from the storage area).
   1. Make sure supplies are available for the next shift.
D. Once per day, take and record the temperature of the refrigerator and record on form.
   1. If the temperature is above 42 degrees F., please contact the Volunteer Coordinator.
   2. The Volunteer Coordinator will collect the sheets monthly and file for a period of one year.
E. Keep area clean and presentable.
   1. Have the front desk concierge call Environmental Services for any spills.
F. Count and roll money at the end of the shift.
   a) Fill out a deposit slip.
   b) Leave some change and approximately $10.00 in one-dollar bills.
   c) Place money and deposit slip in a canvas bag and deposit in the deposit box or give to the Volunteer Coordinator or designee.
G. Return pots, milk and creamers to the Kitchen by 6:00 pm to get washed for the next day.

IV. INDIVIDUAL RESPONSIBLE FOR REVISION: Volunteer Coordinator

V. ORIGINATED: 5/29/00 Revised: 3/31/11 - Ellen Barnes

Department: Patient Financial Services

Effective Date: 11/06/04
Revised Date: 02/02/14

ECHN Eastern Connecticut Health Network

EASTERN CONNECTICUT HEALTH NETWORK
CREDIT & COLLECTION / BAD DEBT POLICY
POLICY AND PROCEDURE

TITLE: Credit & Collection / Bad Debt

APPROVING AUTHORITY: Director, Patient Financial Services

DATE: 02/02/14

TOPIC
The Credit & Collection / Bad Debt policy for ECHN - Manchester Memorial and Rockville General Hospitals Patient Financial Services.

PURPOSE
To ensure that collection efforts are administered for self-pay deductibles co-pays, co-insurances, and other outstanding patient due balances. ECHN will extend collection efforts which are reasonable and compliant with state and federal guidelines on the pursuit of patient due balances and referral to a collection agency.

POLICY
ECHN is committed to assuring that bad debt write-off will take place only after exhausting all reasonable follow-up efforts for the collection of a unpaid debt. This collections process includes billing third party payers (insurance carriers, etc), direct billing, dunning, and phone calls to the patient/ guarantor, as well as referral to outside collection agencies.

PROCEDURE

The following guidelines will apply for patients with no insurance or for self pay balances after insurance has paid.

1. Once the charging and coding process concludes, a final bill will be generated and sent to the third party payer for payment. If the patient does not have health insurance (registered as Self-Pay) an itemized statement will be sent directly to the patient for payment.
    a. After the initial bill has generated self-pay encounters are referred to an outsourced vendor (American Adjustment Bureau) which acts as an extension of the business office and handles all Self-Pay balances.
        i. Registered Self Pay is sent to the Outsourced Vendor at day 1.
        ii. Self Pay after insurance is sent to the Outsourced Vendor 1 day after insurance (primary, secondary, or tertiary) has paid the claim.
        iii. The outsourced vendor (American) receives a daily electronic billing file as self pay claims are generated to initiate account resolution actives.
        iv. The outsourced vendor submits a daily acknowledgement file to the hospital to confirm receipt of the assigned inventory. The acknowledgment file is posted on the z-Early Out folder in the business office shared drive.
2. In accordance with hospital policy, self-pay patients receive:
    a. A series of four (4) statements at approximately 30-day intervals and a pre-collect letter/final notice at approximately 15 days after the 4th statement, from the outsourced self-pay vendor (American).
    b. Automated outbound call campaigns are approximately at 30 day intervals to contact patient/guarantor to resolve outstanding accounts.

ECHN Eastern Connecticut Health Network

EASTERN CONNECTICUT HEALTH NETWORK
CREDIT & COLLECTION / BAD DEBT POLICY
POLICY AND PROCEDURE

c. The statements include dunning messages which are progressive in informing the patients of their obligation, and include notices that the account may be referred to a collection agency if the balance remains outstanding.

Note: At any point along the self-pay collection cycle a patient can inquire and/or request to be considered for a charity care discount. Signage is posted in all Registration and Customer Service areas and all patient statement include information instructing them on the methods of accessing financial counseling assistance. Financial assistance may include charity care, payment arrangements, or other applicable programs.

d. ECHN currently applies an uninsured discount of 30% on all self-pay accounts (uninsured patients registered as self pay) at the time of billing with the exception of a few outpatient services that have been set up with established discounted rates.(Cardiac Rehab Phase III, Massage Therapy) The hospital's billing and accounts receivable system automatically discounts the account at the time of bill generation.

e. ECHN will approve payment arrangements for patients who agree to a minimum of $50 and the monthly payment will be determined by the total amount due and the number of months contracted, which does not extend more than 24 months. Management has the authority to make exceptions to the policy on a case-by-case basis for special circumstances. ECHN is not required to accept patient-initiated payment arrangements and may refer accounts for collection if the patient is unwilling to make acceptable payment arrangements or has defaulted on ECHN approved payment plans.

3. Account balances which have not been resolved after a series of 4 patient statements and a pre-collect notice during the dunning cycle becomes eligible for bad debt write-off.
   a. Bad debt qualification criteria – an account may be referred to collection if it meets one or more of the following;
      i. Self-pay balance not paid 120 days after bill date when all reasonable follow-up efforts have been exhausted.
      ii. Guarantor has received 4 statements and a pre-collect letter
      iii. No reasonable response from the patient
      iv. No payment has been received and no financing could be arranged to pay the account in full in the previous 120 days despite at least four contacts with the responsible party.
      v. Guarantor has defaulted on an "agree to payment plan".
      vi. Exclusions to this protocol are mail returns, small balances write off (under $5.00), unresolved patient disputes or billing issues and bankruptcy discharges, which may result in early placement to bad debt or early discharge of an account.
4. Any outstanding balances that pertain to a self pay or self pay after insurance that all dunning is complete; the outsourcing vendor (American) sends a monthly electronic file to ECHN for bad debt review and referral to outside bad debt agencies. This report identifies those accounts which have progressed through the complete billing cycle and are ready to be written off to Bad Debt.
5. ECHN reviews the potential bad debt file for any accounts that are not eligible for bad debt write off due to established criteria. The accounts are reviewed for any insurance balances, active pay plans, and accounts with recent payments. Once the pre-collect accounts have been determined, the self-pay collector is changed in Meditech.
6. The collector is changed to reflect the corresponding assignment of the bad debt to one of two contracted collection agents. Claim inventory is split alphabetically with patient last names beginning with letter A – L being associated to American adjustment Bureau (PC-AMER) and letter M – Z being assigned to Transcontinental Credit (PC-TRANS).

ECHN Eastern Connecticut Health Network

EASTERN CONNECTICUT HEALTH NETWORK
CREDIT & COLLECTION / BAD DEBT POLICY
POLICY AND PROCEDURE

7. The account balance is subsequently removed from the active accounts receivable and at month end, the system will automatically write off accounts to the assigned collectors/agencies and becomes part of the bad debt receivable.
8. Accounts are refered to collections agencies on a monthly basis. The electronic inventory files are sent to the contracted collection agencies to pursue recoveries of the referred accounts.

I. Purpose:

A. Escort Messenger Volunteers assist hospital staff, patients and visitors by transport patients, specimens, medications, documents, etc. throughout the hospital.

I. Procedure

A. Take calls from staff requesting service.

B. Log requesting department and destination (ie: 3North to Lab; Pharmacy to Bissell 2, 2East – discharge, etc.).

C. Wash hands between each run using proper hand washing protocol with hand sanitizer or soap and water.

D. Transporting specimens

1. Lab specimens and pharmaceuticals are transported in bags placed in a lab box to prevent dropping.

2. Do not touch specimen tube or container with bare hands.

3. If spillage occurs, contact the nursing unit or Environmental Services for clean-up.

E. Transporting blood

1. Volunteer name and signature must be on file with the blood bank.

2. Please reference Blood Product Delivery training presentation.

F. Transporting patients

1. Never leave a patient unattended. Wait for staff to acknowledge the patient has arrived or for their ride to arrive for them before leaving.

2. Do not lift or move patients. If a patient needs more than "courtesy" assistance (a steadying hand) in getting out of or into a wheelchair, seek staff assistance.

3. Do not wheel patients off the curb/sidewalk right outside an entrance.

4. Volunteers should not be asked to transport morbidly obese patients.

a) If you feel a patient is too heavy for you, do not transport the individual. Very discreetly tell the staff that you are unable to handle this task and staff will handle the transport.

IV. INDIVIDUAL RESPONSIBLE FOR REVISION: Volunteer Coordinator

V. ORIGINATED: 5/29/00 Revised: 1/20/2012

Volunteer Coordinator, Human Resources, date

Eucharistic Volunteers

Main Objective: Responsible for bringing Communion Host to patients.

Eucharistic Volunteers are vetted and trained by the Catholic Church. They also go through ECHN Volunteer Services to be on boarded and to receive an ID badge.

Eucharistic Volunteers need to have the ability to present themselves as warm, caring persons who compassionately with the ill, disabled, elderly, and dying. They also need to exercise discretion with patients and family members and maintain confidentiality.

Eucharistic Volunteers show his/her badge in order to review the Patient/Religion list to learn who is appropriate to visit.

Eucharistic Volunteers check in with nursing to make sure that the patient may receive Communion (not NPO etc.)

Eucharistic Volunteers leave messages for Pastoral Care Staff if there are any questions or concerns which need to be passed along.

ECHN
Eastern Connecticut Health Network, Inc.

Volunteer Services
Volunteer Role Descriptions

Role: *Greeter Volunteer*
Date: *01/09/2012*

Department:
- Volunteer Services

Reports to:
- Sr. Business Partner, Volunteer Services (MMH)

Role Objective:
- Provide a warm and welcoming presence in the lobby
- Greet guests and patients and direct or escort them to their destination

Qualifications:
- Friendly, people-oriented individual, having ability to interact with all types of people
- Must be able to communicate in English
- Excellent interpersonal, communication and listening skills
- Excellent customer service skills
- Able to stand and walk for prolonged periods

Competencies:
- Able to follow directions and work cooperatively with others with limited supervision
- Able to maintain strict confidentiality at all times
- Using discretion in the open-lobby environment
- Knowledge of the hospital department locations and able to give clear directions to guests
- Able to accept feedback and develop, acquire and utilize new knowledge and skills as necessary
- Valuing differences in all people; avoiding demonstrating any bias toward individuals or groups by words and actions
- Able to push a wheelchair

Training:
- ECHN Hospital orientation
- HIPAA Education
- Hand Hygiene
- Wheelchair
- Two shifts with a preceptor (staff or volunteer)
- Continuing education as required

Responsibilities:
- Sign in at Volunteer Sign-in Book.
- Report to duty with appropriate attire and identification badge
- Introduce self and volunteer role in an appropriate manner
- Escort patients and visitors to appropriate destination
- Offer wheelchair assistance if appropriate
- Offering to escort guests to their destination
- If unable to help a guest, finding someone who can

Physical Demands:
- Able to stand and walk for prolonged periods
- Able to push a wheelchair

The Family Development Center only uses volunteers in the capacity of serving on various councils and/or committees.

-Head start, Nurturing Families Network and Maternal Infant Early Childhood Home Visiting programs are required by grant stipulation to have an active Advisory Council consisting of community providers and parents. The Advisory Council consists of no fewer than six members.

The Early Head Start program is also required to have a Policy Council, which is a group consisting of parents (51%) and community providers (49%) to oversee the administration of the program (policies and procedure, funding decisions, etc.). The number of parent volunteers varies each program year.

All the FDC program, with the exception of Triple P, are affiliates of the National Parents as Teachers Program, which is the home visiting curriculum used. A requirement of PAT is to have an Advisory Council consisting of community members and parents.

Eastern Connecticut Health Network
Family Development Center Advisory Council
Bylaws

ARTICLE I: Name and purpose of organization

Section 1: The ECHN Family Development Center Advisory Council is established with the approval of the ECHN Board of Trustees to oversee key responsibilities related to program governance and improvement of the Family Development Center programs. These include, but are not limited to: Early Head Start, Nurturing Families Network, Family Resource Centers, Positive Parenting Program, and Successful Teens Excelling as Parents and Partners.

Council members advise the Family Development Center on needs of families within the department's service area and how to effectively and efficiently address them via existing department programs, within the parameters of individual program mandates and guidelines. The Council also suggests partnerships and new directions that may enhance the work and success of the Family Development Center, within the context of ECHN's mission: "To improve your health and well-being by providing high-quality, compassionate care."

Section 2: Roles and Responsibilities

a. To collaborate with the ECHN Board of Trustees in administering and overseeing Family Development Center programs, including the safeguarding of federal and state funds;

b. To provide feedback on direction, appropriateness and quality of services provided by the Family Development Center;

c. To advise the Family Development Center Manager and Program Coordinators as to the best fit of the Family Development Center activities for the community and the region;

d. To suggest new activities and collaborative relationships for the Family Development Center to best meet community/regional needs;

e. To suggest funding sources to allow expansion and continuation of Family Development Center activities; to offer feedback on efficient use of funding;

f. To recommend membership for the Advisory Council;

g. To assist in recruiting parents and volunteers for the Family Development Center;

h. To represent the needs of their own constituency to the Family Development Center and to bring issues and announcements back to their constituency;

i. To determine the best methods of giving feedback , advice and suggestions for measuring/maintaining quality programming; to participate in program self-assessments and quality checks recommended by funding agencies;

j. Other special responsibilities for the Early Head Start program (see Appendix A).

ARTICLE II: Membership

The Family Development Center Advisory Council will consist of, but, is not limited to (1) at least one member of ECHN's senior management, as a non-voting member, to serve as a link with the ECHN upper management and Board of Trustees; (2)representatives of community agencies and groups with which the Family Development Center collaborates; (3) staff of the schools where Family Resource Centers are located; (4)at least, one parent from Early Head Start; (5) parents from the Family Development Center programs; and, (6) additional members which reflect the communities to be served (i.e. parents of children who were formerly enrolled and/or individuals with expertise in education, business administration, or community affairs).

Section 1: Composition

At least one member of the governing body shall have a background and expertise in each of the following areas: fiscal management or accounting; early childhood education and development; be a licensed attorney familiar with issues that come before the Council. In the event that a person with the above specified background/expertise is not available to serve on the Advisory Council, members of ECHN's Board of Trustees with the relevant experience and qualifications will be available to consult with the Advisory Council, as necessary.

Section 2: Council Size

The Advisory Council shall have no fewer than six members.

Section 3: New Members

Members shall be recommended by Advisory Council members, Family Development Staff members and community partners. All new members shall be voted in by a majority of those present at an annual meeting. Notice of the annual meeting must be sent to all members at least 14 days in advance.

Section 4: Term

Advisory Council members may serve indefinitely or as deemed appropriate.

Section 5: Resignation
Resignation from the Advisory Council must be in writing and received by the Family Development Center Manager and Advisory Council Chair.

Section 6: Vacancies
Vacancies shall be filled by the Advisory Council and approved by vote of a simple majority of those attending a meeting.

Section 7: Representation
Each member organization/agency will have one vote. Each individual member (not affiliated with an agency/organization) will have one vote.

Section 8: Officers
Officers will consist of a Chair and Vice Chair. The Chair will preside at the Advisory Council meetings and perform other duties as associated with the office. The Vice Chair will assume the duties of the Chair in his/her absence.

ARTICLE III: Conflict of Interest
Members of the Advisory Council shall: (a). not have financial conflicts of interest with ECHN; (b). not receive compensation for serving on the Advisory Council or for providing service to ECHN; (c). not be employed, nor shall members of their immediate family be employed by ECHN; (d) operate as an entity independent of staff employed by ECHN.

ARTICLE IV: Meetings

Section 1: Membership meetings. The Family Development Center Advisory Council will meet at least four (4) times yearly.

Section 2: Notice. Notice of each meeting shall be given to each member by mail or email, not less than 14 days before the meeting.

Section 3: Special meetings. Special meetings may be called, should the need arise.

Section 4: Voting. Decisions of the Advisory Council will be made by a simple majority of the members voting. A quorum will consist of 50% of the membership.

Section 5: Approvals. Should approval be required for business when no meeting of the Advisory Council is scheduled or when there is no quorum of the membership, pertinent information may be mailed or emailed to Advisory Council members for review and comment, and a vote via email or return mail will be accepted.

ARTICLE IV: Committees
Special committees or task forces may form as needed to carry out the work of the Advisory Council. Membership on committees should be determined by the charge to the committee or task force and need not be confined to the membership of the Advisory Council. The Chair of any appointed task force or committee must be a member of the Advisory Council.

ARTICLE V: Amendments
Bylaws may be altered, amended or repealed by an affirmative vote of a majority of members present and voting at any of the general meetings, provided that written notification of the proposed amendment(s) is included in the general membership meeting notice.

These Bylaws were approved at a meeting of the Advisory Council on: _____

(See appendix on next page, specific to the Early Head Start program)

Appendix A

Responsibilities of the Governing Body Regarding the Early Head Start Program

The ECHN Board of Trustees will have legal responsibility for administering and overseeing the Early Head Start program, including the safeguarding of Federal funds. The Board of Trustees is responsible for primary agency policies and procedures regarding human resources, personnel (including employee code of conduct), and financial issues. For specific issues regarding the Early Head Start program, the Board of Trustees (**BOT**) will share responsibilities with the Advisory Council (**AC**), as described below.

The governing body shall:

(i) Adopt practices that assure active, independent, and informed governance of the Head Start agency, including practices consistent with subsection (d)(1) of the Head Start Performance Standards, and fully participate in the development, planning, and evaluation of the Head Start programs involved; **(AC)**

(ii) Be responsible for ensuring compliance with Federal laws (including regulations) and applicable State, tribal, and local laws, including regulations; **(BOT)**

(iii) Be responsible for other activities, including:

I. Selecting delegate agencies and the service areas for such agencies; **(BOT) (AC)**

II. Establishing procedures and criteria for recruitment, selection and enrollment of children; **(AC)**

III. Reviewing all applications for funding and amendments to applications for funding for the Early Head Start program; **(AC)**

IV. Establishing procedures and guidelines for accessing and collecting information described in subsection (d)(2); **(AC)**

V. Reviewing and approving all major policies of the agency, including:
(aa) the annual self-assessment **(AC)** and financial audit; **(BOT)**
(bb) such agency's progress in carrying out the programmatic and fiscal provisions in such agency's grant application, including implementation of corrective action; **(AC) (BOT)**
(cc) personnel policies of such agencies regarding the hiring, evaluation, termination, and compensation of agency employees. **(BOT)**

VI. Developing procedures for how members of the Policy Council are selected, consistent with paragraph (2) (B); **(AC)**

VII. Approving financial management, accounting, and reporting policies; and compliance with laws and regulations related to financial statements, including the
(aa) approval of all major financial expenditures of the agency; **(BOT)**
(bb) annual approval of the operating budget of the agency/program; **(BOT)(AC)**
(cc) selection of independent financial auditors who shall report all critical accounting policies and practices to the governing body. **(BOT)**

VIII. Reviewing results from monitoring conducted under section 641A(c), including appropriate follow-up activities; **(BOT) (AC)**

IX. Approving personnel policies and procedures, including policies and procedures regarding hiring, evaluation, compensation, and termination of the Executive Director, Head Start Director, Director of Human Resources, Chief Fiscal Officer, and any other person in an equivalent position with the agency; **(BOT)**

X. Establishing, adopting, and periodically updating written standards of conduct that establish standards and formal procedures for disclosing, addressing, and resolving:
(aa) any conflict of interest and any appearance of conflict of interest by the members of the governing body, officers, employees of the Head Start agency, consultants, and agents who provide services or furnish goods to the Head Start agency; **(BOT)**
(bb) complaints, including investigations, when appropriate. **(BOT)**

XI. To the extent practicable and appropriate, at the discretion of the governing body, establishing advisory committees to oversee key responsibilities related to program governance and improvement of the Head Start program involved. **(BOT)**

ECHN Eastern Connecticut Health Network

EASTERN CONNECTICUT HEALTH NETWORK
POLICY AND PROCEDURE

TITLE: Financial Assistance Policy and Procedure **Policy: 500**

TOPIC

Financial Assistance / Charity Care

ECHN is committed to providing financial assistance to persons who have healthcare needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation. Consistent with their mission to deliver compassionate and high quality healthcare services and to advocate those who are poor and disenfranchised, ECHN strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care.

In accordance with the Federal Poverty Level (FPL) guidelines, all other uninsured patient will not be charged more than the amount generally billed to insured patients for emergency or medically necessary care.

PURPOSE

To identify those patients that qualify for charitable assistance and to complete write-off procedures that is in keeping with state and federal regulations.

A. ECHN is committed to providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for emergency or medically necessary care based on their individual financial situation.
B. It is the policy of ECHN to provide Financial Assistance based on indigence or high medical expenses for patients who meet specified financial criteria and request such assistance. The purpose of the following policy is to describe how applications for Federal Assistance should be made, the criteria for eligibility, and the steps for processing each application.
C. Financial assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. This should include a review of the patient's existing medical expenses and obligations (including any accounts having gone to bad debt except those accounts that have gone to lawsuit and a judgment has been obtained) and any projected medical expenses. Financial Assistance Applications may be offered to patients whose accounts are with a collection agency and will apply only to those accounts on which a judgment has not been granted.
D. Race, gender, sexual orientation, religious or political affiliation, social or immigration status will not be taken into consideration.
E. To further ECHN's commitment to their mission to provide healthcare to patients seeking emergency care, ECHN will utilize an abbreviated application for financial assistance for their uninsured patients being seen in the Emergency Room. The patients eligible for this financial assistance must not be eligible for any other insurance benefits or have exhausted their insurance benefits, and do not have active medical assistance coverage. Eligibility will be granted in this case for the one visit only.

POLICY:

In order to provide the level of aid necessary to the greatest number of patients in need, and protect the resources needed to do so, the following guidelines apply:

A. Patient
    a. Services are provided under charity care only when deemed emergency or medically necessary and after patients are found to have met all financial criteria based on the disclosure of proper information and documentation.

b. Any patient who believes that they are qualified may apply for financial assistance under the hospitals' charity care policy or discount policy.
c. Patients are expected to contribute payment for care based on their individual financial situation; therefore, each case will be reviewed separately.
d. Charity Care is not considered an alternative option to payment and patients may be assisted in finding other means of payment or financial assistance before approval for charity care.
e. Uninsured patients who are believed to have the financial ability to purchase health insurance may be encourage to do so in order to ensure healthcare accessibility and overall well-being.

B. Hospital
   a. ECHN will maintain an understandable, written financial assistance policy, clearly stating the eligibility criteria.
   b. ECHN will ensure that all financial assistance policies will be applied consistently.
   c. In applying the Financial Assistance policy, ECHN will assist the patent in determining if he/she is eligible for government- sponsored programs.

C. COMMUNICATION:
   a. Notices regarding availability of Financial Assistance at ECHN will be posted in public places around the hospital, on patient bills, and on our website.
   b. Financial Assistance Applications are available at all ECHN registration locations as well as on the ECHN Website, ECHN.org.
   c. Copies of this policy as well as the Financial Assistance Application can be obtained via the U.S. mail by calling our Customer Service Representative at 1-888-943-6042 or 860-646-1222 x2768.

D. FEDERAL POVERY LEVEL GUIDELINES (UPDATED ANNUALLY)

Family Gross Income Levels

2016 Federal Poverty Guidelines	125%	150%	175%	200%	250%	300%	400%

% of Write Off	100%	90%	80%	70%	60%	50%	40%
Family Size							
1	14,850	17,820	20,790	23,760	29,700	35,640	47,520
2	20,025	24,030	28,035	32,040	40,050	48,060	64,080
3	25,200	30,240	35,280	40,320	50,400	60,480	80,640
4	30,375	36,450	42,525	48,600	60,750	72,900	97,200
5	35,550	42,660	49,770	56,880	71,100	85,320	113,760
6	40,725	48,870	57,015	65,160	81,450	97,740	130,320
7	45,913	55,095	64,278	73,460	91,825	110,190	146,920
8	51,113	61,335	71,558	81,780	102,225	122,670	163,560

Add $4,160 for each additional member

Patient Responsibility	0%	10%	20%	30%	40%	50%	60%

E. DISCOUNT GUIDELINES:

	UNINSURED	UNDERINSURED
Basis for calculating discount:	Hospital Gross Charges. Discounts apply to medically necessary services. Patients eligible for financial assistance will not be charged more than the amount generally billed to patients with insurance for emergency or other medically necessary care.	Hospital Gross Charges or the patient's balance after insurance payments. Discounts apply to medically necessary services. Patients eligible for financial assistance will not be charged more than the amount generally billed to patients with insurance for emergency or other medically necessary care.
Income Requirement for 100% discount	Income at or below 150% of FPL Guidelines	Income at or below 150% of FPL Guidelines
Income Requirements for other discounts	If household gross income is between 150% -400% of the FPL guidelines, the patient may qualify for a discount that is equal to or greater than the average discount received for the same services covered by Medicare, Medicaid and other private insurers. *Information on the discount calculation can be requested from our financial counselor.*	If household gross income is between 150% -400% of the FPL guidelines, the patient may qualify for a discount that is equal to or greater than the average discount received for the same services covered by Medicare, Medicaid and other private insurers. This discount will apply to the account balance. *Information on the discount calculation can be requested from our financial counselor.*
Catastrophic Circumstances	Special circumstances are handled on a case-by-case basis. We will take into consideration those circumstances that affect a patient's ability to pay, such as catastrophic event.	Special circumstances are handled on a case-by-case basis. We will take into consideration those circumstances that affect a patient's ability to pay, such as catastrophic event.

DEFINITIONS

The following terms are meant within this policy to be interpreted as follows:

a. Charity Care means free or discounted health care services rendered by a hospital to persons who cannot afford to pay, including but not limited to, care to the uninsured patient or patients who are expected to pay all or part of a hospital bill based on income guidelines and other financial criteria set forth in statute or in the hospital's charity care policies on file at OCHA.

b. Emergency Care: Immediate care which is necessary to prevent putting the patient's health in serious jeopardy, serious impairment to bodily functions, and serious dysfunction of any organs or parts.

c. Family: Using the Census Bureau definition, a group of two or more people who reside together and who are related by birth, marriage, or adoption. According to Internal revenue Services rules, if the patient claims someone as a dependent on their income tax return, they may be considered a dependent for purposed of the provision of financial assistance.

d. Family Income: family income is determined using the census Bureau definition, which uses the following income when computing federal poverty guidelines.
   i. Includes earnings, unemployment compensation, workers' compensation, Social security, Supplemental security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income form estates, trusts, educational assistance, alimony, child support, assistance form outside the household, and other miscellaneous sources.
   ii. Noncash benefits (such as food stamps and housing subsidies) do not count.
   iii. Determined on a before-tax basis
   iv. If a person lives with a family, includes the income of all family members (non-relatives, such as housemates do not count)

e. Medically Necessary: hospital services or care rendered (both inpatient and outpatient) to a patient in order to diagnose, alleviate, correct, cure or prevent the onset of worsening conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap or result in overall illness.

f. Presumptive: other financial assistance, not charity care.

g. Underinsured: Patients who carry insurance of have third party assistance to help pay for medical services, but who accrue or have the likelihood of accruing out-of-pocket expenses which exceed their financial ability.

h. Uninsured: means a patient who is without health insurance for whom the payer responsible for payment of the bill for hospital services rendered is the patient, the patient's parent or guardian or another responsible person, who is not a third party payer and who is not subsequently reimbursed by another payer for the cost of any of the services rendered to the patient. A patient shall not be classified an uninsured patient, is such subsequent reimbursement takes place.

i. Urgent Care: Services necessary in order to avoid the onset of illness or injury, disability, death, or serious impairment or dysfunction if treated within 12 hours.

PROCEDURE

a. Services Eligible Under This Policy
   i. The following healthcare services are eligible for charity:
      1. Emergency medical services provided in an emergency room setting;
      2. Services for a condition which, if not promptly treated, would lead to an adverse change in the health status of an individual;
      3. Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting; and
      4. Medically necessary services, evaluated on a case-by-case basis at ECHN's discretion.

b. Eligibility for Charity Care
   1. Eligibility for Charity Care will be based on an individual's assessment of financial need.
   2. Requires an application process.
   3. We expect cooperation from patients and guardians.
   4. May rely upon publicly available information and resources to determine the financial resources of the patient or a potential guardian.
   5. Include a review of the patient's outstanding accounts receivable for prior services rendered and the patient's payment history.
   6. The need for financial assistance shall be re-evaluated every six months or at any time additional information relevant to the eligibility of the patient for charity care becomes known.

c. Presumptive Financial Assistance Eligibility
   i. There are instances when a patient may appear eligible for charity care discounts, but are unable to provide supporting documentation. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patient with charity care assistance such as
      1. State-funded prescription programs;
      2. Patient is homeless or received care from a homeless clinic;
      3. Patient files bankruptcy
      4. Participation in Women, Infants and Children programs (WIC);
      5. Patient is eligible for assistance under the Crime Victims Act or Sexual Assault Act
      6. Food stamp eligibility;
      7. Subsidized school lunch program eligibility;
      8. Eligibility for other state or local assistance programs that are unfunded (e.g., Medicaid spend-down);
      9. Low income/subsidized housing is provided as a valid address; and
      10. Patient is deceased with no known estate.

F. ASSESSMENT PROCESS
   1. The application must be fully completed and signed by the patient / responsible party

2. Proof of income for applicant (and spouse if applicable) is verified by two forms of documentation which could include:
    a. Last four pay stubs
    b. Previous Year Federal Income Tax Form
    c. Previous Year W-2 Form
    d. Social Security Statement
    e. Unemployment Benefit Statement
3. Other documentation that may be required:
    a. Proof of disability compensation
    b. For Medicare patients a copy of their social security benefits, pension and retirement benefits and/or bank statements showing deposits
    c. Workers compensation deposits

i. The level of Charity Care provided will be determined based on the Federal Poverty Level in effect (please refer to the current year's sliding scale).

ii. Once a patient has been granted financial assistance, that patient shall not receive any future bills based on undiscounted gross charges.

E. COLLECTION PRACTICES FOR CHARITY CARE PATIENTS

a. Internal and external collection policies and procedures will take into account the extent to which a patient is qualified for charity care or discounts. In additional, patients who qualify for partial discounts are required to make a good faith effort to honor payment agreements with ECHN, including payment plans and discounted hospital bills. ECHN is committed to working with patients to resolve their accounts, and at it discretion, may provide extended payment plans to eligible patients. ECHN will not pursue legal action for non-payment of bills against charity care patients who have cooperated with the hospital to resolve their accounts and have demonstrated their income and/or assets are insufficient to pay medical bills.

b. During the eligibility process, other forms of financial assistance will be considered such as Medicare and Medicaid.

c. All billing is put on hold during the financial assistance application process. Patients are given the opportunity to provide any missing or incomplete information.

Hospital Billing and Collections Practices can be found on the ECHN Website (ECHN.org) or obtained by calling our Customer Service Representative at 1-888-943-6042.

INDIVIDUAL RESPONSIBLE FOR REVISION: Director Patient Financial Services

ORIGINATED: 07/29/02

REVISION DATE:
11/26/12
04/15/13
08/20/14
06/30/15

ECHN
Eastern Connecticut Health Network, Inc.

Volunteer Services
Volunteer Role Descriptions

Role: *Patient Care Healing Hands Volunteer*
Date: *01/09/2012*

Department:
- Volunteer Services

Reports to:
- Sr. Business Partner, Volunteer Services

Role Objective:
- To provide comfort and relaxation to patients and guest through relaxing hand massage and/or guided imagery.

Qualifications:
- Friendly, people-oriented individual, having ability to interact with all types of people
- Having a caring and compassionate disposition
- Must be able to communicate in English
- Excellent interpersonal, communication and listening skills
- Excellent customer service skills

Competencies:
- Able to follow directions and work cooperatively with others with limited supervision
- Able to maintain strict confidentiality at all times
- Able to accept feedback and develop, acquire and utilize new knowledge and skills as necessary
- Valuing differences in all people; avoiding demonstrating any bias toward individuals or groups by words and actions

Training:
- ECHN Hospital orientation
- HIPAA Education
- Hand Hygiene
- Hand Massage with guided imagery
- Healing Hands Procedure
- Two shifts with a preceptor (staff or volunteer)
- Continuing education as required

Responsibilities:
- Sign in at Volunteer Sign-in Book.
- Report to duty with appropriate volunteer attire and identification badge
- Introduce self and volunteer role in an appropriate manner
- ALWAYS wash hands when entering and leaving a patient room and in between errands
- Provide relaxing hand massage and/or guided imagery to patients and guests
- Communicate any concerns about a patient to their nurse or other staff member

Volunteer will NOT:
- Move/boost a patient
- Assist patient getting in/out of a bed or chair.
- Offer medical advice.

- Offer advice on hospital/unit policies/procedures.
- Enter isolation rooms

Physical Demands:

- Able to stand/walk for short periods of time

ECHN
Eastern Connecticut Health Network, Inc.

Volunteer Services
Volunteer Role Descriptions

Role: *Kitchen Work Experience Volunteer*
Date: *01/09/2012*

Department:
- Food Service

Reports to:
- Food Service Supervisor

Role Objective:
- Provide special needs youth work experience and assist the Food Service Staff

Qualifications:
- Special needs youth that is part of a program that partners with ECHN.
- Must be accompanied and supervised during work time by a case manager/job coach from their program.

Competencies:
- Able to follow directions and work cooperatively with others under the supervision of their case manager/job coach
- Able to stand for the duration of the shift
- Able to follow basic directions
- Valuing differences in all people; avoiding demonstrating any bias toward individuals or groups by words and actions

Training:
- ECHN Hospital orientation
- HIPAA Education
- Hand Hygiene
- Preceptor (staff or volunteer with case manager/job coach)
- Continuing education as required

Responsibilities:
- Report to duty with appropriate attire and identification badge
- Washing dishes
- Kitchen clean-up
- Emptying trash

Physical Demands:
- Able to stand for extended periods of time
- Light lifting

Notice of Availability for Uncompensated Care

Eastern Connecticut Health Network, Inc. will provide assistance for those patients who fall within the guidelines below.

To be eligible to receive uncompensated care, your family must be at or below the following current guidelines.

Family Gross Income Levels

2016 Federal Poverty Guidelines	125%	150%	175%	200%	250%	300%	400%

% of Write Off	100%	90%	80%	70%	60%	50%	40%
Family Size							
1	14,850	17,820	20,790	23,760	29,700	35,640	47,520
2	20,025	24,030	28,035	32,040	40,050	48,060	64,080
3	25,200	30,240	35,280	40,320	50,400	60,480	80,640
4	30,375	36,450	42,525	48,600	60,750	72,900	97,200
5	35,550	42,660	49,770	56,880	71,100	85,320	113,760
6	40,725	48,870	57,015	65,160	81,450	97,740	130,320
7	45,913	55,095	64,278	73,460	91,825	110,190	146,920
8	51,113	61,335	71,558	81,780	102,225	122,670	163,560

Add $4,160 for each additional member

Patient Responsibility	0%	10%	20%	30%	40%	50%	60%

If you feel you may be eligible, you may request free or discounted services at the Patient Financial Service Office. Requests may be made prior to admission, during the stay or at time of discharge. A financial evaluation form and application will be provided for the applicant upon request. The Hospital will make a final determination of your eligibility for uncompensated services.

When Third Party coverage is available (Medicare, State, Medicaid LIA, etc) all applicable benefits must be applied first. Patient convenience items such as private room differentials are not covered.

Refusal to take reasonable actions necessary to obtain these available benefits can exclude the granting of uncompensated services.

Source – Federal Register Income Poverty Guidelines

Revised 2/01/2016

ECHN
Eastern Connecticut Health Network, Inc.

Volunteer Services
Volunteer Role Descriptions

Role: *Patient Care Visiting Volunteer*
Date: *01/09/2012*

Department:
- Assigned Inpatient Nursing Unit

Reports to:
- Sr. Business Partner, Volunteer Services

Role Objective:
- To help increase patient and visitor comfort by providing a caring environment, companionship and/or assistance to appropriate patients and staff.

Qualifications:
- Friendly, people-oriented individual, having ability to interact with all types of people
- Having a caring and compassionate disposition
- Must be able to communicate in English
- Excellent interpersonal, communication and listening skills
- Excellent customer service skills
- Must be able to walk and stand for majority of shift

Competencies:
- Able to follow directions and work cooperatively with others with limited supervision
- Able to maintain strict confidentiality at all times
- Able to accept feedback and develop, acquire and utilize new knowledge and skills as necessary
- Able to determine and meet the needs of the customer and provide them with excellent service within the scope of this role
- Valuing differences in all people; avoiding demonstrating any bias toward individuals or groups by words and actions

Training:
- ECHN Hospital orientation
- HIPAA Education
- Hand Hygiene
- Two shifts with a preceptor (staff or volunteer)
- Continuing education as required

Responsibilities:
- Sign in at Volunteer Sign-in Book.
- Report to duty with appropriate volunteer attire and identification badge
- Introduce self and volunteer role in an appropriate manner
- Always honor the patients right to refuse volunteer assistance
- ALWAYS wash hands when entering and leaving a patient room
- Communicate any concerns about the patient to their nurse before leaving the unit
- Visiting may include:
  - Providing food or drink only after approval from the nurse
  - Getting warm blankets
  - Offering reading materials, puzzles, etc.
  - Assisting patients with meal trays—opening containers, cutting

food, etc.

Volunteer will NOT:

- Move/boost a patient
- Assist patient getting in/out of a bed or chair.
- Offer medical advice.
- Offer advice on hospital/unit policies/procedures.
- Enter isolation rooms

Physical Demands:

- Able to stand/walk for moderate periods of time

Subject: Pet Therapy Volunteer Program
Policy Number: 010

Released:

I. Purpose:

A. To allow for safe visits by certified pet therapy volunteers and their certified pet dogs to lift the spirits of patients and visitors.

II. Policy

A. Pet Therapy Volunteer

1. Volunteer must be a certified handler for their pet

2. Volunteer must handle pet according to the below.

3. Volunteer must shadow a current pet therapy volunteer a minimum of two times or until they are comfortable in their position prior to working on their own.

B. Pet Therapy certification for pet and handler from a recognized pet therapy society.

C. Proof of up-to-date vaccinations and good health from veterinarian.

D. Pets must be well groomed and clean prior to visiting.

E. The Pet Therapy Volunteer must ask if the patient would like to have a visit from a dog prior to entering the patient room.

F. The Pet Therapy Volunteer must request to enter Behavioral Health.

1. Visits to behavioral health are best pre-arranged so patients have time to visit with the animal.

G. Care of the dog is responsibility of owner (not staff or patient) at all times. The pet must be under the control of the handler at all times.

H. Pet visits will not be allowed isolation rooms, the intensive care unit or in the perinatal area.

I. Pets must be on a leash or caged during the visit.

J. Pets should not be visiting/working for more than 1 1/2 hrs per-day up to a maximum or three days per week, or as mandated by the pet therapy society certifying the pet, whichever is less.

K. The handler will immediately remove the pet from visitation for any of the following:

1. patient/staff request,

2. allergic responses,

3. medical emergency,

4. animal fatigue or signs of stress, improper behavior (growling/barking).

L. If a patient or staff injury occurs: i.e., scratch, bite, etc., the pet must be removed.

1. The handler must notify the nursing staff.

2. The patient or staff will need to be assessed and appropriate measures will be undertaken.

3. An incident report must be filed.

M. If the pet is injured, the handler will notify the nursing staff, and the handler will bring the pet to a veterinarian for follow-up. An incident report must be filled out.

N. If the pet defecates, urinates or vomits on the unit, either the dog's handler or staff member will be responsible for its removal and placement in a biohazard bag. Hospital staff will be responsible for spraying disinfectant on the affected area and following hand washing procedures.

III. RESPONSIBLE FOR REVISION: Head of Volunteer Services

IV. Revised: 01/20/2012 by Ellen Barnes

V. ORIGINATED: 5/29/2000

ECHN
Eastern Connecticut Health Network, Inc.

Volunteer Services
Volunteer Role Descriptions

Role: *Pharmacy Volunteer*
Date: *01/09/2012*

Department:
- Pharmacy

Reports to:
- Pharmacy Director, Manager, Supervisor or designee

Role Objective:
- Speed delivery of orders to floors and relieve staff of routine duties.

Qualifications:
- Friendly, people-oriented individual, having ability to interact with all types of people
- Must be able to communicate in English
- Excellent interpersonal, communication and listening skills
- Excellent customer service skills
- Must be physically able to make round trips to Nursing Units in the course of a day
- Typing skills helpful but not necessary
- Some lifting and bending

Competencies:
- Able to follow directions and work cooperatively with others with limited supervision
- Able to maintain strict confidentiality at all times
- Able to accept feedback and develop, acquire and utilize new knowledge and skills as necessary
- Valuing differences in all people; avoiding demonstrating any bias toward individuals or groups by words and actions

Training:
- ECHN Hospital orientation
- HIPAA Education
- Hand Hygiene
- Two shifts with a preceptor (staff or volunteer)
- Continuing education as required

Responsibilities:
- Sign in at Volunteer Sign-in Book.
- Report to duty with appropriate volunteer attire and identification badge
- Introduce self and volunteer role in an appropriate manner
- ALWAYS wash hands in between errands
- Transport pharmaceuticals to nursing units as requested
- Filing, Typing, restocking shelves
- Unpack orders, check in and put away on shelves
- Other related duties and errands as requested

Physical Demands:
- Able to walk round trips to nursing units
- Light lifting and bending

ECHN
Eastern Connecticut Health Network, Inc.

SUBJECT: **Pre-Collect and Bad Debt Policy** **POLICY NO: 4005**
SECTION: **PAGE**

I. TITLE: Departmental Pre-Collect and Bad Debt Policy and Procedures

II. POLICY: This policy applies to the Manchester Memorial and Rockville General Hospitals Patient Financial Services

III. PURPOSE: To ensure that bad debt accounts are appropriately identified and consistently processed within the guidelines of the hospital's credit and collection policy.

IV. RESPONSIBILITES:

A. To ensure that accounts with outstanding patient balances beyond 120 days are written off to bad debt. Accounts are considered bad debt once reviewed by the Self Pay Team and the Pre-Collections Unit as uncollectible. It must be determined that the accounts meet the following criteria:
   a. The account has aged 120 days from the date the balance became the responsibility of the patient / guarantor without payment in full.
   b. No reasonable response from the patient in the previous 120 days.
   c. Guarantor has received at least four statements.
   d. Third party carrier has denied in writing the responsibility for any payment (partial or full) towards the account and the collector has documented the patient / guarantor's refusal for payment or financing when applicable.
   e. Guarantor has defaulted on an "agree to payment plan" (for two consecutive months or more)
   f. The account has been flagged as a "bad address" or "mail return".

B. If the above criteria has been met, and at the 4th statement, the account is transferred to the pre-collection list for potential bad debt and is designated to be analyzed for the month end bad debt / write off function. Steps to occur are:
   a. On the 25th of the month
      i. Run is run to capture all accounts set to receive 4 statements from the 25th thru the 24th of the next month.
      ii. Individually review each account to determine if meets criteria for pre-collect letter
         1. Guarantor has received at least 4 statements
         2. Account not paid in full
         3. defaulted on pay plan
            A. PFS will ensure that the guarantor has been notified in writing that they are in default and in danger of going to collection, after first missed month.
         4. Identified as return mail. Researched, collector changed, and 2 months noted on account.
         5. "Dirty buckets" (money in insurance and self pay) need to be resolved prior to pre-collect letter.
         6. The total pre-collect dollars can not exceed the established bad debt turnover number.
         7. Only one pre-collect letter will go out on each account.
         8. Identify accounts that are not eligible for write off-due to established criteria, Medicaid eligibility, bankruptcy, or the patient is deceased.
         9. Document in financial comments the reason that any account is not eligible for bad debt write off.

b. Once the monthly pre-collect accounts have been identified and worked, change the self pay collector for the pre-collect code designated for that month and year .
c. On the fourth day of the month
    i. Finalize pre-collect review
        1. Produce and send out pre-collect letters.
            A. Ensuring that the total dollars do not exceed the bad debt turnover number
            B. No account has been previously send a pre-collect letter
        2. Retain copy of pre-collect report for our records.
d. By the 3rd Friday of the month
    i. Review pre-collect accounts for payments
    ii. Review pre-collect accounts for Medicaid Eligibility
    iii. Request bad debt write off according to the following monetary guidelines:
        1. Balance of between $20 and $999 - no approval necessary
        2. Balances between $1,000 and $3,900 – reviewed by Non Governmental Specialist
        3. Balances between $4,000 and $9,999 – reviewed and approved by Non Gov Manager
        4. Balances greater than $10,000- reviewed and approved by Department Manager
    iv. Report bad debt turnover number to management
e. On the twenty fifth of the month
    i. Review pre-collect accounts for payments
    ii. Review pre-collect accounts for Medicaid Eligibility
    iii. Received appropriate approval from management according to established monetary guidelines, which are retained for our records.
    iv. Review reports to agree with final dollar amount and account age prior to account transfer
    v. Electronically transfer the selected accounts to bad debt status
f. On the last day of the month
    i. Ensure that the self pay payments have been posted for the month
    ii. Review bad debt accounts for payments
    iii. Review bad debt accounts for Medicaid Eligibility
    iv. Report final month end Bad Debt totals to management
g. On the third business day after conclusion of month end process
    i. Final review of bad debt accounts for payments
    ii. Final review of bad debt accounts for Medicaid Eligibility
    iii. Transmit electronic file to collection agency
    iv. Run bad debt report and retain copy of our records

C. It is essential that in conjunction with the bad debt process, that the following areas also need to be kept current and worked daily
    a. Bankruptcies to be worked daily
    b. Mail Return to be worked daily
    c. Charity Care to be worked daily
    d. Pay Plans to be reviewed and worked daily

VII. INDIVIDUAL RESPONSIBLE FOR REVISION: Director, PFS

VIII. ORIGINATED: 11/04 REVISION DATE: 3/11
11/09

Read to Grow
Building literacy from birth
53 School Ground Rd., Branford, CT 06405 • 203.488.6800 • readtogrow@readtogrow.org

Job Description: Books for Babies Volunteer

Purpose: To visit hospitals and provide families on maternity unit information about: infant brain development; infant capabilities; and the importance of talking, reading, singing, and playing with their infants from birth. Also to answer questions that families might have about Read to Grow's Literacy Packet they receive for free.

Objective: To work cooperatively with the hospitals, following their guidelines, in order to bring parents of newborns the information and tools to build their children's early language skills.

Qualifications:

- Ability to work independently within hospital framework/requirements *and* to seek help/direction from site supervisors/unit staff if needed.
- Good listening and effective communication skills.
- Strong interpersonal skills; caring, mentoring personality

Orientation/Evaluation: A Books for Babies orientation with Read to Grow representatives takes place after completing the necessary on-site orientation at the hospital's Volunteer Service Department, per the institution's policy. As a preliminary stage to the Books for Babies orientation, a new volunteer is invited to the office in Branford. The main orientation, however, will be at the hospital.

After two months at the hospital, a volunteer will be mailed an evaluation form from Read to Grow to fill out and return. Sometime between two and three months after starting, a volunteer will speak (on phone or in-person) with a Books for Babies staffer about the job.

Times: to be determined with Read to Grow and the hospitals

Responsibilities:

- Read orientation material and literacy data from Read to Grow;
- Notify site supervisor *and* Read to Grow if unable to volunteer as scheduled;
- Respect patient privacy. Know and comply with hospital policy on patient confidentiality (HIPAA);
- Know and follow hospital emergency procedures and any safety/health requirements;

- Be consistent, dependable and enthusiastic about work;
- Maintain communications with Read to Grow as set out and agreed upon;
- Share ideas and concerns with Read to Grow staff and hospital staff when appropriate.

Other responsibilities on the maternity unit:

- Wear identification badge as directed by the hospital;
- Sign in and out, per hospital policy;
- Let unit secretary know you are on the unit;
- Accurately maintain the Books for Babies **log book**. (This log book—usually a three-ring binder—holds **log sheets** that are filled out by individual volunteers during and after their rounds. A log sheet is passed on from one volunteer to the next and is always found in the log book.)

- Visit with families in a timely, appropriate manner, as outlined here:
  - Check with the appointed staff person to see if there are any patients who should not be visited. Jot down names and reasons in the Books for Babies log sheet so that the volunteer following you will be informed. (For example: patient had surgery, baby ill, etc.)
  - The unit staff is responsible for the actual distribution of Literacy Packets to the mothers. Hospitals usually provide the Literacy Packets upon patient admission or shortly thereafter.
  - Proceed to a patient's room with log sheet. Check for signs alerting you **not** to enter. If none is there, knock and enter room quietly.
  - Introduce yourself as a Books for Babies volunteer. Ask if it is a convenient time for a short visit. If not, check to see if the patient has the Literacy Packet, point it out and wish patient well. (Also ask if there is a good time to return.)
  - If the time is convenient, provide literacy information in a friendly, concise and upbeat manner. Do not tire the patient or overstay your welcome. Remember new mothers may have difficulty learning something new when they are overly tired or excited after giving birth.
  - Continue on rounds, noting patients' names and room numbers on the log sheet. This will prevent your co-volunteers from visiting the same patients. Describe the quality of visits on the log sheet with your own comments about patients' reactions and interactions. These can be brief but to the point.

- When finished with rounds, complete any remaining paperwork, put the log sheet in the log book, sign out, and let your site supervisor know you are leaving.
- Notify Books for Babies staff if supplies are low (203-488-6800).
- Maintain strict adherence to the institution's confidentiality policy (HIPAA). Do not discuss patients, situations, or staff in or out of the hospital.

Limitations: Volunteers must always be aware of their limitations.

- Never perform a task outside of your job description.
- Never give a patient any food or water.
- Never reposition a baby or mother. Seek staff member.
- Never hold a baby, even at the mother's request. Seek staff member.
- Never read the patient's medical record.
- Never comment or offer advice as it relates to the patient's or baby's condition.
- Before entering room of a patient on isolation, read all posted signs and check with staff.
- Step out of the room if a doctor, nurse or clergy arrives.
- Always check with staff if you are uncertain about a situation.

* * * *

STUDENT EDUCATIONAL AFFILIATION AGREEMENT

This Student Educational Affiliation Agreement ("Agreement") is made and entered into as of May 1, 2016 ("Effective Date") by and between _____ and Eastern Connecticut Health Network, Inc. ("ECHN") including but not limited to Manchester Memorial Hospital at 71 Haynes Street, Manchester, CT 06040, Rockville General Hospital at 31 Union Street, Vernon, CT 06066, ECHN ElderCare Services, Inc. d/b/a Woodlake at Tolland Nursing & Rehabilitation Center at 26 Shenipsit Lake Road, Tolland, CT 06084, Visiting Nurse and Health Services of Connecticut at 8 Keynote Drive, Vernon, CT 06066 and any other ECHN affiliates (individually or collectively, as applicable, the "Hospital").

WHEREAS, the School desires to provide supervised clinical, non-clinical or other fieldwork experience and instruction as part of its educational program for its students ("Students"); and

WHEREAS, the Hospital, in the interest of furthering the educational objectives of the School, desires to make its facilities available to the Students for such experience;

NOW THEREFORE, in consideration of the promises and the mutual covenants, agreements and undertakings hereinafter set forth, it is hereby AGREED:

1. Planning of Educational Program. The School shall be responsible for the planning and implementation of all educational aspects of the Students' clinical or other fieldwork experience and instruction, including the requirements for matriculation, promotion and graduation (the "Program"). The purpose of the practicum experiences, which are supplemented with didactic experience, is to develop competence on the part of the Students. The School will designate a faculty member, known as the Academic Coordinator of Clinical Education (ACCE), to work with the designated coordinator at the Hospital on the administrative and academic aspects of the Students' experience at the Hospital.

2. Philosophy and Objectives of Program. The School will convey to Hospital personnel information about the philosophy and objectives of the Program. The School shall also provide the Hospital with current information about its curriculum, clinical or fieldwork educational goals and faculty.

3. Instruction and Supervision. If required by the Program or the Hospital, the School shall provide competent faculty (the "Faculty") for supervision of Students assigned to the Hospital for practicum experience. The Faculty will be available for consultation with Hospital personnel at all times that Students are at the Hospital. Faculty shall be responsible for planning Student assignments and for evaluating and grading Student performance. Faculty may consult with Hospital personnel as appropriate in conducting evaluations of Student performance. The Hospital shall be responsible for assigning Students to clinical areas and patients.

4. Notice of Program. At least thirty (30) days prior to commencement of the Program each term, the School shall submit to the Hospital a description of the types of clinical or other

fieldwork experiences needed, the dates during which such experiences will be needed, the number of Students expected to participate in the Program(s), and the names and professional credentials of the Faculty who will supervise the Students. The School shall inform the Hospital as soon as practicable of any changes in information previously provided to the Hospital regarding the Program. If it becomes necessary to cancel a reserved space or change a Student assignment, the School will promptly notify the Hospital.

5. Compliance with Hospital Rules by the Faculty. The School will instruct its Faculty that they must comply with all rules and regulations of the Hospital. Upon Hospital's request, the School agrees to promptly withdraw any member of the Faculty who fails to comply. The School shall provide evidence of Connecticut licensure, certification and/or registration for Faculty if such is required for the Program, upon the request of Hospital.

6. Compliance with Hospital Rules by the Students. The School will instruct its Students that they must comply with all rules and regulations of the Hospital. The School will notify each Student that he/she is responsible for:

   a. respecting the confidentiality of information regarding patients/clients of the Hospital and maintaining all patient/client records in accordance with Federal and Connecticut law and the Hospital's policies and procedures;

   b. adhering to all policies and procedures of the Hospital;

   c. adhering to the Hospital's dress code, including appropriate uniform and name/identification badge, as required by the Hospital;

   d. arranging for their own transportation;

   e. reporting to the Hospital as scheduled;

   f. obtaining housing and meals when not provided by the Hospital;

   g. providing evidence of required health insurance;

   h. obtaining prior written approval from the Hospital and School before publishing any material relating to their clinical or other fieldwork experience at the Hospital; and

   i. any loss or damage to their own personal property while on Hospital's premises.

7. Confidential Information. The School will instruct Students, Faculty, and other School personnel not to disclose any confidential material or information connected with the Hospital or any of its patients/clients; and, further, the School will ensure that all such information is maintained as confidential in accordance with Federal and Connecticut law. The School shall also enforce compliance by Students and Faculty with the Hospital's policies on confidentiality. In addition, each Student and Faculty (if Faculty will be on-site at the Hospital) shall execute the Confidentiality Statement attached hereto

as Appendix B prior to starting the clinical/fieldwork experience at the Hospital. Each student shall also review the Code of Conduct, sign it and return to the appropriate department.

8. Withdrawal of Students from the Program. The Hospital may immediately withdraw any Student from the clinical or other fieldwork area due to health, academic deficiency, failure to follow Hospital policy, unacceptable performance, inappropriate behavior or other reasons, if such Student's continued participation in the Program is detrimental to the Student and/or any patient/client of the Hospital. The Hospital shall promptly inform the School of such withdrawal.

9. Program Experience. The School shall be responsible for selecting only those Students who have successfully completed all the prerequisite courses and/or previous clinical or other fieldwork experiences as specifically required by the Program or Hospital. In advance of the Students' placement, the parties will develop a planned, supervised educational program at the Hospital that is compatible with the Program goals and objectives of the Student's academic education at the School. The Hospital shall provide the opportunity for qualified Students to perform appropriate clinical procedures or other practical fieldwork under the ultimate supervision of the Faculty, in conjunction with personnel of the Hospital and in accordance with the terms of this Agreement. The Hospital shall at all times retain authority and responsibility for the delivery of patient care.

10. Equipment and Use of Facilities. The Hospital shall provide appropriate space and facilities for use by Students and Faculty. Students and Faculty may use the Hospital's cafeteria at their own expense. There shall be no charges between the parties with respect to the services and responsibilities each undertakes to provide pursuant to this Agreement.

11. Orientation for Faculty and Students. As appropriate, the Hospital shall provide an orientation for the Faculty so that they may familiarize themselves with the Hospital, the physical plant, and relevant policies and procedures prior to bringing Students to the Hospital. The School shall provide appropriate orientation to the Students.

12. Medical Care. The Hospital shall provide emergency medical care to Students and/or Faculty who become ill or who are injured while on duty at the Hospital. The cost of such care shall be the sole responsibility of the individual receiving it. In addition, the School agrees that the School provides adequate medical benefits covering Students for any injuries or illnesses that may occur while on duty at the Hospital, and that the School is fully responsible for any payments or loss related to any such injury or illness, provided that the payment or loss is not the direct result of negligence or wrongdoing by the Hospital. The School acknowledges and agrees that the Hospital is not responsible for providing the Students with medical benefits of any kind.

13. Required Inservices. If the Student(s) will have any direct patient contact, the School shall provide the Hospital with evidence that the mandatory inservices have been provided to Students and Faculty in advance of the first clinical or other fieldwork

experience (unless the Hospital has agreed to provide such inservices to the Students). Mandatory inservices include, as appropriate to the Program, general safety, infection control, OSHA blood borne pathogens and universal precautions, TB, fire safety, hazardous materials, Safe Medical Devices Act, use of electrical equipment and CPR.

14. Immunizations and Physical. The School shall provide the Hospital with evidence that Students, and all on-site Faculty meet the Hospital's requirements for immunizations and physical exam as set forth in Appendix A, which is incorporated herein by reference.

15. Insurance. Upon Hospital's request, the School shall provide professional liability insurance with limits of not less than $1,000,000 per claim and $3,000,000 in the aggregate for Students and Faculty while participating in the Program at the Hospital. The School shall also maintain comprehensive general liability insurance in an amount satisfactory to the Hospital. If required by the Hospital, each Faculty member, while acting within the scope of his/her required duties, shall be covered by Teachers Professional Liability insurance with limits of at least $1,000,000 per occurrence and $3,000,000 in the aggregate.

16. Evaluations. Appropriate Hospital personnel and the School's ACCE shall meet periodically to discuss issues of mutual concern and for the purpose of evaluating the educational rotation at Hospital.

17. Term and Termination of Agreement. This Agreement shall be effective on March 1, 2016 and shall continue in effect for three (3) years until February 28, 2019. Thereafter, this Agreement may be renewed for successive three (3) year terms by the mutual written consent of the parties. Either Party may terminate this Agreement at any time, without cause, by giving sixty (60) days prior written notice to the other Party; provided, however, and subject to Paragraph 8, above, that any Student assigned to the Hospital shall be permitted to complete the current educational term.

17.1 Termination Due to Risk of Safety. Hospital may terminate this Agreement immediately in the event the Student poses a risk of safety to Hospital employees or patients.

17.2 Termination Due to Exclusion. Either Party may terminate this Agreement, upon written notice effective immediately, in the event that the other Party is convicted of a criminal offense related to health care and/or related to the provision of services paid for by Medicare, Medicaid or such other federal health care programs or in the event that the other Party or an officer, director, member, employee or agent of such Party is excluded or suspended from participation in any federal health care program, including Medicare and Medicaid, and such individual is not immediately terminated by such Party.

17.3 Termination for Cause. In the event that either Party shall fail to keep, observe or perform any covenant, term or provision of this Agreement applicable to such Party, the other Party shall give the defaulting Party notice in writing of such default specifying the nature of such default. If the defaulting Party fails to cure

the breach or fails to arrange for a cure of the breach to the satisfaction of the non-breaching Party within five (5) days of receipt of such notice, the non-defaulting Party may terminate this Agreement upon two (2) days written notice.

18. Students and Faculty Not Employees or Agents. Both the School and the Hospital acknowledge that neither Students nor Faculty are to be considered employees or agents of the Hospital. Neither the Faculty nor Students shall receive any compensation from Hospital for the services provided pursuant to this Agreement.

19. Governing Law. This Agreement shall be construed in accordance with, and governed by, the laws of the State of Connecticut applying to contracts made and performed in Connecticut without regard to its conflicts of law principles and the parties hereto submit to the courts of such jurisdiction as the sole forum for resolving any disputes.

20. Entire Agreement and Amendment. This Agreement is the entire agreement between the parties and supersedes and rescinds all prior agreements relating to the subject matter hereof. This Agreement may be amended only in writing signed by both parties.

21. Notices. Any notice required to be given pursuant to the terms of this Agreement shall be in writing and shall be sent, postage prepaid, by certified mail, return receipt requested, to the Hospital or the School at the addresses set forth below. The notice shall be effective on the date of delivery indicated on the return receipt.

If to the Hospital:

Eastern Connecticut Health Network, Inc.
Attn: Legal Department
71 Haynes Street
Manchester, CT 06040

If to the School:

[_____]
[_____]
[_____]
[_____]

22. Assignment. No Party may assign this Agreement without written consent of the other, except that ECHN may assign this Agreement to any entity that directly or indirectly owns or controls ECHN, or is directly or indirectly owned or controlled by ECHN or is an affiliate of ECHN, or to an entity that directly or indirectly acquires all or substantially all of its assets or majority control. Any assignment made without such consent shall be void.

23. Accommodations for Persons with Disabilities. In the event that a Student, Faculty, or other School personnel requires accommodation for a disability beyond those accommodations that are currently available at the Hospital, the School shall be

responsible, at its sole cost, for making arrangements that are necessary to effectuate the additional accommodation.

24. Nondiscrimination. The School and the Hospital, respectively, agree that in the performance of this Agreement, they will not discriminate or permit discrimination against any person or group of persons on the grounds of race, color, religious creed, age, marital status, national origin, ancestry, sex, or mental retardation, physical disability, blindness, or other handicap, in any manner prohibited by the laws of the United States or of the State of Connecticut.

25. Indemnification. To the extent not otherwise inconsistent with the laws of the State of Connecticut, each Party shall indemnify and hold harmless the other from any fines, claims, demands, suits or actions of any kind whatsoever arising from the indemnifying Party's acts or omissions in the course of its performance of its obligations under this Agreement.

IN WITNESS WHEREOF, the parties hereto have executed this Student Educational Affiliation Agreement as of the date written below their signatures.

By: _____

Print name: _____

Title: _____

Date: _____

Eastern Connecticut Health Network, Inc.

By: _____

Print name: _____

Title: _____

Date: _____

Eastern Connecticut Health Network, Inc.

APPENDIX A

REQUIRED HEALTH DATA FOR FACULTY AND STUDENTS

1) Physical Exam - Satisfactory completion of physical exam within the past twelve (12) months or signed statement from student and program director that the student is fit to participate in clinical rotation or fieldwork

2) PPD - Documentation of a mantoux skin test for tuberculosis within the previous twelve (12) months, including the date done and size of reaction. For those with a previous positive reaction, documentation attesting to the fact that the individual is not infectious along with any prophylaxis used and the date and size of reaction must be provided by a physician.

3) Rubella (German Measles) - Written evidence of at least one dose of rubella vaccine, given on or after the first birthday, or serological evidence (blood test) of immunity to rubella, regardless of the age or job status of the person.

4) Rubeola (Regular Measles) - Written evidence of two doses of live measles vaccine or serological evidence (blood test) of immunity. One dose should have been given on or after the first birthday, and at least one dose should have been given after 1968. The two doses should be separated by at least 30 days.

5) Varicella Zoster

   (a) Known history of chicken pox is acceptable evidence of immunity

   (b) Two doses of varicella zoster live virus vaccine given 4-8 weeks apart if age 13 or older

   (c) Serologic testing (blood test) if history of disease is unknown or unclear

6) Hepatitis-B - Vaccination series completed or declination statement on file at the School (if exposure to blood/body fluids is likely).

7) Tetanus booster - Within past ten (10) years recommended not required.

8) Seasonal Flu Vaccine - If clinical rotation or fieldwork occurs during flu season (normally between the months of August and April) proof of vaccination has to be provided by November [•].

Evidence of compliance with these requirements must be submitted to ECHN prior to the first clinical or fieldwork day. The Student(s) will not be permitted to start the clinical/fieldwork experience at Hospital until such documentation is provided.

Eastern Connecticut Health Network, Inc.

APPENDIX B

CONFIDENTIALITY AND SECURITY OF INFORMATION AGREEMENT

ECHN Employees and Workforce Members

This Confidentiality and Security of Information Agreement (hereafter referred to as the "Agreement") applies to Eastern Connecticut Health Network (ECHN), its wholly-owned subsidiaries and affiliates, as well as, anyone conducting business with ECHN or its affiliates. I understand that the ECHN affiliated facility or business entity (the "Organization") for which I work, volunteer or provide services manages health information as part of its mission to treat patients. Further, I understand that the Organization has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their patients' health information. Additionally, the Organization must assure the confidentiality of its human resources, payroll, fiscal, research, internal reporting, strategic planning information, credentialing, intellectual property, or any information that contains Social Security numbers, health insurance claim numbers, passwords, PINs, encryption keys, credit card or other financial account numbers (collectively, with patient identifiable health information, "Confidential Information").

In the course of my employment/assignment at the Organization, I understand that I may come into the possession of this type of Confidential Information. I will access and use this information only when it is necessary to perform my job related duties in accordance with ECHN's Privacy and Security Policies, which are available on the ECHN SharePoint site under Corporate Administrative Policies and Procedures. I further understand that I must sign and comply with this Agreement in order to obtain authorization for access to Confidential Information or Organizational systems.

General Rules

1. I will act in the best interest of the Organization and in accordance with its Code of Conduct at all times during my relationship with the Organization.

2. I understand that I should have no expectation of privacy when using Organizational information systems. The Organization may log, access, review, and otherwise utilize information stored on or passing through its systems, including e-mail, in order to manage systems and enforce security.

3. I understand that violation of this Agreement may result in disciplinary action, up to and including termination of employment, suspension, and loss of privileges, and/or termination of authorization to work within the Organization, in accordance with ECHN's policies and procedures.

Protecting Confidential Information

4. I will not disclose or discuss any Confidential Information with others, including friends or family, who do not have a need to know it. I will not take media or documents containing Confidential Information home with me unless specifically authorized to do so as part of my job.

5. I will not publish or disclose any Confidential Information to others using personal email, or to any Internet sites, or through Internet blogs, including but not limited to sites such as Facebook or Twitter. I will not use Social Media while performing my job responsibilities unless expressly permitted by management. I will not access social media websites using ECHN's equipment unless prior authorization is provided (see Human Resources Policy #619: Social Media).

6. I will not in any way divulge copy, release, sell, loan, alter, or destroy any Confidential Information except as properly authorized. I will only reuse or destroy media in accordance with ,ECHN Information Security Standards and the ECHN record retention policy (CAP Policy #752: Retention and Destruction of Records).

7. In the course of treating patients, I may need to orally communicate health information to or about patients. While I understand that my first priority is treating patients, I will take reasonable safeguards to protect conversations from unauthorized listeners. Such safeguards include, but are not limited to: lowering my voice or using private rooms or areas where available.

8. I will not make any unauthorized transmissions, inquiries, modifications, or purgings of Confidential Information.

9. I will not transmit Confidential Information outside the Organizational network unless I am specifically authorized to do so as part of my job responsibilities. If I do transmit Confidential Information outside of the Organization using email or other electronic communication methods, I will ensure that the Information is encrypted according to ECHN Information Security Standards.

Following Appropriate Access

10. I will only access or use systems or devices I am officially authorized to access, and will not demonstrate the operation or function of systems or devices to unauthorized individuals.

11. I will only access software systems to review patient records or Organizational information when I have a business need to know, as well as any necessary consent. By accessing a patient's record or Organizational information, I am affirmatively representing to the Organization at the time of each access that I have the requisite business need to know and appropriate consent, and the Organization may rely on that representation in granting such access to me.

Using Applications, Mobile Devices, Portable Devices and Removable Media

12. I will not copy or store Confidential Information on any applications including storage applications, mobile devices, portable devices or removable media such as laptops, personal digital assistants (PDAs), cell phones, COs, thumb drives, external hard drives, etc., unless within the scope of my employment responsibilities. If I do copy or store Confidential Information on applications, removable media or devices, it will be while using ECHN approved applications, removable media or devices with appropriate encryption according to ECHN Information Security Standards.

13. I understand that any mobile device (smart phone, PDA, etc.) that synchronizes Organizational data (e.g., Organizational e-mail) may contain Confidential Information and as a result, must be protected as required by ECHN Information Security Standards.

Doing My Part- Personal Security

14. I understand that I will be assigned a user-ID and password to track my access and use of Confidential Information and that the identifier is associated with my personal data provided as part of the initial and/or periodic credentialing and/or employment verification processes.

15. I will:

    a. Use only my officially assigned user-10 and password.

    b. Use only approved licensed software.

    c. Use a device with virus protection software.

16. I will never:

    a. Disclose passwords, PINs, or access codes.

    b. Allow another individual to use my digital identity to access, modify, or delete data and/or use a computer system.

    c. Allow another individual to use my identification badge.

    d. Use tools or techniques to break/exploit security measures.

    e. Connect unauthorized systems or devices to the Organizational network.

17. I will practice good workstation security measures such as locking up electronic storage media when not in use, using screen savers with activated passwords, and positioning screens away from public view in accordance with CAP Policy #730: Safeguarding Confidential Information in the Workplace.

18. I will immediately notify my manager, Chief Information Officer (CIO) or ECHN HelpDesk if:

    a. My password has been seen, disclosed, or otherwise compromised;

    b. Media with Confidential Information stored on it has been lost or stolen;

    c. I suspect a virus infection on any system;

    d. I am aware of any activity that violates this agreement, privacy and security policies; or

    e. I am aware of any other incident that could possibly have any adverse impact on Confidential Information or ECHN systems.

Upon Termination of Employment

19. I agree that my obligations under this Agreement will continue after termination of my employment, expiration of my contract, or my relationship ceases with the Organization.

20. Upon termination, I will immediately return any documents or media containing Confidential Information to the Organization.

21. I understand that I have no right to any ownership interest in any Confidential Information accessed or created by me during and in the scope of my relationship with the Organization.

By signing this document, I acknowledge that I have read this Agreement and I agree to comply with all the terms and conditions stated above.

_____

Employee/Workforce Member Printed Name

_____

Employee/Workforce Member Signature

_____

Department/Business Entity Name Date/Time

As far as volunteer committee participation, we also have our Professional Advisory Committee (9) which is required by CT DPH regulations.

Visiting Nurse & Health Services of Connecticut, Inc.

Professional Advisory Committee Charter

Mission Statement

The Professional Advisory Committee is a group of professionals who participate in the agency's overall Quality Assurance Program. The Committee's role is to advise the agency on professional issues, assist in maintaining relationships with community practitioners and to participate in the evaluation of the agency's programs, and policies. The committee must be composed of professionals in active practice or who have been retired less than five years. Membership must include at least one physician, one community health nurse, one therapist representing one of the skilled therapies offered by the agency, a medical social worker, a pharmacist, a volunteer and members of the other professional disciplines as appropriate.

Goals

1) To improve processes and outcomes in client care and services.
2) To recommend and review annually the agency's policies on:
    a. Scope of services offered
    b. Admission and Discharge Criteria
    c. Medical and Dental supervision and plans of treatment
    d. Clinical records
    e. Personnel Qualifications
    f. Quality assurance activities
    g. Standards of care
    h. Professional issues especially as they related to the delivery of service and findings of the quality assurance program
    i. Emergency care
3) Assist with maintaining Liaison with other health care providers in the community
4) Assist in identifying how the agency can best serve the needs of the community

Hospice Volunteers-These volunteers visit people who are on hospice care and serve needs by reading to patients, sitting with them to talk or listen--some play music, and provide reiki or pet therapy services. Our Hospice volunteers are required by CMS regulations as a condition of participation.

The following policies were developed by Visiting Nurse & Health Services of Connecticut Hospice, a program of Visiting Nurse & Health Services of Connecticut, Inc. Policies are reviewed yearly and revised as necessary.

I. **Purpose of Visiting Nurse & Health Services of Connecticut Hospice and Palliative:** To improve the quality of life of terminally ill patients and their families in North Central Connecticut.

Volunteer services are a very integral part of the Hospice Program of VNHSC. Patients will have appropriate volunteer support provided to them as determined by the IDT and set forth in the IDT Plan of Care. These volunteer services will be coordinated to meet the individual needs based on place of residence, patient level of care, and specific problems, issues, and goals of Plan of Care.

II. **Mission of Visiting Nurse & Health Services of Connecticut Hospice and Palliative:** The mission of Visiting Nurse & Health Services of Connecticut Hospice and Palliative is to provide assistance and care for terminally ill patients and their families. We provide palliative and bereavement care by professionals and volunteers to meet the physical, psychosocial, spiritual and emotional needs arising in the patient and family at the time of terminal illness. Caregivers provide a loving, effective presence to the terminally ill person and his/her loved ones so that life, as long as it continues, is as free from pain and as meaningful as possible.

III. **Range of Services**

Visiting Nurse & Health Services of Connecticut Hospice and Palliative provides both direct patient/family contact and organizational opportunities for volunteers:

A. Patient/Family Volunteer: The Patient/Family volunteer provides services to patients and families under the direction of the Volunteer Coordinator in accordance with the Interdisciplinary Team plan of care at patient's home, Skilled Nursing Facility or in the inpatient facility.

B. Spiritual Care Volunteer: The Spiritual Care volunteer provides spiritual care support to terminally-ill patients and their family members under the direction of the Spiritual Care Coordinator in accordance with the Interdisciplinary Team plan of care.

C. Bereavement Volunteer: The Bereavement volunteer provides bereavement services to families in accordance with the Interdisciplinary Team plan of care.

D. Clerical Volunteer: This volunteer completes office duties (filing, typing, copying, mailings, telephoning) and/or work on a special organizational project, event or fundraising event. Supervision provided by Director of Volunteer Services, Bereavement Coordinator, Spiritual Care Coordinator, and Supervisor of Clinical Services or Vice President of Development.

E. Reiki Volunteer: The Reiki Hospice volunteer provides Reiki treatment to terminally-ill patients and their family members under the direction of the Volunteer Coordinator and in accordance with the Interdisciplinary Team plan of care.

F. Caring Canines: The goal of the Caring Canines Program is to decrease anxiety and isolation while creating a positive interactive experience with North Central Hospice clients, under the direction of the Volunteer Coordinator in accordance with the IDT Plan of Care.

G. Music by Bedside: The goal of the Music by Bedside volunteers allows the patient and their family to experience what they need through music, under the direction of the Volunteer Coordinator.

H. Living Reflections: The Living Reflections volunteer photography provides a photo session to patient and family. It provides a framed photograph and CD of photos to patient, under the direction of the Volunteer Coordinator and in accordance of IDT Plan of Care. Patient will sign release (see Exhibit 8).

I. Aroma Therapy: The Aroma Therapy volunteer provides Aroma Therapy intervention to the identified terminally ill patient and family, under direction of the Volunteer Coordinator and in accordance with the IDT Plan of Care,

IV Volunteer Personnel Policy:

A. Equal Employment Opportunity: Discrimination against any person in recruitment, examination, appointment, training, promotion, retention or any other personnel action because of race, color, creed, national origin, age, sex, sexual orientation, handicap, political affiliation, or any other non-merit factor is prohibited except where such a factor is a bona fide occupational requirement.

B. Insurance: Volunteers are covered by insurance purchased by NCH for claims alleging errors, omissions, mistakes, or negligence while working with patients and families.

C. Hours of Work

C.1 Hours worked by volunteers are assigned according to their specific role and their availability. Volunteers with direct patient/family contact are oriented to their responsibilities and work hours mutually agreeable to themselves and the patient/family.

C.2 All volunteer hours are recorded by the volunteer and reported in a timely manner.

D. Evaluation: It is the belief of NCH that evaluation is an ongoing process. Informal evaluation on a continual basis consists of requesting feedback from and giving feedback to volunteers. Volunteers are formally evaluated at least annually.

;

E. Grievance: In the event that problems are not resolved in the course of informal attempts to do so, the volunteer may use the following procedure:

E.1 Present the complaint in writing to the Volunteer Coordinator.

E.2 If the complaint is not resolved, the volunteer can meet with the Hospice Program Director. The problem must be presented in writing, and the specific relief sought must be stated.

E.3 If the problem remains unresolved, the complainant can request that the problem be presented in written form to the President of VNHSC. The President may bring the complaint to the Executive Committee of the Board if it remains unresolved. This committee will report the results to the Board at the next regularly scheduled Board meeting.

E.4 At each intervention above, a reply is written to the complainant within ten (10) business days.

F. Resignation: Volunteers with direct patient/family contact who plan to resign should do so after completing a case. If it is necessary for a volunteer to resign while working with a patient/family, (s)he should give two weeks' notice so a replacement can be found. Exit interviews are conducted with volunteers upon resignation.

G. Volunteers have signed a Confidentiality Statement and have annual instruction on HIPAA Regulations. All patient information is considered confidential and only information necessary to perform their volunteer role is shared with volunteers. Volunteers report all appropriate information only to Hospice staff.

H. Appointment as a volunteer with direct patient/family contact is contingent upon:

H.1 Completion of application accompanied by three written references and an interview.

H.2 Successful completion of an approved Hospice volunteer education program, commitment to ongoing Hospice education and a commitment to the Hospice philosophy.

H.3 Proof of a negative Mantoux test within one calendar year previous to completion of training or completion of two-step Mantoux test.

H.4 A physician's statement that the volunteer is in good health, has no communicable disease, and has no physical limitations that would hinder being a Hospice volunteer. The statement must be signed and dated prior to becoming an active volunteer and updated every two years.

H.5 Valid Connecticut driver's license and proof of current no-fault car insurance.

H.6 No volunteer will be placed with a patient/family until 12 months after a major loss. Normally, a "major loss" is defined as the death of an immediate family member or close friend, death of a person with whom the volunteer resides, divorce, separation from a spouse or significant other, or at the discretion of the Volunteer Coordinator.

H.7 Documentation of the Plan of Care requested to be fulfilled by the Patient Care/Reiki Bereavement volunteer will be made in the patient's chart. Any subsequent changes in the Plan of Care are documented in the patient chart.

I. The Volunteer would update the Volunteer Coordinator or the Hospice Primary Care Nurse or Hospice Clinical Supervisor on any problems relating to the patient diagnosis or family concerns.

I.1 The Volunteer would report any acute changes in patient's physical or emotional condition or other crisis situation immediately to the Hospital primary care nurse, the Hospice Primary Care Nurse, Volunteer Coordinator or Hospice Clinical Supervisor.

I.2 The Volunteer would follow the Hospice Team's plan of care. At the end of each visit, the Volunteer reports <u>significant</u> information to the Hospice primary care nurse about concerns or changes for the patient/family situation consistent with the Hospice plan of care.

V. DELIVERY OF SERVICE

A. The Volunteer Coordinator

1. The Volunteer Coordinator under the supervision of the Hospice Program Director is responsible for the recruitment, training, in-service presentation, support, and assignment of Hospice volunteers. The Volunteer Coordinator maintains complete and current personnel files on all volunteers in compliance with agency policy and maintains volunteers' participation in mandatory in-service/support meetings.

2. The Volunteer Coordinator also works with Development Staff in fund-raising efforts, to increase the public awareness of Visiting Nurse & Health Services of Connecticut Hospice and Palliative, to coordinate special projects (e.g., the "Holiday Baskets", and to assist with the annual Volunteer Recognition Reception.

3. The Volunteer Coordinator also attends weekly Interdisciplinary Team meetings to up-date the Plan of Care every two weeks, assesses the need for volunteer services with members of the team, assigns volunteers to a family and arranges for orientation by Primary Care Nurse or the Volunteer Coordinator.

B. Assignment of Volunteers with Direct Patient/Family Contact

1. Requests for Volunteer support come from a Hospice Primary Care Nurse to the Volunteer Coordinator.

2. The Volunteer Coordinator assigns an appropriate volunteer to the patient/family based on the request and fills out a Hospice Volunteer Assignment Form Volunteer Exhibit 1). This is given to the Primary Care Nurse, who then puts it in the patient's chart.

3. Volunteers file a Volunteer Time and Visit Report (Volunteer Exhibit 2) weekly. The upper portion of the form, the time sheet, is recorded in the volunteer database; the lower portion of the form is given to Primary Care Nurse and then filed in the patient's chart.

4. Changes to a Volunteer Plan of Care are reported on a Volunteer Contact Sheet (Volunteer Exhibit 3) and placed in the volunteer's file.

5. At each volunteer's initial assignment, the Volunteer Coordinator arranges for a one time orientation of the patient care volunteer by either the PCN, the Volunteer Coordinator, or other appropriate team member. This orientation visit is documented on the Hospice Volunteer Evaluation Home Visit form (Exhibit 4). After this initial visit, joint visit for evaluation of the volunteer will be conducted by the Volunteer Coordinator annually and documented on the Volunteer Evaluation Home Visit form and the appropriate Hospice Volunteer Competency Checklist (direct care or clerical). Evaluation will completed (Exhibit 5 and 6).

North Central Hospice and Palliative Care
A Program of
Visiting Nurse & HEALTH SERVICES OF CONNECTICUT

"Leading the Way in Home Health and Hospice Care Since 1913"

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Toll-free: 866-265-4953 · Business Fax: 860-872-3030 · Referral Fax: 860-872-2419

HOSPICE VOLUNTEER ASSIGNMENT

Client's Name:_____ PCN:_____
Person to be Visited/Phoned:_____

- ❑ Home
- ❑ Inpatient Town:_____ Facility:_____
- ❑ ECF

Date Referral Received:_____ Date Referral Accepted:_____

- ❑ Volunteer Services Refused Reason for refusal:_____
- ❑ Patient died before completion of volunteer placement

Volunteer Information

(#1)Volunteer's Name:_____ Volunteer Category:_____
Phone Number (W):_____ (H):_____ (C):_____
(#2)Volunteer's Name:_____ Volunteer Category:_____
Phone Number (W):_____ (H):_____ (C):_____
(#3)Volunteer's Name:_____ Volunteer Category:_____
Phone Number (W):_____ (H):_____ (C):_____
(#4)Volunteer's Name:_____ Volunteer Category:_____
Phone Number (W):_____ (H):_____ (C):_____

Volunteer Plan of Care

- ❑ Socialization for Patient
- ❑ Respite
- ❑ Errands
- ❑ Aromatherapy
- ❑ Bereavement Visitation/Phone Contact
- ❑ Caring Canines
- ❑ Other
- ❑ Life Review
- ❑ Living Reflections
- ❑ Music by Bedside
- ❑ Reiki
- ❑ Spiritual Care Visitation
- ❑ Vigil

Narrative/case conference:_____

_____

_____ _____
Signature: Volunteer Coordinator or Supervisor Date

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VOLUNTEER TIME

(PLEASE COMPLETE AFTER EACH DATE OF SERVICE IN BLACK INK ONLY)

Volunteer's Name:_____ Date of Service:_____

Check off Type(s) of Care Provided and Document Time:

❑ Patient Care: Regular Visit	Time:		❑ Clerical	Time:
❑ Patient Care: Phone Visit	Time:		❑ Fundraising	Time:
❑ Aromatherapy	Time:		❑ Living Reflections	Time:
❑ Bereavement: Clerical	Time:		❑ Music by Bedside	Time:
❑ Bereavement:Visit/Phone	Time:		❑ Reiki	Time:
❑ Bereavement:Reiki	Time:		❑ Special Event	Time:
❑ Bereavement: Support Group	Time:		❑ Spiritual Care Visit	Time:
❑ Caring Calls	Time:		❑ Team Meeting	Time:
❑ Caring Canines	Time:		❑ Vigil	Time:

VOLUNTEER VISIT REPORT

Patient's Name:_____ Date of Service:_____

Volunteer's Name:_____ Person Visited/Phoned (if NOTPatient):_____

Care Provided

❑ Provided socialization/companionship	❑ Provided Music by Bedside
❑ Provided respite	❑ Provided Living Reflections Photo
❑ Assisted with errands	❑ Provided Reiki
❑ Provided aromatherapy	❑ Supported patient/caregiver w/active listening
❑ Provided Vigil	❑ Directed patient/caregiver in life review
❑ Notified Brvmt. Coord. Re: bereaved's grief responses	❑ Provided prayer/spiritual readings
❑ Provided support to bereaved in identifying strengths, coping skills & support systems	❑ Identified patient/caregiver requests for other rites/rituals & notified Hospice Chaplain
❑ Provided Caring Canine visit	❑ Provided Spiritual Presence

❑ Client was responsive to visit

❑ Client declined visit

Date of Next Visit:_____

Comments:_____

_____

Volunteer's Signature: _____ **PCN Signature**_____

Supervisor's Signature:_____

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VOLUNTEER CONTACTS

Volunteer's Name: _____ ID#: _____

DATE: _____

Volunteer Exhibit 4

VISITING NURSE & HEALTH SERVICES OF CONNECTICUT, INC.

Hospice Volunteer Evaluation
Home Visit

Volunteer's Name: _____

Date of Visit: _____

Hospice Volunteer Coordinator: _____
or
Hospice Nurse: _____

Scale of 0-3

_____ Volunteer kept appointment and was on time.

_____ Volunteer was suitably dressed.

_____ Volunteer asked appropriate questions of Hospice Volunteer Coordinator or Hospice Nurse.

_____ Volunteer showed understanding and confidentiality.

_____ Volunteer showed appropriate behavior/demeanor with patient.

_____ Volunteer's interaction with patient/family was appropriate.

_____ Volunteer seemed to understand role of volunteer and the interdisciplinary team approach.

_____ Volunteer shared appropriate information about self.

_____ Volunteer shared inappropriate information about own personal problems.

Additional information/comments: _____

_____

_____

_____ _____
Signature of Hospice Volunteer Coordinator or Hospice Nurse Date

Volunteer Exhibit 5

VISITING NURSE & HEALTH SERVICES OF CONNECTICUT, INC.

DIRECT CARE HOSPICE VOLUNTEER COMPETENCY CHECKLIST/EVALUATION

Name: _____ **Date:** _____

Skill	Satisfactory	Needs Follow Up	Follow Up Complete	Not Applicable
Able to verbalize hospice goals, philosophy and mission.				
Documentation is completed, appropriate, signed and returned on time.				
Demonstrates understanding and proper use of Universal Precautions/OSHA requirement.				
Demonstrates the ability to respond appropriately to patient/family concerns regarding death and dying.				
Demonstrates appropriate active listening skills.				
Is able to articulate and/or demonstrate principles of bereavement support and intervention.				
Is able to articulate an understanding of high-risk behaviors in patients and families and verbalizes an understanding of when to refer to team members.				
Demonstrates an understanding of the principles of confidentiality.				
Demonstrates the ability to set goals with patient and family and establish an appropriate plan of care. Reinforces the role of the volunteer while setting goals.				

Volunteer Manager Comments: _____

_____

_____

_____

Supervisor Comments: _____

_____

_____

_____

_____ _____

Supervisor Signature **Date**

_____ _____

Volunteer Signature **Date**

Volunteer Exhibit 6

VISITING NURSE & HEALTH SERVICES OF CONNECTICUT, INC.

VOLUNTEER CLERICAL SUPPORT
YEARLY EVALUATION/COMPETENCY REPORT

	Meets Program Criteria	Recommended Changes
Commitment to the Program:		
1. Accepts clerical assignments when asked:	_____	_____
2. Adheres to agreed upon work schedule:	_____	_____
3. Volunteer contacts Volunteer Coordinator if unable to make assignment due to illness or vacation plans:	_____	_____
In-Office Evaluation:		
4. Maintains patient confidentiality:	_____	_____
5. Time sheets are completed following each assignment:	_____	_____
6. Work is completed in a neat and timely fashion:	_____	_____
7. Exhibits good communication and listening skills.	_____	_____

_____ _____
Volunteer's Signature Date

_____ _____
Volunteer Coordinator's Signature Date

Exhibit 7

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RELEASE FORM

I hereby consent that Visiting Nurse & Health Services 5of CT, (VNHSC), or any other person or agent authorized by this organization, may use photogenic, videotape images and/or voice recordings in which I may be included in whole or in any part of any purpose they find appropriate for the purposes of creating promotional materials. I also understand that these photographs, video, or film may be used for the following:

Brochures ❑ Employee Functions ❑ Press Releases ❑
Life Reflection Program ❑ Marketing/Advertising ❑

I hereby waive the right that I may have to approve the unfinished or finished product or the copy, script that may apply.

I have read this authorization and release and agree with the above contents.

Date: _____

Signature of Patient/Legal Guardian: _____

Name (Please Print) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone (____) _____

VNHSC Representative _____

Subject: Volunteer Patient Safety Program
Policy/Procedure Number: 011

Released: 01/13/12

I. Purpose:

A. Patient Safety Volunteers help improve the safety of our patients who are at risk of falling by verifying certain falls-prevention safety precautions are in place and implementing those that are not.

II. Procedure:

A. Obtain from charge nurse or unit secretary the list of all high risk for falls patients on unit including name and bed number.

B. Wash hands or use Purell on hands prior to entering and leaving each room and between patients in the same room.

C. If you are scheduled to come in on a unit for safety rounds and has a cold or flu – like symptoms, volunteer should not be on unit that day.

D. Do not enter isolation rooms.

E. Do not help position or move patients.

F. Use Safety Volunteer Checklist for reference/documentation of safety rounds.

G. Check that all high risk for falls patients have one or more of the below items place:

1. Red Star magnet on door frame
2. Remember Red sign over bed
3. Red slippers on patient
4. Red blanket on patient's bed

H. If high risk for fall patients do not have any of the above in place, mark this on the check list and implement one or more of the High Fall Risk items.

I. Check if the patient's personal items are within reach.

J. Check if call bell is within patient's reach.

K. If the patient is in the bed:

1. Verify that the bed alarm is "on". Turn on alarm if it is off.
2. Verify the call system adapter (circle plug) is plugged in to the wall. Plug in if not plugged in correctly.
3. Verify that the bed's power cord is plugged into the wall. Plug in if not plugged in correctly.

L. If the patient is sitting in a chair:

1. Verify that a TABS chair alarm is in place. Implement a TABS alarm if not.

M. Confirm patients know how to use their call bell and remind patients to use their call bell to call for assistance and to not get up alone.

N. Ask if there is anything else that they need at this time i.e. fill water pitcher if appropriate for the patient (check with the patient's nurse). Help the patient request staff assistance for all other needs.

O. Contact charge nurse or patient's nurse for any questions or problems incurred on safety rounds.

P. Return safety checklist to the nursing station upon completing safety rounds for follow-up.

III. RESPONSIBLE FOR REVISION: Head of Volunteer Services

IV. ORIGINATED: 09/17/2009 – Linda Quirice, Nursing Education

Signature Title Date

ECHN Woodlake at Tolland Volunteers

Volunteers at WAT work under the supervision of the Recreation Director.

They are on boarded by Volunteer Services. In addition to the standard requirements, new adult volunteers at WAT (since the fall of 2015) are required by state law to be screened by fingerprinting prior to volunteering.

Volunteers are involved/help in a variety of ways:

-Cooking groups

-Book Club Reader

-Weaving/Yard club

-Cheer cart & friendly visits

-St Matthews Rosary Service

-Bingo

-Bowling

-Garden club/Indoor plants

-Card games

In addition, we have volunteers who play music and do Pet Therapy. We also have volunteers who assist with transporting patients to activities.

There are groups from the community who come in to visit. These include:

-Tolland Senior Center Singers (they sing appropriately 3 times a year)

-Golden Tone-Stafford Senior Center (sing twice a year)

-Ellington Singers (twice a year)

-From the Heart (once a month for two hours)

-Girl Scout troop visits (once a month)

A Summary of Community Benefit Activities*
Manchester Memorial Hospital
Fiscal Year 2015

Towns Served

Manchester Memorial Hospital, part of the Eastern Connecticut Health Network, primarily serves the following towns with community-based health programs: Manchester, South Windsor, Bolton, Coventry, Andover, Ellington, Tolland, Vernon, and Willington. Its secondary service area includes the towns of Ashford, Somers, Stafford, Union, East Hartford, East Windsor, Glastonbury, Hebron, Columbia and Mansfield. The service areas contain municipalities in Hartford, Tolland and Windham Counties.

Community Health Needs Assessments

Manchester Memorial Hospital regularly conducts community health needs assessments to gather current statistics and qualitative input to determine the key health issues facing residents of its 19-town service area.

With the support of a Community Program Advisory Committee, consisting of medical staff leadership and ECHN Administration, the organization's Community Benefit & Education Department evaluates, coordinates and implements programs to address these needs. Efforts include free health education lectures presented by the medical staff, health screenings, health fair participation, and support groups.

Community health needs are also identified through regular solicitation of the general public and the medical community to identify pertinent health needs they feel need to be addressed.

Community Benefit Activities

- Based on the identified health needs, community health education initiatives/programs are offered to the community and include lecture presentations such as Diabetes Made Simple and Pre-diabetes, Let's Take Action; development and distribution of a wellness magazine to more than 150,000 households in the service area; lactation consultants for new mothers; and demonstrations and health fair participation. For example, a Freedom from Smoking Program is available that is facilitated by an ALA Certified Health Care Professional and includes eight 1½- to 2-hour sessions over 7 weeks, the 4th session being Quit Day. The sessions can be provided at the worksite or other location, daytime or evening. Another example is presentations to the community about breast cancer, preventative/screening recommendations, bone density exams, and free screening programs. These presentations were made at the Greater Hartford Women's Conference; a Women and Youth Advisory Panel Discussion at Manchester Community College; the Town of South Windsor Health and Wellness Fair; Crossroads Community Cathedral Church Health Fair; Women to Women-A Comfortable Conversation; Let's Talk Menopause panel community program; the Vernon Center Middle School; and the Office of Migration, Refugee, and Immigration Services at Catholic Charities of Hartford. Other areas of particular focus include: Heart disease, Cancer, Diabetes, Arthritis, Alzheimer's disease, Multiple Sclerosis, Substance Abuse, and Childhood Lead Screening, which were identified as areas of need in the community health needs assessment conducted in 2013. Over 97,000 people benefitted from these initiatives and programs in FY 15.
- Free health screenings including diabetic foot checks, mammograms, heart disease screenings, blood pressure, bone density, glucose readings, injury screenings and vital sign checks are offered in the

community. For example, blood pressure screenings were done during Wear Red Day. Targeting uninsured/underinsured populations, 156 people benefitted from all these services in FY 15.

- Healthcare support services are provided by the hospital to increase access and quality of care to individuals in need. Efforts include free transportation to behavioral health patients, assistance to enroll in public programs, referrals to social services, and help in finding physicians who accept Medicaid or other government programs. Nurse navigation services help patients and their loved ones navigate through the healthcare system, finding support and resources to manage symptoms, get a second opinion, schedule tests and treatment, find homecare services and coordinate care. A social worker who serves as a survivorship navigator is available to provide supportive counseling and assistance in locating resources to help with finances, disability, medical insurance, advance directives and post treatment survivorship care planning. Four thousand eight hundred and forty (4,840) people benefitted from these efforts in FY 15.

- Partnering with local educational institutions, Manchester Memorial Hospital provides a clinical setting for medical students, nursing students, radiologic technicians, phlebotomy students, respiratory technicians, dietetic interns, pharmacy students, physical therapists and others from the University of New England College of Osteopathic Medicine, University of Connecticut, Manchester Community College, Central Connecticut State University, Goodwin College, Capital Community College, Springfield Technical Community College, University of St. Joseph, Quinnipiac University, Asnuntuck Community College and the University of Hartford. Presentations are also given to local groups on new emergency management services guidelines and updates, EMT education, paramedic skills training, specialty care transport courses, and Narcan and CPAP training.

- Health services which are subsidized by the hospital include neonatal services, diabetes self-management, dialysis services and the behavioral health clinic.

- Specific research initiatives conducted by the hospital include an Institutional Review Committee, which has the primary responsibility to protect the rights and welfare of research subjects and to approve all research studies in accordance with federal regulations.

- Financial and in-kind services and goods are donated to community groups and other not for profit organizations, including patient meals, local fundraisers, facility space to host blood drives, conference rooms for health support groups organizations' meetings, and for oncology clinical research. For example, the hospital provides free meeting space for the ACOA Support Group Adult Children of Alcoholics, Al-Anon, Alcoholics Anonymous, Not So Typical Autism Support Group, Brain Injury Alliance of CT, Multiple Sclerosis Society Caregiver Meeting, Narcotics Anonymous, National Alliance on Mental Illness, Older Adults Recovery & Support Group, and Sweet Talk - Diabetes Support Group.

- The expertise and resources of the organization are dedicated to a number of community building activities that support associations, businesses, programs, initiatives and other valuable local community assets.
    - Through grants provided by the federal and state governments, MMH offers free support programs to prenatal individuals and parents to promote positive family life skills and child

development. In FY 2015, these programs benefited 1,091 individuals with MMH providing over $118,000 in in-kind resources and services.

Other community building activities performed in FY 2015 include participation in regional exercises to evaluate the readiness of the hospital's emergency preparedness capabilities; participation in the Baby Friendly Practices Statewide Collaborative and the statewide CPQC Initiative; serving on the Board and Executive Committee of regional Chambers of Commerce in support of the local business industry; hosting art exhibits of the Manchester Art Association; working with the Manchester Veterans Council to honor veterans in an annual Veterans Day ceremony for the community; partnering with the local school systems and colleges in various workforce development programs; attending School Readiness Council meetings; providing vocational services and employment assistance to residents; serving on the American Hospital Association's Regional Policy Board; and serving on the Department of Public Health's Office of Emergency Medical Service Medical Advisory Committee, the Connecticut EMS Advisory Board, the Connecticut EMS Advisory Committee, the Regional Medical Advisory Committee, the Regional ED Standards Board, the State EMS Education and Training Committee, and EMS Clinical Coordinators.

**Charity care and government-sponsored health care are not included in this summary.*

6/1/2016
Manchester Memorial Hospital
Executive Summary Including Non Community Benefit (Medicare and Bad Debt)
For period from 10/1/2014 through 9/30/2015

	Persons	Benefits
Community Health Improvement Services (A)		
Community Health Education (A1)	97,229	393,404
Community Based Clinical Services (A2)	156	25,665
Health Care Support Services (A3)	4,840	461,965
****** Community Health Improvement Services**	102,225	881,034
Health Professions Education (B)		
Physicians/Medical Students (B1)	92	1,778,938
Nurses/Nursing Students (B2)	281	527,530
Other Health Professional Education (B3)	270	104,752
****** Health Professions Education**	643	2,411,220
Subsidized Health Services (C)		
Neonatal Intensive Care (C2)	193	1,614,666
Hospital Outpatient Services (C3)	5,527	300,066
Renal Dialysis Services (C6)	283	153,062
Behavioral Health Services (C8)	0	513,248
****** Subsidized Health Services**	6,003	2,581,042
Research (D)		
Other Research (D3)	0	30,264
****** Research**	0	30,264
Financial and In-Kind Contributions (E)		
Cash Donations (E1)	0	15,991
Grants (E2)	0	64,268
In-kind Donations (E3)	13,081	111,244
****** Financial and In-Kind Contributions**	13,081	191,503
Community Building Activities (F)		
Economic Development (F2)	0	100
Community Support (F3)	1,091	139,488
Coalition Building (F6)	1	39,439
Community Health Improvement Advocacy (F7)	0	2,454
Workforce Development (F8)	32	71,794
****** Community Building Activities**	1,124	253,275
Community Benefit Operations (G)		
Dedicated Staff (G1)	0	103,618
****** Community Benefit Operations**	0	103,618
Financial Assistance		
Financial Assistance	808	441,332
****** Financial Assistance**	808	441,332
Government Sponsored Health Care		
Medicaid	47,894	10,350,906
****** Government Sponsored Health Care**	47,894	10,350,906
Totals - Community Benefit	171,778	17,244,194

	Persons	Benefits
Totals Including Medicare and Bad Debt	**171,778**	**17,244,194**

NEW ADULT VOLUNTEER PACKET

Name: _____ Date: _____

The following documents must be completed and signed and placed to your file:

1) Contact/Emergency Contact Information
2) Interview Date:_____
3) Commitment to Caring through ECHN Core Values-sign form
4) Confidentiality Agreement-sign form
5) Acknowledgement of HIPAA Privacy and Security-sign form
6) Volunteer Handbook/Orientation-sign form
7) Code of Conduct-sign form
8) 2015 Mandatory Education
9) Medical Clearance by CorpCare
10) Background Check Form
11) Badge form-badge Issued-copy of picture for office

Thank you for volunteering for ECHN.

Please know that volunteers are entitled to a complimentary beverage-1 drink per day when they are in working.

Also- All volunteers are invited to our Annual Volunteer Recognition which usually takes place in April.

Welcome! We appreciate your help and the unique gifts that you bring to all we serve.

NEW TEEN VOLUNTEER PACKET

Name: _____ Date: _____

The following documents must be completed and signed and placed to your file:

1) Contact/Emergency Contact Information
2) *Parent Permission*
3) Reference-*Parents sign*
4) Interview Date:_____
5) Commitment to Caring through ECHN Core Values-sign form
6) Confidentiality Agreement-sign form
7) Acknowledgement of HIPAA Privacy and Security-sign form
8) Volunteer Handbook/Orientation Book-sign form
9) Code of Conduct-sign form
10) 2015 Mandatory Education
11) Medical Clearance by CorpCare-*Parents accompany*

Thank you for volunteering for ECHN.

Please know that volunteers are entitled to a complimentary beverage-1 drink per day when they are in working.

Also- All volunteers are invited to our Annual Volunteer Recognition which usually takes place in April.

Welcome! We appreciate your help and the unique gifts that you bring to all we serve.

A Summary of Community Benefit Activities*
Rockville General Hospital
Fiscal Year 2015

Towns Served

Rockville General Hospital, part of the Eastern Connecticut Health Network, primarily serves the following towns located east of the Connecticut River in northern Connecticut: Vernon, Ellington, Tolland, Willington, Manchester, South Windsor, Bolton, Coventry and Andover. Its secondary service area includes the towns of Ashford, Somers, Stafford, Union, East Hartford, East Windsor, Glastonbury, Hebron, Columbia and Mansfield.

Community Health Needs Assessments

Rockville General Hospital regularly conducts community health needs assessments to gather current statistics and qualitative input to determine the key health issues facing residents of its 19-town service area.

With the support of a Community Program Advisory Committee, consisting of medical staff leadership and ECHN Administration, the organization's Community Benefit & Education Department evaluates, coordinates and implements programs to address these needs. Efforts include free health education lectures presented by the medical staff, health screenings, health fair participation, and support groups.

Community health needs are also identified through regular solicitation of the general public and the medical community to identify pertinent health needs they feel need to be addressed.

Community Benefit Activities

- Community health education initiatives/programs are offered to the community and include lecture presentations, development and distribution of a wellness magazine to more than 150,000 households in the service area, demonstrations, and health fair participation. For example, presentations were made to the community about breast cancer, preventative/screening recommendations, bone density exams, and free screening programs. These presentations were made at the Greater Hartford Women's Conference; a Women and Youth Advisory Panel Discussion at Manchester Community College; the Town of South Windsor Health and Wellness Fair; Town of Vernon Employee Health and Benefit Fair; the Town of Manchester Health and Safety Fair; Crossroads Community Cathedral Church Health Fair; Women to Women-A Comfortable Conversation; Let's Talk Menopause panel community program; the Vernon Center Middle School; and the Office of Migration, Refugee, and Immigration Services at Catholic Charities of Hartford. Other areas of particular focus include: Heart disease, Cancer, Diabetes, Arthritis, Alzheimer's disease, Multiple Sclerosis, Substance Abuse, and Childhood Lead Screening, which were identified as areas of need in the community health needs assessment conducted in 2013. More than 40,000 people benefitted from these initiatives and programs in FY 15.

- Free health screenings including diabetic foot checks, mammograms, heart disease screenings, bone density, glucose readings, injury screenings, blood pressure, vital sign checks and medical exams are offered in the community. For example, blood pressure screenings were done at the American Heart

Association Heart Walk. Risk Factor screenings were done during Wear Red Day. Targeting uninsured/underinsured populations, 53 people benefitted from these services in FY 15.

- Healthcare support services are provided by the hospital to increase access and quality of care to individuals in need. Efforts include assistance to enroll in public programs, referrals to social services, and help in finding physicians who accept Medicaid or other government programs. Twenty-eight (28) people benefitted from these efforts in FY 15.

- Partnering with local educational institutions, Rockville General Hospital provides a clinical setting for medical students, nursing students, radiologic technicians, phlebotomy students, respiratory technicians, dietetic interns, pharmacy students, physical therapists and others from the University of New England College of Osteopathic Medicine, University of Connecticut, Manchester Community College, Central Connecticut State University, Goodwin College, Capital Community College, Springfield Technical Community College, University of St. Joseph, Quinnipiac University, Asnuntuck Community College, Stone Academy, and the University of Hartford. For example, a college senior completed her practicum by spending approximately 525 hours with the hospital's cardiac/pulmonary rehabilitation RN.

- Health services which are subsidized by the hospital include the Early Detection Program, the Maternity Care Center, dialysis services, and the Ryan White Part A program.

- Specific research initiatives conducted by the hospital include an Institutional Review Committee, which has the primary responsibility to protect the rights and welfare of research subjects and to approve all research studies in accordance with federal regulations.

- Financial and in-kind services and goods are donated to community groups and other not for profit organizations, including local fundraisers, facility space to host blood drives, and conference rooms for health support groups organizations' meetings. For example, the hospital provides free meeting space for Compassionate Friends- Providing Grief Support After the Death of a Child, Overeaters Anonymous, and the North Central District Health Department.

- The expertise and resources of the organization are dedicated to a number of community building activities that support associations, businesses, programs, initiatives and other valuable local community assets. For example, the hospital and its employees participate in regional exercises to evaluate the readiness of the hospital's emergency preparedness capabilities, serve on the board and executive committees of regional chambers of commerce in support of the local business industry; partner with the local school systems and colleges in various workforce development programs; serve on the Vernon School Readiness Council, the Cancer Community Outreach Committee and the American Hospital Association's Regional Policy Board; and host art exhibits of the Vernon Art Association.

**Charity care and government-sponsored health care are not included in this summary.*

6/1/2016
Rockville General Hospital
Executive Summary Including Non Community Benefit (Medicare and Bad Debt)
For period from 10/1/2014 through 9/30/2015

	Persons	Benefits
Community Health Improvement Services (A)		
Community Health Education (A1)	40,462	64,249
Community Based Clinical Services (A2)	53	141
Health Care Support Services (A3)	28	24,705
****** Community Health Improvement Services**	40,543	89,095
Health Professions Education (B)		
Physicians/Medical Students (B1)	16	34,220
Nurses/Nursing Students (B2)	76	152,114
Other Health Professional Education (B3)	147	94,583
****** Health Professions Education**	239	280,917
Subsidized Health Services (C)		
Hospital Outpatient Services (C3)	126	34,464
Women's and Children's Services (C5)	1,357	531,059
Renal Dialysis Services (C6)	163	38,105
Behavioral Health Services (C8)	0	0
****** Subsidized Health Services**	1,646	603,628
Research (D)		
Other Research (D3)	0	12,493
****** Research**	0	12,493
Financial and In-Kind Contributions (E)		
Cash Donations (E1)	0	6,608
In-kind Donations (E3)	421	8,795
****** Financial and In-Kind Contributions**	421	15,403
Community Building Activities (F)		
Community Support (F3)	0	13,050
Community Health Improvement Advocacy (F7)	0	1,054
Workforce Development (F8)	5	213
****** Community Building Activities**	5	14,317
Community Benefit Operations (G)		
Dedicated Staff (G1)	0	42,079
****** Community Benefit Operations**	0	42,079
Financial Assistance		
Financial Assistance	322	236,019
****** Financial Assistance**	322	236,019
Government Sponsored Health Care		
Medicaid	15,846	5,926,536
****** Government Sponsored Health Care**	15,846	5,926,536
Totals - Community Benefit	59,022	7,220,487
Totals Including Medicare and Bad Debt	59,022	7,220,487

Schedule 5.25(b)

ECHN – Extended Reporting Period Options

[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]

Schedule 5.30

Tax Claims

[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]

Schedule 7.04(d)

Certain Other Consents

[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]

Schedule 10.03(a)

Certain Subsidiaries of Seller

TIC, LLC (as successor to the business operations of Tolland Imaging Center, LLC)

Greer, Leslie

Subject: FW: Independent Monitor

From: Michele Volpe [mailto:mmv@bvmlaw.com]
Sent: Friday, November 04, 2016 3:08 PM
To: Martone, Kim
Cc: Shapiro, Daniel R.; Cass, Barbara; Lazarus, Steven; Jennifer O'Donnell
Subject: Independent Monitor

Hi □im
Prospect is moving along with the selection of the Independent Monitor for the three hospitals, Manchester, Rockville and Waterbury. Colleen Smith is the candidate that has gone the furthest in the vetting process and has been selected to proceed. She was interviewed via phone and in person by hospital representatives, licensure division within DPH also interviewed Colleen and there are phone interviews set up for next week with PMH Corporate. I will send you Colleen Smith□s resume and contact information so OHCA can make arrangements to speak directly with Ms. Smith as well. I also spoke with Dan Shapiro regarding OHCA participation in the process. Please contact me anytime if I can provide additional information or be of further assistance. Thank you

Michele M. Volpe
Bershtein, Volpe & Mc□eon P.C
105 Court Street
New Haven, CT 06511
Phone: (203) 777-6995
Fax: (203) 777-5806

Greer, Leslie

From: Martone, Kim
Sent: Monday, November 07, 2016 7:58 AM
To: Roberts, Karen; Cotto, Carmen
Cc: Greer, Leslie
Subject: FW: Colleen Smith Resume oct 14, 2012 V4 Jan.13.2015 v5 5.16 .doc
Attachments: Colleen Smith Resume oct 14, 2012 V4 Jan.13.2015 v5 5.16 .doc; ATT00001.htm

Kimberly R. Martone
Director of Operations, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134
Phone: 860-418-7029 Fax: 860-418-7053
Email: Kimberly.Martone@ct.gov Website: www.ct.gov/ohca

From: Michele Volpe [mailto:mmv@bvmlaw.com]
Sent: Friday, November 04, 2016 4:58 PM
To: Martone, Kim
Cc: Shapiro, Daniel R.; Jennifer O'Donnell
Subject: Colleen Smith Resume oct 14, 2012 V4 Jan.13.2015 v5 5.16 .doc

□im
As promised, attached is Colleen Smith□, the proposed independent monitor, resume. Please let me know if I can be of further assistance. Thank you.

41 Laurel Crest Road
Madison, CT 06443
Cell: (203) 671-1348
Email: colleen713.smith@gmail.com

COLLEEN O'BRIEN SMITH, MSN, RN, NEA-BC

EDUCATION

MASTER OF SCIENCE IN NURSING, 1976
University of Connecticut, Storrs, CT

BACHELOR OF SCIENCE IN NURSING, 1973
University of Connecticut, Storrs, CT

EXPERIENCE

2013-present

Nursing Consulting Partners

Healthcare Consultant

Work with clients on their strategic planning efforts, improvements in clinical outcomes, employee engagement and creation of professional practice environments. Conduct Magnet Readiness assessments, including data and document review.

2012

Norwalk Health Systems, Norwalk, Ct.

Interim Chief Operating Officer (March, 2012-August, 2012)

Fulfilled the role of COO during a planned leave of absence. Directed the activities of the following Hospital Departments: Radiology, Laboratory, Emergency Services, EMS, Nursing, and the Cancer Center. As a member of the senior leadership team, participated in strategic planning, service line development and preparation of the operational and capital budget for fiscal year 2013. Served as a member of the Master Facility Planning Project Steering committee.

July-August, 2012

Continued service to this organization in a Quality consultant role, charged with developing structures and processes to assure quality outcomes.

1986 – 2011

MIDDLESEX HEALTH SYSTEMS, Middletown, CT

Chief Nursing Officer (1995 – 2011)

Middlesex Health System is a non-profit healthcare organization serving a population of 250,000 residents. Its service area encompasses the largest geography of any hospital in CT, covering Middletown, Connecticut south to the Shoreline and East of the Connecticut

River. The system includes a 275-bed acute care hospital, Homecare and Hospice Agency, a network of primary care offices, three full service Emergency sites, a diagnostic outpatient center, Ambulatory Surgical Center, and Cancer Center. Middlesex Health System is a four-time winner of the Thompson-Reuters Top 100 Hospitals Award and attained Center of Excellence Certifications in Stroke, CHF, Disease Management, and Bariatric Surgery.

Reporting to the President and CEO, responsible for all Nursing, Emergency, Behavioral Health, Surgical Services, Home Health & Hospice, Case Management, and Pharmacy. Key member of the senior management team responsible for all strategic planning, governance, quality and safety, workforce development and engagement. Responsible for 1,071 FTEs including all Nursing Services, the Departments of Surgery and Anesthesia, Emergency Medicine, Behavioral Health and Hospice.

Managed an operating budget of $650M in gross revenues and $105M in expenses. Responsible for nine Directors and five Physician Chairmen.

Selected Accomplishments:

- Achieved Magnet Designation in 2001 followed by redesignations in 2005, and 2010.
- Reduced RN Vacancy Rate from 12% to 2.5%, sustained over the last three years.
- Reduced Temporary Labor costs from 1.7M to $400,000/year.
- Redesigned several medical surgical units to offer private rooms.
- Developed Peer Review processes at all levels for all areas of responsibility.
- Established a Shared Governance Structure in 2000. Completed a redesign of this structure in 2008.
- Developed an RN Residency Program in 1999. Joined the University Health Consortium in 2008. Annual average new graduate retention rate of 87%.
- Achieved nurse satisfaction rates that surpassed the NDNQI benchmarks since 2002.
- Increased Nurse Certification rates from 34% to 56% in 8 years.
- Developed the Center for Research & Innovation. Secured philanthropic funding for research and evidence based practice projects. Established Clinical Scholars Program to advance evidence based practice.
- Founding Board member of the Middlesex Center for Advanced Orthopedic Surgery. Shared oversight for facility design, build and all operational aspects on this Joint Venture.
- Key member of Service Excellence team. Increased Press Ganey nursing care scores from 82 % to 94 %. All HCHAPS scores now above the state and national benchmark.
- Implemented Cerner Information Systems in Emergency, Inpatient, Pregnancy & Birthing Center, and Surgical Services from 2008 through 2011.
- Developed an outpatient Wound Care Center, the Center for Total Joint Replacement, and a Palliative Care Program.
- Key member of two new building projects: Emergency Department (2008), Critical Care Unit (2011)
- Established an Emergency Crisis Area within the Emergency Department to achieve rapid assessment and safe disposition of acute psychiatric patients.
- Achieved initial designation as a WHO Baby Friendly USA hospital in 2005 and in 2010.
- Established remote telemetry services and central monitoring capability.
- Established formal agreement with University of CT to provide additional nursing research expertise.

- Established a "Dedicated Education Unit" on a Medical unit and established a joint faculty appointment.

Director, Medical/Surgical Nursing (1992 – 1995)

Lead Faculty, Ona M. Wilcox College of Nursing (1986 – 1992)

Faculty for Medical Surgical course in evening program. Overall responsibility for theoretical, clinical, and administrative aspects of course.

Staff Nurse, Connecticut & Florida (1973 – 1986)

Provided nursing care for patients in a variety of clinical settings: Medical/Surgical, ICU, CCU, PACU, & Emergency Department

CERTIFICATIONS

- American Nurses Credentialing Center (ANCC); Magnet Appraiser 2006-2012
- ANCC Certification – Advanced Nursing Administration (NEA-BC) October, 2005 - Present
- Johnson & Johnson – Wharton Fellows Program in Management for Nurse Executives 2005

HEALTHCARE BOARD SERVICE

- Connecticut Hospital Association April, 2015-present
  First Nurse Executive representative appointed to this Board of Ct. CEOs. Responsible for the strategic direction of CHA, oversight of the legislative advocacy platform, and approval of annual operating budget
- Hartford Healthcare Quality and Safety Committee of the HHC Board
  October, 2011-present
  Approval of committee charter, mission, goals and strategic direction for all Quality and Patient Safety initiatives embarked upon by the Hartford Healthcare System. Review of all ongoing Quality and Safety Indicators including installation of an enterprise wide electronic record system

PROFESSIONAL MEMBERSHIPS

- American Nurses Association (ANA)
- American Organization of Nurse Executives (AONE)
- Connecticut Hospital Association (CHA)
  - Past Chair Patient Care Executive Group
  - Committee on Human Resources
    - Subcommittee on Nursing Staffing, Chair
    - Nurse Sensitive Quality Indicators, Chair
  - Hospital Oversight Work Group
- Connecticut Nurses Association (CNA)

- Connecticut Organization of Nurse Executives (ONE-CT)
  - Board Member at Large, 2012-14
  - Past President, Chair, 2010 - Nominations Committee
  - President, 2009
  - President Elect, 2008
  - Board Member, 2007
- Editorial Board of Advances in Nursing
- Founding Member of the Connecticut Nursing Collaborative
- Sigma Theta Tau Nursing Society, 1974 – Present
- VHA CNO Network, Past Co-Chair, Northeast Region

PRESENTATIONS

- "The 5 R's of Redesignation: Relevance, Rewards, Risks, Resources, and Role Redesign", ANCC Magnet Conference, 2014
- "*Building & Sustaining A Magnet Culture – Key Strategies & Lessons Learned*", Leadership Conference – Institute of the Mid South, 2011
- "*How to Blow Up a Council Structure & Begin Again: A Success Story*" – ANCC National Magnet Conference, 2010
- "Documenting the EO's – Six Success Strategies" – ANCC National Magnet Conference, 2010
- "Connecticut Nursing Collaborative – A Plan for Strategic Partners" – Connecticut Nurses Association Annual Convention, 2010
- "*Shared Governance at Middlesex Hospital – Evolving, Empowering, Enculturating"* – Connecticut Hospital Association Nursing Day of Sharing, 2009
- "Department of Nursing – 3rd Generation Magnet – Achieving, Sustaining, Excelling" – Middlesex Hospital Board of Directors Meeting, 2009
- Various Presentations to University of Connecticut, American College of Healthcare Executives, Capitol Alliance Research, Connecticut Hospital Association, and VHA (2008-2002)

PUBLICATIONS

- Leadership Competencies for Clinical Managers; The Renaissance of Transformational Leadership – Chapter 16 "*Achieving Magnet Status: A Story of Leadership*"

AWARDS

- T. Stewart Hamilton, MD, Distinguished Service Award – Connecticut Hospital Association, 2011
- Diamond Jubilee Doris M. Armstrong Award for Outstanding Contributions to Nursing Administration (Connecticut Nurses Association), 2010
- Sixth Annual Distinguished Alumni Award, Eleanor K. Gill Outstanding Award for Clinical Excellence in Nursing, University of Connecticut

Greer, Leslie

From: Roberts, Karen
Sent: Monday, November 28, 2016 3:51 PM
To: Greer, Leslie
Cc: Cotto, Carmen
Subject: FW: Independent Monitor
Attachments: Consulting Agrmt Independent Monitor (BVM clean 11.23.16).pdf; Nursing Consulting Partners Work Plan (BVM 11.28.16).pdf

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From: Jennifer O'Donnell [mailto:jlo@bvmlaw.com]
Sent: Monday, November 28, 2016 2:29 PM
To: Martone, Kim; Roberts, Karen; Cotto, Carmen
Cc: Michele Volpe
Subject: Independent Monitor

Attached please find the Consulting Services Agreement and draft Work Plan being proposed for the Independent Monitor. Please let us know if OHCA has signed off on the IM. Thank you.

Jennifer L. O'Donnell
Paralegal
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor
New Haven, Connecticut 06511-6957
Telephone: (203) 777-5800 (ext. 104)
Direct Line: (203) 777-5804
Facsimile: (203) 777-5806

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IRS CIRCULAR 230 DISCLAIMER: Any tax advice contained in this e-mail is not intended to be used, and cannot be used by any taxpayer, for the purpose of avoiding Federal tax penalties that may be imposed on the taxpayer. Further, to the extent any tax advice contained in this e-mail may have been written to support the promotion or marketing of the transactions or matters discussed in this e-mail, every taxpayer should seek advice based on such taxpayer's particular circumstances from an independent tax advisor.

CONSULTING SERVICES AGREEMENT

This Consulting Services Agreement (this "Agreement") is made and entered into to as of the _____ day of November, 2016 (the "Effective Date"), by and among Prospect ECHN, Inc., a Connecticut corporation ('Prospect ECHN"), Prospect Waterbury, Inc., a Connecticut corporation ("Prospect Waterbury") and Nursing Consulting Partners, LLC, through its nurse consultant Colleen Smith, MSN, RN, NEA-BC, herein collectively referred to as ("Consultant").

RECITALS

A. Prospect ECHN has acquired certain healthcare facilities in Connecticut including The Rockville General Hospital Incorporated and Manchester Memorial Hospital (collectively, the "ECHN Facilities").

B. Prospect Waterbury has acquired certain healthcare facilities in Connecticut including The Waterbury Hospital (collectively, the "GWHN Facilities").

C. The State of Connecticut, Department of Public Health, Facility and Licensing Investigations Section ("FLIS") has required pursuant to a Pre-Licensure Consent Order for Prospect Manchester Hospital, Inc., Prospect Rockville Hospital, Inc. and Prospect Waterbury Hospital, Inc., OHCA Final Decision for Greater Waterbury Health Network, Inc., OHCA Final Decision for Eastern Connecticut Health Network, Inc., Quality Assurance Commitment for Greater Waterbury Health Network, Inc., and Quality Assurance Commitment for Eastern Connecticut Health Network, Inc., copies of which are attached as Exhibit A ("Order") that Prospect ECHN and Prospect Waterbury (each a "Licensee" and collectively, the "Licensees") execute a contract with an Independent Monitor ("IM") pre-approved in writing by the Department of Public Health, Office of Healthcare Access ("OHCA") and FLIS pursuant to which the IM will monitor the ECHN Facilities and the GWHN Facilities (each a "Facility" and collectively with any other Facilities subject to the Order, the "Facilities") in compliance with the Order.

D. Consultant desires to perform the services of the IM described in the Order and the Licensees desire to engage Consultant to perform such services, subject to the terms and conditions of this Agreement and in full compliance with the Order.

In consideration of the mutual covenants contained herein, the parties hereto hereby agree as follows:

1. Scope of Services. Consultant will provide the services of the IM as described in the Order and otherwise comply with the Order (collectively, the "Services"). The Licensees shall cooperate with Consultant and provide access to the Facilities, and management and other representatives of the Facilities in order to enable the IM and the Licensees to fully comply with applicable provisions of the Order.

2. Independent Contractor. Consultant and the Licensees acknowledge and agree that Consultant shall provide services as an independent contractor. Consultant and Licensees acknowledge and agree that no employment relationship, partnership, or joint venture shall be formed due to the performance of this Agreement. This Agreement does

not make Consultant the agent or legal representative of Licensees, and Consultant further agrees that no representation will be made by Consultant that would create an apparent agency, employment, partnership, or joint venture relationship. Consultant acknowledges that he is solely responsible for the taxes on his own income and that, as an independent contractor, his payments will be reported on an IRS Form 1099. In addition, Consultant will provide his own insurance, as necessary, and will not be covered under any Licensee's insurance policy or benefits program.

3. Method of Performing Services. Consultant will determine the method, details, and means of performing the services required by this Agreement.

4. Time and Place of Performing Work. Consultant may perform the Services under this Agreement at any suitable time and location Consultant chooses. Such services will be performed outside the usual course of the Licensees' business although Consultant may, from time to time, as Consultant deems necessary, perform services under this Agreement at the Facilities. Consultant shall observe all safety rules, policies and procedures applicable to visitors and vendors at each facility when on site at the Facilities, including requirements for flu and other vaccinations, if requested.

5. Payment. Consultant shall be paid a monthly retainer during the first twelve (12) months of Seventy-Five Hundred Dollars ($7,500) for all Services and Twenty-Five Hundred dollars ($3,500) during the second proceeding twelve (12) months for all Services. Compensation to be paid to IM under this Agreement under no circumstances shall exceed $300,000 in accordance with the Order. Consultant shall be responsible for all taxes attributable to the compensation paid to him under this Agreement. Consultant shall be entitled to no other payment, remuneration, or benefits other than the compensation described in this Agreement. Because Consultant is an independent contractor, the Licensees will not deduct any amounts from Consultant's payments for income tax or other employment-related withholdings.

6. Billing. Consultant shall provide each Licensee with an invoice on a monthly basis providing a general description of the Services performed and number of hours billed for the Services provided to each Licensee. The invoice shall also list any expenses reasonably incurred by Consultant as part of his consulting services, for which he seeks reimbursement, except that Consultant must obtain prior consent before incurring any expense in excess of $500. Each Licensee's payment of Consultant's invoice is due within thirty (30) days of receipt.

7. Term; Termination. This Agreement will begin on the Effective Date and shall continue for a period of two years in accordance with the Order. This Agreement may not be terminated by either party or by mutual consent unless such termination is approved by OHCA and FLIS. The term may be extended at the direction of FLIS for up to (1) additional year, for an overall total of three (3) years, provided that the compensation cap set forth in paragraph 5 shall include any such extended term.

8. Representations. Consultant warrants that all information provided by Consultant to Licensees is true to the best of Consultant's actual knowledge. Consultant further warrants that he is not restricted by, and has no conflict of interest derived from any other agreement and has no other interest or obligation that would interfere with his

performing work as described in this Agreement, and that he shall inform Licensees immediately should such a limitation or conflict arise. Consultant further warrants that the services of Consultant will be provided utilizing reasonable care and skill in accordance with customary industry standards. Consultant represents he/she has expertise in hospital administration and operations, knowledge of the healthcare environment with a special focus on quality assurance and performance improvement, and considerable knowledge of accepted standards of practice and state and federal laws and regulations applicable to general/acute care hospitals. Consultant represents and warrants that he/she has not been convicted of a criminal offense related to healthcare, debarred, suspended, declared ineligible, or excluded from participating with Medicare, Medicaid or any other plan or program that provides health benefits, whether directly through insurance or otherwise, which is funded directly, in whole or in part, by the United States Government or any State health care program. This shall be an ongoing representation and warranty during the term of this Agreement. Consultant shall immediately notify Licensees of any change in the status of the representations set forth in this section.

9. Adherence to Health Laws. Consultant acknowledges that Licensees receive federal funds and that Contractor will receive payments under this Agreement that are, in whole or in part, from federal funds. Consultant shall follow and adhere to all applicable state and federal laws, rules, and regulations, including, but not limited to, all Medicare laws, regulations and CMS instructions, including, without limitations, (a) federal criminal law; (b) the False Claims Act (31 USC 3729 et seq.); and (c) the anti-kickback statute (42 USC 1320a-7b(b)); (d) the civil monetary penalties law (42 USC 1320a-7a); (e) the physician self-referral law (42 USC 1395nn).

10. Corporate Compliance. Contractor acknowledges that Licensees maintain Corporate Compliance Plans ("CCPs") that foster prevention, detection and resolution of instances of misconduct. Vendor shall cooperate with Licensees' corporate compliance audits, reviews and investigations that relate to the services provided by Contractor under this Agreement. Contractor agrees to immediately notify Licensees' Compliance Officers of any violation of any applicable law, regulation, third party payor requirements or breach of Licenses' CCPs of which Contractor becomes aware during the term hereof.

11. Insurance. Consultant shall, at his/her sole cost and expense, maintain at all times during the term of this Agreement, general liability ("GL") and errors and omissions ("E&O") insurance covering his/her provision of the Services in minimum amounts of One Million Dollars ($1,000,000) per occurrence, Three Million Dollars ($3,000,000) in the aggregate annually, as well as an umbrella/excess liability insurance policy written on an occurrence basis and in an amount of not less than Three Million Dollars ($3,000,000) in the annual aggregate, excess of the limits of his/her GL and E&O policies (collectively, the "Policies"). Said Policies shall be obtained from an insurer licensed or authorized to do business in Connecticut, with an A.M. Best's Insurance Rating of A- or better. Licensees and their officers, directors, agents, employees, and volunteers (the "Licensee Parties") shall be named as additional insureds to all such Policies, and said Policies shall provide that they are primary to and noncontributory with any and all other insurance maintained by or otherwise afforded to the Licensee Parties. Upon a Licensee's request, Consultant shall provide a current certificate of insurance to Licensee evidencing such coverage and shall require

its insurance carrier to notify Licensee immediately of any actual or intended change, cancellation, modification or non-renewal of such coverage. The obligations set forth herein shall survive the expiration or termination of this Agreement.

12. No Assignment or Subcontracting. Consultant shall not assign or otherwise transfer his rights in this Agreement without the prior written consent of the Licensees and the approval of OHCA and FLIS. Consultant may not subcontract the consulting services to any other consultant without the prior written consent of the Licensees and the approval of OHCA and FLIS.

13. Non-exclusivity. Consultant may represent, perform services for, and contract with as many additional clients, persons, or companies as Consultant, in Consultant's sole discretion, sees fit. Consultant shall not, however, perform services for any other entity where such services would create a conflict of interest with the services performed under this Agreement for Licensees.

14. Non-Solicitation. Consultant agrees that during the term of this Agreement, and for a period of two (2) years after the termination of this Agreement, Consultant shall not solicit, either directly or indirectly, any employee, customer, contractor, vendor, business contact, or consultant to leave Licensees.

15. Trade Secrets, Confidential Information.

(A) For purposes of this Agreement, the term "Confidential Information" means any information relating to Licensees (including any of their subsidiaries, shareholders or other affiliates) disclosed to Consultant, whether orally, in writing, or in any other medium, whether prior to or after the Effective Date of this Agreement, by or on behalf of Licensees, including, without limitation, information regarding Licensees assets, real estate holdings, historical and projected financial information; budgets; services; processes; operations; marketing plans and materials; analyses; strategies; forecasts; names, addresses and any other information regarding Licensees' existing or potential patients, employees, vendors or suppliers; or any information derived, summarized or extracted from any of the foregoing.

(B) Confidential Information shall not include any information which (i) is or becomes available to the public other than as a consequence of a breach of this Agreement; (ii) was available to Consultant on a non-confidential basis prior to its disclosure to Consultant by Licensees; (iii) becomes available to Consultant from a source other than Licensees, provided such source is not actually known by Consultant to be bound by a confidentiality obligation to Licensees; or (iv) is required to be disclosed by Consultant or any of its Representatives (as defined below) under the Order or applicable law or regulation.

(C) Consultant hereby agrees to hold in strict confidence all Confidential Information and agrees not to disclose or otherwise provide or transfer, directly or indirectly, any Confidential Information or anything related to the Confidential Information to third parties, including, but not limited to, Consultant's affiliates, without

the prior written consent of Licensees. Consultant further agrees that he may use the Confidential Information only in connection with the work he will perform for Licensees and to comply with the Order and not for any other purpose or for the benefit of any third party.

(D) Consultant shall not disclose to any third party, except where permitted or required by the Order or by law or where such disclosure is expressly approved by Licensees in writing, any patient or medical record information regarding any of the Licensee's patients, and Consultant shall comply with all federal and state laws and regulations, and all bylaws, rules, regulations, and policies of Licensees, its accrediting agency and the medical staff, regarding the confidentiality of such information. Consultant acknowledges that in receiving or otherwise dealing with any records or information from Licensees about (i) Licensees' patients receiving treatment for alcohol or drug abuse, Consultant is fully bound by the provisions of the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 C.F.R. Part 2, as amended from time to time), and/or (ii) Licensees' peer review activities, Consultant is fully bound to maintain the confidentially of such information in accordance with C.G.A.§ 19a-17b(d) . In addition, Consultant shall comply in all respect with HIPAA and the HITECH Act 42 U.S.C. §§300jj et seq.; §§17901 et seq., and shall execute and deliver to Licensees the Business Associate Agreement attached as Exhibit B.

(E) Consultant understands that in the event he fails to comply with paragraph 13 or this paragraph 14, Licensees may suffer irreparable harm, which may not be adequately compensated for by monetary damages alone. Consultant, therefore, agrees that in the event of his breach or threatened breach of paragraph 13 or this paragraph 14, Licensees will be entitled to injunctive and/or other preliminary or equitable relief from a court of law. Consultant understands that this is the sole exception to the binding arbitration of disputes between the parties in accordance with paragraph 20 below.

16. Return of Property and Confidential Information. Consultant agrees that, upon termination of this Agreement, he will promptly return to Licensees all items, documents and materials that are in Consultant's possession or control that were provided to Consultant by Licensees. Consultant further agrees that he will promptly return to Licensees or destroy all written Confidential Information received by Consultant from or on behalf of Licensees, including any and all copies or duplicates of such Confidential Information, and all summaries or extracts thereof in any medium prepared by or on behalf of Consultant. Any destruction of Confidential Information shall be confirmed in writing.

17. Notices. Any required notice under this Agreement shall be deemed made on the date it is personally delivered or, if made by U.S. Mail, Federal Express or similar parcel service, three (3) days after the date it is sent. Notices under this Agreement shall be sent to the following:

If to Consultant:

Nurse Consulting Partners, LLC
6909 S. Park View Court
Franklin, WI 53132

Colleen Smith, MSN, RN, NEA-BC
41 Laurel Crest Road
Madison, CT 06443

If to Licensees:

Prospect ECHN, Inc.
71 Haynes Street
Manchester, CT 06040
Attention: Chief Executive Officer

Prospect Waterbury, Inc.
64 Robbins Street
Waterbury, CT 06708
Attention: Chief Executive Officer

With a copy to:

Prospect Medical Holdings, Inc.
3415 South Sepulveda Blvd., 9th Floor
Los Angeles, CA 90034
Attention: General Counsel

18. Modifications. No Modification or amendment may be made to this Agreement unless it is in writing and signed by Consultant and an authorized officer of Licensees.

19. Entire Agreement. Consultant and Licensees acknowledge and agree that this Agreement which includes Exhibits A and B contains the entire understanding between the parties and that this Agreement replaces and supersedes any other agreement, including any written, oral or implied agreement, regarding the subject matter contained in this Agreement.

20. Arbitration. Any dispute between the parties arising out of this Agreement, including without limitation threshold or jurisdictional issues, such issues of arbitrability on the enforceability of this Agreement, shall be resolved by binding arbitration, pursuant to the commercial dispute rules of the Judicial Arbitration and Mediation Services ("JAMS"). The arbitration shall take place before a single arbitrator. The prevailing party to the arbitration shall be entitled to recover its attorney's fees and costs, including the JAMS arbitration fees. The arbitrator shall be entitled to award any relief or remedy under law, including monetary damages and injunctive relief. Despite this provision, if Consultant breaches paragraph 13 or paragraph 14 of this Agreement, Licensees may seek injunctive relief from a court of law to remedy such a breach.

21. Severability. If any part, clause, or condition of this Agreement is held to

be partially or wholly invalid, unenforceable, or inoperative for any reason whatsoever, such will not affect any other provision or portion hereof, which will continue to be effective as though such invalid, inoperative, or unenforceable part, clause or condition had not been made.

22. Binding Upon Successors. This Agreement will be binding upon and inure to the benefit of the parties hereto and their respective heirs, legal representatives, successors and assigns.

23. Governing Law and Venue. All questions concerning this Agreement, its construction, and the rights and liabilities of the parties hereto will be interpreted and enforced in accordance with the laws of the State of Connecticut as applied to contracts which are executed and performed entirely within the state.

Consultant and Licensees represent that they have read and understand the terms of this Agreement, that they have had the opportunity to review this Agreement with the counsel of their choice, and that they are not relying on any advice from the other party regarding this Agreement.

IN WITNESS WHEREOF, the parties have executed this Agreement to be effective as of the Effective Date.

LICENSEES:

PROSPECT ECHN, INC.

By: _____

Name:

Title:

By: _____

Name:

Title:

PROSPECT WATERBURY, INC.

By: _____

Name:

Title:

By: _____

Name:

Title:

CONSULTANT:

_____

Name: Colleen Smith, MSN, RN, NEA-BC

Nursing Consulting Partners

By: _____
Name:
Title:

EXHIBIT A

1. Pre-Licensure Consent Order for Prospect Manchester Hospital, Inc.
2. Pre-Licensure Consent Order for Prospect Rockville Hospital, Inc.
3. Pre-Licensure Consent Order for Prospect Waterbury, Inc.
4. OHCA Final Decision for Greater Waterbury Health Network, Inc.
5. OHCA Final Decision for Eastern Connecticut Health Network, Inc.
6. Quality Assurance Commitment for Greater Waterbury Health Network, Inc.
7. Quality Assurance Commitment for Eastern Connecticut Health Network, Inc.

EXHIBIT B

BUSINESS ASSOCIATE AGREEMENT

THIS BUSINESS ASSOCIATE AGREEMENT (the "Business Associate Agreement") is made and entered into as of November ___, 2016 (the "Effective Date"), by and among Prospect ECHN, Inc., a Connecticut corporation ('Prospect ECHN"), Prospect Waterbury, Inc., a Connecticut corporation ("Prospect Waterbury") (together, the "Covered Entities") and Nursing Consulting Partners, LLC ("Business Associate")

R E C I T A L S:

WHEREAS, the Business Associate and Covered Entities have entered into and may enter into one or more agreements (the "Agreement(s)") under which the Business Associate performs or assists the Covered Entities with a function or activity involving the Use or Disclosure of Individually Identifiable Health Information;

WHEREAS, the Covered Entities and the Business Associate desire to comply with the requirements of regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

WHEREAS, the HIPAA Standards require that the Covered Entities obtain satisfactory assurances that the Business Associate will appropriately safeguard the Individually Identifiable Health Information Used or Disclosed by the Business Associate in the course of performing services pursuant to the Agreement(s).

NOW, THEREFORE, in consideration of the foregoing and the mutual promises and covenants herein contained, the parties agree as follows:

1. <u>Definitions</u>

a) HIPAA Rules shall mean the Privacy, Security, Breach Notification and Enforcement Rules at 45 C.F.R. Part 160 and Part 164.

b) The following terms Used in this business Associate Agreement shall have the same meaning as those terms defined in the HIPAA Standards: Business Associate, Covered Entity, Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required By Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

c) The Covered Entities and the Business Associate acknowledge and agree that capitalized terms Used, but not otherwise defined, herein are as defined in the HIPAA Standards;

2. Obligations and Activities of Business Associate

a) Business Associate shall not Use or further Disclose Protected Health Information other than as permitted or required by this Business Associate Agreement or as required by law.

b) Business Associate shall Use appropriate safeguards and comply with Subpart C of 45 C.F.R. Part 164 with respect to electronic protected health information, to prevent Use or Disclosure of the Protected Health Information not provided for by this Business Associate Agreement.

c) Business Associate shall immediately report to Covered Entities any Use or Disclosure of Protected Health Information or individually identifiable information not provided for by this Business Associate Agreement, including without limitation any Breach of Protected Health Information or Unsecured Protected Health Information as required and any Security Incident of which the Business Associate becomes aware. Business Associate shall take any reasonable action necessary or requested by the Covered Entities to mitigate, to the extent practicable, any harmful effect that is known to Business Associate.

d) In the event of a Breach of Protected Health Information or Unsecured Protected Health Information, Business Associate's notice to Covered Entities of such Breach shall include, to the extent possible, the identification of each Individual whose Protected Health Information has been, or is reasonably believed to have been, accessed, acquired, or disclosed. Business Associate shall also provide Covered Entities any other available information that the Covered Entities are required to include in the notification to the Individual, even if such information becomes available after notification to the Individual, or take any reasonable action necessary as requested by the Covered Entities to assist Covered Entities in complying with any applicable Breach notification requirements.

e) Business Associate shall ensure that any agent of the Business Associate, including a subcontractor that creates, maintains transmits, or receives Protected Health Information on behalf of Covered Entities agrees to the same restrictions, conditions and requirements that apply through to Business Associate with respect to such information.

f) If the Business Associate maintains Protected Health Information in a Designated Record Set, the Business Associate shall:

(i) provide access or make available to Covered Entities Protected Health Information in a Designated Record Set, to Covered Entities or to an Individual, per Covered Entities' direction in order to meet the requirements under 45 C.F.R. § 164.524; and

(ii) make any amendment(s) to Protected Health Information in a Designated Record Set that the Covered Entities direct or agree to

pursuant to 45 C.F.R. § 164.526 at the request of Covered Entity or an Individual in the time and manner designated by Covered Entity, or take other measures as necessary to satisfy Covered Entities' obligations under 45 C.F.R. 164.526.

g) Business Associate shall maintain and make available to Covered Entity information pertaining to Disclosures of Protected Health Information by Business Associate to permit Covered Entity to respond to a request by an Individual for an accounting of Disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528. In the event that Business Associate receives a direct request from an Individual for an accounting of Disclosures of Protected Health Information made by Business Associate, Business Associate agrees to provide the Individual with such an accounting in accordance with 45 C.F.R. § 164.528.

h) To the extent Business Associate is to carry out one or more of Covered Entities' obligation(s) under Subpart E of 45 C.F.R. Part 164, Business Associate shall comply with the requirements of Subpart E that apply to Covered Entity in the performance of such obligation(s); and

i) Business Associate shall make internal practices, books, and records relating to the Use and Disclosure of Protected Health Information received from, or created, maintained or received by Business Associate on behalf of Covered Entity available to the Covered Entity or the Secretary, in a time and manner designated by the Covered Entity or the Secretary, for purposes of the Secretary determining Covered Entities' or Business Associate's compliance with the HIPAA Rules.

j) Business Associate shall implement and maintain safeguards as necessary to ensure that all Protected Health Information is Used or Disclosed only as authorized under the HIPAA Rules and this Business Associate Agreement. Business Associate agrees to assess potential risks and vulnerabilities to Protected Health Information in its possession and develop, implement and maintain the administrative, physical and technical safeguards required by the HIPAA Rules that protect the confidentiality, availability and integrity of the Protected Health Information that Business Associate creates, receives, maintains or transmits on behalf of the Covered Entity. These measures must be documented and kept current, and must include, at a minimum, those measures that fulfill the requirements outlined in the HIPAA Rules. Business Associate also agrees to implement policies and procedures that address Business Associate's compliance with applicable HIPAA Rules and its efforts to detect, prevent and mitigate the risks of identity theft resulting from the improper Use and/or Disclosure of an Individual's information.

k) In the event that Business Associate has knowledge of a Covered Entity's breach of the HIPAA Rules, Business Associate agrees to notify Covered Entity and take reasonable steps to cure such breach.

l) Business Associate acknowledges that if it violates any of the requirements provided under this Business Associate Agreement, Business Associate will be subject to the same civil and criminal penalties that a Covered Entity would be subject to if such Covered Entity violated the same requirements.

3. <u>Permitted Uses and Disclosures by Business Associate</u>

a) Business Associate may Use or Disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, a Covered Entity as specified in the Agreement(s), provided that such Use or Disclosure would not violate the HIPAA Rules if done by the Covered Entity.

b) Business Associate may Use Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

c) Business Associate may Disclose Protected Health Information for the proper management and administration of the Business Associate, provided that Disclosures are Required by Law, or Business Associate obtains reasonable assurances from the person to whom the information is Disclosed that it will remain confidential and will be Used or further Disclosed only as Required by Law or for the purpose for which it was initially Disclosed to the recipient, and the recipient notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

d) Except as otherwise permitted by the HIPAA Rules, when using or disclosing Protected Health Information or responding to a request for Protected Health Information, Business Associate must limit such Protected Health Information, to the extent practicable, to a Limited Data Set, or if more information than a Limited Data Set is required, Business Associate agrees to make Uses and Disclosures and requests for protected health information consistent with the Minimum Necessary to accomplish the intended purpose of such Use, Disclosure, or request.

e) Except as otherwise permitted by the HIPAA Rules, Business Associate agrees that it will not directly or indirectly receive remuneration in exchange for any Protected Health Information unless the Covered Entity has obtained from an Individual a valid authorization that includes a specification of whether the Protected Health Information can be further exchanged for remuneration by the entity receiving the Individual's Protected Health Information. When the Secretary issues the regulations that address the requirements of this Section and such regulations become effective, Business Associate shall comply with such regulations with respect to receiving remuneration in exchange for any Protected Health Information.

f) If an Individual requests that Business Associate restrict the Disclosure of the Individual's Protected Health Information to carry out treatment, payment, or health care operations, Business Associate agrees that it will comply with the requested restriction if, except as otherwise required by law, the Disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment), and the Protected Health Information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full.

g) Except as otherwise limited in this Business Associate Agreement, Business Associate may Use and Disclose Protected Health Information to provide Data Aggregation services to Covered Entity as permitted by 42 C.F.R. § 164.504(e)(2)(i)(B).

4. Obligations of Covered Entities

a) Covered Entities shall provide Business Associate with the Notice of Privacy Practices that Covered Entities produce in accordance with 45 C.F.R. § 164.520, as well as provide any changes to such Notice and the Business Associate shall comply with such Notice of Privacy Practices.

b) Covered Entities shall provide Business Associate with any changes in, or revocation of, permission by Individual to Use or Disclose Protected Health Information, if such changes affect Business Associate's permitted or required Uses and Disclosures.

c) Covered Entities shall notify Business Associate of any restriction to the Use or Disclosure of Protected Health Information that Covered Entity has agreed to in accordance with 45 C.F.R. § 164.522.

d) Covered Entities shall not request Business Associate to Use or Disclose Protected Health Information in any manner that would not be permissible under the HIPAA Rules if done by Covered Entities.

5. Term and Termination

a) Term. The Term of this Business Associate Agreement shall be effective as of the Effective Date and shall terminate at to a Covered Entity when all of the Protected Health Information provided by the Covered Entity to Business Associate, or created, maintained, or received by Business Associate on behalf of the Covered Entity, is destroyed or returned to the Covered Entity, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this Section.

b) Termination for Cause. Upon a Covered Entity's knowledge of a material breach of this Business Associate Agreement by Business Associate, the Covered Entity shall provide an opportunity for Business Associate to cure

the breach or end the violation. The Covered Entity shall terminate the Business Associate Agreement if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity. The Covered Entity may immediately terminate the Business Associate Agreement if Business Associate has breached a material term of this Business Associate Agreement and cure is not possible, as determined by the Covered Entity in its reasonable discretion.

c) Effect of Termination.

(i) Except as provided in this subsection, upon termination of the Agreement(s) or this Business Associate Agreement, for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Entities, or created, maintained or received by Business Associate on behalf of Covered Entities that the Business Associate still maintains in any form. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.

(ii) In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Covered Entities notification of the conditions that make return or destruction infeasible. Upon mutual agreement of the parties that return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this Business Associate Agreement to such Protected Health Information and limit further Uses and Disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

(iii) The parties hereto understand and agree that the terms of this Business Associate Agreement are reasonable and necessary to protect the interests of the Covered Entities and the Business Associate. The parties further agree that the Covered Entities would suffer irreparable harm if the Business Associate breached this Business Associate Agreement. Thus, in addition to any other rights or remedies, all of which shall be deemed cumulative, the Covered Entities shall be entitled to obtain injunctive relief to enforce the terms of this Business Associate Agreement.

(iv) Survival. The obligations of Business Associate under this Section shall survive the termination of this Business Associate Agreement.

6. Miscellaneous

a) Interpretation. Any ambiguity in this Business Associate Agreement shall be interpreted in a manner that permits the parties to comply with the HIPAA Rules.

b) No Private Cause of Action. This Business Associate Agreement is not intended to and does not create a private cause of action by any individual, other than the parties to this Business Associate Agreement, as a result of any claim arising out of the breach of this Business Associate Agreement, the HIPAA Standards or other state or federal law or regulation relating to privacy or confidentiality.

c) Amendment. Any party shall have the right to amend this Business Associate Agreement by providing written notice to the other parties in order to bring it into compliance with any law or regulation enacted or promulgated regarding the protection of health information that is any way inconsistent with the terms of this Business Associate Agreement or interferes with the parties' obligations with respect to the protection of health information.

d) Application of State Law. Where any applicable provision of Connecticut State law relates to the privacy of health information and is not preempted by HIPAA, as determined by application of the HIPAA Rules, the parties shall comply with the applicable provisions of Connecticut State law.

e) Severability. If any provision of this Business Associate Agreement shall be declared invalid or illegal for any reason whatsoever, then notwithstanding such invalidity or illegality, the remaining terms and provisions of this Business Associate Agreement shall remain in full force and effect in the same manner as if the invalid or illegal provision had not been contained herein, and such invalid, unenforceable or illegal provision shall be valid, enforceable and legal to the maximum extent permitted by law.

f) Governing Law. This Business Associate Agreement shall be interpreted, construed and governed according to the laws of the State of Connecticut. The parties agree that venue shall lie in Federal and State courts in the State in which the Covered Entities maintain their principal places of business, without regard to conflicts of law principles, regarding any and all disputes arising from this Business Associate Agreement.

g) Notices. Any notice or other communication given pursuant to this Business Associate Agreement must be in writing and (i) delivered personally, (ii) delivered by overnight express, or (iii) sent by registered or certified mail, postage prepaid, to the addresses set forth below and shall be considered given upon delivery.

Chief Compliance and Privacy Officer
Prospect ECHN, Inc.

71 Haynes Street
Manchester, CT 06040

Chief Compliance Officer
Prospect Waterbury, Inc.
64 Robbins Street
Waterbury, CT 06708

With a copy to:

Prospect Medical Holdings, Inc.
3415 South Sepulveda Blvd., 9th Floor
Los Angeles, CA 90034
Attention: General Counsel

h) Indemnification. Without limitation to any indemnification obligation that Business Associate may have under the Agreement(s), Business Associate shall indemnify, hold harmless and defend Covered Entities from and against any and all claims, losses, liabilities, costs and other expenses resulting from, or relating to, the acts or omissions of Business Associate, its employees, agents, and subcontractors, in connection with any Use or Disclosure of Protected Health Information, Unsecured Protected Health Information, or an Individual's information not provided for by this Business Associate Agreement, including without limitation any Breach of Protected Health Information, Unsecured Protected Health Information, or an Individual's information or any expenses incurred by Covered Entitles in providing required breach notifications.

IN WITNESS WHEREOF, the parties hereto have executed this Business Associate Agreement as of the Effective Date.

BUSINESS ASSOCIATE
NURSING CONSULTING PARTNERS, LLC

By:_____
Printed Name:
Title:
Date:

COVERED ENTITY
PROSPECT ECHN, INC.

By:_____
Printed Name:
Title:
Date:

COVERED ENTITY
PROSPECT WATERBURY, INC.

By:_____
Printed Name:
Title:
Date:

Nursing Consulting Partners, LLC

PROSPECT ECHN, INC. WOR PLAN

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INDEPENDENT MONITORING PROCEDURES (per Docket Number 15-32016-486)

OHCA Condition	IM Action
CON Condition 4: Within one hundred and eighty (180) days following the Closing Date, PMH shall submit a plan (the "Health Needs Plan") for continuing to support and implement ECHN's 2016 Community Health Needs Assessment ("CHNA") and for conducting the New Hospitals' next comprehensive study of community health needs in the Service Area (the "Community Health Needs Study" or "Study"). The Health Needs Plan shall describe in detail at least the following: (i) the data that will be collected and analy ed to systematically assess health status Indicators of the Service Area; (ii) the identity of key community stakeholders and health organi ations, unaffiliated with PMH, including without limitation, representatives of medically underserved populations, that will be enlisted to participate in the Study and the manner and extent of such participation by stakeholders in both the development of health priorities and planned implementation; (iii) the ualifications of consultants experienced in performing community health needs assessments who will be retained by PMH to ensure that the priority health needs of the community are accurately determined; (iv) the fre uency with which the Study will be repeated; (v) the manner in which results of the Study and the implementation strategy to address the priority health needs identified therein (the "Implementation Strategy") will be distributed to the community; and (vi) the manner in which the Study will complement the population health management objectives of PMH and the New Hospitals.	IM will obtain a copy of the Plan, verify timely submission, verify that it incorporated the re uired elements.
CON Condition 5: Within three (3) years following the Closing Date, PMH shall participate with New ECHN and the New Hospitals, and the key community stakeholders and health organi ations identified pursuant to Condition 4, in conducting a Community Health Needs Study and shall provide a copy of such Study and its Implementation Strategy to OHCA within thirty (30) days of completion. PMH and the participants shall utili e Healthy Connecticut State Health Improvement Plan data and priorities as the starting point for the Study (available at http: www.ct.gov dph lib dph state_health_planning sha-	IM will obtain a copy of the Study, verify timely submission, verify that it incorporated the re uired elements and was published on the website.

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ship hct2020 hct2020_state_hlth_impv_032514.pdf) as well as any applicable community health improvement plan issued by any local health department in the Service Area.[1] The Implementation Strategy shall also adopt the evidence-based interventions identified in the Centers for Disease Control 6 18 initiative (available at http: www.cdc.gov sixeighteen) to the extent the health priorities identified in the Study correlate to the health conditions identified by the CDC and provide information on how any patient outcomes related to the Implementation Strategy will be measured and reported to the community. PMH shall publish the Community Health Needs Study and the Implementation Strategy on the website pages of New MMH and New RGH. Until such time as the Community Health Needs Study and Implementation Strategy are submitted to OHCA, PMH shall continue to support and implement ECHN's current CHNA for MMH and RGH. OHCA is imposing this condition to ensure continued access to health care services to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d(a) 19a-613(b), 19a-639(a)(3) & (7); FF 56-57*	
CON Condition 6: Within one hundred and eighty (180) days following the Closing Date, PMH shall submit a plan demonstrating how health care services will be provided by the New Hospitals for the first three years following the Asset Purchase, including any consolidation, reduction, or elimination of existing services or introduction of new services (the "Services Plan"). The Services Plan will be provided in a format mutually agreed upon by OHCA and the Applicants. OHCA is imposing this condition to ensure continued access to health care services to the patient population. *Legal and Factual Basis: Conn. Stat. §§ 19a-486(a), 19a-613(b), 19a-639(a)(5),(6) (7),(8),(9),(11) & (12); FF 18, 26-27*	IM will obtain a copy of the Plan and verify it incorporated the re uired elements.
CON Condition 7: Until such time as the Services Plan is submitted, PMH shall provide OHCA with notice of any reallocation of inpatient beds and relocation of outpatient services for the New MMH or New RGH specific to those services that existed at each of the Hospitals as of the Decision Date. Such notice shall be provided within ten (10) days of any such reallocation or relocation and published on the website pages of the New Hospitals. OHCA is imposing this condition to ensure continued access to health care services to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486(a), 19a-613(b), 19a-639(a)(5),(6) (7),(8),(9),(11) & (12); FF 18, 26-27*	IM will verify proper notification to OHCA within 10 days of any plan to reallocate inpatient beds and relocation of outpatient services. IM will assure timely publication on New Hospitals website within 10 days of decision to reallocate or relocate services.
CON Condition 8: Within one hundred and eighty (180) days	IM will obtain the Plan, read the plan and verify that

[1] Other tools and resources which the Applicants are encouraged to consider include County Health Rankings and CDC Community Health Improvement Navigator in order to assist with the Study process in terms of an understanding of social, behavioral, and environmental conditions that affect health, identifying priorities, and the use of evidence-based interventions.

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following the Closing Date and thereafter on the same semi-annual schedule as set forth in Conditions 9 and 10 below until the capital commitment is satisfied, PMH shall submit to OHCA a report on the capital investments ("Capital Investment Report") it has made in the New MMH, New RGH and their affiliates from the $75 million Commitment Amount. The Capital Investment Report shall include the following in a format to be agreed upon: a. A list of the capital expenditures that have been made in the prior one hundred and eighty (180) days with descriptions of each associated project; and b. An explanation of why each expenditure was made and a timeframe for the roll out of the associated capital project (including estimated beginning, ending and startup/operation dates); and c. The dates and amounts of withdrawals from each of the New Hospitals' operating account and/or any other sources of funding used to fulfill the Capital Commitment. The reports shall be signed by PMH ECHN's Chief Financial Officer. OHCA is imposing this condition to ensure continued access to health care services to the patient population and to verify the continued financial feasibility of the project. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(3),(4) & (5); FF 38-45*	expenditures/investments made are in accordance with the Plan. IM will confirm timely submissions of all required reports.
CON Condition 9: For three (3) years following the Closing Date, PMH shall file the following information with OHCA on a semi-annual basis for New ECHN, New MMH and New RGH, respectively: a. The cost saving totals achieved in the following Operating Expense Categories for New ECHN, New MMH and New RGH: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Interest Expense, Malpractice Expense, Utilities, Business Expenses and Other Operating Expenses. The categories shall be consistent with the major operating expense categories (Categories A, B, C, D, E, G, H, I, J, and K) which are in use at the time of reporting in the OHCA	IM will review the PMH filings regarding cost savings achieved in accordance with a. 1-2 and b. of Condition 9.

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Hospital Reporting System (□HRS□) Report 175 or successor report. The semi-annual submission shall also contain narratives describing: 1. the major cost savings achieved for each expense category for the semi-annual period; and 2. the effect of these cost savings on the clinical □uality of care. b. A consolidated Balance Sheet, Statement of Operations, and Statement of Cash Flows for New ECHN, New MMH and New RGH. The format shall be consistent with that which is in use at the time of reporting in OHCA□s HRS Reports 100□150, 300□350 or successor reports. For purposes of this Order, semi-annual periods are October 1-March 31 and April 1 – September 30. The re□uired information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th, beginning November 30, 2016. OHCA is imposing this condition to ensure continued access to health care services to the patient population and to verify the continued financial feasibility of the project. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(4) & (5); FF 51, 60-63*	
<u>CON Condition 10:</u> For three (3) years following the Closing Date, PMH shall submit to OHCA a financial measurement report. This report shall be submitted on a semi-annual basis and show current month and year-to-date data and comparable prior year period data for New ECHN, New MMH and New RGH, respectively. The re□uired information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th, beginning November 30, 2016. The following financial measurements□indicators should be addressed in the report: (i) **Operating performance** to include operating margin, non-operating margin, and total margin; (ii) **Liquidity** to include current ratio, days cash on hand, days in net accounts receivables, and average payment period; (iii) **Leverage and capital structure** to include long-term debt to e□uity, long-term debt to capitali□ation, unrestricted cash to debt, times interest earned ratio, debt service coverage ratio, and e□uity financing ratio; and (iv) **Additional Statistics** to include income from operations, revenue over (under) expense, cash from operation, cash and cash e□uivalents, net working capital, free cash flow (and the elements used in the calculation), unrestricted net assets□retained earnings, bad debt as a percentage of gross revenue, and credit ratings.	IM will obtain the financial measurement report and read to confirm that the re□uired elements are addressed in the report; IM will confirm the timely submission of each report.

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CON Condition 11: PMH shall ensure that New MMH and New RGH maintain and adhere to ECHN's current policies regarding charity care, indigent care and community volunteer services at New MMH and New RGH after the Closing Date all as consistent with state and federal law or adopt other policies that are at least as generous and benevolent to the community as ECHN's current policies. These policies shall be posted on the website pages of the New MMH and New RGH, respectively, and as additionally re□uired by applicable law. OHCA is imposing this condition to ensure continued access to health care services to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(5),(6) & (11); FF 52-55, 59*	IM will obtain copies of the relevant financial assistance policies, read and confirm that as adopted financial assistance policies (or policies at least as generous as these policies) using management approval of the policies as evidence. After verifying that this step has been properly completed, IM will confirm that these policies are properly posted on website
CON Condition 12: For three (3) years following the Closing Date, PMH shall provide written notice to OHCA of any modification, amendment or revision to the charity care, indigent care and community volunteer services of New MMH and New RGH within thirty (30) days of such change. The notice of these changes shall be accompanied by copies of any revised policies and the notice and revised policies shall be posted on the website pages of the New Hospitals simultaneously with their submission to OHCA. OHCA is imposing this condition to ensure continued access to health care services to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(5),(6) & (11); FF 52-55, 59*	After obtaining original policies on charity care, indigent care, and community volunteer services, IM will read and assess these policies on an annual basis for changes. When changes are made to these policies, IM will confirm OHCA is notified (as re□uired) and revised policies are posted to the website.
CON Condition 13: PMH shall maintain community benefit programs and community building activities for New MMH and New RGH for three (3) years after the Closing Date consistent with the MMH and RGH most recent Schedule H of IRS Form 990 or shall provide such other community benefit programs and community building activities that are at least as generous and benevolent to the community as ECHN's current programs, and PMH shall apply a 1□ increase per year for the next three (3) years toward community building activities in terms of dollars spent. In determining the New MMH and New RGH participation in and investment in both community benefits and community building activities, PMH shall address the health needs identified by the applicable CHNA or Study in effect at the time and the population health management objectives, including social determinants of health, contained in the related Implementation Strategy. a. On an annual basis, the Applicants shall identify the amounts and uses related to community benefits and community building and shall discuss how such investments and support are being applied toward the health needs identified in the CHNA or Study and population health management objectives. Such reporting shall be filed within thirty days of the anniversary date of the closing for three years and shall be posted on the applicable Hospital website. OHCA is imposing this condition to ensure continued access to health care services to the patient population.	IM will obtain most recent Schedule H of IRS Form 990 to act as a baseline. IM will then compare on an annual basis the results of that year to the baseline in order to verify that the 1 percent increase re□uirement has been met. IM will also obtain the report□summary on the amounts and uses related to community benefits and community building per the categories identified in the CHNA. IM will confirm that these documents are filed in a timely manner and posted to the website.

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Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(5),(6) & (11); FF 52-55, 59	
CON Condition 14: New MMH and New RGH agree to comply with the following general community benefit standards for at least the first three years. (a) the New Hospitals shall provide public health programs to the community and generally promote the welfare of the community; (b) the New Hospitals shall have open medical staffs and not restrict the use of facilities to a particular group of physicians and surgeons to the exclusions of other □ualified doctors; (c) the New Hospitals shall participate in the Medicare and Medicaid programs; and (d) the New Hospitals shall operate 24□7 emergency departments and provide emergency services to patients regardless of their ability to pay. OHCA is imposing this condition to ensure continued access to health care services to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(5),(6) & (11); Tr., Testimony of Tom Reardon, President. PMH East on 5/3/16, pp. 103-04*	IM will verify the New Hospitals' compliance with community benefit standards a through d as stated in Condition 14.
CON Condition 15: New MMH and New RGH shall work toward making culturally and linguistically appropriate services available and integrated throughout their hospital operations. Specifically, New MMH and New RGH shall take reasonable steps to provide meaningful access to each individual with limited English proficiency eligible to be served or likely to be encountered in its health programs and activities, in accordance with the implementing regulations of Section 1557 of the Patient Protection and Affordable Care Act. Additionally, New MMH and New RGH shall provide appropriate insurance navigator services for patients and, where appropriate, English as a second language and cultural competency training for employees. In complying with this Condition, New MMH and New RGH shall be guided by the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care published by the U.S. Department of Health and Human Services □Office of Minority Health. For three (3) years following the Closing Date, PMH shall submit a written report on its activities directed at meeting this Condition. Such reporting shall be filed within thirty days of the anniversary date of the closing for three years and shall be posted on the applicable Hospital website. OHCA is imposing this condition so as to ensure continued access to health care services to the patient population. *Legal and Factual Basis: 45 C.F.R. §92.201; Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(5),(6) & (11); FF 52-55, 59*	IM will obtain and review interpreter services policies and contracts as applicable. Additionally, IM will obtain a cultural competency plan, training, as well as related policies. IM will also obtain report and supporting documents and confirm the timely filing of these materials
CON Condition 16: Within sixty (60) days after the Closing Date, the Applicants shall contract with an Independent Monitor who	IM and PMH will execute a Consulting Services Agreement

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has experience in hospital administration and regulation, including maintaining quality control in a High Reliability Organization ("HRO"). The Independent Monitor shall be retained at the sole expense of PMH, at a cost which shall not exceed $300,000 in the aggregate. Representatives of OHCA and the Facility Licensing and Investigations ("FLIS") section of the Department of Public Health ("DPH") will approve the Independent Monitor's appointment. The Independent Monitor shall be engaged for a minimum period of two (2) years following the Closing Date, which may be extended for another year at OHCA's and/or FLIS's discretion. The Independent Monitor will be responsible for monitoring the Applicants' compliance with the Conditions set forth in this Order. PMH shall provide the Independent Monitor with appropriate access to New Hospitals and their applicable records in order to enable the Independent Monitor to fulfill its functions hereunder. OHCA is imposing this condition to ensure continued access to health care services to the patient population and to verify and monitor compliance with the conditions set forth herein. *Legal and Factual Basis: Conn. Gen. §§ Stat. 19a-486(a), 19a-613(b), 19a-639(a)(1),(2),(4),(5),(6),(7),(11) & (12); FF 26-27, 30-45, 52-57, 59*	by the required date. A draft of this Agreement has been provided to OHCA.
CON Condition 17: The Independent Monitor will report to both OHCA and FLIS. The Independent Monitor shall conduct on-site visits of New Hospitals on no less than a semi-annual basis to assess PMH's modified Quality Assurance Performance Improvement ("QAPI") program, each facility's efforts to remain an HRO, and compliance with the Quality Commitment Letter. The Independent Monitor shall furnish a written report of his or her assessment to OHCA and FLIS within thirty (30) days of the completion of each on-site review. PMH will have the opportunity to review and provide written responses to the report. As OHCA deems necessary, the Independent Monitor shall meet with OHCA and FLIS personnel to discuss the written report and will perform additional periodic reviews and reviews of other PMH affiliated sites of service. OHCA is imposing this condition to ensure continued access to health care services to the patient population and to verify and monitor compliance with the conditions set forth herein. *Legal and Factual Basis: Conn. Gen. §§ Stat. 19a-486(a), 19a-613(b), 19a-639(a)(1),(2),(4),(5),(6),(7),(11) & (12); FF 26-27, 30-45, 52-57, 59*	IM will plan, at a minimum, two site visits per year. The site visits will include meetings with Administration Leadership. IM will verify compliance with the Quality Assurance commitment Letter. IM will provide a written report to OHCA, and FLIS that summaries the activities from the prior six month period along with any recommendations or observations
CON Condition 18: If, at any time within three (3) years following the Closing Date, the New Hospitals' Local Board agrees with PMH to change any of the Seller Quality Programs described in the Quality Commitment Letter other than to make any changes necessary to address (i) an immediate issue of patient safety; (ii) changes in federal, state, and local laws; or (iii) as mandated or recommended in guidance by a governmental agency, PMH shall notify OHCA and the Health Systems Branch in writing within thirty (30) days of any such change going into	IM will verify that PMH notifies OHCA and the Health Systems Branch in writing within 30 days of any change in the Seller Quality Programs with the exceptions i through iii as stated in condition 18.

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effect. If the Independent Monitor disagrees with the change, OHCA may re□uire that a re□uest for modification be submitted and approved as re□uired by C.G.S. □4-18la to make the change. OHCA is imposing this condition to ensure continued access to health care services to the patient population and to verify and monitor compliance with the conditions set forth herein. *Legal and Factual Basis: Stat. §§ 19a-486d, 19a-613(b), 19a-639(a)(1),(2),(5) & (6); FF 30-37*	
CON Condition 19: For three (3) years following the Closing Date, PMH shall hold a joint meeting of the Board of Directors of each of New MMH and New RGH and the Local Board of New MMH and New RGH ("Joint Board Meetings") at least twice annually with one occurring in Manchester and the other occurring in Vernon. Such Joint Board Meetings shall be followed by a meeting to which the public is invited in advance and at which the public is informed of the New Hospitals' activities and afforded an opportunity to ask □uestions and make comments. OHCA is imposing this condition to ensure continued access to health care services to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d, 19a-613(b), 19a-639(a)(2),(3),(5),(7),(8),(11) & (12); FF 28-30*	IM will assure that Joint Board Meetings occur twice annually followed by public meetings as re□uired in Condition 19.
CON Condition 20: For three (3) years following the Closing Date, PMH shall allow for two (2) community representatives to serve as voting members of the New MMH and New RGH Local Board with rights and obligations consistent with other voting members under the Local Board Bylaws. The community representatives shall be selected in consultation with the Mayors of Manchester and Vernon in order to ensure the appointment of two unbiased persons who will fairly represent the interests of the communities served by MMH and RGH, respectively. OHCA is imposing this condition to ensure continued access to health care services to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d, 19a-613(b), 19a-639(a)(2),(3),(5),(7),(8),(11) & (12); FF 28-30*	IM will verify the New MMH and New RGH include 2 community representatives that are voting members of the local boards.
CON Condition 21: PMH, New ECHN, New MMH and New RGH shall abide by all re□uirements of licensure that may be imposed by DPH's Health Systems Branch (HSB) in any Pre-Licensing Consent Order or similar agreement that HSB may enter with these parties. OHCA is imposing this condition to ensure that □uality health care services are provided to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d, 19a-490, 19a-493, 19a-639(a)(1),(2),(5) & (6); FF 30-37*	IM will verify that all re□uirements of licensure are met.

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Greer, Leslie

From: Roberts, Karen
Sent: Monday, November 28, 2016 3:51 PM
To: Greer, Leslie
Cc: Cotto, Carmen
Subject: FW: Independent Monitor

From: Martone, Kim
Sent: Monday, November 28, 2016 2:34 PM
To: 'Jennifer O'Donnell'; Roberts, Karen; Cotto, Carmen
Cc: Michele Volpe
Subject: RE: Independent Monitor

Thank You Jennifer. We will review the documents and get back to you as soon as possible.

Kim

Kimberly R. Martone
Director of Operations, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134
Phone: 860-418-7029 Fax: 860-418-7053
Email: Kimberly.Martone@ct.gov Website: www.ct.gov/ohca

From: Jennifer O'Donnell [mailto:jlo@bvmlaw.com]
Sent: Monday, November 28, 2016 2:29 PM
To: Martone, Kim; Roberts, Karen; Cotto, Carmen
Cc: Michele Volpe
Subject: Independent Monitor

Attached please find the Consulting Services Agreement and draft Work Plan being proposed for the Independent Monitor. Please let us know if OHCA has signed off on the IM. Thank you.

Jennifer L. O'Donnell
Paralegal
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor
New Haven, Connecticut 06511-6957
Telephone: (203) 777-5800 (ext. 104)
Direct Line: (203) 777-5804

Greer, Leslie

From: Roberts, Karen
Sent: Monday, November 28, 2016 3:51 PM
To: Greer, Leslie
Cc: Cotto, Carmen
Subject: FW: Independent Monitor

From: Jennifer O'Donnell [mailto:jlo@bvmlaw.com]
Sent: Monday, November 28, 2016 2:45 PM
To: Roberts, Karen
Cc: Martone, Kim; Cotto, Carmen; Michele Volpe
Subject: RE: Independent Monitor

Yes, the IM is working on the Waterbury work plan and it will be similar to ECHN. Also, please cc Michele Volpe (mmv@bvmlaw.com) on all correspondence as I'm leaving early today. Thank you.

Jennifer L. O'Donnell
Paralegal
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor
New Haven, Connecticut 06511-6957
Telephone: (203) 777-5800 (ext. 104)
Direct Line: (203) 777-5804
Facsimile: (203) 777-5806

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From: Roberts, Karen [mailto:Karen.Roberts@ct.gov]
Sent: Monday, November 28, 2016 2:40 PM
To: Jennifer O'Donnell <jlo@bvmlaw.com>
Cc: Martone, Kim <Kimberly.Martone@ct.gov>; Cotto, Carmen <Carmen.Cotto@ct.gov>
Subject: RE: Independent Monitor

Hi Jennifer – this draft work plan is specific to the ECHN CON Order. Does BVM and the proposed IM anticipate that the work plan for the Waterbury CON order will be very similar, if not identical, to this one? Thanks. Karen Roberts

Karen Roberts

Greer, Leslie

Subject: FW: Independent Monitor

From: Martone, Kim
Sent: Monday, November 28, 2016 3:43 PM
To: 'Jennifer O'Donnell'; Roberts, Karen; Cotto, Carmen
Cc: Michele Volpe
Subject: RE: Independent Monitor

Jennifer, we have reviewed all documents submitted and approve Colleen Smith as the Independent Monitor for the acquisitions of Prospect Medical Holdings in Connecticut. The understanding is that this office and Colleen will continue to refine and revise the draft work plan until we agree upon its finalization. We also look forward to working directly with the hospital representatives to ensure that responsibilities and obligations of the IM and hospitals are clear to everyone involved in this process.

Kim

Kimberly R. Martone
Director of Operations, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134
Phone: 860-418-7029 Fax: 860-418-7053
Email: Kimberly.Martone@ct.gov *Website:* www.ct.gov/ohca

From: Jennifer O'Donnell [mailto:jlo@bvmlaw.com]
Sent: Monday, November 28, 2016 2:29 PM
To: Martone, Kim; Roberts, Karen; Cotto, Carmen
Cc: Michele Volpe
Subject: Independent Monitor

Attached please find the Consulting Services Agreement and draft Work Plan being proposed for the Independent Monitor. Please let us know if OHCA has signed off on the IM. Thank you.

Jennifer L. O'Donnell
Paralegal
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor
New Haven, Connecticut 06511-6957
Telephone: (203) 777-5800 (ext. 104)
Direct Line: (203) 777-5804
Facsimile: (203) 777-5806

Greer, Leslie

From: Roberts, Karen
Sent: Monday, November 28, 2016 3:59 PM
To: Greer, Leslie
Subject: FW: Schedule conference call

From: Cotto, Carmen
Sent: Wednesday, November 09, 2016 5:07 PM
To: Michele Volpe (mmv@bvmlaw.com)
Cc: Jennifer O'Donnell (jlo@bvmlaw.com); Roberts, Karen; Martone, Kim; Olejarz, Barbara
Subject: Schedule conference call

Hi Michele,

Thank you for providing OHCA with a copy of Ms. Smith's resume. In addition to the resume, please provide us with a copy of the Independent Monitor's work plan and engagement letter between Ms. Smith's and the Applicants.

Our office would like to schedule a conference call with you soon, possible next week, to discuss Ms. Smith's qualifications, work plan and engagement letter.

Please contact Ms. Barbara Olejarz at (860)418-7005 or via email at Barbabra.Olejarz@ct.gov to schedule the call.

Thank you,
Carmen

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov



www.ct.gov/dph

From: Martone, Kim
Sent: Monday, November 07, 2016 7:58 AM
To: Roberts, Karen; Cotto, Carmen

Greer, Leslie

From: Roberts, Karen
Sent: Monday, November 28, 2016 3:59 PM
To: Greer, Leslie
Cc: Cotto, Carmen
Subject: FW: Schedule conference call
Attachments: CSmith Consulting Services Agmt.pdf

From: Jennifer O'Donnell [mailto:jlo@bvmlaw.com]
Sent: Thursday, November 17, 2016 9:58 AM
To: Cotto, Carmen; Michele Volpe
Cc: Roberts, Karen; Martone, Kim; Olejarz, Barbara
Subject: RE: Schedule conference call

Ms. Cotto: Attached please find a copy of the proposed contract with Ms. Smith. We are happy to schedule a conference call to discuss Ms. Smith's qualifications, work plan and engagement letter. Please let us know when would be a convenient time for OHCA. Thank you.

Jennifer L. O'Donnell
Paralegal
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor
New Haven, Connecticut 06511-6957
Telephone: (203) 777-5800 (ext. 104)
Direct Line: (203) 777-5804
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From: Cotto, Carmen [mailto:Carmen.Cotto@ct.gov]
Sent: Wednesday, November 9, 2016 5:07 PM
To: Michele Volpe <mmv@bvmlaw.com>
Cc: Jennifer O'Donnell <jlo@bvmlaw.com>; Roberts, Karen <Karen.Roberts@ct.gov>; Martone, Kim <Kimberly.Martone@ct.gov>; Olejarz, Barbara <Barbara.Olejarz@ct.gov>
Subject: Schedule conference call

Hi Michele,

CONSULTING SERVICES AGREEMENT

This Consulting Services Agreement (this "Agreement") is made and entered into to as of the _____ day of November, 2016 (the "Effective Date"), by and among Prospect ECHN, Inc., a Connecticut corporation ('Prospect ECHN"), Prospect Waterbury, Inc., a Connecticut corporation ("Prospect Waterbury") and Colleen Smith, MSN, RN, NEA-BC ("Consultant").

RECITALS

A. Prospect ECHN has acquired certain healthcare facilities in Connecticut including The Rockville General Hospital Incorporated and Manchester Memorial Hospital (collectively, the "ECHN Facilities").

B. Prospect Waterbury has acquired certain healthcare facilities in Connecticut including The Waterbury Hospital (collectively, the "GWHN Facilities").

C. The State of Connecticut, Department of Public Health, Facility and Licensing Investigations Section ("FLIS") has required pursuant to a Pre-Licensure Consent Order, copies of which are attached as Exhibit A ("Order") that Prospect ECHN and Prospect Waterbury (each a "Licensee" and collectively, the "Licensees") execute a contract with an Independent Monitor ("IM") pre-approved in writing by the Department of Public Health, Office of Healthcare Access ("OHCA") and FLIS pursuant to which the IM will monitor the ECHN Facilities and the GWHN Facilities (each a "Facility" and collectively with any other Facilities subject to the Order, the "Facilities") in compliance with the Order.

D. Consultant desires to perform the services of the IM described in the Order and the Licensees desire to engage Consultant to perform such services, subject to the terms and conditions of this Agreement and in full compliance with the Order.

In consideration of the mutual covenants contained herein, the parties hereto hereby agree as follows:

1. Scope of Services. Consultant will provide the services of the IM as described in the Order and otherwise comply with the Order (collectively, the "Services"). The Licensees shall cooperate with Consultant and provide access to the Facilities, and management and other representatives of the Facilities in order to enable the IM and the Licensees to fully comply with applicable provisions of the Order.

2. Independent Contractor. Consultant and the Licensees acknowledge and agree that Consultant shall provide services as an independent contractor. Consultant and Licensees acknowledge and agree that no employment relationship, partnership, or joint venture shall be formed due to the performance of this Agreement. This Agreement does not make Consultant the agent or legal representative of Licensees, and Consultant further agrees that no representation will be made by Consultant that would create an apparent agency, employment, partnership, or joint venture relationship. Consultant acknowledges that he is solely responsible for the taxes on his own income and that, as an independent contractor, his payments will be reported on an IRS Form 1099. In addition,

Consultant will provide his own insurance, as necessary, and will not be covered under any Licensee's insurance policy or benefits program.

3. Method of Performing Services. Consultant will determine the method, details, and means of performing the services required by this Agreement.

4. Time and Place of Performing Work. Consultant may perform the Services under this Agreement at any suitable time and location Consultant chooses. Such services will be performed outside the usual course of the Licensees' business although Consultant may, from time to time, as Consultant deems necessary, perform services under this Agreement at the Facilities. Consultant shall observe all safety rules, policies and procedures applicable to visitors and vendors at each facility when on site at the Facilities, including requirements for flu and other vaccinations, if requested.

5. Payment. Consultant shall be paid an hourly rate of $_____ per hour for all Services. Compensation to be paid to IM under this Agreement under no circumstances shall exceed $300,000 in accordance with the Order. Consultant shall be responsible for all taxes attributable to the compensation paid to him under this Agreement. Consultant shall be entitled to no other payment, remuneration, or benefits other than the compensation described in this Agreement. Because Consultant is an independent contractor, the Licensees will not deduct any amounts from Consultant's payments for income tax or other employment-related withholdings.

6. Billing. Consultant shall provide each Licensee with an invoice on a monthly basis providing a general description of the Services performed and number of hours billed for the Services provided to each Licensee. The invoice shall also list any expenses reasonably incurred by Consultant as part of his consulting services, for which he seeks reimbursement, except that Consultant must obtain prior consent before incurring any expense in excess of $250. Each Licensee's payment of Consultant's invoice is due within thirty (30) days of receipt.

7. Term; Termination. This Agreement will begin on the Effective Date and shall continue for a period of two years in accordance with the Order. This Agreement may not be terminated by either party or by mutual consent unless such termination is approved by OHCA and FLIS. The term may be extended at the direction of FLIS for up to (1) additional year, for an overall total of three (3) years, provided that the compensation cap set forth in paragraph 5 shall include any such extended term.

8. Representations. Consultant warrants that all information provided by Consultant to Licensees is true to the best of Consultant's actual knowledge. Consultant further warrants that he is not restricted by, and has no conflict of interest derived from any other agreement and has no other interest or obligation that would interfere with his performing work as described in this Agreement, and that he shall inform Licensees immediately should such a limitation or conflict arise. Consultant further warrants that the services of Consultant will be provided utilizing reasonable care and skill in accordance with customary industry standards. Consultant represents he/she has expertise in hospital administration and operations, knowledge of the healthcare environment with a special focus on quality assurance and performance improvement, and considerable knowledge of accepted standards of practice and state and federal laws

and regulations applicable to general/acute care hospitals. Consultant represents and warrants that he/she has not been convicted of a criminal offense related to healthcare, debarred, suspended, declared ineligible, or excluded from participating with Medicare, Medicaid or any other plan or program that provides health benefits, whether directly through insurance or otherwise, which is funded directly, in whole or in part, by the United States Government or any State health care program. This shall be an ongoing representation and warranty during the term of this Agreement. Consultant shall immediately notify Licensees of any change in the status of the representations set forth in this section.

9. Adherence to Health Laws. Consultant acknowledges that Licensees receive federal funds and that Contractor will receive payments under this Agreement that are, in whole or in part, from federal funds. Consultant shall follow and adhere to all applicable state and federal laws, rules, and regulations, including, but not limited to, all Medicare laws, regulations and CMS instructions, including, without limitations, (a) federal criminal law; (b) the False Claims Act (31 USC 3729 et seq.); and (c) the anti-kickback statute (42 USC 1320a-7b(b)); (d) the civil monetary penalties law (42 USC 1320a-7a); (e) the physician self-referral law (42 USC 1395nn).

10. Corporate Compliance. Contractor acknowledges that Licensees maintain Corporate Compliance Plans ("CCPs") that foster prevention, detection and resolution of instances of misconduct. Vendor shall cooperate with Licensees' corporate compliance audits, reviews and investigations that relate to the services provided by Contractor under this Agreement. Contractor agrees to immediately notify Licensees' Compliance Officers of any violation of any applicable law, regulation, third party payor requirements or breach of Licenses' CCPs of which Contractor becomes aware during the term hereof.

11. Insurance. Consultant shall, at his/her sole cost and expense, maintain at all times during the term of this Agreement, general liability ("GL") and errors and omissions ("E&O") insurance covering his/her provision of the Services in minimum amounts of One Million Dollars ($1,000,000) per occurrence, Three Million Dollars ($3,000,000) in the aggregate annually, as well as an umbrella/excess liability insurance policy written on an occurrence basis and in an amount of not less than Three Million Dollars ($3,000,000) in the annual aggregate, excess of the limits of his/her GL and E&O policies (collectively, the "Policies"). Said Policies shall be obtained from an insurer licensed or authorized to do business in Connecticut, with an A.M. Best's Insurance Rating of A- or better. Licensees and their officers, directors, agents, employees, and volunteers (the "Licensee Parties") shall be named as additional insureds to all such Policies, and said Policies shall provide that they are primary to and noncontributory with any and all other insurance maintained by or otherwise afforded to the Licensee Parties. Upon a Licensee's request, Consultant shall provide a current certificate of insurance to Licensee evidencing such coverage and shall require its insurance carrier to notify Licensee immediately of any actual or intended change, cancellation, modification or non-renewal of such coverage. The obligations set forth herein shall survive the expiration or termination of this Agreement.

12. No Assignment or Subcontracting. Consultant shall not assign or otherwise transfer his rights in this Agreement without the prior written consent of the Licensees and the approval of OHCA and FLIS. Consultant may not subcontract the consulting services to any other consultant without the prior written consent of the Licensees and the approval of OHCA and FLIS.

13. Non-exclusivity. Consultant may represent, perform services for, and contract with as many additional clients, persons, or companies as Consultant, in Consultant's sole discretion, sees fit. Consultant shall not, however, perform services for any other entity where such services would create a conflict of interest with the services performed under this Agreement for Licensees.

14. Non-Solicitation. Consultant agrees that during the term of this Agreement, and for a period of two (2) years after the termination of this Agreement, Consultant shall not solicit, either directly or indirectly, any employee, customer, contractor, vendor, business contact, or consultant to leave Licensees.

15. Trade Secrets, Confidential Information.

(A) For purposes of this Agreement, the term "Confidential Information" means any information relating to Licensees (including any of their subsidiaries, shareholders or other affiliates) disclosed to Consultant, whether orally, in writing, or in any other medium, whether prior to or after the Effective Date of this Agreement, by or on behalf of Licensees, including, without limitation, information regarding Licensees assets, real estate holdings, historical and projected financial information; budgets; services; processes; operations; marketing plans and materials; analyses; strategies; forecasts; names, addresses and any other information regarding Licensees' existing or potential patients, employees, vendors or suppliers; or any information derived, summarized or extracted from any of the foregoing.

(B) Confidential Information shall not include any information which (i) is or becomes available to the public other than as a consequence of a breach of this Agreement; (ii) was available to Consultant on a non-confidential basis prior to its disclosure to Consultant by Licensees; (iii) becomes available to Consultant from a source other than Licensees, provided such source is not actually known by Consultant to be bound by a confidentiality obligation to Licensees; or (iv) is required to be disclosed by Consultant or any of its Representatives (as defined below) under the Order or applicable law or regulation.

(C) Consultant hereby agrees to hold in strict confidence all Confidential Information and agrees not to disclose or otherwise provide or transfer, directly or indirectly, any Confidential Information or anything related to the Confidential Information to third parties, including, but not limited to, Consultant's affiliates, without the prior written consent of Licensees. Consultant further agrees that he may use the Confidential Information only in connection with the work he will perform for Licensees and to comply with the Order and not for any other purpose or for the benefit of any third party.

(D) Consultant shall not disclose to any third party, except where permitted or required by the Order or by law or where such disclosure is expressly approved by Licensees in writing, any patient or medical record information regarding any of the Licensee's patients, and Consultant shall comply with all federal and state laws and regulations, and all bylaws, rules, regulations, and policies of Licensees, its accrediting agency and the medical staff, regarding the confidentiality of such information. Consultant acknowledges that in receiving or otherwise dealing with any records or information from Licensees about (i) Licensees' patients receiving treatment for alcohol or drug abuse, Consultant is fully bound by the provisions of the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 C.F.R. Part 2, as amended from time to time), and/or (ii) Licensees' peer review activities, Consultant is fully bound to maintain the confidentially of such information in accordance with C.G.A.§ 19a-17b(d) . In addition, Consultant shall comply in all respect with HIPAA and the HITECH Act 42 U.S.C. §§300jj et seq.; §§17901 et seq., and shall execute and deliver to Licensees the Business Associate Agreement attached as Exhibit B.

(E) Consultant understands that in the event he fails to comply with paragraph 13 or this paragraph 14, Licensees may suffer irreparable harm, which may not be adequately compensated for by monetary damages alone. Consultant, therefore, agrees that in the event of his breach or threatened breach of paragraph 13 or this paragraph 14, Licensees will be entitled to injunctive and/or other preliminary or equitable relief from a court of law. Consultant understands that this is the sole exception to the binding arbitration of disputes between the parties in accordance with paragraph 20 below.

16. Return of Property and Confidential Information. Consultant agrees that, upon termination of this Agreement, he will promptly return to Licensees all items, documents and materials that are in Consultant's possession or control that were provided to Consultant by Licensees. Consultant further agrees that he will promptly return to Licensees or destroy all written Confidential Information received by Consultant from or on behalf of Licensees, including any and all copies or duplicates of such Confidential Information, and all summaries or extracts thereof in any medium prepared by or on behalf of Consultant. Any destruction of Confidential Information shall be confirmed in writing.

17. Notices. Any required notice under this Agreement shall be deemed made on the date it is personally delivered or, if made by U.S. Mail, Federal Express or similar parcel service, three (3) days after the date it is sent. Notices under this Agreement shall be sent to the following:

If to Consultant:
Colleen Smith, MSN, RN, NEA-BC
41 Laurel Crest Road
Madison, CT 06443

If to Licensees:

Prospect ECHN, Inc.
71 Haynes Street
Manchester, CT 06040
Attention: Chief Executive Officer

Prospect Waterbury, Inc.
64 Robbins Street
Waterbury, CT 06708
Attention: Chief Executive Officer

With a copy to:

Prospect Medical Holdings, Inc.
3415 South Sepulveda Blvd., 9th Floor
Los Angeles, CA 90034
Attention: General Counsel

18. Modifications. No Modification or amendment may be made to this Agreement unless it is in writing and signed by Consultant and an authorized officer of Licensees.

19. Entire Agreement. Consultant and Licensees acknowledge and agree that this Agreement which includes Exhibits A and B contains the entire understanding between the parties and that this Agreement replaces and supersedes any other agreement, including any written, oral or implied agreement, regarding the subject matter contained in this Agreement.

20. Arbitration. Any dispute between the parties arising out of this Agreement, including without limitation threshold or jurisdictional issues, such issues of arbitrability on the enforceability of this Agreement, shall be resolved by binding arbitration, pursuant to the commercial dispute rules of the Judicial Arbitration and Mediation Services ("JAMS"). The arbitration shall take place before a single arbitrator. The prevailing party to the arbitration shall be entitled to recover its attorney's fees and costs, including the JAMS arbitration fees. The arbitrator shall be entitled to award any relief or remedy under law, including monetary damages and injunctive relief. Despite this provision, if Consultant breaches paragraph 13 or paragraph 14 of this Agreement, Licensees may seek injunctive relief from a court of law to remedy such a breach.

21. Severability. If any part, clause, or condition of this Agreement is held to be partially or wholly invalid, unenforceable, or inoperative for any reason whatsoever, such will not affect any other provision or portion hereof, which will continue to be effective as though such invalid, inoperative, or unenforceable part, clause or condition had not been made.

22. Binding Upon Successors. This Agreement will be binding upon and inure to the benefit of the parties hereto and their respective heirs, legal representatives, successors and assigns.

23. Governing Law and Venue. All questions concerning this Agreement, its construction, and the rights and liabilities of the parties hereto will be interpreted and enforced in accordance with the laws of the State of Connecticut as applied to contracts which are executed and performed entirely within the state.

Consultant and Licensees represent that they have read and understand the terms of this Agreement, that they have had the opportunity to review this Agreement with the counsel of their choice, and that they are not relying on any advice from the other party regarding this Agreement.

IN WITNESS WHEREOF, the parties have executed this Agreement to be effective as of the Effective Date.

LICENSEES:

PROSPECT ECHN, INC.

By: _____

Name:

Title:

By: _____

Name:

Title:

PROSPECT WATERBURY, INC.

By: _____

Name:

Title:

By: _____

Name:

Title:

CONSULTANT:

_____

Name: Colleen Smith, MSN, RN, NEA-BC

EXHIBIT A

COPY OF ORDER

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING AND INVESTIGATIONS SECTION

In Re: Prospect Manchester Hospital, Inc.
d/b/a The Manchester Memorial Hospital
71 Haynes Street
Manchester, CT 06040

Intended Licensee: Prospect Manchester Hospital, Inc.
d/b/a Manchester Memorial Hospital
Referred to herein as the "Intended Licensee"

PRE-LICENSURE CONSENT ORDER

WHEREAS, Prospect Medical Holdings, Inc. ("Prospect") has obtained certain regulatory approvals to acquire, through one or more subsidiaries, various licensed facilities or operations currently affiliated with Eastern Connecticut Health Network, Inc., including: Manchester Memorial Hospital and Rockville General Hospital ("ECHN Facilities"); and,

WHEREAS, Prospect is seeking to also acquire, through one or more subsidiaries, certain licensed facilities or operations currently affiliated with the Greater Waterbury Health Network, Inc., including the Waterbury Hospital ("GWHN Facilities" and together with the ECHN Facilities referred to as the "Prospect CT Group"); and,

WHEREAS, the Intended Licensee, a subsidiary of Prospect is seeking an initial license to operate a general hospital as defined in Conn. Gen. Stat. § 19a-490(b); and,

WHEREAS, upon the execution of this Pre-Licensure Consent Order ("Order") and after meeting all statutory and regulatory requirements, the Intended Licensee shall be issued a license to operate a General Hospital currently known as Manchester Memorial Hospital ("Facility") by the Connecticut Department of Public Health ("Department").

NOW THEREFORE, the Facility Licensing and Investigations Section of the Department ("FLIS") acting herein and through Barbara Cass, Section Chief, and the Intended Licensee and Prospect hereby stipulate and agree as follows:

1. The Order issued by the Department of Public Health, Office of Health Care Access ("OHCA") dated June 10, 2016 ("OHCA Order") shall be incorporated and made part of this Order.
2. This Order shall remain in effect for three (3) years from the effective date of this Order. The effective date of the Order is October 1, 2016. The issuance of the License shall occur when the Department receives proof, to its satisfaction, that the closing regarding the ECHN Facilities will occur within forty-eight hours of the issuance of the license provided all legal requirements for licensure have been met.
3. During the term of this Order, should the Intended Licensee implement any new patient care services, it shall do so in accordance with Connecticut General Statutes sections 19a-638 through 19a-639b. In addition, for one year after the effective date of this Order, the Intended Licensee and any beneficial owner of the Intended Licensee shall notify the Department of its intent to acquire an ownership interest in another general hospital in Connecticut (other than Rockville General Hospital or Waterbury Hospital) or any other state.
4. Within sixty (60) days of the effective date of this Order, Prospect or a subsidiary shall, on behalf of the Intended Licensee, execute a contract with an Independent Monitor ("IM") pre-approved in writing by the FLIS and OHCA. The duties of the IM shall be performed by a single individual unless otherwise approved by the Department. Prospect or its subsidiary shall pay the cost of the IM and all other costs necessary to comply with this Order. The IM shall be contracted to monitor other facilities within the Prospect CT Group as required by the Department. The aggregate cost of the IM to monitor all such facilities under all FLIS and OCHA orders entered into in connection with the licensure of the Prospect CT Group shall not exceed $300,000. The IM shall function in accordance with the IM Guidelines except to the extent there is any conflict between this Order and the Guidelines, the Order shall govern. (Exhibit A, copy attached). The IM shall have expertise in hospital administration and operations,

knowledge of the healthcare environment with a special focus on quality assurance and performance improvement, and considerable knowledge of accepted standards of practice and state and federal laws and regulations applicable to general/acute care hospitals.

5. The IM shall provide services as outlined herein for two (2) years. If the Department determines during the last six months of the first two years of the IM's tenure or within three months after the two year period that the Facility is not in compliance with applicable accepted standards of practice and federal and state statutes and regulations, the services of the IM shall be extended at the direction of the Department for up to one (1) additional year, for an overall total of three (3) years. The Department shall base any decision regarding the extension of time for IM services upon onsite inspections conducted by the Department and based on all other information the Department deems relevant. The terms of the contract executed on behalf of the Intended Licensee with the IM shall include all pertinent provisions, including time frames contained in this Order.

6. In addition to any other remedies available to the Department, noncompliance with any of the provisions of this Order or the OHCA Order, including failure to pay costs associated with the IM's duties shall constitute a violation of this Order and may result in a fine not to exceed one thousand dollars per day.

7. The IM shall conduct an initial assessment of the Intended Licensee's regulatory compliance which identifies areas requiring remediation. The IM shall report any regulatory or statutory violations identified in the initial assessment to FLIS, OHCA and the Intended Licensee. Such assessment shall, at a minimum, include onsite reviews of hospital systems and direct observations of the Facility staffs' performance as further specified in paragraphs eight (8) and nine (9) of the Order.

8. The IM onsite review shall include, but not be limited to, the following professional and hospital services and systems listed below, and the IM shall make recommendations for improvements, when applicable:

   a. Nursing Services;

   b. Infection Control;

   c. Pharmacy;

d. Surgical Services;
e. Emergency Department;
f. Psychiatric Services;
g. Medical Staff;
h. Patient Rights;
i. Medical Services;
j. Medical Records,
k. Quality Assurance and Performance Improvement; and,
l. Facility's professional credentialing process and assessment process for evaluating competency and remediation/monitoring mechanisms.

9. The initial onsite review by the IM shall be scheduled within thirty (30) days of the execution of the contract with the IM and shall include all satellite locations listed on the Facility's license.

10. The IM shall confer with the Intended Licensee's Chief Executive Officer, Chief Medical Officer, Chief Nursing Officer, Vice President of Quality and Safety and other staff determined by the IM to be necessary to the assessment of care and services and the Intended Licensee's compliance with accepted standards of practice and applicable federal and state statutes and regulations.

11. The IM shall have thirty (30) days after the completion of the initial onsite review, to develop a report(s) regarding the Intended Licensee's compliance with applicable state and federal statutes and regulations and provide copies to the Intended Licensee's governing authority, and the Department, including representatives of the FLIS and the OHCA. No party shall be provided with the opportunity to review the report(s) prior to release, and all parties shall receive copies of the documents simultaneously. The report(s) shall identify methods utilized for the analysis, areas reviewed and process, findings and recommendations. IM recommendations shall include, as applicable, areas that need to be addressed, continuing onsite consulting initiatives, and any quality of care issues that require remediation.

12. The IM shall make recommendations to the Intended Licensee's governing authority, Chief Executive Officer, Chief Medical Officer, Vice President of Quality and Safety, the East Regional Vice President of Quality and Patient Safety, the Chief Quality

Officer and Chief Nursing Officer, consistent with accepted standards of practice, for improvement in the delivery of direct patient care in the Facility and compliance with regulatory requirements. If the IM and the Intended Licensee are unable to reach an agreement regarding the IM's recommendation(s), the Department, after meeting with the Intended Licensee and the IM, shall make a final determination, which shall be binding on the Intended Licensee.

13. Upon approval by the Department of the recommendations by the IM, the Intended Licensee shall provide the Department with a proposed timeframe for implementation of the IM recommendations, within twenty-one (21) days of receipt of the report(s). The timeframes shall be subject to approval by the Department and shall become operative upon the Department's approval. All recommendations shall be implemented in accordance with the Department's approved timeframe.

14. The IM shall assess the function, the duties, responsibilities and level of engagement of the Prospect Eastern Regional Quality and Patient Safety Steering Council ("Council") and the Facility's Quality Assurance and Performance Improvement Committee ("Committee") and shall determine their ability to monitor implementation of any recommendations provided. This assessment will be provided to the Intended Licensee's governing authority and to FLIS and OHCA.

15. The IM shall re-evaluate the Facility, within six (6) months following the completion of the initial Facility evaluation and semi-annually thereafter throughout the tenure of the IM's engagement. The re-evaluation shall determine the Licensee's ability to implement and maintain quality of care and services, implementation of recommendations previously made by the IM and compliance with regulatory requirements. Upon conclusion of said reviews, the IM shall provide Prospect, the Intended Licensee and the Department, including representatives of FLIS and OHCA, with a comprehensive report of said assessments.

16. The IM shall act and perform the duties assigned herein at all times to serve the interest of the Department in assuring the safety, welfare and well-being of patients and to secure compliance with applicable federal and state law and regulations and shall not accept any direction or suggestion from Prospect, the Intended Licensee or its employees that will deter or interfere in fulfilling this obligation.

17. Within one hundred eighty (180) days of the effective date of this Order, Prospect, shall:

    a. Collaborate with Facility leadership in identifying initiatives aimed at improving patient care quality and safety;
    b. Collaborate with Facility leadership to build quality, efficiency, effectiveness, and a shared accountability systems model of care;
    c. Collaborate with Facility leadership to ensure ongoing compliance with state and federal laws and regulations;
    d. Collaborate with Facility leadership to strengthen the data and information capabilities of the Facility to ensure quality and data driven quality measures; and,
    e. Collaborate with Facility leadership to ensure sustainment of quality assurance and performance activities, to include but not be limited to, activities that promote a high reliability organization.

18. The Corporate Chief Quality Officer, Regional Vice President of Quality, Chief Executive Officer, Chief Medical Officer, Chief Nursing Officer and Vice President of Quality and Safety and/or their designees shall meet with the Department quarterly for the first six (6) months after the effective date of this Order and thereafter once every six (6) months throughout the tenure of the IM. The meetings shall include discussions of issues related to the care and services provided by the Intended Licensee's compliance with accepted standards of practice and applicable federal and state statutes and regulations. After the first meeting, all subsequent meetings may be attended via teleconference except that no out-of-state participant is required to attend any of the meetings in person.

19. Any records maintained in accordance with any state or federal law or regulation or as required by this Order shall be made available to the IM and the Department, upon request. The IM may attend quality assurance and/or peer review committee meetings and utilize information from such meetings and records for making recommendations or reports. Except where mandated by law or to report illegal conduct to the Department, the IM shall not identify the individual providers subject to peer review. Except for such disclosures to the IM, any rights of the Intended Licensee or any

affiliate to claim and exert privilege to quality assurance or peer review documents under state and/or federal law are preserved and not limited or waived by this Order.

20. A Quality Assurance Performance Improvement Program shall be maintained by the Intended Licensee and monitored by the Committee, consist of, at least, the Intended Licensee' s Chief Medical Officer, Chief Nursing Officer and Vice President of Quality and Safety. The Committee shall focus its activities utilizing a structure, process and outcome model. The Committee shall meet at least once every sixty (60) days and as needed to review all reports or complaints relating to patient care and compliance with accepted standards of practice and federal state laws and regulations. During the tenure of the IM, the IM shall have the right to attend and participate in all Committee meetings and to evaluate and report on the design of the quality assurance programs implemented by the Committee. The activities of the Committee shall include, but not be limited to, compliance with this Order and the IM recommendations, determination and adoption of new policies to be implemented by the Intended Licensee's staff to improve patient care practices; provided that all policies shall be subject to review and approval by the Facility's governing authority, the Local Board and as appropriate, Prospect, consistent with the terms of that certain Quality Assurance Commitment Side Letter dated March 28, 2016 by and between Prospect and Eastern Connecticut Health Network, Inc., as amended to the date hereof ("Quality Letter"). In addition, this Committee shall review and revise, as applicable infection control policies and procedures and monitor their implementation. The Committee shall measure and track the implementation of any changes in the Intended Licensee's policies, procedures. and allocation of resources recommended by the Committee to determine compliance with and effectiveness of such changes. A record of Committee meetings and subject matter discussed will be documented and available for review by the Department. Minutes of all such meetings shall be maintained at the Facility for a minimum period of three (3) years.

21. During the term of this Order the Intended Licensee shall notify the Department within five (5) business days, if any of the following positions become vacant (if such positions exist, in name or in responsibilities, at the Facility):

    a. Corporate Chief Quality Officer;

b. Regional Vice President of Quality;
c. Director of Survey Readiness Team;
d. Chief Executive Officer;
e. Chief Medical Officer
f. Chief Nursing Officer;
g. Vice President of Quality and Patient Safety; and,
h. Vice President of Patient Care Services.

22. Within five (5) business days of the effective date of this Order, the Intended Licensee, shall provide the names and resumes of the proposed Chief Medical Officer, Chief Nursing Officer and Vice President of Quality and Safety.

23. The Intended Licensee within five (5) business days of the execution of this Order, shall designate an individual to be responsible for all notices and correspondence pursuant to this Order. The name, mailing address, email address and phone number of the designated individual shall be provided to the Department within said timeframe. The Intended Licensee may provide for a substitute or alternate individual with two (2) business days written notice to the Department.

24. Any reports required by this document shall be directed to:

Susan Newton, R.N., B.S.
Supervising Nurse Consultant
Facility Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, P.O. Box 340308, MS #12 HSR
Hartford, CT 06134-0308

25. All parties agree that this Order is an Order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. The Intended Licensee agrees that the compliance with all of the terms and conditions of this Order is part of the responsibility of the Intended Licensee's governing authority as set forth in Public Health Code section 19-13-D68(b)(4). The Intended Licensee further agrees that failure to comply with any of the terms and conditions of this Order shall constitute grounds for disciplinary action pursuant to Section 19a-494 of the Connecticut General Statutes Nothing herein shall be construed as limiting the Department's other available legal remedies against the Intended Licensee for violations of this Order or of any other

statutory or regulatory requirements, which may be sought in lieu of or in addition to the methods of relief listed above, or any other administrative and judicial relief provided by law.

26. The execution of this Order has no bearing on any criminal liability without the written consent of the Director of the MFCU or the Bureau Chief of the Department of Criminal Justice's Statewide Prosecution Bureau.

27. The Intended Licensee agrees that this Pre-Licensure Consent Order and the terms set forth herein are not subject to reconsideration, collateral attack or judicial review under any form or in any forum including any right to review under the Uniform Administrative Procedure Act, Chapter 368a of the Statutes, Regulations that exists at the time the Order is executed or may become available in the future, provided that this stipulation shall not deprive the Intended Licensee and its affiliate entities of any other rights that it may have under the laws of the State of Connecticut or of the United States.

28. Each of the hospitals acquired by Intended Licensee shall provide to the Department a plan of correction within forty-five (45) days of receiving a physical plant inspection report from the Department.

29. The Intended Licensee has consulted with its attorney prior to the execution of this Order.

WITNESS WHEREOF, the parties hereto have caused this Pre-Licensure Consent Order to be executed by their respective officers and officials. The undersigned signatories represent and warrant that they are authorized to execute this Pre-Licensure Consent Order on behalf of the party they represent.

By: _____
Ellen J. Shin, Secretary
Prospect Manchester Hospital, Inc.
The Intended Licensee

On this 28th day of September, 2016, before me, personally appeared Ellen J. Shin who acknowledged herself to be the Secretary of the Intended Licensee and that she as Secretary, being authorized so to do, executed the foregoing instrument for the purposes therein contained, by signing her name as Secretary.

My Commission Expires: July 3, 2020
(If Notary Public)

_____
Notary Public [ ]
Commissioner of the Superior Court [ ]

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

By: _____
Barbara Cass, R.N.
Section Chief
Facility Licensing and Investigations Section

September 30, 2016

Exhibit A

FLIS' Independent Monitor Guidelines
For Intended Licensee Prospect Manchester Hospital

Relationship between Independent Monitor (IM) and DPH includes:

- An IM is utilized as a component of DPH's regulatory remedy process. An IM may be agreed upon as a part of a Consent Order between the institution and the Department when significant care and services issues are identified, or when, in connection with a change of ownership, an acquirer is new to the State and has experienced previous compliance issues in another state.
- The IM has a fiduciary or special relationship of trust, confidence and responsibility with the Department.
- The IM's responsibilities include:
  - Reporting to the Department regarding the Facility's compliance with federal and state law and regulation.
  - Monitoring the institution's plan of correction to rectify deficiencies and violations of federal/state laws and regulations. Reports to Department positive and negative issues related to said oversight.
  - Reporting in accordance with the Consent Agreement/Order to the Department of issues identified, plans to address noncompliance and remediation efforts of the institution.

Relationship between IM and the Institution:

- The IM maintains a professional and objective relationship with the institutional staff. The IM is a consultant, not an employee of the institution. The IM exercises independent judgment and initiative to determine how to fully address and complete her/his responsibilities. The institution does not direct or supervise the IM but must cooperate with and respond to requests of the IM related to fulfilling her/his duties.
- The IM's responsibilities, consistent with the terms of the Consent Order, include:
  - Assessment of institution's compliance with recognized standards of practice federal/state laws and regulations.
  - Monitoring of care/services being provided.
  - Assists staff with plans of action to enhance care and services within the institution.
  - Reports in accordance with the Consent Order to the institution re: assessments, issues identified, and monitoring of plans of correction.

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING AND INVESTIGATIONS SECTION

In Re: Prospect Rockville Hospital, Inc.
d/b/a Rockville General Hospital
31 Union Street
Vernon, CT 06066

Intended Licensee: Prospect Rockville Hospital, Inc.
d/b/a Rockville General Hospital
Referred to herein as the "Intended Licensee"

PRE-LICENSURE CONSENT ORDER

WHEREAS, Prospect Medical Holdings, Inc. ("Prospect") has obtained certain regulatory approvals to acquire, through one or more subsidiaries, various licensed facilities or operations currently affiliated with Eastern Connecticut Health Network, Inc., including: Manchester Memorial Hospital and Rockville General Hospital ("ECHN Facilities"); and,

WHEREAS, Prospect is seeking to also acquire, through one or more subsidiaries, certain licensed facilities or operations currently affiliated with the Greater Waterbury Health Network, Inc., including the Waterbury Hospital ("GWHN Facilities" and together with the ECHN Facilities referred to as the "Prospect CT Group"); and,

WHEREAS, the Intended Licensee, a subsidiary of Prospect is seeking an initial license to operate a general hospital as defined in Conn. Gen. Stat. § 19a-490(b); and,

WHEREAS, upon the execution of this Pre-Licensure Consent Order ("Order") and after meeting all statutory and regulatory requirements, the Intended Licensee shall be issued a license to operate a General Hospital currently known as Rockville General Hospital ("Facility") by the Connecticut Department of Public Health ("Department").

NOW THEREFORE, the Facility Licensing and Investigations Section of the Department ("FLIS") acting herein and through Barbara Cass, Section Chief, and the Intended Licensee and Prospect hereby stipulate and agree as follows:

1. The Order issued by the Department of Public Health, Office of Health Care Access ("OHCA") dated June 10, 2016 ("OHCA Order") shall be incorporated and made part of this Order.
2. This Order shall remain in effect for three (3) years from the effective date of this Order. The effective date of the Order is October 1, 2016. The issuance of the License shall occur when the Department receives proof, to its satisfaction, that the closing regarding the ECHN Facilities will occur within forty-eight hours of the issuance of the license provided all legal requirements for licensure have been met.
3. During the term of this Order, should the Intended Licensee implement any new patient care services, it shall do so in accordance with Connecticut General Statutes sections 19a-638 through 19a-639b. In addition, for one year after the effective date of this Order, the Intended Licensee and any beneficial owner of the Intended Licensee shall notify the Department of its intent to acquire an ownership interest in another general hospital in Connecticut (other than Rockville General Hospital or Waterbury Hospital) or any other state.
4. Within sixty (60) days of the effective date of this Order, Prospect or a subsidiary shall, on behalf of the Intended Licensee, execute a contract with an Independent Monitor ("IM") pre-approved in writing by the FLIS and OHCA. The duties of the IM shall be performed by a single individual unless otherwise approved by the Department. Prospect or its subsidiary shall pay the cost of the IM and all other costs necessary to comply with this Order. The IM shall be contracted to monitor other facilities within the Prospect CT Group as required by the Department. The aggregate cost of the IM to monitor all such facilities under all FLIS and OCHA orders entered into in connection with the licensure of the Prospect CT Group shall not exceed $300,000. The IM shall function in accordance with the IM Guidelines except to the extent there is any conflict between this Order and the Guidelines, the Order shall govern. (Exhibit A, copy attached). The IM shall have expertise in hospital administration and operations,

knowledge of the healthcare environment with a special focus on quality assurance and performance improvement, and considerable knowledge of accepted standards of practice and state and federal laws and regulations applicable to general/acute care hospitals.

5. The IM shall provide services as outlined herein for two (2) years. If the Department determines during the last six months of the first two years of the IM's tenure or within three months after the two year period that the Facility is not in compliance with applicable accepted standards of practice and federal and state statutes and regulations, the services of the IM shall be extended at the direction of the Department for up to one (1) additional year, for an overall total of three (3) years. The Department shall base any decision regarding the extension of time for IM services upon onsite inspections conducted by the Department and based on all other information the Department deems relevant. The terms of the contract executed on behalf of the Intended Licensee with the IM shall include all pertinent provisions, including time frames contained in this Order.

6. In addition to any other remedies available to the Department, noncompliance with any of the provisions of this Order or the OHCA Order, including failure to pay costs associated with the IM's duties shall constitute a violation of this Order and may result in a fine not to exceed one thousand dollars per day.

7. The IM shall conduct an initial assessment of the Intended Licensee's regulatory compliance which identifies areas requiring remediation. The IM shall report any regulatory or statutory violations identified in the initial assessment to FLIS, OHCA and the Intended Licensee. Such assessment shall, at a minimum, include onsite reviews of hospital systems and direct observations of the Facility staffs' performance as further specified in paragraphs eight (8) and nine (9) of the Order.

8. The IM onsite review shall include, but not be limited to, the following professional and hospital services and systems listed below, and the IM shall make recommendations for improvements, when applicable:

   a. Nursing Services;

   b. Infection Control;

   c. Pharmacy;

d. Surgical Services;
e. Emergency Department;
f. Psychiatric Services;
g. Medical Staff;
h. Patient Rights;
i. Medical Services;
j. Medical Records,
k. Quality Assurance and Performance Improvement; and,
l. Facility's professional credentialing process and assessment process for evaluating competency and remediation/monitoring mechanisms.

9. The initial onsite review by the IM shall be scheduled within thirty (30) days of the execution of the contract with the IM and shall include all satellite locations listed on the Facility's license.

10. The IM shall confer with the Intended Licensee's Chief Executive Officer, Chief Medical Officer, Chief Nursing Officer, Vice President of Quality and Safety and other staff determined by the IM to be necessary to the assessment of care and services and the Intended Licensee's compliance with accepted standards of practice and applicable federal and state statutes and regulations.

11. The IM shall have thirty (30) days after the completion of the initial onsite review, to develop a report(s) regarding the Intended Licensee's compliance with applicable state and federal statutes and regulations and provide copies to the Intended Licensee's governing authority, and the Department, including representatives of the FLIS and the OHCA. No party shall be provided with the opportunity to review the report(s) prior to release, and all parties shall receive copies of the documents simultaneously. The report(s) shall identify methods utilized for the analysis, areas reviewed and process, findings and recommendations. IM recommendations shall include, as applicable, areas that need to be addressed, continuing onsite consulting initiatives, and any quality of care issues that require remediation.

12. The IM shall make recommendations to the Intended Licensee's governing authority, Chief Executive Officer, Chief Medical Officer, Vice President of Quality and Safety, the East Regional Vice President of Quality and Patient Safety, the Chief Quality

Officer and Chief Nursing Officer, consistent with accepted standards of practice, for improvement in the delivery of direct patient care in the Facility and compliance with regulatory requirements. If the IM and the Intended Licensee are unable to reach an agreement regarding the IM's recommendation(s), the Department, after meeting with the Intended Licensee and the IM, shall make a final determination, which shall be binding on the Intended Licensee.

13. Upon approval by the Department of the recommendations by the IM, the Intended Licensee shall provide the Department with a proposed timeframe for implementation of the IM recommendations, within twenty-one (21) days of receipt of the report(s). The timeframes shall be subject to approval by the Department and shall become operative upon the Department's approval. All recommendations shall be implemented in accordance with the Department's approved timeframe.

14. The IM shall assess the function, the duties, responsibilities and level of engagement of the Prospect Eastern Regional Quality and Patient Safety Steering Council ("Council") and the Facility's Quality Assurance and Performance Improvement Committee ("Committee") and shall determine their ability to monitor implementation of any recommendations provided. This assessment will be provided to the Intended Licensee's governing authority and to FLIS and OHCA.

15. The IM shall re-evaluate the Facility, within six (6) months following the completion of the initial Facility evaluation and semi-annually thereafter throughout the tenure of the IM's engagement. The re-evaluation shall determine the Licensee's ability to implement and maintain quality of care and services, implementation of recommendations previously made by the IM and compliance with regulatory requirements. Upon conclusion of said reviews, the IM shall provide Prospect, the Intended Licensee and the Department, including representatives of FLIS and OHCA, with a comprehensive report of said assessments.

16. The IM shall act and perform the duties assigned herein at all times to serve the interest of the Department in assuring the safety, welfare and well-being of patients and to secure compliance with applicable federal and state law and regulations and shall not accept any direction or suggestion from Prospect, the Intended Licensee or its employees that will deter or interfere in fulfilling this obligation.

17. Within one hundred eighty (180) days of the effective date of this Order, Prospect, shall::

    a. Collaborate with Facility leadership in identifying initiatives aimed at improving patient care quality and safety;
    b. Collaborate with Facility leadership to build quality, efficiency, effectiveness, and a shared accountability systems model of care;
    c. Collaborate with Facility leadership to ensure ongoing compliance with state and federal laws and regulations;
    d. Collaborate with Facility leadership to strengthen the data and information capabilities of the Facility to ensure quality and data driven quality measures; and,
    e. Collaborate with Facility leadership to ensure sustainment of quality assurance and performance activities, to include but not be limited to, activities that promote a high reliability organization.

18. The Corporate Chief Quality Officer, Regional Vice President of Quality, Chief Executive Officer, Chief Medical Officer, Chief Nursing Officer and Vice President of Quality and Safety and/or their designees shall meet with the Department quarterly for the first six (6) months after the effective date of this Order and thereafter once every six (6) months throughout the tenure of the IM. The meetings shall include discussions of issues related to the care and services provided by the Intended Licensee's compliance with accepted standards of practice and applicable federal and state statutes and regulations. After the first meeting, all subsequent meetings may be attended via teleconference except that no out-of-state participant is required to attend any of the meetings in person.

19. Any records maintained in accordance with any state or federal law or regulation or as required by this Order shall be made available to the IM and the Department, upon request. The IM may attend quality assurance and/or peer review committee meetings and utilize information from such meetings and records for making recommendations or reports. Except where mandated by law or to report illegal conduct to the Department, the IM shall not identify the individual providers subject to peer review. Except for such disclosures to the IM, any rights of the Intended Licensee or any

affiliate to claim and exert privilege to quality assurance or peer review documents under state and/or federal law are preserved and not limited or waived by this Order.

20. A Quality Assurance Performance Improvement Program shall be maintained by the Intended Licensee and monitored by the Committee, consist of, at least, the Intended Licensee' s Chief Medical Officer, Chief Nursing Officer and Vice President of Quality and Safety. The Committee shall focus its activities utilizing a structure, process and outcome model. The Committee shall meet at least once every sixty (60) days and as needed to review all reports or complaints relating to patient care and compliance with accepted standards of practice and federal state laws and regulations. During the tenure of the IM, the IM shall have the right to attend and participate in all Committee meetings and to evaluate and report on the design of the quality assurance programs implemented by the Committee. The activities of the Committee shall include, but not be limited to, compliance with this Order and the IM recommendations, determination and adoption of new policies to be implemented by the Intended Licensee's staff to improve patient care practices; provided that all policies shall be subject to review and approval by the Facility's governing authority, the Local Board and as appropriate, Prospect, consistent with the terms of that certain Quality Assurance Commitment Side Letter dated March 28, 2016 by and between Prospect and Eastern Connecticut Health Network, Inc., as amended to the date hereof ("Quality Letter"). In addition, this Committee shall review and revise, as applicable infection control policies and procedures and monitor their implementation. The Committee shall measure and track the implementation of any changes in the Intended Licensee's policies, procedures, and allocation of resources recommended by the Committee to determine compliance with and effectiveness of such changes. A record of Committee meetings and subject matter discussed will be documented and available for review by the Department. Minutes of all such meetings shall be maintained at the Facility for a minimum period of three (3) years.

21. During the term of this Order the Intended Licensee shall notify the Department within five (5) business days, if any of the following positions become vacant (if such positions exist, in name or in responsibilities, at the Facility):

    a. Corporate Chief Quality Officer;

b. Regional Vice President of Quality;
c. Director of Survey Readiness Team;
d. Chief Executive Officer;
e. Chief Medical Officer
f. Chief Nursing Officer;
g. Vice President of Quality and Patient Safety; and,
h. Vice President of Patient Care Services.

22. Within five (5) business days of the effective date of this Order, the Intended Licensee, shall provide the names and resumes of the proposed Chief Medical Officer, Chief Nursing Officer and Vice President of Quality and Safety.

23. The Intended Licensee within five (5) business days of the execution of this Order, shall designate an individual to be responsible for all notices and correspondence pursuant to this Order. The name, mailing address, email address and phone number of the designated individual shall be provided to the Department within said timeframe. The Intended Licensee may provide for a substitute or alternate individual with two (2) business days written notice to the Department.

24. Any reports required by this document shall be directed to:

Susan Newton, R.N., B.S.
Supervising Nurse Consultant
Facility Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, P.O. Box 340308, MS #12 HSR
Hartford, CT 06134-0308

25. All parties agree that this Order is an Order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. The Intended Licensee agrees that the compliance with all of the terms and conditions of this Order is part of the responsibility of the Intended Licensee's governing authority as set forth in Public Health Code section 19-13-D68(b)(4). The Intended Licensee further agrees that failure to comply with any of the terms and conditions of this Order shall constitute grounds for disciplinary action pursuant to Section 19a-494 of the Connecticut General Statutes Nothing herein shall be construed as limiting the Department's other available legal remedies against the Intended Licensee for violations of this Order or of any other

statutory or regulatory requirements, which may be sought in lieu of or in addition to the methods of relief listed above, or any other administrative and judicial relief provided by law.

26. The execution of this Order has no bearing on any criminal liability without the written consent of the Director of the MFCU or the Bureau Chief of the Department of Criminal Justice's Statewide Prosecution Bureau.

27. The Intended Licensee agrees that this Pre-Licensure Consent Order and the terms set forth herein are not subject to reconsideration, collateral attack or judicial review under any form or in any forum including any right to review under the Uniform Administrative Procedure Act, Chapter 368a of the Statutes, Regulations that exists at the time the Order is executed or may become available in the future, provided that this stipulation shall not deprive the Intended Licensee and its affiliate entities of any other rights that it may have under the laws of the State of Connecticut or of the United States.

28. Each of the hospitals acquired by Intended Licensee shall provide to the Department a plan of correction within forty-five (45) days of receiving a physical plant inspection report from the Department.

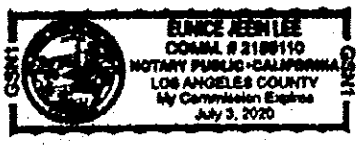
29. The Intended Licensee has consulted with its attorney prior to the execution of this Order.

WITNESS WHEREOF, the parties hereto have caused this Pre-Licensure Consent Order to be executed by their respective officers and officials. The undersigned signatories represent and warrant that they are authorized to execute this Pre-Licensure Consent Order on behalf of the party they represent.

By: _____
Ellen J. Shin, Secretary
Prospect Rockville Hospital, Inc.
The Intended Licensee

On this 28th day of September, 2016, before me, personally appeared Ellen J. Shin who acknowledged herself to be the Secretary of the Intended Licensee and that she as Secretary, being authorized so to do, executed the foregoing instrument for the purposes therein contained, by signing her name as Secretary.

My Commission Expires: July 3, 2020
(If Notary Public)



_____
Notary Public [ ]
Commissioner of the Superior Court [ ]

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

By: _____
Barbara Cass, R.N.
Section Chief
Facility Licensing and Investigations Section

September 30, 2016

Exhibit A

FLIS' Independent Monitor Guidelines
For Intended Licensee Prospect Manchester Hospital

Relationship between Independent Monitor (IM) and DPH includes:

- An IM is utilized as a component of DPH's regulatory remedy process. An IM may be agreed upon as a part of a Consent Order between the institution and the Department when significant care and services issues are identified, or when, in connection with a change of ownership, an acquirer is new to the State and has experienced previous compliance issues in another state.
- The IM has a fiduciary or special relationship of trust, confidence and responsibility with the Department.
- The IM's responsibilities include:
  - Reporting to the Department regarding the Facility's compliance with federal and state law and regulation.
  - Monitoring the institution's plan of correction to rectify deficiencies and violations of federal/state laws and regulations. Reports to Department positive and negative issues related to said oversight.
  - Reporting in accordance with the Consent Agreement/Order to the Department of issues identified, plans to address noncompliance and remediation efforts of the institution.

Relationship between IM and the Institution:

- The IM maintains a professional and objective relationship with the institutional staff. The IM is a consultant, not an employee of the institution. The IM exercises independent judgment and initiative to determine how to fully address and complete her/his responsibilities. The institution does not direct or supervise the IM but must cooperate with and respond to requests of the IM related to fulfilling her/his duties.
- The IM's responsibilities, consistent with the terms of the Consent Order, include:
  - Assessment of institution's compliance with recognized standards of practice federal/state laws and regulations.
  - Monitoring of care/services being provided.
  - Assists staff with plans of action to enhance care and services within the institution.
  - Reports in accordance with the Consent Order to the institution re: assessments, issues identified, and monitoring of plans of correction.

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING AND INVESTIGATIONS SECTION

In Re: Prospect Waterbury, Inc.
d/b/a The Waterbury Hospital
64 Robbins Street
Waterbury, CT 06708

Intended Licensee: Prospect Waterbury, Inc.
d/b/a The Waterbury Hospital
Referred to herein as the "Intended Licensee"

PRE-LICENSURE CONSENT ORDER

WHEREAS, Prospect Medical Holdings, Inc. ("Prospect") has obtained certain regulatory approvals to acquire, through one or more subsidiaries, various licensed facilities or operations currently affiliated with Eastern Connecticut Health Network, Inc., including: Manchester Memorial Hospital and Rockville General Hospital ("ECHN Facilities"); and,

WHEREAS, Prospect is seeking to also acquire, through one or more subsidiaries, certain licensed facilities or operations currently affiliated with the Greater Waterbury Health Network, Inc., including the Waterbury Hospital ("GWHN Facilities" and together with the ECHN Facilities referred to as the "Prospect CT Group"); and,

WHEREAS, the Intended Licensee, a subsidiary of Prospect is seeking an initial license to operate a general hospital as defined in Conn. Gen. Stat. § 19a-490(b); and,

WHEREAS, upon the execution of this Pre-Licensure Consent Order ("Order") and after meeting all statutory and regulatory requirements, the Intended Licensee shall be issued a license to operate a General Hospital currently known as The Waterbury Hospital ("Facility") by the Connecticut Department of Public Health ("Department").

NOW THEREFORE, the Facility Licensing and Investigations Section of the Department ("FLIS") acting herein and through Barbara Cass, Section Chief, and the Intended Licensee and Prospect hereby stipulate and agree as follows:

1. The Order issued by the Department of Public Health, Office of Health Care Access ("OHCA") dated June 10, 2016 ("OHCA Order") shall be incorporated and made part of this Order.
2. This Order shall remain in effect for three (3) years from the effective date of this Order. The effective date of the Order is October 1, 2016. The issuance of the License shall occur when the Department receives proof, to its satisfaction, that the closing regarding the ECHN Facilities will occur within forty-eight hours of the issuance of the license provided all legal requirements for licensure have been met.
3. During the term of this Order, should the Intended Licensee implement any new patient care services, it shall do so in accordance with Connecticut General Statutes sections 19a-638 through 19a-639b. In addition, for one year after the effective date of this Order, the Intended Licensee and any beneficial owner of the Intended Licensee shall notify the Department of its intent to acquire an ownership interest in another general hospital in Connecticut (other than Rockville General Hospital or Waterbury Hospital) or any other state.
4. Within sixty (60) days of the effective date of this Order, Prospect or a subsidiary shall, on behalf of the Intended Licensee, execute a contract with an Independent Monitor ("IM") pre-approved in writing by the FLIS and OHCA. The duties of the IM shall be performed by a single individual unless otherwise approved by the Department. Prospect or its subsidiary shall pay the cost of the IM and all other costs necessary to comply with this Order. The IM shall be contracted to monitor other facilities within the Prospect CT Group as required by the Department. The aggregate cost of the IM to monitor all such facilities under all FLIS and OCHA orders entered into in connection with the licensure of the Prospect CT Group shall not exceed $300,000. The IM shall function in accordance with the IM Guidelines except to the extent there is any conflict between this Order and the Guidelines, the Order shall govern. (Exhibit A, copy attached). The IM shall have expertise in hospital administration and operations,

knowledge of the healthcare environment with a special focus on quality assurance and performance improvement, and considerable knowledge of accepted standards of practice and state and federal laws and regulations applicable to general/acute care hospitals.

5. The IM shall provide services as outlined herein for two (2) years. If the Department determines during the last six months of the first two years of the IM's tenure or within three months after the two year period that the Facility is not in compliance with applicable accepted standards of practice and federal and state statutes and regulations, the services of the IM shall be extended at the direction of the Department for up to one (1) additional year, for an overall total of three (3) years. The Department shall base any decision regarding the extension of time for IM services upon onsite inspections conducted by the Department and based on all other information the Department deems relevant. The terms of the contract executed on behalf of the Intended Licensee with the IM shall include all pertinent provisions, including time frames contained in this Order.

6. In addition to any other remedies available to the Department, noncompliance with any of the provisions of this Order or the OHCA Order, including failure to pay costs associated with the IM's duties shall constitute a violation of this Order and may result in a fine not to exceed one thousand dollars per day.

7. The IM shall conduct an initial assessment of the Intended Licensee's regulatory compliance which identifies areas requiring remediation. The IM shall report any regulatory or statutory violations identified in the initial assessment to FLIS, OHCA and the Intended Licensee. Such assessment shall, at a minimum, include onsite reviews of hospital systems and direct observations of the Facility staffs' performance as further specified in paragraphs eight (8) and nine (9) of the Order.

8. The IM onsite review shall include, but not be limited to, the following professional and hospital services and systems listed below, and the IM shall make recommendations for improvements, when applicable:

   a. Nursing Services;

   b. Infection Control;

   c. Pharmacy;

d. Surgical Services;
e. Emergency Department;
f. Psychiatric Services;
g. Medical Staff;
h. Patient Rights;
i. Medical Services;
j. Medical Records,
k. Quality Assurance and Performance Improvement; and,
l. Facility's professional credentialing process and assessment process for evaluating competency and remediation/monitoring mechanisms.

9. The initial onsite review by the IM shall be scheduled within thirty (30) days of the execution of the contract with the IM and shall include all satellite locations listed on the Facility's license.

10. The IM shall confer with the Intended Licensee's Chief Executive Officer, Chief Medical Officer, Chief Nursing Officer, Vice President of Quality and Safety and other staff determined by the IM to be necessary to the assessment of care and services and the Intended Licensee's compliance with accepted standards of practice and applicable federal and state statutes and regulations.

11. The IM shall have thirty (30) days after the completion of the initial onsite review, to develop a report(s) regarding the Intended Licensee's compliance with applicable state and federal statutes and regulations and provide copies to the Intended Licensee's governing authority, and the Department, including representatives of the FLIS and the OHCA. No party shall be provided with the opportunity to review the report(s) prior to release, and all parties shall receive copies of the documents simultaneously. The report(s) shall identify methods utilized for the analysis, areas reviewed and process, findings and recommendations. IM recommendations shall include, as applicable, areas that need to be addressed, continuing onsite consulting initiatives, and any quality of care issues that require remediation.

12. The IM shall make recommendations to the Intended Licensee's governing authority, Chief Executive Officer, Chief Medical Officer, Vice President of Quality and Safety, the East Regional Vice President of Quality and Patient Safety, the Chief Quality

Officer and Chief Nursing Officer, consistent with accepted standards of practice, for improvement in the delivery of direct patient care in the Facility and compliance with regulatory requirements. If the IM and the Intended Licensee are unable to reach an agreement regarding the IM's recommendation(s), the Department, after meeting with the Intended Licensee and the IM, shall make a final determination, which shall be binding on the Intended Licensee.

13. Upon approval by the Department of the recommendations by the IM, the Intended Licensee shall provide the Department with a proposed timeframe for implementation of the IM recommendations, within twenty-one (21) days of receipt of the report(s). The timeframes shall be subject to approval by the Department and shall become operative upon the Department's approval. All recommendations shall be implemented in accordance with the Department's approved timeframe.

14. The IM shall assess the function, the duties, responsibilities and level of engagement of the Prospect Eastern Regional Quality and Patient Safety Steering Council ("Council") and the Facility's Quality Assurance and Performance Improvement Committee ("Committee") and shall determine their ability to monitor implementation of any recommendations provided. This assessment will be provided to the Intended Licensee's governing authority and to FLIS and OHCA.

15. The IM shall re-evaluate the Facility, within six (6) months following the completion of the initial Facility evaluation and semi-annually thereafter throughout the tenure of the IM's engagement. The re-evaluation shall determine the Licensee's ability to implement and maintain quality of care and services, implementation of recommendations previously made by the IM and compliance with regulatory requirements. Upon conclusion of said reviews, the IM shall provide Prospect, the Intended Licensee and the Department, including representatives of FLIS and OHCA, with a comprehensive report of said assessments.

16. The IM shall act and perform the duties assigned herein at all times to serve the interest of the Department in assuring the safety, welfare and well-being of patients and to secure compliance with applicable federal and state law and regulations and shall not accept any direction or suggestion from Prospect, the Intended Licensee or its employees that will deter or interfere in fulfilling this obligation.

17. Within one hundred eighty (180) days of the effective date of this Order, Prospect, shall::

    a. Collaborate with Facility leadership in identifying initiatives aimed at improving patient care quality and safety;
    b. Collaborate with Facility leadership to build quality, efficiency, effectiveness, and a shared accountability systems model of care;
    c. Collaborate with Facility leadership to ensure ongoing compliance with state and federal laws and regulations;
    d. Collaborate with Facility leadership to strengthen the data and information capabilities of the Facility to ensure quality and data driven quality measures; and,
    e. Collaborate with Facility leadership to ensure sustainment of quality assurance and performance activities, to include but not be limited to, activities that promote a high reliability organization.

18. The Corporate Chief Quality Officer, Regional Vice President of Quality, Chief Executive Officer, Chief Medical Officer, Chief Nursing Officer and Vice President of Quality and Safety and/or their designees shall meet with the Department quarterly for the first six (6) months after the effective date of this Order and thereafter once every six (6) months throughout the tenure of the IM. The meetings shall include discussions of issues related to the care and services provided by the Intended Licensee's compliance with accepted standards of practice and applicable federal and state statutes and regulations. After the first meeting, all subsequent meetings may be attended via teleconference except that no out-of-state participant is required to attend any of the meetings in person.

19. Any records maintained in accordance with any state or federal law or regulation or as required by this Order shall be made available to the IM and the Department, upon request. The IM may attend quality assurance and/or peer review committee meetings and utilize information from such meetings and records for making recommendations or reports. Except where mandated by law or to report illegal conduct to the Department, the IM shall not identify the individual providers subject to peer review. Except for such disclosures to the IM, any rights of the Intended Licensee or any

affiliate to claim and exert privilege to quality assurance or peer review documents under state and/or federal law are preserved and not limited or waived by this Order.

20. A Quality Assurance Performance Improvement Program shall be maintained by the Intended Licensee and monitored by the Committee, consist of, at least, the Intended Licensee' s Chief Medical Officer, Chief Nursing Officer and Vice President of Quality and Safety. The Committee shall focus its activities utilizing a structure, process and outcome model. The Committee shall meet at least once every sixty (60) days and as needed to review all reports or complaints relating to patient care and compliance with accepted standards of practice and federal state laws and regulations. During the tenure of the IM, the IM shall have the right to attend and participate in all Committee meetings and to evaluate and report on the design of the quality assurance programs implemented by the Committee. The activities of the Committee shall include, but not be limited to, compliance with this Order and the IM recommendations, determination and adoption of new policies to be implemented by the Intended Licensee's staff to improve patient care practices; provided that all policies shall be subject to review and approval by the Facility's governing authority, the Local Board and as appropriate, Prospect, consistent with the terms of that certain Quality Assurance Commitment Side Letter dated March 28, 2016 by and between Prospect and Eastern Connecticut Health Network, Inc., as amended to the date hereof ("Quality Letter"). In addition, this Committee shall review and revise, as applicable infection control policies and procedures and monitor their implementation. The Committee shall measure and track the implementation of any changes in the Intended Licensee's policies, procedures, and allocation of resources recommended by the Committee to determine compliance with and effectiveness of such changes. A record of Committee meetings and subject matter discussed will be documented and available for review by the Department. Minutes of all such meetings shall be maintained at the Facility for a minimum period of three (3) years.

21. During the term of this Order the Intended Licensee shall notify the Department within five (5) business days, if any of the following positions become vacant (if such positions exist, in name or in responsibilities, at the Facility):

    a. Corporate Chief Quality Officer;

b. Regional Vice President of Quality;

c. Director of Survey Readiness Team;

d. Chief Executive Officer;

e. Chief Medical Officer

f. Chief Nursing Officer;

g. Vice President of Quality and Patient Safety; and,

h. Vice President of Patient Care Services.

22. Within five (5) business days of the effective date of this Order, the Intended Licensee, shall provide the names and resumes of the proposed Chief Medical Officer, Chief Nursing Officer and Vice President of Quality and Safety.

23. The Intended Licensee within five (5) business days of the execution of this Order, shall designate an individual to be responsible for all notices and correspondence pursuant to this Order. The name, mailing address, email address and phone number of the designated individual shall be provided to the Department within said timeframe. The Intended Licensee may provide for a substitute or alternate individual with two (2) business days written notice to the Department.

24. Any reports required by this document shall be directed to:

Susan Newton, R.N., B.S.
Supervising Nurse Consultant
Facility Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, P.O. Box 340308, MS #12 HSR
Hartford, CT 06134-0308

25. All parties agree that this Order is an Order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. The Intended Licensee agrees that the compliance with all of the terms and conditions of this Order is part of the responsibility of the Intended Licensee's governing authority as set forth in Public Health Code section 19-13-D68(b)(4). The Intended Licensee further agrees that failure to comply with any of the terms and conditions of this Order shall constitute grounds for disciplinary action pursuant to Section 19a-494 of the Connecticut General Statutes Nothing herein shall be construed as limiting the Department's other available legal remedies against the Intended Licensee for violations of this Order or of any other

statutory or regulatory requirements, which may be sought in lieu of or in addition to the methods of relief listed above, or any other administrative and judicial relief provided by law.

26. The execution of this Order has no bearing on any criminal liability without the written consent of the Director of the MFCU or the Bureau Chief of the Department of Criminal Justice's Statewide Prosecution Bureau.

27. The Intended Licensee agrees that this Pre-Licensure Consent Order and the terms set forth herein are not subject to reconsideration, collateral attack or judicial review under any form or in any forum including any right to review under the Uniform Administrative Procedure Act, Chapter 368a of the Statutes, Regulations that exists at the time the Order is executed or may become available in the future, provided that this stipulation shall not deprive the Intended Licensee and its affiliate entities of any other rights that it may have under the laws of the State of Connecticut or of the United States.

28. Each of the hospitals acquired by Intended Licensee shall provide to the Department a plan of correction within forty-five (45) days of receiving a physical plant inspection report from the Department.

29. The Intended Licensee has consulted with its attorney prior to the execution of this Order.

WITNESS WHEREOF, the parties hereto have caused this Pre-Licensure Consent Order to be executed by their respective officers and officials. The undersigned signatories represent and warrant that they are authorized to execute this Pre-Licensure Consent Order on behalf of the party they represent.

By: _____
Ellen J. Shin, Secretary
Prospect Waterbury, Inc.
The Intended Licensee

On this 28th day of September, 2016, before me, personally appeared Ellen J. Shin who acknowledged herself to be the Secretary of the Intended Licensee and that she as Secretary, being authorized so to do, executed the foregoing instrument for the purposes therein contained, by signing her name as Secretary.

My Commission Expires: July 2, 2020
(If Notary Public)

_____
Notary Public [ ]
Commissioner of the Superior Court [ ]

EUNICE JEEN LEE
COMM. # 2150110
NOTARY PUBLIC-CALIFORNIA
LOS ANGELES COUNTY
My Commission Expires
July 2, 2020

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

By: _____
Barbara Cass, R.N.
Section Chief
Facility Licensing and Investigations Section

September 30, 2016

Exhibit A

FLIS' Independent Monitor Guidelines
For Intended Licensee Prospect Manchester Hospital

Relationship between Independent Monitor (IM) and DPH includes:

- An IM is utilized as a component of DPH's regulatory remedy process. An IM may be agreed upon as a part of a Consent Order between the institution and the Department when significant care and services issues are identified, or when, in connection with a change of ownership, an acquirer is new to the State and has experienced previous compliance issues in another state.
- The IM has a fiduciary or special relationship of trust, confidence and responsibility with the Department.
- The IM's responsibilities include:
  - Reporting to the Department regarding the Facility's compliance with federal and state law and regulation.
  - Monitoring the institution's plan of correction to rectify deficiencies and violations of federal/state laws and regulations. Reports to Department positive and negative issues related to said oversight.
  - Reporting in accordance with the Consent Agreement/Order to the Department of issues identified, plans to address noncompliance and remediation efforts of the institution.

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- The IM maintains a professional and objective relationship with the institutional staff. The IM is a consultant, not an employee of the institution. The IM exercises independent judgment and initiative to determine how to fully address and complete her/his responsibilities. The institution does not direct or supervise the IM but must cooperate with and respond to requests of the IM related to fulfilling her/his duties.
- The IM's responsibilities, consistent with the terms of the Consent Order, include:
  - Assessment of institution's compliance with recognized standards of practice federal/state laws and regulations.
  - Monitoring of care/services being provided.
  - Assists staff with plans of action to enhance care and services within the institution.
  - Reports in accordance with the Consent Order to the institution re: assessments, issues identified, and monitoring of plans of correction.

EXHIBIT B

BUSINESS ASSOCIATE AGREEMENT

THIS BUSINESS ASSOCIATE AGREEMENT (the "Business Associate Agreement") is made and entered into as of November ___, 2016 (the "Effective Date"), by and among Prospect ECHN, Inc., a Connecticut corporation ('Prospect ECHN"), Prospect Waterbury, Inc., a Connecticut corporation ("Prospect Waterbury") (together, the "Covered Entities") and Colleen Smith, MSN, RN, NEA-BC ("Business Associate")

RECITALS:

WHEREAS, the Business Associate and Covered Entities have entered into and may enter into one or more agreements (the "Agreement(s)") under which the Business Associate performs or assists the Covered Entities with a function or activity involving the Use or Disclosure of Individually Identifiable Health Information;

WHEREAS, the Covered Entities and the Business Associate desire to comply with the requirements of regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

WHEREAS, the HIPAA Standards require that the Covered Entities obtain satisfactory assurances that the Business Associate will appropriately safeguard the Individually Identifiable Health Information Used or Disclosed by the Business Associate in the course of performing services pursuant to the Agreement(s).

NOW, THEREFORE, in consideration of the foregoing and the mutual promises and covenants herein contained, the parties agree as follows:

1. Definitions

a) HIPAA Rules shall mean the Privacy, Security, Breach Notification and Enforcement Rules at 45 C.F.R. Part 160 and Part 164.

b) The following terms Used in this business Associate Agreement shall have the same meaning as those terms defined in the HIPAA Standards: Business Associate, Covered Entity, Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required By Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

c) The Covered Entities and the Business Associate acknowledge and agree that capitalized terms Used, but not otherwise defined, herein are as defined in the HIPAA Standards;

2. **Obligations and Activities of Business Associate**

a) Business Associate shall not Use or further Disclose Protected Health Information other than as permitted or required by this Business Associate Agreement or as required by law.

b) Business Associate shall Use appropriate safeguards and comply with Subpart C of 45 C.F.R. Part 164 with respect to electronic protected health information, to prevent Use or Disclosure of the Protected Health Information not provided for by this Business Associate Agreement.

c) Business Associate shall immediately report to Covered Entities any Use or Disclosure of Protected Health Information or individually identifiable information not provided for by this Business Associate Agreement, including without limitation any Breach of Protected Health Information or Unsecured Protected Health Information as required and any Security Incident of which the Business Associate becomes aware. Business Associate shall take any reasonable action necessary or requested by the Covered Entities to mitigate, to the extent practicable, any harmful effect that is known to Business Associate.

d) In the event of a Breach of Protected Health Information or Unsecured Protected Health Information, Business Associate's notice to Covered Entities of such Breach shall include, to the extent possible, the identification of each Individual whose Protected Health Information has been, or is reasonably believed to have been, accessed, acquired, or disclosed. Business Associate shall also provide Covered Entities any other available information that the Covered Entities are required to include in the notification to the Individual, even if such information becomes available after notification to the Individual, or take any reasonable action necessary as requested by the Covered Entities to assist Covered Entities in complying with any applicable Breach notification requirements.

e) Business Associate shall ensure that any agent of the Business Associate, including a subcontractor that creates, maintains transmits, or receives Protected Health Information on behalf of Covered Entities agrees to the same restrictions, conditions and requirements that apply through to Business Associate with respect to such information.

f) If the Business Associate maintains Protected Health Information in a Designated Record Set, the Business Associate shall:

(i) provide access or make available to Covered Entities Protected Health Information in a Designated Record Set, to Covered Entities or to an Individual, per Covered Entities' direction in order to meet the requirements under 45 C.F.R. § 164.524; and

(ii) make any amendment(s) to Protected Health Information in a Designated Record Set that the Covered Entities direct or agree to

pursuant to 45 C.F.R. § 164.526 at the request of Covered Entity or an Individual in the time and manner designated by Covered Entity, or take other measures as necessary to satisfy Covered Entities' obligations under 45 C.F.R. 164.526.

g) Business Associate shall maintain and make available to Covered Entity information pertaining to Disclosures of Protected Health Information by Business Associate to permit Covered Entity to respond to a request by an Individual for an accounting of Disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528. In the event that Business Associate receives a direct request from an Individual for an accounting of Disclosures of Protected Health Information made by Business Associate, Business Associate agrees to provide the Individual with such an accounting in accordance with 45 C.F.R. § 164.528.

h) To the extent Business Associate is to carry out one or more of Covered Entities' obligation(s) under Subpart E of 45 C.F.R. Part 164, Business Associate shall comply with the requirements of Subpart E that apply to Covered Entity in the performance of such obligation(s); and

i) Business Associate shall make internal practices, books, and records relating to the Use and Disclosure of Protected Health Information received from, or created, maintained or received by Business Associate on behalf of Covered Entity available to the Covered Entity or the Secretary, in a time and manner designated by the Covered Entity or the Secretary, for purposes of the Secretary determining Covered Entities' or Business Associate's compliance with the HIPAA Rules.

j) Business Associate shall implement and maintain safeguards as necessary to ensure that all Protected Health Information is Used or Disclosed only as authorized under the HIPAA Rules and this Business Associate Agreement. Business Associate agrees to assess potential risks and vulnerabilities to Protected Health Information in its possession and develop, implement and maintain the administrative, physical and technical safeguards required by the HIPAA Rules that protect the confidentiality, availability and integrity of the Protected Health Information that Business Associate creates, receives, maintains or transmits on behalf of the Covered Entity. These measures must be documented and kept current, and must include, at a minimum, those measures that fulfill the requirements outlined in the HIPAA Rules. Business Associate also agrees to implement policies and procedures that address Business Associate's compliance with applicable HIPAA Rules and its efforts to detect, prevent and mitigate the risks of identity theft resulting from the improper Use and/or Disclosure of an Individual's information.

k) In the event that Business Associate has knowledge of a Covered Entity's breach of the HIPAA Rules, Business Associate agrees to notify Covered Entity and take reasonable steps to cure such breach.

l) Business Associate acknowledges that if it violates any of the requirements provided under this Business Associate Agreement, Business Associate will be subject to the same civil and criminal penalties that a Covered Entity would be subject to if such Covered Entity violated the same requirements.

3. Permitted Uses and Disclosures by Business Associate

a) Business Associate may Use or Disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, a Covered Entity as specified in the Agreement(s), provided that such Use or Disclosure would not violate the HIPAA Rules if done by the Covered Entity.

b) Business Associate may Use Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

c) Business Associate may Disclose Protected Health Information for the proper management and administration of the Business Associate, provided that Disclosures are Required by Law, or Business Associate obtains reasonable assurances from the person to whom the information is Disclosed that it will remain confidential and will be Used or further Disclosed only as Required by Law or for the purpose for which it was initially Disclosed to the recipient, and the recipient notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

d) Except as otherwise permitted by the HIPAA Rules, when using or disclosing Protected Health Information or responding to a request for Protected Health Information, Business Associate must limit such Protected Health Information, to the extent practicable, to a Limited Data Set, or if more information than a Limited Data Set is required, Business Associate agrees to make Uses and Disclosures and requests for protected health information consistent with the Minimum Necessary to accomplish the intended purpose of such Use, Disclosure, or request.

e) Except as otherwise permitted by the HIPAA Rules, Business Associate agrees that it will not directly or indirectly receive remuneration in exchange for any Protected Health Information unless the Covered Entity has obtained from an Individual a valid authorization that includes a specification of whether the Protected Health Information can be further exchanged for remuneration by the entity receiving the Individual's Protected Health Information. When the Secretary issues the regulations that address the requirements of this Section and such regulations become effective, Business Associate shall comply with such regulations with respect to receiving remuneration in exchange for any Protected Health Information.

f) If an Individual requests that Business Associate restrict the Disclosure of the Individual's Protected Health Information to carry out treatment, payment, or health care operations, Business Associate agrees that it will comply with the requested restriction if, except as otherwise required by law, the Disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment), and the Protected Health Information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full.

g) Except as otherwise limited in this Business Associate Agreement, Business Associate may Use and Disclose Protected Health Information to provide Data Aggregation services to Covered Entity as permitted by 42 C.F.R. § 164.504(e)(2)(i)(B).

4. Obligations of Covered Entities

a) Covered Entities shall provide Business Associate with the Notice of Privacy Practices that Covered Entities produce in accordance with 45 C.F.R. § 164.520, as well as provide any changes to such Notice and the Business Associate shall comply with such Notice of Privacy Practices.

b) Covered Entities shall provide Business Associate with any changes in, or revocation of, permission by Individual to Use or Disclose Protected Health Information, if such changes affect Business Associate's permitted or required Uses and Disclosures.

c) Covered Entities shall notify Business Associate of any restriction to the Use or Disclosure of Protected Health Information that Covered Entity has agreed to in accordance with 45 C.F.R. § 164.522.

d) Covered Entities shall not request Business Associate to Use or Disclose Protected Health Information in any manner that would not be permissible under the HIPAA Rules if done by Covered Entities.

5. Term and Termination

a) Term. The Term of this Business Associate Agreement shall be effective as of the Effective Date and shall terminate at to a Covered Entity when all of the Protected Health Information provided by the Covered Entity to Business Associate, or created, maintained, or received by Business Associate on behalf of the Covered Entity, is destroyed or returned to the Covered Entity, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this Section.

b) Termination for Cause. Upon a Covered Entity's knowledge of a material breach of this Business Associate Agreement by Business Associate, the Covered Entity shall provide an opportunity for Business Associate to cure

the breach or end the violation. The Covered Entity shall terminate the Business Associate Agreement if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity. The Covered Entity may immediately terminate the Business Associate Agreement if Business Associate has breached a material term of this Business Associate Agreement and cure is not possible, as determined by the Covered Entity in its reasonable discretion.

c) Effect of Termination.

(i) Except as provided in this subsection, upon termination of the Agreement(s) or this Business Associate Agreement, for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Entities, or created, maintained or received by Business Associate on behalf of Covered Entities that the Business Associate still maintains in any form. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.

(ii) In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Covered Entities notification of the conditions that make return or destruction infeasible. Upon mutual agreement of the parties that return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this Business Associate Agreement to such Protected Health Information and limit further Uses and Disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

(iii) The parties hereto understand and agree that the terms of this Business Associate Agreement are reasonable and necessary to protect the interests of the Covered Entities and the Business Associate. The parties further agree that the Covered Entities would suffer irreparable harm if the Business Associate breached this Business Associate Agreement. Thus, in addition to any other rights or remedies, all of which shall be deemed cumulative, the Covered Entities shall be entitled to obtain injunctive relief to enforce the terms of this Business Associate Agreement.

(iv) Survival. The obligations of Business Associate under this Section shall survive the termination of this Business Associate Agreement.

6. **Miscellaneous**

a) Interpretation. Any ambiguity in this Business Associate Agreement shall be interpreted in a manner that permits the parties to comply with the HIPAA Rules.

b) No Private Cause of Action. This Business Associate Agreement is not intended to and does not create a private cause of action by any individual, other than the parties to this Business Associate Agreement, as a result of any claim arising out of the breach of this Business Associate Agreement, the HIPAA Standards or other state or federal law or regulation relating to privacy or confidentiality.

c) Amendment. Any party shall have the right to amend this Business Associate Agreement by providing written notice to the other parties in order to bring it into compliance with any law or regulation enacted or promulgated regarding the protection of health information that is any way inconsistent with the terms of this Business Associate Agreement or interferes with the parties' obligations with respect to the protection of health information.

d) Application of State Law. Where any applicable provision of Connecticut State law relates to the privacy of health information and is not preempted by HIPAA, as determined by application of the HIPAA Rules, the parties shall comply with the applicable provisions of Connecticut State law.

e) Severability. If any provision of this Business Associate Agreement shall be declared invalid or illegal for any reason whatsoever, then notwithstanding such invalidity or illegality, the remaining terms and provisions of this Business Associate Agreement shall remain in full force and effect in the same manner as if the invalid or illegal provision had not been contained herein, and such invalid, unenforceable or illegal provision shall be valid, enforceable and legal to the maximum extent permitted by law.

f) Governing Law. This Business Associate Agreement shall be interpreted, construed and governed according to the laws of the State of Connecticut. The parties agree that venue shall lie in Federal and State courts in the State in which the Covered Entities maintain their principal places of business, without regard to conflicts of law principles, regarding any and all disputes arising from this Business Associate Agreement.

g) Notices. Any notice or other communication given pursuant to this Business Associate Agreement must be in writing and (i) delivered personally, (ii) delivered by overnight express, or (iii) sent by registered or certified mail, postage prepaid, to the addresses set forth below and shall be considered given upon delivery.

Chief Compliance and Privacy Officer
Prospect ECHN, Inc.

71 Haynes Street
Manchester, CT 06040

Chief Compliance Officer
Prospect Waterbury, Inc.
64 Robbins Street
Waterbury, CT 06708

With a copy to:

Prospect Medical Holdings, Inc.
3415 South Sepulveda Blvd., 9th Floor
Los Angeles, CA 90034
Attention: General Counsel

h) Indemnification. Without limitation to any indemnification obligation that Business Associate may have under the Agreement(s), Business Associate shall indemnify, hold harmless and defend Covered Entities from and against any and all claims, losses, liabilities, costs and other expenses resulting from, or relating to, the acts or omissions of Business Associate, its employees, agents, and subcontractors, in connection with any Use or Disclosure of Protected Health Information, Unsecured Protected Health Information, or an Individual's information not provided for by this Business Associate Agreement, including without limitation any Breach of Protected Health Information, Unsecured Protected Health Information, or an Individual's information or any expenses incurred by Covered Entitles in providing required breach notifications.

IN WITNESS WHEREOF, the parties hereto have executed this Business Associate Agreement as of the Effective Date.

BUSINESS ASSOCIATE

By:_____
Printed Name: Colleen Smith, MSN, RN, NEA-BC
Title:
Date:

COVERED ENTITY
PROSPECT ECHN, INC.

By:_____
Printed Name:
Title:
Date:

COVERED ENTITY
PROSPECT WATERBURY, INC.

By:_____
Printed Name:
Title:
Date:

Greer, Leslie

From: Roberts, Karen
Sent: Monday, November 28, 2016 4:00 PM
To: Greer, Leslie
Cc: Cotto, Carmen
Subject: FW: Schedule conference call

From: Olejarz, Barbara
Sent: Thursday, November 17, 2016 10:45 AM
To: Jennifer O'Donnell
Cc: Martone, Kim; Cotto, Carmen; Roberts, Karen
Subject: RE: Schedule conference call

Hi Jennifer,

From OHCA there will be Kim Martone, Karen Roberts and Carmen Cotto. It's okay with OHCA that only Michele call in unless there is someone else that Michele would like to have participate in the conference call. The call in number is Kim's office number at 860- 418-7029. I am sending out a calendar request.

Barbara K. Olejarz
Administrative Assistant to Kimberly Martone
Office of Health Care Access
Department of Public Health
Phone: (860) 418-7005
Email: Barbara.Olejarz@ct.gov

From: Jennifer O'Donnell [mailto:jlo@bvmlaw.com]
Sent: Thursday, November 17, 2016 10:34 AM
To: Olejarz, Barbara <Barbara.Olejarz@ct.gov>
Cc: Cotto, Carmen <Carmen.Cotto@ct.gov>; Roberts, Karen <Karen.Roberts@ct.gov>; Martone, Kim <Kimberly.Martone@ct.gov>; Michele Volpe <mmv@bvmlaw.com>
Subject: RE: Schedule conference call

Yes, Michele is available and can participate on the call. Is there anyone else that you need to participate on the call?

Jennifer L. O'Donnell
Paralegal
Bershtein, Volpe & McKeon P.C.
105 Court Street, 3rd Floor
New Haven, Connecticut 06511-6957
Telephone: (203) 777-5800 (ext. 104)
Direct Line: (203) 777-5804
Facsimile: (203) 777-5806

Greer, Leslie

From: Roberts, Karen
Sent: Tuesday, November 29, 2016 11:36 AM
To: Greer, Leslie
Cc: Cotto, Carmen
Subject: FW: Prospect Medical Holdings

Please add to the two Prospect CONs (ECHN and Waterbury). Karen

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: karen.roberts@ct.gov

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From: Cass, Barbara
Sent: Monday, November 28, 2016 1:17 PM
To: Martone, Kim
Cc: Roberts, Karen; Newton, Susan; Ortelle, Donna; Furniss, Wendy
Subject: Prospect Medical Holdings

Dear Kim:

The Facility Licensing and Investigations Section has met with Colleen Smith, M.S.N., R.N., NEA-BC and has approved her as capable of serving in the capacity of the IM, if the Office of Health Care Access is also in agreement as it relates to the Prospect Medical Holdings acquisition in Connecticut. She has extensive experience in the overall management of hospitals and specific experiences as the chief nursing officer of a magnet hospital.

Best,

Barbara

Barbara S. Cass, R.N.
Section Chief
Facility Licensing and Investigations Section
State of Connecticut, Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Telephone: 860-509-7609

Greer, Leslie

From: Mcconville, Dennis P <dmcconville@echn.org>
Sent: Wednesday, November 30, 2016 3:00 PM
To: User, OHCA
Cc: Martone, Kim; Ellen J. Shin (ellen.shin@prospectmedical.com); Joyce A. Tichy Esq. (joyce.tichy@gmail.com) (joyce.tichy@gmail.com); Michele Volpe; Collins, Michael; Jonathan.Spees; Garrison DeLee (garrison.delee@prospectmedical.com); Frank.Saidara; Basile, Mary C
Subject: 15-32016-486-CON
Attachments: Letter to Janet Brancifort, OHCA re DN 15-32016-486-CON 11 30 16_.pdf

The attached letter is submitted as required for conditions 8, 9 and 10 contained in the Final Decision for Docket Number: 15-32016-486-CON, the Transfer of assets of Eastern Connecticut Health Network, Inc. to Prospect Medical Holdings.

Dennis P. McConville
Senior Vice President
Eastern Connecticut Health Network, Inc.
(860) 533-3429 (office)
dmcconville@echn.org

"This message originates from Eastern Connecticut Health Network. The information contained in this message may be privileged and confidential. If you are the intended recipient, you must maintain this message in a secure and confidential manner. If you are not the intended recipient, please notify the sender immediately and destroy this message. Thank you."

Eastern Connecticut Health Network
71 Haynes Street
Manchester, CT 06040
860.533.3414
www.echn.org

November 30, 2016

VIA EMAIL DELIVERY

Deputy Commissioner Janet M. Brancifort, MPH, RRT
Office of Health Care Access
Department of Public Health
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134

Re: **Docket Number: 15-32016-486**

Project Title: **Transfer of assets of Eastern Connecticut Health Network, Inc. to Prospect Medical Holdings, Inc.**

Dear Ms. Brancifort:

This letter is submitted in accordance with the Order for the above referenced Certificate of Need Final Decision, specifically Condition Number Eight (8), Condition Number Nine (9) and Condition Number Ten (10) regarding the transfer of assets of Eastern Connecticut Health Network, Inc. (ECHN) to Prospect Medical Holdings, Inc. (PMH). Please note that the transaction closed on October 1, 2016 ("Closing Date").

Condition Number Eight (8) requires that starting on November 30, 2016, for the reporting period of April 1, 2016 through September 30, 2016 that PMH provide a report on the capital investments ("Capital Investment Report") it has made in the New MMH, New RGH and their affiliates from the $75 million Commitment Amount. The Capital Investment Report shall include the following in a format to be agreed upon:

a. A list of the capital expenditures that have been made in the prior one hundred and eighty days (180) days with descriptions of each associated project; and

b. An explanation of why each expenditure was made and a timeframe for the roll out of the associated capital project (including estimated beginning, ending, and startup/operation dates); and

c. The dates and amounts of withdrawals from each of the New Hospitals' operating account and/or any other sources of funding used to fulfill the Capital Commitment.

Condition Number Nine (9) requires that by November 30, 2016, for the reporting period of April 1, 2016 through September 30, 2016 that PMH provide a report for New ECHN, New MMH and New RGH with the following information:

a. The cost saving totals achieved in the following Operating Expense Categories for New ECHN, New MMH and New RGH: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Interest Expense, Malpractice Expense, Utilities, Business Expenses, and other Operating Expenses. The categories shall be consistent with the major operating expense categories (Categories A, B, C, D, E, G, H, I, J, and K) which are in use at the time of reporting in the OHCA Hospital Reporting System ("HRIS") Report 175 or successor report. The semi-annual submission shall also contain narratives describing:

    1. The major cost savings achieved for each expense category for the semi-annual period; and

    2. The effect of cost savings on the clinical quality of care.

b. A Consolidated Balance Sheet, Statements of Operations, and Statements of Cash Flows for New ECHN, New MMH and New RGH. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Reports 100/150, 300/350 or successor reports.

Condition Number Ten (10) requires that by November 30, 2016, for the reporting period of April 1, 2016 through September 30, 2016 that PMH provide a report for New ECHN, New MMH and New RGH with the following financial measurements/indicators:

Financial Measurement/Indicators

A. Operating Performance

1. Operating Margin
2. Non-Operating Margin
3. Total Margin

B. Liquidity

1. Current Ratio
2. Days Cash on Hand
3. Days in Net Accounts Receivables
4. Average Payment Period

C. Leverage and Capital Structure

1. Long-term Debt to Equity
2. Long-term Debt to Capitalization
3. Unrestricted Cash to Debt

4. Times Interest Earned Ratio
5. Debt Service Coverage Ratio
6. Equity Financing Ratio

D. <u>Additional Statistics</u>

1. Income from Operations
2. Revenue Over/(Under) Expense
3. Cash from Operations
4. Cash and Cash Equivalents
5. Net Working Capital
6. Free Cash Flow (and the elements used in the calculation)
7. Unrestricted Assets/Retained Earnings
8. Bad Debt as % of Gross Revenue
9. Credit Ratings (S&P, FITCH, or Moody's)

As the reporting periods for the above Conditions are for a period prior to the Closing Date, there is no relevant data to report at this time. Prospect Medical Holdings did not acquire ECHN until October 1, 2016 and was therefore not in a position to make capital investments in the hospitals or demonstrate cost savings. A filing will be made on or before May 31, 2017 with the required information for capital investments made, costs saving achieved and financial measurements requested for the period beginning on October 1, 2016 through March 31, 2017.

If you have any questions or need anything further, please feel free to contact me at (860) 533-3429.

Very truly yours,

Dennis P. McConville
Senior Vice President
Eastern Connecticut Health Network

cc: Kimberly Martone, Director of Operations, Department of Public Health Division of Office of Health Care Access
Ellen J. Shin, General Counsel, Prospect Medical Holdings, Inc.
Joyce A. Tichy, Senior Vice President and General Counsel, ECHN
Michele M. Volpe, Bershtein, Volpe & McKeon, P.C.
Michael Collins, Interim CEO, ECHN
Jonathan Spees, Senior Vice President, Corporate Development, Prospect Medical Holdings, Inc.
Garrison De Lee, Assistant General Counsel, Prospect Medical Holdings, Inc.

User, OHCA

From: Colleen Smith <colleen713.smith@gmail.com>
Sent: Friday, December 09, 2016 9:49 AM
To: User, OHCA
Cc: Colleen Smith
Subject: ECHN Docket# 15-32016-486-CON
Attachments: Nursing Consulting Partners ECHN workplanFinal. MM 12.6.docx

To Whom It May Concern,
Please find the attached Independent Monitor Work Plan for the ECHN Final Decision.
Thank you.
Colleen Smith
Independent Monitor

NURSING CONSULTING PARTNERS
Sustainable Results for Healthcare Solutions

PROSPECT ECHN, INC. WORK PLAN

INDEDEPENDENT MONITORING PROCEDURES (per Docket Number 15-32016-486)

OHCA Condition	IM Action
CON Condition 4: Within one hundred and eighty (180) days following the Closing Date, PMH shall submit a plan (the "Health Needs Plan") for continuing to support and implement ECHN's 2016 Community Health Needs Assessment ("CHNA") and for conducting the New Hospitals' next comprehensive study of community health needs in the Service Area (the "Community Health Needs Study" or "Study"). The Health Needs Plan shall describe in detail at least the following: (i) the data that will be collected and analyzed to systematically assess health status Indicators of the Service Area; (ii) the identity of key community stakeholders and health organizations, unaffiliated with PMH, including without limitation, representatives of medically underserved populations, that will be enlisted to participate in the Study and the manner and extent of such participation by stakeholders in both the development of health priorities and planned implementation; (iii) the qualifications of consultants experienced in performing community health needs assessments who will be retained by PMH to ensure that the priority health needs of the community are accurately determined; (iv) the frequency with which the Study will be repeated; (v) the manner in which results of the Study and the implementation strategy to address the priority health needs identified therein (the "Implementation Strategy") will be distributed to the community; and (vi) the manner in which the Study will complement the population health management objectives of PMH and the New Hospitals.	IM will obtain a copy of the Plan, verify timely submission, verify that it incorporated the required elements.
CON Condition 5: Within three (3) years following the Closing Date, PMH shall participate with New ECHN and the New Hospitals, and the key community stakeholders and health organizations identified pursuant to Condition 4, in conducting a Community Health Needs Study and shall provide a copy of such Study and its Implementation Strategy to OHCA within thirty (30) days of completion. PMH and the participants shall utilize Healthy Connecticut State Health Improvement Plan data and priorities as the starting point for the Study (available at -	IM will obtain a copy of the Study, verify timely submission, verify that it incorporated the required elements and was published on the website.

http://www.ct.gov/dph/lib/dph/state_health_planning/ship/hct2020/hct2020_state_hlth_impv_032514.pdf) as well as any applicable community health improvement plan issued by any local health department in the Service Area.[1] The Implementation Strategy shall also adopt the evidence-based interventions identified in the Centers for Disease Control 6/18 initiative (available at http://www.cdc.gov/sixeighteen) to the extent the health priorities identified in the Study correlate to the health conditions identified by the CDC and provide information on how any patient outcomes related to the Implementation Strategy will be measured and reported to the community. PMH shall publish the Community Health Needs Study and the Implementation Strategy on the website of New MMH and New RGH. Until such time as the Community Health Needs Study and Implementation Strategy are submitted to OHCA, PMH shall continue to support and implement ECHN's current CHNA for MMH and RGH. OHCA is imposing this condition to ensure continued access to health care services to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d(a) 19a-613(b), 19a-639(a)(3) & (7); FF 56-57*	
CON Condition 6: Within one hundred and eighty (180) days following the Closing Date, PMH shall submit a plan demonstrating how health care services will be provided by the New Hospital for the first three years following the Asset Purchase, including any consolidation, reduction, or elimination of existing services or introduction of new services (the "Services Plan"). The Services Plan will be provided in a format mutually agreed upon by OHCA and the Applicants. OHCA is imposing this condition to ensure continued access to health care services to the patient population. *Legal and Factual Basis: Conn. Stat. §§ 19a-486(a), 19a-613(b), 19a-639(a)(5),(6) (7),(8),(9),(11) & (12); FF 18, 26-27*	IM will obtain a copy of the Plan and verify it incorporated the required elements.
CON Condition 7: Until such time as the Services Plan is submitted, PMH shall provide OHCA with notice of any reallocation of inpatient beds and relocation of outpatient services for the New NMH or New RGH specific to those services that existed at each of the Hospitals as of the Decision Date. Such notice shall be provided within ten (10) days of any such reallocation or relocation and published on the website pages of the New Hospitals. OHCA is imposing this condition to ensure continued access to health care services to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486(a), 19a-613(b), 19a-639(a)(5),(6) (7),(8),(9),(11) & (12); FF 18, 26-27*	IM will verify proper notification to OHCA within 10 days of any plan to reallocate inpatient beds and relocation of outpatient services. IM will assure timely publication on New Hospitals website within 10 days of decision to reallocate or relocate services.

[1] Other tools and resources which the Applicants are encouraged to consider include County Health Rankings and CDC Community Health Improvement Navigator in order to assist with the Study process in terms of an understanding of social, behavioral, and environmental conditions that affect health, identifying priorities, and the use of evidence-based interventions.

CON Condition 8: Within one hundred and eighty (180) days following the Closing Date and thereafter on the same semi-annual schedule as set forth in Conditions 9 and 10 below until the capital commitment is satisfied, PMH shall submit to OHCA a report on the capital investments ("Capital Investment Report") it has made in the New MMH, New RGH and its affiliates from the $75 million Commitment Amount. The Capital Investment Report shall include the following in a format to be agreed upon: a. A list of the capital expenditures that have been made in the prior one hundred and eighty (180) days with descriptions of each associated project; and b. An explanation of why each expenditure was made and a timeframe for the roll out of the associated capital project (including estimated beginning, ending and startup/operation dates); and c. The dates and amounts of withdrawals from each of the New Hospitals' operating account and/or any other sources of funding used to fulfill the Capital Commitment. The reports shall be signed by PMH ECHN's Chief Financial Officer. OHCA is imposing this condition to ensure continued access to health care services to the patient population and to verify the continued financial feasibility of the project. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(3),(4) & (5); FF 38-45*	IM will obtain the Plan, read the plan and verify that expenditures/investments made are in accordance with the Plan. IM will confirm timely submissions of all required reports.
CON Condition 9: For three (3) years following the Closing Date, PMH shall file the following information with OHCA on a semi-annual basis for ECHN, New MMH and New RGH, respectively: a. The cost saving totals achieved in the following Operating Expense Categories for New ECHN, New MMH and New RGH: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Interest Expense, Malpractice Expense, Utilities, Business Expenses and Other Operating Expenses. The categories shall be consistent with the major	IM will review the PMH filings regarding cost savings achieved in accordance with a. 1-2 and b. of Condition 9.

operating expense categories (Categories A, B, C, D, E, G, H, I, J, and K) which are in use at the time of reporting in the OHCA Hospital Reporting System ("HRS") Report 175 or successor report. The semi-annual submission shall also contain narratives describing: 1. the major cost savings achieved for each expense category for the semi-annual period; and 2. the effect of these cost savings on the clinical quality of care. b. A consolidated Balance Sheet, Statement of Operations, and Statement of Cash Flows for New ECHN, New MMH and New RGH. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Reports 100/150, 300/350 or successor reports. For purposes of this Order, semi-annual periods are October 1-March 31 and April 1 – September 30. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th, beginning November 30, 2016. OHCA is imposing this condition to ensure continued access to health care services to the patient population and to verify the continued financial feasibility of the project. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(4) & (5); FF 51, 60-63*	
CON Condition 10: For three (3) years following the Closing Date, PMH shall submit to OHCA a financial measurement report. This report shall be submitted on a semi-annual basis and show current month and year-to-date data and comparable prior year period data for New ECHN, New MMH, and New RGH, respectively. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th, beginning November 30, 2016. The following financial measurements/indicators should be addressed in the report: (i) **Operating performance** to include operating margin, non-operating margin, and total margin; (ii) **Liquidity** to include current ratio, days cash on hand, days in net accounts receivables, and average payment period; (iii) **Leverage and capital structure** to include long-term debt to equity, long-term debt to capitalization, unrestricted cash to debt, times interest earned ratio, debt service coverage ratio, and equity financing ratio; and (iv) **Additional Statistics** to include income from operations, revenue over (under) expense, cash from operation, cash and cash equivalents, net working capital, free cash flow (and	IM will obtain the financial measurement report and read to confirm that the required elements are addressed in the report; IM will confirm the timely submission of each report.

the elements used in the calculation), unrestricted net assets/retained earnings, bad debt as a percentage of gross revenue, and credit ratings.	
CON Condition 11: PMH shall ensure that the New MMH and New RGH maintains and adheres to ECHN's current policies regarding charity care, indigent care and community volunteer services at New MMH and New RGH after the Closing Date all as consistent with state and federal law or adopt other policies that are at least as generous and benevolent to the community as ECHN's current policies. These policies shall be posted on the website of the New MMH and New RGH and as additionally required by applicable law. OHCA is imposing this condition to ensure continued access to health care services to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(5),(6) & (11); FF 52-55, 59*	IM will obtain copies of the relevant financial assistance policies, read and confirm that as adopted financial assistance policies (or policies at least as generous as these policies) using management approval of the policies as evidence. After verifying that this step has been properly completed, IM will confirm that these policies are properly posted on website
CON Condition 12: For three (3) years following the Closing Date, PMH shall provide written notice to OHCA of any modification, amendment or revision to the charity care, indigent care and community volunteer services of New MMH and New RGH within thirty (30) days of such change. The notice of these changes shall be accompanied by copies of any revised policies and the notice and revised policies shall be posted on the website of the New Hospital simultaneously with their submission to OHCA. OHCA is imposing this condition to ensure continued access to health care services to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(5),(6) & (11); FF 52-55, 59*	After obtaining original policies on charity care, indigent care, and community volunteer services, IM will read and assess these policies on an annual basis for changes. When changes are made to these policies, IM will confirm OHCA is notified (as required) and revised policies are posted to the website.
CON Condition 13: PMH shall maintain community benefit programs and community building activities for the New MMH and New RGH for three (3) years after the Closing Date consistent with the Hospital's most recent Schedule H of IRS Form 990 or shall provide such other community benefit programs and community building activities that are at least as generous and benevolent to the community as ECHN's current programs, and PMH shall apply a 1% increase per year for the next three (3) years toward community building activities in terms of dollars spent. In determining the New MMH and New RGH participation in and investment in both community benefits and community building activities, PMH shall address the health needs identified by the applicable CHNA or Study in effect at the time and the population health management objectives, including social determinants of health, contained in the related Implementation Strategy. a. On an annual basis, the Applicants shall identify the amounts and uses related to community benefits and community	IM will obtain most recent Schedule H of IRS Form 990 to act as a baseline. IM will then compare on an annual basis the results of that year to the baseline in order to verify that the 1 percent increase requirement has been met. IM will also obtain the report/summary on the amounts and uses related to community benefits and community building per the categories identified in the CHNA. IM will confirm that these documents are filed in a timely manner and posted to the website.

building and shall discuss how such investments and support are being applied toward the health needs identified in the CHNA or Study and population health management objectives. Such reporting shall be filed within thirty days of the anniversary date of the closing for three years and shall be posted on the New Hospital's website. OHCA is imposing this condition to ensure continued access to health care services to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(5),(6) & (11); FF 52-55, 59*	
CON Condition 14: New MMH and New RGH agree to comply with the following general community benefit standards for at least the first three years. (a) the New Hospitals shall provide public health programs to the community and generally promote the welfare of the community; (b) the New Hospitals shall have open medical staffs and not restrict the use of facilities to a particular group of physicians and surgeons to the exclusions of other qualified doctors; (c) the New Hospital shall participate in the Medicare and Medicaid programs; and (d) the New Hospitals shall operate 24/7 emergency departments and provide emergency services to patients regardless of their ability to pay. OHCA is imposing this condition to ensure continued access to health care services to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(5),(6) & (11); Tr., Testimony of Tom Reardon, President. PMH East on 5/3/16, pp. 103-04*	IM will verify the New Hospitals' compliance with community benefit standards a through d as stated in Condition 14.
CON Condition 15: New MMH and New RGH shall work toward making culturally and linguistically appropriate services available and integrated throughout their hospital operations. Specifically, New MMH and new RGH shall take reasonable steps to provide meaningful access to each individual with limited English proficiency eligible to be served or likely to be encountered in its health programs and activities, in accordance with the implementing regulations of Section 1557 of the Patient Protection and Affordable Care Act. Additionally, New MMH and New RGH shall provide appropriate insurance navigator services for patients and, where appropriate, English as a second language and cultural competency training for employees. In complying with this Condition, New MMH and New RGH shall be guided by the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care published by the U.S. Department of Health and Human Services' Office of Minority Health. For three (3) years following the Closing Date, PMH shall submit a written report on its activities directed at meeting this Condition. Such reporting shall be filed within thirty days of the anniversary date of the closing for three years and shall be posted	IM will obtain and review interpreter services policies and contracts as applicable. Additionally, IM will obtain a cultural competency plan, training, as well as related policies. IM will also obtain report and supporting documents and confirm the timely filing of these materials

on the applicable Hospital website. OHCA is imposing this condition so as to ensure continued access to health care services to the patient population. *Legal and Factual Basis: 45 C.F.R. §92.201; Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(5),(6) & (11); FF 52-55, 59*	
CON Condition 16: Within sixty (60) days after the Closing Date, the Applicants shall contract with an Independent Monitor who has experience in hospital administration and regulation, including maintaining quality control in a High Reliability Organization ("HRO"). The Independent Monitor shall be retained at the sole expense of PMH, at a cost which shall not exceed $300,000 in the aggregate. Representatives of OHCA and the Facility Licensing and Investigations ("FLIS") section of the Department of Public Health ("DPH") will approve the Independent Monitor's appointment. The Independent Monitor shall be engaged for a minimum period of two (2) years following the Closing Date, which may be extended for another year at OHCA's and/or FLIS's discretion. The Independent Monitor will be responsible for monitoring the Applicants' compliance with the Conditions set forth in this Order. PMH shall provide the Independent Monitor with appropriate access to New Hospitals and their applicable records in order to enable the Independent Monitor to fulfill its functions hereunder. OHCA is imposing this condition to ensure continued access to health care services to the patient population and to verify and monitor compliance with the conditions set forth herein. *Legal and Factual Basis: Conn. Gen. §§ Stat. 19a-486(a), 19a-613(b), 19a-639(a)(1),(2),(4),(5),(6),(7),(11) & (12); FF 26-27, 30-45, 52-57, 59*	IM and PMH will execute a Consulting Services Agreement by the required date. A draft of this Agreement has been provided to OHCA.
CON Condition 17: The Independent Monitor will report to both OHCA and FLIS. The Independent Monitor shall conduct on-site visits of New Hospitals on no less than a semi-annual basis to assess PMH's modified Quality Assurance Performance Improvement ("QAPI") program, and compliance with the Quality Commitment Letter. The Independent Monitor shall furnish a written report of his or her assessment to OHCA and FLIS within thirty (30) days of the completion of each on-site review. PMH will have the opportunity to review and provide written responses to the report. As OHCA deems necessary, the Independent Monitor shall meet with OHCA and FLIS personnel to discuss the written report and will perform additional periodic reviews and reviews of other PMH affiliated sites of service. OHCA is imposing this condition to ensure continued access to health care services to the patient population and to verify and monitor compliance with the conditions set forth herein. *Legal and Factual Basis: Conn. Gen. §§ Stat. 19a-486(a), 19a-613(b), 19a-639(a)(1),(2),(4),(5),(6),(7),(11) & (12); FF 26-27, 30-45, 52-57, 59*	IM will plan, at a minimum, two site visits per year. The site visits will include meetings with Administration/Leadership. IM will verify compliance with the quality Assurance commitment Letter. IM will provide a written report to OHCA, and FLIS that summarizes the activities from the prior six month period along with any recommendations or observations

CON Condition 18: If, at any time within three (3) years following the Closing Date, the New Hospitals' Local Board agrees with PMH to change any of the Seller Quality Programs described in the Quality Commitment Letter other than to make any changes necessary to address (i) an immediate issue of patient safety; (ii) changes in federal, state, and local laws; or (iii) as mandated or recommended in guidance by a governmental agency, PMH shall notify OHCA and FLIS in writing within thirty (30) days of any such change going into effect. If the Independent Monitor disagrees with the change, OHCA may require that a request for modification be submitted and approved as required by C.G.S. §4-18la to make the change. OHCA is imposing this condition to ensure continued access to health care services to the patient population and to verify and monitor compliance with the conditions set forth herein. *Legal and Factual Basis: Stat. §§ 19a-486d, 19a-613(b), 19a-639(a)(1),(2),(5) & (6); FF 30-37*	IM will verify that PMH notifies OHCA and the Health Systems Branch in writing within 30 days of any change in the Seller Quality Programs with the exceptions i through iii as stated in condition 18.
CON Condition 19: For three (3) years following the Closing Date, PMH shall hold a joint meeting of the Board of each of new MMH and New RGH and the Local Board of new MMH and New RGH ("Joint Board Meetings") at least twice annually with one occurring in Manchester and the other occurring in Vernon. Such Joint Board Meetings shall be followed by a meeting to which the public is invited in advance and at which the public is informed of the New Hospital's activities and afforded an opportunity to ask questions and make comments. OHCA is imposing this condition to ensure continued access to health care services to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d, 19a-613(b), 19a-639(a)(2),(3),(5),(7),(8),(11) & (12); FF 28-30*	IM will assure that Joint Board Meetings occur twice annually followed by public meetings as required in Condition 19.
CON Condition 20: For three (3) years following the Closing Date, PMH shall allow for two (2) community representatives to serve as a voting member of the New MMH and New RGH Local Board with rights and obligations consistent with other voting members under the Local Board Bylaws. The community representative shall be selected in consultation with the Mayor of Manchester and Vernon in order to ensure the appointment of an unbiased person who will fairly represent the interests of the communities served by the MMH and RGJ. OHCA is imposing this condition to ensure continued access to health care services to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d, 19a-613(b), 19a-639(a)(2),(3),(5),(7),(8),(11) & (12); FF 28-30*	IM will verify the New MMH and New RGH include 2 community representatives that are voting members of the local boards.
CON Condition 21: PMH, New ECHN, New MMH and New RGH shall abide by all requirements of licensure that may be imposed by FLIS in any Pre-Licensing Consent Order or similar agreement that FLIS may enter with these parties. OHCA is imposing this condition to ensure that quality health care services	IM will verify that all requirements of licensure are met.

are provided to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d, 19a-490, 19a-493, 19a-639(a)(1),(2),(5) & (6); FF 30-37*	

Greer, Leslie

From: Mcconville, Dennis P <dmcconville@echn.org>
Sent: Thursday, January 12, 2017 4:13 PM
To: User, OHCA
Cc: Martone, Kim; Collen O'Brien Smith; Ellen J. Shin (ellen.shin@prospectmedical.com); Joyce A. Tichy Esq. (joyce.tichy@gmail.com) (joyce.tichy@gmail.com); Collins, Michael; Jonathan.Spees; Garrison DeLee (garrison.delee@prospectmedical.com); Frank.Saidara; Basile, Mary C
Subject: 15-32016-486-CON
Attachments: DN 15-32016-486 Condition 7 - Outpatient Blood Draw 01 12 17.pdf

The attached letter is submitted as required for condition number 7 contained in the Final Decision for Docket Number: 15-32016-486-CON, the Transfer of assets of Eastern Connecticut Health Network, Inc. to Prospect Medical Holdings.

Dennis P. McConville
Senior Vice President
Eastern Connecticut Health Network, Inc.
(860) 533-3429 (office)
dmcconville@echn.org

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ECHN℠
Eastern Connecticut Health Network

71 Haynes Street | Manchester, CT 06040
860.533.3414 | **echn.org**

January 12, 2017

Deputy Commissioner Janet M. Brancifort, MPH, RRT
Office of Health Care Access
Department of Public Health
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134

Via Email

Re: Docket Number: 15-32016-486

Project Title: Transfer of assets of Eastern Connecticut Health Network, Inc. to Prospect Medical Holdings, Inc.

Dear Ms. Brancifort:

This letter is submitted in accordance with the Order for the above referenced Certificate of Need Final Decision, specifically Condition Number Seven (7) regarding the transfer of assets of Eastern Connecticut Health Network, Inc. (ECHN) to Prospect Medical Holdings, Inc. (PMH).

Condition Number Seven (7) requires that "Until such time as the Services Plan is submitted, PMH shall provide OHCA with notice of any reallocation of inpatient beds and relocation of outpatient services for the New MMH or New RGH specific to those services that existed at each of the Hospitals as of the Decision Date. Such notice shall be provided within ten (10) days of any such reallocation or relocation and published on the website pages of the New Hospitals."

Prior to January 3, 2016 ECHN has operated two blood draw stations on Tamarack Avenue in South Windsor, one at 2800 Tamarack Avenue and the other at 2400 Tamarack Avenue. These two buildings are approximately 500 yards from each other in the same medical office complex and share a common drive.

As of January 3, 2017, the 2800 Tamarack Avenue blood draw station is being relocated to the one at 2400 Tamarack Avenue. The hours of operation have been expanded to accommodate the additional volume. The new hours are Monday through Friday, 7:00 AM to 12:30 PM and 1:30 PM to 4:00 PM and Saturday, 8:00 AM to 12:00 PM. There will be no reduction in workforce and no change in operations or services. There is no anticipated change in patient population or payor mix.

Per the Order, this information and the new hours of operation will be published on the ECHN website at www.echn.org.

If you have any questions or need anything further, please feel free to contact me at (860) 533-3429.

Very truly yours,

Dennis P. McConville
Senior Vice President
Eastern Connecticut Health Network

cc: Kimberly Martone, Director of Operations, Department of Public Health Division of Office of Health Care Access
Colleen Smith, Nursing Consulting Partners, LLC
Ellen J. Shin, General Counsel, Prospect Medical Holdings, Inc.
Joyce A. Tichy, Senior Vice President and General Counsel, ECHN
Michael Collins, Interim CEO, ECHN
Jonathan Spees, Senior Vice President, Corporate Development, Prospect Medical Holdings, Inc.
Garrison De Lee, Assistant General Counsel, Prospect Medical Holdings, Inc.

Olejarz, Barbara

From: Olejarz, Barbara
Sent: Wednesday, February 15, 2017 2:09 PM
To: Michael Collins
Subject: Compliance with Stipulation #20

Tracking:

Recipient	Delivery
Michael Collins	
Stan, Christopher	Delivered: 2/15/2017 2:09 PM
Martone, Kim	Delivered: 2/15/2017 2:09 PM
Roberts, Karen	
Karen.Roberts@ct.gov	Delivered: 2/15/2017 2:09 PM

2/15/17

Mr. Michael Collins
Interim Chief Executive Officer
Prospect ECHN, Inc.

Re: Compliance with Stipulation #20 of Certificate of Need under Docket #15-32016-486

Dear Mr. Collins:

It has been brought to the attention of the Office of Health Care Access (OHCA) that the Prospect ECHN Advisory Board (Local Board) may not have two community representatives which have been selected in consultation with the Mayors of Manchester and Vernon in order to "*ensure the appointment of two unbiased persons who will fairly represent the interests of the communities served by MMH and RGH, respectively.*" Please refer to the full wording of both Stipulations #19 and #20, below:

19 For three (3) years following the Closing Date, PMH shall hold a joint meeting of the Board of Directors of each of New MMH and New RGH and the Local Board of New MMH and New RGH ("Joint Board Meetings") at least twice annually with one occurring in Manchester and the other occurring in Vernon. Such Joint Board Meetings shall be followed by a meeting to which the public is invited in advance and at which the public is informed of the New Hospitals' activities and afforded an opportunity to ask questions and make comments. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d, 19a-613(b), 19a-639(a)(2),(3),(5),(7),(8),(11) & (12); FF 28-30*

20 For three (3) years following the Closing Date, PMH shall allow for two (2) community representatives to serve as voting members of the New MMH and New RGH Local Board with rights and obligations consistent with other voting members under the Local Board Bylaws. The community representatives shall be selected in consultation with the Mayors of Manchester and Vernon in order to ensure the appointment of two unbiased persons who will fairly represent the interests of the communities served by MMH and RGH, respectively. OHCA is imposing this Condition to ensure continued access to

health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d, 19a-613(b), 19a-639(a)(2),(3),(5),(7),(8),(11) & (12); FF 28-30*

OHCA requires an immediate update on the status of this Local Board, its structure and representation. Please provide a response to the questions below regarding this matter in order for OHCA to determine whether a compliance issue exists related to Stipulations #19 and #20.

1. Has the Local Board been selected and what was the selection process?
2. List the names and related information for each member of the Local Board.
3. What members are the two community representatives and how were they chosen?
4. Fully explain how the Mayors of Manchester and Vernon were consulted in the selection of these two community representatives.
5. Have any joint Board meetings been held as yet, per Stipulation #19? Have any Local Board meetings occurred at all since the transfer of ownership. If so, please submit the related meeting minutes.
6. If Prospect ECHN has rejected any candidates to be the community representatives, identify such candidates and explain why they were not selected.

Please provide a response to the above by end of day, Friday, February 17, 2017.

Kimberly R. Martone
Director of Operations, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134
Phone: 860-418-7029 Fax: 860-418-7053
Email: Kimberly.Martone@ct.gov Website: www.ct.gov/ohca



Olejarz, Barbara

From: Microsoft Outlook
To: Michael Collins
Sent: Wednesday, February 15, 2017 2:09 PM
Subject: Relayed: Compliance with Stipulation #20

Delivery to these recipients or groups is complete, but no delivery notification was sent by the destination server:

Michael Collins (mcollins@echn.org)

Subject: Compliance with Stipulation #20

Olejarz, Barbara

From: Macdonald, Barbara R <bjolly@echn.org>
Sent: Friday, February 17, 2017 4:17 PM
To: Martone, Kim
Cc: Olejarz, Barbara
Subject: Prospect ECHN, Inc. - Compliance with Stipulation #20 Response
Attachments: OHCA DPH Martone Kimberly 2-17-2017.pdf

Dear. Ms. Martone:

On behalf of Michael Collins, Interim CEO of Prospect ECHN, Inc. I am attaching the response letter to your Compliance with Stipulation #20 request of February 15, 2016. A hard copy of the letter will follow via U.S. Mail.

Regards,

Barbara Macdonald
Executive Secretary
Eastern Connecticut Health Network
bmacdonald@echn.org
860-647-4720

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Eastern Connecticut Health Network
71 Haynes Street
Manchester, CT 06040
860.533.3414
www.echn.org

VIA ELECTRONIC MAIL AND REGULAR MAIL

February 17, 2017

Kimberly R. Martone
Director of Operations, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134

Re: Compliance with Stipulation #20

Dear Ms. Martone:

I am in receipt of your email communication dated February 15, 2017 in which you requested certain information relating to Stipulation #20 of the Certificate of Need listed under Docket #15-32016-486. Below are the responses of Prospect ECHN to the questions set forth in that email.

1. **Has the Local Board been selected and what was the selection process?**

   Yes, the Local Board has been selected. The members of the Local Board were selected by Prospect ECHN in accordance with the requirements the Asset Purchase Agreement dated August 24, 2016 between ECHN as Seller and Prospect Medical Holdings as Buyer, which states as follows:

   > Local Board means the advisory board of each Hospital composed of community representatives, physicians on the respective Hospital's medical staff, and the Chief Executive Officer of each respective Hospital (for avoidance of doubt, each Hospital shall have its own Local Board). The initial members of the Local Board shall include at least five members of the Seller's Board of Trustees immediately prior to Closing and five other individuals identified by the Seller prior to Closing, two of whom shall be members of the community appointed in consultation with the mayor of the town in which the respective Hospital is located.

   Please note that the two Hospital Boards meet contemporaneously and have the same members, in recognition of the fact that Manchester Memorial Hospital and Rockville General Hospital function as an integrated system within Prospect ECHN.

Kimberly R. Martone
Office of Health Care Access
February 17, 2017

2. List the names and related information for each member of the Local Board.

The names and roles of the individuals on the Local Board are:

Name	Role
M. Maher Suede, MD	Medical Staff President, Former Seller Trustee
M. Saud Anwar, MD	Medical Staff Member
Michael Collins	Interim Chief Executive Officer
Mary Roche-Cronin	Community Member Recommended by Manchester Mayor
Molly C. Devanney	Community Member
Joy W. Dorin	Community Member, Former Seller Trustee
Eric L. Kloter	Community Member, Former Seller Trustee
Pamela Lewis, MD	Former Seller Trustee, Medical Staff Member
Saqib Naseer, MD	Medical Staff Vice-President (incoming President-designate)
Dennis G. O'Neill, MD	Medical Staff Member, Former Seller Trustee
Barbara Phillips, MD	Medical Staff Member, Former Seller Trustee
Irene Quong-Conlon	Community Member
Thomas M. Reardon	Prospect Representative
Vacant	Community Member -- Awaiting Vernon Mayor Recommendation

3. What members are the two community representatives and how were they chosen?

In accordance with the requirements of Stipulation #20, ECHN representatives and later Prospect ECHN representatives consulted with Town of Manchester Mayor Jay Moran and Town of Vernon Mayor Daniel Champagne to request their recommendations for individuals to serve as the community representatives for their respective towns.

Per Stipulation #20, the requirements for the position are "two unbiased persons who will fairly represent the interests of the communities served by MMH and RGH, respectively." In the case of Manchester, Mayor Moran recommended Ms. Mary Roche-Cronin, Director of Social Services for the Town of Manchester, for the Manchester community representative position. Because Ms. Roche-Cronin met the qualifications listed in Stipulation #20 Prospect ECHN accepted Mayor Moran's recommendation and selected Ms. Roche-Cronin for the Manchester community representative role.

In the case of Vernon, as of this date Prospect ECHN has not received a recommendation from Mayor Champagne of an "unbiased person" who will "fairly represent the interests of the communit[y] served by RGH". Mayor Champagne did make one recommendation, but Prospect ECHN advised him that the individual did meet the requirement of Stipulation #20 for an "unbiased person". No subsequent recommendation has been received from the Mayor of Vernon.

Kimberly R. Martone
Office of Health Care Access
February 17, 2017

4. Fully explain how the Mayors of Manchester and Vernon were consulted in the selection of these two community representatives.

ECHN representatives met in person with each of the Mayors, described the roles of the community members, discussed the composition of the Local Board, and solicited their recommendations. These communications occurred both before and after the transaction between ECHN and Prospect, which closed on October 1, 2016. ECHN met with Mayor Moran on July 7, 2016 and he recommended Ms. Roche-Cronin on July 25, 2016. ECHN met with Mayor Champagne on July 11, 2016, and Prospect ECHN met with him on October 12, 2016, November 3, 2016, and most recently on January 31, 2017.

5. Have any joint Board meetings been held as yet, per Stipulation #19? Have any Local Board meetings occurred at all since the transfer of ownership. If so, please submit the related meeting minutes.

Prospect ECHN had one informal introductory meeting with the Local Board members on October 10, 2016, followed by meetings on November 16, 2016, December 14, 2016 and January 25, 2017. Because the October 10, 2016 meeting was a "meet and greet" there are no minutes. The minutes for the November and December meetings are attached, with confidential information regarding ongoing strategic initiatives redacted. The minutes for the January meeting are not available as of the current date. Prospect ECHN has not yet conducted a joint Board meeting per Stipulation #19.

6. If Prospect ECHN has rejected any candidates to be the community representatives, identify such candidates and explain why they were not selected.

As indicated above, Prospect ECHN received and approved one recommended candidate for the Town of Manchester, and that person currently sits on the Local Board. Prospect ECHN received one recommendation from the Town of Vernon, which it rejected for the reasons indicated in the response to Question 3. That person's name is Ellen Marmer, MD. Prospect ECHN has asked for additional recommendations from the Mayor of the Town of Vernon on a number of occasions, but to date has not received any.

Thank you for your consideration of this submission.

Very truly yours,

Michael Collins
Interim CEO

Enclosures

PROSPECT MEDICAL HOLDINGS, INC.

ECHN

PROSPECT MANCHESTER HOSPITAL, INC.
PROSPECT ROCKVILLE HOSPITAL, INC.

ADVISORY BOARDSMEETING MINUTES

MEETING: **ADVISORY BOARD**
DATE: December 14, 2016 **LOCATION:** MMH CR A, B & C **CONVENED:** 7:30 a.m. **ADJOURNED:** 8:54 a.m.

TRUSTEES PRESENT: M. Maher, Suede, MD (Chairman); Michael Collins; M. Saud Anwar, MD; Irene Quong-Conlon; Mary Cronin; Mary (Molly) Devanney; Eric Kloter; Pamela Lewis, MD; Saqib Naseer, MD; Barbara. Phillips, MD;

MANAGEMENT PRESENT: Nina Kruse; Katherine Mon; Mary Powers; Linda Quirici; Joel Reich; Todd Rose; Joyce Tichy; Michael Veillette; Chantal Perigo (Recording Secretary)

NOT PRESENT: Joy Dorin; Dennis O'Neill, MD; Thomas Reardon

With a quorum present, Dr. Suede convened the meeting at 7:30 a.m. He thanked the members of the board his election as Chairman of the Advisory Board. He addressed the board about his commitment to the organization during a very exciting and crucial time. The primary goal is to continue to improve patient safety, patient outcomes and the overall patient experience in order to remain strong and competitive as well as improve the perception of Prospect ECHN in the community.

1. **Safety Moment**

DISCUSSION: Ms. Quirici stated that the quality goals for 2017 are in the final stages of the approval process. She shared the results of the 2016 quality goals. The Serious Safety Event Rate (SSER) ended at zero for RGH and has maintained a zero rating into FY2017. Falls with serious injuries ended at zero for both hospitals. Catheter-associated Urinary Tract Infection (CAUTI) rate remains at zero at both hospitals. There has been significant drop in surgical site infections (SSI) at both hospitals during the month of October and November 2016 from FY2015 and FY2016. She noted that for October 2015 the SSI rate was 9 versus 3 for October 2016. November 2015 SSI rate was 10 versus 1 for October 2016. The CAUTI program is in place and continued improvements are anticipated.

2. **Approval of Minutes of November 16, 2016**

DISCUSSION: The members of the Board reviewed the minutes of November 16, 2016. A motion was made and seconded.

ACTION: **VOTED to approve the minutes of November 16, 2016 as presented.**

3. **Proposed Bylaw Amendment Discussion**

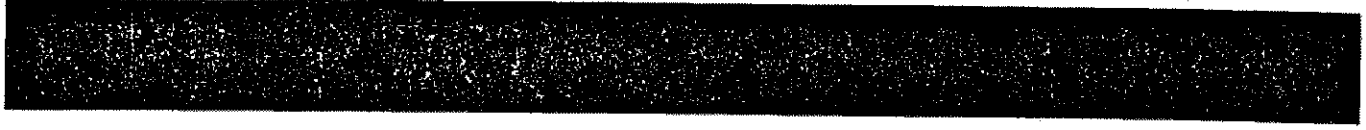
DISCUSSION: The role of the Advisory Board remains in a development phase. Prospect is evaluating the governance processes for its Advisory Boards to determine if common practices can be implemented consistent with regulatory requirements such as those of The Joint Commission (TJC). The Advisory Boards generally advise upon matters that affect the community, including medical staff appointments and quality initiatives. The Prospect ECHN Advisory Board's scope may be expanded to include Prospect ECHN Eldercare Services, Inc. and Prospect ECHN Home Health, Inc., potentially to include review and approval of the Woodlake at Tolland (WAT) medical staff credentials as well as quality oversight for both WAT and the Visiting Nurse and Health Services of CT. In the interim the WAT credentials will be sent directly to the parent board for approval.

4. **Medical Executive Committee Minutes and Approval of Medical Staff Credentials**

DISCUSSION: The Medical Executive Committee minutes of November 8, 2016 were included in the packet for informational purposes. Dr. Suede announced the approval of a nurse driven protocol related to the catheter removal processes. The new protocol allows the nurse to determine patient qualification for catheter removal without physician orders. An update on secure texting and emailing patient health information (PHI) was provided at the MEC meeting. A new feature "patient status order notification" will be added to the Care Thread rollout. A workgroup has been established to update personalized order sets on Meditech.

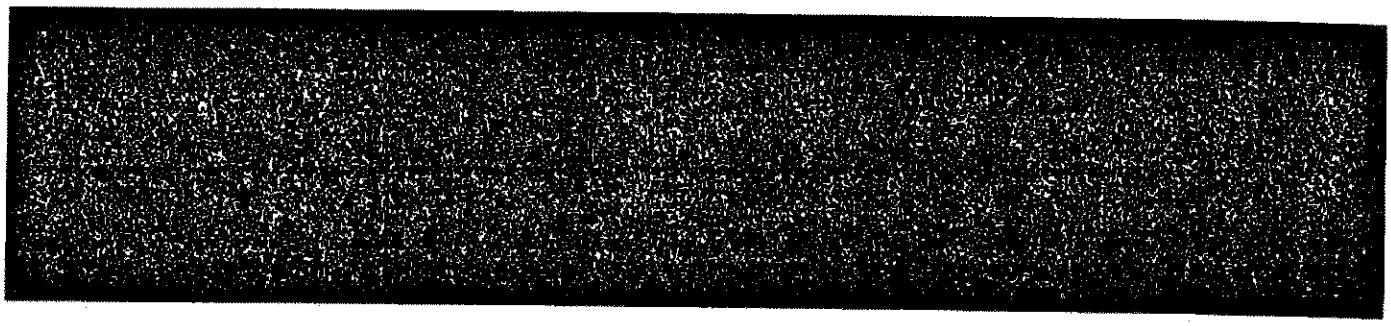
There were no Medical Staff Credentials presented for approval.

6. **Chief Executive Officer's Report**



Ms. Kruse provided an overview of the Marketing and Communications Strategy for 2017 for the following program categories:

Service line marketing; ECHN brand development; digital, radio and Pandora advertisements, community education programs and promotions; employee and medical staff communications and community outreach liaison program. The outreach liaison program is a model developed by Prospect that will be an extension of the Marketing Department. Two individuals will be developing relationships with skilled nursing facilities, assisted living, and community providers to ensure patients experience a smooth transition to acute care hospitals and ultimately enhance the referral base.



In 2017 the marketing team will focus its efforts on website functionality, imagery and calls to action; digital media placement; identifying synergies with Waterbury Hospital; local non-profit and chamber support, service line and brand printed collateral; print advertising for community health education programs; community relations and coffee connections programs; media relations; and community outreach liaisons to enhance the promotion of our services across the ECHN network. Discussion followed regarding goals, advertising resources and referral strategies to help increase market share.

A question arose regarding the status of the new community charitable foundation and partnering opportunities. Ms. Kruse reported that the members have been identified and that a meeting is planned for some time in mid-January 2017, at which time the group will begin the organizational processes. The ECHN Community HealthCare Foundation continues to operate under the oversight of the Legacy ECHN Board of Trustees. Once the new foundation has been established the moneys allocated to the new entity will be transferred. It was noted that ECHN cannot be a beneficiary of fund distributions from the new entity. It was also noted that ECHN could coordinate events to contribute to the new foundation.

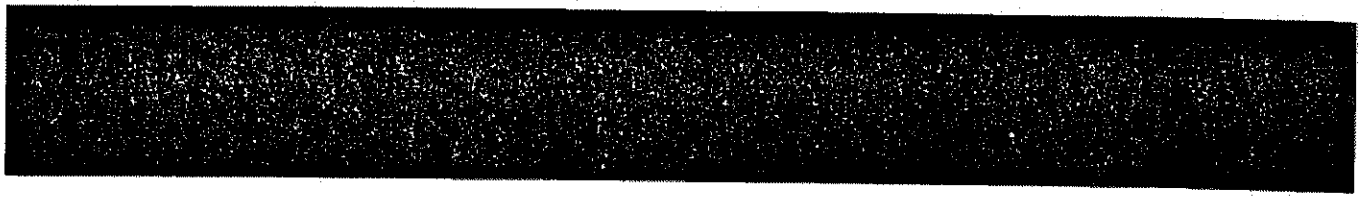
7. Quality Report

a. Quality Assurance & Performance Improvement (QAPI) FY2017 Plans/FY2017 Goals

DISCUSSION: The FY2017 Quality Assurance & Performance Improvement Plans and Goals have been completed. These items were approved by the QAPIC and will be presented to the MEC for approval on January 10, 2017. Final approval will be sought by the Advisory Boards at its next meeting on January 25, 2017.

Ms. Quirici highlighted some of the performances through August 2016 for both MMH and RGH related to patient experience (HCAHPS); Medicare spend per beneficiary; patient safety indicators (PSI) – 90; surgical site infections; central line associated blood stream infection (CLABSI); Clostridium Difficile (C-Diff); Readmissions; Timeliness of Care; falls with serious injury; influenza immunization; serious safety event rate; and stroke measures. These measures were selected to enhance patient care and are monitored by regulatory agencies for reimbursement purposes. Programs are in place to provide staff education and certification related to patient experience. A Sepsis program will go live in January 2017.

ECHN is focused on improving the patient and care giver centered experience star rating by at least 1 star for 2017. This includes improvements in HCAHPS related to communications with nurses and communications with doctors. MMH is currently at a 2 star rating, while RGH is at a 3 star rating. RGH is above achievement thresholds for communication with nurses; Medicare-spend per beneficiary. MMH is positive to achievement thresholds for PSI-90 and C-Diff. Ms. Quirici noted that although abdominal hysterectomy site infections are above thresholds, there has been considerable improvement, with 1 incident through August 2016 versus 6 incidents last year at this time. She also noted that there have been no falls with serious injuries at either hospital. There are 11 stroke measures being monitors of which 8 of 11 are at 100% for MMH and 9 of 11 are at 100% for RGH which is ahead of benchmarks at 90%. A question arose regarding employee satisfaction, which has a strong impact on patient experience. A new survey is planned for some time in late February/early March 2017. A question and answer period followed. The Board has requested a report identifying occurrences of unsafe staffing levels. Ms. Powers provided an overview of the unsafe staffing reporting mechanism that is currently in place and the standard plan of action. A per diem float pool initiative is underway to help address staffing shortages. A certified nursing assistant float pool has also been implemented. Flex positions are being reevaluated and adjusted to address staffing concerns. A staffing plan must be reported to the State of Connecticut on an annual basis to include an action plan for staffing needs.



[redacted]

9. Next Meeting/Adjourment

DISCUSSION: Mr. Collins thanked the members of the board for attending. He noted that the Advisory Board members are advocates for the communities that ECHN services and encouraged them to contact himself or any member of senior leadership any questions or concerns. He wished everyone Happy Holidays.

The next meeting of the Prospect MMH/RGH Board of Directors is scheduled for Wednesday, January 25, 2017 at 7:30 a.m. in the MMH CR A, B & C.

The meeting was adjourned.

Respectfully submitted,

Chantal M. Perigo
Recording Secretary

Irene Quong Conlon
Board Secretary

PROSPECT MEDICAL HOLDINGS, INC.

ECHN

PROSPECT MANCHESTER HOSPITAL, INC.
PROSPECT ROCKVILLE HOSPITAL, INC.

ADVISORY BOARDSMEETING MINUTES

MEETING: **ANNUAL MEETING OF THE ADVISORY BOARD**
DATE: November 16, 2016 **LOCATION:** MMH CR A, B & C **CONVENED:** 7:30 a.m. **ADJOURNED:** 9:09 a.m.

TRUSTEES PRESENT: Michael Collins (Interim CEO); M. Saud Anwar, MD; Irene Quong-Conlon; Mary Cronin; Mary (Molly) Devanney (T); Joy Dorin; Eric Kloter; Pamela Lewis, MD; Saqib Naseer, MD; Dennis O'Neill, MD; , Barbara. Phillips, MD; David Topper

MANAGEMENT PRESENT: Dennis McConville; Mary Powers; Linda Quirici; Joel Reich; Joyce Tichy; Michael Veillette; Chantal Perigo (Recording Secretary)

NOT PRESENT: M. Maher, Suede, MD

GUEST: Deborah Berry, Chief Quality Officer, Prospect Medical Holdings (Prospect)
Garrison De Lee, Corporate Counsel, Prospect (T)
Thomas Reardon, President Prospect Medical Holdings East

With a quorum present, Mr. Collins serving as interim Chairman in lieu of elections convened the meeting at 7:33 a.m. He welcomed Ms. Berry and Messrs. De Lee, Reardon and Topper to the meeting. Formal introductions followed.

1. Proposed Amendment to Bylaws

DISCUSSION: Mr. Topper stated that he is excited about the opportunity to work with ECHN and is looking forward to a long relationship. Due to logistical challenges, including potential travel delays and time zone differences he will step down from his role on the Advisory Board and advised that Thomas Reardon would take his place as a Prospect representative. Mr. Topper expressed the hope that he would remain engaged with the Advisory Board by participating in its meetings as a guest from time to time. He was encouraged to do so to as an excellent means of maintaining ties between the local Prospect ECHN community and Prospect's leadership. A motion was made and seconded.

ACTION: **VOTED to acknowledge the resignation of David Topper as Prospect Representative on the joint Prospect Manchester Hospital and Prospect Rockville Hospital Advisory Boards, and to acknowledge the election of Thomas M. Reardon as Prospect Representative as ex-officio member with vote.**

Amendments to the Prospect Manchester Hospital and Prospect Rockville Hospital Advisory Board Bylaws were presented for approval and recommendation to the Prospect Manchester Hospital, Inc. and Prospect Rockville Hospital, Inc. Boards of Directors. The purpose of such amendments is to revise the composition of the Advisory Board so as to include the President of the Medical Staff as a standing member. It was noted that this Advisory Board Bylaws change would reinforce Prospect's strong commitment to physician participation in the work of the Advisory Board. A motion was made and seconded.

ACTION: **VOTED to approve the amendments to Section 2/Composition of the Prospect Manchester Hospital and Prospect Rockville Hospital Advisory Board Bylaws to change the composition of the Advisory Boards for these entities to include the President of the Medical Staff, and to recommend approval of same by the Prospect Manchester Hospital, Inc. and Prospect Rockville Hospital, Inc. Boards of Directors.**

Additional amendments are being considered to the Advisory Board Bylaws in order to include Prospect ECHN ElderCare Services, Inc. d/b/a Woodlake at Tolland Rehabilitation and Nursing Center (WAT) as an additional entity under Advisory Board oversight, which would allow for Advisory Board review and approval of the Woodlake at Tolland Medical Staff Appointments and quality matters. This change is under review from a corporate governance perspective. It was noted that the Advisory Board is fortunate to have Mr. Kloter as a member of the Advisory Board, as he has been a champion for post- acute care services. A brief discussion followed regarding staff participation from WAT and Prospect ECHN Home Health, Inc. d/b/a Visiting Nurse and Health Services of Connecticut, Inc. as both of these entities are involved in quality initiatives. This proposal will be presented to the incoming Board Chairman for consideration.

2. Board Questionnaire/Non-Disclosure, Code of Conduct and Confidentiality Statement

DISCUSSION: The Board Questionnaire/Non-Disclosure, Code of Conduct and the Confidentiality Statement were included in the meeting packets for completion. Members of the Advisory Board were asked to forward the completed forms to Ms. Perigo, and to direct questions Ms. Tichy or Ms. Perigo. Suggested corrections will be made to the form. A revised document will be sent to Advisory Board members.

3. Nomination and Vote of Officers and Terms

DISCUSSION: The floor was opened for nominations for the election of Advisory Board officers. M. Maher Suede, MD was nominated as Chairman. Nominations were closed and members of the Advisory Board were invited to ask questions or share comments. A motion was made and seconded.

ACTION: **VOTED unanimously to elect M. Maher Suede, MD as Chairman of the Prospect Manchester Hospital Advisory Board and the Prospect Rockville Hospital Advisory Board for a 1-year term to expire in November 2017.**

The floor was open for nominations of Vice Chairman. Eric L. Kloter was nominated to serve as Vice Chairman. Nominations were closed and members of the Advisory Board were invited to ask questions and share comments. A motion was made and seconded.

ACTION: **VOTED unanimously to elect Eric L. Kloter, as Vice Chairman of the Prospect Manchester Hospital Advisory Board and the Prospect Rockville Hospital Advisory Board for a 1-year term to expire in November 2017.**

The floor was open for the nominations of Secretary. Irene Quong Conlon was nominated to serve as Board Secretary. Nominations were closed and members of the Advisory Board were invited to ask questions and share comments. A motion was made and seconded.

ACTION: **VOTED unanimously to elect Irene Quong Conlon as Secretary of the Prospect Manchester Hospital Advisory Board and the Prospect Rockville Hospital Advisory Board for a 1-year term to expire in November 2017.**

Discussion followed regarding setting the Advisory Board member terms in accordance with Section 5 of the Local Advisory Board portion of the Prospect Manchester Hospital and the Prospect Rockville Hospital Bylaws. Mr. Collins read the list of terms attached as Exhibit A, which reflected prior discussions with each member regarding their desired length of term. It was noted that all are eligible for re-election at the conclusion of their initial term. Terms are effective as of the date of the Annual Meeting duly held on November 16, 2016. A question and answer period followed.

4. Review of Board Responsibilities

DISCUSSION: The Local Advisory Boards are responsible for quality, medical staff credentialing and capital expenditure oversight. Appointments, reappointments and status changes of the Manchester and Rockville hospitals medical staff will be presented to the board for review in approval and will include an application checklist of the new physician. The completed files for each candidate are available for Board member review in the Office of Medical Affairs. Board members are also encouraged to make inquiries about the candidates at meetings or by contacting Dr. Reich or Mr. Collins. Capital Expenditures will be reviewed monthly.

5. Medical Executive Committee Minutes and Approval of Medical Staff Credentials

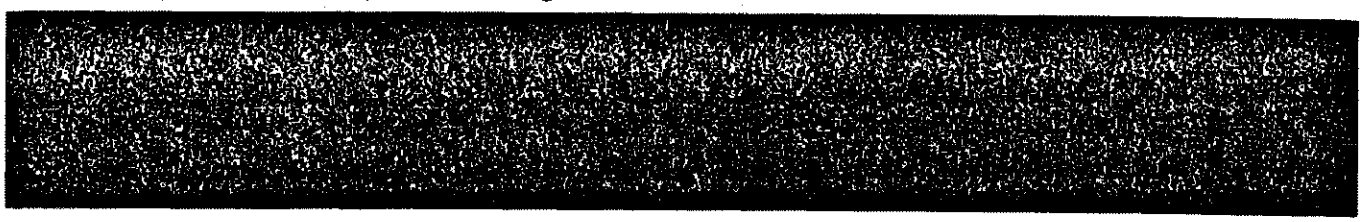
DISCUSSION: The Medical Executive Committee minutes of October 11, 2016 were included in the packet for informational purposes. The Board of Directors were provided an overview of the Medical Staff and Allied Health Professional Staff Credentialing process utilized to ensure qualified candidates meet hospital requirements and all regulatory and accreditation requirements set forth by the State of Connecticut Department of Public Health (DPH), the Centers for Medicare and Medicaid Services (CMS), the Joint Commission (TJC) and the Accreditation Council for Graduate Medical Education/American Osteopathic Association (ACGME/AOA). Once applications have been approved by the service chief and/or department chair; a three step approval process is conducted by the Credentials Committee, the MEC and finally by the governing board. A member of the Advisory Boards would serve on the Credentials Committee and have an integral part of the review process. A summary of the verification and post-verification process was provided and included a sample of the Medical Staff Membership and Privileges Application Checklists for various purposes.

Members of the Board reviewed the recommendations for Medical Staff appointments, status changes and completion of review periods approved by the Credentials Committee on November 1, 2016 and the Medical Executive Committee (MEC) on November 8, 2016. A brief discussion followed regarding the approval process. Once the credentials have been approved by the Advisory Boards they will be forwarded to the Prospect fiduciary boards for final approval by virtue of unanimous consent. Timing of the approval process is a key factor as not all candidates qualify for temporary privileges. Approvals should be completed by the last day of the current month in order to meet regulatory requirements. Copies of the signed unanimous consents from Prospect will be kept in the Advisory Boards meeting binder for permanent record. A motion was made and seconded.

ACTION: **VOTED unanimously to approve the recommendations for Medical Staff appointments, status changes and completion of review periods approved by the Credentials Committee on November 1, 2016 and the Medical Executive Committee (MEC) on November 8, 2016 as presented and recommend approval by the Prospect Manchester Hospital and Prospect Rockville Board of Directors.**

6. **Chief Executive Officer's Report**

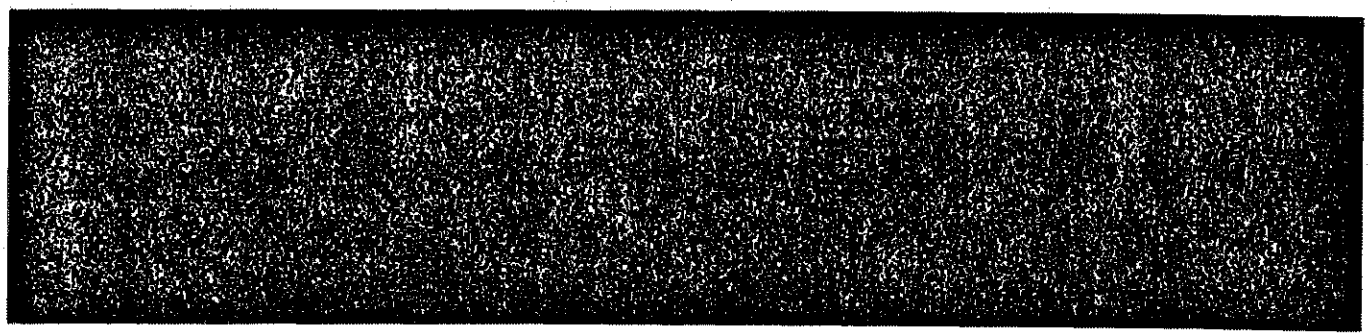
DISCUSSION: Mr. Collins stated that ECHN has been a community based health system for some time and he encouraged removal of the preference of individual identifiers (i.e. Rockville, Manchester, VNHSC etc.) in lieu of ECHN. He recently shared his observations at Employee Forums held in mid-October through early November 2016 and expressed his desire for employees to embrace a "TEAM" view of the system as a whole, rather than individual counterparts. No counterpart within the system would be successful without the others. Employee Forums throughout the system were relatively positive. Reporting mechanisms are being re-evaluated to ensure that issues across the system are being addressed by the appropriate senior leadership member. For example, nursing issues at any of the ECHN facilities would be handled by the Chief Nursing Officer.



A question arose regarding outreach to physicians for patient referrals and an outreach to the patient population. A concierge program, which has been very successful in California, is underway. An overview of the concierge roles and responsibilities to include community outreach was provided. A candidate has been identified and will begin employment in two weeks. The individual will be introduced to the Medical Staff at its next meeting on December 13, 2016. A second concierge position will be filled in the subsequent weeks. A marketing strategy is under development to include advertising of community events in the local media, ECHN's website as well as digital and radio advertising. The Better Being publication is mailed to over 155,000 homes bi-annually and is a vehicle for announcing the community health education programs. It was noted that the best form of advertising is the patient experience. The Vice President of Corporate Communications & Public Affairs provide an update at the next meeting. A question and answer period followed.

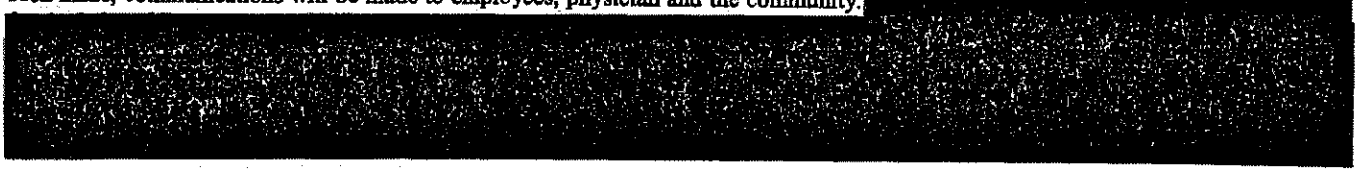
7. **Annual Performance Improvement Plans**

DISCUSSION: The FY2017 Plans (Performance Improvement, Patient Experience, Patient Safety and Risk Management) and the FY2017 Quality Assurance & Performance Improvement (QAPI) Goals have been completed. These items have been submitted to QAPIC for review and approval. The FY2017 plans and FY2017 goals will then be presented to the MEC for approval. Final approval will be sought by the Advisory Boards at its next meeting on December 14, 2016. A Patient/Family Council, endorsed by the Connecticut Hospital Association (CHA), is being developed that will enhance the patient experience process and improve upon quality and safety.



9. **Capital Review**

DISCUSSION: Clinical leaders have been diligently reviewing, evaluating and prioritizing capital requests that have been submitted over the past several years. A list of priority items was provided by category which include: investments to address compliance with regulations for licensure and accreditation; those that provide a return on investment or preservation of revenue; investments that impact patient, physician and/or employee satisfaction ("Splash" capital); and items that are at the end of their useful life. Regulatory licensure inspections were conducted by the CT Department of Public Health at Manchester Hospital, Rockville Hospital, Woodlake at Tolland, 460 Tolland Turnpike and 150 North Main as required for the transaction. Plans of correction were submitted to DPH as a result of the inspections which commit ECHN to engage consultants to conduct studies of building conditions, i.e. heating and ventilation systems, electrical systems, roofs, furnishings and finishes. From those studies, ECHN will need to submit additional plans to DPH that identify work to correct deficiencies. While those plans are being produced, requests for initial "splash" capital investments will be submitted with input from physicians for items that address technology and equipment needed for their specialties. Once splash capital investments have been made, communications will be made to employees, physician and the community.



Mr. Reardon left the meeting at 8:51 a.m.

10. Next Meeting/Adjournment

DISCUSSION: The next meeting of the Prospect MMH/RGH Board of Directors is scheduled for Wednesday, December 14, 2016 at 7:30 a.m. in the MMH CR A, B & C. The calendar of meetings for 2017 was included in the packet for informational purposes. These dates have been posted on the BoardEffect Portal.

Dr. O'Neill stated that it has been approximately 6 ½ weeks since the closing of the transaction and although Mr. Collins had been onsite as Chief Integration Officer, his position as Interim CEO was abrupt due to the precipitous departure of the former CEO. Feedback from the medical staff, hospital staff and the senior management team has been very positive. He commended Mr. Collins for the work his is doing and the current state of the organization.

The meeting was adjourned.

Respectfully submitted,

Chantal M. Perigo
Recording Secretary

Irene Quong Cenlon
Board Secretary

Tichy, Joyce A

From:	Mcconville, Dennis P
Sent:	Friday, February 17, 2017 6:22 PM
To:	Kimberly Martone (Kimberly.Martone@ct.gov)
Cc:	Olejarz, Barbara
Subject:	Prospect ECHN, Inc. - Compliance with Stipulation #20 Response
Attachments:	OHCA DPH Martone Kimberly 2-17-2017 CORRECTED.pdf
Importance:	High

Dear Kim:

After Ms. MacDonald emailed to you at 4:17 pm today the letter from Michael Collins, Interim CEO, that you requested regarding Stipulation #20, we discovered a typographical error that requires correction. Please disregard that letter and replace it with the correct letter that I have attached.

We will also be sending a hard copy of the correct letter to you via regular mail, to replace the incorrect version that we placed in the mail earlier today.

Regards,

Dennis

Dennis P. McConville
Senior Vice President, Chief Strategy Officer
Eastern Connecticut Health Network, Inc.
(860) 533-3429 (office)
(860) 268-4591 (cell)
dmcconville@echn.org

ECHN
Eastern Connecticut Health Network

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ECHN
Eastern Connecticut Health Network

Eastern Connecticut Health Network
71 Haynes Street
Manchester, CT 06040
860.533.3414
www.echn.org

VIA ELECTRONIC MAIL AND REGULAR MAIL

February 17, 2017

Kimberly R. Martone
Director of Operations, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134

Re: Compliance with Stipulation #20

Dear Ms. Martone:

I am in receipt of your email communication dated February 15, 2017 in which you requested certain information relating to Stipulation #20 of the Certificate of Need listed under Docket #15-32016-486. Below are the responses of Prospect ECHN to the questions set forth in that email.

1. **Has the Local Board been selected and what was the selection process?**

   Yes, the Local Board has been selected. The members of the Local Board were selected by Prospect ECHN in accordance with the requirements the Asset Purchase Agreement dated August 24, 2016 between ECHN as Seller and Prospect Medical Holdings as Buyer, which states as follows:

   > Local Board means the advisory board of each Hospital composed of community representatives, physicians on the respective Hospital's medical staff, and the Chief Executive Officer of each respective Hospital (for avoidance of doubt, each Hospital shall have its own Local Board). The initial members of the Local Board shall include at least five members of the Seller's Board of Trustees immediately prior to Closing and five other individuals identified by the Seller prior to Closing, two of whom shall be members of the community appointed in consultation with the mayor of the town in which the respective Hospital is located.

   Please note that the two Hospital Boards meet contemporaneously and have the same members, in recognition of the fact that Manchester Memorial Hospital and Rockville General Hospital function as an integrated system within Prospect ECHN.

Kimberly R. Martone
Office of Health Care Access
February 17, 2017

2. List the names and related information for each member of the Local Board.

The names and roles of the individuals on the Local Board are:

Name	Role
M. Maher Suede, MD	Medical Staff President, Former Seller Trustee
M. Saud Anwar, MD	Medical Staff Member
Michael Collins	Interim Chief Executive Officer
Mary Roche-Cronin	Community Member Recommended by Manchester Mayor
Molly C. Devanney	Community Member
Joy W. Dorin	Community Member, Former Seller Trustee
Eric L. Kloter	Community Member, Former Seller Trustee
Pamela Lewis, MD	Former Seller Trustee, Medical Staff Member
Saqib Naseer, MD	Medical Staff Vice-President (incoming President-designate)
Dennis G. O'Neill, MD	Medical Staff Member, Former Seller Trustee
Barbara Phillips, MD	Medical Staff Member, Former Seller Trustee
Irene Quong-Conlon	Community Member
Thomas M. Reardon	Prospect Representative
Vacant	Community Member -- Awaiting Vernon Mayor Recommendation

3. What members are the two community representatives and how were they chosen?

In accordance with the requirements of Stipulation #20, ECHN representatives and later Prospect ECHN representatives consulted with Town of Manchester Mayor Jay Moran and Town of Vernon Mayor Daniel Champagne to request their recommendations for individuals to serve as the community representatives for their respective towns.

Per Stipulation #20, the requirements for the position are "two unbiased persons who will fairly represent the interests of the communities served by MMH and RGH, respectively." In the case of Manchester, Mayor Moran recommended Ms. Mary Roche-Cronin, Director of Social Services for the Town of Manchester, for the Manchester community representative position. Because Ms. Roche-Cronin met the qualifications listed in Stipulation #20 Prospect ECHN accepted Mayor Moran's recommendation and selected Ms. Roche-Cronin for the Manchester community representative role.

In the case of Vernon, as of this date Prospect ECHN has not received a recommendation from Mayor Champagne of an "unbiased person" who will "fairly represent the interests of the communit[y] served by RGH". Mayor Champagne did make one recommendation, but Prospect ECHN advised him that the individual did not meet the requirement of Stipulation #20 for an "unbiased person". No subsequent recommendation has been received from the Mayor of Vernon.

Kimberly R. Martone
Office of Health Care Access
February 17, 2017

4. Fully explain how the Mayors of Manchester and Vernon were consulted in the selection of these two community representatives.

ECHN representatives met in person with each of the Mayors, described the roles of the community members, discussed the composition of the Local Board, and solicited their recommendations. These communications occurred both before and after the transaction between ECHN and Prospect, which closed on October 1, 2016. ECHN met with Mayor Moran on July 7, 2016 and he recommended Ms. Roche-Cronin on July 25, 2016. ECHN met with Mayor Champagne on July 11, 2016, and Prospect ECHN met with him on October 12, 2016, November 3, 2016, and most recently on January 31, 2017.

5. Have any joint Board meetings been held as yet, per Stipulation #19? Have any Local Board meetings occurred at all since the transfer of ownership. If so, please submit the related meeting minutes.

Prospect ECHN had one informal introductory meeting with the Local Board members on October 10, 2016, followed by meetings on November 16, 2016, December 14, 2016 and January 25, 2017. Because the October 10, 2016 meeting was a "meet and greet" there are no minutes. The minutes for the November and December meetings are attached, with confidential information regarding ongoing strategic initiatives redacted. The minutes for the January meeting are not available as of the current date. Prospect ECHN has not yet conducted a joint Board meeting per Stipulation #19.

6. If Prospect ECHN has rejected any candidates to be the community representatives, identify such candidates and explain why they were not selected.

As indicated above, Prospect ECHN received and approved one recommended candidate for the Town of Manchester, and that person currently sits on the Local Board. Prospect ECHN received one recommendation from the Town of Vernon, which it rejected for the reasons indicated in the response to Question 3. That person's name is Ellen Marmer, MD. Prospect ECHN has asked for additional recommendations from the Mayor of the Town of Vernon on a number of occasions, but to date has not received any.

Thank you for your consideration of this submission.

Very truly yours,

Michael Collins
Interim CEO

Enclosures

PROSPECT MEDICAL HOLDINGS, INC.

ECHN

PROSPECT MANCHESTER HOSPITAL, INC.
PROSPECT ROCKVILLE HOSPITAL, INC.

ADVISORY BOARDSMEETING MINUTES

MEETING: ANNUAL MEETING OF THE ADVISORY BOARD
DATE: November 16, 2016 **LOCATION:** MMH CR A, B & C **CONVENED:** 7:30 a.m. **ADJOURNED:** 9:09 a.m.

TRUSTEES PRESENT: Michael Collins (Interim CEO); M. Saud Anwar, MD; Irene Quong-Conlon; Mary Cronin; Mary (Molly) Devanney (T); Joy Dorin; Eric Kloter; Pamela Lewis, MD; Saqib Naseer, MD; Dennis O'Neill, MD; , Barbara. Phillips, MD; David Topper

MANAGEMENT PRESENT: Dennis McConville; Mary Powers; Linda Quirici; Joel Reich; Joyce Tichy; Michael Veillette; Chantal Perigo (Recording Secretary)

NOT PRESENT: M. Maher, Suede, MD

GUEST: Deborah Berry, Chief Quality Officer, Prospect Medical Holdings (Prospect)
Garrison De Lee, Corporate Counsel, Prospect (T)
Thomas Reardon, President Prospect Medical Holdings East

With a quorum present, Mr. Collins serving as interim Chairman in lieu of elections convened the meeting at 7:33 a.m. He welcomed Ms. Berry and Messrs. De Lee, Reardon and Topper to the meeting. Formal introductions followed.

1. **Proposed Amendment to Bylaws**

DISCUSSION: Mr. Topper stated that he is excited about the opportunity to work with ECHN and is looking forward to a long relationship. Due to logistical challenges, including potential travel delays and time zone differences he will step down from his role on the Advisory Board and advised that Thomas Reardon would take his place as a Prospect representative. Mr. Topper expressed the hope that he would remain engaged with the Advisory Board by participating in its meetings as a guest from time to time. He was encouraged to do so to as an excellent means of maintaining ties between the local Prospect ECHN community and Prospect's leadership. A motion was made and seconded.

ACTION: **VOTED to acknowledge the resignation of David Topper as Prospect Representative on the joint Prospect Manchester Hospital and Prospect Rockville Hospital Advisory Boards, and to acknowledge the election of Thomas M. Reardon as Prospect Representative as ex-officio member with vote.**

Amendments to the Prospect Manchester Hospital and Prospect Rockville Hospital Advisory Board Bylaws were presented for approval and recommendation to the Prospect Manchester Hospital, Inc. and Prospect Rockville Hospital, Inc. Boards of Directors. The purpose of such amendments is to revise the composition of the Advisory Board so as to include the President of the Medical Staff as a standing member. It was noted that this Advisory Board Bylaws change would reinforce Prospect's strong commitment to physician participation in the work of the Advisory Board. A motion was made and seconded.

ACTION: **VOTED to approve the amendments to Section 2/Composition of the Prospect Manchester Hospital and Prospect Rockville Hospital Advisory Board Bylaws to change the composition of the Advisory Boards for these entities to include the President of the Medical Staff, and to recommend approval of same by the Prospect Manchester Hospital, Inc. and Prospect Rockville Hospital, Inc. Boards of Directors.**

Additional amendments are being considered to the Advisory Board Bylaws in order to include Prospect ECHN ElderCare Services, Inc. d/b/a Woodlake at Tolland Rehabilitation and Nursing Center (WAT) as an additional entity under Advisory Board oversight, which would allow for Advisory Board review and approval of the Woodlake at Tolland Medical Staff Appointments and quality matters. This change is under review from a corporate governance perspective. It was noted that the Advisory Board is fortunate to have Mr. Kloter as a member of the Advisory Board, as he has been a champion for post- acute care services. A brief discussion followed regarding staff participation from WAT and Prospect ECHN Home Health, Inc. d/b/a Visiting Nurse and Health Services of Connecticut, Inc. as both of these entities are involved in quality initiatives. This proposal will be presented to the incoming Board Chairman for consideration.

2. **Board Questionnaire/Non-Disclosure, Code of Conduct and Confidentiality Statement**

DISCUSSION: The Board Questionnaire/Non-Disclosure, Code of Conduct and the Confidentiality Statement were included in the meeting packets for completion. Members of the Advisory Board were asked to forward the completed forms to Ms. Perigo, and to direct questions Ms. Tichy or Ms. Perigo. Suggested corrections will be made to the form. A revised document will be sent to Advisory Board members.

3. **Nomination and Vote of Officers and Terms**

DISCUSSION: The floor was opened for nominations for the election of Advisory Board officers. M. Maher Suede, MD was nominated as Chairman. Nominations were closed and members of the Advisory Board were invited to ask questions or share comments. A motion was made and seconded.

ACTION: **VOTED unanimously to elect M. Maher Suede, MD as Chairman of the Prospect Manchester Hospital Advisory Board and the Prospect Rockville Hospital Advisory Board for a 1-year term to expire in November 2017.**

The floor was open for nominations of Vice Chairman. Eric L. Kloter was nominated to serve as Vice Chairman. Nominations were closed and members of the Advisory Board were invited to ask questions and share comments. A motion was made and seconded.

ACTION: **VOTED unanimously to elect Eric L. Kloter, as Vice Chairman of the Prospect Manchester Hospital Advisory Board and the Prospect Rockville Hospital Advisory Board for a 1-year term to expire in November 2017.**

The floor was open for the nominations of Secretary. Irene Quong Conlon was nominated to serve as Board Secretary. Nominations were closed and members of the Advisory Board were invited to ask questions and share comments. A motion was made and seconded.

ACTION: **VOTED unanimously to elect Irene Quong Conlon as Secretary of the Prospect Manchester Hospital Advisory Board and the Prospect Rockville Hospital Advisory Board for a 1-year term to expire in November 2017.**

Discussion followed regarding setting the Advisory Board member terms in accordance with Section 5 of the Local Advisory Board portion of the Prospect Manchester Hospital and the Prospect Rockville Hospital Bylaws. Mr. Collins read the list of terms attached as Exhibit A, which reflected prior discussions with each member regarding their desired length of term. It was noted that all are eligible for re-election at the conclusion of their initial term. Terms are effective as of the date of the Annual Meeting duly held on November 16, 2016. A question and answer period followed.

4. **Review of Board Responsibilities**

DISCUSSION: The Local Advisory Boards are responsible for quality, medical staff credentialing and capital expenditure oversight. Appointments, reappointments and status changes of the Manchester and Rockville hospitals medical staff will be presented to the board for review in approval and will include an application checklist of the new physician. The completed files for each candidate are available for Board member review in the Office of Medical Affairs. Board members are also encouraged to make inquiries about the candidates at meetings or by contacting Dr. Reich or Mr. Collins. Capital Expenditures will be reviewed monthly.

5. **Medical Executive Committee Minutes and Approval of Medical Staff Credentials**

DISCUSSION: The Medical Executive Committee minutes of October 11, 2016 were included in the packet for informational purposes. The Board of Directors were provided an overview of the Medical Staff and Allied Health Professional Staff Credentialing process utilized to ensure qualified candidates meet hospital requirements and all regulatory and accreditation requirements set forth by the State of Connecticut Department of Public Health (DPH), the Centers for Medicare and Medicaid Services (CMS), the Joint Commission (TJC) and the Accreditation Council for Graduate Medical Education/American Osteopathic Association (ACGME/AOA). Once applications have been approved by the service chief and/or department chair; a three step approval process is conducted by the Credentials Committee, the MEC and finally by the governing board. A member of the Advisory Boards would serve on the Credentials Committee and have an integral part of the review process. A summary of the verification and post-verification process was provided and included a sample of the Medical Staff Membership and Privileges Application Checklists for various purposes.

Members of the Board reviewed the recommendations for Medical Staff appointments, status changes and completion of review periods approved by the Credentials Committee on November 1, 2016 and the Medical Executive Committee (MEC) on November 8, 2016. A brief discussion followed regarding the approval process. Once the credentials have been approved by the Advisory Boards they will be forwarded to the Prospect fiduciary boards for final approval by virtue of unanimous consent. Timing of the approval process is a key factor as not all candidates qualify for temporary privileges. Approvals should be completed by the last day of the current month in order to meet regulatory requirements. Copies of the signed unanimous consents from Prospect will be kept in the Advisory Boards meeting binder for permanent record. A motion was made and seconded.

ACTION: **VOTED unanimously to approve the recommendations for Medical Staff appointments, status changes and completion of review periods approved by the Credentials Committee on November 1, 2016 and the Medical Executive Committee (MEC) on November 8, 2016 as presented and recommend approval by the Prospect Manchester Hospital and Prospect Rockville Board of Directors.**

6. **Chief Executive Officer's Report**

DISCUSSION: Mr. Collins stated that ECHN has been a community based health system for some time and he encouraged removal of the preference of individual identifiers (i.e. Rockville, Manchester, VNHSC etc.) in lieu of ECHN. He recently shared his observations at Employee Forums held in mid-October through early November 2016 and expressed his desire for employees to embrace a "TEAM" view of the system as a whole, rather than individual counterparts. No counterpart within the system would be successful without the others. Employee Forums throughout the system were relatively positive. Reporting mechanisms are being re-evaluated to ensure that issues across the system are being addressed by the appropriate senior leadership member. For example, nursing issues at any of the ECHN facilities would be handled by the Chief Nursing Officer.

[redacted]

A question arose regarding outreach to physicians for patient referrals and an outreach to the patient population. A concierge program, which has been very successful in California, is underway. An overview of the concierge roles and responsibilities to include community outreach was provided. A candidate has been identified and will begin employment in two weeks. The individual will be introduced to the Medical Staff at its next meeting on December 13, 2016. A second concierge position will be filled in the subsequent weeks. A marketing strategy is under development to include advertising of community events in the local media, ECHN's website as well as digital and radio advertising. The Better Being publication is mailed to over 155,000 homes bi-annually and is a vehicle for announcing the community health education programs. It was noted that the best form of advertising is the patient experience. The Vice President of Corporate Communications & Public Affairs provide an update at the next meeting. A question and answer period followed.

7. **Annual Performance Improvement Plans**

DISCUSSION: The FY2017 Plans (Performance Improvement, Patient Experience, Patient Safety and Risk Management) and the FY2017 Quality Assurance & Performance Improvement (QAPI) Goals have been completed. These items have been submitted to QAPIC for review and approval. The FY2017 plans and FY2017 goals will then be presented to the MEC for approval. Final approval will be sought by the Advisory Boards at its next meeting on December 14, 2016. A Patient/Family Council, endorsed by the Connecticut Hospital Association (CHA), is being developed that will enhance the patient experience process and improve upon quality and safety.

[redacted]

9. **Capital Review**

DISCUSSION: Clinical leaders have been diligently reviewing, evaluating and prioritizing capital requests that have been submitted over the past several years. A list of priority items was provided by category which include: investments to address compliance with regulations for licensure and accreditation; those that provide a return on investment or preservation of revenue; investments that impact patient, physician and/or employee satisfaction ("Splash" capital); and items that are at the end of their useful life. Regulatory licensure inspections were conducted by the CT Department of Public Health at Manchester Hospital, Rockville Hospital, Woodlake at Tolland, 460 Tolland Turnpike and 150 North Main as required for the transaction. Plans of correction were submitted to DPH as a result of the inspections which commit ECHN to engage consultants to conduct studies of building conditions, i.e. heating and ventilation systems, electrical systems, roofs, furnishings and finishes. From those studies, ECHN will need to submit additional plans to DPH that identify work to correct deficiencies. While those plans are being produced, requests for initial "splash" capital investments will be submitted with input from physicians for items that address technology and equipment needed for their specialties. Once splash capital investments have been made, communications will be made to employees, physician and the community. [redacted]

Mr. Reardon left the meeting at 8:51 a.m.

PROSPECT MEDICAL HOLDINGS, INC.

ECHN

PROSPECT MANCHESTER HOSPITAL, INC.
PROSPECT ROCKVILLE HOSPITAL, INC.

ADVISORY BOARDS MEETING MINUTES

MEETING: **ADVISORY BOARD**
DATE: December 14, 2016 **LOCATION:** MMH CR A, B & C **CONVENED:** 7:30 a.m. **ADJOURNED:** 8:54 a.m.

TRUSTEES PRESENT: M. Maher, Suede, MD (Chairman); Michael Collins; M. Saud Anwar, MD; Irene Quong-Conlon; Mary Cronin; Mary (Molly) Devanney; Eric Kloter; Pamela Lewis, MD; Saqib Naseer, MD; Barbara. Phillips, MD;

MANAGEMENT PRESENT: Nina Kruse; Katherine Mon; Mary Powers; Linda Quirici; Joel Reich; Todd Rose; Joyce Tichy; Michael Veillette; Chantal Perigo (Recording Secretary)

NOT PRESENT: Joy Dorin; Dennis O'Neill, MD; Thomas Reardon

With a quorum present, Dr. Suede convened the meeting at 7:30 a.m. He thanked the members of the board his election as Chairman of the Advisory Board. He addressed the board about his commitment to the organization during a very exciting and crucial time. The primary goal is to continue to improve patient safety, patient outcomes and the overall patient experience in order to remain strong and competitive as well as improve the perception of Prospect ECHN in the community.

1. **Safety Moment**

DISCUSSION: Ms. Quirici stated that the quality goals for 2017 are in the final stages of the approval process. She shared the results of the 2016 quality goals. The Serious Safety Event Rate (SSER) ended at zero for RGH and has maintained a zero rating into FY2017. Falls with serious injuries ended at zero for both hospitals. Catheter-associated Urinary Tract Infection (CAUTI) rate remains at zero at both hospitals. There has been significant drop in surgical site infections (SSI) at both hospitals during the month of October and November 2016 from FY2015 and FY2016. She noted that for October 2015 the SSI rate was 9 versus 3 for October 2016. November 2015 SSI rate was 10 versus 1 for October 2016. The CAUTI program is in place and continued improvements are anticipated.

2. **Approval of Minutes of November 16, 2016**

DISCUSSION: The members of the Board reviewed the minutes of November 16, 2016. A motion was made and seconded.

ACTION: **VOTED to approve the minutes of November 16, 2016 as presented.**

3. **Proposed Bylaw Amendment Discussion**

DISCUSSION: The role of the Advisory Board remains in a development phase. Prospect is evaluating the governance processes for its Advisory Boards to determine if common practices can be implemented consistent with regulatory requirements such as those of The Joint Commission (TJC). The Advisory Boards generally advise upon matters that affect the community, including medical staff appointments and quality initiatives. The Prospect ECHN Advisory Board's scope may be expanded to include Prospect ECHN Eldercare Services, Inc. and Prospect ECHN Home Health, Inc., potentially to include review and approval of the Woodlake at Tolland (WAT) medical staff credentials as well as quality oversight for both WAT and the Visiting Nurse and Health Services of CT. In the interim the WAT credentials will be sent directly to the parent board for approval.

4. **Medical Executive Committee Minutes and Approval of Medical Staff Credentials**

DISCUSSION: The Medical Executive Committee minutes of November 8, 2016 were included in the packet for informational purposes. Dr. Suede announced the approval of a nurse driven protocol related to the catheter removal processes. The new protocol allows the nurse to determine patient qualification for catheter removal without physician orders. An update on secure texting and emailing patient health information (PHI) was provided at the MEC meeting. A new feature "patient status order notification" will be added to the Care Thread rollout. A workgroup has been established to update personalized order sets on Meditech.

There were no Medical Staff Credentials presented for approval.

6. **Chief Executive Officer's Report**

[redacted]

Ms. Kruse provided an overview of the Marketing and Communications Strategy for 2017 for the following program categories:

Service line marketing; ECHN brand development; digital, radio and Pandora advertisements, community education programs and promotions; employee and medical staff communications and community outreach liaison program. The outreach liaison program is a model developed by Prospect that will be an extension of the Marketing Department. Two individuals will be developing relationships with skilled nursing facilities, assisted living, and community providers to ensure patients experience a smooth transition to acute care hospitals and ultimately enhance the referral base.

[redacted]

In 2017 the marketing team will focus its efforts on website functionality, imagery and calls to action; digital media placement; identifying synergies with Waterbury Hospital; local non-profit and chamber support, service line and brand printed collateral; print advertising for community health education programs; community relations and coffee connections programs; media relations; and community outreach liaisons to enhance the promotion of our services across the ECHN network. Discussion followed regarding goals, advertising resources and referral strategies to help increase market share.

A question arose regarding the status of the new community charitable foundation and partnering opportunities. Ms. Kruse reported that the members have been identified and that a meeting is planned for some time in mid-January 2017, at which time the group will begin the organizational processes. The ECHN Community HealthCare Foundation continues to operate under the oversight of the Legacy ECHN Board of Trustees. Once the new foundation has been established the moneys allocated to the new entity will be transferred. It was noted that ECHN cannot be a beneficiary of fund distributions from the new entity. It was also noted that ECHN could coordinate events to contribute to the new foundation.

7. **Quality Report**

a. Quality Assurance & Performance Improvement (QAPI) FY2017 Plans/FY2017 Goals

DISCUSSION: The FY2017 Quality Assurance & Performance Improvement Plans and Goals have been completed. These items were approved by the QAPIC and will be presented to the MEC for approval on January 10, 2017. Final approval will be sought by the Advisory Boards at its next meeting on January 25, 2017.

Ms. Quirici highlighted some of the performances through August 2016 for both MMH and RGH related to patient experience (HCAHPS); Medicare spend per beneficiary; patient safety indicators (PSI) – 90; surgical site infections; central line associated blood stream infection (CLABSI); Clostridium Difficile (C-Diff); Readmissions; Timeliness of Care; falls with serious injury; influenza immunization; serious safety event rate; and stroke measures. These measures were selected to enhance patient care and are monitored by regulatory agencies for reimbursement purposes. Programs are in place to provide staff education and certification related to patient experience. A Sepsis program will go live in January 2017.

ECHN is focused on improving the patient and care giver centered experience star rating by at least 1 star for 2017. This includes improvements in HCAHPS related to communications with nurses and communications with doctors. MMH is currently at a 2 star rating, while RGH is at a 3 star rating. RGH is above achievement thresholds for communication with nurses; Medicare-spend per beneficiary. MMH is positive to achievement thresholds for PSI-90 and C-Diff. Ms. Quirici noted that although abdominal hysterectomy site infections are above thresholds, there has been considerable improvement, with 1 incident through August 2016 versus 6 incidents last year at this time. She also noted that there have been no falls with serious injuries at either hospital. There are 11 stroke measures being monitors of which 8 of 11 are at 100% for MMH and 9 of 11 are at 100% for RGH which is ahead of benchmarks at 90%. A question arose regarding employee satisfaction, which has a strong impact on patient experience. A new survey is planned for some time in late February/early March 2017. A question and answer period followed. The Board has requested a report identifying occurrences of unsafe staffing levels. Ms. Powers provided an overview of the unsafe staffing reporting mechanism that is currently in place and the standard plan of action. A per diem float pool initiative is underway to help address staffing shortages. A certified nursing assistant float pool has also been implemented. Flex positions are being reevaluated and adjusted to address staffing concerns. A staffing plan must be reported to the State of Connecticut on an annual basis to include an action plan for staffing needs.

[redacted]

[redacted]

9. **Next Meeting/Adjourment**

DISCUSSION: Mr. Collins thanked the members of the board for attending. He noted that the Advisory Board members are advocates for the communities that ECHN services and encouraged them to contact himself or any member of senior leadership any questions or concerns. He wished everyone Happy Holidays.

The next meeting of the Prospect MMH/RGH Board of Directors is scheduled for Wednesday, January 25, 2017 at 7:30 a.m. in the MMH CR A, B & C.

The meeting was adjourned.

Respectfully submitted,

Chantal M. Perigo
Recording Secretary

Irene Quong Conlon
Board Secretary

10. Next Meeting/Adjourment

DISCUSSION: The next meeting of the Prospect MMH/RGH Board of Directors is scheduled for Wednesday, December 14, 2016 at 7:30 a.m. in the MMH CR A, B & C. The calendar of meetings for 2017 was included in the packet for informational purposes. These dates have been posted on the BoardEffect Portal.

Dr. O'Neill stated that it has been approximately 6 ½ weeks since the closing of the transaction and although Mr. Collins had been onsite as Chief Integration Officer, his position as Interim CEO was abrupt due to the precipitous departure of the former CEO. Feedback from the medical staff, hospital staff and the senior management team has been very positive. He commended Mr. Collins for the work his is doing and the current state of the organization.

The meeting was adjourned.

Respectfully submitted,

Chantal M. Perigo
Recording Secretary

Irene Quong Conlon
Board Secretary

32016

Olejarz, Barbara

From: Mcconville, Dennis P <dmcconville@echn.org>
Sent: Friday, February 17, 2017 6:22 PM
To: Martone, Kim
Cc: Olejarz, Barbara
Subject: Prospect ECHN, Inc. - Compliance with Stipulation #20 Response
Attachments: OHCA DPH Martone Kimberly 2-17-2017 CORRECTED.pdf

Importance: High

Dear Kim:

After Ms. MacDonald emailed to you at 4:17 pm today the letter from Michael Collins, Interim CEO, that you requested regarding Stipulation #20, we discovered a typographical error that requires correction. Please disregard that letter and replace it with the correct letter that I have attached.

We will also be sending a hard copy of the correct letter to you via regular mail, to replace the incorrect version that we placed in the mail earlier today.

Regards,

Dennis

Dennis P. McConville
Senior Vice President, Chief Strategy Officer
Eastern Connecticut Health Network, Inc.
(860) 533-3429 (office)
(860) 268-4591 (cell)
dmcconville@echn.org

ECHN
Eastern Connecticut Health Network

"This message originates from Eastern Connecticut Health Network. The information contained in this message may be privileged and confidential. If you are the intended recipient, you must maintain this message in a secure and confidential manner. If you are not the intended recipient, please notify the sender immediately and destroy this message. Thank you."

Eastern Connecticut Health Network
71 Haynes Street
Manchester, CT 06040
860.533.3414
www.echn.org

VIA ELECTRONIC MAIL AND REGULAR MAIL

February 17, 2017

Kimberly R. Martone
Director of Operations, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134

Re: Compliance with Stipulation #20

Dear Ms. Martone:

I am in receipt of your email communication dated February 15, 2017 in which you requested certain information relating to Stipulation #20 of the Certificate of Need listed under Docket #15-32016-486. Below are the responses of Prospect ECHN to the questions set forth in that email.

1. **Has the Local Board been selected and what was the selection process?**

   Yes, the Local Board has been selected. The members of the Local Board were selected by Prospect ECHN in accordance with the requirements the Asset Purchase Agreement dated August 24, 2016 between ECHN as Seller and Prospect Medical Holdings as Buyer, which states as follows:

   > Local Board means the advisory board of each Hospital composed of community representatives, physicians on the respective Hospital's medical staff, and the Chief Executive Officer of each respective Hospital (for avoidance of doubt, each Hospital shall have its own Local Board). The initial members of the Local Board shall include at least five members of the Seller's Board of Trustees immediately prior to Closing and five other individuals identified by the Seller prior to Closing, two of whom shall be members of the community appointed in consultation with the mayor of the town in which the respective Hospital is located.

   Please note that the two Hospital Boards meet contemporaneously and have the same members, in recognition of the fact that Manchester Memorial Hospital and Rockville General Hospital function as an integrated system within Prospect ECHN.

Kimberly R. Martone
Office of Health Care Access
February 17, 2017

2. List the names and related information for each member of the Local Board.

The names and roles of the individuals on the Local Board are:

Name	Role
M. Maher Suede, MD	Medical Staff President, Former Seller Trustee
M. Saud Anwar, MD	Medical Staff Member
Michael Collins	Interim Chief Executive Officer
Mary Roche-Cronin	Community Member Recommended by Manchester Mayor
Molly C. Devanney	Community Member
Joy W. Dorin	Community Member, Former Seller Trustee
Eric L. Kloter	Community Member, Former Seller Trustee
Pamela Lewis, MD	Former Seller Trustee, Medical Staff Member
Saqib Naseer, MD	Medical Staff Vice-President (incoming President-designate)
Dennis G. O'Neill, MD	Medical Staff Member, Former Seller Trustee
Barbara Phillips, MD	Medical Staff Member, Former Seller Trustee
Irene Quong-Conlon	Community Member
Thomas M. Reardon	Prospect Representative
Vacant	Community Member -- Awaiting Vernon Mayor Recommendation

3. What members are the two community representatives and how were they chosen?

In accordance with the requirements of Stipulation #20, ECHN representatives and later Prospect ECHN representatives consulted with Town of Manchester Mayor Jay Moran and Town of Vernon Mayor Daniel Champagne to request their recommendations for individuals to serve as the community representatives for their respective towns.

Per Stipulation #20, the requirements for the position are "two unbiased persons who will fairly represent the interests of the communities served by MMH and RGH, respectively." In the case of Manchester, Mayor Moran recommended Ms. Mary Roche-Cronin, Director of Social Services for the Town of Manchester, for the Manchester community representative position. Because Ms. Roche-Cronin met the qualifications listed in Stipulation #20 Prospect ECHN accepted Mayor Moran's recommendation and selected Ms. Roche-Cronin for the Manchester community representative role.

In the case of Vernon, as of this date Prospect ECHN has not received a recommendation from Mayor Champagne of an "unbiased person" who will "fairly represent the interests of the communit[y] served by RGH". Mayor Champagne did make one recommendation, but Prospect ECHN advised him that the individual did not meet the requirement of Stipulation #20 for an "unbiased person". No subsequent recommendation has been received from the Mayor of Vernon.

Kimberly R. Martone
Office of Health Care Access
February 17, 2017

4. Fully explain how the Mayors of Manchester and Vernon were consulted in the selection of these two community representatives.

ECHN representatives met in person with each of the Mayors, described the roles of the community members, discussed the composition of the Local Board, and solicited their recommendations. These communications occurred both before and after the transaction between ECHN and Prospect, which closed on October 1, 2016. ECHN met with Mayor Moran on July 7, 2016 and he recommended Ms. Roche-Cronin on July 25, 2016. ECHN met with Mayor Champagne on July 11, 2016, and Prospect ECHN met with him on October 12, 2016, November 3, 2016, and most recently on January 31, 2017.

5. Have any joint Board meetings been held as yet, per Stipulation #19? Have any Local Board meetings occurred at all since the transfer of ownership. If so, please submit the related meeting minutes.

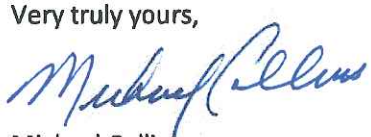
Prospect ECHN had one informal introductory meeting with the Local Board members on October 10, 2016, followed by meetings on November 16, 2016, December 14, 2016 and January 25, 2017. Because the October 10, 2016 meeting was a "meet and greet" there are no minutes. The minutes for the November and December meetings are attached, with confidential information regarding ongoing strategic initiatives redacted. The minutes for the January meeting are not available as of the current date. Prospect ECHN has not yet conducted a joint Board meeting per Stipulation #19.

6. If Prospect ECHN has rejected any candidates to be the community representatives, identify such candidates and explain why they were not selected.

As indicated above, Prospect ECHN received and approved one recommended candidate for the Town of Manchester, and that person currently sits on the Local Board. Prospect ECHN received one recommendation from the Town of Vernon, which it rejected for the reasons indicated in the response to Question 3. That person's name is Ellen Marmer, MD. Prospect ECHN has asked for additional recommendations from the Mayor of the Town of Vernon on a number of occasions, but to date has not received any.

Thank you for your consideration of this submission.

Very truly yours,



Michael Collins
Interim CEO

Enclosures

PROSPECT MEDICAL HOLDINGS, INC.

ECHN

PROSPECT MANCHESTER HOSPITAL, INC.
PROSPECT ROCKVILLE HOSPITAL, INC.

ADVISORY BOARDSMEETING MINUTES

MEETING: **ADVISORY BOARD**
DATE: December 14, 2016 **LOCATION:** MMH CR A, B & C **CONVENED:** 7:30 a.m. **ADJOURNED:** 8:54 a.m.

TRUSTEES PRESENT: M. Maher, Suede, MD (Chairman); Michael Collins; M. Saud Anwar, MD; Irene Quong-Conlon; Mary Cronin; Mary (Molly) Devanney; Eric Kloter; Pamela Lewis, MD; Saqib Naseer, MD; Barbara. Phillips, MD;

MANAGEMENT PRESENT: Nina Kruse; Katherine Mon; Mary Powers; Linda Quirici; Joel Reich; Todd Rose; Joyce Tichy; Michael Veillette; Chantal Perigo (Recording Secretary)

NOT PRESENT: Joy Dorin; Dennis O'Neill, MD; Thomas Reardon

With a quorum present, Dr. Suede convened the meeting at 7:30 a.m. He thanked the members of the board his election as Chairman of the Advisory Board. He addressed the board about his commitment to the organization during a very exciting and crucial time. The primary goal is to continue to improve patient safety, patient outcomes and the overall patient experience in order to remain strong and competitive as well as improve the perception of Prospect ECHN in the community.

1. Safety Moment
DISCUSSION: Ms. Quirici stated that the quality goals for 2017 are in the final stages of the approval process. She shared the results of the 2016 quality goals. The Serious Safety Event Rate (SSER) ended at zero for RGH and has maintained a zero rating into FY2017. Falls with serious injuries ended at zero for both hospitals. Catheter-associated Urinary Tract Infection (CAUTI) rate remains at zero at both hospitals. There has been significant drop in surgical site infections (SSI) at both hospitals during the month of October and November 2016 from FY2015 and FY2016. She noted that for October 2015 the SSI rate was 9 versus 3 for October 2016. November 2015 SSI rate was 10 versus 1 for October 2016. The CAUTI program is in place and continued improvements are anticipated.

2. Approval of Minutes of November 16, 2016
DISCUSSION: The members of the Board reviewed the minutes of November 16, 2016. A motion was made and seconded.

ACTION: **VOTED to approve the minutes of November 16, 2016 as presented.**

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DISCUSSION: The role of the Advisory Board remains in a development phase. Prospect is evaluating the governance processes for its Advisory Boards to determine if common practices can be implemented consistent with regulatory requirements such as those of The Joint Commission (TJC). The Advisory Boards generally advise upon matters that affect the community, including medical staff appointments and quality initiatives. The Prospect ECHN Advisory Board's scope may be expanded to include Prospect ECHN Eldercare Services, Inc. and Prospect ECHN Home Health, Inc., potentially to include review and approval of the Woodlake at Tolland (WAT) medical staff credentials as well as quality oversight for both WAT and the Visiting Nurse and Health Services of CT. In the interim the WAT credentials will be sent directly to the parent board for approval.

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There were no Medical Staff Credentials presented for approval.

6. Chief Executive Officer's Report



Ms. Kruse provided an overview of the Marketing and Communications Strategy for 2017 for the following program categories:

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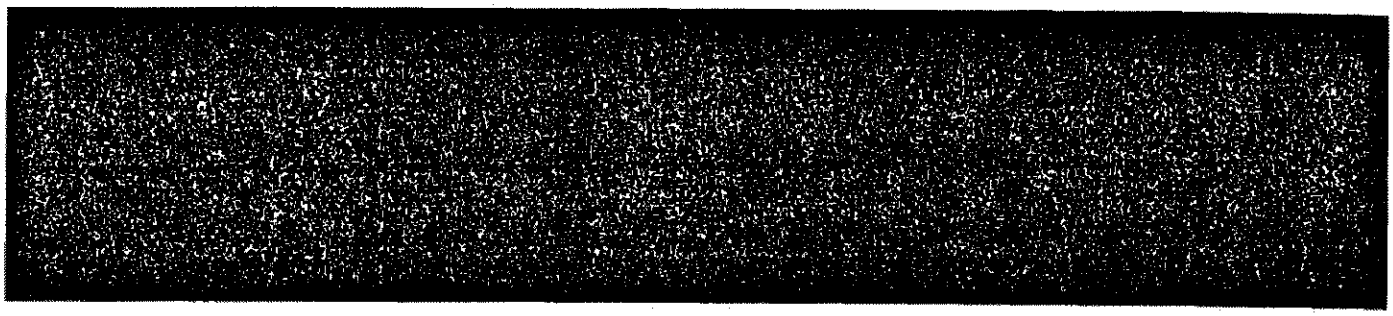

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7. **Quality Report**

a. Quality Assurance & Performance Improvement (QAPI) FY2017 Plans/FY2017 Goals

DISCUSSION: The FY2017 Quality Assurance & Performance Improvement Plans and Goals have been completed. These items were approved by the QAPIC and will be presented to the MEC for approval on January 10, 2017. Final approval will be sought by the Advisory Boards at its next meeting on January 25, 2017.

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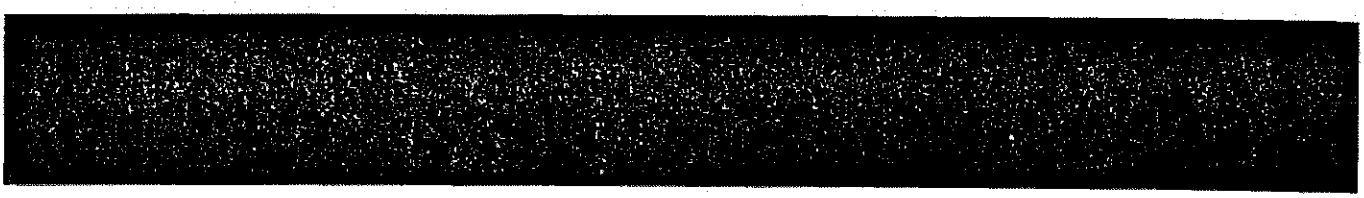


[redacted]

9. Next Meeting/Adjournment

DISCUSSION: Mr. Collins thanked the members of the board for attending. He noted that the Advisory Board members are advocates for the communities that ECHN services and encouraged them to contact himself or any member of senior leadership any questions or concerns. He wished everyone Happy Holidays.

The next meeting of the Prospect MMH/RGH Board of Directors is scheduled for Wednesday, January 25, 2017 at 7:30 a.m. in the MMH CR A, B & C.

The meeting was adjourned.

Respectfully submitted,

Chantal M. Perigo
Recording Secretary

Irene Quong Conlon
Board Secretary

PROSPECT MEDICAL HOLDINGS, INC.

ECHN

PROSPECT MANCHESTER HOSPITAL, INC.
PROSPECT ROCKVILLE HOSPITAL, INC.

ADVISORY BOARDSMEETING MINUTES

MEETING: **ANNUAL MEETING OF THE ADVISORY BOARD**
DATE: November 16, 2016 **LOCATION:** MMH CR A, B & C **CONVENED:** 7:30 a.m. **ADJOURNED:** 9:09 a.m.

TRUSTEES PRESENT: Michael Collins (Interim CEO); M. Saud Anwar, MD; Irene Quong-Conlon; Mary Cronin; Mary (Molly) Devanney (T); Joy Dorin; Eric Kloter; Pamela Lewis, MD; Saqib Naseer, MD; Dennis O'Neill, MD; , Barbara. Phillips, MD; David Topper

MANAGEMENT PRESENT: Dennis McConville; Mary Powers; Linda Quirici; Joel Reich; Joyce Tichy; Michael Veillette; Chantal Perigo (Recording Secretary)

NOT PRESENT: M. Maher, Suede, MD

GUEST: Deborah Berry, Chief Quality Officer, Prospect Medical Holdings (Prospect)
Garrison De Lee, Corporate Counsel, Prospect (T)
Thomas Reardon, President Prospect Medical Holdings East

With a quorum present, Mr. Collins serving as interim Chairman in lieu of elections convened the meeting at 7:33 a.m. He welcomed Ms. Berry and Messrs. De Lee, Reardon and Topper to the meeting. Formal introductions followed.

1. **Proposed Amendment to Bylaws**

DISCUSSION: Mr. Topper stated that he is excited about the opportunity to work with ECHN and is looking forward to a long relationship. Due to logistical challenges, including potential travel delays and time zone differences he will step down from his role on the Advisory Board and advised that Thomas Reardon would take his place as a Prospect representative. Mr. Topper expressed the hope that he would remain engaged with the Advisory Board by participating in its meetings as a guest from time to time. He was encouraged to do so to as an excellent means of maintaining ties between the local Prospect ECHN community and Prospect's leadership. A motion was made and seconded.

ACTION: **VOTED to acknowledge the resignation of David Topper as Prospect Representative on the joint Prospect Manchester Hospital and Prospect Rockville Hospital Advisory Boards, and to acknowledge the election of Thomas M. Reardon as Prospect Representative as ex-officio member with vote.**

Amendments to the Prospect Manchester Hospital and Prospect Rockville Hospital Advisory Board Bylaws were presented for approval and recommendation to the Prospect Manchester Hospital, Inc. and Prospect Rockville Hospital, Inc. Boards of Directors. The purpose of such amendments is to revise the composition of the Advisory Board so as to include the President of the Medical Staff as a standing member. It was noted that this Advisory Board Bylaws change would reinforce Prospect's strong commitment to physician participation in the work of the Advisory Board. A motion was made and seconded.

ACTION: **VOTED to approve the amendments to Section 2/Composition of the Prospect Manchester Hospital and Prospect Rockville Hospital Advisory Board Bylaws to change the composition of the Advisory Boards for these entities to include the President of the Medical Staff, and to recommend approval of same by the Prospect Manchester Hospital, Inc. and Prospect Rockville Hospital, Inc. Boards of Directors.**

Additional amendments are being considered to the Advisory Board Bylaws in order to include Prospect ECHN ElderCare Services, Inc. d/b/a Woodlake at Tolland Rehabilitation and Nursing Center (WAT) as an additional entity under Advisory Board oversight, which would allow for Advisory Board review and approval of the Woodlake at Tolland Medical Staff Appointments and quality matters. This change is under review from a corporate governance perspective. It was noted that the Advisory Board is fortunate to have Mr. Kloter as a member of the Advisory Board, as he has been a champion for post- acute care services. A brief discussion followed regarding staff participation from WAT and Prospect ECHN Home Health, Inc. d/b/a Visiting Nurse and Health Services of Connecticut, Inc. as both of these entities are involved in quality initiatives. This proposal will be presented to the incoming Board Chairman for consideration.

2. Board Questionnaire/Non-Disclosure, Code of Conduct and Confidentiality Statement

DISCUSSION: The Board Questionnaire/Non-Disclosure, Code of Conduct and the Confidentiality Statement were included in the meeting packets for completion. Members of the Advisory Board were asked to forward the completed forms to Ms. Perigo, and to direct questions Ms. Tichy or Ms. Perigo. Suggested corrections will be made to the form. A revised document will be sent to Advisory Board members.

3. Nomination and Vote of Officers and Terms

DISCUSSION: The floor was opened for nominations for the election of Advisory Board officers. M. Maher Suede, MD was nominated as Chairman. Nominations were closed and members of the Advisory Board were invited to ask questions or share comments. A motion was made and seconded.

ACTION: **VOTED unanimously to elect M. Maher Suede, MD as Chairman of the Prospect Manchester Hospital Advisory Board and the Prospect Rockville Hospital Advisory Board for a 1-year term to expire in November 2017.**

The floor was open for nominations of Vice Chairman. Eric L. Kloter was nominated to serve as Vice Chairman. Nominations were closed and members of the Advisory Board were invited to ask questions and share comments. A motion was made and seconded.

ACTION: **VOTED unanimously to elect Eric L. Kloter, as Vice Chairman of the Prospect Manchester Hospital Advisory Board and the Prospect Rockville Hospital Advisory Board for a 1-year term to expire in November 2017.**

The floor was open for the nominations of Secretary. Irene Quong Conlon was nominated to serve as Board Secretary. Nominations were closed and members of the Advisory Board were invited to ask questions and share comments. A motion was made and seconded.

ACTION: **VOTED unanimously to elect Irene Quong Conlon as Secretary of the Prospect Manchester Hospital Advisory Board and the Prospect Rockville Hospital Advisory Board for a 1-year term to expire in November 2017.**

Discussion followed regarding setting the Advisory Board member terms in accordance with Section 5 of the Local Advisory Board portion of the Prospect Manchester Hospital and the Prospect Rockville Hospital Bylaws. Mr. Collins read the list of terms attached as Exhibit A, which reflected prior discussions with each member regarding their desired length of term. It was noted that all are eligible for re-election at the conclusion of their initial term. Terms are effective as of the date of the Annual Meeting duly held on November 16, 2016. A question and answer period followed.

4. Review of Board Responsibilities

DISCUSSION: The Local Advisory Boards are responsible for quality, medical staff credentialing and capital expenditure oversight. Appointments, reappointments and status changes of the Manchester and Rockville hospitals medical staff will be presented to the board for review in approval and will include an application checklist of the new physician. The completed files for each candidate are available for Board member review in the Office of Medical Affairs. Board members are also encouraged to make inquiries about the candidates at meetings or by contacting Dr. Reich or Mr. Collins. Capital Expenditures will be reviewed monthly.

5. Medical Executive Committee Minutes and Approval of Medical Staff Credentials

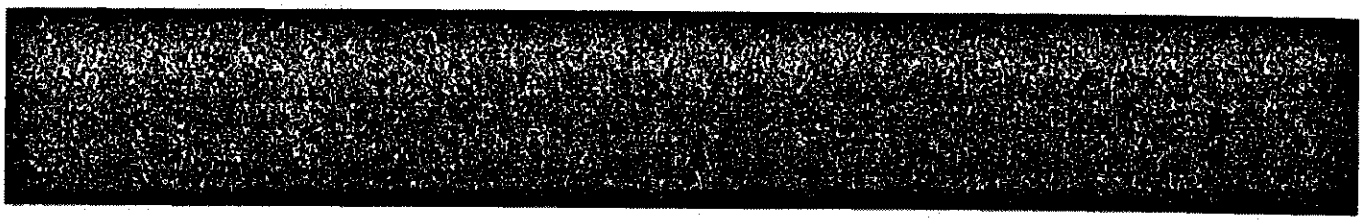
DISCUSSION: The Medical Executive Committee minutes of October 11, 2016 were included in the packet for informational purposes. The Board of Directors were provided an overview of the Medical Staff and Allied Health Professional Staff Credentialing process utilized to ensure qualified candidates meet hospital requirements and all regulatory and accreditation requirements set forth by the State of Connecticut Department of Public Health (DPH), the Centers for Medicare and Medicaid Services (CMS), the Joint Commission (TJC) and the Accreditation Council for Graduate Medical Education/American Osteopathic Association (ACGME/AOA). Once applications have been approved by the service chief and/or department chair; a three step approval process is conducted by the Credentials Committee, the MEC and finally by the governing board. A member of the Advisory Boards would serve on the Credentials Committee and have an integral part of the review process. A summary of the verification and post-verification process was provided and included a sample of the Medical Staff Membership and Privileges Application Checklists for various purposes.

Members of the Board reviewed the recommendations for Medical Staff appointments, status changes and completion of review periods approved by the Credentials Committee on November 1, 2016 and the Medical Executive Committee (MEC) on November 8, 2016. A brief discussion followed regarding the approval process. Once the credentials have been approved by the Advisory Boards they will be forwarded to the Prospect fiduciary boards for final approval by virtue of unanimous consent. Timing of the approval process is a key factor as not all candidates qualify for temporary privileges. Approvals should be completed by the last day of the current month in order to meet regulatory requirements. Copies of the signed unanimous consents from Prospect will be kept in the Advisory Boards meeting binder for permanent record. A motion was made and seconded.

ACTION: **VOTED unanimously to approve the recommendations for Medical Staff appointments, status changes and completion of review periods approved by the Credentials Committee on November 1, 2016 and the Medical Executive Committee (MEC) on November 8, 2016 as presented and recommend approval by the Prospect Manchester Hospital and Prospect Rockville Board of Directors.**

6. Chief Executive Officer's Report

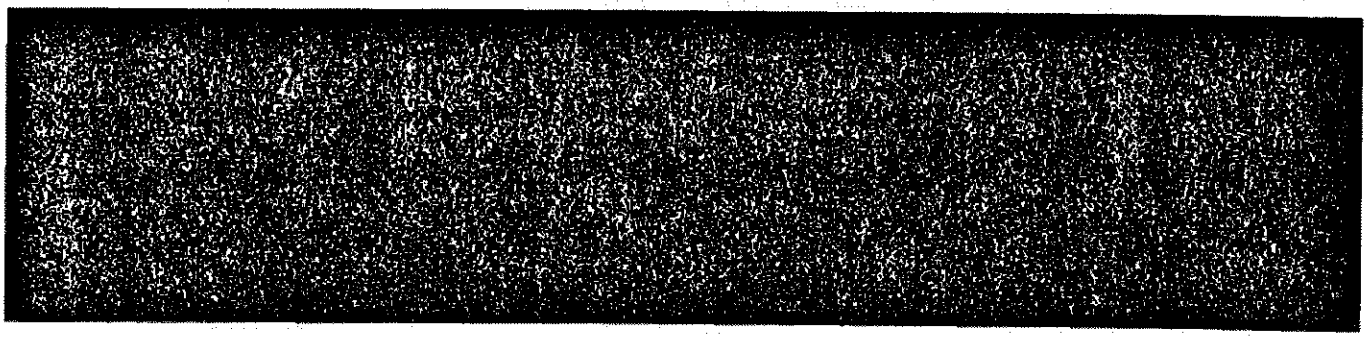
DISCUSSION: Mr. Collins stated that ECHN has been a community based health system for some time and he encouraged removal of the preference of individual identifiers (i.e. Rockville, Manchester, VNHSC etc.) in lieu of ECHN. He recently shared his observations at Employee Forums held in mid-October through early November 2016 and expressed his desire for employees to embrace a "TEAM" view of the system as a whole, rather than individual counterparts. No counterpart within the system would be successful without the others. Employee Forums throughout the system were relatively positive. Reporting mechanisms are being re-evaluated to ensure that issues across the system are being addressed by the appropriate senior leadership member. For example, nursing issues at any of the ECHN facilities would be handled by the Chief Nursing Officer.



A question arose regarding outreach to physicians for patient referrals and an outreach to the patient population. A concierge program, which has been very successful in California, is underway. An overview of the concierge roles and responsibilities to include community outreach was provided. A candidate has been identified and will begin employment in two weeks. The individual will be introduced to the Medical Staff at its next meeting on December 13, 2016. A second concierge position will be filled in the subsequent weeks. A marketing strategy is under development to include advertising of community events in the local media, ECHN's website as well as digital and radio advertising. The Better Being publication is mailed to over 155,000 homes bi-annually and is a vehicle for announcing the community health education programs. It was noted that the best form of advertising is the patient experience. The Vice President of Corporate Communications & Public Affairs provide an update at the next meeting. A question and answer period followed.

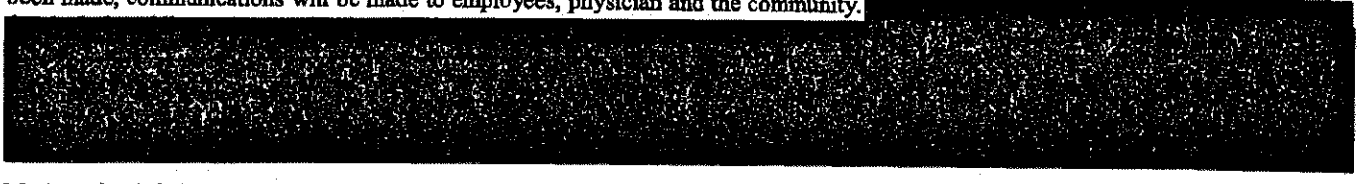
7. Annual Performance Improvement Plans

DISCUSSION: The FY2017 Plans (Performance Improvement, Patient Experience, Patient Safety and Risk Management) and the FY2017 Quality Assurance & Performance Improvement (QAPI) Goals have been completed. These items have been submitted to QAPIC for review and approval. The FY2017 plans and FY2017 goals will then be presented to the MEC for approval. Final approval will be sought by the Advisory Boards at its next meeting on December 14, 2016. A Patient/Family Council, endorsed by the Connecticut Hospital Association (CHA), is being developed that will enhance the patient experience process and improve upon quality and safety.



9. Capital Review

DISCUSSION: Clinical leaders have been diligently reviewing, evaluating and prioritizing capital requests that have been submitted over the past several years. A list of priority items was provided by category which include: investments to address compliance with regulations for licensure and accreditation; those that provide a return on investment or preservation of revenue; investments that impact patient, physician and/or employee satisfaction ("Splash" capital); and items that are at the end of their useful life. Regulatory licensure inspections were conducted by the CT Department of Public Health at Manchester Hospital, Rockville Hospital, Woodlake at Tolland, 460 Tolland Turnpike and 150 North Main as required for the transaction. Plans of correction were submitted to DPH as a result of the inspections which commit ECHN to engage consultants to conduct studies of building conditions, i.e. heating and ventilation systems, electrical systems, roofs, furnishings and finishes. From those studies, ECHN will need to submit additional plans to DPH that identify work to correct deficiencies. While those plans are being produced, requests for initial "splash" capital investments will be submitted with input from physicians for items that address technology and equipment needed for their specialties. Once splash capital investments have been made, communications will be made to employees, physician and the community.



Mr. Reardon left the meeting at 8:51 a.m.

10. Next Meeting/Adjourment

DISCUSSION: The next meeting of the Prospect MMH/RGH Board of Directors is scheduled for Wednesday, December 14, 2016 at 7:30 a.m. in the MMH CR A, B & C. The calendar of meetings for 2017 was included in the packet for informational purposes. These dates have been posted on the BoardEffect Portal.

Dr. O'Neill stated that it has been approximately 6 ½ weeks since the closing of the transaction and although Mr. Collins had been onsite as Chief Integration Officer, his position as Interim CEO was abrupt due to the precipitous departure of the former CEO. Feedback from the medical staff, hospital staff and the senior management team has been very positive. He commended Mr. Collins for the work his is doing and the current state of the organization.

The meeting was adjourned.

Respectfully submitted,

Chantal M. Perigo
Recording Secretary

Irene Quong Cenfon
Board Secretary

Eastern Connecticut Health Network
71 Haynes Street
Manchester, CT 06040
860.533.3414
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VIA ELECTRONIC MAIL AND REGULAR MAIL

February 17, 2017

Kimberly R. Martone
Director of Operations, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134



Re: Compliance with Stipulation #20

Dear Ms. Martone:

I am in receipt of your email communication dated February 15, 2017 in which you requested certain information relating to Stipulation #20 of the Certificate of Need listed under Docket #15-32016-486. Below are the responses of Prospect ECHN to the questions set forth in that email.

1. **Has the Local Board been selected and what was the selection process?**

   Yes, the Local Board has been selected. The members of the Local Board were selected by Prospect ECHN in accordance with the requirements the Asset Purchase Agreement dated August 24, 2016 between ECHN as Seller and Prospect Medical Holdings as Buyer, which states as follows:

   > Local Board means the advisory board of each Hospital composed of community representatives, physicians on the respective Hospital's medical staff, and the Chief Executive Officer of each respective Hospital (for avoidance of doubt, each Hospital shall have its own Local Board). The initial members of the Local Board shall include at least five members of the Seller's Board of Trustees immediately prior to Closing and five other individuals identified by the Seller prior to Closing, two of whom shall be members of the community appointed in consultation with the mayor of the town in which the respective Hospital is located.

   Please note that the two Hospital Boards meet contemporaneously and have the same members, in recognition of the fact that Manchester Memorial Hospital and Rockville General Hospital function as an integrated system within Prospect ECHN.

Kimberly R. Martone
Office of Health Care Access
February 17, 2017

2. List the names and related information for each member of the Local Board.

The names and roles of the individuals on the Local Board are:

Name	Role
M. Maher Suede, MD	Medical Staff President, Former Seller Trustee
M. Saud Anwar, MD	Medical Staff Member
Michael Collins	Interim Chief Executive Officer
Mary Roche-Cronin	Community Member Recommended by Manchester Mayor
Molly C. Devanney	Community Member
Joy W. Dorin	Community Member, Former Seller Trustee
Eric L. Kloter	Community Member, Former Seller Trustee
Pamela Lewis, MD	Former Seller Trustee, Medical Staff Member
Saqib Naseer, MD	Medical Staff Vice-President (incoming President-designate)
Dennis G. O'Neill, MD	Medical Staff Member, Former Seller Trustee
Barbara Phillips, MD	Medical Staff Member, Former Seller Trustee
Irene Quong-Conlon	Community Member
Thomas M. Reardon	Prospect Representative
Vacant	Community Member -- Awaiting Vernon Mayor Recommendation

3. What members are the two community representatives and how were they chosen?

In accordance with the requirements of Stipulation #20, ECHN representatives and later Prospect ECHN representatives consulted with Town of Manchester Mayor Jay Moran and Town of Vernon Mayor Daniel Champagne to request their recommendations for individuals to serve as the community representatives for their respective towns.

Per Stipulation #20, the requirements for the position are "two unbiased persons who will fairly represent the interests of the communities served by MMH and RGH, respectively." In the case of Manchester, Mayor Moran recommended Ms. Mary Roche-Cronin, Director of Social Services for the Town of Manchester, for the Manchester community representative position. Because Ms. Roche-Cronin met the qualifications listed in Stipulation #20 Prospect ECHN accepted Mayor Moran's recommendation and selected Ms. Roche-Cronin for the Manchester community representative role.

In the case of Vernon, as of this date Prospect ECHN has not received a recommendation from Mayor Champagne of an "unbiased person" who will "fairly represent the interests of the communit[y] served by RGH". Mayor Champagne did make one recommendation, but Prospect ECHN advised him that the individual did meet the requirement of Stipulation #20 for an "unbiased person". No subsequent recommendation has been received from the Mayor of Vernon.

Kimberly R. Martone
Office of Health Care Access
February 17, 2017

4. Fully explain how the Mayors of Manchester and Vernon were consulted in the selection of these two community representatives.

ECHN representatives met in person with each of the Mayors, described the roles of the community members, discussed the composition of the Local Board, and solicited their recommendations. These communications occurred both before and after the transaction between ECHN and Prospect, which closed on October 1, 2016. ECHN met with Mayor Moran on July 7, 2016 and he recommended Ms. Roche-Cronin on July 25, 2016. ECHN met with Mayor Champagne on July 11, 2016, and Prospect ECHN met with him on October 12, 2016, November 3, 2016, and most recently on January 31, 2017.

5. Have any joint Board meetings been held as yet, per Stipulation #19? Have any Local Board meetings occurred at all since the transfer of ownership. If so, please submit the related meeting minutes.

Prospect ECHN had one informal introductory meeting with the Local Board members on October 10, 2016, followed by meetings on November 16, 2016, December 14, 2016 and January 25, 2017. Because the October 10, 2016 meeting was a "meet and greet" there are no minutes. The minutes for the November and December meetings are attached, with confidential information regarding ongoing strategic initiatives redacted. The minutes for the January meeting are not available as of the current date. Prospect ECHN has not yet conducted a joint Board meeting per Stipulation #19.

6. If Prospect ECHN has rejected any candidates to be the community representatives, identify such candidates and explain why they were not selected.

As indicated above, Prospect ECHN received and approved one recommended candidate for the Town of Manchester, and that person currently sits on the Local Board. Prospect ECHN received one recommendation from the Town of Vernon, which it rejected for the reasons indicated in the response to Question 3. That person's name is Ellen Marmer, MD. Prospect ECHN has asked for additional recommendations from the Mayor of the Town of Vernon on a number of occasions, but to date has not received any.

Thank you for your consideration of this submission.

Very truly yours,

Michael Collins
Interim CEO

Enclosures

PROSPECT MEDICAL HOLDINGS, INC.

ECHN

PROSPECT MANCHESTER HOSPITAL, INC.
PROSPECT ROCKVILLE HOSPITAL, INC.

ADVISORY BOARDSMEETING MINUTES

MEETING: **ADVISORY BOARD**
DATE: December 14, 2016 **LOCATION:** MMH CR A, B & C **CONVENED:** 7:30 a.m. **ADJOURNED:** 8:54 a.m.

TRUSTEES PRESENT: M. Maher, Suede, MD (Chairman); Michael Collins; M. Saud Anwar, MD; Irene Quong-Conlon; Mary Cronin; Mary (Molly) Devanney; Eric Kloter; Pamela Lewis, MD; Saqib Naseer, MD; Barbara. Phillips, MD;

MANAGEMENT PRESENT: Nina Kruse; Katherine Mon; Mary Powers; Linda Quirici; Joel Reich; Todd Rose; Joyce Tichy; Michael Veillette; Chantal Perigo (Recording Secretary)

NOT PRESENT: Joy Dorin; Dennis O'Neill, MD; Thomas Reardon

With a quorum present, Dr. Suede convened the meeting at 7:30 a.m. He thanked the members of the board his election as Chairman of the Advisory Board. He addressed the board about his commitment to the organization during a very exciting and crucial time. The primary goal is to continue to improve patient safety, patient outcomes and the overall patient experience in order to remain strong and competitive as well as improve the perception of Prospect ECHN in the community.

1. Safety Moment
DISCUSSION: Ms. Quirici stated that the quality goals for 2017 are in the final stages of the approval process. She shared the results of the 2016 quality goals. The Serious Safety Event Rate (SSER) ended at zero for RGH and has maintained a zero rating into FY2017. Falls with serious injuries ended at zero for both hospitals. Catheter-associated Urinary Tract Infection (CAUTI) rate remains at zero at both hospitals. There has been significant drop in surgical site infections (SSI) at both hospitals during the month of October and November 2016 from FY2015 and FY2016. She noted that for October 2015 the SSI rate was 9 versus 3 for October 2016. November 2015 SSI rate was 10 versus 1 for October 2016. The CAUTI program is in place and continued improvements are anticipated.

2. Approval of Minutes of November 16, 2016
DISCUSSION: The members of the Board reviewed the minutes of November 16, 2016. A motion was made and seconded.

ACTION: **VOTED to approve the minutes of November 16, 2016 as presented.**

3. Proposed Bylaw Amendment Discussion
DISCUSSION: The role of the Advisory Board remains in a development phase. Prospect is evaluating the governance processes for its Advisory Boards to determine if common practices can be implemented consistent with regulatory requirements such as those of The Joint Commission (TJC). The Advisory Boards generally advise upon matters that affect the community, including medical staff appointments and quality initiatives. The Prospect ECHN Advisory Board's scope may be expanded to include Prospect ECHN Eldercare Services, Inc. and Prospect ECHN Home Health, Inc., potentially to include review and approval of the Woodlake at Tolland (WAT) medical staff credentials as well as quality oversight for both WAT and the Visiting Nurse and Health Services of CT. In the interim the WAT credentials will be sent directly to the parent board for approval.

4. Medical Executive Committee Minutes and Approval of Medical Staff Credentials
DISCUSSION: The Medical Executive Committee minutes of November 8, 2016 were included in the packet for informational purposes. Dr. Suede announced the approval of a nurse driven protocol related to the catheter removal processes. The new protocol allows the nurse to determine patient qualification for catheter removal without physician orders. An update on secure texting and emailing patient health information (PHI) was provided at the MEC meeting. A new feature "patient status order notification" will be added to the Care Thread rollout. A workgroup has been established to update personalized order sets on Meditech.

There were no Medical Staff Credentials presented for approval.

6. Chief Executive Officer's Report

[redacted]

Ms. Kruse provided an overview of the Marketing and Communications Strategy for 2017 for the following program categories:

Service line marketing; ECHN brand development; digital, radio and Pandora advertisements, community education programs and promotions; employee and medical staff communications and community outreach liaison program. The outreach liaison program is a model developed by Prospect that will be an extension of the Marketing Department. Two individuals will be developing relationships with skilled nursing facilities, assisted living, and community providers to ensure patients experience a smooth transition to acute care hospitals and ultimately enhance the referral base.



In 2017 the marketing team will focus its efforts on website functionality, imagery and calls to action; digital media placement; identifying synergies with Waterbury Hospital; local non-profit and chamber support, service line and brand printed collateral; print advertising for community health education programs; community relations and coffee connections programs; media relations; and community outreach liaisons to enhance the promotion of our services across the ECHN network. Discussion followed regarding goals, advertising resources and referral strategies to help increase market share.

A question arose regarding the status of the new community charitable foundation and partnering opportunities. Ms. Kruse reported that the members have been identified and that a meeting is planned for some time in mid-January 2017, at which time the group will begin the organizational processes. The ECHN Community HealthCare Foundation continues to operate under the oversight of the Legacy ECHN Board of Trustees. Once the new foundation has been established the moneys allocated to the new entity will be transferred. It was noted that ECHN cannot be a beneficiary of fund distributions from the new entity. It was also noted that ECHN could coordinate events to contribute to the new foundation.

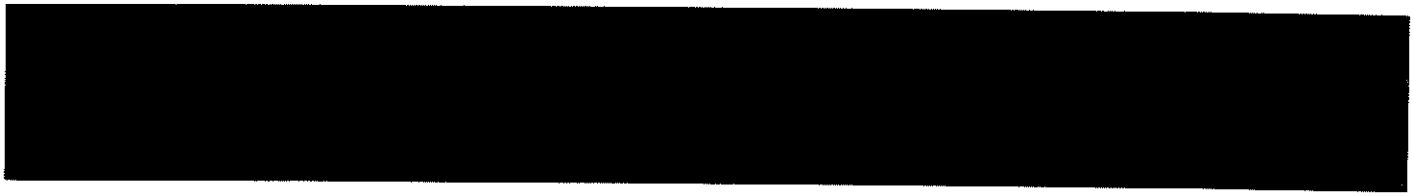
7. **Quality Report**

a. Quality Assurance & Performance Improvement (QAPI) FY2017 Plans/FY2017 Goals

DISCUSSION: The FY2017 Quality Assurance & Performance Improvement Plans and Goals have been completed. These items were approved by the QAPIC and will be presented to the MEC for approval on January 10, 2017. Final approval will be sought by the Advisory Boards at its next meeting on January 25, 2017.

Ms. Quirici highlighted some of the performances through August 2016 for both MMH and RGH related to patient experience (HCAHPS); Medicare spend per beneficiary; patient safety indicators (PSI) – 90; surgical site infections; central line associated blood stream infection (CLABSI); Clostridium Difficile (C-Diff); Readmissions; Timeliness of Care; falls with serious injury; influenza immunization; serious safety event rate; and stroke measures. These measures were selected to enhance patient care and are monitored by regulatory agencies for reimbursement purposes. Programs are in place to provide staff education and certification related to patient experience. A Sepsis program will go live in January 2017.

ECHN is focused on improving the patient and care giver centered experience star rating by at least 1 star for 2017. This includes improvements in HCAHPS related to communications with nurses and communications with doctors. MMH is currently at a 2 star rating, while RGH is at a 3 star rating. RGH is above achievement thresholds for communication with nurses; Medicare-spend per beneficiary. MMH is positive to achievement thresholds for PSI-90 and C-Diff. Ms. Quirici noted that although abdominal hysterectomy site infections are above thresholds, there has been considerable improvement, with 1 incident through August 2016 versus 6 incidents last year at this time. She also noted that there have been no falls with serious injuries at either hospital. There are 11 stroke measures being monitors of which 8 of 11 are at 100% for MMH and 9 of 11 are at 100% for RGH which is ahead of benchmarks at 90%. A question arose regarding employee satisfaction, which has a strong impact on patient experience. A new survey is planned for some time in late February/early March 2017. A question and answer period followed. The Board has requested a report identifying occurrences of unsafe staffing levels. Ms. Powers provided an overview of the unsafe staffing reporting mechanism that is currently in place and the standard plan of action. A per diem float pool initiative is underway to help address staffing shortages. A certified nursing assistant float pool has also been implemented. Flex positions are being reevaluated and adjusted to address staffing concerns. A staffing plan must be reported to the State of Connecticut on an annual basis to include an action plan for staffing needs.



[redacted]

[redacted]

9. Next Meeting/Adjourment

DISCUSSION: Mr. Collins thanked the members of the board for attending. He noted that the Advisory Board members are advocates for the communities that ECHN services and encouraged them to contact himself or any member of senior leadership any questions or concerns. He wished everyone Happy Holidays.

The next meeting of the Prospect MMH/RGH Board of Directors is scheduled for Wednesday, January 25, 2017 at 7:30 a.m. in the MMH CR A, B & C.

The meeting was adjourned.

Respectfully submitted,

Chantal M. Perigo
Recording Secretary

Irene Quong Conlon
Board Secretary

PROSPECT MEDICAL HOLDINGS, INC.

ECHN

PROSPECT MANCHESTER HOSPITAL, INC.
PROSPECT ROCKVILLE HOSPITAL, INC.

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Garrison De Lee, Corporate Counsel, Prospect (T)
Thomas Reardon, President Prospect Medical Holdings East

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1. Proposed Amendment to Bylaws

DISCUSSION: Mr. Topper stated that he is excited about the opportunity to work with ECHN and is looking forward to a long relationship. Due to logistical challenges, including potential travel delays and time zone differences he will step down from his role on the Advisory Board and advised that Thomas Reardon would take his place as a Prospect representative. Mr. Topper expressed the hope that he would remain engaged with the Advisory Board by participating in its meetings as a guest from time to time. He was encouraged to do so to as an excellent means of maintaining ties between the local Prospect ECHN community and Prospect's leadership. A motion was made and seconded.

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Additional amendments are being considered to the Advisory Board Bylaws in order to include Prospect ECHN ElderCare Services, Inc. d/b/a Woodlake at Tolland Rehabilitation and Nursing Center (WAT) as an additional entity under Advisory Board oversight, which would allow for Advisory Board review and approval of the Woodlake at Tolland Medical Staff Appointments and quality matters. This change is under review from a corporate governance perspective. It was noted that the Advisory Board is fortunate to have Mr. Kloter as a member of the Advisory Board, as he has been a champion for post- acute care services. A brief discussion followed regarding staff participation from WAT and Prospect ECHN Home Health, Inc. d/b/a Visiting Nurse and Health Services of Connecticut, Inc. as both of these entities are involved in quality initiatives. This proposal will be presented to the incoming Board Chairman for consideration.

2. Board Questionnaire/Non-Disclosure, Code of Conduct and Confidentiality Statement

DISCUSSION: The Board Questionnaire/Non-Disclosure, Code of Conduct and the Confidentiality Statement were included in the meeting packets for completion. Members of the Advisory Board were asked to forward the completed forms to Ms. Perigo, and to direct questions Ms. Tichy or Ms. Perigo. Suggested corrections will be made to the form. A revised document will be sent to Advisory Board members.

3. Nomination and Vote of Officers and Terms

DISCUSSION: The floor was opened for nominations for the election of Advisory Board officers. M. Maher Suede, MD was nominated as Chairman. Nominations were closed and members of the Advisory Board were invited to ask questions or share comments. A motion was made and seconded.

ACTION: **VOTED unanimously to elect M. Maher Suede, MD as Chairman of the Prospect Manchester Hospital Advisory Board and the Prospect Rockville Hospital Advisory Board for a 1-year term to expire in November 2017.**

The floor was open for nominations of Vice Chairman. Eric L. Kloter was nominated to serve as Vice Chairman. Nominations were closed and members of the Advisory Board were invited to ask questions and share comments. A motion was made and seconded.

ACTION: **VOTED unanimously to elect Eric L. Kloter, as Vice Chairman of the Prospect Manchester Hospital Advisory Board and the Prospect Rockville Hospital Advisory Board for a 1-year term to expire in November 2017.**

The floor was open for the nominations of Secretary. Irene Quong Conlon was nominated to serve as Board Secretary. Nominations were closed and members of the Advisory Board were invited to ask questions and share comments. A motion was made and seconded.

ACTION: **VOTED unanimously to elect Irene Quong Conlon as Secretary of the Prospect Manchester Hospital Advisory Board and the Prospect Rockville Hospital Advisory Board for a 1-year term to expire in November 2017.**

Discussion followed regarding setting the Advisory Board member terms in accordance with Section 5 of the Local Advisory Board portion of the Prospect Manchester Hospital and the Prospect Rockville Hospital Bylaws. Mr. Collins read the list of terms attached as Exhibit A, which reflected prior discussions with each member regarding their desired length of term. It was noted that all are eligible for re-election at the conclusion of their initial term. Terms are effective as of the date of the Annual Meeting duly held on November 16, 2016. A question and answer period followed.

4. Review of Board Responsibilities

DISCUSSION: The Local Advisory Boards are responsible for quality, medical staff credentialing and capital expenditure oversight. Appointments, reappointments and status changes of the Manchester and Rockville hospitals medical staff will be presented to the board for review in approval and will include an application checklist of the new physician. The completed files for each candidate are available for Board member review in the Office of Medical Affairs. Board members are also encouraged to make inquiries about the candidates at meetings or by contacting Dr. Reich or Mr. Collins. Capital Expenditures will be reviewed monthly.

5. Medical Executive Committee Minutes and Approval of Medical Staff Credentials

DISCUSSION: The Medical Executive Committee minutes of October 11, 2016 were included in the packet for informational purposes. The Board of Directors were provided an overview of the Medical Staff and Allied Health Professional Staff Credentialing process utilized to ensure qualified candidates meet hospital requirements and all regulatory and accreditation requirements set forth by the State of Connecticut Department of Public Health (DPH), the Centers for Medicare and Medicaid Services (CMS), the Joint Commission (TJC) and the Accreditation Council for Graduate Medical Education/American Osteopathic Association (ACGME/AOA). Once applications have been approved by the service chief and/or department chair; a three step approval process is conducted by the Credentials Committee, the MEC and finally by the governing board. A member of the Advisory Boards would serve on the Credentials Committee and have an integral part of the review process. A summary of the verification and post-verification process was provided and included a sample of the Medical Staff Membership and Privileges Application Checklists for various purposes.

Members of the Board reviewed the recommendations for Medical Staff appointments, status changes and completion of review periods approved by the Credentials Committee on November 1, 2016 and the Medical Executive Committee (MEC) on November 8, 2016. A brief discussion followed regarding the approval process. Once the credentials have been approved by the Advisory Boards they will be forwarded to the Prospect fiduciary boards for final approval by virtue of unanimous consent. Timing of the approval process is a key factor as not all candidates qualify for temporary privileges. Approvals should be completed by the last day of the current month in order to meet regulatory requirements. Copies of the signed unanimous consents from Prospect will be kept in the Advisory Boards meeting binder for permanent record. A motion was made and seconded.

ACTION: **VOTED unanimously to approve the recommendations for Medical Staff appointments, status changes and completion of review periods approved by the Credentials Committee on November 1, 2016 and the Medical Executive Committee (MEC) on November 8, 2016 as presented and recommend approval by the Prospect Manchester Hospital and Prospect Rockville Board of Directors.**

6. Chief Executive Officer's Report

DISCUSSION: Mr. Collins stated that ECHN has been a community based health system for some time and he encouraged removal of the preference of individual identifiers (i.e. Rockville, Manchester, VNHSC etc.) in lieu of ECHN. He recently shared his observations at Employee Forums held in mid-October through early November 2016 and expressed his desire for employees to embrace a "TEAM" view of the system as a whole, rather than individual counterparts. No counterpart within the system would be successful without the others. Employee Forums throughout the system were relatively positive. Reporting mechanisms are being re-evaluated to ensure that issues across the system are being addressed by the appropriate senior leadership member. For example, nursing issues at any of the ECHN facilities would be handled by the Chief Nursing Officer.

[redacted]

A question arose regarding outreach to physicians for patient referrals and an outreach to the patient population. A concierge program, which has been very successful in California, is underway. An overview of the concierge roles and responsibilities to include community outreach was provided. A candidate has been identified and will begin employment in two weeks. The individual will be introduced to the Medical Staff at its next meeting on December 13, 2016. A second concierge position will be filled in the subsequent weeks. A marketing strategy is under development to include advertising of community events in the local media, ECHN's website as well as digital and radio advertising. The Better Being publication is mailed to over 155,000 homes bi-annually and is a vehicle for announcing the community health education programs. It was noted that the best form of advertising is the patient experience. The Vice President of Corporate Communications & Public Affairs provide an update at the next meeting. A question and answer period followed.

7. Annual Performance Improvement Plans

DISCUSSION: The FY2017 Plans (Performance Improvement, Patient Experience, Patient Safety and Risk Management) and the FY2017 Quality Assurance & Performance Improvement (QAPI) Goals have been completed. These items have been submitted to QAPIC for review and approval. The FY2017 plans and FY2017 goals will then be presented to the MEC for approval. Final approval will be sought by the Advisory Boards at its next meeting on December 14, 2016. A Patient/Family Council, endorsed by the Connecticut Hospital Association (CHA), is being developed that will enhance the patient experience process and improve upon quality and safety.

[redacted]

9. Capital Review

DISCUSSION: Clinical leaders have been diligently reviewing, evaluating and prioritizing capital requests that have been submitted over the past several years. A list of priority items was provided by category which include: investments to address compliance with regulations for licensure and accreditation; those that provide a return on investment or preservation of revenue; investments that impact patient, physician and/or employee satisfaction ("Splash" capital); and items that are at the end of their useful life. Regulatory licensure inspections were conducted by the CT Department of Public Health at Manchester Hospital, Rockville Hospital, Woodlake at Tolland, 460 Tolland Turnpike and 150 North Main as required for the transaction. Plans of correction were submitted to DPH as a result of the inspections which commit ECHN to engage consultants to conduct studies of building conditions, i.e. heating and ventilation systems, electrical systems, roofs, furnishings and finishes. From those studies, ECHN will need to submit additional plans to DPH that identify work to correct deficiencies. While those plans are being produced, requests for initial "splash" capital investments will be submitted with input from physicians for items that address technology and equipment needed for their specialties. Once splash capital investments have been made, communications will be made to employees, physician and the community. [redacted]

Mr. Reardon left the meeting at 8:51 a.m.

10. Next Meeting/Adjourment

DISCUSSION: The next meeting of the Prospect MMH/RGH Board of Directors is scheduled for Wednesday, December 14, 2016 at 7:30 a.m. in the MMH CR A, B & C. The calendar of meetings for 2017 was included in the packet for informational purposes. These dates have been posted on the BoardEffect Portal.

Dr. O'Neill stated that it has been approximately 6 ½ weeks since the closing of the transaction and although Mr. Collins had been onsite as Chief Integration Officer, his position as Interim CEO was abrupt due to the precipitous departure of the former CEO. Feedback from the medical staff, hospital staff and the senior management team has been very positive. He commended Mr. Collins for the work his is doing and the current state of the organization.

The meeting was adjourned.

Respectfully submitted,

Chantal M. Perigo
Recording Secretary

Irene Quong Conlon
Board Secretary

Olejarz, Barbara

From: Olejarz, Barbara on behalf of Martone, Kim
Sent: Thursday, February 23, 2017 11:24 AM
To: Michael Collins
Subject: Compliance with Certificate of Need Agreed Settlement

Tracking:

Recipient	Delivery
Michael Collins	
Martone, Kim	Delivered: 2/23/2017 11:24 AM
Roberts, Karen	
Stan, Christopher	Delivered: 2/23/2017 11:24 AM
Karen.Roberts@ct.gov	Delivered: 2/23/2017 11:24 AM

2/23/17

Mr. Michael Collins
Interim Chief Executive Officer
Prospect ECHN, Inc.

RE: Compliance with Certificate of Need Agreed Settlement under Docket Number 15-32016-486.
Sale of the Assets of Eastern Connecticut Health Network, Inc. to Prospect Medical Holdings, Inc.

Dear Mr. Collins

OHCA has received your response to its Certificate of Need Compliance inquiry regarding the Prospect ECHN Local or Advisory Board composition. OHCA requires additional information and clarification regarding this matter. Please see OHCA's additional questions below:

1. You indicate that the Local Board has been selected. However, as of this date, the Vernon Community Member remains a vacant position. What steps is Prospect ECHN actively taking to resolve the issue of the vacant community representative member?

2. OHCA asked in inquiry question #6, for an explanation as to why any board member who was recommended by the two mayors was not selected and accepted for board membership ("*explain why they were not selected*"). In response, you refer to your response to inquiry question #3, wherein you indicate that Prospect ECHN has not received a recommendation of an unbiased person who will fairly represent the interests of the community served by RGH. OHCA notes that this explanation merely quotes the wording of Stipulation #20 and does not provide further explanation as to the reason for candidate rejection. Please indicate why the recommendation was not accepted for the vacant board position.

Please provide a response to the above by end of day, Tuesday, February 28, 2017.

Kimberly R. Martone
Director of Operations, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134
Phone: 860-418-7029 Fax: 860-418-7053
Email: Kimberly.Martone@ct.gov Website: www.ct.gov/ohca



Olejarz, Barbara

From: Microsoft Outlook
To: Michael Collins
Sent: Thursday, February 23, 2017 11:24 AM
Subject: Relayed: Compliance with Certificate of Need Agreed Settlement

Delivery to these recipients or groups is complete, but no delivery notification was sent by the destination server:

Michael Collins (mcollins@echn.org)

Subject: Compliance with Certificate of Need Agreed Settlement

Olejarz, Barbara

From: Perigo, Chantal <CPerigo@echn.org>
Sent: Tuesday, February 28, 2017 9:15 AM
To: Martone, Kim; Olejarz, Barbara
Cc: Mcconville, Dennis P; Collins, Michael; Tichy, Joyce A; Von.Crockett; Frank.Saidara; 'Thomas Reardon'; 'tom.reardon@chartercare.org'
Subject: Compliance with CON Agreed Settlement under Docket #15.320.16.486
Attachments: Compliance with CON agreed settlement under Docket #15-32016-486.pdf

Importance: High



Sent on behalf of Mr. Collins

Good Morning,

Attached please find ECHN's response to your questionnaire regarding compliance with CON agreed settlement under Docket #15.32016.486. Hard versions have been sent via US Mail.

Regards,
Chantal Perigo
Executive Secretary
ECHN

"This message originates from Eastern Connecticut Health Network. The information contained in this message may be privileged and confidential. If you are the intended recipient, you must maintain this message in a secure and confidential manner. If you are not the intended recipient, please notify the sender immediately and destroy this message. Thank you."

Eastern Connecticut Health Network
71 Haynes Street
Manchester, CT 06040
860.533.3414
www.echn.org

VIA ELECTRONIC MAIL AND REGULAR MAIL

February 28, 2017

Kimberly R. Martone
Director of Operations, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134

Re: Compliance with Certificate of Need Agreed Settlement under Docket #15-32016-486

Dear Ms. Martone:

I am in receipt of your email communication dated February 23, 2017 in which you requested additional information on behalf of OHCA relating to Stipulation #20 of the Certificate of Need listed under Docket #15-32016-486. Below are the responses of Prospect ECHN to the questions set forth in that email.

1. **You indicate that the Local Board has been selected. However, as of this date, the Vernon Community Member remains a vacant position. What steps is Prospect ECHN actively taking to resolve the issue of the vacant community representative member?**

   As indicated in my response to you dated February 17, 2107, ECHN met with Mayor Champagne on July 11, 2016 to discuss the appointment of an Advisory Board member. Subsequently, Prospect ECHN met with him on October 12, 2016, November 3, 2016, and most recently on January 31, 2017 for the same purpose. Additionally, Mayor Champagne volunteered to, and did, attend and participate in the most recent Advisory Board meeting on February 22, 2017. Prospect ECHN welcomes Mayor Champagne's attendance at future Advisory Board meetings, and pending his nomination of an unbiased person we have contacted the Mayor and asked him to serve on the Advisory Board on an interim basis.

2. **OHCA asked in inquiry question #6, for an explanation as to why any board member who was recommended by the two mayors was not selected and accepted for board membership ("explain why they were not selected"). In response, you refer to your response to inquiry question #3, wherein you indicate that Prospect ECHN has not received a recommendation of an unbiased person who will fairly represent the interests of the community served by RGH. OHCA notes that this explanation merely quotes the wording of Stipulation #20 and does not**

provide further explanation as to the reason for candidate rejection. Please indicate why the recommendation was not accepted for the vacant board position. Has the Local Board been selected and what was the selection process?

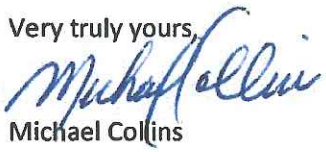
In concluding that Dr. Marmer did not demonstrate the required qualification of being an unbiased person, Prospect relied on the statements that Dr. Marmer made at public hearings and/or on the public record prior to and after the transaction between Eastern Connecticut Health Network, Inc. and Prospect Medical Holdings, Inc. Examples of such statements are enclosed with this letter. With the exception of this position, which as indicated in the response to Question 1 above ECHN has invited the Mayor of Vernon to fill with himself or another qualified designee, the Advisory Board's composition is complete.

In response to your question about the process used to select Advisory Board members, Prospect ECHN provides the following outline describing the process and criteria for selecting those members.

1. Prospect ECHN reviewed the terms of the Asset Purchase Agreement dated August 25, 2016 between Eastern Connecticut Health Network, Inc. and Prospect Medical Holdings, Inc. relating to the composition of the Advisory Board.
2. Prospect ECHN selected physicians, former ECHN Board members and other community members who met the requirements in the Asset Purchase Agreement, with careful consideration given to those individuals' prior demonstrated sustained commitment and community service directly in support of the mission of ECHN.
3. Prospect ECHN reviewed the requirements in Stipulation #20 of the Certificate of Need for "two unbiased persons" to serve as community members "selected in consultation with the Mayors of Manchester and Vernon."
4. Based on ECHN's consultation with the Mayor of Manchester who recommended Mary Roche-Cronin for the MMH community representative, Prospect ECHN determined her to be an unbiased person and named her to the MMH community representative position.
5. Prospect ECHN consulted with the Mayor of Vernon on the dates indicated in the response to Question 1 above, but has not as yet received from the Mayor of Vernon a recommendation for an unbiased person to serve as the RGH community representative. Thus, Prospect ECHN has not been able to fill that position.

Thank you for your consideration of this submission.

Very truly yours,



Michael Collins
Interim CEO

Enclosures

Approved but not OK; ECHN hospital sales questioned

By Don Michak and John Kennedy Journal Inquirer | Posted: Wednesday, April 30, 2014 9:22 am

Eastern Connecticut Health Network President and CEO Peter J. Karl on Tuesday disclosed that three weeks earlier the board of trustees at the regional nonprofit approved a definitive agreement to sell it to a for-profit hospital chain in Texas.

Karl also revealed that under the agreement with Tenet Healthcare Corp. and its junior partner in the joint venture poised to make the acquisition, Yale New Haven Health System, ECHN's Rockville General Hospital in Vernon could not be shuttered for three years after a sale.

When a questioner suggested that period was too short and asked if "you are selling us down the river," Karl adamantly denied doing so.

"This is the best for the community because we are able to invest in the organization," he said, adding the "alternative scenario" would mean that ECHN would have to close both Rockville General and its second, larger hospital, Manchester Memorial, "within a five-year period."

The CEO's comments came as he and others involved in the controversial deal — Trip Pilgrim, the chief development officer at Tenet, and Vincent Petrini, a senior vice president at Yale New Haven Health — were grilled by about a dozen area residents who attended a forum at Rockville High School on the proposed sale.

Several made observations that led to awkward silences among the officials as audience members called out for them to respond.

Though the board of trustees has signed off on the deal, any sale also would require approval by ECHN's "corporators" as well as by state regulators.

'Run them into a ditch'

The most stinging comments came from Vernon resident Jean Merz, who blasted Tenet, its past corporate practices, and its compensation of executives. She also suggested that Karl had mismanaged ECHN and run its Manchester Memorial and Rockville General hospitals into the ground.

Merz said she and others also didn't believe that ECHN had done "due diligence" on Tenet. Karl and his colleagues, she said, appear to have found their corporate partner in "the Cayman Islands," a reference to the annual sojourns ECHN officials and some of their spouses have made to the Caribbean nation, ostensibly for business meetings of the network's offshore insurance subsidiary.

"Mr. Pilgrim, we don't want your company in Connecticut, we don't want you at Rockville," she told the Tenet executive. "We do not want money going to your CEO, who makes $22 million a year. We do not want money going to your stockholders. … We think your company looks for loopholes in Medicare and Medicaid to perpetuate fraud.

"Mr. Karl, we don't think you own Rockville General or Manchester Memorial hospitals, we think that the people of those towns own them," she added. "You've run them — and you've run them into a ditch."

Neither Karl, Pilgrim, nor Petrini responded to Merz.

Dying a slow death

The officials also took flak from two former mayors of Vernon, both Democrats. Rockville General, despite cuts in recent years, remains one of the town's largest private employers.

One of them, Ellen Marmer — a pediatric cardiac surgeon who was on the Rockville General staff for more than three decades — suggested that the financial problems ECHN is experiencing today began with the merger between Manchester Memorial and Rockville General that created the health system.

"We heard the same dog-and-pony show when you lost maternity for us," she said, referring to the closure several years ago of Rockville's birthing unit. "I refuse to let this hospital die a Tenet, Yale, and ECHN death."

She added: "Two people will tell you to go to hell, and from one, you'll ask directions, and the other, you'll want to punch out. I want to punch you out, because you're telling us to go to hell."

Former Mayor Marie Herbst objected to the provision that Karl said would ensure that Rockville General remain open for three years.

Herbst, one of the 261 community volunteers who as ECHN corporators will be asked to approve the trustees' decision to sell, said Rockville General is in a section of Vernon

where residents don't necessarily have cars to drive to other towns for medical care and where many may not be properly insured, so "three years is not a guarantee."

"It is our community hospital — it is our home — it belongs to us," she said, adding that she didn't think the partners in the planned deal had given enough thought to what would happen if the hospital closed.

"You're taking something that belongs to this community and you're giving it away, and the only thing I can find at all is that it might last three years, and that's not enough for me," she said.

Questions ducked

An hour before the 90-minute meeting at the high school, an ECHN spokeswoman, Nina Kruse, offered a limited response to 15 questions about the planned buyout that were posed last weekend by the Journal Inquirer.

Kruse declined, for example, to say whether ECHN had agreed to provide any particular severance benefits to its top executives in the event of a sale, citing a policy of "not sharing private employee matters."

Similarly, asked if ECHN or Tenet had agreed to specific staffing levels after an acquisition, she said such details "are subject to the confidentiality terms in the negotiated agreement" and would be disclosed later during "the regulatory approval process."

The spokeswoman cited the same confidentiality terms as she ducked questions about whether ECHN had negotiated any protections for nonunion employees, especially at Rockville General, in the event of a sale.

Asked if Tenet had agreed not to sell or close ECHN facilities for a certain period of time, Kruse again cited the confidentiality terms — provisions apparently violated by Karl hours later as he responded to questions at the high school.

Karl in a brief address before the audience was invited to comment argued that the "era of free-standing, small hospital environment is coming to an end." He said there has been a "change in the landscape" brought about not only by the new federal health care law, but also by "a whole host of other cuts."

"Our job is to preserve the 3,000 employees that we have at ECHN," he said. "We want to make sure that we keep both hospitals open, that's part of the deal."

He added: "We want to make sure that we don't lose any more market share to Hartford."

The CEO also talked unusually frankly about "profit" — a word that has been studiously avoided by officials at the state's "nonprofit" hospitals, who instead have preferred to discuss "margins."

"We no longer generate enough profit to invest in our facilities," he said. "We need to figure out how to get our costs down as much as possible without eliminating any quality. ... If you don't generate enough of a profit, you simply can't reinvest in your hospitals. We have been generating a profit in the area of $6 million to $8 million a year, and the issue now with all of these added taxes and the sequestration, we can't generate that profit any longer.

"If the Affordable Care Act is successful, an organization is going to be paid completely differently for caring for the whole patient. … We recognize that the only way we can be sustainable is if we can get those costs down by 15 percent or 20 percent, and we can't do that any longer," he continued.

Asked by an Ellington resident "who gets the check" from Tenet upon a sale, Karl said "if there's any funds left over, they go to the attorney general's office, who reviews those funds to make sure all debts are paid, and then into a community foundation that is set up with a completely independent board of directors."

Pilgrim, meanwhile, emphasized that Tenet is well positioned to fix ECHN's financial problems, in part because of its access to capital. He also stressed that Tenet has the advantage of economies of scale, saying it is "like bulk purchasing, like going to Costco."

The benefits would accrue not only to the supply chain, he said, but also in the human resources and information technology departments.

Prospect snubs Vernon critic

Won't recognize Marmer's appointment by mayor to advisory panel

By Kym Soper
Journal Inquirer

The new, for-profit parent company of Rockville General Hospital has repeatedly rejected the Vernon mayor's appointment to a state-mandated advisory board without explanation, leaving that town without a voice, or a vote, at the table.

The move has many local officials baffled and in an uproar, as Vernon Mayor Daniel Champagne's candidate — Dr. Ellen Marmer, a pediatric heart surgeon and a former Vernon mayor — is clearly knowledgeable and qualified for the post.

State Rep. Michael Winkler, D-Vernon, said the appointment to the Prospect Medical Eastern Connecticut Health Network advisory board should be the mayor's prerogative, and that the new owners have no standing to reject it.

Marmer is "uniquely qualified" and "would be a strong advocate for Vernon in the continued operation of Rockville

SEE PROSPECT / PAGE 3

Prospect mum on Marmer's rejection

PROSPECT
CONTINUED FROM PAGE 1

General Hospital," Winkler said. "She's just a fantastic appointment by the mayor."

State Sen. Tony Guglielmo, R-Stafford, whose district includes Vernon and surrounding towns that Rockville General serves, agreed.

"She's certainly qualified as an M.D. and a former mayor, and as someone who will speak her mind," Guglielmo said. "If you go on straight qualifications, there's no question that she's a top flight person" for the job.

Champagne said he's been frustrated by the lack of representation on the board for his town, which is required by the state as a condition of the sale.

In October when California-based Prospect bought nonprofit ECHN in a $105 million deal, state regulators required it maintain an advisory board that includes voting community members from Manchester and Vernon, the two towns where hospitals are located.

Vernon residents, in particular, have grave concerns that Prospect will close Rockville General after the requirement to keep it operating for three years has passed.

Manchester Mayor Jay Moran nominated that town's Human Services Director, Mary Roche Cronin, to the 14-member board, and she said she has attended at least three meetings thus far.

Champagne, Marmer, and the town of Vernon remain steadfast, however, waiting for their seat on the advisory board, which is subordinate to Prospect's board of directors and primarily includes staff doctors from Manchester Memorial and Rockville General, interim CEO Michael Collins, and five individuals from ECHN's Board of Trustees.

ECHN and Prospect officials both refused to comment, either on the rejection of Marmer's appointment or to reveal the board members' names.

Marmer, who worked for decades at Rockville but now has admitting privileges at all Hartford hospitals, said Prospect doesn't want her on the board because she's been a vocal critic of the takeover.

"It's because I know where all the bodies are buried," Marmer said of Prospect's rejection. "They're afraid of me because I'm outspoken and I have a lot of history with the hospital and the town."

Marmer said Prospect's snub was done with "full malice and forethought on their part. The last thing they want is to have a proactive, knowledgeable person on that board."

Prospect and ECHN have already shown bad faith with staff layoffs last week, she said. They want someone who would "rubber-stamp" whatever they do.

"But I will continue to fight for this medical community until somebody shuts me up," she said. "If Prospect gets their way, Rockville won't be an active hospital — it'll be a way station. It's already happening."

And that will be the beginning of the end for Manchester Memorial Hospital, Marmer predicted.

Eventually, when Rockville General is no longer viable, residents from Bolton, Coventry, Ellington, Tolland, and the surrounding area will "hop on the highway and skip right on by Manchester and head into Hartford" only 10 more minutes away to see a doctor or get hospital care, she said.

For now, both Winkler and Guglielmo said they plan to investigate and see if the Vernon mayor has any recourse.

"When you make a contract, you have to keep to it. That's just the way we operate in a civil society," Guglielmo said. "You can't just get rid of what you don't like. Both sides are obligated to honor the deal."

Eastern Connecticut Health Network
71 Haynes Street
Manchester, CT 06040
860.533.3414
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February 28, 2017

Kimberly R. Martone
Director of Operations, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134

Re: Compliance with Certificate of Need Agreed Settlement under Docket #15-32016-486

Dear Ms. Martone:

I am in receipt of your email communication dated February 23, 2017 in which you requested additional information on behalf of OHCA relating to Stipulation #20 of the Certificate of Need listed under Docket #15-32016-486. Below are the responses of Prospect ECHN to the questions set forth in that email.

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provide further explanation as to the reason for candidate rejection. Please indicate why the recommendation was not accepted for the vacant board position. Has the Local Board been selected and what was the selection process?

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3. Prospect ECHN reviewed the requirements in Stipulation #20 of the Certificate of Need for "two unbiased persons" to serve as community members "selected in consultation with the Mayors of Manchester and Vernon."
4. Based on ECHN's consultation with the Mayor of Manchester who recommended Mary Roche-Cronin for the MMH community representative, Prospect ECHN determined her to be an unbiased person and named her to the MMH community representative position.
5. Prospect ECHN consulted with the Mayor of Vernon on the dates indicated in the response to Question 1 above, but has not as yet received from the Mayor of Vernon a recommendation for an unbiased person to serve as the RGH community representative. Thus, Prospect ECHN has not been able to fill that position.

Thank you for your consideration of this submission.

Very truly yours,

Michael Collins
Interim CEO

Enclosures

Approved but not OK; ECHN hospital sales questioned

By Don Michak and John Kennedy Journal Inquirer | Posted: Wednesday, April 30, 2014 9:22 am

Eastern Connecticut Health Network President and CEO Peter J. Karl on Tuesday disclosed that three weeks earlier the board of trustees at the regional nonprofit approved a definitive agreement to sell it to a for-profit hospital chain in Texas.

Karl also revealed that under the agreement with Tenet Healthcare Corp. and its junior partner in the joint venture poised to make the acquisition, Yale New Haven Health System, ECHN's Rockville General Hospital in Vernon could not be shuttered for three years after a sale.

When a questioner suggested that period was too short and asked if "you are selling us down the river," Karl adamantly denied doing so.

"This is the best for the community because we are able to invest in the organization," he said, adding the "alternative scenario" would mean that ECHN would have to close both Rockville General and its second, larger hospital, Manchester Memorial, "within a five-year period."

The CEO's comments came as he and others involved in the controversial deal — Trip Pilgrim, the chief development officer at Tenet, and Vincent Petrini, a senior vice president at Yale New Haven Health — were grilled by about a dozen area residents who attended a forum at Rockville High School on the proposed sale.

Several made observations that led to awkward silences among the officials as audience members called out for them to respond.

Though the board of trustees has signed off on the deal, any sale also would require approval by ECHN's "corporators" as well as by state regulators.

'Run them into a ditch'

The most stinging comments came from Vernon resident Jean Merz, who blasted Tenet, its past corporate practices, and its compensation of executives. She also suggested that Karl had mismanaged ECHN and run its Manchester Memorial and Rockville General hospitals into the ground.

Merz said she and others also didn't believe that ECHN had done "due diligence" on Tenet. Karl and his colleagues, she said, appear to have found their corporate partner in "the Cayman Islands," a reference to the annual sojourns ECHN officials and some of their spouses have made to the Caribbean nation, ostensibly for business meetings of the network's offshore insurance subsidiary.

"Mr. Pilgrim, we don't want your company in Connecticut, we don't want you at Rockville," she told the Tenet executive. "We do not want money going to your CEO, who makes $22 million a year. We do not want money going to your stockholders. … We think your company looks for loopholes in Medicare and Medicaid to perpetuate fraud.

"Mr. Karl, we don't think you own Rockville General or Manchester Memorial hospitals, we think that the people of those towns own them," she added. "You've run them — and you've run them into a ditch."

Neither Karl, Pilgrim, nor Petrini responded to Merz.

Dying a slow death

The officials also took flak from two former mayors of Vernon, both Democrats. Rockville General, despite cuts in recent years, remains one of the town's largest private employers.

One of them, Ellen Marmer — a pediatric cardiac surgeon who was on the Rockville General staff for more than three decades — suggested that the financial problems ECHN is experiencing today began with the merger between Manchester Memorial and Rockville General that created the health system.

"We heard the same dog-and-pony show when you lost maternity for us," she said, referring to the closure several years ago of Rockville's birthing unit. "I refuse to let this hospital die a Tenet, Yale, and ECHN death."

She added: "Two people will tell you to go to hell, and from one, you'll ask directions, and the other, you'll want to punch out. I want to punch you out, because you're telling us to go to hell."

Former Mayor Marie Herbst objected to the provision that Karl said would ensure that Rockville General remain open for three years.

Herbst, one of the 261 community volunteers who as ECHN corporators will be asked to approve the trustees' decision to sell, said Rockville General is in a section of Vernon

where residents don't necessarily have cars to drive to other towns for medical care and where many may not be properly insured, so "three years is not a guarantee."

"It is our community hospital — it is our home — it belongs to us," she said, adding that she didn't think the partners in the planned deal had given enough thought to what would happen if the hospital closed.

"You're taking something that belongs to this community and you're giving it away, and the only thing I can find at all is that it might last three years, and that's not enough for me," she said.

Questions ducked

An hour before the 90-minute meeting at the high school, an ECHN spokeswoman, Nina Kruse, offered a limited response to 15 questions about the planned buyout that were posed last weekend by the Journal Inquirer.

Kruse declined, for example, to say whether ECHN had agreed to provide any particular severance benefits to its top executives in the event of a sale, citing a policy of "not sharing private employee matters."

Similarly, asked if ECHN or Tenet had agreed to specific staffing levels after an acquisition, she said such details "are subject to the confidentiality terms in the negotiated agreement" and would be disclosed later during "the regulatory approval process."

The spokeswoman cited the same confidentiality terms as she ducked questions about whether ECHN had negotiated any protections for nonunion employees, especially at Rockville General, in the event of a sale.

Asked if Tenet had agreed not to sell or close ECHN facilities for a certain period of time, Kruse again cited the confidentiality terms — provisions apparently violated by Karl hours later as he responded to questions at the high school.

Karl in a brief address before the audience was invited to comment argued that the "era of free-standing, small hospital environment is coming to an end." He said there has been a "change in the landscape" brought about not only by the new federal health care law, but also by "a whole host of other cuts."

"Our job is to preserve the 3,000 employees that we have at ECHN," he said. "We want to make sure that we keep both hospitals open, that's part of the deal."

He added: "We want to make sure that we don't lose any more market share to Hartford."

The CEO also talked unusually frankly about "profit" — a word that has been studiously avoided by officials at the state's "nonprofit" hospitals, who instead have preferred to discuss "margins."

"We no longer generate enough profit to invest in our facilities," he said. "We need to figure out how to get our costs down as much as possible without eliminating any quality. ... If you don't generate enough of a profit, you simply can't reinvest in your hospitals. We have been generating a profit in the area of $6 million to $8 million a year, and the issue now with all of these added taxes and the sequestration, we can't generate that profit any longer.

"If the Affordable Care Act is successful, an organization is going to be paid completely differently for caring for the whole patient. … We recognize that the only way we can be sustainable is if we can get those costs down by 15 percent or 20 percent, and we can't do that any longer," he continued.

Asked by an Ellington resident "who gets the check" from Tenet upon a sale, Karl said "if there's any funds left over, they go to the attorney general's office, who reviews those funds to make sure all debts are paid, and then into a community foundation that is set up with a completely independent board of directors."

Pilgrim, meanwhile, emphasized that Tenet is well positioned to fix ECHN's financial problems, in part because of its access to capital. He also stressed that Tenet has the advantage of economies of scale, saying it is "like bulk purchasing, like going to Costco."

The benefits would accrue not only to the supply chain, he said, but also in the human resources and information technology departments.

Prospect snubs Vernon critic

Won't recognize Marmer's appointment by mayor to advisory panel

By Kym Soper
Journal Inquirer

The new, for-profit parent company of Rockville General Hospital has repeatedly rejected the Vernon mayor's appointment to a state-mandated advisory board without explanation, leaving that town without a voice, or a vote, at the table.

The move has many local officials baffled and in an uproar, as Vernon Mayor Daniel Champagne's candidate — Dr. Ellen Marmer, a pediatric heart surgeon and a former Vernon mayor — is clearly knowledgeable and qualified for the post.

State Rep. Michael Winkler, D-Vernon, said the appointment to the Prospect Medical Eastern Connecticut Health Network advisory board should be the mayor's prerogative, and that the new owners have no standing to reject it.

Marmer is "uniquely qualified" and "would be a strong advocate for Vernon in the continued operation of Rockville

■ SEE **PROSPECT** / PAGE 3

Prospect mum on Marmer's rejection

■ **PROSPECT**
CONTINUED FROM PAGE 1

General Hospital," Winkler said. "She's just a fantastic appointment by the mayor."

State Sen. Tony Guglielmo, R-Stafford, whose district includes Vernon and surrounding towns that Rockville General serves, agreed.

"She's certainly qualified as an M.D. and a former mayor, and as someone who will speak her mind," Guglielmo said. "If you go on straight qualifications, there's no question that she's a top flight person" for the job.

Champagne said he's been frustrated by the lack of representation on the board for his town, which is required by the state as a condition of the sale.

In October when California-based Prospect bought nonprofit ECHN in a $105 million deal, state regulators required it maintain an advisory board that includes voting community members from Manchester and Vernon, the two towns where hospitals are located.

Vernon residents, in particular, have grave concerns that Prospect will close Rockville General after the requirement to keep it operating for three years has passed.

Manchester Mayor Jay Moran nominated that town's Human Services Director, Mary Roche Cronin, to the 14-member board, and she said she has attended at least three meetings thus far.

Champagne, Marmer, and the town of Vernon remain steadfast, however, waiting for their seat on the advisory board, which is subordinate to Prospect's board of directors and primarily includes staff doctors from Manchester Memorial and Rockville General, interim CEO Michael Collins, and five individuals from ECHN's Board of Trustees.

ECHN and Prospect officials both refused to comment, either on the rejection of Marmer's appointment or to reveal the board members' names.

Marmer, who worked for decades at Rockville but now has admitting privileges at all Hartford hospitals, said Prospect doesn't want her on the board because she's been a vocal critic of the takeover.

"It's because I know where all the bodies are buried," Marmer said of Prospect's rejection. "They're afraid of me because I'm outspoken and I have a lot of history with the hospital and the town."

Marmer said Prospect's snub was done with "full malice and forethought on their part. The last thing they want is to have a proactive, knowledgeable person on that board."

Prospect and ECHN have already shown bad faith with staff layoffs last week, she said. They want someone who would "rubber-stamp" whatever they do.

"But I will continue to fight for this medical community until somebody shuts me up," she said. "If Prospect gets their way, Rockville won't be an active hospital — it'll be a way station. It's already happening."

And that will be the beginning of the end for Manchester Memorial Hospital, Marmer predicted.

Eventually, when Rockville General is no longer viable, residents from Bolton, Coventry, Ellington, Tolland, and the surrounding area will "hop on the highway and skip right on by Manchester and head into Hartford" only 10 more minutes away to see a doctor or get hospital care, she said.

For now, both Winkler and Guglielmo said they plan to investigate and see if the Vernon mayor has any recourse.

"When you make a contract, you have to keep to it. That's just the way we operate in a civil society," Guglielmo said. "You can't just get rid of what you don't like. Both sides are obligated to honor the deal."

User, OHCA

From: Roberts, Karen
Sent: Monday, March 06, 2017 1:15 PM
To: colleen713.smith@gmail.com
Cc: Martone, Kim; Cotto, Carmen; User, OHCA
Subject: Re: Compliance with CON Docket # 15-32016-486, Prospect ECHN

To: Colleen Scott, MSN, RN, NEA-BC
Independent Monitor for Prospect ECHN CON Docket # 15-32016-486

Hi Ms. Scott – as the Independent Monitor for the Prospect ECHN CON under Docket # 15-32016-486, we wanted to alert you to several compliance related email communications that have recently occurred between the Office of Health Care Access (OHCA) and Mr. Michael Collins, Interim CEO for the two Prospect ECHN hospitals. Please reference PDF pages 716 – 772 of http://www.ct.gov/dph/lib/dph/ohca/con_completed/2016/15_32016_486_compliance.pdf for the recent communications that have occurred.

Condition #20 states:

> 20. For three (3) years following the Closing Date, PMH shall allow for two (2) community representatives to serve as voting members of the New MMH and New RGH Local Board with rights and obligations consistent with other voting members under the Local Board Bylaws. The community representatives shall be selected in consultation with the Mayors of Manchester and Vernon in order to ensure the appointment of two unbiased persons who will fairly represent the interests of the communities served by MMH and RGH, respectively. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d, 19a-613(b), 19a-639(a)(2),(3),(5),(7),(8),(11) & (12); FF 28-30*

At this time, there is no further questions for the Applicant in this regard, but OHCA will continue to need to be kept updated on the status of or any changes to the two community representatives, required pursuant to Condition #20.

Thank you.

Sincerely,

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: *karen.roberts@ct.gov*



User, OHCA

From: Colleen Smith <colleen713.smith@gmail.com>
Sent: Monday, March 06, 2017 4:29 PM
To: Roberts, Karen
Cc: Martone, Kim; Cotto, Carmen; User, OHCA
Subject: Re: Compliance with CON Docket # 15-32016-486, Prospect ECHN

Dear Karen,
Thank you for this update regarding Condition #20. I was aware that ECHN has experienced difficulty in finding a suitable Vernon representative for the local Advisory Board. I will follow up immediately with Dennis McConville and Michael Collins regarding their progress in filling this position with a qualified, unbiased Vernon community representative.
Sincerely,
Colleen Smith

Colleen O'Brien Smith MSN RN NEA-BC
Nursing Consulting Partners, LLC
690C9 S. Park View Court
Franklin, WI 53132
Phone: 203-245-1044
Cell: 203-671-1348
colleen713.smith@gmail.com
http://nursingconsultingpartners.com/

On Mar 6, 2017, at 1:14 PM, Roberts, Karen <Karen.Roberts@ct.gov> wrote:

To: Colleen Scott, MSN, RN, NEA-BC
Independent Monitor for Prospect ECHN CON Docket # 15-32016-486

Hi Ms. Scott – as the Independent Monitor for the Prospect ECHN CON under Docket # 15-32016-486, we wanted to alert you to several compliance related email communications that have recently occurred between the Office of Health Care Access (OHCA) and Mr. Michael Collins, Interim CEO for the two Prospect ECHN hospitals. Please reference PDF pages 716 – 772 of http://www.ct.gov/dph/lib/dph/ohca/con_completed/2016/15_32016_486_compliance.pdf for the recent communications that have occurred.

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health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d, 19a-613(b), 19a-639(a)(2),(3),(5),(7),(8),(11) & (12); FF 28-30*

At this time, there is no further questions for the Applicant in this regard, but OHCA will continue to need to be kept updated on the status of or any changes to the two community representatives, required pursuant to Condition #20.

Thank you.

Sincerely,

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: *karen.roberts@ct.gov*

<image001.jpg>

User, OHCA

From:	Roberts, Karen
Sent:	Tuesday, March 07, 2017 11:17 AM
To:	colleen713.smith@gmail.com
Cc:	Cotto, Carmen; User, OHCA; Martone, Kim
Subject:	CON Compliance issue for Docket # 15-32016-486 Prospect ECHN

To: Colleen O'Brien Smith MSN RN NEA-BC
Nursing Consulting Partners, LLC
690C9 S. Park View Court
Franklin, WI 53132
Phone: 203-245-1044
Cell: 203-671-1348
colleen713.smith@gmail.com
http://nursingconsultingpartners.com/

Hi Colleen

This email is being sent to you as the Independent Monitor for the Certificate of Need (CON) Order issued under Docket Number 15-32016-486 for Prospect ECHN. Please be informed OHCA finds that the submission sent by Prospect ECHN on October 20, 2016 which included the *"final execution copies of the Asset Purchase Agreement with schedules ..."* is deficient in terms of the wording of Condition #3 of the CON Order, which states the following (yellow highlighting added):

3. Applicants shall notify OHCA in writing of the Closing Date of the Asset Purchase authorized by this Order within twenty (20) days of such closing and shall supply final execution copies of all agreements related to same, including but not limited to:
    a. the APA, including any and all schedules and exhibits; and
    b. Bylaws or similar governance documents for New ECHN, as well as for New MMH and New ROH.

The Applicants may redact from the APA any information that is exempt from disclosure under Conn. Gen. Stat. § 1-210. If the Applicants redact materials in accordance with the revious sentence, the Applicants shall provide a list to OHCA, which identifies in general terms the nature of the redacted material and why it is claimed to be exempt for ublic record j)Ur oses.

The material filed by Prospect ECHN on October 20, 2016 {which is on the OHCA website at http://www.ct.gov/dph/lib/dph/ohca/con_completed/2016/15_32016_486_compliance.pdf)} has a significant number of Schedules to the Asset Purchase Agreement, but there are numerous Schedules wherein Prospect ECHN merely lists Redacted per Conn. Gen. Stat. § 1-210(b)" then either sub (2) or (5) is listed. There is no filing of the required list to OHCA identifying the redacted material and "why it is claimed to be exempt for public record purposes."

As Independent Monitor for this CON Docket Number, please have this compliance issue resolved at the earliest possible convenience. Thank you. Karen

Sincerely,

User, OHCA

From:	Colleen Smith <colleen713.smith@gmail.com>
Sent:	Tuesday, March 07, 2017 12:08 PM
To:	Roberts, Karen
Cc:	Cotto, Carmen; User, OHCA; Martone, Kim
Subject:	Re: CON Compliance issue for Docket # 15-32016-486 Prospect ECHN

Dear Karen,
I will follow up with ECHN today.
Thanks,
Colleen Smith

On Mar 7, 2017, at 11:16 AM, Robe1ts, Karen <Karen.Roberts@ct.gov> wrote:

To: Colleen O'Brien Smith MSN RN NEA-BC
Nursing Consulting Partners, LLC
690C9 S. Park View Court
Franklin, WI 53132
Phone: 203-245-1044
Cell: 203-671-1348
colleen7 I 3.smith@gmail.com
http://nursingconsultingpartners.com/

Hi Colleen

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The Applicants may redact from the APA any information that is exempt from disclosure under Conn. Gen. Stat. § 1-210. If the AQPlicants redact materials in accordance with the previous sentence, the Applicants shall provide a list to OHCA, which identifies in general terms the nature of the redacted material and why it is claimed to be exem_Bt for ubl ic record ur oses.

The material filed by Prospect ECHN on October 20, 2016 {which is on the OHCA website at http://www.ct.gov/dph/lib/dph/ohca/con_completed/2016/15_32016_486_compliance.pdf)} has a significant number of Schedules to the Asset Purchase Agreement, but there are numerous Schedules wherein Prospect ECHN merely lists Redacted per Conn. Gen. Stat. § 1-21O(b)" then either sub (2) or (5) is listed. There is no filing of the required list to OHCA identifying the redacted material and "why it is claimed to be exempt for public record purposes."

As Independent Monitor for this CON Docket Number, please have this compliance issue resolved at the earliest possible convenience. Thank you. Karen

Sincerely,

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 *I E: karen.roberts@ct.gov*

<imageOOl.jpg >

User, OHCA

From: Roberts, Karen
Sent: Tuesday, March 07, 2017 2:27 PM
To: Mcconville, Dennis P; colleen713.smith@gmail.com
Cc: User, OHCA; Cotto, Carmen
Subject: Regarding CON Compliance filings for Docket #15-32016-486 (Prospect ECHN)

Hi Mr. McConville

This email is regarding the contents of your letter attached to an email sent to OHCA on November 30, 2016 (see email below) regarding the submission of material required by Conditions #8, #9 and #10 of the Certificate of Need Order. Your letter regards the timing of the initial filings for the material required by these three Conditions. Please note the following regarding the timeframes you mention in your letter:

- Regarding Condition #8, per the wording of the Condition this material is due "*Within one hundred and eighty (180) days following the Closing Date and thereafter on the same semi-annual schedule as set forth in Conditions 9 and 10"*. The initial capital commitment report is due **March 30, 2017**, which is 180 days from the 10/1 closing date. After the initial filing, the submissions follow the 5/31 and 11/30 timeframes. OHCA notes that the **March 30th** date is close to the semi-annual filing date for the additional financial filings in #9 and #10 due on **May 31st**. Please indicate whether the Applicant will be ready to file this material on the due date of **March 30th** or would like OHCA to consider having the initial submission regarding instead filed on **May 31st**.

- Regarding the initial submission of Conditions 9 and 10 on **May 31, 2017** rather than the **November 30, 2016** date listed in the wording of the conditions; that seems reasonable considering the timing of the closing date (10/1/2016).

- OHCA further notes that there are several Conditions that require information to be filed by **March 30, 2017**, 180 days from the closing: Condition #4, Condition #6, and the aforementioned Condition #8.

Please let OHCA know whether the Applicant will be filing the initial financial report due pursuant to Condition #8 on March 30, 2017 or whether the Applicant would like to consider having the initial filing submitted on or by May 31, 2017. Thank you. Karen

Sincerely,

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: *karen.roberts@ct.gov*



From: Mcconville, Dennis P [mailto:dmcconville@echn.org]
Sent: Wednesday, November 30, 2016 3:00 PM
To: User, OHCA
Cc: Martone, Kim; Ellen J. Shin (ellen.shin@prospectmedical.com); Joyce A. Tichy Esq. (joyce.tichy@gmail.com) (joyce.tichy@gmail.com); Michele Volpe; Collins, Michael; Jonathan.Spees; Garrison DeLee (garrison.delee@prospectmedical.com); Frank.Saidara; Basile, Mary C
Subject: 15-32016-486-CON

The attached letter is submitted as required for conditions 8, 9 and 10 contained in the Final Decision for Docket Number: 15-32016-486-CON, the Transfer of assets of Eastern Connecticut Health Network, Inc. to Prospect Medical Holdings.

Dennis P. McConville
Senior Vice President
Eastern Connecticut Health Network, Inc.
(860) 533-3429 (office)
dmcconville@echn.org

"This message originates from Eastern Connecticut Health Network. The information contained in this message may be privileged and confidential. If you are the intended recipient, you must maintain this message in a secure and confidential manner. If you are not the intended recipient, please notify the sender immediately and destroy this message. Thank you."

User, OHCA

From: Roberts, Karen
Sent: Tuesday, March 07, 2017 3:33 PM
To: User, OHCA
Cc: Cotto, Carmen
Subject: FW: Regarding CON Compliance filings for Docket #15-32016-486 (Prospect ECHN)

For the file for Docket # 15-32016-486, Prospect ECHN.

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: *karen.roberts@ct.gov*

From: Martone, Kim
Sent: Tuesday, March 07, 2017 3:32 PM
To: 'dmcconville@echn.org'
Cc: Roberts, Karen
Subject: FW: Regarding CON Compliance filings for Docket #15-32016-486 (Prospect ECHN)

Dennis, your request is fine.

Kim

Kimberly R. Martone
Director of Operations, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134
Phone: 860-418-7029 Fax: 860-418-7053
Email: Kimberly.Martone@ct.gov Website: www.ct.gov/ohca

From: Roberts, Karen
Sent: Tuesday, March 07, 2017 3:29 PM

To: Martone, Kim
Subject: FW: Regarding CON Compliance filings for Docket #15-32016-486 (Prospect ECHN)

From: Mcconville, Dennis P [mailto:dmcconville@echn.org]
Sent: Tuesday, March 07, 2017 3:12 PM
To: Roberts, Karen
Cc: User, OHCA; Cotto, Carmen; colleen713.smith@gmail.com
Subject: RE: Regarding CON Compliance filings for Docket #15-32016-486 (Prospect ECHN)

Karen.

Thank you. I interpreted the language in Condition #8 with the reference to the "*same semi-annual schedule as set forth in Conditions 9 and 10*", as applying to all the required filing dates for Condition #8. With the closing of our transaction on October 1, 2016, it makes sense to me because we are reporting capital investments through March 31, 2017 which marks the end of the 180 day period post-closing. That would give us time to produce the report. Prospect ECHN respectfully requests permission to file the Capital Investment Report with the information for Conditions 9 and 10 no later than May 31, 2017.

The information for Conditions 4 and 6 will be filed by March 30, 2017.

Thank you,

Dennis

From: Roberts, Karen [mailto:Karen.Roberts@ct.gov]
Sent: Tuesday, March 07, 2017 2:27 PM
To: Mcconville, Dennis P; colleen713.smith@gmail.com
Cc: User, OHCA; Cotto, Carmen
Subject: Regarding CON Compliance filings for Docket #15-32016-486 (Prospect ECHN)

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- OHCA further notes that there are several Conditions that require information to be filed by **March 30, 2017**, 180 days from the closing: Condition #4, Condition #6, and the aforementioned Condition #8.

Please let OHCA know whether the Applicant will be filing the initial financial report due pursuant to Condition #8 on March 30, 2017 or whether the Applicant would like to consider having the initial filing submitted on or by May 31, 2017. Thank you. Karen

Sincerely,

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: *karen.roberts@ct.gov*

From: Mcconville, Dennis P [mailto:dmcconville@echn.org]
Sent: Wednesday, November 30, 2016 3:00 PM
To: User, OHCA
Cc: Martone, Kim; Ellen J. Shin (ellen.shin@prospectmedical.com); Joyce A. Tichy Esq. (joyce.tichy@gmail.com) (joyce.tichy@gmail.com); Michele Volpe; Collins, Michael; Jonathan.Spees; Garrison DeLee (garrison.delee@prospectmedical.com); Frank.Saidara; Basile, Mary C
Subject: 15-32016-486-CON

The attached letter is submitted as required for conditions 8, 9 and 10 contained in the Final Decision for Docket Number: 15-32016-486-CON, the Transfer of assets of Eastern Connecticut Health Network, Inc. to Prospect Medical Holdings.

Dennis P. McConville
Senior Vice President
Eastern Connecticut Health Network, Inc.
(860) 533-3429 (office)
dmcconville@echn.org

"This message originates from Eastern Connecticut Health Network. The information contained in this message may be privileged and confidential. If you are the intended recipient, you must maintain this message in a secure and confidential manner. If you are not the intended recipient, please notify the sender immediately and destroy this message. Thank you."

User, OHCA

From: Mcconville, Dennis P <dmcconville@echn.org>
Sent: Tuesday, March 14, 2017 11:36 AM
To: User, OHCA; Roberts, Karen
Cc: Martone, Kim; Colleen Smith; Tichy, Joyce A; Basile, Mary C; Collins, Michael; Frank.Saidara; Garrison DeLee (garrison.delee@prospectmedical.com)
Subject: DN 15-32016-486 CON, List of Redacted Schedules
Attachments: DN 15-32016-486 CON, Letter Addressing Condition #3, Karen Roberts 03 14 17.pdf

Karen,

Please find the attached letter which includes the list of redacted material for the Asset Purchase Agreement for Manchester Memorial Hospital and Rockville General Hospital. The list identifies in general terms the nature of the redacted material and why it is claimed to be exempt for public record purposes.

Regards,

Dennis

Dennis P. McConville
Senior Vice President
Eastern Connecticut Health Network, Inc.
(860) 533-3429 (office)
(860) 268-4591 (cell)
(860) 647-6860 (fax)
dmcconville@echn.org

"This message originates from Eastern Connecticut Health Network. The information contained in this message may be privileged and confidential. If you are the intended recipient, you must maintain this message in a secure and confidential manner. If you are not the intended recipient, please notify the sender immediately and destroy this message. Thank you."

Eastern Connecticut Health Network
71 Haynes Street
Manchester, CT 06040
860.533.3414
www.echn.org

March 14, 2017

VIA EMAIL

Karen Roberts
Principal Healthcare Analyst
Office of Health Care Access
Department of Public Health
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Re: **Docket Number: 15-32016-486**

Project Title: **Transfer of assets of Eastern Connecticut Health Network, Inc. to Prospect Medical Holdings, Inc.**

Dear Ms. Roberts:

Pursuant to Condition Number Three (3) of the Order for the above referenced Certificate of Need Final Decision, please find the attached list of redacted material for the Asset Purchase Agreement for Prospect Manchester Hospital, Inc. and for Prospect Rockville Hospital, Inc. which identifies in general terms the nature of the redacted material and why it is claimed to be exempt for public record purposes.

If you have any questions or need anything further, please feel free to contact me at (860) 533-3429.

Very truly yours,

Dennis P. McConville
Senior Vice President
Eastern Connecticut Health Network

cc: Kimberly Martone, Director of Operations, Department of Public Health Division of Office of Health Care Access
Colleen Smith, Nursing Consultant Partners, LLC
Joyce A. Tichy, Senior Vice President and General Counsel, ECHN
Michael Collins, Interim CEO, ECHN
Frank Saidara, Vice President, Corporate Development, Prospect Medical Holdings, Inc.
Garrison De Lee, Assistant General Counsel, Prospect Medical Holdings, Inc.

Re: Docket Number: 15-32016-486
Project Title: Transfer of assets of Eastern Connecticut Health Network, Inc. to Prospect Medical Holdings, Inc.

Condition Number Three (3)
List of schedules redacted and reason for redaction

Redacted Schedule	Description	Statutory Reference	Reason
Schedule 1.02(i)	Persons with "Seller's Knowledge"	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(2)]	Contains files the disclosure of which would constitute an invasion of personal privacy
Schedule 2.01(b)	Leased Real Property	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]	Contains information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy
Schedule 2.01(c)	Leased Personal Property	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]	Contains (a) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy, and (b) commercial or financial information given in confidence
Schedule 2.01(f)	Assumed Contracts	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]	Contains (a) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy, and (b) commercial or financial information given in confidence
Schedule 2.01(f) Addendum	Resident Agreements for Residents of ECHN Eldercare Services, Inc. d/b/a Woodlake at Tolland Rehabilitation & Nursing Center	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(2) & (b)(5)]	Contains (a) files the disclosure of which would create an invasion of personal privacy; and (b) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy, and (c) commercial or financial information given in confidence
Schedule 2.02(j)	Excluded Contracts	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]	Contains (a) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy, and (b) commercial or financial information given in confidence
Schedule 2.05	Examples of Implementation of Section 2.05	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]	Contains information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy
Schedule 2.05(a)	Joint Venture Valuations	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]	Contains (a) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy, and (b) commercial or financial information given in confidence
Schedule 3.02	Consents	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]	Contains (a) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy, and (b) commercial or financial information given in confidence
Schedule 3.04	Subsidiaries and Third Party Rights	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]	Contains (a) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy; and (b) commercial or financial information given in confidence
Schedule 3.05	Legal and Regulatory Compliance	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]	Contains (a) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy; and (b) commercial or financial information given in confidence

Schedule 3.06	Audited and Unaudited Financial Statements*	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]	Contains (a) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy; and (b) commercial or financial information given in confidence
Schedule 3.08	Recent Activities	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]	Contains (a) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy; and (b) commercial or financial information given in confidence
Schedule 3.08(d)	Sold Assets	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]	Contains (a) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy; and (b) commercial or financial information given in confidence
Schedule 3.10	Equipment Depreciation Schedule	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]	Contains (a) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy; and (b) commercial or financial information given in confidence
Schedule 3.12(c)	Buildings Not Structurally Sound or in Need of Material Repairs	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]	Contains (a) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy; and (b) commercial or financial information given in confidence
Schedule 3.12(g)	Rent Roll	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]	Contains (a) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy; and (b) commercial or financial information given in confidence
Schedule 3.13(a)	Environmental Claims	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]	Contains (a) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy; and (b) commercial or financial information given in confidence
Schedule 3.13(b)	Materials of Environmental Concern Storage Locations/Underground Storage Tanks	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]	Contains (a) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy; and (b) commercial or financial information given in confidence
Schedule 3.14	Intellectual Properties and Information Systems	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]	Contains (a) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy; and (b) commercial or financial information given in confidence
Schedule 3.15	Insurance	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]	Contains (a) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy; and (b) commercial or financial information given in confidence
Schedule 3.17	Unexpected Occurrences	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(2)]	Contains medical files and similar files the disclosure of which would constitute an invasion of personal privacy
Schedule 3.19(d)	Prohibitions on Competition	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]	Contains (a) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy; and (b) commercial or financial information given in confidence
Schedule 3.21(c)	Claims Involving Legal Requirements of Employment	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(2)]	Contains personnel files the disclosure of which would constitute an invasion of personal privacy
Schedule 3.21(d)	Recently Terminated Employees	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(2)]	Contains personnel files the disclosure of which would constitute an invasion of personal privacy

Schedule 3.21(e)	Non-Competition Agreements	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]	Contains (a) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy; and (b) commercial or financial information given in confidence
Schedule 3.22	Employee Benefit Plans	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]	Contains (a) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy; and (b) commercial or financial information given in confidence
Schedule 3.22(g)	Employee Welfare Benefit Plan	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]	Contains (a) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy; and (b) commercial or financial information given in confidence
Schedule 3.23	Proceedings and Claims	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(2)]	Contains personnel and medical files and similar files the disclosure of which would constitute an invasion of personal privacy
Schedule 3.25(a)	Medical Staff	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(2) & (b)(5)]	Contains (a) files the disclosure of which would create an invasion of personal privacy; and (b) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy, and (c) commercial or financial information given in confidence
Schedule 3.25(a)	Medical Staff Members Reported to National Practitioner Databank Reports within Past Three Years	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(2)]	Contains personnel files and similar files the disclosure of which would constitute an invasion of personal privacy
Schedule 3.25(b)	Material Medical Staff Disputes	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(2)]	Contains personnel files and similar files the disclosure of which would constitute an invasion of personal privacy
Schedule 3.30(c)	Outstanding Membership Interests	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]	Contains (a) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy; and (b) commercial or financial information given in confidence
Schedule 3.31	Ten Largest Non-Governmental Payors of Hospital Businesses	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]	Contains (a) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy; and (b) commercial or financial information given in confidence
Schedule 5.03(b)	Written Severance Agreements	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(2)]	Contains personnel files and similar files the disclosure of which would constitute an invasion of personal privacy
Schedule 5.25(b)	ECHN – Extended Reporting Period Options	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]	Contains (a) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy; and (b) commercial or financial information given in confidence
Schedule 5.30	Tax Claims	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]	Contains (a) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy; and (b) commercial or financial information given in confidence
Schedule 7.04(d)	Certain Other Consents	[REDACTED PER CONN. GEN. STAT. § 1-210(b)(5)]	Contains (a) information that derives independent economic value from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and is the subject of efforts that are reasonable under the circumstances to maintain secrecy; and (b) commercial or financial information given in confidence

User, OHCA

From: Roberts, Karen
Sent: Monday, March 20, 2017 2:14 PM
To: colleen713.smith@gmail.com
Cc: Cotto, Carmen; User, OHCA
Subject: RE: CON Compliance Prospect ECNH (DN 15-32016-486)

To: Colleen O□Brien Smith MSN RN NEA-BC
Nursing Consulting Partners, LLC
690C9 S. Park View Court
Franklin, WI 53132
Phone: 203-245-1044
Cell: 203-671-1348
colleen713.smith@gmail.com
http:□nursingconsultingpartners.com□

Hi Colleen:

This email is being sent to you as the Independent Monitor for the Certificate of Need (CON) Order issued under Docket Number 15-32016-486 for Prospect ECHN. Please be informed that the Office of Health Care Access (□OHCA□) re□uires additional clarification for the public record regarding the formation and operation of the Local Board or Boards for Prospect ECHN. The wording of the February 17th and 28th responses to OHCA from Prospect ECHN appear to discuss this body as a singular Local Board (term Board is used instead of Boards).

The following is Finding of Fact □28 of the CON Agreed Settlement for Docket Number 15-32016-486 (underlining added):

> Following the closing, New MMH and New RGH will each maintain an advisory board subordinate to PMH□s Board of Directors and comprised of community representatives, physicians on the medical staffs of New MMH and New RGH, and the New Hospitals□CEO (the □Local Board□). The initial members of the Local Board will include at least five members of ECHN□s Board of Trustees. PMH plans to appoint the same individuals to the Local Board of New MMH and the Local Board of New RGH and to have the boards meet concurrently to encourage interaction within the system. PMH will schedule regular standing meetings to update the Local Board. Ex. G, p. 30; Ex. □, p. 2165

It is unclear from a review of material filed by Prospect ECHN since the transaction date, whether the Local Board is (a) a singular body, or (b) two separate boards that have the same membership and meet concurrently and is being called . As Independent Monitor for this CON Docket Number, please have Prospect ECHN provide clarification of this matter to OHCA at the earliest convenience. Thank you. □aren

Sincerely,

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health

410 Capitol Avenue, MS 13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 F: (860) 418-7053 E:*karen.roberts@ct.gov*

User, OHCA

From: Colleen Smith <colleen713.smith@gmail.com>
Sent: Monday, March 20, 2017 3:06 PM
To: Roberts, Karen
Cc: Cotto, Carmen; User, OHCA
Subject: Re: CON Compliance Prospect ECNH (DN 15-32016-486)

Dear Karen,
Dennis McConville and I have discussed the composition of the RGH and MMH advisory boards. Each does have individual local representatives from the 2 towns. However, most of the other board members are shared and the intent is to meet concurrently as a more efficient process and as stated in the 2/28 response to OHCA to encourage shared communication.
I will speak with Mr. McConville and request the additional clarification for the public record.
Best regards,
Colleen Smith

Colleen O'Brien Smith MSN RN NEA-BC
Nursing Consulting Partners, LLC
690C9 S. Park View Court
Franklin, WI 53132
Phone: 203-245-1044
Cell: 203-671-1348
colleen713.smith@gmail.com
http://nursingconsultingpartners.com/

On Mar 20, 2017, at 2:13 PM, Roberts, Karen <Karen.Roberts@ct.gov> wrote:

To: Colleen O'Brien Smith MSN RN NEA-BC
Nursing Consulting Partners, LLC
690C9 S. Park View Court
Franklin, WI 53132
Phone: 203-245-1044
Cell: 203-671-1348
colleen713.smith@gmail.com
http://nursingconsultingpartners.com/

Hi Colleen:

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The following is Finding of Fact # 28 of the CON Agreed Settlement for Docket Number 15-32016-486 (underlining added):

> Following the closing, New MMH and New RGH will each maintain an advisory board subordinate to PMH's Board of Directors and comprised of community representatives, physicians on the medical staffs of New MMH and New RGH, and the New Hospitals' CEO (the "Local Board"). The initial members of the Local Board will include at least five members of ECHN's Board of Trustees. PMH plans to appoint the same individuals to the Local Board of New MMH and the Local Board of New RGH and to have the boards meet concurrently to encourage interaction within the system. PMH will schedule regular standing meetings to update the Local Board. Ex. G, p. 30; Ex. K, p. 2165

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Sincerely,

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E:*karen.roberts@ct.gov*

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Franklin, WI 53132
Phone: 203-245-1044
Cell: 203-671-1348
colleen713.smith@gmail.com
http://nursingconsultingpartners.com/

User, OHCA

From: Roberts, Karen
Sent: Monday, March 20, 2017 3:08 PM
To: Colleen Smith
Cc: User, OHCA; Cotto, Carmen
Subject: RE: CON Compliance Prospect ECNH (DN 15-32016-486)

Thanks Colleen. We have the list of members from a previous filing and it is one list, but from that it is unclear if there are two organized bodies or one organized body (understanding that there is one set of members). Karen

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: *karen.roberts@ct.gov*

From: Colleen Smith [mailto:colleen713.smith@gmail.com]
Sent: Monday, March 20, 2017 3:06 PM
To: Roberts, Karen
Cc: Cotto, Carmen; User, OHCA
Subject: Re: CON Compliance Prospect ECNH (DN 15-32016-486)

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I will speak with Mr. McConville and request the additional clarification for the public record.
Best regards,
Colleen Smith

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Franklin, WI 53132
Phone: 203-245-1044
Cell: 203-671-1348
colleen713.smith@gmail.com
http://nursingconsultingpartners.com/

On Mar 20, 2017, at 2:13 PM, Roberts, Karen <Karen.Roberts@ct.gov> wrote:

To: Colleen O'Brien Smith MSN RN NEA-BC
Nursing Consulting Partners, LLC
690C9 S. Park View Court
Franklin, WI 53132
Phone: 203-245-1044
Cell: 203-671-1348
colleen713.smith@gmail.com
http://nursingconsultingpartners.com/

Hi Colleen:

This email is being sent to you as the Independent Monitor for the Certificate of Need (CON) Order issued under Docket Number 15-32016-486 for Prospect ECHN. Please be informed that the Office of Health Care Access ("OHCA") requires additional clarification for the public record regarding the formation and operation of the Local Board or Boards for Prospect ECHN. The wording of the February 17th and 28th responses to OHCA from Prospect ECHN appear to discuss this body as a singular Local Board (term Board is used instead of Boards).

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Sincerely,

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E:*karen.roberts@ct.gov*

Colleen O'Brien Smith MSN RN NEA-BC
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colleen713.smith@gmail.com
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User, OHCA

From: Roberts, Karen
Sent: Wednesday, March 29, 2017 2:23 PM
To: User, OHCA; Martone, Kim
Cc: Cotto, Carmen
Subject: FW: Response re Compliance with CON agreed settlement
Attachments: Compliance with CON agreed settlement under docket #15.32016.486.pdf

---

From: Perigo, Chantal [mailto:CPerigo@echn.org] **On Behalf Of** Collins, Michael
Sent: Wednesday, March 29, 2017 2:20 PM
To: Roberts, Karen
Subject: Response re Compliance with CON agreed settlement

Attached is our response to the questions regarding compliance with the CON agreed settlement under docket # 15-32016-486.

Should you have any additional questions, please feel free to contact our office at 860-533-3414

Regards,

Michael Collins
Interim CEO
ECHN

"This message originates from Eastern Connecticut Health Network. The information contained in this message may be privileged and confidential. If you are the intended recipient, you must maintain this message in a secure and confidential manner. If you are not the intended recipient, please notify the sender immediately and destroy this message. Thank you."

Eastern Connecticut Health Network
71 Haynes Street
Manchester, CT 06040
860.533.3414
www.echn.org

VIA ELECTRONIC MAIL AND REGULAR MAIL

March 29, 2017

Karen Roberts
Compliance Officer
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA
P.O. Box 340308
Hartford, Connecticut 06134

Re: Compliance with Certificate of Need Agreed Settlement under Docket #15-32016-486

Dear Ms. Roberts:

We understand that you have requested clarification of the structure of the Prospect ECHN, Inc. ("Prospect ECHN") Advisory Boards (Local Boards); i.e., whether (a) there is one Local Board that is operating as a singular body, or (b) there are two separate boards that have the same membership and meet concurrently.

The arrangement in place at Prospect ECHN for its Local Boards is consistent with description (b). In compliance with its obligation to maintain two separate Local Boards for its two hospitals, Prospect ECHN maintains two separate Local Advisory Boards which share the same membership and meet concurrently. To the extent that the term "Local Board" has been used in the past this was for convenience and in order to convey that because ECHN's two hospitals operate in an integrated manner, and because the Local Boards meet concurrently and have the same members, the Local Boards' activities and actions generally occur simultaneously for the common benefit of both hospitals. When appropriate, however, separate action is taken by the Local Boards with respect to each hospital.

Because this choice of terminology may have led to confusion, Prospect ECHN will endeavor going forward to use the plural term "Boards" when referring to the Local Advisory Boards.

Karen Roberts
Office of Health Care Access
March 29, 2017

Thank you for your consideration of this communication.

Very truly yours,

Michael Collins
Interim CEO

User, OHCA

From: Mcconville, Dennis P <dmcconville@echn.org>
Sent: Wednesday, March 29, 2017 3:11 PM
To: User, OHCA; Martone, Kim; Colleen Smith; Roberts, Karen
Cc: Ellen J. Shin (Legal Department); Tichy, Joyce A; Collins, Michael; Frank.Saidara; Garrison DeLee (garrison.delee@prospectmedical.com); Von.Crockett
Subject: DN 15-32016-486 CON Final Decision, Condition #4 and #6
Attachments: DN 15-32016-486 CON,Letter Addressing Condition #4_03 29 2017.pdf; DN 15-32016-486 CON,Letter Addressing Condition #6_03 29 2017.pdf

The attached letters are submitted as required for condition number 4 and for condition number 6 contained in the Final Decision for Docket Number: 15-32016-486-CON, the Transfer of Assets of Eastern Connecticut Health Network, Inc. to Prospect Medical Holdings.

Dennis P. McConville
Senior Vice President
Eastern Connecticut Health Network, Inc.
(860) 533-3429 (office)
dmcconville@echn.org

"This message originates from Eastern Connecticut Health Network. The information contained in this message may be privileged and confidential. If you are the intended recipient, you must maintain this message in a secure and confidential manner. If you are not the intended recipient, please notify the sender immediately and destroy this message. Thank you."

Eastern Connecticut Health Network
71 Haynes Street
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March 29, 2017

Deputy Commissioner Janet M. Brancifort, MPH, RRT
Office of Health Care Access
Department of Public Health
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134

Re: **Docket Number: 15-32016-486, Final Order, Condition Number Four**

Project Title: **Transfer of assets of Eastern Connecticut Health Network, Inc. to Prospect Medical Holdings, Inc.**

Dear Deputy Commissioner Brancifort:

This letter is submitted in accordance with the Order for the above referenced Certificate of Need Final Decision, specifically Condition Number Four (4) regarding the transfer of assets of Eastern Connecticut Health Network, Inc. (ECHN) to Prospect Medical Holdings, Inc. (PMH).

Condition Number Four (4) requires that PMH will "submit a plan (the "Health Needs Plan") for continuing to support and implement ECHN's 2016 CHNA and for conducting the New Hospital's next comprehensive study of community health needs in the Service Area (the "Community Health Needs Study" or "Study")".

PMH has and will continue to implement the 2016 ECHN Community Health Needs Plan which is enclosed. The following is the information required for Condition Number Four (4) related to the next comprehensive study of community health needs in the service area that PMH will conduct.

(i) The data that will be collected and analyzed to systematically assess health status indicators of the Service Area;

As was done with the 2016 ECHN Community Health Needs Assessment (CHNA) effort, PMH will select a consultant to collect primary and secondary health data from

both quantitative and qualitative sources that will be incorporated in the assessment. Professional Research Consultants, Inc. (PRC) (www.PRCCustomResearch.com) was engaged to conduct the 2016 CHNAs on behalf of the hospitals. Those CHNA Reports may be found at the following URL: http://www.echn.org/community-benefit-reporting . As with PRC's approach, the plan will include the following data: population characteristics, social and economic data that has been shown to influence health, health survey data using a tool that is based on the Centers for Disease Control & Prevention (CDC) Behavioral Risk Factor Surveillance Survey (BRFSS), survey data collected from key community representatives and organizations who can identify primary concerns of the communities that they work with, vital statistics and public health data from various state and national sources. The methodology for the study will include sample design and the quality control procedures used for the collection of data to ensure that the sample is representative and therefore the findings may be generalized to the total population of community members in the defined area with a high degree of confidence. Detailed findings will identify the health needs and include benchmark comparisons against state and national data, comparison against relevant Healthy People 2020 targets and incorporate qualitative findings from key community informants. Finally, the findings will be blended into a single, comprehensive report organized by health topic.

(ii) The identity of key community stakeholders and health organizations, unaffiliated with PMH, including without limitation, representatives of medically underserved populations that will be enlisted to participate in the study and the manner and extent of such participation by stakeholders in both the development of health priorities and planned implementation;

Key community organizations and leaders will be asked to rate the degree to which various health issues are a problem in their own community to assist in the development of health priorities. These key informants will include independent physicians, public health experts/representatives, other health providers, social service representatives and other community leaders. Individuals whose organizations work with low-income, minority populations or other medically underserved populations will be included in the gathering of this qualitative data.

The plan will be to request participation from the key informants that participated in the 2016 study which included the following organizations:

Community Health Resources	Highland Park Market
First Choice Health Centers, Inc.	Lion Heart Health & Fitness
Healthwise Medical Associates, LLP	Manchester Community Services Council

- Manchester Public Schools
- Manchester School Readiness Council
- Manchester Senior, Adult & Family Services
- Manchester Youth Services Bureau
- North Central District Health Department
- Paradigm Chiropractic & Functional Medicine
- Prohealth Chiropractic Center
- Town of Manchester Health Department
- Town of Manchester Senior Center
- Shoprite of East Hartford
- Vernon Public Schools
- WIC Program

In addition, as part of the current Health Needs Plan, the implementation strategy identifies community partners that plan to collaborate with ECHN and its affiliates to address the priority health issues chosen for action in the FY 2016 – FY 2019 period. PMH will look for opportunities to work with these partner organizations for the planning and implementation of the next CHNA and Plan. These partners include but are not limited to:

- Area Churches
- Chambers of Commerce
- Community Health Resources
- Community Physicians & Providers
- CT Community for Addiction Recovery
- CT Suicide Advisory Board
- Early Head Start
- East Central Multidisciplinary Team
- East of the River Action for Substance Abuse Elimination
- First Choice Health Center
- Geissler's Supermarket
- Highland Park Market
- Hockanum Valley Community Council
- Manchester Police Department
- Manchester Public Schools (Family & Community Partnerships)
- Manchester School Readiness Committee
- Manchester & Vernon Juvenile Review Boards
- Manchester & Vernon Local Prevention Council
- Public Schools
- Senior Centers
- Skilled Nursing Facilities
- Town Health and Human Services Agencies
- Vernon School Readiness Committee

(iii) The qualifications of consultants experienced in performing CHNAs who will be retained by PMH to ensure that the priority health needs of the community are accurately determined;

Professional Research Consultants, Inc. conducted the 2016 CHNAs on behalf of the hospitals. PRC is a nationally recognized healthcare consulting firm with over three decades of experience with health-related surveying, including more than twenty years of experience implementing community health assessment tools, methods and protocols.

PRC has conducted CNHAs across the country for health care organizations. PMH will engage a firm of like qualifications for the 2019 study. http://www.prccustomresearch.com/about/who-is-prc/

(iv) The frequency with which the study will be repeated;

The next CHNAs for the hospitals will be conducted in 2019 with PRC or a professional research firm with comparable qualifications.

(v) The manner in which results of the study and the implementation strategy to address the priority health needs identified therein will be distributed to the community;

A copy of the 2016 Community Health Needs Assessment Implementation Strategy for the Eastern Connecticut Health Network – The Manchester Memorial Hospital and The Rockville General Hospital Incorporated is included in this filing. The 2016 CHNAs for Manchester and Vernon are available to the public on the hospitals' website at http://www.echn.org/community-benefit-reporting. In addition, a summary description of the assessment will be published in an upcoming edition of *Better Being*, a widely distributed ECHN Newsletter which promotes the community health education programs available at ECHN.

(vi) The manner in which the study will complement the population health management objectives of PMH and the new hospitals.

PMS's Coordinated Regional Care (CRC) team has established several programs to address the care coordination and care management needs of the ECHN community. These programs use information and data received from multiple sources, i.e., PCP referrals, CMS data or payer claims and utilization data to identify, stratify and outreach to appropriate patients within the population with a targeted intervention. The following programs are currently in place:

Emergency Department (ED) Care Management: The goal of this program is to identify appropriate clinical, behavioral or social resources for patients who seek care at ECHN hospital EDs. It was identified that during the evenings and weekend days there was a greater opportunity to redirect those patients seeking services in the ED to a community based provider including primary care, specialists or behavioral health providers. For those patients without a community based provider, assistance with selecting and accessing a provider was given. The ED care managers also provide education on condition and symptom management in order to avoid subsequent ED visits. The ED

care managers will engage the PCP aligned care coordination staff to provide follow up for those most at risk patients.

Transition of Care: The goal of this program is to identify patients admitted to an ECHN facility with focused conditions, notify the PCP of the admission and to facilitate appropriate physician follow-up once the patient has transitioned back to home. The Transitional Care Coordinator (TCC) focuses on those patients with a diagnosis of heart failure, chronic obstructive pulmonary disease or pneumonia. The TCC meets with patients, their family or caregivers to provide education on their diagnosis, review symptom management and their treatment plan and to facilitate a smooth transition from hospital to the next appropriate level of care. Patients being discharged to home have a PCP follow-up visit scheduled prior to their discharge. The TCC will engage the PCP aligned care coordination staff to ensure the follow up visit is made as scheduled.

Quality Programs: ECHN primary care and select specialists are benchmarked and measured on patient adherence to specific chronic conditions or age and gender specific preventive care measures. Quality data that is received from payers is reviewed with providers in order to prompt patient interventions as necessary. The clinical quality measures that are being addressed are:

- Adult BMI Assessment
- Breast Cancer Screening
- Cervical Cancer Screening
- Colorectal Cancer Screening
- Controlling Blood Pressure
- Chlamydia Screening
- Childhood Immunization Status
- Adolescent Immunization Status
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
    - BMI
    - Nutritional counseling for overweight children/adolescents
    - Physical Activity Assessment
- Annual Physical Exams
- Annual Influenza Vaccines
- Comprehensive Diabetes Management
    - Retinal Eye Exam
    - Medical Attention for Nephropathy
    - Blood Sugar Control
    - Blood Pressure Control

These programs are in place to decrease the cost of healthcare while increasing the efficiency of care, to promote a healthier population and to improve the community's experience with the health system.

PMH is committed to ensuring that the population served by Prospect ECHN has access to healthcare providers, programs and resources that address the identified health needs of its communities. PMH will continue to partner with other community organizations whose purpose and mission align with the goal of improving community health and wellness.

If you have any questions or need anything further, please feel free to contact me at (860) 533-3429.

Very truly yours,



Dennis P. McConville
Senior Vice President
Eastern Connecticut Health Network

Enclosure:
2016 Community Health Needs Assessment – Implementation Strategy

cc: Kimberly Martone, Director of Operations, Office of Health Care Access
Connecticut Department of Public Health
Colleen Smith, Nursing Consultant Partners, LLC
Ellen J. Shin, General Counsel, Prospect Medical Holdings, Inc.
Joyce A. Tichy, Senior Vice President and General Counsel, ECHN
Michael Collins, Interim CEO, ECHN
Frank Saidara, Vice President, Corporate Development, Prospect Medical Holdings, Inc.
Garrison De Lee, Assistant General Counsel, Prospect Medical Holdings, Inc.

2016 Community Health Needs Assessment

Implementation Strategy

Eastern Connecticut Health Network

The Manchester Memorial Hospital

The Rockville General Hospital Incorporated

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Community Health Needs Assessment

About Eastern Connecticut Health Network

Eastern Connecticut Health Network (ECHN) is a community-based healthcare system serving 19 towns across eastern Connecticut. ECHN provides a full spectrum of wellness, prevention, acute care, rehabilitation and restorative care to the community. Our system also operates several outpatient facilities, a comprehensive physician network of primary care and specialty practices.

ECHN is comprised of the following companies:

- The Manchester Memorial Hospital, 71 Haynes Street, Manchester, CT 06040;
    - 249 Licensed Beds
- The Rockville General Hospital Incorporated, 31 Union Street, Vernon, CT 06066;
    - 102 Licensed Beds
- Visiting Nurse and Health Services of Connecticut, 8 Keynote Drive, Vernon, CT 06066
- Eastern Connecticut Medical Professionals Foundation, 71 Haynes Street, Manchester, CT 06040
- Woodlake at Tolland Rehabilitation & Nursing Center, 26 Shenipsit Road, Tolland, CT 06084

ECHN also partners with many other providers through contractual arrangements and in joint venture arrangements offering services such as transportation, radiation oncology, occupational health services and imaging services.

ECHN completed its last Community Health Needs Assessment in 2016. [IRS Form 990, Schedule H, Part V].

Community Served

Definition of Community Served

ECHN's community, as defined for the purposes of the Community Health Needs Assessment, included each of the residential Zip Codes that comprise the hospital's town location including 06040 and 06042 for Manchester Memorial Hospital and 06066 for Rockville General Hospital.

This community definition was determined because the majority of ECHN's patients originate from these areas for use of our hospital services.

Demographics of the Community

The population of Manchester Memorial Hospital's service area is estimated at 58,253 people. It is predominantly non-Hispanic White (71.4%), but also has substantial African America (12.3%) and Hispanic (12%) populations.

Source 2010: http://www.census.gov/quickfacts/table/PST045215/0900344700,00

The population of Rockville General Hospital's service area is estimated at 29,179 people. It is predominantly non-Hispanic White (85.1%), but also has substantial African America (5.8%) and Hispanic (6.5%) populations.

Source 2010: http://www.census.gov/quickfacts/table/PST045215/0901378250,00

Collaboration

How CHNA Data Were Obtained

These assessments incorporate data from both quantitative and qualitative sources. Quantitative data input includes primary research (phone surveys) and secondary research (vital statistics and other existing health-related data); these quantitative components allow for comparison to benchmark data at the state and national levels. Qualitative data input includes primary research gathered through an online key informant survey (OKIS).

The Community Health Needs Assessment was sponsored by a collaboration of community partners and relied on information provided by:

- public health and vital statistics data;
- a variety of existing (secondary) data;
- data representing the most recent BRFSS (Behavioral Risk Factor Surveillance System) prevalence and trends data (published online by the Centers for Disease Control and Prevention);
- state-wide risk factor data;
- nationwide risk factor data;
- Healthy People 2020 which provides science-based, 10-year national objectives for improving the health of all Americans;
- phone surveys (based on the Centers for Disease Control Behavioral Risk Factor Surveillance Survey);
- and online key informant surveys.

The participants for the online surveys included physicians and other health providers, public health experts, social service representatives and community leaders. For a full listing of participating agencies, please reference the 2016 CHNA for Manchester Memorial Hospital or the 2016 CHNA for Rockville General Hospital.

Public Dissemination

These CHNA's are available to the public using the following URL:
http://www.echn.org/community-benefit-reporting

A summary description of the assessment will be published in an upcoming edition of Better Being, a widely distributed ECHN Newsletter which promotes the community health education programs available at ECHN.

Health Needs of the Community

Significant Health Needs of the Community

The following areas represent the more significant health needs of the community and opportunities for improvement, based on the information gathered through the 2016 Community Health Needs Assessment for Manchester Memorial Hospital.

Areas of Opportunity-Manchester

Areas	Specifics
Access to Healthcare Services	• Cost of prescriptions • Skipping/Stretching Prescriptions
Cancer	• Cancer is a leading cause of death • Prostate and Female Breast Cancer Incidence • *Cancer ranked as a top concern in the OKIS*
Chronic Kidney Disease	• Kidney Disease Deaths
Diabetes	• Diabetes Prevalence
Heart Disease & Stroke	• Cardiovascular disease is leading cause of death • High Blood Pressure Prevalence • *Heart Disease & Stroke ranked as a top concern in OKIS*
HIV/AIDS	• HIV Prevalence
Infant Health & Family Planning	• Low-Weight Births • Infant Mortality
Injury & Violence	• *Injury and Violence ranked as a top concern in the OKIS*
Mental Health	• Diagnosed Depression • *Mental Health ranked as a top concern in the OKIS*
Nutrition, Physical Activity & Weight	• Low Food Access • Overweight & Obesity (Adults) • *Nutrition, Physical Activity & Weight ranked as a top concern in the OKIS*
Potentially Disabling Conditions	• Activity Limitations • Arthritis Prevalence (50+) • Blindness/Vision Trouble
Respiratory Disease	• Asthma Prevalence • Chronic Obstructive Pulmonary Disorder (COPD) Prevalence
Sexually Transmitted Diseases	• Chlamydia Incidence
Substance Abuse	• Drug-Induced Deaths • Negatively Affected by Substance Abuse (Self or Others) • *Substance Abuse ranked as a top concern in the OKIS*

OKIS=Online Key Informant Survey

Areas of Opportunity-Rockville/Vernon

The following areas represent the more significant health needs of the community and opportunities for improvement, based on the information gathered through the 2016 Community Health Needs Assessment for Rockville General Hospital.

Areas	Specifics
Access to Healthcare Services	• Primary Care Physicians
Cancer	• Cancer is a leading cause of death • Prostate Cancer Deaths • Female Breast Cancer Incidence
Heart Disease & Stroke	• Cardiovascular disease is leading cause of death • 1+ Cardiovascular Risk Factors
Injury & Violence	• 65+ Falls Age-Adjusted Death Rate
Mental Health	• Suicide Rate
Nutrition, Physical Activity & Weight	• Low Food Access • Overweight & Obesity (Adults) • Recreational/Fitness Facilities • *Nutrition, Physical Activity & Weight ranked as a top concern in the OKIS*
Potentially Disabling Conditions	• Activity Limitations • Arthritis Prevalence (50+) • Osteoporosis (50+)
Respiratory Disease	• CLRD Deaths • Asthma Prevalence (50+) • Chronic Obstructive Pulmonary Disorder (COPD) Prevalence
Substance Abuse	• Cirrhosis/Liver Disease Deaths • *Substance Abuse ranked as a top concern in the OKIS*
Tobacco Use	• *Tobacco Use ranked as a top concern in the OKIS*

OKIS=Online Key Informant Survey

Implementation Strategy

Identify & Prioritizing Health Needs

Identification of Health Needs

The significant health needs ("Areas of Opportunity" outlined above) were determined after consideration of various criteria, including: standing in comparison with benchmark data; identified trends; the preponderance of significant findings within topic areas; the magnitude of the issue in terms of the number of persons affected; and the potential health impact of a given issue.

Prioritization of Health Needs

Prioritization of the needs addressed by this plan included input from community stakeholders and the internal stakeholders of the hospitals gathered to evaluate, discuss and prioritize health issues for the hospital's community based on findings of the 2016 Community Health Needs Assessment (CHNA). We reviewed the scope and severity of each of the identified areas and our ability to impact each health issue given our available resources and competencies.

Implementation Strategy Adoption

This summary outlines Manchester Memorial Hospital and Rockville General Hospital plans (Implementation Strategy) to address certain community's health needs by: 1) sustaining efforts operating within a targeted health priority area; 2) developing programs and initiatives to address identified health needs; and 3) promoting an understanding of these health needs among other community organizations and to the public.

Hospital-Level Community Benefit Planning

Priority Health Issues To Be Addressed

In consideration of the top health priorities identified through the CHNA process — and taking into account hospital resources and overall alignment with the hospital's mission, goals and strategic priorities — it was determined that ECHN would focus on developing and/or supporting strategies and initiatives to improve:

- **Access to Healthcare Services**
- **Cancer**
    - **Screening Programs**
    - **Early Detection Program**
    - **Smoking Prevention and Cessation**
    - **Survivorship Care Plans**
- **Heart Disease & Stroke**
- **Infant Health & Family Planning**
- **Mental Health**
- **Nutrition, Physical Activity & Weight**
- **Substance Abuse**
- **Diabetes**

Implementation Strategies & Action Plans

The following displays outline Manchester Memorial Hospital and Rockville General Hospital's plans to address those priority health issues chosen for action in the FY2016-FY2019 period.

Access to Healthcare Services	
Community Partners/ Planned Collaboration	• Eastern Connecticut Medical Professionals Foundation (ECMPF) • ECHN Graduate Medical Education (GME) Family Medicine Program • Visiting Nurse & Health Services of Connecticut • ECHN Hospitalist Program
Goal	**To improve healthcare access to primary healthcare services by promoting the education, training, recruitment of and communication with primary care providers for the towns of Manchester and Vernon**
Timeframe	FY2017-FY2019
Scope	Residents in Manchester and Vernon/Rockville
Strategies & Objectives	**Strategy #1:** Build the capacity of ECMPF primary care offices to provide primary and preventive healthcare services **Strategy #2:** Continue support for the ECHN GME Family Medicine Residency Program trained at ECHN and actively recruit graduates to practice locally **Strategy #3:** Ensure that ECHN hospital and home health care management programs as well as the ECHN hospitalist practitioners provide effective transitions of care for patients treated at ECHN facilities with an emphasis on communication with primary care physicians
Anticipated Impact	• Maintain and grow the staff of primary care providers • Increase the number of patients who have a designated primary care provider in their community • Prompt and effective communication with primary care physicians regarding their patients hospital and post discharge care
Plan to Evaluate Impact	• Conduct an inventory of primary care providers annually • Measure a baseline of patients under the care of ECMPF primary care providers and then measure annually • Poll ECHN primary care, internal medicine and family practice physicians regarding communication by care managers and hospitalists
Results	*Pending*

Cancer	Screening Programs for Lung, Colorectal and Prostate Cancers
Community Partners/ Planned Collaboration	• Evergreen Endoscopy Center • Community Physicians • Churches • Senior Centers • Town Health and Human Service Agencies
Goals	• **Help our community achieve the nationally recognized benchmark of 80% of eligible patients receiving a colorectal screening** • **Increase the number of eligible patients in our community that have their lung cancer screening** • **Offer a screening program based on new guidelines for prostate screening**
Timeframe	• 2017-2019
Scope	Residents in the community who meet the evidence based eligibility criteria for colorectal, lung and prostate cancers
Strategies and Objectives	**Strategy #1: Colon Cancer - Colorectal screening and education** • Develop a marketing campaign for Colon Cancer Awareness Month each year to create awareness • Hold a colonoscopy screening event to promote screenings, educate the community • Promote the "Open Access Program" offered by local physicians at Evergreen Endoscopy Center that makes convenient appointments easier to obtain for screenings **Strategy #2: Lung Cancer - Promote and educate community on ECHN's Low Dose CT Screening Program** • Maintain ECHN's ACR accreditation as a Designated Cancer Screening Center • Develop marketing and promotional material to create awareness of the need for screening and the community resources available • Provide education to community and physicians through presence at health fairs and by hosting community education lectures **Strategy #3: Prostate Cancer - Host a Prostate Screening Event** • Determine eligibility and process to adhere to national standard of prostate screenings • Collaborate with local physicians and health care workers to hold a screening event • Market and promote a prostate cancer screening event

Anticipated Impact	• Increase the number of eligible adults age 50-75 that have their appropriate colorectal screening (2016 Community Needs Assessment reported this as 79%) • Increase in the number of participants in the Open Access Program • Increase in the number of participants in ECHN's Low Dose CT Program; thereby capturing lung cancer in its earlier and more treatable stages • Educate residents on proper prostate screening and capture prostate in its earlier and more treatable stages
Plan to Evaluate Impact	• Statistical information from the Open Access Program, Low Dose CT Program and the prostate screening event • 2019 Community Needs Assessment
Results	Pending

Cancer	Early Detection Program
Community Partners/ Planned Collaboration	• ECHN Women's Center for Wellness • Town Health and Human Services Agencies • Community Providers • DPH/CDC • Churches • Early Head Start
Goal	**Increase the number of low-income, uninsured, underinsured and underserved women who receive access to breast and cervical cancer screening, diagnostic and treatment referral services. Provide these same women with the knowledge, skills and opportunity to improve diet, physical activity and other life style habits to prevent, delay or control heart disease and other chronic conditions**
Timeframe	Duration of the grant funded program
Scope	This strategy will focus on women in the communities serviced by ECHN
Strategies and Objectives	**Strategy #1: Educate women about the importance of preventative and screening services and lifestyle changes** • Develop and coordinate educational lectures and seminars which will be offered to the community • Publish information in ECHN's Better Being newsletter regarding health screenings, educational programs and lectures • Participate in health fairs and community events • Coordinate with ECHN providers to present educational programs and lectures related to women's health, diabetes and heart disease **Strategy #2: Build community relationships to increase awareness of the ECHN Early Detection Program** • The Community Health Navigator will engage and collaborate with community partners in order to provide education on program benefits and services available • The Community Health Navigator will provide written material, in both English and Spanish, to community partners and providers detailing services available, and contact information for eligibility
Anticipated Impact	• The ECHN Early Detection Program will reach 100% compliance with complete follow-up of abnormal breast and Pap test screening. In addition the Program will reach 100% compliance with the National Breast and Cervical Cancer Early Detection Program's minimum compliance goals for the time between initial abnormal finding(s) to the final diagnosis • The ECHN Early Detection Program will meet the WISEWOMAN Program benchmark for the number of women receiving screenings for heart disease and diabetes
Plan to Evaluate Impact	• Statistical quarterly reports from the DPH/CDC
Results	Pending

Cancer	Smoking Prevention and Cessation
Community Partners/ Planned Collaboration	• Community physicians • Hockanum Valley Community Council • First Choice Health Center • Public schools • Town Health and Human Service Agencies
Goals	• **Educate the community about the hazards of smoking and secondhand smoke.** • **Increase the number of people who quit smoking.**
Timeframe	• 2017-2019
Scope	Residents and students in the ECHN service area
Strategies and Objectives	**Strategy #1: Freedom From Smoking®** • Provide program at least 3 times a year • Advertise program through Better Being and with community partners • Increase number of facilitators to 2 • Provide program at multiple locations **Strategy #2: Offer smoking prevention presentation to public and private schools** • Contact schools with 6th grade classes offering presentations • Participate in health fairs at high schools and vocational schools **Strategy #3: Provide CEU program to community primary care physicians** • Provide education regarding available smoking prevention and cessation programs **Strategy #4: Participate in health fairs** • Provide material on nicotine addiction • Provide material on Freedom From Smoking®
Anticipated Impact	• Individuals will quit smoking as a result of attending Freedom From Smoking® • Community physicians will refer more patients to Freedom From Smoking® and make use of other smoking cessation programs • Children and adolescents will avoid use of nicotine products
Plan to Evaluate Impact	• Freedom From Smoking® end of program questionnaires to determine number of participants who quit smoking • Freedom From Smoking® statistics • County and State surveys • 2019 Community Needs Assessment
Results	Pending

Cancer	Survivorship Care Plans for Eligible Cancer Patients

Community Partners/ Planned Collaboration	• Eastern Connecticut Cancer Institute members including:
	  ○ Community medical oncology providers
	  ○ Community radiation oncology providers
	  ○ ECHN Cancer Committee members
	  ○ Northeast Regional Radiation Oncology Network

Goal	**100% of cancer patients treated at ECHN facilities meeting eligibility criteria will receive a survivorship care plan by 2019**
Timeframe	• 2017 50% of cancer patients will receive a survivorship care plan within 6 months of completion of adjuvant cancer therapy • 2018 75% of cancer patients will receive a survivorship care plan within 6 months of completion of adjuvant cancer therapy • 2019 100% of cancer patients will receive a survivorship care plan within 6 months of completion of adjuvant cancer therapy
Scope	A focus on the patients that have been diagnosed and treated for cancer in the ECHN network
Strategies and Objectives	**Strategy #1: Offer support to cancer survivors:** • Established process to identify patients who have completed cancer therapy and provide patients with summary care plan which includes cancer diagnosis, stage and treatment received **Strategy #2: Educate cancer survivors on managing lifestyle behaviors after treatment completion** • Survivorship care plan will include road map for recommended follow up care • Educate and encourage lifestyle changes to reduce cancer recurrence and/or improve quality of life.
Anticipated Impact	Provide comprehensive cancer care plans for patients in order to obtain all appropriate services within their community
Plan to Evaluate Impact	Not less than once a year, the ECHN Cancer Committee will discuss the process, navigation, and statistical benchmarking of survivorship care plans
Results	Pending

Heart Disease & Stroke	
Community Partners/ Planned Collaboration	• MMH and RGH Cardiac Rehabilitation Departments • Visiting Nurse & Health Services of Connecticut • Community healthcare providers- cardiologists and pulmonologists • Senior Centers • Skilled Nursing Facilities
Goal	**To reduce the behaviors and manage conditions that lead to cardiovascular disease including but not limited to high blood pressure, high blood cholesterol, tobacco use, physical inactivity, poor nutrition, over-weight and obesity and diabetes**
Timeframe	2017 -2019
Scope	This strategy will focus on residents in Manchester and Vernon/Rockville and ECHN employees
Strategies & Objectives	**Strategy #1: Provide education for cardiovascular disease risk factors and behavior modification** • Produce multi-year plan to improve health and reduce risky behaviors of our ECHN employees and families • Provide community education lecture(s) on the signs and symptoms of stroke and heart attack, the early recognition of symptoms and importance of seeking immediate medical care • Promote nutrition counseling services offered by local supermarkets and community centers to promote healthy diets • Promote physical fitness activities/programs available in the community including fitness centers, cardiac rehabilitation programs, schools, parks and recreation programs • Participate in community health fairs throughout service area where blood pressure, cholesterol, body fat composition analysis and education resources will be offered **Strategy #2: Promote the Freedom From Smoking® cessation program** • Provide program at least 3 times a year • Advertise program through Better Being and with community partners • Increase number of facilitators to 2 • Provide program at multiple locations • Promote available smoking cessation programs to physicians in the community and hospitals as an option for patients who smoke

	Strategy #3: Promote cardiac rehabilitation • Promote cardiac rehabilitation services to restore people who have had a heart condition or heart surgery to the highest possible physiological, emotional, social, and vocational level
Anticipated Impact	• Ability for employees and the community to recognize early signs and symptoms of stroke and heart attack • Increased focus on lifestyle, prevention and overall wellness for ECHN employees and residents
Plan to Evaluate Impact	• Repeat community assessment on mortality rates for cardiovascular diseases • Freedom From Smoking® statistics • Increased participation by ECHN employees in health screenings • Attendance by community members at lectures focused on heart disease and healthy lifestyle
Results	*Pending*

Infant Health & Family Planning	
Community Partners/ Planned Collaboration	• ECHN Family Development Center • RGH Maternity Care Center (MCC) • Family Birthing Center Childbirth Educators • Manchester School Readiness Committee* • Vernon School Readiness Committee * • Community physicians (*Both committees include schools, YMCA's, preschools, Departments of Health, places of worship, Family Development Centers)
Goals	• **Improve access to prenatal and parenting education** • **Increase preconception and first trimester prenatal education** • **Improve the low weight birth percentages** • **Decrease infant mortality and increase infant and child health and wellbeing** • **Decrease teenager pregnancy rates**
Timeframe	2017 - 2019
Scope	This strategy will focus on the service areas of Manchester and Vernon.
Strategies & Objectives	**Strategy #1: Improve access to care and education:** • Continue family planning education sessions/tours • Encourage the use of the Maternity Care Center (MCC) at Rockville General Hospital • Provide information through ECHN digital boards, Readiness Committees, ECHN social media and ECHN Website • Continue to publicize educational opportunities through Better Being magazine • Continue the distribution of ECHN prenatal folders through the community practices that contain comprehensive topical information **Strategy #2: Increase preconception and first trimester pregnancy education:** • Encourage regular ECHN birth class attendance • Provide information through ECHN digital boards, Readiness Committees, ECHN social media and Website • Pursue the development of a preconception and an early pregnancy class offering **Strategy #3: Improve the low birth weight percentages** • Identify mothers who are "at-risk" with the neonatal screening program and by working with community OB practices

	• Continue the hospital-based neonatal abstinence syndrome prescreening and education program **Strategy #4: Decrease teenager pregnancy rates** • Partner with schools and other community to offer education • Explore and pursue opportunities for ECHN obstetrical leaders to partner with community groups to identify needs and create solutions **Strategy #5: Decrease infant mortality and promote infant and child health and wellbeing:** • Continue to offer SIDS reduction techniques including safe sleeping • Provide information regarding proper child care through ECHN digital boards, Readiness Committees, ECHN social media and website • Encourage the use of the MCC o Pursue the possibility of expanding the Family Circles Group (Prenatal Care Education) o Pursue the start of a MCC New Mother's group. • Continue to offer new mothers group at both the hospital and at the MCC • Continue to offer expectant grandparent classes • Continue to offer Infant and Child certified CPR and first aid classes to new parents, grandparents and home day care providers • Continue the hospital based neonatal abstinence syndrome prescreening and education program • Continue to offer baby care classes
Anticipated Impact	• Increased access to infant care and education which includes preconception education and first trimester prenatal education offerings • Increased birth weights and lower infant mortality • Decrease in teen pregnancies • Improved infant and childhood health and wellbeing
Plan to Evaluate Impact	• Monitor attendance at education programs • Monitor hospital birth weights • Elicit feedback from community providers, community groups including Readiness Committees • Repeat community assessment 2019
Results	*Pending*

Mental Health	
Community Partners/ Planned Collaboration	• **ECHN Behavioral Health Programs and Providers** • **Community Health Resources (CHR)** • **Manchester Public Schools (Family & Community Partnerships)** • **East Central Multidisciplinary Team** • **Senior Centers** • **Skilled Nursing Facilities** • **Community Centers** • **Chambers of Commerce** • **Community Physicians** • **CT Suicide Advisory Board**
Goal	**Increase access to and use of mental health services**
Timeframe	February 2017- 2019
Scope	This strategy will focus on residents in Manchester and Vernon/Rockville
Strategies & Objectives	**Strategy #1: Establish additional mental health services sites:** • Establish counseling services at the Women's Center for Wellness • Explore opportunities to imbed clinicians at school-based health centers **Strategy #2: Explore the expansion of inpatient psychiatry services to be offered at MMH and RGH** • Study, and if sufficient need exists, develop an inpatient Geropsychiatry Program to be offered by ECHN. • Evaluate the demand, for additional inpatient psychiatric services which could be offered at RGH. **Strategy #3: Participate in the Zero Suicide Initiative to standardize suicide risk assessment and network with providers to secure wrap around supports** • Provide auditorium to CHR for Columbia Suicide Scales training January 2017 • Complete organizational assessment of suicide risk protocols
Anticipated Impact	• Increase points and ease of access to skilled professionals to decrease suicide risk and improve mental health • Increase options of psychiatry support to geriatric population to improve community functioning

Plan to Evaluate Impact	• Patient Satisfaction surveys at satellite sites • Volume of referrals to new psychiatry units • DMHAS report of Zero Suicide Initiative data • Repeat community assessment 2019
Results	*Pending*

Nutrition, Physical Activity & Weight	
Community Partners/ Planned Collaboration	• ECHN's Center for Weight Loss • Community Physicians • Walden Behavioral Care • John A. DeQuattro Cancer Center: Eastern Connecticut Cancer Institute • Geissler's Supermarket • Highland Park Market
Goal	**Ensure that residents have access to food and information about healthy eating habits**
Timeframe	2017-2019
Scope	This strategy will focus on residents in Manchester and Vernon/Rockville
Strategies & Objectives	**Strategy #1: Produce and distribute printed education materials covering various nutrition topics for primary care physician offices to provide to patients** • Distribute education materials individually or placed in waiting rooms. Potential Topics: Fiber Facts, Understanding Fats, Portion Control, Ways to Increase Fruits/Vegetable Intake, Healthy Lunch Options, Guide for Healthy Restaurant Dining, Sugar Content of Commonly Consumed Beverages, Outline of Area Food Pantry/Resources • Materials will include contact information for Outpatient Nutrition Services and the Diabetes Self-Management Program offered by ECHN **Strategy #2: Offer nutrition lectures in community settings (i.e.: Local fire/police departments, senior centers, community centers, Adult Daycare Centers)** **Strategy #3: Collaborate with area supermarkets to provide grocery store tours designed to teach healthy buying habits** **Strategy #4: Promote awareness of the ECHN Center for Weight Loss which offers information about obesity, associated health risks and surgical options for weight loss** • http://www.echn.org/weightloss/ **Strategy #5: Promote awareness of behavioral health eating disorders, i.e. bulimia, anorexia, binge-eating disorder, and the treatment programs available locally** • Provide materials to providers and promote awareness on the internet of the Walden Eating Disorders Center offered by ECHN's Rockville Hospital for inpatient care http://www.waldeneatingdisorders.com/locations/rockville/ and the Walden Clinic in South Windsor offering outpatient education and treatment for eating disorders http://www.waldeneatingdisorders.com/locations/south-windsor/

Anticipated Impact	• Engagement of PCP providers and the public regarding the topics of weight and nutrition
Plan to Evaluate Impact	• Track number of handouts provided by PCP offices • Track clients that attend Grocery Store Tours and Nutrition Lectures; provide surveys for additional comments/suggestions for future events • Track attendance at community lectures on weight loss and eating disorders
Results	*Pending*

Substance Abuse	
Community Partners/ Planned Collaboration	• ECHN Behavioral Health Addiction Services • Manchester & Vernon Local Prevention Councils • Manchester & Vernon Juvenile Review Boards • Manchester Police Department • East of the River Action for Substance Abuse Elimination (ERASE) • CT Community for Addiction Recovery (CCAR) • Community Health Resources (CHR)
Goal	**Increase points of contact for addicts to secure support toward sobriety**
Timeframe	January 2017- 2019
Scope	This strategy will focus on residents in Manchester and Vernon/Rockville
Strategies & Objectives	**Strategy #1: Continue ECHN's partnership with the Manchester Police Department in the H.O.P.E. Initiative (Heroin/Opioid Prevention & Education Initiative)** • Work with police and the RGH and MMH emergency departments serving as the clinical gateways to treat individuals with substance abuse and to enroll them in ECHN's addiction program • With other key partners, connect the individuals quickly to substance abuse treatment supports in the greater community **Strategy #2: Increase prevention supports to youth:** • Actively participate in local prevention council sponsored events/services • Imbed clinician in school-based locations for early intervention **Strategy #3: Enter into formal collaboration with CCAR** • CCAR Recovery Coaches will become active partners in the ED at MMH when individuals present with substance abuse issues by February 2017
Anticipated Impact	• Decrease in overdose deaths • Early detection/intervention of youth with illicit substance use • Increased patient access to peer supports toward successful sobriety
Plan to Evaluate Impact	• Local prevention council focus group feedback • H.O.P.E Initiative program evaluation by UCONN researchers • DMHAS data reporting Recovery Coach involvement
Results	*Pending*

Diabetes	
Community Partners/ Planned Collaboration	• ECHN Diabetes Self-Management Program providers • Primary care providers
Goals	• **Increase public awareness of diabetes and risk factors** • **Encourage a healthy lifestyle toward diabetes prevention** • **Encourage attendance at diabetes education classes** • **Identify people at risk for diabetes**
Timeframe	2017 - 2019
Scope	This strategy will focus on residents in Manchester and Vernon service areas
Strategies & Objectives	**Strategy #1: Raise awareness of diabetes prevalence risk factors and educate the public on ways to manage lifestyle behaviors that affect them including diet, weight and physical activity** • Offer free community health educational lecture and seminar programs presented by hospital medical and clinical staff • Include educational information in each issue of Better Being, ECHN's free community magazine distributed to approximately 155,000 households in service area • Participate in community health fairs throughout service area where free glucose tests are conducted and educational resources are shared **Strategy #2: Offer Diabetes Self-Management Program and Nutrition Counseling for individuals already diagnosed with diabetes** • Offer group and individual classes • Promote classes through www.echn.org/diabetes-services and ECHN's social media sites • Promote classes through ECHN digital screens
Anticipated Impact	• Increase detection of diabetes in the Manchester and Vernon service areas • Increase the number of patients with diabetes receiving education and counseling • Decrease diabetes mortality in the Manchester and Vernon service areas
Plan to Evaluate Impact	• Assess class volumes • Assess lecture volumes • Repeat community assessment 2019
Results	*Pending*

Identified Needs That Are Not Addressed

In acknowledging the wide range of priority health issues that emerged from the CHNA process, ECHN's hospitals determined that it could most effectively focus on those which it deemed most pressing, most under-addressed and most within its ability to influence. While the hospitals and its providers do treat individuals with the following conditions, the plan does not specifically address them with additional resources, providers or programs.

- Chronic Kidney Disease
- HIV/AIDS
- Injury & Violence Prevention
- Potentially Disabling Conditions
- Respiratory Disease
- Sexually Transmitted Diseases

Approval

The strategies detailed in this implementation plan have been reviewed and approved by Prospect ECHN's Local Advisory Boards and its corporate Board.



M. Maher Suede, M.D., Chair
MMH and RGH Local Advisory Boards, Prospect ECHN, Inc.

Samuel S. Lee, Chairman
Prospect ECHN, Inc.

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March 29, 2017

Deputy Commissioner Janet M. Brancifort, MPH, RRT
Office of Health Care Access
Department of Public Health
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134

Re: **Docket Number: 15-32016-486, Final Order, Condition Number Six**

Project Title: **Transfer of assets of Eastern Connecticut Health Network, Inc. to Prospect Medical Holdings, Inc.**

Dear Deputy Commissioner Brancifort:

This Services Plan is submitted in accordance with the Order for the above referenced Certificate of Need Final Decision, specifically Condition Number Six (6) regarding the transfer of assets of Eastern Connecticut Health Network, Inc. (ECHN) to Prospect Medical Holdings, Inc. (PMH).

Condition Number Six (6) requires that "Within one hundred and eighty (180) days following the Closing Date, PMH shall submit a plan demonstrating how health care services will be provided by the New Hospitals for the first three years following the Asset Purchase, including any consolidation, reduction, or elimination of existing services or introduction of new service (the Services Plan)".

As described in the Certificate of Need (CON), Prospect ECHN, Inc. (ECHN) does not anticipate any reduction, elimination or relocation of services or facilities. ECHN, however, does continuously evaluate the need for health care services in our service area. The 2016 Community Health Needs Assessment (CHNA) provides critical information for future services planning. The CHNA process and the implementation of the resulting Health Plan engages the ECHN Medical Staff and community providers in a significant way to guide resource allocation and program development according to community health need.

PMH will support the priority needs identified by the CHNA with a variety of physician alignment and population health management strategies, enhanced through PMH's implementation of Coordinated Regional Care ("CRC"), which focuses on the health of vulnerable populations. CRC provides for clinical integration among hospitals, physicians and other medical, social and community providers working closely with strategic partner health plans and other payers under a value-based, global risk reimbursement payment system. The goal of the CRC model is to ensure that patients receive appropriate care, at the appropriate time, in the appropriate setting, while avoiding unnecessary, inefficient and duplicative services and reducing medical errors.

A critical effort for ECHN is to build and manage a tightly integrated, coordinated regional care system with providers across the continuum. In its development of the CRC model, ECHN is partnering with its physician led Independent Practice Association to address gaps in care and services to ensure the effective management of all patients across the network. Furthermore, clinical integration in partnership with its medical staff will bring the numbers of covered lives needed to be successful in developing and executing programs to manage population health.

In time, the profile of service offerings at ECHN will change as it aligns its hospitals and physicians. With the intensive care management programs of PMH and the commitment to implementing the CRC model in the local service area, ECHN will be positioned to continue to integrate and expand its network of providers and program offerings. The rate of this change will be influenced by the willingness of the health plans to partner under global risk arrangements and in turn will influence further adjustments to hospital inpatient and outpatient service offerings.

Future decisions regarding the introduction of new services or the termination of existing services will consider and follow the CON process.

Below is a listing of ECHN's current service offerings for Manchester Memorial Hospital (MMH) and Rockville General Hospital (RGH). A detailed list by location is also enclosed:

Behavioral Health Services

- Adult Behavioral Health Inpatient Services
- Adult Behavioral Health Outpatient Services
- Adult Partial Hospitalization Program
- Adolescent Inpatient Services
- Child and Adolescent Outpatient Services
- Child and Adolescent Partial Hospitalization Program

- Clinical Day School
- Crisis Services
- Eating Disorders Program

Cardiac, Vascular, & Neurology Services

- Cardiac Diagnostic Testing (i.e., Echo, EKG, etc.)
- Cardiac Rehabilitation
- Cardio Pulmonary Services
- Heart Failure Clinic
- Medical Cardiology
- Medical Neurology
- Sleep Lab
- SPECT (Cardiac Nuclear Medicine)
- Stress Lab
- Telemetry Monitoring
- Telestroke Services

Emergency Services

- Emergency Department
- Urgent Care

General Acute Care Services

- General Medical/Surgical Care
- Medical/Surgical Intensive Care Unit (ICU)
- Other Special Care Unit (SCU)
- Pediatric Medical/Surgical Care
  (age 14+ on adult medical/surgical units)

Laboratory Services

- Laboratory
- Phlebotomy

Medical Imaging Services

- Bone Density
- CT Scan
- Diagnostic Radiology (x-ray)
- Interventional Radiology
- Mammography
- MRI
- Nuclear Medicine

- PET Scan
- Ultrasound

Metabolic Services

- Diabetes Management
- Dialysis
- Nutritional Services

Oncology Services

- Chemotherapy
- Medical Oncology Services
- Radiation Oncology (In partnership with Community Cancer Care)

Rehabilitation Services

- Occupational Therapy
- Physical Therapy
- Speech Therapy

Surgical Services

- Bariatric Surgery
- Colorectal Surgery
- Endoscopy
- General Surgery
- Gynecology
- Joint Replacement
- Minimally Invasive Surgery
- Ophthalmology
- Oral and Maxillofacial Surgery
- Orthopedic Surgery
- Otolaryngology (Ear, Nose and Throat)
- Plastic and Reconstructive Surgery
- Robotic Surgery
- Spine/Neurosurgery
- Thoracic Surgery
- Urology
- Vascular Surgery
- Wound Care

Women and Infant Services

- Breast Ultrasound
- Breast Ultrasound Biopsy

- Maternity Care Center (Prenatal and Postpartum Services)
- Neonatal Intensive Care Unit (Level III NICU)
- Obstetrics
- Stereotactic Breast Biopsy

Other - Miscellaneous Services

- Community Health Education
- Complementary and Alternative Medicine Services
- Home Care Services
- Hospice Care
- Long-Term Care
- Occupational Medicine
- Short-Term Rehabilitation

In addition, the following further describes current efforts underway to enhance existing service line and program offerings, many of which incorporate the priority health needs of our service area as identified in the Community Health Needs Assessment ("CHNA") completed in 2016.

1. **Behavioral Health**
   - **a.** Geropsychiatry Program - An evaluation is underway to introduce a Geropsychiatry Program for inpatients aged 65 and over at MMH.
   - **b.** Adult Psychiatric Beds – An evaluation is also underway to add additional adult psychiatric beds at RGH for a health need that continues to grow in demand.
   - **c.** Mental Health programs (CHNA) - In addition to the current behavioral health service offerings at MMH and RGH described above, ECHN is committed to increasing access to and use of outpatient mental health services for the residents of our service area. This includes participation in the Zero Suicide Initiative to standardize suicidal risk assessment and network with providers to secure wrap around supports. The impact anticipated includes increasing the points of access and the ease to access skilled professionals to decrease suicide risk and improve mental health.
   - **d.** Substance Abuse programs (CHNA) - A commitment has been made to increase points of contact to secure supports toward sobriety for the residents of our service area. One strategy to address this growing problem is a partnership with the Manchester Police Department in the H.O.P.E. Initiative (Heroin/Opioid

Prevention & Education Initiative) and the Emergency Departments at MMH and RGH. Another is to increase prevention supports to local youth with a formal collaboration with the CT Community for Addiction Recovery (CCAR) whereby Recovery Coaches are available in the Emergency Department at MMH when individuals present with substance abuse issues.

2. **Cardiac, Vascular, & Neurology Services** (CHNA) **-** Efforts to reduce the behaviors and manage the conditions that lead to cardiovascular disease include providing education for cardiovascular disease risk factors and behavior modification, promoting the Freedom from Smoking cessation program and promoting cardiac rehabilitation services.

3. **Emergency Services/Urgent Care -** In addition to providing emergency services at MMH and RGH, as well as Urgent Care services in South Windsor, ECHN provides the following in the emergency departments:
   a. H.O.P.E Initiative (CHNA) **-** The H.O.P.E. Initiative is a partnership between ECHN and the Manchester Police Department to treat individuals with substance abuse in the MMH and RGH Emergency Departments and enroll them in ECHN's addiction program and/or connect them to other treatment supports in the greater community.
   b. CCAR Recovery Coaches partnership (CHNA) **-** Recovery Coaches will be active partners in the ED at MMH when individuals present with substance abuse issues as part of the CCAR collaboration.

4. **General Acute Care Services -** The New Hospitals will provide the same General Acute Care Services as prior to the acquisition with no anticipated change in operations or services. There is no anticipated change in patient population or payor mix. Future decisions on the introduction of new services or the termination of existing services will be identified in CON filings where required.

5. **Laboratory Service -** Future decisions regarding lab draw service locations, whether new, relocation or termination, will be identified in CON filings as required.

6. **Medical Imaging Services -** The New Hospitals will provide the same Medical Imaging Services as prior to the acquisition with no anticipated change in operations or services. There is no anticipated change in patient population or payor mix. Future decisions on the introduction of new services, new imaging technology or the termination of existing services will be identified in CON filings as required.

7. **Metabolic Services**
   - **a.** Diabetes (CHNA) - Efforts to raise awareness of diabetes prevalence risk factors include education on ways to manage lifestyle behaviors including diet, weight and physical activity. In addition, the Diabetes Self-Management Program and Nutritional Counseling are available for individuals already diagnosed with diabetes.
   - **b.** Nutrition, Physical Activity and Weight (CHNA) - Strategies and objectives have been developed with the goal to ensure service area residents have access to food and information about healthy eating habits. These include distribution of education materials covering nutrition topics to primary care physician offices, offering nutrition lectures in community settings, and collaborating with area supermarkets to teach healthy buying habits. In addition, information is offered on obesity, associated health risks and surgical options for weight loss, as well as behavioral health eating disorders, including bulimia, anorexia and binge eating disorder. This includes promoting the awareness of the ECHN Center for Weight Loss, the inpatient Walden Eating Disorders Center at RGH and the outpatient eating disorders treatment programs at the Walden Clinic in South Windsor.

8. **Oncology Services –** ECHN's Eastern Connecticut Cancer Institute (ECCI) at the John A. DeQuattro Cancer Center, on the MMH campus, brings ECHN affiliated providers including ECHN Medical Staff, MMH, RGH, Women's Center for Wellness (WCW) and joint venture companies, Community Cancer Care and the Evergreen Endoscopy Center (EEC), together to offer a full range of enhanced programs and services for cancer patients. These services are integrated into a seamless continuum of care from diagnosis to end of treatment and beyond. Many support services including the services of nurse navigators, medical social workers and nutritionists are available. The Commission on Cancer has awarded the Three Year Certificate of Accreditation to the Comprehensive Community Cancer Program at MMH.
   - **a.** Screening programs for Lung, Colorectal and Prostate Cancers (CHNA) - ECHN is committed to help our community receive appropriate lung, colorectal and prostate screenings. The Open Access Program, offered by local physicians at Evergreen Endoscopy Center, makes convenient appointments easier to obtain for colon cancer screenings. MMH is a Designated Cancer Screening Center and is able to provide a Low Dose CT screening which is able to capture lung cancer in its earlier and more treatable stages. Plans are being made to offer a screening program based on the new guidelines for prostate screening in order to capture prostate cancer in its earlier and more treatable stages.

b. Early Detection Program (CHNA) - The ECHN Women's Center for Wellness (WCW), a department of RGH, offers breast cancer screening and diagnostic services. It is home to ECHN's Breast Care Collaborative where nurses help women with a diagnosis of breast cancer navigate the health system for their care. The WCW offers the Connecticut Breast and Cervical Cancer Early Detection Program, which is a DPH grant funded program focused on women in the communities served by ECHN. The goal is to increase the number of low-income, uninsured, underinsured and underserved women who receive access to breast and cervical cancer screening, diagnostic and treatment referral services. In addition, through the related Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN) Program offered at WCW, these women are provided with the knowledge, skills and opportunity to improve diet, physical activity and other life style habits to prevent, delay or control heart disease and other chronic conditions.

c. Smoking Prevention programs (CHNA) – ECCI offers the American Lung Association's "Freedom from Smoking" program with the goals to educate the community about the hazards of smoking and second hand smoke and to increase the number of people who quit smoking. ECHN has committed to provide the program, offer smoking prevention presentations at area schools and provide educational materials at local health fairs.

d. Survivorship Care Plans (CHNA) - ECHN has committed to provide survivorship care plans to cancer patients treated at ECHN facilities which include offering support to cancer survivors and education on managing lifestyle behaviors after treatment completion.

8. **Rehabilitation Services -** ECHN Rehabilitation Services specialize in a wide variety of therapies and treatments which are provided at rehabilitation locations throughout the service area. The New Hospitals will provide the same rehabilitation services as prior to the acquisition with no anticipated change in operations or services. There is no anticipated change in patient population or payor mix. Future decisions on the introduction of new services or the termination of existing services will be identified in CON filings.

9. **Surgical Services -** The ECHN Center for Weigh Loss, located at MMH and in South Windsor, CT, provides non-surgical and surgical (bariatric) options for weight loss. All plans include long-term support and care to ensure better outcomes for patients.

10. **Woman and Infant Services**

a. The Family Development Center offers programs that are committed to helping families develop their strengths, parenting skills and confidence. Programs include Early Head Start, Family Resource Center and Nurturing Families Network for prenatal women, parents, families and children and teens.
b. The Maternity Care Center at RGH offers medical prenatal care and postpartum services to Medicaid beneficiaries.
c. The Family Birthing Center at MMH provides inpatient maternity services using the Labor, Delivery, Recovery, Postpartum (LDRP) model of care. Complete family-centered maternity services are offered, including comprehensive prenatal care and education classes, private LDRP rooms and alternative birthing options.
d. The Women's Center for Wellness, a department of RGH, provides digital mammography, ultrasound, non-surgical breast biopsies and bone density exams as well as integrative medicine and wellness services such as massage, acupuncture, Reiki therapy and nutritional counseling. Free mammogram, Pap test and heart disease screenings are available for women who qualify.
e. Infant Health and Family Planning (CHNA) - The ECHN Family Development Center, the RGH Maternity Care Center, the Family Birthing Center Childbirth educators and community partners are collaborating to improve access to prenatal and parenting education, increase preconception and first trimester prenatal education, improve low birth weight percentages, decrease infant mortality and increase infant and child health and wellbeing and decrease teenage pregnancy rates.

11. Other Services/Programs

a. Community Health Education - ECHN offers health education lectures, free screenings, support groups and other outreach programs each month at various locations throughout the service area.
b. Integrative Medicine Services - Integrative medicine services available through ECHN include acupuncture, therapeutic massage, pregnancy massage, postpartum massage and Reiki therapy at the Women's Center for Wellness. Massage, Reiki and pet therapy are services available for patients with cancer.
c. Long-Term Care & Rehabilitation - Woodlake at Tolland Nursing & Rehabilitation Center is the affiliated 130 bed skilled nursing home and short-term rehabilitation facility.
d. Visiting Nurse & Health Services of CT (VNHSC) - VNHSC offers a variety of home care services including nursing care, home health aides, rehabilitation therapy, medical social work and hospice care.
e. A Caring Hand, the home care agency, provides companions, homemakers, personal care assistants and live-in caregiver services.

f. Eastern Connecticut Medical Professionals Foundation (ECMP) - ECMP is a group of community and hospital-based, multi-specialty practices affiliated with ECHN and is a major provider of primary care service in the ECHN service area.

g. Coordinated Regional Care (CRC) - The CRC team addresses the care coordination and care management needs of the ECHN community. The program's goals are to decrease the cost while increasing the efficiency of care, to promote a healthier population and to improve the community's experience with the health system.

Again, ECHN does not anticipate any reduction, elimination or relocation of hospital services or facilities at this time or for the near future. The goals of the 2016 Health Plan will result in the enhancement of current service offerings. We anticipate adjustments to services will be needed as we will monitor patient utilization and outcomes to evaluate the need to adjust, consolidate existing services or add new services. As we organize and build the Coordinated Regional Care network with our physician led Independent Practice Association, we will invest resources and implement intensive care management programs aimed at promoting population health. These efforts will lead to further clinical integration with the goal of expanding the network of providers and program offerings. More effective management of patients in lower cost outpatient settings will require ongoing evaluation of the demand for hospital services and adjustments to service offerings. It is our hope that we will become more efficient as a health system with a strong and effective network of providers, programs and services to the benefit of our patients and the communities we serve.

If you have any questions or need anything further, please feel free to contact me at (860) 533-3429.

Very truly yours,



Dennis P. McConville
Senior Vice President
Eastern Connecticut Health Network

Enclosures:
MMH and RGH Services Listing and Locations

cc: Kimberly Martone, Director of Operations, Office of Health Care Access
Connecticut Department of Public Health

Colleen Smith, Nursing Consultant Partners, LLC
Ellen J. Shin, General Counsel, Prospect Medical Holdings, Inc.
Joyce A. Tichy, Senior Vice President and General Counsel, ECHN
Michael Collins, Interim CEO, ECHN
Frank Saidara, Vice President, Corporate Development, Prospect Medical Holdings, Inc.
Garrison De Lee, Assistant General Counsel, Prospect Medical Holdings, Inc.

List of ECHN's Current Service Lines and Service Locations

As of March 27, 2017

M = Service falls under Manchester Memorial Hospital *R = Service falls under Rockville General Hospital* *J = Service provided through a joint venture affiliate* *A=Services provided through a wholly owned affiliate*	**Manchester Memorial Hospital** 71 Haynes Street Manchester		**Rockville General Hospital** 31 Union Street Vernon		1707 Boston Turnpike Coventry	11 Pinney Street Ellington	175 West Road Ellington	622 Hebron Avenue Glastonbury	43 Woodland Street Hartford	100 Haynes Street Manchester	130 Hartford Road Manchester	150 North Main Street Manchester	360 Tolland Turnpike Manchester	2400 Tamarack Avenue South Windsor	2600 Tamarack Avenue South Windsor	2800 Tamarack Avenue South Windsor	6 Fieldstone Commons Tolland	26 Shenipsit Lake Road Tolland	428 Hartford Turnpike Vernon	47 Hartford Turnpike Vernon	8 Keynote Drive Vernon
Service (by Service Line)	**IP**	**OP**	**IP**	**OP**	Outpatient Service Locations																
Behavioral Health Services																					
Adult Behavioral Health Inpatient Services	M	M[(1)]																			
Adult Behavioral Health Outpatient Services		M										M									
Adult Partial Hospitalization Program												M									
Adolescent Inpatient Services	M	M[(1)]																			
Child and Adolescent Outpatient Services		M		R																	
Child and Adolescent Partial Hospitalization Program		M																			
Clinical Day School		M																			
Crisis Services		M		R																	
Eating Disorders Program				R										J							
Cardiac, Vascular, & Neurology Services																					
Cardiac Diagnostic Testing (i.e. Echo, EKG, etc.)	M	M	R	R																	
Cardiac Rehabilitation		M		R																	
Cardio Pulmonary Services	M	M	R	R																	
Heart Failure Clinic		M																			
Medical Cardiology	M	M	R	R																	
Medical Neurology	M	M	R	R																	
Sleep Lab		M																			
SPECT (Cardiac Nuclear Medicine)	M	M	R	R																	
Stress Lab	M	M	R	R																	
Telemetry Monitoring	M	M	R	R																	
Telestroke Services	M	M	R	R																	
Emergency Services																					
Emergency Department	M	M	R	R																	
Urgent Care																R					
General Acute Care Services																					
General Medical/Surgical Care	M	M[(1)]	R	R[(1)]																	
Medical/Surgical Intensive Care Unit (ICU)	M	M[(1)]	R	R[(1)]																	
Other Special Care Unit (SCU)	M	M[(1)]	R	R[(1)]																	
Pediatric Medical/Surgical Care[(2)]	M	M[(1)]	R	R[(1)]																	
Laboratory Services																					
Laboratory	M	M	R	R	M		M	M	M	M	M		M		M	M	M		M		
Phlebotomy	M	M	R	R	M		R	M	M	M	M		M		M	M	R		M		
Medical Imaging Services																					
Bone Density								M							R		J				
CT Scan	M	M	R	R												R	J				
Diagnostic Radiology (x-ray)	M	M	R	R				M								R	J				
Interventional Radiology	M	M	R	R																	
Mammography		M		R				M							R		J				
MRI	M	M	R	R												R	J				
Nuclear Medicine	M	M	R	R																	
PET Scan		M																			
Ultrasound	M	M	R	R											R	R	J				

List of ECHN's Current Service Lines and Service Locations

As of March 27, 2017

M = Service falls under Manchester Memorial Hospital *R = Service falls under Rockville General Hospital* *J = Service provided through a joint venture affiliate* *A=Services provided through a wholly owned affiliate*	**Manchester Memorial Hospital** 71 Haynes Street Manchester		**Rockville General Hospital** 31 Union Street Vernon		1707 Boston Turnpike Coventry	11 Pinney Street Ellington	175 West Road Ellington	622 Hebron Avenue Glastonbury	43 Woodland Street Hartford	100 Haynes Street Manchester	130 Hartford Road Manchester	150 North Main Street Manchester	360 Tolland Turnpike Manchester	2400 Tamarack Avenue South Windsor	2600 Tamarack Avenue South Windsor	2800 Tamarack Avenue South Windsor	6 Fieldstone Commons Tolland	26 Shenipsit Lake Road Tolland	428 Hartford Turnpike Vernon	47 Hartford Turnpike Vernon	8 Keynote Drive Vernon
Service (by Service Line)	**IP**	**OP**	**IP**	**OP**	Outpatient Service Locations																
Metabolic Services																					
Diabetes Management		M																			
Dialysis	M	M	R	R																	
Nutritional Services	M	M	R	R											R						
Oncology services																					
Chemotherapy	M	M																			
Oncology services	M	M	R	R						M											
Radiation Oncology										J											
Rehabilitation Services																					
Occupational Therapy	M	M	R	R												M				R	
Physical Therapy	M	M	R	R		R		M								M				R	
Speech Therapy	M	M	R	R																	
Surgical Services																					
Bariatrics	M																				
Colorectal	M	M	R	R																	
Endoscopy	M	M	R	R										J							
General Surgery	M	M	R	R																	
Gynecology	M	M	R	R																	
Joint Replacement	M																				
Minimally Invasive	M	M	R	R																	
Ophthalmology	M	M	R	R																	
Oral and Maxofacial Surgery	M	M	R	R																	
Orthopedic	M	M	R	R																	
Otolaryngology (Ear, Nose and Throat)	M	M	R	R																	
Plastic and Reconstructive	M	M	R	R																	
Robotic	M	M																			
Spine/Neurosurgery	M	M	R	R																	
Thoracic	M	M	R	R																	
Urology	M	M	R	R																	
Vascular	M	M	R	R																	
Wound Care	M	M	R																		
Women and Infant Services																					
Breast Ultrasound	M	M	R	R											R		J				
Breast Ultrasound Biopsy	M	M	R	R											R						
Maternity Care Center (Medical Prenatal & Postpartum Services)				R																	
Neonatal Intensive Care Unit (Level III NICU)	M																				
Obstetrics	M	M[(1)]																			
Stereotactic Breast Biopsy															R						
Other - Miscellaneous Services																					
Community Health Education		M		R						M					R	R					
Complementary and Alternative Medicine Services	M	M	R	R				M		M					R						
Home Care Services																					A
Hospice	M		R																		A
Long-Term Care																		A			
Occupational Medicine																M					
Short-Term Rehabilitation																		A			

(1) Patients may receive outpatient observation services on one of the designated inpatient units.

(2) Manchester Memorial Hospital and Rockville General Hospital do not have dedicated units for inpatient pediatric services. Patients age 14 years and older receive inpatient services on the adult medical/surgical units.

ECHN: System Service Locations

Street	Site	Town	State	Zipcode
1707 Boston Turnpike	Meadowbrook Plaza	Coventry	CT	06238
11 Pinney Street	ECHN Rehabilitation Services at the Ellington Y	Ellington	CT	06029
175 West Road	ECHN Medical Offices	Ellington	CT	06029
622 Hebron Avenue	Glastonbury Wellness Center	Glastonbury	CT	06033
43 Woodland Street	Medical Office Building at Gothic Park	Hartford	CT	06105
100 Haynes Street	John A. DeQuattro Cancer Center	Manchester	CT	06040
130 Hartford Road	Manchester Medical Offices	Manchester	CT	06040
150 North Main Street	ECHN Medical Office Building	Manchester	CT	06042
360 Tolland Turnpike	Tolland Turnpike, East Point	Manchester	CT	06040
71 Haynes Street	Manchester Memorial Hospital	Manchester	CT	06040
2400 Tamarack Avenue	Evergreen Walk	South Windsor	CT	06074
2600 Tamarack Avenue	Women's Center for Wellness	South Windsor	CT	06074
2800 Tamarack Avenue	CorpCare Occupational Health	South Windsor	CT	06074
2800 Tamarack Avenue	ECHN Medical Office Building at Evergreen Walk	South Windsor	CT	06074
2800 Tamarack Avenue	Evergreen Imaging Center	South Windsor	CT	06074
2800 Tamarack Avenue	Urgent Care at South Windsor	South Windsor	CT	06074
6 Fieldstone Commons	ECHN Medical Offices	Tolland	CT	06084
26 Shenipsit Lake Road	Woodlake at Tolland Nursing and Rehabilitation Center	Tolland	CT	06084
31 Union Street	Rockville General Hospital	Vernon	CT	06066
428 Hartford Turnpike	Hartford Turnpike	Vernon	CT	06066
47 Hartford Turnpike	The Rehab Center at Big Sky Fitness	Vernon	CT	06066
8 Keynote Drive	Visiting Nurse and Health Services of Connecticut	Vernon	CT	06066

As of March 27, 2017

Social Justice Study Group
South United Methodist Church
1226 Main St.
Manchester, CT 06040

March 30, 2017

Raul Pino, M.D., M.P.H.
Commissioner, CT Department of Public Health
410 Capitol Ave.
Mail Stop #13COM
Hartford, CT 06106

Dear Commissioner Pino:

We are one of the concerned groups that came to the hearings when a permit was being sought by Prospect Medical Holdings to purchase ECHN, our interest being the need for quality, locally-based health care in the Manchester-Vernon area. At that time, we asked for a community-elected ombudsman with full membership on the Advisory Board. We were disappointed when that was not granted, but were pleased to see that community-appointed representatives from Vernon and Manchester were to serve on the Advisory Board.

Manchester's representative, Mary Roche-Cronin, was appointed as agreed and is representing our concerns effectively. We were, however, very concerned that Vernon's representative, Dr. Ellen Marmer, was denied membership on the Board, possibly because she has been a vocal critic of the merger and is perceived as "biased against Prospect." Vernon Mayor Daniel Champagne had been asked to nominate an individual to fill this position. He apparently felt that Dr. Marmer had the right combination of skills and experience to successfully represent Vernon's interests; however, his expressed choice was ignored and Dr. Marmer has been repeatedly denied membership on the Board. This seems to us an injustice to the communities served by ECHN, and a repudiation of our understanding of the contract.

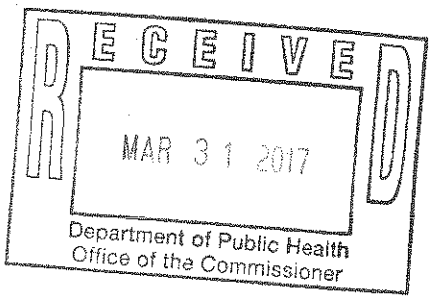
It has also come to our attention that Prospect has acted in ways that are counter to what was originally promised, particularly in the area of layoffs, such as Mayor Jay Moran of Manchester being notified of hospital layoffs as they were occurring. This lack of transparency leads us to believe that ECHN's mission, "to improve ... well-being by providing high-quality, compassionate healthcare," is being discarded in the name of profitability.

We call on the state to investigate any reported violations of the Prospect-ECHN contract.

Thank you for your continued service.

The Members of the Study Group

Cc: Dr. Ellen Marmer
Kimberly Martone, Director, DPH Office of Health Care Access
Rep. Michael Winkler, D-Vernon
Sen. Tony Guglielmo, R-Stafford
Mayor Jay Moran, Manchester, CT
Mayor Daniel Champagne, Vernon, CT



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Office of Health Care Access

April 7, 2017

Members of Social Justice Study Group
South United Methodist Church
1226 Main Street
Manchester, CT 06040

RE: The Certificate of Need Order issued for Prospect ECHN under Docket Number 15-32016-486

Dear Members of the Social Justice Study Group:

The Commissioner of the Department of Public Health, Dr. Raul Pino, received your letter of March 30, 2017 and forwarded it to my office. As the Director of the Office of Health Care Access (OHCA), I am responding on behalf of Dr. Pino. Your letter expresses concerns regarding several issues related to Prospect ECHN since the transfer of ownership. I'd like to take this opportunity to provide you with some information regarding OHCA's post-transaction review of the ECHN hospitals.

Regarding the selection of Manchester and Vernon representatives to the local or advisory bodies, please note that in OHCA's decision under Docket Number 15-32016-486, OHCA issued the following Condition related to community representation on the local boards.

20. For three (3) years following the Closing Date, PMH shall allow for two (2) community representatives to serve as voting members of the New MMH and New RGH Local Board with rights and obligations consistent with other voting members under the Local Board Bylaws. The community representatives shall be selected in consultation with the Mayors of Manchester and Vernon in order to ensure the appointment of two unbiased persons who will fairly represent the interests of the communities served by MMH and RGH, respectively. OHCA is imposing this Condition to ensure continued access to health care services for the patient population.

In February, OHCA questioned Prospect ECHN leadership regarding the status of the Vernon community representative and received responses which are attached to this letter. All of the material that I am providing is already part of OHCA's continuing public record under this docket number (see following link to OHCA website page for hospital transfers of ownership CONs). http://www.ct.gov/dph/cwp/view.asp?a=3902&q=555798&dphNav=|

OHCA's understanding is that Mayor Daniel Champagne of Vernon has been asked to serve on the Advisory Board on an Interim basis. Although OHCA is concerned that the permanent Local Board member for Vernon has not been designated, there is no requirement that the Applicant must accept the Mayor's recommendation for the community representative. Therefore, the Applicant is not in violation of the Order issued under Docket Number 15-32016-486. OHCA will continue to monitor this situation closely.

With respect to layoffs, OHCA does not have jurisdiction over employment matters. Consequently, there were no conditions placed upon the Applicant in the Order issued by OHCA under Docket Number 15-32016-486 regarding layoff notifications.

Sincerely,

Kimberly R. Martone
Director of Operations

Attachments

Cc: Dr. Ellen Marmer
Representative Michael Winkler
Senator Tony Guglielmo
Mayor Jay Moran, Manchester
Mayor Daniel Champagne, Vernon

User, OHCA

From: Roberts, Karen
Sent: Thursday, April 27, 2017 4:22 PM
To: User, OHCA
Subject: FW: Public Meeting at Prospect RGH

From: Colleen Smith [mailto:colleen713.smith@gmail.com]
Sent: Thursday, April 27, 2017 3:00 PM
To: Martone, Kim <Kimberly.Martone@ct.gov>
Cc: Roberts, Karen <Karen.Roberts@ct.gov>; Collins, Michael <mcollins@echn.org>
Subject: Re: Public Meeting at Prospect RGH

You are welcome. Ok, that's fine.
Colleen

Sent from my iPhone

On Apr 27, 2017, at 2:44 PM, Martone, Kim <Kimberly.Martone@ct.gov> wrote:

> Thanks Colleen for the update. Glad to hear that it was well attended and quite informative.
>
> Karen will be following up on additional material that might be helpful for us to have for our file.
>
> Kim
>
> ***Kimberly R. Martone***
> Director of Operations, Office of Health Care Access
> Connecticut Department of Public Health
> 410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134
> Phone: 860-418-7029 Fax: 860-418-7053
> *Email: Kimberly.Martone@ct.gov Website: www.ct.gov/ohca*
>
> <image001.jpg> <image002.jpg>
>
> ---
>
> **From:** Colleen Smith [mailto:colleen713.smith@gmail.com]
> **Sent:** Thursday, April 27, 2017 2:27 PM
> **To:** Martone, Kim
> **Cc:** Roberts, Karen; Collins, Michael
> **Subject:** Public Meeting at Prospect RGH
>
> Dear Kim,
>
> i just wanted to let you know that I had the opportunity to attend a meeting for the communities of Rockville/Vernon last evening at Rockville General Hospital. It was very well attended by the public.
> Michael Collins ran the 90 minute meeting which started off with a report on Quality and Safety initiatives at RGH by Linda Quirici, VP of Quality & Safety. She was followed by Dennis

McConville who provided an overview of planned facility upgrades and capital equipment acquisition. Tom Reardon from Prospect Medical East was also present and made a few remarks concerning PMH and their strategy.
Attendees were invited to ask questions throughout the presentations. There was an additional 45 minute period following the presentations that attendees were afforded the opportunity to get all of their questions and comments answered. They were very attentive and asked good questions regarding future plans for the hospital. In my opinion, M. Collins responded in an honest forthright manner.

Best regards,
Colleen

Colleen O'Brien Smith MSN RN NEA-BC
Nursing Consulting Partners, LLC
690C9 S. Park View Court
Franklin, WI 53132
Phone: 203-245-1044
Cell: 203-671-1348
colleen713.smith@gmail.com
http://nursingconsultingpartners.com/

User, OHCA

From: Roberts, Karen
Sent: Monday, May 01, 2017 10:08 AM
To: Colleen Smith
Cc: User, OHCA; Cotto, Carmen
Subject: RE: Certificate of Need Monitoring Docket #15-32016-486

Hi Colleen.

Regarding the Rockville/Vernon Community meeting last week that you refer to in your email, what materials are you or Prospect ECHN able to provide for the OHCA record regarding this meeting? Are there (will there be) minutes for the meeting, a sign up sheet listing meeting participants, a print out of any PowerPoint presentations made (by the hospitals, Prospect Medical or you), etc.? Also, has there been a meeting for the Manchester community as well or did this cover both communities? Thanks. Karen

Sincerely,

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: *karen.roberts@ct.gov*

From: Colleen Smith [mailto:colleen713.smith@gmail.com]
Sent: Thursday, April 27, 2017 3:00 PM
To: Martone, Kim <Kimberly.Martone@ct.gov>
Cc: Roberts, Karen <Karen.Roberts@ct.gov>; Collins, Michael <mcollins@echn.org>
Subject: Re: Public Meeting at Prospect RGH

You are welcome. Ok, that's fine.
Colleen

Sent from my iPhone

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> Karen will be following up on additional material that might be helpful for us to have for our file.

Kim

Kimberly R. Martone
Director of Operations, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134
Phone: 860-418-7029 Fax: 860-418-7053
Email: Kimberly.Martone@ct.gov Website: www.ct.gov/ohca

<image001.jpg> <image002.jpg>

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To: Martone, Kim
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Cell: 203-671-1348
colleen713.smith@gmail.com
http://nursingconsultingpartners.com/

User, OHCA

From: Colleen Smith <colleen713.smith@gmail.com>
Sent: Monday, May 01, 2017 12:44 PM
To: Roberts, Karen
Cc: User, OHCA; Cotto, Carmen
Subject: Re: Certificate of Need Monitoring Docket #15-32016-486

Dear Karen,
Attendance was taken and so I will ask that Prospect ECHN forward that to you. I am not aware that any minutes were taken. The presentations were verbal only and no Power Points were presented.
The community meeting for Manchester is being planned for 5/31/17. I am out of town and unable to attend that one.

I plan on following up with Dennis McConville today.
Best regards,
Colleen

Colleen O'Brien Smith MSN RN NEA-BC
Nursing Consulting Partners, LLC
690C9 S. Park View Court
Franklin, WI 53132
Phone: 203-245-1044
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colleen713.smith@gmail.com
http://nursingconsultingpartners.com/

On May 1, 2017, at 10:07 AM, Roberts, Karen <Karen.Roberts@ct.gov> wrote:

Hi Colleen.

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Karen Roberts
Principal Health Care Analyst
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Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: *karen.roberts@ct.gov*



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Cc: Roberts, Karen <Karen.Roberts@ct.gov>; Collins, Michael <mcollins@echn.org>
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> Kim
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> ***Kimberly R. Martone***
> Director of Operations, Office of Health Care Access
> Connecticut Department of Public Health
> 410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134
> Phone: 860-418-7029 Fax: 860-418-7053
> *Email: Kimberly.Martone@ct.gov Website: www.ct.gov/ohca*
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> **Sent:** Thursday, April 27, 2017 2:27 PM
> **To:** Martone, Kim
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Colleen

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Franklin, WI 53132
Phone: 203-245-1044
Cell: 203-671-1348
colleen713.smith@gmail.com
http://nursingconsultingpartners.com/

User, OHCA

From: Mcconville, Dennis P <dmcconville@echn.org>
Sent: Monday, May 01, 2017 2:39 PM
To: User, OHCA; Roberts, Karen; Martone, Kim; Colleen Smith
Cc: Ellen J. Shin (Legal Department); Tichy, Joyce A; Collins, Michael; Frank.Saidara; Garrison DeLee (garrison.delee@prospectmedical.com)
Subject: DN 15-32016-486 CON Final Decision, Condition #19
Attachments: Letter to Karen Roberts, OHCA re DN 15-32016-486-CON_05 01 17.pdf

The attached letter is submitted as required for condition number19 contained in the Final Decision for Docket Number: 15-32016-486-CON, the Transfer of Assets of Eastern Connecticut Health Network, Inc. to Prospect Medical Holdings.

Dennis P. McConville
Senior Vice President
Eastern Connecticut Health Network, Inc.
(860) 533-3429 (office)
dmcconville@echn.org

"This message originates from Eastern Connecticut Health Network. The information contained in this message may be privileged and confidential. If you are the intended recipient, you must maintain this message in a secure and confidential manner. If you are not the intended recipient, please notify the sender immediately and destroy this message. Thank you."

Eastern Connecticut Health Network
71 Haynes Street
Manchester, CT 06040
860.533.3414
www.echn.org

May 1, 2017

Karen Roberts
Office of Health Care Access
Department of Public Health
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134

Re: **Docket Number: 15-32016-486**

Project Title: **Transfer of assets of Eastern Connecticut Health Network, Inc. to Prospect Medical Holdings, Inc.**

Dear Ms. Roberts:

This letter is submitted in accordance with the Order for the above referenced Certificate of Need Final Decision, specifically Condition Number Nineteen (19) regarding the transfer of assets of Eastern Connecticut Health Network, Inc. (ECHN) to Prospect Medical Holdings, Inc. (PMH).

Condition Number Nineteen (19) requires that PMH will "hold a joint meeting of the Board of Directors of each of New MMH and New RGH and the Local Board of New MMH and New RGH ("Joint Board Meetings") at least twice annually with one occurring in Manchester and the other occurring in Vernon. Such Joint Board Meetings shall be followed by a meeting to which the public is invited in advance and at which the public is informed of the New Hospitals' activities and afforded an opportunity to ask questions and make comments."

A Joint Meeting of the Boards of Directors for Prospect Rockville Hospital, Inc. and Prospect Manchester Hospital Inc. was held on Wednesday, April 26, 2017 at Rockville General Hospital. That meeting was followed by a meeting for the Vernon community where information about the hospital's activities was shared and the public was encouraged to ask questions and provide comments. The meeting was advertised in both the Courant on April 20 and 25, 2017 and in the Journal Inquirer on April 16 and 23, 2017.

A joint meeting of the Boards is scheduled for May 31, 2017 at Manchester Memorial Hospital to be followed by a meeting where the Manchester community will be invited to

attend. Advertisements for that public meeting will be posted in the Courant and Journal Inquirer in the coming weeks.

If you have any questions or need anything further, please feel free to contact me at (860) 533-3429.

Very truly yours,

Dennis P. McConville
Senior Vice President
Eastern Connecticut Health Network

Enclosures:

Vernon Community Meeting Advertisement
Vernon Community Meeting Sign-In Sheets, 04 26 2017
Rockville General Hospital Community Meeting Agenda, 04 26 2017

cc: Kimberly Martone, Director of Operations, Department of Public Health Division of Office of Health Care Access
Colleen Smith, Nursing Consultant Partners, LLC
Ellen J. Shin, General Counsel, Prospect Medical Holdings, Inc.
Joyce A. Tichy, Senior Vice President and General Counsel, ECHN
Michael Collins, Interim CEO, ECHN
Frank Saidara, Vice President, Corporate Development, Prospect Medical Holdings, Inc.
Garrison De Lee, Assistant General Counsel, Prospect Medical Holdings, Inc.

A conversation on healthcare in your community.

ECHN is pleased to invite you to attend an upcoming community meeting. In this public forum, you'll learn how exciting new developments at ECHN are changing the care you receive – for the better.

It's a time dedicated to hearing directly from ECHN leaders and to having your questions answered. The future of healthcare in your community is taking shape, so please join us for this session and find out more about your local healthcare provider!

Town Hall Meeting

Wednesday, April 26, 2017
5 p.m. – 6:15 p.m.

Rockville General Hospital Cafeteria
31 Union St, Vernon

ECHN℠
Eastern Connecticut Health Network

Prospect Rockville Hospital, Inc.
Community Meeting
April 26, 2017

Rockville General Hospital Speakers:

Michael Collins, Interim CEO, Board Member

Thomas Reardon, President, Prospect Medical Holdings East, Board Member

Linda Quirici, Vice President, Quality & Safety

Dennis McConville, Senior Vice President, Chief Strategy Officer

Agenda:

1. Introductions, Opening Remarks	Michael Collins
2. Quality Report	Linda Quirici
3. Capital Improvements	Dennis McConville
4. Questions and Answers	Members of the Public Michael Collins Linda Quirici Dennis McConville Thomas Reardon
5. Concluding Remarks	Michael Collins

(165)

Town Hall Meeting
Wednesday, April 26, 2017
5 p.m. – 6:15 p.m.
Rockville General Hospital Cafeteria
31 Union St, Vernon

2 people did not sign in

NAME	TOWN OF RESIDENCE
Joseph E. Duplessis	Vernon
Dr. and Mrs Norman Desker	"
Margaret Callaway	"
Eileen Phelps	"
Rueland Phelps	"
Bill Campbell	"
ERIC KLOTER	TOLLAND
Drew Crandall	Ellington
Skye & Norine Edwards	Rockville
Linda Gilleri	Vernon
Fred Kracka	Vernon
WES SHORTS	VERNON
Kristi Coughlin	Vernon
Richard Gatlow	Vernon
Betty + Rudy Roggenkamp	Vernon
Carol Stiegl	Ellington
Jerry Connor	Ellington

Town Hall Meeting
Wednesday, April 26, 2017
5 p.m. – 6:15 p.m.
Rockville General Hospital Cafeteria
31 Union St, Vernon

NAME	TOWN OF RESIDENCE
Danielle Aedi	Vernon
Steve Aedi	Vernon
Bill Dauphin	Vernon
Shawn Gately	TOV
Polly Schaufler	T Vernon + Resident
Ron Freedman	Tolland
J Bentley	S. Windsor
[illegible]	Vernon
[illegible]	Vernon
[illegible]	Stafford
Linda Lee	Vernon
[illegible]	Vernon
[illegible]	Vernon
John Ward	Vernon
[illegible]	Manchester
Paul Skinner	VERNON

Town Hall Meeting
Wednesday, April 26, 2017
5 p.m. – 6:15 p.m.
Rockville General Hospital Cafeteria
31 Union St, Vernon

Colleen Smith RN	Independent Monitor
Tom DiDio	
Tom and Susan Mason	
Bob + Kathy Sumislaski	
Sally [illegible]	~~5 pm~~ Manchester
Kym [illegible]	
R. A. Deliste	
Phil Bunuch	

Town Hall Meeting
Wednesday, April 26, 2017
5 p.m. – 6:15 p.m.
Rockville General Hospital Cafeteria
31 Union St, Vernon

NAME	TOWN OF RESIDENCE
Sue Godlewski	
Sue Malone	
Elmar	
Rick Daigle	
Bob Carroll	
Glen (Engineering RGH)	
Mary Basile Linda Buttero	
Linda Quinchi	
Mary Powers	
Mike Collins	
Joyce Ichy	
Tom Sheraton	
Dennis McConville	
Natalie Cook	
Paul Golino	
Peggy Candito	
Chantal Pierop	

Michael Collins
Thomas Reardon

User, OHCA

From: Mcconville, Dennis P <dmcconville@echn.org>
Sent: Tuesday, May 30, 2017 5:01 PM
To: User, OHCA
Cc: Martone, Kim; Roberts, Karen; Colleen Smith; Ellen J. Shin (ellen.shin@prospectmedical.com); Joyce A. Tichy Esq. (joyce.tichy@gmail.com) (joyce.tichy@gmail.com); Collins, Michael; Garrison DeLee (garrison.delee@prospectmedical.com); Frank.Saidara; Von.Crockett; Basile, Mary C; Veillette, Michael; Golino, Paul
Subject: RE: 15-32016-486-CON
Attachments: DN 15-32016-486 CON, Letter Addressing Conditions 8, 9 & 10_ 05-30-17 Final.pdf

The attached letter is submitted as required for condition numbers 8, 9 and 10 contained in the Final Decision for Docket Number: 15-32016-486-CON, the Transfer of assets of Eastern Connecticut Health Network, Inc. to Prospect Medical Holdings.

Dennis P. McConville
Senior Vice President
Eastern Connecticut Health Network, Inc.
(860) 533-3429 (office)
dmcconville@echn.org



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Eastern Connecticut Health Network
71 Haynes Street
Manchester, CT 06040
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May 30, 2017

VIA EMAIL DELIVERY

Deputy Commissioner Yvonne Addo
Office of Health Care Access
Department of Public Health
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134

Re: **Docket Number: 15-32016-486**

Project Title: **Transfer of assets of Eastern Connecticut Health Network, Inc. to Prospect Medical Holdings, Inc.**

Dear Ms. Addo:

This letter is submitted in accordance with the Order for the above referenced Certificate of Need Final Decision, specifically Condition Number Eight (8), Condition Number Nine (9) and Condition Number Ten (10) regarding the transfer of assets of Eastern Connecticut Health Network, Inc. (ECHN) to Prospect Medical Holdings, Inc. (PMH). Please note that the transaction closed on October 1, 2016 ("Closing Date").

Condition Number Eight (8) requires that on a semi-annual basis until the capital commitment is satisfied, PMH shall submit to OHCA a report on the capital investments ("Capital Investment Report") it has made in the New MMH, New RGH and their affiliates from the $75 million Commitment Amount. Please find the Capital Investment Report for the period beginning on October 1, 2016 through March 31, 2017 labeled as Exhibit A. It includes the following information:

a. A list of the capital expenditures that have been made in the prior one hundred and eighty days (180) days with descriptions of each associated project; and

b. An explanation of why each expenditure was made and a timeframe for the roll out of the associated capital project (including estimated beginning, ending, and startup/operation dates); and

c. The dates and amounts of withdrawals from each of the New Hospitals' operating account and/or any other sources of funding used to fulfill the Capital Commitment.

In addition, please find Exhibit B which includes capital purchases that are approved and in process with purchase orders issued this fiscal year-to-date.

Condition Number Nine (9) requires that PMH provide a report for New ECHN, New MMH and New RGH on a semi-annual basis with the following information:

a. The cost saving totals achieved in the following Operating Expense Categories for New ECHN, New MMH and New RGH: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Interest Expense, Malpractice Expense, Utilities, Business Expenses, and other Operating Expenses. The categories shall be consistent with the major operating expense categories (Categories A, B, C, D, E, G, H, I, J, and K) which are in use at the time of reporting in the OHCA Hospital Reporting System ("HRS") Report 175 or successor report. The semi-annual submission shall also contain narratives describing:

    1. The major cost savings achieved for each expense category for the semi-annual period; and

    2. The effect of cost savings on the clinical quality of care.

b. A Consolidated Balance Sheet, Statements of Operations, and Statements of Cash Flows for New ECHN, New MMH and New RGH. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Reports 100/150, 300/350 or successor reports.

For Condition Number Nine (9.a.), please find Exhibit C which shows the expenses by category using the form of HRS Report 175 which will serve as the baseline for comparison to report any cost savings achieved under PMH's ownership when the next filing for this condition is due on November 30, 2017.

For Condition Number Nine (9.b.), please find Exhibit D using the form of HRS Reports 100/150 and 300/350 which includes the Consolidated Balance Sheet, Statements of Operations, and Statements of Cash Flows for New ECHN, New MMH and New RGH

Condition Number Ten (10) requires that on a semi-annual basis, PMH provide a report for New ECHN, New MMH and New RGH with the following financial measurements/indicators showing current month and year-to-date data and comparable prior year period data for New ECHN, New MMH and New RGH respectively :

Financial Measurement/Indicators
A. Operating Performance

1. Operating Margin
2. Non-Operating Margin
3. Total Margin

B. <u>Liquidity</u>

1. Current Ratio
2. Days Cash on Hand
3. Days in Net Accounts Receivables
4. Average Payment Period

C. <u>Leverage and Capital Structure</u>

1. Long-term Debt to Equity
2. Long-term Debt to Capitalization
3. Unrestricted Cash to Debt
4. Times Interest Earned Ratio
5. Debt Service Coverage Ratio
6. Equity Financing Ratio

D. <u>Additional Statistics</u>

1. Income from Operations
2. Revenue Over/(Under) Expense
3. Cash from Operations
4. Cash and Cash Equivalents
5. Net Working Capital
6. Free Cash Flow (and the elements used in the calculation)
7. Unrestricted Assets/Retained Earnings
8. Bad Debt as % of Gross Revenue
9. Credit Ratings (S&P, FITCH, or Moody's)

Please find Exhibit E for the period beginning on October 1, 2016 through March 31, 2017 showing current month and year to date measurements as required for Condition Ten (10). These measurements will serve as a baseline for comparison measurements for the next report which will be filed by November 30, 2017.

If you have any questions or need anything further, please feel free to contact me at (860) 533-3429.

Very truly yours,

Dennis P. McConville
Senior Vice President
Eastern Connecticut Health Network

Enclosures:

Exhibit A- Condition Number Eight (8) - Capital Investment Report
Exhibit B – Condition Number Eight (8) - Capital purchases that are approved and in process with purchase orders issued this fiscal year-to-date
Exhibit C – Condition Number Nine (9.a) - Expenses by category
Exhibit D – Condition Number Nine (9.b.) - Consolidated Balance Sheets, Statements of Operations, and Statements of Cash Flows for New ECHN, New MMH and New RGH
Exhibit E – Condition Number Ten (10) - Current month and year to date measurements

cc: Kimberly R. Martone, Director of Operations, Office of Health Care Access, Connecticut Department of Public Health
Karen Roberts, Principal Health Care Analyst, Office of Health Care Access, Connecticut Department of Public Health
Colleen Smith, Nursing Consultant Partners, LLC
Ellen J. Shin, General Counsel, Prospect Medical Holdings, Inc.
Joyce A. Tichy, Senior Vice President and General Counsel, ECHN
Michael Collins, Interim CEO, ECHN
Frank Saidara, Vice President, Corporate Development, Prospect Medical Holdings, Inc.
Garrison De Lee, Assistant General Counsel, Prospect Medical Holdings, Inc.

Exhibit A

Capital Investment Report
Paid Capital
FY 2017

Vendor	Entity	Project / Item	PO #	Funding Type	PAYMENT AMOUNT October	November	December	January	February	March	Total
MOREDIRECT INC	MMH	SECURITY SYSTEM UPGRADE	C0016389	F			$3,227				$3,227
ADVANCE SECURITY INTERGATION LLC	MMH	ACCESS CONTROL UPGRADE	C0016390	F				$81,206			$81,206
W.B. MASON COMPANY, INC.	RGH	WALDEN EATING DISORDER -PROJECT	C016300P	F					$1,813		$1,813
RAINTECH SOUND & COMMUNICATION, INC.	RGH	WALDEN EATING DISORDER -PROJECT	C016300R	F		$13,278					$13,278
STRYKER SALES CORPORATION	RGH	WALDEN EATING DISORDER -PROJECT	C01630AU	F					$68,544		$68,544
GE MEDICAL SYSTEMS INFORMATION	RGH	WALDEN EATING DISORDER -PROJECT	C16300AV	F			$2,594				$2,594
GRAYBAR ELECTRIC CO INC.	RGH	WALDEN EATING DISORDER -PROJECT	C16300BB	F		$237					$237
SHI INTERNAIONAL CORP	RGH	WALDEN EATING DISORDER -PROJECT	C16300BC	F		$1,881					$1,881
SHI INTERNAIONAL CORP	RGH	WALDEN EATING DISORDER -PROJECT	C16300BC	F		$155					$155
SOMA TECHNOLOGY, INC.	RGH	WALDEN EATING DISORDER -PROJECT	C16300BD	F		$695					$695
TRI-ANIM HEALTH SERVICES	RGH	WALDEN EATING DISORDER -PROJECT	C16300BG	F	$413						$413
TRI-ANIM HEALTH SERVICES	RGH	WALDEN EATING DISORDER -PROJECT	C16300BG	F		$826					$826
RAINTECH SOUND & COMMUNICATION, INC.	RGH	WALDEN EATING DISORDER -PROJECT	C16300BH	F				$34,882			$34,882
MODERN MECHANICAL SERVICES, INC	MMH	WATER TOWER TANKS	C0016345	N		$90,487					$90,487
ALL-PHASE ENTERPRISES INC	MMH	GENERATOR FLUE STACK	C0016364	N		$9,430					$9,430
SMITHS MEDICAL ASD INC	MMH	TEMP CHECK	C0016379	N	$807						$807
HILL-ROM	MMH	STRETCHER MATTRESSES (7)	C0016388	N		$3,644					$3,644
HILL-ROM	MMH	STRETCHER MATTRESSES (6)	C0016393	N		$2,818					$2,818
SCALES INDUSTRIAL TECHOLOGIES, LLC	MMH	QUINCY OILESS COMPRESSOR	C0016394	N		$12,730					$12,730
SCALES INDUSTRIAL TECHOLOGIES, LLC	MMH	QUINCY OILESS COMPRESSOR	C0016394	N					$1,663		$1,663
SAFEWARE, INC.	RGH	GAS ALERT DETECTOR	C0016398	N					$195		$195
SAFEWARE, INC.	RGH	GAS ALERT DETECTOR	C0016398	N					$2,264		$2,264
SAFEWARE, INC.	RGH	GAS ALERT DETECTOR	C0016398	N							$0
MOREDIRECT INC	WAT	IT - CISCO CATALYST	C0016401	N							$0
JKS SYSTEMS, LLC	WAT	WOODLAKE CABLE RUNS	C0016402	N							$0
PRAXAIR DISTRIBUTION, INC	MMH	FBC - NITRONOX E STAND PACKAGE	C0016403	N						$11,230	$11,230
STERIS CORP	MMH	SPD - 3 LEVEL MANIFOLD RACK	C0016405	N						$13,662	$13,662
OWENS & MINOR	MMH	DIGITAL SCALE WITH HANDRAILS	C0016407	N							$0
CARPETWORKS	MMH	NUCLEAR MED FLOORING	C0016413	N						$5,429	$5,429
CARPETWORKS	RGH	FLOORING - BIII, HOSPICE ICU WAITING ROO	C0016414	N						$19,452	$19,452
CARPETWORKS	RGH	FLOORING - LITHOTRIPSY	C0016415	N						$5,158	$5,158
INTOXIMETERS INC	MMH	INTOXIMETER SENSOR	C0016418	N							$0
SHI INTERNAIONAL CORP	MMH	IPAD AIR ACCESSORIES	C0016421	N							$0
TELEFLEX MEDICAL INCORPORATED	MMH	SURGICAL TOOLS	C0016427	N							$0
AESCULAP	MMH	SURGICAL TOOLS	C0016428	N							$0
INTERA LIFESCIENCES	MMH	LED HEADLIGHT (3)	C0016429	N							$0
SHI INTERNAIONAL CORP	MMH	APPLE IPOD TOUCH (50)	C0016430	N							$0
EHR INTEGRATION	ECMP	PATIENT ADT INTERFACE	C0016463	N							$0
GE HEALTHCARE IITS USA CORP	MMH	FBC EXPANSION -PROJECT	C016281B	N	$3,845						$3,845
MERRY X-RAY CHEMICAL CORP	MMH	VASCULAR- PROJECT	C016312V	N	$652						$652
CHIMENET, INC.	RGH	IDF UPGRADE/NETWORK REDESIGN	C016376A	N				$2,400			$2,400
CHIMENET, INC.	RGH	IDF UPGRADE/NETWORK REDESIGN	C016376A	N					$4,111		$4,111
MOREDIRECT INC	RGH	COMPUTER CABLES	C016376G	N		$1,403					$1,403
DC CONSULTING SERVICE LLC	ECMP	SOFTWARE	C016382B	N	$990						$990
JKS SYSTEMS, LLC	ECMP	COMPUTER SCANNER	C016385A/E	N	$412						$412
FLAGSHIP NETWORKS, INC	ECMP	LICENSE FEE	C016385D	N			$950				$950
MCKESSON MEDICAL SURGICAL	ECMP	BARIATRIC SCALE	C016385F	N	$1,550						$1,550
MOSER PILON NELSON	MMH	MMH BARIATRIC INPATIENT ROOMS -PROJEC	C016395A	N	$2,000						$2,000
MOSER PILON NELSON	MMH	MMH BARIATRIC INPATIENT ROOMS -PROJEC	C016395A	N	$3,950						$3,950
MOSER PILON NELSON	MMH	MMH BARIATRIC INPATIENT ROOMS -PROJEC	C016395A	N	$3,570						$3,570
MOSER PILON NELSON	MMH	MMH BARIATRIC INPATIENT ROOMS -PROJEC	C016395A	N				$2,380			$2,380
MOSER PILON NELSON	MMH	MMH FLUOROSCOPY ROOM-PROJECT	C016396A	N	$1,250						$1,250
MOSER PILON NELSON	MMH	MMH FLUOROSCOPY ROOM-PROJECT	C016396A	N	$6,275						$6,275
MOSER PILON NELSON	MMH	MMH FLUOROSCOPY ROOM-PROJECT	C016396A	N	$3,525						$3,525
MOSER PILON NELSON	MMH	MMH FLUOROSCOPY ROOM-PROJECT	C016396A	N				$2,350			$2,350
MOSER PILON NELSON	MMH	GEROPSYCHIATRY BH UNIT RENOVATIONS	C016409A	N						$45,100	$45,100
MOSER PILON NELSON	RGH	ADULT BEHAVIORAL HEALTH UNIT CONST	C016410A	N						$165,635	$165,635
MOSER PILON NELSON	RGH	ADULT BEHAVIORAL HEALTH UNIT CONST	C016410A	N							$0
CARPETWORKS LLC	MMH	PHARMACY ENGINEERING -PROJECT	C15875HH	N		$670					$670
PRO-TECH	WAT	FIRE BLOCKING		N					$6,391		$6,391
CTGI	MMH	LAB - GI COMPUTER INTERFACE		N						$17,870	$17,870
					$29,238	$138,254	$6,771	$123,219	$84,979	$283,336	$665,798
		Financing (Debt, Lease)		F	$413	$17,073	$5,821	$116,089	$70,357	$0	$209,753
		New FY 2017 Spending		N	$28,825	$121,181	$950	$7,131	$14,622	$283,336	$456,045
		Practice Acquisitions		A							
		TOTAL			$29,238	$138,254	$6,771	$123,219	$84,979	$283,336	$665,798

Michael D. Veillette, Chief Financial Officer, Prospect ECHN, Inc.

5/22/2017

Exhibit B

Prospect ECHN, Inc.
FY 2017 Approved Capital Expenditures
As of May 15, 2017

Vendor	Facility	Item Description	Amount	Purpose	Notes
Otis Elevator	MMH	Elevator Sheave Replacement	35,255.00	Repair	
Connection, JKS Systems	ECHN	Voice Mail System Replacement	76,866.48	Replacement	
Omnicell, Inc.	MMH/RGH	Omnicell Dispensing System	1,306,013.10	Replacement	
Connection, JKS Systems	WAT	Wireless Network Expansion	15,721.32	New, Expansion	
GermFree	RGH	Germfree VF-4USP Compounding Aseptic Isolator	16,015.55	Replacement	
Steris Corporation	MMH	Sterilizer Centry Color Display Upgrade	10,949.80	Replacement	
Steris Corporation	MMH	Steris Manifold Racks and Carts (4)	16,647.94	Replacement	
Owens and Minor	MMH	Digital Bariatric Scale	1,692.29	Replacement	
Hill-Rom	MMH	Sleeper Chairs (2)	4,804.04	Replacement	
Praxair	MMH	Nitrous Oxide Delivery System (2)	11,147.61	New, Expansion	
Moser Pilon Nelson, Standard Builders, Inc.	RGH	Renovations for Adult Behavioral Health Unit	4,172,153.04	Replacement	Renovations to expand adult behavioral health capacity with 24 beds, completetion expected November 2017
Moser Pilon Nelson, Standard Builders, Inc.	MMH	Renovations for Geropsychiatry Unit	818,129.28	Replacement	Renovations to provide separate program spaces for adolescent and geriatric patient populations, completion targeted for November 2017
Standard Builders, Inc.	MMH	BHU Safety Renovations	344,700.00	Replacement	Replace acoustic ceilings with drywall, targeted completion by August 2017
Flagship Networks	ECHN	Citrix Licenses	9,635.40	New, Expansion	
SHI	MMH/RGH	iPods - Communications Services	4,721.74	New, Expansion	
Karl Storz	MMH	Ureteroscope	19,949.77	Replacement	
Carpetworks, LLC	RGH	Replacement Flooring - Lithotripsy Room	5,157.98	Replacement	
Carpetworks, LLC	RGH	Replacement Fooring - RGH Waiting Rooms	21,042.41	Replacement	
Carpetworks, LLC	MMH	Replacement Flooring - MMH Waiting Rooms	5,429.17	Replacement	
Hill Rom Company	RGH	Mattresses (35)	20,136.63	Replacement	
Prestige Medical Imaging	RGH	Portable X-Ray Unit	148,786.65	Replacement	
Intoximeters, Inc.	MMH	Breath Alcohol Tester	590.23	Replacement	
Teleflex Medical	MMH	Laparoscopic Tray	4,624.20	Replacement	
Integra Life Sciences	MMH	Surgical Headlights	19,662.41	Replacement	
Trumpf Medical	MMH	Trumpf OR Table Extension	903.98	New, Expansion	
Aesculap, Inc.	MMH	Orthopedic Large Bone Tray	1,628.15	Replacement	
WB Mason Company, Inc.	MMH	Waiting Rooms & Maternity Education Room Furniture	27,586.13	Replacement	
WB Mason Company, Inc.	RGH	Waiting Rooms & Nurse Lounge Furniture	15,862.10	Replacement	
WB Mason Company, Inc.	RGH	ED Waiting Room Flooring Replacement	13,033.19	Replacement	
CDW/SHI/Flagship	ECMP	Laptops, PCs	7,711.19	New, Expansion	
SHI	MMH/RGH	iPods for Secure Texting	11,022.88	New, Expansion	
Precision Computer Services, Inc.	ECHN	UCS Chassis & Blade Servers	50,885.35	New, Expansion	
Connection/CHIMENET	ECHN	Network Security Firewall	31,980.56	New, Expansion	
All Phase Construction Enterprises, inc.	WAT	CHOW Renovations	517,966.35	Replacement	
WB Mason Company, Inc.	WAT	CHOW Furniture	240,877.43	Replacement	
Eagle Rivet Roofing	RGH	Roof Replacements (3)	152,075.18	Replacement	
CDW/Flagship/SHI/JKS	MMH/RGH	EMR Hardware	41,404.32	Replacement	
Carpetworks, LLC	MMH	2 East Patient Room Flooring	42,534.68	Replacement	
Carpetworks, LLC	MMH	1 East Corridor & Patient Room Flooring	72,647.69	Replacement	
ERBE USA Incorporated	MMH/RGH	ERBE Argon Plasma Coagulation Units (6)	233,965.32	Replacement	
Motara Instruments	MMH/RGH	Treadmills (4)	23,502.91	Replacement	
WB Mason Company, Inc.	MMH/RGH	Bariatric Furniture	25,845.18	Replacement	
Olympus American, Inc.	RGH	Tracheal & Rhino-Laryngoscopes	12,579.55	Replacement	
Follet	RGH	Ice Machine	2,553.15	Replacement	
SHI/JKS/CDW	WAT	PCs	4,678.94	Replacement	
PCP	ECMP	Practice Acquisition	273,200.00	New, Expansion	
WB Mason	RGH	Task Chairs (10)	3,126.69	Replacement	
WB Mason	MMH	Physician Lounge Furniture	5,899.23	Replacement	
ScottCare	MMH	VersaCare Telemetry Monitoring System	48,482.84	Replacement	
Meditech, CareFusion	MMH/RGH	Omnicell Interfaces	87,100.65	Replacement	
Iatric Systems, EHR Integration Services	MMH/RGH	ED Billing Interfaces	19,304.00	New, Expansion	
Connection, Flagship Networks, JKS Systems	CRC	Laptops for new hires	17,754.90	New, Expansion	
Mid-South Telecom LLC, SHI	CRC	Telephones for new hires	1,226.36	New, Expansion	
Connection, Flagship Networks	ECHN	Laptops for Inventory	23,327.82	Replacement	
Carpetworks, LLC	RGH	ICU Flooring Replacement	14,585.90	Replacement	
McKesson	ECMP	Exam Room Diagnostics Wall Units (2)	1,778.85	Replacement	

Prospect ECHN, Inc.
FY 2017 Approved Capital Expenditures
As of May 15, 2017

Mid-South Telecom LLC	ECMP	Telephone Headsets	1,312.95	Replacement	
Ampronix	MMH	HD Medical Video Recorder	4,241.24	Replacement	
Philips Healthcare	ECMP	Stress System, EKG Machine	26,302.80	Replacement	
Carpetworks, LLC Horak Painting, Abatement Plus	RGH	Ground Floor Renovations	92,683.04	Replacement	
Interior Concepts	RGH	Corridor Door Replacements	30,179.75	Replacement	
Classic Restaurant Supply	MMH	Ice cube machines (2)	4,730.43	Replacement	
Hologic	MMH	Hysteroscope & instrument tray	6,907.43	Replacement	
Hovertech International Air Supply & Storage Cart	MMH	HoverMatt Patient Transport System	1,447.42	New, Expansion	
			$ 9,284,668.57		

Exhibit C
Prospect Manchester Hospital, Prospect Rockville Hospital and Prospect ECHN
Report 175 - Operating Expenses by Category
October 2016 - March 2017

Line	Operating Expense by Category	MMH	RGH	ECHN
A	Salaries & Wages	$39,452,567	$14,231,616	$53,684,183
B	Fringe Benefits	$13,795,543	$5,104,868	$18,900,410
C	Contractual Labor Fees	$6,154,048	$2,273,114	$8,427,162
D	Medical Supplies & Phamaceutical Cost	$14,443,402	$3,904,635	$18,348,037
E	Depreciation & Amortization	$3,536,667	$1,478,849	$5,015,516
F	Bad Debts	$0	$0	$0
G	Interest Expense	$3,634,528	$1,075,070	$4,709,598
H	Malpractice Insurance Cost	$1,291,514	$605,301	$1,896,815
I	Utilities	$1,380,083	$665,214	$2,045,297
J	Business Expense	$11,185,763	$5,402,188	$16,587,951
K	Other Operating Expenses	-	-	$0
	Total Operating Expenses - All Expense Categories	$94,874,114	$34,740,855	$129,614,969

PROSPECT ECHN, INC.

AS OF MARCH 31, 2017

FISCAL YEAR 2017

REPORT 300 - PARENT CORPORATION CONSOLIDATED BALANCE SHEET INFORMATION

(1)	(2)	(3)
		MAR 2017
LINE	DESCRIPTION	ACTUAL
I.	**ASSETS**	
A.	**Current Assets:**	
1	Cash and Cash Equivalents	$12,317,043
2	Short Term Investments	
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$41,617,669
4	Current Assets Whose Use is Limited for Current Liabilities	
5	Due From Affiliates	
6	Due From Third Party Payers	
7	Inventories of Supplies	$5,881,292
8	Prepaid Expenses	$4,193,509
9	Other Current Assets	$1,965,964
	Total Current Assets	**$65,975,477**
B.	**Noncurrent Assets Whose Use is Limited:**	
1	Held by Trustee	$0
2	Board Designated for Capital Acquisition	
3	Funds Held in Escrow	
4	Other Noncurrent Assets Whose Use is Limited	
	Total Noncurrent Assets Whose Use is Limited:	**$0**
5	Interest in Net Assets of Foundation	
6	Long Term Investments	$13,953,604
7	Other Noncurrent Assets	$7,859,570
C.	**Net Fixed Assets:**	
1	Property, Plant and Equipment	$325,326,024
2	Less: Accumulated Depreciation	$244,746,974
	Less: Purchase Adjustment	$15,437,301
	Property, Plant and Equipment, Net	**$65,141,749**
3	Construction in Progress	$935,644
	Total Net Fixed Assets	**$66,077,393**

PROSPECT ECHN, INC.

AS OF MARCH 31, 2017

FISCAL YEAR 2017

REPORT 300 - PARENT CORPORATION CONSOLIDATED BALANCE SHEET INFORMATION

(1)	(2)	(3)
		MAR 2017
LINE	DESCRIPTION	ACTUAL
	Total Assets	$153,866,044

PROSPECT ECHN, INC.

AS OF MARCH 31, 2017

FISCAL YEAR 2017

REPORT 300 - PARENT CORPORATION CONSOLIDATED BALANCE SHEET INFORMATION

(1)	(2)	(3)
		MAR 2017
LINE	DESCRIPTION	ACTUAL
II.	**LIABILITIES AND NET ASSETS**	
A.	**Current Liabilities:**	
1	Accounts Payable and Accrued Expenses	$23,145,954
2	Salaries, Wages and Payroll Taxes	$7,623,804
3	Due To Third Party Payers	$4,829,928
4	Due To Affiliates	$11,775,883
5	Current Portion of Long Term Debt	$0
6	Current Portion of Notes Payable	$2,938,638
7	Other Current Liabilities	$542,979
	Total Current Liabilities	**$50,857,186**
B.	**Long Term Debt:**	
1	Bonds Payable (Net of Current Portion)	
2	Notes Payable (Net of Current Portion)	$10,315,643
	Total Long Term Debt	**$10,315,643**
3	Accrued Pension Liability	$67,990,311
4	Other Long Term Liabilities	$19,154,093
	Total Long Term Liabilities	**$97,460,047**
5	Interest in Net Assets of Affiliates or Joint Ventures	
C.	**Net Assets:**	
1	Net Assets or Equity	$5,548,811
2	Temporarily Restricted Net Assets	
3	Permanently Restricted Net Assets	
	Total Net Assets	**$5,548,811**
	Total Liabilities and Net Assets	**$153,866,044**

PROSPECT ECHN, INC.

OCTOBER 2016 THROUGH MARCH 2017

FISCAL YEAR 2017

REPORT 350 - PARENT CORPORATION CONSOLIDATED STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)
		OCT-MAR
LINE	DESCRIPTION	ACTUAL
A.	**Operating Revenue:**	
1	Total Gross Patient Revenue	$497,056,059
2	Less: Allowances	$341,478,789
3	Less: Charity Care	$1,281,566
4	Less: Other Deductions	$0
	Total Net Patient Revenue	**$154,295,704**
5	Provision for Bad Debts	$3,835,978
	Net Patient Service Revenue less provision for bad debts	**$150,459,726**
6	Other Operating Revenue	$10,793,602
7	Net Assets Released from Restrictions	$0
	Total Operating Revenue	**$161,253,328**
B.	**Operating Expenses:**	
1	Salaries and Wages	$73,885,912
2	Fringe Benefits	$24,396,707
3	Physicians Fees	$8,053,331
4	Supplies and Drugs	$18,371,771
5	Depreciation and Amortization	$5,698,189
6	Bad Debts	$0
7	Interest Expense	$325,374
8	Malpractice Insurance Cost	$1,774,010
9	Other Operating Expenses	$29,049,379
	Total Operating Expenses	**$161,554,673**
	Income/(Loss) From Operations	**($301,345)**
C.	**Non-Operating Revenue:**	
1	Income from Investments	$0
2	Gifts, Contributions and Donations	$0
3	Other Non-Operating Gains/(Losses)	($144,770)
	Total Non-Operating Revenue	**($144,770)**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**($446,115)**
	Other Adjustments:	
	Unrealized Gains/(Losses)	$0
	All Other Adjustments	$0

Exhibit D

PROSPECT ECHN, INC.		
OCTOBER 2016 THROUGH MARCH 2017		
FISCAL YEAR 2017		
REPORT 350 - PARENT CORPORATION CONSOLIDATED STATEMENT OF OPERATIONS INFORMATION		
(1)	(2)	(3)
		OCT-MAR
LINE	DESCRIPTION	ACTUAL
	Total Other Adjustments	$0
	Excess/(Deficiency) of Revenue Over Expenses	($446,115)

PROSPECT MANCHESTER HOSPITAL

AS OF MARCH 31, 2017

FISCAL YEAR 2017

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)
		MAR 2017
LINE	DESCRIPTION	ACTUAL
I.	**ASSETS**	
A.	**Current Assets:**	
1	Cash and Cash Equivalents	$2,679,224
2	Short Term Investments	$0
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$25,756,361
4	Current Assets Whose Use is Limited for Current Liabilities	$0
5	Due From Affiliates	$0
6	Due From Third Party Payers	$0
7	Inventories of Supplies	$4,429,309
8	Prepaid Expenses	$1,554,585
9	Other Current Assets	$0
	Total Current Assets	**$34,419,479**
B.	**Noncurrent Assets Whose Use is Limited:**	
1	Held by Trustee	$0
2	Board Designated for Capital Acquisition	$0
3	Funds Held in Escrow	$0
4	Other Noncurrent Assets Whose Use is Limited	$1,552,327
	Total Noncurrent Assets Whose Use is Limited:	**$1,552,327**
5	Interest in Net Assets of Foundation	$0
6	Long Term Investments	$3,909,859
7	Other Noncurrent Assets	$11,605,201
C.	**Net Fixed Assets:**	
1	Property, Plant and Equipment	$205,175,936
2	Less: Accumulated Depreciation	$157,623,013
	Property, Plant and Equipment, Net	**$47,552,923**
3	Construction in Progress	$389,226
	Total Net Fixed Assets	**$47,942,149**
	Total Assets	**$99,429,015**

PROSPECT MANCHESTER HOSPITAL

AS OF MARCH 31, 2017

FISCAL YEAR 2017

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)
		MAR 2017
LINE	DESCRIPTION	ACTUAL
II.	**LIABILITIES AND NET ASSETS**	
A.	**Current Liabilities:**	
1	Accounts Payable and Accrued Expenses	$13,478,861
2	Salaries, Wages and Payroll Taxes	$3,139,969
3	Due To Third Party Payers	$2,913,608
4	Due To Affiliates	$0
5	Current Portion of Bonds	$0
6	Current Portion of Notes Payable	$2,294,118
7	Other Current Liabilities	$20,341,722
	Total Current Liabilities	**$42,168,278**
B.	**Long Term Debt:**	
1	Bonds Payable (Net of Current Portion)	$0
2	Notes Payable (Net of Current Portion)	$5,139,876
	Total Long Term Debt	**$5,139,876**
3	Accrued Pension Liability	$52,806,626
4	Other Long Term Liabilities	$12,269,552
	Total Long Term Liabilities	**$70,216,054**
5	Interest in Net Assets of Affiliates or Joint Ventures	$0
C.	**Net Assets:**	
1	Unrestricted Net Assets or Equity	($12,955,317)
2	Temporarily Restricted Net Assets	$0
3	Permanently Restricted Net Assets	$0
	Total Net Assets	**($12,955,317)**
	Total Liabilities and Net Assets	**$99,429,015**

PROSPECT MANCHESTER HOSPITAL		
OCTOBER 2016 THROUGH MARCH 2017		
FISCAL YEAR 2017		
REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION		
(1)	(2)	(3)
		OCT-MAR
LINE	DESCRIPTION	ACTUAL
A.	**Operating Revenue:**	
1	Total Gross Patient Revenue	$336,306,535
2	Less: Allowances	$240,249,012
3	Less: Charity Care	$897,095
4	Less: Other Deductions	$0
	Total Net Patient Revenue	**$95,160,428**
5	Provision for Bad Debts	$2,267,527
	Net Patient Service Revenue less provision for bad debts	**$92,892,901**
6	Other Operating Revenue	$4,641,099
7	Net Assets Released from Restrictions	($1,983)
	Total Operating Revenue	**$97,532,017**
B.	**Operating Expenses:**	
1	Salaries and Wages	$39,112,524
2	Fringe Benefits	$13,822,026
3	Physicians Fees	$5,029,260
4	Supplies and Drugs	$13,471,362
5	Depreciation and Amortization	$3,536,666
6	Bad Debts	$0
7	Interest Expense	$3,634,528
8	Malpractice Insurance Cost	$1,290,472
9	Other Operating Expenses	$14,977,276
	Total Operating Expenses	**$94,874,114**
	Income/(Loss) From Operations	**$2,657,903**
C.	**Non-Operating Revenue:**	
1	Income from Investments	$0
2	Gifts, Contributions and Donations	$0
3	Other Non-Operating Gains/(Losses)	$2,252,032
	Total Non-Operating Revenue	**$2,252,032**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**$4,909,935**
	Other Adjustments:	
	Unrealized Gains/(Losses)	$0
	All Other Adjustments	$0
	Total Other Adjustments	**$0**
	Excess/(Deficiency) of Revenue Over Expenses	**$4,909,935**

PROSPECT MANCHESTER HOSPITAL		
OCTOBER 2016 THROUGH MARCH 2017		
FISCAL YEAR 2017		
REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION		
(1)	(2)	(3)
		OCT-MAR
LINE	DESCRIPTION	ACTUAL

PROSPECT ROCKVILLE HOSPITAL

AS OF MARCH 31, 2017

FISCAL YEAR 2017

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)
		MAR 2017
LINE	DESCRIPTION	ACTUAL
I.	**ASSETS**	
A.	**Current Assets:**	
1	Cash and Cash Equivalents	$131,224
2	Short Term Investments	$0
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$7,983,339
4	Current Assets Whose Use is Limited for Current Liabilities	$0
5	Due From Affiliates	$0
6	Due From Third Party Payers	$0
7	Inventories of Supplies	$1,255,387
8	Prepaid Expenses	$165,902
9	Other Current Assets	$0
	Total Current Assets	**$9,535,852**
B.	**Noncurrent Assets Whose Use is Limited:**	
1	Held by Trustee	$0
2	Board Designated for Capital Acquisition	$0
3	Funds Held in Escrow	$0
4	Other Noncurrent Assets Whose Use is Limited	$0
	Total Noncurrent Assets Whose Use is Limited:	**$0**
5	Interest in Net Assets of Foundation	$0
6	Long Term Investments	$3,461,894
7	Other Noncurrent Assets	$1,827,899
C.	**Net Fixed Assets:**	
1	Property, Plant and Equipment	$91,757,752
2	Less: Accumulated Depreciation	$68,988,989
	Property, Plant and Equipment, Net	**$22,768,763**
3	Construction in Progress	$546,419
	Total Net Fixed Assets	**$23,315,182**
	Total Assets	**$38,140,827**

PROSPECT ROCKVILLE HOSPITAL

AS OF MARCH 31, 2017

FISCAL YEAR 2017

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)
		MAR 2017
LINE	DESCRIPTION	ACTUAL
II.	**LIABILITIES AND NET ASSETS**	
A.	**Current Liabilities:**	
1	Accounts Payable and Accrued Expenses	$4,182,210
2	Salaries, Wages and Payroll Taxes	$824,229
3	Due To Third Party Payers	$1,221,401
4	Due To Affiliates	$0
5	Current Portion of Bonds	$0
6	Current Portion of Notes Payable	$166,122
7	Other Current Liabilities	$1,505,344
	Total Current Liabilities	**$7,899,306**
B.	**Long Term Debt:**	
1	Bonds Payable (Net of Current Portion)	$0
2	Notes Payable (Net of Current Portion)	$535,512
	Total Long Term Debt	**$535,512**
3	Accrued Pension Liability	$15,183,685
4	Other Long Term Liabilities	$4,610,332
	Total Long Term Liabilities	**$20,329,529**
5	Interest in Net Assets of Affiliates or Joint Ventures	$0
C.	**Net Assets:**	
1	Unrestricted Net Assets or Equity	$9,911,992
2	Temporarily Restricted Net Assets	$0
3	Permanently Restricted Net Assets	$0
	Total Net Assets	**$9,911,992**
	Total Liabilities and Net Assets	**$38,140,827**

PROSPECT ROCKVILLE HOSPITAL		
OCTOBER 2016 THROUGH MARCH 2017		
FISCAL YEAR 2017		
REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION		
(1)	(2)	(3)
		OCT-MAR
LINE	DESCRIPTION	ACTUAL
A.	**Operating Revenue:**	
1	Total Gross Patient Revenue	$117,512,312
2	Less: Allowances	$85,243,699
3	Less: Charity Care	$384,471
4	Less: Other Deductions	$0
	Total Net Patient Revenue	**$31,884,142**
5	Provision for Bad Debts	$1,204,542
	Net Patient Service Revenue less provision for bad debts	**$30,679,600**
6	Other Operating Revenue	$725,658
7	Net Assets Released from Restrictions	$0
	Total Operating Revenue	**$31,405,258**
B.	**Operating Expenses:**	
1	Salaries and Wages	$14,071,000
2	Fringe Benefits	$5,420,851
3	Physicians Fees	$2,271,227
4	Supplies and Drugs	$3,913,060
5	Depreciation and Amortization	$1,478,850
6	Bad Debts	$0
7	Interest Expense	$82,534
8	Malpractice Insurance Cost	$504,808
9	Other Operating Expenses	$6,309,386
	Total Operating Expenses	**$34,051,716**
	Income/(Loss) From Operations	**($2,646,458)**
C.	**Non-Operating Revenue:**	
1	Income from Investments	$0
2	Gifts, Contributions and Donations	$0
3	Other Non-Operating Gains/(Losses)	($28,033)
	Total Non-Operating Revenue	**($28,033)**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**($2,674,491)**
	Other Adjustments:	
	Unrealized Gains/(Losses)	$0
	All Other Adjustments	$0
	Total Other Adjustments	**$0**
	Excess/(Deficiency) of Revenue Over Expenses	**($2,674,491)**

PROSPECT ECHN, INC.

FISCAL YEAR 2017

		MTD						YTD					
		OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH
	DESCRIPTION	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017
	Total Gross Revenue	$81,613,814	$79,220,761	$79,528,541	$86,998,487	$81,707,256	$87,987,208	$81,613,814	$160,834,575	$240,363,116	$327,361,603	$409,068,859	$497,056,067
	Total Allowances	($56,223,666)	($54,407,866)	($53,362,963)	($60,650,579)	($56,713,976)	($61,401,307)	($56,223,666)	($110,631,532)	($163,994,495)	($224,645,074)	($281,359,050)	($342,760,357)
	Bad Debt	($880,497)	($610,712)	($817,000)	($859,527)	($81,611)	($586,631)	($880,497)	($1,491,209)	($2,308,209)	($3,167,736)	($3,249,347)	($3,835,978)
	Net Patient Revenue	$24,509,651	$24,202,183	$25,348,578	$25,488,381	$24,911,669	$25,999,270	$24,509,651	$48,711,834	$74,060,412	$99,548,793	$124,460,462	$150,459,732
	Other Operating Revenue	1,766,193	1,621,693	2,001,093	1,884,657	1,732,449	1,787,519	$1,766,193	$3,387,886	$5,388,979	$7,273,636	$9,006,085	$10,793,604
	Total Operating Revenue	$26,275,844	$25,823,876	$27,349,671	$27,373,038	$26,644,118	$27,786,789	$26,275,844	$52,099,720	$79,449,391	$106,822,429	$133,466,547	$161,253,336
	Total Operating Expenses	26,902,621	26,383,958	27,816,233	27,129,387	25,837,459	30,542,930	$26,902,621	$53,286,579	$81,102,812	$108,232,199	$134,069,658	$164,612,588
	Income/(Loss) From Operations	($626,777)	($560,082)	($466,562)	$243,651	$806,659	($2,756,141)	($626,777)	($1,186,859)	($1,653,421)	($1,409,770)	($603,111)	($3,359,252)
	Total Non-Operating Revenue	(24,904)	(21,096)	3,420	(7,909)	(20,107)	2,983,733	($24,904)	($46,000)	($42,580)	($50,489)	($70,596)	$2,913,137
	Excess/(Deficiency) of Revenue Over Expenses	($651,681)	($581,178)	($463,142)	$235,742	$786,552	$227,592	($651,681)	($1,232,859)	($1,696,001)	($1,460,259)	($673,707)	($446,115)
A.	**Operating Performance**												
1	**Operating Margin**	**-2.39%**	**-2.17%**	**-1.71%**	**0.89%**	**3.03%**	**-8.96%**	**-2.39%**	**-2.28%**	**-2.08%**	**-1.32%**	**-0.45%**	**-2.05%**
2	**Non-Operating Margin**	**-0.09%**	**-0.08%**	**0.01%**	**-0.03%**	**-0.08%**	**9.70%**	**-0.09%**	**-0.09%**	**-0.05%**	**-0.05%**	**-0.05%**	**1.77%**
3	**Total Margin**	**-2.48%**	**-2.25%**	**-1.69%**	**0.86%**	**2.95%**	**0.74%**	**-2.48%**	**-2.37%**	**-2.14%**	**-1.37%**	**-0.51%**	**-0.27%**
D.8	**Bad Debt as % of Gross Revenue**	**1.08%**	**0.77%**	**1.03%**	**0.99%**	**0.10%**	**0.67%**	**1.08%**	**0.93%**	**0.96%**	**0.97%**	**0.79%**	**0.77%**
	Income/(Loss) From Operations	($626,777)	($560,082)	($466,562)	$243,651	$806,659	($2,756,141)	($626,777)	($1,186,859)	($1,653,421)	($1,409,770)	($603,111)	($3,359,252)
	Total Operating Revenue	$26,275,844	$25,823,876	$27,349,671	$27,373,038	$26,644,118	$27,786,789	$26,275,844	$52,099,720	$79,449,391	$106,822,429	$133,466,547	$161,253,336
	Total Non-Operating Revenue	($24,904)	($21,096)	$3,420	($7,909)	($20,107)	$2,983,733	($24,904)	($46,000)	($42,580)	($50,489)	($70,596)	$2,913,137
	Total Revenue	$26,250,940	$25,802,780	$27,353,091	$27,365,129	$26,624,011	$30,770,522	$26,250,940	$52,053,720	$79,406,811	$106,771,940	$133,395,951	$164,166,473
	Excess/(Deficiency) of Revenue Over Expenses	($651,681)	($581,178)	($463,142)	$235,742	$786,552	$227,592	($651,681)	($1,232,859)	($1,696,001)	($1,460,259)	($673,707)	($446,115)
	Unrealized gain/(loss) in investments (self-insurance fu	($17,418)	$20,901	($8,239)	$24,328	$13,242	$5,678	($17,418)	$3,483	($4,755)	$19,573	$32,815	$38,494
	Unrestricted Net Assets	($669,099)	($1,229,376)	($1,700,757)	($1,440,686)	($640,892)	$5,548,810	($669,099)	($1,229,376)	($1,700,757)	($1,440,686)	($640,892)	$5,548,810
	Total Net Assets	($669,099)	($1,229,376)	($1,700,757)	($1,440,686)	($640,892)	$5,548,810	($669,099)	($1,229,376)	($1,700,757)	($1,440,686)	($640,892)	$5,548,810

PROSPECT ECHN, INC.

FISCAL YEAR 2017

		MTD						YTD					
		OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH
	DESCRIPTION	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017
	Total Gross Revenue	$81,613,814	$79,220,761	$79,528,541	$86,998,487	$81,707,256	$87,987,208	$81,613,814	$160,834,575	$240,363,116	$327,361,603	$409,068,859	$497,056,067
	Total Allowances	($56,223,666)	($54,407,866)	($53,362,963)	($60,650,579)	($56,713,976)	($61,401,307)	($56,223,666)	($110,631,532)	($163,994,495)	($224,645,074)	($281,359,050)	($342,760,357)
B.	**Liquidity**												
1	**Current Ratio**	**1.53**	**1.39**	**1.45**	**1.51**	**1.35**	**1.39**	**1.53**	**1.39**	**1.45**	**1.51**	**1.35**	**1.39**
	Total Current Assets	$53,789,301	$57,971,282	$66,689,028	$59,807,731	$53,350,265	$54,199,594	$53,789,301	$57,971,282	$66,689,028	$59,807,731	$53,350,265	$54,199,594
	Total Current Liabilities	$35,143,529	$41,728,038	$45,985,765	$39,526,662	$39,472,734	$39,081,303	$35,143,529	$41,728,038	$45,985,765	$39,526,662	$39,472,734	$39,081,303
2	**Days Cash on Hand**	**5**	**4**	**9**	**9**	**3**	**13**	**5**	**4**	**9**	**9**	**3**	**14**
	Cash and Cash Equivalents	$4,446,884	$3,585,374	$7,929,513	$7,397,213	$2,848,360	$12,317,043	$4,446,884	$3,585,374	$7,929,513	$7,397,213	$2,848,360	$12,317,043
	Short Term Investments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Total Cash and Short Term Investments	$4,446,884	$3,585,374	$7,929,513	$7,397,213	$2,848,360	$12,317,043	$4,446,884	$3,585,374	$7,929,513	$7,397,213	$2,848,360	$12,317,043
	Total Operating Expenses	$26,902,621	$26,383,958	$27,816,233	$27,129,387	$25,837,459	$30,542,930	$26,902,621	$53,286,579	$81,102,812	$108,232,199	$134,069,658	$164,612,588
	Depreciation Expense	$998,179	$969,552	$959,794	$953,226	$963,594	$853,961	$998,179	$1,967,731	$2,927,525	$3,880,751	$4,844,345	$5,698,306
	Operating Expenses less Depreciation Expense	$25,904,442	$25,414,406	$26,856,439	$26,176,161	$24,873,865	$29,688,969	$25,904,442	$51,318,848	$78,175,287	$104,351,448	$129,225,313	$158,914,282
3	**Days in Net Acounts Receivables**	**51**	**50**	**57**	**59**	**46**	**44**	**51**	**51**	**58**	**60**	**50**	**44**
	Net Patient Accounts Receivable	$ 41,733,492	$ 44,679,012	$ 51,205,414	$ 50,989,930	$ 44,208,941	$ 41,617,669	$41,733,492	$44,679,012	$51,205,414	$50,989,930	$44,208,941	$41,617,669
	Due From Third Party Payers	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Due To Third Party Payers	$1,653,608	$4,043,744	$4,443,801	$2,251,594	$2,848,960	$4,829,928	$1,653,608	$4,043,744	$4,443,801	$2,251,594	$2,848,960	$4,829,928
	Total Net Patient Accounts Receivable and Third Party Payer Activity	$ 40,079,884	$ 40,635,268	$ 46,761,613	$ 48,738,337	$ 41,359,981	$ 36,787,740	$ 40,079,884	$ 40,635,268	$ 46,761,613	$ 48,738,337	$ 41,359,981	$ 36,787,740
	Total Net Patient Revenue	$24,509,651	$24,202,183	$25,348,578	$25,488,381	$24,911,669	$25,999,270	$24,509,651	$48,711,834	$74,060,412	$99,548,793	$124,460,462	$150,459,732
4	**Average Payment Period**	**42**	**49**	**53**	**47**	**44**	**41**	**42**	**50**	**54**	**47**	**46**	**45**
	Total Current Liabilities	$35,143,529	$41,728,038	$45,985,765	$39,526,662	$39,472,734	$39,081,303	$35,143,529	$41,728,038	$45,985,765	$39,526,662	$39,472,734	$39,081,303
	Total Operating Expenses	$26,902,621	$26,383,958	$27,816,233	$27,129,387	$25,837,459	$30,542,930	$26,902,621	$53,286,579	$81,102,812	$108,232,199	$134,069,658	$164,612,588
	Depreciation Expense	$998,179	$969,552	$959,794	$953,226	$963,594	$853,961	$998,179	$1,967,731	$2,927,525	$3,880,751	$4,844,345	$5,698,306
	Total Operating Expenses less Depreciation Expense	$25,904,442	$25,414,406	$26,856,439	$26,176,161	$24,873,865	$29,688,969	$25,904,442	$51,318,848	$78,175,287	$104,351,448	$129,225,313	$158,914,282

PROSPECT ECHN, INC.

FISCAL YEAR 2017

		MTD						YTD					
		OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH
	DESCRIPTION	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017
	Total Gross Revenue	$81,613,814	$79,220,761	$79,528,541	$86,998,487	$81,707,256	$87,987,208	$81,613,814	$160,834,575	$240,363,116	$327,361,603	$409,068,859	$497,056,067
	Total Allowances	($56,223,666)	($54,407,866)	($53,362,963)	($60,650,579)	($56,713,976)	($61,401,307)	($56,223,666)	($110,631,532)	($163,994,495)	($224,645,074)	($281,359,050)	($342,760,357)
C.	**Leverage and Capital Structure**												
1	**Long-term Debt to Equity**	**(16.8)**	**(8.9)**	**(6.4)**	**(7.5)**	**(16.4)**	**1.9**	**(16.8)**	**(8.9)**	**(6.4)**	**(7.5)**	**(16.4)**	**1.9**
2	**Long Term Debt to Capitalization Ratio**	**106.3**	**112.6**	**118.4**	**115.5**	**106.5**	**65.0**	**106.3**	**112.6**	**118.4**	**115.5**	**106.5**	**65.0**
	Total Long Term Debt	$11,216,043	$10,993,131	$10,925,544	$10,760,682	$10,481,568	$10,315,644	$11,216,043	$10,993,131	$10,925,544	$10,760,682	$10,481,568	$10,315,644
	Total Net Assets	($669,099)	($1,229,376)	($1,700,757)	($1,440,686)	($640,892)	$5,548,810	($669,099)	($1,229,376)	($1,700,757)	($1,440,686)	($640,892)	$5,548,810
	Total Long Term Debt and Total Net Assets	$10,546,944	$9,763,755	$9,224,788	$9,319,995	$9,840,676	$15,864,454	$10,546,944	$9,763,755	$9,224,788	$9,319,995	$9,840,676	$15,864,454
3	**Unrestricted Cash to Total Debt Ratio**	**0.7**	**0.7**	**0.9**	**2.4**	**3.5**	**2.2**	**0.7**	**1.4**	**2.2**	**4.8**	**8.3**	**10.6**
	Excess/(Deficiency) of Revenues Over Expenses	($651,681)	($581,178)	($463,142)	$235,742	$786,552	$227,592	($651,681)	($1,232,859)	($1,696,001)	($1,460,259)	($673,707)	($446,115)
	Depreciation Expense	$998,179	$969,552	$959,794	$953,226	$963,594	$853,961	$998,179	$1,967,731	$2,927,525	$3,880,751	$4,844,345	$5,698,306
	Excess of Revenues Over Expenses and Depreciation Expense	$346,498	$388,374	$496,652	$1,188,968	$1,750,146	$1,081,553	$346,498	$734,872	$1,231,524	$2,420,492	$4,170,638	$5,252,191
	Total Current Liabilities	$35,143,529	$41,728,038	$45,985,765	$39,526,662	$39,472,734	$39,081,303	$35,143,529	$41,728,038	$45,985,765	$39,526,662	$39,472,734	$39,081,303
	Total Long Term Debt	$11,216,043	$10,993,131	$10,925,544	$10,760,682	$10,481,568	$10,315,644	$11,216,043	$10,993,131	$10,925,544	$10,760,682	$10,481,568	$10,315,644
	Total Current Liabilities and Total Long Term Debt	$46,359,573	$52,721,169	$56,911,309	$50,287,344	$49,954,301	$49,396,947	$46,359,573	$52,721,169	$56,911,309	$50,287,344	$49,954,301	$49,396,947
4	**Times Interest Earned**	**8.1**	**12.2**	**11.7**	**14.5**	**40.3**	**0.6**	**8.1**	**9.8**	**10.5**	**12.1**	**16.8**	**1.5**
5	**Debt Service Coverage Ratio**	**1.45**	**1.17**	**1.58**	**3.86**	**4.86**	**1.17**	**1.45**	**1.29**	**1.39**	**2.02**	**2.64**	**1.55**
	Excess Revenues over Expenses	($651,681)	($581,178)	($463,142)	$235,742	$786,552	$227,592	($651,681)	($1,232,859)	($1,696,001)	($1,460,259)	($673,707)	($446,115)
	Interest Expense	$52,154	$36,417	$45,916	$88,460	$45,053	$4,461,546	$52,154	$88,571	$134,487	$222,947	$268,000	$4,729,546
	Depreciation and Amortization Expense	$998,179	$969,552	$959,794	$953,226	$963,594	$853,961	$998,179	$1,967,731	$2,927,525	$3,880,751	$4,844,345	$5,698,306
	Principal Payments	$223,620	$325,617	$296,790	$242,787	$324,613	$289,057	$223,620	$549,237	$846,028	$1,088,814	$1,413,428	$1,702,485
6	**Equity Financing Ratio**	**(0.5)**	**(0.9)**	**(1.2)**	**(1.1)**	**(0.5)**	**3.9**	**(0.5)**	**(0.9)**	**(1.2)**	**(1.1)**	**(0.5)**	**3.9**
	Total Net Assets	($669,099)	($1,229,376)	($1,700,757)	($1,440,686)	($640,892)	$5,548,810	($669,099)	($1,229,376)	($1,700,757)	($1,440,686)	($640,892)	$5,548,810
	Total Assets	$128,240,634	$134,455,264	$138,360,194	$130,692,629	$136,041,250	$142,090,161	$128,240,634	$134,455,264	$138,360,194	$130,692,629	$136,041,250	$142,090,161
D.	**Additional Statistics**												
1	**Income from Operations**	**-$626,777**	**-$560,082**	**-$466,562**	**$243,651**	**$806,659**	**-$2,756,141**	**-$626,777**	**-$1,186,859**	**-$1,653,421**	**-$1,409,770**	**-$603,111**	**-$3,359,252**
2	**Revenue Over/(Under) Expense**	**-$651,681**	**-$581,178**	**-$463,142**	**$235,742**	**$786,552**	**$227,592**	**-$651,681**	**-$1,232,859**	**-$1,696,001**	**-$1,460,259**	**-$673,707**	**-$446,115**
3	**EBITDA**	**$423,556**	**$445,887**	**$539,148**	**$1,285,337**	**$1,815,306**	**$2,559,366**	**$423,556**	**$869,443**	**$1,408,591**	**$2,693,928**	**$4,509,234**	**$7,068,600**
4	**Cash from Operations**	**$21,957,353**	**$23,750,032**	**$20,410,238**	**$23,428,234**	**$23,630,289**	**$26,844,798**	**$21,957,353**	**$45,707,385**	**$66,117,623**	**$89,545,857**	**$113,176,146**	**$140,020,944**
5	**Cash and Cash Equivalents**	**$4,446,884**	**$3,585,374**	**$7,929,513**	**$7,397,213**	**$2,848,360**	**$12,317,043**	**$4,446,884**	**$3,585,374**	**$7,929,513**	**$7,397,213**	**$2,848,360**	**$12,317,043**
6	**Net Working Capital**	**$18,645,772**	**$16,243,243**	**$20,703,263**	**$20,281,069**	**$13,877,532**	**$15,118,291**	**$18,645,772**	**$16,243,243**	**$20,703,263**	**$20,281,069**	**$13,877,532**	**$15,118,291**
7	**Unrestricted Assets**	**-$669,099**	**-$1,229,376**	**-$1,700,757**	**-$1,440,686**	**-$640,892**	**$5,548,810**	**-$669,099**	**-$1,229,376**	**-$1,700,757**	**-$1,440,686**	**-$640,892**	**$5,548,810**
9	**Credit Ratings (S&P, FITCH, and Moody's)**												

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FISCAL YEAR 2017

		MTD						YTD					
		OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH
	DESCRIPTION	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017
	Total Gross Revenue	$55,644,298	$53,192,078	$52,850,074	$59,381,565	$55,170,613	$60,067,909	$55,644,298	$108,836,376	$161,686,450	$221,068,015	$276,238,628	$336,306,537
	Total Allowances	($40,427,577)	($37,965,460)	($36,698,937)	($42,892,832)	($39,671,267)	($43,490,035)	($40,427,577)	($78,393,037)	($115,091,974)	($157,984,806)	($197,656,073)	($241,146,108)
	Bad Debt	($597,341)	($430,749)	($555,335)	($604,481)	$180,823	($260,444)	($597,341)	($1,028,090)	($1,583,425)	($2,187,906)	($2,007,083)	($2,267,527)
	Net Patient Revenue	$14,619,380	$14,795,869	$15,595,802	$15,884,252	$15,680,169	$16,317,430	$14,619,380	$29,415,249	$45,011,051	$60,895,303	$76,575,472	$92,892,902
	Other Operating Revenue	775,272	740,245	834,034	729,436	760,930	3,167,968	$775,272	$1,515,517	$2,349,551	$3,078,987	$3,839,917	$7,007,885
	Total Operating Revenue	$15,394,652	$15,536,114	$16,429,836	$16,613,688	$16,441,099	$19,485,398	$15,394,652	$30,930,766	$47,360,602	$63,974,290	$80,415,389	$99,900,787
	Total Operating Expenses	15,387,630	15,075,148	15,785,230	15,569,444	14,708,540	18,348,121	$15,387,630	$30,462,778	$46,248,008	$61,817,452	$76,525,992	$94,874,113
	Income/(Loss) From Operations	$7,022	$460,966	$644,606	$1,044,244	$1,732,559	$1,137,277	$7,022	$467,988	$1,112,594	$2,156,838	$3,889,397	$5,026,674
	Total Non-Operating Revenue	(22,091)	(7,188)	(32,203)	(14,392)	(9,690)	(31,173)	($22,091)	($29,279)	($61,482)	($75,874)	($85,564)	($116,737)
	Excess/(Deficiency) of Revenue Over Expenses	($15,069)	$453,778	$612,403	$1,029,852	$1,722,869	$1,106,104	($15,069)	$438,709	$1,051,112	$2,080,964	$3,803,833	$4,909,937
A.	**Operating Performance**												
1	**Operating Margin**	**0.05%**	**2.97%**	**3.93%**	**6.29%**	**10.54%**	**5.85%**	**0.05%**	**1.51%**	**2.35%**	**3.38%**	**4.84%**	**5.04%**
2	**Non-Operating Margin**	**-0.14%**	**-0.05%**	**-0.20%**	**-0.09%**	**-0.06%**	**-0.16%**	**-0.14%**	**-0.09%**	**-0.13%**	**-0.12%**	**-0.11%**	**-0.12%**
3	**Total Margin**	**-0.10%**	**2.92%**	**3.73%**	**6.20%**	**10.49%**	**5.69%**	**-0.10%**	**1.42%**	**2.22%**	**3.26%**	**4.74%**	**4.92%**
D.8	**Bad Debt as % of Gross Revenue**	**1.07%**	**0.81%**	**1.05%**	**1.02%**	**-0.33%**	**0.43%**	**1.07%**	**0.94%**	**0.98%**	**0.99%**	**0.73%**	**0.67%**
	Income/(Loss) From Operations	$7,022	$460,966	$644,606	$1,044,244	$1,732,559	$1,137,277	$7,022	$467,988	$1,112,594	$2,156,838	$3,889,397	$5,026,674
	Total Operating Revenue	$15,394,652	$15,536,114	$16,429,836	$16,613,688	$16,441,099	$19,485,398	$15,394,652	$30,930,766	$47,360,602	$63,974,290	$80,415,389	$99,900,787
	Total Non-Operating Revenue	($22,091)	($7,188)	($32,203)	($14,392)	($9,690)	($31,173)	($22,091)	($29,279)	($61,482)	($75,874)	($85,564)	($116,737)
	Total Revenue	$15,372,561	$15,528,926	$16,397,633	$16,599,296	$16,431,409	$19,454,225	$15,372,561	$30,901,487	$47,299,120	$63,898,416	$80,329,825	$99,784,050
	Excess/(Deficiency) of Revenue Over Expenses	($15,069)	$453,778	$612,403	$1,029,852	$1,722,869	$1,106,104	($15,069)	$438,709	$1,051,112	$2,080,964	$3,803,833	$4,909,937
	Unrealized gain/(loss) in investments (self-insurance fu	($17,418)	$20,901	($8,239)	$24,328	$13,242	$5,678	($17,418)	$3,483	($4,755)	$19,573	$32,815	$38,494
	Unrestricted Net Assets	($32,487)	$442,192	$1,046,357	$2,100,537	$3,836,648	$4,948,431	($32,487)	$442,192	$1,046,357	$2,100,537	$3,836,648	$4,948,431
	Total Net Assets	($32,487)	$442,192	$1,046,357	$2,100,537	$3,836,648	$4,948,431	($32,487)	$442,192	$1,046,357	$2,100,537	$3,836,648	$4,948,431

PROSPECT MANCHESTER HOSPITAL, INC.

FISCAL YEAR 2017

		MTD						YTD					
		OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH
	DESCRIPTION	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017
B.	**Liquidity**												
1	**Current Ratio**	**2.13**	**2.03**	**1.89**	**2.03**	**1.86**	**2.71**	**2.13**	**2.03**	**1.89**	**2.03**	**1.86**	**2.71**
	Total Current Assets	$46,842,822	$47,642,623	$53,559,905	$50,880,329	$46,261,482	$65,988,394	$46,842,822	$47,642,623	$53,559,905	$50,880,329	$46,261,482	$65,988,394
	Total Current Liabilities	$22,000,101	$23,415,706	$28,400,160	$25,018,323	$24,934,736	$24,336,934	$22,000,101	$23,415,706	$28,400,160	$25,018,323	$24,934,736	$24,336,934
2	**Days Cash on Hand**	**(1)**	**0**	**9**	**4**	**4**	**5**	**(1)**	**0**	**9**	**4**	**4**	**6**
	Cash and Cash Equivalents	($663,350)	$124,486	$4,536,426	$1,846,450	$2,034,272	$2,879,427	($663,350)	$124,486	$4,536,426	$1,846,450	$2,034,272	$2,879,427
	Short Term Investments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Total Cash and Short Term Investments	($663,350)	$124,486	$4,536,426	$1,846,450	$2,034,272	$2,879,427	($663,350)	$124,486	$4,536,426	$1,846,450	$2,034,272	$2,879,427
	Total Operating Expenses	$15,387,630	$15,075,148	$15,785,230	$15,569,444	$14,708,540	$18,348,121	$15,387,630	$30,462,778	$46,248,008	$61,817,452	$76,525,992	$94,874,113
	Depreciation Expense	$631,809	$601,534	$595,578	$591,875	$598,505	$517,366	$631,809	$1,233,343	$1,828,921	$2,420,796	$3,019,301	$3,536,667
	Operating Expenses less Depreciation Expense	$14,755,821	$14,473,614	$15,189,652	$14,977,569	$14,110,035	$17,830,755	$14,755,821	$29,229,435	$44,419,087	$59,396,656	$73,506,691	$91,337,446
3	**Days in Net Acounts Receivables**	**53**	**48**	**53**	**58**	**44**	**43**	**53**	**49**	**54**	**60**	**49**	**45**
	Net Patient Accounts Receivable	$ 25,097,057	$ 25,647,346	$ 29,082,871	$ 30,775,476	$ 26,091,128	$ 25,756,361	$25,097,057	$25,647,346	$29,082,871	$30,775,476	$26,091,128	$25,756,361
	Due From Third Party Payers	$ -	$ -	$ -	$ -	$ -	$ -	$0	$0	$0	$0	$0	$0
	Due To Third Party Payers	$240,525	$1,985,471	$2,453,224	$980,071	$1,357,162	$2,913,608	$240,525	$1,985,471	$2,453,224	$980,071	$1,357,162	$2,913,608
	Total Net Patient Accounts Receivable and Third Party Payer Activity	$ 24,856,532	$ 23,661,876	$ 26,629,648	$ 29,795,406	$ 24,733,966	$ 22,842,753	$ 24,856,532	$ 23,661,876	$ 26,629,648	$ 29,795,406	$ 24,733,966	$ 22,842,753
	Total Net Patient Revenue	$14,619,380	$14,795,869	$15,595,802	$15,884,252	$15,680,169	$16,317,430	$14,619,380	$29,415,249	$45,011,051	$60,895,303	$76,575,472	$92,892,902
4	**Average Payment Period**	**46**	**49**	**58**	**52**	**49**	**42**	**46**	**49**	**59**	**52**	**51**	**49**
	Total Current Liabilities	$22,000,101	$23,415,706	$28,400,160	$25,018,323	$24,934,736	$24,336,934	$22,000,101	$23,415,706	$28,400,160	$25,018,323	$24,934,736	$24,336,934
	Total Operating Expenses	$15,387,630	$15,075,148	$15,785,230	$15,569,444	$14,708,540	$18,348,121	$15,387,630	$30,462,778	$46,248,008	$61,817,452	$76,525,992	$94,874,113
	Depreciation Expense	$631,809	$601,534	$595,578	$591,875	$598,505	$517,366	$631,809	$1,233,343	$1,828,921	$2,420,796	$3,019,301	$3,536,667
	Total Operating Expenses less Depreciation Expense	$14,755,821	$14,473,614	$15,189,652	$14,977,569	$14,110,035	$17,830,755	$14,755,821	$29,229,435	$44,419,087	$59,396,656	$73,506,691	$91,337,446

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		MTD						YTD					
	DESCRIPTION	OCTOBER FY 2017	NOVEMBER FY 2017	DECEMBER FY 2017	JANUARY FY 2017	FEBRUARY FY 2017	MARCH FY 2017	OCTOBER FY 2017	NOVEMBER FY 2017	DECEMBER FY 2017	JANUARY FY 2017	FEBRUARY FY 2017	MARCH FY 2017
C.	**Leverage and Capital Structure**												
1	**Long-term Debt to Equity**	**(185.2)**	**13.2**	**5.4**	**2.6**	**1.4**	**1.0**	**(185.2)**	**13.2**	**5.4**	**2.6**	**1.4**	**1.0**
2	**Long Term Debt to Capitalization Ratio**	**100.5**	**92.9**	**84.4**	**72.4**	**57.9**	**50.9**	**100.5**	**92.9**	**84.4**	**72.4**	**57.9**	**50.9**
	Total Long Term Debt	$6,018,218	$5,824,694	$5,652,580	$5,509,766	$5,272,679	$5,139,876	$6,018,218	$5,824,694	$5,652,580	$5,509,766	$5,272,679	$5,139,876
	Total Net Assets	($32,487)	$442,192	$1,046,357	$2,100,537	$3,836,648	$4,948,431	($32,487)	$442,192	$1,046,357	$2,100,537	$3,836,648	$4,948,431
	Total Long Term Debt and Total Net Assets	$5,985,731	$6,266,887	$6,698,937	$7,610,303	$9,109,328	$10,088,306	$5,985,731	$6,266,887	$6,698,937	$7,610,303	$9,109,328	$10,088,306
3	**Unrestricted Cash to Total Debt Ratio**	**2.2**	**3.6**	**3.5**	**5.3**	**7.7**	**5.5**	**2.2**	**5.7**	**8.5**	**14.7**	**22.6**	**28.7**
	Excess/(Deficiency) of Revenues Over Expenses	($15,069)	$453,778	$612,403	$1,029,852	$1,722,869	$1,106,104	($15,069)	$438,709	$1,051,112	$2,080,964	$3,803,833	$4,909,937
	Depreciation Expense	$631,809	$601,534	$595,578	$591,875	$598,505	$517,366	$631,809	$1,233,343	$1,828,921	$2,420,796	$3,019,301	$3,536,667
	Excess of Revenues Over Expenses and Depreciation Expense	$616,740	$1,055,312	$1,207,981	$1,621,727	$2,321,374	$1,623,470	$616,740	$1,672,052	$2,880,033	$4,501,760	$6,823,134	$8,446,604
	Total Current Liabilities	$22,000,101	$23,415,706	$28,400,160	$25,018,323	$24,934,736	$24,336,934	$22,000,101	$23,415,706	$28,400,160	$25,018,323	$24,934,736	$24,336,934
	Total Long Term Debt	$6,018,218	$5,824,694	$5,652,580	$5,509,766	$5,272,679	$5,139,876	$6,018,218	$5,824,694	$5,652,580	$5,509,766	$5,272,679	$5,139,876
	Total Current Liabilities and Total Long Term Debt	$28,018,320	$29,240,400	$34,052,740	$30,528,089	$30,207,415	$29,476,810	$28,018,320	$29,240,400	$34,052,740	$30,528,089	$30,207,415	$29,476,810
4	**Times Interest Earned**	**16.1**	**38.9**	**32.3**	**41.6**	**75.8**	**1.5**	**16.1**	**25.2**	**27.7**	**31.5**	**39.1**	**3.4**
5	**Debt Service Coverage Ratio**	**3.42**	**3.87**	**5.03**	**7.58**	**8.72**	**1.38**	**3.42**	**3.68**	**4.15**	**4.95**	**5.79**	**2.48**
	Excess Revenues over Expenses	($15,069)	$453,778	$612,403	$1,029,852	$1,722,869	$1,106,104	($15,069)	$438,709	$1,051,112	$2,080,964	$3,803,833	$4,909,937
	Interest Expense	$42,298	$28,063	$39,637	$40,330	$31,179	$3,453,021	$42,298	$70,361	$109,998	$150,328	$181,507	$3,634,528
	Depreciation and Amortization Expense	$631,809	$601,534	$595,578	$591,875	$598,505	$517,366	$631,809	$1,233,343	$1,828,921	$2,420,796	$3,019,301	$3,536,667
	Principal Payments	$150,273	$252,225	$208,259	$178,959	$238,763	$215,612	$150,273	$402,498	$610,757	$789,716	$1,028,479	$1,244,091
6	**Equity Financing Ratio**	**(0.0)**	**0.5**	**1.1**	**2.2**	**3.8**	**4.9**	**(0.0)**	**0.5**	**1.1**	**2.2**	**3.8**	**4.9**
	Total Net Assets	($32,487)	$442,192	$1,046,357	$2,100,537	$3,836,648	$4,948,431	($32,487)	$442,192	$1,046,357	$2,100,537	$3,836,648	$4,948,431
	Total Assets	$91,857,160	$93,852,209	$99,351,394	$96,098,478	$100,358,275	$101,059,053	$91,857,160	$93,852,209	$99,351,394	$96,098,478	$100,358,275	$101,059,053
D.	**Additional Statistics**												
1	**Income from Operations**	**$7,022**	**$460,966**	**$644,606**	**$1,044,244**	**$1,732,559**	**$1,137,277**	**$7,022**	**$467,988**	**$1,112,594**	**$2,156,838**	**$3,889,397**	**$5,026,674**
2	**Revenue Over/(Under) Expense**	**-$15,069**	**$453,778**	**$612,403**	**$1,029,852**	**$1,722,869**	**$1,106,104**	**-$15,069**	**$438,709**	**$1,051,112**	**$2,080,964**	**$3,803,833**	**$4,909,937**
3	**EBITDA**	**$681,129**	**$1,090,563**	**$1,279,821**	**$1,676,449**	**$2,362,243**	**$5,107,664**	**$681,129**	**$1,771,692**	**$3,051,513**	**$4,727,962**	**$7,090,205**	**$12,197,869**
4	**Cash from Operations**	**$13,311,451**	**$14,700,164**	**$12,315,867**	**$14,613,537**	**$14,479,139**	**$15,414,320**	**$13,311,451**	**$28,011,615**	**$40,327,482**	**$54,941,019**	**$69,420,158**	**$84,834,478**
5	**Cash and Cash Equivalents**	**-$663,350**	**$124,486**	**$4,536,426**	**$1,846,450**	**$2,034,272**	**$2,879,427**	**-$663,350**	**$124,486**	**$4,536,426**	**$1,846,450**	**$2,034,272**	**$2,879,427**
6	**Net Working Capital**	**$24,842,721**	**$24,226,917**	**$25,159,745**	**$25,862,006**	**$21,326,746**	**$41,651,460**	**$24,842,721**	**$24,226,917**	**$25,159,745**	**$25,862,006**	**$21,326,746**	**$41,651,460**
7	**Unrestricted Assets**	**-$32,487**	**$442,192**	**$1,046,357**	**$2,100,537**	**$3,836,648**	**$4,948,431**	**-$32,487**	**$442,192**	**$1,046,357**	**$2,100,537**	**$3,836,648**	**$4,948,431**
9	**Credit Ratings (S&P, FITCH, and Moody's)**												

PROSPECT ROCKVILLE HOSPITAL, INC.

FISCAL YEAR 2017

		MTD						YTD					
		OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH
	DESCRIPTION	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017
	Total Gross Revenue	$18,726,168	$18,640,535	$19,515,950	$20,580,951	$19,496,668	$20,552,045	$18,726,168	$37,366,703	$56,882,653	$77,463,604	$96,960,272	$117,512,317
	Total Allowances	($13,221,502)	($13,686,816)	($14,029,353)	($15,131,662)	($14,351,835)	($15,207,002)	($13,221,502)	($26,908,318)	($40,937,671)	($56,069,333)	($70,421,168)	($85,628,170)
	Bad Debt	($221,737)	($118,796)	($202,498)	($194,224)	($201,767)	($265,520)	($221,737)	($340,533)	($543,031)	($737,255)	($939,022)	($1,204,542)
	Net Patient Revenue	$5,282,929	$4,834,923	$5,284,099	$5,255,065	$4,943,066	$5,079,523	$5,282,929	$10,117,852	$15,401,951	$20,657,016	$25,600,082	$30,679,605
	Other Operating Revenue	88,667	99,563	127,556	126,081	153,929	129,861	$88,667	$188,230	$315,786	$441,867	$595,796	$725,657
	Total Operating Revenue	$5,371,596	$4,934,486	$5,411,655	$5,381,146	$5,096,995	$5,209,384	$5,371,596	$10,306,082	$15,717,737	$21,098,883	$26,195,878	$31,405,262
	Total Operating Expenses	5,591,350	5,500,253	6,049,317	5,746,090	5,554,009	6,299,840	$5,591,350	$11,091,603	$17,140,920	$22,887,010	$28,441,019	$34,740,859
	Income/(Loss) From Operations	($219,754)	($565,767)	($637,662)	($364,944)	($457,014)	($1,090,456)	($219,754)	($785,521)	($1,423,183)	($1,788,127)	($2,245,141)	($3,335,597)
	Total Non-Operating Revenue	(576)	(11,945)	35,623	6,483	(10,417)	641,937	($576)	($12,521)	$23,102	$29,585	$19,168	$661,105
	Excess/(Deficiency) of Revenue Over Expenses	($220,330)	($577,712)	($602,039)	($358,461)	($467,431)	($448,519)	($220,330)	($798,042)	($1,400,081)	($1,758,542)	($2,225,973)	($2,674,492)
A.	**Operating Performance**												
1	**Operating Margin**	**-4.09%**	**-11.49%**	**-11.71%**	**-6.77%**	**-8.98%**	**-18.64%**	**-4.09%**	**-7.63%**	**-9.04%**	**-8.46%**	**-8.56%**	**-10.40%**
2	**Non-Operating Margin**	**-0.01%**	**-0.24%**	**0.65%**	**0.12%**	**-0.20%**	**10.97%**	**-0.01%**	**-0.12%**	**0.15%**	**0.14%**	**0.07%**	**2.06%**
3	**Total Margin**	**-4.10%**	**-11.74%**	**-11.05%**	**-6.65%**	**-9.19%**	**-7.67%**	**-4.10%**	**-7.75%**	**-8.89%**	**-8.32%**	**-8.49%**	**-8.34%**
D.8	**Bad Debt as % of Gross Revenue**	**1.18%**	**0.64%**	**1.04%**	**0.94%**	**1.03%**	**1.29%**	**1.18%**	**0.91%**	**0.95%**	**0.95%**	**0.97%**	**1.03%**
	Income/(Loss) From Operations	($219,754)	($565,767)	($637,662)	($364,944)	($457,014)	($1,090,456)	($219,754)	($785,521)	($1,423,183)	($1,788,127)	($2,245,141)	($3,335,597)
	Total Operating Revenue	$5,371,596	$4,934,486	$5,411,655	$5,381,146	$5,096,995	$5,209,384	$5,371,596	$10,306,082	$15,717,737	$21,098,883	$26,195,878	$31,405,262
	Total Non-Operating Revenue	($576)	($11,945)	$35,623	$6,483	($10,417)	$641,937	($576)	($12,521)	$23,102	$29,585	$19,168	$661,105
	Total Revenue	$5,371,020	$4,922,541	$5,447,278	$5,387,629	$5,086,578	$5,851,321	$5,371,020	$10,293,561	$15,740,839	$21,128,468	$26,215,046	$32,066,367
	Excess/(Deficiency) of Revenue Over Expenses	($220,330)	($577,712)	($602,039)	($358,461)	($467,431)	($448,519)	($220,330)	($798,042)	($1,400,081)	($1,758,542)	($2,225,973)	($2,674,492)
								$0	$0	$0	$0	$0	$0
	Unrestricted Net Assets	($220,330)	($798,042)	($1,400,081)	($1,758,542)	($2,225,973)	($2,674,492)	($220,330)	($798,042)	($1,400,081)	($1,758,542)	($2,225,973)	($2,674,492)
	Total Net Assets	($220,330)	($798,042)	($1,400,081)	($1,758,542)	($2,225,973)	($2,674,492)	($220,330)	($798,042)	($1,400,081)	($1,758,542)	($2,225,973)	($2,674,492)

PROSPECT ROCKVILLE HOSPITAL, INC.

FISCAL YEAR 2017

		MTD						YTD					
		OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH
	DESCRIPTION	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017
	Total Gross Revenue	$18,726,168	$18,640,535	$19,515,950	$20,580,951	$19,496,668	$20,552,045	$18,726,168	$37,366,703	$56,882,653	$77,463,604	$96,960,272	$117,512,317
	Total Allowances	($13,221,502)	($13,686,816)	($14,029,353)	($15,131,662)	($14,351,835)	($15,207,002)	($13,221,502)	($26,908,318)	($40,937,671)	($56,069,333)	($70,421,168)	($85,628,170)
B.	**Liquidity**												
1	**Current Ratio**	**2.48**	**2.21**	**1.87**	**2.01**	**1.77**	**1.90**	**2.48**	**2.21**	**1.87**	**2.01**	**1.77**	**1.90**
	Total Current Assets	$13,537,159	$14,147,936	$15,510,299	$13,230,878	$11,577,805	$12,822,482	$13,537,159	$14,147,936	$15,510,299	$13,230,878	$11,577,805	$12,822,482
	Total Current Liabilities	$5,453,541	$6,395,701	$8,289,316	$6,595,624	$6,557,953	$6,745,746	$5,453,541	$6,395,701	$8,289,316	$6,595,624	$6,557,953	$6,745,746
2	**Days Cash on Hand**	**(1)**	**1**	**24**	**10**	**11**	**15**	**(1)**	**1**	**25**	**10**	**11**	**16**
	Cash and Cash Equivalents	($256,143)	$124,486	$4,536,426	$1,846,450	$2,034,272	$2,879,427	($256,143)	$124,486	$4,536,426	$1,846,450	$2,034,272	$2,879,427
	Short Term Investments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Total Cash and Short Term Investments	($256,143)	$124,486	$4,536,426	$1,846,450	$2,034,272	$2,879,427	($256,143)	$124,486	$4,536,426	$1,846,450	$2,034,272	$2,879,427
	Total Operating Expenses	$5,591,350	$5,500,253	$6,049,317	$5,746,090	$5,554,009	$6,299,840	$5,591,350	$11,091,603	$17,140,920	$22,887,010	$28,441,019	$34,740,859
	Depreciation Expense	$253,780	$250,362	$249,802	$247,086	$250,893	$226,927	$253,780	$504,142	$753,944	$1,001,030	$1,251,923	$1,478,850
	Operating Expenses less Depreciation Expense	$5,337,570	$5,249,891	$5,799,515	$5,499,004	$5,303,116	$6,072,913	$5,337,570	$10,587,461	$16,386,976	$21,885,980	$27,189,096	$33,262,009
3	**Days in Net Acounts Receivables**	**51**	**52**	**55**	**59**	**46**	**41**	**51**	**51**	**56**	**60**	**47**	**40**
	Net Patient Accounts Receivable	$ 8,851,523	$ 9,152,197	$ 10,621,628	$ 10,651,636	$ 8,854,832	$ 7,983,339	$8,851,523	$9,152,197	$10,621,628	$10,651,636	$8,854,832	$7,983,339
	Due From Third Party Payers	$ -	$ -	$ -	$ -	$ -	$ -	$0	$0	$0	$0	$0	$0
	Due To Third Party Payers	$119,909	$723,548	$1,290,832	$595,579	$806,265	$1,221,401	$119,909	$723,548	$1,290,832	$595,579	$806,265	$1,221,401
	Total Net Patient Accounts Receivable and Third Party Payer Activity	$ 8,731,614	$ 8,428,648	$ 9,330,796	$ 10,056,057	$ 8,048,567	$ 6,761,938	$ 8,731,614	$ 8,428,648	$ 9,330,796	$ 10,056,057	$ 8,048,567	$ 6,761,938
	Total Net Patient Revenue	$5,282,929	$4,834,923	$5,284,099	$5,255,065	$4,943,066	$5,079,523	$5,282,929	$10,117,852	$15,401,951	$20,657,016	$25,600,082	$30,679,605
4	**Average Payment Period**	**32**	**37**	**44**	**37**	**35**	**34**	**32**	**37**	**47**	**37**	**36**	**37**
	Total Current Liabilities	$5,453,541	$6,395,701	$8,289,316	$6,595,624	$6,557,953	$6,745,746	$5,453,541	$6,395,701	$8,289,316	$6,595,624	$6,557,953	$6,745,746
	Total Operating Expenses	$5,591,350	$5,500,253	$6,049,317	$5,746,090	$5,554,009	$6,299,840	$5,591,350	$11,091,603	$17,140,920	$22,887,010	$28,441,019	$34,740,859
	Depreciation Expense	$253,780	$250,362	$249,802	$247,086	$250,893	$226,927	$253,780	$504,142	$753,944	$1,001,030	$1,251,923	$1,478,850
	Total Operating Expenses less Depreciation Expense	$5,337,570	$5,249,891	$5,799,515	$5,499,004	$5,303,116	$6,072,913	$5,337,570	$10,587,461	$16,386,976	$21,885,980	$27,189,096	$33,262,009

PROSPECT ROCKVILLE HOSPITAL, INC.

FISCAL YEAR 2017

		MTD						YTD					
	DESCRIPTION	OCTOBER FY 2017	NOVEMBER FY 2017	DECEMBER FY 2017	JANUARY FY 2017	FEBRUARY FY 2017	MARCH FY 2017	OCTOBER FY 2017	NOVEMBER FY 2017	DECEMBER FY 2017	JANUARY FY 2017	FEBRUARY FY 2017	MARCH FY 2017
	Total Gross Revenue	$18,726,168	$18,640,535	$19,515,950	$20,580,951	$19,496,668	$20,552,045	$18,726,168	$37,366,703	$56,882,653	$77,463,604	$96,960,272	$117,512,317
	Total Allowances	($13,221,502)	($13,686,816)	($14,029,353)	($15,131,662)	($14,351,835)	($15,207,002)	($13,221,502)	($26,908,318)	($40,937,671)	($56,069,333)	($70,421,168)	($85,628,170)
C.	**Leverage and Capital Structure**												
1	**Long-term Debt to Equity**	**(2.7)**	**(0.7)**	**(0.4)**	**(0.3)**	**(0.2)**	**(0.2)**	**(2.7)**	**(0.7)**	**(0.4)**	**(0.3)**	**(0.2)**	**(0.2)**
2	**Long Term Debt to Capitalization Ratio**	**157.7**	**(287.1)**	**(69.6)**	**(47.2)**	**(33.0)**	**(25.0)**	**157.7**	**(287.1)**	**(69.6)**	**(47.2)**	**(33.0)**	**(25.0)**
	Total Long Term Debt	$602,245	$591,887	$574,499	$564,141	$552,918	$535,512	$602,245	$591,887	$574,499	$564,141	$552,918	$535,512
	Total Net Assets	($220,330)	($798,042)	($1,400,081)	($1,758,542)	($2,225,973)	($2,674,492)	($220,330)	($798,042)	($1,400,081)	($1,758,542)	($2,225,973)	($2,674,492)
	Total Long Term Debt and Total Net Assets	$381,915	($206,155)	($825,582)	($1,194,401)	($1,673,055)	($2,138,980)	$381,915	($206,155)	($825,582)	($1,194,401)	($1,673,055)	($2,138,980)
3	**Unrestricted Cash to Total Debt Ratio**	**0.6**	**(4.7)**	**(4.0)**	**(1.6)**	**(3.0)**	**(3.0)**	**0.6**	**(4.2)**	**(7.3)**	**(10.6)**	**(13.7)**	**(16.4)**
	Excess/(Deficiency) of Revenues Over Expenses	($220,330)	($577,712)	($602,039)	($358,461)	($467,431)	($448,519)	($220,330)	($798,042)	($1,400,081)	($1,758,542)	($2,225,973)	($2,674,492)
	Depreciation Expense	$253,780	$250,362	$249,802	$247,086	$250,893	$226,927	$253,780	$504,142	$753,944	$1,001,030	$1,251,923	$1,478,850
	Excess of Revenues Over Expenses and Depreciation Expense	$33,450	($327,350)	($352,237)	($111,375)	($216,538)	($221,592)	$33,450	($293,900)	($646,137)	($757,512)	($974,050)	($1,195,642)
	Total Current Liabilities	$5,453,541	$6,395,701	$8,289,316	$6,595,624	$6,557,953	$6,745,746	$5,453,541	$6,395,701	$8,289,316	$6,595,624	$6,557,953	$6,745,746
	Total Long Term Debt	$602,245	$591,887	$574,499	$564,141	$552,918	$535,512	$602,245	$591,887	$574,499	$564,141	$552,918	$535,512
	Total Current Liabilities and Total Long Term Debt	$6,055,786	$6,987,588	$8,863,815	$7,159,765	$7,110,870	$7,281,259	$6,055,786	$6,987,588	$8,863,815	$7,159,765	$7,110,870	$7,281,259
4	**Times Interest Earned**	**7.9**	**(63.3)**	**(78.1)**	**(1.7)**	**(17.2)**	**0.1**	**7.9**	**(27.6)**	**(44.5)**	**(12.6)**	**(13.3)**	**(0.7)**
5	**Debt Service Coverage Ratio**	**1.45**	**(12.19)**	**(10.37)**	**(1.14)**	**(7.08)**	**0.76**	**1.45**	**(5.37)**	**(7.31)**	**(4.78)**	**(5.16)**	**(0.10)**
	Excess Revenues over Expenses	($220,330)	($577,712)	($602,039)	($358,461)	($467,431)	($448,519)	($220,330)	($798,042)	($1,400,081)	($1,758,542)	($2,225,973)	($2,674,492)
	Interest Expense	$4,916	$4,906	$4,901	$43,286	$11,354	$1,005,707	$4,916	$9,822	$14,723	$58,009	$69,363	$1,075,070
	Depreciation and Amortization Expense	$253,780	$250,362	$249,802	$247,086	$250,893	$226,927	$253,780	$504,142	$753,944	$1,001,030	$1,251,923	$1,478,850
	Principal Payments	21,554.00	21,554.00	28,584.18	16,662.25	17,646.18	21,496.28	$21,554	$43,108	$71,692	$88,354	$106,001	$127,497
6	**Equity Financing Ratio**	**(0.9)**	**(3.3)**	**(5.4)**	**(7.5)**	**(9.0)**	**(10.9)**	**(0.9)**	**(3.3)**	**(5.4)**	**(7.5)**	**(9.0)**	**(10.9)**
	Total Net Assets	($220,330)	($798,042)	($1,400,081)	($1,758,542)	($2,225,973)	($2,674,492)	($220,330)	($798,042)	($1,400,081)	($1,758,542)	($2,225,973)	($2,674,492)
	Total Assets	$24,066,139	$24,498,487	$25,845,233	$23,557,954	$24,820,630	$24,629,494	$24,066,139	$24,498,487	$25,845,233	$23,557,954	$24,820,630	$24,629,494
D.	**Additional Statistics**												
1	**Income from Operations**	**-$219,754**	**-$565,767**	**-$637,662**	**-$364,944**	**-$457,014**	**-$1,090,456**	**-$219,754**	**-$785,521**	**-$1,423,183**	**-$1,788,127**	**-$2,245,141**	**-$3,335,597**
2	**Revenue Over/(Under) Expense**	**-$220,330**	**-$577,712**	**-$602,039**	**-$358,461**	**-$467,431**	**-$448,519**	**-$220,330**	**-$798,042**	**-$1,400,081**	**-$1,758,542**	**-$2,225,973**	**-$2,674,492**
3	**EBITDA**	**$38,942**	**-$310,499**	**-$382,959**	**-$74,572**	**-$194,767**	**$142,178**	**$38,942**	**-$271,557**	**-$654,516**	**-$729,088**	**-$923,855**	**-$781,677**
4	**Cash from Operations**	**$4,489,094**	**$5,100,462**	**$4,178,303**	**$5,499,311**	**$4,982,462**	**$5,644,869**	**$4,489,094**	**$9,589,556**	**$13,767,859**	**$19,267,170**	**$24,249,633**	**$29,894,502**
5	**Cash and Cash Equivalents**	**-$256,143**	**$124,486**	**$4,536,426**	**$1,846,450**	**$2,034,272**	**$2,879,427**	**-$256,143**	**$124,486**	**$4,536,426**	**$1,846,450**	**$2,034,272**	**$2,879,427**
6	**Net Working Capital**	**$8,083,618**	**$7,752,234**	**$7,220,983**	**$6,635,254**	**$5,019,852**	**$6,076,736**	**$8,083,618**	**$7,752,234**	**$7,220,983**	**$6,635,254**	**$5,019,852**	**$6,076,736**
7	**Unrestricted Assets**	**-$220,330**	**-$798,042**	**-$1,400,081**	**-$1,758,542**	**-$2,225,973**	**-$2,674,492**	**-$220,330**	**-$798,042**	**-$1,400,081**	**-$1,758,542**	**-$2,225,973**	**-$2,674,492**
9	**Credit Ratings (S&P, FITCH, and Moody's)**												

User, OHCA

From: Mcconville, Dennis P <dmcconville@echn.org>
Sent: Monday, June 12, 2017 1:20 PM
To: User, OHCA
Cc: Martone, Kim; Roberts, Karen; Colleen Smith; Ellen J. Shin (ellen.shin@prospectmedical.com); Tichy, Joyce A (Legal Department); Collins, Michael; Garrison DeLee (garrison.delee@prospectmedical.com); Frank.Saidara; Von.Crockett; Basile, Mary C
Subject: RE: 15-32016-486-CON
Attachments: Letter to Yvonne Addo, OHCA re DN 15-32016-486-CON 06 12 17 .pdf

The attached letter is submitted as required for condition number nineteen (19) contained in the Final Decision for Docket Number: 15-32016-486-CON, the Transfer of Assets of Eastern Connecticut Health Network, Inc. to Prospect Medical Holdings, Inc.

Dennis P. McConville
Senior Vice President
Eastern Connecticut Health Network, Inc.
(860) 533-3429 (office)
dmcconville@echn.org

"This message originates from Eastern Connecticut Health Network. The information contained in this message may be privileged and confidential. If you are the intended recipient, you must maintain this message in a secure and confidential manner. If you are not the intended recipient, please notify the sender immediately and destroy this message. Thank you."

Eastern Connecticut Health Network
71 Haynes Street
Manchester, CT 06040
860.533.3414
www.echn.org

June 12, 2017

VIA EMAIL DELIVERY

Deputy Commissioner Yvonne Addo
Office of Health Care Access
Department of Public Health
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134

Re: **Docket Number: 15-32016-486**

Project Title: **Transfer of assets of Eastern Connecticut Health Network, Inc. to Prospect Medical Holdings, Inc.**

Dear Ms. Addo:

This letter is submitted in accordance with the Order for the above referenced Certificate of Need Final Decision, specifically Condition Number Nineteen (19) regarding the transfer of assets of Eastern Connecticut Health Network, Inc. (ECHN) to Prospect Medical Holdings, Inc. (PMH).

Condition Number Nineteen (19) requires that PMH will "hold a joint meeting of the Board of Directors of each of New MMH and New RGH and the Local Board of New MMH and New RGH (Joint Board Meetings) at least twice annually with one occurring in Manchester and the other occurring in Vernon. Such Joint Board Meetings shall be followed by a meeting to which the public is invited in advance and at which the public is informed of the New Hospitals activities and afforded an opportunity to ask uestions and make comments."

A Joint Meeting of the Boards of Directors for Prospect Rockville Hospital, Inc. and Prospect Manchester Hospital Inc. was held on Wednesday, May 31, 2017 at Manchester Memorial Hospital. That meeting was followed by a meeting for the Manchester community where information about the hospital's activities was shared and the public was encouraged to ask uestions and provide comments. The meeting was advertised in both The Hartford Courant on May 25 and May 28, 2017 and in the Journal In uirer on May 25 and May 30, 2017.

If you have any questions or need anything further, please feel free to contact me at (860) 533-3429.

Very truly yours,



Dennis P. McConville
Senior Vice President
Eastern Connecticut Health Network

Enclosures:

Manchester Community Meeting Advertisement
Manchester Memorial Hospital Community Meeting Agenda, 05 31 2017
Manchester Community Meeting Sign-In Sheets, 05 31 2017

cc: Kimberly Martone, Director of Operations, Department of Public Health Division of Office of Health Care Access
Colleen Smith, Nursing Consultant Partners, LLC
Ellen J. Shin, General Counsel, Prospect Medical Holdings, Inc.
Joyce A. Tichy, Senior Vice President and General Counsel, ECHN
Michael Collins, Interim CEO, ECHN
Frank Saidara, Vice President, Corporate Development, Prospect Medical Holdings, Inc.
Garrison De Lee, Assistant General Counsel, Prospect Medical Holdings, Inc.

A conversation on healthcare in your community.

ECHN is pleased to invite you to attend an upcoming community meeting. In this public forum, you'll learn how exciting new developments at ECHN are changing the care you receive – for the better.

It's a time dedicated to hearing directly from ECHN leaders and to having your questions answered. The future of healthcare in your community is taking shape, so please join us for this session and find out more about your local healthcare provider!

Community Meeting
Wednesday, May 31, 2017
5 p.m. – 6:15 p.m.

Manchester Memorial Hospital
71 Haynes Street, Manchester

ECHN℠
Eastern Connecticut Health Network

Prospect Manchester Hospital, Inc.
Community Meeting
May 31, 2017

Manchester Memorial Hospital Speakers:

Michael Collins, Interim CEO, Board Member

Linda Quirici, Vice President, Quality & Safety

Dennis McConville, Senior Vice President, Chief Strategy Officer

Agenda:

1. Introduction, Opening Remarks	Michael Collins
2. Quality Report	Linda Quirici
3. Capital Improvements	Dennis McConville
4. Questions and Answers	Members of the Public Michael Collins Linda Quirici Dennis McConville
5. Concluding Remarks	Michael Collins

Town Hall Meeting
Wednesday, May 31, 2017
5 p.m. – 6:15 p.m.
Manchester Memorial Hospital
71 Haynes Street

NAME	TOWN OF RESIDENCE
NORMA MADERAZO, M.D. of Dr. Eufrecio Maderazo	Manchester
MATT REISER	VERNON
Bob Bodner	Southwindsor.
Linda Bailey	South Windsor
Mary Basile	Granby
Paula Nelson	Vernon
Kim Palma	Vernon
Linda Quirici	Coventry
Jason Bell	Vernon
M & E. Harris	Colchester
Lynn Soper	CT
Dan Nelson	Vernon
Liz Martinez	Manchester
Sue Malone	Bolton
Jennifer Tross	Enfield
Nina Knese	Glastonbury
Mary Powers	Vernon

Town Hall Meeting
Wednesday, May 31, 2017
5 p.m. – 6:15 p.m.
Manchester Memorial Hospital
71 Haynes Street

NAME	TOWN OF RESIDENCE
Phil Susag	Manchester
Missy Susag	Manchester
Sibby Ghabrial	Manchester
Michael MAKulis	Manchester
Michael Collins	Vernon (CEO)
~~Thomas Reardon~~	~~Prospect~~
Rick Daigle	MMHC
Sallie Bovenzi	South Windsor
Kathy DiPietro	NH
Chantal Berg	Ellington
Joy Dan	Manchester
Barbara Mullins	Coventry
Sue Berte	Manchester
Betty Benavides	Manchester

Town Hall Meeting
Wednesday, May 31, 2017
5 p.m. – 6:15 p.m.
Manchester Memorial Hospital
71 Haynes Street

NAME	TOWN OF RESIDENCE
Jaked Compasso	Manchester
Joyce Tichy	Manchester
Marcie LaBelle	Manchester
Clara Buzzell	Manchester
Vinick, CAR	MANCHESTER
Natalie Cook	Glastonbury
Tom Reardon	Massachusetts
Lois Pabst	Tolland.

User, OHCA

From: Roberts, Karen
Sent: Tuesday, July 18, 2017 3:30 PM
To: User, OHCA
Cc: Cotto, Carmen; Clarke, Ormand
Subject: FW: Second Assessment MMH & RGH
Attachments: ECHN Cover letter for second visit assessment 7.15.17.docx; ATT00001.htm; Second Assessment MMH 7.18.17CS mm.docx; ATT00002.htm; second Assessment RGH CS 7.17.17.docx; ATT00003.htm

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From: Colleen Smith [mailto:colleen713.smith@gmail.com]
Sent: Tuesday, July 18, 2017 2:16 PM
To: Martone, Kim <Kimberly.Martone@ct.gov>; Newton, Susan <Susan.Newton@ct.gov>; Debbie Berry (Debbie.Berry@prospectmedical.com) <Debbie.Berry@prospectmedical.com>; Karen Nefores <Karen.Nefores@altacorp.com>; Linda L Quirici <LQuirici@echn.org>; Powers, Mary <mpowers@echn.org>; Michael Collins <mcollins@echn.org>; Dennis P Mcconville <dmcconville@echn.org>; Roberts, Karen <Karen.Roberts@ct.gov>
Subject: Second Assessment MMH & RGH

Greetings,
Enclosed please find a cover letter and both the MMH and RGH assessments for my second visit to the Prospect ECHN facilities. As previously, I enjoyed a very good visit and was treated with courtesy. All documents requested were freely shared with me.
Please contact me if you have any questions.
Best regards,
Colleen Smith

Colleen O'Brien Smith MSN RN NEA-BC
Nursing Consulting Partners, LLC
690C9 S. Park View Court
Franklin, WI 53132
Phone: 203-245-1044
Cell: 203-671-1348
colleen713.smith@gmail.com
http://nursingconsultingpartners.com/

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SECOND VISIT ASSESSMENT – PROSPECT ECHN, Inc.

June27-29, 2017
Colleen O. Smith, MSN, RN, NEA-BC

OVERVIEW

The enclosed reports summarize my second visits to MMH and RGH campuses during the last week of June. The principle focus of this visit is to follow up on all of my recommendations from the initial visit as well as note any new accomplishments, progress to date on quality initiatives, and identify any new areas of concern. I concentrated my visit agenda for the 3 days on all of the inpatient clinical areas only as I had not found any areas of concern in the outpatient services during my initial visit in late January 2017. Since my first visit, average daily census has been more manageable. The organization continues to utilize their high reliability practices that are incorporated into all patient care. ECHN continues to conduct the daily Safety Huddles and Quality/Patient Safety meetings are started with a "Good Catch" safety story.

Regular Quality/Patient Safety conference calls are held with Prospect Medial Holdings. This is their opportunity to report out their quality data and also share practices/approaches that are working well. Wide participation is expected and received from member organizations. Overall, both hospitals are experiencing challenges with ED Throughput, ED and Inpatient Satisfaction, and both hospital wide readmission rates and for select diagnoses. Performance Improvement committees are in place to work on these processes. Overall, both hospitals are doing quite well in the area of Patient Safety outcomes. A Sepsis protocol was initiated on 2/14/17.

Facilities on both campuses are receiving much needed cosmetic renovations and plant updates. Staff and leaders are able to describe recent capitol acquisitions that have improved their daily workday. Additional surgical equipment has been purchased as well as OMNICELL for the Patient Care areas.

Methods and Processes Used for Analysis

Processes utilized to conduct this on site review include:

1. Face to face meetings with the CNO, the VP for Quality/Patient Safety, the newly appointed CMO, and the Director of Risk Management.

2. Tours of all Inpatient Clinical Services outlined in the Consent Decree. Outpatient services were not revisited, as there were no areas of concern noted on the initial assessment. The IM spoke with the leaders of all areas visited and several staff members in the clinical areas. Time was spent interviewing leaders in each service area and also speaking with direct care giving staff such as RNs, PCAs, pharmacists, and other ancillary employees.
3. Review of Infection Prevention, Medical Executive and Quality/Performance improvement minutes from the months of February through May 2017. The quality dashboards and accompanying action plans for first quarter 2017 were reviewed.
4. Review of all new nursing hires in Nursing Services.
5. Attendance at the Advisory Board meeting for review of Quality Indicators and special reports.
6. Review of the revised ECHN organizational chart.
7. Review of all logs, audits, and minutes associated with IM recommendations from the Initial On-site Assessment.

Approach to Assessment

The following report is organized by:

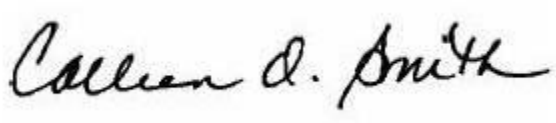
A) Service Visited

B) Observations

C) Recommendations

Under each Service please find categories of comments that are pertinent to each service visited.

Thank you for this opportunity to engage with Prospect ECHN to assist in assuring quality of care to all patient populations of the Greater Manchester and Rockville communities.



Colleen O. Smith, MSN, RN, NEA-BC
Independent Monitor
Nursing Consulting Partners
July 10, 2017

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SECOND ASSESSMENT: Rockville General Hospital COLLEEN O. SMITH MSN, RN, NEA-BC June 29, 2017		
CATEGORY	**OBSERVATIONS**	**RECOMMENDATIONS**
NURSING SERVICES –RGH Bissell 2, ICU		
• Staffing	Hospital Census at RGH on the day of the IM visit was in the low 30s. Nurses on the Bissell 2 M/S unit had a 1:5 pt. ratio. The capacity on this unit is 32 although census was low at 17. 4 RNs were on duty at time of IM visit. Nurses voluntarily float to MMH when census is low. The CNAs had assignments of 8-9 pts. and most of the patients required an assist of 2 staff. Many of the patients were fall risks. ICU has a bed capacity of 9 beds. Census on day of visit had not reached capacity. Nurses report an average daily census of 4-5 patients. RN staffing on day of IM visit was very adequate. Charge nurses usually have full assignments. The Float nursing pool has been expanded with several additional nurses and PCAs to augment staffing when census is high. ICU nurses also float to the MMH ICU when needed. Several per diem staff have also ben added. Many Certified Nurses aides are cross-trained as unit secretaries to aid in staffing flexibility. RNs are also cross training in certain areas.	Continue your efforts to cross train nurses to float to other units and across both campuses to increase flexibility with staffing.
• Physical Environment	The M/S Nursing unit is laid out in an H design. It is an older unit but clean with semi private rooms and two designated hospice rooms that are private and down at the end of the hallway. Appropriate signage regarding pt.'s rights and responsibilities, financial counseling assistance, and help for hearing impaired and those who speak a different language were posted in all pt. care areas. The code cart is visible and accessible in the middle of the hallway. White boards for assignments are visible at all nursing stations. Some are better organized and more comprehensive than others. Initials are used for pt. names to protect pt. privacy. The ICU is well lit with an open central nursing station and private rooms.	**Recommend** finding a quiet protected location for a Medication room in the RGH ICU. Relocation of med room has been considered but there is no separate room to accommodate. There is a separate alcove however, proximal to nursing station but in an area that would provide some auditory protection. Recommend

CATEGORY	OBSERVATIONS	RECOMMENDATIONS
	There is good pt. visibility. However there is no medication room in the **RGH** ICU. The Pyxis cabinets are part of the central nursing station. The temperatures of the medication refrigerators are remotely monitored by a central system. The code cart was visible and accessible.	relocating medication dispensing unit to that area as soon as possible. CNO and IM discussed and agreed to this solution.
NURSING SERVICES		
• Culture of Safety	Nurses and PCAs on Bissell 2 are conducting a pilot test for hourly rounding on all patients. This initiative began on March 16 2017. Minutes from an April meeting demonstrated a 95.5% compliance rate with the hourly rounding project. Nurses report a collaborative relationship with hospitalists. Nursing units collect Nurse Sensitive Indicators: Falls, Falls with Injury, HAPIs through NDNQI and CLABSIs, and CAUTIs through NHSN. The CAUTI rate is currently 0. A nurse driven Foley Removal protocol is in place. The ICU has not experienced a CAUTI or a CLABSI within 1 year. There is a good Fall Prevention Program in place but falls on M/S need to be decreased. Consistent Fall risk signage was posted in clear view outside all appropriate pt.'s rooms. The M/S unit also needs to improve HCAPHS scores on "communication with nurses". Multidisciplinary pt. care rounds occur daily. IM attended rounds at RGH on 6/29/17. Hospitalists, nurses, SW, Case Management participate. Hospitalists and nurses have a very collaborative relationship. Nurses suggest interventions and state that physicians listen to their assessments.	**Recommend** the implementation of hourly bedside rounding by nursing once the pilot is completed and revised as appropriate.
NURSING SERVICES		
• Culture of Safety	The I**CU** is an "open" unit meaning hospitalists and private attending physicians can admit into the unit. Respiratory therapists assist with changing ventilator settings per weaning protocols. Code and Defib	

CATEGORY	OBSERVATIONS	RECOMMENDATIONS
	carts checked in all areas. An Intensivist is on call every night to cover ICU at nights. The nurses enjoy a collaborative relationship with the ICU team.	
• HR / Personnel	The CNO and the VP for Quality/Safety Officer come to the RGH campus 1-2x/wk. and have an office in the hospital. All ECHN leaders round consistently at RGH. Several Nurse Managers now have responsibility for nursing services on both ECHN and RGH campuses. Generally, there are clinical coordinators on each nursing unit that help manage daily operations. On the day of the IM's visit the Nurse Manager of the Critical Care units was filling the role of the "Charge" nurse in the RGH ICU. There was a new clinical coordinator on Bissell II that was orienting to her role. She stated that her orientation was going well. Much of the staff is fairly long tenured. Only a small percentage of nursing staff is certified in their practice specialty. Very few nurses belong to their professional organizations. A new grad was interviewed on M/S at **RGH.** She was a previous PCA at RGH and feels she is getting a very good orientation. Spoke highly of her preceptor. She felt comfortable in asking questions and getting help as needed.	IM encourages Nurse Leaders to collaborate with staff to set unit goals for specialty certification. Exam Prep study groups are supported and encouraged and exam fees are reimbursed upon passing. Certified nurses should continue to be formally recognized and celebrated. Nurses should also be encouraged to join their professional specialty organizations.

CATEGORY	OBSERVATIONS	RECOMMENDATIONS
NURSING SERVICES		
• HR / Personnel	The Administrative director for HR is developing self-assessment tools for professional staff to be used at the time of their performance evaluations. She has also developed a tool for the development of SMART goals for the professional staff and mangers to utilize. These are in DRAFT form and will be implemented with the next annual review period starting January 2018.	**Recommend** All professional staff complete a self-evaluation and develop goals for accomplishment over the coming year. Implement the use of SMART goals to write measureable and specific goals. This is in progress.
• Confidentiality	Personnel logged out of computer screens when walking away from computer the majority of the time. Curtains pulled around patients when care was provided.	
INFECTION CONTROL		
• Staffing	1.5 FTEs cover both MMH and RGH campuses. 1.0 FTE is an RN with 20 yrs. yrs. experience. She is a member of APIC and holds certification. She provides monthly orientation for all new employees. The other member of the Dept. is 20 hrs. and has a microbiology background and a graduate degree in Public Health. The Medical Director of the program is an Infectious Disease physician who has been with the hospital 35+ yrs. This physician also runs a busy HIV Clinic. There was evidence of a few “safety champions” in patient care areas.	
INFECTION CONTROL		
• Culture of Safety	A vigorous hand washing campaign is continuing. Overall hospital inpatient hand washing compliance rates are measured and displayed on QI Boards throughout the clinical areas. IM did not observe any lapses in hand hygiene on her visit to the RGH campus. A strong antibiotic stewardship program has been in place since the 1980’s. Staff round on inpt units 3x/wk. IP staff communicate with Microbiology several days/wk. All isolation cases are reviewed on a	

CATEGORY	OBSERVATIONS	RECOMMENDATIONS
	daily basis. IP staff state that nurses do a very good job of placing pts. on isolation precautions and D/C precautions at the appropriate time. The Infection Prevention dept. has an IP Hotline. The Infection Control liaison group has been reinvigorated. IM read minutes of Infection Prevention Comm meeting of 2/17. They have added HH Observers to the group to assure more frequent observations of hand washing. All employees completed HH education by 2/15/17. Recurring employee lapses in hand hygiene results in progressive discipline up to and including termination. . Much work has been accomplished to bring SSI rates down below benchmark. There is a subcommittee of the Infection Prevention Committee that is focused on Hospital Acquired Infections and these rates are decreasing. RGH is doing quite well with their Patient Safety Outcomes. However, c difficile rates are currently 1.177 at RGH.	Recommend continuing to work with the Infection Prevention liaisons to conduct frequent observations. Report HH rates by unit so each patient care area is getting their own specific data as well as an aggregate rate. IM will review HH rates at each periodic site site visit.
INFECTION CONTROL		
• Compliance with State & Federal Regulations	Good surveillance program in place. Infection Prevention committee meets monthly. Minutes and agendas reviewed by IM. Attendance by appropriate departments is usually good but surgical representation is sometimes lacking. Pharmacy, Microbiology and environmental, nursing representation have consistent representation.	The IP Medical Director has assured consistent representation by a surgeon at Infection Prevention committee Minutes reflected surgeon attendance at the March meeting.
PHARMACY		
• Staffing	The Pharmacy Dept. is staffed with 1 Pharmacist at RGH on day shift and one at RGH from 3-8pm. There is now a night pharmacist on duty Sunday through Thursday. There is one Pharmacy tech assigned to the entire hospital.	**Recommend** adding a pharmacist to the nighttime staffing plan as soon as possible. This recommendation has been completed Sunday through Thursday nights.

CATEGORY	OBSERVATIONS	RECOMMENDATIONS
• Physical Environment	The Pharmacy at RGH is less crowded and visibility and prep areas are adequate.	IM will revisit the pharmacy on return visit.
PHARMACY		
• Culture of Safety	Automated dispensing system and DOSE-EDGE systems in place. All medications coming into department are scanned in and barcoded. The hospitals use SMART pumps with an extensive medication library. Med library use by RNs is monitored by the pharmacy. Medication fill error rates and Medication errors are being tracked closely.	

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CATEGORY	OBSERVATIONS	RECOMMENDATIONS
PHARMACY		
• Compliance with State & Federal Regulations	A Pharmacy and Therapeutics Committee meets monthly and reports into the QAPI. All adverse Drug events are reviewed within the Medication Safety Subcommittee. A strong Antibiotic Stewardship program is in place. Pharmacists have oversight for Renal dosing adjustments and Vancomycin dosing and utilization.	
• HR / Personnel	Pharmacy Director has been with ECHN for 13 yrs. and is appropriately credentialed. Pharmacy technicians have to obtain certification within one yr. of hire. The pharmacist on duty at RGH on day of IM visit has long tenure at ECHN and likes it very much. Highly complimentary of the Pharmacy director who she described as very supportive.	
SURGICAL SERVICES Ambulatory Surg Unit, GI, Pre OP, OR, PACU, Central Sterile Processing		
• Staffing	I.M. observed appropriate RN staffing ratios throughout the tour of Surgical Services. The surgical volume continues to decrease at RGH. IM asked how staff maintains competencies with volume being low. Manager discussed the regular floating of RGH personnel to the MMH campus to maintain competency in all service lines.	
• Physical Environment	Tour of the Operating Room suites demonstrated a much more organized outer core. Surgical Services leadership has changed and much attention has been focused on reducing inventory so that frequently used equipment and supplies are accessible and equipment infrequently needed is stored in materials management. In addition an underutilized OR has been converted to a storage room for various pieces of larger equipment and monitors.	IM encourages the initiation of a checking process to assure all appropriate carts are locked in this area since it is more remote and less frequently entered.
• Culture of Safety	IM visited OR in early AM to observe the start of a case but the surgery was delayed and IM unable to observe start of the case and time out as planned. IP minutes reflected 1 colon and 1 total hip replacement infection in the past year.	IM will revisit OR on next visit.

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CATEGORY	OBSERVATIONS	RECOMMENDATIONS
SURGICAL SERVICES Ambulatory Surg Unit, GI, Pre OP, OR, PACU, Central Sterile Processing		
• Policies and Procedures	Carts were locked and checks were completed on code carts.	.
• HR / Personnel	**RGH** Overall, nurses in surgical services areas do not hold certification in their respective specialties although 50% of the OR nurses hold an AORN. The Unit Educator is responsible for education throughout surgical services: PACUs, ORs, GI lab, Amb. Surgery and Central Sterile Processing. In-service education is provided every 2 weeks.	
• Confidentiality	Pt. Confidentiality was upheld throughout the tours through the various surgical services area. Screens have been placed over windows leading into the ORs to protect patient privacy.	
EMERGENCY DEPARTMENT		
• Staffing	The ED utilizes flexible staffing which changes according to time of day. They staff in 8, 10 and 12 hr. shifts. Additional staff is added very 4 hrs. to accommodate changing census.	

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CATEGORY	OBSERVATIONS	RECOMMENDATIONS
EMERGENCY DEPARTMENT		
• Physical Environment	The ED at RGH sees 21,500 visits/year. It has an open design with a central station. Pts. are easily visualized. Waiting rooms are adequate and have appropriate signage: pt. privacy, language lines, financial counseling and assistance for the hearing impaired. Emergency carts are placed to allow easy access by staff. The environment is well organized and free of clutter. There is no separate area for the behavioral health population**.** There is a Clinical Decision Unit that sees lower acuity (ESI 3 & 4) pts. It has the capacity for 7 pts. It is staffed from 10am -10:30pm during the ED's highest volume hours. This unit does not have cardiac monitors and was closed during IM's visit.	
• Culture of Safety	The ED has once again attained GWTG Advanced Stroke Certification. Congratulations! Several QI indicators are in place: Timeliness of Care, ED arrival to departure, Admit decision to ED departure. However, length of time from arrival to departure and arrival to admission is very long and trending upwards. A task force has been set up with the CNO and interim Medical Director to drive new processes to decrease wait and visit times. "Left Without Being Seen" rates are are 3% and above the benchmark. The slow throughput has not had a negative effect on patient satisfaction scores in the ED which rank 80 and 81 in Ct. Psychiatrists see behavioral health patients admitted through ED within 24 hrs. of admission. Children needing admission are sent to CCMC. .	
• HR / Personnel	In addition to the Nurse Manager, the EDs share a Unit Educator. All RNS have ACLS with the first year of hire.	
• Confidentiality	There was appropriate spacing between pts. registering in the ED to protect auditory confidentiality. White boards did not contain patient's names.	

NURSING CONSULTING PARTNERS
Sustainable Results for Healthcare Solutions

CATEGORY	OBSERVATIONS	RECOMMENDATIONS
• Confidentiality	There was appropriate spacing between pts. registering in the ED to protect auditory confidentiality. White boards did not contain patient's names.	

CATEGORY	OBSERVATIONS	RECOMMENDATIONS
PSYCHIATRIC SERVICES **RGH** Eating Disorders Unit (EDU)		
• Staffing	A multidisciplinary team of professionals provides care for this pt. population: Psychiatrists, RNs, SW, psych technicians, recreational therapists. Adolescents also have a teacher on staff who is certified in Grades K-!2. Staffing guidelines have recently been revised to reflect a 1:5 nurse/patient ratio. The former staffing plan was a 1:6 nurse/patient ratio. Census in the BHU has increased to 12 from the previous 8 patients and many licensed staff is being hired and oriented. The unit is undergoing a period of instability as a result of a lot of recent staff turnover. IM discussed plans for staffing retention efforts and team building for the BHU with both the CNO and Nursing Director. Staffing plans in the **BHU at RGH** include an entire multidisciplinary team of professionals: RNs and Psych technicians (minimum of a bachelor's degree) SWs and nutritionist. There are no CNAs.	
• Physical Environment	**T**his is a new inpatient unit that opened to patients in August 2016. It is a nationally known specialty unit that admits patient from all over the country. It takes both adults and adolescents and the majority of patients treated have diagnoses of anorexia, bulimia, and binge eating. The unit has the capacity for 30 pts. and current census at the time of visit had increased to 12. It is an "L" configuration and adults are separated from the adolescents. Staff on the adolescent side carries walkie-talkies as a safety precaution. Pt. rooms are all safe with flush door handles; sink faucets and no glass mirrors. A special "Wicket" door was used in all pt. rooms. It allows staff to access the pt. from the hallway in case of an emergency, i.e. the pt. has barricaded himself in his room. While patient rooms had flush door handles the nonpatient rooms (storage closets etc.) along the hallway did not. This did not seem consistent and bears investigation. IM discussed with the nursing director who will look into the rationale behind the differing handles. All exit doors consistently locked and fire egress plans reviewed with Nursing Director. A fire drill was	IM will revisit area on next visit.

CATEGORY	OBSERVATIONS	RECOMMENDATIONS
	held recently and all staff performed well.	
PSYCHIATRIC SERVICES BHU Adult and Adolescent		
• HR / Personnel	Professional Staff is appropriately trained and credentialed to perform their jobs. All ancillary personnel coming on to this unit must also be trained regarding safety practices. Professional staff in the **BHU at RGH** was sent to Walden in Mass. for a full 8 hr. day of education and training for this specialty unit. Staff were hired early in 2016 and oriented for several months prior to the opening of the unit in August 2016. Two FT team psychiatrists are on staff. They have the ability to frequently consult with psychiatrists at The Eating disorders program in Walden, Ma.	EDU has experienced a good deal of staff turnover over last few months. Census is expanding. Currently average daily census is 12 an increase from 8 at IM's last visit. New BH director over this program was interviewed about his plans to replace staff and retain current staff and build a stable team.
QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT		
• Staffing	The Quality Department is comprised of 4.5 FTEs who report into the VP of Quality, Safety and Pt. Experience and cover both Rockville and MMH campuses as well as outpatient sites. The existing staffing structure has remained unchanged in the previous 6 months. There are 3 QI Managers who are supported by an Environmental Safety Officer. A Pt. Experience Coordinator and Quality Analytics Manager (0.5FTE) report directly into the VP. Two Data Abstractors (1.4 FTEs) report into the Quality Analytics Manager (0.5FTEs). The QI personnel's offices reside at the MMH campus. VP of quality rounds at RGH 1-2x/wk. The QI Managers have focused areas of responsibility. All conduct RCAs,	IM will attempt to observe this meeting on next site visit.

CATEGORY	OBSERVATIONS	RECOMMENDATIONS
	and investigate serious safety events and precursors. The QI dept. coordinates a Quality/Safety/Risk huddle held every Monday that includes the CMO, CNO, VP Quality, Risk Management, and VP of Nursing. This group reviews serious events rom the previous week. The Pt. Experience Coordinator also has responsibility for Pt. rights, Grievances, and Complaints.	
QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT		
• Culture of Safety	In the area of Pt. Safety, the following structures and processes are in place: Daily Safety Huddles, Patient Safety committee, Patient Safety Coach committee, HRO education during orientation of new employees and physicians. A large variety of other committees and task forces exist to support Pt. Safety. IM Reviewed QI minutes from Jan, March 2017 and the May Quality Dashboard. RGH has made considerable progress in decreasing readmission rates for Heart Failure and Stroke. Similar efforts need to be applied to readmissions for the Pneumonia and COPD populations that are 24.6% and 29.4% respectively. Overall all diagnosis readmission rates at RGH are 12.9% which is above stale and national benchmarks. An AHRQ Pt. Safety Culture survey is being considered for the Fall, 2017. IM will review results of employee safety survey if completed at next site visit. Multidisciplinary Committees are in place to reduce Falls, CAUTIs, and CLABSIs. “Days Since Last Fall” is always listed on the Safety Huddle white board The CAUTI rate is almost zero and there were 2 CLABSIs in 2016. Root cause Analyses are completed on all CLABSIs after Infection Prevention has determined it to be a true CLABSI. Action plans are developed for all scores falling below internal goals.	IM will review all QI indicators, dashboards, minutes at next site visit.
QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT		
• Culture of Safety	ECHN was again awarded TJC Advanced Stroke Accreditation for 2017. The Risk Management program is the same as on the MMH campus. The director of RM also collaborates closely with the Chair of the Environment of Care Committee. The Patient Experience Coordinator	

CATEGORY	OBSERVATIONS	RECOMMENDATIONS
	covers both hospital campuses. HCAHPS scores are quite low at RGH—well under the 50th percentile. Several initiatives are underway with both the inpatient nursing staff and the hospitalists to improve the scores. Hourly bedside rounding has ben started on the M/S unit and this best practice should be expanded to all nursing units.	

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SECOND ASSESSMENT: PROSPECT Manchester Memorial Hospital COLLEEN O. SMITH MSN, RN, NEA-BC JUNE 27-28 2017		
CATEGORY	**OBSERVATIONS**	**RECOMMENDATIONS**
NURSING SERVICES – MMH-3 North, Critical Care, 2 East, 1 East, OB/NICU		
• Staffing	IM visited on average census days. M/S Nurses generally had a 1:5 pt. ratio and 4:1 on the Telemetry unit. 1 East (cardiac and observation) had a census of 14 with 4 RNs on Day shift. The CNAs had assignments of 10 pts. and most of the patients required an assist of 2 staff. Many Certified Nurses aides are cross-trained as unit secretaries to aid in staffing flexibility. The Critical care unit had a relatively low census with 2:1 nurse/patient ratios maintained. The Step-down unit only had 4 pts. With very adequate nurse staffing. Assignment boards were clear and well organized. The Monitor tech was watching approximately 32 monitors and stated she got regular breaks and as needed. I.M. reviewed the Monitor Tech Break log that was being used to audit break times and it demonstrated full compliance with breaks by qualified techs. Staffing in the Family Birthing Center and NICU was appropriate. Family Birthing Center follows the AWHONN Perinatal Nursing guidelines, 4th edition 2014. IM reviewed all the nursing hires across both RGH and MMH campuses since last visit in January. The RN float Pool has been augmented by a total of 6 FTEs representing varied hours. In addition to the Float Pool, several per diem nurses joined ECHN. They have been used to aid staffing the Oncology unit and Medical/Surgical units. Many new per diem nurses have been deployed to the Eating Disorders unit on the RGH campus as well as Behavioral Health and the EDs. The CNO mentioned that some additional voluntary cross training among RN staff has occurred and this has been quite successful and effective. Patient Care Technicians, cardiac secretaries, and OR scrub techs have also been added to the Float pool. There has not been any new regular contract FTEs hired.	

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CATEGORY	OBSERVATIONS	RECOMMENDATIONS
NURSING SERVICES		
• Physical Environment	Nursing units were clean and hallways free of clutter. Appropriate signage regarding pt.'s rights and responsibilities, financial counseling assistance, and help for hearing impaired and those who speak a different language were posted in all pt. care areas. Capacity on M/S units range from 23 beds to 32 with a mix of private and semi private rooms. White boards for assignments are visible at all nursing stations. Some are better organized and more comprehensive than others. On some units, the white boards are not completely filled out. Initials are used for pt. names to protect pt. privacy. In CCU the white board was very organized and comprehensive. It included: Braden scores, central lines, and restraints. **Critical Care** was built in 2008 and has a North and South side with 12 and 10 beds respectively. The unit is well lit with north and south nursing stations, many areas for electronic charting and good pt. visibility. Every pt. room can handle dialysis and 4 rooms are negative pressure. Anterooms were an ample size and laid out well. Medication rooms all locked by keypad. Med rooms were small but adequate and offered a quiet environment for medication preparation. The temperatures of the medication refrigerators are remotely monitored by a central system. The temp logs were consistently filled in and up to date by nursing personnel. **The Family Birthing Center** has 12 LDRPs, 2 ORs and a Level 3 NICU whose ADC is 2-3 neonates. The unit is pleasant.	

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CATEGORY	OBSERVATIONS	RECOMMENDATIONS
NURSING SERVICES		
• Culture of Safety	Nurses are not yet doing hourly rounds at MMH but some units do conduct bedside change of shift report. Quality boards have been updated and all units have them in prominent locations. Nurses report a collaborative relationship with hospitalists. Nursing units collect Nurse Sensitive Indicators: Falls, Falls with Injury, HAPUs through NDNQI and CLABSIs, and CAUTIs through NHSN. There is a good Fall Prevention Program in place. Fall risk signage was recently updated and consistently visible outside of patient rooms. Multidisciplinary pt. care rounds occur daily. Hospitalists, nurses, SW, Case Management participate. Hospitalists and nurses have a very collaborative relationship. Nurses suggest interventions and state that physicians listen to their assessments. Certified Wound Care (WCC) nurses are on each pt. care unit. They assist with skin assessment and early identification and intervention to prevent pressure ulcers. They are role models and educators for nursing staff. A WOCN nurse oversees this function. **Oncology 2 East** IM reviewed chemotherapy administration protocol with nurse. Good system of checks and balances including drug dosage calculations in place to assure patient safety. Nurses state initial chemotherapy and immunotherapy administration requires 1:1 nurse/pt. ratio.	**Recommend** a formal evaluation of the hourly rounding pilot being conducted on Bissell 2 at RGH once the pilot has been completed. Revise rounding process as needed and disseminate best practice to the other units across both campuses.

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CATEGORY	OBSERVATIONS	RECOMMENDATIONS
NURSING SERVICES		
• Culture of Safety	The **CCU** is an "open" unit meaning hospitalists and private attending physicians can admit into the unit. However, all vented pts. in the CCU are seen by the Intensivists who manage their pulmonary care. Respiratory therapists assist with changing ventilator settings per weaning protocols. The CAUTI rate in Critical Care has been zero since December 2015 and the CLABSI rate had been zero since May 2016. In May 2017 there was one CLABSI that met criteria for reporting. In the **Family Birthing Center**, all nurses have completed the GNOSIS training program and the physicians are almost complete with the same training. Clinicians were pre tested and then took a posttest after program completion. IM reviewed OB Departmental minutes and found evidence discussion regarding GNOSIS education and current completion rates. There is a multidisciplinary Departmental Quality Meeting where many Quality Indicators are reviewed as well as any adverse events. Mock Code, Dystocia and Postpartum Hemorrhage drills are held. Blue emergency buttons are in every pt. room on OB so that nurses can summon immediate help. Nursing personnel spoke highly of the current anesthesia providers. It is policy that all post partum pts. Are assisted by 2 nurses for their first time out of bed after a delivery. There have been no pt. falls or infant descents on the OB unit.	Consider moving the FBC quality board to a more prominent location so that the data can be more readily displayed and seen by staff**.**
• Compliance with State & Federal Regulations	IM randomly checked Glucometer strips and solutions for appropriate dating. Code and Defib carts randomly checked in select areas. All had been checked with RN signature and up to date. The staffing committee meets annually in September to review all nurse staffing plans. It is chaired by the CNO. Staff Nurses comprise the majority of the membership who voice their suggestions regarding adjustments in staffing plans. Additional sitters and nurses for the Float Pool have been recent decisions.	

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CATEGORY	OBSERVATIONS	RECOMMENDATIONS
NURSING SERVICES		
• HR / Personnel	Much of the staff is fairly long tenured. IM spoke with nurses who had practiced at for 35+ years. Certified nurse are recognized and celebrated with a certification bonus but only a small percentage of Nursing staff is currently certified in their practice specialty. There seems to be growing enthusiasm among some nursing staff however. One Oncology RN investigated getting certified by ONS and found the program "FREETAKE". The hospital has committed to paying for the exam and the nurse can take it up to 2 times. She is now pursuing getting a minimum of 10 of her nurse colleagues to study and sit for certification exams. Great work and demonstration of initiative and hospital support! IM met and spoke with some CNAs who were cross-trained as Unit Secretaries to augment and provide flexibility in staffing. **FBC** Very few staff nurses on OB are certified. There is a certified Lactation Consultant on OB and several additional nurses who have special training in lactation. They cover the unit 7days/wk. IM discussed Baby Friendly designation with the Nursing Director who has been in place for almost 2 years. While she feels it is an important pursuit, she states that she has other more important competing priorities this year. 87% of mothers are breastfeeding on D/C from hospital. There are a few LPNs on the OB unit who are assigned to care for Mother/baby couplets. They are not assigned to labor and delivery; however, they are trained to be scrub technicians in the 2 c/section ORs. **HUMAN RESOURCE**- IM reviewed the new DRAFT Self Assessment and Goal Planning forms to be utilized for all licensed professional staff at the time of their periodic Performance Management Appraisal. The relevant employees will be educated regarding SMART goals and the new approach will begin in January 2018 ad be completed in April, 2018 which represents the normal timeframe for evaluations at ECHN. At this time all Management personnel will be expected to coach professional staff with their annual self-assessments and SMART goal development for the coming year.	IM encourages Nurse Leaders to collaborate with staff to set unit goals for specialty certification. ECHN has established baseline data of all currently certified nurses. IM encourages that the aggregate list be broken down by unit so that each unit can see their unit certification rate and set goals towards increasing their numbers. Nurses should also be encouraged to join their professional specialty organizations. ECHN is starting on the Pathway to Excellence. Shared governance with unit-based councils has begun. Some units are further a long with their councils than others. These professional pursuits will be discussed within the councils. **FBC** Consider utilizing the Baby Friendly Ten Steps to guide current practice while considering formal application in future. IM will review some licensed personnel's evaluations and self-assessments during future visits.

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CATEGORY	OBSERVATIONS	RECOMMENDATIONS
NURSING SERVICES		
• Confidentiality	IM did not witness any breaches of confidentiality during second visit.	
• Cultural Sensitivity	Language line utilized by staff for staff of different ethnic cultures. Bariatric equipment and furniture was present in waiting rooms and pt. care areas.	
INFECTION CONTROL		
• Staffing	1.5 FTEs cover both MMH and RGH campuses. 1.0 FTE is an RN with 20 yrs. yrs. experience. She is a member of APIC and holds certification. She provides monthly orientation for all new employees. The other member of the Dept. is 20 hrs. and has a microbiology background and a graduate degree in Public Health. The Medical Director of the program is an Infectious Disease physician who has been with the hospital 35+ yrs. This physician also runs a busy HIV Clinic	
• Culture of Safety	A vigorous hand washing campaign is underway. Hand washing compliance rates have increased. IM did not observe any lapses in hand hygiene. A strong antibiotic stewardship program has been in place since the 1980's. Staff round on inpt units 3x/wk. IP staff communicate with Microbiology several days/wk. All isolation cases are reviewed on a daily basis. IP staff state that nurses do a very good job of placing pts. on isolation precautions and D/C precautions at the appropriate time. The Infection Prevention dept. has an IP Hotline.	

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CATEGORY	OBSERVATIONS	RECOMMENDATIONS
INFECTION CONTROL		
• Culture of Safety	There is consistent up follow by surgeon offices on SSI following surgery. IP staff and Medical Director state there is very with good communication with surgeon offices. The Infection Control liaison group has been able to conduct more frequent observations of hand washing. I.M. reviewed the Infection Prevention committee minutes from Feb-May, 2017. C difficile rates are under the NHSN benchmark. Much work has been accomplished to bring SSI rates down below benchmark. There is a subcommittee of the Infection Prevention Committee that is focused on Hospital Acquired Infections.	Infection Prevention liaison group has been reestablished throughout organization. The Safety Hand Hygiene Liaison group has met 2x. It is part of the IP leader's goals for coming year. Consider the value in changing H.H. observations to include the rate going into the room and the rate coming out of the room as two different rates to obtain an even more accurate picture of compliance. .
• Policies and Procedures	IM observed appropriate isolation techniques in many different pt. care units. Signage outside of rooms and appropriate attire in isolation carts.	
• Compliance with State & Federal Regulations	Good surveillance program in place. Infection Prevention committee meets monthly. Minutes and agendas reviewed by IM. Attendance by appropriate departments is usually good. IM reviewed recent IP committee minutes and there was evidence of surgical representation. Pharmacy, Microbiology and environmental, nursing representation have consistent representation.	**C**onsistent representation by a surgeon at Infection Prevention committee has started in May 2017.

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CATEGORY	OBSERVATIONS	RECOMMENDATIONS
PHARMACY		
• Staffing	There have been staffing reductions in the Pharmacy Dept. since last visit in January 2017. There has been a decrease of 2.1 Pharmacist FTEs. There is no longer a Clinical Coordinator or IT Pharmacist. Their workloads have been redistributed. The dept. uses a decentralized staffing model whereby one clinical pharmacist is assigned to cover groupings of pt. care units. The staffing pattern decreases to 1 pharmacist on evening 3-11:30pm shift at MMH. One pharmacist has been reassigned to night shift Sunday through Thursday. There is no on site pharmacist on Friday and Saturday nights. Any new urgent orders can be reviewed by on call pharmacist remotely on those 2 nights. ECHN is keeping a log to audit the timely review of medication orders by the pharmacist on the night shift. There is no longer a Pharmacy tech assigned to the ED to assist with collecting accurate medication histories.	The recommendation to add a pharmacist to the nighttime staffing plan has been completed. One pharmacist covers both hospitals 5 days/wk. Sunday thru Friday. IM reviewed the audit log of all nighttime medications ordered on Friday and Saturday nights. Many meds reviewed with 2 hours. Some medication orders took 6-8 hours for review but these were most likely non-urgent, new drugs. IM recommends revising the current auditing tool to reflect the name of the drugs ordered during nights.to assure that high risk and urgent drugs ordered on nights are reviewed by a Pharmacist in a timely manner.
• Physical Environment	The Pharmacy at MMH has been relocated to the basement level of the hospital to gain more space. Even in the newer location, the pharmacy is crowded. Plain IV solutions are stored in an adjacent space to the main Pharmacy due to space constraints. Currently, there are plans to have plain IV solutions maintained by the Materials Management Dept. The hospital will be transitioning from Care Fusion to Omnicell as part of the Prospect acquisition. The Omnicell equipment is also currently stored in this adjacent area making egress rather narrow.	Omnicell (Prospect Medical contract) being implemented soon. Storage area very crowded. CNO committed to resolving issue. Engineering responsive to moving things around to allow better egress.

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CATEGORY	OBSERVATIONS	RECOMMENDATIONS
PHARMACY		
• Culture of Safety	Automated dispensing system and DOSE-EDGE systems in place. All medications coming into department are scanned in and barcoded. The hospitals use SMART pumps with an extensive medication library. Med library use by RNs is monitored by the pharmacy. Pharmacists make 300-400 Clinical Interventions per month.	**Recommend** a more system wide approach be taken to dissemination of blinded information following RCAs that have potential for harm. Provide widespread education to care providers to alert them to significant events to improve awareness and reinforce safety behaviors. This new process is being developed for implementation in June 2017. I.M. will check its progress on next visit.
• Compliance with State & Federal Regulations	A Pharmacy and Therapeutics Committee meets monthly and reports into the QAPI. All adverse Drug events are reviewed within the Medication Safety Subcommittee. A strong Antibiotic Stewardship program is in place. Pharmacists have oversight for Renal dosing adjustments and Vancomycin dosing and utilization.	
• HR / Personnel	Pharmacy staff in a state of transition and some instability due to recent staffing changes which have impacted their workloads. Quite a bit of turnover has occurred in this dept. Pharmacy is now reporting directly to the CNO who is well aware of the work climate and is coaching Director. He has been with ECHN for 13 yrs. and seems to be well liked by his staff. He is appropriately credentialed. Pharmacy technicians have to obtain certification within one yr. of hire.	Lost 2.1 FTEs. Clinical Coordinator and IT liaison. 1.0 FTE moved to nights.

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CATEGORY	OBSERVATIONS	RECOMMENDATIONS
SURGICAL SERVICES Ambulatory Surg Unit, Ambulatory Med Unit, GI, Pre OP, OR, PACU Phase 1 & 2		
• Staffing	I.M. observed appropriate RN staffing ratios throughout the tour of Surgical Services. In the GI lab, 3 new physicians have joined staff and visits have increased as well as patient acuity. 2 new 24 hr. RN positions have been added to accommodate this new volume. IM met the chair of Anesthesia. The group employs anesthesiologists and CRNAs. The usual physician to CRNA supervisory ratio is 2:1, which well exceeds the standards required. There is very little turnover of the staff and a few CRNAs have been newly recruited from area hospitals. An anesthesiologist is always in house on night shift at MMH. Anesthesiologists are on call for RGH and need to be within a 45 minute drive of the hospital for emergencies. The Nursing Director explained that emergent high risk surgical cases would be transported to a larger center in Hartford during the night. Nurses all take night and weekend call. They described their cross training requirements and the system they have in place to ensure ongoing competency in all services.	
• Physical Environment	**MMH** has 9 ORs and 1 Cysto room. Overall, spaces were well organized, clean and free of clutter. Emergency carts and equipment was easily accessible. Ambulatory spaces were quite crowded with pt. cubicles separated by a curtain. To better assure physical and auditory privacy, nurses in the Medical ambulatory unit placed pts. In every other cubicle. Day Surgery waiting room was quite pleasant although due for an upgrade to flooring. Appropriate signage and an electronic tracking board were present. Only pt.'s initials were used and tracked by a code that was given to the pt.'s family. New surgical equipment has been ordered for the orthopedic and other services and is in use. This should decrease flash sterilization rates.	

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CATEGORY	OBSERVATIONS	RECOMMENDATIONS
SURGICAL SERVICES Ambulatory Surg Unit, Ambulatory Med Unit, GI, Pre OP, OR, PACU Phase 1 & 2		
• Culture of Safety	IM toured unoccupied ORs and observed surgical personnel. Caps covered all hair, masks in place. IM visited the G.I.Scope cleaning area and found all required testing in compliance. Scopes are separated and hanging in a nice storage cabinet according to standards. In keeping with the Hand Hygiene initiative, observations of scrubbing in the inner core will commence in July.	
• Policies and Procedures	Emergency carts locked and checked according to standard.	
SURGICAL SERVICES Ambulatory Surg Unit, Ambulatory Med Unit, GI, Pre OP, OR, PACU Phase 1 & 2, Interventional Radiology		
• Compliance with State & Federal Regulations	Medication refrigerators, food refrigs are within safe range. Code carts checked and up to date. Appropriate dates of expiration placed on glucometer control solutions.	
• HR / Personnel	The OR Nurse Manager position has been eliminated. The Administrative Director has direct responsibility for all surgical services, endoscopy, and biomedical engineering across both campuses. Clinical coordinators in the OR report into her. 95% of the OR RN staff has attained AORN certification. They plan for turnover by preparing their own OR nurses. They run a perioperative course to teach new nurses. This program has been very effective. In the PACU area, 80% of the RNs are certified. Nurses in the GI lab have not expressed interest in obtaining certification. The Unit Educator is responsible for education throughout surgical services: PACUs, ORs, GI lab, Amb. Surgery and Central Sterile Processing. In-service education is provided every 2 weeks. A new competency in Bariatric Surgery has been added to Health Stream education.	
• Confidentiality	Pt. Confidentiality was upheld throughout the tours through the various surgical services area.	

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CATEGORY	OBSERVATIONS	RECOMMENDATIONS
EMERGENCY DEPARTMENT		
• Staffing	IM visited ED in late afternoon on June 27, 2017. Although the ED was quite full, the atmosphere was orderly and the staffing was appropriate. ED utilizes flexible staffing which changes according to time of day. They staff in 8, 10 and 12 hr. shifts. Additional staff is added very 4 hrs. to accommodate changing census. 8 nurses are in the ED from 11am-11pm for the peak volume hrs. Staffing flexes down to 5 RNs between 3-7am. ED nurses staff the Behavioral Health unit at MMH when it is open. A technician and Crisis Prevention staff assists them. Security personnel are in the ED at all times.	
• Physical Environment	The ED has 19 beds and sees 40,000 pts. /yr. and May 2017 visit volume has stayed rather stable from May 2016 stats. The ED has an open design with a central station. Pts. are easily visualized. Waiting rooms are adequate and have appropriate signage: pt. privacy, language lines, financial counseling and assistance for the hearing impaired. Emergency carts are placed to allow easy access by staff. The environment is well organized and free of clutter. A separate 11-bed unit has been established for the Behavioral Health population. It was closed at the time of the IM visit. On tour of the BHU, IM found the unit safe for BH pts. Non-mechanical beds were bolted to floor and in low position. No sharp edges. All entrances and exits locked.	No patients in the Psych ED area at time of visit.
• HR/Personnel	In addition to the Nurse Manager, the EDs share a Unit Educator. 2-3 RNs are certified SANE nurses at MMH. All RNS have ACLS with the first year of hire. Staff in the BHU all has Physical Management Training (PMT). Crisis Intervention workers staff the BHU until 12 midnight. There were no patients in the BHU on IM's visits to the ED behavioral health area.	
• Culture of Safety	MMH has earned "Get with the Gold" Advanced Stroke Certification again. All relevant performance indicators are at 100%. Congratulations! It is also part of a Sepsis Campaign. Psychiatrists see behavioral health patients admitted through ED within 24 hrs. of	

CATEGORY	OBSERVATIONS	RECOMMENDATIONS
	admission. Approximately 18% of the MMH ED pt. population is pediatric. Children needing admission are sent to CCMC. Several QI indicators are in place: Timeliness of Care, ED arrival to departure (433min) Admit decision to ED departure (238min). These performance improvement efficiency indicators have not yet met goal and have trended upwards from 2016. The CNO has partnered with the Emergency Medicine Medical director to improve the throughput times and patient flow through the ED.	
PSYCHIATRIC SERVICES – MMH in-patient Adult and Adolescent		
• Staffing	The former nurse manager at MMH has been promoted to Nursing Director with inpatient responsibilities across both the MMH and RGH campuses. He is a seasoned Behavioral Health nurse leader with solid clinical experience. His plan is to promote 2 nurses into Clinical Coordinator positions that will report into him once they are ready and get oriented. A multidisciplinary team of professionals provides care for this pt. population: Psychiatrists, RNs, SW, psych technicians, recreational therapists. Adolescents also have a teacher on staff who is certified in Grades K-12.	
• Physical Environment	The unit is many years old and in need of renovation. Plans are in progress to move this service to the RGH campus and renovate the area to accommodate a 16-bed Geri/Psych population. IM reviewed restraint and seclusion log. The unit uses very few restraints and rarely uses seclusion. IM observed solid, flush door handles on all pt. rooms. In common areas, regular door handles were still in use. Pt. rooms had low unmovable non-mechanical beds. Bathrooms were compliant with regulations: breakaway shower rods, polycarbonate mirrors, flush faucets, and angled doors.	
PSYCHIATRIC SERVICES In-patient Adult and Adolescent		
• Culture of Safety	Patients are rounded on every 15 minutes. There is a central monitor at the nursing station so that pts are continually observed. Multidisciplinary rounds occur daily for care planning purposes	Restraint/seclusion log checked by IM. Very low use. Low sensory modulation room discussed. No room for it in current unit.

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CATEGORY	OBSERVATIONS	RECOMMENDATIONS

CATEGORY	OBSERVATIONS	RECOMMENDATIONS
PSYCHIATRIC SERVICES – MMH in-patient Adult and Adolescent		
• Staffing	The former nurse manager at MMH has been promoted to Nursing Director with inpatient responsibilities across both the MMH and RGH campuses. He is a seasoned Behavioral Health nurse leader with solid clinical experience. His plan is to promote 2 nurses into Clinical Coordinator positions that will report into him once they are ready and get oriented. A multidisciplinary team of professionals provides care for this pt. population: Psychiatrists, RNs, SW, psych technicians, recreational therapists. Adolescents also have a teacher on staff who is certified in Grades K-12.	
• Physical Environment	The unit is many years old and in need of renovation. Plans are in progress to move this service to the RGH campus and renovate the area to accommodate a 16-bed Geri/Psych population. IM reviewed restraint and seclusion log. The unit uses very few restraints and rarely uses seclusion. IM observed solid, flush door handles on all pt. rooms. In common areas, regular door handles were still in use. Pt. rooms had low unmovable non-mechanical beds. Bathrooms were compliant with regulations: breakaway shower rods, polycarbonate mirrors, flush faucets, angles doors.	
PSYCHIATRIC SERVICES In-patient Adult and Adolescent		
• Culture of Safety	Patients are rounded on every 15 minutes. There is a central monitor at the nursing station so that pts are continually observed. Multidisciplinary rounds occur daily for care planning purposes	Restraint/seclusion log checked by IM. Very low use. Low sensory modulation room discussed. No room for it in current unit.
PSYCHIATRIC SERVICES In-patient Adult and Adolescent		
• Policies and Procedures	All pts. are searched on admission and belongings are secured in locked metal lockers located at entrance to the unit. Valuables are secured in a safe. All visitors are searched prior to entering the unit.	
• Compliance with State & Federal Regulations	IM reviewed with the procedures that are in place to protect exit doors during a fire drill with the Nursing Director. Drills are held periodically.	
• HR/ Personnel	Staff is appropriately trained and credentialed to perform their jobs	
• Confidentiality	Appropriate measures in place to safeguard pt.'s confidentiality. IM did	

CATEGORY	OBSERVATIONS	RECOMMENDATIONS
	not observe any breaches in confidentially.	
QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT		
• Culture of Safety	In the area of Pt. Safety, the following structures and processes are in place: Daily Safety Huddles, Patient Safety committee, Patient Safety Coach committee, HRO education during orientation of new employees and physicians. A large variety of other committees and task forces exist to support Pt. Safety. Patient Safety Outcome measures are doing well. A Sepsis protocol was initiated on 2/14/2017. Aggressive plans are underway to decrease Hospital Acquired Infections. SSI colon and hysterectomy infection rates and c. difficile are all currently above the CMS 50th %ile. Readmission rates hospital wide are 10.8% for 4th quarter May, which is increased from May 2016 but just slightly over benchmark. Aggressive attention needs to paid reduce CHF (27.5%)and AMI (33.3%) readmission rates which are both trending well above the national mean. Action plans are initiated for all QI indicators that do not meet goal. An AHRO patient safety culture survey is being considered for the Fall, 2017. Currently, there is no active Ethics committee in place. A small team would be pulled together if an ethical dilemma presented. The CNO has plans to ask the next chaplain that is hired to assume the role of Chair of an Ethics comm. This is expected to commence in the Fall 2017.	IM will review results of survey at next visit. IM will check progress with starting a formal Ethics committee on next visit.
QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT		
• Staffing	The Quality Department is comprised of 4.5 FTEs who report into the VP of Quality, Safety and Pt. Experience. They are responsible for all performance improvement initiatives across both hospitals and out services. There are 3 QI Managers who are supported by an Environmental Safety Officer. A Pt. Experience Coordinator and Quality Analytics Manager (0.5FTE) report directly into the VP. Two Data Abstractors (1.4 FTEs) report into the Quality Analytics Manager (0.5FTEs). The QI managers have focused areas of responsibility. All conduct RCAs and investigate. Staffing in this department has remained	Meet with Dir. Of RM. IM requested meeting with Dir. of RM. Discussed HRO and openness of staff to report incidents.

CATEGORY	OBSERVATIONS	RECOMMENDATIONS
	stable since the PMH acquisition.	
RISK MANAGEMENT		
	IM met on June 27, 2017 with Director of Risk Management for ECHN. Very productive meeting. An external risk analysis is being completed for the Family Birthing Center at MMH in the Fall of 2017 by RL Solutions. Director reported that Prospect Medical has voiced plans to use this firm for their other facilities high-risk areas including OB, Behavioral Health and the ED and the surgical services at RGH due to declining surgical volumes. Director has collaborative relationships with Quality, Nursing, and Medical Staff. Very pleased with appointment of new CMO and looks forward to her plans to revise the current peer review process. Described the Interim CEO as "Fantastic. Unafraid to take on any issue." States nurses report issues more quickly since the initiation of the high reliability practices. Incident reporting volumes have stabilized since 2014. ECHN saw an anticipated rise in incident reporting as a result of starting HRO in 2012. The RM Director meets regularly with the Pt. Experience Coordinator and the Grievance Committee to review relevant complaints and grievances. These are tracked through the feedback module of the Incident Reporting Information Systems (IRIS). They adhere to all CMS Guidelines. RM also collaborates closely with the Chair of the Environment of Care Committee.	

NURSING CONSULTING PARTNERS
Sustainable Results for Healthcare Solutions

CATEGORY	OBSERVATIONS	RECOMMENDATIONS

NURSING CONSULTING PARTNERS
Sustainable Results for Healthcare Solutions

CATEGORY	OBSERVATIONS	RECOMMENDATIONS

NURSING CONSULTING PARTNERS
Sustainable Results for Healthcare Solutions

CATEGORY	OBSERVATIONS	RECOMMENDATIONS

User, OHCA

From: Roberts, Karen
Sent: Tuesday, July 18, 2017 4:32 PM
To: User, OHCA
Subject: FW: Second Assessment MMH & RGH

From: Nefores, Karen [mailto:Karen.Nefores@altacorp.com]
Sent: Tuesday, July 18, 2017 4:27 PM
To: Colleen Smith <colleen713.smith@gmail.com>; Martone, Kim <Kimberly.Martone@ct.gov>; Newton, Susan <Susan.Newton@ct.gov>; Debbie Berry (Debbie.Berry@prospectmedical.com) <Debbie.Berry@prospectmedical.com>; Linda L Quirici <LQuirici@echn.org>; Powers, Mary <mpowers@echn.org>; Michael Collins <MCollins@ECHN.org>; Dennis P Mcconville <dmcconville@echn.org>; Roberts, Karen <Karen.Roberts@ct.gov>
Subject: RE: Second Assessment MMH & RGH

Thank you Colleen. Very fair assessments and we appreciate your recommendations. Excellent work to Linda and Team as well!

Karen

Karen J. Nefores, RN, BSN,MBA, CPHQ, CPPS
East Regional Vice President, Quality and Patient Safety
Prospect Medical Holdings
Cell – 562-405-4603

From: Colleen Smith [mailto:colleen713.smith@gmail.com]
Sent: Tuesday, July 18, 2017 2:16 PM
To: Martone, Kim <Kimberly.Martone@ct.gov>; Susan Newton <Susan.Newton@ct.gov>; Debbie Berry (Debbie.Berry@prospectmedical.com) <Debbie.Berry@prospectmedical.com>; Nefores, Karen <Karen.Nefores@altacorp.com>; Linda L Quirici <LQuirici@echn.org>; Powers, Mary <mpowers@echn.org>; Michael Collins <MCollins@ECHN.org>; Dennis P Mcconville <dmcconville@echn.org>; Karen Roberts <Karen.Roberts@ct.gov>
Subject: Second Assessment MMH & RGH

Greetings,
Enclosed please find a cover letter and both the MMH and RGH assessments for my second visit to the Prospect ECHN facilities. As previously, I enjoyed a very good visit and was treated with courtesy. All documents re□uested were freely shared with me.
Please contact me if you have any □uestions.
Best regards,
Colleen Smith

Colleen O'Brien Smith MSN RN NEA-BC
Nursing Consulting Partners, LLC
690C9 S. Park View Court
Franklin, WI 53132

Phone: 203-245-1044
Cell: 203-671-1348
colleen713.smith@gmail.com
http://nursingconsultingpartners.com/

User, OHCA

From: Roberts, Karen
Sent: Tuesday, August 29, 2017 9:02 AM
To: User, OHCA
Cc: Cotto, Carmen
Subject: FW: OHCA condition of Participation #19 for ECHN

For Docket #32016

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: *karen.roberts@ct.gov*

From: Colleen Smith [mailto:colleen713.smith@gmail.com]
Sent: Monday, August 28, 2017 5:36 PM
To: Martone, Kim
Cc: Dennis P Mcconville
Subject: OHCA condition of Participation #19 for ECHN

Dear im,

I hope you have enjoyed your summer. They always seem to fly by. I am seeking clarification regarding the COP 19 for ECHN:
CON Condition 19: For three (3) years following the Closing Date, PMH shall hold a joint meeting of the Board of each of new MMH and New RGH and the Local Board of new MMH and New RGH (Joint Board Meetings) at least twice annually with one occurring in Manchester and the other occurring in Vernon.
I want to verify that since two Joint Board meetings have been held, one at RGH on April 26, 2017 and one at MMH on May 31, 2017 that ECHN has meet this re uirement for Joint board meetings followed by public meetings for this year.

I appreciate your assistance in clarifying this re uirement for me.

Best regards,
Colleen Smith
Independent Monitor

Colleen O'Brien Smith MSN RN NEA-BC
Nursing Consulting Partners, LLC

690C9 S. Park View Court
Franklin, WI 53132
Phone: 203-245-1044
Cell: 203-671-1348
colleen713.smith@gmail.com
http://nursingconsultingpartners.com/

User, OHCA

From: Cotto, Carmen
Sent: Wednesday, August 30, 2017 4:32 PM
To: 'colleen713.smith@gmail.com'
Cc: Martone, Kim; Roberts, Karen; User, OHCA
Subject: FW: OHCA condition of Participation #19 for ECHN

Hi Colleen,

We have some additional questions prior to responding to your question in your August 28th email:

In reference to both meetings held at Rockville and Manchester, April 26 and May 3, 2017, respectively, please address the following:

- Supporting documentation related to the meetings, on file at OHCA dated May 1, 2017 and June 12, 2017, stated that a joint meeting of the Boards of Directors from Prospect Rockville Hospital, Inc. and Prospect Manchester Hospital, Inc. was held on April and May at the hospitals' campuses. The documents also indicated that the meetings were followed by a public meeting for their respective communities where information about the hospitals' activities was shared with the public and that they were encouraged to ask questions and provide comments.

  Condition #19 stipulates that *"…PMH shall hold a joint meeting of the Boards of each of New MMH and New RGH and the Local Board of New MMH and New RGH… and such Joint Board Meetings shall be followed by a meeting for the public…".*

  The submitted documents to support the meeting of this condition do not indicate whether the Local Board for each hospital was in attendance at the meetings and the specific timeline for the public meeting. It appears that the Local Board was missing and that the public meeting was held on the same date, Is this correct? Please provide supporting documentation that shows that each hospital's Local Board was in attendance. Also, provide the specific timelines and supporting documentation for public meetings held after both Boards, the hospital's and Local, have met.

It is also requested that you submit your responses via electronic mail by using the OHCA general email inbox which is OHCA@ct.gov. In addition, please continue to reference the CON docket number in the subject line of the email when transmitting.
You may contact me at (860) 418-7039 or Karen Roberts, Principal Health Analyst at (860) 418-7041, if you have any questions regarding this request.

Thank you,

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134

P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov



www.ct.gov/dph

From: Colleen Smith [mailto:colleen713.smith@gmail.com]
Sent: Monday, August 28, 2017 5:36 PM
To: Martone, Kim
Cc: Dennis P Mcconville
Subject: OHCA condition of Participation #19 for ECHN

Dear im,

I hope you have enjoyed your summer. They always seem to fly by. I am seeking clarification regarding the COP 19 for ECHN:
CON Condition 19: For three (3) years following the Closing Date, PMH shall hold a joint meeting of the Board of each of new MMH and New RGH and the Local Board of new MMH and New RGH (Joint Board Meetings) at least twice annually with one occurring in Manchester and the other occurring in Vernon.
I want to verify that since two Joint Board meetings have been held, one at RGH on April 26, 2017 and one at MMH on May 31, 2017 that ECHN has meet this re uirement for Joint board meetings followed by public meetings for this year.

I appreciate your assistance in clarifying this re uirement for me.

Best regards,
Colleen Smith
Independent Monitor

Colleen O'Brien Smith MSN RN NEA-BC
Nursing Consulting Partners, LLC
690C9 S. Park View Court
Franklin, WI 53132
Phone: 203-245-1044
Cell: 203-671-1348
colleen713.smith@gmail.com
http://nursingconsultingpartners.com/

User, OHCA

From: Roberts, Karen
Sent: Tuesday, September 05, 2017 8:23 AM
To: User, OHCA
Cc: Cotto, Carmen
Subject: FW: OHCA condition of Participation #19 for ECHN

From: colleen713.smith@gmail.com [mailto:colleen713.smith@gmail.com]
Sent: Sunday, September 3, 2017 10:53 AM
To: Cotto, Carmen <Carmen.Cotto@ct.gov>
Cc: Martone, Kim <Kimberly.Martone@ct.gov>; Roberts, Karen <Karen.Roberts@ct.gov>
Subject: Re: OHCA condition of Participation #19 for ECHN

Hello Carmen,
I apologi□e for the delay in my response. I am in Europe and have had some trouble finding consistent service. When I return 9□15, I will communicate with ECHN and ask them to send the necessary documentation.
Best regards,
Colleen Smith

Sent from my iPad

On Aug 30, 2017, at 11:32 PM, Cotto, Carmen □Carmen.Cotto@ct.gov□ wrote:

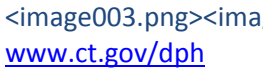
> Hi Colleen,
>
> We have some additional questions prior to responding to your question in your August 28th email:
>
> In reference to both meetings held at Rockville and Manchester, April 26 and May 3, 2017, respectively, please address the following:
>
> - Supporting documentation related to the meetings, on file at OHCA dated May 1, 2017 and June 12, 2017, stated that a joint meeting of the Boards of Directors from Prospect Rockville Hospital, Inc. and Prospect Manchester Hospital, Inc. was held on April and May at the hospitals' campuses. The documents also indicated that the meetings were followed by a public meeting for their respective communities where information about the hospitals' activities was shared with the public and that they were encouraged to ask questions and provide comments.
>
>   Condition #19 stipulates that *"…PMH shall hold a joint meeting of the Boards of each of New MMH and New RGH and the Local Board of New MMH and New RGH… and such Joint Board Meetings shall be followed by a meeting for the public…".*
>
>   The submitted documents to support the meeting of this condition do not indicate whether the Local Board for each hospital was in attendance at the meetings and the

specific timeline for the public meeting. It appears that the Local Board was missing and that the public meeting was held on the same date, Is this correct? Please provide supporting documentation that shows that each hospital's Local Board was in attendance. Also, provide the specific timelines and supporting documentation for public meetings held after both Boards, the hospital's and Local, have met.

It is also requested that you submit your responses via electronic mail by using the OHCA general email inbox which is OHCA@ct.gov. In addition, please continue to reference the CON docket number in the subject line of the email when transmitting.
You may contact me at (860) 418-7039 or Karen Roberts, Principal Health Analyst at (860) 418-7041, if you have any questions regarding this request.

Thank you,

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov


www.ct.gov/dph

From: Colleen Smith [mailto:colleen713.smith@gmail.com]
Sent: Monday, August 28, 2017 5:36 PM
To: Martone, Kim
Cc: Dennis P Mcconville
Subject: OHCA condition of Participation #19 for ECHN

Dear □im,

I hope you have enjoyed your summer. They always seem to fly by. I am seeking clarification regarding the COP □19 for ECHN:
CON Condition 19: □For three (3) years following the Closing Date, PMH shall hold a joint meeting of the Board of each of new MMH and New RGH and the Local Board of new MMH and New RGH (□Joint Board Meetings□) at least twice annually with one occurring in Manchester and the other occurring in Vernon.□
I want to verify that since two Joint Board meetings have been held, one at RGH on April 26, 2017 and one at MMH on May 31, 2017 that ECHN has meet this re□uirement for Joint board meetings followed by public meetings for this year.

I appreciate your assistance in clarifying this re□uirement for me.

Best regards,

Colleen O'Brien Smith MSN RN NEA-BC
Nursing Consulting Partners, LLC
690C9 S. Park View Court
Franklin, WI 53132
Phone: 203-245-1044
Cell: 203-671-1348
colleen713.smith@gmail.com
http://nursingconsultingpartners.com/

User, OHCA

From: Mcconville, Dennis P <dmcconville@echn.org>
Sent: Thursday, September 14, 2017 5:12 PM
To: User, OHCA; Cotto, Carmen; Martone, Kim; Colleen Smith
Cc: Collins, Michael; Ellen J. Shin (Legal Department); Tichy, Joyce A (Legal Department); Garrison DeLee (garrison.delee@prospectmedical.com); Frank.Saidara
Subject: Docket Number: 15-32016-486
Attachments: Letter to Carmen Cotto, OHCA re DN 15-32016-486-CON 09 14 17 .pdf

Dear Ms. Cotto,

Please find the attached letter that provides additional information regarding Condition 19 for Docket Number 15-32016-486, Transfer of Assets of
Eastern Connecticut Health Network, Inc. to Prospect Medical Holdings, Inc.

Sincerely,

Dennis P. McConville
Senior Vice President, Chief Strategy Officer
Eastern Connecticut Health Network, Inc.
(860) 533-3429 (office)
(860) 268-4591 (cell)
dmcconville@echn.org

"This message originates from Eastern Connecticut Health Network. The information contained in this message may be privileged and confidential. If you are the intended recipient, you must maintain this message in a secure and confidential manner. If you are not the intended recipient, please notify the sender immediately and destroy this message. Thank you."

Eastern Connecticut Health Network
71 Haynes Street
Manchester, CT 06040
860.533.3414
www.echn.org

September 14, 2017

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Department of Public Health
410 Capitol Avenue, MS 13HCA
P.O. Box 340308
Hartford, CT 06134

Re: **Docket Number: 15-32016-486**

Project Title: **Transfer of assets of Eastern Connecticut Health Network, Inc. to Prospect Medical Holdings, Inc.**

Dear Ms. Cotto:

This letter is submitted in accordance with the Order for the above referenced Certificate of Need Final Decision, specifically to clarify reports made by me to OHCA on May 1, 2017 and on June 12, 2017 for Condition Number Nineteen (19) regarding the transfer of assets of Eastern Connecticut Health Network, Inc. (ECHN) to Prospect Medical Holdings, Inc. (PMH).

Condition Number Nineteen (19) requires that PMH will "hold a joint meeting of the Board of Directors of each of New MMH and New RGH and the Local Board of New MMH and New RGH (Joint Board Meetings) at least twice annually with one occurring in Manchester and the other occurring in Vernon. Such Joint Board Meetings shall be followed by a meeting to which the public is invited in advance and at which the public is informed of the New Hospitals activities and afforded an opportunity to ask uestions and make comments."

Please see the attached affidavit signed by Michael Collins, CEO of Prospect ECHN, which addresses the attendance at the two re uired Joint Board Meetings and provides details for the public meetings that were held in Vernon and in Manchester.

If you have any uestions or need anything further, please feel free to contact me at (860) 533-3429.

Very truly yours,



Dennis P. McConville
Senior Vice President
Eastern Connecticut Health Network

Enclosures:

Affidavit of Michael Collins, CEO ECHN, September 13, 2017
Journal In□uirer article, April 27, 2017 "RGH to remain open, but change focus"
Journal In□uirer article, June 1, 2017 "Prospect ECHN officials outline plans for MMH"

cc: □imberly Martone, Director of Operations, Department of Public Health Division of Office of Health Care Access
Colleen Smith, Nursing Consultant Partners, LLC
Ellen J. Shin, General Counsel, Prospect Medical Holdings, Inc.
Joyce A. Tichy, Senior Vice President and General Counsel, ECHN
Michael Collins, Interim CEO, ECHN
Frank Saidara, Vice President, Corporate Development, Prospect Medical Holdings, Inc.
Garrison De Lee, Assistant General Counsel, Prospect Medical Holdings, Inc.

AFFIDAVIT

Applicant: **Prospect Medical Holdings, Inc.**

Docket Number: **15-32016-486**

Project Title: **Transfer of assets of Eastern Connecticut Health Network, Inc. to Prospect Medical Holdings, Inc.**

I, **Michael Collins,** **CEO** of
(Individual's Name) (Position Title – CEO or CFO)

Prospect Manchester Hospital, Inc. and Prospect Rockville Hospital, Inc.
(Hospital or Facility Name)

being duly sworn, depose and state the following information submitted on behalf of

Prospect Manchester Hospital, Inc. and Prospect Rockville Hospital, Inc.
(Hospital or Facility Name)

1. Condition Number Nineteen (19) of the Certificate of Need Final Decision for the above referenced Project requires that Prospect Medical Holdings, Inc. will:

> hold a joint meeting of the Board of Directors of each of New MMH and New RGH and the Local Board of New MMH and New RGH ("Joint Board Meetings") at least twice annually with one occurring in Manchester and the other occurring in Vernon. Such Joint Board Meetings shall be followed by a meeting to which the public is invited in advance and at which the public is informed of the New Hospitals' activities and afforded an opportunity to ask questions and make comments.

2. On April 26, 2017 the Local Advisory Board of Prospect Manchester Hospital, Inc. and the Local Advisory Board of Prospect Rockville Hospital, Inc., met together with members of the Boards of Prospect Manchester Hospital, Inc. and Prospect Rockville Hospital, Inc. on the premises of Prospect Rockville Hospital, Inc. located in Vernon, CT.

3. Subsequent to the April 26, 2017 meeting described above and on the same day (i.e., April 26, 2017 at 5 PM), a meeting was held for the Vernon community in the cafeteria of Rockville General Hospital where information about the hospital's activities was shared and the public was encouraged to ask questions and provide comments. The meeting was advertised in both the Hartford Courant on April 20 and 25, 2017 and in the Journal Inquirer on April 16 and 23, 2017. Members of both the Local Boards and the New MMH and New RGH Boards were present. The meeting was called to order at approximately 5 PM and concluded at approximately 7 PM, after which Board and Local Board representatives remained on hand to address questions or concerns that the members of the public wanted to discuss individually. Please see the attached article with an account of the meeting published by the Journal Inquirer on April 27, 2017.

4. On May 31, 2017 the Local Advisory Board of Prospect Manchester Hospital, Inc. and the Local Advisory Board of Prospect Rockville Hospital, Inc., met together with members of the Boards of Prospect Manchester Hospital, Inc. and Prospect Rockville Hospital, Inc. on the premises of Prospect Manchester Hospital located in Manchester, CT.

5. Subsequent to the May 31, 2017 meeting described above and on the same day (i.e., May 31, 2017 at 5 PM), a meeting was held for the Manchester community in the auditorium of Manchester Memorial Hospital where information about the hospital's activities was shared and the public was encouraged to ask questions and provide comments. The meeting was advertised in the Hartford Courant on May 25 and May 28, 2017 and in the Journal Inquirer on May 25 and May 30, 2017. Members of

both the Local Boards and the New MMH and New RGH Boards were present. The meeting was called to order at approximately 5 PM and concluded at approximately 6:30 PM, after which Board and Local Board representatives remained on hand to address questions or concerns that the members of the public wanted to discuss individually. Please see the attached article with an account of the meeting published by the Journal Inquirer on June 1, 2017.

Signature _____ Date 9/14/17

Subscribed and sworn to before me on September 14, 2017

_____

Notary Public/Commissioner of Superior Court

My commission expires: August 31, 2019

Journal Inquirer.com
NORTH-CENTRAL CONNECTICUT'S HOMETOWN NEWSPAPER

RGH to remain open, but change focus

By Kym Soper
Journal Inquirer | Posted: Thursday, April 27, 2017 12:01 pm

VERNON — Prospect ECHN officials announced Wednesday at a public hearing that Rockville General Hospital would remain open, but with a different focus, as two-thirds of the downtown facility would be locked behavioral units.

Interim CEO Michael Collins also said he would revisit the rejection of Vernon's candidate to the advisory board, Dr. Ellen Marmer, after hearing the roomful of support for her at the meeting.

Plans call for diversification, the new for-profit owners told the packed room of residents, with the century-old hospital split into thirds: a medical-surgical unit and emergency department, the new eating disorder unit that opened in August, and a new adult psychiatric unit that's expected to open by the end of the year.

Nearly □10 million has been set aside for renovations to the Vernon facility, with a fair amount of work to be completed by November, Collins said, adding: "We're hoping to make it more vibrant."

Thomas Reardon, president of Prospect Medical East, echoed the sentiment, telling the doubtful crowd that it made no sense to close the hospital.

"Why would we as a company spend what we're going to spend, only to close it down?" he asked. "We want this hospital to thrive."

The trust between the new owners and the community is at an all-time low, Vernon Town Council member William Campbell told Collins.

Not even meeting with Marmer, a well-respected surgeon who would be a strong advocate for the town and transparency, shows that Prospect wants board members who'll rubber stamp whatever they propose, another audience member said as the crowd clapped in approval.

Prospect Medical Holdings Inc., a California-based company that's a subsidiary of hedge-fund Leonard Green and Partners L.P., bought Eastern Connecticut Health

Network and its two hospitals, Rockville General in Vernon and Manchester Memorial, for □105 million in October with a promise to spend an additional □75 million in improvements to its facilities over the next five years. Prospect also purchased Waterbury Hospital around the same time for □45 million, with a promise of □55 million for upgrades there.

Dennis McConville, senior vice president of strategic planning for ECHN, said there is a backlog of some □125 million in identified deferred maintenance and repairs that have accumulated over the years.

About □9.1 million has been re□uested for immediate capital projects at Rockville General, with □8.7 million approved so far, he said.

Much of the initial funding would go toward updating heating, ventilation, and electrical systems, a new roof, and some aesthetic projects like new floors, painted walls, and ceiling tiles, he said.

A good chunk, however, is being set aside to convert the Bissell 1 nursing unit into a locked, 24-bed adult psychiatric behavioral health ward for short-term stays of seven to 10 days.

An additonal □1.3 million is being spent now on renovations at the Woodlake at Tolland nursing home with construction that started Monday.

“So, out of the gate, we’ve got a lot of things lined up,” he said of the projects on tap.

Prospect ECHN officials also touted the low infection rates among its facilities, and the standard for safety in fall prevention and bed sores, which were below industry norms or non-existent on a recent report. Rockville General and Manchester Memorial also received federal certification for advanced stroke care.

Issues raised by the packed crowd in the Rockville General cafeteria Wednesday included staffing levels, renovations to the long unused historical front entrance, and how Prospect ECHN planned to expand its consistently low patient census rate.

Some 14 staffers were laid off recently, Collins said, but not one was a bedside nurse. Overall, Prospect ECHN expects to see an increase of about 60 full-time employees from the current 2,800 by November, he added.

More security and a refurbished entrance to the original colonial building at Rockville General is on the “to-do list,” Collins and McConville said. And the company is planning

to mount an aggressive marketing campaign to attract more patients while at the same time grooming new doctors with its residency program, now in its third year.

There also will be a “paradigm shift” with doctors who take their surgical patients to only Hartford hospitals, Collins noted, adding that they’ll no longer receive referrals from ECHN.

“It’s going to be sort of a war,” he said.

Town Administrator John Ward said he and Mayor Daniel Champagne were “pleased to hear that Prospect is committed to having the hospital open and create more jobs, and we’ll always be here to work with them.”

Journal Inquirer.com
NORTH-CENTRAL CONNECTICUT'S HOMETOWN NEWSPAPER

Prospect ECHN officials outline plans for MMH

By Kym Soper
Journal Inquirer | Posted: Thursday, June 1, 2017 1:32 pm

MANCHESTER — About 50 area residents and medical staff on Wednesday learned the short-term plans for Manchester Memorial Hospital: more maternity and geriatric psychiatric beds, as well as a push to increase the number of outpatient, minimally invasive surgeries.

Long term, new owners Prospect ECHN also hope to establish a cardiac catheter lab that can insert life-saving stents in failing hearts within 30 minutes. But that re□uires state approval and is "many years away," officials say.

The former nonprofit Eastern Connecticut Health Network, which includes Manchester Memorial and Rockville General hospitals as well as Woodlake at Tolland nursing home, was bought for □105 million in October by Prospect Medical Holdings Inc., a for-profit California company, with a promise to spend an additional □75 million on capital projects.

According to the plan, all of Manchester's adult psychiatric patients will move to Rockville General when a new 24-bed locked ward is created on a refurbished nursing unit in Vernon. Work will start there this week, interim CEO Michael Collins said, and be completed by November.

Adolescent, geriatric

psychiatric care

The Manchester psychiatric ward now has six adolescents as patients in a segregated area, but it's not the best situation, Collins said, noting that the youths need more living and activity space for when they're not in therapy.

While the number of adolescent beds would remain the same, geriatric psychiatric beds eventually would increase, he said, from the current census of three or four patients to at least 17, and eventually up to 21.

“The need is there,” Collins said, adding that often, adult children are forced to take home aging parents who’ve had a psychotic break as there’s no satisfactory in-patient medical care now offered for that population.

Renovations to the emergency department, meanwhile, will be minimal, said Dennis McConville, senior vice president of strategic planning, with most of the work concentrated on the waiting areas.

Maternity expansion

The maternity ward, however, will see an increase from 12 to 15 rooms where labor, delivery, and recovery all take place in the same space.

The expansion is re□uired after a Mansfield obstetrics group joined Prospect ECHN, bumping up the number of births at Manchester from the current 1,200 to 1,500 a year.

Some years ago, before Rockville General closed its birthing center, patient census at Manchester’s maternity ward held at 900 births a year, Collins said.

McConville said there is a list of roughly □125 million in identified deferred maintenance and “wish list” items for upgrades throughout network properties, with about □9.1 million approved for immediate projects, mostly in Vernon.

At Manchester, the list includes imaging, pharmacy, surgery, and cardiac rehab e□uipment, he said.

Cosmetic changes also will occur to waiting and patient rooms, and buildings on all three campuses will get much-needed attention to roofs and mechanical systems, like heating and ventilation.

The Manchester parking garage will also be improved, McConville said.

Those attending the state-mandated meeting questioned the network’s ratings and patient surveys, saying more than the current 3 percent should be polled about their stays. Officials said patients could comment on the ECHN Facebook page, and they’d also consider including a □uestionnaire with all discharge paperwork.

As for its ratings, out of a possible five stars the federal Centers for Medicare and Medicaid Services lists Rockville at 3 and Manchester at 2.

Officials say they expect that to go up next fiscal year starting in October, following recent efforts to reduce infection rates, falls, and bedsores, which were below industry norms or non-existent on a recent report.

Both hospitals also recently became certified for advanced stroke care, and are working to reduce re-admissions by focusing on home care and follow-up with discharged patients, said Linda Quirici, Prospect ECHN vice president of □uality and safety.

One resident asked how the current congressional debate on health care would affect patients here, to which Collins responded, “it’s unknown” until budgets are set on both the federal and state level. But he envisions an eventual evolution to block grant payments for patient care under a revised Medicare system.

Prospect’s model of regional, community care also would keep costs down for local patients, he said, noting that large urban hospitals charge much more for the same service.

For example, a colonoscopy at an urban hospital can cost between □5,000 and □6,000 while a community hospital would charge only about □2,000 for the same test, he said.

“It’s really not fair,” for employers or their staff with co-pays, he said, noting that one employee could opt to go into Hartford for the routine exam while another staffer goes to the community hospital for less money, and winds up subsidi□ing the co-worker’s procedure.

And while Manchester won’t be performing brain or heart surgery anytime soon, it does have a robot for minimally invasive surgical procedures like gall bladder removal, knee repairs, or bariatric procedures for weight loss.

Some of that work has been lost to six new surgi-centers that have sprung up in the surrounding area in recent years, Collins said. And unlike ECHN, those facilities aren’t re□uired to care for the poor or Medicaid patients, taking only more lucrative private insurance payers.

“But we still have to keep the machines running and maintain the equipment,” he said.

User, OHCA

From: Roberts, Karen
Sent: Friday, September 29, 2017 10:21 AM
To: User, OHCA
Cc: Cotto, Carmen
Subject: FW: OHCA condition of Participation #19 for ECHN

From: Martone, Kim
Sent: Friday, September 29, 2017 10:20 AM
To: Roberts, Karen <Karen.Roberts@ct.gov>
Subject: FW: OHCA condition of Participation #19 for ECHN

Kimberly R. Martone
Director of Operations, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134
Phone: 860-418-7029 Fax: 860-418-7053
Email: Kimberly.Martone@ct.gov *Website:* www.ct.gov/ohca

From: Colleen Smith [mailto:colleen713.smith@gmail.com]
Sent: Friday, September 29, 2017 10:18 AM
To: Cotto, Carmen
Cc: Martone, Kim
Subject: Re: OHCA condition of Participation #19 for ECHN

Dear Carmen,

I am writing in regards to Docket □15-32016-486. I trust that the letter and affidavit that you received from Dennis McConville at ECHN on 9□14□17 has satisfied your re□uest for more information regarding Condition □19.

I would like to follow up to my □uery of 8□28□17 concerning condition □19. Specifically, i want to verify that the 2 joint Board meetings followed by public community meetings held last spring in April and May on the Rockville and Manchester campuses satisfies the re□uirements of condition □19.
I appreciate your guidance and attention to this matter.

Sincerely,

Colleen O. Smith
Independent Monitor

Colleen O'Brien Smith MSN RN NEA-BC
Nursing Consulting Partners, LLC
690C9 S. Park View Court
Franklin, WI 53132
Phone: 203-245-1044
Cell: 203-671-1348
colleen713.smith@gmail.com
http://nursingconsultingpartners.com/

On Aug 30, 2017, at 4:32 PM, Cotto, Carmen Carmen.Cotto@ct.gov wrote:

Hi Colleen,

We have some additional questions prior to responding to your question in your August 28th email:

In reference to both meetings held at Rockville and Manchester, April 26 and May 3, 2017, respectively, please address the following:

- Supporting documentation related to the meetings, on file at OHCA dated May 1, 2017 and June 12, 2017, stated that a joint meeting of the Boards of Directors from Prospect Rockville Hospital, Inc. and Prospect Manchester Hospital, Inc. was held on April and May at the hospitals' campuses. The documents also indicated that the meetings were followed by a public meeting for their respective communities where information about the hospitals' activities was shared with the public and that they were encouraged to ask questions and provide comments.

  Condition #19 stipulates that *"…PMH shall hold a joint meeting of the Boards of each of New MMH and New RGH and the Local Board of New MMH and New RGH… and such Joint Board Meetings shall be followed by a meeting for the public…".*

  The submitted documents to support the meeting of this condition do not indicate whether the Local Board for each hospital was in attendance at the meetings and the specific timeline for the public meeting. It appears that the Local Board was missing and that the public meeting was held on the same date, Is this correct? Please provide supporting documentation that shows that each hospital's Local Board was in attendance. Also, provide the specific timelines and supporting documentation for public meetings held after both Boards, the hospital's and Local, have met.

It is also requested that you submit your responses via electronic mail by using the OHCA general email inbox which is OHCA@ct.gov. In addition, please continue to reference the CON docket number in the subject line of the email when transmitting.
You may contact me at (860) 418-7039 or Karen Roberts, Principal Health Analyst at (860) 418-7041, if you have any questions regarding this request.

Thank you,

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov

www.ct.gov/dph

From: Colleen Smith [mailto:colleen713.smith@gmail.com]
Sent: Monday, August 28, 2017 5:36 PM
To: Martone, Kim
Cc: Dennis P Mcconville
Subject: OHCA condition of Participation #19 for ECHN

Dear im,

I hope you have enjoyed your summer. They always seem to fly by. I am seeking clarification regarding the COP 19 for ECHN:
CON Condition 19: For three (3) years following the Closing Date, PMH shall hold a joint meeting of the Board of each of new MMH and New RGH and the Local Board of new MMH and New RGH (Joint Board Meetings) at least twice annually with one occurring in Manchester and the other occurring in Vernon.
I want to verify that since two Joint Board meetings have been held, one at RGH on April 26, 2017 and one at MMH on May 31, 2017 that ECHN has meet this re uirement for Joint board meetings followed by public meetings for this year.

I appreciate your assistance in clarifying this re uirement for me.

Best regards,
Colleen Smith
Independent Monitor

Colleen O'Brien Smith MSN RN NEA-BC
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User, OHCA

From: Mcconville, Dennis P <dmcconville@echn.org>
Sent: Monday, October 30, 2017 3:57 PM
To: User, OHCA
Cc: Martone, Kim; Roberts, Karen; Colleen Smith; Ellen J. Shin (ellen.shin@prospectmedical.com); Tichy, Joyce A (Legal Department); Collins, Michael; Garrison DeLee (garrison.delee@prospectmedical.com); Frank.Saidara; Von.Crockett; Basile, Mary C; Veillette, Michael
Subject: RE: 15-32016-486-CON
Attachments: Letter to Yvonne Addo OHCA re DN 15-32016-486-CON 10 30 17 Final. docx.pdf

The attached letter is submitted as required for condition number nineteen (13) and condition number fifteen (15) contained in the Final Decision for Docket Number: 15-32016-486-CON, the Transfer of Assets of Eastern Connecticut Health Network, Inc. to Prospect Medical Holdings, Inc.

Dennis P. McConville
Senior Vice President
Eastern Connecticut Health Network, Inc.
(860) 533-3429 (office)
dmcconville@echn.org

"This message originates from Eastern Connecticut Health Network. The information contained in this message may be privileged and confidential. If you are the intended recipient, you must maintain this message in a secure and confidential manner. If you are not the intended recipient, please notify the sender immediately and destroy this message. Thank you."

Eastern Connecticut Health Network
71 Haynes Street
Manchester, CT 06040
860.533.3414
www.echn.org

October 30, 2017

VIA EMAIL DELIVERY

Deputy Commissioner Yvonne Addo
Office of Health Care Access
Department of Public Health
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134

Re: **Docket Number: 15-32016-486**

Project Title: **Transfer of assets of Eastern Connecticut Health Network, Inc. to Prospect Medical Holdings, Inc.**

Dear Ms. Addo:

This letter is submitted in accordance with the Order for the above referenced Certificate of Need Final Decision, specifically Condition Number Thirteen (13) and Condition Number Fifteen (15) regarding the transfer of assets of Eastern Connecticut Health Network, Inc. (ECHN) to Prospect Medical Holdings, Inc. (PMH).

Condition Thirteen

Condition Number Thirteen (13) requires that "PMH shall maintain community benefit programs and community building activities for New MMH and New RGH for three (3) years after the Closing Date consistent with the MMH and RGH most recent Schedule H of IRS Form 990 or shall provide such other community benefit programs and community building activities that are at least as generous and benevolent to the community as ECHN's current programs, and PMH shall apply a 1% increase per year for the next three (3) years toward community building activities in terms of dollars spent."

For fiscal year 2017, Prospect ECHN maintained the same community benefit activities and community building activities that Legacy ECHN's hospitals had offered the community prior to the acquisition by PMH. Overall, PMH invested $27,361,380 in community benefit activities in fiscal year 2017. This was $317,714 more than the investments made by Legacy ECHN in fiscal year 2016 representing a 1.2% increase.

The dollar amounts of community benefit programs and community building activities for Legacy MMH and Legacy RGH for fiscal year 2016 that were filed with the IRS on Form 990, Schedule H in August 2017 and the amounts for Prospect MMH and Prospect RGH for fiscal year 2017 are included in the following table.

Total Community Benefit - MMH	**Legacy MMH FY 2016**	**Prospect MMH FY 2017**
Financial Assistance at Cost *IRS 990 Schedule H Part I, 7a*	505,744	490,213
Unreimbursed Medicaid Services *IRS 990 Schedule H Part I, 7b*	11,685,254	12,795,199
Other Community Benefits *IRS 990 Schedule H Part I, 7j*	6,300,288	6,522,646
Community Building Activities *IRS 990 Schedule H Part II, 10*	243,695	263,693
Total	**18,734,981**	**20,071,751**

Total Community Benefit - RGH	**Legacy RGH FY 2016**	**Prospect RGH FY 2017**
Financial Assistance at Cost *IRS 990 Schedule H Part I, 7a*	382,466	270,027
Unreimbursed Medicaid Services *IRS 990 Schedule H Part I, 7b*	6,805,720	5,853,317
Other Community Benefits *IRS 990 Schedule H Part I, 7j*	1,104,947	1,148,393
Community Building Activities *IRS 990 Schedule H Part II, 10*	15,552	17,892
Total	**8,308,685**	**7,289,629**

Total Community Benefit	**Legacy ECHN FY 2016**	**Prospect ECHN FY 2017**
Total	**27,043,666**	**27,361,380**

Financial Assistance and Unreimbursed Medicaid Services

Prospect ECHN continues to treat patients regardless of their ability to pay for services and hospital policies regarding charity care have not changed since the transaction closed. The hospitals continue to provide the same level of financial assistance to patients that qualify based on need. The decrease in Financial Assistance at Cost is the result of successful efforts

to enroll patients in the Medicaid program. As a result, the hospitals continue to see an increase in Unreimbursed Medicaid Services.

Community Health Improvement and Health Needs Addressed

Prospect ECHN has continued to invest in providing free health information and education in partnership with the ECHN Medical Staff through a series of lectures offered to the public. Three times each year, the ECHN Community Education Department invites ECHN medical staff and allied health professionals to submit health education programs for presentation to the public. A Community Program Advisory Committee with representation from the medical staff and management considers each request, giving priority to submissions that address identified community health needs. The community health education programs, along with other information on health topics, are published in ECHN's *Better Being* magazine which is distributed to 110,000 households (Exhibit A). The magazine lists special events, health screenings, cancer education & support programs, safety education classes, parent education & playgroup programs and finally the numerous support groups hosted by the hospitals. Its cost for this past year was $96,406.

In 2017, ECHN sponsored twenty-six (26) community programs that served 844 community members. Please see Exhibit B for the ECHN Community Education Program Guidelines and Exhibit C for the list of programs held by ECHN this past year.

Prospect ECHN's community benefit investments and community building activities focused on the health needs identified in its 2016 Community Health Needs Assessment (CHNA) and Implementation Plan. Investments included the time and effort of staff throughout ECHN who contributed to the production of the Community Health Needs Implementation Plan and the meetings held with health officials from the Town of Manchester to review the community health needs and develop strategies that were included in the plan. The following are some examples of the community benefit activities supporting the CHNA Implementation Plan.

Access to Care

Prospect ECHN, through Prospect MMH and Prospect RGH, continues to support the education of healthcare professionals. The goal is to ensure that there is access to care with adequate numbers of healthcare providers to serve the community's healthcare needs. In 2017, the hospitals offered clinical training opportunities for over 900 students of college and university programs. Exhibit D lists the educational institutions that the hospitals have agreements with to provide clinical experiences to students. The amount of community benefit provided by the hospitals for health professions education in 2017 was $3,297,704.

Medical residents of the ECHN Eastern Connecticut Family Medicine Residency Program at Prospect Manchester Hospital volunteered their time and provided free health screenings to the men, women and children living at Squire Village, a 379-unit, newly renovated subsidized housing complex in the town of East Hartford. On Fridays, from 9 a.m. to noon, a resident

physician is available to check blood pressure and body mass index, provide education and flu vaccinations.

Prospect ECHN contracts with Conifer Health Solutions to offer a free physician referral service to the public. The telephone service is posted on the ECHN website and available 24 hours, 7 days a week. In 2016, 135 physician referrals were made to individuals covered by Medicaid.

Cancer Screening

Prospect RGH, at the ECHN Women's Center for Wellness in South Windsor, has continued ECHN's participation with the CT Department of Public Health in the Connecticut Breast and Cervical Cancer Early Detection Program, a comprehensive screening program for medically underserved women. This grant funded program offers free breast and cervical cancer screening, diagnostic and treatment referral services. Thirty women received mammograms and twenty women received pap smear and HPV testing last year at the Women's Center. Prospect RGH provided $111,000 in in-kind support for the program.

Cancer Support and Survivorship

Prospect ECHN employs patient navigators who provide support to cancer survivors, helping them manage symptoms, obtain second opinions, schedule tests and treatment, arrange for homecare services and care coordination. These nurse navigators also support cancer patients with survivorship care plans that include key information for patients' diagnoses, stage of cancer, treatment received and a roadmap for continued follow up care and recommended lifestyle changes to reduce cancer reoccurrence or improve their quality of life. There is no cost to the patients for these services.

On September 10, 2017, Prospect ECHN continued a long-standing ECHN tradition by hosting the 14th Annual Cancer Survivors Day event. The event featured a brunch and a talk by a humorist. It was free to cancer survivors and their families, friends and caregivers. Two hundred and sixty-five (265) people attended the event.

Smoking Cessation

In fiscal year 2017, ECHN patient navigators conducted educational sessions on smoking cessation at the Vernon Middle School, Manchester High School and at a Tolland Chamber of Commerce event. The classes served over 300 people.

Heart Disease & Stroke

In 2017, Prospect MMH and Prospect RGH received advanced certification as primary stroke centers from The Joint Commission as well as recognition for the American Heart Association/American Stroke Association for their commitment and success in the acute treatment of stroke patients. Because a stroke patient loses 1.9 million neurons each minute

stroke treatment is delayed, ECHN developed a campaign to raise awareness, educate the public and improve access to brain-saving treatment available in eastern Connecticut. The campaign included information on how to recognize signs of a stroke and the recording of an educational video on the life-saving treatment that can be administered. The campaign targeted EMS personnel and the general public, appeared in ECHN's Better Being magazine and social media outlets and continues to run throughout ECHN facilities on digital screens and on our website.

Community education programs were offered to promote physical fitness, healthy nutrition and heart health. In January 2017, a physical therapist presented a community education program covering the proper way to begin a total body workout program, which includes stretching, strength and cardio training as well as nutritional advice before and after exercise.

In February 2017, in observance of American Heart Health Month, a special event was held for the public entitled "From the Inside Out" where mini lectures and screenings were offered. An ECHN cardiologist led a discussion on heart health, prevention and healthy lifestyle choices. A registered dietitian presented information on making healthy food choices and ECHN's women's health nurse navigator discussed the importance of caring for the total body, managing stress and nurturing the spirit.

Infant Health & Family Planning

The Prospect ECHN CHNA Implementation Plan includes goals to improve access to prenatal and parenting education, increase preconception and first trimester prenatal education, and to decrease infant mortality and increase infant and child health and wellbeing. Prospect MMH continues to operate the Family Development Center (FDC) programs for families needing support with parenting and with other family issues. These programs are funded by state and federal grants. Prospect MMH continued the same support for the FDC grant funded programs in 2017 with in-kind contributions totally $121,252. Exhibit E describes the Family Development Center Programs.

Mental Health

On January 27, 2017, Prospect MMH hosted a program sponsored by Community Health resources and Garrett Lee Smith Suicide Prevention Community Network of Care for behavioral health professionals on the Columbia-Suicide Severity Rating Scale. There were over 100 attendees.

Substance Abuse

In December 2016, the Manchester Police Department and ECHN began working together to develop a strategy to combat the ever growing issue of heroin/opioid addiction and the devastating effects that it has in our communities. As a result, the H.O.P.E. (Heroin and Opiate Prevention and Education) Initiative was developed. One of the main goals of the

initiative is to provide a safe means for individuals to seek treatment for their addiction without fear of prosecution.

Nutrition, Physical Activity & Weight Management

Some of the benefit activities for this category of health needs included numerous community education lectures were presented in FY 2017 by registered dietitians and physicians on diet/healthy eating. The programs were intended to engage people struggling with obesity, heart disease, arthritis, diabetes and individuals seeking healthy lifestyles. Two grocery store tours were also organized where a registered dietician instructed participants on label reading. Surgical weight loss support groups were held three times a month.

Diabetes

The ECHN Diabetes Self-Management Program is a subsidized health service staffed by diabetes educators, nurses and registered dieticians, who offered individual and group classes, counseling, workshops, screenings and support groups to patients with diabetes. This program served 1,179 patients in fiscal year 2017. The costs not covered by insurance were $203,990.

In addition to the education sessions on nutrition topics and the label reading tours mentioned above, Prospect ECHN hosted community education lectures addressing diabetes with topics that included: “Pre-Diabetes: Let’s take Action” and “Diabetes and the Eye.”

Population Health Management

Prospect MMH and Prospect RGH’s community benefit investments and community building activities have also focused on providing education regarding population health management as PMH builds its model of Coordinated Regional Care. In January 2017, Prospect ECHN hosted the Manchester Community Services Council at MMH where Dr. Joel Reich, ECHN Chief Medical Officer, made a presentation on the state of healthcare in the United States and the reasons for healthcare reform and moving to a model focused on population health. At the meeting, I talked to the Council about ECHN’s population health initiatives. The Manchester Community Services Council is a non-profit organization comprised of agencies devoted to providing and improving health or social services to residents in the greater Manchester area.

In June 2017, Michael Collins, CEO, and I made a presentation to the Vernon Community Network at their Annual Meeting. The Vernon Community Network is a consortium of 40 public education, non-profit, faith-based and government organizations serving the Vernon region. At the meeting, we shared ECHN’s plans for RGH and talked about ECHN’s efforts to address the community’s health needs. We also presented information about healthcare payment reform and the investments that ECHN is making in its care delivery system as the organization moves to population health management.

Community Building Activities

Prospect ECHN has continued to invest in the community/coalition building activities that the public has come to rely on for support from its hospitals. ECHN staff volunteer to serve on boards and committees of local charitable organizations and Chambers of Commerce. In keeping with Manchester Memorial Hospital's long history of support for our veterans, Prospect ECHN hosted an annual dinner for the Manchester Veterans Council and the annual Veterans Day Ceremony at MMH. In addition, this past year, Prospect ECHN, MMH and RGH sponsored local charitable organizations' fundraising events. Those sponsorships are included in Exhibit F.

Condition Fifteen

Condition Number Fifteen (15) states that New MMH and New RGH shall work toward making culturally and linguistically appropriate services available and integrated throughout their hospital operations guided by the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care published by the U.S. Department of Health and Human Services' Office of Minority Health. In addition, New MMH and New RGH shall take reasonable steps to provide meaningful access to each individual with limited English proficiency eligible to be served in accordance with the regulations of Section1557 of the Patient Protection and Affordable Care Act. Finally, New MMH and New RGH shall provide insurance navigator services for patients and, where appropriate, English as a second language and cultural competency training for employees.

Prospect MMH and Prospect RGH are committed to making culturally and linguistically appropriate services available and integrated throughout the organization, providing meaningful access to individuals with limited English proficiency, providing insurance navigator services and providing cultural competency training for all employees.

ECHN has Corporate Administrative Policies in place to ensure persons with limited English proficiency and persons requiring auxiliary aids and services have access to the healthcare services available at the hospitals and throughout the organization. They include:

Policy #205: Nondiscrimination – Auxiliary Aids and Services (Exhibit G)
Policy #206: Nondiscrimination – Language Assistance to Persons with Limited English Proficiency (Exhibit H)

These policies are available online for all employees. The hospitals offer access to auxiliary communication aids and services, including alternative formats and sign language interpreters, for individuals with disabilities. Information about these services is posted throughout the hospitals.

Also posted throughout the hospitals is a notice of consumer rights, providing information about communication assistance, with tag lines posted in the top 15 languages spoken by individuals with limited English proficiency, indicating the availability of such assistance.

As of September 2016, Prospect MMH and Prospect RGH have partnered with iTi Translation Services to provide timely services to our patients with a wide variety of language needs. These services include:

1. In-Person Interpreters/Translators
2. Video Remote Interpreting (VRI)
3. Telephonic Interpreting for Individuals with Limited English Proficiency
4. Written Document Translation

All of these services are provided at no cost to our patients. All staff is educated annually on these policies and procedures and the services are used without hesitation to serve the needs of our patients. Video Remote Interpreting (VRI) equipment is available for use throughout the organization.

Additionally, Prospect MMH and Prospect RGH provide insurance navigation services for uninsured patients who are identified as eligible for Medicaid or have the financial ability to purchase health insurance. The Financial Assistance Policy and Procedure describes the services provided (Exhibit I). The policy is available on the ECHN website. Specifically, Section A.e. of the policy states that "uninsured patients who may meet the State of CT Department of Social Services guidelines for Medicaid eligibility will be provided assistance in determining their eligibility as well as assisting with obtaining eligibility." ECHN contracts with MedData to make a Medicaid Eligibility counselor available Monday through Friday during normal business hours to assist patients with determining eligibility and the application process. This counselor is located at MMH and travels to RGH as needed. In Fiscal Year 2017, Prospect MMH and Prospect RGH assisted 1,715 people to enroll in the Medicaid program at a cost to the hospitals of $243,938.

Section A.f. of the policy provides that "uninsured patients who are believed to have the financial ability to purchase health insurance may be encouraged to do so in order to ensure healthcare accessibility and overall well-being." A full-time Financial Counselor is employed by the hospitals to assist eligible patients in obtaining health insurance. In fiscal year 2017, Prospect MMH and Prospect RGH assisted 567 patients in applying for and receiving financial assistance under ECHN's Financial Assistance Policy.

Prospect MMH and Prospect RGH's commitment to enhancing cultural awareness and embracing diversity is evident through numerous employee education initiatives including:

- New Employee Orientation: Diversity training is included with general information about culture, belief systems and cultural responsiveness with case studies for discussion.
- Annual Mandatory Education: This requirement of all employees includes a review of the patient experience, the organization's mission and core values, and a review of services and equipment available for patients and families who are visually impaired, deaf or hearing impaired, speech impaired or with limited English proficiency. The

Corporate Administrative Policies referenced above, policies #205 and #206 are included in the annual education.

- Additional Education: Prospect MMH and Prospect RGH use the HealthStream Online Learning Center for staff to complete various education modules throughout the year. Topics such as "Providing Culturally Competent Care" and "Diversity in the Workplace" are included in this mandatory education.

This report is posted on the ECHN website at http://www.echn.org/community-benefit-reporting. If you have any questions or need anything further, please feel free to contact me at (860) 533-3429.

Very truly yours,



Dennis P. McConville
Senior Vice President
Eastern Connecticut Health Network

Enclosures: Exhibit A – ECHN Better Being, Summer 2017
Exhibit B – ECHN Community Education Program Guidelines
Exhibit C – ECHN 2017 Community Education Programs
Exhibit D – ECHN Student Education Affiliations
Exhibit E – Prospect MMH Family Development Center Programs
Exhibit F – Fiscal Year 2017 Prospect ECHN, MMH & RGH Sponsorships
Exhibit G – ECHN Corporate Administrative Policy #205: Nondiscrimination - Auxiliary Aids and Services
Exhibit H – ECHN Corporate Administrative Policy #206: Nondiscrimination – Language Assistance to Persons with Limited English Proficiency
Exhibit I – ECHN Financial Assistance Policy and Procedure

cc: Kimberly Martone, Director of Operations, Department of Public Health Division of Office of Health Care Access
Colleen Smith, Nursing Consultant Partners, LLC
Ellen J. Shin, General Counsel, Prospect Medical Holdings, Inc.
Joyce A. Tichy, Senior Vice President and General Counsel, ECHN
Michael Collins, CEO, ECHN
Von Crocket, Senior Vice President, Corporate Development, Prospect Medical Holdings, Inc.

Frank Saidara, Vice President, Corporate Development, Prospect Medical Holdings, Inc.
Garrison De Lee, Assistant General Counsel, Prospect Medical Holdings, Inc.

Exhibit A

Better Being

SUMMER 2017

Ways to a better you from Eastern Connecticut Health Network

east of ordinary



ECHN℠
Eastern Connecticut Health Network

community health education programs inside

East of Ordinary

welcome

You may think it isn't ordinary for community hospitals to have the same technology and resources as big city hospitals. But at ECHN, some of the brightest healthcare advances are right here in eastern Connecticut. Robotic-assisted minimally invasive surgeries, exceptional cancer services and advanced stroke care are just down the road from where you live. At ECHN you will always have access to board-certified physicians and skilled clinicians, our renowned family birthing center and comprehensive emergency care whenever you need us.

ECHN may be a community healthcare system but don't be fooled by the "community" label. We may be small town, but we're not small thinking. We're proud to provide care that is not just east of the river, it's east of ordinary.

We hope you are enjoying an extraordinary summer and find some time to attend some of our community programs and classes. We look forward to seeing you!

Special Event 3

Health Screenings 4

Health Education Programs & Lectures 4

Cancer Education & Support 7

Safety Education Classes 9

Parent Education & Playgroup Programs 9

Support Groups 14

Registration Form 15

community health education programs

special event

save the date to celebrate survivorship





Save the date for ECHN's 14th Annual Cancer Survivors Day event – A Celebration of Life. Cancer survivors and the families, friends and caregivers who supported the fight every step of the way are invited to join us for an afternoon of laughter. Our keynote speaker, author and humorist, Gina Barreca, will present "Generosity, Comfort, and Spirit: Why We Need Humor Every Day."

"Humor allows us to have new perspectives on moments of our lives that are otherwise lost to sadness, fear or misery. Laughing with someone is as close as you can get to them without giving them a hug, and sometimes it can make a hug even better."

- Gina Barreca

This free event will also feature a buffet brunch and giveaways. Pre-registration is required.

Date: **Sunday, September 10**

Time: **11 a.m.–1 p.m. Check-in starts at 10:30 a.m.**

Site: **Hartford/Windsor Marriott**
28 Day Hill Road, Windsor

Free / Registration opens August 1. See page 15 to register.

health screenings

Lung Cancer Screening

If you are a current or former smoker who has quit within the last 15 years, who has smoked at least one pack a day for 30 years or two packs a day for 15 years and are between age 55 and 80 (for those on Medicare between age 55 and 77) with no personal history of lung cancer, call oncology nurse navigator Leslie Juliani, RN, BSN, OCN, at 860.646.1222, ext. 1406.

Free Mammograms, Pap Test & Heart Disease Screenings

Available to women who are between ages 30-64 who have limited income, no health insurance, health insurance that excludes routine Pap tests and/or mammograms or have a high insurance deductible ($1,000 or more).

To see if you quality for these free services offered at various ECHN locations, please call the ECHN Early Detection Program, at 860.872.5368.



health education programs & lectures

Nerve Pain & Neuropathy: Causes, Symptoms and Treatment Options

Symptoms of nerve pain can range from prickling or tingling to a chronic burning sensation and can interfere with your daily life. Neuromusculoskeletal medicine specialist Michael Waddington, DO, will discuss the common types of neuropathy, causes and conventional and alternative treatment options.

Date: Tuesday, June 6
Time: 11 a.m.-noon
Site: Manchester Memorial Hospital

Free / See page 15 to register.

Label Reading in Real Life: A Visit to the Grocery Store

Join ECHN's registered dietitian Amy Rapone, RD, CDN, for an informative tour through the grocery store discussing healthy food choices and label reading aisle by aisle.

Date: Wednesday, June 7
Time: 5-6 p.m.
Site: Highland Park Market 317 Highland Street, Manchester

Free / See page 15 to register.

Stand Up to Hip & Knee Pain

Say goodbye to hip and knee pain and say hello to life! Come learn about MAKOplasty, a new robotic-assisted hip and knee replacement technology at ECHN that can help you recover faster, feel less pain and improve your mobility. Presented by orthopedic surgeon Vipul Dua, MD.

Date: Wednesday, June 14
Time: 6-7:30 p.m.
Site: Manchester Memorial Hospital

Free / See page 15 to register.



Preparing for Your Doctor's Appointment

Healthcare is ever-changing. Family medicine doctor Sabesan Karuppiah, MD, will discuss what to bring to your appointment, useful information including online resources and strategies to make the most of the time with your doctor to ensure you get the best possible care.

Date: Tuesday, July 11
Time: 11 a.m.-noon
Site: Manchester Memorial Hospital

Free / See page 15 to register.

health education programs continued on page 6

when the doctor will see you





Saby Karuppiah, MD, MPH

Getting an appointment to see a doctor can sometimes feel as challenging as getting tickets to a hot Broadway show. The first available appointment may be weeks away and not always at a time that is convenient for you. So when you do get time with a provider, it's important to make the most of your visit.

The reported average length of time a provider spends with a patient is just 15 minutes. In this short period of time, the provider needs to gather information about what brought the patient in, perform any necessary exams or evaluation, make a diagnosis and provide treatment, such as a referral or prescription.

"The number one recommendation I would give to patients is to come prepared," says family physician Saby Karuppiah, MD, MPH. "The staff is going to ask if there are any changes to things like your insurance information, medical history and the medications you're taking. Have that information organized, in written form if necessary. Better yet, bring your medications with you."

When you are with the doctor, it's best to be efficient with your time. "Be prepared to concisely and honestly explain what the issue is, when your symptoms started, how you've tried to manage them and for how long," explains Dr. Karuppiah. This will help your doctor make an accurate diagnosis and informed recommendation for next steps.

"Clear communication is key," says Dr. Karuppiah; "Never hesitate to ask for clarification about what your doctor has told you. When in doubt, ask. We are here to help you."

Dr. Karuppiah is an ECHN provider now seeing patients in the new Manchester Family Physicians practice located at 29 Haynes Street, right next to Manchester Memorial Hospital. The practice, including providers Tricia Hall, DO, and Katarzyna Pomianowski, MD, welcomes new patients of all ages, Monday through Friday 8 a.m. to 4 p.m. Most insurances accepted. To schedule an appointment, please call 860.533.4678.

fast stats from the cdc

Nearly 84% of adults have contact with a healthcare professional each year.

More than 53% of visits are made to primary care physicians (PCPs).

The most commonly diagnosed condition: **hypertension**

Coughs are the most common illness-related reason for office visits.

**source https://www.cdc.gov/nchs/fastats/physician-visits.htm*

Feeling Dizzy? It Could Be Vertigo

Do you get the sensation that everything is spinning or moving around you? It may be vertigo. Physical therapists Gina Koudelka, DPT, LSVT, Priscilla Kowal, PT and Stephanie Torchia, DPT, will explain what vertigo is and its effect on your daily functions. Treatment and long-term management options will also be discussed.

Date: Tuesday, July 18
Time: 6-7:30 p.m.
Site: ECHN Community Education Room, 2600 Tamarack Avenue, South Windsor

Free / See page 15 to register.



A Healthy Start For Your Baby's Body, Brain & Behavior

Early nutrition is essential for your baby's developing brain and body. Neuromusculoskeletal medicine specialist, Michael Waddington, DO, will discuss ways to help your baby sleep through the night, prevention and natural treatment for common problems such as colic, reflux and ear infections.

Date: Tuesday, July 25
Time: 11 a.m.-noon
Site: Manchester Memorial Hospital

Free / See page 15 to register.



Options in Spine Care

Orthopedic surgeon Jesse Eisler, MD, PhD, will discuss the complex anatomy of the back as well as proper exercises and habits to maintain a healthy spine. Operative and non-operative treatment options will also be discussed.

Date: Thursday, August 3
Time: 6-7:30 p.m.
Site: ECHN Community Education Room, 2600 Tamarack Avenue, South Windsor

Free / See page 15 to register.

Acupuncture 101

Have you ever wondered if acupuncture could help you with conditions such as arthritis, pain, side effects of cancer or anxiety? Want to learn how it's administered? Join licensed acupuncturist Heather Finn, LAc to get your questions answered. Interested participants will have the opportunity to experience an acupuncture needle insertion.

Date: Thursday, August 17
Time: 6-7:30 p.m.
Site: ECHN Community Education Room, 2600 Tamarack Avenue, South Windsor

Free / See page 15 to register.

Pre-Diabetes: Let's Take Action!

Learn how to incorporate healthy lifestyle changes to help prevent or delay the onset of diabetes. Diabetes educator Nina Milone, RD, CDE, CDN, will explain goal setting, risk factors and diagnosis.

Date: Wednesday, Aug. 30
Time: 11 a.m.-noon
Site: Manchester Memorial Hospital

Free / See page 15 to register.



ECHN's Joint Effort Program

For individuals scheduled to have total or partial hip or knee replacement surgery and for those thinking about having this type of surgery. ECHN staff will explain, step by step, the surgery day procedures, recovery care options, pain management and the rehabilitation process. Individuals who will be assisting a loved one's recovery after surgery are encouraged to attend.

Dates: Tuesdays, June 13, July 11 or August 8
Time: 1-3 p.m.
Site: Manchester Memorial Hospital

Dates: Wednesdays, June 28, July 26 or August 23
Time: 1-3 p.m.
Site: Manchester Memorial Hospital

Free / See page 15 to register.





ECHN Center for Weight Loss Information Sessions

These free group sessions, which are offered twice a month, are the best way to learn more about surgical weight loss at ECHN. You'll meet bariatric surgeon Mark Tousignant, MD, get answers to your questions and find out if it's right for you.

For more information and to register, call 860.533.4692 or visit echn.org/weightloss.

Heart Talk

Education for people living with heart failure. Learn how to proactively manage heart disease and improve quality of life. Caregivers and family members are encouraged to attend as well.

Date: Third Thursday of each month
Time: 2-4 p.m.
Site: ASM Conference Room, 275 New State Road, Manchester

cancer education & support

Look Good...Feel Better

For women coping with appearance related effects of cancer treatment. Free cosmetic kits provided. Offered in partnership with the American Cancer Society.

Dates: Second Tuesday of each month
Time: 10:30 a.m.-12:30 p.m.
Site: John A. DeQuattro Cancer Center

Free / Call 1.800.227.2345 to register.



Fit for the Journey

For people living with a current or past cancer diagnosis who would like to improve their fitness. Individually designed exercise program, which may include strength/weight training, cardiovascular, balance or flexibility exercises which are held in a small group setting.

Dates: Assessments by appointment only; classes held Tuesday and Thursday afternoons
Site: Manchester Memorial Hospital

Call Mary Pesce at 860.647.6485 for more information regarding fee schedule and to register.

a new look at colonoscopy

East of Ordinary

If you're age 50 or older your doctor has likely talked to you about getting a colonoscopy, the procedure often used to screen for cancer or precancerous growths in the colon or rectum, known as polyps.

It's an important discussion since, according to the American Cancer Society, colorectal cancer is the third most common cancer diagnosed in men and women in the U.S. It is the third leading cause of cancer-related deaths in women and second leading cause in men. But, with regular colon screening, cancers are being found earlier when the disease is easier to treat.[1]



With a standard colonoscopy, a mild sedative is often administered to the patient before the procedure to help promote relaxation and comfort. For patients who do not want or cannot tolerate sedation, there is virtual colonoscopy.

"Virtual colonoscopy is a safe, effective and minimally invasive imaging scan, rather than an endoscopic procedure," explains colon and rectal surgeon Amanda Ayers, MD. A computed tomography (CT) scan produces three-dimensional images of the colon that a radiologist examines for signs of cancer and precancerous polyps. The procedure generally takes about 10 minutes and does not require sedation. If nothing abnormal is found, the screening should be repeated every five years.

"Virtual colonoscopy is ideal for people who have average risk factors for colorectal cancer and are afraid of sedation or who are shying away from the standard colonoscopy procedure altogether," says Dr. Ayers. "It's important to be screened. Virtual colonoscopy makes it easy."

Virtual Colonoscopy is now performed at Manchester Memorial Hospital.

Accredited by the American College of Radiology. Learn more at acr.org/VirtualCT. Talk to your doctor about scheduling your virtual colonoscopy today.

[1] *https://www.cancer.org/cancer/colon-rectal-cancer/about/key-statistics.html*

safety education classes

AARP Driver Safety

A one-day classroom refresher course offered by AARP for individuals age 50 and older. No memorization of laws or tests.

Date: Tuesday, June 6
Time: 12:30-4:30 p.m.
Site: Manchester Memorial Hospital

Date: Tuesday, July 18
Time: 12:30-4:30 p.m.
Site: Rockville General Hospital Boardroom

$20 paid at class / $15 for AARP members. Call 860.533.6550 to register.





Infant, Child & Adult CPR Skills for Parents & Child Care Providers

This is the American Heart Association's Friends and Family CPR program. It imparts the lifesaving skills of both CPR and relief of choking for infants, children and adults. A registered nurse, who is also a certified CPR educator, teaches the course.

Dates: Mondays, July 10 or August 7
Time: 6-9:30 p.m.
Site: Manchester Memorial Hospital

$40 / Call 860.647.4790 to register.

First Aid for Parents & Child Care Providers

This four-hour course, taught by a registered nurse, covers uses of a first aid kit, handling of emergencies, and management of infectious diseases. When taken with "Infant, Child & Adult CPR for Parents and Child Care Providers," it meets Connecticut requirements for home daycare providers.

Date: Mondays, June 12 or August 14
Time: 6-10 p.m.
Site: Manchester Memorial Hospital

$35 / Call 860.647.4790 to register.

parent education & playgroup programs



Pregnant & Uninsured or Underinsured?

The Maternity Care Center at Rockville General Hospital offers complete prenatal and postpartum care to women on any state medical insurance plan, or who are uninsured or underinsured. Our full service group prenatal care model, "Family Circles" provides information on healthy pregnancy and prepares families for labor and birth at The Family Birthing Center at Manchester Memorial Hospital. Access to ultrasound, laboratory services and other prenatal testing provided as well as assistance enrolling in Husky plans.

Monday, Wednesday or Friday, between 9 a.m. and 4 p.m.

Call 860.872.5170.



Family Circles Program

The ECHN Maternity Care Center's Family Circles program provides group prenatal care to eight to 12 women, who are all due to give birth within eight weeks of each other. The group meets every other week to receive prenatal care and assessment from a healthcare professional, education/parenting skill development and nurturing support from women who are experiencing similar physiological and psychological changes. The classes are visual and interactive. A snack and small gift is provided at each class.

For more information, call 60.872.5170.

Childbirth Education Classes

All classes held at Manchester Memorial Hospital unless otherwise indicated.

For more information and to register, visit echn.org/calendar or call 860.647.4790.

Prepared Childbirth – Basic Five-Week Series

Learn the essentials for labor and birth, breastfeeding, and baby care in five weeks.

Mondays, 6-8:30 p.m.,
June 26-July 24;
August 28-October 2
(no class September 4)

Tuesdays, 6-8:30 p.m.
June 6-July 11 (no class July 4)
August 8-September 5

Wednesdays, 6-8:30 p.m.
July 12-August 9

$125 per couple; $140 Advanced Package Deal (includes Advanced Comfort Skills for Labor and hospital tour).



Prepared Childbirth Weekend No-Frills Option

Learn the essentials for labor and birth in one weekend.

Friday 6-9 p.m. & Saturday 10 a.m.-3 p.m.
June 16 & 17; July 28 & 29

$90 per couple; $125.00 per couple for Package Deal (includes Preparation for Labor & Delivery, Breastfeeding and Baby Care); $140.00 per couple for Advanced Package Deal (includes Package Deal above plus Advanced Comfort Skills for Labor and hospital tour).

Advanced Comfort Skills for Labor & Tour

Interactive class for parents who have completed the Basic Five-Week Series, Weekend No-Frills Option, Understanding Birth eClass or have had a baby before and want to learn more advanced comfort skills for labor.

Mondays, 5:30-8 p.m.,
June 12 or August 7

Tuesdays, 5:30-8 p.m., July 25

Wednesday, 5:30-8 p.m.,
July 5 or August 30

Tour is optional. $25 per couple.

Baby Care Class

Learn how to get through the first few weeks with a newborn. Hands-on instruction for diapering, swaddling and much more.

Thursday, 6-9 p.m., July 20

$30 per couple.



Breastfeeding Class

Get off to a good start with breastfeeding and learn what to expect in the first few weeks.

Thursdays, 6-8:30 p.m, June 29 or August 3

$35 per couple.

HypnoBirthing: The Mongan Method

Learn self-hypnosis, deep relaxation, simple breathing and visualization to release fear and achieve a calm, peaceful birth.

Tuesdays 6:30 p.m.-9 p.m., July 11-August 8

$250 per couple.

Prepared Childbirth Package Deals are also available. Visit our website: echn.org/classes for more information.





Just for You Sibling Class

Interactive class for children ages two through 10 who will soon have a newborn in the house. Includes a kid-friendly tour of the Family Birthing Center.

Thursday, 6-7 p.m., June 15 or July 27

$12 per child / $25 for families with 3 or more children.

Expectant Grandparent Class

Learn what is new with birthing practices, baby care, infant feeding and safety plus practical tips on how to best support the new family.

Thursdays, 6-8:30 p.m. June 22 or August 10

$15 per person.

Fit For Delivery

This ongoing prenatal exercise class helps moms feel better during pregnancy with improved muscle tone, energy, posture and so much more. Designed for all fitness levels.

Date: ***Every Tuesday & Thursday***
Time: ***6:30-7:30 p.m.***
Site: ***Community Y Manchester***

Fit After Delivery

A postpartum exercise class designed for mom and baby (age four weeks to crawling). Specially designed to help mom recover from pregnancy and birth at her own pace.

Fridays, 11:00 a.m.-noon June 2-June 23; July 7-July 28; August 11-September 8 (no class September 1)

$28 per 4-week session.



The following programs are offered through ECHN's Family Development Center. Trained staff will assist with placement in the appropriate program that best meets your needs.

"Parent as Teachers (PAT)" The PAT curriculum used in programs is a nationally recognized parent education and family support program serving families throughout pregnancy until their child enters kindergarten. The PAT program includes monthly one-on-one personal visits in your home with a certified PAT Parent Educator. Also included are regular screenings for your child to assess their overall development, information on parent workshops and information on resources in your community.



Early Head Start

Home visiting and play group opportunities. Offers child development, developmental screening, parent education, health, dental, disabilities and behavioral health services for prenatal women and children ages newborn to three.



Family Resource Centers *(Vernon & Manchester)*

Home visiting, parent-child playgroups, positive youth development, parenting education, developmental screening, support for family child care providers, resource and referral, links to adult education, preschool and after-school care.

Nurturing Connections

Supportive telephone calls by trained volunteers for first-time parents.

Nurturing Families Network

Free, federally funded program provides home visiting, parenting education, parent-child group experiences, and special services for dads/male partners. It is available to pregnant moms and their partners.

Parenting Support Services

Free, funded through the Department of Children and Families to provide focused, home visiting services to families around quality relationship building and/or parenting support for challenging behaviors.

The Positive Parenting Program curriculum and the internationally recognized Circle of Security program are used for support.

For more information on Family Development Center programs, call 860.432.5278 ext. 125.

The following playgroup programs are offered by ECHN's Vernon Family Resource Center. Included in your registration for these programs is a personal visit with a certified Parent Educator and a free developmental screening for your child.





Storybooks and Creations

Join us for a special story hour for your two- to four-year-old. "Mrs. Z," the children's librarian, will read stories that both children and adults love, followed by activities that make the stories come alive!

Date: *The first 3 Wednesdays of each month*
Time: *10:30-11:30 a.m.*
Site: *Rockville Public Library, 52 Union Street, Vernon*

Free / Call 860.335.6954 to register.

The following programs are offered at ECHN's Manchester Family Resource Center.

Play and Learn Together

This educational playgroup is for children birth through five years old. Learning activities are provided for parents and children to do together. They include art projects, story time, singing and educational toys. Snack is included.

Busy Bees
(Ages newborn-2 yrs old)

Dates: *June 7, 14, 26 & 28*
July 10, 12, 26 & 31
Aug. 2, 7, 9, 14, 16, 21, 23
Time: *10-11 a.m.*
Site: *Washington Elementary School, 94 Cedar Street, Manchester*

Free / Call 860.647.3330 to register.



Busy Bees
(Ages 3-5 years old)

Dates: *June 8, 15, 27 & 29*
July 18, 25 & 27
August 1, 3, 8, 10, 15, 17, 22, 24
(Call to confirm if class is being held on July 22 and August 22)
Time: *10-11 a.m.*
Site: *Washington Elementary School, 94 Cedar Street, Manchester*

Free / Call 860.647.3330 to register.



Welcoming My Baby

This eight-week group will help prepare expectant mothers to welcome their babies. Topics will include healthy pregnancy, healthy eating, baby development, preparing for the big day and care after birth. Snack is included.

Date: *June 15, 22 & 29; July 6 & 13*
Time: *10:30 a.m.-noon*
Site: *Babies R Us, 169 Hale Road, Manchester*

Free / Call 860.432.5278, ext. 122 to register.



support groups

Al-Anon

For families and friends of alcoholics.

Saturdays, 10-11:45 a.m.

Manchester Memorial Hospital

Alcoholics Anonymous

Sundays, 7:30-8:30 p.m.
Tuesdays, 5:30-6:30 p.m.

Manchester Memorial Hospital

Alzheimer's Support Group

Third Wednesday of each month, 9:30-11:30 a.m.

Visiting Nurse & Health Services of Connecticut

Call 860.872.9163, ext. 8346 to register.

ECHN Center for Weight Loss Bariatric Wellness Group

Support group meetings for pre- and postoperative weight loss surgical patients.

Call 860.533.4692 for more information and to register.

Bereavement & Grief Support Group

Every Monday

Visiting Nurse & Health Services of Connecticut

Call 860.872.9163, ext. 8425 for meeting times. Pre-registration required.

Brain Injury Alliance of CT Support Group

First Thursday of each month, 6-7 p.m.

Manchester Memorial Hospital

Call 860.219.0291, ext. 302 for information.

Breast Cancer Network of Strength

Twice each month on Mondays (excluding holidays), 5:30-7 p.m.

John A. DeQuattro Cancer Center

Call 860.875.2768 for more info.

Caregiver Support Group

First and third Thursday of each month, 10-11:30 a.m.

Visiting Nurse & Health Services of Connecticut

Call 860.872.9163, ext. 8611. Pre-registration required.

Charcot-Marie-Tooth Support Group

Manchester Memorial Hospital

Call 239.682.6785 for meeting schedule.

Diabetes Support Group: Sweet Talk

Third Tuesday of each month, 11 a.m.-noon

Manchester Memorial Hospital

Call Marie at 860.569.6436 for information.

ECHN Prostate Cancer Support Group

Second Wednesday of each month, 7-8:30 p.m.

John A. DeQuattro Cancer Center

Call 860.646.8168 for information.

Family Support Night

For families who are dealing with behavioral health or addiction issues.

Fourth Tuesday of each month, 6-7 p.m.

150 North Main Street, Manchester, CT

Call 860.533.3434, ext. 3818 for information.

La Leche League

Third Wednesday of each month, 6-8 p.m.

Manchester Memorial Hospital

Narcotics Anonymous

Wednesdays, 7-9 p.m.
Fridays, 7-10 p.m.

Manchester Memorial Hospital

Not So Typical Autism Support Group

Second Monday of each month, 6:30-8 p.m.

Manchester Memorial Hospital

Ostomy Support Group

First Tuesday of each month, 7-8:30 p.m.

Visiting Nurse & Health Services of Connecticut

Call 860.872.9163, ext. 8388 to register.

Overeaters Anonymous

Saturdays, 10-noon
Sundays, 10-noon

Rockville General Hospital Boardroom

Call 860.533.6550 for additional information on any of the support groups listed.

registration is easy!

Please register for programs using one of the following options:

ONLINE: Visit **echn.org/calendar** for convenient 24-hour online registration for many programs.

PHONE: Call **860.533.6550** Monday through Friday, 8 a.m.-4 p.m. After hours, please leave a message and we will return your call the next business day.

MAIL: Please complete this registration form and mail it to:

ECHN Community Education Department
71 Haynes Street
Manchester, CT 06040

FAX: Complete this registration form and fax it to **860.647.6415**.

Please print. Photocopy this form for multiple registrants.

Name:

Address:

City:

State: Zip:

Day Phone:

Evening Phone:

Email Address:

Name of Program	Site	Date / Time

Do you have any special needs or disabilities for which you will need assistance?

Notice of Nondiscrimination and Accessibility Policies
Discrimination is Against the Law

Eastern Connecticut Health Network (ECHN) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ECHN does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

ECHN:

- ***Provides free aids and services to people with disabilities to communicate effectively with us, such as:***
  - » ***Qualified sign language interpreters***
  - » ***Written information in other formats***
- ***Provides free language services to people whose primary language is not English, such as:***
  - » ***Qualified interpreters***
  - » ***Information written in other languages***

If you need these services, contact ECHN's Civil Rights Coordinator.

If you believe that ECHN has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Patient Non-Discrimination Coordinator
71 Haynes Street, Manchester, CT 06040
860.646.1222 or CivilRights@echn.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, ECHN's Civil Right Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Dept. of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1.800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Eastern Connecticut Health Network

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Manchester, CT 06040

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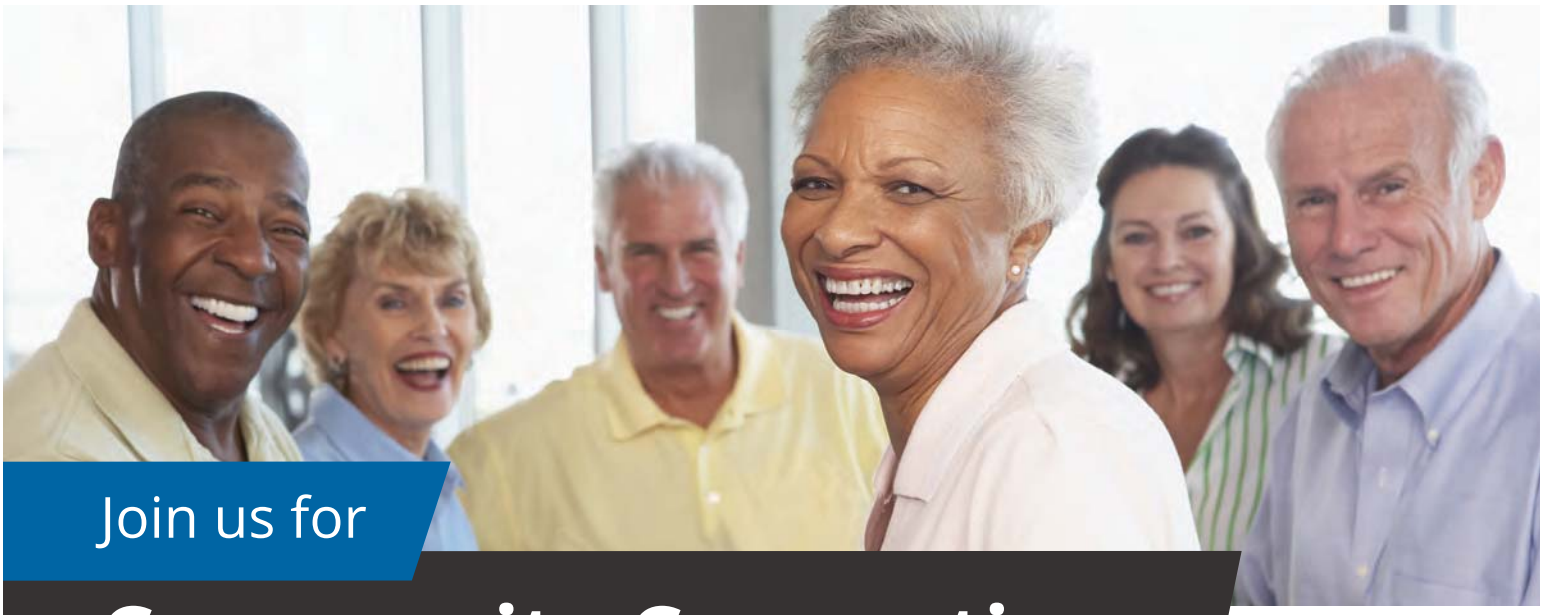
- Manchester Memorial Hospital
- Rockville General Hospital
- Woodlake at Tolland
- John A. DeQuattro Cancer Center, home of the Eastern Connecticut Cancer Institute
- Eastern Connecticut Medical Professionals
- Visiting Nurse & Health Services of CT
- and more



Join us for

Community Connection

Get together with fellow community members and learn about exciting new programs happening at ECHN.

This will be a wonderful opportunity to connect with your neighbors while enjoying complimentary coffee and other refreshments.

Registration is appreciated.
Please call 860.647.6841 or email athompson@echn.org

When: **Fourth Wednesday of each month**
11:00 a.m. - noon

Where: **John A. DeQuattro Cancer Center**
100 Haynes Street
Manchester

echn.org

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Exhibit B

ECHN Community Health Education
Programming Guidelines

OVERVIEW
ECHN has a commitment to improving community health and wellness beyond the patient care that is provided within its facilities' walls.

Community health education programming is an important part of ECHN's community benefit efforts. Free or reduced-cost health screenings to underserved populations (i.e. those who are uninsured/underinsured, medically disabled, chronically ill, indigent, elderly, etc.) and free educational presentations and workshops that promote awareness and prevention of health concerns are examples of qualified community education programs.

To help ensure programming meets the requirements of community benefit standards, an ECHN Community Program Advisory Committee has been established. The following guidelines have been developed in consultation with the Committee and its members are involved with the selection of the education programs to be presented.

SOLICITATION & SUBMISSION PROCEDURE
All ECHN employees and members of the medical staff are welcome to submit a request to present a community education program or screening.

By submitting a Request to Present form, a presenter understands that he/she is acting as an educational representative of the ECHN organization.

Three times per year, the ECHN Community Education department places a call for submissions to all members of the ECHN Active Medical Staff and ECHN Groups 1-5 via email, fax or mail.

Submissions are requested in February for programs that will take place May - August, in June for programs that will take place September - December, and in October for programs that will take place January - April.

The Request to Present form must be completed in its entirety and submitted to the Community Education department. Incomplete submissions will be returned.

For planning purposes, submissions will not be accepted if received past the deadline stated on the Request to Present form.

SELECTION OF PROGRAMS
All completed Requests to Present will be brought before the ECHN Community Program Advisory Committee. The Committee will select the programs to be presented based on the following conditions:

- Top consideration is given to submissions that address an identified community health need(s).
- A maximum of twelve (12) unique programs will be scheduled per four-month session.

SCHEDULING
Once a program is selected for presentation, staff from the ECHN Community Education department will contact the presenter to coordinate scheduling and other logistics including presentation date, time, location, and equipment needs. Presenters of programs not selected for presentation will also be notified.

Exhibit B

PROMOTION

All scheduled programs will receive the following promotional support:

- Listing in ECHN's community magazine, *Better Being*, which is distributed to over 150,000 households in the ECHN service area
- Posting on the ECHN website (echn.org)
- Listing in ECHN's monthly community calendar print ad in local newspapers (programs that are nearing maximum enrollment may not be advertised)

REGISTRATION

The community must register for all programs via the ECHN website, mail or ECHN's community program registration line (860.533.6550).

The Community Education department reserves the right to cancel a program if fewer than ten people have registered for a program the day before the program is scheduled to be presented. If ten or more people are registered the day before a program, the presenter is expected to move forward with the presentation.

PRESENTATION REQUIREMENTS

Presenters must have a professional headshot photograph to be used in promotional efforts. If one is not on file with ECHN, the presenter must make arrangements to have his/her photograph taken with ECHN's photographer. All costs will be covered by ECHN.

If presenting a PowerPoint presentation, it must be e-mailed to the Community Benefit department the day before the scheduled presentation.

A presenter is expected to begin and end his/her presentation as scheduled. Presenters who, on more than one occasion, do not present their program as scheduled (for reasons other than weather-related) will not be selected as a presenter for a period of one year.

Presenters who need to cancel a presentation, due to unforeseen circumstances, may resubmit their program to the Community Program Advisory Committee to be considered for presentation during a future session. Rescheduling, for reasons other than weather-related, during the same session is not permitted.

Failure to comply with the above requirements may jeopardize eligibility to present future presentations.

Attendees will be asked to complete a short evaluation of the presenter and program content. All feedback received will be shared with the presenter as well as the ECHN Community Program Advisory Committee.

QUESTIONS

Questions regarding these guidelines should be directed to Community Education Program Coordinator, Karen Charry, who can be reached via phone at 860.646.1222, extension 2292, or via email at kcharry@echn.org. All questions will be brought before the ECHN Community Program Advisory Committee.

Revised 10/17/16

Exhibit C

FY20 17 ECHN Community Health Education Programs

Date	Program Title	Presenter	Attendance
10/6/2016	Fall Prevention and Balance	Victoria DePietro, DPT and Gina Koudelka, DPT	55
10/17/2016	The Ins and Outs of Hearing Aids	Valerie Knorr, AuD and Jeanne Evenson, AuD	52
10/24/2016	Shoulder Pain & Arthroscopic Rotator Cuff Repair	Daniel Veltri, MD	39
10/25/2016	Lunch & Conversation: Breast Health Screening	Julie Gershon, MD and Donna Cameron, BS, RN, CBCN	5
11/1/2016	Diabetes and the Eye	Ilona Shternfeld, MD	8
11/10/2016	Food for Thought	Mark Tousignant, MD	26
11/17/2016	Recurrent Urinary Tract Inections in Women	AeuMuro Lake, MD	52
11/30/2016	Don't Let Knee Pain Hold You Back Anymore!	Vipul Dua, MD	36
1/26/2017	Non-Surgical Options for Common Knee Problems	Kenneth Alleyne, MD	46
2/2/2017	New Year's Resolutions: Exercise and Nutrition	Alyssa Itzkowitz, DPT	57
2/8/2017	Pre-Diabetes: Let's Take Action	Nina Milone, RD, CDE, CDN	32
2/16/2017	From the Inside Out	Donna Cameron, BS, RN, CBCN, Women's Health Nurse Navigator; Hazar Dahhan, MD and Bridget Sutherland, MBA, RDN, CDN	39
2/21/2017	Chronic Pain Management	Raymond Squier, MD	27
3/7/2017	Fall Prevention and Balance	Gina Koudelka, DPT, LSVT and Victoria DePietro, DPT, CKTP	42
3/15/2017	Understanding Arthritic Conditions	Timothy Quan, MD	42
3/23/2017	The Art of Healthy Eating	Bridget Sutherland, MBA, RDN, CDN	50
3/29/2017	Glaucoma & Screenings	Ilona Shternfeld, MD	29
4/6/2017	Massage for General Well Being	Patricia Reagan, LMT (contracted massage therapist and reiki practitioner at the Women's Center for Wellness)	14
4/19/2017	Parkinson's Disease: Improving Speech and Movement	Peggy Bologna, RPT and Karen Aicher, CCC-SLP, PhD	19
6/6/2017	Nerve Pain and Neuropathy: Causes, Symptoms & Treatment Options	Michael Waddington, DO	37
6/7/2017	Label Reading in Real Life: A Visit to the Grocery Store	Amy Rapone, RD, CDN	2
7/18/2017	Feeling Dizzy? It Could be Vertigo	Gina Koudelka, DPT, LSVT; Priscilla Kowal, PT; Stephanie Torchia, DPT	45
8/17/2017	Acupuncture 101	Heather Finn, Lac	15
8/29/2017	Options in Spine Care	Jesse Eisler, MD, PhD	43
8/30/2017	Pre-Diabetes: Let's Take Action	Nina Milone, RD, CDE, CDN	27
9/20/2017	Label Reading in Real Life: A Visit to the Grocery Store	Amy Rapone, RD, CDN	5
		Total People Served	**844**

Exhibit D

Student Education Affiliations

Prospect Memorial Hospital and Prospect Rockville Hospital provide clinical settings for medical residents, medical students, nursing students, radiologic technicians, phlebotomy students, respiratory technicians, dietetic interns, pharmacy students, physical therapists, social workers and other students. The hospitals have agreements for student experiences with the following educational institutions:

Albertus Magnus College
American International College
Asnuntuck Community College
Aspen University
Boston University, rehabilitation
Branford Hall Career
Capital Community College
Central Connecticut State University
Eastern Connecticut State University
Edward Via College of Osteopathic Medicine
Fairfield University
Fordham University
Goodwin College
Manchester Community College
Marian University College of Osteopathic Medicine
Massachusetts College of Pharmacy and Health Sciences
Naugatuck Valley Community College
New York College of Podiatric Medicine
Nova Southeastern University
Porter and Chester Institute
Quinnipiac University
Sacred Heart University
Saint Joseph's College of Maine
Salisbury University
Samuel Merritt University
Southern Connecticut State University
Springfield College
Stone Academy
Three Rivers Community College
Touro College of Osteopathic Medicine
University of Cincinnati
University of Connecticut

Exhibit D

Student Education Affiliations

University of Hartford
University of New England College of Osteopathic Medicine
University of St. Joseph
Walden University
Western Connecticut State University
Widener University Center for Social Work
William Carey University
Yale University School of Nursing

Exhibit E

Prospect MMH Family Development Center

Early Head Start Program

The Early Head Start (EHS) program serves low-income children (birth to age three), pregnant women and their families residing in Manchester and/or Vernon. A Family Development Educator (FDE) provides parent education, child development information and learning activities.

EHS provides families with opportunities to get involved in their child's education.

Positive Parenting Program

Positive Parenting Program (Triple P) is a Connecticut State Department of Children and Families funded grant program. Triple P is suitable for parents with concerns about a child's behavior or who wish to learn a variety of parenting skills that will promote the development and potential of their child or teenager.

Nurturing Families Network Programs

The Nurturing Families Network (NFN) is designed to help new parents and consists of: (i) home visitation which helps first-time parents get off to a great start with a new baby and provides infant development and care information; (ii) Nurturing Connections provides phone support to help first-time parents adjust to their first few weeks home with a new baby; and (iii) Nurturing Group Classes for parents including information on prenatal wellness, nutrition, infant and child development, and parenting skills.

Maternal, Infant and Early Childhood Home Visiting Program (MIECHV)

The purpose of this program is to implement, expand and/or enhance high quality evidenced-based home visiting programs for children and families who reside in high-risk communities. The program provides home visiting, parent-child social activities, parent education groups, and a fatherhood initiative to prevent child abuse, promote healthy and safe children and strengthen families.

School-based Family Resource Center Services

The ECHN Family Resource Centers (FRC), located at Washington Media Arts Magnet School in Manchester and Maple Street School in Vernon, offer education and support services for the entire family Services included child care, school-age care, parent-child playgroups, parent education, home visits, support for child care providers, positive youth development, adult education, resources and referrals to community services.

Exhibit F

Prospect ECHN, MMH & RGH Sponsorships

Fiscal Year 2017

Organization	Date	Amount
Manchester Road Race	9/13/2016	$25,000.00
Glastonbury Education Foundation	12/2/2016	$2,500.00
Nutmeg Senior Rides	12/12/2016	$500.00
Greater Manchester Chamber of Commerce	12/20/2016	$1,300.00
Downtown Manchester Special Services District	1/10/2017	$400.00
The Sculpture Project	1/19/2017	$1,000.00
The Governor's Prevention Partnership, Inc.	2/22/2017	$5,000.00
MCC Foundation	2/24/2017	$1,500.00
South Windsor Chamber of Commerce	2/28/2017	$2,500.00
Taste of Manchester	3/22/2017	$500.00
Gift Shop	4/1/2017	$125.00
Hockanum Valley Community Council, Inc.	4/10/2017	$5,000.00
Highland Park Families Foundation	4/11/2017	$1,500.00
Bench Craft Company	4/11/2017	$750.00
Manchester Police Activities League	4/26/2017	$750.00
The Governor's Partnership to Protect CT's Workforce, Inc.	4/26/2017	$5,000.00
The Rotary Club of Manchester Foundation	4/26/2017	$400.00
The Allied Printing Services Charitable Foundation	5/4/2017	$1,000.00
MHS Football Booster Club	6/20/2017	$500.00
Hockanum Valley Community Council, Inc.	6/20/2017	$150.00
Manchester Rotary Foundation	6/26/2017	$700.00
Tolland County Chamber of Commerce	8/1/2017	$2,500.00
Almada Lodge Times Farm Camp Corp.	8/14/2017	$175.00
American Foundation for Suicide Prevention	8/16/2017	$1,000.00
Little Theatre of Manchester	8/16/2017	$500.00
Foodshare	8/17/2017	$750.00
Manchester Mayors' Foundation	8/29/2017	$500.00
South Windsor Chamber of Commerce	9/7/2017	$500.00
	Total	**$62,000.00**

ECHN
Eastern Connecticut Health Network, Inc.

CORPORATE ADMINISTRATIVE POLICY MANUAL

Title: Nondiscrimination: Auxiliary Aids and Services	**Section:**	200
	Policy Number:	205
	Effective Date:	11/01/16
	Page:	**1** of **11**

I. SCOPE:

The policies and procedures contained in this manual apply to Eastern Connecticut Health Network (ECHN) and its wholly-owned subsidiaries and affiliates.

II. PURPOSE:

The purpose of this policy is to develop a plan that accommodates individuals with special needs, as defined in Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act (ADA) of 1990 and Section 1557 of the Affordable Care Act of 2010, which prohibit discrimination on the basis of disability in the delivery of healthcare services. Individuals in need must be provided with auxiliary aids and services, at no cost, to allow them an equal opportunity to participate in and benefit from healthcare services. The appropriate communication method will be determined by considering the individual's demonstrated need in conjunction with the individual's preference.

ECHN Facilities are committed to full compliance with federal and state laws barring discrimination on the basis of disability. ECHN recognizes its legal obligations to ensure effective communication with persons who are deaf, hard of hearing or visually impaired. Furthermore, ECHN is committed to proactively assessing communication needs as well as providing the highest quality of services to all who use them. Qualified interpreters and/or other auxiliary aids and services are necessary to provide equal access to health services for deaf and hard of hearing individuals as well as those individuals that are visually impaired.

III. DEFINITIONS:

A. **Auxiliary Aids and Services** – services or devices that enable persons with impaired sensory, manual, or speaking skills to have an equal opportunity to participate in, and enjoy the benefits of, programs or activities conducted by ECHN. For example, auxiliary aids useful for persons with impaired vision include readers, audio recordings, and other similar services and devices. Auxiliary aids useful for persons with impaired hearing include telephone handset amplifiers, telephones compatible with hearing aids, text telecommunication devices (TTYs), sign language interpreters, note takers, written materials, and other similar services and devices.

B. **Companion** – includes a person who is one of the following:
   1. A person whom the patient designates to communicate with ECHN Workforce Members on his or her behalf regarding the patient's condition or care or to help the patient act on the information, advice or instructions provided by ECHN;
   2. A person legally authorized to make healthcare decisions on behalf of the patient; or

3. Such other family member, friend or associate of the patient who, along with the patient, is an appropriate person with whom ECHN should communicate.

C. **Disability** – with respect to an individual, a physical or mental impairment that substantially limits one or more major life activities of such individual.

D. **Deaf** – a condition in which the person does not receive audible sounds, including speech, and must perform major life activities without audible cues.

E. **ECHN Workforce Member** – includes, but is not limited to all employees of Eastern Connecticut Health Network, Inc. and its subsidiaries; active, consulting, and courtesy medical staff, including those with temporary and permanent medical staff privileges, and members of their office staff who handle ECHN generated patient information; the Board of Trustees; Corporators; volunteers; contractors, subcontractors or those who bid for contracts or subcontracts; Auxilians; students; clergy and lay ministry, and designated members of their office staff; and transport personnel.

F. **Effective Communication** – any form of communication (for example, writing or speech) that leads to demonstrated understanding and is appropriate given the circumstances of the situation.

G. **Hard-of-Hearing** – a condition where the sense of hearing is defective, but functional to some degree, usually with the use of hearing aids, for purposes of most major life activities.

H. **Hearing Impaired** – a general term used to describe all types of hearing losses, ranging from a very minute loss to profound deafness.

I. **Interpretation** – the oral or physical transmittal of a message from one language into another.

J. **Non-scheduled Request** – a situation in which there are less than two (2) hours between the time when a patient or companion makes a request for an interpreter and when the services of an interpreter are necessary (*e.g.*, walk-ins, emergency situations, etc.).

K. **Protected Characteristic** – a characteristic of a person which cannot be targeted for discrimination in accordance with federal and/or state law. For the purposes of this policy protected characteristics include, but are not limited to: race, color, national or ethnic origin, age, religion, mental or physical disability, sex, sexual orientation, gender identity and expression, socio-economic status, marital status, medical condition, veteran status or any other characteristic protected under applicable federal or state law.

L. **Qualified Interpreter** – an interpreter who, via Video Remote Interpreting (VRI) service, telephonic interpreting or an on-site appearance, is able to interpret effectively, accurately and impartially both receptively and expressively, using any necessary specialized vocabulary. Not all interpreters are qualified for all situations. For example, an interpreter who is qualified to interpret using American Sign Language may not be qualified to interpret non-English languages.

M. **Scheduled Requests** – situations in which a patient or the patient's representative has made ECHN aware of a communication need when scheduling the appointment and there are two (2) or more hours between the time when an appointment is scheduled and when the services of the qualified interpreter are required.

N. **Telephonic Interpreting** – a service that connects qualified interpreters via telephone to individuals who wish to speak to each other, but do not share a common language.

O. **Text Telephone (TTY)** – a device that allows people with hearing or speech impairments to communicate over the telephone using some form of keyboard input and visual display output.

P. **Translation** – the process of translating words or text from one language into another.

Q. **Video Remote Interpreting (VRI)** – an interpreting service that uses video conference technology over dedicated lines or wireless technology offering high-speed, wide-bandwidth video connection that delivers high-quality video images. Whenever VRI is provided or used, ECHN shall ask the patient or companion whether the VRI is meeting his or her communication needs.

IV. POLICY:

It is the policy of ECHN not to exclude, deny services to, or otherwise discriminate against any person on the basis of protected characteristic(s) under applicable federal or state law. Reasonable accommodations will be made to ensure everyone, regardless of any characteristic, has an equal opportunity to participate in their own healthcare, or that of a companion's.

ECHN Workforce Members will provide qualified sign-language interpreters and/or other appropriate auxiliary aids and services where necessary to ensure effective communication with individuals with disabilities. This includes an obligation to provide effective communication to the companions of patients who are persons with disabilities. To achieve that goal, ECHN Workforce Members will inform patients and companions with disabilities of the availability, **at no cost to them**, of qualified interpreters and/or other auxiliary aids, and will provide each service promptly upon request.

ECHN has adopted an internal grievance procedure requiring prompt and equitable resolution of all complaints and grievances. Any person who believes he or she has been subjected to discrimination on the basis of a protected characteristic may file a grievance under this procedure. It is against the law and ECHN's policies and procedures for any member of ECHN to retaliate against anyone who files a grievance or cooperates in the investigation of a grievance (see Corporate Administrative Policy #202: Rights and Responsibilities of Clients, Patients and Residents and Corporate Administrative Policy #203: Patient Complaints and Grievances).

V. PROCEDURE:

A. Patient Nondiscrimination Coordinator

1. The Patient Experience Coordinator, or respective affiliate designee(s), will serve as the Patient Nondiscrimination Coordinator to ensure compliance with any state or federal regulation related to the provisioning of auxiliary aids and services to patients or companions.
2. The Patient Nondiscrimination Coordinator, or respective affiliate designee(s), will know where the appropriate auxiliary aids are stored and how to operate them, and will be responsible for ensuring their maintenance, repair, replacement and distribution.

3. The Patient Nondiscrimination Coordinator, or respective affiliate designee(s), will distribute this policy as well as Attachment A: Communication and Language Services Quick Reference Guide for information on ECHN's language interpreting agency (see Corporate Administrative Policy #206: Nondiscrimination: Language Assistance to Persons with Limited English Proficiency (LEP)).
4. In addition, the Patient Nondiscrimination Coordinator, or respective affiliate designee(s), will ensure that all ECHN Workforce Members are trained on the auxiliary aids and services described in this policy.
5. The Patient Nondiscrimination Coordinator, or respective affiliate designee(s), will be responsible for the implementation of the Grievance Procedure outlined in Corporate Administrative Policy #203: Patient Complaints and Grievances.

B. Procedure for Patients or Companions with Auxiliary Aids and Services Needs

1. Initial Intake and Assessment of Patients

a. All ECHN Facilities shall ask every patient, as soon as practicable, upon scheduling or registration, whether the patient or any companion will be in need of communication services.

b. A proactive Communication Assessment Form (Attachment B) will be performed, as soon as the patient's condition reasonably allows, to assess the patient's or companion's needs in order to ensure effective communication:

   i. At the time an appointment is scheduled;
   ii. At the time ECHN becomes aware that a patient or companion may require auxiliary aids or services is being transferred or transported to an ECHN Facility; or
   iii. At the time the patient or companion initially arrives at ECHN or encounters an ECHN Workforce Member.

c. The assessment shall consider and take into account all relevant facts and circumstances, including without limitation the following:

   i. The patient's or companion's request for, stated need, or preference for, a qualified interpreter or other specific auxiliary aid(s) or service(s);
   ii. The nature, length, complexity and importance of the communication at issue;
   iii. The individual's disability, communication skills and knowledge;
   iv. The patient's health status or changes thereto;

v. The reasonably foreseeable healthcare activities of the patient (*e.g.*, medical tests or procedures, rehabilitation services, meetings with healthcare professionals or social workers, discussions regarding billing, insurance, self-care, prognoses, history and discharge); and

vi. Any factors relevant to determine whether the specific type of auxiliary aid or service will be effective.

d. If a patient or companion with communication needs has an ongoing relationship with ECHN, with respect to each of the subsequent visits, ECHN shall continue to provide appropriate auxiliary aids and services to the patient or companion during the entire period of the patient's hospitalization and/or outpatient visits, without requiring subsequent Communication Assessments or requests for the appropriate auxiliary aids and services by the patient or companion unless the patient or companion indicates otherwise.

e. The Communication Assessment Form shall be completed as soon as practicable as indicated in section (V)(B)(1)(b) for every patient or companion with indication of a communication services need unless there is indication or documentation of the following:

   i. The patient or companion has had a Communication Assessment completed within a month prior to the current visit, in which case ECHN Workforce Members shall rely on the previously documented Communication Assessment; or

   ii. The patient is arriving due to an emergency situation, in which case, a Communication Assessment of either the patient or companion shall be completed as soon as the patient's condition reasonably allows.

f. If a Communication Assessment was completed on a patient or companion a month prior to the current visit and the patient or companion subsequently waived communication services, another Communication Assessment will be completed for the patient or companion.

g. If ECHN determines that it cannot provide a particular auxiliary aid or service requested by a patient or companion with communication needs, ECHN Workforce Members shall advise the individual requesting the auxiliary aid or service of the determination.

h. ECHN Workforce Members shall document the basis for the determination if requested services cannot be provided, including the date of the determination, the name and title of the ECHN Workforce Member who made the determination and the alternative auxiliary aid or service, if any, that ECHN decided to provide, in the patient's medical record.

i. The ECHN Facility will retain the Communication Assessment and/or Waiver Form in the patient's medical record.

2. *Interpreting Services for Persons Who are Hearing-Impaired*
   a. ECHN shall provide, in a timely manner, a qualified interpreter and/or other appropriate auxiliary aids and services in all circumstances where necessary for effective communication with a patient or companion.
   b. For scheduled requests, when an interpreter is necessary to ensure effective communication, the servicing department shall make a qualified interpreter available at the time of the appointment.
   c. If an interpreter fails to arrive, the supervisor for the department/area shall be contacted immediately.
   d. The supervisor shall assist staff in contacting interpreter service or another resource to arrange for another qualified interpreter.
   e. The delay or non-arrival of the interpreter shall be documented in the patient's medical record and the Patient Nondiscrimination Coordinator, or respective affiliate designee(s), shall be notified.
   f. For non-scheduled requests, ECHN shall make a qualified interpreter available as soon as practicable, but no later than:
      i. Two (2) hours from the time the request for an on-site interpreter is made by the patient, the patient's representative or the patient's companion; or
      ii. Within fifteen (15) minutes of the request for an interpreter when providing an interpreter through VRI.
   g. If ECHN chooses to provide qualified interpreters via the VRI service, the ECHN Facility will ensure that it provides:
      i. Real-time, full motion video and audio over a dedicated, high-speed, wide-bandwidth video connection or wireless connection that delivers high-quality video images that do not produce lags, choppy, blurry, or grainy images or irregular pauses in communication;
      ii. A sharply delineated image that is large enough to display the interpreter's face, arms, hands and fingers and the participating individual's face, arms, hands and fingers regardless of his or her body position;
      iii. A clear, audible transmission of voices;
      iv. A qualified interpreter who is capable of communicating effectively with the patient or companion; and

v. Adequate training to users of the technology and other individuals involved, so that they may quickly and efficiently set up and operate the VRI.

3. *Services for Persons Who Are Blind or Visually Impaired*
   a. ECHN Workforce Members will provide appropriate auxiliary aids and services for blind or visually impaired patients or companions including qualified readers, large print materials, audio tape recordings of policies and procedures, as well as reading to the patient or companion.
   b. For any specific requests, ECHN Workforce Members shall contact the Patient Nondiscrimination Coordinator.
   c. Service Animals ***will*** be allowed in ECHN Facilities in accordance with Corporate Administrative Policy #213: Service Animals and Miniature Horses.
4. *Ongoing Assessment and Redetermination*
   a. ECHN shall reassess its determination of which auxiliary aids and services are necessary, in consultation with the patient or companion, when the patient or companion indicates that communication has not been effective.

C. Prohibition of Surcharges and Restricted Use of Minors or Adult Companions
   1. All appropriate auxiliary aids or services shall be provided ***free of charge*** to the patient or companion when such aids or services are necessary to ensure effective communication.
   2. ECHN shall not require a patient or companion to bring another individual to interpret or provide other communication services for him or her.
   3. ECHN shall not rely on a minor accompanying a patient or companion to interpret or facilitate communications between ECHN Workforce Members and a patient or companion except in an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no interpreter available.
   4. ECHN may not rely on an adult accompanying a patient or companion to interpret or facilitate communications between ECHN Workforce Members and a patient or companion except in an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no interpreter available or unless the following four factors are present:
      a. Where the individual with a disability specifically requests that the accompanying adult interpret or facilitate communication and such person agrees to provide such assistance;
      b. Such use is necessary or appropriate under circumstances, giving appropriate consideration to any privacy and confidentiality issues that may arise;

c. The patient or companion has been made aware of ECHN's full range of auxiliary aids and services available free of charge; and
d. The patient or companion provides written confirmation that he or she was made aware of relevant auxiliary aids and services available free of charge and agrees to the use of such person to interpret or facilitate communication (see Attachment C: Waiver of Interpreter Services Provided by ECHN).

5. ECHN may not rely on staff if they are not ***qualified*** interpreters, in order to communicate directly with individuals.

D. Waiver of Interpreter Services Provided by ECHN
1. If a person in need of communication services rejects a qualified interpreter, the ECHN Facility must secure a signed Waiver Form (Attachment C) from the individual (or note in the patient's chart that the patient or companion has refused an ECHN supplied interpreter and refused to sign the Waiver Form); such forms should be maintained in the patient's medical record.
2. Any patient or companion who initially executes the waiver can change his or her mind at any time simply by telling an ECHN Workforce Member that they want an interpreter to be provided.

E. Emergencies
1. The staff member should not compromise the patient's care by delaying the medical assessment and treatment when interpreter services are inappropriate or unavailable.
2. During an emergency, all available methods of communication will be utilized.

F. Complaints and Grievances
1. Any patient or companion dissatisfied with a decision made concerning auxiliary aids and services will have the ability to file a complaint or grievance as part of the Patient's Rights process, according to Corporate Administrative Policy #203: Patient Complaints and Grievances.
2. It is the policy of ECHN that any complaint or grievance received from a patient or their representative/companion will be investigated and an appropriate resolution will be communicated to the patient or representative/companion.
3. ECHN will not retaliate against or coerce in any way any person who made, or is making, a complaint or grievance, or who has assisted or participated in the investigation of any such matter.

G. Posting of Signage
1. ECHN Facilities will post a General Notice of Non-Discrimination, information on how to file a grievance and a Notice of Available Auxiliary Aids and Services in a conspicuous size and print in visible locations throughout the organization.
2. These notices will also be displayed on ECHN's website and published in ECHN's Patient Handbooks.

H. Training
1. ECHN shall provide training on auxiliary aids and services as well as nondiscrimination for all ECHN personnel.
2. ECHN shall provide training to new employees as part of their initial orientation and annually for all other ECHN employees.
3. ECHN shall maintain copies of the training material and attendance records.

VI. ATTACHMENTS:

Attachment A: Communication & Language Services Quick Reference Guide
Attachment B: Communication Assessment Form
Attachment C: Waiver of Interpreter Services Provided by ECHN

VII. INDIVIDUAL RESPONSIBLE FOR REVISION:

Patient Experience Coordinator

VIII. HISTORY:

Originated:	09/93
Reviewed, No Revisions:	
Reviewed, With Revisions:	11/98, 07/01, 11/07, 06/09, 10/16

IX. CROSS REFERENCE:

Corporate Administrative Policy #200: Nondiscrimination Policy
Corporate Administrative Policy #202: Rights and Responsibilities of Clients, Patients and Residents
Corporate Administrative Policy #203: Patient Complaints and Grievances
Corporate Administrative Policy #206: Nondiscrimination: Language Assistance to Persons with Limited English Proficiency (LEP)
Corporate Administrative Policy #213: Service Animals and Miniature Horses

X. REFERENCES:

29 U.S.C. §791 *et seq*
29 U.S.C. §794(a)
42 U.S.C. §1981(a) *et seq*
42 U.S.C. §2000(a) *et seq*
42 U.S.C. §12111 *et seq*
42 U.S.C. §12201-12204 and 12210
42 U.S.C §18116
28 CFR Part 36
29 CFR Part 32
42 CFR 482.13
42 CFR 483.10
42 CFR 483.12
42 CFR 482.58
45 CFR Part 80
45 CFR §84.7(b)
81 F.R. 31375
Joint Commission Standard RC.02.01.01
Joint Commission Standard RI.01.01.01
Joint Commission Standard RI.01.01.03

Lillanya Dantzler, Patient Experience Coordinator

Individual Responsible for Policy Development/Revisions

Rebecca Ford

Chief Compliance and Privacy Officer

Michael Collins

Interim President/CEO Date

Attachment A

COMMUNICATION & LANGUAGE SERVICES QUICK REFERENCE GUIDE

Interpreters and Translators, Inc. (iTi) provides language services for ECHN.

REQUESTING IN-PERSON INTERPRETER/TRANSLATOR

1. Information needed: Your Name, Phone Number, Language needed, Facility Location, Department Name, Patient's Name, Medical Record Number, Date and Time needed, Duration of appointment, Subject (ex. Informed consent, Medical procedure), Name of the staff the interpreter is meeting
2. Dial: 860-647-0686
3. An interpreter coordinator will answer and assist with scheduling

*Note: Because interpreters are in high demand, scheduled in-person visits are recommended but not required.

TELEPHONIC INTERPRETING (FOR LIMITED ENGLISH-PROFICIENT INDIVIDUALS ONLY)

1. Information needed: Your Name, Phone Number, Language needed, Facility Location, Department Name, Patient's Name, and Medical Record Number
2. Use Conference Hold to place the limited English speaker on hold.
3. DIAL: 1-800-245-9647 (this number is assigned to ECHN)
4. An operator will pick up and ask for your customer code.
5. ECHN Customer Code is: 182061

CALLING AN INDIVIDUAL WHO IS DEAF, HARD OF HEARING, DEAF-BLIND, SPEECH-DISABLED

1. From a regular phone, dial: 7-1-1 Relay CT
2. TTY phones may be used to contact individuals who are deaf, hard of hearing or speech impaired only if the person is known to have a TTY machine. They are located:
    a. MMH: Nursing Supervisor's office and Emergency Department
    b. RGH: Nursing Education office and Emergency Department

VIDEO REMOTE INTERPRETING (VRI)

1. Information needed: Your Name, Facility Name, Department Name, Patient Name and MRN
2. Log into the VRI iPad
3. Select the VRI application
4. Tap the language needed
5. Greet your interpreter, provide the information needed and proceed with communication

Eastern Connecticut Health Network, Inc.

Attachment A

REQUESTING WRITTEN DOCUMENT TRANSLATION

1. Complete the Translation Request Form located in Access E-Forms and on ECHN Portal/Quality Department/Patient Experience Section
2. Manager approval signature is required.
3. Email document along with the request form to: Translations@iTitranslates.com
4. An iTi Project Manager will confirm receipt of your request and provide you with a quote. This quote must be approved by you before they will proceed.
5. Forward the quote to the approving manager for record retention.
6. Final translated document will be emailed securely back to requestor.
7. Certificates of Accuracy are available at no additional cost

IMPORTANT TIPS:

DIALECTS: Because languages encompass various dialects, check periodically with the individual to ensure the language/dialect spoken is one they understand. If another dialect is needed, inform the interpreter, and try to obtain another. The telephonic language service covers a larger amount of languages/dialects.

UNKNOWN LANGUAGE: If you do not know what language to request, an iTi representative will help you.

WORKING WITH AN INTERPRETER: Give the Interpreter specific questions to relay. Group your thoughts or questions to help the conversation flow quickly. Speak directly to the individual and not to the interpreter. Use statements like “how are you today?” not “ask him how he is doing today?”

LENGTH OF CALL: Expect interpreted comments to run a bit longer than English phrases. Interpreters convey meaning-for-meaning, not word-for-word. Concepts familiar to English speakers often require explanation or elaboration in other languages and cultures.

INTERPRETER IDENTIFICATION: Interpreters identify themselves by their first name and number only. For reasons of confidentiality, they do not divulge either their full names or phone number.

DEMONSTRATION LINE: To hear a recorded demonstration of over-the-phone interpretation call iTi’s demonstration line at 1-800-996-8808

CONCERNS: should be reported to the manager as soon as possible.

Eastern Connecticut Health Network, Inc.

Attachment B

COMMUNICATION ASSESSMENT FORM

*It is the policy of ECHN to provide auxiliary aids and services **FREE OF CHARGE** to ensure effective communication with patients and companions.*

DATE/TIME: _____

Does the Patient/Companion Have a Need for Communication Services? ☐ YES ☐ NO

SECTION 1: PATIENT/COMPANION INFORMATION

1A. PATIENT NAME:		1B. DOB (MM/DD/YYYY):
1C. REQUESTED FOR:	1D. COMPANION NAME/RELATION TO PATIENT (IF COMPANION NEEDS SERVICES):	
☐ PATIENT ☐ COMPANION		
1E. TYPE OF VISIT:		1F. LOCATION:
☐ SCHEDULED APPOINTMENT ☐ NON-SCHEDULED APPOINTMENT		

1G. TYPE OF COMMUNICATION NEED (CHECK ALL THAT APPLY):	
SENSORY: ☐ DEAF/HARD OF HEARING ☐ BLIND/VISUAL IMPAIRMENT	
LANGUAGE: ☐ SPEECH IMPAIRMENT ☐ LIMITED ENGLISH PROFICIENCY (LEP)	
1H. PRIMARY LANGUAGE:	
1I. CAN INDIVIDUAL READ/WRITE ENGLISH	
1J. DOES INDIVIDUAL HAVE A COCHLEAR IMPLANT OR HEARING AID?	

NOTE: IF INDIVIDUAL WOULD LIKE TO WAIVE AUXILIARY AIDS/SERVICE PROCEED TO WAIVER FORM

SECTION 2: AUXILIARY AID(S)/SERVICE(S) REQUESTED AND PROVIDED

2A. TYPE OF AUXILIARY AID(S) OR SERVICE(S) REQUESTED:			
2B. DATE REQUESTED:		2C.TIME REQUESTED:	
2D. NATURE OF AUXILIARY AID(S)/SERVICE(S) PROVIDED (CHECK ALL THAT APPLY)			
☐ QUALIFIED INTERPRETER (see Sec. 3) ☐ VIDEO REMOTE INTERPRETIVE (VRI) SERVICE ☐ CT RELAY SERVICE ☐ TTY/TDD (Text Telephone)			
2E. ALTERNATIVE AUXILIARY AID(S) OR SERVICE(S) PROVIDED (Including Information on CD or Flash Drive, Audiotape, Braille, Large Print, Translated Materials):			

SECTION 3: NEED FOR QUALIFIED INTERPRETER

3A. TYPE OF QUALIFIED INTERPRETER NEEDED (*e.g.*, American Sign Language, Spanish, Polish, etc.):			
3B. REQUEST MADE TO (Name of Company):		3C. REQUEST DATE/TIME:	

IF A REQUEST FOR COMMUNICATIONS SERVICES IS DENIED, ECHN STAFF SHALL DOCUMENT THE BASIS FOR THE DETERMINATION, DATE/TIME, THE NAME AND TITLE OF THE INDIVIDUAL WHO MADE THE DETERMINATION, AND ANY ALTERNATIVE AID/SERVICE PROVIDED IN THE PATIENT'S MEDICAL RECORD.

MEDICAL RECORD COPY

Eastern Connecticut Health Network, Inc.

Attachment C

WAIVER OF INTERPRETER SERVICES PROVIDED BY ECHN

To be completed by the patient/companion ONLY if patient/companion would like to decline right to services for this visit.

It is your choice whether you use an interpreter provided by ECHN. ECHN has informed you that it does not require a patient or companion to bring someone to interpret for him or her. Additionally, ECHN has informed you of the range of auxiliary aids and services that are available to you ***free of charge***. By signing below, you are acknowledging that ECHN has offered to provide you with an interpreter free of charge, and that you have declined ECHN's offer. **If at any point in time during your course of treatment with ECHN, you wish to change any of your prior answers to the questions on this form or revoke your waiver, please notify your provider.**

Check all that apply:

☐ I prefer that _____ (name of individual to interpret) interpret or facilitate communications between ECHN personnel and myself.

☐ I do not use sign language or do not use an interpreter.

☐ I do not feel an interpreter is necessary or do not want one for this visit.

☐ Other (explain): _____

AUTHORIZATION

_____ _____

PRINT NAME/SIGNATURE OF PATIENT OR COMPANION **DATE/TIME**

_____ _____

PRINT NAME/SIGNATURE OF STAFF MEMBER **DATE/TIME**

MEDICAL RECORD COPY

ECHN
Eastern Connecticut Health Network, Inc.

CORPORATE ADMINISTRATIVE POLICY MANUAL

Title: Nondiscrimination: Language Assistance to Persons with Limited English Proficiency (LEP)	**Section:**	200
	Policy Number:	206
	Effective Date:	11/01/16
	Page:	**1** of **9**

I. SCOPE:

The policies and procedures contained in this manual apply to Eastern Connecticut Health Network (ECHN) and its wholly-owned subsidiaries and affiliates.

II. PURPOSE:

The purpose of this policy is to develop effective means, consistent with all federal and state laws requiring that persons with Limited English Proficiency (LEP) have equal and meaningful access to healthcare services.

III. DEFINITIONS:

A. **Companion** – includes a person who is one of the following:
   1. A person whom the patient designates to communicate with ECHN personnel on his or her behalf regarding the Patient's condition or care or to help the Patient act on the information, advice or instructions provided by ECHN;
   2. A person legally authorized to make healthcare decisions on behalf of the Patient; or
   3. Such other family member, friend or associate of the Patient who, along with the Patient, is an appropriate person with whom ECHN should communicate.

B. **ECHN Workforce Member** – includes, but is not limited to all employees of Eastern Connecticut Health Network, Inc. and its subsidiaries; active, consulting, and courtesy medical staff, including those with temporary and permanent medical staff privileges, and members of their office staff who handle ECHN generated patient information; the Board of Trustees; Corporators; volunteers; contractors, subcontractors or those who bid for contracts or subcontracts; Auxilians; students; clergy and lay ministry, and designated members of their office staff; and transport personnel.

C. **Effective Communication** – any form of communication (for example, writing or speech) that leads to demonstrated understanding and is appropriate given the circumstances of the situation.

D. **Interpretation** – the oral or physical transmittal of a message from one language into another.

E. **Language Assistance** – all oral and written language services needed to assist LEP individuals to communicate effectively with ECHN Workforce Members and to provide LEP individuals with meaningful access to, and an equal opportunity to participate fully in, the services, activities, programs, or other benefits provided by ECHN.

F. **Limited-English Proficient (LEP) Individual** – an individual who does not speak English as his or her primary language and who has a limited ability to read, write, speak, or understand English in a manner that permits him or her to communicate effectively with ECHN and have meaningful access to, and an equal opportunity to participate fully in, the services, activities, programs, or other benefits administered by ECHN.

G. **Non-scheduled Request** – a situation in which there are less than two (2) hours between the time when a patient or companion makes a request for an interpreter and when the services of an interpreter are necessary (e.g., walk-ins, emergency situations, etc.).

H. **Primary Language** – the language that an LEP individual identifies as the language that he or she uses to communicate effectively, and is the language which the individual has indicated they would prefer to use to communicate with ECHN.

I. **Protected Characteristic** – a characteristic of a person which cannot be targeted for discrimination in accordance with federal and state law. For the purposes of this policy protected characteristics include, but are not limited to: race, color, national or ethnic origin, age, religion, mental or physical disability, sex, sexual orientation, gender identity and expression, socio-economic status, marital status, medical condition, veteran status or any other characteristic protected under applicable federal or state law.

J. **Qualified Interpreter** – an interpreter who, via Video Remote Interpreting (VRI) service, telephonic interpreting or an on-site appearance, is able to interpret effectively, accurately and impartially both receptively and expressively, using any necessary specialized vocabulary. Not all interpreters are qualified for all situations. For example, an interpreter who is qualified to interpret using American Sign Language may not be qualified to interpret non-English languages.

K. **Scheduled Requests** – situations in which a patient or the patient's representative has made ECHN aware of a communication need when scheduling the appointment and there are two (2) or more hours between the time when an appointment is scheduled and when the services of the qualified interpreter are required.

L. **Telephonic Interpreting** – a service that connects qualified interpreters via telephone to individuals who wish to speak to each other, but do not share a common language.

M. **Translation** – the process of translating words or text from one language into another.

N. **Vital Documents** – include, but are not limited to: consent forms; complaint forms; letters or notices pertaining to eligibility for benefits; letters or notices pertaining to the reduction, denial or termination of services or benefits or that require a response from the LEP person; documents that must be provided by law; and notices regarding the availability of free language assistance services for LEP individuals.

O. **Video Remote Interpreting (VRI)** – an interpreting service that uses video conference technology over dedicated lines or wireless technology offering high-speed, wide-bandwidth video connection that delivers high-quality video images. Whenever VRI is provided or used, ECHN shall ask the Patient or Companion whether the VRI is meeting his or her communication needs and make a record of his or her response.

IV. POLICY:

ECHN will take reasonable steps to ensure that persons with Limited English Proficiency (LEP) have meaningful access and an equal opportunity to participate in services, activities, programs and other benefits. It is the policy of ECHN to ensure meaningful communication with all patients including LEP patients and their authorized representatives, who may be participating in treatment discussions and decision making.

All interpreters, translators and other aids shall be provided without cost and all patients, representatives and visitors shall be informed of the availability of such assistance. Language assistance will be provided through use of qualified interpreters and all staff shall be trained in effective communication techniques, including the effective use of an interpreter.

ECHN prohibits discrimination or harassment against any person because of any protected characteristic(s) under applicable federal or state law.

V. PROCEDURE:

A. Patient Nondiscrimination Coordinator

1. The Patient Experience Coordinator, or respective affiliate designee(s), will serve as the Patient Nondiscrimination Coordinator to ensure compliance with any state or federal regulation related to the provisioning of auxiliary aids and services to patients or companions.
2. The Patient Nondiscrimination Coordinator, or respective affiliate designee(s), will distribute this policy as well as Attachment A: Communication & Language Services Quick Reference Guide for information on ECHN's language interpreting agency.

3. In addition, the Patient Nondiscrimination Coordinator, or respective affiliate designee(s), will ensure that all ECHN Workforce Members are trained on obtaining language services through the contracted vendor.
4. The Patient Nondiscrimination Coordinator, or respective affiliate designee(s), will be responsible for the implementation of the Grievance Procedure outlined in Corporate Administrative Policy #203: Patient Complaints and Grievances.

B. Communication Assessment and Primary Language Identification

1. All ECHN Facilities shall ask every patient, as soon as practicable, upon scheduling or registration whether the patient or any companion will be in need of communication services.
2. A proactive Communication Assessment Form (Attachment B) will be performed, as soon as the patient's condition reasonably allows, to assess the patient's or companion's needs in order to ensure effective communication:
   a. At the time an appointment is scheduled;
   b. At the time ECHN becomes aware that a patient or companion may require language services is being transferred or transported to an ECHN Facility; or
   c. At the time the patient or companion initially arrives at ECHN or encounters ECHN Workforce Members.
3. The assessment shall consider and take into account all relevant facts and circumstances, including without limitation the following:
   a. The patient's or companion's request for, stated need, or preference for, a qualified interpreter;
   b. The nature, length, complexity and importance of the communication at issue;
   c. The individual's communication skills and knowledge;
   d. The patient's health status or changes thereto; and
   e. The reasonably foreseeable healthcare activities of the patient (*e.g.*, medical tests or procedures, rehabilitation services, meetings with healthcare professionals or social workers, discussions regarding billing, insurance, self-care, prognoses, history and discharge).
4. If a patient or companion with language needs has an ongoing relationship with ECHN, with respect to each of the subsequent visits, ECHN shall continue to provide appropriate language services to the patient or companion during the entire period of the patient's hospitalization and/or outpatient visits, without requiring subsequent Communication Assessments or requests for language services by the patient or companion unless the patient or companion indicates otherwise.
5. The Communication Assessment Form shall be completed as soon as practicable as indicated in section (V)(B)(2) for every patient or companion with indication of a

communication services need unless there is indication or documentation of the following:

a. The patient or companion has had a Communication Assessment completed within a month prior to the current visit, in which case the ECHN Facility shall rely on the previously documented Communication Assessment; or
b. The patient is arriving due to an emergency situation, in which case, a Communication Assessment of either the patient or companion shall be completed as soon as the patient's condition reasonably allows.

6. If a Communication Assessment was completed on a patient or companion a month prior to the current visit and the patient or companion subsequently waived communication services, another Communication Assessment will be completed for the patient or companion.
7. If ECHN determines that it cannot provide a particular language service requested by a patient or companion with LEP needs, ECHN Workforce Members shall advise the individual requesting the language service of the determination.
8. ECHN shall document the basis for the determination if requested services cannot be provided, including the date of the determination, the name and title of the ECHN Workforce Member who made the determination and the alternative auxiliary aid or service, if any, that ECHN decided to provide, in the patient's medical record.
9. The ECHN Facility will retain the Communication Assessment and/or Waiver Form in the patient's medical record.

C. Requests for Language Services

1. *In Person Interpreter*
   a. ECHN shall provide, in a timely manner, a qualified interpreter in all circumstances where necessary for effective communication with a patient or companion (see Attachment A: Communication & Language Services Quick Reference Guide).
   b. For scheduled requests, when an interpreter is necessary to ensure effective communication, the servicing department shall make a qualified interpreter available at the time of the appointment.
   c. If an interpreter fails to arrive, the supervisor for the department/area shall be contacted immediately.
   d. The supervisor shall assist staff in contacting interpreter service or another resource to arrange for another qualified interpreter.
   e. The delay or non-arrival of the interpreter shall be documented in the patient's record.
   f. For non-scheduled requests, ECHN shall make a qualified interpreter available as soon as practicable, but no later than:
      i. Two (2) hours from the time the request for an on-site interpreter is made by the patient, the patient's representative or the patient's companion; or

ii. Within fifteen (15) minutes of the request for an interpreter when providing an interpreter through VRI.

2. *Video Remote Interpreting*
   a. If ECHN chooses to provide qualified interpreters via the VRI service, the ECHN Facility will ensure that it provides:
      i. Real-time, full motion video and audio over a dedicated, high-speed, wide-bandwidth video connection or wireless connection that delivers high-quality video images that do not produce lags, choppy, blurry, or grainy images or irregular pauses in communication;
      ii. A sharply delineated image that is large enough to display the interpreter's face, arms, hands and fingers and the participating individual's face, arms, hands and fingers regardless of his or her body position;
      iii. A clear, audible transmission of voices;
      iv. A qualified interpreter who is capable of communicating effectively with the patient or companion; and
      v. Adequate training to users of the technology and other individuals involved, so that they may quickly and efficiently set up and operate the VRI.
3. *Telephonic Interpreting*
   a. For LEP individuals only, ECHN provides telephonic interpreting (see Attachment A: Communication & Language Services Quick Reference Guide).
4. *Requesting Written Document Translation*
   a. For the translation of documents, ECHN staff shall complete the iTi Document Translation Request Form (Attachment D), which is appended to this policy and can also be found in Access E-Forms and on the ECHN Portal/Quality Department/Patient Experience.
   b. Staff should follow directions provided in Attachment A: Communication & Language Services Quick Reference Guide.

D. Prohibition of Surcharges and Restricted Use of Minors or Adult Companions
   1. All appropriate language services shall be provided ***free of charge*** to the patient or companion when such aids or services are necessary to ensure effective communication.
   2. ECHN shall not require a patient or companion to bring another individual to interpret for him or her.
   3. ECHN shall not rely on a minor accompanying a patient or companion to interpret or facilitate communications between ECHN personnel and a patient or companion except in an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no interpreter available or when communication is limited to simple, straightforward matters such as scheduling appointments or confirming an

address and telephone number.

4. ECHN may not rely upon an adult accompanying a patient or companion to interpret or facilitate communications between ECHN personnel and a patient or companion except in an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no interpreter available or unless the following four factors are present:
   a. Where the individual specifically requests that the accompanying adult interpret or facilitate communication and such person agrees to provide such assistance;
   b. Such use is necessary or appropriate under the circumstances, giving appropriate consideration to any privacy and confidentiality issues that may arise;
   c. The patient or companion has been made aware of ECHN's full range of interpretation and translation services available free of charge;
   d. The patient or companion provides written confirmation that he or she was made aware of relevant interpretation and translation services available free of charge and agrees to the use of such person to interpret or facilitate communication (see Attachment C: Waiver of Interpreter Services Provided by ECHN).
5. ECHN may not rely on staff if they are not qualified interpreters, in order to communicate directly with individuals.

E. Waiver of Interpreter Services Provided by ECHN
   1. If a person in need of communication services rejects a qualified interpreter, the ECHN Facility must secure a signed Waiver Form (Attachment C) from the individual (or note in the patient's chart that the patient or companion has refused an ECHN supplied interpreter and refused to sign the Waiver Form); such forms should be maintained in the patient's medical record.
   2. ECHN will provide an interpreter if there is reason to believe that communication is being hindered by the family member or friend selected to interpret.

F. Emergencies
   1. The staff member should not compromise the patient's care by delaying the medical assessment and treatment when interpreter services are inappropriate or unavailable.
   2. During an emergency, all available methods of communication will be utilized.

G. Complaints and Grievances
   1. Any Patient or Companion dissatisfied with a decision made concerning language services will have the ability to file a complaint or grievance as part of the Patient's Rights process, according to Corporate Administrative Policy #203: Patient Complaints and Grievances.

2. It is the policy of ECHN that any complaint or grievance received from a Patient or their Representative/Companion will be investigated and an appropriate resolution will be communicated to the patient or representative/companion.
3. ECHN will not retaliate against or coerce in any way any person who made, or is making, a complaint or grievance, or who has assisted or participated in the investigation of any such matter.

H. Posting of Signage
1. ECHN Facilities will post notices of nondiscrimination and include taglines that alert individuals with LEP to the availability of language assistance services free of charge.
2. Such notices are also included on ECHN's website as well as in the Patient Guidebook.
3. Notices and signs will be posted and provided in intake areas and other points of entry, including but not limited to the Emergency Room, outpatient areas, etc.

I. Training
1. ECHN shall provide training on auxiliary aids and services as well as nondiscrimination for all ECHN personnel.
2. ECHN shall provide training to new employees as part of their initial orientation and annually for all other ECHN employees.
3. ECHN shall maintain copies of the training material and attendance records.

VI. ATTACHMENTS:

Attachment A: Communication & Language Services Quick Reference Guide
Attachment B: Communication Assessment Form
Attachment C: Waiver of Interpreter Services Provided by ECHN
Attachment D: iTi Document Translation Request Form

VII. INDIVIDUAL RESPONSIBLE FOR REVISION:

Patient Experience Coordinator

VIII. HISTORY:

Originated: 09/93
Reviewed, No Revisions:
Reviewed, With Revisions: 05/03, 10/07, 03/12, 10/16

IX. CROSS REFERENCE:

Corporate Administrative Policy #200: Nondiscrimination Policy

Corporate Administrative Policy #202: Rights and Responsibilities of Clients, Patients and Residents
Corporate Administrative Policy #203: Patient Complaints and Grievances
Corporate Administrative Policy #205: Nondiscrimination: Auxiliary Aids and Services

X. REFERENCES:

29 U.S.C. §794(a)
42 U.S.C. §1981(a) *et seq*
42 U.S.C. §2000(a) *et seq*
42 U.S.C §18116
42 CFR 482.13
42 CFR 483.10
42 CFR 483.12
42 CFR 482.58
45 CFR Part 80
45 CFR §84.7(b)
81 F.R. 31375
Executive Order 13166
Joint Commission Standard RC.02.01.01
Joint Commission Standard RI.01.01.01
Joint Commission Standard RI.01.01.03

Lillanya Dantzler, Patient Experience Coordinator

Individual Responsible for Policy Development/Revisions

Rebecca Ford

Chief Compliance and Privacy Officer

Michael Collins

Interim President/CEO Date

Attachment A

COMMUNICATION & LANGUAGE SERVICES QUICK REFERENCE GUIDE

Interpreters and Translators, Inc. (iTi) provides language services for ECHN.

REQUESTING IN-PERSON INTERPRETER/TRANSLATOR

1. Information needed: Your Name, Phone Number, Language needed, Facility Location, Department Name, Patient's Name, Medical Record Number, Date and Time needed, Duration of appointment, Subject (ex. Informed consent, Medical procedure), Name of the staff the interpreter is meeting
2. Dial: 860-647-0686
3. An interpreter coordinator will answer and assist with scheduling

*Note: Because interpreters are in high demand, scheduled in-person visits are recommended but not required.

TELEPHONIC INTERPRETING (FOR LIMITED ENGLISH-PROFICIENT INDIVIDUALS ONLY)

1. Information needed: Your Name, Phone Number, Language needed, Facility Location, Department Name, Patient's Name, and Medical Record Number
2. Use Conference Hold to place the limited English speaker on hold.
3. DIAL: 1-800-245-9647 (this number is assigned to ECHN)
4. An operator will pick up and ask for your customer code.
5. ECHN Customer Code is: 182061

CALLING AN INDIVIDUAL WHO IS DEAF, HARD OF HEARING, DEAF-BLIND, SPEECH-DISABLED

1. From a regular phone, dial: 7-1-1 Relay CT
2. TTY phones may be used to contact individuals who are deaf, hard of hearing or speech impaired only if the person is known to have a TTY machine. They are located:
    a. MMH: Nursing Supervisor's office and Emergency Department
    b. RGH: Nursing Education office and Emergency Department

VIDEO REMOTE INTERPRETING (VRI)

1. Information needed: Your Name, Facility Name, Department Name, Patient Name and MRN
2. Log into the VRI iPad
3. Select the VRI application
4. Tap the language needed
5. Greet your interpreter, provide the information needed and proceed with communication

Attachment A

REQUESTING WRITTEN DOCUMENT TRANSLATION

1. Complete the Translation Request Form located in Access E-Forms and on ECHN Portal/Quality Department/Patient Experience Section
2. Manager approval signature is required.
3. Email document along with the request form to: Translations@iTitranslates.com
4. An iTi Project Manager will confirm receipt of your request and provide you with a quote. This quote must be approved by you before they will proceed.
5. Forward the quote to the approving manager for record retention.
6. Final translated document will be emailed securely back to requestor.
7. Certificates of Accuracy are available at no additional cost

IMPORTANT TIPS:

DIALECTS: Because languages encompass various dialects, check periodically with the individual to ensure the language/dialect spoken is one they understand. If another dialect is needed, inform the interpreter, and try to obtain another. The telephonic language service covers a larger amount of languages/dialects.

UNKNOWN LANGUAGE: If you do not know what language to request, an iTi representative will help you.

WORKING WITH AN INTERPRETER: Give the Interpreter specific questions to relay. Group your thoughts or questions to help the conversation flow quickly. Speak directly to the individual and not to the interpreter. Use statements like “how are you today?” not “ask him how he is doing today?”

LENGTH OF CALL: Expect interpreted comments to run a bit longer than English phrases. Interpreters convey meaning-for-meaning, not word-for-word. Concepts familiar to English speakers often require explanation or elaboration in other languages and cultures.

INTERPRETER IDENTIFICATION: Interpreters identify themselves by their first name and number only. For reasons of confidentiality, they do not divulge either their full names or phone number.

DEMONSTRATION LINE: To hear a recorded demonstration of over-the-phone interpretation call iTi’s demonstration line at 1-800-996-8808

CONCERNS: should be reported to the manager as soon as possible.

Eastern Connecticut Health Network, Inc.

Attachment B

COMMUNICATION ASSESSMENT FORM

*It is the policy of ECHN to provide auxiliary aids and services **FREE OF CHARGE** to ensure effective communication with patients and companions.*

DATE/TIME: _____

Does the Patient/Companion Have a Need for Communication Services? ☐ YES ☐ NO

SECTION 1: PATIENT/COMPANION INFORMATION

1A. PATIENT NAME:		1B. DOB (MM/DD/YYYY):
1C. REQUESTED FOR:	1D. COMPANION NAME/RELATION TO PATIENT (IF COMPANION NEEDS SERVICES):	
☐ PATIENT ☐ COMPANION		
1E. TYPE OF VISIT:		1F. LOCATION:
☐ SCHEDULED APPOINTMENT ☐ NON-SCHEDULED APPOINTMENT		
1G. TYPE OF COMMUNICATION NEED (CHECK ALL THAT APPLY):		
SENSORY: ☐ DEAF/HARD OF HEARING ☐ BLIND/VISUAL IMPAIRMENT ***LANGUAGE:*** ☐ SPEECH IMPAIRMENT ☐ LIMITED ENGLISH PROFICIENCY (LEP)		
1H. PRIMARY LANGUAGE:		
1I. CAN INDIVIDUAL READ/WRITE ENGLISH		
1J. DOES INDIVIDUAL HAVE A COCHLEAR IMPLANT OR HEARING AID?		

NOTE: IF INDIVIDUAL WOULD LIKE TO WAIVE AUXILIARY AIDS/SERVICE PROCEED TO WAIVER FORM

SECTION 2: AUXILIARY AID(S)/SERVICE(S) REQUESTED AND PROVIDED

2A. TYPE OF AUXILIARY AID(S) OR SERVICE(S) REQUESTED:			
2B. DATE REQUESTED:		2C.TIME REQUESTED:	
2D. NATURE OF AUXILIARY AID(S)/SERVICE(S) PROVIDED (CHECK ALL THAT APPLY)			
☐ QUALIFIED INTERPRETER (see Sec. 3) ☐ VIDEO REMOTE INTERPRETIVE (VRI) SERVICE ☐ CT RELAY SERVICE ☐ TTY/TDD (Text Telephone)			
2E. ALTERNATIVE AUXILIARY AID(S) OR SERVICE(S) PROVIDED (Including Information on CD or Flash Drive, Audiotape, Braille, Large Print, Translated Materials):			

SECTION 3: NEED FOR QUALIFIED INTERPRETER

3A. TYPE OF QUALIFIED INTERPRETER NEEDED (*e.g.*, American Sign Language, Spanish, Polish, etc.):			
3B. REQUEST MADE TO (Name of Company):		3C. REQUEST DATE/TIME:	

IF A REQUEST FOR COMMUNICATIONS SERVICES IS DENIED, ECHN STAFF SHALL DOCUMENT THE BASIS FOR THE DETERMINATION, DATE/TIME, THE NAME AND TITLE OF THE INDIVIDUAL WHO MADE THE DETERMINATION, AND ANY ALTERNATIVE AID/SERVICE PROVIDED IN THE PATIENT'S MEDICAL RECORD.

MEDICAL RECORD COPY

Attachment C

WAIVER OF INTERPRETER SERVICES PROVIDED BY ECHN

To be completed by the patient/companion ONLY if patient/companion would like to decline right to services for this visit.

It is your choice whether you use an interpreter provided by ECHN. ECHN has informed you that it does not require a patient or companion to bring someone to interpret for him or her. Additionally, ECHN has informed you of the range of auxiliary aids and services that are available to you ***free of charge***. By signing below, you are acknowledging that ECHN has offered to provide you with an interpreter free of charge, and that you have declined ECHN's offer. **If at any point in time during your course of treatment with ECHN, you wish to change any of your prior answers to the questions on this form or revoke your waiver, please notify your provider.** Check all that apply:

☐ I prefer that _____ (name of individual to interpret) interpret or facilitate communications between ECHN personnel and myself.
☐ I do not use sign language or do not use an interpreter.
☐ I do not feel an interpreter is necessary or do not want one for this visit.
☐ Other (explain): _____

AUTHORIZATION

_____ _____
PRINT NAME/SIGNATURE OF PATIENT OR COMPANION **DATE/TIME**

_____ _____
PRINT NAME/SIGNATURE OF STAFF MEMBER **DATE/TIME**

MEDICAL RECORD COPY

Attachment D

iTi DOCUMENT TRANSLATION REQUEST FORM

Send requests via email to:

iTi Translation Department
Email: Translations@iTitranslates.com

Date of Request: _____

Name of Requestor & Title: _____

Location of Requestor: _____

Phone Number: _____

ECHN E-mail address: _____

Department Name: _____

Services Being Requested For: ☐ Patient ☐ Companion

Patient's Name and Medical Record Number: _____

Language Combination (e.g., English to Spanish): _____

Date Translated Document Needed: _____

Comments (e.g., Rush, Needed ASAP): _____

****APPROVAL REQUIRED****

(Manager's Signature Must Be Obtained Prior to Submitting Request)

_____	_____	_____
Manager's Print Name/Title	Manager's Signature	Date/Time

Total Number of Pages to Be Translated (Including Cover Page): _____

A Certificate of Accuracy must be obtained. Both the certificate and final translated document shall be forwarded to the respective Patient Nondiscrimination Coordinator or designee for record keeping.

MEDICAL RECORD COPY

Exhibit I

EASTERN CONNECTICUT HEALTH NETWORK
POLICY AND PROCEDURE

TITLE: Financial Assistance Policy and Procedure **Policy: 500**

TOPIC

Financial Assistance / Charity Care

ECHN is committed to providing financial assistance to persons who have healthcare needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation. Consistent with their mission to deliver compassionate and high quality healthcare services and to advocate those who are poor and disenfranchised, ECHN strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care.

In accordance with the Federal Poverty Level (FPL) guidelines, all other uninsured patient will not be charged more than the amount generally billed to insured patients for emergency or medically necessary care.

PURPOSE

To identify those patients that qualify for charitable assistance and to complete write-off procedures that is in keeping with state and federal regulations.

A. ECHN is committed to providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for emergency or medically necessary care based on their individual financial situation.
B. It is the policy of ECHN to provide Financial Assistance based on indigence or high medical expenses for patients who meet specified financial criteria and request such assistance. The purpose of the following policy is to describe how applications for Federal Assistance should be made, the criteria for eligibility, and the steps for processing each application.
C. Financial assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. This should include a review of the patient's existing medical expenses and obligations (including any accounts having gone to bad debt except those accounts that have gone to lawsuit and a judgment has been obtained) and any projected medical expenses. Financial Assistance Applications may be offered to patients whose accounts are with a collection agency and will apply only to those accounts on which a judgment has not been granted.
D. Race, gender, sexual orientation, religious or political affiliation, social or immigration status will not be taken into consideration.
E. To further ECHN's commitment to their mission to provide healthcare to patients seeking emergency care, ECHN will utilize an abbreviated application for financial assistance for their uninsured patients being seen in the Emergency Room. The patients eligible for this financial assistance must not be eligible for any other insurance benefits or have exhausted their insurance benefits, and do not have active medical assistance coverage. Eligibility will be granted in this case for the one visit only.

POLICY:

In order to provide the level of aid necessary to the greatest number of patients in need, and protect the resources needed to do so, the following guidelines apply:

Exhibit I

ECHN Eastern Connecticut Health Network

EASTERN CONNECTICUT HEALTH NETWORK
POLICY AND PROCEDURE

A. Patient
   a. Services are provided under charity care only when deemed emergency or medically necessary and after patients are found to have met all financial criteria based on the disclosure of proper information and documentation.
   b. Any patient who believes that they are qualified may apply for financial assistance under the hospitals' charity care policy or discount policy.
   c. Patients are expected to contribute payment for care based on their individual financial situation; therefore, each case will be reviewed separately.
   d. Charity Care is not considered an alternative option to payment and patients may be assisted in finding other means of payment or financial assistance before approval for charity care.
   e. Uninsured patients who may meet the State of CT Dept. of Social Services guidelines for Medicaid eligibility will be provided assistance in determining their eligibility as well as assisting with obtaining eligibility.
   f. Uninsured patients who are believed to have the financial ability to purchase health insurance may be encourage to do so in order to ensure healthcare accessibility and overall well-being.

B. Hospital
   a. ECHN will maintain an understandable, written financial assistance policy, clearly stating the eligibility criteria.
   b. ECHN will ensure that all financial assistance policies will be applied consistently.
   c. In applying the Financial Assistance policy, ECHN will assist the patent in determining if he/she is eligible for government- sponsored programs.

C. COMMUNICATION:
   a. Notices regarding availability of Financial Assistance at ECHN will be posted in public places around the hospital, on patient bills, and on our website.
   b. Financial Assistance Applications are available at all ECHN registration locations as well as on the ECHN Website, ECHN.org.
   c. Copies of this policy as well as the Financial Assistance Application can be obtained via the U.S. mail by calling our Customer Service Representative at 1-888-943-6042 or 860-646-1222 x2768.

D. FEDERAL POVERY LEVEL GUIDELINES (UPDATED ANNUALLY)

2017 Federal Poverty Guidelines	125%	150%	175%	200%	250%	300%	400%

% of Write Off	100%	90%	80%	70%	60%	50%	40%
Family Size							
1	15,075	18,090	21,105	24,120	30,150	36,180	48,240
2	20,300	24,360	28,420	32,480	40,600	48,720	64,960
3	25,525	30,630	35,735	40,840	51,050	61,260	81,680
4	30,750	36,900	43,050	49,200	61,500	73,800	98,400
5	35,975	43,170	50,365	57,560	71,950	86,340	115,120
6	41,200	49,440	57,680	65,920	82,400	98,880	131,840

7	46,425	55,710	64,995	74,280	92,850	111,420	148,560
8	51,650	61,980	72,310	82,640	103,300	123,960	165,280

Add $4,180 for each additional member

E. DISCOUNT GUIDELINES:

	UNINSURED	UNDERINSURED
Basis for calculating discount:	Hospital Gross Charges. Discounts apply to medically necessary services. Patients eligible for financial assistance will not be charged more than the amount generally billed to patients with insurance for emergency or other medically necessary care.	Hospital Gross Charges or the patient's balance after insurance payments. Discounts apply to medically necessary services. Patients eligible for financial assistance will not be charged more than the amount generally billed to patients with insurance for emergency or other medically necessary care.
Income Requirement for 100% discount	Income at or below 150% of FPL Guidelines	Income at or below 150% of FPL Guidelines
Income Requirements for other discounts	If household gross income is between 150% -400% of the FPL guidelines, the patient may qualify for a discount that is equal to or greater than the average discount received for the same services covered by Medicare, Medicaid and other private insurers. *Information on the discount calculation can be requested from our financial counselor.*	If household gross income is between 150% -400% of the FPL guidelines, the patient may qualify for a discount that is equal to or greater than the average discount received for the same services covered by Medicare, Medicaid and other private insurers. This discount will apply to the account balance. *Information on the discount calculation can be requested from our financial counselor.*
Catastrophic Circumstances	Special circumstances are handled on a case-by-case basis. We will take into consideration those circumstances that affect a patient's ability to pay, such as catastrophic event.	Special circumstances are handled on a case-by-case basis. We will take into consideration those circumstances that affect a

		patient's ability to pay, such as catastrophic event.

DEFINITIONS

The following terms are meant within this policy to be interpreted as follows:

a. Charity Care means free or discounted health care services rendered by a hospital to persons who cannot afford to pay, including but not limited to, care to the uninsured patient or patients who are expected to pay all or part of a hospital bill based on income guidelines and other financial criteria set forth in statute or in the hospital's charity care policies on file at OCHA.

b. Emergency Care: Immediate care which is necessary to prevent putting the patient's health in serious jeopardy, serious impairment to bodily functions, and serious dysfunction of any organs or parts.

c. Family: Using the Census Bureau definition, a group of two or more people who reside together and who are related by birth, marriage, or adoption. According to Internal revenue Services rules, if the patient claims someone as a dependent on their income tax return, they may be considered a dependent for purposed of the provision of financial assistance.

d. Family Income: family income is determined using the census Bureau definition, which uses the following income when computing federal poverty guidelines.
   i. Includes earnings, unemployment compensation, workers' compensation, Social security, Supplemental security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income form estates, trusts, educational assistance, alimony, child support, assistance form outside the household, and other miscellaneous sources.
   ii. Noncash benefits (such as food stamps and housing subsidies) do not count.
   iii. Determined on a before-tax basis
   iv. If a person lives with a family, includes the income of all family members (non-relatives, such as housemates do not count)

e. Medically Necessary: hospital services or care rendered (both inpatient and outpatient) to a patient in order to diagnose, alleviate, correct, cure or prevent the onset of worsening conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap or result in overall illness.

f. Presumptive: other financial assistance, not charity care.

g. Underinsured: Patients who carry insurance of have third party assistance to help pay for medical services, but who accrue or have the likelihood of accruing out-of-pocket expenses which exceed their financial ability.

h. Uninsured: means a patient who is without health insurance for whom the payer responsible for payment of the bill for hospital services rendered is the patient, the patient's parent or guardian or another responsible person, who is not a third party payer and who is not subsequently reimbursed by another payer for the cost of any of the services rendered to the patient. A patient shall not be classified an uninsured patient, is such subsequent reimbursement takes place.

EASTERN CONNECTICUT HEALTH NETWORK
POLICY AND PROCEDURE

i. Urgent Care: Services necessary in order to avoid the onset of illness or injury, disability, death, or serious impairment or dysfunction if treated within 12 hours.

PROCEDURE

a. Services Eligible Under This Policy
   i. The following healthcare services are eligible for charity:
      1. Emergency medical services provided in an emergency room setting;
      2. Services for a condition which, if not promptly treated, would lead to an adverse change in the health status of an individual;
      3. Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting; and
      4. Medically necessary services, evaluated on a case-by-case basis at ECHN's discretion.

b. Eligibility for Charity Care
   1. Eligibility for Charity Care will be based on an individual's assessment of financial need.
   2. Requires an application process.
   3. We expect cooperation from patients and guardians.
   4. May rely upon publicly available information and resources to determine the financial resources of the patient or a potential guardian.
   5. Include a review of the patient's outstanding accounts receivable for prior services rendered and the patient's payment history.
   6. The need for financial assistance shall be re-evaluated every six months or at any time additional information relevant to the eligibility of the patient for charity care becomes known.

c. Presumptive Financial Assistance Eligibility
   i. There are instances when a patient may appear eligible for charity care discounts, but are unable to provide supporting documentation. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patient with charity care assistance such as
      1. State-funded prescription programs;
      2. Patient is homeless or received care from a homeless clinic;
      3. Patient files bankruptcy
      4. Participation in Women, Infants and Children programs (WIC);
      5. Patient is eligible for assistance under the Crime Victims Act or Sexual Assault Act
      6. Food stamp eligibility;
      7. Subsidized school lunch program eligibility;
      8. Eligibility for other state or local assistance programs that are unfunded (e.g., Medicaid spend-down);
      9. Low income/subsidized housing is provided as a valid address; and
      10. Patient is deceased with no known estate.

EASTERN CONNECTICUT HEALTH NETWORK
POLICY AND PROCEDURE

F. ASSESSMENT PROCESS

1. The application must be fully completed and signed by the patient / responsible party
2. Proof of income for applicant (and spouse if applicable) is verified by two forms of documentation which could include:
    a. Last four pay stubs
    b. Previous Year Federal Income Tax Form
    c. Previous Year W-2 Form
    d. Social Security Statement
    e. Unemployment Benefit Statement
3. Other documentation that may be required:
    a. Proof of disability compensation
    b. For Medicare patients a copy of their social security benefits, pension and retirement benefits and/or bank statements showing deposits
    c. Workers compensation deposits

i. The level of Charity Care provided will be determined based on the Federal Poverty Level in effect (please refer to the current year's sliding scale).

ii. Once a patient has been granted financial assistance, that patient shall not receive any future bills based on undiscounted gross charges.

E. COLLECTION PRACTICES FOR CHARITY CARE PATIENTS

a. Internal and external collection policies and procedures will take into account the extent to which a patient is qualified for charity care or discounts. In additional, patients who qualify for partial discounts are required to make a good faith effort to honor payment agreements with ECHN, including payment plans and discounted hospital bills. ECHN is committed to working with patients to resolve their accounts, and at it discretion, may provide extended payment plans to eligible patients. ECHN will not pursue legal action for non-payment of bills against charity care patients who have cooperated with the hospital to resolve their accounts and have demonstrated their income and/or assets are insufficient to pay medical bills.
b. During the eligibility process, other forms of financial assistance will be considered such as Medicare and Medicaid.
c. All billing is put on hold during the financial assistance application process. Patients are given the opportunity to provide any missing or incomplete information.

Hospital Billing and Collections Practices can be found on the ECHN Website (ECHN.org) or obtained by calling our Customer Service Representative at 1-888-943-6042.

Exhibit I

EASTERN CONNECTICUT HEALTH NETWORK
POLICY AND PROCEDURE

INDIVIDUAL RESPONSIBLE FOR REVISION: Director Patient Financial Services

ORIGINATED: 07/29/02

REVISION DATE:
11/26/12
04/15/13
08/20/14
06/30/15
02/19/16
02/07/17

User, OHCA

From: Cotto, Carmen
Sent: Friday, November 03, 2017 1:30 PM
To: Colleen Smith
Cc: Martone, Kim; Roberts, Karen; User, OHCA
Subject: RE: Compliance with CON Docket # 15-32016-486, Prospect ECHN_Condition #20

Hi Colleen,

This email is to follow up on any progress related to ECHN s search for a Community Representative at Vernon to join the local Advisory Board, as re uired under Condition 20, Docket 15-302016-486-CON.

Correspondence from ECHN received at OHCA on March 3, 2017 indicated that the Applicants had asked Vernon s Mayor to act as the
interim Community Representative and that he had attended the latest Advisory Board meeting on February 22, 2017.

Correspondence from you received at OHCA on March 6, 2017 below indicated that you will follow up on the progress regarding this matter.

No additional documentation has been received at OHCA after March 6th related to Condition 20 .

Please provide OHCA with an update on the search for a Community Representative at Vernon by the Applicants.

Thank you,
Carmen

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov

www.ct.gov/dph

From: Colleen Smith [mailto:colleen713.smith@gmail.com]
Sent: Monday, March 6, 2017 4:29 PM
To: Roberts, Karen <Karen.Roberts@ct.gov>

Cc: Martone, Kim <Kimberly.Martone@ct.gov>; Cotto, Carmen <Carmen.Cotto@ct.gov>; User, OHCA <OHCA@ct.gov>
Subject: Re: Compliance with CON Docket # 15-32016-486, Prospect ECHN

Dear aren,
Thank you for this update regarding Condition 20. I was aware that ECHN has experienced difficulty in finding a suitable Vernon representative for the local Advisory Board. I will follow up immediately with Dennis McConville and Michael Collins regarding their progress in filling this position with a ualified, unbiased Vernon community representative.
Sincerely,
Colleen Smith

Colleen O'Brien Smith MSN RN NEA-BC
Nursing Consulting Partners, LLC
690C9 S. Park View Court
Franklin, WI 53132
Phone: 203-245-1044
Cell: 203-671-1348
colleen713.smith@gmail.com
http://nursingconsultingpartners.com/

On Mar 6, 2017, at 1:14 PM, Roberts, aren aren.Roberts@ct.gov wrote:

To: Colleen Scott, MSN, RN, NEA-BC
Independent Monitor for Prospect ECHN CON Docket # 15-32016-486

Hi Ms. Scott – as the Independent Monitor for the Prospect ECHN CON under Docket # 15-32016-486, we wanted to alert you to several compliance related email communications that have recently occurred between the Office of Health Care Access (OHCA) and Mr. Michael Collins, Interim CEO for the two Prospect ECHN hospitals. Please reference PDF pages 716 – 772 of http://www.ct.gov/dph/lib/dph/ohca/con_completed/2016/15_32016_486_compliance.pdf for the recent communications that have occurred.

Condition #20 states:

> 20. For three (3) years following the Closing Date, PMH shall allow for two (2) community representatives to serve as voting members of the New MMH and New RGH Local Board with rights and obligations consistent with other voting members under the Local Board Bylaws. The community representatives shall be selected in consultation with the Mayors of Manchester and Vernon in order to ensure the appointment of two unbiased persons who will fairly represent the interests of the communities served by MMH and RGH, respectively. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d, 19a-613(b), 19a-639(a)(2),(3),(5),(7),(8),(11) & (12); FF 28-30*

At this time, there is no further questions for the Applicant in this regard, but OHCA will continue to need to be kept updated on the status of or any changes to the two community representatives, required pursuant to Condition #20.

Thank you.

Sincerely,

Karen Roberts
Principal Health Care Analyst
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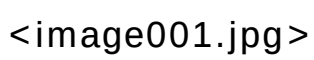
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: *karen.roberts@ct.gov*



User, OHCA

From: Colleen Smith <colleen713.smith@gmail.com>
Sent: Friday, November 03, 2017 4:01 PM
To: Cotto, Carmen
Cc: Martone, Kim; Roberts, Karen; User, OHCA
Subject: Re: Compliance with CON Docket # 15-32016-486, Prospect ECHN_Condition #20

Dear Carmen,

In follow up to your □uestion concerning the Vernon community Board representative, the current mayor of Vernon, Mr. Dan Champagne, continues to serve as the Vernon community representative to the Board. He has voiced his intent to continue his service to the Board and has faithfully attended the monthly board meetings. At the current time, there are no plans to replace him.
I will notify you if this situation changes.

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Colleen smith

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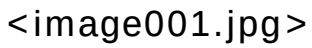

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Sent: Friday, November 03, 2017 5:38 PM
To: Colleen Smith
Cc: Martone, Kim; Roberts, Karen; User, OHCA
Subject: RE: Compliance with CON Docket # 15-32016-486, Prospect ECHN_Condition #20

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You will received a response to your re□uest related to Condition □19 early next week.

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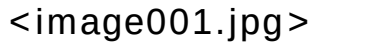

User, OHCA

From: Colleen Smith <colleen713.smith@gmail.com>
Sent: Friday, November 03, 2017 6:12 PM
To: Cotto, Carmen
Cc: Martone, Kim; Roberts, Karen; User, OHCA
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Colleen

Sent from my iPhone

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> You will received a response to your re uest related to Condition 19 early next week.
>
> Carmen
>
> Carmen Cotto, MBA
> Associate Health Care Analyst
> Office of Health Care Access
> Connecticut Department of Public Health
> 410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
> P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov
>
> www.ct.gov/dph

From: Colleen Smith [mailto:colleen713.smith@gmail.com]
Sent: Friday, November 3, 2017 4:01 PM
To: Cotto, Carmen <Carmen.Cotto@ct.gov>
Cc: Martone, Kim <Kimberly.Martone@ct.gov>; Roberts, Karen <Karen.Roberts@ct.gov>; User, OHCA <OHCA@ct.gov>
Subject: Re: Compliance with CON Docket # 15-32016-486, Prospect ECHN_Condition #20

Dear Carmen,

In follow up to your □uestion concerning the Vernon community Board representative, the current mayor of Vernon, Mr. Dan Champagne, continues to serve as the Vernon community representative to the Board. He has voiced his intent to continue his service to the Board and has faithfully attended the monthly board meetings. At the current time, there are no plans to replace him.
I will notify you if this situation changes.

I would also like to follow up to my □uery of 8□28□17 concerning condition □19. Specifically, I want to verify that the 2 joint Board meetings followed by public community meetings held last spring in April and May on the Rockville and Manchester campuses satisfiy the re□uirements of condition □19.
I appreciate your guidance and attention to this matter.

Best regards,

Colleen smith

> On Nov 3, 2017, at 1:30 PM, Cotto, Carmen □Carmen.Cotto@ct.gov□ wrote:
>
> Hi Colleen,
>
> This email is to follow up on any progress related to ECHN□s search for a Community Representative at Vernon to join the local Advisory Board, as re□uired under Condition □20, Docket □15-302016-486-CON.
>
> Correspondence from ECHN received at OHCA on March 3, 2017 indicated that the Applicants had asked Vernon□s Mayor to act as the interim Community Representative and that he had attended the latest Advisory Board meeting on February 22, 2017.
>
> Correspondence from you received at OHCA on March 6, 2017 below indicated that you will follow up on the progress regarding this matter.
>
> No additional documentation has been received at OHCA after March 6th related to Condition □20 .
>
> Please provide OHCA with an update on the search for a Community Representative at Vernon by the Applicants.
>
> Thank you,
> Carmen
>
> Carmen Cotto, MBA
> Associate Health Care Analyst
> Office of Health Care Access
> Connecticut Department of Public Health
> 410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
> P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov


www.ct.gov/dph

From: Colleen Smith [mailto:colleen713.smith@gmail.com]
Sent: Monday, March 6, 2017 4:29 PM
To: Roberts, Karen <Karen.Roberts@ct.gov>
Cc: Martone, Kim <Kimberly.Martone@ct.gov>; Cotto, Carmen <Carmen.Cotto@ct.gov>; User, OHCA <OHCA@ct.gov>
Subject: Re: Compliance with CON Docket # 15-32016-486, Prospect ECHN

Dear aren,
Thank you for this update regarding Condition 20. I was aware that ECHN has experienced difficulty in finding a suitable Vernon representative for the local Advisory Board. I will follow up immediately with Dennis McConville and Michael Collins regarding their progress in filling this position with a ualified, unbiased Vernon community representative.
Sincerely,
Colleen Smith

Colleen O'Brien Smith MSN RN NEA-BC
Nursing Consulting Partners, LLC
690C9 S. Park View Court
Franklin, WI 53132
Phone: 203-245-1044
Cell: 203-671-1348
colleen713.smith@gmail.com
http://nursingconsultingpartners.com/

On Mar 6, 2017, at 1:14 PM, Roberts, aren
aren.Roberts@ct.gov wrote:

To: Colleen Scott, MSN, RN, NEA-BC
Independent Monitor for Prospect ECHN CON Docket # 15-32016-486

Hi Ms. Scott – as the Independent Monitor for the Prospect ECHN CON under Docket # 15-32016-486, we wanted to alert you to several compliance related email communications that have recently occurred between the Office of Health Care Access (OHCA) and Mr. Michael Collins, Interim CEO for the two Prospect ECHN hospitals. Please reference PDF pages 716 – 772 of http://www.ct.gov/dph/lib/dph/ohca/con_completed/2016/15_32016_486_compliance.pdf for the recent communications that have occurred.

Condition #20 states:

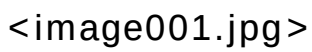
20. For three (3) years following the Closing Date, PMH shall allow for two (2) community representatives to serve as voting members of the New MMH and New RGH Local Board with rights and obligations consistent with other voting members under the Local Board Bylaws. The community representatives shall be selected in consultation with the Mayors of Manchester and Vernon in order to ensure the appointment of two unbiased persons who will fairly represent the interests of the communities served by MMH and RGH, respectively. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d, 19a-613(b), 19a-639(a)(2),(3),(5),(7),(8),(11) & (12); FF 28-30*

At this time, there is no further questions for the Applicant in this regard, but OHCA will continue to need to be kept updated on the status of or any changes to the two community representatives, required pursuant to Condition #20.

Thank you.

Sincerely,

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: *karen.roberts@ct.gov*



User, OHCA

From: Cotto, Carmen
Sent: Friday, November 03, 2017 5:38 PM
To: Colleen Smith
Cc: Martone, Kim; Roberts, Karen; User, OHCA
Subject: RE: Compliance with CON Docket # 15-32016-486, Prospect ECHN_Condition #20

Follow Up Flag: Follow up
Flag Status: Completed

Dear Colleen,

Thank you for your prompt response.

You will received a response to your re□uest related to Condition □19 early next week.

Carmen

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov

www.ct.gov/dph

From: Colleen Smith [mailto:colleen713.smith@gmail.com]
Sent: Friday, November 3, 2017 4:01 PM
To: Cotto, Carmen <Carmen.Cotto@ct.gov>
Cc: Martone, Kim <Kimberly.Martone@ct.gov>; Roberts, Karen <Karen.Roberts@ct.gov>; User, OHCA <OHCA@ct.gov>
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Carmen

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
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www.ct.gov/dph

From: Colleen Smith [mailto:colleen713.smith@gmail.com]
Sent: Monday, March 6, 2017 4:29 PM
To: Roberts, Karen <Karen.Roberts@ct.gov>

Cc: Martone, Kim <Kimberly.Martone@ct.gov>; Cotto, Carmen <Carmen.Cotto@ct.gov>; User, OHCA <OHCA@ct.gov>
Subject: Re: Compliance with CON Docket # 15-32016-486, Prospect ECHN

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Colleen Smith

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690C9 S. Park View Court
Franklin, WI 53132
Phone: 203-245-1044
Cell: 203-671-1348
colleen713.smith@gmail.com
http://nursingconsultingpartners.com/

On Mar 6, 2017, at 1:14 PM, Roberts, aren aren.Roberts@ct.gov wrote:

To: Colleen Scott, MSN, RN, NEA-BC
Independent Monitor for Prospect ECHN CON Docket # 15-32016-486

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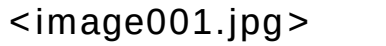
Thank you.

Sincerely,

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: *karen.roberts@ct.gov*



User, OHCA

From: Roberts, Karen
Sent: Thursday, November 16, 2017 12:06 PM
To: User, OHCA
Cc: Cotto, Carmen
Subject: FW: Request

From: Martone, Kim
Sent: Thursday, November 16, 2017 12:01 PM
To: 'Mcconville, Dennis P' <dmcconville@echn.org>
Cc: Roberts, Karen <Karen.Roberts@ct.gov>; Cotto, Carmen <Carmen.Cotto@ct.gov>
Subject: RE: Request

Dennis, your extension request is approved.

Kim

Kimberly R. Martone
Director of Operations, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134
Phone: 860-418-7029 Fax: 860-418-7053
Email: Kimberly.Martone@ct.gov Website: www.ct.gov/ohca

From: Mcconville, Dennis P [mailto:dmcconville@echn.org]
Sent: Wednesday, November 15, 2017 3:22 PM
To: Martone, Kim
Subject: RE: Request

Thanks Kim,

I will wait for her reply.

Dennis

From: Martone, Kim [mailto:Kimberly.Martone@ct.gov]
Sent: Wednesday, November 15, 2017 2:27 PM
To: Mcconville, Dennis P
Subject: RE: Request

CAUTION: This email originated outside of ECHN. Do not click links or open attachments unless you recognize the sender and know the content is safe.

Hi Dennis, sorry I have been out of the office but I did get your voice mail. Any extension requests for conditions in settlements should be sent to Karen Roberts.

I did forward this to her. Thanks.

Kim

Kimberly R. Martone
Director of Operations, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134
Phone: 860-418-7029 Fax: 860-418-7053
Email: Kimberly.Martone@ct.gov Website: www.ct.gov/ohca

From: Mcconville, Dennis P [mailto:dmcconville@echn.org]
Sent: Wednesday, November 15, 2017 1:23 PM
To: Martone, Kim
Subject: Request

Kim,

I'm writing to request an extension for a filing that is due November 30 for DN# 15-32016-486. Conditions 8, 9 and 10 from that decision require us to file financial information and our finance staff have asked if it is possible to move the due date to December 15. They are busy with the audits. Please let me know. Thank you.

Best regards,

Dennis

Dennis P. McConville
Senior Vice President, Chief Strategy Officer
Eastern Connecticut Health Network, Inc.
(860) 533-3429 (office)
(860) 268-4591 (cell)
dmcconville@echn.org

"This message originates from Eastern Connecticut Health Network. The information contained in this message may be privileged and confidential. If you are the intended recipient, you must maintain this message in a secure and confidential manner. If you are not the intended recipient, please notify the sender immediately and destroy this message. Thank you."

User, OHCA

From: Mcconville, Dennis P <dmcconville@echn.org>
Sent: Friday, December 15, 2017 10:19 AM
To: User, OHCA
Cc: Martone, Kim; Roberts, Karen; Colleen Smith; Ellen J. Shin (ellen.shin@prospectmedical.com); Tichy, Joyce A (Legal Department); Collins, Michael; Garrison DeLee (garrison.delee@prospectmedical.com); Frank.Saidara; Von.Crockett; Basile, Mary C; Veillette, Michael
Subject: 15-32016-486-CON
Attachments: Letter to Yvonne Addo, OHCA re DN 15-32016-486-CON 12 15 17 Final.pdf

The attached letter is submitted as required for condition number eight (8), condition number nine (9) and condition number ten (10) contained in the Final Decision for Docket Number: 15-32016-486-CON, the Transfer of Assets of Eastern Connecticut Health Network, Inc. to Prospect Medical Holdings, Inc.

Dennis P. McConville
Senior Vice President
Eastern Connecticut Health Network, Inc.
(860) 533-3429 (office)
(860) 268-4591 (cell)
dmcconville@echn.org

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Eastern Connecticut Health Network
71 Haynes Street
Manchester, CT 06040
860.533.3414
www.echn.org

December 15, 2017

VIA EMAIL DELIVERY

Deputy Commissioner Yvonne Addo
Office of Health Care Access
Department of Public Health
410 Capitol Avenue, MS 13HCA
P.O. Box 340308
Hartford, CT 06134

Re: **Docket Number: 15-32016-486**

Project Title: **Transfer of assets of Eastern Connecticut Health Network, Inc. to Prospect Medical Holdings, Inc.**

Dear Ms. Addo:

This letter is submitted in accordance with the Order for the above referenced Certificate of Need Final Decision, specifically Condition Number Eight (8), Condition Number Nine (9) and Condition Number Ten (10) regarding the transfer of assets of Eastern Connecticut Health Network, Inc. (ECHN) to Prospect Medical Holdings, Inc. (PMH).

Condition Number Eight (8) requires that on a semi-annual basis until the capital commitment is satisfied, PMH shall submit to OHCA a report on the capital investments ("Capital Investment Report") it has made in the New MMH, New RGH and their affiliates from the 75 million Commitment Amount. Please find the Capital Investment Report for Fiscal Year 2017 labeled as Exhibit A which includes payment dates, amounts and sources of funding. In addition, please find Exhibit B which includes all capital purchases for Fiscal Year 2017 that have been made or approved with purchase orders issued. The timeframes for the roll out of capital projects are also noted.

Condition Number Nine (9) requires that PMH provide a report for New ECHN, New MMH and New RGH on a semi-annual basis with the following information:

a. The cost saving totals achieved in the following Operating Expense Categories for New ECHN, New MMH and New RGH: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Interest Expense, Malpractice Expense, Utilities, Business

Expenses, and other Operating Expenses. The categories shall be consistent with the major operating expense categories (Categories A, B, C, D, E, G, H, I, J, and) which are in use at the time of reporting in the OHCA Hospital Reporting System ("HRS") Report 175 or successor report. The semi-annual submission shall also contain narratives describing:

1. The major cost savings achieved for each expense category for the semi-annual period; and

2. The effect of cost savings on the clinical uality of care.

b. A Consolidated Balance Sheet, Statements of Operations, and Statements of Cash Flows for New ECHN, New MMH and New RGH. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Reports 100/150, 300 350 or successor reports.

For Condition Number Nine (9.a.), please find Exhibit C which shows the expenses by category using the form of HRS Report 175 for the period of April 1, 2017 through September 30, 2017 as compared to the first half of Fiscal Year 2017, October 1, 2016 through March 31, 2017. Exhibit D contains information relating to the clinical uality of care provided at New MMH and New RGH this past year.

For Condition Number Nine (9.b.), please find Exhibit E using the form of HRS Reports 100 150 and 300 350 which includes the Consolidated Balance Sheet, Statements of Operations, and Statements of Cash Flows for New ECHN, New MMH and New RGH

Condition Number Ten (10) re uires that on a semi-annual basis, PMH provide a report for New ECHN, New MMH and New RGH with the following financial measurements indicators showing current month and year-to-date data and comparable prior year period data for New ECHN, New MMH and New RGH respectively :

Financial Measurement/Indicators

A. Operating Performance

1. Operating Margin
2. Non-Operating Margin
3. Total Margin

B. Liquidity

1. Current Ratio
2. Days Cash on Hand
3. Days in Net Accounts Receivables
4. Average Payment Period

C. Leverage and Capital Structure

1. Long-term Debt to E uity
2. Long-term Debt to Capitali ation
3. Unrestricted Cash to Debt

4. Times Interest Earned Ratio
5. Debt Service Coverage Ratio
6. E□uity Financing Ratio

D. <u>Additional Statistics</u>

1. Income from Operations
2. Revenue Over (Under) Expense
3. Cash from Operations
4. Cash and Cash E□uivalents
5. Net Working Capital
6. Free Cash Flow (and the elements used in the calculation)
7. Unrestricted Assets□Retained Earnings
8. Bad Debt as □ of Gross Revenue
9. Credit Ratings (S&P, FITCH, or Moody's)

Please find Exhibit F for the periods beginning on October 1, 2016 through March 31, 2017 and April 1, 2017 through September 30, 2017 showing current month and year to date measurements as re□uired for Condition Ten (10). Future reports will compare the data to the comparable period for the prior year.

If you have any □uestions or need anything further, please feel free to contact me at (860) 533-3429.

Very truly yours,

Dennis P. McConville
Senior Vice President
Eastern Connecticut Health Network

Enclosures:

Exhibit A- Condition Number Eight (8) - Capital Investment Report
Exhibit B – Condition Number Eight (8) – Fiscal Year 2017 Approved Capital Expenditures
Exhibit C – Condition Number Nine (9.a) - Expenses by Category
Exhibit D – Condition Number Nine (9.a) – Effect of Cost Savings on Clinical Quality of Care
Exhibit E – Condition Number Nine (9.b.) - Consolidated Balance Sheets, Statements of Operations, and Statements of Cash Flows for New ECHN, New MMH and New RGH
Exhibit F – Condition Number Ten (10) - Current Month and Year to Date Measurements

cc: imberly R. Martone, Director of Operations, Office of Health Care Access, Connecticut Department of Public Health
aren Roberts, Principal Health Care Analyst, Office of Health Care Access, Connecticut Department of Public Health
Colleen Smith, Nursing Consultant Partners, LLC
Ellen J. Shin, General Counsel, Prospect Medical Holdings, Inc.
Joyce A. Tichy, Senior Vice President and General Counsel, ECHN
Michael Collins, CEO, ECHN
Von Crocket, Senior Vice President, Corporate Development, Prospect Medical Holdings, Inc.
Frank Saidara, Vice President, Corporate Development, Prospect Medical Holdings, Inc.
Garrison De Lee, Assistant General Counsel, Prospect Medical Holdings, Inc.

Exhibit A

Capital Investment Report
Paid Capital
FY 2017

Vendor	Entity	Item	Purpose	PO #	FundingType	October	November	December	January	February	March	Total	April	May
												********PAYMENT AMOUNT********		
MOREDIRECT INC	MMH	SECURITY SYSTEM UPGRADE	Replacement	C0016389	F			$3,227				$3,227		
ADVANCE SECURITY INTERGATION LLC	MMH	ACCESS CONTROL UPGRADE	Replacement	C0016390	F				$81,206			$81,206		
SECURITY 101	MMH	ACCESS CONTROL UPGRADE	Replacement	C0016390	F									
W.B. MASON COMPANY, INC.	RGH	WALDEN EATING DISORDER UNIT	Renovation	C016300P	F					$1,813		$1,813		
RAINTECH SOUND & COMMUNICATION, INC.	RGH	WALDEN EATING DISORDER UNIT	Renovation	C016300R	F		$13,278					$13,278		
STRYKER SALES CORPORATION	RGH	WALDEN EATING DISORDER UNIT	Renovation	C01630AU	F					$68,544		$68,544		
GE MEDICAL SYSTEMS INFORMATION	RGH	WALDEN EATING DISORDER UNIT	Renovation	C16300AV	F			$2,594				$2,594		
GRAYBAR ELECTRIC CO INC.	RGH	WALDEN EATING DISORDER UNIT	Renovation	C16300BB	F		$237					$237		
SHI INTERNAIONAL CORP	RGH	WALDEN EATING DISORDER UNIT	Renovation	C16300BC	F		$1,881					$1,881		
SHI INTERNAIONAL CORP	RGH	WALDEN EATING DISORDER UNIT	Renovation	C16300BC	F		$155					$155		
SOMA TECHNOLOGY, INC.	RGH	WALDEN EATING DISORDER UNIT	Renovation	C16300BD	F		$695					$695		
TRI-ANIM HEALTH SERVICES	RGH	WALDEN EATING DISORDER UNIT	Renovation	C16300BG	F	$413						$413		
TRI-ANIM HEALTH SERVICES	RGH	WALDEN EATING DISORDER UNIT	Renovation	C16300BG	F		$826					$826		
RAINTECH SOUND & COMMUNICATION, INC.	RGH	WALDEN EATING DISORDER UNIT	Renovation	C16300BH	F				$34,882			$34,882		
MODERN MECHANICAL SERVICES, INC	MMH	WATER TOWER TANKS	Replacement	C0016345	N		$90,487					$90,487		
ALL-PHASE ENTERPRISES INC	MMH	GENERATOR FLUE STACK	Replacement	C0016364	N		$9,430					$9,430		
SMITHS MEDICAL ASD INC	MMH	TEMP CHECK	Replacement	C0016379	N	$807						$807		
HILL-ROM	MMH	STRETCHER MATTRESSES (7)	Replacement	C0016388	N		$3,644					$3,644		
HILL-ROM	MMH	STRETCHER MATTRESSES (6)	Replacement	C0016393	N		$2,818					$2,818		
SCALES INDUSTRIAL TECHOLOGIES, LLC	MMH	QUINCY OILESS COMPRESSOR	Replacement	C0016394	N		$12,730					$12,730		
SCALES INDUSTRIAL TECHOLOGIES, LLC	MMH	QUINCY OILESS COMPRESSOR	Replacement	C0016394	N					$1,663		$1,663		
SAFEWARE, INC.	RGH	GAS ALERT DETECTOR	Replacement	C0016398	N					$195		$195		
SAFEWARE, INC.	RGH	GAS ALERT DETECTOR	Replacement	C0016398	N					$2,264		$2,264		
SAFEWARE, INC.	RGH	GAS ALERT DETECTOR	Replacement	C0016398	N								$2,458	
MOREDIRECT INC	WAT	IT - CISCO CATALYST	Replacement	C0016401	N								$10,884	
MOREDIRECT, INC.	RGH	IT - CISCO CATALYST	Replacement	C0016401	N									
JKS SYSTEMS, LLC	WAT	WOODLAKE CABLE RUNS	Replacement	C0016402	N								$5,241	
PRAXAIR DISTRIBUTION, INC	MMH	FBC - NITRONOX E STAND PACKAGE	Replacement	C0016403	N						$11,230	$11,230		
STERIS CORP	MMH	CENTURY STERILIZER COLOR DISPLAY	Replacement	C0016404	N									$10,29
STERIS CORP	MMH	SPD - 3 LEVEL MANIFOLD RACK	Replacement	C0016405	N						$13,662	$13,662		
GERMFREE LABORATORIES, INC	RGH	PHARMACY COMPOUNDING ISOLATOR	Replacement	C0016406	N									
OWENS & MINOR	MMH	DIGITAL SCALE WITH HANDRAILS	Replacement	C0016407	N								$1,606	
HILL-ROM	MMH	CLUB SLEEPER/MATRESS (MATERNITY)	Replacement	C0016408	N									$4,51
CARPETWORKS	MMH	NUCLEAR MED FLOORING	Replacement	C0016413	N						$5,429	$5,429		
CARPETWORKS	RGH	FLOORING - BIII, HOSPICE ICU WAITING RO	Replacement	C0016414	N						$19,452	$19,452		
CARPETWORKS LLC	RGH	FLOORING - BIII, HOSPICE ICU WAITING RO	Replacement	C0016414	N									
CARPETWORKS LLC	RGH	FLOORING - BIII, HOSPICE ICU WAITING RO	Replacement	C0016414	N									
CARPETWORKS	RGH	FLOORING - LITHOTRIPSY	Replacement	C0016415	N						$5,158	$5,158		
HILL ROM COMPANY INCORPORATED	RGH	MATTRESS REPLACEMENT	Replacement	C0016416	N									
KARL STORZ ENDOSCOPY AMERICA, INC.	MMH	VIDEO URETEROSCOPE	Replacement	C0016417	N									
INTOXIMETERS INC	MMH	INTOXIMETER SENSOR	Replacement	C0016418	N								$555	
FLAGSHIP NETWORKS, INC	MMH	CITRIX EDUCATION LICENSING	Replacement	C0016420	N									
SHI INTERNAIONAL CORP	MMH	IPAD AIR ACCESSORIES	Replacement	C0016421	N								$249	
SHI INTERNAIONAL CORP	MMH	APPLE IPAD AIR/ACCESSORIES (5)	Replacement	C0016421	N									$4,05
TRUMPF MEDICAL SYSTEMS	MMH	FOOT SUPPORT, ROTATABLE	Replacement	C0016422	N									$85
W.B. MASON CO INC	MMH	MATERNITY WAITING ROOM FURNITURE	Replacement	C0016425	N									
CDW GOVERNMENT INC	ECMP	HP PROBOOK WITH ACCESSORIES (4)	Replacement	C0016426	N									$4,41
TELEFLEX MEDICAL INCORPORATED	MMH	SURGICAL TOOLS	Replacement	C0016427	N								$3,279	
AESCULAP	MMH	SURGICAL TOOLS	Replacement	C0016428	N								$1,531	
INTERA LIFESCIENCES	MMH	LED HEADLIGHT (3)	Replacement	C0016429	N								$18,479	
SHI INTERNAIONAL CORP	MMH	APPLE IPOD TOUCH (50)	Replacement	C0016430	N								$10,365	
MOREDIRECT, INC.	MMH	FIREWALL REPLACEMENT	Replacement	C0016433	N									
MOREDIRECT, INC.	MMH	FIREWALL REPLACEMENT	Replacement	C0016433	N									
MOREDIRECT, INC.	MMH	FIREWALL REPLACEMENT	Replacement	C0016433	N									
CHIMENET, INC.	MMH	FIREWALL	Replacement	C0016434	N									
PRECISION COMPUTER SERVICES, INC	MMH	IT - CISCO B2000 SERVER/ACCESSORIES	Replacement	C0016435	N									$43,43
PRECISION COMPUTER SERVICES, INC.	MMH	CISCO B200 M4 BLADES/IMPLEMENTATION	Replacement	C0016435	N									
OLYMPUS AMERICA, INC	RGH	PORTABLE RHINO-LARYNGO FIBERSCOPE	Replacement	C0016436	N									$13,11
MORTARA INSTRUMENT, INC.	MMH	CARDIAC REHAB TREADMILL	Replacement	C0016437	N									
MORTARA INSTRUMENT, INC.	RGH	RHAB TREADMILL	Replacement	C0016438	N									
FOLLETT LLC	RGH	EDU - ICE MAKER/WATER DISPENSER	Replacement	C0016439	N									
ERBE USA INCORPORATED	MMH	ENDOSCOPY ACP SYSTEM	Replacement	C0016440	N									
ERBE USA INCORPORATED	RGH	ENDOSCOPY ACP SYSTEM	Replacement	C0016441	N									
ALL-PHASE ENTERPRISES, INC.	WAT	CHOW PLAN OF CORRECTION RENO	Renovation	C0016445	N									
ALL-PHASE ENTERPRISES, INC.	WAT	CHOW PLAN OF CORRECTION RENO	Renovation	C0016445	N									

Exhibit A

Capital Investment Report
Paid Capital
FY 2017

													********** PAYMENT AMOUNT **********		
Vendor	Entity	Item	Purpose	PO #	FundingType	October	November	December	January	February	March	Total	April	May	
ALL-PHASE ENTERPRISES, INC.	WAT	CHOW PLAN OF CORRECTION RENO	Renovation	C0016445	N										
ALL-PHASE ENTERPRISES, INC.	WAT	CHOW PLAN OF CORRECTION RENO	Renovation	C0016445	N										
ALL-PHASE ENTERPRISES, INC.	WAT	CHOW PLAN OF CORRECTION RENO	Renovation	C0016445	N										
ALL-PHASE ENTERPRISES, INC.	WAT	CHOW PLAN OF CORRECTION RENO	Renovation	C0016445	N										
W.B. MASON CO INC	WAT	CHOW RESIDENT ROOM FURNITURE	Renovation	C0016447	N										
W.B. MASON CO INC	MMH	BARIATRIC FURNITURE	Replacement	C0016448	N										
SHI INTERNAIONAL CORP	WAT	CISCO CATALYST - WAT COMPUTER ACCE	Replacement	C0016449	N									$2,247	
JKS SYSTEMS, LLC	WAT	IT WIRING AND CABLE INSTALL	Replacement	C0016450	N										
W.B. MASON CO INC	MMH	PHYSICIAN LOUNGE FURNITURE	Replacement	C0016454	N										
SCOTTCARE CORPORATION	MMH	VERSA CARE TELEMETRY MONITORING SY	Replacement	C0016455	N									$45,628	
CDW GOVERNMENT INC.	MMH	PT MIGRATION TO MEDITECH	Replacement	C0016456	N										
CDW GOVERNMENT INC.	MMH	PT MIGRATION TO MEDITECH	Replacement	C0016456	N										
SHI INTERNAIONAL CORP	MMH	HP745-PT MIGRATION TO MEDITECH	Replacement	C0016457	N									$25,014	
JKS SYSTEMS, LLC	MMH	REHAB ACCESS POINTS	Replacement	C0016458	N										
W.B. MASON CO INC	RGH	ED TASK CHAIRS (10)	Replacement	C0016460	N										
EHR INTEGRATION	ECMP	PATIENT ADT INTERFACE	Replacement	C0016463	N								$5,625		
EHR INTEGRATION SERVICES, LLC	ECMP	ED transition to ECMP Billing	Replacement	C0016463	N										
EHR INTEGRATION SERVICES, LLC	ECMP	ED transition to ECMP Billing	Replacement	C0016463	N										
EHR INTEGRATION SERVICES, LLC	ECMP	ED transition to ECMP Billing	Replacement	C0016463	N										
IATRIC SYSTEMS	MMH	ED TRANSITION TO ECMP BILLING	Replacement	C0016464	N										
JKS SYSTEMS, LLC	MMH	IT CABLING - 44 HAYNES	Replacement	C0016466	N										
MOREDIRECT, INC.	MMH	CRC HARDWARE	Replacement	C0016467	N										
MID-SOUTH TELECOM LLC	MMH	CRC PHONES	Replacement	C0016469	N										
AMPRONIX, INC.	MMH	MEDICAL VIDEO RECORDER	Replacement	C0016470	N										
MOREDIRECT, INC.	MMH	LAPTOP INVENTORY (20)	Replacement	C0016471	N										
MOREDIRECT, INC.	MMH	LAPTOP INVENTORY (20)	Replacement	C0016471	N										
FLAGSHIP NETWORKS, INC	MMH	MCAFEE FOR LAPTOPS (20)	Replacement	C0016472	N										
MCKESSON MEDICAL SURGICAL INC.	ECMP	INFECTIOUS DISEASE WALL UNITS	Replacement	C0016475	N										
EAGLE RIVET ROOF SERVICE CORP.	RGH	CHOW PLAN OF CORRECTION ROOF	Replacement	C0016476	N										
EAGLE RIVET ROOF SERVICE CORP.	RGH	CHOW PLAN OF CORRECTION ROOF	Replacement	C0016476	N										
EAGLE RIVET ROOF SERVICE CORP.	RGH	CHOW PLAN OF CORRECTION ROOF	Replacement	C0016476	N										
PHILIPS HEALTHCARE	RGH	CHOW PLAN OF CORRECTION ROOF	Replacement	C0016477	N										
HOLOGIC LIMITED PARTNERSHIP	MMH	MYOSURE HYSTEROSCOPE	Replacement	C0016478	N										
CLASSIC RESTAURANT SUPPLY	MMH	ICE MACHINE	Replacement	C0016479	N										
INTERIOR CONCEPTS	RGH	CORRIDOR DOOR REPLACEMENT	Replacement	C0016482	N										
INTERIOR CONCEPTS	RGH	CORRIDOR DOOR REPLACEMENT	Replacement	C0016482	N										
MCPHEE ELECTRICAL LTD	RGH	ICU Transformer Replacement	Replacement	C0016486	N										
SHI INTERNATIONAL CORP.	MMH	MED EDU HARDDRIVES AND BATTERIES	Replacement	C0016488	N										
SHI INTERNATIONAL CORP.	MMH	MED EDU HARDDRIVES AND BATTERIES	Replacement	C0016488	N										
SHI INTERNATIONAL CORP.	MMH	LAB DOCUMENT SCANNER	Replacement	C0016489	N										
CONNECTICUT BUSINESS SYSTEMS, LLC	RGH	PRINTER/SCANNER	Replacement	C0016490	N										
CONNECTICUT BUSINESS SYSTEMS, LLC	MMH	PRINTER	Replacement	C0016491	N										
MCKESSON MEDICAL-SURGICAL	WAT	TUB	Replacement	C0016492	N										
SMITH & NEPHEW ENDOSCOPY DIV.	MMH	SHOULDER POSITIONER	Replacement	C0016496	N										
SMITH & NEPHEW ENDOSCOPY DIV.	MMH	SHOULDER POSITIONER	Replacement	C0016496	N										
JKS SYSTEMS, LLC	RGH	WIRING - GI, CARDIO & OR	Replacement	C0016497	N										
SIEMENS MEDICAL SOLUTIONS USA, INC.	MMH	PACS UPGRADE	Replacement	C0016498	N										
HELMER SCIENTIFIC	MMH	LAB REFRIGERATOR	Replacement	C0016500	N										
GE HEALTHCARE IITS USA CORP	MMH	FBC EXPANSION -PROJECT	Replacement	C016281B	N	$3,845						$3,845			
MERRY X-RAY CHEMICAL CORP	MMH	VASCULAR- PROJECT	Replacement	C016312V	N	$652						$652			
CHIMENET, INC.	RGH	IDF UPGRADE/NETWORK REDESIGN	Replacement	C016376A	N				$2,400			$2,400			
CHIMENET, INC.	RGH	IDF UPGRADE/NETWORK REDESIGN	Replacement	C016376A	N					$4,111		$4,111			
MOREDIRECT INC	RGH	COMPUTER CABLES	Replacement	C016376G	N		$1,403					$1,403			
DC CONSULTING SERVICE LLC	ECMP	SOFTWARE	Replacement	C016382B	N	$990						$990			
JKS SYSTEMS, LLC	ECMP	COMPUTER SCANNER	Replacement	C016385A/E	N	$412						$412			
FLAGSHIP NETWORKS, INC	ECMP	LICENSE FEE	Replacement	C016385D	N			$950				$950			
MCKESSON MEDICAL SURGICAL	ECMP	BARIATRIC SCALE	Replacement	C016385F	N	$1,550						$1,550			
MOSER PILON NELSON	MMH	MMH BARIATRIC INPATIENT ROOMS -PROJ	Renovation	C016395A	N	$2,000						$2,000			
MOSER PILON NELSON	MMH	MMH BARIATRIC INPATIENT ROOMS -PROJ	Renovation	C016395A	N	$3,950						$3,950			
MOSER PILON NELSON	MMH	MMH BARIATRIC INPATIENT ROOMS -PROJ	Renovation	C016395A	N	$3,570						$3,570			
MOSER PILON NELSON	MMH	MMH BARIATRIC INPATIENT ROOMS -PROJ	Renovation	C016395A	N				$2,380			$2,380			
MOSER PILON NELSON	MMH	MMH FLUOROSCOPY ROOM-PROJECT	Renovation	C016396A	N	$1,250						$1,250			
MOSER PILON NELSON	MMH	MMH FLUOROSCOPY ROOM-PROJECT	Renovation	C016396A	N	$6,275						$6,275			
MOSER PILON NELSON	MMH	MMH FLUOROSCOPY ROOM-PROJECT	Renovation	C016396A	N	$3,525						$3,525			
MOSER PILON NELSON	MMH	MMH FLUOROSCOPY ROOM-PROJECT	Renovation	C016396A	N				$2,350			$2,350			
MOSER PILON NELSON	MMH	GEROPSYCHIATRY BH UNIT RENOVATIONS	Renovation	C016409A	N						$45,100	$45,100			

Exhibit A

Capital Investment Report
Paid Capital
FY 2017

Vendor	Entity	Item	Purpose	PO #	FundingType	October	November	December	January	February	March	Total	April	May
						**********	**********	**********	**********	**********	PAYMENT AMOUNT	**********	**********	**********
MOSER PILON NELSON	MMH	GEROPSYCHIATRY BH UNIT RENOVATIONS	Renovation	C016409A	N									
MOSER PILON NELSON	MMH	GEROPSYCHIATRY BH UNIT RENOVATIONS	Renovation	C016409A	N									
MOSER PILON NELSON	MMH	GEROPSYCHIATRY BH UNIT RENOVATIONS	Renovation	C016409A	N									
STANDARD BUILDERS, INC.	RGH	GEROPSYCHIATRY BH UNIT RENOVATIONS	Renovation	C016409B	N									
IRVING D. MOY	RGH	GEROPSYCHIATRY BH UNIT RENOVATIONS	Renovation	C016409L	N									
IRVING D. MOY	RGH	GEROPSYCHIATRY BH UNIT RENOVATIONS	Renovation	C016409L	N									
MOSER PILON NELSON	RGH	ADULT BEHAVIORAL HEALTH UNIT	Renovation	C016410A	N						$165,635	$165,635		
MOSER PILON NELSON	RGH	ADULT BEHAVIORAL HEALTH UNIT	Renovation	C016410A	N								$10,000	
MOSER PILON NELSON	RGH	ADULT BEHAVIORAL HEALTH UNIT	Renovation	C016410A	N									$55,250
MOSER PILON NELSON	RGH	ADULT BEHAVIORAL HEALTH UNIT	Renovation	C016410A	N									
STANDARD BUILDERS, INC.	RGH	ADULT BEHAVIORAL HEALTH UNIT	Renovation	C016410B	N									
STANDARD BUILDERS, INC.	RGH	ADULT BEHAVIORAL HEALTH UNIT	Renovation	C016410B	N									
ABATEMENT PLUS, LLC	RGH	ADULT BEHAVIORAL HEALTH UNIT	Renovation	C016410T	N									
ABATEMENT PLUS, LLC	RGH	ADULT BEHAVIORAL HEALTH UNIT	Renovation	C016410T	N									
ALL-PHASE ENTERPRISES, INC.	RGH	ADULT BEHAVIORAL HEALTH UNIT	Renovation	C016410U	N									
HORAK PAINTING CONTRACTORS	RGH	RGH GROUND FLOOR CORRIDOR PAINTIN	Renovation	C016480C	N									
HORAK PAINTING CONTRACTORS	RGH	RGH GROUND FLOOR CORRIDOR PAINTIN	Renovation	C016480C	N									
CARPETWORKS LLC	MMH	PHARMACY ENGINEERING -PROJECT	Replacement	C15875HH	N		$670					$670		
PRO-TECH	WAT	FIRE BLOCKING	Replacement		N					$6,391		$6,391		
CTGI	MMH	LAB - GI COMPUTER INTERFACE	Replacement		N						$17,670	$17,670		
						$29,238	**$138,254**	**$6,771**	**$123,219**	**$84,979**	**$283,336**	**$665,798**	**$70,273**	**$208,818**
		Financing (Debt, Lease)			F	**$413**	**$17,073**	**$5,821**	**$116,089**	**$70,357**	**$0**	**$209,753**	**$0**	**$0**
		New FY 2017 Spending (Operations)			N	**$28,825**	**$121,181**	**$950**	**$7,131**	**$14,622**	**$283,336**	**$456,045**	**$70,273**	**$208,818**
		TOTAL				**$29,238**	**$138,254**	**$6,771**	**$123,219**	**$84,979**	**$283,336**	**$665,798**	**$70,273**	**$208,818**

Michael D. Veillette, Chief Financial Officer, Prospect ECHN, Inc.

Exhibit B

Prospect ECHN, Inc.
FY2017 Approved Capital Expenditures

Vendor Name	Facility	Item Description	Amount	Purpose	Notes
Otis Elevator	MMH	Elevator Sheave Replacement	35,255.00	Repair	
Connection, JKS Systems	ECHN	Voice Mail System Replacement	76,866.48	Replacement	
Omnicell, Inc.	MMH/RGH	Omnicell Dispensing System	1,306,013.10	Replacement	
Connection, JKS Systems	WAT	Wireless Network Expansion	15,721.32	New, Expansion	
GermFree	RGH	Germfree VF-4USP Compounding Aseptic Isolator	16,015.55	Replacement	
Steris Corporation	MMH	Sterilizer Centry Color Display Upgrade	10,949.80	Replacement	
Steris Corporation	MMH	Steris Manifold Racks and Carts (4)	16,647.94	Replacement	
Owens and Minor	MMH		1,692.29	Replacement	
Hill-Rom	MMH	Sleeper Chairs (2)	4,804.04	Replacement	
Praxair	MMH	Nitrous Oxide Delivery System (2)	11,147.61	New, Expansion	
Standard Builders, Inc.	RGH	Renovations for Adult Behavioral Health Unit	4,172,153.04	Replacement	Renovations in process to expand adult behavioral health capacity with 24 beds, completion expected December 2017
Standard Builders, Inc.	MMH	Renovations for Geropsychiatry Unit	818,129.28	Replacement	Renovations underway to provide separate program spaces for adolescent and geriatric patient populations, completion targeted for December 2017
Standard Builders, Inc.	MMH	BHU Safety Renovations	344,700.00	Replacement	In process, with replacement of acoustic ceilings with drywall, targeted completion by December 2017
Flagship Networks	ECHN	Citrix Licenses	9,635.40	New, Expansion	
SHI	MMH/RGH	iPods - Communications Services	4,721.74	New, Expansion	
Karl Storz	MMH	Ureteroscope	19,949.77	Replacement	
Carpetworks, LLC	RGH	Replacement Flooring - Lithotripsy Room	5,157.98	Replacement	
Carpetworks, LLC	RGH	Replacement Flooring - RGH Waiting Rooms	21,042.41	Replacement	
Carpetworks, LLC	MMH	Replacement Flooring - MMH Waiting Rooms	5,429.17	Replacement	
Hill Rom Company	RGH	Mattresses (35)	20,136.63	Replacement	
Prestige Medical Imaging	RGH	Portable X-Ray Unit	148,786.65	Replacement	
Intoximeters, Inc.	MMH	Breath Alcohol Tester	590.23	Replacement	
Teleflex Medical	MMH	Laparoscopic Tray	4,624.20	Replacement	
Integra Life Sciences	MMH	Surgical Headlights	19,662.41	Replacement	
Trumpf Medical	MMH	Trumpf OR Table Extension	903.98	New, Expansion	
Aesculap, Inc.	MMH	Orthopedic Large Bone Tray	1,628.15	Replacement	
WB Mason Company, Inc.	MMH	Waiting Rooms & Maternity Education Room Furniture	27,586.13	Replacement	
WB Mason Company, Inc.	RGH	Waiting Rooms & Nurse Lounge Furniture	15,862.10	Replacement	
WB Mason Company, Inc.	RGH	ED Waiting Room Flooring Replacement	13,033.19	Replacement	
CDW/SHI/Flagship	ECMP	Laptops, PCs	7,711.19	New, Expansion	
SHI	MMH/RGH	iPods for Secure Texting	11,022.88	New, Expansion	
Precision Computer Services, Inc.	ECHN	UCS Chassis & Blade Servers	50,885.35	New, Expansion	
Connection/CHIMENET	ECHN	Network Security Firewall	31,980.56	New, Expansion	
All Phase Construction Enterprises, Inc.	WAT	CHOW Renovations	517,966.35	Replacement	

Exhibit B

Prospect ECHN, Inc.
FY2017 Approved Capital Expenditures

WB Mason Company, Inc.	WAT	CHOW Furniture	240,877.43	Replacement	
Eagle Rivet Roofing	RGH	Roof Replacements (3)	152,075.18	Replacement	
CDW/Flagship/SHI/JKS	MMH/RGH	EMR Hardware	41,404.32	Replacement	
Carpetworks, LLC	MMH	2 East Patient Room Flooring	42,534.68	Replacement	
Carpetworks, LLC	MMH	1 East Corridor & Patient Room Flooring	72,647.69	Replacement	
ERBE USA Incorporated	MMH/RGH	ERBE Argon Plasma Coagulation Units (6)	233,965.32	Replacement	
Motara Instruments	MMH/RGH	Treadmills (4)	23,502.91	Replacement	
WB Mason Company, Inc.	MMH/RGH	Bariatric Furniture	25,845.18	Replacement	
Olympus American, Inc.	RGH	Tracheal & Rhino-Laryngoscopes	12,579.55	Replacement	
Follet	RGH	Ice Machine	2,553.15	Replacement	
SHI/JKS/CDW	WAT	PCs	4,678.94	Replacement	
PCP	ECMP	Practice Acquisition	273,200.00	New, Expansion	
WB Mason	RGH	Task Chairs (10)	3,126.69	Replacement	
WB Mason	MMH	Physician Lounge Furniture	5,899.23	Replacement	
ScottCare	MMH	VersaCare Telemetry Monitoring System	48,482.84	Replacement	
Meditech, CareFusion	MMH/RGH	Omnicell Interfaces	87,100.65	Replacement	
Iatric Systems, EHR Integration Services	MMH/RGH	ED Billing Interfaces	19,304.00	New, Expansion	
Connection, Flagship Networks, JKS Systems	CRC	Laptops for new hires	17,754.90	New, Expansion	
Mid-South Telecom LLC, SHI	CRC	Telephones for new hires	1,226.36	New, Expansion	
Connection, Flagship Networks	ECHN	Laptops for Inventory	23,327.82	Replacement	
Carpetworks, LLC	RGH	ICU Flooring Replacement	14,585.90	Replacement	
McKesson	ECMP	Exam Room Diagnostics Wall Units (2)	1,778.85	Replacement	
Mid-South Telecom LLC	ECMP	Telephone Headsets	1,312.95	Replacement	
Ampronix	MMH	HD Medical Video Recorder	4,241.24	Replacement	
Philips Healthcare	ECMP	Stress System, EKG Machine	26,302.80	Replacement	
Carpetworks, LLC Horak Painting, Abatement Plus	RGH	Ground Floor Renovations	92,683.04	Replacement	
Interior Concepts	RGH	Corridor Door Replacements	30,179.75	Replacement	
Classic Restaurant Supply	MMH	Ice cube machines (2)	4,730.43	Replacement	
Hologic	MMH	Hysteroscope & instrument tray	6,907.43	Replacement	
Hovertech International Air Supply & Storage Cart	MMH	HoverMatt Patient Transport System	1,447.42	New, Expansion	
CDW	MMH	3 Laptops	3,203.26	New, Expansion	
SHI	MMH	9 computer laptop hard drives & batteries	1,289.85	New, Expansion	
CBS	RGH	Printer/Scanner	1,302.79	New, Expansion	
Smith & Nephew	RGH	Shoulder positioner	4,439.05	New, Expansion	
Carpetworks, LLC	MMH	Vinyl flooring, ASC	11,858.03	Replacement	
Accurate Doors	RGH	Exterior doors (3)	12,740.73	Replacement	
SHI	MMH	Document scanner	944.12	New, Expansion	
K.M. Medical, Inc.	MMH	Lead aprons	7,174.22	Replacement	
K.M. Medical, Inc.	RGH	Lead aprons	2,080.21	Replacement	

Exhibit B

Prospect ECHN, Inc.
FY2017 Approved Capital Expenditures

JKS Systems	RGH	Data cabling	1,372.39	New, Expansion	
McPhee Electric	RGH	Transformer	48,921.00	Replacement	
McKesson	WAT	Tub with lift	12,102.63	Replacement	
Direct Supply	WAT	Hoyer Lifts with scales	4,852.80	New, Expansion	
Direct Supply	WAT	Vital Signs Monitors with stands	11,293.08	Replacement	
CBS	MMH	Printer	1,544.20	New, Expansion	
Siemens	ECHN	PACs System Upgrade	153,207.26	Replacement	
Karl Storz	MMH	Difficult Airways Carts (Two)	76,337.86	New, Expansion	
Olympus	MMH	Vacuum Curettage System	7,269.77	Replacement	
WB Mason	MMH	Office Chairs	8,975.94	Replacement	
Carpetworks, LLC	RGH	Bissell 2 Corridor Flooring Replacement	22,375.24	Replacement	
Carpetworks, LLC	MMH	Sleep Center Carpet Replacement	14,288.05	Replacement	
Helmer	MMH	Laboratory Refrigerator	5,503.46	Replacement	
Meditech	ECHN	Patient Portal	233,863.65	Replacement	
Smiths Medical	RGH	Infuser	10,004.08	New, Expansion	
W.B. Mason	MMH	Office Chairs	4,702.35	Replacement	
JKS Systems	ECHN	Cable data runs for wireless networks	2,677.30	New, Expansion	
Security 101	RGH	CCTV Replacement for Sterile Processing Facility	16,595.05	Replacement	
Eastcoast Paving Services	RGH	Service Drive and East Parking Lot Paving	73,010.00	Replacement	
Hartford Sprinkler Company	MMH	Garage Standpipe Replacement	17,600.93	Replacement	
Security 101	RGH	RGH Security Video Infrastructure	34,486.94	Replacement	
KTW Group	MMH	Surgical Case Carts	28,269.73	Replacement	
Stryker	RGH	Psychiatric Beds	76,959.65	Replacement	
Encore Fire Protection	RGH	Additional Sprinklers	29,964.11	New, Expansion	
Wells Johnson Company	MMH	Plastic Surgery Infiltration Pump	2,793.69	Replacement	
Stryker	MMH	Makoplasty Total Knee Application	297,780.00	New, Expansion	
Silktown Roofing, Inc.	MMH	CHOW POC Roof Replacements	1,326,920.97	Replacement	
All Phase Enterprises	MMH	Paving and Concrete Work	136,071.40	Replacement	
TPC Associatess, Inc	MMH	Hugs Infant Protection System	94,055.94	Replacement	
Alcon Laboratories	MMH	Alcon Constellation Retina Vitrectomy Machine	99,543.60	Replacement	
Electrical Wholesalers, Inc.	MMH	Replacement Exit Signs	14,632.91	Replacement	
Mindray	MMH/RGH	18 Anesthesia Machines	711,946.79	Replacement	
			$ 12,909,623.60		

Exhibit C
Prospect Manchester Hospital, Prospect Rockville Hospital and Prospect ECHN
Report 175 - Operating Expenses by Category
Comparison: October 2016 - March 2017 and April 2017 - September 2017

		October 2016 - March 2017			April 2017 - September 2017			Variance		
Line	Operating Expense by Category	MMH	RGH	ECHN	MMH	RGH	ECHN	MMH	RGH	ECHN
A	Salaries & Wages	$39,112,524	$14,071,000	$53,183,524	$37,836,794	$13,359,480	$51,196,274	($1,275,730)	($711,520)	($1,987,250)
B	Fringe Benefits	$13,822,026	$5,117,453	$18,939,479	$7,537,643	$3,238,088	$10,775,730	($6,284,383)	($1,879,365)	($8,163,749)
C	Contractual Labor Fees	$5,029,260	$2,271,227	$7,300,487	$6,638,425	$3,290,725	$9,929,150	$1,609,165	$1,019,498	$2,628,663
D	Medical Supplies & Phamaceutical Cost	$13,471,362	$3,913,060	$17,384,422	$13,316,492	$2,360,289	$15,676,781	($154,870)	($1,552,771)	($1,707,641)
E	Depreciation & Amortization	$3,536,666	$1,478,850	$5,015,516	$3,364,656	$1,452,043	$4,816,699	($172,010)	($26,807)	($198,817)
F	Bad Debts	$0	$0	$0	$0	$0	$0	$0	$0	$0
G	Interest Expense	$3,634,528	$1,075,070	$4,709,598	$3,598,889	$1,087,538	$4,686,428	($35,639)	$12,468	($23,171)
H	Malpractice Insurance Cost	$1,290,472	$504,808	$1,795,280	$153,148	$272,714	$425,862	($1,137,324)	($232,094)	($1,369,418)
I	Utilities	$1,380,083	$665,214	$2,045,297	$1,363,160	$628,562	$1,991,722	($16,922)	($36,652)	($53,574)
J	Business Expense	$13,597,193	$5,644,173	$19,241,366	$15,554,280	$5,874,021	$21,428,301	$1,957,087	$229,848	$2,186,935
K	Other Operating Expenses	-	-	-	-	-	-	$0	$0	$0
	Total Operating Expenses - All Expense Categories	$94,874,114	$34,740,855	$129,614,969	$89,363,489	$31,563,458	$120,926,947	($5,510,625)	($3,177,396)	($8,688,022)

Exhibit D - Effect of Cost Savings on Clinical Quality of Care

The clinical □uality of care at Manchester Memorial Hospital (MMH) and Rockville General Hospital (RGH) has improved over the past year as evidenced in the key □uality metrics charts below. This is attributed to the strong culture of safety that continues at the hospitals. The daily safety huddle, safety moments to begin every meeting and the continued education on HRO Safety culture to all staff and physicians are examples of the safety culture fully supported by the hospitals' senior leadership.

Manchester Memorial Hospital

Quality Metric	2016	2017	Change
Overall Infection Rate	0.8□	0.6□	-0.2□
Surgical Site Infection Rate	0.7□	0.4□	-0.3□
Colorectal SSI Rate	8.3□	7.1□	-1.2□
Abd Hysterectomy SSIs	1	1	0
Total Hip and □nee Infections	3	0	-3
C-Section Infections	13	0	-13
Handwashing Compliance Rate	48.0□	95.0□	47.0□
C-diffle Rate	0.7□	0.4□	-0.3□
CLABSIS, ICU	2	1	-1
CAUTIs, ICU	0	0	0
CAUTIs, Non - ICU	3	2	-1
Ventilator Ac□uired Events	13.7□	9.0□	-4.7□
Readmission Rates	9.2□	6.6□	-2.6□
Penalty Rates (readmissions)	1.05□	0.51□	-0.54□

Rockville General Hospital

Quality Metric	2016	2017	Change
Overall Infection Rate	0.8□	0.7□	-0.1□
Surgical Site Infection Rate□	0.3□	0.5□	0.2□
Colorectal SSI Rate	0	0	0
Abd Hysterectomy SSIs	0	0	0
Total Hip and □nee Infections	n□a	n□a	n□a
C-Section Infections	n□a	n□a	n□a
Handwashing Compliance Rate	78.0□	91.0□	13.0□
C-diffle Rate	0.9□	0.3□	-0.6□
CLABSIS, ICU	2	0	-2
CAUTIs, ICU	0	1	1
CAUTIs, Non - ICU	0	0	0
Ventilator Ac□uired Events	23.1□	15.2□	-7.9□
Readmission Rates	11.4□	10.6□	-0.8□
Penalty Rates (readmission)	1.83□	0.72□	-1.11□

□The overall number of SSIs is down from 5 in 2016 to 4 in 2017. Denominator decreased making the rate higher.

Exhibit D - Effect of Cost Savings on Clinical Quality of Care

In addition, positions have been added to the Quality and Safety department. A full-time and a part-time Quality Manager have been added as well as a Clinical Educator (shared between ECHN and Waterbury Hospital). As important, The PMH Chief Quality Officer sponsors monthly □uality calls and is available for □uestions and advice. The Regional Vice President for Quality and Safety works directly with the hospitals on □uality projects and initiatives and is also a valuable resource. The recent PMH Mock Survey is an example of a value added service by PMH to prepare our hospitals for the upcoming TJC surveys next year.

As evidenced by the key □uality metrics, added positions and available regional and corporate resources, the clinical □uality of care at MMH and RGH has been strengthened over the past year. Leadership at the local, regional and national levels has empowered the hospitals to continue to advance the culture of safety.

EXHIBIT E

PROSPECT ECHN, INC.		
AS OF SEPTEMBER 30, 2017		
FISCAL YEAR 2017		
REPORT 300 - PARENT CORPORATION CONSOLIDATED BALANCE SHEET INFORMATION		
(1)	(2)	(3)
		SEPT 2017
LINE	DESCRIPTION	ACTUAL
I.	**ASSETS**	
A.	**Current Assets:**	
1	Cash and Cash Equivalents	$4,194,382
2	Short Term Investments	
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$40,804,492
4	Current Assets Whose Use is Limited for Current Liabilities	
5	Due From Affiliates	$7,637,864
6	Due From Third Party Payers	
7	Inventories of Supplies	$6,054,400
8	Prepaid Expenses	$4,140,461
9	Other Current Assets	$2,435,581
	Total Current Assets	**$65,267,180**
B.	**Noncurrent Assets Whose Use is Limited:**	
1	Held by Trustee	$0
2	Board Designated for Capital Acquisition	
3	Funds Held in Escrow	
4	Other Noncurrent Assets Whose Use is Limited	
	Total Noncurrent Assets Whose Use is Limited:	**$0**
5	Interest in Net Assets of Foundation	
6	Long Term Investments	$13,734,336
7	Other Noncurrent Assets	$9,430,650
C.	**Net Fixed Assets:**	
1	Property, Plant and Equipment	$328,929,302
2	Less: Accumulated Depreciation	$250,110,586
	Less: Purchase Adjustment	$18,316,556
	Property, Plant and Equipment, Net	**$60,502,160**
3	Construction in Progress	$1,687,933
	Total Net Fixed Assets	**$62,190,093**
	Total Assets	**$150,622,259**

EXHIBIT E

PROSPECT ECHN, INC.		
AS OF SEPTEMBER 30, 2017		
FISCAL YEAR 2017		
REPORT 300 - PARENT CORPORATION CONSOLIDATED BALANCE SHEET INFORMATION		
(1)	(2)	(3)
		SEPT 2017
LINE	DESCRIPTION	ACTUAL
II.	**LIABILITIES AND NET ASSETS**	
A.	**Current Liabilities:**	
1	Accounts Payable and Accrued Expenses	$22,013,628
2	Salaries, Wages and Payroll Taxes	$5,641,078
3	Due To Third Party Payers	$2,192,261
4	Due To Affiliates	$1,793,691
5	Current Portion of Long Term Debt	$0
6	Current Portion of Notes Payable	$2,599,963
7	Other Current Liabilities	$10,280,642
	Total Current Liabilities	**$44,521,263**
B.	**Long Term Debt:**	
1	Bonds Payable (Net of Current Portion)	
2	Notes Payable (Net of Current Portion)	$8,929,268
	Total Long Term Debt	**$8,929,268**
3	Accrued Pension Liability	$66,866,795
4	Other Long Term Liabilities	$15,376,744
	Total Long Term Liabilities	**$91,172,807**
5	Interest in Net Assets of Affiliates or Joint Ventures	
C.	**Net Assets:**	
1	Net Assets or Equity	$14,928,189
2	Temporarily Restricted Net Assets	
3	Permanently Restricted Net Assets	
	Total Net Assets	**$14,928,189**
	Total Liabilities and Net Assets	**$150,622,259**

EXHIBIT E

PROSPECT ECHN, INC.				
FISCAL YEAR 2017				
REPORT 350 - PARENT CORPORATION CONSOLIDATED STATEMENT OF OPERATIONS INFORMATION				
(1)	(2)	(3)	(4)	
		OCT-MAR	APR-SEP	YTD SEPT 17
LINE	DESCRIPTION	ACTUAL	ACTUAL	ACTUAL
A.	**Operating Revenue:**			
1	Total Gross Patient Revenue	$497,056,059	495,473,693	$992,529,752
2	Less: Allowances	$341,478,789	340,297,357	$681,776,146
3	Less: Charity Care	$1,281,566	1,403,978	$2,685,544
4	Less: Other Deductions	$0	-	$0
	Total Net Patient Revenue	**$154,295,704**	**$153,772,358**	**$308,068,062**
5	Provision for Bad Debts	$3,835,978	3,823,267	$7,659,245
	Net Patient Service Revenue less provision for bad debts	**$150,459,726**	**$149,949,091**	**$300,408,817**
6	Other Operating Revenue	$10,793,602	13,395,083	$24,188,685
7	Net Assets Released from Restrictions	$0	-	$0
	Total Operating Revenue	**$161,253,328**	**$163,344,174**	**$324,597,502**
B.	**Operating Expenses:**			
1	Salaries and Wages	$73,885,912	74,572,521	$148,458,433
2	Fringe Benefits	$23,050,448	15,221,280	$38,271,728
3	Physicians Fees	$8,053,331	10,257,207	$18,310,538
4	Supplies and Drugs	$18,371,771	16,671,870	$35,043,641
5	Depreciation and Amortization	$5,698,189	5,209,480	$10,907,669
6	Bad Debts	$0	-	$0
7	Interest Expense	$4,729,540	4,703,035	$9,432,575
8	Malpractice Insurance Cost	$1,774,010	1,303,960	$3,077,970
9	Other Operating Expenses	$29,049,379	30,215,848	$59,265,227
	Total Operating Expenses	**$164,612,580**	**$158,155,201**	**$322,767,781**
	Income/(Loss) From Operations	**($3,359,252)**	**$5,188,973**	**$1,829,721**
C.	**Non-Operating Revenue:**			
1	Income from Investments	$0	-	$0
2	Gifts, Contributions and Donations	$0	-	$0
3	Other Non-Operating Gains/(Losses)	$2,913,137	1,063,254	$3,976,391
	Total Non-Operating Revenue	**$2,913,137**	**$1,063,254**	**$3,976,391**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**($446,115)**	**$6,252,227**	**$5,806,112**
	Other Adjustments:			
	Unrealized Gains/(Losses)	$0	-	$0
	All Other Adjustments	$0	-	$0
	Total Other Adjustments	**$0**	**$0**	**$0**
	Excess/(Deficiency) of Revenue Over Expenses	**($446,115)**	**$6,252,227**	**$5,806,112**

PROSPECT MANCHESTER HOSPITAL		
AS OF SEPTEMBER 30, 2017		
FISCAL YEAR 2017		
REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION		
(1)	(2)	(3)
		SEPT 2017
LINE	DESCRIPTION	ACTUAL
I.	**ASSETS**	
A.	**Current Assets:**	
1	Cash and Cash Equivalents	$187,195
2	Short Term Investments	$0
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$25,353,520
4	Current Assets Whose Use is Limited for Current Liabilities	$0
5	Due From Affiliates	$28,172,147
6	Due From Third Party Payers	$0
7	Inventories of Supplies	$4,543,626
8	Prepaid Expenses	$1,169,286
9	Other Current Assets	$51,857
	Total Current Assets	**$59,477,631**
B.	**Noncurrent Assets Whose Use is Limited:**	
1	Held by Trustee	$0
2	Board Designated for Capital Acquisition	$0
3	Funds Held in Escrow	$0
4	Other Noncurrent Assets Whose Use is Limited	$0
	Total Noncurrent Assets Whose Use is Limited:	**$0**
5	Interest in Net Assets of Foundation	$0
6	Long Term Investments	$3,794,969
7	Other Noncurrent Assets	$3,029,736
C.	**Net Fixed Assets:**	
1	Property, Plant and Equipment	$206,836,787
2	Less: Accumulated Depreciation	$160,975,889
	Less: Purchase Adjustment	$487,696
	Property, Plant and Equipment, Net	**$45,373,202**
3	Construction in Progress	$683,673
	Total Net Fixed Assets	**$46,056,875**
	Total Assets	**$112,359,211**

EXHIBIT E

PROSPECT MANCHESTER HOSPITAL		
AS OF SEPTEMBER 30, 2017		
FISCAL YEAR 2017		
REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION		
(1)	(2)	(3)
		SEPT 2017
LINE	DESCRIPTION	ACTUAL
II.	**LIABILITIES AND NET ASSETS**	
A.	**Current Liabilities:**	
1	Accounts Payable and Accrued Expenses	$14,932,883
2	Salaries, Wages and Payroll Taxes	$2,694,055
3	Due To Third Party Payers	$788,545
4	Due To Affiliates	$10,122,005
5	Current Portion of Bonds	$0
6	Current Portion of Notes Payable	$2,120,518
7	Other Current Liabilities	$82,105
	Total Current Liabilities	**$30,740,111**
B.	**Long Term Debt:**	
1	Bonds Payable (Net of Current Portion)	$0
2	Notes Payable (Net of Current Portion)	$3,954,712
	Total Long Term Debt	**$3,954,712**
3	Accrued Pension Liability	$52,162,410
4	Other Long Term Liabilities	$11,309,575
	Total Long Term Liabilities	**$67,426,697**
5	Interest in Net Assets of Affiliates or Joint Ventures	$0
C.	**Net Assets:**	
1	Unrestricted Net Assets or Equity	$14,192,403
2	Temporarily Restricted Net Assets	$0
3	Permanently Restricted Net Assets	$0
	Total Net Assets	**$14,192,403**
	Total Liabilities and Net Assets	**$112,359,211**

EXHIBIT E

PROSPECT MANCHESTER HOSPITAL					
FISCAL YEAR 2017					
REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION					
(1)	(2)	(3)		(4)	
LINE	DESCRIPTION	OCT-MAR ACTUAL		APR-SEP ACTUAL	YTD SEPT 17 ACTUAL
A.	**Operating Revenue:**				
1	Total Gross Patient Revenue	$336,306,535		341,770,277	$678,076,812
2	Less: Allowances	$240,249,012		245,237,735	$485,486,747
3	Less: Charity Care	$897,095		891,350	$1,788,445
4	Less: Other Deductions	$0		-	$0
	Total Net Patient Revenue	**$95,160,428**		**$95,641,192**	**$190,801,620**
5	Provision for Bad Debts	$2,267,527		2,331,749	$4,599,276
	Net Patient Service Revenue less provision for bad debts	**$92,892,901**		**$93,309,443**	**$186,202,344**
6	Other Operating Revenue	$4,641,099		4,411,751	$9,052,850
7	Net Assets Released from Restrictions	($1,983)		609	($1,374)
	Total Operating Revenue	**$97,532,017**		**$97,721,803**	**$195,253,820**
B.	**Operating Expenses:**				
1	Salaries and Wages	$39,112,524		37,836,793	$76,949,317
2	Fringe Benefits	$13,822,026		7,537,643	$21,359,669
3	Physicians Fees	$5,029,260		6,638,425	$11,667,685
4	Supplies and Drugs	$13,471,362		13,316,493	$26,787,855
5	Depreciation and Amortization	$3,536,666		3,364,656	$6,901,322
6	Bad Debts	$0		-	$0
7	Interest Expense	$3,634,528		3,598,890	$7,233,418
8	Malpractice Insurance Cost	$1,290,472		153,148	$1,443,620
9	Other Operating Expenses	$14,977,276		16,917,441	$31,894,717
	Total Operating Expenses	**$94,874,114**		**$89,363,489**	**$184,237,603**
	Income/(Loss) From Operations	**$2,657,903**		**$8,358,314**	**$11,016,217**
C.	**Non-Operating Revenue:**				
1	Income from Investments	$0		-	$0
2	Gifts, Contributions and Donations	$0		-	$0
3	Other Non-Operating Gains/(Losses)	$2,252,032		790,912	$3,042,944
	Total Non-Operating Revenue	**$2,252,032**		**$790,912**	**$3,042,944**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**$4,909,935**		**$9,149,226**	**$14,059,161**
	Other Adjustments:				
	Unrealized Gains/(Losses)	$0		-	$0
	All Other Adjustments	$0		-	$0
	Total Other Adjustments	**$0**		-	$0
	Excess/(Deficiency) of Revenue Over Expenses	**$4,909,935**		**$9,149,226**	**$14,059,161**

EXHIBIT E

PROSPECT ROCKVILLE HOSPITAL		
AS OF SEPTEMBER 30, 2017		
FISCAL YEAR 2017		
REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION		
(1)	(2)	(3)
LINE	DESCRIPTION	SEP 2017 ACTUAL
I.	**ASSETS**	
A.	**Current Assets:**	
1	Cash and Cash Equivalents	$1,037
2	Short Term Investments	$0
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$7,440,504
4	Current Assets Whose Use is Limited for Current Liabilities	$0
5	Due From Affiliates	$2,070,993
6	Due From Third Party Payers	$0
7	Inventories of Supplies	$1,220,807
8	Prepaid Expenses	$469,984
9	Other Current Assets	$283,071
	Total Current Assets	**$11,486,396**
B.	**Noncurrent Assets Whose Use is Limited:**	
1	Held by Trustee	$0
2	Board Designated for Capital Acquisition	$0
3	Funds Held in Escrow	$0
4	Other Noncurrent Assets Whose Use is Limited	$0
	Total Noncurrent Assets Whose Use is Limited:	**$0**
5	Interest in Net Assets of Foundation	$0
6	Long Term Investments	$3,352,337
7	Other Noncurrent Assets	$218,639
C.	**Net Fixed Assets:**	
1	Property, Plant and Equipment	$92,922,999
2	Less: Accumulated Depreciation	$70,435,459
	Less: Purchase Adjustment	$13,867,063
	Property, Plant and Equipment, Net	**$8,620,477**
3	Construction in Progress	$1,004,260
	Total Net Fixed Assets	**$9,624,737**
	Total Assets	**$24,682,109**

EXHIBIT E

PROSPECT ROCKVILLE HOSPITAL		
AS OF SEPTEMBER 30, 2017		
FISCAL YEAR 2017		
REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION		
(1)	(2)	(3)
LINE	DESCRIPTION	SEP 2017 ACTUAL
II.	**LIABILITIES AND NET ASSETS**	
A.	**Current Liabilities:**	
1	Accounts Payable and Accrued Expenses	$3,442,840
2	Salaries, Wages and Payroll Taxes	$538,322
3	Due To Third Party Payers	$639,008
4	Due To Affiliates	$4,246,725
5	Current Portion of Bonds	$0
6	Current Portion of Notes Payable	$159,691
7	Other Current Liabilities	($5,069)
	Total Current Liabilities	**$9,021,517**
B.	**Long Term Debt:**	
1	Bonds Payable (Net of Current Portion)	$0
2	Notes Payable (Net of Current Portion)	$445,778
	Total Long Term Debt	**$445,778**
3	Accrued Pension Liability	$14,704,385
4	Other Long Term Liabilities	$3,626,284
	Total Long Term Liabilities	**$18,776,447**
5	Interest in Net Assets of Affiliates or Joint Ventures	$0
C.	**Net Assets:**	
1	Unrestricted Net Assets or Equity	($3,115,855)
2	Temporarily Restricted Net Assets	$0
3	Permanently Restricted Net Assets	$0
	Total Net Assets	**($3,115,855)**
	Total Liabilities and Net Assets	**$24,682,109**

EXHIBIT E

PROSPECT ROCKVILLE HOSPITAL					
FISCAL YEAR 2017					
REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION					
(1)	(2)	(3)		(4)	
		OCT-MAR		APR-SEP	YTD SEPT 17
LINE	DESCRIPTION	ACTUAL		ACTUAL	ACTUAL
A.	**Operating Revenue:**				
1	Total Gross Patient Revenue	$117,512,312		111,285,475	$228,797,787
2	Less: Allowances	$85,243,699		79,722,557	$164,966,256
3	Less: Charity Care	$384,471		512,628	$897,099
4	Less: Other Deductions	$0		$0	$0
	Total Net Patient Revenue	**$31,884,142**		**$31,050,290**	**$62,934,432**
5	Provision for Bad Debts	$1,204,542		878,752	$2,083,294
	Net Patient Service Revenue less provision for bad debts	**$30,679,600**		**$30,171,538**	**$60,851,138**
6	Other Operating Revenue	$725,658		677,221	$1,402,879
7	Net Assets Released from Restrictions	$0		-	$0
	Total Operating Revenue	**$31,405,258**		**$30,848,759**	**$62,254,017**
B.	**Operating Expenses:**				
1	Salaries and Wages	$14,071,000		13,359,480	$27,430,480
2	Fringe Benefits	$5,117,453		3,238,087	$8,355,540
3	Physicians Fees	$2,271,227		3,290,725	$5,561,952
4	Supplies and Drugs	$3,913,060		2,360,289	$6,273,348
5	Depreciation and Amortization	$1,478,850		1,452,043	$2,930,893
6	Bad Debts	$0		-	$0
7	Interest Expense	$1,075,070		1,087,539	$2,162,609
8	Malpractice Insurance Cost	$504,808		272,714	$777,522
9	Other Operating Expenses	$6,309,386		6,502,582	$12,811,969
	Total Operating Expenses	**$34,740,854**		**$31,563,459**	**$66,304,313**
	Income/(Loss) From Operations	**($3,335,596)**		**($714,700)**	**($4,050,296)**
C.	**Non-Operating Revenue:**				
1	Income from Investments	$0		-	$0
2	Gifts, Contributions and Donations	$0		-	$0
3	Other Non-Operating Gains/(Losses)	$661,105		273,337	$934,442
	Total Non-Operating Revenue	**$661,105**		**$273,337**	**$934,442**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**($2,674,491)**		**($441,363)**	**($3,115,854)**
	Other Adjustments:				
	Unrealized Gains/(Losses)	$0			
	All Other Adjustments	$0			
	Total Other Adjustments	**$0**		**$0**	**$0**
	Excess/(Deficiency) of Revenue Over Expenses	**($2,674,491)**		**($441,363)**	**($3,115,854)**

EXHIBIT F

PROSPECT ECHN, INC.

FISCAL YEAR 2017

		30	31	30	31	31	30	212	243	273	304	335	365
		MTD						YTD					
		APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER
	DESCRIPTION	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017
	Total Gross Revenue	$82,691,702	$88,343,824	$83,439,485	$76,823,377	$82,825,517	$81,349,780	$579,747,769	$668,091,593	$751,531,078	$828,354,455	$911,179,972	$992,529,752
	Total Allowances	($56,884,573)	($62,418,710)	($57,386,457)	($52,059,374)	($57,273,245)	($55,678,974)	($399,644,930)	($462,063,640)	($519,450,097)	($571,509,471)	($628,782,716)	($684,461,690)
	Bad Debt	($609,259)	($621,247)	($625,192)	($627,115)	$110,367	($1,450,823)	($4,445,236)	($5,066,483)	($5,691,675)	($6,318,790)	($6,208,423)	($7,659,246)
	Net Patient Revenue	$25,197,870	$25,303,867	$25,427,836	$24,136,888	$25,662,639	$24,219,983	$175,657,603	$200,961,470	$226,389,306	$250,526,194	$276,188,833	$300,408,816
	Other Operating Revenue	1,790,192	1,749,148	2,534,456	2,571,286	2,228,382	2,521,619	$12,583,796	$14,332,944	$16,867,400	$19,438,686	$21,667,068	$24,188,687
	Total Operating Revenue	$26,988,062	$27,053,015	$27,962,292	$26,708,174	$27,891,021	$26,741,602	$188,241,399	$215,294,414	$243,256,706	$269,964,880	$297,855,901	$324,597,503
	Total Operating Expenses	27,089,663	27,705,300	27,511,370	27,697,629	27,727,440	20,423,791	$191,702,251	$219,407,551	$246,918,921	$274,616,550	$302,343,990	$322,767,781
	Income/(Loss) From Operations	($101,601)	($652,285)	$450,922	($989,455)	$163,581	$6,317,811	($3,460,852)	($4,113,137)	($3,662,215)	($4,651,670)	($4,488,089)	$1,829,722
	Total Non-Operating Revenue	491,654	488,324	437,838	452,013	512,535	(1,319,110)	$3,404,791	$3,893,115	$4,330,953	$4,782,966	$5,295,501	$3,976,391
	Excess/(Deficiency) of Revenue Over Expenses	$390,053	($163,961)	$888,760	($537,442)	$676,116	$4,998,701	($56,061)	($220,022)	$668,738	$131,296	$807,412	$5,806,113
A	**Operating Performance**												
1	**Operating Margin**	**-0.37%**	**-2.37%**	**1.59%**	**-3.64%**	**0.58%**	**24.85%**	**-1.81%**	**-1.88%**	**-1.48%**	**-1.69%**	**-1.48%**	**0.56%**
2	**Non-Operating Margin**	**1.79%**	**1.77%**	**1.54%**	**1.66%**	**1.80%**	**-5.19%**	**1.78%**	**1.78%**	**1.75%**	**1.74%**	**1.75%**	**1.21%**
3	**Total Margin**	**1.42%**	**-0.60%**	**3.13%**	**-1.98%**	**2.38%**	**19.66%**	**-0.03%**	**-0.10%**	**0.27%**	**0.05%**	**0.27%**	**1.77%**
4	**Bad Debt as % of Gross Revenue**	**0.74%**	**0.70%**	**0.75%**	**0.82%**	**-0.13%**	**1.78%**	**0.77%**	**0.76%**	**0.76%**	**0.76%**	**0.68%**	**0.77%**
	Income/(Loss) From Operations	($101,601)	($652,285)	$450,922	($989,455)	$163,581	$6,317,811	($3,460,852)	($4,113,137)	($3,662,215)	($4,651,670)	($4,488,089)	$1,829,722
	Total Operating Revenue	$26,988,062	$27,053,015	$27,962,292	$26,708,174	$27,891,021	$26,741,602	$188,241,399	$215,294,414	$243,256,706	$269,964,880	$297,855,901	$324,597,503
	Total Non-Operating Revenue	$491,654	$488,324	$437,838	$452,013	$512,535	($1,319,110)	$3,404,791	$3,893,115	$4,330,953	$4,782,966	$5,295,501	$3,976,391
	Total Revenue	$27,479,716	$27,541,339	$28,400,130	$27,160,187	$28,403,556	$25,422,492	$191,646,190	$219,187,529	$247,587,659	$274,747,846	$303,151,402	$328,573,894
	Excess/(Deficiency) of Revenue Over Expenses	$390,053	($163,961)	$888,760	($537,442)	$676,116	$4,998,701	($56,061)	($220,022)	$668,738	$131,296	$807,412	$5,806,113
	Unrealized gain/(loss) in investments (self-insurance fu	($16,938)	$35,621	$22,301	$28,283	$33,560	$50,419	$8,951,891	$8,987,512	$9,009,813	$9,038,096	$9,071,656	$9,122,076
	Unrestricted Net Assets	$8,895,830	$8,767,490	$9,678,551	$9,169,392	$9,879,069	$14,928,189	$8,895,830	$8,767,490	$9,678,551	$9,169,392	$9,879,069	$14,928,189
	Total Net Assets	$8,895,830	$8,767,490	$9,678,551	$9,169,392	$9,879,069	$14,928,189	$8,895,830	$8,767,490	$9,678,551	$9,169,392	$9,879,069	$14,928,189

EXHIBIT F

PROSPECT ECHN, INC.

FISCAL YEAR 2017

		30	31	30	31	31	30	212	243	273	304	335	365
		MTD						YTD					
	DESCRIPTION	APRIL FY 2017	MAY FY 2017	JUNE FY 2017	JULY FY 2017	AUGUST FY 2017	SEPTEMBER FY 2017	APRIL FY 2017	MAY FY 2017	JUNE FY 2017	JULY FY 2017	AUGUST FY 2017	SEPTEMBER FY 2017
	Total Gross Revenue	$82,691,702	$88,343,824	$83,439,485	$76,823,377	$82,825,517	$81,349,780	$579,747,769	$668,091,593	$751,531,078	$828,354,455	$911,179,972	$992,529,752
	Total Allowances	($56,884,573)	($62,418,710)	($57,386,457)	($52,059,374)	($57,273,245)	($55,678,974)	($399,644,930)	($462,063,640)	($519,450,097)	($571,509,471)	($628,782,716)	($684,461,690)
B.	**Liquidity**												
1	**Current Ratio**	**1.40**	**1.59**	**1.51**	**1.44**	**1.47**	**1.47**	**1.40**	**1.59**	**1.51**	**1.44**	**1.47**	**1.47**
	Total Current Assets	$56,328,390	$60,703,755	$70,504,415	$71,818,936	$69,714,185	$65,267,180	$56,328,390	$60,703,755	$70,504,415	$71,818,936	$69,714,185	$65,267,180
	Total Current Liabilities	$40,275,522	$38,067,856	$46,537,992	$49,827,911	$47,301,237	$44,521,263	$40,275,522	$38,067,856	$46,537,992	$49,827,911	$47,301,237	$44,521,263
2	**Days Cash on Hand**	**9**	**11**	**12**	**15**	**14**	**6**	**9**	**11**	**12**	**15**	**14**	**5**
	Cash and Cash Equivalents	$7,587,205	$9,775,808	$10,647,848	$12,779,817	$12,532,259	$4,194,385	$7,587,205	$9,775,808	$10,647,848	$12,779,817	$12,532,259	$4,194,385
	Short Term Investments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Total Cash and Short Term Investments	$7,587,205	$9,775,808	$10,647,848	$12,779,817	$12,532,259	$4,194,385	$7,587,205	$9,775,808	$10,647,848	$12,779,817	$12,532,259	$4,194,385
	Total Operating Expenses	$27,089,663	$27,705,300	$27,511,370	$27,697,629	$27,727,440	$20,423,791	$191,702,251	$219,407,551	$246,918,921	$274,616,550	$302,343,990	$322,767,781
	Depreciation Expense	$776,073	$888,311	$883,274	$887,385	$890,575	$883,868	$6,474,264	$7,362,575	$8,245,849	$9,133,234	$10,023,809	$10,907,677
	Operating Expenses less Depreciation Expense	$26,313,590	$26,816,989	$26,628,096	$26,810,244	$26,836,865	$19,539,923	$185,227,987	$212,044,976	$238,673,072	$265,483,316	$292,320,181	$311,860,104
3	**Days in Net Acounts Receivables**	**42**	**47**	**41**	**47**	**48**	**48**	**43**	**46**	**42**	**44**	**49**	**47**
	Net Patient Accounts Receivable	$40,969,091	$40,878,585	$37,820,022	$41,140,424	$42,155,215	$40,842,344	$ 40,969,091	$ 40,878,585	$ 37,820,022	$ 41,140,424	$ 42,155,215	$ 40,842,344
	Due From Third Party Payers	$0	$0	$300,000	$0	$0	$0	$ -	$ -	$ 300,000	$ -	$ -	$ -
	Due To Third Party Payers	$5,691,145	$2,606,185	$3,696,877	$4,493,912	$2,045,166	$2,192,261	$ 5,691,145	$ 2,606,185	$ 3,696,877	$ 4,493,912	$ 2,045,166	$ 2,192,261
	Total Net Patient Accounts Receivable and Third Party Payer Activity	$ 35,277,946	$ 38,272,400	$ 34,423,146	$ 36,646,513	$ 40,110,049	$ 38,650,083	$ 35,277,946	$ 38,272,400	$ 34,423,146	$ 36,646,513	$ 40,110,049	$ 38,650,083
	Total Net Patient Revenue	$25,197,870	$25,303,867	$25,427,836	$24,136,888	$25,662,639	$24,219,983	$175,657,603	$200,961,470	$226,389,306	$250,526,194	$276,188,833	$300,408,816
4	**Average Payment Period**	**46**	**44**	**52**	**58**	**55**	**68**	**46**	**44**	**53**	**57**	**54**	**52**
18	Total Current Liabilities	$40,275,522	$38,067,856	$46,537,992	$49,827,911	$47,301,237	$44,521,263	$40,275,522	$38,067,856	$46,537,992	$49,827,911	$47,301,237	$44,521,263
19	Total Operating Expenses	$27,089,663	$27,705,300	$27,511,370	$27,697,629	$27,727,440	$20,423,791	$191,702,251	$219,407,551	$246,918,921	$274,616,550	$302,343,990	$322,767,781
20	Depreciation Expense	$776,073	$888,311	$883,274	$887,385	$890,575	$883,868	$6,474,264	$7,362,575	$8,245,849	$9,133,234	$10,023,809	$10,907,677
20	Total Operating Expenses less Depreciation Expense	$26,313,590	$26,816,989	$26,628,096	$26,810,244	$26,836,865	$19,539,923	$185,227,987	$212,044,976	$238,673,072	$265,483,316	$292,320,181	$311,860,104

EXHIBIT F

PROSPECT ECHN, INC.

FISCAL YEAR 2017

		30	31	30	31	31	30	212	243	273	304	335	365
		MTD						YTD					
	DESCRIPTION	APRIL FY 2017	MAY FY 2017	JUNE FY 2017	JULY FY 2017	AUGUST FY 2017	SEPTEMBER FY 2017	APRIL FY 2017	MAY FY 2017	JUNE FY 2017	JULY FY 2017	AUGUST FY 2017	SEPTEMBER FY 2017
	Total Gross Revenue	$82,691,702	$88,343,824	$83,439,485	$76,823,377	$82,825,517	$81,349,780	$579,747,769	$668,091,593	$751,531,078	$828,354,455	$911,179,972	$992,529,752
	Total Allowances	($56,884,573)	($62,418,710)	($57,386,457)	($52,059,374)	($57,273,245)	($55,678,974)	($399,644,930)	($462,063,640)	($519,450,097)	($571,509,471)	($628,782,716)	($684,461,690)
C.	**Leverage and Capital Structure**												
1	**Long-term Debt to Equity**	**1.1**	**1.1**	**1.0**	**1.0**	**0.9**	**0.6**	**1.1**	**1.1**	**1.0**	**1.0**	**0.9**	**0.6**
2	**Long Term Debt to Capitalization Ratio**	**53.1**	**52.9**	**49.2**	**50.0**	**47.7**	**37.4**	**53.1**	**52.9**	**49.2**	**50.0**	**47.7**	**37.4**
	Total Long Term Debt	$10,088,319	$9,859,330	$9,364,527	$9,179,342	$9,011,701	$8,929,268	$10,088,319	$9,859,330	$9,364,527	$9,179,342	$9,011,701	$8,929,268
	Total Net Assets	$8,895,830	$8,767,490	$9,678,551	$9,169,392	$9,879,069	$14,928,189	$8,895,830	$8,767,490	$9,678,551	$9,169,392	$9,879,069	$14,928,189
	Total Long Term Debt and Total Net Assets	$18,984,149	$18,626,820	$19,043,079	$18,348,735	$18,890,770	$23,857,458	$18,984,149	$18,626,820	$19,043,079	$18,348,735	$18,890,770	$23,857,458
3	**Unrestricted Cash to Total Debt Ratio**	**2.3**	**1.5**	**3.2**	**0.6**	**2.8**	**11.0**	**12.7**	**14.9**	**15.9**	**15.7**	**19.2**	**31.3**
	Excess/(Deficiency) of Revenues Over Expenses	$390,053	($163,961)	$888,760	($537,442)	$676,116	$4,998,701	($56,061)	($220,022)	$668,738	$131,296	$807,412	$5,806,113
	Depreciation Expense	$776,073	$888,311	$883,274	$887,385	$890,575	$883,868	$6,474,264	$7,362,575	$8,245,849	$9,133,234	$10,023,809	$10,907,677
	Excess of Revenues Over Expenses and Depreciation Expense	$1,166,126	$724,350	$1,772,034	$349,943	$1,566,691	$5,882,569	$6,418,203	$7,142,553	$8,914,587	$9,264,530	$10,831,221	$16,713,790
	Total Current Liabilities	$40,275,522	$38,067,856	$46,537,992	$49,827,911	$47,301,237	$44,521,263	$40,275,522	$38,067,856	$46,537,992	$49,827,911	$47,301,237	$44,521,263
	Total Long Term Debt	$10,088,319	$9,859,330	$9,364,527	$9,179,342	$9,011,701	$8,929,268	$10,088,319	$9,859,330	$9,364,527	$9,179,342	$9,011,701	$8,929,268
	Total Current Liabilities and Total Long Term Debt	$50,363,840	$47,927,186	$55,902,519	$59,007,254	$56,312,938	$53,450,531	$50,363,840	$47,927,186	$55,902,519	$59,007,254	$56,312,938	$53,450,531
4	**Times Interest Earned**	**1.9**	**1.3**	**2.7**	**0.9**	**2.3**	**10.2**	**1.5**	**1.5**	**1.6**	**1.6**	**1.6**	**2.4**
5	**Debt Service Coverage Ratio**	**1.91**	**1.37**	**2.33**	**1.11**	**2.19**	**6.61**	**1.60**	**1.57**	**1.66**	**1.61**	**1.66**	**2.05**
	Excess Revenues over Expenses	$390,053	($163,961)	$888,760	($537,442)	$676,116	$4,998,701	($56,061)	($220,022)	$668,738	$131,296	$807,412	$5,806,113
	Interest Expense	$792,670	$780,201	$777,187	$783,649	$783,748	$785,576	$5,522,216	$6,302,417	$7,079,604	$7,863,253	$8,647,001	$9,432,577
	Depreciation and Amortization Expense	$776,073	$888,311	$883,274	$887,385	$890,575	$883,868	$6,474,264	$7,362,575	$8,245,849	$9,133,234	$10,023,809	$10,907,677
	Principal Payments	$233,006	$315,493	$318,361	$237,392	$289,829	$223,349	$1,935,491	$2,250,985	$2,569,346	$2,806,738	$3,096,567	$3,319,916
6	**Equity Financing Ratio**	**6.2**	**6.0**	**6.3**	**5.9**	**6.4**	**9.9**	**14.4**	**20.3**	**25.4**	**30.9**	**37.6**	**48.5**
	Total Net Assets	$8,895,830	$8,767,490	$9,678,551	$9,169,392	$9,879,069	$14,928,189	$20,659,447	$29,426,937	$39,105,488	$48,274,881	$58,153,950	$73,082,139
	Total Assets	$143,387,283	$144,991,947	$154,202,809	$156,382,644	$154,740,289	$150,622,259	$143,387,283	$144,991,947	$154,202,809	$156,382,644	$154,740,289	$150,622,259
D.	**Additional Statistics**												
1	**Income from Operations**	**-$101,601**	**-$652,285**	**$450,922**	**-$989,455**	**$163,581**	**$6,317,811**	**-$3,460,852**	**-$4,113,137**	**-$3,662,215**	**-$4,651,670**	**-$4,488,089**	**$1,829,722**
2	**Revenue Over/(Under) Expense**	**$390,053**	**-$163,961**	**$888,760**	**-$537,442**	**$676,116**	**$4,998,701**	**-$56,061**	**-$220,022**	**$668,738**	**$131,296**	**$807,412**	**$5,806,113**
3	**EBITDA**	**$1,467,142**	**$1,016,227**	**$2,111,383**	**$681,579**	**$1,837,904**	**$7,987,255**	**$8,535,628**	**$9,551,855**	**$11,663,238**	**$12,344,817**	**$14,182,721**	**$22,169,976**
4	**Cash from Operations**	**$25,688,679**	**$25,874,040**	**$27,883,504**	**$22,741,347**	**$24,391,189**	**$24,805,434**	**$165,709,624**	**$191,583,664**	**$219,467,168**	**$242,208,515**	**$266,599,704**	**$291,405,138**
5	**Cash and Cash Equivalents**	**$7,587,205**	**$9,775,808**	**$10,647,848**	**$12,779,817**	**$12,532,259**	**$4,194,385**	**$7,587,205**	**$9,775,808**	**$10,647,848**	**$12,779,817**	**$12,532,259**	**$4,194,385**
6	**Net Working Capital**	**$16,052,868**	**$22,635,898**	**$23,966,424**	**$21,991,024**	**$22,412,948**	**$20,745,917**	**$16,052,868**	**$22,635,898**	**$23,966,424**	**$21,991,024**	**$22,412,948**	**$20,745,917**
7	**Unrestricted Assets**	**$8,895,830**	**$8,767,490**	**$9,678,551**	**$9,169,392**	**$9,879,069**	**$14,928,189**	**$8,895,830**	**$8,767,490**	**$9,678,551**	**$9,169,392**	**$9,879,069**	**$14,928,189**
8	**Credit Ratings (S&P, FITCH, and Moody's)**												

Exhibit F

PROSPECT MANCHESTER HOSPITAL, INC.

FISCAL YEAR 2017

		MTD						YTD					
		APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER
	DESCRIPTION	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017
	Total Gross Revenue	$57,190,419	$62,011,421	$58,249,543	$52,240,481	$57,175,197	$54,903,217	$393,496,956	$455,508,377	$513,757,920	$565,998,401	$623,173,598	$678,076,815
	Total Allowances	($40,954,136)	($45,678,815)	($41,865,212)	($37,385,278)	($41,360,126)	($38,885,518)	($282,100,244)	($327,779,059)	($369,644,271)	($407,029,549)	($448,389,675)	($487,275,193)
	Bad Debt	($366,630)	($395,964)	($370,710)	($384,566)	$331,334	($1,145,213)	($2,634,156)	($3,030,120)	($3,400,830)	($3,785,396)	($3,454,062)	($4,599,275)
	Net Patient Revenue	$15,869,653	$15,936,642	$16,013,621	$14,470,637	$16,146,405	$14,872,486	$108,762,556	$124,699,198	$140,712,819	$155,183,456	$171,329,861	$186,202,347
	Other Operating Revenue	745,670	766,440	808,675	713,984	547,239	830,354	$5,384,786	$6,151,226	$6,959,901	$7,673,885	$8,221,124	$9,051,478
	Total Operating Revenue	$16,615,323	$16,703,082	$16,822,296	$15,184,621	$16,693,644	$15,702,840	$114,147,342	$130,850,424	$147,672,720	$162,857,341	$179,550,985	$195,253,825
	Total Operating Expenses	16,096,345	16,438,914	16,017,749	15,617,281	15,705,227	9,487,981	$110,970,458	$127,409,372	$143,427,121	$159,044,402	$174,749,629	$184,237,610
	Income/(Loss) From Operations	$518,978	$264,168	$804,547	($432,660)	$988,417	$6,214,859	$3,176,884	$3,441,052	$4,245,599	$3,812,939	$4,801,356	$11,016,215
	Total Non-Operating Revenue	378,027	370,736	345,041	334,323	387,641	(1,024,856)	$2,630,059	$3,000,795	$3,345,836	$3,680,159	$4,067,800	$3,042,944
	Excess/(Deficiency) of Revenue Over Expenses	$897,005	$634,904	$1,149,588	($98,337)	$1,376,058	$5,190,003	$5,806,943	$6,441,847	$7,591,435	$7,493,098	$8,869,156	$14,059,159
A	**Operating Performance**												
1	**Operating Margin**	**3.05%**	**1.55%**	**4.69%**	**-2.79%**	**5.79%**	**42.34%**	**2.72%**	**2.57%**	**2.81%**	**2.29%**	**2.61%**	**5.56%**
2	**Non-Operating Margin**	**2.22%**	**2.17%**	**2.01%**	**2.15%**	**2.27%**	**-6.98%**	**2.25%**	**2.24%**	**2.22%**	**2.21%**	**2.22%**	**1.53%**
3	**Total Margin**	**5.28%**	**3.72%**	**6.70%**	**-0.63%**	**8.06%**	**35.36%**	**4.97%**	**4.81%**	**5.03%**	**4.50%**	**4.83%**	**7.09%**
4	**Bad Debt as % of Gross Revenue**	**0.64%**	**0.64%**	**0.64%**	**0.74%**	**-0.58%**	**2.09%**	**0.67%**	**0.67%**	**0.66%**	**0.67%**	**0.55%**	**0.68%**
	Income/(Loss) From Operations	$518,978	$264,168	$804,547	($432,660)	$988,417	$6,214,859	$3,176,884	$3,441,052	$4,245,599	$3,812,939	$4,801,356	$11,016,215
	Total Operating Revenue	$16,615,323	$16,703,082	$16,822,296	$15,184,621	$16,693,644	$15,702,840	$114,147,342	$130,850,424	$147,672,720	$162,857,341	$179,550,985	$195,253,825
	Total Non-Operating Revenue	$378,027	$370,736	$345,041	$334,323	$387,641	($1,024,856)	$2,630,059	$3,000,795	$3,345,836	$3,680,159	$4,067,800	$3,042,944
	Total Revenue	$16,993,350	$17,073,818	$17,167,337	$15,518,944	$17,081,285	$14,677,984	$116,777,401	$133,851,219	$151,018,556	$166,537,500	$183,618,785	$198,296,769
	Excess/(Deficiency) of Revenue Over Expenses	$897,005	$634,904	$1,149,588	($98,337)	$1,376,058	$5,190,003	$5,806,943	$6,441,847	$7,591,435	$7,493,098	$8,869,156	$14,059,159
	Unrealized gain/(loss) in investments (self-insurance fu	$18,683	$0	$22,301	$0	$33,560	$20,203	$57,176	$57,176	$79,477	$79,477	$113,038	$133,241
	Unrestricted Net Assets	$5,864,119	$6,499,023	$7,670,912	$7,572,575	$8,982,194	$14,192,400	$5,864,119	$6,499,023	$7,670,912	$7,572,575	$8,982,194	$14,192,400
	Total Net Assets	$5,864,119	$6,499,023	$7,670,912	$7,572,575	$8,982,194	$14,192,400	$5,864,119	$6,499,023	$7,670,912	$7,572,575	$8,982,194	$14,192,400

Exhibit F

PROSPECT MANCHESTER HOSPITAL, INC.

FISCAL YEAR 2017

		MTD						YTD					
		APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER
	DESCRIPTION	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017
B.	**Liquidity**												
1	**Current Ratio**	**1.96**	**2.03**	**2.15**	**2.11**	**2.24**	**1.93**	**1.96**	**2.03**	**2.15**	**2.11**	**2.24**	**1.93**
	Total Current Assets	$48,008,847	$49,489,861	$49,864,591	$50,732,656	$51,123,418	$59,477,631	$48,008,847	$49,489,861	$49,864,591	$50,732,656	$51,123,418	$59,477,631
	Total Current Liabilities	$24,478,757	$24,388,664	$23,153,525	$24,059,719	$22,853,391	$30,740,111	$24,478,757	$24,388,664	$23,153,525	$24,059,719	$22,853,391	$30,740,111
2	**Days Cash on Hand**	**15**	**1**	**2**	**6**	**3**	**1**	**15**	**1**	**2**	**6**	**3**	**0**
	Cash and Cash Equivalents	$7,587,205	$550,675	$774,588	$2,859,986	$1,463,164	$187,195	$7,587,205	$550,675	$774,588	$2,859,986	$1,463,164	$187,195
	Short Term Investments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Total Cash and Short Term Investments	$7,587,205	$550,675	$774,588	$2,859,986	$1,463,164	$187,195	$7,587,205	$550,675	$774,588	$2,859,986	$1,463,164	$187,195
	Total Operating Expenses	$16,096,345	$16,438,914	$16,017,749	$15,617,281	$15,705,227	$9,487,981	$110,970,458	$127,409,372	$143,427,121	$159,044,402	$174,749,629	$184,237,610
	Depreciation Expense	$546,096	$555,303	$553,598	$553,085	$572,219	$584,357	$4,082,763	$4,638,066	$5,191,664	$5,744,749	$6,316,968	$6,901,325
	Operating Expenses less Depreciation Expense	$15,550,249	$15,883,611	$15,464,151	$15,064,196	$15,133,008	$8,903,624	$106,887,695	$122,771,306	$138,235,457	$153,299,653	$168,432,661	$177,336,285
3	**Days in Net Acounts Receivables**	**43**	**48**	**42**	**50**	**50**	**50**	**44**	**49**	**44**	**46**	**50**	**48**
	Net Patient Accounts Receivable	$25,969,460	$26,085,719	$24,651,032	$25,717,306	$26,523,669	$25,353,520	$25,969,460	$26,085,719	$24,651,032	$25,717,306	$26,523,669	$25,353,520
	Due From Third Party Payers	$0	$0	$300,000	$0	$0	$0	$0	$0	$300,000	$0	$0	$0
	Due To Third Party Payers	$3,449,589	$1,160,093	$2,423,677	$2,378,427	$725,111	$788,545	$3,449,589	$1,160,093	$2,423,677	$2,378,427	$725,111	$788,545
	Total Net Patient Accounts Receivable and Third Party Payer Activity	$ 22,519,871	$ 24,925,627	$ 22,527,356	$ 23,338,878	$ 25,798,558	$ 24,564,975	$ 22,519,871	$ 24,925,627	$ 22,527,356	$ 23,338,878	$ 25,798,558	$ 24,564,975
	Total Net Patient Revenue	$15,869,653	$15,936,642	$16,013,621	$14,470,637	$16,146,405	$14,872,486	$108,762,556	$124,699,198	$140,712,819	$155,183,456	$171,329,861	$186,202,347
4	**Average Payment Period**	**49**	**48**	**46**	**50**	**47**	**107**	**7**	**6**	**5**	**5**	**4**	**5**
18	Total Current Liabilities	$24,478,757	$24,388,664	$23,153,525	$24,059,719	$22,853,391	$30,740,111	$24,478,757	$24,388,664	$23,153,525	$24,059,719	$22,853,391	$30,740,111
19	Total Operating Expenses	$16,096,345	$16,438,914	$16,017,749	$15,617,281	$15,705,227	$9,487,981	$110,970,458	$127,409,372	$143,427,121	$159,044,402	$174,749,629	$184,237,610
20	Depreciation Expense	$546,096	$555,303	$553,598	$553,085	$572,219	$584,357	$4,082,763	$4,638,066	$5,191,664	$5,744,749	$6,316,968	$6,901,325
20	Total Operating Expenses less Depreciation Expense	$15,550,249	$15,883,611	$15,464,151	$15,064,196	$15,133,008	$8,903,624	$106,887,695	$122,771,306	$138,235,457	$153,299,653	$168,432,661	$177,336,285

Exhibit F

PROSPECT MANCHESTER HOSPITAL, INC.

FISCAL YEAR 2017

	DESCRIPTION	MTD APRIL FY 2017	MTD MAY FY 2017	MTD JUNE FY 2017	MTD JULY FY 2017	MTD AUGUST FY 2017	MTD SEPTEMBER FY 2017	YTD APRIL FY 2017	YTD MAY FY 2017	YTD JUNE FY 2017	YTD JULY FY 2017	YTD AUGUST FY 2017	YTD SEPTEMBER FY 2017
C.	**Leverage and Capital Structure**												
1	**Long-term Debt to Equity**	**0.8**	**0.7**	**0.6**	**0.6**	**0.4**	**0.3**	**0.8**	**0.7**	**0.6**	**0.6**	**0.4**	**0.3**
2	**Long Term Debt to Capitalization Ratio**	**45.9**	**42.3**	**36.2**	**35.7**	**30.8**	**21.8**	**45.9**	**42.3**	**36.2**	**35.7**	**30.8**	**21.8**
	Total Long Term Debt	$4,966,683	$4,764,776	$4,351,659	$4,204,097	$4,003,180	$3,954,712	$4,966,683	$4,764,776	$4,351,659	$4,204,097	$4,003,180	$3,954,712
	Total Net Assets	$5,864,119	$6,499,023	$7,670,912	$7,572,575	$8,982,194	$14,192,400	$5,864,119	$6,499,023	$7,670,912	$7,572,575	$8,982,194	$14,192,400
	Total Long Term Debt and Total Net Assets	$10,830,802	$11,263,799	$12,022,571	$11,776,673	$12,985,374	$18,147,112	$10,830,802	$11,263,799	$12,022,571	$11,776,673	$12,985,374	$18,147,112
3	**Unrestricted Cash to Total Debt Ratio**	**4.9**	**4.1**	**6.2**	**1.6**	**7.3**	**16.6**	**33.6**	**38.0**	**46.5**	**46.8**	**56.5**	**60.4**
	Excess/(Deficiency) of Revenues Over Expenses	$897,005	$634,904	$1,149,588	($98,337)	$1,376,058	$5,190,003	$5,806,943	$6,441,847	$7,591,435	$7,493,098	$8,869,156	$14,059,159
	Depreciation Expense	$546,096	$555,303	$553,598	$553,085	$572,219	$584,357	$4,082,763	$4,638,066	$5,191,664	$5,744,749	$6,316,968	$6,901,325
	Excess of Revenues Over Expenses and Depreciation Expense	$1,443,101	$1,190,207	$1,703,186	$454,748	$1,948,277	$5,774,360	$9,889,706	$11,079,913	$12,783,099	$13,237,847	$15,186,124	$20,960,484
	Total Current Liabilities	$24,478,757	$24,388,664	$23,153,525	$24,059,719	$22,853,391	$30,740,111	$24,478,757	$24,388,664	$23,153,525	$24,059,719	$22,853,391	$30,740,111
	Total Long Term Debt	$4,966,683	$4,764,776	$4,351,659	$4,204,097	$4,003,180	$3,954,712	$4,966,683	$4,764,776	$4,351,659	$4,204,097	$4,003,180	$3,954,712
	Total Current Liabilities and Total Long Term Debt	$29,445,441	$29,153,440	$27,505,184	$28,263,817	$26,856,571	$34,694,823	$29,445,441	$29,153,440	$27,505,184	$28,263,817	$26,856,571	$34,694,823
4	**Times Interest Earned**	**2.8**	**2.4**	**3.3**	**1.2**	**3.6**	**12.3**	**2.7**	**2.7**	**2.7**	**2.6**	**2.7**	**3.5**
5	**Debt Service Coverage Ratio**	**2.63**	**2.13**	**2.72**	**1.32**	**3.00**	**8.22**	**2.50**	**2.45**	**2.48**	**2.37**	**2.43**	**2.89**
	Excess Revenues over Expenses	$897,005	$634,904	$1,149,588	($98,337)	$1,376,058	$5,190,003	$5,806,943	$6,441,847	$7,591,435	$7,493,098	$8,869,156	$14,059,159
	Interest Expense	$607,372	$602,553	$590,261	$599,511	$599,331	$599,863	$4,241,900	$4,844,453	$5,434,714	$6,034,225	$6,633,556	$7,233,419
	Depreciation and Amortization Expense	$546,096	$555,303	$553,598	$553,085	$572,219	$584,357	$4,082,763	$4,638,066	$5,191,664	$5,744,749	$6,316,968	$6,901,325
	Principal Payments	$173,192	$238,695	$252,309	$196,199	$249,995	$175,524	$1,417,283	$1,655,978	$1,908,286	$2,104,485	$2,354,480	$2,530,004
6	**Equity Financing Ratio**	**5.8**	**6.3**	**7.5**	**7.3**	**8.7**	**12.6**	**5.8**	**6.3**	**7.5**	**7.3**	**8.7**	**12.6**
	Total Net Assets	$5,864,119	$6,499,023	$7,670,912	$7,572,575	$8,982,194	$14,192,400	$5,864,119	$6,499,023	$7,670,912	$7,572,575	$8,982,194	$14,192,400
	Total Assets	$101,817,940	$103,109,815	$102,909,184	$103,332,665	$103,591,068	$112,359,211	$101,817,940	$103,109,815	$102,909,184	$103,332,665	$103,591,068	$112,359,211
D.	**Additional Statistics**												
1	**Income from Operations**	**$518,978**	**$264,168**	**$804,547**	**-$432,660**	**$988,417**	**$6,214,859**	**$3,176,884**	**$3,441,052**	**$4,245,599**	**$3,812,939**	**$4,801,356**	**$11,016,215**
2	**Revenue Over/(Under) Expense**	**$897,005**	**$634,904**	**$1,149,588**	**-$98,337**	**$1,376,058**	**$5,190,003**	**$5,806,943**	**$6,441,847**	**$7,591,435**	**$7,493,098**	**$8,869,156**	**$14,059,159**
3	**EBITDA**	**$1,672,446**	**$1,422,024**	**$1,948,406**	**$719,936**	**$2,159,967**	**$7,399,079**	**$11,501,547**	**$12,923,571**	**$14,871,977**	**$15,591,913**	**$17,751,880**	**$25,150,959**
4	**Cash from Operations**	**$15,454,486**	**$16,195,163**	**$17,253,860**	**$14,428,071**	**$15,247,673**	**$14,882,399**	**$100,288,965**	**$116,484,128**	**$133,737,988**	**$148,166,059**	**$163,413,732**	**$178,296,131**
5	**Cash and Cash Equivalents**	**$7,587,205**	**$550,675**	**$774,588**	**$2,859,986**	**$1,463,164**	**$187,195**	**$7,587,205**	**$550,675**	**$774,588**	**$2,859,986**	**$1,463,164**	**$187,195**
6	**Net Working Capital**	**$23,530,090**	**$25,101,197**	**$26,711,066**	**$26,672,937**	**$28,270,027**	**$28,737,520**	**$23,530,090**	**$25,101,197**	**$26,711,066**	**$26,672,937**	**$28,270,027**	**$28,737,520**
7	**Unrestricted Assets**	**$5,864,119**	**$6,499,023**	**$7,670,912**	**$7,572,575**	**$8,982,194**	**$14,192,400**	**$5,864,119**	**$6,499,023**	**$7,670,912**	**$7,572,575**	**$8,982,194**	**$14,192,400**
8	**Credit Ratings (S&P, FITCH, and Moody's)**												

Exhibit F

PROSPECT ROCKVILLE HOSPITAL, INC.

FISCAL YEAR 2017

		MTD						YTD					
		APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER
	DESCRIPTION	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017
	Total Gross Revenue	$18,412,122	$19,283,549	$18,192,153	$17,776,249	$18,737,703	$18,883,700	$135,924,439	$155,207,988	$173,400,141	$191,176,390	$209,914,093	$228,797,793
	Total Allowances	($13,324,074)	($14,212,013)	($12,970,581)	($12,320,032)	($13,538,658)	($13,869,828)	($98,952,244)	($113,164,257)	($126,134,838)	($138,454,870)	($151,993,528)	($165,863,356)
	Bad Debt	($181,373)	($154,116)	($154,815)	($140,382)	($128,800)	($119,266)	($1,385,915)	($1,540,031)	($1,694,846)	($1,835,228)	($1,964,028)	($2,083,294)
	Net Patient Revenue	$4,906,675	$4,917,420	$5,066,757	$5,315,835	$5,070,245	$4,894,606	$35,586,280	$40,503,700	$45,570,457	$50,886,292	$55,956,537	$60,851,143
	Other Operating Revenue	126,677	116,504	102,205	151,945	45,589	134,301	$852,334	$968,838	$1,071,043	$1,222,988	$1,268,577	$1,402,878
	Total Operating Revenue	$5,033,352	$5,033,924	$5,168,962	$5,467,780	$5,115,834	$5,028,907	$36,438,614	$41,472,538	$46,641,500	$52,109,280	$57,225,114	$62,254,021
	Total Operating Expenses	5,344,727	5,519,967	5,325,730	5,641,034	5,389,931	4,342,076	$40,085,586	$45,605,553	$50,931,283	$56,572,317	$61,962,248	$66,304,324
	Income/(Loss) From Operations	($311,375)	($486,043)	($156,768)	($173,254)	($274,097)	$686,831	($3,646,972)	($4,133,015)	($4,289,783)	($4,463,037)	($4,737,134)	($4,050,303)
	Total Non-Operating Revenue	113,627	117,588	93,371	118,113	124,907	(294,267)	$774,732	$892,320	$985,691	$1,103,804	$1,228,711	$934,444
	Excess/(Deficiency) of Revenue Over Expenses	($197,748)	($368,455)	($63,397)	($55,141)	($149,190)	$392,564	($2,872,240)	($3,240,695)	($3,304,092)	($3,359,233)	($3,508,423)	($3,115,859)
A	**Operating Performance**												
1	**Operating Margin**	**-6.05%**	**-9.43%**	**-2.98%**	**-3.10%**	**-5.23%**	**14.51%**	**-9.80%**	**-9.76%**	**-9.01%**	**-8.39%**	**-8.10%**	**-6.41%**
2	**Non-Operating Margin**	**2.21%**	**2.28%**	**1.77%**	**2.11%**	**2.38%**	**-6.22%**	**2.08%**	**2.11%**	**2.07%**	**2.07%**	**2.10%**	**1.48%**
3	**Total Margin**	**-3.84%**	**-7.15%**	**-1.20%**	**-0.99%**	**-2.85%**	**8.29%**	**-7.72%**	**-7.65%**	**-6.94%**	**-6.31%**	**-6.00%**	**-4.93%**
4	**Bad Debt as % of Gross Revenue**	**0.99%**	**0.80%**	**0.85%**	**0.79%**	**0.69%**	**0.63%**	**1.02%**	**0.99%**	**0.98%**	**0.96%**	**0.94%**	**0.91%**
	Income/(Loss) From Operations	($311,375)	($486,043)	($156,768)	($173,254)	($274,097)	$686,831	($3,646,972)	($4,133,015)	($4,289,783)	($4,463,037)	($4,737,134)	($4,050,303)
	Total Operating Revenue	$5,033,352	$5,033,924	$5,168,962	$5,467,780	$5,115,834	$5,028,907	$36,438,614	$41,472,538	$46,641,500	$52,109,280	$57,225,114	$62,254,021
	Total Non-Operating Revenue	$113,627	$117,588	$93,371	$118,113	$124,907	($294,267)	$774,732	$892,320	$985,691	$1,103,804	$1,228,711	$934,444
	Total Revenue	$5,146,979	$5,151,512	$5,262,333	$5,585,893	$5,240,741	$4,734,640	$37,213,346	$42,364,858	$47,627,191	$53,213,084	$58,453,825	$63,188,465
	Excess/(Deficiency) of Revenue Over Expenses	($197,748)	($368,455)	($63,397)	($55,141)	($149,190)	$392,564	($2,872,240)	($3,240,695)	($3,304,092)	($3,359,233)	($3,508,423)	($3,115,859)
	Unrestricted Net Assets	($2,872,240)	($3,240,695)	($3,304,092)	($3,359,233)	($3,508,423)	($3,115,859)	($2,872,240)	($3,240,695)	($3,304,092)	($3,359,233)	($3,508,423)	($3,115,859)
	Total Net Assets	($2,872,240)	($3,240,695)	($3,304,092)	($3,359,233)	($3,508,423)	($3,115,859)	($2,872,240)	($3,240,695)	($3,304,092)	($3,359,233)	($3,508,423)	($3,115,859)

Exhibit F

PROSPECT ROCKVILLE HOSPITAL, INC.

FISCAL YEAR 2017

		MTD						YTD					
		APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER
	DESCRIPTION	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017
	Total Gross Revenue	$18,412,122	$19,283,549	$18,192,153	$17,776,249	$18,737,703	$18,883,700	$135,924,439	$155,207,988	$173,400,141	$191,176,390	$209,914,093	$228,797,793
	Total Allowances	($13,324,074)	($14,212,013)	($12,970,581)	($12,320,032)	($13,538,658)	($13,869,828)	($98,952,244)	($113,164,257)	($126,134,838)	($138,454,870)	($151,993,528)	($165,863,356)
B.	**Liquidity**												
1	**Current Ratio**	**1.63**	**1.64**	**1.68**	**1.59**	**1.57**	**1.27**	**1.63**	**1.64**	**1.68**	**1.59**	**1.57**	**1.27**
	Total Current Assets	$11,619,188	$11,353,838	$11,279,435	$11,589,385	$10,987,353	$11,486,396	$11,619,188	$11,353,838	$11,279,435	$11,589,385	$10,987,353	$11,486,396
	Total Current Liabilities	$7,146,594	$6,922,098	$6,700,460	$7,295,133	$6,986,532	$9,021,517	$7,146,594	$6,922,098	$6,700,460	$7,295,133	$6,986,532	$9,021,517
2	**Days Cash on Hand**	**(0)**	**1**	**1**	**7**	**2**	**0**	**(7)**	**(6)**	**(5)**	**2**	**4**	**4**
	Cash and Cash Equivalents	($80,010)	$154,797	$161,436	$1,262,686	$264,212	$1,037	($80,010)	$154,797	$161,436	$1,262,686	$264,212	$1,037
	Short Term Investments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Total Cash and Short Term Investments	($80,010)	$154,797	$161,436	$1,262,686	$264,212	$1,037	($1,219,752)	($1,064,955)	($903,519)	$359,167	$623,378	$624,415
	Total Operating Expenses	$5,344,727	$5,519,967	$5,325,730	$5,641,034	$5,389,931	$4,342,076	$40,085,586	$45,605,553	$50,931,283	$56,572,317	$61,962,248	$66,304,324
	Depreciation Expense	$235,173	$236,738	$234,266	$239,210	$239,431	$267,226	$1,714,023	$1,950,761	$2,185,027	$2,424,237	$2,663,668	$2,930,894
	Operating Expenses less Depreciation Expense	$5,109,554	$5,283,229	$5,091,464	$5,401,824	$5,150,500	$4,074,850	$38,371,563	$43,654,792	$48,746,256	$54,148,080	$59,298,580	$63,373,430
3	**Days in Net Acounts Receivables**	**35**	**40**	**34**	**36**	**45**	**42**	**340**	**381**	**415**	**450**	**495**	**537**
	Net Patient Accounts Receivable	$7,219,864	$7,161,273	$6,826,652	$7,476,334	$7,943,900	$7,440,504	$63,335,019	$70,496,293	$77,322,944	$84,799,278	$92,743,178	$100,183,682
	Due From Third Party Payers	$ -	$ -	$ -	$ -	$ -	$ -	$0	$0	$0	$0	$0	$0
	Due To Third Party Payers	$1,539,548	$748,252	$1,042,444	$1,370,929	$576,026	$639,008	$6,297,082	$7,045,334	$8,087,779	$9,458,708	$10,034,733	$10,673,741
	Total Net Patient Accounts Receivable and Third Party Payer Activity	$ 5,680,317	$ 6,413,022	$ 5,784,207	$ 6,105,405	$ 7,367,874	$ 6,801,496	$57,037,937	$63,450,958	$69,235,166	$75,340,571	$82,708,445	$89,509,941
	Total Net Patient Revenue	$4,906,675	$4,917,420	$5,066,757	$5,315,835	$5,070,245	$4,894,606	$35,586,280	$40,503,700	$45,570,457	$50,886,292	$55,956,537	$60,851,143
4	**Average Payment Period**	**42**	**41**	**39**	**42**	**42**	**66**	**39**	**39**	**38**	**41**	**39**	**52**
18	Total Current Liabilities	$7,146,594	$6,922,098	$6,700,460	$7,295,133	$6,986,532	$9,021,517	$7,146,594	$6,922,098	$6,700,460	$7,295,133	$6,986,532	$9,021,517
19	Total Operating Expenses	$5,344,727	$5,519,967	$5,325,730	$5,641,034	$5,389,931	$4,342,076	$40,085,586	$45,605,553	$50,931,283	$56,572,317	$61,962,248	$66,304,324
20	Depreciation Expense	$235,173	$236,738	$234,266	$239,210	$239,431	$267,226	$1,714,023	$1,950,761	$2,185,027	$2,424,237	$2,663,668	$2,930,894
20	Total Operating Expenses less Depreciation Expense	$5,109,554	$5,283,229	$5,091,464	$5,401,824	$5,150,500	$4,074,850	$38,371,563	$43,654,792	$48,746,256	$54,148,080	$59,298,580	$63,373,430

Exhibit F

PROSPECT ROCKVILLE HOSPITAL, INC.

FISCAL YEAR 2017

		MTD						YTD					
		APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER
	DESCRIPTION	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017
	Total Gross Revenue	$18,412,122	$19,283,549	$18,192,153	$17,776,249	$18,737,703	$18,883,700	$135,924,439	$155,207,988	$173,400,141	$191,176,390	$209,914,093	$228,797,793
	Total Allowances	($13,324,074)	($14,212,013)	($12,970,581)	($12,320,032)	($13,538,658)	($13,869,828)	($98,952,244)	($113,164,257)	($126,134,838)	($138,454,870)	($151,993,528)	($165,863,356)
C.	**Leverage and Capital Structure**												
1	**Long-term Debt to Equity**	**(0.2)**	**(0.2)**	**(0.1)**	**(0.1)**	**(0.1)**	**(0.1)**	**(0.2)**	**(0.2)**	**(0.1)**	**(0.1)**	**(0.1)**	**(0.1)**
2	**Long Term Debt to Capitalization Ratio**	**(22.4)**	**(18.8)**	**(16.9)**	**(16.2)**	**(14.9)**	**(16.7)**	**(22.4)**	**(18.8)**	**(16.9)**	**(16.2)**	**(14.9)**	**(16.7)**
	Total Long Term Debt	$524,837	$513,744	$478,241	$467,411	$456,288	$445,778	$524,837	$513,744	$478,241	$467,411	$456,288	$445,778
	Total Net Assets	($2,872,240)	($3,240,695)	($3,304,092)	($3,359,233)	($3,508,423)	($3,115,859)	($2,872,240)	($3,240,695)	($3,304,092)	($3,359,233)	($3,508,423)	($3,115,859)
	Total Long Term Debt and Total Net Assets	($2,347,403)	($2,726,951)	($2,825,851)	($2,891,821)	($3,052,135)	($2,670,081)	($2,347,403)	($2,726,951)	($2,825,851)	($2,891,821)	($3,052,135)	($2,670,081)
3	**Unrestricted Cash to Total Debt Ratio**	**0.5**	**(1.8)**	**2.4**	**2.4**	**1.2**	**7.0**	**(15.1)**	**(17.3)**	**(15.6)**	**(12.0)**	**(11.3)**	**(2.0)**
	Excess/(Deficiency) of Revenues Over Expenses	($197,748)	($368,455)	($63,397)	($55,141)	($149,190)	$392,564	($2,872,240)	($3,240,695)	($3,304,092)	($3,359,233)	($3,508,423)	($3,115,859)
	Depreciation Expense	$235,173	$236,738	$234,266	$239,210	$239,431	$267,226	$1,714,023	$1,950,761	$2,185,027	$2,424,237	$2,663,668	$2,930,894
	Excess of Revenues Over Expenses and Depreciation Expense	$37,425	($131,717)	$170,869	$184,069	$90,241	$659,790	($1,158,217)	($1,289,934)	($1,119,065)	($934,996)	($844,755)	($184,965)
	Total Current Liabilities	$7,146,594	$6,922,098	$6,700,460	$7,295,133	$6,986,532	$9,021,517	$7,146,594	$6,922,098	$6,700,460	$7,295,133	$6,986,532	$9,021,517
	Total Long Term Debt	$524,837	$513,744	$478,241	$467,411	$456,288	$445,778	$524,837	$513,744	$478,241	$467,411	$456,288	$445,778
	Total Current Liabilities and Total Long Term Debt	$7,671,431	$7,435,842	$7,178,700	$7,762,544	$7,442,820	$9,467,295	$7,671,431	$7,435,842	$7,178,700	$7,762,544	$7,442,820	$9,467,295
4	**Times Interest Earned**	**0.6**	**(0.4)**	**1.4**	**1.4**	**0.8**	**6.2**	**(0.5)**	**(0.5)**	**(0.3)**	**(0.1)**	**(0.0)**	**0.5**
5	**Debt Service Coverage Ratio**	**1.14**	**0.24**	**1.71**	**1.90**	**1.41**	**4.21**	**0.07**	**0.09**	**0.28**	**0.43**	**0.52**	**0.83**
	Excess Revenues over Expenses	($197,748)	($368,455)	($63,397)	($55,141)	($149,190)	$392,564	($2,872,240)	($3,240,695)	($3,304,092)	($3,359,233)	($3,508,423)	($3,115,859)
	Interest Expense	$179,836	$178,095	$183,771	$180,638	$182,856	$182,343	$1,254,906	$1,433,001	$1,616,772	$1,797,410	$1,980,266	$2,162,609
	Depreciation and Amortization Expense	$235,173	$236,738	$234,266	$239,210	$239,431	$267,226	$1,714,023	$1,950,761	$2,185,027	$2,424,237	$2,663,668	$2,930,894
	Principal Payments	$10,676	$18,740	$23,021	$10,829	$11,124	$17,686	$138,172	$156,912	$179,933	$190,762	$201,886	$219,572
6	**Equity Financing Ratio**	**(11.5)**	**(13.2)**	**(13.6)**	**(13.6)**	**(14.5)**	**(12.6)**	**(11.5)**	**(13.2)**	**(13.6)**	**(13.6)**	**(14.5)**	**(12.6)**
	Total Net Assets	($2,872,240)	($3,240,695)	($3,304,092)	($3,359,233)	($3,508,423)	($3,115,859)	($2,872,240)	($3,240,695)	($3,304,092)	($3,359,233)	($3,508,423)	($3,115,859)
	Total Assets	$24,871,148	$24,523,819	$24,242,243	$24,630,841	$24,236,389	$24,682,109	$24,871,148	$24,523,819	$24,242,243	$24,630,841	$24,236,389	$24,682,109
D.	**Additional Statistics**												
1	**Income from Operations**	**-$311,375**	**-$486,043**	**-$156,768**	**-$173,254**	**-$274,097**	**$686,831**	**-$3,646,972**	**-$4,133,015**	**-$4,289,783**	**-$4,463,037**	**-$4,737,134**	**-$4,050,303**
2	**Revenue Over/(Under) Expense**	**-$197,748**	**-$368,455**	**-$63,397**	**-$55,141**	**-$149,190**	**$392,564**	**-$2,872,240**	**-$3,240,695**	**-$3,304,092**	**-$3,359,233**	**-$3,508,423**	**-$3,115,859**
3	**EBITDA**	**$103,634**	**-$71,210**	**$261,269**	**$246,594**	**$148,190**	**$1,136,400**	**-$678,043**	**-$749,253**	**-$487,984**	**-$241,390**	**-$93,200**	**$1,043,200**
4	**Cash from Operations**	**$5,957,007**	**$5,208,157**	**$5,560,291**	**$4,928,006**	**$4,883,110**	**$5,239,344**	**$5,957,007**	**$5,208,157**	**$5,560,291**	**$4,928,006**	**$4,883,110**	**$5,239,344**
5	**Cash and Cash Equivalents**	**-$80,010**	**$154,797**	**$161,436**	**$1,262,686**	**$264,212**	**$1,037**	**-$80,010**	**$154,797**	**$161,436**	**$1,262,686**	**$264,212**	**$1,037**
6	**Net Working Capital**	**$4,472,594**	**$4,431,740**	**$4,578,975**	**$4,294,252**	**$4,000,821**	**$2,464,879**	**$4,472,594**	**$4,431,740**	**$4,578,975**	**$4,294,252**	**$4,000,821**	**$2,464,879**
7	**Unrestricted Assets**	**-$2,872,240**	**-$3,240,695**	**-$3,304,092**	**-$3,359,233**	**-$3,508,423**	**-$3,115,859**	**-$2,872,240**	**-$3,240,695**	**-$3,304,092**	**-$3,359,233**	**-$3,508,423**	**-$3,115,859**
8	**Credit Ratings (S&P, FITCH, and Moody's)**												

User, OHCA

From: Cotto, Carmen
Sent: Wednesday, December 27, 2017 3:30 PM
To: Dennis P. McConville (dmcconville@echn.org) (dmcconville@echn.org)
Cc: Roberts, Karen; User, OHCA; 'colleen713.smith@gmail.com'
Subject: FW: 15-32016-486-CON
Attachments: Letter to Yvonne Addo, OHCA re DN 15-32016-486-CON 12 15 17 Final.pdf

Good afternoon Dennis,

In reference to the attached documents, please also provide us with the same documents in Excel format, as applicable. In particular, those related to capital commitment investment, cost savings and quarterly financial measures.
As you might already know, Excel format makes it easier to filter and analyzed data. It will be very helpful to us to receive them in this format.

Thank you in advance for your assistance.
Carmen

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
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From: Mcconville, Dennis P [mailto:dmcconville@echn.org]
Sent: Friday, December 15, 2017 10:19 AM
To: User, OHCA
Cc: Martone, Kim; Roberts, Karen; Colleen Smith; Ellen J. Shin (ellen.shin@prospectmedical.com); Tichy, Joyce A (Legal Department); Collins, Michael; Garrison DeLee (garrison.delee@prospectmedical.com); Frank.Saidara; Von.Crockett; Basile, Mary C; Veillette, Michael
Subject: 15-32016-486-CON

The attached letter is submitted as required for condition number eight (8), condition number nine (9) and condition number ten (10) contained in the Final Decision for Docket Number: 15-32016-486-CON, the Transfer of Assets of Eastern Connecticut Health Network, Inc. to Prospect Medical Holdings, Inc.

Dennis P. McConville

Senior Vice President
Eastern Connecticut Health Network, Inc.
(860) 533-3429 (office)
(860) 268-4591 (cell)
dmcconville@echn.org



"This message originates from Eastern Connecticut Health Network. The information contained in this message may be privileged and confidential. If you are the intended recipient, you must maintain this message in a secure and confidential manner. If you are not the intended recipient, please notify the sender immediately and destroy this message. Thank you."

Eastern Connecticut Health Network
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December 15, 2017

VIA EMAIL DELIVERY

Deputy Commissioner Yvonne Addo
Office of Health Care Access
Department of Public Health
410 Capitol Avenue, MS 13HCA
P.O. Box 340308
Hartford, CT 06134

Re: **Docket Number: 15-32016-486**

Project Title: **Transfer of assets of Eastern Connecticut Health Network, Inc. to Prospect Medical Holdings, Inc.**

Dear Ms. Addo:

This letter is submitted in accordance with the Order for the above referenced Certificate of Need Final Decision, specifically Condition Number Eight (8), Condition Number Nine (9) and Condition Number Ten (10) regarding the transfer of assets of Eastern Connecticut Health Network, Inc. (ECHN) to Prospect Medical Holdings, Inc. (PMH).

Condition Number Eight (8) requires that on a semi-annual basis until the capital commitment is satisfied, PMH shall submit to OHCA a report on the capital investments ("Capital Investment Report") it has made in the New MMH, New RGH and their affiliates from the 75 million Commitment Amount. Please find the Capital Investment Report for Fiscal Year 2017 labeled as Exhibit A which includes payment dates, amounts and sources of funding. In addition, please find Exhibit B which includes all capital purchases for Fiscal Year 2017 that have been made or approved with purchase orders issued. The timeframes for the roll out of capital projects are also noted.

Condition Number Nine (9) requires that PMH provide a report for New ECHN, New MMH and New RGH on a semi-annual basis with the following information:

a. The cost saving totals achieved in the following Operating Expense Categories for New ECHN, New MMH and New RGH: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Interest Expense, Malpractice Expense, Utilities, Business

Expenses, and other Operating Expenses. The categories shall be consistent with the major operating expense categories (Categories A, B, C, D, E, G, H, I, J, and) which are in use at the time of reporting in the OHCA Hospital Reporting System ("HRS") Report 175 or successor report. The semi-annual submission shall also contain narratives describing:

1. The major cost savings achieved for each expense category for the semi-annual period; and

2. The effect of cost savings on the clinical uality of care.

b. A Consolidated Balance Sheet, Statements of Operations, and Statements of Cash Flows for New ECHN, New MMH and New RGH. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Reports 100/150, 300 350 or successor reports.

For Condition Number Nine (9.a.), please find Exhibit C which shows the expenses by category using the form of HRS Report 175 for the period of April 1, 2017 through September 30, 2017 as compared to the first half of Fiscal Year 2017, October 1, 2016 through March 31, 2017. Exhibit D contains information relating to the clinical uality of care provided at New MMH and New RGH this past year.

For Condition Number Nine (9.b.), please find Exhibit E using the form of HRS Reports 100 150 and 300 350 which includes the Consolidated Balance Sheet, Statements of Operations, and Statements of Cash Flows for New ECHN, New MMH and New RGH

Condition Number Ten (10) re uires that on a semi-annual basis, PMH provide a report for New ECHN, New MMH and New RGH with the following financial measurements indicators showing current month and year-to-date data and comparable prior year period data for New ECHN, New MMH and New RGH respectively :

Financial Measurement/Indicators

A. Operating Performance

1. Operating Margin
2. Non-Operating Margin
3. Total Margin

B. Liquidity

1. Current Ratio
2. Days Cash on Hand
3. Days in Net Accounts Receivables
4. Average Payment Period

C. Leverage and Capital Structure

1. Long-term Debt to E uity
2. Long-term Debt to Capitali ation
3. Unrestricted Cash to Debt

4. Times Interest Earned Ratio
5. Debt Service Coverage Ratio
6. E□uity Financing Ratio

D. <u>Additional Statistics</u>

1. Income from Operations
2. Revenue Over (Under) Expense
3. Cash from Operations
4. Cash and Cash E□uivalents
5. Net Working Capital
6. Free Cash Flow (and the elements used in the calculation)
7. Unrestricted Assets□Retained Earnings
8. Bad Debt as □ of Gross Revenue
9. Credit Ratings (S&P, FITCH, or Moody's)

Please find Exhibit F for the periods beginning on October 1, 2016 through March 31, 2017 and April 1, 2017 through September 30, 2017 showing current month and year to date measurements as re□uired for Condition Ten (10). Future reports will compare the data to the comparable period for the prior year.

If you have any □uestions or need anything further, please feel free to contact me at (860) 533-3429.

Very truly yours,

Dennis P. McConville
Senior Vice President
Eastern Connecticut Health Network

Enclosures:

Exhibit A- Condition Number Eight (8) - Capital Investment Report
Exhibit B – Condition Number Eight (8) – Fiscal Year 2017 Approved Capital Expenditures
Exhibit C – Condition Number Nine (9.a) - Expenses by Category
Exhibit D – Condition Number Nine (9.a) – Effect of Cost Savings on Clinical Quality of Care
Exhibit E – Condition Number Nine (9.b.) - Consolidated Balance Sheets, Statements of Operations, and Statements of Cash Flows for New ECHN, New MMH and New RGH
Exhibit F – Condition Number Ten (10) - Current Month and Year to Date Measurements

cc: imberly R. Martone, Director of Operations, Office of Health Care Access, Connecticut Department of Public Health
aren Roberts, Principal Health Care Analyst, Office of Health Care Access, Connecticut Department of Public Health
Colleen Smith, Nursing Consultant Partners, LLC
Ellen J. Shin, General Counsel, Prospect Medical Holdings, Inc.
Joyce A. Tichy, Senior Vice President and General Counsel, ECHN
Michael Collins, CEO, ECHN
Von Crocket, Senior Vice President, Corporate Development, Prospect Medical Holdings, Inc.
Frank Saidara, Vice President, Corporate Development, Prospect Medical Holdings, Inc.
Garrison De Lee, Assistant General Counsel, Prospect Medical Holdings, Inc.

Exhibit A

Capital Investment Report
Paid Capital
FY 2017

Vendor	Entity	Item	Purpose	PO #	FundingType	October	November	December	January	February	March	Total	April	May
												********PAYMENT AMOUNT********		
MOREDIRECT INC	MMH	SECURITY SYSTEM UPGRADE	Replacement	C0016389	F			$3,227				$3,227		
ADVANCE SECURITY INTERGATION LLC	MMH	ACCESS CONTROL UPGRADE	Replacement	C0016390	F				$81,206			$81,206		
SECURITY 101	MMH	ACCESS CONTROL UPGRADE	Replacement	C0016390	F									
W.B. MASON COMPANY, INC.	RGH	WALDEN EATING DISORDER UNIT	Renovation	C016300P	F					$1,813		$1,813		
RAINTECH SOUND & COMMUNICATION, INC.	RGH	WALDEN EATING DISORDER UNIT	Renovation	C016300R	F		$13,278					$13,278		
STRYKER SALES CORPORATION	RGH	WALDEN EATING DISORDER UNIT	Renovation	C01630AU	F					$68,544		$68,544		
GE MEDICAL SYSTEMS INFORMATION	RGH	WALDEN EATING DISORDER UNIT	Renovation	C16300AV	F			$2,594				$2,594		
GRAYBAR ELECTRIC CO INC.	RGH	WALDEN EATING DISORDER UNIT	Renovation	C16300BB	F		$237					$237		
SHI INTERNAIONAL CORP	RGH	WALDEN EATING DISORDER UNIT	Renovation	C16300BC	F		$1,881					$1,881		
SHI INTERNAIONAL CORP	RGH	WALDEN EATING DISORDER UNIT	Renovation	C16300BC	F		$155					$155		
SOMA TECHNOLOGY, INC.	RGH	WALDEN EATING DISORDER UNIT	Renovation	C16300BD	F		$695					$695		
TRI-ANIM HEALTH SERVICES	RGH	WALDEN EATING DISORDER UNIT	Renovation	C16300BG	F	$413						$413		
TRI-ANIM HEALTH SERVICES	RGH	WALDEN EATING DISORDER UNIT	Renovation	C16300BG	F		$826					$826		
RAINTECH SOUND & COMMUNICATION, INC.	RGH	WALDEN EATING DISORDER UNIT	Renovation	C16300BH	F				$34,882			$34,882		
MODERN MECHANICAL SERVICES, INC	MMH	WATER TOWER TANKS	Replacement	C0016345	N		$90,487					$90,487		
ALL-PHASE ENTERPRISES INC	MMH	GENERATOR FLUE STACK	Replacement	C0016364	N		$9,430					$9,430		
SMITHS MEDICAL ASD INC	MMH	TEMP CHECK	Replacement	C0016379	N	$807						$807		
HILL-ROM	MMH	STRETCHER MATTRESSES (7)	Replacement	C0016388	N		$3,644					$3,644		
HILL-ROM	MMH	STRETCHER MATTRESSES (6)	Replacement	C0016393	N		$2,818					$2,818		
SCALES INDUSTRIAL TECHOLOGIES, LLC	MMH	QUINCY OILESS COMPRESSOR	Replacement	C0016394	N		$12,730					$12,730		
SCALES INDUSTRIAL TECHOLOGIES, LLC	MMH	QUINCY OILESS COMPRESSOR	Replacement	C0016394	N					$1,663		$1,663		
SAFEWARE, INC.	RGH	GAS ALERT DETECTOR	Replacement	C0016398	N					$195		$195		
SAFEWARE, INC.	RGH	GAS ALERT DETECTOR	Replacement	C0016398	N					$2,264		$2,264		
SAFEWARE, INC.	RGH	GAS ALERT DETECTOR	Replacement	C0016398	N								$2,458	
MOREDIRECT INC	WAT	IT - CISCO CATALYST	Replacement	C0016401	N								$10,884	
MOREDIRECT, INC.	RGH	IT - CISCO CATALYST	Replacement	C0016401	N									
JKS SYSTEMS, LLC	WAT	WOODLAKE CABLE RUNS	Replacement	C0016402	N								$5,241	
PRAXAIR DISTRIBUTION, INC	MMH	FBC - NITRONOX E STAND PACKAGE	Replacement	C0016403	N						$11,230	$11,230		
STERIS CORP	MMH	CENTURY STERILIZER COLOR DISPLAY	Replacement	C0016404	N									$10,29
STERIS CORP	MMH	SPD - 3 LEVEL MANIFOLD RACK	Replacement	C0016405	N						$13,662	$13,662		
GERMFREE LABORATORIES, INC	RGH	PHARMACY COMPOUNDING ISOLATOR	Replacement	C0016406	N									
OWENS & MINOR	MMH	DIGITAL SCALE WITH HANDRAILS	Replacement	C0016407	N								$1,606	
HILL-ROM	MMH	CLUB SLEEPER/MATRESS (MATERNITY)	Replacement	C0016408	N									$4,51
CARPETWORKS	MMH	NUCLEAR MED FLOORING	Replacement	C0016413	N						$5,429	$5,429		
CARPETWORKS	RGH	FLOORING - BIII, HOSPICE ICU WAITING RO	Replacement	C0016414	N						$19,452	$19,452		
CARPETWORKS LLC	RGH	FLOORING - BIII, HOSPICE ICU WAITING RO	Replacement	C0016414	N									
CARPETWORKS LLC	RGH	FLOORING - BIII, HOSPICE ICU WAITING RO	Replacement	C0016414	N									
CARPETWORKS	RGH	FLOORING - LITHOTRIPSY	Replacement	C0016415	N						$5,158	$5,158		
HILL ROM COMPANY INCORPORATED	RGH	MATTRESS REPLACEMENT	Replacement	C0016416	N									
KARL STORZ ENDOSCOPY AMERICA, INC.	MMH	VIDEO URETEROSCOPE	Replacement	C0016417	N									
INTOXIMETERS INC	MMH	INTOXIMETER SENSOR	Replacement	C0016418	N								$555	
FLAGSHIP NETWORKS, INC	MMH	CITRIX EDUCATION LICENSING	Replacement	C0016420	N									
SHI INTERNAIONAL CORP	MMH	IPAD AIR ACCESSORIES	Replacement	C0016421	N								$249	
SHI INTERNAIONAL CORP	MMH	APPLE IPAD AIR/ACCESSORIES (5)	Replacement	C0016421	N									$4,05
TRUMPF MEDICAL SYSTEMS	MMH	FOOT SUPPORT, ROTATABLE	Replacement	C0016422	N									$85
W.B. MASON CO INC	MMH	MATERNITY WAITING ROOM FURNITURE	Replacement	C0016425	N									
CDW GOVERNMENT INC	ECMP	HP PROBOOK WITH ACCESSORIES (4)	Replacement	C0016426	N									$4,41
TELEFLEX MEDICAL INCORPORATED	MMH	SURGICAL TOOLS	Replacement	C0016427	N								$3,279	
AESCULAP	MMH	SURGICAL TOOLS	Replacement	C0016428	N								$1,531	
INTERA LIFESCIENCES	MMH	LED HEADLIGHT (3)	Replacement	C0016429	N								$18,479	
SHI INTERNAIONAL CORP	MMH	APPLE IPOD TOUCH (50)	Replacement	C0016430	N								$10,365	
MOREDIRECT, INC.	MMH	FIREWALL REPLACEMENT	Replacement	C0016433	N									
MOREDIRECT, INC.	MMH	FIREWALL REPLACEMENT	Replacement	C0016433	N									
MOREDIRECT, INC.	MMH	FIREWALL REPLACEMENT	Replacement	C0016433	N									
CHIMENET, INC.	MMH	FIREWALL	Replacement	C0016434	N									
PRECISION COMPUTER SERVICES, INC	MMH	IT - CISCO B2000 SERVER/ACCESSORIES	Replacement	C0016435	N									$43,43
PRECISION COMPUTER SERVICES, INC.	MMH	CISCO B200 M4 BLADES/IMPLEMENTATION	Replacement	C0016435	N									
OLYMPUS AMERICA, INC	RGH	PORTABLE RHINO-LARYNGO FIBERSCOPE	Replacement	C0016436	N									$13,11
MORTARA INSTRUMENT, INC.	MMH	CARDIAC REHAB TREADMILL	Replacement	C0016437	N									
MORTARA INSTRUMENT, INC.	RGH	RHAB TREADMILL	Replacement	C0016438	N									
FOLLETT LLC	RGH	EDU - ICE MAKER/WATER DISPENSER	Replacement	C0016439	N									
ERBE USA INCORPORATED	MMH	ENDOSCOPY ACP SYSTEM	Replacement	C0016440	N									
ERBE USA INCORPORATED	RGH	ENDOSCOPY ACP SYSTEM	Replacement	C0016441	N									
ALL-PHASE ENTERPRISES, INC.	WAT	CHOW PLAN OF CORRECTION RENO	Renovation	C0016445	N									
ALL-PHASE ENTERPRISES, INC.	WAT	CHOW PLAN OF CORRECTION RENO	Renovation	C0016445	N									

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													********** PAYMENT AMOUNT **********		
Vendor	Entity	Item	Purpose	PO #	FundingType	October	November	December	January	February	March	Total	April	May	
ALL-PHASE ENTERPRISES, INC.	WAT	CHOW PLAN OF CORRECTION RENO	Renovation	C0016445	N										
ALL-PHASE ENTERPRISES, INC.	WAT	CHOW PLAN OF CORRECTION RENO	Renovation	C0016445	N										
ALL-PHASE ENTERPRISES, INC.	WAT	CHOW PLAN OF CORRECTION RENO	Renovation	C0016445	N										
ALL-PHASE ENTERPRISES, INC.	WAT	CHOW PLAN OF CORRECTION RENO	Renovation	C0016445	N										
W.B. MASON CO INC	WAT	CHOW RESIDENT ROOM FURNITURE	Renovation	C0016447	N										
W.B. MASON CO INC	MMH	BARIATRIC FURNITURE	Replacement	C0016448	N										
SHI INTERNAIONAL CORP	WAT	CISCO CATALYST - WAT COMPUTER ACCE	Replacement	C0016449	N									$2,247	
JKS SYSTEMS, LLC	WAT	IT WIRING AND CABLE INSTALL	Replacement	C0016450	N										
W.B. MASON CO INC	MMH	PHYSICIAN LOUNGE FURNITURE	Replacement	C0016454	N										
SCOTTCARE CORPORATION	MMH	VERSA CARE TELEMETRY MONITORING SY	Replacement	C0016455	N									$45,628	
CDW GOVERNMENT INC.	MMH	PT MIGRATION TO MEDITECH	Replacement	C0016456	N										
CDW GOVERNMENT INC.	MMH	PT MIGRATION TO MEDITECH	Replacement	C0016456	N										
SHI INTERNAIONAL CORP	MMH	HP745-PT MIGRATION TO MEDITECH	Replacement	C0016457	N									$25,014	
JKS SYSTEMS, LLC	MMH	REHAB ACCESS POINTS	Replacement	C0016458	N										
W.B. MASON CO INC	RGH	ED TASK CHAIRS (10)	Replacement	C0016460	N										
EHR INTEGRATION	ECMP	PATIENT ADT INTERFACE	Replacement	C0016463	N								$5,625		
EHR INTEGRATION SERVICES, LLC	ECMP	ED transition to ECMP Billing	Replacement	C0016463	N										
EHR INTEGRATION SERVICES, LLC	ECMP	ED transition to ECMP Billing	Replacement	C0016463	N										
EHR INTEGRATION SERVICES, LLC	ECMP	ED transition to ECMP Billing	Replacement	C0016463	N										
IATRIC SYSTEMS	MMH	ED TRANSITION TO ECMP BILLING	Replacement	C0016464	N										
JKS SYSTEMS, LLC	MMH	IT CABLING - 44 HAYNES	Replacement	C0016466	N										
MOREDIRECT, INC.	MMH	CRC HARDWARE	Replacement	C0016467	N										
MID-SOUTH TELECOM LLC	MMH	CRC PHONES	Replacement	C0016469	N										
AMPRONIX, INC.	MMH	MEDICAL VIDEO RECORDER	Replacement	C0016470	N										
MOREDIRECT, INC.	MMH	LAPTOP INVENTORY (20)	Replacement	C0016471	N										
MOREDIRECT, INC.	MMH	LAPTOP INVENTORY (20)	Replacement	C0016471	N										
FLAGSHIP NETWORKS, INC	MMH	MCAFEE FOR LAPTOPS (20)	Replacement	C0016472	N										
MCKESSON MEDICAL SURGICAL INC.	ECMP	INFECTIOUS DISEASE WALL UNITS	Replacement	C0016475	N										
EAGLE RIVET ROOF SERVICE CORP.	RGH	CHOW PLAN OF CORRECTION ROOF	Replacement	C0016476	N										
EAGLE RIVET ROOF SERVICE CORP.	RGH	CHOW PLAN OF CORRECTION ROOF	Replacement	C0016476	N										
EAGLE RIVET ROOF SERVICE CORP.	RGH	CHOW PLAN OF CORRECTION ROOF	Replacement	C0016476	N										
PHILIPS HEALTHCARE	RGH	CHOW PLAN OF CORRECTION ROOF	Replacement	C0016477	N										
HOLOGIC LIMITED PARTNERSHIP	MMH	MYOSURE HYSTEROSCOPE	Replacement	C0016478	N										
CLASSIC RESTAURANT SUPPLY	MMH	ICE MACHINE	Replacement	C0016479	N										
INTERIOR CONCEPTS	RGH	CORRIDOR DOOR REPLACEMENT	Replacement	C0016482	N										
INTERIOR CONCEPTS	RGH	CORRIDOR DOOR REPLACEMENT	Replacement	C0016482	N										
MCPHEE ELECTRICAL LTD	RGH	ICU Transformer Replacement	Replacement	C0016486	N										
SHI INTERNATIONAL CORP.	MMH	MED EDU HARDDRIVES AND BATTERIES	Replacement	C0016488	N										
SHI INTERNATIONAL CORP.	MMH	MED EDU HARDDRIVES AND BATTERIES	Replacement	C0016488	N										
SHI INTERNATIONAL CORP.	MMH	LAB DOCUMENT SCANNER	Replacement	C0016489	N										
CONNECTICUT BUSINESS SYSTEMS, LLC	RGH	PRINTER/SCANNER	Replacement	C0016490	N										
CONNECTICUT BUSINESS SYSTEMS, LLC	MMH	PRINTER	Replacement	C0016491	N										
MCKESSON MEDICAL-SURGICAL	WAT	TUB	Replacement	C0016492	N										
SMITH & NEPHEW ENDOSCOPY DIV.	MMH	SHOULDER POSITIONER	Replacement	C0016496	N										
SMITH & NEPHEW ENDOSCOPY DIV.	MMH	SHOULDER POSITIONER	Replacement	C0016496	N										
JKS SYSTEMS, LLC	RGH	WIRING - GI, CARDIO & OR	Replacement	C0016497	N										
SIEMENS MEDICAL SOLUTIONS USA, INC.	MMH	PACS UPGRADE	Replacement	C0016498	N										
HELMER SCIENTIFIC	MMH	LAB REFRIGERATOR	Replacement	C0016500	N										
GE HEALTHCARE IITS USA CORP	MMH	FBC EXPANSION -PROJECT	Replacement	C016281B	N	$3,845						$3,845			
MERRY X-RAY CHEMICAL CORP	MMH	VASCULAR- PROJECT	Replacement	C016312V	N	$652						$652			
CHIMENET, INC.	RGH	IDF UPGRADE/NETWORK REDESIGN	Replacement	C016376A	N				$2,400			$2,400			
CHIMENET, INC.	RGH	IDF UPGRADE/NETWORK REDESIGN	Replacement	C016376A	N					$4,111		$4,111			
MOREDIRECT INC	RGH	COMPUTER CABLES	Replacement	C016376G	N		$1,403					$1,403			
DC CONSULTING SERVICE LLC	ECMP	SOFTWARE	Replacement	C016382B	N	$990						$990			
JKS SYSTEMS, LLC	ECMP	COMPUTER SCANNER	Replacement	C016385A/E	N	$412						$412			
FLAGSHIP NETWORKS, INC	ECMP	LICENSE FEE	Replacement	C016385D	N			$950				$950			
MCKESSON MEDICAL SURGICAL	ECMP	BARIATRIC SCALE	Replacement	C016385F	N	$1,550						$1,550			
MOSER PILON NELSON	MMH	MMH BARIATRIC INPATIENT ROOMS -PROJ	Renovation	C016395A	N	$2,000						$2,000			
MOSER PILON NELSON	MMH	MMH BARIATRIC INPATIENT ROOMS -PROJ	Renovation	C016395A	N	$3,950						$3,950			
MOSER PILON NELSON	MMH	MMH BARIATRIC INPATIENT ROOMS -PROJ	Renovation	C016395A	N	$3,570						$3,570			
MOSER PILON NELSON	MMH	MMH BARIATRIC INPATIENT ROOMS -PROJ	Renovation	C016395A	N				$2,380			$2,380			
MOSER PILON NELSON	MMH	MMH FLUOROSCOPY ROOM-PROJECT	Renovation	C016396A	N	$1,250						$1,250			
MOSER PILON NELSON	MMH	MMH FLUOROSCOPY ROOM-PROJECT	Renovation	C016396A	N	$6,275						$6,275			
MOSER PILON NELSON	MMH	MMH FLUOROSCOPY ROOM-PROJECT	Renovation	C016396A	N	$3,525						$3,525			
MOSER PILON NELSON	MMH	MMH FLUOROSCOPY ROOM-PROJECT	Renovation	C016396A	N				$2,350			$2,350			
MOSER PILON NELSON	MMH	GEROPSYCHIATRY BH UNIT RENOVATIONS	Renovation	C016409A	N						$45,100	$45,100			

Exhibit A

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Vendor	Entity	Item	Purpose	PO #	FundingType	October	November	December	January	February	March	Total	April	May
						**********	**********	**********	**********	**********	PAYMENT AMOUNT	**********	**********	**********
MOSER PILON NELSON	MMH	GEROPSYCHIATRY BH UNIT RENOVATIONS	Renovation	C016409A	N									
MOSER PILON NELSON	MMH	GEROPSYCHIATRY BH UNIT RENOVATIONS	Renovation	C016409A	N									
MOSER PILON NELSON	MMH	GEROPSYCHIATRY BH UNIT RENOVATIONS	Renovation	C016409A	N									
STANDARD BUILDERS, INC.	RGH	GEROPSYCHIATRY BH UNIT RENOVATIONS	Renovation	C016409B	N									
IRVING D. MOY	RGH	GEROPSYCHIATRY BH UNIT RENOVATIONS	Renovation	C016409L	N									
IRVING D. MOY	RGH	GEROPSYCHIATRY BH UNIT RENOVATIONS	Renovation	C016409L	N									
MOSER PILON NELSON	RGH	ADULT BEHAVIORAL HEALTH UNIT	Renovation	C016410A	N						$165,635	$165,635		
MOSER PILON NELSON	RGH	ADULT BEHAVIORAL HEALTH UNIT	Renovation	C016410A	N								$10,000	
MOSER PILON NELSON	RGH	ADULT BEHAVIORAL HEALTH UNIT	Renovation	C016410A	N									$55,250
MOSER PILON NELSON	RGH	ADULT BEHAVIORAL HEALTH UNIT	Renovation	C016410A	N									
STANDARD BUILDERS, INC.	RGH	ADULT BEHAVIORAL HEALTH UNIT	Renovation	C016410B	N									
STANDARD BUILDERS, INC.	RGH	ADULT BEHAVIORAL HEALTH UNIT	Renovation	C016410B	N									
ABATEMENT PLUS, LLC	RGH	ADULT BEHAVIORAL HEALTH UNIT	Renovation	C016410T	N									
ABATEMENT PLUS, LLC	RGH	ADULT BEHAVIORAL HEALTH UNIT	Renovation	C016410T	N									
ALL-PHASE ENTERPRISES, INC.	RGH	ADULT BEHAVIORAL HEALTH UNIT	Renovation	C016410U	N									
HORAK PAINTING CONTRACTORS	RGH	RGH GROUND FLOOR CORRIDOR PAINTIN	Renovation	C016480C	N									
HORAK PAINTING CONTRACTORS	RGH	RGH GROUND FLOOR CORRIDOR PAINTIN	Renovation	C016480C	N									
CARPETWORKS LLC	MMH	PHARMACY ENGINEERING -PROJECT	Replacement	C15875HH	N		$670					$670		
PRO-TECH	WAT	FIRE BLOCKING	Replacement		N					$6,391		$6,391		
CTGI	MMH	LAB - GI COMPUTER INTERFACE	Replacement		N						$17,670	$17,670		
						$29,238	**$138,254**	**$6,771**	**$123,219**	**$84,979**	**$283,336**	**$665,798**	**$70,273**	**$208,818**
		Financing (Debt, Lease)			F	**$413**	**$17,073**	**$5,821**	**$116,089**	**$70,357**	**$0**	**$209,753**	**$0**	**$0**
		New FY 2017 Spending (Operations)			N	**$28,825**	**$121,181**	**$950**	**$7,131**	**$14,622**	**$283,336**	**$456,045**	**$70,273**	**$208,818**
		TOTAL				**$29,238**	**$138,254**	**$6,771**	**$123,219**	**$84,979**	**$283,336**	**$665,798**	**$70,273**	**$208,818**

Michael D. Veillette, Chief Financial Officer, Prospect ECHN, Inc.

Exhibit B

Prospect ECHN, Inc.
FY2017 Approved Capital Expenditures

Vendor Name	Facility	Item Description	Amount	Purpose	Notes
Otis Elevator	MMH	Elevator Sheave Replacement	35,255.00	Repair	
Connection, JKS Systems	ECHN	Voice Mail System Replacement	76,866.48	Replacement	
Omnicell, Inc.	MMH/RGH	Omnicell Dispensing System	1,306,013.10	Replacement	
Connection, JKS Systems	WAT	Wireless Network Expansion	15,721.32	New, Expansion	
GermFree	RGH	Germfree VF-4USP Compounding Aseptic Isolator	16,015.55	Replacement	
Steris Corporation	MMH	Sterilizer Centry Color Display Upgrade	10,949.80	Replacement	
Steris Corporation	MMH	Steris Manifold Racks and Carts (4)	16,647.94	Replacement	
Owens and Minor	MMH		1,692.29	Replacement	
Hill-Rom	MMH	Sleeper Chairs (2)	4,804.04	Replacement	
Praxair	MMH	Nitrous Oxide Delivery System (2)	11,147.61	New, Expansion	
Standard Builders, Inc.	RGH	Renovations for Adult Behavioral Health Unit	4,172,153.04	Replacement	Renovations in process to expand adult behavioral health capacity with 24 beds, completion expected December 2017
Standard Builders, Inc.	MMH	Renovations for Geropsychiatry Unit	818,129.28	Replacement	Renovations underway to provide separate program spaces for adolescent and geriatric patient populations, completion targeted for December 2017
Standard Builders, Inc.	MMH	BHU Safety Renovations	344,700.00	Replacement	In process, with replacement of acoustic ceilings with drywall, targeted completion by December 2017
Flagship Networks	ECHN	Citrix Licenses	9,635.40	New, Expansion	
SHI	MMH/RGH	iPods - Communications Services	4,721.74	New, Expansion	
Karl Storz	MMH	Ureteroscope	19,949.77	Replacement	
Carpetworks, LLC	RGH	Replacement Flooring - Lithotripsy Room	5,157.98	Replacement	
Carpetworks, LLC	RGH	Replacement Flooring - RGH Waiting Rooms	21,042.41	Replacement	
Carpetworks, LLC	MMH	Replacement Flooring - MMH Waiting Rooms	5,429.17	Replacement	
Hill Rom Company	RGH	Mattresses (35)	20,136.63	Replacement	
Prestige Medical Imaging	RGH	Portable X-Ray Unit	148,786.65	Replacement	
Intoximeters, Inc.	MMH	Breath Alcohol Tester	590.23	Replacement	
Teleflex Medical	MMH	Laparoscopic Tray	4,624.20	Replacement	
Integra Life Sciences	MMH	Surgical Headlights	19,662.41	Replacement	
Trumpf Medical	MMH	Trumpf OR Table Extension	903.98	New, Expansion	
Aesculap, Inc.	MMH	Orthopedic Large Bone Tray	1,628.15	Replacement	
WB Mason Company, Inc.	MMH	Waiting Rooms & Maternity Education Room Furniture	27,586.13	Replacement	
WB Mason Company, Inc.	RGH	Waiting Rooms & Nurse Lounge Furniture	15,862.10	Replacement	
WB Mason Company, Inc.	RGH	ED Waiting Room Flooring Replacement	13,033.19	Replacement	
CDW/SHI/Flagship	ECMP	Laptops, PCs	7,711.19	New, Expansion	
SHI	MMH/RGH	iPods for Secure Texting	11,022.88	New, Expansion	
Precision Computer Services, Inc.	ECHN	UCS Chassis & Blade Servers	50,885.35	New, Expansion	
Connection/CHIMENET	ECHN	Network Security Firewall	31,980.56	New, Expansion	
All Phase Construction Enterprises, Inc.	WAT	CHOW Renovations	517,966.35	Replacement	

Exhibit B

Prospect ECHN, Inc.
FY2017 Approved Capital Expenditures

WB Mason Company, Inc.	WAT	CHOW Furniture	240,877.43	Replacement	
Eagle Rivet Roofing	RGH	Roof Replacements (3)	152,075.18	Replacement	
CDW/Flagship/SHI/JKS	MMH/RGH	EMR Hardware	41,404.32	Replacement	
Carpetworks, LLC	MMH	2 East Patient Room Flooring	42,534.68	Replacement	
Carpetworks, LLC	MMH	1 East Corridor & Patient Room Flooring	72,647.69	Replacement	
ERBE USA Incorporated	MMH/RGH	ERBE Argon Plasma Coagulation Units (6)	233,965.32	Replacement	
Motara Instruments	MMH/RGH	Treadmills (4)	23,502.91	Replacement	
WB Mason Company, Inc.	MMH/RGH	Bariatric Furniture	25,845.18	Replacement	
Olympus American, Inc.	RGH	Tracheal & Rhino-Laryngoscopes	12,579.55	Replacement	
Follet	RGH	Ice Machine	2,553.15	Replacement	
SHI/JKS/CDW	WAT	PCs	4,678.94	Replacement	
PCP	ECMP	Practice Acquisition	273,200.00	New, Expansion	
WB Mason	RGH	Task Chairs (10)	3,126.69	Replacement	
WB Mason	MMH	Physician Lounge Furniture	5,899.23	Replacement	
ScottCare	MMH	VersaCare Telemetry Monitoring System	48,482.84	Replacement	
Meditech, CareFusion	MMH/RGH	Omnicell Interfaces	87,100.65	Replacement	
Iatric Systems, EHR Integration Services	MMH/RGH	ED Billing Interfaces	19,304.00	New, Expansion	
Connection, Flagship Networks, JKS Systems	CRC	Laptops for new hires	17,754.90	New, Expansion	
Mid-South Telecom LLC, SHI	CRC	Telephones for new hires	1,226.36	New, Expansion	
Connection, Flagship Networks	ECHN	Laptops for Inventory	23,327.82	Replacement	
Carpetworks, LLC	RGH	ICU Flooring Replacement	14,585.90	Replacement	
McKesson	ECMP	Exam Room Diagnostics Wall Units (2)	1,778.85	Replacement	
Mid-South Telecom LLC	ECMP	Telephone Headsets	1,312.95	Replacement	
Ampronix	MMH	HD Medical Video Recorder	4,241.24	Replacement	
Philips Healthcare	ECMP	Stress System, EKG Machine	26,302.80	Replacement	
Carpetworks, LLC Horak Painting, Abatement Plus	RGH	Ground Floor Renovations	92,683.04	Replacement	
Interior Concepts	RGH	Corridor Door Replacements	30,179.75	Replacement	
Classic Restaurant Supply	MMH	Ice cube machines (2)	4,730.43	Replacement	
Hologic	MMH	Hysteroscope & instrument tray	6,907.43	Replacement	
Hovertech International Air Supply & Storage Cart	MMH	HoverMatt Patient Transport System	1,447.42	New, Expansion	
CDW	MMH	3 Laptops	3,203.26	New, Expansion	
SHI	MMH	9 computer laptop hard drives & batteries	1,289.85	New, Expansion	
CBS	RGH	Printer/Scanner	1,302.79	New, Expansion	
Smith & Nephew	RGH	Shoulder positioner	4,439.05	New, Expansion	
Carpetworks, LLC	MMH	Vinyl flooring, ASC	11,858.03	Replacement	
Accurate Doors	RGH	Exterior doors (3)	12,740.73	Replacement	
SHI	MMH	Document scanner	944.12	New, Expansion	
K.M. Medical, Inc.	MMH	Lead aprons	7,174.22	Replacement	
K.M. Medical, Inc.	RGH	Lead aprons	2,080.21	Replacement	

Exhibit B

Prospect ECHN, Inc.
FY2017 Approved Capital Expenditures

JKS Systems	RGH	Data cabling	1,372.39	New, Expansion	
McPhee Electric	RGH	Transformer	48,921.00	Replacement	
McKesson	WAT	Tub with lift	12,102.63	Replacement	
Direct Supply	WAT	Hoyer Lifts with scales	4,852.80	New, Expansion	
Direct Supply	WAT	Vital Signs Monitors with stands	11,293.08	Replacement	
CBS	MMH	Printer	1,544.20	New, Expansion	
Siemens	ECHN	PACs System Upgrade	153,207.26	Replacement	
Karl Storz	MMH	Difficult Airways Carts (Two)	76,337.86	New, Expansion	
Olympus	MMH	Vacuum Curettage System	7,269.77	Replacement	
WB Mason	MMH	Office Chairs	8,975.94	Replacement	
Carpetworks, LLC	RGH	Bissell 2 Corridor Flooring Replacement	22,375.24	Replacement	
Carpetworks, LLC	MMH	Sleep Center Carpet Replacement	14,288.05	Replacement	
Helmer	MMH	Laboratory Refrigerator	5,503.46	Replacement	
Meditech	ECHN	Patient Portal	233,863.65	Replacement	
Smiths Medical	RGH	Infuser	10,004.08	New, Expansion	
W.B. Mason	MMH	Office Chairs	4,702.35	Replacement	
JKS Systems	ECHN	Cable data runs for wireless networks	2,677.30	New, Expansion	
Security 101	RGH	CCTV Replacement for Sterile Processing Facility	16,595.05	Replacement	
Eastcoast Paving Services	RGH	Service Drive and East Parking Lot Paving	73,010.00	Replacement	
Hartford Sprinkler Company	MMH	Garage Standpipe Replacement	17,600.93	Replacement	
Security 101	RGH	RGH Security Video Infrastructure	34,486.94	Replacement	
KTW Group	MMH	Surgical Case Carts	28,269.73	Replacement	
Stryker	RGH	Psychiatric Beds	76,959.65	Replacement	
Encore Fire Protection	RGH	Additional Sprinklers	29,964.11	New, Expansion	
Wells Johnson Company	MMH	Plastic Surgery Infiltration Pump	2,793.69	Replacement	
Stryker	MMH	Makoplasty Total Knee Application	297,780.00	New, Expansion	
Silktown Roofing, Inc.	MMH	CHOW POC Roof Replacements	1,326,920.97	Replacement	
All Phase Enterprises	MMH	Paving and Concrete Work	136,071.40	Replacement	
TPC Associatess, Inc	MMH	Hugs Infant Protection System	94,055.94	Replacement	
Alcon Laboratories	MMH	Alcon Constellation Retina Vitrectomy Machine	99,543.60	Replacement	
Electrical Wholesalers, Inc.	MMH	Replacement Exit Signs	14,632.91	Replacement	
Mindray	MMH/RGH	18 Anesthesia Machines	711,946.79	Replacement	
			$ 12,909,623.60		

Exhibit C
Prospect Manchester Hospital, Prospect Rockville Hospital and Prospect ECHN
Report 175 - Operating Expenses by Category
Comparison: October 2016 - March 2017 and April 2017 - September 2017

		October 2016 - March 2017			April 2017 - September 2017			Variance		
Line	Operating Expense by Category	MMH	RGH	ECHN	MMH	RGH	ECHN	MMH	RGH	ECHN
A	Salaries & Wages	$39,112,524	$14,071,000	$53,183,524	$37,836,794	$13,359,480	$51,196,274	($1,275,730)	($711,520)	($1,987,250)
B	Fringe Benefits	$13,822,026	$5,117,453	$18,939,479	$7,537,643	$3,238,088	$10,775,730	($6,284,383)	($1,879,365)	($8,163,749)
C	Contractual Labor Fees	$5,029,260	$2,271,227	$7,300,487	$6,638,425	$3,290,725	$9,929,150	$1,609,165	$1,019,498	$2,628,663
D	Medical Supplies & Phamaceutical Cost	$13,471,362	$3,913,060	$17,384,422	$13,316,492	$2,360,289	$15,676,781	($154,870)	($1,552,771)	($1,707,641)
E	Depreciation & Amortization	$3,536,666	$1,478,850	$5,015,516	$3,364,656	$1,452,043	$4,816,699	($172,010)	($26,807)	($198,817)
F	Bad Debts	$0	$0	$0	$0	$0	$0	$0	$0	$0
G	Interest Expense	$3,634,528	$1,075,070	$4,709,598	$3,598,889	$1,087,538	$4,686,428	($35,639)	$12,468	($23,171)
H	Malpractice Insurance Cost	$1,290,472	$504,808	$1,795,280	$153,148	$272,714	$425,862	($1,137,324)	($232,094)	($1,369,418)
I	Utilities	$1,380,083	$665,214	$2,045,297	$1,363,160	$628,562	$1,991,722	($16,922)	($36,652)	($53,574)
J	Business Expense	$13,597,193	$5,644,173	$19,241,366	$15,554,280	$5,874,021	$21,428,301	$1,957,087	$229,848	$2,186,935
K	Other Operating Expenses	-	-	-	-	-	-	$0	$0	$0
	Total Operating Expenses - All Expense Categories	$94,874,114	$34,740,855	$129,614,969	$89,363,489	$31,563,458	$120,926,947	($5,510,625)	($3,177,396)	($8,688,022)

Exhibit D - Effect of Cost Savings on Clinical Quality of Care

The clinical □uality of care at Manchester Memorial Hospital (MMH) and Rockville General Hospital (RGH) has improved over the past year as evidenced in the key □uality metrics charts below. This is attributed to the strong culture of safety that continues at the hospitals. The daily safety huddle, safety moments to begin every meeting and the continued education on HRO Safety culture to all staff and physicians are examples of the safety culture fully supported by the hospitals' senior leadership.

Manchester Memorial Hospital

Quality Metric	2016	2017	Change
Overall Infection Rate	0.8□	0.6□	-0.2□
Surgical Site Infection Rate	0.7□	0.4□	-0.3□
Colorectal SSI Rate	8.3□	7.1□	-1.2□
Abd Hysterectomy SSIs	1	1	0
Total Hip and □nee Infections	3	0	-3
C-Section Infections	13	0	-13
Handwashing Compliance Rate	48.0□	95.0□	47.0□
C-diffle Rate	0.7□	0.4□	-0.3□
CLABSIS, ICU	2	1	-1
CAUTIs, ICU	0	0	0
CAUTIs, Non - ICU	3	2	-1
Ventilator Ac□uired Events	13.7□	9.0□	-4.7□
Readmission Rates	9.2□	6.6□	-2.6□
Penalty Rates (readmissions)	1.05□	0.51□	-0.54□

Rockville General Hospital

Quality Metric	2016	2017	Change
Overall Infection Rate	0.8□	0.7□	-0.1□
Surgical Site Infection Rate□	0.3□	0.5□	0.2□
Colorectal SSI Rate	0	0	0
Abd Hysterectomy SSIs	0	0	0
Total Hip and □nee Infections	n□a	n□a	n□a
C-Section Infections	n□a	n□a	n□a
Handwashing Compliance Rate	78.0□	91.0□	13.0□
C-diffle Rate	0.9□	0.3□	-0.6□
CLABSIS, ICU	2	0	-2
CAUTIs, ICU	0	1	1
CAUTIs, Non - ICU	0	0	0
Ventilator Ac□uired Events	23.1□	15.2□	-7.9□
Readmission Rates	11.4□	10.6□	-0.8□
Penalty Rates (readmission)	1.83□	0.72□	-1.11□

□The overall number of SSIs is down from 5 in 2016 to 4 in 2017. Denominator decreased making the rate higher.

Exhibit D - Effect of Cost Savings on Clinical Quality of Care

In addition, positions have been added to the Quality and Safety department. A full-time and a part-time Quality Manager have been added as well as a Clinical Educator (shared between ECHN and Waterbury Hospital). As important, The PMH Chief Quality Officer sponsors monthly □uality calls and is available for □uestions and advice. The Regional Vice President for Quality and Safety works directly with the hospitals on □uality projects and initiatives and is also a valuable resource. The recent PMH Mock Survey is an example of a value added service by PMH to prepare our hospitals for the upcoming TJC surveys next year.

As evidenced by the key □uality metrics, added positions and available regional and corporate resources, the clinical □uality of care at MMH and RGH has been strengthened over the past year. Leadership at the local, regional and national levels has empowered the hospitals to continue to advance the culture of safety.

EXHIBIT E

PROSPECT ECHN, INC.		
AS OF SEPTEMBER 30, 2017		
FISCAL YEAR 2017		
REPORT 300 - PARENT CORPORATION CONSOLIDATED BALANCE SHEET INFORMATION		
(1)	(2)	(3)
		SEPT 2017
LINE	DESCRIPTION	ACTUAL
I.	**ASSETS**	
A.	**Current Assets:**	
1	Cash and Cash Equivalents	$4,194,382
2	Short Term Investments	
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$40,804,492
4	Current Assets Whose Use is Limited for Current Liabilities	
5	Due From Affiliates	$7,637,864
6	Due From Third Party Payers	
7	Inventories of Supplies	$6,054,400
8	Prepaid Expenses	$4,140,461
9	Other Current Assets	$2,435,581
	Total Current Assets	**$65,267,180**
B.	**Noncurrent Assets Whose Use is Limited:**	
1	Held by Trustee	$0
2	Board Designated for Capital Acquisition	
3	Funds Held in Escrow	
4	Other Noncurrent Assets Whose Use is Limited	
	Total Noncurrent Assets Whose Use is Limited:	**$0**
5	Interest in Net Assets of Foundation	
6	Long Term Investments	$13,734,336
7	Other Noncurrent Assets	$9,430,650
C.	**Net Fixed Assets:**	
1	Property, Plant and Equipment	$328,929,302
2	Less: Accumulated Depreciation	$250,110,586
	Less: Purchase Adjustment	$18,316,556
	Property, Plant and Equipment, Net	**$60,502,160**
3	Construction in Progress	$1,687,933
	Total Net Fixed Assets	**$62,190,093**
	Total Assets	**$150,622,259**

EXHIBIT E

PROSPECT ECHN, INC.		
AS OF SEPTEMBER 30, 2017		
FISCAL YEAR 2017		
REPORT 300 - PARENT CORPORATION CONSOLIDATED BALANCE SHEET INFORMATION		
(1)	(2)	(3)
		SEPT 2017
LINE	DESCRIPTION	ACTUAL
II.	**LIABILITIES AND NET ASSETS**	
A.	**Current Liabilities:**	
1	Accounts Payable and Accrued Expenses	$22,013,628
2	Salaries, Wages and Payroll Taxes	$5,641,078
3	Due To Third Party Payers	$2,192,261
4	Due To Affiliates	$1,793,691
5	Current Portion of Long Term Debt	$0
6	Current Portion of Notes Payable	$2,599,963
7	Other Current Liabilities	$10,280,642
	Total Current Liabilities	**$44,521,263**
B.	**Long Term Debt:**	
1	Bonds Payable (Net of Current Portion)	
2	Notes Payable (Net of Current Portion)	$8,929,268
	Total Long Term Debt	**$8,929,268**
3	Accrued Pension Liability	$66,866,795
4	Other Long Term Liabilities	$15,376,744
	Total Long Term Liabilities	**$91,172,807**
5	Interest in Net Assets of Affiliates or Joint Ventures	
C.	**Net Assets:**	
1	Net Assets or Equity	$14,928,189
2	Temporarily Restricted Net Assets	
3	Permanently Restricted Net Assets	
	Total Net Assets	**$14,928,189**
	Total Liabilities and Net Assets	**$150,622,259**

EXHIBIT E

PROSPECT ECHN, INC.				
FISCAL YEAR 2017				
REPORT 350 - PARENT CORPORATION CONSOLIDATED STATEMENT OF OPERATIONS INFORMATION				
(1)	(2)	(3)	(4)	
		OCT-MAR	APR-SEP	YTD SEPT 17
LINE	DESCRIPTION	ACTUAL	ACTUAL	ACTUAL
A.	**Operating Revenue:**			
1	Total Gross Patient Revenue	$497,056,059	495,473,693	$992,529,752
2	Less: Allowances	$341,478,789	340,297,357	$681,776,146
3	Less: Charity Care	$1,281,566	1,403,978	$2,685,544
4	Less: Other Deductions	$0	-	$0
	Total Net Patient Revenue	**$154,295,704**	**$153,772,358**	**$308,068,062**
5	Provision for Bad Debts	$3,835,978	3,823,267	$7,659,245
	Net Patient Service Revenue less provision for bad debts	**$150,459,726**	**$149,949,091**	**$300,408,817**
6	Other Operating Revenue	$10,793,602	13,395,083	$24,188,685
7	Net Assets Released from Restrictions	$0	-	$0
	Total Operating Revenue	**$161,253,328**	**$163,344,174**	**$324,597,502**
B.	**Operating Expenses:**			
1	Salaries and Wages	$73,885,912	74,572,521	$148,458,433
2	Fringe Benefits	$23,050,448	15,221,280	$38,271,728
3	Physicians Fees	$8,053,331	10,257,207	$18,310,538
4	Supplies and Drugs	$18,371,771	16,671,870	$35,043,641
5	Depreciation and Amortization	$5,698,189	5,209,480	$10,907,669
6	Bad Debts	$0	-	$0
7	Interest Expense	$4,729,540	4,703,035	$9,432,575
8	Malpractice Insurance Cost	$1,774,010	1,303,960	$3,077,970
9	Other Operating Expenses	$29,049,379	30,215,848	$59,265,227
	Total Operating Expenses	**$164,612,580**	**$158,155,201**	**$322,767,781**
	Income/(Loss) From Operations	**($3,359,252)**	**$5,188,973**	**$1,829,721**
C.	**Non-Operating Revenue:**			
1	Income from Investments	$0	-	$0
2	Gifts, Contributions and Donations	$0	-	$0
3	Other Non-Operating Gains/(Losses)	$2,913,137	1,063,254	$3,976,391
	Total Non-Operating Revenue	**$2,913,137**	**$1,063,254**	**$3,976,391**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**($446,115)**	**$6,252,227**	**$5,806,112**
	Other Adjustments:			
	Unrealized Gains/(Losses)	$0	-	$0
	All Other Adjustments	$0	-	$0
	Total Other Adjustments	**$0**	**$0**	**$0**
	Excess/(Deficiency) of Revenue Over Expenses	**($446,115)**	**$6,252,227**	**$5,806,112**

PROSPECT MANCHESTER HOSPITAL		
AS OF SEPTEMBER 30, 2017		
FISCAL YEAR 2017		
REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION		
(1)	(2)	(3)
		SEPT 2017
LINE	DESCRIPTION	ACTUAL
I.	**ASSETS**	
A.	**Current Assets:**	
1	Cash and Cash Equivalents	$187,195
2	Short Term Investments	$0
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$25,353,520
4	Current Assets Whose Use is Limited for Current Liabilities	$0
5	Due From Affiliates	$28,172,147
6	Due From Third Party Payers	$0
7	Inventories of Supplies	$4,543,626
8	Prepaid Expenses	$1,169,286
9	Other Current Assets	$51,857
	Total Current Assets	**$59,477,631**
B.	**Noncurrent Assets Whose Use is Limited:**	
1	Held by Trustee	$0
2	Board Designated for Capital Acquisition	$0
3	Funds Held in Escrow	$0
4	Other Noncurrent Assets Whose Use is Limited	$0
	Total Noncurrent Assets Whose Use is Limited:	**$0**
5	Interest in Net Assets of Foundation	$0
6	Long Term Investments	$3,794,969
7	Other Noncurrent Assets	$3,029,736
C.	**Net Fixed Assets:**	
1	Property, Plant and Equipment	$206,836,787
2	Less: Accumulated Depreciation	$160,975,889
	Less: Purchase Adjustment	$487,696
	Property, Plant and Equipment, Net	**$45,373,202**
3	Construction in Progress	$683,673
	Total Net Fixed Assets	**$46,056,875**
	Total Assets	**$112,359,211**

EXHIBIT E

PROSPECT MANCHESTER HOSPITAL		
AS OF SEPTEMBER 30, 2017		
FISCAL YEAR 2017		
REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION		
(1)	(2)	(3)
		SEPT 2017
LINE	DESCRIPTION	ACTUAL
II.	**LIABILITIES AND NET ASSETS**	
A.	**Current Liabilities:**	
1	Accounts Payable and Accrued Expenses	$14,932,883
2	Salaries, Wages and Payroll Taxes	$2,694,055
3	Due To Third Party Payers	$788,545
4	Due To Affiliates	$10,122,005
5	Current Portion of Bonds	$0
6	Current Portion of Notes Payable	$2,120,518
7	Other Current Liabilities	$82,105
	Total Current Liabilities	**$30,740,111**
B.	**Long Term Debt:**	
1	Bonds Payable (Net of Current Portion)	$0
2	Notes Payable (Net of Current Portion)	$3,954,712
	Total Long Term Debt	**$3,954,712**
3	Accrued Pension Liability	$52,162,410
4	Other Long Term Liabilities	$11,309,575
	Total Long Term Liabilities	**$67,426,697**
5	Interest in Net Assets of Affiliates or Joint Ventures	$0
C.	**Net Assets:**	
1	Unrestricted Net Assets or Equity	$14,192,403
2	Temporarily Restricted Net Assets	$0
3	Permanently Restricted Net Assets	$0
	Total Net Assets	**$14,192,403**
	Total Liabilities and Net Assets	**$112,359,211**

EXHIBIT E

PROSPECT MANCHESTER HOSPITAL					
FISCAL YEAR 2017					
REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION					
(1)	(2)	(3)		(4)	
LINE	DESCRIPTION	OCT-MAR ACTUAL		APR-SEP ACTUAL	YTD SEPT 17 ACTUAL
A.	**Operating Revenue:**				
1	Total Gross Patient Revenue	$336,306,535		341,770,277	$678,076,812
2	Less: Allowances	$240,249,012		245,237,735	$485,486,747
3	Less: Charity Care	$897,095		891,350	$1,788,445
4	Less: Other Deductions	$0		-	$0
	Total Net Patient Revenue	**$95,160,428**		**$95,641,192**	**$190,801,620**
5	Provision for Bad Debts	$2,267,527		2,331,749	$4,599,276
	Net Patient Service Revenue less provision for bad debts	**$92,892,901**		**$93,309,443**	**$186,202,344**
6	Other Operating Revenue	$4,641,099		4,411,751	$9,052,850
7	Net Assets Released from Restrictions	($1,983)		609	($1,374)
	Total Operating Revenue	**$97,532,017**		**$97,721,803**	**$195,253,820**
B.	**Operating Expenses:**				
1	Salaries and Wages	$39,112,524		37,836,793	$76,949,317
2	Fringe Benefits	$13,822,026		7,537,643	$21,359,669
3	Physicians Fees	$5,029,260		6,638,425	$11,667,685
4	Supplies and Drugs	$13,471,362		13,316,493	$26,787,855
5	Depreciation and Amortization	$3,536,666		3,364,656	$6,901,322
6	Bad Debts	$0		-	$0
7	Interest Expense	$3,634,528		3,598,890	$7,233,418
8	Malpractice Insurance Cost	$1,290,472		153,148	$1,443,620
9	Other Operating Expenses	$14,977,276		16,917,441	$31,894,717
	Total Operating Expenses	**$94,874,114**		**$89,363,489**	**$184,237,603**
	Income/(Loss) From Operations	**$2,657,903**		**$8,358,314**	**$11,016,217**
C.	**Non-Operating Revenue:**				
1	Income from Investments	$0		-	$0
2	Gifts, Contributions and Donations	$0		-	$0
3	Other Non-Operating Gains/(Losses)	$2,252,032		790,912	$3,042,944
	Total Non-Operating Revenue	**$2,252,032**		**$790,912**	**$3,042,944**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**$4,909,935**		**$9,149,226**	**$14,059,161**
	Other Adjustments:				
	Unrealized Gains/(Losses)	$0		-	$0
	All Other Adjustments	$0		-	$0
	Total Other Adjustments	**$0**		-	$0
	Excess/(Deficiency) of Revenue Over Expenses	**$4,909,935**		**$9,149,226**	**$14,059,161**

EXHIBIT E

PROSPECT ROCKVILLE HOSPITAL		
AS OF SEPTEMBER 30, 2017		
FISCAL YEAR 2017		
REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION		
(1)	(2)	(3)
LINE	DESCRIPTION	SEP 2017 ACTUAL
I.	**ASSETS**	
A.	**Current Assets:**	
1	Cash and Cash Equivalents	$1,037
2	Short Term Investments	$0
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$7,440,504
4	Current Assets Whose Use is Limited for Current Liabilities	$0
5	Due From Affiliates	$2,070,993
6	Due From Third Party Payers	$0
7	Inventories of Supplies	$1,220,807
8	Prepaid Expenses	$469,984
9	Other Current Assets	$283,071
	Total Current Assets	**$11,486,396**
B.	**Noncurrent Assets Whose Use is Limited:**	
1	Held by Trustee	$0
2	Board Designated for Capital Acquisition	$0
3	Funds Held in Escrow	$0
4	Other Noncurrent Assets Whose Use is Limited	$0
	Total Noncurrent Assets Whose Use is Limited:	**$0**
5	Interest in Net Assets of Foundation	$0
6	Long Term Investments	$3,352,337
7	Other Noncurrent Assets	$218,639
C.	**Net Fixed Assets:**	
1	Property, Plant and Equipment	$92,922,999
2	Less: Accumulated Depreciation	$70,435,459
	Less: Purchase Adjustment	$13,867,063
	Property, Plant and Equipment, Net	**$8,620,477**
3	Construction in Progress	$1,004,260
	Total Net Fixed Assets	**$9,624,737**
	Total Assets	**$24,682,109**

EXHIBIT E

PROSPECT ROCKVILLE HOSPITAL		
AS OF SEPTEMBER 30, 2017		
FISCAL YEAR 2017		
REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION		
(1)	(2)	(3)
LINE	DESCRIPTION	SEP 2017 ACTUAL
II.	**LIABILITIES AND NET ASSETS**	
A.	**Current Liabilities:**	
1	Accounts Payable and Accrued Expenses	$3,442,840
2	Salaries, Wages and Payroll Taxes	$538,322
3	Due To Third Party Payers	$639,008
4	Due To Affiliates	$4,246,725
5	Current Portion of Bonds	$0
6	Current Portion of Notes Payable	$159,691
7	Other Current Liabilities	($5,069)
	Total Current Liabilities	**$9,021,517**
B.	**Long Term Debt:**	
1	Bonds Payable (Net of Current Portion)	$0
2	Notes Payable (Net of Current Portion)	$445,778
	Total Long Term Debt	**$445,778**
3	Accrued Pension Liability	$14,704,385
4	Other Long Term Liabilities	$3,626,284
	Total Long Term Liabilities	**$18,776,447**
5	Interest in Net Assets of Affiliates or Joint Ventures	$0
C.	**Net Assets:**	
1	Unrestricted Net Assets or Equity	($3,115,855)
2	Temporarily Restricted Net Assets	$0
3	Permanently Restricted Net Assets	$0
	Total Net Assets	**($3,115,855)**
	Total Liabilities and Net Assets	**$24,682,109**

EXHIBIT E

PROSPECT ROCKVILLE HOSPITAL					
FISCAL YEAR 2017					
REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION					
(1)	(2)	(3)		(4)	
		OCT-MAR		APR-SEP	YTD SEPT 17
LINE	DESCRIPTION	ACTUAL		ACTUAL	ACTUAL
A.	**Operating Revenue:**				
1	Total Gross Patient Revenue	$117,512,312		111,285,475	$228,797,787
2	Less: Allowances	$85,243,699		79,722,557	$164,966,256
3	Less: Charity Care	$384,471		512,628	$897,099
4	Less: Other Deductions	$0		$0	$0
	Total Net Patient Revenue	**$31,884,142**		**$31,050,290**	**$62,934,432**
5	Provision for Bad Debts	$1,204,542		878,752	$2,083,294
	Net Patient Service Revenue less provision for bad debts	**$30,679,600**		**$30,171,538**	**$60,851,138**
6	Other Operating Revenue	$725,658		677,221	$1,402,879
7	Net Assets Released from Restrictions	$0		-	$0
	Total Operating Revenue	**$31,405,258**		**$30,848,759**	**$62,254,017**
B.	**Operating Expenses:**				
1	Salaries and Wages	$14,071,000		13,359,480	$27,430,480
2	Fringe Benefits	$5,117,453		3,238,087	$8,355,540
3	Physicians Fees	$2,271,227		3,290,725	$5,561,952
4	Supplies and Drugs	$3,913,060		2,360,289	$6,273,348
5	Depreciation and Amortization	$1,478,850		1,452,043	$2,930,893
6	Bad Debts	$0		-	$0
7	Interest Expense	$1,075,070		1,087,539	$2,162,609
8	Malpractice Insurance Cost	$504,808		272,714	$777,522
9	Other Operating Expenses	$6,309,386		6,502,582	$12,811,969
	Total Operating Expenses	**$34,740,854**		**$31,563,459**	**$66,304,313**
	Income/(Loss) From Operations	**($3,335,596)**		**($714,700)**	**($4,050,296)**
C.	**Non-Operating Revenue:**				
1	Income from Investments	$0		-	$0
2	Gifts, Contributions and Donations	$0		-	$0
3	Other Non-Operating Gains/(Losses)	$661,105		273,337	$934,442
	Total Non-Operating Revenue	**$661,105**		**$273,337**	**$934,442**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**($2,674,491)**		**($441,363)**	**($3,115,854)**
	Other Adjustments:				
	Unrealized Gains/(Losses)	$0			
	All Other Adjustments	$0			
	Total Other Adjustments	**$0**		**$0**	**$0**
	Excess/(Deficiency) of Revenue Over Expenses	**($2,674,491)**		**($441,363)**	**($3,115,854)**

EXHIBIT F

PROSPECT ECHN, INC.

FISCAL YEAR 2017

		30	31	30	31	31	30	212	243	273	304	335	365
		MTD						YTD					
		APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER
	DESCRIPTION	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017
	Total Gross Revenue	$82,691,702	$88,343,824	$83,439,485	$76,823,377	$82,825,517	$81,349,780	$579,747,769	$668,091,593	$751,531,078	$828,354,455	$911,179,972	$992,529,752
	Total Allowances	($56,884,573)	($62,418,710)	($57,386,457)	($52,059,374)	($57,273,245)	($55,678,974)	($399,644,930)	($462,063,640)	($519,450,097)	($571,509,471)	($628,782,716)	($684,461,690)
	Bad Debt	($609,259)	($621,247)	($625,192)	($627,115)	$110,367	($1,450,823)	($4,445,236)	($5,066,483)	($5,691,675)	($6,318,790)	($6,208,423)	($7,659,246)
	Net Patient Revenue	$25,197,870	$25,303,867	$25,427,836	$24,136,888	$25,662,639	$24,219,983	$175,657,603	$200,961,470	$226,389,306	$250,526,194	$276,188,833	$300,408,816
	Other Operating Revenue	1,790,192	1,749,148	2,534,456	2,571,286	2,228,382	2,521,619	$12,583,796	$14,332,944	$16,867,400	$19,438,686	$21,667,068	$24,188,687
	Total Operating Revenue	$26,988,062	$27,053,015	$27,962,292	$26,708,174	$27,891,021	$26,741,602	$188,241,399	$215,294,414	$243,256,706	$269,964,880	$297,855,901	$324,597,503
	Total Operating Expenses	27,089,663	27,705,300	27,511,370	27,697,629	27,727,440	20,423,791	$191,702,251	$219,407,551	$246,918,921	$274,616,550	$302,343,990	$322,767,781
	Income/(Loss) From Operations	($101,601)	($652,285)	$450,922	($989,455)	$163,581	$6,317,811	($3,460,852)	($4,113,137)	($3,662,215)	($4,651,670)	($4,488,089)	$1,829,722
	Total Non-Operating Revenue	491,654	488,324	437,838	452,013	512,535	(1,319,110)	$3,404,791	$3,893,115	$4,330,953	$4,782,966	$5,295,501	$3,976,391
	Excess/(Deficiency) of Revenue Over Expenses	$390,053	($163,961)	$888,760	($537,442)	$676,116	$4,998,701	($56,061)	($220,022)	$668,738	$131,296	$807,412	$5,806,113
A	**Operating Performance**												
1	**Operating Margin**	**-0.37%**	**-2.37%**	**1.59%**	**-3.64%**	**0.58%**	**24.85%**	**-1.81%**	**-1.88%**	**-1.48%**	**-1.69%**	**-1.48%**	**0.56%**
2	**Non-Operating Margin**	**1.79%**	**1.77%**	**1.54%**	**1.66%**	**1.80%**	**-5.19%**	**1.78%**	**1.78%**	**1.75%**	**1.74%**	**1.75%**	**1.21%**
3	**Total Margin**	**1.42%**	**-0.60%**	**3.13%**	**-1.98%**	**2.38%**	**19.66%**	**-0.03%**	**-0.10%**	**0.27%**	**0.05%**	**0.27%**	**1.77%**
4	**Bad Debt as % of Gross Revenue**	**0.74%**	**0.70%**	**0.75%**	**0.82%**	**-0.13%**	**1.78%**	**0.77%**	**0.76%**	**0.76%**	**0.76%**	**0.68%**	**0.77%**
	Income/(Loss) From Operations	($101,601)	($652,285)	$450,922	($989,455)	$163,581	$6,317,811	($3,460,852)	($4,113,137)	($3,662,215)	($4,651,670)	($4,488,089)	$1,829,722
	Total Operating Revenue	$26,988,062	$27,053,015	$27,962,292	$26,708,174	$27,891,021	$26,741,602	$188,241,399	$215,294,414	$243,256,706	$269,964,880	$297,855,901	$324,597,503
	Total Non-Operating Revenue	$491,654	$488,324	$437,838	$452,013	$512,535	($1,319,110)	$3,404,791	$3,893,115	$4,330,953	$4,782,966	$5,295,501	$3,976,391
	Total Revenue	$27,479,716	$27,541,339	$28,400,130	$27,160,187	$28,403,556	$25,422,492	$191,646,190	$219,187,529	$247,587,659	$274,747,846	$303,151,402	$328,573,894
	Excess/(Deficiency) of Revenue Over Expenses	$390,053	($163,961)	$888,760	($537,442)	$676,116	$4,998,701	($56,061)	($220,022)	$668,738	$131,296	$807,412	$5,806,113
	Unrealized gain/(loss) in investments (self-insurance fu	($16,938)	$35,621	$22,301	$28,283	$33,560	$50,419	$8,951,891	$8,987,512	$9,009,813	$9,038,096	$9,071,656	$9,122,076
	Unrestricted Net Assets	$8,895,830	$8,767,490	$9,678,551	$9,169,392	$9,879,069	$14,928,189	$8,895,830	$8,767,490	$9,678,551	$9,169,392	$9,879,069	$14,928,189
	Total Net Assets	$8,895,830	$8,767,490	$9,678,551	$9,169,392	$9,879,069	$14,928,189	$8,895,830	$8,767,490	$9,678,551	$9,169,392	$9,879,069	$14,928,189

EXHIBIT F

PROSPECT ECHN, INC.

FISCAL YEAR 2017

		30	31	30	31	31	30	212	243	273	304	335	365
		MTD						YTD					
	DESCRIPTION	APRIL FY 2017	MAY FY 2017	JUNE FY 2017	JULY FY 2017	AUGUST FY 2017	SEPTEMBER FY 2017	APRIL FY 2017	MAY FY 2017	JUNE FY 2017	JULY FY 2017	AUGUST FY 2017	SEPTEMBER FY 2017
	Total Gross Revenue	$82,691,702	$88,343,824	$83,439,485	$76,823,377	$82,825,517	$81,349,780	$579,747,769	$668,091,593	$751,531,078	$828,354,455	$911,179,972	$992,529,752
	Total Allowances	($56,884,573)	($62,418,710)	($57,386,457)	($52,059,374)	($57,273,245)	($55,678,974)	($399,644,930)	($462,063,640)	($519,450,097)	($571,509,471)	($628,782,716)	($684,461,690)
B.	**Liquidity**												
1	**Current Ratio**	**1.40**	**1.59**	**1.51**	**1.44**	**1.47**	**1.47**	**1.40**	**1.59**	**1.51**	**1.44**	**1.47**	**1.47**
	Total Current Assets	$56,328,390	$60,703,755	$70,504,415	$71,818,936	$69,714,185	$65,267,180	$56,328,390	$60,703,755	$70,504,415	$71,818,936	$69,714,185	$65,267,180
	Total Current Liabilities	$40,275,522	$38,067,856	$46,537,992	$49,827,911	$47,301,237	$44,521,263	$40,275,522	$38,067,856	$46,537,992	$49,827,911	$47,301,237	$44,521,263
2	**Days Cash on Hand**	**9**	**11**	**12**	**15**	**14**	**6**	**9**	**11**	**12**	**15**	**14**	**5**
	Cash and Cash Equivalents	$7,587,205	$9,775,808	$10,647,848	$12,779,817	$12,532,259	$4,194,385	$7,587,205	$9,775,808	$10,647,848	$12,779,817	$12,532,259	$4,194,385
	Short Term Investments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Total Cash and Short Term Investments	$7,587,205	$9,775,808	$10,647,848	$12,779,817	$12,532,259	$4,194,385	$7,587,205	$9,775,808	$10,647,848	$12,779,817	$12,532,259	$4,194,385
	Total Operating Expenses	$27,089,663	$27,705,300	$27,511,370	$27,697,629	$27,727,440	$20,423,791	$191,702,251	$219,407,551	$246,918,921	$274,616,550	$302,343,990	$322,767,781
	Depreciation Expense	$776,073	$888,311	$883,274	$887,385	$890,575	$883,868	$6,474,264	$7,362,575	$8,245,849	$9,133,234	$10,023,809	$10,907,677
	Operating Expenses less Depreciation Expense	$26,313,590	$26,816,989	$26,628,096	$26,810,244	$26,836,865	$19,539,923	$185,227,987	$212,044,976	$238,673,072	$265,483,316	$292,320,181	$311,860,104
3	**Days in Net Acounts Receivables**	**42**	**47**	**41**	**47**	**48**	**48**	**43**	**46**	**42**	**44**	**49**	**47**
	Net Patient Accounts Receivable	$40,969,091	$40,878,585	$37,820,022	$41,140,424	$42,155,215	$40,842,344	$ 40,969,091	$ 40,878,585	$ 37,820,022	$ 41,140,424	$ 42,155,215	$ 40,842,344
	Due From Third Party Payers	$0	$0	$300,000	$0	$0	$0	$ -	$ -	$ 300,000	$ -	$ -	$ -
	Due To Third Party Payers	$5,691,145	$2,606,185	$3,696,877	$4,493,912	$2,045,166	$2,192,261	$ 5,691,145	$ 2,606,185	$ 3,696,877	$ 4,493,912	$ 2,045,166	$ 2,192,261
	Total Net Patient Accounts Receivable and Third Party Payer Activity	$ 35,277,946	$ 38,272,400	$ 34,423,146	$ 36,646,513	$ 40,110,049	$ 38,650,083	$ 35,277,946	$ 38,272,400	$ 34,423,146	$ 36,646,513	$ 40,110,049	$ 38,650,083
	Total Net Patient Revenue	$25,197,870	$25,303,867	$25,427,836	$24,136,888	$25,662,639	$24,219,983	$175,657,603	$200,961,470	$226,389,306	$250,526,194	$276,188,833	$300,408,816
4	**Average Payment Period**	**46**	**44**	**52**	**58**	**55**	**68**	**46**	**44**	**53**	**57**	**54**	**52**
18	Total Current Liabilities	$40,275,522	$38,067,856	$46,537,992	$49,827,911	$47,301,237	$44,521,263	$40,275,522	$38,067,856	$46,537,992	$49,827,911	$47,301,237	$44,521,263
19	Total Operating Expenses	$27,089,663	$27,705,300	$27,511,370	$27,697,629	$27,727,440	$20,423,791	$191,702,251	$219,407,551	$246,918,921	$274,616,550	$302,343,990	$322,767,781
20	Depreciation Expense	$776,073	$888,311	$883,274	$887,385	$890,575	$883,868	$6,474,264	$7,362,575	$8,245,849	$9,133,234	$10,023,809	$10,907,677
20	Total Operating Expenses less Depreciation Expense	$26,313,590	$26,816,989	$26,628,096	$26,810,244	$26,836,865	$19,539,923	$185,227,987	$212,044,976	$238,673,072	$265,483,316	$292,320,181	$311,860,104

EXHIBIT F

PROSPECT ECHN, INC.

FISCAL YEAR 2017

		30	31	30	31	31	30	212	243	273	304	335	365
		MTD						YTD					
	DESCRIPTION	APRIL FY 2017	MAY FY 2017	JUNE FY 2017	JULY FY 2017	AUGUST FY 2017	SEPTEMBER FY 2017	APRIL FY 2017	MAY FY 2017	JUNE FY 2017	JULY FY 2017	AUGUST FY 2017	SEPTEMBER FY 2017
	Total Gross Revenue	$82,691,702	$88,343,824	$83,439,485	$76,823,377	$82,825,517	$81,349,780	$579,747,769	$668,091,593	$751,531,078	$828,354,455	$911,179,972	$992,529,752
	Total Allowances	($56,884,573)	($62,418,710)	($57,386,457)	($52,059,374)	($57,273,245)	($55,678,974)	($399,644,930)	($462,063,640)	($519,450,097)	($571,509,471)	($628,782,716)	($684,461,690)
C.	**Leverage and Capital Structure**												
1	**Long-term Debt to Equity**	**1.1**	**1.1**	**1.0**	**1.0**	**0.9**	**0.6**	**1.1**	**1.1**	**1.0**	**1.0**	**0.9**	**0.6**
2	**Long Term Debt to Capitalization Ratio**	**53.1**	**52.9**	**49.2**	**50.0**	**47.7**	**37.4**	**53.1**	**52.9**	**49.2**	**50.0**	**47.7**	**37.4**
	Total Long Term Debt	$10,088,319	$9,859,330	$9,364,527	$9,179,342	$9,011,701	$8,929,268	$10,088,319	$9,859,330	$9,364,527	$9,179,342	$9,011,701	$8,929,268
	Total Net Assets	$8,895,830	$8,767,490	$9,678,551	$9,169,392	$9,879,069	$14,928,189	$8,895,830	$8,767,490	$9,678,551	$9,169,392	$9,879,069	$14,928,189
	Total Long Term Debt and Total Net Assets	$18,984,149	$18,626,820	$19,043,079	$18,348,735	$18,890,770	$23,857,458	$18,984,149	$18,626,820	$19,043,079	$18,348,735	$18,890,770	$23,857,458
3	**Unrestricted Cash to Total Debt Ratio**	**2.3**	**1.5**	**3.2**	**0.6**	**2.8**	**11.0**	**12.7**	**14.9**	**15.9**	**15.7**	**19.2**	**31.3**
	Excess/(Deficiency) of Revenues Over Expenses	$390,053	($163,961)	$888,760	($537,442)	$676,116	$4,998,701	($56,061)	($220,022)	$668,738	$131,296	$807,412	$5,806,113
	Depreciation Expense	$776,073	$888,311	$883,274	$887,385	$890,575	$883,868	$6,474,264	$7,362,575	$8,245,849	$9,133,234	$10,023,809	$10,907,677
	Excess of Revenues Over Expenses and Depreciation Expense	$1,166,126	$724,350	$1,772,034	$349,943	$1,566,691	$5,882,569	$6,418,203	$7,142,553	$8,914,587	$9,264,530	$10,831,221	$16,713,790
	Total Current Liabilities	$40,275,522	$38,067,856	$46,537,992	$49,827,911	$47,301,237	$44,521,263	$40,275,522	$38,067,856	$46,537,992	$49,827,911	$47,301,237	$44,521,263
	Total Long Term Debt	$10,088,319	$9,859,330	$9,364,527	$9,179,342	$9,011,701	$8,929,268	$10,088,319	$9,859,330	$9,364,527	$9,179,342	$9,011,701	$8,929,268
	Total Current Liabilities and Total Long Term Debt	$50,363,840	$47,927,186	$55,902,519	$59,007,254	$56,312,938	$53,450,531	$50,363,840	$47,927,186	$55,902,519	$59,007,254	$56,312,938	$53,450,531
4	**Times Interest Earned**	**1.9**	**1.3**	**2.7**	**0.9**	**2.3**	**10.2**	**1.5**	**1.5**	**1.6**	**1.6**	**1.6**	**2.4**
5	**Debt Service Coverage Ratio**	**1.91**	**1.37**	**2.33**	**1.11**	**2.19**	**6.61**	**1.60**	**1.57**	**1.66**	**1.61**	**1.66**	**2.05**
	Excess Revenues over Expenses	$390,053	($163,961)	$888,760	($537,442)	$676,116	$4,998,701	($56,061)	($220,022)	$668,738	$131,296	$807,412	$5,806,113
	Interest Expense	$792,670	$780,201	$777,187	$783,649	$783,748	$785,576	$5,522,216	$6,302,417	$7,079,604	$7,863,253	$8,647,001	$9,432,577
	Depreciation and Amortization Expense	$776,073	$888,311	$883,274	$887,385	$890,575	$883,868	$6,474,264	$7,362,575	$8,245,849	$9,133,234	$10,023,809	$10,907,677
	Principal Payments	$233,006	$315,493	$318,361	$237,392	$289,829	$223,349	$1,935,491	$2,250,985	$2,569,346	$2,806,738	$3,096,567	$3,319,916
6	**Equity Financing Ratio**	**6.2**	**6.0**	**6.3**	**5.9**	**6.4**	**9.9**	**14.4**	**20.3**	**25.4**	**30.9**	**37.6**	**48.5**
	Total Net Assets	$8,895,830	$8,767,490	$9,678,551	$9,169,392	$9,879,069	$14,928,189	$20,659,447	$29,426,937	$39,105,488	$48,274,881	$58,153,950	$73,082,139
	Total Assets	$143,387,283	$144,991,947	$154,202,809	$156,382,644	$154,740,289	$150,622,259	$143,387,283	$144,991,947	$154,202,809	$156,382,644	$154,740,289	$150,622,259
D.	**Additional Statistics**												
1	**Income from Operations**	**-$101,601**	**-$652,285**	**$450,922**	**-$989,455**	**$163,581**	**$6,317,811**	**-$3,460,852**	**-$4,113,137**	**-$3,662,215**	**-$4,651,670**	**-$4,488,089**	**$1,829,722**
2	**Revenue Over/(Under) Expense**	**$390,053**	**-$163,961**	**$888,760**	**-$537,442**	**$676,116**	**$4,998,701**	**-$56,061**	**-$220,022**	**$668,738**	**$131,296**	**$807,412**	**$5,806,113**
3	**EBITDA**	**$1,467,142**	**$1,016,227**	**$2,111,383**	**$681,579**	**$1,837,904**	**$7,987,255**	**$8,535,628**	**$9,551,855**	**$11,663,238**	**$12,344,817**	**$14,182,721**	**$22,169,976**
4	**Cash from Operations**	**$25,688,679**	**$25,874,040**	**$27,883,504**	**$22,741,347**	**$24,391,189**	**$24,805,434**	**$165,709,624**	**$191,583,664**	**$219,467,168**	**$242,208,515**	**$266,599,704**	**$291,405,138**
5	**Cash and Cash Equivalents**	**$7,587,205**	**$9,775,808**	**$10,647,848**	**$12,779,817**	**$12,532,259**	**$4,194,385**	**$7,587,205**	**$9,775,808**	**$10,647,848**	**$12,779,817**	**$12,532,259**	**$4,194,385**
6	**Net Working Capital**	**$16,052,868**	**$22,635,898**	**$23,966,424**	**$21,991,024**	**$22,412,948**	**$20,745,917**	**$16,052,868**	**$22,635,898**	**$23,966,424**	**$21,991,024**	**$22,412,948**	**$20,745,917**
7	**Unrestricted Assets**	**$8,895,830**	**$8,767,490**	**$9,678,551**	**$9,169,392**	**$9,879,069**	**$14,928,189**	**$8,895,830**	**$8,767,490**	**$9,678,551**	**$9,169,392**	**$9,879,069**	**$14,928,189**
8	**Credit Ratings (S&P, FITCH, and Moody's)**												

Exhibit F

PROSPECT MANCHESTER HOSPITAL, INC.

FISCAL YEAR 2017

		MTD						YTD					
		APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER
	DESCRIPTION	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017
	Total Gross Revenue	$57,190,419	$62,011,421	$58,249,543	$52,240,481	$57,175,197	$54,903,217	$393,496,956	$455,508,377	$513,757,920	$565,998,401	$623,173,598	$678,076,815
	Total Allowances	($40,954,136)	($45,678,815)	($41,865,212)	($37,385,278)	($41,360,126)	($38,885,518)	($282,100,244)	($327,779,059)	($369,644,271)	($407,029,549)	($448,389,675)	($487,275,193)
	Bad Debt	($366,630)	($395,964)	($370,710)	($384,566)	$331,334	($1,145,213)	($2,634,156)	($3,030,120)	($3,400,830)	($3,785,396)	($3,454,062)	($4,599,275)
	Net Patient Revenue	$15,869,653	$15,936,642	$16,013,621	$14,470,637	$16,146,405	$14,872,486	$108,762,556	$124,699,198	$140,712,819	$155,183,456	$171,329,861	$186,202,347
	Other Operating Revenue	745,670	766,440	808,675	713,984	547,239	830,354	$5,384,786	$6,151,226	$6,959,901	$7,673,885	$8,221,124	$9,051,478
	Total Operating Revenue	$16,615,323	$16,703,082	$16,822,296	$15,184,621	$16,693,644	$15,702,840	$114,147,342	$130,850,424	$147,672,720	$162,857,341	$179,550,985	$195,253,825
	Total Operating Expenses	16,096,345	16,438,914	16,017,749	15,617,281	15,705,227	9,487,981	$110,970,458	$127,409,372	$143,427,121	$159,044,402	$174,749,629	$184,237,610
	Income/(Loss) From Operations	$518,978	$264,168	$804,547	($432,660)	$988,417	$6,214,859	$3,176,884	$3,441,052	$4,245,599	$3,812,939	$4,801,356	$11,016,215
	Total Non-Operating Revenue	378,027	370,736	345,041	334,323	387,641	(1,024,856)	$2,630,059	$3,000,795	$3,345,836	$3,680,159	$4,067,800	$3,042,944
	Excess/(Deficiency) of Revenue Over Expenses	$897,005	$634,904	$1,149,588	($98,337)	$1,376,058	$5,190,003	$5,806,943	$6,441,847	$7,591,435	$7,493,098	$8,869,156	$14,059,159
A	**Operating Performance**												
1	**Operating Margin**	**3.05%**	**1.55%**	**4.69%**	**-2.79%**	**5.79%**	**42.34%**	**2.72%**	**2.57%**	**2.81%**	**2.29%**	**2.61%**	**5.56%**
2	**Non-Operating Margin**	**2.22%**	**2.17%**	**2.01%**	**2.15%**	**2.27%**	**-6.98%**	**2.25%**	**2.24%**	**2.22%**	**2.21%**	**2.22%**	**1.53%**
3	**Total Margin**	**5.28%**	**3.72%**	**6.70%**	**-0.63%**	**8.06%**	**35.36%**	**4.97%**	**4.81%**	**5.03%**	**4.50%**	**4.83%**	**7.09%**
4	**Bad Debt as % of Gross Revenue**	**0.64%**	**0.64%**	**0.64%**	**0.74%**	**-0.58%**	**2.09%**	**0.67%**	**0.67%**	**0.66%**	**0.67%**	**0.55%**	**0.68%**
	Income/(Loss) From Operations	$518,978	$264,168	$804,547	($432,660)	$988,417	$6,214,859	$3,176,884	$3,441,052	$4,245,599	$3,812,939	$4,801,356	$11,016,215
	Total Operating Revenue	$16,615,323	$16,703,082	$16,822,296	$15,184,621	$16,693,644	$15,702,840	$114,147,342	$130,850,424	$147,672,720	$162,857,341	$179,550,985	$195,253,825
	Total Non-Operating Revenue	$378,027	$370,736	$345,041	$334,323	$387,641	($1,024,856)	$2,630,059	$3,000,795	$3,345,836	$3,680,159	$4,067,800	$3,042,944
	Total Revenue	$16,993,350	$17,073,818	$17,167,337	$15,518,944	$17,081,285	$14,677,984	$116,777,401	$133,851,219	$151,018,556	$166,537,500	$183,618,785	$198,296,769
	Excess/(Deficiency) of Revenue Over Expenses	$897,005	$634,904	$1,149,588	($98,337)	$1,376,058	$5,190,003	$5,806,943	$6,441,847	$7,591,435	$7,493,098	$8,869,156	$14,059,159
	Unrealized gain/(loss) in investments (self-insurance fu	$18,683	$0	$22,301	$0	$33,560	$20,203	$57,176	$57,176	$79,477	$79,477	$113,038	$133,241
	Unrestricted Net Assets	$5,864,119	$6,499,023	$7,670,912	$7,572,575	$8,982,194	$14,192,400	$5,864,119	$6,499,023	$7,670,912	$7,572,575	$8,982,194	$14,192,400
	Total Net Assets	$5,864,119	$6,499,023	$7,670,912	$7,572,575	$8,982,194	$14,192,400	$5,864,119	$6,499,023	$7,670,912	$7,572,575	$8,982,194	$14,192,400

Exhibit F

PROSPECT MANCHESTER HOSPITAL, INC.

FISCAL YEAR 2017

		MTD						YTD					
		APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER
	DESCRIPTION	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017
B.	**Liquidity**												
1	**Current Ratio**	**1.96**	**2.03**	**2.15**	**2.11**	**2.24**	**1.93**	**1.96**	**2.03**	**2.15**	**2.11**	**2.24**	**1.93**
	Total Current Assets	$48,008,847	$49,489,861	$49,864,591	$50,732,656	$51,123,418	$59,477,631	$48,008,847	$49,489,861	$49,864,591	$50,732,656	$51,123,418	$59,477,631
	Total Current Liabilities	$24,478,757	$24,388,664	$23,153,525	$24,059,719	$22,853,391	$30,740,111	$24,478,757	$24,388,664	$23,153,525	$24,059,719	$22,853,391	$30,740,111
2	**Days Cash on Hand**	**15**	**1**	**2**	**6**	**3**	**1**	**15**	**1**	**2**	**6**	**3**	**0**
	Cash and Cash Equivalents	$7,587,205	$550,675	$774,588	$2,859,986	$1,463,164	$187,195	$7,587,205	$550,675	$774,588	$2,859,986	$1,463,164	$187,195
	Short Term Investments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Total Cash and Short Term Investments	$7,587,205	$550,675	$774,588	$2,859,986	$1,463,164	$187,195	$7,587,205	$550,675	$774,588	$2,859,986	$1,463,164	$187,195
	Total Operating Expenses	$16,096,345	$16,438,914	$16,017,749	$15,617,281	$15,705,227	$9,487,981	$110,970,458	$127,409,372	$143,427,121	$159,044,402	$174,749,629	$184,237,610
	Depreciation Expense	$546,096	$555,303	$553,598	$553,085	$572,219	$584,357	$4,082,763	$4,638,066	$5,191,664	$5,744,749	$6,316,968	$6,901,325
	Operating Expenses less Depreciation Expense	$15,550,249	$15,883,611	$15,464,151	$15,064,196	$15,133,008	$8,903,624	$106,887,695	$122,771,306	$138,235,457	$153,299,653	$168,432,661	$177,336,285
3	**Days in Net Acounts Receivables**	**43**	**48**	**42**	**50**	**50**	**50**	**44**	**49**	**44**	**46**	**50**	**48**
	Net Patient Accounts Receivable	$25,969,460	$26,085,719	$24,651,032	$25,717,306	$26,523,669	$25,353,520	$25,969,460	$26,085,719	$24,651,032	$25,717,306	$26,523,669	$25,353,520
	Due From Third Party Payers	$0	$0	$300,000	$0	$0	$0	$0	$0	$300,000	$0	$0	$0
	Due To Third Party Payers	$3,449,589	$1,160,093	$2,423,677	$2,378,427	$725,111	$788,545	$3,449,589	$1,160,093	$2,423,677	$2,378,427	$725,111	$788,545
	Total Net Patient Accounts Receivable and Third Party Payer Activity	$ 22,519,871	$ 24,925,627	$ 22,527,356	$ 23,338,878	$ 25,798,558	$ 24,564,975	$ 22,519,871	$ 24,925,627	$ 22,527,356	$ 23,338,878	$ 25,798,558	$ 24,564,975
	Total Net Patient Revenue	$15,869,653	$15,936,642	$16,013,621	$14,470,637	$16,146,405	$14,872,486	$108,762,556	$124,699,198	$140,712,819	$155,183,456	$171,329,861	$186,202,347
4	**Average Payment Period**	**49**	**48**	**46**	**50**	**47**	**107**	**7**	**6**	**5**	**5**	**4**	**5**
18	Total Current Liabilities	$24,478,757	$24,388,664	$23,153,525	$24,059,719	$22,853,391	$30,740,111	$24,478,757	$24,388,664	$23,153,525	$24,059,719	$22,853,391	$30,740,111
19	Total Operating Expenses	$16,096,345	$16,438,914	$16,017,749	$15,617,281	$15,705,227	$9,487,981	$110,970,458	$127,409,372	$143,427,121	$159,044,402	$174,749,629	$184,237,610
20	Depreciation Expense	$546,096	$555,303	$553,598	$553,085	$572,219	$584,357	$4,082,763	$4,638,066	$5,191,664	$5,744,749	$6,316,968	$6,901,325
20	Total Operating Expenses less Depreciation Expense	$15,550,249	$15,883,611	$15,464,151	$15,064,196	$15,133,008	$8,903,624	$106,887,695	$122,771,306	$138,235,457	$153,299,653	$168,432,661	$177,336,285

Exhibit F

PROSPECT MANCHESTER HOSPITAL, INC.

FISCAL YEAR 2017

	DESCRIPTION	MTD APRIL FY 2017	MTD MAY FY 2017	MTD JUNE FY 2017	MTD JULY FY 2017	MTD AUGUST FY 2017	MTD SEPTEMBER FY 2017	YTD APRIL FY 2017	YTD MAY FY 2017	YTD JUNE FY 2017	YTD JULY FY 2017	YTD AUGUST FY 2017	YTD SEPTEMBER FY 2017
C.	**Leverage and Capital Structure**												
1	**Long-term Debt to Equity**	**0.8**	**0.7**	**0.6**	**0.6**	**0.4**	**0.3**	**0.8**	**0.7**	**0.6**	**0.6**	**0.4**	**0.3**
2	**Long Term Debt to Capitalization Ratio**	**45.9**	**42.3**	**36.2**	**35.7**	**30.8**	**21.8**	**45.9**	**42.3**	**36.2**	**35.7**	**30.8**	**21.8**
	Total Long Term Debt	$4,966,683	$4,764,776	$4,351,659	$4,204,097	$4,003,180	$3,954,712	$4,966,683	$4,764,776	$4,351,659	$4,204,097	$4,003,180	$3,954,712
	Total Net Assets	$5,864,119	$6,499,023	$7,670,912	$7,572,575	$8,982,194	$14,192,400	$5,864,119	$6,499,023	$7,670,912	$7,572,575	$8,982,194	$14,192,400
	Total Long Term Debt and Total Net Assets	$10,830,802	$11,263,799	$12,022,571	$11,776,673	$12,985,374	$18,147,112	$10,830,802	$11,263,799	$12,022,571	$11,776,673	$12,985,374	$18,147,112
3	**Unrestricted Cash to Total Debt Ratio**	**4.9**	**4.1**	**6.2**	**1.6**	**7.3**	**16.6**	**33.6**	**38.0**	**46.5**	**46.8**	**56.5**	**60.4**
	Excess/(Deficiency) of Revenues Over Expenses	$897,005	$634,904	$1,149,588	($98,337)	$1,376,058	$5,190,003	$5,806,943	$6,441,847	$7,591,435	$7,493,098	$8,869,156	$14,059,159
	Depreciation Expense	$546,096	$555,303	$553,598	$553,085	$572,219	$584,357	$4,082,763	$4,638,066	$5,191,664	$5,744,749	$6,316,968	$6,901,325
	Excess of Revenues Over Expenses and Depreciation Expense	$1,443,101	$1,190,207	$1,703,186	$454,748	$1,948,277	$5,774,360	$9,889,706	$11,079,913	$12,783,099	$13,237,847	$15,186,124	$20,960,484
	Total Current Liabilities	$24,478,757	$24,388,664	$23,153,525	$24,059,719	$22,853,391	$30,740,111	$24,478,757	$24,388,664	$23,153,525	$24,059,719	$22,853,391	$30,740,111
	Total Long Term Debt	$4,966,683	$4,764,776	$4,351,659	$4,204,097	$4,003,180	$3,954,712	$4,966,683	$4,764,776	$4,351,659	$4,204,097	$4,003,180	$3,954,712
	Total Current Liabilities and Total Long Term Debt	$29,445,441	$29,153,440	$27,505,184	$28,263,817	$26,856,571	$34,694,823	$29,445,441	$29,153,440	$27,505,184	$28,263,817	$26,856,571	$34,694,823
4	**Times Interest Earned**	**2.8**	**2.4**	**3.3**	**1.2**	**3.6**	**12.3**	**2.7**	**2.7**	**2.7**	**2.6**	**2.7**	**3.5**
5	**Debt Service Coverage Ratio**	**2.63**	**2.13**	**2.72**	**1.32**	**3.00**	**8.22**	**2.50**	**2.45**	**2.48**	**2.37**	**2.43**	**2.89**
	Excess Revenues over Expenses	$897,005	$634,904	$1,149,588	($98,337)	$1,376,058	$5,190,003	$5,806,943	$6,441,847	$7,591,435	$7,493,098	$8,869,156	$14,059,159
	Interest Expense	$607,372	$602,553	$590,261	$599,511	$599,331	$599,863	$4,241,900	$4,844,453	$5,434,714	$6,034,225	$6,633,556	$7,233,419
	Depreciation and Amortization Expense	$546,096	$555,303	$553,598	$553,085	$572,219	$584,357	$4,082,763	$4,638,066	$5,191,664	$5,744,749	$6,316,968	$6,901,325
	Principal Payments	$173,192	$238,695	$252,309	$196,199	$249,995	$175,524	$1,417,283	$1,655,978	$1,908,286	$2,104,485	$2,354,480	$2,530,004
6	**Equity Financing Ratio**	**5.8**	**6.3**	**7.5**	**7.3**	**8.7**	**12.6**	**5.8**	**6.3**	**7.5**	**7.3**	**8.7**	**12.6**
	Total Net Assets	$5,864,119	$6,499,023	$7,670,912	$7,572,575	$8,982,194	$14,192,400	$5,864,119	$6,499,023	$7,670,912	$7,572,575	$8,982,194	$14,192,400
	Total Assets	$101,817,940	$103,109,815	$102,909,184	$103,332,665	$103,591,068	$112,359,211	$101,817,940	$103,109,815	$102,909,184	$103,332,665	$103,591,068	$112,359,211
D.	**Additional Statistics**												
1	**Income from Operations**	**$518,978**	**$264,168**	**$804,547**	**-$432,660**	**$988,417**	**$6,214,859**	**$3,176,884**	**$3,441,052**	**$4,245,599**	**$3,812,939**	**$4,801,356**	**$11,016,215**
2	**Revenue Over/(Under) Expense**	**$897,005**	**$634,904**	**$1,149,588**	**-$98,337**	**$1,376,058**	**$5,190,003**	**$5,806,943**	**$6,441,847**	**$7,591,435**	**$7,493,098**	**$8,869,156**	**$14,059,159**
3	**EBITDA**	**$1,672,446**	**$1,422,024**	**$1,948,406**	**$719,936**	**$2,159,967**	**$7,399,079**	**$11,501,547**	**$12,923,571**	**$14,871,977**	**$15,591,913**	**$17,751,880**	**$25,150,959**
4	**Cash from Operations**	**$15,454,486**	**$16,195,163**	**$17,253,860**	**$14,428,071**	**$15,247,673**	**$14,882,399**	**$100,288,965**	**$116,484,128**	**$133,737,988**	**$148,166,059**	**$163,413,732**	**$178,296,131**
5	**Cash and Cash Equivalents**	**$7,587,205**	**$550,675**	**$774,588**	**$2,859,986**	**$1,463,164**	**$187,195**	**$7,587,205**	**$550,675**	**$774,588**	**$2,859,986**	**$1,463,164**	**$187,195**
6	**Net Working Capital**	**$23,530,090**	**$25,101,197**	**$26,711,066**	**$26,672,937**	**$28,270,027**	**$28,737,520**	**$23,530,090**	**$25,101,197**	**$26,711,066**	**$26,672,937**	**$28,270,027**	**$28,737,520**
7	**Unrestricted Assets**	**$5,864,119**	**$6,499,023**	**$7,670,912**	**$7,572,575**	**$8,982,194**	**$14,192,400**	**$5,864,119**	**$6,499,023**	**$7,670,912**	**$7,572,575**	**$8,982,194**	**$14,192,400**
8	**Credit Ratings (S&P, FITCH, and Moody's)**												

Exhibit F

PROSPECT ROCKVILLE HOSPITAL, INC.

FISCAL YEAR 2017

		MTD						YTD					
		APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER
	DESCRIPTION	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017
	Total Gross Revenue	$18,412,122	$19,283,549	$18,192,153	$17,776,249	$18,737,703	$18,883,700	$135,924,439	$155,207,988	$173,400,141	$191,176,390	$209,914,093	$228,797,793
	Total Allowances	($13,324,074)	($14,212,013)	($12,970,581)	($12,320,032)	($13,538,658)	($13,869,828)	($98,952,244)	($113,164,257)	($126,134,838)	($138,454,870)	($151,993,528)	($165,863,356)
	Bad Debt	($181,373)	($154,116)	($154,815)	($140,382)	($128,800)	($119,266)	($1,385,915)	($1,540,031)	($1,694,846)	($1,835,228)	($1,964,028)	($2,083,294)
	Net Patient Revenue	$4,906,675	$4,917,420	$5,066,757	$5,315,835	$5,070,245	$4,894,606	$35,586,280	$40,503,700	$45,570,457	$50,886,292	$55,956,537	$60,851,143
	Other Operating Revenue	126,677	116,504	102,205	151,945	45,589	134,301	$852,334	$968,838	$1,071,043	$1,222,988	$1,268,577	$1,402,878
	Total Operating Revenue	$5,033,352	$5,033,924	$5,168,962	$5,467,780	$5,115,834	$5,028,907	$36,438,614	$41,472,538	$46,641,500	$52,109,280	$57,225,114	$62,254,021
	Total Operating Expenses	5,344,727	5,519,967	5,325,730	5,641,034	5,389,931	4,342,076	$40,085,586	$45,605,553	$50,931,283	$56,572,317	$61,962,248	$66,304,324
	Income/(Loss) From Operations	($311,375)	($486,043)	($156,768)	($173,254)	($274,097)	$686,831	($3,646,972)	($4,133,015)	($4,289,783)	($4,463,037)	($4,737,134)	($4,050,303)
	Total Non-Operating Revenue	113,627	117,588	93,371	118,113	124,907	(294,267)	$774,732	$892,320	$985,691	$1,103,804	$1,228,711	$934,444
	Excess/(Deficiency) of Revenue Over Expenses	($197,748)	($368,455)	($63,397)	($55,141)	($149,190)	$392,564	($2,872,240)	($3,240,695)	($3,304,092)	($3,359,233)	($3,508,423)	($3,115,859)
A	**Operating Performance**												
1	**Operating Margin**	**-6.05%**	**-9.43%**	**-2.98%**	**-3.10%**	**-5.23%**	**14.51%**	**-9.80%**	**-9.76%**	**-9.01%**	**-8.39%**	**-8.10%**	**-6.41%**
2	**Non-Operating Margin**	**2.21%**	**2.28%**	**1.77%**	**2.11%**	**2.38%**	**-6.22%**	**2.08%**	**2.11%**	**2.07%**	**2.07%**	**2.10%**	**1.48%**
3	**Total Margin**	**-3.84%**	**-7.15%**	**-1.20%**	**-0.99%**	**-2.85%**	**8.29%**	**-7.72%**	**-7.65%**	**-6.94%**	**-6.31%**	**-6.00%**	**-4.93%**
4	**Bad Debt as % of Gross Revenue**	**0.99%**	**0.80%**	**0.85%**	**0.79%**	**0.69%**	**0.63%**	**1.02%**	**0.99%**	**0.98%**	**0.96%**	**0.94%**	**0.91%**
	Income/(Loss) From Operations	($311,375)	($486,043)	($156,768)	($173,254)	($274,097)	$686,831	($3,646,972)	($4,133,015)	($4,289,783)	($4,463,037)	($4,737,134)	($4,050,303)
	Total Operating Revenue	$5,033,352	$5,033,924	$5,168,962	$5,467,780	$5,115,834	$5,028,907	$36,438,614	$41,472,538	$46,641,500	$52,109,280	$57,225,114	$62,254,021
	Total Non-Operating Revenue	$113,627	$117,588	$93,371	$118,113	$124,907	($294,267)	$774,732	$892,320	$985,691	$1,103,804	$1,228,711	$934,444
	Total Revenue	$5,146,979	$5,151,512	$5,262,333	$5,585,893	$5,240,741	$4,734,640	$37,213,346	$42,364,858	$47,627,191	$53,213,084	$58,453,825	$63,188,465
	Excess/(Deficiency) of Revenue Over Expenses	($197,748)	($368,455)	($63,397)	($55,141)	($149,190)	$392,564	($2,872,240)	($3,240,695)	($3,304,092)	($3,359,233)	($3,508,423)	($3,115,859)
	Unrestricted Net Assets	($2,872,240)	($3,240,695)	($3,304,092)	($3,359,233)	($3,508,423)	($3,115,859)	($2,872,240)	($3,240,695)	($3,304,092)	($3,359,233)	($3,508,423)	($3,115,859)
	Total Net Assets	($2,872,240)	($3,240,695)	($3,304,092)	($3,359,233)	($3,508,423)	($3,115,859)	($2,872,240)	($3,240,695)	($3,304,092)	($3,359,233)	($3,508,423)	($3,115,859)

Exhibit F

PROSPECT ROCKVILLE HOSPITAL, INC.

FISCAL YEAR 2017

		MTD						YTD					
		APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER
	DESCRIPTION	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017
	Total Gross Revenue	$18,412,122	$19,283,549	$18,192,153	$17,776,249	$18,737,703	$18,883,700	$135,924,439	$155,207,988	$173,400,141	$191,176,390	$209,914,093	$228,797,793
	Total Allowances	($13,324,074)	($14,212,013)	($12,970,581)	($12,320,032)	($13,538,658)	($13,869,828)	($98,952,244)	($113,164,257)	($126,134,838)	($138,454,870)	($151,993,528)	($165,863,356)
B.	**Liquidity**												
1	**Current Ratio**	**1.63**	**1.64**	**1.68**	**1.59**	**1.57**	**1.27**	**1.63**	**1.64**	**1.68**	**1.59**	**1.57**	**1.27**
	Total Current Assets	$11,619,188	$11,353,838	$11,279,435	$11,589,385	$10,987,353	$11,486,396	$11,619,188	$11,353,838	$11,279,435	$11,589,385	$10,987,353	$11,486,396
	Total Current Liabilities	$7,146,594	$6,922,098	$6,700,460	$7,295,133	$6,986,532	$9,021,517	$7,146,594	$6,922,098	$6,700,460	$7,295,133	$6,986,532	$9,021,517
2	**Days Cash on Hand**	**(0)**	**1**	**1**	**7**	**2**	**0**	**(7)**	**(6)**	**(5)**	**2**	**4**	**4**
	Cash and Cash Equivalents	($80,010)	$154,797	$161,436	$1,262,686	$264,212	$1,037	($80,010)	$154,797	$161,436	$1,262,686	$264,212	$1,037
	Short Term Investments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Total Cash and Short Term Investments	($80,010)	$154,797	$161,436	$1,262,686	$264,212	$1,037	($1,219,752)	($1,064,955)	($903,519)	$359,167	$623,378	$624,415
	Total Operating Expenses	$5,344,727	$5,519,967	$5,325,730	$5,641,034	$5,389,931	$4,342,076	$40,085,586	$45,605,553	$50,931,283	$56,572,317	$61,962,248	$66,304,324
	Depreciation Expense	$235,173	$236,738	$234,266	$239,210	$239,431	$267,226	$1,714,023	$1,950,761	$2,185,027	$2,424,237	$2,663,668	$2,930,894
	Operating Expenses less Depreciation Expense	$5,109,554	$5,283,229	$5,091,464	$5,401,824	$5,150,500	$4,074,850	$38,371,563	$43,654,792	$48,746,256	$54,148,080	$59,298,580	$63,373,430
3	**Days in Net Acounts Receivables**	**35**	**40**	**34**	**36**	**45**	**42**	**340**	**381**	**415**	**450**	**495**	**537**
	Net Patient Accounts Receivable	$7,219,864	$7,161,273	$6,826,652	$7,476,334	$7,943,900	$7,440,504	$63,335,019	$70,496,293	$77,322,944	$84,799,278	$92,743,178	$100,183,682
	Due From Third Party Payers	$ -	$ -	$ -	$ -	$ -	$ -	$0	$0	$0	$0	$0	$0
	Due To Third Party Payers	$1,539,548	$748,252	$1,042,444	$1,370,929	$576,026	$639,008	$6,297,082	$7,045,334	$8,087,779	$9,458,708	$10,034,733	$10,673,741
	Total Net Patient Accounts Receivable and Third Party Payer Activity	$ 5,680,317	$ 6,413,022	$ 5,784,207	$ 6,105,405	$ 7,367,874	$ 6,801,496	$57,037,937	$63,450,958	$69,235,166	$75,340,571	$82,708,445	$89,509,941
	Total Net Patient Revenue	$4,906,675	$4,917,420	$5,066,757	$5,315,835	$5,070,245	$4,894,606	$35,586,280	$40,503,700	$45,570,457	$50,886,292	$55,956,537	$60,851,143
4	**Average Payment Period**	**42**	**41**	**39**	**42**	**42**	**66**	**39**	**39**	**38**	**41**	**39**	**52**
18	Total Current Liabilities	$7,146,594	$6,922,098	$6,700,460	$7,295,133	$6,986,532	$9,021,517	$7,146,594	$6,922,098	$6,700,460	$7,295,133	$6,986,532	$9,021,517
19	Total Operating Expenses	$5,344,727	$5,519,967	$5,325,730	$5,641,034	$5,389,931	$4,342,076	$40,085,586	$45,605,553	$50,931,283	$56,572,317	$61,962,248	$66,304,324
20	Depreciation Expense	$235,173	$236,738	$234,266	$239,210	$239,431	$267,226	$1,714,023	$1,950,761	$2,185,027	$2,424,237	$2,663,668	$2,930,894
20	Total Operating Expenses less Depreciation Expense	$5,109,554	$5,283,229	$5,091,464	$5,401,824	$5,150,500	$4,074,850	$38,371,563	$43,654,792	$48,746,256	$54,148,080	$59,298,580	$63,373,430

Exhibit F

PROSPECT ROCKVILLE HOSPITAL, INC.

FISCAL YEAR 2017

		MTD						YTD					
		APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER
	DESCRIPTION	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017
	Total Gross Revenue	$18,412,122	$19,283,549	$18,192,153	$17,776,249	$18,737,703	$18,883,700	$135,924,439	$155,207,988	$173,400,141	$191,176,390	$209,914,093	$228,797,793
	Total Allowances	($13,324,074)	($14,212,013)	($12,970,581)	($12,320,032)	($13,538,658)	($13,869,828)	($98,952,244)	($113,164,257)	($126,134,838)	($138,454,870)	($151,993,528)	($165,863,356)
C.	**Leverage and Capital Structure**												
1	**Long-term Debt to Equity**	**(0.2)**	**(0.2)**	**(0.1)**	**(0.1)**	**(0.1)**	**(0.1)**	**(0.2)**	**(0.2)**	**(0.1)**	**(0.1)**	**(0.1)**	**(0.1)**
2	**Long Term Debt to Capitalization Ratio**	**(22.4)**	**(18.8)**	**(16.9)**	**(16.2)**	**(14.9)**	**(16.7)**	**(22.4)**	**(18.8)**	**(16.9)**	**(16.2)**	**(14.9)**	**(16.7)**
	Total Long Term Debt	$524,837	$513,744	$478,241	$467,411	$456,288	$445,778	$524,837	$513,744	$478,241	$467,411	$456,288	$445,778
	Total Net Assets	($2,872,240)	($3,240,695)	($3,304,092)	($3,359,233)	($3,508,423)	($3,115,859)	($2,872,240)	($3,240,695)	($3,304,092)	($3,359,233)	($3,508,423)	($3,115,859)
	Total Long Term Debt and Total Net Assets	($2,347,403)	($2,726,951)	($2,825,851)	($2,891,821)	($3,052,135)	($2,670,081)	($2,347,403)	($2,726,951)	($2,825,851)	($2,891,821)	($3,052,135)	($2,670,081)
3	**Unrestricted Cash to Total Debt Ratio**	**0.5**	**(1.8)**	**2.4**	**2.4**	**1.2**	**7.0**	**(15.1)**	**(17.3)**	**(15.6)**	**(12.0)**	**(11.3)**	**(2.0)**
	Excess/(Deficiency) of Revenues Over Expenses	($197,748)	($368,455)	($63,397)	($55,141)	($149,190)	$392,564	($2,872,240)	($3,240,695)	($3,304,092)	($3,359,233)	($3,508,423)	($3,115,859)
	Depreciation Expense	$235,173	$236,738	$234,266	$239,210	$239,431	$267,226	$1,714,023	$1,950,761	$2,185,027	$2,424,237	$2,663,668	$2,930,894
	Excess of Revenues Over Expenses and Depreciation Expense	$37,425	($131,717)	$170,869	$184,069	$90,241	$659,790	($1,158,217)	($1,289,934)	($1,119,065)	($934,996)	($844,755)	($184,965)
	Total Current Liabilities	$7,146,594	$6,922,098	$6,700,460	$7,295,133	$6,986,532	$9,021,517	$7,146,594	$6,922,098	$6,700,460	$7,295,133	$6,986,532	$9,021,517
	Total Long Term Debt	$524,837	$513,744	$478,241	$467,411	$456,288	$445,778	$524,837	$513,744	$478,241	$467,411	$456,288	$445,778
	Total Current Liabilities and Total Long Term Debt	$7,671,431	$7,435,842	$7,178,700	$7,762,544	$7,442,820	$9,467,295	$7,671,431	$7,435,842	$7,178,700	$7,762,544	$7,442,820	$9,467,295
4	**Times Interest Earned**	**0.6**	**(0.4)**	**1.4**	**1.4**	**0.8**	**6.2**	**(0.5)**	**(0.5)**	**(0.3)**	**(0.1)**	**(0.0)**	**0.5**
5	**Debt Service Coverage Ratio**	**1.14**	**0.24**	**1.71**	**1.90**	**1.41**	**4.21**	**0.07**	**0.09**	**0.28**	**0.43**	**0.52**	**0.83**
	Excess Revenues over Expenses	($197,748)	($368,455)	($63,397)	($55,141)	($149,190)	$392,564	($2,872,240)	($3,240,695)	($3,304,092)	($3,359,233)	($3,508,423)	($3,115,859)
	Interest Expense	$179,836	$178,095	$183,771	$180,638	$182,856	$182,343	$1,254,906	$1,433,001	$1,616,772	$1,797,410	$1,980,266	$2,162,609
	Depreciation and Amortization Expense	$235,173	$236,738	$234,266	$239,210	$239,431	$267,226	$1,714,023	$1,950,761	$2,185,027	$2,424,237	$2,663,668	$2,930,894
	Principal Payments	$10,676	$18,740	$23,021	$10,829	$11,124	$17,686	$138,172	$156,912	$179,933	$190,762	$201,886	$219,572
6	**Equity Financing Ratio**	**(11.5)**	**(13.2)**	**(13.6)**	**(13.6)**	**(14.5)**	**(12.6)**	**(11.5)**	**(13.2)**	**(13.6)**	**(13.6)**	**(14.5)**	**(12.6)**
	Total Net Assets	($2,872,240)	($3,240,695)	($3,304,092)	($3,359,233)	($3,508,423)	($3,115,859)	($2,872,240)	($3,240,695)	($3,304,092)	($3,359,233)	($3,508,423)	($3,115,859)
	Total Assets	$24,871,148	$24,523,819	$24,242,243	$24,630,841	$24,236,389	$24,682,109	$24,871,148	$24,523,819	$24,242,243	$24,630,841	$24,236,389	$24,682,109
D.	**Additional Statistics**												
1	**Income from Operations**	**-$311,375**	**-$486,043**	**-$156,768**	**-$173,254**	**-$274,097**	**$686,831**	**-$3,646,972**	**-$4,133,015**	**-$4,289,783**	**-$4,463,037**	**-$4,737,134**	**-$4,050,303**
2	**Revenue Over/(Under) Expense**	**-$197,748**	**-$368,455**	**-$63,397**	**-$55,141**	**-$149,190**	**$392,564**	**-$2,872,240**	**-$3,240,695**	**-$3,304,092**	**-$3,359,233**	**-$3,508,423**	**-$3,115,859**
3	**EBITDA**	**$103,634**	**-$71,210**	**$261,269**	**$246,594**	**$148,190**	**$1,136,400**	**-$678,043**	**-$749,253**	**-$487,984**	**-$241,390**	**-$93,200**	**$1,043,200**
4	**Cash from Operations**	**$5,957,007**	**$5,208,157**	**$5,560,291**	**$4,928,006**	**$4,883,110**	**$5,239,344**	**$5,957,007**	**$5,208,157**	**$5,560,291**	**$4,928,006**	**$4,883,110**	**$5,239,344**
5	**Cash and Cash Equivalents**	**-$80,010**	**$154,797**	**$161,436**	**$1,262,686**	**$264,212**	**$1,037**	**-$80,010**	**$154,797**	**$161,436**	**$1,262,686**	**$264,212**	**$1,037**
6	**Net Working Capital**	**$4,472,594**	**$4,431,740**	**$4,578,975**	**$4,294,252**	**$4,000,821**	**$2,464,879**	**$4,472,594**	**$4,431,740**	**$4,578,975**	**$4,294,252**	**$4,000,821**	**$2,464,879**
7	**Unrestricted Assets**	**-$2,872,240**	**-$3,240,695**	**-$3,304,092**	**-$3,359,233**	**-$3,508,423**	**-$3,115,859**	**-$2,872,240**	**-$3,240,695**	**-$3,304,092**	**-$3,359,233**	**-$3,508,423**	**-$3,115,859**
8	**Credit Ratings (S&P, FITCH, and Moody's)**												

User, OHCA

From: Mcconville, Dennis P <dmcconville@echn.org>
Sent: Wednesday, December 27, 2017 5:35 PM
To: Cotto, Carmen
Cc: Roberts, Karen; User, OHCA; 'colleen713.smith@gmail.com'
Subject: RE: 15-32016-486-CON
Attachments: Exhibit A - Capital Investment Report.xlsx; Exhibit B - Approved Capital Expenditures FY2017.xlsx; Exhibit C - MMH RGH REPORT 175 Oct 16-Mar 17 vs Apr 17 - Sep 17.xlsx; Exhibit E - 9.b. HRS Reports 300 350 100 150 FY2017.xlsx; Exhibit F - 10. CON - Financial Stats Apr17-Sep17.xls

Carmen,

Please find the Excel spreadsheets as requested. As a point of clarification, the financial statements are unaudited.

Dennis

From: Cotto, Carmen [mailto:Carmen.Cotto@ct.gov]
Sent: Wednesday, December 27, 2017 3:30 PM
To: Mcconville, Dennis P
Cc: Roberts, Karen; User, OHCA; 'colleen713.smith@gmail.com'
Subject: FW: 15-32016-486-CON

CAUTION: This email originated outside of ECHN. Do not click links or open attachments unless you recognize the sender and know the content is safe.

Good afternoon Dennis,

In reference to the attached documents, please also provide us with the same documents in Excel format, as applicable. In particular, those related to capital commitment investment, cost savings and quarterly financial measures.
As you might already know, Excel format makes it easier to filter and analyzed data. It will be very helpful to us to receive them in this format.

Thank you in advance for your assistance.
Carmen

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov

www.ct.gov/dph

From: Mcconville, Dennis P [mailto:dmcconville@echn.org]
Sent: Friday, December 15, 2017 10:19 AM
To: User, OHCA
Cc: Martone, Kim; Roberts, Karen; Colleen Smith; Ellen J. Shin (ellen.shin@prospectmedical.com); Tichy, Joyce A (Legal Department); Collins, Michael; Garrison DeLee (garrison.delee@prospectmedical.com); Frank.Saidara; Von.Crockett; Basile, Mary C; Veillette, Michael
Subject: 15-32016-486-CON

The attached letter is submitted as required for condition number eight (8), condition number nine (9) and condition number ten (10) contained in the Final Decision for Docket Number: 15-32016-486-CON, the Transfer of Assets of Eastern Connecticut Health Network, Inc. to Prospect Medical Holdings, Inc.

Dennis P. McConville
Senior Vice President
Eastern Connecticut Health Network, Inc.
(860) 533-3429 (office)
(860) 268-4591 (cell)
dmcconville@echn.org

"This message originates from Eastern Connecticut Health Network. The information contained in this message may be privileged and confidential. If you are the intended recipient, you must maintain this message in a secure and confidential manner. If you are not the intended recipient, please notify the sender immediately and destroy this message. Thank you."

Exhibit A

Capital Investment Report
Paid Capital
FY 2017

Vendor	Entity	Item	Purpose	PO #	FundingType	October	November	December	January	February	March	Total	April	May	June	July	August	Sept	Total
						**********						PAYMENT AMOUNT	**********						
MOREDIRECT INC	MMH	SECURITY SYSTEM UPGRADE	Replacement	C0016389	F			$3,227				$3,227							
ADVANCE SECURITY INTERGATION LLC	MMH	ACCESS CONTROL UPGRADE	Replacement	C0016390	F				$81,206			$81,206							
SECURITY 101	MMH	ACCESS CONTROL UPGRADE	Replacement	C0016390	F													$86,363	$86,363
W.B. MASON COMPANY, INC.	RGH	WALDEN EATING DISORDER UNIT	Renovation	C016300P	F					$1,813		$1,813							
RAINTECH SOUND & COMMUNICATION, INC.	RGH	WALDEN EATING DISORDER UNIT	Renovation	C016300R	F		$13,278					$13,278							
STRYKER SALES CORPORATION	RGH	WALDEN EATING DISORDER UNIT	Renovation	C01630AU	F					$68,544		$68,544							
GE MEDICAL SYSTEMS INFORMATION	RGH	WALDEN EATING DISORDER UNIT	Renovation	C16300AV	F			$2,594				$2,594							
GRAYBAR ELECTRIC CO INC.	RGH	WALDEN EATING DISORDER UNIT	Renovation	C16300BB	F		$237					$237							
SHI INTERNAIONAL CORP	RGH	WALDEN EATING DISORDER UNIT	Renovation	C16300BC	F		$1,881					$1,881							
SHI INTERNAIONAL CORP	RGH	WALDEN EATING DISORDER UNIT	Renovation	C16300BC	F		$155					$155							
SOMA TECHNOLOGY, INC.	RGH	WALDEN EATING DISORDER UNIT	Renovation	C16300BD	F		$695					$695							
TRI-ANIM HEALTH SERVICES	RGH	WALDEN EATING DISORDER UNIT	Renovation	C16300BG	F	$413						$413							
TRI-ANIM HEALTH SERVICES	RGH	WALDEN EATING DISORDER UNIT	Renovation	C16300BG	F		$826					$826							
RAINTECH SOUND & COMMUNICATION, INC.	RGH	WALDEN EATING DISORDER UNIT	Renovation	C16300BH	F				$34,882			$34,882							
MODERN MECHANICAL SERVICES, INC	MMH	WATER TOWER TANKS	Replacement	C0016345	N		$90,487					$90,487							
ALL-PHASE ENTERPRISES INC	MMH	GENERATOR FLUE STACK	Replacement	C0016364	N		$9,430					$9,430							
SMITHS MEDICAL ASD INC	MMH	TEMP CHECK	Replacement	C0016379	N	$807						$807							
HILL-ROM	MMH	STRETCHER MATTRESSES (7)	Replacement	C0016388	N		$3,644					$3,644							
HILL-ROM	MMH	STRETCHER MATTRESSES (6)	Replacement	C0016393	N		$2,818					$2,818							
SCALES INDUSTRIAL TECHOLOGIES, LLC	MMH	QUINCY OILESS COMPRESSOR	Replacement	C0016394	N		$12,730					$12,730							
SCALES INDUSTRIAL TECHOLOGIES, LLC	MMH	QUINCY OILESS COMPRESSOR	Replacement	C0016394	N					$1,663		$1,663							
SAFEWARE, INC.	RGH	GAS ALERT DETECTOR	Replacement	C0016398	N					$195		$195							
SAFEWARE, INC.	RGH	GAS ALERT DETECTOR	Replacement	C0016398	N					$2,264		$2,264							
SAFEWARE, INC.	RGH	GAS ALERT DETECTOR	Replacement	C0016398	N								$2,458						$2,458
MOREDIRECT INC	WAT	IT - CISCO CATALYST	Replacement	C0016401	N								$10,884						$10,884
MOREDIRECT, INC.	RGH	IT - CISCO CATALYST	Replacement	C0016401	N										$313				$313
JKS SYSTEMS, LLC	WAT	WOODLAKE CABLE RUNS	Replacement	C0016402	N								$5,241						$5,241
PRAXAIR DISTRIBUTION, INC	MMH	FBC - NITRONOX E STAND PACKAGE	Replacement	C0016403	N						$11,230	$11,230							$0
STERIS CORP	MMH	CENTURY STERILIZER COLOR DISPLAY	Replacement	C0016404	N									$10,296					$10,296
STERIS CORP	MMH	SPD - 3 LEVEL MANIFOLD RACK	Replacement	C0016405	N						$13,662	$13,662							$0
GERMFREE LABORATORIES, INC	RGH	PHARMACY COMPOUNDING ISOLATOR	Replacement	C0016406	N										$15,059				$15,059
OWENS & MINOR	MMH	DIGITAL SCALE WITH HANDRAILS	Replacement	C0016407	N								$1,606						$1,606
HILL-ROM	MMH	CLUB SLEEPER/MATRESS (MATERNITY)	Replacement	C0016408	N									$4,517					$4,517
CARPETWORKS	MMH	NUCLEAR MED FLOORING	Replacement	C0016413	N						$5,429	$5,429							
CARPETWORKS	RGH	FLOORING - BIII, HOSPICE ICU WAITING RO	Replacement	C0016414	N						$19,452	$19,452							
CARPETWORKS LLC	RGH	FLOORING - BIII, HOSPICE ICU WAITING RO	Replacement	C0016414	N													$2,090	$2,090
CARPETWORKS LLC	RGH	FLOORING - BIII, HOSPICE ICU WAITING RO	Replacement	C0016414	N													$1,912	$1,912
CARPETWORKS	RGH	FLOORING - LITHOTRIPSY	Replacement	C0016415	N						$5,158	$5,158							
HILL ROM COMPANY INCORPORATED	RGH	MATTRESS REPLACEMENT	Replacement	C0016416	N												$20,117		$20,117
KARL STORZ ENDOSCOPY AMERICA, INC.	MMH	VIDEO URETEROSCOPE	Replacement	C0016417	N										$18,818				$18,818
INTOXIMETERS INC	MMH	INTOXIMETER SENSOR	Replacement	C0016418	N								$555						$555
FLAGSHIP NETWORKS, INC	MMH	CITRIX EDUCATION LICENSING	Replacement	C0016420	N										$9,635				$9,635
SHI INTERNAIONAL CORP	MMH	IPAD AIR ACCESSORIES	Replacement	C0016421	N								$249						$249
SHI INTERNAIONAL CORP	MMH	APPLE IPAD AIR/ACCESSORIES (5)	Replacement	C0016421	N									$4,056					$4,056
TRUMPF MEDICAL SYSTEMS	MMH	FOOT SUPPORT, ROTATABLE	Replacement	C0016422	N									$850					$850
W.B. MASON CO INC	MMH	MATERNITY WAITING ROOM FURNITURE	Replacement	C0016425	N												$27,444		$27,444
CDW GOVERNMENT INC	ECMP	HP PROBOOK WITH ACCESSORIES (4)	Replacement	C0016426	N									$4,410					$4,410
TELEFLEX MEDICAL INCORPORATED	MMH	SURGICAL TOOLS	Replacement	C0016427	N								$3,279						$3,279
AESCULAP	MMH	SURGICAL TOOLS	Replacement	C0016428	N								$1,531						$1,531
INTERA LIFESCIENCES	MMH	LED HEADLIGHT (3)	Replacement	C0016429	N								$18,479						$18,479
SHI INTERNAIONAL CORP	MMH	APPLE IPOD TOUCH (50)	Replacement	C0016430	N								$10,365						$10,365
MOREDIRECT, INC.	MMH	FIREWALL REPLACEMENT	Replacement	C0016433	N										$3,184				$3,184
MOREDIRECT, INC.	MMH	FIREWALL REPLACEMENT	Replacement	C0016433	N										$11,149				$11,149
MOREDIRECT, INC.	MMH	FIREWALL REPLACEMENT	Replacement	C0016433	N										$11,267				$11,267
CHIMENET, INC.	MMH	FIREWALL	Replacement	C0016434	N												$6,060		$6,060
PRECISION COMPUTER SERVICES, INC	MMH	IT - CISCO B2000 SERVER/ACCESSORIES	Replacement	C0016435	N									$43,437					$43,437
PRECISION COMPUTER SERVICES, INC.	MMH	CISCO B200 M4 BLADES/IMPLEMENTATION	Replacement	C0016435	N											$4,410			$4,410
OLYMPUS AMERICA, INC	RGH	PORTABLE RHINO-LARYNGO FIBERSCOPE	Replacement	C0016436	N									$13,113					$13,113
MORTARA INSTRUMENT, INC.	MMH	CARDIAC REHAB TREADMILL	Replacement	C0016437	N												$11,098		$11,098
MORTARA INSTRUMENT, INC.	RGH	RHAB TREADMILL	Replacement	C0016438	N										$11,098				$11,098
FOLLETT LLC	RGH	EDU - ICE MAKER/WATER DISPENSER	Replacement	C0016439	N										$3,341				$3,341
ERBE USA INCORPORATED	MMH	ENDOSCOPY ACP SYSTEM	Replacement	C0016440	N										$157,507				$157,507
ERBE USA INCORPORATED	RGH	ENDOSCOPY ACP SYSTEM	Replacement	C0016441	N										$79,191				$79,191
ALL-PHASE ENTERPRISES, INC.	WAT	CHOW PLAN OF CORRECTION RENO	Renovation	C0016445	N										$24,945				$24,945
ALL-PHASE ENTERPRISES, INC.	WAT	CHOW PLAN OF CORRECTION RENO	Renovation	C0016445	N										$6,845				$6,845

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Vendor	Entity	Item	Purpose	PO #	FundingType	October	November	December	January	February	March	Total	April	May	June	July	August	Sept	Total
						**********						PAYMENT AMOUNT	**********						
ALL-PHASE ENTERPRISES, INC.	WAT	CHOW PLAN OF CORRECTION RENO	Renovation	C0016445	N											$94,639			$94,639
ALL-PHASE ENTERPRISES, INC.	WAT	CHOW PLAN OF CORRECTION RENO	Renovation	C0016445	N												$104,552		$104,552
ALL-PHASE ENTERPRISES, INC.	WAT	CHOW PLAN OF CORRECTION RENO	Renovation	C0016445	N													$110,135	$110,135
ALL-PHASE ENTERPRISES, INC.	WAT	CHOW PLAN OF CORRECTION RENO	Renovation	C0016445	N													$84,266	$84,266
W.B. MASON CO INC	WAT	CHOW RESIDENT ROOM FURNITURE	Renovation	C0016447	N										$28,927				$28,927
W.B. MASON CO INC	MMH	BARIATRIC FURNITURE	Replacement	C0016448	N												$25,845		$25,845
SHI INTERNAIONAL CORP	WAT	CISCO CATALYST - WAT COMPUTER ACCE	Replacement	C0016449	N									$2,247					$2,247
JKS SYSTEMS, LLC	WAT	IT WIRING AND CABLE INSTALL	Replacement	C0016450	N										$1,546				$1,546
W.B. MASON CO INC	MMH	PHYSICIAN LOUNGE FURNITURE	Replacement	C0016454	N												$5,890		$5,890
SCOTTCARE CORPORATION	MMH	VERSA CARE TELEMETRY MONITORING SY	Replacement	C0016455	N									$45,628					$45,628
CDW GOVERNMENT INC.	MMH	PT MIGRATION TO MEDITECH	Replacement	C0016456	N											$3,491			$3,491
CDW GOVERNMENT INC.	MMH	PT MIGRATION TO MEDITECH	Replacement	C0016456	N											$363			$363
SHI INTERNAIONAL CORP	MMH	HP745-PT MIGRATION TO MEDITECH	Replacement	C0016457	N									$25,014					$25,014
JKS SYSTEMS, LLC	MMH	REHAB ACCESS POINTS	Replacement	C0016458	N											$2,238			$2,238
W.B. MASON CO INC	RGH	ED TASK CHAIRS (10)	Replacement	C0016460	N											$3,127			$3,127
EHR INTEGRATION	ECMP	PATIENT ADT INTERFACE	Replacement	C0016463	N								$5,625						$5,625
EHR INTEGRATION SERVICES, LLC	ECMP	ED transition to ECMP Billing	Replacement	C0016463	N												$3,000		$3,000
EHR INTEGRATION SERVICES, LLC	ECMP	ED transition to ECMP Billing	Replacement	C0016463	N												$2,813		$2,813
EHR INTEGRATION SERVICES, LLC	ECMP	ED transition to ECMP Billing	Replacement	C0016463	N												$2,813		$2,813
IATRIC SYSTEMS	MMH	ED TRANSITION TO ECMP BILLING	Replacement	C0016464	N											$2,185			$2,185
JKS SYSTEMS, LLC	MMH	IT CABLING - 44 HAYNES	Replacement	C0016466	N											$1,014			$1,014
MOREDIRECT, INC.	MMH	CRC HARDWARE	Replacement	C0016467	N											$15,331			$15,331
MID-SOUTH TELECOM LLC	MMH	CRC PHONES	Replacement	C0016469	N											$936			$936
AMPRONIX, INC.	MMH	MEDICAL VIDEO RECORDER	Replacement	C0016470	N										$3,988				$3,988
MOREDIRECT, INC.	MMH	LAPTOP INVENTORY (20)	Replacement	C0016471	N											$18,362			$18,362
MOREDIRECT, INC.	MMH	LAPTOP INVENTORY (20)	Replacement	C0016471	N											$2,732			$2,732
FLAGSHIP NETWORKS, INC	MMH	MCAFEE FOR LAPTOPS (20)	Replacement	C0016472	N											$2,234			$2,234
MCKESSON MEDICAL SURGICAL INC.	ECMP	INFECTIOUS DISEASE WALL UNITS	Replacement	C0016475	N										$1,673				$1,673
EAGLE RIVET ROOF SERVICE CORP.	RGH	CHOW PLAN OF CORRECTION ROOF	Replacement	C0016476	N												$80,750		$80,750
EAGLE RIVET ROOF SERVICE CORP.	RGH	CHOW PLAN OF CORRECTION ROOF	Replacement	C0016476	N												$26,439		$26,439
EAGLE RIVET ROOF SERVICE CORP.	RGH	CHOW PLAN OF CORRECTION ROOF	Replacement	C0016476	N													$23,750	$23,750
PHILIPS HEALTHCARE	RGH	CHOW PLAN OF CORRECTION ROOF	Replacement	C0016477	N													$13,666	$13,666
HOLOGIC LIMITED PARTNERSHIP	MMH	MYOSURE HYSTEROSCOPE	Replacement	C0016478	N											$6,495			$6,495
CLASSIC RESTAURANT SUPPLY	MMH	ICE MACHINE	Replacement	C0016479	N											$4,730			$4,730
INTERIOR CONCEPTS	RGH	CORRIDOR DOOR REPLACEMENT	Replacement	C0016482	N												$4,730		$4,730
INTERIOR CONCEPTS	RGH	CORRIDOR DOOR REPLACEMENT	Replacement	C0016482	N												$12,435		$12,435
MCPHEE ELECTRICAL LTD	RGH	ICU Transformer Replacement	Replacement	C0016486	N													$12,230	$12,230
SHI INTERNATIONAL CORP.	MMH	MED EDU HARDDRIVES AND BATTERIES	Replacement	C0016488	N												$708		$708
SHI INTERNATIONAL CORP.	MMH	MED EDU HARDDRIVES AND BATTERIES	Replacement	C0016488	N												$506		$506
SHI INTERNATIONAL CORP.	MMH	LAB DOCUMENT SCANNER	Replacement	C0016489	N												$888		$888
CONNECTICUT BUSINESS SYSTEMS, LLC	RGH	PRINTER/SCANNER	Replacement	C0016490	N													$1,303	$1,303
CONNECTICUT BUSINESS SYSTEMS, LLC	MMH	PRINTER	Replacement	C0016491	N													$1,544	$1,544
MCKESSON MEDICAL-SURGICAL	WAT	TUB	Replacement	C0016492	N													$11,380	$11,380
SMITH & NEPHEW ENDOSCOPY DIV.	MMH	SHOULDER POSITIONER	Replacement	C0016496	N												$4,209		$4,209
SMITH & NEPHEW ENDOSCOPY DIV.	MMH	SHOULDER POSITIONER	Replacement	C0016496	N												$5,109		$5,109
JKS SYSTEMS, LLC	RGH	WIRING - GI, CARDIO & OR	Replacement	C0016497	N												$1,290		$1,290
SIEMENS MEDICAL SOLUTIONS USA, INC.	MMH	PACS UPGRADE	Replacement	C0016498	N												$13,152		$13,152
HELMER SCIENTIFIC	MMH	LAB REFRIGERATOR	Replacement	C0016500	N											$5,175			$5,175
GE HEALTHCARE IITS USA CORP	MMH	FBC EXPANSION -PROJECT	Replacement	C016281B	N	$3,845						$3,845							
MERRY X-RAY CHEMICAL CORP	MMH	VASCULAR- PROJECT	Replacement	C016312V	N	$652						$652							
CHIMENET, INC.	RGH	IDF UPGRADE/NETWORK REDESIGN	Replacement	C016376A	N				$2,400			$2,400							
CHIMENET, INC.	RGH	IDF UPGRADE/NETWORK REDESIGN	Replacement	C016376A	N					$4,111		$4,111							
MOREDIRECT INC	RGH	COMPUTER CABLES	Replacement	C016376G	N		$1,403					$1,403							
DC CONSULTING SERVICE LLC	ECMP	SOFTWARE	Replacement	C016382B	N	$990						$990							
JKS SYSTEMS, LLC	ECMP	COMPUTER SCANNER	Replacement	C016385A/E	N	$412						$412							
FLAGSHIP NETWORKS, INC	ECMP	LICENSE FEE	Replacement	C016385D	N			$950				$950							
MCKESSON MEDICAL SURGICAL	ECMP	BARIATRIC SCALE	Replacement	C016385F	N	$1,550						$1,550							
MOSER PILON NELSON	MMH	MMH BARIATRIC INPATIENT ROOMS -PROJ	Renovation	C016395A	N	$2,000						$2,000							
MOSER PILON NELSON	MMH	MMH BARIATRIC INPATIENT ROOMS -PROJ	Renovation	C016395A	N	$3,950						$3,950							
MOSER PILON NELSON	MMH	MMH BARIATRIC INPATIENT ROOMS -PROJ	Renovation	C016395A	N	$3,570						$3,570							
MOSER PILON NELSON	MMH	MMH BARIATRIC INPATIENT ROOMS -PROJ	Renovation	C016395A	N				$2,380			$2,380							
MOSER PILON NELSON	MMH	MMH FLUOROSCOPY ROOM-PROJECT	Renovation	C016396A	N	$1,250						$1,250							
MOSER PILON NELSON	MMH	MMH FLUOROSCOPY ROOM-PROJECT	Renovation	C016396A	N	$6,275						$6,275							
MOSER PILON NELSON	MMH	MMH FLUOROSCOPY ROOM-PROJECT	Renovation	C016396A	N	$3,525						$3,525							
MOSER PILON NELSON	MMH	MMH FLUOROSCOPY ROOM-PROJECT	Renovation	C016396A	N				$2,350			$2,350							
MOSER PILON NELSON	MMH	GEROPSYCHIATRY BH UNIT RENOVATIONS	Renovation	C016409A	N						$45,100	$45,100							

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						********** PAYMENT AMOUNT **********														
Vendor	Entity	Item	Purpose	PO #	FundingType	October	November	December	January	February	March	Total	April	May	June	July	August	Sept	Total
MOSER PILON NELSON	MMH	GEROPSYCHIATRY BH UNIT RENOVATIONS	Renovation	C016409A	N										$2,500				$2,500
MOSER PILON NELSON	MMH	GEROPSYCHIATRY BH UNIT RENOVATIONS	Renovation	C016409A	N										$14,014				$14,014
MOSER PILON NELSON	MMH	GEROPSYCHIATRY BH UNIT RENOVATIONS	Renovation	C016409A	N													$1,980	$1,980
STANDARD BUILDERS, INC.	RGH	GEROPSYCHIATRY BH UNIT RENOVATIONS	Renovation	C016409B	N												$6,010		$6,010
IRVING D. MOY	RGH	GEROPSYCHIATRY BH UNIT RENOVATIONS	Renovation	C016409L	N											$800			$800
IRVING D. MOY	RGH	GEROPSYCHIATRY BH UNIT RENOVATIONS	Renovation	C016409L	N											$200			$200
MOSER PILON NELSON	RGH	ADULT BEHAVIORAL HEALTH UNIT	Renovation	C016410A	N						$165,635	$165,635							$0
MOSER PILON NELSON	RGH	ADULT BEHAVIORAL HEALTH UNIT	Renovation	C016410A	N								$10,000						$10,000
MOSER PILON NELSON	RGH	ADULT BEHAVIORAL HEALTH UNIT	Renovation	C016410A	N									$55,250					$55,250
MOSER PILON NELSON	RGH	ADULT BEHAVIORAL HEALTH UNIT	Renovation	C016410A	N													$26,834	$26,834
STANDARD BUILDERS, INC.	RGH	ADULT BEHAVIORAL HEALTH UNIT	Renovation	C016410B	N												$25,773		$25,773
STANDARD BUILDERS, INC.	RGH	ADULT BEHAVIORAL HEALTH UNIT	Renovation	C016410B	N												$225,982		$225,982
ABATEMENT PLUS, LLC	RGH	ADULT BEHAVIORAL HEALTH UNIT	Renovation	C016410T	N										$4,650				$4,650
ABATEMENT PLUS, LLC	RGH	ADULT BEHAVIORAL HEALTH UNIT	Renovation	C016410T	N												$51,634		$51,634
ALL-PHASE ENTERPRISES, INC.	RGH	ADULT BEHAVIORAL HEALTH UNIT	Renovation	C016410U	N										$29,459				$29,459
HORAK PAINTING CONTRACTORS	RGH	RGH GROUND FLOOR CORRIDOR PAINTIN	Renovation	C016480C	N										$12,177				$12,177
HORAK PAINTING CONTRACTORS	RGH	RGH GROUND FLOOR CORRIDOR PAINTIN	Renovation	C016480C	N													$12,177	$12,177
CARPETWORKS LLC	MMH	PHARMACY ENGINEERING -PROJECT	Replacement	C15875HH	N		$670					$670							
PRO-TECH	WAT	FIRE BLOCKING	Replacement		N					$6,391		$6,391							
CTGI	MMH	LAB - GI COMPUTER INTERFACE	Replacement		N						$17,670	$17,670							
						$29,238	**$138,254**	**$6,771**	**$123,219**	**$84,979**	**$283,336**	**$665,798**	**$70,273**	**$208,818**	**$451,286**	**$168,461**	**$669,245**	**$389,631**	**$1,957,714**
		Financing (Debt, Lease)			**F**	**$413**	**$17,073**	**$5,821**	**$116,089**	**$70,357**	**$0**	**$209,753**	**$0**	**$0**	**$0**	**$0**	**$0**	**$86,363**	**$86,363**
		New FY 2017 Spending (Operations)			**N**	**$28,825**	**$121,181**	**$950**	**$7,131**	**$14,622**	**$283,336**	**$456,045**	**$70,273**	**$208,818**	**$451,286**	**$168,461**	**$669,245**	**$303,268**	**$1,871,351**
		TOTAL				**$29,238**	**$138,254**	**$6,771**	**$123,219**	**$84,979**	**$283,336**	**$665,798**	**$70,273**	**$208,818**	**$451,286**	**$168,461**	**$669,245**	**$389,631**	**$1,957,714**

Michael D. Veillette, Chief Financial Officer, Prospect ECHN, Inc.

Exhibit B

Prospect ECHN, Inc.
FY2017 Approved Capital Expenditures

Vendor Name	Facility	Item Description	Amount	Purpose	Notes
Otis Elevator	MMH	Elevator Sheave Replacement	35,255.00	Repair	
Connection, JKS Systems	ECHN	Voice Mail System Replacement	76,866.48	Replacement	
Omnicell, Inc.	MMH/RGH	Omnicell Dispensing System	1,306,013.10	Replacement	
Connection, JKS Systems	WAT	Wireless Network Expansion	15,721.32	New, Expansion	
GermFree	RGH	Germfree VF-4USP Compounding Aseptic Isolator	16,015.55	Replacement	
Steris Corporation	MMH	Sterilizer Centry Color Display Upgrade	10,949.80	Replacement	
Steris Corporation	MMH	Steris Manifold Racks and Carts (4)	16,647.94	Replacement	
Owens and Minor	MMH		1,692.29	Replacement	
Hill-Rom	MMH	Sleeper Chairs (2)	4,804.04	Replacement	
Praxair	MMH	Nitrous Oxide Delivery System (2)	11,147.61	New, Expansion	
Standard Builders, Inc.	RGH	Renovations for Adult Behavioral Health Unit	4,172,153.04	Replacement	Renovations in process to expand adult behavioral health capacity with 24 beds, completion expected December 2017
Standard Builders, Inc.	MMH	Renovations for Geropsychiatry Unit	818,129.28	Replacement	Renovations underway to provide separate program spaces for adolescent and geriatric patient populations, completion targeted for December 2017
Standard Builders, Inc.	MMH	BHU Safety Renovations	344,700.00	Replacement	In process, with replacement of acoustic ceilings with drywall, targeted completion by December 2017
Flagship Networks	ECHN	Citrix Licenses	9,635.40	New, Expansion	
SHI	MMH/RGH	iPods - Communications Services	4,721.74	New, Expansion	
Karl Storz	MMH	Ureteroscope	19,949.77	Replacement	
Carpetworks, LLC	RGH	Replacement Flooring - Lithotripsy Room	5,157.98	Replacement	
Carpetworks, LLC	RGH	Replacement Flooring - RGH Waiting Rooms	21,042.41	Replacement	
Carpetworks, LLC	MMH	Replacement Flooring - MMH Waiting Rooms	5,429.17	Replacement	
Hill Rom Company	RGH	Mattresses (35)	20,136.63	Replacement	
Prestige Medical Imaging	RGH	Portable X-Ray Unit	148,786.65	Replacement	
Intoximeters, Inc.	MMH	Breath Alcohol Tester	590.23	Replacement	
Teleflex Medical	MMH	Laparoscopic Tray	4,624.20	Replacement	
Integra Life Sciences	MMH	Surgical Headlights	19,662.41	Replacement	
Trumpf Medical	MMH	Trumpf OR Table Extension	903.98	New, Expansion	
Aesculap, Inc.	MMH	Orthopedic Large Bone Tray	1,628.15	Replacement	
WB Mason Company, Inc.	MMH	Waiting Rooms & Maternity Education Room Furniture	27,586.13	Replacement	
WB Mason Company, Inc.	RGH	Waiting Rooms & Nurse Lounge Furniture	15,862.10	Replacement	
WB Mason Company, Inc.	RGH	ED Waiting Room Flooring Replacement	13,033.19	Replacement	
CDW/SHI/Flagship	ECMP	Laptops, PCs	7,711.19	New, Expansion	
SHI	MMH/RGH	iPods for Secure Texting	11,022.88	New, Expansion	
Precision Computer Services, Inc.	ECHN	UCS Chassis & Blade Servers	50,885.35	New, Expansion	
Connection/CHIMENET	ECHN	Network Security Firewall	31,980.56	New, Expansion	
All Phase Construction Enterprises, Inc.	WAT	CHOW Renovations	517,966.35	Replacement	

Exhibit B

Prospect ECHN, Inc.
FY2017 Approved Capital Expenditures

WB Mason Company, Inc.	WAT	CHOW Furniture	240,877.43	Replacement	
Eagle Rivet Roofing	RGH	Roof Replacements (3)	152,075.18	Replacement	
CDW/Flagship/SHI/JKS	MMH/RGH	EMR Hardware	41,404.32	Replacement	
Carpetworks, LLC	MMH	2 East Patient Room Flooring	42,534.68	Replacement	
Carpetworks, LLC	MMH	1 East Corridor & Patient Room Flooring	72,647.69	Replacement	
ERBE USA Incorporated	MMH/RGH	ERBE Argon Plasma Coagulation Units (6)	233,965.32	Replacement	
Motara Instruments	MMH/RGH	Treadmills (4)	23,502.91	Replacement	
WB Mason Company, Inc.	MMH/RGH	Bariatric Furniture	25,845.18	Replacement	
Olympus American, Inc.	RGH	Tracheal & Rhino-Laryngoscopes	12,579.55	Replacement	
Follet	RGH	Ice Machine	2,553.15	Replacement	
SHI/JKS/CDW	WAT	PCs	4,678.94	Replacement	
PCP	ECMP	Practice Acquisition	273,200.00	New, Expansion	
WB Mason	RGH	Task Chairs (10)	3,126.69	Replacement	
WB Mason	MMH	Physician Lounge Furniture	5,899.23	Replacement	
ScottCare	MMH	VersaCare Telemetry Monitoring System	48,482.84	Replacement	
Meditech, CareFusion	MMH/RGH	Omnicell Interfaces	87,100.65	Replacement	
Iatric Systems, EHR Integration Services	MMH/RGH	ED Billing Interfaces	19,304.00	New, Expansion	
Connection, Flagship Networks, JKS Systems	CRC	Laptops for new hires	17,754.90	New, Expansion	
Mid-South Telecom LLC, SHI	CRC	Telephones for new hires	1,226.36	New, Expansion	
Connection, Flagship Networks	ECHN	Laptops for Inventory	23,327.82	Replacement	
Carpetworks, LLC	RGH	ICU Flooring Replacement	14,585.90	Replacement	
McKesson	ECMP	Exam Room Diagnostics Wall Units (2)	1,778.85	Replacement	
Mid-South Telecom LLC	ECMP	Telephone Headsets	1,312.95	Replacement	
Ampronix	MMH	HD Medical Video Recorder	4,241.24	Replacement	
Philips Healthcare	ECMP	Stress System, EKG Machine	26,302.80	Replacement	
Carpetworks, LLC Horak Painting, Abatement Plus	RGH	Ground Floor Renovations	92,683.04	Replacement	
Interior Concepts	RGH	Corridor Door Replacements	30,179.75	Replacement	
Classic Restaurant Supply	MMH	Ice cube machines (2)	4,730.43	Replacement	
Hologic	MMH	Hysteroscope & instrument tray	6,907.43	Replacement	
Hovertech International Air Supply & Storage Cart	MMH	HoverMatt Patient Transport System	1,447.42	New, Expansion	
CDW	MMH	3 Laptops	3,203.26	New, Expansion	
SHI	MMH	9 computer laptop hard drives & batteries	1,289.85	New, Expansion	
CBS	RGH	Printer/Scanner	1,302.79	New, Expansion	
Smith & Nephew	RGH	Shoulder positioner	4,439.05	New, Expansion	
Carpetworks, LLC	MMH	Vinyl flooring, ASC	11,858.03	Replacement	
Accurate Doors	RGH	Exterior doors (3)	12,740.73	Replacement	
SHI	MMH	Document scanner	944.12	New, Expansion	

Exhibit B

Prospect ECHN, Inc.
FY2017 Approved Capital Expenditures

K.M. Medical, Inc.	MMH	Lead aprons	7,174.22	Replacement	
K.M. Medical, Inc.	RGH	Lead aprons	2,080.21	Replacement	
JKS Systems	RGH	Data cabling	1,372.39	New, Expansion	
McPhee Electric	RGH	Transformer	48,921.00	Replacement	
McKesson	WAT	Tub with lift	12,102.63	Replacement	
Direct Supply	WAT	Hoyer Lifts with scales	4,852.80	New, Expansion	
Direct Supply	WAT	Vital Signs Monitors with stands	11,293.08	Replacement	
CBS	MMH	Printer	1,544.20	New, Expansion	
Siemens	ECHN	PACs System Upgrade	153,207.26	Replacement	
Karl Storz	MMH	Difficult Airways Carts (Two)	76,337.86	New, Expansion	
Olympus	MMH	Vacuum Curettage System	7,269.77	Replacement	
WB Mason	MMH	Office Chairs	8,975.94	Replacement	
Carpetworks, LLC	RGH	Bissell 2 Corridor Flooring Replacement	22,375.24	Replacement	
Carpetworks, LLC	MMH	Sleep Center Carpet Replacement	14,288.05	Replacement	
Helmer	MMH	Laboratory Refrigerator	5,503.46	Replacement	
Meditech	ECHN	Patient Portal	233,863.65	Replacement	
Smiths Medical	RGH	Infuser	10,004.08	New, Expansion	
W.B. Mason	MMH	Office Chairs	4,702.35	Replacement	
JKS Systems	ECHN	Cable data runs for wireless networks	2,677.30	New, Expansion	
Security 101	RGH	CCTV Replacement for Sterile Processing Facility	16,595.05	Replacement	
Eastcoast Paving Services	RGH	Service Drive and East Parking Lot Paving	73,010.00	Replacement	
Hartford Sprinkler Company	MMH	Garage Standpipe Replacement	17,600.93	Replacement	
Security 101	RGH	RGH Security Video Infrastructure	34,486.94	Replacement	
KTW Group	MMH	Surgical Case Carts	28,269.73	Replacement	
Stryker	RGH	Psychiatric Beds	76,959.65	Replacement	
Encore Fire Protection	RGH	Additional Sprinklers	29,964.11	New, Expansion	
Wells Johnson Company	MMH	Plastic Surgery Infiltration Pump	2,793.69	Replacement	
Stryker	MMH	Makoplasty Total Knee Application	297,780.00	New, Expansion	
Silktown Roofing, Inc.	MMH	CHOW POC Roof Replacements	1,326,920.97	Replacement	
All Phase Enterprises	MMH	Paving and Concrete Work	136,071.40	Replacement	
TPC Associatess, Inc	MMH	Hugs Infant Protection System	94,055.94	Replacement	
Alcon Laboratories	MMH	Alcon Constellation Retina Vitrectomy Machine	99,543.60	Replacement	
Electrical Wholesalers, Inc.	MMH	Replacement Exit Signs	14,632.91	Replacement	
Mindray	MMH/RGH	18 Anesthesia Machines	711,946.79	Replacement	
			$ 12,909,623.60		

Exhibit C
Prospect Manchester Hospital, Prospect Rockville Hospital and Prospect ECHN
Report 175 - Operating Expenses by Category
Comparison: October 2016 - March 2017 and April 2017 - September 2017

		October 2016 - March 2017			April 2017 - September 2017			Variance		
Line	Operating Expense by Category	MMH	RGH	ECHN	MMH	RGH	ECHN	MMH	RGH	ECHN
A	Salaries & Wages	$39,112,524	$14,071,000	$53,183,524	$37,836,794	$13,359,480	$51,196,274	($1,275,730)	($711,520)	($1,987,250)
B	Fringe Benefits	$13,822,026	$5,117,453	$18,939,479	$7,537,643	$3,238,088	$10,775,730	($6,284,383)	($1,879,365)	($8,163,749)
C	Contractual Labor Fees	$5,029,260	$2,271,227	$7,300,487	$6,638,425	$3,290,725	$9,929,150	$1,609,165	$1,019,498	$2,628,663
D	Medical Supplies & Phamaceutical Cost	$13,471,362	$3,913,060	$17,384,422	$13,316,492	$2,360,289	$15,676,781	($154,870)	($1,552,771)	($1,707,641)
E	Depreciation & Amortization	$3,536,666	$1,478,850	$5,015,516	$3,364,656	$1,452,043	$4,816,699	($172,010)	($26,807)	($198,817)
F	Bad Debts	$0	$0	$0	$0	$0	$0	$0	$0	$0
G	Interest Expense	$3,634,528	$1,075,070	$4,709,598	$3,598,889	$1,087,538	$4,686,428	($35,639)	$12,468	($23,171)
H	Malpractice Insurance Cost	$1,290,472	$504,808	$1,795,280	$153,148	$272,714	$425,862	($1,137,324)	($232,094)	($1,369,418)
I	Utilities	$1,380,083	$665,214	$2,045,297	$1,363,160	$628,562	$1,991,722	($16,922)	($36,652)	($53,574)
J	Business Expense	$13,597,193	$5,644,173	$19,241,366	$15,554,280	$5,874,021	$21,428,301	$1,957,087	$229,848	$2,186,935
K	Other Operating Expenses	-	-	-	-	-	-	$0	$0	$0
	Total Operating Expenses - All Expense Categories	$94,874,114	$34,740,855	$129,614,969	$89,363,489	$31,563,458	$120,926,947	($5,510,625)	($3,177,396)	($8,688,022)

EXHIBIT E

PROSPECT ECHN, INC.		
AS OF SEPTEMBER 30, 2017		
FISCAL YEAR 2017		
REPORT 300 - PARENT CORPORATION CONSOLIDATED BALANCE SHEET INFORMATION		
(1)	(2)	(3)
		SEPT 2017
LINE	DESCRIPTION	ACTUAL
I.	**ASSETS**	
A.	**Current Assets:**	
1	Cash and Cash Equivalents	$4,194,382
2	Short Term Investments	
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$40,804,492
4	Current Assets Whose Use is Limited for Current Liabilities	
5	Due From Affiliates	$7,637,864
6	Due From Third Party Payers	
7	Inventories of Supplies	$6,054,400
8	Prepaid Expenses	$4,140,461
9	Other Current Assets	$2,435,581
	Total Current Assets	**$65,267,180**
B.	**Noncurrent Assets Whose Use is Limited:**	
1	Held by Trustee	$0
2	Board Designated for Capital Acquisition	
3	Funds Held in Escrow	
4	Other Noncurrent Assets Whose Use is Limited	
	Total Noncurrent Assets Whose Use is Limited:	**$0**
5	Interest in Net Assets of Foundation	
6	Long Term Investments	$13,734,336
7	Other Noncurrent Assets	$9,430,650
C.	**Net Fixed Assets:**	
1	Property, Plant and Equipment	$328,929,302
2	Less: Accumulated Depreciation	$250,110,586
	Less: Purchase Adjustment	$18,316,556
	Property, Plant and Equipment, Net	**$60,502,160**
3	Construction in Progress	$1,687,933
	Total Net Fixed Assets	**$62,190,093**
	Total Assets	**$150,622,259**

EXHIBIT E

PROSPECT ECHN, INC.		
AS OF SEPTEMBER 30, 2017		
FISCAL YEAR 2017		
REPORT 300 - PARENT CORPORATION CONSOLIDATED BALANCE SHEET INFORMATION		
(1)	(2)	(3)
		SEPT 2017
LINE	DESCRIPTION	ACTUAL
II.	**LIABILITIES AND NET ASSETS**	
A.	**Current Liabilities:**	
1	Accounts Payable and Accrued Expenses	$22,013,628
2	Salaries, Wages and Payroll Taxes	$5,641,078
3	Due To Third Party Payers	$2,192,261
4	Due To Affiliates	$1,793,691
5	Current Portion of Long Term Debt	$0
6	Current Portion of Notes Payable	$2,599,963
7	Other Current Liabilities	$10,280,642
	Total Current Liabilities	**$44,521,263**
B.	**Long Term Debt:**	
1	Bonds Payable (Net of Current Portion)	
2	Notes Payable (Net of Current Portion)	$8,929,268
	Total Long Term Debt	**$8,929,268**
3	Accrued Pension Liability	$66,866,795
4	Other Long Term Liabilities	$15,376,744
	Total Long Term Liabilities	**$91,172,807**
5	Interest in Net Assets of Affiliates or Joint Ventures	
C.	**Net Assets:**	
1	Net Assets or Equity	$14,928,189
2	Temporarily Restricted Net Assets	
3	Permanently Restricted Net Assets	
	Total Net Assets	**$14,928,189**
	Total Liabilities and Net Assets	**$150,622,259**

PROSPECT ROCKVILLE HOSPITAL, INC.

FISCAL YEAR 2017

		MTD						YTD					
		APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER
	DESCRIPTION	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017
	Total Gross Revenue	$18,412,122	$19,283,549	$18,192,153	$17,776,249	$18,737,703	$18,883,700	$135,924,439	$155,207,988	$173,400,141	$191,176,390	$209,914,093	$228,797,793
	Total Allowances	($13,324,074)	($14,212,013)	($12,970,581)	($12,320,032)	($13,538,658)	($13,869,828)	($98,952,244)	($113,164,257)	($126,134,838)	($138,454,870)	($151,993,528)	($165,863,356)
	Bad Debt	($181,373)	($154,116)	($154,815)	($140,382)	($128,800)	($119,266)	($1,385,915)	($1,540,031)	($1,694,846)	($1,835,228)	($1,964,028)	($2,083,294)
	Net Patient Revenue	$4,906,675	$4,917,420	$5,066,757	$5,315,835	$5,070,245	$4,894,606	$35,586,280	$40,503,700	$45,570,457	$50,886,292	$55,956,537	$60,851,143
	Other Operating Revenue	126,677	116,504	102,205	151,945	45,589	134,301	$852,334	$968,838	$1,071,043	$1,222,988	$1,268,577	$1,402,878
	Total Operating Revenue	$5,033,352	$5,033,924	$5,168,962	$5,467,780	$5,115,834	$5,028,907	$36,438,614	$41,472,538	$46,641,500	$52,109,280	$57,225,114	$62,254,021
	Total Operating Expenses	5,344,727	5,519,967	5,325,730	5,641,034	5,389,931	4,342,076	$40,085,586	$45,605,553	$50,931,283	$56,572,317	$61,962,248	$66,304,324
	Income/(Loss) From Operations	($311,375)	($486,043)	($156,768)	($173,254)	($274,097)	$686,831	($3,646,972)	($4,133,015)	($4,289,783)	($4,463,037)	($4,737,134)	($4,050,303)
	Total Non-Operating Revenue	113,627	117,588	93,371	118,113	124,907	(294,267)	$774,732	$892,320	$985,691	$1,103,804	$1,228,711	$934,444
	Excess/(Deficiency) of Revenue Over Expenses	($197,748)	($368,455)	($63,397)	($55,141)	($149,190)	$392,564	($2,872,240)	($3,240,695)	($3,304,092)	($3,359,233)	($3,508,423)	($3,115,859)
A	**Operating Performance**												
1	**Operating Margin**	**-6.05%**	**-9.43%**	**-2.98%**	**-3.10%**	**-5.23%**	**14.51%**	**-9.80%**	**-9.76%**	**-9.01%**	**-8.39%**	**-8.10%**	**-6.41%**
2	**Non-Operating Margin**	**2.21%**	**2.28%**	**1.77%**	**2.11%**	**2.38%**	**-6.22%**	**2.08%**	**2.11%**	**2.07%**	**2.07%**	**2.10%**	**1.48%**
3	**Total Margin**	**-3.84%**	**-7.15%**	**-1.20%**	**-0.99%**	**-2.85%**	**8.29%**	**-7.72%**	**-7.65%**	**-6.94%**	**-6.31%**	**-6.00%**	**-4.93%**
4	**Bad Debt as % of Gross Revenue**	**0.99%**	**0.80%**	**0.85%**	**0.79%**	**0.69%**	**0.63%**	**1.02%**	**0.99%**	**0.98%**	**0.96%**	**0.94%**	**0.91%**
	Income/(Loss) From Operations	($311,375)	($486,043)	($156,768)	($173,254)	($274,097)	$686,831	($3,646,972)	($4,133,015)	($4,289,783)	($4,463,037)	($4,737,134)	($4,050,303)
	Total Operating Revenue	$5,033,352	$5,033,924	$5,168,962	$5,467,780	$5,115,834	$5,028,907	$36,438,614	$41,472,538	$46,641,500	$52,109,280	$57,225,114	$62,254,021
	Total Non-Operating Revenue	$113,627	$117,588	$93,371	$118,113	$124,907	($294,267)	$774,732	$892,320	$985,691	$1,103,804	$1,228,711	$934,444
	Total Revenue	$5,146,979	$5,151,512	$5,262,333	$5,585,893	$5,240,741	$4,734,640	$37,213,346	$42,364,858	$47,627,191	$53,213,084	$58,453,825	$63,188,465
	Excess/(Deficiency) of Revenue Over Expenses	($197,748)	($368,455)	($63,397)	($55,141)	($149,190)	$392,564	($2,872,240)	($3,240,695)	($3,304,092)	($3,359,233)	($3,508,423)	($3,115,859)
	Unrestricted Net Assets	($2,872,240)	($3,240,695)	($3,304,092)	($3,359,233)	($3,508,423)	($3,115,859)	($2,872,240)	($3,240,695)	($3,304,092)	($3,359,233)	($3,508,423)	($3,115,859)
	Total Net Assets	($2,872,240)	($3,240,695)	($3,304,092)	($3,359,233)	($3,508,423)	($3,115,859)	($2,872,240)	($3,240,695)	($3,304,092)	($3,359,233)	($3,508,423)	($3,115,859)

PROSPECT ROCKVILLE HOSPITAL, INC.

FISCAL YEAR 2017

		MTD						YTD					
		APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER
	DESCRIPTION	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017
	Total Gross Revenue	$18,412,122	$19,283,549	$18,192,153	$17,776,249	$18,737,703	$18,883,700	$135,924,439	$155,207,988	$173,400,141	$191,176,390	$209,914,093	$228,797,793
	Total Allowances	($13,324,074)	($14,212,013)	($12,970,581)	($12,320,032)	($13,538,658)	($13,869,828)	($98,952,244)	($113,164,257)	($126,134,838)	($138,454,870)	($151,993,528)	($165,863,356)
B.	**Liquidity**												
1	**Current Ratio**	**1.63**	**1.64**	**1.68**	**1.59**	**1.57**	**1.27**	**1.63**	**1.64**	**1.68**	**1.59**	**1.57**	**1.27**
	Total Current Assets	$11,619,188	$11,353,838	$11,279,435	$11,589,385	$10,987,353	$11,486,396	$11,619,188	$11,353,838	$11,279,435	$11,589,385	$10,987,353	$11,486,396
	Total Current Liabilities	$7,146,594	$6,922,098	$6,700,460	$7,295,133	$6,986,532	$9,021,517	$7,146,594	$6,922,098	$6,700,460	$7,295,133	$6,986,532	$9,021,517
2	**Days Cash on Hand**	**(0)**	**1**	**1**	**7**	**2**	**0**	**(7)**	**(6)**	**(5)**	**2**	**4**	**4**
	Cash and Cash Equivalents	($80,010)	$154,797	$161,436	$1,262,686	$264,212	$1,037	($80,010)	$154,797	$161,436	$1,262,686	$264,212	$1,037
	Short Term Investments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Total Cash and Short Term Investments	($80,010)	$154,797	$161,436	$1,262,686	$264,212	$1,037	($1,219,752)	($1,064,955)	($903,519)	$359,167	$623,378	$624,415
	Total Operating Expenses	$5,344,727	$5,519,967	$5,325,730	$5,641,034	$5,389,931	$4,342,076	$40,085,586	$45,605,553	$50,931,283	$56,572,317	$61,962,248	$66,304,324
	Depreciation Expense	$235,173	$236,738	$234,266	$239,210	$239,431	$267,226	$1,714,023	$1,950,761	$2,185,027	$2,424,237	$2,663,668	$2,930,894
	Operating Expenses less Depreciation Expense	$5,109,554	$5,283,229	$5,091,464	$5,401,824	$5,150,500	$4,074,850	$38,371,563	$43,654,792	$48,746,256	$54,148,080	$59,298,580	$63,373,430
3	**Days in Net Acounts Receivables**	**35**	**40**	**34**	**36**	**45**	**42**	**340**	**381**	**415**	**450**	**495**	**537**
	Net Patient Accounts Receivable	$7,219,864	$7,161,273	$6,826,652	$7,476,334	$7,943,900	$7,440,504	$63,335,019	$70,496,293	$77,322,944	$84,799,278	$92,743,178	$100,183,682
	Due From Third Party Payers	$ -	$ -	$ -	$ -	$ -	$ -	$0	$0	$0	$0	$0	$0
	Due To Third Party Payers	$1,539,548	$748,252	$1,042,444	$1,370,929	$576,026	$639,008	$6,297,082	$7,045,334	$8,087,779	$9,458,708	$10,034,733	$10,673,741
	Total Net Patient Accounts Receivable and Third Party Payer Activity	$ 5,680,317	$ 6,413,022	$ 5,784,207	$ 6,105,405	$ 7,367,874	$ 6,801,496	$57,037,937	$63,450,958	$69,235,166	$75,340,571	$82,708,445	$89,509,941
	Total Net Patient Revenue	$4,906,675	$4,917,420	$5,066,757	$5,315,835	$5,070,245	$4,894,606	$35,586,280	$40,503,700	$45,570,457	$50,886,292	$55,956,537	$60,851,143
4	**Average Payment Period**	**42**	**41**	**39**	**42**	**42**	**66**	**39**	**39**	**38**	**41**	**39**	**52**
18	Total Current Liabilities	$7,146,594	$6,922,098	$6,700,460	$7,295,133	$6,986,532	$9,021,517	$7,146,594	$6,922,098	$6,700,460	$7,295,133	$6,986,532	$9,021,517
19	Total Operating Expenses	$5,344,727	$5,519,967	$5,325,730	$5,641,034	$5,389,931	$4,342,076	$40,085,586	$45,605,553	$50,931,283	$56,572,317	$61,962,248	$66,304,324
20	Depreciation Expense	$235,173	$236,738	$234,266	$239,210	$239,431	$267,226	$1,714,023	$1,950,761	$2,185,027	$2,424,237	$2,663,668	$2,930,894
20	Total Operating Expenses less Depreciation Expense	$5,109,554	$5,283,229	$5,091,464	$5,401,824	$5,150,500	$4,074,850	$38,371,563	$43,654,792	$48,746,256	$54,148,080	$59,298,580	$63,373,430

PROSPECT ROCKVILLE HOSPITAL, INC.

FISCAL YEAR 2017

		MTD						YTD					
		APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER
	DESCRIPTION	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017	FY 2017
	Total Gross Revenue	$18,412,122	$19,283,549	$18,192,153	$17,776,249	$18,737,703	$18,883,700	$135,924,439	$155,207,988	$173,400,141	$191,176,390	$209,914,093	$228,797,793
	Total Allowances	($13,324,074)	($14,212,013)	($12,970,581)	($12,320,032)	($13,538,658)	($13,869,828)	($98,952,244)	($113,164,257)	($126,134,838)	($138,454,870)	($151,993,528)	($165,863,356)
C.	**Leverage and Capital Structure**												
1	**Long-term Debt to Equity**	**(0.2)**	**(0.2)**	**(0.1)**	**(0.1)**	**(0.1)**	**(0.1)**	**(0.2)**	**(0.2)**	**(0.1)**	**(0.1)**	**(0.1)**	**(0.1)**
2	**Long Term Debt to Capitalization Ratio**	**(22.4)**	**(18.8)**	**(16.9)**	**(16.2)**	**(14.9)**	**(16.7)**	**(22.4)**	**(18.8)**	**(16.9)**	**(16.2)**	**(14.9)**	**(16.7)**
	Total Long Term Debt	$524,837	$513,744	$478,241	$467,411	$456,288	$445,778	$524,837	$513,744	$478,241	$467,411	$456,288	$445,778
	Total Net Assets	($2,872,240)	($3,240,695)	($3,304,092)	($3,359,233)	($3,508,423)	($3,115,859)	($2,872,240)	($3,240,695)	($3,304,092)	($3,359,233)	($3,508,423)	($3,115,859)
	Total Long Term Debt and Total Net Assets	($2,347,403)	($2,726,951)	($2,825,851)	($2,891,821)	($3,052,135)	($2,670,081)	($2,347,403)	($2,726,951)	($2,825,851)	($2,891,821)	($3,052,135)	($2,670,081)
3	**Unrestricted Cash to Total Debt Ratio**	**0.5**	**(1.8)**	**2.4**	**2.4**	**1.2**	**7.0**	**(15.1)**	**(17.3)**	**(15.6)**	**(12.0)**	**(11.3)**	**(2.0)**
	Excess/(Deficiency) of Revenues Over Expenses	($197,748)	($368,455)	($63,397)	($55,141)	($149,190)	$392,564	($2,872,240)	($3,240,695)	($3,304,092)	($3,359,233)	($3,508,423)	($3,115,859)
	Depreciation Expense	$235,173	$236,738	$234,266	$239,210	$239,431	$267,226	$1,714,023	$1,950,761	$2,185,027	$2,424,237	$2,663,668	$2,930,894
	Excess of Revenues Over Expenses and Depreciation Expense	$37,425	($131,717)	$170,869	$184,069	$90,241	$659,790	($1,158,217)	($1,289,934)	($1,119,065)	($934,996)	($844,755)	($184,965)
	Total Current Liabilities	$7,146,594	$6,922,098	$6,700,460	$7,295,133	$6,986,532	$9,021,517	$7,146,594	$6,922,098	$6,700,460	$7,295,133	$6,986,532	$9,021,517
	Total Long Term Debt	$524,837	$513,744	$478,241	$467,411	$456,288	$445,778	$524,837	$513,744	$478,241	$467,411	$456,288	$445,778
	Total Current Liabilities and Total Long Term Debt	$7,671,431	$7,435,842	$7,178,700	$7,762,544	$7,442,820	$9,467,295	$7,671,431	$7,435,842	$7,178,700	$7,762,544	$7,442,820	$9,467,295
4	**Times Interest Earned**	**0.6**	**(0.4)**	**1.4**	**1.4**	**0.8**	**6.2**	**(0.5)**	**(0.5)**	**(0.3)**	**(0.1)**	**(0.0)**	**0.5**
5	**Debt Service Coverage Ratio**	**1.14**	**0.24**	**1.71**	**1.90**	**1.41**	**4.21**	**0.07**	**0.09**	**0.28**	**0.43**	**0.52**	**0.83**
	Excess Revenues over Expenses	($197,748)	($368,455)	($63,397)	($55,141)	($149,190)	$392,564	($2,872,240)	($3,240,695)	($3,304,092)	($3,359,233)	($3,508,423)	($3,115,859)
	Interest Expense	$179,836	$178,095	$183,771	$180,638	$182,856	$182,343	$1,254,906	$1,433,001	$1,616,772	$1,797,410	$1,980,266	$2,162,609
	Depreciation and Amortization Expense	$235,173	$236,738	$234,266	$239,210	$239,431	$267,226	$1,714,023	$1,950,761	$2,185,027	$2,424,237	$2,663,668	$2,930,894
	Principal Payments	$10,676	$18,740	$23,021	$10,829	$11,124	$17,686	$138,172	$156,912	$179,933	$190,762	$201,886	$219,572
6	**Equity Financing Ratio**	**(11.5)**	**(13.2)**	**(13.6)**	**(13.6)**	**(14.5)**	**(12.6)**	**(11.5)**	**(13.2)**	**(13.6)**	**(13.6)**	**(14.5)**	**(12.6)**
	Total Net Assets	($2,872,240)	($3,240,695)	($3,304,092)	($3,359,233)	($3,508,423)	($3,115,859)	($2,872,240)	($3,240,695)	($3,304,092)	($3,359,233)	($3,508,423)	($3,115,859)
	Total Assets	$24,871,148	$24,523,819	$24,242,243	$24,630,841	$24,236,389	$24,682,109	$24,871,148	$24,523,819	$24,242,243	$24,630,841	$24,236,389	$24,682,109
D.	**Additional Statistics**												
1	**Income from Operations**	**-$311,375**	**-$486,043**	**-$156,768**	**-$173,254**	**-$274,097**	**$686,831**	**-$3,646,972**	**-$4,133,015**	**-$4,289,783**	**-$4,463,037**	**-$4,737,134**	**-$4,050,303**
2	**Revenue Over/(Under) Expense**	**-$197,748**	**-$368,455**	**-$63,397**	**-$55,141**	**-$149,190**	**$392,564**	**-$2,872,240**	**-$3,240,695**	**-$3,304,092**	**-$3,359,233**	**-$3,508,423**	**-$3,115,859**
3	**EBITDA**	**$103,634**	**-$71,210**	**$261,269**	**$246,594**	**$148,190**	**$1,136,400**	**-$678,043**	**-$749,253**	**-$487,984**	**-$241,390**	**-$93,200**	**$1,043,200**
4	**Cash from Operations**	**$5,957,007**	**$5,208,157**	**$5,560,291**	**$4,928,006**	**$4,883,110**	**$5,239,344**	**$5,957,007**	**$5,208,157**	**$5,560,291**	**$4,928,006**	**$4,883,110**	**$5,239,344**
5	**Cash and Cash Equivalents**	**-$80,010**	**$154,797**	**$161,436**	**$1,262,686**	**$264,212**	**$1,037**	**-$80,010**	**$154,797**	**$161,436**	**$1,262,686**	**$264,212**	**$1,037**
6	**Net Working Capital**	**$4,472,594**	**$4,431,740**	**$4,578,975**	**$4,294,252**	**$4,000,821**	**$2,464,879**	**$4,472,594**	**$4,431,740**	**$4,578,975**	**$4,294,252**	**$4,000,821**	**$2,464,879**
7	**Unrestricted Assets**	**-$2,872,240**	**-$3,240,695**	**-$3,304,092**	**-$3,359,233**	**-$3,508,423**	**-$3,115,859**	**-$2,872,240**	**-$3,240,695**	**-$3,304,092**	**-$3,359,233**	**-$3,508,423**	**-$3,115,859**
8	**Credit Ratings (S&P, FITCH, and Moody's)**												

Eastern Connecticut Health Network
71 Haynes Street
Manchester, CT 06040
860.533.3414
www.echn.org

December 22, 2017

VIA FEDEX AND EMAIL DELIVERY

Gary Hawes, Assistant Attorney General
Office of the Attorney General
55 Elm Street
P.O. Box 120
Hartford, CT 06141-0120

Steve W. Lazarus, Associate Healthcare Analyst
Office of Health Care Access, Department of Public Health
410 Capitol Avenue
Hartford, CT 06134

Re: Docket No. OAG 15-486-01

Dear Mr. Hawes and Mr. Lazarus:

As required by Condition #4 of the Office of the Attorney General's Final Decision in Docket NO. OAG 15-486-01, Prospect ECHN, Inc. and Legacy ECHN, Inc. respectfully submit the final closing statement agreed upon by the parties as required in the Asset Purchase Agreement dated August 24, 2016.

Please contact Michael Veillette, Chief Financial Officer of Prospect ECHN, Inc. by phone at (860) 533-3404 or via email at mveillette@echn.org if you have any questions or require any additional information.

Very truly yours,

Robert Schwartz, M.D.
President, Legacy ECHN, Inc.

Samuel S. Lee
Chief Executive Office, Prospect Medical Holdings, Inc.

cc: Kimberly Martone, Director of Operations, Department of Public Health Division of Office of Health Care Access
Kevin Hansted, Staff Attorney, Department of Public Health Division of Office of Health Care Access
Perry Zinn Rowthorn, Deputy Attorney General, Office of the Attorney General
Henry Salton, Assistant Attorney General, Office of the Attorney General
Rebecca Matthews, Wiggin and Dana LLP
Joyce Tichy, Eastern Connecticut Health Network, Inc.

Eastern Connecticut Health Network
Final Closing Statement Pursuant to Section 2.05(h)
7/25/2017

I. Net Working Capital True-Up Section 2.05(h)(i)

	Final NWC
Balance Sheet	
Current Assets:	
A/R net	$ 31,004,505
GME (IME/DME) Receivable	$ 89,379
Inventory	$ 5,584,352
Prepaid and Other	$ 3,462,351
Total Current Assets	$ 40,140,587
Current Liabilities	
A/P and Accrued Exp	$ 28,692,014
State Provider Tax	$ 3,092,624
Credit Balances Payable	$ 1,490,617
Other current liabilities	$ 4,326,822
Total Current Liabilities	$ 37,602,077
Exclusions / Adjustments to NWC	
CHIC related Assets and Liabilities	$ 1,687,009
Workers' Compensation Liabilities	$ 569,462
Medical Staff Funds	$ 107,212
Woodlake Resident Trust Fund	$ 40,032
Foundation & Legacy related assets and liabilities	$ (448,297)
Total Adjustments	$ 1,955,418
Final NWC	$ 4,493,928
Target NWC	$ 24,000,000
Final NWC shortfall	$ 19,506,072
Deduction For Estimated NWC Shortfall at Closing	$ 9,281,000
Amount due to (from) Prospect for NWC Shortfall	**$ 10,225,072**

II. Unfunded Pension Liability True-Up Section 2.05(h)(ii) & (v)

Deduction for Pension Liability and Post Retiree Health Plan at Closing	$ 67,800,000
Final Pension Liability and Post Reitree Health Plan	$ 66,901,822
Amount due to (from) Prospect	**$ (898,178)**

III. CHIC Liability and Workers' Comp Liability True-up Section 2.05(iii)

Total Deduction for CHIC Liability and Workers' Compensation Liability at Close	$ 3,336,000
Final CHIC Net Liability	$ 6,832,303
Final Workers' Compensation Net Liability	$ 2,013,157
Total CHIC and Workers' Compensation Liability	$ 8,845,460
Amount Due to (from) Prospect	**$ 5,509,460**
Total Due to (from) Prospect	**$ 14,836,354**

IV. Reduction in Capital Commitment

Reduction in Capital Expenditure Commitment Due to Additional Cash Paid At Closing	$ 12,736,634
Additional Cash PMH Received from ECHN Post Closing available on 9/30/16	$ (455,978)
Additional Reduction in Capital Expenditure Commitment Due to Final Closing Statement	$ 14,836,354
Total Deduction to Capital Expenditure Commitment	**$ 27,117,010**

V. Capital Expenditure Commitement

Capital Expenditure Commitment per APA	$ 75,000,000
Reduction in Capital Expenditure Commitment per APA	$ (27,117,010)
Total Capital Expenditure Commitment Remaning under APA due to adjustment under the APA	**$ 47,882,990**

User, OHCA

From: Roberts, Karen
Sent: Wednesday, January 31, 2018 3:14 PM
To: User, OHCA
Cc: Cotto, Carmen
Subject: FW: Prospect ECHN Docket Number 15-32016_Compliance Material Submission and Condition #16

From: Cotto, Carmen
Sent: Wednesday, January 31, 2018 2:52 PM
To: 'colleen713.smith@gmail.com'<colleen713.smith@gmail.com>
Cc: Martone, Kim <Kimberly.Martone@ct.gov>; Roberts, Karen <Karen.Roberts@ct.gov>
Subject: Prospect ECHN Docket Number 15-32016_Compliance Material Submission and Condition #16

Dear Colleen:

Please address the following in reference to Docket number 15-32016-486:

1) OHCA is requesting that all compliance filings from the hospital staff, first go to you, as the Independent Monitor ("IM"), and then you file the material with OHCA. This will provide OHCA with verification that you have reviewed the material to determine compliance to the order prior to OHCA's review of the material. The submission of compliance documents by the hospitals' staff directly to OHCA and only copied to you does not allow OHCA to clearly identify the IM's involvement in the process of reviewing and submitting the documents.

2) Condition #16 stipulates that the IM is "*…to be responsible for monitoring the Applicants' compliance with the Conditions set forth in this Order*". The IM is required to look at the material filed and verify compliance for each condition. OHCA's records show that no reports have been filed regarding this task. Please submit to OHCA a report of your review of Prospect's ECHN material to date that verifies compliance for each of the conditions set forth in the Order. In terms of how this report could be formatted, OHCA suggests to refer back to the IM's work plan documents submitted to OHCA on December 16, 2016 which lists all of the conditions and actions that will be taking place then add a column to this document describing the IM's observations on how compliance for each of the conditions listed has been met. After this catch up IM report, please file this on a semi-annual basis through the end of the IM contractual period.

It is also requested that you submit your responses via electronic mail by using the OHCA general email inbox which is OHCA@ct.gov. In addition, please continue to reference the CON docket number in the subject line of the email when transmitting.

You may contact me at (860) 418-7039 or Karen Roberts, Principal Health Analyst at (860) 418-7041, if you have any questions regarding this request.

Sincerely,
Carmen

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov



www.ct.gov/dph

User, OHCA

From: Roberts, Karen
Sent: Friday, February 09, 2018 8:38 AM
To: User, OHCA
Cc: Cotto, Carmen
Subject: FW: Third IM On Site Assessments
Attachments: ECHN Cover letter for third visit assessment 2.8.18.docx; ATT00001.htm; third Assessment MMH CS 2.8.18 final.docx; ATT00002.htm; third Assessment RGH CS 2.8.18.docx; ATT00003.htm

Follow Up Flag: Follow up
Flag Status: Completed

From: Martone, Kim
Sent: Thursday, February 8, 2018 2:17 PM
To: Roberts, Karen <Karen.Roberts@ct.gov>; Cotto, Carmen <Carmen.Cotto@ct.gov>; Clarke, Ormand <Ormand.Clarke@ct.gov>
Subject: FW: Third IM On Site Assessments

Kimberly R. Martone
Director of Operations, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134
Phone: 860-418-7029 Fax: 860-418-7053
Email: Kimberly.Martone@ct.gov Website: www.ct.gov/ohca

From: Colleen Smith [mailto:colleen713.smith@gmail.com]
Sent: Thursday, February 08, 2018 2:05 PM
To: Newton, Susan; Martone, Kim; Dennis P Mcconville; Michael Collins; Powers, Mary; kdavis@echn.org; Karen Nefores; Debbie Berry
Subject: Third IM On Site Assessments

Dear Colleagues,

Attached please find a cover letter and the two reports I developed following my on site visits to MMH and RGH last week. Please do not hesitate to communicate any questions or concerns.

Respectfully,

Colleen Smith
Independent Monitor

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THIRD VISIT ASSESSMENT – PROSPECT ECHN, Inc.

JANUARY 30-FEBUARY 1, 2018
Colleen O. Smith, MSN, RN, NEA-BC

OVERVIEW

The enclosed reports summarize my third visits to MMH and RGH campuses during the last week of January. The principle focus of this visit is to follow up on all of my recommendations from the previous visits as well as note any new accomplishments, capital improvements, progress to date on quality initiatives, and identify any new areas of concern. I concentrated my visit agenda for the 3 days on all of the inpatient clinical areas only as I had not found any areas of concern in the outpatient services during my initial visit in late January 2017.

Several executive position changes have occurred since my last visit in June 2017. The Interim CEO, Michael Collins, has been made the permanent CEO. The VP for Quality and Patient Safety has been promoted to the PMH corporate quality position. Kathleen Davis RN has just filled this position. She was able to accompany me on all of my rounds. And a new position of COO has been added and filled by an administrator from Bridgeport Hospital. I attended the Advisory Board meeting where volume metrics and quality reports were reviewed. Substantial improvements in infrastructure, cosmetic upgrades and additional equipment have been procured in the last 6 months. Another 3M of capital has been approved thus far with additional approvals pending. The Adult Behavioral Health Unit has been moved to the RGH campus and the Eating Disorders Unit at RGH has greatly increased their patient census. A small Geri-Psych unit has been established on the MMH campus.

The organization continues to utilize their high reliability practices that are incorporated into all patient care. ECHN continues to conduct the daily Safety Huddles and Quality/Patient Safety meetings are started with a “Good Catch” safety story.

Regular Quality/Patient Safety conference calls are held with Prospect Medial Holdings. This is their opportunity to report out their quality data and also share practices/approaches that are working well. Wide participation is expected and received from member organizations. Overall, both hospitals are experiencing challenges with ED Throughput, ED and Inpatient Satisfaction, and all cause readmission rates and for select diagnoses. Performance Improvement committees are in place to work on these processes. The COO and CNO are now chairing a

special committee aimed to improve ED throughput. Overall, both hospitals are doing quite well in the area of Patient Safety outcomes. Hand Hygiene compliance is trending up.

Facilities on both campuses are receiving much needed cosmetic renovations and plant updates. Staff and leaders are able to describe recent capitol acquisitions that have improved their daily workday. Additional surgical equipment has been purchased as well as OMNICELL for the Patient Care areas.

Methods and Processes Used for Analysis

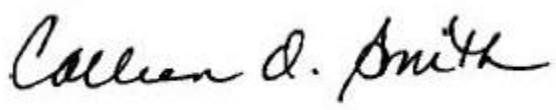
Processes utilized to conduct this on site review include:

1. Face to face meetings with the CNO, the VP for Quality/Patient Safety, VP for HR, the CMO, and the Director of Risk Management.
2. Tours of all Inpatient Clinical Services outlined in the Consent Decree. Outpatient services were not revisited, as stated above. The IM spoke with the leaders of all areas visited and several direct care staff members in the clinical areas, such as RNs, CNAs, pharmacists, secretaries, and other ancillary employees.
3. Review of Quality/Performance Improvement minutes, the annual Quality Plan, and the 2018 quality and safety goals. IM reviewed the quality dashboards for calendar year 2017.
4. Meeting with the chairs of the Nursing Unit Based Council and Nurse Managers to discuss their initiatives and outcomes.
5. Attendance at the Advisory Board meeting for review of Quality Indicators and special reports. IM shared several perceptions of her time spent on the clinical units.
6. Random checks on Code/Defibrillator carts, medication refrigerators and glucometers.

Approach to Assessment

The following report is organized by: Service Visited, Observations and Recommendations

Under each Service please find categories of comments that are pertinent to each service visited. Thank you for this opportunity to engage with Prospect ECHN to assist in assuring quality of care to all patient populations of the Greater Manchester and Rockville communities.



Colleen O. Smith, MSN, RN, NEA-BC
Independent Monitor, Nursing Consulting Partners

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THIRD ASSESSMENT: PROSPECT Manchester Memorial Hospital COLLEEN O. SMITH MSN, RN, NEA-BC JANUARY 30- FEBUARY 1 2018		
CATEGORY	**OBSERVATIONS**	**RECOMMENDATIONS**
NURSING SERVICES – MMH-3 North, Critical Care, 2 East, 1 East, OB/NICU		
• Staffing	RN and CNA patient care assignments and nurse/patient ratios were assessed on every patient care unit and found to meet standards. M/S Nurses generally had a 1:5 pt. ratio and 4:1 on the Telemetry unit. 3 North, primarily a surgical unit had 12 patients with 4 RNs and 3 CNAs. They are working on being designated a Center of Excellence for Bariatrics. CNAs are doing hourly bedside rounding and have seen a reduction in patient falls and call lights. Their last CAUTI was 3 months ago and they have an action plan in place to prevent further events. They use a nurse driven protocol for foley removal. CCU had a census of 14 with 7 RNs on duty and 2 RN orientees. They have experienced a 50% vacancy rate and the Nurse Manager has been busy filling positions. Vacancy rate is expected to decrease to 25% once the nurses are hired. On 2 East the census was 26 and they had 5 RNs and 4 CNAs on duty. Their ADC increased on this unit and they were able to add an additional RN to their staffing matrix. 1 East (cardiac and observation) had a census of 16 with 4 RNs on Day shift. The CNAs had assignments of 8 pts. Many Certified Nurses aides are cross-trained as unit secretaries to aid in staffing flexibility. The Monitor tech was watching approximately 32 monitors and stated she got regular breaks and as needed. Staffing in the Family Birthing Center and NICU was appropriate. Family Birthing Center follows the AWHONN Perinatal Nursing guidelines, 4th edition 2014. The ADC in the NICU is 2-3 and 3 RNs are always on duty. They are cross-trained to care for the mother/baby couplets. IM spoke with nurses on various units about adequacy of staffing. Nurses voiced their reliance on float pool to augment staffing when needed for sick calls and LOAs. They are very pleased with how the float pool is working. In addition to the Float Pool, several per diem nurses joined ECHN. They have been used to aid staffing the Oncology unit and Medical/Surgical units. Many new per diem nurses have been deployed to the Eating Disorders unit on the RGH campus as well as Behavioral Health and the EDs. The CNO	Recommend toilet supports on all patient bathroom toilets to support the bariatric population. Staff currently using bariatric commodes at bedside for select patients.

CATEGORY	OBSERVATIONS	RECOMMENDATIONS
	mentioned that some additional voluntary cross training among RN staff has occurred and this has been quite successful and effective. Patient Care Technicians, cardiac secretaries, and OR scrub techs have also been added to the Float pool.	

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CATEGORY	OBSERVATIONS	RECOMMENDATIONS
NURSING SERVICES		
• Physical Environment	Nursing units were clean and hallways free of clutter. A new cleaning service has been hired and they are doing an excellent job with keeping floors polished. Appropriate signage regarding pt.'s rights and responsibilities, financial counseling assistance, and help for hearing impaired and those who speak a different language were posted in all pt. care areas. Capacity on M/S units range from 23 beds to 32 with a mix of private and semi private rooms. White boards for assignments are visible at all nursing stations. In CCU the white board was very organized and comprehensive. It included: Braden scores, central lines, and restraints and foley catheters. **Critical Care** was built in 2008 and has a North and South side with 12 and 10 beds respectively. The unit is well lit with north and south nursing stations, many areas for electronic charting and good pt. visibility. Every pt. room can handle dialysis and 4 rooms are negative pressure. Anterooms were an ample size and laid out well. Medication rooms all locked by keypad. Med rooms were small but adequate and offered a quiet environment for medication preparation. The temperatures of the medication refrigerators are remotely monitored by a central system. The temp logs were consistently filled in and up to date by nursing personnel. **The Family Birthing Center** has 12 LDRPs, 2 ORs and a Level 3 NICU. The unit is pleasant. A new OB group has joined ECHN. There are plans to add another 5-6 beds due to increased volume from 1200 to 1500 births/yr. The unit will be undergoing a major 2.7M renovation this year.	

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CATEGORY	OBSERVATIONS	RECOMMENDATIONS
NURSING SERVICES		
• Culture of Safety	Nurses are not yet doing hourly rounds consistently at MMH in all units although some units have begun this practice (CCU, Med/Onc). Many units do conduct bedside change of shift report. CNAs conduct hourly rounds on 3 North and have seen improved patient outcomes. Quality boards have been updated and all units have them in prominent locations. Nurses report a collaborative relationship with hospitalists. Nursing units collect Nurse Sensitive Indicators: Falls, Falls with Injury, HAPUs through NDNQI and CLABSIs, and CAUTIs through NHSN. There is a good Fall Prevention Program in place. Fall risk signage was recently updated and consistently visible outside of patient rooms. Multidisciplinary pt. care rounds occur daily. Hospitalists, nurses, SW, Case Management participate. Nurse driven Care Rounds occur @ 11:15am everyday on 2 East (Med/Onc) and the Nurse Navigator from the Cancer Center joins these rounds. They had a Fall with Injury in 12/17 with 5 Falls occurring in January. “Days since last Fall” is prominently highlighted on their white board across form nurses station. Many interventions are in place to eliminate Falls. Hospitalists and nurses have a very collaborative relationship. Nurses suggest interventions and state that physicians listen to their assessments. Certified Wound Care (WCC) nurses are on each pt. care unit. They assist with skin assessment and early identification and intervention to prevent pressure ulcers. They are role models and educators for nursing staff. A WOCN nurse oversees this function. HAPU rates are very low.	**Recommend** conducting bedside rounds on all units across both campuses. Recommend disseminating unit level Hand Hygiene results to all units.

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CATEGORY	OBSERVATIONS	RECOMMENDATIONS
NURSING SERVICES		
• Culture of Safety	The **CCU** is an "open" unit meaning hospitalists and private attending physicians can admit into the unit. However, all vented pts. in the CCU are seen by the Intensivists who manage their pulmonary care. Respiratory therapists assist with changing ventilator settings per weaning protocols. The CAUTI rate in Critical Care has been zero since December 2015 and there have been no falls with injury since October 2016. In May 2017 there was one CLABSI that met criteria for reporting. In the **Family Birthing Center**, all nurses have completed the GNOSIS training program and the physicians are also complete with the same training. Clinicians were pre tested and then took a posttest after program completion. There is a multidisciplinary Departmental Quality Meeting where many Quality Indicators are reviewed as well as any adverse events. Mock Code, Dystocia and Emergency Postpartum Hemorrhage drills are held on a regular basis. All PP Hemorrhage training will be completed by 3/18. Nurse Manager relayed a "Great Save" that occurred after the GNOSIS education. It resulted in a stat caesarean section after an RN correctly interpreted a fetal monitoring strip. Blue emergency buttons are in every pt. room on OB so that nurses can summon immediate help. It is policy that all post partum pts. Are assisted by 2 nurses for their first time out of bed after a delivery. There have been no pt. falls or infant descents on the OB unit. 2 nurses certified in lactation are on everyday. The breastfeeding rate on D/C has increased from in the 70s to greater that 90% in the last 2 mos. Nurses do all they can to encourage breastfeeding while being culturally sensitive to patient's wishes and accommodating their birth plan. On 1/31/2018 IM met with the chairs of the Unit Based Councils and the Nurse Managers on both RGH and MMH campuses. IM conducted a roundtable with all UBC chairs to discuss the new innovations and practices that they were implementing on their units through their	The FBC unit practice council is looking at the use of Nitrous Oxide during labor. Consider starting a research study on Nitrous Oxide's effect on reducing laboring patient's anxiety levels. IM suggests continuing the great work of the Shared Governance Councils: developing and implementing a standardized agenda for meetings, educating the scribes on how to take precise minutes and revising the form used to better capture action items, responsible person (s) and due date.

CATEGORY	OBSERVATIONS	RECOMMENDATIONS
	council engagement. Every unit reported on their initiatives such as improving Patient Satisfaction scores, decreasing falls, getting a bladder scanner for their area and implementing bedside rounds. Their excitement and pride in their work was obvious. IM suggested that they summarize all the UBC practice changes semiannually and disseminate to all staff.	
• Compliance with State & Federal Regulations	IM randomly checked Glucometer strips and solutions for appropriate dating. Code and Defib carts randomly checked in all areas. All had been checked with RN signature and up to date. Medication refrigerators were also checked and all were in compliance. The staffing committee met on September 21 2017 to review all nurse staffing plans, review travel nurses, float pool and per diem needs etc. IM reviewed these minutes. It is chaired by the CNO. Staff Nurses comprise the majority of the membership who voice their suggestions regarding adjustments in staffing plans.	Recommend using a fine point "sharpie" marker for marking these containers so dates are more legible.
NURSING SERVICES		
• HR / Personnel	Much of the staff is fairly long tenured. IM spoke with nurses who had practiced at for 35+ years. Certified nurse are recognized and celebrated with a certification bonus but only a small percentage of Nursing staff is currently certified in their practice specialty. There seems to be growing enthusiasm among some nursing staff however. On 2 East 5 nurses are OCN certified. ECHN is starting on the Pathway to Excellence. Shared governance with unit-based councils has begun. Some units are further a long with their councils than others. These professional development pursuits are being discussed within the councils. **FBC** Very few staff nurses on OB are certified. There is a Lactation Consultant on OB and several additional nurses who have special training in lactation. They cover the unit 7days/wk. The OB Educator is PhD prepared. IM encouraged her to begin some research on the unit. There is no Social Work coverage on the W/E and holidays which is concerning to staff.	IM encourages Nurse Leaders to collaborate with staff to set unit goals for specialty certification. ECHN has established baseline data of all currently certified nurses. IM encourages that the aggregate list be broken down by unit so that each unit can see their unit certification rate and set goals towards increasing their numbers. Nurses should also be encouraged to join their professional specialty organizations. Strong consideration should be given to assuring a MSW is on call during W/E and holidays.

CATEGORY	OBSERVATIONS	RECOMMENDATIONS
	HUMAN RESOURCE- IM met with the VP for HR. IM reviewed the new Self Assessment and Goal Planning forms that are utilized for all licensed professional staff at the time of their periodic Performance Management Appraisal. The relevant employees are complying with this process but need to be educated regarding development of SMART goals. IM reviewed results of the 2017 employee engagement survey. 1372 responses were received. IM reviewed the Action Plans that were developed to address the highest priority employee issues. One of the issues needing improvement was communication about strategic direction and plans for the organization. An area with high scores was in the category of Pride and Commitment and "I have an Effective Supervisor". Overall the survey results were quite positive and the highest with the PMH system. Current vacancy rate is 6.9% all employee turnover rate is 15.32%. RN turnover is 15.15%	**Recommend** developing an education module on Healthstream regarding how to develop SMART goals to assist staff in developing appropriate professional goals.
NURSING SERVICES		
• Confidentiality	IM did not witness any breaches of confidentiality during the third visit. Computer screens were not left up without staff in attendance.	
• Cultural Sensitivity	Language line utilized by staff for patients of different ethnic cultures. Bariatric equipment and furniture was present in waiting rooms and pt. care areas. Additional bariatric furniture has been purchased and delivered.	
INFECTION CONTROL		
• Staffing	1.5 FTEs cover both MMH and RGH campuses. 1.0 FTE is an RN with 20 yrs. experience. She is a member of APIC and holds certification. She provides monthly orientation for all new employees. The other member of the Dept. is 20 hrs. and has a microbiology background and a graduate degree in Public Health. The Medical Director of the program is an Infectious Disease physician who has been with the hospital 35+ yrs. This physician also runs a busy HIV Clinic	

CATEGORY	OBSERVATIONS	RECOMMENDATIONS
• Culture of Safety	A vigorous hand washing campaign is underway. Overall Hand Hygiene compliance rates have increased and continue a positive trend line. IM did not observe any lapses in hand hygiene. A strong antibiotic stewardship program has been in place since the 1980's. Staff round on inpt units 3x/wk. IP staff communicate with Microbiology several days/wk. All isolation cases are reviewed on a daily basis. IP staff state that nurses do a very good job of placing pts. on isolation precautions and D/C precautions at the appropriate time. The Infection Prevention dept. has an IP Hotline.	**Recommend** disseminating unit level results to all practice areas so staff is aware of their unit's specific HH compliance rates.
INFECTION CONTROL		
• Culture of Safety	There is consistent follow up by surgeon offices on SSI following surgery. IP staff and Medical Director state there is very with good communication with surgeon offices. The Infection Control liaison group has been able to conduct more frequent observations of hand washing. House Nursing Supervisors and other Department Heads are now also conducting HH observations of staff. C difficile rates are under the NHSN benchmark. Much work has been accomplished to bring SSI rates down below benchmark. There is a subcommittee of the Infection Prevention Committee that is focused on Hospital Acquired Infections.	Consider the value in changing H.H. observations to include the rate going into the room and the rate coming out of the room as two different rates to obtain an even more accurate picture of compliance. .
• Policies and Procedures	IM observed appropriate isolation techniques in many different pt. care	

CATEGORY	OBSERVATIONS	RECOMMENDATIONS
	units. Signage outside of rooms and appropriate attire in isolation carts.	
• Compliance with State & Federal Regulations	Good surveillance program in place. Infection Prevention Committee meets monthly. Attendance by appropriate departments is usually good. IM reviewed recent IP committee minutes and there was evidence of surgical representation. Pharmacy, Microbiology and environmental, nursing representation have consistent representation.	**C**onsistent representation by a surgeon at Infection Prevention committee had started in May 2017.

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CATEGORY	OBSERVATIONS	RECOMMENDATIONS
PHARMACY		
• Staffing	There have been staffing reductions in the Pharmacy Dept. since last visit in January 2017. There has been a decrease of 2.1 Pharmacist FTEs. There is no longer a Clinical Coordinator or IT Pharmacist. Their workloads have been redistributed. The dept. uses a decentralized staffing model whereby one clinical pharmacist is assigned to cover groupings of pt. care units. The staffing pattern decreases to 1 pharmacist on evening 3-11:30pm shift at MMH. One pharmacist has been reassigned to night shift Sunday through Thursday. With the addition of a night pharmacist, nighttime drug "overrides" by nursing supervisors have decreased. IM spoke with a Pharmacist who recently completed a night shift and reported that the workload is very manageable and stated that additional Performance Improvement activities could be accomplished on the night shift on most nights. There is no on site pharmacist on Friday and Saturday nights. All new urgent orders are reviewed by the on call pharmacist remotely on those 2 nights. There is no longer a Pharmacy tech assigned to the ED to assist with collecting accurate medication histories. The Director reports that Adverse Drug Events have **not** increased post staff reductions.	The recommendation to add a pharmacist to the nighttime staffing plan has been completed. One pharmacist covers both hospitals 5 days/wk. Sunday thru Friday.
• Physical Environment	The Pharmacy at MMH has been relocated to the basement level of the hospital to gain more space. Even in the newer location, the pharmacy is crowded. Plain IV solutions are stored in an adjacent space to the main Pharmacy due to space constraints. Currently, there are plans to have plain IV solutions maintained by the Materials Management Dept. The hospital transitioned from Pyxis and Care Fusion to Omnicell as part of the Prospect acquisition. This change occurred during Sept/Oct of 2017. While there were some initial manufacturing issues with drawers not opening and paper jamming, these issues have been worked through. Overall staff seems pleased with them.	

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CATEGORY	OBSERVATIONS	RECOMMENDATIONS
PHARMACY		
• Culture of Safety	Automated dispensing system and DOSE-EDGE systems in place. All medications coming into department are scanned in and barcoded. The hospitals use SMART pumps with an extensive medication library. Med library use by RNs is monitored by the pharmacy. Pharmacists make 300-400 Clinical Interventions per month. Fill errors are consistently tracked with nursing usually doing the reporting. The Director consistently disseminates any errors and near misses to the pharmacy staff. ADEs go to the Medication Safety committee for discussion and action planning. No specific trends in errors have been noted. Staff does report drug errors at the daily Safety Huddles and all errors are followed up. They are entered into the Incident Reporting system. The review of "Rescue" or "Trigger" drugs such as Narcan has not been completed in recent months. IM and CNO discussed resuming that practice and giving that responsibility to the pharmacist on nights.	Resume routine review of Trigger Drugs.
• Compliance with State & Federal Regulations	A Pharmacy and Therapeutics Committee meets monthly and reports into the QAPI. All Adverse Drug Events are reviewed within the Medication Safety Subcommittee. A strong Antibiotic Stewardship program is in place. Pharmacists have oversight for Renal dosing adjustments and Vancomycin dosing and utilization.	

CATEGORY	OBSERVATIONS	RECOMMENDATIONS
• HR / Personnel	Pharmacy staff seems to remain in a state of transition as they try to adjust to their workloads. The Omnicell conversion and dealing with daily drug shortages have put additional strain on the department.	
SURGICAL SERVICES Ambulatory Surg Unit, Ambulatory Med Unit, GI, Pre OP, OR, PACU Phase 1 & 2		
• Staffing	I.M. observed appropriate RN staffing ratios throughout the tour of Surgical Services. Nurses all take night and weekend call. They described their cross training requirements and the system they have in place to ensure ongoing competency in all services. Many more nurses and surgical techs are now working in both the MMH and RGH ORs which also adds to the staffing flexibility and reinforces their competencies. The ORs have a 0 vacancy rates for RNs and have a 20 hr. position currently open for a Surg. Tech. RN hours have been reduced through attrition in the GI area due to a decrease in volume. An RN FTE was converted to a 36 hr. CNA position based on need voiced by staff.	
• Physical Environment	**MMH** has 9 ORs and 1 Cysto room. Overall, spaces were well organized, clean and free of clutter. Emergency carts and equipment was easily accessible. The Day Surgery waiting room was quite pleasant and new flooring has been installed. Appropriate signage and an electronic tracking board were present. Only pt.'s initials were used and tracked by a code that was given to the pt.'s family. Much new surgical equipment has been ordered for the orthopedic and other services and is in use. This should decrease flash sterilization rates. Anesthesia is quite pleased with their new anesthesia machines.	

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CATEGORY	OBSERVATIONS	RECOMMENDATIONS
SURGICAL SERVICES Ambulatory Surg Unit, Ambulatory Med Unit, GI, Pre OP, OR, PACU Phase 1 & 2		
• Culture of Safety	IM toured unoccupied ORs and observed surgical personnel. Caps covered all hair, masks in place. In keeping with the Hand Hygiene initiative, random observations of scrubbing in the inner core have been initiated. Staff back injuries have been kept low due to the consistent use of hover mats on the OR tables. Nurses described the preventative measures that they take to assure no patient pressure ulcer injuries. Gel mattresses are added to the OR tables for all cases lasting greater than 2 hrs. In the Pre-Op area, IM observed an anesthesiologist obtaining consent for repair of a fractured ankle and a nurse prepping the patient for surgery. One performance improvement initiative that has been successful is decreasing the opening and closing of doors during a surgical procedure. Staff breaks have been revised to assist with this new requirement. Special care is taken to assure that all anticipated equipment and supplies are ready in the OR prior to case start. Many measures have been taken to keep the surgical site infection rates low like institution of CHG baths and no hair clipping in the OR.	
• Policies and Procedures	Emergency carts locked and checked according to standard. Performance improvement initiatives like “On Time First Case Starts” should be considered to improve operating efficiencies.	
SURGICAL SERVICES Ambulatory Surg Unit, Ambulatory Med Unit, GI, Pre OP, OR, PACU Phase 1 & 2, Interventional Radiology		
• Compliance with State & Federal Regulations	Medication refrigerators, food refrigs, blanket warmers are within safe range. Code and defib carts checked and up to date. All carts storing medications found locked. Appropriate dates of expiration placed on glucometer control solutions.	
• HR / Personnel	The OR Nurse Manager position has been eliminated. The Administrative Director has responsibility for all surgical services and central sterile. There is a nurse manager responsible for the GI Lab. Charge nurses in the OR report into her. 95% of the OR RN staff has attained AORN certification. They plan for turnover by preparing their	

CATEGORY	OBSERVATIONS	RECOMMENDATIONS
	own OR nurses. They run a perioperative course to teach new nurses. This program has been very effective. 5 Graduate nurses have been successful in completing through this course. In the PACU area, 80% of the RNs are certified. Nurses in the GI lab have not expressed interest in obtaining certification. The Unit Educator is responsible for education throughout surgical services on both the MMH and RGH campuses: PACUs, ORs, GI lab, Amb. Surgery and Central Sterile Processing. In-service education is provided every 2 weeks. The OPS area is proud of their new patient D/C teaching booklets. This was an idea generated by their unit based nursing council. Anesthesia is a contracted hospital service. They cover both hospital campuses and are always available at night. The group expressed satisfaction with the ECHN and staff enjoys a good relationship with the Anesthesiologists and CRNAs. Staffing and supervision of CRNAs is appropriate.	
• Confidentiality	Pt. Confidentiality was upheld throughout the tours through the various surgical services area.	

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CATEGORY	OBSERVATIONS	RECOMMENDATIONS
EMERGENCY DEPARTMENT		
• Staffing	Although the ED was quite full, the atmosphere was orderly and the staffing was appropriate. Census was 22 with 7 RNs and 3 techs on duty. Currently there is one night RN position open. In addition, there are 4 Float Pool nurses competent to work in the ED. They have developed a position of "Clinical Liaison" who augments the staffing by doing safety checks on patients. ED utilizes flexible staffing which changes according to time of day. They staff in 8, 10 and 12 hr. shifts. Additional staff is added very 4 hrs. to accommodate changing census. 8 nurses are in the ED from 11am-11pm for the peak volume hrs. Staffing flexes down to 5 RNs between 3-7am. ED nurses staff the Behavioral Health unit at MMH when it is open. It was not open during the IM's visit. A technician and Crisis Prevention staff assists them. Security personnel are in the ED at all times.	
• Physical Environment	The main ED has 19 beds and saw 38,000 pts. in 2017. Approximately 15% of those visits result in admission. Visit volume has not increased since last year. There is a Clinical Decision Unit adjacent to the main ED. The ED has an open design with a central station. Pts. are easily visualized. Waiting rooms are adequate and have appropriate signage: pt. privacy, language lines, financial counseling and assistance for the hearing impaired. Emergency carts are placed to allow easy access by staff. The environment is well organized and free of clutter. A separate 11-bed unit has been established for the Behavioral Health population. It was closed at the time of the IM visit.	
• HR/Personnel	In addition to the Nurse Manager, the EDs share a Unit Educator. 2-3 RNs are certified SANE nurses at MMH. All RNS have ACLS with the first year of hire. Staff in the BHU all has Physical Management Training (PMT). Crisis Intervention workers staff the BHU until 12 midnight. There are several mid level providers to assist the physicians in seeing appropriate acuity patients. The physicians are a contracted service. The Medical Director is partnering with staff and Administration to improve throughput times.	

CATEGORY	OBSERVATIONS	RECOMMENDATIONS
• Culture of Safety	MMH has earned "Get with the Gold" Advanced Stroke Certification again. All relevant performance indicators are at 100%. Congratulations! It is also part of a Sepsis Campaign. Psychiatrists see behavioral health patients admitted through ED within 24 hrs. of admission. Approximately 18% of the MMH ED pt. population is pediatric. Children needing admission are sent to CCMC. Several QI indicators are in place: Timeliness of Care for M/S patients in the last quarter of 2017 are: ED arrival to departure (355 min) Admit decision to ED departure (152 min), Arrival to provider seen (23 min.) While these performance improvement efficiency indicators have not yet met goal they have trended in a positive direction from last year. The Left without Being Seen rate has also decreased into the 1.3% range. The CNO and COO have partnered with the Emergency Medicine Medical director and nurse Manager to improve the throughput times and patient flow through the ED. The Medical director has changed his provider staffing pattern to better cover times of high volume. A new throughput committee for this purpose has been established.	
PSYCHIATRIC SERVICES – MMH in-patient Geri-Psych and Adolescent		
Staffing	The former nurse manager at MMH has been promoted to Nursing Director with inpatient responsibilities across both the MMH and RGH campuses. He is a seasoned Behavioral Health nurse leader with solid clinical experience. He recently promoted a nurse to the Nurse Manager position however this new Manager has resigned her position. This position will need to be replaced. A multidisciplinary team of professionals provides care for this pt. population: Psychiatrists, RNs, SW, psych technicians, recreational therapists. On the day of the IM visit, 1RN and 1 psych tech and 1 charge nurse were on duty for the 6 geri psych patients.	
• Physical Environment	The former Adult Behavioral Health unit has been moved to the RGH campus. A new Geri-Psych unit has just opened in early January 2017. Census is being kept to 6 patients at this time. It will have the capacity to take 16 patients in the future. IM observed solid, flush door handles on all pt. rooms. In common areas, regular door handles were still in	**Recommend** removing the metal nameplates on the doors of patients' rooms. They present a risk and are no longer utilized.

CATEGORY	OBSERVATIONS	RECOMMENDATIONS
	use. Pt. rooms had weighted low unmovable non-mechanical beds. Bathrooms were compliant with regulations: breakaway shower rods, polycarbonate mirrors, flush faucets, and angled doors. The seclusion room was closed until the DPH inspects and signs off on it. IM also toured the new adolescent unit. IM noted a broken panel over one of the fluorescent lights in the ceiling of the hallway. Engineering was contacted to replace it. Handrails that presented a ligature risk were also still intact along the main central hallway although a work order had been processed to remove them. IM suggested they be removed immediately and this was completed on 2/1/18.	
PSYCHIATRIC SERVICES In-patient Geri Psych and Adolescent		

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CATEGORY	OBSERVATIONS	RECOMMENDATIONS
PSYCHIATRIC SERVICES – MMH in-patient Geri Psych and Adolescent		
• Culture of Safety	Patients are rounded on every 15 minutes. There is a central monitor at the nursing station so that pts. are continually observed. Restraint/seclusion log checked by IM. Very low use. Multidisciplinary rounds occur daily for care planning purposes	Consider establishing a Low Sensory Modulation room on the Adolescent unit.
PSYCHIATRIC SERVICES In-patient Geri Psych and Adolescent		
• Policies and Procedures	All pts. are searched on admission and belongings are secured in locked metal lockers located at entrance to the unit. Valuables are secured in a safe. All visitors are searched prior to entering the unit.	
• Compliance with State & Federal Regulations	IM reviewed with the procedures that are in place to protect exit doors during a fire drill with the Nurse Manager. Drills are held periodically.	
• HR/ Personnel	The newly hired Medical Director has left his position and has not yet been replaced. A search is open. Staff is appropriately trained and credentialed to perform their jobs	
• Confidentiality	Appropriate measures in place to safeguard pt.'s confidentiality. IM did not observe any breaches in confidentially.	
QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT		
• Culture of Safety	In the area of Pt. Safety, the following structures and processes are in place: Daily Safety Huddles, Patient Safety committee, Patient Safety Coach committee, HRO education during orientation of new employees and physicians. A large variety of other committees and task forces exist to support Pt. Safety. There is a multidisciplinary SSI Task force that meets monthly. The last Colon SSI that occurred was October. One Hysterectomy SSI occurred during the summer 2017. Patient Safety Outcome measures are doing well. A Sepsis protocol was initiated on 2/14/2017. Aggressive plans are underway to decrease Hospital Acquired Infections. SSI colon and hysterectomy infection rates and c. difficile are all currently above the CMS 50th %ile. Readmission rates hospital wide are over benchmark for 3rd quarter 2017. This is increased from May 2016 but just slightly over benchmark. Aggressive attention needs to paid reduce CHF, Pneumonia, COPD and AMI readmission rates which are trending well	

CATEGORY	OBSERVATIONS	RECOMMENDATIONS
	above the national mean. Quality department nurses stated that the Care Transitions nurses have been eliminated. Alternative processes are being developed to help decrease readmissions. There is a Multidisciplinary Readmissions Committee that meets monthly and reviews all readmissions and develops actions to address. Action plans are initiated for all QI indicators that do not meet goal. The 2018 Quality Assurance and Performance Improvement Plan was approved by the Advisory Board at its meeting on 1/31/18 as were the Action Plan and Goals for 2018. An Ethics committee, chaired by a newly hired chaplain will begin meeting this month.	IM encourages the initiation of Schwartz rounds to help support caregiving staff once the Ethics committee is established.
QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT		
• Staffing	The Quality Department is comprised of 4.5 FTEs who report into the VP of Quality, Safety and Pt. Experience. They are responsible for all performance improvement initiatives across both hospitals and out patient services. There are 3 QI Managers who are supported by an Environmental Safety Officer. A Quality Analytics Manager (0.5FTE) report directly into the VP. Two Data Abstractors (1.4 FTEs) report into the Quality Analytics Manager (0.5FTEs). The QI managers have focused areas of responsibility. All conduct RCAs and investigate. Staffing in this department has remained stable since the PMH acquisition.	
RISK MANAGEMENT		
	IM met on January 31, 2018 with Director of Risk Management for ECHN. We discussed the results of the external risk analysis of the Family Birthing Center at MMH that was completed in December by RL Solutions. Director reported that Prospect Medical has voiced plans to use this firm for their other high-risk areas including Behavioral Health and the ED and the surgical services at RGH. The RM Director has collaborative relationships with Quality, Nursing, and Medical Staff. She is pleased with the appointment of a new chair of the OB/GYN department and feels that the culture is improving. An additional FTE	

CATEGORY	OBSERVATIONS	RECOMMENDATIONS
	has been added to RM as a result of adding coverage of medical groups. States nurses report issues more quickly since the initiation of the high reliability practices. RM collaborates closely with the CMO, CNO and Chair of the Environment of Care Committee. In addition to the Director of Risk Management, IM met with the CMO who has been in her position for about 6 months. She has revamped the medical staff peer review process so that cases are reviewed by a group of multiple physicians from a variety of specialty backgrounds. She feels this approach reduces any possible bias. She is also continuing her work on the Aging Physician. She has drafted a new policy that will go before the Medical Executive committee in the near future. The CMO has also created a Physician Health and Wellness committee. Her efforts to improve clinical quality are to be recognized! Since the IM's last visit a new chair of the OB Dept. has been appointed. This physician has tightened criteria on the types of patients the midwives can care for. She has also stipulated that all patients in labor must have an obstetrical provider present in the physical building.	

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THIRD ASSESSMENT: Rockville General Hospital COLLEEN O. SMITH MSN, RN, NEA-BC February 1 2018		
CATEGORY	**OBSERVATIONS**	**RECOMMENDATIONS**
NURSING SERVICES –RGH Bissell 2, ICU		
• Staffing	Hospital Census at RGH on the day of the IM visit had increased from the last visit (35) to approximately 65. Nurses on the Bissell 2 M/S unit had a 1:5 pt. ratio. The capacity on this unit is 32 and census was 27. 6 RNs and 3 CNAs were on duty at time of IM visit. A Transport Aide assisted them. The CNAs had assignments of 9 pts. and most of the patients required an assist of 2 staff. Many of the patients were fall risks. ICU has a bed capacity of 9 beds. ICU had a full census on day of IM visit. RN staffing on day of IM visit was very adequate. There was a seasoned charge nurse on duty that rounded with the IM. Charge nurses usually have full assignments. The Float nursing pool has been expanded with several additional nurses and PCAs to augment staffing when census is high. ICU nurses also float to the MMH ICU when needed. Several per diem staff have also ben added. Many Certified Nurses aides are cross-trained as unit secretaries to aid in staffing flexibility. RNs are also cross training in certain areas.	Continue your efforts to cross train nurses to float to other units and across both campuses to increase flexibility with staffing.
• Physical Environment	The M/S Nursing unit is laid out in an H design. It is an older unit but clean with semi private rooms and two designated hospice rooms that are private and down at the end of the hallway. It will be getting new floor as part of a planned upgrade to patient care areas. Appropriate signage regarding pt.'s rights and responsibilities, financial counseling assistance, and help for hearing impaired and those who speak a different language were posted in all pt. care areas. The code cart is visible and accessible in the middle of the hallway. White boards for assignments are visible at both ICU and M/S nursing stations. The ICU is well lit with an open central nursing station and private rooms.	Per IMs previous recommendation, an alcove around the corner from the central station is being fit out for a quieter more secluded area in which to prepare medications.

CATEGORY	OBSERVATIONS	RECOMMENDATIONS
	There is good pt. visibility. However there was a back door leading into a stairwell at the far end of one of the corridors. There was no alarm on this door although the door was locked from the stairwell to the ICU. ICU staff stated that there are sometimes flight risk patients in their ICU. IM discussed with leadership and engineering who agreed to put an alarm on the back door. Currently, there is no medication room in the **RGH** ICU. Engineering and leadership have responded by developing a design plan. The last planning meeting is to be held this week and then the build out for a medication area should begin shortly. Omnicell has replaced the Care Fusion units throughout RGH patient care areas. The temperatures of the medication refrigerators are remotely monitored by a central system. The code cart was visible and accessible and signatures up to date. The ICU will be getting their stained, worn flooring replaced in the near future.	
NURSING SERVICES		
• Culture of Safety	Nurses and PCAs on Bissell 2 have completed their pilot on hourly rounding on all patients. This initiative began on March 16 2017. Minutes from an April meeting demonstrated a 95.5% compliance rate with the hourly rounding project. Nurses on the RGH campus conduct bedside rounds. Nurses report a collaborative relationship with hospitalists. Nursing units collect Nurse Sensitive Indicators: Falls, Falls with Injury, HAPIs through NDNQI and CLABSIs, and CAUTIs through NHSN. The CAUTI rate is currently 0. A nurse driven Foley Removal protocol is in place. The ICU has not experienced a CAUTI or a CLABSI within 1 year. There is a good Fall Prevention Program in place but falls on M/S need to be decreased. In the month of January 2018 the Bissell 2 unit experienced 5 falls, one with injury. Staff is making a concerted effort to decrease falls on their unit and they are tracking “Days since Last Fall” on a white board in the middle of a central hallway. Consistent Fall risk signage was posted in clear view outside all appropriate pt.’s rooms. The M/S unit also needs to improve HCAPHS scores on “communication with nurses”.	Falls on the M/S unit need improvement.

CATEGORY	OBSERVATIONS	RECOMMENDATIONS
	Multidisciplinary pt. care rounds occur daily. Hospitalists, nurses, SW, Case Management participate. As a result of the very high population of ETOH withdrawal patients in the ICU and M/S, IM requested a meeting with the social worker. She confirms a very high percentage of patients require interventions. Discussed the community services like Rivereast in Vernon and Steps in Manchester. Both are on the bus line so access is available to these patients. Although referrals are made, relapses causing readmissions are common. Hospitalists and nurses have a very collaborative relationship. Nurses suggest interventions and state that physicians listen to their assessments.	IM suggests identifying the patients with the highest rates of recidivism (# of ED visits and admissions) and initiating a hospital/community collaborative that meets monthly. The goal of the collaborative is to attempt to tightly manage their care by wrapping community services around these most vulnerable patients.
NURSING SERVICES		
• Culture of Safety	The I**CU** is an "open" unit meaning hospitalists and private attending physicians can admit into the unit. Respiratory therapists assist with changing ventilator settings per weaning protocols. Code and Defib carts checked in all areas. An Intensivist is on call every night to cover ICU at nights. The nurses enjoy a collaborative relationship with the ICU team.	

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CATEGORY	OBSERVATIONS	RECOMMENDATIONS
• HR / Personnel	The CNO and the other executive staff come to the RGH campus 1-2x/wk. and have offices in the hospital. Since IM's last visit, an Administrative VP has been assigned to the RGH campus. He oversees all daily operations. In addition, ECHN leaders round consistently at RGH. Several Nurse Managers now have responsibility for nursing services on both ECHN and RGH campuses. Generally, there are clinical coordinators on each nursing unit that help manage daily operations. The new clinical coordinator on Bissell II is working out well and has a good focus on patient safety. Much of the staff is fairly long tenured. Only a small percentage of nursing staff is certified in their practice specialty. Very few nurses belong to their professional organizations.	IM encourages Nurse Leaders to collaborate with staff to set unit goals for specialty certification. Exam Prep study groups are supported and encouraged and exam fees are reimbursed upon passing. Certified nurses should continue to be formally recognized and celebrated. Nurses should also be encouraged to join their professional specialty organizations.

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CATEGORY	OBSERVATIONS	RECOMMENDATIONS
NURSING SERVICES		
• HR / Personnel	IM reviewed the self-assessment tools for professional staff that have been used at the time of their performance evaluations. While professional staff is writing goals for the coming year, they are not in a SMART goal format and are not necessarily realistic or measureable. IM also reviewed results of the latest Employee Engagement Survey and some action plans that were developed by management to improve the highest priority areas.	**Recommend** a short educational module be added to Healthstream on how to write SMART goals.
• Confidentiality	Personnel logged out of computer screens when walking away from computer. Curtains pulled around patients when care was provided.	
INFECTION CONTROL		
• Staffing	1.5 FTEs cover both MMH and RGH campuses. 1.0 FTE is an RN with 20 yrs. yrs. experience. She is a member of APIC and holds certification. She provides monthly orientation for all new employees. The other member of the Dept. is 20 hrs. and has a microbiology background and a graduate degree in Public Health. The Medical Director of the program is an Infectious Disease physician who has been with the hospital 35+ yrs. This physician also runs a busy HIV Clinic. There was evidence of a few “safety champions” in patient care areas.	
INFECTION CONTROL		
• Culture of Safety	A vigorous hand washing campaign is continuing. Overall hospital inpatient hand washing compliance rates are measured and displayed on QI Boards throughout the clinical areas. IM did not observe any lapses in hand hygiene on her visit to the RGH campus. A strong antibiotic stewardship program has been in place since the 1980’s. IP staff communicates with Microbiology several days/wk. All isolation cases are reviewed on a daily basis. IP staff state that nurses do a very good job of placing pts. on isolation precautions and D/C precautions	

CATEGORY	OBSERVATIONS	RECOMMENDATIONS
	at the appropriate time. The Infection Prevention dept. has an IP Hotline. Much work has been accomplished to bring SSI rates down below benchmark. There is a subcommittee of the Infection Prevention Committee that is focused on Hospital Acquired Infections and these rates are decreasing. RGH is doing quite well with their Patient Safety Outcomes.	Recommend continuing to work with the Infection Prevention liaisons to conduct frequent observations. Report HH rates by unit so each patient care area is getting their own specific data as well as an aggregate rate. HH rates have trended up in 2017.
INFECTION CONTROL		
• Compliance with State & Federal Regulations	Good surveillance program in place. Pharmacy, Microbiology and environmental, surgery, nursing all have consistent representation at the monthly IP meeting.	.
PHARMACY		
• Staffing	The Pharmacy Dept. is staffed with 1 Pharmacist at RGH on day shift and one at RGH from 3-8pm. The daytime pharmacist stated that staffing could be greatly augmented by a second pharmacist added to staffing plan from 12:30pm-8: 30pm. There is now a night pharmacist on duty Sunday through Thursday. There is one Pharmacy tech assigned to the entire hospital. In times of higher census this tech is quite stretched. Consider supplementing the RGH staffing with per diem staff to add flexibility in times of high census.	

CATEGORY	OBSERVATIONS	RECOMMENDATIONS
• Physical Environment	The Pharmacy at RGH has adequate space and visibility and prep areas are adequate.	
PHARMACY		
• Culture of Safety	Automated dispensing system and DOSE-EDGE systems in place. All medications coming into department are scanned in and barcoded. The hospitals use SMART pumps with an extensive medication library. Med library use by RNs is monitored by the pharmacy. Medication fill error rates and Medication errors are being tracked closely and have not increased.	

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CATEGORY	OBSERVATIONS	RECOMMENDATIONS
PHARMACY		
• Compliance with State & Federal Regulations	A Pharmacy and Therapeutics Committee meets monthly and reports into the QAPI. All adverse Drug events are reviewed within the Medication Safety Subcommittee. A strong Antibiotic Stewardship program is in place. Pharmacists have oversight for Renal dosing adjustments and Vancomycin dosing and utilization. Drug errors are mentioned in daily safety Huddles and tracked through the ISIS reporting system.	
• HR / Personnel	Pharmacy Director has been with ECHN for 14 yrs. and is appropriately credentialed. Pharmacy technicians have to obtain certification within one yr. of hire. Staff at RGH appears stressed with the increase in census and expansion of the Behavioral Health patients.	
SURGICAL SERVICES Ambulatory Surg Unit, GI, Pre OP, OR, PACU, Central Sterile Processing		
• Staffing	I.M. observed appropriate RN staffing ratios throughout the tour of Surgical Services. The surgical volume continues to decrease at RGH. IM asked how staff maintains competencies with volume being low. Manager discussed the regular floating of RGH personnel from PACU and the OR to the MMH campus and vice versa to maintain competency in all service lines.	
• Physical Environment	Tour of the Operating Room suites demonstrated a much more organized outer core. Surgical Services leadership has changed and much attention has been focused on reducing inventory so that frequently used equipment and supplies are accessible and equipment infrequently needed is stored in materials management. In addition an underutilized OR has been converted to a storage room for various pieces of larger equipment and monitors. IM noted some rusty areas on a small storage cart in the inner core. This cart was replaced that day.	
• Culture of Safety	IM visited OR in early AM. Observed an anesthesiologist obtaining consent and the nurse prepping an orthopedic patient for surgery in the pre-op area. A vascular case was in progress. The staff is working	Reinforce the importance of not opening the OR suite doors unnecessarily with all care

CATEGORY	OBSERVATIONS	RECOMMENDATIONS
	on reducing SSI and has an initiative in place to decrease the doors opening and closing during OR cases and assuring all needed equipment is in the room prior to the start of a case. IM witnessed a staff member open the door in the midst of the vascular case to take a break.	providers on the surgical team.
SURGICAL SERVICES Ambulatory Surg Unit, GI, Pre OP, OR, PACU, Central Sterile Processing		
• Policies and Procedures	Carts were locked and checks were completed on code carts in all areas of surgical services. Medication refrigerator logs were signed off appropriately.	.
• HR / Personnel	Overall, nurses in surgical services areas do not hold certification in their respective specialties although 50% of the OR nurses hold an AORN. IM spoke with a nurse in PACU who is certified and working on her BSN. She is a very engaged nurse who is chairing the unit-based council and involved in evidence-based practice. The Unit Educator is responsible for education throughout surgical services: PACUs, ORs, GI lab, Amb. Surgery and Central Sterile Processing. In-service education is provided every 2 weeks. A clinical ladder for surgical techs will begin in June 2018.	
• Confidentiality	Pt. Confidentiality was upheld throughout the tours through the various surgical services area. Screens have been placed over windows leading into the ORs to protect patient privacy.	
EMERGENCY DEPARTMENT		
• Staffing	At the time of IM visit, 7 patients were in the ED. Their capacity is 12 with another 8 bays in a clinical decision unit. That area opens when there are appropriate patients. The ED utilizes flexible staffing which changes according to time of day. They staff in 8, 10 and 12 hr. shifts. Additional staff is added very 4 hrs. to accommodate changing census.	

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CATEGORY	OBSERVATIONS	RECOMMENDATIONS
EMERGENCY DEPARTMENT		
• Physical Environment	The ED at RGH had approximately 19,000 visits in 2017 and visit volume is declining. Admit rate is stable. It has an open design with a central station. Pts. are easily visualized. Waiting rooms are adequate and have appropriate signage: pt. privacy, language lines, financial counseling and assistance for the hearing impaired. Emergency carts are placed to allow easy access by staff. The environment is well organized and free of clutter However the Formica area around one of the hand washing sinks in the nurses' station needs immediate attention. A work order had been placed several days prior. There is no separate area for the behavioral health population**.** There is a Clinical Decision Unit that sees lower acuity (ESI 3 & 4) pts. It has the capacity for 8 pts. It is staffed from 10am -10:30pm during the ED's highest volume hours. This unit does not have cardiac monitors and was closed during IM's visit.	Repair sink area at nurses' station as soon as possible.
• Culture of Safety	The ED has once again attained GWTG Advanced Stroke Certification. Congratulations! Several QI indicators are in place: Timeliness of Care, ED arrival to departure is just over 2 hrs. However, median arrival to admission remains well above benchmark at 325 min. A task force has been set up with the CNO and COO and Medical Director to drive new processes to decrease wait and visit times. "Left Without Being Seen" rates have decreased significantly to 0.7% in Q4 2017. Congratulations! Most throughput indicators are trending in a positive direction. Median door to provider is 18 minutes. Psychiatrists see behavioral health patients admitted through ED within 24 hrs. of admission. Children needing admission are sent to CCMC. .	
• HR / Personnel	In addition to the Nurse Manager, the EDs share a Unit Educator. All RNS have ACLS with the first year of hire.	
• Confidentiality	There was appropriate spacing between pts. registering in the ED to protect auditory confidentiality. White boards did not contain patient's	

CATEGORY	OBSERVATIONS	RECOMMENDATIONS
	names.	

PSYCHIATRIC SERVICES RGH Eating Disorders Unit (EDU) and Adult Behavioral Health		
• Staffing	**EDU** IM toured this unit with a new Nurse Manager. The BH Director was off duty. A multidisciplinary team of professionals provides care for this pt. population: Psychiatrists, RNs, SW, psych technicians, recreational therapists. Adolescents also have a teacher on staff who is certified in Grades K-!2. Staffing guidelines have been revised to reflect a 1:5 nurse/patient ratio. The former staffing plan was a 1:6 nurse/patient ratio. Census in the BHU has increased to 24 from the previous 8 patients and many licensed staff have been hired and oriented. The unit is undergoing a period of instability as new employees come on board. The Nurse Manager is making good efforts to build a sense of team among the staff. Staffing plans in the Adult **BHU at RGH** include an entire multidisciplinary team of professionals: RNs and Psych technicians (minimum of a bachelor's degree) SWs and nutritionist. There are no CNAs. The nurse to patient ratio on this unit is 1:6. The census was 23 on the day of IM visit. 4 nurses and 3 psych techs were on duty. There are 2.0 FTES open.	
• Physical Environment	**EDU T**his is a new inpatient unit that opened to patients in August 2016. It is a nationally known specialty unit that admits patient from all over the country. It takes both adults and adolescents and the majority of patients treated have diagnoses of anorexia, bulimia, and binge eating. The unit has the capacity for 30 pts. and current census at the time of visit had increased to 24. An external risk analysis was recently performed on the EDU. The analysis recommended an enclosure around the nurse's station in an effort to prevent patients from getting into the nurse station area and to better protect staff. Plans are in	**Recommend immediate remediation of the safety risks on the EDU.** Flush door handles will be installed by the vendor 2/15/18.

CATEGORY	OBSERVATIONS	RECOMMENDATIONS
	place to get this work completed. On the EDU the nurse manger has started the practice of performing "room sweeps" as a result of finding a plastic knife under a patients bed. The unit is an "L" configuration and adults are separated from the adolescents. Staff on the adolescent side carries walkie-talkies as a safety precaution. Pt. rooms are all safe with flush door handles; sink faucets and no glass mirrors. A special "Wicket" door was used in all pt. rooms. It allows staff to access the pt. from the hallway in case of an emergency, i.e. the pt. has barricaded himself in his room. While patient rooms had flush door handles the nonpatient rooms (storage closets, offices etc.) along the hallway across from the patient rooms did not. IM also noticed 2 doors with closing mechanisms that represented a hanging risk. While all of the windows were closed shut with a plate and screw, 2 of these plates had sharp edges. The rest had been blunted. A cover covering an electrical panel in one of the hallways could be pried open enough to hide potentially harmful contraband. The CNO and VP for Quality and Nurse Manager all witnessed these same safety risks. IM called David Kromas, Inspector at the State DPH to confer and immediately notified ECHN administration of findings. Hospital engineering personnel were to attend to these environmental concerns that afternoon. Per Dennis McConville at ECHN on 2/6, the sharp edges on the windows had been blunted and the electrical panel door was secured with tamper proof screws. Engineering will confer with Davis Kromas at DPH concerning the door hinges to develop the best approach. **Adult Behavioral Heath Unit**. A newly renovated unit for adult behavioral health patients opened on 1/3/18. It is a nice brightly lit unit with plenty of space for patient conferences, group therapy and recreational therapies. "Wicket" doors have been utilized in the unit. All beds and storage cabinets and chairs were weighted and non-moveable. IM observed that all physical safety precautions were incorporated into this unit.	

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CATEGORY	OBSERVATIONS	RECOMMENDATIONS
PSYCHIATRIC SERVICES Eating Disorders Unit and Adult Behavioral Health Unit		
• HR / Personnel	Professional staff in the **BHU at RGH** was sent to Walden in Mass. for a full 8 hr. day of education and training for this specialty unit. Staff were hired early in 2016 and oriented for several months prior to the opening of the unit in August 2016. Two FT team psychiatrists are on staff. They have the ability to frequently consult with psychiatrists at The Eating disorders program in Walden, Ma.jobs. All ancillary personnel coming on to this unit must also be trained regarding safety practices. Professional Staff is appropriately trained and credentialed to perform their jobs. All behavioral health RNs and techs have Physical Management Training. Security personnel have MOAB training. Mock drills on restraints are held frequently throughout the year.	EDU has experienced a good deal of staff turnover over last several months. Census has tripled since IM's last visit. Recommend continuous education and reinforcement of all safety practices.
QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT		
• Staffing	The Quality Department is comprised of 4.5 FTEs who report into the VP of Quality, Safety and Pt. Experience and cover both Rockville and MMH campuses as well as outpatient sites. The existing staffing structure has remained unchanged in the previous 6 months. There are 3 QI Managers who are supported by an Environmental Safety Officer. A Pt. Experience Coordinator and Quality Analytics Manager (0.5FTE) report directly into the VP. Two Data Abstractors (1.4 FTEs) report into the Quality Analytics Manager (0.5FTEs). The QI personnel's offices reside at the MMH campus. VP of quality rounds at RGH 1-2x/wk. The QI Managers have focused areas of responsibility. All conduct RCAs, and investigate serious safety events and precursors. The QI dept. coordinates a Quality/Safety/Risk huddle held every Monday that includes the CMO, CNO, VP Quality, Risk Management, and VP of Nursing. This group reviews serious events rom the previous week. The Pt. Experience Coordinator also has responsibility for Pt. rights,	

CATEGORY	OBSERVATIONS	RECOMMENDATIONS
	Grievances, and Complaints.	
QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT		
• Culture of Safety	RGH shares all the same Quality/Safety structures and processes that are in place at MMH. In the area of Pt. Safety, the following structures and processes are in place: Daily Safety Huddles, Patient Safety committee, Patient Safety Coach committee, HRO education during orientation of new employees and physicians. The department is developing a plan for a HRO Refresher course during 2018. A large variety of other committees and task forces exist to support Pt. Safety. IM Reviewed QI Plan for 2018 and the Quality/Safety goals for 2018. IM also reviewed the quality dashboard through 3rd quarter 2017. RGH has made considerable progress in decreasing readmission rates for Heart Failure and Stroke. Similar efforts need to be applied to readmissions for the Pneumonia and COPD populations. Overall all diagnosis readmission rates at RGH above state and national benchmarks. Multidisciplinary Committees are in place to reduce Falls, CAUTIs, and CLABSIs. "Days Since Last Fall" is always listed on the Safety Huddle white board The CAUTI rate is almost zero and there were 2 CLABSIs in 2016. Root Cause Analyses are completed on all CLABSIs after Infection Prevention has determined it to be a true CLABSI. Action plans are developed for all scores falling below internal goals.	
QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT		
• Culture of Safety	ECHN was again awarded TJC Advanced Stroke Accreditation for 2017. The Risk Management program is the same as on the MMH campus. The director of RM also collaborates closely with the Chair of the Environment of Care Committee. The Patient Experience Coordinator covers both hospital campuses. HCAHPS scores are quite low at RGH—well under the 50th percentile. Several initiatives are underway with both the inpatient nursing staff and the hospitalists to improve the scores. Hourly bedside rounding has ben started on the M/S unit and ICU.	

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CATEGORY	OBSERVATIONS	RECOMMENDATIONS

User, OHCA

From: Colleen Smith <colleen713.smith@gmail.com>
Sent: Monday, February 12, 2018 6:02 PM
To: User, OHCA; Cotto, Carmen; Martone, Kim; Colleen Smith; Collins, Michael; Ellen J. Shin (Legal Department); Tichy, Joyce A (Legal Department); Garrison DeLee (garrison.delee@prospectmedical.com); Frank.Saidara; Roberts, Karen
Subject: Docket Number 15-32016-486
Attachments: Nursing Consulting Partners ECHN workplanFinal.12.6 CS 8.28.17CS2.9.18final.docx; ATT00001.htm

Follow Up Flag: Follow up
Flag Status: Completed

To Whom It May Concern,

Please find the attached filing regarding Docket Number 15-3206-486, Transfer of Assets to Eastern Connecticut Health Network From Prospect Medical Holdings. Independent Monitor has made 3 on site visits to ECHN during the past year, January 2017 -January 2018. Independent Monitor has reviewed all required policies and procedures on an ongoing basis as outlined in the Conditions. Independent Monitor has found ECHN in full compliance with all requirements set forth in the order.

Sincerely,
Colleen Smith
Independent Monitor

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PROSPECT ECHN, INC. WORK PLAN

INDEDEPENDENT MONITORING PROCEDURES (per Docket Number 15-32016-486)

OHCA Condition	IM Action	IM Review of Compliance with Condition
CON Condition 4: Within one hundred and eighty (180) days following the Closing Date, PMH shall submit a plan (the "Health Needs Plan") for continuing to support and implement ECHN's 2016 Community Health Needs Assessment ("CHNA") and for conducting the New Hospitals' next comprehensive study of community health needs in the Service Area (the "Community Health Needs Study" or "Study"). The Health Needs Plan shall describe in detail at least the following: (i) the data that will be collected and analyzed to systematically assess health status Indicators of the Service Area; (ii) the identity of key community stakeholders and health organizations, unaffiliated with PMH, including without limitation, representatives of medically underserved populations, that will be enlisted to participate in the Study and the manner and extent of such participation by stakeholders in both the development of health priorities and planned implementation; (iii) the qualifications of consultants experienced in performing community health needs assessments who will be retained by PMH to ensure that the priority health needs of the community are accurately determined; (iv) the frequency with which the Study will be repeated; (v) the manner in which results of the Study and the implementation strategy to address the priority health needs identified therein (the "Implementation Strategy") will be distributed to the	IM will obtain a copy of the Plan, verify timely submission, and verify that it incorporated the required elements.	IM reviewed the Plan for submission of a Community Health Needs Study within 180 days post closing on 3/14/17. All required elements of the Plan were included: the data analyzed, key stakeholders, the firm to conduct the study, frequency of study, communication to the community, and how the plan reflects the population health management objectives as outlined in the CHNA. The Plan will follow the same format as the CHNA study submitted in 2016.

community; and (vi) the manner in which the Study will complement the population health management objectives of PMH and the New Hospitals.		
CON Condition 5: Within three (3) years following the Closing Date, PMH shall participate with New ECHN and the New Hospitals, and the key community stakeholders and health organizations identified pursuant to Condition 4, in conducting a Community Health Needs Study and shall provide a copy of such Study and its Implementation Strategy to OHCA within thirty (30) days of completion. PMH and the participants shall utilize Healthy Connecticut State Health Improvement Plan data and priorities as the starting point for the Study (available at - http://www.ct.gov/dph/lib/dph/state_health_planning/ship/hct2020/hct2020_state_hlth_impv_032514.pdf) as well as any applicable community health improvement plan issued by any local health department in the Service Area.[1] The Implementation Strategy shall also adopt the evidence-based interventions identified in the Centers for Disease Control 6/18 initiative (available at http://www.cdc.gov/sixeighteen) to the extent the health priorities identified in the Study correlate to the health conditions identified by the CDC and provide information on how any patient outcomes related to the Implementation Strategy will be measured and reported to the community. PMH shall publish the Community Health Needs Study and the	IM will obtain a copy of the Study, verify timely submission, verify that it incorporated the required elements and was published on the website.	During IM on site visits to ECHN on January 23-28, June 2017 and January 2018, IM checked on the progress with the plan for the Community Health Needs Study. IM will review the completed study prior to 9/30/19.

[1] Other tools and resources which the Applicants are encouraged to consider include County Health Rankings and CDC Community Health Improvement Navigator in order to assist with the Study process in terms of an understanding of social, behavioral, and environmental conditions that affect health, identifying priorities, and the use of evidence-based interventions.

Implementation Strategy on the website of New MMH and New RGH. Until such time as the Community Health Needs Study and Implementation Strategy are submitted to OHCA, PMH shall continue to support and implement ECHN's current CHNA for MMH and RGH. OHCA is imposing this condition to ensure continued access to health care services to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d(a) 19a-613(b), 19a-639(a)(3) & (7); FF 56-57*		
CON Condition 6: Within one hundred and eighty (180) days following the Closing Date, PMH shall submit a plan demonstrating how health care services will be provided by the New Hospital for the first three years following the Asset Purchase, including any consolidation, reduction, or elimination of existing services or introduction of new services (the "Services Plan"). The Services Plan will be provided in a format mutually agreed upon by OHCA and the Applicants. OHCA is imposing this condition to ensure continued access to health care services to the patient population. *Legal and Factual Basis: Conn. Stat. §§ 19a-486(a), 19a-613(b), 19a-639(a)(5),(6) (7),(8),(9),(11) & (12); FF 18, 26-27*	IM will obtain a copy of the Plan and verify it incorporated the required elements.	IM reviewed the Services Plan on 3/14/17 that included current services as well as plans for future expansion of Behavioral Health services. These include a Gero-Psychiatry program, addiction services and enhancement of cardiac, cancer and diabetes services. These services complement the needs outlined in the Community Health Needs Assessment.
CON Condition 7: Until such time as the Services Plan is submitted, PMH shall provide OHCA with notice of any reallocation of inpatient beds and relocation of outpatient services for the New NMH or New RGH specific to those services that existed at each of the Hospitals as of the Decision Date. Such notice shall be provided within ten (10) days of any such reallocation or relocation and published on the website pages of the New Hospitals. OHCA is imposing this condition to ensure continued access to health care services to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486(a), 19a-613(b), 19a-639(a)(5),(6) (7),(8),(9),(11) & (12); FF*	IM will verify proper notification to OHCA within 10 days of any plan to reallocate inpatient beds and relocation of outpatient services. IM will assure timely publication on New Hospitals website within 10 days of decision to reallocate or relocate services.	IM reviewed the notification to OHCA on 1/12/17 regarding the closing of a lab drawing station. IM verified with ECHN that any such future changes will be discussed with IM before action is taken.

18, 26-27		
CON Condition 8: Within one hundred and eighty (180) days following the Closing Date and thereafter on the same semi-annual schedule as set forth in Conditions 9 and 10 below until the capital commitment is satisfied, PMH shall submit to OHCA a report on the capital investments ("Capital Investment Report") it has made in the New MMH, New RGH and its affiliates from the $75 million Commitment Amount. The Capital Investment Report shall include the following in a format to be agreed upon: a. A list of the capital expenditures that have been made in the prior one hundred and eighty (180) days with descriptions of each associated project; and b. An explanation of why each expenditure was made and a timeframe for the roll out of the associated capital project (including estimated beginning, ending and startup/operation dates); and c. The dates and amounts of withdrawals from each of the New Hospitals' operating account and/or any other sources of funding used to fulfill	IM will obtain the Plan, read the plan and verify that expenditures/investments made are in accordance with the Plan. IM will confirm timely submissions of all required reports.	IM reviewed the filings and exhibits associated with Condition 8 on 5/23/17 prior to its filing with OHCA. IM was aware of the extension request of 11/15/17 and verified its approval on 11/16/17. IM verified that conditions 8,9, & 10 were completed as requested in Excel format and submitted by 12/15/17.

the Capital Commitment. The reports shall be signed by PMH ECHN's Chief Financial Officer. OHCA is imposing this condition to ensure continued access to health care services to the patient population and to verify the continued financial feasibility of the project. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(3),(4) & (5); FF 38-45*		
CON Condition 9: For three (3) years following the Closing Date, PMH shall file the following information with OHCA on a semi-annual basis for ECHN, New MMH and New RGH, respectively: a. The cost saving totals achieved in the following Operating Expense Categories for New ECHN, New MMH and New RGH: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Interest Expense, Malpractice Expense, Utilities, Business Expenses and Other Operating Expenses. The categories shall be consistent with the major operating expense categories (Categories A, B, C, D, E, G, H, I, J, and K) which are in use at the time of reporting in the OHCA Hospital Reporting System ("HRS") Report 175 or successor report. The semi-annual submission shall also contain narratives describing: 1. the major cost savings achieved for each expense category for the semi-annual period; and 2. the effect of these cost savings on the clinical quality of care. b. A consolidated Balance Sheet, Statement of Operations, and Statement of	IM will review the PMH filings regarding cost savings achieved in accordance with a. 1-2 and b. of Condition 9.	IM reviewed draft of filing related to condition 9 on 5/22/17 and verified submission to OHCA on 5/31/17. IM was aware of the extension request of 11/15/17 and approval by OHCA on 11/16/17 of extension of due date to 12/15/17. IM verified that conditions 8,9, & 10 were completed as requested in Excel format and submitted by 12/15/17.

Cash Flows for New ECHN, New MMH and New RGH. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Reports 100/150, 300/350 or successor reports. For purposes of this Order, semi-annual periods are October 1-March 31 and April 1 – September 30. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th, beginning November 30, 2016. OHCA is imposing this condition to ensure continued access to health care services to the patient population and to verify the continued financial feasibility of the project. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(4) & (5); FF 51, 60-63*		
CON Condition 10: For three (3) years following the Closing Date, PMH shall submit to OHCA a financial measurement report. This report shall be submitted on a semi-annual basis and show current month and year-to-date data and comparable prior year period data for New ECHN, New MMH, and New RGH, respectively. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th, beginning November 30, 2016. The following financial measurements/indicators should be addressed in the report: (i) **Operating performance** to include operating margin, non-operating margin, and total margin; (ii) **Li□uidity** to include current ratio, days cash on hand, days in net accounts receivables, and average payment period; (iii) **Leverage and capital structure** to include long-term debt to equity, long-term debt to capitalization, unrestricted cash to debt, times interest earned ratio, debt service coverage ratio, and equity financing ratio; and (iv) **Additional**	IM will obtain the financial measurement report and read to confirm that the required elements are addressed in the report; IM will confirm the timely submission of each report.	IM reviewed draft of filing related to condition 10 on 5/23/17 and verified submission to OHCA on 5/31/17. IM was aware of the extension request of 11/16/17 and approval by OHCA of extension of due date to 12/15/17. IM verified that conditions 8,9, & 10 were completed as requested in Excel format and submitted by 12/15/17. IM verified that all the required elements were present in the financial measurement reports and submitted to OHCA by 12/15/17.

Statistics to include income from operations, revenue over (under) expense, cash from operation, cash and cash equivalents, net working capital, free cash flow (and the elements used in the calculation), unrestricted net assets/retained earnings, bad debt as a percentage of gross revenue, and credit ratings.		
CON Condition 11: PMH shall ensure that the New MMH and New RGH maintains and adheres to ECHN's current policies regarding charity care, indigent care and community volunteer services at New MMH and New RGH after the Closing Date all as consistent with state and federal law or adopt other policies that are at least as generous and benevolent to the community as ECHN's current policies. These policies shall be posted on the website of the New MMH and New RGH and as additionally required by applicable law. OHCA is imposing this condition to ensure continued access to health care services to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(5),(6) & (11); FF 52-55, 59*	IM will obtain copies of the relevant financial assistance policies, read and confirm that as adopted financial assistance policies (or policies at least as generous as these policies) using management approval of the policies as evidence. After verifying that this step has been properly completed, IM will confirm that these policies are properly posted on website	IM obtained copies of all required policies relating to charity and indigent care and volunteer services on initial site visit in January 23-28 2017. IM verified that policies remained unchanged during subsequent visits in June 2017 and January 2018. IM reviewed all policies and verified their public posting on the hospital's website. www.echn.org
CON Condition 12: For three (3) years following the Closing Date, PMH shall provide written notice to OHCA of any modification, amendment or revision to the charity care, indigent care and community volunteer services of New MMH and New RGH within thirty (30) days of such change. The notice of these changes shall be accompanied by copies of any revised policies and the notice and revised policies shall be posted on the website of the New Hospital simultaneously with their submission to OHCA. OHCA is imposing this condition to ensure continued access to health care services to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(5),(6) & (11); FF*	After obtaining original policies on charity care, indigent care, and community volunteer services, IM will read and assess these policies on an annual basis for changes. When changes are made to these policies, IM will confirm OHCA is notified (as required) and revised policies are posted to the website.	IM obtained and read and assessed all relevant policies on initial site visit on January 23-28 2017 and verified that they remain unchanged during the subsequent site visit on January 30-31 2018. IM verified posting of these policies on the hospital's website. www.echn.org

52-55, 59		
CON Condition 13: PMH shall maintain community benefit programs and community building activities for the New MMH and New RGH for three (3) years after the Closing Date consistent with the Hospital's most recent Schedule H of IRS Form 990 or shall provide such other community benefit programs and community building activities that are at least as generous and benevolent to the community as ECHN's current programs, and PMH shall apply a 1% increase per year for the next three (3) years toward community building activities in terms of dollars spent. In determining the New MMH and New RGH participation in and investment in both community benefits and community building activities, PMH shall address the health needs identified by the applicable CHNA or Study in effect at the time and the population health management objectives, including social determinants of health, contained in the related Implementation Strategy. a. On an annual basis, the Applicants shall identify the amounts and uses related to community benefits and community building and shall discuss how such investments and support are being applied toward the health needs identified in the CHNA or Study and population health management objectives. Such reporting shall be filed within thirty days of the anniversary date of the closing for three years and shall be posted on the New Hospital's website. OHCA is imposing this condition to ensure continued access to health care services to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(5),(6) & (11); FF 52-55, 59*	IM will obtain most recent Schedule H of IRS Form 990 to act as a baseline. IM will then compare on an annual basis the results of that year to the baseline in order to verify that the 1 percent increase requirement has been met. IM will also obtain the report/summary on the amounts and uses related to community benefits and community building per the categories identified in the CHNA. IM will confirm that these documents are filed in a timely manner and posted to the website.	IM has verified that the requirement of a 1% increase in community benefit spending has been met. ECHN spending on community benefit programs reflected a 1.2% increase from 2016 to 2017. IM reviewed report on 10/30/17 and verified that categories of spending and dollars spent reflect the health needs outlined in the CHNA completed in late 2016. Community benefit programs are being supported in the following areas: substance abuse and opiod addiction, Maternal/Child Health and family planning, early interventions for school age children, alcohol recovery programs, weight management, and exercise, diabetes, cardiac care and stroke prevention.
CON Condition 14: New MMH and New RGH agree to comply with the following general community benefit standards for at least the first three	IM will verify the New Hospitals' compliance with community benefit standards a through d	IM has verified ECHN's compliance with the community benefit standards a-d during the initial on site visit on January 23-28, 2017 and again during the visit

years. (a) the New Hospitals shall provide public health programs to the community and generally promote the welfare of the community; (b) the New Hospitals shall have open medical staffs and not restrict the use of facilities to a particular group of physicians and surgeons to the exclusions of other qualified doctors; (c) the New Hospital shall participate in the Medicare and Medicaid programs; and (d) the New Hospitals shall operate 24/7 emergency departments and provide emergency services to patients regardless of their ability to pay. OHCA is imposing this condition to ensure continued access to health care services to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(5),(6) & (11); Tr., Testimony of Tom Reardon, President. PMH East on 5/3/16, pp. 103-04*	as stated in Condition 14.	on January 30, 31 and February 1 2018.
CON Condition 15: New MMH and New RGH shall work toward making culturally and linguistically appropriate services available and integrated throughout their hospital operations. Specifically, New MMH and new RGH shall take reasonable steps to provide meaningful access to each individual with limited English proficiency eligible to be served or likely to be encountered in its health programs and activities, in accordance with the implementing regulations of Section 1557 of the Patient Protection and Affordable Care Act. Additionally, New MMH and New RGH shall provide appropriate insurance navigator services for patients and, where appropriate, English as a second language and cultural competency training for employees. In complying with this Condition, New MMH and New RGH shall be guided by the National Standards for Culturally and Linguistically Appropriate Services in Health and Health	IM will obtain and review interpreter services policies and contracts as applicable. Additionally, IM will obtain a cultural competency plan, training, as well as related policies. IM will also obtain report and supporting documents and confirm the timely filing of these materials	IM obtained, reviewed and verified that appropriate interpreter policies and contracts exist. During on site visits in January 23-28 2017 and January 2018, IM verified culturally and linguistically appropriate services are available and well posted throughout the MMH and RGH campuses. Notification signs of these services were observed in the ED, main hallways, and Patient Care Units. ECHN has signed a contract with iTi a language and translation service to assist those with limited English language proficiency. Financial counseling and insurance navigator services are readily available at the hospitals. IM reviewed the required written report to OHCA on 10/30/17.

Care published by the U.S. Department of Health and Human Services' Office of Minority Health. For three (3) years following the Closing Date, PMH shall submit a written report on its activities directed at meeting this Condition. Such reporting shall be filed within thirty days of the anniversary date of the closing for three years and shall be posted on the applicable Hospital website. OHCA is imposing this condition so as to ensure continued access to health care services to the patient population. *Legal and Factual Basis: 45 C.F.R. §92.201; Stat. §§ 19a-486d(a), 19a-613(b), 19a-639(a)(5),(6) & (11); FF 52-55, 59*		
CON Condition 16: Within sixty (60) days after the Closing Date, the Applicants shall contract with an Independent Monitor who has experience in hospital administration and regulation, including maintaining quality control in a High Reliability Organization ("HRO"). The Independent Monitor shall be retained at the sole expense of PMH, at a cost which shall not exceed $300,000 in the aggregate. Representatives of OHCA and the Facility Licensing and Investigations ("FLIS") section of the Department of Public Health ("DPH") will approve the Independent Monitor's appointment. The Independent Monitor shall be engaged for a minimum period of two (2) years following the Closing Date, which may be extended for another year at OHCA's and/or FLIS's discretion. The Independent Monitor will be responsible for monitoring the Applicants' compliance with the Conditions set forth in this Order. PMH shall provide the Independent Monitor with appropriate access to New Hospitals and their applicable records in order to enable the Independent Monitor to fulfill its functions hereunder. OHCA is imposing this condition to ensure continued access to health care services to the patient population and to verify and monitor compliance with the conditions	IM and PMH will execute a Consulting Services Agreement by the required date. A draft of this Agreement has been provided to OHCA.	IM and PMH contract for IM services fully executed by both parties on 12/5/16.

set forth herein. *Legal and Factual Basis: Conn. Gen. §§ Stat. 19a-486(a), 19a-613(b), 19a-639(a)(1),(2),(4),(5),(6),(7),(11) & (12); FF 26-27, 30-45, 52-57, 59*		
CON Condition 17: The Independent Monitor will report to both OHCA and FLIS. The Independent Monitor shall conduct on-site visits of New Hospitals on no less than a semi-annual basis to assess PMH's modified Quality Assurance Performance Improvement ("QAPI") program, and compliance with the Quality Commitment Letter. The Independent Monitor shall furnish a written report of his or her assessment to OHCA and FLIS within thirty (30) days of the completion of each on-site review. PMH will have the opportunity to review and provide written responses to the report. As OHCA deems necessary, the Independent Monitor shall meet with OHCA and FLIS personnel to discuss the written report and will perform additional periodic reviews and reviews of other PMH affiliated sites of service. OHCA is imposing this condition to ensure continued access to health care services to the patient population and to verify and monitor compliance with the conditions set forth herein. *Legal and Factual Basis: Conn. Gen. §§ Stat. 19a-486(a), 19a-613(b), 19a-639(a)(1),(2),(4),(5),(6),(7),(11) & (12); FF 26-27, 30-45, 52-57, 59*	IM will plan, at a minimum, two site visits per year. The site visits will include meetings with Administration/Leadership. IM will verify compliance with the quality Assurance commitment Letter. IM will provide a written report to OHCA, and FLIS that summarizes the activities from the prior six month period along with any recommendations or observations	IM visited the MMH and RGH campuses from January 23-27, 2017 and visited all relevant inpatient and outpatient services. IM visited the MMH and RGH campuses again in June 2017. Reports have been furnished within 30 days of each visit. A third visit occurred on January 30, 31 and February 1, 2018. This report was submitted to DPH and OHCA on 2/8/18.
CON Condition 18: If, at any time within three (3) years following the Closing Date, the New Hospitals' Local Board agrees with PMH to change any of the Seller Quality Programs described in the Quality Commitment Letter other than to make any changes necessary to address (i) an immediate issue of patient safety; (ii) changes in federal, state, and local laws; or (iii) as mandated or recommended in guidance by a governmental agency, PMH shall notify OHCA and FLIS in writing within thirty (30) days of any such change	IM will verify that PMH notifies OHCA and the Health Systems Branch in writing within 30 days of any change in the Seller Quality Programs with the exceptions i through iii as stated in condition 18.	IM has verified that PMH is aware of their obligation to notify the IM and OHCA and the Health Systems Branch in writing within 30 days of any change in Quality Programs. IM is aware of exceptions i, ii, and iii. Compliance is verified on each site visit.

going into effect. If the Independent Monitor disagrees with the change, OHCA may require that a request for modification be submitted and approved as required by C.G.S. §4-18la to make the change. OHCA is imposing this condition to ensure continued access to health care services to the patient population and to verify and monitor compliance with the conditions set forth herein. *Legal and Factual Basis: Stat. §§ 19a-486d, 19a-613(b), 19a-639(a)(1),(2),(5) & (6); FF 30-37*		
CON Condition 19: For three (3) years following the Closing Date, PMH shall hold a joint meeting of the Board of each of new MMH and New RGH and the Local Board of new MMH and New RGH ("Joint Board Meetings") at least twice annually with one occurring in Manchester and the other occurring in Vernon. Such Joint Board Meetings shall be followed by a meeting to which the public is invited in advance and at which the public is informed of the New Hospital's activities and afforded an opportunity to ask questions and make comments. OHCA is imposing this condition to ensure continued access to health care services to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d, 19a-613(b), 19a-639(a)(2),(3),(5),(7),(8),(11) & (12); FF 28-30*	IM will assure that Joint Board Meetings occur twice annually followed by public meetings as required in Condition 19.	IM attended the Joint Board Meeting and Public meeting at RGH on 4/26/17. IM was told in advance of the Board and public meetings held on the MMH campus the following month on May 31 2017. ECHN provided IM with the agenda and attendance sheet and a summary of the meeting. Board and public meetings are being scheduled for the end of June 2018 on both MMH and RGH campuses. IM plans on attending both.
CON Condition 20: For three (3) years following the Closing Date, PMH shall allow for two (2) community representatives to serve as a voting member of the New MMH and New RGH Local Board with rights and obligations consistent with other voting members under the Local Board Bylaws. The community representative shall be selected in consultation with the Mayor of Manchester and Vernon in order to ensure the appointment of an unbiased person who will fairly represent the interests of the communities served by the MMH and RGJ. OHCA is imposing this condition to	IM will verify the New MMH and New RGH include 2 community representatives that are voting members of the local boards.	IM has verified that ECHN has made substantial efforts to find a qualified and equitable community representative for their boards. IM has verified with OHCA on 3/20/17 that the Manchester and Vernon community representatives to the boards are acceptable.

ensure continued access to health care services to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d, 19a-613(b), 19a-639(a)(2),(3),(5),(7),(8),(11) & (12); FF 28-30*		
CON Condition 21: PMH, New ECHN, New MMH and New RGH shall abide by all requirements of licensure that may be imposed by FLIS in any Pre-Licensing Consent Order or similar agreement that FLIS may enter with these parties. OHCA is imposing this condition to ensure that quality health care services are provided to the patient population. *Legal and Factual Basis: Stat. §§ 19a-486d, 19a-490, 19a-493, 19a-639(a)(1),(2),(5) & (6); FF 30-37*	IM will verify that all requirements of licensure are met.	IM has verified during all on site visits January 23-28 2017, June 27 & 28 2017, and January 30,31, February 1, 2018 and during off site ongoing review of documentation that ECHN is in compliance with all requirements of licensure.

User, OHCA

From: Cotto, Carmen
Sent: Tuesday, February 13, 2018 9:48 AM
To: Colleen Smith; User, OHCA; Martone, Kim; Collins, Michael; Ellen J. Shin (Legal Department); Tichy, Joyce A (Legal Department); Garrison DeLee (garrison.delee@prospectmedical.com); Frank.Saidara; Roberts, Karen
Subject: RE: Docket Number 15-32016-486

Follow Up Flag: Follow up
Flag Status: Completed

Hi Colleen,

We will let you know if we have any additional questions or concerns.

Thank you,
Carmen

Carmen Cotto, MBA Associate
Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov

www.ct.gov/dph

From: Colleen Smith [mailto:colleen713.smith@gmail.com]
Sent: Monday, February 12, 2018 6:02 PM
To: User, OHCA <OHCA@ct.gov>; Cotto, Carmen <Carmen.Cotto@ct.gov>; Martone, Kim <Kimberly.Martone@ct.gov>; Colleen Smith <colleen713.smith@gmail.com>; Collins, Michael <mcollins@echn.org>; Ellen J. Shin (Legal Department) <Ellen.Shin@prospectmedical.com>; Tichy, Joyce A (Legal Department) <jtichy@echn.org>; Garrison DeLee (garrison.delee@prospectmedical.com) <garrison.delee@prospectmedical.com>; Frank.Saidara <Frank.Saidara@prospectmedical.com>; Roberts, Karen <Karen.Roberts@ct.gov>
Subject: Docket Number 15-32016-486

To Whom It May Concern,

Please find the attached filing regarding Docket Number 15-3206-486, Transfer of Assets to Eastern Connecticut Health Network From Prospect Medical Holdings. Independent Monitor has made 3 on site visits

to ECHN during the past year, January 2017 -January 2018. Independent Monitor has reviewed all required policies and procedures on an ongoing basis as outlined in the Conditions. Independent Monitor has found ECHN in full compliance with all requirements set forth in the order.

Sincerely,
Colleen Smith
Independent Monitor

Colleen O'Brien Smith MSN RN NEA-BC
Nursing Consulting Partners, LLC
690C9 S. Park View Court
Franklin, WI 53132
Phone: 203-245-1044
Cell: 203-671-1348
colleen713.smith@gmail.com
http://nursingconsultingpartners.com/

User, OHCA

From:	Colleen Smith <colleen713.smith@gmail.com>
Sent:	Monday, March 12, 2018 11:16 AM
To:	User, OHCA; Martone, Kim; Roberts, Karen; Cotto, Carmen
Cc:	Mcconville, Dennis P; Ellen J. Shin (Legal Department); Garrison DeLee (garrison.delee@prospectmedical.com); Frank.Saidara
Subject:	Docket Number: 15-32016-486 Project Title: Transfer of assets of Eastern Connecticut Health Network, Inc. to Prospect Medical Holdings, Inc.
Attachments:	Letter to Colleen O'Brien Smith re Condition 4 DN 15-32016-486-CON 03 27 2018.pdf; ATT00001.htm

To All Concerned Parties,

Please find the attached letter describing how Prospect ECHN has been participating with key community stakeholders over the past year to implement its CHNA plan as required by Condition 4 of the CON Decision, Docket # 15-32016-486

Eastern Connecticut Health Network
71 Haynes Street
Manchester, CT 06040
860.533.3414
www.echn.org

February 27, 2018

Colleen O'Brien Smith, MSN, RN, NEA-BC
Independent Monitor
Nursing Consulting Partners
6909 S. Park View Court
Franklin, WI 53132

Re: **Docket Number: 15-32016-486**

Project Title: **Transfer of assets of Eastern Connecticut Health Network, Inc. to Prospect Medical Holdings, Inc.**

Dear Ms. Smith,

This letter is in response to your request for a summary of the efforts of Prospect ECHN (ECHN) to engage members of its communities in the implementation of the 2016 ECHN Community Health Needs Plan (Health Plan) which was filed with the Office of Health Care Access (OHCA) on March 29, 2017. For reference, a copy of the Health Plan may be found using this link.

As stated in the OHCA filing referenced above, ECHN has and will continue to look for opportunities to work with these and other community organizations to address the community health needs identified in the Health Plan:

- Town Health and Human Services Agencies
- Manchester Police Department
- First Choice Health Center
- Vernon School Readiness Committee
- Early Head Start
- Area Churches
- Hockanum Valley Community Council
- Public Schools
- Community Health Resources (CHR)
- Highland Park Market
- Senior Centers
- Manchester School Readiness Committee
- Skilled Nursing Facilities
- Community Physicians & Providers
- Community Centers

- Chambers of Commerce
- CT Suicide Advisory Board
- Geissler's Supermarket
- East Central Multidisciplinary Team
- Manchester Public Schools (Family & Community Partnerships)
- Manchester & Vernon Local Prevention Council
- East of the River Action for Substance Abuse Elimination (ERASE)
- Manchester & Vernon Juvenile Review Boards
- CT Community for Addiction Recovery (CCAR)

Community Health Education

ECHN has a long-standing practice of promoting and offering community health education to our community. ECHN continues to provide free health information and education, in partnership with the ECHN Medical Staff, through a series of lectures offered to the public. Three times each year, the ECHN Community Education Department invites members of the ECHN medical staff and allied health professionals to submit health education programs for presentation to the public at large. A Community Program Advisory Committee, with representation from the medical staff and management, considers each request, giving priority to submissions that address identified community health needs. Seventy (70%) these program presenters are independent, private practice physicians from the community with the balance of programs conducted by employees of ECHN. The community health education programs, along with other information on health topics, are published in ECHN's Better Being magazine which is distributed to 110,000 households, three times per year. The magazine lists special events, health screenings, cancer education & support programs, safety education classes, parent education & playgroup programs and numerous support groups hosted by the hospitals.

The following are the ECHN Community Education Programs which have been held or are scheduled to be held during Fiscal Year 2018. You will note that several of the lectures address stroke signs, nutrition, physical activity and weight in addition to diabetes which are included in the Health Plan.

Fiscal Year 2018 Health Education Programs & Lectures

Program Title	**Date**
Shoulder Pain and Arthroscopic Rotator Cuff Repair	Monday, October 23, 2017
Glaucoma: Understanding the Disease	Tuesday, October 31, 2017
Understanding Eating Disorders	Monday, November 6, 2017

The Art of Healthy Eating	Wednesday, November 15, 2017
Massage Therapy & Self-Care	Tuesday, November 21, 2017
Moving Forward: Exercising for Fat Loss and Fitness	Tuesday, November 28, 2017
Movement Therapy and Mental Health	Tuesday, December 5, 2017
Diabetes & Wound Care	Tuesday, December 19, 2017
Body Aches During Pregnancy: An Osteopathic Approach	Tuesday, January 30, 2018
Kickstart Your New Year's Resolutions: Exercise & Nutrition	Thursday, February 1, 2018
BMI: Bariatric Medicines In-Depth	Tuesday, February 6, 2018
Learn FAST: Stroke & TIA	Wednesday, February 28, 2018
Pre-Diabetes: Let's Take Action	Tuesday, March 27, 2018
Parkinson's Disease: Improving Speech and Movement	Tuesday, April 10, 2018
Urinary Tract Infections	Monday, April 16, 2018
Glaucoma: Understanding the Disease	Tuesday, April 24, 2018

Behavioral Health

The Health Plan includes a goal of increasing access to and use of behavioral health services. Addressing the behavioral health needs has been a major focus of ECHN in the months leading up to and since the Prospect Medical Holdings (PMH)-ECHN transaction closed. To date, PMH has funded over $11 million in renovations at both Manchester Memorial Hospital (MMH) and Rockville General Hospital (RGH) to add both programs and bed capacity for patients needing inpatient behavioral healthcare. A thirty-bed inpatient

behavioral health unit dedicated to treating patients with severe eating disorders was opened at Rockville General in partnership with Walden Behavioral Care. ECHN and Walden have been offering an outpatient eating disorders program in partnership since 2012. Also, a newly renovated twenty-four bed adult inpatient behavioral health unit, operating under the MMH license, was opened at RGH in January. With the addition of more behavioral health capacity at RGH, ECHN behavioral health leadership met with area emergency medical services staff and the Vernon police to present information about the treatment of patients with behavioral health conditions, the care that would be provided on the new unit and to answer any questions or speak to any concerns raised by those community partners. Renovations were also made to the inpatient behavioral health unit at MMH creating a twenty-one bed geriatric psychiatry unit which opened this past January. Those renovations also added approximately 1,000 square feet of dedicated program space for the six-bed inpatient adolescent unit at MMH. Additional access to behavioral health services was made at ECHN's Women's Center for Wellness where outpatient behavioral health counseling services were added at it South Windsor location.

A collaborative of community agencies has come together to form the Behavioral Health Community of Care Committee. ECHN and the Town of Manchester Social Services Department host the group. The purpose of this committee is to build and sustain a collaborative model of care that leverages community and competency-based supports and services effectively for behavioral health consumers in our community. The committee meets monthly from September through June and provides a local forum to understand, educate and coordinate the behavioral health care for patients within our community. ECHN behavioral health leadership, crisis services, Visiting Nurse and Health Services, Coordinated Regional Care representatives and Prospect's Independent Practice Association staff represent ECHN. Other member organizations include:

- Ambulance Service of Manchester
- Beacon Health Options
- Community Health Resources (CHR)
- Connecticut Community for Addition Recovery
- Fresh River Healthcare Center
- Genesis
- Hebrew Healthcare
- iCare
- Intercommunity Mental Health
- Manchester Area Conference of Churches
- Manchester Fire , Rescue and EMS
- Manchester Police
- National Healthcare

- New England Home Care
- Primary Care Physicians in the community
- Riverside Health and Rehabilitation
- Touchpoints of Manchester
- Town of Manchester Social Services
- Tri-Town Shelter services
- Unitarian Universalist Society
- Vernon Police
- Walden Behavioral Care

ECHN is aligned with CHR and CT DMHAS with the Zero Suicide Initiative and ECHN is a provider under the Garrett Lee Smith Grant to support suicide prevention and reduce youth suicide by enhancing suicide assessment and connections to care.

ECHN continues its partnership with the Manchester Police Department in the Heroin/Opioid Prevention & Education (H.O.P.E.) Initiative. ECHN's emergency providers work with police to enroll individuals with substance abuse into addiction programs. ECHN is represented on the Manchester Local Prevention Council, a DMHAS initiative for alcohol, tobacco and other drug abuse prevention. ECHN is also working with the Connecticut Community for Addition Recovery to assist persons with drug addiction. We were a sponsor and attended their annual walk to promote recovery at Bushnell Park in Hartford in September.

Cancer Care

ECHN nurse navigators at the Women's Center for Wellness promoted ECHN's participation in the Connecticut Choosing Wisely Collaborative (CCWC) which is a multi-stakeholder group that is committed to the widespread adoption of Choosing Wisely in Connecticut. The Choosing Wisely campaign is a national initiative sponsored by the American Board of Internal Medicine (ABIM) Foundation and Consumer Reports. CCWC promotes informed patient-provider communication to improve health care practice and prevent unnecessary care and costs. Nurse navigators are promoting the 5 Choosing Wisely Questions to help empower and engage patients in their overall health and understanding of medical procedures and potential prevention of disease progression. Some of the other community organizations also participating include Access Health CT, Community Health Center Association of CT, Community Health Network of Connecticut, Connecticut Business Group on Health, Connecticut Center for Primary Care, Connecticut Health Foundation, Donaghue Foundation, National Physicians Alliance, Office of the Comptroller of CT, Office of the Healthcare Advocate, Qualidigm and Universal Health Care Foundation.

Infant Health and Family Planning

ECHN's Family Development Center (FDC) continues its work to provide and improve access to prenatal and parenting education as one of the goals of the Health Plan. The FDC is organized with an Advisory Board that includes board members representing the Manchester Human Services Department, the Manchester School Readiness Council, the Manchester Youth Service Bureau, the Town of Manchester's Health Department, the Vernon Youth Services Bureau, Real Dads Forever, and community volunteers.

Access to Care

ECHN provides clinical experiences for health professionals from over forty-five educational institutions and continues to offer its Family Practice Graduate Medical Education Program which has twenty-seven residents in the program. The residents volunteer their time to participate in health fairs and screenings. They recently volunteered at the Little Manchester Road Race, health events at the Crossroads Community Cathedral in East Hartford and conducted health screenings at the Squire Village, a 379 unit subsidized housing complex in Manchester.

Eastern Connecticut Medical Professionals (ECMP) is the employed medical group of the Prospect CT Medical Foundation at ECHN. ECMP has hired thirteen new primary care physicians and Allied Health Professionals since June 2016 in an effort to expand community access to primary healthcare in Manchester, Vernon and surrounding towns.

In the regular discussions with leadership from our local communities, it was recognized that there are opportunities to better coordinate care with the Town of Manchester staff to the benefit of patients. To that end, ECHN hosted a meet and greet for Manchester social workers and human services staff and their ECHN counterparts. In Vernon, a meeting has been set with town leadership to discuss health initiatives to be offered at the new Vernon Senior Center.

Population Health Management

Condition 4 of the CON decision requires ECHN to identify the manner in which the next community needs study will complement the population health management objectives of PMH and the new hospitals. Since the acquisition of ECHN by PMH, considerable effort has been made to build the Coordinated Regional Care Model (CRC) at ECHN. It has actively engaged the payer community to secure contracts that include risk-based payments for the

lives attributed to ECHN providers. In addition, ECHN participates in a CMS Next Generation Accountable Care Organization, Prospect Northeast ACO.

CRC staff has made many contacts with community organizations as referrals are made for patients. This has been a daily effort in an attempt to not only connect patients to services, but also to help patients deal with the cost of healthcare while increasing the patient's education and foundation of knowledge relating to their conditions. The goal is to promote a healthier lifestyle and engage patients to be active participants in their health and well-being while also improving their overall experience with the health system.

The CRC and ACO staffs have implemented a robust inpatient and skilled nursing facility transition of care program. For patients admitted to an ECHN facility, a CRC care manager rounds daily with hospital care managers and hospital staff to share pertinent information from the Primary Care Physician (PCP) practice, meet with patients and family members to review the discharge plan, discuss PCP follow-up and to introduce a post-discharge contact person. A dedicated Transition of Care nurse reaches out to those patients who have a complex or a high-risk diagnosis. Referrals to a CRC nurse or social worker care manager are made based on patient's clinical or psychosocial needs. Additionally, community based primary care providers may make referrals to the CRC Care Management team to assist patients within the community who would benefit from additional care coordination, disease management support or social needs.

The CRC team has successfully developed a quality program that includes outreach to our patients with gaps in care by Quality Care Coordinators. CRC staff work closely with the Quality Committee of the ECHN Independent Practice Association and Prospect Provider Group to review trends, develop initiatives and increase patient adherence with obtaining needed healthcare services. In 2017, we saw an improvement in Quality Measure results for several key health plan partners.

The CRC care coordination staff has a primary role in connecting patients and their providers. The CRC social work staff assists patients with new referrals to mental health providers such as CHR, as well as many other psychiatric agencies and Diagnostic Assessment Centers. They assist with many social services including Department of Social Services cash assistance, food stamps, Protective Services for Elderly, referrals for homecare, local and state transportation, financial assistance working with all municipalities for energy assistance, renter's rebate, etc. The staff works in collaboration with the DeQuattro Cancer Center team on disease management/chronic care education, medication education that includes discussions with pharmacies, patients' inability to manage co-pay costs, caregiver assistance, and for support group referrals for patients and caregivers alike. They make

referrals to local durable medical equipment providers to secure lower cost options, such as donated and refurbished equipment, for individuals with limited income or whose insurances will not cover those purchases. The CRC staff also participates on the Manchester Community Service Council (MCSC), a local organization of community health and social services organizations, on a monthly basis for continued exposure, introduction and networking.

Prospect ECHN will continue to partner with other community organizations whose purpose and mission align with the goal of improving community health and wellness.

If you have any questions or need anything further, please feel free to contact me at (860) 533-3429.

Very truly yours,



Dennis P. McConville
Senior Vice President
Eastern Connecticut Health Network

cc: Ellen J. Shin, General Counsel, Prospect Medical Holdings, Inc.
Joyce A. Tichy, Senior Vice President and General Counsel, ECHN
Michael Collins, CEO, ECHN
Frank Saidara, Vice President, Corporate Development, Prospect Medical Holdings, Inc.
Garrison De Lee, Assistant General Counsel, Prospect Medical Holdings, Inc.